

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 16 July 2026 at 09.00 to 13.00

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	PAPER	TIME
1.	Chair's welcome and introduction	Information		09.00
2.	Apologies for absence	Information		
3.	Declarations of interest (pertaining to agenda)	Approval		
4.	Minutes of previous meeting <i>14th May 2026</i>	Approval	Yes	09.05
5.	Matters arising	Assurance		
6.	Questions from the public	Information		09.10
7.	Patient Story	Information		09.15
8.	Chair's report <i>Deborah Evans-Chair</i>	Information	Yes	09.25
9.	Chief Executive's Report <i>Kevin McNamara, Chief Executive</i>	Information	Yes	09.35
MATERNITY SERVICES				
10.	Maternity Services Regulatory Compliance Report (section 31 Notice Response) <i>Matt Holdaway, Chief Nurse & Director of Quality</i>	Assurance	Yes	09.50
11.	Perinatal Quality Oversight Model (Quarter 4) <i>Matt Holdaway, Chief Nurse & Director of Quality</i>			10.00
12.	Audit and Assurance Committee Report <i>Shawn Smith, Non-Executive Director</i>	Assurance	Yes	10.10
13.	Health and Safety Assurance Report <i>Kerry Rogers, Director of Integrated Governance</i>	Assurance	Yes	10.20
14.	Corporate Governance Report • Committee Effectiveness and Terms of Reference Review • Fit and Proper Person Requirements • Trust Seal <i>Kerry Rogers, Director of Integrated Governance</i>	Assurance	Yes	10.30
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
15.	People and Organisational Development Committee Report <i>Marie-Annick Gournet, Non-Executive Director</i>	Assurance	Yes	10.45
16.	Freedom to Speak Up Guardian Annual Report <i>Louisa Hopkins, Freedom to Speak Up Guardian</i>	Assurance	Yes	10.55
17.	Engagement and Involvement annual review <i>James Brown, Director of Engagement, Involvement and Communications</i>	Assurance	Yes	11.10

18.	NHS Staff Survey 2025: Assurance of Progress, Key Risks and Improvement Priorities <i>Deborah Tunnell, Deputy Director for People & OD</i>	Assurance	Yes	11.20
BREAK				
QUALITY AND PERFORMANCE				
19.	Quality and Performance Committee Report <i>Sam Foster, Non-Executive Director</i>	Assurance	Yes	11.40
20.	Integrated Performance Report <i>Al Sheward, Chief Operating Officer and Executive Director colleagues</i>	Assurance	Yes	11.50
21.	Quality Account <i>Matt Holdaway, Chief Nurse and Director of Quality (and Suzie Cro)</i>	Assurance	Yes	12.20
FINANCE				
22.	Finance and Resources Committee Report <i>John Noble, Non-Executive Director</i>	Assurance	Yes	12.30
23.	Any other business	Information		12.40
24.	Governor observations	Information		
25.	Date and time of next meeting: 10 September 2026 at 09.00 Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital	Information		

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 14 May 2026, 09:00 -12.30, Sandford Education Centre, Cheltenham General Hospital		
Present	Deborah Evans	Chair, Non-Executive Director
	Sam Foster	Non-Executive Director
	John Noble	Non-Executive Director
	Sally Moyle	Non-Executive Director
	Shawn Smith	Non-Executive Director
	Kaye Law-Fox	Gloucestershire Managed Services Chair/Associate Non-Executive
	Raj Kakar-Clayton	Associate Non-Executive
	Kevin McNamara	Chief Executive Officer
	Will Cleary-Gray	Director of Improvement and Delivery
	Matt Holdaway	Chief Nurse and Director of Quality
	Karen Johnson	Director of Finance
	Lee Pester*	Chief Digital Information Officer
	Mark Pietroni	Medical Director and Director of Safety
	Kerry Rogers*	Director of Integrated Governance
Attending	James Brown	Director of Engagement, Involvement and Communications
	Sarah Favell	Trust Secretary
	Deborah Tunnell	Deputy Director for People & Organisational Development
	Dr Ailsa McKinlay	Chief Resident
	Alexandra Mathews	Deputy Chief Operating Officer
Apologies	Al Sheward	Chief Operating Officer
	Vareta Bryan	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director (delayed)
Observers		
Governors	Andrea Holder, Mike Ellis, Emma Mawby, Ian Craw	
Public	Five	
Ref	Item	
1	Chair's welcome and introduction	
	Deborah Evans, Chair, opened the meeting, welcoming all members of the public and governors in attendance.	
2	Apologies for absence	
	Apologies were received from Vareta Bryan, Non-Executive Director and Al Sheward, Chief Operating Officer. Alex Matthews, Deputy Chief Operating Officer was welcomed in his stead.	
3	Declarations of interest	
	There were no declarations of interest in respect of agenda items.	
4	Minutes of previous meeting	
	The Board reviewed the minutes of the public board meeting held on 12 th March 2026.	
	RESOLVED: The Board APPROVED, as a true and accurate record, the minutes of the meeting held on 12 th March 2026.	

5	Matters arising
	There were no matters arising. The action log was reviewed with it being confirmed that a report on the management of complaints would be brought to the next full meeting (July). The action relating to the infographic within the IPR had been completed. Other items are within the relevant Committee workplan. It is intended the actions will be complete by the July board meeting.
6	Questions from the public
	Four questions had been submitted to the Board Meeting. One related to the governance arrangements for Subject Access Requests. It was agreed this would be responded to in writing, as it had been received outside process. It was confirmed that, in relation to such matters, Lee Pester, Chief Digital and Information Officer, was the relevant executive as Senior Information Risk Officer. Three questions had been received from representatives of Gloucestershire Maternity Action Group. These questions related to the postnatal pathway; in particular the risk assessment process, evidence base for decision making and the completion of an Equality Impact Assessment. A response was provided by Matt Holdaway, Chief Nurse as follows: <i>'The current postnatal care guideline was produced in May 2024. Since then, the only change has been a terminology update, earlier this year, replacing MEOWS (Modified Early Obstetric Warning Score) with MEWS (Modified Early Warning Score). Recent media reports suggested that the Trust had introduced further changes; however, this was not accurate. Recently, all community midwives have been reminded of the existing guidelines already in place, particularly in relation to who undertakes postnatal appointments within the community teams and the arrangements for women and babies who are suitable to be seen in a clinic setting. The first postnatal contact is always with a midwife, as is the discharge and handover to the health visitor. Midwives retain professional autonomy to determine the most appropriate form of postnatal contact based on the individual clinical and social needs of the family. This includes deciding whether an appointment should take place at home or in a clinic, whether additional appointments are needed, and whether contact is most appropriately undertaken by a midwife or by a maternity care assistant, where this is within the agreed pathway. As the pathway was not newly introduced, no separate standalone clinical risk assessment was undertaken in relation to the recent staff communication. All of our guidelines include an Equality Impact Assessment, which was completed when the guideline was produced in 2024. An Equality Impact Assessment has been completed for the Postnatal Care Guideline (a link is included within the guideline). The guideline promotes individualised, holistic postnatal care and applies equitably across all protected characteristics. Its focus on personalised care planning, continuity, safeguarding, mental health and social wellbeing supports inclusive and responsive care delivery. Potential equality considerations relate to reliance on digital systems and telephone contacts, which may present barriers for some individuals (for example, people with disabilities, limited English proficiency, or who are digitally excluded). These risks are mitigated through professional judgement, flexibility in care pathways, and adapting communication methods to meet individual needs.'</i>

	<i>The guideline uses inclusive language, avoids assumptions about family structure or identity, and enables care to be tailored to cultural, religious and social circumstances. No adverse equality impacts have been identified.</i> <i>Overall, the guideline is assessed as having a neutral to positive equality impact, with proportionate mitigations in place and opportunities to continue strengthening alignment with health inequalities priorities through implementation and monitoring.</i> <i>The approach outlined in the guideline is consistent with national guidance. NICE postnatal care guideline NG194 states that postnatal care should be responsive to the woman's needs and preferences; information and care should be individualised; and the first postnatal midwife contact should take place within 36 hours after transfer of care and is usually at home, depending on the woman's circumstances and preferences. It does not require all subsequent postnatal contacts to be home-based or undertaken only by a midwife.</i> <i>It is also consistent with NHS England's Improving postnatal care toolkit, which describes postnatal care as needing to be personalised, co-ordinated and delivered across community settings, with women and families supported to make informed decisions about their care. In addition, NHS England's Maternity support worker competency, education and career development framework recognises maternity care assistants and maternity support workers as part of the maternity workforce, able to undertake delegated care within agreed protocols, training, supervision and scope of practice, as set out in our postnatal guideline.</i> <i>The Trust's current guideline supports an individualised approach and states that the midwife and woman or birthing person should discuss and agree a plan of care, which is reviewed at each contact, and that the date, time and venue for the next contact should be agreed. The recent communication to staff therefore reinforced the existing guideline and operational process; it did not introduce a new or revised postnatal pathway.</i> <i>In summary, there has been no substantive recent change to the postnatal pathway. The recent communication was a reminder of existing arrangements, including the expectation that midwives continue to use their professional judgement to determine whether postnatal care is best provided at home or in clinic, and whether it should be delivered by a midwife or maternity care assistant, according to the needs of the woman/birthing person and baby.'</i> It was confirmed that the response would be entered into the minutes and a written response would be provided.
7	Staff Story: A briefing on the 'Improving Resident Doctors' working lives' plan <i>Mark Pietroni, Medical Director and Dr Ailsa McKinlay, Chief Resident</i>
	Mark Pietroni, Medical Director, introduced a presentation provided by Dr McKinlay, Chief Resident on the work being done to implement the NHS England 20-point plan to improve Resident Doctors' working lives. The plan focused on measures to improve the working environment and work schedules, reduce payroll errors, improve consistency in mandatory training, address course related expenses and reduce the impact of rotations/moving employers. Mark Pietroni spoke of the need to do better to support this cohort of staff and identified a number of key initiatives in progress, including the full implementation of Health Rota which should make a real difference to workload and leave planning. Other practical issues being

	explored within the Trust were access to transport outside core hours and access to hot food options at night. Kevin McNamara, Chief Executive, acknowledged the contribution of Resident Doctors and the particular issues that cohort of staff faced and confirmed that the Trust Leadership Team was progressing the work on the out-of-hours food offering. He observed that although some of the issues and improvements were unique to Resident Doctors, a significant proportion were applicable to all staff groups, in particular the importance of reducing or avoiding payroll errors. Deborah Evans, Chair, commented on a prior improvement programme focused on hot food at night and ended the segment by thanking the Trust's Resident Doctors for their contribution to the Trust and Dr McKinlay for the informative presentation. RESOLVED: The Board NOTED the report for information.
8	Chair's Report <i>Deborah Evans, Chair</i>
	Deborah Evans, Chair, presented her report (taking the report as read) and focused on the role and future role of the Trust's governors, in light of the King's Speech in Parliament the previous day and confirmation that the governance structures of Foundation Trusts would fundamentally change, with the planned abolition of the Council of Governors. She acknowledged the contribution of the governors and the importance of their work as representatives of the Trust's community, both public and staff. She acknowledged the uncertainty created by the transition to new governance structures and confirmed that she was working with other regional chairs to address issues collectively. Deborah Evans spoke of the changing role of the Integrated Care Boards as the system moved into a 'cluster' arrangement with Bristol, North Somerset and South Gloucestershire. She confirmed that the newly appointed Regional Chair, Dame Gill Morgan, would be visiting the Trust in the near future. Finally, she commented positively on the phlebotomists' return to work following a period of industrial action, with the team benefiting from the support of Julie Highfield, Head of Psychology, during the period of re-integration. RESOLVED: The Board NOTED the report for information
9	Chief Executive's Report <i>Kevin McNamara, Chief Executive</i>
	Kevin McNamara, Chief Executive, presented his report to the Board, taking it as read but highlighting the continued focus on maternity services, in particular the ongoing suspension of the home birth service and the recent media attention on Stroud based maternity services. He confirmed that, contrary to some media commentary, there were no plans to close the service. There were proposals, as part of the work to re-establish community/home-birth services countywide, as to how the service would be provided and those proposals required a period

	of staff consultation. He confirmed that the key focus was on providing choice to patients in the context of a safe and sustainable service. He noted the significant milestone achieved in the development of the Gloucestershire Cancer Centre with the planning application submitted at the end of March 2026. It was confirmed that the generosity of donors had meant that the Appeal had reached £9.7m of the £17.5m target which was a real achievement. It was acknowledged that the initial building works were creating challenges for other clinical services which were being worked through. The recent industrial action by Resident Doctor staff was noted and whilst the numbers of those on strike were reduced and the impact on clinical services was less, there was still a financial impact, with the Trust having to fund alternative cover from its budget. Kevin McNamara highlighted the recent agreement of a Memorandum of Understanding with NHS Gloucestershire Integrated Care Board, Gloucestershire Health and Care and the GP collaborative to deliver on the transformation priorities outlined in the five-year strategic commissioning plan. A report would be brought to a future board meeting, but he highlighted one of the principal areas of focus would be frailty, with its impact on patients, carers and local resources. The focus on 'Digital First' as a strategic aim of the Trust was explored, with reference to the upgrade in April of the Trust's Electronic Patient Record, which went reasonably well with a system down time of approximately 14 hours and effective contingency plans in place. Finally, it was confirmed that the Care Quality Commission report for the July 2025 inspection of dialysis services managed by Diaverum in partnership with the Trust, had been received. The Service had been rated as 'Good'. Kevin McNamara commented on the number of Care Quality Commission inspection reports which remained outstanding a significant time after the initial inspections. It was recognised that those delays impacted on both the driving of improvement but also the morale of staff within a service. This was the subject of representations, both to the Care Quality Commission and centrally, but it was acknowledged that there was no quick solution as this was a national issue impacting several trusts. RESOLVED: The Board NOTED the report for information.
10	Maternity Services Regulatory Compliance Report (section 31 Notice) <i>Matt Holdaway, Chief Nurse and Director of Quality</i>
	Matt Holdaway, Chief Nurse, presented this report, which he confirmed was a standing item before the Board, a key element of the continued focus on maternity services. The report provided an update on progress/compliance against the s31 Enforcement Notice issued in May 2024. The report was taken as read with highlights as follows: The Trust had self-assessed all eight conditions, imposed by the Care Quality Committee, as having been fully met and sustainably embedded. It was also confirmed that, as at early May, the enhanced oversight provided by the Integrated Care System, through the Quality Improvement Group, had been stood down. There was a discussion about the decision to invite the Care Quality Commission to re-inspect against the eight conditions. Matt Holdaway advised that it was not considered appropriate to

	do so until the Trust had received the inspection report from the inspection of maternity services which took place in September 2025. Until that re-inspection had taken place and the conditions had been removed the compliance report would continue to be reported to Board, with the Quality and Performance Committee receiving regular assurance reports. RESOLVED: The Board NOTED the content of this report for assurance, in particular: • NOTED the progress set out in this report and the Trust's assessment that all eight CQC Section 31 conditions have been met, supported by evidence of delivery, governance and oversight, and NOTED the key current issues highlighted including: (i) the outstanding CQC draft inspection report (September 2025) which is required to enable submission of the formal condition-removal request; (ii) a single-month dip in the hourly peer review ("fresh eyes") metric; (iii) implementation of the national MEWS (go-live 5 May 2026) with interim assurance arrangements; and (iv) system-wide improvement actions for pre-booking thromboprophylaxis/VTE standards (primary care/community pathway). • RECEIVED assurance that the recent variance in hourly peer review ("fresh eyes") for fetal monitoring (75% against a target of 85%, small sample) has been identified through routine monitoring, reviewed at the Intrapartum Forum and is subject to tracked improvement actions; further assurance would be provided through next month's data, with escalation through the Perinatal Oversight and Assurance Meeting if thresholds are not met or variance is sustained. • NOTED that enhanced external oversight remained in place (including ICB Enhanced Oversight Group, NHS England MNIST support and participation in the Independent National Maternity Investigation) and agree that any material change in regulatory position, risk profile or delivery trajectory would be escalated to the Board via established reporting routes. • SUPPORTED the Trust's intention to consider submission of a formal request to the Care Quality Commission for removal of the Section 31 conditions, subject to receipt and consideration of the final CQC inspection report. • AGREED that ongoing oversight of maternity safety, regulatory compliance and the associated strategic risk (SR1) will continue through established Trust governance and assurance mechanisms. • SUPPORTED continued engagement with the Care Quality Commission regarding the Trust's compliance with the Section 31 conditions,
11	Perinatal Quality Oversight Report (as at March 2026) <i>Matt Holdaway, Chief Nurse & Director of Quality</i>
	Matt Holdaway, Chief Nurse, presented the report, taking it as read. Before presenting the narrative within the report Matt Holdaway acknowledged and responded to recent media reports focusing on the Stroud Maternity Unit. He advised that he believed the recent level of media commentary was because of recently commenced consultations with staff regarding the implementation of a proposed transformation programme. He confirmed that there were no plans to close the site and that it was important that was made clear because of the potential impact on patients who were making decisions regarding their birth experience and would be concerned by inaccurate social media. It was important that patients and families were correctly informed as to the options available to them and he

assured the board that the Service remained committed to midwife led care with the aim of re-establishing good, safe and sustainable choice.

He also confirmed that over the past few months recruitment to key leadership roles within the Service had been achieved with appointments to the Deputy Director of Midwifery, Consultant Midwife and Director of Midwifery roles, with start dates in the next few months.

Returning to the report before the Board, Matt Holdaway confirmed that the report was designed to ensure compliance with Maternity Incentive Scheme requirements.

Referencing the Alert section within the report the following was highlighted:

- Workforce items of note were the recruitment to two of the four consultant obstetrician posts and the achievement of a ninety percent compliance rate for newborn life support from a lower baseline of thirty percent.
- He confirmed that there continued to be a focus on maternity triage estates with progress being made against the Action Plan and a project manager allocated.
- He highlighted the backlog in external Perinatal Maternity Mortality Reviews and confirmed that the outstanding were three reviews that required completion by external Trusts in relation to the care provided by those Trusts.

Also highlighted was the work underway with the Maternity and Neonatal Voices partnership, which was now embedded across workstreams to support co-produced improvements, ensuring the voice of service users and families across the community was heard.

Deborah Evans, Chair, commented on the item within the Alert section relating to the suspension of the homebirth service and sought clarity as to the purpose of the recommendation within the report as this was a matter which the Board already had significant oversight over, both through direct reports to the Board and via assurance provided to Quality and Performance Committee. It was confirmed that there was no requirement for specific action on the part of the board but that it was felt important that the Board was formally informed of the extension to the suspension period, whilst work continued to re-establish safe services.

Kevin McNamara commented on the quality improvement projects being undertaken (section 2.13) and the particular importance of the obstetric anal sphincter injury project for members of Black and Minority Ethnic communities, within the wider context of increasing the profile and visibility of maternity issues relevant to this community.

Deborah Evans, Chair, requested a briefing note to be brought to Quality and Performance Committee on the issue identified at paragraph 3.36 from the March 2026 MBRRACE-UK benchmarking report. Matt Holdaway confirmed that the report was being considered through the maternity governance processes and would be reported to Quality and Performance Committee.

John Noble, Non-Executive Director, commented on the format and size of the report. It was confirmed that the report complied with the national reporting model but would evolve over time, as the report and surrounding governance processes became embedded. It was

	expected that any duplication would reduce. It was recognised that the challenge came from the fact that the Maternity Incentive Scheme requirements were not necessarily aligned with the current national maternity focus. It was agreed that a flowchart of the various national reporting requirements would be helpful for the non-executive members of the Board. The impact of the volume and overlap of various reporting requirements had been raised with Baroness Amos during her recent visit. RESOLVED: • The Board NOTED the Perinatal Quality Oversight Report assurance position, including the key risks and exceptions escalated in this report. • The Board NOTED the Integrated Care Board decision on funding for safety-critical workforce posts (including four whole time equivalent consultant obstetrician posts). • The Board NOTED the request for continued Board-level oversight of the Newborn Life Support Training recovery plan until competence assurance is restored, with progress monitored through the Perinatal Quality Oversight Meeting governance and reported by exception. • The Board REQUESTED assurance on the maternity triage estates and decant programme (including interim risk controls) and continued oversight of delivery through the established governance route. • The Board NOTED the current service suspensions (including the county-wide homebirth pathway) and request ongoing oversight of the restoration plan and any impact on access, experience and outcomes. • The Board NOTED the reliance on external Trust-led Perinatal Mortality Review Tool reviews and backlogs as a risk to timely learning and assurance, and requested continued escalation and tracking by exception until resolved
12	Case for Change: Maternity Services Report <i>Matt Holdaway, Chief Nurse & Director of Quality</i> Matt Holdaway presented a summary of the published Case for Change for Gloucestershire NHS Maternity Services (completed in March 2026) and advised that this was being shared for discussion and should not be considered as a full options appraisal. It was provided as an evidence base to inform decisions as to the evolution of the county's maternity services He confirmed that the key drivers for change were; • rising clinical complexity and changing patterns of care, • inequalities in access, experience and outcomes linked to deprivation, ethnicity and inclusion health factors which require a targeted approach; • variable experience of consistent care; and • the financial realities within the NHS, with various priorities competing for finite resources. It was recognised that the service needed to be provided differently, more aligned to the patient and communities requirements, and this document was intended to provide an evidence base to inform the Trust's improvement work, its approach to governance and set out the structure for the next phase of engagement and co-design of services would be undertaken. The Trust would be working closely with NHS Gloucestershire Integrated Care Board, Maternity and Neonatal Voices Partnership, the Local Authority and relevant voluntary sector partners in that re-design process.

It was confirmed that the report would also be considered by Gloucestershire County Council's Health Oversight & Scrutiny Committee. Deborah Evans, Chair, confirmed that the Trust would fully contribute to those discussions, supporting the Integrated Care Board in their decision making and, if public consultation was required, fully engaging with the process being led by the Integrated Care Board.

Kevin McNamara, Chief Executive, commented that it would be for the Integrated Care Board to identify the commissioning decisions based on health outcomes and for the providers to identify how it was going to be provided. It was acknowledged that there was the potential for tension between what the commissioners will need to fund and what the Trust, as a provider, will need to provide. Engagement in the design of services would be key with a focus on the service co-design being clinically led and evidence based, with community voices being heard.

Mark Pietroni, Medical Director, welcomed the document as an opportunity for a clinically led discussion involving both senior obstetricians and midwives to ensure a joined-up service provision.

Will Cleary-Gray commented on the extent of the consultation which led to the Case for Change document and whether the Trust could be confident that it heard from the community impacted by the re-design of the service. It was confirmed that the consultation had been led by the Integrated Care Board with a significant amount of stakeholder engagement undertaken. He also commented on the focus on reducing health inequalities and Matt Holdaway confirmed that a significant proportion of staff had undertaken the Black Maternity Matters training which was prompting an inclusive approach to service provision and co-design. The continuing work of the Trust's Health Inequalities team would be vital in this, through the provision of strong data on service impact upon different community groups.

RESOLVED:

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

	• DISCUSSED the implications for the Trust (quality, safety, workforce, capacity and financial sustainability) and the level of assurance and ongoing oversight required as the system progressed through co-design and options development • NOTED the proposed next steps: continued engagement with women, families, staff and stakeholders (including MNVP), alignment with the maternity health needs assessment, and development of potential future service options for formal consideration through system and provider governance routes.
13	Audit and Assurance Committee Report <i>Shawn Smith, Non-Executive Director</i>
	Shawn Smith, Committee Chair, presented the report following the April meeting of the Committee, with much of the report being taken as read. He confirmed that the Committee had considered both the Going Concern Report and the draft Annual Governance Statement for inclusion within the Annual Report for 2025-26 with it being recognised that financial sustainability, primarily the reliance on non-recurrent savings, was likely to remain a significant control weakness for the purposes of the Audit, although it was noted there was a clear plan to address this within the Medium-Term plan. RESOLVED: The Board NOTED the report as assurance.
14	Integrated Governance Report – Legal, Regulatory and Policy Update <i>Kerry Rogers, Director of Integrated Governance</i>
	Kerry Rogers, Director of Integrated Governance, presented the report, providing an update on recent regulatory, compliance and policy developments relevant to the Trust or where awareness of the relevant issue was necessary to support effective board oversight. Included within the report, as an addendum, was a 'True for Us' section, intended to surface learning from external failures, inspections or regulatory insight. Particular highlights were the recently published investigation report into insulin safety in in-patient settings, recent analysis by DAC Beachcrofts of the national picture relating to HM Coroner's 'Prevention of Future Deaths' and Care Quality Commission briefings exploring the implications of the national reform proposals that would remove the statutory requirement for Foundation Trusts to maintain Councils of Governors. In discussion, it was highlighted that the Head of Legal would be providing a report on Inquests, with a focus on 'Prevention of Future Deaths, to the Trust Leadership Team (in August). It was acknowledged that many of the clinical issues identified within the report were in the areas of focus for the Quality and Performance Committee; front door pressures, corridor care within Emergency Departments and mental health services in an acute setting. The report was welcomed by the Board as a useful prompt to consider the 'true for us' question and to prompt both board and board committees to be curious in seeking relevant assurance. It was noted that the Report was reviewed at the meetings of the Committee Chairs as part of workplan reviews. RESOLVED: 1. NOTED the content of this report 2. SUPPORTED Board Committee Chairs and the Corporate Governance Team to ensure the themes and risk areas highlighted are reflected, where appropriate, in Committee agendas,

	workplans and deep-dive activity, with a particular focus on areas where assurance may benefit from further testing or visibility
15	Risk Report <i>Kerry Rogers, Director of Integrated Governance</i> The report was presented by Kerry Rogers, Director of Integrated Governance, who highlighted that during the reporting period overall risk exposure had reduced modestly, reflecting both sustained mitigation activity and a more proportionate application of the revised Trust risk appetite. The Trust Risk Register continued to be dominated by systemic risks, particularly relating to patient safety/operational delivery, workforce sustainability, estates risk and digital resilience but the Board was assured that the Trust's risk management framework remained effective and embedded. The Board also received an update on the embedding of the refreshed Board Assurance Framework, aligned to the Trust's strategic aims. Discussions focused on clinical and operational risks, in particular corridor care use within the Emergency Department, noting that it had not been required in the in-patient ward environment for an extended period. In response to a question from a non-executive colleague Matt Holdaway, Chief Nurse, gave assurance that corridor care was only utilised post clinical assessment and was only used for the most stable patients with close monitoring. It was recognised that the use of corridor care was not acceptable and there was an improvement plan in place, including the use of additional temporary space. Kevin McNamara, Chief Executive and executive colleagues were clear that the use of corridor care would not and should not be normalised RESOLVED: The Board: • NOTED the current risk profile and assured itself that this reflects the organisational risk, indicating the recently refreshed Risk Appetite was suitable and sufficient • NOTED the current level of assurance and areas of improvement • SUPPORTED continued executive focus on strengthening accountability and assurance depth, particularly in the management of overdue actions, persistent high risks, and policy compliance • AGREED the current position of the Board Assurance Framework, including the articulation of principal strategic risks, and support the continued strengthening of assurance arrangements.
16	Annual Provider Licence Requirements <i>Kerry Rogers, Director of Integrated Governance</i> The Board received the annual review of provider licence compliance and were advised that appropriate arrangements remained in place to support continued compliance with licence obligations. Compliance with the licence was routinely monitored through the Single Oversight Framework with segmentation ratings allocated by NHS England. For the relevant period, the Trust was primarily rated 2, reflecting that minimal support or intervention was required. The Trust was required to self-certify its compliance with the following conditions after the

	financial year-end (2025/2026): 1.3.1. Condition G3: Fit and Proper Persons as Governors and Directors 1.3.2. Condition G5: Systems for Compliance with Provider Licence conditions. 1.3.3. NHS 1 & 2: Good governance arrangements 1.3.4. Condition CoS7: Provider has reasonable expectation that required resources will be available to deliver the designated services. The report confirmed that the Trust complied with the relevant sections, detailing evidence relied upon to support this assurance. RESOLVED: The Board NOTED the report and confirmed assurance on compliance.
17	Quality and Performance Committee Report <i>Sam Foster, Non-Executive Director</i>
	Sam Foster, Committee Chair, presented the report detailing the assurance received by the Committee at its meetings in March and April 2026. It was confirmed that the 'deep dive' into surgery, culminating in an extensive visit across surgical specialities and critical care, based at the Cheltenham site, had gone very well with an opportunity for the Committee to hear directly from staff within the Service about the patient services they provided and the challenges they faced. The Board heard that maternity services, urgent and emergency care performance, patient experience and strategic risks remained key areas of focus. Particular attention had been given to deep-dive reviews and triangulation of assurance through committee visits and frontline engagement. Matters highlighted to the Board included the continued fragility of the maternity workforce, evidenced by high sickness rates and reduced appraisal completion. It was also highlighted that the programme to resolve the suspension of the home birth service remained a focus for the Committee. Positive assurance was provided in respect of both the debrief on Winter plan delivery, including ambulance handover performance and the completion of the centralisation of acute medical services. It was noted that complaints performance remained an area of concern with a planned focus at June's Committee meeting, together with the anticipated receipt of a planned internal audit report. Matt Holdaway, Chief Nurse, provided the Board with a brief update regarding issues arising with the Trust's Central Sterile Services Department, primarily relating to equipment for the Trauma and Orthopaedic surgical service. It was confirmed that the Director and Deputy Director of Infection Prevention & Control were supporting the department with an action plan to address the areas of concern. Kaye Law-Fox, Chair of Gloucestershire Managed Services, confirmed that the team was working closely with the Director of Infection Prevention and Control with the GMS Board receiving regular updates.

	Sam Foster, Non-Executive Director, closed her report by referencing the never events recorded, primarily within the trauma and orthopaedic surgical service. Mark Pietroni, Medical Director, provided assurance as to the work of the task and finish group and confirmed it was an area of focus for the newly appointed speciality director. He confirmed that there was a focus on embedding the learning from these incidents, with oversight provided by the Safety and Experience Review Group. It was commented that there would be value in having a future board development session from the patient safety team by way of a thematic review of incidents, including never events. RESOLVED: The Board NOTED the report for assurance.
18	Integrated Performance Report <i>Alex Matthews, Deputy Chief Operating Officer, Matt Holdaway – Chief Nurse. Mark Pietroni – Medical Director. Deborah Tunnell – Deputy Chief People Officer, Karen Johnson – Director of Finance</i>
	The Board received the Integrated Performance Report and reviewed quality, operational, workforce and financial indicators and discussed actions underway or planned to improve performance and productivity. Areas of focus are set out below. Performance Alex Matthews, Deputy Chief Operating Officer, presented the performance section of the Integrated Performance Report for March 2026 <u>Urgent and Emergency Care</u> Urgent Care performance continued to improve with four-hour performance improving to 64.6% in March, compared with 62.8% in February. This was despite increased attendance during March. There were improvements in the admitted pathway, but non-admitted performance remained variable, particularly overnight. Ambulance handover performance remained well controlled, with average handovers reducing to 20 minutes in March. The focus continued to be on 12 hours wait performance with a planned 'improvement week' to focus on delays within the non-admitted pathway <u>RTT (referral to treatment) (Standard 85%)</u> Planned care continued to stabilise with RTT performance improving to 74.3% in March (71.7% February). This was largely driven by a focus on long-wait recovery <u>Diagnostics</u> Diagnostic performance remained broadly flat during February/March. Notable in-month improvements were seen in Cystoscopy, Colonoscopy and CT but challenges remained with deterioration in non-obstetric ultrasound. Overall waiting lists had increased with breaches increasing by 159, indicating capacity remained insufficient to meet demand. The Health

Inequalities Group were monitoring the impact of the longer waits on groups including patients with Learning Disabilities and the Armed Forces Covenant.

Cancer

Performance remained fragile, impacted by known capacity and pathway constraints with 62-day performance remaining below the national standard. The 28-day Faster Day Standard improved to 75.9% (unvalidated), driven primarily by recovery within breast services but overall, April performance was expected to present a delivery risk against national standards.

Quality and Safety Metrics

Matt Holdaway, Chief Nurse and Director of Quality, highlighted that overall the Friends & Family Test figures remained positive but there was a significant difference in scores between the Gloucester and Cheltenham Emergency departments which was being monitored but was recognised to be a likely consequence of the demand placed on the Gloucester Hospital as the primary Emergency Department overnight.

He confirmed that, whilst there had been a spike in C. difficile cases the Trust had finished the year (March) below the annual C. difficile threshold, which was a positive. Areas of concern were general ward cleanliness and estates condition, but actions were in place. It was noted falls levels remained low and it was acknowledged that this was a sensitive indicator of nursing capacity/staffing levels.

The declining performance within the Complaints team was noted and primarily attributed to workforce and leadership gaps with several key roles vacant at a time of increased volume. There was increased focus on divisional oversight of complaints within Quality of Care meetings as part of the new strategic focus and it was hoped this direct ownership would support improved performance and early resolution of complaints. Mark Pietroni, Medical Director, confirmed rigorous oversight with weekly executive-led meetings with the complaints team, focused on backlog improvement

Use of Resources/Finance metrics

Karen Johnson, Director of Finance, provided an update on financial performance as at Month 12 with revenue at £4.9m favourable to planned breakeven position. Areas of concern continued to be agency spend, which was £2m higher than NHS England target and bank spend £8m off target. The financial sustainability programme was £7.3m adverse to plan. It was noted that the Trust was reporting a surplus internally, but it was important to ensure this was communicated to staff appropriately as whilst it was achieved through effective management it was also a result of additional funding from Gloucestershire Integrated Care Board and NHS England.

Month 1 position was reported as being in line with plan but the focus must remain on achieving recurrent efficiencies through a transformation programme.

People

Deborah Tunnell, Deputy Director for People provided an update on the current workforce issues. She confirmed the focus remained on areas of under-performance; sickness, appraisals and use of bank and agency staff. Sickness rates and causes was the focus of a paper to the Trust Leadership Team with the intention of better understanding hotspots and a

	programme of targeted work. Agency spend remained high within medical workforce, particularly Emergency Department and Frailty but the division was working through exit plans for high cost agency staff. RESOLVED; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
19	Nursing Safer Staffing Annual Report <i>Matt Holdaway, Chief Nurse</i> Matt Holdaway, Chief Nurse, presented the Annual Nursing Safer Staffing Report, noting that it had been considered and approved by the Quality and Performance Committee. The presentation provided a summary of the progress since 2022, with a shift towards a robust data-led approach to staffing levels, rota design and the deployment of staff. Significant improvements in vacancy rates and turnover were noted, positively benchmarked against national data as well as good performance against 'soft' indicators including staff survey and CQC inpatient survey results. This was also reflected through positive clinical outcomes; reduced fall rates, reduced infection rates and reduced hospital acquired pressure ulcer rates. These improvements are also demonstrated in the financial measures with real terms reduction of bank and agency of 47% since 2022/23 and a decreased nursing & midwifery bill of 4.2% in real terms. Performance was overall strong with a small number of services carrying localised risks, primarily in areas of high acuity: Emergency Department, paediatrics and critical care but these were being addressed at a divisional level. Karen Johnson, Director of Finance, acknowledged the achievement in reducing nursing agency spend which was work led by the divisional senior nursing teams. John Noble, Non-Executive Director, asked about the impact on student nurses. It was acknowledged that it was getting harder to place graduating nurses into employed roles but there were programmes in place and last year all students had been placed once qualified. Deborah Evans, Chair, proposed that the Board receive a similar report for other staff groups (medical/non-clinical/AHP), via People and Organisational Development Committee (six monthly to Committee and annually to Board). Kevin McNamara concurred, noting the Trust's significant medical agency spend. This would be picked up by the Executive Team. Mark Pietroni, Medical Director, commented that there had been a significant reduction in long-term medical locums and that those that remained were in shortage services. ACTION. RESOLVED: 1. NOTED and agreed the recommendations in the report, especially the following: • Medicine divisional leadership team to optimise nurse-to-patient ratios in older adult wards by re-aligning establishment from wards with consistent Care Hours per Patient Day (CHpPD) above the demand.

	• Surgery divisional leadership team, to re-align establishments in surgical wards where there has been consistent Care Hours per Patient Day (CHpPD) above the demand. • PAUSED recruitment in the areas identified as having higher Care Hours per Patient Day (CHpPD) than demand whilst plans to develop. 2. NOTED the positive progress on nurse staffing since 2022. 3. NOTED a commitment to align nursing establishments to demand.
20	People and Organisational Development Committee Report <i>Marie-Annick Gournet, Non-Executive Director</i>
	In the absence of the Committee Chair this report was summarised by Deborah Tunnell, Deputy Chief People Officer. Items that were flagged within the report included the identified inconsistencies in consultant recruitment processes, with a risk of bias in shortlisting and informal pre-interview engagement, with not all candidates made aware of the appropriateness of pre-interview engagement. This is the subject of continued targeted work. Also flagged was the emerging risk to workforce because of recent changes to government visa policies, largely affecting dependants of Trust employees, which in turn made it challenging for Trust employees to remain. RESOLVED: The Board NOTED the report for assurance.
21	Finance and Resource Committee Report <i>John Noble, Non-Executive Director</i>
	John Noble presented the Committee report with the Board receiving assurance regarding financial sustainability, capital programme oversight, productivity initiatives and estate management. Discussion reflected on the financial challenges facing the NHS and the importance of transforming services whilst maintaining quality and safety. Items specifically flagged to the Board were the Committee's concerns regarding the timely and effective implementation of the Finance System, noting the significant milestones which were in the control of the supplier. It was confirmed that a decision whether to proceed would be taken later in the financial year. RESOLVED: The Board NOTED the report for assurance.
23	Any other business
	There was no other business before the Board.
24	Governor observations
	Andrea Holder, Lead Governor, commented positively on a recent visit to the Stroud Maternity Unit but observed that staff were feeling anxious about the proposed service changes and she noted that it would be important to ensure that staff felt heard in the planned consultation exercise. She also commented on the proposed NHS Bill and the implications for the statutory governor role and the importance of ensuring the public and patient voice was still heard, particularly as the Trust moved into a larger cluster arrangement.
Close: 12:30	

Date and time of next meeting: 16th July 2026, 09:00, Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

ACTIONS/DECISIONS			
Item	Action	Lead / Due Date	Update
26/Jan Item 16	A report to PODC on violence and aggression against staff, looking at the effectiveness of the Challenging Behaviour Panel generally and with a specific focus on issues relating to Equality, Diversity and Inclusion (hate crime incidents)	Director for People and OD/PODC	July 2026 board Complete
26/Jan Item 16 & 26/Mar Item 16	A report providing assurance on the management of complaints (long-term delayed responses) to QPC. To include details of workload/capacity of team	Medical Director	April 2026 QPC Complete – June QPC
26/Jan Item 16	A report on Duty of Candour compliance to be brought to QPC	Medical Director	April 2026 Complete – June QPC
26/Jan Item 16	A report on the update of employee support programmes/psychological services by staff of sick for mental health reasons	Director for People & OD	April PODC meeting 2026 Complete
26/Jan Item 18	A report to PODC on how to capture the outputs and value from the additional investment in staff networks and additional EDI initiatives	Director for People & OD	April PODC 2026 Complete
26/Mar Item 7	Medical Director/Chief Nurse to review patient story with relevant Services to agree any improvement actions	Medical Director/Chief Nurse	May 2026 Board
26/Mar Item 16	Update to QPC on use of corridor care within Emergency Department (GRH)	Chief Operating Officer/Chief Nurse	By May 2026 QPC Complete – June QPC
26/Mar	Freedom to Speak Up Guardian Annual Report to include section on sexual charter work within the Trust	Freedom to Speak Up Guardian	July 2026 Complete
26/May	Executives to consider bringing a report equivalent to the Nursing Safer Staffing Report for non-nursing staff groups to People and Organisational Development Committee (6 monthly) and Board (annually). Initial focus to be on medical workforce	Medical Director/Chief Nurse/Chief People Officer	November 2026

Report to Board of Directors

Date of Meeting	16 July 2026
Report title	Chairs report to July board
Sponsoring Director/Author	Deborah Evans, Trust Chair

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

Executive Summary	
The purpose of this report is to provide information about my activities as Chair of this Trust since our May 2026 Board.	
Previously considered by	N/A

Recommendations:
The board are asked to NOTE the report.

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



Main Report

1. Purpose

- The purpose of this report is to provide information about my activities as Chair of this Trust since our May 2026 Board.

2. Visits

- Since the beginning of this calendar year, our Quality and Performance Committee has changed its programme to hold 6 business meetings a year interspersed with 4 “deep dives” to allow executives and on executives to understand specific areas and issues in more detail. Most recently this has included a presentation from and visit to the Frailty services at Gloucestershire Royal Hospital.
- Volunteers long service awards – on Thursday 11 May we had our volunteers long service awards evening. This is always a moving occasion where we witness and hear the stories of local people who have been volunteering with us for many years – on this occasion it was a total of 460! The longest serving individual has been supporting the Trust for 35 years. We also heard from a colleague, Ade, who has come to Gloucestershire from Nigeria to do a Master’s Degree and to give something back is volunteering on wards at Cheltenham General. I always enjoy meeting volunteers and I have come away with a list of people and places to visit. Thanks are due to our Charity for supporting this event financially.
- Health Overview and Scrutiny Committee. In the company of executive colleagues, I am a regular attender at Health Overview and Scrutiny committee where local authority councillors understand our perspectives and hold us to account. On this occasion, the main focus for GHFT was the Case for Change in Maternity Services.

3. Relationships with Bristol, North Somerset, South Gloucestershire and Gloucestershire ICB and South West Region.

- Since our last Board meeting, I have had 1:1s with Jeff Farrar, chair BNSSGG ICB, Jane Cummings link non-executive from Gloucestershire ICB, Ingrid Barker, chair Bristol Trusts group, and Graham Russell, chair Gloucestershire Health and Care. We have also held the first BNSSGG chairs meeting which I am following up with visits to those chairs I haven’t worked with previously.
- I have had meetings with Sue Doheny, interim South West Regional Director, Jill Crook, Regional Nurse, Dame Gill Morgan, chair NHS South West and two Regional Chairs meeting

The purpose of all of these meetings is to represent our Trust’s interests, to identify opportunities to collaborate with colleagues and to understand their issues and concerns.

4. Non-Executive Director items

Welcome back to Jaki Meekings Davis our chair of Finance and Resources who has returned to us after a short career break.

I have spent much of the last two months on our annual exercise of Non-Executive Director appraisals. I value all the feedback I have received and it is very valuable to Non-Executive Directors in supporting their development.

I am working with on NHS England on creating a twelve-month NExT Director placement for colleagues who work in senior roles in the NHS and may be interested in Non-Executive roles in future. It is particularly aimed at disabled colleagues and people who are racially minoritised.

5. Reciprocal Mentoring

I am one of a number of colleagues across the Trust who is taking part in a reciprocal mentoring programme this year. Thanks are due to Coral Boston and our equalities team for all the work that makes this a success.

Enclosures: None

FOI: Public

Chief Executive Report to Council of Board – July 2026

1 Patient Experience

1.1 Amos Report

Our Trust was one of 12 organisations included in the national review. The local Trust reports are intended as snapshots of services to help inform national learning; they are not regulatory inspections, do not provide Trust ratings and do not make recommendations directed at individual Trusts.

For any organisation and indeed the wider NHS, it's important to acknowledge that on too many occasions, we haven't got this right for babies, mother and families. We are very sorry for any occasion when we have let down, or harmed, anyone under our care.

Maternity care is becoming more complex, both nationally and in Gloucestershire. Women are increasingly having babies later in life and more women are living with long-term health conditions during pregnancy. As a result, more women need specialist support, monitoring and intervention during pregnancy and birth. For example, more babies are now being born by caesarean section than in previous years. These births require larger clinical teams and longer hospital stays, placing additional demand on maternity services.

We are continuing to reshape our services so they can safely meet these changing needs, including plans for the safe reopening of services in Cheltenham and the return of home births when it is safe and sustainable to do so. This work is being developed with staff and our communities to ensure services meet the needs of local families now and in the future.

The Amos report reinforces these national themes in the context of wider maternity services, including the importance of listening to women, families and staff, responding well when concerns are raised, and ensuring improvement is shaped by lived experience as well as clinical standards. We are committed to being open about where we need to improve, responding to concerns, complaints and patient safety incidents with compassion, and making the changes needed to build confidence in our services.

The Amos report identified eight themes that were seen across maternity services nationally:

- Women and families did not always feel listened to or involved in decisions about their care.
- Services are under pressure from increasing demand and more complex care needs.
- Staffing shortages affect both families' experiences and staff wellbeing.
- Some organisations have struggled to make improvements quickly enough.
- When things have gone wrong, families have not always received the response and support they deserved.
- Inequalities mean some groups face poorer experiences and outcomes.
- Some maternity facilities are no longer fit for modern healthcare needs.
- Digital systems do not always work well together, making it harder to share information.

Many of the themes highlighted in the report are not new to us. They reflect issues already identified through CQC inspections, independent reviews and feedback from women, families and staff, and which form part of the Maternity Improvement Plan we are delivering.

We are already taking action but the report reinforces the need for improvement to be more consistent, more ambitious and more clearly shaped around the experiences of women, families and staff, not only in individual trusts but also across the NHS.

Following the publication of the Amos and Ockenden Reports, NHS England wrote to all NHS Trusts setting out an immediate 10-point plan and announcing the creation of the first ever National

Maternity and Neonatal Commissioner and a new National Maternity and Neonatal Taskforce. The national action plan will bring together around 850 recommendations from previous reviews and inquiries into a single programme of improvement, supported by an initial 100-day programme focused on listening to women and families with the extension of Martha's Rule, addressing inequalities, supporting staff to speak up, strengthening patient safety and ensuring services are safe and responsive around the clock. It will also include new national maternity triage standards, guidance for home birth and care outside established clinical guidance, and improvements to how concerns, complaints, patient safety incidents, bereavement and post-death care are handled.

We welcome this approach and will play our full part in the national improvement programme. Locally, we will continue to deliver our Maternity Improvement Plan, strengthen leadership, culture and governance, listen to women and families, support staff, improve equity of care and continue investing in services. While many families already receive safe and compassionate care, we know there is more to do. Our ambition is that every woman, baby and family receives safe, compassionate care every time they use our services.

As has been the case at every Board meeting over the past several years, we will continue to ensure there is good Board visibility and open discussion at these meetings with transparent information published on our work on the issues identified through this review.

1.2 Ockenden Report

The Ockenden Report, published on 24 June, is the largest maternity investigation in NHS history, examining the experiences of nearly 2,500 families between 2012 and 2025 and identifying longstanding and systemic failures in safety, governance, leadership and culture. The report highlighted widescale harm, including more than 500 cases of potentially avoidable harm, 94 potentially avoidable stillbirths, 62 neonatal deaths, 120 babies with brain injuries and six maternal deaths.

The report concludes that failures to listen to women and families, recognise deterioration, escalate concerns and learn from incidents led to avoidable harm and loss, often over many years.

The report sets out a series of Immediate and Essential Actions (IEAs) to be implemented across all maternity services in England, intended to drive urgent improvement in safety, culture and accountability.

The most significant overarching expectations are that women, families and staff must be able to seek urgent independent review where concerns arise, that women must be at the centre of decision making and communication, and that there must be consistent national approaches to assessment, escalation and clinical management.

Improving governance and learning is a further core requirement, with the report identifying long standing failures to investigate incidents, learn from harm and embed change. Boards are expected to ensure robust oversight, timely investigation and demonstrable learning across maternity services.

The report also emphasises equity and personalised care, noting disparities in outcomes, unacceptable racism and discrimination, and the need to address inequalities, improve communication, and ensure that care is inclusive and responsive to the needs of all women and families.

The national announcement accompanying the report confirms that Martha's Rule will be extended to all maternity settings in England, giving women, families and staff the right to request an urgent independent clinical review where they are concerned that deterioration is not being recognised or acted upon. The Government has also confirmed that a full national response to the Ockenden recommendations will be published in September 2026 and will inform the wider National Maternity and Neonatal Taskforce programme.

1.3 Pseudomonas – Water Safety

In August 2022, a patient receiving cancer care at Cheltenham General Hospital, Dr Christopher Elliot, developed an infection caused by *Pseudomonas aeruginosa*, a bacterium commonly found in the environment, including within water systems. Patients who are immunocompromised, including those undergoing cancer treatment, are particularly vulnerable to this type of infection.

The infection was subsequently linked to the hospital environment, specifically a contaminated shower outlet in the patient's room. Evidence confirmed that a water sample from this outlet had previously tested positive for *Pseudomonas aeruginosa*; however, this information was not shared and acted upon in a timely way, and the outlet remained in use.

Dr Christopher Elliot died and medical evidence indicated it was highly likely that the infection contributed to his death. We are deeply sorry for his death, a patient under our care, and for the profound impact this has had on his family. This was a tragedy that should never have happened.

The Trust was prosecuted by the Care Quality Commission (CQC) under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to its duty to provide safe care and treatment.

The Trust entered a guilty plea at Cheltenham Magistrates' Court on 15 June 2026 and was fined £300,000 and ordered to pay additional costs and a statutory surcharge. The Trust accepts the outcome of the case in full and takes complete organisational responsibility for the failings identified.

A Coroner's inquest into the patient's death was suspended in 2023 pending the outcome of the CQC investigation and is expected to resume following the conclusion of the court proceedings.

A separate legal case brought by the Health and Safety Executive (HSE) relating to Gloucestershire Managed Services (GMS) is ongoing and concerns operational aspects of water safety management at the time of this incident.

Gloucestershire Managed Services (GMS), which provides estates and facilities services for the Trust, was responsible for the day-to-day operational delivery of water safety arrangements. However, the Trust retained overall regulatory responsibility for ensuring that these risks were appropriately managed and overseen. The test results indicating contamination were not shared and acted upon in a timely way, which prevented appropriate action being taken to remove the risk.

Since the incident in 2022, the Trust, working closely with Gloucestershire Managed Services, has implemented a comprehensive programme of improvements to strengthen water safety, infection prevention and governance arrangements.

The systems now in place are clearer, more robust and subject to regular monitoring and assurance. Positive water safety results are acted upon promptly, with defined escalation routes to clinical teams and infection prevention specialists. There is strengthened organisational oversight, with clear lines of accountability and routine reporting through established governance structures, including the Water Safety Group and Board-level assurance processes.

These arrangements are designed to ensure that risks are identified early and managed effectively, particularly for patients who are most vulnerable to infection.

The Trust remains committed to being open about what happened and to ensuring that the improvements made continue to protect patients now and in the future. Patient safety remains the Trust's highest priority, and the strengthened systems now in place are designed to provide greater assurance that risks are effectively identified and managed.

1.4 Resident Doctors Industrial Action

The planned resident doctors' industrial action, due to take place from Monday 15 June to Friday 19 June 2026, was called off at short notice following national developments, including a comprehensive Government and NHS England offer on pay, training and working conditions being put to a national ballot.

The Trust had already implemented robust contingency plans and responded quickly to maintain safe services and minimise disruption to patients. This included specific planning for Cheltenham General Hospital Emergency Department, where the planned temporary closure was stood down, allowing services to continue running smoothly and safely throughout

On 29 June it was confirmed that Resident doctors had voted to accept the offer, bringing the industrial dispute to a close and ending the programme of planned strike action that first began in March 2023. This is good news given the significant work that is required to plan for strike action and also the impact it has on cancellations for patients.

The agreed package includes pay reforms linked to training progression, reimbursement of professional examination and membership fees, additional specialty training opportunities, improvements to working lives through the resident doctors' 10-point plan, and strengthened terms, conditions and career progression for locally employed doctors.

As with previous periods of industrial action, the Trust's preparations ensured services could continue with minimal disruption despite the late notice change. The acceptance of the national offer provides greater certainty for patients and staff and supports continued focus on delivering safe, high-quality care. Patient safety and access to urgent care remain our highest priorities.

There remains work to do for the Trust and the wider NHS to fully implement the Resident Dr 10 Point Plan and the outputs of the agreements reached nationally. Prof. Mark Pietroni as Medical Director is our Executive Lead for this work and will keep the Board updated on progress.

On 6 July 2026 the BMA announced that consultant doctors across England have voted in favour industrial action over pay and pensions. They have a mandate for strike action over the next 12 months. Specialist, associate specialist and specialty (SAS) doctors did not meet the legal turnout threshold. We will continue to monitor the situation and keep Board updated.

1.5 Sangeet Memory Box launched to support Hindu dementia patients

The Trust has worked with Gloucestershire charity Mindsong and local Hindu communities to launch the "Sangeet Memory Box", a culturally relevant music playlist supporting Hindu patients living with dementia.

Developed with communities in Gloucester and Cheltenham, the playlist includes devotional music and familiar Indian cinema soundtracks to help evoke memories, reduce anxiety, and provide comfort and identity. It is intended for use in hospital and at home by patients, families and carers, and encourages personalised playlists that reflect individual memories and life experiences.

The initiative, delivered with Mindsong, the Hindu Community Centre Elders and Carers Support Group in Cheltenham, and the Hindu Cultural Association of Gloucester, supports the Trust's commitment to personalised, culturally and spiritually sensitive care.

It also builds on wider work to improve dementia care, including more dementia-friendly environments and personalised approaches to support.

1.6 Mann Review

The Lord Mann Review is a national independent review into racism within the NHS, with a particular focus on antisemitism and anti-Muslim hostility. It was commissioned in response to

evidence from staff experience, patient feedback and wider societal factors that racism continues to be experienced within healthcare settings, and that responses have not been consistently effective.

The key message from the Mann Review is that tackling racism, in any form, cannot be treated as a peripheral workforce issue. The review found that discrimination continues to be experienced by staff and patients and that organisations need much stronger leadership accountability, clearer standards, improved reporting mechanisms and a culture where racism is challenged consistently and visibly. The expectation on Trust Boards is to demonstrate active leadership rather than passive compliance.

The review sets out a comprehensive series of recommendations designed to strengthen leadership accountability, improve organisational capability, and ensure more consistent, robust responses to racism across the NHS.

The review was formally published on 4 June 2026, with NHS organisations subsequently receiving a national letter from NHS England outlining the required actions and expectations for providers. This communication marked the transition from recommendation to implementation and included clear expectations for organisational response, reporting and Board oversight.

NHS England, alongside Government, has accepted the recommendations in full and has established a clear national programme of work. This includes adoption of the NHS Race and Health Observatory's Seven Anti-Racism Principles, the introduction of new Staff Standards, strengthened accountability through the NHS Oversight Framework, and the development of national training, guidance and data improvements. This positions the agenda as both a delivery expectation and a core part of organisational assurance.

Our own staff continue to share their own stories about their experience not only when out in the community but in our Trust. Also not only shocking examples of patient and visitor racism to staff but also between staff. Our own data also reflects those concerns. Race discrimination remains the most significant theme reported through a range of staff feedback mechanisms, and we continue to see evidence that some ethnic minority colleagues experience discrimination, bullying or unequal treatment more frequently than their white colleagues.

We also know that a number of staff are willing to share their experiences but lack confidence that organisations will always respond effectively or consistently. That mirrors the findings of the Mann Review nationally and reinforces why this is not simply an EDI issue; it is a leadership, culture and staff wellbeing issue that requires sustained attention from Boards and leaders.

For NHS organisations, there are clear expectations including visible Board level leadership, completion and enhancement of Equality, Diversity and Human Rights training, adoption of national definitions, and strengthened processes for reporting, investigating and responding to racism. Organisations are also expected to improve the use of data to identify inequities and evidence measurable progress.

Later in July a dedicated whole Board Development session is scheduled focused on EDI where the outputs of the Mann Review will be discussed in more detail to help shape our response which we will bring more formally back to a Public Board meeting in September. Alongside that, our work on EDI and tackling racism includes closer working with the police to identify opportunities to strengthen our approach to supporting staff subject to hate crime and strengthening our offer to our staff networks as a safe space for lived experience to be shared and help shape our approach as an organisation.

2 People, Culture and Leadership

2.1 Advanced Practitioners

There has been some high profile media and online coverage, led by the British Medical Association (BMA) about Advanced Practitioners, during their industrial action dispute with the government.

Advanced Practitioners play an important role in delivering care and supporting patient safety across the Trust. They are a valued part of multidisciplinary teams and work across a wide range of services.

Advanced Practitioners are experienced registered healthcare professionals who have developed additional skills and training. They are able to assess, diagnose, treat and manage patients, often working independently within agreed clinical guidelines, while remaining part of wider clinical teams.

Within the Trust, this includes professionals such as nurses, physiotherapists, occupational therapists, radiographers and other allied health professionals. Advanced practice is not a separate profession, but a level of practice developed through further education, training and experience. All Advanced Practitioners remain accountable to their professional regulator and work within an agreed scope of practice.

They work as part of established clinical teams alongside doctors and other healthcare professionals, with clear routes for advice, support and escalation when needed. Their contribution supports timely access to care, continuity for patients, and safe and effective treatment.

2.2 Transforming People Services

Transforming People Services (TPS) is a national NHS England programme to modernise HR and People functions. The vision is for it to be delivered through a more standardised, digitally enabled and system-focused model.

The intent is to improve efficiency, workforce insight, and employee experience, with future services delivered through three core components: streamlined transactional services, centres of expertise operating at scale, and retained People teams within NHS provider organisations focused on strategic partnering and delivery. This change is being progressed alongside the wider corporate transformation programme within the Trust.

The South West, alongside London, has been identified as an Early Accelerator region, leading the initial design and testing phase ahead of national rollout. The programme is currently in early mobilisation, with 2026/27 focused on detailed design, baselining data, production of the outline business case, and general preparedness. Implementation across Early Accelerator regions is expected to follow in the period 2027/29, subject to national decisions and readiness.

Regional governance arrangements are being established, including programme boards and functional design groups. Trusts are being asked to identify subject matter experts and leads to support the development of the Target Operating Model. External partners are also being procured to support aspects of design and implementation.

At this stage, there remains some uncertainty regarding the timing and scope of adoption of the new Future NHS Workforce Solution (FWS) the replacement system for ESR, including whether elements may be introduced alongside the TPS implementation.

For the Trust, this means active engagement in shaping the future model and influencing the design at a regional level, while maintaining current service delivery and organisational stability.

The Board People Committee will ensure there is oversight of this programme as it progresses.

3 Digital

3.1 Managing cyber security

NHS England has asked Trust boards to treat cyber security as a core organisational risk, with clear executive accountability, sustained assurance and evidence that risks are actively managed across the organisation.

The national position is tightening in response to growing global risks, including conflict and increased AI use. Trusts must meet Data Security and Protection requirements, show continuous improvement, and implement new controls such as multi-factor authentication and enhanced monitoring from September 2026.

Boards are expected to oversee resilience as well as compliance, including preparedness for cyber incidents, recovery plans for critical systems, and assurance on areas such as asset management, supply chain risk, access controls, vulnerability management, backups, security monitoring and incident response.

The Trust has a cyber accountable lead, the Chief Digital Information Officer, and regularly reviews cyber risk through the Board Assurance Framework. The Board has received assurance reporting, the Trust was compliant with Data Security and Protection in 2025, and further progress will be reported in response to NHS England requirements.

3.2 Project PRISM

Project PRISM is delivering the Board's decision from May 2025 to replace the Trust's current major imaging systems. The Trust is moving from the existing PACS (Picture Archiving and Communications System) and RIS (Radiology Information System) to new systems from Intelera (PACS) and Aptivision (RIS). These systems have been bought through the West of England Imaging Network (WoEIN) procurement framework, which the Trust helped to set up with other organisations across the region.

The new systems will give the Trust a modern, cloud-based imaging platform. Buying them alongside partners in the WoEIN will also make it easier over time to share images and workflow across the region. This will improve patient care by giving clinicians access to more complete imaging histories when diagnosing and treating patients. It will also help reduce duplicated scans, meaning less unnecessary radiation for patients. In addition, better image sharing and new features, such as a patient portal, The new systems will improve patient experience and support improvement in staff welfare through improved reliability of these systems.

The team is working to ensure the new systems are introduced as smoothly as possible in the autumn and meet the Trust's needs. This includes a thorough testing phase before any decision is made to go live.

This is not just a radiology project. It is being led by Senior Responsible Officer and Consultant Radiologist Charles Carder, with input from clinical and operational teams across Radiology, Nuclear Medicine, Vascular and Breast services. They are working closely with digital and technical colleagues, as well as suppliers, to make sure the Trust gets the full benefit from the new systems.

3.3 Twinkle – Paediatric Diabetes System

The Trust has successfully implemented Twinkle, a specialist digital system to support the care of children and young people with diabetes, which went live on 1 April 2026. The introduction of Twinkle strengthens the Trust's ability to monitor clinical outcomes and manage patient information in a more structured and reliable way, supporting improvements in quality of care and compliance with national reporting requirements.

By reducing reliance on manual processes and improving access to real-time data, the system supports clinical decision-making and enables teams to focus more effectively on direct patient

care. This implementation forms part of the Trust's wider digital programme to enhance data quality, patient outcomes and service efficiency, while providing a more robust platform for future service development and assurance.

3.4 BadgerDiaries – Digital Baby Diary

BadgerDiaries was introduced across Women's and Children's services on 6 May 2026, replacing the previous system and establishing a single, consistent digital offer for families. The platform enhances patient and family experience by enabling secure, timely communication and access to information about a baby's care, supporting greater involvement and reassurance during often complex and sensitive care pathways.

The move to a single system simplifies the digital estate within the service, improves consistency for staff, and supports more effective communication between clinical teams and families. In addition to these quality and experience benefits, the change delivers a financial saving compared to the previous arrangement. This initiative aligns with the Trust's strategic ambition to improve patient experience, streamline digital systems, and ensure the effective use of resources while strengthening engagement with patients and families.

4 Regulatory

4.1 NHS National Oversight Framework

In the latest NHS England update for Quarter 4 (January-March 2026) published in June, the Trust has moved up to Segment 2, with a national league table position of 22nd out of 134 acute trusts. This represents an improvement from our Quarter 3 position, where we were placed in Segment 3 and ranked joint 38th nationally.

Our performance has improved since Quarter 3, reflecting progress across our services and recovery from the temporary financial pressures caused by Residential Doctors' industrial action. The Trust also delivered a balanced financial position for 2025/26.

Report to Care Quality Commission and the Trust Board of Directors – 16th July 2026

Report title	CQC Section 31 Conditions Report (as at 29 June 2026)
Sponsoring Director/Author	Matt Holdaway – Chief Nurse and Director of Quality Suzie Cro – Director of Quality Governance

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

Executive Summary

- Executive summary**
- 1.1.** The Trust has self-assessed that all eight CQC Section 31 conditions have been met. The report provides triangulated evidence that the required controls are established, monitored and sustainable, and supports formal applications for condition removal subject to completion of the factual accuracy process and receipt of the final CQC inspection report.
- ALERT**
- 1.2.** The Trust remains under Section 31 conditions relating to maternity services at Gloucestershire Royal Hospital. The key Board judgement is whether the residual risks described in this report are sufficiently controlled through routine governance to support formal applications for removal. The report concludes that they are.
- ADVISE**
- 1.3.** The evidence demonstrates embedded systems for postpartum haemorrhage, fetal monitoring, maternal early warning score escalation, VTE risk assessment, agency workforce induction and regulatory reporting. Assurance is provided through approved policies, audit, dashboards, thematic review, action tracking, staff learning and ward-to-Board escalation routes.
- 1.4.** External oversight has informed the Trust's self-assessment. The draft CQC inspection report remains subject to factual accuracy review and final determination.
- 1.5.** The recommendations set out the proposed Board support and executive authorisation route for formal condition-removal applications.
- ASSURE**
- 1.6.** The Board can take assurance that the conditions are supported by clear governance controls, named executive and clinical accountability, routine audit and dashboard review, PSIRF-aligned learning, closed-loop action tracking and defined escalation routes.
- APPLAUD**

- 1.7.** The Board is asked to recognise the sustained work of maternity clinical teams, divisional leadership and corporate support functions in delivering a complex improvement programme under regulatory scrutiny. The service is now moving from Section 31 recovery to sustained improvement, with the NHS England Maternal Care Bundle implementation as the next governance-led improvement focus.
- 1.8. In conclusion,** the report provides assurance that the original regulatory risks have been addressed, that residual risks are visible and managed through business-as-usual governance, and that the Trust has a sufficiently strong evidence base to support formal applications for removal of the CQC Section 31 conditions.

Previously considered by	<i>New report</i>
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Recommendations:

The Trust Board is asked to:

1. Note the Trust’s self-assessment that all eight CQC Section 31 conditions have been met, supported by triangulated evidence of delivery, monitoring, governance and external oversight.
2. Be assured that residual risks, including the 80% hourly peer review result against the 85% local target, national MEWS implementation and VTE whole-pathway improvement (implementation of the NHS England Maternal Care Bundle published January 2026), are visible and managed through routine governance, audit, action tracking and escalation routes.
3. Support the submission of formal applications to CQC for removal of the Section 31 conditions, with final submission authorised through the Chief Executive, Chief Nurse/Director of Quality Governance and Medical Director, subject to completion of the factual accuracy process and receipt of the final CQC inspection report. Following Board support and executive authorisation, the completed CQC removal forms, additional condition sections, updated Statement of Purpose and evidence pack will be submitted to CQC.
4. Agree that ongoing oversight of maternity safety, regulatory compliance and the associated strategic risk will continue through established Trust governance, committee and Board assurance arrangements, with Maternal Care Bundle implementation as the next governance-led improvement focus.

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

 Digital first	X
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Impact on any Strategic Risks?

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

This report has a positive impact on SR1: Inability to deliver safe and effective services against regulatory and statutory requirements. The evidence indicates that the maternity-related component of SR1 has reduced from immediate regulatory non-compliance to managed residual risk under routine governance. Ongoing scrutiny remains in place for specific areas of residual risk, including hourly peer review compliance, national MEWS implementation and VTE whole-pathway improvement, with escalation through established maternity, executive and Board assurance routes where required.

Implications on:

Equality, Diversity and Inclusion	The report supports more equitable and consistent maternity care by strengthening safety-critical processes, escalation and governance for all women and birthing people.
Health Inequalities	Improved recognition of deterioration, escalation, fetal monitoring, risk assessment and workforce reliability supports safer, more consistent care for women and birthing people with differing clinical or social needs.
Finance and Resources	Actions have largely been delivered within existing resources. Ongoing oversight and residual-risk monitoring will continue through business-as-usual workforce, governance, training and improvement arrangements.
Regulation/Legal	The report supports Board consideration of formal applications for removal of the CQC Section 31 conditions, subject to completion of factual accuracy and receipt of the final CQC inspection report.
CQC-Key line of enquiry	Safe, effective, caring, responsive and well-led.
Green Plan	No significant direct Green Plan implications; the actions focus on clinical practice, digital reliability, governance and workforce arrangements within existing pathways.

2. Purpose of the report

- 2.1.** The purpose of this report is to provide the Trust Board and CQC with assurance that the Trust has self-assessed all eight Section 31 conditions as met, supported by triangulated evidence of delivery, monitoring and governance. The report sets out the residual risks, confirms how ongoing compliance will be sustained through business-as-usual governance, and supports Board consideration of formal applications for condition removal.

3. Background

- 3.1.** CQC imposed Section 31 conditions on maternity services at Gloucestershire Royal Hospital following concerns about the systems in place to manage specified safety and governance risks.
- 3.2.** The conditions required the Trust to implement effective systems of control across clinical risk assessment, escalation, fetal monitoring, workforce induction and regulatory reporting.

Specifically, the conditions were:

- **Condition 1:** implement an effective system for ensuring staff at Gloucestershire Royal Hospital continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH).
- **Condition 2:** ensure maternity staff at Gloucestershire Royal Hospital complete hourly peer reviews, also known as “fresh eyes”, during intrapartum care in line with national guidance.
- **Condition 3:** implement an effective system for ensuring staff at Gloucestershire Royal Hospital interpret fetal monitoring traces accurately and escalate in line with Trust guidance to ensure women, birthing people and babies are cared for safely and effectively in line with national guidance.
- **Condition 4:** implement an effective system for ensuring staff at Gloucestershire Royal Hospital complete and escalate maternity early obstetric warning score charts in line with national guidance during intrapartum and postnatal care.
- **Condition 5:** implement an effective system for ensuring staff complete venous thromboembolism (VTE) risk assessments.
- **Condition 6:** implement an effective system for ensuring agency midwifery staff have a comprehensive induction to the unit, can access the maternity electronic records system and Trust policies, and can enter and exit the unit without delay.
- **Conditions 7 and 8:** submit action plans, monthly progress updates, Board assurance reports and maternity dashboard information to CQC.

4. Current situation

4.1. Care Quality Commission

4.2. Maternity core service inspection, September 2025

- 4.3.** CQC inspected maternity services at Gloucestershire Royal Hospital and Stroud Maternity Unit in September 2025. The draft report was received on 21 May 2026. The Trust has submitted its factual accuracy response, and the draft report remains subject to CQC review and final determination.
- 4.4.** The draft report indicates improvement in maternity services and material progress against the original Section 31 concerns.
- 4.5.** CQC advised the Trust to await the draft inspection report before submitting formal requests for condition removal. That stage has now been reached.

4.6. Trust self-assessment against Section 31 conditions

4.7. The Trust has self-assessed that all eight Section 31 conditions have been met, supported by the triangulated evidence set out in this report. The Board is asked to support submission of formal condition-removal applications to CQC subject to completion of the factual accuracy process and receipt of the final CQC inspection report.

4.8. Table: Summary of position against CQC conditions

Position	Self-assessment	Total 8
Conditions met	Self-assessed as met and under routine governance oversight.	8/8

4.9. External oversight for maternity services

4.10. The ICB-led Enhanced Oversight Group for maternity services has now closed, with formal confirmation received.

4.11. The NHS England Maternity and Neonatal Improvement Team continues to support the Trust through Maternity and Neonatal Improvement Advisors. Executive meetings continue monthly, with the most recent meeting held on 17 June 2026. The Section 31 conditions are no longer a primary focus of these meetings, reflecting the transition from regulatory recovery to sustained improvement.

4.12. On 15 September 2025, it was announced that the Trust was included in the national rapid investigation of maternity and newborn care across England. The final national report and the local Gloucestershire Hospitals report are expected to be published on 30 June 2026.

5. Conditions with reasons and evidence for removal

Condition 1

The registered provider must implement an effective system for ensuring staff at Gloucestershire Royal Hospital continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH).

5.1. Summary

- 5.2. In summary, the Trust has implemented an effective system for the continual risk assessment and management of postpartum haemorrhage and potential major obstetric haemorrhage, supported by standardised guidance, quantified blood loss, defined escalation triggers, structured management tools, multidisciplinary training and routine governance oversight.
- 5.3. The core controls required by the condition are embedded in routine practice. These include risk identification at key points in care, explicit communication of high-risk women during handovers and safety huddles, activation of the major obstetric haemorrhage pathway for blood loss greater than 1,500 ml, and use of haemorrhage documentation and the REDUCE checklist to support reliable stepwise management.
- 5.4. Outcome data is reviewed alongside process assurance and case review findings. April 2026 is the latest nationally published Clinical Quality Improvement Metrics data. For April 2026, the Trust's rate of postpartum haemorrhage of 1,500 ml or more was above the national comparator, and the six-month rolling average indicates that this represents sustained variation rather than a single-month fluctuation. However, the Trust remains within the expected statistical range and is not identified as a statistical outlier. This metric remains under active surveillance and is interpreted alongside evidence of quantified blood loss, case ascertainment, escalation practice, multidisciplinary review and tracked improvement actions.
- 5.5. Oversight is provided through established maternity governance arrangements, with review at the Intrapartum Forum and escalation through the Perinatal Oversight and Assurance Meeting where required. This provides clear line of sight from clinical area to Board and supports timely action where variance, learning themes or emerging risks are identified.
- 5.6. Learning from major obstetric haemorrhage events is embedded through weekly multidisciplinary review of significant bleeds, monthly dissemination of learning to staff, and tracked improvement actions. This closed-loop approach supports continuous improvement and provides assurance that the system remains responsive to variation and emerging risk.
- 5.7. Taken together, the Trust can demonstrate that the immediate regulatory risk identified in Condition 1 has been addressed through embedded controls, ongoing governance oversight and routine review. While outcome data continues to require scrutiny, the available evidence supports the conclusion that the Trust has an effective and sustainable system for continual risk assessment and management of postpartum haemorrhage and potential major obstetric haemorrhage.

5.8. Reasons and evidence for PPH condition removal

- 5.9. The Trust has embedded a structured system for the continual risk assessment and management of postpartum haemorrhage and potential major obstetric haemorrhage, with controls focused on early identification of risk, timely escalation and coordinated multidisciplinary response.

5.10. Governance and clinical leadership

5.11. Clinical leaders

- 5.12. Clinical accountability for postpartum haemorrhage and major obstetric haemorrhage improvement is assigned to defined obstetric, midwifery, anaesthetic, education and patient safety roles. These roles provide collective oversight of guideline review, training, multidisciplinary case review, audit, action tracking and escalation through maternity governance.

- 5.13.** Named postholders are maintained within the divisional governance structure to ensure clear accountability, continuity of oversight and handover should personnel change.
- Obstetric clinical leadership for PPH/MOH, labour ward practice and senior clinical review.
 - Midwifery leadership for labour ward practice, escalation, documentation standards and implementation of learning.
 - Anaesthetic leadership for major obstetric haemorrhage response, resuscitation, blood management and multidisciplinary review.
 - Education and training leadership for multidisciplinary emergency training, trolley teaching and reinforcement of local documentation standards.
 - Patient safety and quality leadership for case review, thematic learning, governance reporting and action tracking.

5.14. Governance

- 5.15.** Oversight of the effectiveness of the PPH/MOH system is provided through the Intrapartum Forum, which reviews relevant audit findings, case review themes, improvement actions and emerging risks. Where sustained variance, unresolved actions or material risk is identified, escalation is made to the Perinatal Oversight and Assurance Meeting and, where required, onward through executive-led maternity governance and Board assurance routes. This provides clear ward-to-Board visibility of performance, risk and improvement.

Governance control	Frequency	Review route	Assurance provided
PPH/MOH case reviews for bleeds greater than 2 litres	Weekly	Multidisciplinary MOH review forum, with themes reported to the Intrapartum Forum	Learning, contributory factors, actions and escalation themes
PPH risk assessment, documentation and REDUCE checklist review	Case-based and thematic	PPH improvement team and Intrapartum Forum	Compliance with guideline, escalation and documentation standards
CQIM+ PPH $\geq 1,500$ ml data	Monthly	Intrapartum Forum, with escalation to POAM by exception	Outcome surveillance, variation monitoring and residual-risk oversight
Learning dissemination to staff	Monthly	PPH team and maternity governance routes	Evidence that learning is shared and embedded in practice
Action tracker	Reviewed at each MOH review and through governance where required	MOH review forum, Intrapartum Forum and POAM for overdue or high-risk actions	Closed-loop improvement with ownership, due dates and completion evidence

5.16. Standardised management policy

- 5.17.** The Trust's approved Management of PPH Guideline (M1042, review date March 2026) provides the standardised clinical framework for risk assessment, early recognition, escalation and management of postpartum haemorrhage and potential major obstetric haemorrhage.
- 5.18.** The current approved guideline remains in force while the scheduled review is completed, ensuring that staff continue to have an operative standard for practice. The review will align the guideline to the NHS England Maternal Care Bundle now that the national benchmarking tool is published, with any changes implemented through governance-approved updates, staff communication and audit.

5.19. Visual aids within the policy

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

5.21. Active management of the third stage

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

5.23. Major obstetric haemorrhage initiation for blood loss greater than 1,500 ml

5.24. There is a specific, streamlined trigger to activate a multidisciplinary response: 2222 – Major Obstetric Haemorrhage. This includes immediate access to O-negative blood and haemorrhage packs A and B.

5.25. Quantified Blood Loss (QBL)

5.26. Quantified blood loss is used in place of estimated blood loss to provide a more reliable basis for early recognition of haemorrhage and timely escalation to the major obstetric haemorrhage pathway.

5.27. REDUCE checklist

5.28. The REDUCE checklist supports reliable stepwise management during PPH/MOH events by prompting key clinical actions, escalation and documentation during high-pressure situations. Continued use of the checklist is monitored through case-based review and audit, providing assurance that the control remains embedded in practice.

5.29. Risk assessment compliance

5.30. The PPH team oversees compliance with risk assessment processes and reports through the Intrapartum Forum. Thematic reviews undertaken as part of NHS England Maternal Care Bundle (published January 2026) implementation now include review of documented postpartum haemorrhage risk assessment and early warning score completion.

5.31. Outcome metrics

5.32. The Trust reviews postpartum haemorrhage outcome data as part of its wider assurance framework, using local multidisciplinary case review, quantified blood loss practice and governance oversight to identify learning, monitor variation and support improvement.

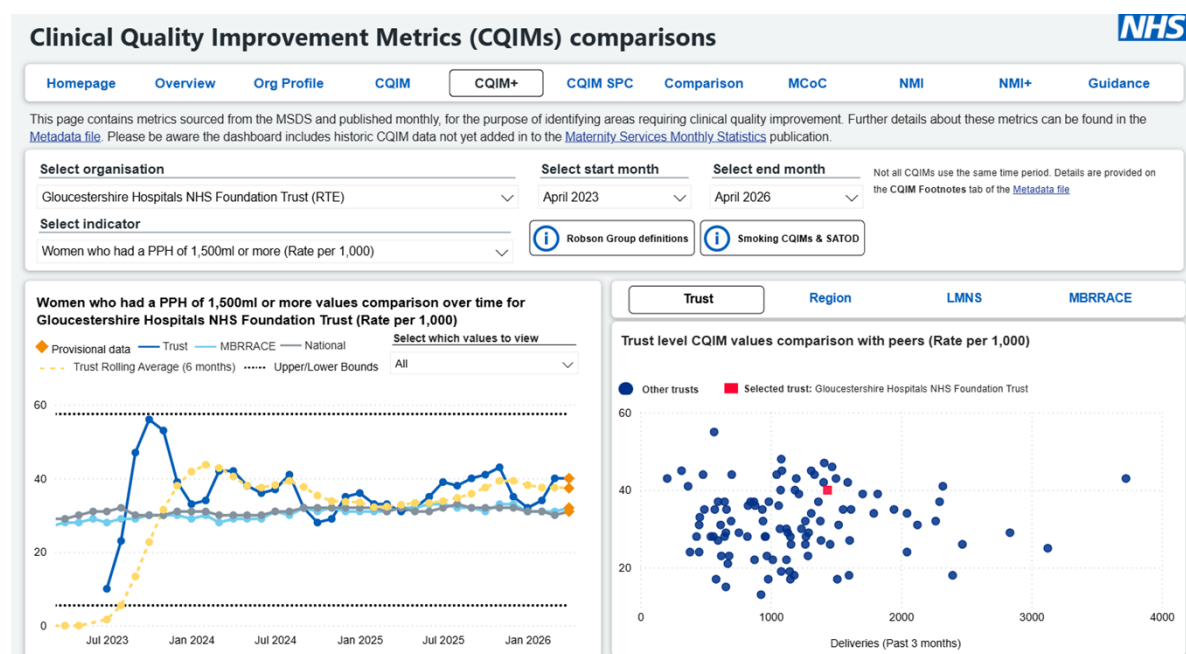
5.33. CQIM+

5.34. The Board is asked to note that this metric remains an area of active surveillance, but current data does not indicate statistical deterioration or outlier performance. The metric is managed as a residual risk through monthly data review, multidisciplinary case review, audit of controls and escalation through maternity governance where required.

5.35. Table: Monthly data and 6 monthly rolling average PPH >1.5L per 1000 deliveries

CQIMs Data	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026	April 2026
National	32	32	32	32	32	32	32	32	31	30	31
Trust data and 6 month rolling average	35	39	38	40	41	43	35	31	34	40	40
	33.33	33.83	34.67	35.83	37.5	39.33	39.33	38.17	37.5	37.5	37.33

5.36. Graph: Maternity National Database CQIM data April 2026 (this is the latest data)



5.37. Staff training

5.38. Mandatory training

5.39. Training for PPH management is part of the Maternity Core Competency Framework (v2), which expects 90% of each relevant maternity staff group to attend an in-house multidisciplinary training day covering a minimum of four maternity emergencies over a three-year cycle, prioritised according to locally identified training needs. PPH scenarios have been included in the Trust's maternity emergency training programme for the last two years. Training compliance is monitored through maternity training governance arrangements and forms part of the wider assurance framework for maternity emergency preparedness. Practical Obstetric Multi Professional Training (PROMPT) training is monitored via the Perinatal Quality Oversight Model report.

5.40. Trolley teaching

5.41. In addition to mandatory specialty training, the PPH team carried out trolley teaching with teams as new documentation was introduced.

5.42. Culture of continuous improvement

5.43. Care bundle implementation

5.44. On 6 January 2026, NHS England released the Maternal Care Bundle. Element 5 relates to the management of obstetric haemorrhage. The PPH improvement team is undertaking a gap analysis against the recommendations and developing an action plan to ensure implementation of all relevant elements, with a target date of March 2027.

5.45. Next steps will focus on completing the Maternal Care Bundle gap analysis, confirming local compliance against the national best-practice standards, and embedding any additional actions through the existing PPH/MOH governance route, including weekly case review, audit and staff learning.

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

5.46. Anonymised evidence extract: multidisciplinary MOH review process

Recent anonymised multidisciplinary MOH review summary:

Multidisciplinary case review meeting: The following anonymised summary demonstrates the Trust's process for reviewing major obstetric haemorrhage cases through a structured multidisciplinary forum. The meeting focused on clinical management, escalation, documentation, learning and agreed improvement actions. All patient and staff identifiers have been removed.

Summary of review process and key learning

- **Case selection and attendance:** The forum reviewed recent major obstetric haemorrhage cases involving blood loss greater than 2 litres. Cases were prepared in advance using a standard proforma. The meeting included representation from obstetrics, anaesthetics, transfusion, theatres, neonatology and patient safety to ensure broad clinical input and systems-based review.
- **Clinical management and escalation:** The cases reviewed included haemorrhage associated with caesarean section and significant postnatal bleeding. The review considered recognition of bleeding, timing of escalation, transfer to delivery suite, use of uterotonics, tranexamic acid, cell salvage, ROTEM testing, cannulation and transfusion decision-making. The forum identified examples of appropriate clinical management as well as opportunities to strengthen earlier transfer and clearer documentation of escalation decisions.
- **Blood management and post-haemorrhage monitoring:** The team reviewed use of cell salvage and ROTEM testing, including the need to repeat samples where clotting occurred. The forum identified an opportunity to clarify and standardise the post-PPH “six-hourly bloods” protocol, including full blood count, clotting screen and urea and electrolytes. This was converted into a tracked improvement action to clarify the local post-PPH blood monitoring protocol and consider electronic order sets to improve reliability and consistency.
- **Documentation and Duty of Candour:** The review identified an opportunity to strengthen the consistency of documentation of Duty of Candour discussions and high dependency care, while recognising that appropriate care and review had been undertaken. The agreed learning was to strengthen use of the relevant electronic documentation fields, ensure patients are informed that their cases are reviewed, and improve direct communication with medical staff about documentation expectations.
- **Transfer and escalation learning:** The forum reinforced that transfer to delivery suite should be considered promptly once significant postnatal bleeding is recognised, unless there is a clearly documented clinical rationale for remaining in situ. The review also reinforced the importance of documenting the rationale for transfer decisions and ensuring appropriate access to uterotonic medication while transfer arrangements are being made.
- **Agreed improvement actions:** Actions from the review included seeking final senior clinical review where required, clarifying the post-PPH blood monitoring protocol, improving documentation of high dependency care and Duty of Candour, considering electronic order sets, reviewing operative note clarity, reinforcing transfer expectations, and sharing learning with relevant clinical teams through established governance and communication routes. Actions are recorded, allocated and tracked through the review process, with escalation through maternity governance where completion or impact requires further oversight.
- **Assurance from the meeting:** The meeting demonstrates an embedded, multidisciplinary and learning-focused approach to reviewing major obstetric haemorrhage cases. It provides evidence of case identification, structured review, specialty input, identification of good practice, recognition of learning themes, and conversion of learning into tracked improvement actions.

5.47. Patient Safety Incident Framework (PSIRF)

- 5.48. Weekly multidisciplinary Major Obstetric Haemorrhage (MOH) review meetings are held every Monday (09:00–10:00) to review all cases with blood loss >2L; these reviews are now undertaken in a dedicated forum with attendance from the Reduce Team and the Perinatal Governance Team, applying PSIRF methodology and SEIPS analysis to strengthen learning by taking a systems-based approach to identifying contributory factors (including human factors, tasks, environment and teamworking) and translating these into proportionate, tracked improvement actions.
- 5.49. Learning from these reviews is consolidated into a monthly infographic and shared with staff; in addition, the team has strengthened the data collection proforma to include completion of the Maternal Early Warning Score (MEWS) and PPH risk assessment.
- 5.50. The process is designed to ensure that learning is not limited to individual case discussion. Themes are aggregated, shared with staff, used to update documentation or training where required, and reviewed through subsequent case review or audit to assess whether improvement actions have had the intended effect.

5.51. Actions from the weekly review are recorded on an action tracker with allocated ownership, due date, status and completion evidence. Overdue or high-risk actions are escalated through the Intrapartum Forum, with further escalation to the Perinatal Oversight and Assurance Meeting where required.

5.52. Handovers and Safety Huddles

5.53. High-risk women and birthing people are explicitly identified during shift handovers and safety huddles so that the multidisciplinary team, including anaesthetics and haematology where relevant, has shared situational awareness and can plan escalation or preparedness actions.

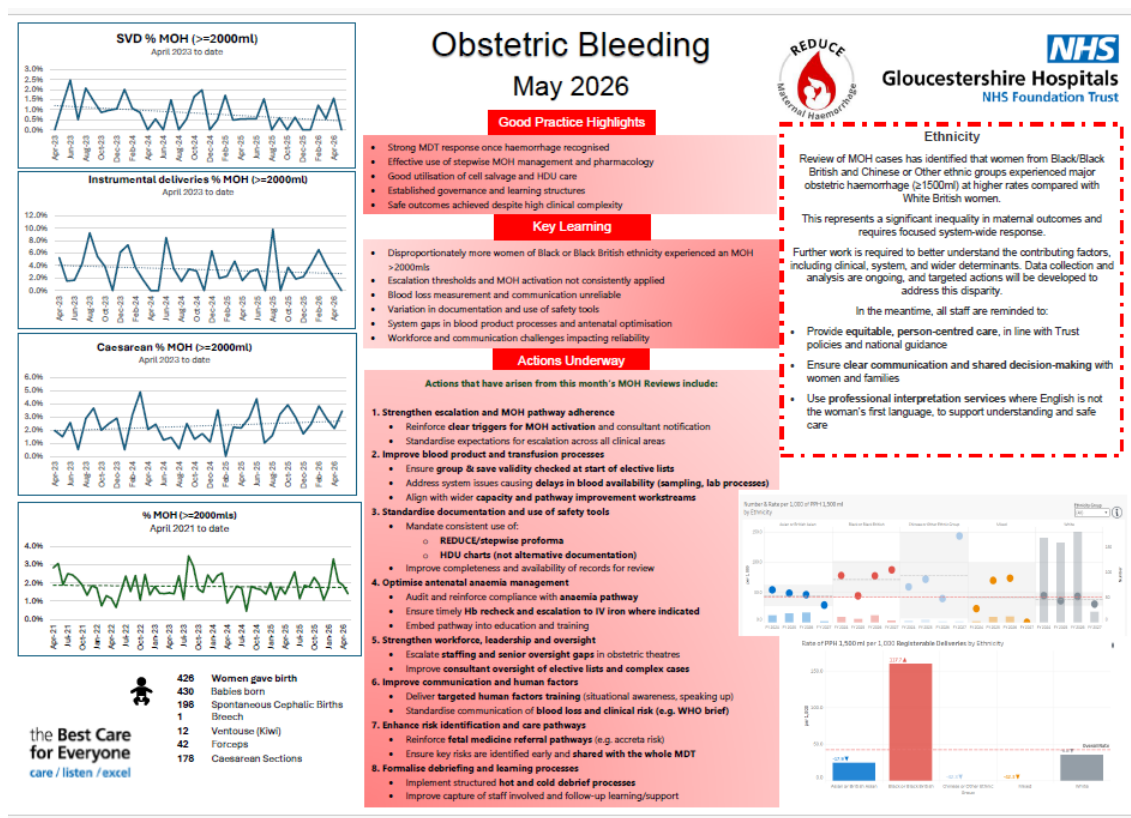
5.54. Patient experience

5.55. Debrief service

5.56. Women and birthing people affected by significant haemorrhage or traumatic birth experience are offered access to debrief and support. Feedback and themes from post-event discussions are used alongside clinical case review to inform learning, improve communication and strengthen patient-centred care.

5.57. Summary data reported to the Intrapartum Forum in May 2026 and then shared with staff

5.58. Picture: Monthly overview of obstetric bleeding



5.59. In conclusion, the Trust can demonstrate that Condition 1 has been met. The service has established a sustainable system for continual PPH/MOH risk assessment and management, supported by approved guidance, quantified blood loss, escalation triggers, structured documentation, multidisciplinary training, weekly case review, audit, outcome surveillance and clear governance escalation. Residual risk, including the PPH $\geq 1,500\text{ml}$ rate being above the national comparator, is recognised and actively managed through routine governance. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.

Condition 2

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

5.60. Summary

- 5.61.** In summary, the Trust has embedded an effective system to ensure hourly peer review, also known as “fresh eyes”, is expected, monitored, reviewed, escalated and acted upon during intrapartum care. Hourly peer review is retained as a local safety control supporting reliable second review, shared situational awareness and timely escalation.
- 5.62.** Although national guidance has evolved and hourly peer review is no longer framed as a national audit requirement in the same way, the Trust has retained hourly peer review as a local safety control because it supports reliable second review, shared situational awareness and timely escalation during intrapartum care.
- 5.63.** Assurance is provided through an approved intrapartum fetal monitoring policy, competency-based training, routine audit, dashboard monitoring and established governance review through the Intrapartum Forum, with escalation to the Perinatal Oversight and Assurance Meeting (POAM) where thresholds are not met, improvement is not demonstrated, or variance is sustained.
- 5.64.** The latest audit reported hourly peer review compliance at 80% against the Trust’s local target of 85%. This represents a one-month variance from the agreed threshold and is not presented as achievement of the metric for that reporting period. However, the variance was identified through routine monitoring, reviewed through the Intrapartum Forum, and is subject to targeted corrective action and continued monthly oversight. The result demonstrates that the governance system is operating as intended: the Trust is sighted on the metric, understands the variance, has retained clear ownership through the fetal monitoring leadership team, and has established escalation routes through POAM if the variance is sustained.
- 5.65.** On this basis, the Trust’s self-assessment remains that Condition 2 has been met. The condition required an effective system for ensuring hourly peer review during intrapartum care; the Trust has that system in place, with policy, audit, dashboard oversight, governance review, leadership accountability, staff communication, targeted corrective action and escalation. The one-month dip below target is being managed as a residual risk through business-as-usual governance and does not undermine the overall assurance that the system is established, monitored and responsive.

5.66. Reasons and evidence for condition removal**5.67. Clinical leaders**

- 5.68.** Clinical accountability for fetal monitoring and hourly peer review is assigned to defined obstetric, fetal wellbeing and education roles. The Fetal Monitoring update presented to the Intrapartum Forum on 12 June 2026 confirmed active leadership through the obstetric lead for fetal monitoring, the fetal wellbeing lead and the training and education lead. These roles provide collective oversight of policy, competency-based training, audit review, fetal monitoring improvement, staff communication and escalation through maternity governance.
- 5.69.** Named postholders are maintained within the divisional governance structure to ensure clear accountability, continuity of oversight and handover should personnel change.
- Obstetric clinical leadership for fetal monitoring standards, senior review, escalation and improvement oversight.
 - Fetal wellbeing leadership for hourly peer review practice, intrapartum fetal deterioration learning, audit review, staff support and improvement delivery.
 - Training and education leadership for competency-based fetal monitoring training, intrapartum fetal deterioration education, and reinforcement of local documentation and escalation standards.

5.70. Governance

- 5.71.** Oversight of fetal monitoring and hourly peer review compliance is provided through the Intrapartum Forum. The Fetal Monitoring update presented on 12 June 2026 provided evidence of active review of fetal monitoring improvement work, including intrapartum fetal deterioration learning, digital intrapartum documentation development, staff communication and ongoing training. Where thresholds are not met, variance is sustained, or material risk is identified, escalation is made to the Perinatal Oversight and Assurance Meeting and, where required, onward through executive-led

maternity governance and Board assurance routes. This provides clear ward-to-Board visibility of performance, risk and improvement.

Governance control	Frequency	Review route	Assurance provided
Hourly peer review audit	Monthly	Intrapartum Forum	Compliance with the local fresh eyes safety control
Fetal monitoring dashboard	Monthly	Intrapartum Forum, with escalation to POAM by exception	Trend oversight, threshold review and variance monitoring
Fetal monitoring competency and training	Ongoing through mandatory training cycle	Fetal monitoring team and maternity training governance	Staff competence to interpret, document, peer review and escalate
Missed or undocumented peer review analysis	Monthly or by exception	Intrapartum Forum	Contributory factors, corrective action and learning
Fetal Wellbeing Wednesday communications	Weekly	Fetal monitoring team	Learning dissemination and reinforcement of practice standards
Action tracking	Monthly and by exception	Intrapartum Forum and POAM for overdue or high-risk actions	Closed-loop improvement with ownership, due dates and completion evidence

5.72. Standardised management policy

5.73. The Trust has an approved intrapartum fetal monitoring policy in place (M1068, review date April 2027). This policy sets out the local requirement for hourly peer review during intrapartum care, alongside the standards for interpretation, documentation and escalation. The June 2026 fetal monitoring update confirmed continued work to support intrapartum documentation, including paper-based intrapartum documentation and development of a digital version through BadgerNet.

5.74. Audit data

5.75. Hourly peer review compliance remains monitored through the fetal monitoring audit and dashboard arrangements reviewed through the Intrapartum Forum. The latest audit result is 80% against the Trust's local target of 85%. This is a one-month variance from the agreed threshold within an established and functioning oversight system. The June 2026 Fetal Monitoring update provides current assurance that fetal monitoring improvement remains subject to active review, with ongoing focus on intrapartum fetal deterioration learning, documentation reliability, training and staff communication. Where monthly audit identifies variation from the local threshold, this is reviewed through intrapartum governance, corrective action is agreed and further escalation is available through POAM where improvement is not demonstrated or variance is sustained.

5.76. The corrective action includes focused reinforcement of hourly peer review documentation expectations through fetal monitoring leads, targeted staff communication, and review of missed or undocumented cases at the next Intrapartum Forum.

5.77. The Trust continues to retain hourly peer review as a local safety control to support reliable second review and timely escalation during intrapartum care. As national guidance evolves, this control will remain subject to routine governance review; however, any future change would require formal assessment through established assurance routes to ensure that an equivalent or stronger safety control is in place.

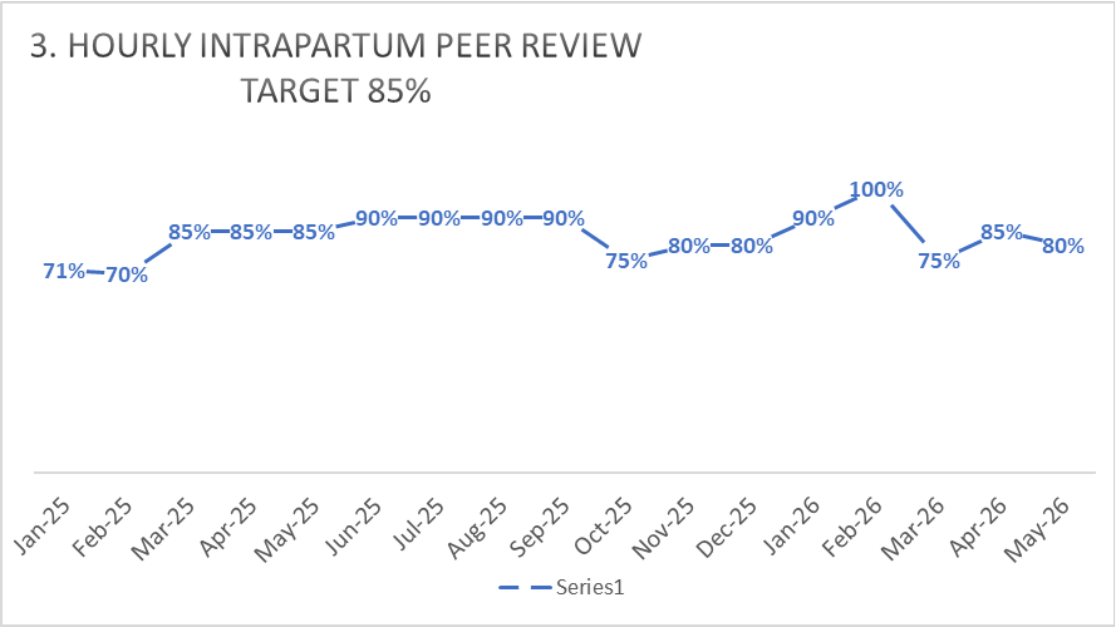
5.78. The current improvement programme also includes targeted work on ABC – Intrapartum Fetal Deterioration, providing additional assurance that hourly peer review is being considered within a wider fetal monitoring safety system focused on recognition, escalation, communication and timely multidisciplinary response.

5.79. Residual risk and mitigation

5.80. The principal residual risk is variation in completion or documentation of hourly peer review during periods of operational pressure. The latest monthly audit result of 80% against the 85% local target confirms this remains an area of active scrutiny. This risk is mitigated through monthly audit, dashboard review, review of missed or undocumented peer reviews, fetal monitoring leadership

oversight, weekly learning communications, targeted corrective action, ongoing intrapartum fetal deterioration learning, and escalation through the Intrapartum Forum and POAM if improvement is not demonstrated or if variance is sustained.

5.81. Graph: Hourly peer reviews 80% against local target of 85%



5.82. Culture of continuous improvement

5.83. The fetal monitoring improvement team continues to support implementation of Saving Babies’ Lives Care Bundle Version 3, Element 4, with a focus on competency in intrapartum fetal monitoring interpretation, documentation, escalation, intrapartum fetal deterioration learning and shared learning.

5.84. Fetal Wellbeing Wednesday provides a weekly mechanism for sharing learning, reinforcing standards and supporting consistency of fetal monitoring and hourly peer review practice. The June 2026 Intrapartum Forum update also confirmed ongoing communication with staff on intrapartum documentation and ABC – Intrapartum Fetal Deterioration.

5.85. Picture: Example weekly “Fetal Wellbeing Wednesday” communications to staff

18 June 2025

Importance of recording uterine activity on CTG

Recording uterine activity accurately along with fetal heart rate it is crucial for appropriate interpretation of the CTG trace.

Toco (Tocodynamometer):
This specific part of the CTG machine is a strain gauge that detects the changes in abdominal tension caused by uterine contractions. It provides information about the frequency, duration, and intensity of contractions.

Recording uterine activity with the TOCO can be very challenging in reality. There are many factors which can interfere with the accuracy, such as maternal position, BMI, gestational age etc.

- Adjust the TOCO as and when required
- Ensure it is always set to baseline (20) once it is in position
- Palpate contractions with your hand if required and document as comment on Badger CTG trace

MATERNITY RAPID CLINICAL LEARNING

- 5.86.** In conclusion, the Trust can demonstrate that Condition 2 has been met. Hourly peer review is retained as a monitored local safety control during intrapartum care, supported by approved policy, competency-based training, monthly audit, fetal monitoring leadership oversight, staff learning communications, intrapartum fetal deterioration learning and clear governance escalation. The latest one-month dip to 80% against the 85% local target is being managed as a residual risk through established governance and does not undermine the Trust's self-assessment that the system required by Condition 2 is in place, monitored and responsive. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.
- 5.87.** Condition 2 should be read alongside Condition 3, which provides further assurance on the wider fetal monitoring safety system, including interpretation, escalation, competency, thematic review and learning.

Condition 3

The registered provider must implement an effective system for ensuring staff at Gloucestershire Royal Hospital interpret fetal monitoring traces accurately and escalate in line with Trust guidance to ensure all women and birthing people and their babies are cared for in a safe and effective manner in line with national guidance.

5.88. Summary

- 5.89. This condition is related to, but distinct from, Condition 2. While Condition 2 focuses on completion of hourly peer review, Condition 3 addresses the wider system for accurate fetal monitoring interpretation and timely escalation.
- 5.90. In summary, the Trust has implemented an embedded and monitored system to support accurate interpretation of intrapartum fetal monitoring and timely escalation in line with Trust guidance and relevant national standards. This system is underpinned by an approved intrapartum fetal monitoring policy, competency-based training, defined escalation pathways, local audit, thematic case review, staff learning communications and established governance oversight.
- 5.91. Assurance is provided through routine review of fetal monitoring audit data, monitoring method selection, interpretation and escalation, competency-based training compliance, PSIRF-aligned review of perinatal compromise cases and review through the Intrapartum Forum. Where themes, variance or material risk are identified, these are escalated through the Perinatal Oversight and Assurance Meeting and onward through executive-led maternity governance routes where required.
- 5.92. Available evidence, including Maternity Incentive Scheme Safety Action compliance, local snapshot audit findings and thematic review of perinatal compromise cases, indicates that interpretation and escalation are subject to routine scrutiny and that identified themes are acted upon through targeted improvement, staff communication and re-measurement.

5.93. Reasons and evidence for condition removal

5.94. Saving babies lives version 3 implementation

- 5.95. The Trust's approach to fetal monitoring is aligned to **NHS England Saving Babies' Lives Care Bundle Version 3, Element 4**, and provides evidence that the intent of the CQC condition is met: appropriate monitoring method, accurate interpretation and timely escalation. Supporting evidence is summarised below.
- 5.96. Saving Babies' Lives Care Bundle Version 3, Element 4: assurance standards and supporting evidence:
- **Competency and training:** a competency-based programme is in place for CTG interpretation and intermittent auscultation, with compliance evidenced through training records and oversight of mandatory update rates across staff groups (including bank/agency where relevant).
 - **Peer review ("fresh eyes"):** structured second review is maintained as a local safety control (target 85%), with performance monitored through audit/dashboards and reviewed at the Intrapartum Forum, with escalation where variance is sustained or thresholds are not met.
 - **Effective monitoring (right method, right time):** intrapartum risk assessment is documented and used to determine the appropriate monitoring modality (CTG vs IA), with compliance evidenced through audit against defined standards and exception reporting where deviations occur.
 - **Escalation and senior review:** escalation pathways are clearly defined within the intrapartum fetal monitoring guideline and are audited through documentation of interpretation, escalation and response; governance review ensures that any themes or delays are identified and addressed.
 - **Audit, review and learning:** ongoing assurance is provided through routine audit and dashboard monitoring, alongside PSIRF-aligned review of relevant incidents and themes (including intrapartum compromise), with actions tracked to completion and re-measurement used to evidence closed-loop improvement.
- 5.97. Taken together, the Trust can demonstrate that Condition 3 has been met. The service has an approved policy, defined standards for interpretation and escalation, competency-based training, routine audit and thematic review processes to support safe intrapartum fetal monitoring practice. Available evidence indicates that staff are supported to select the appropriate monitoring method, interpret traces in clinical context and escalate concerns in line with local guidance, and that where variance or learning themes are identified these are reviewed through governance, translated into

targeted action and re-measured. The Trust therefore considers that the immediate regulatory risk has been addressed and that the system for interpretation and escalation is embedded, monitored and sustainable.

5.98. Governance and clinical leadership

5.99. Clinical leaders

5.100. Clinical accountability for fetal monitoring interpretation and escalation is assigned to defined obstetric, fetal wellbeing and education roles. These roles provide collective oversight of policy, competency-based training, audit review, thematic learning, fetal monitoring improvement, staff communication and escalation through maternity governance.

5.101. Named postholders are maintained within the divisional governance structure to ensure clear accountability, continuity of oversight and handover should personnel change.

- Obstetric clinical leadership for fetal monitoring standards, senior review, interpretation, escalation and improvement oversight.
- Fetal wellbeing leadership for audit review, intrapartum fetal deterioration learning, staff support, improvement delivery and reinforcement of escalation standards.
- Training and education leadership for competency-based fetal monitoring training, intrapartum fetal deterioration education and reinforcement of interpretation, documentation and escalation standards.

5.102. Governance

5.103. Oversight of fetal monitoring interpretation, documentation and escalation is provided through the Intrapartum Forum, which reviews audit findings, dashboard data, thematic learning from perinatal compromise cases, corrective actions and emerging risks. Where sustained variance, unresolved actions or material risk is identified, escalation is made to the Perinatal Oversight and Assurance Meeting and, where required, onward through executive-led maternity governance and Board assurance routes. This provides clear ward-to-Board visibility of performance, risk and improvement.

Governance control	Frequency	Review route	Assurance provided
Fetal monitoring audit: monitoring method, interpretation and escalation	Monthly / routine cycle	Fetal monitoring team and Intrapartum Forum	Assurance that monitoring method selection, interpretation and escalation are reviewed against local standards
Maternity Incentive Scheme Safety Action 6	Annual submission with local monitoring	Maternity governance and Board sign-off route	External assurance against national fetal monitoring standards
Fetal monitoring competency and training	Ongoing through mandatory training cycle	Fetal monitoring team and maternity training governance	Staff competence to interpret, document, contextualise and escalate fetal monitoring concerns
Perinatal compromise thematic review	Thematic / by reporting cycle	PSIRF learning route, Intrapartum Forum and fetal monitoring leads	Identification of themes relating to interpretation, escalation, communication and documentation
Fetal Wellbeing Wednesday and staff communications	Weekly / as required	Fetal monitoring team	Learning dissemination and reinforcement of interpretation and escalation standards
Action tracking	Monthly and by exception	Intrapartum Forum and POAM for overdue or high-risk actions	Closed-loop improvement with ownership, timescales and completion evidence

5.104. Standardised management policy

5.105. The Trust has an approved intrapartum fetal monitoring policy in place (M1068, review date April 2027), which sets the current operative standard for fetal monitoring interpretation, clinical contextualisation, documentation and escalation. The current approved policy remains in force

while updates are made to maintain alignment with revised NICE guidance, ensuring that staff continue to have a clear standard for practice and audit.

5.106. Staff engagement in the BadgerNet development and testing process is being used to support usability, implementation and adoption of digital intrapartum documentation, strengthening the reliability of fetal monitoring documentation and escalation records.

5.107. Audit data: Saving Babies' Lives Care Bundle Version 3, Element 4, effective fetal monitoring

5.108. Local assurance against Element 4 is provided through competency-based training, audit of the monitoring method selected, review of documentation relating to interpretation and escalation, and governance review of incident themes. This allows the Trust to assess whether staff are using the appropriate monitoring modality, interpreting traces accurately and escalating concerns in line with local guidance.

5.109. The latest snapshot audit of 10 cases provides local assurance that, within this sample, initial risk assessment, accurate interpretation and appropriate escalation standards were met. The Trust recognises that this is a small sample and therefore interprets it as one component of a wider triangulated assurance framework, alongside routine audit, thematic review, competency monitoring and governance oversight.

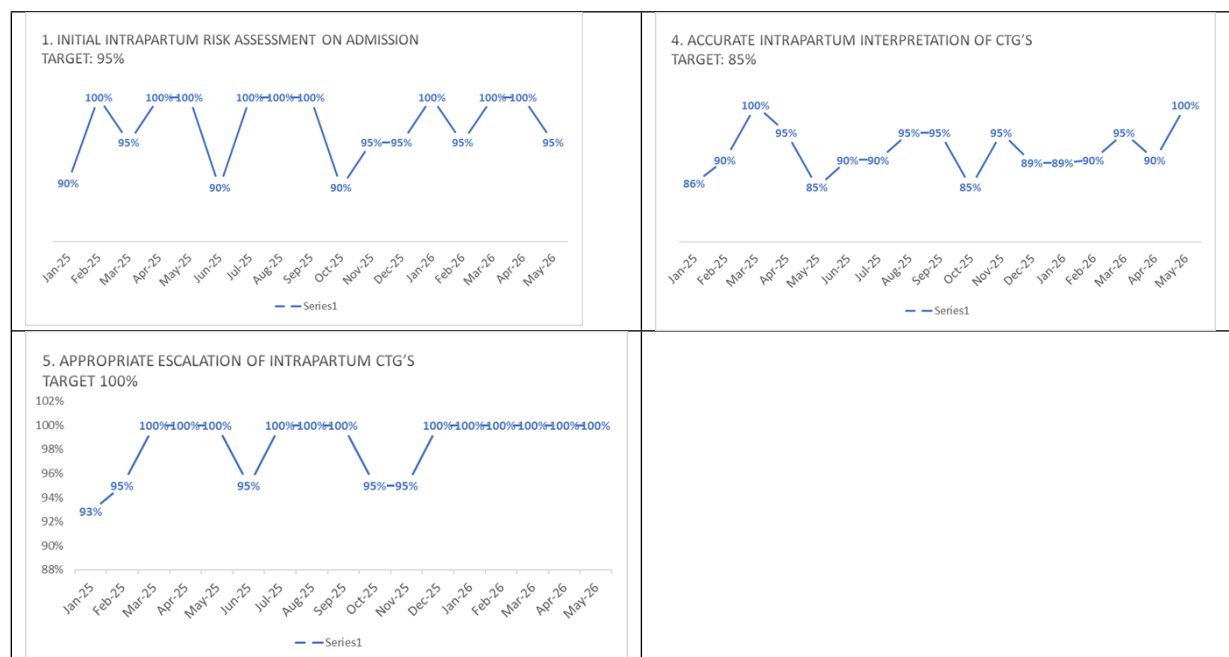
June 2026 data

Risk assessment: 95% against a target of 95%

Accurate interpretation 100%

Appropriate escalation 100%

5.110. Graphs: snapshot audit of 10 cases covering initial risk assessment, accurate interpretation and appropriate escalation



5.111. PSIRF - Patient Safety Themes presented to the Intrapartum Forum May 2026

5.112. Perinatal compromise Datix thematic review, June 2025 to February 2026

5.113. The Intrapartum Forum received a thematic review of 134 perinatal compromise cases in May 2026. The cases reviewed included babies with low Apgar scores, low cord gases or a requirement for neonatal resuscitation.

5.114. Review of these cases identified themes relevant to Condition 3, including fetal monitoring interpretation, timeliness of escalation, communication and documentation. These findings are being managed through the Trust's PSIRF learning and improvement processes, with targeted actions agreed through governance forums, monitored by fetal monitoring leads and used to inform refresher training, safety communications, updates to local guidance and re-measurement through audit.

5.115. Actions in response to the findings were presented to the Intrapartum Forum in May 2026 and are being monitored by fetal monitoring leads through routine governance and action tracking.

5.116. Residual risk and mitigation

5.117. The principal residual risk is variation in fetal monitoring interpretation, documentation or escalation during periods of clinical complexity or operational pressure. This risk is mitigated through an approved policy, competency-based training, routine audit, review of monitoring method selection, PSIRF-aligned thematic review of perinatal compromise cases, fetal monitoring leadership oversight, weekly staff learning communications and escalation through the Intrapartum Forum and POAM where themes, sustained variance or unresolved actions are identified.

5.118. Culture of continuous improvement

5.119. The fetal monitoring improvement team continues to support implementation of Saving Babies' Lives Care Bundle Version 3, Element 4, with a focus on competency in fetal monitoring interpretation, clinical contextualisation, documentation, escalation and learning from intrapartum fetal deterioration. Learning is shared with staff through established fetal wellbeing communications and reinforced through training, audit and governance review.

5.120. In conclusion, the Trust can demonstrate that Condition 3 has been met. The service has established a sustainable system for fetal monitoring interpretation and escalation, supported by approved policy, competency-based training, local audit, Maternity Incentive Scheme Safety Action 6 compliance, PSIRF-aligned thematic review, fetal monitoring leadership oversight, staff learning communications and clear governance escalation. Residual risk relating to variation in interpretation, documentation or escalation is recognised and actively managed through routine governance. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.

Condition 4

The registered provider must implement an effective system for ensuring staff at Gloucestershire Royal Hospital complete and escalate maternity early obstetric warning score charts in line with national guidance during intrapartum and postnatal care.

5.121. Summary

- 5.122.** The Trust has established and sustained an effective system for completion, review and escalation of maternal early warning scores across intrapartum and postnatal care. This provides assurance that maternal deterioration is recognised and escalated promptly in line with Trust guidance and relevant standards.
- 5.123.** Assurance is now supported by the national Maternal Early Warning Scores (MEWS) escalation framework, which categorises concern as low, low-medium, medium or high according to the total MEWS score, with defined expectations for escalation, clinical review timing, observation frequency and secondary escalation where the expected response is not achieved.
- 5.124.** Oversight is provided through established maternity governance routes, including the Postnatal Forum and escalation to the Perinatal Oversight and Assurance Meeting where required, giving clear line of sight from clinical areas to executive and Board oversight.
- 5.125.** The Trust implemented the national Maternal Early Warning Score system on 5 May 2026. Early audit of implementation provides additional assurance that the transition from the previous maternity early obstetric warning score arrangements is being managed safely and that adoption of the new standard is being actively tested.
- 5.126.** Taken together, the available evidence supports the conclusion that Condition 4 has been met. Historic audit data under the previous maternity early obstetric warning score process demonstrated consistently high compliance, and current implementation assurance demonstrates that arrangements for recognising and escalating maternal deterioration remain embedded, monitored and subject to appropriate governance during transition to the national system.

5.127. Reasons and evidence for condition removal

- 5.128.** The Trust can demonstrate evidence of compliance through audit, staff training, governance oversight and implementation assurance.

5.129. Governance and clinical leadership

- 5.130.** Clinical accountability for maternal deterioration and MEWS implementation is assigned to defined obstetric, midwifery, ward leadership and education roles. These roles provide collective oversight of policy, training, audit, implementation assurance, escalation practice and governance reporting.
- 5.131.** Named postholders are maintained within the divisional governance structure to ensure clear accountability, continuity of oversight and handover should personnel change.
- Obstetric clinical leadership for maternal deterioration standards, senior review and escalation.
 - Midwifery leadership for MEWS completion, escalation practice, ward implementation and staff support.
 - Ward leadership for day-to-day adoption, documentation reliability, local feedback and escalation of implementation issues.
 - Education and training leadership for MEWS training, staff communication and reinforcement of escalation standards.

5.132. Governance

- 5.133.** Oversight of MEWS completion, escalation and implementation is provided through the Postnatal Forum, which reviews audit findings, implementation themes, spot-check results, staff feedback and improvement actions. Where sustained variance, unresolved actions or material risk is identified, escalation is made to the Perinatal Oversight and Assurance Meeting and, where required, onward through executive-led maternity governance and Board assurance routes. This provides clear ward-to-Board visibility of performance, risk and improvement.

Governance control	Frequency	Review route	Assurance provided
MEWS completion and escalation audit	Routine cycle / spot checks during implementation	Postnatal Forum	Assurance that charts are completed and escalated in line with the national MEWS low, low-medium, medium and high concern framework
National MEWS implementation review	During implementation and by reporting cycle	Postnatal Forum and maternity governance routes	Safe adoption of the new national standard and identification of implementation issues
MEWS level of concern and response review	Routine audit / by exception	Postnatal Forum, with escalation to POAM where required	Evidence that deterioration triggers, additional concerns, clinical review timing and secondary escalation expectations are recognised and acted upon appropriately
Martha's Rule implementation	Trust Deteriorating Patient Committee (DPC)	Via Postnatal Forum to DPC	Additional assurance that concerns about clinical deterioration can be escalated independently and acted upon promptly.
Staff training and communication	During implementation and through mandatory training governance	Education team and maternity governance	Staff awareness of the new MEWS process, escalation expectations and documentation standards
Action tracking	Monthly and by exception	Postnatal Forum and POAM for overdue or high-risk actions	Closed-loop improvement with ownership, due dates and completion evidence

5.134. Standardised management policy

5.135. The previous maternity early obstetric warning score process was set out in the MOEWS clinical guideline for the severely ill obstetric patient (M2010), which provided the operative standard for completion, review and escalation at the time of the original condition.

5.136. The national Maternal Early Warning Score system was implemented on 5 May 2026, supported by a new MEWS policy. The policy sets out the current standard for completion, review, escalation and response during intrapartum and postnatal care, and supersedes the legacy MOEWS audit approach while retaining the core safety objective of timely recognition and escalation of maternal deterioration.

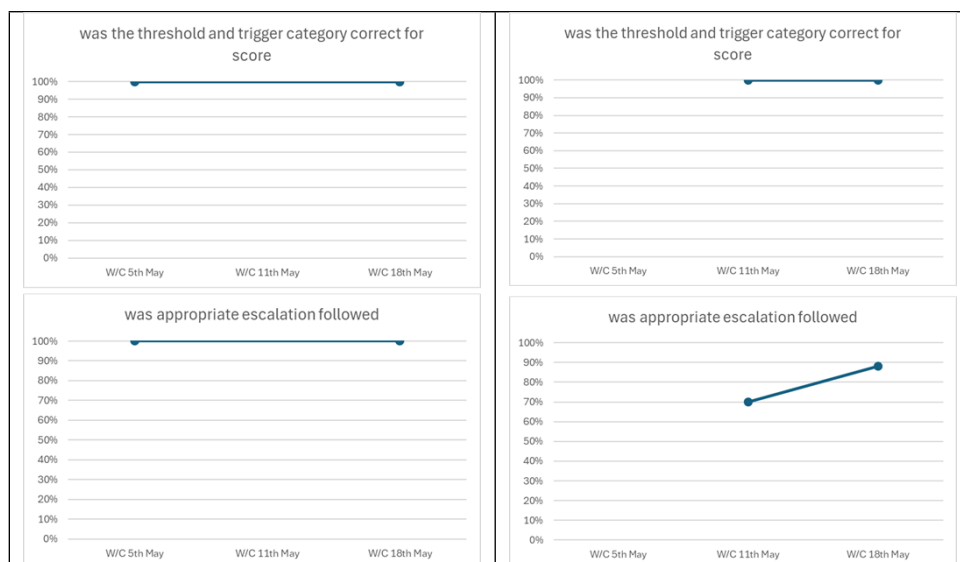
5.137. The national MEWS chart uses total score thresholds to categorise concern as low, low-medium, medium or high, and also requires staff to consider additional concerns, including professional concern, woman or family concern, significant bleeding, reduced urine output, altered responsiveness, increased pain or significant additional therapies.

5.138. Audit data

5.139. The national Maternal Early Warning Score system was implemented on 5 May 2026. Audit arrangements have been reset to test implementation of the new system, recognising that this is a new standard for the Trust compared with the system in place at the time of the Care Quality Commission inspection and Section 31 notice. This provides active assurance that safe implementation is being monitored rather than assumed. The audit approach includes review of chart completion, accuracy of scoring, correct application of the low, low-medium, medium and high concern escalation thresholds, documented response, observation frequency, timely clinical review, additional concerns and secondary escalation where the expected response is not achieved.

May 2026 audits

Maternity Ward	Delivery Suite
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5.140. Plan

5.141. The Trust implemented the new national MEWS system on 5 May 2026 and has therefore concluded the previous audit format linked to the legacy maternity early obstetric warning score process. A new audit tool is being used to review implementation of the national system. This enables the Trust to provide early assurance that the new standard is being adopted safely and consistently, and that any implementation issues are identified promptly and managed through established governance arrangements.

5.142. Residual risk and mitigation

5.143. The principal residual risk is variation in completion, scoring or escalation during transition to the national MEWS system. This is mitigated through spot-check audit of chart completion, scoring accuracy, level of concern, additional concerns, observation frequency, clinical review timing and secondary escalation, alongside ward leadership oversight, staff communication, implementation support and escalation through the Postnatal Forum and POAM where themes, sustained variance or unresolved actions are identified.

5.144. Culture of continuous improvement

5.145. Learning from early implementation of the national MEWS system is being used to refine staff communications, strengthen documentation reliability and support consistent application of the national escalation framework, including additional concerns, level of concern, clinical review timing, observation frequency and secondary escalation. This ensures that adoption of the new standard is treated as an active improvement process, with learning reviewed through governance and used to inform ongoing training and audit.

5.146. The next phase of improvement will align MEWS implementation with the Maternal Care Bundle element on pre-hospital and acute care, ensuring that recognition of maternal deterioration, escalation, observation frequency, clinical review timing and secondary escalation are consistently embedded across maternity and linked care settings.

5.147. In conclusion, the Trust can demonstrate that Condition 4 has been met. The service has established a sustainable system for completion and escalation of maternal early warning scores, supported by approved policy, staff training, national MEWS concern thresholds, additional-concern triggers, routine audit, implementation assurance, clinical leadership oversight and clear governance escalation. Residual risk relating to transition to the national MEWS system is recognised and actively managed through routine governance. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.

Condition 5

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

5.148. Summary

- 5.149.** In summary, the Trust has established and maintained a monitored system to ensure completion of venous thromboembolism risk assessments across the maternity pathway. This system is aligned with NICE and RCOG guidance and supports prompt identification of risk at key points of care.
- 5.150.** Core controls are embedded through mandatory digital VTE risk assessment within the electronic patient record, clear clinical guidance and defined expectations for reassessment where a woman's clinical condition changes. These arrangements reduce the risk of omission and support consistent clinical decision-making across antenatal, intrapartum and postnatal care.
- 5.151.** Performance is monitored through routine audit and Production Board reporting. Oversight is provided through maternity governance arrangements and the Trust-wide VTE Prevention Improvement Group, providing clear line of sight to executive and Board assurance.
- 5.152.** The service is also using wider pathway improvement work, including discharge information and Maternal Care Bundle implementation, to strengthen reliability beyond the immediate condition requirements.
- 5.153.** Taken together, the Trust can demonstrate that Condition 5 has been met. The service has established and maintained a monitored system for completion of VTE risk assessments, supported by an approved guideline aligned to NICE and RCOG standards, mandatory digital assessment within the electronic patient record, defined expectations for reassessment where clinical condition changes, routine audit and clear governance oversight. Manual audit performance has consistently met or exceeded the 95% target in recent cycles, including 100% in the latest completed audit, supporting the conclusion that completion of admission risk assessments is embedded and reliable.
- 5.154.** Wider pathway improvement work, including Maternal Care Bundle implementation and strengthening of pre-booking thromboprophylaxis processes, provides additional evidence of continuous improvement but does not detract from the core assurance that the immediate regulatory risk identified in Condition 5 has been addressed. The available evidence therefore supports the conclusion that the Trust's arrangements for VTE risk assessment are established, monitored and sustainable.

5.155. Reasons and evidence for condition removal

- 5.156.** The Trust has implemented a structured system to support completion of VTE risk assessments through approved guidance, digital prompts within BadgerNet, mandatory assessment fields, routine audit, pathway review and governance oversight. The system is designed to support risk identification at key points in the maternity pathway and to reduce the risk of omitted assessments.

5.157. Governance and clinical leadership

5.158. Maternity

- 5.159.** Clinical accountability for maternity VTE risk assessment is assigned to defined obstetric, midwifery, ward leadership, digital pathway and governance roles. These roles provide collective oversight of guideline review, digital pathway reliability, staff communication, audit, pathway improvement and governance reporting.
- 5.160.** Named postholders are maintained within the divisional governance structure to ensure clear accountability, continuity of oversight and handover should personnel change.
- Obstetric clinical leadership for VTE risk assessment standards, prescribing decisions, escalation and pathway improvement.
 - Midwifery leadership for completion of VTE risk assessment, reassessment where clinical condition changes, staff support and pathway reliability.
 - Ward and governance leadership for audit review, documentation reliability, learning, action tracking and escalation through maternity governance.

5.161. Trust-wide VTE prevention

- 5.162.** The Trust-wide VTE Prevention Improvement Group, led by the Medical Director, provides wider organisational oversight of VTE prevention data, improvement work and learning. Maternity VTE risk assessment assurance is linked into this wider Trust governance route where relevant.

5.163. Governance

5.164. Oversight of maternity VTE risk assessment completion, reassessment, digital pathway reliability and pathway improvement is provided through maternity governance arrangements, with linkage to the Trust-wide VTE Prevention Improvement Group. Audit findings, Production Board data, pathway issues, Maternal Care Bundle learning and improvement actions are reviewed through established governance routes. Where sustained variance, unresolved actions or material risk is identified, escalation is made through maternity governance and onward to executive-led or Trust-wide governance routes as required. This provides clear ward-to-Board visibility of performance, risk and improvement.

Governance control	Frequency	Review route	Assurance provided
Admission VTE risk assessment audit	Quarterly, following sustained high compliance	Maternity governance and Production Board reporting	Assurance that VTE risk assessment completion remains embedded and reliable
BadgerNet mandatory VTE assessment prompts	Continuous digital control, reviewed through audit and pathway feedback	Maternity governance and digital pathway review	Reduction in omitted assessments and improved reliability of completion
Reassessment when clinical condition changes	Case-based and by audit cycle	Ward leadership and maternity governance	Assurance that risk is reviewed when clinical circumstances change
Thromboprophylaxis and discharge information review	Spot check and pathway review	Maternity governance and Trust-wide VTE routes where required	Assurance that risk assessment links to appropriate prophylaxis and patient information
Maternal Care Bundle VTE pathway improvement	Gap analysis and action plan, with re-audit planned	Perinatal Governance Team and Maternity Clinical Effectiveness Group	Whole-pathway learning beyond the immediate condition requirement

5.165. Standardised management policy

5.166. Guideline M2014, VTE Disorders: Diagnosis and Treatment – Thromboprophylaxis during Pregnancy, Labour and After Delivery, describes the Trust’s maternity VTE risk assessment and management system. The guideline is aligned with NICE NG89 and RCOG Green-top guidance 37a and 37b, and sets out expectations for risk assessment, thromboprophylaxis, reassessment where clinical condition changes and escalation where required.

5.167. Digital systems

5.168. The VTE risk assessment is embedded within BadgerNet, with prompts and mandatory fields in the antenatal booking and postnatal admission pathways. These digital controls support staff to complete the assessment consistently and reduce the risk that assessment is omitted.

5.169. BadgerNet prompts also support identification of intermediate and high-risk women and birthing people, prompting appropriate clinical review, thromboprophylaxis consideration and documentation in line with the maternity VTE pathway.

Table: BadgerNet prompts for intermediate and high-risk VTE risk assessment

Antenatal intermediate VTE risk assessment	Antenatal high-risk VTE assessment
Indication ☐ Low VTE Risk ☒ Intermediate VTE Risk ☐ High VTE Risk Recommendation Consider antenatal prophylaxis with LMWH Assessment Verified Authorise Thromboprophylactic Medication ☐ Dalteparin ☐ Enoxaparin	Indication ☐ Low VTE Risk ☐ Intermediate VTE Risk ☒ High VTE Risk Recommendation Requires antenatal prophylaxis with LMWH. Refer to trust-nominated thrombosis in pregnancy expert/team Assessment Verified Authorise Thromboprophylactic Medication ☐ Dalteparin ☐ Enoxaparin

5.170. Reassessment Documentation

5.171. The current guideline and electronic pathway require reassessment of VTE risk where a woman’s clinical condition changes. Ongoing pathway work is focused on strengthening the consistency and documentation of reassessment during admission, postnatal care and consultant review, ensuring that changes in clinical risk are visible, acted upon and auditable.

5.172. Audit - risk assessments

5.173. Given sustained high compliance, quarterly audit has been agreed as the routine assurance frequency for admission VTE risk assessment completion. Performance has consistently met or exceeded the 95% target in recent cycles, including 100% in the latest completed audit for February 2026, supporting the conclusion that this control is embedded and reliable.

5.174. Quarterly audits have been agreed as the ongoing assurance frequency, with the next audit due in September 2026. Any variance from the 95% target will be reviewed through maternity governance, with corrective action and escalation through Trust-wide VTE governance where required.

5.175. Table: VTE Risk assessment compliance Production Board data

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

Thromboprophylaxis

5.176. Spot-check audits for antenatal and postnatal women continue to demonstrate 95–100% compliance. The relevant fields are mandatory within the digital pathway, supporting consistently high completion and providing assurance that risk assessment is embedded in routine practice.

5.177. Residual risk and mitigation

5.178. The principal residual risk is variation in reassessment, thromboprophylaxis initiation or documentation when clinical circumstances change or where care spans community, primary care and maternity services. This is mitigated through mandatory BadgerNet assessment prompts, quarterly audit, spot-check review, pathway improvement work, discharge information review, PSIRF-style review of hospital-associated thrombosis where identified, and escalation through maternity and Trust-wide VTE governance where themes, sustained variance or unresolved actions are identified.

5.179. Patient Information

5.180. Discharge Education

5.181. The service is continuing to strengthen documentation that women and birthing people have received written information on VTE risks, symptoms of deep vein thrombosis and pulmonary embolism, and the importance of prescribed thromboprophylaxis on discharge. This supports patient understanding, adherence and escalation if symptoms develop after discharge.

5.182. Patient Safety Incident Framework response

5.183. Investigation of Events

5.184. The service is encouraging all cases of hospital-associated thrombosis to be reported as safety incidents. Where identified, these cases will be reviewed using a PSIRF-style multidisciplinary approach to understand contributory factors, including whether assessment, reassessment, prescribing, administration, patient information or follow-up processes could be strengthened.

5.185. Next steps

5.186. Quarterly audits will continue to monitor completion of VTE risk assessments, with the next audit due in September 2026 and escalation through maternity governance if performance falls below the 95% target.

5.187. The next phase of service improvement is implementation of the NHS England Maternal Care Bundle. Element 1 focuses on reducing VTE through earlier risk identification, timely thromboprophylaxis and whole-pathway working across early pregnancy, community, primary care and maternity services.

5.188. The Perinatal Governance Team has started the gap analysis against the Maternal Care Bundle VTE recommendations and will develop an action plan to support implementation of all relevant elements, with a target date of March 2027. A first baseline audit against the Maternal Care Bundle standards has been completed while the national tool is awaited, and findings will be used to strengthen early thromboprophylaxis pathways and documentation with system partners.

5.189. Maternal Care Bundle Baseline Audit – prebooking thromboprophylaxis

5.190. This baseline audit relates to a wider whole-pathway standard introduced through the Maternal Care Bundle and is supplementary to, rather than determinative of, the Trust's compliance with Condition 5. It is included here to demonstrate continued pathway improvement beyond the core requirement for completion of VTE risk assessments within the Trust's maternity service.

5.191. The first audit reviewed local implementation of NHS England's Maternal Care Bundle, Element 1: venous thromboembolism. This standard is primarily delivered before women reach the maternity service, at the first maternity service contact, often in primary care or community settings and before the antenatal booking appointment. It requires timely VTE risk identification and commencement of low molecular weight heparin for women identified as high risk. In a Trust snapshot of 15 women identified as high risk at booking, 9/15 had low molecular weight heparin started before booking, 2/15 had not started despite meeting criteria, and 4/15 had variable or unclear pathways, commonly where initiation was delayed pending obstetric review or where risk status was later revised.

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

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

5.194. The service is using these learning points to strengthen a whole-pathway system approach with partners, standardising early pregnancy processes across primary care, community and maternity services. This includes reinforcing community-led initiation and a 72-hour safety net for high-risk cases, refreshing multidisciplinary training and communications for referrers, embedding the national questionnaire across all referral and self-referral routes, introducing a structured BadgerNet template to improve documentation and auditability, reviewing cases where risk was downgraded to share learning, and providing ongoing oversight through the Maternity Clinical Effectiveness Group, with re-audit planned within six months.

5.195. Culture of continuous improvement

5.196. Condition 5 is supported by a maturing improvement approach that extends beyond completion of the initial VTE risk assessment. The service is strengthening whole-pathway reliability through digital prompts, reassessment documentation, discharge information, review of hospital-associated thrombosis, Maternal Care Bundle implementation and engagement with community and primary care partners where early thromboprophylaxis is required.

5.197. In conclusion, the Trust can demonstrate that Condition 5 has been met. The service has established a sustainable system for completion of VTE risk assessments, supported by approved guidance aligned to NICE and RCOG standards, mandatory digital assessment prompts, reassessment expectations, routine audit, Production Board reporting, Trust-wide VTE oversight and clear governance escalation. Residual risk relating to reassessment, thromboprophylaxis initiation and whole-pathway documentation is recognised and actively managed through routine governance and improvement work. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.

Condition 6

The registered provider must implement an effective system for ensuring agency midwifery staff at Gloucestershire Royal Hospital have a comprehensive induction to the unit, are able to access the maternity electronic records system and Trust policies as well as enter and exit the unit without delay.

Summary

- 5.199.** In summary, the Trust has established a monitored system to ensure agency midwifery staff working at Gloucestershire Royal Hospital receive a comprehensive local induction and can access the unit, the maternity electronic patient record and essential Trust policies in a timely way. This supports safe care from the start of each shift and reduces reliance on informal workarounds.
- 5.200.** Core controls are embedded through the Trust Temporary Workforce Policy, a structured local maternity induction process, a published maternity action card for temporary staff, and defined arrangements for physical access, electronic systems access and supervision. These controls reduce reliance on informal workarounds and support consistent safe deployment of temporary staff.
- 5.201.** Oversight is provided through established maternity workforce governance arrangements, including routine monitoring of bank and agency usage, review through the Workforce Meeting and escalation to the Maternity Oversight and Assurance Committee where required. This provides clear line of sight to executive and Board assurance and supports timely action where workforce, induction or access issues are identified.
- 5.202.** These arrangements support safe and proportionate use of agency midwifery staff during periods of workforce pressure while maintaining clear accountability, local familiarity and access to the information and systems required for safe practice.
- 5.203.** Taken together, the Trust can demonstrate that the immediate regulatory risk identified in Condition 6 has been addressed through embedded induction, access and governance controls. The available evidence supports the conclusion that agency staff induction and access arrangements are established, monitored and sustainable.
- 5.204.** The Trust's self-assessment is that Condition 6 has been met because the required system is established, monitored and responsive. Residual risk relates principally to short-notice deployment, access delays or inconsistent completion of local induction, and is managed through workforce governance, escalation routes and local shift-level controls.

5.205. Reasons and evidence for condition removal

- 5.206.** The Trust has implemented a structured system for agency midwifery induction and access through approved temporary workforce policy requirements, a maternity-specific action card, local induction arrangements, defined access processes, electronic patient record access arrangements and workforce governance oversight.

5.207. Governance and workforce leadership

- 5.208.** The Deputy Director of Midwifery is the lead for this work, with accountability for agency midwifery induction, access and safe deployment supported by defined maternity workforce, ward leadership, digital access, education and governance roles. These roles provide collective oversight of booking, induction, system access, policy access, local supervision, monitoring and escalation.
- Maternity workforce leadership for monitoring bank and agency usage, deployment and temporary workforce risks.
 - Ward leadership for local induction, shift-level orientation, supervision and confirmation that agency midwives can access key systems and areas.
 - Digital and administrative support for maternity electronic patient record access, temporary log-in arrangements and escalation of access issues.
 - Governance leadership for review of incidents, feedback, recurring issues and action tracking through maternity workforce governance.
- 5.209.** Bank and agency usage, induction arrangements, access issues and temporary workforce risks are monitored through maternity workforce governance arrangements. The Workforce Meeting provides oversight, with escalation to the Maternity Oversight and Assurance Committee where workforce risk, access delays, recurring induction issues or unresolved actions are identified.
- 5.210.** The Trust Temporary Workforce Policy requires all new temporary staff to receive an induction before commencing a shift. For maternity services, this is supported by a published action card

(B0720), which sets out local processes, access arrangements and key expectations for safe practice.

5.211. This provides a defined route for reviewing temporary workforce demand, induction compliance, access to the maternity electronic patient record, access to Trust policies, physical access to the unit, and any feedback or incidents relating to agency staff deployment.

Governance control	Frequency	Review route	Assurance provided
Bank and agency usage monitoring	Monthly reviews of data	Workforce Meeting by exception	Visibility of temporary workforce reliance, deployment patterns and workforce risk
Agency midwife local induction	At first shift / deployment	Flow Midwife and Workforce Meeting by exception	Assurance that temporary staff receive local orientation and understand key safety processes before independent practice
Electronic patient record access	Before or at start of shift, with escalation by exception	Ward leadership, digital support and Workforce Meeting where required	Assurance that agency staff can document care and access maternity records without avoidable delay
Policy and action-card access	At induction and during shift as required	Flow Midwife/Ward leadership and maternity governance by exception	Assurance that temporary staff can access essential Trust and maternity-specific guidance
Physical access to the unit	At each deployment, with escalation by exception	Ward leadership and site/security access routes where required	Assurance that agency staff can enter and exit clinical areas without avoidable delay
Action tracking and escalation	Monthly and by exception	Workforce Meeting and Maternity Oversight and Assurance Committee	Closed-loop improvement for recurring issues, delayed access or unresolved workforce risks

5.212. Standardised induction and access controls

5.213. The Trust Temporary Workforce Policy requires new temporary staff to receive induction before commencing a shift. In maternity, this is supported by the maternity temporary staff action card, which sets out local expectations, access arrangements, escalation contacts, key safety processes and how to access essential Trust and maternity-specific policies.

5.214. Ward leadership confirms local orientation at the start of deployment, including access to the maternity electronic patient record, local emergency processes, escalation routes, controlled areas, equipment and relevant policies. Any access delay or unresolved issue is escalated through the shift leadership route and reviewed through workforce governance where required.

5.215. Residual risk and mitigation

5.216. The principal residual risk is that short-notice agency deployment could result in delayed access to the unit, delayed electronic patient record access, or inconsistent completion of local induction. This is mitigated through pre-shift booking and access arrangements where possible, ward-level induction, temporary workforce policy requirements, maternity action-card guidance, shift leadership oversight, escalation of access issues and monthly workforce governance review.

5.217. Culture of continuous improvement

- Learning from temporary workforce deployment, staff feedback, access issues and any incidents involving agency staff is reviewed through workforce governance and used to strengthen induction materials, action-card content, access processes and communication with temporary staffing providers.

- In conclusion, the Trust can demonstrate that Condition 6 has been met. The service has established a sustainable system for agency midwifery induction and access, supported by the Trust Temporary Workforce Policy, maternity-specific action-card guidance, local induction, access arrangements for the maternity electronic patient record and Trust policies, workforce governance oversight and clear escalation routes. Residual risk relating to short-notice deployment, access delay or inconsistent induction is recognised and actively managed through routine workforce governance. This provides the Board and CQC with reasonable assurance that the original regulatory risk has been addressed and that ongoing compliance is monitored through business-as-usual arrangements.

Condition 7

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

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

5.218. Summary

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

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

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

5.222. Reasons and evidence for condition removal

5.223. The Trust submitted the required quality improvement plan within 21 days of the notice in May 2024. The plan included the required short- and medium-term actions for PPH and fetal monitoring, immediate actions to reduce risk, named responsibilities, timescales and measurable actions.

5.224. Governance and accountability

5.225. Accountability for delivery and reporting of the Section 31 action plans has been maintained through executive-led maternity governance, divisional leadership, clinical leads and corporate quality governance support. This has ensured that actions were assigned, monitored, escalated where required and reported through Board and committee routes.

Governance control	Frequency	Review route	Assurance provided
Section 31 quality improvement plan submission	Initial submission within 21 days	CQC and Trust governance routes	Evidence that the required PPH and fetal monitoring plans were submitted on time with responsibilities, timescales and measurable actions
Monthly Section 31 progress reporting	Monthly	CQC, Trust Board and committees	Ongoing visibility of actions, risk, progress, evidence and escalation
Board and committee review	Routine cycle	Trust Board, Quality and Performance Committee and executive-led maternity forums	Ward-to-Board oversight of delivery, residual risk and escalation

Project - Plan On A Page

Title: Effectiveness of Fetal Monitoring

Project lead: Rebecca Evans-Jones, Rachael Harris

Sponsor: Lisa Stephens

Team: Lead Fetal Monitoring Midwives Sasha Wainfor, Ridwana Pandor; Fetal monitoring Consultant Leona El-Rochi

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

Current Situation

The CQC have reviewed our audits and do not feel assured that staff are identifying and escalating fetal compromise effectively. The fetal monitoring policy was rewritten in line with national guidance (NICE 2022 and the fetal physiology guideline). It was approved and ratified through an MDT guideline committee before being published in April 2024.

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

Breakdown of the problem (Diagnostics)

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

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

Measures and Data Collection

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

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

Driver Diagram and Prioritisation of Change Ideas

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

SMART Aim

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

PDSA

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

Scale Up and Spread

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

5.229. Residual risk and mitigation

5.230. The principal residual risk is that, following removal of enhanced monthly reporting, oversight could become less visible or less frequent. This is mitigated by embedding the actions and measures into routine maternity governance, Board reporting (through the Perinatal Quality Oversight Model Report, dashboard review, audit, PSIRF-aligned learning and exception escalation.

5.231. Culture of continuous improvement

5.232. The reporting discipline required by Condition 7 has strengthened the Trust's approach to action planning, evidence collation, measurable improvement and Board assurance. These disciplines have now been embedded within routine maternity governance and continue to support transparency, escalation and sustained improvement.

5.233. In conclusion, the Trust can demonstrate that Condition 7 has been met. The required quality improvement plan was submitted within the specified timeframe, and monthly reporting to the CQC and Trust Board has provided consistent evidence of action delivery, accountable ownership, measurable progress and escalation where required. The reporting requirement has fulfilled its purpose, and the controls are now embedded within business-as-usual governance. This provides the Board and CQC with reasonable assurance that the original regulatory reporting risk has been addressed and that continued oversight will be maintained through established governance arrangements.

Condition 8

Within 21 days of this notice and monthly thereafter, the registered provider must provide to the CQC the following:

- a. An updated action plan with clear details of progress on all conditions contained within this notice.
- b. All reports written to provide assurance to the senior leadership team and/or Trust board to demonstrate compliance with the conditions.
- c. The Trust maternity dashboard.

5.234. Summary

5.235. In summary, the Trust has met the requirements of Condition 8 by providing monthly submissions to CQC, including updated action plans, Board-level assurance reports and the maternity dashboard. These submissions have provided a consistent evidence trail of progress against each condition and demonstrated how risks were being monitored, managed and escalated where required.

5.236. The reporting required under Condition 8 has supported regulatory and senior leadership oversight throughout the period of enhanced scrutiny. Reports were reviewed through established Trust governance arrangements, including Trust Board, Quality and Performance Committee and executive-led maternity forums, providing visibility of maternity safety, improvement delivery and compliance.

5.237. As improvements across Conditions 1–6 have become embedded, assurance has appropriately transitioned from enhanced regulatory reporting to routine business-as-usual governance. This is supported by integrated dashboards, audit, PSIRF-aligned learning and established escalation routes, reflecting improved stability and a reduced regulatory risk profile.

5.238. Taken together, the Trust can demonstrate that the requirements of Condition 8 have been met, that ongoing risks are managed through established governance arrangements, and that continued compliance is sustainable without enhanced monthly regulatory reporting.

5.239. Governance and accountability

5.240. Accountability for Condition 8 reporting has been maintained through executive-led maternity governance, corporate quality governance support and established Board and committee reporting routes. This has ensured that updated action plans, assurance reports and dashboard information were collated, reviewed, submitted and escalated where required.

Governance assurance Governance control	Frequency	Review route	Assurance provided
Monthly CQC submission	Monthly	CQC and Trust governance routes	Evidence that updated action plans, Board assurance reports and the maternity dashboard were provided
Trust Board and committee reporting	Routine cycle	Trust Board, Quality and Performance Committee and executive-led maternity forums	Senior oversight of risk, progress, compliance and escalation
Maternity dashboard reporting	Monthly / routine cycle	Board, committee and maternity governance routes	Data-led oversight of quality, safety, risk and improvement
Transition to business-as-usual oversight and reporting within the Perinatal Quality Oversight Model Report	Following embedding of controls	Established maternity, divisional and Trust governance routes	Assurance that oversight continues without enhanced monthly reporting

5.241. Evidence of compliance with the condition

5.242. Table: Outline of the reporting schedule to CQC:

Dates due	Update
29 May 2024	– complete
28 June 2024	– complete
31 July 2024	– complete
30 August 2024	– complete
27 September 2024	– complete
30 October 2024	– complete
29 November 2024	– complete
31 December 2024 8 January 2025	– complete
31 January 2025	– complete
28 February 2025	– complete
31 March 2025	– complete
30 April 2025	– complete
30 May 2025	– complete
30 June 2025	– complete
31 July 2025	– complete
29 August 2025	– complete
30 September 2025	– complete
31 October 2025	– complete
28 November 2025	– complete
31 December 2025 9 January 2026	– complete
30 January 2026	– complete
27 February 2026	– complete
31 March 2026	– complete
30 April 2026	– complete
29 May 2026	– complete
30 June 2026	This report
Future reporting	Future reporting to continue through business-as-usual governance, subject to CQC determination of condition removal.

5.243. Maternity services dashboard

5.244. The Trust reports maternity quality and safety information through the Perinatal Dashboard, which complements the Perinatal Oversight Report and supports Board, committee and divisional oversight of performance, risk and improvement.

5.245. Trust Board

5.246. The Trust Board received the April 2026 report at its meeting on 14 May 2026. Further reporting will continue through the routine Board cycle, with the next scheduled Board meeting in July 2026. Board papers are published on the Trust website and retained within Trust governance records.

5.247. Quality and Performance Committee (sub board)

5.248. The Quality and Performance Committee reviewed the most recent Section 31 report on 23 April 2026 and will continue to receive updates through the routine committee cycle, with the next review scheduled for July 2026.

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

5.250. The Perinatal Delivery Group met on 13 May 2026 and received the latest Section 31 report, noting the progress made. No escalations were raised to the Group. Membership included representation from Maternity Voice, the Local Maternity and Neonatal System and Integrated Care Board partners.

5.251. Residual risk and mitigation

5.252. The principal residual risk is that, following removal of enhanced monthly reporting to CQC, visibility of progress could reduce or become less frequent. This is mitigated by embedding relevant actions, metrics and exceptions into routine maternity governance, Trust Board and committee reporting, dashboard review, audit, PSIRF-aligned learning and defined escalation routes.

5.253. Conclusion

5.254. In conclusion, the Trust can demonstrate that Condition 8 has been met. Monthly submissions to CQC have included updated action plans, Board-level assurance reports and the maternity dashboard, providing continued visibility of progress, risk and compliance throughout the period of enhanced regulatory scrutiny. The reporting requirement has fulfilled its purpose, and the relevant controls are now embedded within business-as-usual governance. This provides the Board and CQC with reasonable assurance that the original regulatory reporting risk has been addressed and that continued oversight will be maintained through established governance arrangements.

5.255. Conclusion

5.256. In conclusion, the Board may take assurance that robust ward-to-Board governance arrangements are now established and operating effectively to maintain oversight of maternity safety and ongoing compliance with the CQC Section 31 conditions. These arrangements provide clear visibility of performance, risk and improvement through routine audit, dashboard reporting and exception management, with defined escalation routes enabling timely intervention where variation or emerging risk is identified. Taken together, the governance framework described in this report supports the Trust's position that the conditions have been met, that controls are sustainable, and that residual risk is being managed appropriately through business-as-usual oversight.

5.257. Following Board approval, the final submission will be authorised through the Chief Executive, Chief Nurse/Director of Quality Governance and Medical Director. The completed CQC removal forms, additional condition sections, updated Statement of Purpose, Section 31 Conditions Report and evidence pack will then be submitted to CQC, subject to completion of the factual accuracy process and receipt of the final CQC inspection report. Ongoing oversight of residual risks will continue through established maternity, executive and Board governance routes while CQC considers the application.

5.258. The next improvement focus for the service is implementation of the NHS England Maternal Care Bundle, which sets best-practice standards across five areas of clinical care: venous thromboembolism, pre-hospital and acute care, epilepsy in pregnancy, maternal mental health and obstetric haemorrhage. This work will be managed through existing maternity governance so that progress is monitored without duplicating the Section 31 assurance framework.

5.259. Key governance benefits

- A clear ward-to-board line of sight enables the Board to maintain oversight of maternity safety, assure itself that risks are visible at the appropriate level, and hold executive leads to account for delivery and sustained compliance.
- Routine audit, dashboard reporting and exception management support early identification of variance, providing assurance that concerns are recognised promptly and addressed through proportionate action before risk escalates.
- Defined escalation routes through established governance forums provide assurance that sustained variance, non-compliance or emerging risks will be reviewed at the right level and acted upon without delay.
- Triangulated assurance from policy and standards, staff training and competency, and performance data provides the Board with greater confidence that compliance is embedded and sustainable rather than reliant on one-off improvement activity.
- A strengthened learning culture, supported by Patient Safety Incident Response Framework aligned review and closed-loop action tracking, provides assurance that lessons are translated into measurable improvement and that identified weaknesses are not left unresolved.
- Consistent reporting and governance oversight provide transparent assurance to regulators, system partners and the Board that progress is being maintained, concerns are being managed openly, and the Trust remains sighted on any material change in risk or compliance position.
- Implementation of the Maternal Care Bundle provides the next phase of structured improvement by aligning the Trust's existing Section 31 controls with national best-practice standards across venous thromboembolism, acute and pre-hospital care, obstetric haemorrhage and wider maternal safety priorities. Managing this work through established maternity governance will support sustained improvement, avoid duplication of the Section 31 framework and provide the Board with ongoing assurance that learning is being translated into whole-pathway safety improvements.

Authors:

Women's and Children's Division
Perinatal Governance Team
Supported by Director of Quality Governance - Suzie Cro

Sponsors:

Women and Children's Division Chief of Service - Simon Pirie
Director of Quality and Chief Nurse – Matt Holdaway
Director of Safety and Medical Director – Mark Pietroni
CEO – Kevin McNamara

Enclosures

Evidence pack being made available to be retained within Trust governance records.

FOI: *Public*

Report to Board of Directors

Report title	Perinatal Quality Oversight Report Exceptions – April 2026 Quarter 4
Sponsoring Director/Authors	Matt Holdaway, Chief Nurse and Director of Quality /Board Perinatal Safety Champion Sarah Ashwood, Perinatal Quality and Governance Lead Suzie Cro, Director of Quality Governance

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

Executive Summary
This report provides Trust Board with an overview of the key exceptions, assurance and improvement activity arising from the Quarter 4 Perinatal Quality Oversight Report. It has been reviewed through the established maternity governance route, including the Perinatal Oversight and Assurance Meeting, the executive-led Perinatal Delivery Group and the Quality and Performance Committee. It is now presented to Board for oversight and discussion in line with the NHS England Perinatal Quality Oversight Model and the strengthened requirements of the new Maternity Incentive Scheme Year 8 (published in April 2026). The report provides evidence of strengthened maternity and neonatal governance, continued executive oversight and active monitoring of safety, quality, workforce, health inequalities and patient experience risks. Positive assurance is provided through continued Perinatal Mortality Review Tool compliance, no new direct concerns from Maternity and Newborn Safety Investigations, NHS Resolution or the Care Quality Commission during March 2026, and no Maternity Outcomes Signal System safety alerts in the reporting period. There has been measurable progress in a number of priority areas, including improved maternity triage performance, increased completion of Perinatal Transformation Plan actions, sustained compliance in several Saving Babies’ Lives Care Bundle measures, recruitment to key leadership roles, and progress towards meeting the Care Quality Commission Section 31 conditions. Targeted quality improvement is also progressing in obstetric anal sphincter injury, postpartum haemorrhage, transitional care, fetal monitoring, bereavement support and health inequalities. The principal risks requiring continued Board oversight relate to workforce and training capacity, including insufficient training headroom and urgent recovery of Newborn Life Support competence; ultrasound scanning resilience; delayed triage estates work and decant planning; continued suspension of elements of community birth provision; and complaints response

timeliness, with 46 open complaints at the point of reporting, including 30 overdue cases. These issues continue to affect assurance against safe, effective, equitable and responsive care.

Following review by Quality and Performance Committee, the Board is asked to note the progress and areas of assurance, recognise the material exceptions, and discuss whether current mitigations and recovery plans provide sufficient assurance in relation to residual risks, including the impact on Strategic Risk SR01. Continued Board oversight will be required until recovery actions are delivered, impact is evidenced and improvements are embedded.

Previously considered by	This report was previously presented at the Perinatal Oversight and Assurance Group, the executive-led Perinatal Delivery Group and the Quality and Performance Committee.
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Recommendations:

The Board is asked to note the report, recognise the areas of progress and material exception, and discuss whether the current mitigations and recovery plans provide sufficient assurance in relation to maternity and neonatal safety, quality, workforce, patient experience and compliance risks, including the impact on Strategic Risk SR01.

Strategic Aims (tick as appropriate)

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

Impact on any Strategic Risks?

SR01 - Inability to deliver safe and effective services against regulatory and statutory requirements

Strategic Risk SR01 is impacted by the ongoing risk that maternity and neonatal services may be unable to deliver consistently safe and effective care in line with regulatory and statutory

requirements. The Gloucestershire Royal Hospital site has eight Care Quality Commission Section 31 conditions in place (self-assessed as meeting all 8 conditions).

Implications on:

Equality, Diversity and Inclusion	The report, reviewed by Quality and Performance Committee, highlights the need for accessible, culturally appropriate maternity and neonatal services, with continued focus on ethnicity, language need and deprivation.
Health Inequalities	The report identifies persistent variation in perinatal outcomes and experience by deprivation, ethnicity and language need, requiring continued Board oversight of actions to reduce avoidable inequality.
Finance and Resources	Delivery of the recovery programme may require additional staffing, training, estates and improvement capacity. Continued MIS Year 8 non-compliance may also increase financial exposure.
Regulation/Legal	Following Quality and Performance Committee review, Board oversight is required for Section 31-related risks and wider regulatory, legal and enforcement exposure.
Care Quality Commission key lines of enquiry	The report identifies assurance and gaps across Safe, Effective, Caring, Responsive and Well-led, particularly relating to workforce, training, governance, complaints and service suspensions.
Green Plan	Improvement actions should continue to align with the Trust Green Plan, particularly through sustainable estates, digital and community service redesign.

Main Report

1. Introduction

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

- 1.2. The purpose of this report is to update Trust Board on current and emerging perinatal safety concerns, assurance and improvement activity, following prior review through maternity governance routes and Quality and Performance Committee.
- 1.3. In line with the Perinatal Quality Oversight Model, we are required to report the information outlined in the data measures template at least quarterly to the Trust Board, and the report covers:
 - Structures and standards underpinning safer, personalised and equitable care.
 - Culture of learning, safety and support
 - Workforce
 - Listening to women and families
- 1.4. Data is for quarter 4 (up to March 2026), except where any exceptions are highlighted.

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

2.1. Three Year Maternity and Neonatal Delivery Plan (3YDP)

- 2.2. The service continues to focus on priority improvement plans, including Care Quality Commission Section 31, scanning, triage and community transformation, while awaiting the outcome of the national maternity and neonatal investigation and the new national plan expected for maternity and neonatal services in 2026.

2.3. Perinatal Transformation Plan

- 2.4. The Perinatal Transformation Plan continues to progress under strengthened programme governance, with actions reviewed to ensure they are specific, measurable and deliverable, supported by Maternity and Neonatal Intensive Support Team improvement advisors and overseen through the Perinatal Transformation Board. Following approval of the Bereavement and Tackling Tobacco Dependency plans, phase 1 now comprises 559 Trust-owned actions, with completion increasing from 13.3 per cent in February to 24.3 per cent in April despite the expanded scope. Key escalations requiring continued executive oversight include funding for bereavement room soundproofing, workforce and training pressures in bereavement and triage, delayed triage estates work, and ongoing scanning capacity risks, including leadership vacancy and limited improvement despite mitigating action.

2.5. Equitable care - Perinatal Health Needs Assessment (HNA)

- 2.6. The Health Needs Assessment confirms a clear strategic case for change in maternity services, driven by rising clinical complexity, national policy changes, evolving service-user choice and workforce pressures. It highlights persistent inequalities in outcomes and experience, particularly for women living in more deprived communities and for women from ethnic minority groups, and will inform the community transformation programme to ensure future services are safe, equitable, sustainable and preserve choice.
- 2.7. A Case for Change has been developed and is now progressing through governance, having been presented to the Integrated Care Board in March, with Trust Board and Overview and Scrutiny Committee consideration scheduled for May 2026. Development of improvement options will continue through spring and summer, followed by public consultation where required.

2.8. Maternity and Neonatal Intensive Support Team

- 2.9. The Maternity and Neonatal Intensive Support Team Executive Meeting for Gloucestershire in April 2026 confirmed that Gloucestershire Hospitals NHS Foundation Trust remains under intensive support from January to December 2026, with evidence of progress alongside continuing risk, particularly in relation to leadership and workforce capacity.
- 2.10. Key achievements include successful recruitment to the Director of Midwifery role, developing workforce plans across midwifery, obstetrics and neonatal services, progress with NLS training recovery, and assurance regarding Section 31 with plans for removal pending inspection reporting. However, delivery against the first-quarter immediate actions remains challenging, with the majority delayed due to capacity constraints. Priority risks requiring continued executive lead oversight include implementation of a meaningful, measurable culture improvement plan, strengthened leadership of the Perinatal Improvement Plan, delivery of the community midwifery and homebirth restoration programme, timely resolution of human resource (HR) and maternity support worker reviews, confirmation of funding for additional obstetric consultant posts, and sustained progress on workforce

expansion to support training, quality and safety across the service.

2.11. **National Maternity and Neonatal Investigation**

2.12. Gloucestershire Hospitals NHS Foundation Trust remains one of 12 Trusts included in the national maternity and neonatal investigation. The Trust submitted the required data in January 2026, and senior leaders, including the Chief Executive, Chief Nurse, Medical Director, Director of Midwifery and Non-Executive Director Perinatal Safety Champion, have contributed to the review process. An action plan has been developed in response to Baroness Amos' late spring report, and the Trust now awaits publication of the final report.

Data

2.13. Perinatal Quality Dashboard - oversight

2.14. The Perinatal Quality Dashboard supports oversight of safety, quality and health inequalities by using routine maternity data to identify early warning signals, variation and emerging risks. Current dashboard review highlights inequality signals by ethnicity and deprivation across several outcomes, including neonatal deaths, obstetric anal sphincter injury, postpartum haemorrhage and breastfeeding initiation, although some findings are based on small numbers and require continued monitoring and use of multi-year data to confirm persistent patterns.

2.15. The Perinatal Quality Dashboard was provided in Appendix 1 to the Quality and Performance Committee as a separate data set attached to the report. This is a new approach and forms part of a wider programme to improve data quality and use data more effectively to support outcome-focused decision-making.

2.16. The intranet version of the Perinatal Health Inequalities Dashboard now includes sub-group analysis (deprivation deciles and ethnicity where data is available) and monitoring of health inequalities in relation to perinatal outcomes across any flagging data.

2.17. National Perinatal Health Equity Dashboard

2.18. There is a newly launched national perinatal health inequalities dashboard using existing datasets focusing on ethnicity and deprivation; however, the available data is minimal and is generally older (NHS England perinatal health inequalities dashboard – [link](#)).

2.19. The Maternity and Neonatal Equalities Dashboard provides a nationally consistent, MSDS-derived view of key maternity outcomes stratified by deprivation and ethnicity, supporting the Trust's PQOM responsibilities for routine surveillance of outcome variation and health inequalities. The data highlights persistent inequality in preterm birth rates, which needs to be considered alongside local safety intelligence, quality improvement activity, and maternity governance assurance.

2.20. **National Maternity Services Dashboard**

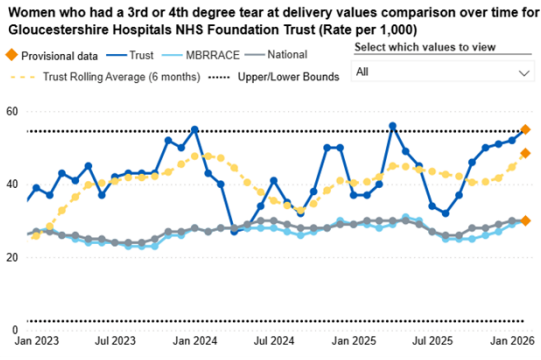
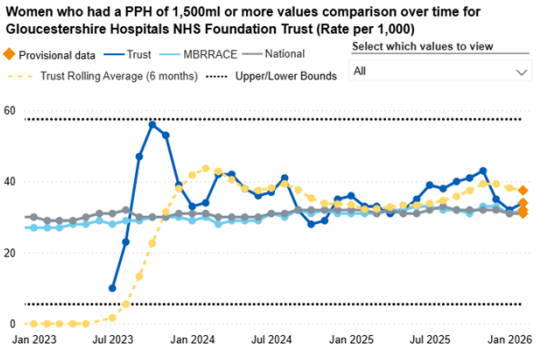
2.21. The dashboard enables the Trust to compare performance with peer organisations, supporting the identification of areas requiring improvement. We currently have one metric flagging: third- and fourth-degree tears, for which an improvement group is in place (see table below). In addition, we are trialling the ONIRY Spectrometer for two months to support the detection of obstetric anal sphincter injury. The aim is to evaluate the true rates of Obstetric Anal Sphincter Injury (OASI) over the two-month period, as the obstetric team currently hypothesises that OASI may be over diagnosed to avoid missing any potential cases.

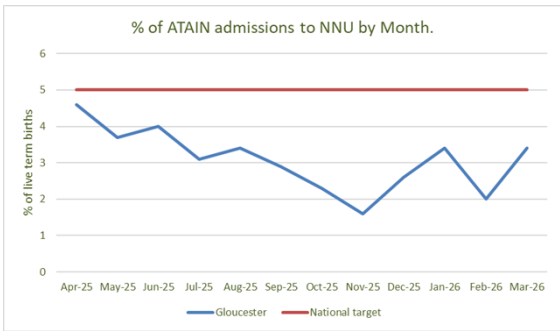
2.22. **Quality Improvement work in maternity**

2.23. Quality improvement work in maternity services is essential to ensure safe, compassionate and evidence-based care for mothers and babies, with the overall aim of reducing preventable harm and mortality. It is driven by the need to address persistent safety concerns, reduce unwarranted variation in care, and improve the overall experience of care for families.

Table: Perinatal improvement groups and thematic reviews

Improvement group	Learning and improvement
Obstetric Anal Sphincter Injury (OASI) MDT reviews	Themes have been identified through the weekly OASI meetings to include antenatal education, documentation, clinical decision making and

Improvement group	Learning and improvement
Our local data for March 2026 is demonstrating an improving picture in the number of OASI, however as there is a lag with the national data, our current rate on the national dashboard is 52 per 1000 and rolling average 44.67 (Jan 2026 national rate 29.0). Data from the Maternity Services Dashboard for Feb 2026 	training and education for midwives and obstetricians. The OASI leads are being supported to include this learning within a quality improvement project for OASI with a continued trial of ONIRY Spectrometer for 2 months to support the identification of obstetric anal sphincter injury. The OASI leads and lead midwife for training and education are currently scoping for an additional OASI training day for staff
Maternal Care Bundle – element 5 Massive Obstetric haemorrhage reviews (>2L) 	The Maternal Care Bundle (January 2026) requires a multidisciplinary review of all women with significant haemorrhage greater than two litres, and of all cases involving cryoprecipitate and fibrinogen concentrate use, within one month. This multidisciplinary meeting is held weekly and focuses on learning from clinical outcomes by reviewing contributory factors and system gaps. Health inequalities are also considered as part of the review. Learning from reviews undertaken between February and April identified themes relating to: • Documentation of PPH proformas and HDU care • Communication and escalation • Preventative blood management and anaemia optimisation antenatally Actions taken to improve practice include: • Learning shared at key forums and displayed in clinical areas • Individual supportive discussions • Development of a haemoglobin optimisation pathway • Development of a refreshed PPH improvement plan
Avoiding Term Admission (ATAIN) MDT Reviews	Improvement work arising from these meetings is focused on neonatal hypoglycaemia, jaundice and thermoregulation, and includes: • Thematic review of hypoglycaemia

Improvement group	Learning and improvement																																							
For Q4 the ATAIN rate was 3% (national target 5%) with the most common reason for admission being respiratory factors % of ATAIN admissions to NNU by Month. <table><caption>% of ATAIN admissions to NNU by Month</caption><thead><tr><th>Month</th><th>Gloucester (%)</th><th>National target (%)</th></tr></thead><tbody><tr><td>Apr-25</td><td>4.5</td><td>5.0</td></tr><tr><td>May-25</td><td>3.8</td><td>5.0</td></tr><tr><td>Jun-25</td><td>4.0</td><td>5.0</td></tr><tr><td>Jul-25</td><td>3.2</td><td>5.0</td></tr><tr><td>Aug-25</td><td>3.5</td><td>5.0</td></tr><tr><td>Sep-25</td><td>3.0</td><td>5.0</td></tr><tr><td>Oct-25</td><td>2.5</td><td>5.0</td></tr><tr><td>Nov-25</td><td>1.8</td><td>5.0</td></tr><tr><td>Dec-25</td><td>3.2</td><td>5.0</td></tr><tr><td>Jan-26</td><td>3.5</td><td>5.0</td></tr><tr><td>Feb-26</td><td>2.0</td><td>5.0</td></tr><tr><td>Mar-26</td><td>3.5</td><td>5.0</td></tr></tbody></table>	Month	Gloucester (%)	National target (%)	Apr-25	4.5	5.0	May-25	3.8	5.0	Jun-25	4.0	5.0	Jul-25	3.2	5.0	Aug-25	3.5	5.0	Sep-25	3.0	5.0	Oct-25	2.5	5.0	Nov-25	1.8	5.0	Dec-25	3.2	5.0	Jan-26	3.5	5.0	Feb-26	2.0	5.0	Mar-26	3.5	5.0	- Updated guidance on hypoglycaemia and jaundice - New non-invasive Transcutaneous bilirubinometers purchased for use in the community to detect jaundice - Infant feeding improvement plan in place - Management of temperature of babies born in theatre under review with immediate learning shared via rapid clinical learning, team talk and posters in the clinical area Quarterly thematic reviews are undertaken to support learning, ensure that Duty of Candour requirements have been met, and confirm that appropriate Patient Safety Incident Response Framework learning responses have been commissioned where required.
Month	Gloucester (%)	National target (%)																																						
Apr-25	4.5	5.0																																						
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Mar-26	3.5	5.0																																						

2.24. Maternity Triage Improvement Programme

2.25. The Maternity Triage Improvement Programme is delivering measurable operational improvement, with more than 80 per cent of actions now complete or in progress and improved performance in initial and secondary assessment contributing to reduced 24-hour re-attendance, shorter length of stay, fewer midwifery staffing red flags and fewer moderate or above safety incidents. The main residual risk is the current triage environment, where extensive estates work is required to address insufficient capacity for approximately 15,000 annual attendances and poor line of sight to the waiting area, as previously highlighted by the Care Quality Commission. The Triage improvement programme remains under mandated support and continues to require close oversight until estates and service model risks are resolved.

2.26. Maternity (Perinatal) Incentive Scheme

2.27. The Trust has completed an initial assessment against the newly published Maternity Incentive Scheme Year 8 Safety Actions A to F, using the national guidance and supplementary good practice standards to assess current readiness and identify the actions required to evidence compliance with the new requirements. The initial assessment identifies the main areas of focus as Training (Safety Action B) and Board Oversight, Governance, Culture and Leadership (Safety Action F).

2.28. Each Safety Action has been rated to reflect the level of change required to meet the Year 8 standards.

- Green / minimal gap: on track and already meeting the Year 8 standards.
- Amber / moderate gap: further action is required to meet the Year 8 standards.
- Red / critical gap: significant change, focused recovery action and senior oversight required.

Safety Action	Rating
Safety Action A- Workforce and Capacity	Amber
Safety Action B- Training	Red
Safety Action C- Learning from Reviews and Investigations	Amber
Safety Action D- Service-User Voice and Equity	Amber
Safety Action E- Care Bundles	Amber
Safety Action F- Board Oversight, Governance, Culture and Leadership	Red

2.29. The strengthened Maternity Incentive Scheme framework provides a clearer route for oversight, escalation and evidence of progress. However, material risks remain in relation to training

compliance, leadership and culture capacity, and the consistency of assurance evidence. Prompt delivery of the Maternity Incentive Scheme Year 8 plan is therefore required to reduce compliance risk and strengthen Board-level assurance.

2.30. **Care Bundles**

2.31. Saving Babies Lives Care Bundle

2.32. The Saving Babies' Lives Care Bundle is a mandatory national initiative designed to reduce perinatal mortality through action on smoking in pregnancy, fetal growth restriction, reduced fetal movements, effective fetal monitoring and preterm birth. NHS England requires all provider trusts to implement the latest version to support national safety ambitions.

- Implementation of the Saving Babies' Lives Care Bundle is directly linked to NHS Resolution Maternity Incentive Scheme Safety Action E.

Maternity Incentive Scheme Year 8 changes include:

- **Quarterly Saving Babies' Lives Care Bundle version 3.2 reports are required at Trust Board level, reflecting local progress, implementation, incidents and safety intelligence.**
- ICB assurance step removed as ICBs no longer hold a formal oversight role.

2.33. Quarter 4 Report 2025-2026:

2.34. Quarter 4 data across Saving Babies' Lives Care Bundle Elements 1 to 6 shows a mixed position. Strong performance was maintained in intrapartum fetal monitoring, preterm birth optimisation and diabetes in pregnancy, with national targets met or exceeded by quarter end.

2.35. However, performance remains below target in smoking cessation, uterine artery Doppler completion and timely growth scanning for recurrent reduced fetal movements, with limited evidence of sustained improvement despite local action. The main cross-cutting risks are workforce and training compliance, booking pathway reliability and ultrasound scanning capacity, and these continue to require focused attention to improve compliance.

2.36. **Element 1 – Reducing Smoking in Pregnancy**

Data

- CO monitoring at booking below target (Jan 93%, Feb 94.6%; target 95%).
- 4-week quit rates declining and well below target (Jan 50%, Feb 42.9%, Mar 37.5%; target 50–60%).
- VBA e-learning compliance below target (Jan 79%, Feb 75%; target 80–95%).

Actions

- Communications issued to community midwives and team leaders reinforcing CO monitoring at booking and follow-up visits.
- Additional CO monitors offered where availability was a barrier.
- VBA non-compliant staff contacted individually to prompt completion.
- Issues raised at community midwifery team meetings.

Escalations to the perinatal senior leadership team

- Persistent difficulty improving VBA e-learning compliance among medical staff.
- Requires obstetric leadership support; escalated via TTD Action Plan.

2.37. **Element 2 – Fetal Growth: Risk Assessment, Surveillance and Management**

Data

- Uterine artery Doppler (UtAD) completion by 22 weeks remains below target (Jan 60.5%, Feb 68%; target 80%).
- Non-compliance evident for three consecutive months.

Actions

- Audit findings escalated to senior clinical leads.
- Communications sent to community leads reinforcing the need to re-request scans for high-risk women at booking.
- Engagement with screening team regarding timing of USS requests (booking vs FPOC).

Escalations to the perinatal senior leadership team

- Sustained non-compliance unlikely to improve without fundamental changes to booking pathways.
- Formal escalation due to repeated failure to meet target.

2.38. **Element 3 – Raising Awareness of Reduced Fetal Movements**

Data

- Growth scans within one working day for recurrent RFM remain inconsistent (Jan 47.6%, Feb 33.3%, Mar 35.5%).
- No improvement since introduction of midwife sonographers to GDELIV lists.

Actions

- All triage core midwives granted CRIS access to directly book growth scans (implemented mid-April).

Escalations to the perinatal senior leadership team

- Ongoing quality improvement has not yet delivered a sustained improvement, fed back to project.
- Scanning project to explore further mitigations.

2.39. **Element 4 – Effective Fetal Monitoring in Labour**

Data

- All intrapartum fetal monitoring audit metrics met or exceeded national targets in Q4.

Focus

- Continue roll-out of the *Listen2Baby* toolkit.
- Maintain routine auditing of intermittent auscultation with reporting at the Intrapartum Forum.

Actions

- Continued audit and oversight of CTG and auscultation practices.

2.40. **Element 5 – Reducing Preterm Births and Optimising Perinatal Care**

Data

- PERIPrem metrics met or exceeded national targets in February and March.
- January under-performance for magnesium sulphate and IV antibiotics attributed to clinical exceptions (gestation or rapid birth).
- IV antibiotic compliance recovered to 100% in Feb/March following January anomaly.

Focus

- Continue PERIPrem audit programme.
- Ongoing education to reinforce perinatal optimisation, particularly within Triage and Delivery Suite teams.

Actions

- Exception reviews completed to validate January data anomalies.
- Continued awareness-raising across relevant clinical teams.

2.41. **Element 6 – Management of Pre-existing Diabetes in Pregnancy**

Data

- All Q4 audit measures at 100% compliance.

Focus

- Roll-out of updated diabetes in pregnancy guideline.
- Recruitment of diabetes champions across clinical areas to increase staff knowledge and awareness.

Actions

- Preparation for guideline implementation.
- Engagement with clinical teams to identify local diabetes champions.

2.42. Maternity Care Bundle

2.43. The Trust is required under Maternity Incentive Scheme Year 8 to develop a Board-overseen implementation plan for the Maternity Care Bundle by March 2027. Formal planning is currently dependent on publication of the national implementation tool, which remains outstanding from NHS England. In the interim, the Trust is maintaining oversight through existing maternity safety and

governance arrangements so that implementation can progress at pace once the national framework is issued.

2.44. Neonatal Transitional Care (NTC) Action Plan

- 2.45. The Neonatal Transitional Care programme continues to support Maternity Incentive Scheme objectives to minimise avoidable separation between mothers and babies, with the Transitional Care Working Group reporting strong overall delivery against the action plan.
- 2.46. The table shows that 66 of 68 actions are complete, on track or progressing, with one current escalation relating to the Neonatal Outreach Service pending confirmation of whether the expired fixed-term post will be extended or made permanent. Continued oversight is required to secure this role and maintain delivery momentum.

NTC Action Plan	Complete	Working towards	On track	Escalations/alert
Actions	36	1	30	1

3. Culture of learning, safety and support

Culture

3.1. Cultural Improvement Programme

- 3.2. The Cultural Improvement Programme is progressing and remains an important component of compliance with Maternity Incentive Scheme Year 8 requirements. An update has been reviewed through executive mandated support, and a focused improvement approach is now being developed with Leadership and Organisational Development input to identify priority cultural actions, targeted support and clear measures of progress. Key next steps are completion of a one-page improvement plan, agreement of a communication plan through the Perinatal Quad, and establishment of a performance monitoring template, with quarterly reporting to provide continued Committee assurance on delivery and impact.

Safety

3.3. Patient Safety Incident Response Framework

3.4. Patient Safety Response Plan – perinatal (maternity) safety priority

- 3.5. The maternity safety priority remains delay in recognising and escalating deterioration during pregnancy or birth. The Trust has reviewed its Patient Safety Response Plan to ensure alignment with Patient Safety Incident Response Framework standards and current service risks, and has continued targeted improvement in areas including Martha's Rule, postpartum haemorrhage risk assessment, fetal monitoring and early warning score escalation. Current assurance indicates improved consistency in several core controls, including CTG interpretation and escalation, with further strengthening planned through Maternal Care Bundle implementation and introduction of the national Maternity Early Warning Scores system in Badgernet from May 2026.

3.6. Patient Safety Incident Investigations and Learning Responses

- 3.7. Patient Safety Incident Response Framework arrangements continue to support a learning-led approach to maternity incidents. No new Patient Safety Incident Investigations were commissioned in March 2026. Three open investigations remain in progress and all are within timeframe. A wider programme of After Event Reviews and Multiprofessional Reviews is also progressing through governance, with the majority in date and action plans either underway or scheduled for review through the Women and Children Safety and Experience Review Group. The overall position provides assurance that current learning responses are active and governed, with no immediate timeliness exceptions within the formal investigation caseload.

3.8. Maternity and Newborn Safety Investigation Programme (MNSI)

- 3.9. There were no new MNSI referrals in March 2026. One final investigation report was received, identifying learning in fetal monitoring, the timing of newborn observations and recognition of the need for hypoglycaemia monitoring; an action plan will be taken through the Safety and Experience Review Group. No further final reports are currently outstanding. The overall position provides assurance that external investigation activity is being actively managed and that learning is being translated into formal governance action.

Table: MNSI cases and progress

MNSI Reference number	Reason for referral	Date of confirmed MNSI investigation	Family Informed	Duty of Candour (DOC) Y/N	Early notification, external notifications and other investigations
MI-043955	Cooling/ potential Hypoxic ischaemic encephalopathy (HIE)	24/07/2025 31/07/2025- confirmed rationale: trust and family concerns, not brain injury as no evidence of HIE- infarct only.	Yes	24/6/25	Not reported to NHSR under ENS scheme as it did not meet the reporting criteria (no HIE)
MI-045356	Potential HIE (not cooled)	26/08/2025 – rationale: brain injury	Yes	25/9/25	NHSR ENS ref: M25CT619/007
MI-046523	Cooling /HIE	15/10/2025 – rationale: family concerns (head MRI abnormal, but not HIE)	Yes	25/9/25	NHSR ENS ref: M25CT619/009
MI-046524	Cooling/ HIE	08/10/2025- proceeding due to trust concerns. 24/10/2025- Confirmed rationale upgraded to severe brain injury following head MRI findings	Yes	23/9/25	NHSR ENS ref M25CT619/008

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

- 3.11. The Trust can provide assurance that no Coroners' Regulation 28 Prevention of Future Deaths reports relating to maternity or neonatal services were received during the reporting period.

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

- 3.13. There was one antepartum stillbirth at 28 weeks' gestation during March and this case was presented to the Patient Safety Review Panel and appropriate review agreed.

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

- 3.15. Care is graded in terms of care up to the point of the baby having died and after confirmation of death. This review is undertaken by an MDT panel with an external member; see Table 5 below.

Table: PMRT grading key

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

- 3.16. The current Perinatal Mortality Review Tool position is 15 open cases, comprising five cases for which the Trust is the lead reviewer and 10 cases with an external Trust as lead reviewer. There are no overdue cases for those led by this Trust.

Table current open cases

Number of open cases with GHNHSFT as lead reviewer	Number of cases with external Trust as lead reviewer	Number of cases overdue with GHNHSFT as lead reviewer	Number of cases overdue with external Trust as lead reviewer
5	10	0	7

- 3.17. All PMRT cases, for which the Trust is the designated lead reviewer, remain within the required six-month timeframe for review and closure. Seven cases are under review by external Trusts and these reviews are progressing and are either at pre-publication stage or in the report-writing phase. An updated position will be provided in the next report.

- 3.18. Table: PMRT cases reviewed in March 2026 with grades

PMRT cases reviewed in March	Grading of care up to the point of baby having died	Grading following the confirmation of death	Actions Taken
100939/1	B-A re-scan was booked at 4 weeks and 1 day when the scan should have been booked between 3-4 weeks.	B – Little or no narrative around lack of community midwifery appointments. Unable to ascertain if this is because the mother declined or appointments were not offered.	Scanning concerns are linked within the Antenatal clinic QI project and linked to the current risk on the Trust risk register. Lead bereavement midwife to link with community midwifery team leads regarding ongoing concerns around lack of community midwifery appointments postnatally.
96698/1	A- No issues with care identified.	A- No issues with care identified.	

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

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

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

3.21. Thematic review of PMRT reviews from Quarter 4

- 3.22. This thematic review is in line with the new Year 8 Safety Action C (learning from reviews and investigations) and Safety Action F (Board oversight).
- 3.23. Between 1/1/2026 and 31/3/2026 (Q4) there were 3 perinatal deaths reported to MBRRACE-UK (3 antepartum stillbirths at 28 weeks, 30+1 weeks and 33 weeks' gestation). A total of 6 cases were reviewed during this period. The cases included 5 antepartum stillbirths and 1 neonatal death.
- 3.24. All cases have been reviewed through local governance processes and presented at Patient Safety Review Panel (PSRP).
- 3.25. All parents have been informed that a review of their care will take place, and parents' perspectives have been sought to support the review process.
- 3.26. Ethnicity data was reviewed for all women experiencing a perinatal loss. Of the 6 mothers affected, 5 mothers were White British and 1 belonged to the Global Ethnic Majority.
- 3.27. Deprivation data was also reviewed for the women experiencing a perinatal loss during this period. 1 of the 6 women affected lived in areas corresponding to Indices of Multiple Deprivation (IMD) categories 1 and 2.

MBRRACE ID	Type of perinatal death	MDT involvement in review	External panel member at review	Grading of care up to the point of baby having died	Grading following confirmation of death
99860	Antepartum	Yes	Yes	C (taken back	B

	stillbirth			through PSRP following placental histology and PSII declared)	
99778	Antepartum stillbirth	Yes	Yes	B	B
99957	Antepartum stillbirth	Yes	Yes	B	A
100570	Antepartum stillbirth	Yes	Yes	C (taken back through PSRP following placental histology and PSII declared)	A
100939	Antepartum stillbirth	Yes	Yes	B	B

MBRRACE ID	Type of perinatal death	MDT involvement in review	External panel member at review	Grading of care of the mother and baby up to the point of the birth of the baby	Grading of care of the baby up to the death of the baby	Grading of care of the mother
96698 (joint case with UHBW)	Neonatal death	Yes	Yes	A	A	A

Learning and themes from PMRT for Trust Board members to note

Quarter 1

Theme/ issues	Action taken/Improvement work
Aspirin provision	- Aspirin Standard Operation Procedure and Patient Group Direction in place - Risk assessment updated on Badgernet and learning shared with teams - Working with pharmacy to enable community midwives to safely store and administer aspirin - Part of Saving Babies Lives Care Bundle version 3 audits, with monthly monitoring via dashboard and PQOM
Translation and interpretation services	- Wordski on wheels purchased - Continued focus on bookings and using systems for non-booked/ emergency activity
Triage	- Triage improvement plan in place with ongoing action plan - Current Trust-level risk - Over 80% of actions complete or in progress - Triage specific study days - Triage guideline review - Real-time dashboard in triage - Estates improvement plan

Quarter 2

Theme	Action taken/Improvement work
Communication	• Learning shared with individual for reflection and wider team • Communication included in PROMPT mandatory day
Triage	• Triage improvement plan in place with ongoing action plan • Current Trust-level risk • Over 80% of actions complete or in progress • Triage specific study days • Triage guideline review • Real-time dashboard in triage • Estates improvement plan
Diabetes	• Current Trust-level risk • Guidelines have been benchmarked against NICE guidance and awaiting ratification • Diabetes training included on PROMPT mandatory day • Additional training provided by Diabetes lead midwife • Workforce review to include Diabetes specialist posts • Part of Saving Babies Lives Care bundle version 3 audits, with monthly monitoring via SBL dashboard and PQOM

Quarter 3

Theme	Action taken/Improvement work
Midwifery fundamentals	• Midwifery fundamentals training • Weekly production boards introduced • Audits undertaken by community leads
Escalation	• Clinical escalation guideline in progress • Included in PROMPT • Skills drills
Diabetes	• Current Trust-level risk • Guidelines have been benchmarked against NICE guidance and awaiting ratification • Diabetes training included on PROMPT mandatory day • Additional training provided by Diabetes lead midwife • Workforce review to include Diabetes specialist posts • Part of Saving Babies Lives Care bundle version 3 audits, with monthly monitoring via SBL dashboard and PQOM

Quarter 4

Theme	Action taken/Improvement work
Aspirin risk assessment	Clevermed/Badgernet updates requested to ensure specific risk factors trigger risk Staff education
Ultrasound scanning (missed scans due to administration issues and capacity)	Ongoing Ultrasound QI

3.28. End-of-year summary of Quarter 1 to Quarter 4 Perinatal Mortality Review Tool themes

3.29. Across the year, Perinatal Mortality Review Tool themes have shown recurring learning in a small number of high-impact areas, most notably triage, communication, risk assessment, diabetes pathways and ultrasound scanning. These themes are now reflected within active improvement programmes and broader service risks described elsewhere in this report and will continue to require oversight to demonstrate sustained impact on safety and outcomes.

3.30. Regulatory Activity and Notification of Concern (MNSI/NHSR/CQC)

3.31. There were no new concerns received by Maternity and Newborn Safety Investigations (MNSI), NHS Resolution or the CQC directly to the Trust during March 2026.

3.32. NHSE Maternity Outcomes Signals System (MOSS)

3.33. During March 2026, there were no MOSS system safety alerts for the Trust.

3.34. As part of the new MIS Year 8, the Trust is required to simulate a MOSS alert if none have been issued to the Trust. A date is currently being agreed, and this will likely be held during the summer months using the MIS template.

3.35. CQC Inspection activity

3.36. There was a CQC inspection in September 2025 and the draft report is still awaited (7 months post inspection).

3.37. An enforcement notice was received in May 2024 and 8 conditions were placed on the Trust registration. The service has self-assessed and considers it has now met 8/8 conditions and will be applying to get the conditions removed (there is a separate detailed CQC 31 report).

3.38. **Trust Commissioned External Independent Perinatal Mortality Reviews (published September 2025)**

3.39. The Chief Executive Officer (CEO) commissioned 2 external reviews – one focused on neonatal mortality between the years 2020-2023, and another focussed on our safety systems and maternal mortality between 2017-2022.

3.40. Maternal Mortality Review (INC-34492)

3.41. The action plan was presented to the Trust Safety and Experience Review Group (SERG) for closure in January 2026, further assurance was requested for the 1 action related to VTE. The action plan will be re-presented at the May SERG meeting for closure.

3.42. Table: Summary of action plan actions

Incident number	Number of actions open	Number of actions completed	Target completion date of final action
INC-34492 (Maternal Death review)	0	5	Closed

3.43. Neonatal Mortality Review (INC-31171)

3.44. A team of external reviewers reviewed a selection of cases to identify any themes or learning from neonatal deaths, between the years of 2020-2023. They made 5 primary recommendations (and 13 sub recommendations (80+ recommendations)) and these have been reviewed through a gap analysis process. Many of the recommendations have or are already being implemented and are within our Perinatal Transformation Plan. There are 17 actions that have been completed and 5 actions open, 4 of which are now overdue, and action owners have been supported to complete.

Table: Summary of action plan progress

Incident number	Number of actions open	Number of actions completed	Target completion date of final action
INC-31171 (NND review)	5	17	Extended to 30 September 2026

Support

3.45. **Perinatal Safety Champions Meetings/ Engagement Events**

3.46. There was a Perinatal Safety Champions walk around 23rd March 2026 on Delivery Suite with a focus on bereavement.

3.47. Table: Perinatal Safety Champion Feedback

Feedback raised by staff	Action and progress
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7-day service for bereavement (Ockenden 2 recommendation) will be supported by the addition of 8 new bereavement champions	Recruitment completed
No current psychological support available for bereaved families	Petals charity bid decision awaited
Soundproofing for the bereavement suite	Quotes received and under review
Feedback raised by service users	Action and progress
None received via safety champions (see below thematic review of patient feedback)	N/A
Additional safety champions intelligence	Action and progress
Thematic review of feedback provided by bereaved parents between 2024-2025 using the Maternity Bereavement Experience Measure (MBEM) and the Perinatal Mortality Review Tool (PMRT) parents' perspectives	Feedback provided was themed into 7 areas and included both learning and positive feedback: • Care • Aftercare • Communication • Environment • Signposting and information • Memory making • Staff The thematic review will be presented at the patient experience meeting and will support the ongoing bereavement improvement plan

4. Workforce: Safer Perinatal Staffing

4.1. Training Compliance

- 4.2. Training compliance is a risk against the new Maternity Incentive Scheme Year 8 Safety Action B and the Maternity Core Competency Framework (see Appendix 2). The principal risks are insufficient training headroom, currently 21 per cent against a minimum requirement of 24 per cent and potentially up to 26 per cent to deliver the full programme, incomplete compliance data for some cross-divisional staff groups, and reduced oversight capacity due to gaps in administrative and practice development support.
- 4.3. In addition, a recent spot-check identified only 31 per cent compliance with the Newborn Life Support algorithm among relevant midwifery staff, requiring urgent recovery action.
- 4.4. Recovery actions are in progress. The training programme has been reviewed against the national framework, a refreshed Training Needs Analysis and revised headroom assessment are being completed, and medical safeguarding requirements are being clarified to improve transparency and reporting. Statutory and mandatory training is being monitored through Monday.com and divisional governance routes, while recruitment to strengthen administrative and practice development capacity has been completed and start dates are awaited. A dedicated Newborn Life Support recovery plan is in place, supported by maternity and neonatal improvement advisors, with urgent reset training underway to restore competence across relevant staff groups and provide updated assurance through Perinatal Quality Oversight reporting and the Quality and Performance Committee.
- 4.5. Appendix 2 provides supporting evidence of deterioration in maternity training compliance from December 2025 to March 2026 across several core safety areas and staff groups, most notably Practical Obstetric Multiprofessional Training (PROMPT), fetal monitoring, Newborn Life Support, equality and personalised care, and care during labour and the immediate postnatal period. Declines are evident across midwifery, support worker and medical groups, including obstetric and anaesthetic staff.

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

- 4.7. Workforce resilience remains mixed. Midwifery fill rates for March were 93 per cent in inpatient areas by day and 96 per cent at night, and obstetric rota gaps were fully covered. Recruitment to vacant midwifery posts is in progress and workforce reviews are underway for support worker roles. However, longer-term medical workforce resilience remains constrained by delay to approval of the business case for four additional obstetric consultant posts, which have recently been approved.

4.8. Table: Maternity MDT Staffing Vacancy Rates March

Staff group	Vacancy
Midwifery	10.43 WTE (2 midwifery conversion students starting in April, offer of increased hours for current staff, recruitment and retention lead midwife to meet with finance)
Midwife Support workers (MSW)	Pending workforce review of MSW requirements
Obstetric consultants Resident doctors	2 WTE
Neonatal Nurses	Band 5 (QIS and non-QIS) 9.33 WTE
Neonatology consultants Resident doctors	To be confirmed - Chief of service to action.
Obstetric anaesthetists Resident doctors	Difficulty in obtaining data due to the job role being split across services. The division has been asked to review how the data can be provided. This has been escalated to the Quad for action.

4.9. Table: Obstetric Rota Gaps

Obstetric Rota Gaps- February	Percentage covered	Gap	Gaps covered by
Obstetric Consultant Rota for Delivery Suite 24/7	100%	No gaps	N/A
		08:30-17:30: 4 gaps	4 External locum cover 0 Internal locum cover
		17:30-08:30: 6 gaps	4 External locum cover 2 Internal locum cover
Obstetric Consultant Unscheduled Care	100%	4 gaps	4 Internal cover (1 senior registrar) 2 senior residents acting up 1 consultant cover uncovered
Obstetric Middle-Grade Delivery Suite and gynaecology	100%	12 gaps	10 Internal locum cover 2 External locums
Obstetric Middle Grade Triage 08:30 – 17:00 7 days	100%	3 gaps	2 Internal 1 External
Locum cost in month £54,517.42			

4.10. **Red flag reporting**

- 4.11. Red flag reporting continues through the Birthrate Plus acuity tool, but local audit indicates that recording compliance remains below the required standard, limiting assurance on the full scale of staffing-related safety pressures.
- 4.12. Core indicators for March remained strong, with 100 per cent compliance for both one-to-one care in established labour and supernumerary labour ward coordinator status. Eleven red flags were reported in March, mainly relating to missed or delayed care (six occasions) and delayed or cancelled time-critical activity (three occasions), with no reported red flags for delays in triage, pain relief, induction

processes, abnormal observations, or failure to provide one-to-one care. An improvement plan is in place, including review of the flow midwife role to strengthen reporting discipline and improve data reliability.

4.13. **Closures and suspensions of services**

- 4.14. Service suspensions remain actively risk-managed through established governance and monitoring arrangements, with alternative birth setting capacity maintained for low-risk women and the impact on outcomes and experience under ongoing review. However, continued suspension of elements of community birth provision remains a material exception requiring sustained oversight until the redesigned community model is implemented and services can be safely restored.

Table Service suspensions/ closures	Date	Plan
Temporary homebirth service county wide	November 2025 for 2 weeks and then extended for at least 6 months	New model of community care being designed and implemented, including all community birth provision including free standing birth units
Temporary Cheltenham Aveta Birth Centre	April 2022	
Temporary Stroud Postnatal beds	September 2022	

5. **Listening to women and families – patient experience and voice**

5.1. **Insights from service users**

- 5.2. This section provides an overview of patient experience data for maternity services, highlighting key themes, trends, and areas for learning and improvement.
- 5.3. Overall, feedback remains largely positive, with Family and Friends Test ratings stable across the reporting period. Complaint numbers reduced in February and March, while Patient Advice and Liaison Service concerns increased slightly, mainly in relation to communication, feeling listened to, and appointment or procedure cancellations.
- 5.4. Experience scores varied across pathways. Birth services recorded a reduction in ratings, including two very poor responses, while outpatient obstetric feedback improved significantly to 92 per cent, notably above the reported average of 77 per cent. Maternity ward ratings remained broadly stable at approximately 78 per cent.

Thematic review

- 5.5. A thematic review of community antenatal care feedback for January to March 2026 provides broadly positive assurance, with 86.25 per cent of respondents rating their experience positively and particularly valuing compassionate staff, clear communication and continuity of midwifery care where achieved. The principal areas for improvement relate to coordination and internal communication between services, especially around tests, scans, referrals and blood pressure monitoring, together with the need for clearer face-to-face information and greater involvement of women in decisions about their care. Questionnaire refinement is now planned to enable derivation of a Family and Friends Test score and strengthen triangulation, local learning and prioritisation of improvement action across the maternity pathway.

5.6. CQC Maternity Survey 2024/2025

- 5.7. The Maternity Experience Improvement Plan continues to coordinate action in response to Care Quality Commission maternity survey findings, with the main themes remaining communication, maternity ward responsiveness and environment, triage delays and communication, and infant feeding support. Delivery against the current plan is mixed, with nine actions complete, three on track, one in progress and three escalated, including delayed work on translation and interpretation

improvement. Development of the co-designed response to the 2025 national maternity survey has been delayed pending mobilisation of the new Maternity and Neonatal Voices Partnership team, launched in January 2026. The existing improvement plan therefore remains in place, with exceptions monitored through the monthly maternity experience meeting and escalated through the Perinatal Oversight and Assurance Group.

5.8. Cross Cultural Communication and Language Support

5.9. A gap analysis against the Royal College of Obstetricians and Gynaecologists' Cross-cultural Communication and Language Support standards has been completed and confirms progress in strengthening translation and interpretation support through improved staff training, clearer guidance, video interpreting technology and better use of health inequalities data. However, women who do not speak English as a primary language remain at increased risk of later booking, reduced engagement with care and poorer outcomes, particularly where services continue to rely on on-demand interpretation and video access is inconsistent. The key next steps are to procure additional Wordski on Wheels devices, standardise pre-booked interpreters for planned and semi-planned pathways, and embed language-related monitoring within routine governance, incident, complaint and provider reporting to provide stronger assurance on safety and equity.

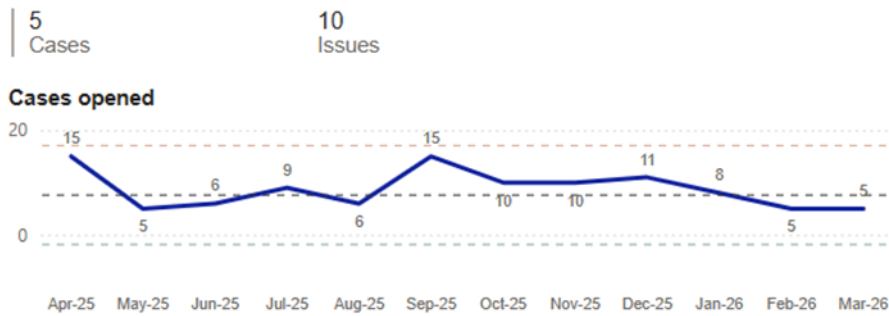
5.10. Birth Review and Reflect Service

5.11. The Birth Review and Reflect Service received 24 direct referrals in March 2026, mainly for clinically complex obstetric-led follow-up, with emergency caesarean birth, birth trauma and instrumental birth among the most common reasons for review. Feedback continues to provide valuable quality intelligence, identifying recurring themes in listening and validation, communication and consent, system reliability, pain management, neonatal and postnatal pathways, and psychological safety, alongside positive recognition of timely escalation, strong multidisciplinary working, evidence-based care and compassionate reflective follow-up. The main operational risk is increasing waiting times, particularly for obstetric appointments, indicating growing pressure on service capacity and less predictable access for some women. Ethnicity, language and deprivation data are now being captured to strengthen equity monitoring, and the service is under review, including future access options for all women.

5.12. Complaints – deep dive

5.13. Complaints continue to provide important quality intelligence, particularly in relation to communication, responsiveness and consistency of care, and governance has strengthened through clearer divisional ownership, improved senior oversight and closer linkage with patient safety and patient experience processes. However, response timeliness remains the principal area of risk. At the point of reporting, 46 complaints remained open, including 30 overdue cases, with an average age of 114 days, and communication was the largest and longest-running complaint theme. Fifteen complaints were awaiting final senior sign-off and expected to close imminently, but the remaining backlog continues to represent a significant responsiveness and assurance challenge. The service can therefore provide partial assurance only, with continued executive and Committee focus required to reduce the backlog, improve turnaround times and ensure complaint learning translates into visible service improvement.

Complaints



Subjects of issues raised by Service

Issue (Subject)	Maternity	Total
Delay or failure in treatment or procedure (including delay in...	2	2
Appointment not kept by Staff	1	1
Attitude of Nursing Staff/midwives	1	1
Communication with patient	1	1
Delay or failure to diagnose (inc e.g. missed fracture)	1	1
Failure to provide adequate care (inc. overall level of care pr...	1	1
Mismanagement of labour	1	1
Patient not listened to	1	1
Policy decisions	1	1
Total	10	10

6. Conclusion

- 6.1. This report has been reviewed through the established maternity governance route, including Quality and Performance Committee, and is now presented to Trust Board for oversight and discussion. It provides evidence of strengthened governance, improving triage performance, continued perinatal mortality review compliance, targeted quality improvement and progress against key improvement plans. However, assurance remains partial with workforce and training capacity constraints, ultrasound scanning resilience, continued suspension of elements of community birth provision and complaints response timeliness. These issues require continued Board oversight until improvement is delivered and embedded.

Appendix	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
Training Compliance for all staff groups in Maternity						
Perinatal Day	Midwives 96% MCA/Nurses 92%	Midwives 96% MCA/Nurses 92%	Midwives 93% MCA/Nurses 92%	Midwives 80% MCA/Nurses 84%	Midwives 80% MCA/Nurses 84%	Midwives 77% MCA/Nurses 80%
Fetal Monitoring	Midwives 94% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 94% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 95% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 92% Obstetric Consultant 93% Obstetric registrar 76%	Midwives 92% Obstetric Consultant 92% Obstetric registrar 70%	Midwives 86% Obstetric Consultant 93% Obstetric registrar 52%
PROMPT	Midwives 95% MSW/Nurses 94% Obstetric Consultant 100% Obstetric Registrar 91% Obstetric ST1/2 100% Anaesthetist – Missing data SAS/Consultant 91% Anaesthetic Trainee 100%	Midwives 95% MCA/Nurses 94% Obstetric Consultant 100% Obstetric Registrar 92% Obstetric ST1/2 100% Anaesthetist –Missing data SAS/Consultant 96% Anaesthetic Trainee	Midwives 97% MCA/Nurses 94% Obstetric Consultant 93% Obstetric Registrar 91% Obstetric ST1/2 100% SHO GP/FY – 93% Anaesthetist – SAS/Consultant 95% Anaesthetic Trainee 100%	Midwives 77% MCA/Nurses 78% Obstetric Consultant 71% Obstetric Registrar 76% Obstetric ST1/2 100% SHO GP/FY – 89% Anaesthetist – SAS/Consultant 82% Anaesthetic Trainee 85%	Midwives 92% MCA/Nurses 83% Obstetric Consultant 83% Obstetric Registrar 80% Obstetric ST1/2 100% SHO GP/FY – 100% Anaesthetist – SAS/Consultant 86% Anaesthetic Trainee 100%	Midwives 72% MCA/Nurses 72% Obstetric Consultant 62% Obstetric Registrar 63% Obstetric ST1/2 100% SHO GP/FY – 50% Anaesthetist – SAS/Consultant 68% Anaesthetic Trainee 54%
Newborn Life Support	Neonatal consultants 100% Neonatal juniors missing data Neonatal nurses MSD 98% Neonatal Nursing 72% Midwives 96% MSW 92%	Neonatal consultants 100% Neonatal juniors missing data Neonatal nurses 72% Neonatal nurses MSD 98% Midwives 96% MSW 92%	Neonatal consultants Neonatal juniors Neonatal nurses Neonatal nurses MSD Midwives 93% MSW 92%	Neonatal consultants Neonatal juniors Neonatal nurses Neonatal nurses MSD Midwives 80% MSW 84%	Midwives 80% MSW 84%	Midwives 77% MCA/Nurses 80%
Mandatory Training	Midwives 88% MSW 88% Neonatal Nursing 98%	Midwives 88% MSW 88% Neonatal Nursing 98%	Midwives – 89% MSW 87%	Midwives – 89% MSW – 89%	Midwives – 89% MSW – 91%	
Equality/ equity/ personalised care	Midwives 95% MSW	Midwives 95% MSW 94%	Midwives 97% MSW 94%	Midwives 77% MSW 78%	Midwives 92% MCA/Nurses 83%	Midwives 72% MCA/Nurses 72%
Care during labour and immediate post-natal period	Midwives 95% MSW 92%	Midwives 96% MSW 92%	Midwives 93% MSW 92%	Midwives 80% MSW 84%	Midwives 80% MSW 84%	Midwives 77% MCA/Nurses 80%
December						
Safeguarding Children's	Non-Medical	Medical	TBA			

Children L1	97%	n/a	Non-medical – 97% Medical – n/a	Non-medical 98% Medical – na	Non-medical 100% Medical - na	Non medical – 100% Medical - na
Children L2	94%	74%	Non-medical 97% Medical 74%	Non-medical 94% Medical 71%	Non-medical 94% Medical 71%	Non-medical – 94% Medical – 75%
Children Multiagency Day	92%	71%	Non-medical 92% Medical 71%	Non-medical 94% Medical 72%	Non-medical 94% Medical 77%	Non-medical 94% Medical 86%
Children L3 (1 Year)	85%	68%	Non-Medical 85% Medical 68%	Non-medical 81% Medical 77%	Non-medical 81% Medical 77%	Non-medical 81% Medical 100%
Adults L1	98%	n/a	Non-medical n/a Medical -98%	Non-medical 98% Medical -na	Non-medical 100% Medical - na	Non-medical 100% Medical - na
Adults L2	90%	54%	Non-medical n/a Medical 90%	Non-medical 88% Medical – na	Non-medical 89% Medical - na	Non-medical 91% Medical - na
Adults L3			Non-medical 85% Medical 54%	Non-medical 83% Medical 51%	Non-medical 80% Medical – 48%	Non-medical 81% Medical – 64%

Alert, Advise and Assure Report to the Board of Directors Meeting held on 16 July 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Audit and Assurance Committee held on 24 June 2026
Board member lead(s)		Shawn Smith, Non-Executive Director (Chair)
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	Approval	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

To present an update to the Board of Directors from the Audit & Assurance Committee meeting held on 24 June 2026 (quorate). The Committee reviewed the final Annual Report and Accounts, External Audit findings, Internal Audit Annual Opinion and key governance, risk and assurance reports. The Committee provides assurance on the adequacy and effectiveness of governance, risk management, internal control and financial reporting arrangements.

Key points

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

- Financial sustainability remains a significant weakness in value for money arrangements. External Audit confirmed a modified Value for Money conclusion due to continued reliance on non-recurrent savings and the scale of savings required to deliver future financial plans. While financial performance has improved, financial sustainability remains the sole significant weakness identified by external audit.
- Complaints management received a Limited Assurance opinion for operational effectiveness. Internal Audit identified significant weaknesses in timeliness, data quality, visibility and oversight, including average complaint response times of 79 days, a substantial backlog of open complaints and concerns regarding the completeness of Board reporting. The Committee expressed significant concern regarding the extent to which the organisation previously understood the true

position and requested ongoing oversight through the Quality & Performance Committee.

- Risk action management remains a material governance concern. Whilst risk reporting maturity continues to improve, 44% of risk management actions and 68% of incident actions remain overdue. The Committee noted that delayed actions may weaken the effectiveness of controls and hinder timely implementation of learning.
- Health and safety risks continue to require sustained Board oversight, particularly fire safety enforcement notices, ventilation and air handling unit resilience, violence and aggression towards staff, and wider estates compliance risks.

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

- Internal Audit reported an overall opinion of “Generally Satisfactory with Improvements Required”, but noted that delivery of the annual audit programme had been placed at risk by delays to individual audits. Future extensions to audit reviews will only be permitted in exceptional circumstances with oversight from the Committee Chair.
- Policy compliance continues to present limited assurance, with approximately 31% of Trust policies overdue for review and significant variation across divisions.
- The Trust continues to operate in a high-risk environment, with around 550 live risks across the organisation and a substantial proportion classified as high or extreme.
- The Perinatal Mortality Review Tool (PMRT) Audit identified moderate assurance but highlighted weaknesses in action tracking, evidence of implementation, parental engagement and review timeliness. Given ongoing maternity scrutiny, assurance regarding learning from reviews and family involvement remains important.
- The Health & Safety Annual Report highlighted the need for further organisational focus on prevention and management of violence and aggression towards staff, particularly in high-risk clinical areas.

ASSURE: inform the board where positive assurance has been received

- External Auditors concluded that the audit of the Annual Report and Accounts is substantially complete and expects to issue an unmodified opinion on the financial statements, with no evidence of fraud, management override or material bias in management judgements.
- The Committee received assurance that the previous significant governance weakness relating to CQC enforcement action has been successfully addressed and were no longer considered a significant control weakness by External Audit.
- The Annual Accounts, Annual Report, Annual Governance Statement and Code of Governance disclosures were reviewed and recommended to the Board for approval, subject only to final minor amendments.
- The Head of Internal Audit Opinion remained “Generally Satisfactory with Improvements Required”, consistent with the previous year and providing overall assurance regarding governance, risk management and control arrangements.
- The Fit and Proper Person review found the Trust to be substantially compliant with statutory requirements, with all Board members meeting the applicable standards.
- The Board Assurance Framework continues to mature, with strengthened articulation of strategic risks, controls and sources of assurance and increasing use as a live strategic management tool.

- The Quality Account was reviewed and endorsed, with quality priorities aligned to the Trust Strategy and focused on patient experience, timeliness of care, reducing health inequalities and implementation of the quality management system.

APPROVALS: decisions made by the Committee

- Recommended the Annual Report and Accounts 2025/26, including the Annual Governance Statement and Code of Governance compliance disclosures, to the Board for approval.
- Accepted External Audit's ISA260 Report and Auditor's Annual Report and supported Board approval of the final financial statements.
 - Approved the updated Audit & Assurance Committee Terms of Reference, including enhanced provisions relating to Freedom to Speak Up and whistleblowing assurance.

Implications

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

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

Board assurance framework

BAF reference	All
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Risks discussed

The Committee considered the full Risk Report and Board Assurance Framework report. Particular focus was given to financial sustainability and reliance on non-recurrent savings; complaints management and organisational responsiveness; overdue risk and incident actions; policy compliance; fire safety and ventilation risks; violence and aggression towards staff; maternity governance and learning systems; and the effectiveness of strategic risk controls and assurance arrangements.

Recommendations

The Board of Directors is asked to:

- TAKE ASSURANCE from the Committee's work and conclusions
- NOTE the continuing significant weakness identified by External Audit relating to financial sustainability and reliance on non-recurrent savings.
- NOTE the Limited Assurance opinion relating to complaints management and support continued executive focus and Quality & Performance Committee oversight of the improvement programme.
- SUPPORT continued executive action to improve timely completion of risk and incident actions, address policy compliance backlogs, and strengthen assurance over key health and safety risks including fire safety, ventilation resilience and violence and aggression towards staff.
- APPROVE the Annual Report and Accounts 2025/26 as recommended by the Committee

Report to Board of Directors

Date of Meeting	July 2026
Report title	Health & Safety Annual Report
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Lee Troake, Head of Risk H&S

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

Purpose This report presents the Trust’s Annual Health & Safety Report for the period 1 April 2025 to 31 March 2026 and provides the Board assurance on the effectiveness of the Trust’s arrangements for managing health and safety risks, compliance with statutory duties and delivery of the Health and Safety Plan 2025-2027. The report supports the Board in discharging its responsibilities under the Health and Safety at Work etc. Act 1974 and associated legislation by receiving and scrutinising assurance regarding health and safety performance and compliance. Duties The Board retains ultimate accountability for ensuring the Trust has appropriate systems, governance arrangements and controls in place to safeguard the health, safety and welfare of employees, patients, visitors and others who may be affected by the Trust's activities. The Board is also responsible for satisfying itself that appropriate assurance mechanisms are in place to identify, monitor and manage significant health and safety risks The Annual Health and Safety Report provides a comprehensive review of performance during 2025–26, including statutory compliance, progress against strategic objectives, significant risks, incident and RIDDOR trends, governance effectiveness, and areas requiring ongoing oversight. Overall, the Trust can provide reasonable assurance, with defined areas of partial and limited assurance requiring continued executive and Board oversight. It supports delivery of the Trust's strategic objectives relating to patient, public and staff safety, organisational resilience and good governance

Governance and Assurance Route

The report has been subject to detailed scrutiny and challenge through the Trust's established governance arrangements and is presented to the Board following consideration by:

- Group Health and Safety Committee – detailed review and endorsement of the report and assurance ratings within it
- Trust Leadership Team – consideration of key findings, ratings, risks and improvement priorities
- Audit and Assurance Committee – review of the assurance position and adequacy of governance and control arrangements, with recommendation to the Board

No material concerns were identified that would prevent the Board from taking assurance from the report. The Board is therefore asked to focus on the overall level of assurance, material risks, compliance position and strategic improvement priorities rather than the operational detail already considered by those forums.

The Board should satisfy itself that appropriate governance, risk management and control arrangements are in place to manage health and safety risks, the assurance presented is sufficient to support the Board in discharging its statutory and fiduciary duties in relation to health and safety and appropriate improvement actions and resources are being directed towards areas of greatest residual risk.

Key Assurances

There has been measurable progress against the Year 1 objectives of the Health and Safety Plan, particularly in governance maturity, compliance frameworks, and reporting culture. Controls across Objectives 1–14 are largely effective, although assurance is not uniform. There is evidence of sustained improvement across key areas including water safety, COSHH and health and safety resources.

Areas of Partial Assurance include:

- Asbestos management
- Electrical safety
- Working at height and confined spaces
- Workplace inspections
- Risk assessment quality

Whilst these areas have improved, they require continued delivery and strengthening of consistency in 2026-2027 to achieve a suitable level of compliance.

Incident reporting levels remain high, reflecting a positive safety culture, though recurrence of known risks limits full assurance. Key systemic themes include align with areas of limited assurance.

Key Issues for Board Attention

- Several high-risk areas remain above tolerance particularly:
 - Fire safety (subject to enforcement action)
 - Ventilation and ageing infrastructure (critical infrastructure risk)

- Violence and aggression affecting staff safety (systemic workforce and patient-related drivers)
- Estates resilience and infrastructure-related risks
- Reliance on the continued successful implementation of the revised Health and Safety Management Framework, specifically improved governance at sub-group level
- Contractual arrangements with GMS require strengthening to provide clear accountability for estates-related safety risks

These risks require sustained executive and Board oversight into 2026–27, with focus on the proposed priorities in the H&S Plan for 2026–27 to address areas where assurance remains partial or limited. In addition, any remaining unmet objectives from 2025-2026 will be included in the oncoming year’s work.

Forward Priorities (2026–27)

Key priorities include:

- Discharge the fire enforcement actions and regulatory compliance
- Develop and agree a funded, risk-based ventilation (Air Handling Unit) replacement plan
- Strengthening workplace inspection and risk assessment quality to increase the identification of risk at the earliest opportunity
- Conduct a gap analysis of our violence and aggression prevention and response against the national standard and review its effectiveness
- Align estates investment with safety risk priorities
- Deliver Year 2 of the Health & Safety Plan

Previously considered by	Group Health & Safety Committee, Trust Leadership Team, Audit & Assurance Committee
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Recommendations:

The Board is invited to:

- **Review and note** the Annual Health & Safety Report 2025–26
- **Take assurance** from the scrutiny undertaken by the Group Health and Safety Committee, Trust Leadership Team and Audit and Assurance Committee
- **Acknowledge** the overall assurance opinion of reasonable assurance, with identified areas of partial and limited assurance requiring ongoing oversight
- **Scrutinise areas of limited assurance**, particularly fire safety, ventilation, abuse and aggression and estates risks, confirming continued Board oversight will be maintained for those risks
- **Endorse** the prioritised improvement programme for 2026–27 and continued focus on the Trust's highest health and safety risks
- **Confirm** that it is satisfied appropriate governance arrangements are in place to oversee delivery of the improvement programme.
- **Identify** any additional areas requiring Board oversight

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

Impact on any Strategic Risks?
Health and Safety Governance BAF - The Annual Health and Safety Report provides a key source of assurance against the Trust's Health and Safety Governance BAF risk. The report demonstrates continued progress in strengthening governance arrangements, accountability, assurance mechanisms and compliance monitoring during 2025–26. However, it also identifies areas where assurance remains partial or limited, particularly in relation to fire safety, ventilation safety, estates resilience and violence and aggression. These risks continue to contribute to the Health and Safety Governance BAF risk and require ongoing Board oversight, investment and delivery of improvement plans during 2026–27.

Implications on:	
Equality, Diversity and Inclusion	The report identifies continued incidents of abuse, violence and aggression towards staff, including incidents involving discriminatory behaviour. Ongoing work to improve staff safety, security arrangements, behavioural standards processes and support mechanisms contributes to the Trust's commitment to an inclusive and safe working environment for all staff.
Health Inequalities	No direct implications identified within this report.
Finance and Resource	Delivery of compliance improvements will require continued investment in estates infrastructure and risk mitigation programmes, including fire safety, ventilation systems, electrical infrastructure, security arrangements and wider estates resilience. The report also identifies workforce and specialist resource requirements necessary to sustain compliance and assurance.
Regulation/Legal	Supports the Board in discharging its statutory duties under the Health and Safety at Work etc. Act 1974 by providing assurance regarding health and safety governance, compliance and risk management. The report also highlights ongoing regulatory engagement, including fire enforcement notices and other compliance-related matters requiring Board oversight.
CQC-Key line of enquiry	Well-Led – demonstrates oversight of risk management, governance, assurance, compliance and organisational learning. The report also

	supports elements of the Safe domain through monitoring of health and safety risks and controls.
Green Plan	No direct implications identified within this report, although future estates investment programmes may provide opportunities to align safety and sustainability objectives.

Main Report	
<i>See attached</i>	
Enclosures: Annual H&S Report 2025-26, Progress against Year 1 – H&S Plan	
FOI: Public	



Annual Health and Safety Report

April 2026

TROAKE, Lee (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION
TRUST)

1. Executive Summary

This Annual Health and Safety Report provides assurance on health and safety performance for the period 1 April 2025 to 31 March 2026, in line with the Trust's duties under the Health and Safety at Work etc. Act 1974 and associated regulations.

Overall, the Trust continues to demonstrate a strong reporting culture, improved governance maturity, and sustained improved performance across several core compliance areas, including asbestos, water safety, COSHH, and governance. Near-miss reporting remains high, indicating continued cultural maturity.

Taken together, controls across Objectives 1–14 are largely effective. However, assurance is partial in several priority risk areas, reflecting the scale, complexity and legacy nature of some risks. Significant risks remain, most notably within:

- Fire safety compliance, including enforcement action by Gloucestershire Fire and Rescue Service (GFRS)
- Ventilation and ageing infrastructure, particularly critical air handling units
- Violence and aggression
- Estates resilience, where repeated environmental failures indicate systemic risks rather than isolated issues

These risks remain above the Trust's risk tolerance and will require sustained executive oversight, investment, and operational delivery in 2026–27.

Overall Assurance Statement

There is reasonable assurance with defined areas of partial and limited assurance that require active management and Board oversight.

2. Governance and Leadership

The Chief Executive and Trust Board maintain overall accountability for health and safety compliance, delivered through the [Health & Safety Management Framework](#). This sets out the operating model for H&S (appendix 1), which was revised in December 2025 following a workshop on its implementation.

The Group Health & Safety Committee (Group H&SC) is chaired by the Executive Director of Integrated Governance and seeks to review and challenge matters connected to health and safety including assessing resilience and process safety. Group H&SC reports to Trust Leadership Team (TLT), providing an annual and mid-

year bi-annual report in 2025-26. In addition, more frequent reports from high-risk subgroups such as Fire, Water and Ventilation have been provided.

An annual report and a position statement have also been provided to the Audit and Assurance Committee (A&AC), which plays a key role in assuring compliance and making recommendations to the Board.

3. Group H&SC Activities and Effectiveness 2025-2026

Governance, Frameworks and Assurance

During 2025–26, the Group H&SC strengthened Trust-wide governance, assurance and escalation arrangements by:

- Reviewing and approving the revised Health & Safety Management Framework and Accountability Framework, improving clarity of roles, escalation routes and subgroup reporting
- Reviewing the Health & Safety Board Assurance Framework (BAF), confirming a continued score of 16 and formally recognising gaps in governance maturity, accountability clarity and alignment with ACOPs and HTMs
- Agreeing a move to bi-monthly Committee meetings, with risk-based prioritisation of agenda items
- Providing oversight of the Annual Health & Safety Performance Report, endorsing RAG ratings and escalating priority risks to TLT and Board
- Monitoring implementation of structured reporting (e.g., KIAR and AAA) by divisions and sub-groups to provide assurance
- Tracking delivery of risk-based action plans across specialist sub-groups
- Identifying and escalating cross-cutting risks (including resourcing, Authorised Person capacity, survey programmes)
- Commissioning a workshop to support implementation of the Framework

Estates and Fire Safety Risks

In 2025-26, the Committee provided strategic oversight of high-consequence estates and fire safety risks, including:

- Fire safety enforcement actions relating to the Tower Block, including alarms, compartmentation, fire doors and evacuation arrangements
- Restructuring of Fire Safety governance into distinct assurance and operational sub-committees, with revised Terms of Reference and policies
- Scrutiny of fire safety compliance, including governance arrangements and staff capability
- Review of significant estates-related risks, including:
 - Asbestos management, survey coverage and incident investigation (including RIDDORs)
 - Ventilation and HTM03 compliance risks affecting theatres, maternity and pharmacy manufacturing

- Electrical safety risks, including power resilience, Authorised Person capacity, generator faults and single ring main exposure
- Work at height and confined space compliance, including gaps in AP appointments, policies and rescue arrangements

Occupational Health and Staff Safety

In 2025-26, the Committee maintained oversight of key staff safety risks and controls, including:

- Gaps in health surveillance recording and assurance
- Manual handling risks, including bariatric care, training provision and equipment availability
- Violence and aggression risks, including security provision and training
- Trends in accidents, incidents and RIDDOR reporting and investigation
- COSHH compliance, including audit outcomes and substitution activity
- Entonox exposure risks in maternity, gynaecology and endoscopy
- Emerging risks including lithium battery storage, DSEAR, lead in paint and contractor safety

Infection Prevention and Water Safety

In 2025-26, the Committee oversaw assurance relating to the healthcare environment, including:

- Closure of the Pseudomonas incident action plan and transition of residual actions into business-as-usual governance
- Progress against recommendations from an independent external water safety review
- Ongoing risks relating to estates responsibility in leased buildings
- Monitoring of a pharmacy contamination incident

Workforce Engagement and Trade Union Involvement

In 2025-26, the Committee:

- Received and responded to Trade Union escalations and representations

4. H&S Strategy & Objectives

4.1 Asbestos Management (Objective 1)

Residual Risk Rating: Minor
Objective Delivery: 77% achieved
Board Assurance: Partial to good assurance

The Trust has made significant improvements in asbestos management in 2025-2026. Core controls are now in place and largely effective. However, governance slippage within the Asbestos Management Group has limited full assurance, and formal ratification of the revised Asbestos Management Plan remains outstanding.

Strengths

- A revised Asbestos Management Policy approved in July 2025
- A suitably qualified Authorising Engineer has been appointed and is actively supporting assurance and compliance
- A new asbestos management survey was completed across both sites in 2025, with the asbestos register updated to reflect current, consolidated information from management and refurbishment/demolition surveys
- Contractor controls have been strengthened through improved permit-to-work arrangements, managed via GMS
- All staff operating under the Asbestos Management Plan completed role-appropriate asbestos training in 2025, delivered by a competent provider
- Incident response arrangements were tested and followed appropriately during the single asbestos-related incident reported in-year

Key gaps and risks

- The Asbestos Management Group stalled during 2025, resulting in delays to governance oversight and formal ratification of the revised Asbestos Management Plan
- While escalation to Executive level has taken place, the Group has not yet been fully re-established
- One asbestos-related incident highlighted legacy contractor controls and historic survey gaps, reinforcing the need for sustained assurance

Overall, this risk remains within tolerance, subject to governance arrangements being restored.

Incident Learning

Incident (INC-27167) related to asbestos debris found in the centre block plant room during the management survey. GMS' investigation findings were that the debris was likely to have occurred during work carried by a contractor approximately 18 months earlier without an appropriate survey. Four GMS maintenance staff carried out work

in the plant room between the contractor work and when the debris was identified in the survey. The HSE was notified of the potential exposure, and area was decontaminated and a licenced contractor removed the asbestos.

4.2 Fire Safety Compliance (Objective 2)

Residual Risk Rating: Major
Objective Delivery: 77% achieved
Board Assurance: Limited assurance

Fire safety remains one of the Trust's most significant health and safety risks. While material progress has been made during 2025–26, the receipt of multiple enforcement notices confirms that compliance remains below acceptable tolerance and requires sustained executive oversight.

Strengths

- Revised Fire Safety Policy and digital action tracking implemented
- Updated Tower Block Fire Risk Assessment completed
- Approximately 80% of Tower compartmentation works completed
- Improved fire training compliance
- Re-structured fire governance framework implemented

Key gaps and risks

- Local Fire Risk Assessment completion remains significantly below the 95% target at approximately 42% completion – being addressed via Contract Management processes
- Enforcement Notices issued by GFRS reflect long-standing infrastructure issues rather than isolated failures
- Delivery remains dependent on complex decant, capital works, high-investment and regulatory engagement
- Four items will not be achieved within short-term notice timeframes

Enforcement Notice EN361 – Short Term Notice

The Trust has complied with two items on EN361 and is on track to comply with a further 11 of the short-term actions by the deadline of 30 April 2026. A Notice extension has been formally requested on four actions that will not be achieved within the original timescale.

These are:

- Fire Risk Appraisal of External Wall Construction

- Add Detection to Fire Alarm System
- Fire Fighting Lift Maintenance (request to transfer to long-term EN)
- Premise Information Boxes

Appendix 2 provides further detail on the position of each item.

Whilst governance, transparency and delivery confidence have improved, fire safety risk remains above tolerance pending completion of enforcement actions and capital works. The Board must retain direct oversight of this risk.

Enforcement Notice EN365 - Long Term Enforcement Notice

This Notice relates to the installation of a new fire alarm in the Tower and remedy of fire safety infrastructure. This work is part of a 3-year fire programme which requires the decant of a whole floor and movement of wards to accommodate a complex refurbishment programme. The Notice deadline of 2028 reflects the complexity of the work.

Enforcement Notice EN367 – Basement

EN367 contained 12 items and has an enforcement deadline of 30 July 2026. Four items are complete – Basement Fire Risk Assessment, Signage, Obstructions and Waste Removal. A further 8 items are part of the comprehensive fire programme for the basement which is subject to building control requirements.

Engagement with Building Safety Regulator (BSR)

The Trust has engaged with the account manager for the NHS with the BSR, this has opened a productive dialogue on the progression of any necessary BSR applications linked to the Tower works. GMS will provide the BSR further information to determine whether any fire door work can be completed under the definition of emergency works to avoid delays in progressing with safety critical upgrades and replacements required as part of the EN365 and EN367. The BSR also provided guidance on the status of the basement as regards the independence of the structure from the high-rise Tower.

Priorities for 2026–27:

- Complete enforcement notice actions and secure regulator sign-off
- Improve ward-level FRA completion and ownership
- Progress long-term Tower fire strategy aligned to decant programme and reduce reliance on interim mitigation measures

4.3 Electrical Safety Compliance (Objective 3)

Residual Risk Rating: Moderate
Objective Delivery: 71% achieved
Board Assurance: Partial assurance

Electrical safety arrangements across the Trust have strengthened this year, with improved governance, clearer accountability, and a defined improvement programme informed by the Authorising Engineer (AE) Audit findings. However, resilience risks and dependency on ageing infrastructure remain, meaning assurance is currently partial rather than full.

Strengths

- Revised Electrical Safety Policy providing clearer alignment to statutory requirements and guidance
- Governance and reporting arrangements have been clarified, spanning operational delivery, Group H&SC oversight and Trust Board escalation
- A risk-based and costed improvement plan has been developed in response to the 2024 AE audit
- Electrical risks on Trust risk registers have been reviewed and remain current
- Scrutiny of ward and department level electrical risks has increased following identification of emerging themes

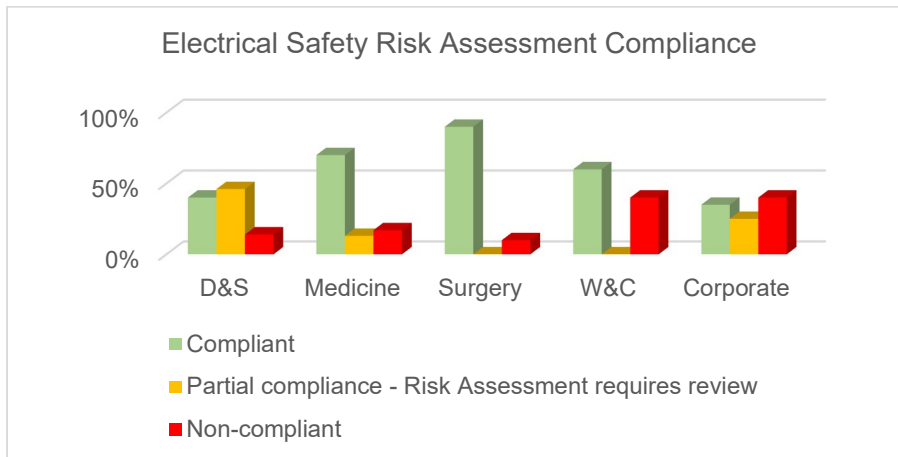
Key gaps and risks

- Appointed Person (AP) resilience remains a significant risk, particularly at Cheltenham General Hospital (CGH), due to limited numbers of competent APs, imminent retirement of experienced staff and succession planning
- Approval for funding of external out-of-hours electrical cover remains outstanding, limiting escalation and response resilience
- Approximately 50% of electrical panels identified in the AE audit require urgent replacement. The costed plan identifies £563.5k required for the most urgent replacements (20 panels / 10 units).
- Evidence supporting alternative maintenance approaches (e.g. thermal imaging, non-intrusive techniques) has not yet been formally submitted for Trust approval

Departmental electrical risk assessments

As a supplementary assurance activity, all divisions were required to review local electrical risk assessments in response to identified poor practice and unsafe management of electrical items.

Compliance varies across the divisions, with surgery demonstrating the strongest compliance and corporate the weakest. Divisions will be expected to continue to improve compliance in quarter 1 of 2026-27.



Priorities for 2026–27

- Secure approval for external electrical cover funding to improve resilience
- Implement succession planning and competency development for AP roles
- Deliver the AE-recommended electrical panel replacement programme
- Formalise and approve alternative LV panel maintenance options where appropriate

4.4 Working at Height Compliance (Objective 4)

Residual Risk Rating: Moderate
Objective Delivery: 78% achieved
Board Assurance: Partial assurance

The Trust has made notable progress in strengthening Working at Height (WAH) governance, competence, and control arrangements during 2025–26. However, gaps remain in equipment/safety controls at height, meaning assurance is currently partial rather than full.

Strengths

- Work at Height Policy has been developed, supported by a detailed safety procedure
- Governance and competence arrangements have improved through the formal appointment of four trained Appointed Persons, with certification and appointment evidence in place
- A permit-to-work system has been established for higher-risk activities including scaffolding, MEWPs, staging, access equipment and roof access
- Ladder safety controls have strengthened with three competent ladder inspectors trained and a ladder register implemented

- The principal WAH risk has been reviewed, informed by the February 2026 AE report

Key gaps and risks

- GMS training needs analysis does not currently identify general WAH awareness, only estates roof access, although training is in place in practice
- Equipment-related gaps include the maintenance of roof access systems, identification and signage of fragile surfaces, remedial work on numerous defective guardrails, missing gates, and gaps in harness and lanyard provision as identified in the AE audit. These pose serious safety risks and infrastructure-related deficiencies requiring a structured delivery plan

Priorities for 2026–27

- Embed the Work at Height Policy and procedures
- Finalise and deliver the GMS risk-based action plan responding to AE findings
- Expand training needs analysis to include all staff exposed to WAH risks
- Improve assurance over roof access, fragile surfaces and edge protection

4.5 Confined Spaces Compliance (Objective 5)

Residual Risk Rating: Low
Objective Delivery: 71%
Board Assurance: Good to partial assurance

Confined space controls are broadly effective, and the risk is currently within tolerance. While some documentation gaps remain, there is no indication of an unmanaged operational risk. Assurance is limited by an incomplete asset at CGH.

Strengths

- A new Confined Spaces Policy has been developed, supported by a detailed procedure defining roles, responsibilities and safe systems of work
- Governance and competency arrangements have strengthened through the appointment of two Appointed Persons and Coordinating Appointed Persons
- Confined space training delivered to 20 operational staff, the Appointed Persons and Coordinating Appointed Persons aligned to ACOP L101
- Safety rules and permit-to-work integration are in place to control access, and controls include use of qualified contractors for high-risk confined space work

Key gaps and risks

- Incomplete CGH confined space register

Priorities for 2026–27

- Complete the confined space register for CGH
- Maintain assurance through periodic audit and AE oversight
- Embed confined space governance fully within the Health & Safety Framework

4.6 Ventilation Safety Compliance (Objective 6)

Residual Risk Rating: Major
Objective Delivery: 67%
Board Assurance: Limited assurance

Ventilation safety remains a significant and unresolved infrastructure risk for the Trust. While policy and governance arrangements have improved, critical failures in air handling infrastructure continue to place clinical services at risk, particularly in Theatres and CSSD. The absence of an agreed, risk-based replacement programme for ageing air handling units (AHUs) represents a material gap in assurance and the ventilation risk remains above the Trust's risk tolerance. The Trust cannot demonstrate robust assurance against HTM requirements or long-term service resilience.

Strengths

- Revised Ventilation Safety Policy has been developed with improved alignment to HTM standards
- Increased Group H&SC oversight of ventilation risks
- Additional non-recurrent funding of £130k secured to address immediate compliance shortfalls
- Targeted remedial works commissioned to mitigate the highest-risk deficiencies. Approximately £87k of the additional funding has been committed to remedial works across CSSD, DCC, W&C and Theatres GRH and CGH

Key gaps and risks

- Twenty+ AHUs are rated as failing, non-compliant or beyond end of useful life
- Non-compliant AHUs do not reliably achieve required air change rates, increasing risks related to infection, service continuity and unplanned theatre closures
- A risk-based, prioritised replacement programme has not yet been tabled, despite recurring requests from the Group H&SC
- Continued reliance on interim and remedial measures increases the likelihood of system failure and service disruption

Priorities for 2026–27

- Produce and agree a risk-based, costed AHU replacement programme as a matter of urgency
- Align ventilation investment planning with the Estates strategy and capital programme
- Ensure ventilation risks are explicitly reflected in Trust-level risk registers and Board reporting

4.7 Water Safety Compliance (Objective 7)

Residual Risk Rating: Minor
Objective Delivery: 100%
Board Assurance: Good assurance

Water safety arrangements across the Trust remain robust and well-controlled, with effective governance, competent Responsible Persons, and assurance from internal and external review. Significant progress has been made in resolving legacy risks arising from the 2022 Pseudomonas incident, and water safety risks are now largely managed through business-as-usual (BAU) processes, rather than escalation.

Strengths

- Pseudomonas incident action plan was formally closed in late 2025, with residual actions appropriately transferred to BAU management through the Water Safety Group (WSG)
- Remaining Pseudomonas-related engineering works have been scheduled or incorporated into capital planning
- Schematics commissioned and commenced in February 2026; predicted to be completed by June 2026
- An independent external water safety review confirmed strong alignment with HTM requirements. The few remaining actions have been transferred into the WSG to the Business as Usual (BAU) action tracker
- The AE (Water) annual audit (January 2026) concluded a high level of water hygiene management, well-managed procedures, and good quality records
- Governance arrangements are well embedded, with Water Safety Group oversight and escalation routes through IPC and the Quality Performance Committee
- ZetaSafe exception monitoring has improved, with weekly reviews now embedded
- External consultants have been commissioned to independently review the Water Safety Policy, Written Scheme and Procedural Notes
- A BAU action tracker is reviewed as a standing agenda item at monthly WSG meetings; details of open actions are included in Appendix 3

Key gaps and risks

While overall assurance is good, a small number of residual and structural risks remain:

- Reliance on out date water system schematics until new ones are completed
- Clarity on estates responsibility in some leased buildings remains a risk
- Single-person dependency at CGH creates a resilience risk within the water hygiene function
- Delivery of some actions is dependent on complex engineering works, capital funding, or third-party support
- Interoperability issues between ZetaSafe and MyCad continue to affect system efficiency
- Flushing reports are not consistently provided to WSG
- Water safety resourcing and resilience within GMS staff / roles remains an issue and can impact on completion of PPMs

These risks are recognised and actively managed but require sustained oversight to prevent regression.

Priorities for 2026–27

- Complete updated water system schematics across all sites
- Resolve single-point-of-failure risks in water hygiene resourcing
- Finalise estates responsibility clarity in leased premises
- Improve asset and PPM data integration between ZetaSafe and MyCad
- Resolve flushing risks and reporting
- Maintain strong assurance and prevent regression

CQC Prosecution

The pending CQC prosecution linked to a serious incident in 2022, is scheduled to be heard in May 2026.

4.8 Workplace Inspection Compliance (Objective 8)

Residual Risk Rating: Moderate
Objective Delivery: 50%
Board Assurance: Partial assurance

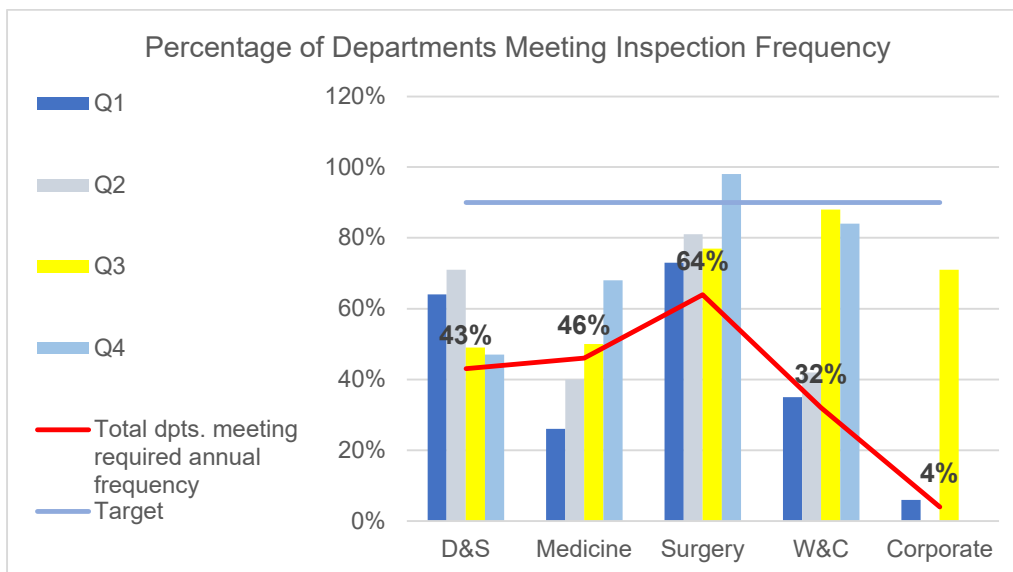
Workplace inspection compliance improved during the second half of 2025–26, following the recruitment of additional Health & Safety Advisors. However, overall compliance remains below the Trust target, with fewer than half of expected inspections recorded at year-end. Assurance is therefore partial, with sustained management focus required.

Strengths

- Defined workplace inspection programme, aligned to statutory requirements and risk profile, with clear inspection frequency
- Compliance reporting at divisional health and safety meetings to address local barriers
- Surgery has performed consistently well remaining between 70% and 90% compliance per quarter, while D&S performed better in Q1&2 than in Q3&4
- Targeted support from newly appointed H&S Advisors (from September 2025) has driven significant improvement in Q3 and Q4, particularly in:
 - Medicine improved from 26% in Q1 to almost 70% in Q4
 - Corporate from 6% in Q1/Q2 to 71% in Q3/Q4
 - W&C from 35% in Q1 to 84% in Q4

Key gaps and risks

The graph below shows the level of compliance for 2025-26. No division met the target across the year.



Whilst some improvements have been made in the number of workplace inspections being completed, there remains a proportion of areas that are not recording inspections.

Priorities for 2026–27

- Increase recorded inspection compliance to meet or exceed the 90% target
- Strengthen line-manager accountability for inspection completion/recording
- Focus improvement support on persistently under-performing areas

4.9 Risk Assessment Quality (Objective 9)

Residual Risk Rating: Moderate
Objective Delivery: 71%
Board Assurance: Partial assurance

Risk assessment capability across the Trust remains variable, with inconsistencies in quality and compliance limiting assurance. While the number of trained staff has increased significantly, audits demonstrate that many assessments do not meet expected standards of suitability and sufficiency.

Strengths

- Access to risk assessment training has expanded, delivered via monthly sessions open to all staff
- 60 staff have been trained in risk assessment this year, bringing the total approx. 400 staff trained across the Trust (including those trained via IOSH course modules)
- Approximately 70% of departments now have at least one trained risk assessor, representing a material improvement in baseline capability
- D&S, Surgery and Medicine have all met or exceeded the Trust target of 80% departmental coverage (see appendix 4)
- Targeted auditing of Access & Egress and First Aid risk assessments has provided valuable learning and feedback
- Individual feedback provided to risk assessment authors following audits
- Increased advisory support from H&S team to divisions with identified weaknesses

Key gaps and risks

- Initial audit results showed low first-pass compliance
- Corporate Division continues to lag, reflecting historic lack of dedicated H&S support (mitigated since September 2025)
- The poor functionality of the SharePoint-based risk library where risk assessments are stored limits proactive management, monitoring and review of approximately 3,500 assessments

Priorities for 2026–27

- Improve quality standards for risk assessments through clearer expectations and refresher training
- Explore implementation of a more functional digital risk assessment system
- Continue increasing trained assessor coverage, particularly in Corporate and W&C divisions

4.10 COSHH Assessments (Objective 10)

Residual Risk Rating: Minor
Objective Delivery: 100%
Board Assurance: Reasonable assurance

The Trust has established a robust and maturing COSHH management system, underpinned by improved divisional inventories and increasing sophistication in risk profiling. While hazardous substances remain inherent to healthcare delivery, controls are generally effective and proportionate, and the Trust can demonstrate reasonable assurance that COSHH risks are being actively managed.

Strengths

- All COSHH assessments are managed through a centralised digital platform (Sypol), with over 1,500 substances recorded and 2,500 assessments
- Divisional and departmental inventories of COSHH substances have been completed, improving visibility
- Filterable dashboard enables identification of substances with acute, chronic, health and environmental impacts
- High-risk substances have been identified:
 - Only 2% of substances present a high acute exposure risk, mainly in Estates and Medical Engineering
 - 23% are categorised as high risk to health, including commonly used cleaning agents and formalin
 - 7% are classed as high risk to the environment
- Substitution opportunities are being actively explored
- Improved COSHH training materials have been developed

Key gaps and risks

- Residual risk remains due to the routine and widespread use of hazardous substances across clinical and non-clinical settings
- Assurance depends on ongoing substitution activity, and compliance with control measures, rather than initial assessment completion
- Recording of health surveillance remains a key issue with no digital solution

Priorities for 2026–27

- Progress substitution of high-risk substances where reasonably practicable
- Roll out enhanced COSHH training Trust-wide

4.11 V&A (Objective 11)

Residual Risk Rating: Moderate
Objective Delivery: 100%
Board Assurance: Partial assurance

Violence and aggression (V&A) incidents remain a high-frequency risk for the Trust and continue to increase in line with national NHS trends. While the Trust has delivered against its stated objectives the underlying risk drivers remain systemic, resulting in partial assurance.

Strengths

- The initial phase of a revised dedicated ED security model has been implemented and has provided additional security resources in ED
- Following escalation by Group H&SC, the full security model approval has been confirmed. GMS to begin implementation in April 2026
- Enhanced Care Team now operating on several wards following successful pilot
- Activity coordinators trial completed by Safeguarding team. Now being expanded to other wards to test scalability
- New initiatives are being explored to support a different response to V&A incidents involving patients without capacity
- The Trust has employed a Mental Health Lead who is supporting a trauma-aware approach to patients and is now a member of the Behaviour Standards Panel
- The Behaviour Standards Panel continues to support staff safety through its weekly reviews / activities
- Learning from serious incidents is supported through structured debriefs and psychological support is being utilised

Key gaps and risks

- Many incidents involve patients with delirium, dementia, mental health crises or substance withdrawal; a different approach is required
- Progress on the full security business case has been slow due to complexity and financial scale
- Current arrangements for restraint and de-escalation training are ad hoc and rely heavily on interim controls rather than a fully implemented model
- V&A data now captured on RSL is not available to H&S to provide a holistic approach

Priorities for 2026–27

- Ensure to provide de-escalation and breakaway training for relevant staff
- Improve early identification and management of high-risk patients (e.g. cognitive screening)

- Strengthen multidisciplinary approach to V&A

4.12 Governance (Objective 12)

Residual Risk Rating: Minor
Objective Delivery: 100%
Board Assurance: Reasonable assurance

During 2025–26, the Trust has achieved a step-change in health and safety governance maturity, supported by the full review and implementation of a revised Health & Safety Management Framework.

Strengths

Roles, responsibilities, escalation routes and assurance mechanisms are now clearer and more consistently applied across the Trust and its subsidiary, providing the Board with assurance. Ongoing oversight through Group H&SC and Audit & Assurance Committee and annual and mid-year reporting cycles have been embedded.

Strengthened partnership working has also been demonstrated through annual strategic meetings between the Director of Integrated Governance, Head of Risk, Health & Safety and key partners e.g. Trade Unions and Authorising Engineers. A multi-stakeholder governance workshop was held in October 2025 to test the practicality of the Framework, identify resource, training and process gaps.

Key gaps and risks

- Delivery remains reliant on capacity within GMS and the Trust in relation to operational or sub-group governance
- There is a risk of governance drift without continued reinforcement and assurance monitoring

Priorities for 2026–27

- Strengthen assurance at operational/sub-group level to prevent governance drift
- Continue joint assurance work with Trade Unions and AEs

4.13 Investigation and Learning (Objective 13)

Incident themes and significant events are shared via the divisional H&S meetings and through the Group H&S Committee. Year 1 of the plan (2026-27) did not include

specific objectives in relation to this. However, objectives in Year 2 will build on learning opportunities.

4.14 H&S Resources (Objective 14)

Residual Risk Rating: Low
Objective Delivery: 100%
Board Assurance: Reasonable assurance

Health and Safety resourcing across the Trust has been strengthened and stabilised during 2025–26, significantly improving advisory coverage, responsiveness and support for divisions. While recruitment to one support post remains ongoing, overall Advisor capacity will now be focussed on underpinning delivery of the Health & Safety Plan.

Strengths

- Successful recruitment of two additional Risk, Health & Safety Advisors has resulted in advisory coverage across all divisions
- Increased visibility and presence of the H&S team have supported tangible improvements since onboarding the new Advisors 6 months ago e.g. in:
 - Improved workplace inspection compliance
 - Enhanced risk assessment training uptake
 - Risk assessment compliance
 - COSHH compliance
 - Investigation support
- A comprehensive suite of H&S resources is in place and actively used, including the H&S A–Z guidance pages, policies, action cards and risk assessments, tools for sharp injuries, RIDDOR reporting and ergonomic assessments
- Prioritisation of advisory activity based on risk, rather than universal coverage
- Draft communication plan developed to support engagement and learning in Year 2

Key gaps and risks

- Recruitment to the H&S Support Officer post remains ongoing, leading to no administrative H&S support capacity in the short term for Advisors
- Admin resources are shared with Patient Safety, with no resources dedicated to the H&S team, this has led to persistent delays and quality issues in Committee and sub-group management and a lack of day-to-day admin resource within the team
- No dedicated non-pay budget due to delayed restructure in quality and patient safety
- Increasing volume and complexity of assurance activity related to increased oversight of GMS led functions e.g., fire, ventilation etc risks capacity stretch for Head of Risk, H&S and team, reducing focus on occupational H&S compliance within the Trust

Priorities for 2026–27

- Complete recruitment to the H&S Support Officer post
- Implement the draft H&S communication plan
- Continue to focus H&S resource on highest-risk areas
- Support sustainable capability building within divisions to reduce dependency on central advisory input
- Stability with GMS key compliance and estates roles to prevent over-reliance for operational input on Trust H&S resources

5. Training & Competency

Training for H&S-related competencies show high compliance overall, with most training areas above 90% across divisions. There is good compliance in HSW (95%), Conflict Resolution (93%), DSE (94%), Sharps (non-clinical teams) (96%) and Manual Handling Level 1 (96%). Sharps (clinical) is at 89%, just 1% off target, with non-division staff extremely low at 38%.

Manual Handling Level 2 shows the lowest completion rate at 85%. Targeted follow-up by line managers and divisional leaders would drive the greatest improvement.

	HSW	Conflict Resolution	DSE	Sharps - Clinical	Sharps - Nonclinical	Moving & Handling L1	Moving & Handling L2
Grand Total	95%	93%	94%	89%	96%	96%	85%
Corporate Division	96%	92%	97%	84%	96%	98%	90%
D&S Division	96%	93%	96%	92%	96%	97%	85%
Medicine Division	94%	93%	92%	86%	97%	95%	84%
Non-Division	94%	96%	77%	38%	100%	100%	100%
Surgery Division	95%	93%	94%	90%	95%	96%	86%
W&C Division	94%	94%	94%	88%	98%	95%	86%

6. Authorised Engineer (AE) & AE Audits 2025-2026

The purpose of an AE audit is to provide independent, competent assurance that statutory and high-risk technical safety systems are being managed in line with legal requirements and recognised guidance. A number of high-risk systems are managed via a Healthcare Technical Memorandum (HTM) or an Approved Code of Practice (ACOP). The following assurance has been provided to Group H&SC by GMS on the appointment of authorised engineers.

AE GHFT/GMS HTM Management Compliance & Assurance									
HTM	Discipline	Title:	Name:	Site location GRH/CGH	When Procured? (Issue date)	Next Review Date:	Expiry Date	Letter signed by MD?	Signed copy received by Appointee?
HTM 01	Decontamination	AE	Deconcidal Ltd	GRH/CGH	Apr-25	Apr-26	Mar-27	Y	Y
HTM 02	Medical Gas	AE	Health Technical Limited	GRH/CGH	Oct-25	Oct-26	Oct-28	Y	Y
HTM 03	Ventilation Systems	AE	DRLC Ltd	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
HTM 04	Water	AE	Harper Water	GRH/CGH	Feb-26	Mar-26	Mar-27	Y	Y
HTM 05	Fire	AE	DRLC Ltd	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
HTM 06	Electrical safety	AE	Avonside Safety Management Limited	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
HTM 07	Environmental Management (Waste)	AE	TBC (Not included in Procurement)						
HTM 08	Specialised Services Lift	AE	ILECS Limited	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
INDG_401	Working at height	AE	Morsafe Limited	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
Non-HTM	Asbestos	AE	CE Consultants Europe Ltd	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
ACOP-L101	Confined Spaces	AE	Morsafe Limited	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y
ACOP	Pressure Systems	AE	ETA Projects	GRH/CGH	Jan-25	Dec-26	Dec-27	Y	Y

The annual AE audits are coordinated on behalf of the Trust by GMS, with the following schedule in 2025-2026. The electrical, medical gas and asbestos audits are due to be received by the Group H&SC in Q1 of 2026-27.

HTM	Hospital	Audit Report	Date of current Audit	Date of next Audit
HTM-01 - Decontamination	GMS	✓	Mar-25	Mar-26
HTM -02 - Medical Gas	CGH	✓	Dec-24	Jan-26
	GRH	✓	Dec-24	Jan-26
HTM-03 - Ventilation	CGH	✓	Mar-25	Oct-26
	GRH	✓	Apr-25	Oct-26
HTM-04 - Water	GMS	✓	Jan-25	Jan-26
HTM-05 - Fire	GMS	✓	May-25	May-26
HTM-06 - Electrical	CGH	✓	Dec-24	Feb-26
	GRH	✓	Dec-24	Feb-26
HTM-07-01 - Waste	GMS	X	X	NA
HTM -08-06 - Lifts	CGH	✓	Jun-25	Jun-26
	GRH	✓	Apr-25	April-26
INDG_401 Working at Height	GMS	✓	Mar-25	Mar-26
Non-HTM Asbestos	GMS	✓	Dec-24	Jan-26
ACOP-L101 Confined Spaces	GMS	✓	Mar-25	Mar-26
ACOP Pressure Systems	GMS	✓	May-25	Mar-26

7. Appointed Persons

An Appointed Person (AP) for an HTM or ACOP is a competent individual formally appointed by the organisation to take day-to-day operational responsibility for managing a specific high-risk safety discipline in accordance with recognised standards and legal requirements. GMS has delegated authority to ensure suitably qualified and experienced APs are in place.

The following assurance has been provided to Group H&SC by GMS on the appointment of APs. As noted below, several APs are undergoing training and assessment before they can be formally appointed and deemed competent to carry out the role. Further assurance is required from GMS on progress with appointments.

HTM	SI	PG - Named AP's	Training Propo	Current Trainin	Training Comple	Assessment Comple	Refresher Training	Refresher Comple	GMS Offer Letter	Comments
HTM01 - Decontamination	GRH	Callum Merchant		✓	✓					Assessment - Feb 26
	GRH	Jamie Smallman				✓			✓	Complete
	CGH	Micheal Cameron			✓					AP Letter to be issued - Jan 26
	CGH	Brett Cameron			✓	✓				AP Letter to be issued - Jan 26
HTM02 - Medical Gas	GRH	Callum Merchant		✓	✓	✓				AP Letter to be issued - Jan 26
	GRH	Neil Baldwin					✓		✓	Complete
	CGH	Tom Ferguson					✓			AP Letter to be issued - Jan 26
	CGH	Brett Cameron					✓		✓	Complete
HTM03 - Ventilation	GRH	Callum Merchant		✓	✓					Assessment - Feb 26
	GRH	Neil Baldwin					✓		✓	Complete
	CGH	Tom Ferguson					✓			AP Letter to be issued - 13th Feb 26
	CGH	Jack Stubbs		✓	✓					Assessment - Feb 26
HTM05 - Fire	GRH	Jane Taylor			✓	✓				AP Letter to be issued - Jan 26
	GRH	Matt Sewell			✓	✓				AP Letter to be issued - Jan 26
HTM06 - Electrical	GRH	Scott Hamblin					✓		✓	Complete
	GRH	Adrain Weir					✓		✓	Complete
	GRH	Chris Gogh					✓		✓	Complete
	CGH	Alan Hatton					✓		✓	Complete
	CGH	Artur Nash		✓	✓					Assessment - Feb 26
HTM08 - Lifts	GRH	Ade Ole					✓		✓	Complete
	GRH	Scott Hamblin			✓	✓			✓	Complete
	CGH	Artur Nash			✓	✓			✓	Complete
	CGH	Micheal Cameron							✓	Complete
Confined Spaces	GRH	Paul Grayston			✓				✓	Complete
	GRH	Andy Kingscote			✓				✓	Complete
	CGH	Darren Williams	✓							Training to be completed by April 26
	CGH	Tom Ferguson		✓	✓				✓	Complete
Working At Heights	GRH	Paul Grayston			✓				✓	Complete
	GRH	Andy Kingscote			✓				✓	Complete
	Both	Umar Sayi			✓	✓			✓	Complete
	Both	Mark Buckland			✓	✓			✓	Complete
	CGH	Micheal Cameron							✓	Complete
	CGH	Darren Williams							✓	Complete
Pressure Systems	GRH	Jamie Smallman					✓		✓	Complete
	GRH	Chris Gough	✓							Training to be organised - Jan / Feb 26
	CGH	Jack Stubbs	✓							Training to be organised - Jan / Feb 26
	CGH	Tom Ferguson					✓		✓	Complete
Asbestos	GRH	Andy Kingscote		✓						Training to be completed by April 26
	GRH	Iona Giles (Capital)		✓						Training to be completed by April 26
	GRH	Paul Grayston		✓						Training to be completed by April 26
	CGH	Darren Williams		✓						Training to be completed by April 26
	CGH	Neil Giles (Capital)		✓						Training to be completed by April 26

8. Accident and Incident Analysis 2025-2026

Over 10,000 incidents relating to health and safety were reported in 2025/26, broadly consistent with the previous year. Reporting levels remain high, reflecting a sustained positive reporting culture, particularly for near-misses.

Incident Profile and Harm Severity

Most incidents caused no harm or minor harm, resulting in the overall severity profile remaining consistent with 2024–25. No evidence was present of widespread increase in serious harm, but persistent pockets of elevated risk remain.

Near-miss reporting provided valuable early-warning intelligence. There was no significant increase or reduction in incident reporting month-to-month. Reporting remained steady and consistent.

Dominant Themes

High-frequency incident categories continue to dominate H&S reporting including:

- Abuse/Aggression/Violence (verbal & physical)
- Communication Failures (internal & interdepartmental)
- Staffing Capacity Issues
- Medical Device/Equipment Failures
- Environmental & Estates Failures
- Security incidents
- Sharps & Splash Contamination Injuries
- Manual Handling Injuries

The consistency of these themes indicates systemic drivers, rather than isolated failures, particularly linked to workforce pressure, ageing infrastructure, and operational demand surges.

8.1 RIDDORs

Overall, there has been a 2.8% increase in RIDDORs from the previous financial year. The most growth was in moderate harm incidents, which accounted for 70% of all RIDDORs as opposed to 60% in the previous year. This may reflect the Trust improving RIDDOR identification and reporting accuracy or increased level of severity of incidents. Eight of the 36 RIDDORs were reported by GMS.

Actual Level of Harm	FY 2024–25	FY 2025–26	Change	Observation
No harm	3	3		No change – consistent
Minor Injury	9	6	-3	Declined by 30%
Moderate (Specified Injury / over 7 days)	21	27	+6	Notable increase
Death	2	0	-2	Positive reduction: fall-related RIDDOR deaths not reported in 25/26
Total	35	36	+1	Overall minor increase

The following themes dominate RIDDORs:

- **ED (7), Theatres (6), DCC (5), Respiratory (4)** – relating to exposure (bio/chem hazards), manual handling, V&A and equipment related incidents
- **Manual Handling Injuries** are a major contributing category with ten incidents reported as RIDDOR in 2025-26, including one which related to a GMS employee. Mainly in back, shoulder and neck injuries.
- **V&A** – six incidents where patients became aggressive, kicking and hitting staff or requiring restraint for safety. These predominantly related to patients with delirium, dementia, confusion, with underlying causes reported as dependence on 1:1 enhanced care and staffing shortages, patients with acute confusion not risk-assessed in a timely way and inconsistent application of de-escalation techniques.

V&A RIDDORs have included a staff member sustaining a fractured wrist from being kicked in the hand, another sustaining fractured toe which required prolonged sickness and over 7-day sickness following restraint strains. One RIDDOR involved time off sick after a patient pushed over a pregnant staff member.

- **Slips, Trips & Falls** – this remains a consistent RIDDOR theme with seven RIDDOR reportable incidents, three of which were employees in GMS. Of the seven RIDDORs in the Trust, three were reportable patient falls (e.g. specified injuries). However, there were no reported patient-deaths from falls flagged by the Falls Hub in the last 12 months as RIDDOR reportable (previous year was two). One staff member fell in Mayhill carpark due to a damaged surface; two others slipped on wet floors. Improvement opportunities are regular workplace inspections to detect hazards and address before an incident, good housekeeping and estates investment.
- **Sharp, Splash & Hazardous Substance Exposures** - A decline from seven in the previous year to two sharps and splash RIDDORs in 25–26 which both related to BBV-related exposures to a Hepatitis B+ patient. Incidents also related to potential exposure to asbestos debris due to contractor oversight and failed access controls.
- **Equipment Failures (trolleys, doors, C-arms, autoclaves)** - examples include an Autoclave trolley wheel failure which led to a fracture, sensor doors closing unexpectedly, C-arm becoming stiff, causing back injury and wrong mattress on trolleys leading to collapse of rails.

8.2 Violence & Aggression Incidents (Highest Frequency Trend)

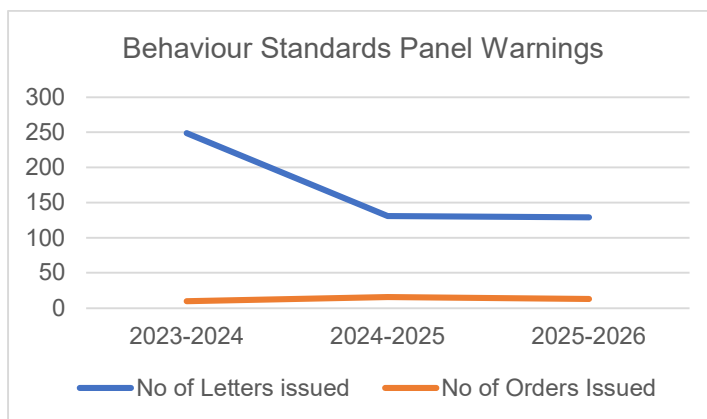
V&A incidents remain chronically problematic with continued frequent verbal abuse. Hotspots continue to include ED, Care of the Elderly, Paediatrics, and Trauma. Risk ratings on incidents regularly reflect the potential for serious risk even in incidents

that resulted in no or minor harm. Behaviour is often linked to confusion, mental health crises, drugs/alcohol, or safeguarding issues.

Incidents include:

- Verbal abuse towards staff (patients, relatives, public)
- Physical assaults (kicks, punches, bites, grabbing, headbutting)
- Dementia-/delirium-related aggression
- Sexualised behaviour and inappropriate touching in several cases

The Panel have issued 129 letters and 13 Orders in 2025-26, similar to the preceding year. Three Orders involved the same three patients who received Orders in 2024-2025, and repeated behaviours once the Order expired. This necessitated the Trust re-issuing it.



The Trust's power is very limited. Body-worn cameras have played a significant role in providing evidence of behaviours to the police, contributing to injunctions and court orders in the longer-term.

Overall, controls mitigate risk but do not yet reduce exposure. Clinical staff remain first responders without consistent access to de-escalation or breakaway training, and response capacity is limited during peak pressure.

Forward focus

Shift from reactive response to early risk identification, a change in approach for patients without capacity, consistent training for frontline staff, and full delivery of the revised security response model.

8.3 Sexual Safety

Sexual safety incidents on Report, Support and Learn (RSL)

In 2025, a new online platform, RSL, provided a confidential space for reporting staff to staff incidents, including sexual safety incidents. Sexual safety data from RSL is

not currently shared with the V&A Group or Group H&SC so is not included in this report.

Sexual safety incidents on DATIX

Sexual safety incidents where the alleged perpetrator is a patient or visitor, are reported on DATIX and our response managed via the Police, Safeguarding Team or the Behaviour Standards Panel process. These range from sexual comments to physical assault (sexualised non-consensual touch) and sexual acts (e.g. public masturbation).

The table below depicts the number sexualised behaviour incidents reported on Datix by financial year. The data shows 13 incidents reported compared to 31 in the previous year. However, as 2025 data excludes incidents reported on RSL, it is not possible to provide a direct comparison.

In nine of the incidents in 2025-26 reported on DATIX, a staff member was the victim, while in 3 incidents the victim was a patient and on one occasion a visitor.

	Who was harmed – Sexual Incidents			
	Patient	Staff	Visitor/ Public	Total
2024/2025	7	24	0	31
2025/2026	3	9	1	13
Total	10	33	1	44

The person exhibiting the alleged sexualised behaviours were as follows:

	Alleged Perpetrator – Sexual Incidents					
	Inpatient	Outpatient	Patient relative, friend, acquaintance	Public - visitor, third party	Staff	Total
2024/2025	20	4	2	2	3	31
2025/2026	8	1	1	1	2	13
Total	28	5	3	3	4	44

One incident occurred where a male staff member was alleged to have inappropriately touched a patient. Learning from the incident reflected the need to explain the medical process to a patient with learning difficulties which led to a misinterpretation by the patient of the staff members clinical interventions. A female member of staff was present. A further incident involved a patient alleging sexual assault by a male staff member, this was referred to the police by IRSH.

Four of the alleged perpetrators did not have capacity and a further patient was noted as 'unsure' - fluctuating capacity. Of the eight alleged perpetrators deemed to have capacity, six were patients who were reported to have victimised staff while two were staff reported to have harmed patients.

	Capacity			
	No	Unsure	Yes	Total
2024/2025	13	8	10	31
2025/2026	4	1	8	13
Total	15	11	17	44

8.4 Communication Failures (Systemic Trend Across Trust)

Communication failures reflect a stable but significant incident trend, with over 420 incidents reported in the last annual reporting period. Incidents stemmed from underlying drivers of risk, predominantly linked to workforce pressures (e.g., staffing levels/skill mix/workload intensity) which contributed to delays and communication breakdowns.

Strong themes cut across all divisions including:

- Bleeps not answered/wrong person holding bleeps
- Incorrect or missing documentation
- Missed, poor or delayed handovers
- Poor professional communication between teams or interdepartmental coordination
- Miscommunication regarding booking, equipment, patient flow

In some instances, the communication category was incorrectly used to report incidents of abuse and aggression. This most commonly occurred in the Emergency Department and Care of the Elderly services.

The impact of communication incidents is mainly patient related with delayed diagnostics and discharges, delays to Theatre procedures and patient dissatisfaction. These incidents should form part of the monitoring, trend analysis and learning through the patient safety team and processes, so are not examined in detail here.

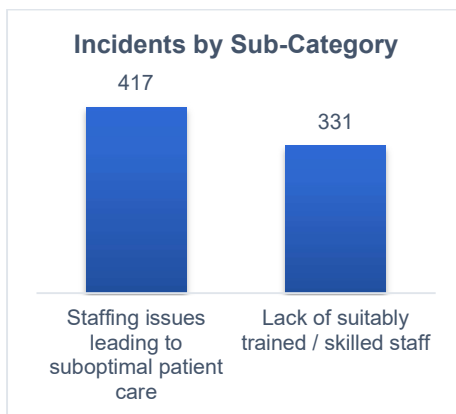
Incidents relating to patient/public adverse communication towards staff or others are generally responded to via the Behaviour Standards Panel. Incidents between staff are now reported on RSL and fall within the remit of the People and OD team. Data from RSL has not been made available for this report.

8.5 Staffing Shortages (High-Risk Sustained Trend)

In 2025-26 the Trust reported 748 staffing related incidents. Incidents are more prevalent over the winter months, worsening at times of high activity; directly linked with surges in ED.



These incidents are further broken down into staffing issues leading to suboptimal patient care and lack of suitably trained skilled staff.



Key trends summary

Recurrent issues linked to acuity surges, rota gaps, sickness, phlebotomy strike impact, lack of RMN's and pressures on enhanced care.

Staffing reports are seen repeatedly in:

- ED minors (e.g., 90+ patients with two nurses)
- Rheumatology (unable to provide advice line)
- Paediatrics (insufficient HCAs for 1:1 care)
- Preop/notes backlog (lack of anaesthetist review capacity)

Recurrent patient safety risks involved with staffing issues include:

- Missed observations/deteriorating patient not reviewed
- Delayed medications (including IVs, insulin, analgesia)
- Failure to provide basic care due to workload
- Increased falls risk when enhanced care unavailable
- Delayed triage in maternity and ED resulting in breaches
- Delayed medication rounds

- Unsafe patient flow

Recurrent staff safety risks include:

- Burnout, morale issues, missed breaks
- Increased personal risk (lone working, handling complex patients)

Harm Levels

Most incidents have been recorded as no harm (667); however one was recorded as major harm, 13 moderate harm and 67 recorded as minor harm. Themes amongst the moderate harm level incidents include unsafe skill mix leading to unsafe situations with inexperienced staff required to undertake complex work, areas where demand exceeded capacity and service closure or reduced function due to staffing shortfalls. In many incidents, staff escalated appropriately, but no support was available, either due to site-wide pressure or lack of reserve capacity.

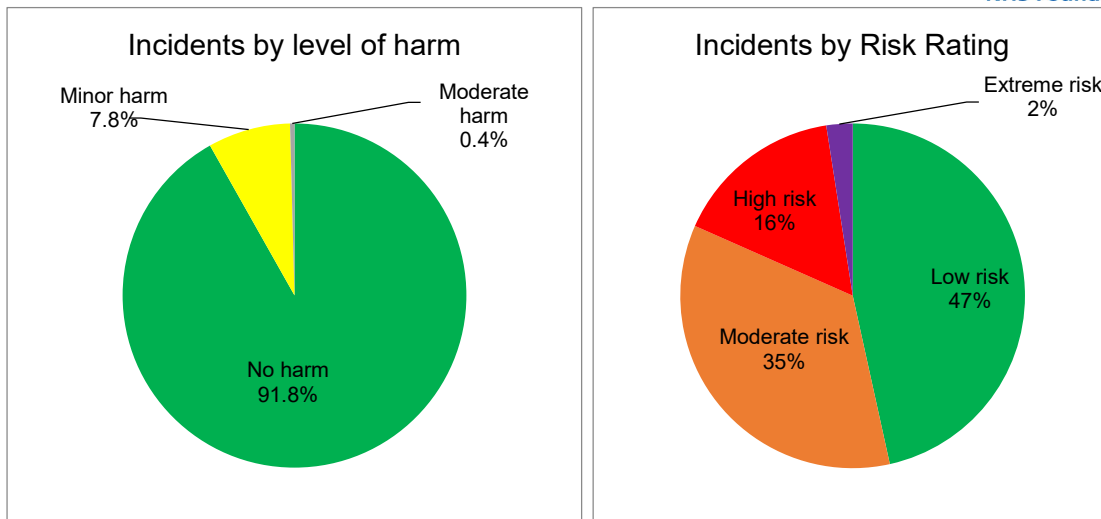
Forward Focus

Staffing-related incidents remain a chronic and system-wide risk. Staffing incident intelligence should be used to inform workforce planning, escalation models, and safer staffing decisions.

8.6 Medical Devices & Equipment Issues (Reoccurring Trend)

In 2025-26, 245 incidents involving medical devices and equipment affecting staff, visitors and the organisation were reported. This represents a substantial decrease from 419 incidents reported the previous year, but remains largely reports on holes in sets, wet sets and missing items.

92% of incidents in 2025-26 caused no harm, 8% resulted in minor harm and one caused moderate harm, leading to a RIDDOR report due to an injury sustained while moving a faulty imaging arm in Theatre. 82% of incidents pose a low or moderate risk of harm.

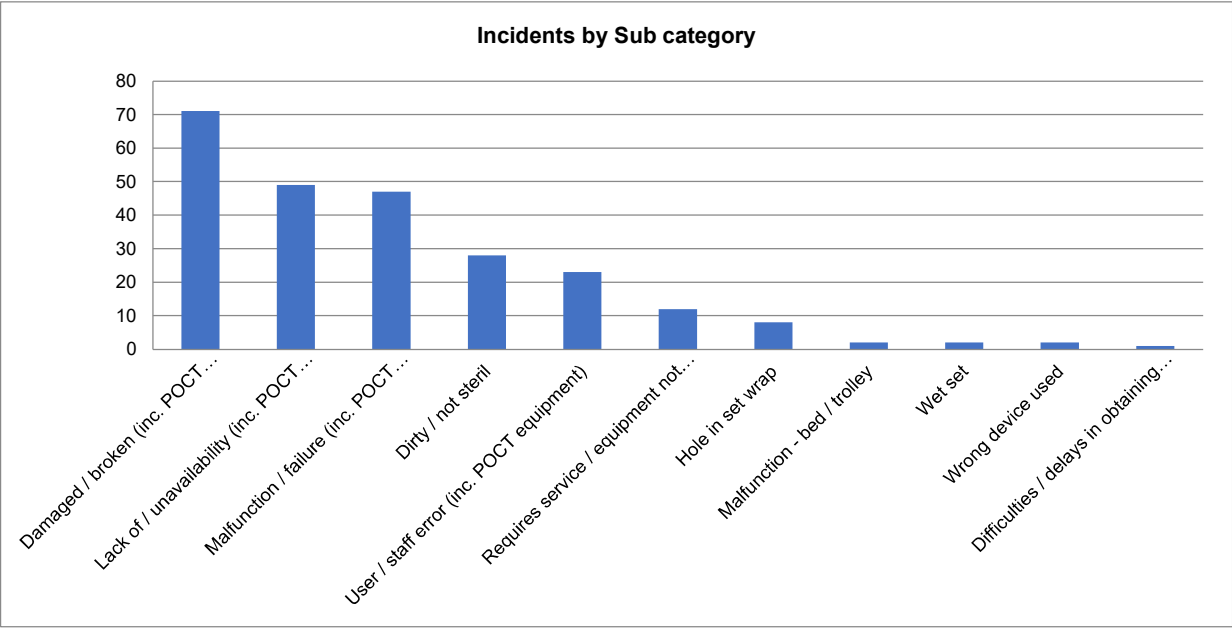


The key themes across all medical devices and equipment incidents are:

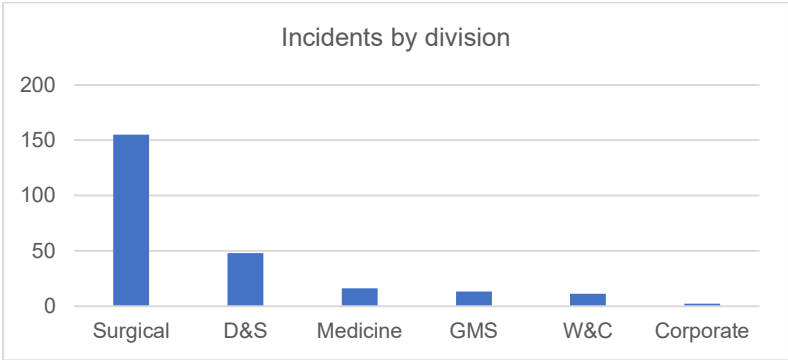
- Continuing issues with CSSD and decontamination processes
- Damaged or blurry laparoscopes/endoscopes
- Dirty/unsterile equipment/wet sets
- Faulty alarms
- Equipment shortages - missing instruments or incorrect tray contents
- Delays in repairs, servicing and maintenance
- Ageing equipment in need of replacement
- Software and digital system issues e.g. updates, integration and system outages
- Cross-departmental and cross-site communication and process failures, such as late returns, chain-of-custody gaps and procurement and IT issues

The impact of these incidents includes:

- Theatre delays & case cancellations
- Additional manual handling demands
- Safety concerns re sterility
- Ongoing issues with faulty scopes, missing instruments, damaged kits, wet sets.
- These delays affect theatres repeatedly.



The distribution of incidents across the divisions shows that over half are attributed to the Surgical division, with Theatres accounting for the majority of these. Most of those rated high or extreme risk typically involved issues with sterility of sets or damaged/missing equipment that had potential to cause harm to patients or delay surgery. The next largest division is D&S, with most of their medical devices and equipment incidents coming from Radiology.



A peer report in CSSD in January 2026 recommended a joint action plan between Theatres and CSSD to reduce set contamination. An action group has been established to implement measures to reduce the risk.

Forward focus

Despite these issues, the overall risk of harm remains low as most problems with equipment are caught before use, which indicates a strong culture of pre-use checks and a proactive approach to preventing harm. A review of the patient safety and

infection control processes in CSSD/Theatres to address contaminated sets is on-going.

The Trust should strengthen end-to-end equipment assurance (procurement, tracking, maintenance, decontamination) and reduce dependency on staff catching failures before use.

8.7 Estates, Maintenance and Environmental Failures

Environmental incidents are high-frequency. Although most incidents did not result in actual harm, many created high-risk environments, particularly where temperatures affected staff wellbeing, clinical performance, or medicines storage. Several departments experienced operational disruption, particularly Theatres, Endoscopy, Paediatrics, Emergency Departments, and administrative offices affected by flooding or excessive heat.

Moderate harm incidents included major flooding in the Orchard Centre, recurrent headaches due to a lack of blinds in a tower block office, temperature issues and a staff member tripping over cables. Minor harm incidents include temperature issues, cuts and grazes, space issues and pests (drain flies).

Common themes include:

- Persistent high temperatures (>25°C) affecting labs, pharmacy, clinical areas
- Unsecured buildings and defective doors
- Obstructed corridors (materials, cages, mattresses)

Impact:

- Heat-related discomfort, equipment shutdown
- Infection control concerns
- Fire safety risks
- Damp and mould
- Drainage issues
- Pests – flies, maggots, silverfish and cockroaches
- Disruption of clinical services due to poor estates
- Leaks, faulty doors, blocked fire exits, and poor workspace safety

Incidents occur consistently throughout the year and are not sporadic. However, there are clear seasonal spikes, especially:

- Spring–Summer (May–July) e.g., heat, ventilation, pests, smoking
- Autumn–Winter (Oct–Feb) e.g., leaks, flooding, cold environments, estates failures

Many issues are repeated reports of the same hazard, indicating control measures are often temporary and underlying estate or system issues remain unresolved. This suggests a systemic estates and resilience issue, not isolated lapses and reflects the known infrastructure capacity risks identified on the risk register such as ventilation, fire, electrical, waste etc.

Degraded assets, such as the Orchard Centre, feature persistent repeated callouts to safety and infection control issues, which is indicative of environmental safety and hygiene vulnerabilities in this building. Environmental issues act as a multiplier for staff wellbeing (sickness, reduced performance), workforce retention (morale and value) and patient safety risks.

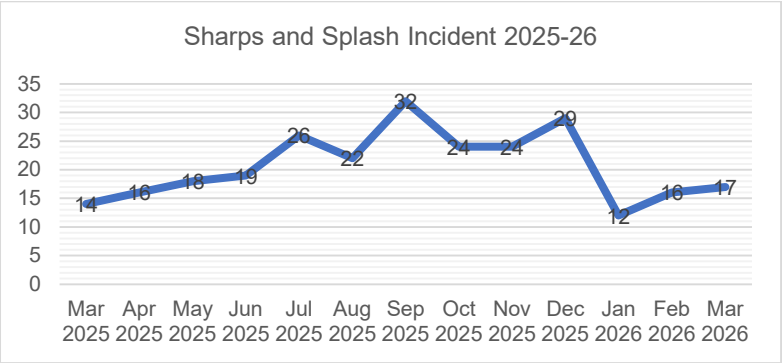
Behavioural issues also persist in relation to smoking on the Trust estates, both from patients outside ED or the main entrance and staff who smoke in known areas such as gated pathway between the discharge lounge walkway and the mortuary building.

Next Steps:

- A clearer estates strategy, and prioritised investment aligned to safety risk rather than failure response is essential to addressing risk
- Short, medium and long-term estates action plan
- Estates assurance reports to CMG could include number of repeat incidents per site
- Install physical deterrents in areas where patients and staff smoke on site e.g., planters, barriers, outdoor smoke detectors
- Integrate environmental themes into staff surveys, exit interviews or wellbeing metrics to build intelligence on the impact on staff

8.8 Sharps, Splashes & Occupational Exposure

In 2025-26, the Trust recorded 269 sharps-related and splash contamination incidents. This is consistent with the previous 12 months of data.

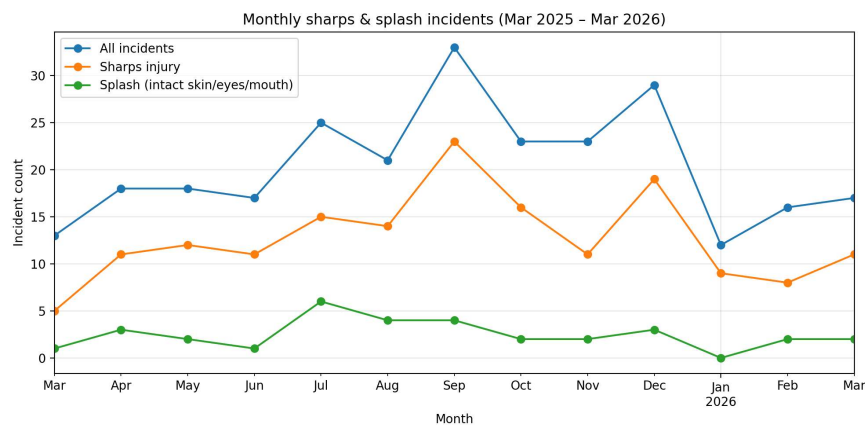


The broad categories of sharps and splashes are shown in the table below:

Metric	Count
Total incidents	265
Sharps injuries	165
Splash contaminations	47
Sharps found (no injury)	31
Sharps incorrectly disposed/stored	13

Trend over Time

The data showed a steady increase in the number of incidents being reported with a peak occurring in September 2025 (32 incidents) and a second highest in December 2025 (29 incidents). The lowest month was January 2026 (12 incidents) with incident reports remaining consistently lower for quarter 4.



Sharps injuries are the main driver of month-to-month variation particularly around theatre activity and invasive procedures. Splashes are smaller in volume but cluster in high-acuity areas such as Critical Care, Cardiology/Cath Lab, Maternity and Theatres where eye/face exposure risk rises due to the type of clinical activity such as suction, extubation and baby delivery.

Incident where sharps are found, without injury (e.g., incorrectly disposed, stored or returned in an unsafe condition to CSSD) are a material latent hazard and appear frequently enough to merit targeted controls. Together these consist of around 28% of all non-contact events recorded (75 incidents across categories/themes).

Themes

From incident narratives, recurring scenarios stand out including:

- Cannulation/venepuncture workflow (incl. butterfly/vacutainer/bloods): 54 incidents.
- Sharps bin issues (overfilled, lids not locked, needles protruding): 33 incidents.

- CSSD/SSD sets returned with sharps still in them: 31 incidents.
- ABG/arterial line handling (incl. radial sheath): 9 incidents.
- LMWH (enoxaparin/Fragmin/Inhixa) issues, often failed retraction: 9 incidents.

Splash incidents commonly involved blood or bodily fluids contacting staff eyes or face during airway care, line flushing or surgical activity.

Clusters:

GRH reports more than double the number of sharps/splash incidents (178 / 68%) compared to CGH (83 incidents / 31%). This reflects differences in service mix, patient acuity, and procedural volume. In GRH, sharps injuries occur due to large procedural areas (Theatres, Critical Care, ED, Stroke, Medical specialties). Theatres accounts for 40 of the incidents in GRH.

While in CGH there is a meaningful volume, it is significantly lower and concentrated in Ophthalmology, Theatres, Oncology/Haematology and Urology. This may be due to a stronger elective, day case and outpatient footprint in CGH where incidents reflect routine care processes (e.g., lens/forceps left out, sharps in trolleys, incorrect disposal).

Category	GRH	CGH	Comment
Total incidents	178	83	GRH >2× CGH
Sharps injuries	High	Moderate	Driven by emergency & surgical activity
Splash injuries	High	Lower	GRH Critical Care/Cath Lab major contributors
Sharps found/no injury	Moderate	Moderate–High	CGH has recurring Ophthalmology & SSD issues
Sharps disposal problems	High	Lower	GRH wards & theatres
High-risk procedures	Many	Fewer	Explains incident volume differences

The highest reporting division for sharps and splash incidents was the Surgical Division, accounting for 102 incidents, followed by the Medical Division with 87 incidents, and Women's & Children's with 39 incidents. These three areas represent the majority of all incidents reported Trust-wide over the 12-month period.

Sharps injuries concentrate in Theatres (23), Maternity (16), ED (15) and Stroke (10). Splashes cluster in Critical Care (12), Theatres (8), Cardiology (4) and Maternity (4).

Harm levels

Most incidents are no or minor harm (accounting for 97% of all incidents Trust-wide). Two sharps or splashes incidents have led to a RIDDOR being reported to the HSE

in the past 12 months (1 Medicine, 1 Surgery). This was due to the patients being Hep A and Hep B positive.

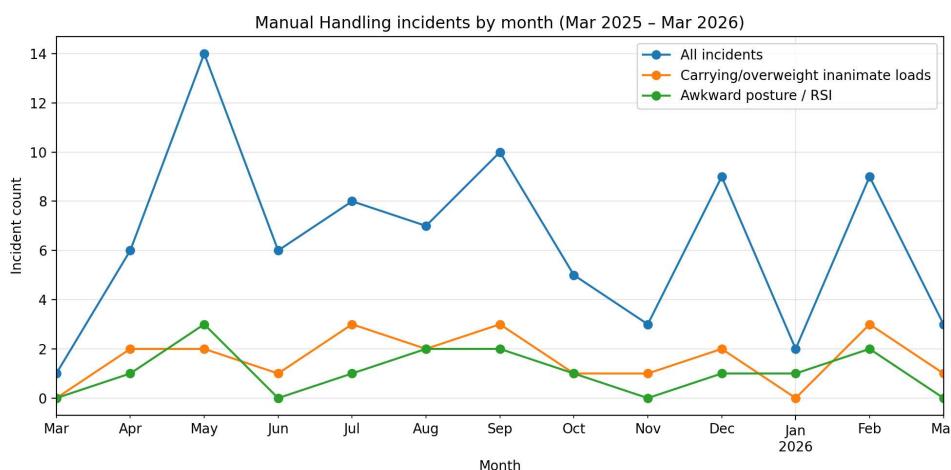
Forward Focus

While most incidents resulted in no or minimal harm, the frequency highlights a need for strengthened sharps-disposal practice, improved PPE use in high-risk tasks, and targeted training in departments with repeated patterns such as ED, Critical Care, Stroke, Theatres and Cardiology. A focused action plan is being implemented to address sharps bin management, reinforce safe disposal behaviours, and improve staff protection during known splash-risk procedures.

8.9 Manual Handling Injuries

The dataset covers a very wide range of manual handling scenarios, from patient transfers to pushing equipment to handling inanimate loads (boxes, cages, bins, trolleys) across both GRH and CGH. 83 incidents were reported in the 12-month period, with a peak in May 2025 (14 incidents). GRH accounts for 58% of the incidents reported and CGH for 41% with the remaining occurring off site.

The most notable division is surgery with particular focus on Theatres and Recovery (heavy sets and trolleys, bariatric patients, equipment unsuitability, automated doors failing). However, Health Records also reported a number of incident (8) related to overfilled boxes and notes bags and Care of the Elderly reported patients becoming unsteady or collapsing during transfers, staff catching or supporting patients during falls.



Overall patterns show:

Inanimate loads:

- Overfilled notes boxes/bags/cages, heavy instrument sets and food waste caddies are recurring breaches of safe load limits. Strong cluster in Health Records and SSD/Theatres
- Beds/trolleys/cages with faulty wheels, tight routes, slopes, heavy doors or broken automatic doors, bariatric bed manoeuvres

Awkward posture / RSI

- Static or constrained postures during spinals, endoscopy with low trolleys, ultrasound probing; and working through long lists without rotation
- Critical Care (bariatric patients, rolling/turning of dependant patients)

Bed/Chair transfers/Hoists

- Staff strain due to patient unpredictability (legs give way, sudden grab/lunge/resistance) during bed/chair/commode moves-staff back injuries; common in Care of the Elderly, Stroke, Respiratory
- Radiology (supporting patients on and off the table, faulty equipment)
- a lack of patient documentation before transfer, incorrect information about a patient's size and poor communication during patient transfer
- Isolated technique and set-up issues with a patient hoist (battery/LOLER/compatibility); one patient injury case requiring RIDDOR

Harm levels

Most incidents have resulted in no or low harm (61 incidents). However, 22 incidents were reported as moderate harm where back injuries have occurred leading to over 7-day injuries for RIDDOR. Work-related sickness data for manual handling is not currently available to the Risk, H&S team to triangulate sickness absence with reported incidents. Further exploration is also needed in relation to the percentage of staff self-reporting manual handling injuries in the staff survey which does not correlate with the number of incidents reported. This could indicate a level of under reporting or presenteeism.

Proactive Harm Reduction Work

The Moving and Handling Team are working with Theatres to support improvements in training, risk assessment, equipment provision and access to specialist advice.

Other work underway to help reduce manual handling incidents include:

- Increased provision of Moving & Handling Link Workers across clinical areas to strengthen local expertise, improve compliance, and support safer practice at ward level and in non-clinical areas

- Rolled out bespoke, in-house training for the Emergency Department, tailored to their specific equipment, environment, and patient acuity
- Collating EPR patient data and incident information to improve in-house provision of bariatric equipment, alongside more streamlined processes for accessing specialist equipment
- Working with ward and department managers to enhance moving & handling risk assessment capability, including increased support for staff returning to work following musculoskeletal absence
- Developing a “train the trainer” programme in collaboration with GMS for high-risk departments, enabling sustainable, locally delivered training and improved competency
- Upskilling the Moving & Handling team through NEBOSH training in incident investigation and manual handling risk assessment
- Scoping and planning for implementation of the new national Statutory and Mandatory Training reform programme, which will move away from the 2-year renewal model toward a competency-based approach aligned to role and working environment.

9. Conclusions

9.1 Overall Summary of Compliance Against Objectives 1–14

Across Objectives 1–14, the Trust has made material progress in strengthening health and safety governance, technical compliance and organisational maturity during 2025–26. The majority of objectives have been achieved or partially achieved, with demonstrable improvements in policy, assurance frameworks, competence, and visibility of risk.

Overall, the Trust can provide moderate assurance on compliance with statutory health and safety duties. However, assurance is not uniform, and several high-impact risks remain above the Trust's preferred tolerance, requiring sustained executive oversight moving into 2026–27.

Summary of Objective Performance

- Objectives Achieved with Good Assurance
 - Objective 7 – Water Safety
 - Objective 10 – COSHH
 - Objective 12 – Governance
 - Objective 14 – Health & Safety Resources

These areas demonstrate embedded systems, effective controls, and stable BAU governance arrangements. Residual risks are largely within tolerance and subject to routine monitoring and audit.

- Objectives Partially Achieved with Partial Assurance
 - Objective 1 – Asbestos
 - Objective 3 – Electrical Safety
 - Objective 4 – Working at Height
 - Objective 5 – Confined Spaces
 - Objective 8 – Workplace Inspections
 - Objective 9 – Risk Assessment Quality

In these areas, foundational controls are in place, governance visibility has improved, and credible improvement plans exist. However, delivery dependency, variable local compliance, infrastructure constraints, or workforce exposure limit full assurance at this time.

- Objectives with Elevated Residual Risk Requiring Ongoing Board Oversight
 - Objective 2 – Fire Safety
 - Objective 6 – Ventilation Safety

- Objective 11 – Violence & Aggression (from a people-safety perspective)

These objectives remain above risk tolerance, largely due to ageing and complex infrastructure, reliance on capital programmes, decant and systemic pressures within the operating environment.

9.2 Assurance Position on Incidents

Accident and incident data provides partial assurance. The Trust can be assured that:

- Hazards are being identified and reported
- Controls are broadly effective in preventing serious harm
- Learning is captured

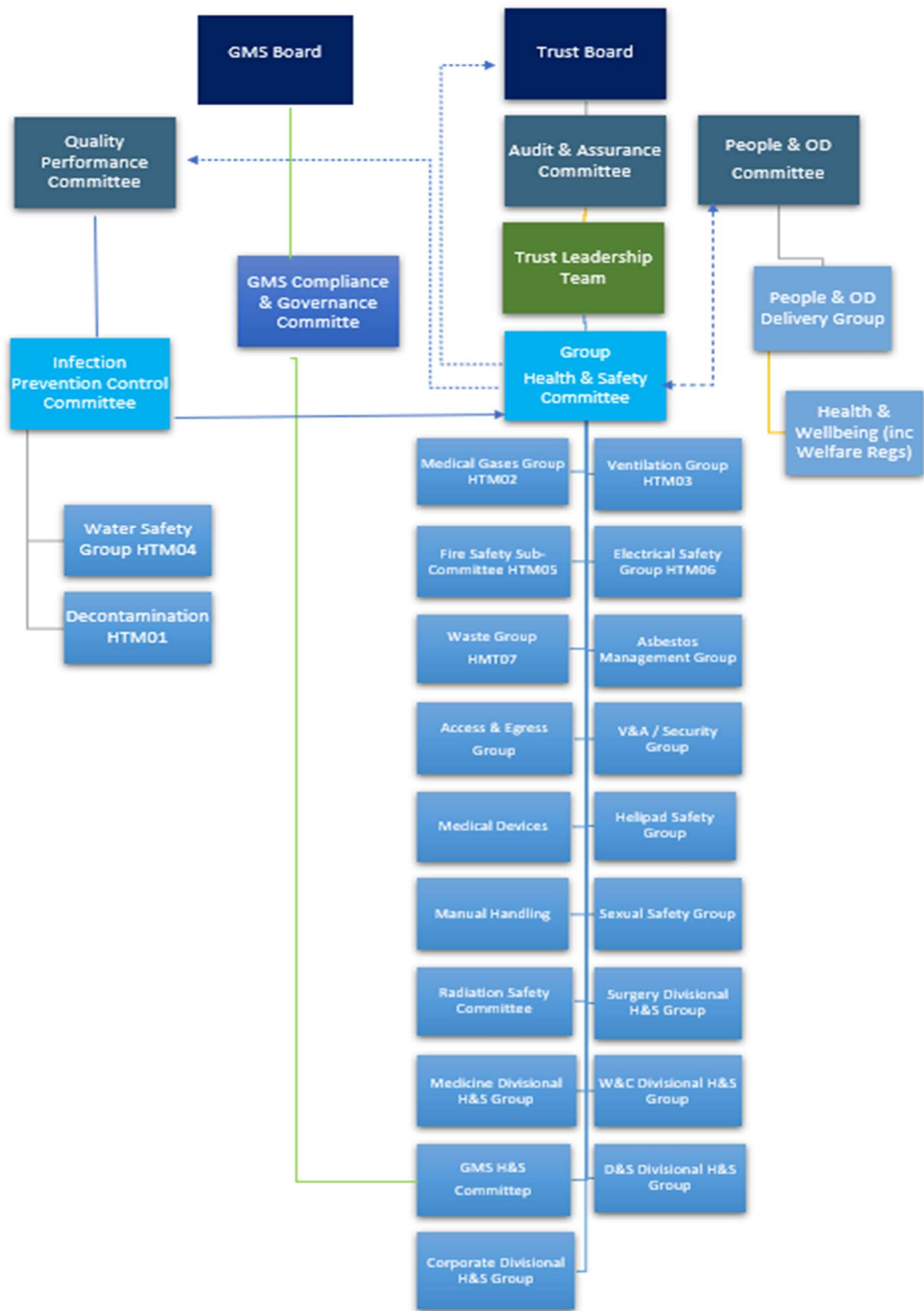
However, assurance is limited by repeat exposure to known risks, reliance on staff mitigation rather than systemic prevention and infrastructure, estates and workforce dependencies. A shift from measuring volume of incidents to reducing recurrence is needed by using incident intelligence to prioritise intervention and investment.

10. Recommendations

The Group H&S Committee is invited to:

- i. Review the annual health and safety report and confirm agreement to the assurance ratings assigned in the report.
- ii. Review the annual health and safety report and confirm commitment to ensuring a safe and healthy workplace for all employees and visitors by supporting the improvement activity highlighted.
- iii. Confirm it is assured that the key areas of improvement activity will address any shortcomings identified in the report.
- iv. Support the prioritised improvement actions for 2026–27, including:
 - Continued executive oversight of high-risk objectives remaining above tolerance
 - Delivery of Year 2 of the Health & Safety Plan, aligned to incident intelligence and risk prioritisation
- v. Recommend this report to the Trust Leadership Team and Audit and Assurance Committee

Appendix 1 – Group H&SC Governance Structure



Appendix 2 – Fire Enforcement Notice Progress Summary

1. Items Acknowledged as Discharged by GFRS

Item 5 – Electrical Installation

Evidence of the mains electrical installation test certificate has been provided. GFRS has confirmed by email that this item is discharged.

Item 6 – Portable Appliance Testing

Evidence of portable appliance testing within the Tower Block has been provided and confirmed by GFRS as discharged.

2. Items on Track for Completion by 30 April 2026

Item 1 – Tower Fire Risk Assessment

A Fire Risk Assessment for the Tower Block, completed by a competent person, has been provided, along with a separate basement FRA.

At the meeting on 9 April 2026, GFRS confirmed that submission of the FRA action plan and confirmation of actions being updated within the FRA were required to fully discharge this item. This information will be provided by the Notice deadline.

Item 4 – Obstructed Escape Routes

Lift landing lobbies are routinely monitored as part of fire watch arrangements, and evidence has already been supplied to GFRS.

Plans are in place to remove bin store infrastructure from lift lobbies. This requires careful sequencing to avoid infection control risks or the introduction of additional fire loading within ward areas. A solution has been identified involving alterations to dirty utility rooms across Tower wards to accommodate waste bins.

Works are scheduled to commence on 16 April 2026 and are expected to take approximately one week. Following completion, waste bins will be relocated, and an enhanced waste collection regime implemented to prevent waste accumulation.

An Asbestos survey has concluded that there is ACM in the floor tiles and fixings of the stores themselves. This will need removal/making safe by a licenced contractor as part of the removal of the bin store compartments. This element may extend the planned work beyond the deadline; however, all fire loading will be removed from the lift lobbies and the bins locked off by the Notice deadline.

Item 7 – Provision of information to Employees

The Trust has provided evidence of the Tower Evacuation Plan and fire safety information issued to agency staff prior to commencing work. All staff have access to ward fire folders containing relevant fire safety information.

At the meeting on 9 April, GFRS clarified that ward-specific evacuation plans aligned to the Tower FRA were required. These will be provided by the Notice deadline.

Item 8 – Firefighting Training

An external provider has been engaged to deliver fire extinguisher training. Training sessions are scheduled throughout April and May, with capacity to train approximately 70 staff per day, subject to clinical release. Catering staff training will be completed by the end of April.

GFRS confirmed on 9 April that evidence of training delivery would be required to discharge this item. This will be submitted by the Notice deadline.

Item 9 – Firefighting Equipment Testing and Maintenance

Evidence of the annual examination and monthly visual checks will be provided by 30 April.

Item 10 – Remove Lithium Battery Chargers

The Trust has procured new computer on wheels which were assessed by the Fire Team and deemed to be a safer alternative with an integral battery which does not require removal to charge. To date, the Trust has replaced 86 computers and removed the chargers on wards that are complete. The remaining 73 computers are on track to be replaced by the Notice deadline.

Item 11 – Level 1 Management System

At a previous meeting, GFRS requested evidence of our governance structure and meetings for Fire Safety to discharge this item. The Trust collated this for the meeting on 9 April.

On 9 April, GFRS referred to financial arrangements between the Trust and GMS for purchasing fire safety equipment or progressing remedial works. It was confirmed that compliant procurement processes are in place, with GMS also maintaining a budget for remedial works which managed via the MICAD system.

It was agreed a written summary of these arrangements will be provided to GFRS to discharge this item.

Item 13 – Signage

Evidence of the signage order for the Tower has been provided. The new signage will be installed by 30 April.

Item 15 - Fire Service Coordination

The Trust has provided its revised Evacuation Plan and action cards detailing the roles and responsibilities of the Fire Response Team and other staff during a fire alarm. These were tested during a multi-agency exercise and subsequently refined. The Fire Response Team is the operational emergency coordination function (e.g. Site, Fire, Estates, Security, Portring) and is distinct from the Fire Team in GMS which manages technical fire safety on a day-to-day basis. Updated action cards and evidence of Fire Response Team tabards will be provided by the Notice deadline.

Item 16 – Evacuation Equipment

The Trust has already supplied an inventory and justification for the evacuation equipment provided in the Tower Block, including suitability for patient profiles, ward layout, compatible equipment, and building constraints. GFRS has since requested a risk assessment covering the use of evacuation equipment to discharge this item. This will be provided by 30 April.

Item 17 – Staff Communications

Emergency radios have been purchased for deployment to each ward, with a dedicated emergency channel. Over the next two weeks, nominated staff will be trained prior to issue. Radios will be fully implemented by 30 April.

3. Items Requiring an Extension

Item 2 – Fire Risk Appraisal of External Wall Construction

An appropriately qualified expert has been identified and a scope of work developed. Clarification was required regarding the need for an EWS1 certificate, and GFRS has confirmed this is not required.

The expert will be formally instructed shortly. The FRAEW is anticipated to take a minimum of **six weeks** following instruction and therefore will extend beyond the current deadline.

Item 3 – Add Detection to Fire Alarm System

The item includes a required action to upgraded to a full L1 alarm system, which also forms part of the long-term Enforcement Notice with a deadline in 2028. Interim measures are also required to ensure adequate protection coverage.

The Trust has procured a temporary alarm system for contingency use and commissioned a Wi-Fi survey to support this, with results expected week commencing 13 April.

A specialist provider has also been instructed to undertake a gap analysis of the existing system, with completion anticipated by 1 May 2026. An action plan will be developed once findings are confirmed. Completion of all required works will extend beyond 30 April and is currently **estimated at 2–3 months**, subject to survey outcomes and complexity of addressing the findings.

Item 12 – Fire Fighting Lift Maintenance

The firefighting lift is now operational, and service records and LOLER documentation will be provided. However, due to the age of the building, Lift 8 does not meet EN81-72.

An initial survey has been completed indicating the scale and cost of required upgrades. A detailed feasibility design was commenced on 9 April. Following receipt of a design, a formal tender process will commence. This programme of work is expected to take **a minimum of 12 months** and may extend further depending on asbestos, structural, or electrical constraints.

GFRS has acknowledged that this item may need to transfer to the longer-term Enforcement Notice.

Item 14 – PIBs

Evidence of PIB orders has been provided. However, the lead time for the full order is **5-6 weeks**. The supplier is yet to provide a definitive date for delivery. The Trust anticipates that the PIBs will arrive by the end of May and will be installed in all buildings by **end of June**.

A temporary PIB has been placed in the Tower, ground floor, second entrance. This contains relevant information for the GFRS on arrival, including floor plans as requested.

Appendix 3 – Water Safety

BAU Tracker Update

The action tracker is being actively monitored by WSG as a standing agenda item on monthly meetings. Remaining actions are largely dependent on complex engineering and capital works, external support or documentation updates.

Open actions status update – 24 March 2026

- **Shower base replacement programme:** Nine shower bases at CGH require replacement and a quote has been received for the work. A start date is still pending. The GRH shower replacement programme is on hold due to wider building regulations issues. These will be added to the water capital fund for 2026/2027.
- **Water system surveys and schematics:** Surveyors are consolidating the new surveys with multiple historic drawings for CGH, using 3D model before site verification. Once consolidation is complete, surveyors will return on site to check accuracy. Once CGH is completed the surveys will begin at GRH.
- **Flexible hose removal:** Deputy RP at CGH is addressing this action as of January 2026 – completion date awaited
- **Sample tracking software implementation:** A meeting with the external software company and GMS is scheduled to finalise details, with the AE and IPCT invited for oversight.
- **Water safety policy and written scheme and procedure notes:** external consultants appointed by GMS are currently undertaking independent scrutiny/review of these documents due by the end of March 2026.
- **Water safety team / resourcing:** An options paper for a long-term solution will be provided by GMS shortly, with predicted implementation in 2026/2027.
- **New tank installation in pathology:** Expected completion is by the end of March 2026.
- **Sentinel outlets:** New sentinel outlets will be identified and confirmed once updated schematics are finalised.
- **ZetaSafe / asset & PPM consolidation (to support sample tracking software use):** asset consolidation within ZetaSafe (linked to SFG20 and PPM assurance) remains a key dependency. GMS confirm consolidation and verification work may take approximately four months. This timeline has been challenged by the Deputy DIPC.
- **Estates Terrier:** GMS reported that their legal team have completed approximately 75% of the lease information. Due to be completed and shared with WSG in April 2026

Appendix 4 – Risk Assessment Capability

Audit Findings

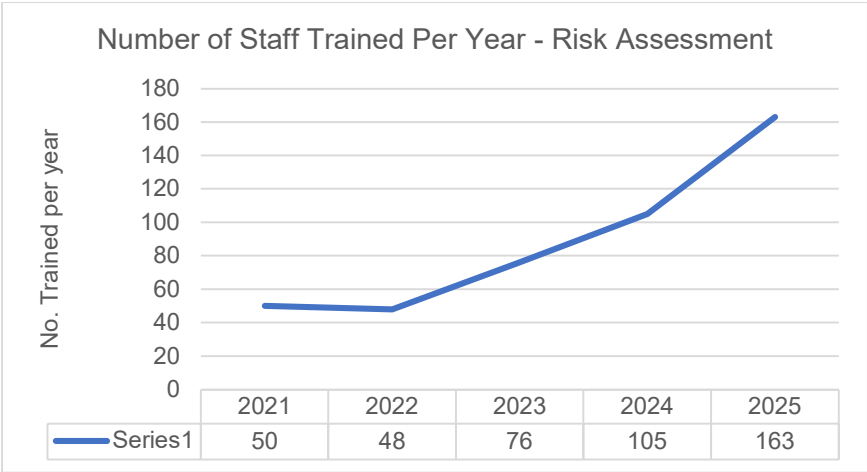
Access and Egress	D&S	Medicine	Surgery	W&C	Corporate
Met standard expected on first review:	0%	0%	40%	20%	40%
Did not meet standard expected on first review:	100%	100%	60%	80%	60%
Feedback given to the authors:	Yes	Yes	Yes	Yes	Yes

First Aid	D&S	Medicine	Surgery	W&C	Corporate
Met standard expected on first review:	0%	0%	0%	0%	20%
Did not meet standard expected on first review:	100%	100%	100%	100%	80%
Feedback given to the authors:	Yes	Yes	Yes	Yes	Yes

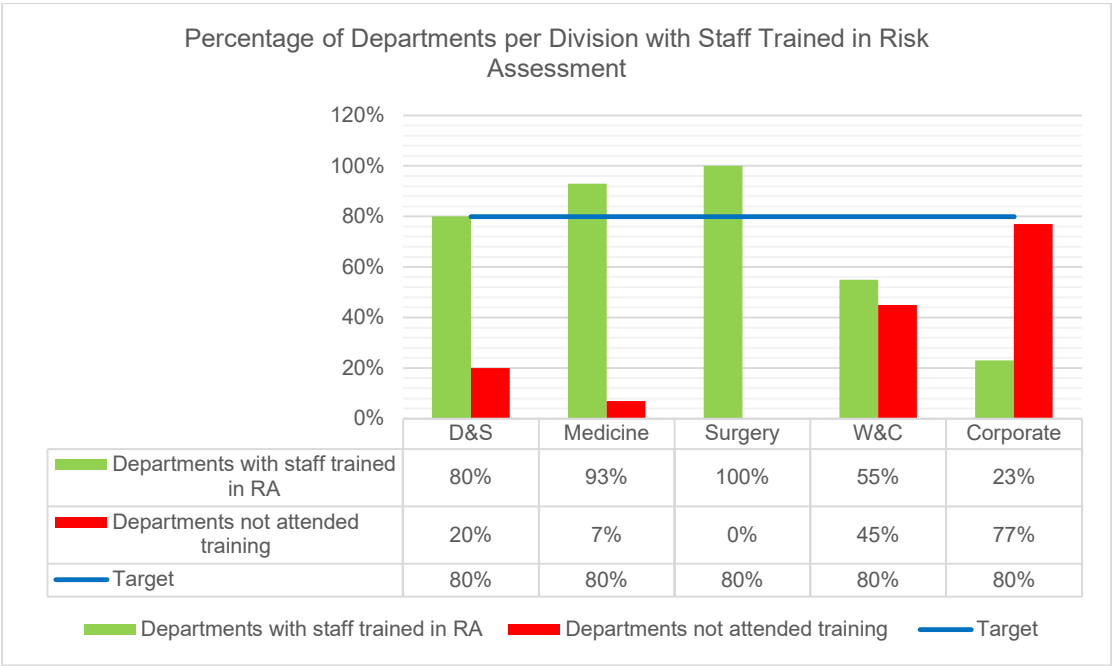
Staff trained in Risk Assessment

Training for staff carrying out risk assessments is available in bi-weekly. There has been a drive this year to achieve one trained person in each department to improve risk assessment quality.

The number of staff attending risk assessment training has increased, with a total of 442 staff now trained compared to 279 in the previous reporting period. This demonstrates an 158% increase in staff trained across the Trust.



Overall, 70% of departments have one or more individual trained to carry out risk assessments, a fundamental 16% improvement across all departments. Crucially, D&S, Surgery and Medicine have achieved the 80% of target for one or more trained staff in each of their departments, while W&C have increased compliance from 29% in the previous reporting period to 55% and Corporate from 9% to 23%.



Progress against Year 1 Objectives and Targets 2025-26

Each objective is outlined below and progress indicated using the following key:



Achieved



Partially Achieved



Not achieved



Changed during the course of the Plan

Asbestos Safety Compliance (Objective 1)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Asbestos Compliance	Establish a robust asbestos management governance structure within GMS and the Trust, with evidence of regular compliance reporting	Year 1 (31 March 2026)		Asbestos governance structure confirmed – GMS operational asbestos management group, reporting to Trust Asbestos Safety Group (oversight) and to Group H&SC (assurance). However, Trust-led oversight group has not convened for some time due to absence of a Chair (previously exec for S, T&C, now portfolio director estates). Escalated monthly since October 2025 by H&S to exec lead and portfolio director. Requires resolution
	Review the Asbestos Policy and publishing a compliant version, including roles and responsibilities which will apply to the Group	Year 1 (31 March 2026)		Published asbestos policy in July 2025 Includes roles and responsibilities

Appoint a competent Responsible / Appointed Person for Asbestos, signed off by the Authorised Engineer	Year 1 (31 March 2026)		GMS has identified RPs for GRH as AK, IG, PG and CGH as DW, NG – all require training which is due to be completed by April 2026
Review the Asbestos Management Plan and approving a new fit-for-purpose plan, supported by the Authorised Engineer	Year 1 (31 March 2026)		Plan has been drafted but not formally agreed due to the Asbestos Safety Group not running
GMS to implement a robust permit-to-work procedure, including the completion of refurbishment and demolition surveys as required	Year 1 (31 March 2026)		Part of the ECO system and has been and has been through penetration testing. Waiting for IG to approve the system but is in use.
Add historical refurbishment and demolition surveys to the asbestos register as far as is reasonably practicable	Year 1 (31 March 2026)		GMS confirmed that all relevant data has now been added to the new online register
Add new refurbishment and demolition surveys to the asbestos register	Year 1 (31 March 2026)		All new surveys from 2025 onwards added to ECO – new online register software
Complete a Management Survey for Asbestos at GRH and CGH and update the asbestos register	Year 1 (31 March 2026)		95% complete – remaining 5% of areas are not accessible and will be treated as assumed to contain asbestos
Conduct a training needs analysis covering staff working within the Group	Year 1 (31 March 2026)		Completed in May 2025 and approved by AE for Asbestos. Contained with new Asbestos Policy
Ensuring relevant staff within the Group are appropriately trained in asbestos management	Year 1 (31 March 2026)		Training took place in 2025 – delivered by the AE face to face. Awareness and Duty to Manage training sessions completed.

	Centrally record training on ESR for all staff within the Group	Year 1 (31 March 2026)		Certificates on ESR / training now recorded
	Review and update the asbestos risk on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		Last reviewed on 18.3.26 – will consider risk rating reduction on receipt of AE audit
	The Trust to agree on a risk-based and prioritised costed action plan for remedial works related to asbestos (which may span several years)	Year 1 (31 March 2026)		GMS have agreed a risk-based plan with the asbestos AE

Fire Safety Compliance (Objective 2)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Fire Safety	Complete a fire compartmentation survey and making drawings available	Year 1 (31 March 2026)		Compartment survey completed and available through software managed by GMS
	Complete Local Department Fire Risk Assessments (FRAs) (Secondary Fire Risk Assessments under the HMT) for all areas and reviewing them in line with policy requirements (Secondary FRAs – HMT05)	Year 1 (31 March 2026)		GMS reported a completion rate of approx. 42% over four consecutive months at CMG, which failed to meet the contractual KPI of 95% completion. The executive lead for fire will formally write to GMS in relation to this breach.

	The Fire Team, GMS, to undertake a fire safety gap analysis	Year 1 (31 March 2026)		A gap analysis was provided to Fire Safety Sub Committee but was not a comprehensive gap analysis against the HMT 05
	GMS to introduce digital fire risk assessment software, with automated reminders and improved compliance monitoring	Year 1 (31 March 2026)		A dashboard has been developed and is now available on the intranet GMS SharePoint - Fire Folder Status - All Staff
	Conduct a whole building fire risk assessment for the Tower Block, GRH by the Fire team, GMS	Year 1 (31 March 2026)		Tower Block GRH FRA completed and revised as works progress in the Tower. V.3 Feb 2026
	Implement a process to record the completion of fire risk assessment actions	Year 1 (31 March 2026)		fire action monitoring system implemented GMS SharePoint - 2025 Fire Risk Assessment Actions List - All Items
	Review the Group Fire Safety Policy and publishing a compliant version, including roles and responsibilities (reviewed annually)	Year 1 (31 March 2026)		Fire Safety Policy reviewed and approved December 2025
	Review and publish a Trust Evacuation Plan	Year 1 (31 March 2026)		Fire Evacuation Plan reviewed and approved December 2025. This will require a further review to agree the shelter provisions for a full decant. EPPR will support this work through partners
	Conduct a training needs analysis (TNA) for Group staff	Year 1 (31 March 2026)		Completed and approved by FSSC. Contained with new Policy

	Ensure relevant staff, as outlined in the TNA, are appropriately trained in fire safety, with training recorded centrally, including for fire wardens	Year 1 (31 March 2026)		E-learning fire training has good compliance level at 90%. Fire warden is ongoing and fire extinguisher training will commence soon
	Develop a costed and risk-based plan for fire safety improvements for compartmentation and fire doors, and agreeing on it with the Trust (in-line with Building Safety Regulations)	Year 1 (31 March 2026)		Cost-based fire programme for compartmentation and fire doors, focussed on the Tower and basement. 80% of compartmentation in Tower is remedied. Decant required to complete.
	GMS to implement a robust procedure and permit-to-work process to prevent the risk of compartmentation breaches	Year 1 (31 March 2026)		Permit to work system developed. SOP provided by GMS and system implemented via the Compliance Team in GMS
	Review and update the fire risks on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		All fire risk in date as of 31 March 2026

Electrical Safety Compliance (Objective 3)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Electrical Safety	Review and update Electrical Safety Policy	Year 1 (31 March 2026)		Policy finalised and awaiting publication.

	Establish governance and assurance for electrical safety within GMS and the Trust, including robust reporting	Year 1 (31 March 2026)		Organigram of governance structure – GMS operational HT06 electrical safety group, reporting to Trust electrical Safety Group, and to Group H&SC, TLT and Board
	GMS to agree approach to increase resilience in on-call HV and LV Appointed Persons within current funding, and /or propose options if increased funding is necessary	Year 1 (31 March 2026)		AP resilience at CGH, is a potential point of weakness, as the AP is not yet fully competent and can only act with limited authorisation whilst gaining experience. Another AP is approaching retirement and there is no current succession plan in place. At GRH there are 3 APs, with one being trained in HV and will receive valuable experience with upcoming projects. Another potential AP for GRH will take 6-9 months to be appointed. Approval for funding an on-call external contractor to cover out of hours is still pending.
	Produce risk-based costed plan in response to the Authorising Engineer's Audit from 2024, including addressing the 50% of panels identified as needing urgent replacement	Year 1 (31 March 2026)		Cost-based plan provided by the Appointed Person to replace 50% of the panels classed as urgent includes design and survey of panel, panel supply, testing and certification – typical cost per panel £30-55K. Costs proposed for 20 urgent panels (10 replacements) £563,500. The programme will be overseen by the Estates Electrical Authorised Person Authorising Engineer. Regular updates will

				be provided to the Estates Governance Group and the Trust Risk Committee
	Carry out risk assessment on inability of to isolate LV panel for maintenance tasks	Year 1 (31 March 2026)		Risk assessment provided in word document – not on correct template
	Explore and agree options for LV panel maintenance e.g., thermal imaging and non-intrusive inspections	Year 1 (31 March 2026)		Evidence of the options has not been presented to the Trust
	Review and update the electrical risks on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		Electrical risks in date as of 31.3.26

Work at Height Compliance (Objective 4)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Work at Height	Review and publish the Work at Height Policy, including a safe system of work	Year 1 (31 March 2026)		A new overarching policy has been developed for publication to meet the needs of the Trust and is supported by a detailed safety procedure
	GMS to appoint a competent Appointed Person for Work at Height	Year 1 (31 March 2026)		Four APs appointed for WAH. Evidence of appointment letters and certificates provided by GMS

	Creation of a ladder register to be held and maintained by GMS	Year 1 (31 March 2026)		3 Ladder inspectors trained by GMS – evidence of training provided by GMS. Ladder register developed. Trust to audit ladders in clinical areas as part of next steps
	Implementation of a robust process for scaffolding, mobile elevated working platform (MEWP), staging and access equipment to be reviewed by the Appointed Person for Work at Height	Year 1 (31 March 2026)		Work at Height Safety Rules documented and implemented alongside permit to work system
	Implementation of a robust process for roof top access	Year 1 (31 March 2026)		Work at Height Safety Rules documented and implemented alongside permit to work system
	Ensure all roof access equipment has been maintained and all fragile surfaces are identified and appropriately signed	Year 1 (31 March 2026)		Assurance of the maintenance of roof access equipment and signage to mark fragile surfaces as not been presented to the Trust
	Training needs analysis for Work at Height for GMS staff	Year 1 (31 March 2026)		A training needs analysis for H&S has been provided by GMS which identifies roof top safety training. However, there is no WAH awareness training identified, or duty to manage training for CP/APs listed on the TNA.
	GMS to implement training for relevant staff for Work at Height and records held centrally	Year 1 (31 March 2026)		Training records provided by GMS for ladder inspection and safe use certification. Training provided by Mooresafe

	Review and update the work at height risks on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		Risk #1079 has been revised to include findings from the AE report in Feb 2026.
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Confined Spaces Compliance (Objective 5)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Confined spaces	Develop and publish a robust Confined Spaces Policy, including a safe system of work	Year 1 (31 March 2026)		A new overarching policy has been developed for publication to meet the needs of the Trust and is supported by a detailed safety procedure
	GMS to appoint a competent Appointed Person for Confined Spaces	Year 1 (31 March 2026)		Appointment letters provided for two Appointed Persons and two Coordinating Appointed Persons. A third person has been recommended for appointment by the AE – awaiting fully signed appointment letter
	Implementation of a robust process for safe working in confined spaces (e.g., confined space safety rules	Year 1 (31 March 2026)		Work at Height Safety Rules documented and implemented alongside permit to work system
	GMS to develop a register of confined spaces through a full site review	Year 1 (31 March 2026)		Confined space register hosted by GMS for GRH site. Confined space register for CGH site outstanding.

	Training needs analysis for Confined Spaces to cover all Group staff	Year 1 (31 March 2026)		A training needs analysis for H&S has been provided by GMS which identifies confined space awareness training for estates only. However, no duty to manage training for CP/APs listed on the TNA
	Implementation of training for relevant staff for Confined Spaces and records held centrally	Year 1 (31 March 2026)		Training Records held by GMS for 20 operatives in Confined Space Awareness in accordance with ACOP L101. 4 Days AP course training certificates in accordance with ACOP L101 for three APs and two Coordinating APs.
	Review and update the confined space risk on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		Confined space risk # 1166 up to date as of 31 March 2026

Ventilation Safety Compliance (Objective 6)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Ventilation Safety	Review and publish the Ventilation Policy	Year 1 (31 March 2026)		Final version developed for approval at Group H&SC
	Develop a risk-based plan for the replacement of the non-compliant and end of life AHUs	Year 1 (31 March 2026)		This has not yet been agreed and remains a critical gap. The Trust has provided £130k of additional funding to enabled a

				remedial schedule to meet immediate compliance shortfalls across failing/non-compliant AHUs. Approximately £87k worth of remedial work has been commissioned to date (CSSD, DCC, WSR and Theatres – GRH; DCC and Theatres – CGH). GMS is awaiting further quotes to utilise the remainder of the funds.
	Review and update the ventilation risks on the Trust's risk registers in line with the Risk Management Framework	Year 1 (31 March 2026)		All ventilation risks were in date as of 31 March 2026

Water Safety Compliance (Objective 7)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Water Safety	Commission water schematics for Trust premises	Year 1 (31 March 2026)		Schematics commissioned and due to be completed in early summer
	Close any remaining actions on the pseudomonas action plan, transferring long-term / business as	Year 1 (31 March 2026)		All actions closed and remaining actions e.g. schematics / zeta safe moved to BAU of water safety

	usual actions to the workstream of the Water Safety Group			group. (see Team channel Pseudomonas Action Plan and WSG BAU tracker)
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Workplace Inspection Compliance (Objective 8)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Workplace Inspections	Divisions to drive compliance with workplace inspection frequency to achieve 90% compliance	Year 1 (31 March 2026)		At the close of 2025-26, less than half of all expected inspections had been recorded. No division met the target across the year, although Medicine, Surgery and Corporate divisions significantly improved compliance in Q3 and Q4 following support from the H&S Advisors recruited in September 2025 to support those divisions. • Medicine improved from 26% in Q1 to over almost 70% in Q4 • Corporate from 6% in Q1/Q2 to 71% in Q3/Q4 • W&C from 35% in Q1 to 84% in Q4 • Surgery has performed consistently well remaining between 70% and 90% compliance per quarter • D&S performed better in Q1&2 but declined in Q3&4

	Risk, H&S to explore online solutions for recording	Year 1 (31 March 2026)		Datix Team explored use of compliance audit on DATIX but is not part of package and has limitations. iAuditor or other software available at cost.

Risk Assessment Compliance (Objective 9)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Risk Assessment	Review the risk assessment learning programme to improve the quality of risk assessment and compliance against key themes	Year 1 (31 March 2026)		Risk assessment, risk scoring and Datix guide updated for training updated in 2025 and 2026
	Direct departments and divisions to suitable resources to support learning and improvement around the key themes	Year 1 (31 March 2026)		Provided in divisional meetings and A-Z through 2025-2026
	Departments within the Trust and its subsidiary have at least one individual who has attended risk assessment training	Year 1 (31 March 2026)		Surgery 100% - target met Medicine 93% - target met D&S 80% - target met W&C 55% - not met but have improved by 26% Corporate 23% not met but have improved by 14%

				The two weaker areas are on track to improve compliance with targeted support from the new H&S Advisor in these divisions (previously a vacant role)
	Trust to carry out a sampling audit of risk assessments and compliance across all divisions for two key themes annually, including observation in the workplace	Year 1 (31 March 2026)		Two themed risk assessment audits (Access and Egress and First Aid) were conducted across all Trust divisions.
	GMS to carry out a sampling audit of risk assessments and compliance across all GMS departments for two key themes annually, including observation in the workplace	Year 1 (31 March 2026)		GMS have verbally confirmed that slips and trips risk assessments have been audited. Evidence of this or a second key theme has not been provided to the Trust.
	GMS to ensure a robust system is in place for risk assessment prior to capital projects that considers risks to all staff (Trust and GMS), patients and the public and includes informing the Trust as required of any significant risks	Year 1 (31 March 2026)		Amendments made to capital projects process Director / Lead (TH and ED)
	GMS to ensure a robust system is in place for ensuring the activities of contractors have been risk assessed and consider risks to all staff (Trust and GMS), patients and the public and includes informing the Trust as required of any significant risks	Year 1 (31 March 2026)		Control of contractor's system is in phase 2 of implementation within GMS. Trust to ensure divisions align with this system – requires funding on Trust-side

Health and wellbeing (Objectives 10 & 11)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Protect the health of staff, patients and visitors through Control of substances hazardous to health (COSHH) assessments	Each department has an identifiable folder for their specific COSHH assessments on SYPOL	Year 1 (31 March 2026)		This has been set up on SYPOL and COSHH assessments specific to that department have been placed in the relevant folder (See Sypol dept index)
	A master list of all substances has been established for each department	Year 1 (31 March 2026)		Master-list of substances in departments across the Trust has been collated by Risk, H&S. Lists of substances will not be required from low-risk Corporate Division / admin areas, except where hazardous substances may be present such as nurseries and research only.
	Identify high-risk substances	Year 1 (31 March 2026)		High risk substances identified. 2% of substances are acute health risks, 3% chronic risk, 23% high risk to health. Highest health risks are in medicine and surgery. Safer substances report on Sypol to be used to identify potential lower risk substitutes
	Develop an improved training programme for COSHH accessible to all staff	Year 1 (31 March 2026)		Improved COSHH training programme developed. Next step is to update the e-learning programme through L&D

Improved measures to reduce the risk of abuse, violence and aggression	Agree and approve a finalised security model	Year 1 (31 March 2026)		Following escalation to executive by Group H&SC. Business case / model approval has been confirmed. GMS to begin recruitment and implementation plan in April 2026.
	Develop an Enhance Care Team to support vulnerable patients	Year 1 (31 March 2026)		Enhanced Care Team now operating on several wards following successful pilot
	Trial activity coordinators to reduce patient inactivity and distress	Year 1 (31 March 2026)		Activity coordinators trial completed by Safeguarding team. Now being expanded to other wards to test scalability

Governance of H&S (Objective 12)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Governance	The Board will review the governance and reporting structure for health and safety	Year 1 (31 March 2026)		Review conducted in April 2025, new framework produced, consulted on and approved by July 2025
	A review will be conducted in relation to the governance within GMS and between GMS and the Trust in relation to health and safety	Year 1 (31 March 2026)		Review conducted by GMS Governance lead

	Publish a Health and Safety Framework and engage with stakeholders on implementation	Year 1 (31 March 2026)		Framework published in July 2025. Stakeholder workshop in October 2025
	Develop a stronger health and safety profile through strengthened partnership arrangements	Year 1 (31 March 2026)		• Annual meeting between the Authorised Engineers, the Director of Integrated Governance and the Head of Risk, Health and Safety • Annual meeting between recognised Trade Union health and safety representatives the Trust's Director of Integrated Governance and the Head of Risk, Health and Safety

Investigation and Learning (Objective 13)

Objectives are for year two only.

Health and Safety Resources (Objective 14)

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Information for staff	The Risk, Health and Safety Team will use a rolling programme to review and expand information pages to ensure they remain current	Year 1 (31 March 2026)		A-Z resource has been expanded and updated throughout the year.

	Develop a stronger health and safety profile through communications e.g., podcasts, newsletters, staff stories - Communication Plan developed for health and safety	Year 1 (31 March 2026)		Communication plan developed. To be implemented in year 2 of the plan
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Report to Board of Directors

Date of Meeting	16 July 2026
Report title	Corporate Governance Report
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Sarah Favell, Trust Secretary

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

Executive Summary
This report brings together three key areas of corporate governance assurance for 2025/26: the annual Committee Effectiveness Reviews, compliance with the NHS England Fit and Proper Person Test (FPPT) Framework, and the annual report on the use of the Trust Seal. The Committee Effectiveness Reviews of the Audit & Assurance Committee, Finance & Resources Committee, Quality & Performance Committee and People & Organisational Development Committee confirm that the Board's committee structure remains effective, well-led and fit for purpose. The reviews found strong governance foundations, constructive challenge, positive committee cultures and effective oversight arrangements across all committees. Whilst no significant weaknesses were identified, the reviews highlighted opportunities to further strengthen assurance reporting, improve the strategic focus of committee discussions, enhance data and intelligence, and reduce duplication across the committee structure. To support continued governance maturity, revised Committee Terms of Reference have been developed to reflect the Trust's refreshed strategic priorities and assurance framework. The report recommends adoption of a biennial effectiveness review cycle, supported by annual desktop reviews, to maintain assurance whilst ensuring a proportionate approach to governance oversight. The report also provides the Board with assurance regarding compliance with the NHS England Fit and Proper Person Test Framework. Following a comprehensive annual review process, all Executive and Non-Executive Directors have been assessed and confirmed as fit and proper persons in accordance with statutory requirements. The Audit & Assurance Committee reviewed the detailed compliance assessment and concluded that the Trust remains fully

compliant, with no concerns identified during the reporting period. The Chair has completed and submitted the required annual declaration to NHS England.

Finally, the report presents the annual update regarding the Trust Seal. No sealings were undertaken during the period 1 April 2025 to 31 March 2026, providing assurance that the Trust Seal continues to be used only in circumstances where execution as a deed is legally required and that appropriate governance controls remain in place.

Overall, the report provides assurance that the Trust has effective governance arrangements, compliant board assurance processes and appropriate statutory governance controls. The proposed actions will support further strengthening of strategic assurance, governance effectiveness and Board oversight during 2026/27.

Previously considered by	Board Assurance Committees during May/June 2026 except People and Organisational Development Committee
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Recommendations:

- The Board is asked to:
- 1. NOTE the findings of the 2025/26 Committee Effective Reviews.
 - 2. APPROVE the revised Committee Terms of Reference and the adoption of a biennial review approach supported by interim desktop reviews.
 - 3. Receive ASSURANCE that the board committee structure remains effective and fit for purpose and NOTE the identified improvement actions.
 - 4. Receive ASSURANCE regarding compliance with the NHS Fit and Proper Test Framework for 2025/26.
 - 5. NOTE that the Chair has completed the annual FPPT declaration and submission to NHS England.
 - 6. NOTE that all Board members have been assessed and concluded to be fit and proper during the reporting period.
 - 7. NOTE the use of the Trust Seal during the period April 2025 to March 2026

Strategic Aims (tick as appropriate)

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

Impact on any Strategic Risks?

Effective governance, committee oversight and Board assurance arrangements support the management and mitigation of all strategic risks within the Board Assurance Framework and strengthen the Board's ability to identify, monitor and respond to emerging risks.

Implications on:

Equality, Diversity and Inclusion	The report supports effective oversight of EDI through committee assurance arrangements and strengthened reporting requirements, particularly within the People & Organisational Development Committee.
Health Inequalities	The proposed improvements to committee reporting include greater consideration of health inequalities impacts and assurance within Board and committee decision-making.
Finance and Resource	The recommendations have no material financial implications and support the effective governance and oversight of financial resources through strengthened committee assurance arrangements.
Regulation/Legal	The report provides assurance regarding compliance with the NHS Code of Governance, NHS England Fit and Proper Person Test Framework, Regulation 5 of the Health and Social Care Act 2008 and the Trust's Standing Order
CQC-Key line of enquiry	The report supports the Well-Led domain by demonstrating effective governance, board oversight, accountability and assurance arrangements across the organisation.
Green Plan	No direct impact

Main Report

Committee Effectiveness Review 2025/2026

1. This report presents the outcomes of the annual effectiveness reviews undertaken during 2025/26 for the Board's principal assurance committees:
 - Audit & Assurance Committee (AAC)
 - Finance & Resources Committee (FRC)
 - Quality & Performance Committee (QPC)
 - People & Organisational Development Committee (PODC) (to be presented at the September Committee meeting).
2. The reviews were undertaken to assess the effectiveness of committee governance, leadership, culture, assurance processes, reporting arrangements and alignment with strategic priorities. The reviews form part of the Trust's commitment to continuous improvement, good governance and compliance with the NHS Code of Governance.
3. During March and April 2026, a structured review process was undertaken for each Board committee. The reviews incorporated:

- a. Quantitative survey responses from committee members and regular attendees;
- b. Qualitative narrative feedback;
- c. Review of committee operation against Terms of Reference;
- d. Assessment of governance arrangements and assurance flows;
- e. Consideration of alignment with best practice governance expectations.

4. The reviews focused on:

- a. Clarity of purpose and delegated authority;
- b. Membership, skills and succession;
- c. Leadership and culture;
- d. Quality of information and reporting;
- e. Risk oversight and assurance;
- f. Effectiveness of meetings;
- g. Escalation and reporting to Board.

5. Overall, the findings provide assurance that the Board's committee structure is functioning effectively and continues to provide a robust framework through which the Board receives assurance regarding quality, performance, finance, risk, workforce, internal control and regulatory compliance. All committees demonstrate strong leadership, good governance practices, constructive challenge and high levels of engagement from members.

6. Whilst no fundamental weaknesses were identified, a number of common themes emerged across all reviews. These relate principally to the quality and focus of committee papers, clarity of assurance reporting, avoidance of duplication between committees, strengthening induction and succession arrangements, and the need to maximise time devoted to strategic discussion and risk assurance.

7. The reviews indicate that the committees are mature and effective but have not yet consistently achieved the level of strategic assurance and streamlined reporting associated with a fully optimised governance system. Consequently, the Audit & Assurance Committee was assessed as **Amber/Green**, whilst the Finance & Resources Committee, People and Organisational Development Committee and Quality & Performance Committee were assessed as **Amber**.

8. Overall Assessment:

Overall Assessment	Strengths	Areas for improvement
Audit and Assurance Committee (Amber/Green)		
The Committee continues to demonstrate a high level of maturity and effectiveness and provides credible independent assurance to the Board regarding internal control, risk management, financial governance and audit activity	• Strong and effective chairing. • Open and constructive culture. • High-quality scrutiny and challenge. • Clear governance arrangements. • Strong	• Paper quality and presentation • Reducing duplication of reporting with other committees • Strengthening induction and future continuity

	understanding of delegated authority. • Effective oversight of internal control and risk management systems.	
Finance and Resource Committee (Amber)		
The Committee operates effectively and provides robust scrutiny of the Trust's financial position, resource utilisation, digital strategy and estates agenda Members particularly valued the Committee's role in strategic financial oversight. There is a desire for increased focus on future-facing discussions concerning capital programme, estates strategy, digital transformation	• Effective financial scrutiny. • Strong governance support. • Constructive challenge and debate. • Good attendance and engagement. • Clear visibility of strategic risks. • Effective risk escalation arrangements.	• Paper quality and consistency. Focus on assurance purpose and the 'so what' element. • Greater focus on strategic assurance rather than operational reporting. • Improved use of benchmarking and trend analysis. • Enhanced oversight of significant contracts. • Succession planning and skills development. • Clarification of interfaces with other committees.
People and Organisational Development Committee (Amber)		
The Committee is operating effectively and provides an important mechanism through which the Board receives assurance regarding workforce sustainability, organisational culture, leadership development, staff engagement, equality, diversity and inclusion, and organisational development priorities.	• Strong and constructive committee culture. • Effective chairing and positive member engagement. • Good levels of attendance and quoracy. • Open challenge and scrutiny from both executive and non-executive members. • Valuable use of deep-dive discussions to explore complex workforce and organisational development issues. • Broad oversight of	• Improved paper quality and assurance reporting • Stronger use of workforce data and benchmarking • Greater evidence of the impact and effectiveness of interventions • Stronger triangulation of information • Improve outcome-focused reporting • More consistent evaluation of workforce initiatives and mitigations.

	strategic workforce priorities.	
Quality and Performance Committee (Amber)		
Strong foundations, effective leadership and a positive culture that supports scrutiny of quality, safety and operational performance.	• Good Committee leadership. • Psychological safety and openness. • Clear Delegated authority arrangements. • Valuable Deep-dive discussions on priority issues. • Effective Risk oversight mechanisms.	• Paper quality; excessively lengthy, operational focused, insufficiently focused on assurance, lack of clarity regarding required decisions or actions. • Need for improved data presentation, triangulation between performance measures and risks, clearer articulation of assurance levels, focus on the 'so what' • Overcrowded agendas

9. Themes across the Committee Reviews

- a. Strong leadership and culture – this represents a significant governance strength and provides an important foundation for continued improvement.
- b. Paper quality and assurance focus – across committees, members expressed a need for papers that were more concise, clearer about required action and purpose, more explicitly focused on assurance and with stronger links to strategic risks within the Board Assurance Framework.
- c. Strategic focus and assurance – committee members identified opportunities for increased focus on strategic risk and emerging risk oversight, future-looking discussions, gaps in assurance.
- d. Better use of data and intelligence- members identified a need to improve benchmarking information, trend analysis dashboard reporting, data triangulation and integration of performance and risk data with an increased role for the Business Intelligence resource.

10. Priorities for 2026/2027

- a. Based on the findings the following priorities have been identified for 2026/27
 - i. **Strengthen paper quality:** utilising the new report templates and focused on providing explicit assurance statements, clearer purpose, articulation of outcomes, evaluation of impact and precise recommendations, stronger EDI and health inequalities prompts and appropriate use of appendices and/or reading rooms. Less descriptive of 'what' and more detail on the 'why' and 'so what'
 - ii. **Strengthen strategic focus assurance:** focus on alignment to strategic risks and aims, structured dee-dive reviews, greater focus on assurance gaps, enhanced discussion of emerging risks. In People and Organisational Committee feedback there was a consistent ask for clearer evidence

demonstrating whether workforce interventions and organisational development initiatives are delivering the intended benefits, alongside stronger evaluation of mitigations where assurance levels remain limited

- iii. **Improve committee coordination:** both via the refreshed Terms of Reference and regular Committee Chair meetings aim to be clear on committee responsibilities, reduce duplication, streamline reporting and strengthen assurance escalation
- iv. **Improve data and reporting intelligence:** strengthen dashboard reporting, risk triangulation and trend analysis to support evidence-based assurance and decision-making. Members expressed a desire for assurance reports that place greater emphasis on strategic insight, evidence of impact and the effectiveness of interventions, rather than purely descriptive reporting

11. Terms of Reference Review

- a. As part of the effectiveness review process, each committee reviewed its Terms of Reference with significant work undertaken to align them with the Trust's refreshed strategic priorities and assurance framework. The revised documents provide greater clarity regarding committee purpose, responsibilities and reporting relationships (see Appendix 1).
- b. The Terms of Reference for People and Organisational Development Committee have been revised to reflect the Trust's strategy, but it is anticipated that these will be reviewed and substantially revised post the appointment of the Chief People Officer (July 2026) and recognising the proposed move to a committee model of 'People, Place and Partnership.
- c. To ensure proportionality and avoid unnecessary duplication, committees have proposed a biennial full review of Terms of Reference, supplemented by a desktop review in alternate years led by the Committee Chair and Trust Secretary, with any material changes brought forward for formal approval.

12. Conclusion

The 2025/26 Committee Effectiveness Reviews provide assurance that the Board's committee structure remains effective and continues to support sound governance, robust assurance and informed decision-making.

The findings demonstrate strong leadership, positive committee cultures and effective governance foundations across all committees. The opportunities identified relate primarily to further maturation of the assurance framework rather than the correction of significant weaknesses.

Implementation of the proposed improvement programme will support greater consistency of reporting, stronger strategic assurance, improved coordination across the committee structure and enhanced governance maturity during 2026/27.

13. The Board is required under the NHS England Fit and Proper Person Test (FPPT) Framework to receive an annual report confirming compliance with the Fit and Proper Person Test arrangements operated by the Trust. The Framework places explicit accountability on the Chair to undertake and document annual assessments of all Board members and to submit a formal declaration to the NHS England Regional Director confirming that each Board member has been assessed and concluded to be fit and proper. The Framework also requires Foundation Trusts to report compliance to their Board of Directors and, where appropriate, their Council of Governors.
14. The Fit and Proper Person Test is a statutory requirement established through Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations and forms a key component of the NHS governance framework. NHS England introduced an enhanced FPPT Framework in response to the recommendations of the Kark Review to strengthen accountability, transparency and leadership standards across NHS organisations.
15. The Framework applies to all Executive and Non-Executive Directors and requires NHS organisations to maintain robust systems for assessing and evidencing the fitness and propriety of Board members. Key requirements include:
 - a. Annual self-attestation by Board members.
 - b. Completion and retention of appropriate recruitment and reference checks.
 - c. Ongoing assessment of conduct, competence and capability.
 - d. Maintenance of supporting evidence and ESR records.
 - e. Formal annual review by the Chair.
 - f. Completion of an annual declaration and submission to NHS England.
16. In addition, the Framework requires Chairs to:
 - a. Reach and record a formal conclusion regarding each Board member's fitness and propriety.
 - b. Submit an annual declaration to the NHS England Regional Director.
 - c. Report compliance arrangements annually to the Board and, for Foundation Trusts, to the Council of Governors
17. This report provides the Board with assurance regarding the Trust's compliance with the statutory requirements set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations and the NHS England FPPT Framework. It summarises the conclusions previously considered by the Audit & Assurance Committee and provides confirmation of the Trust's annual submission to NHS England.
18. The Audit & Assurance Committee reviewed the detailed compliance assessment at its meeting on 24 June 2026 and concluded that the Trust remains compliant with FPPT requirements, with no Board members identified as not fit and proper during the reporting period. The Committee endorsed the Trust's annual submission and supported a small number of further improvements designed to strengthen documentation, evidence management and alignment with the NHS Leadership Competency Framework.
19. The process is managed by the Trust Secretary, supported by the Corporate Governance team.
20. The Trust Secretary confirms that:
 - a. All Board members completed the required annual assessment process

- b. Appropriate self-attestation, declarations of interest and supporting checks were undertaken
- c. Governance oversight arrangements are established and operating effectively
- d. The annual return was completed in accordance with NHS England requirements
- e. The Chair's declaration confirms that all Board members were assessed and deemed fit and proper during the reporting period.

21. The Trust compliance position is supported by wider assurance sources including:

- a. Internal Audit review of FPPT processes in October 2025, which identified the Trust's procedures as an area of strength and resulted in recommendations that have now been addressed
- b. The wider Provider Licence assessment reported to the Board, which concluded that FPPT arrangements were compliant with only minor improvements required
- c. Positive verbal feedback received during the 2026 Care Quality Commission Well-Led inspection process, although the final inspection report remains awaited.

22. In conclusion, the Board can be assured that the Trust has established and operates a comprehensive Fit and Proper Person Test process that is consistent with the requirements of Regulation 5 and the NHS England FPPT Framework. The annual review confirms that all Board members have been assessed and concluded to be fit and proper, and that the Chair's annual declaration has been completed and submitted to NHS England.

Annual Trust Seal Report

23. The Trust's Standing Orders require that the use of the Seal is authorised by the Board of Directors and entered in the Register of Sealings. The Seal is used to execute deeds (for example, conveyances of land, leases and other legal documents) where execution under seal is required by law or considered appropriate. The Trust Secretary is the Custodian of the Trust Seal and is responsible for maintaining the Register of Sealings.

24. Use of the Trust Seal is tightly controlled and applied only where execution as a deed is legally required or considered best practice, typically in relation to property transactions or documents requiring enhanced legal formality. All sealings are supported by appropriate authority and recorded to ensure compliance with the Trust's Standing Orders and to provide a clear audit trail.

25. During the period 1 April 2025 to 31 March 2026 the Trust Seal has not been applied to any deed with the last use in March 2025.

26. The Audit and Assurance Committee received an update on the use of the Trust Seal in June 2025 and subsequently noted that there had been no further use of the Seal during the periods reported at meetings in November 2025 and June 2026. This provides assurance that use of the Seal has remained limited to circumstances where execution as a deed was required and that appropriate governance controls continue to operate effectively.

**Corporate Governance
July 2026**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

Accountable to	Board of Directors
Chair Executive Lead(s)	Non-Executive Director Director of Finance and Director of Integrated Governance
Frequency of Meetings	Quarterly plus annual meeting for annual report and accounts
Quorum	Two non-executive directors
Approval	June 2026
Review date	Full Committee – June 2028

CONSTITUTION

In accordance with the Constitution of the Trust, a committee is established, to be known as the Audit and Assurance Committee (“the Committee”).

PURPOSE

- a) The Audit and Assurance Committee will monitor the integrity of the financial statements of the Trust, any formal announcements relating to the Trust’s financial performance, and review significant financial reporting judgements contained in them.
- b) The Committee will assist the Board with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy and effectiveness of the processes for governance, assurance, internal control and risk management across the whole of the Trust’s activities, that support the achievement of the Trust’s objectives.
- c) The Committee will, where appropriate, facilitate and support through its independence, the attainment of effective processes.
- d) The Committee will review the effectiveness of the Trust’s internal audit and external audit function and provide assurance to the Board that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.
- e) The Committee will, in accordance with the Group/Trust Scheme of Delegation, receive assurance from the Gloucestershire Managed Services Board and Cheltenham and Gloucester Hospitals Charity regarding its delivery of its independent internal audit programme.

AUTHORITY

The Audit and Assurance Committee is a committee of the Board comprised of non-executive directors and has no executive powers, other than those specified in these

Terms of Reference or otherwise by the Board of Directors in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any Trust employee, and all employees are required to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

DUTIES

The Committee is responsible for the following:

Governance, risk management and internal control

The Committee will review the adequacy and effectiveness of:

- a. the Trust's Risk Management Framework, including but not limited to, the Trust's Health and Safety Framework;
- b. risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board;
- c. the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
- d. The policies for ensuring compliance with relevant regulatory, legal and Code of Conduct requirements and any related reporting and self-certifications, including the NHS code of governance and the NHS provider licence.
- e. policies and procedures for all work related to counter-fraud, bribery and corruption as required by the NHS Counter-Fraud Authority.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the committee, accountable officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved;
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work on an annual basis. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;
- Reviewing all external audit reports, including the report to those charged with governance (before submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the Trust, where relevant to the governance, risk management and assurance of the Trust.

These may include, but are not limited to, any reviews by regulators (e.g. Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions. The Committee recognises that these reports may be primarily consider by other Board Committees but, insofar, as it is relevant to the remit of the Audit and Assurance Committee, it will be considered by the committee.

The Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit and Assurance Committee's own area of responsibility. In particular, this will include any committees covering safety/quality, for which assurance from clinical audit can be assessed, and risk management.

Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist It will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the Trust.

Financial Reporting

The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board , including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is in place, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted misstatements in the financial statements;
- Significant judgments resulting from the audit;
- Letters of representation;
- Explanations for significant variances.

The committee will ensure that the Standing Financial Instructions (SFIs) and Standing Orders (SOs) are maintained and are kept up to date, with a biennial review or earlier, in the event of any material change to relevant legislation or regulation.

To review any instances where the SFIs/SOs have been overruled by any individual within the Trust; or any occasions where SOs have been suspended at a meeting

To review any instances where the Trust has waived competitive tendering or competitive quotation requirements, or has given approval to a tender invitation to a firm not on the approved list

To review any special payments made with respect to compensation for any losses.

Health and Safety and Security Management

The Committee shall review and have oversight of the effectiveness of the arrangements in place for the management of health and safety and security management.

Emergency Preparedness, Resilience and Response ('EPRR')

The Committee shall review and have oversight of the effectiveness of the arrangements in place for the management of EPRR.

Systems for raising concerns and Whistle-blowing

The committee shall review the adequacy and effectiveness of the arrangements in place for allowing staff (and contractors) to raise concerns about possible improprieties in any area of the Trust (financial, clinical, safety or workforce matters) and ensure that the process for investigation and management of those concerns is independent, proportionate and effective and in compliance with the relevant policies.

Governance regulatory compliance

The committee shall review the Trust's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the fit and proper person regulations.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interests.

MEMBERSHIP

The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent non-executive members. One of the members shall be appointed chair of the committee by the Board.

Members of the Committee will be:

- Three non-executive members of the Board.

Where papers, particularly Internal Audit reports, relate to the remit of another board assurance committee, non-executive members of that committee will be invited to the Audit Committee meeting at which those papers will be considered.

The following staff will have standing invitations to the Committee:

- Director of Finance (or their appointed Deputy)
- Director of Integrated Governance
- Head of Counter Fraud Services
- Head of Risk and Safety

QUORUM

The quorum for the Committee shall be 2 Non-Executive Director members.

In the event that a meeting is not quorate, any Non-Executive Director of the Board may attend for the purpose of making the meeting quorate. Such attendance shall be for that meeting only, and the Non-Executive Director shall be deemed a full member of the Committee for the duration of that meeting, with full voting rights.

This arrangement shall be exceptional, shall not confer ongoing membership of the Committee, and shall be explicitly recorded in the minutes of the meeting.

ATTENDANCE AT MEETINGS

The Director of Finance and Director of Integrated Governance and appropriate internal and external audit representatives shall normally attend all meetings.

The Counter-Fraud specialist will attend a minimum of two committee meetings a year.

The Trust Secretary will attend all meetings.

The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Audit and Assurance Committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual reports and accounts

Other managers, executive directors, non-executive directors, associate non-executive directors, external advisors or observers may attend meetings (at the discretion of the Committee Chair) particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director or manager.

At such frequency as the Chair considers appropriate, the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required

In the absence of the Chair, a meeting of the Committee may be chaired by one of the other non-executive members of the Committee.

Where vacancy or absence prevents core non-executive membership, an additional non-executive member of the Board may be co-opted as an interim member of the Committee, as required.

BEHAVIOURS AND CONDUCT

Members will be expected to conduct business in line with the Trust's values and objectives.

Members of, and those attending, the committee shall behave in accordance with the Trust's Constitution, Standing Orders and Code of Conduct.

Members must demonstrably consider the equality and diversity implications of decisions they make

MEETING ADMINISTRATION

The Committee shall be supported administratively by the Trust Secretary. Their duties in this respect shall include:

- Agreement of agendas with the Chair and key attendees;
- Preparation, collation and circulation of papers in good time;
- Ensuring that those invited to each meeting attend or apologies received;
- Taking the minutes and helping the Chair to prepare reports to the Board;
- Keeping a record of matters arising and issues to be carried forward;
- Arranging meetings for the Chair, e.g. with the internal/external auditors or local counter fraud specialists;
- Maintaining records of members appointments and renewal dates;
- Advising the committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings;
- Ensuring that committee members receive the development and training they need.

Notice of each meeting, including an agenda and supporting papers, shall be sent to each member of the Committee not less than five working days before the date of the meeting. This can be waived under exceptional circumstances and agreed by the Chair.

Meetings will normally be held by video conference.

Participation in meetings by telephone, video or computer link shall be deemed to constitute presence in person at the meeting. Minutes of the meetings of the Committee shall be taken, and a record of meetings submitted to the Board of Directors via a key issues and assurance report for consideration in its meetings held in public.

An annual schedule of reporting shall be set and regularly reviewed.

The Committee will evaluate its membership and performance on a regular basis through an annual review of its activities over the course of the previous year and undertake an annual audit of compliance with its Terms of Reference.

The Committee will review and update its terms of reference on an annual basis.

The Chair of the Committee shall attend meetings of the Council of Governors or its committees on request to enable the Council of Governors to perform its duty to hold the non-executive directors to account for the performance of the Board.

REVIEW

These terms of reference shall be reviewed biannually by the full Committee with a desktop review by the Committee Chair, supported by the Trust Secretary, in the alternate year. Any proposed amendments to the terms of reference will be submitted to the board for approval.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Accountable to	Board of Directors
Chair	Non-Executive Director
Executive Lead(s)	Chief Nurse and Medical Director
Frequency of Meetings	Minimum of 6 x per annum plus optional deep dive sessions
Quorum	A minimum of two Non-Executive Director members, including Committee Chair (or nominated if absent) and at least one of: - the Chief Nurse - Medical Director, or - Chief Operating Officer
Approval	April 2026
Review date	April 2028

CONSTITUTION

In accordance with the Constitution of the Trust, a Committee is established, to be known as the Quality and Performance Committee (“the Committee”).

PURPOSE

- a. The Committee is established to provide assurance to the Board of Directors (‘the Board’) that there are adequate controls in place to ensure high quality and safe care is provided to the patients using the services provided by the Trust, specifically in relation to patient safety, clinical effectiveness, responsiveness and patient experience. It will do so by:
- seeking assurance that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently high quality care and to meet the Trust’s legal and regulatory obligations;
 - reviewing assurances of progress against the Trust’s quality priorities and quality improvement plans as set out in the Quality Account.
 - seeking assurance that key risks relating to quality of care, patient safety and service delivery, as included in the Board Assurance Framework and Corporate Risk Register, are being effectively managed and mitigated.
 - identifying and reviewing themes and trends in key quality indicators, seeking assurance that appropriate action is being taken to respond and learn from these;
 - seeking assurance that appropriate progress is being made in implementing action plans put in place to address any shortcomings in quality of care and/or performance
 - seeking assurance as to performance across the Trust’s clinical and operational services, to ensure a comprehensive approach to patient care.

- b. The Quality and Performance Committee will provide the Board with assurance that risks to the quality of clinical care and to the safety of the Trust's, patients and their families have been identified, and included on the Board Assurance Framework and the Corporate Risk Register and are being effectively managed and appropriately controlled.
- c. The Quality and Performance Committee shall have oversight of the delivery of the Trust's key quality and safety strategies.
- d. The Committee's role is one of assurance, scrutiny and escalation, not operational management. It seeks assurance that:
 - Executive arrangements are effective
 - Interventions are evidence-based and proportionate
 - Impact is understood and monitored
 - Persistent or systemic issues are recognised and acted upon

The Committee places reliance on the Trust's designated delivery oversight forums to undertake the operational management of clinical plan delivery and to provide structured assurance upward, enabling the Committee to report assurance and escalate concerns to the Board where required.

- e. In discharging its role, the Committee will:
 - Focus on assurance, analysis and learning, rather than activity reporting
 - Seek evidence of impact and effectiveness, not just completion
 - Commission deep dives where risks to patient services persist or trends are not improving.
 - Escalate material concerns to the Board where sufficient assurance cannot be obtained.

AUTHORITY

The Committee is a committee of the Board comprised of executive directors and independent non-executive directors and has no executive powers, other than those specified in these Terms of Reference or otherwise by the Board of Directors in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any Trust employee, and all employees are required to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary subject to following the Trust's Legal Services processes for instructing external legal advisers, as appropriate.

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the minutes accordingly.

DUTIES

It is the responsibility of the Committee to ensure there are effective systems for quality governance, risk management and internal control, particularly in relation to safety, effectiveness and patient and family experience. In particular, the duties of the Committee on behalf of the Board are to:

- Monitor the Trust's arrangements to ensure its services are safe, effective, caring, responsive and well-led.
- Scrutinise the assessment of quality and performance risks identified in the Board Assurance Framework, ensuring there is sufficient assurance that these risks are adequately managed, including actions to eliminate gaps in controls.
- Review the arrangements in place to monitor compliance with key statutory and regulatory requirements and guidance including, in particular, the Health and Social Care Act 2008 and associated regulations.
- Oversee the process by which quality and performance measures are developed and maintained and recommend to the Board the range of indicators that should be monitored.
- Monitor performance of the Trust's services against key quality and performance indicators, including clinical outcomes measures, as determined by the Board.
- Monitor arrangements to establish and maintain a culture that reflects the vision and values of the Trust, encouraging openness and transparency and promoting good quality care. In doing so, the Committee focuses on the impact of culture, workforce and improvement on the quality and safety of care, and refers broader workforce or culture matters to the People and OD Committee where appropriate.
- Scrutinise the work of the relevant sub-committees through regular review of sub-committee reports.
- Regularly review the Trust's process of quality impact assessment of cost improvement plans (CIPs) and post-implementation reviews.
- Receive reports covering Maternity and Perinatal care, including regulatory and compliance updates.
- Provide information as required to enable the Audit and Assurance Committee to discharge its duties in relation to internal control and risk management. The Chair or another Non-Executive Director of the Committee will be a member of the Audit and Assurance Committee and will engage through combined Chairs meetings to ensure effective coordination of assurance and risk oversight.

- Receives assurance from the Caldicott Guardian and relevant teams as to the confidentiality and governance in respect of patient identifiable information
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- Where the Committee is concerned that identified risks have a material impact on the remit of either the Audit and Assurance Committee, the Finance and Resources Committee, and the People and Organisational Development Committee, to refer the details to the other relevant committee.
- Identify any gaps or weaknesses in the quality governance framework.
- Undertake thematic reviews of quality and performance topics identified for priority focus through the work of the Committee.
- Receive and scrutinise reports from the internal auditor relating to quality governance and other quality and performance matters.
- Recommend to the Audit and Assurance Committee areas of focus for the internal audit plan. Review the findings of Internal and External Audit reports covering matters within the remit of the Committee when referred by the Audit Committee and seek assurance that appropriate actions are identified and implemented in response to recommendations and that learning is shared across the organisation.
- Review the Trust's draft annual Quality Account prior to adoption by the Board.
- Receive regular assurance on medicines management and safety, including compliance with statutory and professional standards, with material risks escalated to the Committee where necessary
- Receive and review the following annual (or other frequency to be agreed *) reports and plans on behalf of the Board of Directors:
 - Infection Prevention and Control
 - Safeguarding Children and Vulnerable Adults
 - Patient Experience Report including complaints report
 - End of Life Care
 - Learning from Deaths Report
- In reviewing annual reports or other assurance reports, the Committee's role is to provide assurance to the Board on statutory compliance, consistency with in-year assurance, identification of systemic risks, and the adequacy of learning and improvement actions; it does not re-perform operational review.

In fulfilling these duties, the Committee will seek assurance through structured reporting from delivery and oversight forums and will not routinely review underlying operational performance data except where escalation, triangulation or targeted testing is required.

MEMBERSHIP

Members of the Committee will be:

- Three non-executive members of the Board
- Chief Executive
- Chief Nurse and Director of Quality
- Medical Director and Director of Safety
- Chief Operating Officer
- Director of Improvement and Delivery.
- Director of Integrated Governance

Other members of staff, executive directors, non-executive directors, associate non-executive directors, external advisors or observers may attend meetings at the discretion of the Committee Chair.

A quorum shall be three members, comprising two Non-Executive Directors and one Executive Director. In exceptional circumstances, an Executive Director member may send an appropriate nominated deputy in their place and this will count towards the quorum.

One of the non-executive members will be appointed Chair of the Committee by the Chair of the Board. In the absence of the Chair, a meeting of the Committee may be chaired by one of the other non-executive members of the Committee. Where vacancy or absence prevents full non-executive membership, an additional non-executive member of the Board may be co-opted as an interim member of the Committee, as required. Membership may also include any other members of the Board of Directors and any other directors, senior managers and associate non-executive directors as considered appropriate.

MEETING ADMINISTRATION

Notice of each meeting, including an agenda and supporting papers, shall be sent to each member of the Committee not less than five working days before the date of the meeting. This can be waived under exceptional circumstances and agreed by the Chair.

Meetings will normally be held by video conference but may include meetings in person, particularly for 'deep dive' sessions and service visits.

Participation in meetings by telephone, video or computer link shall be deemed to constitute presence in person at the meeting.

The Trust Secretary will ensure that the Corporate Governance team provides a Secretary to the Committee and appropriate administrative support to the Chair and Committee members. This will include agreement of the agenda with the Chair and Executive Leads, collation and circulation of papers, producing the minutes of the meeting, keeping a record of agreed actions and follow-up and advising the Chair and members of the Committee as appropriate.

Minutes of the meetings of the Committee shall be taken, and a record of meetings submitted to the Board of Directors via a key issues and assurance report for consideration in its meetings held in public.

An annual schedule of reporting shall be set and regularly reviewed.

The Committee will evaluate its membership and performance on a regular basis through an annual review of its activities over the course of the previous year and undertake an annual audit of compliance with its Terms of Reference.

The Committee will review and update its terms of reference on a biennial basis or earlier if necessary, as a result of legislative or regulatory changes. In the alternate year the terms of reference will be reviewed by the Committee Chair, supported by the Trust Secretary.

The Chair of the Committee shall attend meetings of the Council of Governors or its committees on request to enable the Council of Governors to perform its duty to hold the non-executive directors to account for the performance of the Board.

The Committee shall receive regular reports from its sub-committees in accordance with the requirements of each respective terms of reference.

FORMAL SUB-GROUPS

The Committee places reliance on designated delivery and oversight forums to provide structured assurance on performance, risk and improvement. Core sub-groups will provide proportionate assurance reporting focused on risks, controls, impact and escalation, rather than operational detail. The list of core sub-groups and reporting expectations will be maintained within the Committee's annual workplan.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FINANCE AND RESOURCES COMMITTEE

TERMS OF REFERENCE

Accountable to	Board of Directors
Chair Executive Lead(s)	Non-Executive Director Director of Finance/Deputy Chief Executive/Chief Digital Information Officer
Frequency of Meetings	A minimum of 10 'ordinary' meetings per annum
Quorum	The quorum shall be two Non-Executive Directors, the Director of Finance (or nominated deputy), and at least one other Executive Director (or nominated deputy), ordinarily drawn from the executive leads (or deputies) for Estates or Digital in line with the main business of the meeting.
Approval	Tbc
Review date	March 2028

CONSTITUTION

In accordance with the Constitution of the Trust, a committee is established, to be known as the Finance and Resources Committee ("the Committee").

PURPOSE BY DOMAIN

a) The Committee will provide assurance to the Board of Directors ('the Board') that the Trust has:

b) **Finance**

- Robust and effective arrangements in place for the planning, delivery, control and sustainability of its finances and resources
- Appropriate governance, oversight and mitigation of financial and resource-related risks
- Clear accountability and grip over the delivery of agreed financial plans, without duplicating executive operational management.
- Financial strategy and plans are coherent, credible and aligned to the Trust strategy
- Delivery against financial plans is being effectively overseen by the executive
- Variances, risks and emerging issues are identified early and are subject to effective corrective action.

The Committee places reliance on the Trust's designated Finance delivery oversight forums to undertake the operational management of financial plan delivery and to provide structured assurance upward, enabling the Committee to report assurance and escalate concerns to the Board where required.

c) **Estates**

The Committee provides assurance to the Board that the Trust has effective arrangements in place for the governance, planning, investment, safety and sustainability of its estate, and that estates-related risks are identified, managed and controlled in line with regulatory and strategic requirements. It seeks assurance that:

- A clear and coherent Estates Strategy is developed, in place and aligned to clinical, workforce and financial strategies
- The executive has effective arrangements for the delivery and oversight of estates plans, including statutory compliance and capital programmes
- Estates related risks (including backlog maintenance, safety and resilience, sustainability) are understood, appropriately mitigated and reflected in corporate risk reporting.

The Committee places reliance on the Trust's designated Estates delivery and capital oversight forums to undertake the operational management of estates activity and to provide structured assurance upward, enabling the Committee to report assurance and escalate concerns to the Board where required.

d) **Digital**

The Committee provides assurance to the Board that the Trust has effective arrangements in place for the governance, investment and delivery of digital, data and information technology, including benefits realisation and risk management. It seeks assurance that:

- A clear and deliverable Digital Strategy and roadmap is developed, in place, aligned to clinical, financial and workforce priorities
- The executive has effective controls over the delivery of digital programmes, the efficacy of systems, benefits realisation and value for money
- Risks relating to cyber security, data, system resilience, interoperability and digital safety are identified, mitigated and escalated appropriately.

The Committee places reliance on the Trust's digital delivery and information governance forums to manage operational delivery and to provide timely, structured assurance, enabling the Committee to report assurance and escalate concerns to the Board where required.

AUTHORITY

The Committee is a committee of the Board comprised of independent non-executive directors and executive directors and has no executive powers, other than those specified in these Terms of Reference or otherwise delegated by the Board through its Scheme of Delegation and Standing Financial Instructions.

The Committee is authorised by the Board to consider proposals and/or business cases that align with the Trust Strategy in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any Trust or Gloucestershire Managed Services employee, and all employees, of both the Trust and Gloucestershire Managed Services (including officers) are required to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

The Committee will place formal reliance on the groups and forums reporting to it as the Trust's primary executive forums responsible for the operational delivery of strategies and plans and for the management of associated delivery risks. These groups will provide structured assurance to the Committee using the 4As format.

DUTIES

The Committee will seek assurance on the effectiveness of systems for governance, risk management and internal control within its remit. It will seek assurance on the following:

Financial Strategy The Committee will seek assurance on:	Digital Strategy The Committee will seek assurance on:	Estates and Facilities Strategy: The Committee will seek assurance on:
• The credibility, alignment and coherence of short, medium and long-term financial plans (including operational planning and capital plans) • The effectiveness of executive oversight arrangements for the delivery of agreed plans, including recovery actions where required • The robustness of controls over cash, liquidity and financial governance, including forecasting and in	• The effectiveness of arrangements for the development, approval and delivery of the Trust's Digital Strategy and roadmap aligned to Trust priorities • The effectiveness of prioritisation, resourcing and dependency management across digital programmes • investment discipline: affordability, value for money and benefits realisation for major digital programmes • The management of digital risk including cyber security, system resilience, interoperability and digital safety; and escalation of significant incidents	• The effectiveness of arrangements for the development, approval and delivery of the Estates strategy aligned to clinical, workforce and financial strategies. • The scale, risk profile and management of backlog maintenance, including trajectory and alignment to the Board's risk appetite • The effectiveness of processes for the prioritisation and oversight of capital investment, including affordability, deliverability and benefits realisation • The identification mitigation and escalation of estates related risks, including resilience, sustainability and infrastructure failure.

year grip on financial sustainability plans • The robustness of controls over cash, capital, liquidity and financial governance • Cash flow status • Whether material financial risks are appropriately reflected in the BAF and corporate risk reporting • The adequacy of controls and mitigation where delivery risks or adverse variances are identified, and appropriateness of escalation • Sustainable service commissioning • Overview of key contractual arrangements and service delivery agreements where these pose material financial or risk exposure • The appropriateness of key financial policies and Standing Financial Instructions; recommending changes to the Board where required	• Assurance that the Trust's digital infrastructure and services are fit for purpose, resilient, and scalable • That digital implementation and support structures are properly resourced, are embedded throughout the organisation and appropriately involve users and other stakeholders. • Oversight of relevant internal audit recommendations and follow-up actions • Any other relevant matters as referred by the Board.	• The effectiveness of arrangements governing the interface between the Trust and GMS including assurance over contractual performance, service quality and risk. • . Assurance (not operational direction) that GMS is delivering its strategic plan, approved annual business plan and contractual commitments within agreed resources and tolerances, with material issues escalated via agreed governance routes • Assurance as to the Trust's sustainability agenda, including Green Plan. • Assurance over fulfilment of the Trust's corporate services provided to GMS under SLA agreements where material • Oversight of relevant internal audit recommendations and follow-up actions • Any other business relevant to the Reserved Matters of the subsidiary company.
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- Any other relevant matters as referred by the Board. - Oversight of relevant internal audit recommendations and follow-up actions		
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MEMBERSHIP

- Three non-executive directors (one appointed as Chair of the Committee)
- Chief Executive or Deputy Chief Executive
- Director of Finance
- Director of Improvement and Delivery
- Chief Digital and Information Officer
- Chief Operating Officer (Estates executive lead)
- Medical Director and Director of Safety (as relevant to agenda items)
- Chief Nurse and Director of Quality (as relevant to agenda items)
- Director of Integrated Governance

Other executive directors, associate NEDs, subsidiary leaders, external advisors or observers may attend by invitation at the discretion of the Committee Chair.

One of the non-executive members will be appointed Chair of the Committee by the Chair of the Board.

In the absence of the Chair, a meeting of the Committee may be chaired by one of the other non-executive members of the Committee.

Where vacancy or absence prevents full non-executive membership affecting quoracy, an additional non-executive member of the Board may be co-opted as an interim member of the Committee, as required.

Membership may also include any other members of the Board of Directors and any other directors, senior managers and associate non-executive directors as considered appropriate.

MEETING ADMINISTRATION

The Trust Secretary will be responsible for providing secretariat support to the Committee.

Notice of each meeting, including an agenda and supporting papers, shall be sent to each member of the Committee not less than five working days before the date of the meeting. This can be waived under exceptional circumstances and agreed by the

Chair. A Call Agenda will be agreed and circulated not less than ten working days before the date of the meeting.

Meetings may be held in person or virtually; remote participation will be deemed presence in person.

Minutes of the meetings of the Committee shall be taken, and a record of meetings submitted to the Board of Directors via a Key Issues and Assurance Report (4As) for consideration in its meetings held in public. The Committee will escalate to the Board where sufficient assurance cannot be obtained, or financial/digital/estates risks exceed agreed tolerances or threaten strategic delivery.

An annual schedule of reporting shall be set and regularly reviewed.

The Committee will evaluate its membership and performance on a regular basis through an annual review of its activities and effectiveness over the course of the previous year. An annual audit of compliance of its Terms of Reference will be undertaken and reported to the Board

The Committee will review and update its Terms of Reference on a biennial basis, or earlier should any change to relevant legislation or regulation require. In the interim year the Trust Secretary, in consultation with the Committee Chair, will undertake a desktop review.

The Chair of the Committee shall attend meetings of the Council of Governors or its committees on request to enable the Council of Governors to perform its duty to hold the non-executive directors to account for the performance of the Board.

FORMAL SUB-GROUPS

In discharging these duties, the Committee will rely on structured assurance from designated executive delivery groups and will not substitute itself for operational management or programme governance.

Each sub-group reporting to the Committee,(to include any Group wholly owned subsidiary) will provide a Key Issues and Assurance Report (4As) for consideration of any highlighted risks or decisions to be made. The list of formal sub groups will be confirmed and maintained within the forward schedule of business.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

Accountable to	Board of Directors
Chair	Non-Executive Director
Executive Leads	Director for People and Organisational Development
Frequency of Meetings	Minimum of 6 x per annum
Quorum	Two non-executive director members, including Committee Chair (or nominated deputy if absent) and Director for People and Organisational Development (or nominated deputy)
Approval	tbc
Review date	April 2028

CONSTITUTION

In accordance with the Constitution of the Trust, a committee is established, to be known as the People and Organisational Development Committee (“the Committee”).

PURPOSE

The Committee is established to provide assurance to the Board of Directors that the Trust has effective, equitable and well-governed arrangements in place for:

- The delivery of the Trust’s People and Staff Experience Strategy
- Compliance with national and local workforce obligations
- The identification, mitigation and escalation of workforce-related risks
- The creation and maintenance of a safe, inclusive and psychologically supportive working environment.

The Committee’s role is one of assurance, scrutiny and escalation, not operational management. It seeks assurance that:

- Executive arrangements are effective
- Interventions are evidence-based and proportionate
- Impact is understood and monitored
- Persistent or systemic issues are recognised and acted upon.

The Committee provides focused assurance to the Board on areas where staff experience, safety, culture and conduct directly affect organisational performance, quality of care and regulatory confidence.

The Committee places reliance on the Trust’s designated People & OD delivery oversight forums to undertake the operational management of financial plan delivery and to provide structured assurance upward, enabling the Committee to report assurance and escalate concerns to the Board where required

AUTHORITY

The Committee is a committee of the Board comprised of independent non-executive directors and executive directors and has no executive powers, other than those specified in these Terms of Reference or otherwise by the Board of Directors in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any Trust employee.

The Committee is authorised by the Board to commission legal advice via the legal services department or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as is considered necessary to support the Committee in the performance of its duties.

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the minutes accordingly.

In discharging its role, the Committee will:

- Focus on assurance, analysis and learning, rather than activity reporting
- Seek evidence of impact and effectiveness, not just completion
- Commission deep dives where workforce risks persist or trends are not improving
- Place formal reliance on executive delivery and governance forums, without duplicating them
- Escalate material concerns to the Board where sufficient assurance cannot be obtained.

DUTIES

On behalf of the Board of Directors the Committee will:

- Provide assurance to the Board that the Trust has effective arrangements in place to meet its statutory workforce obligations, including those relating to safe staffing, staff competence, training, supervision and wellbeing.
- Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

Staff Experience, Culture and Engagement

- assurance on delivery of the Staff Experience Strategy, informed by both national and local workforce data
- analysis of National Staff Survey outcomes, including themes such as bullying, harassment, discrimination, inclusion and psychological safety
- triangulation of survey findings with grievance, FTSU, turnover, sickness absence and safety incident data

- requirement for targeted deep dives where outcomes are static, deteriorating or present material risk
- assurance that identified actions are evaluated for impact over time and adjusted where they are not shifting outcomes.

Equality, Diversity and Inclusion

- compliance with statutory and national EDI obligations including WRES, WDES and other mandated standards
- understanding and addressing systemic inequalities in workforce experience and outcomes
- assurance on the effectiveness and impact of EDI interventions, rather than activity alone.

Workforce Health, Safety and Wellbeing

- assurance on workforce-specific health and safety risks, including violence and aggression towards staff
- granular understanding of staff safety incidents and emerging themes
- learning from occupational health, wellbeing and safety data and effectiveness of mitigations
- alignment with, but not duplication of, the Group Health and Safety Committee remit concerning workforce specific obligations.

Freedom to Speak Up, Conduct and Employee Relations

- effectiveness of systems enabling staff to raise concerns safely in the widest sense
- themes and learning from Freedom to Speak Up, grievances, disciplinary processes and ET cases
- identification of repeat or systemic issues indicating cultural or leadership risk
- assurance that learning is acted upon and monitored for sustained improvement.

Risk, Escalation and Board Assurance

- identification and oversight of workforce-related risks within the Committee's remit
- assurance that material people risks are reflected in the Board Assurance Framework where appropriate
- escalation to the Board where assurance cannot be obtained or risks exceed tolerance.

Divisional workforce insight and Assurance

The Committee will seek assurance that the Trust has effective arrangements to:

- identify and understand divisional-level workforce risks, culture, safety and experience issues
- analyse variation between divisions (including hotspots or outliers)
- ensure that divisional issues are escalated, addressed and monitored for improvement.

This will include assurance that workforce intelligence is routinely disaggregated at divisional (and where appropriate departmental) level rather than reported solely at aggregate organisational level.

Assurance on divisional workforce issues will normally be provided through the Trust's executive People and Organisational Development governance arrangements (including the People & OD Group), rather than through routine divisional attendance at the Committee.

MEMBERSHIP

Members of the Committee will be:

- Three non-executive members of the Board (one appointed as Chair of the Committee)
- Director for People and Organisational Development (or deputy)
- Chief Nurse and Director of Quality
- Medical Director and Director of Safety
- Director of Integrated Governance (or deputy)
- Director of Finance (or deputy)
- Chief Operating Officer (or deputy)

In Attendance will be:

- Deputy Directors of People and OD
- Head of Health, Safety and Risk
- Divisional representatives

Other executive directors, associate NEDs, subsidiary leaders, Divisional Directors, Heads of Service, external advisors or observers may attend by invitation at the discretion of the Committee Chair.

One of the non-executive members will be appointed Chair of the Committee by the Chair of the Board.

In the absence of the Chair, a meeting of the Committee may be chaired by one of the other non-executive members of the Committee.

Where vacancy or absence prevents full non-executive membership, an additional non-executive member of the Board may be co-opted as an interim member of the Committee, as required.

Membership may also include any other members of the Board of Directors and any other directors, senior managers and associate non-executive directors as considered appropriate.

MEETING ADMINISTRATION

The Trust Secretary will be responsible for ensuring the provision of secretariat support to the Committee. Notice of each meeting, including an agenda and supporting papers, shall be sent to each member of the Committee not less than five

working days before the date of the meeting. This can be waived under exceptional circumstances and agreed by the Chair.

Meetings may be held in person or virtually; remote participation will be deemed presence in person.

Minutes of the meetings of the Committee shall be taken, and a record of meetings submitted to the Board of Directors via a Key Issues and Assurance Report (4As) for consideration in its meetings held in public.

The Committee will escalate to the Board where sufficient assurance cannot be obtained, or people and OD risks exceed agreed tolerances or threaten strategic delivery.

An annual schedule of reporting shall be set and regularly reviewed.

The Committee will evaluate its membership and performance on a regular basis through an annual review of its activities over the course of the previous year. An annual audit of compliance of its Terms of Reference will be undertaken and reported to the Board. The Committee will review and update its Terms of Reference on a biennial basis or earlier should any change to relevant legislation or regulation require it.

The Chair of the Committee shall attend meetings of the Council of Governors or its committees on request to enable the Council of Governors to perform its duty to hold the non-executive directors to account for the performance of the Board.

FORMAL SUB-GROUPS

In discharging these duties, the Committee will rely on structured assurance from designated executive delivery groups and will not substitute itself for operational management or programme governance.

Each sub-group reporting to the Committee will provide a Key Issues and Assurance Report (4As) for consideration of any highlighted risks or decisions to be made. The list of formal sub groups will be confirmed and maintained within the forward schedule of business.

Alert, Advise and Assure Report to the Board of Directors Meeting held on 16 July 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the People and Organisational Development Committee held on 16 June 2026
Board member lead(s)		Marie-Annick Gournet, Non-Executive Director (Chair)
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	Approval	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the People and Organisational Development Committee held on 16 June 2026. The Committee received assurance and scrutiny across workforce sustainability, culture and retention, workforce transformation, staff experience, speaking up, workforce performance and workforce risks. The Committee noted both significant workforce transformation requirements arising from the NHS Medium Term Planning Framework and Transforming People Services (TPS) Programme, whilst also considering the organisational culture, staff experience and workforce risks associated with delivering this scale of change.

Key points

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

- **Workforce Transformation Programme and Workforce Reduction Requirements**

The Committee received a detailed update on the Workforce Transformation Programme, which forms a critical component of the Trust's financial recovery and medium-term planning assumptions. The Trust is required to deliver a £10 million pay reduction equivalent to approximately 174 WTE during 2026/27 through a combination of strengthened workforce controls, workforce reset measures and longer-term transformation programmes. Members emphasised that delivery of these targets must be achieved through genuine service redesign and

transformation rather than solely through vacancy controls, recognising lessons learned from previous workforce reduction activity. The Committee heard evidence that workforce pressures remain significant and that staff are already experiencing increased workload and anxiety associated with organisational change.

- **Staff Experience, Workload and Workforce Pressures**

The Committee reviewed the 2025 NHS Staff Survey and noted persistent concerns regarding workload, staffing levels, confidence in organisational responsiveness, access to career development and equality of experience. Survey response rates reduced significantly, potentially reflecting reduced confidence amongst staff that feedback results in visible change. Particular concern was expressed regarding continued variation in staff experience between divisions and the ongoing pressure being experienced by operational teams.

- **Violence, Aggression and Discriminatory Abuse Towards Staff**

The Committee received a comprehensive report regarding violence and aggression incidents and noted evidence of ongoing discriminatory abuse directed towards staff, particularly racial abuse. Members recognised the significant psychological impact on staff arising from repeated exposure to abuse and discriminatory behaviour. The Committee also noted emerging concerns regarding under-reporting and the need for enhanced organisational measures to better recognise, measure and respond to psychological harm resulting from violence, aggression and discrimination. The Committee noted the wider national context, including the recommendations arising from the Lord Mann Independent Review into Antisemitism in the NHS, and recognised the importance of ensuring robust reporting mechanisms, visible organisational action, staff confidence in escalation routes, and a consistently supportive culture for all staff who experience discrimination, harassment or hate incidents. It is recommended that a further report be brought to the Committee on the Mann Report action plan.

- **Speaking up responsiveness and discrimination:** The Freedom to Speak Up report highlighted that staff continue to raise concerns, but confidence in organisational responsiveness and visible action remains a key risk. Discrimination, particularly racism experienced from managers or colleagues, was highlighted as an area requiring stronger and more consistent organisational response

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

- **Embedding Divisional Accountability for Staff Experience**

The Committee supported a significant shift towards divisional ownership of staff experience improvement. Whilst recognising this as the appropriate direction of travel, members highlighted the importance of ensuring clear accountability, robust governance arrangements and sufficient organisational development support to enable divisional leadership teams to deliver meaningful improvements. Further assurance regarding divisional people governance arrangements will be presented to a future meeting.

Staff Networks Reset and Refresh Programme

- The Committee reviewed progress on the Staff Networks Reset and Refresh Programme. Members welcomed the strengthened governance arrangements, leadership development support and proposals for a more transparent funding model. Discussion focused particularly on ensuring that staff networks retain their role as safe spaces for support, connection and lived-experience discussions whilst strengthening their influence on organisational decision-making. Further work continues on sustainable funding arrangements and the measurement of impact.
- **Transforming People Services (TPS) Programme**
The Committee noted continuing national and system-wide development of the NHS Transforming People Services (TPS) Programme and wider Integrated Care System workforce initiatives. Members recognised that future workforce transactional services, recruitment and wider people functions are expected to evolve through both the regional TPS programme and wider system collaboration. The Trust continues to monitor these developments closely to ensure alignment with local workforce transformation and organisational redesign work whilst minimising duplication and change fatigue for staff.
- **Workforce Culture and Psychological Safety**
Members noted continuing themes emerging from the Staff Survey, Freedom to Speak Up arrangements, violence and aggression reporting, and wider workforce intelligence regarding confidence, psychological safety, speaking up and workplace culture. While progress has been made in strengthening governance and oversight arrangements, these issues require continued scrutiny and sustained leadership focus.

ASSURE: inform the board where positive assurance has been received

- **Behaviour Standards Panel Arrangements**
The Committee received assurance regarding the operation of the Trust's Behaviour Standards Panel and associated processes for managing violence, aggression and abuse. Members acknowledged the substantial volume of warning letters and behaviour orders issued and recognised evidence that early intervention and behavioural management measures are often effective in preventing recurrence.
- **Improved Staff Survey Intelligence and Insight-Led Improvement Approach**
The Committee welcomed the development of a more integrated and triangulated approach to understanding staff experience. Staff Survey findings are now being considered alongside WRES, WDES, Freedom to Speak Up, staff network and workforce data to provide a more sophisticated understanding of workforce culture and experience. Members received assurance that future improvement activity will focus on a smaller number of clearly defined priorities with measurable outcomes.

Strengthened Workforce Transformation Governance

The Committee received assurance that workforce transformation activity is supported through strengthened governance arrangements, including dedicated transformation oversight structures, finance oversight mechanisms, workforce controls and staff-side engagement processes. A strong emphasis is being placed on staff engagement, equality impact assessment, redeployment and minimising compulsory redundancies wherever possible.

APPROVALS: decisions made by the Committee

- **One Gloucestershire Redeployment Framework**
The Committee approved the revised One Gloucestershire Redeployment Memorandum of Understanding. Members received assurance that the framework provides a consistent, compassionate and system-wide approach to supporting staff affected by organisational change, reducing redundancy risk and retaining skills across Gloucestershire partner organisations while maintaining service resilience.

Implications

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

Board assurance framework

BAF reference	SR2 & SR3
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Risks discussed

The Committee discussed the following principal risks: • Workforce Sustainability (SR02) • Culture, Experience and Retention (SR03) • Workforce Transformation Delivery • Workforce Capacity and Workload Pressures • Staff Experience and Psychological Safety • Violence, Aggression and Discriminatory Behaviour • Equality of Experience and Workforce Inclusion • Transforming People Services (TPS) Programme Implications • Organisational Change and Workforce Morale • System-wide Workforce and Redeployment Risks

Recommendations

The Board is asked to: • TAKE ASSURANCE from the strengthened governance arrangements supporting workforce transformation, workforce performance and staff experience improvement.

- NOTE the significant workforce transformation challenge associated with delivery of medium-term planning requirements and associated workforce reductions.
- NOTE ongoing developments associated with the NHS Transforming People Services (TPS) Programme and wider system workforce reforms which will continue to influence future delivery models for People services.

Report to Board of Directors: July 2026

Date of Meeting	16 July 2026
Report title	Freedom to Speak Up Annual Report 2026
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Louisa Hopkins, Freedom to Speak Up Guardian

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

Executive Summary
This report provides an overview of Freedom to Speak Up (FTSU) activity and organisational insight during 2025/26. It draws on information from contacts with the Freedom to Speak Up team, Report Support and Learn (RSL), and the NHS Staff Survey to provide a triangulated view of speaking-up culture across Gloucestershire Hospitals NHS Foundation Trust. The evidence shows that staff continue to access formal speaking-up routes across all staff groups and divisions. This suggests that staff are aware of the routes available to them and are willing to use them when they feel unable to raise concerns through local channels. During the reporting period, there has been a noticeable shift in the nature of concerns raised, with staff increasingly using FTSU to describe their experiences of local processes, leadership responses, and organisational barriers to resolution. This has provided valuable insight into how concerns are experienced and managed across the organisation, alongside opportunities for organisational learning. Analysis of all available data sources presents a mixed picture. While the ability and willingness of staff to speak up provides positive assurance, there remains a consistent difference between staff feeling able to raise concerns and having confidence that those concerns will be acted upon effectively. Organisational responsiveness continues to influence staff experience, with variation in local responses, timeliness of action, and visibility of outcomes affecting confidence in the process. Behavioural concerns remain the most frequently reported theme and continue to feature prominently across speaking-up activity. Concerns relating to discrimination also remain significant, particularly those associated with race. The recurring nature of these themes suggests that whilst routes for raising concerns are established, challenges relating to behaviours, inclusion, and staff experience remain present within parts of the organisation.

The report also highlights the significance of passive cases relating to discrimination, where individuals seek support, share information, or disclose experiences but do not wish concerns to be formally escalated. Whilst these cases provide important cultural intelligence, they may also indicate reduced confidence in organisational response or concern about the consequences of progressing issues further. This presents a risk that opportunities for learning, action, and improvement may not always be fully realised.

Variation in reporting levels across staff groups and divisions suggests that experiences of psychological safety and confidence in speaking up are not consistent across the organisation. Areas of high reporting may indicate confidence in speaking-up mechanisms, whereas areas of lower reporting may warrant further exploration to understand whether organisational silence, barriers to speaking up, or differing local cultures are influencing reporting behaviours.

The evidence also highlights the important role leaders and managers play in shaping staff experiences when concerns are raised. Whilst speaking-up routes remain available and accessible, staff experiences continue to be influenced by local responses, leadership capability and the ability to resolve concerns effectively. Feedback from speaking-up activity indicates variability in these experiences, highlighting the importance of leadership accountability, effective local resolution, and visible organisational learning.

Alongside these findings, the report reflects a number of positive developments during the year, including the expansion of FTSU data collection beyond national minimum requirements, the introduction of additional insight relating to discrimination, manager and leader responses, and sexual safety, and the Trust's continued contribution to regional Freedom to Speak Up development and collaboration.

Overall, the evidence indicates that speaking-up mechanisms are established and continue to be used across the organisation. The key challenge identified is ensuring that concerns raised consistently translate into timely action, visible learning, and improved staff confidence in organisational responsiveness, thereby strengthening both staff experience and the wider organisational culture.

Previously considered by	<i>People and Organisational Development Committee – June 2026.</i>
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Recommendations:

The Board is asked to receive the Freedom to Speak Up Annual Report 2026 and note the mixed assurance position.

The report provides positive assurance that staff continue to access established speaking-up routes and are willing to raise concerns. However, it identifies a continuing gap between staff feeling able to raise concerns and confidence that concerns will be acted upon effectively.

The Board is asked to endorse the continued focus on organisational responsiveness, leadership accountability, visible learning, strengthened organisational insight through enhanced data collection, targeted support for areas of lower confidence, and ongoing oversight of behavioural concerns and discrimination, particularly race discrimination.

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

Impact on any Strategic Risks?

Implications on:	
Equality, Diversity and Inclusion	Staff have raised concerns relating to discrimination across a range of protected characteristics, including disability, pregnancy and maternity, religion, sexual orientation, race, and age. Data indicates that discrimination, particularly race discrimination, remains a significant theme. The presence of passive cases highlights reduced confidence in escalation for some staff, indicating potential inequalities in experience and barriers to resolution. The FTSU service provides an independent route to support equitable speaking up; however, continued focus is required to ensure concerns are addressed consistently and lead to improved staff experience.
Health Inequalities	Freedom to Speak Up concerns include issues relating to patient safety, quality of care, and system processes, supporting the identification and escalation of risks to patients. Staff willingness to raise concerns enables early intervention and organisational learning
Finance and Resource	No direct impact
Regulation/Legal	The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns: - NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian. - National NHS Freedom to Speak Up raising concerns policy (2022)

	NHS Constitution:
CQC-Key line of enquiry	Freedom to Speak Up arrangements and learning are reviewed as part of the Well Led domain in CQC inspections.
Green Plan	No direct impact

Main Report

Freedom to Speak Up Annual Report 2025/2026

1.Purpose:

This report provides an overview of Freedom to Speak Up (FTSU) activity and organisational insight for 2025/26. It draws on data from FTSU, Report Support and Learn, and the NHS Staff Survey to triangulate information and present a comprehensive view of speaking-up culture within the Trust.

The report aims to support openness and transparency by identifying key themes, risks, and patterns in speaking-up, and by highlighting the experiences of staff when raising concerns. It provides the Board with assurance on the effectiveness of speaking-up arrangements and identifies areas where further development is required to strengthen confidence, responsiveness, and organisational learning.

2. Background:

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian (FTSUG) were created in response to recommendations made in Sir Robert Francis' report 'The Freedom to Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). In this report, Sir Robert found that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.

Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided.

Freedom to Speak up Guardians are employed to promote an open and transparent culture of speaking up and raising concerns. FTSUG provide impartial support to speaking up matters, monitoring and supporting any concerns of detriment or disadvantageous behaviour toward staff because of speaking up.

For the past nine years, the National Guardian's Office has operated as an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. Following the DASH report [Review of patient safety across the health and care landscape - GOV.UK](#) the government accepted the Dash review's recommendation that the National Guardian's Office should close, with some of its responsibilities incorporated into providers and functions aligned with other staff voice initiatives in NHS England.

The NGO closed on 30th June 2026 with all responsibilities being passed onto NHSE
<https://www.england.nhs.uk/publication/the-future-of-freedom-to-speak-up/>

3. Update from the National Guardians Office:

The Freedom to Speak Up Guardian role is confirmed to remain a mandatory part of the NHS Standard Contract for 2026/27, ensuring continuity and support for staff speaking up about patient care concerns, despite the NGO closing, with NHS England taking over national support functions from 2026/27. This commitment provides crucial certainty, reinforcing a culture where staff feel safe to raise issues like unsafe practices, bullying, or financial concerns, with leaders required to listen and act, as detailed in the NHS Standard Contract documents and guidance.

The Freedom to Speak Up Annual Report 2024/25 was laid before Parliament on 27th November 2025. The report highlights the work of FTSUG, detailing the continued progress in strengthening the speaking-up culture across healthcare. With a record 38,158 cases raised, it highlights the trust that healthcare workers have in the Freedom to Speak up system, strategic developments, and ongoing work to address detriment and improve workplace culture.

4. Regional Update:

The Lead FTSU Guardian continues to attend regional meetings, including mentoring and supporting new FTSU Guardians and chairing South West support for new FTSU guardians. GHFT contributed to regional leadership in 2025/26, having hosted two of the four South West FTSU events and supporting Freedom to Speak Up Guardians across the region to learn, collaborate, and strengthen practice.

5. Review and update on matters raised in 2024/25 FTSU annual report:

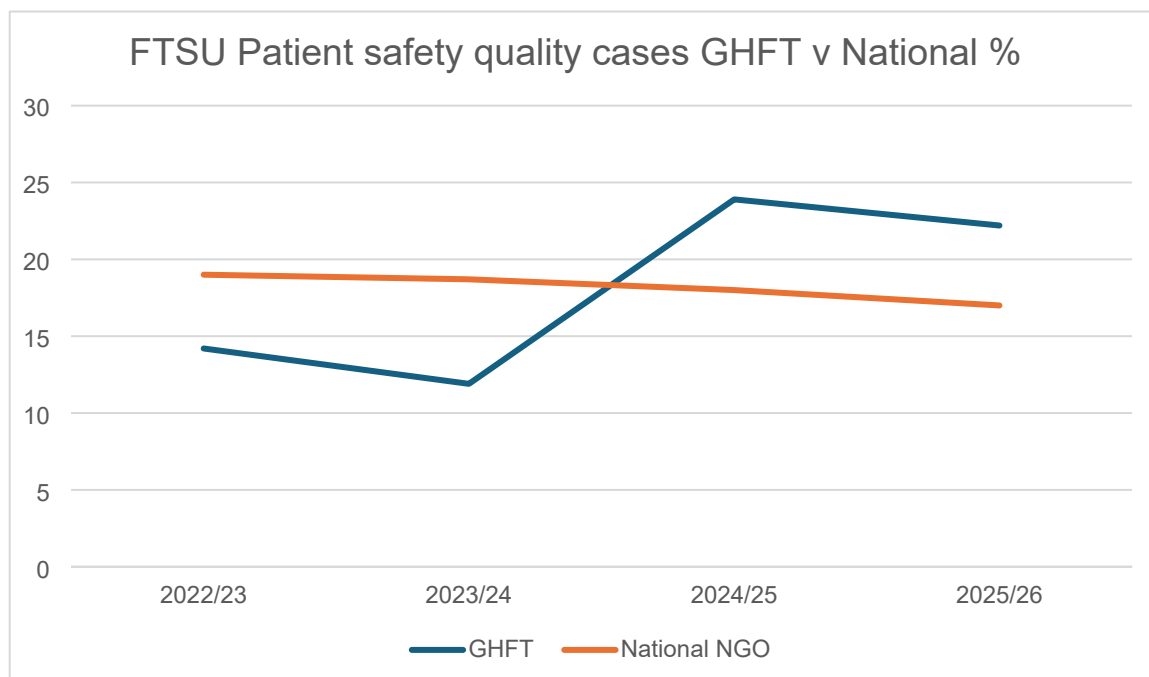
Last year the FTSU service committed to taking a deeper dive to look at patient safety concerns and staff experience of discrimination. Taking this approach has captured learning for the organisation regarding the barriers staff experience to speaking up and the cultural challenges staff face.

Patient safety/ quality concerns:

During the reporting period of 2025/26, 36 Freedom to Speak Up (FTSU) cases related to patient safety and quality, accounted for 22.2% of all cases raised to Freedom to Speak Up Guardians. The % of patient safety and quality concerns raised remain consistently higher than the national benchmark but remain within an expected range. The higher % is more reassuring than a lower rate, which may indicate under-reporting or reduced confidence in speaking up. It is reassuring that staff are willing to raise safety concerns when risks arise and seek alternative routes when their current systems fail or are perceived to be not suitable for their speaking up matter. The continued increase in patient safety speaking up matters suggests staff are willing to speak up and voice safety issues even when they may have experienced barriers in speaking up.

Analysis of the patient safety concerns highlights variations in local escalation and response. There were cases where incidences of workload, capacity issues, process gaps, and unclear pathways impacted confidence for staff. Staff frequently accessed the FTSU service after initial attempts to raise concerns through line management had not resulted in action or resolution hoped by the staff member, indicating gaps in local responsiveness and confidence. This pattern suggests that while staff are willing to speak up, organisational

processes for addressing concerns are not always consistently effective, presenting a risk to early intervention and learning. In each case, escalation routes reflected the validity of the concerns raised, reinforcing that these were appropriate issues that merited attention and action.



Positively, learning has been identified and achieved in different divisions. Learning relating to behaviours has been captured by the Medicine division in cultural support work in areas of the division. In Surgery, communication was identified as a factor impacting staff perception of a patient quality issue. This has now been improved and consequently improved staff experience and trust.

In summary, staff utilise FTSU when there are challenges in trust, response, and confidence in local escalation. These cases highlight the ongoing need for an FTSU presence within the organisation, as they consistently represent staff experiencing genuine barriers to speaking up. Continued focus is required regarding behavioural in response to speaking up, restoring manager's capability and capacity, and strengthening a restorative, just and learning culture to ensure all staff feel safe and supported to raise concerns early.

Discrimination

In response to the publication of *Too Hot to Handle: why concerns about racism are not heard or acted upon*; the National Guardian's Office incorporated equity, diversity and belonging into the mandatory refresher training for all FTSU Guardians to give all guardians an understanding of discrimination <https://nationalguardian.org.uk/2024/02/07/response-to-too-hot-to-handle/>.

The report promotes the better use of FTSU Guardians, who as part of their role have a focus on encouraging their organisations to remove the barriers which workers face in speaking up. In response to the report, GHFT committed to widening the data collection of 2025/ 26 cases looking into discrimination to explore the impact on staff in GHFT.

The data collection revealed that 21.6% of all FTSU cases related to discrimination. This represents a substantial proportion of speaking-up activity and suggests that discrimination continues to be experienced by staff across the organisation.

Cases are also logged under different categories; Bullying & Harassment, Systems & Processes, or Inappropriate Behaviour, and this indicates;

- staff experience discrimination in different forms
- staff interpret their experiences differently
- discrimination is not always labelled explicitly as “discrimination” even when that is the underlying issue

It was found nearly half 48% of discrimination cases came from registered nurses, midwives and healthcare support workers, slightly higher than their 44% representation in the workforce. This over incidence may reflect increased exposure to workplace interactions, differences in reporting behaviour, or underlying cultural factors affecting these staff groups.

The data revealed two protected characteristics: 32 race concerns and 3 disability concerns. Of the race concerns, 27 were reported as passive where staff did not want concerns to be escalated due to barriers of confidence and trust in the organisation. The disability concerns related to sickness management and how staff were treated by the line managers in relation to their disability. Staff survey data shows that 9.08% of staff reported experiencing discrimination at work from a manager/team leader or other colleague, and 8.46% reported experiencing discrimination at work from patients/service users, their relatives or other members of the public. Of those experiencing discrimination in the staff survey, 8.86% said it was due to a disability. Which matches the FTSU data of 8.5% cases being connected to disability.

Taking a wider view, RSL also holds discrimination as a data point with 191 reported discrimination data points from 129 staff cases relating to discrimination, 30.4% of total cases.

Considered together, the data collected shows that discrimination remains a significant issue within the organisation. It also highlights clear differences in how various forms of discrimination are experienced, reported, and escalated. Rather than presenting a single, consistent reporting pattern, there is variation in staff confidence, perceived seriousness which is a risk to staff confidence and safety.

Race discrimination emerges as the most significant and consistent theme across all three data sources, and it accounts for the highest proportion of discrimination reported in the staff survey, indicating a widespread lived experience.

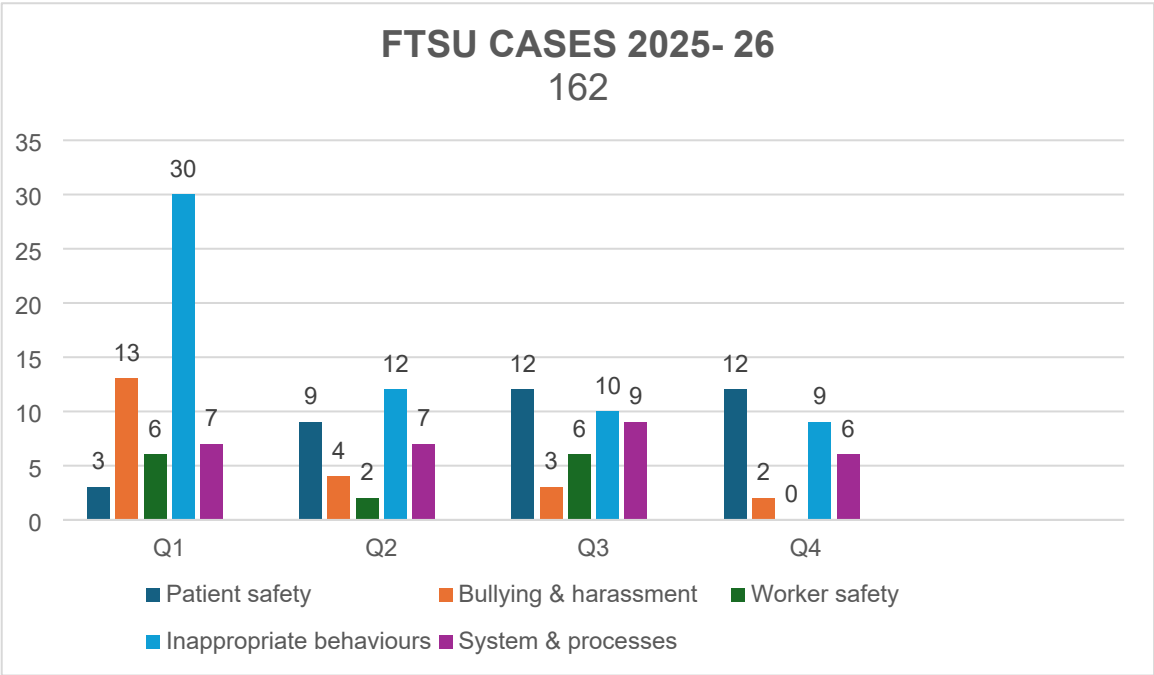
This alignment in the data suggests that race discrimination is regularly experienced and clearly recognised as serious by the staff experiencing it. Staff appear more confident in raising these concerns through formal routes, however, staff also express a lack of trust in the organisations ability to manage effectively. This remains an ongoing organisational risk and requires continued leadership focus.

6. FTSU Activity, Trends and Emerging Themes (2025/26):

All FTSU concerns are triaged and escalated within the Trust, with regular engagement with the Chief Executive and the Non-Executive Director responsible for FTSU providing additional escalation routes.

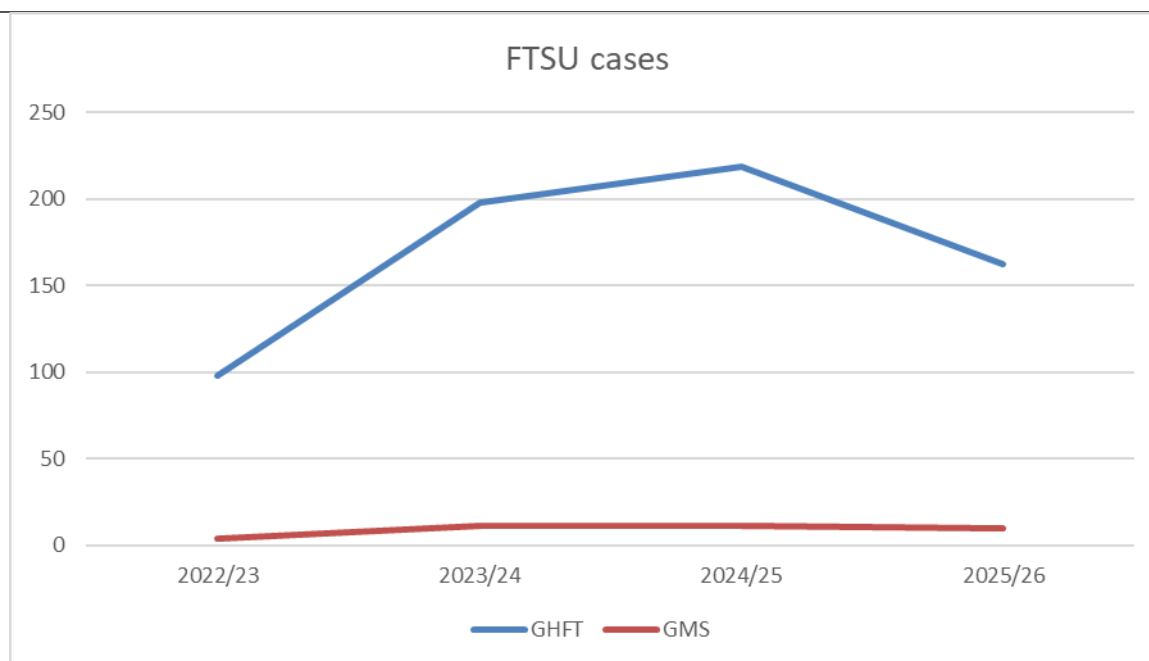
In 2025/26, with 162 concerns raised, staff accessing the FTSU service are increasingly articulating barriers as the primary reason for contacting FTSU, indicating a clear shift in speaking-up behaviour. In past years, staff more frequently engaged FTSU alongside active managerial support resulting in more concerns raised. This change in behaviour coincides

with a 26% reduction in FTSU cases. This change indicates concerns are being escalated more appropriately to the FTSU service (when barriers exist), generating richer intelligence about the barriers in speaking up and enabling the organisation to learn more effectively. While the reduction may reflect the introduction of RSL, it will require ongoing monitoring to ensure it does not indicate reduced confidence in formal speaking-up routes.



The Lead FTSUG continues to support GMS with access to FTSU to ensure equity of service across the organisations. Staff raising FTSU concerns in GMS are present in all categories and are reported within the GMS structure. GMS cases are lower in comparison to GHFT cases, at 13 cases per 1000 staff compared with GHFT Trust cases at 19 cases per 1000 staff. A theme this last year has been staff expressing a lack of trust in GMS to resolve speaking up matters, voicing a preference to seek GHFT leadership support. This indicates reduced confidence in local resolution within GMS and a reliance on external escalation routes.

GMS is dedicated to the speaking up agenda and work is ongoing to instil a GMS FTSU Guardian within the GMS structure to support GMS staff and promote an open and transparent speaking up culture.

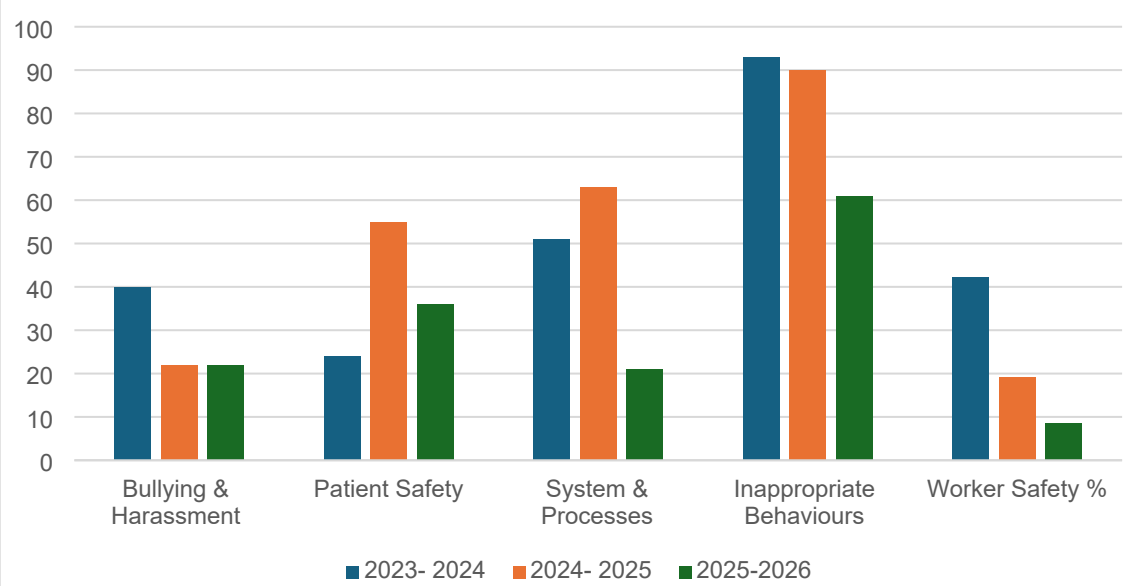


Anonymous reporting has continued to decrease over the last 12 months. The NGO/ NHSE identifies anonymous reporting as a potential indicator that some staff may feel more comfortable raising concerns without being identified, reinforcing the need to continue building trust and confidence in speaking-up arrangements. As expected, the continued stability of a Lead Guardian and FTSU team has decreased anonymous reporting, supporting more open concerns and less anonymised reporting. This year, a full year of data is not accessible due to the system being out of action for a period of time, but Q4 2025/26 had 7.1% anonymous FTSU cases.

In response to the Trust signing the NHS Sexual Safety Charter in May 2024, FTSU has taken several actions to support delivery. The Lead FTSU Guardian is an active member of the Sexual Safety Working and Steering Group. All FTSU Guardians and Champions are required to complete NHS England sexual safety training, with ongoing support and supervision in place. The FTSU policy has been updated to include reference to the Trust Sexual Behaviours Policy.

FTSU has also introduced a new reporting category from Q1 2026/27, Sexual Safety, to capture all related concerns raised through FTSU. This enables effective triangulation of intelligence and supports proactive prevention of harm to staff and patients.

Annual data FTSU



Please note worker safety changed to a national category in 2025, therefore for comparison it is recorded in %. However, the change means the data point is reduced.

In 2024/25, inappropriate behaviours and attitudes remained the most common reason for speaking up at GHFT, accounting for 39.1% of all cases, closely mirroring the National Guardian’s Office figure of 40%, with 423 reports received through RSL. However, concerns relating to inappropriate behaviours and attitudes have not reduced proportionately, remaining high at 37.6% overall.

Quarterly analysis shows an increase across the year, rising from 18.5% in Q1 to 31% in Q4. This suggests that underlying behavioural issues remain persistent, despite continued reporting. This indicates that while staff continue to have confidence to speak up, the prevalence of these concerns has not yet reduced within FTSU reporting.

This data highlights the need for targeted organisational interventions focused on behavioural standards, leadership capability, and prevention, alongside continued support for speaking up.

The National Guardian’s Office / NHSE do not publish comparison data between Trusts but state that speaking up is considered healthy and an expected output of a psychologically safe workforce. Freedom to Speak Up activity across the Trust remains a strong indicator of staff confidence and cultural openness, and all divisions alongside GMS have engaged with speaking up over the last year. Activity levels range from 11 to 27 cases per 1,000 staff, reflecting speaking up activity across the organisation. However, staff survey results indicate that although staff are speaking up, they doubt the organisation’s ability to address and respond to concerns as cited in Q25e (*I feel safe to speak up about anything that concerns me in this organisation*).

Division / area	Case per 1000 staff
Women & Children’s	27
Medicine	26
Diagnostics & Specialities	14
Corporate	14
GMS	13
Surgery	11

In conclusion, while staff continue to speak up, the data highlights a shift in reporting behaviour towards barriers in local resolution and a gap between raising concerns and confidence in organisational response. Ongoing behavioural concerns, variation across divisions, and reduced trust in local resolution present a risk to psychological safety and confidence, requiring focused action to strengthen responsiveness, accountability, and visible outcomes.

To support low confidence speaking up areas, FTSU will target the lowest 10 teams/ wards/ areas of the Trust using staff survey data and work with the teams over 6 months to improve speaking up culture. This work will be in partnership with RSL and the People and OD function.

7. Organisational responsiveness in speaking up:

How staff experience the timeliness of responses to their concerns directly influences their perception of the speaking-up process. The National Guardian's Office identifies futility as a consequence of insufficient organisational responsiveness, where staff believe that raising concerns will not lead to meaningful action. Organisational responsiveness is therefore closely linked to the quality of follow-up provided to staff, with timely updates, clear actions, and visible outcomes being critical in maintaining confidence that concerns are taken seriously and addressed.

It was agreed at Board last year to begin monitoring response times and the duration that cases remain open, to better understand and establish expectations for FTSU responsiveness. The Lead FTSU Guardian continues to maintain a robust service, responding to 98% of cases within 48 hours of initial contact. However, progression beyond this point is dependent on wider organisational capacity and competing priorities. As a result, staff experience can vary depending on manager capability and availability, staff engagement, and the complexity of the concern raised.

Overall, the average time a FTSU case is open is 61 days. When compared with other responsiveness data from RSL where a report is open for an average of 75 days.

The combined volume of 585 cases across FTSU and RSL does not indicate a lack of speaking up within the Trust; rather, it demonstrates that staff are actively raising concerns through formal routes. This is reflected in staff survey results, where the proportion of staff who feel safe to speak up (*"I feel safe to speak up about anything that concerns me in this organisation"* – Q25e) has remained broadly stable at 54% (down marginally from 55.1% in 2024).

However, while staff feel able to speak up, the time taken to respond to concerns aligns with a growing responsiveness and confidence gap. When triangulated with survey data, confidence that concerns will be addressed is significantly lower at 37.16% (down 2.64 percentage points from 2024), indicating a decline in trust in organisational response (*"If I spoke up about something that concerned me, I am confident the organisation would respond to my concern"* – Q25f).

The data demonstrates that staff continue to raise concerns through FTSU and RSL, indicating trust in formal speaking up routes. However, prolonged response times across both systems suggest a significant barrier to confidence that the organisation is listening and responding effectively.

This is reflected in staff survey results. Confidence that concerns will be addressed has decreased, with question 20b (*I am confident that my organisation would address my concern*) reducing by 1.7%, and question 25f (*If I spoke up about something that concerned me, I am confident my organisation would address my concern*) decreasing by 2.5% in the 2025 survey.

This decline is significant when considered alongside relatively stable scores for feeling safe to speak up, highlighting that while staff are willing to raise concerns, there is weaker confidence that action will follow. This mirrors national findings, with the National Guardian's Office reporting that 66% of Freedom to Speak Up Guardians identify a perception that *nothing will be done* as a key barrier to speaking up.

While closing some cases is a challenge in the FTSU function, some delays are worker/ staff motivated and of the 24 cases open for over 100 days, only 2 experienced delays due to organisational challenges in providing timely feedback, while the remaining 22 were influenced by staff-led factors.

Relating to supporting timely responsiveness in FTSU, scoping has begun for a system wide quality improvement project (2026/2027) alongside the Freedom to Speak Up Guardian at Gloucester Health Care NHS Foundation Trust, in reducing barriers to speaking up. This will include setting best practice, time frames along a defined Freedom to Speak Up process, improve accountability in the organisation in terms of responding to concerns through an escalation pathway. The outcome will be to improve colleague experience, strengthening leadership accountability and responsiveness to concerns, and impact on a desired just and learning culture.

8. Confidence in the FTSU service:

Over the past three years, the FTSU function has evolved significantly, transitioning from a model with multiple voluntary guardians to one led by a Lead FTSU Guardian, supported by a network of Champions. During this period, the service has also benefited from additional investment, including the support of a fixed-term Guardian for 12 months.

A deeper analysis of this year's NQPS results has identified barriers to understanding the FTSU service, including a misunderstanding of the role and remit of FTSU, particularly in relation to advocacy and response by staff. These misconceptions can impact both staff experience and confidence in the service.

The Trust has supported FTSU with a consistent communications plan to address and support staff understanding of the FTSU function alongside consistent champion and guardian visibility and engagement with staff. In the last two years, NQPS results show an overall improvement of 7.9% in the question "*If I had a concern, I would feel confident to raise it with a Freedom to Speak Up Guardian*". In April 2026 there was an increase of 3.4% in this question, however, the results were showing decline over the last three previous surveys. Despite this, it does not appear to reflect the experience of staff who have used the FTSU service, with 78% users reporting that they would speak up again, which is closely aligned with the national NGO reported benchmark of 80%.

In response to ensuring confidence is maintained in the FTSU function, the Trust has reviewed whether Freedom to Speak Up is best positioned within the People and OD structure. An independence FTSU review, alongside a service line review, identified concerns regarding the ability of a service to maintain impartiality when embedded within a working team. These concerns were also reflected in staff comments and perception within NQPS survey and a FTSU Service Line Survey in June 2025. Combined with the need for FTSU to

confidently challenge and hold the organisation to account on speaking-up culture, the Trust has decided to reposition FTSU within Governance and Risk. This change creates a strengthened platform for review, improvement, increased independence and organisational learning.

9. Key actions:

This report identifies the need to strengthen organisational responsiveness to speaking up, with a clear focus on improving the timeliness, consistency, and quality of responses to concerns. This includes establishing clearer expectations for how concerns are progressed, ensuring that staff receive timely updates and visible outcomes, and embedding consistent approaches across all divisions. As discussed, work is underway to support this through the development of responsiveness standards and a system-wide quality improvement approach to reduce variation and delays.

A central priority is restoring manager and leader capacity, capability, and accountability in responding to concerns. This includes supporting managers to confidently receive, escalate, and act on concerns at an early stage, reducing reliance on FTSU as the primary route for resolution. Actions include enhancing practical support and guidance for managers, strengthening leadership ownership of concerns, and introducing improved feedback mechanisms that capture leadership response. This will enable deeper organisational learning, improve transparency, and support the development of a more consistent and effective restorative, just and learning culture. It is critical however, that FTSU messaging supports managers and leaders to enable effective speaking up within teams, rather than positioning success as a reduction in FTSU case numbers.

FTSU will strengthen feedback mechanisms to include manager and leader responses, improving transparency of outcomes, and embedding learning within local leadership practice.

FTSU will also strengthen data collection and insight with 'Discrimination' and 'Sexual safety' categories added to the overall FTSU data collection permanently.

This combined increased insight will inform targeted engagement with teams, using tools such as the Speaking Up Improvement Tool to better understand barriers and support improvements in speaking up culture. Further work is needed to address ongoing cultural and behavioural challenges, including discrimination and variation in speaking-up experience across staff groups and divisions. This includes strengthening how discrimination is understood and managed, particularly in relation to race, improving trust in escalation pathways, and, as highlighted earlier in the report, proactively identifying areas of low reporting as a potential risk.

10. Conclusion:

The evidence presented within this report provides assurance that Gloucestershire Hospitals NHS Foundation Trust continues to maintain accessible and established routes for workers to raise concerns. Staff across a broad range of professional groups, staff networks, and divisions continue to engage with Freedom to Speak Up and other formal reporting mechanisms, providing assurance that many workers feel able to speak up when concerns arise.

The triangulated analysis of Freedom to Speak Up data, Report Support and Learn data, and the NHS Staff Survey provides a consistent picture of the organisation's speaking-up culture. While there is positive evidence that staff are willing to raise concerns, there remains a

significant gap between speaking up and confidence that concerns will be acted upon effectively. Organisational responsiveness, visible action, and timely resolution continue to be key factors influencing staff trust in the process and their willingness to raise future concerns.

Behavioural concerns remain the most frequently reported theme and continue to indicate underlying cultural challenges. In addition, discrimination, particularly race discrimination, remains a significant concern. The number of passive cases suggests that some workers are willing to share concerns but do not feel sufficiently confident to pursue escalation, creating a risk that valuable insight, learning, and opportunities for improvement may not be fully realised.

As Freedom to Speak Up Guardian, my independent assessment is that the Trust has made progress in maintaining accessible speaking-up arrangements and supporting staff to raise concerns. However, confidence in organisational responsiveness is not yet consistently experienced across the organisation. The opportunity for improvement now lies less in encouraging staff to speak up and more in demonstrating that concerns raised lead to timely action, meaningful learning, and visible change.

Enclosures

FOI: Public

Report to Board of Directors/Committee

Date of Meeting	16 th July 2026
Report title	Engagement and Involvement Annual Review 2025-2026
Sponsoring Director/Author	Will Cleary-Gray – Director of Improvement and Delivery James Brown, Director of Engagement, Involvement & Communications Juwairiyia Motala, Community Engagement and Involvement Manager

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

Executive Summary
Background This is the sixth formal report on our engagement and involvement activity. The report has been shared and discussed at Quality Delivery Group and Quality and Performance Committee. It has been endorsed by and is recommended to Board by Quality and Performance Committee. Purpose - To present the Engagement and Involvement Annual Review 2025-2026. - The Annual Review will be published to sit alongside our Annual Report and Quality Accounts and is a key part of the Trust Strategy - The review provides a summary, case studies, and activities over the last year, as well as next steps. - The reviews are an important part of our evidence for CQC well-led framework and the NHS 10 Year Plan for community and public engagement.

Key issues to note

- The annual review sets out why engagement and involvement are important to the Trust and how we have worked with local people, community groups, and partners over the last year.
- The review sets out who our local communities are and the challenges of health inequalities across the county.
- Our commitment to engagement is a core element of the Care Quality Commission (CQC)'s well-led domain. We have shared previous annual reviews with CQC as part of the Well-led review.
- The Trust has continued to develop and improve the Community Engagement Tracker, detailing the monthly activity undertaken, themes, and impact.
- The CQC has significantly changed the focus of much of its regulatory framework, with a primary focus on ‘people and communities’ and assessing how NHS organisations involve, engage, and listen to local people in improving services.

Engagement & Involvement Annual Review 2025–26 and Community Engagement Tracker.:

- To present the draft Engagement & Involvement Annual Review 2025–26 and Community Engagement Tracker.
- The Review (sixth annual report) summarises engagement activity, key themes, case studies, and priorities, and will be published alongside the Annual Report and Quality Accounts.
- Demonstrates engagement with local communities and partners, with a focus on health inequalities and seldom-heard groups.
- Provides evidence of ongoing development in capturing insight and impact, aligned to CQC Well-led requirements and emerging NHS England expectations.
- Engagement and involvement are increasingly embedded as core business, aligned to the Patient Experience and Voice strategic priority.
- Continued focus on strengthening impact, insight use, and inclusive engagement to improve outcomes and reduce inequalities

Previously considered by

- Quality delivery Group 9th June 2026
- Improvement & Delivery Team Monthly Meet -10th June 2026
- Quality & Performance Committee 25th June 2026

Recommendations:

The board is asked to:

- **NOTE** the contents of the Engagement & Involvement Annual Review 2025–26, including key achievements, themes, challenges and priorities identified during the reporting period.

• APPROVE the publication of the Engagement & Involvement Annual Review 2025–26 alongside the Trust Annual Report and Quality Accounts. • APPROVE the development of a new joint Patient Experience and Voice strategic plan, aligned to the Trust's refreshed strategic objectives, to replace the existing Engagement & Involvement Strategy (2020–2024). • PROVIDE FEEDBACK AND COMMENTS on the findings of the review and the proposed priorities for 2026–27. • DISCUSS and identify any areas for future development to strengthen engagement, involvement, co-production and community partnership working across the Trust.

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

Impact on any Strategic Risks?
SR10

Implications on:	
Equality, Diversity and Inclusion	Provide evidence of our delivery against statutory duty to engage and involve patients and the public in planning, developing, and changing services, ensuring decisions reflect community needs and reduce health inequalities.
Health Inequalities	Provide evidence of our delivery against statutory duty to engage and involve patients and the public in planning, developing, and

	changing services, ensuring decisions reflect community needs and reduce health inequalities.
Finance and Resource	<i>n/a</i>
Regulation/Legal	Provide evidence of our delivery against statutory duty to engage and involve patients and the public in planning, developing, and changing services, ensuring decisions reflect community needs and reduce health inequalities.
CQC-Key line of enquiry	Provides evidence of ongoing development in capturing insight and impact, aligned to CQC Well-led requirements and emerging NHS England expectations.
Green Plan	<i>n/a</i>

Main Report

1. Purpose

- This report presents the Engagement & Involvement Annual Review 2025–26 and Community Engagement Tracker (Appendix 1).
- The review summarises key engagement and involvement activity, achievements, themes, impact and priorities for future development. It will be published alongside the Trust's Annual Report and Quality Accounts.

2. Background

- Engagement and involvement support the Trust's commitment to delivering person-centred care and ensure that patient, carer and community voices inform service development and decision-making.
- The Trust serves diverse communities with differing needs and experiences. Understanding these perspectives is essential to improving outcomes and reducing health inequalities.

3. Current Position

- Engagement and involvement activity continues to be embedded across the Trust and aligned to the Patient Experience and Voice strategic priority.
- During 2025–26, activity included community outreach, co-production projects, partnership working, targeted engagement with seldom-heard groups and initiatives to improve accessibility and inclusion.
- The Young Influencers Programme has continued to provide valuable opportunities for young people to shape services and contribute to improvement initiatives across the Trust.

4. Key Themes and Emerging Risks

- Key themes from engagement activity include communication, access to services, reducing inequalities, and the importance of involving communities in decision-making.

- Demand for engagement and involvement activity continues to increase, placing pressure on available capacity and resources.
- Strong progress in outreach and partnership working has enhanced engagement with underserved communities and supported work to address health inequalities.
- The Young Influencers programme remains a highly impactful example of meaningful engagement, amplifying youth voice. However, risk to resourcing would impact the Trust's ability to engage effectively with younger people and sustain the programme.
- Further work is required to strengthen the capture, triangulation and use of engagement insight and to improve demographic data quality to better understand and address health inequalities.
- The current Engagement & Involvement Strategy (2020–2024) is out of date and no longer fully reflects the Trust's refreshed strategic priorities.
- There is a growing risk of abuse, antisemitism, islamophobia, racism and other forms of discrimination being experienced within some areas of Gloucestershire and at community events. Community engagement activities are undertaken in accordance with the Trust's Lone Worker Policy, with risk assessments completed and mitigations implemented to ensure the safety and wellbeing of staff, volunteers and participants.

5. Next Steps

Priorities for 2026–27 include:

- Developing a joint Patient Experience and Voice strategic plan, aligned to the Trust Strategy.
- Strengthen co-design and engagement with underserved and seldom-heard communities, while improving the capture, triangulation and use of engagement insight to inform service improvement, decision-making and the reduction of health inequalities.
- Reviewing options to support the sustainability of the Young Influencers Programme.
- Improving the quality and completeness of demographic data.
- Further develop the Community Engagement Tracker and work in partnership with the Trust's Business Intelligence Team to establish a Community Engagement Dashboard, strengthening reporting, impact measurement and organisational insight, while improving visibility of engagement activity, reach, themes, outcomes and impact across the organisation.

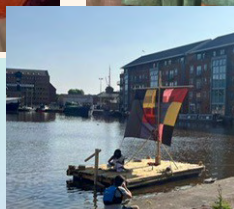
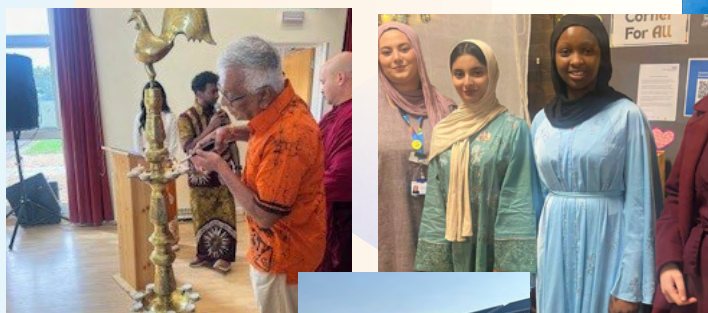
6. Conclusion

- The review demonstrates continued progress in embedding engagement and involvement across the Trust through community outreach, partnership working and co-production.
- The report provides assurance that engagement activity continues to support improved patient experience, reduced inequalities and stronger community partnership working, while identifying key priorities for future development.

Enclosures

Appendix 1: Community Engagement Tracker is provided for assurance and to support the Group's understanding of the scale, reach and impact of community engagement activity undertaken during 2025–26.

FOI: Public,



Engagement and Involvement Review

2025 – 2026

Annual Engagement and Involvement Review 2026 Foreword

As the Young Influencer Group, we're excited to introduce this year's report. Over the past year, we've seen first-hand how much of a difference it makes when young people are involved in shaping health and care, not just talked about, but listened to.

One of the biggest moments for us this year was the Trust signing up to The Power of Youth Charter. For us, this wasn't just a box-ticking exercise. It meant a real commitment to making sure young people, especially those from marginalised and ethnic minority backgrounds, have a voice in decisions that affect them. This matters because these are the groups who often face the biggest barriers to good health. Making space for their voices links directly to the Trust's golden thread of tackling health inequalities, and we're proud to be part of that work.

Being involved in projects across the hospital has shown us how powerful it is when different perspectives come together. Young people notice things adults sometimes miss. We ask questions that challenge assumptions, and we bring experiences that help staff understand what it feels like to use services at our age.

We've met so many brilliant people this year across the hospital and within the community who've shared their ideas and listened to our feedback. These conversations need to continue to help understand what really matters to people, what needs to change and what part we can all play to bring about this change.

We want to say a massive thank you to everyone who's supported us. The Gloucestershire Hospitals Charity has helped us grow, learn, and take on projects we never thought we'd be part of. And to the staff and Governors who've welcomed us in and taken our ideas seriously, thank you.

We're proud of what's been achieved this year, and we're even more excited about what's coming next. Young people have a huge role to play in shaping the future of health and care in Gloucestershire, and we're just getting started.



Executive Summary

“Coming together is a beginning; keeping together is progress; working together is success.”

Vincent Van Gogh

The relationships we continue to build with our communities across Gloucestershire are fundamental to delivering health and care services that are truly patient-centred, equitable and accessible. At Gloucestershire Hospitals NHS Foundation Trust, we believe that meaningful engagement and involvement are not separate from the work we do – they are central to how we listen, learn and improve.

This year, we have strengthened our commitment to ensuring that patient experience and community voice shape everything we do, working closely with patients, carers, colleagues and communities as equal partners in the design and delivery of services. Through these partnerships, we are gaining deeper insight into the diverse needs, experiences and challenges faced by our local population, particularly those who may face barriers to accessing care.

By working collaboratively with community groups, voluntary organisations and system partners, we have been able to develop more inclusive, culturally responsive and impactful approaches to engagement. This has enabled us to improve access to services, build trust, and ensure that the voices of our communities influence real change.

Executive Summary



Juwairiyia Motala

Community Engagement and
Involvement Manager



James Brown

Director of Engagement,
Involvement and
Communications

We are proud of the strong partnerships we continue to build with communities, including those who are often seldom heard. Our collaborative approach has enabled us to reach more people across the county and create more opportunities for individuals to share their experiences in ways that are accessible and meaningful to them. Whether through community events, partnership working, or innovative digital platforms, we are continuing to enhance how people can get involved and influence our work.

Ultimately, our engagement and involvement activity supports the delivery of better care, improved experiences and stronger outcomes. By working in partnership, we can address inequalities, improve health outcomes and create more connected and resilient communities.

As we look ahead, we remain committed to strengthening our relationships with communities and embedding engagement as a core part of how we operate. We will continue to listen, learn and adapt, ensuring that the needs of our population are understood and responded to as they evolve.

We would like to extend our sincere thanks to all individuals, partners and organisations who have contributed to our engagement and involvement work this year. Together, we will continue to ensure that the voices of local people and communities remain at the heart of health and care decision-making in Gloucestershire.

Who we are and what we do

We are an NHS Foundation Trust of over 9,000 staff, providing care for the population of Gloucestershire and neighbouring counties.

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. We also provide Maternity Services at Stroud Maternity Hospital and a range of outpatient clinics and some surgery services from community hospitals throughout Gloucestershire.



GRH

**Gloucestershire
Royal Hospital**



CGH

**Cheltenham
General Hospital**



SMU

**Stroud
Maternity Unit**

Our vision

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

Our vision is simple, we want to:

Deliver the best care every day for everyone

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

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

Our values

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

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

→ **We are Caring**

Always showing kindness and concern for others

→ **We are Compassionate**

Focusing on our relationships with others by listening, respecting and valuing their experiences

→ **We are Inclusive**

Ensuring everyone gets the care and support they need regardless of identity or background

→ **We are Accountable**

Taking personal responsibility for our actions, decisions and behaviours

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

Our commitment to engagement and involvement

Why is engagement and involvement important?

Our colleagues, patients and communities are at the heart of our ambition to deliver the best care for everyone. By actively listening to those who use and care about our services, we can better understand diverse health and care needs and respond accordingly.



What are we doing?

We are committed to embedding engagement and involvement throughout our hospitals.

Our goal is to ensure that the voices of patients, carers, and colleagues are continually heard and that they shape our decision-making process. We strive to make our organisation a great place to work and receive care.

By working together, we can make better decisions, and we will be able to:

- Improve the quality of care and services.
- Improve patient safety.
- Improve colleague and patient experiences.
- Shape services around what local communities tell us matters most to them.
- Attract, recruit, and retain the best staff to the Trust.
- Support and celebrate the diversity of our local community in promoting healthy living.

Community and patient partnerships

At the centre of our approach is a commitment to working alongside patients, carers and communities as equal partners in shaping services.

This reflects a shift towards co-production, where people are actively involved in influencing decisions and developing solutions. Over the past year, we have strengthened partnerships with VCSE organisations, Healthwatch Gloucestershire, faith and cultural groups, system partners and community leaders.

These partnerships enable us to:

- Reach underserved and seldom-heard communities
- Build trust and confidence in services
- Ensure engagement is inclusive and accessible
- Understand barriers to care

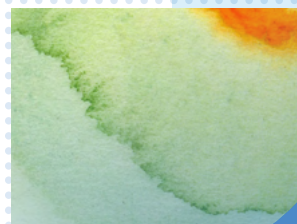
By working with trusted community networks, we are creating more meaningful and effective approaches to engagement.

Our partners

We are committed to working with our partners to deliver the best outcomes for our local communities.

This means playing an active role in the Gloucestershire Integrated Care System (ICS) and formal partnerships with our regional collaboratives and neighbouring NHS Trusts.

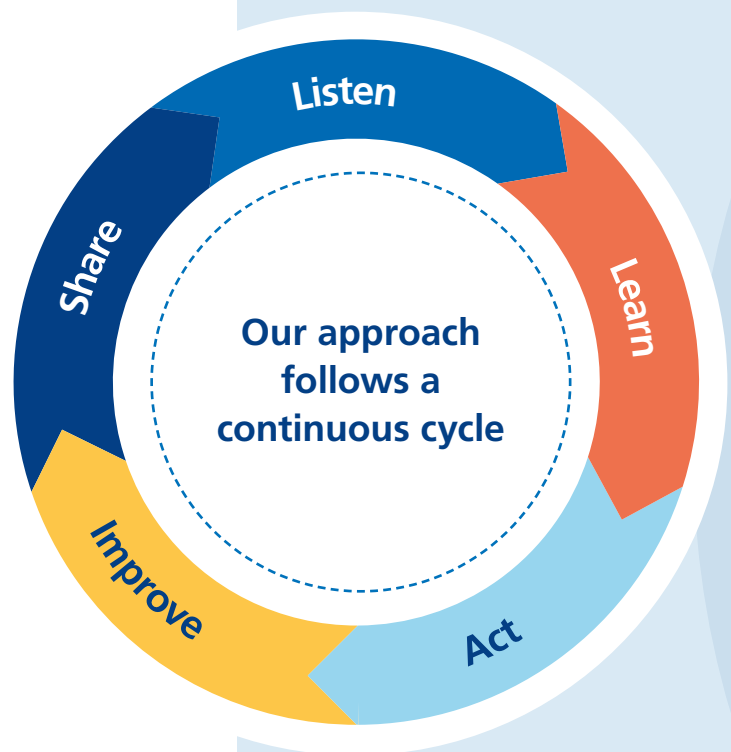
We also work closely with a wide range of diverse community organisations, including Inclusion Gloucestershire, Healthwatch and the VCSE Alliance to ensure we listen and understand the needs of our local population and to ensure we can shape services effectively.



Embedding patient experience and voice

A key principle of our work is that patient experience and community voice shape everything we do.

We have strengthened how feedback is used by embedding engagement into service improvement, using patient stories to inform decision-making, and co-designing services with communities.



This ensures engagement is part of everyday practice, not a one-off activity.

Partnership working plays a key role in addressing health inequalities and improving access to care.

Through collaboration with community organisations, we have engaged underserved groups, delivered targeted outreach, and improved access to culturally appropriate information. This includes work with refugee communities, faith-based initiatives such as Ramadan, and community wellbeing programmes.

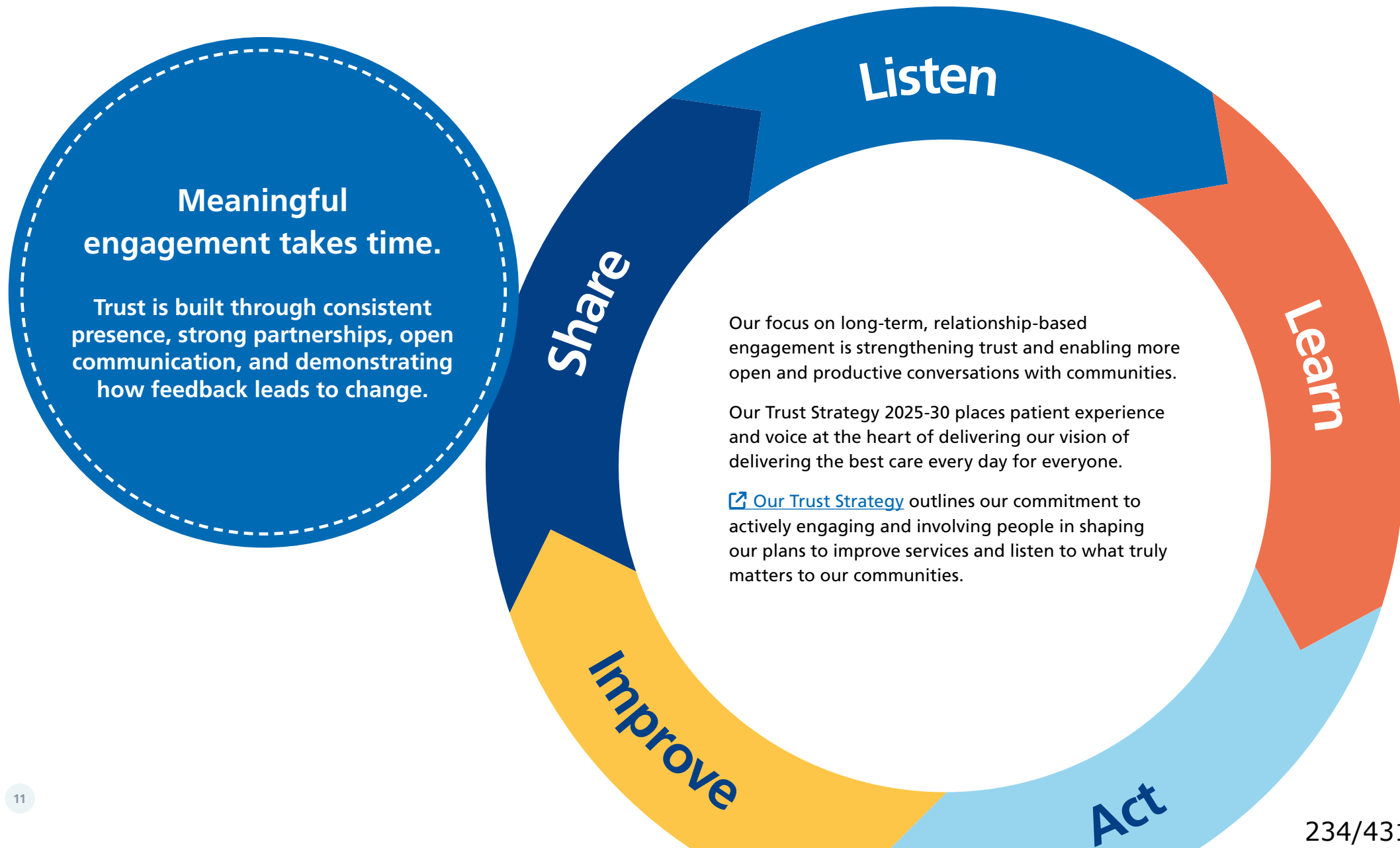
These approaches ensure services are inclusive and reflective of the diverse communities we serve.

We continue to embed co-production across our work, including:

- Partnership work with Mindsong on dementia resources
- Youth-led service improvement through Young Influencers
- Delivery of community health awareness initiatives

Combining clinical expertise with lived experience helps create services that are more effective and sustainable.

Embedding patient experience and voice



An introduction to Gloucestershire

An introduction to Gloucestershire

Gloucestershire is a county of contrasts, combining areas of outstanding natural beauty with communities facing deprivation and rural isolation. From ancient forests and iconic rivers to vibrant towns and villages, these diverse environments shape how people live, access services and experience health and wellbeing.

The county is also increasingly diverse, with over 100 languages spoken across a mix of rural and urban communities. This diversity is reflected within Gloucestershire Hospitals NHS Foundation Trust, where more than 9,000 colleagues from over 795 nationalities bring a wide range of skills, experiences and cultural understanding to the care we provide.

As a key local anchor institution, the Trust recognises its responsibility to work in partnership with communities and organisations across Gloucestershire. By building strong relationships and working collaboratively, we aim to improve health outcomes, reduce inequalities and ensure services are accessible and responsive to local needs.

Through these partnerships, we are better able to understand the communities we serve and deliver care that reflects their needs and experiences.



Gloucestershire Hospitals
NHS Foundation Trust



Our Trust in numbers

£2.3m

Average daily Trust spend



30k

patients admitted to a bed via our EDs per year



537

procedures performed by our 4 robots per year



155k

patients attending our Emergency Departments per year



2.3k

number of research participants per year



120

number of research studies per year



568k

Radiology images and scans per year



36

number of air ambulance arrivals per year



856

number of beds in our hospitals



177k

video and telephone appointments per year



791k

outpatient attendances per year



26k

cancer referrals per year



38

number of organs retrieved for transplants in 2025



3.1m

diagnostic tests per year



660k

population of Gloucestershire, 2023



5.3k

Average births per year



28k

Children seen by the Paediatric team per year



33

number of operating theatres in our hospitals



33k

patients treated in our SDEC units per year



900k

meals prepared for patients and staff



36k

Ambulance attendances per year



1.5m

items of post



33k

planned operations per year



Working with our partners, places and communities

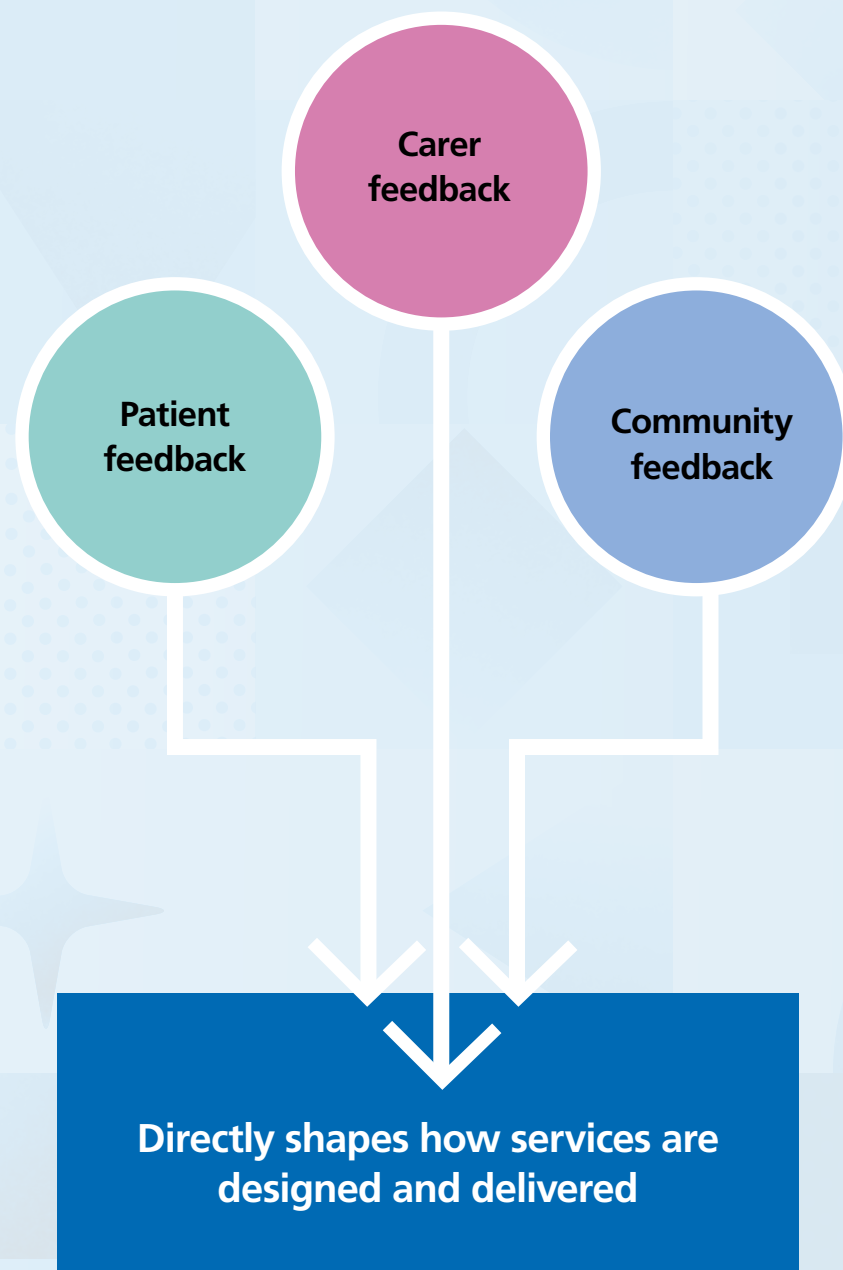
We work closely with partners across the One Gloucestershire Integrated Care System (ICS) to deliver joined-up, person-centred health and care services. This collaborative approach supports the Trust Strategy commitment to working in partnership with patients, carers and communities to shape services and improve outcomes.

Understanding what matters most to our communities is central to delivering the Best Care for Everyone. Gloucestershire has diverse rural, urban and cultural populations, each with different needs and experiences. We are committed to ensuring that patient voice and lived experience inform decision-making, so services remain inclusive, accessible and responsive.

Our partnerships with the Voluntary, Community and Social Enterprise (VCSE) sector, Healthwatch Gloucestershire and wider system partners are essential in helping us reach communities, particularly those who may experience barriers to accessing care.

Through these partnerships, we can:

- Reach underserved and seldom-heard groups
- Build trust and strengthen relationships
- Improve access to services and information
- Develop culturally appropriate and inclusive approaches

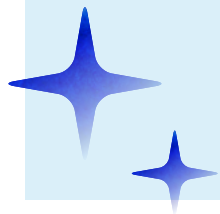


How people get involved

People can contribute in several ways, including:

Governors and Trust Membership	Get Involved platforms	VCSE partnerships and Young Influencers
Feedback channels (FFT, Care Opinion, PALS)	Community events, social media and patient stories	Trust Board and Annual Members Meetings

These opportunities enable a wide range of voices to influence health and care across Gloucestershire.



Strengthening engagement, impact and outcomes

We continue to improve engagement by increasing accessibility and combining digital and face-to-face approaches.

[Our Community Engagement Tracker](#) helps us monitor activity, understand priorities, identify gaps and support evidence-based decisions.

Between April 2025 and March 2026, we engaged over 7000 people through 42 activities, leading to improved access to information and services, increased use of VCSE support, better appointment attendance and stronger community relationships.

We will continue using feedback and data to refine our approach, ensuring services reflect local needs and reduce inequalities.



Case studies

1. Codesigning the Trust Strategy
2. Spotlight on impact: working in partnership with communities – Mindsong Collaboration
3. Strengthening youth voice and leadership (Young Influencers programme)
4. Community volunteers recruited to talk to young people about organ and tissue donation
5. Leadership visibility and community voice
6. 16 days of action against domestic abuse and partnership working
7. Refugee Week 2025 and community partnerships
8. Ramadan engagement and Iftar events
9. Experience-based co-design improvement project – Maternity Triage
10. Diabetes awareness – Jewish community
11. Neonatal and Maternal Mortality Reviews Update

1 Codesigning the Trust Strategy

BRIEF DESCRIPTION

This report summarises engagement and involvement activity delivered during 2024–2025 to support service improvement and delivery of the Trust Strategy (launched November 2025).

Our approach reflects the Trust’s commitment to putting patients, carers and communities at the heart of everything we do, ensuring services are shaped by lived experience and responsive to local need.

Engagement took place across Gloucestershire in hospitals, community settings and online, supporting the strategic ambitions to:

- Deliver “the best care for our people”
- Tackle “inequalities and improve access”
- Strengthen “partnership working with our communities”

We also worked proactively with community partners to ensure engagement was inclusive, representative and accessible.

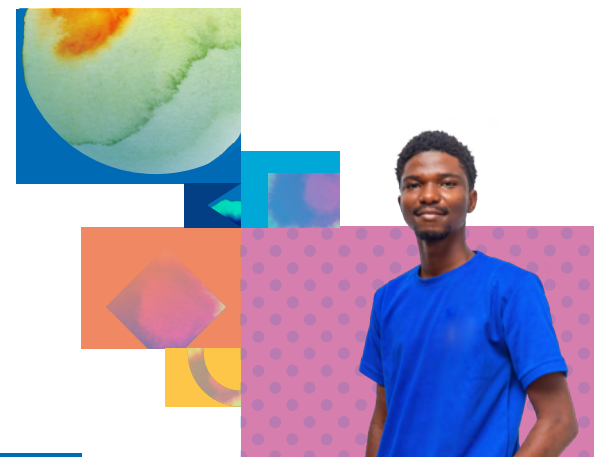
Who did we speak to?

We spoke to over 2000 people and diverse range of people, including:

- Patients, families and carers with recent experience of our services
- Members of the public across Gloucestershire
- Community and voluntary sector organisations
- Young people, including our Young Influencers group
- People from underserved and seldom-heard communities
- Trust staff and clinical teams
- System partners across health and care

In line with the Trust Strategy priority to ‘reduce health inequalities’, we prioritised engagement with people who:

- Experience barriers to accessing care
- Have poorer health outcomes
- Are less likely to engage through traditional methods
- Bring lived experience of specific services



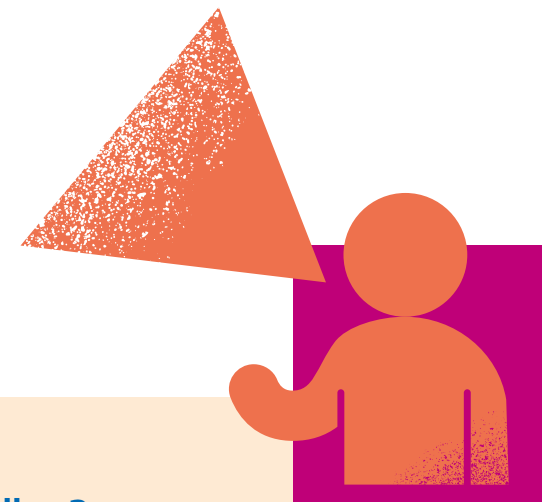
1 Codesigning the Trust Strategy

What and how did we ask?

We used a wide range of engagement methods to ensure people could share their views in ways that worked for them:

- Community outreach and listening events
- Surveys (online and paper-based)
- Focus groups and co-design workshops
- Online engagement platforms and forums
- Social media activity, including Facebook Live sessions
- Partnership-led engagement through voluntary and community organisations
- Targeted work with specific groups (e.g. young people, culturally diverse communities)

This approach supports the Trust's ambition to "improve access, experience and participation".



What did people tell us?

Across engagement activity, people told us that:

- Communication about services is not always clear or easy to understand
- They want to feel "listened to, respected and involved" in decisions about their care
- Waiting times and access to services remain a key concern
- Services can feel fragmented and difficult to navigate
- Care should be more "culturally appropriate and inclusive"
- Digital services are helpful, but alternatives must remain available

1 Codesigning the Trust Strategy

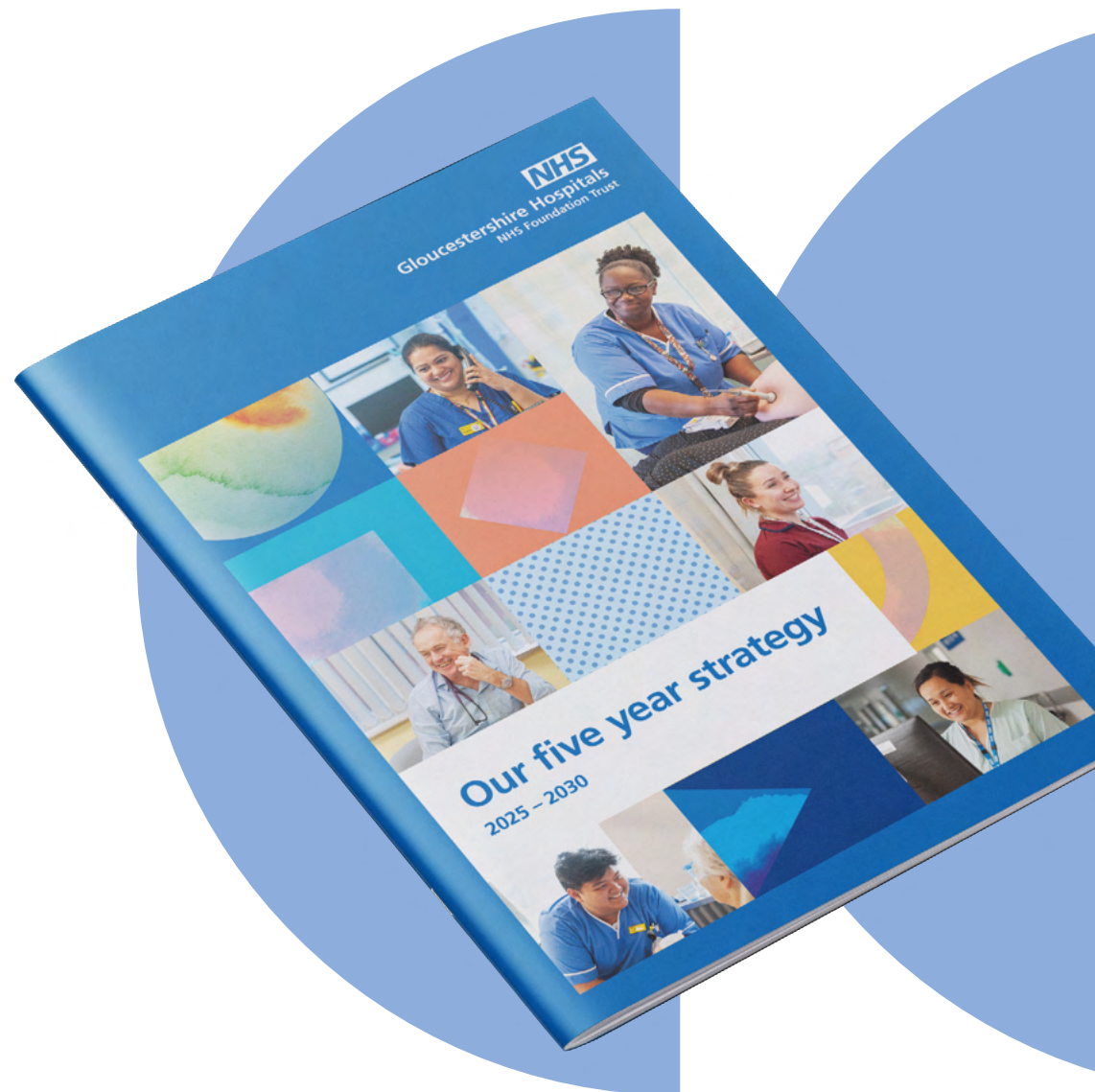


What did people tell us mattered most to them?

Key themes that mattered most to people included:

- Person-centred care – being treated as individuals
- Equity of access – fair access regardless of background
- Continuity and coordination of care
- Clear, timely communication
- Trust and transparency
- Opportunities to influence services and see change happen**

These priorities directly support delivery of the Trust Strategy commitments to quality, inclusion and partnership.



1 Codesigning the Trust Strategy

What did we do?

To respond to what we heard, we:

- Embedded “co-production approaches” in key programmes and service redesign
- Strengthened relationships with community and voluntary sector partners
- Improved the clarity and accessibility of patient information
- Increased targeted outreach to underserved groups
- Expanded digital engagement while maintaining inclusive offline options
- Supported staff to build confidence and capability in engagement and inclusion

As a result of this work:

- Service improvements have been shaped by patient and community insight
- Engagement has reached a broader and more diverse audience
- Changes have been made to improve access, communication and experience
- Feedback is increasingly influencing decision-making and service design
- Engagement and involvement are becoming embedded as ****core business****

Further information is available at:

You can access the full strategy:

[🔗](#) GHNHSFT Strategy 2025–2030 and a supporting summary version.

You can also explore the Strategic Framework in the one-page snapshot of our vision, values, and priorities: [Strategic Framework](#)

2 Spotlight on impact: working in partnership with communities – Mindsong Collaboration

BRIEF DESCRIPTION

This year has seen a significant strengthening of our partnership with Mindsong and local communities. Mindsong is a Gloucestershire charity that specialises in providing music-based services for people with a dementia and their families. Several of these services are commissioned and funded by the ICB, recognising that music and sound are some of the most powerful tools in dementia care. Music offers a stimulus to the brain which is like no other and helps people to stay connected with memories and life experiences, as well as with family, community, faith and culture.

Building on the success of Sounds of the Soul (co-created with the South Asian Muslim community in 2025), we expanded this approach by working closely with the Hindu community in Cheltenham and Gloucester to develop the Sangeet Memory Box—a culturally meaningful resource rooted in music, memory and lived experience.

This work reflects the importance of sustained, relationship-based engagement, where community insight directly informs care and service development.

Who did we speak to?

We worked closely with:

- People living with dementia and their families
- Members of the South Asian Muslim and Hindu communities
- Community leaders and groups
- Mindsong
- Adult Social Care and Memory Teams at Gloucestershire Health and Care NHS Foundation Trust

Audience and why them?

We focused on culturally diverse communities who may experience barriers to accessing dementia support.

This approach ensured that services and resources are inclusive, culturally relevant and shaped by lived experience, aligning with the Trust's commitment to reducing health inequalities and improving access.

2 Spotlight on impact: working in partnership with communities – Mindsong Collaboration

What and how did we ask?

Engagement was relationship-based and ongoing.

We:

- Visited community settings regularly
- Held informal conversations with families and community members
- Listened to personal stories and experiences of dementia
- Explored the cultural significance of music, memory and storytelling



What did people tell us?

- People shared that music plays a powerful role in:
- Unlocking long-term memories
- Evoking emotion and identity
- Strengthening connections with family and culture

They highlighted the importance of dementia support that reflects their cultural beliefs, traditions and lived experiences.

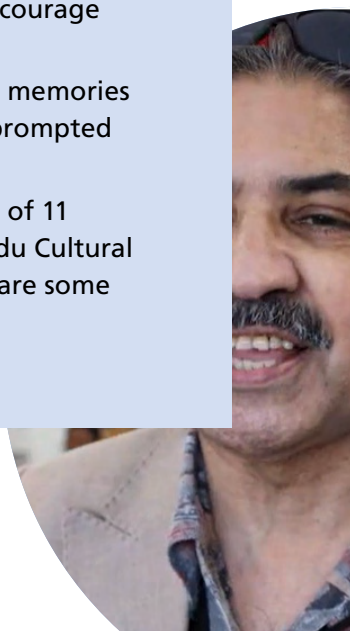
- What did people tell us mattered most to them?
- Feeling understood and represented in services
- Maintaining identity, culture and memory
- Supporting family connections across generations
- Access to culturally meaningful resources



2 Spotlight on impact: working in partnership with communities – Mindsong Collaboration

What did we do?

- Working as a team with Mindsong and Adult Social Care, we made regular visits to the Hindu Elders and Carers Support group in Cheltenham.
- We invited them to share with us their favourite music. Listening together as a group, we used online streaming platforms to identify the most important and significant tracks for this group of people, based on their memories and life experiences. We also invited them to share in music-making with simple instruments and singing culturally familiar songs together to encourage interaction, spontaneity and self-expression.
- We supported free-ranging discussions, shared memories and documented people's stories which were prompted by the music.
- Together with the group we created a shortlist of 11 tracks. We then consulted members of the Hindu Cultural Association in Gloucester who were keen to share some further choices with us.



2 Spotlight on impact: working in partnership with communities – Mindsong Collaboration

This work demonstrates how partnership working between the NHS, communities and voluntary organisations can create more inclusive, compassionate and effective services.

As a result of this work:

- Co-created the Sangeet Memory Box – an online resource for people of Hindu background and culture containing links to 17 tracks including devotional music, Bollywood soundtracks and meditative chants.
- Developed a culturally meaningful resource tailored to community needs
- Strengthened inclusive dementia care pathways
- Improved engagement with diverse communities
- Supported individuals and families through creative, person-centred approaches

Find out more here:

Sangeet Memory Box:

www.mindsong.org.uk/sangeet-memory-box/

Find out more:

www.mindsong.org.uk/sangeet-memory-box/

Listen here:

www.bbc.co.uk/programmes/p001z6bm

3 Strengthening youth voice and leadership (Young Influencers programme)

BRIEF DESCRIPTION

The Trust Young Influencers programme creates a dedicated space for young people aged 14–22 to shape the Trust’s work and ensure their perspectives genuinely inform our decisions. Meeting monthly, either in person or online, the group has continued to grow in both size and strength over the past year. Together, members share insights that help strengthen services across the Trust and work with partner organisations to build connections and extend the Trust’s reach within the wider community.



Who did we speak to?

The Young Influencers spent the last year building strong connections across the community and within the Trust.

They engaged with children and families at the Refugee Week Picnic in Gloucester in June 2025, where they acted as a welcoming presence, as well as at the No Child Left Behind event in Cheltenham in August 2025, where they gave out over 200 glitter tattoos and gathered questions from the community about working in the hospital. They enabled local primary school pupils to share handwritten thank you messages with hospital staff, strengthening morale and celebrating their dedication, alongside connecting with hundreds of staff, patients, and visitors, inviting them to add their fingerprint to a lion sculpture as part of the Cheltenham and Gloucester Hospital Charities Lions at Large fundraising project. The finished sculpture now stands in the Children’s Ward as a symbol of everyone connected to the hospital and the community the Trust serves.

3 Strengthening youth voice and leadership (Young Influencers programme)

What and how did we ask?

- Young Influencers focus on sharing their own opinions and experiences as well as inviting honest feedback from peers to help shape services across the Trust. At community events, they asked children, families, and young people about their questions or worries about coming to the hospital, and what would help them feel more confident during their visit. They ask this through surveys or face-to-face discussions.
- Inside the Trust, they asked hospital teams what support they needed from young people to improve resources, environments, and communication tools. They explored how information for young patients could be clearer and how spaces could feel more welcoming.



What did people tell us?

Young Influencer members told us they take part because they recognise the difference their voices can make when they are genuinely listened to. They feel proud to represent the Trust and value having a space where they can speak openly, share honest views, and know their contributions are taken seriously.



3 Strengthening youth voice and leadership (Young Influencers programme)

What did we do?

- Over the past year, the Young Influencers have continued to play an active role in shaping services across the Trust by responding to feedback requests from a wide range of hospital teams. They contributed to artwork design for new adult changing spaces at Cheltenham Hospital and Gloucestershire Royal Hospital, reviewed workbooks for young people with diabetes, provided input on handbooks for young carers, and, alongside the Patient Experience Team, took part in a PLACE review of the Children's Ward. Their digital filming project in the Children's Ward also continued to grow, producing new videos that explain food options, show bedspaces, and introduce the playroom to help young people feel more at ease.
- This year also saw the development of the group's Celebrating Languages project. With the support of the hospital charity, the Young Influencers helped introduce a badge-making initiative that produces "Hello" badges for staff who speak additional languages. These badges celebrate the many languages represented within the Trust and make it easier for staff, patients, and visitors to identify colleagues who share a common language, helping people feel welcomed, understood, and supported.
- Beyond the hospital, members represented the hospital and two youth empowerment events as part of the Trust's commitment to the Power of Youth Charter, attended a Gloucester County Council feedback session exploring how outdoor spaces can support public health, and participated in the winter flu campaign to promote vaccination among young care workers. This year also marked the launch of the first Young Influencers School Hub, an important step towards creating a network of hubs within Secondary Schools that will enable many more young people to share their views and influence decision-making across the Trust.
- We also held our first annual Young Influencers Award and Recognition Event, bringing together friends, family, and hospital staff to celebrate their achievements and thank them for their dedication to improving services for the community.



4 Community volunteers recruited to talk to young people about organ and tissue donation

BRIEF DESCRIPTION

We recruited 19 volunteers from across Gloucestershire who will be visiting schools to talk about their experiences of organ and tissue donation.

In January 2026 the Trust sought help from the local community to find patients, families and members of the public with lived experience to engage with young people and raise awareness about the lifesaving gift of organ and tissue donation.

There are 8,000 people waiting for a transplant across the United Kingdom and one person dies every day because they did not get the transplant they so badly needed.

Who did we speak to and why?

Double transplant recipient Adrian Heeley has already delivered a presentation to year 10 students at Balcarras School, Cheltenham alongside Clinical Lead for Organ Donation, Marcin Pachucki and Chair of the Organ Donation Committee, Ian Mean.

It is hoped that young people will have conversations about organ donation with their families and confirm their decision on the Organ Donor Register.



4 Community volunteers recruited to talk to young people about organ and tissue donation

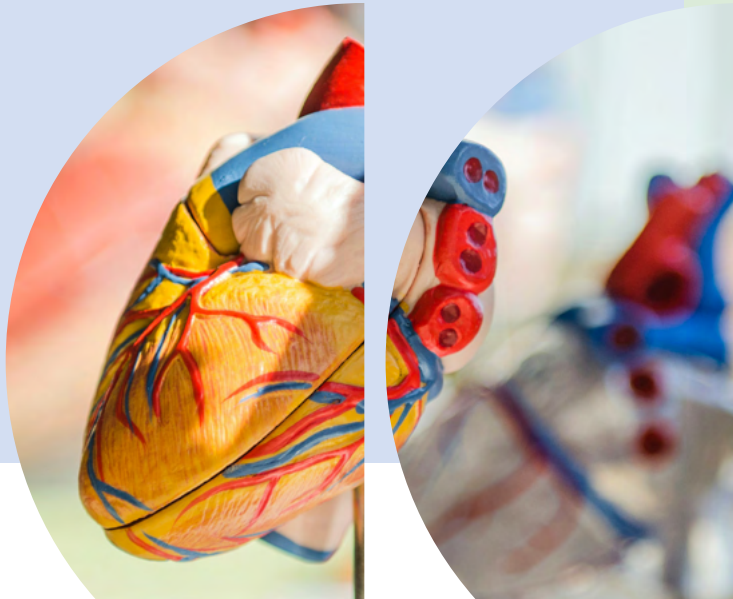


What did we do?

- The volunteers participated in a welcome meeting at Gloucestershire Royal Hospital in February 2026. Members of the Organ Donation Committee listened as each volunteer shared their experience.
- Volunteers will form a special sub-committee supporting the Trust in raising awareness in schools, community groups and at public events, encouraging conversations about organ donation and promoting the gift of life.

Feedback from members highlights the importance of being genuinely heard:

- Young people told us they value having a space where their voices matter and where they can influence real change across the Trust.
- This work demonstrates our commitment to building youth-informed services and empowering the next generation of community leaders.



5 Leadership visibility and community voice

BRIEF DESCRIPTION

As part of strengthening transparency and connection with our communities, the Trust has also begun developing new ways to share engagement work more openly.

This includes a Community Engagement Vlog featuring the Trust CEO, showcasing real conversations with communities, highlighting lived experiences, and demonstrating how feedback directly informs decision-making.

This approach supports greater visibility, accountability and trust between the Trust and the populations we serve.

Across all areas of work, a consistent theme has emerged: strong partnerships, authentic listening, and co-creation with communities lead to better outcomes.

Whether through culturally responsive dementia support, youth-led service improvement, or strengthened VCSE collaboration, our engagement work continues to ensure that services are shaped by the people who use them.



“By working alongside local communities and partners, we are creating services that are inclusive, meaningful and rooted in real human connection.”

6 16 days of action against domestic abuse and partnership working

BRIEF DESCRIPTION

As part of the 16 Days of Action Against Domestic Abuse, we worked collaboratively with partners across Gloucestershire through the newly formed Local Engagement Against Domestic Abuse (LEAD) network.

A coordinated programme of events created space for open, community-led conversations, helping to raise awareness and explore the realities of domestic abuse across different communities. This work highlighted the importance of partnership approaches in understanding both visible and hidden barriers to support, particularly where culture, family, and lived experience intersect.



Who did we speak to and why?

We engaged with victims and survivors, migrant and minority ethnic communities, faith groups, frontline professionals, and partner organisations.

This inclusive engagement enabled us to hear directly from those with lived experience, while also capturing insights from those supporting individuals across health, community, and specialist domestic abuse services.

“Victims like myself who face multiple barriers are not seen or heard.”

6 16 days of action against domestic abuse and partnership working

What and how did we ask?

Engagement took place through:

- Community conversations and listening opportunities during the 16 Days of Action
- Partnership events and workshops
- Informal discussions within trusted community settings
- Learning from the Domestic Abuse Needs Assessment
- The programme of activity created multiple entry points for discussion, enabling people to speak openly in ways that felt safe and accessible.



What did people tell us?

Participants consistently shared that disclosing domestic abuse is complex and deeply personal. Feelings of shame, fear, and judgement can prevent people from seeking support, regardless of background.

For some communities, these experiences are further layered by stigma, family expectations, and uncertainty about services, making disclosure even more difficult.

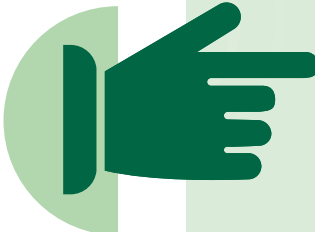
“Silence becomes survival.”

“It can be difficult to know who to confidentially speak to within your own community.”

There was also a strong message that abuse is often misunderstood, normalised, or hidden, which can delay recognition and access to support.



6 16 days of action against domestic abuse and partnership working



What did people tell us **mattered most to them?**

- Feeling safe, believed, and not judged when speaking up
- Access to clear, culturally relevant information
- Trust in services and confidence in confidentiality
- Support that understands family and community dynamics without excusing harm
- Having choice and control over decisions

“To be believed without judgement.”

“Leaving abuse is not just leaving a person — it can mean losing your entire world.”

“Small moments of understanding from professionals can change outcomes.”



6 16 days of action against domestic abuse and partnership working

What did we do?

Through partnership working, we:

- Created safe, inclusive spaces for conversations about domestic abuse
- Shared accessible, culturally informed information
- Strengthened relationships between health services, community organisations, and specialist providers
- Promoted trauma-informed and culturally aware approaches
- Used insights to better understand how trust is built when people access services
- This work also reinforced the importance of listening to lived experience to challenge assumptions and shape more effective responses.

As a result of this work:

- Strengthened partnership working and shared understanding across sectors
- Identified gaps in awareness, access, and service provision
- Improved understanding of how victims experience and navigate support systems
- Increased visibility of available services within communities
- Recognised how crucial and fragile trust is for those seeking help

This ongoing partnership has provided a stronger foundation for future work, ensuring that services continue to be shaped by community insight and lived experience. It also reinforced the importance of working with communities to build trust and improve access, rather than relying on traditional approaches alone.

7 Refugee Week 2025 and community partnerships

BRIEF DESCRIPTION

Refugee Week 2025 in Gloucester was a vibrant, cross-sector programme celebrating inclusion, belonging, and the city's identity as a place of sanctuary. Delivered in partnership with Gloucester Guildhall, the City Council, NHS partners, and grassroots organisations, the programme combined arts, culture, and health to support refugee and asylum-seeking communities.

Gloucester's work was nationally recognised through Stories of Change, with the city highlighted as one of only three locations across the UK for its innovative, community-led approach and impact. The programme demonstrated how a city can come together to create a shared sense of belonging and pride.

"Through Refugee Week, Gloucester has found a new story: as a port of welcome and a place of diversity in which all cultures are celebrated."

Who did we speak to and why?

We engaged with refugees, asylum seekers, migrant communities, local residents, young people, volunteers, artists, and partner organisations including GARAS, ESOL providers, and community networks.

This broad engagement ensured we heard both lived experiences and wider community perspectives, strengthening mutual understanding and shared ownership.

"Personally, I feel heard...
it allowed me to grow."

Community participant / artist



7 Refugee Week 2025 and community partnerships

What and how did we ask?

Engagement took place through creative and accessible approaches, including:

- NHS Listening Benches in community settings
- Informal conversations during events and activities
- Large-scale events such as the Celebration of Belonging Picnic
- Arts-based engagement, including the Moonlit Arrival installation
- Workshops, volunteering, and school sessions
- These approaches created safe, welcoming spaces where people could connect and share their experiences naturally.



“Sometimes the simplest methods are the best... it became a place where people could connect.”

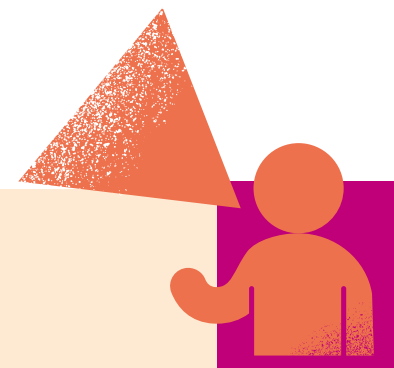
What did people tell us?

Participants shared that navigating healthcare, and wider support systems can be complex and overwhelming, particularly for those new to the UK. Experiences of isolation and uncertainty were common.

However, people consistently described the positive impact of coming together through Refugee Week activities — creating opportunities for connection, visibility, and shared understanding.

“It was wonderful to witness... there was a space for everyone.”
– NHS Young Influencer

“Hearing ‘hello’ in so many different languages was awe-inspiring.”



7 Refugee Week 2025 and community partnerships

What did people tell us mattered most to them?

- Feeling welcomed, safe, and valued
- Opportunities to connect across cultures
- Accessible, culturally relevant health information
- Being included and able to contribute
- Removing barriers such as cost and accessibility

"To be completely inclusive there needed to be no barriers to the gathering."

"It's a reminder that we are never truly alone, and we are all far more alike than we think."

What did we do?

We worked collaboratively with partners to:

- Deliver culturally appropriate health information in trusted spaces
- Embed NHS engagement within community-led events
- Support trauma-informed training and approaches
- Enable refugees and asylum seekers to actively participate in volunteering and delivery
- Contribute to creative and cultural activities that supported wellbeing and storytelling

"This year showed us what's possible when we listen, build relationships and work with people rather than simply doing things for them."



7 Refugee Week 2025 and community partnerships

“What began...
has evolved into
a vibrant, year-
round ecosystem”

Refugee Week National Producer

“Everyone coming
together as a whole
community has never
happened before
in Gloucester. But
through Refugee
Week, we did.”

As a result of this work:

- Strengthened partnerships across sectors
- Built trust with communities who may previously have felt excluded
- Increased awareness and understanding of NHS services
- Shifted approaches towards genuine co-production
- Contributed to a wider cultural shift in Gloucester as a welcoming and inclusive city

The programme also supported increased volunteering from refugee communities, stronger community connections, and a more coordinated response to challenges.

Find out more here:

[🔗 Stories for change](#)

8 Ramadan engagement and Iftar events

BRIEF DESCRIPTION

Creating inclusive spaces for Muslim staff and raising awareness across the Trust.

Who did we speak to?

Muslim colleagues and wider staff community.

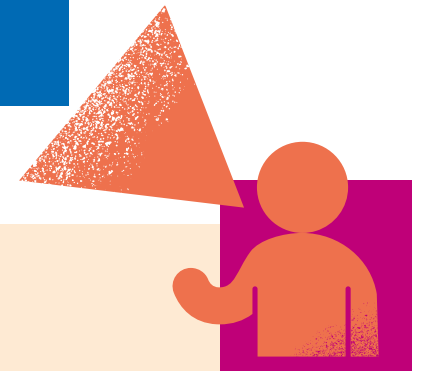
What and how did we ask?

→ Informal engagement through drop-in sessions and shared spaces.



What did people tell us?

→ Inclusive environments improve connection and understanding.



8 Ramadan engagement and Iftar events



What did we do?

- Introduced Ramadan spaces across hospital sites.
- What did we do as a result?
- Strengthened inclusion and staff wellbeing.

What did people tell us mattered most to them?

- Feeling supported at work
- Cultural awareness



9

Experience-based co-design improvement project – Maternity Triage

BRIEF DESCRIPTION

Feedback from the Friends and Family Test (FFT) identified Maternity Triage as an area where improvements would enhance patient experience. In response, an Experience Based Co-Design (EBCD) approach was initiated in September 2025.

The project brings together patients, partners, staff, and community stakeholders to collaboratively design improvements to the service over a 12-month period. This approach focuses on understanding lived experiences and using these insights to shape meaningful, sustainable change across the service.



Who did we speak to and why?

We engaged with:

- Women accessing Maternity Triage and their partners
- Patients, carers, and relatives
- Maternity staff, including the Triage team and Matron
- Community groups and representatives from the Maternity and Neonatal Voices Partnership (MNVP) and Gloucestershire Maternity Action Group (GMAG)
- Internal teams including Digital and Health Inequalities
- This wide-ranging engagement ensured that both lived experience and staff perspectives informed the development of improvements.

9 Experience-based co-design improvement project – Maternity Triage

What and how did we ask?

A range of engagement methods were used to gather insight, including:

- Direct observations and conversations within the Triage environment
- In-depth interviews with patients and staff
- Staff engagement activities and department-based feedback exercises
- Community engagement events and attendance at local groups
- A joint co-design workshop bringing together patients, community representatives, and staff
- Use of video and audio, including patient experience films and staff experience clips
- These approaches enabled people to share their experiences in different ways, creating a rich and detailed understanding of the service.

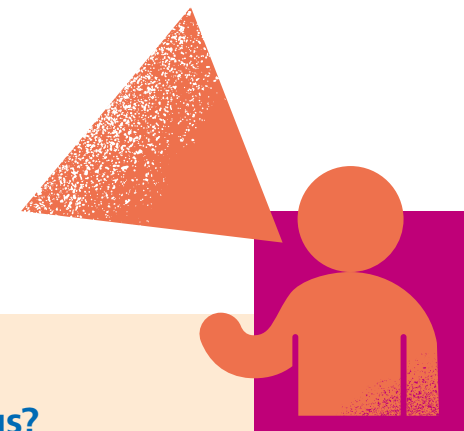


What did people tell us?

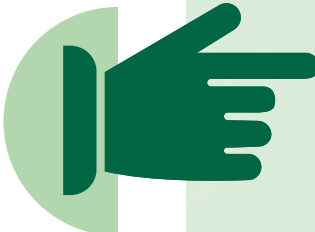
Participants shared both positive and challenging experiences of Maternity Triage. While many valued the care provided, they highlighted inconsistencies in communication, long waiting times, and environmental challenges within the unit.

Patients described uncertainty about what to expect and difficulties accessing or navigating the service, particularly at night. Staff highlighted pressures linked to staffing levels, space constraints, and changes in clinical processes which can impact waiting times.

There was also a shared recognition that experiences can feel overwhelming, particularly when people are anxious or in unfamiliar surroundings, making clear communication and reassurance essential.

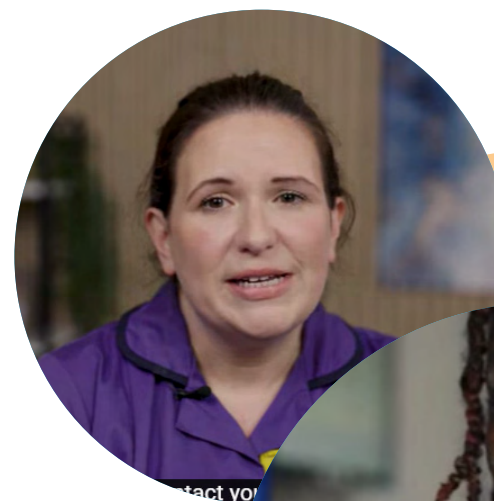


9 Experience-based co-design improvement project – Maternity Triage



What did people tell us mattered most to them?

- Clear and consistent communication about what to expect and waiting times
- Feeling safe, reassured, and supported throughout their visit
- Understanding their care plan and next steps
- A comfortable, accessible, and well-designed environment
- Visible, approachable staff and opportunities to ask questions
- Participants also valued opportunities to work directly with staff to shape improvements, highlighting the importance of being listened to and involved.



9 Experience-based co-design improvement project – Maternity Triage

What did we do?

Working collaboratively with stakeholders, we have:

- Developed a patient information film: “Welcoming you to Maternity Triage, Your Care, Our Priority”, to support understanding before attending
- Introduced colour-coded triage cards to clearly communicate urgency, care plans, and expected waiting times, translated into the five most commonly spoken languages
- Recruited and embedded volunteers within the Triage environment to provide additional support and reassurance
- Improved signage and information within waiting areas, including practical information about facilities
- Held a joint co-design workshop, identifying three priority themes:
 - Staffing and Training
 - Environment
 - Communication
- Begun environmental improvements, with plans to continue co-design with community representatives
- Strengthened relationships and communication channels with MNVP, GMAG, and community partners

As a result of this work:

- Established a strong foundation for ongoing co-design and continuous improvement
- Improved patient understanding and experience through clearer information and communication tools
- Enhanced support within the Triage environment through volunteer involvement
- Built stronger, more collaborative relationships between staff and the community
- Identified clear priority areas for improvement, with work now progressing across all themes

Importantly, this work has helped to rebuild trust and create open, constructive dialogue between services and the communities they serve. Patients and partners reported valuing the opportunity to work alongside staff and contribute to shaping the future of the service.

Find out more here:

[🔗 Maternity Triage Film](#)

10 Diabetes awareness – Jewish community

BRIEF DESCRIPTION

A targeted health education session supporting diabetes awareness.

Who did we speak to?

Members of the Jewish community.

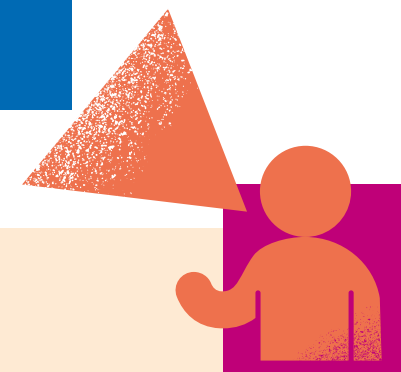
What and how did we ask?

- Interactive education session with healthcare professionals.

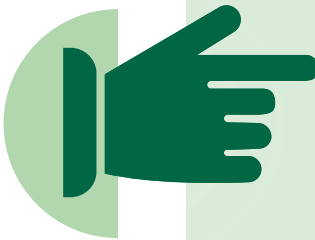


What did people tell us?

- There is a need for culturally tailored health information.



10 Diabetes awareness – Jewish community



What did people tell us mattered most to them?

- Early detection
- Practical lifestyle advice

What did we do?

- Delivered culturally appropriate education.

What did we do as a result?

- Improved awareness and strengthened community relationships.

"A Jewish lady, who could not attend the session on Breast Cancer Awareness for Jewish people, was however, prompted to arrange a breast screening for herself since it had been too long since her last investigation. She had the test and was, to her surprise, recalled. She has a treatable lesion. If left for any longer than that, she was told, it would not be the case.

Keep up the good work!

Best wishes

Jenny"



11

Neonatal and Maternal Mortality Reviews (September 2025)

BRIEF DESCRIPTION

Maternity services at the Trust have undergone significant scrutiny in recent years, including CQC inspections (2022 and 2024) and a BBC Panorama programme (January 2024), highlighting concerns around care and patient experience.

In response, and to ensure continuous improvement, the Trust commissioned two independent reviews of maternal (2017–2023) and neonatal deaths (2020–2023). As part of our commitment to openness and transparency, we engaged bereaved families ahead of the public release of the reports.

Who did we speak to and why?

We engaged with:

- Bereaved families of seven maternal deaths and 44 neonatal deaths were included in the reviews
- Maternity and neonatal clinical teams are involved in supporting engagement

11 Neonatal and Maternal Mortality Reviews (September 2025)

What and how did we ask?

A range of engagement methods were used to gather insight, including:

- Families were contacted via a written letter from the Chief of Service, carefully chosen as the least distressing method.
- Letters explained the reviews, the possibility of media coverage, and invited families to make contact at a time of their choosing
- Contact details were provided for the Maternity and Neonatal Independent Senior Advocate for independent, confidential support
- Information was made accessible through translated letters and reports, and FAQs in the top 10 languages

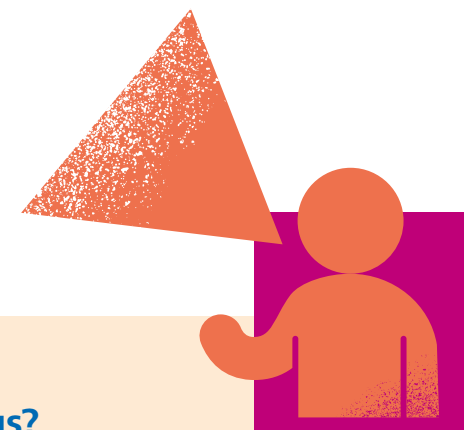


What did people tell us?

Families fed back that, although difficult, receiving a letter was preferable to an unexpected phone call.

Some families chose to engage in further discussion with clinical teams, while others did not wish for additional contact.

Staff found the process challenging, but valued the importance of openness and ensuring families were informed and supported.



11

Neonatal and Maternal Mortality Reviews (September 2025)

What did we do?

- Adopted a trauma-informed approach, giving families choice and control over engagement
- Sent letters by recorded delivery and followed up sensitively where appropriate
- Provided options for families to opt out of further contact
- Ensured accessibility through translation and inclusive communication approaches
- Published review findings and recommendations on the Trust's website
- Developed and shared frequently asked questions (FAQs) to support wider understanding following media coverage

Find out more here:

[🔗 Neonatal and Maternal Mortality Reports: September 2025](#)

[🔗 Neonatal and Maternal Mortality reviews: Frequently Asked Questions \(FAQs\)](#)

How we work with communities throughout the year

How we work with communities throughout the year

Our approach to Engagement and Involvement is continuous, relationship-driven, and built on trust. Rather than one-off activities, our work follows a year-round cycle of engagement, involvement, co-production, and learning, ensuring that community insight directly informs service development and delivery.

We organise our work into four interconnected pillars that demonstrate how engagement happens in practice and how impact is achieved over time.

Community engagement: reaching people where they are

We proactively meet communities in familiar and accessible settings, ensuring health information, prevention messages and NHS services are visible and inclusive.

This includes attending community events, outreach via the NHS Bus, and working alongside partners to promote health awareness and early intervention.

Examples include:

- Cultural and community celebrations such as the Sri Lankan New Year, the Polish Heritage Day, the Philippines Day and the Jamaica Day
- Community-based health promotion and awareness activities
- Multi-agency outreach events with system partners

Impact:

- This approach helps us build trust, improve access to health information, and reach communities who may not traditionally engage with health services.

Involving communities: listening, co-design and shared decision-making

We create structured opportunities for communities to influence decision-making, ensuring their voices shape services, environments and future priorities.

Key examples include:

- ICS and VCSE Partnership Development – contributing to system-wide mapping and co-design of a more equitable and sustainable VCSE infrastructure
- Communities Against Cancer Grants Panel – supporting co-designed approaches to early diagnosis and reducing inequalities
- Cinderford Community Mapping (Active Gloucestershire) – working with residents to co-design place-based health and wellbeing solutions
- Patient and Carer Race Equality Framework (PCREF) – co-producing anti-racist approaches and shared language for equity in care
- Health Research Engagement – ensuring diverse communities are represented in research (e.g. SAMS Men's Group, Reflective Futures)

Community education and prevention: sharing knowledge and building confidence

We deliver targeted health education and awareness sessions directly within communities, focusing on prevention, early intervention and improving health literacy.

Activities include:

- Health education sessions in community settings (e.g. mosques, schools, community groups, and cultural organisations)
- Themed health events such as NHS Health Information Days and Community Maternity Events
- Targeted sessions on cancer awareness, screening and diagnostic pathways
- Wellbeing activities such as walking groups, community cafés and outdoor engagement sessions

Impact:

- Communities are better informed, more confident in accessing services, and empowered to make healthier choices.

Partnership working: building strong, lasting relationships

Partnership working underpins all engagement activity and enables us to deliver inclusive, culturally responsive and sustainable initiatives.

We work closely with:

- VCSE organisations and community leaders
- Local authorities, Adult Social Care and public health teams
- NHS system partners and charities
- Key examples include:
- Refugee Week activities (e.g. Listening Bench, Moomins Picnic, Welcome Chorus)
- GARAS partnership supporting refugees and resettled families
- Mindsong collaboration (e.g. Sangeet Memory Box)
- 16 Days of Action against Domestic Abuse – multi-agency awareness and support initiatives
- Windrush and cultural heritage events promoting belonging and identity
- Ramadan/Iftar, International Women's Day and other inclusive community events

Impact:

- Strong partnerships enable deeper reach, culturally appropriate engagement, and long-term trust with diverse communities.

Bringing it all together: a continuous cycle of engagement

Across the year, these four pillars work together as a continuous cycle:

Engage → Involve → Co-Create → Learn → Improve

- We engage communities through outreach and presence
- We involve them in meaningful conversations and decision-making
- We co-create solutions alongside partners
- We learn from lived experience and insight
- We improve services and feed learning back into practice
- This approach ensures that engagement is not a standalone activity, but a core part of how the Trust listens, learns and evolves.

Overall impact

Through this structured and relationship-based approach, we:

- Each a wide range of communities across Gloucestershire
- Strengthen trust and long-term relationships
- Amplify seldom-heard voices
- Support culturally responsive and inclusive care
- Ensure community insight drives real service change.

Other ways we involve and engage

Over the last year, we have continued to strengthen and develop the range of ways we are able to engage and work with local people and colleagues. As an NHS organisation, we also have several established approaches to ensure the voice of local communities is represented, and we publish this on our website and through our social media:

www.gloshospitals.nhs.uk/about-us/get-involved

We have continued to build our connections with our NHS and voluntary partners across Gloucestershire. There is a clear benefit to local people in health and social care working together on engagement and involvement opportunities, helping us to have more meaningful conversations and ensuring our voluntary and community sector have an active role.

Get Involved Gloucestershire

In 2021, NHS partners launched 'Get Involved in Gloucestershire', which is an online participation space for people to share views, experiences and ideas about local health and care services.

The new digital platform will be a central point for the NHS and local people to find out and directly get involved in shaping local services. The experiences shared through the platform will help inform and influence the decisions local NHS organisations make.

Further information about Get Involved in Gloucestershire and free registration can be found here:

getinvolved.glos.nhs.uk

Governors

An important way local people can directly get involved with the Trust is as Member and staff through our Council of Governors. We have 22 public, staff and appointed governors who represent the views and interests of Trust members and the local community, to ensure our Trust reflects the needs of local people.

Our governors ensure we listen to the views of patients and people who live locally, along with our staff and other interested parties. They hold us accountable and ensure we can make improvements to our services and the information we provide.

The Council of Governors meet six times a year to provide feedback on developments and decisions at our hospitals. These meetings are open to the public, who are welcome to attend.

Further information about Governors can be found here:

www.gloshospitals.nhs.uk/about-us/governors

Other ways we involve and engage

Members

As a Foundation Trust, we are accountable to local people, and we actively promote the benefits of becoming a member and how to stand for election as a governor.

Members are our staff, our patients and members of the public who either have a general interest in healthcare or are interested in a specific condition or speciality. Members are regularly invited to get actively involved with the Trust to develop services which will best suit the needs of local people.

For more information and to become a Member, visit:

www.gloshospitals.nhs.uk/about-us/get-involved/support-our-trust/join-our-foundation-trust/

Watch our Governors talk about their experience when they joined us at last year's Community Events

<https://youtu.be/FoHhSvkYPo>

Find out more here:

www.gloshospitals.nhs.uk/about-us/support-our-trust/join-our-foundation-trust/

Patient Experience

Our patient experience matters to us. Our Trust's strategy has a commitment to create a culture where patients really are at the heart of everything we do and that a patient centred care is embedded across the Trust.

We know from international evidence that outstanding patient experience improves patient safety and clinical effectiveness and also improves the experience of NHS colleagues.

As a Trust, we produce an Annual Patient Experience Report which focuses on all our patient experience initiatives, including Friends and Family, compliments, comments and complaints and projects that have happened across the organisation this year.

This can be read at:

www.gloshospitals.nhs.uk/about-us/reports-and-publications/reports/

People's Panel

As part of our One Gloucestershire approach to involvement, we have supported the recruitment of more than 1000 residents to join a People's Panel. The Panel is made up of individuals whose anonymous feedback will be used at a county and a more local level to shape health and care services and support. The Panel includes people who live in priority areas of the county, the Core20, where underserved communities experience greater health inequalities than elsewhere in Gloucestershire.

Other ways we involve and engage

Patient and colleague stories

Patient and colleague stories are regularly presented at the beginning of Trust Board meeting. The stories provide an example of the lived experience of patients and colleagues to highlight examples of excellence and where there are areas for improvement.

www.gloshospitals.nhs.uk/about-us/our-board/board-papers/

Our Annual Members Meeting

Our Annual Members Meeting is where the Trust shares key highlights and achievements, reflects on the previous year's performance, and where we share some future developments planned for the year ahead. You can watch the Annual Members Meeting again at:

www.youtube.com/@GlosHospitalsNHS

Healthwatch Gloucestershire

The Trust works closely with Healthwatch Gloucestershire (HWG), and they are actively involved in our work and plans, including attendance at Trust Board, Partnership Involvement Network and a number of service projects, including the Covid vaccination programme. More information about Healthwatch can be found here:

www.healthwatchgloucestershire.co.uk/

Maternity and Neonatal Voices Partnership

Gloucestershire Maternity and Neonatal Voices Partnership is made up of volunteers who represent the voice of women and families from all communities and cultures to inform improvements in local maternity care. The partnership is directly involved with the Trust's Maternity and Midwifery services and provides an important independent voice in shaping our services.

<https://evolvingcommunities.co.uk/gloucestershire-mnvp/>

We have several social media channels that anyone can follow and these are outlined below:



Twitter:

www.twitter.com/gloshospitals



Facebook:

<https://www.facebook.com/gloshospitalsNHS>



YouTube:

www.youtube.com/c/GlosHospitalsNHS



LinkedIn:

<https://www.linkedin.com/company/gloucestershire-hospitals-nhs-foundation-trust/>

What will we be doing this year?

KEY PRIORITIES INCLUDE:

Maternity Improvement Journey

Working with women, families and communities to inform ongoing maternity service improvements.

Mindsong Partnership

Expanding dementia support through culturally meaningful resources, including music-based initiatives.

Health Inequalities Creative Programme

Delivering “Your Health Journey, Your Story, Your Way” with Create Gloucestershire to capture lived experiences and reduce inequalities.

City of Sanctuary and Refugee Week 2026

Strengthening engagement with refugee and asylum-seeking communities to improve access and inclusion.

Health Inequalities Strategy

Supporting development through community insight and lived experience.

Cancer Awareness Programme

Delivering a year-round calendar of community sessions to increase awareness and improve screening uptake

Over the past year, we have worked with partners to strengthen our engagement approach, enabling us to connect with communities through local events, outreach and collaborative programmes.

Moving forward, we will continue to explore new ways to engage, ensuring our work remains responsive to local needs and shaped by community voice.

What will we be doing this year?

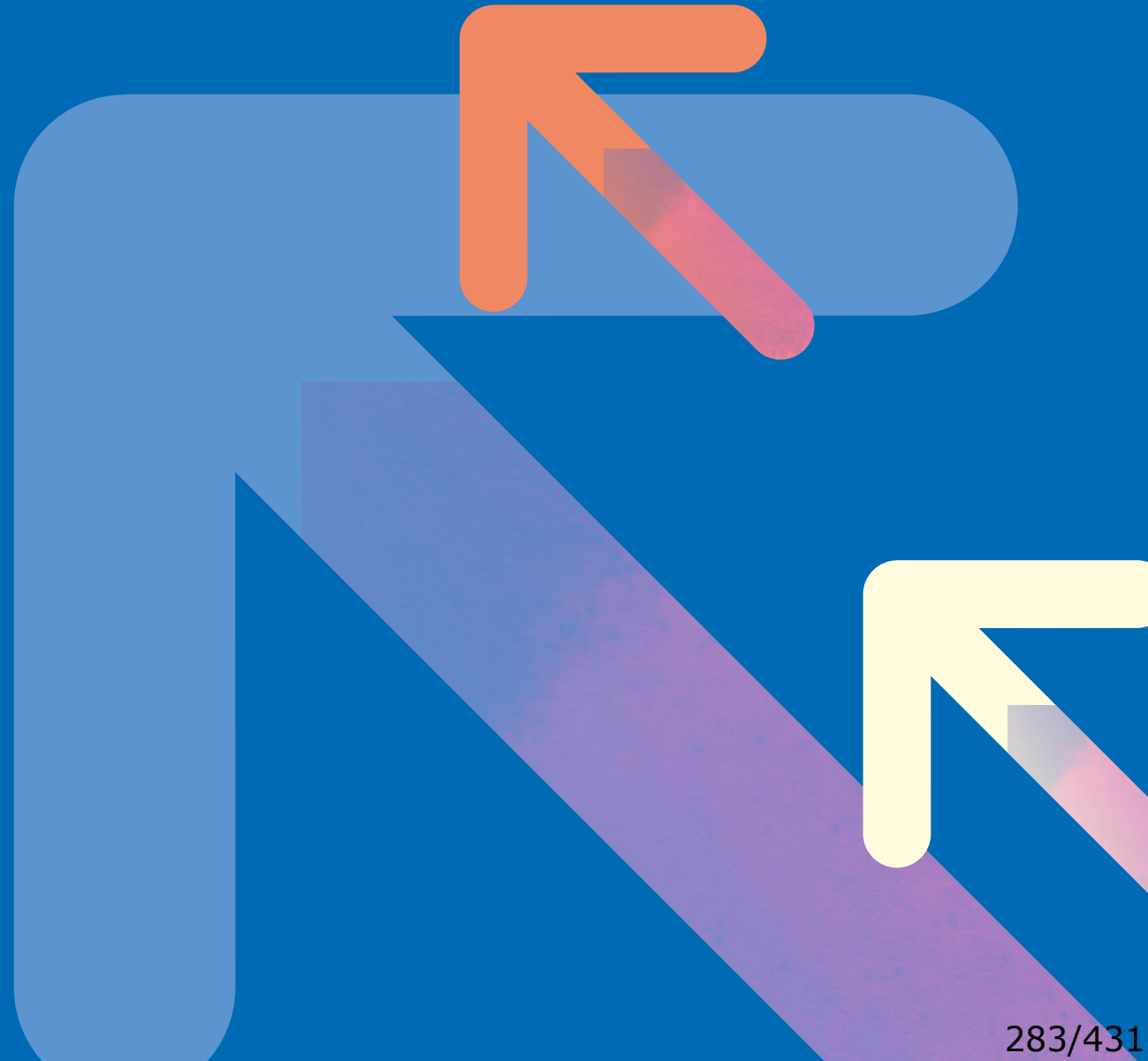
Across all priorities, we will continue to strengthen community and patient partnerships, ensuring local voices shape service development and delivery.

If you want to find out more about the activities mentioned above, make sure you join the 'Get Involved in Gloucestershire'

🔗 <https://getinvolved.glos.nhs.uk> platform

where you can also share your views, experiences and ideas about local health and care services across the county. You can also visit the Trust website to find out how to get involved in supporting the hospitals:

🔗 www.gloshospitals.nhs.uk/about-us/get-involved/



Involvement and Engagement Tracker - 1 April 2025 to 31 March 2026

Why we engage and involve

Listening to colleagues, patients, and communities across Gloucestershire helps us understand experiences of health and care services and identify where improvements are needed. Engagement ensures decisions are informed by lived experience, supports person-centred care, and strengthens relationships with the communities we serve.

How do we reach our communities

Over the past 12 months, we engaged with 8000 people through visits to 43 community groups and events. Through these interactions, we gained insights into what matters most to our communities, with a key focus on improving access and information.

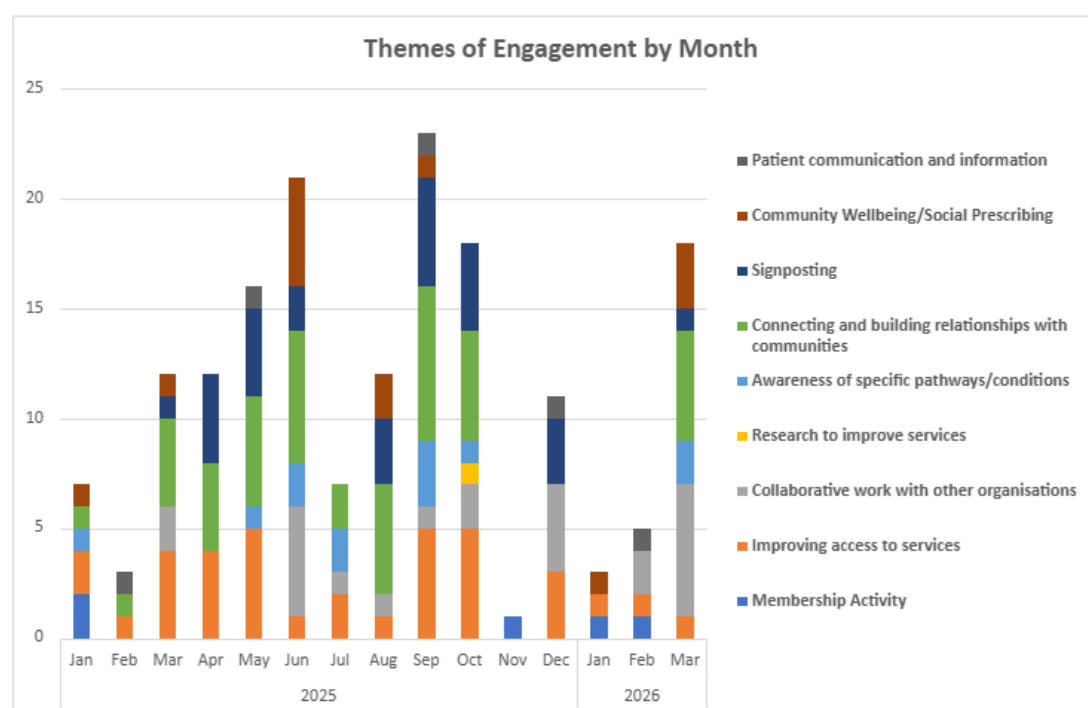
What do we focus on

Our engagement activity is guided by clear priorities to ensure feedback leads to meaningful action. Monthly activity centred on three key areas:

- **Signposting to VCSE Groups** – connecting people with Voluntary, Community, and Social Enterprise (VCSE) organisations for appropriate support;
- **Building Relationships** – maintaining trusted connections with local communities to support ongoing dialogue;
- **Service Improvement Research** – gathering feedback to inform the design and delivery of healthcare services.

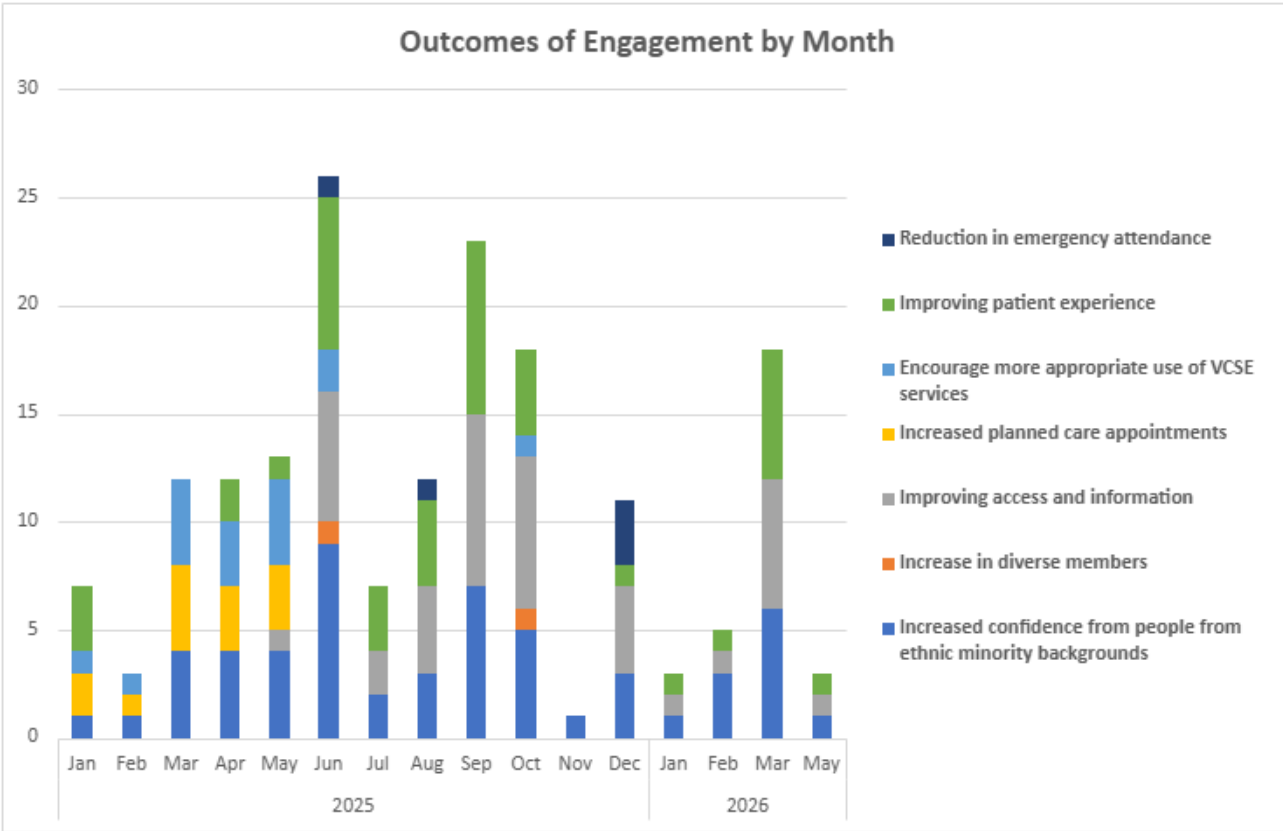
Themes of involvement and engagement by month

Reviewing engagement themes ensures activity remains aligned with organisational priorities, supporting a balanced approach to community support, relationship-building, and service improvement.



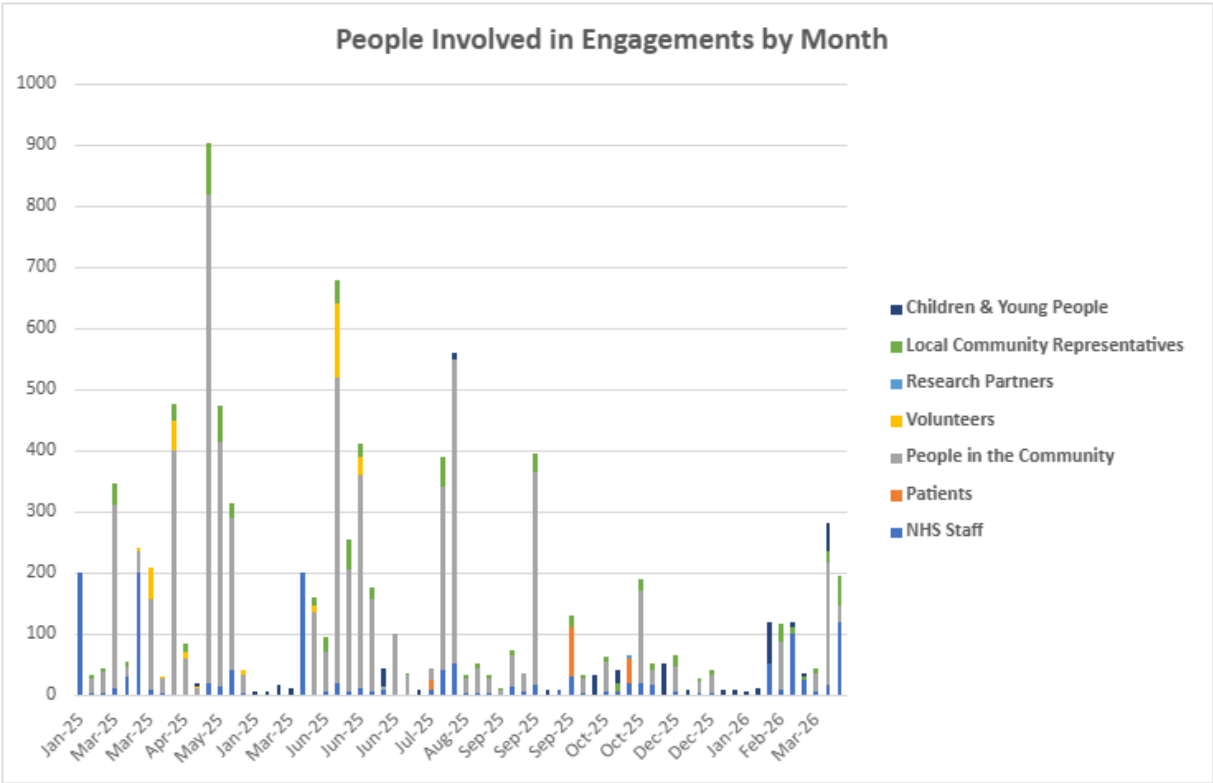
Outcomes of involvement and engagement by month

Tracking outcomes shows how community insight informs action. Feedback from engagement has contributed to service improvements, clearer communication, and more responsive ways of working, helping ensure engagement delivers measurable value.



People involved and engaged by month

Monitoring monthly participation provides a clear view of our reach and helps identify opportunities to strengthen community connections. This supports inclusive involvement and ensures a wide range of voices contribute to shaping services.



Report to Board of Directors

Date of Meeting	Thursday 16 th July 2026
Report title	NHS Staff Survey 2025: Assurance of Progress, Risks and Improvement Priorities
Sponsoring Director: Authors:	Debbie Tunnell: Deputy Director of People and OD Maria Smith: Associate Director for Organisational Development (OD), Culture and People Development

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

Executive Summary
The 2025 NHS Staff Survey highlighted ongoing workforce issues, including workload, confidence to speak up, access to career development, and equality of experience. Although there have been some improvements, particularly in appraisal completion and team effectiveness, the results indicate that further effort is needed to ensure a consistently positive staff experience across the organisation. Detailed survey results have already been shared via Trust governance channels. The Board can be assured that a thorough organisational response has been implemented in response to the 2025 survey results. These findings have been examined by Divisional Triumvirates, Divisional Boards, Service Line Triumvirates, and local management teams, ensuring transparency and accountability from the Trust level down to individual cost centres. Improvement efforts are continuously tracked through existing governance mechanisms, including Service Line Reviews, divisional governance meetings, HR Business Partner oversight, and the new Divisional People Boards. Additionally, detailed local action plans are underway across Divisions and are managed through established accountability procedures. Engagement was notably lower, prompting lessons learned to boost survey participation, including clearer communication about ongoing and planned activities related to survey completion, both locally and trust-wide. Staff Experience is moving towards a triangulated strategy for workforce intelligence by integrating Staff Survey results with other sources, including the National Education and Training Survey (NETS), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Freedom to Speak Up data, Report Support Learn information, Staff Network feedback, and broader staff engagement activities. This approach enhances confidence in the identified themes and promotes a more evidence-driven process for making

improvements and setting priorities. This aligns with the results of national reports, reviews, and recommendations, such as Lord Mann.

In addition to divisional improvement efforts, various Trust-wide initiatives persist to enhance workforce experience and culture. These initiatives comprise the Staff Networks Reset and Refresh Programme, specific Equality, Diversity, and Inclusion projects, leadership and development activities, and broader measures aimed at improving staff experience and opportunities.

The Board should note that whilst the Staff Experience Improvement Programme (SEIP) has been paused pending review by the incoming Chief People Officer, work is underway to develop a refreshed Staff Experience Programme. This programme will provide a single strategic framework for staff experience, culture, leadership, wellbeing, equality and workforce development, drawing on triangulated workforce intelligence, cultural insight and learning from national reviews and emerging NHS workforce standards (Staff Standards and Manager Standards).

The Board can therefore be assured that governance and accountability arrangements are in place, that improvement activity is underway across all Divisions, and that the organisation is strengthening its approach to monitoring progress, risks and impact. Whilst it is too early to demonstrate sustained improvements arising from the 2025 survey cycle, the foundations are being laid to support a more integrated, evidence-based and sustainable approach to improving staff experience across the Trust as we move into engagement to complete the 2026 survey.

Previously considered by	Main Staff Survey results summary: ◦ People & Organisational Development Delivery Group (13th January 2026) ◦ Confidential Board (15th January 2026) ◦ People & Organisational Development Committee (17th February 2026) ◦ People & Organisational Development Committee (16th June 2026)
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Recommendations:

The Board is asked to:

- **Acknowledge** the persistent organisational challenges highlighted in the 2025 Staff Survey and their impact on staff experience, workforce stability and patient care
- **Support** a shift towards a more focused, insight-led approach to improvement, using triangulated staff experience data to inform a small number of clearly defined organisational priorities rather than multiple parallel action plans
- **Endorse** strengthened divisional ownership and accountability for staff experience, recognising that improvement is driven locally
- **Endorse** the development of a clear thematic narrative for staff experience improvement, linking staff survey findings with wider workforce insight, leadership, management development and staff networks
- **Note** the need for sustained leadership focus on the following priority areas:
 - Workforce capacity and workload
 - Confidence in speaking up and organisational responsiveness
 - Equality of experience

- **Support** a prioritised and triangulated approach to improvement, recognising that meaningful and sustainable change requires focus, consistency and visible impact

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

Impact on any Strategic Risks?
Board Assurance Framework – BAF SR3: Culture, Experience and Retention.

Implications on:	
Equality, Diversity and Inclusion	The annual Staff Survey enables us to monitor progress against the Workforce Race Equality Standards and Workforce Disability Equality Standards indicators.
Health Inequalities	-
Finance and Resource	-
Regulation/Legal	-
CQC-Key line of enquiry	CQC Well-Led Domain – Staff Experience, Leadership, Equality, Diversity and Inclusion, Freedom to Speak Up
Green Plan	-

Main Report
1. Purpose The purpose of this report is to provide the Board with assurance on the organisation's response to the 2025 NHS Staff Survey, the governance arrangements in place to oversee

improvement activity, and the progress in translating staff feedback into local, divisional and Trust-wide action.

The detailed survey findings have previously been reported through Trust governance arrangements and are therefore not repeated in this paper. Instead, this report focuses on providing assurance on the actions being undertaken, the accountability arrangements that support delivery, and the maturity of the governance framework established to monitor progress and impact.

The report details how staff survey results have been reviewed across the organisation, highlights progress on local and divisional improvement initiatives, and explains how these efforts are supported by Divisional People Boards, HR Business Partners, organisational development support, and broader staff experience initiatives. It also outlines how the Trust is enhancing assurance mechanisms to track progress, identify risks, and address barriers through PODDG, PODC, and ultimately the Board.

Recognising that the Staff Survey is just one indicator of workforce experience, the report also shows how these findings are cross-referenced with NETS, WRES, WDES, Freedom to Speak Up intelligence, Report Support Learn data, Staff Network feedback, and broader workforce metrics. This approach aims to provide a more comprehensive view of staff experience and to help prioritise improvement initiatives.

Overall, this paper aims to confirm that staff feedback is addressed, that improvement efforts are ongoing across the organisation, and that governance and accountability structures are evolving to ensure sustainable improvements to the staff experience.

2. Assurance of Progress and Divisional Response

The Trust has implemented a structured, locally led approach to address the findings of the 2025 NHS Staff Survey. It recognises that significant improvements in staff experience primarily occur at the team and service levels. The Staff Experience and Culture Manager first reviewed the survey results with the Divisional Triumvirates, then presented them to the Divisional Boards and shared them with the Service Line Triumvirates and individual managers. This process ensured that the survey findings were transparent and understood across all levels, from the Trust to individual cost centres.

Divisions were asked to review their local results, involve staff in discussions of the findings, identify improvement priorities, and set local actions to address the issues identified. These improvement efforts have been integrated into current divisional governance structures, such as Service Line Reviews, allowing staff experience priorities to be balanced with operational, quality, and workforce considerations.

Several Divisions have evaluated progress on actions from the 2024 Staff Survey, comparing earlier results with recent findings to assess whether previous efforts have led to significant improvements. This process has helped recognise areas of progress and identify where ongoing attention is needed. Some Divisions are also developing long-term plans to address workforce and cultural challenges that cannot be fully resolved through annual action planning.

Detailed action planning is also underway at the team and cost-centre levels. HR Business Partners support progress, while the Staff Experience and Culture Manager coordinates through Divisional Triumvirates, ensuring local monitoring and progress on actions.

The introduction of Divisional People Boards marks a substantial enhancement of workforce governance. These forums provide greater oversight of the workforce, culture, and staff

experience priorities, and are beginning to establish a more unified approach to tracking progress, identifying risks, and addressing barriers to improvement. As these arrangements develop, they serve as a vital mechanism for scrutinising and supporting local initiatives.

Further efforts are underway to formalise reporting and assurance pathways across Divisional People Boards, PODDG, PODC, and the Board. This aims to enhance organisational oversight, from local action plans to Trust-wide assurance, and to enable more systematic reporting on progress, impact, risks, and emerging themes.

In addition to the main NHS Staff Survey, the Temporary Staffing Team has reviewed the 2025 NHS Bank Staff Survey results. The findings have been shared with bank workers via the Bank Forum and are informing improvement activity to demonstrate to bank colleagues how their feedback is being used. The Trust has also received the free-text comments from both surveys, and a facilitated workshop with Divisional and Staff Group leads will explore these alongside the quantitative data to deepen understanding of the themes and inform future improvement priorities.

3. Triangulation of Workforce Intelligence

The Trust is now using a triangulated approach, rather than relying solely on the NHS Staff Survey, to understand workforce experience. This method combines multiple sources of workforce data, providing a more comprehensive assessment of staff experience and informing organisational priorities.

This includes review of:

- National Education and Training Survey (NETS)
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Freedom to Speak Up intelligence
- Report Support Learn data
- Staff Network feedback
- Local engagement activity
- Wider workforce metrics and organisational indicators
- National Reports, Reviews and Recommendations.

Reviewing these data sources strengthens confidence that several themes from the Staff Survey are consistently observed across multiple dimensions of workforce intelligence. These themes include workload pressures, leadership and management experience, confidence in organisational responsiveness, access to development opportunities, psychological safety, and inequalities in workforce experience.

The triangulation of Staff Survey results with WRES and WDES data has been crucial for understanding differences in experiences across staff groups and for pinpointing persistent inequalities. Likewise, NETS findings offer important insights into the experiences of learners and future workforce members, helping ensure that workforce improvement efforts address both current and future workforce needs.

This triangulated approach provides a more robust evidence base for decision-making, enabling the organisation to move beyond merely tracking activity and to assess whether interventions genuinely improve staff experience. It will also be a key component of the upcoming Staff Experience Programme and future assurance reports.

4. Trust-Wide Improvement Activity

Alongside divisional action planning, a range of Trust-wide programmes are improving the workforce experience and addressing areas highlighted in the Staff Survey findings.

The Staff Networks Reset and Refresh Programme enhances staff voice mechanisms and the role of staff networks in organisational decision-making. Its aim is to promote greater inclusion, engagement, and psychological safety across the organisation, ensuring staff experiences are more accurately reflected in decision-making.

Targeted Equality, Diversity, and Inclusion interventions aim to reduce inequalities in the workforce experience and improve access to development, progression, and leadership opportunities. These programmes are guided by Staff Survey results, WRES, and WDES data, and address disparities in staff experience identified across multiple workforce sources.

The Board should be aware that the Staff Experience Improvement Programme (SEIP) is currently on hold pending review by the new Chief People Officer. Although this pause reduces the visibility of specific Trust-wide initiatives, improvement efforts continue through divisional action plans and broader organisational initiatives.

Work is underway to create a renewed Staff Experience Programme that will serve as the primary framework for future staff experience initiatives. This programme will unify Staff Survey results, NETS data, staff voice insights, workforce equality information, leadership and organisational development, wellbeing, and culture-improvement efforts into a single strategic framework. Its goal is to minimise fragmentation, enhance prioritisation, and strengthen the organisation's capacity to demonstrate impact over time, provide insight, and question conflicting intelligence.

5 What Assurance Can Be Taken at This Stage

Although it's premature to assess the full effects of the 2025 Staff Survey actions, the Board can be confident that a unified organisational response is in place and that improvement efforts are underway across all Divisions.

Specifically, the Board can be assured that:

- Survey findings have been reviewed and acted upon at Trust, divisional, service and cost centre levels.
- Improvement actions have been incorporated into existing governance arrangements rather than being managed through separate reporting structures.
- Divisional People Boards are increasing local oversight, accountability and scrutiny of staff experience activities.
- Workforce intelligence is being triangulated to support prioritisation and decision-making.
- Trust-wide interventions continue to address key themes relating to staff voice, inclusion, leadership and workforce culture.
- Work is underway to strengthen organisational assurance arrangements and improve reporting on progress, impact and risk.

6. Key Risks and Areas Requiring Continued Focus

Although progress has been made in establishing governance structures and local accountability, some risks persist.

These include:

Consistency of Delivery – Ensuring that improvement actions are implemented with the same level of focus and quality across all Divisions and services.

Demonstrating Impact – Moving beyond action planning and activity reporting to evidence measurable improvements in workforce experience and outcomes.

Maturity of Assurance Arrangements – Continuing to develop clear reporting and escalation routes across local governance processes, Divisional People Boards, PODDG, PODC, and the Board.

Organisational Focus During Transition – Maintaining momentum whilst the incoming Chief People Officer reviews the Trust's future strategic approach to staff experience.

Workforce Inequalities – Addressing persistent inequalities in workforce experience identified through the Staff Survey, WRES, WDES and wider workforce intelligence.

Staff Confidence in Organisational Response – Ensuring staff can see visible evidence that feedback from surveys and other staff voice mechanisms results in meaningful action and improvement.

The development of the new Staff Experience Programme offers an opportunity to address these risks through a more integrated framework, clearer accountability arrangements and stronger organisational measures of success

7. Overall Assurance

The Board can be assured that a structured, comprehensive response to the 2025 NHS Staff Survey is already underway and continuing throughout the organisation. Governance arrangements are increasingly embedded, local ownership of improvement activity is evident, and workforce intelligence is being used more effectively to inform organisational priorities.

While it is too soon to demonstrate sustained improvements in staff experience from the 2025 survey cycle, the organisation has laid the groundwork to support progress. Further efforts are needed to strengthen assurance reporting, demonstrate impact, and mature governance structures. Nonetheless, the revamped Staff Experience Programme offers a valuable opportunity to develop a more cohesive, evidence-based, and strategically aligned approach to enhancing the workforce experience across the Trust.

Enclosures: N/A

FOI: N/A

Alert, Advise and Assure Report to the Board of Directors Meeting -16 July 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the QPC Committee held in May and June 2026
Board member lead(s)		NED Chair – Sam Foster and Executive leads CNO/CMO/COO and Deputy CEO
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	Approval	
	Assurance	X
	Discussion	X
	Note	

Purpose of report

To present an update to the Board of Directors from the meetings of the QPC Committee held in May (deep dive- frailty) and June 2026. This committee meets monthly and is attended by members of the Board and senior managers.

Chair's summary

During the May meeting, the Committee undertook a dedicated deep-dive review of frailty services, including a presentation from the multidisciplinary leadership team and a visit to the Frailty Assessment Unit. Members were impressed by the maturity of the frailty model, which brings together front-door assessment, same day emergency care, virtual ward provision and community-based support within a coherent pathway designed to improve outcomes for older people living with frailty. The Committee noted evidence of innovative quality improvement work, strong multidisciplinary collaboration and a clear focus on reducing unnecessary hospital admissions and length of stay. Members were particularly encouraged by the use of data and quality improvement methodologies to drive service development and by the positive patient and staff feedback received. The visit provided assurance that frailty services are making an important contribution to improving patient flow, supporting the Trust's strategic objectives and responding proactively to the needs of an ageing population

During May and June the Committee undertook detailed scrutiny of maternity services, urgent and emergency care, elective and diagnostic recovery, clinical effectiveness, patient safety, patient experience and community engagement. The Committee also considered the effectiveness of its own assurance arrangements and approved several significant governance and quality documents on behalf of the Board.

The Committee received evidence of continued progress in maternity governance, patient safety systems, mortality surveillance, quality improvement capability and community engagement. It was encouraged by the strengthening of governance arrangements across a number of services and by positive developments in patient outcomes, workforce stability and regulatory compliance. However, the Committee also identified several areas where risks remain material and where sustained executive focus is required. These include urgent and emergency care performance, corridor care, complaints performance, elective and diagnostic sustainability, maternity workforce resilience and cultural concerns within cardiology services.

Overall, the Committee is satisfied that significant organisational risks are understood, appropriately governed and subject to active management, whilst recognising that a number of improvement programmes remain at a relatively early stage and will require sustained focus during 2026/27.

Key points

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

Urgent and Emergency Care Performance and Corridor Care

- Long waits within Emergency Care continue to present both operational and patient experience challenges.
- Corridor care remains in use within the Emergency Department and Medical Assessment Unit despite successful elimination from downstream ward areas.
- Continued system-wide flow constraints and discharge delays remain a significant challenge.
- Whilst ambulance handover performance remains strong, the sustainability of wider urgent care improvements remains fragile.

Complaints Performance and Timeliness

- Complaints handling arrangements continue to require improvement.
- Workforce instability and limited service resilience have affected delivery against timeliness standards.
- Whilst improvement plans are in place and maternity complaints performance is improving, the Committee believes this remains an area requiring continued Board visibility.

Cardiology Culture and Leadership

- Significant concerns were identified regarding leadership, team dynamics, behaviours and culture within cardiology services.
- External reviews identified concerns regarding governance, culture and working relationships notwithstanding the absence of concerns regarding individual clinical practice.
- A formal improvement programme and external Royal College review are underway.

Maternity Workforce Resilience and Service Recovery

- Training compliance, workforce capacity, ultrasound resilience, triage staffing and restoration of suspended services continue to present risks.
- The Committee noted the importance of sustaining pace of improvement and ensuring delivery of Maternity Incentive Scheme recovery actions.

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

Quality Improvement and Clinical Effectiveness Assurance

- The Committee identified opportunities to strengthen organisational assurance regarding the impact of quality improvement activity and compliance with NICE guidance.
- Members requested stronger articulation of outcomes and measurable impact rather than process compliance alone.
- Further work is underway through the Quality Governance Framework.

Elective Recovery, Diagnostics and Cancer Performance

- Overall elective performance remains comparatively strong but sustainability remains dependent upon improved forecasting, operational grip and pathway management.
- Continued scrutiny is required regarding RTT performance, diagnostics productivity, histopathology turnaround times and selected cancer pathways.

Patient Experience, Engagement and Health Inequalities

- The Committee welcomed increasing focus on health inequalities, patient voice and community engagement.
- Further development is required to strengthen measurement of outcomes and better demonstrate how patient insight translates into service improvement.
- The Committee supported development of the new Patient Experience and Voice Strategy.

Committee Effectiveness and Strategic Assurance

- Members recognised the need to continue moving away from operational reporting towards strategic assurance.
- Work is underway to strengthen alignment between Committee business, strategic priorities, quality objectives and Board Assurance Framework risks.

ASSURE: inform the board where positive assurance has been received

Maternity Governance and Regulatory Compliance

- Assurance was received regarding strengthened maternity governance arrangements.
- All Section 31 conditions remain compliant.
- Closure of the external maternity oversight group represented a significant milestone.
- Positive progress was reported in complaints management, workforce leadership appointments and health inequalities initiatives.

Quality Improvement, Clinical Effectiveness and Patient Safety

- The Committee received assurance regarding compliance with clinical effectiveness requirements and national audit arrangements.
- The Gloucestershire Safety and Quality Improvement Academy continues to demonstrate strong engagement across the organisation with more than 4,500 staff having completed Quality Improvement training.
- Strong assurance was received regarding the maturity of patient safety governance and implementation of the Patient Safety Incident Response Framework.

Learning from Deaths and Mortality Indicators

- Mortality surveillance continues to show positive trends.

- Delay-related harm metrics have improved and no emerging mortality concerns requiring escalation were identified.
- Existing governance arrangements provide effective oversight of mortality indicators
-

Frailty Services

- Strong assurance was received regarding the development of frailty pathways and multidisciplinary care models.
- The Committee welcomed evidence of improved patient flow and recognised the strategic importance of frailty services in supporting future NHS priorities.

Community Engagement and Patient Voice

- The Committee was assured by the breadth of engagement activity being undertaken across Gloucestershire communities.
- Effective partnerships with community organisations continue to support improved patient outcomes and experiences.
- Development of a new Patient Experience and Voice Strategy was welcomed.

APPROVALS: decisions made by the Committee, & Applaud Positive Achievements, Examples of Excellence, or Noteworthy Progress

The Committee approved the Quality Account on behalf of the Board and received assurance that it provides a comprehensive and balanced assessment of organisational quality performance and future priorities

The Committee:

- Approved the Engagement and Involvement Annual Review.
- Approved the Patient Safety Incident Response Framework Policy and Plan.
- Approved the Quality Account 2025/26 on behalf of the Board.
- Approved the Committee Effectiveness Improvement Plan and revised Terms of Reference.

The Committee particularly applauds:

- Closure of the maternity external oversight arrangements.
- Improvements in ambulance handover performance and patient flow initiatives.
- Continued progress in health inequalities work within maternity services.
- The sustained success of the Gloucestershire Safety and Quality Improvement Academy.
- The work of community engagement teams and young influencers.
- Strong organisational commitment to patient safety, quality improvement and learning.

Implications

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

Board assurance framework

BAF reference	SR10
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Risks discussed

The Committee discussed the following risks: The Committee discussed a range of risks that enabled triangulation with the BAF

Recommendations

The Board of Directors is asked to take assurance from the report and note the areas detailed in the report to be advised and areas for applauding.

Report to Public Board of Directors

Date of Meeting	16 th July 2026
Report title	Integrated Performance Report (IPR)
Sponsoring Director/Author	Chief Operating Officer (COO) Chief Medical Officer (CMO) Chief Nurse (CN) Deputy Director for People & OD (DfP&OD) Director of Finance (DoF)

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

Executive Summary	
Previously considered by	Reports into delivery groups

Recommendations:
To note the contents of the Integrated Performance Report (IPR)

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

 Quality, safety and delivery	X
 Digital first	

Impact on any Strategic Risks?

The most significant strategic risks relate to system flow and discharge performance, elective and cancer recovery, delivery of financial sustainability plans, workforce capacity, and dependency on wider system partners to improve patient flow and discharge pathways. These risks have the potential to affect the Trust's ability to deliver its operational, financial, quality and transformation objectives during 2026/27.

Implications on:

Equality, Diversity and Inclusion	None
Health Inequalities	While no specific health inequalities issues are reported, the operational pressures across urgent care, planned care, diagnostics and cancer pathways have the potential to disproportionately affect vulnerable and underserved populations. Continued monitoring of access, experience and outcomes by population group is required to ensure inequalities are identified and mitigated.
Finance and resource	The Trust remains on plan financially but faces material risks to delivery during the remainder of the year. Workforce capacity and productivity remain critical enablers of operational recovery, quality improvement and financial sustainability objectives
Regulation/Legal	NHSE mandated performance report
CQC-Key line of enquiry	The report identifies ongoing challenges primarily within the Safe, Effective and Responsive domains due to system flow, access and capacity pressures. Nonetheless, assurance is provided through maintained safety outcomes, strong governance arrangements, improvements in patient safety indicators, and continued organisational focus on recovery and quality improvement.
Green Plan	None

Main Report

See attached IPR slides.

PERFORMANCE

Performance remains challenged across Urgent and Emergency Care (UEC), Planned Care, Diagnostics and Cancer, with system flow continuing to be the primary constraint. Four-hour performance reduced to **63.7%**, driven by persistent discharge delays and limited inpatient capacity, although ambulance handovers and paediatric performance continued to improve.

Discharge performance has plateaued, with the discharge-ready cohort remaining high at **110–120 patients** and length of stay increasing, indicating ongoing pressures within community and onward care pathways.

RTT performance remained broadly stable at **74.2%**, but long waits continue to rise, particularly in Orthopaedics and Spinal Services. There were **14 patients waiting over 52 weeks**, with CSSD constraints continuing to impact elective activity and theatre productivity.

Diagnostic performance improved modestly, largely driven by echocardiography recovery, although several other modalities remain under pressure.

Cancer performance remains a significant concern. The **62-day standard deteriorated to 66.0%**, while the Faster Diagnosis Standard improved to **77.3%**. Backlogs continue to grow across several tumour pathways, reflecting ongoing diagnostic and treatment capacity constraints.

Overall, improving discharge capacity and patient flow remains the key requirement to support recovery across operational performance standards.

QUALITY

Alert – Key Risks

- Patient experience variation remains between Gloucester and Cheltenham Emergency Departments, with postnatal ward experience also below expected levels.
- Complaints performance remains impacted by vacancies within Complaints leadership and management teams, although compliance has improved to **38%** and recruitment is underway.

Advise – Priority Actions

- Strengthen oversight of patient experience through improved divisional governance and integration of feedback sources.
- Maintain focus on infection prevention and control, falls prevention, pressure ulcer reduction and PSIRF delivery.
- Stabilise PALS and Complaints teams to improve response timeliness and sustain public confidence.

Assure – Stable Areas

- Friends and Family Test performance remains strong at **92.9%**, above benchmark.
- PALS continues to perform well, with **86%** of concerns closed within five days despite high demand.

- Mortality indicators remain within expected limits and no Never Events were reported in May.
- Mixed-sex accommodation breaches remain low and linked to operational pressures.

Applaud – Achievements

- Falls performance continues to improve, with the lowest rate recorded in the last two years.
- No hospital-acquired Category 3 pressure ulcers were reported in May.
- Continued improvements in risk management performance within a number of divisions.

FINANCE

At the end of month 2 the Trust has reported a year to date deficit of c£4.8m - this is better than the planned position by £0.1m. Included within this position are pressures related to industrial action (c£0.7m) and non-pass through drugs (c£1m) which are being offset through corporate underspends (£0.6m) and earlier than planned deliver of financial sustainability schemes (£1.2m). Whilst this shows that the year-to-date position is on plan the impact of some of these pressures will be present later in the year as the early delivery of financial sustainability schemes will reduce back in line with plan profiles.

On a full year basis, the Trust is reporting delivery of its overall plan position, however it should be noted that there are significant risks within this. The primary risk comes from the overall delivery of financial sustainability schemes due to the level of red rated and to be developed schemes. There are additional risks from hyperinflation linked to the global situation and from potential reductions in capacity supporting acute flow which may impact elective activity pathways.

The Trust has total capital resources of c£62m for 26/27 and at the end of month 2 is reporting YTD underspend of c£4.5m. This is due to slippage in the timing of deliverables and plans within the estate's programmes - the Portfolio Director for estates will be working with GMS capital leads to determine the recovery trajectories for these schemes.

Workforce

The workforce section highlights areas where performance has deteriorated against standard people metrics, or where ongoing close monitoring is required. This month, continued focus is on appraisal compliance, sickness absence, job planning, and bank usage. Agency use has also been included, reflecting the heightened priority on temporary staffing spend and the requirement to achieve significant reductions.

The accompanying narrative sets out the services contributing to current performance and the recovery actions in place to drive improvement against target.

Enclosures

Integrated Performance Report (IPR)

Integrated Performance Report (IPR)

May 2026

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

SPC Chart Guidance

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

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

How to interpret variation results:

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

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
 - **Blue icons** indicate that you would expect to **consistently achieve a target**
 - **Orange icons** indicate that you would expect to **consistently miss a target**
 - **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**
- The **red lines** on the charts show the **target** for that performance metric.
 - The **black lines** on the charts show the **mean** for that performance metric.

Operational Performance Metrics

NOF Segment

This information is calculated nationally, on a quarterly basis

NHS Oversight Framework - Acute trusts

Current data: Q3 2025-26
Published: 18 March 2026 (updated 1 April 2026)

About

Overview

League table

Metrics table

Trust map

Trust chart

Timeseries table

Timeseries chart

Statistics table

Metric metadata

Glossary

Select a trust

Gloucestershire Hospitals NHS Foundation Trust (RTE)

Average score

2.07

Higher by 0.18 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

Trust has entered financial deficit

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

3 - Below average and/or financial deficit

Previous quarter's segment: 1

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

38 out of 134

Previous quarter's rank: 17 out of 134

Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).

How has rank been calculated?

Performance domains

Access to services

Finance and productivity

Effectiveness and experience

Patient safety

People and workforce

2 - Above average

1 - High performing

2 - Above average

3 - Below average

3 - Below average

Average score by trust rank placement

NOF Metrics

Segment drivers

Domain	Description	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Access to services	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	>80%	81.6%	↑ 82.3%	↑ 85.5%	↓ 84.1%	↓ 80.3%	↓ 77.0%	↓ 76.5%	↓ 75.3%	↓ 70.3%	↓ 57.5%	↑ 68.5%	↑ 75.9%	↓ 74.2%	↑ 76.9%
	Percentage of patients treated for cancer within 62 days of referral	>75%	69.0%	↑ 69.2%	↑ 75.5%	↑ 77.6%	↓ 75.0%	↑ 77.5%	↓ 76.1%	↑ 78.7%	↑ 84.0%	↓ 76.3%	↓ 74.0%	↓ 71.7%	↑ 75.0%	↓ 64.70%
	Percentage of patients waiting over 52 weeks for elective treatment	0.00%	0.14%	↑ 0.12%	↑ 0.08%	↑ 0.07%	↑ 0.06%	⇒ 0.06%	↑ 0.04%	↓ 0.05%	⇒ 0.05%	↑ 0.03%	↑ 0.02%	↑ 0.01%		
	Percentage of patients waiting over 52 weeks for community services	0.00%	0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%	⇒ 0.00%
	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	>92%	69.00%	↓ 68.61%	↑ 68.89%	↓ 67.91%	↓ 67.25%	↑ 69.76%	↓ 69.38%	↑ 70.00%	↓ 69.27%	↓ 68.51%	↑ 71.74%	↑ 74.55%		
	Difference between planned and actual 18 week performance															
	Percentage of emergency department attendances admitted, transferred or discharged within four hours	>78%	60.80%	↑ 62.72%	↑ 63.12%	↓ 60.84%	↑ 60.91%	↑ 62.78%	↑ 62.93%	↑ 64.17%	↓ 64.13%	↓ 60.29%	↑ 62.73%	↑ 64.57%	↑ 64.93%	
	Percentage of emergency department attendances spending over 12 hours in the department	<2%	11.11%	↑ 9.75%	↑ 8.32%	↓ 9.96%	↑ 8.90%	↓ 9.21%	↑ 9.19%	↓ 10.06%	↑ 10.00%	↓ 12.19%	↑ 10.37%	↑ 9.38%	↑ 9.25%	↓ 10.35%
Effectiveness and experience	Average number of days from discharge ready date to actual discharge date (including zero days)															
	Summary Hospital-level Mortality Indicator		1.1365	↑ 1.127	↑ 1.095	↑ 1.083	↑ 1.045	↑ 1.038	↑ 1.010	↑ 0.993	↑ 0.980	↑ 0.957	↑ 0.944	↑ 0.927	↑ 0.911	↑ 0.901
	CQC inpatient survey satisfaction rate															

Analytical Highlight

The Trust stays in Segment 3 under the NOF, driven by sustained underperformance in A&E access, elective backlog growth, and workforce gaps.

Watch Measures

		Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Elective Care	Short notice (within 72h) cancellation rate – total	<9%	9.4%	↑ 8.7%	↓ 9.6%	↓ 10.7%	↓ 10.7%	↓ 15.9%	↑ 12.4%	↑ 11.0%	↑ 10.2%	↓ 10.6%	↓ 11.4%	↑ 9.7%	↓ 10.7%	↑ 10.1%
	Same Day Non-Clinical Cancellations		57	↑ 38	↓ 60	↓ 84	↑ 70	↓ 104	↑ 74	↑ 68	↑ 38	↓ 53	↑ 46	↓ 55	↓ 59	↓ 61
	Cancellations not rebooked within 28 days	0	7	↓ 12	↓ 14	↑ 9	↓ 25	↑ 11	↓ 28	↑ 16	↑ 14	↑ 9	↓ 13	↑ 5	↓ 12	↑ 9
	Angiogram Waiting List Position		293	↑ 288	↑ 274	↓ 280	↑ 265	↑ 231	↑ 220	↑ 216	↓ 232	↓ 250	↓ 255	↑ 237	↓ 263	↑ 254
Flow	G&A Occupancy - CGH	92%	88%	↑ 89%	↓ 88%	↓ 86%	↓ 85%	↑ 87%	⇒ 87%	↓ 86%	↑ 89%	↑ 91%	↓ 90%	↑ 92%	⇒ 92%	↓ 91%
	G&A Occupancy - GRH	92%	95%	↓ 94%	↓ 92%	↑ 94%	⇒ 94%	⇒ 94%	↑ 95%	⇒ 95%	↓ 94%	↑ 97%	⇒ 97%	↓ 96%	↑ 97%	⇒ 97%
Safe Care	VTE assessment completed - excluding short stay (%)	95%	95.8%	↓ 95.5%	↓ 95.4%	↓ 90.9%	↑ 93.8%	↓ 92.9%	↑ 92.9%	↑ 93.9%	↓ 93.4%	↓ 92.7%	↓ 92.0%	↑ 92.9%	↓ 91.7%	↑ 92.1%
	Number of Category 2 pressure ulcers acquired as inpatient		15	↓ 19	↑ 11	⇒ 11	↓ 21	↑ 11	↓ 24	↑ 11	↓ 15	⇒ 15	↑ 6	↓ 12	↑ 9	↓ 14
	Smoking Status Compliance (%)	95%	97.11%	↑ 97.16%	↓ 97.09%	↑ 97.12%	↑ 97.54%	↑ 98.41%	↑ 98.56%	↓ 98.16%	↓ 98.04%	↓ 97.96%	↓ 97.56%	↑ 98.44%	↓ 98.26%	↓ 97.67%
	Severe Harm from Patient Medication Errors	0	2	↑ 1	↑ 0	⇒ 0	↓ 1	↑ 0	⇒ 0	⇒ 0	⇒ 0	↓ 1	↑ 0	⇒ 0	⇒ 0	⇒ 0

UEC: Performance

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

Analytical Highlights:

4-hour performance slightly decreased in May to 63.7%, from 64.9% in April, following 3 months of improvement.

12-hour performance also decreased, by 1.1%.

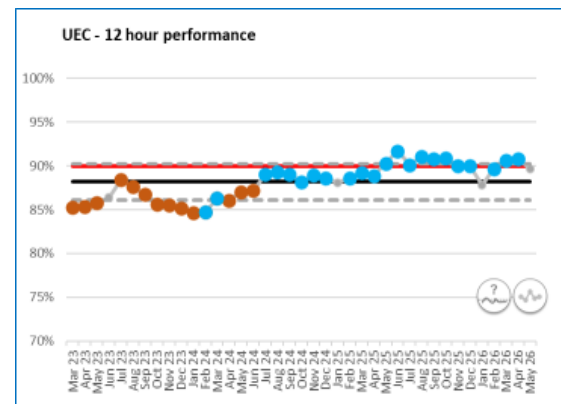
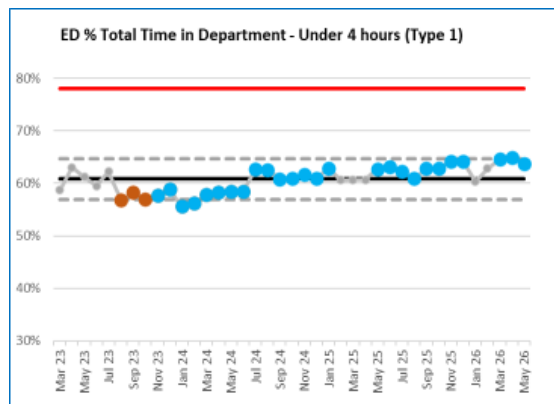
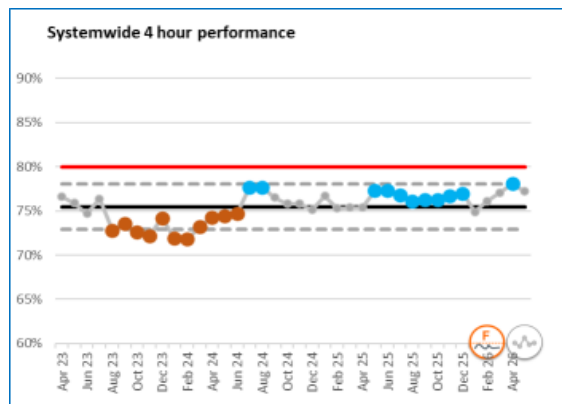
Areas for Concern:

Performance remains below the operational standard.

Time to clinician remains a key area for improvement

Learning & Improvement:

Significant upcoming recruitment (nursing and medical)



Actions

Action plan in place to support improvements in CGH ED, Paediatrics and Minors. These include appointment of some sub-specialist staff into this area, increased Ops presence in CGH.

UEC: Performance

Standard: a min of 78% of patients seen within 4 hours by March 26

Analytical Highlights:

Non-admitted performance has been improving since January, however performance decreased in May to 66.2% from 67.6% in April.

Admitted performance has also decreased, to reaching 54.4% in May compared to 55.7% in April.

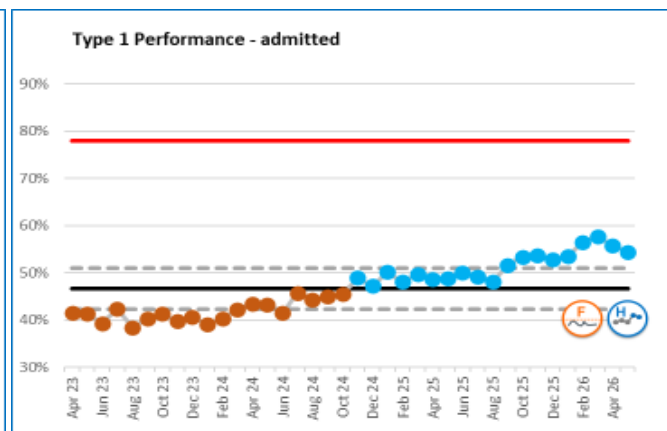
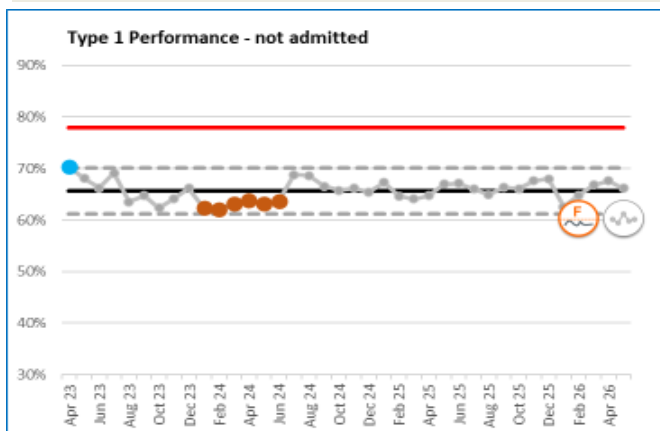
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Action plan in place to support improvements in CGH ED, Paediatrics and Minors. These include appointment of some sub-specialist staff into this area, increased Ops presence in CGH.

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

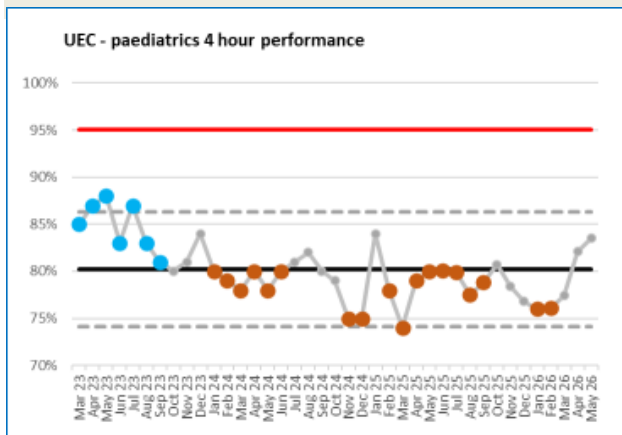
Analytical Highlights:

Despite overall 4 hour performance worsening in May, paediatric 4 hour performance has continued to improve month on month since January, achieving 83.5% in May (a 1.4% increase on April).

Mental Health waits over 24 hours have been increasing over the last 6 months. MH long waits were above average in May (31 waits of 24+ hours, against mean of 28). This is an increase of 7 patients compared to April.

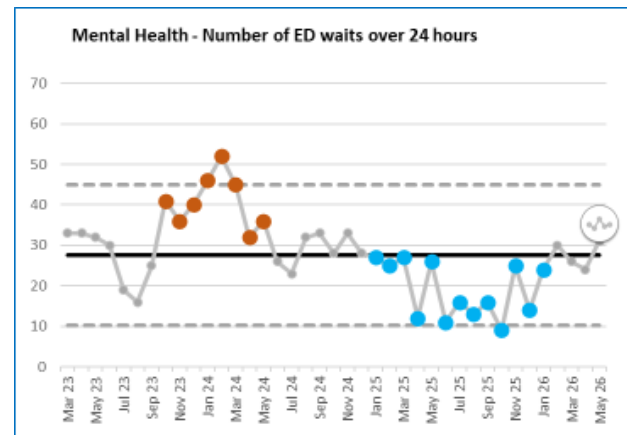
Areas for Concern:

Paediatric performance remains below the operational standard however performance has significantly improved in recent months.



Learning & Improvement:

Significant upcoming recruitment (nursing and medical) which includes Consultants in Paediatric Emergency Medicine



Actions

Paed B7 Nurse supporting departmental improvements and escalations across both sites

Average Handover Time

Analytical Highlights:

The average handover time for ambulances remained at 20 mins in May, the same as March and April. This is the lowest average offload times since reporting began in 2021.

The % of ambulance handovers within 15 minutes has improved over the last year, from 20.81% in April 2025, to 33.83% in May 2026 (13.02% increase).

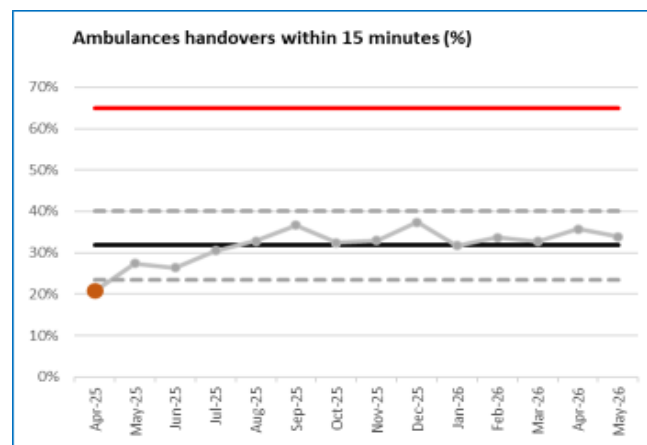
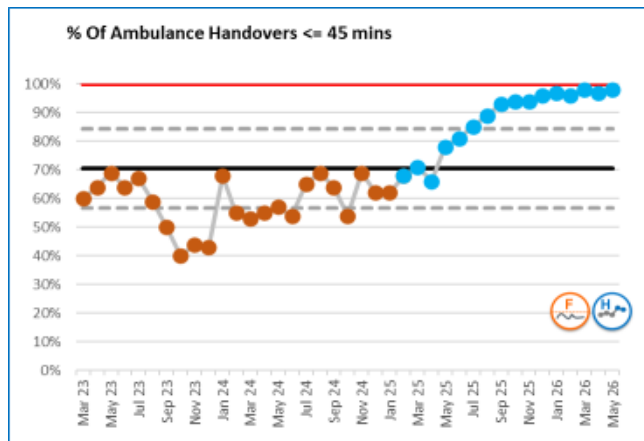
Areas for Concern:

Although significant improvements to the number of patients offloaded within 45 minutes, the gold standard would be that all patients are offloaded within 15 minutes

65% of offloads to be completed within 15 minutes of arrival

Learning & Improvement:

Work required to gain assurance about patients being offloaded into non-ED assessment areas/wards.



Actions

Review of admin team to relocate receptionist closer to the ambulance bay in order to speed up process of registering patients and therefore improve offload times

RTT performance & First OP

Patients treated and OP waiters with first appointment in 18 weeks.

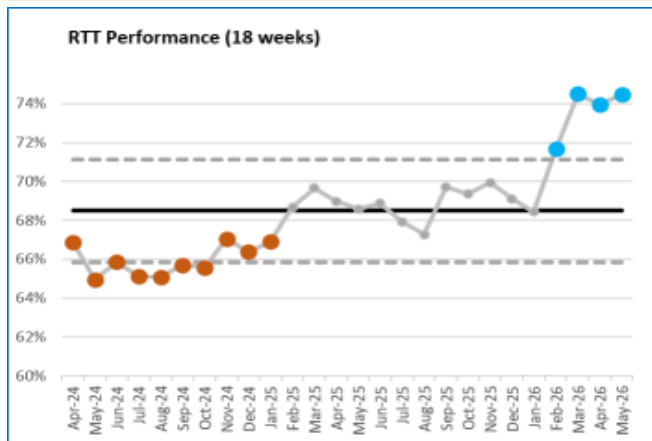
Analytical Highlights:

RTT 18-week performance is still subject to change as validated position is yet to be confirmed. Currently May performance is 74.47%, which is a 0.51% increase from April (73.96%).

1st OP appointment within 18-weeks has shown a marginal increase, reverting to the position of March 2026 after a 0.05% decline in April. This is the highest performance recorded.

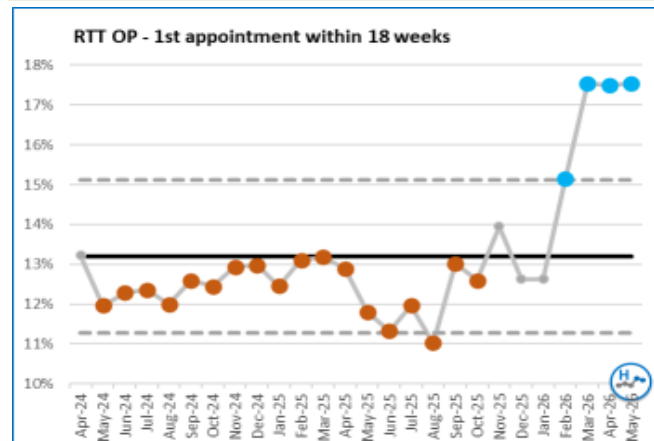
Areas for Concern:

Although RTT performance & is stable, no gains have been made in the past 2 months. Increases in >18wks have primarily been seen in Gynae, Dermatology, Cardiology & Orthopaedics.



Learning & Improvement:

Further focus on wait to 1st appointment and median waiting times.



Actions

- Assess the 12-week RTT challenge via the Patient Access team to accelerate delivery of specialties under 45 weeks. Launched formally 14th April 2026.
- Specialties in breach of 45 weeks to create a sustainability plan to deliver reductions. Specific focus to be placed on Orthopaedics; Spines; Gynaecology; Dermatology, Rheumatology & GI surgery

RTT EDI groups

RTT waiters with learning disabilities and armed forces CCG (13Q)

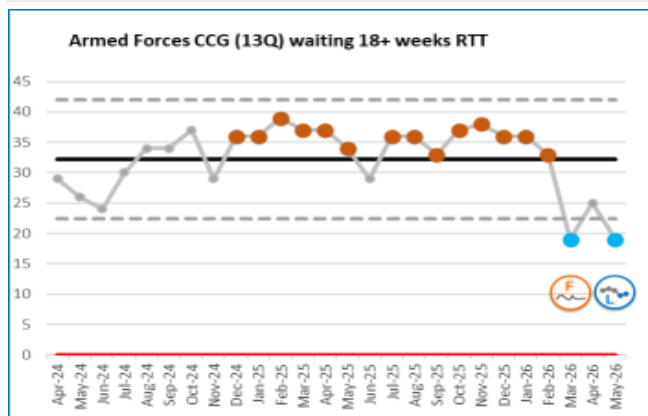
Analytical Highlights:

The armed forces cohort (13Q CCG) has shown a small decline in the number waiting 18+ weeks for treatment, with 19 pathways remaining. Of those waiting 18+ weeks for treatment, the average wait is 29 weeks. The longest wait is 48 weeks.

Those awaiting treatment with learning disabilities has decreased by 9 from April to 55 in May 2026. Of those waiting 18+ weeks the average wait is 28 weeks. The longest wait is 43 weeks.

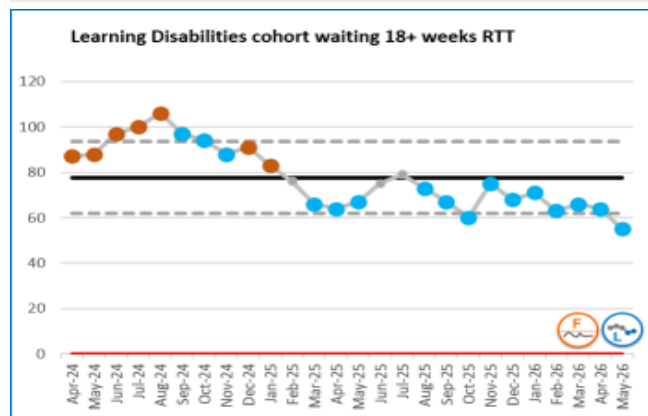
Areas for Concern:

None. The required target of zero 18wk breaches for ENT & Orthopaedics has been sustained for the last 3 months (excluding patient choice). Attention is now shifting to other specialties. Of the current 14 Armed Forces, 8 have dates in June/July.



Learning & Improvement:

Continued reduction in patients waiting over 18W. Increased visibility for LD RTT reporting for specialties and integration into weekly RTT governance.



Actions

- 1) All other services recently advised of requirements to achieve zero 18-week breaches. 8 of the 14 current patients have dates in June/July, with steps being taken to date/bring forward others.
- 2) Focus will remain on Serving BAF personnel, before turning attention to 13Q patients on other waiting lists, and then reviewing Veterans, Retired, Reservists, Dependents.
- 3) Further promotion of timely treatment of patients with LD and review through meetings such as Check & Challenge & Long Waiters

Elective: RTT 45 and 52 Week Waits

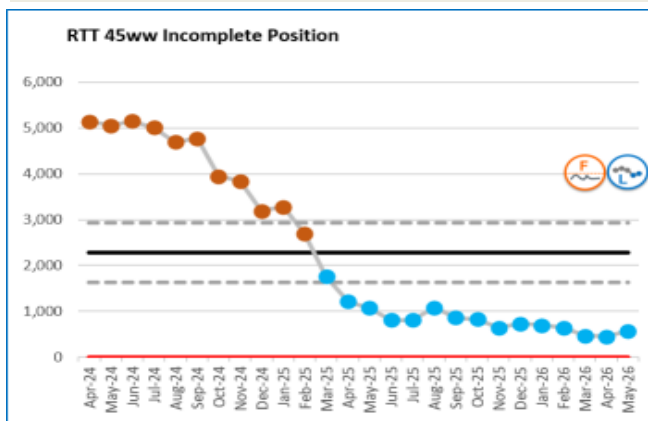
Analytical Highlights:

The 45-week waiting cohort has increased by 119 from April position, resulting in 570 pathways. The largest cohort within this figures is trauma and orthopaedics with 230 pathways.

Similarly, the 52-week cohort stays above the target of 0 for end of fiscal year 2025/26. The position for May is currently 14. Most of this cohort is made up from spinal surgery, with 10 patients. 7 of this cohort have TCI booked for June.

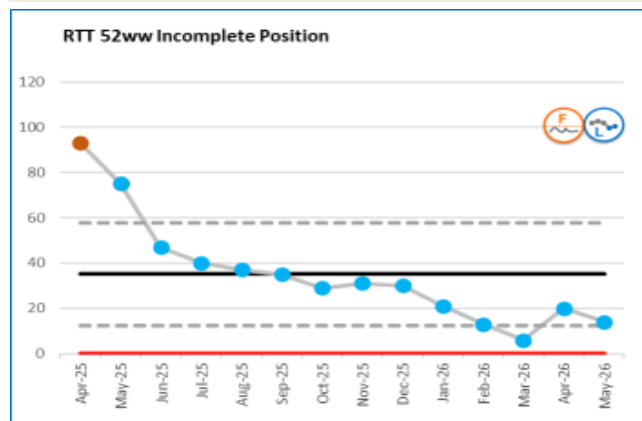
Areas for Concern:

The number of 45wk patients for May remains approx. 100 above March position. This primarily relates to Orthopaedics/ Spines who had 195 (March), compared to an approx. 325 (May). CSSD had bearing & also pending Industrial Action likely to influence position with lost capacity.



Learning & Improvement:

Learning to be shown through RCA's and pathway reviews.



Actions

Resolution of CSSD issues.

Tabletop exercise with Gynae to understand increase in referrals and patients waiting >18wks.

More validation support to be provided to Orthopaedics who are particularly challenged at present.

Opportunities to maximise usage of Independent Sector where appropriate.

Cancer: % Patients seen within 62 Days *Standard: 85%*

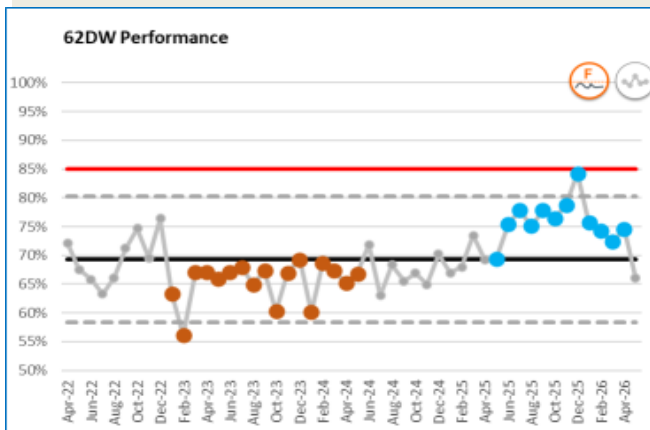
Analytical Highlights:

62-day cancer performance in May was 66.0%, down from 74.6% in Apr and significantly below planned trajectory of 76.5%. Overall performance for the past 6 months shows a downward trend.

Due to delayed impact of the capacity issues in the Breast speciality at the beginning of the year.

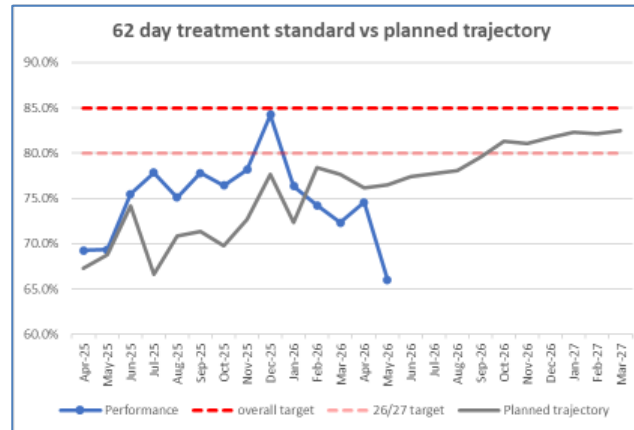
Areas for Concern:

Theatre capacity for LGI, Urology and Gynae to enable timely dating of patients as necessary.
Skin capacity as we enter summer months when we know we have significantly more patients and maintaining current position.



Learning & Improvement:

Do expect to see improvement as Breast capacity improves for 2ww capacity.
Working with H&N and Oncology on improved first OPA capacity



Actions

Working closely with our closest tertiary providers to help support patient pathways across site.

Funding has now been released to help support key initiatives over the coming months that will hopefully impact performance.

Revision of the Cancer delivery group recovery actions for each speciality to better support sustained recovery, whilst giving early oversight to the Cancer Programme Board of any issues (launches in July 2026).

Cancer: Faster Diagnoses Standard (28 Day FDS) % with trajectory

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

Analytical Highlights:

28-day cancer performance improved for the second consecutive month in May at 77.3% and close to the planned trajectory for 78.4% for May.

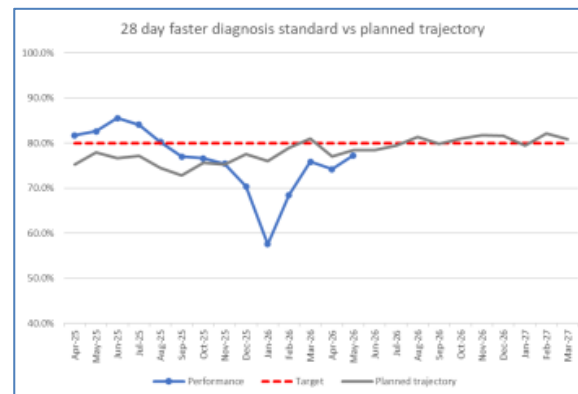
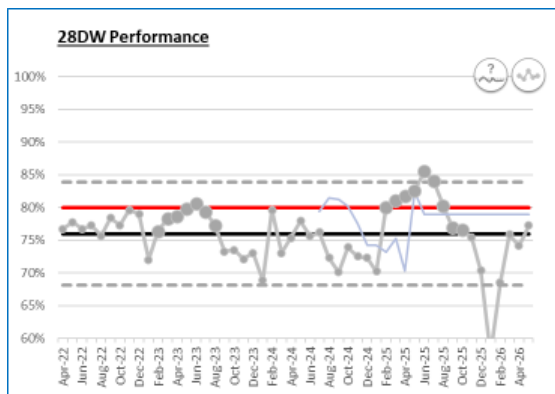
Significant improvements due to improved capacity issues in the Breast speciality performance which is now above 80% target for the second consecutive month.

Areas for Concern:

First OPA capacity for H&N, Derm, Urology (Haematuria), Colorectal and Oncology capacity long term. Breast capacity continues to improve and now booking to day 14-15. Delays in Histopathology T.A.T, particularly within Gynae and H&N and Colorectal

Learning & Improvement:

Work continues with Skin to ensure support and early escalation of challenges as we come into summer months

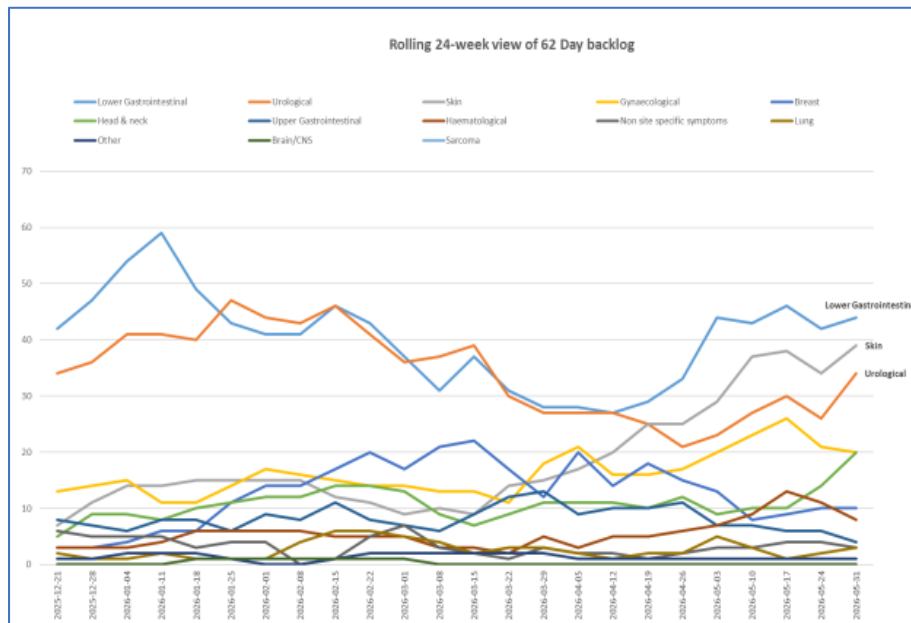


Actions

To achieve the new target of 80% FDS, some of the planned actions include:

- D&C modelling of first OPA capacity to book in line with BTPP – this will begin with H&N in an effort to get down to booking at day 3
- Weekly skin meetings to provide opportunity to respond adequately to seasonal variation

Cancer 62 Day Backlog Position



Analytical Highlights:

Backlog data shows position at end of the week (for the past 24 weeks) for 2WW referrals that have waited over 62 days. Position at 31/05 was 186. Lower GI, Skin, Urological and Head & Neck backlog growing.

Areas for Concern:

Lower GI backlog continues to increase with an upward trajectory due to capacity issues within the surgical aspect of the pathway, complex patients and operational pressures

Urology nephrectomy capacity is particularly challenged at present with mitigations being considered, as is the skin backlog. An emerging risk is the Gynae backlog that is also steadily increasing.

Learning & Improvement:

Sustained backlog recovery of no more than 6% of our PTL expected March-27. Anticipated continued non-compliance in Colorectal and Urology; increased waiting times in Endoscopy DM01 likely to create capacity pressures on the straight-to-test colorectal pathway.

Actions

Implementation of "Day 0" pathway analysis and new escalation policy to be devised with timelines supporting treatment or discharge before day 62

Focus on specialty level recovery and diagnostic pathways, especially within Urology

Improving pathways of patients at tertiary centres who may also be contributing to this backlog position, particularly with the QE in the first instance

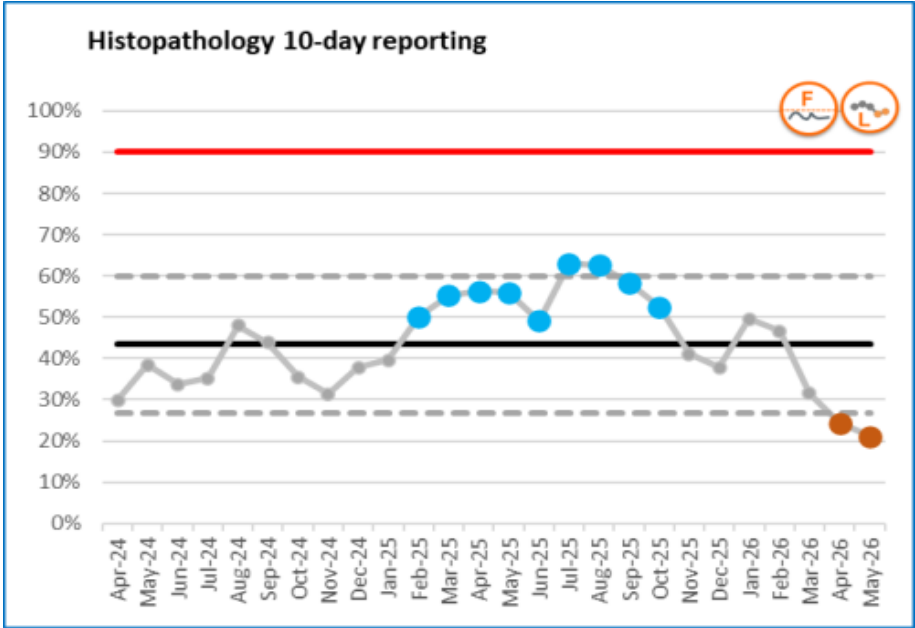
Cancer Waiting Times Performance for the last 3 months

Please Note – May is unvalidated

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

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26
Acute leukaemia											100.0%	100.0%
Brain/CNS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Breast	17.9%	10.6%	14.5%	72.9%	79.2%	82.6%	94.0%	94.1%	92.1%	67.4%	65.4%	62.5%
Gynaecological	86.1%	85.6%	84.3%	67.0%	53.8%	53.5%	90.8%	86.3%	66.7%	48.6%	35.7%	27.6%
Haematological	86.7%	62.5%	50.0%	33.3%	44.4%	33.3%	100.0%	98.3%	97.1%	69.0%	71.4%	55.6%
Head & neck	91.6%	72.7%	73.4%	76.8%	72.8%	79.6%	93.5%	96.9%	100.0%	81.5%	60.9%	57.9%
Lower GI	96.8%	87.4%	87.7%	78.9%	72.1%	77.0%	94.7%	91.2%	88.7%	63.9%	52.1%	57.6%
Lung	100.0%	88.2%	95.5%	92.3%	87.5%	95.7%	94.3%	92.6%	82.8%	64.7%	66.7%	64.7%
Other			0.0%			0.0%	90.0%	90.9%	100.0%	72.7%	100.0%	11.1%
Sarcomas								50.0%	100.0%			
Skin	60.1%	53.9%	38.7%	83.8%	78.6%	75.5%	96.8%	96.9%	100.0%	91.2%	90.0%	100.0%
Non site specific sympto	6.1%	0.0%	0.0%	7.0%	3.4%	12.0%						
Testicular	100.0%	100.0%	81.8%	100.0%	88.9%	100.0%				100.0%	100.0%	
Upper GI	94.0%	95.3%	92.9%	90.6%	91.7%	92.8%	100.0%	100.0%	100.0%	82.6%	82.3%	92.3%
Urological	97.4%	91.8%	87.4%	63.5%	59.2%	66.2%	92.8%	97.2%	75.0%	68.6%	85.9%	76.7%
Trust Total	69.5%	63.6%	61.3%	75.3%	73.4%	76.3%	94.5%	94.9%	87.4%	72.3%	74.6%	65.3%

Histopathology 10-day reporting



Analytical Highlights:

19.8 % of Histo specimens reported in May met the 10-day turnaround time. For urgent specimens, 38.3% met the target turnaround time in May.

Histo TAT declining performance is driven by GI Biopsies and resections which, in combination, have continued on a downward trajectory. For this cohort of specimens (GI), performance was 77% in May 2025 down to 17% in Apr 2026.

Areas for Concern:

Staff shortages both laboratory and consultant are leading to the decline in conjunction with increasing workload

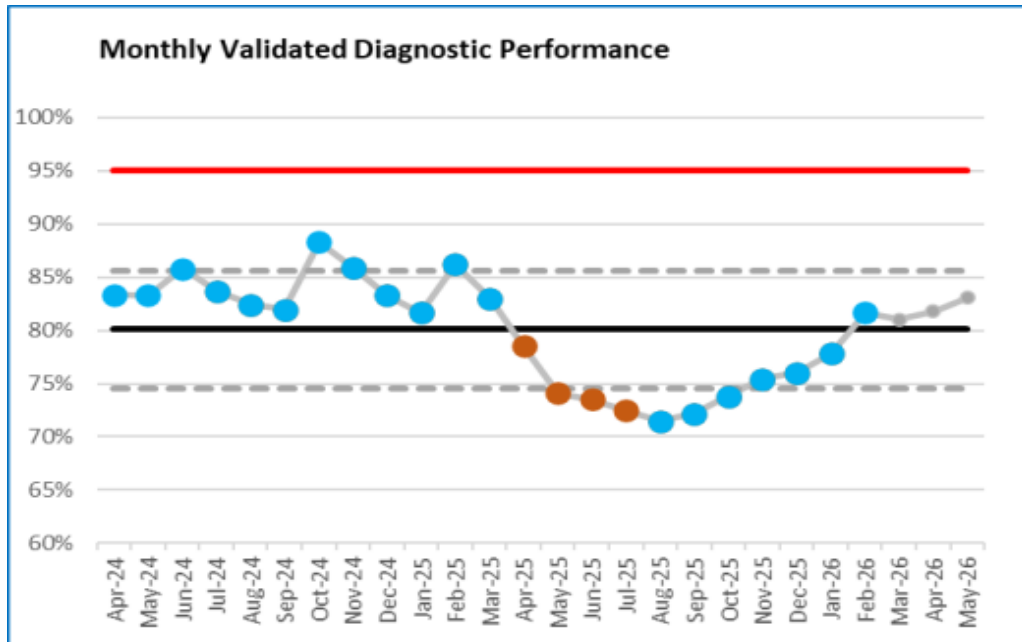
Learning & Improvement:

Digital reporting uptake is high. The Trust is in the top 10 for reporting digitally

Actions

Input here

Diagnostics: Performance Trend



Analytical Highlights:

May has shown a 1.3% improvement for performance compared to April and is the highest performance since February 2025. This has been driven significantly by cardiology echocardiography, where there are 429 fewer breaches than in April (1238 down to 809), a total waiting list reduction of 102 resulting in a 20.29% improvement in performance for this modality.

Areas for Concern:

Five modalities have deteriorated in month (Colonoscopy, OGD, Urodynamics, Neurophysiology, and Sleep Studies).

OGD has deteriorated 9.99% and Cystoscopy by 10.08% however this has been mitigated by the significant performance improvement of ECHO

Learning & Improvement:

Total diagnostic waiting list likely to continue reducing as long as ECHO capacity remains consistent. September 2026 step change in Endoscopy performance anticipated with the introduction of 6 day working.

Actions

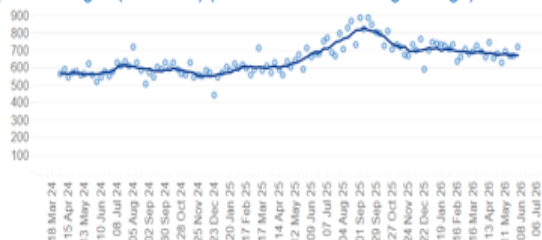
- Neurophysiology has had a minor deterioration of their position; recovery remains slow.
- Endoscopy - September 2026 milestone for additional capacity, although sustainable recovery will not be achieved within phase 2 business case investment. GICB response due by end of June 2026.
- ECHO – 2 staffing gaps recruited into, start dates August & September. Mutual aid to be considered to support reduction in breaches. Weekend lists have been completed in May and will continue in June.
- Sleep Studies - recovery actions implemented – deterioration minor (1.78% = 1 patient)

Diagnostics: Performance Trend

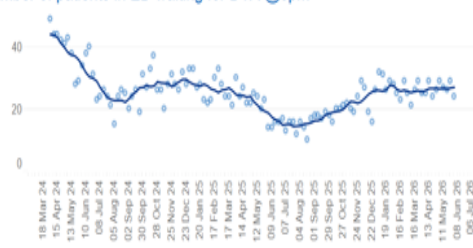
DM01 Performance	Month ▼													
Modality ▼	2025-04-01	2025-05-01	2025-06-01	2025-07-01	2025-08-01	2025-09-01	2025-10-01	2025-11-01	2025-12-01	2026-01-01	2026-02-01	2026-03-01	2026-04-01	2026-05-01
Audiology - Audiology Assessments	99.38%	📉 98.98%	📈 99.22%	➡ 99.22%	📉 98.27%	📈 99.76%	📉 99.66%	📉 99.65%	📈 99.88%	📈 100.00%	📉 99.80%	📉 99.60%	📉 99.07%	📈 99.09%
Barium Enema	83.55%	📈 99.08%	📈 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%
Cardiology - echocardiography	47.08%	📉 33.24%	📉 28.80%	📉 22.98%	📈 29.40%	📉 19.63%	📈 23.41%	📈 26.52%	📈 30.78%	📉 28.52%	📈 41.82%	📉 28.15%	📈 34.36%	📈 54.65%
Colonoscopy	67.16%	📈 72.55%	📉 64.09%	📉 51.96%	📉 45.87%	📈 48.34%	📈 51.27%	📉 50.60%	📉 48.91%	📈 50.00%	📈 53.16%	📈 53.35%	📉 49.91%	📉 49.18%
Computed Tomography	92.83%	📉 91.28%	📉 90.81%	📉 89.75%	📉 86.15%	📈 88.47%	📈 89.11%	📉 87.28%	📉 87.07%	📈 88.64%	📈 92.64%	📈 93.44%	📈 94.60%	📈 95.34%
Cystoscopy	45.18%	📉 38.97%	📉 33.40%	📉 28.29%	📈 36.31%	📉 28.36%	📈 32.75%	📈 36.93%	📈 39.83%	📈 41.96%	📈 46.20%	📈 58.65%	📈 73.46%	📉 63.38%
DEXA Scan	100.00%	➡ 100.00%	➡ 100.00%	📉 99.77%	📈 100.00%	➡ 100.00%	➡ 100.00%	📈 99.82%	📈 100.00%	➡ 100.00%	➡ 100.00%	📉 99.18%	📈 100.00%	➡ 100.00%
Flexi sigmoidoscopy	74.47%	📉 61.40%	📉 51.05%	📉 45.05%	📉 40.29%	📈 42.34%	📉 41.69%	📉 38.54%	📉 37.40%	📈 47.55%	📈 52.76%	📉 52.18%	📉 51.06%	📈 55.69%
Gastroscopy	86.10%	📉 80.38%	📉 75.00%	📈 77.54%	📉 74.81%	📉 73.63%	📉 71.75%	📈 73.81%	📉 73.77%	📈 82.48%	📉 82.23%	📈 84.31%	📉 80.09%	📉 70.10%
Magnetic Resonance Imaging	77.59%	📉 76.09%	📈 85.26%	📈 91.42%	📈 99.17%	📉 98.90%	📈 99.10%	📉 97.84%	📈 99.11%	📉 99.02%	📈 99.45%	📉 99.03%	📈 99.38%	📉 99.03%
Neurophysiology - peripheral neurophysiology	40.88%	📈 43.82%	📉 35.68%	📈 53.05%	📈 56.86%	📈 60.87%	📈 62.28%	📈 75.14%	📉 59.76%	📈 69.67%	📈 75.80%	📉 75.16%	📈 79.84%	📉 78.48%
Non-obstetric ultrasound	99.68%	📈 99.93%	📉 99.49%	📉 99.18%	📈 99.40%	📈 99.47%	📈 99.64%	📈 99.91%	📉 99.63%	📉 99.36%	📉 98.21%	📉 96.67%	📉 94.36%	📈 95.41%
Respiratory physiology - sleep studies	98.26%	📉 90.38%	📈 96.73%	📉 96.43%	📈 97.90%	📉 94.22%	📈 96.27%	📈 99.22%	📉 91.69%	📉 82.23%	📈 96.30%	📉 93.01%	📈 95.49%	📉 93.71%
Urodynamics - pressures & flows	76.09%	📈 100.00%	📉 75.81%	📈 87.50%	📈 100.00%	➡ 100.00%	➡ 100.00%	➡ 100.00%	📉 91.67%	📈 100.00%	➡ 100.00%	➡ 100.00%	📉 87.50%	📈 92.59%

Flow Summary

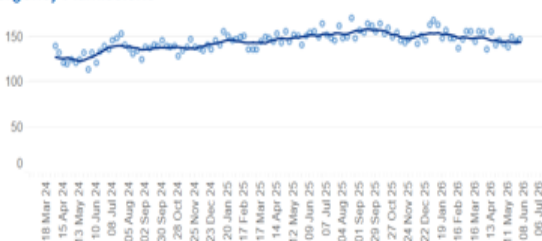
Simple discharges (Non OCT) (incl moves to discharge lounge)



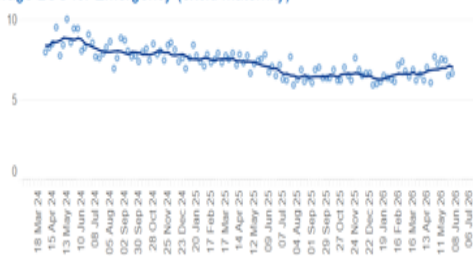
Number of patients in ED waiting for DTA @6pm



Emergency Admissions



Average LOS for Emergency (excl maternity)



Analytical Highlights:

- Simple discharges remain above the 2024 baseline, although down from the autumn peak.
- Emergency LOS remains well below 2024 levels, with a small recent increase.
- Admissions have eased from winter highs, but demand is still high.

Areas for Concern:

- ED DTA waits at 6pm have risen from the 2025 low and are now in the mid-20s.
- Discharge volumes have levelled off while front-door demand remains high.
- The recent LOS increase suggests improvements may not hold without reliable discharge capacity.

Learning & Improvement:

- Daily discharge reliability is the key area to focus on.
- SDEC and admission avoidance capacity need to be flexible to support on high-demand days.
- Seven-day discharge and CLD need to maintain the simple-discharge baseline.

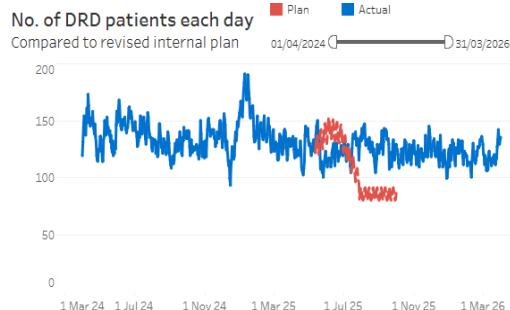
Actions

- Use CLD and the discharge lounge to bring simple-discharge numbers back up.
- Review of front-door escalation and SDEC pathways in line with CVOF workstreams to reduce DTA waits.
- Ward level reviews of LOS and weekend discharges weekly where delays persist.

Discharge Ready Summary

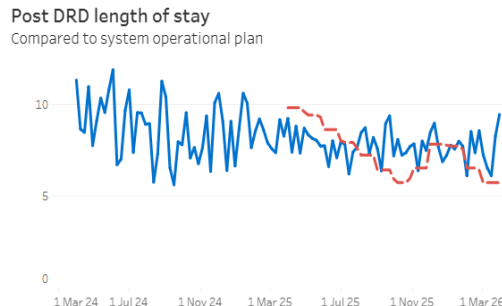
No. of DRD patients each day

Compared to revised internal plan



Post DRD length of stay

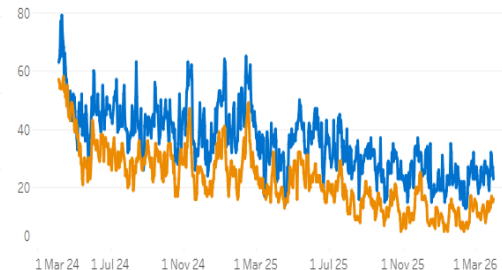
Compared to system operational plan



No. of patients who are DRD for >21 days



DRD patients with internal actions



Analytical Highlights:

- The >21-day DRD cohort is much lower than 2024, however a recent upward trend has persisted
- Internal-action DRD numbers have come down over time, but are still above plan.
- Post-DRD LOS has significantly risen in the past month

Areas for Concern:

- Total DRD is still above the revised internal plan, with recent actuals around 110–120.
- Progress has stalled if not deteriorated, increasing the gap to plan.
- Pathway 1–2 capacity constraints are still driving excess days.

Learning & Improvement:

- A focused >21-day pathway review should support the next improvement step.
- Weekend and early-week discharge reliability is key to driving overall numbers and delays down.

Actions

- Review each DRD pathway weekly against plan.
- Increase pathway 1 starts and pathway 2 packages/bed capacity for complex patients.
- Prioritise >21-day cases and post-DRD LOS reviews through system escalation as highest risk group
- Consideration of formal escalation at trust level in relation to the deterioration in the DRD position considering we are in the summer months

Delay Related Harm Summary

Analytical Highlights:

- Deaths with a discharge-ready period remain below the historic mean and control limit.
- Reverting to CTR remains within expected variation and below earlier peaks.
- The current data does not show a clear increase in harm, despite discharge pressure.

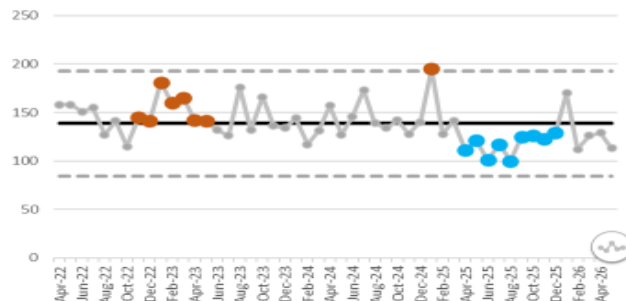
Areas for Concern:

- Reverting to CTR has increased from the 2025 lows and should be watched closely.
- Risk is still concentrated in patients with long DRD delays, particularly pathways 1–2.
- Pathway 2 acuity/dependency continue to make onward flow difficult.

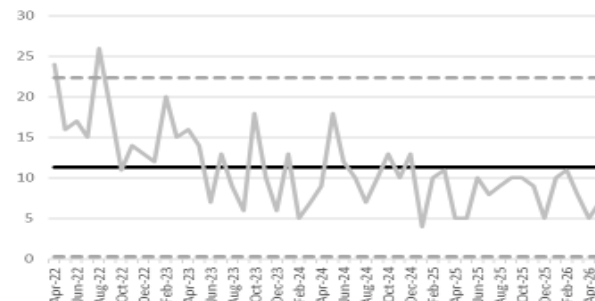
Learning & Improvement:

- Harm reduction needs a focus on the highest-risk delayed patients, not just the average position.
- Pathway 2 capacity needs to match acuity, dependency and package availability.
- Case study reviews should be used to check whether discharge delays contributed to harm over the longer term.

Reverting to Criteria to Reside Instances



Deaths with Discharge Ready Period



Actions

- Continue harm surveillance, with exception review of DRD deaths and CTR reversions.
- Match pathway 2 beds/packages to acuity and dependency assumptions.
- Escalate long-delay/high-risk cases weekly with clinical and system partners.

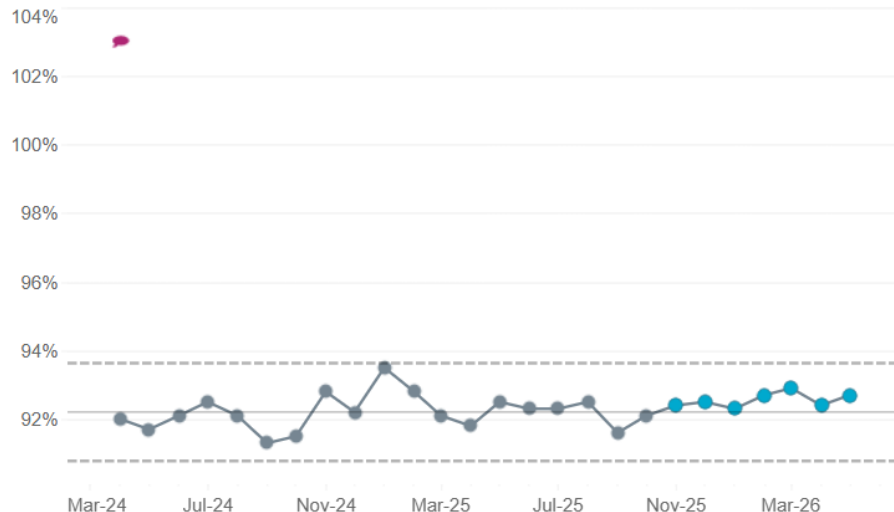
Quality Metrics

(Safety, experience and effectiveness)

Quality of Care: FFT Positive Response

[156] Total % positive

Trustwide



Quality Highlights:

FFT positive score remains above average. An increase in overall positive score is due to improvements in scores for outpatients, maternity and ED with a stable score for inpatient areas.

Areas for Concern:

The difference in experiences between each ED at CGH to GRH remains significant.
Postnatal ward experiences remain low.

Learning & Improvement:

Would expect overall position to remain static into June.

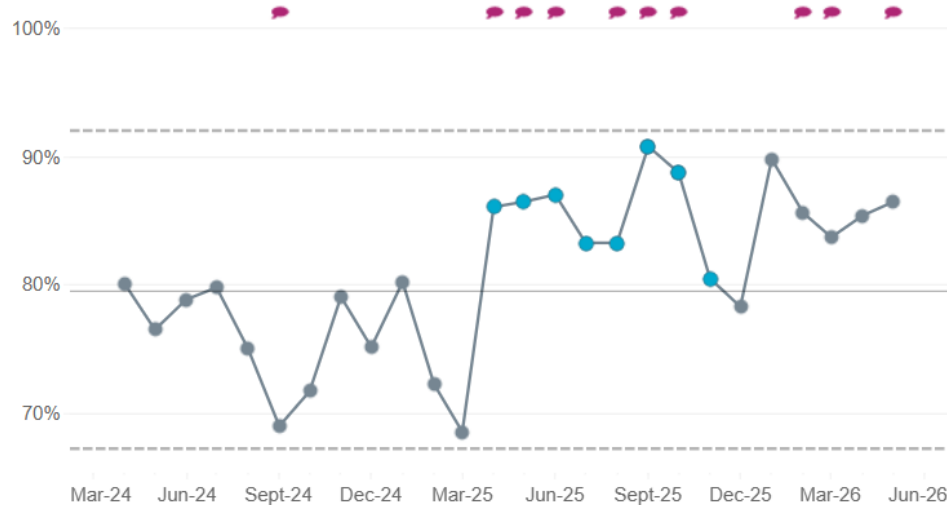
Actions

Improved reporting ongoing with divisions with a strengthening of quality governance and a specific focus on patient experience linked to Trust strategy.
Patient Experience Team to work with Maternity and ED leads to support experience improvement in areas regularly experiencing lower scores.

PALS

[569] % of PALS concerns closed in 5 days

Trustwide



Quality Highlights:

Closure rate maintained above target (75%) at 86% and is sustained position on the previous two months. (Number closed in 5 working days = 293. Total closed in month = 339)
Team remain committed to ensuring a high quality, responsive service for patients.
Position remains positive relating to KPI

Areas for Concern:

Volume of cases remains very high with May seeing the largest number of concerns in over 2 years (392).
Further sickness in the team, holding a vacancy and a backdrop of increasing volume and complexity of cases is causing significant pressure and negative impact on staff wellbeing.

Learning & Improvement:

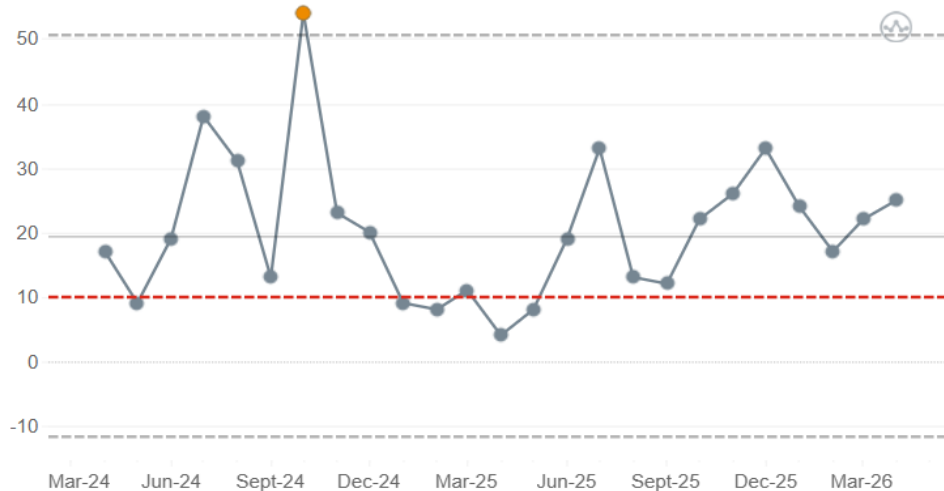
Anticipate staying in line with KPI with vacancy out to advert
Further adjustments to processes including access to the service, triage of cases, escalation of ongoing concerns.

Actions

Workload distribution continues to be reviewed to support PALS staff including support from the wider Patient Experience Team.
Advert for bank support is now live with a 0.8 WTE substantive vacancy also out to advert.
Escalation of areas experiencing the highest number of concerns.
Adjustment to access to service including closure of drop-in service and management of telephone calls outside service core hours.
Improved triangulation with complaints data.
Quality concerns relating to ongoing pressure has been added to risk register reference number 1128.

Patient Care: Mixed Sex Breaches

[148] Number of breaches of mixed sex accommodation
Trustwide



Analytical Highlights:

Mixed sex accommodation breaches remain low and are an exception

Areas for Concern:

Delays in transferring out of Critical Care and Recovery create MSA breaches at times of high acuity with low levels of discharges.

Learning & Improvement:

Expected to remain within limits of expected performance.

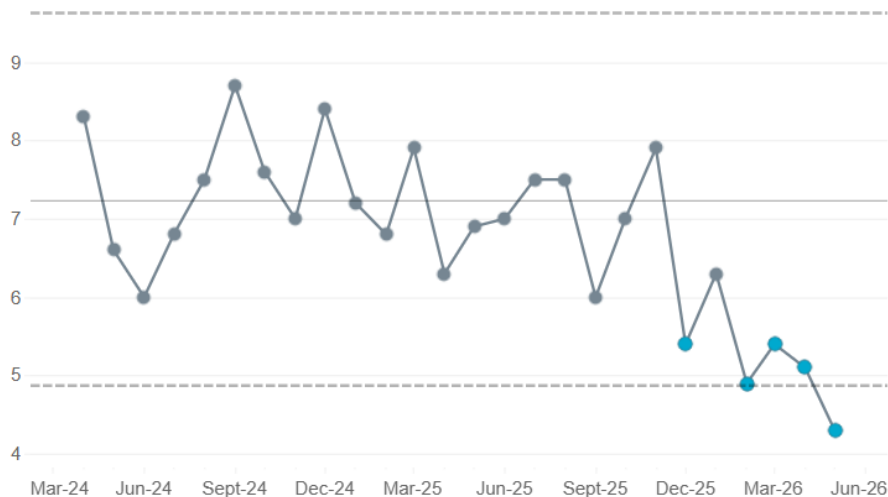
Actions

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

Safety Priority: Patient Falls

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

Trustwide



Quality Highlights:

Number of falls within the trust has fallen to 6 falls per 1000 bed days. There were no falls resulting in injury during May.

Areas for Concern:

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

Learning & Improvement:

We have a continuous improvement programme of work which is ongoing.

Actions

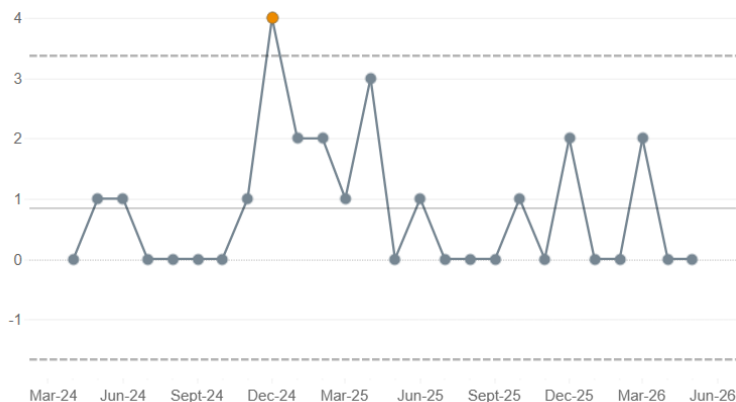
Improvement focus is on specialist review of patients who have fallen twice during admission, if appropriate. A comprehensive training package has been launched by the Falls Team and is being very well attended; this is a key focus for us.

Quality improvement programmes continue with Datix development to include Hot Debrief questions within the reporting Datix form. The EPR documentation complete, sitting with the EPR team for uploading. Immediate Post falls forms for both Nursing and Medical staff now live on EPR and in use – education sessions continue for both professions.

Safety Priority:

Pressure Ulcers Cat 3

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



Quality Highlights:

There were no Category 3 pressure ulcers reported this month.

Areas for Concern:

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

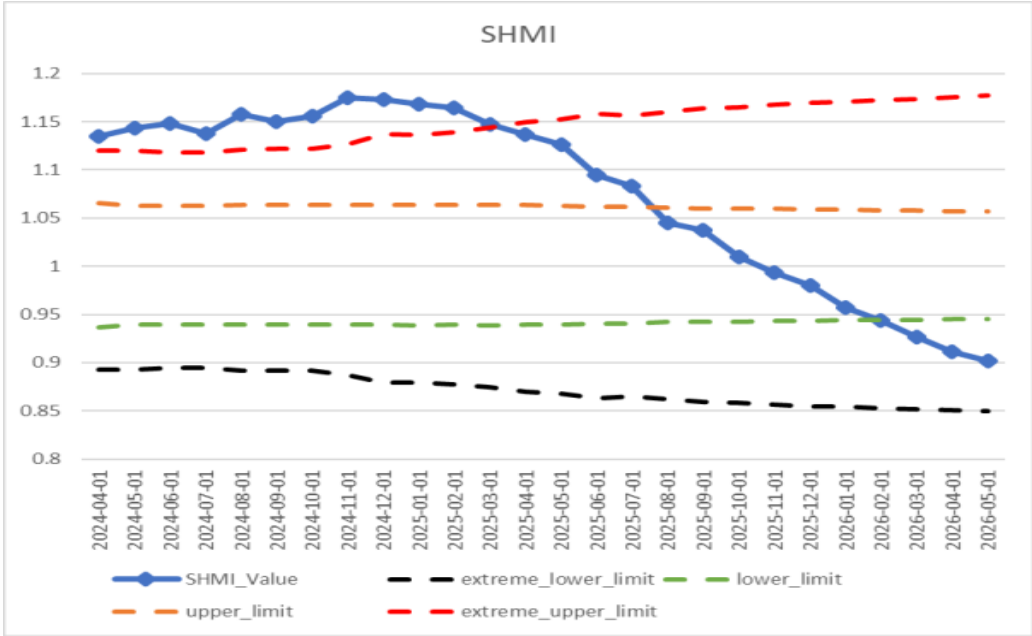
Learning & Improvement:

We continue with the prevention of pressure ulcers in our PSIRF Plan and are using thematic review to drive our improvement plan.

Actions

Improvement focus continues on specialist review of all hospital acquired category 3 pressure ulcers. Specialist equipment for prevention of pressure ulcers has been procured by individual wards. The Tissue Viability Team deliver comprehensive simulated training in the prevention of pressure ulcers monthly at a variety of locations.

Mortality – SHMI National Data



Quality Highlights:

SHMI (NHS Digital) published 14/5/26 = 0.90
(data Jan – Dec 25), continues to fall

Areas for Concern:

Ongoing monitoring of SHMI without remedial coding
Clinical audits guided by mortality alerts (BAU)
• Currently this includes aspiration pneumonia/sepsis
ED delay related harm

Learning & Improvement:

Sepsis group now set up to co-ordinate improvement work

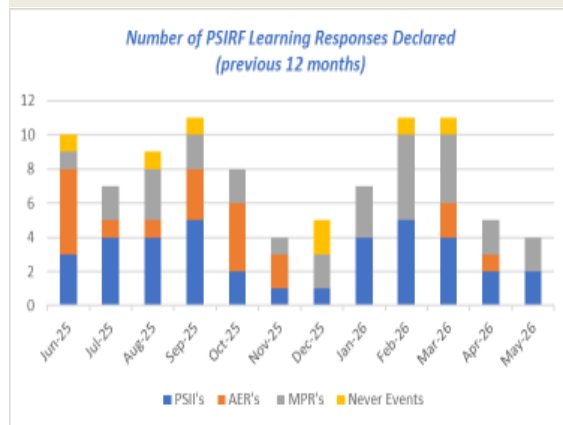
Actions

Ongoing monitoring of Alerts via HMG

PSIRF (Patient Safety Incident Response Framework) Learning Responses

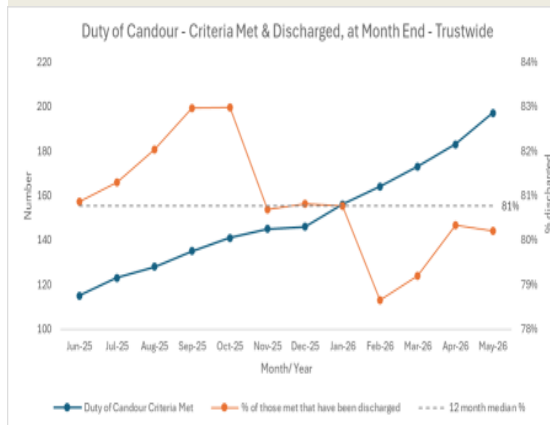
Highlights:

92 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 7.6 per month.



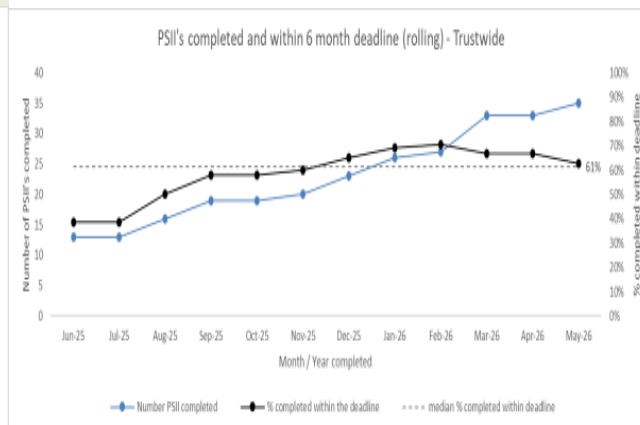
Areas for Concern:

Median on time for PSII's increased to 61%, AER's increased to 72% and MPR's remained at 70%. The median % discharge rate at the end of the month remained at 81% (i.e. statutory DoC had been discharged in 158 of the 197 cases declared)



Learning & Improvement:

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



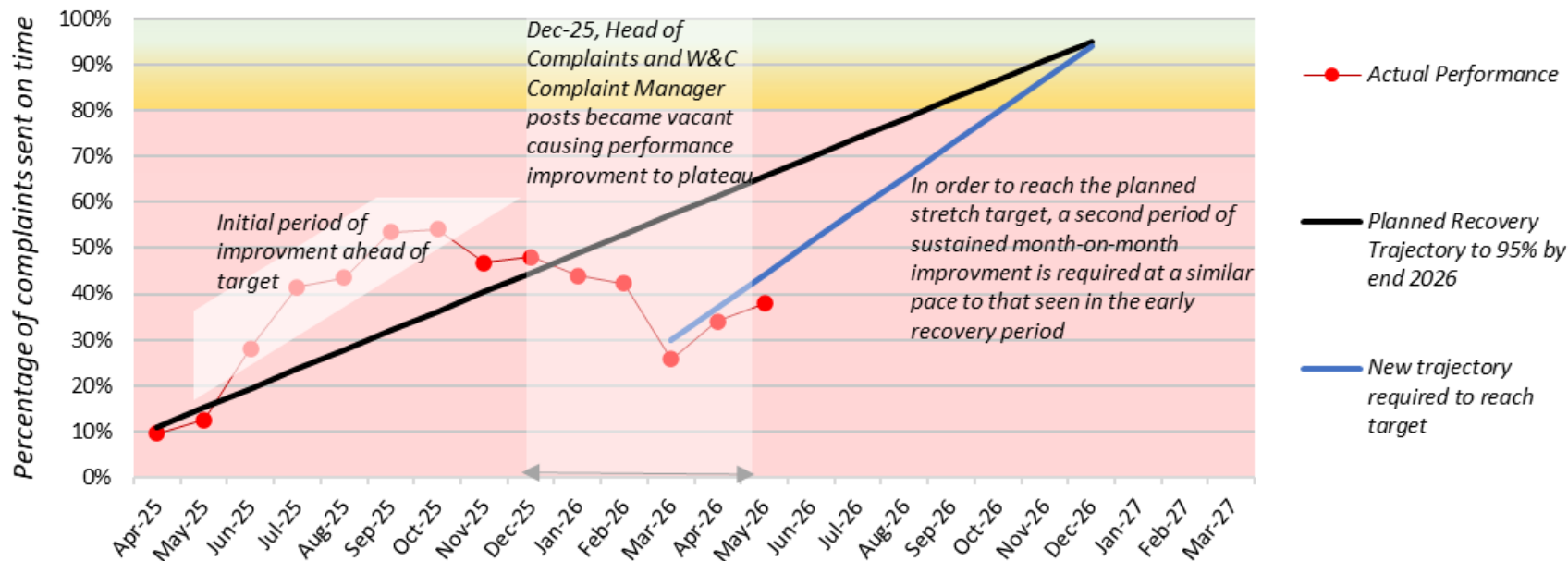
Actions

Resource: Implementation of the Quality Governance Framework

Never Events: Thematic Analysis completed and shared with Trust Board. Learning Responses are prioritised and being completed within required timeframes

Complaint Performance – 2025/26 to date

Complaints performance - Percentage of complaints sent within required timescales



Complaint Performance 2025/2026 (May)

Highlights

Percentage of complaints sent within required timescales, increased to 38% in May from 34% in April 2026 (red). W&C/D&S Complaint Manager in post as of 13.05.26. Temporary Head of Complaints post offered following successful interview on 15.05.26. Anticipated start date 30.06.26. Temporary staffing in place to support with backlog

Areas of concern

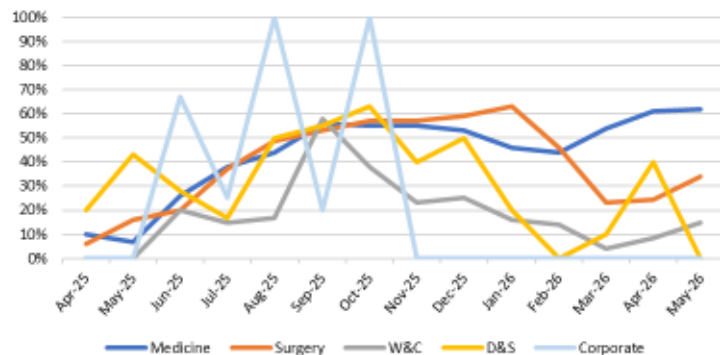
Workforce and leadership gaps have adversely affected delivery and consequently performance, alongside notable increases in numbers of complaints received in Jan to May 2026. Complaint Improvement Programme remains on hold. This will be reinstated when Head of Complaints in post. Oldest complaints (>6 months) remain a delivery risk, although numbers reducing with temporary staffing support.

Looking forward:

Performance expected to remain constrained short-term. Recovery dependent on: Workforce stabilisation, targeted backlog clearance (oldest & highest risk) and Trust-wide

adoption of New Complaint Framework, including Early Resolution. Full implementation removes central drafting as rate-limiting step and supports return to 95% timeliness

Percentage of Complaints sent within required timescales - by Division



Number of complaints received and responses sent

Division		2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05
Corporate	Received		1	9	5	6	7	6
	Closed	7	4				1	
Diagnostics and Specialties	Received	3	8	7	5	5	9	12
	Closed	6	6		7	3	1	7
Gloucestershire Managed Services	Received				3		4	
	Closed	2	2					
Medical	Received	35	33	43	47	42	55	57
	Closed	40	30	28	31	47	43	68
Surgical	Received	36	32	54	42	58	48	48
	Closed	44	35	43	35	42	17	40
Virtual Ward Hub	Received	1						
	Closed					1		
Women's and Children's	Received	27	19	20	22	19	24	20
	Closed	19	15	12	7	10	12	37
Trust Total	Received	102	93	133	124	130	147	143
	Closed	118	92	83	80	103	74	152

Technical Analysis and Planned Actions:

May position: 38%. Whilst remaining below standard, there has been improvement from the 27% in March.

Mitigations in place: overtime, bank support with drafting: Locum Registrar in place from w/c 18/5/26. Temporary Head of Complaints position offered. .

Recovery actions: Stabilise workforce. Targeted backlog plan reinstated. Restart Complaint Improvement Programme when Head of Complaints in post

Progress monitored via weekly executive oversight with monthly reporting

Risk Management Performance

Analytical Highlights:

Overall, the risk exposure rate is declining which shows increasing control and reduction of risk. High degree of compliance in relation to all live risks having controls and risk-reduction actions in place. Risk Reviews – All divisions (except Medicine) remain amber for this KPI, with D&S and Surgery close to a green RAG. Medicine remains a red RAG with almost 1/3 of risks overdue.

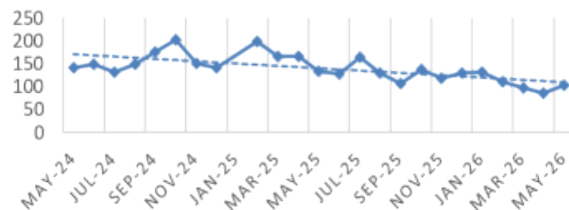
Areas for Concern:

Timeliness and effectiveness of risk reviews declined with 18% overdue compared to 15% previously **Medicine remain red at 29% of risks not reviewed, although this has improved on the earlier 36%** Overdue actions on risks increased again from 42% to 44% this month, while overdue actions on incidents increased from 63% to 68%. This level of performance is well-beyond the tolerance level of the KPI

Learning & Improvement:

RMG has consistently called for divisional leaders to contact teams and individuals to identified as having persistent or multiple overdue risks and actions, and to address barriers to improving performance.

No. of overdue risk reviews



Overdue actions on risks

	No. overdue	Total open	% overdue	Change since last month
Corporate	40	119	33%	↓
Medical	47	106	44%	↓
Surgical	62	117	53%	↑
D&S	34	145	23%	↑
W&C	59	98	60%	↑
GMS	55	87	63%	↑
Trust	297	672	44%	↑

Overdue actions on incidents

	No. overdue	Total open	% overdue	Change since last month
Corporate	17	45	37%	↑
Medical	60	77	78%	↓
Surgical	58	58	100%	↑
D&S	33	42	78%	↑
W&C	160	262	61%	↑
GMS	7	9	78%	↓
Trust	335	493	68%	↑

Actions

Risk exposure reduced again this month by 1.1% with 13 risks closed. Across all registers 69% of risks are scored as high-risk and a further 9% scored as extreme-risk. The graph (left) denotes that there was a slight increase in the number of risks reported this month as overdue. However, overall, this trend is reducing. Across all registers, the KPI is rated amber with 18% overdue. The tables (centre and right) show performance against the actions KPI. Compliance performance is well-beyond the tolerance level of the KPI

Use of Resources Metrics

Financial Metrics

Finance Highlights

The M2 revenue position is £4.78m deficit which is £0.08m favourable to plan. FSP has delivered £5m which is £1.19m ahead of plan. Capital spend is £3.2m which is behind plan by £4.4m

Areas for concern

FSP target increases significantly from Q2 and there remains an unidentified gap of £6.6m. This has improved from prior month due to non recurrent efficiencies identified.

Learning & Improvement

The underlying position for the Trust is £66.5m deficit which assumes full delivery of 26/27 recurrent FSP.



2026/27 Financial Overview	Plan £000s	Actual £000s	Variance £000s	Metric Calculation	Score (1 Best) (4 Worst)
<u>NHS Oversight Framework - Financial Metrics</u>					
Planned (Surplus)/Deficit (Full Year)	(0)			0.0%	1
Variance year to date to financial plan (YTD)	4,856	4,778	(78)	-1.6%	1
<u>Internal Financial Metrics</u>					
Revenue (surplus)/deficit YTD	4,856	4,778	(78)	-1.6%	1
Agency spend against NHSE YTD	819	1,266	447	54.6%	4
Agency spend against NHSE target Forecast	5,392	6,560	1,168	21.7%	4
Bank spend against NHSE target YTD	5,956	7,089	1,133	19.0%	4
Bank spend against NHSE target Forecast	33,097	39,434	6,337	19.1%	4
FSP YTD	(3,852)	(5,043)	(1,191)	-30.9%	1
FSP Forecast	(52,345)	(45,736)	6,609	12.6%	4
Capital vs budget plan YTD	7,645	3,236	(4,409)	-57.7%	1
Capital vs budget plan Forecast	59,774	62,241	2,467	4.1%	4
	Days/%	Days/%	Days/%		
Nos days operating cash	5	19	14	-100.0%	1
BPP - nos invoices paid in 30 days	95%	98%	0.03	-3.2%	1

Director of Finance Summary

Month 2 Overview

The month 2 year to date position is £4.78m deficit which is £78k favourable to plan. The plan is £4.86m deficit.

The variance is driven mainly by:

- FSP (£1.19m) above plan
- Industrial Action £0.7m (April)
- Non pass through drugs £1m
- Pay underspends on other clinical staff (£0.6m)

Looking Ahead

There are risks to the financial position that are currently being managed to ensure they are mitigated. The delivery of financial sustainability plans continues to be the biggest risk. In addition, further industrial action has been announced to take place in June with no additional funding to cover the cost.

Next Steps

The finance oversight sub-committee is now in place. The focus for June will be financial sustainability schemes (divisional and transformational), understanding the drugs overspend, having a plan for temporary workforce reductions and agreeing actions to mitigate divisional overspends within Medicine and D&S.

M02 Revenue Position

Finance Highlights

The M2 revenue position is £78k favourable to plan. Over performance against FSP plans are offsetting industrial action and drugs costs.

Areas for concern

Whilst FSP has over delivered YTD, this is due to non-recurrent savings rather than recurrent or transformation schemes. The FSP targets increase significantly from Q2 to deliver transformation schemes.

Learning & Improvement

The underlying position for the Trust is £66.5m deficit which assumes full delivery of 26/27 recurrent FSP.

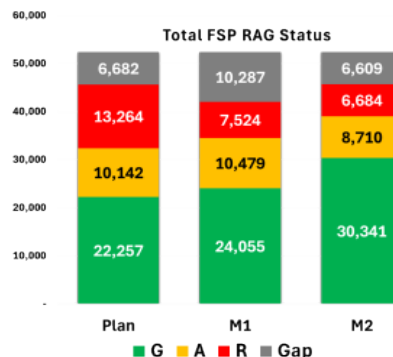
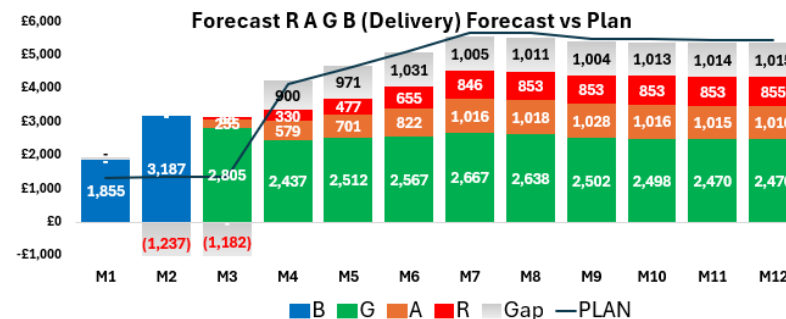
YTD Month 2 Financial Position	TRUST POSITION				GMS POSITION				GROUP POSITION			
	FY Plan £000s	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	FY Plan £000s	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	FY Plan £000s	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s
SLA & Commissioning Income	798,882	133,147	133,572	425	0	0	0	0	798,882	133,147	133,572	425
PP Overseas and RTA Income	8,520	1,124	1,049	(75)	0	0	0	0	8,520	1,124	1,049	(75)
Other Income from Patient Activities	10,325	1,742	1,598	(144)	0	0	0	0	12,835	1,817	2,647	830
Operating Income	44,171	7,512	7,831	319	93,958	15,660	14,188	(1,471)	38,150	6,483	7,784	1,301
Total Income	861,898	143,525	144,050	525	93,958	15,660	14,188	(1,471)	858,387	142,571	145,052	2,481
Substantive	(487,856)	(82,582)	(79,763)	2,820	(31,271)	(5,212)	(4,949)	263	(496,518)	(83,748)	(84,720)	(972)
Bank	(20,280)	(3,383)	(4,326)	(943)	0	0	(5)	(5)	(21,057)	(3,504)	(4,331)	(828)
Agency	(2,664)	(435)	(1,056)	(622)	0	0	(148)	(148)	(5,389)	(898)	(1,266)	(368)
Locum	(12,033)	(2,008)	(2,758)	(749)	0	0	0	0	(12,033)	(2,008)	(2,758)	(749)
Total Pay	(522,833)	(88,408)	(87,903)	505	(31,271)	(5,212)	(5,102)	110	(534,997)	(90,158)	(93,075)	(2,917)
Drugs	(105,817)	(17,637)	(19,352)	(1,716)	(0)	(0)	(3)	(3)	(105,817)	(17,637)	(19,355)	(1,718)
Clinical Supplies	(50,641)	(7,423)	(7,489)	(66)	(8,864)	(1,477)	(2,675)	(1,198)	(59,505)	(8,900)	(10,164)	(1,264)
Other Non-Pay	(174,922)	(34,561)	(33,119)	1,442	(51,470)	(8,578)	(6,040)	2,538	(147,659)	(29,016)	(25,902)	3,114
Total Non Pay	(331,381)	(59,621)	(59,960)	(339)	(60,334)	(10,056)	(8,717)	1,338	(312,981)	(55,553)	(55,421)	132
Total Expenditure	(854,214)	(148,029)	(147,863)	166	(91,605)	(15,267)	(13,819)	1,448	(847,978)	(145,711)	(148,496)	(2,785)
EBITDA	7,684	(4,504)	(3,813)	691	2,354	392	369	(23)	10,409	(3,140)	(3,444)	(304)
EBITDA %age	0.9%	(3.1%)	(2.6%)	131.7%	2.5%	2.5%	2.6%	1.6%	1.2%	(2.2%)	(2.4%)	12.3%
Non-Operating Costs	(8,634)	(1,574)	(2,180)	(605)	(2,354)	(392)	(369)	23	(11,359)	(2,938)	(2,549)	389
Surplus / (Deficit)	(950)	(6,078)	(5,993)	85	0	0	(0)	(0)	(950)	(6,078)	(5,993)	85
Donated Asset, IFRIC & Salix Grant Adjust	950	1,222	1,215	(7)	0	0	0	0	950	1,222	1,215	(7)
Adjusted Surplus / (Deficit)	(0)	(4,856)	(4,778)	78	0	0	(0)	(0)	0	(4,856)	(4,778)	78

M02 FSP

Finance Highlights

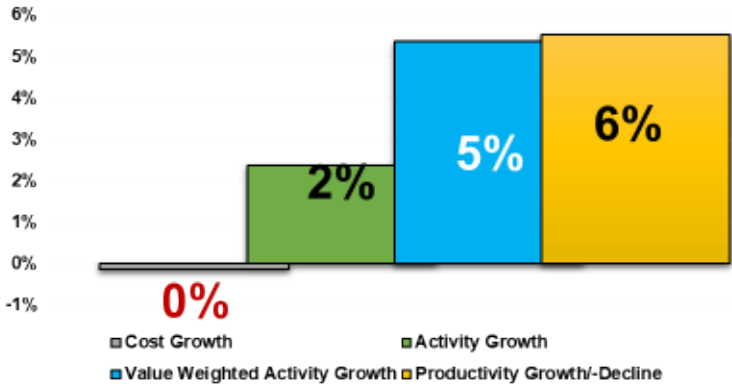
- YTD delivery of 5.0M YTD against a plan of £3.9M
 - Key drivers of YTD delivery
 - Divisions are above plan currently however a large proportion of this is badged as non-recurrent.
 - £1.9M of the £5.0M YTD delivery relates to new schemes that weren't included in the original plan.
 - Full year forecast currently treating cost pressures £13.8M as delivering.
 - This will be subject to a true-up in month 3
 - In month 2 the value of cost pressures declared as delivered is £2.2M
 - Subject to transformation schemes delivering to plan and divisions fully closing their gaps, we will start to show a gap in month 4 at this stage
 - If there is a delay in delivery of transformation schemes from M4 onwards on a ramping trajectory, we will fall further behind
- The total gap to delivering the plan has reduced from £10.3M in M1 to £6.6M in M2
- This includes a forecast to deliver all but £1.6M of the transformation programme while the delivery plans become clearer
- Any delay to delivery of the submitted plan for transformation schemes will result in a larger gap

Total Programme	Full Year			YTD		
	Plan	Forecast	B/ (W) vs Plan	Plan	Actual	B/ (W) vs Plan
Total Recurrent	39,258	35,404	(3,855)	3,754	3,481	(273)
Total Non-Recurrent	13,086	10,333	(2,753)	97	1,562	1,465
Total Schemes	52,345	45,736	(6,608)	3,851	5,043	1,191



Productivity

YTD M11 Productivity 24/25 vs 25/26
Trust Wide



The latest position from the South West Productivity Network (M10 25/26) shows GHFT as ranking number 1 in the region for productivity growth, stating a 6.4% implied productivity growth. This is comfortably above the national acute average of 2.8%. GHFT ranks 16th nationally of 134 Trusts.

	M10			Movement			Productivity Rank		
	Inflation adj. expenditure growth (EG)	Cost-weighted activity growth (CWA)	Implied productivity growth (IP)	Inflation adj. expenditure growth (EG)	Cost-weighted activity growth (CWA)	Implied productivity growth (IP)	Trust Rank (1 highest productivity; 13 lowest productivity)	System Rank (1 highest productivity; 7 lowest productivity)	National Acute Rank by Type (1 = highest productivity)
UHBW	0.7%	3.9%	3.1%	0.2%	0.2%	-0.1%	3		57 / 134
NBT	1.6%	3.8%	2.2%	-0.4%	-0.1%	0.3%	7		
BNSSG Acutes	1.1%	3.8%	2.7%	-0.1%	0.0%	0.2%		4	
Salisbury	1.3%	4.3%	3.0%	-0.3%	0.3%	0.6%	5		63 / 134
GUWH	-2.1%	1.9%	4.1%	-0.4%	0.2%	0.6%	2		37 / 134
RUH	2.7%	4.5%	1.8%	3.6%	0.2%	-3.5%	9		82 / 134
BSW Acutes	0.6%	3.6%	2.9%	1.1%	0.2%	-0.9%		2	
CORNWALL Acute	-2.4%	-1.4%	1.1%	-0.7%	-0.3%	0.5%	11	6	96 / 134
RDUH	3.0%	0.4%	-2.6%	-0.4%	0.2%	0.5%	13		123 / 134
T&SD	0.7%	3.8%	3.1%	-0.5%	-0.2%	0.3%	3		57 / 134
UH Plymouth	0.5%	2.0%	1.5%	0.5%	0.3%	-0.2%	10		87 / 134
DEVON Acutes	1.5%	1.6%	0.1%	-0.2%	0.2%	0.4%		7	
Dorset County	1.0%	0.6%	-0.5%	-0.3%	-0.3%	-0.1%	12		110 / 134
UH Dorset	0.8%	2.9%	2.1%	-0.1%	0.3%	0.4%	8		77 / 134
DORSET Acutes	0.8%	2.3%	1.5%	-0.3%	0.1%	0.4%		5	
GLOUCS Acute	-0.5%	5.8%	6.4%	0.0%	-0.4%	-0.3%	1	1	16 / 134
SOMERSET Acute	0.0%	2.9%	2.8%	0.7%	0.2%	-0.7%	6	3	68 / 134
SOUTH WEST REGION Acutes	0.7%	2.7%	2.0%	0.2%	0.0%	-0.2%			6
NATIONAL Acutes	-0.4%	2.4%	2.8%	-0.3%	0.0%	0.3%			

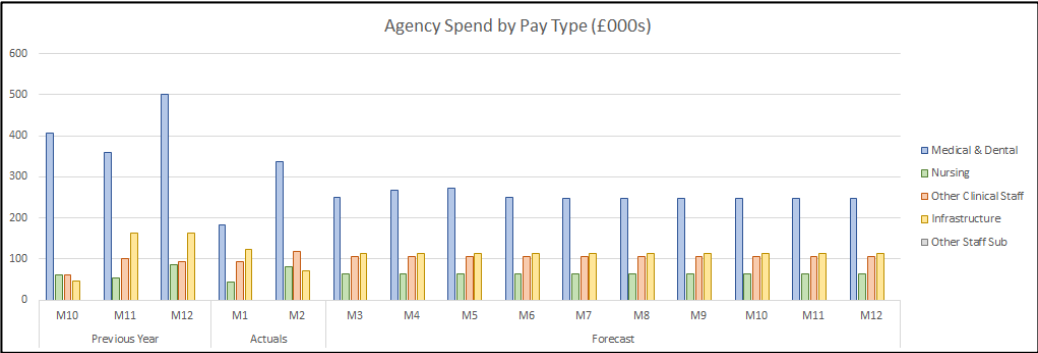
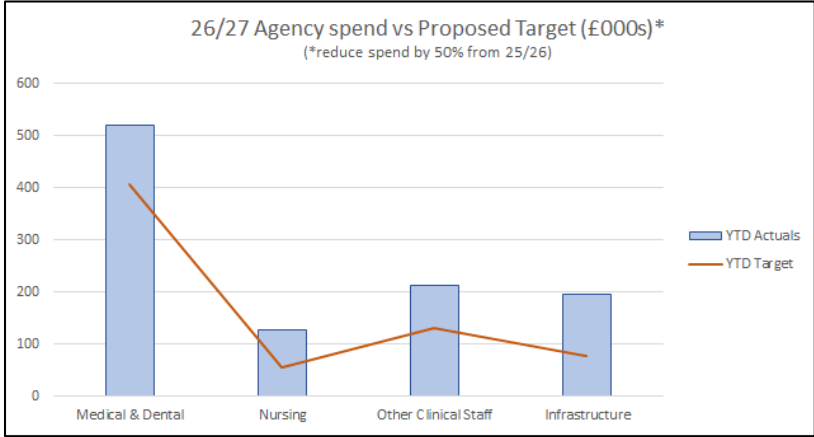
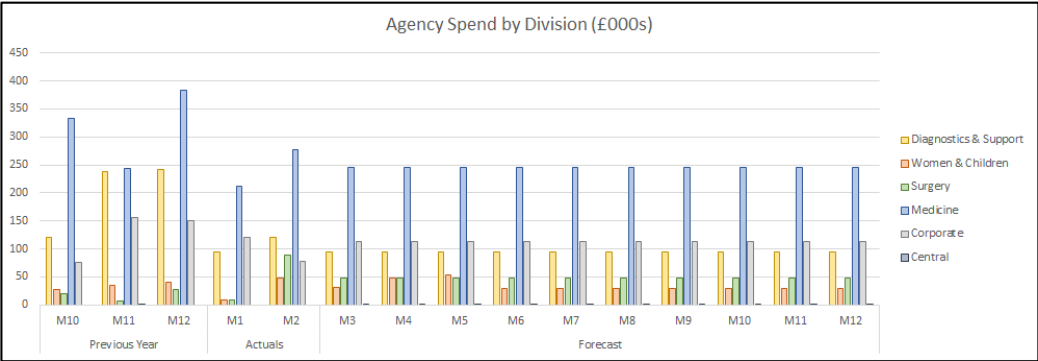
Finance Highlights

The graph above is from our own internal Productivity dashboard and is based on M11, where we are showing 6% productivity growth compared to M11 24/25

Agency Staffing – Spend

Finance Highlights

NHSE has set a target for GHFT to reduce agency spend to £5,391k in 26/27. The Group needs to reduce spend by c.50% from £10,469k last year to be able to meet the target. Month 2 spend is higher than Month 1, which increases in D&S and Medicine. This is partially due to year end adjustments benefitting Month 1. Month 2 YTD spend is £1,266k which is £368k above the NHSE target. If no action is taken, full year spend will be c£6.5m.



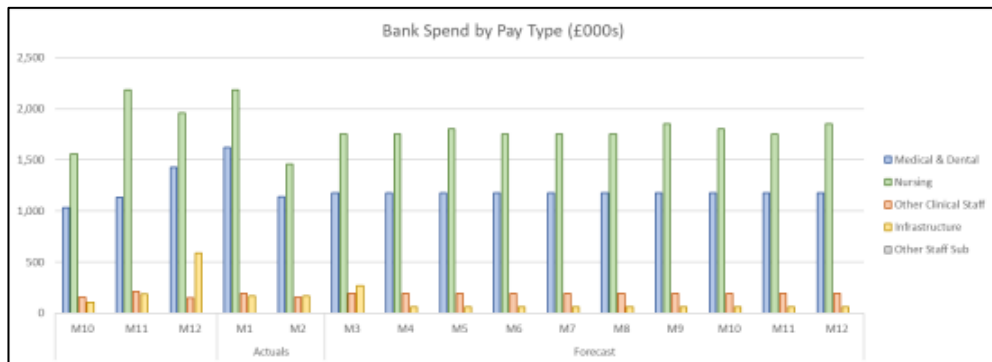
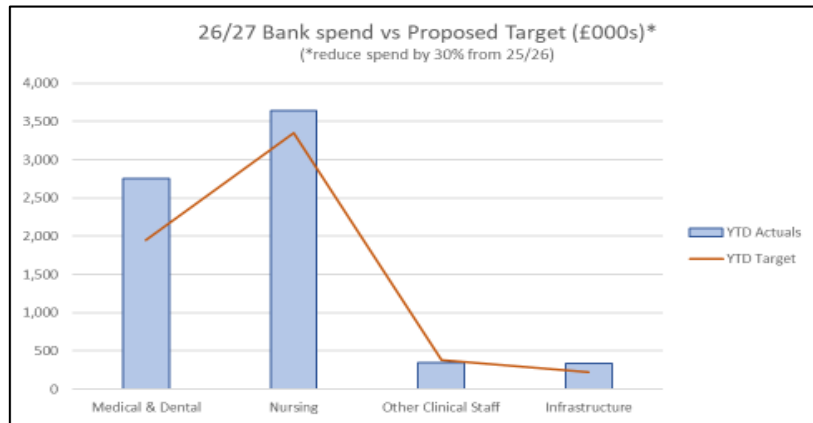
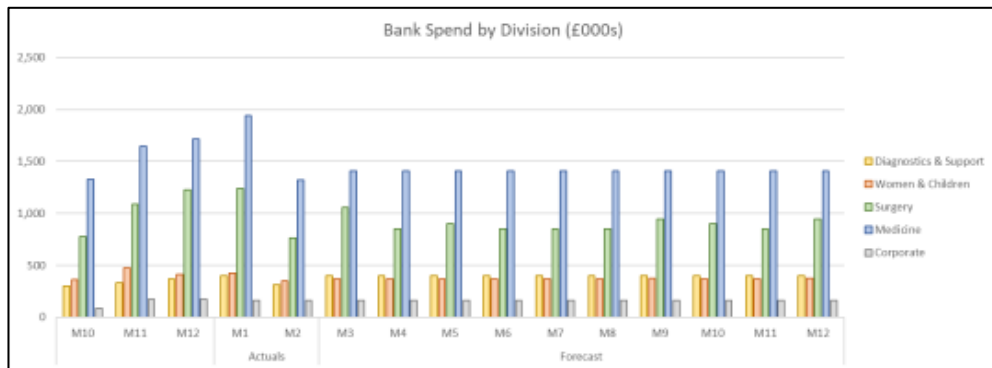
Bank Staffing – Spend

Finance Highlights

The Group needs to reduce spend by c.30% from £45,968k last year to £33,090k to be able to meet the NHSE target.

Month 2 spend is lower than Month 1 due partly to there being no industrial action in month but mainly due to nursing bank. Fill rates are lower than last year e.g. within Surgery division, the roster shows that the fill rate for the last 6 months of 25/26 was c.92% compared to c.88% in month 1 & 2 with the percentage in month 2 having come down from month 1. This could be due to a reduction in enhanced rates although it is too early to confirm this yet.

Month 2 YTD spend is £7,084k which is £1,200 above the NHSE target. If no action is taken, full year spend will be £39,400k.



Note: the allocation of targets to workforce group is based on a desktop calculation and has not been agreed by execs yet so could change.

M02 Capital Position

Finance Highlights

As of the end of May (M2), YTD expenditure on the Trust capital programme totalled £3.3m, against a planned spend of £7.8m, equating to a variance of £4.5m behind plan.

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	968	1,178	(210)	7,277	7,418	(141)
MEDICAL EQUIPMENT	333	502	(169)	5,630	5,630	0
ESTATES	5,222	1,526	3,696	25,207	27,869	(2,662)
CORPORATE	0	(292)	292	67	0	67
Total Charge against Capital Allocation (incl. IFRS 16)	6,523	2,913	3,610	38,181	40,917	(2,736)
NAT PROG: ESTATES SAFETY	874	262	612	12,000	12,000	0
NAT PROG: CONST STANDARDS	187	0	187	10,614	10,614	0
IFRIC 12	91	91	0	546	546	0
DONATIONS VIA CHARITABLE FUNDS	84	15	69	900	900	(0)
Total Expenditure against Additional Funding	1,236	369	868	24,060	24,060	(0)
Gross Capital Spend Total	7,759	3,281	4,478	62,241	64,977	(2,736)
Less Donations and Grants Received	(84)	(15)	(69)	(900)	(900)	(0)
Less PFI Capital (IFRIC12)	(91)	(91)	0	(546)	(546)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	61	61	0	366	366	0
Total Capital Departmental Expenditure Limit (CDEL)	7,645	3,236	4,409	61,161	63,897	(2,736)

Analysis

The Trust submitted a gross capital expenditure plan for the 26-27 financial year totalling £59.8m. Subsequently we have been notified of a further allocation of £2m of National funding for Estates Safety. In addition a further £400k of charitable donations are expected to be received, in total therefore the gross capital allocation available to spend this year is now £62.2m

Spend on System Capital funded projects is £3.6m behind plan YTD driven by Estates as a result of timing differences in relation to M1 and M2 valuations on DCC, Electrical Infrastructure Phase 2, and Lithotripter/Urology, together with programme delays on DCC, due to the need to identify a suitable compound for the build, as well as Prescott and Kemerton Ward refurbishments.

Despite the YTD position being behind plan it is expected that Estates will recover the position by the end of the financial year and the current forecast is £2.7m above allocation across the whole Capital programme. Forecasts are currently under review with project teams to bring them into line with allocation and the next phase will be agreed schemes to have business cases submitted to Capital Steering Group for review and approval.

Workforce

Workforce Performance Indicators

Workforce Highlights:

- Sickness absence has risen slightly
- Temporary staffing (agency and bank) has fallen after three consecutive months of increases

Areas for Concern:

- Temporary staffing significantly close to the workforce plan in M02, with bank below and agency above
- Appraisal compliance still generally between 82-84%, below target

Learning & Improvement:

- Continued focus on temporary staffing reductions in the multiyear plan
- Spending caps for temporary staffing have been set as part of the multiyear plan, entailing significant reductions each year

KPI (Trust)		Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Turnover		11%	8.40%	8.34%	8.64%	8.13%	8.03%	8.73%	8.48%	8.47%	8.57%	8.52%	8.65%	8.99%
Vacancy		8%	7.48%	7.45%	7.99%	6.85%	6.87%	6.96%	7.29%	7.09%	7.37%	7.95%	7.06%	7.91%
Sickness		4%	4.62%	4.39%	4.39%	4.40%	4.41%	4.43%	4.47%	4.47%	4.54%	4.55%	4.57%	
Appraisal		90%	83%	84%	84%	84%	83%	82%	83%	82%	82%	84%	82%	81%
Essential Training		90%	90%	91%	91%	91%	90%	90%	91%	91%	91%	91%	90%	90%

		Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Bank WTE	Medium Term Plan	509.92	511.41	518.04	521.41	524.79	496.7	501.69	505.01	510.58	495.82	499.15	493.35
	Actual (PWR)	562.63	470.88										
	Difference	52.71	-40.53										
Agency WTE	Medium Term Plan	41.80	41.06	31.68	31.26	30.89	30.48	27.34	27	22.91	22.6	22.28	17.72
	Actual (PWR)	64.98	57.32										
	Difference	23.18	16.26										

Analysis & Actions

There is a complex interplay between turnover, vacancy and establishment movements.

Caution should be taken when interpreting the vacancy against the target, as it can be impacted due to e.g. short term changes in non-recurrent funding.

- Establishment is updated on ESR from the Ledger.
- Sickness absence is reported 1 month in arrears, as it is not all uploaded to ESR until ~20th each month (with the payroll)

Workforce: Sickness Absence

Workforce Highlights:

Overall trust absence is up compared to previous 12 months (+0.2%)

Mental health makes up the largest proportion of absence reasons across all staff groups except M&D, where respiratory is now slightly higher

Areas for Concern:

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

Learning & Improvement:

Rollout of Medical e-rostering may result in higher reported absence rates, based on experience in of roll outs other trusts.

The medium term plan specifies that the trust should improve its sickness rate year on year.

Trust	WTE	Trend				Division (Past 12 months)					Top 5 Absence Reasons (latest 12 months)**				
	Latest	Prev. 12m	Last 12m	Difference	Trendline	Corporate	D&S	Medicine	Surgery	W&C	Mental Health	Musculoskel	Respiratory	Gastrointest	Urinary/Gynae
	7440.34	4.4%	4.6%	0.2%		4.3%	4.6%	4.5%	4.5%	5.2%	27.0%	18.8%	15.6%	10.4%	4.4%
Add Prof Scientific & Tech	233.60	2.9%	4.7%	1.9%		*	3.9%	9.0%	6.2%	*	30.1%	10.3%	13.1%	7.6%	2.8%
Additional Clinical Services	1262.79	6.3%	6.6%	0.3%		6.2%	6.8%	6.2%	7.5%	4.8%	24.8%	22.2%	13.8%	12.0%	4.9%
Administrative and Clerical	1561.72	4.2%	4.6%	0.4%		4.2%	4.7%	5.3%	5.7%	4.7%	29.7%	17.7%	14.6%	7.8%	2.8%
Allied Health Professionals	473.94	3.3%	3.3%	0.0%		*	3.2%	*	4.0%	*	32.7%	15.7%	20.5%	11.6%	4.9%
Estates and Ancillary	32.97	4.9%	6.6%	1.7%		*	8.3%	*	*	*	37.0%	24.0%	4.4%	3.6%	1.6%
Healthcare Scientists	267.91	2.7%	4.0%	1.3%		*	4.1%	4.8%	3.3%	*	21.4%	15.4%	21.3%	10.7%	4.3%
Medical and Dental	1093.71	2.1%	1.9%	-0.3%		2.5%	1.6%	2.2%	1.7%	1.7%	12.5%	7.6%	15.1%	7.1%	0.2%
Nursing & Midwifery	2513.70	4.9%	4.9%	0.0%		4.5%	5.4%	4.6%	4.3%	6.4%	28.8%	20.6%	17.1%	11.7%	6.0%

Actions

- Monitoring of absence KPIs on Medical e-rostering is underdevelopment as part of the rollout.
- The HRBPs are analysing areas with the high levels of MH (Stress)cases across their divisions to look at themes/potential links and root causes.

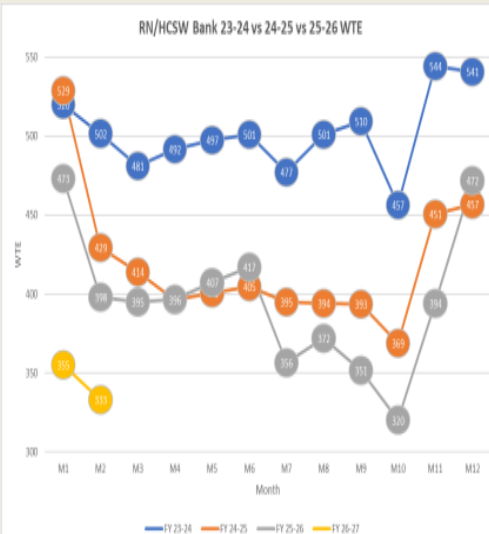
Workforce: Bank

Workforce Highlights:

- The Trust has seen a decrease in temporary RN/HCSW Staffing of 117 WTE (From M01 355 to M02 33 WTE).
- This chart does not follow previous years M01 and M12 rough equivalence. The M01 reduction is a significant variation from previous WTE used.
- In comparison with M02 of 25/26 FY, there has been a decrease of 65 WTE RN/HCSW
- Medicine** is the highest user of Bank & Locum staff.
- Top 3 users in M02 are ED, Acute and COTE. AED & Acute areas have decreased temporary staffing use compared to M12.
- ED** (75 to 65 WTE), **COTE** (29 to 30 WTE) Acute (28 to 25 WTE)
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the improvements achieved throughout the FY.

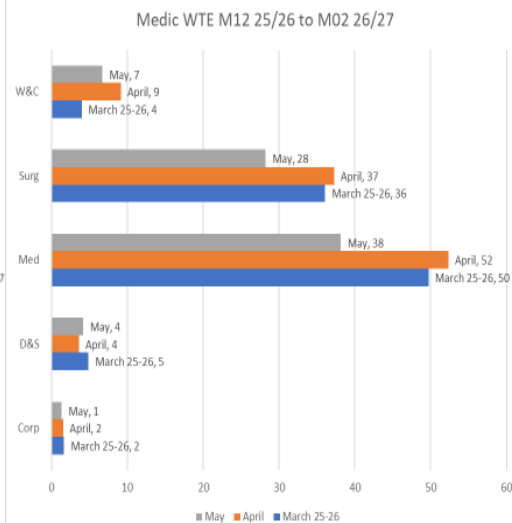
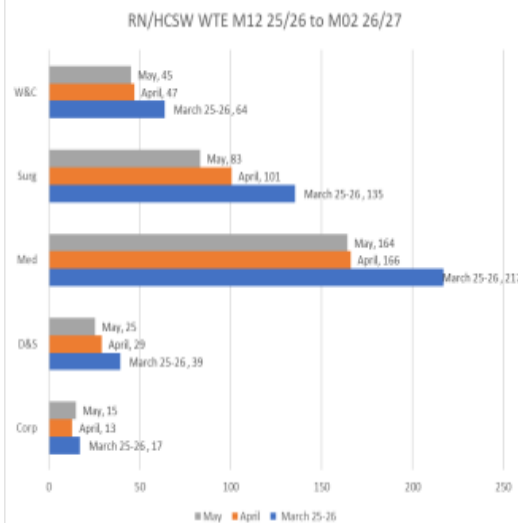
Areas for Concern:

- Overall WTE and £ use of bank target is under review for 26/27
- M02 for RN/HCSW bank use is lower in 26/27 than 25/26



Learning & Improvement:

- As the trend for FY23-24, 24-25 and 25-26 WTE use is broadly similar, it is reasonable to assume that M3 FY26-27 will also see a similar WTE use.
- If future IA is taken, the trust can expect increases in Medic and RN/HCSW WTE as displayed in the data in this slide



Actions

- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

Workforce: Appraisal

Analytical Highlights:

Appraisal compliance is 81%, remaining below the Trust target of 90%. Although rates have been broadly stable over the past 18 months, there is a declining trend over the last two months. Variation across the organisation persists, with corporate as a divisional outlier at 75%, and Integrated Governance a service line outlier at 47% (the only service line below 50%)

Organisation-wide only 15% of service lines are achieving $\geq 90\%$, the majority (64%) are in the 70-89% range, and 21% are below 70%.

Areas for Concern:

Where compliance is the primary focus, quality indicators for appraisal in Staff Survey show deterioration against our national position.

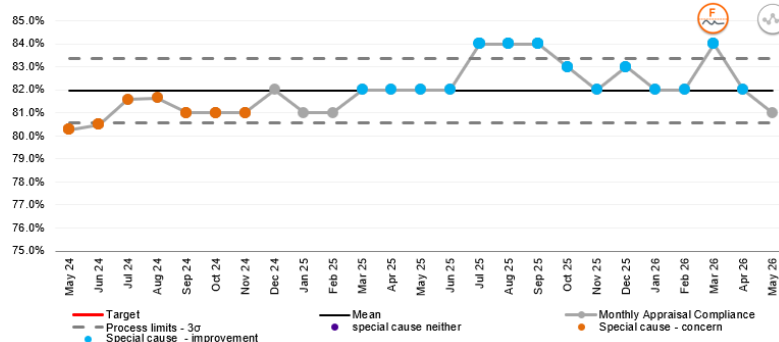
Interventions implemented over the past 12 months have not delivered sustained or significant improvement in compliance, indicating limited impact of current approaches.

Learning & Improvement:

BDO Field Work Reports are currently being collated.

We believe that the decline in compliance is partly due to a backlog of recorded appraisals not yet uploaded into ESR.

Appraisal % - Trust starting 01/05/24



Actions

BDO Audit received 170 survey responses and themes will be reported in next month's IPR. Guidance developed to support accurate ESR recording – in process of realising. Cost codes with no named supervisor accessing compliance reports will be contacted to ensure accountability sits at a local level. To review the reporting form process and consider decommissioning / changes to the system

Staff Group / Date	31-May-26
Add Prof Scientific and Technic	85%
Additional Clinical Services	78%
Administrative and Clerical	77%
Allied Health Professionals	86%
Estates and Ancillary	86%
Healthcare Scientists	78%
Medical Staff - Consultants	91%
Medical Staff - SAS	85%
All Medical Staff	90%
Nursing and Midwifery Registered	82%
GHT Total	81%

Division / Date	31-May-26
Corporate Division	75%
Diagnostic & Specialty Division	84%
Medicine Division	80%
Surgery Division	81%
Women & Children Division	84%
GHT Total	81%

Workforce: Agency

Workforce Highlights:

Registered Nurse (RN)

- The trust has seen a decrease in temporary RN agency Staffing over the last 3 financial years. Average use 23/24 of 88 WTE to 11 WTE in 25/26
- M01 and M02 of this year are following a similar average use to that of 25/26.
- 7 WTE of Agency Shifts are for RMN's 1.8 WTE for Midwifery
- Medicine** is the highest user of agency in M02

Medical & Dental

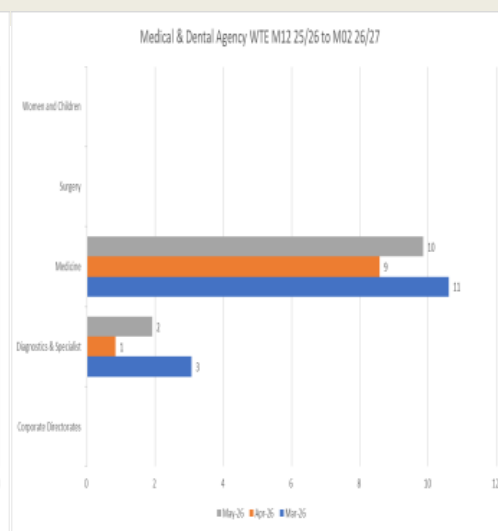
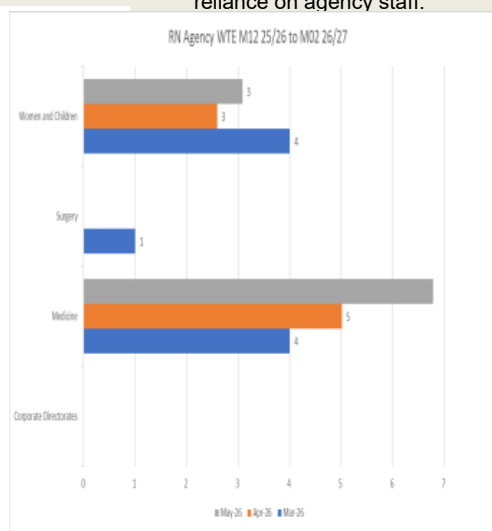
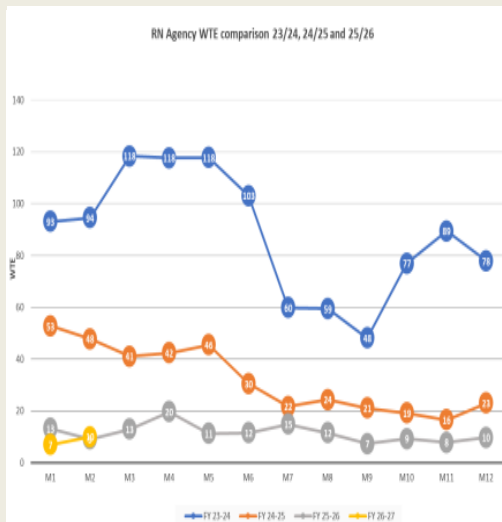
- Medicine are the highest users of agency
- Top 3 agency users in M02 are ED, Acute and COTE.
- Reductions in agency use when comparing the same month in 25/26 shows a reduction of 5 WTE in the medical division
- Surgery have not had agency for the last 3 months M12-M02
- Women's & Children have not had agency cover 8 months

Areas for Concern:

- Overall WTE and £ use of Agency is not yet at the trust reduction target of 50% in M02
- Lead time – on the day sickness is the biggest driver for using high-cost agency for registered nurses

Learning & Improvement:

- Registered Nurse** - As the trend for WTE agency use in FY25-26 and M01 and M02 use is broadly similar, it is reasonable to assume that M3 FY26-27 will also see a similar WTE use.
- Medical & Dental** – Grip and control meetings are strengthening workforce planning by bringing focus to exit strategies and support measures to reduce reliance on agency staff.



Actions

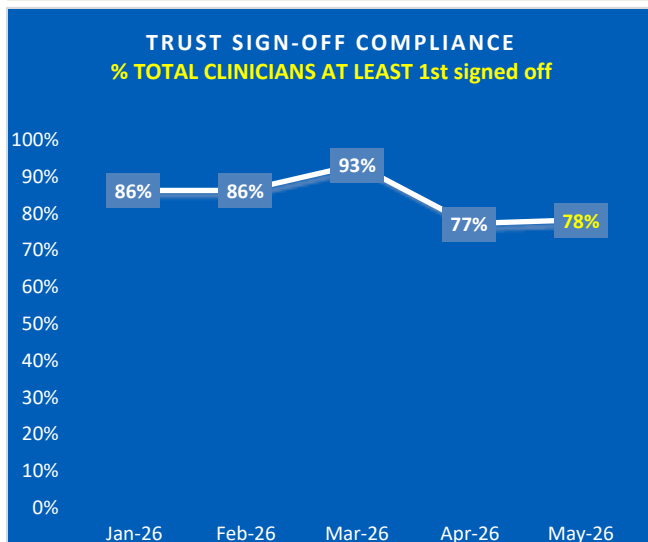
- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

Job Plan Compliance

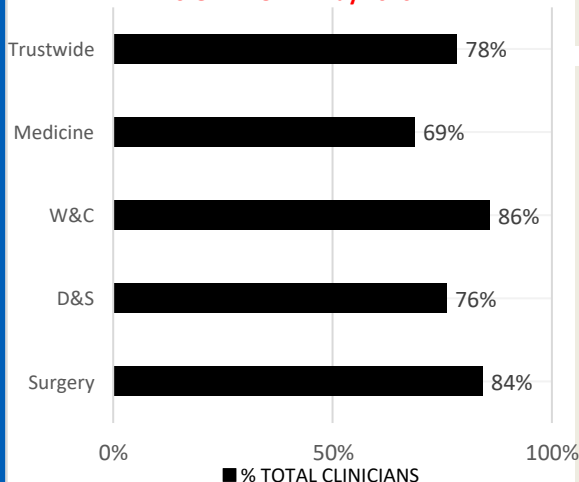
(Target: 95% job plan sign offs by March 31st, 2027)

Workforce Highlights:

- Job Planning is currently included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- Last financial year's NHSE job-plan-sign-off goal of 95% March 31, 2026, was *nearly met* at 93% - 2% shy of target.
- That 93% had dropped to 77% as of April 30th, 2026, and climbing back up again at 78% this May 31st, 2026. The initial drop was due to about 25% of Trust job plans being republished in April to restart with the new financial year.



% Division JOB PLANS that are at least 1st SIGNED-OFF - May 2026



Areas for Concern:

Since data submissions have been required for job planning metrics, the definitions and requirements have changed frequently. However, this reports aligns with the most recent NHSE PWR requirements, with reported job plans *now* being *in-date* (i.e. started within the last 12 months) and at least first signed off by Clinical Lead or Speciality Director. **Data reported on, this MAY 2026, is for a Trust-wide total of 585 Clinicians (i.e. 484 Cons. 101 SAS doctors).**

Learning & Improvement:

- The last NHSE target for Consultant and SAS job plans was for 95% of Trust job plans to be at least 1st signed off by March 31, 2026. We managed to reach 93%, *just 2% shy of that goal*. We expect this target to remain for this new financial year. Current goal is to leverage on the efforts that got us that close and improve on it as to hit subsequent milestones in due time.
- Plans are also underway to switch the job planning software from ALLOCATE to HEALTHROTA. This switch is expected to improve on the job planning process, job plan sign offs, as well as the quality of job plans.

Actions

- Utilise the lever of e.rostering to improve job planning. This has helped ensure 100% job plan sign offs in departments where e-rostering has been deployed e.g. Acute Medicine.
- Continue monthly POD reporting to support SDs, CLs, unit managers, Chiefs and other job planning stakeholders trust-wide.
- The Job Planning department continues to actively support clinicians and Leads with the process.

Thank you

Report to Trust Board

Date of Meeting	16 July 2026
Report title	Quality Account 2025/26
Sponsoring Director/Authors	Chief Nurse and Director of Quality - Matt Holdaway Director of Quality Governance - Suzie Cro Head of Quality - Debra Ritsperis

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

Executive Summary
The Quality Account 2025/26 is the Trust’s statutory annual report on quality of care, improvement during the year and priorities for 2026/27. It has been prepared in accordance with the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010, as amended, and NHS England’s Quality Accounts reporting requirements. The report includes the required statements of assurance, mandated quality indicators, external stakeholder statements and Statement of Directors’ Responsibilities, and has been approved for publication by the Quality and Performance Committee. It is presented to the Board in public for information and assurance. Overall, the report demonstrates tangible progress in strengthening quality governance and improvement during 2025/26. Key areas of progress include further embedding of the Patient Safety Incident Response Framework, strengthened incident learning and safety governance, progress in reducing overdue outpatient follow-ups, improvement in ambulance handover times and 12-hour Emergency Department performance, continued evidence of maternity improvement and strengthened assurance following the Care Quality Commission Section 31 conditions imposed in May 2024, including the Trust’s self-assessment that all eight conditions have been met since October 2025, pending the publication and outcome of the latest Care Quality Commission inspection report, and strengthened fire safety governance and regulatory oversight. Patient feedback remained positive overall, with Friends and Family Test positivity above 90%, while recognising persistent themes relating to communication, waiting and discharge. The Trust also maintained strong participation in national clinical audit and confidential enquiry. The report is deliberately balanced and identifies areas requiring continued Board oversight. These include timely access and flow across urgent, cancer, diagnostic and elective pathways;

reducing delay-related harm; improving complaints responsiveness; strengthening early recognition of patient deterioration; improving data quality, particularly demographic data; and reducing unwarranted variation in safety-critical controls.

The agreed priorities for 2026/27 provide a clear forward improvement agenda aligned to the Trust Strategy 2025–2030. They focus on strengthening patient experience, voice and learning; improving the timeliness and reliability of care; reducing inequalities in access, experience and outcomes; embedding a Trust-wide quality management system; and improving safety through staffing, culture, speaking up and delivery of the Patient Safety Incident Response Framework safety priorities.

The Board is asked to note the Quality Account for information and assurance, recognising both the progress made during 2025/26 and the areas where sustained focus will be required during 2026/27.

Previously considered by	Quality Delivery Group and approved for publication by the Quality and Performance Committee
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Recommendations:

The Board is asked to note the Quality Account 2025/26 for information and assurance, following approval by the Quality and Performance Committee, and to note the key highlights, areas for continued improvement and agreed priorities for 2026/27.

Strategic Aims (tick as appropriate)

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

Impact on any Strategic Risks?

SR01 – Quality and patient safety. The Quality Account provides Board-level assurance on 2025/26 quality performance and the agreed improvement priorities for 2026/27.

Implications on:	
Equality, Diversity and Inclusion	Supports equitable, inclusive care and staff culture.
Health Inequalities	Includes analysis and priorities to reduce inequalities in access, experience and outcomes.
Finance and Resource	No direct financial implications from presentation to Board for information.
Regulation/Legal	Supports compliance with statutory Quality Account requirements.
CQC-Key line of enquiry	Supports all five CQC domains: safe, effective, caring, responsive and well-led.
Green Plan	No direct Green Plan implications identified.

Main Report
The full Quality Account 2025/26 is enclosed and forms the main report for this item. It provides the Trust's statutory public account of quality performance during 2025/26, including progress against agreed priorities, statements of assurance, mandated indicators, patient experience, regulatory oversight and external stakeholder statements. In summary, the report demonstrates progress in strengthening quality governance and improvement, while remaining transparent about areas requiring continued focus, including access and flow, delay-related harm, complaints responsiveness, early recognition of deterioration, data quality and variation in safety-critical controls. The 2026/27 priorities are aligned to the Trust Strategy 2025–2030 and focus on patient experience and voice, timeliness and reliability of care, reducing inequalities, embedding a Trust-wide quality management system, and improving safety through staffing, culture, speaking up and delivery of the Patient Safety Incident Response Framework safety priorities. The Quality Account has been reviewed through the Trust's governance arrangements and approved for publication by the Quality and Performance Committee. It is presented to the Board for information and assurance.

Enclosures

Quality Account 2025/26
FOI: <i>Public</i>

The background of the cover is composed of several overlapping geometric shapes in various colors: orange, yellow, light green, and light blue. Some shapes have patterns, such as a yellow rectangle with blue polka dots in the top right. A large blue rectangle is positioned in the lower left, containing the title text.

Quality Account

2025 – 2026



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.

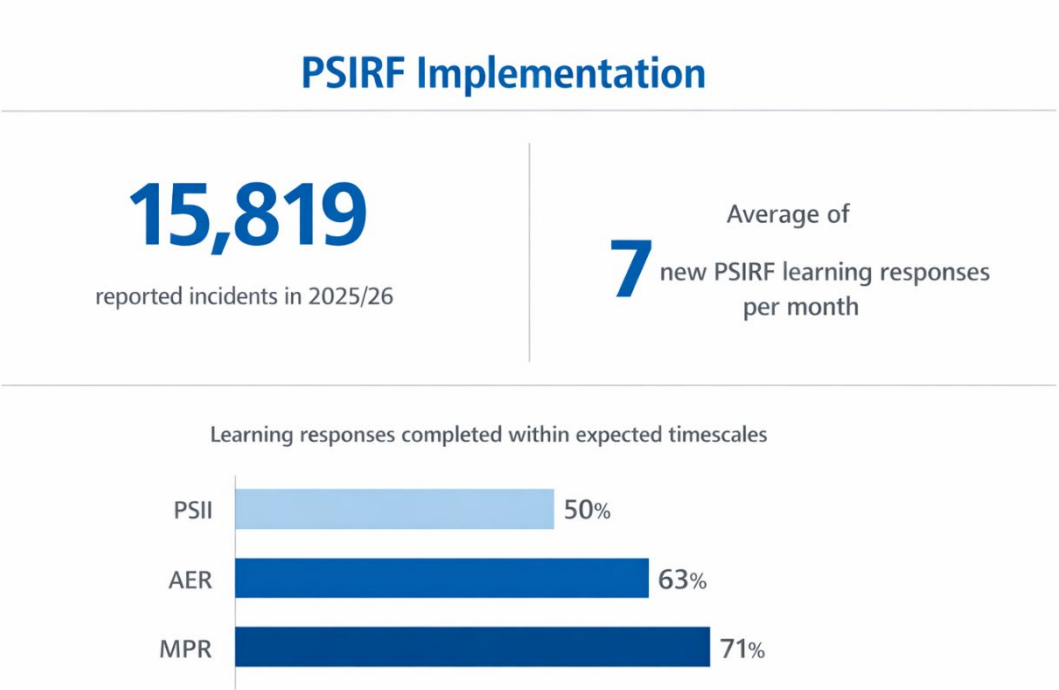
What we did

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.



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.

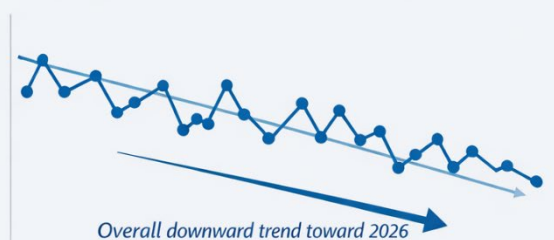
How we measured success

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

Hospital-acquired pressure ulcers



Most monthly rates within expected statistical limits

Risk assessment compliance:

approx. **68%**

SSKIN bundle compliance improving

✓ Improving

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.

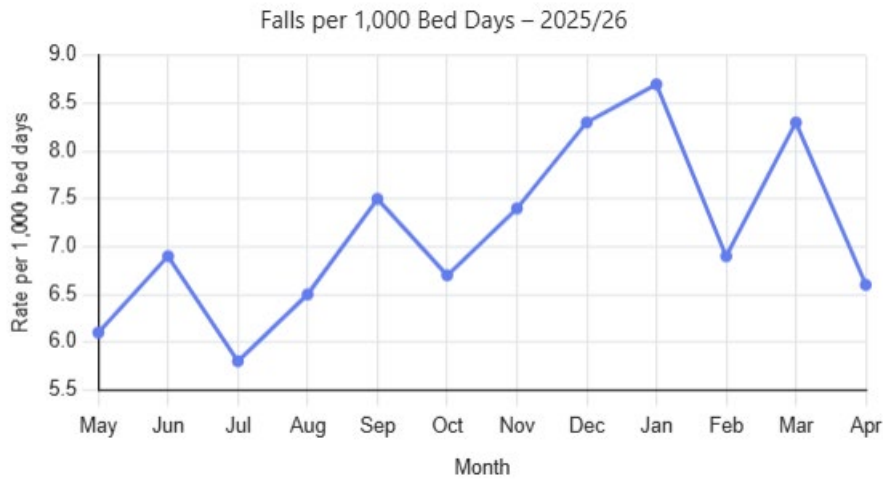


Chart 2: Injurious falls by month

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.

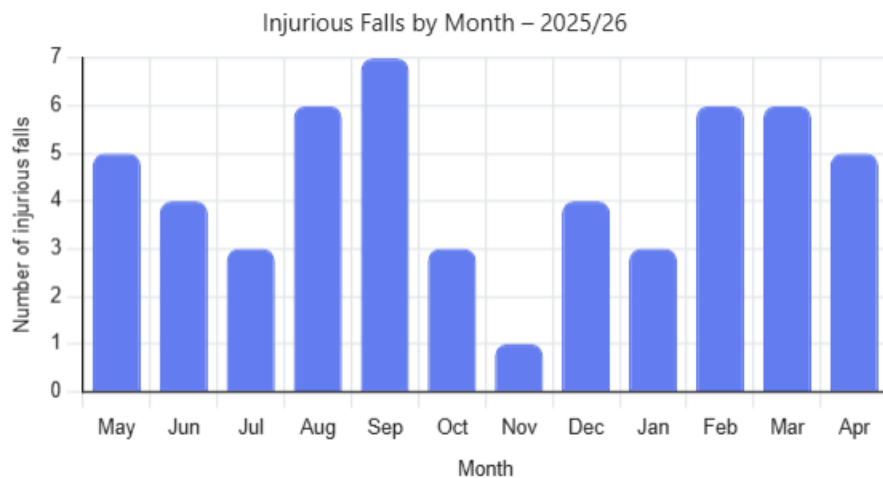
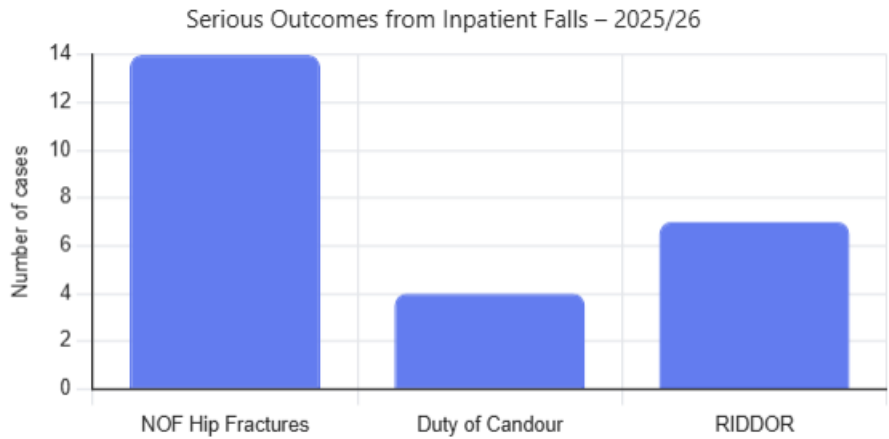


Chart 3: Serious outcomes from inpatient falls (2025/26)

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

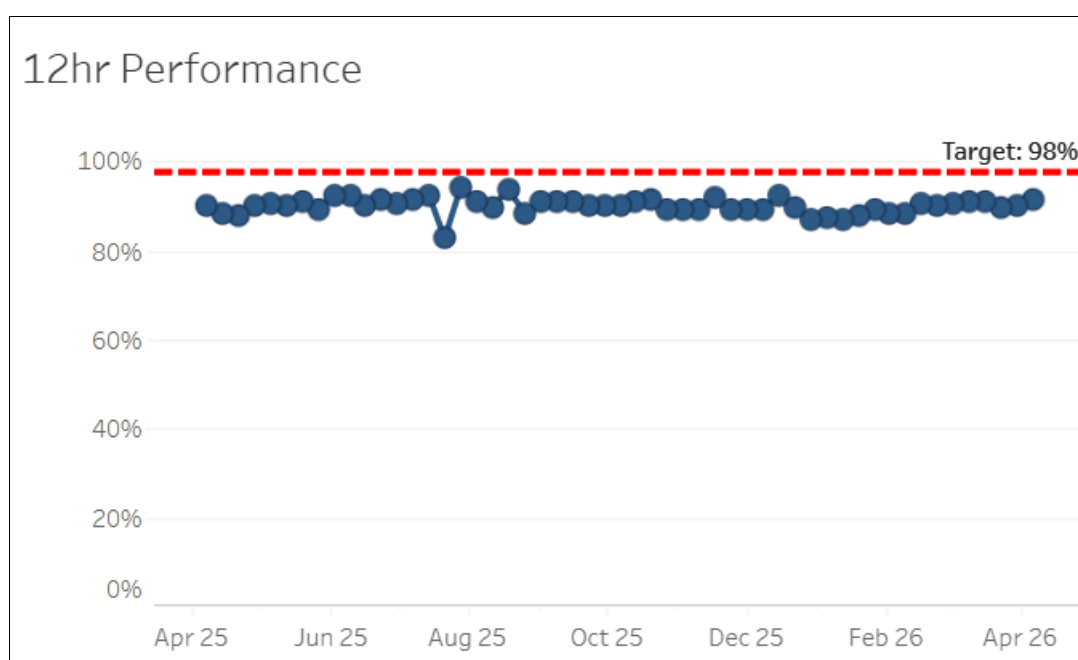
The programme continued as a clinically led quality improvement approach spanning the whole patient journey, supported by the Urgent Care & Flow Improvement Board and the Urgent and Emergency Care Improvement Board. Work focused particularly on Emergency Department service improvement, reducing ambulance 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.

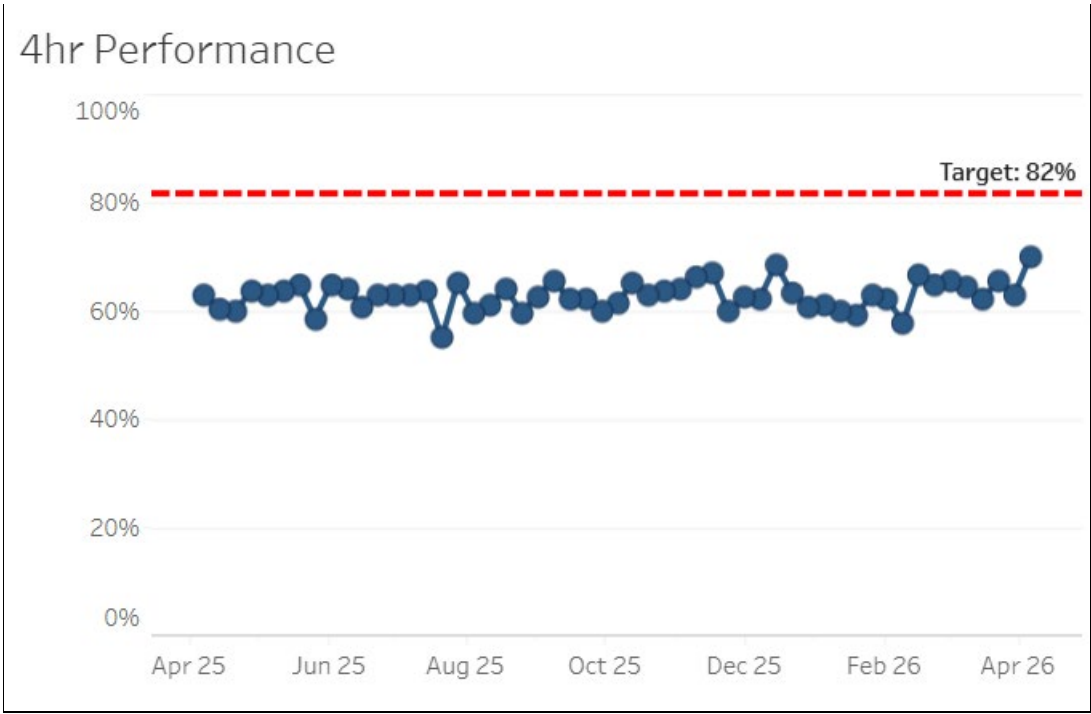
How we measured success

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

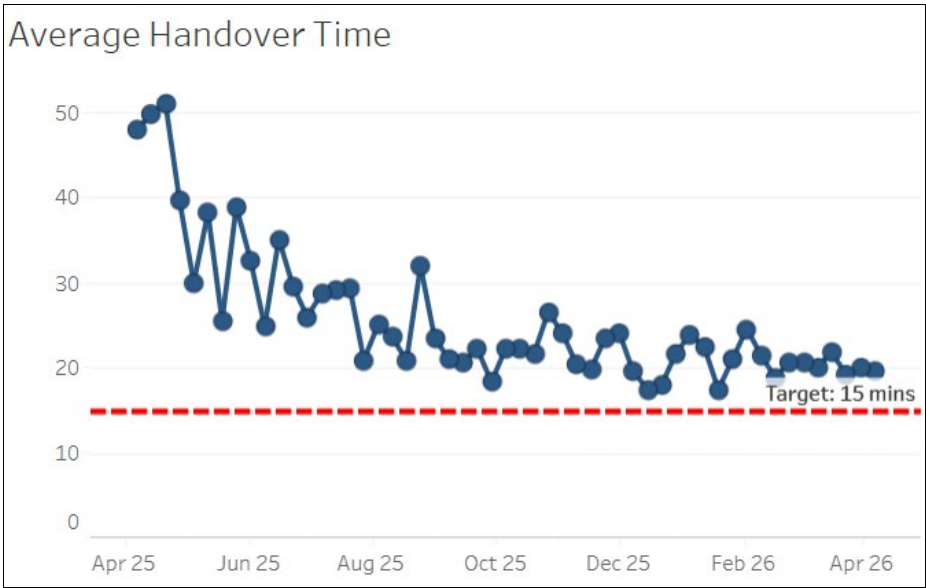
Graph: 12-hour Emergency Department performance, tracks the percentage of patients who spend more than 12 hours in the Emergency Department before being admitted, transferred or discharged. The graph demonstrates near achievement of our 98% target.



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

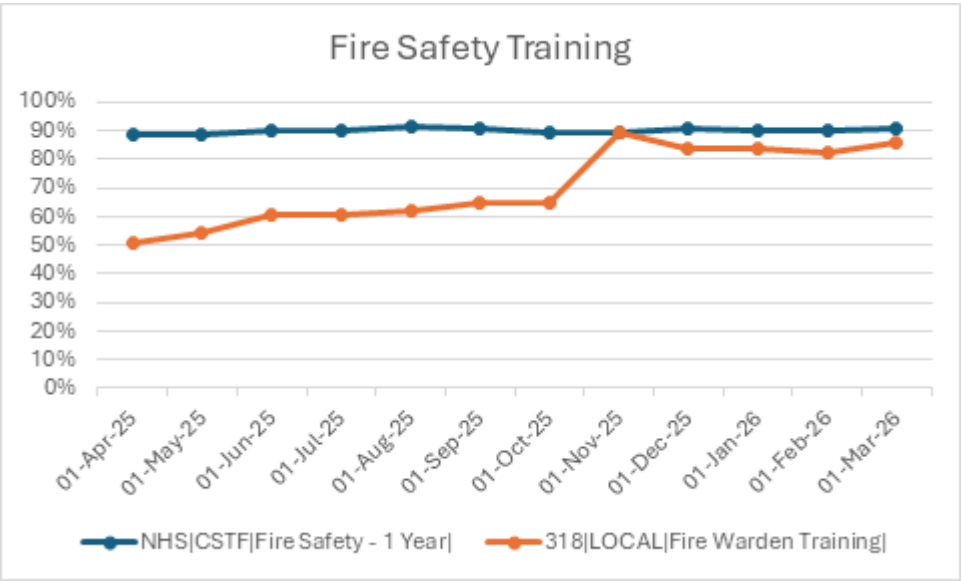
During 2025/26, the Trust strengthened its fire safety arrangements through a structured compliance and governance framework, supported by the Fire Safety Sub-Committee, Trust leadership oversight and ongoing engagement with Gloucestershire Fire and Rescue Service. Work progressed on enforcement-related 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.

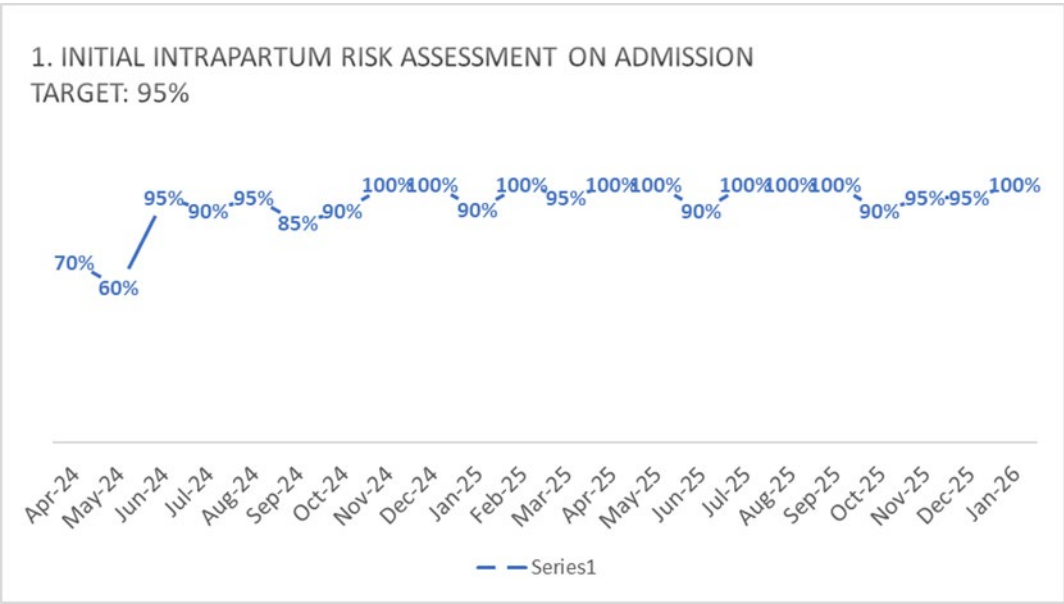
Systems to support safe fetal monitoring and timely escalation were strengthened and aligned to Saving Babies' Lives Care Bundle Version 3, NICE guidance and Maternity Incentive Scheme requirements. This included competency-based training, structured escalation pathways, senior clinical oversight and 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.

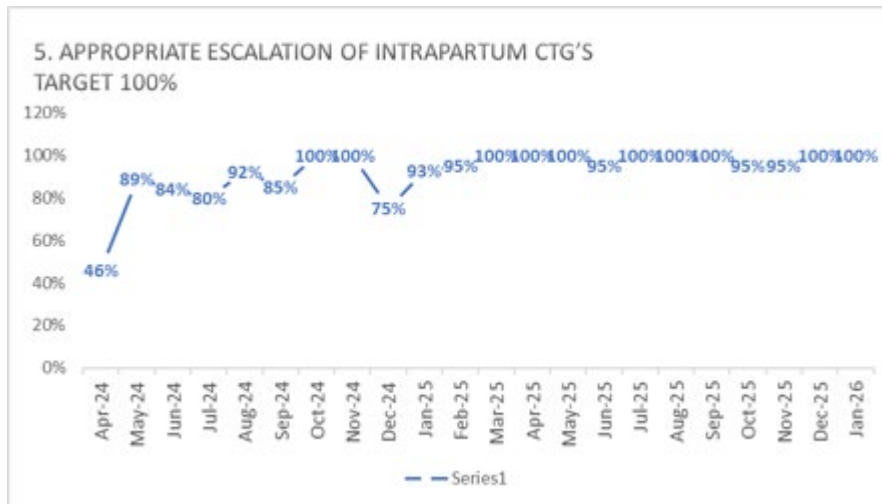
How we measured success

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.

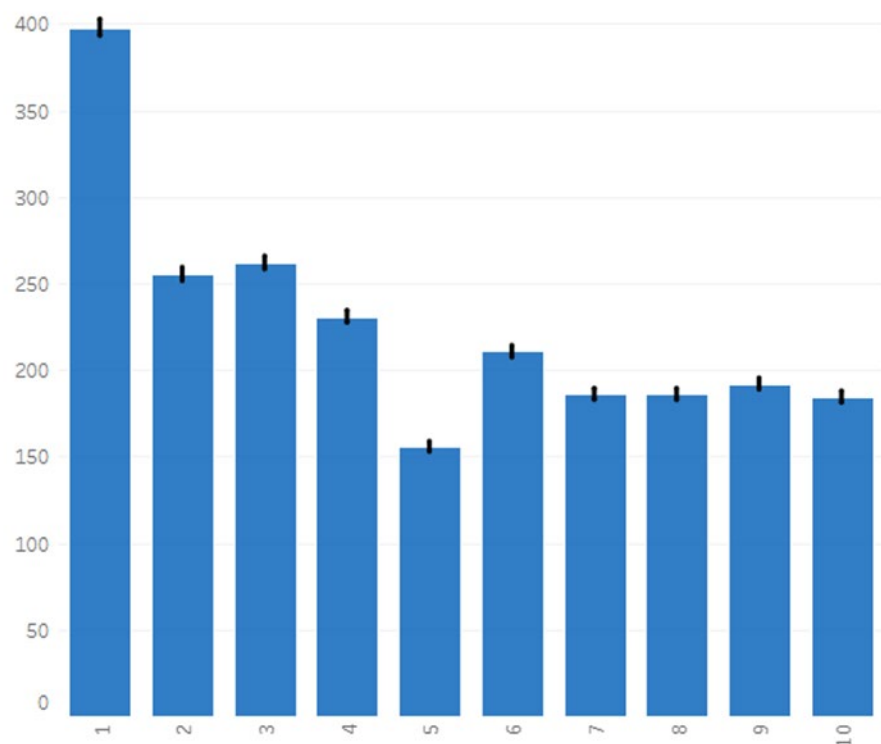
Improving Access and Outcomes Through Elective Recovery

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 (NDFA)	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	
	Trust %	England %	Trust %	England %	Trust %	England %
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

Alert, Advise and Assure Report to the Board of Directors Meeting held on 16 July 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 23 June 2026
Board member lead(s)		Committee Chair: Jaki Meekings Davis Executive Directors: Karen Johnson, Director of Finance Lee Pester, Chief Digital and Information Officer Al Sheward, Chief Operating Officer Kerry Rogers, Director of Integrated Governance Mark Petroni, Medical Director
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	Approval	
	Assurance	✓
	Discussion	✓
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the Finance and Resources Committee held on 23 June 2026. The meeting was quorate.

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

Key points

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

- **Finance System update** – The Committee remained concerned about the procurement element of the new finance and procurement system. This significant weakness (previously reported) creates a governance and potential fraud risk. The potential bridging solution is to be the subject of an all-party workshop in July and a definitive solution identified. The October implementation timeframe is at risk and further escalation may be required.
- **Digital infrastructure and cyber resilience** – The Committee noted ongoing cyber and infrastructure risks, including gaps in control, the changing threat landscape associated

with Artificial Intelligence, and fragility within the data centre environment. The Committee was advised that the Microsoft Defender for Endpoint score was being suppressed while the data centre upgrade remained outstanding, and that the supplier-led project was being rebased and treated with urgency.

- **Capital programme delivery capacity** – The Committee noted concern regarding the capacity of Estates and GMS to deliver the continuing scale and complexity of the capital programme. Problems in delivery would continue to arise unless resourcing levels were improved. The Committee requested benchmarking of staff costs for equivalent capital programmes in the next report.
- **Financial Position including Financial Sustainability Programme** – The Committee noted that the Month 2 revenue position was on track and that the Financial Sustainability Programme was slightly ahead of plan. However, there remained an unidentified gap of £6.6m and £6.7m red schemes in the Sustainability plan. Risks to delivery include scheme slippage, continued reliance on non-recurrent savings, use of temporary staff, nursing regrading costs and pressures in the Medicine division which were being monitored through mandated support measures. A pipeline of agency reductions was reported and a working group established to consider control mechanisms around pass-through drugs. Further information was requested on escalation measures and productivity levels compared to the 2019/20 baseline.

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

- **Digital Estate Condition Survey** – The Committee was assured that digital estate risks were known, understood and actively managed, with no immediate service-impacting failures identified at the time of review. A structured and time-bound mitigation plan was in place.
- **Digital Strategy (including EPR programme)** – The Committee approved the Digital Strategy and Roadmap 2026–31 as the framework for delivery of the Trust's Digital First strategic aim. The Committee noted the scale of transformation required, the need for sustained investment and prioritisation and that detailed financial requirements would be brought forward through future business cases, including the EPR Outline Business Case. The Committee sought clarity as to how this and related strategies/plans would be reconciled within the existing cost and resource envelopes.
- **PACS and RIS replacement** – The Committee noted that the PACS and RIS replacement programme remained Amber, with a revised estimated go-live date of October 2026 and an associated financial impact of approximately £50k in missed savings. Given the Board's earlier interest in this scheme, an update was requested for the next Board meeting.

ASSURE: inform the board where positive assurance has been received

- **Financial Sustainability governance** – The Committee noted that governance, oversight, and engagement had been significantly strengthened, with the programme embedded as a core priority and active executive engagement in place. Risks were clearly identified, actively managed and escalated appropriately.
- **Digital Programme delivery** – The Committee received assurance that the Digital Programme portfolio was rated Green, with successful delivery of core initiatives including the Sunrise Upgrade, Twinkle and BadgerDiaries. Service performance

remained stable, with strong call handling and improving resolution rates. The EPR business case would be signed off in August.

- **Data Centre Colocation project** – The Committee noted that the Data Centre Hosting Project remained Green/Amber and supported ongoing mitigation actions, particularly urgent estates remediation. The Committee endorsed continued investment in the programme based on resilience, safety, and operational benefits.

APPROVALS: decisions made by the Committee

- The Committee APPROVED the Digital Strategy and Roadmap 2026–31 as the framework for delivery of the Trust’s Digital First strategic aim.
- The Committee APPROVED the Trust policy on Intellectual Property and the Intellectual Property, Revenue Sharing and Equity Policy.
- The Committee APPROVED Risk 754, relating to the risk of inability to identify clinical trial patients and potential breach of NIHR/statutory guidelines.
- The Committee APPROVED the new Wide Area Network contract and consolidation of the WAN contract on a shared, multi-organisation basis aligned to the IT operating model.
- The Committee APPROVED the award of contracts for Outsourced Teleradiology Reporting Services to Hexarad Group Ltd and Everlight Radiology Ltd, with a total estimated contract value of £13.1m over four years, funded from existing Trust revenue budgets.
- The Committee APPROVED the Research and Innovations Annual Report and took assurance from the progress made during the year.

Implications

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

Board assurance framework

BAF reference	SR04, SR06, SR07, SR08
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Risks discussed

The Committee discussed the following risks: financial sustainability, temporary workforce and divisional financial pressures, capital programme delivery capacity, finance system procurement controls, cyber security, digital infrastructure resilience, data centre condition, digital transformation delivery, PACS/RIS programme delivery, EPR re-procurement, and research and innovation financial and operational risks.

Recommendations

The Board of Directors is asked to take **assurance** from the report, note the matters escalated for attention, and note the approvals made by the Committee.