NHS
Gloucestershire Hospitals
NHS Foundation Trust

Annual Report and Accounts

2025 – 2026

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Gloucestershire Hospitals NHS Foundation Trust

Annual Report and Accounts 2025-2026

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Contents

This Annual Report and Accounts has been prepared on a group basis, Gloucestershire Hospitals NHS Foundation Trust, the Charity and its subsidiary company Gloucestershire Managed Services are said 'group' and collectively hereinafter jointly referred to as 'Gloucestershire Hospitals NHS Foundation Trust', 'the Trust', 'we', 'us', 'our'.

Foreword by the Chair and Chief Executive

Foreword by the Chair and Chief Executive

We are pleased to introduce our Annual Report for 2025–2026, reflecting a year in which colleagues across Cheltenham General Hospital, Gloucestershire Royal Hospital and our community-based services have continued to work with determination and compassion to provide safe, high-quality care for the people of Gloucestershire.

This has been a year of meaningful progress. Patient flow and safety have continued to improve. Ambulance handover times continued to fall and were on average 22 minutes over the year, reflecting consistent effort across urgent, emergency and inpatient teams as well as South West Ambulance teams. Corridor care on inpatient wards stopped in July 2024 and continues to be an important marker for patient dignity and safety. We can see the positive impact of this on patient experience and safety with delay related harm falling and is a testament to the teams across the Trust. However, we are clear that pressures remain within the emergency department and urgent care areas, and further work continues to address these challenges.

There have also been strong improvements in elective and planned care, helping more patients to receive treatment more quickly. We have seen a 897reduction in waiting lists over the past year and 742 fewer patients waiting longer than 45 weeks for treatment, placing us amongst the best performing Trusts in the country when it comes to elective performance. A test of change for surgery at Cirencester Hospital has begun, supporting care closer to home for some patients and helping to make best use of capacity across the county. These improvements sit alongside continued investment in the quality and safety of our estate, including work to improve the infrastructure and fire systems following a small fire at Gloucestershire Royal Hospital in November 2025.

Over the year, the Trust also expanded and invested in its services from the endoscopy service expansion with new state-of-the-art imaging technology, to a new modular MRI unit at Gloucestershire Royal Hospital, marking an important milestone in strengthening diagnostic services for patients. We secured future funding for the Radiotherapy Late Effects service and invested in Robotic waterjet ablation enhances urology care. All of these things reflect a year of focused investment and innovation, helping us deliver faster, safer and more advanced care for patients across Gloucestershire.

We welcomed a ‘Good’ rating for Medical Services at Cheltenham General Hospital following an inspection by the Care Quality Commission in July 2024. The full report was published on the CQC’s website on 30 May 2025.The CQC found that leadership and management across services demonstrated a strong safety culture. Leaders investigated incidents and shared learning to promote good practice. Staff reported feeling supported, with learning needs met through supervision, appraisal and specialist training. Effective governance structures were in place to monitor quality and drive continuous improvement, and staff felt confident raising concerns. Patient feedback was mostly positive, with many people reporting they were treated with kindness, empathy and compassion.

Progress has also continued for the new Cancer Centre at Cheltenham General Hospital, with the submission of the planning application marking a major milestone. Fundraising has been a remarkable success, including the Lions at Large trail, which brought thousands of people into Gloucester and Cheltenham and raised £370,000 for the appeal. The generosity of our communities, patients and supporters has been truly inspiring and demonstrates the strength of local commitment to improving cancer care.

Alongside these achievements, the year also brought challenges. This included periods of sustained national and local pressures. Industrial action continued to affect services, including the resident doctors’ strikes, with three periods of five-day action during 2025 and locally our phlebotomy dispute, which concluded in March 2026. We recognise the disruption

this caused and are grateful to patients for their patience, as well as to staff across the organisation who worked tirelessly to maintain services.

The Trust also made a number of difficult but necessary decisions in the interests of safety and quality. This included the temporary suspension of home births, a decision taken with great care following concerns raised by staff, and with the safety of mothers and babies as the overriding priority.

During the year, the Trust also published its perinatal reports into neonatal and maternal mortality reports that we commissioned to check whether that as a Trust we had undertaken to right actions and learning from neonatal and maternal deaths in previous years. In September, we were named as one of the 12 trusts included in the Baroness Amos review which aims to draw out learning and recommendations relevant for the whole NHS when it comes to improving the quality and safety of maternity and neonatal services. We remain committed to openness, learning and improvement, and to rebuilding confidence of women and families and look forward to the final recommendations from the Amos review as well as continuing to drive forward the improvements we have been focussed on throughout the year.

This year also saw significant national change. In March 2025, the government announced major reforms to the NHS and published the NHS 10-Year Plan, setting out three key shifts: from hospital to community, from analogue to digital, and from treatment to prevention. Against this backdrop, the Trust launched its new five-year strategy, shaped by the voices of more than 2,000 staff and over 600 people from our local communities. This strategy sets a clear direction for the organisation and reflects a shared ambition to deliver compassionate, high-quality care today while building a more sustainable future.

Supporting staff remains central to everything we do. The year has seen further focus on staff experience, reflected in slight improvements in our NHS Staff Survey results, while recognising that there is still more to do. A particular area of attention has been on strengthening our approach to speaking up, ensuring staff feel safe and able to raise concerns and share learning. These steps are essential to creating an environment where staff feel valued, supported and able to provide the best possible care.

Education and development remain central to the Trust's ability to deliver safe, high-quality care and to support staff to grow and thrive in their roles. Through strong partnerships with the South West Deanery, the University of Gloucestershire and the University of Worcester, the Trust continues to support staff, from early career placements and apprenticeships to clinical training and leadership development. These partnerships help build a skilled, confident and sustainable workforce, strengthening services for patients now and into the future. This commitment was recognised recently when the Postgraduate Medical Education (PGME) team was named Team of the Year 2026 at the Medical Education Leaders UK conference.

During the year, the Government published a new national league table used to assess performance. In its first league table the Trust was ranked 17th (out of 134 Trusts) nationally, making it the highest placed trust in the South West and the third ranked large acute trust in the country. These rankings are provided on a quarterly basis, and the Trust ended the reporting period ranked 22nd nationally. This reflects the significant commitment of staff across our hospitals in reducing waiting lists, improving services for patients and maintaining financial stability.

The pressures facing the NHS remain significant, and the year ahead will continue to require difficult choices and close collaboration with partners across Gloucestershire and beyond. What remains constant is the dedication of our staff and volunteers, and the trust placed in us by our patients and communities.

We thank everyone who has contributed to the Trust this year: our staff, governors, volunteers, partners, patients and our local communities. Everything we have achieved has been built together and we look forward to further progress in the coming year ahead.

Kevin McNamara
Chief Executive 25 June 2026

Deborah Evans
Chair 25 June 2026

Performance Report

In this section:

- Overview
- Statement from Chief Executive on Performance
- Performance Analysis

Performance Report

Overview

Gloucestershire Hospitals NHS Foundation Trust is a provider of local and acute care, delivering good-quality services to over 650,000 people living across the county. We provide whole-life care and are here to support our communities to live healthier lives as well as taking care of them when they need us the most.

We directly employ almost 9,000 colleagues and together we provide a wide range of inpatient and outpatient services, as well as emergency and planned care at our two main district hospitals.

About Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust received authorisation on 1 July 2004, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. It was formed from Gloucestershire Hospitals NHS Trust, which was established following a reconfiguration of health services in Gloucestershire in 2002.

The Trust has a long and proud history which goes back as far as 1755 when the Gloucestershire Infirmary was constructed and later awarded the title 'Royal' by King Edwards VII in 1909. Similarly, Cheltenham General Hospital dates back to 1813 when it was a dispensary. They both became part of the National Health Service when it was established in 1948, and they have a long history of serving those most in need within our communities. This continues to this day, alongside the work of the Hospitals Charities, with our links to community groups and our focus on eliminating health inequalities.

Our hospitals

Gloucestershire Royal Hospital (GRH)

Gloucestershire Royal Hospital (GRH) is located close to the city centre in Gloucester and specialises in unscheduled care, urgent and emergency care, cardiology, renal care, maternity and neonatal care, is also the base for our children's wards and emergency department.

Cheltenham General Hospital (CGH)

Cheltenham General Hospital is located in the east of the county and is our planned care centre, providing specialist cancer and oncology services, Stroke, Urology, Care of the Elderly as well as an emergency department.

Stroud Maternity Hospital

Stroud Maternity Hospital is a midwife-led centre that helps deliver around 80 births every year, supporting births at home and in the unit.

In November 2025 the home-birth service was suspended, following safety concerns raised by our staff. The Trust has been working to safely reinstate the service across the county and to also reopen the midwifery-led Cheltenham Birth Centre. Although good progress has been made, there is still more to do to be able to reopen safely, and therefore our home birth service will remain suspended until the autumn 2026.

Other community-based services

The Trust also delivered a range of surgery, outpatient clinics, diagnostic and screening services from community hospitals throughout Gloucestershire and the Community

Diagnostics Centre (CDC). The Trust also provides services at the satellite oncology centre in Hereford County Hospital.

Our Trust in numbers: a snapshot of our care

Every year, our teams provide a wide range of care, treatments and services for our communities.

Management Structure

The Trust's management structure is based around Divisions, plus a wholly owned subsidiary company, Gloucestershire Managed Services (GMS), and our Charity, Cheltenham and Gloucester Hospitals Charity administered via a General Charitable Fund.

These are designed to support and facilitate delegation of decision-making to clinical teams and to enable more involvement of clinical leaders in strategic issues.

We have four clinical patient-facing divisions, each comprised of a Chief of Service, Divisional Operations Director, and a Divisional Director of Quality and Nursing and they are supported by our corporate services division.

These are outlined below and full details are on our website: https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

- Women and Children Division
- Surgery Division
- Medicine Division
- Diagnostics and Specialities Division
- Corporate Division

Vision, mission and values

Our vision

Our vision is simple, we want to: *Deliver the best care every day for everyone*

Our values

- **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 Strategy 2025–2030

Our five-year strategy sets out a bold vision: *to deliver the best care every day for everyone.*

We want our patients, staff and the public to be proud of our hospitals and the care and support we deliver. For our staff and our communities, we want their hospitals to be recognised as a place to receive high-quality care and support.

We also want to support primary care and help shape the future development of neighbourhood health services, with a focus on long-term conditions and frailty.

Co-designing the strategy

We are extremely grateful for the contributions that helped shape our new strategy. More than 2,000 people were involved in workshops and discussions, providing valuable feedback and insight.

People told us that they believe the best care happens when it is compassionate, inclusive and responsive.

Central to our strategy is a focus on the 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.

What people told us

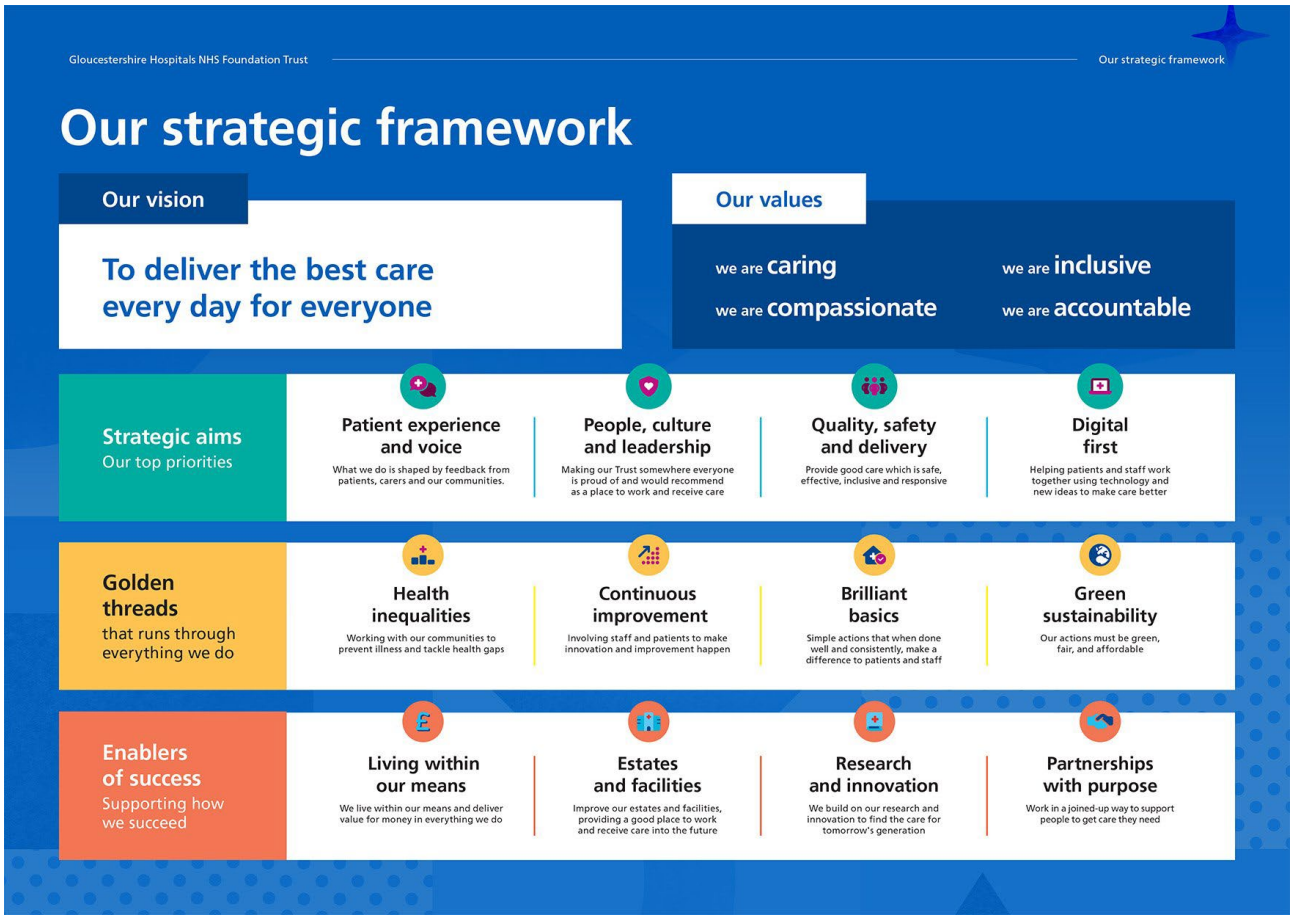
In developing the strategy, staff and communities told us what matters most to them:

- What we do is shaped by feedback from patients, staff and our communities.
- We are known as a good place to work and receive care.
- We provide good care which is safe, effective, inclusive and responsive.
- We get the basics right by doing the simple things well and consistently.
- We live within our means and deliver value for money in everything we do.
- We work together to improve our estates and facilities, providing a good place to work and receive care in the future.
- We deliver our core acute and specialist services well and support wider health and care provision.
- We work in a joined-up way to support people to get care more locally where needed and in hospital when necessary

- We build on our research and innovation to find the care for tomorrow's generation.
- Our digital systems are easy to use and connect patients to better manage their own health.

Our strategic framework

Our strategic framework sets out our key aims and priorities.



Our Strategic Aims

There are our four strategic aims to support our vision.

- **Patient experience and voice** – What we do is shaped by feedback from patients, carers and our communities.
- **People, culture and leadership** – Making our Trust somewhere everyone is proud of and would recommend as a place to work and receive care
- **Quality, safety and delivery** – Provide good care which is safe, effective, inclusive and responsive
- **Digital first** – Helping patient and staff work together using technology and new ideas to make care better.

Our Golden Threads

We have identified four golden threads that run through our strategy and all that we do.

- **Health inequalities** – Working with our communities to prevent illness and tackle health gaps

- **Continuous improvement** – Involving staff and patients to make innovation and improvement happen
- **Brilliant basics** – Simple actions that, when done well and consistently, make a difference to patients and staff
- **Green sustainability** – Our actions must be green, fair, and affordable

Our Enablers of Success

There are four key strategic enablers that are central to delivering our strategy, working alongside our other priorities and day-to-day activities.

- **Living within our means** – We live within our means and deliver value for money in everything we do
- **Estates and facilities** – Improve our estates and facilities, providing a good place to work and receive care into the future
- **Research and innovation** – We build on our research and innovation to find the care for tomorrow's generation
- **Partnerships with purpose** – Work in a joined-up way to support people to get the care they need

Why this matters

The strategy is our commitment to patients, staff, and partners. It sets out the priorities we will focus on to address our challenges and make the most of opportunities, helping us deliver our vision and ambition for patients and our staff. The Board ensures that the Trust's governance arrangements actively support the delivery of its strategy and long-term sustainability through a clear governance structure, alignment between strategic objectives, principal risks and our performance reporting.

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 (Voluntary, Community and Social Enterprise) Alliance to ensure we listen and understand the needs of our local population and shape services effectively.

During the year, NHS partners in Gloucestershire agreed a new way of working through the establishment of the Gloucestershire Provider Partnership. NHS Gloucestershire Integrated Care Board (ICB) has signed a Memorandum of Understanding with local NHS providers, bringing together GP practices, Gloucestershire Health and Care NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust as a single Provider Partnership.

This agreement reflects a shift in how services are planned and delivered, with the ICB focusing on setting overall priorities based on local population health needs, and providers working together to redesign care and improve outcomes.

The Provider Partnership will focus on improving support for older people, including those living with frailty and dementia, transforming care for people with multiple long-term conditions, and expanding community mental health and crisis support. It also supports delivery of the national Neighbourhood Health Framework, which aims to strengthen care in local communities and prevent ill health. Gloucestershire County Council and voluntary and

community organisations will play a key role, and during 2026/27 the Provider Partnership will take on a lead role in delivering this work.

The Trust is a formal member of both the statutory Integrated Care Partnership in Gloucestershire and NHS Gloucestershire Integrated Care Board. The Trust is represented at these forums by the Executive Director of Improvement and Delivery, Deputy Chief Executive and Medical Director, ensuring that the voice and perspective of acute hospital services are reflected in system-wide discussions and decision-making.

For both key statutory forums, there is regular and consistent attendance and contribution to public and confidential board meetings, as well as dedicated development sessions that provide opportunities to build shared understanding and strengthen collaboration across organisational boundaries.

The Trust is also a member of a number of formal sub-committees of the ICB, including the One Gloucestershire strategic executive and finance committees, and other groups and forums that support partnership working on patient safety, quality and delivery. These include the system safety committee and system quality group, with representation from the Chief Nursing Officer and Director of Quality.

Our engagement with stakeholders and community

Gloucestershire Hospitals NHS Foundation Trust remains committed to engaging with our communities, ensuring their voices shape our services.

Throughout 2025–26, our Community Engagement & Involvement Team has deepened partnerships across the Voluntary, Community and Social Enterprise (VCSE) sector, strengthened links with seldom-heard groups, and supported innovative programmes to improve accessibility, equity and health outcomes

Our collaborative work with VCSE partners, Healthwatch Gloucestershire, system colleagues and community leaders continues to provide vital insight, ensuring our services are responsive to the diverse needs of people across Gloucestershire.

Below is a snapshot of our key activity and impact this year.

Cancer Centre Branding Community Workshops

As part of early work to build a new Cancer Centre at Cheltenham General Hospital, the Community Engagement and Involvement Team supported community engagement by:

- Involving community groups and underserved voices in the co-design of the new centre's brand identity.
- Delivering two facilitated workshops (27–28 May) involving local communities, access users and underrepresented groups.
- Working to gather qualitative insights into naming preferences, tone of voice and cultural relevance.

These sessions ensured that the vision for the new cancer centre is informed by the lived experience of patients, families and local communities.

Domestic Violence and Honour-Based Abuse Awareness -November to December 2025

During the 16 Days of Action, the team worked closely with the Office of the Police and Crime Commissioner, GDASS and Gloucestershire County Council to raise awareness of domestic abuse, with a focus on honour-based abuse within minoritised communities.

Activities included:

- A film screening at Gloucester Guildhall with signposting from specialist support agencies.
- Creative writing workshops, survivor well-being days, and White Ribbon bystander training.
- Targeted, discreet outreach delivered via trusted VCSE partners to safely reach victim-survivors who may experience cultural or social barriers to seeking support.

This partnership-led approach ensured culturally sensitive engagement with at-risk communities.

Refugee Week June 2025 – Raft Building, NHS Listening Bench & Community Partnerships

Refugee Week continued to grow into a vibrant cross-sector collaboration celebrating Gloucester as a "port of welcome."

The Community Engagement & Involvement Team:

- Supported migrant and asylum-seeking communities to participate fully in the programme.
- Hosted NHS Listening Benches to create relaxed spaces for conversations about health, access and lived experience.
- Shared culturally relevant health information in partnership with Healthwatch.
- Helped strengthen emerging partnerships between cultural organisations, refugee networks and the NHS.

This work-built trust, promoted belonging, and supported better access to health information for displaced communities.

Young Influencer Development Programme

Our Young Influencer Programme continues to grow and is now a key component of our youth engagement strategy.

Highlights from this year:

- Expansion to 25 active members, representing diverse backgrounds and experiences.
- The Trust signed the' Power of Youth Charter' and joined the national #iwill movement.
- Young Influencers attended citywide youth leadership events and contributed to community-facing filming projects with hospital staff.
- Launch of our first **NHS Young Influencer Hub** at St Peter's Secondary School, with plans to expand into additional schools.
- Ongoing participation in service improvement, including patient experience reviews, health campaigns and peer-led resource development.

Their contribution is helping us build youth-informed services across the Trust.

Community Co-Creation for Dementia Awareness – Sounds of the Soul

"Sounds of the Soul" has developed into a significant cultural resource for Muslim people living with dementia.

Working with Mindsong, South Asian elders, carers and faith leaders, the team supported:

- Development of a curated playlist featuring Qur'anic recitation and nasheeds.

- Inclusion of multilingual printed resources for mosques, community centres and care homes.
- Wider sharing during Dementia Action Week to support memory, identity, and spiritual well-being.

A parallel Hindu Community Playlist is now in development to support spiritual connection for Hindu elders living with dementia, which shall be launched during Dementia Action Week in May 2026.

Cancer Prevention and Early Diagnosis – Communities Against Cancer Grants Panel

The team played an active role in the Gloucestershire Communities Against Cancer grants panel, delivered in partnership with the ICB and Gloucestershire Community Foundation.

Our contribution included:

- Reviewing community-led proposals to improve early cancer diagnosis.
- Supporting the launch event, which outlined system ambitions for culturally competent, community-based cancer interventions.
- Helping shape co-designed approaches with VCSE partners focused on underserved communities, including refugees, migrants, LGBTQ+ groups, veterans, Gypsy/Traveller communities and people facing homelessness.

Ramadan for All Corners and Iftar Events 2026

This year, the Trust introduced ‘Ramadan for All Corners' at both Gloucester and Cheltenham hospitals, providing welcoming spaces for Muslim colleagues to break their fast with dates and water, and offering all staff an opportunity to learn about Ramadan and support fasting colleagues.

This year’s approach focuses on creating a relaxed, community-centred engagement atmosphere, allowing colleagues to drop in around their shifts, connect, and share the spirit of Ramadan in an accessible and inclusive way.

Ramadan 2026 marked an important moment of inclusivity and connection across both hospital sites

The Diabetes Awareness session

The Diabetes Awareness Education Session, delivered in collaboration with Gloucestershire Hospitals, the ICB and the Cheltenham Hebrew Congregation, aimed to support Jewish community members in understanding diabetes prevention, early identification and culturally sensitive approaches to managing the condition.

The session explored key risk factors, symptoms, and the importance of routine health checks, with a focus on issues particularly relevant to the Jewish population. Led by local healthcare professionals, attendees learned practical strategies for maintaining healthy lifestyles, recognising early signs of diabetes and accessing local support services. The event encouraged open dialogue, strengthened trust between the community and healthcare partners, and marked a positive step toward future collaborative health education initiatives.

Supporting System Development – ICS & VCSE Partnerships

The team contributed to the ICS–VCSE Partnership Development Group’s work to shape a new countywide model for VCSE infrastructure support, including:

- Supporting workshops, engagement events and surveys.
- Helping collate insight into gaps, strengths and opportunities in current infrastructure.

- Contributing to recommendations for a future model that is sustainable, equitable and inclusive.

This work will support long-term collaboration between the NHS and community organisations.

Engagement with seldom-heard Groups

We continued to strengthen relationships with groups whose voices are often underrepresented in health planning. Activities included:

- Wellness talks with Hindu community groups.
- Women's health sessions with Sahara Saheli and South Asian Elderly Women's Groups.
- Walk & Talk programmes with Active Gloucestershire.
- Outreach with GARAS supporting refugees and asylum seekers.
- Community events across Cheltenham, Gloucester, Cinderford and the Forest of Dean.
- Cheltenham Hebrew Congregation,

This work ensures health information reaches communities facing the greatest barriers.

Community Events and NHS Presence in Local Spaces

Our team joined partners at key events across the county, including:

- Polish Heritage Day
- Cheltenham & Stroud Pride
- Big Health Day
- Jamaica Day
- Windrush Day
- No Child Left Behind
- Hindu Community Health Day
- Chinese Community Wellbeing Event
- Refugee Week Moomins Picnic

We also continued to work alongside the NHS partners to improve visibility and access to Trust information, membership and volunteering opportunities.

Education, Training and Workforce Inclusion

Throughout the year, the team supported a range of initiatives to help people from the local community into work and volunteer roles. This included:

- CV-writing and NHS careers workshops with refugees and asylum seekers in partnership with "We Want You", Gloucestershire Managed Services and Gloucestershire Action for Refugees and Asylum Seekers (GARAS)
- Delivered a Teaching Session for University of Gloucestershire nursing students on health inequalities and culturally informed care.
- Presentations to oncology teams on community partnerships and equitable cancer awareness.
- Contributions to anti-racism and equity sessions as part of the Patient & Carer Race Equality Framework.

Events and Analytics

As part of our commitment to transparency and impact reporting, we continue to publish our annual Engagement and Involvement Review and Impact Tracker, shared on our Trust website. These documents summarise how community insight influences decision-making across services. These are published on our website: https://www.gloshospitals.nhs.uk/about-us/get-involved/listen-action-and-impact/

Highlights of the year

In our 'Proud to Care' report we provide details of much of the excellent work undertaken by our staff for the benefit of our patients and local population. Below are just a few of the highlights from the year.

New MiniTom Child-Friendly Imaging Simulator
In May 2025, a new child-friendly imaging simulator arrived to help reduce anxiety and improve the experience of children attending for scans. The Siemens MiniTom simulator unit was introduced to support young patients preparing for imaging procedures such as CT and MRI. The equipment was funded by a generous donation from The Pied Piper Appeal through the Cheltenham and Gloucester Hospitals Charity. It includes a learning simulator designed to help children understand what will happen during their scan before their appointment takes place.

"Sounds of the Soul" Playlist Launched to Support Muslim Dementia Patients
During Dementia Action Week, a new music initiative was launched to support the wellbeing of Muslim patients living with dementia. Working in collaboration with Gloucestershire charity Mindsong, we introduced "Sounds of the Soul", a culturally sensitive playlist designed to enhance comfort and connection.
The playlist features a carefully selected range of calming and traditional songs that reflected the cultural and spiritual heritage of the Muslim community. It was developed in response to the recognised benefits of music for people living with dementia, particularly in supporting emotional wellbeing, reducing anxiety and encouraging familiarity.

Opening of New Modular MRI Unit at Gloucestershire Royal Hospital
June 2025 saw the official opening of a new modular MRI unit at Gloucestershire Royal Hospital, marking an important milestone in strengthening diagnostic services for patients. The new unit is making a difference for patients, enabling more people to be seen more quickly and helping to reduce delays for those waiting for urgent and emergency scans in the Emergency Department and acute medicine. This investment helps ensure patients can access MRI scans sooner, in a calmer setting, supported by teams with the space and equipment they need.

Newborns in Gloucestershire to benefit from groundbreaking Genomic Study

Newborns in Gloucestershire now have access to advanced genomic screening as we take part in the national Generation Study, a major research programme exploring how whole genome sequencing can improve the early diagnosis of rare genetic conditions.

Led by Genomics England and supported by NHS England, the Generation Study aims to recruit up to 100,000 babies across England. It focuses on identifying more than 200 rare, early-onset and treatable genetic conditions shortly after birth, often before symptoms appear. Participating sites locally include Gloucestershire Royal Hospital and Stroud Maternity Hospital.

Charity-funded artwork brings joy to Cheltenham's Battledown Ward

Children visiting the Children's Outpatients Department at Cheltenham General Hospital are now welcomed by bright, playful artwork designed to make hospital visits feel more positive and reassuring.

Visual artist Alice Humphries was commissioned to transform Battledown Ward with bold colours, shapes and imaginative designs that encourage curiosity and a sense of wonder. Our Arts Co-ordinator Anoushka Duroe-Richards worked closely with clinicians to ensure the designs were inclusive, supportive and suitable for a wide range of sensory needs.

Robotic waterjet ablation enhances urology care at Cheltenham General Hospital

Robotic waterjet ablation offers an advanced treatment option for men living with benign prostatic hyperplasia (BPH). We first introduced Aquablation therapy in 2023, using the AquaBeam Robotic System from PROCEPT BioRobotics. The technology uses a heat-free, high-pressure waterjet to remove prostate tissue with precision, guided by real-time imaging and planning software. This approach provides lasting symptom relief while preserving sexual function and urinary continence.

Cervical screening appointments at Gloucestershire Royal Hospital

In February 2026, an initiative was launched by our gynaecology service to offer cervical screening appointments at Gloucestershire Royal Hospital for staff and members of the public, providing a supportive and accessible alternative for people whose screening is due. The service is designed for anyone who may struggle to book an appointment with their GP, feel uncertain about the screening process or prefer not to see a male clinician. Appointments are delivered by an all-female team of experienced nurses who provide friendly, understanding and non-judgemental care and welcome people from all backgrounds.

Principal Risks

Our principal strategic risks are mapped to our strategic objectives, and are regularly reviewed by the Board, Committees, and Executives through our Board Assurance Framework (BAF) and are set out within the Annual Governance Statement. As of 31 March 2026, our principal strategic risks are:

- Inability to deliver safe and effective services against regulatory and statutory requirements
- Inability to attract and sustain a skilled, diverse and adaptable workforce may lead to skills shortages, reduced service quality, reduced operational productivity, and increased costs.
- Inability to retain a skilled, compassionate and diverse workforce that reflects the communities we serve because of a poor cultural environment and lack of development opportunities, impacting overall staff experience
- Failure to meet statutory and regulatory requirements to manage financial resources.
- Failure to provide timely access to services for patients.
- Infrastructure & Cyber – Reliable Digital Foundations
- Strategic Digital Risk: Digital Transformation & Culture
- State of Estates – risk of sub-standard asset condition and estate compliance position impacting safety and experience (patients and staff)
- Health and Safety risk - Failure to implement a robust health and safety governance framework

Our principal operational and clinical risks included:

- Fire safety: infrastructure; statutory breach/enforcement notices (score 20), evacuation (score 15)
- Cyber threats (score 20)
- Emergency Department flow/overcrowding: delayed assessment/treatment; overcrowding in minors (scores 16–20)
- Critical workforce shortages: interventional radiologists (score 20), critical care consultants (score 16), oncology consultants (score 16) general anaesthetics (score 16)
- Maternity risks: delayed triage review/treatment; lack of dedicated maternity ultrasound scanning (score 16), consultant obstetricians (score 16), diabetes in pregnancy (score 16)
- Tower Block windows (score 15)
- Asbestos management (score 16)
- Clinical pathway capacity: fractured neck of femur pathway/theatre capacity (score 16)
- Facilities/estate adequacy: critical care bed base/estate/facilities (score 16), East block estate (score
- Compliance with NICE guidance: specialist psychology services for cancer/palliative care (score 15)
- Service continuity: pharmacy manufacturing service closure (score 16), ophthalmology relocation (score 15)
- Performance/KPI risks: breast screening KPIs; glaucoma follow-up delays (score 16)

Further information on our risk and control framework is provided in the Performance Analysis section and Annual Governance Statement section of the Annual Report and are contained in the risk reports which are within the published board papers.

Going Concern Disclosure

The Board of Directors is clear about its responsibility for preparing the Annual Report and Accounts. The Board sees the Annual Report and Accounts considered as a whole, as fair, balanced and understandable, and as providing the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The Board also describes some of the principal risks and uncertainties facing the Trust in the Annual Governance Statement. The Trust has prepared its 2025/2026 accounts on a going concern basis.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Statement from Chief Executive on Performance

Gloucestershire Hospitals NHS Foundation Trust (GHFT) provides a wide range of services across Gloucestershire Royal Hospital and Cheltenham General Hospital, including emergency and critical care, inpatient and outpatient services, and an integrated flow hub working closely with community and social care partners to support timely discharge and return to the community.

During 2025/26, the Trust sustained a strong focus on recovery against national standards for elective care and urgent and emergency care. While the ongoing legacy of the Covid-19

pandemic continued to influence long waits in part, the year saw material improvement across several key access and flow measures.

Significant progress was made in reducing long waits for planned care, with the number of patients waiting more than 52 weeks for treatment reducing from 93 at the start of the year to 6 by year end. Longer waits reduced further, with the 78-week cohort eradicated and only a small number of 65-week waits present in the early months of the year.

Performance against the 18-week RTT standard improved steadily, supported by long-waiter initiatives and focused validation activity, with year-end performance reaching 74.5%, representing the best performance across the South West region.

In urgent and emergency care, performance improved over the course of the year, supported by sustained work to strengthen patient flow and reduce delays across the hospitals. Demand for urgent and emergency care remained consistently high, with Emergency Department activity increasing to an average of 13,759 attendances per month, equivalent to 452 attendances per day. Despite this sustained pressure, the Trust delivered improvements across several critical safety and flow indicators.

Four-hour Emergency Department performance improved to 64.6% by March 2026 (60.7%-March 2025) (national standard 95%), and average time spent in the Emergency Department reduced by 33 minutes year on year to 306 minutes. A major achievement during the year was the sustained improvement in ambulance handover performance, with average time lost to handover delays reducing by 72%, and total delays reducing to 13 hours per day by year end, compared with 55 hours in March 2025. This achievement reflected the closer working with system partners and improvements in internal processes. Despite some gains, this remains below the national standards and remains a focus for the Trust.

Performance against the 12-hour standard remained below target at 90.6%, reinforcing the continued need to strengthen end-to-end flow and discharge reliability with system partners as the Trust moves into 2026/27. Importantly, the elimination of corridor care on inpatient wards has been maintained, representing a significant step forward in protecting patient dignity and safety. While demand has remained high and discharge pressures persist, the Trust's focus has stayed firmly on improving access, safety and the overall experience of care for patients.

In elective care, the Trust made strong progress in reducing waiting lists and long waits for treatment. This reflects a combination of increased productivity, improved theatre utilisation and new ways of working across clinical teams. As a result, the Trust is now performing strongly in comparison with national benchmarks for elective recovery.

Diagnostic capacity has also been strengthened, with additional investment in imaging and endoscopy services improving both access and resilience. These developments are supporting earlier diagnosis and more timely treatment, particularly for patients on cancer pathways.

Quality and safety remain central to the Trust's performance. During the year, the Trust continued to reduce avoidable harm associated with delays in care and strengthened its approach to learning from incidents and improving practice. External assurance recognised this progress, including a positive Care Quality Commission inspection for Medical Services at Cheltenham General Hospital, which highlighted a strong safety culture, effective leadership and supportive working environments. The Trust also saw significant improvements in the Standardised Hospital Mortality Indicator (SHMI) which measures the number of expected v unexpected deaths.

Financial performance has been carefully managed within a constrained environment. As with many organisations across the NHS, the Trust has faced ongoing cost pressures

alongside the need to invest in services and infrastructure, particularly where safety may be compromised. A continued focus on productivity, efficiency and value for money will be essential in the year ahead to ensure financial sustainability while maintaining quality of care.

The workforce remains the Trust's greatest strengths. Despite industrial action and workforce pressures, staff across the organisation maintained services and drove improvement. The Trust saw some progress in staff experience, including modest improvements in some staff survey results, but recognises the need to go further in supporting wellbeing, reducing pressures and strengthening a culture of speaking up.

Partnership working has been critical to the Trust's progress this year. Many of the improvements described have been delivered through collaborative working with partners across the Gloucestershire system, including primary care, community services, social care and the ambulance service. This system approach will be increasingly important as the Trust responds to the ambitions set out in the NHS 10 Year Plan.

Overall, the Trust enters the next year in a stronger position, with improved performance in key areas, a clear strategic direction and a continued focus on recovery and transformation. However, the scale of the challenge remains significant. Demand continues to grow, expectations are high, and the need to deliver sustainable services within available resources is increasingly complex.

The Trust's priority for the year ahead is to build on the progress made, further improving access, reducing variation, strengthening quality and delivering the ambitions set out in the new five-year strategy. Above all, the Trust remains committed to providing high-quality, compassionate care for patients and communities.

Kevin McNamara **Date: 25 June 2026**

Chief Executive

Performance Report:

Performance Analysis

Performance analysis

Monitoring Performance

The Board of Directors is responsible for the performance of the Trust, to ensure that resources are secured and utilised to provide safe, effective, and high-quality care to the population it serves. To this end, the Board oversees a set of key performance indicators, comprising quality and safety measures determined internally in response to known risks and priorities, as well as priorities determined by external regulators, commissioners, and partner organisations from across the health and care economy.

The Board receives a monthly Integrated Performance Report with supporting explanatory narrative. This has been scrutinised by the Quality and Performance Committee. This report ensures that key metrics and constitutional standards are reported and deviations can be explored and responses developed. This is complemented by quarterly thematic deep-dives covering Urgent and Emergency Care; Diagnostic Services; Planned Care and Cancer Performance. The below tables summarise the Trust's performance in respect of the Single Oversight Framework.

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Quality of Care, Access & Outcomes	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	0%	47.3%	36.7%	34.5%	29.8%	25.9%	19.9%	22.3%	22.7%	17.3%	22.2%	22.0%	17.0%
		Proportion of patients spending more than 12 hours in an emergency department	<10%	11.1%	9.7%	8.3%	10.0%	8.9%	9.2%	9.2%	10.1%	10.0%	12.2%	10.4%	9.4%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	107%	112%	110%	107%	118%	108%	107%	118%	102%	106%	133%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%	157%	140%	147%	149%	137%	142%	148%	137%	138%	175%
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	No Target	161	160	125	135	144	152	152	115	139	162	172	138
		Total patients waiting over 62 days to begin cancer treatment compared with baseline	<=6%	8.05%	7.98%	6.03%	6.59%	6.89%	7.48%	6.70%	4.76%	6.42%	7.16%	6.98%	5.76%
		Proportion of patients meeting the faster cancer diagnosis standard	75%	82%	83%	86%	84%	80%	78%	77%	76%	70%	57%	68%	76%
		Total patients treated for cancer compared with the same point in 2019/20	No Target	357	362	344	334	343	406	304	280	311	313	284	301
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.92%	104.97%	109.42%	110.14%	106.43%	120.21%	109.32%	107.68%	118.60%	102.80%	104.16%	123.71%
	Discharge	Proportion of patients discharged from hospital to their usual place of residence	No Target	97.16%	97.47%	97.28%	97.62%	97.65%	97.41%	97.42%	97.45%	97.31%	97.49%	97.64%	0.00%
	Safe Care	Summary Hospital -level Mortality Indicator	No Target	1.137	1.127	1.095	1.083	1.045	1.038	1.010	0.993	0.980	0.957	0.944	0.927
		Summary Hospital -level Mortality Indicator Limits		Within	Within	Within	Within	Within	Within	Within	Within	Within	Within	Within	Within
		Clostridium difficile infection rate per 100,000 bed days	<104	25.7	30.6	44.9	33.8	42.7	26	51.5	40	37	14.1	38.4	21
		E. coli bloodstream infection rate per 100,000 bed days	<71	21.5	17.5	22.4	25.3	17.1	26	38.6	48.9	29.6	14.1	23	21

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Watch Measures	Urgent Care	ED Armed Forces 4 hour breaches (TRAK flag)	0	5	8	4	5	2	2	9	3	1	2	4	4
		ED Learning Disabilities 4 hour breaches	0	63	101	81	92	65	70	76	66	84	80	53	71
	Elective Care	52ww RTT	0	94	75	47	40	37	36	29	31	30	21	13	6
		Short notice (within 72h) cancellation rate – total	<9%	9.4%	8.7%	9.6%	10.7%	10.7%	15.9%	12.4%	11.0%	10.2%	10.6%	11.3%	9.5%
		Same Day Non-Clinical Cancellations		57	38	59	84	69	104	74	68	38	51	45	54
		Cancellations not rebooked within 28 days	0	7	12	14	9	25	11	28	16	14	9	13	13
		Angiogram Waiting List Position		293	288	274	280	265	231	220	216	232	250	255	237
		Histopathology 10-day reporting	90%	56%	56%	49%	63%	63%	58%	52%	41%	38%	50%	47%	31%
	Flow	G&A Occupancy - CGH	92%	88%	89%	88%	86%	85%	87%	87%	86%	89%	91%	90%	92%
		G&A Occupancy - GRH	92%	95%	94%	92%	94%	94%	94%	95%	95%	94%	97%	97%	96%
		Daily Average of boarded patients	0	4	3	1	4	2	3	3	3	3	3	3	2
	Safe Care	VTE Assessment within 14 hours (%)	95%	91%	90%	91%	85%	89%	87%	87%	88%	88%	86%	86%	86%
		VTE assessment completed - excluding short stay (%)	95%	96%	95%	95%	91%	94%	93%	93%	94%	93%	93%	92%	93%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19	11	11	21	11	24	11	15	15	6	12
		Smoking Status Compliance (%)	95%	97.11%	97.16%	97.09%	97.12%	97.54%	98.40%	98.56%	98.16%	98.04%	97.96%	97.54%	98.32%
		Severe Harm from Patient Medication Errors	0	2	1	0	0	1	0	0	0	0	1	0	0

Operational Performance analysis 2025-26

The following section provides analysis of key areas of Trust performance and complements the earlier narrative on key risks. Constitutional Standards are monitored and delivered as two thematic portfolios; Planned Care and Urgent & Emergency Care.

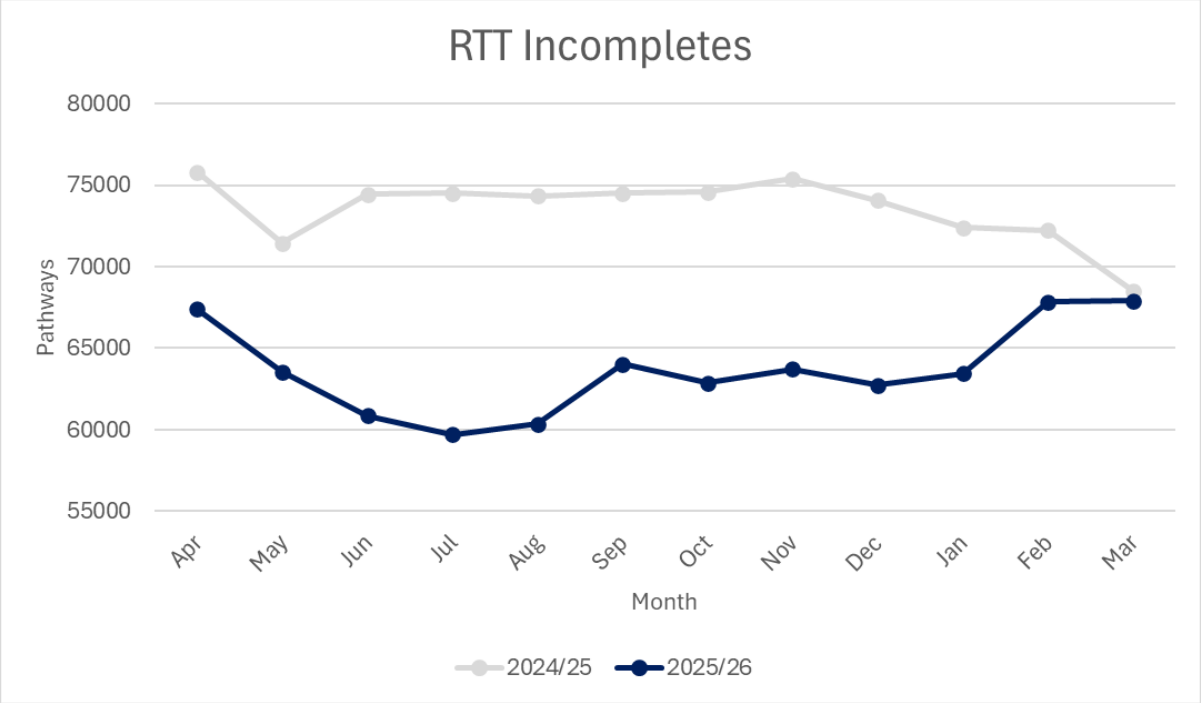
The 2025/26 year proved challenging in all the key performance domains:

Referral to treatment (RTT)

The organisation set ambitious milestones in the continued recovery of waiting times regarding Referral to Treatment (RTT) post-pandemic. The 78-week, and 65-week waiting list cohort has been eliminated throughout 2025/26, with only a handful of 65-week breaches reported in the preliminary months.

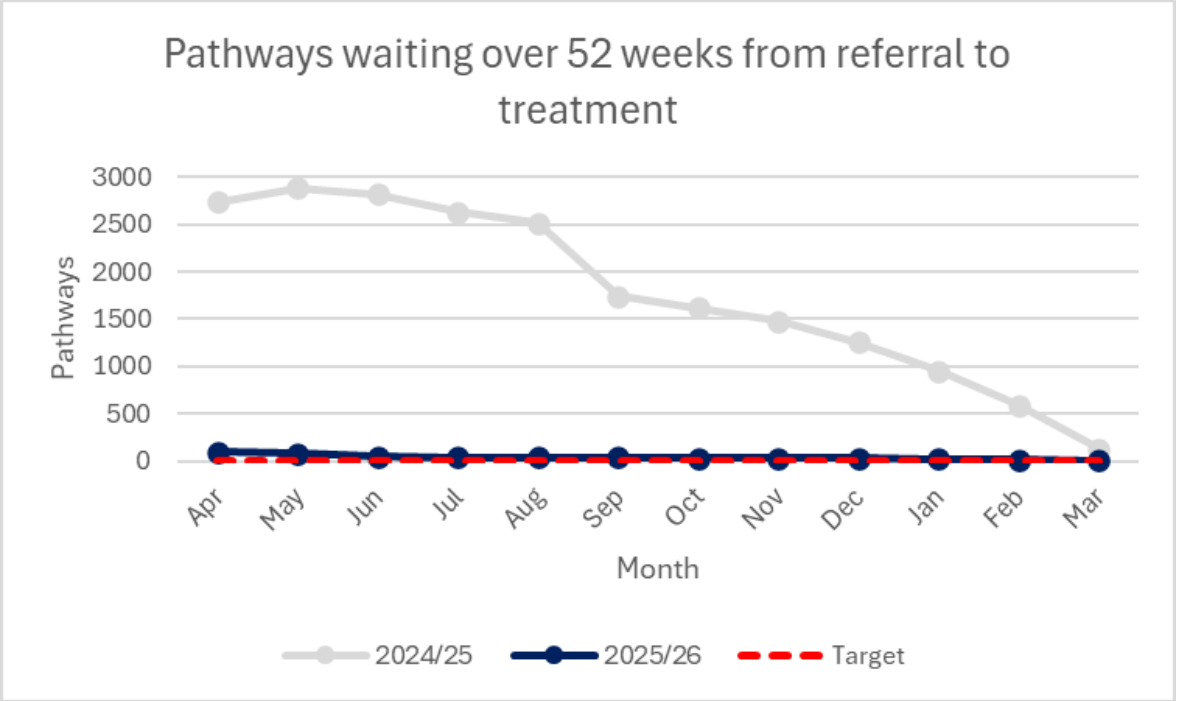
The waiting list initially showed a downward trajectory in the early months of the financial year, with the waiting list size reverting back to a similar size as in April 2025. However, with the NHS-wide 12-week focus on waiting lists, beginning in April 2026, we anticipate the waiting list size to decrease back towards 60,000 patient pathways.

When we refer to RTT Incompletes in our data we are referring to patients who have been referred for hospital treatment and are still waiting for that treatment to finish or to be reassured and discharged back to the care of their GP.

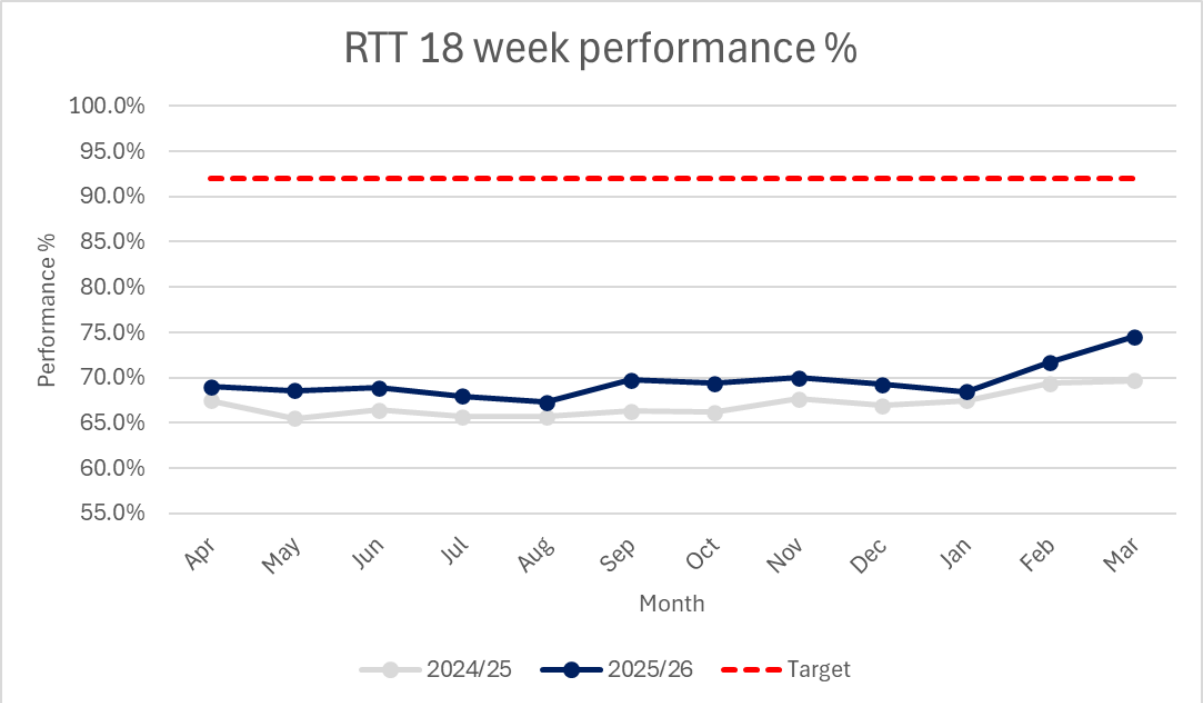


There has been considerable progress made in the reduction of the number of patients waiting 52 weeks across 2025/26, with the Trust starting with 93 and finishing with 6 patients as per graph below, a significant difference from the previous year and significant progress has been made in reducing our 45- week waiting cohort.

Although the target had been to achieve no patients within this cohort by March 2026, it should be noted that the handful of patients remaining within this cohort is as a result of the complexity of pathway. Treatment pathways can be complex for a number of reasons; for example, where treatment requires items which are subject to a national or international shortages or where patients require specialist tests which may require onward referral.



We continue to work towards the national constitutional standard of 92% of patients seen before 18 weeks, as per the graph below. Although there is still some considerable work to be done to achieve this target, our performance is continuing to improve, partly due to the work undertaken to reduce our number of patients waiting for an extended period. The expectancy from the national team was to prove a 5% improvement by the close of March 2026 based on mid-year performance. The trust was to achieve 72.1% which GHFT has eclipsed, anticipating a performance north of 74% waiting less than 18 weeks for treatment, once validation has been completed



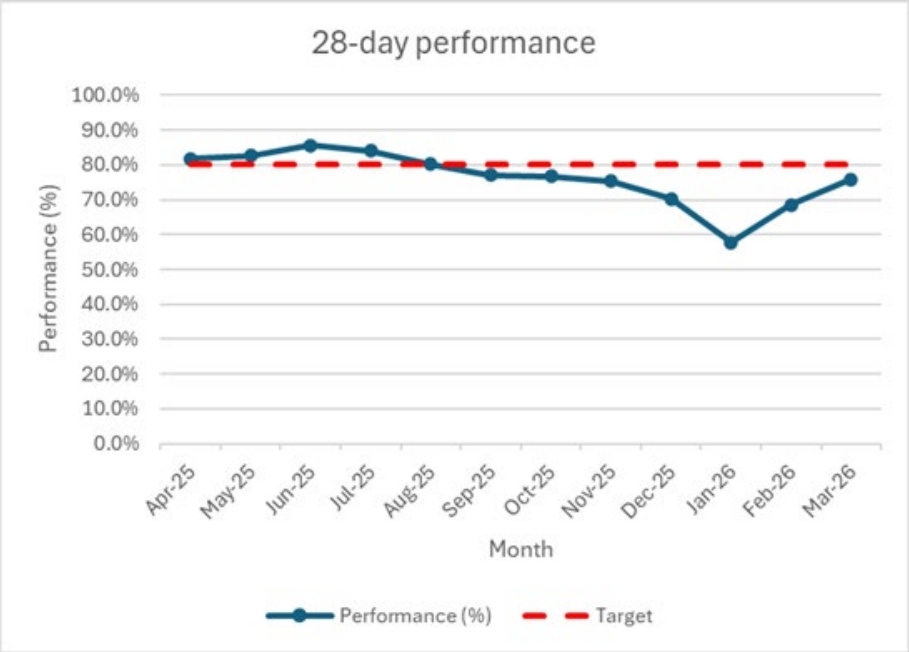
Cancer performance

Cancer performance has struggled to consistently improve comparatively to the NHS England agreed trajectory for 28 days, 31 days and 62 days national performance standards. These targets are defined as follows:

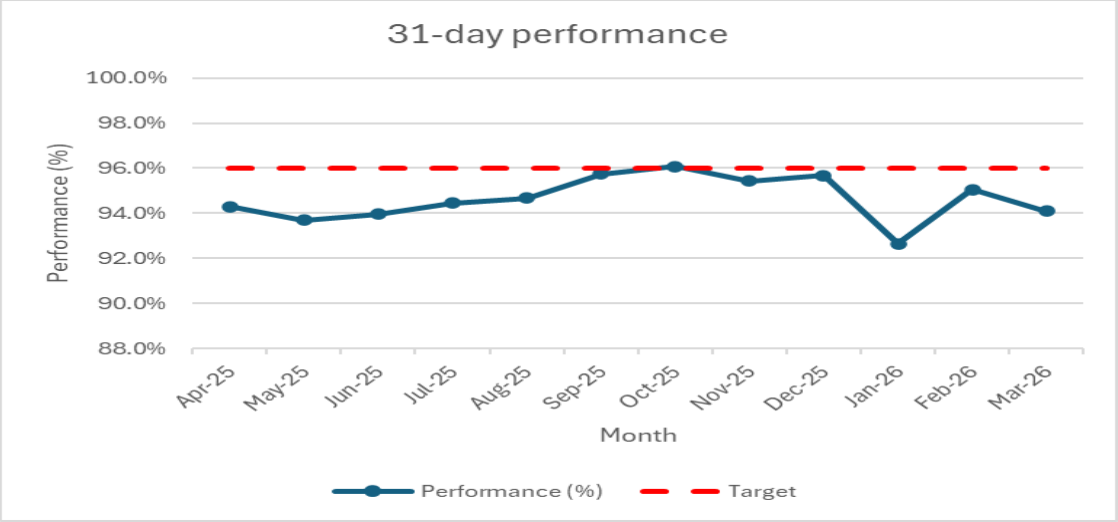
- 28 days: From urgent referral to diagnosis a patient should wait no more than 28 days to receive a definitive diagnosis or reassurance they do not have cancer.
- 31 days: From decision to treat to treatment commencing a patient should receive this within 31 days.
- 62 days: From urgent referral to first definitive treatment the 62-day pathway measures the total time taken to complete all parts of the pathway (diagnosis, tests, MDT discussions, and treatment planning as well as treatment).

Cancer performance 2025/26 graphs shown below, please note these are current figures rather than submitted.

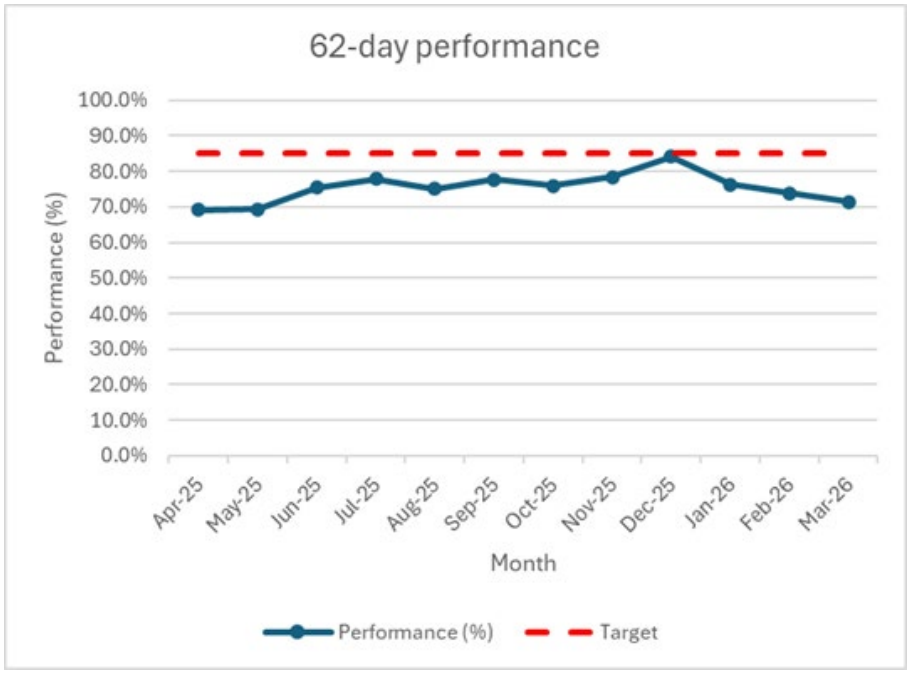
The Trust was above the 80% target for the 28-day faster diagnosis standard in the first 5 months of the financial year before dropping below the target line for the rest of the year. However, the 28-day standard shows improvement in the last 3 months of the year with March performance at 75.9% (80% target). Underperformance is mainly due to capacity issues in the Breast cancer specialty which recovered within Quarter 1 2026/27.



The 31-day standard was met once in this financial year and has remained below the 96% target. March performance was 94.1% with performance only meeting target in October 2025. Please note that the y-axis in the graph below does not start at zero, to present variations in the trend more clearly.



62-day standard has been below-target throughout the 25/26 financial year, and performance stood at 71.6% in March, as shown in graph below.



Note these are current figures and are slightly different from submitted (national submission) due to retrospective updates in the clinical system. Submission audits take place every 6 months to update national portal.

In 2025/26, the capacity issues in the Breast specialty impacted the overall 28-day performance significantly in late Q3 and early Q4, with compliance achieved in April/May 2026 for the 28-day Faster Diagnosis Standard, in line with the recovery plan trajectory.

In quarters 2 and 3 of 2024-25 Breast and Skin cancer service were challenged in delivering to the 28-day pathway, leading to an overall underperformance in all tumour sites. Urology has been the most challenged specialty in reaching 28 days and 62 days target performance throughout the year. Histopathology reporting turnaround have highlighted the variable in-

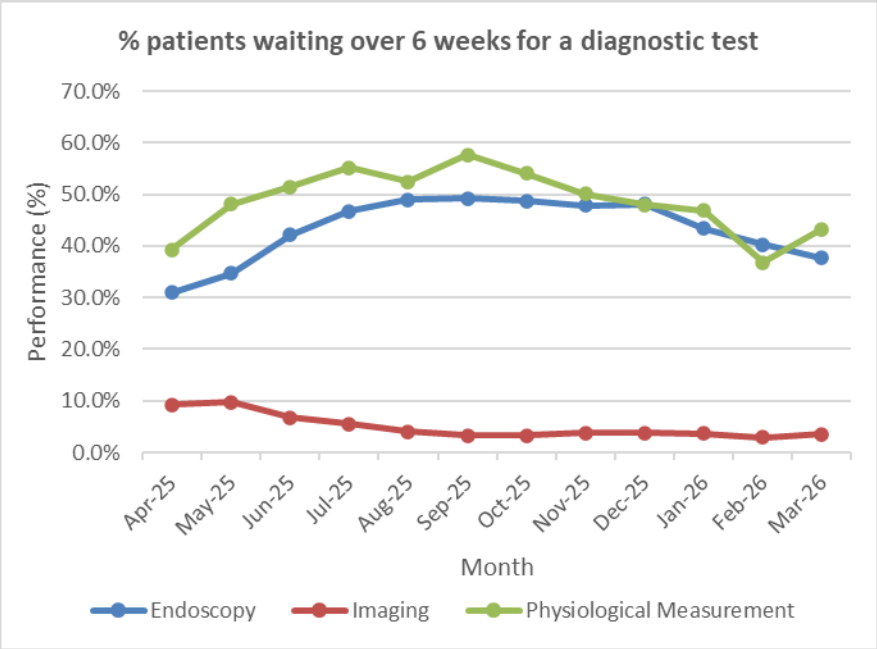
house capacity that has led to further outsourcing of reports. All four specialties have been subject to formal “mandated support”.

This is part of the Trust’s internal performance management support process, where services are provided with targeted support which includes weekly governance oversight meetings in line with the Performance Accountability Framework (PAF). The increased frequency of conversations and supervision has supported challenged services in making sustainable improvements. 2025-26 improvement focus will be in delivering 28-day as standard across the majority of tumour sites with specific focus on Urology, Histopathology and Colorectal.

Diagnostics

Performance for patients waiting over 6 weeks for a diagnostic test (DM01) shows improvement for Imaging which was initially impacted by capacity issues with MRI scanners at the beginning of the financial year. Imaging performance peaked at 9.8% in May 2025 and stands at 3.5% in March 2026.

Diagnostic performance 2025/26 shown in image below as percentage of patients waiting over 6 weeks for a diagnostic test - less than 1% of patients should wait 6 weeks or more for a diagnostic test.



Endoscopy modality group performance improved over the second half of the financial year. Following a peak of 49.2% in September, performance reduced to 37.7% by March.

The principal driver of this improved performance is Cystoscopy which is a Urology test and not internally reported within the Endoscopy service. Cystoscopy recorded an average of 61.1% across the year, peaking at 71.7% in July before improving steadily to 41.4% in March.

Physiological Measurement demonstrated improvement over the latter part of the year. Performance peaked at 57.6% in September and improved to 43.3% by March. Key contributing modalities include Cardiac Echocardiography and Neurophysiology.

Cardiac Echocardiography reported an average performance of 70.0% across the year, peaking at 80.4% in September and reducing to 71.8% in March. Neurophysiology showed notable improvement, reducing from a peak of 64.3% in June to 24.8% in March.

Urgent and Emergency Care

Overall, the Trust made measurable progress across several aspects of Urgent and Emergency Care during 2025/26, despite operating in a sustained high-demand environment. Performance against national standards remained below target; however, sustained improvement was delivered across key flow and ambulance handover measures, alongside stabilisation of core ED processes.

A key development for the Service was the mobilisation of a new Integrated Urgent Care provider in November 2024, delivered by Gloucestershire Health and Care NHS Foundation Trust. This included pre-hospital services, Minor Injury and Illness Units and GP Out of Hours provision. The transition supported continued access to alternative urgent care pathways during a period of increasing emergency demand. Winter system pressures, including widespread norovirus and influenza, resulted in a system-wide Critical Incident over the Christmas period. While challenging, this provided important learning to inform winter planning and resilience for 2025/26.

Emergency Department attendances increased year on year, with demand peaking during the winter months and remaining at a higher baseline than previous years. Average daily attendances increased across both Gloucestershire Royal Hospital and Cheltenham General Hospital, driving sustained pressure on flow, particularly for non-admitted patients and overnight pathways. Despite this, overall Emergency Department length of stay improved during the year, reflecting benefits from changes to clinical assessment and flow models.

A major area of improvement was ambulance handover performance. The Trust worked closely with South Western Ambulance Service NHS Foundation Trust to implement the Timely Handover Protocol, ensuring that no patient waits more than 90 minutes to be offloaded from an ambulance. Gloucestershire had previously been among the poorest-performing organisations nationally for handover delays; however, sustained improvement was achieved during 2025/26. Average handover times reduced steadily across the year, falling to approximately 20 minutes by December and remaining well within national expectations by year end. Total hours lost to handover delays reduced significantly, demonstrating a structural improvement rather than short-term fluctuation.

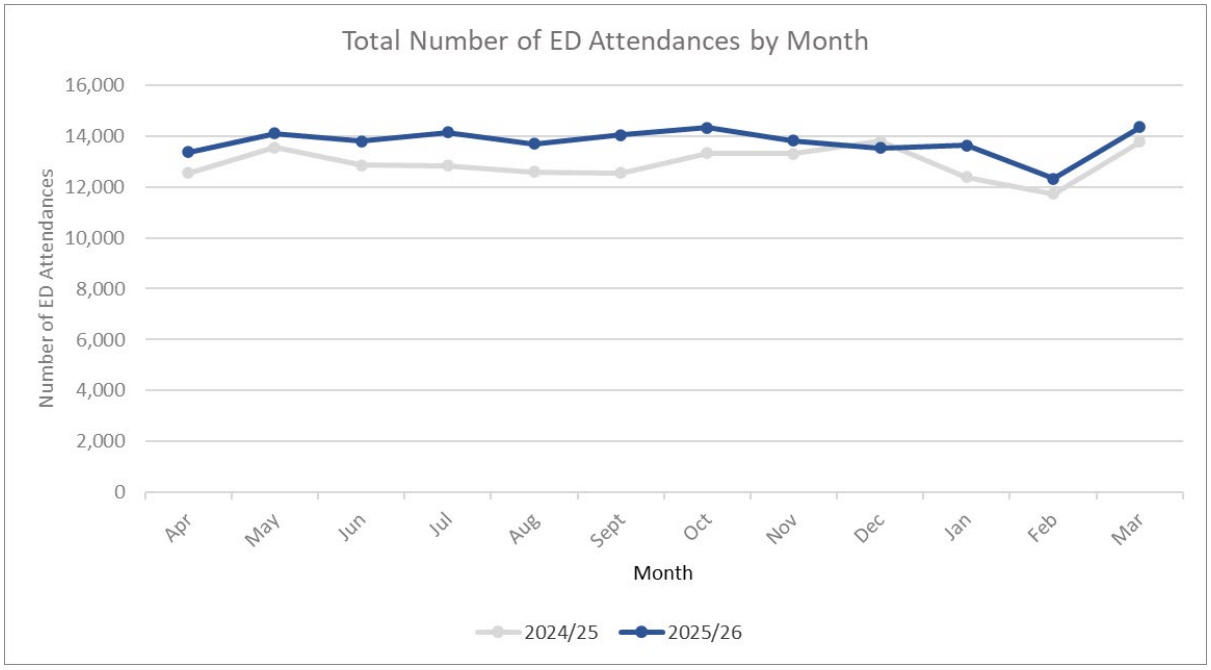
Strengthening paediatric emergency care remained a specific area of focus. Fluctuating paediatric attendances, combined with mental health presentation complexity, affected four-hour performance during periods of peak demand. Targeted actions included increased senior clinical oversight, enhanced scrutiny through mandated support arrangements and plans to recruit additional consultant capacity with sub-specialist paediatric expertise.

Overall, while Urgent and Emergency Care performance remained below national constitutional standards, the Trust delivered sustained improvement in critical areas of patient safety and system resilience, particularly ambulance handover delays and emergency department flow. The focus moving into 2026/27 is to embed learning from sprint activity, further strengthen non-admitted flow, stabilise paediatric provision and work with system partners to improve discharge reliability and end-to-end patient flow.

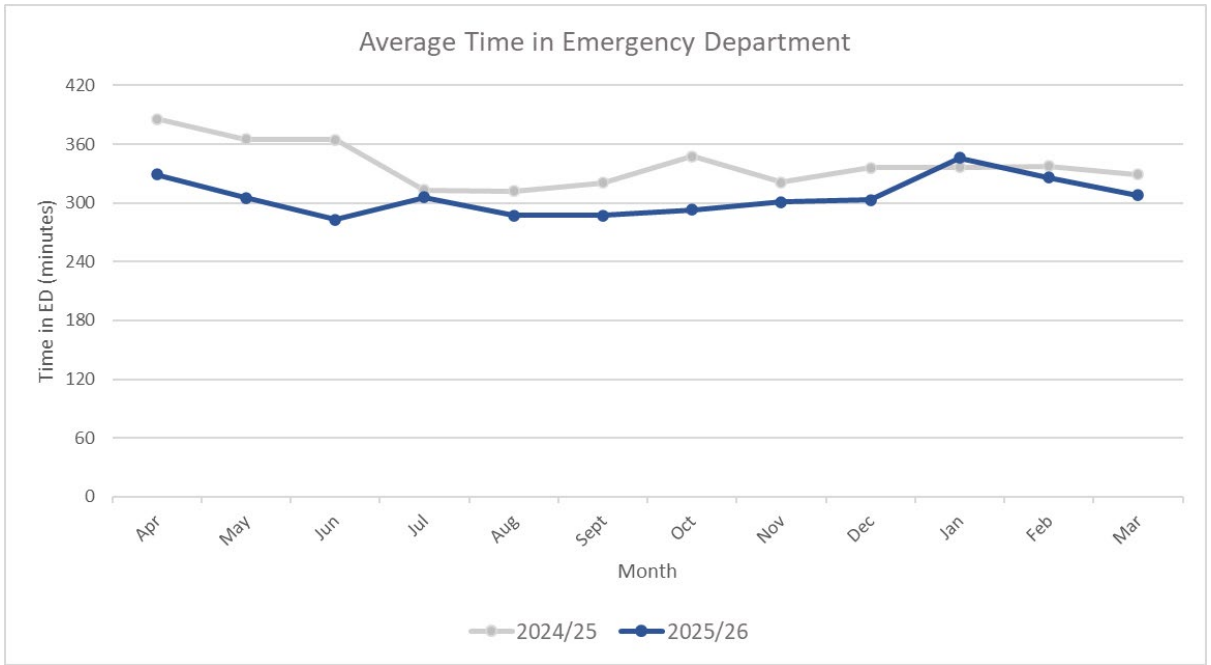
Since 2025/26 the Trust has reduced average time lost to handover delays by 72% and has increased the number of ambulances offloaded in the Emergency Department within 15 minutes. The numbers of patients conveyed by ambulance who have been delayed by more than an hour has continued to reduce month on month, with less than 1% of all delays now being over 60 minutes.

Emergency Department attendances increased overall, with the Trust seeing on average 13,759 attendances per month; making a daily average of 452 attendances compared to 425

in 2024/25. The largest increases were seen throughout the summer months (June – October).



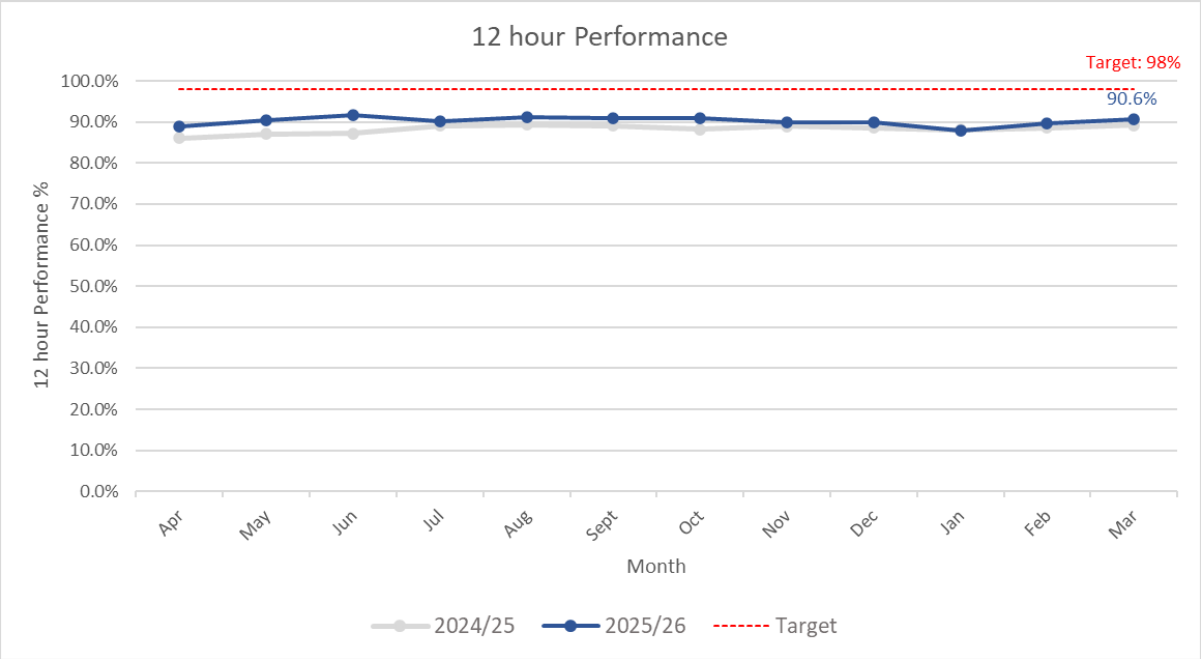
Average time spent in the department remained high but saw an improvement in year of -33 mins from 339 minutes in 2024/25 to 306 minutes overall in 2025/26, further work is planned to continue to reduce this further in 2026/27.



Performance against the 4-hour national target showed little improvement, and remained below our target of 78%, ending the year at 64.6%. However, this was still an improvement of nearly 4% from March 2025. The reduction in ambulance handover delays has in turn put more pressure on the Emergency Department.

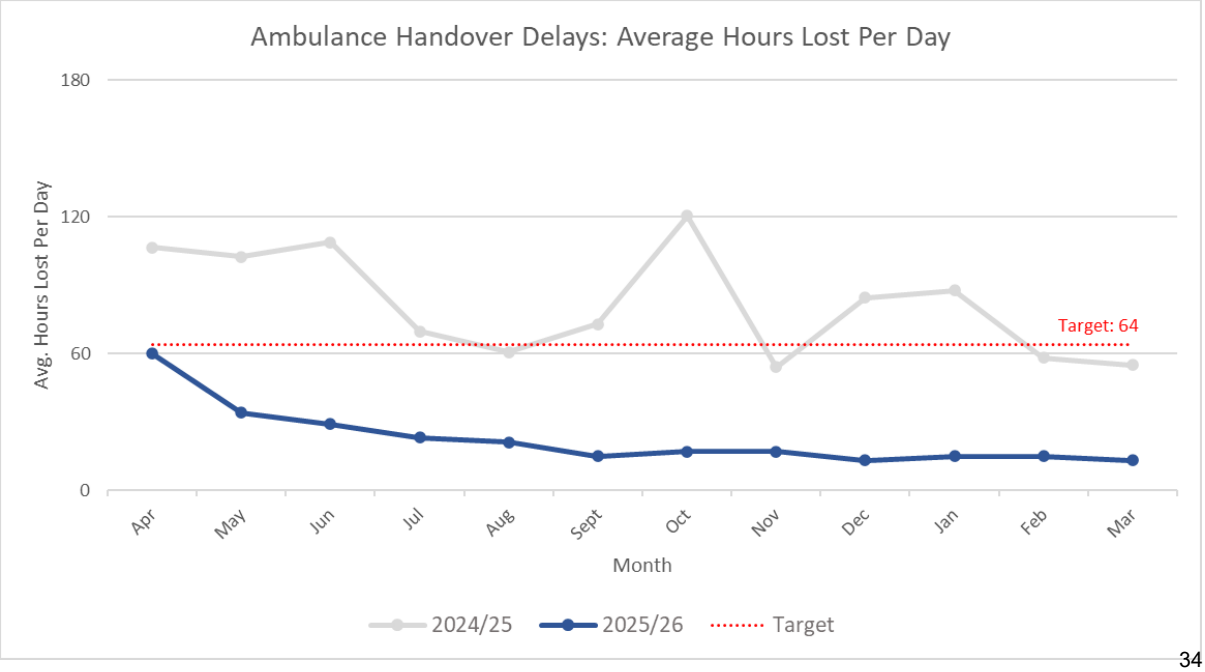
Performance against the 12-hour standard (98%) was also not achieved, remaining at 90.6% patients admitted, transferred or discharged within 12 hours of arrival at the Emergency

Department. There continues to be work needed to improve this even further and patients waiting for extended periods remain a primary focus of the Trust as we enter 2026/27 with the aim of returning to compliance with national standards. We recognise the importance of this work, in terms of both our patient experience and staff morale.

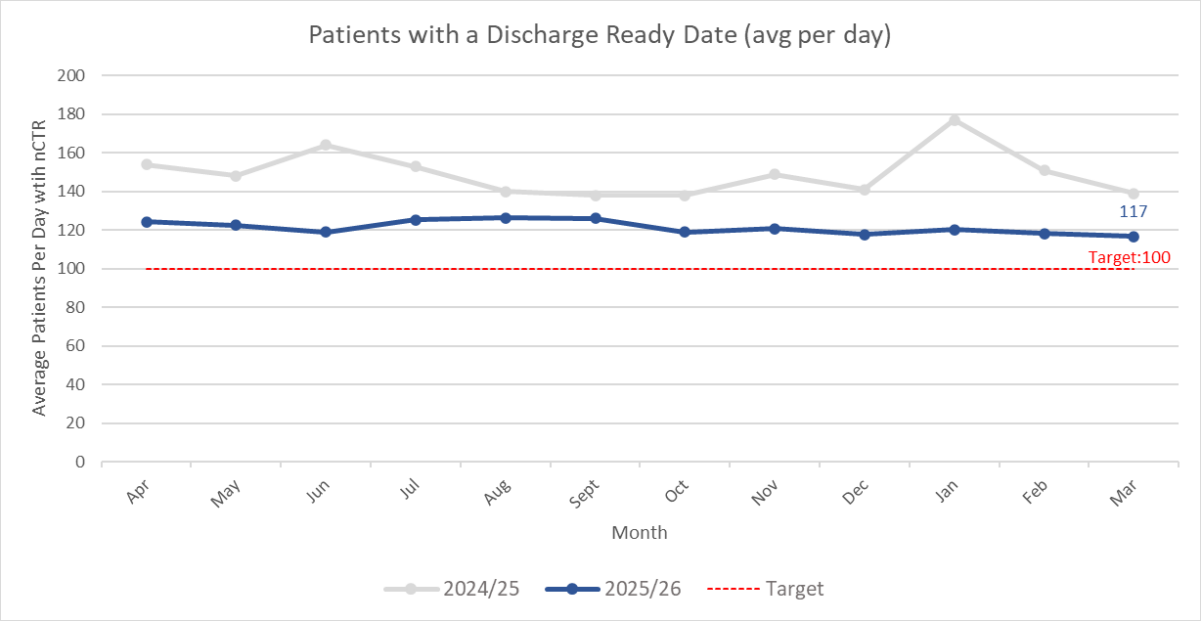


One of the greatest achievements in 2025/26 was the reduction in ambulance handover delays. A greater proportion of ambulances are being offloaded by the 15-minute standard and improvements have been demonstrated in all other offload indicators showing a real improvement in all areas. Delays are now well below the target of 64 hours per day, ending 2025/26 at 13 hours per day (compared with 55 hours in March 2024/25, and 111 hours in March 2023/24).

We remain committed to achieving timely ambulance handovers, with a focus on safely offloading patients within 15 minutes wherever possible. At times, to ensure ambulances can return quickly to respond to patients in the community, some patients may experience short waits within the Emergency Department environment at Gloucester Royal Hospital. We carefully manage this to balance patient safety and service demand. Our clear ambition is to eliminate any corridor care in our Emergency Department.



in 2025/26. The shared system target is to maintain a figure below under 87 consistently with the Trust's initial target set at 100.



Quality priorities achievement

2025-2026 Quality priorities achievement

This section summarises progress against the Trust's 2025–2026 quality and safety priorities, aligned to the NHS England Patient Safety Incident Response Framework (PSIRF). It outlines how we have used proportionate, system-based learning responses, informed by effective data quality, and supportive oversight to translate learning from patient safety incidents into improvement.

Table: Summary of improvements made for the Quality and Safety priorities during 2025–2026

Patient Safety Incident type or issue	Description	Improved position during April 2025 – March 2026
Pressure Ulcer Prevention	Risks and incidents relating to hospital-acquired pressure ulcers, including higher-grade and medical device related ulcers.	In line with Patient Safety Incident Response Framework, pressure ulcer incident response has been refocused on proportionate, system-based learning to strengthen prevention. Hot debriefs are used to capture timely learning and agree improvement actions, supported by the Pressure Ulcer Prevention Improvement Group (Tissue Viability led) reporting via the Quality Delivery Group. A Trust-wide dashboard supports ward-level oversight

Patient Safety Incident type or issue	Description	Improved position during April 2025 – March 2026
		of risk assessment and prevention compliance.
Falls Prevention	Risks and incidents associated with patient falls, including repeat falls and injurious falls.	In line with Patient Safety Incident Response Framework, learning from falls is strengthened through proportionate learning responses, including hot debriefs for all falls, with themes recorded in Datix to inform targeted improvement. Delivery is supported through the full-day training programme and Falls Link education days, alongside strengthened electronic documentation (including bed rails and post-fall assessment) to improve consistency of risk management.
Recognition and Escalation of Deterioration	Risks where delays in recognising or escalating clinical deterioration could compromise patient safety.	The Trust uses data-led oversight and proportionate learning responses to improve recognition and escalation of deterioration. Assurance is provided through the Deteriorating Patient & Resuscitation Committee, divisional governance and the Acute Care Response Team, supported by National Early Warning Scores (NEWS2) dashboards and audit. Escalation for NEWS2 ≥5 remains high (often 80–100%), and Martha's Rule is implemented across adult, paediatric and maternity inpatient areas to support escalation for concern.
Outpatient Transformation	Risks associated with delayed care, inefficiency, and patient experience in outpatient pathways.	Outpatient transformation is supported by governance and continuous improvement informed by pathway performance and patient feedback. Patient Initiated Follow-Up (PIFU) is established as the default pathway in most specialties, releasing capacity and supporting patient choice. Clinic utilisation has increased (approximately 65% to 78–79%) and data quality has improved through standardised templates, with digital changes reducing administrative burden.
Clinical Vision of Flow (including emergency	Risks relating to delayed patient flow, overcrowding, and harm associated with	The Trust uses data-led oversight and learning from harm associated with delay to prioritise improvement across urgent and emergency care. The Urgent Care &

Patient Safety Incident type or issue	Description	Improved position during April 2025 – March 2026
department improvements)	prolonged waits across urgent and emergency care pathways.	Flow Improvement Board oversees delivery of agreed actions, including improved performance against the 12-hour Emergency Department standard, improved ambulance handovers, and expanded capacity in Same Day Emergency Care, Virtual Wards and the Discharge Lounge. These changes support safer, timelier care and discharge.
Fire Prevention and Safety	Risks associated with fire safety compliance, infrastructure, and emergency response across Trust sites.	Fire safety improvement is informed by learning from incidents and supported by strengthened governance and external assurance. A formal compliance framework is in place, enforcement-led remediation programmes are monitored, and statutory fire training compliance is consistently above 90%. Learning from incidents (including a lithium-ion battery fire) has been embedded through updated risk assessments, targeted training and strengthened emergency command arrangements.
Maternity Service Improvements	Meeting all the requirements of our CQC S31 enforcement notice through delivery of the maternity transformation plan	All eight requirements set out in the CQC registration conditions have been self-assessed as met with routine oversight at Board level. In 2026/2027 the Trust will receive the inspection report from the last CQC inspection of Maternity Services, which took place in September 2025, at which point a decision will be taken to make representations to the CQC to review those conditions and seek their removal. Maternity safety improvements are underpinned by strengthened systems learning, compassionate engagement, and governance to ensure learning is translated into sustained improvement.

The Trust has delivered measurable progress against its 2025–2026 quality and safety priorities; however, continuous improvement remains essential. During 2026–2027, the Trust will build on this work through sustained Board oversight, robust governance and systematic learning, with a continued focus on reducing avoidable harm, improving the reliability of care and strengthening patient experience across all services.

Risk profile of the Trust

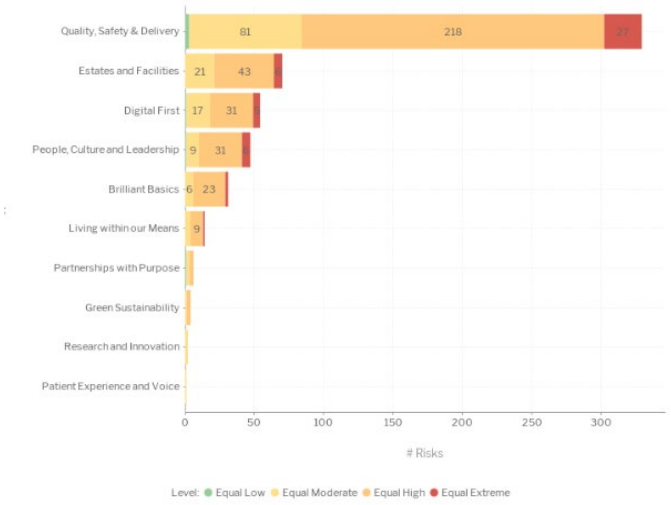
The Trust and Gloucestershire Managed Services ('GMS') (the Group) operates three levels of risk register (speciality, divisional and Trust) in addition to the strategic risks set out within the Board Assurance Framework. The appropriate register for a risk is determined by the Trust Risk Appetite.

The Group collectively maintains over 500 active risks on its risk registers. The Trust-wide risk profile is broad, mature and systemic, with risks spanning clinical, operational, workforce, estates, digital, financial and compliance domains.

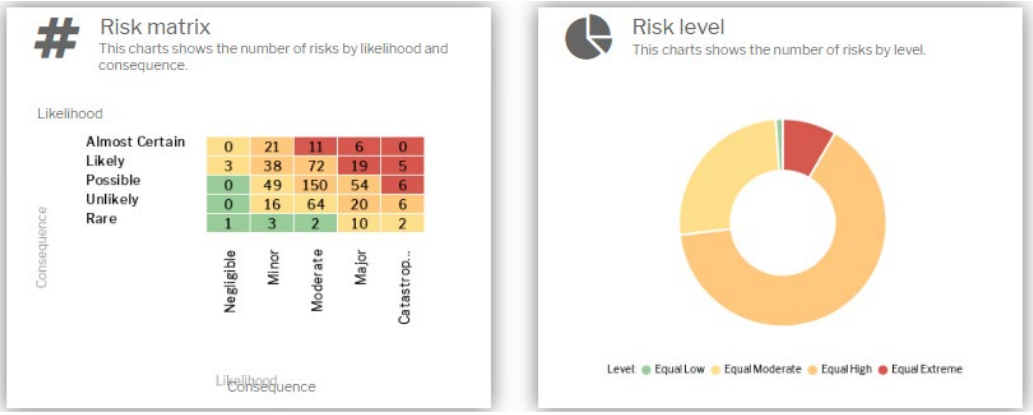
Safety, quality, and delivery represent the most significant risk theme, cutting across all divisions. These risks include delayed diagnosis and treatment, patient deterioration linked to flow, capacity and staffing constraints, corridor care, medication safety, infection control, and safeguarding. These risks are largely systemic and arise from sustained operational pressures rather than an absence of controls.

Workforce risks continue to form a significant cluster, particularly in radiology, critical care, oncology, and maternity, and to a lesser extent within nursing and Allied Health Professional (AHP) roles. A growing proportion of higher-scoring risks relate to estates, including water, fire, ventilation, and unsuitable clinical environments, all of which require investment to reduce ongoing exposure.

Whilst not always the highest, digital transformation risks have become increasingly prominent with data integrity and interoperability risks being recognised through the digital programme.



Lower-scoring risks (rated moderate and low) remain numerous, indicating effective risk identification at the operational level and appropriate visibility of pressures, even where mitigating controls are in place.



Risks ratings across all registers

High Scoring Operational Risks

There are six risks on the Trust Risk Register with a score of 20. These include three newly escalated risks—fire safety contraventions, cyber security, and IT infrastructure failure—as well as three persistent risks since March 2025: overcrowding in minors, shortage of interventional radiologists, and corridor care.
A further sixteen risks score 16 and predominantly reflect systemic pressures rather than isolated hazards. Many of these have persisted from the previous reporting period and span multiple services and divisions. These include hospital flow, specialist workforce capacity (particularly in nationally scarce or hard-to-recruit roles), clinical quality and effectiveness (notably for older people, cancer care, and time-sensitive interventions), estates backlog, ventilation, and bed capacity.
Addressing these risks typically requires multi-year programmes, including capital investment, workforce expansion, and collaboration with system partners.

Linking Risk to Performance and Achievement of the Trust's Strategic Objectives

The Trust Risk Register indicates a concentration of active risks scoring 15–20, primarily clustered around:

- Patient safety and experience (particularly urgent, maternity and cancer pathways)
- Workforce sustainability and capacity
- Ageing estate, fire safety and statutory compliance
- Digital resilience, cyber security and infrastructure

These risks impact delivery across all four strategic aims, with the most significant impact on Quality, Safety and Delivery and People, Culture and Leadership, and consequential impacts on Digital First and Patient Experience and Voice**.**

Quality, Safety and Delivery
"Provide good care which is safe, effective, inclusive and responsive"

This aim is affected by the largest volume high-rated risks, including:

- Patient and staff safety risks (fire safety, evacuation, windows, asbestos)
- Operational performance risks (Emergency Department flow, capacity, delayed treatment)
- Clinical effectiveness risks (cancer psychology, pharmacy manufacturing, maternity diabetes)
- Estates and infrastructure risks affecting theatres and critical care.

These risks directly impact patient safety outcomes and compliance with statutory duties, national standards (RTT, ED 4-hour target, maternity and cancer standards) and equity of access and outcomes.

Without effective mitigation, these risks limit the Trust's ability to transition from reactive risk management to proactive quality improvement, which remains a key strategic objective. This strategic aim is currently the most exposed but is appropriately managed with controls in place.

People, Culture and Leadership
"Making our Trust somewhere everyone is proud of and would recommend as a place to work"

Workforce sustainability remains a key challenge, with shortages across multiple specialist areas, including interventional radiology, anaesthetics, oncology, critical care, and obstetrics. Improvements in staff retention rates indicate increasing workforce stability overall.

However, environment risks, relating to fire safety, asbestos, evacuation, falls from height (Risks 363, 368, 674, 1042) are impacting on staff experience, morale and the Trust's ability to achieve top-quartile NHS Staff Survey outcomes.

Workforce shortages and fatigue erode staff capacity to consistently deliver compassionate, attentive care. These matters are monitored by relevant delivery groups and assurance committees.

Digital First
"Helping patients and staff work together using technology and new ideas"

Digital risks include cyber security vulnerabilities, resilience failures, infrastructure disruption, and digital workforce capacity constraints.

These risks directly affect the Trust's ability to advance digital maturity, including reliance on the Electronic Patient Record (EPR), patient portals, and digital pathways, as well as staff confidence in digital systems.

A significant cyber or infrastructure incident could result in service disruption, patient harm, and reputational damage, thereby impeding progress across all strategic aims. Digital transformation remains a critical enabler but continues to present fragility.

Patient Experience and Voice
"What we do is shaped by feedback from patients, carers and our communities"

Key risks include emergency department overcrowding, corridor care, delayed diagnosis and treatment pathways, maternity service pressures, and suboptimal care environments.
These risks undermine the Trust's ability to deliver timely, personalised, and responsive care, and to maintain dignity and trust. Persistent emergency care pressures are reflected in negative patient feedback, including FFT results, complaints, and PALS contacts, as well as CQC experience metrics. Delivery of this aim is closely dependent on improvements in flow and workforce capacity.

Health Inequalities

Several risks, if not effectively managed, may exacerbate health inequalities, disproportionately affecting vulnerable groups. For example:

- Emergency department pressures may disproportionately affect individuals from deprived communities
- Delays in cancer diagnosis and treatment may widen outcome inequalities

- Maternity risks may impact higher-risk groups, including those identified through equity programmes
- Digital risks may contribute to digital exclusion, limiting equitable access to care

Brilliant Basics

Risks relating to deteriorating environments conflict with expectations of clean, safe, and welcoming care settings. Many risks represent fundamental challenges to the consistent delivery of safe care, including fire safety, asbestos, infrastructure limitations, and ageing facilities.

Continuous Improvement

The current risk profile constrains the Trust's capacity for continuous improvement due to:
- Persistent operational pressures necessitating reactive management
- Workforce instability limiting psychological safety and improvement capability
- Digital fragility reducing confidence in data and analytical tools
- Estates and compliance backlogs diverting leadership attention and resources

Collectively, these factors reinforce short-term operational responses rather than sustained improvement.

Green Sustainability

Several risks conflict with the Trust's sustainability and net zero ambitions, including:
- Ageing and inefficient estates increasing energy consumption
- Infrastructure failures increasing reliance on temporary and carbon-intensive solutions
- Digital outages leading to increased paper usage and duplication

Risk Mitigation

Review of de-escalated risks identifies two distinct drivers:

Risk Appetite-Driven De-escalation
Risks de-escalated in November 2025 reflect the implementation of a revised risk appetite framework. These changes represent improved risk alignment and governance clarity, rather than a reduction in underlying risk exposure.

Risk Reduction-Driven De-escalation
All other de-escalations reflect demonstrable reductions in risk, achieved through strengthened controls, delivery of action plans, workforce stabilisation, service redesign, and improved performance outcomes.
Examples include improvements in:
- Midwifery staffing
- Patient flow
- Pharmacy manufacturing
- End-of-life discharge pathways
- Specialist workforce capacity

These demonstrate tangible progress in reducing risk exposure and improving outcomes.

Key Performance Indicators

Key Performance Indicators

The Group monitors KPIs monthly through the Risk Management Group and divisional governance structures. These KPIs are also overseen by the Board and Audit and Assurance Committee.
Overall:

- Risk identification and control: Strong (0% gaps)
- Risk review compliance: Requires improvement (17% overdue reviews)
- Action completion: Significant area of concern (41% overdue actions)
- Incident review timeliness: Substantial non-compliance in patient safety reviews
- Investigation performance: Mixed performance across categories
- Duty of Candour compliance: Below target (79%)
- Serious incident completion: Below target (67%)

These metrics indicate that while risk identification processes are robust, timeliness of action delivery, incident review, and investigation completion remain key areas requiring improvement.

Financial Performance

Trust's Financial Performance overview

During 2025/26 the Trust planned to deliver high quality services for its patients whilst continuing to manage significant non elective pressures and delivering increased elective performance. At the same time the Trust has been managing a high level of discharge ready date patients who have remained in our hospitals due to a lack of suitable onward support for them in the community. Consequently, this has led to a lack of flow in our Emergency Departments and the loss of beds for elective activity to care and accommodate medically sick patients. Despite this the Trust has worked hard to deliver against several performance targets.

The Trust has also maintained several workforce controls with the aim of limiting growth and reducing the use of higher cost agency and bank staff to cover operational areas. Combined with support for recruitment to key posts the Group has been able to reduce its use of temporary agency staffing to 1.8% of the total pay bill (2.5% in 2024/25).

Payments to the Trust from commissioners for patient care activity were made using Aligned Payment Incentive (API) contracts. In simple terms these comprise a fixed payment element (approx. 70%) to cover non elective services and a variable element (approx. 30%) for elective services. Our main commissioner, Gloucestershire Integrated Care Board, has operated an overall fixed contract to provide overall stability of income flows – we are looking for this to transition to more recognise API terms in 2026/27.

The Group (representing the Trust and GMS) planned to deliver an overall breakeven financial position for 2025/26, set against a backdrop of needing c£41.8m of financial sustainability schemes.

During the year the Group has faced material financial challenges:

- Recruitment issues leading to continued temporary staffing costs.
- A challenging financial sustainability programme, in particular its ability to deliver recurrent (ongoing) schemes.
- Patient flow challenges and delays within our Emergency Department, due to discharge ready date levels.
- Non pay inflation costs

Upon identification of pressures to the Group position, support arrangements were put in place to focus on the drivers and available actions to address these – with actions being undertaken

both by the Trust and by system partners, which include the ICS, Gloucester Health and Care (community and mental health provider) and the Council. Actions included:

- Operational expenditure reviews with divisions;
- System level expenditure reviews to identify opportunities;
- Impact of workforce plans and temporary staffing arrangements;
- Review of balance sheet and one-off opportunities.

Using non-recurrent measures (including one-off savings, slippage on investments and one-off income), the Group position has been able to deliver a breakeven position – prior to NHS England requirements explained below – this is in comparison against the adjusted financial position which NHS England monitor against.

During the planning for 2025/26 NHS England set aside deficit support funding for Trusts that were not able to deliver a breakeven even plan – our Trust was not one of those. A number of Trusts have underdelivered against their plans which has led NHS England to withhold and redistribute some of this funding to Trusts who have delivered their plans. This has meant that the Trust has received c£4.9m which it has been directed to show as a direct improvement to its financial position. This now means against the NHS England control total (of breakeven) the Trust is reporting a £4,933k surplus.

When compared against the statutory reported position there is an operational deficit of c£5.2m for the Group, taking account of asset revaluations and impairments (prior year £28.3m deficit).

A summary of the adjusted financial performance of the Group is shown below:

All £'000s	2025/26	2024/25
Income	914,904	872,261
Expenditure	920,090	900,561
Operating surplus / (deficit) for the year from SOCI	-5,186	-28,300
Adjustments for impairments	10,025	29,041
IFRIC 12 adjustments	285	365
Removal of capital grants and donations	1,122	-340
Adjusted financial performance surplus / (deficit)	6,246	766

Planning for 2026/27 has been built based upon individual organisational positions, in line with the approach required by NHS England. For 2026/27 the Group has planned to deliver a breakeven financial position. As a Trust we are planning to deliver a breakeven position which is predicated on delivering c£52.3m of financial sustainability schemes. In order to improve the underlying position of the Trust we are planning for 75% of these schemes to be delivered on a recurrent (or ongoing) basis.

The collective plan for the Gloucestershire Integrated Care System (ICS) in 2026/27sees a significant financial, and operational challenge. As a system there is a material underlying deficit from 2025/26 of c£129m. For 2025/26 the ICS has submitted a financial plan with a break-even position which requires the system to deliver c£89m of sustainability solutions.

Operationally colleagues continue to face the challenge of capacity in relation to workforce availability, urgent care demand and bed capacity due to a lack of onward care capacity for patients. The Trust continues to work with its partners to seek to address these challenges.

Financial sustainability schemes

Supported by our Programme Management Office divisional colleagues developed plans which have drawn upon a variety of locally identified opportunities and nationally informed opportunities (utilising benchmarking from Model Hospital, Getting it Right First Time etc.).

At the end of 2025/26 the Programme Management Office have reported part delivery of our 2025/26 target as shown below

2025/26 position	Rec	NR	Total
Target £'m	25.2	16.6	41.8
Delivery £'m	15.8	18.7	34.5

The need to deliver recurrent sustainability opportunities remains a significant challenge for the Trust, and wider NHS, moving into future years. Our plan for 2026/2027 looks to approach the savings plan in a more sustainable and transformational way with clear programmes of work owned by executive leads, the intention is to improve upon the recurrent delivery levels with an ambition to deliver 75% of our overall schemes on a recurrent basis.

Financial governance

Throughout the year strong financial governance has been maintained. This is demonstrated on a day-to-day basis through the use of the scheme of delegation to approve expenditure for requisitions and invoices, obtain quotes for non-pay items etc. Financial reporting processes have continued through monthly reporting at various levels in the organisation – at divisional Executive reviews, at Finance and Resources Committee, at Trust Leadership Team and at Board. Financial training also continued albeit on a virtual and in person basis which proved to be very successful and welcomed by the managers who attended.

The Trust utilises an Accountability Framework which provides measurable targets for each division spanning operational, quality, workforce and finance. This has resulted in escalation of support for those divisions that need it.

To further support our financial governance arrangements both internal and external auditors have undertaken reviews. In relation to external audit there were some control recommendations highlighted which, once implemented, will further strengthen the year-end assurance process.

Income disclosures required by section 43(2a) of the NHS Act 2006.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2025/26 financial year.

Information on the impact that other income it has received has had on its provision of goods and services for the purposes of health services in England

Other income received has had no impact on the provision of goods and services for the purposes of the health service in England.

Financial Risk Management

The Trust continued to embed its risk management arrangements with good levels of engagement from risk owners and divisional strategic leaders. The assurance arrangements

had been strengthened and a robust process put in place to monitor risks for potential threats to the achievement of the Trust's strategic objectives.

The profile of Trust risks still remains heavily safety orientated as clinical services continue to work through the constraints of industrial action, winter pressures, service recovery and increased patient demand. The wider ICS risk of patient flow and timely discharge dominated the risk horizon and are reflected in the number internal incidents focused on patient flow. Workforce or skill shortage and ageing technology or equipment are also pre-dominate risks which impact on progress against our objectives. However, risk management remains a key focus at all levels, with appropriate escalation of critical risks. Our risk management culture continued to mature, supported by an active leadership in risk management.

From a financial perspective our key strategic risk remains around ensuring that we have a financially sustainable organisation. To deliver this we need to ensure that our transformation and financial sustainability schemes are delivered on a recurrent, or ongoing, basis.

Historical financial performance

Across the last five years the Trust has seen an improvement and stabilisation in its financial position although the underlying position continues to show a material financial challenge which is being supported by our local Integrated Commissioning Board (ICB) – addressing this continues to be the focus of future years. Shown below is the position reported against the NHS England (NHSE) control total calculation:

	£'000s				
	2025/26	2024/25	2023/24	2022/23	2021/22
Deficit / (Surplus)	-4,933	-67	535	0	51

It should be noted that for 2025/26 the financial position is reporting a substantial financial surplus. During the 2025/26 planning period NHS England set aside deficit support funding for organisations who were planning on reporting an in-year deficit – the Trust was not one of these.

Through the year NHS England have monitored organisations against their performance and where there has not been delivery of their plans, they have withdrawn this support funding and reallocated it to organisations who have delivered their financial plans. The Trust was a recipient of this redistribution of funding and received £4,915k in March 2026 which was required to be reported as a direct improvement against the Trust's financial position.

Future financial plans

Looking ahead to 2026/27 the Trust has now submitted a balanced plan, along with our ICS partners - this plan was submitted to NHS England on 18th March 2026.

This plan includes a significant level of savings in order to achieve this position, totalling c£52.3m, which will comprise of business-as-usual savings alongside transformation schemes, with four main areas of focus. Those areas are estates rationalisation, the non-clinical target operating model, income generation and Out-Patient service transformation.

Financial risk issues

Issue	Response
Net asset of net current liability position	Total net assets employed at 31st March 2026 are c£292m, compared with c£271m for 2024/25 – the net change predominantly reflects the changes in the level of current assets and liabilities
Cash position	Total cash position of the group at 31st March 2026 is c£49.8m, compared with March 2025 value of c£49.6m.
Debt repayment	All Public Dividend Capital payments made by due dates with no suspensions or arrears
PFI payments and impact	No issues to report
ICS Financial support arrangements	No issues to report. The ICS work on a collaborative basis to support the oversight framework requirements.
Inability to pay creditors on due dates	At the end of March 2026, the Trust paid 96.8% of invoices by volume and 90.0% of invoices by value within the target outlined in the Better Payment Practice code.
Reduction in normal terms of trade credit by suppliers	No issues to report
Loss of key management without replacement	Key colleagues are replaced should vacancies arise. The Trust also supports staff through national programmes and has shared leadership programmes at an ICS level.
Loss of key staff without replacement	
Staffing difficulties or shortages of important supplies	Recruitment remains a risk to all providers and is an area of focus for the Trust. Overall, Trust vacancy levels in March 2026 (the latest available period) were 7.95% (7.21% in March 2025). Supplies are sourced without significant shortages.
Non-compliance with statutory requirements	No issues to report
Pending legal or regulatory proceedings against the trust, which if successful, would result in claims that are not capable of being satisfied	There is one pending legal issue which provision for is currently included in the Trust's forecast outturn position. No other issues to report
Changes in legislation or government policy expected to adversely affect the entity	None anticipated.

Other financial considerations

The local NHS commissioner has highlighted a number of key services provided by the Trust as designated services. In the event that the Trust was not able to operate these services would be required to be continued, potentially by a successor public sector body. This is important in the context of going concern as a key test is whether operations can continue and the designation of services supports this continuation.

Workforce Performance

Overall, the Trust (including Gloucestershire Managed Services) vacancy rate has remained within the 8% target in 2025-2026. The number of substantive staff employed by the Trust was 8185.99 whole time equivalent (WTE) in March 2026, compared to 8247.69 in March 2025. The Trust's turnover (substantive employees) has reduced from 9.15% to 8.39% over the last 12 months.

During the past year, the Trust's workforce has operated in a challenging environment, including the impact of the national maternity investigation, industrial action, workforce headcount reductions, and ongoing fire safety requirements. Alongside this, there has been sustained focus on Maternity and Cardiology services. Despite these pressures, colleagues have continued to demonstrate strong commitment and professionalism in delivering high-quality care to patients across Gloucestershire.

The 2025 NHS Staff Survey highlights some improvements. More staff reported receiving an appraisal or development review, teams are meeting more regularly to discuss effectiveness, fewer colleagues intend to leave the organisation, and more staff feel they have autonomy in how they carry out their work. These improvements reflect focused investment in organisational development, leadership development, and meaningful appraisal and team-based approaches.

The survey also identifies areas for improvement, including access to nutritious and affordable food at work, perceptions of staffing levels, enthusiasm for roles, and clarity of career development opportunities. These remain key factors in supporting staff wellbeing, engagement and retention.

These findings continue to inform our workforce and cultural priorities. Our focus remains on creating a supportive and inclusive environment, including continued delivery of the Licence to Lead programme, leadership and manager development, a strong focus on sexual safety at work, and strengthened governance through the introduction of an Organisational Development Oversight Group.

Estates, Facilities and Capital (2025/26)

The Trust delivers services across two principal hospital sites—Gloucestershire Royal Hospital and Cheltenham General Hospital, together with a range of community and off-site facilities. The estate is diverse in age, design and condition, with some buildings dating back to the early 19th century.

The Board recognises that the age and configuration of parts of the estate present ongoing challenges to the delivery of high-quality, safe and efficient care, and require continued investment to maintain and improve the environment for patients, visitors and staff.

The Trust operates its estates and facilities through its wholly owned subsidiary, Gloucestershire Managed Services (GMS), which is responsible for operational delivery, maintenance and capital programme implementation. The Trust retains oversight of strategic direction, investment priorities and statutory compliance.

Estate Condition and Risks

The Trust's estate continues to present a number of risks associated with ageing infrastructure, historic underinvestment and increasing demand on facilities. These include backlog maintenance, infrastructure resilience issues, and compliance risks across areas such as fire safety, water systems, ventilation, electrical infrastructure and building condition. While significant work is underway to address these risks, they remain a material consideration for the Board and are reflected within the Trust's overall risk profile. The Trust has therefore

prioritised a programme of investment and improvement to mitigate these risks over the medium term. A multi-year programme of fire safety improvement is in progress, supported by investment exceeding £12 million. This programme includes upgrades to fire alarm systems, fire compartmentation, and other safety critical infrastructure.

Capital Investment and Estate Improvement (2025/26)

During 2025/26, the Trust and GMS progressed a range of capital schemes aimed at improving estate quality, capacity and compliance. Key developments included: a new Department of Critical Care (off-site modular build), fire safety upgrades across the estate, completion of the Tower Block façade upgrade, and multiple clinical refurbishment schemes including pharmacy manufacturing, urology, ward upgrades and ophthalmology capacity.

Strategic Estate Development

The Trust continues to advance longer-term estate planning through development of a Strategic Asset Management Plan (SAMP), Estate Masterplan and Development Control Plan to guide future investment and rationalisation.

Forward Investment Priorities

Priorities include reducing backlog maintenance, improving statutory compliance, enhancing infrastructure resilience, supporting service transformation and delivering major capital developments including the Gloucestershire Cancer Centre.

Sustainability and Efficiency

The Trust is committed to improving environmental performance through energy efficiency measures, modernisation and sustainable estate planning.

Partnership Working
The Trust continues to work with system partners to explore opportunities for shared estate use and improved utilisation.

Summary

In 2025/26, the Trust has made measurable progress in improving its estate through targeted investment and planning. However, the estate continues to present ongoing risks associated with ageing infrastructure, backlog maintenance and capacity constraints, requiring sustained investment and long-term transformation.

Subsidiary Operations

Gloucestershire Managed Services (GMS) is a wholly owned subsidiary of Gloucestershire Hospitals NHS Foundation Trust and operates as an integral part of the Trust Group. The company provides a comprehensive range of estates, facilities and support services that underpin the delivery of safe and effective patient care across the Trust. Its activities are fully aligned to Trust priorities, with a focus on maintaining reliable infrastructure, supporting clinical services, and delivering value for money.

Gloucestershire Managed Services delivers a broad portfolio of non-clinical services including estates management, capital development, catering, domestic services, portering, sterile services, medical engineering, logistics, fire safety, security, and sustainability functions. These services are essential to the day-to-day operation of the Trust and

contribute directly to patient experience, safety and operational performance. The company also supports aspects of service provision for local NHS partners where appropriate.

The company operates with a formal governance structure, led by a Board of Directors responsible for oversight of strategy, performance and compliance with statutory and regulatory requirements. Governance arrangements are aligned with those of the Trust, ensuring consistency in approach to risk management, internal control and assurance. The Chair and Managing Director maintain strong links with the Board and senior leadership structures, supporting effective integration across the Group.

During 2025/26, Gloucestershire Managed Services continued to strengthen its governance and organisational capability. This included external review of governance arrangements, leadership development activity, and the establishment of dedicated functions to support learning and development, internal audit, and business intelligence. These developments have enhanced the company's ability to monitor performance, manage risk and support continuous improvement.

Gloucestershire Managed Services employs approximately 920 staff and is a significant contributor to the Trust Group's operational capacity. Workforce indicators during the year remained broadly stable, with improvements in vacancy rates and training compliance. The company continued to focus on workforce sustainability, reducing reliance on temporary staffing and investing in staff development and engagement to support service delivery.

Financial performance is consolidated within the Trust's accounts, with Gloucestershire Managed Services achieving financial sustainability objectives. In 2025/26, the company improved its dividend payment to the Trust compared to the prior year from £2.13m in 2024/25 to £2.34m in 2025/26, reflecting further improved financial position and performance over the period. Gloucestershire Managed Services also continued to deliver efficiency improvements and support the Trust's wider financial objectives.

The company maintained a strong focus on operational performance, achieving consistently high levels of compliance against contractual key performance indicators. GMS played a key role in supporting the Trust's response to operational pressures, including infrastructure challenges, estate maintenance requirements and service resilience, ensuring continuity of critical support services.

Gloucestershire Managed Services is responsible for delivering the Trust's capital programme, managing a significant portfolio of infrastructure and development projects. In 2025/26, this included progression of major schemes to improve estate quality, safety and capacity, alongside ongoing investment in fire safety, electrical infrastructure and backlog maintenance. The company continues to develop its capital delivery model to support future investment and ensure effective programme management across the Trust Group.

Task-force on Climate-related Financial Disclosures

The Trust has prepared its climate-related financial disclosures in alignment with the Task Force on Climate-related Financial Disclosures (TCFD) framework, as adopted within the NHS England Annual Reporting Manual 2025/26.

These disclosures reflect the final year of the phased implementation, incorporating the four pillars of Governance, Strategy, Risk Management, and Metrics and Targets.

The Trust considers climate change to represent a material and strategic issue, given its potential impact on service demand, estate resilience, operational delivery, and long-term financial sustainability. Climate-related considerations are therefore embedded within the Trust's governance, risk management and strategic planning processes.

Governance

Board oversight

The Board recognises climate change as a significant risk and strategic priority, with implications for the sustainability of healthcare delivery and the resilience of infrastructure.

Executive leadership for climate-related matters is delegated to the Director of Improvement and Delivery, who acts as the Board lead. The Finance and Resources Committee receives regular reports and assurance regarding delivery of the Trust's sustainability objectives.

Following the refresh of the Trust's Strategy in November 2025 a realignment of the previous strategic risk relating to sustainability is currently under review, with implementation anticipated during Quarter 2, 2026-2027.

The Board, via the Finance and Resource Committee, receives an annual sustainability report, providing an overview of performance against targets, key achievements, and priorities for the year ahead. There is an expectation that all reports to board will consider the implications of the report upon the Trust's Green Plan.

Management arrangements

The Trust has established the Climate Emergency Response Leadership (CERL) Group responsible for leading delivery of the Trust's climate and carbon strategy, monitoring the Green Action Plan, and ensuring reporting requirements are met. The Chair of the Group can also draw the attention of the Finance and Resource Committee to any sustainability related issue that requires disclosure to the Board or requires executive action. The Trust has established a sustainability fund, held by the Director of Improvement and Delivery and managed through the CERL Group. The Trust also collaborates across the One Gloucestershire system to support a system-wide response to climate-related risks.

Strategy

Sustainability is embedded within the Trust's Strategy (2025-2030) across a number of key priorities; estates and facilities improvement, value for money/living within our means and system working for long-term resilience. Within those spheres there is a commitment to efficient use of resources, recognition that the estate must be fit for the future and the importance of long-term sustainability. The Green Plan Framework sets out how the Trust seeks to reduce environmental impact with a focus on:

- Net zero ambition (carbon neutral target of 2040)
- Emissions reduction across estates, travel, procurement and care models.
- Climate adaptation

It is recognised that there is continued work to both refresh and embed these areas of focus into organisational planning cycles and the delivery strategies which are being developed to underpin the Trust strategy 2025-2030.

The Trust is clear that climate-change represents a direct risk to health outcomes. The relevant risks are identified below:

- Short term (0–3 years): increased demand due to extreme weather, operational disruption, and opportunities in energy efficiency and service redesign.
- Medium term (3–10 years): risks relating to net zero delivery and estate resilience, with opportunities in modernisation and efficiency.
- Long term (10+ years): sustained demand increases and infrastructure risk, with opportunities to transition to low-carbon models of care.

The Trust has been working with Climate Leadership Gloucestershire on the Climate Response Vulnerability Assessment. This provides an evidence base to understand the key climate risks across the county, demonstrating the impact, likelihood and overall risk posed by climate change across a variety of climate hazards. The report includes climate adaptation projects covering sectors such as built environment, infrastructure, health and green space. Many projects will be addressed through Climate Leadership Gloucestershire, and the Trust will work with the Integrated Care System to share resources to address common actions applicable to the NHS. The Trust is taking action to reduce energy related carbon emissions, encourages active transport and actions to reduce waste. The Trust Strategy (November 2025) includes Green Sustainability as a Golden Thread and this will be used to put sustainability at the core of everything we do, assist with engagement at all levels of the organisation and enable actions to reduce carbon emissions. Further information on our sustainability actions, carbon footprint and progress towards reduction are available in the X section of the annual report.

Risk management

The Trust maintains climate-related risks on its Corporate Risk Register and a relevant Strategic Risk is being refreshed to ensure alignment with the Trust's Strategy (2025-2030) and it is envisaged this will be considered by the Board for inclusion within the Board Assurance Framework by Quarter 2, 2026-2027.

Climate-related risks, including physical risks arising from rising temperatures and extreme weather and transition risks linked to estate condition and infrastructure investment, are integrated into the risk register and managed through the Trust's Risk Management Framework. This ensures climate risk is treated as a strategic and operational risk, rather than as a standalone sustainability issue. Risks are escalated in accordance with the Trust's risk appetite which includes a risk appetite statement as follows:

We maintain an open appetite for sustainability-related risks, including risks associated with energy efficiency upgrades, green / renewable technologies, carbon reduction initiatives, sustainable transport, logistics optimisation and waste reduction. Risks are accepted where they align with the NHS Net Zero strategy and our Green Plan, and where long-term benefits outweigh short-term disruption. We accept risk for initiatives that where green measures protect health and reduce environmental impact, provided safety, due diligence and equity are maintained.

The Trust has three risks relating to Climate Change on the Corporate Risk Register. These cover the risk posed by extreme weather events, the risk of not meeting net zero targets by 2040 and the risk of the Trust not progressing actions due to staff resources. As part of addressing these risks, the Trust is updating our Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

All risks identified will impact on the Trust's achievement of its strategic objectives. Climate-linked risks such as overheating, poor ventilation and poor infection control will impact both patient safety and experience and staff well-being, productivity and retention. Contractual penalties, emergency capital spend and revenue repair costs, create financial pressures which reduce the Trust's ability to invest in low-carbon estate upgrades, digital transformation and climate adaption measures.

Climate risks are predominantly identified through estates and infrastructure intelligence, emergency preparedness, response and resilience (EPRR) and business continuity risks (e.g., floods, power failures and IT outage). The assessment of these are generally based on operational and financial impacts, with controls often limited to short-term measures.

However, many estates risks are climate-led, driving higher energy use, preventing decarbonisation, or locking the Trust into carbon-intensive infrastructure. Examples include:

- Heating, cooling, and ventilation failures
- Estate condition and infrastructure backlog
- Waste and environmental compliance
- Risks with an indirect but material impact on climate emissions.
- Failure to meet Net Zero and Green Plan objectives

Metrics and targets

The Trust has adopted NHS net zero targets: net zero by 2040 for direct emissions and 2045 for indirect emissions.

Carbon emissions for scope 1 and 2, and part of scope 3 (waste, water and business travel), are calculated annually and included in the sustainability annual report. These have been reported annually since 2017-18. Data used for energy, water and waste is also reported within the annual ERIC (Estates Return Information Collection) submission.

While emissions data are not disclosed locally, climate-related risks are actively identified, assessed, and managed through the Trust's Risk Management Framework as outlined above. Should national policy or NHS England guidance change to require emissions disclosure at trust level, the Trust will respond accordingly.

The Trust's Green Plan is a core delivery mechanism for managing climate-related estate and infrastructure risks, rather than a separate sustainability initiative. It is explicitly designed to address material physical climate risks—including overheating, cooling failure, infrastructure fragility and service disruption—which are already present in the Trust's Corporate Risk Register and Board Assurance Framework.

Climate change is recognised as a risk amplifier for existing estate vulnerabilities. The Green Plan therefore focuses on reducing risk exposure to patient safety, service continuity, workforce wellbeing and financial sustainability, while also supporting the NHS's national Net Zero objectives.

Future development

The Trust will continue to enhance its approach, including financial impact assessment, scenario modelling, and expanded metrics, to support robust and decision-useful disclosures.

Tackling health inequalities

Health inequalities are preventable, unfair and unjust systemic differences in health outcomes, access to services and experiences of care across different population groups. These differences are shaped by the conditions in which people are born, grow, live, work and age, often referred to as the wider determinants of health, including deprivation, education, employment and housing.

Despite Gloucestershire being a relatively affluent county, there are pockets of significant deprivation, with 12 neighbourhoods among the 10% most deprived nationally. Residents in these areas experience poorer health, shorter life expectancy and higher levels of long-term conditions compared with those living in more affluent communities. In Gloucestershire, males born in the most deprived areas can expect to live over seven years fewer than those in the least deprived areas, while the gap for females exceeds five years.

The population of Gloucestershire is ageing, and evidence shows that people living in more deprived neighbourhoods are spending a greater proportion of their lives in ill health, often developing multiple long-term conditions at younger ages. Although the county has a comparatively small ethnic minority population relative to the national average, it is becoming increasingly diverse, and the Trust recognises the importance of monitoring and responding to emerging inequalities relating to ethnicity, migration status and language needs.

Activity takes place across the Trust, and with key partners (most importantly the ICS) to tackle inequalities in access and in outcomes. This is in line with NHS England's Healthcare Inequalities Improvement Programme's vision is for the NHS to deliver 'exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes'.

In line with NHS England guidance for acute trusts, the Trust uses data to monitor health inequalities in its catchment area, using this data to set its priorities and monitor its progress. Specific indicators we monitor are:

- Elective activity compared with pre-pandemic levels for adults and children
- Urgent and emergency care activity
- Children's oral health, measured by inpatient tooth extractions due to decay (aged 10 and under)
- Smoking cessation and tobacco dependency treatment as a key modifiable risk factor

Health Inequalities Group

Over the past year, a Health Inequalities Working Group has been established, with the Executive Director for Improvement and Delivery providing executive leadership. The group coordinates analysis oversees delivery and supports alignment with wider Trust priorities and system partners.

Through robust analysis, transparent reporting and clear executive accountability, this report demonstrates how the Trust is meeting its statutory health inequalities duty while strengthening readiness to respond to future population health needs, regulatory expectations and system-wide priorities.

Social, community, human rights, and anti-bribery

Human rights, the dignity of our patients, and welfare of our people are central to who we are as a Trust. We continue to work closely in partnership with the Integrated Care Board, our neighbouring Trusts, primary healthcare providers and voluntary sector organisations, to tackle the challenges that face our community. Staff are trained in adult and child safeguarding at a level appropriate to their role and the Trust reviews and monitors the work underpinning its statement on an annual basis. This was last reviewed in March 2026.

The Trust has its own internal Counter Fraud Service which ensures a robust counter fraud, bribery and corruption risk and control framework. Our Counter Fraud, Bribery and Corruption Policy was updated in 2025-26 and remains compliant with the NHS Counter Fraud Authority 3-Year Strategy. In 2025-26, the Trust benchmarked itself against other NHS organisations in the South-West, ranking highest for number of referrals, identified loss, recoveries, prevented fraud and sanctions. This demonstrates a robust and effective counter fraud framework and a strong commitment to combatting fraud and maintaining high standards of governance and accountability. The Head of Gloucestershire NHS Counter Fraud Service presents a detailed progress report to each Audit and Assurance Committee meeting and the annual Cabinet Office Government Functional Standard 013: Counter Fraud return confirmed the Trust rating green in all 12 standards.

Ensuring equality of service delivery

Public Sector Equality Duty

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. This is overseen by the Board with regular reporting on access and diversity, led by the Director for People and Organisational Development.

The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

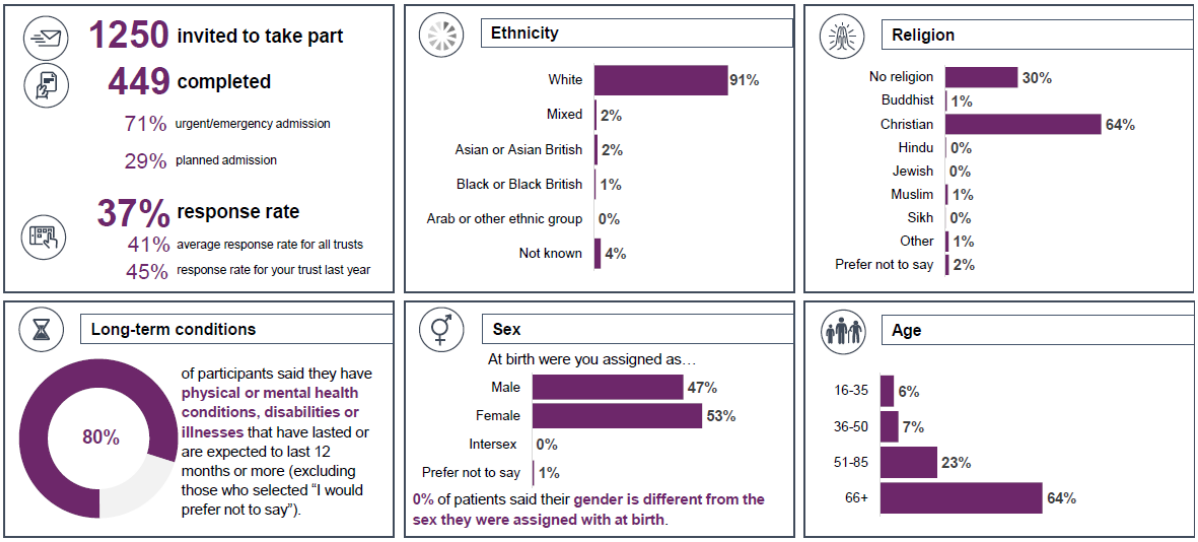
- Eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share and people who do not share relevant protected characteristic
- Foster good relations between people who share and people who do not share a relevant protected characteristic

Patient satisfaction

CQC National Survey Programme provides patient satisfaction scores broken down by protected characteristic, additionally we have been able to work with our business intelligence team to better understand the wider determinants of health, particularly deprivation. This has helped us to begin to identify and foster good relations with people with protected characteristics where we are receiving less feedback including specific religions, young people and those with long term health conditions.

National Inpatient Survey 2024, published 2025

The following charts show the patient demographic of those that completed the survey:

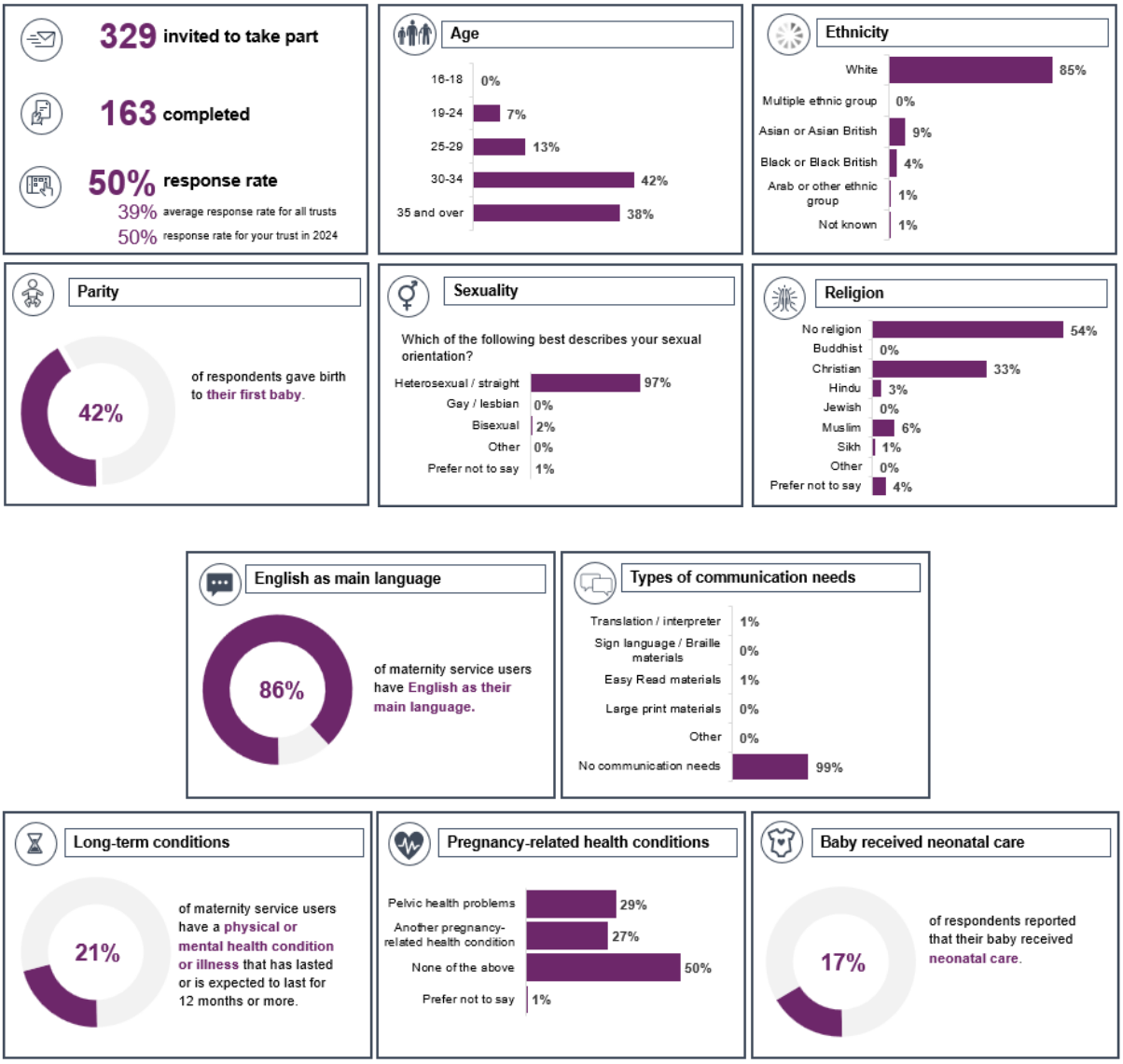


When looking at our results against protected characteristic, in some cases, particularly religion, some ethnic groups and the breakdown of long-term health conditions, the number of responses is too low and therefore the results are suppressed. We can see, however, that certain disabilities and long-term health conditions report a poorer experience to those with no long-term health condition. We can also see from the data that the majority of patients responding to the survey, report having a long-term health condition.

Further work with our Business Intelligence team has also reviewed the responses against deprivation deciles and we have identified that those patients living in areas with high deprivation are not responding to the survey. We therefore, need to ensure we have other options for patients to provide feedback should they wish, we do this through Friends and Family Test, our Patient Advice and Liaison Service (PALS) and our patient stories webpage.

National Maternity Survey 2025, results published 2025

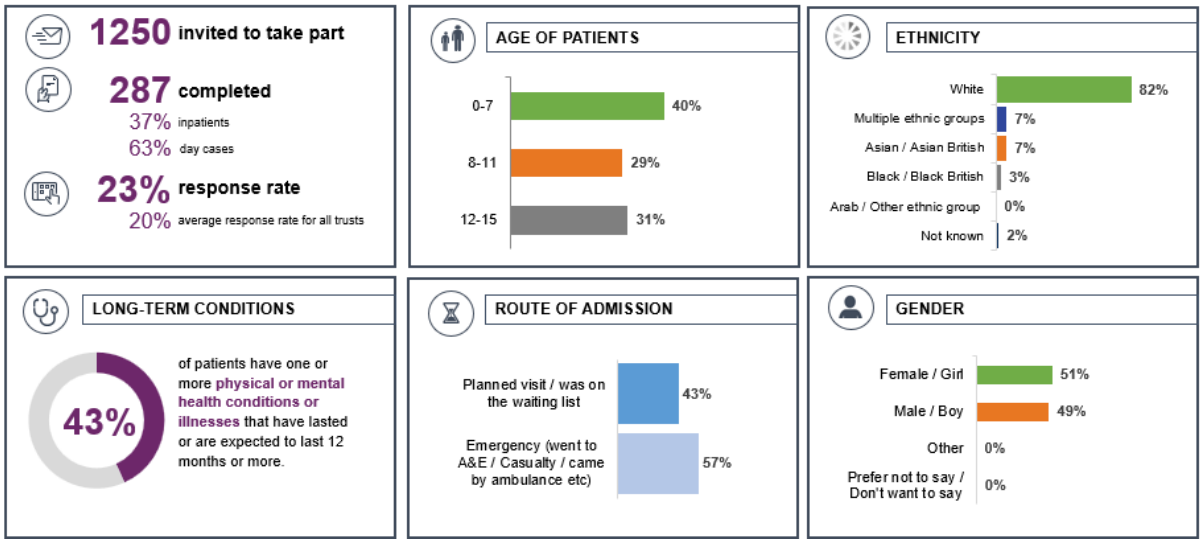
The following charts show the patient demographic of those that completed the survey:



Unfortunately, due to the numbers of responses against some of the protected characteristic groups being lower than the threshold for the data to be published, the data has been suppressed. This means we cannot compare and draw conclusions about the experiences of women within some of the protected characteristic groups, e.g. ethnicity. We can see that women that report that they have a long-term health condition report a below average experience.

To support our understanding of outcomes based on determinants of health we have a maternity health inequalities dashboard. Where we have comparable experience data available, we can overlay this to outcomes. By identifying where experiences are less positive, we can begin to work alongside Gloucestershire Maternity and Neonatal Partnership, women, birthing people and staff to improve experiences.

National Children and Young People Survey 2024, published 2025
The following charts show the patient demographic of those that completed the survey:



Unfortunately, again, due to the numbers of responses against protected characteristic groups being below the threshold for the data to be published, we have a large amount of suppressed data. This means we cannot compare and draw conclusions about the experiences of children and young people within the majority of the protected characteristic groups. We can see that our responses are fairly evenly spread across the age bands.

Activities being undertaken

Translation and interpreting services are essential for ensuring patients who have language barriers can access healthcare information and services in a way that they can understand. By facilitating understanding, we can improve the quality of care, safety, experience and support a reduction of health inequalities. To support our patients where English is not their first language, we have introduced a robust video interpreting offer across departments with the highest interpreting activity including within Maternity services. This offer will expand further into more departments in the coming year.

Under the Equality Act 2010, and latterly the Accessible Information Standard (AIS), organisations have a responsibility for providing information in a format that meets their communication needs. We have worked with our Accessibility Panel to improve our position in compliance with the AIS which has led to an improvement in recording of communication need. Next steps are to work with clinical teams and experts by experience through our Accessibility Panel to ensure we are meeting patients' communication needs.

Overseas operations

There were no overseas operations during 2025-2026 (2024-25 none).

Significant events post year end

There have been no significant events since year-end 2025-2026 affecting the financial statements.

Accountability Report

In this section:

- Director's Report
- Remuneration Report
- Staff Report
- Code of Governance
- Statement of Accounting Officer's Responsibilities
- NHS Oversight Framework
- Annual Governance Statement
- Accountability Report Conclusion

Accountability Report:

Directors' Report

Directors' Report

The Directors are responsible for preparing the annual report and accounts. We consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model, and strategy.

The Board of Directors

Biographies for individuals who served as Directors on the Board during the year 2025-26 are detailed on the following pages. Summary biographies are provided in respect of Michael Napier and Balvinder Heran whose terms of office finished in May 2025. The Board of Directors composition, balance of skills, and depth of experience is detailed through this report, and is considered by the Governance and Nominations Committee to be reasonable to lead the Trust.

Independent Non-Executive Directors are identified in this report. There are currently no circumstances that may impair any Non-Executive Director's independence, including considerations of tenure, relationships or potential conflicts of interests. A review of the Fit and Proper Persons process is undertaken annually.

Deborah Evans, Chair
Appointed May 2022

Deborah is an experienced Chair with 25 years Board-level involvement in health and social care. Notable appointments from her executive career include Chief Executive of NHS Bristol; Chief Executive of Bristol, North Somerset, and South Gloucestershire PCT cluster; and latterly Managing Director of West of England Academic Health Science Network, which convened 21 NHS Trusts/CCGs, 3 universities and other stakeholders to promote innovation and spread improvement in the NHS. From 2017 to 2023 Deborah has been Trustee and Chair of Brunelcare, a housing and social care charity providing nursing homes, re-enablement, home care, and supported living.

Vareta Bryan, independent Non-Executive Director
Appointed February 2023

Vareta is a proven and commitment leader in the health and care sector. Her experience spans over 25 years' director and senior management roles in local government, Social Care, the NHS and the voluntary sector.

Her expertise spans health and social care service provision, leading partnership working across the health and social care system to deliver service transformation that improves services and outcomes for patients, service users and staff. She also has a strong background in, and commitment to, equality, diversity and inclusion in service provision, employment practice and organisational development.

Prior to joining the Trust, she held a similar role with Gloucestershire NHS Clinical Commissioning Group and was a Trustee with North and West Gloucester Advice Bureau. Vareta has a longstanding commitment to the voluntary and community sectors having both worked and held voluntary positions on a range of boards in the sector. Vareta's interests are travelling, gardening, healthy lifestyle coaching, teaching plant-based cooking, and enjoying her grandchildren.

Vareta has recently commenced her second three-year term of office and provides additional support to the Trust's maternity services through her role as Non-Executive Director champion.

John Cappock, independent Non-Executive Director
Appointed July 2023, resigned March 2026

John Cappock lives in Bristol. He is a Chartered Accountant and is originally from Dublin. A graduate of University College, Dublin, John undertook his professional accountancy qualification at the University of the West of England, Bristol. John has spent the bulk of his career within Higher Education and has served as University Secretary and Chief Operating Officer at a number of universities.

He was a Non-Executive Member, deputy Board Chair and Chair of Finance of Bristol, North Somerset and South Gloucestershire (BNSSG) NHS Clinical Commissioning Group. He is an Independent Non-Executive Member and Chair of Audit and Risk for the BNSSG NHS Integrated Care Board. John also serves as an independent member of the Audit and Risk Committee of the General Optical Council, which is the regulator for the Optical profession.

He previously served as a Non-Executive in Higher and Further Education and on the Board of a Housing Association. During his term of office with the Trust John was a valued colleague in the role of Vice-Chair and Chair of the Audit and Assurance Committee.

Sam Foster, independent Non-Executive Director
Appointed April 2024

Sam Foster is an Independent Non-Executive Director at Gloucestershire Hospitals NHS Foundation Trust and Chair of the Quality & Performance Committee.

She currently works as a Chief Nursing Officer within HCA Healthcare UK, with executive responsibility for clinical services, quality, safety, governance and professional standards.

Previously, Sam was Executive Nurse Director for Professional Practice at the Nursing and Midwifery Council (NMC), where she led national work to progress the

regulation of advanced nursing and midwifery practice and had executive responsibility for safeguarding.

Sam has held two Chief Nursing Officer roles within the NHS, including five years at Oxford University Hospitals NHS Foundation Trust. Her responsibilities included professional leadership and education for nursing, midwifery and allied health professional staff, joint leadership of the system Urgent Care Improvement Programme with Oxfordshire County Council, and executive oversight of estates and facilities and the Trust capital programme. Prior to this, Sam was Chief Nursing Officer at Heart of England NHS Foundation Trust.

Sam's professional background is in critical care nursing, and she continued clinical practice during the COVID-19 pandemic

Marie-Annick Gournet, independent Non-Executive Director
Appointed December 2020

Marie-Annick is Associate Pro Vice-Chancellor (Reparative and Civic Futures) at the University of Bristol. She has over 20 years' experience in senior leadership roles across higher education and the voluntary sector. She joined the University of Bristol as Director of Part-Time Programmes in August 2019 and, in February 2024, was seconded as Programme Lead for the University's Reparative Futures mobilisation phase.

Prior to joining the University of Bristol, she worked at UWE Bristol, where she held a range of leadership roles. In September 2017, she founded MAG Consulting, offering consultancy, research, training and coaching services with a focus on diversity and inclusion.

In June 2019, she also established the Global Majority Teachers Network, a community of practice that brings together qualified teachers from global majority backgrounds, with a focus on staff support, curriculum development, and improving access, retention and progression within the education sector.

Throughout her professional career, Marie-Annick has worked with a range of organisations in diverse Non-Executive Director roles. She is currently a Non-Executive Director at Gloucestershire Hospitals NHS Foundation Trust, where she serves as Chair of the People and Organisational Development Committee and is the Freedom to Speak Up Non-Executive Director Champion.

Jaki Meekings-Davis, independent Non-Executive Director (Senior Independent Director to December 2025)
Appointed February 2023 (commenced a leave of absence December 2025)

Jaki has more than thirty years' experience in the NHS in both commissioning and finance roles including Director of Specialist Commissioning for the South of England and Director of Finance of the South West Regional Health Authority.

Prior to joining the NHS, she had a successful career as an accountant in local government and the water industry. She has lived in Gloucestershire since 1998. Jaki is a former president of the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Healthcare Financial Management Association. Jaki is also a Co-opted member of University of Gloucestershire Finance and General Purposes Committee.

An experienced Non-Executive Director and Trustee, her recent roles include Non-Executive Director and Chair of the Audit and Charitable Funds Committees at North Bristol NHS Trust and Trustee of The Cheltenham Trust and Friends of the Wilson charities.

Sally Moyle, independent Non-Executive Director (Vice Chair and Senior Independent Director from December 2025)

Appointed May 2025 (previously an Associate Non-Executive Director)

As a Professor in Health and Care Education Sally has over 25 years' academic experience of developing and leading innovation and change within Higher Education. She is currently the Pro Vice Chancellor for Health and Science at the University of Worcester and is a member of the University Executive Board. She provides academic leadership to the Academic Schools of Nursing and Midwifery, Allied Health and Community, Medicine, Sports and Exercise, Science and the Environment and Psychology with a focus on delivering an outstanding academic experience for all students, enhancing research and enterprise, and developing the University's educational offer.

She previously worked in a range of senior leadership roles at the University of West of England, Bristol. She is passionate about ensuing that health and care programmes develop practitioners for the future who will have a positive impact in their chosen field. Sally's professional background is in nursing, and her area of expertise is within the field of Emergency Care and Advanced Clinical Practice, with a focus of developing and supporting new roles within the health and care sector. She has extensive experience of working in partnership with external organisations to develop innovative programmes to support workforce need.

Sally is currently Vice-Chair and Senior Independent Director (since December 2025) and chair's the Trust's Charitable Funds Committee.

John Noble, independent Non-Executive Director

Appointed May 2025

John is a highly experienced senior executive and non-executive board member with a strong background in national security, technology, and public service. He has lived in Gloucestershire for the past 20 years and has a deep commitment to contributing to patient care.

John has strong senior leadership experience across government and the private sector, with particular expertise in technology, digital strategy, and governance. As the Director of

Incident Management, John was one of the founding members of the National Cyber Security Centre's Management Board, leading the response to a large number of major cyberattacks. He has been a board member for two successful tech start-ups and was a Non-Executive Director at NHS Digital and NHS England. In these roles, he was responsible for assuring the Board on the security of NHS IT systems.

Passionate about public service, education, and diversity, he is dedicated to improving patient care and mentoring future leaders. He was awarded a CBE for his work preparing for the London Olympics,

John hopes to bring a wealth of experience in technology, governance, and strategic leadership to the role. With this background in national security and NHS digital transformation, combined with their local connection to Gloucestershire, makes him well-equipped to contribute to the Trust's technological advancement and overall strategic direction.

Shawn Smith, independent Non-Executive Director
Appointed December 2025

Shawn is an experienced board member with over 30 years of senior finance experience having served on many boards across different industries in the UK, Poland and India. Having gained a degree in Economics, Shawn qualified as an accountant and is a Fellow of the Chartered Association of Certified Accountants.

Shawn's most recent executive role was as Chief Financial Officer of European Operations of a global aerospace company. Shawn was also responsible for the growth and development of the company's Indian operations. In addition, Shawn was also heavily involved several acquisitions in the UK, Poland and India.

Shawn is also a Non-Executive Director at North Bristol NHS Trust, where he has served as Chair of the Audit and Risk Committee, in addition he is currently Chair of the North Bristol Trust Merger Committee, and a member of the Quality, Digital and People Committees.

In addition to his NHS roles, Shawn is also a Non-Executive Director at Elim Housing Association, a governor at City of Bristol Collage and a trustee at Bristol based charities Frank Water and The Green House Project.

Shawn is Chair of the Trust's Audit and Assurance Committee.

Kaye Law Fox, Associate Non-Executive Director, Chair: Gloucestershire Managed Services
Appointed January 2023

Kaye Law Fox has 25 years' public sector executive and senior leadership experience. She is non-executive director Chair of Gloucestershire Managed Services (GMS) the

Trust's wholly owned subsidiary estates and facilities company, and associate non-executive director on the Trust Board.

Prior to focusing on non-executive board roles, Kaye directed and delivered complex national and regional change programmes in regulated sectors, notably for the Serious Organised Crime Agency and Security Industry Authority (both agencies of the Home Office), and the London Ambulance Service NHS Trust. Kaye specialises in aligning strategic governance frameworks to business needs and regulatory requirements, including corporate systems of internal control and risk management. Her business governance experience includes work in the not for profit, charity and private sectors.

Kaye has extensive board level experience and has been an independent board member since 2003. She is currently senior independent director of a registered social housing provider in Wales and has previously chaired boards and committees of a registered housing association, commercial asset management and development subsidiary company, operations, audit and risk, remuneration and professional standards, and led many executive and non-executive director appointment panels.

Raj Kakar-Clayton, Associate Non-Executive Director
Appointed May 2025

Raj is a recent graduate of the Gatenby Sanderson Insight Programme for NHS Non-Executives, which provided him with valuable experience in NHS board operations and governance. They have a strong background in business, finance, and charitable work, bringing a diverse perspective to the role.

He has a strong background in business, finance, and governance, with experience as a trustee for charitable organisations and work in complex environments. Raj completed the Gatenby Sanderson Insight Programme for NHS Non-Executives and brings strengths in strategic planning, financial management, and community engagement. Passionate about improving patient care and driving positive change, he is committed to effective, inclusive governance and continuous learning, with a collaborative and innovative approach to leadership.

During the course of the year (May 2025) two of the Trust's independent non-executive directors left at the expiry of their terms of office. The Trust is grateful for the commitment and service of both Michael Napier and Balvinder Heran. Full biographies can be found in the Trust's Annual Report for 2024-2025.

In May 2025 Andrew Champness was appointed as an Associate Non-Executive Director but, due to other commitments stepped down from this role in March 2026. The Trust is grateful for Andy's time with the Trust.

Kevin McNamara, Chief Executive
Appointed January 2024

Kevin joined the Trust as Chief Executive Officer (CEO) in January 2024 from Great Western Hospital NHS Foundation Trust, an integrated Acute and Community provider based in Swindon, where he was the CEO from 2019, leading over 5,500 staff and local communities through the COVID-19 pandemic.

Kevin has worked for the NHS since 2003, having worked for the South-Central Strategic Health Authority, before joining Great Western Hospital in 2009 where he was the Director of Strategy and Community Service before becoming CEO in 2019.

As CEO, Kevin is ultimately responsible for the day-to-day leadership of the organisation through the executive team and for ensuring the implementation of the Board's strategic objectives.

Al Sheward, Chief Operating Officer and Deputy Chief Executive
Appointed December 2023

Al joined the Trust in December 2023 from Great Western Hospitals where he had held the position of Deputy Chief Operating Officer since May 2020. Prior to his time at Great Western, Al was Winter Director for the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System.

Al played a key role in establishing the Swindon Integrated Care Alliance Coordination Centre building on experience from his time on the Isle of Wight and West Yorkshire, where he led a team using video-based technology to support residents in over 750 care homes across the UK.

Al was appointed to the role of Deputy Chief Executive in December 2025 and took on additional responsibilities in respect of the estates portfolio.

Prof Mark Pietroni, Director for Safety and Medical Director
Appointed March 2019

Mark has had a varied career path starting in London in Infectious Diseases, then 15 years in Bangladesh, and returning in 2012 to a role as Director of Public Health for South Gloucestershire. He was appointed to a part-time role as a consultant in Acute Medicine at this Trust in 2016 and then as Specialty Director for Unscheduled Care in 2017.

A year into his role as Medical Director his overseas experience proved invaluable to the Trust's response to the Covid pandemic. Mark was Deputy Chief Executive until December 2025 but released that role to enable him to focus on the safety agenda of the Trust and the professional support and management of the medical and dental workforce.

Matt Holdaway, Director of Quality and Chief Nurse
Appointed February 2022

With a background in Critical Care nursing, Matt has extensive experience in nursing management, having previously held senior positions at Oxford University Hospitals NHS Foundation Trust where he was Divisional Director of Nursing before joining our Trust in 2021 as Deputy Director of Quality and Deputy Chief Nurse.

Matt was appointed to the Chief Nurse and Director of Quality position initially as an interim appointment and has held the substantive role since 2022. He continues to make a significant impact on our nursing workforce and the wider Trust.

Karen Johnson, Director of Finance
Appointed January 2020

Karen Johnson is responsible for ensuring good stewardship of the public finances. She has worked in the public sector over 30 years, which includes workings in the NHS for 16 years. She prides herself on helping to make a difference to individuals and the community. She is fully committed to ensuring the Trust provides good value for money while maintaining good quality services.

Her key focus is to move the Trust to a financially sustainable position and will work closely with divisions and individuals to achieve this. Karen joined the Trust in January 2020 from Great Western Hospitals NHS Foundation Trust, where she was Director of Finance from 2015.

Will Cleary-Gray, Director of Improvement and Delivery
Appointed September 2024

Will joined the Trust in September 2024 as our Executive Director of Improvement and Delivery. He brings over 25 years of experience working within the NHS and partner organisations at a local, regional and national level in board-level, clinical and research roles. He started his NHS career as a critical care nurse and has diverse experience from working in acute, community and primary care and roles with NICE, the RCN, the University of York, Greater Manchester System and the Department of Health, before joining South Yorkshire.

His most recent role was Executive Director of Strategy and Partnerships at South Yorkshire Integrated Care Board leading for the board and system on strategy, planning, improvement, transformation and partnerships. Will was instrumental in establishing one of the first large and complex Integrated Care Systems in England and shaping the NHS's contribution to the wider social and economic development of the region as anchor organisation, working with

NHS organisations, VCSE sector, local government and South Yorkshire Combined Mayoral Authority.

Will is passionate about improving quality, outcomes and experience for patients, families and working with local communities. He is a champion for improving population health and addressing health inequalities and harnessing the power of collaboration to tackle some of our most complex challenges. He has experience of leading change in large, complex systems to give measurable improvements for patients, families and staff. Will is the Trusts executive lead for Improvement and has a range of executive portfolio responsibilities including strategy and transformation, health inequalities, sustainability and our role as an anchor organisation and partner.

Dr Claire Radley, Director for People and Organisational Development

Appointed February 2022 and resigned March 2026

Claire joined the Trust in February 2022 having previously been the Director for People at the Royal United Hospital Bath NHS Foundation Trust and Assistant Director of Organisational Development at Cardiff and Vale Health Board. Before that Claire worked in policing in roles spanning research, performance, culture change, and organisational development. She has worked for a local police force and in national roles, including as the advisor to the Chair of the College of Policing. She has a Ph.D. in organisational culture and is a Fellow of the CIPD.

Claire left the Trust in March 2026 to take up a role as Chief People, Culture and Improvement Officer at The Royal Wolverhampton NHS Trust.

Kerry Rogers, Director of Integrated Governance

Appointed April 2024

Kerry joined the Board of Directors as a non-voting executive director in April 2024, having previously been Director of Corporate Affairs and Company Secretary at Oxford Health for over eight years.

Kerry has more than 30 years board level experience including director roles in the NHS; in acute, mental health and community services. Kerry was previously a lay member for the Nursing and Midwifery Council and on the Business Planning and Governance Committee. She was, for 6 years, a trustee for Age UK Oxfordshire and has been a Board member of The Hill, an organisation which works with NHS trusts, universities, digital developers, innovators and investors to promote and encourage commercial and impactful technological solutions to problems in health and care.

With over 30 years' experience in business and finance in both public and private sectors, Kerry champions good governance, and in her role provides the essential interface between the Board and all stakeholders. Prior to joining the NHS in 2005, her early public sector career was as an Inspector of Taxes for Her Majesty's Inspector of Taxes. She then went on to be a Finance Director and Company Secretary in the private sector for an IT professional

services company contributing to the strategic direction and operational excellence of the business.

Lee Pester, Chief Digital and Information Governance
Appointed March 2025

Lee joined the Trust as Chief Digital Information Officer (non-voting) in February 2025 from University Hospitals Plymouth NHS Trust. where he had led on all aspects of digital strategy, transformation, delivery, and operations. Lee has worked in the NHS since 2013 and has a background in NHS Procurement.

Before his time in the NHS, Lee has a varied career including time spent in the armed forces and commercial sector.

Lee's current role includes driving forward the digital strategy within the Trust with the aim of empowering staff in their roles and patients in their healthcare. He has and continues to champion digital inclusion, ensuring the delivery of technology does not create barriers to healthcare across the population.

No external recruitment consultants were instructed in the recruitment of the Non-Executive Directors appointed during 2025/26.

Directors' and Governors' interests

Directors and Governors are required to declare relevant interests on appointment and to update these at least annually, as well as declaring any interests at meetings.

Where a potential conflict of interest arises, it is managed in line with Trust policy, including withdrawal from discussion or decision-making where appropriate.

Directors' indemnity arrangements: the Trust has appropriate indemnity and insurance arrangements in place for its Directors, in accordance with its statutory powers.

Further information on the Trust's governance arrangements and Code of Governance disclosures is provided in the Accountability Report

The Trust's public registers of interests, are maintained at:

https://intranet.gloshospitals.nhs.uk/departments/corporate-division/corporate-governance/

Political Donations

No political donations were made during the course of the year nor the previous year.

HM Treasury compliance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better payment practice code

The aim of the better payment practice code is to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed. Please see compliance tables below

For the financial year 2025/26 the Better Payment Practice Code (BPPC) performance was 90% by value and 97% by number as detailed below. 95% of bills paid within 30 days of receiving an invoice is the best practice benchmark.

	Cumulative for the financial year	
	Number	£000s
Total bills paid within period	112,115	316,317
Total bills paid within target	108,547	284,702
Percentage of bills paid within target	97%	90%

The split between NHS and Non-NHS payables are shown below.

	Cumulative for the financial year			
	NHS Payables		Non-NHS payables	
	Number	£000s	Number	£000s
Total bills paid within period	3,015	68,128	109,100	248,189
Total bills paid within target	2,694	58,343	105,853	226,359
Percentage of bills paid within target	89%	86%	97%	91%

The Trust has not paid any interest under the Late Payment of Commercial Debts (Interest) Act. The notional interest under the terms of the Act for 2024/25 would be £174.2k.

Income generation and disclosures

This information is incorporated in the annual accounts

Well-Led Framework

External Well-Led Review and Leadership Development

In 2025/26, the Trust commissioned Code of Governance (the Advancing Quality Alliance) to undertake an external Well-Led review against NHS England's Well-Led Framework. The review was deliberately used as a reflective exercise to "hold up a mirror" to our leadership, governance and organisational practices, and to challenge ourselves on how effectively we lead the Trust.

The findings from the Aqua review were considered alongside our own internal assessments, including our self-assessment against the *Insightful Board* maturity framework as part of the NHS England Provider Capability Assessment. Taken together, this triangulated view enabled the Trust to identify a clear and coherent set of development priorities, which have been brought together into an integrated leadership and governance development plan, overseen by the Board.

The work with Aqua also highlighted the critical role of effective reporting in supporting good governance, constructive challenge and informed decision-making. In response, the Trust reviewed its approach to report writing and assurance, resulting in the rollout of new Board and committee report templates. These templates are designed to sharpen focus on what matters most, support clearer articulation of risks and opportunities, and strengthen the Board's ability to exercise insight and oversight

Care Quality Commission Well-Led Inspection

In February 2026, the Care Quality Commission undertook a formal Well-Led inspection of the Trust as part of its regulatory programme. At the time of writing this Annual Report, the Trust has not yet received the final inspection report or outcome. The Trust has nonetheless reflected on the themes explored during the inspection and will consider the findings carefully once formally reported, integrating any required actions with the existing leadership and governance development programme.

Well-led in the context of patient services

As a Foundation Trust, we are accountable to local people through our Council of Governors, representing residents, staff and key stakeholders. Governors provide independent scrutiny of the quality of patient services through engagement, ward and service visits, and review of quality and performance information.

The Board provides oversight through our Integrated Performance Report (IPR), reviewed at every public Board meeting, and through committees that scrutinise safety, quality and experience. We use audits, incidents and learning, complaints and compliments, surveys and outcomes data to identify priorities, agree actions and track impact for patients. Our Quality Account for 2025/26 provides further detail on progress against our quality priorities.

External scrutiny supports our assurance and improvement. In 2025, the Care Quality Commission (CQC) inspected a number of core services including Maternity (September 2025), Urgent and Emergency Care (December 2025), and Medical and Frailty (December 2025). At the time of writing, final reports are awaited; we will publish outcomes when available and act on any recommendations.

Recent service improvements include:

- Progressing plans for the new Gloucestershire Cancer Centre at Cheltenham General Hospital, including submission of the planning application.
- Opening a modular MRI unit at Gloucestershire Royal Hospital to support diagnostic capacity and improve patient experience.
- Developing additional critical care capacity through the new four-storey Critical Care Unit project at Gloucestershire Royal Hospital.
- Strengthening maternity and neonatal services, including maternity triage co-production and a UNICEF UK Baby Friendly Initiative Certificate of Commitment for the Neonatal Unit.
- Reducing inequalities in children's diabetes care by adopting the Poverty Proofing® approach and improving accessibility for families.
- Dialysis Services at Gloucestershire Royal Hospital rated 'Good' by the CQC.
- An upgraded mobile cancer care unit ('Helen') with Hope for Tomorrow, supporting care closer to home.

These examples show how we turn oversight and feedback into measurable service improvement.

In 2026/27 we will build on this progress through a focused improvement programme to deliver safer care, better experience, reduced waiting times and increased capacity where demand is highest. This includes continued investment in diagnostics and critical care, strengthening maternity and neonatal pathways, and targeted action to reduce inequalities. Progress will be monitored through our committees and the public board meetings, with ongoing engagement and transparent reporting.

Stakeholder engagement

Gloucestershire Hospitals NHS Foundation Trust remains committed to engaging with our communities, ensuring their voices shape our services. This year, we have continued to expand our outreach, strengthened partnerships, and delivered impactful projects to improve accessibility and inclusivity in healthcare. We keep our engagement mechanisms under review to ensure they remain effective in informing strategic decisions.

The Board ensures that the views of stakeholders, including patients, staff and system partners, are actively considered in decision making. A prime example of this was the consultation on the design of the recently approved Trust Strategy for 2025-2030.

We work closely with our partner NHS and Local Authority organisations with the Trust being a formal member of both the statutory Integrated Care Partnership in Gloucestershire, represented by both the Director of Improvement and Delivery and Deputy Chief Executive. The Trust is also a number of formal sub-committees of the ICB including the One Gloucestershire strategic executive and finance of committees' groups and forums which support and enhance partnership working on patient safety, quality issues and delivery. These include the system safety committee and system quality group with representation from the Trust's Chief Nursing Officer and Director of Quality.

From April 2026, the Trust has entered into a partnership with both Gloucestershire Health and Care NHS Foundation Trust and Primary Care through the General Practice Collaborative to for the Gloucestershire NHS provider Partnership. The partnership seeks to provider a mechanism for shared working across primary and community, general practice and acute and specialist services. The Partnership is underlined by a memorandum of understanding and partnership governance and involves joint working with wider partners.

Our partnership with the Voluntary, Community and Social Enterprise Sector (VCSE) and Healthwatch helps provide vital insight and reach into groups with particular needs across our communities so that our services are accessible and responsive to all. Much of this is evidenced within the Performance Report.

Accountability Report:

Remuneration Report

Remuneration Report

Scope of the Report

The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application for the 2025/26 financial year, in respect of the Executive and Non-Executive Directors. It describes how the Trust applies the principles of good corporate governance in relation to Directors' remuneration as defined in the NHS FT Code of Governance, in Section 420 to 422 of the Companies Act 2006 in so far as they apply to Foundation Trusts; and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS Foundation Trusts; Parts 2 and 4 of Schedule 8 of the Regulations and elements of the NHS Foundation Trust Code of Governance. Details of Executive Directors' remuneration and pension benefits; and non-Executives' remuneration are set out in tables later in this report.

Appointments and Remuneration Committee

The Board appoints and delegates responsibility for remuneration and Board appointments to the Appointments and Remuneration Committee, whose membership comprises only Non-Executive Directors.

The Committee's remit includes:

- determining the remuneration framework for Executive Directors and Very Senior Managers;
- approving Executive Director appointments and terms and conditions;
- undertaking the remuneration decisions reserved to the Board as shareholder in respect of wholly-owned subsidiaries; and
- ensuring compliance with the Fit and Proper Person Regulations.

The Committee approved the policy for compliance with the Fit and Proper Persons Regulations and were apprised of application of the process when presented with the outcome of the appraisals of each of the executive directors.

The Committee also approved the appointment of a new Chief People Officer during March 2026; remuneration disclosures will be reflected in the subsequent reporting period due to the appointee due to commence at the Trust in July 2026.

All voting Non-Executive Directors are members of the Committee. The Committee has met on 5 occasions during 2025-2026. During the year, the following Non-Executive Directors have served on the Committee as core members:

Committee Member	Attendance
John Cappock	1/5
Deborah Evans (Chair of the Trust)	5/5
Vareta Bryan	3/5
Jaki Meekings Davis	3/4

Marie-Annick Gournet	0/5
Sally Moyle	3/5
John Noble	2/5
Sam Foster	4/5
Shawn Smith	1/1

The Committee was supported by the Chief Executive Officer, Director of People and Organisational Development, Director of Integrated Governance, and Trust Secretary. Executives did not participate in decisions relating to their own remuneration.

Senior Managers' Remuneration Policy

The Trust's approach to remuneration is intended to ensure that it can attract, retain and motivate a high calibre senior management team to ensure it is best positioned to deliver its business plans, while remaining proportionate, affordable, and aligned with national NHS guidance and benchmarking.

The Trust defines its senior managers as those managers who have the authority or responsibility for directing or controlling the major activity of the Trust - those who influence the Trust as a whole. For the purposes of this report, 'senior managers' are defined as the voting and non-voting members of the Board of Directors.

The Trust is required to comply with the NHS Very Senior Manager (VSM) Pay Framework, published by the Department of Health and Social Care and NHS England, which applies to all NHS trusts and NHS foundation trusts. The 2025/26 VSM Pay Framework came into effect during the reporting year. The Trust confirms that it has complied with the requirements of the framework in determining the remuneration, pay progression and pay awards for Very Senior Managers during the year.

Where remuneration decisions require approval in accordance with the framework, including the application of nationally approved pay awards or consideration of remuneration arrangements that may exceed defined thresholds, the Trust can confirm it has processes in place to deal with any pay case to NHS England required and, where applicable, seek and obtain the appropriate approvals prior to implementation.

The Trust did not approve any departures from the NHS Very Senior Manager Pay Framework during the reporting year. Where judgments were required in applying the framework, including the treatment of allowances and role-related responsibilities, these were made consistently with national guidance and were subject to appropriate governance, assurance and payroll validation processes.

During the year the Trust adhered to the principles of the agreed pay framework that remunerated the performance of the Executive Directors based on the delivery of objectives as defined within the Trust's plans.

There are no contractual arrangements for performance related pay for Executive Directors and as such no payments were made in 2025-2026. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility needed to adapt to the dynamics of an ever-changing NHS and the remuneration policy is modelled upon the guidance in the NHS Foundation Trust; Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health). The key principles of the approach are

that pay and reward are assessed based on the delivery of individual objectives and relative to the performance of the whole Trust and in line with available benchmarks.

Annual Statement on Remuneration from the Chair of the Committee

During 2025/26, the Appointments and Remuneration Committee considered and approved a range of remuneration-related matters, all in accordance with national guidance, the NHS Very Senior Manager Pay Framework, and the Trust's Standing Operating Procedures governing executive pay.

The Committee approved the application of the nationally recommended 3.25% inflationary uplift to Executive Directors and other Very Senior Managers, backdated to 1 April 2025, following confirmation from NHS England that the Trust met the eligibility criteria under the NHS Oversight Framework.

The Committee noted that:

- the Trust was segmented at Oversight Framework level 1 for Quarter 1 and 2, and segment 3 for Quarter 3 due to the financial override relating to industrial action costs but returned to segment 2 for Quarter 4;
- all relevant Executive Directors had met local eligibility criteria; and
- the uplift was consistent with Agenda for Change and medical workforce awards for the year.

In line with national guidance and prior Committee decisions:

- the uplift was applied to management allowances where linked to graded pay;
- fixed responsibility allowances were not uplifted.

The Committee also approved the rectification of a historic salary mis-banding relating to one Executive Director which aligned the post-holder with the appropriate point on the Very Senior Manager scale and was consistent with previous Committee decisions. Having been considered by the Chief People Officer, a pay case to NHS England in accordance with the principles of the 2025/26 Very Senior Manager Pay Framework was deemed not required given the accumulative effect of the mis-banding.

Executive appointments to the Board of Directors continue under permanent contracts and during 2026-2026, no substantive director held a fixed term employment contract. The Chief Executive and all other executive directors (voting and non-voting) hold office under notice periods of six months except when related to conduct or capability. This information is detailed later in this report.

There were no interim members of the Board of Directors during 2025-2026.

During the year, the Committee approved changes to the executive structure to strengthen deputy arrangements and support succession planning. The Committee:

- supported the redesign of the Deputy Chief Executive Officer (DCEO) role to include additional strategic and cross-portfolio responsibilities;
- approved the appointment of the Chief Operating Officer to the DCEO role for a three-year term, effective 11 December 2025;
- approved the remuneration structure for the role, including a responsibility allowance and accountability premia.

The Committee approved changes to the Medical Director's role, moving to a full-time management position with no clinical duties, and approved the revised salary, aligned with South West regional benchmarking.

Subsidiary Company Remuneration (Gloucestershire Managed Services)

The remuneration arrangements for senior executives employed by the Trust's wholly-owned subsidiary, Gloucestershire Managed Services, are governed by separate contractual and legal frameworks to those applying to Trust Executive Directors. As a company incorporated under the Companies Act 2006, the subsidiary is subject to different statutory requirements in respect of remuneration disclosure, including provisions relating to commercial confidentiality and directors' reporting.

In its role acting on behalf of the Trust Board as shareholder, the Appointments and Remuneration Committee exercises oversight of subsidiary executive remuneration to ensure that arrangements are appropriate, proportionate and aligned with the Trust's overall governance and reward principles. While individual remuneration details for subsidiary directors are disclosed in line with company law and applicable accounting standards, this may differ from the level of disaggregation required for Trust executives within NHS Annual Reports and Accounts. The Trust is satisfied that, taken together, these arrangements provide appropriate transparency and assurance, while remaining compliant with the relevant statutory and regulatory frameworks.

Although not directly applicable to Gloucestershire Managed Services pay decisions, the Committee applies the same standards of scrutiny and proportionality as set out in the NHS Very Senior Manager Pay Framework, including additional oversight of any remuneration packages exceeding £170,000.

In its role acting on behalf of the Trust Board as shareholder, the Committee:

- approved the continuation of a subsidiary director appointment for a further fixed period, supporting stability and delivery of capital programmes; and
- approved the transition of the Managing Director of Gloucestershire Managed Services from a fixed-term contract to a substantive permanent contract and the associated remuneration.

Other remuneration matters

There are no additional elements that constitute any senior managers' remuneration, including executive and non-executive directors, in addition to those specified in the table of salaries and allowances which feature later in the report. The amounts that are designated salary in the table represent a single contracted annual salary and there are no particular remuneration arrangements which are specific to any senior manager. There were no changes made in the period to existing components of the remuneration policy and no components were added.

The majority of staff employed by the Trust are contracted on Agenda for Change terms and conditions and the general policy on remuneration contained within these terms and conditions is applied to senior managers' remuneration (and all other staff employed on non-Agenda for Change contracts), with the exception of the Medical Director, to whom Medical and Dental terms and conditions apply.

Remuneration for senior managers is set on appointment or following benchmark comparison or substantial change in responsibilities, with reference to reports on NHS senior manager pay and NHS benchmarking data collected by organisations such as NHS Providers. The main consideration for annual pay increases for senior managers has been the inflationary uplift

award made under Agenda for Change and the Very Senior Manager guidance from regulators and against benchmark comparators.

The Code of Governance submits that the Board of Directors should not agree to a full-time Executive Director taking on more than one Non-Executive Directorship of an NHS Foundation Trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation. No Executive Director of the Trust served as a Non-Executive Director on organisations of comparable size elsewhere throughout the year.

NHS Equality Delivery System (EDS2)

We are committed to making our services fair, inclusive and accessible for everyone. To help us do this, we use the NHS Equality Delivery System (EDS2), a national framework that supports organisations like ours to improve equality for patients, communities and staff.

The EDS2 helps us assess how well we are doing and where we need to improve. It has helped us set clear equality priorities and build on the progress we've already made through a wide range of partnerships, inclusive practices and collaborative initiatives.

We have a Trust-wide strategy for Equality, Diversity and Inclusion (EDI), which includes specific work streams and action plans to help us achieve our goals. Progress on this work is regularly reported to our Board of Directors through the Appointments and Remuneration Committee. These reports are also discussed as part of the Board's development programmes, ensuring that our leadership stays informed and accountable.

Further details about our EDI strategy and our objectives can be found in the Staff Report section of this Annual Report and on our Trust's website Equality, Diversity and Inclusion.

Non-Executive Directors' Remuneration

The remuneration for Non-Executive Directors has been determined by the Council of Governors and is set at a level to recognise the significant responsibilities of Non-Executive Directors in Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

They each have terms of no more than three years and are able to serve two consecutive terms dependent on formal assessment, confirmation of satisfactory on-going performance and the needs of the organisation. Exceptionally, a third term of three years or less may be served, subject to on-going positive appraisals and a broader review considering the needs of the Board and the Trust and the ongoing independence of the individual under consideration. The maximum period of office of any Non-Executive Director shall not exceed nine years.

The Non-Executive Directors' Remuneration, as agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2025-2026 has been consistent with that framework. From 1st April 2025, the governors awarded the Non-Executive Directors and Chair a 3.5% inflationary increase consistent with the percentage national increase of the Executives.

All trusts have discretion to award limited supplementary payments, proportionate to organisational size, to recognise designated additional responsibilities. Where a foundation trust departs from the recommended framework issued in 2021, it is expected to set out a clear rationale.

The responsibility allowance (for chairing Board committees or other significant duties) will not be increased for existing Non-Executive Directors. Although current guidance sets this allowance at £2,000, those appointed prior to 2021/22 will continue to receive the previously agreed rate of £3,000 for the duration of their tenure. From April 2026, the £3,000

arrangements will cease, and all new allowances will be capped at £2,000 unless and until further national guidance is issued.

The disparity between the current payment and that in the guidance (expected to be phased in over several years) is to ensure that no Director receives a reduction in their remuneration. Current Non-Executive Directors' total remuneration (regarding the £2,000 responsibility cap) will not reduce until their terms at the Trust expire. New appointments or new responsibilities attracting payments will be in accordance with the guidance and the responsibility allowance will not exceed £2,000 and from 1st April 2026, no non-executive director will be receiving more than £2,000.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and are not entitled to any termination payments. The entire Council of Governors determine the Terms and Conditions of the Non-Executive Directors. The Trust does not make any contribution to the pension arrangements of Non-Executive Directors. Fees reflect individual responsibilities including higher rates for the Senior Independent Director and one Guardian role (previously awarded to the Deputy Chair), with all Non-Executive Directors otherwise subject to the same terms and conditions.

The Code of Governance section of the Annual Report comments on non-executive director appointments and retirements in year and the role of the Governors' Governance and Nominations Committee.

Annual Report on Remuneration

This section of the remuneration report includes some elements that are subject to audit.

Termination Payments

Notice periods under senior managers' contracts are determined and agreed taking into consideration the need to protect the Trust from extended vacancies on the one hand and the needs of the employee and financial risks to the Trust on the other. The maximum notice period is six months.

Payments to senior managers for loss of office are governed by and compliant with the NHS standard conditions and regulations; where relevant, payments are submitted to NHSI for Treasury approval. There were no payments made to senior managers for loss of office during the period, as was the case for 2024/25.

Fair Pay Disclosures (audited)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2025-26 was £260k to £265k (2024-25 £270k to £275k) a movement of -3.67%.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole (excluding the highest paid director), the range of remuneration in 2025-26 was from £24k to £427k (2024-25 £1k to £428k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 1.81%.

21 employees received remuneration in excess of the highest-paid director in 2025-26 (14 employees in 2024-25).

The relationship between the remuneration of the highest paid director against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce is set out below and also shows the pay ratio between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

In calculating the 2025-26 values we have refined our estimate by removing the employees with zero contract hours for bank and locum staff as these individuals annualised salary could not be accurately calculated. In order to ensure that this did not distort the fair pay multiple these were excluded.

2025-26	25th Percentile	Median	75th Percentile
Salary Component of Pay	£30,913.13	£43,089.23	£57,785.42
Total pay and benefits excluding Pension benefits	£30,913.13	£43,089.23	£57,785.42
Pay and benefits excluding pension: pay ratio for highest paid director	8.46	6.07	4.53

2024-25	25th Percentile	Median	75th Percentile
Salary Component of Pay	£26,576.36	£38,158.32	£53,081.50
Total pay and benefits excluding Pension benefits	£26,576.36	£38,158.32	£53,081.50
Pay and benefits excluding pension: pay ratio for highest paid director	10.32	7.19	5.17

To achieve its goals, the Trust must attract and retain high calibre and experienced members of the Executive Team to ensure the Trust is best positioned to succeed. As referenced within this Remuneration Report, the Trust applies the principles of the Code of Governance and NHS guidance on remuneration, in addition to a regular review of available benchmark information, and consideration of pay and conditions across the wider Trust and the associated pay increases each year.

The Governors' Governance and Nominations Committee includes Staff Governor representation amongst the other constituency classes, and the Committee is consulted prior to recommendations to the Council with regard to any changes in Non-Executive Director remuneration.

The Non-Executive Directors' Appointments and Remuneration Committee is satisfied that it has taken appropriate steps to ensure where any senior manager is paid more than £150,000

that the level of remuneration is reasonable and proportionate, including benchmarking of job content and complexity, responsibility, internal consistency and salary across similar sized organisations.

Expenses

There were 8 non-executive directors who served in office during the financial year 2025-2026 and 3 Associate non-Executive directors (2024/25, 8 and 2), of which, 6 (2024/25, 6) received expenses with a total value of £5,088.36 (23/24 £3,390.29).

During 2025-2026, the Trust had 22 governor seats available. Full details of the governors in post through the year can be found in the Council of Governors report of this Annual Report. Whilst the role is voluntary, governors are entitled to claim reasonable expenses. In 2025-2026,4 governors' (2024/25, 4) expenses were reimbursed for £574.72 (total value of £676.98 2024/25).

Salaries and Allowances

Details of Executive Directors' remuneration and pension benefits and Non-Executive Directors' remuneration are set out in the tables available next. Remuneration, cash equivalent transfer values (CETV), exit packages, staff costs and staff numbers are all subject to audit.

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2026		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Kevin McNamara	Chief Executive Officer	245-250	0	N/A	N/A	40-42.5	285-290
Matt Holdaway	Director of Quality and Chief Nurse	180-185	0	N/A	N/A	137.5-140	315-320
Karen Johnson	Director of Finance	190-195	0	N/A	N/A	57.5-60	250-255
Mark Pietroni	Medical Director and Deputy Chief Executive	260-265	100	N/A	N/A	0	260-265
Claire Radley	Director for People and Organisational Development (Left 29th March 2026)	155-160	0	N/A	N/A	45-47.5	200-205
Lee Pester	Executive Chief Digital and Information Officer	150-155	3100	N/A	N/A	55-57.5	210-215
Willlam Cleary-Gray	Director of Strategy and Transformation	160-165	0	N/A	N/A	365-367.5	525-530
Al Sheward	Chief Operating Officer	175-180	200	N/A	N/A	242.5-245	420-425
Kerry Rogers	Director of Integrated Governance	160-165	200	N/A	N/A	60-62.5	220-225
Deborah Evans	Chair	60-65	1200	N/A	N/A	0	60-65
Vareta Bryan	Non-Executive Director	15-20	100	N/A	N/A	0	15-20
Marie-Annick Gournet	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Balvinder Kaur Heran	Non-Executive Director (Left 7th May 2025)	0-5	0	N/A	N/A	0	0-5
Kaye Law-Fox (ANED)	Associate Non-Executive Director	5-10	1000	N/A	N/A	0	5-10
Jaki Meekings-Davis	Non-Executive Director Left (30th November 2025)	10-15	0	N/A	N/A	0	10-15
Sally Moyle (ANED)	Associate Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Mike Napier	Non-Executive Director Left (11th May 2025)	0-5	0	N/A	N/A	0	0-5
John Cappock	Non-Executive Director Left (31st March 2026)	15-20	0	N/A	N/A	0	15-20
Sam Foster	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
John Noble	Non-Executive Director from (1st May 2025)	10-15	0	N/A	N/A	0	10-15
Andrew Champness	Associate Non-Executive Director Left (31st March 2026)	5-10	0	N/A	N/A	0	5-10
Raj Kakar-Clayton	Associate Non-Executive Director	5-10	600	N/A	N/A	0	5-10
Shawn Smith	Non-Executive Director from (1st December 2025)	5-10	0	N/A	N/A	0	5-10

Notes:

Salary for Mark Pietroni includes £46k for clinical role for months 1-7. Month 8-12 he had no remuneration for his clinical role as he left this role

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2025		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Kevin McNamara	Chief Executive Officer	245-250	0	N/A	N/A	185-187.5	430-435
Matt Holdaway	Director of Quality and Chief Nurse	160-165	0	N/A	N/A	162.5-165	320-325
Karen Johnson	Director of Finance	185-190	0	N/A	N/A	97.5-100	280-285
Mark Pietroni	Medical Director and Deputy Chief Executive	270-275	100	N/A	N/A	60-62.5	335-340
Claire Radley	Director for People and Organisational Development	155-160	0	N/A	N/A	40-42.5	195-200
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (until 16th February 25)	165-170	0	N/A	N/A	0-2.5	165-170
Lee Pester	Executive Chief Digital and Information Officer (from 17th February 25)	15-20	3100	N/A	N/A	27.5-30	45-50
Ian Quinnell	Interim Director of Strategy and Transformation (until 29th September 24)	75-80	0	N/A	N/A	27.5-30	105-110
Willlam Cleary-Gray	Director of Strategy and Transformation (from 30th September 24)	75-80	0	N/A	N/A	0-2.5	75-80
Al Sheward	Chief Operating Officer	150-155	200	N/A	N/A	115-117.5	265-270
Kerry Rogers	Director of Integrated Governance (from 29th April 24)	145-150	200	N/A	N/A	85-87.5	230-235
Deborah Evans	Chair	55-60	1200	N/A	N/A	0	55-60
Vareta Bryan	Non-Executive Director	15-20	100	N/A	N/A	0	15-20
Marie-Annick Gournet	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Balvinder Kaur Heran	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Kaye Law-Fox (ANED)	Associate Non-Executive Director	5-10	1000	N/A	N/A	0	5-10
Jaki Meekings-Davis	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Alison Moon	Non-Executive Director (Left March 24)	0-5	100	N/A	N/A	0	0-5
Sally Moyle (ANED)	Associate Non-Executive Director	5-10	0	N/A	N/A	0	5-10
Mike Napier	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
John Cappock	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Sam Foster	Non-Executive Director (from 1st April 24)	15-20	0	N/A	N/A	0	15-20

Notes:

Salary for Mark Pietroni includes £75k for clinical role

Director Pensions 2025-26								
Pension benefits of Senior Managers		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2026	Lump sum at age pension age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value as at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value as at 31 March 2026
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000
Kevin McNamara	Chief Executive Officer	2.5 to 5	0	60 to 65	125 to 130	1,049	26	1,123
Matt Holdaway	Director of Quality and Chief Nurse	5 to 7.5	10 to 12.5	60 to 65	140 to 145	1,077	134	1,251
Karen Johnson	Director of Finance	2.5 to 5	0 to 2.5	45 to 50	0 to 5	695	48	778
Mark Pietroni	Medical Director and Deputy Chief Executive	0	0 to 2.5	40 to 45	5 to 10	752	0	745
Claire Radley	Director for People and Organisational Development (Left 29th March 2026)	2.5 to 5	0 to 2.5	25 to 30	0 to 5	352	34	411
Lee Pester	Executive Chief Digital and Information Officer	2.5 to 5	0 to 2.5	15 to 20	0 to 5	194	32	248
Willlam Cleary-Gray	Director of Strategy and Transformation	15 to 17.5	40 to 42.5	40 to 45	80 to 85	465	380	873
Al Sheward	Chief Operating Officer	10 to 12.5	25 to 27.5	65 to 70	170 to 175	1,232	247	1,522
Kerry Rogers	Director of Integrated Governance	2.5 to 5	0 to 2.5	40 to 45	95 to 100	919	67	1,021

Notes:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:
A change in role with a resulting change in pay and impact on pension benefits
A change in the pension scheme itself
Changes in the contribution rates
Changes in the wider remuneration package of an individual

Negative values are not disclosed in this table but are substituted for a zero.

Cash Equivalent Transfer Value (CETV) are calculated using the guidance on discount rates for calculating unfunded public service Pension Contribution rates that was extant at 31 March 2026. HM Treasury published updated gudance in April 2025; this guidance will be used in the calculation of 2024-25 CETV figures.

On 10 March 2022 the Public Service Pensions and Judicial Offices Act 2022 gained Royal Assent. This act sets a deadline of 1 October 2023 to pass regulations enabling the necessary retrospective adjustments arisingdue to the McCloud judgement. This involves an initial roll back of all eligible members so their relevant service is switched to become Final salary and then offering members a choice on their actual retirement date between CARE and Final Salary benefits for their service between 2015 and 2022.

Salary for Mark Pietroni includes £46k for clinical role for months 1-7. Month 8-12 he had no remuneration for his clinical role as he left this role

Director Pensions 2024/25								
Pension benefits of Senior Managers		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at age pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value as at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value as at 31 March 2025
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000
Kevin McNamara	Chief Executive Officer	7.5 to 10	15 to 17.5	55 to 60	130 to 135	813	151	1,049
Matt Holdaway	Director of Quality and Chief Nurse	7.5 to 10	15 to 17.5	50 to 55	130 to 135	848	153	1,077
Karen Johnson	Director of Finance	5 to 7.5	0 to 2.5	40 to 45	0 to 5	563	76	695
Mark Pietroni	Medical Director and Deputy Chief Executive	2.5 to 5	0 to 2.5	40 to 45	5 to 10	630	55	752
Claire Radley	Director for People and Organisational Development	2.5 to 5	0 to 2.5	20 to 25	0 to 5	284	30	352
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (until 16 February 25)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	491	0	0
Lee Pester	Executive Chief Digital and Information Officer (from 17th February 25)	0 to 2.5	0 to 2.5	15 to 20	0 to 5	161	0	194
Ian Quinnell	Interim Director of Strategy and Transformation (until 29th September 24)	0 to 2.5	0 to 2.5	20 to 25	0 to 5	284	19	338
William Cleary-Gray	Director of Strategy and Transformation (from 30 September 24)	0 to 2.5	0 to 2.5	20 to 25	40 to 45	0	489	465
Al Sheward	Chief Operating Officer	5 to 7.5	10 to 12.5	55 to 60	145 to 150	1,026	119	1,232
Kerry Rogers	Director of Integrated Governance (from 29th April 24)	2.5 to 5	5 to 7.5	35 to 40	90 to 95	919	0	919

Notes:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:
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Changes in the wider remuneration package of an individual

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Salary for Mark Pietroni includes £75k for clinical role

Helen Ainsbury was opted in to pension for six months only 01/04/2024 – 31/12/2024 and opted out from 31/12/24 onwards.

Contract Type and Notice Period

Name	Start Date as Senior Manager	Contract Type	Notice Period by Employee	Notice Period by Employer
Kevin McNamara	01/01/2024	Permanent	6 months	6 months
Mark Pietroni	01/02/2019	Permanent	6 months	6 months
Karen Johnson	06/01/2020	Permanent	6 months	6 months
Matthew Holdaway	13/12/2021	Permanent	6 months	6 months
Claire Radley	07/02/2022	Permanent	6 months	6 months
Alan Sheward	11/12/2023	Permanent	6 months	6 months
Kerry Rogers	29/04/2024	Permanent	6 months	6 months
William Cleary Gray	30/09/2024	Permanent	6 months	6 months
Lee Pester	17/02/2025	Permanent	6 months	6 months

Notes: No senior manager has a contract of employment with a notice period greater than six months.

Analysis of Staff Costs – *Subject to Audit*

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	417,349	3,202	**420,551**	401,990
Social security costs	59,277	-	**59,277**	44,354
Apprenticeship levy	2,323	-	**2,323**	2,218
Employer's contributions to NHS pension scheme	90,533	-	**90,533**	84,558
Temporary staff	-	10,469	**10,469**	13,479
NHS charitable funds staff	553	-	**553**	487
Total gross staff costs	**570,035**	**13,671**	**583,706**	**547,086**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**570,035**	**13,671**	**583,706**	**547,086**
Of which				
Costs capitalised as part of assets	1,894	-	**1,894**	723

Analysis of Average Staff Numbers (WTE Basis) – *Subject to Audit*

	Permanent Number	Other Number	2025/26 Total Number	2024/25 Total Number
Medical and dental	510	658	**1,168**	1,144
Ambulance staff	9	1	**10**	10
Administration and estates	2,098	206	**2,304**	2,365
Healthcare assistants and other support staff	1,253	253	**1,506**	1,586
Nursing, midwifery and health visiting staff	2,456	295	**2,751**	2,766
Nursing, midwifery and health visiting learners	100	2	**102**	89
Scientific, therapeutic and technical staff	658	88	**746**	720
Healthcare science staff	272	15	**287**	275
Social care staff	-	-	**-**	-
Other	1	3	**4**	4
Total average numbers	**7,357**	**1,521**	**8,878**	**8,957**
Of which:				
Number of employees (WTE) engaged on capital projects	29	-	**29**	12

**WTE - Whole Time Equivalent. WTE shown is an average throughout the year*

Exit Packages

There were no exit package payments made to employees on Very Senior Manager contracts. The Staff Report within this Annual Report contains information regarding other exit package payments.

Service Contracts Obligations

There are no obligations contained within senior managers' service contracts that could give rise to or impact upon remuneration payments which are not disclosed elsewhere in the remuneration report.

Kevin McNamara
Chief Executive Date:25 June 2026

Accountability Report:

Staff Report

Staff Report

Staff Overview

We have over 10,910 staff inclusive of bank workers and Gloucestershire Managed Services (GMS), seeing the Gloucestershire Hospitals Group as the largest employer in the County. Everyone continues to make such a difference in delivering high quality care to our patients, their carers and families. Most colleagues live in the local community and they and their families are also users of the services.

This Staff Report provides an overview of the Trust's workforce during the year ended 31 March 2026, including workforce composition, staff experience and engagement, and the required disclosures on exit packages and off-payroll arrangements.

Staff Analysis

Staff numbers

Average Number of Staff and Staff costs: 1 April 2025 to 31 March 2026 (subject to audit)

Using the most up to date available data, the following tables set out the average number of staff (whole time equivalent [WTE]) and staff costs for the year

Average Staff Numbers (WTE)

	Permanent Number	Other Number	2025/26 Total Number	2024/25 Total Number
Medical and dental	510	658	**1,168**	1,144
Ambulance staff	9	1	**10**	10
Administration and estates	2,098	206	**2,304**	2,365
Healthcare assistants and other support staff	1,253	253	**1,506**	1,586
Nursing, midwifery and health visiting staff	2,456	295	**2,751**	2,766
Nursing, midwifery and health visiting learners	100	2	**102**	89
Scientific, therapeutic and technical staff	658	88	**746**	720
Healthcare science staff	272	15	**287**	275
Social care staff	-	-	**-**	-
Other	1	3	**4**	4
Total average numbers	**7,357**	**1,521**	**8,878**	**8,957**
Of which:				
Number of employees (WTE) engaged on capital projects	29	-	**29**	12

Bank and agency worked WTE is included in 'Other'. Whole time equivalent is an average throughout the year.

Staff Costs

	Group			
			2025/26	2024/25
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	417,349	3,202	**420,551**	401,990
Social security costs	59,277	-	**59,277**	44,354
Apprenticeship levy	2,323	-	**2,323**	2,218
Employer's contributions to NHS pension scheme	90,533	-	**90,533**	84,558
Temporary staff	-	10,469	**10,469**	13,479
NHS charitable funds staff	553	-	**553**	487
Total gross staff costs	**570,035**	**13,671**	**583,706**	**547,086**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**570,035**	**13,671**	**583,706**	**547,086**
Of which				
Costs capitalised as part of assets	1,894	-	**1,894**	723

Workforce composition and diversity.

Gender Distribution - Trust & Gloucestershire Managed Services (subsidiary)

The table below shows the gender breakdown of substantive staff (bank staff are not included). The data is reflected by headcount.

		March 2026			March 2025
	Gender	Trust	GMS	TOTAL	Trust
Chairs & Directors *	Male	9	5	**14**	**8**
	Female	8	2	**10**	**10**
Senior Managers **	Male	142	11	**153**	**131**
	Female	349	9	**358**	**318**
Employees	Male	1,616	440	**2,056**	**1,567**
	Female	6,457	404	**6,861**	**6,512**
All Employees	Male	1,767	456	**2,223**	**1,702**
	Female	6,814	415	**7,229**	**6,842**

*Voting and non-voting Executive and Non-Executive Directors

**Band 8A and above

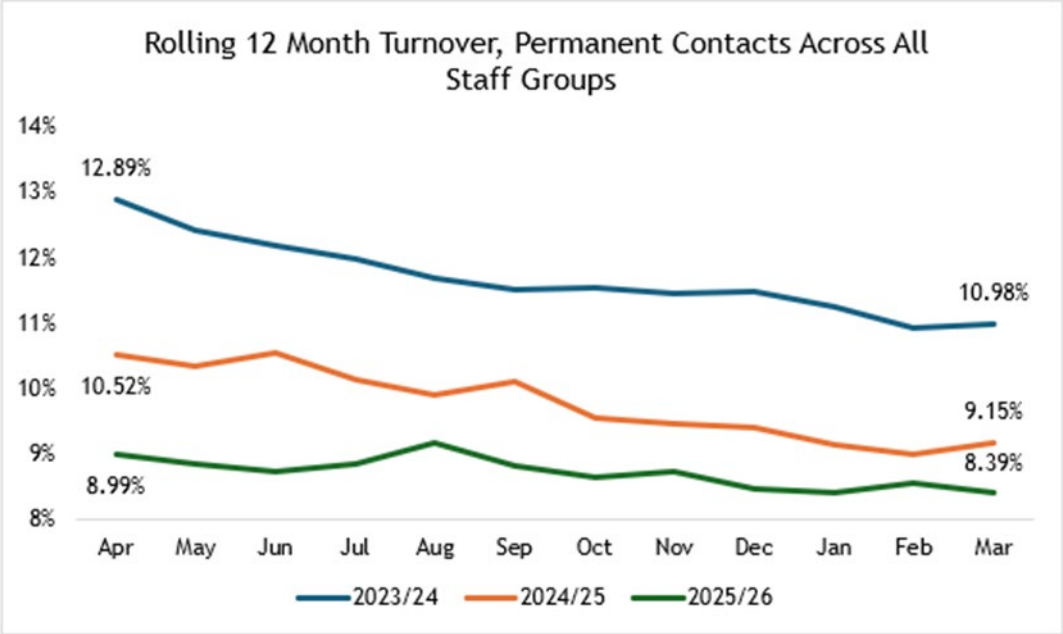
Within the trust, the numbers of Senior Managers increased overall from 2025/2026 in terms of both male and females. The overall female representation in percentage terms slightly increased by 0.95% from 70.15% in 2024/2025, to 71.10% in 2025/2026.

The Trust monitors workforce diversity metrics to support equality, diversity and inclusion (EDI) priorities and to inform targeted actions where experience and outcomes differ between groups.

Staff Turnover

The Trust's turnover (for permanent staff) reduced from 9.15% (2024/2025 report % adjusted from 8.95% to 9.15% to include GMS) to 8.39% (includes GMS) over the last twelve months and continues to perform favourably when benchmarked to other Trusts within the region.

This staff turnover information now includes Gloucestershire Managed Services (GMS), a wholly owned subsidiary of the Trust. Therefore, the following graph has been adjusted to show the turnover for the past three financial years, to include Gloucestershire Managed Services.



Turnover for registered nurse & midwifery staff reduced from 6.52% to 5.58% during the year 2025/2026 with Medical & Dental staff turnover reduced from 4.52% to 4.27% during the same period.

More detailed workforce statistics can be found at (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics)

Turnover is monitored through executive performance reviews and workforce reporting such as the Integrated Performance Report, with actions targeted at hard-to-recruit areas and roles with higher turnover.

Sickness absence

The Trust sickness rate for 2025/26 of 4.38% is below the NHS England average of 5.9%*. This is a 0.23% decrease compared to the previous financial year.

* source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates - December 2025 NB: latest available data

Short-term absence has seen a marginal decrease in comparison to the previous year of 0.01% while long-term absence decreased by 0.22%.

The table below shows the sickness rate broken down to long term (sickness episode >28 days) and short term:

		2024-25	2025-26
Sickness Absence	Short Term	2.19%	2.18%
	Long Term	2.42%	2.20%
Annual Sickness Absence	**Total**	**4.61%**	**4.38%**

Sickness absence is reported on an ESR basis and is benchmarked against NHS England published sickness absence statistics where available.

Reducing agency staffing

During 2025–2026, the Trust continued to implement targeted action to reduce reliance on agency staffing and associated costs. This included strengthening internal controls, improving rostering arrangements, and contributing to regional cost-saving initiatives. Together, these measures have improved workforce oversight, supported better use of internal staffing resources, and reduced avoidable temporary staffing expenditure.

Grip and Control Groups for medical, nursing and, during the year, non-medical staffing has provided robust scrutiny of temporary staffing requests. Senior divisional involvement ensures that all requests are clinically justified, proportionate and aligned with workforce and financial priorities, embedding a stronger culture of challenge and cost-conscious decision-making across the organisation.

Improvements in nursing and healthcare support worker rostering have reduced unjustified staffing requests and ensured substantive and bank staff are utilised before agency escalation. As a result, nursing agency expenditure has reduced by approximately 70% compared to the previous financial year, reflecting strengthened controls, improved planning, and continued recruitment.

The Trust also commenced the rollout of medical rostering, starting within the Medicine division. Early implementation has delivered reductions in locum usage within Emergency Department and Acute Medicine services, historically the Trust's highest users of temporary medical staffing. Rollout will continue across remaining divisions, with close monitoring of impact on locum utilisation and workforce efficiency.

Alongside these measures, the Trust has prioritised substantive recruitment into hard-to-fill nursing and medical roles, reducing vacancy levels in critical areas and supporting a sustained reduction in agency dependence. Regionally, the Trust has worked with partner organisations to implement standardised agency rate cards across the South West, helping to control costs and improve value for money across the system.

The Trust remains fully committed to delivering against NHS England requirements for the removal of agency staffing. Achieving this will continue to require careful and robust decision-making to balance workforce deployment, financial control and patient safety. During 2026–2027, further progress will be driven through strengthened governance, improved medical and nursing workforce planning, and targeted recruitment in services with the highest residual agency reliance.

Recruitment (substantive and bank)

During 2025–2026, the Trust continued to strengthen recruitment processes for both substantive and bank staff, with a focus on streamlining procedures, supporting flexible career pathways, and retaining experienced colleagues. These improvements have contributed to reduced vacancies, improved workforce stability, and lower reliance on agency staffing. An inclusive recruitment review

for consultant (medical) roles is now nearing completion and is designed to improve fairness, transparency, speed and consistency across the end-to-end Consultant recruitment process.

These improvements are, however, taking place within a more challenging national context. Changes to UK sponsorship and immigration rules introduced in July 2025 have significantly restricted the Trust's ability to recruit internationally. The closure of the Health and Care Worker visa route for new overseas healthcare support workers, the increase in the Skilled Worker visa requirement to RQF Level 6, and higher salary thresholds for non-clinical roles have removed a substantial number of previously eligible posts from sponsorship. As a result, the Trust can no longer rely on international recruitment for several critical support roles, increasing the importance of strong domestic recruitment and retention pipelines.

Progress in strengthening internal workforce pipelines has been demonstrated through a number of key initiatives. Time to hire has reduced significantly, falling from 79 days to an average of 40 working days, supporting faster vacancy filling and reducing the need for temporary staffing. Further improvements are planned through the use of new technology to accelerate pre-employment checks.

The Trust has also expanded flexible employment options to retain skills and experience within the organisation. Retire and return schemes have enabled experienced staff, particularly those with specialist clinical expertise, to continue contributing to flexible roles. Clear pathways from bank to substantive employment have been established in hard-to-fill areas, while a substantive-to-bank option allows staff leaving permanent roles to remain connected to the organisation.

Targeted support through hard-to-recruit forums has helped divisions address persistent recruitment challenges in key services, including emergency and stroke care. In parallel, enhanced recruitment attraction activity, including a dedicated recruitment website, refreshed employer branding, community engagement, and on-site recruitment events, has strengthened the Trust's position as an employer of choice.

During 2026–2027, the Trust will focus on sustaining these improvements, further reducing time to hire, and strengthening domestic recruitment pipelines in roles most affected by national labour market pressures and sponsorship constraints.

Equality, diversity and inclusion

Equality, Diversity and Inclusion (EDI) remain central to the Trust's values and priorities. During 2025/26, work focused on strengthening a sense of belonging, improving staff experience, and embedding inclusive behaviours across all levels of the organisation. A key milestone was the launch of the EDI Leadership Development Programme, bringing together Board members, the Trust Leadership Team and Staff Networks to build shared capability and accountability for inclusive culture change. The programme will continue to evolve, supporting leaders to understand lived experience, challenge inappropriate behaviours, and set clear expectations for inclusion in everyday practice.

The Report, Support and Learn platform has played an increasingly important role in strengthening the Trust's approach to addressing inappropriate behaviour. The platform has enabled staff to report concerns related to discrimination, bullying, harassment, sexual misconduct and incivility more safely and confidently. Improved insight has supported more timely and sensitive management responses, strengthened the Freedom to Speak Up function, and helped shape Trust-wide priorities for improvement.

Staff Inclusion Networks have continued to mature and increase their strategic influence. Alongside established Women's, Ethnic Minority, LGBTQ+ and Disability Networks, a structured development programme for Network Chairs and members was introduced, focusing on leadership, influence and their role within the wider speaking-up and inclusion agenda. In 2026/27, further investment will support a refresh of network purpose, governance and resourcing, including protected time,

leadership development and enhanced facilitation. The Disability Network will also formally expand to include neurodiversity.

During the year, the Trust continued delivery of its eight Equality, Diversity and Inclusion actions, which have guided anti-discrimination and inclusive practice. Notable progress has been made through the Inclusive Recruitment Programme, including the use of Inclusion Champions in senior recruitment and improved oversight of recruitment data and outcomes. From 2026/27, this work will be focused through three priority areas: Inclusive Recruitment, Discrimination, and Leadership Practices, reflecting staff feedback, national frameworks and learning from Report, Support and Learn.

Inclusive practice is also being embedded within leadership and development pathways. All internal coaches will undertake neurodiversity coaching training to ensure a more inclusive, person-centred approach to development. In parallel, progress has continued with the Reasonable Adjustments Project, including the introduction of a central fund to support Access to Work applications. This work aims to improve consistency, timeliness and staff experience, building on insights from the NHS Staff Survey and the Purple Passport.

Together, these actions represent continued progress in embedding fairness, equity and inclusion across the Trust. The focus for the year ahead will be on strengthening leadership responsibility, enhancing learning from reporting, supporting staff networks, and ensuring that EDI priorities deliver meaningful and measurable improvements in staff experience.

Freedom to Speak Up (FTSU)

Our Trust is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life and in all of its practices. The Trust recognises that those who work for our organisation are in the best position to recognise when something needs to be spoken up about, whether it be an improvement or an issue that needs action and resolution.

Freedom to Speak Up Guardians are trained by The National Guardians Office to work independently in the Trust to support staff with speaking up matters. The Freedom to Speak Up Guardian works to break down speaking up barriers and signpost staff to voice their speaking up matters to the right leader.

With the introduction of additional speaking up support; Report, Support and Learn, Freedom to speak up cases have reduced this year, from 230 staff in 2024-2025 to 173 staff accessing the service. This change has supported a positive increase in patient quality and system issues being raised, providing more opportunities for the organisation to learn and improve in vital areas of the Trust.

People, policies and governance

During 2025/26, the Trust continued to work in close partnership with staff side and recognised trade union colleagues to develop and review people policies, ensuring they reflect legislative requirements, case law and best practice. Key stakeholders were actively involved in policy development and review to ensure policies are practical, relevant and informed by the realities of the workplace.

Following the focused work programme delivered in 2024/25, where 34 of 36 policies were reviewed, progress was sustained throughout 2025/26 through early planning for forthcoming reviews and strengthened governance arrangements. This approach has supported clearer ownership of policies by the appropriate specialist teams and helped ensure the people policy offer remains current, coherent and accessible.

In preparation for 2026/27, work commenced on the development of a People Policy Framework. This framework will support consistent and high-quality policy development and will include guidance for policy authors, clear expectations for consultation with key stakeholders and trade

unions, and consideration of any associated people development or capability needs. Alongside this, a planned review of the overall number of people policies will assess whether documents are best positioned as formal policies or guidance, supporting greater clarity and ease of use for staff and managers.

All Trust people policies continue to be subject to an Equality Impact Assessment as an integral part of the review process. This ensures that equality, diversity and inclusion remain central to policy development and decision-making, supported by the ongoing work of the Quality and Equality Impact Assessment Review Group to drive continuous improvement in outcomes for the workforce.

The Board recognises that culture is critical to the delivery of high-quality care and organisational performance. The Board monitors organisational culture through:

- NHS Staff Survey results
- Freedom to Speak Up reporting
- Workforce metrics
- Qualitative feedback from staff engagement opportunities.

Where the Board identifies areas of potential misalignment between culture and the Trust's vision and values, it seeks assurance that management has taken appropriate action, via its assurance committees.

Gender balance and pay gaps

This year, for the first time, the Trust has published a comprehensive Pay Gap Report covering the Gender, Ethnicity and Disability Pay Gaps, using snapshot data from 31 March 2025. Gender representation remained unchanged from 2024, with women at 78.1% and men at 21.9%. The mean gender pay gap increased to 26.5% (from 23.3%), and the median gap rose to 17.8% (from 17.2%). In line with the Public Sector Equality Duty, these figures were published by 30 March 2026.Although reporting on Ethnicity and Disability Pay Gaps is not mandatory, the Trust chooses to publish this information to support transparency and improvement. The Ethnicity Pay Gap analysis shows a mean gap of 1.2% and a median gap of 3.4%, both in favour of EM staff. The Disability Pay Gap shows a mean gap of 13.1% and a median gap of 12.6%, both in favour of non-disabled staff. In response to the findings across all three gaps, nine actions have been identified for 2026/2027. These include improving inclusive recruitment, strengthening staff networks, supporting progression, enhancing use of cultural ambassadors, and improving access to reasonable adjustments.

The Trust publishes pay gap information in line with statutory and public sector reporting expectations and uses the findings to inform targeted actions to improve fairness, progression and inclusion. The full report is available on both the Trust website and the Cabinet Office website.

Pay Gap report 2026

(https://gender-pay-gap.service.gov.uk/)

Organisational development, staff wellbeing and support

Health & Wellbeing

Wellbeing isn't built by increasing staff resilience to endure more; it's built by creating conditions where they don't have to. The focus of wellbeing work at GHT continues to be on how we can develop the workplace culture to improve work experience and reduce negative impacts on staff.

Data from sickness absence and the NHS Staff Survey highlight ongoing challenges, particularly with stress, mental health, and musculoskeletal (MSK) issues, underscoring the need for sustained focus. In 2025, sickness absence attributable to mental health issues cost the Trust £3,680,723, whilst sickness linked to musculoskeletal cost £2,339,620 in MSK absence; though in both cases it is not currently known whether the sickness was attributable to the workplace. We are looking to improve our sickness recording in this area.

Some of the key activities in 2025 include:

- **‘**Free health checks for staff’: The Charity funded a pilot of onsite health checks for staff. From June 2025 to March 2026, 752 staff have had a health check intervention on site (approximately 7% of the workforce), with 98% recommending the service, and 95% stating they would make behaviour change as a result.
- Health education sessions - A calendar of talks was launched, with guest speakers educating staff on topics from menopause to suicide and stress.
- Formation of OD Oversight Group - To improve insights and HR and Manager support, this new group pulls together information across the People function in new Quarterly Divisional ‘Culture Reports’.
- The 2025 Wellbeing Annual Report was published in March 2026, as part of ongoing efforts to increase transparency.
- Appointment of NED Wellbeing Guardian - Raj Kakar-Clayton is now in role, representing workplace wellbeing at the Board.
- Substantiation of role Lead for Colleague Health & Wellbeing - The fixed-term role was made permanent, allowing strategic work the investment and stability to progress.
- Divisional Wellbeing Leads identified – with regular meetings to discuss needs and represent divisional activity at the Wellbeing Steering Group.
- Development of new Acute Incident response guidance – a new resource is being developed within Staff Psychology to improve the staff support processes following acute incidents. Substantiation of role Lead for Colleague Health & Wellbeing.
- Wellbeing Survey: our annual wellbeing survey heard from 908 staff; whose feedback contributed to the Wellbeing Strategic Plan for 2026.

Key activity and plans for 2026:

- Wellbeing Strategic Action Plan, 2026: outlines all activity intended to improve staff wellbeing. This is overseen by the Wellbeing Steering & Delivery Group.
- Workplace Adjustments: a review is underway to seek to improve the Trust approach.
- Manager training: A new in-reach approach is being piloted to target the manager training on ‘Supporting wellbeing in your team’.
- Team stress assessments: we will be reviewing the Trust approach for mangers to work with teams to identify their wellbeing using a standardised tool; to enhance prevention of issues, meaningful response to existing issues, and improved local reporting on challenges with team wellbeing and culture more broadly.

The Trust continues its transition from viewing wellbeing as a reactive/responsive approach, into a proactive/preventative space; namely by seeking to further understand and address contributing factors of poor wellbeing. This is anchored around enhancing local insight and accountability; using a single assessment tool for collecting data locally by managers and their teams to discuss and address contributing factors.

Occupational Health

The Trust’s occupational health services are provided by Working Well.

Working Well provides the Trust with a breadth of occupational health services for Trust staff which includes all pre-employment screening, immunisation checks, blood tests and vaccines. It supports staff with ill health retirement applications, health surveillance, contract tracing driven by disease outbreaks, clinical support across all management and staff self-referrals.

Health and Safety

The Risk, Health and Safety team protects patients, staff, visitors, and the organisation itself by identifying, assessing, and controlling risks, while ensuring compliance with health and safety law and NHS standards. Its purpose is both preventative and assurance-focused. It aims to reduce harm and loss by proactively managing risks, compliance and supporting safe, effective care delivery. Regular reports are provided to both our Health and Safety Committee and our People and Organisational Development Committee.

Counter-Fraud

The Trust operates an internal Counter Fraud Service that provides a robust control framework for managing the risks of fraud, bribery, and corruption. Our bespoke Counter Fraud, Bribery and Corruption Policy was updated in 2025-26 to reflect the introduction of the Failure to Prevent Fraud offence and remains aligned with the NHS Counter Fraud Authority's 3-Year Strategy. Additional information can be seen throughout this Annual Report.

Recognition of our workforce

Recognition of our workforce continued to strengthen throughout 2025/26 following the launch of the Trust's new Recognition Framework in August 2025. Our colleagues are at the heart of Gloucestershire Hospitals, and this refreshed approach ensures that staff at all levels are recognised for their dedication, compassion and the positive impact they make every day.

The framework brings together all elements of recognition into a single, coherent approach, providing a clear and consistent way for colleagues to celebrate achievements and contributions across the Trust. It now encompasses the Annual Staff Awards, Long Service Awards, Monthly *Living Our Values* Awards and Everyday Appreciation, making recognition more visible, accessible and meaningful.

A key highlight of the year was the 2025 Staff Awards, which brought together colleagues from across the Trust and Gloucestershire Managed Services. The awards received a record 940 nominations, reflecting the strength of appreciation and respect across the organisation. Finalists were selected by the Executive Team and previous award winners from an exceptionally strong field. The event was made possible through the generous support of the Trust's charity, whose sponsorship enabled us to recognise colleagues making an outstanding difference to patients, colleagues and the wider community.

The framework has also strengthened how we recognise long service, celebrating colleagues who have dedicated 25 to over 50 years to the NHS. It has been a privilege to honour these individuals, including through local media engagement, highlighting their exceptional commitment and lasting contribution to healthcare.

Learning and development

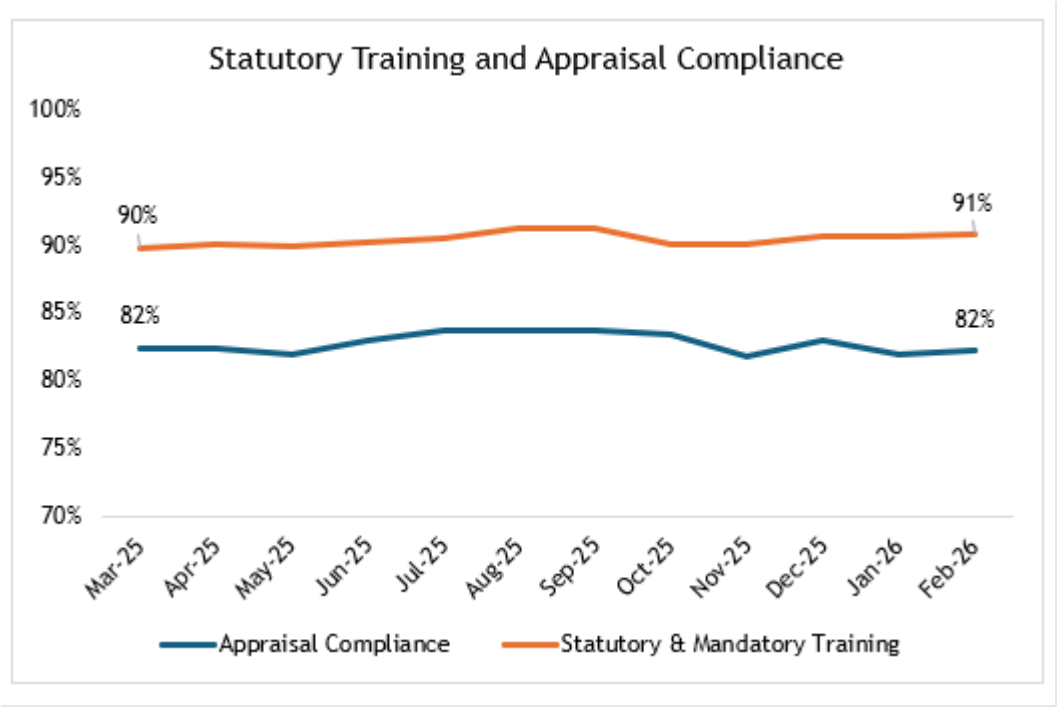
Education and People Development

The Education and People Development service continues to support the Trust's ambition to equip staff with the skills, knowledge and confidence required for both individual development and organisational effectiveness.

The Trust remains strongly committed to apprenticeships, offering a diverse portfolio of standards from Level 2 to Level 7 across clinical and non-clinical roles. During 2025/26, 114 apprenticeships were successfully completed, reflecting sustained investment in skills development and career progression. Apprenticeships continue to be delivered collaboratively across all divisions and Gloucestershire Management Services, alongside ongoing engagement with local education partners to support early career pathways, including T-Level industry placements.

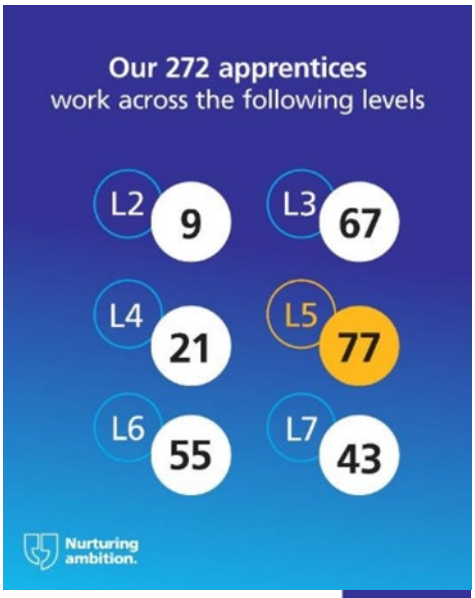
The Education and People Development portfolio has continued to broaden during the year. Appraisal compliance reached its highest level for several years, supported by clearer guidance, refreshed development conversation tools and targeted appraisal skills training for managers. This has strengthened the quality and consistency of appraisal conversations and reinforced their role in supporting staff wellbeing, engagement and performance.

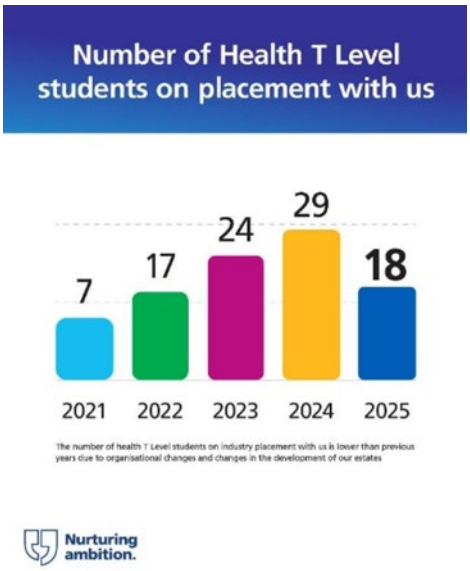
The figure below shows the trust's statutory and mandatory training compliance and appraisal compliance, with the latest data for the financial year 2025/2026. Over this period the trust has had an average 83% appraisal compliance and 90% statutory and mandatory training compliance. Please note that GMS are not included in this data.

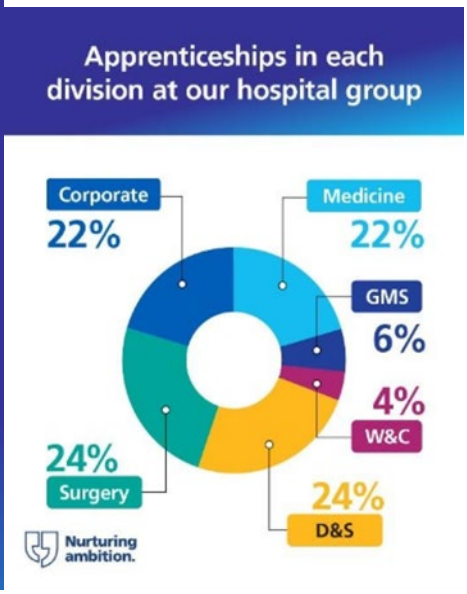


The leadership and management development offer has also expanded, providing clearer pathways for colleagues at different stages of their leadership journey. This includes an enhanced programme of leadership and management development activity, with Senior Leadership Forums now explicitly mapped to structured developmental programmes, ensuring leadership development is aligned to organisational priorities and compassionate, inclusive leadership expectations.

The Trust is proud of its medical workforce in training, offered in partnership with the University of Bristol and the Three Counties Medical School. Each academic year, supervised service provision is delivered across multiple specialties and divisions, ensuring the safe delivery of high-quality patient care. Trainees and undergraduate students receive structured training in a wide range of clinical settings. Continuous efforts to enhance training quality and trainee wellbeing have led to sustained improvements, as reflected in positive feedback from the National Education and Training Survey (NETS) and the GMC National Training Survey (NTS).







We continue to work with local colleges as a T-level industry placement provider, with 30 students currently placed across the hospital, and were a finalist for the Southwest T-level 'Employer of the Year.'

Supporting learners within the organisation remains a priority and this year we signed up to the NHS England Safe Learning Environment Charter and are committed to embedding its principles to strengthen the workforce by advancing high-quality learning environments, reducing learner attrition, and improving the retention of newly qualified staff. We have also met the terms of NHS England's Statutory and mandatory training programme, resulting in the trust having declared alignment to the core skills training framework, utilising the NHS England e-learning for healthcare (elfh) content, and establishing a local mandatory training oversight group.

Approach to staff engagement

The Trust uses a combination of the annual NHS Staff Survey, quarterly pulse surveys, local feedback mechanisms and staff networks to understand staff experience. Priorities are coordinated

through the Staff Experience Improvement Programme and reviewed through established governance arrangements.

National Staff Survey Results

The NHS Staff Survey is conducted annually and aligns to the seven elements of the NHS People Promise, alongside the themes of Staff Engagement and Morale. Indicators are reported on a 0–10 scale based on aggregated survey responses.

In 2025/26, 4,313 staff responses were received, representing a response rate of 50% (2024/25: 65%; 2023/24: 68%). The Trust is benchmarked against Acute and Acute & Community Trusts.

Scores for each indicator together with that of the survey benchmarking group are presented below.

Indicators ('People Promise' elements and themes)	**2025/26**		**2024/25**		**2023/24**	
	Trust Score	Benchmarking group score	Trust Score	Benchmarking group score	Trust Score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.08	7.28	7.10	7.29	7.04	7.31
We are recognised and rewarded	5.72	5.87	5.76	5.92	5.64	5.94
We each have a voice that counts	6.30	6.60	6.38	6.67	6.30	6.70
We are safe and healthy	6.00	6.07	6.08	6.13	5.95	6.11
We are always learning	5.45	5.57	5.44	5.64	5.26	5.62
We work flexibly	5.99	6.22	5.99	6.24	5.87	6.20
We are a team	6.61	6.75	6.53	6.75	6.50	6.75
Staff Engagement	6.43	6.74	6.53	6.84	6.44	6.91
Morale	5.73	5.84	5.78	5.93	5.61	5.90

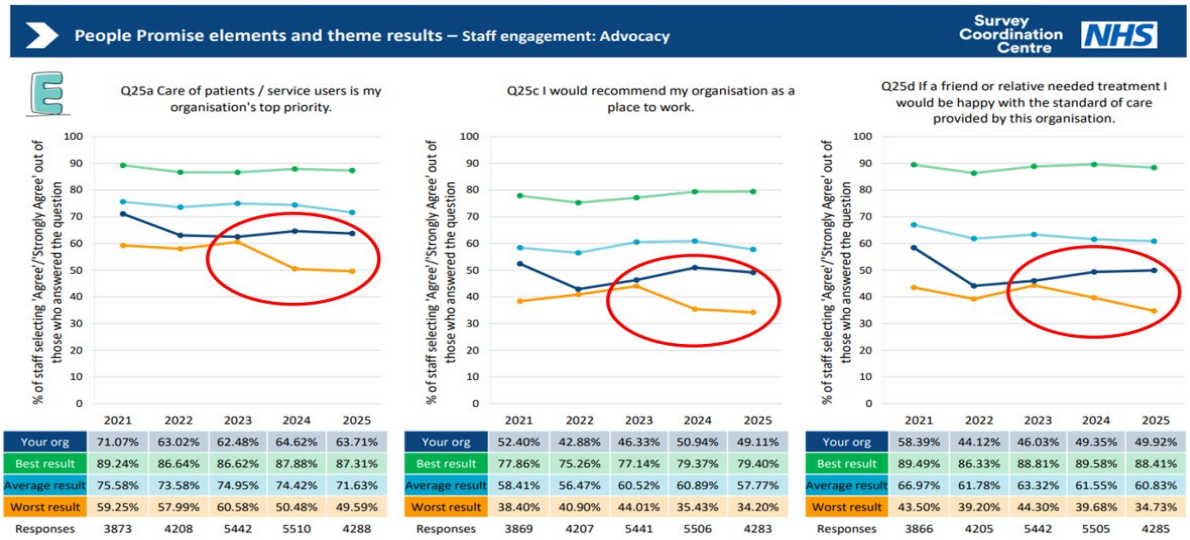
Performance in 2025/26 remained broadly stable, with small improvements in compassionate and inclusive culture and teamwork. However, there were declines in staff engagement, voice that counts, and perceptions of safety and wellbeing. The Trust performed below the benchmarking group average across all headline indicators. The most significant gaps were in Staff Engagement and Voice that Counts.

Future priorities (2026/2027)

- Measurable reductions in inappropriate behaviours, including discrimination.
- Reducing inequalities in staff experience
- Improving the proportion of staff who feel they have a voice that counts
- Strengthening accountability at all levels
- Building stronger local ownership with a clear line of sight from staff feedback and staff networks to action and impact.

Monitoring arrangements

Progress will be monitored through the Staff Experience Improvement Programme, quarterly pulse surveys, governance reporting to relevant committees, and annual NHS Staff Survey outcomes.



Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.10	5511	7.08	4299	Not significant
We are recognised and rewarded	5.76	5510	5.72	4295	Not significant
We each have a voice that counts	6.38	5487	6.30	4246	Significantly lower
We are safe and healthy	6.08	5487	6.00	4260	Significantly lower
We are always learning	5.44	5263	5.45	4173	Not significant
We work flexibly	5.99	5493	5.99	4266	Not significant
We are a team	6.59	5502	6.61	4289	Not significant
Themes					
Staff Engagement	6.53	5518	6.43	4294	Significantly lower
Morale	5.78	5519	5.73	4299	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Staff Experience Improvement Programme

We have continued to support these improvements through our Staff Experience Improvement Programme, established in 2022/23 to drive meaningful and sustained progress across three interconnected workstreams.

Following publication of the 2024 Staff Survey results, the programme was refreshed in 2025/26 to ensure a clear and targeted focus on the areas where improvement was most needed. Our priority areas for 2025/26 were:

- Teamwork Development
- Inappropriate Behaviours
- Supporting a Safe Speaking Up Culture

These were underpinned by two enabling workstreams:

- Communications and Engagement
- Restorative Just and Learning Culture

During 2025/26, the programme delivered a number of important milestones. These included the launch of Report, Support and Learn in July 2025 – an important step forward in strengthening how we support staff to report and address inappropriate behaviours. This was complemented by a targeted organisational campaign on inappropriate behaviours and the continued delivery of teamwork development interventions in partnership with our external organisational development colleagues.

Looking ahead to 2026/27, and informed by the 2025 Staff Survey results, we are undertaking a refresh and reset of the programme. As some elements have now become embedded as business-as-usual within our corporate enabling teams, we will shift our focus towards the areas of greatest concern identified by our staff.

The refreshed programme will centre on two core workstreams, alongside three key Staff Survey questions, ensuring that our efforts remain closely aligned to what matters most to colleagues. Our aim is to deliver visible, meaningful improvements that positively impact staff experience in their day-to-day working lives.

Consultancy expenditure

Consultancy expenditure

2025/26 £96,319
2024/25 £117,307

The Trust produced and issued guidance in April 2017 on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations. On occasion the Trust will procure consultancy support for specific work programmes which follow appropriate governance routes for agreement.

Off-Payroll Engagements

The Trust only utilises the use of off-payroll arrangements where there are specific and immediate shortages or specific skill requirements that it cannot fulfil from the substantive workforce. By their nature, these arrangements are of a short, definitive period with clearly defined objectives and outcomes. In all circumstances the Trust complies with HM Revenue and Customs and NHS England rules and procedures.

The following disclosures are presented in line with HM Treasury off-payroll reporting requirements for engagements with a daily rate greater than £245 (to approximate the minimum point of the pay scale for a Senior Civil Servant).

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater

Number of existing engagements as of 31st March 2026	8
Of which...	
No. that have existed for less than one year at time of reporting	3
No. that have existed for between one and two years at time of report	5
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2026	22
Of which:	
Not subject to off-payroll legislation *	21
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	1
Number of engagements reassessed for compliance / assurance purposes during the year	1
Of which: number of engagements that saw a change to IR35 status following the review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0

People Engagement and Trade Union Consultation

The Trust has a range of established mechanisms to enable meaningful staff involvement in decision-making and future developments, supporting a culture of engagement, openness and shared accountability. These include the annual NHS Staff Survey, quarterly Pulse Surveys, local departmental feedback arrangements, and active staff networks. Performance information and organisational updates are regularly communicated to support staff understanding of priorities and to encourage collective ownership of the Trust's objectives. Staff Governors play an important role in staff communication and consultation, providing an additional channel for engagement, and staff receive regular briefings on key issues through the Trust intranet.

The Trust's Organisational Change Policy provides a clear and structured framework for managing and implementing change in a way that is fair, consistent and sensitive to the needs of staff. The policy emphasises early engagement, meaningful consultation with staff and recognised staff-side representatives, and clear communication to ensure the rationale for change is understood. Openness and transparency underpin all organisational change activity, with a focus on minimising disruption and supporting staff through periods of change. As part of the Trust's ongoing commitment to effective partnership working, a review of the Partnership Agreement with staff-side representatives is planned during 2026/27.

Note: Trade Union Facility Time statutory disclosures have been removed from 2025/26 annual report requirements following legislative change; therefore, the Trust has not included the previously required facility time tables for 2025/26.

Exit Packages

The Trust discloses summary information on exit packages agreed in the year, with comparative information, in accordance with the required template disclosure. Any redundancy and other departing costs have been paid in accordance with the provisions of Agenda for Change. Ill health retirement costs are met by the NHS Pension Scheme and are not included. The below table does not relate to any employee employed on a Very Senior Manager contract.

Reporting of compensation schemes - exit packages 2025/26

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**2**	**2**
Total cost (£)	£0	£32,000	**£32,000**

No special payments were made during 2025/26.

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**2**	**2**
Total resource cost (£)	£0	37,000	**£37,000**

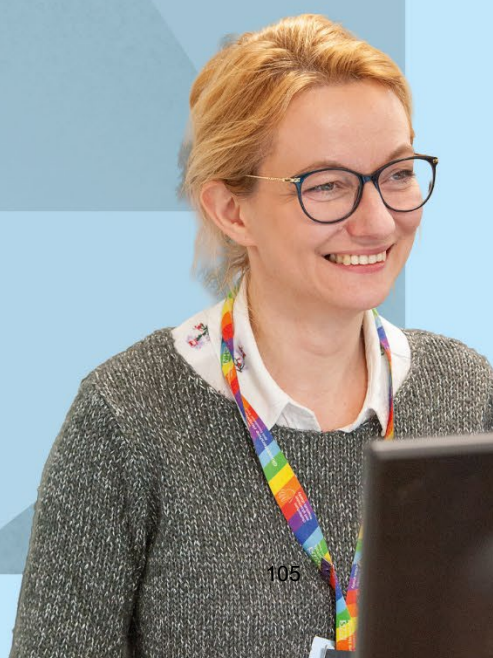
No special payments were made during 2024/25.

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	32	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	7
Non-contractual payments requiring HMT / DHSC approval	-	-	1	30
Total	**2**	**32**	**2**	**37**
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Accountability Report:

Code of Governance



Code of Governance for NHS provider trusts

The Code of Governance for NHS Provider Trusts (the Code) was published in October 2022 and has been applicable since 1 April 2023. It sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts) on a comply or explain basis, reflecting developments in UK corporate governance and the development of integrated care systems.

Disclosures are made throughout the Annual Report as required by the Code and NHS England's Foundation Trust Annual Reporting Manual.

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving standards of corporate governance and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. The Code is implemented through key governance documents and policies, including:

- The Constitution
- Standing Orders and Standing Financial Instructions
- Schedule of Reserved Matters
- Annual Plan
- Board Committee Structure

Trust Board

The Board is responsible for strategic oversight and management of the Trust, with a view to maximise success for the benefit of members and the public as a whole.

The Board comprises Non-Executive Directors and Executive Directors, as detailed in the Directors' Report.

Meetings and attendance throughout the year

The number of meetings of the Board in public and individual members' attendance for 2025/2026 is detailed below.

Member	Role	Meetings held	Meetings attended
Deborah Evans	Chair	6	5
Vareta Bryan	Non-Executive Director	6	3
John Cappock	Non-Executive Director	6	6
Sam Foster	Non-Executive Director	6	5
Marie-Annick Gournet	Non-Executive Director	6	3
Balvinder Heran (left May 2025)	Non-Executive Director	0	0
Jaki Meekings-Davis (leave of absence December 2025)	Non-Executive Director	4	4
Mike Napier (left May 2025)	Non-Executive Director	0	0
Sally Moyle (appointed May 2025)	Non-Executive Director	6	5
John Noble (appointed May 2025)	Non-Executive Director	6	5
Shawn Smith (appointed December 2025)	Non-Executive Director	1	1
Kaye Law-Fox	Associate Non-Executive Director/ Chair, GMS	6	6
Raj Kakar-Clayton	Associate Non-Executive Director	6	6
Andrew Champness	Associate Non-Executive Director	6	5
Kevin McNamara	Chief Executive	6	6

Will Cleary-Gray	Director of Improvement and Delivery	6	6
Matt Holdaway	Chief Nurse, Director of Quality	6	6
Karen Johnson	Director of Finance	6	6
Mark Pietroni	Medical Director, Director of Safety	6	6
Claire Radley	Director for People and Organisational Development	6	5
Al Sheward	Chief Operating Officer	6	5
Lee Pester	Chief Digital and Information Officer	6	5
Kerry Rogers	Director of Integrated Governance	6	6

Balance and completeness of the Board of Directors

The Executive and Non-Executive Directors of the Board provide a balance and breadth of knowledge, experience and skills appropriate to the needs of the Trust. The Executive Directors have at a senior level considerable NHS experience in a range of areas including finance, medicine, nursing, strategic and operational planning, digital, system partnership working, corporate governance, research and workforce development. Their expertise is complemented by the Non-Executive Directors who have extensive private and public sector experience in clinical practice, business, commerce, banking, accounting, audit, research, management and leadership, marketing, NHS service provision, health care and social policy, and local enterprise.

The Governance and Nominations Committee and the Appointments and Remuneration Committee, referred to below, consider the balance and breadth of knowledge, experience and skills required on the Board at each appointment and reappointment of directors and have ensured the maintenance of a balanced and complete Board throughout the year.

The Board maintains a Schedule of Matters Reserved which sets out those decisions that are reserved to the Board ad those delegated to committees and executive management.

Board Committees

The Board's committee structure is comprised of:

- Statutory Committees
    - Appointments and Remuneration Committee
    - Audit and Assurance Committee
- Non-Statutory oversight and assurance committees
    - Finance and Resources Committee
    - People and Organisational Development Committee
    - Quality and Performance Committee

Committee Terms of Reference are publicly available on the Trust's website and are reviewed annually. They can also be accessed by contacting the Trust's Corporate Governance team.

A summary of the role of each Board Committee is provided below, and the number of committee meetings and individuals' attendance are also provided.

Appointments and Remuneration Committee

The role of the Remuneration Committee in setting senior managers' remuneration is detailed in the remuneration report, along with its meetings and attendance in 2025-2026. In addition, the Committee is responsible for reviewing the performance and succession planning of the Chief

Executive Officer and Executive Directors. The frequency of meetings and attendance for this Committee is contained within the Remuneration Report.

Audit and Assurance Committee

The Audit Committee is responsible for reviewing the adequacy of the governance, risk management, and internal control processes within the Trust, as described in the annual governance statement. The Committee also reviews and approves the annual external audit, internal audit, and counter fraud work plans, financial reporting and control arrangements, risk management processes, and the Trust's Annual Report and Accounts.

During the year, the Committee reviewed the integrity of the financial statements and considered significant accounting issues. It also, at each meeting, reviewed the internal audit programme and findings lending its support to ensuring proactive engagement with the internal audit process.

A review of the effectiveness and independence of the external auditor was not undertaken during 2025-2036 but is planned for Quarter 2, 2026-2027 with a report to the Council of Governors in September 2027.

In its meeting in June 2026 the Committee considered the Annual Report and Accounts and was satisfied that the Annual Report, particularly the Annual Governance Statement, is fair, balanced and understandable.

The Audit and Assurance Committee met 5 times during 2025-2026. Attendance in (x) indicates the meetings during the year for which the director was a member of the Committee.

Member		Meetings held	Meetings attended
John Cappock (Chair to December 2025)	Non-Executive Director	5(4)	4
Sam Foster	Non-Executive Director	5(4)	4
Jaki Meekings-Davis (to December 2025)	Non-Executive Director	5(3)	2
John Noble	Non-Executive Director	5(4)	4
Shawn Smith	Non-Executive Director	5(1)	0
Mike Napier (to May 2025)	Non-Executive Director	5(1)	1
Karen Johnson	Director of Finance	5	5
Kerry Rogers	Director of Integrated Governance	5	5

Finance and Resource Committee

The Committee considers annual financial plans, financial and operational performance, and delivery and effectiveness of transformation programmes and has delegated authority for recommending or approving major business cases in accordance with the Trust's standing financial instructions.

The Finance and Resource Committee met 9 times during 2025-2026. Attendance in (x) indicates the meetings during the year for which the director was a member of the Committee

Members	Meetings held	Meetings held	Meetings attended
Jaki Meekings-Davis (to December 2025)	Non-Executive Director/Committee Chair	9(6)	6
Deborah Evans	Non-Executive Director	9	7
Mike Napier (to May 2025	Non-Executive Director	9(0)	0

John Cappock	Non-Executive Director (Committee Chair from December 2025)	9	8
Sally Moyle	Non-Executive Director	9	7
John Noble	Non-Executive Director	9	9
Shawn Smith	Non-Executive Director	9(3)	3
Karen Johnson	Director of Finance	9	7
Kevin McNamara	Chief Executive	9	7
Will Cleary-Gray	Director of Strategy and Transformation	9	8
Lee Pester	Chief Digital and Information Officer	9	8
Al Sheward	Chief Operating Officer	9	7
Kerry Rogers	Director of Integrated Governance	9	6

People and Organisational Development Committee

The Committee provides assurance to the Board that the People Strategy supports the corporate aims of the Trust and that key People, Workforce and Equality, Diversity and Inclusion strategies are being delivered. It provides the Board with assurance that risks associated with attraction, retention, and all workforce and people issues have been identified and appropriately controlled.

The People and Organisational Development Committee met 5 times during 2025-2026. Attendance in (x) indicates the meetings during the year for which the director was a member of the Committee

Member		Meetings held	Meetings attended
Marie-Annick Gournet (Chair)	Non-Executive Director	5	4
Vareta Bryan	Non-Executive Director	5	4
Deborah Evans	Chair, Non-Executive Director	5	5
John Cappock	Non-Executive Director	5(2)	2
Claire Radley	Director for People and OD	5	5
Matt Holdaway*	Chief Nurse and Director of Quality	5	0
Mark Pietroni*	Medical Director and Director of Safety	5	3
Karen Johnson*	Director of Finance	5	0
Al Sheward*	Chief Operating Officer	5	0
Kerry Rogers	Director of Integrated Governance	5	3

Attendance as required for specific reports *

Quality and Performance Committee

The Committee provides assurance to 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 and that risks to the quality of clinical care and to the safety of the Trust's staff, patients, their families, and visitors have been identified and appropriately controlled. The Committee oversees the delivery of the Trust's key quality and safety strategies.

The Quality and Performance Committee met 5 times during 2025-2026. Attendance in (x) indicates the meetings during the year for which the director was a member of the Committee

Member		Meetings held	Meetings attended
Sam Foster (Chair)	Non-Executive Director	10	10
Mike Napier (to May 2025)	Non-Executive Director	10(1)	1
Vareta Bryan	Non-Executive Director	10	7
Kevin McNamara*	Chief Executive	10	9

Matt Holdaway	Chief Nurse and Director of Quality	10	9
Mark Pietroni	Medical Director and Director of Safety	10	7
Al Sheward	Chief Operating Officer	10	9
Kerry Rogers	Director of Integrated Governance	10	7

Council of Governors

The Council of Governors' role is to hold Non-Executive Directors to account for the performance of the Board of Directors and influence the strategic direction of the Trust to ensure it reflects the views and needs of our members, the local community, and key stakeholders.

Key decisions taken by the Council of Governors include:

- Appointing or removing the Chair, Non-Executive Directors, and Chief Executive Officer;
- Determining the remuneration and other terms and conditions of office of the Chair and Non-Executive Directors
- Appointing or removing the Trust's external auditor
- Approving significant transactions
- Approving any changes to the Trust's Constitution.

Governors are encouraged to canvass opinions and concerns of the members they represent at a series of public constituency meetings (promoted as 'health events'), particularly on the Trust's plans, priorities, and strategies. They also canvass opinion at other Trust events, both formal and informal, and via their own initiatives and networks. Governors' and members' views are fed back to the Board at quarterly Council of Governors meetings and at other meetings with Directors, or directly, via the Chair or individual communications as appropriate.

Members can contact their respective governor using the **contact a governor form** which is available on the website and is promoted to members through bulletins and other communications they receive.

The link forwards a message to an inbox which is managed by the Corporate Governance team, for the relevant Service to provide a response. The Governor is kept informed of the progress of the enquiry and the outcome.

Members can also contact their governor by writing to the Trust Secretary at Gloucestershire Hospitals NHS Foundation Trust, Trust Headquarters, Sandford Road, Alexandra House, Cheltenham, GL53 7AN.

General Council meetings are open to the public and details are published on the website together with the papers and minutes of the meetings.

The Council of Governors is comprised of Public Governors (elected), Staff Governors (elected), and Stakeholder Governors (appointed).

In accordance with the Code, and the Trust's Constitution, Governors may be elected or appointed for a maximum of three consecutive terms of three years (total nine years). The composition of our Council of Governors is set out in the table below.

The lead Governor for 2025/2026 was Andrea Holder.

Constituency	Governor	Tenure	Meeting Attendance	
			Council of Governors	Governance and Nominations Committee
Public Governors				
Cheltenham Borough Council Area	Mike Ellis	Oct 2021 – Oct 2024 Oct 2024 – Oct 2027	4/4	4/4
	Peter Mitchener	Oct 2022 – Oct 2025	2/2	2/2
	Nicola Hayward	Oct 2025 – Oct 2028	1/2	-
Cotswold District Council Area	Bryony Armstrong	Sept 2023 – Sept 2026	2/4	-
	Douglas Butler	April 2024 – Sep 2026	3/4	-
Forest of Dean District Council Area	Angharad Watson	Sept 2025 – Sept 2028	2/2	-
	Vacancy			
Gloucester City Council Area	Emma Mawby	Apr 2024 – Sept 2026	3/4	-
	Fiona Hodder	Oct 2022 – Oct 2025 Oct 2025 – Oct 2028	4/4	-
Stroud District Council Area	Deborah Balkwill	Oct 2024 – Oct 2027	3/4	-
	Pat Eagle	Oct 2016 – Oct 2019 Oct 2019 – Oct 2022 Oct 2022 – Oct 2025	2/2	-
	Gwyn Morris	Oct 2025 – Oct 2028	1/2	0/2
Tewkesbury Borough Council Area	Ian Craw	April 2024 – Sep 2026	2/4	
	Andrea Holder (lead governor)	Oct 2021 – Oct 2024 Oct 2024 – Oct 2027	3/4	3/4
Out of County	Vacancy			
Staff Governors				
Allied Healthcare Professionals	Samantha Bostock	April 2024 – Sep 2026	2/4	-
Medical/Dental Staff	Russell Peek	Oct 2020 – Oct 2023 Oct 2023 – Oct 2026	3/4	1/4
Nursing/Midwifery Staff	Bilgy Laurence Pellissery	Oct 2023 – Oct 2026	1/4	-
	Asma Pandor	Oct 2022 – Oct 2025 Oct 2025 – Oct 2028	4/4	-
Other/Non-Clinical Staff	Oliver Warner	Oct 2023 – Oct 2026	3/4	-
Appointed / Stakeholder Governors				
Gloucestershire County Council	Kate Usmar	July 2025 – July 2028	1/3	-
Healthwatch	Debs Andrew	Mar 2026 – Mar 2029	0/0	-
Age UK Gloucestershire	Helen Bown	Oct 2023 - Oct 2026	3/4	-
VACANCY				

Governance and Nominations Committee

The Governance and Nominations Committee is responsible for assessing the Board's structure, size, composition, and performance, identifying and nominating Non-Executive Directors for appointment to the Board, and reviewing Non-Executive Directors' remuneration. The Nominations Committee considers any new non-executive appointments as necessary. The Committee's duties include consideration of equality, diversity and inclusion issues as and when required, to ensure that diversity of the Board reflects diversity of the Trust's workforce and wider membership.

The Committee supports the Board and Council of Governors in ensuring robust succession planning, transparent and merit-based appointments and open recruitment processes. It ensures that appointments are made in accordance with the principles of fairness, openness and merit.

Where a Non-Executive Director vacancy is identified, the Governance and Nominations Committee meets to agree the vacancy role profile, person specification, and recruitment process. The vacancy is then advertised, supported by Trust HR and external recruitment agencies where required. The Committee then shortlist and its members are involved in the interview of potential candidates, taking the views of stakeholders into account. Following interviews, the Governance and Nominations Committee recommends their selected candidate to the Council of Governors for appointment.

During the period of this annual report, the Governance and Nominations Committee had oversight of the appointment of a non-executive director following the decision by one of our Non-Executive Directors to take a leave of absence. This was to address the need for continued non-executive expertise in finance, accountancy and audit. It is confirmed that the Non-Executive Director who had taken a leave of absence during the reporting period will be taking up her second term of office from June 2026.

Relationship with the Board

All Board members are invited to attend Council of Governors' meetings in order to gain an understanding of the views of the Trust's Governors and members. The Council of Governors may require individual Directors to attend for the purpose of providing assurance or to report on progress of any key matters of interest, in accordance with Schedule 7 of the National Health Service Act 2006.

The Board reports to the Council of Governors on the performance of the Trust and its progress against agreed strategic and corporate objectives and consults on its forward plan.

In the event of a dispute or disagreement between the Council of Governors and Board of Directors, in the first instance the Chair would endeavour to resolve this. Should a resolution not be reached, then a disputes resolution process would be engaged, as described in the Trust's Constitution. An Engagement Policy was approved by the Council of Governors in December 2025 which will support the relationship between the Council and Board during the period of transition envisaged as a result of the announcements within the NHS 10-year plan regarding the statutory role of the Council of Governors.

The Council of Governors' process for appointing the Chair and Non-Executive Directors is detailed in the Trust's Constitution and supported by the work of the Governance and Nominations Committee.

Governance Working Group

The Governance Working Group is a forum consisting of governors and board members, including the Chair and Director of Integrated Governance, responsible for the review of the Trust's Constitution and periodic review of other governance matters as required, and recommending changes or required action for agreement by the Board and Council of Governors. It also considers ways in which to encourage engagement with and of the wider community. It provides a focus on issues relating to both the quality and staff agenda.

Decision-making framework

The Trust's Constitution contains a schedule of decisions reserved for the Board, Council of Governors, Committees, individual Directors, and other individuals with delegated authority. More detail is provided in the Board's Reservation of Powers and Scheme of Delegation, and individual

committee Terms of Reference. All documents relating to the Trust's decision-making framework are reviewed at public meetings of the Board or Council of Governors and are available on the Trust's website.

External Audit

The Trust's external auditor is currently Deloitte. They were initially appointed by the Council of Governors on a three-year contract commencing in financial year 2020/21, which was further extended by 2 years. Deloitte were re-appointed for a period of three years, with the option to extend this by a further 2 years, starting from financial year 2025/26.

The Audit and Assurance Committee did not undertake an annual review of effectiveness of the external auditor during 2025-2026, with a comprehensive review being planned for 2026-2027.

No non-audit services were undertaken by Deloitte in the year 2025-26.

Internal Audit

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services, BDO United Kingdom. In September 2024, the Trust, alongside other Integrated Care System partner organisations, exercised an option to extend the contract for a period of two years. The role of the internal auditor is to provide independent, objective assurance on the risk management, control, and governance processes within the Trust, through a systemic approach to evaluation and improvement of such processes. The internal audit team agrees a programme of work with the Audit and Assurance Committee and provides reports to the Committee during the year.

Compliance with the Code of Governance:

The Trust has applied the principles of the NHS England Code of Governance for Provider Trusts (2022) for the reporting period 2025-2026 on a 'comply or explain' basis.

Whilst the Trust believes it remains compliant with the majority of the provisions of the Code it is recognised there are areas where the Trust needs to strengthen compliance. The following provisions are highlighted in order to explain the areas we feel there is further work to undertake to evidence full compliance.

Appendix C: Provision 5.6

The Trust had identified opportunities to reinstate a more focused training and development programme for governors. All governors received a welcome and introduction/induction session on appointment along with a copy of the governor handbook and code of conduct. Meetings with the Chair, Chief Executive and Director of Integrated Governance, alongside a bespoke induction session for new governors in the period of this report have emphasised the statutory role but it is recognised that the proposed implementation of the Health Bill (NHS Modernisation Bill 2026) has impacted the advancement of the training programme.

Appendix A, Section C, Provisions 2.9, 4.4, 4.8 Appendix B, Provisions 2.1 and 2.2

It was intended that the Trust, in conjunction with its Council of Governors, would undertake a review of the Trust's Constitution. However, with the announcement within the NHS 10-year plan as to the proposed abolition of the statutory function of the Council of Governors it was determined that this should be delayed until the relevant legislation was implemented.

The Trust complies with all relevant provisions of the Code except where stated above. Where departures from the Code have occurred, the Audit Committee, on behalf of the Board, has considered these carefully and is satisfied that alternative arrangements remain consistent with

the underlying principles of good governance, including effective leadership, accountability, and oversight.

Accountability Report:

Statement of Accounting Officer's Responsibilities

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Gloucestershire Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Gloucestershire NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Gloucestershire NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

• observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

• make judgements and estimates on a reasonable basis

• state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

• ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

• confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and

• prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Kevin McNamara
Chief Executive Date: 25 June 2026

Accountability Report:

NHS Oversight Framework

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments.'

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) considering financial override which may limit a segment to be no better than 3

c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) capability assessments which consider the organisation's leadership and governance.
Segmentation

Under the NHS England National Oversight Framework, trusts are segmented quarterly using a nationally defined set of performance, quality, workforce and financial metrics. During Quarter 2 (July–September 2025), the Trust was placed in Segment 1, reflecting strong performance across the metrics and a stable national position.

Based on the most up-to-date information available at the time of preparing this Annual Report, the Trust was placed in Segment 3 at Quarter 3 (October–December 2025). This reflected a temporary and immaterial deviation to the financial plan at Month 9, arising primarily from the impact of resident doctors' industrial action and associated unfunded costs during this period.

This segmentation was driven by the application of a national financial override rather than a deterioration in the Trust's overall operational, quality or leadership performance, which remained strong across many indicators. The industrial action costs were subsequently funded, and the Trust remained on track to deliver its planned year-end financial position. The year end position was that the Trust returned to segment 2 for Quarter 4.

No formal enforcement action was taken by NHS England in respect of this Quarter 3 segmentation, and no additional regulatory interventions were initiated during the year.

This segmentation information is the trust's position as at 31 March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables/

The trust is included on the acute hospital trust dashboard.

Accountability Report:

Annual Governance Statement

Annual Governance Statement

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS foundation trust accounting officer memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gloucestershire Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gloucestershire Hospitals NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The Board of Directors has overall responsibility for risk management. This includes the identification and effective management of emerging and principal risks to the achievement of the Trust's strategic objectives. The Board is supported in this by a board committee structure and governance processes. These strategic risks are captured on and managed through the Board Assurance Framework (BAF), which provides a structured summary of the Trust's principal risks, the controls in place, sources of assurance and planned mitigating actions. The Board Assurance Framework is reviewed regularly by the Board and its committees. The Board is also responsible for ensuring that effective systems and processes for managing risk are in place across the organisation.

As Accounting Officer, I ensure that sufficient resources are invested in managing risk. I am supported in this role by the Director of Integrated Governance who is the executive lead for governance and risk management.

Executive Directors are collectively responsible for the identification, assessment and management of risks within their portfolios and regularly report to the Board and board committees via the Board Assurance Framework mechanism.

All clinical divisions' senior management teams have a leadership responsibility for risk management within their own areas and are accountable to the Board through regular reporting.

Non-Executive Directors receive regular updates on strategic and operational risks through Board and committee reporting, providing appropriate scrutiny and challenge. Risk management is embedded through training, guidance, and routine governance processes, with staff supported to identify and manage risks appropriate to their roles.

Whilst monitoring of the Trust's risk management processes and control systems is very much embedded in the 'business as usual' work of both the Board and assurance

committees the Trust also undertakes an annual review of both the Terms of Reference and effectiveness of the individual assurance committees.

Operational and clinical risks are regularly reviewed, by the Risk Management Group, chaired by our Director of Integrated Governance. The Risk Management Group reports to the Audit and Assurance Committee, chaired by a Non-Executive Director. The review of relevant Trust Risks informs the review of the Trust's Strategic Risks within the Board Assurance Framework.

Recognising the significance of information governance, I am supported by both the Medical Director, as Caldicott Guardian, and our Chief Digital Information Officer, who hold responsibility for the correct use of patient identifiable information and protecting the confidentiality of patient's health information. Our Chief Digital Officer, as the Trust's Senior Information Risk Owner, is responsible for all information risks within the Trust. Both individuals have undertaken the necessary training to discharge their responsibilities effectively.

Training and equipping staff to manage risk.

The identification and subsequent assessment and management of risk is the responsibility of all staff, from ward to board. The Trust's mandatory training programme which forms part of the staff induction, includes responsibilities and processes relating to risk management. Compliance with mandatory training is reported through workforce performance data in the Integrated Performance Report to Board and its relevant committees and operationally, via the monthly and quarterly Executive Review programme.

With the launch of the Trust's refreshed Strategy (for 2025-2030) in Autum 2025, additional training was provided to the Board and senior managers on risk management, specifically the redesign of the Board Assurance Framework and realignment of the risk appetite. Divisional staff receive training on operational risk management as required in relation to their specific responsibilities.

Our staff are supported to manage risk based on their responsibilities, through the Trust's Risk Management Framework and further guidance including intranet resources, updates and divisional governance meetings. Staff are supported by our Risk, Health & Safety team, who provide advice and support to staff on all aspects of risk management. Training on risk management is provided through a number of different programmes including face to face training, online modules, guidance notes including the Risk Register Guide and risk management resources provided on the intranet. Divisions and Services can also seek the support of the team on specific risk issues. Specific guidance includes:

- Risk appetite and risk tolerance
- The difference between a risk and an issue
- Risk registers and how risks are managed within divisions, including managing actions designed to mitigate risk.
- Inherent risks, cause and effect
- Controls and gaps in controls
- Risk categories and risk rating (initial, current and target)
- How risks are managed on Datix, the Trust's web-based system for reporting and managing incidents and risks

In 2025-2026, risk management training was delivered through a combination of face-to-face sessions, online modules and targeted divisional support. Completion and coverage are monitored through the Trust's mandatory training and governance reporting routes, and feedback from divisions is used to refine content and focus on areas where risk identification, scoring or escalation require strengthening.

The Risk Register Guide is a document that contains step by step directions on raising a risk, scoring, evidencing, managing and reviewing the risk and how to escalate the risk on our registers. The Risk Management Framework sets out the governance process around risk also.

The risk and control framework

The Trust's risk profile during 2025/26 has been characterised by sustained system pressures across urgent and emergency care, workforce capacity and infrastructure resilience, alongside delivery of strategic transformation priorities. These pressures are reflected consistently across the Performance Report, Board Assurance Framework and Corporate Risk Register, and are actively managed through established governance and assurance processes.

Risk Management strategy and policy

The Board recognises that a significant proportion of the Trust's risks arise from wider system pressures, including demand for urgent and emergency care, patient flow constraints and workforce supply challenges. These risks are evidenced within the Performance Report through Emergency Department performance, ambulance handover metrics and elective recovery trajectories, and are managed through structured improvement programmes and system partnership arrangements.

The Trust's risk management strategy supports the delivery of the Trust's strategy and objectives and sets out the approach to identifying, assessing, recording and managing risk within our Risk Management Policy.

The Board sets the Trust's risk appetite, aligning it with statutory and regulatory requirements and the Trust's commitment to safe, high-quality patient care and financial sustainability. The risk appetite was refreshed during the year to reflect the updated Trust Strategy for 2025–2030 and will be subject to ongoing review to ensure that it is embedded in risk decision making.

Risk appetite is articulated through a set of appetite statements by risk domain (for example: quality and safety, workforce, finance, estates and digital), supported by a common scoring matrix defining consequence and likelihood. For each strategic and operational risk, an initial (unmitigated) score, current score and target (tolerable) score are agreed, with the target score reflecting the desired level of risk once mitigated to as low as is reasonably practicable. Appetite is embedded through: (i) the requirement that new and emerging risks specify alignment to appetite and rationale for any residual exposure; (ii) escalation triggers where risks remain outside tolerance or where trajectory deteriorates; and (iii) committee scrutiny of mitigations and assurance where risks sit at or above appetite. The Board Assurance Framework (BAF) provides the primary mechanism for monitoring whether principal risks are being managed within appetite and for directing additional mitigations where required.

The Risk, Health and Safety team are responsible for facilitating risk management processes across the Trust, providing specialist advice and support to staff to identify, assess, record and manage risks in accordance with the risk management policy. This work, supporting divisional colleagues, informs the review and management of the Trust's strategic risks as set out within the Board Assurance Framework.

The identification and management of risk is a responsibility for all staff, and this is achieved through the use of the Datix risk management system, local, divisional and corporate risk registers and the regular review of those registers. Each risk is assessed and scored, based on both consequence and likelihood of realisation with an initial score and a target tolerable

score aligned to the Trust's risk appetite. This, in turn, informs the prioritisation of resource with the aim to address and mitigate risk as appropriate. The Trust aims to reduce all risks to a tolerable level through mitigation actions. The route of escalation for the management of risks commences with the individual risk managers, through the speciality and divisional structures to both executive management groups and board assurance committees, as appropriate.

Board Assurance Framework

The Board is responsible for the identification, assessment and monitoring of the strategic risks via the Board Assurance Framework mechanism, with regular reports to Board and Board committees. Board Committees scrutinise risks relating to their areas of oversight and risk domains throughout the year as follows:

- Quality and Performance Committee: Oversight of patient safety, quality, patient experience and statutory & regulatory clinical governance risks.
- People and Organisational Development Committee: Oversight of workforce, equality, diversity and inclusion, and health and safety (staff).
- Finance and Resources Committee: Oversight of finance and business, digital, cyber and data security, and risks relating to estates and facilities, and the subsidiary company Gloucestershire Managed Services (GMS).
- Audit and Assurance Committee: Responsible for scrutinising the overall systems of internal risk management and oversight processes, both in relation to operational and strategic risks.

The Board Assurance Framework acts as the Trust's primary mechanism for ensuring that the Board receives assurance that the Trust is actively pursuing its corporate objectives and the risks to these objectives are being treated and mitigated. It enables the Board to understand the risks which have the potential to impact on the organisational strategic objectives and how these are being managed. It is regularly reviewed by Executives, board committees and the full Board.

The implementation, at the start of the year, of the Trust's Health and Safety Management Framework which created a new health and safety governance structure codified the Trust's continued focus on health and safety, both operationally and from a governance perspective. In turn this prompted the escalation of the issue as a risk to the Board Assurance Framework. This decision reflected the Board's continued focus on managing this risk to patient services, safety and the well-being of staff.

During 2025/26, the Trust refreshed its five-year strategy (2025–2030), which led to a realignment of strategic risks within the Board Assurance Framework. This has strengthened the alignment between strategic objectives, principal risks, operational delivery and performance reporting, ensuring a clear line of sight between strategy, risk management and assurance.

An overview of the Trust's strategic risks is provided below: (these are split into two tables; the first for the period April-December 2025 and the second sets out the realigned risks following the implementation of the Trust's new Strategy in January 2026.

Board Assurance Framework: April – December 2025	
Strategic Risk	Key controls applied
Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	• Range of work programmes to support with managing demand internally and with system partners. • Trust Flow and Escalation Policies. • Urgent Emergency Care and Flow Improvement Board established and reporting monthly to Quality & Performance Committee

	• Clinical Vision of Flow Programme established and operational • Improvement dashboard being utilised with standardised data set considered 'business as usual'
Failure to successfully implement the quality governance framework	• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • Monitoring of performance, access and quality metrics via Quality & Performance Report • Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report • Quality Strategy (insight, involve, improve) • Risk Management processes • Quality priorities and reporting through Quality Account • Executive Review process
Workforce Culture Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve	• Staff Experience Improvement Programme: o Leadership and Team Working o Anti – Discrimination o Raising Concerns and Speaking Up o Taskforce o Colleague Communications and Engagement o Restorative Just principles and practice, four steps approach and people polices and processes • Divisional colleague engagement plans • EDI Development Plan – specific work with the Divisions • Steering Groups o Health and Wellbeing Steering Group o EDI Steering Group o ELD Steering Group o Local Mandatory Training Oversight Steering Group
Recruitment and Retention Inability to attract a skilful, compassionate workforce that is representative of the communities we serve	▪ International recruitment pipeline – doctors, midwives and AHPs ▪ UK RN graduate cohorts ▪ Increased apprenticeships, TNA Cohorts and student placement capacity ▪ Advanced Care and other alternative speciality roles ▪ Accreditation of Preceptorship module ▪ Annual workforce Operational Plan submission to NHSE, integrated with the ICB ▪ Wide-reaching Workforce Sustainability Programme ▪ Focussed hard to fill recruitment plans ▪ Innovative marketing and attraction strategies ▪ Improved time to hire and customer experience
Failure to implement effective improvement approaches as a core part of change management	• Quality and Performance Committee Report to Board • Strategy and Transformation Board Report to Board • PSIRF implementation that requires a prioritised approach
Individual organisational priorities and resources are not aligned to deliver integrated care	• System wide development and agreement of Operational Plan (2024/25) • Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU • System Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.

	• Delivery Group exception reporting (Maternity, Quality, Unscheduled Care, Planned Care and Cancer) • Urgent and Emergency Care (UEC) boards at System and Acute Provider level • Monitoring of key performance metrics via Quality and Performance Report (QPR) GHFT • Efficiency Board in place • ICB attendance at Q&P Committee • Triumvirates in place for the Operational/Clinical Divisions
Failure to deliver recurrent financial sustainability	• Internal Trust communication regarding the financial position – clearly articulating the why and what we need to focus on during the financial year • Workplan - engagement on the long-term operational and financial plan. • National grip and control assurance checklist review and actions identified where gaps appear with a tracker to capture progress. • A Trust wide non pay oversight group has been established which looks at in year issues and year on year changes to identify areas of opportunity for each division. • Understanding the drivers of the deficit – an exercise has been completed in December to understand the drivers which will be used to help explain the organisational position and to seek areas of opportunity. • Quarterly executive reviews to focus on forward planning, not the here and now. This will need to evolve into longer term planning. • Corporate executive review to ensure all areas are held to account in terms of delivery of the Financial Sustainability Programme. • Financial Sustainability Programme targets communicated to divisions and corporate areas. • Senior representation of the Trust at System transformational programmes through a portfolio structure. This focuses on end-to-end pathway redesign to drive out duplication and reduce cost. • Regular reporting to the System governance process to provide further oversight.
The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance	• Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk • All NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas • Improved risk reporting of estates risks through GMS, RMG, Committee, Board & ICS • Indicative 5-year estates capital programme to provide assurance & timescale of when highest risks will be addressed, but with agile component allowing for national funding support and required failure mitigations • Exploring options to dispose of estate with capital receipt used to address backlog risks (whilst assessing the IFR16 implications on leased accommodation) • Developing 'library' of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes • Improved awareness across ICS partners of level of risk GHFT is carrying across estate and equipment via monthly meetings taking place.

	• Explore commercial/strategic partnerships to support the investment in the estate to support • Estates operational team created process for evaluating prioritising backlog maintenance • Asbestos Management Survey completed for main sites • Authorising Engineers appointed across all disciplines
Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	• All new strategic estate schemes designed to meet BREEAM good (refurb) or excellent (new build) ratings • Continue to pursue external grant funding (Public Sector Decarbonisation Scheme – PSDS) to retrofit existing buildings and migrate energy supplies away from fossil fuels • Invest in GHFT electrical infrastructure to support transition to Hybrid and Electric Vehicles (EV)for i) GHFT/ ICS fleet ii) visitors and colleagues • Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into F&R Committee • ICS Sustainability Group established to oversee delivery of ICS Green Plan (Statutory requirement)
Failure to detect and control risks to cyber security	• The Trust participates in the national NHS Cyber Security Programme, gaining access to shared defences, guidance and coordinated threat intelligence. • A range of protective measures are in place across Trust systems, including strengthened access controls, network protections and modern endpoint security tools. • Backups of key systems are securely stored and regularly reviewed to support recovery following a cyber incident, though further assurance work is ongoing. • The Trust is delivering a programme to replace or upgrade older and unsupported systems, reducing exposure to known vulnerabilities. • Work is progressing to improve visibility and oversight of connected devices, including medical and Internet of Things equipment, to ensure risks are better understood and managed. • The Information Asset Owner (IAO) structure provides accountability for data and system security, though consistency of assurance continues to develop. • Business continuity and disaster recovery plans exist for key systems and are being strengthened and tested to improve readiness for cyber or technical disruption. • The Trust continues to meet DSPT standards and align its approach with the NHS Cyber Assessment Framework, using these as benchmarks for improvement. • Cyber awareness and training activities support staff to recognise and respond appropriately to threats, with further work planned to reach harder-to-engage groups. • Supplier assurance checks are undertaken to confirm that external partners meet NHS security and data protection requirements, with ongoing review of higher-risk suppliers. • The Cyber Security Team maintains continuous oversight and reporting through established governance routes, providing visibility of progress and areas needing further attention.

Inability to optimise digital systems functionality and progress as a digital Trust	• Sunrise Clinical wrap aims to be single source of clinical information, • Data Warehouse provides one version of the truth supporting clinical and operational dashboards used for planning across the ICS. • ITIL (IT best practice) operating standards in place to support incidents, requests, and technical change processes • Implementations must provide quantifiable benefits; financial, patient care and/or safety benefits – and reduce risk • Programme Management Office and defined programme processes • Digital embedded in business planning, annual planning • Clinical safety governance and oversight • Tactical environmental monitoring • Maturing Digital governance model • Software Interface/integration technology to help data flow across systems
Failure to invest in research active departments that deliver high quality care	• Continual review of Research Office processes by Senior RIG Team • RIG Team working with interested clinical teams to support them • RIG Team to support training and educational development of Trust staff • RIG Team linking with Division Leads more effectively

Board Assurance Framework January to March 2026	
Strategic Risk	Key controls applied
Patient experience and voice – our goal is to put patient experience and feedback as the main influencing factors drawn upon to shape and re-shape their services	
Failure to engage and involve patients, carers and communities in shaping services and experience	• Engagement and Involvement Strategy • Annual review of engagement and involvement • Annual engagement tracker • Annual Member's Meeting • Significant stakeholder engagement in developing the new Trust five-year strategy (2025-30) • One Gloucestershire approach to public involvement – codesign of 'Working with People & Communities' Strategy • Significant success and progress of the Young Influencers Group • Development and publication of Proud to Care. • Development and tracking of digital systems, including patient leaflets and advice
People, culture and leadership – our goal is to enhance staff experience and sustainability in an organisation where everyone can flourish	
Inability to attract and sustain a skilled, diverse and adaptable workforce may lead to skills shortages, reduced service quality, reduced operational productivity, and increased costs.	• High quality recruitment and on-boarding • Innovative marketing and attraction strategies • Vacancy controls • Focus on temporary staffing • Pay controls • Production and monitoring of quality workforce data • Workforce sustainability programme
Inability to retain a skilled, compassionate and diverse workforce that reflects the	• Staff Experience Improvement programme • Culture Heatmap • EDI Development plan

communities we serve because of a poor cultural environment and lack of development opportunities, impacting overall staff experience	• Steering Groups and Oversight Groups • Leadership and management development • Reward and Recognition programmes
Quality, safety and delivery – our goal is to provide timely and responsive, high-quality, safe and effective services always for everyone	
Inability to deliver safe and effective services against regulatory and statutory requirements	• Board Assurance Framework • Effective quality governance and clinical services strategy • Risk management and risk registers • Learning from deaths • Patient Safety Response Framework • External regulatory enforcement, special measures/enhanced support, system oversight • Quality improvement and current evidence based clinical practice guidelines • Quality priority development and reporting • Safer staffing audits • Effective complaint management (Regulation 16) • NHSE Experience of Care Improvement Framework
Failure to meet statutory and regulatory requirements to manage financial resources	• Statutory financial reporting • Trust financial plan • Financial Sustainability Programme • Key financial controls • Payroll controls • Counter-fraud activity and Functional Standard • Finance policies • Reliable systems and data • Effective staff communications regarding financial position of Trust. • Effective forward business planning • Review and rebasing of contractual activity to accurately reflect recurrent costs.
Risk of sub-standard asset condition and estate compliance position impacting safety and experience (staff and patients), historic and current capital investment insufficient to maintain NHS requirements, estates suitability and facilities not supporting high-quality care or optimal patient experience	• Procurement of an external consultant to support development of the Estates Strategy, strategic asset management plan, master plan and development control plan is underway. • Estates data and asset management surveys form part of GMS business plan. • Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk which forms part of the ERIC submission. • All NHSE capital bids include costs to address backlog maintenance risks in immediate and/or linked development areas • Improved risk reporting of estates risks through GMS, RMG, Committee, Board & ICS • Indicative 5-year estates capital programme to provide assurance & timescale of when highest risks will be addressed, but with agile component allowing for national funding support and required failure mitigations
Health & Safety - Failure to implement a robust health and safety governance framework which defines the role of the	• Group H&S Committee Group H&SC • Group Health and Safety Framework agreed and published

board and those in safety leadership, the structure through which the health and safety vision and commitment is set, safety objectives are agreed and the framework for monitoring performance is established with a view to ensuring compliance with legislation	• GMS Compliance reporting moved from Contract Management to Group H&SC • Trust Health & Safety Policy and associated subject-specific policies • GMS Board and health and safety committee • Group H&SC reporting to Trust leadership team, Audit and Assurance Committee and Board • Appointed exec with accountabilities
Digital first – our goal is to support patients and staff to be supported by technology and an innovative culture	
Infrastructure & Cyber – Reliable Digital Foundations There is a risk that the Trust's digital infrastructure and cyber security arrangements may not be sufficiently robust, resilient, connected, or up-to-date to support safe, effective, and continuous service delivery – including a solid platform for digital transformation	• The Trust participates in the national NHS Cyber Security Programme, gaining access to shared defences, guidance and coordinated threat intelligence. • A range of protective measures are in place across Trust systems, including strengthened access controls, network protections and modern endpoint security tools. • Backups of key systems are securely stored and regularly reviewed to support recovery following a cyber incident, though further assurance work is ongoing. • Input into business planning cycle and active risk management • The Trust is delivering a programme to replace or upgrade older and unsupported systems, reducing exposure to known vulnerabilities. • Work is progressing to improve visibility and oversight of connected devices, including medical and Internet of Things equipment, to ensure risks are better understood and managed. • The Information Asset Owner (IAO) structure provides accountability for data and system security, though consistency of assurance continues to develop. • Business continuity and disaster recovery plans exist for key systems and are being strengthened and tested to improve readiness for cyber or technical disruption. • The Trust continues to meet DSPT standards and align its approach with the NHS Cyber Assessment Framework, using these as benchmarks for improvement. • Cyber awareness and training activities support staff to recognise and respond appropriately to threats, with further work planned to reach harder-to-engage groups. • Supplier assurance checks are undertaken to confirm that external partners meet NHS security and data protection requirements, with ongoing review of higher-risk suppliers. • The Cyber Security Team maintains continuous oversight and reporting through established governance routes, providing visibility of progress and areas needing further attention.
Digital Transformation & Culture There is a risk that the Trust may not develop or sustain a digital culture, operating models, software architecture,	• Trust Strategy 2025 – Vision and strategic direction for digital transformation and cultural improvement • Programme Management Office (PMO) – Portfolio oversight for digital transformation programmes, including prioritisation, governance and resource allocation.

skills, and leadership skills necessary to deliver digital transformation at scale and pace	• Risk Management Policy and BAF Process – Quarterly review of strategic risks, linked to operational risk registers and Trust risk appetite. • Workforce Development Initiatives – Digital leadership development and training programmes for clinical and operational teams. • Clinical informatics team and Clinical Safety Officer – provides clinical engagement, assurance and oversight to ensure safe design, deployment and optimisation of digital systems • Integrated Care System (ICS) Digital Governance – Provides system-level coordination, interoperability standards, and shared investment decisions

All the Strategic Risks detailed above were continuously reviewed and overseen by the relevant Board committees. No additional principal risks identified by the Board at the time of writing.

During the year, there were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHSE ratings or Care Quality Commission assessments.

The principle clinical risks identified within the year were:

- Emergency Department flow and capacity, resulting in delayed assessment or treatment. This was despite significant improvements in ambulance handover periods. This issue was and remains the focus of a Service action plan.
- Critical workforce shortages, particularly of interventional radiologists and critical care consultants. Appropriate recruitment and wider focus action plans are in place.
- Maternity risks, in particular delayed triage review/treatment and lack of dedicated maternity ultrasound scanning. An action plan is in place and monitored by both the appropriate delivery group and the Quality and Performance Committee.

Estates related risks have continued to be an area of focus, with a deliberate Group assessment and engagement process (Health & Safety Management Framework) which better incorporates our subsidiary Health and Safety risks and supports earlier identification of emerging risks and development of appropriate controls and mitigations. This has strengthened the Trust's group-wide approach to relevant management systems in areas such as asbestos, water safety and fire safety.

Fire safety and estate compliance risks remain material to the Trust's risk profile. These risks primarily reflect the condition, configuration and age of significant parts of the estate rather than deficiencies in governance or control arrangements. They have been appropriately escalated through established governance processes and are subject to active management through a structured programme of remediation, capital investment and regulatory engagement.

The Trust recognises that effective risk management relies on a range of contributions, and collaborative work is undertaken with many stakeholders to identify risks that may impact on them, including Gloucestershire Integrated Care System, local authorities, Healthwatch, associated charities, patients and carers. We encourage stakeholders to raise concerns or potential risks through engagement opportunities, our Council of Governors, complaints and enquiries, social media commentary, friends and family tests, patient and staff stories

delivered at Board, and patient experience surveys. The Trust values the contribution of system partners including Gloucestershire Integrated Care Board.

Embedding risk management within the organisation

Good practice and learning are shared within the organisation through a range of measures including impact assessments, business continuity plans, risk assessments, incident reporting, safety huddles, routine communications, training, meetings and de-brief sessions. The Trust has a strong culture of safety, aligned to the new national Patient Safety Incident Response Framework (PSIRF). All staff are trained in incident reporting and are encouraged to report and assess all incidents through Datix, to take forward any learning or actions required. Incidents are reviewed on a daily basis through the incident response safety huddle, attended by senior clinicians and managers. Robust governance processes with clear routes of escalation are in place, from Ward to Board to ensure appropriate prioritisation of incidents and risks.

Quality impact assessments are undertaken to assess potential impact of service changes where appropriate, recognising this is an evolving methodology which needs to be consistently embedded. Equality impact assessments are undertaken to assess potential equality risks of service or policy changes, to ensure mitigations are implemented and any potential negative impact removed.

Quality governance arrangements

At the heart of the Trust's strategy and development is the ongoing improvement of the quality of services we provide for our local population. Improving the quality of care and outcomes for patients drives the decisions taken by the Board of Directors and the systems established within the Trust. The role of the Quality and Performance Committee in leading oversight and improvement is set out earlier in this report.

The Board maintains robust clinical/quality governance arrangements to support quality and patient safety across the organisation. Quality governance is delivered through a structured framework of committees with clear terms of reference and reporting lines from service level to Board. Operational quality issues are reviewed through local ward/service and divisional governance structures and divisional quality forums, with escalations to the Quality Delivery Group and for assurance to the Quality and Performance Committee. Issues are escalated onward to the Board via integrated performance and quality reports received by both board committee and Board on a frequent basis.

The quality of performance information is assessed routinely through defined data standards, named data owners, and validation checks (for example, reconciliation to source records, completeness and timeliness checks, exception reporting and outlier review). Performance reports are triangulated with other sources of assurance including complaints and compliments, incidents and near misses, claims, patient experience feedback, audit findings, workforce indicators, and external benchmarking; themes and actions are tracked with accountable leads and due dates, and progress is monitored until closed.

Assurance is obtained through a programme of clinical audit and quality improvement, internal audit, case note reviews, mortality and morbidity review processes, and learning from safety incidents, supported by a risk management process that ensures key risks are recorded, reviewed, and escalated appropriately.

Compliance with Care Quality Commission (CQC) registration requirements is assured through an established compliance framework that maps requirements to policies,

procedures and controls, supported by routine audits, document review and spot checks, mandatory training monitoring, and periodic self-assessment against the Key Lines of Enquiry (KLOEs). Any gaps in compliance are recorded on the risk register with mitigating actions, timescales and executive oversight, and are reviewed (at least monthly) through governance meetings and reported through the quality governance structure to provide routine Board assurance.

The Trust holds divisional performance reviews, providing the opportunity for Executive Directors to review divisional performance against a range of metrics and hold management teams to account for performance. The reviews also assist divisions in identifying resources to tackle problem areas.

Care Quality Commission (CQC) registration requirements

The Trust continues to be registered with Care Quality Commission, and the overall Trust rating remains at 'Requires Improvement'. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

On 9 May 2024, the Trust was notified of Care Quality Commission's decision to serve an enforcement notice under section 31 of the Health and Social Care Act. Eight conditions were imposed, and the Trust has provided the Care Quality Commission with the required monthly update reports, including the maternity service dashboard data. The Trust has self-assessed that all eight conditions have been met; however, it awaits the final report outcome, from an inspection undertaken in September 2025 before submitting the required removal request forms. Extensive support has been provided to the service, and regular briefings on progress have been delivered by service leads at every public Board session since the notice was received.

It is recognised that maternity services remains an area of focus for the Trust, with active measures in place to mitigate identified issues of risk which have been identified through the Trust's own governance processes and participation in external reviews, including the interim report by Baroness Amos's National Maternity and Neonatal Investigation.

Regulatory and other inspection activity

During the year the following core service inspections were carried out:

- Maternity services at Stroud and the Gloucestershire Royal Hospital sites were inspected on 9, 10, 16 and 17 September 2025. The Trust has not yet received the two final inspection reports.
- Urgent and Emergency Care services were inspected on 8 and 9 December 2025 at the Cheltenham General Hospital and Gloucestershire Royal Hospital sites. The Trust has not yet received the two inspection reports.
- Medical and frailty care services were inspected on 8 and 9 December 2025 at the Gloucestershire Royal Hospital site. The Trust has not yet received the inspection report.

In October and November 2025, the Care Quality Commission carried out an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection, no breaches meeting the threshold for enforcement action were identified, and no areas requiring quality improvement were noted. The inspection was formally closed in December 2025.

On 15 September 2025, it was announced that the Trust was amongst fourteen Trusts to be included in a national rapid investigation of maternity and newborn care across England. The

purpose of the investigation is to make recommendations to urgently improve care and safety in maternity and neonatal services nationally. On 28th February 2026 Baroness Amos published the investigations interim findings on a national basis and an action plan has been developed within the Service to respond to the national issues identified.

Seven Never Events were reported during the period, compared to one during the previous year. All incidents were subject to immediate Executive review through the Incident Response Safety Huddle, ensuring senior leadership oversight from the outset. Each event was subsequently reviewed by the Patient Safety Review Panel, with an appropriate Patient Safety Learning Response agreed. A thematic review of the Never Events, including contributory factors and organisational learning, has been reported to the Board of Directors, providing assurance on the robustness of investigation and learning processes. All incidents have been reported through the Learn from Patient Safety Events Service (LFPSE), providing transparency and enabling regulatory oversight, with access available to the Care Quality Commission (CQC).

Data Security

The Trust complies with NHS Digital guidance for reporting, managing and investigating data security risks and breaches. Data risks are monitored through the corporate risk register, by the Board via both the Board Assurance Framework and separate reports and operational delivery forums including the digital senior leadership team. Further information is provided in the information governance and data governance sections of this report.

Well-Led

The Trust's governance processes are informed by the CQC and NHS England well-led framework. During the year an external review of the Trust's performance against components of the well-led framework was undertaken by the Advancing Quality Alliance with the report informing improvements to the Trust's governance and assurance apparatus.

Strengths were identified in relation to strategic vision, cultural transformation, leadership development, the Equality, Diversity and Inclusion agenda, governance and accountability, partnership working, Freedom to Speak Up, and sustainability. It is recognised, however, that the Trust remains on a journey of improvement and must continue to embed supporting delivery strategies, fully integrate the Trust's new vision and values, strengthen deputy and divisional leadership, enhance organisational risk maturity, and improve the consistent adoption of learning across divisions.

As part of its ongoing assessment of leadership effectiveness and governance maturity, the Board undertook a self-assessment against NHS England's Provider Capability Assessment. This assessment, along with the external Well Led review above, informed the development of a targeted Board Development Plan, ensuring that identified strengths are consolidated and that areas for further development are addressed in a structured and transparent way. Progress against the Board Development Plan is monitored by the Board and contributes to the Board's overall assurance on its effectiveness and leadership capability.

In February 2026 the Care Quality Commission undertook a Well-Led inspection. At the time of writing the report has not been received. On receipt an action plan will be developed to respond to any recommendations made within the inspection report that are not already captured as areas of improvement focus in the current development plan.

Provider Licence Compliance

The Trust is compliant with the NHS Provider Licence section 4 (governance). As required annually, the Board self-certified its compliance with the General and Trust conditions as outlined in its Licence requirements, legislation and NHS Constitution.

	Risk	Mitigation
Effective Governance Structures	Ineffective governance structures, non- compliance with the Code of Governance for NHS Provider Trusts and accepted standards.	• Utilisation of the Code of Governance for NHS Provider Trusts for best practice • external well-led review in 2025-26 • annual committee effectiveness reviews • CQC Well Led inspection February 26.
Responsibilities of Directors and Sub-committees	Lack of clarity, duplication or omission of duties, ineffective oversight, monitoring and escalation process	• Role profiles issued on appointment and on portfolio change • Biennial review of core financial governance documents including reservation of powers, standing financial instructions. • Review of committee terms of reference and work plans.
Reporting lines and accountability	Lack of clarity and accountability, ineffective escalation processes.	• Board committee structure map in place, including sub committees • each committee led by Non-Executive Director and Trust Leadership Team forum by the CEO, all provide regular reports to Board. • Organisational and departmental structure charts regularly updated.
Board oversight of performance	Reduced assurance of performance, poor patient experience, non-compliance with health care standards, reduced leadership and decision-making ability	• Weekly Director of Operations performance meetings. • Integrated Performance Report to Quality and Performance Committee and to Board

Business Continuity

The Trust has existing and exciting new plans to improve our arrangements to meet its statutory duties under the Civil Contingencies Act 2004, the Health and Care Act 2022, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

Overall accountability sits with the Chief Operating Officer in their role as Authorised Emergency Officer, supported by established governance, oversight and assurance processes. The Trust's EPRR framework encompasses emergency response, business continuity, recovery and system-wide partnership working. All directorates maintain aligned business continuity plans, which are reviewed regularly and validated through assurance processes, live incidents, and exercises.

The Trust operates structured debriefing and lessons-learned arrangements following events and critical incidents, ensuring learning is embedded into future planning and risk mitigation. These arrangements provide continual assurance that the Trust remains resilient and prepared to respond effectively to a wide range of disruptive and emergency scenarios while maintaining safety and care to our staff and patients.

Stakeholders

Effective performance and risk management relies on a range of contributions, and collaborative work is undertaken with external stakeholders to support the identification of risks that may impact on them, including Gloucestershire Integrated Care System, local authorities, Healthwatch and other forums for both patients and carers, directly and through involvement with our Council of Governors. Other vehicles for engagement include complaints and patient feedback, friends and family test responses and patient stories delivered at Board meetings.

Workforce strategies and risks

Significant workforce risks are monitored through the corporate risk register, the People and Organisational Development Committee and the Board including via the Board Assurance Framework. The People Strategy sets out the Trust's commitment to ensuring staffing processes are safe, sustainable and effective.

Gloucestershire Hospitals NHS Foundation Trust has workforce strategies and staffing systems in place across the short, medium and long term to support the delivery of safe, effective and sustainable care, consistent with the principles set out in the NHS England Developing Workforce Safeguards.

Workforce planning is integrated with clinical strategy, operational delivery and financial planning, enabling the Board to maintain appropriate oversight and assurance that staffing arrangements are proportionate, transparent and subject to robust governance in line with the Developing Workforce Safeguards framework.

Workforce risks are actively monitored and managed through established governance routes, including the Corporate Risk Register, the Board Assurance Framework, Executive Performance Reviews, the People & Organisational Development Delivery Group, the People & Organisational Development Committee, and the Board. Risk reporting provides visibility of People & OD related risks that directly impact delivery of the Trust's workforce priorities, as set out within the overarching People Strategy and the Directorate's well-led priorities.

The Trust recognises that insufficient control of workforce risks could adversely affect recruitment, training and retention, statutory and regulatory compliance, patient safety, staff

experience and financial sustainability. Mitigating actions and controls are therefore identified, implemented and routinely reviewed by named Risk Leads to ensure risks remain within tolerance.

The Trust's People Strategy, implemented in 2019, is currently under review as part of the development of the five-year Integrated Delivery Plan. This will align with the new Trust Strategy, which reaffirms the Trust's commitment to being a place where people are proud to work and would recommend for care, supported by workforce arrangements that are safe, sustainable, inclusive and effective.

Compliance with NHS England Developing Workforce Safeguards recommendations is routinely monitored from ward to Board, with assurance gained through the Quality & Performance Committee and the Board. Transparency is supported through the publication of monthly workforce data on the Trust's website, enabling public scrutiny.

Control measures are also in place to ensure the Trust meets its obligations under equality, diversity and human rights legislation, in keeping with the safeguards' emphasis on fairness and inclusion. All service changes and business cases are subject to Quality and Equality Impact Assessments to ensure proposals do not adversely affect service quality or equality of access. Further strengthening of equality, diversity and inclusion is a key area of focus for the coming year and aligns with the Trust's wider cultural development programme.

Register of Interests

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past 12 months as required by the Managing conflicts of interest in the NHS guidance. The Trust's register of interests is published at Conflict of interests register

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Inclusion

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Climate Control

The Trust has undertaken risk assessments on the effects of climate change and severe weather events, particularly on human health and these are included in the Corporate Risk Register.

As part of addressing the risk the Trust has developed a Green Plan following the guidance of the Greener NHS programme. The Green Plan is being reviewed and is scheduled to be considered by both board assurance committees and the board during the first half of

2026-2027.The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In line with the Task Force on Climate-related Financial Disclosures requirements as interpreted for NHS foundation trusts, and as set out above within the Performance Report, the Trust considers how climate-related risks and opportunities could affect its operations, strategy and financial planning. Climate-related risks (including acute and chronic physical risks and transition risks) are assessed through the corporate risk management process and, where material, reflected in the Corporate Risk Register and the Board Assurance Framework (ongoing review). The Trust's Green Plan, which is being refreshed, sets out the delivery roadmap to net zero and informs estates planning, capital prioritisation, energy resilience and service continuity considerations. Climate adaptation and mitigation actions are overseen through established governance routes and are linked to financial planning assumptions and investment decisions where relevant.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a well-established set of arrangements to ensure its resources are used economically, efficiently and effectively. These include providing the Board with regular assurance over affordability of the Trust's cost base, ongoing scrutiny of the Financial Sustainability Programme, and regular integrated performance monitoring at all levels of the organisation.

The Board has in place an effective system of internal control to ensure that resources are used economically, efficiently, and effectively, aided by monitoring and scrutiny through the board committees (attendance details within the Directors Report above):

- Audit and Assurance Committee – reviews of key governance structures and documents, internal and external audit reports and assurance received from Counter-Fraud Services;
- Finance and Resource Committee – regular finance and performance reports;
- Quality and Performance Committee; and
- People and Organisational Development Committee.

The Board receives, at each meeting, a Key Issues and Assurance Report (4A methodology) from each board committee detailing the use of resources generally and the controls in place, when relevant updates as to business cases and specific projects.

Controls to ensure the effective, efficient and economic use of resources include:

- Board approval of the Trust's annual/medium-term plans, which reflects national and local service and operational requirements and financial targets and incorporates required efficiency savings.
- The implementation of the accountability framework that is managed through the divisional and corporate executive reviews, escalation into enhanced oversight or mandated support will be an outcome if deviation to plans are material.
- Regular finance and performance reports to Committees and Board which include key performance indicators, aiming to triangulate financial performance with operational, workforce, quality, safety and other factors.

- Detailed biennial review of the reservation of powers, standing financial instructions, and related schemes of delegation by the Audit and Assurance Committee and Board);
- A Business planning approach which clearly articulate the level of risks and mitigation;
- Executive review with Gloucestershire Managed Services and Trust Divisional colleagues to focus on high-risk areas relating to compliance, workforce and financial position;
- Regular system updates where system wide challenges can be addressed;

There have been no significant issues identified in relation to the financial statements in 2025-2026

The Audit Committee continues to play a key role in overseeing the Trust's financial governance arrangements and management of financial risks and controls. In its work, the Audit Committee draws on assurance provided by the external and internal audit functions

Internal Audit

The Trust's Internal Auditors, BDO, undertake an annual risk-based audit plan, agreed by the Audit and Assurance Committee and key executive directors. The plan is aligned with the Trust's strategic risks and is intelligence-led. Internal Auditor provides assurance reports on the design and operating effectiveness of controls and follows up on implementation of recommendations. For 2025-2026, the Head of Internal Audit provided a Moderate ('generally satisfactory with improvements required in some areas') assurance opinion on the effectiveness of the system of internal control. This indicates that, while a generally sound control framework is in place, improvements are required in specific areas, including timeliness of action completion, incident review processes and aspects of risk management maturity. From the full programme of twelve audits, three resulted in moderate design/limited effectiveness outcomes and one resulted in a limited design outcome. The high risk findings from the first two internal audit reports received have been resolved. Those received by the Audit Committee in April and June 2026 remain open with ongoing action plans. Management action plans are in place for those that are not resolved and are actively monitored through the Audit and Assurance Committee to ensure timely delivery and sustained improvement.

The Trust notes the positive position as at March 2026 with the Head of Internal Audit Opinion for the year. This reflects the focused efforts of the Trust by promoting the importance of the role of internal audit across the senior management team, Comprehensive engagement from executives around the development of the plan provided ownership. Accountability and responsiveness.

External Audit

The Trust's external auditors, Deloitte, provide assurance through their annual audit of the Annual Report and Accounts. For 2025/26, the external auditor issued an unmodified opinion in relation to the financial statements and reported one significant control weakness in relation to 'Value for Money'. The Audit and Assurance Committee has reviewed the ISA260 report and continues to monitor management responses to audit findings.

Alongside its review of external sources of assurance, the Audit Committee continues to receive, as standing items on its agenda, reports regarding losses, special payments and compensations, write-off bad debts and contingent liabilities.

Information Governance

Information Governance incidents are reviewed and investigated throughout the year and reported internally. Incident reports are triaged and any incident which meets the criteria set out within the NHS Digital Guidance were reported via the Data Security Incident Reporting Tool

There has been one incident reported to the Information Commissioner's Office between April 2025 and March 2026 (inclusive)

Date reported to ICO	Incident	ICO action
March 2026	Complaint received regarding the Trust's response to a subject access request in 2024-2025	Open – ICO is undertaking a review of the Trust's response.

Summary of Information Governance reported incidents during 2025-2026.

The following have been submitted as Data Security & Protection (Information Governance) incidents within the Trust during the period April 2025 to March 2026 inclusive) and were assessed and determined to not meet the threshold for notification.

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

The effectiveness of these systems has been monitored by the Trust's Digital and Information Service Governance Group, the Digital Care Delivery Group with a report presented to the Finance and Resource Committee on a six-monthly basis. This forms the basis of the Trust's annual submission for the Data Security Protection Toolkit. The governance in place ensures the Trust is implementing the ten data security standards recommended by the National Data Guardian and that we are meeting our legal obligations as to data protection and data security.

During the year ended 31 March 2026 a total of 186 breaches in relation to information governance were reported in line with the Trust's incident reporting policy. A 'personal data breach' under General Data Protection Regulation Article 4 (12) is defined as 'a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed'. There are three types of personal data breaches:

• Confidentiality breach is unauthorised or accidental disclosure of, or access to, personal data;

• Availability breach is an unauthorised or accidental loss of access to, or destruction of, personal data;

• Integrity breach is an unauthorised or accidental alteration of personal data.

Data quality and governance

The Trust recognises that reliable data and high-quality information are essential for delivering safe, effective patient care and informing service design and improvement efforts. High-quality information is defined as complete, accurate, relevant, up-to-date (timely), and free from duplication.

Data quality and governance is monitored through the Trust Leadership Team Forum, chaired by the Chief Executive, with the Caldicott Guardian (Medical Director) and Senior Information Risk Officer (Chief Digital & Information Officer) present, and the Board, through specific risk, performance, and assurance reports, and the Board Assurance Framework.

To enhance data quality, the Trust has undertaken the following actions:

- Identification, review, and resolution of potential duplication of patient records.
- Review of processes to ensure correct payment for activity undertaken and to reduce unnecessary administrative burden.
- Daily Data Quality (DQ) reports monitored by Support Teams.
- Formation of a coding improvement team to support clinical and operational teams to rectify any data quality issues.
- Gathering of user feedback.
- Review and revision of all existing reports.
- Automation of routine data quality reports, making them routinely available to all staff on the Trust intranet via the Business Intelligence portal 'BI Hub'.
- Collaboration with an external partner to optimize the recording of clinical information and the capture of clinical coding data.
- Regular submission of mandatory secondary user services (SUS) data to NHS Digital, with actions taken based on SUS DQ reports to improve data quality.
- Attendance at Provider User Groups for national submissions to review best practices and benchmark against other Trusts.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and assurance committee and the other committees of the board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control and the plans to address weaknesses and improvement includes:

- The structure and content of Board meetings during the year which ensures an environment within which the Board can provide adequate challenge on and gain appropriate assurance in relation to issues impacting patient services and our staff, namely issues relating to performance, quality and safety;

- A robust board committee structure providing assurance on quality, safety, operational and financial performance, and workforce strategy implementation
- A robust Audit and Assurance Committee which provides assurance that the system of internal controls is sound and agrees both an annual internal audit plan and an annual counter-fraud plan in addition to approving the external audit plan and reviewing the ISA260 and monitors the control recommendations within it.
- The effective engagement with Internal Audit and an internal audit plan targeted at areas where the control environment can be strengthened;
- Assurance from the Board Committees and senior risk managers, including Executive Directors and Divisional management on issues ranging from quality and safety, information governance, risk management and effective clinical leadership.
- A comprehensive clinical audit programme prioritising national statutory and mandatory audits.
- An effective Council of Governors, which obtains assurance regarding the performance of the Board from the Non-Executive Directors and holds them to account for the same.

Continuous improvement and development work within the governance arena throughout the Trust is undertaken to strengthen internal controls and mitigate gaps on an ongoing basis and key issues and escalations from board committees to the board of directors ensures oversight of areas where weaknesses in the control environment need to be addressed.

Conclusion

As Accounting Officer, having reviewed the effectiveness of the system of internal control for the year ended 31 March 2026, I am satisfied that Gloucestershire Hospitals NHS Foundation Trust has in place a sound system of governance, risk management and internal control that provides reasonable assurance over the achievement of the Trust's objectives, the safety and quality of services, and the stewardship of public resources.

This conclusion is informed by the range of assurances described within this Annual Governance Statement, including the work of Internal and External Audit, Board and Committee oversight, clinical audit and quality improvement activity, regulatory assurance, and the executive and divisional management structures that support delivery. These arrangements have enabled the Board to identify and manage the Trust's principal risks, to monitor performance and compliance, and to take timely action where improvement is required.

In accordance with the NHS Foundation Trust Annual Reporting Manual, the Trust has assessed whether any matters identified during the year constitute a "significant control weakness." For the purposes of this statement, a significant control weakness is defined as a fundamental failure of governance, risk management or internal control arrangements.

In making this assessment, the Trust has considered the scale and nature of its principal risks, including those relating to:

- Urgent and emergency care performance and patient flow
- Workforce capacity constraints
- Maternity services and regulatory oversight
- Estate condition, infrastructure resilience and fire safety compliance
- Financial sustainability.

While these represent material risks to the delivery of services and require ongoing management and regulatory engagement, the Board is satisfied that:

- These risks have been appropriately identified, recorded and escalated through established governance mechanisms
- Mitigating controls, improvement programmes and investment plans are in place and actively monitored
- Board and Committee oversight has remained effective, with appropriate challenge and assurance

These matters therefore represent significant operational and strategic risks under active management, rather than fundamental failures in internal control arrangements.

For 2025/26, the Board has determined that financial sustainability represents a significant control weakness for the purposes of the Annual Governance Statement and the external audit opinion on value for money.

Whilst the Trust has delivered its in-year financial position, this has been achieved in part through the use of non-recurrent measures, including one-off savings, slippage on planned expenditure and non-recurrent income. The Financial Sustainability Programme (FSP) has required the delivery of £41.8m of savings, of which a material proportion has not been recurrent in nature. This reflects both the scale of the financial challenge and the limited availability of immediately deliverable recurrent opportunities within the year.

The Board recognises that continued reliance on non-recurrent measures does not represent a sustainable long-term approach and is therefore indicative of a weakness in the underlying financial position for the purposes of the external audit value for money assessment.

In response, the Trust has taken and is continuing to take a number of actions to strengthen its financial sustainability and shift towards a more recurrent savings position. These include:

- Transformation and improvement programmes, with strengthened executive leadership and external support to identify and deliver recurrent efficiency and productivity opportunities;
- Enhanced medium-term financial planning, aligned to the Trust's five-year strategy, with a clear trajectory to improve the underlying financial position;
- A strengthened Financial Sustainability Programme for 2026/27, with an ambition for approximately 75% of schemes to be recurrent in nature with incremental recurrent delivery in future years;
- Continued system working and external benchmarking, including engagement with NHS England, system partners and external advisors to identify further cost improvement opportunities;
- Enhanced governance and oversight, with regular reporting to the Board and Finance and Resources Committee on delivery, risk and mitigations.

The Board is clear that restoring financial sustainability is a key strategic priority and is committed to delivering a progressive shift towards a more sustainable, recurrent financial model over the medium term. Progress will continue to be closely monitored and reported through established governance arrangements.

In carrying out the above assessment, the Trust considered (among other factors): the potential impact on delivery of strategic priorities; whether the matter could undermine the integrity or trust and confidence in the Trust or the wider NHS; the views of the Audit and Assurance Committee; internal and external audit advice; whether achievement of the standards expected of the Accounting Officer could be at risk; whether the matter increased exposure to fraud or misuse of resources; whether it diverted resources from other significant activities; whether it could have a material impact on the financial statements; and whether

information governance or data integrity could be put at risk. This assessment was triangulated against the Board Assurance Framework, the Corporate Risk Register, internal audit findings, external audit reporting, regulatory feedback and performance and quality intelligence considered by the Board and its committees.

During 2025/26, the Trust has continued to operate in a challenging environment, with sustained pressures across urgent and emergency care, workforce, estates, financial sustainability and system integration. The Board has maintained a strong focus on these areas through the Board Assurance Framework, supported by a refreshed risk appetite and realignment of strategic risks to the Trust's new five-year strategy. Where risks remain significant, they are recognised, actively managed and subject to clear plans for mitigation and improvement.

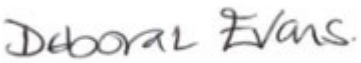
The Trust acknowledges areas where further strengthening of governance, risk maturity and assurance arrangements is required, including the continued embedding of cultural transformation, consistent adoption of learning, estates and infrastructure risk management, and the ongoing development of digital and data resilience to support our strategic aim of Digital First. Action plans are in place and monitored to address these matters and to ensure continuous improvement.

Based on the assurances received and the review undertaken, I confirm that, while the Trust has identified a number of material risks during the year – including in relation to financial sustainability, estates and fire safety – these have been appropriately recognised, escalated and managed through the Trust's governance and assurance framework. The Board has exercised active oversight of these matters, including regulatory engagement, targeted improvement programmes and enhanced assurance reporting.

The Board remains satisfied that governance, risk management and internal control arrangements are operating effectively in the context of a complex and pressured operating environment, and that identified risks are being actively managed within a structured and robust assurance framework. It remains committed to maintaining and further improving robust governance, transparency and accountability in support of high-quality, safe and sustainable patient care. The systems described in this statement will continue to evolve in response to emerging risks, regulatory expectations and the needs of our patients, staff and partners.

Accountability Report Conclusion

This concludes the Accountability Report of Gloucestershire Hospitals NHS Foundation Trust for the year ending 31 March 2026.



Kevin McNamara
Chief Executive

Date: 25 June 2026

Independent Auditor's Report

Independent auditor's report to the board of governors and board of directors of Gloucestershire Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Gloucestershire Hospitals NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2026 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 40.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit, local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such valuations regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2026, is subjective: we tested a sample of expenditure to assess whether the expenditure met the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure was recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;

- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, reviewing internal audit reports and correspondence with Care Quality Commission (CQC).

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

In our opinions on the financial statements for the years ended 31 March 2024 and 31 March 2025, issued on 27 June 2024 and 27 June 2025 respectively, we reported to the foundation trust a significant weakness in its arrangements to secure financial sustainability, impacting the economy, efficiency and effectiveness in the use of resources. The significant weakness reported was:

- In respect of the foundation trust's arrangements to secure financial sustainability, specifically how the Trust is able to achieve its cost improvement target for the year and the reliance on non-recurrent savings. Our recommendations for improvement include that the Trust continue its efforts to identify and realise specific opportunities to deliver its plan, and in planning for future periods, begin the identification of savings opportunities and project planning for their delivery further ahead of the start of the period to identify greater recurrent saving opportunities.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

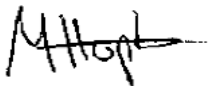
As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Gloucestershire Hospitals NHS Foundation Trust for the year ended 31

March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Gloucestershire Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Michelle Hopton FCA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
26 June 2026

Annual Accounts 2025–2026

Gloucestershire Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Kevin McNamara**
Job title **Chief Executive**
Date **25 June 2026**

Consolidated Statement of Comprehensive Income

	Note	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Operating income from patient care activities	3	851,004	851,787	806,026	806,828
Other operating income	4	51,241	59,931	52,849	61,072
Operating expenses	6,8	(901,855)	(907,670)	(882,783)	(888,609)
Operating surplus/(deficit) from continuing operations		**390**	**4,048**	**(23,908)**	**(20,709)**
Finance income	10	4,911	3,186	6,087	4,361
Finance expenses	11	(4,457)	(4,457)	(4,277)	(4,277)
PDC dividends payable		(7,248)	(7,248)	(6,729)	(6,729)
Net finance costs		**(6,794)**	**(8,519)**	**(4,919)**	**(6,645)**
Other losses	12	(35)	65	(172)	(192)
Corporation tax expense		-	(780)	-	(754)
Deficit for the year from continuing operations		**(6,439)**	**(5,186)**	**(28,999)**	**(28,300)**
Deficit for the year		**(6,439)**	**(5,186)**	**(28,999)**	**(28,300)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(1,556)	(1,556)	(1,135)	(1,135)
Revaluations	7,14	75	75	1,700	1,700
Total other comprehensive income for the period		**(1,481)**	**(1,481)**	**565**	**565**
Total comprehensive expense for the period		**(7,920)**	**(6,667)**	**(28,434)**	**(27,735)**
Deficit for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(6,439)	(5,186)	(28,999)	(28,300)
Total		**(6,439)**	**(5,186)**	**(28,999)**	**(28,300)**
Total comprehensive expense for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(7,920)	(6,667)	27,299	(27,735)
Total		**(7,920)**	**(6,667)**	**27,299**	**(27,735)**

Statements of Financial Position

	Note	Trust 31 March 2026 £000	Group 31 March 2026 £000	Trust 31 March 2025 £000	Group 31 March 2025 £000
Non-current assets					
Intangible assets	13	14,049	14,049	15,263	15,263
Property, plant and equipment	14	339,961	339,961	327,196	327,204
Right of use assets	17	17,350	17,350	21,545	21,545
Other investments / financial assets	18	-	1,886	-	1,790
Receivables	22	3,075	3,075	3,356	3,356
Other assets	24	600	-	600	-
Total non-current assets		**375,035**	**376,321**	**367,960**	**369,158**
Current assets					
Inventories	21	12,845	13,679	11,376	12,160
Receivables	22	27,001	29,737	29,116	30,059
Cash and cash equivalents	25	35,273	49,841	41,966	49,650
Total current assets		**75,119**	**93,257**	**82,458**	**91,869**
Current liabilities					
Trade and other payables	26	(82,853)	(96,816)	(91,974)	(98,375)
Borrowings	28	(9,958)	(9,958)	(9,556)	(9,556)
Provisions	29	(6,063)	(6,063)	(6,519)	(6,519)
Other liabilities	27	(13,519)	(13,519)	(13,606)	(13,606)
Total current liabilities		**(112,393)**	**(126,356)**	**(121,655)**	**(128,056)**
Total assets less current liabilities		**337,761**	**343,222**	**328,763**	**332,971**
Non-current liabilities					
Borrowings	28	(43,473)	(43,473)	(51,658)	(51,658)
Provisions	29	(3,133)	(3,133)	(3,444)	(3,444)
Other liabilities	27	(4,521)	(4,521)	(6,478)	(6,478)
Total non-current liabilities		**(51,127)**	**(51,127)**	**(61,580)**	**(61,580)**
Total assets employed		**286,634**	**292,095**	**267,183**	**271,391**
Financed by					
Public dividend capital		437,319	437,319	409,948	409,948
Revaluation reserve		31,054	31,054	32,535	32,535
Other reserves		210	210	210	210
Income and expenditure reserve		(181,949)	(181,949)	(175,510)	(175,510)
Charitable fund reserves	20	-	5,461	-	4,208
Total taxpayers' equity		**286,634**	**292,095**	**267,183**	**271,391**

The notes on pages 9 to 60 form part of these accounts.

Signed .....

Name Kevin McNamara

Position Chief Executive

Date **25 June 2026**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**409,948**	**32,535**	**210**	**(175,510)**	**267,183**
Deficit for the year	-	-	-	(6,439)	**(6,439)**
Impairments	-	(1,556)	-	-	**(1,556)**
Revaluations	-	75	-	-	**75**
Total Comprehensive Income (expense) for the year	-	(1,481)	-	(6,439)	(7,920)
Public dividend capital received	27,371	-	-	-	**27,371**
Taxpayers' and others' equity at 31 March 2026	**437,319**	**31,054**	**210**	**(181,949)**	**286,634**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**407,649**	**31,970**	**210**	**(146,511)**	**293,318**
Implementation of IFRS 17 at 1 April 2024 transition date	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2024 - restated	**407,649**	**31,970**	**210**	**(146,511)**	**293,318**
Deficit for the year	-	-	-	(28,999)	**(28,999)**
Impairments	-	(1,135)	-	-	**(1,135)**
Revaluations	-	1,700	-	-	**1,700**
Total Comprehensive Income (expense) for the year	**-**	**565**	**-**	**(28,999)**	**(28,434)**
Public dividend capital received	2,326	-	-	-	**2,326**
Public dividend capital repaid	(27)	-	-	-	**(27)**
Taxpayers' and others' equity at 31 March 2025	**409,948**	**32,535**	**210**	**(175,510)**	**267,183**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**409,948**	**32,535**	**210**	**(175,510)**	**4,208**	**271,391**
Surplus/(deficit) for the year	-	-	-	(6,439)	1,253	**(5,186)**
Impairments	-	(1,556)	-	-	-	**(1,556)**
Revaluations	-	75	-	-	-	**75**
Total Comprehnsive income (expense) for the year	-	(1,481)	-	(6,439)	1,253	(6,667)
Public dividend capital received	27,371	-	-	-	-	**27,371**
Taxpayers' and others' equity at 31 March 2026	**437,319**	**31,054**	**210**	**(181,949)**	**5,461**	**292,095**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**407,649**	**31,970**	**210**	**(146,511)**	**3,509**	**296,827**
Total Comprehensive Income						
Surplus/(deficit) for the year	-	-	-	(28,999)	699	**(28,300)**
Impairments	-	(1,135)	-	-	-	**(1,135)**
Revaluations	-	1,700	-	-	-	**1,700**
Total Comprehnsive income (expense) for the year	**-**	**565**	**-**	**(28,999)**	**699**	**(27,735)**
Public dividend capital received	2,326	-	-	-	-	**2,326**
Public dividend capital repaid	(27)	-	-	-	-	**(27)**
Taxpayers' and others' equity at 31 March 2025	**409,948**	**32,535**	**210**	**(175,510)**	**4,208**	**271,391**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
On the original setting up of the Trust in 2003 there was an error made on the initial PDC to cover the value of the net assets of the organisation. The adjustment was creditied to other reserves and will remain with the Trust until the Trust is dissolved.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20.

Statements of Cash Flows

	Note	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Cash flows from operating activities					
Operating surplus / (deficit)		390	4,048	(23,908)	(20,709)
Non-cash income and expense:					
Depreciation and amortisation	6.1	35,710	35,718	35,653	35,682
Net impairments	7	10,287	10,287	29,041	29,041
Income recognised in respect of capital donations	4	(248)	(248)	(1,557)	(1,557)
(Increase) / decrease in receivables and other assets		2,396	96	(935)	(2,056)
(Increase) / decrease in inventories		(1,469)	(1,519)	360	344
Increase / (decrease) in payables and other liabilities		(9,354)	(1,068)	(3,663)	(665)
Increase / (decrease) in provisions		(739)	(739)	2,630	2,630
Movements in charitable fund working capital		-	(348)	-	218
Tax paid		-	(766)	-	(754)
Net cash flows from operating activities		**36,973**	**45,461**	**37,621**	**42,174**
Cash flows from investing activities					
Interest received		2,570	2,993	3,956	4,196
Purchase of intangible assets		(3,734)	(3,734)	(5,028)	(5,028)
Purchase of PPE and investment property		(52,195)	(52,195)	(33,547)	(33,547)
Sales of PPE and investment property		-	-	3	3
Receipt of cash donations to purchase assets		217	217	1,086	1,086
Net cash flows from charitable fund investing activities		-	197	-	300
Net cash flows from used in investing activities		**(53,142)**	**(52,522)**	**(33,530)**	**(32,990)**
Cash flows from financing activities					
Public dividend capital received		27,371	27,371	2,326	2,326
Public dividend capital repaid		-	-	(27)	(27)
Movement on loans from DHSC		(1,729)	(1,729)	(1,729)	(1,729)
Capital element of lease liability repayments		(5,082)	(5,082)	(5,307)	(5,307)
Capital element of PFI, LIFT and other service concession payments		(3,493)	(3,493)	(2,969)	(2,969)
Interest on loans		(580)	(580)	(673)	(673)
Interest paid on lease liability repayments		(463)	(463)	(392)	(392)
Interest paid on PFI, LIFT and other service concession obligations		(1,970)	(1,970)	(2,090)	(2,090)
PDC dividend paid		(6,802)	(6,802)	(8,094)	(8,094)
Cash flows from (used in) other financing activities		2,224	-	1,985	-
Net cash flows from financing activities		**9,476**	**7,252**	**(16,970)**	**(18,955)**
Increase / (decrease) in cash and cash equivalents		**(6,693)**	**191**	**(12,879)**	**(9,771)**
Cash and cash equivalents at 1 April - brought forward		**41,966**	**49,650**	**54,845**	**59,421**
Cash and cash equivalents at 31 March	25	**35,273**	**49,841**	**41,966**	**49,650**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the Corporate Trustee to the Gloucestershire Hospitals charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Gloucestershire Hospitals Subsidiary Company Ltd

The Trust wholly owns Gloucestershire Hospitals Subsidiary Company Ltd. (known as Gloucestershire Managed Services, GMS) which form part of the consolidated accounts. GMS provides the estates, facilities, sterile services and materials management services for the Trust. Its turnover for the period ended 31 March 2026 was £111m (2024-25 £97m) and its gross assets at 31 March 2026 totalled £29m (2024-25 £18.1m).

The Gloucestershire Hospitals Subsidiary Company Ltd statutory accounts are prepared to 31 March in accordance with UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the company's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from Government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

A full revaluation is required every 5 years. A full revaluation, on an MEA basis and excluding VAT, was undertaken by the Trust's independent valuer as at 31 March 2025. A desktop valuation on an MEA basis and exluding VAT was undertaken by the Trust's independent valuer the Valuation Office Agency as at 31 March 2026.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences in the quarter after the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	15	93
Dwellings	42	68
Plant & machinery	1	16
Transport equipment	1	12
Information technology	1	15
Furniture & fittings	1	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequent measurement of intangible assets is at cost less amortisation.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	1	5
Development expenditure	1	5
Software licences	1	7

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy inventory is measured on a weighted average basis and all other inventories are measured using the first in, first out (FIFO) method.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income. Within the group accounts shares held by the charity are held at fair value.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract receivables the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by type and age of receivable with differing percentages applied to the various categories of receivables.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Depreciation

Right of Use Assets are depreciated over the term of the lease. Depreciation starts in the same period that the lease commences.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 29.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 30 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 30.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to Corporation Tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core health care and are not subject to tax. However, the Trust's commercial subsidiary is subject to Corporation Tax.

The Trust operates a wholly owned subsidiary limited liability company Gloucestershire Managed Services (GMS) which has a liability for Corporation Tax due on surpluses at financial year end. Corporation Tax payable on surpluses at financial year end is assessed by a qualified financial advisor and a Corporation Tax liability is recorded in the Trust balance sheet.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £251m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £247m at 31 March 2026. We are unable to quantify the impact of this change at this time.

Note 1.26 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Note 1.9 describes the MEA approach for valuation of PPE. The MEA model has been updated to take account of changes to the Trusts PPE valuation. The Trust has made a judgement regarding the required size and location of assets required in order to deliver health care services using the MEA valuation. This methodology was adopted several years ago based on professional advice. There have been no changes in the judgements regarding the MEA in 2025/26. These would be revisited if there was a change in clinical strategy or service provision, no such changes are anticipated.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property Valuation

Land, buildings and dwellings were valued at £250,770k by the Trust's independent valuer The Valuation Office Agency with a valuation date as at 31st March 2026. The valuation has been made by applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 Red Book. The value does not take into account potential future changes in the market value which cannot be predicted with any certainty. The valuer is an expert therefore there is a high degree of reliance on the valuers expertise.

Impairments

Impairments are based on the Revaluation Offices revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use or identified for disposal. Estimates and judgements are used where the valuations and the assumptions are used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances where an impairment has occurred.

Note 2 Operating Segments

The financial information presented to the Trust Board by the Director of Finance regarding performance of the Trust is based on the whole Trust as one entity (i.e. it is not split over operating segments). The Trust's internal management structure is based on operating divisions i.e. Surgery, Medicine, Diagnostics and Specialties, Women and Children, Estates and Facilities and Corporate Services. The Divisional boards are provided with financial information specific to their operational areas. The group position includes the Trust's subsidiary company and its charity (which is not seperately shown due to materiality).

For segmental reporting, information is provided to the Board to inform them of the Trust, GMS and overall group position. This is shown below.

	2025/26			2024/25		
	Trust	GMS	Consolidated Group	Trust	GMS	Consolidated Group
	£000	£000	£000	£000	£000	£000
Expenditure	913,595	109,271	920,090	893,961	95,974	900,561
Income	907,156	111,612	914,904	864,962	98,105	872,261
Operational surplus / (deficit)	**(6,439)**	**2,341**	**(5,186)**	**(28,999)**	**2,131**	**(28,300)**

Assets and Liabilities of the group are not reported seperately to the board.

Reconciliation of Statement of Comprehensive Income (SOCI)

	2025/26	2024/25
	£000	£000
Statement of Comprehensive Income	(6,439)	(28,999)
Net Impairments charged to operating deficit	10,025	29,041
IFRIC 12 Adjustments	285	365
Grants and donations	1,122	(340)
Adjusted finanical performance surplus	**4,993**	**67**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Income from acute services	808,978	808,978	762,717	762,717
Private patient income	4,828	4,828	5,084	5,084
National pay award central funding***	-	-	2,924	2,924
Additional pension contribution central funding**	35,001	35,784	32,975	33,777
Other clinical income	2,197	2,197	2,326	2,326
Total income from activities	**851,004**	**851,787**	**806,026**	**806,828**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Income from patient care activities received from:				
NHS England *	111,007	111,790	179,763	180,565
Integrated care boards	725,199	725,199	609,588	609,588
Other NHS providers	389	389	411	411
NHS other	7,383	7,383	7,027	7,027
Non-NHS: private patients	4,828	4,828	5,084	5,084
Non-NHS: overseas patients (chargeable to patient)	581	581	277	277
Injury cost recovery scheme	612	612	1,091	1,091
Non NHS: other	1,005	1,005	2,785	2,785
Total income from activities	**851,004**	**851,787**	**806,026**	**806,828**
Of which:				
Related to continuing operations	851,004	851,787	806,026	806,828
Related to discontinued operations	-	-	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	581	277
Cash payments received in-year	176	201
Amounts added to provision for impairment of receivables	-	8
Amounts written off in-year	117	61

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,441	-	**3,441**	3,299	-	**3,299**
Education and training	28,415	1,378	**29,793**	24,557	1,323	**25,880**
Non-patient care services to other bodies	12,449	-	**12,449**	12,787	-	**12,787**
Income in respect of employee benefits accounted on a gross basis	3,830	-	**3,830**	4,245	-	**4,245**
Receipt of capital grants and donations and peppercorn leases	-	248	**248**	-	1,557	**1,557**
Charitable and other contributions to expenditure	-	272	**272**	-	270	**270**
Charitable fund incoming resources	-	2,954	**2,954**	-	2,535	**2,535**
Other income	6,944	-	**6,944**	10,499	-	**10,499**
Total other operating income	**55,079**	**4,852**	**59,931**	**55,387**	**5,685**	**61,072**
Of which:						
Related to continuing operations			59,931			61,072
Related to discontinued operations			-			-

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

* Analysis of Other operating income: Other contract income	2025/26	2024/25
	Total	Total
	£000	£000
Car parking	1,103	4,835
Creche services	1,120	1,060
Catering	1,657	1,457
Other	3,064	3,147
Total	**6,944**	**10,499**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period (Group)

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	13,606	15,354

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 5.2 Transaction price allocated to remaining performance obligations (Group)

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026 £000	31 March 2025 £000
within one year	13,519	13,606
after one year, not later than five years	1,791	3,476
after five years	2,730	3,002
Total revenue allocated to remaining performance obligations	**18,040**	**20,084**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 5.3 Income from activities arising from commissioner requested services (Group)

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	844,761	797,591
Income from services not designated as commissioner requested services	7,026	9,237
Total	**851,787**	**806,828**

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 5.4 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

Where fees exceed £1m these have been recorded in note 4 analysis of other operating income.

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 6.1 Operating expenses	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	19	19	24	24
Purchase of healthcare from non-NHS and non-DHSC bodies	2,734	2,734	4,114	4,114
Staff and executive directors costs	550,535	581,812	516,714	546,363
Remuneration of non-executive directors	223	272	203	249
Supplies and services - clinical (excluding drugs costs)	51,399	74,548	52,688	74,913
Supplies and services - general	102,159	34,993	102,378	38,278
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	111,865	111,875	101,974	101,985
Consultancy costs	1,117	1,215	1,304	1,344
Establishment	2,303	2,647	2,189	2,344
Premises	4,293	18,687	2,853	17,256
Transport (including patient travel)	2,499	3,403	2,963	3,822
Depreciation on property, plant and equipment	30,072	30,080	30,667	30,696
Amortisation on intangible assets	5,638	5,638	4,986	4,986
Net impairments	10,287	10,287	29,041	29,041
Movement in credit loss allowance: contract receivables / contract assets	(3,399)	(3,441)	1,406	1,473
Change in provisions discount rate(s)	7	7	(1)	(1)
Fees payable to the external auditor				
audit services- statutory audit	378	485	367	419
Internal audit costs	92	112	80	99
Clinical negligence	22,264	22,264	20,049	20,049
Legal fees	889	1,411	1,622	1,851
Insurance (as a policy holder)	711	1,112	629	967
Research and development	107	107	78	78
Education and training	3,649	3,881	4,181	4,363
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,766	1,766	1,774	1,774
Car parking & security	-	64	-	65
Hospitality	18	19	30	30
Losses, ex gratia & special payments	27	27	16	16
Other NHS charitable fund resources expended	-	1,441	-	1,494
Other	203	205	454	517
Total	**901,855**	**907,670**	**882,783**	**888,609**
Of which:				
Related to continuing operations	901,855	907,670	882,783	888,609
Related to discontinued operations	-	-	-	-

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 7 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	262	-
Unforeseen obsolescence	141	-
Changes in market price	(15)	(12)
Other *	9,899	29,053
Total net impairments charged to operating surplus / deficit	**10,287**	**29,041**
Impairments charged to the revaluation reserve	1,556	1,135
Total net impairments	**11,843**	**30,176**

*This relates to the impairment in relation to the revaluation of the Trusts land and buildings.

Note 8 Employee benefits	Trust 2025/26 Total £000	Group 2025/26 Total £000	Trust 2024/25 Total £000	Group 2024/25 Total £000
Salaries and wages	395,999	420,551	377,524	401,990
Social security costs	56,380	59,277	42,831	44,354
Apprenticeship levy	2,216	2,323	2,140	2,218
Employer's contributions to NHS pensions	88,559	90,533	82,830	84,558
Temporary staff (including agency)	9,275	10,469	12,112	13,479
NHS charitable funds staff	-	553	-	487
Total gross staff costs	**552,429**	**583,706**	**517,437**	**547,086**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**552,429**	**583,706**	**517,437**	**547,086**
Of which				
Costs capitalised as part of assets	1,894	1,894	723	723

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 7 early retirements from the Trust agreed on the grounds of ill-health (10 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,302k (£913k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Interest on bank accounts	2,570	2,993	3,956	4,196
NHS charitable fund investment income	-	193	-	165
Other finance income	2,341	-	2,131	-
Total finance income	**4,911**	**3,186**	**6,087**	**4,361**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Interest expense:				
Interest on loans from the Department of Health and Social Care	581	581	667	667
Interest on lease obligations	463	463	392	392
Finance costs on PFI, LIFT and other service concession arrangements:				
Main finance costs	1,970	1,970	2,090	2,090
Remeasurement of the liability resulting from change in index or rate	1,371	1,371	1,058	1,058
Total interest expense	**4,385**	**4,385**	**4,207**	**4,207**
Unwinding of discount on provisions	72	72	70	70
Total finance costs	**4,457**	**4,457**	**4,277**	**4,277**

Note 11.2 The late payment of commercial debts (interest) Act 1998

The Trust did not incur any late payment penaties (2024/25 Nil).

Note 12 Other gains / (losses)

	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Losses on disposal of assets	(35)	(35)	(172)	(172)
Total gains / (losses) on disposal of assets	**(35)**	**(35)**	**(172)**	**(172)**
Fair value gains / (losses) on charitable fund investments & investment properties	-	100	-	(20)
Total other gains / (losses)	**(35)**	**65**	**(172)**	**(192)**

Note 13.1 Intangible assets - 2025/26

Group	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**12,132**	**344**	**14,519**	**4,309**	**31,304**
Additions	114	-	-	3,620	**3,734**
Reclassifications	4,197	(43)	2,622	(3,598)	**3,178**
Disposals / derecognition	(1,750)	-	(7,887)	-	**(9,637)**
Cost at 31 March 2026	**14,693**	**301**	**9,254**	**4,331**	**28,579**
Amortisation at 1 April 2025 - brought forward	**6,592**	**-**	**9,449**	**-**	**16,041**
Provided during the year	2,960	59	2,619	-	**5,638**
Reclassifications	2,488	-	-	-	**2,488**
Disposals / derecognition	(1,750)	-	(7,887)	-	**(9,637)**
Amortisation at 31 March 2026	**10,290**	**59**	**4,181**	**-**	**14,530**
Net book value at 31 March 2026	**4,403**	**242**	**5,073**	**4,331**	**14,049**
Net book value at 1 April 2025	**5,540**	**344**	**5,070**	**4,309**	**15,263**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

A separate note for the Trust is not provided as the Group figures relate to the Trust only.

Note 13.2 Intangible assets - 2024/25

Group	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**12,105**	**-**	**12,807**	**1,364**	**26,276**
Additions	27	344	828	3,829	**5,028**
Reclassifications	-	-	884	(884)	**-**
Valuation / gross cost at 31 March 2025	**12,132**	**344**	**14,519**	**4,309**	**31,304**
Amortisation at 1 April 2024 - brought forward	**3,863**	**-**	**7,192**	**-**	**11,055**
Provided during the year	2,729	-	2,257	-	**4,986**
Amortisation at 31 March 2025	**6,592**	**-**	**9,449**	**-**	**16,041**
Net book value at 31 March 2025	**5,540**	**344**	**5,070**	**4,309**	**15,263**
Net book value at 1 April 2024	**8,242**	**-**	**5,615**	**1,364**	**15,221**

A separate note for the Trust is not provided as the Group figures relate to the Trust only.

Note 14.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**12,400**	**245,059**	**272**	**12,364**	**69,476**	**140**	**43,410**	**116**	**383,237**
Additions	-	10,453	-	31,923	5,178	-	2,546	-	**50,100**
Impairments	-	(11,719)	-	(262)	-	-	-	-	**(11,981)**
Reversals of impairments	-	256	8	-	-	-	-	-	**264**
Revaluations	-	(10,077)	-	-	-	-	-	-	**(10,077)**
Reclassifications	-	3,842	-	(6,866)	2,264	-	(2,418)	-	**(3,178)**
Disposals / derecognition	-	-	-	-	(1,707)	-	(2,811)	-	**(4,518)**
Valuation/gross cost at 31 March 2026	**12,400**	**237,814**	**280**	**37,159**	**75,211**	**140**	**40,727**	**116**	**403,847**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**30,072**	**111**	**25,796**	**54**	**56,033**
Provided during the year	-	10,032	-	-	7,932	12	6,850	12	**24,838**
Impairments	-	-	-	-	96	-	45	-	**141**
Revaluations	-	(10,152)	-	-	-	-	-	-	**(10,152)**
Reclassifications	-	120	-	-	(120)	-	(2,488)	-	**(2,488)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,698)	-	(2,788)	-	**(4,486)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**36,282**	**123**	**27,415**	**66**	**63,886**
Net book value at 31 March 2026	**12,400**	**237,814**	**280**	**37,159**	**38,929**	**17**	**13,312**	**50**	**339,961**
Net book value at 1 April 2025	**12,400**	**245,059**	**272**	**12,364**	**39,404**	**29**	**17,614**	**62**	**327,204**

Note 14.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**12,400**	**239,880**	**256**	**37,501**	**57,677**	**140**	**46,468**	**115**	**394,437**
Additions	-	12,421	-	11,438	8,738	-	2,854	-	**35,451**
Impairments	-	(30,395)	-	-	-	-	-	-	**(30,395)**
Reversals of impairments	-	192	15	-	-	-	-	-	**207**
Revaluations	-	(8,934)	-	-	-	-	-	-	**(8,934)**
Reclassifications	-	32,350	1	(36,575)	5,103	-	797	1	**1,677**
Disposals / derecognition	-	(454)	-	-	(2,042)	-	(6,709)	-	**(9,205)**
Valuation/gross cost at 31 March 2025	**12,400**	**245,059**	**272**	**12,364**	**69,476**	**140**	**43,410**	**116**	**383,237**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**5**	**-**	**-**	**23,646**	**99**	**25,069**	**42**	**48,862**
Provided during the year	-	11,066	-	-	6,836	12	7,447	12	**25,373**
Revaluations	-	(10,634)	-	-	-	-	-	-	**(10,634)**
Reclassifications	-	17	-	-	1,494	-	(45)	-	**1,466**
Disposals / derecognition	-	(454)	-	-	(1,904)	-	(6,675)	-	**(9,033)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**30,072**	**111**	**25,796**	**54**	**56,034**
Net book value at 31 March 2025	**12,400**	**245,059**	**272**	**12,364**	**39,404**	**29**	**17,614**	**62**	**327,204**
Net book value at 1 April 2024	**12,400**	**239,874**	**256**	**37,501**	**34,031**	**41**	**21,399**	**73**	**345,575**

Disclosure

Included within the dwelling figures above at 31 March 2026 are a number of properties formerly in the ownership of Gloucestershire Royal NHS Trust and East Gloucestershire NHS Trust (which now form the Gloucestershire Hospitals NHS Foundation Trust) sold to a registered Housing Association in April 2000 and June 2004 respectively. These units were for residential accommodation mainly to NHS staff and families. The registered Housing Association is now responsible for this provision with the Trust having nomination rights. Both separate agreement contain a 99 year lease with a Trust option to break at 30 years and every 5 years, which if exercised will enable the Trust to take back the freehold of the land and buildings with vacant possession at no cost. They have been valued by the independent professional advisor on a residual value basis.

Included within buildings is the PFI scheme consisting of a Diagnostic & Treatment centre, therapy services, a new accident and emergency department and 75 inpatient bed spaces. The scheme was handed over in April 2002 and runs for 31 years and 10 months from that date. The initial scheme cost including all fees was £39.6m. The value of the building at the Statement of Financial Position date is £50.5m (2024/25 £52.2m).

Land and Buildings values have been determined by the Trust's Independent Valuer the Valuation Office Agency, their revaluation of the Trust estate to DRC values is consistent with Department of Health and Social Care guidance.

The residential accommodation properties have been valued at residual value.

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 14.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	12,400	181,622	280	36,955	36,429	-	13,312	43	-	**281,041**
On-SoFP PFI contracts and other service concession arrangements	-	50,536	-	-	-	-	-	-	-	**50,536**
Owned - donated/granted	-	5,656	-	204	2,500	17	-	7	-	**8,384**
NBV total at 31 March 2026	**12,400**	**237,814**	**280**	**37,159**	**38,929**	**17**	**13,312**	**50**	**-**	**339,961**

Note 14.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	12,400	187,160	272	12,343	36,093	-	17,614	48	-	**265,930**
On-SoFP PFI contracts and other service concession arrangements	-	52,170	-	-	-	-	-	-	-	**52,170**
Owned - donated/granted	-	5,729	-	21	3,311	29	-	14	-	**9,104**
NBV total at 31 March 2025	**12,400**	**245,059**	**272**	**12,364**	**39,404**	**29**	**17,614**	**62**	**-**	**327,204**

Note 15 Donations of property, plant and equipment

Donated Additions - relate to assets either purchased wholly or items partially funded from the Trust's own charitable funds. The Charitable Funds are administered by the Trust's Main Board as Corporate Trustee. Funds are registered with the Charity Commissioner as registration number 1051606. Additionally from time-to-time, an external charity working closely with the Trust may provide funding directly for a capital project. The Trust received donated medical equipment valued at £65k (2024/25 donated total valued at £309k).

Note 16 Revaluations of property, plant and equipment

The value and remaining useful asset lives of land and buildings assets are estimated by the Trust's Independent Valuer. The valuations are carried out in accordance the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

The Modern Equivalent Asset Optimised Alternative Site model was reviewed and a desk top valuation was undertaken by the Trust's independent valuer the Valuation Office Agency as at 31 March 2026. The underlying principle is that the valuation of land and buildings should reflect a modern configuration of the estate required for the provision of the same services as already provided by the existing estate. With service delivery requirements evolving, this requires the Trust to consider whether the existing buildings are optimal in terms of number and size. If the Trust were starting with a "clean sheet", the Modern Equivalent Asset aligned to service delivery would be very different to the current layout in terms of buildings configuration and the number of sites.

Note 17 Leases - Gloucestershire Hospitals NHS Foundation Trust as a lessee

The Trust leases various properties for the provision of services and accommodation, medical equipment and vehicles.

Note 17.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**13,860**	**25,191**	**1,057**	**227**	**40,335**	**384**
Additions	70	438	42	-	**550**	-
Remeasurements of the lease liability	13	565	15	6	**599**	(118)
Movements in provisions for restoration / removal costs	(100)	-	-	-	**(100)**	-
Reversal of impairments	15	-	-	-	**15**	-
Revaluations	(90)	-	-	-	**(90)**	-
Reclassifications	-	1	-	(1)	**-**	-
Disposals / derecognition	(58)	(631)	(46)	-	**(735)**	-
Valuation/gross cost at 31 March 2026	**13,710**	**25,564**	**1,068**	**232**	**40,574**	**266**
Accumulated depreciation at 1 April 2025 - brought forward	**4,186**	**14,195**	**390**	**19**	**18,790**	**77**
Provided during the year	2,124	2,811	293	14	**5,242**	76
Revaluations	(90)	-	-	-	**(90)**	-
Disposals / derecognition	(58)	(630)	(30)	-	**(718)**	-
Accumulated depreciation at 31 March 2026	**6,162**	**16,376**	**653**	**33**	**23,224**	**153**
Net book value at 31 March 2026	**7,548**	**9,188**	**415**	**199**	**17,350**	**113**
Net book value at 1 April 2025	**9,674**	**10,996**	**667**	**208**	**21,545**	**307**
Net book value of right of use assets leased from other NHS providers						113
Net book value of right of use assets leased from other DHSC group bodies						-

Note 17.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,229**	**24,263**	**618**	**227**	**38,337**	**425**
Transfers by absorption	-	-	-	-	**-**	-
Additions	616	258	593	-	**1,467**	384
Remeasurements of the lease liability	285	3,179	8	-	**3,472**	-
Movements in provisions for restoration / removal costs	(37)	-	-	-	**(37)**	-
Reversal of impairments	12	-	-	-	**12**	-
Revaluations	(87)	-	-	-	**(87)**	-
Reclassifications	371	(2,165)	1	-	**(1,793)**	-
Disposals / derecognition	(529)	(344)	(163)	-	**(1,036)**	(425)
Valuation/gross cost at 31 March 2025	**13,860**	**25,191**	**1,057**	**227**	**40,335**	**384**
Accumulated depreciation at 1 April 2024 - brought forward	**2,548**	**13,350**	**266**	**5**	**16,169**	**425**
Transfers by absorption	-	-	-	-	**-**	-
Provided during the year	2,045	2,981	283	14	**5,323**	77
Revaluations	(87)	-	-	-	**(87)**	-
Reclassifications	209	(1,792)	1	-	**(1,582)**	-
Disposals / derecognition	(529)	(344)	(160)	-	**(1,033)**	(425)
Accumulated depreciation at 31 March 2025	**4,186**	**14,195**	**390**	**19**	**18,790**	**77**
Net book value at 31 March 2025	**9,674**	**10,996**	**667**	**208**	**21,545**	**307**
Net book value at 1 April 2024	**10,681**	**10,913**	**352**	**222**	**22,168**	**-**
Net book value of right of use assets leased from other NHS providers						307
Net book value of right of use assets leased from other DHSC group bodies						-

A separate note for the Trust is not provided as the Group figures relate to the Trust only.

Note 17.3 Revaluations of right of use assets

ROU assest were remeasured in line with lease contracts.

Revaluations were carried out on peppercorn leases.

Note 17.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 28.1.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**21,051**	**21,581**	**21,051**	**21,581**
Lease additions	550	1,305	550	1305
Lease liability remeasurements	599	3,472	599	3472
Interest charge arising in year	463	392	463	392
Lease payments (cash outflows)	(5,545)	(5,699)	(5,545)	(5,699)
Carrying value at 31 March	**17,118**	**21,051**	**17,118**	**21,051**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 17.5 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,153	54	5,153	54
- later than one year and not later than five years;	8,338	76	8,338	76
- later than five years.	5,629	-	5,629	-
Total gross future lease payments	**19,120**	**130**	**19,120**	**130**
Finance charges allocated to future periods	(2,002)	(8)	(2,002)	(8)
Net lease liabilities at 31 March 2026	**17,118**	**122**	**17,118**	**122**
Of which:				
Leased from other NHS providers		122		122
Leased from other DHSC group bodies		-		-

Note 17.6 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,216	86	5,216	86
- later than one year and not later than five years;	11,299	259	11,299	259
- later than five years.	6,906	-	6,906	-
Total gross future lease payments	**23,421**	**345**	**23,421**	**345**
Finance charges allocated to future periods	(2,370)	(31)	(2,370)	(31)
Net finance lease liabilities at 31 March 2025	**21,051**	**314**	**21,051**	**314**
Of which:				
Leased from other NHS providers		314		314
Leased from other DHSC group bodies		-		-

Note 18 Other investments / financial assets (non-current)

	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
Carrying value at 1 April - brought forward	**-**	**1,790**	**-**	**1,944**
Acquisitions in year	-	279	-	428
Movement in fair value through income and expenditure	-	100	-	(20)
Disposals	-	(283)	-	(562)
Carrying value at 31 March	**-**	**1,886**	**-**	**1,790**

Note 18.1 Other investments / financial assets (current)

The Group has no current investments/financial assets (2025/26 nil).

Note 19 Disclosure of interests in other entities

The Trust has no interests in other non-consolidated subsidiaries, joint ventures, associates or unconsolidated entities (2025/26 nil).

Note 20 Analysis of charitable fund reserves

The Gloucestershire Hospitals Charitable Fund has been consolidated within this set of accounts.

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	701	1,410
Restricted funds:		
Other restricted income funds	4,760	2,798
	5,461	**4,208**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 21 Inventories

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Drugs	5,997	5,997	5,005	5,005
Consumables	6,563	7,397	6,076	6,860
Energy	285	285	295	295
Total inventories	**12,845**	**13,679**	**11,376**	**12,160**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £146,870k (2024/25: £140,263k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 22.1 Receivables

	Trust 31 March 2026 £000	Group 31 March 2026 £000	Trust 31 March 2025 £000	Group 31 March 2025 £000
Current				
Contract receivables	18,356	18,990	25,899	26,954
Allowance for impaired contract receivables / assets	(1,678)	(1,726)	(5,239)	(5,345)
Prepayments (non-PFI)	4,926	5,364	4,058	4,437
PDC dividend receivable	406	406	852	852
VAT receivable	4,929	6,555	3,501	2,969
Other receivables	62	62	45	45
NHS charitable funds receivables	-	86	-	147
Total current receivables	**27,001**	**29,737**	**29,116**	**30,059**
Non-current				
Contract receivables	1,822	1,822	1,951	1,951
Other receivables	1,253	1,253	1,405	1,405
Total non-current receivables	**3,075**	**3,075**	**3,356**	**3,356**
Of which receivable from NHS and DHSC group bodies:				
Current	13,067	13,314	6,481	6,481
Non-current	1,253	1,253	1,405	1,405

Note 22.2 Allowances for credit losses - 2025/26

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**5,345**	**-**	**5,239**	**-**
New allowances arising	92	-	92	-
Reversals of allowances	(3,533)	-	(3,492)	-
Utilisation of allowances (write offs)	(178)	-	(161)	-
Allowances as at 31 Mar 2026	**1,726**	**-**	**1,678**	**-**

Note 22.3 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	**3,957**	**-**	**3,917**	**-**
New allowances arising	1,473	-	1,406	-
Utilisation of allowances (write offs)	(85)	-	(84)	-
Allowances as at 31 Mar 2025	**5,345**	**-**	**5,239**	**-**

Note 22.4 Exposure to credit risk

The Trust considers there is currently no material exposure to credit risk, the majority of receivables value is for the NHS contracts, the remaining values are for Road Traffic accidents which has a Compensation Recovery Unit bad debt percentage notified to the Trust

Note 23 Finance leases (Gloucestershire Hospitals NHS Foundation Trust as a lessor)

The Trust does not receive any lease income.

Note 24 Other assets

Other assets represent Gloucestershire Hospitals 100% holding in its subsidiary company GMS which is a limited company registered within England and Wales. The company is a trading subsidary providing estates, facilities, sterile services and material management.

Note 25.1 Non-current assets held for sale and assets in disposal groups

There are no non-current assets held for sale or in assets in the disposal group.

Note 25.2 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Trust 2025/26 £000	Group 2025/26 £000	Trust 2024/25 £000	Group 2024/25 £000
At 1 April	**41,966**	**49,650**	**54,845**	**59,421**
Net change in year	(6,693)	191	(12,879)	(9,771)
At 31 March	**35,273**	**49,841**	**41,966**	**49,650**
Broken down into:				
Cash at commercial banks and in hand	-	11,007	-	7,684
Cash with the Government Banking Service	35,273	38,834	41,966	41,966
Total cash and cash equivalents as in SoFP	**35,273**	**49,841**	**41,966**	**49,650**
Total cash and cash equivalents as in SoCF	**35,273**	**49,841**	**41,966**	**49,650**

Note 25.3 Third party assets held by the trust

The Trust does not hold any cash or cash equivalents which relate to monies held on behalf of patients or other parties (2024/25 nil)

Note 26.1 Trade and other payables

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	17,664	24,629	15,983	21,079
Capital payables	319	319	2,445	2,445
Accruals	44,971	51,113	55,670	55,695
Social security costs	12,517	13,072	11,024	11,415
Pension contributions payable	7,382	7,611	6,852	7,260
NHS charitable funds: trade and other payables	-	72	-	481
Total current trade and other payables	**82,853**	**96,816**	**91,974**	**98,375**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	9674	9,684	9914	11,164
Non-current	-	-	-	-

Note 27 Other liabilities

	Trust 31 March 2026 £000	Group 31 March 2026 £000	Trust 31 March 2025 £000	Group 31 March 2025 £000
Current				
Deferred income: contract liabilities	13,519	13,519	13,606	13,606
Total other current liabilities	**13,519**	**13,519**	**13,606**	**13,606**
Non-current				
Deferred income: contract liabilities	4,521	4,521	6,478	6,478
Total other non-current liabilities	**4,521**	**4,521**	**6,478**	**6,478**

Note 28.1 Borrowings

	Trust 31 March 2026 £000	Group 31 March 2026 £000	Trust 31 March 2025 £000	Group 31 March 2025 £000
Current				
Loans from DHSC	1,730	1,730	1,729	1,729
Lease liabilities	4,808	4,808	4,772	4,772
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	3,420	3,420	3,055	3,055
Total current borrowings	**9,958**	**9,958**	**9,556**	**9,556**
Non-current				
Loans from DHSC	8,717	8,717	10,446	10,446
Lease liabilities	12,310	12,310	16,279	16,279
Obligations under PFI, LIFT or other service concession contracts	22,446	22,446	24,933	24,933
Total non-current borrowings	**43,473**	**43,473**	**51,658**	**51,658**

Note 28.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2025	**12,175**	**21,051**	**27,988**	**61,214**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,729)	(5,082)	(3,493)	**(10,304)**
Financing cash flows - payments of interest	(580)	(463)	(1,970)	**(3,013)**
Non-cash movements:				
Additions	-	550	-	**550**
Lease liability remeasurements	-	599	-	**599**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,371	**1,371**
Application of effective interest rate	581	463	1,970	**3,014**
Carrying value at 31 March 2026	**10,447**	**17,118**	**25,866**	**53,431**

Group - 2024/25	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**13,910**	**21,581**	**29,899**	**65,390**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,729)	(5,307)	(2,969)	**(10,005)**
Financing cash flows - payments of interest	(673)	(392)	(2,090)	**(3,155)**
Non-cash movements:				
Additions	-	1,305	-	**1,305**
Lease liability remeasurements	-	3,472	-	**3,472**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,058	**1,058**
Application of effective interest rate	667	392	2,090	**3,149**
Carrying value at 31 March 2025	**12,175**	**21,051**	**27,988**	**61,214**

Note 29.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2025	**1,207**	**75**	**8,681**	**9,963**
Change in the discount rate	7	-	(201)	**(194)**
Arising during the year	18	-	763	**781**
Utilised during the year	(109)	(27)	(62)	**(198)**
Reversed unused	(12)	-	(1,300)	**(1,312)**
Unwinding of discount	29	-	127	**156**
At 31 March 2026	**1,140**	**48**	**8,008**	**9,196**
Expected timing of cash flows:				
- not later than one year;	106	48	5,909	**6,063**
- later than one year and not later than five years;	422	-	188	**610**
- later than five years.	612	-	1,911	**2,523**
Total	**1,140**	**48**	**8,008**	**9,196**

Neither the GMS or the Charity have any provisions therefore the Trust is the same as the Group.

The pensions provisions relate to payments made to NHS Pensions for staff members who have had to retire early. Payments are made quarterly.

The Legal claims provision relates to clinical negligence legal costs where the Trust is liable to pay the excess costs.

Other provisions include £1,315k (2024/25 £1,450k) relating to an NHSI requirement to provide for tax charges relating to pensions, this is offset by a long term debtor for the same value.

Note 29.2 Clinical negligence liabilities

At 31 March 2026, £332,194k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2025: £284,421k).

Note 30 Contingent assets and liabilities

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(13)	(13)	(16)	(16)
Other	(285)	(285)	(252)	(252)
Gross value of contingent liabilities	**(298)**	**(298)**	**(268)**	**(268)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(298)**	**(298)**	**(268)**	**(268)**
Net value of contingent assets	**-**	**-**	**-**	**-**

Note 31 Contractual capital commitments

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	27,458	27,458	4,508	4,508
Intangible assets	193	193	7	7
Total	**27,651**	**27,651**	**4,515**	**4,515**

Note 32 Other financial commitments

The Trust has no non-cancellable contracts (which are not leases,PFI contracts or other service concession arrangements) (2024/25 Nil).

Note 33 Defined benefit pension schemes

The Trust's past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

Information on PFI is included in note 14.2

Note 34.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**38,011**	**38,011**	**41,325**	**41,325**
Of which liabilities are due				
- not later than one year;	5,152	5,152	4,938	4,938
- later than one year and not later than five years;	19,635	19,635	19,269	19,269
- later than five years.	13,224	13,224	17,118	17,118
Finance charges allocated to future periods	(12,145)	(12,145)	(13,337)	(13,337)
Net PFI, LIFT or other service concession arrangement obligation	**25,866**	**25,866**	**27,988**	**27,988**
- not later than one year;	3,420	3,420	3,055	3,055
- later than one year and not later than five years;	15,209	15,209	13,999	13,999
- later than five years.	7,237	7,237	10,934	10,934

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**68,991**	**68,991**	**75,313**	**75,313**
Of which payments are due:				
- not later than one year;	7,956	7,956	7,616	7,616
- later than one year and not later than five years;	33,863	33,863	32,417	32,417
- later than five years.	27,172	27,172	35,280	35,280

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Trust	Group	Trust	Group
	2025/26	2025/26	2024/25	2024/25
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**7,762**	**7,762**	**7,430**	**7,430**
Consisting of:				
- Interest charge	1,970	1,970	2,090	2,090
- Repayment of balance sheet obligation	3,493	3,493	2,968	2,968
- Service element and other charges to operating expenditure	1,766	1,766	1,774	1,774
- Capital lifecycle maintenance	533	533	598	598
Total amount paid to service concession operator	**7,762**	**7,762**	**7,430**	**7,430**

Note 35 Financial instruments

Note 35.1 Financial risk management

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

IFRS 7, Financial Instruments Disclosure and Presentation, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Credit Risk

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Intergrated Care Boards and NHS England and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of credit risk faced by many other business entities. The maximun exposures at at 31 March 2026 are in receivables from customers as disclosed in note 22.1 to the accounts. The Trust mitigates its exposure to credit risk through regular review of the debtor balances and calculating a bad provision at the year end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised.

	31 March 2026 £000	31 March 2025 £000
By up to 3 months	1,753	2,098
By three to six months	244	252
By more than 6 months	84	723
	2,081	3,073

Market Risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices.

The NHS Foundation Trust has limited powers to borrow or invest surplus funds. Cash is held on deposit with a number of safe harbour institutions which are deemed to have significantly low risk and high liquidity.

100% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The Trusts PFI scheme unitary payments are linked to RPI.

Liquidity risk

This is the risk that the NHS Foundation Trust will encounter difficulties meeting obligations associated with financial
The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Intergrated
Inflation risk

There is a risk moving forward that charges in relation to the PFI may be affected by excess inflationary pressures in the economy.

Note 35.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	20,401	-	**20,401**
Cash and cash equivalents	46,280	-	**46,280**
Consolidated NHS Charitable fund financial assets	3,647	1,886	**5,533**
Total at 31 March 2026	**70,328**	**1,886**	**72,214**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	25,010	-	**25,010**
Cash and cash equivalents	46,898	-	**46,898**
Consolidated NHS Charitable fund financial assets	2,899	1,790	**4,689**
Total at 31 March 2025	**74,807**	**1,790**	**76,597**

Note 35.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	19,815	-	**19,815**
Cash and cash equivalents	35,273	-	**35,273**
Total at 31 March 2026	**55,088**	**-**	**55,088**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	24,914	-	**24,914**
Cash and cash equivalents	41,966	-	**41,966**
Total at 31 March 2025	**66,880**	**-**	**66,880**

Note 35.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	10,447	**10,447**
Obligations under leases	17,118	**17,118**
Obligations under PFI, LIFT and other service concessions	25,866	**25,866**
Trade and other payables excluding non financial liabilities	69,768	**69,768**
Consolidated NHS charitable fund financial liabilities	72	**72**
Total at 31 March 2026	**123,271**	**123,271**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	12,175	**12,175**
Obligations under leases	21,051	**21,051**
Obligations under PFI, LIFT and other service concessions	27,988	**27,988**
Trade and other payables excluding non financial liabilities	73,780	**73,780**
Consolidated NHS charitable fund financial liabilities	481	**481**
Total at 31 March 2025	**135,475**	**135,475**

Note 35.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	10,447	**10,447**
Obligations under leases	17,118	**17,118**
Obligations under PFI, LIFT and other service concessions	25,866	**25,866**
Trade and other payables excluding non financial liabilities	56,790	**56,790**
Total at 31 March 2026	**110,221**	**110,221**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	12,175	**12,175**
Obligations under leases	21,051	**21,051**
Obligations under PFI, LIFT and other service concessions	27,988	**27,988**
Trade and other payables excluding non financial liabilities	68,659	**68,659**
Total at 31 March 2025	**129,873**	**129,873**

Note 35.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Trust	Group	Trust	Group
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£000	£000	£000	£000
In one year or less	69,320	82,370	81,122	86,724
In more than one year but not more than five years	36,018	36,018	38,954	38,954
In more than five years	20,722	20,722	27,776	27,776
Total	**126,060**	**139,110**	**147,852**	**153,454**

Note 36 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Bad debts and claims abandoned	1,423	175	984	89
Total losses	**1,423**	**175**	**984**	**89**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	2	17
Extra-contractual payments	-	-	-	-
Ex-gratia payments	21	13	21	13
Special severance payments	-	-	1	15
Total special payments	**21**	**13**	**24**	**45**
Total losses and special payments	**1,444**	**188**	**1,008**	**134**

Compensation payments received

Note 37 Gifts

There are no gifts which require disclosure.

Note 38 Related parties

Gloucestershire Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Gloucestershire Hospitals NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the period, Gloucestershire Hospitals NHS Foundation Trust, including in carrying out its role of host to the Gloucestershire Finance, Procurement and Estates Shared Services, has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Related parties may include but are not limited to:

- Department of Health and Social Care Ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- ICB's and NHS England
- Other Health Bodies
- Other Government Departments
- Local authorities

Note 39 Events after the reporting date

On the 15th June 2026, the Trust was notified of the outcome of the prosecution by CQC, around a pseudomonas case, which has resulted in a fine of c£324k.

In 2023/24, the Trust included a provision in the financial statements for the impact of this fine from the CQC, as the investigations were ongoing. This provision has been maintained across the proceeding financial years, including the current year, whilst an outcome was pending.

Owing to the timing of this announcement, and the associated reporting thresholds, the accounts have not been adjusted for the difference in value.

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