

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 10 September 2026 at 09.00 to 12.30

Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital

AGENDA

| REF                                          | ITEM                                                                                                                                                                                                    | PURPOSE     | PAPER | TIME  |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------|-------|
| 1.                                           | <b>Chair's welcome and introduction</b>                                                                                                                                                                 | Information |       | 09.00 |
| 2.                                           | <b>Apologies for absence</b>                                                                                                                                                                            | Information |       |       |
| 3.                                           | <b>Declarations of interest (pertaining to agenda)</b>                                                                                                                                                  | Approval    |       |       |
| 4.                                           | <b>Minutes of previous meeting</b><br>16 July 2026                                                                                                                                                      | Approval    |       | 09.03 |
| 5.                                           | <b>Matters arising</b>                                                                                                                                                                                  | Assurance   |       |       |
| 6.                                           | <b>Questions from the public</b>                                                                                                                                                                        | Information |       | 09.10 |
| 7.                                           | <b>Staff Story</b>                                                                                                                                                                                      | Information |       | 09.15 |
| 8.                                           | <b>Chair's report</b><br><i>Deborah Evans-Chair</i>                                                                                                                                                     | Information |       | 09.25 |
| 9.                                           | <b>Chief Executive's Report</b><br><i>Kevin McNamara, Chief Executive</i>                                                                                                                               | Information |       | 09.35 |
|                                              |                                                                                                                                                                                                         |             |       |       |
| 10.                                          | <b>Maternity Services Regulatory Compliance Report (section 31 Notice Response)</b><br><i>Matt Holdaway, Chief Nurse &amp; Director of Quality</i>                                                      | Assurance   |       | 09.45 |
| 11.                                          | <b>Perinatal Quality Oversight Model</b> <ul style="list-style-type: none"> <li>To include 10-point plan assurance process (11a)</li> </ul> <i>Matt Holdaway, Chief Nurse &amp; Director of Quality</i> | Assurance   |       | 09.55 |
|                                              |                                                                                                                                                                                                         |             |       |       |
| 12.                                          | <b>Integrated Governance update including updates on legal, regulatory and policy</b><br><i>Kerry Rogers, Director of Integrated Governance</i>                                                         | Assurance   |       | 10.10 |
| 13.                                          | <b>Combined Risk Management Report</b> <ul style="list-style-type: none"> <li>Corporate Risks</li> <li>Board Assurance Framework</li> </ul> <i>Kerry Rogers, Director of Integrated Governance</i>      | Assurance   |       | 10.20 |
| <b>PEOPLE AND ORGANISATIONAL DEVELOPMENT</b> |                                                                                                                                                                                                         |             |       |       |
| 14.                                          | <b>Chief People Officer's Insights Report</b><br><i>Caroline Julien, Chief People Officer</i>                                                                                                           | Assurance   |       | 10.30 |
| 15.                                          | <b>Guardian of Safe Working Annual Report</b><br><i>Shyam Bhakthavalsala, Guardian of Safe Working</i>                                                                                                  | Assurance   |       | 10.40 |
| <b>BREAK (11.10 to 11.20)</b>                |                                                                                                                                                                                                         |             |       |       |
| <b>QUALITY AND PERFORMANCE</b>               |                                                                                                                                                                                                         |             |       |       |
| 16.                                          | <b>Quality and Performance Committee Report</b>                                                                                                                                                         | Assurance   |       | 10.50 |

|                       |                                                                                                                                                                                                                                |             |  |       |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--|-------|
|                       | <i>Sam Foster, Non-Executive Director</i> <ul style="list-style-type: none"> <li>• Infection Prevention and Control Annual Report</li> <li>• Safeguarding Annual Report</li> </ul> <p>Full reports within the Reading Room</p> |             |  |       |
| 17.                   | <b>Integrated Performance Report</b><br><i>Al Sheward-Chief Operating Officer, Karen Johnson-Director of Finance, Matt Holdaway-Chief Nurse, Mark Pietroni-Medical Director, Caroline Julien-Chief People Officer</i>          | Assurance   |  | 11.00 |
| 18.                   | <b>Appraisal Revalidation Report</b><br><i>Mark Pietroni, Medical Director &amp; Director of Safety</i>                                                                                                                        | Assurance   |  | 11.40 |
| 19.                   | <b>Winter planning 2026/27 – Assurance Process Report</b><br><i>Al Sheward, Chief Operating Officer</i>                                                                                                                        |             |  | 11.50 |
| <b>SUSTAINABILITY</b> |                                                                                                                                                                                                                                |             |  |       |
| 20.                   | <b>Green Plan</b><br><i>Will Cleary-Gray, Director of Improvement and Delivery</i>                                                                                                                                             |             |  | 12.05 |
| <b>FINANCE</b>        |                                                                                                                                                                                                                                |             |  |       |
| 21.                   | <b>Finance and Resources Committee Report</b><br><i>John Noble, Non-Executive Director</i>                                                                                                                                     | Assurance   |  | 12.15 |
| 22.                   | <b>Any other business</b>                                                                                                                                                                                                      | Information |  |       |
| 23.                   | <b>Governor observations</b>                                                                                                                                                                                                   | Information |  |       |
|                       | <b>Date and time of next meeting:</b><br>Thursday 12 <sup>th</sup> November<br>09.00 Lecture Hall, Redwood Education Centre,<br>Gloucester Royal Hospital                                                                      | Information |  |       |

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**  
**Minutes of the Public Board of Directors' Meeting**  
**16 July 2026, 09:00 -12.30**  
**Sandford Education Centre, Cheltenham General Hospital**

|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |
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| <b>Present</b>   | Deborah Evans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Chair, Non-Executive Director                                           |
|                  | Vareta Bryan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Non-Executive Director                                                  |
|                  | Will Cleary-Gray                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Director of Improvement and Delivery                                    |
|                  | Matt Holdaway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Chief Nurse and Director of Quality                                     |
|                  | Kevin McNamara                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Chief Executive Officer                                                 |
|                  | John Noble                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Non-Executive Director                                                  |
|                  | Shawn Smith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Non-Executive Director                                                  |
|                  | Al Sheward                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Chief Operating Officer                                                 |
|                  | Lee Pester                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Chief Digital Information Officer                                       |
|                  | Kerry Rogers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Director of Integrated Governance                                       |
|                  | Raj Kakar-Clayton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Associate Non-Executive Director                                        |
|                  | Kaye M Law                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Gloucestershire Managed Services Chair/Associate Non-Executive Director |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |
| <b>Attending</b> | James Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Director of Engagement, Involvement and Communications                  |
|                  | Suzie Cro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Director of Quality Governance                                          |
|                  | Lisa Evans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Deputy Trust Secretary                                                  |
|                  | Kate Hellier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Deputy Medical Director                                                 |
|                  | Katherine Holland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Head of Patient Experience                                              |
|                  | Juwairiyia Motola                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Community Engagement and Involvement Manager                            |
|                  | Steve Perkins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Director of Operational Finance                                         |
|                  | Deborah Tunnell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Deputy Director for People and Organisational Development               |
| <b>Apologies</b> | Karen Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Director of Finance                                                     |
|                  | Sarah Favell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Trust Secretary                                                         |
|                  | Sam Foster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Non-Executive Director                                                  |
|                  | Marie-Annick Gournet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Non-Executive Director                                                  |
|                  | Jaki Meekings Davis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Non-Executive Director                                                  |
|                  | Sally Moyle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Non-Executive Director                                                  |
|                  | Mark Pietroni                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Medical Director and Director of Safety                                 |
| <b>Observers</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |
| Governors        | Andrea Holder, Mike Ellis, Russell Peek, Debs Andrew                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |
| Public           | Eight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |
| <b>Ref</b>       | <b>Item</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                         |
| <b>1</b>         | <b>Chair's welcome and introduction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         |
|                  | <p>Deborah Evans, Chair, opened the meeting, welcoming all members of the public and governors in attendance.</p> <p>The Chair acknowledged that a number of members of the public attending today had recently corresponded with the Trust on matters of significant personal importance to them. The Board was committed to openness, transparency and responding to concerns through the appropriate processes. The questions would be responded to orally at the meeting with full written responses to follow.</p> |                                                                         |

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|          | The Board noted that a separate process was taking place and senior members of staff had offered to meet with the family. The legitimacy of their concerns was recognised.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>2</b> | <b>Apologies for absence</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|          | Apologies were noted as above.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>3</b> | <b>Declarations of interest</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|          | There were no declarations of interest in respect of agenda items.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>4</b> | <b>Minutes of previous meeting</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|          | <p>The Board reviewed the minutes of the previous meeting.</p> <p><b>RESOLVED:</b> The minutes of the meeting held on 14 May 2026 were APPROVED, as a true and accurate record.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>5</b> | <b>Matters arising</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|          | The Committee noted the updates to the Matters Arising and APPROVED the closed items.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>6</b> | <b>Questions from the public</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | <p>Four questions had been submitted to the Board Meeting from one family. These were read out and written responses would be provided outside of the meeting:</p> <ul style="list-style-type: none"> <li>• Following the national infected blood scandal, what specific assurance has the Board sought or received that the Trust can identify, preserve and disclose historic transfusion and blood-product records where patients, families, personal representatives or estates need those records for statutory disclosure, patient-safety, legal or compensation-related purposes?</li> <li>• Where the Board receives assurance on audit, governance, performance and quality, what mechanism ensures that cross-cutting record-governance issues are logged, allocated to a named executive lead, tracked to closure, and reported back to the Board? In particular, when the same clinical record is relevant to multiple processes—such as incident investigation, statutory disclosure, claims handling and organisational learning—how does the Board assure itself that those processes are based on a complete, auditable and preserved record, rather than being handled separately as isolated operational matters?</li> <li>• What assurance does the Board receive that incidents recorded on Datix, or any successor patient-safety incident reporting system, are actively used to identify recurring themes in diagnostic pathway failures, including referral, booking, template, imaging, follow-up and administrative handover errors? In particular, where an incident involves a missed or delayed diagnostic test, what assurance does the Board have that the Trust does not treat it as an isolated administrative error, but instead examines whether the same process, template, booking pathway, reporting code, handover point or follow-up system has created risk for other patients? How does the Board assure itself that learning from Datix-reported diagnostic delays is translated into measurable action, audit, re-audit and sustained change, rather than closed once an individual investigation concludes?</li> <li>• What assurance does the Board receive that patients recorded as having 'no fixed abode,' unknown or unclear accommodation, uncertain GP registration, missing next-</li> </ul> |



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|          | <p>of-kin information or unreliable contact details are identified as a patient-safety and discharge-risk group, and that this information is actively checked, corrected, audited and acted upon where it may affect discharge planning, follow-up appointments, diagnostic results, medication safety, safeguarding, cancer-pathway follow-up, end-of-life care, family communication or access to records after death? As part of that assurance, please explain how the Board is satisfied that incidents or risks involving inaccurate demographic, accommodation or contact information are captured, reviewed, escalated where necessary, and translated into measurable learning rather than treated as routine administrative errors.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>7</b> | <p><b>Patient Story: Presentation from a Young Carer</b></p> <p>Katherine Holland introduced a story which highlighted the experiences of young carers in the county. The board was shown a short film which included the stories of three young carers. Millie, who was 14, and a young carer for her older brother who had cerebral palsy, Mary who was 11 shared her story of caring for her mother who had epilepsy and Grace 15 shared her experience of caring for her mother who was diagnosed with leukaemia and encephalitis.</p> <p>Fin who was 18, attended the meeting, he spoke about how he had been caring for his mother, who suffered with complex illnesses, since he was a very young child. He was accompanied by Hana Gill from Gloucestershire Young Carers who reported that there were currently around 7000 young carers in Gloucestershire. She highlighted a Memorandum of Understanding that had been signed by Young Gloucestershire and Gloucestershire Health and Care NHS Foundation Trust and encouraged the Trust to consider becoming a signatory. Matt Holdaway agreed to discuss the Memorandum of Understanding with Hana. <b>ACTION</b></p> <p>Matt noted that the young carers in the film had asked that those involved in the care of their loved ones, listened to them more. He asked Fin what advice he would give to professionals. Finn asked that they relay information to the young person as well as to the patient.</p> <p>The Chair thanked Hana and Fin for attending the Board meeting and noted how powerful the film was. The Chair confirmed that the Trust was committed to working with young people.</p> |
| <b>8</b> | <p><b>Chair's Report</b><br/> <i>Deborah Evans, Chair</i></p> <p>Deborah Evans presented her report which provided information about her activities as Chair of the Trust since the last Board meeting in May. The report was taken as read.</p> <p><b>RESOLVED:</b> The Board NOTED the report.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>9</b> | <p><b>Chief Executive's Report</b><br/> <i>Kevin McNamara, Chief Executive</i></p> <p>Kevin McNamara presented his report which was taken as read. Kevin highlighted that Maternity remained a priority for the Trust, noting that maternity care was becoming more complex. The service was going through a period sustained scrutiny and ongoing improvement.</p> <p>The Trust had been selected as one of the twelve Trusts for review as part of the Amos Report, which was published in June. That report identified eight themes that were seen across maternity services nationally and brought recommendations together. The importance of pace and consistency, compassionate responses and engagement with families was noted; Kevin</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|    | <p>highlighted that the Trust was listening to families and the Trust Strategy would amplify the patient voice. The Board noted that this review had led to concern around the professional identity of midwives, a further report was expected in September.</p> <p>Kevin reported that the Home Birth Service had been reviewed. A communications programme was being worked through and staff would be consulted. Further updates would be shared at future Board meetings and on the Trust website.</p> <p>The Ockenden report, published on 24 June, was the largest maternity investigation in NHS history, examining the experiences of nearly 2,500 families between 2012 and 2025 and identifying longstanding and systemic failures in safety, governance, leadership and culture. The report highlighted widescale harm, including more than 500 cases of potentially avoidable harm, 94 potentially avoidable stillbirths, 62 neonatal deaths, 120 babies with brain injuries and six maternal deaths. Kevin reported that updates would continue to be brought to the Board.</p> <p>The Mann Review into racism and antisemitism was formally published on 4 June 2026. NHS organisations had received a letter from NHS England outlining the required actions and expectations for providers. This communication marked the transition from recommendation to implementation and included clear expectations for organisational response, reporting and Board oversight. The Board noted that that black and brown women were more likely to experience harm and considered how this correlated to other services across the Trust. Kevin reported that the Trust was rolling out Martha's Law and was listening to and acting upon data; more cultural work would be carried out. Triage was an area of focus for the CQC.</p> <p>The Board received an update on the pseudomonas case from August 2022. Dr Christopher Elliot, a patient receiving cancer care at Cheltenham General Hospital, contracted pseudomonas aeruginosa, linked to the hospital environment, and passed away. The Trust had acknowledged its failings and entered a guilty plea at the court case brought by the CQC. The Trust's oversight of Gloucestershire Managed Services who delivered the service was not strong enough at the time; improved governance and oversight in place now was noted. The Trust recognised the impact on the family and had apologised. The Health and Safety Executive was bringing a separate case against Gloucestershire Managed Services.</p> <p>John Noble noted that NHS England had asked Trust boards to treat cyber security as a core organisational risk, with clear executive accountability, sustained assurance and evidence that risks were actively managed across the organisation. He asked if the board should review the Data Security and Protection Toolkit, which was currently overseen by the Audit and Assurance Committee. Lee Pester confirmed that he was planning a Board Development Session on digital, later that year and would ensure that the Toolkit was discussed there.</p> <p><b>RESOLVED:</b> The Board NOTED the report.</p> |
| 10 | <p><b>Maternity Services Regulatory Compliance Report (section 31 Notice)</b></p> <p><i>Matt Holdaway, Chief Nurse and Director of Quality</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|    | <p>Matt Holdaway presented the report, which was a standing item before the Board and a key element of the continued focus on maternity services. The report provided an update on progress/compliance against the s31 Enforcement Notice issued in May 2024.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

Matt updated the Board on progress with leadership recruitment in the maternity service. Nicola Moore had joined the Trust from Bristol, as Deputy Director of Midwifery and Claire Litchfield had joined from Oxford, as Consultant Midwife. A Director of Midwifery had also been recruited.

Matt reported that the Trust had self-assessed that all eight CQC Section 31 conditions had been met and the external governance from the Integrated Care Board had been stood down. The report provided triangulated evidence that the required controls were established, monitored and sustainable, and supported formal applications for condition removal subject to completion of the factual accuracy process and receipt of the final CQC inspection report. Matt reported that he had asked the CQC not to undertake a further inspection until that report was received in September. The CQC would visit the Trust again in August to undertake a deep dive; this was welcomed.

The Trust remained under Section 31 conditions relating to maternity services at Gloucestershire Royal Hospital. The key Board judgement was whether the residual risks described were sufficiently controlled through routine governance to support formal applications for removal. The Board received assurance that the original regulatory risks had been addressed, that residual risks were visible and managed through business-as-usual governance, and that the Trust had a sufficiently strong evidence base to support formal applications for removal of the CQC Section 31 conditions.

The Chair commended the report and noted that a full discussion had taken place at the previous meeting. Vareta Bryan acknowledged that the Amos and Ockenden reports were uncomfortable reading and noted the impact on staff morale. She confirmed that efforts were being made to support staff. Staff were being proactive and were working through the recommendations made, including to strengthen patient engagement.

**RESOLVED:**

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

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| 11 | <b>Perinatal Quality Oversight Report (as of March 2026)</b><br><i>Matt Holdaway, Chief Nurse &amp; Director of Quality</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|    | <p>Matt Holdaway reported that the report covered the quarter four position and had been through the Trust governance process and was presented for oversight and assurance. Matt reported that maternity governance continued to be strengthened, with robust oversight in place. The Board noted that no new concerns had been raised by the CQC during the period.</p> <p>Matt provided assurance that Perinatal Mortality Review Tool compliance remained strong. There were no new direct concerns from Maternity and Newborn Safety Investigations, NHS Resolution or the Care Quality Commission during March 2026, and no Maternity Outcomes Signal System safety alerts in the reporting period. Progress in other priority areas was noted. Matt highlighted compliance in notifying deaths at 100% and in Triage, over 80% of actions were complete or in progress. The Maternity Triage Improvement Programme was delivering measurable operational improvement, with more than 80 per cent of actions now complete or in progress and improved performance in others was noted and Matt reported that he was looking to share the outcome with staff.</p> <p>On the CQC Section 31, Matt reported that there were a number of measures that the Trust needed to demonstrate compliance with, and the Board noted that improvement was being seen. The Internal Audit of the service had provided moderate assurance; there was further work to do on governance arrangements. Current compliance with Maternity Incentive Scheme Safety Action was noted, 2 safety actions were red. The Perinatal Delivery Group had met the previous week and discussed the red areas; actions were being put place.</p> <p>The board noted that the Cultural Improvement Programme was behind schedule but progressing. Training compliance was a risk against the new Maternity Incentive Scheme Year 8 Safety Action B and the Maternity Core Competency Framework; recovery actions were in progress and improvement was being seen. Another risk around ultrasound scanning, due to administration issues and capacity was noted, work to improve resilience was ongoing.</p> <p>The Homebirth service remained closed and the reduced choice this had led to was noted.</p> <p><b>RESOLVED:</b> The Board NOTED the report, recognising the areas of progress and material exception.</p> |
| 12 | <b>Audit and Assurance Committee Report</b><br><i>Shawn Smith, Non-Executive Director</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|    | <p>Shawn Smith, Committee Chair, presented the report following the June meeting of the Committee, with much of the report being taken as read. Shawn focussed on the Alert areas, highlighting that Financial sustainability remained a significant weakness in value for money arrangements due to continued reliance on non-recurrent savings and the scale of savings required to deliver future financial plans. While financial performance had improved, financial sustainability remained the sole significant weakness identified by external audit. The board noted that there was focus on this.</p> <p>Complaints management had received a Limited Assurance opinion for operational effectiveness. Internal Audit identified significant weaknesses in timeliness, data quality, visibility and oversight, including average complaint response times of 79 working days. Risk</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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|           | <p>action management remained a material governance concern and Health and safety risks continued to require sustained Board oversight, particularly fire safety enforcement notices, ventilation and air handling unit resilience, violence and aggression towards staff, and wider estates compliance risks.</p> <p>Policy compliance continued to present limited assurance, with approximately 31% of Trust policies overdue for review and significant variation across divisions. Approvals were noted.</p> <p>Shawn commended the work being undertaken by Karen Johnson, Steve Perkins and the wider Finance team.</p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The Board took ASSURANCE from the Committee's work and conclusions.</li> <li>• The Board NOTED the continuing significant weakness identified by External Audit relating to financial sustainability and reliance on non-recurrent savings.</li> <li>• The Board NOTED the Limited Assurance opinion relating to complaints management and SUPPORTED the continued executive focus and Quality and Performance Committee oversight of the improvement programme.</li> <li>• The Board SUPPORTED continued executive action to improve timely completion of risk and incident actions, address policy compliance backlogs, and strengthen assurance over key health and safety risks including fire safety, ventilation resilience and violence and aggression towards staff.</li> <li>• The Board APPROVED the Annual Report and Accounts 2025/26 as recommended by the Committee.</li> </ul>                                                                                                                                                                                  |
| <b>13</b> | <p><b>Health and Safety Annual Assurance Report</b><br/> <i>Kerry Rogers, Director of Integrated Governance</i></p> <p>Kerry Rogers presented the Trust's second Annual Health and Safety Report for the period 1 April 2025 to 31 March 2026 and provided the Board with assurance on the effectiveness of the Trust's arrangements for managing health and safety risks, compliance with statutory duties and delivery of the Health and Safety Plan 2025-2027. The report supported the Board in discharging its responsibilities under the Health and Safety at Work etc. Act 1974 and associated legislation by receiving and scrutinising assurance regarding health and safety performance and compliance.</p> <p>The report provided a comprehensive review of performance during 2025/26, including statutory compliance, progress against strategic objectives, significant risks, incident and RIDDOR trends, governance effectiveness, and areas requiring ongoing oversight. Overall, the Trust provided reasonable assurance, with defined areas of partial and limited assurance requiring continued executive and Board oversight. The report supported delivery of the Trust's strategic objectives relating to patient, public and staff safety, organisational resilience and good governance.</p> <p>There had been measurable progress against the Year 1 objectives of the Health and Safety Plan, particularly in governance maturity, compliance frameworks, and reporting culture. Controls across Objectives 1–14 were largely effective, although assurance was not uniform. There was evidence of sustained improvement across key areas including water safety, COSHH and health and safety resources. Areas of Partial Assurance were noted.</p> |



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|           | <p>Kaye M Law reported that the improvements being seen were due to a group effort, involving Gloucestershire Managed Services and the Trust, adding that the subsidiary was fully integrated and held to account by the Trust. The Board noted the issues caused by the aged estate. The Chair noted the important prioritisation work which would take place on Estates works .</p> <p>The Chair welcomed the report and noted that the Chief Executive had commended Kerry earlier for the strength around Health and Safety. The Board asked Kerry to consider how areas/objectives were assessed/rated in the next report to provide additional consistency.</p> <p><b>ACTION</b></p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The Board <b>APPROVED</b> the Annual Health and Safety Report 2025/26 and was assured by the scrutiny undertaken by the Group Health and Safety Committee, Trust Leadership Team and Audit and Assurance Committee</li> <li>• The Board acknowledged the overall assurance opinion of reasonable assurance, with identified areas of partial and limited assurance requiring ongoing oversight and scrutinised areas of limited assurance, particularly fire safety, ventilation, abuse and aggression and estates risks, confirming continued Board oversight will be maintained for those risks.</li> <li>• The Board endorsed the prioritised improvement programme for 2026/27 and continued focus on the Trust's highest health and safety risks and was satisfied that appropriate governance arrangements were in place to oversee delivery of the improvement programme.</li> </ul>                                  |
| <b>14</b> | <p><b>Corporate Governance Report</b><br/> <i>Kerry Rogers, Director of Integrated Governance</i></p> <p>The Trust Secretary's report brought together three key areas of corporate governance assurance for 2025/26: the annual Committee Effectiveness Reviews, compliance with the NHS England Fit and Proper Person Test Framework, and the annual report on the use of the Trust Seal. The report provided assurance that the Trust had effective governance arrangements, compliant board assurance processes and appropriate statutory governance controls in place. The proposed actions would further strengthen strategic assurance, governance effectiveness and Board oversight.</p> <p>Kerry Rogers reported that revised Committee Terms of Reference had been developed to reflect the Trust's refreshed strategic priorities and assurance framework. The report recommended adoption of a biennial effectiveness review cycle, supported by annual desktop reviews, to maintain assurance whilst ensuring a proportionate approach to governance oversight. Kerry highlighted the scrutiny of the Fit and Proper process, which included reporting to NHSE, external assurance from the Auditors and verbal feedback from the CQC following the well led visit.</p> <p>The Board noted that there had been no sealings during the period.</p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The findings of the 2025/26 Committee Effective Reviews were NOTED.</li> <li>• The Board <b>APPROVED</b> the revised Committee Terms of Reference and the adoption of a biennial review approach supported by interim desktop reviews and was</li> </ul> |

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|           | <p>ASSURED that the board committee structure remained effective and fit for purpose. The identified improvement actions were noted.</p> <ul style="list-style-type: none"> <li>• The Board was ASSURED regarding compliance with the NHS Fit and Proper Test Framework for 2025/26.</li> <li>• The Board NOTED that the Chair had completed the annual FPPT declaration and submission to NHS England.</li> <li>• The Board NOTED that all Board members had been assessed and concluded to be fit and proper during the reporting period.</li> <li>• The Board NOTED the use of the Trust Seal during the period April 2025 to March 2026.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>15</b> | <p><b>People and Organisational Development Committee Report</b><br/> <i>Deborah Tunnell, Deputy Director for People and Organisational Development</i></p> <p>In the absence of Marie-Annick Gournet (Committee Chair) Deborah Tunnell presented the update from the People and Organisational Development Committee meeting held on 16 June.</p> <p>The Committee had considered a number of items being reported on at this Board meeting. The Committee received assurance around workforce sustainability, culture and retention, workforce transformation, staff experience, speaking up, workforce performance and workforce risks. The Committee noted significant workforce transformation requirements arising from the NHS Medium Term Planning Framework and Transforming People Services Programme, whilst also considering the organisational culture, staff experience and workforce risks associated with delivering this scale of change. The Committee had received a detailed update on the Workforce Transformation Programme and Workforce Reduction Requirements and these areas were highlighted in the Alert section of the report to this meeting. The programme formed a critical component of the Trust's financial recovery and medium-term planning assumptions. The Trust was required to deliver a £10 million pay reduction equivalent to approximately 174 WTE staff members during 2026/27 through a combination of strengthened workforce controls, workforce reset measures and longer-term transformation programmes. The Committee discussed how delivery of these targets must be achieved through genuine service redesign and transformation.</p> <p>The 2025 Staff Survey was reviewed and persistent concerns around staff experience, workload and workforce pressures were noted. The Committee also received a comprehensive report regarding violence and aggression incidents and noted evidence of ongoing discriminatory abuse directed towards staff, particularly racial abuse. Members recognised the significant psychological impact on staff arising from repeated exposure to abuse and discriminatory behaviour.</p> <p>The revised One Gloucestershire Redeployment Memorandum of Understanding had been approved. Members received assurance that the framework provided a consistent, compassionate and system-wide approach to supporting staff affected by organisational change, reducing redundancy risk and retaining skills across Gloucestershire partner organisations while maintaining service resilience.</p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The Board was ASSURED around the strengthened governance arrangements supporting workforce transformation, workforce performance and staff experience improvement.</li> </ul> |

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|           | <ul style="list-style-type: none"> <li>• The Board NOTED the significant workforce transformation challenge associated with delivery of medium-term planning requirements and associated workforce reductions.</li> <li>• The Board NOTED ongoing developments associated with the NHS Transforming People Services Programme and wider system workforce reforms which will continue to influence future delivery models for People services.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>16</b> | <b>Freedom to Speak Up Guardian Annual Report</b><br><i>Louisa Hopkins, Freedom to Speak Up Guardian</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|           | <p>Louisa Hopkins provided an overview of Freedom to Speak Up activity and organisational insight during 2025/26. The report drew on information from contacts with the Freedom to Speak Up team, Report Support and Learn, and the NHS Staff Survey to provide a triangulated view of the speaking-up culture across the Trust.</p> <p>The evidence provided demonstrated that staff continued to access formal speaking-up routes across all staff groups and divisions. This suggested that staff were aware of the routes available to them and were willing to use them when they felt unable to raise concerns through local channels. However, Louisa highlighted a continuing gap between staff feeling able to raise concerns and confidence that concerns would be acted upon effectively. Louisa reported that work was continuing to address that gap and improve confidence in the process. Issues around discrimination were also noted.</p> <p>Steve Perkins noted that this work helped to inform workplans and asked if it was possible to share responses by staff groups or bands, to help services consider where to focus efforts. Louisa confirmed that this work was being carried out.</p> <p>Kevin McNamara confirmed that he held regular meetings with Louisa to allow her to raise issues. He added that the Freedom to Speak Up work was being brought into the Integrated Governance directorate, which would provide objective executive leadership. Louisa reported that she was hoping to work with Kerry Roger's to continue to triangulate information from across the Trust. She also reported that she was working with Gloucestershire Health and Care Service on a framework. Kate Hellier asked how this work linked to the Trust's Report, Support and Learn work. Louisa reported that Freedom to Speak up considered concerns where there were barriers; Report, Support and Learn was separate but the two areas of work were beginning to be brought together. Kaye M Law asked if the cultural heatmap work was included. Deborah Tunnell confirmed that that data was part of the staff survey report.</p> <p>Concerns around responsiveness were discussed. Vareta Bryan noted that staff were speaking up but were losing confidence in the system, adding that the Trust needed to identify a way to share anonymised feedback where confidentiality was a barrier. Matt Holdaway noted the importance for colleagues to see that the process had resulted in a tangible outcome. He confirmed that that work had started, anonymised outcomes were being shared. Louisa noted that their remained a challenge in demonstrating that speaking up made a difference.</p> <p>The Chair highlighted that staff were speaking up about discrimination and noted the difference in responding to concerns about race compared with issues of sexual safety.</p> <p><b>RESOLVED:</b></p> |



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|           | <ul style="list-style-type: none"> <li>• The Board RECEIVED the Freedom to Speak Up Annual Report 2026 and NOTED the mixed assurance position.</li> <li>• The Board ENDORSED the continued focus on organisational responsiveness, leadership accountability, visible learning, strengthened organisational insight through enhanced data collection, targeted support for areas of lower confidence, and ongoing oversight of behavioural concerns and discrimination, particularly race discrimination.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>17</b> | <p><b>Engagement and Involvement Annual Review</b><br/> <i>James Brown, Director of Engagement, Involvement and Communications and Juwairiyia Motola, Community Engagement and Involvement Manager</i></p> <p>James Brown reported that this was the sixth formal report on the Trust's engagement and involvement activity. The Board noted that the report had been shared and discussed at Quality Delivery Group and Quality and Performance Committee; it had been endorsed by and was recommended to Board by Quality and Performance Committee.</p> <p>James reported that the annual review set out the importance of engagement and involvement and how the Trust worked with local people, community groups, and partners over the last year. The review described the local communities and the challenges of health inequalities across the county.</p> <p>The Board noted that colleagues had met with over 7000 people during the past year through events, engagement and partnership working. The team focussed on areas of deprivation across the county and were linking with Gloucestershire Health and Care Foundation Trust. Al Sheward noted that people from deprived areas were far more likely to attend the Emergency Department, he asked James and Juwairiyia to consider how they could assist with that work. Lee Pester reported that there was strong engagement with local councils and offered to assist with this piece of work. <b>ACTION</b></p> <p>Work with Mindsong was noted. James commended their work to build trust with dementia patients. James highlighted challenges during the past year, particularly Refugee Week where colleagues and volunteers had experienced racism. The importance of the Lord Mann review into antisemitism and other forms of racism in the NHS and healthcare regulatory system was noted.</p> <p>The Trust's focus on health education had been strengthened by working alongside community and voluntary sector partners. The support provided to local people was noted; this work improved awareness, built trust and supported more informed healthcare choices. Juwairiyia reported that Community engagement was increasingly becoming a vehicle for prevention, education and reducing health inequalities. The work of the young influencers was noted, particularly the 'Say Hello in any language' initiative, where badges were designed which enabled staff to display which language they spoke; 51 languages were represented. Vareta Bryan commended this work and reported concern about changes to the Governor role. James confirmed that Young Influencer would remain part of the engagement work, he added that he was working with Katherine Holland to ensure that the Trust continued to engage Governors once any changes to the role were confirmed.</p> <p>Key priorities for the year ahead were noted. These included:</p> <ul style="list-style-type: none"> <li>• Tackling health inequalities</li> <li>• Organ donation awareness and engagement</li> </ul> |

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|    | <ul style="list-style-type: none"> <li>• Strengthening local partnerships</li> <li>• Understanding and addressing digital exclusion</li> <li>• Continuing to amplify community and patient voice</li> </ul> <p>The Board welcomed the work.</p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The Board NOTED the contents of the Engagement and Involvement Annual Review 2025/26, including key achievements, themes, challenges and priorities identified during the reporting period.</li> <li>• The Board APPROVED the publication of the Engagement &amp; Involvement Annual Review 2025–26 alongside the Trust Annual Report and Quality Accounts.</li> <li>• The Board APPROVED the development of a new joint Patient Experience and Voice strategic plan, aligned to the Trust's refreshed strategic objectives, to replace the existing Engagement and Involvement Strategy (2020–2024).</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 18 | <p><b>NHS Staff Survey 2025: Assurance of Progress, Key Risks and Improvement Priorities</b><br/> <i>Deborah Tunnell, Deputy Director for People and Organisational Development</i></p> <p>Deborah Tunnell provided the board with assurance around the activity undertaken in response to the 2025 NHS Staff Survey. Ongoing workforce issues, including workload, confidence to speak up, access to career development, and equality of experience were noted. The Organisational Development team was sharing information and the results of the survey were being owned by divisions. ‘Quick wins’ were being developed and some divisions had a range of work they were undertaking, including around staff experience, wellbeing and career development. These initiatives were already making a difference. Issues around capacity and inequalities were being worked through.</p> <p>The Board noted that although there had been some improvements, particularly in appraisal completion and team effectiveness, the results indicated that further effort was needed to ensure a consistently positive staff experience across the organisation. Detailed survey results had already been shared via Trust governance channels.</p> <p>Shawn Smith noted that no incentive was offered to staff this year, to encourage them to complete the survey and asked if this had affected the response rate. Deborah confirmed that it had and this would be reviewed.</p> <p><b>RESOLVED:</b></p> <ul style="list-style-type: none"> <li>• The Board ACKNOWLEDGED the persistent organisational challenges highlighted in the 2025 Staff Survey and their impact on staff experience, workforce stability and patient care.</li> <li>• The Board SUPPORTED a shift toward a more focused, insight-led approach to improvement, using triangulated staff experience data to inform a small number of clearly defined organisational priorities rather than multiple parallel action plans.</li> <li>• The Board ENDORSED strengthened divisional ownership and accountability for staff experience, recognising that improvement was driven locally, and the development of a clear thematic narrative for staff experience improvement, linking staff survey findings with wider workforce insight, leadership, management development and staff networks.</li> <li>• The Board NOTED the need for sustained leadership focus on the following priority areas:</li> </ul> |

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|           | <ul style="list-style-type: none"> <li>○ Workforce capacity and workload</li> <li>○ Confidence in speaking up and organisational responsiveness</li> <li>○ Equality of experience</li> <li>• The Board SUPPORTED a prioritised and triangulated approach to improvement, recognising that meaningful and sustainable change required focus, consistency and visible impact.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>19</b> | <b>Quality and Performance Committee Report</b><br><i>Vareta Bryan, Non-Executive Director</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|           | <p>Vareta Bryan, presented the report detailing the assurance received by the Committee at its meetings in May and June 2026.</p> <p>During the May meeting, the Committee undertook a dedicated deep-dive review of frailty services, including a presentation from the multidisciplinary leadership team and a visit to the Frailty Assessment Unit. The Committee noted evidence of innovative quality improvement work, strong multidisciplinary collaboration and a clear focus on reducing unnecessary hospital admissions and length of stay. The visit provided assurance that frailty services were making an important contribution to improving patient flow, supporting the Trust's strategic objectives and responding proactively to the needs of an ageing population.</p> <p>The Committee undertook detailed scrutiny of maternity services, urgent and emergency care, elective and diagnostic recovery, clinical effectiveness, patient safety, patient experience and community engagement. Continued improvement was being seen, however areas of risk were also identified.</p> <p>Vareta highlighted a number of red Alert areas related to Urgent and Emergency Care Performance and Corridor Care, Complaints Performance and Timeliness, Cardiology Culture and Leadership and Maternity Workforce Resilience and Service Recovery. Advise and Assure areas were noted. The Committee approved the Engagement and Involvement Annual Review, the Patient Safety Incident Response Framework Policy and Plan, the Committee Effectiveness Improvement Plan and revised Terms of Reference and the Quality Account 2025/26, on behalf of the Board.</p> <p>Clinical Vision of Flow was discussed and the Chair asked Al Sheward and Kate Hellier to discuss a real time improvement event. Kate reported that as part of this work the previous week, the wards had been visited daily to see if help was needed or if there were any blockages. Despite challenges the target that no one should wait more than 30 minutes for a bed was met. The Board noted the difficult situation that the Emergency Department had been working in for some time and the importance of focussed and timely discharges. Kevin McNamara highlighted the success the Trust was still seeing in ambulance handover times noting that this was not the case across the region.</p> <p>The Board noted the need to decant from the tower due to the fire safety issue. This had been escalated to the Integrated Care Board who were raising with partners.</p> <p>The Chair commended the achievements reported, particularly around ambulance handover times and the prevention of corridor care on the wards.</p> <p><b>RESOLVED:</b> The Board noted the report.</p> |

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| 20 | <p><b>Integrated Performance Report</b><br/> <i>Matt Holdaway – Chief Nurse, Kate Hellier, Deputy Medical Director, Deborah Tunnell – Deputy Chief People Officer and Steve Perkins, Director of Operational Finance</i></p> <p>The Board received the Integrated Performance Report which covered the period to May, and reviewed quality, operational, workforce and financial indicators and discussed actions underway or planned to improve performance and productivity. Areas of focus were noted.</p> <p>Al Sheward reported that performance remained challenged across Urgent and Emergency Care, Planned Care, Diagnostics and Cancer, with system flow continuing to be the primary constraint, impacted by the heat which had led to the need to cancel some patients. Emergency Preparedness, Resilience and Response plans were being reviewed.</p> <p>Challenges around the aged estate and bed capacity were noted. Four-hour performance reduced to 63.7%, driven by persistent discharge delays and limited inpatient capacity. Ambulance handovers and paediatric performance continued to improve. Discharge performance had plateaued, with the discharge-ready cohort remaining high at 110–120 patients and length of stay increasing, indicating ongoing pressures in community and onward care pathways. The Board noted that clinicians involved in the Clinical Vision of Flow work had accepted that the delays and challenges around patient flow, were not solely due to patients with ‘No Criteria to Reside’.</p> <p>Al Sheward reported that the Trust had moved back to segment 2 of the NHS Oversight Framework, due to a slight deterioration in Urgent and Emergency Care. Development work was underway. Matt Holdaway added that the system escalation plan was being rewritten.</p> <p>Referral to Treatment performance remained broadly stable at 74.2%, but long waits continued to rise, particularly in Orthopaedics and Spinal Services. A lack of theatre capacity and issues with instruments, had led to challenges in trauma and orthopaedic performance. Diagnostic performance had improved modestly, largely driven by echocardiography recovery, although several other modalities remained under pressure. Cancer performance remained a significant concern. The 62-day standard had deteriorated to 66.0%, while the Faster Diagnosis Standard improved to 77.3%. Backlogs continued to grow across several tumour pathways, reflecting ongoing diagnostic and treatment capacity constraints. Challenges in the histopathology services were noted and a recovery plan was in place.</p> <p>Matt Holdaway reported on the quality key risks, priority actions and areas of stability. Scores remained above average, although some concern was noted around overcrowding in the Emergency Department, impacting flow and colleague experience. Maternity work was ongoing and further updates would be shared at the Quality and Performance Committee. The Board noted that the Patient Advice and Liaison Team was currently seeing the highest number of contacts in the past 2 years; work to support them was in place.</p> <p>There was good news around the quality and safety metrics. Falls continued to reduce and the Board noted that there had been no falls resulting in injury during May. The summary Hospital-level Mortality Indicator continued to fall and areas for improvement, including Sepsis were being monitored. Challenges in complaints and risk were noted.</p> |
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|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|           | <p>The Board noted that overall, improving discharge capacity and patient flow remained the key requirement to support recovery across operational performance standards. AI reported that most patients leaving the Trust left to their own homes but some may need reablement. The Local Authority commissioned Gloucestershire Health and Care Foundation Trust to provide this service and they were not able to meet requirements. The work taking place with the Integrated Care Board and system partners was noted.</p> <p>Steve Perkins updated the Board on the financial sustainability position and reported delivery of £5m year to date, against a plan of £3.9m. The key drivers were noted. The total gap to delivering the plan had reduced from £10.3m in M1 to £6.6m in M2, this included a forecast to deliver all but £1.6m of the transformation programme. Any delay to delivery of the submitted plan for transformation schemes would result in a larger gap. Work was taking place to reprofile schemes to address any slippage.</p> <p>The Trust continued to experience pressure of temporary work force costs and work continued to reduce these. Opportunities to reduce non-pass through costs were also noted.</p> <p>Steve also reported that the latest position from the South West Productivity Network showed the Trust was ranked number 1 in the region for productivity growth, stating a 6.4% implied productivity growth. This was comfortably above the national acute average of 2.8% and 16<sup>th</sup> nationally of 134 Trusts.</p> <p>Deborah Tunnell reported that targets for reducing agency spend were published in May 2026. The Trust was currently under plan for bank but over plan for agency and for sickness. Deborah reported that data identifying the reasons for sickness absence was being triangulated. Vacancies across the Trust had increased. Bank usage had decreased, the reasons for this were not yet clear. An increase in the use of high cost framework agency staff in midwifery and mental health was noted. Medicine continued to be the highest user of agency staff but grip and control was now in place and high cost locum spend was being removed. Appraisal compliance remained a concern. Job planning compliance was improving, with a focus on quality. A new job planning system was being procured which would work with the current e-rostering system. The Chair asked that an update on job planning be brought to the next meeting. <b>ACTION</b></p> <p><b>RESOLVED</b></p> <ul style="list-style-type: none"> <li>The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.</li> </ul> |
| <b>21</b> | <p><b>Quality Account</b><br/> <i>Matt Holdaway, Chief Nurse</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|           | <p>Matt Holdaway presented the Quality Account 2025/26; the Trust's statutory annual report on quality of care, improvement during the year and priorities for 2026/27. It had been prepared in accordance with the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010, as amended, and NHS England's Quality Accounts reporting requirements.</p> <p>The report included the required statements of assurance, mandated quality indicators, external stakeholder statements and Statement of Directors' Responsibilities.</p> <p>The 2026/27 priorities were aligned to the Trust Strategy 2025/2030 and focussed on patient</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |



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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                | <p>experience and voice, timeliness and reliability of care, reducing inequalities, embedding a trust-wide quality management system, and improving safety through staffing, culture, speaking up and delivery of the Patient Safety Incident Response Framework safety priorities. The Quality Account had been reviewed through the Trust's governance arrangements and approved for publication by the Quality and Performance Committee. It was presented to the Board for information and assurance.</p> <p><b>RESOLVED:</b><br/>The Board NOTED the Quality Account 2025/26 for information and assurance, following approval by the Quality and Performance Committee, and to note the key highlights, areas for continued improvement and agreed priorities for 2026/27.</p> |
| <b>22</b>                                                                                                                                                                                                                      | <p><b>Finance and Resource Committee Report</b><br/><i>John Noble, Non-Executive Director</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                | <p>John Noble presented the Committee report with the Board receiving assurance regarding financial sustainability, capital programme oversight, productivity initiatives and estate management.</p> <p>Discussion reflected on the financial challenges facing the NHS and the importance of transforming services whilst maintaining quality and safety. Items specifically flagged to the Board were the Committee's concerns regarding the finance system, digital infrastructure and cyber resilience, capital programme delivery capacity and the financial position and financial sustainability programme.</p> <p><b>RESOLVED:</b> The Board NOTED the report for assurance.</p>                                                                                             |
| <b>23</b>                                                                                                                                                                                                                      | <p><b>Any other business</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                | <p>There was no further business for discussion.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>24</b>                                                                                                                                                                                                                      | <p><b>Governor observations</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                | <p>Andrea Holder spoke on behalf of the governors, noting the powerful patient story and the update on Freedom to Speak Up.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p><b>Close: 12:55</b><br/> <b>Date and time of next meeting:</b> <i>Thursday 10<sup>th</sup> September, 09.00 to 12.30</i><br/> <i>Lecture Hall, Redwood Education Centre,</i><br/> <i>Gloucestershire Royal Hospital</i></p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



| Actions/Decisions |                                                                                                                                                                                                                                                                       |                                                                            |        |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------|
| Item              | Action                                                                                                                                                                                                                                                                | Lead / Due Date                                                            | Update |
| 7/July            | <b>Patient Story: Presentation from a Young Carer</b><br>Matt Holdaway to discuss the Young Carers Memorandum of Understanding with Hannah Gil of Gloucestershire Young Carers.                                                                                       | Matt Holdaway / <b>September 2026</b>                                      |        |
| 13/July           | <b>Health and Safety Annual Assurance Report</b><br>Kerry to consider how areas/objectives were assessed/rated in the next report to provide additional consistency.                                                                                                  | Kerry Rogers / <b>September 2026</b>                                       |        |
| 17/July           | <b>Engagement and Involvement Annual Review</b><br>Noting that local people from deprived areas were far more likely to attend the Emergency Department, James and Juwairiyia agreed to consider how they could assist with this work. Lee Pester offered to support. | James Brown / <b>September 2026</b>                                        |        |
| 20/July           | <b>Integrated Performance Report</b><br>Noting that job planning compliance was improving and a new job planning system was being developed. The Chair asked that an update on job planning be brought to the next meeting.                                           | Deborah Tunnell/Caroline Julien <b>September 2026</b>                      |        |
| 26/May            | Executives to consider bringing a report equivalent to the Nursing Safer Staffing Report for non-nursing staff groups to People and Organisational Development Committee (6 monthly) and Board (annually). Initial focus to be on medical workforce                   | Medical Director / Chief Nurse / Chief People Officer <b>November 2026</b> |        |

Report to Board of Directors

|                            |                                                          |
|----------------------------|----------------------------------------------------------|
| Date of Meeting            | 10 September 2026                                        |
| Report title               | Chairs report to September’s Board of Directors’ meeting |
| Sponsoring Director/Author | Deborah Evans, Trust Chair                               |

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

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

| Recommendations:                        |
|-----------------------------------------|
| The board are asked to NOTE the report. |

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



## Main Report

### 1. Purpose

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

### 2. Jason Arday

Colleagues will be aware of the publicity that surrounded the resignation and subsequent suicide of Jason Arday, Cambridge University's youngest black professor. It provides us with an opportunity to reflect on how we support our leaders who are personally attacked in their leadership roles, often in the media or on social media, and specifically where racism and lack of understanding of neurodivergence are concerned.

It has also given us an opportunity to consider how we treat individuals in circumstances where concerns have been raised as to their conduct which warrant investigation and whether we apply our policies fairly and with compassion and sensitivity.

### 3. Visits and ambassadorial activities.

I have been active in visits and engagement as ever and taken advantage of "Committee light August". Some highlights are below:

- I shadowed a volunteer at Gloucestershire Royal Emergency Department giving out refreshments on a Tuesday evening. A rare opportunity to talk with patients and their families. I was impressed with the food choices on offer and the huge skill of the volunteers
- I met with the chaplaincy team at Gloucestershire Royal Hospital
- I shadowed the volunteers at the Welcome Desk at the Atrium GRH, met plenty of patients and extend my daily step count!
- I had a series of MP visits including Alex McIntyre, Simon Opher and Geoffrey Clifton Brown
- A night duty visit to Cheltenham General Hospital with Vareta Bryan, Non-Executive Director and Coral Boston, Equality Diversity and Inclusion officer
- I launched the Gloucestershire Advanced Research Innovation hub at Gloucestershire Royal Hospital
- I joined a staff education session on domestic abuse
- I had a regular catch up with James Clifford, our neuro diversity network lead.
- A visit with Non-Executive Directors / Governors to Medical Engineering
- Raj Kaker-Clayton, Associate Non-Executive and I met with Kaye Fox, Chair-Gloucestershire Managed Services, and colleagues to talk about catering at Gloucester Royal Hospital in the context of the Resident Doctors 10-point plan and to review the plans to improve Fosters restaurant
- I held meetings with Nicola de Jongh, Chair of University of Gloucestershire Council, Ingrid Barker, Chair Bristol Trust and Graham Russell, chair of Gloucestershire Health and Care

#### **4. Non-Executive director changes.**

At the end of November, we say goodbye and thank you to Marie Annick Gournet, who served as an Associate Non-Executive Director with the Trust for two years, followed by two terms as a Non-Executive Director. Most recently she has chaired our People and Organisational Development Committee. Marie Annick has also been our NED Freedom to Speak Up link and has been the non-executive link with our Inclusion Network for Global Majority colleagues.

We are currently recruiting for a non-executive director, and the selection days will be at the end of October.

From early September we will welcome a colleague on a year's part time placement from the NHSE NExT Director programme, which is aimed at people from groups who are under represented on NHS Boards to prepare for Non-Executive Director roles. Farzana Mohammed is a pharmacist who works for the Hereford and Worcester Integrated Care Board, and she will attend Board and Committee meetings as well as join governors at the Council of Governors and on visits.

#### **5. Evolving from our Council of Governors to respond better as Gloucestershire and the NHS Plan develop**

The government announced in the NHS Plan that as Foundation Trusts are replaced with other organisation forms, so Council of Governors would no longer be defined in their current form.

We have been considering collectively over the past few months:

- what has been most valuable about the current arrangements;
- what should be preserved;
- where there may be opportunities to strengthen patient and community involvement; and
- what principles should guide any future development.

In discussion with Andrea Holder, Lead Governor and Kerry Rogers, Director of Integrated Governors we agreed that the scheduled October 15<sup>th</sup> workshop is used to develop a new model which would:

- preserve the valued contribution made by Governors;
- improve the way the Trust hears from patients and communities;
- strengthen the influence of lived experience on decision-making;
- involve groups whose voices may not always be heard;
- support the Trust's work on health inequalities;
- reflect the changing emphasis on partnership and collaboration; particularly in the context of neighbourhood services and our growing connection with primary care through the Provider Collaborative
- maintain a visible and meaningful connection with the population we serve.

A future approach could be designed around involvement, insight, challenge and improvement rather than formal voting and approval processes. Possible activities could include:

- testing early ideas for service development;
- contributing to service redesign;
- identifying gaps in community engagement;
- advising on how to involve particular communities;
- participating in service and Non-Executive Director visits;
- contributing to PLACE (patient-led assessments of the care environment) assessments;

- supporting health literacy and digital inclusion;
- commenting on patient experience and health inequalities;
- helping shape engagement priorities;
- contributing to the Annual General Meeting;
- recognising good practice in patient experience and community engagement; and
- producing an annual assessment of how community voice has influenced the Trust.

We will produce a discussion document in advance of that workshop and will offer meetings to our staff governors, partners and stakeholders to solicit their views.

Enclosures: None

FOI: Public

# Chief Executive Report to Board September 2026

## 1 Patient Experience

### 1.1 Care Quality Commission (CQC) Well-Led Assessment and Inspection Reports

The Care Quality Commission (CQC) has published the Trust's Well-Led Assessment alongside a number of previously delayed inspection reports covering maternity services, urgent and emergency care and medicine which took place at various times between September 2025 and February 2026.

The overall ratings are as follows:



| CQC Inspection                                                                                          | Previous Rating             | New Rating – 2026    |
|---------------------------------------------------------------------------------------------------------|-----------------------------|----------------------|
| Maternity:<br>Gloucestershire Royal Hospital<br><i>September 2025</i>                                   | Inadequate (2024)           | Requires Improvement |
| Maternity:<br>Stroud Maternity Hospital<br><i>September 2025</i>                                        | Requires Improvement (2024) | Good                 |
| Urgent and Emergency Care:<br>Cheltenham General Hospital<br><i>December 2025</i>                       | Good (2019)                 | Good                 |
| Urgent and Emergency Care:<br>Gloucestershire Royal Hospital<br><i>December 2025</i>                    | Requires Improvement (2023) | Requires Improvement |
| Medical Care (including older people's care):<br>Gloucestershire Royal Hospital<br><i>December 2025</i> | Good (2019)                 | Good                 |
| Well-led<br><i>February 2026</i>                                                                        | Requires Improvement (2022) | Good                 |

The reports recognise good progress made across several areas of the Trust. In particular, the CQC has identified improvements in maternity services – moving from Inadequate to Requires Improvement at Gloucestershire Royal and from Requires Improvement to Good in Stroud Maternity Hospital. They also highlight improvement in culture and governance with the Well-Led rating moving from Requires Improvement to Good, recognising the work undertaken to strengthen leadership, governance, culture and organisational oversight.

These improvements reflect the hard work colleagues across the Trust have put in to tackling some of the more difficult issues we face. They also reflect the extensive work undertaken across the Trust to address issues identified by previous inspections and to deliver lasting improvements in quality, safety and patient experience.

The reports also acknowledge areas where further improvement is required. While there has been positive progress, our ambition is to continue to focus on what matters most to patients and the community so that we build on these improvements and are open about both the challenges we face and importantly, what we are doing about them.

Some services continue to be rated Requires Improvement and the findings highlight a number of issues that we are already seeking to address through established improvement programmes. In



Urgent and Emergency care for example, the sustained improvement we have delivered in improving ambulance handover delays is making a real difference to the quality and safety of our patients and local community and it is work like this that we continue to build on with our goal of ensuring every patient receives consistently high standards of care every time they use our services.

As some reports are from inspection almost a year ago, many of the key issues identified by the CQC have already been the focus of significant work since the inspections took place. For example, in maternity services, improvements have been made to triage processes, incident reporting and staffing arrangements. The CQC recognised evidence of progress against the actions put in place following previous inspections and acknowledged the improvements achieved for women, babies and families.

There is still much more for us to do in maternity and the Community Maternity Transformation programme that we are working on will help re-establish comprehensive choice this year for women across the county in a way that is safe and sustainable, which will further build on these improvements.

Similarly, in Urgent and Emergency Care, inspectors recognised the compassion, commitment and professionalism of staff working within very busy services. We know that Urgent and Emergency Care remains one of the most challenging areas across the NHS nationally and whilst we have seen some of the biggest improvements in ambulance handover delays and ward based corridor care, we need to go further as a Trust and as a whole system as we continue to invest in service redesign, patient flow improvements and additional capacity to improve patient experience and safety.

As we look forward and continue our improvement work across these key services, our focus is not on the rating itself, but on continuing that work to ensure patients receive consistently high-quality care. We will continue to work closely with all our partners and local communities to ensure that the improvement work we are doing remains focused on those areas that will make the greatest difference to patients and the public.

I am particularly pleased that inspectors recognised the dedication, professionalism and compassion of our staff, in caring for patients, and I am hugely grateful for our colleagues for the work they do every day in serving the people of Gloucestershire that has helped contributed to the progress the CQC highlights.

## **1.2 Local Government Reorganisation (LGR) Update**

The Government has confirmed that Gloucestershire will move to a single unitary authority, bringing together the functions currently delivered by Gloucestershire County Council and the county's six district, borough and city councils into one organisation, to be known as Gloucestershire Council.

This follows a Government consultation in which 65% of responding residents and partner organisations expressed a preference for a single council model.

The new authority will be represented by 110 councillors, with a Joint Committee comprising representatives from all existing councils established to oversee the transition. Jo Walker, Chief Executive of Gloucestershire County Council, has been appointed as the Senior Responsible Officer for the implementation programme.

At present, Gloucestershire residents receive services from:

- Gloucestershire County Council (including adult and children's social care, education, highways and waste disposal);

- Six district councils (including housing, planning, licensing, revenues and benefits, and waste collection); and
- Parish and town councils delivering very local services.

Under the proposals, county and district council responsibilities will be consolidated within a single organisation, with the stated aim of creating more joined-up services, clearer accountability and a simpler experience for residents accessing public services.

The transition programme will continue throughout 2026-27. Elections to a new shadow authority are scheduled for May 2027, with Gloucestershire Council expected to formally assume responsibility for services in April 2028. Until then, existing councils will continue to operate and deliver services as normal.

The transition to the new arrangements will require extensive work from our Local Authority partners and for healthcare means we will need to play an active part in supporting these changes and helping existing & new councillors fulfil their duties, whilst the NHS itself navigates complex changes and challenges which will require good public engagement.

### **1.3 CQC Adult Inpatient Survey 2025 results**

Patients have rated their experiences of care at Gloucestershire Royal and Cheltenham General hospitals positively, with the latest Care Quality Commission (CQC) Adult Inpatient Survey highlighting particularly strong feedback about the kindness and compassion shown by staff.

The 2025 survey published by the CQC asked people who had stayed in hospital during November 2025 about different aspects of their care, from admission and treatment through to leaving hospital.

A total of 451 patients from Gloucestershire Hospitals NHS Foundation Trust responded to the survey. Nationally, 58,139 people responded across 130 NHS trusts.

The Trust was rated as performing 'better than expected' in one question and 'somewhat better than expected' in a further seven questions. It was rated about the same as most other trusts across the majority of the questions measured.

The 2025 survey shows the Trust performing particularly well for kindness and compassion, and respect and dignity, with both areas scoring 9.4 out of 10 and rated as 'somewhat better than expected' compared with other trusts.

Patients also gave high scores for privacy when being examined or treated (9.7), having enough to drink while in hospital (9.7), confidence and trust in doctors (9.3), confidence and trust in nurses (9.2), and the answers they received from doctors and nurses when they had questions (9.1 for both).

The survey also found that patients were less likely to report being given conflicting information by different members of staff, with this question scoring 8.3 and rated better than expected.

The survey also provides a clear picture of where the patient experience is not yet where the Trust wants it to be. Discharge is one of these areas, particularly making sure patients and the people supporting them feel involved, know what happens next and have the information they need when they leave hospital.

### **1.4 Consultant Doctors Industrial Action**

The British Medical Association (BMA) has secured a mandate for potential industrial action from consultant doctors in England following a national ballot on pay and working conditions. Of those consultants who voted, 76% voted in favour of industrial action, with a turnout of just over 51%,

providing the BMA with a mandate for action for up to 12 months. At the time of writing, no consultant strike dates have been announced.

Consultants are seeking further progress on pay, contractual arrangements and working conditions, including professional development time and recognition for out-of-hours work.

The Trust continues to monitor national developments closely and is working with regional and national partners to understand any operational implications. Should industrial action be announced, the Trust will activate established industrial action planning arrangements to protect urgent and emergency services, maintain patient safety and minimise disruption to planned care wherever possible.

## **2 People, Culture and Leadership**

### **2.1 NHS Staff Standards**

In July 2026 the Department of Health and Social Care and NHS England published new NHS Staff Standards, setting out the minimum standards that staff should expect from their employer across six areas:

- line management;
- health and wellbeing;
- tackling racism;
- flexible working;
- violence prevention and reduction;
- sexual safety.

The standards align closely with the Trust's existing workforce, culture and staff wellbeing priorities.

Work is underway to review current arrangements against each of the six standards, identifying areas of strong practice and any gaps requiring further improvement. This includes progress through the People Strategy, NHS People Promise, Freedom to Speak Up arrangements, Equality, Diversity and Inclusion programme, staff wellbeing initiatives and leadership development programmes provides a strong foundation for implementation.

Over the coming months, the Trust will work with staff, staff networks, trade union colleagues and partners to embed the standards within existing governance, workforce and organisational development programmes. Progress will be monitored through established workforce metrics, staff feedback and national assurance processes as the standards become incorporated into the NHS Oversight Framework.

The standards reinforce the Trust's commitment to being a compassionate, inclusive and supportive employer and will help ensure staff experience receives the same focus as other organisational priorities, recognising the direct relationship between staff wellbeing, retention and high-quality patient care.

This work also links directly to the Board development programme underway which is focused on strengthening inclusive leadership and ensuring that a wider range of voices and experiences informs Board thinking and decision-making. The challenge for the Board is to translate its stated commitment to improving the working lives of staff into visible and meaningful change: listening consistently, acting on what colleagues tell us, holding leaders to account for the quality of staff experience and using the Staff Standards to test whether improvements are being felt in day-to-day working life across every part of the Trust.

## **2.2 Adult Social Care Reform and the Casey Commission**

Adult social care reform has moved up the national policy agenda following the launch of the independent Casey Commission on Adult Social Care, chaired by Baroness Louise Casey.

The Commission has been asked by Government to develop proposals for a future National Care Service and establish a long-term plan for reforming adult social care in England. The Commission will report directly to the Prime Minister and is being undertaken in two phases, with medium-term recommendations due first, followed by longer-term reform proposals.

The first phase of the Commission will focus on how existing resources can be used more effectively to improve outcomes, make social care more preventative and productive, and strengthen the interface between health and care services. Importantly for the NHS, the terms of reference explicitly identify reducing unnecessary hospital admissions and addressing delayed discharges as key objectives, recognising the critical interdependency between adult social care capacity and NHS performance.

A significant development during the reporting period has been the launch of the "Big Conversation on Care", a national engagement exercise seeking views from the public, people who use services, carers, care workers and partner organisations on the future of adult social care. The consultation is intended to build public consensus around what adult social care should provide and how a future National Care Service might operate.

The Government has also signalled its intention to accelerate reform. The Prime Minister has announced cross-party discussions on social care, arguing that sustainable reform will require political consensus and a long-term approach. Alongside the Commission, ministers have highlighted ambitions for better integration between health and social care, improvements in workforce pay and career progression, and closer alignment between social care and NHS services.

## **3 Quality, Performance and Safety**

### **3.1 New Department of Critical Care (DCC)**

Work is underway on a new Department of Critical Care (DCC) at Gloucestershire Royal Hospital, representing a significant investment in the future of acute and critical care services across Gloucestershire. The development will provide a modern, purpose-built environment for some of the Trust's sickest and most vulnerable patients, including those requiring intensive care following major trauma, severe illness, sepsis, pneumonia or complex surgery.

The new facility is being developed in response to increasing demand for critical care services, driven by an ageing population, rising numbers of people living with complex long-term conditions and ongoing seasonal pressures. The department will initially provide 24 critical care beds, with the flexibility to expand to 36 beds in future subject to funding and as demand grows. It is expected to care for more than 1,500 patients each year.

The development is also an important enabler of the Trust's programme to improve fire safety in the Tower Block, where the current Department of Critical Care is based. Moving critical care into the new purpose-built facility will support the safe decant of services from the Tower and create the access, capacity and operational flexibility needed to progress the planned fire-safety remediation and wider improvement works already underway. It therefore forms an integral part of the phased decant and improvement programme, helping the Trust manage risk while maintaining safe and resilient clinical services throughout the works.

### **3.2 Heatwave and extreme weather**

The recent series of heatwaves has highlighted the growing operational challenges that periods of prolonged high temperatures can present for the Trust and the wider NHS. National reporting has indicated that extreme heat events are becoming more frequent and are expected to increase in both intensity and duration in future years, requiring organisations to adapt their planning and resilience arrangements.

During the recent period of exceptionally hot weather, the Trust experienced operational pressures associated with high temperatures and humidity, particularly within some clinical environments and around critical equipment.

Existing cooling systems reached their operating limits in certain areas, affecting the performance of MRI and CT scanners and creating challenges in maintaining optimal temperatures within some clinical spaces. Lessons learned have been identified and are being incorporated into future resilience planning.

The impact of extreme heat also reflects the challenges associated with the Trust's ageing estate and infrastructure. The Trust continues to manage significant estate-related risks arising from historic underinvestment, infrastructure resilience issues and ageing buildings, all of which can limit the ability to effectively control temperatures in some parts of the estate during sustained periods of hot weather. These risks are recognised within the Trust's estate strategy and long-term investment plans.

In response, the Trust is increasingly planning on the basis that significant heat events will become a more regular occurrence rather than isolated incidents. As a result, resilience arrangements are evolving from a predominantly winter-focused approach towards a year-round model that incorporates both Winter Planning and Summer Planning.

This will ensure that operational, workforce, clinical, estate and infrastructure risks associated with extreme weather are anticipated and managed proactively, drawing on the same systematic planning principles used for winter pressures. This work includes reviewing cooling system performance, identifying short and longer-term mitigation measures, and considering how future estate investment and redesign can improve resilience to both extreme heat and extreme cold.

While the Trust responded effectively to the recent heatwave it clearly has had an impact on cancellations for patients and our staff who have worked in very difficult circumstances in the heat to care for patients. The experience reinforces the need to continue investing in estate resilience and adaptation measures to ensure that patients, staff and critical services remain safe and operational as climate-related weather events become more common.

### **3.3 Estates Strategy Programme**

The issues highlighted above are part of a much wider strategic challenge. The condition of the Trust's estate, together with limited access to meaningful capital investment, is likely to represent one of our greatest challenges over the next decade as we seek to improve the resilience and safety of our infrastructure and provide better environments for patients and staff.

The significant scale of backlog maintenance means that we need a clear long-term plan for prioritising schemes, reducing the most serious risks and ensuring that the Trust is ready to access external funding if and when opportunities arise. This will require difficult choices about where services are located, a stronger drive to improve utilisation so that we make the best possible use of the estate we already have, and, where necessary, the disposal of buildings where continued investment is neither sustainable nor economically justified.

To respond to this challenge, work is underway to develop a long-term Estates Strategy that aligns the estate with the Clinical Strategy and wider transformation programmes. It will provide the framework for balancing immediate safety and resilience priorities with longer-term service needs,

affordability and investment decisions. The strategy is being developed with specialist external support and is expected to be completed by the end of the year.

The programme is establishing a robust evidence base through estate surveys, data analysis and engagement with clinical, operational and corporate teams. This will assess the condition, safety, suitability, cost and utilisation of Trust buildings, alongside operational constraints and future service requirements, so that competing schemes can be prioritised transparently according to risk, clinical benefit, deliverability and value for money.

Building on this evidence, a Strategic Asset Management Plan will set out how the Trust can make better use of its property assets, strengthen the management of space and accommodation, and target investment where it will reduce the greatest risk or deliver the greatest benefit. It will cover both owned and leased accommodation and identify where consolidation, improved utilisation, alternative use or disposal offers a more sustainable solution than continuing to invest in unsuitable or uneconomic buildings.

The next phase will develop and test future masterplan options for the Trust's sites, including the implications of different service locations and estate configurations for patients, staff, operational resilience and long-term affordability. These options will inform a Development Control Plan, providing a phased roadmap for estate transformation, a clear basis for difficult prioritisation decisions and a stronger platform from which to respond quickly and credibly when capital funding opportunities become available.

Together, these outputs will give the Trust a coherent short, medium and long-term framework for reducing estate risk, improving resilience and utilisation, sequencing investment and making evidence-based choices about development, service location and disposal. The caveat is that alongside this, clarity on national capital availability will be needed given the scale of the challenges Trusts like ours face at this time in terms of poor estate and aging infrastructure.

### **3.4 National end of life care audit shows progress**

Gloucestershire Hospitals is continuing its work to improve care for patients who die in hospital through participation in the National Audit of Care at the End of Life (NACEL).

NACEL is an annual national quality improvement programme that reviews the care provided to people who die in hospital. It helps organisations understand how well they support patients, families and carers during a patient's final hospital admission, while identifying opportunities to improve care and learn from best practice.

The audit examines several aspects of care, including recognising when a patient is dying, symptom management, communication with patients and families, documentation of care preferences and support for bereaved relatives. It also looks at whether individual needs relating to faith, culture, language and personal beliefs are recognised and respected.

By taking part in NACEL, Gloucestershire Hospitals can compare its services against national standards, identify areas of good practice and continue improving the support provided to patients and those close to them.

The latest NACEL results show overall improvement against the Trust's end of life care improvement plan. Examples of improvements highlighted through the audit include the introduction of an electronic patient record (EPR) Last Days of Life Care Plan, commissioning a specialist end of life nursing education programme delivered by Sue Ryder, and improved recording of spiritual care involvement.



Our Specialist Palliative Care Team works closely with colleagues across Gloucestershire Royal Hospital and Cheltenham General Hospital to support patients with life-limiting illness and those approaching the end of life. While the team is not resourced to provide a seven-day face-to-face service, specialist palliative care advice is available to healthcare professionals on an on-call basis 24 hours a day, seven days a week. This helps ensure clinical teams can access expert advice whenever it is needed.

### **3.5 Gloucestershire cancer centre plan approved**

Cheltenham Borough Council has granted planning approval for our new state-of-the-art cancer care centre at Cheltenham General Hospital

The new cancer centre will offer patients modern clinical and treatment spaces, access to digital consultations, a dedicated support centre for patients and loved ones, as well as peaceful therapeutic gardens.

Now the community's support is needed to help make the centre a reality. More than 10,000 people have already donated to Cheltenham and Gloucester Hospitals Charity's Big Space Cancer Appeal to help transform cancer care in Gloucestershire and beyond. Over £9.8million has been raised towards the £12m estimated cost for the new build.

Our vision as a Trust is to deliver the best possible care and experience for the people of Gloucestershire and the wider regions. Ahead of submission, over one thousand patients, carers and members of the public were consulted to ensure the plans reflected what matters most to our community.

The new facility will also enhance the work of our dedicated clinical teams, who have been instrumental in designing a space that meets the needs of the patients they care for.

## **4. Digital**

### **4.1 Electronic prescribing in maternity**

The introduction of electronic prescribing and medicines administration within maternity is improving safety for women by providing clearer, more accurate medicines information at the point of care.

Moving away from paper-based processes helps reduce the risk of prescribing and administration errors, supports more consistent care through agreed treatment plans, and gives clinical teams better visibility of medicines throughout a patient's journey. The result is safer medicines management, better communication between professionals, and greater confidence that the right treatment is being provided at the right time.

This is a significant step in the Trust's wider digital transformation programme, bringing maternity services in line with modern electronic clinical workflows and reducing reliance on paper records. The implementation was supported through a robust governance process, including clinical safety review, testing, training, operational readiness checks, and formal approval processes to ensure risks were managed appropriately before go-live.

The focus now is on refining maternity prescribing pathways and order sets so that evidence-based care is easier to deliver consistently and safely. By reducing variation and supporting clinical decision-making at the point of care, this will further improve medication safety and help ensure women receive the right care at the right time.

## **4.2 Pre-operative Assessment Digital Go-Live**

The main nursing assessment used in anaesthetic pre-operative care is now live within the electronic patient record (EPR), marking an important step towards a fully digital surgical pathway.

All new assessments are completed electronically, improving the consistency of documentation and giving teams clearer visibility of each patient's progress. Removing reliance on paper records will reduce delays and the risk of misplaced notes, supporting safer and more efficient operating lists.

Dashboards are being developed to monitor completion and support further service improvement. A short transition period will remain while patients with historic paper records complete their pathway, and further work will enhance tracking, questionnaires and the digital capture of diagnostics such as ECGs.

## **4.3 Subject Access Requests**

The Trust continues to experience significant pressure in responding to Subject Access Requests within the statutory one-month timescale. Demand remains high, with 1,209 requests received between January and July 2026. Although 866 disclosures were completed during this period, the backlog increased to 552 outstanding requests by the end of July, including 251 that had been open for more than three months. Performance improved from 43.1% of requests completed within one month in June to 53.4% in July, but this remains below the required standard.

A comprehensive recovery programme is under way, including additional temporary capacity, improved tracking and prioritisation, clearer separation of new, overdue and escalated requests, strengthened executive oversight and reduced reliance on paper-based processes. These actions have improved governance and operational control, but a sustained reduction in the backlog has not yet been demonstrated. The programme therefore remains rated Amber, with monthly monitoring focused on statutory compliance, backlog reduction, recruitment and delivery of digital improvements.

It is acknowledged that delays are having a significant impact on people requesting their records, including those who need the information to understand or progress their care, support a complaint or legal matter, or gain clarity about their treatment. Extended waits and limited updates can cause frustration, uncertainty and a loss of confidence in the Trust, particularly where the information requested is sensitive or time-critical. We are actively triaging requests according to urgency and potential impact, while progressing the recovery programme to reduce the backlog and improve compliance with the statutory timescale.

## **4.4 Digital Strategy and Roadmap 2026-31 launched**

The Trust has launched our Digital Strategy and Roadmap 2026-31, setting out how technology will support our ambition to deliver safer, simpler and more joined-up care.

The strategy focuses on improving the experience of both patients and staff. For patients, the main benefit will be safer care, with clinicians able to access more complete patient information when and where it is needed. Currently, staff often work across multiple systems that do not connect well and many processes still rely on paper records. This can lead to delays, duplication and unnecessary risk.

Our roadmap will create a single electronic patient record, reduce the use of paper in key clinical pathways and give staff better access to information across services. This will support safer handovers, quicker decision-making and a more consistent experience for patients. We are also developing a single digital front door linked to the NHS App, making it easier for patients to manage appointments, access information and receive care closer to home.

Successful delivery of the strategy will depend on people as well as technology. We will support staff and patients to use digital tools confidently, including emerging technologies such as artificial intelligence.

A wider launch with staff, partners and stakeholders is planned later this year. In the meantime, teams are developing detailed plans to turn the strategy into practical improvements across the Trust.

## Report to Care Quality Commission and the Trust Board of Directors

|                                   |                                                                                                                                                |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Report title</b>               | CQC Section 31 Conditions Report (28 August 2026)                                                                                              |
| <b>Sponsoring Director/Author</b> | Matt Holdaway – Chief Nurse and Director of Quality<br>Director of Midwifery – Zita Martinez<br><br>Suzie Cro – Director of Quality Governance |

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

### Executive Summary

#### Executive summary

- 1.1.** This August report presents the Trust's final self-assessment against all eight CQC Section 31 conditions. The latest CQC inspection report was published on 27 August 2026 and rated maternity services Requires Improvement. It identified one regulatory breach relating to medicines management, for which an action plan is required by 7 September 2026; this is being managed separately through the agreed regulatory response and does not form part of the eight Section 31 conditions. The inspection findings provide historical external validation that improvement was evident in September 2025, including in the areas covered by the Section 31 conditions. As the inspection evidence is now nearly a year old, the Trust's current self-assessment is based principally on the more recent 2026 audit, performance, governance and action-tracking evidence presented in this report. Following publication, the Trust will submit formal condition-removal applications, supported by the completed removal forms, condition-specific evidence, updated Statement of Purpose and evidence pack. The Trust has self-assessed all eight conditions as met, based on triangulated evidence that the required controls are established, monitored and sustainable.

#### ALERT

- 1.2.** The Trust remains under Section 31 conditions relating to maternity services at Gloucestershire Royal Hospital until advised by CQC that they have been removed.

#### ADVISE

- 1.3.** The evidence demonstrates embedded systems for postpartum haemorrhage and major obstetric haemorrhage, hourly peer review, fetal monitoring interpretation and escalation, national MEWS

implementation, VTE risk assessment, agency and bank midwife induction, action-plan reporting and maternity dashboard reporting. Assurance is provided through approved policies, audit, dashboards, thematic review, action tracking, staff learning and ward-to-Board escalation routes.

- 1.4. Residual risks are visible, owned and managed through routine governance. These include hourly peer review compliance at 75% against the 85% local target; implementation maturity of the national MEWS system; and continued surveillance of PPH ≥1,500 ml outcomes. The August fetal monitoring audit met all three standards: risk assessment 95%, accurate interpretation 100% and appropriate escalation 100%.
- 1.5. The Board approved in July 2026 that the Chief Executive and Chief Nurse may authorise submission of the condition-removal applications to CQC. Following completion of the removal forms, condition-specific evidence, updated Statement of Purpose and evidence pack, the Chief Executive and Chief Nurse will authorise submission under that delegated authority.
- 1.6. CQC has advised that it intends to undertake a further inspection after receipt of the condition-removal applications and before the end of 2026. The new Director of Midwifery is leading a systematic fresh-eyes review of each pathway covered by the conditions to test whether the documented controls are evident and reliable in practice and to ensure that any gaps are addressed before inspection.

**ASSURE**

- 1.7. The Board can take assurance that all eight conditions are supported by clear governance controls, named executive and clinical accountability, routine audit and dashboard review, PSIRF-aligned learning, closed-loop action tracking and defined escalation routes. Enhanced Section 31 reporting has served its intended purpose and oversight is now embedded through business-as-usual maternity, executive, committee and Board governance arrangements.

**APPLAUD**

- 1.8. The Board is asked to recognise the sustained work of maternity clinical teams, divisional leadership and corporate support functions in delivering a complex improvement programme under regulatory scrutiny. The service is now moving from Section 31 recovery to sustained improvement, with Maternal Care Bundle implementation, community transformation, maternity triage and family and staff voice forming the next governance-led improvement priorities.
- 1.9. **Conclusion:** the original regulatory risks have been addressed, all eight Section 31 conditions are self-assessed as met, and residual risks are visible, owned and managed through business-as-usual governance. The latest CQC inspection report was published on 27 August 2026 and provides additional external evidence supporting the formal condition-removal applications, while Board oversight of maternity safety and sustained improvement is maintained.

|                          |                   |
|--------------------------|-------------------|
| Previously considered by | <i>New report</i> |
|--------------------------|-------------------|

**Recommendations:**

The Trust Board is asked to:

- 1. Note that the latest CQC inspection report was published on 27 August 2026 and rated maternity services Requires Improvement, confirming progress from the previous position. The report identified one regulatory breach relating to medicines management, with an action plan required by 7 September 2026; this is being managed separately through the agreed regulatory response and is not one of the eight Section 31 conditions.

- Note that all eight Section 31 conditions are self-assessed as met and, under the Board's July 2026 delegation, the Chief Executive and Chief Nurse will authorise submission of the condition-removal applications to CQC.
- Note CQC's intention to undertake a further inspection after receipt of the condition-removal applications and before the end of 2026, and the preparatory fresh-eyes pathway review being led by the new Director of Midwifery.

| Strategic Aims (tick as appropriate)                                                                                    |   |
|-------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>   | X |
|  <b>People, culture and leadership</b> | X |
|  <b>Quality, safety and delivery</b>   | X |
|  <b>Digital first</b>                  | X |

| Impact on any Strategic Risks?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>SR1 - Inability to deliver safe and effective services against regulatory and statutory requirements</b></p> <p>The evidence indicates that the maternity-related component of SR1 has reduced from immediate regulatory non-compliance to managed residual risk under routine business-as-usual governance. The Trust has self-assessed that all eight CQC Section 31 conditions have been met, supported by triangulated evidence of embedded controls, audit, dashboard review, action tracking, CQC engagement and ward-to-Board escalation routes.</p> |

| Implications on:                         |                                                                                                                                                                                                                                                                                                      |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | No adverse equality impact identified. The controls supporting all eight conditions promote consistent recognition, escalation and safer maternity care for all women and birthing people; patient and family voice, communication and equity remain embedded within routine improvement governance. |
| <b>Health Inequalities</b>               | The embedded controls support more consistent care for people with differing clinical, social and cultural needs. Health inequalities will continue to be monitored through patient and family voice, pathway review and routine maternity governance.                                               |
| <b>Finance and Resources</b>             | Actions have been delivered largely within existing resources. Ongoing assurance and residual-risk management will continue through established workforce, training, governance and improvement                                                                                                      |

|                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                               | arrangements; any additional requirements will be managed through normal business-planning processes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Regulation/Legal</b>       | The latest CQC inspection report was published on 27 August 2026 and identified one regulatory breach relating to medicines management. An action plan is required by 7 September 2026 and is being managed separately through the agreed regulatory response. The Trust has self-assessed all eight Section 31 conditions as met; the medicines management breach is separate from those conditions. Following publication, the Chief Executive and Chief Nurse will authorise submission of the condition-removal applications under the Board's July 2026 delegation. The Trust remains subject to the conditions until CQC confirms removal. |
| <b>CQC quality statements</b> | Primary alignment is with the Safe and Well-led quality statements, with relevant links to Effective, Caring and Responsive. The evidence in this report supports the Trust's self-assessment that all eight conditions are met.                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Green Plan</b>             | No material direct Green Plan impact. The controls are delivered through existing clinical, digital, workforce and governance pathways.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



## Main Report

### 2. Purpose of the report

- 2.1.** The purpose of this report is to provide the Trust Board and CQC with assurance that the Trust has self-assessed all eight Section 31 conditions as met, supported by triangulated evidence of delivery, monitoring and governance. It sets out residual risks and confirms how ongoing compliance will be sustained through business-as-usual governance. In line with the Board's July 2026 delegation, the report provides the final assurance basis for the Chief Executive and Chief Nurse to authorise submission of the condition-removal applications.

### 3. Background

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

Specifically, the conditions were:

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

### 4. Current situation

#### 4.1. Care Quality Commission

#### 4.2. Maternity core service inspection, September 2025

- 4.3.** CQC inspected maternity services at Gloucestershire Royal Hospital and Stroud Maternity Unit in September 2025. The draft report was received on 21 May 2026 and the Trust submitted its factual accuracy response. The latest CQC inspection report was published on 27 August 2026. The report

rated maternity services Requires Improvement, representing material progress against the original Section 31 concerns. One breach relating to medicines management requires an action plan by 7 September 2026; this is being managed separately through the agreed regulatory response. Following publication, the Trust will submit formal applications for removal of the Section 31 conditions.

- 4.4.** In the inspection report CQC recorded positive evidence of improvement across the areas covered by the conditions: PPH — staff followed evidence-based practice, with systematic audit and senior review of outcomes; MEWS — staff used a recognised maternity early warning tool, generally identified and responded to deterioration, and achieved 90–95% compliance with repeat observations within one hour for amber scores; agency induction — agency midwives received unit induction, systems information and access keys to move safely around the unit; VTE — risk assessments were now mostly completed, an improvement from the previous inspection, with evidence that the monitored assessment tools were meeting Trust targets; fetal monitoring — hourly fresh-eyes reviews had been strengthened, and systems for accurate CTG interpretation and escalation achieved 90% and 95% respectively; and governance — the Trust had introduced a new governance structure with defined forums and Board pathways, structured ward and team safety meetings, appropriate multidisciplinary review of perinatal deaths, local audit and risk-register oversight, executive-led review through the Perinatal Delivery Group, and reliable maternity dataset submissions that passed all data-quality tests.
- 4.5.** The Board should note that the report reflects evidence gathered during the September 2025 inspection and therefore provides historical external validation of improvement at that point in time. Current assurance is derived from the more recent 2026 audit, performance and governance evidence presented in this report.
- 4.6.** Trust self-assessment against Section 31 conditions
- 4.7.** The Trust has self-assessed all eight Section 31 conditions as met, supported by the triangulated evidence in this report. In accordance with the Board's July 2026 delegation, the Chief Executive and Chief Nurse will authorise submission of the condition-removal applications following review of the completed submission pack.
- 4.8.** As a further pre-inspection assurance control, the new Director of Midwifery is walking each relevant clinical and governance pathway to test implementation at the point of care, triangulate practice with the submitted evidence, identify any gaps and confirm corrective action. A documented pathway checklist and action log will be retained as pre-inspection evidence, recording findings, named ownership, completion dates, evidence requirements and closure status. Findings and actions will be tracked through the Perinatal Oversight and Assurance Meeting and reported to the executive-led Perinatal Delivery Group.
- 4.9.** Table: Summary of position against CQC conditions

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

**4.10. External oversight for maternity services**

- 4.11.** The NHS England Maternity and Neonatal Improvement Team continues to support the Trust through Maternity and Neonatal Improvement Advisors. Executive meetings continue monthly, with the most recent meeting held on 19 August 2026. The Section 31 conditions are no longer a primary focus of these meetings, reflecting the transition from regulatory recovery to sustained improvement.

#### Condition 1

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

#### 4.12. Summary

**4.13.** In summary, the Trust has implemented an effective system for continual PPH/MOH risk assessment and management. Core controls include approved guidance, risk assessment at defined pathway points, quantified blood loss, wider escalation at blood loss greater than 1,500 ml, the REDUCE checklist, multidisciplinary training, weekly review of significant haemorrhage events, outcome surveillance and governance escalation.

#### 4.14. Reasons and evidence for PPH condition removal

**4.15.** The system is designed to ensure PPH/MOH risk is identified, communicated, escalated and reviewed throughout the maternity pathway, rather than treated as a single-point assessment.

**4.16.** Continual risk assessment is embedded at booking, admission to labour ward, intrapartum handover and safety huddles, following clinical change, during third-stage management, at quantified blood loss escalation points and through post-event multidisciplinary review.

#### 4.17. Governance and clinical leadership

##### 4.18. Clinical leaders

**4.19.** Clinical accountability is assigned to defined obstetric, midwifery, anaesthetic, education and patient safety roles, with collective oversight of guideline review, training, multidisciplinary case review, audit, action tracking and escalation through maternity governance.

##### 4.20. Governance

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

**4.22.** Actions remain open until completion evidence is reviewed and accepted through the relevant governance route. Overdue, recurrent or high-risk actions are escalated through the Intrapartum Forum and, where required, to the Perinatal Oversight and Assurance Meeting, ensuring that learning from PPH/MOH review is converted into closed-loop improvement rather than remaining as discussion only.

| Governance control                                    | Frequency | Review route                                                                      | Assurance provided                                            |
|-------------------------------------------------------|-----------|-----------------------------------------------------------------------------------|---------------------------------------------------------------|
| PPH/MOH case reviews for bleeds greater than 2 litres | Weekly    | Multidisciplinary MOH review forum, with themes reported to the Intrapartum Forum | Learning, contributory factors, actions and escalation themes |

|                                                                |                                                                   |                                                                                                                    |                                                                           |
|----------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| PPH risk assessment, documentation and REDUCE checklist review | Case-based and thematic                                           | PPH improvement team and Intrapartum Forum                                                                         | Compliance with guideline, escalation and documentation standards         |
| CQIM+ PPH $\geq 1,500$ ml data                                 | Monthly                                                           | Intrapartum Forum, with escalation to the Perinatal Oversight and Assurance Meeting by exception                   | Outcome surveillance, variation monitoring and residual-risk oversight    |
| Learning dissemination to staff                                | Monthly                                                           | PPH team and maternity governance routes                                                                           | Evidence that learning is shared and embedded in practice                 |
| Action tracker                                                 | Reviewed at each MOH review and through governance where required | MOH review forum, Intrapartum Forum and Perinatal Oversight and Assurance Meeting for overdue or high-risk actions | Closed-loop improvement with ownership, due dates and completion evidence |

#### 4.23. Core clinical controls

**4.24.** The approved Management of PPH Guideline provides the clinical framework for risk assessment, active management of the third stage, quantified blood loss, major obstetric haemorrhage activation at blood loss greater than 1,500 ml, access to blood products, use of haemorrhage documentation and the REDUCE checklist. Compliance is monitored through case review, audit and the Intrapartum Forum.

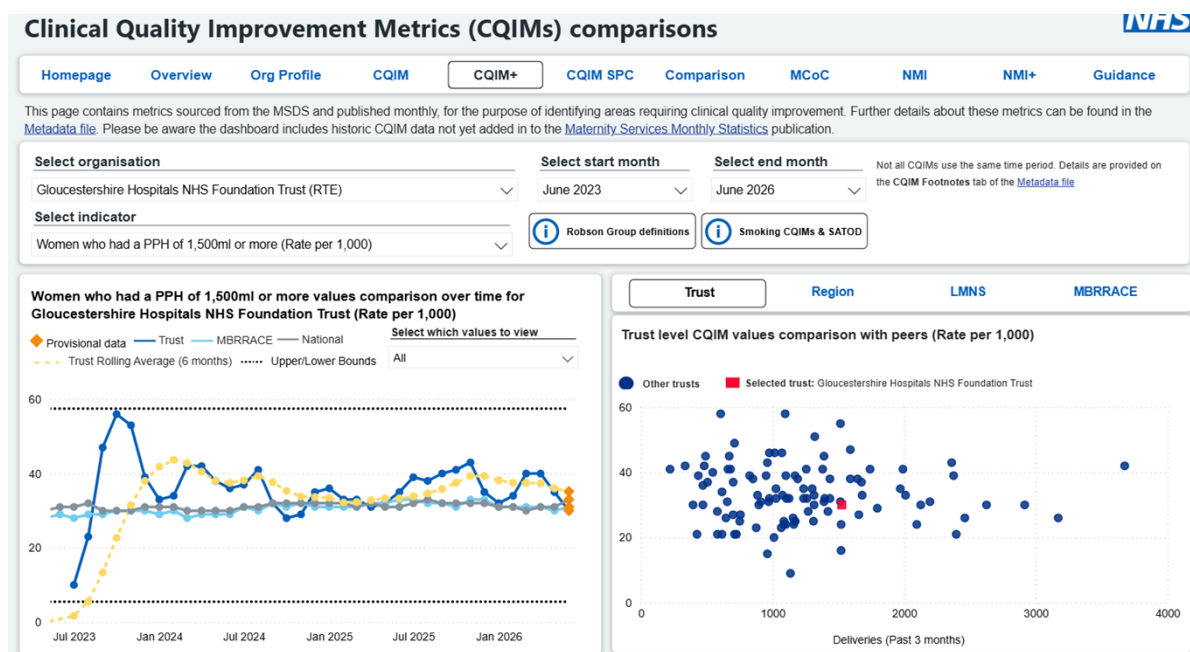
#### 4.25. Outcome metrics

**4.26.** Outcome data is reviewed as part of the wider assurance framework. The June 2026 CQIM+ rate for PPH  $\geq 1,500$  ml was **30 per 1,000 births**, below the **national rate of 33** and below the Trust's **six-month rolling average of 35.17**. The rolling average remains above the national comparator and therefore remains under surveillance. This metric is triangulated with QBL reliability, escalation practice, harm grading, theatre access, transfusion management, documentation quality, action closure and thematic case review findings.

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

| CQIMs Data                             | Aug 2025 | Sept 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | March 2026 | April 2026 | May 2026 | June  |
|----------------------------------------|----------|-----------|----------|----------|----------|----------|----------|------------|------------|----------|-------|
| National                               | 32       | 32        | 32       | 32       | 32       | 32       | 31       | 30         | 31         | 32       | 33    |
| Trust data and 6 month rolling average | 38       | 40        | 41       | 43       | 35       | 31       | 34       | 40         | 40         | 35       | 30    |
|                                        | 34.67    | 35.83     | 37.5     | 39.33    | 39.33    | 38.17    | 37.5     | 37.5       | 37.33      | 36       | 35.17 |

**4.28.** Graph: Maternity National Database CQIM data June 2026, latest available data at the time of reporting



## 4.29. Staff training

### 4.30. Mandatory training

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

### 4.32. Trolley teaching

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

## 4.34. Culture of continuous improvement

### 4.35. Care bundle implementation

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

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

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

### 4.38. Anonymised evidence extract: multidisciplinary MOH review process

#### **Recent anonymised multidisciplinary MOH review summary**

The multidisciplinary MOH review held on 10 August 2026 demonstrates that the weekly review process is active and learning-focused. Four anonymised haemorrhage cases greater than 2

litres were reviewed, covering assisted birth, caesarean section, manual removal of placenta, theatre access, escalation, transfusion, medication timing, documentation, handover and harm grading.

Actions from the review are recorded on the MOH action tracker with allocated ownership, due dates, completion evidence and escalation where required. This provides assurance that significant haemorrhage events are reviewed through a structured multidisciplinary forum and that learning is converted into closed-loop improvement across documentation, escalation, emergency theatre access, inter-agency handover, infection-risk communication, medication timing and targeted staff feedback.

#### 4.39. Handovers and Safety Huddles

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

#### 4.41. **Patient experience**

##### 4.42. Debrief service

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

#### 4.44. **Summary data reported to the Intrapartum Forum in July 2026 and then shared with staff**

4.45. The August review of July 2026 data at the Intrapartum Forum demonstrates active surveillance, curiosity and improvement action where new themes are identified.

### Actions underway from themes identified during MOH July MOH Meeting

| Actions                                                                             |                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>Standardise MOH call activation</b> – MOH call activation to be done at 1500mls to ensure all teams, including blood transfusion, are aware of the potential for deterioration |
|  | <b>Reinforce postnatal PPH escalation</b> – communications and training for postnatal ward staff including MSW on recognition and escalation of abnormal blood loss               |
|  | <b>Improve MOH documentation</b> – Share information regarding documentation requirements and standards                                                                           |
|  | <b>Address system and communication barriers</b>                                                                                                                                  |
|  | <b>Continue audits and thematic review</b> – to enable effective actions related to the issues/concerns found to improve care                                                     |

### Request by IRSH: For Discussion following Datix submission:

INC-55794

IOL for PET, no blood tests taken between admission and delivery. Unable to have spinal anaesthesia. Is there a trend/theme with bloods tests not being taken during admissions? Do we need to complete a spot check audit? Is the pathway/guideline clear? Do staff know what the pathway/guidance is?

**4.46. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 1 has been met.** An effective system is in place for continual PPH/MOH risk assessment and management, supported by approved guidance, defined pathway risk assessment points, quantified blood loss, clear escalation triggers, structured documentation, multidisciplinary training, weekly review of the highest-risk haemorrhage events, action tracking, outcome surveillance and governance escalation. Residual risk remains visible through PPH  $\geq 1,500$  ml rates and MOH variation, but is actively monitored and managed through business-as-usual maternity governance. This residual risk does not indicate ongoing failure of the system required by the condition.



**Condition 2**

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

**4.47. Summary**

- 4.48.** In summary, the Trust has implemented a monitored system for hourly peer review, also known as "fresh eyes", during intrapartum care. Although national guidance has evolved, hourly peer review remains a local safety control to support second review, shared situational awareness and timely escalation.
- 4.49.** Assurance is provided through the approved intrapartum fetal monitoring policy, competency-based training, monthly audit, dashboard monitoring, fetal monitoring leadership oversight, staff learning communications and governance review through the Intrapartum Forum, with escalation to the Perinatal Oversight and Assurance Meeting where thresholds are not met or variance is sustained.
- 4.50.** The latest audit result is 75% against the Trust's 85% local target. This has been reviewed by the fetal monitoring leadership team and through intrapartum governance. The variance is visible, owned and subject to corrective action, including reinforcement of documentation expectations, review of missed or undocumented reviews, targeted staff communication and continued monthly monitoring. Escalation to the Perinatal Oversight and Assurance Meeting will occur if improvement is not demonstrated or variance is sustained.
- 4.51.** The Trust can provide reasonable assurance to Trust Board and CQC that Condition 2 has been met. The regulatory requirement is for an effective system that ensures hourly peer review is required, monitored and acted upon. That system is established and operating through approved policy, competency-based training, monthly audit, named clinical leadership, corrective action and defined governance escalation. Current compliance of 75% remains below the Trust's 85% local target and is therefore retained as an actively managed residual risk rather than evidence that the required system is absent or ineffective. The variance is visible, owned and subject to targeted improvement action, with monthly monitoring and escalation to the Perinatal Oversight and Assurance Meeting if progress is not demonstrated or performance deteriorates. Sustained improvement remains necessary to evidence the continued effectiveness and reliability of the control through business-as-usual governance.

**4.52. Reasons and evidence for condition removal****4.53. Clinical leaders**

- 4.54.** Clinical accountability for fetal monitoring and hourly peer review is assigned to defined obstetric, fetal wellbeing and education roles. These roles oversee policy, competency-based training, audit review, improvement action, staff communication and escalation through maternity governance.

**4.55. Governance**

- 4.56.** Oversight is provided through the Intrapartum Forum, which reviews audit results, dashboard trends, missed or undocumented reviews, staff communication, corrective actions and residual risk. Sustained variance, unresolved actions or material risk are escalated to the Perinatal Oversight and Assurance Meeting, which reports to the executive-led Perinatal Delivery Group, with onward escalation through Board assurance routes where required.

| Governance control       | Frequency | Review route      | Assurance provided                                  |
|--------------------------|-----------|-------------------|-----------------------------------------------------|
| Hourly peer review audit | Monthly   | Intrapartum Forum | Compliance with the local fresh eyes safety control |



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

#### 4.57. Standardised management policy

**4.58.** The Trust has an approved intrapartum fetal monitoring policy in place (M1068, review date August 2029). The policy sets the local requirement for hourly peer review during intrapartum care and defines expectations for interpretation, documentation and escalation. Supporting documentation work, including paper-based and BadgerNet development, is being used to strengthen reliability of recording and review.

#### 4.59. Audit data

**4.60.** Hourly peer review compliance is monitored through the fetal monitoring audit and dashboard reviewed at the Intrapartum Forum. The latest result is 75% against the 85% local target. Review has identified missed or undocumented reviews during periods of acuity, second stage care, epidural insertion and theatre decision-making. Corrective action includes reinforcing documentation expectations, targeted staff communication, review of missed cases, and testing of a clinical flow midwife role on delivery suite.

### Proposal: Trial of a Clinical Flow Midwife Role



#### Aim:

To explore the introduction of a supernumerary Clinical Flow Midwife (Band 6 core as per feedback from midwives) on each shift as a pilot initiative to support intrapartum care, safety, and workforce resilience.

#### Potential Responsibilities:

- Attend and support women entering second stage of labour early when required.
- Undertake CTG peer reviews and provide real-time support/escalation.
- Act as second midwife on the GBU when needed.
- Support management of workload and patient flow across the unit.
- Assist with timely escalation and multidisciplinary communication.

#### Proposed Pilot:

- Trial for 2-3 months.
- Role to remain **supernumerary** wherever possible.
- Measure impact through:
  - CTG documentation and peer review audit outcomes.
  - Compliance with intrapartum care standards.
  - Staff feedback and confidence.
  - Escalation and incident themes.
  - Birth suite flow and workload management.

Drop-in sessions in September for staff to get feedback and ideas of solution

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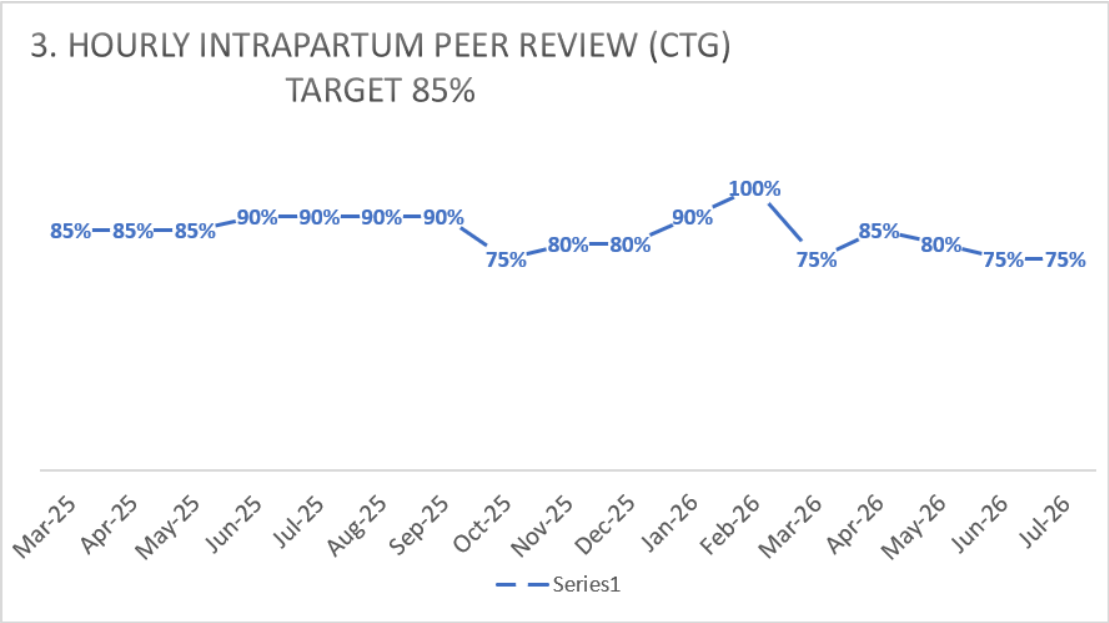
**4.61.** The Trust continues to retain hourly peer review as a local safety control to support reliable second review and timely escalation during intrapartum care. As national guidance evolves, this control will remain subject to routine governance review; however, any future change would require formal

assessment through established assurance routes to ensure that an equivalent or stronger safety control is in place.

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

**4.63. Residual risk and mitigation**

**4.64.** The principal residual risk is variation in completion or documentation of hourly peer review during periods of clinical acuity or operational pressure. This is mitigated through monthly audit, dashboard review, missed-case analysis, fetal monitoring leadership oversight, staff communication, targeted corrective action, intrapartum fetal deterioration learning and escalation through the Intrapartum Forum and Perinatal Oversight and Assurance Meeting if improvement is not demonstrated or variance is sustained. The Perinatal Oversight and Assurance Meeting reports to the executive-led Perinatal Delivery Group.



**4.65. Culture of continuous improvement**

**4.66.** The fetal monitoring improvement team continues to support Saving Babies’ Lives Care Bundle Version 3, Element 4, including competency in intrapartum fetal monitoring, documentation, escalation, intrapartum fetal deterioration learning and shared learning.

**4.67.** Fetal Wellbeing Wednesday provides a weekly mechanism for sharing learning and reinforcing hourly peer review, documentation and escalation standards.

**4.68.** Condition 2 should be read alongside Condition 3, which provides assurance on the wider fetal monitoring safety system, including interpretation, escalation, competency, thematic review and learning.

**Condition 3**

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

**4.69. Summary**

**4.70.** Condition 3 covers the wider system for accurate fetal monitoring interpretation and timely escalation; it should be read alongside Condition 2 on hourly peer review.

**4.71.** The Trust has an embedded and monitored system supported by an approved intrapartum fetal monitoring policy, competency-based training, defined escalation pathways, audit, thematic case review, staff learning and governance oversight.

**4.72.** Assurance is triangulated through monitoring-method selection, interpretation and escalation audit, competency compliance, Maternity Incentive Scheme Safety Action 6 evidence, PSIRF-aligned review of perinatal compromise and oversight through the Intrapartum Forum. Sustained variance, unresolved actions or material risks are escalated to the Perinatal Oversight and Assurance Meeting, which reports to the executive-led Perinatal Delivery Group.

**4.73. Reasons and evidence for condition removal****4.74. Saving babies lives version 3 implementation**

**4.75.** The system aligns with NHS England Saving Babies' Lives Care Bundle Version 3, Element 4. Core controls are competency-based CTG and intermittent auscultation training, documented intrapartum risk assessment and monitoring-method selection, defined interpretation and escalation standards, hourly peer review as a local safety control, routine audit, thematic review and action tracking to completion.

**4.76. Governance and clinical leadership****4.77. Clinical leaders**

**4.78.** Clinical accountability is assigned to defined obstetric, fetal wellbeing and education roles, with collective oversight of policy, training, audit, thematic learning, improvement action, staff communication and governance escalation.

**4.79. Governance**

**4.80.** The Intrapartum Forum reviews audit performance, dashboard data, perinatal compromise themes, actions and emerging risks. Sustained variance, overdue actions or material risk are escalated to the Perinatal Oversight and Assurance Meeting, which reports to the executive-led Perinatal Delivery Group, with onward escalation through Board assurance routes where required. Actions remain open until completion evidence is accepted.

| Governance control                                                       | Frequency                               | Review route                                  | Assurance provided                                                                                             |
|--------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Fetal monitoring audit: monitoring method, interpretation and escalation | Monthly / routine cycle                 | Fetal monitoring team and Intrapartum Forum   | Assurance that monitoring method selection, interpretation and escalation are reviewed against local standards |
| Maternity Incentive Scheme Safety Action 6                               | Annual submission with local monitoring | Maternity governance and Board sign-off route | External assurance against national fetal monitoring standards                                                 |

| Governance control                                 | Frequency                                | Review route                                                                                     | Assurance provided                                                                               |
|----------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Fetal monitoring competency and training           | Ongoing through mandatory training cycle | Fetal monitoring team and maternity training governance                                          | Staff competence to interpret, document, contextualise and escalate fetal monitoring concerns    |
| Perinatal compromise thematic review               | Thematic / by reporting cycle            | PSIRF learning route, Intrapartum Forum and fetal monitoring leads                               | Identification of themes relating to interpretation, escalation, communication and documentation |
| Fetal Wellbeing Wednesday and staff communications | Weekly / as required                     | Fetal monitoring team                                                                            | Learning dissemination and reinforcement of interpretation and escalation standards              |
| Action tracking                                    | Monthly and by exception                 | Intrapartum Forum and Perinatal Oversight and Assurance Meeting for overdue or high-risk actions | Closed-loop improvement with ownership, timescales and completion evidence                       |

#### 4.81. Standardised management policy

**4.82.** Approved policy M1068, review date August 2029, defines the operative standard for fetal monitoring interpretation, clinical contextualisation, documentation and escalation and remains in force while updates maintain alignment with revised NICE guidance.

**4.83.** BadgerNet development and staff testing are strengthening the reliability of digital documentation and escalation records.

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

**4.85.** The August 2026 snapshot audit of 10 cases showed risk assessment at 95% against the 95% target, accurate interpretation at 100% against the 85% target, and appropriate escalation at 100% against the 100% target. The small sample is interpreted within the wider assurance framework of routine audit, competency monitoring, thematic review and governance oversight.

**4.86. Residual risk and mitigation** Residual risk is variation in interpretation, documentation or escalation during clinical complexity or operational pressure. Mitigation includes non-compliant case review, targeted feedback, competency-based training, fetal monitoring leadership oversight, weekly staff learning, intrapartum fetal deterioration learning, continued audit and escalation through the Intrapartum Forum and Perinatal Oversight and Assurance Meeting.

#### 4.87. Culture of continuous improvement

**4.88.** Saving Babies' Lives Element 4 improvement continues to focus on competency, clinical contextualisation, documentation, escalation and learning from intrapartum fetal deterioration, reinforced through training, Fetal Wellbeing Wednesday, audit and governance review.

**4.89. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 3 has been met.** A sustainable system is in place for accurate fetal monitoring interpretation and timely escalation, supported by approved policy, national alignment, competency-based training, audit, Maternity Incentive Scheme evidence, PSIRF-aligned thematic review, staff learning, action tracking and clear governance escalation. The latest audit met all three standards. Residual risk relating to variation during complexity or pressure remains visible, owned and actively managed through business-as-usual governance; it does not indicate failure of the system required by the condition.



**Condition 4**

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

**4.90. Summary**

- 4.91.** The Trust implemented the national Maternal Early Warning Score (MEWS) system on 5 May 2026, establishing a standardised system for recognising and escalating maternal deterioration across intrapartum and postnatal care.
- 4.92.** The national framework categorises concern as low, low-medium, medium or high and defines observation frequency, escalation, clinical review timing and secondary escalation, including response to professional, patient or family concern and other clinical triggers.
- 4.93.** Assurance is provided through approved policy, staff training, implementation audit and spot checks, ward leadership oversight and review through the Postnatal Forum, with escalation to the Perinatal Oversight and Assurance Meeting and Board routes where sustained variance, unresolved actions or material risk are identified.

**4.94. Reasons and evidence for condition removal**

- 4.95.** Compliance is evidenced through the national MEWS policy, training and communication, implementation audits across maternity settings, review of scoring, escalation and response, action tracking and governance oversight.

**4.96. Governance and clinical leadership**

- 4.97.** Clinical accountability is assigned to defined obstetric, midwifery, ward leadership and education roles, with collective oversight of policy, training, audit, escalation practice, implementation assurance and governance reporting.

**4.98. Governance**

- 4.99.** The Postnatal Forum reviews audit and spot-check findings, implementation themes, staff feedback and actions. Sustained variance, overdue actions or material risk are escalated to the Perinatal Oversight and Assurance Meeting, which reports to the executive-led Perinatal Delivery Group, with onward escalation through Board assurance routes where required. Actions remain open until completion evidence is accepted.

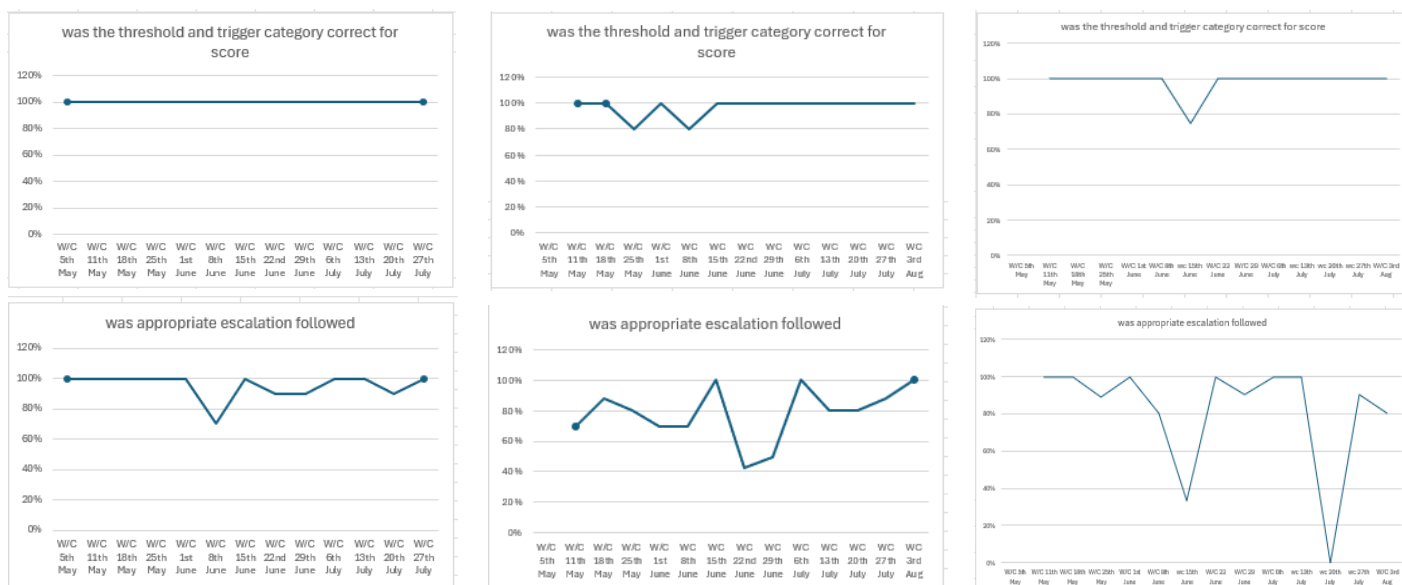
**4.100. Standardised management policy**

- 4.101.** The national MEWS policy, implemented on 5 May 2026, supersedes the legacy MOEWS process and defines the current requirements for scoring, additional-concern triggers, observation frequency, escalation, clinical review and secondary escalation during intrapartum and postnatal care.

**4.102. Audit data**

- 4.103.** Audit arrangements were reset following national MEWS implementation. July 2026 audits, presented to the Postnatal Forum in August, tested practice across the maternity ward, delivery suite and birth unit, including chart completion, scoring accuracy, concern thresholds, documented response, observation frequency, timely review, additional concerns and secondary escalation. Findings are used to reinforce communication, documentation and corrective action.

Graphs: MEWS completion and escalation



#### 4.104. Residual risk and mitigation

**4.105.** The principal residual risk is variation while the national MEWS system matures, particularly in scoring accuracy, recognition of additional concerns, documentation, observation frequency, timely review and secondary escalation. This is mitigated through spot checks, ward leadership oversight, staff communication, Postnatal Forum review, action tracking and escalation to the Perinatal Oversight and Assurance Meeting where themes, sustained variance or unresolved actions are identified. The Perinatal Oversight and Assurance Meeting reports to the executive-led Perinatal Delivery Group.

#### 4.106. Culture of continuous improvement

**4.107.** Early implementation learning is being used to strengthen documentation, training and consistent application of the national escalation framework. The next phase will align MEWS assurance with the Maternal Care Bundle across maternity and linked care settings.

**4.108. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 4 has been met.** A sustainable national MEWS-based system is in place for completion and escalation of maternal early warning scores, supported by approved policy, defined concern thresholds and response requirements, staff training, implementation audit, clinical leadership and clear governance escalation. Residual risk relating to implementation maturity is visible, owned and actively managed through business-as-usual governance and does not indicate failure of the system required by the condition.

### Condition 5

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

#### 4.109. Summary

**4.110.** The Trust has established a monitored maternity VTE risk-assessment system aligned with NICE and RCOG guidance. Core controls are approved guidance, mandatory BadgerNet assessment prompts, reassessment when clinical condition changes, quarterly audit, Production Board reporting and maternity and Trust-wide VTE governance.

#### 4.111. Reasons and evidence for condition removal

**4.112.** The system supports risk identification at key points in the maternity pathway, reduces omitted assessments through mandatory digital controls and links risk assessment to clinical review, thromboprophylaxis and documented escalation.

#### 4.113. Governance and clinical leadership

**4.114.** Clinical accountability is assigned to defined obstetric, midwifery, ward, digital and governance roles, with collective oversight of guidance, digital pathway reliability, audit, staff communication, improvement action and escalation.

#### 4.115. Governance

**4.116.** Maternity governance reviews audit findings, Production Board data, digital pathway issues and improvement actions, with linkage to the Trust-wide VTE Prevention Improvement Group. Sustained variance, unresolved actions or material risk are escalated through maternity and executive governance, providing clear ward-to-Board visibility.

| Governance control                                  | Frequency                                                               | Review route                                                  | Assurance provided                                                          |
|-----------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------|
| Admission VTE risk assessment audit                 | Quarterly, following sustained high compliance                          | Maternity governance and Production Board reporting           | Assurance that VTE risk assessment completion remains embedded and reliable |
| BadgerNet mandatory VTE assessment prompts          | Continuous digital control, reviewed through audit and pathway feedback | Maternity governance and digital pathway review               | Reduction in omitted assessments and improved reliability of completion     |
| Reassessment when clinical condition changes        | Case-based and by audit cycle                                           | Ward leadership and maternity governance                      | Assurance that risk is reviewed when clinical circumstances change          |
| Thromboprophylaxis and discharge information review | Spot check and pathway review                                           | Maternity governance and Trust-wide VTE routes where required | Assurance that risk assessment links to                                     |



|                                              |                                                     |                                                                      |                                                                   |
|----------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------|
|                                              |                                                     |                                                                      | appropriate prophylaxis and patient information                   |
| Maternal Care Bundle VTE pathway improvement | Gap analysis and action plan, with re-audit planned | Perinatal Governance Team and Maternity Clinical Effectiveness Group | Whole-pathway learning beyond the immediate condition requirement |

#### **4.117. Standardised management policy**

**4.118.** Guideline M2014 defines risk assessment, thromboprophylaxis, reassessment following clinical change and escalation and is aligned with NICE NG89 and RCOG Green-top guidance 37a and 37b.

#### **4.119. Digital systems**

**4.120.** BadgerNet embeds mandatory VTE assessment fields and prompts within antenatal booking and postnatal admission, supporting consistent completion and identification of intermediate and high-risk patients requiring clinical review and thromboprophylaxis consideration.

#### **4.121. Audit - risk assessments**

**4.122.** Admission VTE risk-assessment audits have consistently met or exceeded the 95% target, including 100% in the latest completed audit in May 2026. Quarterly audit is now proportionate following sustained high compliance; the next audit is due in September 2026.

**4.123.** Between formal audits, assurance is maintained through mandatory BadgerNet prompts, Production Board reporting, pathway review and spot checks. Any variance from the 95% target is subject to corrective action and escalation through maternity and Trust-wide VTE governance.

#### **4.124. Residual risk and mitigation**

**4.125.** Residual risk is variation in reassessment, thromboprophylaxis initiation or documentation when clinical circumstances change or care crosses organisational boundaries. Mitigation includes mandatory digital prompts, quarterly audit, spot checks, pathway and discharge-information review, multidisciplinary review of hospital-associated thrombosis and escalation through maternity and Trust-wide VTE governance.

**4.126.** The next formal compliance point is the September 2026 audit. Wider improvement through NHS England Maternal Care Bundle Element 1 is addressing earlier risk identification, timely thromboprophylaxis, discharge information and whole-pathway working, with implementation planned by March 2027.

**4.127. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 5 has been met.** A sustainable VTE risk-assessment system is in place, supported by NICE- and RCOG-aligned guidance, mandatory BadgerNet controls, reassessment requirements, quarterly audit, Production Board reporting and maternity and Trust-wide governance. Recent audits have consistently met or exceeded the 95% target, including 100% in May 2026; the next audit is due in September 2026. Residual whole-pathway risk is visible, owned and actively managed through routine governance and does not indicate failure of the system required by the condition.

**Condition 6**

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

**Summary**

- 4.129.** The Trust has an established system ensuring agency midwives receive local induction before deployment and timely access to the unit, maternity electronic records and essential Trust policies. Controls comprise the Temporary Workforce Policy, maternity action card B0720, the July 2026 approved information pack, ward orientation, access checks, supervision and escalation.
- 4.130.** The Deputy Director of Midwifery is accountable for delivery, supported by workforce, ward, digital, education and governance leads. Monthly monitoring and the Workforce Meeting review temporary staffing, induction, physical and digital access, feedback, incidents and actions; recurring or unresolved risks escalate to the Perinatal Oversight and Assurance Meeting and, where required, executive and Board routes.
- 4.131.** Policy requires induction before a temporary staff member commences a shift. Action card B0720 and the July 2026 pack specify local emergency and ward contacts, key safety processes, BadgerNet and other electronic access, policy and physical access, supervision and escalation routes.

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

**4.132.** Ward leadership confirms orientation and access at deployment. The current information pack covers BadgerNet, electronic prescribing and records, Trust policies, physical access and key maternity safety processes, including MEWS, PPH/MOH, fetal monitoring, VTE, Datix and escalation. Feedback, incidents and access issues inform updates to induction materials and controls.

**4.133. Residual risk and mitigation** Short-notice deployment may delay induction or physical/digital access. Mitigation comprises pre-shift arrangements where practicable, ward induction and supervision, shift-lead checks, rapid escalation of access issues, monthly workforce review and escalation of recurring or unresolved risks to the Perinatal Oversight and Assurance Meeting, which reports to the executive-led Perinatal Delivery Group.

**4.134. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 6 has been met.** The system is supported by approved policy, maternity-specific guidance, current induction materials, ward-level checks, monthly workforce oversight and defined escalation. Residual risk from short-notice deployment or access delay is visible, owned and actively managed through business-as-usual governance and does not indicate failure of the required system.

### Condition 7

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

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

### 4.135. Summary

- 4.136.** The Trust submitted the required quality improvement plan within 21 days in May 2024 and provided monthly progress reports thereafter. The plan covered PPH and fetal monitoring, immediate and medium-term actions, assigned responsibilities, timescales and measurable outcomes.
- 4.137.** Monthly submissions gave CQC, Trust Board and committees visibility of delivery, evidence, residual risk and escalation. Actions were tracked through executive-led maternity governance until completion evidence was accepted, with no unresolved issues arising from the reporting process.
- 4.138.** Controls from Conditions 1–6 are now embedded in routine maternity governance, audit, dashboard review, PSIRF-aligned learning and Board reporting. Enhanced Section 31 reporting has therefore transitioned to business-as-usual oversight without loss of ward-to-Board visibility.
- 4.139.** The July 2026 CQC engagement meeting and the latest inspection report, published on 27 August 2026, provide additional evidence that the original action-plan controls are embedded. Following publication, the Trust will submit the condition-removal application.

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

| Governance control                         | Frequency                       | Review route                                                  | Assurance provided                                              |
|--------------------------------------------|---------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------|
|                                            |                                 | and executive-led maternity forums                            |                                                                 |
| Action tracking                            | Monthly and by exception        | Perinatal governance and executive-led maternity governance   | Ownership, timescales, measurable actions and closure evidence  |
| Transition to business-as-usual governance | Following embedding of controls | Established maternity, divisional and Trust governance routes | Evidence that controls are sustained without enhanced reporting |

#### 4.140. Residual risk and mitigation

**4.141.** The principal residual risk is reduced visibility after enhanced monthly reporting ends. This is mitigated by embedding actions, metrics and exceptions within routine maternity governance, the Perinatal Quality Oversight Model report, dashboard review, audit, PSIRF-aligned learning, Board and committee reporting and defined escalation routes.

**4.142. The Trust can provide reasonable assurance to Trust Board and CQC that Condition 7 has been met.** The required plan was submitted within 21 days and monthly reports provided accountable ownership, measurable progress, evidence and escalation. Enhanced reporting has fulfilled its purpose, the controls are embedded in business-as-usual governance, and residual visibility risk is actively managed through established assurance routes.

**Condition 8**

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

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

**4.143. Summary**

- 4.144.** The Trust has met the reporting requirements of Condition 8. From May 2024, monthly submissions to CQC comprised an updated action plan covering all conditions, Board and senior leadership assurance reports, and the maternity dashboard. The reporting schedule records completion of each required submission through July 2026.
- 4.145.** Submissions provided CQC, Trust Board, the Quality and Performance Committee and executive-led maternity forums with consistent visibility of progress, evidence, risk, dashboard performance, actions and escalation.
- 4.146.** Following embedding of the controls in Conditions 1–6, assurance has transitioned to business-as-usual oversight through the Perinatal Quality Oversight Model report, maternity dashboard, audit, PSIRF-aligned learning, action tracking and defined escalation routes.
- 4.147.** The reporting schedule below provides the evidence trail of completed CQC submissions from May 2024 to July 2026.

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

| Dates due      | Update      |
|----------------|-------------|
| 30 June 2026   | – complete  |
| 31 July 2026   | – complete  |
| 28 August 2026 | This report |

#### 4.148. Maternity services dashboard

4.149. The Perinatal Dashboard and Perinatal Quality Oversight Model report provide continuing data-led oversight of maternity quality, safety, risk and improvement through Board, committee and divisional governance routes.

#### 4.150. **Residual risk and mitigation**

4.151. The principal residual risk is reduced visibility after enhanced monthly CQC reporting ends. This is mitigated by embedding relevant actions, metrics and exceptions within the Perinatal Quality Oversight Model report, maternity dashboard, audit, PSIRF-aligned learning, Board and committee reporting and defined escalation routes.

#### 4.152. **Conclusion**

4.153. **The Trust can provide reasonable assurance to Trust Board and CQC that Condition 8 has been met.** The required updated action plans, senior leadership and Board assurance reports, and maternity dashboards were submitted monthly to CQC, with a documented evidence trail through July 2026. Ongoing oversight is embedded in routine governance, dashboard reporting, audit, action tracking and escalation. Residual visibility risk is actively managed and does not indicate failure of the reporting system required by the condition.

#### **Authors:**

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

#### **Sponsors:**

Women and Children's Division Chief of Service - Simon Pirie  
Director of Midwifery – Zita Martinez  
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Director of Safety and Medical Director – Mark Pietroni  
CEO – Kevin McNamara

#### **Enclosures**

*None*

**FOI:** *Public*

## Report to Trust Board

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of Meeting</b>             | 10 September 2026                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Report title</b>                | Maternity and Neonatal 10 Point Plan: Board Assurance Update                                                                                                                                                                                                                                                                                                                                               |
| <b>Sponsoring Director/Authors</b> | <p>Matt Holdaway, Chief Nurse and Director of Quality<br/>Mark Pietroni, Medical Director and Director of Safety<br/>Joint Executive Sponsors, with shared Board-level accountability for maternity and neonatal safety, quality, experience and improvement.</p> <p>Nicola Moore, Deputy Director of Midwifery<br/>Zita Martinez, Director of Midwifery<br/>Suzie Cro, Director of Quality Governance</p> |

### Purpose (confirm the appropriate box)

| For approval | For discussion | For information |
|--------------|----------------|-----------------|
| x            |                |                 |

### Executive Summary

This paper provides the Trust Board with an update on the national expectations set out by NHS England in relation to the Maternity and Neonatal 10 Point Plan assurance process. The letter, issued on 12 August 2026, confirms that all trusts are required to complete a standardised national assurance template, with a baseline Board-approved submission due to the NHS England region by 25 September 2026 and a further progress update due by 31 December 2026. The process is intended to evidence delivery of urgent national actions arising from recent independent maternity and neonatal reviews, while aligning as far as possible with existing assurance routes, including Maternity Incentive Scheme Year 8 requirements, Board reports, committee papers and minutes.

The Board is asked to approve the Trust's baseline assurance assessment, the completed maternity triage benchmarking assessment and associated 12-month improvement plan; confirm executive ownership and scrutiny of the partially compliant areas; and note that the approved Board minute will form part of the evidence for regional submission. The principal residual risks relate to workforce sustainability, triage responsiveness, inequalities, patient and family engagement, and post-death care assurance.



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Previously considered by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Perinatal Delivery Group |
| <b>Recommendations:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |
| <p><i>The Board is asked to:</i></p> <ul style="list-style-type: none"> <li>note the national requirements set out in the NHS England Maternity and Neonatal 10 Point Plan assurance process;</li> <li>approve the Trust's baseline assurance assessment for submission to the NHS England regional team by 25 September 2026;</li> <li>approve the completed maternity triage benchmarking assessment and associated 12-month improvement plan;</li> <li>confirm the Chief Nurse and Medical Director's joint executive accountability for maternity and neonatal safety, quality, experience and improvement, including shared ownership of Board-level risk, delivery and escalation; and confirm executive oversight of the 14 partially compliant deliverables, each supported by a completion date and evidence requirement;</li> <li>note that the 10 Point Plan assessment contains no non-compliant deliverables, while the separate triage benchmark contains one standard rated not in place relating to the dynamic staffing model;</li> <li>require progress, residual risks and evidence of impact to be monitored through the Quality and Performance Committee and reported to Trust Board before the December 2026 return;</li> <li>note that the approved Board minute and evidence of successful regional submission must be retained; and</li> <li>agree that any material risks to delivery, regulatory compliance or patient safety are escalated through the Integrated Care Board and NHS England regional routes as required.</li> </ul> |                          |
| <b>Strategic Aims</b> (tick as appropriate)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |
|  <b>Patient experience and voice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X                        |
|  <b>People, culture and leadership</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | X                        |
|  <b>Quality, safety and delivery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X                        |
|  <b>Digital first</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |
| <b>Impact on any Strategic Risks?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |
| <p><b>SR1 - Inability to deliver safe and effective services against regulatory and statutory requirements</b></p> <p>The paper directly supports mitigation of SR1 by providing Board oversight of the Trust's baseline position against the Maternity and Neonatal 10 Point Plan. The current position</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |

provides developing assurance, with no non-compliant areas identified; however, 14 deliverables remain partially compliant and require continued oversight to manage residual risks relating to workforce, triage, inequalities, patient and family engagement, and post-death care assurance.

#### Implications on:

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | The national programme is directly relevant to equality, diversity and inclusion because it responds to identified variation in maternity and neonatal outcomes, experience and safety. Local assurance will need to demonstrate how the voices of women, birthing people, babies and families are heard, particularly those from communities known to experience poorer outcomes or barriers to access.                                                                                                                                                                                                                |
| <b>Health Inequalities</b>               | The assurance process requires attention to outcomes, experience and service responsiveness. This supports the Trust's focus on reducing unwarranted variation and ensuring that maternity and neonatal improvement activity is informed by patient experience, clinical outcomes and local population need.                                                                                                                                                                                                                                                                                                            |
| <b>Finance and Resource</b>              | The principal resource pressure relates to the maternity triage and wider perinatal workforce position. The dynamic triage staffing model and associated 24/7 telephone triage, training, resilience and dedicated-assessment requirements are not yet fully funded and remain subject to approval of the maternity workforce business case. Temporary staffing and divisional controls provide interim mitigation. Any additional workforce, digital, estates or audit costs identified through implementation will require quantified financial assessment and approval through established business-planning routes. |
| <b>Regulation/Legal</b>                  | The paper supports the Trust's regulatory and statutory responsibilities for safe, effective, responsive and well-led maternity and neonatal services. The Board-approved baseline submission is required by 25 September 2026, with a further progress update due by 31 December 2026. Material concerns must be escalated through Integrated Care Board and NHS England regional routes.                                                                                                                                                                                                                              |
| <b>CQC-Key line of enquiry</b>           | Relevant to CQC quality statements for safe care and treatment, safeguarding, learning culture, governance, management and sustainability, equity in access, and involving people to manage risks and improve services.                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Green Plan</b>                        | No direct Green Plan impact has been identified through this paper.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

### 1. Background and national context

NHS England wrote to trusts on 12 August 2026 setting out the assurance process for the Maternity and Neonatal 10 Point Plan. The letter follows the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust. NHS England has confirmed that the immediate national priority is delivery of the 10 Point Plan while the Maternity and Neonatal Taskforce develops a wider national action plan by the end of the year.

The assurance process is intended to support and evidence progress without creating a separate reporting burden. Trusts are expected to use existing governance, evidence and reporting routes, including Board papers, committee reports, minutes, dashboards and evidence aligned to Maternity Incentive Scheme Year 8 requirements where relevant.

### 2. National requirements for Board assurance

Trusts are required to submit the standardised national assurance template to the NHS England region at two points: a baseline assessment by 25 September 2026 and a progress update by 31 December 2026. Both submissions must be approved by the Trust Board. NHS England expects Boards to provide visible ownership and scrutiny of delivery, ensure actions are progressing at pace, oversee the management of risks, and ensure significant concerns are escalated through Integrated Care Board and regional routes where required.

The completed templates for both the Maternity and Neonatal 10 Point Plan and Maternity Triage, together with all supporting evidence, must be submitted via the Futures Portal by close of play on 25 September 2026. The Trust will aim to complete submission by 24 September 2026, where possible, to provide contingency time to identify and resolve any portal, evidence or completeness issues before the national deadline.

The national template is designed to draw on existing assurance activity wherever possible. This includes evidence already developed for Maternity Incentive Scheme Year 8, local maternity and neonatal governance, clinical audit, patient safety incident response, complaints and concerns, patient experience, workforce and culture, triage, and post-death care.

### 3. Key areas requiring local oversight

The Board will need to maintain oversight of delivery against the 10 Point Plan and the associated national support programme. Particular areas of focus include listening to women and families through real-time and transparently reported experience and outcome data; strengthening clinical audit; ensuring 24/7 safety and responsiveness of services; responding to patient safety incidents, complaints and concerns with openness, humanity and candour; and ensuring that improvement activity is informed by staff voice and learning from national reviews.

NHS England has also issued a maternity triage benchmarking tool to support local assessment against the national maternity triage specification. Trusts are expected to use this tool to assess their current position, identify gaps and develop an action plan. The expectation is that the board-level triage audit is completed by the September submission, with Board oversight of triage quality, performance and improvement plans over the following 12 months.

The letter also confirms the need for continued Board assurance in relation to post-death care, including completion of the Board assurance statement by 31 July 2026 and ongoing oversight of matters relating to mortuaries, dignity, security and implementation of relevant national recommendations.

4. Maternity triage benchmarking assurance

The completed national maternity triage benchmarking tool provides substantial but not yet full assurance across all ten specification principles. Of 77 applicable standards, 58 (75%) are fully in place, 17 (22%) are partially in place and one (1%) is not in place; one further standard is not relevant to the local pathway. Strengths include recognition of triage as urgent care, 24/7 access pathways, facilities, service-user voice, equity monitoring and data governance, with all standards under Principle 10 fully evidenced. The principal residual risk is workforce: the dynamic staffing model is not yet in place, and related gaps remain in dedicated 24/7 telephone triage, separation of initial assessment from ongoing care, training assurance and resilience during escalation. Further actions address accessible information, inter-service pathways, experience of delays, reception oversight and completion of selected metrics. Mitigations comprise the maternity workforce business case, temporary staffing arrangements, divisional action-plan monitoring, governance approval of revised procedures, manual audit pending digital reporting and escalation of system-dependent actions. No immediate unmanaged safety risk is identified; however, assurance is conditional on Board approval of the workforce model, delivery of time-bound actions and continued oversight of performance and inequalities data through established governance routes.

5. Summary baseline position from reporting template

The baseline 10 Point Plan assessment covers 26 deliverables: 12 compliant, 14 partially compliant and none non-compliant or not applicable. This represents developing but credible assurance, supported by established governance and evidence, while confirming that further implementation or documentation is required in several areas. This position is distinct from the more granular maternity triage benchmarking assessment, which includes one standard rated not in place in relation to the dynamic staffing model.

Table: Current position

| Compliant | Partially compliant | Non-compliant | Total |
|-----------|---------------------|---------------|-------|
| 12        | 14                  | 0             | 26    |

Key assurance

Established arrangements include Martha’s Rule rollout; recurring triangulation and Board reporting of outcomes, experience, audit and safety intelligence; joint executive accountability; consultant presence above the Maternity Incentive Scheme Year 8 threshold; oversight of homebirth services; embedded Patient Safety Incident Response Framework and complaints-learning processes; a defined maternity triage improvement programme; and completion of the post-death care Board assurance statement.

Key gaps

The partially compliant position reflects incomplete implementation, pending approval or insufficient documentary evidence. Priorities are Board attendance and accountability, formal inequalities review and Maternal Care Bundle approval, workforce and locum assurance, 24/7 anaesthetic support, resource deployment, compassionate family support, completion of maternity triage reporting, and evidence of the 10-year post-death care incident-record review.

## Evidence and oversight

The return is supported by Board and committee papers and minutes, the Perinatal Quality Oversight Model, workforce reporting, the maternity triage audit, the post-death care assurance statement and the Perinatal Clinical Governance Framework. Before submission, executive leads will verify that each evidence reference is current, version-controlled, attributable to a named owner, consistent with the stated rating and accessible to the NHS England regional team. The minimum sufficient evidence will be used to avoid duplication.

No immediate unmanaged safety risks are identified. Assurance remains dependent on completing planned actions, strengthening evidence and securing timely approvals. The Quality and Performance Committee and Executive leads will oversee delivery and escalate any material concerns through Integrated Care Board and NHS England regional routes.

## 6. Action-level assurance summary

| 10 Point Plan action                         | Baseline position                             | Summary assurance position                                                                                                                                                                                                                      |
|----------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Martha's Rule                             | Compliant                                     | Rollout has commenced across the mother-and-baby pathway, supported by an operational standard operating procedure, patient information and a single 24/7 rapid review number.                                                                  |
| 2. Listening, outcomes, experience and audit | Compliant                                     | Monthly reporting and Board oversight are established, with outcome, experience, complaints, audit, inequalities and improvement intelligence triangulated through existing governance routes.                                                  |
| 3. Dual Board-level accountability           | Mixed: one compliant, one partially compliant | Joint Chief Nurse and Medical Director accountability is evidenced; consistent Director of Midwifery and Clinical or Specialty Director attendance at Board requires further evidence following leadership transition.                          |
| 5. Inequalities                              | Partially compliant                           | Inequalities intelligence is visible in Board reporting, but the six-monthly dashboard review cycle, impact tracking and Board approval of the Maternal Care Bundle plan require further formalisation.                                         |
| 6. 24/7 safety and responsiveness            | Mixed: one compliant, six partially compliant | Consultant presence is compliant, but residual risks remain in relation to neonatal and midwifery workforce plans, locum database evidence, trained anaesthetic assistant assurance, acuity, establishment gaps and resource deployment review. |

| 10 Point Plan action                  | Baseline position                             | Summary assurance position                                                                                                                                                                                                       |
|---------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7. Homebirth services                 | Compliant                                     | The Board has received and scrutinised the homebirth position, with risks, mitigations and restoration planning subject to ongoing governance and regional engagement.                                                           |
| 8. Incidents, complaints and concerns | Mixed: two compliant, one partially compliant | Patient Safety Incident Response Framework and thematic complaints arrangements are embedded, but further evidence is required on named family contacts, compassionate debriefing and early senior duty of candour arrangements. |
| 9. Maternity triage                   | Mixed: one compliant, two partially compliant | The baseline audit reports 75% compliance and amber delivery confidence, with no immediate unmanaged safety risks. Board endorsement, regional reporting and maturation of triage quality and inequalities data remain required. |
| 10. Post-death care                   | Mixed: one compliant, one partially compliant | The Board assurance statement was completed and submitted by the deadline. Ongoing oversight is evidenced, but the specific 10-year incident-record review requires completion and documentation.                                |

## 7. Trust response and governance route

The Trust has coordinated completion of the baseline assessment through existing maternity, neonatal, quality and safety governance arrangements. The process has drawn together evidence from divisional governance, maternity and neonatal safety reports, clinical audit, patient experience and complaints intelligence, incident response and learning, workforce and culture workstreams, and existing Board and committee assurance reports.

Executive oversight was used to confirm the completeness and quality of the assurance return prior to Board approval. Every partially compliant deliverable will be managed through a single action plan recording the executive owner, operational lead, SMART completion date, required evidence and escalation threshold. Progress and evidence of impact will be monitored through the relevant maternity and neonatal governance forums and the Quality and Performance Committee, with exceptions reported to Trust Board before the December 2026 return or sooner where material risk arises.

Following Board approval on 10 September 2026, the final 10 Point Plan and Maternity Triage templates and their supporting evidence will be uploaded to the Futures Portal. Executive leads will complete a final check for completeness, rating consistency, external accessibility and version control in advance of the Trust's 24 September 2026 submission target. The approved Board minute and portal submission confirmation will be retained as evidence.

## 8. Risks, gaps and mitigations

The principal residual risk is workforce sustainability across maternity triage and the wider perinatal service. The dynamic triage staffing model is not yet in place and remains dependent on approval and funding of the maternity workforce business case; related risks include dedicated 24/7 telephone triage, separation of initial assessment from ongoing care, staff training and



resilience during escalation. Temporary staffing arrangements, divisional action-plan monitoring and established escalation controls provide interim mitigation, but do not remove the need for a sustainable funded model.

Further delivery and evidence risks relate to inequalities review and impact tracking, completeness of triage waiting-time and outcome data, family contact and compassionate debriefing, the trained anaesthetic-assistant requirement, and completion of the 10-year post-death care incident-record review. These matters will be managed through time-bound action plans, with named ownership, evidence requirements and escalation through the Quality and Performance Committee and Trust Board.

## 9. Next steps

Following Board approval, the Trust will submit the completed Maternity and Neonatal 10 Point Plan and Maternity Triage templates, with supporting evidence, via the Futures Portal. Submission is targeted for 24 September 2026, ahead of the national deadline of close of play on 25 September 2026.

The 14 partially compliant deliverables and the one triage standard rated not in place will be progressed through a consolidated action plan with executive owners, operational leads, SMART milestones, required evidence and escalation thresholds. Delivery and impact will be monitored through established maternity, neonatal, quality and safety governance arrangements, with material exceptions reported to the Quality and Performance Committee and Trust Board.

Before submission, the report date and named executive sign-off will be confirmed, all provisional wording will be updated to reflect the Board decision, and the approved minute and portal confirmation will be retained. Progress and any change in the assurance position will be reported to the Board before the December 2026 return.

### Enclosures

Enclosure 1: NHS England letter, *Maternity and Neonatal 10 Point Plan assurance process*, 12 August 2026.

Enclosure 2: NHS England reporting template, *Maternity and Neonatal Services Reporting Template*, baseline assessment and progress report.

Enclosure 3: Completed national *Maternity Triage Specification Benchmarking Audit Tool*, including the site assessment, dashboard and associated improvement action plan.

FOI: *Public*

To: NHS trust:

- chief executives
- chairs
- chief nursing officers
- medical directors
- chief operating officer
- communications directors

NHS England  
Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

12 August 2026

cc. Integrated care board (ICB):

- chief executives
- chief nursing officers
- medical directors

NHS England:

- regional directors
- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

Dear colleagues,

## **Maternity and Neonatal 10 Point Plan assurance process**

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the [assurance process](#) and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.



The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with [Maternity Incentive Scheme \(MIS\) Year 8](#) requirements, enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the [standardised national template](#) to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, 'Amos into action' will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out [in his letter](#), this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a [maternity](#)

[triage benchmarking tool](#) to support implementation of the [national maternity triage specification](#). You can find the full detail in the Appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,



**Duncan Burton**

Chief Nursing Officer for England



**Professor Frankie Swords**

National Medical Director

## Appendix: Maternity and Neonatal 10 Point Plan – support available

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the [Model Board Report](#) to support their reporting process.

Support will be available to help trusts and systems implement the 10 Point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided in the table below. For any queries relating to the reporting template, please contact [england.maternitytransformation@nhs.net](mailto:england.maternitytransformation@nhs.net).

| Action        | National Support Available                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Martha's Rule | <p>Trusts should follow the implementation and reporting processes outlined by the <a href="#">Martha's Rule</a> national team in NHS England. A webinar is scheduled for <b>Wednesday 12 August, 15:00–16:30hrs</b> to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication.</p> <p>The session will provide key information to support local implementation, including:</p> <ul style="list-style-type: none"><li>• an overview of the three components of Martha's Rule</li><li>• the national implementation approach</li><li>• learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings</li><li>• the implementation support, resources and tools available to local teams.</li></ul> |

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       | <p>The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team.</p> <p>The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email <a href="mailto:england.psimprovement@nhs.net">england.psimprovement@nhs.net</a></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Maternity and Neonatal 10 Point Plan supporting webinar series</b> | <p>The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in <b>August</b>.</p> <p>The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on:</p> <ol style="list-style-type: none"> <li>1. Listen to women and their families using real-time and transparently reported outcomes and experience, <b>Monday 17 August 2026, 11:30 – 12:00</b></li> <li>2. Clinical audit, <b>Wednesday 19 August 2026, 15:30 – 16:00</b></li> <li>3. Ensuring 24/7 safety and responsiveness of services, <b>Wednesday 19 August 2026, 11:30 – 12:00</b></li> <li>4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, <b>Thursday 20 August 2026, 12:00 – 12:30</b></li> </ol> <p>Further information will be shared soon.</p> |
| <b>Amos into Action staff listening exercise</b>                      | <p>This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services. Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                   | <p>follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Safe and effective maternity triage</b></p> | <p>The <a href="#">triage benchmarking tool</a> has been shared by NHS England to support implementation of the <a href="#">maternity triage specification</a>.</p> <p>Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.</p> |
| <p><b>Post death care</b></p>                     | <p>Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: <a href="#">NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry</a></p>                                                                                                                                                                                                                                                         |

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

Name of trust or organisation:  
Report prepared by:  
Report date:  
Reporting period covered:

GHT  
Nicola Moore  
sep-26



| Baseline Assessment |                      |    | Summary by Action - Baseline                                                                                                                                   |       |                |               |                     |           |
|---------------------|----------------------|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------|---------------|---------------------|-----------|
| Key Metrics         |                      |    | Action                                                                                                                                                         | Total | Compliance     |               |                     |           |
|                     |                      |    |                                                                                                                                                                |       | Not applicable | Non-compliant | Partially compliant | Compliant |
| Total deliverables  |                      | 26 | 1. Listening to women and families by rolling out Martha's Rule                                                                                                | 1     | 0              | 0             | 0                   | 1         |
|                     |                      | 0  | 2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level | 3     | 0              | 0             | 0                   | 3         |
|                     |                      | 0  | 3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care                                        | 2     | 0              | 0             | 1                   | 1         |
|                     |                      | 14 | 5. Addressing inequalities in maternity and neonatal outcomes                                                                                                  | 3     | 0              | 0             | 3                   | 0         |
|                     |                      | 12 | 6. Ensuring 24/7 safety and responsiveness of services                                                                                                         | 7     | 0              | 0             | 6                   | 1         |
| Compliance          |                      |    | 7. Trust review of homebirth services                                                                                                                          | 2     | 0              | 0             | 0                   | 2         |
|                     |                      | 0  | 8. Responding to incidents, complaints and concerns with humanity and candour                                                                                  | 3     | 0              | 0             | 1                   | 2         |
|                     |                      |    | 9. Deliver safe and effective triage in maternity services                                                                                                     | 3     | 0              | 0             | 2                   | 1         |
|                     |                      |    | 10. Post death care                                                                                                                                            | 2     | 0              | 0             | 1                   | 1         |
|                     |                      |    |                                                                                                                                                                |       |                |               |                     |           |
| Regional Match      | Regional match - Yes | 0  |                                                                                                                                                                |       |                |               |                     |           |
|                     | Regional match - No  | 0  |                                                                                                                                                                |       |                |               |                     |           |

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the Friday 25th September 2026. It is intended to provide a baseline assessment of delivery against the 10-point plan.  is separate to the tab 2.

Report signed off by Trust Board (named Exec):

Kevin McNamara  
On Board agenda for 10  
September 2026

Trust Board sign off date:

| Trust Board Assurance Template                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| No.                                                                                                                                                              | Deliverable / Scoping Prompt                                                                                                                                                                                                                                                                                                               | Baseline Compliance Rating | Baseline Evidence Reference<br><i>Please input reference number as listed in 3. Evidence Log tab</i> | Gaps in Assurance<br><i>Please provide detail of any gaps in assurance</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Improvement Actions (Including Temporary Mitigations)                                                                                                                                                                                                                                                                                                                | Comments                                                                                                                                                                                                                                                                                                                              |
| 1. Listening to women and families by rolling out Martha's Rule                                                                                                  |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |
| 1.1                                                                                                                                                              | Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?                                                                                                                                                                                                                                                   | Compliant                  | EV-02, EV-09, EV-10, EV-15                                                                           | Martha's Rule maternity rollout commenced on 1 April 2025 and the service covers mothers and babies. The maternity SOP defines the operational pathway for women, families and carers, including escalation by the Flow Midwife to obstetric or neonatal registrars/consultants and logging of calls and outcomes for audit. The revised maternity leaflet, poster and easy-read guide all consistently provide the same rapid-review number—0300 422 2222—and confirm the service is available 24 hours a day, seven days a week. A public Trust webpage also supports patient and family access.                                                                                                                                                                                  | Maintain document and version control so the SOP, webpage and all patient materials remain aligned. Confirm the SOP's current review/approval status and retain call logs, response and outcome audits, staff communications and evidence that materials are available throughout maternity and neonatal pathways.                                                   | Compliant: the evidence confirms that rollout has commenced across the mother-and-baby pathway, with an operational SOP, obstetric and neonatal escalation, consistent patient information and a single 24/7 contact number.                                                                                                          |
| 2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level. |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |
| 2.1                                                                                                                                                              | Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach? | Compliant                  | EV-02, EV-05, EV-07, EV-12, EV-13                                                                    | The May and July Board packs demonstrate an established monthly cycle of maternity assurance reporting and analysis. The papers bring together monthly regulatory dashboards and audits, clinical outcomes and safety metrics, patient-experience and complaints intelligence, CQC findings, MNVP/service-user input, inequalities information and improvement actions. Reports are provided monthly to the CQC and Maternity Delivery Group, with assurance through Quality and Performance Committee and recurring Trust Board reporting. The action trackers are reviewed at each meeting, with exceptions, corrective actions and escalation documented.                                                                                                                        | Maintain the monthly data and governance cycle; retain source dashboards, audit reports, experience/FFT and MNVP intelligence, meeting minutes and action trackers. Implement the Perinatal Listening and Learning Group as an enhancement to systematic triangulation and targeted outreach, rather than as the start of the reporting cycle.                       | Compliant: the May and July Board papers evidence regular collection, analysis and governance of maternity and neonatal quality, outcome and experience intelligence, including action tracking and escalation. The planned Listening and Learning Group will strengthen consistency and co-production.                               |
| 2.2                                                                                                                                                              | Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?                                                                              | Compliant                  | EV-02, EV-05, EV-07, EV-12, EV-13                                                                    | The May and July Board packs demonstrate routine recurring maternity reporting across successive Board cycles. The underlying Section 31 and Perinatal Quality Oversight reporting includes monthly reports to the CQC and Maternity Delivery Group, assurance through Quality and Performance Committee, and action trackers reviewed at each meeting. The evidence records progress from six of eight Section 31 conditions assessed as met to all eight assessed as fully met and sustainably embedded; closure of agency-induction and MEWS audit workstreams; tracked fetal-monitoring "fresh eyes" improvement after a 75% result against an 85% target; and ongoing actions for VTE, triage estates, newborn life-support recovery, homebirth restoration and PMRT backlogs. | Continue the established reporting cycle and retain Board/committee minutes and tracker extracts demonstrating action closure, sustained performance and impact. Escalate exceptions through POAM, Quality and Performance Committee and Trust Board.                                                                                                                | Compliant: the published Board packs and action trackers evidence regular reporting, Board scrutiny, decisions and escalation, with progress and impact tracked through metrics, closed workstreams and named follow-up actions.                                                                                                      |
| 2.3                                                                                                                                                              | Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?                                                                                      | Compliant                  | EV-02, EV-05, EV-07, EV-11, EV-12, EV-13                                                             | The May and July Board packs identify maternity and neonatal outcome and experience inequalities by ethnicity and deprivation. The July PQOM reports inequality signals across neonatal deaths, obstetric anal sphincter injury, postpartum haemorrhage and breastfeeding initiation, and explicitly notes limitations from small numbers and the need for continued monitoring and multi-year analysis. The Q1 report adds language, interpreter-access and under-represented-community data, while perinatal staff can review variation through the internal Perinatal Health Inequalities Dashboard.                                                                                                                                                                             | Continue routine dashboard and PQOM review; complete the Quality and Performance Committee briefing requested by the Board, maintain targeted actions, named owners and measures for identified variation; strengthen ethnicity, deprivation, language and interpreter data quality and report impact through Board assurance.                                       | Compliant: the reports identify variation and data limitations, and the Board has demonstrated response by scrutinising the OASI project's importance for Black and Minority Ethnic communities and requesting a briefing on the March 2026 MBRRACE-UK benchmarking issue. Ongoing monitoring and impact measurement should continue. |
| 3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care                                          |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |
| 3.1                                                                                                                                                              | Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?                                                                                                                                                                    | Compliant                  | EV-02, EV-14                                                                                         | The CQC Maternity Services Deep Dive presentation explicitly confirms joint executive responsibility between the Chief Nurse and Medical Director for maternity safety, quality, experience and improvement. It describes one aligned executive view across nursing, midwifery, medical, neonatal and operational leadership, with shared ownership of Board-level risk, assurance, delivery pace, escalation and sustained improvement. The CEO opened the CQC engagement meeting, demonstrating organisational leadership and visibility.                                                                                                                                                                                                                                         | Retain the CQC meeting record and final presentation with the supporting governance terms of reference. Continue to evidence joint Chief Nurse and Medical Director oversight through Board and committee reports, decisions and escalation.                                                                                                                         | Compliant: the presentation provides explicit, externally presented evidence of shared Chief Nurse and Medical Director accountability, a single Board-level view of risk and a defined PDG-to-committee-to-Board governance route.                                                                                                   |
| 3.2                                                                                                                                                              | Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?                                                                                                                                                 | Partially compliant        | EV-02, EV-05, EV-12, EV-13                                                                           | Director of Midwifery attendance had previously been established, but there was a temporary leadership gap at the May and July 2026 Board meetings because the post was vacant. Recruitment had been completed, but the new Director's start date was after the July meeting. Director of Midwifery attendance is expected to resume at the September 2026 Board. Specialty/Clinical Director attendance also requires consistent evidence when maternity and neonatal matters are discussed.                                                                                                                                                                                                                                                                                       | Ensure the Director of Midwifery and relevant Clinical/Specialty Directors attend the September Board for maternity and neonatal items; retain the agenda and approved minutes as evidence. Document required representation, deputies and escalation arrangements to maintain continuity during future vacancies.                                                   | Partially compliant: the governance expectation was established and recruitment is complete, but a documented gap affected May and July Board attendance. Reassess after evidence of restored attendance at the September Board. This needs to include Neonates,becca Swintler                                                        |
| 5. Addressing inequalities in maternity and neonatal outcomes                                                                                                    |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |
| 5.1                                                                                                                                                              | Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?                                                                                                                                    | Partially compliant        | EV-02                                                                                                | The national Perinatal Equity and Anti-Discrimination Programme training offer has not yet launched in the South West region, so participation and associated staff-release arrangements cannot yet be implemented locally. In the interim, the Trust is supporting staff to attend Black Maternity Matters training as a proactive step to strengthen equity and anti-discrimination capability.                                                                                                                                                                                                                                                                                                                                                                                   | Continue to release staff for Black Maternity Matters training. When the national programme launches in the South West, confirm eligibility and cohort requirements, agree a multidisciplinary participation and staff-release plan, and report progress through the appropriate governance route.                                                                   | Partially compliant: the national programme is not yet available in the South West, which currently prevents full participation. The Trust is taking proportionate interim action by sending staff to Black Maternity Matters training; reassess once the national launch timetable and cohort arrangements are confirmed.            |
| 5.2                                                                                                                                                              | Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?                                                                                                                                                                                | Partially compliant        | EV-02, EV-05, EV-07, EV-11, EV-12, EV-13                                                             | The Perinatal Health Inequalities Dashboard is live and available to perinatal staff. The May and July Board packs contain inequalities intelligence and demonstrate Board scrutiny, including discussion of the OASI improvement project for Black and Minority Ethnic communities and a request for a Quality and Performance Committee briefing on the March 2026 MBRRACE-UK benchmarking issue. However, the packs do not evidence a completed recurring six-monthly review of the full dashboard with documented trend analysis, agreed actions and subsequent impact assessment.                                                                                                                                                                                              | Formalise the six-monthly dashboard review cycle. Produce a dated dashboard report covering key trends by ethnicity, deprivation and other relevant factors; take it through maternity governance and Board/QPC; document decisions, named owners, due dates and measures; and report at the next six-month review whether actions reduced the identified variation. | Partially compliant and requires development: dashboard access and examples of Board scrutiny are evidenced, but the full six-monthly review-to-action-to-impact cycle required by 5.2 is not yet demonstrated.                                                                                                                       |
| 5.3                                                                                                                                                              | Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?                                                                                                                                                                                                                                                   | Partially compliant        | EV-02, EV-07                                                                                         | The Q1 PQOM scheduled for the 12 September 2026 Trust Board includes Maternal Care Bundle benchmarking, named elements and the trajectory for full implementation by March 2027. The current paper reports progress but does not explicitly ask the Board to approve or endorse the implementation plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Amend the September Board paper cover sheet and recommendations so the Board is explicitly asked to approve or endorse the Maternal Care Bundle implementation plan, milestones, owners and March 2027 completion trajectory. Retain the approved Board minutes as evidence.                                                                                         | Partially compliant pending the September Board decision. If the cover sheet is amended and the minutes record approval or endorsement, this requirement can be reassessed as compliant.                                                                                                                                              |
| 6. Ensuring 24/7 safety and responsiveness of services                                                                                                           |                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                       |

|                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6.1                                                                                  | Is the trust complying with the RCOG 'Roles and Responsibilities of the Consultant providing acute care' standard? In line with MIS Year 8, is there a minimum 280% consultant presence in defined acute care situations?                                                                                                                                                                                                                                                                                                                               | Compliant           | EV-02, EV-08                      | The six-monthly staffing report records 89.6% consultant presence in situations where attendance was mandatory and 100% documented compliance in "should attend" situations for October–December 2025. This exceeds the 280% MIS standard. Non-attendance cases were reviewed and learning shared through consultant, resident-doctor and intrapartum forums.                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Continue quarterly consultant-presence audit, case review and governance reporting; retain the underlying audit with the Board paper.                                                                                                                                                                                                                                                                                     | Direct audit evidence confirms compliance with the required threshold and was reported through the July Trust Board workforce assurance route.                                                                                                                                                                                               |
| 6.2                                                                                  | Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)                                                                                                                                                                                                                                                                                                                                    | Partially compliant | EV-02, EV-08                      | The Obstetrics and Gynaecology Staffing Policy is aligned to RCOG locum guidance. An audit of tier 2/3 short-term locums for 1 January–31 March 2026 showed 100% compliance, following introduction of a clear appointment process; the one long-term locum was also 100% compliant. The report does not explicitly demonstrate the continuously updated trust-specific database required by MIS Year 8. This is the MIS Year 7 assurance position. The next six-monthly staffing report, covering January–September 2026 and the updated Year 8 requirements, is due to the November 2026 Trust Board.                                                                                                                                                                                                                      | Retain the locum audit and policy; evidence the continuously updated local register, pre-engagement eligibility checks, annual review, update frequency and responsible owner. Ensure the November 2026 staffing report explicitly confirms the live Trust-specific locum database and Year 8 controls.                                                                                                                   | Certification controls and audit compliance are strong, but the specific live-database requirement is not explicitly evidenced in this report. The rating should be reassessed when the January–September 2026 report has been received by the November Board.                                                                               |
| 6.3                                                                                  | Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)                                                                                                                                                                                                                                                                                           | Partially compliant | EV-02, EV-07, EV-08               | Neonatal medical staffing met MIS Year 7 standards: seven consultants were in place, medical posts were funded and no rota gaps were forecast. Nursing staffing was funded for ten neonatal nurses and one nursery nurse per shift and reviewed daily using SafeCare, but QIS compliance was 62.6% against the 70% BAPM recommendation and nurse-to-baby ratios were not consistently achieved at periods of high acuity. The updated MIS Year 8 neonatal nursing and medical establishment position will be included in the next six-monthly staffing report covering January–September 2026, due to the November 2026 Trust Board.                                                                                                                                                                                         | Complete and fund the neonatal workforce plan against BAPM standards and the 2020 workforce calculator; deliver the QIS action plan with the South West Neonatal Network and report progress to Board, LMNS and ODN. Ensure the November report explicitly maps the funded neonatal establishment, vacancies, QIS recovery and medical/nursing gaps to BAPM standards and the 2020 neonatal nursing workforce calculator. | Medical establishment is compliant, but nursing skill mix and consistent BAPM ratio compliance remain gaps. Reassess 6.3 after the November Board receives the updated Year 8 staffing report and action plan.                                                                                                                               |
| 6.4                                                                                  | Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)                                                                                                                                                                                                                                                    | Partially compliant | EV-02, EV-07, EV-08               | The December 2025 Birthrate Plus review found a funded establishment of 281.05 WTE and a 2.69 WTE overall deficit using the 21% uplift. A 26% uplift may be required for training needs. The ward establishment was not aligned to Birthrate Plus findings, and a workforce strategy and action plan were in development.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Complete and approve the funded workforce strategy using Birthrate Plus, the 26% training requirement and professional judgement; align ward deployment and report recommendations and affordability to Board.                                                                                                                                                                                                            | A current Birthrate Plus review exists, but the report explicitly identifies an establishment deficit and an unfinished funding/workforce response.                                                                                                                                                                                          |
| 6.5                                                                                  | Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? (In line with MIS Year 8)                                                                                                                                                                                                                                                                                                                         | Partially compliant | EV-02, EV-08                      | The report confirms a duty anaesthetist was immediately available to the obstetric unit 24/7 with 100% compliance against ACSA 1.7.2.1 from October 2025 to March 2026. It does not provide direct compliance evidence for a trained anaesthetic assistant available 24/7 under ACSA 1.3.1.2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Retain the anaesthetic rota/audit and add evidence of trained anaesthetic-assistant availability 24/7 against ACSA 1.3.1.2, including any gaps and actions.                                                                                                                                                                                                                                                               | Duty-anaesthetist compliance is fully evidenced; the separate trained-assistant element remains unconfirmed.                                                                                                                                                                                                                                 |
| 6.6                                                                                  | Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?                                                                                                                                         | Partially compliant | EV-02, EV-05, EV-07, EV-08, EV-12 | The six-monthly report gives integrated Board oversight of midwifery, obstetric, neonatal and anaesthetic staffing, rota gaps, fill rates, acuity, redeployment, red flags and escalation. Fill rates were green, supernumerary coordinator compliance was 100%, and staffing mitigations were defined. However, ward staffing met recorded acuity only 6%–30%, the midwifery shortfall was 10.43 WTE in March and workforce investment plans remained in development. The Board noted the Integrated Care Board funding decision for safety-critical workforce posts, including four WTE consultant obstetrician posts, and required continued Board oversight of the newborn life-support recovery plan. It also noted recruitment to key maternity leadership roles.                                                      | Complete and fund the workforce strategy; correct acuity-tool use and align ward establishment to Birthrate Plus; continue integrated six-monthly Board reporting and escalation of persistent capacity risks. Track recruitment, competence recovery and workforce risks through the PQOM and exception-reporting routes, retaining evidence of delivery and impact.                                                     | Board oversight and escalation are established, but significant residual establishment, acuity and sustainability gaps remain. The minutes provide direct evidence of Board workforce scrutiny and follow-up requirements.                                                                                                                   |
| 6.7                                                                                  | Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service. | Partially compliant | EV-02, EV-08                      | The report documents active deployment measures during staffing pressure: relocating staff, clinical deployment of managers and specialist midwives, reviewing elective workload, using community on-call midwives and reviewing birth-unit activity. It also records recruitment and senior-leadership restructuring. It does not demonstrate completion of the broader review of non-frontline roles, specialist-post resilience training and the full impact of redeployment.                                                                                                                                                                                                                                                                                                                                             | Complete and document the full internal resource-deployment review, including non-frontline roles, resilience when specialist staff are unavailable, required education/training and the safety impact of redeployment.                                                                                                                                                                                                   | The report evidences operational redeployment controls, but the complete strategic review required by this deliverable.                                                                                                                                                                                                                      |
| <b>7. Trust review of homebirth services</b>                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                              |
| 7.1                                                                                  | Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?                                                                                                                                                                                                                                                                                                                                                | Compliant           | EV-02, EV-05, EV-12               | The July Board paper confirms service suspensions were actively risk-managed through established governance, with alternative birth-setting capacity maintained for low-risk women and outcomes and experience kept under review. The Board had significant existing oversight of the county-wide homebirth suspension through direct Board reports and Quality and Performance Committee assurance. It formally noted the extended suspension and requested ongoing oversight of the restoration plan and effects on access, experience and outcomes.                                                                                                                                                                                                                                                                       | Continue risk-register oversight, consultation and monitoring of outcomes and experience; report the updated risk position and sustainable future model through governance and to Board. Continue reporting the restoration plan, risk controls and effects on access, experience and outcomes until safe and sustainable services are restored.                                                                          | Board-paper evidence strengthens assurance that the completed homebirth review and ongoing mitigations receive active governance oversight. The minutes provide direct evidence that the Board received and scrutinised the homebirth position and required continued oversight.                                                             |
| 7.2                                                                                  | Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?                                                                                                                                                                                                                                                                                                                                                            | Compliant           | EV-02                             | Mitigations and timescales are described and shared with the Regional NHS England team.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Maintain the risk-register action plan, complete consultation by August 2026, and confirm formal sharing/escalation to the regional team.                                                                                                                                                                                                                                                                                 | Rating based on the PDG paper.                                                                                                                                                                                                                                                                                                               |
| <b>8. Responding to incidents, complaints and concerns with humanity and candour</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                              |
| 8.1                                                                                  | Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?                                                                                                                                                                                                           | Compliant           | EV-02, EV-07, EV-12, EV-16        | The Perinatal Clinical Governance Framework formally applies the Trust-wide Patient Safety Incident Response Framework policy (B0758), Patient Safety Incident Response Plan, Reporting and Learning from Incidents policy (B0393), learning-response process and duty-of-candour arrangements to maternity and neonatal services. It defines responsibilities for incident investigation, action-plan development and monitoring, risk escalation and learning from point of care through the perinatal quadrumvirate, Executive Team and Trust Board. The Q1 PQOM demonstrates these arrangements operating through triangulation of incidents, PMRT, MNSI, PSIRF, complaints, claims and audits; parental-engagement tracking; action plans; governance escalation; and Board reporting.                                  | Continue to operate the single Trust PSIRF policy, plan and incident-reporting process through the perinatal governance framework. Complete and monitor outstanding family communications, action closures, Datix audit checks and external PMRT reviews, reporting exceptions and evidence of learning impact through PQOM and Trust Board.                                                                              | Compliant: a clearly defined Trust PSIRF system is embedded within the perinatal governance framework and its operation is demonstrated in the Q1 report and Board assurance route. Outstanding case actions represent ongoing improvement and exception management rather than absence of the required governance process.                  |
| 8.2                                                                                  | Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?                                                                                                                                                                                                                                                                                                                                                | Compliant           | EV-02, EV-05, EV-07, EV-12, EV-13 | The May and July Board packs demonstrate routine thematic review and reporting of maternity complaints and concerns. The May PQOM confirms that complaints and PALS themes are monitored through governance, managed through weekly case review and prioritisation of overdue cases, with safety themes escalated into patient-safety governance; monthly experience data is translated into improvement actions. The July PQOM includes a complaints deep dive identifying communication, responsiveness and consistency of care as recurring themes, reports 46 open complaints including 30 overdue with an average age of 114 days, and describes clear divisional ownership, senior oversight and linkage to patient safety and experience processes. The Q1 report adds SMART learning actions, named leads and dates. | Continue the thematic complaints and experience cycle, weekly case management and quarterly PQOM reporting. Deliver the backlog and timeliness recovery plan, monitor action completion and demonstrate visible service impact, with exceptions escalated through Quality and Performance Committee and Trust Board.                                                                                                      | Compliant: complaints are reviewed thematically, learning and improvement actions are tracked through established governance, and themes, performance and residual risks are routinely reported through QPC to Board. Response timeliness remains a material improvement risk but does not negate the embedded review and reporting process. |
| 8.3                                                                                  | Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?                                                                                                                                                                                                                                                               | Partially compliant | EV-02, EV-07, EV-16               | The Perinatal Clinical Governance Framework describes established systems for compassionate engagement and involvement of people affected by incidents, structured family notification and consent for MNSI referrals, open and early professional and statutory duty of candour, apology and reasonable support, and referral support to the Maternity and Neonatal Independent Senior Advocate. It requires feedback from women, families, MNVP/MNSIA, complaints and incidents to be triangulated into a continuous learning-and-improvement cycle with actions and impact monitoring. The Q1 PQOM demonstrates parental-engagement tracking, family perspectives and planned consultant debriefs.                                                                                                                        | Make the family-contact standard explicit in the framework or supporting SOP; assign and document a named key contact for every affected family, define responsibility for early senior-manager candour, and record offers and completion of compassionate debriefing. Audit compliance and report exceptions and learning through PQOM.                                                                                  | Partially compliant: robust systems for open learning, compassionate engagement, family support, advocacy, candour and feedback-informed improvement are documented. Full compliance requires explicit evidence that every family receives a named key contact and early duty of candour from an appropriately senior manager.               |
| <b>9. Deliver safe and effective triage in maternity services</b>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                              |



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| 9.1                        | Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced? | Partially compliant | EV-01, EV-02, EV-06               | A Board-level baseline audit and gap analysis against the ten National Maternity Triage Specification principles has been completed. Overall compliance is 75% (Amber); no immediate unmanaged safety risks were identified, and triage remains on the Trust risk register at 16 with mitigations. The paper was considered by PDG on 12 August 2026 and is on the agenda for the 12 September 2026 Trust Board, after which regional reporting evidence is required.                                                                                                                                                                                                                                                                                                                                                                                               | Secure Trust Board endorsement on 12 September 2026; retain the Board minute; submit/share the audit and implementation position with the regional NHS England team. Complete staffing modelling, competency and redeployment assurance.                                                                                                                      | Provisional partial compliance: the audit is complete and includes staffing/capacity risks, but public Board consideration and regional reporting have not yet occurred.                                                                                                                   |
| 9.2                        | Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?                                | Partially compliant | EV-02, EV-05, EV-06, EV-12, EV-13 | The May and July Board packs demonstrate clear and recurring oversight of maternity triage. The May PQOM reports performance against the 15-minute assessment standard using statistical process control and notes that more than 80% of improvement actions were complete or in progress, with performance stabilising. The July PQOM reports measurable improvement in initial and secondary assessment, reduced 24-hour re-attendance, shorter length of stay, fewer midwifery staffing red flags and fewer moderate-or-above safety incidents. Board and Quality and Performance Committee oversight of the estates, capacity and decant risks is documented. Patient-experience work identified long waits, communication and environmental issues and led to translated triage cards, clearer waiting-time information, a patient film and volunteer support. | Complete the monthly triage dashboard so it consistently reports assessment and review times, waiting times, telephone responsiveness, redeployment, delays, outcomes and experience, stratified by ethnicity, deprivation, language and other relevant factors. Retain Board/QPC review, decisions and evidence that actions improve performance and equity. | Partially compliant: the Board packs demonstrate established oversight, regular timeliness data and measurable improvement. Full compliance requires a complete, consistently reported dataset covering redeployment, review times, delays and outcomes with mature inequality monitoring. |
| 9.3                        | Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?                                               | Compliant           | EV-02, EV-06                      | The report states the Trust is well positioned to achieve full compliance within the required 12 months. A governed implementation programme is in place with executive leads, milestones and quarterly reporting; Board approval by September 2026; dashboard, staffing, telephone-triage and estates reviews by December 2026; systematic service-user feedback by March 2027; and re-audit/report to Board by July 2027.                                                                                                                                                                                                                                                                                                                                                                                                                                         | Deliver the 12-month programme and evidence measurable improvement, not only action completion. Provide quarterly Board updates and complete the July 2027 re-audit.                                                                                                                                                                                          | Compliant for being on track: delivery confidence is Amber and depends on sustained implementation, particularly staffing, assessment timeliness, service-user voice, equity and data quality.                                                                                             |
| <b>10. Post death care</b> |                                                                                                                                                                                                                                                |                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                            |
| 10.1                       | Has the trust board completed an assurance statement and submitted it by 31 July 2026?                                                                                                                                                         | Compliant           | EV-03, EV-04                      | Board Assurance Statement signed by the Trust Chair on 29 July 2026 and submitted under the Chief Executive's covering letter dated 31 July 2026, meeting the NHS England deadline.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Retain submission/receipt evidence with the signed assurance statement and CEO covering letter.                                                                                                                                                                                                                                                               | Formal response confirms Board consideration of mortuary oversight, post-death care and Fuller Inquiry actions.                                                                                                                                                                            |
| 10.2                       | Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?            | Partially compliant | EV-03, EV-04                      | Board oversight is evidenced through the HTA Governance Meeting, Audit and Assurance Committee, Quality Delivery Group and Quality and Performance Committee. A February 2026 Mortuary Controls internal audit gave Moderate assurance: accepted actions have named owners and dates, with estates works due by 30 September 2026. The documents do not explicitly confirm review of incident records covering the past 10 years.                                                                                                                                                                                                                                                                                                                                                                                                                                   | Complete and evidence the 10-year incident-record review; close and report the Mortuary Controls action plan by 30 September 2026; complete the Perinatal Safety Champions/MNV pathway walk-through and escalate any further actions.                                                                                                                         | Cautious provisional rating: strong evidence of governance and active implementation, but the specific 10-year incident-record requirement is not evidenced in these documents.                                                                                                            |



| Current Status | RAG | Evidence ID<br><i>Please input reference number as listed in 3. Evidence Log tab</i> | Key Gaps / Risks | Improvement action required | Due Date(s) |
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## Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary

*Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and (to the trust).*

| Evidence ID | Action No      | Evidence Type                   | Document / Meeting / Dataset                                | Date                     | Owner                                                                             |
|-------------|----------------|---------------------------------|-------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------|
| EV-01       | 9,1            | benchmarking document           | Document                                                    | 13.08.2026               | Collette Townsend                                                                 |
| EV-02       | 1, 2, 3, 5, 6, | Committee assurance report      | Initial assurance position and proposed res                 | 08 jul 2026              | Matt Holdaway, Chi                                                                |
| EV-03       | 10.1, 10.2     | Board assurance statement       | Annex 3 - Board Assurance Statement for NHS Provider Trusts | 2026-07-31T00:00:00.000Z | Kevin McNamara, Chief Executive / Accountable Officer; Deborah Evans, Trust Chair |
| EV-04       | 10.1, 10.2     | Chief Executive covering letter | CEO Covering Letter - Mortuary Oversight 31 July 2026       | 2026-07-31T00:00:00.000Z | Kevin McNamara, Chief Executive                                                   |

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| EV-05 | 2.1, 2.2, 2.3 | Published Trust Board paper     | July 2026 FINAL Boardbook – Perinatal Quality Oversight Report Exceptions, April 2026 Quarter 4       | July 2026                | Matt Holdaway, Chief Nurse and Director of Quality / Board Perinatal Safety Champion; Sarah Ashwood, Perinatal Quality and Governance Lead; Suzie Cro, Director of Quality Governance    |
| EV-06 | 9.1, 9.2, 9.3 | Board-level audit and assurance | Maternity Triage: Board-Level Audit and Assurance Report in Response to the NHS England System Letter | 2026-08-12T00:00:00.000Z | Matt Holdaway, Chief Nurse and Director of Quality / Board Safety Champion; Zita Martinez, Director of Midwifery; Collette Townsend, Matron, Triage, Day Assessment and Antenatal Clinic |

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| EV-07 | 2.1, 2.2, 2.3 | Quarterly perinatal quality | Perinatal Quality Oversight Model Report – Quarter 1 (April–June 2026 data)                | 2026-08-12T00:00:00.000Z | Matt Holdaway, Chief Nurse and Director of Quality; Sarah Ashwood, Perinatal Quality and Governance Lead; Suzie Cro, Director of Quality Governance; Perinatal Team |
| EV-08 | 6.1, 6.2, 6.3 | Six-monthly integrated work | Six Monthly Midwifery, Maternity and Neonatal Staffing Report – October 2025 to March 2026 | July 2026                | Rachael Glasson, Deputy Regional Chief Midwife, NHS England South West, on behalf of GHNHSFT; presented by Matt Holdaway, Director of Quality and Chief Nurse       |

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| EV-09 | 1,1      | Public patient information | Martha's Rule – Gloucestershire Hospitals NHS Foundation Trust                  | Accessed 14 Aug 2026  | Gloucestershire Hospitals NHS Foundation Trust |
| EV-10 | 1,1      | Patient communication pack | Martha's Rule maternity easy-read guide, maternity leaflet and maternity poster | Reviewed 14 Aug 2026  | Gloucestershire Hospitals NHS Foundation Trust |
| EV-11 | 2.3, 5.2 | Internal data dashboard    | Perinatal Health Inequalities Dashboard                                         | Confirmed 14 Aug 2026 | Gloucestershire Hospitals NHS Foundation Trust |



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| EV-12 | 2.2, 2.3, 6.6 | Published Trust Board minutes | May 2026 Trust Board minutes published in the July 2026 Boardbook – Maternity Regulatory Compliance and Perinatal Quality Oversight | May 2026 | Matt Holdaway, Chief Nurse and Director of Quality; Trust Board |
| EV-13 | 2.2           | Published Trust Board pac     | May 2026 FINAL Boardbook – maternity reports and March 2026 Board minutes                                                           | May 2026 | Matt Holdaway, Chief Nurse and Director of Quality; Trust Board |

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| EV-14 | 3,1 | CQC engagement present       | GHNHSFT Maternity Services Deep Dive – CQC Engagement Meeting | Date not stated in supplied presentation | Kevin McNamara, Chief Executive; Chief Nurse and Medical Director; maternity leadership team |
| EV-15 | 1,1 | Standard operating procedure | Maternity Call for Concern – implementing Martha's Rule       | Issued 01 Apr 2025                       | Zoe Robinson; Maternity Department; approved by Clinical Effectiveness Assurance Group       |

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| EV-16 | 8.1, 8.3 | Perinatal clinical governan | Perinatal Services Governance and Accountability Framework – Perinatal Clinical Governance Framework | Version 1; date not stated in supplied copy | Perinatal Services, Gloucestershire Hospitals NHS Foundation Trust |
| EV-17 |          |                             |                                                                                                      |                                             |                                                                    |
| EV-18 |          |                             |                                                                                                      |                                             |                                                                    |
| EV-19 |          |                             |                                                                                                      |                                             |                                                                    |
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| EV-27 |          |                             |                                                                                                      |                                             |                                                                    |
| EV-28 |          |                             |                                                                                                      |                                             |                                                                    |
| EV-29 |          |                             |                                                                                                      |                                             |                                                                    |
| EV-30 |          |                             |                                                                                                      |                                             |                                                                    |



Identify where the evidence can be found; assurance notes should explain what the evidence may support more than one deliverable where appropriate. Trusts are encouraged to use evidence to demonstrate assurance.

Progress Report as needed. Please note the evidence submitted should be accessible externally

| Location / Link Reference                                                             | Assurance Notes                                                                                                                                                                                                                                                                                                                                          | Evidence Quality |
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| Attached file: Report_to_PDG 08.07.2                                                  | PDG paper provides the Trust position                                                                                                                                                                                                                                                                                                                    | Adequate         |
| Supplied attachment: Annex 3 - Board Assurance Statement for NHS Provider Trusts.docx | Confirms clear cross-service mortuary responsibilities, quarterly HTA governance, review against the 29 NHS-relevant Fuller Inquiry recommendations, Moderate internal-audit assurance, accepted time-limited actions, Board oversight and submission by 31 July 2026. Does not explicitly evidence a review of incident records over the past 10 years. | Strong           |
| Supplied attachment: CEO Covering Letter - Mortuary Oversight 31 July 2026.docx       | Formal submission letter confirms Board consideration of mortuary oversight, post-death care and Fuller Inquiry requirements; ongoing executive and Board oversight; time-limited improvement plans; and escalation through established risk and quality governance.                                                                                     | Strong           |

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| <p><a href="https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf">https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf</a></p> | <p>Presented to Trust Board for oversight and discussion after review through the Perinatal Oversight and Assurance Meeting, Perinatal Delivery Group and Quality and Performance Committee. Evidences perinatal exceptions and improvement activity, inequality signals by ethnicity and deprivation, workforce-acuity/red-flag oversight, and active governance of service suspensions. Published Board minutes should be retained to evidence discussion and decisions.</p>                                                                                                   | <p>Strong</p> |
| <p>Supplied attachment: 07. Triage Assurance Board paper for PDG.pdf; scheduled for Trust Board agenda on 12 September 2026</p>                                                    | <p>Completed baseline audit and gap analysis against the ten national triage principles. Reports 75% overall compliance and Amber delivery confidence; no immediate unmanaged safety risks; reasonable assurance from existing leadership, governance and improvement infrastructure. Highest risks are staffing, 15-minute assessment timeliness, service-user voice, equity monitoring and data maturity. A 12-month implementation plan and quarterly reporting route are defined. Trust Board endorsement and evidence of regional NHS England reporting remain pending.</p> | <p>Strong</p> |

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| Supplied attachment: 08. Quarterly PQOM - Q1 2026 Final for PDG.pdf; scheduled for Trust Board agenda on 12 September 2026 | Discussed at PDG for onward assurance to Trust Board. Consolidates workforce, training, neonatal staffing, incidents and reviews, service-user voice, equity, care bundles, governance, culture and leadership. Provides detailed Q1 metrics, residual risks, controls and dated actions. Assurance remains developing in several areas; Trust Board consideration on 12 September 2026 and the resulting minutes/actions are still required.       | Strong |
| Supplied attachment: 08. Six Monthly Perinatal Staffing Report 17 04 14 v1.0 (1).pdf; received by July 2026 Trust Board    | Provides integrated Board assurance on midwifery, obstetric, neonatal and anaesthetic staffing. Confirms 89.6% mandatory consultant presence, 100% locum-audit compliance, 100% 24/7 duty-anaesthetist compliance and compliant neonatal medical staffing. Identifies a 2.69 WTE Birthrate Plus deficit, potential 26% training uplift, neonatal QIS at 62.6% versus 70% BAPM, variable acuity compliance and workforce plans still in development. | Strong |

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| <a href="https://www.gloshospitals.nhs.uk/your-visit/staying-us/during-your-stay/marthas-rule/">https://www.gloshospitals.nhs.uk/your-visit/staying-us/during-your-stay/marthas-rule/</a>               | Publicly accessible Trust webpage supporting evidence that Martha's Rule has commenced and that information is available to patients, families and carers. It strengthens communications assurance but does not by itself confirm complete coverage across every maternity setting, neonatal implementation, staff training or operational testing.                                                           | Adequate |
| Supplied attachments:<br>Marthas_Rule_ADULT_easy_read_A4-compressed-maternity.docx;<br>Marthas_Rule_ADULT_leaflet_A4_Editable-maternity.pdf;<br>Marthas_Rule_ADULT_Poster_A4_Editable-maternity (1).pdf | The revised maternity communication pack consistently lists 0300 422 2222 for rapid review and confirms 24/7 availability. The materials support mothers, babies, families and carers by explaining deterioration, escalation to the care team and the right to request a further rapid review. Used with the maternity SOP, the pack supports evidence of implementation across the mother-and-baby pathway. | Strong   |
| <a href="https://ghtreporting.glos.nhs.uk/dashboard/perinatal-health-inequalities-dashboard">https://ghtreporting.glos.nhs.uk/dashboard/perinatal-health-inequalities-dashboard</a>                     | Perinatal staff have access to the internal dashboard to review perinatal health-inequality data and identify variation. Supporting governance reports, minutes and action tracking are required separately to evidence six-monthly Board review and resulting action.                                                                                                                                        | Adequate |

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| <a href="https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf">https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf</a>                     | <p>The July Board pack contains the approved May Board minutes and subsequent maternity assurance. It records all eight Section 31 conditions assessed as fully met and sustainably embedded, routine monitoring of a “fresh eyes” variance at 75% against an 85% target with tracked corrective actions and escalation thresholds, and Board follow-up on triage estates, newborn life-support recovery, homebirth restoration, inequalities and PMRT backlogs. Together with EV-13, it demonstrates recurring reporting and tracked follow-through.</p> | <p>Strong</p> |
| <a href="https://www.gloshospitals.nhs.uk/media/documents/2026-05-07_10-21-36_FINAL-Boardbook.pdf">https://www.gloshospitals.nhs.uk/media/documents/2026-05-07_10-21-36_FINAL-Boardbook.pdf</a> | <p>The May Board pack contains the Perinatal Oversight and Section 31 maternity reports plus March Board minutes. It evidences monthly reporting to the CQC and Maternity Delivery Group, assurance through Quality and Performance Committee, action trackers reviewed at each meeting, progress against the eight conditions, and closure of specific workstreams including agency-staff induction and MEWS audit compliance. The subsequent July pack demonstrates continuation of this reporting and action cycle.</p>                                | <p>Strong</p> |



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| Supplied attachment:<br>GHNHSFT_Maternity Services CQC<br>Engagement Meeting.pptx | Slide 3 explicitly states joint executive responsibility and shared accountability between the Chief Nurse and Medical Director for maternity safety, quality, experience and improvement. It describes one executive view across midwifery, medical, neonatal and operational leadership; one Board-level view of risk; and escalation from PDG through committees to Board. The CEO provided the welcome and introductions for the CQC engagement meeting.                                                                                                       | Strong   |
| Supplied attachment:<br>SOP_Worries_and_Concerns_Mate<br>rernity_-_Final.doc      | Defines the maternity Call for Concern pathway for women, families and carers. Switchboard routes calls to the Flow Midwife, with fallback escalation after two unanswered attempts to the CDS Midwife in Charge. The Flow Midwife triages concerns and may escalate to obstetric or neonatal registrars/consultants. Calls and outcomes are logged for audit monitoring, and medical, midwifery, nursing and Switchboard responsibilities are defined. Version 1.0 shows a review date of 08 May 2025, so current review and approval status should be confirmed. | Adequate |

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| Supplied attachment:<br>PERINATAL_SERVICES_Governance_and_Accountability_framework_Final_version_v2_1.docx | Links perinatal services to the Trust PSIRF, incident-reporting, learning-response and duty-of-candour systems. It requires compassionate engagement, structured family notification and consent, apology and reasonable support, MNISA information/referral support, and use of patient/family feedback in continuous learning and improvement. It does not explicitly state that every affected family must receive a named key contact or that early candour must be led by a senior manager; these controls require clarification or separate evidence. | Strong |
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|          | 6,6  |
|          | 6,7  |
| Action 7 | 7,1  |
|          | 7,2  |
| Action 8 | 8,1  |
|          | 8,2  |
|          | 8,3  |
| Action 9 | 9,1  |
|          | 9,2  |
|          | 9,3  |
|          | 10,1 |

|           |      |
|-----------|------|
| Action 10 | 10,2 |
|-----------|------|

| Deliverable                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?                                                                                                                                                                                             |
| The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach? |
| The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?                                          |
| The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?                                                                                                                                                                                              |
| Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?                                                                                                                                 |
| Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?                                                                                                                  |
| Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?                                                                                                                                                     |
| The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?                                                                                                                                                                               |
| Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?                                                                                                                                             |
| Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?                                                                                |
| The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? <i>(In line with MIS Year 8)</i>                                                                                |
| The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? <i>(In line with MIS Year 8)</i>                                         |
| The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? <i>(In line with MIS Year 8)</i>  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?                                                                                                                                                                                                                                                                                                                                                      |
| Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?                                                                                                                                         |
| Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service. |
| Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?                                                                                                                                                                                                                                                                                                                                                                                         |
| Where significant risks have been identified, have they been communicated with the Regional NHSE team?                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?                                                                                                                                                                                                           |
| Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?                                                                                                                                                                                                                                                                                                                                                |
| Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?                                                                                                                                                                                                                                                               |
| Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?                                                                                                                                                                                                                                                                                                          |
| Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?                                                                                                                                                                                                                                                                                                                                                                |
| Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?                                                                                                                                                                                                                                                                                                                                                        |
| Board assurance statement completed and submitted by 31 July 2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?



## Suggested evidence

▪ Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.

▪ Analytical reports

▪ Board report and minutes

▪ Board report and minutes  
▪ Quarterly MIS thematic report

▪ Board ToR  
▪ Job plans

▪ Job plans  
▪ Minutes of Executive board meetings

▪ Board report and minutes

▪ Board report  
▪ Quarterly MIS thematic report  
▪ Equity dashboard reports  
▪ Core20PLUS5 reporting  
▪ Maternity equity action plans

▪ Maternal Care Bundle implementation plans.  
▪ Board Report  
▪ MIS return

▪ Workforce plan  
▪ Biannual workforce papers  
▪ Staff experience survey  
▪ Cappuccini-style assurance exercise

▪ Database

▪ Workforce plan  
▪ Biannual workforce papers  
▪ BAPM workforce standards compliance  
▪ Staff experience survey

▪ BR+ review and workforce plan  
▪ Biannual workforce papers  
▪ Staff experience survey

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>▪ Workforce plan</li> <li>▪ Biannual workforce papers</li> <li>▪ Cappuccini-style assurance exercise</li> </ul>                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> <li>▪ Biannual workforce papers</li> <li>▪ Cappuccini-style assurance exercise</li> </ul>                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> <li>▪ Biannual workforce papers</li> <li>▪ Cappuccini-style assurance exercise</li> </ul>                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                             |
| <ul style="list-style-type: none"> <li>▪ Correspondence</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> <li>▪ A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services</li> <li>▪ PSIRF implementation within Maternity and Neonatal Services, governance and review processes.</li> <li>▪ Process for sharing outcomes and learning from PSIRF reviews with women and families.</li> <li>▪ Mechanisms to identify, monitor and learn from positive practice and areas of improvement.</li> </ul> |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> <li>▪ Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach.</li> <li>▪ Recommendations arising from thematic reviews are monitored, reviewed and acted upon.</li> </ul>                                                                                                                                                                                                  |
| <ul style="list-style-type: none"> <li>▪ Board report and minutes</li> <li>▪ Debrief guidance</li> <li>▪ Education and Training for Staff involved in debriefing women and families</li> </ul>                                                                                                                                                                                                                                                                                           |
| <ul style="list-style-type: none"> <li>▪ Triage Benchmarking tool completed template</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                          |
| <ul style="list-style-type: none"> <li>▪ Board paper</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ul style="list-style-type: none"> <li>▪ Plan and progress reports</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>▪ Assurance statement</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                  |

- Board Report
- Review report

## Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Please enter the **trust site** below:

### Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

### Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

### Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

### Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

### Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

### **Benchmark rating**

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

**There is a drop down menu incorporating the following:**

**Fully in place, evidenced and embedded**

**Partially in place, but inconsistent or not fully evidenced**

**Not in place, significant gaps or limited evidence**

**Not relevant to local pathway/context**

### **Support required from Trust board to progress compliance**

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

**What happens if selecting:**

**Partially in place, but inconsistent or not fully evidenced**

**Not in place, significant gaps or limited evidence**

**There is automatic functionality built in that takes you to the Support required from trust board column.**

### **Metrics**

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

### **Data captured per site**

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

**There is a drop down menu incorporating the following:**

**Site captures this data**

**Site partially captures this data**

**Site doesn't capture this data**

### **Support required from Trust board to progress the metric**

**What happens if selecting:**

**Site partially captures this data**

**Site doesn't capture this data**

**There is automatic functionality that takes you to the support required to progress this metric column**

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

### **Estimated financial requirements to support compliance**

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

### **Principles Menu**

This functionality will enable you to navigate between the principles tabs more easily.

# Matern

Click below to link through to each principle

**Principle 1:**

**Access and integration**

**Principle 2:**

**Recognition as urgent care**

**Principle 3:**

**Assessment and care of women**

**Principle 4:**

**Clear information for women**

**Principle 5:**

**Telephone maternity triage**

**Principle 6:**

**Service user voice and experience**

**Principle 7:**

**Facilities and estates**

**Principle 8:**

**Staffing**

**Principle 9:**

**Equity and equality**

**Principle 10:**

**Data and measurement**

| Maternity Triage Specification                                                                                                           |                |                    |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------|
|                                                                                                                                          | Fully in place | Partially in place |
| Clear, local 24/7 pathways so women know where to go and are supported between services.                                                 | 73 %           | 27 %               |
| Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such. | 90 %           | 10 %               |
| Every woman receives timely assessment, prioritisation and a clear plan of care.                                                         | 40 %           | 40 %               |
| Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.                                   | 67 %           | 33 %               |
| A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.                                           | 88 %           | 13 %               |
| Women's feedback must shape service design, improvement and experience.                                                                  | 80 %           | 20 %               |
| Triage needs safe, visible, fit-for-purpose space designed for urgent care.                                                              | 90 %           | 10 %               |
| Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.                               | 50 %           | 42 %               |
| Services must use data and targeted action to identify and reduce inequalities.                                                          | 80 %           | 20 %               |
| Data must drive oversight, learning from incidents and continuous improvement.                                                           | 100 %          | 0 %                |



| Not in place | Not relevant | Data not complete | Estimated cost to progress compliance of specification standard |
|--------------|--------------|-------------------|-----------------------------------------------------------------|
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 20 %         | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 8 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |
| 0 %          | 0 %          | 0 %               | £0,00                                                           |

| Principle 1: Access pathways so women know where to go |                                  |                                                                   | Principles m                                              |   |   |   |   |   |
|--------------------------------------------------------|----------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------|---|---|---|---|---|
| Dashboard                                              |                                  |                                                                   | Previous                                                  | 2 | 3 | 4 | 5 | 6 |
| Locations in line with R                               |                                  |                                                                   | Support required from Trust Board                         |   |   |   |   |   |
| Work                                                   | 1. Local                         | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Provide                                                | 1. All                           | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Agree                                                  | 1. A                             | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Ensure inclusive access                                | 1. A documented policy exists to | Partially in place, but                                           | Please outline what support you require from your trust b |   |   |   |   |   |
| Maintain                                               | 1. All                           | Fully in place                                                    | None- Divissional action and action pla                   |   |   |   |   |   |
| Provide                                                | 1. The                           | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Define                                                 | 1. Agreed                        | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Establish                                              | 1. Documente                     | Partially in place                                                | Please outline what support you require from your trust b |   |   |   |   |   |
| Plan ongoing                                           | 1. Defined pathways are in place | Partially in place                                                | Please outline what support you require from your trust b |   |   |   |   |   |
| Share                                                  | 1. A formal                      | Fully in place                                                    | None- divissional action and action pla                   |   |   |   |   |   |
| Provide                                                | 1. A clearly                     | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Metrics                                                | Data                             | Support required from Trust Boards to                             |                                                           |   |   |   |   |   |
| Metric: Rate of                                        | Site captures                    | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric:                                                | Site                             | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric:                                                | Site                             | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric: Proporti                                       | Site doesn't capture this        | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
|                                                        |                                  |                                                                   | In Data warehouse- BI to add to                           |   |   |   |   |   |
|                                                        |                                  |                                                                   | Principles m                                              |   |   |   |   |   |
| Dashboard                                              |                                  |                                                                   | Previous                                                  | 2 | 3 | 4 | 5 | 6 |

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| Menu                            |                   |                   |                    |                      | Estimated cost to |
| <a href="#">7</a>               | <a href="#">8</a> | <a href="#">9</a> | <a href="#">10</a> | <a href="#">Next</a> |                   |
| s to progress compliance        |                   |                   |                    |                      |                   |
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| board below                     |                   |                   |                    |                      |                   |
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| September to agree Regional SOP |                   |                   |                    |                      |                   |
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| Menu                            |                   |                   |                    |                      |                   |
| <a href="#">7</a>               | <a href="#">8</a> | <a href="#">9</a> | <a href="#">10</a> | <a href="#">Next</a> |                   |

| Principle 2: Recd                                       |                                               |                                                                    | Principles m                                              |          |          |          |          |          |          |
|---------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------|----------|----------|----------|----------|----------|----------|
| the safety-critical emergency front door for urgent and |                                               |                                                                    | Dashboard                                                 | Previous | <u>1</u> | <u>3</u> | <u>4</u> | <u>5</u> | <u>6</u> |
| cation stations in linehmark R                          |                                               |                                                                    | Support required from Trust Board                         |          |          |          |          |          |          |
| Materni                                                 | 1. Maternity                                  | Fully in place                                                     |                                                           |          |          |          |          |          |          |
| Design maternity triage                                 | 1. A Local standard is in place requiring all | Partially in place, but                                            | Please outline what support you require from your trust b |          |          |          |          |          |          |
| Ensure                                                  | 1. All                                        | Fully in place                                                     | None. Divissional actions monit                           |          |          |          |          |          |          |
| Embed                                                   | 1. The                                        | Fully in                                                           | No further action required                                |          |          |          |          |          |          |
| Provide                                                 | 1. The                                        | Fully in                                                           | No further action required                                |          |          |          |          |          |          |
| Operat                                                  | 1. All                                        | Fully in place                                                     | No further action required                                |          |          |          |          |          |          |
| Keep                                                    | 1. Through                                    | Fully in                                                           | No further action required                                |          |          |          |          |          |          |
| Define materni                                          | 1. A documente                                | Fully in place,                                                    | None. Divissional actions monit                           |          |          |          |          |          |          |
| Clearly signpos                                         | 1. Maternity triage is                        | Fully in place,                                                    | None. Divisional actions moni                             |          |          |          |          |          |          |
| Recogn                                                  | 1. A                                          | Fully in place                                                     | No further action required                                |          |          |          |          |          |          |
| Particip                                                | 1. The trust                                  | Fully in                                                           | No further action required                                |          |          |          |          |          |          |
| Metrics                                                 | Data                                          | Support required from Trust Boards to                              |                                                           |          |          |          |          |          |          |
| Metric:                                                 | Site captures                                 | Please outline what support you require from your trust board belo |                                                           |          |          |          |          |          |          |
| Reason                                                  |                                               |                                                                    |                                                           |          |          |          |          |          |          |
|                                                         |                                               |                                                                    |                                                           |          |          |          |          |          |          |
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|                                                         |                                               |                                                                    | Principles m                                              |          |          |          |          |          |          |
| Dashboard                                               |                                               |                                                                    | Previous                                                  | <u>1</u> | <u>3</u> | <u>4</u> | <u>5</u> | <u>6</u> |          |

| Menu                         |          |          |           |             | Estimated<br>cost to<br>progress<br>compliance |
|------------------------------|----------|----------|-----------|-------------|------------------------------------------------|
| <u>7</u>                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                                                |
| Costs to progress compliance |          |          |           |             |                                                |
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| progress the metric          |          |          |           |             | Total                                          |
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| Menu                         |          |          |           |             |                                                |
| <u>7</u>                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                                                |

| Principle 3: Assessment           |                           |                                                                                                                                            | Principles m                                                                                                              |   |   |   |   |   |
|-----------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---|---|---|---|---|
| Every woman receives timely       |                           | Dashboard                                                                                                                                  | Previous                                                                                                                  | 1 | 2 | 4 | 5 | 6 |
| Education sections in linehmark R |                           |                                                                                                                                            | Support required from Trust Board                                                                                         |   |   |   |   |   |
| Align                             | 1.The                     | Fully in place                                                                                                                             | No further action required                                                                                                |   |   |   |   |   |
| Ensure triage                     | 1. The service can        | Partially in                                                                                                                               | Please outline what support you require from your trust board action plan that includes Education framework for maternity |   |   |   |   |   |
| Aim to                            | 1. The                    | Fully in                                                                                                                                   | No further action required                                                                                                |   |   |   |   |   |
| If not using                      | 1. Where BSOTS is         | Not relevant                                                                                                                               | No further action required                                                                                                |   |   |   |   |   |
| Ensure triage                     | 1. The maternity          | Partially in                                                                                                                               | Please outline what support you require from your trust board Divission to review TNA. Explore Tainin                     |   |   |   |   |   |
| Metrics                           | Data                      | Support required from Trust Boards to                                                                                                      |                                                                                                                           |   |   |   |   |   |
| Metric: Proportion of             | Site captures this data   | Please outline what support you require from your trust board below                                                                        |                                                                                                                           |   |   |   |   |   |
| Metric:                           | Site captures             | Please outline what support you require from your trust board below                                                                        |                                                                                                                           |   |   |   |   |   |
| Metric: Proportion of             | Site Partially            | Please outline what support you require from your trust board below reporting on wait times for transfer- Urgent ticket raised with system |                                                                                                                           |   |   |   |   |   |
| Metric: Proportion of             | Site doesn't capture this | Please outline what support you require from your trust board below Need to explore where that is recorded on Badgernet-                   |                                                                                                                           |   |   |   |   |   |
|                                   |                           |                                                                                                                                            | Principles m                                                                                                              |   |   |   |   |   |
| Dashboard                         |                           |                                                                                                                                            | Previous                                                                                                                  | 1 | 2 | 4 | 5 | 6 |

|                                                 |   |   |    |      |                   |
|-------------------------------------------------|---|---|----|------|-------------------|
| Menu                                            |   |   |    |      | Estimated cost to |
| 7                                               | 8 | 9 | 10 | Next |                   |
| Is to progress compliance                       |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| board below                                     |   |   |    |      |                   |
| ty Triage and Divission to support bank to back |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| and evidenced                                   |   |   |    |      |                   |
| board below                                     |   |   |    |      |                   |
| g options to enhance point 2.                   |   |   |    |      |                   |
| progress the metric                             |   |   |    |      |                   |
| ow                                              |   |   |    |      | Total estimated   |
|                                                 |   |   |    |      |                   |
|                                                 |   |   |    |      | £0,00             |
| ow                                              |   |   |    |      |                   |
| ow                                              |   |   |    |      |                   |
| em C. In interim added to monthly mannual aud   |   |   |    |      |                   |
| ow                                              |   |   |    |      |                   |
| - Urgent ticket raised with system C            |   |   |    |      |                   |
| Menu                                            |   |   |    |      |                   |
| 7                                               | 8 | 9 | 10 | Next |                   |

| Principle 4: Clear messaging must be clear, welcoming |                  |                       | Principles m                                                      |   |   |   |   |   |
|-------------------------------------------------------|------------------|-----------------------|-------------------------------------------------------------------|---|---|---|---|---|
| Dashboard                                             |                  |                       | Previous                                                          | 1 | 2 | 3 | 5 | 6 |
| Education stations in linehmark R                     |                  |                       | Support required from Trust Board                                 |   |   |   |   |   |
| Provide                                               | 1. Women         | Fully in place        | No further action required                                        |   |   |   |   |   |
| Offer informa                                         | 1. Information   | Fully in place,       | No further action required                                        |   |   |   |   |   |
|                                                       |                  |                       | Discuss easy read formats with P                                  |   |   |   |   |   |
| Provide timely                                        | 1. The service   | Fully in place, embed | No further action required                                        |   |   |   |   |   |
|                                                       |                  |                       | Included in 2026 Triage annual training plan                      |   |   |   |   |   |
| Provide consist                                       | 1. A standardise | Fully in place,       | No further action required                                        |   |   |   |   |   |
|                                                       |                  |                       | Captured on Bad                                                   |   |   |   |   |   |
| Ensure effectiv                                       | 1. A guideline   | Partiall y in         | Please outline what support you require from your trust b         |   |   |   |   |   |
|                                                       |                  |                       | SOP written and going thro                                        |   |   |   |   |   |
| Metrics                                               | Data             |                       | Support required from Trust Boards to                             |   |   |   |   |   |
| Metric:                                               | Site captures    |                       | Please outline what support you require from your trust board bel |   |   |   |   |   |
| Reason                                                |                  |                       |                                                                   |   |   |   |   |   |
|                                                       |                  |                       |                                                                   |   |   |   |   |   |
|                                                       |                  |                       |                                                                   |   |   |   |   |   |
|                                                       |                  |                       |                                                                   |   |   |   |   |   |
|                                                       |                  |                       | Principles m                                                      |   |   |   |   |   |
| Dashboard                                             |                  |                       | Previous                                                          | 1 | 2 | 3 | 5 | 6 |



|                                     |          |          |           |             |                   |
|-------------------------------------|----------|----------|-----------|-------------|-------------------|
| Menu                                |          |          |           |             | Estimated cost to |
| <u>7</u>                            | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                   |
| Steps to progress compliance        |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
| Patient information team            |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
| a. Included in perinatal update day |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
| Gigernet                            |          |          |           |             |                   |
| Board below                         |          |          |           |             |                   |
| Through governance                  |          |          |           |             |                   |
| Progress the metric                 |          |          |           |             | estimated         |
| How                                 |          |          |           |             | cost to           |
|                                     |          |          |           |             | £0.00             |
|                                     |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
|                                     |          |          |           |             |                   |
| Menu                                |          |          |           |             |                   |
| <u>7</u>                            | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                   |

|                                     |                        |                                                                   |                                                           |   |   |   |   |   |
|-------------------------------------|------------------------|-------------------------------------------------------------------|-----------------------------------------------------------|---|---|---|---|---|
| Principle 5: Tele                   |                        |                                                                   | Principles m                                              |   |   |   |   |   |
| maternity helpline must be answered |                        | Dashboard                                                         | Previous                                                  | 1 | 2 | 3 | 4 | 6 |
| cation sections in linehmark R      |                        |                                                                   | Support required from Trust Board                         |   |   |   |   |   |
| Provide a well-                     | 1. A single, dedicated | Partially in place                                                | Please outline what support you require from your trust b |   |   |   |   |   |
|                                     |                        |                                                                   | X2 Midwives who are no longer clinical. Do                |   |   |   |   |   |
| Encourage                           | 1. All access          | Fully in place,                                                   | No further action required                                |   |   |   |   |   |
|                                     |                        |                                                                   | Update website with                                       |   |   |   |   |   |
| Ensure                              | 1. All                 | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Operat                              | 1.                     | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Do not                              | 1. Guidance            | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Do not allow                        | 1. The service has     | Fully in place,                                                   | No further action required                                |   |   |   |   |   |
|                                     |                        |                                                                   | SOP needs trienia                                         |   |   |   |   |   |
| Maintai                             | 1. The                 | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Docum                               | 1. All                 | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Metrics                             | Data                   | Support required from Trust Boards to                             |                                                           |   |   |   |   |   |
| Metric: Rate of                     | Site captures          | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric: Proporti                    | Site Partially         | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
|                                     |                        | Review whether we can get this information from Trak- added to    |                                                           |   |   |   |   |   |
| Metric:                             | Site                   | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
|                                     |                        |                                                                   | Principles m                                              |   |   |   |   |   |
| Dashboard                           |                        |                                                                   | Previous                                                  | 1 | 2 | 3 | 4 | 6 |

|                                               |          |          |           |             |                   |
|-----------------------------------------------|----------|----------|-----------|-------------|-------------------|
| Menu                                          |          |          |           |             |                   |
| <u>7</u>                                      | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> | Estimated cost to |
| Is to progress compliance                     |          |          |           |             |                   |
| board below                                   |          |          |           |             | workforce b       |
| ont have a staffing model for 24/7            |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
| h point 4                                     |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
| l review                                      |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
|                                               |          |          |           |             |                   |
| progress the metric                           |          |          |           |             | Total estimated   |
| ow                                            |          |          |           |             |                   |
|                                               |          |          |           |             | £0.00             |
| ow                                            |          |          |           |             |                   |
| o mannual telephone audit of 50 sets of notes |          |          |           |             |                   |
| ow                                            |          |          |           |             |                   |
| Menu                                          |          |          |           |             |                   |
| <u>7</u>                                      | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                   |

|                                                                    |                         |                                                                   |                                                           |   |   |   |   |   |
|--------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------|-----------------------------------------------------------|---|---|---|---|---|
| Principle 6: Service design must shape service design, improvement |                         |                                                                   | Principles m                                              |   |   |   |   |   |
| Dashboard                                                          |                         |                                                                   | Previous                                                  | 1 | 2 | 3 | 4 | 5 |
| cation stations in linehmark R                                     |                         |                                                                   | Support required from Trust Board                         |   |   |   |   |   |
| Develo                                                             | 1.The                   | Fully in place                                                    | No further action required                                |   |   |   |   |   |
| Gather                                                             | 1.The                   | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Present monthly                                                    | 1. The service has      | Fully in place, embed                                             | No further action required                                |   |   |   |   |   |
| Clearly inform                                                     | 1. The service has      | Partially in                                                      | Please outline what support you require from your trust b |   |   |   |   |   |
|                                                                    |                         |                                                                   | Add link to marthas rule to                               |   |   |   |   |   |
| Adopt the                                                          | 1. The service has      | Fully in place,                                                   | No further action required                                |   |   |   |   |   |
|                                                                    |                         |                                                                   | Not yet availa                                            |   |   |   |   |   |
| Value                                                              | 1. The                  | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Work                                                               | 1. The                  | Fully in                                                          | No further action required                                |   |   |   |   |   |
| Metrics                                                            | Data                    |                                                                   | Support required from Trust Boards to                     |   |   |   |   |   |
| Metric: Qualitat                                                   | Site captures this data | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric:                                                            | Site                    | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
| Metric:                                                            | Site captures           | Please outline what support you require from your trust board bel |                                                           |   |   |   |   |   |
|                                                                    |                         |                                                                   |                                                           |   |   |   |   |   |
|                                                                    |                         |                                                                   | Principles m                                              |   |   |   |   |   |
| Dashboard                                                          |                         |                                                                   | Previous                                                  | 1 | 2 | 3 | 4 | 5 |

|                              |          |          |           |             |                         |
|------------------------------|----------|----------|-----------|-------------|-------------------------|
| Menu                         |          |          |           |             | Estimated cost to       |
| <u>7</u>                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                         |
| Steps to progress compliance |          |          |           |             |                         |
|                              |          |          |           |             |                         |
|                              |          |          |           |             |                         |
|                              |          |          |           |             |                         |
| experience meeting           |          |          |           |             |                         |
| board below                  |          |          |           |             |                         |
| clinical guideline           |          |          |           |             |                         |
|                              |          |          |           |             |                         |
| ible                         |          |          |           |             |                         |
|                              |          |          |           |             |                         |
|                              |          |          |           |             |                         |
| progress the metric          |          |          |           |             | Total estimated cost to |
| ow                           |          |          |           |             | £0,00                   |
|                              |          |          |           |             |                         |
| ow                           |          |          |           |             |                         |
| ow                           |          |          |           |             |                         |
|                              |          |          |           |             |                         |
| Menu                         |          |          |           |             |                         |
| <u>7</u>                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                         |

|                                                                 |                     |                                                                     |                                                                                                         |          |          |          |                                       |
|-----------------------------------------------------------------|---------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------|----------|----------|---------------------------------------|
| Principle 7: Facilities<br>Triage needs safe, visible, fit-for- |                     | Principles m                                                        |                                                                                                         |          |          |          |                                       |
| Dashboard                                                       |                     | Previous                                                            | <u>1</u>                                                                                                | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u>                              |
| Locations in line                                               |                     | Support required from Trust Board                                   |                                                                                                         |          |          |          |                                       |
| The                                                             | 1. The              | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Provide                                                         | 1. A                | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Include a                                                       | 1. Maternity triage | Partially in place                                                  | Please outline what support you require from your trust board<br>24/7 ward clerk required for permanent |          |          |          |                                       |
| Maintain                                                        | 1. A                | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Ensure appropriate                                              | 1. The maternity    | Fully in place                                                      | No further action required<br>Meets minimum standard but Board asked to support e                       |          |          |          |                                       |
| Include                                                         | 1. A                | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Ensure                                                          | 1. Maternity        | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Meet                                                            | 1. The              | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Be                                                              | 1. Maternity        | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Design                                                          | 1. The              | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Support                                                         | 1. Maternity        | Fully in place                                                      | No further action required                                                                              |          |          |          |                                       |
| Metrics                                                         | Data                |                                                                     |                                                                                                         |          |          |          | Support required from Trust Boards to |
| Metric: Clinical                                                | Site captures       | Please outline what support you require from your trust board below |                                                                                                         |          |          |          |                                       |
|                                                                 |                     |                                                                     |                                                                                                         |          |          |          |                                       |
|                                                                 |                     |                                                                     |                                                                                                         |          |          |          |                                       |
|                                                                 |                     |                                                                     |                                                                                                         |          |          |          |                                       |
| Dashboard                                                       |                     | Principles m                                                        |                                                                                                         |          |          |          |                                       |
|                                                                 |                     | Previous                                                            | <u>1</u>                                                                                                | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u>                              |

|                                              |          |          |           |             |                   |
|----------------------------------------------|----------|----------|-----------|-------------|-------------------|
| Menu                                         |          |          |           |             | Estimated cost to |
| <u>6</u>                                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                   |
| s to progress compliance                     |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
| board below                                  |          |          |           |             | TBC               |
| ent oversight of attendees                   |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
| estates work to meet primary assessment KPIs |          |          |           |             | ee capital bid    |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
| progress the metric                          |          |          |           |             | Total             |
| ow                                           |          |          |           |             | estimated         |
|                                              |          |          |           |             | £0.00             |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
|                                              |          |          |           |             |                   |
| Menu                                         |          |          |           |             |                   |
| <u>6</u>                                     | <u>8</u> | <u>9</u> | <u>10</u> | <u>Next</u> |                   |





| Menu                                            |   |   |    |      |                   |
|-------------------------------------------------|---|---|----|------|-------------------|
| 6                                               | 7 | 9 | 10 | Next | Estimated cost to |
| Is to progress compliance                       |   |   |    |      |                   |
| board below                                     |   |   |    |      | Business ca       |
| t board for approval                            |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| board below                                     |   |   |    |      |                   |
| an monitored on Monday.com                      |   |   |    |      |                   |
| board below                                     |   |   |    |      | kforce busine     |
| Currently suported by temporary staffing mode   |   |   |    |      |                   |
| board below                                     |   |   |    |      | kforce busine     |
| Board for Triage workforce model with agreed fu |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| board below                                     |   |   |    |      |                   |
| an monitored on Monday.com                      |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| board below                                     |   |   |    |      |                   |
| n monitored on Monday.com                       |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| progress the metric                             |   |   |    |      | Total             |
| ow                                              |   |   |    |      | estimated         |
|                                                 |   |   |    |      | £0.00             |
| ow                                              |   |   |    |      |                   |
| r reporting                                     |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
|                                                 |   |   |    |      |                   |
| Menu                                            |   |   |    |      |                   |
| 6                                               | 7 | 9 | 10 | Next |                   |

|                                             |          |                                                                   |                                                           |          |          |          |          |          |          |
|---------------------------------------------|----------|-------------------------------------------------------------------|-----------------------------------------------------------|----------|----------|----------|----------|----------|----------|
| Principle 9: Equip                          |          |                                                                   | Principles m                                              |          |          |          |          |          |          |
| data and targeted<br>action to identify and |          |                                                                   | Dashboard                                                 | Previous | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u> |
| cation sections in linehmark R              |          |                                                                   | Support required from Trust Board                         |          |          |          |          |          |          |
| Acknow                                      | 1. The   | Fully in                                                          | No further action required                                |          |          |          |          |          |          |
| ledge                                       | service  | place,<br>embed                                                   | Guideline                                                 |          |          |          |          |          |          |
| Underst                                     | 1. The   | Fully in                                                          | No further action required                                |          |          |          |          |          |          |
| Use                                         | 1. The   | Fully in                                                          | No further action required                                |          |          |          |          |          |          |
| Work                                        | 1. The   | Fully in                                                          | No further action required                                |          |          |          |          |          |          |
| Ensure                                      | 1. Staff | Partiall                                                          | Please outline what support you require from your trust b |          |          |          |          |          |          |
| all staff                                   | have     | y in                                                              | None- Divissional actions monit                           |          |          |          |          |          |          |
| Metrics                                     | Data     | Support required from Trust Boards to                             |                                                           |          |          |          |          |          |          |
| Note:                                       | Site     | Please outline what support you require from your trust board bel |                                                           |          |          |          |          |          |          |
| Refer                                       | captures |                                                                   |                                                           |          |          |          |          |          |          |
| Metric:                                     | Site     | Please outline what support you require from your trust board bel |                                                           |          |          |          |          |          |          |
|                                             |          |                                                                   |                                                           |          |          |          |          |          |          |
|                                             |          |                                                                   |                                                           |          |          |          |          |          |          |
|                                             |          |                                                                   | Principles m                                              |          |          |          |          |          |          |
| Dashboard                                   |          |                                                                   | Previous                                                  | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u> |          |

|                          |          |          |           |             |                  |
|--------------------------|----------|----------|-----------|-------------|------------------|
| menu                     |          |          |           |             | cost to progress |
| <u>6</u>                 | <u>7</u> | <u>8</u> | <u>10</u> | <u>Next</u> |                  |
| s to progress compliance |          |          |           |             |                  |
|                          |          |          |           |             |                  |
|                          |          |          |           |             |                  |
|                          |          |          |           |             |                  |
|                          |          |          |           |             |                  |
| board below              |          |          |           |             |                  |
| tored on Monday.com      |          |          |           |             |                  |
| progress the metric      |          |          |           |             | Total            |
| ow                       |          |          |           |             | estimated        |
|                          |          |          |           |             | £0.00            |
| ow                       |          |          |           |             |                  |
|                          |          |          |           |             |                  |
|                          |          |          |           |             |                  |
|                          |          |          |           |             |                  |
| menu                     |          |          |           |             |                  |
| <u>6</u>                 | <u>7</u> | <u>8</u> | <u>10</u> | <u>Next</u> |                  |

| Principle 10: Data oversight, learning from incidents and |                |                 | Principles m                      |          |          |          |          |          |
|-----------------------------------------------------------|----------------|-----------------|-----------------------------------|----------|----------|----------|----------|----------|
| Dashboard                                                 |                |                 | Previous                          | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u> |
| cation stations in linehmark R                            |                |                 | Support required from Trust Board |          |          |          |          |          |
| Collect                                                   | 1. The         | Fully in place  | No further action required        |          |          |          |          |          |
| Where                                                     | 1. The         | Fully in        | No further action required        |          |          |          |          |          |
| Review                                                    | 1. The         | Fully in        | No further action required        |          |          |          |          |          |
| Establis                                                  | 1. The         | Fully in        | No further action required        |          |          |          |          |          |
| Embed                                                     | 1. Maternity   | Fully in        | No further action required        |          |          |          |          |          |
| Include demogr                                            | 1. The service | Fully in place, | Quarterly reports from September  |          |          |          |          |          |
| Be                                                        | 1. Women       | Fully in        | No further action required        |          |          |          |          |          |
|                                                           |                |                 | Principles m                      |          |          |          |          |          |
| Dashboard                                                 |                |                 | Previous                          | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> | <u>5</u> |

| Menu                     |          |          |          |             |                   |
|--------------------------|----------|----------|----------|-------------|-------------------|
| <u>6</u>                 | <u>7</u> | <u>8</u> | <u>9</u> | <u>Next</u> | Estimated cost to |
| s to progress compliance |          |          |          |             |                   |
|                          |          |          |          |             |                   |
|                          |          |          |          |             |                   |
|                          |          |          |          |             |                   |
|                          |          |          |          |             |                   |
|                          |          |          |          |             |                   |
| er. Monthly in PQOM      |          |          |          |             |                   |
|                          |          |          |          |             |                   |
| Menu                     |          |          |          |             | Total estimated   |
| <u>6</u>                 | <u>7</u> | <u>8</u> | <u>9</u> | <u>Next</u> | £0.00             |

# Report to Trust Board

|                             |                                                                                                                                                                                                                       |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Meeting date                | 10 September 2026                                                                                                                                                                                                     |
| Report title                | Perinatal Quality Oversight Model Report – Quarter 1 (April-June data)                                                                                                                                                |
| Sponsoring Director/Authors | Matt Holdaway, Chief Nurse and Director of Quality<br><br>Sarah Ashwood, Perinatal Quality and Governance Lead<br>Zita Martinez, Director of Midwifery<br>Suzie Cro, Director of Quality Governance<br>Perinatal Team |

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

| Executive Summary        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Previously considered by | <p>The report is being presented to Trust Executive Board for discussion and assurance. This report has not been presented at Quality and Performance Committee as there was no meeting in August.</p> <p>The Q1 Perinatal Quality Oversight Model report provides the Trust Executive Board with an integrated assessment of perinatal safety, quality, workforce, experience and governance for April to June 2026.</p> <p>The main risks for noting relate to midwifery, obstetric and neonatal workforce sustainability, obstetric theatre and recovery capacity, training compliance, incomplete workforce and acuity data and equitable communication with women and families.</p> <p>Midwifery fill rates reduced to 87% in June, 45 staffing red flags were recorded, and reliance on temporary staffing remains significant. Obstetric rota gaps were largely covered, but the volume of internal cover indicates limited resilience, and the associated</p> |

|  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>Trust risk remains scored at 16. Neonatal nursing fill rates remain at 70%, Qualified in Specialty compliance is 57%, and neonatal medical night-cover gaps continue. Current controls have maintained operational delivery, but they do not resolve the underlying workforce risk.</p> <p>Training oversight has strengthened through monthly trajectory monitoring and recovery planning. All obstetric medical staff are booked onto the remaining Practical Obstetric Multi-Professional Training days before November 2026, and plans are in place to book the two anaesthetists with outstanding requirements. Neonatal Life Support recovery plans are being developed jointly by the Neonatal Specialty Lead and the Lead Midwife for Training and Education. Nevertheless, some staff groups remain below the required 90% threshold, and reporting continues to depend on manual reconciliation. Sustained compliance and validated medical training records are therefore required before full assurance can be taken.</p> <p>Positive assurance is provided by maintenance of one-to-one care in labour, consultant attendance in 96% of eligible complex situations, completion of multidisciplinary simulation requirements, established perinatal mortality review arrangements, and strengthened triangulation of learning from incidents, reviews and family feedback. No neonatal unit or cot closures, workforce-related neonatal transfers, maternity safety alerts, coroners' reports or Regulation 28 reports were recorded during Quarter 1.</p> <p>Further work is required to demonstrate that improvement actions are embedded and effective. Priorities for Quarter 2 include delivery of sustainable workforce plans; recovery of training compliance; improved Birthrate Plus and red flag reporting; development of theatre and recovery capacity options; strengthened interpreter and accessibility recording; completion of care bundle benchmarking; and measurable evidence that learning from reviews and service-user feedback has changed practice.</p> |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Recommendations:

The Trust Executive Board is asked to discuss the Quarter 1 perinatal quality oversight position and note that assurance is developing across workforce, training, neonatal staffing, theatre

capacity, learning from reviews, service-user voice, equity, Board oversight, governance, culture and leadership.

The Trust Executive board is asked to:

- recognise that current operational controls are managing, but have not resolved, the principal workforce, capacity and training risks
- endorse continued executive oversight of the identified recovery plans
- require Quarter 2 evidence of sustained improvement, including validated training compliance, workforce and capacity trajectories, stronger data quality, and evidence that learning has been embedded
- support timely consideration of sustainable workforce, theatre, recovery and digital reporting solutions.

Strategic Aims (tick as appropriate)



Patient experience and voice

X



People, culture and leadership

X



Quality, safety and delivery

X



Digital first

X

Impact on any Strategic Risks?

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

Implications on:



|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b>            | The report highlights specific equality, diversity and inclusion implications in relation to equitable access, inclusive communication, interpretation provision, patient information accessibility and engagement with communities who may be less likely to provide feedback through existing routes. The establishment of the Perinatal Listening and Learning Group, with Maternity and Neonatal Voices Partnership involvement, will support triangulation of feedback and development of co-produced actions.                                                                                                    |
| <b>Health Inequalities</b>                          | Health inequalities implications relate to variation in access, experience and outcomes for women, babies and families, particularly where language, interpretation needs, digital accessibility, community engagement or social vulnerability may affect informed choice, consent, communication and continuity of care. Quarter 2 work will strengthen data quality, interpreter recording, accessibility of patient information and feedback from under-represented groups.                                                                                                                                         |
| <b>Finance and Resources</b>                        | There are finance and resource implications linked to workforce sustainability, temporary staffing, off-framework agency use, obstetric and neonatal rota resilience, theatre and recovery capacity, training delivery, digital reporting and data quality improvement. The workforce business case, national funding opportunities and development of sustainable staffing models will be key controls to reduce reliance on temporary mitigations and support safer, more efficient service delivery.                                                                                                                |
| <b>Regulation/Legal</b>                             | Regulatory and legal implications include compliance with Maternity Incentive Scheme Year 8 requirements, Care Quality Commission expectations, statutory duty of candour, Perinatal Mortality Review Tool standards, Maternity and Newborn Safety Investigation learning, safeguarding requirements, national maternity and neonatal guidance, and Trust risk management processes. Continued Board and executive oversight is required where residual risks remain, particularly workforce capacity, training compliance, theatre capacity, neonatal staffing, service-user voice and evidence of embedded learning. |
| <b>Care Quality Commission key lines of enquiry</b> | The report supports assurance against the Care Quality Commission domains of safe, effective, caring, responsive and well-led. Key areas relate to safe staffing, training and competence, incident learning, fetal monitoring, escalation, service-user voice,                                                                                                                                                                                                                                                                                                                                                        |

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                   | equity, governance, leadership visibility, culture, risk oversight and evidence that improvement actions are tracked and embedded.                                                                                                                                                                                                                                                                                                |
| <b>Green Plan</b> | There are no significant Green Plan implications identified within this report. Opportunities to support the Green Plan may arise through reducing avoidable travel, improving digital access to information, supporting efficient use of estate and theatre capacity, and strengthening sustainable workforce planning where this can reduce reliance on short-notice temporary staffing and unnecessary operational escalation. |

Main Report

Introduction

This Quarter 1 Perinatal Quality Oversight Model report provides a consolidated overview of maternity and neonatal quality, safety, experience and governance intelligence for April to June 2026. The report brings together evidence from workforce and capacity data, training compliance, learning from incidents and reviews, service-user voice, equity, care bundle implementation, Board oversight, culture and leadership. Its purpose is to support the Trust Executive Board in reviewing the current assurance position, identifying areas of residual risk, and confirming the controls and improvement actions required to strengthen safety and quality across perinatal services.

Overall, the Quarter 1 position demonstrates developing assurance across the Perinatal Quality Oversight Model domains, with several areas of positive progress, including strengthened governance reporting, establishment of improvement trajectories, enhanced service-user engagement and clearer triangulation of learning. However, the report also identifies ongoing risks requiring continued executive and Board oversight, particularly workforce sustainability, obstetric and neonatal rota resilience, training recovery, theatre and recovery capacity, interpreter access, data quality, and evidence that learning is embedded and sustained in practice.

# Workforce

## Midwifery Workforce

A full Birthrate Plus review was undertaken in 2025 and indicated a deficit from funded clinical and specialist baseline establishment. A full maternity workforce review was undertaken by the Deputy Regional Chief Midwife. The workforce plan and business case has been costed and will progress to the Trust Leadership team meeting for consideration in August 2026.

## Quarter 1 summary

Quarter 1 BirthRate Plus acuity data demonstrates that reporting is established within maternity services, with stronger completion on Delivery Suite than on the maternity ward. Delivery Suite compliance remained relatively stable at 84.44% in April, 85.48% in May and 82.78% in June. This provides assurance that clinical demand is being monitored in that setting, although compliance remains below the level required for full whole-service assurance.

However, maternity ward compliance was significantly lower and declined from 67.86% in April to 64.29% in May and June. This limits the level of assurance that can be taken from the data, as incomplete acuity reporting may reduce visibility of ward-level workload, complexity, staffing pressures and escalation requirements. The current position demonstrates that acuity monitoring is in place, but the assurance is not yet sufficiently mature to support a reliable whole-service view of workforce demand and capacity. Further work is therefore required to embed BirthRate Plus consistently across all areas as a core workforce and capacity oversight tool.

The key governance risk is that incomplete acuity recording, particularly on the maternity ward, may limit the ability to triangulate staffing levels, red flag events, one-to-one care in labour, temporary staffing, incidents, delays, escalation and patient safety outcomes. This should remain under executive oversight as part of the wider workforce and capacity assurance programme.

### Next steps

- The Deputy Director of Midwifery will review barriers to BirthRate Plus completion on the maternity ward and agree a Quarter 2 recovery trajectory, including a minimum internal compliance standard and exception reporting where compliance falls below the agreed threshold.
- BirthRate Plus compliance and acuity outputs will be incorporated into the quarterly integrated maternity workforce report and triangulated with staffing fill rates, red flags, incidents, escalation activity, temporary staffing and patient safety indicators.
- Compliance will be monitored monthly through maternity governance, with persistent low compliance or deterioration escalated to Perinatal Delivery Group.
- A Quarter 2 update will be provided through the integrated maternity workforce report, with onward assurance to Quality and Performance Committee or Trust Board as required.

These actions will be monitored monthly through maternity governance, with progress and exceptions incorporated into the quarterly integrated maternity workforce report. Ongoing areas of concern will be escalated to Perinatal Delivery Group, with onward assurance to Quality and Performance Committee or Trust Board as required.

*CDS Birthrate Plus compliance*

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| April - 26                                                                                                                                                                                                                         | May - 26                                                                                                                                                                                                                           | June - 26                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Acuity Summary<br/>01/04/2026 to 30/04/2026</p> <p>● Meets Acuity (N = 113)<br/>● Up to 3 MW's short (N = 38)<br/>● 3 or more MW's short (N = 1)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 84.44%</p> | <p>Acuity Summary<br/>01/05/2026 to 31/05/2026</p> <p>● Meets Acuity (N = 132)<br/>● Up to 3 MW's short (N = 26)<br/>● 3 or more MW's short (N = 1)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 85.48%</p> | <p>Acuity Summary<br/>01/06/2026 to 30/06/2026</p> <p>● Meets Acuity (N = 108)<br/>● Up to 3 MW's short (N = 39)<br/>● 3 or more MW's short (N = 2)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 82.78%</p> |

Table 1

### Maternity Ward Birthrate Plus compliance

| April - 26                                                                                                                                                                                       | May - 26                                                                                                                                                                                         | June - 26                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Acuity Summary<br/>01/04/2026 to 30/04/2026</p> <p>● Meets Acuity (N = 19)<br/>● Does Not Meet Acuity (N = 59)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 67.86%</p> | <p>Acuity Summary<br/>01/05/2026 to 31/05/2026</p> <p>● Meets Acuity (N = 29)<br/>● Does Not Meet Acuity (N = 49)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 64.29%</p> | <p>Acuity Summary<br/>01/06/2026 to 30/06/2026</p> <p>● Meets Acuity (N = 25)<br/>● Does Not Meet Acuity (N = 51)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 64.29%</p> |

Table 2

### Gloucester Birth Unit Birthrate Plus compliance

| April - 26                                                                                                                                                                                                                        | May - 26                                                                                                                                                                                                                          | June - 26                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Acuity Summary<br/>01/04/2026 to 30/04/2026</p> <p>● Meets Acuity (N = 78)<br/>● Up to 2 MW's short (N = 14)<br/>● 2 or more MW's short (N = 0)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 49.44%</p> | <p>Acuity Summary<br/>01/05/2026 to 31/05/2026</p> <p>● Meets Acuity (N = 36)<br/>● Up to 2 MW's short (N = 10)<br/>● 2 or more MW's short (N = 1)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 57.53%</p> | <p>Acuity Summary<br/>01/06/2026 to 30/06/2026</p> <p>● Meets Acuity (N = 82)<br/>● Up to 2 MW's short (N = 18)<br/>● 2 or more MW's short (N = 0)</p> <p>*The % is rounded to nearest whole number</p> <p>Compliance: 56.11%</p> |

Table 3

### Midwifery fill rates for Quarter 1

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| Month      | % fill rate |
|------------|-------------|
| April - 26 | 90%         |
| May - 26   | 92%         |
| June - 26  | 87%         |

Table 4

Midwifery fill rates remained broadly stable during Quarter 1, increasing from 90% in April to 92% in May before reducing to 87% in June. The June reduction coincided with increased long-term sickness absence and higher temporary staffing utilisation. This provides some assurance that substantive staffing remained relatively resilient during the quarter; however, the reduction in June and continued reliance on temporary staffing indicate an ongoing workforce sustainability risk. This will require continued triangulation with acuity, red flag reporting, incidents, escalation activity and patient safety indicators through the integrated maternity workforce report.

### Temporary staffing utilisation

Temporary staffing data should be considered alongside vacancy, sickness, maternity leave and acuity pressures. Bank and agency use supported safe staffing during Quarter 1, but continued reliance on temporary staffing indicates ongoing workforce fragility and should be triangulated through the integrated maternity workforce report.

### Midwifery Temporary Staffing

|                                                     | April - 26 | May - 26 | June - 26 |
|-----------------------------------------------------|------------|----------|-----------|
| Bank use (WTE)<br>B567 use (divided by 162.94)      | 17.29      | 13.49    | 14.54     |
| Bank unfilled shifts (WTE) B567 (divided by 162.94) | 13.1       | 8.2      | 10.1      |

Table5

Midwifery remains the highest off-framework agency user in the Trust. This reflects ongoing workforce fragility, including gaps in substantive staffing, sickness, maternity leave and rota resilience.

The current midwifery unit on-call model provides additional overnight and weekend support but should not be viewed as the primary mitigation for safe staffing. Safe staffing needs to be addressed through the substantive workforce establishment, supported by the perinatal workforce business case currently in development.

A review of the on-call offer is underway to consider whether the current model remains appropriate, sustainable and equitable. This will include staff engagement and union representation as required.

The outcome of the workforce business case and on-call review will be used to inform a more sustainable staffing model and reduce reliance on temporary and off-framework agency staffing.

**Sickness**

Sickness absence is a significant contributor to workforce capacity pressures across maternity services. Quarter 1 data indicates that long-term absence is having the greatest impact, particularly within Band 6 and Band 7 midwifery roles and inpatient maternity areas. The main themes relate to long-term health and wellbeing absence, alongside pregnancy-related sickness, which creates predictable workforce gaps prior to maternity leave. This should be considered alongside vacancy, maternity leave, bank and agency use when assessing the overall workforce position.

The data suggests that sickness pressures are not solely seasonal and require a planned workforce response. Future reporting will triangulate sickness absence with acuity, red flag reporting, incidents, temporary staffing, staff wellbeing and retention actions to better understand the impact on safe staffing and service resilience.

For Quarter 2, the focus should be on strengthening sickness oversight, identifying areas with recurrent long-term absence, ensuring appropriate wellbeing support is in place, and using the perinatal workforce business case to address the underlying capacity gap rather than relying on temporary staffing as the main mitigation.

**Maternity Leave WTE**

Maternity leave is a predictable workforce pressure and should be included consistently in workforce reporting. Quarter 1 data shows sustained absence across midwifery and MSW groups, with midwifery maternity leave increasing to 20.79 WTE in June. This impacts safe staffing and reliance on temporary staffing.

| Maternity leave WTE | April - 26 | May - 26 | June - 26 |
|---------------------|------------|----------|-----------|
| Midwives            | 17.06      | 15.88    | 20.79     |
| MSWS                | 3.01       | 2.78     | 3.46      |

Table 7

**National Newly Qualified Midwife (NQM) Recruitment Support Offer**

As part of the national response to the Amos Investigation, NHS England has introduced a Newly Qualified Midwife (NQM) Recruitment Support Offer. The offer is intended to strengthen maternity staffing, improve preceptorship and supervision, and support providers to recruit newly qualified midwives into additional Band 5 posts.

The offer provides up to £10,000 per additional midwifery post. Providers are expected to use this investment to support both the creation of additional Band 5 NQM posts and any associated workforce capacity required for safe deployment. Posts funded through this offer must be new. GHNHSFT maternity services have consistently carried an average maternity leave position of approximately 16 WTE over several years. This represents a known and predictable workforce requirement rather than an unexpected pressure and should be tracked within the wider workforce position.

Taking up this offer to recruit against a predictable requirement provides a safer and more financially sustainable approach than continued reliance on bank, agency and fixed-term arrangements. An expression of interest to access this funding was submitted on 31 July 2026.

Red flag reporting Q1

A total of 45 red flag events were recorded across Quarter 1, compared with 32 in Quarter 4 2025/26. The highest number was reported on the maternity ward in June. This should be interpreted alongside acuity completion, fill rates, temporary staffing, sickness, maternity leave and incident data to support a fuller understanding of the safe staffing position.

Q1 26-27 Red Flag Reporting

| Month | CDS | Ward | GBU |
|-------|-----|------|-----|
| April | 5   | 0    | 5   |
| May   | 2   | 2    | 4   |
| June  | 5   | 18   | 4   |
| TOTAL | 12  | 20   | 13  |

Table 8

One-to-one care in labour and supernumerary coordinator cover were maintained; however, the reliability and consistency of red flag recording requires improvement. A Quarter 2 improvement plan will be led by the Deputy Director of Midwifery to strengthen red flag capture, validation, review and action tracking.

Recruitment pipeline

Vacancy Rate WTE MWs

| April - 26 | May - 26 | June - 26 |
|------------|----------|-----------|
| 12.23      | 10.08    | 9.33      |

Table 9

Vacancy Rate WTE MSWs

| April - 26 | May - 26 | June - 26 |
|------------|----------|-----------|
|------------|----------|-----------|

|      |     |      |
|------|-----|------|
| 5.74 | 5.9 | 6.54 |
|------|-----|------|

Table 10

### Maternity Support Worker workforce

The MSW workforce position should be considered alongside the wider midwifery workforce data, as MSWs provide essential support to inpatient areas, community services and clinical flow. Quarter 1 data shows an increase in MSW vacancies from 5.74 WTE in April to 6.54 WTE in June, indicating a deterioration in staffing capacity across this group.

### Progress against recruitment and retention plans

Recruitment is being actively monitored through weekly workforce trajectory meetings with Finance to ensure establishment, recruitment activity and staffing forecasts remain aligned. This has strengthened oversight of workforce planning and supported timely decision-making where variances against trajectory are identified.

Historically, nursing conversion students were automatically offered substantive positions on completion of their programme. Whilst beneficial for recruitment, this impacted workforce trajectories and reduced opportunities to advertise Band 5 posts for fee-paying undergraduate students approaching qualification. For the next cohort commencing in September, this approach has been revised, and the two successful candidates have had secondments approved, providing a substantive post to return to should suitable vacancies not be available.

To further strengthen governance and ensure consistency, all recruitment activity, including both internal and external vacancies, is now being managed through Trac. This supports a fair, transparent and standardised recruitment process across the service.

Whilst current efforts are focused on recruitment, retention will become a key priority over the coming months. Planned initiatives include the development of career development pathways and the introduction of preference rostering to improve staff experience and support workforce stability. Delivery of these initiatives is dependent on the launch of the MSW Skills Passport, expected in early August.

### Obstetric Workforce

| Obstetric rota gaps Quarter 1                     | April                                                             | May                                                                     | June                                                | Quarter 1 summary                                                                                                        |
|---------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Obstetric Consultant Rota for Delivery Suite 24/7 | <b>100% covered (15/15)</b><br>5-day gaps: 4 external, 1 internal | <b>100% covered (10/10)</b><br>1 day gap: 1 internal<br>5-night gaps: 1 | <b>100% covered (8/8)</b><br>3-day gaps: 3 internal | Thirty-three Delivery Suite consultant rota gaps were reported across Quarter 1 and were recorded as covered each month. |



|                                                                                |                                                                              |                                                                             |                                                                                              |                                                                                                                                           |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                | 10-night gaps: 7 external, 3 internal                                        | external, 3 internal. Cover source for 1 gap not specified in source table. | 5-night gaps: 2 external, 1 internal. Cover source for 2 gaps not specified in source table. |                                                                                                                                           |
| Obstetric Consultant Unscheduled Care 08:30–17:30 Monday to Friday             | <b>100% covered (3/3)</b><br>3 internal covers, including 1 senior registrar | <b>100% covered</b><br>0 gaps                                               | <b>100% covered (2/2)</b><br>2 internal covers, including 1 senior registrar                 | Five unscheduled care consultant gaps were reported across Quarter 1 and were covered.                                                    |
| Obstetric Middle-grade Obstetrics on Call / Obstetrics and Gynaecology on Call | <b>100% covered (20/20)</b><br>20 internal locums, 0 external locums         | <b>100% covered (23/23)</b><br>20 internal locums, 3 external locums        | <b>100% covered (29/29)</b><br>28 internal locums, 1 external locum                          | Seventy-two middle-grade on-call gaps were reported across Quarter 1. The majority were covered internally, with four covered externally. |
| Obstetric Middle-grade Triage 08:30–17:00 seven days                           | <b>100% covered (5/5)</b><br>0 external, 5 internal, 0 uncovered             | <b>100% covered (4/4)</b><br>0 external, 4 internal, 0 uncovered            | <b>Partially covered (2.5/3)</b><br>1 external, 1.5 internal, 0.5 uncovered                  | Twelve triage middle-grade gaps were reported across Quarter 1. One half-session remained uncovered in June.                              |

Table 11

## Obstetric Rota Gaps and Workforce Risk

Quarter 1 obstetric rota data demonstrates that operational cover was maintained for all reported obstetric consultant and middle-grade rota gaps, with the exception of one half-session middle-grade triage gap in June. This provides assurance that immediate service cover was actively managed during the quarter. However, the volume of gaps remains significant and indicates ongoing fragility within the obstetric medical workforce. In Quarter 1, thirty-three Delivery Suite consultant rota gaps, five unscheduled care consultant gaps, seventy-two middle-grade on-call gaps and twelve middle-grade triage gaps were reported. Most middle-grade gaps were covered internally, with limited use of external cover, which supports short-term service continuity but may increase pressure on the existing workforce and reduce resilience.

Obstetric staffing currently remains a Trust-level risk, with a risk score of 16. This risk is recognised within the Perinatal Workforce Plan and requires continued executive oversight, particularly in relation to sustainable rota cover, reliance on internal locum arrangements, workforce fatigue, training capacity, consultant presence and timely senior decision-making. The Quarter 1 position demonstrates effective operational mitigation, but not resolution of the underlying workforce risk. Further assurance is required that obstetric staffing trajectories, recruitment and retention plans, temporary staffing use, training impacts and escalation arrangements are being monitored through divisional and perinatal governance, with clear reporting to Trust-level committees until the risk is reduced.

The obstetric workforce risks also need to be considered alongside the Maternity Incentive Scheme Year 8 requirements for Board oversight of maternity staffing, escalation and capacity. Rota resilience, consultant availability, middle-grade cover, anaesthetic capacity, recovery staffing and ward flow all directly affect the ability to provide timely planned and emergency Caesarean section care. The following section therefore sets out the related theatre capacity position and the controls currently in place to manage this demand.

### **Obstetric Consultant presence at Complex Situations Audit Q1**

The Quarter 1 obstetric staffing audit provides positive assurance against the relevant Maternity Incentive Scheme Year 8 requirements for obstetric workforce oversight, consultant presence and safe escalation. During the reporting period from 1 April to 30 June 2026, consultant attendance was achieved in 96% of situations where consultant presence was required, exceeding the agreed compliance standard of 80%. Compliance was strongest in high-acuity and emergency scenarios, including major obstetric haemorrhage, maternal collapse, sepsis-related deterioration, return to theatre and second theatre opening, where consultant presence was consistently documented. Consultant attendance was also achieved in 100% of situations where attendance was required because the most senior resident doctor was not signed off as competent, providing assurance that supervision and escalation arrangements are functioning effectively.

The audit identified two cases where consultant presence was required but not documented: one Caesarean section for a woman with a body mass index greater than 50 and one Caesarean section for posterior placenta praevia. Both cases were reviewed, neither resulted in complication, and the unscheduled care consultant was available on site. However, these findings highlight the need to strengthen staff awareness of the specific situations requiring consultant attendance and to improve documentation of consultant presence. Actions have therefore been identified and are being progressed, including theatre prompts, Team Talk communication, continued sharing of findings through consultant and resident doctor forums, and improved electronic data capture through a Microsoft Forms process introduced from Quarter 2.

The locum audit provides further assurance that obstetric staffing risks were actively managed during Quarter 1. Labour ward consultant cover was maintained at 100%, and all locum doctors reviewed met national and local requirements for short-term locum working in obstetrics and gynaecology. Rota gaps were identified across consultant and middle-grade medical staffing;

Q1 PQOM

however, the majority were filled through internal or appropriately approved external locum cover. A small number of middle-grade triage gaps remained uncovered across the quarter, which should continue to be monitored through divisional workforce governance and escalation processes.

Overall, the Quarter 1 findings provide substantial assurance that the service is compliant with the relevant expectations of Maternity Incentive Scheme Year 8, with consultant presence and locum governance arrangements in place and supported by evidence. The report also demonstrates an appropriate governance response to areas requiring improvement, with clear actions, owners and timescales. Continued monitoring through Quarter 2 should focus on sustaining compliance above the 80% standard, evidencing implementation of the theatre and communication actions, strengthening documentation of consultant attendance, and maintaining oversight of any uncovered rota gaps and associated mitigations.

### **Planned Caesarean Section and Obstetric Theatre Capacity**

The annual maternity demand and capacity review has been completed in line with the requirements of Maternity Incentive Scheme Year 8 Safety Action 4, which requires Trust Board oversight of whether maternity services have the required staffing, theatre capacity and escalation arrangements to meet current and forecast demand safely.

The review identifies a sustained increase in obstetric theatre activity, with elective Caesarean sections increasing by 29% and emergency Caesarean sections by 42% since 2019/20. Forecast modelling indicates further growth during 2026/27, with projected demand of 1,116 planned Caesarean sections and 1,464 emergency Caesarean sections. Current theatre provision comprises one dedicated planned obstetric theatre operating Monday to Friday and one dedicated emergency obstetric theatre available 24 hours a day, supported by escalation arrangements for a third theatre when required.

The emergency obstetric theatre access continues to be maintained through established escalation processes, daily operational oversight and multidisciplinary governance review. However, the review demonstrates that current capacity is not sufficient to consistently meet planned demand without disruption. Thirty-six per cent of elective lists experienced at least one cancellation, and a third theatre was required on at least nine occasions during the year. Sixty-one incidents were linked to theatre capacity pressures, including nine occasions where alternative theatre environments were required because an obstetric theatre was unavailable.

The key residual risk is that increasing emergency activity, workforce constraints, recovery capacity and ward flow pressures continue to impact elective Caesarean section delivery, patient experience and staff experience. This is reflected in Risk #987, which remains open with a current risk score of 12.

Improvement work is underway and includes extended planned theatre hours, earlier patient review, complexity-based scheduling, recovery nurse recruitment, midwifery model redesign and strengthened daily oversight. These actions have improved flow and list efficiency; however, they do not fully mitigate the underlying gap between demand and capacity.

The Board is asked to note the findings of the annual review, recognise that current controls are supporting operational management of theatre demand, and acknowledge that these controls do not yet provide sustainable capacity for the projected level of planned and emergency Caesarean section activity. Continued oversight is required while sustainable theatre, recovery and workforce capacity options are developed. Further assurance will be provided through audit of decision-to-delivery performance, monitoring of cancellations and delays, review of patient experience impact, and continued oversight of the divisional risk and associated improvement plan.

### **Obstetric Anaesthetic Workforce**

Obstetric anaesthetic cover is consistently maintained due to the prioritisation of the obstetric anaesthetic on call. The rota remains a key dependency for emergency theatre access, planned Caesarean delivery and escalation capacity. This should be considered alongside the wider maternity theatre capacity and workforce resilience plan, including any requirement for an additional out-of-hours obstetric anaesthetic tier.

### **Neonatal Medical Workforce**

Neonatal medical workforce reporting indicates rota fragility, particularly in relation to night cover. Twenty-four rota gaps have been reported, including fourteen night-cover gaps. Early Quarter 2 intelligence indicates a further concentration of gaps in July, which should be monitored as a specific risk indicator.

A risk remains recorded on the Trust risk register regarding neonatal medical workforce compliance with British Association of Perinatal Medicine standards. This supports continued executive oversight of neonatal medical capacity, rota resilience, national standard compliance and the effectiveness of mitigating actions through the neonatal workforce plan.

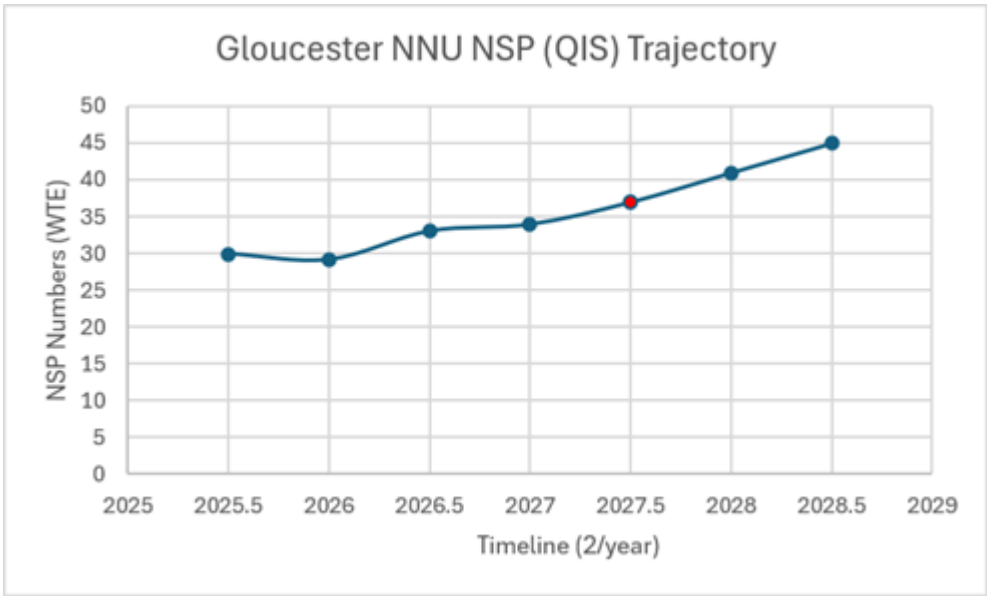
Quarter 2 reporting should begin to strengthen neonatal medical rota gap oversight through a more consistent monthly tracker, supported by a named neonatal medical workforce lead. Reporting should set out the available evidence on rota gaps, cover arrangements, escalation themes and any known impact on dependency levels, cot capacity, staffing-related transfers, incidents, training or temporary staffing use.

### **Neonatal Nursing Workforce**

Neonatal nursing fill rates are currently reported at 70% and should be interpreted alongside acuity and SafeCare data. Staffing decisions are adjusted according to acuity, and there were no neonatal unit closures, cot closures or transfers due to workforce pressures during Quarter 1. This provides assurance that operational capacity was maintained during the reporting period.

However, the underlying workforce risk remains significant. Risk 482 remains open in relation to the ability to ensure adequate numbers of trained staff, particularly Qualified in Specialty staff, in line with British Association of Perinatal Medicine standards. At the end of June 2026, neonatal nursing vacancies totalled 13.73 WTE, predominantly at Band 5 level. A further 5.4 WTE Band 5 staff have been recruited, although start dates remain unconfirmed. Qualified in Specialty compliance remains at 57%, below the expected standard. Four staff are scheduled to undertake specialist training in September and December 2026.

Quarter 2 reporting should set out the available evidence on neonatal workforce risks and identify any gaps in current data capture, including rota gaps, vacancy trajectory, Qualified in Specialty recovery, acuity and SafeCare triangulation, and any known staffing-related impact on cot capacity, transfers or dependency mismatch. This will support development of a more consistent neonatal workforce dataset through the neonatal workforce plan and ongoing oversight of Risk 482.



## Training

### Risk updates

Quarter 1 training assurance has improved through implementation of trajectory-based monitoring (please see below charts). Fetal Monitoring and Neonatal Resuscitation provide the strongest assurance and all multidisciplinary simulation requirements have been completed. Residual risk

remains within PROMPT compliance, rotational medical workforce validation and sustainability of reporting processes. Overall assurance is assessed as Amber with active recovery plans in place to ensure the trajectories meet the 90% required compliance by November 2026..

## Summary

Governance oversight, trajectory monitoring and recovery plans are established as recommended within MIS Year 8, with improving assurance across key training domains. Fetal Monitoring and Neonatal Resuscitation demonstrate the strongest performance, whilst PROMPT remains the principal area requiring further recovery. Medical staff have now been scheduled onto the remaining PROMPT and Fetal Monitoring training days. This will ensure that all new rotational medical staff and those who will be out of compliance will be trained and in date.

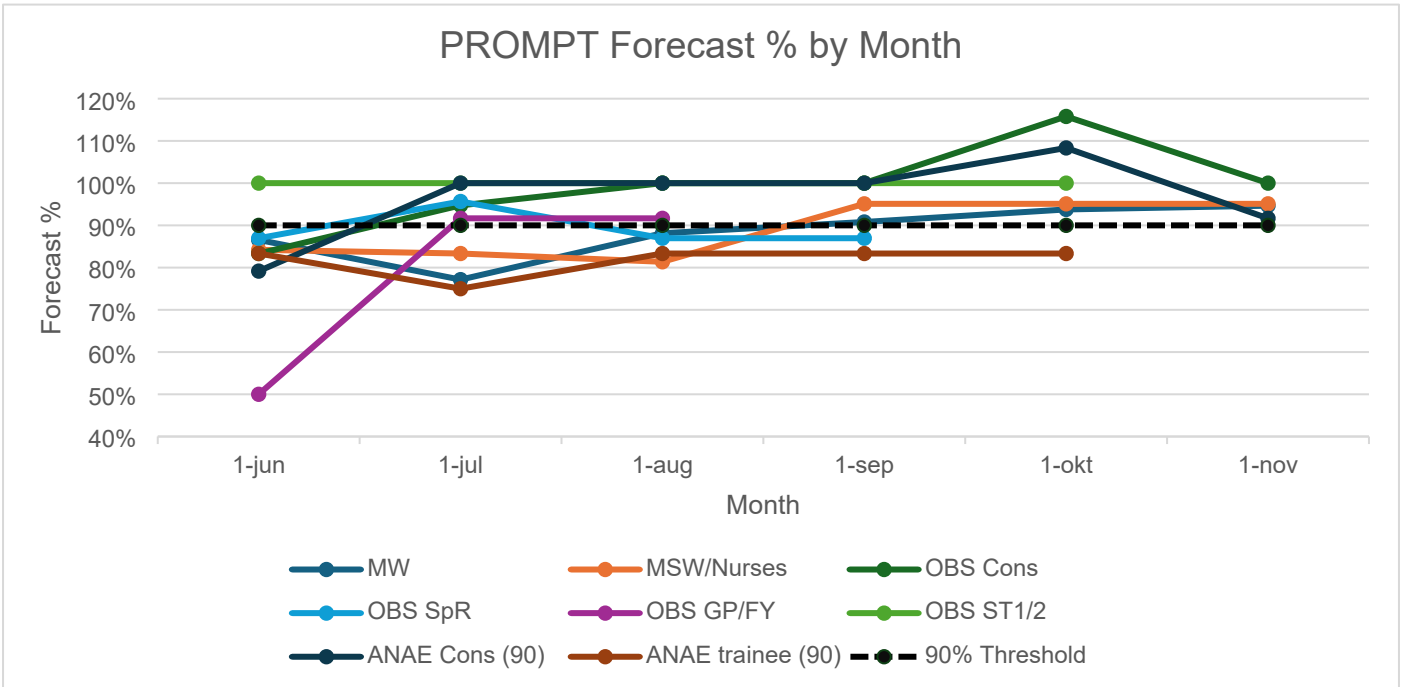
Quarter 1 training assurance demonstrates that the Trust has strengthened oversight of training through monthly trajectory monitoring, established multidisciplinary training programmes and improved governance through the Education and Training Forum, Perinatal Operational Assurance and Quality reporting, Perinatal Delivery Group and Board reporting routes. The Training Needs Analysis remains aligned to the Core Competency Framework Version 2 and annual multidisciplinary maternity training is established. Compliance trajectories show improvement in several key domains, particularly fetal monitoring and neonatal resuscitation, with neonatal resuscitation compliance recovering from approximately 79% in April 2026 to above the 90% benchmark by May 2026 and forecast to remain between 95% and 100% for neonatal nursing staff throughout the remainder of the reporting period.

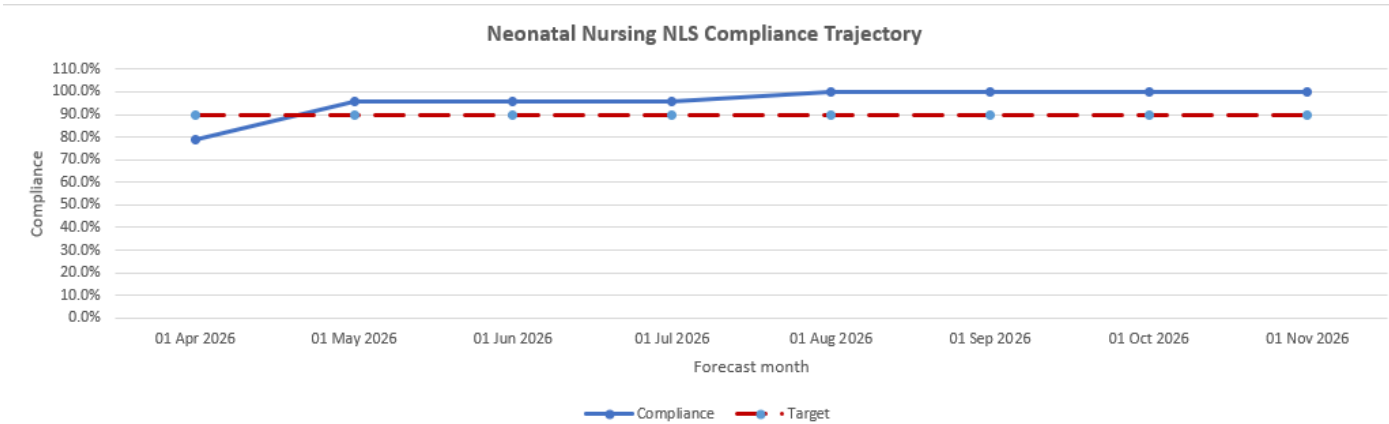
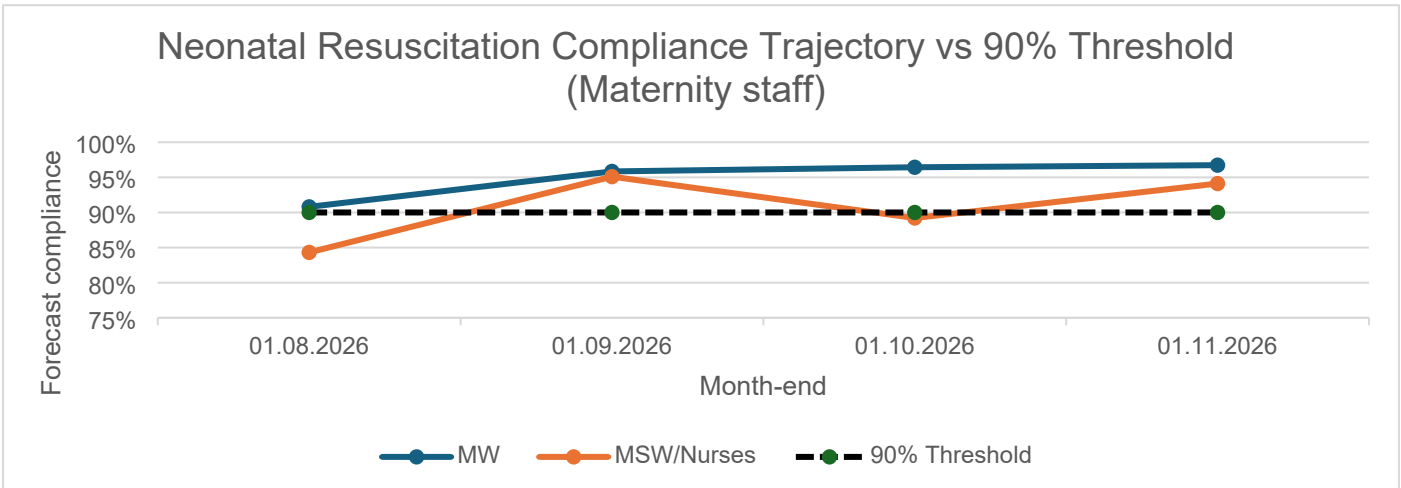
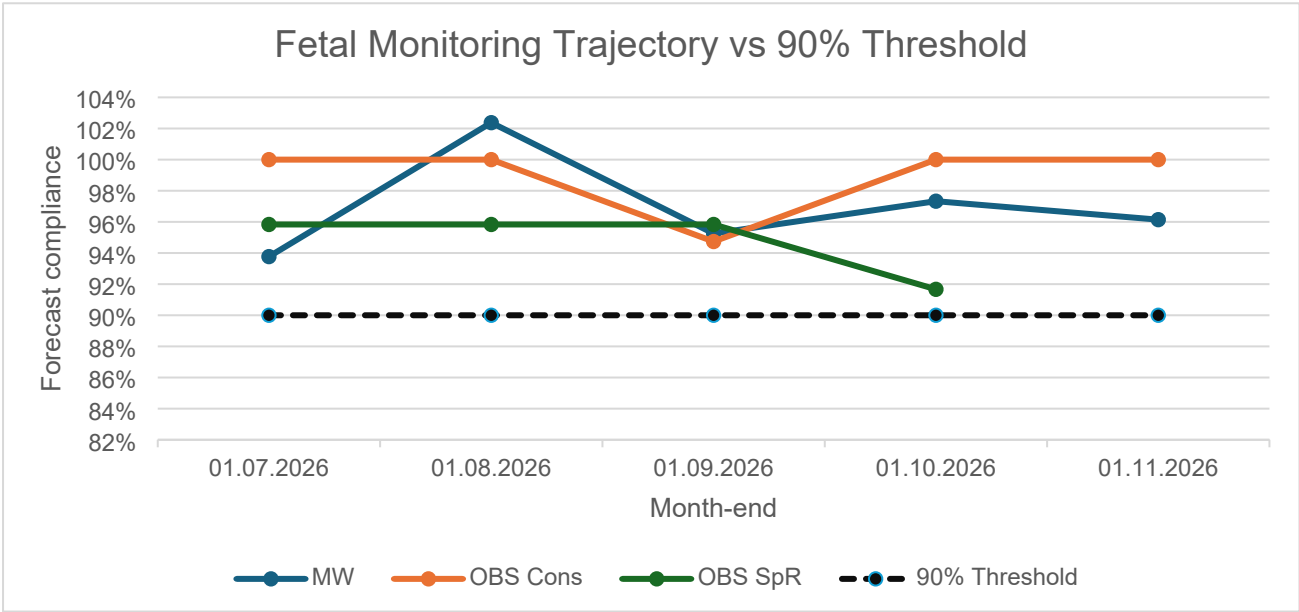
The principal residual risk relates to sustaining compliance above the 90% benchmark during Quarter 2, particularly for Practical Obstetric Multi-Professional Training, obstetric, neonatal and anaesthetic medical cohorts affected by planned workforce rotations. This is an anticipated workforce effect rather than a training delivery failure, but it requires active oversight because delays in validating incoming staff training records, releasing staff for training or maintaining recovery capacity could reduce assurance against Safety Action B. All obstetric medical staff have now been booked onto the remaining Practical Obstetric Multi-Professional Training days before November 2026. Two anaesthetists have outstanding training requirements and plans are in place to book them onto one of the four remaining Practical Obstetric Multi-Professional Training days before November 2026. Plans for Neonatal Life Support recovery are being worked through jointly with the Neonatal Specialty Lead and the Lead Midwife for Training and Education. Additional risk remains in relation to the current absence of a sustainable digital solution for whole-divisional training oversight, with reporting still reliant on manual reconciliation. Business Intelligence support has been engaged, and an update is expected at the end of August 2026.

Safeguarding training provides Amber assurance, with Level 3 compliance gaps across both children's and adults' safeguarding, particularly within medical staff groups. Targeted recovery, completion of the medical safeguarding training needs analysis and clear exception reporting are required to demonstrate improvement. The wider training governance position is improving, with

trajectory monitoring embedded and dashboard development being explored, but full assurance is dependent on a named Safety Action B lead, validated training dashboard, robust administrative support and consistent escalation where any staff group falls below trajectory.

Overall, the Quarter 1 position provides developing assurance. There is evidence of strengthened control, improved visibility of compliance risk, completed multidisciplinary simulation activity, embedded in-situ skills drills and integration of Avoiding Brain Injury in Childbirth impacted fetal head training within PROMPT. The Board is asked to note the improved trajectory, take assurance from the recovery of neonatal resuscitation compliance, acknowledge the residual risks associated with rotating medical cohorts and manual reporting, and require a Quarter 2 update demonstrating sustained compliance, validated medical workforce training records, progress with dashboard development and evidence that recovery actions are maintaining compliance with Maternity Incentive Scheme Year 8 Safety Action B.







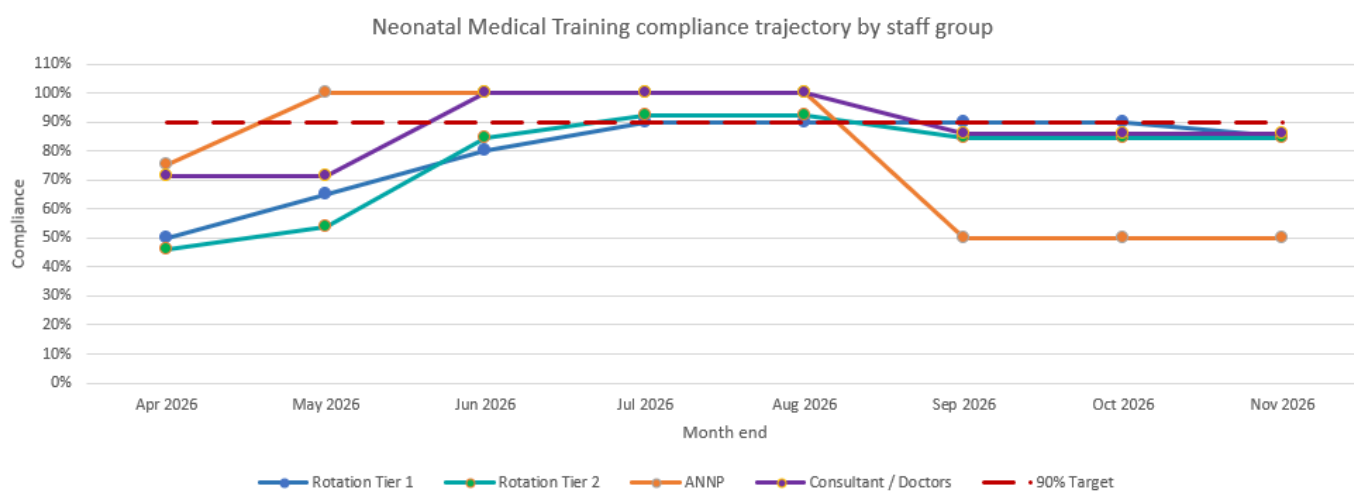
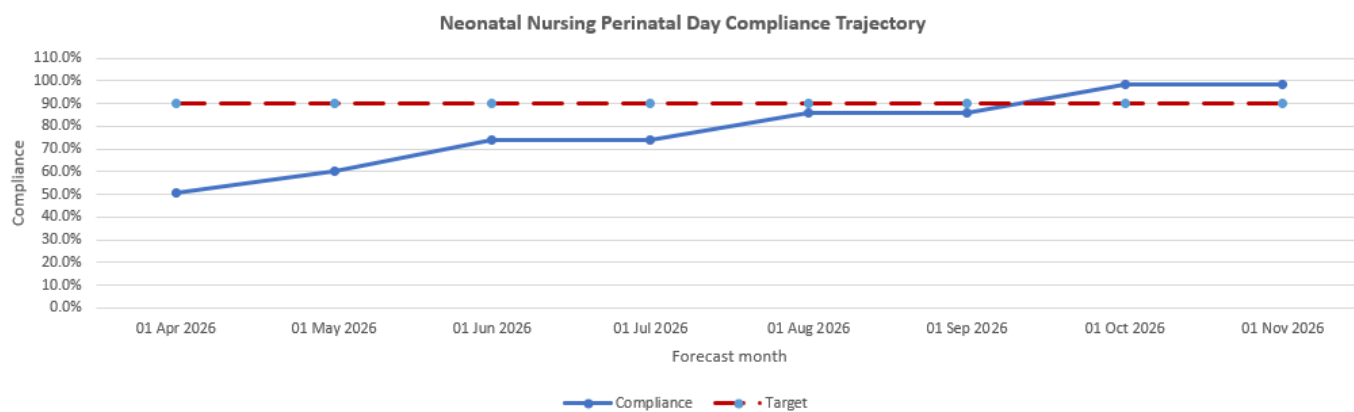


Table: Training and Competency assurance

| Training domain                                                                       | Staff groups in scope                                                                                                                                                                                   | Current position / compliance                                                                                                                                                                                                                                                                                                                                                                                                                 | Safety or assurance risk                                                                                                                                                                                                    | Recovery action / current control                                                                                                                                                                                                            | Evidence required for assurance                                                                                                         | Assurance rating | Next Committee requirement                                                                                                                                |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fetal monitoring training</b>                                                      | Midwives, obstetric consultants, obstetric registrars and all staff with antenatal or intrapartum fetal surveillance responsibility.                                                                    | June data: midwives 89%; obstetric consultants 88%; obstetric registrars 88%. All groups remain below the 90% threshold. Projections now completed and all groups are projected to be >90% July-November                                                                                                                                                                                                                                      | Reduced assurance would arise if staff involved in fetal surveillance, interpretation and escalation do not maintain current competence. Workforce rotations and staff expiry remain ongoing risks if not actively managed. | Continue trajectory-based monitoring, prioritised booking of staff approaching expiry, validation of medical workforce training records and monthly governance review through Education & Training Forum and maternity governance processes. | Validated compliance by staff group; recovery trajectory; exception report; evidence of action where compliance dips.                   | Red              | Confirm whether all required staff groups are on trajectory to achieve and sustain 90% compliance at the declared checkpoint.                             |
| <b>Practical Obstetric Multi-Professional Training / maternity emergency training</b> | Midwives, maternity care assistants and nurses, obstetric consultants, obstetric registrars, junior doctors, anaesthetic consultants, anaesthetic trainees and relevant theatre or perioperative staff. | June data: midwives 80%; maternity care assistants/nurses 83%; obstetric consultants 89%; obstetric registrars 88%; Obs GP/FY: 50%; anaesthetic consultants 76%; anaesthetic trainees 82%. Following projection work, we have assurance that our larger staff groups will achieve >90% compliance. Obstetric and anaesthetic trainee compliance remains subject to confirmation following rotation and transfer of training evidence (August) | Reduced assurance of multi-professional emergency preparedness, teamworking, escalation and human factors training.                                                                                                         | Additional training provision, focused booking activity, trajectory monitoring, prioritisation of rotational staff, workforce release, and validation of incoming trainee compliance with departmental leads                                 | Compliance by staff group, validated trainee records, recovery trajectory to 90%, attendance plans and evidence of governance oversight | Red              | Receive validated compliance position for incoming obstetric and anaesthetic cohorts and evidence of recovery trajectory to sustain compliance above 90%. |
| <b>Neonatal resuscitation and airway capability</b>                                   | Midwives, neonatal consultants, neonatal medical staff, neonatal nurses and any staff who may act as an unsupervised first attender or primary resuscitator.                                            | June data shows:<br>Midwives 94%<br>Neonatal nursing 96%<br>Neonatal Medical:<br>Neonatal consultants 100%<br>Junior doctors Tier 1: 80%<br>Junior doctors Tier 2: 85%<br><br>improving assurance and positive recovery following NLS reset activity. Training recovery continues and trajectories indicate improved compliance.                                                                                                              | Reduced assurance would arise if staff involved in neonatal airway management do not maintain current competence                                                                                                            | Continue neonatal resuscitation recovery programme, agree sustainable arrangements for neonatal training data capture. Agree sustainability plan for trainers                                                                                | Compliance by staff group, competency assessment records, certification evidence, exception reporting and sustainability plan           | Green            | Confirm neonatal compliance data and sustainability plan before first quarter one sign-off.                                                               |
| <b>In-situ multi-professional maternity emergency simulation</b>                      | Midwifery, obstetric, anaesthetic, neonatal, theatre and relevant wider teams depending on scenario.                                                                                                    | All multidisciplinary simulation requirements for MIS Year 8 Safety Action B have been completed. This provides additional positive                                                                                                                                                                                                                                                                                                           | Without structured debrief and action tracking, simulation learning may fail to translate into sustainable improvements in practice,                                                                                        | Continue simulation programme, capture debrief themes, identify actions, monitor completion and share learning through governance structure                                                                                                  | Simulation schedule; attendance record; scenario details; debrief themes;                                                               | Green            | Confirm learning has been embedded within training programmes and governance reporting                                                                    |

| Training domain                                                  | Staff groups in scope                                                                    | Current position / compliance                                                                                                                                                                                                                                                                                                                                             | Safety or assurance risk                                                                                                                                              | Recovery action / current control                                                                                                                                  | Evidence required for assurance                                                                                                              | Assurance rating | Next Committee requirement                                                                                                            |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  |                                                                                          | assurance that multidisciplinary emergency simulation requirements are being delivered and embedded.                                                                                                                                                                                                                                                                      | teamwork and escalation processes                                                                                                                                     |                                                                                                                                                                    | action log; evidence of learning shared and embedded.                                                                                        |                  |                                                                                                                                       |
| <b>Safeguarding training</b>                                     | Non-medical and medical staff according to role and training needs analysis.             | June data shows gaps at Level 3: Children Level 3 non-medical 88%, medical 77%; Adults Level 3 non-medical 86%, medical 80%.                                                                                                                                                                                                                                              | Gaps in higher-level safeguarding training may reduce assurance around recognition, escalation and management of safeguarding concerns.                               | Targeted recovery for Level 3 staff; finalise medical safeguarding training needs analysis; provide exception reporting.                                           | Compliance by level and staff group; training needs analysis; trajectory to 90%; exception report.                                           | Amber / Red      | Confirm trajectory to 90% and escalate any staff groups with persistent non-compliance.                                               |
| <b>Training governance, data quality and recovery trajectory</b> | All maternity, neonatal, obstetric, anaesthetic and relevant perioperative staff groups. | Training trajectory monitoring is now embedded within governance processes and has significantly strengthened oversight of compliance, forecast recovery and staff expiry risk. However, reporting remains heavily reliant on manual reconciliation between spreadsheets, ESR and workforce systems. Sustainable digital reporting solutions are currently being explored | Manual reporting processes increase the risk of delayed escalation, inconsistent assurance, administrative burden and difficulty evidencing compliance at Board level | Maintain trajectory monitoring, continue governance scrutiny, strengthen administrative support and progress BI/ESR reporting solutions and dashboard development. | Named Safety Action B lead, validated training dashboard, trajectory reports, exception reporting, governance review and escalation records. | Green            | Receive update on dashboard development, data validation processes, governance oversight and sustainability of reporting arrangements |

# Learning from Reviews & Investigations

Learning from reviews and investigations provides assurance that the Trust is identifying, understanding and responding to risks affecting women, babies and families. Triangulation across incidents, PMRT, MNSI, Early Notification cases, complaints, claims, audits and national reports enables recurrent themes to be identified, actions to be tracked, and learning to be translated into sustainable improvements in safety, quality, experience and equity.

The focus is not only on what happened, but on what has been learned, what has changed, and whether previous actions have improved outcomes.

## Reported Incidents

SPEN, MOSS, PMRT, MNSI, PSIRF findings, National reports

| Incident Type | Incident                                                              | What action has been implemented                                                                                                                   | Family views/DOC                                     | External reviewer            |
|---------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------|
| SPEN/PMRT     | Term Stillbirth                                                       | No care issues identified at initial MDT review.                                                                                                   | Parent perspectives received.                        | To be reviewed in August.    |
| SPEN/PMRT     | 24 weeks stillbirth with known fetal abnormalities.                   | Partogram not used in labour- learning shared within July 26 Bereavement newsletter.                                                               | Parent perspectives received.                        | Yes                          |
| SPEN/PMRT     | 24+5 weeks stillbirth                                                 | No care issues identified at initial MDT review                                                                                                    | Parents perspectives sought                          | To be reviewed in August.    |
| SPEN/PMRT     | Term Stillbirth                                                       | GDM not reviewed as per NICE guidance- staffing issues within team- escalated to Divisional Board, not felt to have contributed to the outcome.    | Parents perspectives sought                          | To be reviewed in September. |
| SPEN/MNSI     | Hypoxic Ischaemic Encephalopathy (HIE)/parental concerns (normal MRI) | CTG interpretation and escalation, - Supportive conversation and individualised learning. Inclusion of this case within fetal monitoring training. | MNSI supporting. Contact has been made with parents. | MNSI                         |

Quarter 1 learning themes indicate the need for continued focus on timely recognition and escalation, fetal monitoring interpretation, adherence to agreed clinical pathways, communication with women and families, documentation of consent and decision-making, and completion of duty of candour and debrief processes. Workforce pressures were also identified as a contributory theme in some reviews and should continue to be triangulated with incidents, complaints, PMRT findings, MNSI learning and audit outcomes.

### Perinatal Mortality Review Tool compliance assurance

Perinatal Mortality Review Tool compliance demonstrates that core review processes are in place for the Quarter 1 cases reviewed. Cases have evidence of external review arrangements, with Maternity and Neonatal Voices Partnership representation included. Parent and family engagement has been achieved in most cases, with parent perspectives either included within the review report, obtained through direct communication, or sought through documented attempts. One case records multiple attempts to engage with the family where contact was not achieved; this should remain recorded as a documented exception.

Communication of review outcomes to families is planned, mainly through consultant debrief, with one external case due to be shared by the external Trust. The key outstanding requirement is completion and tracking of family communication, action closure and evidence that learning has been embedded into practice. Continued oversight through the live Perinatal Mortality Review Tool tracker is required to confirm family engagement, external review input, communication of findings, action completion and learning impact.

Overall, the Quarter 1 PMRT position shows that review arrangements are established, with continued oversight required to ensure family feedback, action closure and embedded learning are completed and evidenced.

| PMRT Case                   | External Reviewer                                | MNVP Representative | Parental Engagement                                                     | Communication to family            |
|-----------------------------|--------------------------------------------------|---------------------|-------------------------------------------------------------------------|------------------------------------|
| 963181/1<br>(external case) | Yes- Midwife and Consultant                      | Yes                 | Yes- Parents perspectives included in report.                           | To be shared by external trust     |
| 101396/1                    | Yes- Midwife and Consultant                      | Yes                 | Yes- Parents perspectives included in report.                           | To be shared at consultant debrief |
| 102416/1                    | Yes x 2 Midwives, Maternity Improvement Advisor. | Yes                 | Yes- via text message included within the report                        | To be shared at consultant debrief |
| 102589/1                    | Yes -Midwife                                     | Yes                 | Multiple attempts made to engage with family, unable to contact.        | To be shared at consultant debrief |
| 102782/1                    | Yes- Midwife                                     | Yes                 | Parent asked for their perspectives several times, verbal update given. | To be shared at consultant debrief |

### Perinatal Mortality Review Tool Improvement Action Plan progress

The improvement action plan is the mechanism for addressing the outstanding requirements identified through the PMRT assurance review, particularly the need to strengthen action tracking, documentation, parental engagement oversight and evidence that learning has been embedded. The Perinatal Mortality Review Tool Improvement Action Plan was developed in response to the BDO internal audit findings and provides a structured programme to strengthen governance, documentation, parental engagement tracking, action management and evidence of embedded learning. The plan also supports clearer alignment between PMRT reviews, patient safety investigation processes, MNSI, PSIRF and wider maternity governance arrangements.

Several immediate governance controls have already been strengthened. Review of actions and confirmation of quoracy have been added as standing items within Perinatal Mortality Review Tool review meetings, with the standard operating procedure updated to reflect these requirements. A parental engagement tracker is also in place and overseen by the Deputy Perinatal Quality and Governance Lead, providing improved visibility of family contact, offers of follow-up discussion and sharing of review outcomes. These actions provide early assurance that key governance weaknesses are being addressed.

Key actions remain in progress, including completion and approval of the revised Perinatal Mortality Review Tool standard operating procedure, implementation of periodic Datix audit checks, alignment of related governance documents, and review of neonatal consultant capacity to support timely and effective multidisciplinary review.

Progress of the audit action plan will be monitored through SERG, with updates escalated through perinatal governance routes as required.

**Maternity Safety Roundups: Learning themes for Quarter 1 (data included from Claims Scorecard 2015-2025, PMRT, MNSI, MNVP feedback, and complaints for Q1)**

| Theme                  | SMART action/improvement                                                                                                                                                                                                                                                   | Responsible Lead                                                                   | Target date for completion |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|
| Recognise and escalate | Complete a targeted review of Quarter 1 incidents involving delayed escalation, including massive obstetric haemorrhage, sepsis, pain concerns and fetal monitoring, and identify the top three contributory factors for shared learning. Findings to be presented through | Deputy Perinatal Quality and Governance Lead/Perinatal Quality and Governance Lead | 30th September 2026        |

|                                            |                                                                                                                                                                                                                                                                                                |                                                                                 |                     |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------|
|                                            | maternity governance with agreed actions.                                                                                                                                                                                                                                                      |                                                                                 |                     |
| CTG reviews and uterine activity awareness | Include the Quarter 1 fetal monitoring case learning within fetal monitoring training and safety huddles, with evidence of attendance and staff feedback collected. Compliance and learning impact to be reviewed through the fetal monitoring forum.                                          | Fetal Monitoring Lead<br>Midwife/ Fetal Monitoring Lead<br>Obstetric Consultant | 30th September 2026 |
| Maternal observations and sepsis awareness | Undertake a documentation and escalation audit of 20 maternity records where maternal observations or sepsis screening were indicated, to assess completion of observations, escalation and response times. Findings to inform targeted teaching and be reported through maternity governance. | Consultant Midwife                                                              | 30th September 2026 |
| Listening to women reporting pain          | Develop and share a one-page learning brief on listening to women and escalating concerns about pain, using anonymised complaint and incident themes. Evidence of dissemination to be captured through ward safety huddles and newsletter circulation.                                         | Birth Review and Reflect Coordinator and Consultant Midwife                     | 30th September 2026 |

|                                              |                                                                                                                                                                                                                                                                                               |                                                                                                |                                 |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------|
| Closed-loop communication during emergencies | Add closed-loop communication as a specific learning objective in emergency simulation scenarios, with debrief themes captured and reviewed quarterly to identify improvements in team communication and escalation.                                                                          | Training and Education Lead<br>Midwife and Training and Education Lead<br>Obstetric Consultant | 30th September 2026             |
| Communicating delays with patients           | Introduce a spot-check audit of 10 cases per month where delay occurred, including induction of labour, triage or theatre delay, to confirm whether communication with women and families was documented clearly. Results to be reviewed monthly and escalated where compliance is below 90%. | Matron team                                                                                    | 30th September 2026             |
| Consent and clinical documentation           | Audit 20 records across Quarter 2 to assess whether consent discussions, risks, benefits, alternatives and agreed plans are clearly documented for key interventions. Results to be shared with obstetric and midwifery leads with targeted feedback where gaps are identified.               | Consultant Midwife                                                                             | 30 <sup>th</sup> September 2026 |
| Professional duty of candour and debrief     | Review all Quarter 1 incidents requiring duty of candour or debrief to confirm that discussions were offered, documented and                                                                                                                                                                  | Deputy Perinatal Quality and Governance Lead/Perinatal Quality and Governance Lead             | 30 <sup>th</sup> September 2026 |



|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                    |                                 |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------|
|                                      | followed up. Any gaps to be added to the governance action tracker with named owners.                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                    |                                 |
| Following agreed pathways            | Undertake a focused audit of 20 Quarter 1 cases where pathway adherence was a contributory theme, including gestational diabetes follow-up, induction of labour, fetal monitoring, escalation and bereavement care. Findings should identify any variation from agreed guidance, confirm whether escalation occurred, and result in targeted learning with actions recorded on the governance action tracker.                                                           | Deputy Perinatal Quality and Governance Lead/Perinatal Quality and Governance Lead | 30 <sup>th</sup> September 2026 |
| System enablers and learning culture | Introduce a quarterly maternity learning summit or equivalent multidisciplinary review to triangulate incidents, complaints, Perinatal Mortality Review Tool findings, Maternity and Newborn Safety Investigation learning, claim's themes, staff feedback and service user voice. Outputs should include agreed learning priorities, named action owners, due dates and evidence of dissemination through safety huddles, newsletters, training and governance routes. | Deputy Perinatal Quality and Governance Lead/Perinatal Quality and Governance Lead | 30 <sup>th</sup> September 2026 |

## MOSS Alerts

There were no MOSS alerts received during Q1.

## Coroners Reports

No coroner's reports relating to maternity or neonatal services were received in Quarter 1. Ongoing monitoring will continue, with any future coronial correspondence, findings or required actions escalated through maternity governance, Quality and Performance Committee and Executive Board.

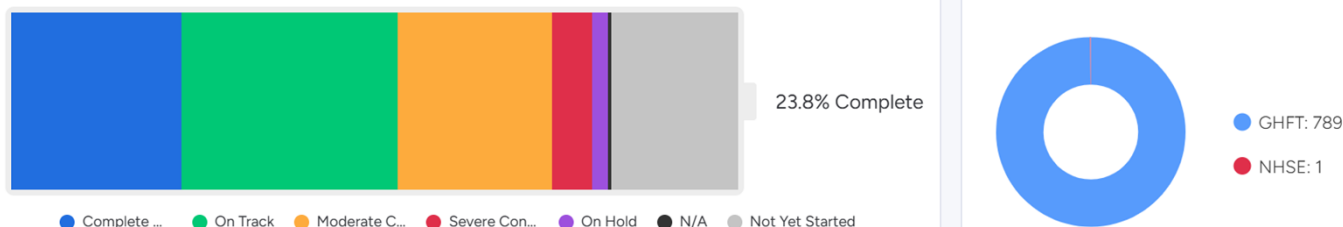
## Regulation 28 Report Issued

No Regulation 28 Reports to Prevent Future Deaths were received in Quarter 1. This provides assurance that no statutory coronial actions were issued to the Trust during the reporting period. Ongoing monitoring will continue, with any future reports escalated through maternity governance, Quality and Performance Committee and Executive Board.

## Perinatal Transformation Plan

This section provides an exception-based update on the Perinatal Transformation Plan using the Alert, Advise, Assure and Applaud approach. It highlights areas requiring escalation, actions in progress, developing assurance and progress delivered during the quarter.

Summary: The Perinatal Transformation Plan is progressing, with launch activity completed and several key workstreams moving forward. The main areas requiring continued oversight relate to maternity experience improvement, Maternity Incentive Scheme Board reporting, triage redevelopment, culture plan refresh, interim triage staffing and completion of outstanding Ockenden 2 close-down evidence. The Alert, Advise, Assure and Applaud approach provides a clear exception-based view of progress, risks and next steps, with further assurance expected through PTP Board, PDG and wider governance routes.



### Alert

**Maternity experience improvement plan actions remain Red-rated pending review and refresh of action plan following leadership changes and recent CQC feedback.**

**Action being taken:** The Consultant Midwife is reviewing the Maternity Experience improvement plan and Safety Action D evidence requirements, including service-user

feedback, complaints, reasonable adjustments, interpretation support and Board assurance evidence. The updated position will return to the next PTP Board.

**Delays to the Infant Feeding Champions programme.**

**Action being taken:** Infant Feeding Leads will be asked for a further update on funding and course arrangements for MSWs. Workforce impact and backfill requirements will be reviewed by the Deputy Director of Midwifery before MCAs/MSWs are released to attend training.

**Maternity Incentive Scheme board reporting remains at risk until the first quarterly report and template have completed governance review and Trust Board reporting.**

**Action being taken:** The quarterly Board report template and data requirements are being finalised. The Quarter 1 report is planned through PDG in August and Trust Board in September, reflecting recent mobilisation of safety action leads, with retrospective divisional governance review.

**Triage redevelopment remains partly delayed, particularly the clinical space element, due to ventilation and air-handling prioritisation.**

**Action being taken:** Office works and CCTV installation are progressing. The clinical area remains under review while ventilation requirements are prioritised. Further review will continue through estates and the PTP action log until the works are complete.

**The culture plan requires six-monthly QPC review and has been delayed with last update in October 2025 due to review of the plan.**

**Action being taken:** The Chief of Service will confirm the revised culture plan, timeline and route for QPC review, with progress tracked through Monday.com. This has been included in the Q1 PQOM report for noting.

**Interim Triage Midwifery staffing requires VCP approval to meet national standards.**

**Action being taken:** Director of Operations to review the VCP and confirm interim staffing arrangements against national triage standards.

**Advise**

**Quarterly workforce and training reporting arrangements are being established.**

**Action being taken:** Templates are being finalised, with the first quarterly report delayed but expected in August. BI support has been identified to produce SPC charts for training.

**Workforce dashboard development has been deferred while minimum MIS evidence requirements are prioritised.**

**Action being taken:** Deputy Director of Midwifery is prioritising evidence required to meet the minimum MIS requirements. The dashboard is expected to follow later, with retrospective Quarter 1 data to be included once the Quarter 2 dashboard/reporting arrangement is developed.

**Benchmarking against national maternity care bundles and triage standards is underway.**

**Action being taken:** Benchmarking has commenced with relevant clinical leads and has been added to Clinical Effectiveness governance. The detailed Safety Action E position will be reported through the separate Safety Action E paper. Completion of the benchmarking

review is expected by 1 September, with any workforce or pathway implications escalated through PTP Board and perinatal governance.

### **Assure**

**PTP Launch Week took place from 20–24 July, with staff engagement events, supporting communications and an intranet page established to support ongoing access to materials.**

**Action being taken:** Additional resources and communications will be added to the intranet page, with wider staff communication planned by 14 August. Service-user communications are being developed, with quarterly updates to continue.

**Ockenden 2 is being reviewed to close down action plan in preparation for new reports.**

**Action being taken:** Outstanding evidence is being collated with action owners to enable closure, transfer of any residual actions into PTP Phase 1, and completion of a close-down report.

### **Applaud**

Thanks were noted for the colleagues who supported PTP Launch Week, staff engagement events and the development of supporting communications. Their work has helped build visibility, momentum and shared ownership of the Perinatal Transformation Plan.

## **Service-User Voice & Equity**

Compliance with Safety Action D – Service-user voice and equity provides assurance that maternity and neonatal services are clinically safe, accessible, inclusive and responsive to the needs of the population served.

### **Establishment of Perinatal Listening and Learning Group**

Following the appointment of the new Consultant Midwife, the current maternity patient experience meeting will be revised into a Perinatal Listening and Learning Group. The group will be co-chaired by the Consultant Midwife and MNVP Lead, with representation from midwifery, obstetrics, neonatal services, patient experience and safety, and community engagement.

The group will triangulate patient experience intelligence from complaints, incidents, Birth Review and Reflect, Friends and Family Test feedback, community engagement events, MNVP feedback and regulatory surveys. It will also review the accessibility of patient information, including the availability of alternative formats and interpreting services.

The inclusion of the Trust's Community Engagement and Involvement Officer will support engagement with communities who may be less likely to provide feedback through existing channels.

The group's primary output will be a dynamic Listening and Learning Plan, translating thematic findings into prioritised interventions with clear ownership and timelines. MNVP involvement from the outset will support meaningful co-production. The plan will be:

- **Thematic** — organised around the key domains of experience emerging from the data.
- **Prioritised** — reflecting the severity and frequency of concerns, with particular attention to health inequalities, access and equity.
- **Accountable** — with named leads for each action and regular progress reporting to the group.
- **Transparent** — shared with service users, governance committees and external partners to close the loop between feedback and response.

The group will retain oversight of the plan, reviewing progress at each meeting and adjusting priorities as new data emerges. This cycle of listening, learning and action will support a more responsive and inclusive approach to improving experience.

The first meeting is planned for September 2026. The group will meet monthly, with upward reporting to POAM.

Summary: The proposed Perinatal Listening and Learning Group will provide a clearer route for triangulating service-user feedback, equity themes, complaints, incidents and community engagement intelligence. Its focus will be on converting feedback into co-produced, prioritised and measurable actions, with oversight through POAM and wider perinatal governance.

### **Maternity and Neonatal Voices Partnership Update**

The Maternity and Neonatal Voices Partnership continues to strengthen the service-user voice across maternity and neonatal governance. During Quarter 1, the Partnership has increased its visibility across Trust and Integrated Care Board forums, contributed to Patient Safety Champion meetings, and engaged with regional and national learning, including the South West MNVP Network, a 15 Steps learning visit with Somerset colleagues, and work linked to Avoiding Brain Injury in Childbirth and intrapartum fetal deterioration.

A key area of progress is engagement with communities who may be less likely to provide feedback through traditional routes. The Partnership has built relationships with community groups including Black Mothers Matter, Lives of Colour, Moments of Motherhood, Traveller communities, Polish community groups, Gloucestershire Deaf Association, faith groups and doulas. The new Engagement and Volunteer Officer, expected from September 2026, should further strengthen capacity to recruit and support volunteers and broaden the reach of service-user engagement.

Feedback from unit visits, community engagement and online surveys identifies both positive experience and areas for improvement. Positive themes include community midwifery, personalised care, smaller and quieter units, the Stroud care model, feeding support and neonatal

care. Areas requiring continued focus include communication, informed choice, access to birth options, dignity, consent, emotional safety, staffing pressures and coordination between maternity and neonatal teams. These themes will be triangulated through the Perinatal Listening and Learning Group alongside complaints, incidents, Friends and Family Test feedback, audit findings and workforce data.

The Partnership has refreshed its online feedback surveys to improve accessibility and engagement. Since January 2026, 33 survey responses have been received, with increased activity in April and May. A new infant feeding survey launched in June has identified early feedback about variation in antenatal feeding advice and a preference for flexible postnatal support, including home-based and digital options. This will inform the Listening and Learning Plan and planned collaboration with the Specialist Infant Feeding, Midwifery and Health Visiting teams. Overall, the Quarter 1 MNVP update demonstrates growing service-user engagement and stronger links between feedback, equity intelligence and safety governance. The next step is to ensure these insights are systematically captured through the Perinatal Listening and Learning Group and translated into prioritised, co-produced actions with clear ownership and reporting through POAM.

Interpreter access has been identified as a specific equity and accessibility theme for further review, alongside wider work to strengthen service-user voice and inclusive communication.

Use of Interpreters

Quarter 1 BadgerNet data has been reviewed to assess recording of primary language and interpreter requirements. Variation in recording means the data does not yet fully show whether communication needs are being consistently identified and documented.

This is an initial data-quality and equity finding. Reliable recording of language and interpreter need supports informed choice, consent, personalised care and equitable access. Findings will be considered through the Perinatal Listening and Learning Group alongside complaints, MNVP feedback, Birth Review and Reflect themes and community engagement intelligence.

|       | Women<br>booked in<br>period | Primary<br>language not<br>recorded | Primary<br>language not<br>English | Primary language<br>not English,<br>interpreter<br>requirement not<br>recorded |
|-------|------------------------------|-------------------------------------|------------------------------------|--------------------------------------------------------------------------------|
| Total | 1598                         | 109                                 | 182                                | 38                                                                             |

The data provides evidence that women are being offered and using interpreters within the service, however there is also evidence of inconsistency in recording this offer and usage between areas within the service.

|                      | Care contacts<br>with women<br>requiring an<br>interpreter in<br>period | Interpreter not<br>used at contact | Use of<br>interpreter not<br>recorded |
|----------------------|-------------------------------------------------------------------------|------------------------------------|---------------------------------------|
| Antenatal Assessment | 304                                                                     | 77                                 | 139                                   |
| Assessment Unit      | 140                                                                     | 47                                 | 65                                    |
| Communications       | 155                                                                     | 11                                 | 121                                   |
| Postnatal Assessment | 124                                                                     | 17                                 | 91                                    |
| Specialist Review    | 358                                                                     | 15                                 | 311                                   |
| Total                | 1081                                                                    | 167                                | 727                                   |

Following review of this data, the maternity digital team is exploring solutions to make information about language and requirement for interpreter a mandatory field in BadgerNet, which will address the “not recorded” categories. The findings from this review will be shared with the community midwifery teams and the obstetric teams to improve data entry in these fields.

A poster and information campaign to be shared with staff is planned for the next quarter about when and how to use interpreters in the service.

**Patient Information and Accessibility**

A plan is in place to review the current patient information and accessibility of patient information, easy read, top 4 languages, Bengali, Romanian, Pashto, Turkish and Arabic, local to Gloucester. An initial benchmarking will have been completed by Q2 with essential information available frequently required for example induction of labour.

Care bundles

The Maternity Care Bundle and Saving Babies’ Lives Care Bundle Version 3.2 are important indicators of safety and quality because they show whether evidence-based interventions are being delivered reliably in practice. Monitoring compliance, exceptions and improvement actions provides assurance that national standards are being implemented, risks are identified early, and learning is translated into safer care for women and babies.

## Saving Babies Lives Version 3.2

Previous Saving Babies' Lives trajectories were agreed locally with the Local Maternity and Neonatal System, reflecting service configuration, population need and governance arrangements at that time. Following the merger with Bristol, North Somerset and South Gloucestershire, and the appointment of a new Director of Midwifery, these trajectories will be reviewed and refreshed through local maternity governance.

This will ensure future trajectories are locally agreed, aligned to revised system arrangements, reflective of current service priorities, and able to provide clear assurance on progress, delivery and improvement.

|                                                               | % of interventions fully implemented | Areas of focus required                                                                                                                                                                                                                                                                                                                                                                | Action                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Element 1: Reducing smoking in pregnancy</b>               | 90%                                  | <p>CO measurement at 36 weeks currently 92% (National target 95%)</p> <p>Percentage of smokers that have an opt-out referral at booking to an in-house/in-reach tobacco dependence service currently 88% (National target 95%)</p> <p>Percentage of smokers that set a quit date and are identified as CO verified non-smokers at 4 weeks currently at 44.4% (National target 60%)</p> | <p>Targeted education for community, maternity day assessment, triage and antenatal clinic regarding CO screening</p> <p>Education for community midwives regarding opt out referrals at booking</p> <p>Treating Tobacco Dependency Lead to continue failsafe checks to ensure all smokers are referred to tobacco dependency service</p> |
| <b>Element 2: Fetal Growth: Risk Assessment, Surveillance</b> | 90%                                  | Percentage of pregnancies where an SGA fetus (between 3rd to <10th centiles) is antenatally detected - audit awaited                                                                                                                                                                                                                                                                   | <p>The current Q1 audit findings are awaited</p> <p>Monthly meeting to be scheduled to review audit findings monthly for oversight and action</p>                                                                                                                                                                                         |



|                                                                             |      |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                             |      | Women risk assessed as high risk for fetal growth restriction where uterine artery dopplers were not requested currently at 67.9%                                                                                                                                   | Deputy Director of Midwifery working with community leads regarding uterine artery doppler requests                                                                                                                                                                              |
| <b>Element 3:<br/>Raising Awareness of Reduced Fetal Movement</b>           | 50%  | Proportion of women who attend with recurrent RFM who had an ultrasound scan by the next working day to assess fetal growth 38.8% (National target 80%)                                                                                                             | Ultrasound QI ongoing<br>Midwife sonographer development is progressing, with three currently in post, two in training and a further three due to commence training in January 2027<br>A new obstetric ultrasound space has been established at CGH to support service capacity. |
| <b>Element 4:<br/>Effective Fetal Monitoring During Labour</b>              | 100% | Staff training compliance for CTG interpretation, intermittent auscultation, human factors, situational awareness and completion of mandatory annual competency currently under the 90% required compliance figure (see training trajectory within Safety Action B) | Training projections place the MDT on track to be above 90% compliant with Fetal Monitoring training and competency by November 2026                                                                                                                                             |
| <b>Element 5:<br/>Reducing Preterm Births and Optimising Perinatal Care</b> | 100% | Following meeting with Heath Innovation South-West, data quality on Badgernet requires review                                                                                                                                                                       | Monthly PeriPrem meeting to be arranged with leads, data cleansing by the digital team to focus targeted improvement areas                                                                                                                                                       |
| <b>Element 6:<br/>Management of Pre-existing</b>                            | 100% | Compliant with no concerns                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                  |

|                       |  |  |  |
|-----------------------|--|--|--|
| Diabetes in Pregnancy |  |  |  |
|-----------------------|--|--|--|

## Maternal Care Bundle Implementation Plan

The initial benchmarking exercise against the Maternal Care Bundle is currently underway and is expected to be completed by 1 September 2026. This work will establish the current position against each element and inform any required improvement actions. At this stage, full implementation of the Maternal Care Bundle remains on trajectory for completion by March 2027.

|                                                | Current position                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Element 1: Venous thromboembolism (VTE)</b> | <p>Self-assessment questionnaire on VTE on antenatal referral forms in place</p> <p>Pathways for early prescription of low molecular weight heparin currently being reviewed with ICB</p> <p>Initial audit completed into early low molecular weight heparin for women who have risk factors for VTE</p>                                                                                                                                                                                                                                                                                                                       |
| <b>Element 2: Pre-hospital and acute care</b>  | <p>National MEWS embedded within maternity and ED with further role out planned across the trust with support from ED consultant and deteriorating patient lead for the Trust (paper form at present)</p> <p>Maternity Guideline in place but needs to include Trust-wide processes</p> <p>Pre-alert system in place with ambulance service and red phone</p> <p>Review of signage currently being arranged with Lead Midwife for SWAST and Labour Ward Matron</p> <p>Maternal Medicine Referral Pathway action card in place – to review process from all acute settings and to review with the Maternal Medicine Network</p> |
| <b>Element 3: Epilepsy in Pregnancy</b>        | <p>Initial regional benchmarking tool completed showing 49% compliance - MDT meeting being arranged with lead epilepsy nurse, perinatal quality and governance lead and maternal medicine lead consultant</p>                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Element 4: Maternal Mental Health</b> | <p>Initial benchmarking completed by the maternal mental health leads (obstetric and midwifery)</p> <p>Current practice is partially aligned with Maternity Care Bundle Element 4 but does not yet meet all recommended requirements. Women are currently asked the Whooley questions at booking, and emotional wellbeing is discussed during routine community midwifery appointments; however, this is not self-administered ahead of key antenatal and postnatal contacts as recommended.</p> <p>Badgernet does not currently support the Edinburgh Postnatal Depression Scale, meaning the service is not compliant with the requirement for a standardised follow-up assessment where concerns are identified. There is also no formally allocated additional appointment time within routine community midwifery or general antenatal clinic pathways to support compassionate conversations, care planning, or referral for women with emerging or lower-level mental health needs. Feedback on women's experience of mental health conversations in community midwifery is not routinely captured.</p> <p>Next steps have been identified by the leads for implementation.</p> |
| <b>Element 5: Obstetric haemorrhage</b>  | <p>PPH Guideline in place, required additions identified</p> <p>Additional audit requirements identified, to be commenced and presented at intrapartum forum</p> <p>All 2L and above bleeds reviewed weekly in line with maternal care bundle requirements, 94% of cases reviewed within the 28-day period specified</p> <p>ROTEM and guideline in place</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

### Neonatal Pulse Oximetry

Neonatal pulse oximetry testing launched on 1 June 2026 under guideline A2342, with an initial audit planned for Quarter 2. The audit will provide early assurance on implementation, documentation and any learning required to embed the pathway reliably.

# Board Oversight, Governance, Culture & Leadership

## Safety Champions

During Quarter 1, two safety walkabouts were undertaken at Stroud Maternity Unit and Cheltenham Birth Centre. These visits provided an opportunity for staff to speak directly with Safety Champions about safety, operational pressures, culture, escalation routes and any concerns affecting women, babies, families or staff. No safety concerns were raised by staff during either walkabout.

The walkabouts also provided an opportunity to discuss key service updates with staff, including the temporary suspension and subsequent reinstatement of the homebirth service, and the developing plans for the reopening of Cheltenham Birth Centre. These discussions supported visible senior leadership, enabled staff to receive updates directly, and provided assurance that service changes were being communicated and considered through established governance arrangements.

## Perinatal Culture Improvement Plan

The focus over the last quarter has been to review recent intelligence and further develop the W&C Divisional Culture Improvement Plan to support a positive, compassionate and psychologically safe culture in which staff feel heard, leadership is visible and teams are enabled to deliver safe, inclusive care. Its overarching vision is “We are safe, supported and enabled to deliver the inclusive, compassionate care that we would want ourselves and our loved ones to receive”.

## Development of the plan

The Cultural Plan was developed through the triangulation of multiple sources of culture, workforce and safety intelligence. This included the SCORE survey, CQC findings, national patient safety expectations, Maternity and Neonatal Improvement Strategy (MNIST) requirements, the NHS Three-Year Delivery Plan and Trust values. While these sources highlighted a broad range of priorities, common patterns emerged across them, including staff voice and speaking up, wellbeing and burnout, compassionate and visible leadership, teamwork, communication, psychological safety, learning from incidents and staff empowerment.

The 2025 NHS Staff Survey data was a key lens through which to examine these priorities and understand where improvements would have the greatest impact on staff experience and organisational culture. The survey highlighted areas relating to raising concerns, health and safety climate, burnout and work pressure, teamworking, line management, staff involvement, and opportunities for learning and development. These were strengthened by wider intelligence,

including feedback from team specific surveys and patient voice, that pointed to the need for better communication and organisational learning.

Taken together, the evidence demonstrated that many of the identified issues were interconnected rather than standalone challenges. To create a clear and deliverable improvement programme, the broad range of national, regional and local priorities were consolidated into three overarching themes: Safety Culture, Staff Wellbeing, Leadership and Teamwork. These themes provide focus while encompassing the full range of improvement areas identified through the evidence. Cross-cutting priorities, including psychological safety, speaking up, feedback and continuous learning, are embedded throughout the plan and underpin all improvement actions. The resulting programme includes actions that are behavioural, such as developing a safe speaking-up culture by embedding feedback into daily routines, structural, for example improving wellbeing by teaching staff to set their default meetings to 25 minutes or 50 minutes, and process based, such as having positive news as standing items in key meetings.

### **Improvement approach and measurement**

A structured improvement approach has been adopted. Driver information was collated with commissioned evidence reviews to identify evidence-based interventions and appropriate approaches to measuring cultural change. A shared cultural model and Plan on a Page methodology have been developed to translate the divisional themes into locally relevant actions, while enabling service lines and individual teams to respond to their own intelligence and priorities.

The action plan (appendix 1) identifies measures for success, including participation in cultural development and wellbeing interventions; staff feedback; uptake of team check-ins and 50-minute meetings; evidence of leadership visibility; implementation of team-level cultural actions; and evidence that learning, positive feedback and improvement stories are routinely shared. Longer-term impact will be assessed through repeat staff feedback, pulse measures, focus groups and relevant culture, workforce and safety intelligence.

Delivery will be supported through Plan on a Page discussion at divisional, service-line and team level. This approach is intended to provide a clear link between the evidence used to identify priorities, the interventions undertaken and the resulting impact. Initial activity has included commissioning cultural development training, delivery of autonomy and delegation training, team-based organisational development work, development of team charters, leadership and wellbeing interventions, and work with maternity teams to strengthen unity and address incivility.

### **Engagement and governance**

Teams will be supported to identify local cultural priorities and select actions that respond to both divisional themes and their specific circumstances. Planned feedback loops will provide staff insight to influence change, including narrative communications, positive stories and “you said, we

did" updates. The plan also recognises the importance of incorporating service-user feedback and MNVP insight alongside staff, workforce, incident, audit and safety intelligence as the improvement cycle develops.

Progress will be reviewed through maternity and neonatal governance including the Divisional People Board quarterly and presented to Quality and Performance Committee through the quarterly PQOM report, with culture incorporated into routine reporting and specific improvement plan

## Appendices

### Appendix 1- Culture Improvement Plan

#### Safe Speaking Up Culture

| Cultural theme | 26-27 focus              | Lead        | Action                                                                                                                                | Tasks                                                                                                                                     | KPI                                                                                                                                      | Owner                              | Deadline                                                          | RAG / status                                                       |
|----------------|--------------------------|-------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------|
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Increase access to Confidence in Conversations training across maternity teams.                                                       | Promote available places through team routes and newsletter; confirm bookings; prepare Tea Trolley delivery model from September.         | All available places booked; number registered and attending; evidence of Tea Trolley delivery plan.                                     | Matrons / MGC / AGS                | 1 November 2026; newsletter milestone 1 August 2026               | Amber – newsletter milestone overdue and requires confirmation.    |
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Establish a consistent process for sharing positive patient feedback and demonstrating action taken in response to negative feedback. | Agree process through People Board; confirm tools/options; agree communications approach; begin routine evidence sharing.                 | Feedback process approved by People Board; evidence of feedback communicated; actions arising from negative feedback tracked and closed. | KP / AGS / maternity matrons / MGC | 1 October 2026; source milestones July, August and September 2026 | Amber – July milestone requires update.                            |
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Introduce regular team-level reflection on learning from failure and feedback.                                                        | Agree Feedback/Failure Fridays format; confirm launch and review dates; capture evidence through team minutes or pulse feedback.          | Number of teams trialling the format; evidence of learning discussed; pulse feedback on usefulness.                                      | AGS                                | 1 October 2026                                                    | Not yet rated – target and baseline required.                      |
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Embed Speaking Up Culture Core Options within team Plan on a Page arrangements.                                                       | Confirm Core Options; brief teams; support each team to select one action and include it in their Plan on a Page.                         | Number and proportion of teams with a Speaking Up Core Options action included in Plan on a Page.                                        | AGS / Quad                         | 1 October 2026                                                    | Not yet rated – Quad to confirm scope and accountable owner.       |
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Strengthen autonomy and delegation practice through targeted training.                                                                | Deliver half-day training session; adapt learning into Tea Trolley model with Steph Cuthill from September; collect participant feedback. | Attendance and reach of training; participant feedback; evidence of Tea Trolley model launched.                                          | AGS                                | Started June 2026; Tea Trolley from September 2026                | Green/Amber – delivery commenced; wider reach requires monitoring. |
| Safety Culture | Safe Speaking Up Culture | Simon Pirie | Improve communication of outcomes from staff feedback and speaking up.                                                                | Develop communications approach; agree feedback-                                                                                          | Evidence that feedback outcomes and resulting actions are communicated to                                                                | AGS / MGC / Quad                   | 31 August 2026                                                    | Amber – discussion and                                             |

|  |  |  |  |                                                   |                                |  |  |                        |
|--|--|--|--|---------------------------------------------------|--------------------------------|--|--|------------------------|
|  |  |  |  | outcome routes; publish examples of action taken. | staff through agreed channels. |  |  | confirmation required. |
|--|--|--|--|---------------------------------------------------|--------------------------------|--|--|------------------------|

#### Staff Wellbeing

| Cultural theme  | 26-27 focus        | Lead         | Action                                                                            | Tasks                                                                                                                                                         | KPI                                                                                                                                      | Owner                | Deadline                                                                           | RAG / status                                                                |
|-----------------|--------------------|--------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Staff Wellbeing | Mindful Meetings   | Becky Hughes | Improve meeting practice by embedding check-ins and 50-minute meeting principles. | Design training with the Wellbeing Team; book and deliver sessions for Wellbeing Champions; support teams to pilot check-ins and shorter meetings.            | Number of Wellbeing Champions trained; number of teams using regular check-ins; proportion of relevant meetings using 50-minute default. | AGS / Wellbeing Team | End June 2026 design; 1 October 2026 tracker deadline; pilot by end September 2026 | Red/Amber – end-June design milestone requires status update.               |
| Staff Wellbeing | Addressing burnout | Becky Hughes | Use routine meetings to reinforce positive news and staff recognition.            | Add Positive News as a standing item to Divisional Board, People Board, PN Oversight and Assurance, and relevant local forums.                                | Number of selected meeting agendas including Positive News; number of positive stories recorded in minutes.                              | HW / Quad            | 31 August 2026                                                                     | Amber – agenda change to be confirmed.                                      |
| Staff Wellbeing | Addressing burnout | Becky Hughes | Create a regular newsletter route for sharing positive news.                      | Identify a light-touch tool for capturing positive stories; promote the tool; establish a newsletter standing item.                                           | Number of positive stories submitted; number of newsletters including positive news; evidence of staff contribution route.               | MGC / AGS            | 31 August 2026                                                                     | Amber – milestone brought forward from tracker date.                        |
| Staff Wellbeing | Addressing burnout | Becky Hughes | Increase access to Emotional Intelligence training.                               | Confirm total capacity; fill remaining places; record delivered sessions and attendance.                                                                      | Number booked and attending; attendance versus capacity; participant feedback.                                                           | AGS                  | 1 November 2026                                                                    | Amber – one session delivered with four delegates; total capacity required. |
| Staff Wellbeing | Addressing burnout | Becky Hughes | Improve staff access to rest breaks through the Boosting Breaks workstream.       | Book small group sessions with maternity teams; agree monitoring method with CWP; confirm baseline, numerator and denominator; implement improvement actions. | 90% break compliance on the maternity ward by 30 September 2026; number and proportion of staff reporting they are able to take breaks.  | AGS / CWP            | End June 2026 monitoring milestone; end September 2026 target                      | Red/Amber – June monitoring milestone requires confirmation.                |



|                 |                    |              |                                                                                                                   |                                                                                                                                                      |                                                                                                                                           |                      |                                            |                                                                   |
|-----------------|--------------------|--------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------|-------------------------------------------------------------------|
| Staff Wellbeing | Addressing burnout | Becky Hughes | Launch a narrative communications plan to support cultural improvement.                                           | Agree plan with the Quad; develop personal narratives and reflections; launch through agreed communication channels.                                 | Communications plan approved; number of narrative items shared; reach, engagement and staff-understanding measures.                       | MGC / Quad           | September 2026                             | Amber – launch to align with new Quad.                            |
| Staff Wellbeing | Addressing burnout | Becky Hughes | Complete and evidence the PMA improvement plan, including restorative supervision, debrief and emotional support. | Define MNIST deliverable and April 2027 end-state; confirm accountable owner; distinguish or merge duplicated PMA actions; assign follow-up actions. | Completed PMA improvement plan; evidence of increased restorative supervision, debrief and emotional support; staff feedback on PMA role. | Quad / AGS / NM / AL | End September 2026; 1 April 2027 end-state | Red – duplicated action and placeholder tasks require resolution. |

#### Leadership and Teamwork

| Cultural theme          | 26-27 focus                       | Lead        | Action                                                                                               | Tasks                                                                                                                                                  | KPI                                                                                                                                    | Owner                 | Deadline                                                                     | RAG / status                                                            |
|-------------------------|-----------------------------------|-------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Leadership and Teamwork | Visible, compassionate leadership | Karen Pudge | Increase visible and compassionate leadership across maternity services.                             | Identify barriers with Matrons, Band 7s and Quad; develop visibility standards; communicate best practice; implement Quad walkabout rota.              | Visibility plan in place; number of walkabouts completed; staff feedback demonstrates increased visibility.                            | AGS / Quad / MGC / HW | End June 2026 visibility plan; end September 2026 delivery milestones        | Red/Amber – June milestone overdue unless evidence confirms completion. |
| Leadership and Teamwork | Visible, compassionate leadership | Karen Pudge | Ensure HR capacity supports required service improvement and restructuring.                          | Validate governing MNIST reference; confirm accountable owner; document current HR support model; confirm evidence of RSL use and performance support. | HR support model confirmed; RSL in use; evidence that performance and behaviour processes are being supported effectively.             | Karen Pudge / Quad    | End June 2026                                                                | Red/Amber – source evidence and current status required.                |
| Leadership and Teamwork | Visible, compassionate leadership | Karen Pudge | Develop an effective Perinatal Leadership Team that can drive improvement and escalate by exception. | Benchmark PLT against published role descriptors; hold PLT away day; agree improvement plan; embed PLT within leadership structure.                    | Benchmarking completed; PLT improvement plan agreed; PLT action logs show progress; mandated support stood down when PLT is effective. | Quad / PLT            | End June 2026 benchmark; end September 2026 away day; 1 April 2027 end-state | Red/Amber – overdue milestones require exception review.                |

|                         |                                   |             |                                                                                  |                                                                                                                                                |                                                                                                                                           |                                     |                                                     |                                                                      |
|-------------------------|-----------------------------------|-------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|
| Leadership and Teamwork | Visible, compassionate leadership | Karen Pudge | Strengthen ward-to-board leadership transparency and reduce perceived hierarchy. | Define action plan, evidence sources, owner and reporting route; align with staff forums, union feedback and Freedom to Speak Up intelligence. | Action plan agreed; staff survey and staff forum feedback show improved transparency; relevant Freedom to Speak Up intelligence reviewed. | Quad                                | 1 April 2027                                        | Not yet rated – action plan and evidence source required.            |
| Leadership and Teamwork | Visible, compassionate leadership | Karen Pudge | Relaunch leadership values-in-action and personal narrative communications.      | Develop VIA narratives; agree communications plan; launch personal narratives, podcast or walkabout reflections with Quad and MGC.             | Communications plan approved; number of narratives/reflections shared; evidence of relaunch and engagement.                               | AGS / MGC / Quad                    | September 2026                                      | Amber – relaunch to be finalised.                                    |
| Leadership and Teamwork | Inclusive supportive teams        | Karen Pudge | Increase access to coaching training for maternity teams.                        | Confirm capacity and dates; promote training; deliver half-day sessions; explore Tea Trolley delivery model.                                   | Attendance versus capacity; number of sessions delivered; participant feedback.                                                           | AGS                                 | Date to be confirmed                                | Amber – target, capacity and dates required.                         |
| Leadership and Teamwork | Inclusive supportive teams        | Karen Pudge | Improve obstetric teamworking through facilitated conversations.                 | Agree subject matter and approach with RS and AGS; book sessions; confirm whether 10 July Insights session completed; plan October rollout.    | Facilitated sessions completed; feedback from obstetricians indicates improved teamworking; October rollout plan agreed.                  | RS / AGS                            | 10 July 2026 Insights session; October 2026 rollout | Amber – confirm whether July session completed and capture feedback. |
| Leadership and Teamwork | Inclusive supportive teams        | Karen Pudge | Complete EDI deep dive and agree response actions.                               | Chase MIA EDI specialist report; confirm report owner and response deadline; agree and assign follow-up actions.                               | EDI deep dive report received; response action plan agreed; follow-up actions allocated and tracked.                                      | Quad / named report chaser required | Report deadline to be confirmed                     | Blue/Amber – deep dive completed; report awaited.                    |
| Leadership and Teamwork | Inclusive supportive teams        | Karen Pudge | Establish EDI leads across service lines.                                        | Confirm EDI lead job description; document Michelle Grant appointment; BS and NM to seek expressions of interest for remaining                 | EDI leads identified for all service lines; role description approved; service-line coverage confirmed by Perinatal Quad.                 | BS / NM / Perinatal Quad            | September 2026                                      | Amber – further expressions of interest required.                    |

|                         |                            |             |                                                                                         |                                                                                                                                                    |                                                                                                                        |                                     |                       |                                                                |
|-------------------------|----------------------------|-------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------|----------------------------------------------------------------|
|                         |                            |             |                                                                                         | service lines by September.                                                                                                                        |                                                                                                                        |                                     |                       |                                                                |
| Leadership and Teamwork | Inclusive supportive teams | Karen Pudge | Evidence completion of the maternity ward EDI intervention and track follow-up actions. | File report from 20 May facilitated discussion; assign follow-up actions from session with Coral Boston and Sehrish Amjad; add actions to tracker. | 20 May facilitated discussion recorded as complete; report filed; follow-up actions assigned and monitored.            | Coral Boston / Sehrish Amjad / Quad | Completed 20 May 2026 | Blue – complete, pending report filing and follow-up tracking. |
| Leadership and Teamwork | Inclusive supportive teams | Karen Pudge | Embed Civility and Respect toolkit actions within team Plan on a Page arrangements.     | AGS and JJ to support teams to select actions; confirm scope, target and completion date; add selected actions to Plan on a Page.                  | Number and proportion of teams with Civility and Respect action included in Plan on a Page; completion date confirmed. | AGS / JJ / Quad                     | Date to be confirmed  | Not yet rated – scope, target and deadline required.           |

# Report to Board of Directors

|                            |                                                                    |
|----------------------------|--------------------------------------------------------------------|
| Date of Meeting            | 10 September 2026                                                  |
| Report title               | Integrated Governance Report – Legal, Regulatory and Policy Update |
| Sponsoring Director/Author | Kerry Rogers, Director of Integrated Governance                    |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p>This report provides an update to inform the Board of Directors of recent regulatory, compliance and policy developments issued by bodies such as NHS England, the Care Quality Commission and others, where their publications or actions have a direct or foreseeable impact on the Trust, or where awareness is necessary to support effective Board oversight.</p> <p>The report is not intended to be exhaustive. Instead, it highlights a selection of current issues for awareness and enquiry, recognising that areas most pertinent to the Trust’s business and risk profile will feature across future reports. What is included in this iteration is therefore illustrative, supporting wider Board development/enquiry rather than assurance unless available. An Addendum (‘True for Us’) is included to surface learning from external failures, inspections or regulatory insight, and to stimulate Board curiosity rather than closure. This supports the Board in testing whether similar conditions or risks might exist locally, without presumption that they do.</p> <p>Proactive assessment of regulatory and compliance developments is a core component of effective Board governance. It enables early identification of emerging risks, provides an opportunity to stress-test new or evolving expectations, and supports the Board in understanding the cumulative impact of regulatory change on the Trust’s overall risk profile, capacity and control environment.</p> <p>In considering the concept of <i>‘True for Us’</i>, it is recognised that post-failure regulation often seeks to strengthen accountability, including placing greater clarity and responsibility on directors individually and collectively. Active Board engagement with learning from external failures supports a culture of openness, integrity and continuous improvement, and helps ensure that internal controls, escalation routes and oversight arrangements remain proportionate, effective and grounded in reality.</p> <p>Collectively, the developments described in this report indicate an increasingly integrated view of governance, patient safety, workforce experience and organisational culture. Across maternity services, patient voice, digital transformation, leadership standards and regulatory reform, there is a growing expectation that Boards can demonstrate not only compliance with requirements, but how those arrangements improve outcomes, experience and organisational performance. A recurring theme across</p> |

many of the publications reviewed is the importance of organisational curiosity, psychological safety, effective escalation and the ability to recognise emerging concerns before they become embedded or normalised. Future assessments of provider effectiveness are therefore likely to place increasing weight on culture, leadership, workforce inclusion, organisational learning, responsiveness and the Board's ability to triangulate intelligence from multiple sources to identify developing risks and opportunities for improvement.

|                          |     |
|--------------------------|-----|
| Previously considered by | N/A |
|--------------------------|-----|

## Recommendations:

The Board of Directors is invited to:

1. Note and consider the content of this report and satisfy itself that appropriate arrangements are in place to respond to emerging regulatory expectations.
2. Consider the implications of the external learning and "True for Us" sections, particularly regarding organisational culture, psychological safety and visibility of frontline concerns.
3. Recognise that the Committee Chairs' meeting will reflect on relevant themes within future work programmes and assurance activities where appropriate.

## Strategic Aims (tick as appropriate)

|                                                                                                                           |   |
|---------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>   | / |
|  <b>People, culture and leadership</b> | / |
|  <b>Quality, safety and delivery</b>   | / |
|  <b>Digital first</b>                  | / |

## Impact on any Strategic Risks?

Strategic misalignment – regulations and 'corporate' failure can clash with existing strategies, requiring difficult trade-offs between national goals (eg reducing inequalities/improving safety, delivering sustainability objectives) and local service delivery. Where external regulatory failures highlight gaps between formal assurance and operational reality, Board may need to test whether strategic intent is

being consistently translated into practice. Any perception of an organisational learning deficit, or weak grip on emerging risk, can damage public and staff trust and confidence.

The developments outlined in this meeting's Report, reinforce existing strategic risks relating to:

- organisational culture and leadership;
- patient safety and quality governance;
- workforce engagement;
- digital transformation and assurance;
- financial sustainability;
- system integration and neighbourhood working;
- regulatory compliance and external oversight.

There is an increasing expectation from regulators that Boards can demonstrate alignment between strategic intent, assurance reporting and frontline reality.

### Implications on:

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

### Main Report

## A. SITUATION

This report provides an overview of recent legal, regulatory and policy guidance issued by NHS England, the Care Quality Commission and other relevant bodies where their publications or actions have a material or emerging relevance for the Trust, or where early Board awareness supports effective governance and preparedness. The report is intended to support situational awareness and enquiry, rather than provide full assurance. It highlights selected developments that may give rise to new obligations, changes in regulatory expectation, or learning from external failures, with the aim of helping the Board consider potential implications for strategy, risk, oversight and organisational focus. Content included at this stage is illustrative, recognising that topics most pertinent to the Trust's evolving risk profile will be addressed across future reports.

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

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

## B. BACKGROUND

### 1. National Response to the Amos Maternity Investigation

*Published June/July 2026*

Following publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England, NHS England has issued a national 10-point action plan for providers and systems. The response is noteworthy because it moves beyond traditional safety and governance recommendations and places significant emphasis on organisational culture, listening, compassionate leadership and the experiences of women, families and staff. Key requirements include:

- implementation of Martha's Rule across maternity services;
- Board visibility of patient outcomes and experience;
- joint accountability between Chief Nursing Officers and Medical Directors;
- a national staff listening exercise ("Amos into Action");
- stronger focus on maternity inequalities;
- safe maternity triage arrangements;
- trauma-informed responses to complaints and incidents;
- enhanced Board oversight of maternity services.

<https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

**Trust Position:** The themes emerging from the Amos response are broadly consistent with work already underway within the Trust and reinforce many of the areas being considered through

**local maternity improvement activity. Of particular relevance are the increased expectations regarding patient experience, staff voice, organisational culture and visible executive leadership. The Trust's maternity investigation provides an important opportunity for the organisation to consider how these national expectations align with local learning and improvement priorities.**

## **2. 10 Year Capital Plan for Health and Social Care**

*Published July 2026*

The Government has published a new 10-Year Capital Plan for Health and Social Care, supported by a record NHS capital settlement. The plan is intended to underpin delivery of the 10-Year Health Plan and is explicitly aligned with the three national shifts:

- hospital to community;
- analogue to digital;
- sickness to prevention.

The plan includes significant investment in estate modernisation, technology, primary care infrastructure, neighbourhood health centres and maintenance of critical NHS infrastructure. It also places considerable emphasis on digital infrastructure and system transformation.

<https://www.gov.uk/government/news/10-year-capital-plan-to-rebuild-nhs-and-bring-care-closer-to-home>

**Trust Position: Although primarily a national strategy document, the plan provides important insight into future funding priorities and investment criteria. Organisations able to demonstrate contribution to neighbourhood care, digital transformation, productivity and prevention objectives may be well positioned within future capital allocation processes. Our 5 year Capital Plan will be presented to the September meeting of the Finance and Resources Committee prior to presentation to the Board in November.**

## **3. NHS Staff Standards and Leadership Framework**

*Published July 2026*

The DHSC has published the first NHS Staff Standards, establishing national requirements regarding racism, violence and aggression, sexual safety, flexible working, line management and staff wellbeing. The standards introduce significantly greater Board-level accountability for workforce culture and experience. Requirements include appointment of a senior responsible officer for tackling racism, publication of Board-level objectives and monitoring of organisational performance against workforce indicators. Performance against the standards will increasingly be reflected in national oversight arrangements.

Alongside the Staff Standards, NHS England has published the NHS Leadership and Management Framework and Leadership Code. The framework establishes a consistent set of expectations for NHS leaders and managers and introduces principles of accountability, curiosity, inclusion, collaboration, compassion and integrity. The framework is expected to become embedded within appraisal arrangements and future leadership assessment processes.

These developments reinforce a growing national shift whereby workforce experience, inclusion, leadership behaviours and organisational culture are becoming matters of Board accountability rather than solely workforce management issues.

**NHS Staff Standards:** <https://www.gov.uk/government/publications/nhs-staff-standards>



**NHS Leadership and Management Framework:** <https://lmframework.leadershipacademy.nhs.uk/>

**Trust Position:** The requirements align closely with the Trust's existing focus on culture, health and wellbeing, violence and aggression reduction, Freedom to Speak Up and workforce engagement. The publications provide further evidence of increasing national expectations regarding the role of Boards in monitoring workplace culture and staff experience. Developments regarding a new People, Place and Partnership Committee will provide the required oversight across these areas.

#### **4. Workforce Equality and Inclusion**

*Published June 2026*

Lord Mann's Review into Antisemitism and Other Forms of Racism in the NHS and Healthcare Regulatory System has now been published and accepted by Government and NHS England. The review concludes that racism, including antisemitism, remains a persistent challenge across the NHS and recommends strengthened Board accountability, enhanced reporting and investigation arrangements, stronger workforce data, improved training and greater organisational focus on creating inclusive cultures. NHS England has committed to implementing a number of recommendations through the NHS Staff Standards, Oversight Framework and leadership accountability arrangements. [\[england.nhs.uk\]](https://www.england.nhs.uk/), [\[hansard.parliament.uk\]](https://hansard.parliament.uk/)

**Trust Position:** *The review reinforces the importance of visible Board leadership on equality, diversity and inclusion, and aligns with wider national developments including the NHS Staff Standards, workforce experience agenda and organisational culture expectations. The Trust will continue to review implications arising from the review and subsequent NHS England guidance and the Board Development programme will incorporate key areas for Board focus across this domain.* [\[england.nhs.uk\]](https://www.england.nhs.uk/), [\[nhsemployers.org\]](https://www.nhsemployers.org/)

#### **5. The Future of Neighbourhood Health**

*Emerging National Direction*

Publication of the Neighbourhood Health Framework and subsequent implementation guidance provides further clarity regarding the Government's ambition to shift care closer to home through integrated neighbourhood-based delivery models. The framework positions neighbourhood health as a fundamental component of the 10-Year Health Plan and sets expectations regarding multidisciplinary working, prevention, integration and population health.

Independent analysis from The King's Fund has broadly welcomed the clarity provided by the Framework whilst highlighting questions regarding implementation capacity, resources and the balance between national expectations and local flexibility.

NHS England: Next Steps on Neighbourhood Health and New Delivery Models: <https://www.england.nhs.uk/long-read/next-steps-on-neighbourhood-health-and-new-delivery-models/>

The King's Fund: What is Neighbourhood Health?: <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

The King's Fund: Neighbourhood Health Framework Analysis: <https://www.kingsfund.org.uk/insight-and-analysis/blogs/neighbourhood-health-framework-clarity-gaps-what-comes-next>

**Trust Position:** The continued prominence of neighbourhood health reinforces the strategic importance of community partnership working, integrated models of care and prevention-focused

**approaches. Whilst much of the implementation responsibility rests at system level, acute providers are likely to play an increasingly important role in the redesign of pathways and delivery models.**

## **6. National Maternity Triage Specification**

*Published July 2026*

NHS England has published a National Maternity Triage Specification requiring all Trust Boards to undertake a diagnostic review of local maternity triage arrangements within three months and implement any required improvements within twelve months. The specification introduces greater consistency in expectations regarding accessibility, responsiveness, governance and oversight. Trust Boards are explicitly identified as responsible for delivery and oversight.

**Trust Position: The Trust will assess existing maternity triage arrangements against the national specification and ensure that compliance and improvement activity are overseen through established maternity governance arrangements and relevant Board Committees. The Quality and Performance Committee workplan will need to reflect the appropriate oversight arrangements and matters arising from the new Commissioner role below.**

## **7. Maternity and Neonatal Commissioner**

One of the significant announcements arising from the Amos Review response is the creation of England's first Maternity and Neonatal Commissioner. The role is intended to provide an independent voice for women, babies and families and will co-chair the National Maternity and Neonatal Taskforce. This is likely to increase national scrutiny of maternity performance, patient experience and organisational accountability.

NHS England: Amos Response and National Maternity & Neonatal Improvement Programme  
<https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

## **8. Model Discharge Pathway**

*Published July 2026*

NHS England has published a Model Discharge Pathway intended to standardise discharge planning and reduce variation in discharge practice across providers. The model places particular emphasis on clinically-led discharge, daily operational discipline and improved patient flow. The guidance also introduces expectations regarding local self-assessment and performance measurement.

**Trust Position: The Trust is reviewing the guidance to understand alignment with existing discharge arrangements and to identify any further development opportunities. The publication reinforces the importance of effective discharge processes to patient flow, quality of care and system performance.**

## **9. NHS Bill – Progression and Emerging Governance Implications**

*Ongoing Parliamentary Consideration*

The NHS Bill continues its progression through Parliament and provides increasing clarity regarding the future operating model of the NHS. Of particular relevance to providers are proposals relating to:

- abolition of NHS England;
- creation of the Single Patient Record;
- revised arrangements for patient and public voice;
- changes to Foundation Trust governance structures;

- increased ministerial accountability;
- further evolution of Integrated Care Boards and commissioning responsibilities.

NHS Modernisation Bill 2026: <https://bills.parliament.uk>

The King's Fund: NHS Modernisation Bill Analysis: <https://www.kingsfund.org.uk/insight-and-analysis/projects/nhs-modernisation-bill-2026>

**Trust Position: The Bill remains subject to parliamentary scrutiny and amendment. The Trust will continue to monitor developments, particularly those relating to governance, accountability, patient engagement and future provider operating arrangements. A recent Board development session (July) focused on areas of developing policy.**

## **10. Patient Voice – From Engagement to Accountability**

*Emerging National direction*

Alongside proposals within the NHS Bill, national guidance increasingly reflects a shift from simply gathering patient feedback towards demonstrating how feedback has influenced decisions and driven improvement. The emerging expectation is that patient experience and engagement become core elements of organisational assurance rather than standalone activities.

**Trust Position: This direction aligns strongly with the Trust's strategic priorities and existing work regarding patient experience. The Trust will continue to strengthen arrangements ensuring that patient feedback is visibly linked to improvement activity and assurance reporting. The work with our Governors at the impending October 'Board to Board' workshop will also focus on patient voice influencing Board decision making.**

## **11. Digital Prescribing Safety Risks in NHS Hospitals**

*Published June 2026*

HSSIB has published a national investigation examining Electronic Prescribing and Medicines Administration (ePMA) systems. The report highlights variation in digital design, procurement, interoperability, safety assurance and clinical governance arrangements across providers. It identifies a potential risk that digital transformation may progress more quickly than the mechanisms required to assure digital clinical safety.

<https://www.hssib.org.uk/patient-safety-investigations/digital-prescribing-safety-risks-in-nhs-hospitals/>

**Trust Position: The report is relevant to the Trust's broader digital transformation programme and reinforces the importance of ensuring governance, digital safety capability and clinical oversight develop alongside technological capability.**

## **12. HSSIB Reform**

*Emerging National Debate*

Significant discussion continues regarding Government proposals to transfer HSSIB functions into the Care Quality Commission. Concerns have been raised nationally regarding the ability to preserve truly independent systems-based patient safety investigations within a regulatory environment. The debate reflects wider questions regarding how the NHS learns from harm and balances investigation with performance management and regulation.

**Trust Position:** Whilst organisational responsibility for patient safety improvement remains unchanged, the debate is relevant to the way learning, investigation and systems thinking may evolve nationally in future years.

### **13. Patient Safety Partners – From Participation to Influence**

*Published August 2026*

NHS England has published a national review of Patient Safety Partners (PSPs), drawing on the 2025 survey of implementation across NHS organisations. The review concludes that Patient Safety Partners have the potential to make a meaningful contribution to safety improvement and governance, but that implementation remains variable and their influence is not always fully realised. The report highlights the importance of ensuring PSPs are integrated into governance structures, have visibility of safety discussions and are able to contribute to learning and improvement activity rather than acting in a purely advisory role. The findings reinforce the broader national direction of travel towards strengthening patient voice, experience and co-production within formal assurance arrangements.

<https://www.england.nhs.uk/publication/patient-safety-partners-2025-survey-review-and-recommendations/>

**Trust Position:** The report aligns with the Trust's wider focus on patient experience, patient voice and organisational learning. As national expectations continue to evolve, opportunities may emerge to further demonstrate how patient insight influences quality, safety and improvement activity through existing governance arrangements. The Quality and Performance Committee will receive updates on PSPs as part of their oversight through regular Patient Safety Investigation Reporting Framework updates and the Board may wish to consider inviting Partners to a future Board meeting to hear of their experience of the role and its impact.

### **14. NHS Quality Strategy – Quality as the Organising Principle**

*Published July 2026*

The National Quality Board has published a refreshed quality strategy for NHS-funded care, positioning quality as the organising principle for NHS organisations rather than as a discrete workstream. The strategy places particular emphasis on improvement capability, organisational learning, patient safety, staff experience and reducing unwarranted variation. It reinforces expectations that organisations should use quality intelligence proactively and move from compliance-based assurance towards continuous improvement and learning. HSSIB has publicly welcomed the strategy, highlighting its alignment with systems thinking and learning-focused approaches to safety and improvement.

**Source:**<https://www.hssib.org.uk/news-events-blog/our-response-to-the-quality-strategy-for-nhs-funded-care-in-england/>

**Trust Position:** The themes align strongly with existing Trust priorities around quality governance, patient safety, organisational learning and culture. The strategy provides further reinforcement of the increasing expectation that quality, safety, workforce experience and patient outcomes are considered together rather than through separate assurance mechanisms.

### **15. HSSIB Investigation – Advice and Guidance Services**

*Published August 2026*

HSSIB has published an interim investigation into NHS Advice and Guidance (A&G) services, highlighting potential patient safety risks where implementation and governance arrangements are insufficiently mature. The report identifies examples of delayed diagnosis, delayed treatment and harm where local

pathway design, digital infrastructure or clinical responsibilities were unclear. HSSIB concludes that whilst Advice and Guidance can improve access to specialist expertise and reduce unnecessary referrals, there is currently insufficient national evaluation of safety impact as implementation expands. The report also highlights the challenge of understanding risk where safety incidents cannot be consistently identified through existing national datasets.

<https://www.hssib.org.uk/news-events-blog/rapid-evaluation-of-nhs-advice-and-guidance-services-needed-to-protect-patients/>

**Trust Position: Whilst Advice and Guidance pathways are intended to improve responsiveness and access to specialist expertise, the report serves as a reminder that service redesign can introduce unintended safety consequences if governance, clinical oversight and digital infrastructure do not develop at the same pace. Local implementation should continue to maintain focus on patient safety, accountability and outcomes alongside efficiency benefits.**

## **16. HSSIB Investigation – Ambient Voice Technology**

*Published August 2026*

HSSIB has launched a national investigation into the use of Ambient Voice Technology (AVT) in hospitals. The investigation reflects concerns that adoption of AI-enabled clinical documentation tools is accelerating whilst understanding of the associated patient safety risks, accountability arrangements and governance frameworks remains immature. HSSIB notes that national implementation activity has focused heavily on productivity and efficiency benefits, with less attention paid to patient safety risks, reporting mechanisms and organisational accountability. Findings are expected during 2027.

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

**Trust Position: The investigation aligns closely with wider national discussions regarding AI, digital transformation and the Single Patient Record. As organisations increasingly adopt AI-enabled tools, the Trust will need to continue balancing innovation and productivity opportunities with appropriate clinical safety, governance and assurance arrangements. The Chief Digital Information Officer received Corporate Board approval in September for inclusion of AI risks on the Divisional Risk Register to ensure oversight of the emerging control environment and mitigations.**

## **17. On the Horizon**

The following issues are likely to feature more prominently in future reports:

### **Single Patient Record**

The proposed Single Patient Record remains central to Government policy and represents one of the most significant digital transformation programmes currently under development. Future implications for governance, information governance, interoperability and patient engagement are likely to be substantial. Although detailed implementation plans are still emerging, multiple recent publications, including the NHS Bill, HSSIB investigations and the 10-Year Capital Plan, point towards increasing expectations regarding digital maturity, interoperability, information governance and digital clinical safety.

[\[kingsfund.org.uk\]](https://kingsfund.org.uk), [\[hssib.org.uk\]](https://hssib.org.uk), [\[gov.uk\]](https://gov.uk)

### **Cardiovascular Disease Prevention Framework**

The recently announced cardiovascular framework reflects increasing policy emphasis on prevention, health inequalities and avoidable mortality. These themes are likely to become increasingly important within future oversight arrangements and population health measures.

### **Provider Selection Regime**

As the Provider Selection Regime matures, further guidance and case law are expected to clarify expectations regarding commissioning, transparency and procurement governance.

<https://www.england.nhs.uk/publication/provider-selection-regime/>

### **C. CONCLUSION**

The Board is expected to form a collective view that appropriate governance and internal control arrangements are in place to meet statutory, regulatory and policy obligations. This report therefore invites Board members to consider whether they are satisfied, through existing sources of assurance and enquiry, that where relevant, compliance mechanisms remain robust, and that any emerging gaps or uncertainties are being addressed through planned improvement activity, targeted deep dives or Committee oversight where required.

The report is designed to ensure that external regulatory insight and learning from others informs internal reflection and prioritisation, and is appropriately connected to established governance tools, including the Board Assurance Framework and the Trust Risk Register. Taken together, the illustrative themes highlighted in this report point to the importance of strong Board grip on how regulatory expectations, organisational learning and frontline reality align in practice. Recurring insights from external inspections and failures emphasise the need for effective translation of assurance into delivery, leadership visibility of risk during change, and cultures that support escalation and learning before harm occurs.

The developments outlined in this meeting's report reinforce a consistent national message regarding the direction of travel for NHS organisations. The emphasis increasingly extends beyond traditional measures of performance and compliance towards broader themes of culture, leadership, patient voice, organisational learning and demonstrable impact. The external examples included within this report suggest that future organisational success will depend not only on the strength of governance arrangements, but on the extent to which Boards are able to understand frontline reality, recognise emerging concerns early and translate insight into sustained action and improvement.

Across maternity services, digital transformation, patient safety, governance reform and patient engagement, there is a growing expectation that Boards are able to evidence not only what actions are being taken, but how those actions are experienced by patients, families and staff. Taken together, these developments suggest that future assessment of provider effectiveness is likely to place increasing weight on organisational insight, learning capability, psychological safety, responsiveness and the relationship between assurance and lived experience.

The last Board Development Session considered Advanced Foundation Trust's and Integrated Health Organisations. The designation of the first of these during July 2026 provides an early indication of the direction of travel for future provider accountability and population-based delivery models and will be monitored through future reports. Our imminent consideration of the Provider Capability Assessment should therefore be informed by the recurring themes highlighted throughout this report. Increasingly, organisational capability is being judged not solely through performance outcomes, but through the quality of leadership, the visibility of risk, the authenticity of patient and staff voice, the maturity of organisational learning and the extent to which assurance reflects lived reality. The PCA provides an opportunity for the Board to test where confidence is supported by evidence, where knowledge may be incomplete, and whether the organisation is demonstrating the curiosity, grip and responsiveness increasingly expected by regulators, oversight bodies and system partners.



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**Addendum****AWARENESS/LEARNING/'TRUE FOR US'/THOUGHT PIECES****CQC Inspections and updates****County Durham and Darlington NHS Foundation Trust***CQC, report published June 2026*

The CQC published inspection findings identifying an **Inadequate Well-Led rating**, alongside concerns regarding oversight, governance, complaints handling and escalation processes. Inspectors highlighted the need to improve leadership arrangements, strengthen oversight of externally delivered services and ensure risks are escalated and addressed earlier. The Trust accepted the findings and subsequently introduced strengthened arrangements for executive review of complaints, oversight of third-party providers and escalation of emerging concerns. The findings reinforce the continuing regulatory expectation that Boards can demonstrate effective visibility of operational risk, timely escalation, oversight of outsourced or partner-delivered services and effective organisational learning from incidents and complaints. The report also illustrates the close relationship between governance maturity and CQC assessment of organisational leadership. [\[cddft.nhs.uk\]](https://cddft.nhs.uk)

**Oxford University Hospitals NHS Foundation Trust***CQC, published June 2026*

The CQC published reports following maternity inspections across Oxford University Hospitals' sites. Both units demonstrated improvement, with services moving from Requires Improvement to Good, reflecting progress in leadership, governance and quality improvement arrangements. Inspectors recognised strengthened learning from incidents, workforce commitment and initiatives to reduce inequalities. However, concerns remained regarding staffing, governance, environmental risks and compliance with aspects of the Safe domain. [\[ouh.nhs.uk\]](https://ouh.nhs.uk)

**Of interest/relevance:****Care Quality Commission (CQC) Reform Programme**

Following the Dash and Richards Reviews, the CQC has continued its programme of regulatory reform and has now published draft sector-specific assessment frameworks covering hospitals, mental health services, primary care/community services and adult social care. The proposals move away from the Single Assessment Framework and seek to provide clearer, more sector-relevant assessment criteria and rating characteristics. In addition, the CQC has begun piloting revised assessment methods and has identified clearing aged ratings and rebuilding confidence in regulation as key organisational priorities. [\[cqc.org.uk\]](https://cqc.org.uk) The Board may wish to monitor development of the hospital framework as it is likely to influence future regulatory assessment and inspection activity.

**Neighbourhood Health Framework***Published March 2026, with continued implementation focus through Summer 2026*

The NHS Alliance has published detailed analysis of the Government's Neighbourhood Health Framework and views it as one of the most significant service transformation programmes currently underway. The Alliance highlights the expectation that ICBs, local authorities, providers and the voluntary sector develop integrated neighbourhood models focused on prevention, proactive care and alternatives to hospital-based services. Particular emphasis is placed on population health, multidisciplinary neighbourhood teams and shifting care closer to home.

The Alliance considers neighbourhood health to be the principal delivery mechanism for achieving the Government's "hospital to community" shift and argues that success will require changes to commissioning, provider collaboration, workforce deployment and local accountability arrangements. Whilst implementation will largely occur through systems and places, acute providers are likely to play a critical role in pathway redesign, population health management and integration with community services.

Neighbourhood Health is now moving from policy concept to implementation programme. A consistent message emerging from NHS Alliance publications is that the NHS is entering a period of fundamental service redesign rather than incremental improvement. The Alliance characterises neighbourhood health as a shift from organisations acting independently towards providers operating as part of broader place-based partnerships with local government, voluntary organisations and communities. Success is likely to depend as much on culture, relationships and collaboration as on structural reform.

### **First NHS Organisations Approved as Integrated Health Organisations**

*Published July 2026*

NHS England has formally designated Northumbria Healthcare NHS Foundation Trust and Northamptonshire Healthcare NHS Foundation Trust as the first organisations eligible to hold Integrated Health Organisation (IHO) contracts. IHOs represent one of the principal delivery models described within the 10-Year Health Plan, with organisations expected to take responsibility for planning services, improving population health outcomes and managing health and care resources for defined populations. NHS England has indicated an expectation that the first live IHO contracts will commence during 2027.

This provides an early indication of the characteristics NHS England considers necessary for organisations seeking this status, including partnership maturity, population health capability and advanced governance arrangements.

Northumbria Healthcare NHS FT IHO Designation Letter: <https://www.england.nhs.uk/wp-content/uploads/2019/04/northumbria-healthcare-nhs-foundation-trust-integrated-health-organisation-designation.pdf>

Northamptonshire Healthcare NHS FT IHO Designation Letter: <https://www.england.nhs.uk/wp-content/uploads/2019/04/northamptonshire-healthcare-nhs-foundation-trust-integrated-health-organisation-designation.pdf>

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### **HIGH PROFILE FAILINGS – LEARNING/‘TRUE FOR US’**

High profile corporate governance failures and/or weaknesses continually litter the headlines and the events that damage such organisations do not just happen. They are commonly linked to boards being blind to the underlying risks that threaten their organisations and to the effectiveness of governance



systems. Whilst these are predominantly headline news items with some containing allegations to be investigated – they will be routinely presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perceptions on reputation through trust and confidence) and to give due regard to there being any risk of it being 'true for us'.

The ambition remains to develop a Framework to ensure that in a planned way we assess where any of these significant failings could happen at the Trust in order to learn and improve control environments accordingly, but regardless, each member of the Board should consider their individual responsibilities to 'be assured' and as such consider requirements to support attaining that position and consider as necessary what it might mean for GHFT.

**Organisational Culture, Psychological Safety and Leadership Visibility - Mersey Care Culture Review**  
*Workforce Challenge Partners Culture Review (Board Development Update, November 2025) commissioned by NHS England North West for Mersey Care NHS Foundation Trust, as reported by HSJ on 27 July 2026.*

A recently disclosed culture review undertaken at Mersey Care NHS Foundation Trust identified concerns regarding psychological safety, leadership relationships, communication, governance, trust and organisational culture. The review concluded that internal dynamics had, over time, become organisational risks in their own right, contributing to anxiety, reduced trust and distraction from organisational purpose. A recurring theme throughout the review was the gap between formal governance arrangements and the experience reported by staff.

### **True for Us?**

The value of the review does not lie in whether the specific findings are directly transferable to Gloucestershire Hospitals but in understanding the conditions that allowed concerns to develop and become embedded over time. The review highlights the importance of:

- psychological safety;
- effective relationships between leaders and teams;
- visibility of emerging concerns;
- confidence in speaking up;
- alignment between formal assurance and staff experience;
- leadership focus on organisational priorities rather than internal dynamics.

These themes are relevant when considered alongside:

- the Trust's culture heatmap work;
- ongoing improvement activity within Theatres;
- improvement activity within Outpatients;
- concerns and improvement work within Cardiology;
- Freedom to Speak Up intelligence;
- staff survey findings;
- wider organisational listening activity.

The review is also notable because the organisation had previously been viewed externally as successful and well-led, illustrating that positive performance indicators do not eliminate the need for continual curiosity regarding culture, relationships and psychological safety. The question for reflection is therefore in considering if the conclusions could be "true for us", whether current sources of cultural intelligence provide sufficient visibility of emerging concerns before they become operational, workforce or patient experience issues.

<https://www.hsj.co.uk/workforce/divisive-and-toxic-culture-found-at-trust/8123895.article>

The increasing prominence of culture, staff experience and listening within the Amos response, workforce equality discussions and emerging oversight arrangements suggests these issues are likely to remain important areas of future Board enquiry and external scrutiny.

### **Increasing Regulatory Focus on Culture**

A common theme across recent publications from NHS England, HSSIB, the Amos Review, The King's Fund and the wider policy community is an increasing emphasis on culture as a regulatory and organisational effectiveness issue rather than simply a workforce issue. Listening, psychological safety, leadership visibility, speaking up and staff experience are increasingly being treated as indicators of organisational performance and patient safety. [england.nhs.uk](https://www.england.nhs.uk), [kingsfund.org.uk](https://www.kingsfund.org.uk), [wired-gov.net](https://www.wired-gov.net)

### **True for Us? Leadership, Culture and Staff Voice**

Recent CQC findings at King's College Hospital NHS Foundation Trust identified concerns regarding culture, staff confidence in speaking up and the extent to which organisational values were experienced consistently across the Trust. Of particular interest was the gap identified between the organisation's stated ambitions and some staff experiences of day-to-day working. [cqc.org.uk](https://www.cqc.org.uk), [kch.nhs.uk](https://www.kch.nhs.uk)

Whilst there is no suggestion that similar findings would apply at Gloucestershire Hospitals, the report raises important questions regarding how Boards obtain assurance regarding culture and psychological safety. The findings may be considered alongside the Trust's own culture heatmap work, Freedom to Speak Up intelligence, staff survey results and ongoing improvement activity within specific services in the Trust. [cqc.org.uk](https://www.cqc.org.uk), [kch.nhs.uk](https://www.kch.nhs.uk)

### **Expanding on May's report Thirlwall - Escalation, Organisational Curiosity and the Risk of Normalisation**

Whilst the final Thirlwall Inquiry report awaits publication, evidence heard throughout the Inquiry has highlighted recurring themes relating to escalation, challenge, organisational culture, speaking up, clinical leadership and the management of emerging concerns. At the heart of the Inquiry is the question of how concerns raised by clinicians were recognised, assessed, challenged and acted upon by leaders at multiple levels of the organisation. [hansard.pa...liament.uk](https://hansard.parliament.uk), [parallelpas...ment.co.uk](https://parallelpas.ment.co.uk)

A recurring line of enquiry has been whether unusual events became normalised over time, whether leaders were sufficiently curious about concerns being raised, and whether there was adequate visibility and escalation between ward, specialty, executive and Board level.

The significance of the Inquiry may ultimately extend beyond the specific circumstances of the Countess of Chester Hospital. Many public inquiries identify a similar pattern where:

- concerns are identified but not fully understood;
- incidents are considered individually rather than collectively;
- information exists in different parts of the organisation but is not effectively triangulated;
- leaders seek reassurance before seeking explanation;
- normalisation occurs as unusual events become accepted as part of day-to-day operations.

The emerging lessons are therefore likely to be relevant across all NHS organisations regardless of the Inquiry's eventual conclusions.

### **Board Reflection**

Perhaps the most important question arising from Thirlwall is how confident are we that our governance, culture and escalation arrangements would identify emerging concerns early enough to prevent them becoming embedded or normalised?

### **Violence and Aggression: Shifting from Tolerance to Enforcement**

Royal Berkshire NHS Foundation Trust has reported new partnership arrangements with Thames Valley Police aimed at increasing prosecution of assaults and abuse against NHS staff. The initiative arose following feedback from police that NHS organisations may be too willing to tolerate behaviours that would not be accepted in other workplaces. The Trust has introduced a more assertive approach to incident reporting, prosecution and exclusion of persistent offenders.

National staff survey results continue to identify violence, aggression and abuse as significant concerns across the NHS workforce. The article raises important questions regarding organisational expectations, support available to staff who report incidents and the balance between compassion and accountability.

The issue resonates strongly with work undertaken through the Trust's Violence & Aggression Workshop, Health & Safety Annual Report, staff survey findings and ongoing efforts to improve the experience of frontline teams.

<https://www.hsj.co.uk/patient-safety/youre-too-gentle-with-those-who-abuse-staff-police-tell-trust/8123898.article>

### **Known Risks, Repeated Findings and Organisational Response**

In July 2026, Priory Healthcare was fined £600,000 following the death of a patient assessed as being at high risk of self-harm. The prosecution arose after a coroner concluded that neglect had contributed to the death because the organisation had failed to adequately address a known ligature risk. Importantly, ligature audits had identified the same risk on at least two previous occasions, yet remedial action had not been taken.

The most significant aspect of the case is not the specific clinical circumstances but the fact that the hazard was already known to the organisation. Many major failures are not caused by unknown risks. Rather, they arise when:

- risks are identified but not resolved;
- actions are delayed or not completed;
- assurances are accepted without verification;
- repeated findings become normalised;
- responsibility for resolution becomes unclear over time.

A recurring theme in public inquiries, regulatory action and serious incident investigations is that organisations were often aware of the underlying risk long before harm occurred.

### **True for Us?**

The Board may wish to reflect on:

- How confident are we that actions arising from audits, inspections and risk assessments are always completed and sustained?
- How do we monitor overdue actions relating to significant or recurring risks?
- Where known risks remain unresolved, how visible are they to the relevant leadership and governance forums?

- How do we gain assurance that actions reported as completed have achieved the intended outcome?
- Are there any areas where concerns have repeatedly reappeared across inspections, audits, incidents, complaints or risk registers?

This learning may be considered alongside:

- Health and Safety audit findings;
- Estates compliance programmes;
- Fire, ligature and environmental risk assessments;
- CQC action plans;
- Internal audit recommendations;
- Serious incident learning;
- Board Assurance Framework risks.

<https://www.hsj.co.uk/mental-health/provider-fined-600k-over-death/8123911.article>

Whilst specific to a mental health Trust, this item is relevant because it speaks directly to assurance, risk management, action tracking and governance, which are universal Board responsibilities. It also complements the Thirlwall theme around normalisation, curiosity and responding to warning signs.

Enclosures: None

FOI: Public

## Report to Board of Directors

|                                   |                                                                                                                  |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------|
| <b>Date of Meeting</b>            | 10 September 2026                                                                                                |
| <b>Report title</b>               | Risk Management Assurance Report                                                                                 |
| <b>Sponsoring Director/Author</b> | Kerry Rogers, Director of Integrated Governance<br>Lee Troake, Head of Risk H&S<br>Sarah Favell, Trust Secretary |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The purpose of this report is to provide the Board of Directors with an integrated view of the effectiveness of the Trust's risk management framework, the current organisational risk profile and the Board Assurance Framework (BAF). It brings together operational risk intelligence from the Trust Risk Register with strategic assurance regarding the principle risks to delivery of the Trust's strategic objectives.</p> <p>The Trust continues to demonstrate a mature and embedded approach to risk management, providing reasonable assurance that strategic, operational, clinical and corporate risks are being identified, assessed and managed through established governance arrangements. During the reporting period, 552 active risks were recorded across all risk registers. Overall risk exposure reduced by 0.2%, and a number of significant risks reduced following implementation of mitigating controls and service improvements.</p> <p>The Trust's operational risk profile continues to reflect the challenges facing the organisation and wider NHS. The Trust Risk Register contains multiple extreme-rated risks relating to Emergency Department overcrowding, corridor care, fire safety infrastructure, cyber security, critical workforce shortages, ageing estates infrastructure and the resilience of key clinical services. These risks have the potential to impact directly on patient outcomes, regulatory compliance, operational performance and are reflected in the Board Assurance Framework.</p> <p>High-rated risks associated with fire safety compliance, ageing air handling units, infrastructure resilience, maintenance backlog and the long-term sustainability of the Tower Block highlight the increasing dependency on ageing infrastructure and the requirement for continued investment and strategic oversight.</p> |

Digital and cyber risks remain amongst the organisation's most significant strategic threats. The Trust currently holds extreme-rated risks relating to cyber security, core IT infrastructure resilience and the potential loss of access to critical systems. Given the Trust's reliance on digital systems to support clinical care, diagnostics, prescribing, communications and patient records, cyber resilience remains both a patient safety and organisational resilience issue requiring sustained Board oversight.

Maternity services continue to feature prominently within the risk profile, with several Trust-level risks relating to consultant obstetric workforce, maternity scanning capacity, triage delays, diabetes management during pregnancy and the sustainability of home birth provision. While there have been positive reductions in several maternity risks during the reporting period, maternal and neonatal safety remains a significant area of focus for the Trust.

The quality of risk records remains strong, with high levels of compliance in the recording of controls and mitigating actions. Risk governance processes continue to operate effectively, with evidence of active review, escalation and closure of risks where appropriate. However, assurance is reduced by the level of overdue reviews and overdue actions across the organisation.

There have been no material reductions in the strategic risk scores covered by the BAF update. Nevertheless, Board Assurance Committees have received evidence of strengthening controls and assurance in financial reporting and budget ownership, workforce controls, quality governance, cyber assurance, health and safety governance and longer-term estates planning. In several areas, stronger governance has not yet translated into lower residual risk because sustainable improvement remains dependent on multi-year delivery, investment, workforce capacity and organisational change.

A proposed new strategic risk relating to Research, Innovation and Genomics has also been developed for approval, having been considered by Finance and Resource Committee (June meeting). This reflects the strategic importance of research, innovation, digital transformation and genomics, together with the risks of failing to integrate and scale these capabilities safely, equitably and effectively.

Overall, the Board can take reasonable assurance that the Trust maintains an effective framework for identifying, escalating and managing risk. However, further improvement is required in the timely completion of actions and reviews to ensure that risk exposure continues to reduce and that assurance can progress from reasonable towards substantial assurance.

|                          |                                                      |
|--------------------------|------------------------------------------------------|
| Previously considered by | Risk Management Group, Audit and Assurance Committee |
|--------------------------|------------------------------------------------------|

## Recommendations:

Board is invited to:

- Note the integrated position of the Trust Risk Register and Board Assurance Framework and consider whether it reflects the principal risks to delivery of the Trust's strategic objectives;
- Take reasonable assurance that strategic and operational risks continue to be subject to defined executive ownership, active management and committee oversight;
- Note that no material reduction in the strategic risk scores covered by this report has been identified, notwithstanding evidence of strengthening controls and assurance in a number of areas;

- Support continued executive focus on the management of extreme-rated risks, the timely completion of overdue reviews and actions, and evidence that controls are having the intended impact;
- Approve the proposed Research, Innovation and Genomics strategic risk and the intention to consider its formal inclusion within the BAF.

#### Strategic Aims (tick as appropriate)

|                                                                                                                         |   |
|-------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>   |   |
|  <b>People, culture and leadership</b> |   |
|  <b>Quality, safety and delivery</b>   | ✓ |
|  <b>Digital first</b>                  |   |

#### Impact on any Strategic Risks?

All current BAF strategic risks: Safe and Effective Services; Workforce Sustainability; Culture, Experience and Retention; Financial Sustainability; Digital Infrastructure and Cyber Resilience; Digital Transformation and Culture; State of the Estates; and Health and Safety Governance. The report also notes the proposed Research, Innovation and Genomics strategic risk.-

#### Implications on:

|                                          |                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | Effective risk management supports equitable and safe care delivery for all patients and helps ensure risks affecting people with protected characteristics are identified, assessed and managed appropriately. There are no specific adverse equality impacts arising directly from this report.                                                                                       |
| <b>Health Inequalities</b>               | Effective risk management supports the Trust's ability to identify and mitigate risks that could contribute to health inequalities. There are no specific health inequality implications arising directly from this report.                                                                                                                                                             |
| <b>Finance and Resource</b>              | Failure to effectively manage identified risks may result in increased financial costs through service disruption, regulatory intervention, litigation, agency expenditure, capital investment requirements and loss of operational efficiency. Several high-rated risks continue to have a significant financial impact and require high-levels of investment and resources to reduce. |
| <b>Regulation/Legal</b>                  | Failure to manage high-rated risks may expose the Trust to regulatory challenge or legal liability.                                                                                                                                                                                                                                                                                     |



|                                |                                                                                                                                                      |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CQC-Key line of enquiry</b> | This report supports assurance against the CQC domains of Safe, Effective, Well-Led and Responsive by demonstrating arrangements for risk management |
| <b>Green Plan</b>              | Several risks within the risk profile relate to sustainability. Effective risk management supports delivery of the Trust's Green Plan.               |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
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| <b>Main Report</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <div><p><b>INTEGRATED RISK ASSURANCE REPORT</b><br/><b>BOARD OF DIRECTORS</b><br/><b>SEPTEMBER 2026</b></p><p><b>1. Overall Assessment</b></p><p>The Trust's approach to risk management continues to mature, with risks being consistently identified, captured and reviewed across all levels. Assurance remains reasonable as principal risks to the delivery of the Trust's objectives are being documented and escalated, with evidence of action plans to actively manage and reduce exposure. However, assurance in relation to the completion of actions remains lower than expected, which prevents the Trust consistently achieving a good level of assurance.</p><p><b>2. Current Trust Risk Profile</b></p><p>The Trust continues to maintain a comprehensive system of risk management with 552 active risks recorded across all risk registers. During July 2026, active risk management resulted in a net reduction in risk exposure of 0.2% and the volume of risks remained stable.</p><p>The Trust remains exposed to a number of high-consequence strategic risks, which broadly mirror the known key operational challenges within the organisation - patient safety, workforce, estates infrastructure, digital resilience and flow. These risks directly threaten delivery of all four strategic aims, with the greatest cumulative impact on Quality, Safety and Delivery, People, Culture and Leadership, and Digital First ambitions.</p><p>A summary of the TRR is provided in Appendix 1.</p><ul style="list-style-type: none"><li><b>Safety, Quality and Delivery</b></li></ul><p>The largest proportion of risks relate to direct patient safety and quality of care, including:</p><ul style="list-style-type: none"><li>Emergency Department overcrowding</li><li>Delays to diagnostics and treatment</li><li>Maternity safety</li><li>Critical care capacity</li><li>Cancer pathways</li><li>Ophthalmology waiting times</li><li>Safe staffing levels and higher patient demand</li></ul><ul style="list-style-type: none"><li><b>Workforce Sustainability</b></li></ul></div> |  |



Workforce pressures remain a significant driver of risk across multiple clinical services, particularly in Emergency Medicine, Critical Care, Oncology, Interventional Radiology, Pathology and Maternity.

- **Estates and Infrastructure**

A substantial proportion of high-scoring risks arise from ageing infrastructure and estate condition. With over 60 estates-related risks identified, the estates-risks profile is a significant barrier to the Trust's objective to improve its estate as an enabler to clinical success. Notable estates risks include fire safety compliance and the Tower Block infrastructure, with major programmes ongoing over the medium term to address fire compartmentation, fire doors, fire alarm deficiencies, electrical deficiencies and general dilapidation of the estate. Risks to the programme timing include a potential 3-year delay to the fire alarm installation as outlined in recent Fire Reports to the Board.

Air handling units remain a significant risk to the Trust, particularly in clinical environments, such as theatres, critical care, imaging and specialist treatment areas. These require safety-critical ventilation system to control exposure to hazardous substances and pathogens, rather than for simple environmental comfort. Poor ventilation infrastructure continues to directly impact operational resilience, flow, finance and safety through repeated closure of Theatres and disruption to MRI services. Cancelled procedures lead to increased waiting times, deterioration in performance against national standards, reduced capacity and increased elective recovery pressures.

Collectively, with identified risks in relation to the Tower soil-stack failure and the maintenance backlog across the estate, these risks indicate increasing dependency on ageing assets approaching operational failure and risk multiple infrastructure failures occurring simultaneously. Continued Board oversight and investment planning is required to reduce exposure and maintain safe service delivery.

- **Digital and Cyber Assurance**

The Trust currently holds several high and extreme-rated cyber and digital resilience risks on the Trust Risk Register, including:

- Cyber threats
- Failure of core IT infrastructure and loss of access to business-critical systems and data
- Insufficient disaster recovery and business continuity arrangements following a cyber incident
- Workforce constraints affecting the development and sustainability of digital services and infrastructure

A successful cyber-attack or significant IT outage could affect many systems such as patient information, diagnostic systems, pathology reporting, radiology imaging, prescribing systems and communications. Loss of these systems may delay diagnosis and treatment, result in cancelled operations, procedures and outpatient appointments and reduce emergency care capacity. Reversion to paper-based records leads significant disruption and loss of productivity.

The Trust's cyber risks are not limited to preventing attacks. The Board must also be assured that the organisation can recover effectively when incidents occur.

- **Operational Capacity and Performance**

Demand and capacity pressures continue to impact the risk register profile with Emergency Department capacity and over-crowding risks remaining extreme-rated, alongside the risk of corridor care in the Emergency Department. Poor patient flow through the Emergency Department also remains a high-risk.

Maternity services continue to feature prominently within the Trust's risk profile, with a number of high and extreme risks recorded on both the Women's & Children's Divisional Risk Register and the Trust Risk Register. These risks remain above target scores and require ongoing Board oversight due to their potential impact on maternal and neonatal outcomes.

#### Trust-Level Maternity Risks

- Failure to provide a safe and high-quality maternity service due to inadequate Consultant Obstetrician numbers
- Failure to provide a safe and high-quality maternity ultrasound service due to lack of a dedicated maternity scanning service
- Delayed review, identification and treatment of women and babies attending triage
- Poor outcomes and harm to women and babies resulting from current diabetes management arrangements during pregnancy, labour and post-birth
- Inability to safely provide a home birth service across Gloucestershire

A number of risks relate to the Trust's ability to provide timely access to maternity services:

- Delays to induction of labour processes
- Over-capacity within obstetric theatres affecting safety and quality
- Lack of dedicated multiple pregnancy clinic provision
- Delays in perinatal birth review and reflect services following traumatic births
- Limited consultant capacity to support inpatient reviews and ward rounds

The register also identifies maternity risks associated with governance and assurance processes:

- Overdue Datix maternity incident reviews
- Guidelines not being reviewed or updated in a timely manner
- Lack of appropriate guidance for women birthing outside standard clinical recommendations
- Compliance with National Institute for Health and Care Excellence (NICE) requirements for intermittent auscultation

Digital risks remain an important component of the maternity profile:

- Fetal harm associated with BadgerNet (clinical system) configuration and guidance changes
- Lack of compatible neonatal electronic patient records
- Information governance breaches through BadgerNet single sign-on arrangements

### **3. Risk Mitigation**

In June and July 2026, 28 risks were closed all risk registers, reflecting continued management of risks where controls have been implemented, exposure reduced, or the risk is no longer considered material.

Notable closures during the period included risks relating to:

- National Standards of Healthcare Cleanliness 2021 compliance
- Clinical IT system resilience and Data Security and Protection Toolkit compliance

- Workforce pressures within elderly care services
- Corridor care within the Medical Assessment Zone
- Fire and explosion risks associated with the Cheltenham Energy Centre.

The Board can take assurance that risk registers continue to be actively managed where a risk is no longer considered a credible threat.

Severn risks were also reduced in June and July. These included several maternity risks:

- Fetal Anomaly Screening Programme - reduced as a result of the introduction of a lead Sonographer (risk reduced)
- Major obstetric haemorrhage - robust measures in place now to review all MOH > 2000mls as per maternity care bundle Loss 500-1500 10 cases a month reviewed to check for themes (risk reduced)
- Timely review of obstetric guidelines – new clinical effectiveness midwife now in post to review guidelines (risk reduced)

#### **4. Quality of Risk Management – KPIs**

Risk quality indicators provide strong assurance that risks on active risk registers have controls recorded and identified mitigating actions.

##### **4.1 Reviews and Timeliness**

The number of risks overdue for review rose to 25% in this reporting period, seven of these are Trust-level risks. All risks with review dates prior to July 2025 have now been updated. However, the oldest risk # 92 has been overdue for a year. This has been escalated consistently at RMG and Corporate Divisional Board but has yet to be addressed.

Automated reminders and monthly divisional oversight reports remain in place, as does monthly escalation through the executive review process.

##### **4.2 Actions and Delivery**

Overdue actions are a key indicator of the effectiveness of risk management. A high level of overdue actions may indicate that risks are not being mitigated at the pace required and weakens confidence that risks are being effectively controlled. This creates a risk that exposure to risks will remain static or deteriorate.

Two overdue actions remain on the old system Datix-Web. Both relate to safeguarding matters, with one action overdue by 23 months. This has been escalated consistently at RMG and Corporate Divisional Board for resolution. Action owners have been invited to attend RMG.

There remain significant levels of overdue actions with 338 overdue actions from 659 open actions; an overall overdue rate: 51%. Whilst the number of users with multiple overdue actions has reduced compared with the previous month, further improvement is required to ensure planned mitigations are implemented within agreed timescales.

Overdue actions leave the organisation vulnerable to regulatory scrutiny if identified during inspection, investigation or external review. Continued executive oversight is required to ensure actions associated with high and extreme risks are prioritised and delivered.

## **5. Board Assurance Framework – Strategic Assurance Position**

The Board Assurance Framework provides the strategic line of sight from the Trust's objectives to the principal risks, controls, sources of assurance and identified gaps. Read alongside the Trust Risk Register, it enables the Board to consider whether operational pressures are being translated appropriately into strategic risk and whether the response is sufficient to protect delivery of the Trust Strategy.

The overall strategic risk profile remains highly challenged. No material reductions in the strategic risk scores covered by this update have been identified. The position reflects continued operational, workforce, financial, regulatory and infrastructure pressures, despite evidence of improving governance and strengthening controls in a number of areas.

### **SR1 – Delivery of Safe and Effective Services (12; target 6)**

This Strategic Risk will be reviewed by the Quality and Performance Committee in September 2026.

Assurance continues to be provided through implementation of the Patient Safety Incident Response Framework, mortality and learning-from-deaths arrangements, quality governance transformation, regulatory reporting and maternity oversight. Material gaps remain in NICE compliance, patient involvement, Patient Safety Partner recruitment, complaints improvement, maternity services and the completion of quality governance actions. The operational risk profile, including emergency department crowding, specialist workforce shortages, maternity risks and delayed clinical pathways, reinforces the continuing strategic exposure.

### **SR2 – Workforce Sustainability (15; target 12)**

This Strategic Risk was reviewed by People and Organisational Development Committee in June 2026 and was updated with a reduction in current score from 16 to 15. This reflected continued improvements in vacancy rates and stabilisation of turnover with both recruitment and retention risks on the Trust Risk Register reducing from 16 to 12 during Quarter 1 2026/27. It is recognised that further work is required to achieve a fully sustainable workforce.

Assurance has strengthened through the Workforce Sustainability Programme, workforce controls, targeted recruitment, medical e-rostering and improved alignment of workforce, activity and finance. Gaps remain in establishment control, workforce forecasting and intelligence, succession planning, complete e-rostering implementation and benefits evaluation. High-scoring operational workforce risks in Interventional Radiology, Critical Care, Oncology and other specialist services demonstrate the direct link between the BAF and Trust Risk Register.

### **SR3 – Culture, Experience and Retention (16; target 12)**

The control framework includes staff experience improvement, Freedom to Speak Up, Restorative Justice and Learning Culture approaches, Report, Support and Learn, cultural heatmapping and leadership development. The risk remains scored at 16 with assurance remaining limited by inconsistent staff experience, variable confidence in raising concerns, under-reporting of inappropriate behaviours, high employee relations caseloads and gaps in organisational development capacity, appraisal, succession and talent management. Further work is focused on strengthening the link between insight and targeted intervention through improving leadership capability, aligning resource to risk areas and refreshing both Speaking Up and Equality, Diversity and Inclusion strategies.

Both workforce strategic risks are being reviewed by the People and Organisational Development team with the intention of amending the risks to a consolidated single risk. This revised workforce risk will be brought to the September meeting of People, Partnership & Place Committee for review and approval.

#### **SR4 – Financial Sustainability (25; target for 2026/27 - 25)**

This risk has been regularly reviewed by the Finance and Resource Committee, with the last review in July. This review included updates to reflect the current position that the full year programme was behind trajectory and reliance on non-recurrent funding remains a challenge.

Financial sustainability remains the Trust's highest-scoring strategic risk. Assurance has been reported through the balanced 2026/27 plan, Financial Sustainability Programme oversight, improved budget ownership, the unmodified 2025/26 audit opinion and review of the NHS England Well-Led Financial Governance Toolkit. The score remains unchanged because recurrent savings delivery is behind trajectory, reliance on non-recurrent funding persists and workforce, temporary staffing, procurement and finance-system pressures continue.

#### **SR5 – Performance and Delivery (25; target 9)**

This strategic risk relates to the Trust's ability to provide timely access to services across urgent and emergency care, elective care, cancer services and diagnostics, whilst meeting national performance standards and productivity requirements. The risk encompasses the impact of increasing demand, capacity constraints, workforce pressures, patient flow challenges and wider system dependencies on the Trust's ability to deliver safe, effective and timely care.

Key areas of strategic exposure include Emergency Department overcrowding, delayed patient flow and discharge, extended elective waiting times, cancer pathway performance, diagnostic waiting times, workforce capacity and the resilience of operational delivery arrangements. These challenges have the potential to affect patient outcomes, experience, regulatory compliance, financial performance and organisational reputation. Assurance is provided through performance reporting, recovery programmes, Patient Tracking Lists, operational oversight arrangements and committee scrutiny, including through the Quality and Performance Committee.

Whilst the risk has not been subject to a formal review since February 2026, performance-related risks and recovery actions have continued to be monitored through routine governance processes and operational performance management. A comprehensive review of the risk is scheduled during Quarter 2 (September meeting) to reassess the risk score, controls, assurances and alignment with the current operational environment.

#### **SR6 – Digital Infrastructure and Cyber Resilience (20; target 12)**

The Finance and Resources Committee received evidence of measurable improvement in the Trust's cyber security posture during the June 2026 review. Microsoft Defender for Endpoint assurance data demonstrated that identified vulnerabilities had reduced by approximately 50% across both server and endpoint estates, reflecting improvements in patch management, configuration compliance and device management. Independent external benchmarking through BitSight placed the Trust as the highest-performing NHS organisation in the South West for cyber performance, whilst penetration testing and vulnerability assessment work confirmed successful remediation of a number of previously identified weaknesses. The Trust continues to demonstrate compliance with DSPT requirements however, material issues have arisen in the performance of the Subject Access Request process, which are being reported through the relevant committees through September.

Additional assurance was provided through ongoing remediation of end-of-life systems, strengthened backup and network segmentation arrangements, enhanced supplier assurance

processes, development of improved asset management arrangements, approval and delivery of the datacentre relocation programme and strengthened cyber awareness activity across the workforce. However, material gaps remain in relation to legacy systems awaiting replacement, visibility of all connected and medical devices, organisation-wide testing of business continuity and disaster recovery arrangements, assurance over third-party hosted systems, workforce capacity and long-term capital funding. As a consequence, the strategic risk score remains unchanged notwithstanding evidence of improving control effectiveness.

#### **SR7 – Digital Transformation and Culture (20; target 10)**

Since the previous review, significant progress has been made in strengthening the foundations required to support digital transformation. The Trust's refreshed Digital Strategy is nearing final approval, tactical delivery plans have been agreed with divisions following the business planning process and a structured framework for evaluating, prioritising and sequencing digital initiatives has been established and is being embedded across the organisation. Recruitment has been completed to the Chief Digital Transformation Officer and Chief Operational Information Officer roles, both commencing in July 2026, significantly strengthening senior leadership capacity for digital transformation.

Further progress has been reported in development of the Trust's digital transformation operating model, including work on architecture, software development and change management approaches. However, significant challenges remain in relation to workforce capacity, digital skills shortages, organisational change capability, interoperability between systems, benefits realisation, dependence on national funding and the development of a sustainable digital workforce model. The risk therefore remains significant and requires continued oversight through the Finance and Resources Committee as the Trust moves from planning and governance development into large-scale delivery and adoption.

#### **SR8 – State of the Estates (16; target 12)**

This risk was substantially updated and reviewed by the Finance and Resource Committee in July 2026, reflecting a robust assessment of risk, mitigation gaps with the focus on the introduction and implementation of key controls, including an Estates Strategy.

The BAF records an estimated £86 million backlog maintenance liability, including £57 million relating to critical infrastructure risk. Assurance is developing through work on the Estates Strategy, Strategic Asset Management Plan, Masterplan, Development Control Plan, feasibility studies, capital governance and external support. However, strategic documents and asset surveys are incomplete, capital remains constrained and operational risks relating to fire safety, ventilation, the Tower Block and ageing infrastructure continue to demonstrate significant exposure.

#### **SR9 – Health and Safety Governance (16; target 6)**

Governance has strengthened through the Group Health and Safety Committee, approved framework, executive leadership, Authorising Engineer assurance and specialist sub-groups. Operational progress includes water treatment works, removal of lithium battery chargers, evacuation arrangements and installation of window restrictors. Substantial gaps remain in consistent accountability, subgroup governance, compliance assessment, fire safety, asbestos, ventilation, Building Safety Regulator requirements and delivery of the Tower fire programme.

#### **SR10 – Stakeholder engagement, involvement and community partnership (4; target 3)**

The low score for this strategic risk reflects established arrangements for patient, public and stakeholder involvement across the Trust. Assurance is provided through engagement and involvement programmes, governor and membership engagement, delivery of the Young Influencers programme, development of a new Engagement and Involvement Strategy, and significant stakeholder engagement undertaken in support of the Trust's 2025-30 Strategy.

Whilst the risk remains stable, ongoing challenges include changes to system partner organisations, the future role of governors, capacity to support engagement activity and ensuring the Trust continues to reach seldom-heard communities. Accordingly, the risk remains under review through the Quality and Performance Committee but will be substantially amended during the course of the year to reflect both the internal focus on the strategic voice of patient voice and experience and the external focus on hearing from key community stakeholders.

#### **SR11– Research, Innovation and Genomics (9; target 6)**

A proposed strategic risk has been developed concerning failure to develop, integrate and scale research, innovation, digital transformation and genomics capability in a way that delivers equitable, safe and high-performing outcomes. The draft risk is scored at 9, with a target of 6. The risk was approved at the June meeting of Finance and Performance Committee, which also approved a linked Trust risk relating to the risk of a failure to identify clinical trial patients, breaching National Institute for Health and Care Research (NIHR).

Board is requested to approve the draft Strategic Risk (Appendix 3)

#### **Proposed new strategic risk**

The Director of Improvement and Delivery is currently the need for a strategic risk(s) focused on issues of partnership working and/or transformation. Any proposed strategic risk will be brought to both board and relevant board assurance committee for approval.

#### **CONCLUSION**

The operational and strategic risk positions are broadly aligned. The Trust Risk Register provides evidence of the operational manifestation of the principal strategic risks, while the Board Assurance Framework continues to provide reasonable assurance that the Trust's principal strategic risks are identified, owned and monitored through established executive and Committee oversight arrangements. There is evidence of strengthening governance, more mature articulation of assurance gaps and clearer alignment between the Board Assurance Framework and the Trust Risk Register.

However, the strategic risk environment remains highly pressured, and the risk scores covered by this update have not materially reduced. Sustainable risk reduction will depend on successful delivery of financial recovery, workforce and cultural improvement, quality governance transformation, long-term estates investment, health and safety compliance programmes, and continued progress in digital transformation and cyber resilience.

The Board is invited to take assurance from the progress in governance and oversight, whilst recognising that sustained executive focus, investment, partnership working and evidence of control impact will be required before material reductions in residual risk can be demonstrated.

#### **Enclosures:**

Trust Risk Register (Appendix 1)

Board Assurance Framework Summary (August) (Appendix 2)

Draft Risk 11: Research Innovation and Governance

FOI: Public



## Appendix 1 – Trust Risk Register

| Risk ID | Risk Description                                                                                                                                                                                                                                          | Division                    | Type                       | Current likelihood | Current consequence | Current rating | Target rating | Review Date |
|---------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------|--------------------|---------------------|----------------|---------------|-------------|
| 368     | 3751 The risk of exposure to asbestos due to a failure to manage asbestos in our buildings, leading to avoidable harm to staff, contractors, patients or visitors                                                                                         | Corporate                   | Brilliant Basics           | 3                  | 4                   | 12             | 5             | 01/12/2026  |
| 162     | 2610 The risk of not adhering to numerous pieces of NICE guidance through the inadequate resource of specialist psychology services for cancer and palliative care patients.                                                                              | Diagnostics and Specialties | Quality, Safety & Delivery | 5                  | 3                   | 15             | 1             | 27/08/2026  |
| 374     | 3930 The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC                      | Corporate                   | Quality, Safety & Delivery | 3                  | 5                   | 15             | 4             | 31/03/2026  |
| 674     | 2719 The risk of harm affecting patient and staff safety due to the inefficient evacuation of a hospital building in the event of fire due to poor uptake in evacuation drills and training and a clear evacuation plan.                                  | Corporate                   | Quality, Safety & Delivery | 3                  | 5                   | 15             | 6             | 31/08/2026  |
| 1012    | The risk of critical disruption to operational and clinical services, due to decreased sustainability and delays in development of digital services, systems and infrastructure caused by strategic and tactical workforce constraints.                   | Corporate                   | Digital First              | 5                  | 3                   | 15             | 2             | 30/10/2026  |
| 1042    | Risk of a fall from height from a Tower Block window in Gloucestershire Royal Hospital leading to serious or fatal harm to patients, particularly those without capacity or with mental health conditions                                                 | Corporate                   | Quality, Safety & Delivery | 3                  | 5                   | 15             | 5             | 31/07/2026  |
| 1097    | The risk of insufficient cyber resilience, disaster recovery and business continuity causing prolonged loss of critical systems after a Cyber incident, leading to service disruption, patient harm, financial, regulatory and reputational consequences. | Corporate                   | Digital First              | 3                  | 5                   | 15             | 6             | 30/10/2026  |
| 266     | 3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment due to poor patient flow in the Emergency Department.                                                                                                | Medical                     | Quality, Safety & Delivery | 4                  | 4                   | 16             | 6             | 01/07/2026  |
| 293     | 3879 The inability to provide a Pharmacy Manufacturing Service due to the closure of the department.                                                                                                                                                      | Diagnostics and Specialties | Quality, Safety & Delivery | 4                  | 4                   | 16             | 3             | 01/09/2026  |



|      |                                                                                                                                                                                                                                                            |                             |                                |   |   |    |   |            |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------|---|---|----|---|------------|
| 333  | 3968 Risk of a delay to follow-up appointments leading to significant reduction of vision within the Glaucoma sub-specialty due to insufficient workforce resources.                                                                                       | Surgical                    | People, Culture and Leadership | 4 | 4 | 16 | 6 | 30/11/2026 |
| 425  | 2424 The risk of increased financial impact on theatres and the trust due to ageing and ineffective air handling units                                                                                                                                     | Corporate                   | Estates and Facilities         | 4 | 4 | 16 | 6 | 31/05/2026 |
| 458  | 3326 The risk to quality from an inadequate bed base, estate and facilities within the Department of Critical Care in Gloucestershire Royal Hospital (DCCG)                                                                                                | Surgical                    | Estates and Facilities         | 4 | 4 | 16 | 1 | 24/08/2026 |
| 490  | 3685 The risk of harm to pregnant women and babies due to delayed review, identification and treatment when attending triage.                                                                                                                              | Women's and Children's      | Quality, Safety & Delivery     | 4 | 4 | 16 | 6 | 02/09/2026 |
| 746  | The risk of failure to provide a safe and high-quality maternity service due to inadequate number of Consultant Obstetricians.                                                                                                                             | Women's and Children's      | Quality, Safety & Delivery     | 4 | 4 | 16 | 5 | 02/09/2026 |
| 751  | The risk of failure to provide a safe and high-quality maternity ultrasound service due to a lack of current dedicated maternity scanning service                                                                                                          | Women's and Children's      | Quality, Safety & Delivery     | 4 | 4 | 16 | 3 | 27/08/2026 |
| 764  | S2045 The risk of reduced quality of care in the fractured neck of femur (NOF) pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Roy | Surgical                    | Quality, Safety & Delivery     | 4 | 4 | 16 | 8 | 19/10/2026 |
| 850  | The risk of increased workplace stress in Oncology due to an imbalance of consultant workforce across Oncology against workload                                                                                                                            | Diagnostics and Specialties | People, Culture and Leadership | 4 | 4 | 16 | 2 | 09/09/2026 |
| 911  | The risk of significantly reduced quality of patient care and management caused by insufficient general anaesthetic workforce to manage the clinical demands upon service                                                                                  | Surgical                    | Quality, Safety & Delivery     | 4 | 4 | 16 | 4 | 30/09/2026 |
| 1001 | The risk to the quality of breast services within Gloucestershire Hospitals due to the breast screening service being unable to meet key performance indicators                                                                                            | Surgical                    | Quality, Safety & Delivery     | 4 | 4 | 16 | 1 | 30/09/2026 |
| 1016 | The risk of reduced quality of service provision caused by insufficient Critical Care consultant workforce to manage the clinical demands upon service.                                                                                                    | Surgical                    | Quality, Safety & Delivery     | 4 | 4 | 16 | 4 | 31/08/2026 |
| 1060 | The risk of poor outcomes and harm to women and babies as a result of the current diabetes management and guidelines during pregnancy, labour and post-birth                                                                                               | Women's and Children's      | Quality, Safety & Delivery     | 4 | 4 | 16 | 4 | 01/09/2026 |

|      |                                                                                                                                                                                                                                                           |                             |                                |   |   |    |   |            |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------|---|---|----|---|------------|
| 1143 | The risk of harm to women, babies and staff due to an inability to safely provide a home birth provision across Gloucestershire.                                                                                                                          | Women's and Children's      | Quality, Safety & Delivery     | 4 | 4 | 16 | 3 | 31/08/2026 |
| 363  | 3371 The risk of statutory intervention due to non-compliant fire safety infrastructure including an obsolete fire alarm at GRH, poor compartmentation / fire doors and insufficient break-glass points; leading to harm to patients, visitors and staff. | Corporate                   | Brilliant Basics               | 4 | 5 | 20 | 6 | 23/07/2026 |
| 401  | The risk of core IT infrastructure equipment failure and loss of access to business-critical data as a result of environmental hazards, e.g. loss of essential service; power / AC, heatwave, floods water leaks and ingress etc.                         | Corporate                   | Digital First                  | 4 | 5 | 20 | 3 | 30/10/2026 |
| 426  | 2268 The risk to patients within the Minors Area of the Emergency Department due to overcrowding and staffing                                                                                                                                             | Medical                     | Quality, Safety & Delivery     | 5 | 4 | 20 | 4 | 01/07/2026 |
| 600  | The risk of patient harm, cancelled or delayed surgical procedures, and degradation of service quality arising from recurrent failures in systems and processes in SSD & Theatres                                                                         | Surgical                    | Quality, Safety & Delivery     | 5 | 4 | 20 | 3 | 31/10/2026 |
| 841  | The risk of being unable to deliver acute and cancer patient care due to a critical shortage of Interventional Radiologists                                                                                                                               | Diagnostics and Specialties | People, Culture and Leadership | 5 | 4 | 20 | 6 | 08/10/2026 |
| 1096 | The risk of the Trust's digital environment being compromised by cyber threats exploiting vulnerabilities (e.g. unsupported systems, poor patching, unmanaged devices, weak controls and asset management), leading to loss of data or system integrity,  | Corporate                   | Digital First                  | 4 | 5 | 20 | 6 | 30/09/2026 |
| 1185 | The risk of significant and sustained critical staffing shortages amongst the non-consultant medical and ACCP workforce within Critical Care impacting staff wellbeing, service quality and safety.                                                       | Surgical                    | People, Culture and Leadership | 5 | 4 | 20 | 8 | 10/08/2026 |
| 1202 | The risk to patient safety of compromised clinical care due to being placed in a corridor within the emergency department at GRH                                                                                                                          | Medical                     | Quality, Safety & Delivery     | 5 | 4 | 20 | 4 | 01/07/2026 |



## APPENDIX 2 – BOARD ASSURANCE FRAMEWORK SUMMARY (SEPTEMBER 2026)

| Strategic aim                                  | Risk title and description                                                                                                                                                                                                                         | Initial score   | Current score | Target score         | Risk owner | Committee |
|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------|----------------------|------------|-----------|
| <b>SR1</b><br>Quality, Safety & Delivery       | Inability to deliver safe and effective services against regulatory and statutory requirements.                                                                                                                                                    | 20<br>5x4       | 12<br>4x3     | 6<br>3x2             | CN/MD      | QPC       |
| <b>SR2</b><br>People, Culture & Leadership     | Inability to attract and sustain a skilled, diverse and adaptable workforce, leading to skills shortages, reduced service quality, reduced productivity and increased costs.                                                                       | 20<br>4x5       | 15<br>5x3     | 12<br>4x3            | CPO        | PODC      |
| <b>SR3</b><br>People, Culture & Leadership     | Inability to retain a skilled, compassionate and diverse workforce because of a poor cultural environment and insufficient development opportunities, adversely affecting staff experience.                                                        | 20<br>4x5       | 16<br>4x4     | 12<br>4x3            | CPO        | PODC      |
| <b>SR4</b><br>Quality, Safety & Delivery       | Failure to meet statutory and regulatory requirements for the management of financial resources.                                                                                                                                                   | 25<br>5x5       | 25<br>5x5     | 25<br>5x5<br>2026/27 | DoF        | FRC       |
| <b>SR5</b><br>Quality, Safety & Delivery       | Failure to provide timely access to urgent and emergency, elective, cancer and diagnostic services, and to meet national performance and productivity requirements.                                                                                | N/A<br>New risk | 25            | 9                    | COO        | QPC       |
| <b>SR6</b><br>Digital First                    | Infrastructure and Cyber – Reliable Digital Foundations. Risk that digital infrastructure and cyber security arrangements are not sufficiently robust, resilient, connected or current to support safe, effective and continuous service delivery. | 15<br>3x5       | 20<br>4x5     | 12<br>3x4            | CDIO       | FRC       |
| <b>SR7</b><br>Digital First                    | Digital Transformation and Culture. Risk that the Trust may not develop or sustain the culture, operating models, architecture, skills and leadership required to deliver digital transformation at scale and pace.                                | N/A             | 20<br>4x5     | 10<br>2x5            | CDIO       | FRC       |
| <b>SR8</b><br>Quality, Safety & Delivery       | State of the Estates. Risk that sub-standard asset condition and estate compliance adversely affect safety, patient and staff experience, operational resilience and service delivery.                                                             | 20<br>4x5       | 16<br>4x4     | 12<br>4x3            | COO        | FRC       |
| <b>SR9</b><br>Quality, Safety & Delivery       | Health and Safety Governance. Risk that the Trust does not maintain a robust, integrated and consistently embedded framework for meeting statutory health and safety duties.                                                                       | 20<br>4x5       | 16<br>4x4     | 6<br>3x2             | DoIG       | AAC       |
| <b>SR10</b><br>Patient Experience & Voice      | Failure to engage and involve patients, carers and communities in shaping services and experience.                                                                                                                                                 | 4<br>2x2        | 4<br>2x2      | 3<br>1x3             | DoID       | QPC       |
| <b>SR11</b><br>Research, Innovation & Genomics | Failure to develop, integrate and scale research, innovation, digital transformation and genomics capability in a way that delivers equitable, safe and high-performing outcomes.                                                                  | N/A<br>New risk | 9             | 6                    | MD         | FRC       |

|               |                                                                                                                                                                                                    |            |             |                              |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------|------------------------------|
| Risk Title    | Proposed Single Strategic Risk (RIG)                                                                                                                                                               |            |             |                              |
|               | Failure to develop, integrate and scale research, innovation, digital transformation and genomics capability in a way that delivers equitable, safe and high-performing outcomes across the Trust. |            |             |                              |
| Strategic Aim | Research and Innovation                                                                                                                                                                            | Risk Owner | Date Opened | Oversight Committee or Group |
|               |                                                                                                                   | Noel Peter |             | Finance & Resources          |

| Initial Score<br>(lxc)with no controls applied                                                                                                                                                                                                                                                           | Current score<br>(lxc)with controls in place                     | Target Score<br>(lxc) after actions are completed                                                           | Last reviewed | Current Score History                                                                                                                                                                                       |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
|                                                                                                                                                                                                                                                                                                          | <b>9 (High)</b><br>(Consistent across all three component risks) | <b>6 (Moderate)</b><br>Reflecting the same trajectory and external dependencies identified across the risks |               |                                                                                                                                                                                                             |  |  |  |  |  |
| <b>Causes:</b> <ul style="list-style-type: none"><li>Insufficient R&amp;I workforce capacity and limited protected clinical academic time</li><li>Weak integration between research, digital functions and clinical services</li><li>Limited digital and AI capability and governance maturity</li></ul> |                                                                  |                                                                                                             |               | <b>Impact:</b> <ul style="list-style-type: none"><li>Reduced access to clinical trials, genomics and innovation for patients</li><li>Increased health inequalities and inequitable service access</li></ul> |  |  |  |  |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Legacy systems, interoperability issues and variable digital literacy</li> <li>• Underdeveloped innovation governance frameworks and SOPs</li> <li>• Underrepresentation of disadvantaged populations and limited community engagement</li> <li>• Inadequate demographic intelligence and equity data</li> <li>• External pressures including funding competition and national performance metrics)</li> </ul> | <ul style="list-style-type: none"> <li>• Patient safety risks associated with digital and AI implementation</li> <li>• Failure to realise productivity and transformation benefits</li> <li>• Reduced organisational attractiveness and workforce sustainability</li> <li>• Loss of funding, partnerships and innovation opportunities</li> <li>• Reputational damage and failure to meet NHS strategic objectives</li> <li>• </li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| Controls<br>What is in place to manage the risk?                                                                                                                                                                                                                                                                                                                                                                                                                  | Assurance/Evidence<br>How do we know we are making an impact?                                                                                                                                                                                                                                                                                                                                                                           | Gaps in Controls<br>Actions to be taken to achieve target                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Key Controls / Mitigations</b> <ul style="list-style-type: none"> <li>• RIG governance structures and oversight processes</li> <li>• Digital transformation programmes (e.g. EPR, FDP)</li> <li>• Clinical safety and data security frameworks</li> <li>• PPIE and equality impact assessment processes</li> <li>• Collaboration with academic, ICS and community partners</li> <li>• R&amp;D delivery teams and existing NIHR/commercial portfolio</li> </ul> | <b>Assurance Position</b><br><b>Positive</b> <ul style="list-style-type: none"> <li>• Existing governance, reporting and benchmarking frameworks</li> <li>• Internal audit and regulatory oversight</li> </ul> <b>Negative</b> <ul style="list-style-type: none"> <li>• Workforce fragility</li> <li>• Variable engagement and adoption across the Trust</li> <li>• Limited performance intelligence and governance maturity</li> </ul> | <ul style="list-style-type: none"> <li>• Limited integration with clinical divisions and inconsistent engagement</li> <li>• Workforce capability and succession planning gaps</li> <li>• Immature AI and innovation governance frameworks</li> <li>• Limited real-time performance and innovation pipeline reporting</li> <li>• Insufficient equity data and community insight</li> <li>• Inconsistent digital adoption and evaluation frameworks</li> </ul> |

| Action to address gaps in assurance / control                                                                                   | Lead       | Date – when will action be completed? | Status update                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------|------------|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Strengthen <b>divisional accountability and clinical engagement</b></li> </ul>           | Noel Peter | August 2027                           | Regular meetings with Chief of Services and departmental leads are being established.                                                                                                                                                                                                          |
| <ul style="list-style-type: none"> <li>Develop <b>Trust-wide innovation and AI governance framework</b></li> </ul>              | Noel Peter | March 2027                            | Due Diligence SOP has been completed. Further SOP and Governance Framework in progress for external and internal AI/Innovation projects                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Build <b>workforce capability (research, digital, AI, inclusive practice)</b></li> </ul> | Noel Peter | January 2028                          | Homegrown research working group programme is being established. There are plans to develop and run a training/education programme for staff to increase understanding and capability around research and innovation. We anticipate the first cohort to commence in January 2027               |
| <ul style="list-style-type: none"> <li>Expand <b>academic, commercial and community partnerships</b></li> </ul>                 | Noel Peter | January 2028                          | <p>We have been informed PASU/PMU will reopen to commercial studies from January 2027, this will give us the opportunity to increase activity and strengthen partnerships.</p> <p>Academic links with UoG have been established and a programme of research opportunities to be developed.</p> |
| <ul style="list-style-type: none"> <li>Improve <b>equity data, inclusion and community-led research models</b></li> </ul>       | Noel Peter | July 2027                             | Health Inequality working group to be set up with UoG, ICB and GCC to establish a focus on inclusion and community-led research.                                                                                                                                                               |
| <ul style="list-style-type: none"> <li>Establish <b>innovation evaluation methodology</b></li> </ul>                            | Noel Peter | March 2027                            | Internal Innovation disclosure, development, and governance processes being set-up.                                                                                                                                                                                                            |

| Link to the Board Risk Register: key linked operational risks |                  |       |               |                 |
|---------------------------------------------------------------|------------------|-------|---------------|-----------------|
| Ref.                                                          | Risk description | Score | Review Status | Action in place |
|                                                               |                  |       |               |                 |
|                                                               |                  |       |               |                 |
|                                                               |                  |       |               |                 |

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## Report to Board of Directors

|                                   |                                       |
|-----------------------------------|---------------------------------------|
| <b>Date of Meeting</b>            | 10 <sup>th</sup> September 2026       |
| <b>Report title</b>               | Chief People Officer's Insights       |
| <b>Sponsoring Director/Author</b> | Caroline Julien, Chief People Officer |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| <p>This report updates the Board on a significant programme of national workforce reforms and developments requiring oversight, assurance, and implementation planning during 2026/27. These include the NHS Staff Standards, the NHS Leadership and Management Framework, national job evaluation and nursing profile review requirements, workforce culture and equality developments, Transforming People Services, NHS PeoplePortal and the Employment Rights Act 2025. Collectively, these represent a major shift towards nationally monitored standards, stronger employment protections, clearer leadership accountability, improved staff experience, and enhanced Board-level assurance.</p> <p>The report highlights that the Trust has already commenced activity across a number of these areas, including gap analysis, project governance, and People, Place &amp; Partnership Committee oversight (previously People &amp; OD Committee). Key areas of focus include improving staff safety, tackling racism and other forms of discrimination, strengthening leadership and management capability, managing job evaluation and equal pay risks, preparing for digital workforce transformation, and ensuring compliance with evolving legal and regulatory requirements.</p> <p>From the new Chief People Officer for the Trust, having joined in July, this report provides an opportunity to present the Board with an important overview of key workforce matters. The Board is asked to note the scale and significance of these national reforms and support the proposed approach for oversight through the People, Place &amp; Partnership Committee, with escalation to Board where strategic direction or further scrutiny is required. Further work will be needed to establish baseline positions, finalise delivery plans, define measurable outcomes and risks, and provide ongoing evidence of compliance, improvement and impact.</p> |     |
| Previously considered by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | N/A |

## Recommendations:

The Board is asked to:

- NOTE the scale and significance of the national workforce reforms outlined in this paper and the implications for Board oversight, assurance and organisational readiness.
- SUPPORT the proposed approach for oversight of individual programmes through the People, Place & Partnership Committee, with regular reporting, targeted deep dives and escalation to Board where strategic direction or further scrutiny of service –delivery issues is required.
- REQUEST that delivery plans for each priority area will include clear baseline Trust positions, principal measurable outcomes, milestones, risks, mitigations and evidence of impact/current assurance ratings be reported to the People, Place & Partnership Committee.
- ENDORSE the alignment of these programmes with the Trust's workforce, culture, inclusion, digital, productivity and transformation priorities as described in the Trust's strategy.
- NOTE that further updates will be brought to the Board as national requirements, implementation plans and local risks become clearer.

## Strategic Aims (tick as appropriate)

|                                                                                                                           |   |
|---------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>     |   |
|  <b>People, culture and leadership</b> | X |
|  <b>Quality, safety and delivery</b>   |   |
|  <b>Digital first</b>                  |   |

## Impact on any Strategic Risks?

A review of the Workforce Strategic Risks is being undertaken and will be considered at the People, Place and Partnership Committee in September. These developments will need to be assessed in that context with a reconsideration of the risk descriptions, current controls and gaps in control or assurance. It is anticipated that the revised risk will be finalised and approved by PPPC at its November meeting.

## Implications on:

|                                          |                                                                                                                                                                                                                          |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | The implementation of the workforce changes referred to in the report should lead to improvements in staff experience and a reduction in unwarranted variations between staff groups based on protected characteristics. |
| <b>Health Inequalities</b>               | No direct impact anticipated.                                                                                                                                                                                            |

|                                |                                                                                                                           |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Finance and Resource</b>    | A full finance/resource assessment is not yet complete.                                                                   |
| <b>Regulation/Legal</b>        | Compliance with the workforce changes referred to in the report are either a legal or regulation requirement, or both.    |
| <b>CQC-Key line of enquiry</b> | The report aligns with the CQC Well-Led domain by evidencing effective leadership, governance and oversight arrangements. |
| <b>Green Plan</b>              | Not assessed                                                                                                              |

## Main Report

### 1. Introduction

This briefing updates the Board on significant national workforce developments from the Department of Health and Social Care (DHSC), NHS England (NHSE) and the NHS Staff Council that require Board oversight, assurance and implementation planning during 2026/27.

It is proposed that these priority areas are overseen by the People, Place & Partnership Committee on behalf of the Board through regular reports and targeted deep dives, with escalation and opportunities for full Board scrutiny, engagement and strategic direction-setting where required.

The key developments are:

1. **Implementation of the NHS Staff Standards**
2. **Implementation of the NHS Leadership and Management Framework**
3. **National Job Evaluation and Nursing Profile Review Programme**
4. **Workforce culture, safety, leadership and equality**
5. **Transforming People Services**
6. **Employment Rights Act 2025**

Collectively these developments represent the most substantial national people agenda reforms since the introduction of the NHS People Promise and reflect the ambitions of the NHS 10-Year Health Plan. The emphasis is on moving from voluntary improvement activity to nationally monitored standards, with Board-level accountability for delivery. There are also significant legal changes impacting the Trust as an employer.

Considerable activity is already underway within the Trust. These developments provide an opportunity to review, strengthen and innovate our approach, improve governance of key workforce matters, and assess performance against nationally set standards and expectations.

### 2. NHS Staff Standards

NHS England and DHSC published the new NHS Staff Standards in July 2026. They are **reducing violence against staff, tackling racism, promoting flexible working, championing sexual safety, health and wellbeing, and line management**. They establish mandatory minimum expectations for NHS employers and will be monitored through the NHS Oversight Framework and wider assurance processes.

Unlike previous staff experience initiatives, the Standards are intended to be measurable and monitored nationally with staff experience expected to be given the same level of attention as operational and financial performance.

Delivery plans will need to demonstrate impact as well as activity, including measurable improvements in staff experience, evidence-based interventions, compliance with statutory duties and targeted action where inequalities are identified.

The Trust's current performance against the NHS Staff Standards, initial gap analysis, proposed governance arrangements and delivery framework will be presented to the People, Place & Partnership Committee in September 2026. This will include identification of areas of strong assurance, gaps requiring further development, and the measures that will be used to monitor improvement and provide ongoing Board assurance.

| Staff Experience Framework: one integrated model for culture, experience and retention                                                                                          |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>National drivers</b><br>NHS Staff Standards<br>NHS People Promise<br>Leadership and Management Framework<br>Lord Mann, Ockenden and Amos reviews                             | <b>Staff Standards</b><br>Reducing violence against staff<br>Tackling racism<br>Promoting flexible working<br>Championing sexual safety<br>Health and wellbeing<br>Line management | <b>Local intelligence</b><br>Staff Survey and National Quarterly Pulse Survey, Wellbeing Survey<br>Workforce Race and Disability Standards (WRES/WDES), Pay gaps<br>Freedom to Speak Up, Report, Support & Learn, employee relations themes<br>Staff networks and lived experience, Divisional culture insight |
| <b>Cross-cutting strategic enablers</b><br>Leadership, Learning and Organisational Development<br>Safe, Healthy and Respectful Workplaces, Inclusion, Belonging and Staff Voice |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                |
| <b>Delivery method</b><br>Map existing work<br>Complete gap analysis<br>Prioritise targeted action<br>Measure activity, reach, experience and impact                            | <b>Integrated Staff Experience Committee</b><br>Single strategic steering and assurance forum replacing fragmented governance, with specialist reporting routes where required.    | <b>Assurance route</b><br>Divisional ownership<br>People and OD governance<br>Executive and Board oversight with clear line of sight to Board Assurance Framework                                                                                                                                              |
| <b>Intended outcomes:</b> Improved staff experience, stronger retention, safer workplaces, inclusive culture, better leadership, clearer assurance, and reduced duplication.    |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                |

**3. NHS Leadership and Management Framework**

The NHS Leadership and Management Framework marks a significant national shift towards professionalising leadership and management across the NHS. Developed in response to the Messenger and Kark reviews, it sets consistent national expectations for leadership practice and places greater emphasis on capability, accountability, culture and organisational performance.

The framework is a critical enabler of the Trust's wider workforce, culture and staff experience ambitions, rather than a standalone leadership development initiative. Published in July 2026, it aligns with the NHS Staff Standards, NHS People Promise and national expectations on culture, inclusion, wellbeing, speaking up and leadership accountability.

It includes:

- **A Leadership and Management Code** - Expected behaviours and principles for leaders and managers.
- **National Standards and Competencies** - A common set of standards across leadership levels.
- **National Curriculum-** To be published in Winter 2026.



NHS England expects provider organisations to embed the framework across the employee lifecycle, including recruitment, selection, appraisal, leadership development, succession planning and talent management. Boards are expected to identify executive sponsorship and ensure adoption across their organisations.

A comprehensive gap analysis is underway and will inform a Trust-wide implementation plan covering leadership development, talent management, succession planning, appraisal, recruitment and organisational development. Findings, proposed governance and assurance arrangements will be presented to the People, Place & Partnership Committee to support Board oversight of implementation and organisational readiness.

#### 4. NHS Nursing Job Evaluation Programme

In 2025, the Secretary of State and NHS England issued clear expectations that organisations must strengthen application of the NHS Job Evaluation Scheme which underpins the terms and conditions of staff on Agenda for Change terms and conditions.

Trust Boards were asked to be sighted on risks associated with outdated job descriptions, inconsistent application of job evaluation, lack of current matching records and equal pay exposure, with particular concerns regarding nursing and midwifery roles.

Trust Boards were also asked to ensure clear executive accountability, sufficient organisational capability and robust governance arrangements to support consistent application of the NHS Job Evaluation Scheme. Appropriate assurance is required on workforce, financial, employee relations and equal pay risks. National guidance also emphasises effective partnership working with recognised trade unions, staff confidence in role evaluation and sufficient Job Evaluation capacity and capability.

Board-level responsibility for job evaluation rests with the Chief People Officer.

##### a. National Band 5 Nursing Profile Review

Updated nursing and midwifery profiles for Bands 4-9 were published in June 2025. National guidance requires organisations to review local job documentation and job evaluation arrangements.

NHSE wrote to NHS Boards and asked for assurance that the Board:

- Understand local job evaluation risks
- Have executive sponsorship
- Ensure governance arrangements are in place

- Monitor nursing profile implementation
- Understand equal pay exposure
- Receive regular assurance reporting

Matt Holdaway, Chief Nurse, is the executive Senior Responsible Officer for this workstream, working with the CPO, as the Board-level director responsible for job evaluation. A project group has been established to oversee delivery, in partnership with Staff Side. Both the Board and People & OD Committee have received regular updates, including ahead of the July 2026 submission to NHS England on the plan for Band 5 nurses to review their roles against their job descriptions.

The Trust has established a Nursing and Midwifery Job Evaluation Project Group to oversee delivery, monitor risks, support governance and coordinate implementation. The Trust is also using additional infrastructure funding to increase Job Evaluation capacity and is exploring additional project management resource to support delivery. Successful delivery should strengthen the organisation's ongoing capability to undertake matching, evaluations, quality assurance and future role reviews in line with national requirements.

## **5. Workforce culture, safety, leadership and equality**

### **a. NHS Review into Organisational Culture and Inclusion**

Recent national reviews have reinforced expectations that NHS organisations create cultures that are psychologically safe, inclusive, free from discrimination and bullying, able to hear and act on staff concerns, and clear about accountability for leadership behaviours.

The Lord Mann Review ([Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system - GOV.UK](#)) has strengthened attention on:

- Racism and discrimination
- Speaking up culture
- Inclusive leadership
- Fair treatment in workforce processes
- Board visibility of culture risks

At a recent Board development session, the Board discussed these matters and confirmed that it would, in accordance with NHS England guidance, accept the recommendations from the Lord Mann review. It also committed to developing a plan aligned with NHS standards, with an emphasis on moving beyond statements to visible, sustained action on inclusion, accountability and culture, integrated with wider organisational priorities and frameworks.

Most of this work will form part of the delivery plan under the relevant Staff Standards, as well as the work to review and update the Board Assurance Framework strategic risks related to people and culture through the People, Place & Partnership Committee.

### **b. Supreme Court Judgment on Sex and the Equality Act and the EHRC Code of Practice and Guidance**

In April 2025 the UK Supreme Court ruled that, for the purposes of the Equality Act 2010, references to "sex", "woman" and "man" should be interpreted as biological sex. The ruling has significant implications across public services, including NHS employers, and guidance from both the Equality and Human Rights Commission (EHRC) and NHS England was therefore key to Trusts responding to the ruling, which resulted in a delay in individual Trust responses.



The ruling does **not** remove legal protections for individuals with the protected characteristic of gender reassignment under the Equality Act 2010. Those protections continue to apply.

Areas potentially affected include:

- Staff changing facilities and toilets
- Single-sex accommodation and single-sex services
- Policies and guidance relating to sex and gender
- Equality impact assessments

Following the Supreme Court ruling, the Equality and Human Rights Commission (EHRC) updated its Code of Practice for Services, Public Functions and Associations and guidance relating to the application of the Equality Act, which came into force in August 2026.

The EHRC guidance states that where organisations lawfully provide single-sex services or facilities, these should generally operate on the basis of biological sex. At the same time, organisations must continue to consider their obligations towards transgender people and seek to avoid unlawful discrimination. The guidance notes that alternative provision, such as gender-neutral facilities, may need to be considered where appropriate.

The EHRC states that the updated code does not create new law but provides authoritative guidance on the application of existing legislation.

The Trust has established a multidisciplinary working group to review the implications of the Supreme Court judgment and the updated EHRC statutory Code of Practice for Services, Public Functions and Associations, in line with EHRC guidance.

The group is undertaking a structured review with the following workstreams:

- Estates and Facilities
- Clinical Services and Pathways
- Workforce
- Policies and Governance
- Data and Digital Systems
- Communications, Education and Culture

Progress, risks, and proposed changes will be reported through the appropriate governance routes to provide assurance to the People, Places & Partnership Committee, the Finance & Resources Committee, and/or the Quality & Performance Committee.

## **6. Transforming People Services (TPS)**

NHS England's Transforming People Services (TPS) programme is establishing a national Target Operating Model for NHS People Services. The programme aims to modernise, standardise and redesign HR & OD functions to improve efficiency, productivity, employee experience and strategic workforce impact. The ambition is for People Services to become more digitally enabled, customer-focused and aligned to organisational priorities.

Nationally, the programme is focused on:

- Standardisation and simplification of people processes
- Greater use of digital platforms, automation and artificial intelligence
- Reduction in transactional activity
- Strengthening strategic workforce planning capability
- Improved employee and manager experience
- Greater collaboration across organisations and systems

The Southwest has been identified as one of NHS England's accelerator regions for TPS, meaning the region is expected to progress implementation at pace and help shape the national model. This places the Trust in the early phases of transformation activity and increases the importance of local readiness and engagement.

While the final national operating model remains under development, it is anticipated that NHS organisations may need to adapt aspects of their People Services delivery model, workforce structure, digital systems and ways of working to align with emerging national requirements.

Current regional planning assumptions include:

- Development of a Southwest regional Outline Business Case (OBC) during September 2026.
- Progression to a Full Business Case (FBC) in January 2027.
- Consideration of future operating arrangements across provider organisations, including opportunities for standardisation, shared delivery models, digital enablement and service redesign.

Within the Trust, a TPS Group has been established to oversee local implementation, assess emerging national requirements, identify risks and opportunities, and ensure organisational readiness. Karen Johnson chairs the Southwest TPS Chief Finance Officer group, and Faye Bradley, Deputy Director for People & OD, is the Trust lead for TPS implementation.

The People, Place & Partnership Committee received an update on the TPS programme in June and will receive further updates as the programme progresses.

The People & OD function is reviewing its services to align with the Trust's strategic priorities, operational requirements and the emerging TPS model. This will provide greater clarity on the function's core purpose, service offer, operating model, workforce capability requirements and opportunities for digital enablement and continuous improvement. An overview of the People & OD delivery framework will be presented to the PPPC in September with a more detailed report on programmes coming to its November meeting.

#### **a. NHS PeoplePortal**

NHS PeoplePortal is the national workforce platform that will replace the current Electronic Staff Record (ESR) and support the full employee lifecycle, including recruitment, onboarding, workforce management, payroll, career development and retirement processes.

The programme is intended to provide a more modern, integrated and digitally enabled workforce infrastructure, support improved workforce planning and management information, and align with the wider Transforming People Services agenda.

The national programme has been formally rebranded as 'NHS PeoplePortal', reflecting its transition from programme design into delivery. It represents a major national investment in workforce infrastructure and aims to replace ESR and multiple local workforce systems with a single integrated platform for NHS organisations across England and Wales.

The programme is currently progressing through the design and implementation phase. Several NHS organisations have been invited to participate as early adopters (although not GHFT), with implementation and go-live activity expected from early 2028. The wider NHS rollout is expected to commence from 2028 onwards.



The People, Place & Partnership Committee will receive reports to ensure ongoing oversight and assurance on organisational readiness, emerging risks and opportunities, and alignment with the Trust's broader workforce transformation agenda.

## **7. Employment Rights Act 2025**

The Employment Rights Act 2025 has already introduced measures since it received Royal Assent in December 2025, while some elements are still subject to consultation or have an effective date of later in 2026 or 2027. The Act shifts the employment relationship towards earlier employment protections, stronger worker rights, enhanced trade union involvement, increased family-friendly benefits, and greater employer accountability.

Two of the most significant upcoming elements for the Trust are changes to unfair dismissal and proposed changes to zero-hours contracts.

From January 2027, the two-year unfair dismissal qualifying service period will reduce to six-months and the statutory cap on compensatory awards will be removed. This will impact probation periods and will require changes to the relevant policies, as well as strengthened management of early performance, attendance or conduct issues. It may also result in more employment tribunal claims being lodged against the Trust and a great financial impact.

It is also anticipated that, from 2027 zero-hours, low-hours and agency workers will be offered guaranteed-hours contracts and compensation where shifts are cancelled at short notice. NHS Employers have asked the government to pause its proposed changes; its Chief Executive, Ben Morrin says “the current proposals risk creating significant unintended consequences for the NHS”. [Pause zero-hours reforms over cost risk, warns NHS Employers | NHS Employers](#) The outcome of the consultation and next steps will help determine the scale of the financial impact for the Trust and the work needed to be undertaken to ensure compliance to the new requirements.

As changes take effect, the Trust must ensure it updates its policies and procedures, and any relevant training and documentation. It is the role of the refreshed People & OD Oversight Group to ensure operationalisation of the changes and to report to the People, Places and Partnership Committee to provide assurance of compliance, highlight identified risks and mitigating actions.

## **8. Conclusion**

The NHS Staff Standards, NHS Leadership and Management Framework, national Job Evaluation updates, equality and inclusion developments, Transforming People Services and the Employment Rights Act 2025 collectively represent significant changes to the NHS people agenda and will require sustain organisational attention throughout 2026/27 and beyond.

A number of local governance and delivery arrangements are in place or being urgently reviewed to develop robust plans, monitor delivery, manage risks and maximise the opportunities these developments present for workforce experience, organisational performance and patient care. Further work is needed to establish baseline positions, finalise delivery plans, define measurable outcomes and risks, and strengthen assessment and reporting of evidence of compliance, improvement and impact.

Reports including baseline assessment, measurable milestones, agreed outcome indicators, dashboard reporting, triangulation of quantitative and qualitative evidence, and clear line of sight to the Board Assurance Framework. will be provided to the People, Place & Partnership Committee, which will oversee this work on behalf of the Board, with escalation when required.

|                                                |
|------------------------------------------------|
| Enclosures                                     |
| Appendix 1 Key risks and mitigation strategies |
| FOI: Public                                    |

## Appendix 1 - Key risks and mitigation strategies

The following cross-cutting risks will have oversight through the People, Place & Partnership Committee, with escalation to Board as required.

| Risk                                           | Potential impact                                                                                                                                                                                         | Mitigation and assurance route                                                                                                                                                                                                            |
|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Delivery capacity and competing priorities     | Insufficient capacity to deliver multiple national workforce reforms at pace, leading to delayed implementation or fragmented delivery.                                                                  | Prioritised delivery plans, clear executive sponsorship, programme governance, regular reporting to the People, Place & Partnership Committee.                                                                                            |
| Compliance and legal exposure                  | Failure to meet statutory, regulatory or national requirements, including employment rights, equality duties, job evaluation obligations and staff safety standards.                                     | Legal and HR policy review, equality impact assessment, partnership working with Staff Side, strengthened documentation, clear audit trails and targeted assurance against national requirements.                                         |
| Equality, inclusion and culture risk           | Failure to address discrimination, bullying, racism, sexual safety, speaking up or unequal staff experience may affect staff confidence, retention, regulatory confidence and organisational reputation. | Integrated Staff Experience governance, use of Staff Survey, WRES, WDES, pay gap, FTSU and employee relations intelligence, targeted interventions, staff network engagement and reporting through People, Place & Partnership Committee. |
| Financial and equal pay risk                   | Inconsistent job evaluation, outdated job descriptions or insufficient matching records may increase equal pay exposure and create unplanned financial consequences.                                     | Nursing and Midwifery Job Evaluation Project Group, executive SRO oversight, increased job evaluation capacity, Staff Side partnership, risk monitoring and regular Board and Committee assurance.                                        |
| Digital and workforce transformation readiness | Insufficient readiness for Transforming People Services and NHS PeoplePortal could affect service continuity, data quality, workforce reporting, employee experience and benefits realisation.           | TPS Group, regional engagement, local readiness assessment, People & OD service review, digital planning and updates to People, Place & Partnership Committee.                                                                            |
| Measurement and evidence of impact             | Activity may be delivered without clear evidence of improvement, making it difficult to demonstrate compliance, impact or value for money.                                                               | Baseline assessment, measurable milestones, agreed outcome indicators, dashboard reporting, triangulation of quantitative and qualitative evidence, and clear line of sight to the Board Assurance Framework.                             |

## Report to Public Board of Directors

|                                   |                                                                                                                                                                                            |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of Meeting</b>            | <b>Thursday, 10<sup>th</sup> September 2026</b>                                                                                                                                            |
| <b>Report title</b>               | <b>Annual Report of the Guardian of Safe Working Hours (GOSW) for Doctors and Dentists in Training</b>                                                                                     |
| <b>Sponsoring Director/Author</b> | Professor Mark Pietroni, Medical Director/Director of Safety<br>Dr Shyam Bhakthavasala, Guardian of Safe Working<br>Paula Baudry, Governance and Business Lead – Medical Director's Office |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <p><b>1. Executive Summary</b></p> <p>1.1 This annual report covers the period of 1st April 2025 to 31st March 2026.</p> <p>1.2 During this period, there were 262 exception reports logged, compared to the 389 Exception Reports (ER) logged during a similar reporting period last year. There were problems with the reporting system for part of this reporting period resulting in some ERs being missed, however there is likely a genuine reduction in the exceptions being reported, this year.</p> <p>1.3 0 fines were levied.</p> <p>1.4 New exception reporting rules have been implemented from 04/02/2026 and is being monitored.</p> |                                                                                       |
| Previously considered by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Previous quarterly reports submitted to People & Organisational Development Committee |

|                         |
|-------------------------|
| <b>Recommendations:</b> |
|-------------------------|

The board are asked to NOTE the report.

**Strategic Aims** (tick as appropriate)



**Patient experience and voice**



**People, culture and leadership**

X



**Quality, safety and delivery**

X



**Digital first**

**Impact on any Strategic Risks?**

Nil

**Implications on:**

**Equality, Diversity and Inclusion**

N/A

**Health Inequalities**

N/A

**Finance and Resource**

**Regulation/Legal**

Meets the requirements laid out in the resident doctor's terms and conditions of service for NHS doctors and dentists in training.

**CQC-Key line of enquiry**

N/A

**Green Plan**

N/A

**Main Report**

**2. Introduction**

2.1 Under the 2016 Terms and Conditions of Service (TCS) for Resident Doctors, the Trust provides an exception reporting (ER) process for working hours, senior clinical support and educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of compliance with safe working hours

limits. Significant reforms were made by NHS England to exception reporting rules, and these were implemented nationally from 4 February 2026, to address residents' concerns regarding confidentiality and the risk of bullying/adverse consequences when submitting exception reports.

## 2.2 The changes include

- Removal of educational supervisor sign off
- Speedier resolution of ERs within 7 days
- Automatic approval for exceptions below 2 hours
- New financial penalties for breaches of confidentiality, delayed resolution as well as failure to give timely access to the reporting system.

2.3 The Trust implemented these changes from 04/02/2026. The reporting platform also moved to Health Rota for all resident doctors, regardless of whether their rotas were held on the system at the time. Some resident doctors, whose rotas were already on the system could use Health Rota to submit ERs prior to this date.

2.4 The change from Allocate exception reporting to Health Rota allowed consolidation of rotas and exception reporting on a single platform, that can be easily accessed by resident doctors through a single app.

2.5 The structure of this report follows guidance provided by NHS Employers.

## High level data (March 2026)

|                                                    |      |
|----------------------------------------------------|------|
| Number of doctors / dentists in training (total):  | 496  |
| No. of trust doctors                               | 225  |
| Total Resident doctors                             | 496  |
| Amount of time available in job plan for guardian: | 1PA  |
| Administrative support:                            | 4Hrs |

Time allocated in job plans for Educational Supervision: 0.25/0.125 PAs  
(first/additional trainees to maximum 0.5 SPA)

## 3. Resident Doctor Vacancies as of January 2026-March 2026

| Department           | Additional training and trust grade vacancies |
|----------------------|-----------------------------------------------|
| ED                   | 0                                             |
| T&O                  | 0                                             |
| Surgery              | 2x ED<br>1 Anaesthetics reg                   |
| General Medicine     | 0                                             |
| Women's & Children's | 1 x Trust doctor obs and gynae                |

|                                  |   |
|----------------------------------|---|
| Diagnostic & Speciality Division | 0 |
|----------------------------------|---|

These numbers may be falsely re-assuring as it refers to funded, but unrecruited posts, rather than actual gaps on the Rota, caused by long term sickness or maternity leave. There are also a large number of gaps arising from acute sickness, which is a common theme being picked up on these reports.

**4. Medical Agency and Bank for resident/staff grade doctors**

- 4.1 This data is supplied by Finance.
- 4.2 The total expenditure on agency and bank locum cover, across all divisions, over this period was £11,322,159.55.

## Monthly breakdown of medical agency and bank spend by division for resident doctors and staff grades- 1 April 2025-31 March 2026

| Medical and dental agency         |             |            |            |            |            |            |            |            |             |             |            |             |             |
|-----------------------------------|-------------|------------|------------|------------|------------|------------|------------|------------|-------------|-------------|------------|-------------|-------------|
| Division                          | Apr-25      | May-25     | Jun-25     | Jul-25     | Aug-25     | Sep-25     | Oct-25     | Nov-25     | Dec-25      | Jan-26      | Feb-26     | Mar-26      | TOTAL       |
| Diagnostics & Specialist Medicine | -£11,661.20 | £4,189.23  | £1,280.35  | £18,406.00 | £4,571.31  | £3,755.32  | £44,331.24 | £29,800.38 | £105,092.05 | -£12,821.65 | £78,274.84 | £76,678.91  | £341,896.78 |
|                                   | £9,059.80   | £10,728.48 | £59,050.90 | £1,843.27  | £27,689.50 | £18,440.82 | £33,027.25 | -£1,921.73 | £8,978.16   | £3,000.00   | -£3,530.90 | £24,755.00  | £191,120.55 |
| Surgery                           | £2,195.11   | £0.00      | £0.00      | £0.00      | £1,015.00  | £0.00      | £0.00      | £0.00      | -£239.87    | £0.00       | £0.00      | £0.00       | £2,970.24   |
| Women and Children                | £0.00       | £0.00      | £8,648.74  | £11,489.62 | £13,161.83 | -£7,305.08 | £87.00     | £2,483.05  | -£2,686.05  | -£56.00     | £2.41      | £0.00       | £25,825.52  |
| TOTAL                             | -£406.29    | £14,917.71 | £68,979.99 | £31,738.89 | £46,437.64 | £14,891.06 | £77,445.49 | £30,361.70 | £111,144.29 | -£9,877.65  | £74,746.35 | £101,433.91 | £561,813.09 |

| Medical and dental bank           |             |             |             |               |             |             |             |             |               |             |             |             |                |
|-----------------------------------|-------------|-------------|-------------|---------------|-------------|-------------|-------------|-------------|---------------|-------------|-------------|-------------|----------------|
| Division                          | Apr-25      | May-25      | Jun-25      | Jul-25        | Aug-25      | Sep-25      | Oct-25      | Nov-25      | Dec-25        | Jan-26      | Feb-26      | Mar-26      | TOTAL          |
| Diagnostics & Specialist Medicine | £55,571.38  | £6,056.65   | £28,986.74  | £55,111.58    | £44,520.12  | £31,378.60  | £20,902.81  | £28,682.49  | £44,098.31    | £22,532.60  | £11,593.28  | £9,318.08   | £358,752.64    |
|                                   | £448,718.47 | £539,080.44 | £465,672.85 | £772,314.33   | £261,689.79 | £436,421.80 | £374,062.96 | £556,381.76 | £494,857.48   | £362,378.48 | £407,631.08 | £450,734.08 | £5,569,943.52  |
| Reserves                          | £3,477.84   | £3,477.84   | £3,477.84   | £3,477.84     | -£13,911.36 | £0.00       | £0.00       | -£1,211.41  | £0.00         | £0.00       | £0.00       | -£947.75    | -£2,159.16     |
| Surgery                           | £298,461.15 | £373,863.21 | £335,210.53 | £373,867.77   | £350,710.47 | £374,172.25 | £289,162.74 | £292,160.38 | £435,226.54   | £223,062.10 | £260,032.25 | £290,547.00 | £3,896,476.39  |
| Women and Children                | £66,891.10  | £75,085.75  | £73,514.14  | £85,002.22    | £102,596.53 | £62,314.49  | £75,104.92  | £82,922.43  | £132,974.00   | £63,095.53  | £58,064.13  | £59,767.83  | £937,333.07    |
| TOTAL                             | £873,119.94 | £997,563.89 | £906,862.10 | £1,289,773.74 | £745,605.55 | £904,287.14 | £759,233.43 | £958,935.65 | £1,107,156.33 | £671,068.71 | £737,320.74 | £809,419.24 | £10,760,346.46 |

## 5. Additional Cost

- 5.1 A total of £3,218.69 was paid to junior doctors because of exception reporting of additional hours worked in the last year.
- 5.2 A total of 156.45 hours was given as time off in lieu as a result of exception reporting of additional hours worked.

## 6. Exception Reports

- 6.1 A total of 262 exceptions have been reported during the period 1 April '25 – 31 March '26 including 5 exceptions reported as immediate safety concern (ISC). This contrasts with 389 reports with 21 ISCs for the previous year.
- 6.2 Some of the exceptions raised during the transition from Allocate to Health rota do not have the same level of detail and the table below has not captured these.

6.2 The following exception reports were raised across specialties:

| <b>Exceptions Raised</b>         |                      |                                  |                                  |                              |
|----------------------------------|----------------------|----------------------------------|----------------------------------|------------------------------|
| <b>Specialty</b>                 | <b>Working Hours</b> | <b>Educational Opportunities</b> | <b>Service Support Available</b> | <b>Of which, no. of ISCs</b> |
| <b>A&amp;E</b>                   | 3                    | 1                                | 0                                | 0                            |
| <b>Acute Medicine</b>            | 11                   | 0                                | 1                                | 1                            |
| <b>General Medicine</b>          | 44                   | 0                                | 4                                | 2                            |
| <b>General Surgery</b>           | 8                    | 1                                | 0                                | 0                            |
| <b>Neuro</b>                     | 2                    | 0                                | 0                                | 0                            |
| <b>Gastroenterology</b>          | 0                    | 1                                | 2                                | 0                            |
| <b>Respiratory</b>               | 3                    | 0                                | 0                                | 0                            |
| <b>Surgical specialty</b>        | 9                    | 0                                | 0                                | 0                            |
| <b>Intensive Care Unit</b>       | 2                    | 0                                | 0                                | 0                            |
| <b>Ophthalmology</b>             | 10                   | 0                                | 0                                | 0                            |
| <b>GP training</b>               | 1                    | 0                                | 0                                | 0                            |
| <b>Obs &amp; Gynae</b>           | 9                    | 1                                | 1                                | 0                            |
| <b>Care of the Elderly</b>       | 10                   | 1                                | 4                                | 2                            |
| <b>Dermatology</b>               | 3                    | 0                                | 0                                | 0                            |
| <b>ENT</b>                       | 2                    | 0                                | 0                                | 0                            |
| <b>Paediatrics</b>               | 3                    | 0                                | 0                                | 0                            |
| <b>Medical Oncology</b>          | 1                    | 0                                | 10                               | 0                            |
| <b>Vascular</b>                  | 5                    | 0                                | 0                                | 0                            |
| <b>Trauma &amp; Orthopaedics</b> | 40                   | 9                                | 0                                | 0                            |
| <b>SUB-TOTALS</b>                | <b>166</b>           | <b>14</b>                        | <b>22</b>                        | <b>5</b>                     |



**7. Fines Levied**

7.1 For the period 1 April 2025 to 30 March 2026, no fines have been levied.

**8. Issues Arising**

8.1 There were 5 ERs with immediate safety concerns, 166 related to hours or pattern, 14 to inadequate educational opportunities and 22 relating to service support, including inadequate time for handover.

8.2. With the change in the ER reporting rules, we have identified issues with some of the non resident on call rotas, mainly in relation to the inadequate time allocated for the 'resident' component. As the new system will automatically identify breaches of rota rules, some of the breaches that went unrecognized previously are also being flagged up, though none during this reporting period.

8.3 An analysis of ISCs against clinical incidents reported through Datix relating to staffing did not identify any direct correlation.

8.4 The Trust's licence for the digital exception reporting platform, Allocate, expired in November 2025. An interim exception reporting process was introduced at the end of December. Owing to delays in the implementation of the replacement system, exception reports submitted outside the usual reporting timeframes were accepted, with payment or time off in lieu awarded where appropriate. However, the interim reporting forms did not capture the same level of detail as the Allocate system. As a result, the data presented in this report may be incomplete. In addition, some trainees may not have been aware of the interim reporting process, which could have contributed to a reduction in the number of exception reports submitted during this period.

8.5 All resident doctors have access to exception reporting aspect of Health Rota from 04/02/2026. These changes were communicated to all resident doctors as well as educational supervisors by e-mail. Guardian page on intranet has been updated to include relevant changes.

8.6 The changes have also removed the role of Educational Supervisors in the exception reporting process. While this may reduce the risk of trainees perceiving adverse consequences or feeling discouraged from raising exception reports, it also removes an important mechanism for providing feedback to departments and identifying trainees who may require additional support. In addition, the changes have increased the administrative burden on the Guardian of Safe Working and the supporting administrative team, who must now undertake responsibilities that were previously carried out by Educational Supervisors.

8.7 Although this falls outside the reporting period covered by this report, there appears to have been an increase in the number of exception reports submitted through the new process. This trend will be monitored over the coming months to assess whether it is sustained and to understand any impact on workload and reporting patterns.

**9. Actions Taken to Resolve Issues**

9.1 As GOSW, I would follow up all exception reports raised as an immediate safety concern with a view to escalating to the medical director's office where necessary. I would also

review exception reports to identify themes and patterns and those which appear stalling at the local level. Trainees can also contact me by email if they feel their concerns have not been addressed. Any exception reports relating to educational matters are referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary.

- 9.2 Since the introduction of these changes, the responsibilities of the Guardian of Safe Working (GoSW) have increased significantly. In addition to managing a higher volume of exception reports, the GoSW now undertakes detailed review and scrutiny of all reports involving more than two hours of additional work prior to approval. Requests for time off in lieu involve further liaison with both the reporter and the relevant department to facilitate resolution while ensuring that confidentiality is maintained and not inadvertently compromised. Furthermore, any communication regarding a specific exception report with individuals outside the reporter and the GoSW administrative team now takes place with the reporter's explicit consent. GoSW also meets with individual resident doctors if there appears to be a persistent problem with specific rotas in order to explore the issue further and provide feedback to the department.

## **10. Post Graduate Doctors Forum**

- 10.1 The Resident Doctors Forum (RDF) meet every other month and is a useful forum for residents to raise any issue of concern and keep informed of current business issues within the Trust.
- 10.2 Meetings of the forum are attended by the GoSW and DME as well as representatives from medical staffing and the Medical Director's office. Resident doctors are also supported by a representative from BMA.
- 10.3 The Resident Doctors' Forum have contributed significantly to the implementation of the above-mentioned changes and have provided valuable support in monitoring the effectiveness of the system. They have also played an important role in identifying and highlighting any challenges faced by resident doctors while using the new system. Other agenda items included availability of 'too tired to drive rooms', as well as the 10 point plan for improving resident doctor's conditions.

## **11. Summary**

- 11.1 262 exception reports have been raised from the beginning of April 2025 to the end of March 2026.
- 11.2 No fines have been levied during that period.
- 11.3 The overall rate of exception reports has dropped during this reporting period, but there has been an upward trend since the implementation of the new reporting process.
- 11.4 A total of £3,218.69 was paid to junior doctors because of exception reporting of additional hours worked in the last year.
- 11.5 In addition 156.45 hours have been given as time off in lieu due to additional hours worked and reported to GOSW.

Enclosures:

**Appendices:**

FOI: Public

## Rota rules at a glance

The below table highlights the rota rules outlined in the [terms and conditions of service](#) (TCS) and provides further notes for employers on each rule. For full details please refer to schedule 3 of the TCS.

| Rule                                                                                                                | Notes                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Max 48 hour average working week                                                                                    | A guardian of safe working hours fine will apply if this rule is breached                                                                                                                                                                                                                                                                                |
| Max 72 hours work in any consecutive period of 168 hours                                                            | A guardian of safe working hours fine will apply if this rule is breached                                                                                                                                                                                                                                                                                |
| Max 13 hour shift length                                                                                            | On-call periods can be up to 24 hours                                                                                                                                                                                                                                                                                                                    |
| 46-hours of rest required after any number of rostered night shifts                                                 |                                                                                                                                                                                                                                                                                                                                                          |
| Max 4 consecutive long shifts*, at least 48 hours rest following the fourth shift                                   | Long shift (a shift rostered to last longer than 10 hours)                                                                                                                                                                                                                                                                                               |
| Max 4 consecutive long daytime/evening shifts, at least 48 hours rest following the fourth shift                    | Long evening shift: a long shift starting before 16.00 rostered to finish after 23.00 (a long shift starting after 16.00 will fall in to the definition of a night shift)                                                                                                                                                                                |
| Max 4 consecutive night shifts. At least 46 hours rest following the third or fourth such shift                     | Night shift: at least 3 hours of work in the period 23.00 to 06.00. Rest must be given at the conclusion of the final shift, which could be the third or fourth                                                                                                                                                                                          |
| Max 7 consecutive shifts* (except on low intensity on-call rotas), at least 48 hours rest following the final shift | Low intensity on-call: duty on a Saturday and Sunday where 3 hours, or less, work takes place on each day, and no more than 3 episodes of work each day. Up to 12 consecutive shifts can be worked in this scenario provided that no other rule is breached                                                                                              |
| Max frequency of 1 in 3 weekends can be worked                                                                      | Weekend work (any shifts/on-call duty periods where any work falls between 00.01 Saturday and 23.59 Sunday)<br><br>Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working.                           |
| Normally at least 11 hours continuous rest between rostered shifts (separate on-call provisions below).             | Breaches of rest subject to time off in lieu (TOIL) which must be given within 24 hours. In exceptional circumstances where rest is reduced to fewer than 8 hours, time will be paid at a penalty rate and the doctor is not expected to work more than 5 hours the following day. A guardian of safe working hours fine will apply in this circumstance |

|                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>30 minute break for 5 hours work, a second 30 minute break for more than 9 hours</p> <p>A third 30-minute paid break for a night shift rostered to last 12 hours or more</p> | <p>A guardian of safe working hours fine will apply if breaks are missed on at least 25 per cent of occasions across a 4 week reference period. Breaks should be taken separately but if combined must be taken as near as possible to the middle of the shift</p>                         |
| <b>Specific to on-call working patterns</b>                                                                                                                                     |                                                                                                                                                                                                                                                                                            |
| <p>No consecutive on-call periods apart from Saturday &amp; Sunday. No more than 3 on-call periods in 7 consecutive days</p>                                                    | <p>A maximum of 7 consecutive on-call periods can be agreed locally where safe to do so and no other safety rules would be breached; likely to be low intensity rotas only</p>                                                                                                             |
| <p>Day after an on-call period must not be rostered to exceed 10 hours</p>                                                                                                      | <p>Where more than 1 on-call period is rostered consecutively (e.g. Saturday/Sunday), this rule applies to the day after the last on-call period</p>                                                                                                                                       |
| <p>Expected rest while on-call is 8 hours per 24 hour period, of which at least 5 hours should be continuous between 22.00 and 07.00</p>                                        | <p>If it is expected this will not be met, the day after must not exceed 5 hours. Doctor must inform employer where rest requirements are not met, TOIL must be taken within 24 hours or the time will be paid. A guardian of safe working hours fine will apply in this circumstance.</p> |
| <p>No doctor should be rostered on-call to cover the same shift as a doctor on the same rota is covering by working a shift</p>                                                 | <p>Unless there is a clearly defined clinical reason agreed by the clinical director and the working pattern is agreed by both the guardian and the director of medical education</p>                                                                                                      |

\*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

## Alert, Advise and Assure Report to the Board of Directors Meeting – 10th September 2026

| Title                           |            | ADVISE, ALERT and ASSURE Report of the Quality and Performance Committee meeting held on 30 July 2026      |
|---------------------------------|------------|------------------------------------------------------------------------------------------------------------|
| Board member lead(s)            |            | Committee Chair: Sam Foster<br>Executive leads - Chief Nurse, Medical Director and Chief Operating Officer |
| Written by                      |            | Committee Chair                                                                                            |
| Confidentiality                 |            | None                                                                                                       |
| Requires<br>Tick as appropriate | Approval   |                                                                                                            |
|                                 | Assurance  | X                                                                                                          |
|                                 | Discussion | X                                                                                                          |
|                                 | Note       |                                                                                                            |

### Purpose of report

To present an update to the Board of Directors from the meeting of the Quality and Performance Committee held on 30 July 2026. The report highlights the principal matters requiring Board attention, areas under continued monitoring, positive assurance received and decisions made by the Committee.

### Key points

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

#### Maternity assurance and Maternity Incentive Scheme compliance

Governance visibility and escalation continue to improve, and the Trust remains self-assessed as compliant with all eight Section 31 conditions.

Maternity Incentive Scheme Year 8 compliance remains a significant residual risk, with Safety Actions A, B, D, E and F rated red and Safety Action C rated amber.

Training governance, workforce resilience, neonatal staffing and safeguarding capacity require sustained executive oversight and clear recovery trajectories.

#### Trauma and Orthopaedics mandated support

Trauma and Orthopaedics is in mandated support following concerns across the pathway, including theatre productivity, sterile instruments, governance, workforce and culture.

The Committee received partial assurance. Early improvement was recognised, but material risks remain in fractured neck of femur performance, theatre utilisation, fracture clinic capacity, pathway reliability and sustainable recovery.

A further mandated support progress update is due to the Committee in November 2026.

### **Cardiology mandated support and external assurance**

Cardiology remains under mandated support and enhanced oversight, with concerns principally relating to culture, behaviour, process, governance and pathway improvement.

The formal Royal College report had not yet been received. Cardiology will remain within the Regulatory Report pending evidence that actions are progressing through the single live improvement plan and Executive-led oversight route.

### **Operational performance and flow**

June performance deteriorated across urgent and emergency care, referral to treatment, diagnostics and 62-day cancer performance.

System flow and discharge capacity, diagnostic bottlenecks and specialty recovery plans remain connected constraints, compounded by estate and service disruption during prolonged hot weather.

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

### **Perinatal oversight and workforce planning**

The maternal death action plan has closed. Formal closure of the neonatal action plan and a maternity, neonatal and administrative workforce plan, including training compliance, will return through Committee governance.

Future reporting is expected to describe the practical position behind compliance percentages, including staff outstanding, training bookings and trajectory.

### **Mandated support programmes**

The Committee supported structured, Executive-led recovery arrangements for Trauma and Orthopaedics and Cardiology.

Progress will continue to be monitored through future Committee reports, with updates to Board governance where appropriate.

### **Health inequalities and patient experience**

The Committee welcomed strengthened health inequalities governance but requested sharper reporting on the issue, responsible governance route, action and closure.

All future papers and deep dives should explicitly draw out healthcare inequalities, actions and learning.

### **Regulatory oversight**

Maternity remains the principal regulatory risk. Continued oversight is also required for post-death care, Cardiology, fire enforcement, safeguarding Level 3 training and the Pharmacy Aseptic Services Unit.

## **ASSURE: inform the board where positive assurance has been received**

### **Infection Prevention and Control Annual Report 2025/26**

The Committee received, scrutinised and approved the Annual Report and was satisfied that it provided sufficient assurance to meet the Board oversight requirements for infection prevention and control.

The report provided assurance on governance, surveillance, education, incident learning, estates, facilities and decontamination and was considered to meet the relevant Code of Practice criterion.

The Committee also noted the Antimicrobial Stewardship Annual Report and supported the 2026/27 improvement priorities and workplan ambitions.

### **Safeguarding Adults and Children Annual Report**

The Committee received, scrutinised and approved the Annual Report and was satisfied that it provided sufficient assurance to meet the Board oversight requirements for safeguarding adults and children.

The report set out strengthened external partnership working, improved governance and oversight, an improved audit cycle, updated policies and a positive external audit report for adult safeguarding.

The Committee recognised increasing workload and complexity and supported development of the maternity safeguarding workforce and improvement in mandatory and statutory training compliance.

### **Maternity governance and regulatory compliance**

Positive assurance was received on the continued embedding of the Perinatal Quality Oversight Model, continued self-assessed compliance with all eight Section 31 conditions and progress with safety investigation and mortality review actions.

The maternal death action plan was formally recorded as closed, with strengthened leadership appointments and improving governance visibility.

### **Quality and regulatory governance**

The Committee took moderate assurance from the Quality Delivery Group update, noting active governance controls while recognising ongoing fragility across key quality and patient experience indicators.

Required post-death care and Human Tissue Authority submissions were reported as progressing within the required national timescales.

## **APPROVALS: decisions made by the Committee, & Applaud Positive Achievements, Examples of Excellence, or Noteworthy Progress**

### **Approvals and decisions**

The Committee received and approved the Infection Prevention and Control Annual Report 2025/26 for Board assurance and supported its 2026/27 priorities.

The Committee received and approved the Safeguarding Adults and Children Annual Report for Board assurance and supported the identified workforce and training actions.

The Committee endorsed the regulatory oversight approach and approved completed matters arising for closure.

### **The Committee particularly applauds**

The accessible and comprehensive Infection Prevention and Control Annual Report and the work of the IPC team, including the C. difficile improvement programme and antimicrobial stewardship.

The safeguarding team's work to strengthen governance, partnership working, audit and staff education while managing increasing demand and complexity.

The strengthening of maternity leadership and governance, and the rapid establishment of structured mandated support for Trauma and Orthopaedics and Cardiology.

Implications

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

Board assurance framework

|               |      |
|---------------|------|
| BAF reference | SR10 |
|---------------|------|

Risks discussed

The Committee discussed risks relating to maternity regulatory compliance and workforce resilience; Trauma and Orthopaedics and Cardiology mandated support; urgent and emergency care and discharge flow; elective, diagnostic and cancer recovery; infection prevention, water safety and the care environment; safeguarding capacity and training compliance; post-death care; and climate and estate resilience. These discussions enabled triangulation with the Board Assurance Framework.

Recommendations

- The Board of Directors is asked to:
- take assurance from the Committee's scrutiny of maternity services, Trauma and Orthopaedics mandated support and Cardiology mandated support;
  - take assurance that the Committee's receipt and approval of the Infection Prevention and Control Annual Report 2025/26 and the Safeguarding Adults and Children Annual Report is sufficient to meet the relevant regulatory Board oversight requirements; and note the matters highlighted for continued monitoring and Board visibility.



Report to Public Board of Directors

|                            |                                                                                                                                             |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Meeting            | 10 <sup>th</sup> September 2026                                                                                                             |
| Report title               | Integrated Performance Report (IPR)                                                                                                         |
| Sponsoring Director/Author | Chief Operating Officer (COO)<br>Chief Medical Officer (CMO)<br>Chief Nurse (CN)<br>Chief People Officer (CPO)<br>Director of Finance (DoF) |

| Purpose (confirm the appropriate box) |                          |                          |               |
|---------------------------------------|--------------------------|--------------------------|---------------|
| For approval                          | For discussion           | For information          | For assurance |
| <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> | X             |

| Executive Summary        |                                                                                            |
|--------------------------|--------------------------------------------------------------------------------------------|
|                          |                                                                                            |
| Previously considered by | <div><div>-</div>Trust Leadership Team (TLT)<div>-</div>Divisional Executive Reviews</div> |

| Recommendations:                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div><div>-</div>To note the contents of the Integrated Performance Report (IPR)<div>-</div>Assess improvements and deteriorations including assurance on actions to respond to performance changes.</div> |

| Strategic Aims (tick as appropriate)                                                                                                             |   |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---|
| <div><div></div><div>Patient experience and voice</div></div> | ✓ |

|                                                                                                                         |   |
|-------------------------------------------------------------------------------------------------------------------------|---|
|  <b>People, culture and leadership</b> | ✓ |
|  <b>Quality, safety and delivery</b>   | ✓ |
|  <b>Digital first</b>                  |   |

### Impact on any Strategic Risks?

The report suggests that strategic risks remain highest in-patient flow and discharge, elective and cancer recovery, workforce sustainability and delivery of the financial sustainability programme. Improvements in urgent and emergency care provide assurance that some interventions are having a positive impact; however, these gains remain vulnerable if discharge performance, workforce pressures and capacity constraints are not addressed.

### Implications on:

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Health Inequalities</b>               | There are no specific reported health inequality measures or analyses within the report. However, ongoing pressures in emergency care, discharge, planned care, diagnostics and cancer services all carry a risk of widening health inequalities by reducing timely access to care and potentially impacting vulnerable and disadvantaged populations disproportionately. Continued monitoring of performance by population group would be important to understand and mitigate these risks.                                                                       |
| <b>Finance and resource</b>              | The Trust remains financially on plan; however, continued operational pressures, temporary staffing reliance, income recovery risks, delivery of financial sustainability schemes, and growing elective, diagnostic and cancer backlogs represent the principal financial and resource risks requiring ongoing monitoring and mitigation.                                                                                                                                                                                                                          |
| <b>Regulation/Legal</b>                  | NHSE mandated performance report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>CQC-Key line of enquiry</b>           | The report suggests the strongest evidence of risk sits within the <b>Responsive, Safe and Effective</b> domains, driven primarily by discharge delays, elective and cancer backlogs, diagnostic waiting times and ongoing flow pressures. Positive improvements in urgent and emergency care performance, ambulance handovers, governance oversight and financial control provide evidence of progress within the <b>Well-Led</b> domain, although sustained recovery will be required to demonstrate consistent improvement across all CQC key lines of enquiry. |
| <b>Green Plan</b>                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

### Main Report

## PERFORMANCE

### Urgent & Emergency Care

Urgent and emergency care improved in July: Type 1 four-hour performance rose to 66.1% and 12-hour performance to 93.5%, the best position for over a year. Performance remains below trajectory, with time to clinician a continuing focus.

Paediatric performance remained strong at 85.2%. Ambulance handovers improved to an 18-minute average, with 50% completed within 15 minutes.

### System Flow and Discharge

Flow remains the principal operational challenge. Emergency length of stay and decision-to-admit waits improved, but continued progress depends on reliable discharge.

Discharge deteriorated in July, with discharge-ready patients above plan and increases in delays beyond 21 days. Pathways 1 and 2 remain under pressure, constraining bed availability.

Actions focus on reducing long delays, improving discharge reliability and strengthening community capacity.

### Planned Care (RTT)

Referral to Treatment (RTT) performance reduced to 71.7% in July, reflecting planned waiting-list validation. The list remains below 70,000, but waits over 18 weeks increased, particularly in Orthopaedics and Spinal Surgery, Gynaecology and gastrointestinal services.

Long waits remain the main risk: 782 pathways exceeded 45 weeks and 25 exceeded 52 weeks. Recovery focuses on specialty oversight, theatre capacity, demand and capacity alignment, and appropriate independent sector use.

### Diagnostics (DM01)

Diagnostic performance deteriorated in July, mainly because heat and humidity disrupted magnetic resonance imaging (MRI) capacity, increasing breaches from 213 to 388.

Nine modalities deteriorated, although some high-volume endoscopy services improved. Recovery includes additional endoscopy capacity, six-day working and insourcing for echocardiography.

### Cancer

Cancer performance remains below national standards. The 62-day standard improved slightly to 70.4%, but treatment capacity and histopathology delays continue to affect Lower gastrointestinal, Urology and Gynaecology pathways.

The 28-day Faster Diagnosis Standard fell to 74.7%. Outpatient capacity and histopathology turnaround remain key constraints, while Breast services continued to improve.

At 2 August, 188 patients had waited over 62 days. Recovery centres on additional diagnostic and treatment capacity, targeted specialty review and strengthened executive oversight.

## QUALITY

The Quality metrics show a broadly stable position, with several indicators demonstrating sustained improvement. SHMI remains favourable at 0.90 due to improved data quality, Category 3 pressure ulcers and the number of falls per 1000 bed days have risen slightly, but numbers remain low. Complaint performance is at 39% of complaints closed in the required timeframe; the Complaints improvement programme re-starts in Sept 26.

Key pressures remain in patient experience, flow and responsiveness. FFT positive scores have decreased to 91.5%, driven particularly by GRH ED at 68.2% and postnatal ward at 61% positive experience. While PALS demand is at its highest level in over two years, there has been a decrease in

the rate of concerns closed within 5 days to 71%. Mixed sex accommodation breaches have reduced to around 27, indicating continued flow constraints.

Falls remain a priority (designated safety priority within our PSIRF Plan), with 5.7 falls per 1,000 bed days, 4 injury falls and 2 #NOF falls reported in July.

## **WORKFORCE**

The Workforce section highlights a continuing deterioration or sustained pressure across a small number of core people metrics which require close monitoring. In particular, the current reporting period places emphasis on appraisal compliance, sickness absence, the use of temporary staffing (bank and agency) and job planning compliance.

While there are signs of stabilisation in some areas, performance remains below Trust targets. Collectively, these metrics highlight the importance of consistent local management practice, strengthened leadership capability, and targeted intervention in areas of persistent variance.

The narrative supporting the metrics provides Divisional / Service level context, identifying where pressures are most evident and reflect actions in train. These actions are aligned to both Trust priorities and national requirements, including the NHS Medium Term Plan 2026/27.

## **FINANCE**

At the end of month 4 the Trust has reported a position in line with its profiled year to date deficit position of c£7.4m. This position includes the impact of industrial action and non pay pressures (pre-dominantly relating to drugs and clinical supplies) which are being offset by central underspends, including corporate areas.

Commissioning income is reported in arrears due to the timing of data – the M3 freeze position shows a slight under-recovery of income and work will be taken on the M4 information at division / speciality level as the initial M4 flex information is showing a deterioration of this position.

Overall pay expenditure is underspent year to date however there are pressures against the NHS England temporary staffing caps with significant reductions in run rates needed (50% agency, 30% bank) in order to come back in line with the target values.

Financial sustainability plans continue to be a key area of focus in order to deliver the financial plan – currently there is risk to this from red rated and unidentified schemes which the Improvement and Delivery Team will be focussed on.

Capital expenditure is currently lower than expected due to delays in approvals for some building schemes. The capital team have previously been asked to produce a realistic re-profile of expenditure commitments so that decisions can be made to support the utilisation of the capital resources – this is now expected in September 2026.

Enclosures

Integrated Performance Report (IPR)

# Integrated Performance Report (IPR)

July 2026

- Operational Performance
- Quality & Safety
- Use of Resources
- Workforce

# SPC Chart Guidance

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

Where a metric has shown improvement, entering **special cause variation**, the metric will be moved to watch measures and removed from the slide deck.

## How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- Common cause variation: Grey icons indicate **no significant change**

## How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- Grey icons indicate that **sometimes the target will be achieved and sometimes it will be missed**

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

# Operational Performance Metrics

NOF Segment

This information is calculated nationally, on a quarterly basis

NHS Oversight Framework - Acute trusts

Current data: Q4 2025-26  
Published: 11 June 2026

NHS England

About

Overview

League table

Metrics table

Trust map

Trust chart

Timeseries table

Timeseries chart

Statistics table

Metric metadata

Glossary

Select a trust

Gloucestershire Hospitals NHS Foundation Trust (RTE)

View the glossary page

Average score

2.04

Lower by 0.03 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

Trust has entered financial deficit

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

2 - Above average

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

22 out of 134

Previous quarter's rank: 38 out of 134

Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).

How has rank been calculated?

Performance domains

Access to services

Finance and productivity

Effectiveness and experience

Patient safety

People and workforce

2 - Above average

1 - High performing

2 - Above average

3 - Below average

3 - Below average

Average score by trust rank placement

View full league table

Segment

1

2

3

4

Selected trust

Average score

1 out of 134 (highest ranked)

20

40

60

80

100

120

134 out of 134 (lowest ranked)

Trust rank

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# NOF Metrics

Segment drivers

| Domain                       | Description                                                                                          | Target | Aug-25 | Sep-25  | Oct-25  | Nov-25  | Dec-25  | Jan-26  | Feb-26  | Mar-26  | Apr-26  | May-26  | Jun-26  | Jul-26 |
|------------------------------|------------------------------------------------------------------------------------------------------|--------|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|--------|
| Access to services           | Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral       | >80%   | 80.3%  | ↓77.0%  | ↓76.5%  | ↓75.3%  | ↓70.2%  | ↓57.5%  | ↑68.4%  | ↑75.8%  | ↓74.0%  | ↑76.6%  | ↓75.3%  | ↓74.6% |
|                              | Percentage of patients treated for cancer within 62 days of referral                                 | >75%   | 75.0%  | ↑77.5%  | ↓76.1%  | ↑78.7%  | ↑84.0%  | ↓76.3%  | ↓74.0%  | ↓71.7%  | ↑75.1%  | ↓68.9%  | ↑69.4%  | ↑70.8% |
|                              | Percentage of patients waiting over 52 weeks for elective treatment                                  | 0.00%  | 0.06%  | ↑0.06%  | ↑0.04%  | ↓0.05%  | ↑0.05%  | ⇒0.03%  | ↑0.02%  | ↑0.01%  | ⇒0.03%  | ↑0.02%  |         |        |
|                              | Percentage of patients waiting over 52 weeks for community services                                  | 0.00%  | 0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  | ⇒0.00%  |         |        |
|                              | Percentage of cases where a patient is waiting 18 weeks or less for elective treatment               | >92%   | 67.25% | ↑69.76% | ↓69.38% | ↑70.00% | ↓69.27% | ↓68.51% | ↑71.74% | ↑74.55% | ↓73.99% | ↑74.51% |         |        |
|                              | Difference between planned and actual 18 week performance                                            |        |        |         |         |         |         |         |         |         |         |         |         |        |
|                              | Percentage of emergency department attendances admitted, transferred or discharged within four hours | >78%   | 60.91% | ↑62.78% | ↑62.93% | ↑64.17% | ↓64.13% | ↓60.29% | ↑62.73% | ↑64.57% | ↑64.93% | ↓63.85% | ↓62.32% |        |
|                              | Percentage of emergency department attendances spending over 12 hours in the department              | <2%    | 8.93%  | ↓9.21%  | ↑9.19%  | ↓10.06% | ↑10.00% | ↓12.19% | ↑10.37% | ↑9.38%  | ↑9.26%  | ↓10.35% | ↓11.45% | ↑6.49% |
| Effectiveness and experience | Average number of days from discharge ready date to actual discharge date (including zero days)      |        | 0.8    | ⇒0.8    | ↑0.7    | ⇒0.7    | ↓0.8    | ↑0.7    | ↑0.6    | ⇒0.6    | ↓0.8    | ⇒0.8    | ↓0.9    |        |
|                              | Summary Hospital-level Mortality Indicator                                                           |        | 1.0448 | ↑1.038  | ↑1.010  | ↑0.9931 | ↑0.980  | ↑0.957  | ↑0.944  | ↑0.927  | ↑0.911  | ↑0.901  | ↓0.902  | ↓0.903 |
|                              | CQC inpatient survey satisfaction rate                                                               |        |        |         |         |         |         |         |         |         |         |         |         |        |

## Analytical Highlight

The Trust has risen to Segment 2 under the NOF, driven by sustained underperformance in A&E access, elective backlog growth, and workforce gaps.

# Watch Measures

|               |                                                            | Target | Aug-25 | Sep-25   | Oct-25   | Nov-25   | Dec-25   | Jan-26   | Feb-26   | Mar-26   | Apr-26   | May-26   | Jun-26   | Jul-26   |
|---------------|------------------------------------------------------------|--------|--------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Elective Care | Short notice (within 72h) cancellation rate – total        | <9%    | 10.7%  | ↓ 15.9%  | ⇒ 15.9%  | ↑ 11.0%  | ↑ 10.2%  | ↓ 10.6%  | ↓ 11.4%  | ↑ 9.6%   | ↓ 10.7%  | ↑ 10.2%  | ↓ 12.4%  | ↓ 14.1%  |
|               | Same Day Non-Clinical Cancellations                        |        | 70     | ↓ 104    | ↑ 74     | ↑ 68     | ↑ 38     | ↓ 53     | ↑ 50     | ↓ 56     | ↓ 59     | ↓ 63     | ↓ 89     | ↓ 117    |
|               | Cancellations not rebooked within 28 days                  | 0      | 25     | ↑ 11     | ↓ 28     | ↑ 16     | ↑ 14     | ↑ 9      | ↓ 13     | ↑ 5      | ↓ 12     | ↑ 9      | ↓ 10     | ↓ 40     |
|               | Angiogram Waiting List Position                            |        | 265    | ↑ 231    | ↑ 220    | ↑ 216    | ↓ 232    | ↓ 250    | ↓ 255    | ↑ 237    | ↓ 263    | ↑ 254    | ↑ 245    | ↑ 227    |
| Flow          | G&A Occupancy - CGH                                        | 92%    | 85%    | ↑ 87%    | ⇒ 87%    | ↓ 86%    | ↑ 89%    | ↑ 91%    | ↓ 90%    | ↑ 92%    | ⇒ 92%    | ↓ 91%    | ↓ 90%    | ⇒ 90%    |
|               | G&A Occupancy - GRH                                        | 92%    | 94%    | ⇒ 94%    | ↑ 95%    | ⇒ 95%    | ↓ 94%    | ↑ 97%    | ⇒ 97%    | ↓ 96%    | ↑ 97%    | ⇒ 97%    | ↓ 96%    | ↓ 95%    |
| Safe Care     | VTE assessment completed - excluding short stay (%)        | 95%    | 93.8%  | ↓ 92.9%  | ↑ 92.9%  | ↑ 93.9%  | ↓ 93.4%  | ↓ 92.7%  | ↓ 92.0%  | ↑ 92.9%  | ↓ 91.8%  | ↑ 92.2%  | ↑ 93.6%  | ↓ 90.9%  |
|               | Number of Category 2 pressure ulcers acquired as inpatient |        | 21     | ↑ 11     | ↓ 24     | ↑ 11     | ↓ 15     | ⇒ 15     | ↑ 6      | ↓ 12     | ↑ 9      | ↓ 14     | ↑ 12     | ↑ 6      |
|               | Smoking Status Compliance (%)                              | 95%    | 97.54% | ↑ 98.41% | ↑ 98.56% | ↓ 98.16% | ↓ 98.04% | ↓ 97.96% | ↓ 97.56% | ↑ 98.45% | ↓ 98.28% | ↓ 97.82% | ↓ 97.78% | ↓ 97.57% |
|               | Severe Harm from Patient Medication Errors                 | 0      | 1      | ↑ 0      | ⇒ 0      | ⇒ 0      | ⇒ 0      | ↓ 1      | ↑ 0      | ⇒ 0      | ⇒ 0      | ⇒ 0      | ⇒ 0      | ⇒ 0      |

# UEC: Performance (Standard: a min of 78% of patients seen within 4 hours by March 26)

## Analytical Highlights:

Type 1 4-hour performance rose to 66.1% in July, up from 62.3% in June – closing the gap to the 78% standard.

12-hour performance improved significantly, rising from 88.6% in June to 93.5% in July. The highest level of performance demonstrated in over a year.

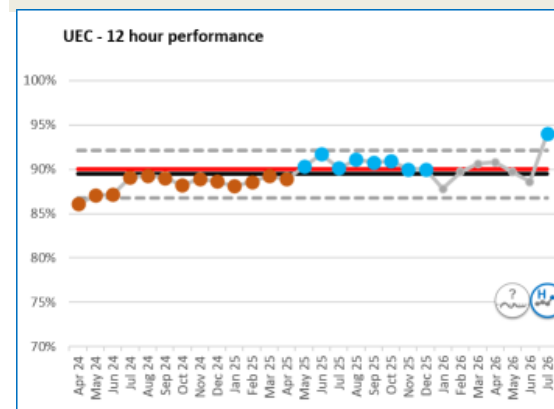
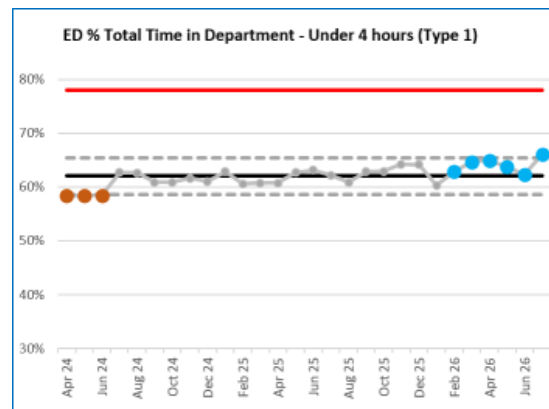
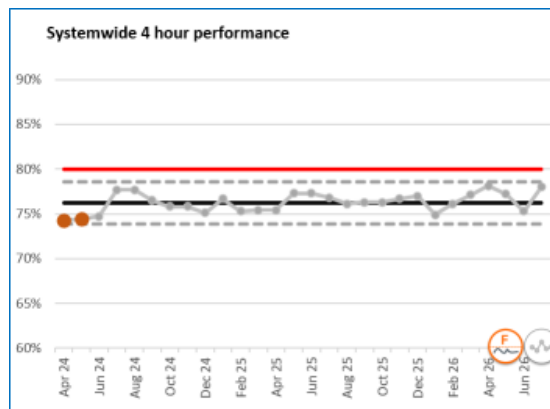
## Areas for Concern:

Performance remains below the required operational standard across the key 4-hour measures.

Time to clinician continues to require targeted focus as part of the wider improvement programme.

## Learning & Improvement:

Recruitment remains a key improvement lever, including nursing and medical roles. A focused action plan is in place to support improvements across CGH ED, Paediatrics and Minors, including sub-specialist appointments and increased operational presence at CGH



## Actions

Continue delivery of the CGH ED, Paediatrics and Minors action plan, with emphasis on operational grip, workforce recruitment and reduction in time to clinician.

# UEC: Performance

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

## Analytical Highlights:

Non-admitted performance recovered well in **July, reaching 69.7%**, the strongest performance in the reporting period. Up from **65.2% in June**.

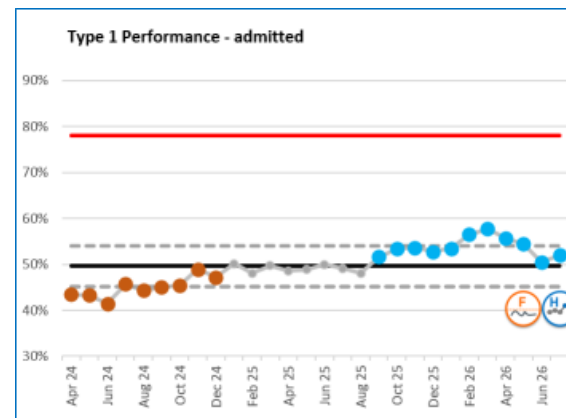
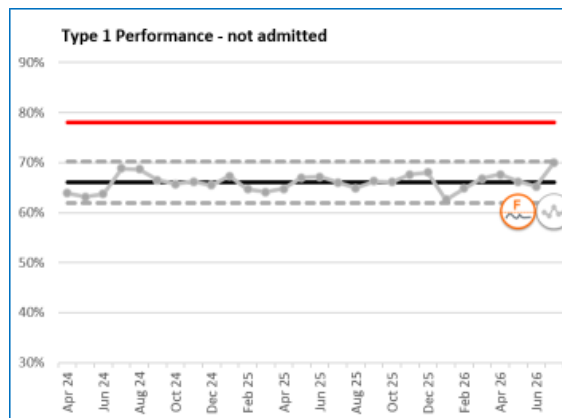
Admitted performance likewise began to recover, following 3 months of deteriorating performance. Rising from **50.5% in June to 51.8% in July** – reflecting the successes of the 'Breaking the Cycle' CVoF Week.

## Areas for Concern:

Both admitted and non-admitted pathways remain below the operational standard. The admitted pathway remains the greater area of concern, despite a slight increase in July performance

## Learning & Improvement:

Time to clinician remains a key area for improvement, alongside the continued need to strengthen operational grip and pathway flow. Recruitment remains a core improvement lever, including nursing and medical roles.



## Actions

Maintain delivery of the CGH ED, Paediatrics and Minors action plan, with particular focus on admitted pathway flow, time to clinician and operational presence at CGH.

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

## Analytical Highlights:

Paediatric 4-hour performance demonstrated strong improvement in **July, rising to 85.2%** - up from 82.8% in June and up 4% from the same period last year.

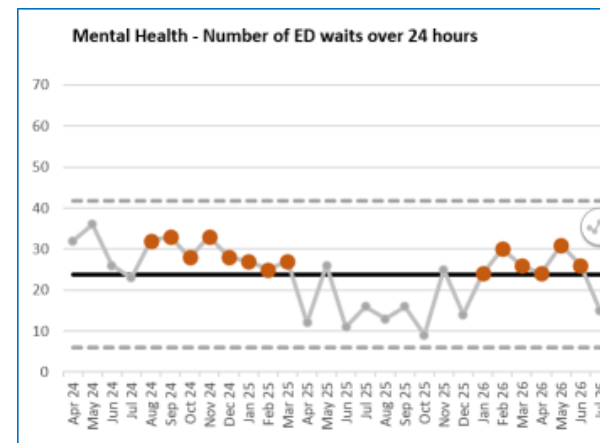
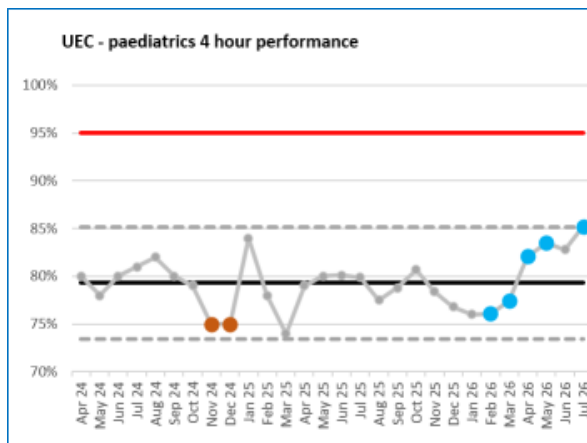
Mental Health waits have reduced further again to **15 in July, down from 26 in June**; however, 2026/27 year-to-date waits remain **48% higher than the same period last year**.

## Areas for Concern:

Mental Health waits have reduced in-month but remain significantly higher year-to-date than the same period last year.

## Learning & Improvement:

Recruitment remains a key improvement lever, including Consultants in Paediatric Emergency Medicine. Continued focus is required on sustaining paediatric performance and reducing Mental Health waits.



## Actions

Continue the role of the Paediatric Band 7 Nurse in supporting departmental improvements and escalation across both sites, alongside targeted work to reduce Mental Health waits.

# Average Handover Time

## Analytical Highlights:

Average handover time improved well in July, falling to **18 minutes in July from 22 minutes in June**. Again, this represents the **strongest performance** in the reporting period.

The proportion of handovers completed in 15 minutes has also improved, hitting **50% in July**, the best performance demonstrated in the chart and a strong improvement from **35% in June**.

**In July, only 1% of handovers exceeded 45 minutes.**

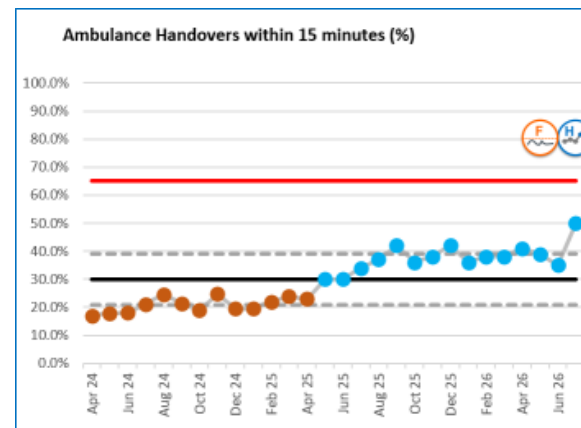
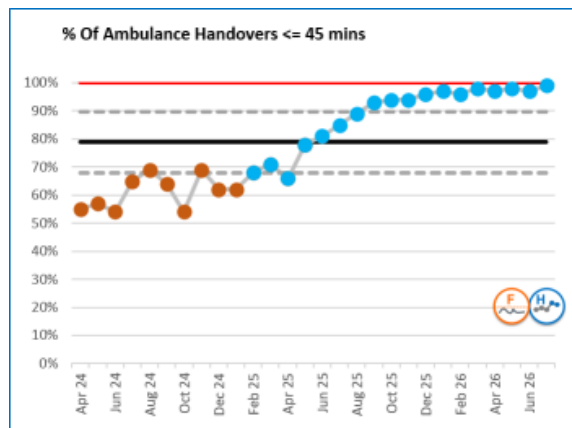
## Areas for Concern:

Despite strong performance, operational ambition remains to offload patients within 15 minutes wherever possible. The strong improvement in July represents a meaningful move towards this target.

65% of offloads to be completed within 15 minutes of arrival

## Learning & Improvement:

Further assurance is required that patients are being offloaded promptly into appropriate non-ED assessment areas or wards, supported by timely registration and clear ambulance bay processes.



## Actions

Review admin team location and move receptionist cover closer to the ambulance bay to speed registration and support improvement in ambulance offload times.

# RTT performance & First OP

Patients treated and OP waiters with first appointment in 18 weeks.

## Analytical Highlights:

RTT 18-week performance for July performance is 72%, which is a 1.51% decrease from June (73.51%). This has been the result of a cleanse of the waiting list, removing cohorts that are not RTT applicable, of whom all fall under 18 weeks.

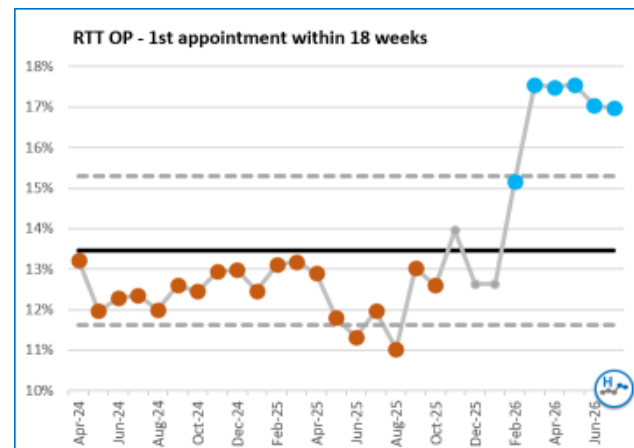
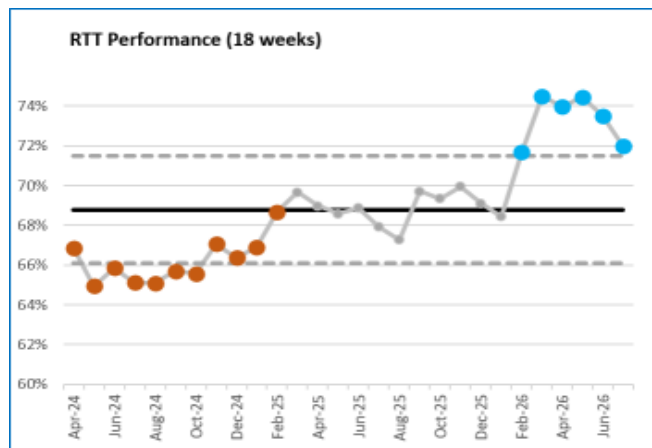
1st OP appointment within 18-weeks has shown a 0.07% decrease from June to July, with 16.97% having a first appointment before 18 weeks.

## Areas for Concern:

RTT performance dipped in month, as forecast, due to focus on Total Incomplete reduction, Number of patients >18 weeks increased with circa 1,000 additional – spread across most specialties. Key concerns Ortho/Spines; Gynae; GI services.

## Learning & Improvement:

Further focus on wait to 1st appointment and median waiting times.



## Actions

- Twice weekly line by line meeting with Ortho/Spines and DCOO given risk regarding 52 weeks.
- Action Plan in place and continuing to focus on reduction of Total Incompletes, specifically DQ issues, noting impact of RTT %. Initial progress resulted in Total Incompletes now below 70,000

# RTT EDI groups

RTT waiters with learning disabilities and armed forces CCG (13Q)

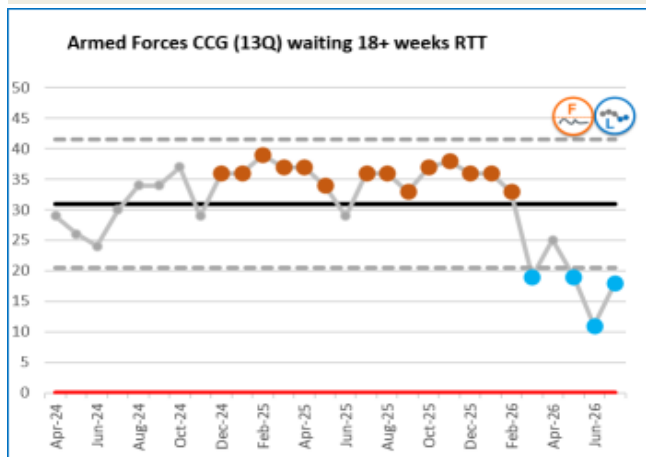
## Analytical Highlights:

The British Armed Forces cohort (13Q CCG) has shown an increase in the number waiting 18+ weeks for treatment, with 18 pathways remaining, up from 11 in June. Of those waiting 18+ weeks for treatment, the average wait is 24 weeks. The longest wait is 43 weeks.

Those awaiting treatment with learning disabilities has increased by 3 from June to 57 in July. Of those waiting 18+ weeks the average wait is 28 weeks. The longest wait is 46 weeks.

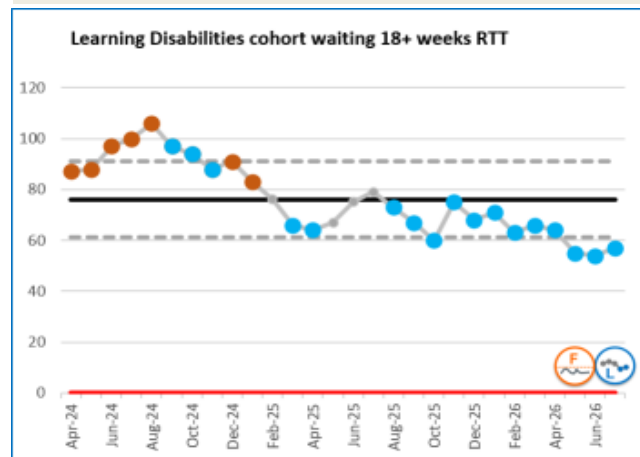
## Areas for Concern:

Overall number of BAF reduced albeit >18wks increased. The required target of no 18wk breaches for ENT & Ortho continues to be achieved (with 1 Patient Choice breach). Focus remains on other non-mandated specialties.



## Learning & Improvement:

Increased visibility for LD RTT reporting for specialties and integration into weekly RTT governance.



## Actions

- 1) Services continue to be advised of requirements to achieve zero 18-week breaches..
- 2) Focus will remain on Serving BAF personnel, before turning attention to 13Q patients on other waiting lists, and then reviewing Veterans, Retired, Reservists, Dependents.
- 3) Further promotion of timely treatment of patients with LD and review through meetings such as Check & Challenge & Long Waiters



# Elective: RTT 45 and 52 Week Waits

## Analytical Highlights:

The 45-week waiting cohort has increased by 141 from June position, resulting in 772 pathways. The largest cohort within this figures is trauma and orthopaedics with 315 pathways, and a further 137 spinal surgery.

Similarly, the 52-week cohort remains above the target of 0 for end of fiscal year 2025/26. The position for July is 25. Fourteen of the cohort have TCI booked for August.

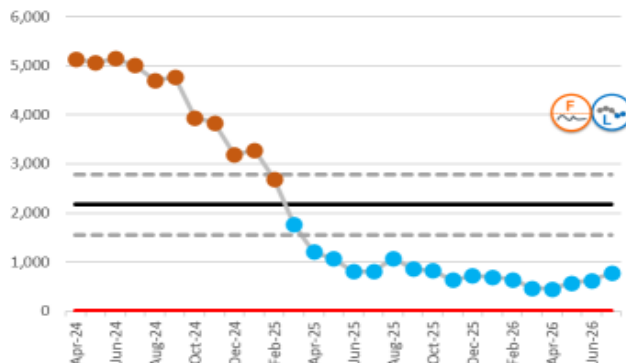
## Areas for Concern:

The key area remains Ortho/Spines which accounts for 80% of the 52 week breaches and 58% of the 45 week cohort, with the backlog having developed due to CSSD and heat related issues. Both Gynae and Colorectal demonstrating pressures.

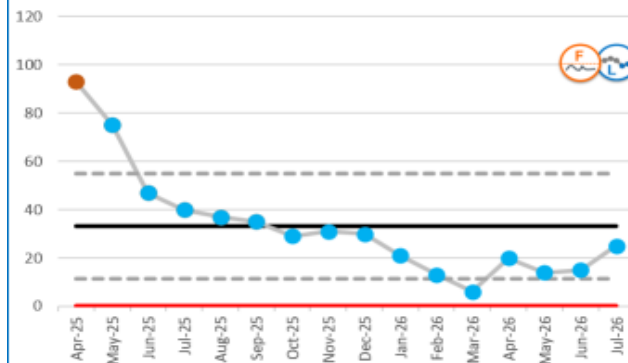
## Learning & Improvement:

Learning to be identified through RCA's and pathway reviews, and Demand and Capacity.

RTT 45ww Incomplete Position



RTT 52ww Incomplete Position



## Actions

Resolution of CSSD issues.  
Challenged services to consider alternative arrangements during heat alerts  
Opportunities to maximise usage of Independent Sector where appropriate.

# Cancer: % Patients seen within 62 Days *Standard: 85%*

## Analytical Highlights:

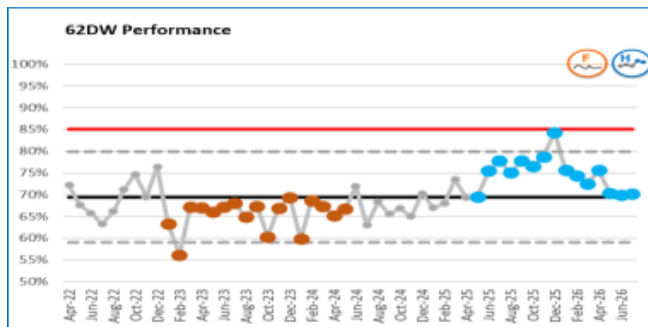
62-day performance improved marginally to **70.4%** in July (from **69.6%** in June) but remained significantly below both the 85% standard and the planned trajectory of 77.8%.

Recovery remains constrained by diagnostic delays and treatment capacity pressures across key tumour sites; however, additional capacity and strengthened recovery plans are expected to support improvement through August and September.

## Areas for Concern:

Treatment capacity constraints across Lower GI, Urology and Gynaecology, alongside ongoing diagnostic delays, particularly histopathology, continue to impact recovery against the 62-day trajectory.

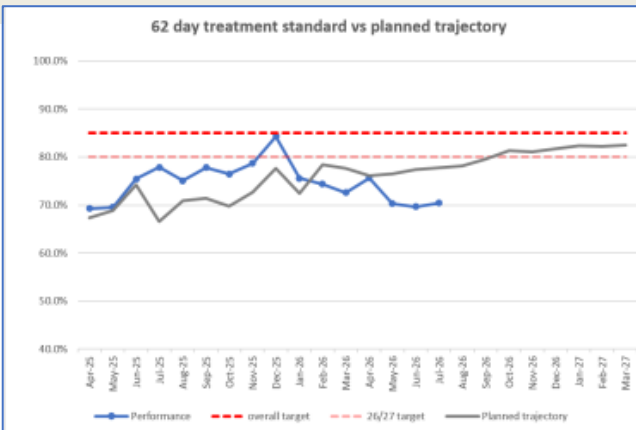
Backlog growth remains a risk in key tumour sites, exacerbated by capacity pressures and external pathway dependencies.



## Learning & Improvement:

July's story is less about a major improvement in performance and more about stabilisation and the first signs of recovery, rather than a step change in delivery.

There is a growing backlog position that requires immediate senior level intervention.



## Actions

1. Additional diagnostic and treatment capacity deployed in priority tumour sites (Dermatology, Gynae-Oncology, Fine Needle Aspiration (FNA)).
2. Weekly oversight of specialty recovery plans through strengthened cancer governance – presented by Directors of Operations
3. Escalation and support for pathways delayed by tertiary provider dependencies.
4. Focused recovery of histopathology turnaround times and other diagnostic bottlenecks.
5. Revised Cancer Delivery Group actions to provide earlier identification and escalation of risks.

# Cancer: Faster Diagnoses Standard (28 Day FDS) % with trajectory

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

## Analytical Highlights:

FDS performance was **74.7%** in July, down from **75.3%** in June and below both the 80% standard and planned trajectory of 79.4%.

Breast capacity continued to improve, with patients now being booked within 14-15 days, helping to mitigate performance pressures in one of the Trust's largest pathways.

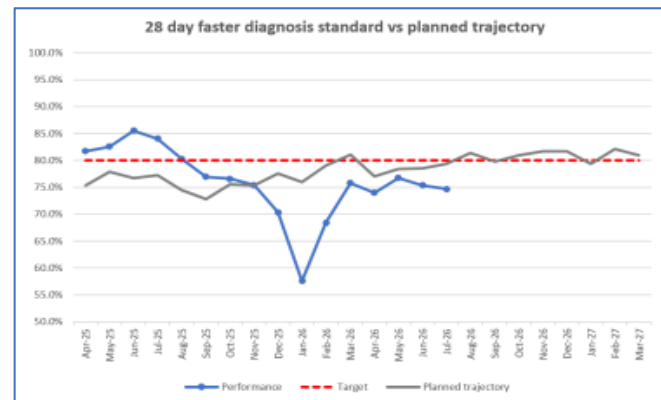
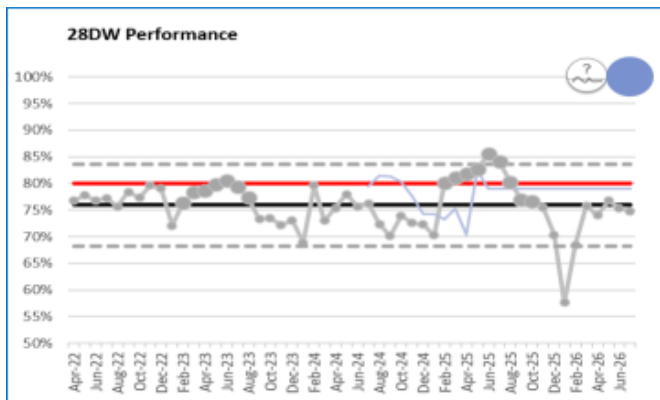
## Areas for Concern:

First outpatient capacity remains constrained across Head & Neck, Dermatology, Urology, Colorectal and Oncology pathways.  
Histopathology turnaround times continue to impact timely diagnosis, particularly within Gynaecology, Head & Neck and Colorectal services.

## Learning & Improvement:

Improving first outpatient access and reducing diagnostic delays remain the key opportunities to recover performance towards the 80% standard

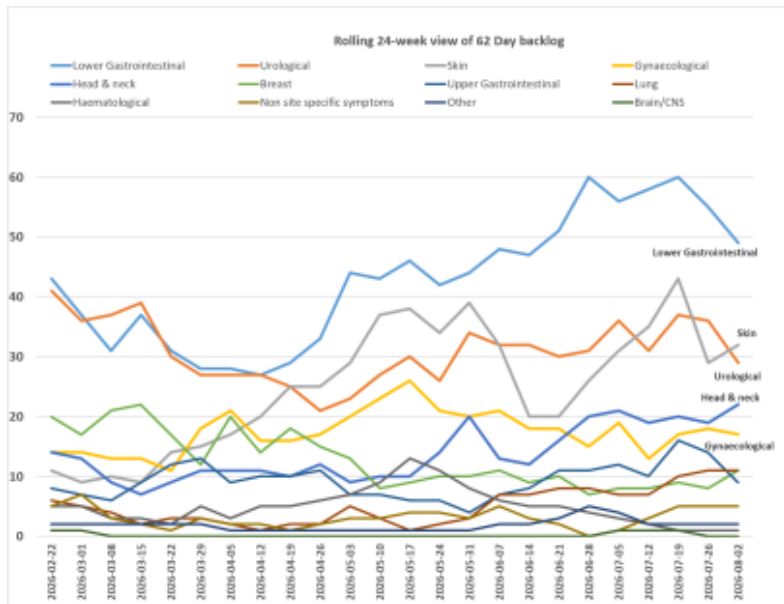
Skin remains the tumour site with least confidence in delivery but a significant impact on the aggregate trustwide position. Organisational focus therefore is on supporting an accelerated improvement plan.



## Actions

1. Increase first outpatient capacity in priority tumour sites.
2. Deliver Head & Neck demand and capacity review to support earlier booking.
3. Continue weekly skin pathway oversight to manage seasonal demand.
4. Reduce histopathology turnaround times in priority pathways.
5. Escalate diagnostic bottlenecks through cancer recovery governance.

# Cancer 62 Day Backlog Position



## Analytical Highlights:

Backlog data shows position at end of the week (for the past 24 weeks) for 2WW referrals that have waited over 62 days. Position at 02/08 was **188**.

Lower GI and Urological show a steady reduction in the past 3-4 weeks while Skin and Head & Neck backlogs continue to grow.

## Areas for Concern:

- Growing backlogs in Skin and Head & Neck pathways.
- Treatment capacity constraints across Urology, Lower GI and Gynaecology.
- Ongoing histopathology and diagnostic delays.
- Delays in pathway progression and clinical decision-making.
- Continued dependency on tertiary providers for timely treatment.

## Learning & Improvement:

Targeted recovery actions in Urology and Lower GI have demonstrated improvement, however Skin, Head & Neck, Gynaecology and Colorectal continue to be constrained by capacity and diagnostic delays. Earlier escalation of pathway delays, improved clinical decision-making and sustained focus on histopathology turnaround times remain critical to backlog recovery.

## Actions

1. Additional treatment capacity is being deployed within Urology and Lower GI, whilst weekly specialty RAG reviews continue to focus on decision-making delays, outstanding results, clinic outcome delays and pathway progression.
2. Targeted action is underway to reduce histopathology delays affecting Gynaecology, Head & Neck and Colorectal pathways, alongside strengthened oversight of Skin and Head & Neck backlogs and closer working with tertiary providers to improve timely access to treatment.

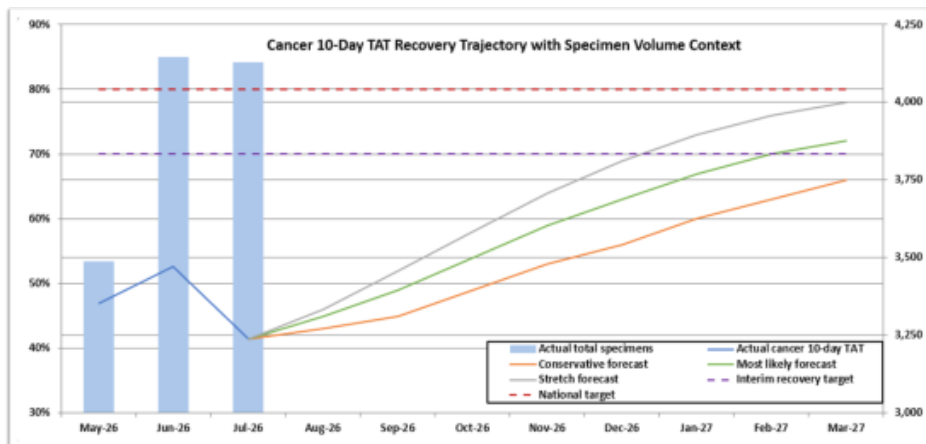
# Cancer Waiting Times Performance for the last 3 months

*Please Note – July position awaiting validation*

CWT Metrics – 3 prev. months position (excluding Breast. Symptomatic referrals)

| CWT Standards              | Two week wait |        |        | 28 Day FDS |        |        | 31 Day Treatment |        |        | 62 Day Treatment |        |        |
|----------------------------|---------------|--------|--------|------------|--------|--------|------------------|--------|--------|------------------|--------|--------|
|                            | May-26        | Jun-26 | Jul-26 | May-26     | Jun-26 | Jul-26 | May-26           | Jun-26 | Jul-26 | May-26           | Jun-26 | Jul-26 |
| Acute leukaemia            |               |        |        |            |        |        |                  |        |        | 50.0%            |        | 100.0% |
| Brain/CNS                  | 100.0%        | 83.3%  | 100.0% | 100.0%     | 75.0%  | 50.0%  |                  |        |        |                  |        |        |
| Breast                     | 14.3%         | 49.5%  | 47.1%  | 82.4%      | 84.2%  | 84.9%  | 94.7%            | 94.4%  | 90.8%  | 61.8%            | 72.5%  | 69.5%  |
| Gynaecological             | 84.3%         | 78.4%  | 61.8%  | 53.7%      | 48.8%  | 48.6%  | 78.8%            | 87.3%  | 86.2%  | 30.0%            | 47.4%  | 61.1%  |
| Haematological             | 52.4%         | 93.3%  | 100.0% | 31.6%      | 41.2%  | 30.0%  | 100.0%           | 100.0% | 100.0% | 58.1%            | 61.5%  | 77.8%  |
| Head & neck                | 72.8%         | 80.2%  | 71.5%  | 79.6%      | 77.0%  | 75.9%  | 100.0%           | 94.4%  | 93.3%  | 57.9%            | 14.3%  | 23.8%  |
| Lower GI                   | 88.0%         | 82.1%  | 77.2%  | 76.2%      | 66.7%  | 69.9%  | 93.5%            | 88.5%  | 84.7%  | 61.4%            | 54.9%  | 63.2%  |
| Lung                       | 95.5%         | 92.6%  | 88.9%  | 89.3%      | 86.7%  | 95.2%  | 89.1%            | 98.0%  | 84.1%  | 56.5%            | 63.2%  | 61.1%  |
| Other                      | 0.0%          |        |        | 0.0%       |        | 0.0%   | 100.0%           | 100.0% | 83.3%  | 11.1%            | 0.0%   | 66.7%  |
| Sarcomas                   |               |        |        |            |        |        | 100.0%           | 100.0% | 100.0% | 100.0%           | 100.0% | 100.0% |
| Skin                       | 38.3%         | 77.6%  | 61.5%  | 74.5%      | 76.2%  | 72.3%  | 93.9%            | 89.4%  | 95.0%  | 96.3%            | 79.4%  | 88.9%  |
| Non site specific symptoms | 0.0%          | 16.0%  | 87.9%  | 4.2%       | 21.2%  | 37.5%  |                  |        |        |                  |        |        |
| Testicular                 | 81.8%         | 88.9%  | 100.0% | 100.0%     | 87.5%  | 75.0%  |                  |        |        | 100.0%           | 100.0% |        |
| Upper GI                   | 93.5%         | 96.7%  | 89.5%  | 92.1%      | 88.5%  | 92.3%  | 100.0%           | 100.0% | 97.8%  | 91.5%            | 91.7%  | 85.5%  |
| Urological                 | 87.8%         | 91.9%  | 90.9%  | 65.8%      | 63.9%  | 57.7%  | 91.8%            | 87.3%  | 88.3%  | 74.4%            | 69.0%  | 62.7%  |
| Trust Total                | 61.5%         | 75.2%  | 69.4%  | 75.8%      | 74.1%  | 73.7%  | 93.8%            | 92.2%  | 90.4%  | 70.3%            | 69.9%  | 70.3%  |

# Histopathology 10-day reporting



## Analytical Highlights:

3000 paraffin block backlog from May/June has now been cleared.

10-day Cancer TAT performance was 53% in June, up from 47% in May, now down to 41% in July. Volume increase between May and June is **+18%**, **significant additional pressure. Driver is D6 endoscopy ID-Medical Clinics, currently unfunded within histopathology**

## Areas for Concern:

Unfunded activity preventing recovery in histopathology

Recruitment slippage – monitoring

Lack of physical dissection space – GMS escalation (ventilation)

## Actions

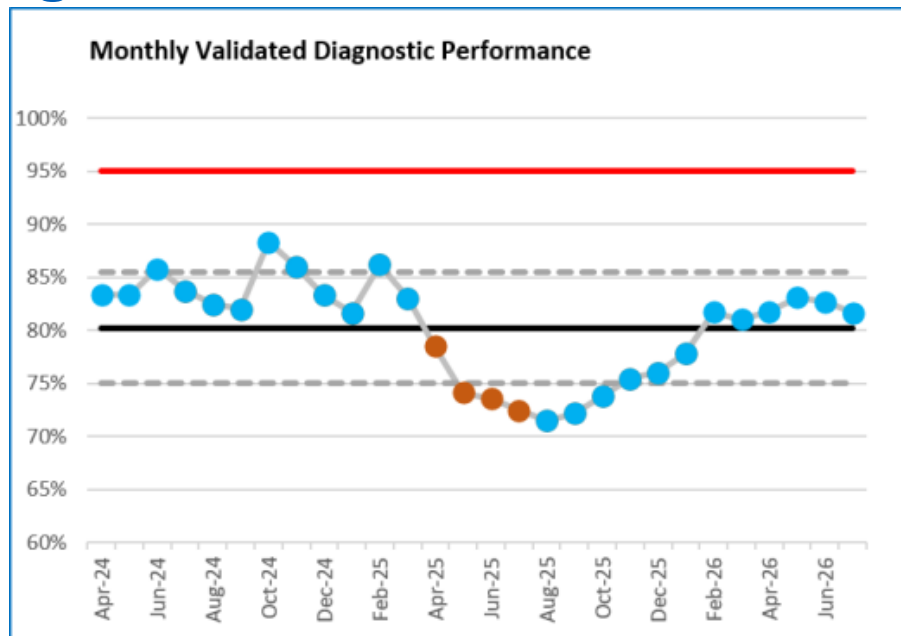
### Histopathology Recruitment and Tumour-Site Coverage Timeline

| Coverage / role                                        | Recruitment status                          | Start / milestone    | End / review                       | Jul-26 | Aug-26 | Sep-26 | Oct-26 | Nov-26 | Dec-26 | Jan-27 |
|--------------------------------------------------------|---------------------------------------------|----------------------|------------------------------------|--------|--------|--------|--------|--------|--------|--------|
| Gynae & breast substantive consultant capacity         | Appointed; acceptance documents outstanding | Jan-27 expected      | Not stated                         |        |        |        |        |        |        | ◆      |
| Gynae & breast interim consultant cover                | Interim appointment                         | 25-Aug-26            | Initial 3 months; likely extension |        | ▶      | ■      | ■      | ◆      |        |        |
| GI maternity cover                                     | Cover required                              | 22-Jul-26            | 05-Nov-26                          | ■      | ■      | ■      | ■      | ▶      |        |        |
| Gynae, GI and future medical liver consultant capacity | Started; induction completed                | 03-Aug-26            | Ongoing                            |        | ▶      | ■      | ■      | ■      | ■      | ■      |
| Substantive Specialty Doctor capacity                  | Three interviews scheduled                  | 13-Aug-26 interviews | Vacancy risk from 28-Aug-26        |        | ■      | ◆      |        |        |        |        |

### Legend

|   |                                            |
|---|--------------------------------------------|
| ◆ | Recruitment decision / interview milestone |
| ▶ | Start date                                 |
| ■ | Coverage active                            |
| ■ | Coverage gap / cover required              |
| ◆ | Expected start or review point             |
| ▶ | Known end of leave / gap                   |

# Diagnostics: Performance Trend



## Analytical Highlights:

Performance has decreased by 1.07% from June position. A contributing factor towards this has been the adverse weather conditions which has continued to impact MRI due to humidity. For context, from August 2025 to May 2026, our breaches have consistently been below 20 for this modality. June and July 2026 has shown 213 and 388 breaches, respectively.

## Areas for Concern:

Nine modalities have deteriorated in month (Cystoscopy, OGD MRI, CT, Barium Enema, Audiology, Echo, Neurophysiology, Sleep Studies).

Excluding MRI, performance deterioration has been small in patient volume and mostly mitigated by improvement in high volume modalities: Colonoscopy, Flexi Sig. Gastroscopy total PTL size has reduced, impacting on performance despite breach numbers reducing.

## Learning & Improvement:

Total diagnostic waiting list likely to continue reducing due to incurring for high volume modalities: Echo and Endoscopy.

Imaging modalities: MRI and Barium Enema will continue to be impacted by July heatwave – recovery tail through August performance into September

## Actions

- Endoscopy - Additional Endoscopy capacity and 6 day working drives the step change in performance improvement from July onwards with anticipated acceleration in recovery from October.
- ECHO – Healthnow insourcing commenced 01/08; providing approx. 450 dedicated DM01 slots per month

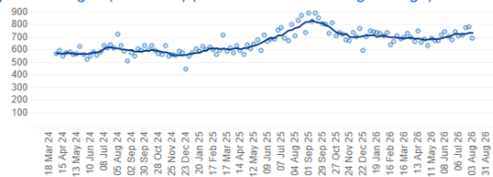
# Diagnostics: Performance Trend

| DM01 Performance                             | Month |            |            |            |            |            |            |            |            |            |            |            |            |
|----------------------------------------------|-------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Modality                                     |       | 2025-08-01 | 2025-09-01 | 2025-10-01 | 2025-11-01 | 2025-12-01 | 2026-01-01 | 2026-02-01 | 2026-03-01 | 2026-04-01 | 2026-05-01 | 2026-06-01 | 2026-07-01 |
| Audiology - Audiology Assessments            |       | 98.27%     | ↑ 99.76%   | ↓ 99.66%   | ↓ 99.65%   | ↑ 99.88%   | ↑ 100.00%  | ↓ 99.80%   | ↓ 99.60%   | ↓ 99.07%   | ↑ 99.09%   | ↓ 97.87%   | ↑ 98.50%   |
| Barium Enema                                 |       | 100.00%    | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ↓ 88.73%   | ↓ 72.97%   |
| Cardiology - echocardiography                |       | 29.40%     | ↓ 19.63%   | ↑ 23.41%   | ↑ 26.52%   | ↑ 30.78%   | ↓ 28.52%   | ↑ 41.82%   | ↓ 28.15%   | ↑ 34.36%   | ↑ 54.65%   | ↓ 44.77%   | ↓ 43.80%   |
| Colonoscopy                                  |       | 45.87%     | ↑ 48.34%   | ↑ 51.27%   | ↓ 50.60%   | ↓ 48.91%   | ↑ 50.00%   | ↑ 53.16%   | ↑ 53.35%   | ↓ 49.91%   | ↓ 49.18%   | ↑ 51.43%   | ↑ 59.93%   |
| Computed Tomography                          |       | 86.15%     | ↑ 88.47%   | ↑ 89.11%   | ↓ 87.28%   | ↓ 87.07%   | ↑ 88.64%   | ↑ 92.64%   | ↑ 93.44%   | ↑ 94.60%   | ↑ 95.34%   | ↓ 92.83%   | ↓ 92.61%   |
| Cystoscopy                                   |       | 36.31%     | ↓ 28.36%   | ↑ 32.75%   | ↑ 36.93%   | ↑ 39.83%   | ↑ 41.96%   | ↑ 46.20%   | ↑ 58.65%   | ↑ 73.46%   | ↓ 63.38%   | ↑ 66.52%   | ↓ 65.56%   |
| DEXA Scan                                    |       | 100.00%    | ⇒ 100.00%  | ⇒ 100.00%  | ↓ 99.82%   | ↑ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ↓ 99.18%   | ↑ 100.00%  | ⇒ 100.00%  | ↓ 99.45%   | ↑ 99.82%   |
| Flexi sigmoidoscopy                          |       | 40.29%     | ↑ 42.34%   | ↓ 41.69%   | ↓ 38.54%   | ↓ 37.40%   | ↑ 47.55%   | ↑ 52.76%   | ↓ 52.18%   | ↓ 51.06%   | ↑ 55.69%   | ↑ 59.10%   | ↑ 68.16%   |
| Gastroscopy                                  |       | 74.81%     | ↓ 73.63%   | ↓ 71.75%   | ↑ 73.81%   | ↓ 73.77%   | ↑ 82.48%   | ↓ 82.23%   | ↑ 84.31%   | ↓ 80.09%   | ↓ 70.10%   | ↑ 71.56%   | ↓ 68.58%   |
| Magnetic Resonance Imaging                   |       | 99.17%     | ↓ 98.90%   | ↑ 99.10%   | ↓ 97.84%   | ↑ 99.11%   | ↓ 99.02%   | ↑ 99.45%   | ↓ 99.03%   | ↑ 99.38%   | ↓ 99.03%   | ↓ 90.58%   | ↓ 84.09%   |
| Neurophysiology - peripheral neurophysiology |       | 56.86%     | ↑ 60.87%   | ↑ 62.28%   | ↑ 75.14%   | ↓ 59.76%   | ↑ 69.67%   | ↑ 75.80%   | ↓ 75.16%   | ↑ 79.84%   | ↓ 78.48%   | ↓ 68.94%   | ↑ 76.42%   |
| Non-obstetric ultrasound                     |       | 99.40%     | ↑ 99.47%   | ↑ 99.64%   | ↑ 99.91%   | ↓ 99.63%   | ↓ 99.36%   | ↓ 98.21%   | ↓ 96.67%   | ↓ 94.36%   | ↑ 95.41%   | ↑ 96.34%   | ↓ 94.27%   |
| Respiratory physiology - sleep studies       |       | 97.90%     | ↓ 94.22%   | ↑ 96.27%   | ↑ 99.22%   | ↓ 91.69%   | ↓ 82.23%   | ↑ 96.30%   | ↓ 93.01%   | ↑ 95.49%   | ↓ 93.71%   | ↓ 82.44%   | ↑ 88.10%   |
| Urodynamics - pressures & flows              |       | 100.00%    | ⇒ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ↓ 91.67%   | ↑ 100.00%  | ⇒ 100.00%  | ⇒ 100.00%  | ↓ 87.50%   | ↑ 92.59%   | ↓ 92.31%   | ↑ 100.00%  |

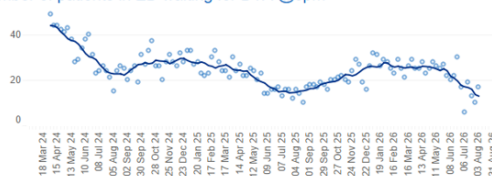


# Flow Summary

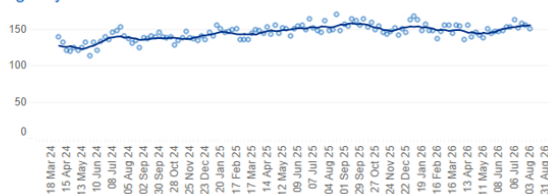
Simple discharges (Non OCT) (incl moves to discharge lounge)



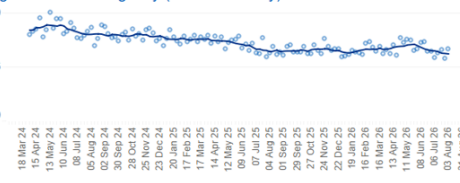
Number of patients in ED waiting for DTA @6pm



Emergency Admissions



Average LOS for Emergency (excl maternity)



## Analytical Highlights:

- Emergency length of stay remains materially below the 2024 baseline; the latest points have eased after an early-2026 rise, although performance remains variable.
- ED waits for a decision to admit at 6pm have fallen sharply in the latest period to one of the lowest levels in the series.
- Simple discharges remain above the 2024 baseline, but below the late-2025 peak, with the latest position broadly stable amid weekly variation.
- Emergency admissions remain high and close to the upper historic range, so current flow gains continue to be delivered under sustained demand.

## Areas for Concern:

- Emergency LOS remains volatile, showing that the improvement is not yet consistently embedded across the system.
- Simple discharge performance has eased from its strongest level, increasing the risk that DTA and LOS gains could reverse if reliability weakens.
- The sharp fall in DTA waits now needs to be sustained and translated into consistently lower emergency LOS.
- High admission volumes leave limited headroom for deterioration in discharge capacity, bed availability or front-door alternatives.

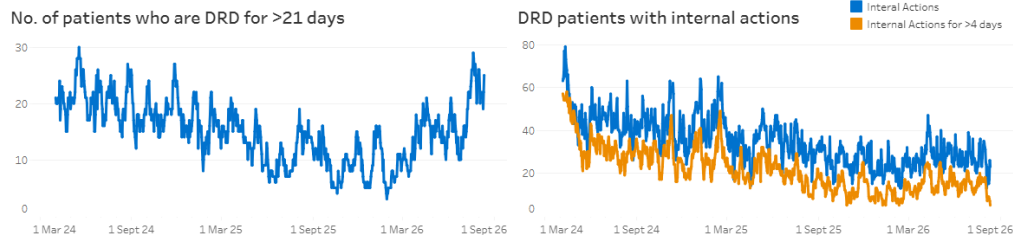
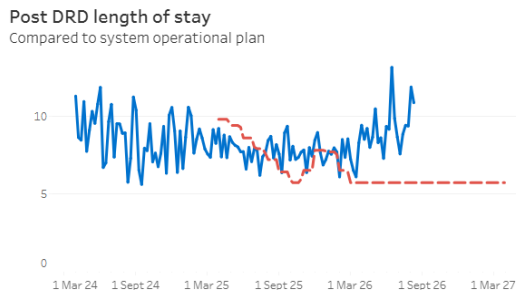
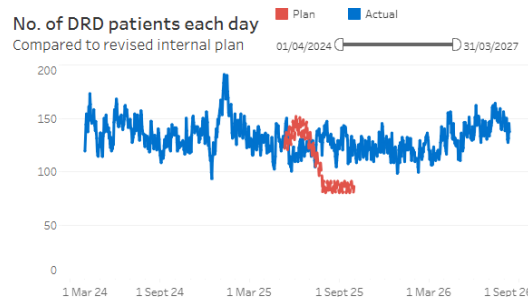
## Learning & Improvement:

- The latest DTA reduction shows that stronger operational flow can deliver improvement despite sustained demand.
- Daily discharge reliability, early identification of simple discharges and effective use of CLD and the discharge lounge remain central to maintaining flow.
- Weekly review should distinguish normal variation from emerging deterioration in emergency LOS and discharge performance.
- SDEC, admission avoidance and front-door escalation should flex on high-demand days to protect the latest gains.

## Actions

- Restore simple discharges towards the strongest 2025 levels through CLD, discharge lounge use and ward-level expected discharge reviews.
- Use CVOF workstreams to align front-door escalation, SDEC pathways and admission avoidance capacity.
- Maintain focused review of weekend discharge and stranded-patient cohorts to protect lower emergency LOS.

# Discharge Ready Summary



## Analytical Highlights:

- Total DRD has risen again in the latest period and is materially above the revised internal plan, reversing much of the earlier improvement.
- The over-21-day DRD cohort has increased sharply and returned close to the higher range seen earlier in the series.
- Post-DRD length of stay has deteriorated markedly, with the latest points among the highest in the series and well above plan.
- DRD cases with internal actions remain lower over the longer term, but recent performance has not offset the wider rise in delays.

## Areas for Concern:

- The gap to the revised DRD plan is widening, with both patient numbers and post-DRD LOS moving in the wrong direction.
- Growth in the over-21-day cohort indicates that the backlog is ageing and long-delay control has weakened.
- Pathway 1 and 2 capacity, case resolution and discharge timing remain the main risks to bed availability and flow resilience.

## Learning & Improvement:

- Earlier reductions were not sustained; clear the longest-delay cohort while controlling new DRD cases.
- Review internal and external delays together to resolve, not transfer, pathway risk.
- Escalate the latest deterioration rapidly before delays become embedded.

## Actions

- Review DRD against plan weekly, quantifying the gap and the pathways driving the latest deterioration.
- Prioritise over-21-day cases and patients with the highest post-DRD LOS through daily system escalation.
- Increase grip on pathway 1 starts and pathway 2 capacity, including packages of care and bedded provision.
- Escalate the current deterioration at Trust and system level because of its impact on bed availability and flow resilience.

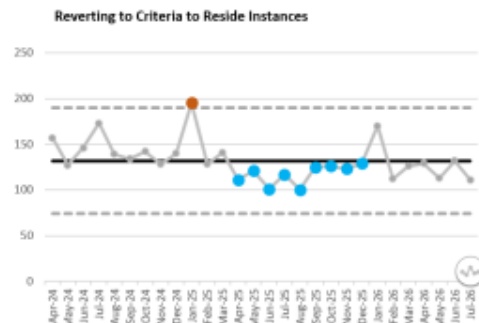
# Delay Related Harm Summary

## Analytical Highlights:

- Deaths with a discharge-ready period remain within expected variation and below the historic upper control limit; the latest rise has eased.
- Reversions to criteria to reside remain around the established range; the early-2026 increase was not sustained and the latest position has reduced.
- Aggregate harm measures therefore show no clear concurrent deterioration, despite the worsening DRD and post-DRD LOS indicators.

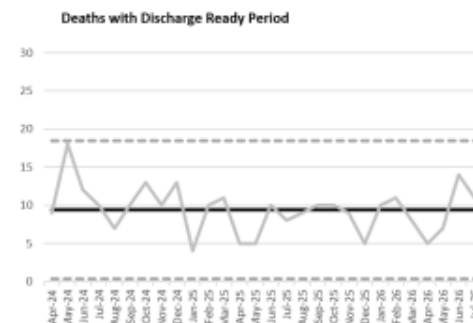
## Areas for Concern:

- Stable aggregate harm measures may lag or mask patient-level harm as discharge delays and post-DRD LOS increase.
- Short-lived increases in both measures still require case review, even where control limits are not breached.
- Risk is most likely to be concentrated in the longest-delay patients, particularly where complexity, dependency or pathway 2 capacity are factors.



## Learning & Improvement:

- Harm surveillance should combine aggregate SPC measures with case-level review of high-risk delayed patients.
- DRD volume, post-DRD LOS and pathway capacity should be used as leading indicators rather than waiting for harm measures to deteriorate.
- Case reviews should test whether delay contributed to deterioration, harm or reversion to criteria to reside and feed learning back into pathway action.



## Actions

- Continue exception review of DRD deaths, reversions to criteria to reside and the longest-delay cases.
- Triangulate harm data with DRD volume, post-DRD LOS and pathway capacity to identify emerging risk earlier.
- Escalate high-risk pathway 1 and 2 cases weekly, prioritising patients whose delay is lengthening.
- Use case-review learning to direct discharge escalation, pathway capacity planning and harm-reduction action.

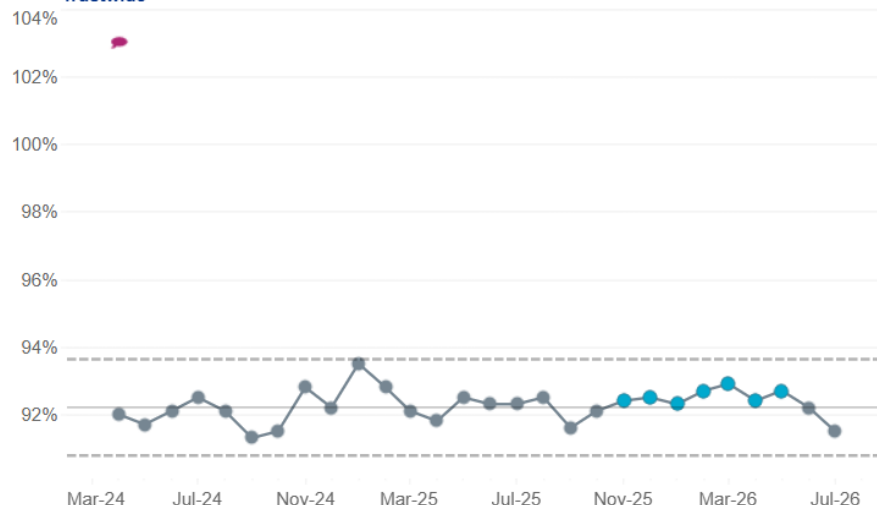
# Quality Metrics

(Safety, experience and effectiveness)

# Quality of Care: FFT Positive Response

[156] Total % positive

Trustwide



## Quality Highlights:

- FFT positive score has dropped for a second month to a below average position. A decrease in overall positive score is due to a reduction in scores for inpatients, outpatients and maternity.
- Positively, GRH ED saw the only increase in positive score across all services.

## Areas for Concern:

- The difference in experiences between each ED at CGH to GRH remains significant (86.5% and 68.2% respectively) but is reducing, however, there is a m-o-m deterioration of CGH ED score.
- Postnatal ward experiences have further deteriorated (61.1%) with reductions across all maternity surveys therefore reducing their score.
- Inpatient reported experience also experiencing a m-o-m deterioration.

## Learning & Improvement:

Patient experience data is now reported monthly to divisions with most areas now discussing as part of their quality governance arrangements.

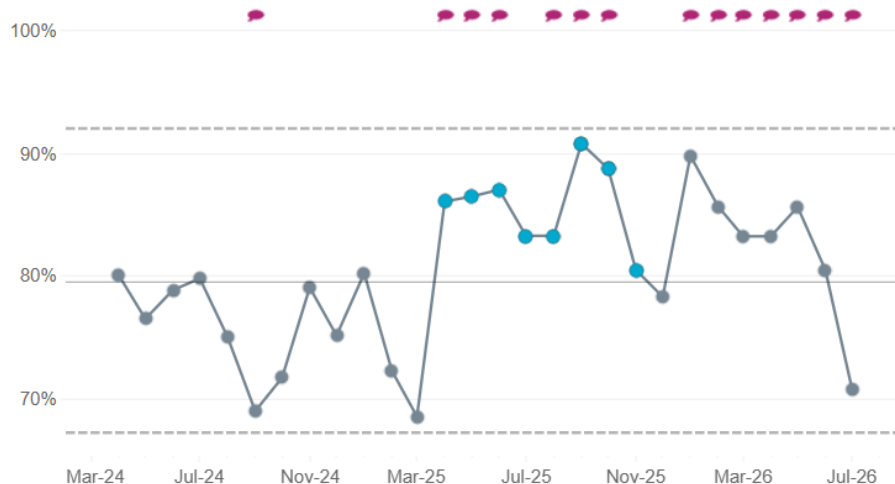
## Actions

- Improved reporting ongoing with divisions with a strengthening of quality governance and a specific focus on patient experience linked to Trust strategy.
- Patient Experience Team to work with Maternity and ED leads to support experience improvement in areas regularly experiencing lower scores.
- CQC National Inpatient Survey report due to be published 26 August 2026 so further triangulation will be done.
- Work ongoing with BI colleagues to further surface and share the intelligence from our patients' feedback along with other metrics to support divisions with improvement and identify gaps in feedback.
- Review of outpatient experiences to be discussed at Outpatient Transformation Board to support improvement.

# PALS

[569] % of PALS concerns closed in 5 days

Trustwide



## Quality Highlights:

- Closure rate dropped below target (75%) at 71% and is a significantly decreased position. (Number closed in 5 working days = 333, increase on previous month. Total closed in month = 471 and 70 cases more than previous month).
- Team working in escalation process for 2 weeks and as of 10/8/2026 had cleared all backlog and working back in business as usual. This focussed work to clear backlog will have affected closure rate for the month.

## Areas for Concern:

- Volume of cases remains very high with at 469 with the adjusted June figure now reading at 489. Adjustments to figures has seen all previous months recording more concerns than previously reported.
- The increasing volume and complexity of cases is causing significant pressure and negative impact on staff wellbeing. The team are being supported by bank admin support and adjustments to working environment to support wellbeing.

## Learning & Improvement:

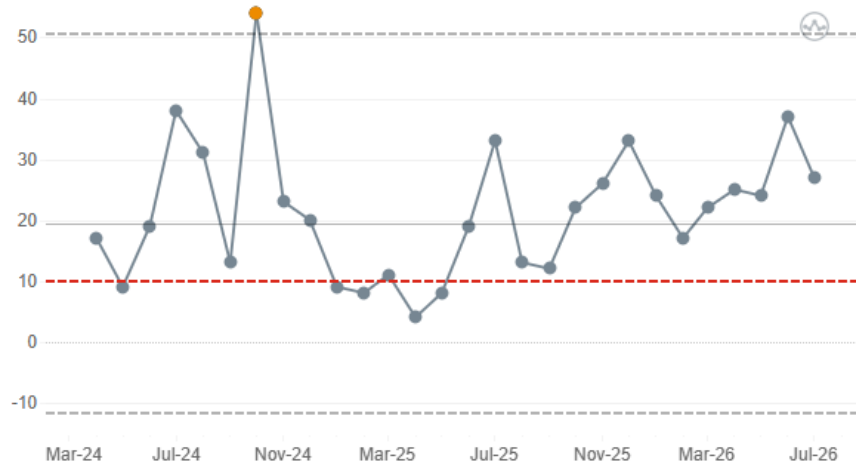
Anticipate moving back in line with KPI.  
Further adjustments to processes including access to the service, triage of cases, escalation of ongoing concerns will continue.

## Actions

- Working in escalation for 2 weeks to clear backlog and to support 'reset' of service. Successful in terms of performance but reduced continuity and personalisation of service. Have moved out of escalation and back into a revised BAU.
- Band 2 bank admin support remains in place
- 0.8 WTE substantive band 4 PALS advisor starting 17/8/2026. Member of staff on LTS to return 12/8/2026.
- Escalation of areas experiencing the highest number of concerns e.g. Subject Access Requests, Trauma and Orthopaedics.
- Adjustment to access to service including closure of drop-in service and management of telephone calls outside service core hours. Updated webpages.
- Quality concerns relating to ongoing pressure has been added to risk register reference number 1128.

# Patient Care: Mixed Sex Breaches

[148] Number of breaches of mixed sex accommodation  
Trustwide



## Analytical Highlights:

Mixed sex accommodation breaches have increased again in recent months. The latest position is around **37 breaches**, above both the expected tolerance line and recent performance levels.

## Areas for Concern:

This is no longer just a low-level exception pattern. Breaches are recurring, with several months above tolerance, suggesting ongoing flow pressures — particularly delays moving patients out of Critical Care and Recovery.

## Learning & Improvement:

The low-breach period in early 2025 shows improvement is achievable, but it has not been sustained. The focus should be on understanding what worked then and applying it consistently..

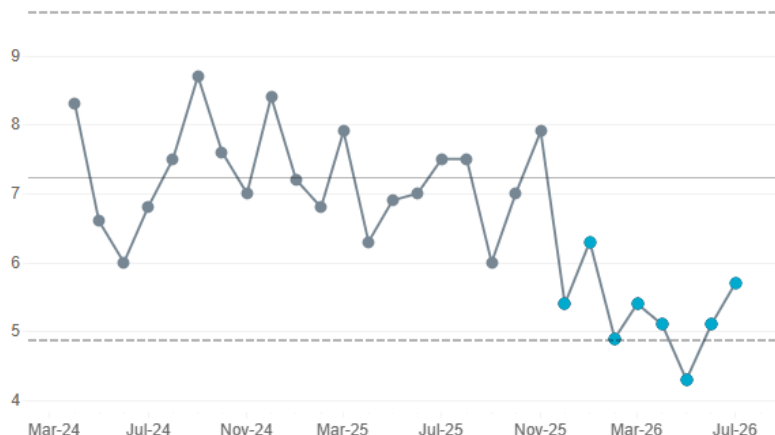
## Actions

Continue daily review of breaches through site calls, strengthen escalation for transfer delays, and agree targeted actions to bring breaches back below tolerance.

# Safety Priority: Patient Falls

## [112] Number of falls per 1,000 bed days

Trustwide



### Quality Highlights:

Number of falls within the trust 5.7 per 1000 bed days. There were 4 falls resulting in injury during July. 2 of which resulted in a DoC letter to the pt/family due to lack of accurate documentation around assessment of falls risk

### Areas for Concern:

Falls remain a challenge for the Trust, due to the acuity of the patients and the increasing hot weather has also been a challenge for our patients at risk of falls. True collapses are often reported as falls, however a true collapse is not a fall.

### Learning & Improvement:

We have a continuous improvement programme of work which is ongoing.

## Actions

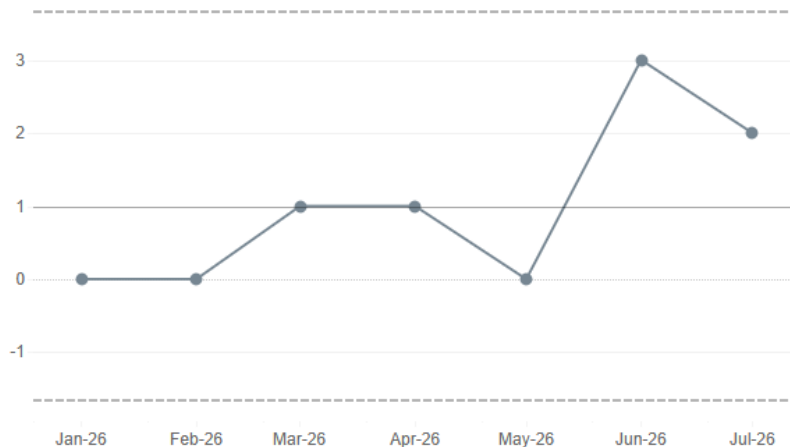
Improvement focus is on specialist review of patients who have fallen twice during admission, if appropriate. A comprehensive training package launched by the Falls Team continues and very well attended; this is a key focus for us.

Quality improvement programmes continue with Datix development to include Hot Debrief questions within the reporting Datix form. The EPR documentation complete, sitting with the EPR team for uploading. Immediate Post falls forms for both Nursing and Medical staff now live on EPR and in use – education sessions continue for both professions.



# Safety Priority: Patient Falls

[614] Number of falls resulting in broken neck of femur  
Trustwide



## Quality Highlights:

Falls resulting on #NOF numbered 3. One resulted in DoC. Both falls occurred following the 1st inpatient fall

## Areas for Concern:

In July there were 3 falls resulting in #NOF's (neck of Femur) all were following a 1st fall.  
Lack of documented accurate assessment noted following these falls

## Learning & Improvement:

We have a continuous improvement programme of work which is ongoing.

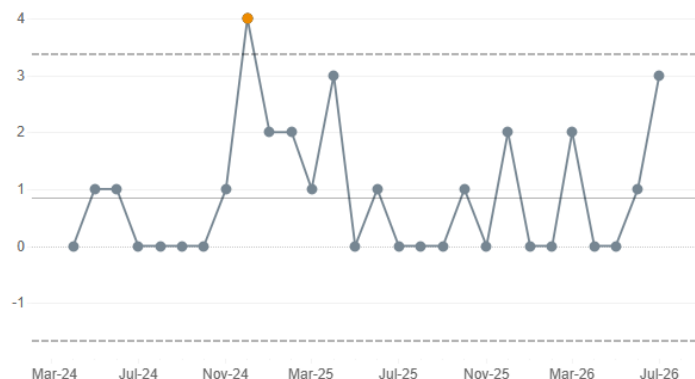
## Actions

All inpatient falls resulting in a #NOF are presented at the weekly Falls Review Panel and recorded as severe on the Datix system. Any areas of learning are identified, either at ward level or at trust level.

# Safety Priority:

## Pressure Ulcers Cat 3

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



### Quality Highlights:

Category 3 pressure ulcers remain low overall.

### Areas for Concern:

There is ongoing variation month to month, so continued vigilance is needed.

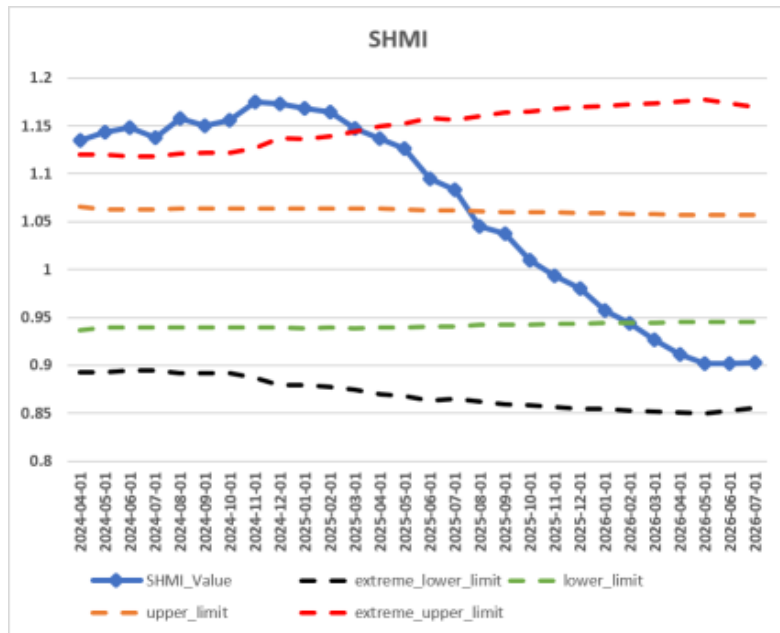
### Learning & Improvement:

Each reported case should continue to be reviewed to identify themes and strengthen prevention practice.

## Actions

Maintain specialist review of all hospital-acquired Category 3 pressure ulcers, continue prevention training, and monitor whether ward-level equipment and improvement actions are reducing recurrence.

# Mortality – SHMI National Data



## Quality Highlights:

SHMI continues to improve, with the latest published position at **0.90**, showing a sustained downward trend from the 2024 peak.

## Areas for Concern:

Ongoing monitoring of SHMI without remedial coding  
Clinical audits guided by mortality alerts (BAU)

- Currently this includes aspiration pneumonia/sepsis ED delay related harm

## Learning & Improvement:

Mortality alerts continue to guide clinical audit priorities, including aspiration pneumonia, sepsis and ED delay-related harm.

## Actions

Continue monitoring SHMI and mortality alerts through HMG, maintain audit oversight, and progress the sepsis improvement workstream.

# PSIRF (Patient Safety Incident Response Framework) Learning Responses

## Highlights:

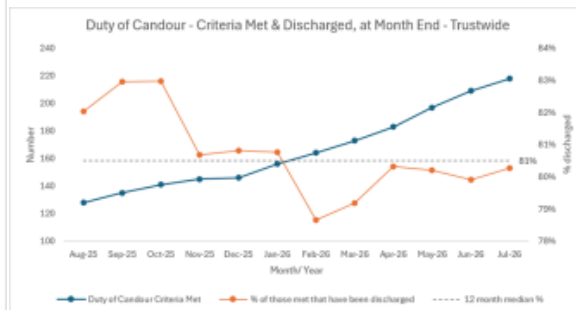
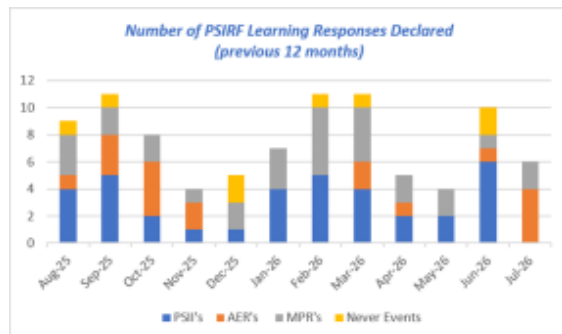
91 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 7.5 per month.

## Areas for Concern:

Median on time for PSII's remains at 63%, AER's increased to 75% and MPR's remained at 70%. The median % discharge rate at the end of the month remained at 81%

## Learning & Improvement:

Resource and Capacity within Divisions and the Patient Safety team will be addressed through implementation of the Quality Governance Framework.



## Actions

**Resource:** Implementation of the Quality Governance Framework

**Never Events:** Thematic Analysis completed and shared with Trust Board. Learning Responses are prioritised and being completed within required timeframes

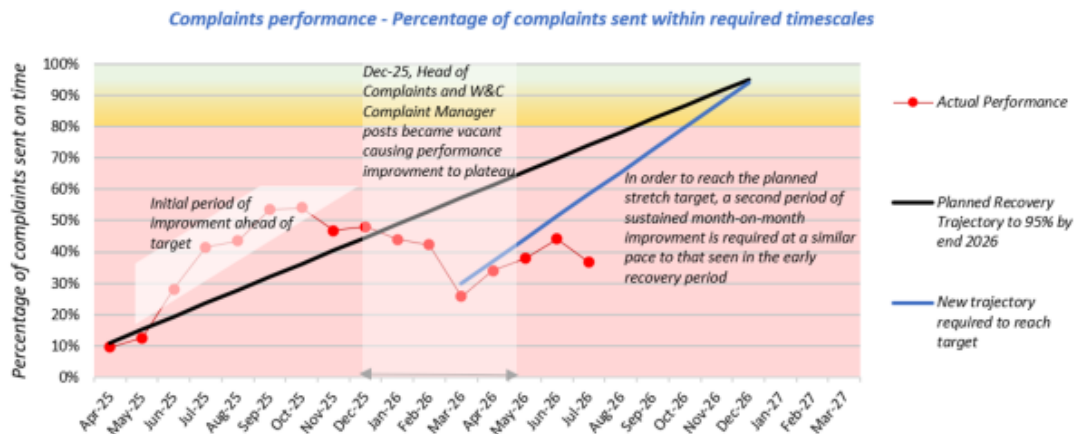
# Complaint Performance (July 2026)

## Quality Highlights:

Timeliness was 39% in July, with 43 of 111 complaints closed within the required timescale, compared with 44% in June. Although performance remains below the 95% standard, 210 complaints were closed—the highest monthly total in the past 24 months. This indicates increased throughput, but not yet sustained improvement in timeliness.

## Areas for Concern:

Complaints aged over six months remain the principal quality and delivery risk, despite reductions supported by temporary staffing. There is a notable increase in the number of complaints allocated to the corporate Division. This is primarily due to delayed Subject Access Requests. The Complaint Improvement Programme is scheduled to restart in September 2026.



## Learning & Improvement:

Performance is expected to remain constrained in the short term. Recovery depends on stabilising the workforce, prioritising the oldest and highest-risk complaints, and implementing the New Complaint Framework across the Trust. The framework is expected to strengthen early resolution, increase divisional ownership, reduce reliance on central drafting and support the recovery trajectory to the 95% standard required.

## Actions

**July position:** 39%. Whilst remaining below standard, with a slight decrease in percentages sent on time, the concentrated effort on complaints that have missed their deadline is reflected in 210 complaints having been closed in month.

**Mitigations in place:** overtime, bank support with drafting: Locum Registrar in place from w/c 18/5/26. Temporary Head of Complaints position now filled

**Recovery actions:** Restart Complaint Improvement Programme and roll out New Complaint Framework; increasing Division/Specialty accountability and responsibility and consequently reducing reliance on central complaints team for drafting.

**Progress monitored** via weekly executive oversight with monthly reporting

# Complaint Performance (July 2026)

YearMonth

Jul-26

Received

149

Total Closed

210

Due for closure

111

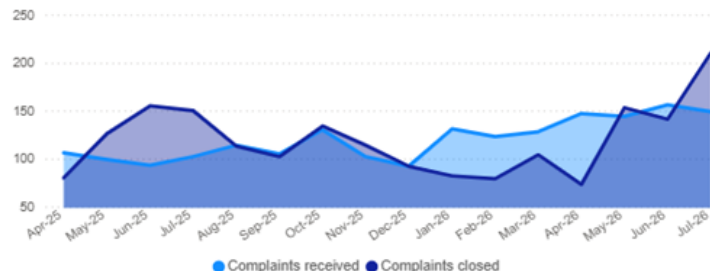
Closed within due date

43

% closed within due ...

39%

Complaints received vs Complaints closed

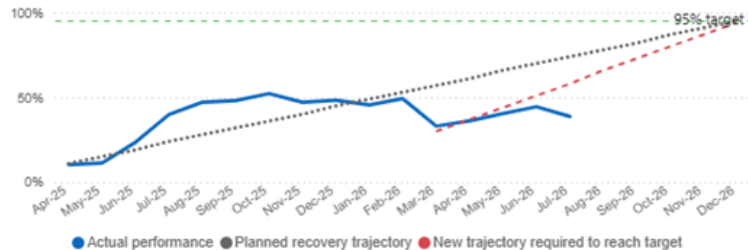


Complaints Received, Closed, and Due - by Division

| Division                 | Received   | Total Closed | Due for closure | Closed within due date | % closed within due date |
|--------------------------|------------|--------------|-----------------|------------------------|--------------------------|
| Corporate                | 15         | 39           | 8               | 4                      | 50%                      |
| Diagnostics and Speci... | 16         | 22           | 4               | 1                      | 25%                      |
| Gloucestershire Mana...  | 1          | 3            | 1               |                        |                          |
| Medical                  | 50         | 55           | 46              | 27                     | 59%                      |
| Surgical                 | 38         | 64           | 38              | 9                      | 24%                      |
| Women's and Children's   | 29         | 27           | 14              | 2                      | 14%                      |
| <b>Total</b>             | <b>149</b> | <b>210</b>   | <b>111</b>      | <b>43</b>              | <b>39%</b>               |

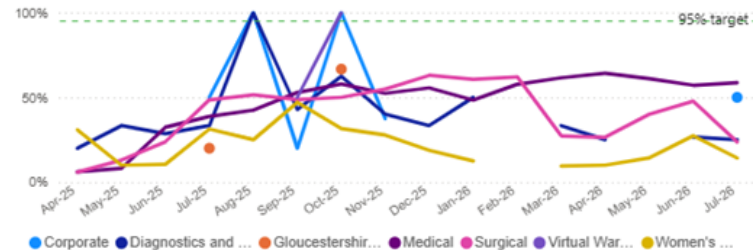
Complaints Performance - Trustwide

Percentage closed within due date



Complaints Performance - by Division

Percentage closed within due date



# Risk Management Performance

## Analytical Highlights:

Overall risk exposure reduced slightly, with 13 risks closed and 12 opened during the month, resulting in a net reduction in risks across the Trust. There are currently no active risks without controls demonstrating good compliance with risk management requirements. Seven risks reduced in score during the month, including three that achieved their target score and can be considered examples of effective risk treatment.

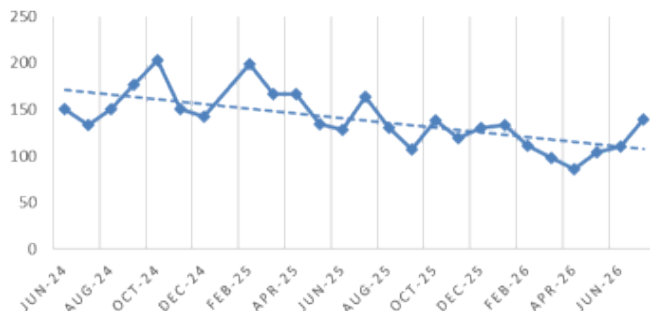
## Areas for Concern:

25% of risks have not been reviewed within the required timescale. There remain several long-overdue risks, with the oldest review overdue since July 2025. Overdue actions remain a significant concern, with over 50% **overdue on risks and incidents**. Two safeguarding-related incident actions remain overdue, including one action that is 23 months overdue.

## Learning & Improvement:

The increase in high and extreme risks highlights the importance of ensuring timely reviews and action completion so that emerging risks are identified and managed proactively. Overdue reviews and actions continue to be concentrated among a relatively small number of owners - targeted support and management oversight is required

NO. OF RISKS OVERDUE A REVIEW



### Overdue actions on risks

|           | No. overdue | Total open | % overdue | Change since last month |
|-----------|-------------|------------|-----------|-------------------------|
| Corporate | 37          | 133        | 29%       | ↑                       |
| Medical   | 55          | 92         | 59%       | ↑                       |
| Surgical  | 71          | 119        | 60%       | ↓                       |
| D&S       | 52          | 138        | 37%       | ↔                       |
| W&C       | 45          | 89         | 51%       | ↓                       |
| GMS       | 78          | 88         | 89%       | ↑                       |
| Trust     | 338         | 659        | 51%       | ↑                       |

### Overdue actions on incidents

|           | No. overdue | Total open | % overdue | Change since last month |
|-----------|-------------|------------|-----------|-------------------------|
| Corporate | 14          | 31         | 45%       | ↑                       |
| Medical   | 70          | 96         | 73%       | ↑                       |
| Surgical  | 31          | 39         | 79%       | ↓                       |
| D&S       | 24          | 58         | 41%       | ↓                       |
| W&C       | 77          | 196        | 39%       | ↓                       |
| GMS       | 9           | 9          | 100%      | ↔                       |
| Trust     | 225         | 429        | 52%       | ↓                       |

## Actions

Divisional leadership to continue targeted engagement with risk owners responsible for the highest numbers of overdue reviews and actions. Escalate concerns regarding long over overdue risk reviews and actions.

# Use of Resources Metrics



# Financial Metrics

## Highlights

The M4 revenue position is £7.4m deficit which is £0.02m favourable to plan. FSP has delivered £10.35m which is £0.34m ahead of plan. Capital spend is £9.1m which is behind plan by £6.6m

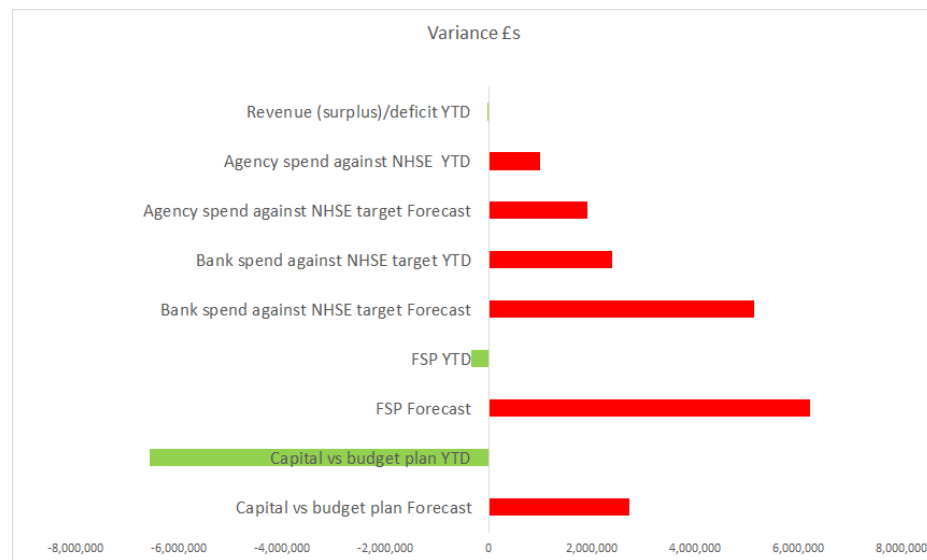
## Areas of concern

FSP target has started to increase significantly from M4 and there remains an unidentified gap of £6.2m.

## Looking forward

The underlying position for the Trust is £66.5m deficit which assumes full delivery of 26/27 recurrent FSP. NHSE has introduced new NOF metrics which measure temporary staffing spend as a percentage of pay bill.

| 2026/27 Financial Overview                   | Plan<br>£000s | Actual<br>£000s | Variance<br>£000s | Metric<br>Calculation | Score<br>(1 Best)<br>(4 Worst) |
|----------------------------------------------|---------------|-----------------|-------------------|-----------------------|--------------------------------|
| <b>Financial Metrics</b>                     |               |                 |                   |                       |                                |
| Revenue (surplus)/deficit YTD                | 7,384         | 7,354           | (30)              | -0.4%                 | 1                              |
| Agency spend against NHSE YTD                | 1,795         | 2,786           | 991               | 55.2%                 | 4                              |
| Agency spend against NHSE target Forecast    | 5,392         | 7,307           | 1,916             | 35.5%                 | 4                              |
| Agency spend as % of total pay bill YTD      | 1.0%          | 1.5%            | 0.5%              | 1.5%                  | 4                              |
| Agency spend as % of total pay bill Forecast | 1.0%          | 1.3%            | 0.4%              | 1.3%                  | 4                              |
| Bank spend against NHSE target YTD           | 11,024        | 13,416          | 2,392             | 21.7%                 | 4                              |
| Bank spend against NHSE target Forecast      | 33,097        | 38,240          | 5,143             | 15.5%                 | 4                              |
| Bank spend as % of total pay bill YTD        | 6.0%          | 7.3%            | 1.3%              | 7.3%                  | 4                              |
| Bank spend as % of total pay bill Forecast   | 6.1%          | 7.0%            | 0.9%              | 7.0%                  | 4                              |
| FSP YTD                                      | (10,010)      | (10,351)        | (341)             | -3.4%                 | 1                              |
| FSP Forecast                                 | (52,345)      | (46,117)        | 6,228             | 11.9%                 | 4                              |
| Capital vs budget plan YTD                   | 15,691        | 9,114           | (6,577)           | -41.9%                | 1                              |
| Capital vs budget plan Forecast              | 62,376        | 65,109          | 2,733             | 4.4%                  | 4                              |
|                                              | <b>Days/%</b> | <b>Days/%</b>   | <b>Days/%</b>     |                       |                                |
| Nos days operating cash                      | 5             | 20              | 15                | -100.0%               | 1                              |
| BPP - nos invoices paid in 30 days           | 95%           | 96%             | 1%                | -1.1%                 | 1                              |



# Director of Finance Summary

## Month 4 Overview

The month 4 year to date position is £7.4m deficit which is £0.03m favourable to plan. The plan is £7.4m deficit.

The variance is driven mainly by:

- FSP (£0.3m) above plan
- Industrial Action £0.7m (April)
- Drugs £0.5m
- API underperformance £0.5m
- HEE income above plan (£1.3m)

## Looking Ahead

The Trust remains marginally favourable to plan at Month 4, but the position is fragile. The favourable year-to-date variance is supported by non-recurrent benefits, central schemes and the current phasing of savings, while the in-month adverse variance indicates increasing run-rate risk from Month 5 onwards.

Areas of focus for forthcoming months

- Accelerate recurrent FSP delivery: Close the £6.2m FSP gap and reduce reliance on non-recurrent vacancies and central schemes.
- Reduce temporary staffing costs: Continue reductions in agency, bank and locum spend, with targeted action to reduce the £3.4m combined excess above NHSE caps.
- Recover API performance: Use the Internal Contract Review meeting to hold specialties to account for underperformance, particularly radiotherapy and other key specialties by commissioner.
- Mitigate cost pressures: Require divisions to provide clear, time-bound plans for the £4.5m Amber and Red cost pressure risk ahead of Finance Oversight Sub Committee reporting.

# M04 Revenue Position

## Highlights

The M4 revenue position is £0.03m favourable to plan. Over performance against FSP plans are offsetting industrial action and supplies costs.

## Areas of concern

Whilst FSP has over delivered again YTD, the rate of over-delivery is slowing due to targets increasing. In year delivery is a concern, compounded by the current over-delivery being entirely due to non-recurrent savings (£3.2m).

## Looking forward

The underlying position for the Trust is £66.5m deficit which assumes full delivery of 26/27 recurrent FSP. This is at risk, with the current gap on recurrent schemes being £6.4m.

| YTD Month 4 Financial Position                | TRUST POSITION   |                  |                   |                    | GMS POSITION    |                 |                   |                    | GROUP POSITION   |                  |                   |                    |
|-----------------------------------------------|------------------|------------------|-------------------|--------------------|-----------------|-----------------|-------------------|--------------------|------------------|------------------|-------------------|--------------------|
|                                               | FY Plan £000s    | YTD Plan £000s   | YTD Actuals £000s | YTD Variance £000s | FY Plan £000s   | YTD Plan £000s  | YTD Actuals £000s | YTD Variance £000s | FY Plan £000s    | YTD Plan £000s   | YTD Actuals £000s | YTD Variance £000s |
| SLA & Commissioning Income                    | 806,042          | 268,681          | 268,190           | (491)              | 0               | 0               | 0                 | 0                  | 806,042          | 268,681          | 268,190           | (491)              |
| PP Overseas and RTA Income                    | 8,520            | 2,333            | 2,168             | (165)              | 0               | 0               | 0                 | 0                  | 8,520            | 2,333            | 2,168             | (165)              |
| Other Income from Patient Activities          | 10,481           | 3,572            | 3,783             | 211                | 0               | 0               | 0                 | 0                  | 18,533           | 5,610            | 5,951             | 341                |
| Operating Income                              | 45,024           | 15,423           | 16,941            | 1,518              | 94,935          | 31,645          | 31,371            | (274)              | 40,363           | 13,677           | 16,817            | 3,140              |
| <b>Total Income</b>                           | <b>870,066</b>   | <b>290,008</b>   | <b>291,082</b>    | <b>1,074</b>       | <b>94,935</b>   | <b>31,645</b>   | <b>31,371</b>     | <b>(274)</b>       | <b>873,459</b>   | <b>290,301</b>   | <b>293,126</b>    | <b>2,825</b>       |
| Substantive                                   | (490,443)        | (165,490)        | (159,314)         | 6,176              | (32,805)        | (10,935)        | (9,880)           | 1,055              | (505,872)        | (170,178)        | (168,872)         | 1,306              |
| Bank                                          | (20,277)         | (6,759)          | (7,947)           | (1,188)            | (14)            | (5)             | (14)              | (10)               | (21,041)         | (6,995)          | (8,177)           | (1,182)            |
| Agency                                        | (2,549)          | (850)            | (2,135)           | (1,285)            | 0               | 0               | (651)             | (651)              | (5,389)          | (1,796)          | (2,786)           | (990)              |
| Locum                                         | (12,049)         | (4,029)          | (5,239)           | (1,210)            | 0               | 0               | 0                 | 0                  | (12,049)         | (4,029)          | (5,239)           | (1,210)            |
| <b>Total Pay</b>                              | <b>(525,318)</b> | <b>(177,128)</b> | <b>(174,635)</b>  | <b>2,494</b>       | <b>(32,819)</b> | <b>(10,940)</b> | <b>(10,546)</b>   | <b>394</b>         | <b>(544,351)</b> | <b>(182,998)</b> | <b>(185,074)</b>  | <b>(2,076)</b>     |
| Drugs                                         | (108,968)        | (36,324)         | (37,534)          | (1,210)            | (0)             | (0)             | (4)               | (4)                | (108,968)        | (36,324)         | (37,538)          | (1,214)            |
| Clinical Supplies                             | (49,326)         | (14,687)         | (16,005)          | (1,318)            | (8,828)         | (2,943)         | (5,910)           | (2,967)            | (58,154)         | (17,630)         | (21,915)          | (4,286)            |
| Other Non-Pay                                 | (178,724)        | (67,448)         | (68,189)          | (741)              | (51,021)        | (17,007)        | (14,257)          | 2,751              | (151,576)        | (57,300)         | (53,224)          | 4,076              |
| <b>Total Non Pay</b>                          | <b>(337,019)</b> | <b>(118,460)</b> | <b>(121,729)</b>  | <b>(3,269)</b>     | <b>(59,849)</b> | <b>(19,950)</b> | <b>(20,170)</b>   | <b>(221)</b>       | <b>(318,699)</b> | <b>(111,255)</b> | <b>(112,678)</b>  | <b>(1,423)</b>     |
| <b>Total Expenditure</b>                      | <b>(862,336)</b> | <b>(295,588)</b> | <b>(296,363)</b>  | <b>(775)</b>       | <b>(92,668)</b> | <b>(30,889)</b> | <b>(30,716)</b>   | <b>173</b>         | <b>(863,050)</b> | <b>(294,253)</b> | <b>(297,752)</b>  | <b>(3,500)</b>     |
| EBITDA                                        | 7,730            | (5,580)          | (5,282)           | 298                | 2,267           | 756             | 655               | (101)              | 10,409           | (3,952)          | (4,626)           | (674)              |
| EBITDA %age                                   | 0.9%             | (1.8%)           | (1.8%)            | 27.8%              | 2.4%            | 2.4%            | 2.1%              | 36.8%              | 1.2%             | (1.4%)           | (1.6%)            | 23.9%              |
| Non-Operating Costs                           | (8,680)          | (3,002)          | (3,239)           | (237)              | (2,267)         | (756)           | (655)             | 101                | (11,359)         | (4,624)          | (3,893)           | 731                |
| <b>Surplus / (Deficit)</b>                    | <b>(950)</b>     | <b>(8,582)</b>   | <b>(8,520)</b>    | <b>61</b>          | <b>(0)</b>      | <b>(0)</b>      | <b>(0)</b>        | <b>(0)</b>         | <b>(950)</b>     | <b>(8,576)</b>   | <b>(8,519)</b>    | <b>57</b>          |
| Donated Asset, IFRIC & Salix Grant Adjustment | 950              | 1,192            | 1,165             | (27)               | 0               | 0               | 0                 | 0                  | 950              | 1,192            | 1,165             | (27)               |
| <b>Adjusted Surplus / (Deficit)</b>           | <b>(0)</b>       | <b>(7,390)</b>   | <b>(7,355)</b>    | <b>34</b>          | <b>(0)</b>      | <b>(0)</b>      | <b>(0)</b>        | <b>(0)</b>         | <b>0</b>         | <b>(7,384)</b>   | <b>(7,354)</b>    | <b>30</b>          |

# M04 FSP

## YTD delivery

YTD delivery of £10.4M YTD against a plan of £10.0M  
Forecast delivery of £46.1m (88%) against a plan of £52.3m.  
The unidentified gap remains around £6.2m (12%).

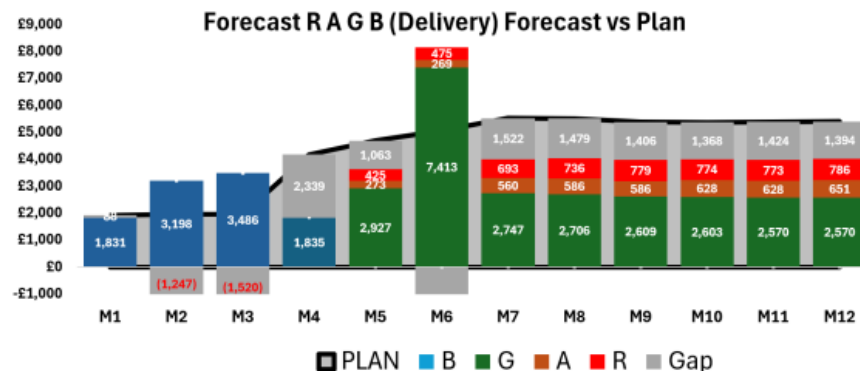
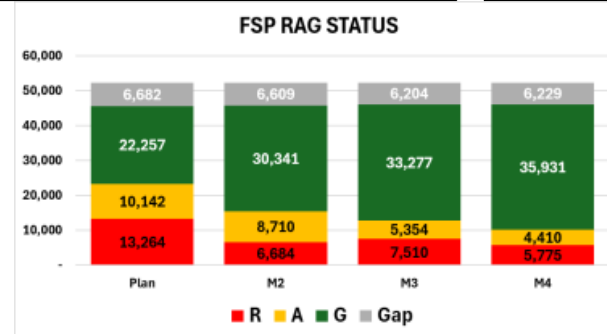
Divisions are above plan currently however a large proportion of this is non-recurrent.

## Forecast

Full year forecast assumes that the cost pressure FSP of £13.8M will deliver. This is being regularly reviewed as there is a risk that mitigations have not been identified and that this won't fully deliver.

The forecast assumes that transformation schemes will deliver to plan and that divisions fully close their gaps. There remains a gap of £6.2m and the Trust is now showing an in-month shortfall in delivery in month 4.

| Total Programme      | Full Year     |               |                | YTD           |               |               |
|----------------------|---------------|---------------|----------------|---------------|---------------|---------------|
|                      | Plan          | Forecast      | B/(W) vs Plan  | Plan          | Actual        | B/(W) vs Plan |
| Total Recurrent      | 39,258        | 32,812        | (6,446)        | 8,801         | 6,025         | (2,776)       |
| Total Non-Recurrent  | 13,086        | 13,304        | 218            | 1,209         | 4,326         | 3,117         |
| <b>Total Schemes</b> | <b>52,345</b> | <b>46,117</b> | <b>(6,228)</b> | <b>10,010</b> | <b>10,351</b> | <b>340</b>    |



# Productivity

|                                 | M12                                    |                                     |                                  | Movement                               |                                     |                                  | Productivity Rank                                           |                                                             |                                                        |
|---------------------------------|----------------------------------------|-------------------------------------|----------------------------------|----------------------------------------|-------------------------------------|----------------------------------|-------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------|
|                                 | Inflation adj. expenditure growth (EG) | Cost-weighted activity growth (CWA) | Implied productivity growth (IP) | Inflation adj. expenditure growth (EG) | Cost-weighted activity growth (CWA) | Implied productivity growth (IP) | Trust Rank (1 highest productivity; 13 lowest productivity) | System Rank (1 highest productivity; 7 lowest productivity) | National Acute Rank by Type (1 = highest productivity) |
| UHBW                            | 2.2%                                   | 4.0%                                | 1.7%                             | 0.6%                                   | -0.1%                               | -0.8%                            | 7                                                           |                                                             | 81 / 134                                               |
| NBT                             | 2.8%                                   | 3.9%                                | 1.1%                             | 1.4%                                   | -0.2%                               | -1.5%                            | 9                                                           |                                                             | 89 / 134                                               |
| <b>BNSSG Acutes</b>             | 2.4%                                   | 3.9%                                | <b>1.4%</b>                      | 1.3%                                   | 0.1%                                | -1.3%                            |                                                             | 5                                                           |                                                        |
| Salisbury                       | 1.9%                                   | 4.0%                                | 2.1%                             | 0.7%                                   | -0.3%                               | -1.0%                            | 6                                                           |                                                             | 76 / 134                                               |
| GWH                             | -1.7%                                  | -0.6%                               | 1.1%                             | 0.8%                                   | -0.3%                               | -1.2%                            | 9                                                           |                                                             | 89 / 134                                               |
| RUH                             | 1.7%                                   | 6.7%                                | 4.9%                             | -1.4%                                  | -0.1%                               | 1.3%                             | 2                                                           |                                                             | 29 / 134                                               |
| <b>BSW Acutes</b>               | 0.5%                                   | 3.6%                                | <b>3.0%</b>                      | -0.1%                                  | 1.6%                                | 1.7%                             |                                                             | 3                                                           |                                                        |
| <b>CORNWALL Acute</b>           | -2.4%                                  | -2.6%                               | <b>-0.2%</b>                     | 0.1%                                   | -0.6%                               | <b>-0.8%</b>                     | 11                                                          | 6                                                           | 104 / 134                                              |
| RDUH                            | 2.8%                                   | 6.4%                                | 3.5%                             | 0.3%                                   | 0.6%                                | 0.3%                             | 3                                                           |                                                             | 52 / 134                                               |
| T&SD                            | 1.8%                                   | 3.3%                                | 1.5%                             | 1.5%                                   | -0.3%                               | -1.8%                            | 8                                                           |                                                             | 83 / 134                                               |
| UH Plymouth                     | 1.2%                                   | 3.9%                                | 2.7%                             | 0.5%                                   | 0.2%                                | -0.3%                            | 5                                                           |                                                             | 66 / 134                                               |
| <b>DEVON Acutes</b>             | 2.0%                                   | 5.0%                                | <b>2.9%</b>                      | 0.5%                                   | 1.4%                                | <b>0.9%</b>                      |                                                             | 4                                                           |                                                        |
| Dorset County                   | 2.0%                                   | 1.0%                                | -1.0%                            | 0.4%                                   | 0.5%                                | 0.1%                             | 13                                                          |                                                             | 112 / 134                                              |
| UH Dorset                       | 3.7%                                   | 2.7%                                | -0.9%                            | 3.2%                                   | -0.1%                               | -3.2%                            | 12                                                          |                                                             | 110 / 134                                              |
| <b>DORSET Acutes</b>            | 3.2%                                   | 2.2%                                | <b>-1.0%</b>                     | 2.4%                                   | -0.1%                               | <b>-2.6%</b>                     |                                                             | 7                                                           |                                                        |
| <b>GLOUCS Acute</b>             | -0.6%                                  | 5.3%                                | <b>5.9%</b>                      | 0.9%                                   | -0.3%                               | <b>-1.3%</b>                     | 1                                                           | 1                                                           | 24 / 134                                               |
| <b>SOMERSET Acute</b>           | 0.6%                                   | 4.1%                                | <b>3.5%</b>                      | 0.3%                                   | 0.2%                                | <b>-0.1%</b>                     | 3                                                           | 2                                                           | 52 / 134                                               |
| <b>SOUTH WEST REGION Acutes</b> | 1.4%                                   | 3.6%                                | <b>2.2%</b>                      | 1.4%                                   | 3.6%                                | <b>2.2%</b>                      |                                                             |                                                             | 5                                                      |
| <b>NATIONAL Acutes</b>          | 0.2%                                   | 2.7%                                | <b>2.5%</b>                      | 0.2%                                   | 2.7%                                | <b>2.5%</b>                      |                                                             |                                                             |                                                        |

The latest position from the South West Productivity Network (M12 25/26) shows GHFT as still ranking number 1 in the region for productivity growth, stating a 5.9% implied productivity growth, a reduction from the 7.1% reported at M11. However, this is comfortably above the national acute average of 2.5%. GHFT ranks 24<sup>th</sup> nationally of 134 Trusts.

Regionally only RUH Bath have shown a significant positive increase in productivity from M11.

# Agency Staffing – Spend

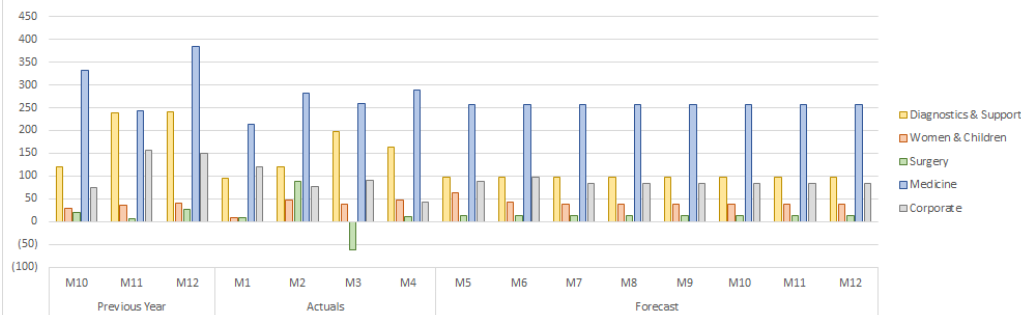
NHSE has set a target for GHFT to reduce agency spend to £5,391k in 26/27. The Group needs to reduce spend by c.50% from £10,469k last year to be able to meet the target.

Month 4 spend for the Trust has increased by £32k from prior month which had the benefit of recodes. There have been reductions in D&S and W&C spend.

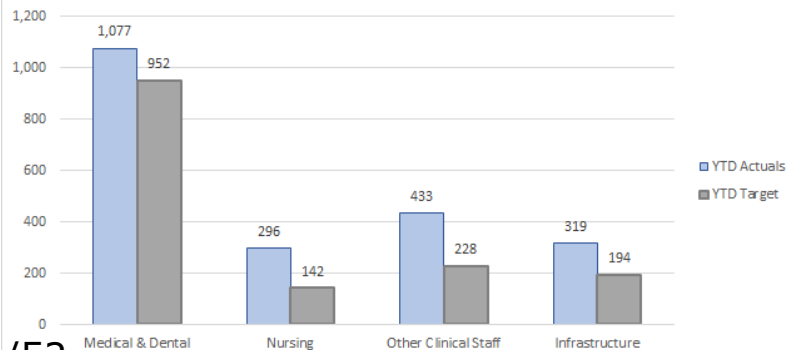
Month 4 YTD spend is £2.8m which is £0.7m lower than last year but £1m above the NHSE target. If no action is taken, full year spend will be c£7.3m. This is £3m lower than last year but £2m above NHSE target.

| Agency Spend         | M1-M4<br>25/26<br>£000 | M1-M4<br>26/27<br>£000 | (Reduction)<br>/Increase<br>£000 | (Reduction)<br>/Increase<br>% | Full Year<br>25/26<br>£000 | Forecast<br>26/27<br>£000 | (Reduction)<br>/Increase<br>£000 | (Reduction)<br>/Increase<br>% |
|----------------------|------------------------|------------------------|----------------------------------|-------------------------------|----------------------------|---------------------------|----------------------------------|-------------------------------|
| Medical & Dental     | 1,849                  | 1,077                  | (772)                            | -42%                          | 5,684                      | 2,739                     | (2,944)                          | -52%                          |
| Nursing              | 275                    | 296                    | 20                               | 7%                            | 856                        | 970                       | 113                              | 13%                           |
| Other Clinical Staff | 444                    | 443                    | (0)                              | 0%                            | 1,255                      | 1,340                     | 85                               | 7%                            |
| Infrastructure       | 377                    | 319                    | (58)                             | -15%                          | 1,461                      | 1,022                     | (439)                            | -30%                          |
| GMS                  | 559                    | 651                    | 92                               | 16%                           | 1,213                      | 1,200                     | (13)                             | -1%                           |
| Total                | 3,504                  | 2,786                  | (718)                            | -20%                          | 10,469                     | 7,271                     | (3,198)                          | -31%                          |

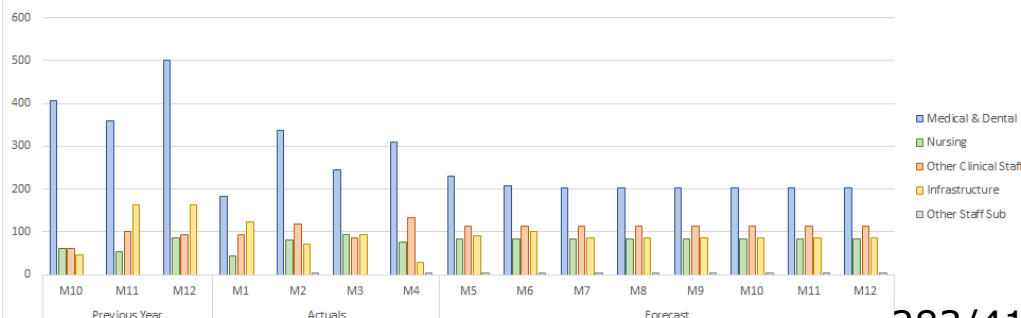
Agency Spend by Division (£000s)



26/27 Agency spend vs Proposed Target (£000s)\*  
(\*reduce spend by 50% from 25/26)



Agency Spend by Pay Type (£000s)



# Bank Staffing – Spend

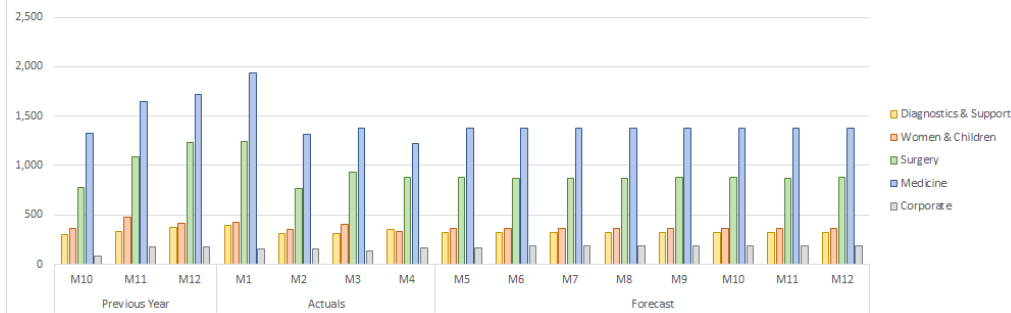
The Group needs to reduce spend by c.30% from £45,968k last year to £33,090k to be able to meet the NHSE target.

Month 4 spend has reduced by £179k from prior month, mainly due to recoding of locum spend within Surgery (from agency) last month..

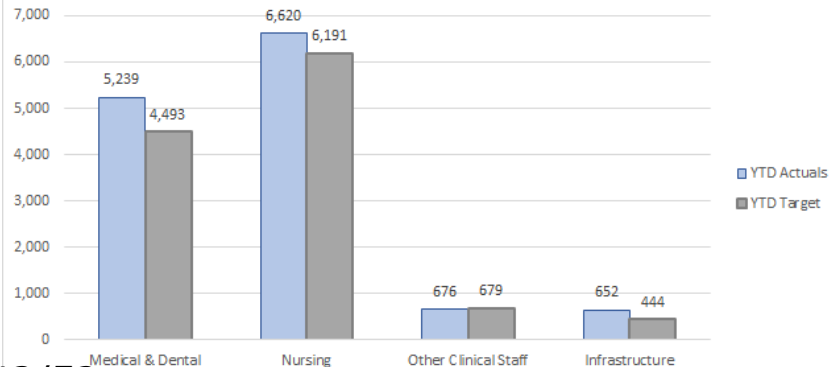
Month 4 YTD spend is £13.4m which is £3.1m lower than last year but still £2.4m above the NHSE target. If no action is taken, full year spend will be £38m. This would be a reduction of £7.7m from last year but £5m above the NHSE target.

| Bank Spend           | M1-M4<br>25/26 | M1-M4<br>26/27 | (Reduction)<br>/Increase | (Reduction)<br>/Increase | Full Year<br>25/26 | Forecast<br>26/27 | (Reduction)<br>/Increase | (Reduction)<br>/Increase |
|----------------------|----------------|----------------|--------------------------|--------------------------|--------------------|-------------------|--------------------------|--------------------------|
|                      | £000           | £000           | £000                     | %                        | £000               | £000              | £000                     | %                        |
| Medical & Dental     | 6,241          | 5,239          | (1,002)                  | -16%                     | 16,625             | 14,659            | (1,966)                  | -12%                     |
| Nursing              | 8,599          | 6,620          | (1,980)                  | -23%                     | 24,187             | 19,463            | (4,724)                  | -20%                     |
| Other Clinical Staff | 942            | 892            | (51)                     | -5%                      | 2,621              | 1,960             | (661)                    | -25%                     |
| Infrastructure       | 617            | 652            | 35                       | 6%                       | 2,316              | 2,115             | (201)                    | -9%                      |
| GMS                  | 157            | 14             | (143)                    | -91%                     | 218                | 43                | (175)                    | -80%                     |
| <b>Total</b>         | <b>16,556</b>  | <b>13,416</b>  | <b>(3,140)</b>           | <b>-19%</b>              | <b>45,968</b>      | <b>38,240</b>     | <b>(7,727)</b>           | <b>-17%</b>              |

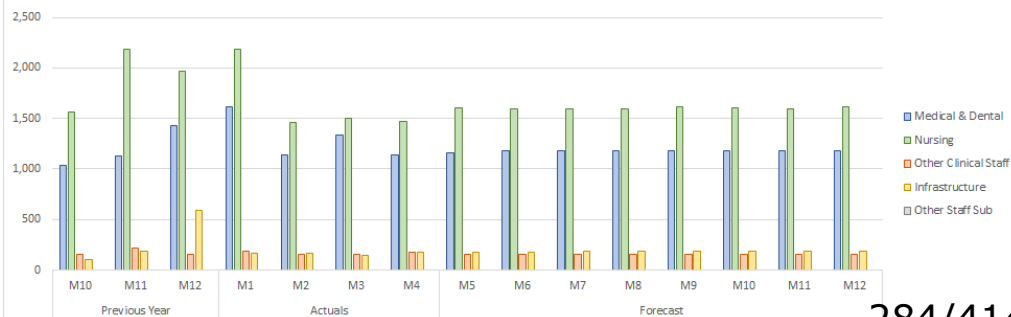
Bank Spend by Division (£000s)



26/27 Bank spend vs Proposed Target (£000s)\*  
(\*reduce spend by 30% from 25/26)



Bank Spend by Pay Type (£000s)



# M04 Capital Position

## Highlights

As of the end of July (M4), YTD expenditure on the Trust capital programme totalled £9.1m, against a planned spend of £15.7m, equating to a variance of £6.6m behind plan.

| in £000s                                                       | Year to Date  |              |              | Forecast      |               |                |
|----------------------------------------------------------------|---------------|--------------|--------------|---------------|---------------|----------------|
|                                                                | Plan          | Actual       | Variance     | Allocation    | Forecast      | Variance       |
| DIGITAL                                                        | 1,936         | 1,453        | 483          | 7,277         | 7,318         | (41)           |
| MEDICAL EQUIPMENT                                              | 633           | 952          | (319)        | 5,630         | 5,630         | 0              |
| ESTATES                                                        | 10,476        | 4,632        | 5,844        | 25,207        | 27,966        | (2,759)        |
| CORPORATE                                                      | 0             | (293)        | 293          | 67            | 0             | 67             |
| <b>Total Charge against Capital Allocation (incl. IFRS 16)</b> | <b>13,045</b> | <b>6,743</b> | <b>6,302</b> | <b>38,181</b> | <b>40,914</b> | <b>(2,733)</b> |
| NAT PROG. ESTATES SAFETY                                       | 1,748         | 1,738        | (10)         | 12,000        | 12,000        | 0              |
| NAT PROG. CONST STANDARDS                                      | 548           | 150          | 398          | 10,614        | 10,614        | 0              |
| IFRIC 12                                                       | 182           | 182          | 0            | 546           | 546           | 0              |
| DONATIONS VIA CHARITABLE FUNDS                                 | 168           | 281          | (113)        | 1,035         | 1,035         | 0              |
| <b>Total Expenditure against Additional Funding</b>            | <b>2,646</b>  | <b>2,372</b> | <b>274</b>   | <b>24,195</b> | <b>24,195</b> | <b>0</b>       |
| <b>Gross Capital Spend Total</b>                               | <b>15,691</b> | <b>9,114</b> | <b>6,577</b> | <b>62,376</b> | <b>65,109</b> | <b>(2,733)</b> |
| Less Donations and Grants Received                             | (168)         | (281)        | 113          | (1,035)       | (1,035)       | (0)            |
| Less PFI Capital (IFRIC12)                                     | (182)         | (182)        | 0            | (546)         | (546)         | 0              |
| Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)       | 122           | 122          | 0            | 366           | 366           | 0              |
| <b>Total Capital Departmental Expenditure Limit (CDEL)</b>     | <b>15,463</b> | <b>8,773</b> | <b>6,690</b> | <b>61,161</b> | <b>63,894</b> | <b>(2,733)</b> |

## Analysis

The Trust submitted a gross capital expenditure plan for the 26-27 financial year totalling £59.8m. Subsequently we have been notified of a further allocation of £2m of National funding for Estates Safety together with an extra £0.1m System Capital allocation as part of the 25/26 Revenue Incentive Scheme. In addition, £0.5m of charitable donations were deferred from last year. The current allocation for 26/27 therefore stands at £62.3m.

Spend on System Capital funded projects is £6.3m behind plan YTD driven by Estates as a result of timing differences in valuations on DCC and Electrical Infrastructure Phase 2, together with programme delays on DCC and the Prescott Ward refurbishments.

Despite the YTD position being behind plan it is expected that Estates will recover the position by the end of the financial year and the current forecast is £2.7m above allocation across the whole Capital programme. Forecasts are currently under review with project teams to bring them into line with allocation. Before spend can commence on nationally funded programme such as Urgent Treatment Centre and Same Day Emergency care business cases are required to be submitted for review NHSE. These are currently progressing through Trust governance.



# Workforce

# Workforce Performance Indicators

## Workforce Highlights:

- Sickness absence has fallen slightly
- While bank usage remains below plan, agency usage is significantly above

## Areas for Concern:

- High agency usage is being driven by GMS, but is included in our position against the Medium Term Plan
- Appraisal compliance has drifted down to 79%, and continues to be below target

## Learning & Improvement:

- Continued focus on temporary staffing reductions in the multiyear plan
- Spending caps for temporary staffing have been set as part of the multiyear plan, entailing significant reductions each year

| KPI (Trust)          |  | Target | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 |
|----------------------|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Turnover (Headcount) |  | 11%    | 8.64%  | 8.13%  | 8.03%  | 8.73%  | 8.48%  | 8.47%  | 8.57%  | 8.52%  | 8.65%  | 8.99%  | 8.73%  | 8.65%  |
| Vacancy              |  | 8%     | 7.99%  | 6.85%  | 6.87%  | 6.96%  | 7.29%  | 7.09%  | 7.37%  | 7.95%  | 7.06%  | 7.91%  | 8.02%  | 8.27%  |
| Sickness             |  | 4%     | 4.39%  | 4.40%  | 4.41%  | 4.43%  | 4.47%  | 4.47%  | 4.54%  | 4.55%  | 4.57%  | 4.62%  | 4.60%  |        |
| Appraisal            |  | 90%    | 84%    | 84%    | 83%    | 82%    | 83%    | 82%    | 82%    | 84%    | 82%    | 81%    | 80%    | 79%    |
| Essential Training   |  | 90%    | 91%    | 91%    | 90%    | 90%    | 91%    | 91%    | 91%    | 91%    | 90%    | 90%    | 90%    | 89%    |

|            |                  | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 | Sep-26 | Oct-26 | Nov-26 | Dec-26 | Jan-27 | Feb-27 | Mar-27 |
|------------|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Bank WTE   | Medium Term Plan | 509.92 | 511.41 | 518.04 | 521.41 | 524.79 | 496.7  | 501.69 | 505.01 | 510.58 | 495.82 | 499.15 | 493.35 |
|            | Actual (PWR)     | 562.63 | 470.88 | 436.94 | 469.46 |        |        |        |        |        |        |        |        |
|            | Difference       | 52.71  | -40.53 | -81.10 | -51.95 |        |        |        |        |        |        |        |        |
| Agency WTE | Medium Term Plan | 41.80  | 41.06  | 31.68  | 31.26  | 30.89  | 30.48  | 27.34  | 27     | 22.91  | 22.6   | 22.28  | 17.72  |
|            | Actual (PWR)     | 64.98  | 57.32  | 93.78  | 92.22  |        |        |        |        |        |        |        |        |
|            | Difference       | 23.18  | 16.26  | 62.10  | 60.96  |        |        |        |        |        |        |        |        |

## Analysis & Actions

There is a complex interplay between turnover, vacancy and establishment movements.

Caution should be taken when interpreting the vacancy against the target, as it can be impacted due to e.g. short term changes in non-recurrent funding.

- Establishment is updated on ESR from the Ledger.
- Sickness absence is reported 1 month in arrears, as it is not all uploaded to ESR until ~20<sup>th</sup> each month (with the payroll)

# Workforce: Sickness Absence

## Workforce Highlights:

Overall trust absence is up compared to previous 12 months (+0.2%)

Mental health makes up the largest proportion of absence reasons across all staff groups except M&D, where respiratory is now slightly higher

## Areas for Concern:

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

## Learning & Improvement:

Rollout of Medical e-rostering may result in higher reported absence rates, based on experience in of roll outs other trusts.

The medium term plan specifies that the trust should improve its sickness rate year on year.

|                 |                              | WTE     | Trend     |          |            |           | Division (Past 12 months) |      |          |         |      | Top 5 Absence Reasons (latest 12 months)** |             |             |              |               |
|-----------------|------------------------------|---------|-----------|----------|------------|-----------|---------------------------|------|----------|---------|------|--------------------------------------------|-------------|-------------|--------------|---------------|
|                 |                              | Latest  | Prev. 12m | Last 12m | Difference | Trendline | Corporate                 | D&S  | Medicine | Surgery | W&C  | Mental Health                              | Musculoskel | Respiratory | Gastrointest | Urinary/Gynae |
| Trust           |                              | 7440.34 | 4.4%      | 4.6%     | 0.2%       |           | 4.4%                      | 4.6% | 4.6%     | 4.6%    | 5.2% | 27.0%                                      | 18.8%       | 15.6%       | 10.4%        | 4.4%          |
| ESR Staff Group | Add Prof Scientific & Tech   | 233.60  | 2.9%      | 4.8%     | 2.0%       |           | *                         | 3.8% | 9.4%     | 6.7%    | *    | 30.1%                                      | 10.3%       | 13.1%       | 7.6%         | 2.8%          |
|                 | Additional Clinical Services | 1262.79 | 6.3%      | 6.6%     | 0.3%       |           | 6.0%                      | 6.8% | 6.2%     | 7.3%    | 4.9% | 24.8%                                      | 22.2%       | 13.8%       | 12.0%        | 4.9%          |
|                 | Administrative and Clerical  | 1561.72 | 4.2%      | 4.7%     | 0.5%       |           | 4.3%                      | 4.8% | 5.3%     | 5.8%    | 4.7% | 29.7%                                      | 17.7%       | 14.6%       | 7.8%         | 2.8%          |
|                 | Allied Health Professionals  | 473.94  | 3.3%      | 3.4%     | 0.1%       |           | *                         | 3.3% | *        | 4.0%    | *    | 32.7%                                      | 15.7%       | 20.5%       | 11.6%        | 4.9%          |
|                 | Estates and Ancilliary       | 32.97   | 4.9%      | 6.6%     | 1.6%       |           | *                         | 7.5% | *        | *       | *    | 37.0%                                      | 24.0%       | 4.4%        | 3.6%         | 1.6%          |
|                 | Healthcare Scientists        | 267.91  | 2.8%      | 4.0%     | 1.2%       |           | *                         | 4.1% | 4.9%     | 3.4%    | *    | 21.4%                                      | 15.4%       | 21.3%       | 10.7%        | 4.3%          |
|                 | Medical and Dental           | 1093.71 | 2.1%      | 1.9%     | -0.2%      |           | 2.5%                      | 1.6% | 2.3%     | 1.7%    | 1.5% | 12.5%                                      | 7.6%        | 15.1%       | 7.1%         | 0.2%          |
|                 | Nursing & Midwifery          | 2513.70 | 4.9%      | 4.9%     | 0.1%       |           | 4.5%                      | 5.6% | 4.7%     | 4.3%    | 6.4% | 28.8%                                      | 20.6%       | 17.1%       | 11.7%        | 6.0%          |

\* Fewer than 20 assignments

\*\* As a proportion of Absence for each Staff Group

## Actions

- Monitoring of absence KPIs on Medical e-rostering is underdevelopment as part of the rollout.
- The HRBPs are analysing areas with the high levels of MH (Stress) cases across their divisions to look at themes/potential links and root causes.

# Workforce: Appraisal

## Analytical Highlights:

Trust appraisal compliance has fallen to 79%, continuing a four-month downward trend.

Variation remains significant across divisions, with half of Corporate and one-fifth of Women & Children's division below 70% compliance

Corporate, Medicine and Surgery have 250 staff without an appraisal in the previous 12 months.

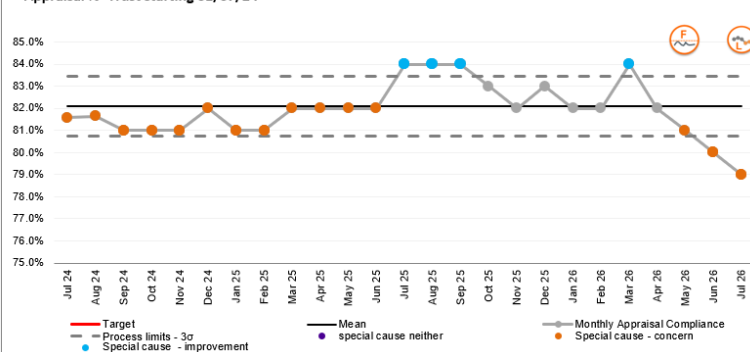
Smaller teams / cost-code with 'very low' compliance (below 50%) may have a disproportionate effect on overall performance, with a small number of overdue appraisals significantly impacting compliance rates in lower headcount areas.

Wider workforce data trends may be contributing to the overall ability for services to meet their appraisal demand (i.e. sickness / turnover)

## Areas for Concern:

- Only 1 service line is currently achieving the national target, compared with 5 service lines in May.
- Delays in recording completed appraisals are affecting the reported month-end position, with an average 9.5-day delay between appraisal completion and recording; approximately 20% of completed appraisals are not reflected within the reporting month

Appraisal % -Trust starting 01/07/24



## Learning & Improvement:

- Appraisal added to NQPS to strengthen our understanding of quality indicators throughout the year
- Application of a stronger accountability framework saw positive response from direct escalation to Directors of portfolios seeing month on month deterioration, and the position is now trending positively

### Breakdown by Division

| Division / Date                 | 31-Jul-26  |
|---------------------------------|------------|
| Corporate Division              | 70%        |
| Diagnostic & Specialty Division | 81%        |
| Medicine Division               | 80%        |
| Surgery Division                | 80%        |
| Women & Children Division       | 84%        |
| <b>GHT Total</b>                | <b>79%</b> |

### Breakdown by Staff Group

| Staff Group / Date               | 31-Jul-26  |
|----------------------------------|------------|
| Add Prof Scientific and Technic  | 82%        |
| Additional Clinical Services     | 80%        |
| Administrative and Clerical      | 70%        |
| Allied Health Professionals      | 78%        |
| Estates and Ancillary            | 80%        |
| Healthcare Scientists            | 80%        |
| Medical Staff - Consultants      | 89%        |
| Medical Staff - SAS              | 84%        |
| <b>All Medical Staff</b>         | <b>88%</b> |
| Nursing and Midwifery Registered | 83%        |
| <b>GHT Total</b>                 | <b>79%</b> |

## Actions

Improve data quality and accountability by reducing retrospective recording and removing manual process steps by:

- Analysis and review of retrospective logging to strengthen accountability and reporting accuracy
- Removal of the appraisal reporting form remains an active workstream, with opportunities for automation and robotic process automation (RPA) being explored to streamline the process and reduce manual intervention.

End-to-end appraisal process and documentation review is underway in response to recommendations arising from the BDO audit

# Workforce: Bank

## Workforce Highlights:

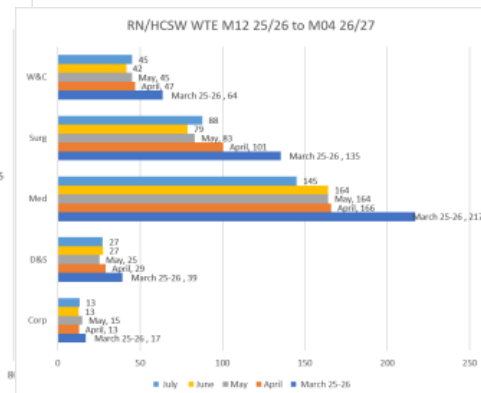
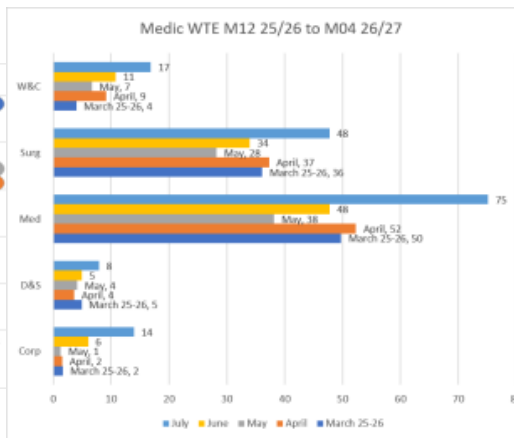
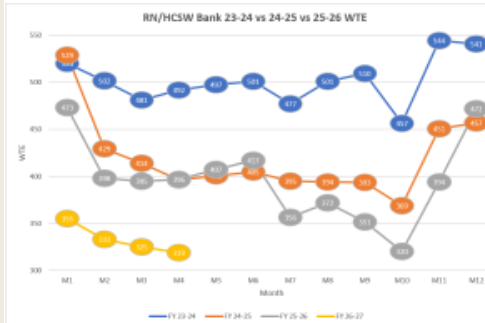
- The Trust has seen a decrease in temporary RN/HCSW Staffing of 6 WTE (From M03 325 to M04 319 WTE).
- This chart is following previous years M01 to M04 use profile.
- In comparison with M04 of 25/26 FY, there has been a decrease of 70 WTE RN/HCSW
- Medicine** is the highest user of Bank & Locum staff.
- Top 3 users in M04 are ED, Acute and COTE. COTE has decreased temporary staffing use compared to M04.
- ED** (71 to 80 WTE), **COTE** (30 to 27 WTE) **Acute** (30 to 39 WTE)
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the improvements achieved throughout the FY.

## Areas for Concern or Highlight:

- Overall WTE and £ use of bank target is over target for 26/27
- M04 for RN/HCSW bank use is lower in 26/27 than 25/26

## Learning & Improvement:

- As the trend for FY23-24, 24-25 and 25-26 WTE use is broadly similar, it is reasonable to assume that M4 FY26-27 will also see a similar WTE use.
- There has been a significant increase in Medical locum shifts in M04 primarily driven by sickness



## Actions

- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

# Workforce: Agency

## Workforce Highlights:

### Registered Nurse (RN)

- The trust has seen a decrease in temporary RN agency Staffing over the last 3 financial years. Average use 23/24 of 88 WTE to 11 WTE in 25/26
- M01 and M04 of this year are following a similar average use to that of 25/26.
- 8.5 WTE of Agency Shifts are for RN's 2.5 WTE for Midwifery
- Medicine** is the highest user of agency in M03

### Medical & Dental

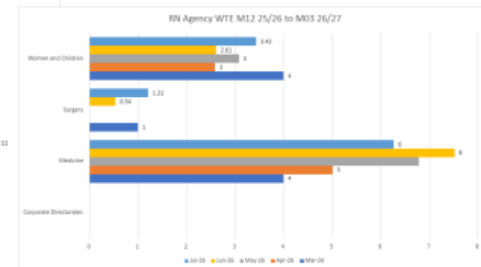
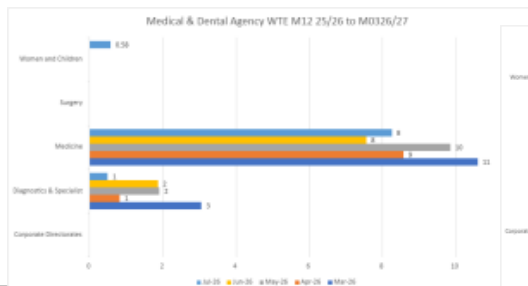
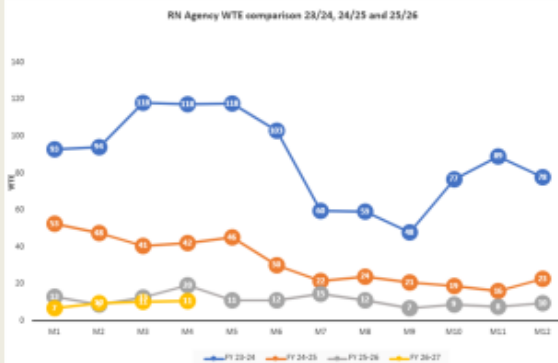
- Medicine is the highest user of agency
- Top 3 agency users in M03 are ED, Acute and COTE.
- Reductions in agency use when comparing the same month in 25/26 shows a reduction of 2.5 WTE in the medical division
- Surgery have not had agency for the last 5 months M12-M04
- W&C used agency for the first time in 10 months

## Areas for Concern:

- Overall WTE and £ use of Agency is not yet at the trust reduction target of 50% in M03
- Lead time – on the day sickness is the biggest driver for using high-cost agency for registered nurses

## Learning & Improvement:

- Registered Nurse** - As the trend for WTE agency use in FY25-26 and M01-M04 use is broadly similar, it is reasonable to assume that M5 FY26-27 will also see a similar WTE use.
- Medical & Dental** – Grip and control meetings are strengthening workforce planning by bringing focus to exit strategies and support measures to reduce reliance on agency staff.



## Actions

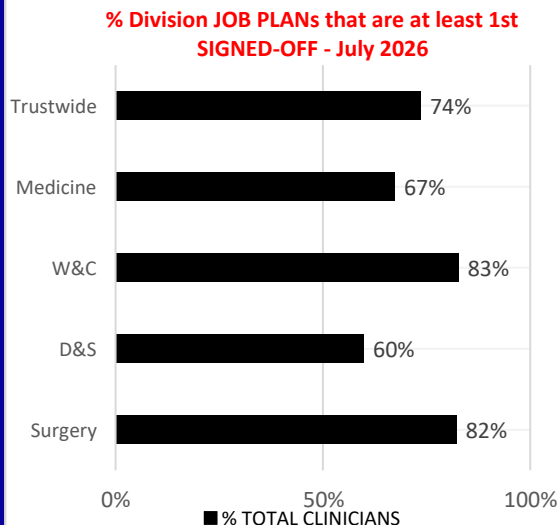
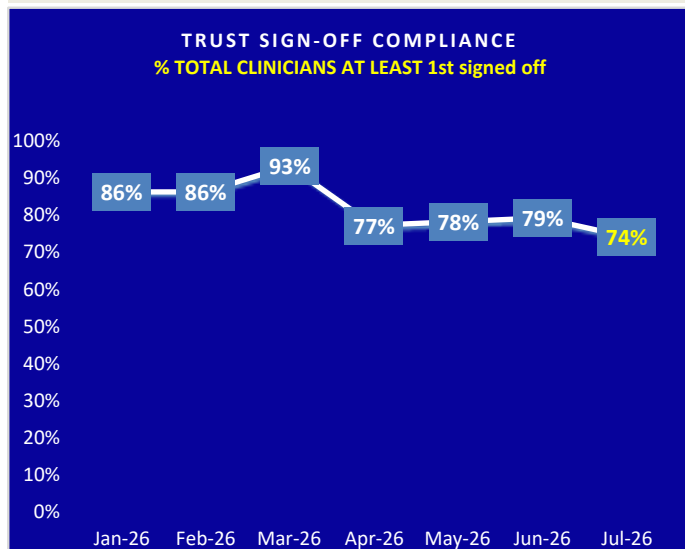
- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

# Job Plan Compliance

(Target: 95% job plan sign offs by March 31st, 2027)

## Workforce Highlights:

- Job Planning is currently included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- Last financial year's NHSE job-plan-sign-off goal of 95% March 31, 2026, was *nearly met* at 93% - just 2% shy of target.
- That 93% had dropped to 77% as of April 30th, 2026, **and now currently at 74% as of July 31st, 2026**. The initial drop was due to about 25% of Trust job plans being republished in April to restart with the new financial year.



## Areas for Concern:

Since data submissions have been required for job planning metrics, the definitions and requirements have changed frequently. However, this reports aligns with the most recent NHSE PWR requirements, with reported job plans *now* being *in-date* (i.e. started within the last 12 months) and at least first signed off by Clinical Lead or Speciality Director.

Data reported on, this JULY 2026, is for a Trust-wide total of 605 Clinicians (i.e. 502 Cons. 103 SAS doctors)

## Learning & Improvement:

- The last NHSE target for Consultant and SAS job plans was for 95% of Trust job plans to be at least 1st signed off by March 31, 2026. We managed to reach 93%, *just 2% shy of that goal*. We expect this target to remain for this new financial year. Current goal is to leverage on the efforts that got us that close and improve on it as to hit subsequent milestones in due time.
- Plans are also underway to switch the job planning software from ALLOCATE to HEALTHROTA. This is expected to improve on the job planning process, job plan sign offs, as well as the quality of job plans.

## Actions

- Utilise the lever of e.rostering to improve job planning. This has helped ensure 100% job plan sign offs in departments where e-rostering has been deployed e.g. Acute Medicine.
- Continue monthly POD reporting to support SDs, CLs, unit managers, Chiefs and other job planning stakeholders trust-wide.
- The Job Planning department continues to actively support clinicians and Leads with the process.

# Thank you



## Report to Board of Directors

|                                   |                                                                                                                                                                                  |
|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of Meeting</b>            | 10 <sup>th</sup> September 2026                                                                                                                                                  |
| <b>Report title</b>               | Higher Level Responsible Officer (HLRO) South West Region - FQAI/Board Report Returns Year 2025/26 (Appraisal Revalidation Report for Gloucester Hospitals Foundation NHS Trust) |
| <b>Sponsoring Director/Author</b> | Prof Mark Pietroni, Medical Director/Director of Safety<br>Dr Kate Tredgett, Associate Medical Director - Revalidation                                                           |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>This report, which is submitted annually as required by NHS England, contains the information and metrics that a designated body is expected to report upwards. The reporting takes place through their Higher Level Responsible Officer (HLRO) for the South West Region who leads on Professional Standards, oversees Designated Bodies' Responsible Officers, and reports to the National Medical Director while providing system leadership and clinical advice to ensure patient safety and care quality.</p> <p>The purpose is to provide assurance of:</p> <ul style="list-style-type: none"> <li>-compliance with the regulations</li> <li>-commitment to continual quality improvement</li> </ul> <p>in the delivery of professional standards in the appraisal, and the revalidation with the General Medical Council, of doctors connected to the designated body.</p> <p>The appraisal and revalidation metrics evidence the system is running effectively. There is an ongoing process of recruitment and training of new appraisers to make sure there is adequate support of the appraisal process. Quality Assurance processes are in place. The diversity characteristics of appraisers' mirror those of senior medical workforce as a whole. Revalidation Oversight Group meetings are occurring regularly as are Appraiser Support Groups, with high attendance levels and high satisfaction levels with the content of the training.</p> <p>Over the forthcoming year there will be continued development of the appraisal and revalidation process through the ongoing development of our appraisers to consistently provide supportive and developmental appraisals for our connected doctors. This will be complemented by inclusion of increasingly rigorous clinician level data and supporting information, which will continue to be subject to regular quality assurance review.</p> |

|                          |     |
|--------------------------|-----|
|                          |     |
| Previously considered by | N/A |

| Recommendations:                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>The board are asked to: APPROVE</i> the submission to NHS England as set out at Annex A: <b>Illustrative Designated Body Annual Board Report and Statement of Compliance for Gloucestershire Hospitals NHS Foundation Trust</b> |

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

| Impact on any Strategic Risks? |
|--------------------------------|
|                                |

| Implications on:                  |                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Equality, Diversity and Inclusion |                                                                                                                                                                                                                                                                                                                          |
| Health Inequalities               |                                                                                                                                                                                                                                                                                                                          |
| Finance and Resource              |                                                                                                                                                                                                                                                                                                                          |
| Regulation/Legal                  | The report contains the information and metrics that a designated body is expected to report upwards to NHS England, through their Higher Level Responsible Officer (HLRO), to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards in |

|                         |                                                                                                       |
|-------------------------|-------------------------------------------------------------------------------------------------------|
|                         | appraisal and revalidation with the General Medical Council of doctors connected the designated body. |
| CQC-Key line of enquiry |                                                                                                       |
| Green Plan              |                                                                                                       |

| Main Report                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| As Executive Summary above and Annex A enclosed.                                                                                                           |  |
| Enclosure: <b>Annex A: Illustrative Designated Body Annual Board Report and Statement of Compliance for Gloucestershire Hospitals Foundation NHS Trust</b> |  |
| N/A                                                                                                                                                        |  |
| FOI: Public                                                                                                                                                |  |

## Annex A

### Illustrative Designated Body Annual Board Report and Statement of Compliance – Gloucestershire Hospitals NHS Foundation Trust

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

#### Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

#### 1A – General

The board/executive management team of: Gloucestershire Hospitals NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

| Y/N                    | Y                                                                 |
|------------------------|-------------------------------------------------------------------|
| Action from last year: | Ensure Revalidation Oversight Group (ROG) continues twice yearly. |
| Comments:              | Action achieved.                                                  |

|                       |                                                                                                                                                                        |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       | Prof. Mark Pietroni is the Responsible Officer. 4 trained deputy ROs in place. 2 new Associate Medical Directors (AMDs) to complete their training for deputy RO role. |
| Action for next year: | New AMDs to undertake RO training                                                                                                                                      |

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

|                        |                                                                                                                                                |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                              |
| Action from last year: | Complete recruitment and training of appraisers in 25/26 round. Continue to monitor appraiser numbers and recruit further as required          |
| Comments:              | A further 6 appraisers were recruited in Autumn 2025. Following some retirements we will undertake another round of recruitment in Autumn 2026 |
| Action for next year:  | Complete recruitment and training of appraisers in the 26/27 round. Continue to monitor appraiser numbers and recruit further as required      |

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

|                        |                          |
|------------------------|--------------------------|
| Y/N                    | Y                        |
| Action from last year: | Continue as currently    |
| Comments:              | System in place          |
| Action for next year:  | Continue current process |

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

|                        |                                                                                                                                   |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                 |
| Action from last year: | Ensure that the updated Appraisal and Revalidation Policy is ratified and replaces the current policy on the Trust Intranet site. |
| Comments:              | Currently with Policy Administration Team for review and upload.                                                                  |
| Action for next year   | Ensure that the updated Appraisal and Revalidation Policy is ratified and replaces the current policy on the Trust Intranet site. |

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

|                        |                                                                                                                                                                                                                                        |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                      |
| Action from last year: | Continue to monitor appraisal and revalidation performance through ROG                                                                                                                                                                 |
| Comments:              | High Level RO visit took place in August 2023 and Appraisal and Revalidation Audit reported in September 2023. All actions are complete.<br><br>Regular reviews take place of process – see section B below. Oversight is through ROG. |
| Action for next year:  | Continue to monitor appraisal and revalidation performance through ROG                                                                                                                                                                 |

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

|                        |                                                       |
|------------------------|-------------------------------------------------------|
| Y/N                    | Y                                                     |
| Action from last year: | Continue                                              |
| Comments:              | Induction is overseen by medical staffing. There is a |

|                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      | <p>shortened Clinical Feedback Appraisal Form (CF Form) to record appraisal meetings which take place with educational or clinical supervisors for locally employed doctors below SAS Grade. Senior doctors connected the Trust are all supported through the same process as our other senior doctors. This undergoes frequent review and update. Good communication is maintained with other employing organisations.</p> <p>As per the revalidation and appraisal policy, doctors need to be working a minimum of 4 sessions / month over a 3 month rolling average to be connected to the Trust. Where they are working less frequently than this, they need to connect to an independent organization and are expected to provide confirmation to the revalidation and appraisal team that they have such a connection in place.</p> |
| Action for next year | No additional action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

## 1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Action from last year: | Continue to monitor appraisal and revalidation performance through ROG. Continue work with complaints team to establish a more robust process by which complaints are identified for complaints reports and continue to review the effectiveness of this process once in place.                                                                                                                                                                                                                                                                   |
| Comments:              | Audits have taken place regarding concordance of appraisal evidence and reports received for complaints, serious incidents and completeness of information from private providers. There have all been discussed at ROG. Where there have been inconsistencies, action has been taken to address this. The main area for focus continues to be on complaints reports and work is ongoing to address this. We are also commencing work to explore how concerns reported to PALS are fed back to doctors, and where appropriate fed into appraisal. |

|                       |                                                                                                                                                                                                                                                             |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       |                                                                                                                                                                                                                                                             |
| Action for next year: | Continue to work to improve concordance of complaints reports with those reported by doctors in their appraisals. Explore and agree appropriate mechanism for concerns reported to PALS to be fed back to doctors and where appropriate fed into appraisal. |

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

|                        |                     |
|------------------------|---------------------|
| Y/N                    | Y                   |
| Action from last year: | No actions required |
| Comments:              | See 1Bi above       |
| Action for next year:  | See 1 Bi above      |

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

|                        |                                                                                                                                                  |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                                  |
| Action from last year: | Ensure that the updated Appraisal and Revalidation Policy is ratified and replaces the current policy on the Trust Intranet site.                |
| Comments:              | The policy has been agreed by the Revalidation Oversight Group (ROG) and is currently with the Policy Administration Team for review and upload. |
| Action for next year:  | Ensure that the updated Appraisal and Revalidation Policy replaces the current policy on the Trust Intranet site.                                |



1B(iv) Our organisation has the necessary number of trained appraisers<sup>1</sup> to carry out timely annual medical appraisals for all its licensed medical practitioners.

|                        |                                                                                                                                                                                                                                   |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                 |
| Action from last year: | Appraiser reviews to take place as per annual cycle in Autumn 2025                                                                                                                                                                |
| Comments:              | <p>Appraiser reviews took place in Autumn 2025 and 100% of appraisers engaged with this.</p> <p>In order to maintain sufficient appraisers, given recent retirements, we will be recruiting further appraisers in Autumn 2026</p> |
| Action for next year:  | Recruit and train new cohort of appraisers                                                                                                                                                                                        |

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

|                        |                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                                                                                                                                                     |
| Action from last year: | Continue performance and quality review process                                                                                                                                                                                                                                                                                                                       |
| Comments:              | <p>Appraiser support groups occur twice yearly and are face to face. Attendance by appraisers is a requirement for the appraiser role and more than 80% of appraisers attended last year. We have been using the EXCELLENCE scoring tool to peer review our appraisal summaries. Following feedback from appraisers and consideration of other options we will be</p> |

<sup>1</sup> While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

|                       |                                                                                                                                                                                                                                                                                                                                          |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       | trialling the ASPAT tool in 26/27. All appraisers receive an individual feedback report from the summary review process and also from the feedback provided by their appraisees. They are required to reflect on this before their annual meeting with the Appraisal Lead. All appraisers attended their annual review meeting in 25/26. |
| Action for next year: | Trial the ASPAT tool for peer review of appraisal summaries                                                                                                                                                                                                                                                                              |

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

|                        |                                                                                                                                                                                                                                   |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                                                                                                                   |
| Action from last year: | Continue current process                                                                                                                                                                                                          |
| Comments:              | ROG meetings take place twice yearly. The Revalidation and Appraisal Team meet weekly with the Revalidation and Appraisal Lead to ensure all issues are rapidly addressed. There is regular dialogue between the team and the RO. |
| Action for next year:  | Continue current process                                                                                                                                                                                                          |

## 1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

|                        |                                                                                                            |
|------------------------|------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                          |
| Action from last year: | Deputy RO to complete training                                                                             |
| Comments:              | There have been some changes in Associate Medical Directors who undertake the deputy RO function alongside |

|                       |                                                                                                                                                                                                                 |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       | <p>the Deputy Medical Director. Currently there are 4 fully trained deputy ROs and 2 awaiting the GMC training.</p> <p>There is full compliance with GMC timescales regarding revalidation recommendations.</p> |
| Action for next year: | RO training to be completed by the 2 associate medical directors.                                                                                                                                               |

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

|                        |                                                                                                                                                                                 |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                               |
| Action from last year: | No changes required                                                                                                                                                             |
| Comments:              | All revalidation recommendations are made in a timely manner, with doctors notified of their outcome. Should a deferral or non-engagement be appropriate, then contact is made. |
| Action for next year:  | No changes required                                                                                                                                                             |

## 1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

|                        |                                                                                                               |
|------------------------|---------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                             |
| Action from last year: | Continue work to ensure relevant clinician level data is routinely included in Form A meetings and appraisals |

|                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Comments:             | <p>Inclusion of clinician level outcome data in Form A meetings and appraisals represents an ongoing process of development and improvement. Having completed the National Consultant Information portal (NCIP) pilot with the urology team, work is now underway to make sure that key metrics, where they exist, including radiology red flag compliance and NCIP data is included and discussed in Form A meetings and fed through to the appraisal meeting.</p> <p>See also 1Bi above</p> |
| Action for next year: | Audit of compliance of NCIP data inclusion in Form As and appraisals will take place in 27/28                                                                                                                                                                                                                                                                                                                                                                                                 |

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Action from last year: | No further action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Comments:              | <p>The process is embedded within the Trust. Policies are in place which provide the performance management framework to be followed should there be conduct or performance concerns raised. These policies include Revalidation and Appraisal, Maintaining High Professional Standards, Performance Management, Disciplinary etc.</p> <p>Performance / conduct matters being formally managed are monitored in accordance with policy requirement with RO / NED oversight. Restrictions / exclusions / suspensions are reported monthly through the Procedural Oversight Report submitted to the Private Board</p> <p>The Associate Medical Director with responsibility for appraisal and revalidation attends the monthly meeting with the MD ad AMD and HR where conduct and performance matters are discussed to ensure information is fed through to appraisal and revalidation where appropriate.</p> |
| Action for next year:  | No new action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

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1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

|                        |                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                                                                                                                                                |
| Action from last year: | Continue work to ensure relevant clinician level outcome data is routinely included in Form A meetings and appraisals                                                                                                                                                                                                                                            |
| Comments:              | A project is underway to make sure data such as from NCIP is routinely included in Form A meetings and in the appraisal – see also 1Di above. The Form A has been updated to support this and appraisers have received training on NCIP. Trust reports on complaints and incidents are automatically uploaded into the doctor's portfolio by the appraisal team. |
| Action for next year:  | Audit in 2027                                                                                                                                                                                                                                                                                                                                                    |

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Action from last year: | No additional action required                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Comments:              | <p>Policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised against any licenced practitioner as described in Dii above. There are reviewed to ensure they met the necessary requirements.</p> <p>Progress of practitioners through the process is reviewed monthly at a meeting attended by HR, the Medical Director, Deputy Medical Director and Associate Medical Director with responsibility for appraisal and revalidation</p> |

|                       |                               |
|-----------------------|-------------------------------|
| Action for next year: | No additional action required |
|-----------------------|-------------------------------|

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

|                        |                                                                                                                                                                                                                                                                                                                                            |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                                                                                                                                                                                                                            |
| Action from last year: | No additional action required                                                                                                                                                                                                                                                                                                              |
| Comments:              | As described in Dii above, medical cases are regularly reviewed. Formal care work is monitored in accordance with policy requirements and reported through the Procedural Oversight Board, submitted to the Private Board monthly. There is a requirement to provide workforce race and disability equality standard reports to the board. |
| Action for next year:  | No additional action required                                                                                                                                                                                                                                                                                                              |

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

|                        |                                                                                                                                                   |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                                   |
| Action from last year: | No additional action required                                                                                                                     |
| Comments:              | A review was undertaken in December 2024 regarding MPIT process. It demonstrated 98.6% compliance of transferring and receiving this information. |

|                       |                               |
|-----------------------|-------------------------------|
| Action for next year: | No additional action required |
|-----------------------|-------------------------------|

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

|                        |                                                                                                                                                                                                   |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Yes                                                                                                                                                                                               |
| Action from last year: | Ongoing work in this area                                                                                                                                                                         |
| Comments:              | The Equality and Diversity Steering Group oversee the Trust Equality and Diversity agenda and the Equality, Diversity and Inclusion policy. Associated e-learning is a requirement for all staff. |
| Action for next year:  | No additional action required.                                                                                                                                                                    |

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

|                        |                                                                                                                                |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    |                                                                                                                                |
| Action from last year: | Continue current approach                                                                                                      |
| Comments:              | Senior leadership meetings and engagement events with staff were implemented following CQC reports. Action plans are in place. |
| Action for next year:  | Continue current approach                                                                                                      |

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

|                        |                                                                                                                                                                                                                                                                                                          |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Action from last year: | No additional action required                                                                                                                                                                                                                                                                            |
| Comments:              | Recent Good Medical Practice guidance published by the GMC was shared with appraisers at appraiser support groups and also with senior doctors more widely throughout the Trust.<br><br>The appraisal process for non medical staff has recently been refreshed with resources available on the intranet |
| Action for next year:  | No additional action required                                                                                                                                                                                                                                                                            |

## 1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

|                        |                                                                                                    |
|------------------------|----------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                  |
| Action from last year: | No additional action, continue current process                                                     |
| Comments:              | This is regularly reviewed and changes are made to the process if notice provided by NHS Employers |
| Action for next year:  | Continue current process                                                                           |



## 1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

|                        |                                                                                                                                                                                                                                        |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                      |
| Action from last year: | As per 1Di                                                                                                                                                                                                                             |
| Comments:              | See 1Di<br><br>Daily safety huddles take place across the Trust to learn lessons from any near miss cases. The Trust has adopted the Patient Safety Incident Response Framework with a focus on compassionate leadership and learning. |
| Action for next year:  | No additional action required                                                                                                                                                                                                          |

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

|                        |                                                                                                                                 |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                               |
| Action from last year: | No additional actions currently required                                                                                        |
| Comments:              | Diversity data of Trust appraisers has been reviewed and found to mirror that of the workforce as a whole. See also 1Dvii above |
| Action for next year:  | No additional action required                                                                                                   |

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of

whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

|                        |                                                                                                                                                                                                                                                                                                                                                       |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                                                                                                                                                                                                                     |
| Action from last year: | Trust implementing the Report, Support, Learn initiative                                                                                                                                                                                                                                                                                              |
| Comments:              | Implementation of Report, Support, Learn continues. The Trust has adopted a Restorative Just and Learning Culture (RJLC) approach to respond to incidences in a way that explores why things happen rather than who is to blame. As part of that response there is an emphasis on fairness, support and learning. RJLC training is provided to staff. |
| Action for next year:  | No additional action required                                                                                                                                                                                                                                                                                                                         |

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

|                        |                                                                                                      |
|------------------------|------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                    |
| Action from last year: | Continue                                                                                             |
| Comments:              | Signposting through the appraisal process, DATIX process and daily incident response safely huddles. |
| Action for next year:  | No additional action required                                                                        |

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

|                        |                                                                                                                                                    |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                                                                                  |
| Action from last year: | Continue this work                                                                                                                                 |
| Comments:              | Diversity data of Trust appraisers have been reviewed and shown to mirror that of the senior medical workforce as a whole. See also 1Fii and 1Dvii |
| Action for next year:  | Continue                                                                                                                                           |

### 1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

|                        |                                                                                              |
|------------------------|----------------------------------------------------------------------------------------------|
| Y/N                    | Y                                                                                            |
| Action from last year: | To continue as currently                                                                     |
| Comments:              | HLRO visit took place in 2023. All HLRO meetings and SW appraisal lead meetings are attended |
| Action for next year:  | Continue to engage fully as previously                                                       |

## Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

|                                                                                                                                                                                            |     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| The number of doctors with a prescribed connection to the designated body on the last day of the year under review                                                                         | 672 |
| Total number of appraisals completed                                                                                                                                                       | 647 |
| Total number of appraisals approved missed                                                                                                                                                 | 25  |
| Total number of unapproved missed                                                                                                                                                          | 0   |
| The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle | 52  |
| Total number of late recommendations                                                                                                                                                       | 0   |
| Total number of positive recommendations                                                                                                                                                   | 43  |
| Total number of deferrals made                                                                                                                                                             | 9   |
| Total number of non-engagement referrals                                                                                                                                                   | 0   |
| Total number of doctors who did not revalidate                                                                                                                                             | 0   |
| Total number of trained case investigators                                                                                                                                                 | 30  |
| Total number of trained case managers                                                                                                                                                      | 36  |
| Total number of concerns received by the Responsible Officer <sup>2</sup>                                                                                                                  | 4   |
| Total number of concerns processes completed                                                                                                                                               | 3   |
| Longest duration of concerns process of those open on 31 March (working days)                                                                                                              | 340 |

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<sup>2</sup> Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

|                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Median duration of concerns processes closed (working days) <sup>3</sup>                               | 80                                                                                                                                                                                                                                                                                                                                              |
| Total number of doctors excluded/suspended during the period                                           | 3                                                                                                                                                                                                                                                                                                                                               |
| Total number of doctors referred to GMC                                                                | 2                                                                                                                                                                                                                                                                                                                                               |
| Total number of appeals against the designated body's professional standards processes made by doctors | 0                                                                                                                                                                                                                                                                                                                                               |
| Total number of these appeals that were upheld                                                         | 0                                                                                                                                                                                                                                                                                                                                               |
| Total number of new doctors joining the organisation                                                   | 497                                                                                                                                                                                                                                                                                                                                             |
| Total number of new employment checks completed before commencement of employment                      | For a new doctor joining the Trust there are 6 pre-employments to be completed, for internal candidates switching roles only 2 are required. We do not allow a doctor to start without all pre-employment checks complete unless approved by the Medical Director / RO. If this occurs, we will chase until the pre-employment checks are done. |
| Total number claims made to employment tribunals by doctors                                            | 5                                                                                                                                                                                                                                                                                                                                               |
| Total number of these claims that were not upheld <sup>4</sup>                                         | 0                                                                                                                                                                                                                                                                                                                                               |

### Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

#### General review of actions since last Board report

<sup>3</sup> Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

<sup>4</sup> Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Summary of actions from last year and *responses*:

Complete recruitment and training of appraisers in 25/26 round. Continue to monitor appraiser numbers and recruit further as required

*A further 6 appraisers were recruited in Autumn 2025. Following some retirements we will undertake another round of recruitment in Autumn 2026*

Complete training of outstanding deputy RO

*Prof. Mark Pietroni is the Responsible Officer. 4 trained deputy ROs in place. 2 new AMDs to complete training*

Continue work to ensure that complaints reports are accurate

*Audits have taken place regarding concordance of appraisal evidence and reports received for complaints, serious incidents and completeness of information from private providers. There have all been discussed at ROG. Where there have been inconsistencies, action has been taken to address this. The main area for focus continues to be on complaints reports and work is ongoing to address this. We are also commencing work to explore how concerns reported to PALS are fed back to doctors, and where appropriate fed into appraisal.*

Continue work to ensure relevant clinician level outcome data is routinely included in Form A meetings and appraisals

*This represents an ongoing process of development and improvement. Having completed the NCIP pilot, work is now underway to make sure that key metrics where they exist, including radiology red flag compliance and NCIP data is included and discussed in Form A meetings and fed through to the appraisal meeting.*

Ensure that the updated Appraisal and Revalidation Policy is ratified and replaces the current policy on the Trust Intranet site.

*Currently with policy administration team.*

### **Actions still outstanding**

Ensure that the updated Appraisal and Revalidation Policy is ratified and replaces the current policy on the Trust Intranet site.

### **Current issues**

Continue to work to improve concordance of complaints reports with those reported by doctors in their appraisals. Explore and agree appropriate mechanism for concerns reported to PALS to be fed back to doctors and where appropriate fed into appraisal

**Actions for next year (replicate list of 'Actions for next year' identified in Section 1):**

Continue to monitor appraisal and revalidation performance through ROG

Recruit and train new cohort of appraisers

Trial the ASPAT tool for peer review of appraisal summaries

Training to be completed for the 2 new deputy ROs

Audit NCIP data inclusion project in 2027

Continue to work to improve concordance of complaints reports with those reported by doctors in their appraisals. Explore and agree appropriate mechanism for concerns reported to PALS to be fed back to doctors and where appropriate fed into appraisal

**Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):**

Achievements – Appraisal and revalidation metrics evidence the system is running effectively. There is ongoing training of Deputy ROs as they come into post, and this continues. Similarly, there is an ongoing process of recruitment and training of new appraisers to make sure there is adequate support of the appraisal process. Quality Assurance processes are in place and 100% of appraisers underwent their annual review with the appraisal lead in 25/26. The diversity characteristics of appraisers' mirror those of senior medical workforce as a whole. Appraiser support groups and ROG meetings are occurring regularly with high attendance levels and high satisfaction levels with the content of the training.

Challenges – This continues to be around ensuring that complaints data is accurate – this is one of the actions as outlined above.

Aspirations – To continue to develop the appraisal and revalidation process through the ongoing development of our appraisers to consistently provide helpful and supportive and developmental appraisals for our connected doctors. Ensure that this is complemented by development of increasingly rigorous clinician level data and supporting information which is subject to regular quality assurance review.

**Section 4 – Statement of Compliance**

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

|                                       |  |
|---------------------------------------|--|
| Official name of the designated body: |  |
|---------------------------------------|--|

|         |  |
|---------|--|
| Name:   |  |
| Role:   |  |
| Signed: |  |
| Date:   |  |

|                                          |  |
|------------------------------------------|--|
| Name of the person completing this form: |  |
| Email address:                           |  |



## Report to Board of Directors/Committee

|                                   |                                                 |
|-----------------------------------|-------------------------------------------------|
| <b>Date of Meeting</b>            | 10 September 2026                               |
| <b>Report title</b>               | Winter Plan 2026/27 – Board Assurance Statement |
| <b>Sponsoring Director/Author</b> | Al Sheward                                      |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Assure:</b> The Board Assurance Statement confirms that the Trust's winter planning arrangements provide full assurance across governance, prevention, flow and discharge, capacity, urgent and emergency care, infection prevention and control, and operational leadership.</p> <p><b>Advise:</b> The winter plan has been developed through cross-divisional and system engagement and is built around early demand and capacity modelling, admission avoidance, improved discharge, workforce resilience, elective protection and clear OPEL-based escalation. It sets a clear organisational position that routine corridor care will not be normalised.</p> <p><b>Alert:</b> Final assurance remains dependent on completion of the regional winter exercise on 16 September, incorporation of lessons learned, confirmation of vaccination recording through RAVS and ESR, completion of the QEIA, and formal Board and executive sign-off by 30 September 2026.</p> |                                                                                                                                                                                                                                                                                                                     |
| Previously considered by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>• Cross-divisional Winter Planning Task and Finish Group</li> <li>• Divisional Operational Assurance Group</li> <li>• Urgent Care and Flow Improvement Board</li> <li>• Trust Leadership Team</li> <li>• Regional winter exercise scheduled for 16 September 2026</li> </ul> |

| Recommendations:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The Board is asked to:</p> <ul style="list-style-type: none"> <li>• <b>ASSURE</b> itself that the Winter Plan 2026/27 addresses the national Board Assurance Statement requirements.</li> <li>• <b>NOTE</b> the current self-assessment result of 5 – Full assurance across all applicable domains.</li> <li>• <b>NOTE</b> the remaining actions: regional exercise and local stress test, confirmation of RAVS/ESR vaccination recording, completion of the QEIA, and final executive sign-off.</li> <li>• <b>APPROVE</b> submission of the completed Board Assurance Statement to NHS England by 30 September 2026, subject to incorporation of any final Board amendments and exercise learning.</li> </ul> |

| Strategic Aims (tick as appropriate)                                                                                    |   |
|-------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>   | ✓ |
|  <b>People, culture and leadership</b> | ✓ |
|  <b>Quality, safety and delivery</b>   | ✓ |
|  <b>Digital first</b>                  |   |

| Impact on any Strategic Risks?                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Supports mitigation of strategic risks relating to patient safety, urgent and emergency care performance, operational capacity, workforce resilience, infection outbreaks, estate disruption and delivery of elective and cancer pathways. The plan strengthens prevention, early escalation, command and control, discharge and system coordination; residual risk remains during sustained extreme pressure. |

| Implications on:                         |                                                                                                                                                                                                                                                                                  |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | A quality and equality impact assessment has informed the plan and is included as an appendix. The principal impact is positive through improved access, safety and patient dignity; delivery will be monitored for differential impact on patients and staff.                   |
| <b>Health Inequalities</b>               | The plan uses population health intelligence and system risk stratification to identify vulnerable and high-risk cohorts, with targeted vaccination, admission avoidance, urgent community response and home-first discharge arrangements.                                       |
| <b>Finance and Resource</b>              | The plan is based on year-round use of existing capacity and resources, with targeted reprioritisation and deployment where required. Any additional resource requirements will be managed through existing financial governance and must demonstrate clear operational benefit. |
| <b>Regulation/Legal</b>                  | The report supports compliance with NHS England winter planning requirements, the OPEL framework, emergency preparedness and business continuity duties, and the Health and Social Care Act 2008 code of practice on infection prevention and control.                           |
| <b>CQC-Key line of enquiry</b>           | Aligns with the CQC Safe, Responsive and Well-led domains through clear patient-safety controls, escalation thresholds, leadership accountability, performance oversight and system governance.                                                                                  |
| <b>Green Plan</b>                        | Indirect positive impact through increased use of same-day care, virtual wards and home-based alternatives, reducing avoidable travel and inpatient resource use. No material adverse impact identified.                                                                         |

## Main Report

### 1. Purpose

This report provides the Board with assurance that the Trust's Winter Plan 2026/27 (appendix 1) addresses the national Board Assurance Statement requirements (appendix 2) and sets out the evidence, residual risks and actions required before submission to NHS England on the 30<sup>th</sup> September.

### 2. Assurance position

The self-assessment currently records a score of 5 – Full assurance across governance and executive leadership; prevention; flow, occupancy and discharge; capacity and community; urgent and emergency care flow; infection prevention and control; and leadership and operational grip.

The plan has been developed through a cross-divisional Task and Finish Group and reviewed through DOAG, UCFIB and TLT. It has been aligned with the system winter plan, including system flow and OPEL escalation arrangements.

### 3. Key controls

- Demand and capacity modelling based on a bad-winter scenario, seasonal infection intelligence and known estate constraints.
- Admission avoidance through SDEC, the Medical Assessment Zone, specialty assessment units, frailty pathways and virtual wards.
- Discharge improvement through the Discharge Lounge, Clinical Vision of Flow, the Care Transfer Hub, seven-day pathway oversight and targeted review of long delays.
- Workforce resilience through rota review, minimum staffing controls, senior decision-maker cover, sickness and annual leave oversight, vaccination and wellbeing support.
- A clear Trust position that routine corridor care is not acceptable, supported by escalation triggers, dynamic risk assessment and executive oversight.
- Protection of urgent elective, cancer and diagnostic activity, with controlled and clinically led reprioritisation only where required during defined surge periods.
- Daily operational grip, live dashboards, OPEL-based escalation and formal oversight through UCFIB, QPC and Board by exception.

### 4. Outstanding assurance actions

- Complete the regional winter exercise on 16 September and incorporate learning into the final plan.
- Complete the local winter stress test planned for November.
- Confirm that all frontline vaccination activity will be recorded on RAVS and that the FHCW flag is applied within ESR.
- Complete final review and approval by the Chief Executive, Chair and Executive Winter Sponsor before submission by 30 September 2026.

### 5. Conclusion

The Trust has a comprehensive and credible winter plan with clear operational controls and governance. The remaining actions are limited and capable of completion within the submission timetable. The Board is therefore asked to take full assurance, subject to completion of the identified actions and incorporation of exercise learning.

Enclosures: Appendix 1 – GHFT Winter Plan 2026/27

Appendix 2 - Winter Plan 2026/27 Board Assurance Statement PowerPoint.

FOI: Public

# GHFT Winter Plan 2026/27

**Purpose:** to set out GHFT's approach to maintaining safe, timely and effective care through winter 2026/27, with clear focus on patient safety, patient flow, discharge, workforce resilience, elective protection and Board assurance.

|                    |                                              |
|--------------------|----------------------------------------------|
| Executive lead     | Al Sheward, Chief Operating Officer          |
| Board paper period | November 2026 to April 2027                  |
| Prepared for       | Trust Board discussion and assurance         |
| Version            | Updated report, 20 <sup>th</sup> August 2026 |

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## 1. Executive Summary

GHFT enters winter 2026/27 with a clearer operational base than in previous years, but with material residual risk in urgent and emergency care demand, discharge flow, workforce resilience, estate disruption, infection pressures and the potential re-emergence of unsafe care in non-designated spaces if pressure is not controlled.

The plan is positioned as a single organisational Trust plan focused on protecting patient safety and dignity, reducing avoidable admission and delay, improving ambulance offload and front-door flow, strengthening discharge discipline, protecting urgent elective and cancer pathways where possible, and assuring the Board through a concise set of metrics, escalation triggers and governance reviews.

The proposed approach does not rely on traditional bed escalation alone. It depends on sustained Same Day Emergency Care, assessment unit utilisation, stronger specialty streaming, Discharge Lounge discipline, virtual wards, ward-flow improvement through the Clinical Vision of Flow programme and robust command-and-control supported by the Operational Pressures Escalation Level framework.

**Trust position: routine care in corridors or other non-designated clinical areas is not acceptable and will not be normalised. Any exceptional use of temporary escalation space must be clinically risk assessed, time limited, authorised through executive command and reported through governance routes.**

## 2. Strategic Context

Winter 2026/27 should be treated as a predictable period of heightened acuity and capacity pressure. The Trust remains under operational pressure before winter begins and must continue to improve urgent and emergency performance while maintaining priority elective and cancer delivery. For Board purposes, the strategic context is straightforward: internal flow remains the main determinant of resilience; discharge performance and same-day pathways are central; winter readiness must be integrated with estate works and workforce planning; and assurance must test whether safer care can be sustained under pressure.

## 3. Key Winter Risks

| Risk                                           | Board implication                                                                                                                                                                                              |
|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Front-door crowding and prolonged waits</b> | Increasing Emergency Department attendances, direct admissions and delays to clinical assessment create risk to four-hour and twelve-hour performance, ambulance offload, patient privacy and clinical safety. |
| <b>Flow and discharge failure</b>              | Patients without an effective discharge-ready pathway, high occupancy and weak morning discharge discipline can reduce resilience and increase pressure on assessment areas.                                   |
| <b>Corridor care and non-designated areas</b>  | The Trust requires one clear position that routine corridor care and unsafe boarding are not acceptable, supported by prevention actions and immediate executive oversight if escalation space is considered.  |
| <b>Workforce resilience</b>                    | Staffing availability, sickness, leave management, senior cover, consultant job planning, bank and agency use and surge redeployment need early and visible control.                                           |
| <b>Infection and capacity</b>                  | Influenza, respiratory syncytial virus, norovirus and COVID-19 remain operational threats through bed closures, cohorting requirements and staff absence.                                                      |
| <b>Estate and infrastructure constraints</b>   | Estate works, decant requirements, bed reallocation and infrastructure resilience require close operational oversight.                                                                                         |
| <b>Elective and cancer disruption</b>          | Winter pressure, industrial action risk and bed reconfiguration may compromise protected elective and cancer capacity unless ringfencing and prioritisation remain disciplined.                                |
| <b>Policy and escalation ambiguity</b>         | Incomplete or placeholder sections in the draft should be replaced before Board approval, especially command and control, escalation and operational assurance detail.                                         |

## 4. Strategic Priorities

- **Protect patient safety, dignity and clinical quality** at all times, with clear prevention of corridor care and unsafe boarding.
- **Improve front-door flow** through streaming, early senior decision-making, Same Day Emergency Care and specialty assessment pathways.
- **Reduce avoidable admission and length of stay** through discharge-ready discipline, Discharge Lounge utilisation, virtual wards and stronger pathway management.
- **Protect urgent elective, cancer and specialty pathways** through ringfenced capacity, explicit prioritisation and early operational decisions.
- **Deploy workforce, escalation and command arrangements earlier** and more predictively, particularly for weekends, bank holidays and known surge periods.
- **Strengthen Board assurance** through a live winter dashboard, explicit escalation thresholds and regular Quality and Performance Committee review.

## 5. Delivery Programmes

### Same Day Emergency Care and assessment pathways

Medical Assessment Zone, Medical Same Day Emergency Care, Surgical Assessment Unit, frailty services, Head and Neck, cardiology, gynaecology and Urology Assessment Unit pathways should function as alternatives to standard admission, with Board focus on utilisation, opening profile, specialty ownership and impact.

### Medical Assessment Zone and specialty assessment units

Protected non-inpatient assessment capacity should reduce Emergency Department footfall and speed clinical decision-making. The operating model, staffing, opening hours and escalation rules should be confirmed.

### Urology Assessment Unit and lithotripsy pathway

The urology pathway is a priority area, with the Board requiring clear assurance on the interim assessment model and the route to full operating maturity.

### Discharge profile and Discharge Lounge

The Discharge Lounge should become the destination of choice for suitable patients identified to leave hospital, supported by flexible opening hours and a stronger morning discharge culture.

### DRD reduction in conjunction with Gloucestershire Provider Partnership

Improvement through the reduction in both the number of patients with a discharge ready date (DRD) and the associated bed days lost due to delays in discharging this patient cohort. Focus on delivery of this both ahead of the peak winter period to reduced bed occupancy, along with during to support overall balance of bedded capacity.

### Virtual wards and home-based alternatives

Virtual wards should support admission avoidance and early discharge, with assurance on occupancy, criteria, step-up and step-down activity and escalation support.

## Clinical Vision of Flow

The Clinical Vision of Flow programme should drive ward process improvement, board rounds, earlier discharge, reduced delay and stronger multidisciplinary ownership of flow.

## Elective protection and ringfenced pathways

Ringfenced orthopaedic, cancer, trauma, gynaecology and other specialty capacity should be protected through explicit operational escalation decisions.

# 6. Operational Approach

| Phase          | Purpose                                                                                                                                                   | Board assurance focus                                                   |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>Prepare</b> | Complete readiness review, confirm policies, identify forecast pressure points and agree operational triggers before winter.                              | Evidence of completion, accountable owner and measurable trigger points |
| <b>Test</b>    | Use scenario testing and internal exercises to validate escalation policy, command arrangements, divisional readiness and operational decision-making.    | Evidence of completion, accountable owner and measurable trigger points |
| <b>Respond</b> | Operate a live command-and-control model through peak winter, with dynamic risk assessment, in-season learning and clear escalation to executive command. | Evidence of completion, accountable owner and measurable trigger points |

## Escalation and command

- **Use one agreed Trust escalation policy** aligned to current Operational Pressures Escalation Level principles and Trust incident response arrangements.
- **Confirmed routine operating cadence** including site huddles, divisional escalation points, tactical review and executive oversight by exception.
- **Use the Incident Control Centre** to support operational, estates, emergency preparedness, resilience and response, clinical and technical coordination for major disruption.
- **Document dynamic risk assessments** whenever pressure escalates or any temporary escalation space is considered.

## Trust position on corridor care

**Routine care in corridors or other non-designated clinical areas is not acceptable and will not be normalised. If extremis conditions arise, temporary escalation space must be exceptional, clinically risk assessed, time limited, authorised through executive command and reported through governance routes.**



## **Demand and capacity modelling**

The Trust has strengthened its demand and capacity modelling through the development of highly accurate predictor tools that support operational planning throughout the year, not only during winter surge. These tools provide both daily and weekly demand profiles, allowing the organisation to anticipate pressure across emergency attendances, admissions, bed occupancy, discharge requirements, infection-related capacity loss, and elective flexibility. The modelling draws on historic activity, current operational performance, seasonal infection intelligence, and known public behaviour patterns around weekends, bank holidays, Christmas, New Year and school holiday periods. This enables earlier identification of likely pressure points, supports proactive deployment of workforce and capacity, informs decisions on escalation and elective adjustment, and provides the Board with a clearer evidence base for testing whether the winter plan is sufficient to maintain safe flow during periods of peak demand.

## **Maintaining elective care capacity**

The Board should take assurance that elective activity planning for 2026/27 is being considered as a year-round capacity management issue rather than a reactive winter decision. Discussions through winter planning and UCFIB have recognised that additional capacity may be required during periods of peak winter surge, and that this will need to be created through a planned and proportionate approach to outpatient, SPA and elective activity across Q1, Q2 and Q3. The agreed principle is to maximise delivery and create headroom earlier in the year, particularly through Q1 and Q2, while maintaining sufficient flexibility in Q3 to step down lower-priority outpatient and elective activity if urgent and emergency care pressure, bed occupancy, infection-related capacity loss or ambulance handover risk requires additional senior clinical decision-making, ward-based support or inpatient capacity.

Any decision to reduce outpatient or elective care will be clinically led, time limited and taken through the Trust's operational command route, with explicit protection for cancer, clinically urgent pathways, diagnostics that support cancer and urgent care, and patients at greatest risk of harm from further delay. Divisions will be expected to identify, in advance, which activity can safely be deferred or converted to alternative models, which staff groups could be redeployed to support winter surge, and the thresholds that would trigger escalation. The aim is not to normalise elective cancellation, but to provide a clear and controlled mechanism to release capacity during defined surge periods while minimising harm to elective recovery, cancer standards and long-waiting patients.

## **Integrated Care System approach**

The Trust has maintained and strengthened its working relationship with other Health and Social Care organisations in Gloucestershire, with the move of Integrated Care Board towards strategic commissioning and the implementation of the Provider Partnership. Within the Provider Partnership, the Working as One Programme (UEC) is delivering the following to support delivery of the winter period:

- A Single Point of Clinical Access within Gloucestershire Care Services (GHC) which will provide a single referral route for patients in the community who need access to a health service to prevent an attendance at the Emergency Department and subsequent admission.
- A Care Transfer Hub located within the Trust with input from GHC and Gloucestershire County Council social services, to enable patients to be discharged from the Trust on Pathway 1-3 in a

timely manner and reducing the need for re-admission. To achieve this the Care Transfer Hub will implement three core pillars before and during the winter period with an emphasis on left shift to admission avoidance as well as Pathway 1-3 discharges:

- Discharge Co-ordination and Case Management
- Trusted Assessment on Pathway Decisions
- Demand allocation to Capacity

Alongside these transformation schemes, the ICB and GCC have re-commissioned the Pathway 1 service in Gloucestershire, splitting reablement and Homefirst into separate services. The new services will begin on the 1<sup>st</sup> September with the aim to providing same day/next day discharges for patients requiring support at Home.

## 7. Workforce and Wellbeing

The Board plan should frame workforce resilience as both a people issue and a patient-safety issue. Sustained operational pressure, fatigue, sickness absence and repeated surge response directly affect safe care delivery. The Trust should therefore commit to earlier surge workforce planning, maximum senior decision-maker presence at peak periods and weekends, proactive redeployment triggers, seasonal vaccination delivery, visible wellbeing support and regular review of sickness, vacancies and temporary staffing reliance.

### Seasonal Influenza and COVID-19 Vaccination Programme

The seasonal influenza and COVID-19 vaccination programme will support the Trust's Winter Plan by reducing the risk of avoidable respiratory infection, protecting clinically vulnerable patients and supporting workforce resilience during the period of greatest operational pressure.

Staff vaccination clinics will run from 1 October to 14 December 2026. The Gloucestershire Royal Hospital clinic will be based in the Redwood Education Centre, Sweet Success Conservatory. A Cheltenham General Hospital clinic will also be provided, with the final location to be confirmed. Staff will be offered seasonal influenza vaccination and, where nationally indicated and locally available, COVID-19 vaccination. Booking information will be available through the Gloucestershire Hospitals NHS Foundation Trust intranet.

A roving vaccination model will be in place to improve access for staff working nights, weekends and in clinical areas where release to attend fixed clinics may be difficult. This approach is intended to support equity of access, maximise uptake across frontline teams and reduce avoidable disruption to service delivery.

The Trust will aim to exceed the previous frontline staff seasonal influenza vaccination uptake of 67%. Uptake for both seasonal influenza and COVID-19 vaccination will be monitored through the winter vaccination programme governance arrangements, with escalation where uptake is lower than expected or access barriers are identified.

Eligible inpatients will be offered vaccination in line with national eligibility and clinical guidance. Seasonal influenza vaccination will be offered from 1 October 2026 to inpatients aged 65 years and over, and to patients aged 18 to 65 years who are eligible due to clinical risk factors or learning

disability. Consideration will be given to any long stay patients or patients who are being discharged into care homes if they have not already been captured in the above. Seasonal influenza and COVID-19 vaccination arrangements for inpatients will be aligned to confirmed national autumn and winter eligibility guidance and managed in conjunction with partner organisations to consider population health intelligence and support of the at risk residents of Gloucestershire.

Pregnant patients will be offered seasonal influenza vaccination from 1 September 2026. Children aged two to three years will also be offered seasonal influenza vaccination in line with national eligibility guidance. Any COVID-19 vaccination offer for these cohorts will be delivered in accordance with confirmed national eligibility guidance.

Requests for patient vaccination should be made by emailing [ghn-tr.c19vaxbookings@nhs.net](mailto:ghn-tr.c19vaxbookings@nhs.net) once the appropriate prescription has been completed.

### **Sickness management and Annual Leave**

The Trust recognises sickness absence and annual leave management as a material winter patient safety and operational resilience risk. Discussions through the Urgent Care and Flow Improvement Board and winter planning process have highlighted the need for a strengthened workforce plan for the Christmas and New Year period, with particular focus on senior clinical decision-maker presence, safe staffing, weekend and bank holiday cover, and the requirement for annual leave approval to be aligned first to maintenance of clinical services. The Board should take assurance that this risk is being actively managed through divisional workforce review, prospective annual leave profiling, sickness absence monitoring, temporary staffing controls and explicit escalation where staffing availability creates risk to urgent, emergency, elective or cancer services.

Sickness absence will be monitored as part of the winter workforce dashboard, with particular attention to short-notice absence, services with repeated rota fragility, and areas where absence affects escalation capacity or the ability to maintain core services. Divisions will be expected to demonstrate active sickness management, timely return-to-work processes, visibility of hotspot areas and a clear route for escalation where absence materially compromises safety, flow or delivery of planned activity.

Annual leave will be managed in line with Trust policy and the overriding requirement to maintain safe clinical services. Divisions will review leave allocation across the peak winter weeks, including the period between Christmas and New Year, and will confirm that approvals do not create avoidable gaps in clinical cover, ward leadership, theatre and procedural capacity, diagnostic support, therapy input, discharge coordination or site management arrangements. Any service unable to demonstrate safe cover will be required to agree a recovery action through divisional governance and escalate residual risk through the operational command route.

## **8. Infection Prevention and Control (IPC)**

The Trust has well-established Infection prevention and control governance arrangements led by the Director of Infection Prevention and Control (DIPC) and supported by the Infection Control Committee. IPC representation is embedded within winter planning (task and finish group) and operational escalation processes. IPC teams are involved in assessing proposed pathways and bed capacity

changes, undertaking infection risks assessments, supporting cohorting decisions, and providing advice on the safe reconfiguration and use of clinical areas. GMS and operational teams work collaboratively with IPC to ensure patient safety is maintained during periods of escalation. The Trust has established outbreak management processes and policy, daily surveillance and communication processes and escalation routes to support rapid response to respiratory and gastrointestinal infections. The site team have an overview of all single rooms and indication for use (which is reported on site calls) and decisions to de-escalate/ prioritise isolation is supported by the IPCT when capacity is full including decision to cohort. The IPC team provide onsite and on-call weekend outbreak management support during the winter season. The IPC engage in system-wide, regional, and national winter sit reps and touch points meetings.

## 9. Governance and Assurance

For 2026/27, the governance and assurance approach is deliberately simplified and action-led. The Board is not being asked to approve a long descriptive winter plan; it is being asked to support a smaller number of explicit delivery plans that set out what will be done, by whom, by when, what benefit is expected and what escalation will occur if delivery is not on track. This reflects the winter planning requirement discussed through the Task and Finish Group, DOAG, UCFIB and TLT that assurance should be based on visible action, measurable impact and clear operational grip rather than narrative description alone.

Delivery against the plan will be monitored both in the build-up to winter and throughout the winter period through daily operational meetings, with formal monthly review through UCFIB and QPC to test progress, risk, impact and escalation requirements. Board reporting will be by exception where actions are off track, risks exceed agreed tolerance, or executive escalation decisions are required.

### Performance Dashboards

| Domain                    | Core metric(s)                                                                              | Reporting                               |
|---------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------|
| Ambulance handover        | Average handover time and proportion over 30 minutes / 45 minutes                           | Daily and weekly                        |
| Emergency Department flow | Four-hour performance, twelve-hour waits, majors occupancy, time to treatment               | Daily and weekly                        |
| Bed position              | Overall bed occupancy, escalation bed use, beds closed for infection prevention and control | Daily and weekly                        |
| Discharge                 | Discharges before midday, discharge-ready patients, length of stay over 7,14 and 21 days    | Daily and weekly                        |
| Same day pathways         | Same Day Emergency Care activity, conversion rate, specialty assessment utilization         | Weekly                                  |
| DRD Numbers and Delays    | Discharge ready date patients numbers and bed days associated (delays)                      | Daily and weekly                        |
| Virtual wards             | Occupied virtual ward places and step-up / step-down activity                               | Weekly                                  |
| Workforce                 | Sickness absence, vacancy rate, temporary staffing fill and spend                           | Weekly / monthly                        |
| Safety and dignity        | Corridor-care incidents or temporary escalation-space use, patient harm themes by exception | Immediate escalation and monthly review |

## 10. Conclusion

GHFT enters winter 2026/27 with a more complete and Board-ready plan, grounded in the areas that will determine resilience: front-door flow, discharge discipline, assessment capacity, workforce availability, infection prevention and control, estate readiness, elective protection and clear operational command.

The plan sets out the core delivery routes required to manage winter risk, including Same Day Emergency Care, specialty assessment pathways, DRD reduction, Discharge Lounge utilisation, virtual wards, Clinical Vision of

Flow, demand and capacity modelling, vaccination, sickness and annual leave management, and a stronger Integrated Care System interface.

Board approval should now focus on assurance that the remaining tests and simulation are completed before winter: final confirmation of escalation and command arrangements, alongside clear ownership of delivery actions across divisions and system partners. With these controls in place, the plan provides a credible framework for maintaining safe care, protecting patient dignity and managing operational pressure through the winter period.

## 11. Appendix 1 – Divisional Schemes and Actions

### Medicine Division

#### 1. Front Door

| Winter scheme                             | Priority                                                                                                                                       | Expected operational impact                                                                                                      |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| UTC phase 1                               | Mobilise phase 1 of the Urgent Treatment Centre model.                                                                                         | Improve front-door streaming, reduce avoidable emergency department pressure, and support timely access to same-day urgent care. |
| Paediatric ED cover and rapid PAU pathway | Provide 24/7 dedicated paediatric ED cover supported by a rapid Paediatric Assessment Unit pathway aligned to Internal Professional Standards. | Improve paediatric flow, reduce waits, and support timely senior clinical review.                                                |

#### 2. Admission Pathways

| Winter scheme                   | Priority                                                                                                     | Expected operational impact                                                                                              |
|---------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Enhanced senior decision makers | Increase senior clinical decision-making capacity at key admission points.                                   | Support earlier disposition decisions, reduce unnecessary admissions, and improve same-day emergency care opportunities. |
| Frailty cover                   | Deliver 12-hour frailty cover to support early identification, assessment, and management of frail patients. | Improve admission avoidance, reduce length of stay, and strengthen multidisciplinary discharge planning.                 |

#### 3. Inpatient and Discharge Pathways

| Winter scheme                    | Priority                                                                                                    | Expected operational impact                                                                                                              |
|----------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Operational management           | Provide 12-hour General Manager and Matron cover to strengthen operational grip across inpatient areas.     | Improve real-time escalation, bed flow oversight, and discharge coordination.                                                            |
| NHSE Improvement Activity        | Maintain focused operational review of Red to Green status. 14 & 21-day length of stay review.              | Reduce internal delays and support delivery of timely discharge. Identify barriers to discharge and enable targeted senior intervention. |
| Cardiac day case                 | Planned pause of cardiac day case activity through winter to release capacity for cardiac surge management. | Provide escalation capacity during periods of increased acute cardiac demand.                                                            |
| Rota management                  | Confirm minimum staffing agreements across all services to support safe escalation planning.                | Maintain safety and resilience during periods of pressure, sickness, or increased demand.                                                |
| Virtual ward resource allocation | Reallocate virtual ward resource to match demand, including home                                            | Support admission avoidance, earlier supported discharge, and flexible capacity management.                                              |



|  |                                                             |  |
|--|-------------------------------------------------------------|--|
|  | oxygen step-down capacity for the respiratory virtual ward. |  |
|--|-------------------------------------------------------------|--|

## Surgery Division

### 1. Assessment and Specialty Pathways

| Winter scheme                        | Priority                                                                                                                                             | Expected operational impact                                                                                 |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| Surgical Assessment Unit             | Confirm SAU model, staffing, criteria, specialty ownership and escalation arrangements for winter.                                                   | Reduce surgical admissions through ED, support faster senior surgical review and improve surgical flow.     |
| Trauma Assessment Unit               | Progress TAU development and confirm arrangements for trauma assessment, escalation and links with theatre and bed capacity.                         | Improve trauma flow, reduce ED congestion and provide a clearer pathway for trauma patients.                |
| Urology Assessment Unit              | Continue development of the Urology Assessment Unit and associated interim arrangements, including links to lithotripsy and urgent urology pathways. | Increase direct access to specialty assessment, reduce avoidable admission and improve pathway reliability. |
| HANSU / specialist surgical pathways | Maintain oversight of HANSU and other specialist pathways through scheduled UCFIB review.                                                            | Improve assurance on specialty flow, risk management and pathway resilience during winter.                  |

### 2. Elective and Theatre Flexibility

| Winter scheme                                   | Priority                                                                                                                                                                                                    | Expected operational impact                                                                                                 |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Elective prioritisation and theatre flexibility | Identify surgical outpatient, theatre and elective activity that could be safely reprioritised during defined peak pressure periods, while protecting urgent, cancer and clinically time-critical activity. | Create controlled operational headroom during surge without normalising elective cancellation or increasing avoidable harm. |
| Trauma and fracture pathways                    | Continue review of trauma pathways, including neck of femur and urgent theatre access.                                                                                                                      | Maintain safety and timeliness for high-risk surgical cohorts during winter pressure.                                       |

## Diagnostics and Specialties Division

### 1. Discharge and Flow Support

| Winter scheme    | Priority                                                                                                                                                               | Expected operational impact                                                                               |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Discharge Lounge | Strengthen the Discharge Lounge as the destination of choice for suitable patients, including flexible opening hours and clearer ward expectations for early transfer. | Increase morning discharge, reduce ward congestion and improve bed availability for emergency admissions. |
| Therapies        | Confirm therapy staffing plans for peak winter weeks, including the first weeks of January, weekend                                                                    | Maintain discharge momentum, reduce avoidable delay and support ward flow during known high-risk periods. |

|                 |                                                                                                                                               |                                                                                             |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
|                 | cover, outpatient flexibility and discharge support.                                                                                          |                                                                                             |
| Pharmacy / TTOs | Review TTO and pharmacy support, particularly for weekend and bank holiday periods, discharge-dependent medication and ward-level escalation. | Reduce discharge delays related to medicines and improve reliability of same-day discharge. |

## 2. Diagnostics and Specialty Capacity

| Winter scheme                   | Priority                                                                                                                                                 | Expected operational impact                                                                                                |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| Diagnostics                     | Confirm diagnostic capacity and winter escalation arrangements, including support for urgent care, infection testing and pathways that enable discharge. | Reduce diagnostic delay, improve clinical decision-making and strengthen support to both urgent and planned care.          |
| Oncology / AHOU                 | Review oncology and acute haematology/oncology capacity, including bed occupancy, demand management and routes to maintain urgent cancer pathways.       | Protect cancer and urgent oncology care while managing winter demand and inpatient capacity risk.                          |
| Urgent interventional radiology | Maintain scheduled oversight of urgent IR capacity and escalation arrangements.                                                                          | Support emergency and specialty pathways where timely intervention is required to avoid admission, deterioration or delay. |

## Women and Children's Division

### 1. Paediatric and Gynaecology Pathways

| Winter scheme                                              | Priority                                                                                                                           | Expected operational impact                                                                                               |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Paediatric Assessment Unit / paediatric ED                 | Confirm winter model for enhanced paediatric assessment capacity, escalation, staffing and links with ED.                          | Improve paediatric flow, reduce ED congestion and support safer management of seasonal respiratory demand.                |
| Gynaecology Assessment Unit / Gynaecology Emergency Clinic | Maintain development and oversight of GAU/GEC pathways as alternatives to ED attendance or admission where clinically appropriate. | Improve specialty streaming, reduce avoidable ED attendances and support faster decision-making for gynaecology patients. |
| Emergency women's pathways                                 | Review emergency pathways across women's services, including escalation triggers and winter staffing resilience.                   | Provide clearer operational response during peak demand and reduce pathway delay.                                         |

### 2. Elective Flexibility and Workforce Resilience

| Winter scheme                       | Priority                                                                                                    | Expected operational impact                                                                        |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Elective and outpatient flexibility | Identify activity that could be safely reprioritised during peak pressure periods, while protecting urgent, | Support Trust-wide capacity resilience while minimising harm to planned care and cancer standards. |



|                      |                                                                                                                         |                                                                                  |
|----------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
|                      | cancer and clinically high-risk pathways.                                                                               |                                                                                  |
| Workforce resilience | Confirm rota, leave and sickness management arrangements for peak winter periods, including bank holidays and weekends. | Maintain safe cover and reduce avoidable service fragility during surge periods. |

## Corporate, System and Enabling Schemes

### 1. Flow, Discharge and Alternatives to Admission

| Winter scheme                    | Priority                                                                                                                                                  | Expected operational impact                                                                                                      |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Care Transfer Hub                | Continue development of the Care Transfer Hub model, including clearer interfaces with system partners and out-of-hospital capacity.                      | Reduce discharge delay, improve pathway grip and strengthen system accountability for patients who no longer require acute care. |
| Clinical Vision of Flow          | Continue roll-out of CVOF workstreams including patient pact, internal professional standards, 4 questions, ward process improvement and delay reduction. | Improve ward-flow discipline, earlier discharge planning and reduce delay-related harm.                                          |
| Virtual wards / Hospital at Home | Maximise use of virtual ward capacity and Hospital at Home as admission avoidance and early discharge routes.                                             | Increase care outside hospital, reduce bed occupancy and improve resilience during peak demand.                                  |

### 2. Escalation, Workforce and Resilience

| Winter scheme                               | Priority                                                                                                                                                            | Expected operational impact                                                                                                                                                                            |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Integrated Flow Hub / Operational Hub / ICC | Consolidate operational hub, Integrated Flow Hub and Incident Control Centre arrangements to support escalation, tactical coordination and dynamic risk management. | Strengthen command and control, clarify escalation routes and improve real-time operational grip.                                                                                                      |
| Corridor care and escalation policy         | Finalise corridor care SOP, escalation policy and associated dynamic risk assessment process.                                                                       | Set a clear organisational position that routine corridor care is not acceptable, with executive oversight where temporary escalation space is considered.                                             |
| Bed capacity and estate decant              | Continue ward reconfiguration, estate decant planning and bed capacity review linked to winter modelling.                                                           | Support earlier identification of capacity risk and better alignment between estate works, winter demand and operational resilience. Achieving 80% bed occupancy ahead of the Christmas holiday period |
| Workforce reporting                         | Improve visibility of workforce capacity through HealthRoster reporting, sickness monitoring, annual leave oversight and temporary staffing controls.               | Provide better assurance on staffing risk, earlier escalation and more targeted deployment of available workforce.                                                                                     |

### 3. Infection, Emergency Preparedness and Governance

| Winter scheme                           | Priority                                                                                                                                                                 | Expected operational impact                                                                               |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Vaccination programme                   | Deliver staff and inpatient influenza and COVID-19 vaccination programme, including fixed clinics, roving model, uptake monitoring and escalation of barriers.           | Reduce avoidable infection risk, improve workforce resilience and protect clinically vulnerable patients. |
| IPC and respiratory infection readiness | Confirm flu forecasting, point-of-care testing, PPE communications, FFP3 fit testing, norovirus testing arrangements and mitigation of care home IPC nurse removal risk. | Improve infection response, reduce capacity loss and better support discharge pathways.                   |
| EPRR and severe weather preparedness    | Complete Exercise Goldfinch and severe weather preparedness work, alongside review of business continuity and on-call training.                                          | Improve organisational readiness for major disruption, severe weather and sustained escalation.           |
| Winter governance                       | Establish Winter Operational Group / Winter IMT governance, with monthly UCFIB review and escalation to DOAG, TLT, QPC or Board by exception.                            | Ensure actions remain visible, measurable and owned, with clear escalation where delivery is off track.   |

## 12. Appendix 2 – EQIA

The below embedded document outlines the Equality Impact Assessment in relation to the winter planning for 2026.



Winter Plan EQIA  
2026.xlsx

# Winter Plan 2026/27

## Board Assurance Statement

Governance, prevention, flow and discharge, capacity, urgent and emergency care, infection prevention and control, and operational leadership

Executive Lead: Al Sheward | Board of Directors: 10 September 2026

**For approval, discussion, information and assurance**

# Introduction and purpose

Board assurance on the strength of the plan, evidence underpinning the assessment and deliverability of remaining actions

## The self-assessment records 5 – Full assurance across all applicable domains.

### Purpose

Confirm the plan addresses the national Board Assurance Statement requirements.

### Assurance position

Full assurance across governance, prevention, flow, discharge, capacity, UEC, IPC and leadership.

### Key controls

Demand modelling, admission avoidance, discharge, workforce resilience, elective protection and escalation.

### Outstanding actions

Regional exercise, vaccination recording, QEIA completion and final sign-off.

### Board decision

Approve submission to NHS England by 30 September 2026, subject to final amendments and exercise learning.

# Board Assurance Statement requirements

What the Board is being asked to confirm

**The assurance statement confirms oversight of the winter plan and the key controls required for delivery.**

## 1. Board oversight

All key considerations have been met and are covered by the Trust Winter Plan.

## 2. Guidance and checklist

Section A provides the Board Assurance Statement. Section B provides the 2026/27 Winter Plan checklist.

## 3. Submission

Completed assurance statements are required for national submission by 30 September 2026.

**Board test: is the evidence sufficient, are residual actions controlled, and is delivery credible before winter?**

# Governance and executive leadership

FULL ASSURANCE

Section A: Board Assurance Statement

**All six governance and executive leadership statements are confirmed “Yes”.**

## Development and approval

Winter Plan prepared for Board discussion.  
Cross-divisional Task and Finish Group.  
Reviewed through DOAG, UCFIB and TLT.  
Board approval planned by 30 September.

## System alignment and testing

Developed with input from system partners.  
Aligned to the system winter plan and OPEL escalation.  
Regional exercise on 16 September.  
Additional local stress test planned for November.

## Leadership and operational grip

Named Executive Winter Sponsor: Al Sheward.  
Daily governance and escalation routes.  
OPEL, EPRR and incident management embedded.  
Senior cover reviewed for peak periods.

**Residual condition: incorporate learning from the regional exercise and complete final executive and Board sign-off.**

# Prevention, occupancy and discharge

**FULL ASSURANCE**

Section B: 2026/27 Winter Plan checklist

## Prevention

Frontline flu vaccination programme planned.  
Clinics across both sites from 1 October to 14 December 2026.  
Roving model for nights, weekends and clinical areas.  
Eligible inpatients offered vaccination in line with national guidance.  
Confirmation required on ESR recording.

## Occupancy and discharge

Pre-Christmas and holiday occupancy reduction plans confirmed.  
Care Transfer Hub coordinates system pathways.  
Pathway 1 implementation supports same-day and next-day discharge.  
Seven-day oversight and targeted review of long delays.

## Patient safety position

Routine corridor care will not be normalised.  
Defined thresholds, escalation triggers and Board oversight.  
Model ED and Model Discharge self-assessments completed with implementation plans.  
Home-based alternatives and assessment pathways included.

# Capacity, urgent care flow and system escalation

FULL ASSURANCE

Section B: 2026/27 Winter Plan checklist

## Capacity and alternatives

Demand and capacity modelling based on a bad-winter scenario.  
Admission avoidance through SDEC, Medical Assessment Zone, specialty assessment, frailty and virtual wards.  
Known estate constraints reflected in planning.

## Urgent and emergency care flow

Ambulance handover arrangements and escalation processes confirmed.  
Further improvement planned towards the 15-minute national standard.  
ED crowding mitigations and escalation triggers in place.

## System coordination

System partners linked through daily position calls.  
Care Transfer Hub supports transfer of care.  
Updated system flow OPEL framework agreed.  
Regional repatriation routes and mutual aid arrangements in place.



# Infection prevention and control

FULL ASSURANCE

Section B: 2026/27 Winter Plan checklist

**IPC governance, surveillance and rapid reconfiguration controls are embedded within the winter plan.**

## Governance and surveillance

DIPC-led governance through the Infection Control Committee.  
Daily surveillance and outbreak management.  
On-site and weekend on-call outbreak support.  
IPC input to winter planning and sign-off.

## Cohorting and diagnostics

Risk-based cohorting plan available for activation.  
Oversight of isolation capacity and de-escalation.  
Rapid respiratory testing and POCT pathways.  
Environmental risk assessment supports reconfiguration.

## PPE and workforce controls

PPE and FFP3 stock monitoring with escalation routes.  
Fit-testing training, competency and equipment available.  
Compliance monitored through ICAF.  
Dynamic risk assessment supports operational decisions.

# Leadership, resilience and final actions

ASSURANCE WITH  
ACTIONS

Section B: leadership and operational grip

## Operational resilience

Business continuity plans reviewed.  
Severe weather and infrastructure contingencies reviewed.  
Industrial action contingencies established.  
Mutual aid and regional repatriation routes available.

## Workforce and welfare

Senior decision-maker cover reviewed.  
Sickness and annual leave oversight.  
Wellbeing support visible.  
Fatigue, sickness and sustained pressure treated as patient-safety risks.

## Actions before submission

Complete regional exercise on 16 September.  
Confirm RAVS and ESR vaccination recording.  
Complete QEIA.  
Secure Chief Executive, Chair and Executive Winter Sponsor sign-off.  
Submit by 30 September 2026.

**Recommendation: take full assurance, subject to completion of the identified actions and incorporation of exercise learning.**

| Equality Impact Initial Assessment Stage 1                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                  | Scheme name                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | GHFT Trust-wide Winter Plan 2026/27 |         |                                        |       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------|----------------------------------------|-------|-------------------------------------------------|
| Scheme No                                                                                                                                                                                                                                                                                                                                                  | TBC                                                                                                                                              | Scheme FYE value (if financial)(£'000s)                                                                                                                                                                                                                                                                                                                                                                                                                                           | N/A                                 |         |                                        |       |                                                 |
| Trust-wide plan for November 2026 to April 2027 to maintain safe, timely and effective care through winter, focusing on patient safety and dignity, urgent and emergency flow, discharge, workforce resilience, infection control, elective and cancer protection, and Board assurance. Evidence source: GHFT Winter Plan 2026/27, updated 20 August 2026. |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| Patient Safety*                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| What is the impact on partner organisations and any aspect of shared care?                                                                                                                                                                                                                                                                                 |                                                                                                                                                  | Positive system intent with residual interdependency risk. The Care Transfer Hub, Gloucestershire Provider Partnership, virtual wards/Hospital at Home and system escalation should reduce discharge delay. Mitigation: named partner interfaces, shared escalation routes, daily/weekly flow monitoring and monthly UCFIB review.                                                                                                                                                |                                     |         |                                        |       |                                                 |
| What is the impact on people and adults?                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                  | Faster assessment, admission avoidance, earlier supported discharge and protected urgent pathways. Older and frail people, people with long-term conditions, learning disability or clinical vulnerability may benefit most. Residual risk remains if access, discharge support, transport, housing or carer capacity is unequal.                                                                                                                                                 |                                     |         |                                        |       |                                                 |
| What is the impact on patients?                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                  | Expected benefits are shorter waits, earlier senior review, reduced avoidable admission and delay, and better protection of dignity. Residual adverse risk arises from crowding, infection, high occupancy, estate disruption, elective reprioritisation and temporary escalation-space use.                                                                                                                                                                                      |                                     |         |                                        |       |                                                 |
| What is the impact on preventable harm?                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                  | The plan targets preventable harm from delayed assessment, prolonged length of stay, deconditioning, infection, discharge delay and unsafe non-designated care. Controls include same-day pathways, frailty cover, Red-to-Green/14- and 21-day review, dynamic risk assessment and immediate escalation of corridor-care incidents.                                                                                                                                               |                                     |         |                                        |       |                                                 |
| Will it affect the reliability of safety systems?                                                                                                                                                                                                                                                                                                          |                                                                                                                                                  | Safety systems should be strengthened through one escalation policy, site huddles, tactical and executive oversight, the Incident Control Centre, documented dynamic risk assessment, dashboards and governance review. Residual risk remains until final command arrangements, testing and named ownership are confirmed.                                                                                                                                                        |                                     |         |                                        |       |                                                 |
| How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?                                                                                                                                                                                                                          |                                                                                                                                                  | Positive IPC controls include DIPC-led governance, daily surveillance, outbreak processes, isolation/cohorting support, weekend IPC cover, testing readiness, vaccination and IPC review of pathway/bed changes. Residual infection and capacity risk remains from influenza, RSV, norovirus and COVID-19.                                                                                                                                                                        |                                     |         |                                        |       |                                                 |
| What is the impact on clinical workforce capability care and skills?                                                                                                                                                                                                                                                                                       |                                                                                                                                                  | The plan requires enhanced senior decision makers, frailty, paediatric, therapy, pharmacy, diagnostic and operational cover; minimum staffing agreements; redeployment triggers; and HealthRoster/sickness oversight. Benefits depend on adequate competence, induction and supervision during redeployment.                                                                                                                                                                      |                                     |         |                                        |       |                                                 |
| Clinical Effectiveness *                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| What is the impact on implementation of evidence based practice?                                                                                                                                                                                                                                                                                           |                                                                                                                                                  | The plan uses demand/capacity modelling, seasonal infection intelligence, same-day emergency care, frailty and specialty assessment pathways. Mitigation action: confirm criteria, operating models, staffing, escalation rules and scenario testing before winter, and review outcomes through UCFIB/QPC.                                                                                                                                                                        |                                     |         |                                        |       |                                                 |
| What is the impact on clinical leadership?                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                  | Clinical leadership is strengthened through senior decision-maker presence, ward leadership, divisional escalation, tactical review and executive command. Residual risk: roles and ownership must be explicit for weekends, bank holidays, surge periods and cross-divisional decisions.                                                                                                                                                                                         |                                     |         |                                        |       |                                                 |
| Does it reduce or have a negative impact on variations in care provision?                                                                                                                                                                                                                                                                                  |                                                                                                                                                  | Potential to reduce unwarranted variation through standardised streaming, Internal Professional Standards, Clinical Vision of Flow, board rounds and common escalation rules. Equality action: audit access, waits, discharge and outcomes by protected characteristic, deprivation and service/site.                                                                                                                                                                             |                                     |         |                                        |       |                                                 |
| Does it affect supporting staff to stay well?                                                                                                                                                                                                                                                                                                              |                                                                                                                                                  | Sustained winter pressure may adversely affect fatigue, sickness, morale and retention. Controls include prospective leave review, sickness management, safe minimum staffing, vaccination including roving access, visible wellbeing support, temporary staffing controls and escalation where cover is unsafe.                                                                                                                                                                  |                                     |         |                                        |       |                                                 |
| Does it promote self care for people with long term conditions?                                                                                                                                                                                                                                                                                            |                                                                                                                                                  | Virtual wards, Hospital at Home and early discharge can support self-management for long-term conditions. Mitigation: individual clinical suitability, informed choice, accessible education, carer assessment, equipment/monitoring support, reasonable adjustments and a non-digital/inpatient alternative where home care is unsafe.                                                                                                                                           |                                     |         |                                        |       |                                                 |
| Is the clinical effectiveness affected on where the care is provided (setting)?                                                                                                                                                                                                                                                                            |                                                                                                                                                  | More care will be delivered through same-day units, specialty assessment, virtual wards and home-based alternatives. Benefits depend on safe criteria, step-up/step-down support and accessible pathways. No patient should be disadvantaged by disability, digital exclusion, language, housing, transport or lack of unpaid care.                                                                                                                                               |                                     |         |                                        |       |                                                 |
| Does it eliminate inefficiency and waste by design?                                                                                                                                                                                                                                                                                                        |                                                                                                                                                  | The plan aims to remove avoidable admission, repeated waits and discharge delay through streaming, same day pathways, Discharge Lounge use, virtual wards, morning discharge, Care Transfer Hub and ward-flow standards. Monitor for unintended duplication, failed discharge and reattendance.                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| Does it lead to improvements in care pathways?                                                                                                                                                                                                                                                                                                             |                                                                                                                                                  | Expected improvement through UTC, SDEC, frailty, paediatric, surgical, urology, gynaecology, trauma, discharge and virtual-ward pathways. Mitigation: confirmed ownership, criteria, staffing, escalation, diagnostics/pharmacy/therapy support and protection of cancer and time-critical care.                                                                                                                                                                                  |                                     |         |                                        |       |                                                 |
| Patient Experience *                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| What is the impact on race, gender, age, disability, sexual orientation, religion and belief for individual and community health access to services and experience?                                                                                                                                                                                        |                                                                                                                                                  | Likely positive impact for older/frail people, disabled people, pregnant patients, children and clinically vulnerable groups through targeted pathways and vaccination. Potential adverse inequality from long waits, reprioritisation, inaccessible communication, digital exclusion, transport, housing or carer needs. Require reasonable adjustments, interpretation, accessible information, non-digital options and monitoring by protected characteristic and deprivation. |                                     |         |                                        |       |                                                 |
| What is the likely impact on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/Incidents).                                                                                                                                                                                                       |                                                                                                                                                  | Likely improvement from shorter waits, earlier decisions, protected dignity and reduced delay. Experience may worsen during crowding, temporary escalation-space use, elective deferral or poorly supported discharge. Monitor patient experience, complaints, PALS, incidents, dignity/privacy themes and feedback by patient group.                                                                                                                                             |                                     |         |                                        |       |                                                 |
| How will it impact patient choice?                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                  | Choice may increase through same-day, specialty, virtual-ward and home-based options, but must remain clinically appropriate and genuinely informed. Mitigation: explain alternatives and risks in accessible formats, record consent and preferences, involve carers/advocates where appropriate and retain hospital/non-digital options.                                                                                                                                        |                                     |         |                                        |       |                                                 |
| How will it impact on compassionate and personalised care?                                                                                                                                                                                                                                                                                                 |                                                                                                                                                  | The plan explicitly prioritises safety and dignity and prohibits normalising corridor care. Compassionate personalised care requires individual risk assessment, privacy, communication needs, cultural/religious needs, disability adjustments, carer involvement and safe discharge planning even during surge.                                                                                                                                                                 |                                     |         |                                        |       |                                                 |
| Stage 1 Equality Initial Impact Assessment                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| Answer positive, neutral or adverse (P/N/A) against each area. If Adverse score the impact, likelihood and total in the appropriate box. Note if score is 8 or above (i.e. Divisional or Trust Risk) on any 'Area of Quality' below the 'Stage 2 QIA' tab will need to be completed.                                                                       |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        |       |                                                 |
| Area of Quality                                                                                                                                                                                                                                                                                                                                            | Details (include mitigation)                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | P/N/A                               | Impact* | Likely-hood*                           | Score | Full Assessment?                                |
| Patient Safety                                                                                                                                                                                                                                                                                                                                             | Potential for serious harm from crowding, delayed assessment/discharge, infection and unsafe escalation space. Controls are detailed in Stage 2. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Adverse                             | 4       | 4                                      | 16    | Yes – Stage 2 completed                         |
| Clinical Effectiveness                                                                                                                                                                                                                                                                                                                                     | Potential disruption to evidence-based, timely care and urgent/elective pathways during surge. Controls are detailed in Stage 2.                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Adverse                             | 4       | 4                                      | 16    | Yes – Stage 2 completed                         |
| Patient Experience                                                                                                                                                                                                                                                                                                                                         | Potential impact on waits, dignity, privacy, choice and equitable access; equality safeguards and monitoring are detailed in Stage 2.            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Adverse                             | 3       | 4                                      | 12    | Yes – Stage 2 completed                         |
| Overall Risk Score (highest from above quality domains)                                                                                                                                                                                                                                                                                                    |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     |         |                                        | 16    | Do a stage 2 QIA if overall score is 8 or above |
| Stage 1 Review Date:                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                  | 21 aug 2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Completed by:                       |         | David Taylor (Interim DCOO UEC & FLOW) |       |                                                 |

| Equality Impact Initial Assessment Stage 2                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Workstream name                                                             |                                                                                                                                                                                                                                                 | GHFT Trust-wide Winter Plan 2026/27                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                  |                     |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------|
| Division                                                                                                                                                                             | Trust-wide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Divisional Tri / Quad Lead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Al Sheward, Chief Operating Officer                                         |                                                                                                                                                                                                                                                 | Initial Application or Resubmission                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                  | Initial application |                       |
| Service                                                                                                                                                                              | All divisions, services and corporate areas                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Clinical Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Trust-wide clinical leadership through TLT, UCFIB and divisional governance |                                                                                                                                                                                                                                                 | Date                                                                                                                                                                                                                                                                                                                                                                                      | 21 aug 2026                                                                                                                                                                                                                                                                                                                                                                      | QIA ID No.          | TBC through QIA group |
| <b>Scheme Overview</b><br><br><i>Embed proposal (PID) form or link to FSP workbook</i>                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | GHFT Winter Plan 2026/27 for November 2026 to April 2027. The plan combines urgent and emergency flow, same-day and specialty assessment, frailty, discharge improvement, virtual wards/hospital at Home, workforce resilience, infection prevention, estate readiness, elective/cancer protection, predictive modelling, escalation command and Board assurance. Routine corridor care is not acceptable; any temporary escalation space must be exceptional, clinically risk assessed, time limited, executive authorised and governed. |                                                                             | <b>Did this scheme involve clinical engagement?</b><br><br><b>Please describe the clinical engagement undertaken to develop this scheme. If this Scheme did not involve clinical engagement, please provide a reason why this was the case.</b> |                                                                                                                                                                                                                                                                                                                                                                                           | <b>The source plan records development and assurance of the scheme, shared the plan, Winter Task and Finish Group, DOAG, UCFIB divisional schemes and system interfaces. Full implementation: document patient/public, staff safeguarding, carers and partner feedback, I</b>                                                                                                    |                     |                       |
| Will this Scheme potentially impact another service within or outside your Division or Corporate area. If this is a Corporate Scheme, will there be an impact on clinical Divisions? |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Name of the service(s) and Division(s) potentially impacted</b>          | All clinical divisions; GMS; Care Transfer Hub; Gloucestershire Provider Partnership; out-of-hospital and wider system partners                                                                                                                 | <b>Impact detail and mitigation</b>                                                                                                                                                                                                                                                                                                                                                       | Impacts include changes to admission avoidance, specialty streaming, discharge, virtual ward deployment, elective prioritisation, infection response and estate use. Mitigation: named ir owners, shared escalation thresholds, daily operational coordination, system capacity over led/time-limited decisions, and monthly UCFIB/QPC review with Board escalation by executive |                     |                       |
| Clinical Risk Assessment                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  |                     |                       |
| Inherent Risks (Before Mitigation)                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                           | Residual Risk (After Mitigation)                                                                                                                                                                                                                                                                                                                                                 |                     |                       |
| Clinical impact (assessment)                                                                                                                                                         | Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Consequence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Likelihood                                                                  | Impact Score                                                                                                                                                                                                                                    | Mitigation                                                                                                                                                                                                                                                                                                                                                                                | Consequence                                                                                                                                                                                                                                                                                                                                                                      | Likelihood          |                       |
| <b>Patient Safety (Impact)</b><br>(e.g. SUIs, Medication Errors, Falls and Trips, Death etc)                                                                                         | Inherent risk of serious harm from front-door crowding, ambulance delays, prolonged waits, high occupancy, delayed discharge, infection-related closures, estate disruption and unsafe care in non-designated spaces. Frail, disabled and clinically vulnerable patients may be disproportionately affected.                                                                                                                                                                                            | 4 - Major                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 - Likely                                                                  | 16                                                                                                                                                                                                                                              | SDEC and specialty assessment; enhanced senior decision makers; 12-hour frailty cover; Discharge Lounge and DRD reduction; virtual wards/hospital at Home; predictive demand/capacity tools; IPC surveillance/cohorting; minimum staffing; one escalation policy; dynamic risk assessments; executive authorisation and immediate reporting for any temporary escalation space; equality  | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 3 - Possible        |                       |
| <b>Clinical Effectiveness (Impact)</b><br>(e.g. Readmission Rates, Mortality Rates etc)                                                                                              | Winter pressure may delay evidence-based assessment, diagnostics, treatment and discharge; disrupt urgent elective/cancer pathways; increase length of stay, readmission or deterioration; and create variation across sites, specialties or patient groups.                                                                                                                                                                                                                                            | 4 - Major                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 - Likely                                                                  | 16                                                                                                                                                                                                                                              | Clinical Vision of Flow, board rounds and Internal Professional Standards; protected assessment capacity; confirmed pathway criteria/ownership; diagnostics, pharmacy and therapy escalation; Red-to-Green and 14/21-day reviews; clinically led, time-limited elective changes with cancer/urgent/time-critical protection; scenario testing and weekly outcome monitoring.              | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 3 - Possible        |                       |
| <b>Patient experience</b>                                                                                                                                                            | Crowding and delay may impair dignity, privacy, communication, compassionate care, choice and confidence. Home-based pathways or reprioritisation may disadvantage people with disability, limited English, digital exclusion, poor housing, transport barriers or insufficient carer support.                                                                                                                                                                                                          | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4 - Likely                                                                  | 12                                                                                                                                                                                                                                              | No normalisation of corridor care; patient-level clinical risk assessment; accessible information and interpretation; reasonable adjustments; informed choice and non-digital/inpatient alternatives; carer/advocate involvement; safe discharge criteria; monitor experience, complaints, PALS, incidents and dignity themes by protected characteristic, deprivation, service and site. | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 2 - Unlikely        |                       |
| <b>Workforce</b><br>(e.g Vacancies, turnover, staff morale)                                                                                                                          | Fatigue, sickness, vacancies, rota fragility, leave gaps, redeployment and reliance on temporary staff may reduce safe cover, capability, morale and retention, especially at weekends, bank holidays and peak periods.                                                                                                                                                                                                                                                                                 | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4 - Likely                                                                  | 12                                                                                                                                                                                                                                              | Prospective leave and rota review; minimum staffing agreements; sickness and HealthRoster monitoring; senior decision-maker and operational cover; temporary staffing controls; competency-based redeployment with induction/supervision; vaccination with roving access; visible wellbeing support; escalation where staffing compromises safety or core services.                       | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 2 - Unlikely        |                       |
| Non-clinical or other impact (Assessment)                                                                                                                                            | Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Consequence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Likelihood                                                                  | Impact Score                                                                                                                                                                                                                                    | Mitigation                                                                                                                                                                                                                                                                                                                                                                                | Consequence                                                                                                                                                                                                                                                                                                                                                                      | Likelihood          |                       |
| <b>Contract or Performance</b><br>(e.g Delivering KPIs, contract retention, impact on other contracts)                                                                               | Failure to deliver flow, ambulance handover, four-/twelve-hour, discharge, elective recovery, cancer, infection, workforce and occupancy objectives could affect contractual and regulatory performance and increase cost.                                                                                                                                                                                                                                                                              | 4 - Major                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 - Likely                                                                  | 16                                                                                                                                                                                                                                              | Winter modelling; daily/weekly dashboard; protected urgent, cancer and time-critical pathways; controlled elective flexibility; action-led delivery plans with owners, dates, benefits and triggers; daily operational review, monthly UCFIB/QPC assurance and Board escalation when actions are off track or tolerance is exceeded.                                                      | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 2 - Unlikely        |                       |
| <b>Reputational Risks</b>                                                                                                                                                            | Visible corridor care, prolonged waits, cancelled activity, inequitable access, infection outbreaks or poor discharge could damage public, staff, partner and regulator confidence.                                                                                                                                                                                                                                                                                                                     | 4 - Major                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3 - Possible                                                                | 12                                                                                                                                                                                                                                              | Clear organisational position on dignity and corridor care; transparent incident and harm reporting; clinically led/time-limited escalation; complaints and patient-experience surveillance; executive command; measurable actions and governance reporting; prompt communication with patients, staff, partners and Board when services change.                                          | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 2 - Unlikely        |                       |
| <b>Risks to Partner organisations (including shared care) and Stakeholder Relationships</b>                                                                                          | Discharge and admission-avoidance plans depend on partner and out-of-hospital capacity. Weak interfaces may cause delayed transfer, readmission, unsafe handover, duplicated work or unequal access across Gloucestershire.                                                                                                                                                                                                                                                                             | 4 - Major                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3 - Possible                                                                | 12                                                                                                                                                                                                                                              | Care Transfer Hub; Gloucestershire Provider Partnership DRD work; virtual wards/hospital at Home with step-up/step-down criteria; shared escalation and named owners; daily/weekly flow and delay review, partner involvement in vaccination and population-health response; system, regional and national IPC touchpoints.                                                               | 3 - Moderate                                                                                                                                                                                                                                                                                                                                                                     | 2 - Unlikely        |                       |
| Overall Quality Impact Score (Before Mitigation)                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             | 96                                                                                                                                                                                                                                              | Overall Quality Impact Score (After Mitigation)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  |                     |                       |
| Quality Indicators                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  |                     |                       |
| <b>Quality Indicators identified</b><br>(Waiting times, Patient satisfaction levels, SIs, Complaints, LOS)                                                                           | Ambulance handover average and >30/>45 minutes; four-hour performance and twelve-hour waits; majors occupancy and time to treatment; bed occupancy, escalation beds and IPC closures; discharges before midday, DRD patients/delay bed days and LOS >7/14/21 days; SDEC/specialty utilisation and conversion; virtual-ward occupancy and step-up/down; sickness, vacancies and temporary staffing; corridor-care/temporary-space incidents; harm, complaints, PALS, experience and equality breakdowns. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             | <b>Baseline data</b><br>(Specify the measures and actual data which will be used to monitor impact for example current waiting list is 10 patients)                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                           | The Board plan defines the measures and reporting frequency / provide numeric baseline values. Baselines must be populated dashboard/current operational performance before November 2 segmented where possible by protected characteristic, deprived service. Previous frontline staff influenza vaccination uptake: 61 to exceed this.                                         |                     |                       |
| <b>Tolerance levels accepted</b><br>(Specify the level which if exceeded will trigger an escalation)                                                                                 | Immediate escalation for any corridor-care incident or temporary escalation-space use; ambulance handovers breaching 30/45-minute measures; any patient-harm or dignity theme requiring action; staffing below safe minimum; infection-related capacity loss; urgent/cancer/time-critical pathway compromise; or any dashboard/action outside its agreed local tolerance. Equality trigger: material disparity or worsening trend between patient groups.                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                             | <b>Monitoring and agreed reporting process</b><br>(Where will the impact be monitored? How will it be escalated?)                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                           | Daily operational meetings and site huddles; daily/weekly write immediate executive escalation for safety/dignity events; weekly day, discharge, virtual-ward and workforce measures; monthly review of delivery, risk and impact; DOAG/TLT/QPC/Board escalation where actions are off track, tolerances are exceeded decisions are required.                                    |                     |                       |

|                                                                                                        |
|--------------------------------------------------------------------------------------------------------|
|                                                                                                        |
|                                                                                                        |
|                                                                                                        |
| governance                                                                                             |
| Yes                                                                                                    |
|                                                                                                        |
| urance through the<br>B and TLT, with<br>rther action before<br>aff-side, equality,<br>, including how |
| wards, workforce<br>interfaces and<br>ersight, clinically<br>eption.                                   |
|                                                                                                        |
|                                                                                                        |
| Impact Score                                                                                           |
| 9                                                                                                      |
| 9                                                                                                      |
| 6                                                                                                      |
| 6                                                                                                      |
| Impact Score                                                                                           |
| 6                                                                                                      |
| 6                                                                                                      |
| 6                                                                                                      |
| 48                                                                                                     |
|                                                                                                        |
| / but does not<br>f from the live winter<br>2026 and<br>ation, site and<br>37%; 2026/27 aim is         |
| er dashboard;<br>dy review of same-<br>/ UCFIB and QPC<br>calation by<br>d or executive                |

| Possible EQIA Quality Indicators  |                                          |                                            |
|-----------------------------------|------------------------------------------|--------------------------------------------|
| % Agency Cost                     | Emergency Activity                       | Number of Staff                            |
| 28 Day Breaches                   | Emergency Admissions                     | Outliers                                   |
| 31 Days                           | Emergency Readmissions                   | Outpatient Activity                        |
| 4 Hour Waits                      | Falls                                    | Overall Time in Department                 |
| 62 Days                           | Funded Establishment                     | Patient Experience Score                   |
| A&E Activity                      | GP Referrals                             | Pressure Ulcers                            |
| Backlog > 18 weeks                | Leavers                                  | Rate of Surgical Site Infections           |
| Bed Days Lost                     | Left without being seen rate (%)         | RTT                                        |
| Bed Occupancy                     | Length of Stay (Exclude Day Case)        | Run Rate (£000's)                          |
| Births                            | Medication Related Errors                | Sickness Absence Rate                      |
| Cancelled Outpatient Appointments | Midwife/Birth Ratio                      | Staff Turnover                             |
| Cleaning Standards                | Mortality                                | TIA                                        |
| Clostridium Difficile             | MRSA                                     | Time to Initial Assessment                 |
| Compliments                       | MSSA - Single Sex Accommodation Breaches | Total Bookings                             |
| Day Case Rates                    | Net Promoter Score                       | Total Number of Vacant Slots               |
| Day of Surgery Admission          | Never Events                             | Training                                   |
| Daycase Activity                  | New Starters                             | Unplanned Reattendance                     |
| Delayed Transfers of care         | NHSP Nursing                             | Utilisation                                |
| Deliveries                        | No. of Cardiac Arrests                   | Vacancies                                  |
| Direct Admission                  | No. Patients on Inpatient Waiting List   | VTE Risk Assessment                        |
| DNA Rate                          | No. Patients on Outpatient Waiting List  | Weekly Hours of Dedicated Consultant Cover |
| Elective Activity                 | Non Contract Activity                    | WHO Compliance                             |
| Elective Admissions               | Number of Complaints                     |                                            |
| Eligible Staff                    | Number of Surgical Infections            |                                            |

|         |           |                  |
|---------|-----------|------------------|
| Pay     | Corporate | Transformational |
| Non-Pay | GMS       | Transactional    |
| Income  | D&S       |                  |
|         | Medicine  |                  |
|         | Surgery   |                  |
|         | W&C       |                  |
|         | Trustwide |                  |
|         | ICS       |                  |

Please choose from drop-down selection

Technical Accounting (receiving more/spending less for the same: no change to service & no impact on staff/patients)

Change to procedure/process, service provision, workforce, products used etc.

|                               |                   | Likelihood of risk occurring |               |               |             |                     |
|-------------------------------|-------------------|------------------------------|---------------|---------------|-------------|---------------------|
| Score                         |                   | 1<br>Rare                    | 2<br>Unlikely | 3<br>Possible | 4<br>Likely | 5<br>Almost certain |
| Consequence of risk occurring | 5<br>Catastrophic | 5                            | 10            | 15            | 20          | 25                  |
|                               | 4<br>Major        | 4                            | 8             | 12            | 16          | 20                  |
|                               | 3<br>Moderate     | 3                            | 6             | 9             | 12          | 15                  |
|                               | 2<br>Minor        | 2                            | 4             | 6             | 8           | 10                  |
|                               | 1<br>Negligible   | 1                            | 2             | 3             | 4           | 5                   |
|                               | -1<br>Positive    | -1                           | -2            | -3            | -4          | -5                  |



|                                               |                                                                                            |                                               |
|-----------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------|
| Not started                                   | Not started                                                                                | Consequence<br>1 - Negligible                 |
| In draft                                      | In draft                                                                                   | 2 - Minor                                     |
| Awaiting Sign-off<br>Signed-off by SRO / Lead | Awaiting Sign-off<br>Signed-off by SRO / Lead<br>N/A - Stage 1 scores below 8 on all items | 3 - Moderate<br>4 - Major<br>5 - Catastrophic |

## Likelihood

1 - Rare

2 - Unlikely

3 - Possible

4 - Likely

5 - Almost Certain

## Report to Board of Directors/Committee

|                                   |                                                                                                     |
|-----------------------------------|-----------------------------------------------------------------------------------------------------|
| <b>Date of Meeting</b>            | 10 <sup>th</sup> September 2026                                                                     |
| <b>Report title</b>               | Green Plan                                                                                          |
| <b>Sponsoring Director/Author</b> | Will Cleary-Gray – Director of Improvement and Delivery<br>Jen Cleary – Head of Sustainability, GMS |

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

| Executive Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The Gloucestershire Hospitals NHS Foundation Trust Green Plan 2026-2030 sets out the key actions we will take over the next five years to achieve our aims of reaching net zero carbon on our directly controlled emissions by 2040, and on our indirect emissions by 2045. It also details our strategy and approach for embedding sustainability as part of business as usual across all aspects of health and care delivery. Having green sustainability as a golden thread will enable and empower us to deliver our aim of reducing carbon emissions and helping to address climate change, as we recognise that climate change is both an environmental and a health challenge.</p> <p>Rising temperatures, extreme weather events, poor air quality and pressures on infrastructure already affect the health and wellbeing of our patients, staff and communities. This Green Plan recognises that action to reduce carbon emissions must go hand in hand with building resilience, improving population health and ensuring that healthcare services remain safe, effective and sustainable for future generations.</p> <p>Over the five years of our previous Green Plan our direct carbon emissions have decreased by 23% and for 2025-26 were 18,490 tCO<sub>2</sub>e. To be on track to reach net zero by 2040 we need to reduce our carbon to at least 13,694 tCO<sub>2</sub>e by March 2030. To help us towards this interim target a detailed action plan will be developed and will include use of digital services, building resilience into our estate and energy supplies, reducing the impact of travel and transport, reducing waste and introducing adaptation and mitigation strategies. However further actions and funding still need to be identified.</p> |                                                                                                                                                                                                         |
| Previously considered by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Climate Emergency Response Leadership group</li> <li>• Finance and Resource Committee</li> <li>• Finance and Capital Committee</li> <li>• GMS Board</li> </ul> |

## Recommendations:

The board are asked to:

Approve – this Green Plan, accepting the aims, targets and focus on green sustainability over the next five years.

## Strategic Aims (tick as appropriate)

|                                                                                                                         |   |
|-------------------------------------------------------------------------------------------------------------------------|---|
|  <b>Patient experience and voice</b>   |   |
|  <b>People, culture and leadership</b> | X |
|  <b>Quality, safety and delivery</b>   | X |
|  <b>Digital first</b>                 |   |

## Impact on any Strategic Risks?

Links to Corporate Risk 127 *The risk that the Trust does not meet net zero carbon emissions by 2040* and Corporate Risk 130 *The risk that the Trust does not progress actions defined in the Green Plan due to a continued reliance on goodwill and out of hours work from colleagues in order to progress actions at a local level.*

## Implications on:

|                                          |                                                                                                                                                                                                                                                                   |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Equality, Diversity and Inclusion</b> | Green sustainability and reduction of carbon emissions are viewed as the responsibility of all.                                                                                                                                                                   |
| <b>Health Inequalities</b>               | Green Plan and Health Inequalities are linked and addressed within the Green Plan. Some aspects of carbon emission reduction e.g. improvements to air quality from the reduction in transport related emissions, will have positive effects on population health. |
| <b>Finance and Resource</b>              | The need for future funding for projects including infrastructure and capital improvements is noted.                                                                                                                                                              |
| <b>Regulation/Legal</b>                  | All trusts are required to have a Green Plan which sets out how we will meet Net Zero Carbon Emissions by 2040/45.                                                                                                                                                |
| <b>CQC-Key line of enquiry</b>           | The Green Plan is a requirement within the CQC Well-Led domain. This Green Plan will evidence effective leadership, governance and oversight arrangements of green sustainability and carbon emission reduction.                                                  |

|            |                         |
|------------|-------------------------|
| Green Plan | This is the Green Plan. |
|------------|-------------------------|

| Main Report                                                                                                    |                                        |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------|
| As the report long it is attached as an enclosure.                                                             |                                        |
| Enclosures                                                                                                     |                                        |
|                               | 8529 Green Plan 26<br>30 PROOF V.2.pdf |
| FOI: Public. A comms plan is in place for the publication of this Green Plan following approval by this Board. |                                        |

# Green Plan

## 2026–2030

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Gloucestershire  
Hospitals NHS  
Foundation Trust

Gloucestershire  
Managed  
Services

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# Foreword

It is my pleasure to introduce the Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Green Plan 2026-2030.

As healthcare organisations, our purpose is to improve health and wellbeing. Yet we also recognise that climate change is now one of the greatest threats to the health of our communities and to the long-term sustainability of health and care services. Rising temperatures, extreme weather events, poor air quality and increasing pressures on infrastructure are already affecting the lives of our patients, our staff and the populations we serve.

This Green Plan sets out our commitment to addressing these challenges while continuing to deliver high-quality, safe and compassionate care. It describes how we will contribute to the NHS ambition of achieving net zero carbon emissions, while embedding sustainability into every aspect of our organisation, from clinical practice and digital transformation to estates, procurement, workforce development and partnership working. Sustainability is not an additional priority; it is fundamental to delivering better health outcomes, reducing inequalities, improving efficiency and ensuring our services remain resilient now and for future generations.

We are building on strong foundations. Since publishing our first Green Plan, colleagues across the Trust and Gloucestershire Managed Services have delivered significant progress, reducing emissions, investing in low-carbon infrastructure, expanding digital services, improving sustainable procurement and developing innovative models of care. These achievements demonstrate what is possible when sustainability becomes part of everyday decision-making and continuous improvement.

However, the scale of the challenge means there is much more to do. Success will depend on the collective efforts of our staff, patients, volunteers, partners, suppliers and local communities. By working together, we can create a healthcare system that is greener, fairer and more sustainable, while supporting healthier lives and stronger communities across Gloucestershire.

As one of the county's largest employers and public sector organisations, we also recognise our responsibility as an anchor institution. Through the choices we make, the services we provide and the partnerships we build, we have an opportunity to create wider social, economic and environmental value for the people we serve. This Green Plan reflects our commitment to doing so.

Our ambition is clear. By 2030, we will have further embedded sustainability into the culture, leadership and everyday practice of our organisation. We will continue to reduce our environmental impact, strengthen resilience to climate change, support the NHS net zero ambition and improve outcomes for patients and communities.

I would like to thank everyone who has contributed to the development of this plan and all those who will help deliver it over the coming years. Together, we can ensure that our actions remain green, fair and affordable, creating a healthier future for Gloucestershire and for generations to come.



**Will Cleary-Gray**

Director of Improvement  
and Delivery Executive  
Lead for Sustainability



# Introduction

## About us



### Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust delivers high quality acute elective and specialist health care for a population of more than 660,000 people in Gloucestershire and beyond.

Our core acute hospital services are provided from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. We also provide maternity services at Stroud Maternity Hospital, and a range of planned care services, including surgery, from community hospitals around the county.

The Trust is the largest employer in Gloucestershire with over 9,000 colleagues.



### Gloucestershire Managed Services

Gloucestershire Managed Services (GMS) is a wholly owned subsidiary company set up by Gloucestershire Hospitals NHS Foundation Trust on 1st April 2018. GMS provides the estates, facilities, sterile services and materials management services for the Trust. Our capital, energy and sustainability teams have been a key part in the sitewide carbon emission reductions we have achieved to date.



# Introduction

## About us



We have our own Trust charity, Cheltenham and Gloucester Hospitals Charity, which supports patients, families and our staff by fundraising for state-of-the-art equipment, local cancer care, research and mental health and well-being. We also have many other charities and volunteers who make a real difference and help enhance the services and the support we offer.



Together, Gloucestershire Hospitals NHS Foundation Trust works with Gloucestershire Managed Services and Cheltenham and Gloucester Hospitals Charity, who form our hospital group.



# Executive Summary

The Gloucestershire Hospitals NHS Foundation Trust Green Plan 2026-2030 sets out the key actions we will take over the next five years to achieve our aims of reaching net zero carbon emissions directly controlled emissions by 2040, and indirect emissions by 2045. It also details our strategy and approach for embedding sustainability across all aspects of health and care delivery. This will enable us to deliver our aim of reducing carbon emissions and helping to address climate change, recognising that the health of people and the health of the planet are deeply connected.

Climate change is both an environmental and a health challenge. Rising temperatures, extreme weather events, poor air quality and pressures on infrastructure already affect the health and wellbeing of our patients, staff and communities. This Green Plan recognises that action to reduce carbon emissions must go hand in hand with building resilience, improving population health and ensuring that healthcare services remain safe, effective and sustainable for future generations.

The Trust enters this next phase from a strong foundation. Since publication of the previous Green Plan, we have reduced our carbon footprint, delivered significant reductions in anaesthetic gas emissions, secured external funding for major estate decarbonisation projects, expanded digital services, embedded sustainability considerations into procurement processes and strengthened sustainability leadership across the organisation. These achievements demonstrate our commitment to continuous improvement and provide confidence that further progress can be delivered during the lifetime of this plan.

## The Green Plan focuses on practical steps, such as:

- Building sustainability knowledge amongst our staff.
- Embedding sustainability into everyday care.
- Harnessing digital technology to reduce waste and emissions.
- The importance of prevention and community partnerships.
- Reducing our energy consumption and increasing on site renewable generation.

## Key initiatives include:

- Switching to greener medicines.
- Modernising our estate to improve energy efficiency.
- Reviewing clinical pathways and practices to ensure they incorporate green sustainability.
- Supporting active travel.
- Transforming procurement to favour sustainable suppliers.
- Adapting to the changing climate, ensuring that healthcare services remain resilient in the face of extreme weather and other risks.



# Executive Summary

Delivery of the Green Plan will be underpinned by clear governance arrangements, measurable objectives and regular reporting. Annual sustainability objectives, performance indicators and action plans will ensure that progress is monitored, achievements are recognised and areas requiring additional focus are identified and addressed.

The key actions within the document will be supported by an action plan. This will be a working document, monitored by the Climate Emergency Response Leadership group and reported to GMS and GHFT at regular intervals.

This Green Plan will be delivered in alignment with the Trust's Health Inequalities Strategy, recognising that climate change, poor air quality, access to green space, digital exclusion, transport barriers, food environments and the wider determinants of health do not affect all communities equally.

As one of Gloucestershire's largest employers and public sector organisations, the Trust also recognises its responsibility as an anchor institution. Through employment, procurement, partnership working and investment in local communities, we will seek to maximise social value, support local economic resilience and contribute to healthier, fairer and more sustainable communities.

Ultimately, this Green Plan is about embedding sustainability into every aspect of healthcare delivery and decision-making. By working collaboratively across Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Managed Services, our Integrated Care System partners, suppliers and local communities, we will reduce our environmental impact, strengthen organisational resilience, improve health outcomes and create lasting value for the populations we serve. Through this collective effort, we will continue our journey towards net zero while ensuring that our actions remain green, fair and affordable for future generations.

# Strategic Alignment

## GHNHSFT Strategy

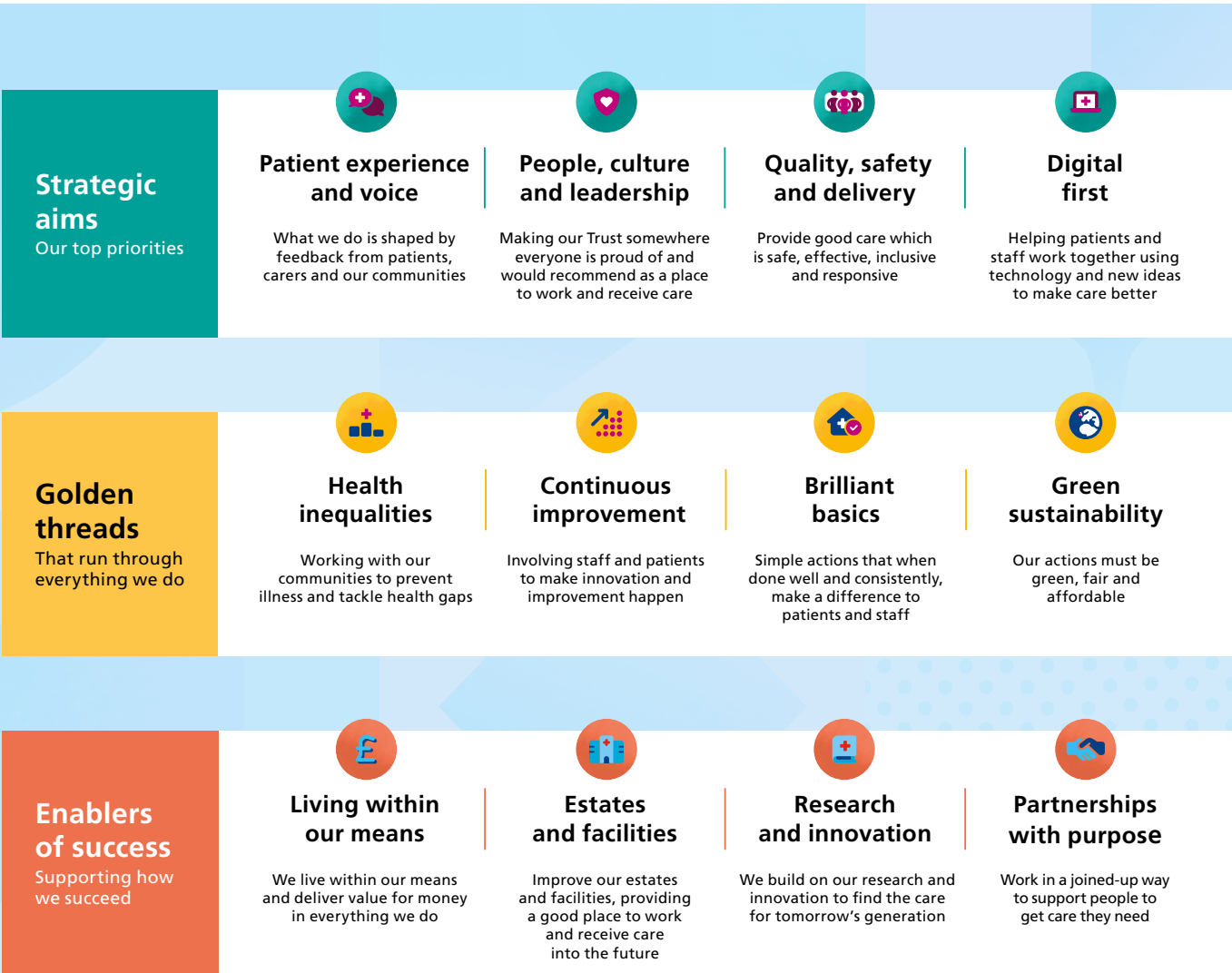
Our vision

To deliver the best care every day for everyone

Our values

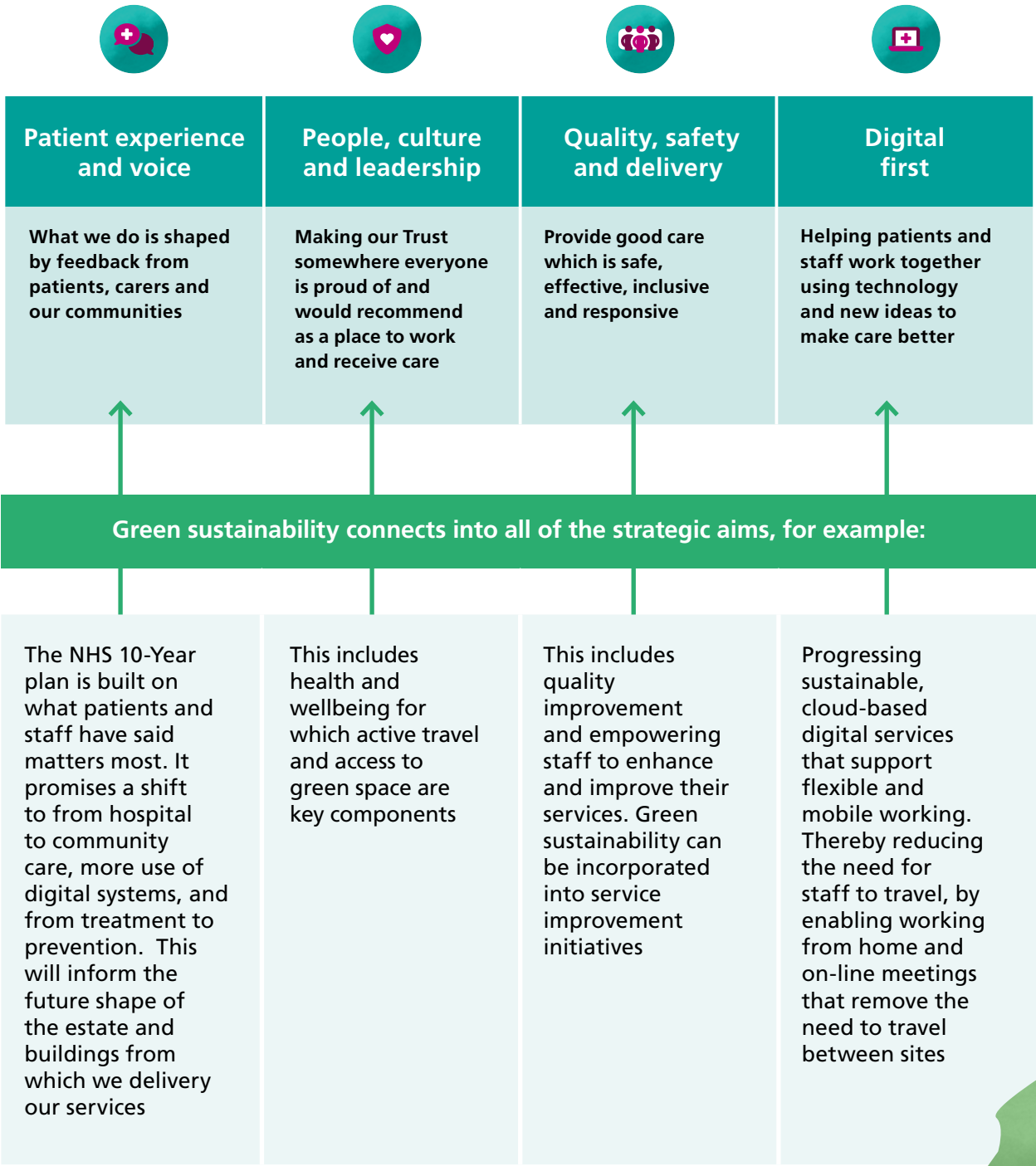
we are **caring**  
we are **compassionate**

we are **inclusive**  
we are **accountable**



# Strategic Alignment

## GHNHSFT Strategy





# Green Sustainability as Golden Thread

The Golden Threads of Health Inequalities, Continuous Improvement and Brilliant Basics will all have an impact on sustainability, **but of particular note is Green Sustainability and the commitment that ‘our actions must be green, fair and affordable’.**

Having Green Sustainability as a Golden Thread will ensure that this influences every strategic aim and operational decision. The approach goes beyond environmental considerations, by encompassing social value, economic resilience, and health equity to ensure long-term benefits for patients, staff, and communities. This golden thread 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 (and hopefully funding) to reduce carbon emissions and meet the agreed target of net zero carbon by 2040.

## Golden threads

run through everything 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 actions must be green, fair and affordable*



# Alignment with the Health Inequalities Strategy

The Green Plan supports the Trust’s Health Inequalities Strategy by ensuring that sustainability decisions are assessed for their impact on inclusion, access and outcomes. Climate change and environmental harm disproportionately affect communities already experiencing poorer health outcomes, including people living in deprivation, people with long-term conditions, disabled people, ethnic minority communities, older people, children and those with limited access to transport, digital tools or green space. By aligning both strategies, the Trust will ensure that green transformation contributes to fairer access, improved prevention, healthier environments and reduced avoidable differences in outcomes.

| Green Plan area         | Health inequalities link                                                                                                                              |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| Digital transformation  | Ensure digital-first pathways do not widen exclusion for people with low digital confidence, language barriers, disability or limited internet access |
| Travel and transport    | Consider patients, staff and carers who rely on public transport, have mobility needs, or live in rural/deprived areas                                |
| Medicines               | Ensure greener prescribing supports shared decision-making and does not reduce patient choice or worsen asthma/COPD outcomes                          |
| Food and nutrition      | Align sustainable food with affordable, culturally appropriate, nutritious choices                                                                    |
| Estates and green space | Prioritise access to green space and climate-resilient environments for patients, staff and communities most affected by poor health                  |
| Procurement             | Use social value to support local employment, VCSE partners, ethical supply chains and community benefit                                              |
| Adaptation              | Identify population groups most vulnerable to heat, poor air quality, flooding and service disruption                                                 |



# Alignment with the Health Inequalities Strategy

As an anchor institution, GHFT recognises that its decisions as a major employer, purchaser, estate holder, service provider and system partner have a significant impact on the social, economic and environmental wellbeing of local communities. This Green Plan supports the Trust's anchor role by using sustainability action to create wider public value, including local employment and skills, social value through procurement, ethical supply chains, improved access to green space, healthier travel options, climate resilience, community wellbeing and reduced health inequalities. By aligning the Green Plan with anchor institution principles, the Trust will ensure that action on carbon reduction also contributes to fairer, healthier and more resilient communities across Gloucestershire.

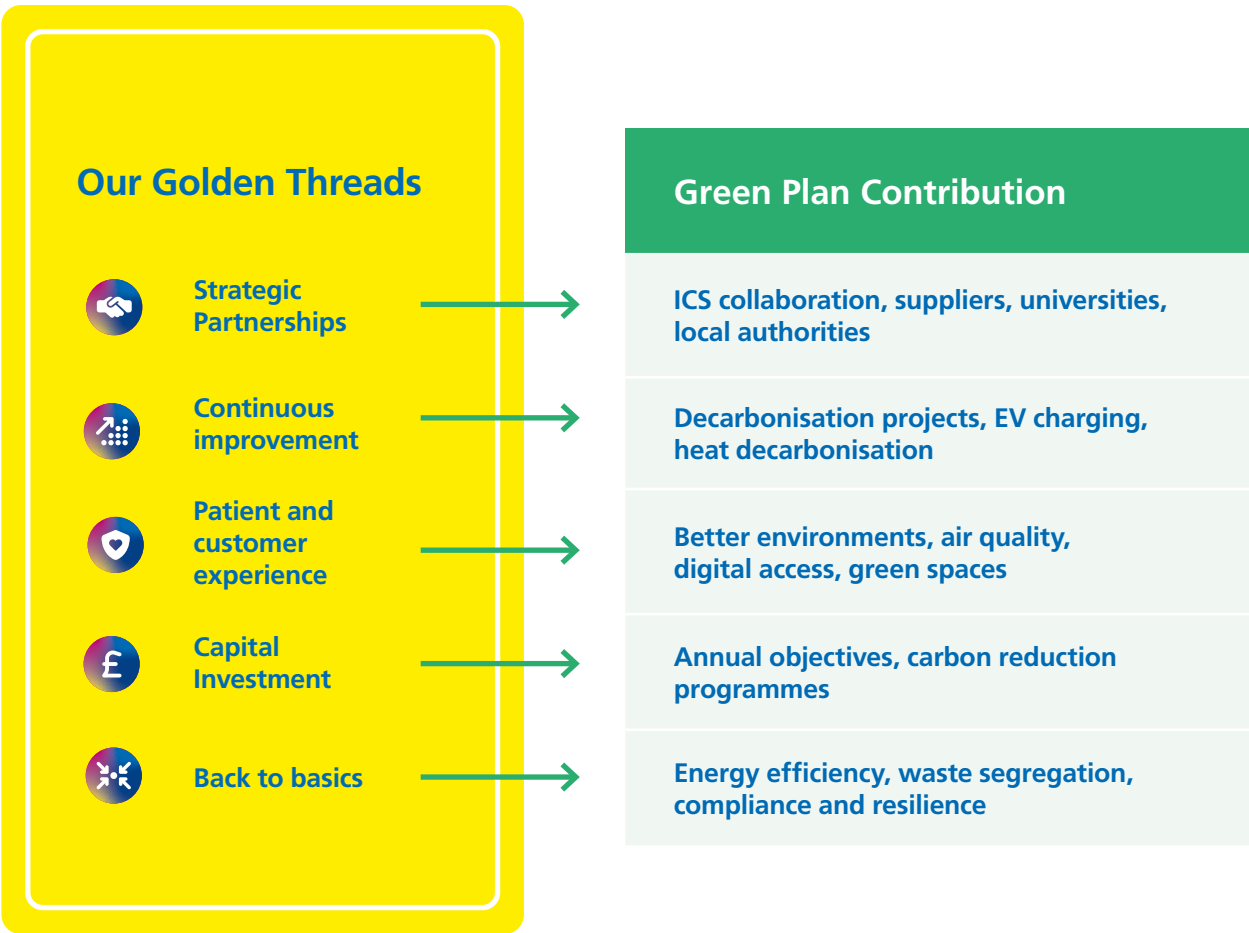
# Strategic Alignment

## GMS Strategy



# Strategic Alignment

## The GMS golden thread’s link through the Green Plan.



Capital investment is a fundamental enabler to reducing carbon emissions. Building and infrastructure projects must include adaptation and mitigation measures against climate change and the NHS Net Zero Building Standard (2023) will be used to support the development of sustainable, resilient and energy efficient buildings. Continuous improvement methodologies, using quality improvement approaches, data-driven decision making and staff-led innovation will deliver sustainable improvements.

The GMS strategic pillar of Compliance and Quality is reflected in the development of the environmental management system ISO 14001. Whilst this is initially being developed to cover the back-up generators, it will be expanded to cover all GMS areas. It will identify the environmental impact of GMS services and inform measures that can remove, reduce or mitigate that impact. GMS will audit their services for sustainable, carbon reduction opportunities that will have a positive impact on this Green Plan.

# Progress to Date

## Carbon Targets

The Trust is aligned to the national NHS Net Zero targets:

Net Zero Carbon by 2040 for our NHS Carbon Footprint, with an ambition to reach an

**80%** 

**REDUCTION**

by 2028 to 2032

Net Zero Carbon by 2045 for our NHS Carbon Footprint Plus, with an ambition to reach an

**80%** 

**REDUCTION**

by 2036 to 2039

## Carbon Footprint

In 2025/2026, the Trust’s total carbon footprint was 18,490 tCO<sub>2</sub>e. This is for energy, water, waste, anaesthetic gas, fleet and business travel. This is a 5.4% decrease from 2024-25. It should be noted that this figure has been calculated locally in line with the Carbon Footprint Reporting Methodology.

In 2025 / 2026

The Trust’s total carbon footprint was

**18,490**  
tCO<sub>2</sub>e

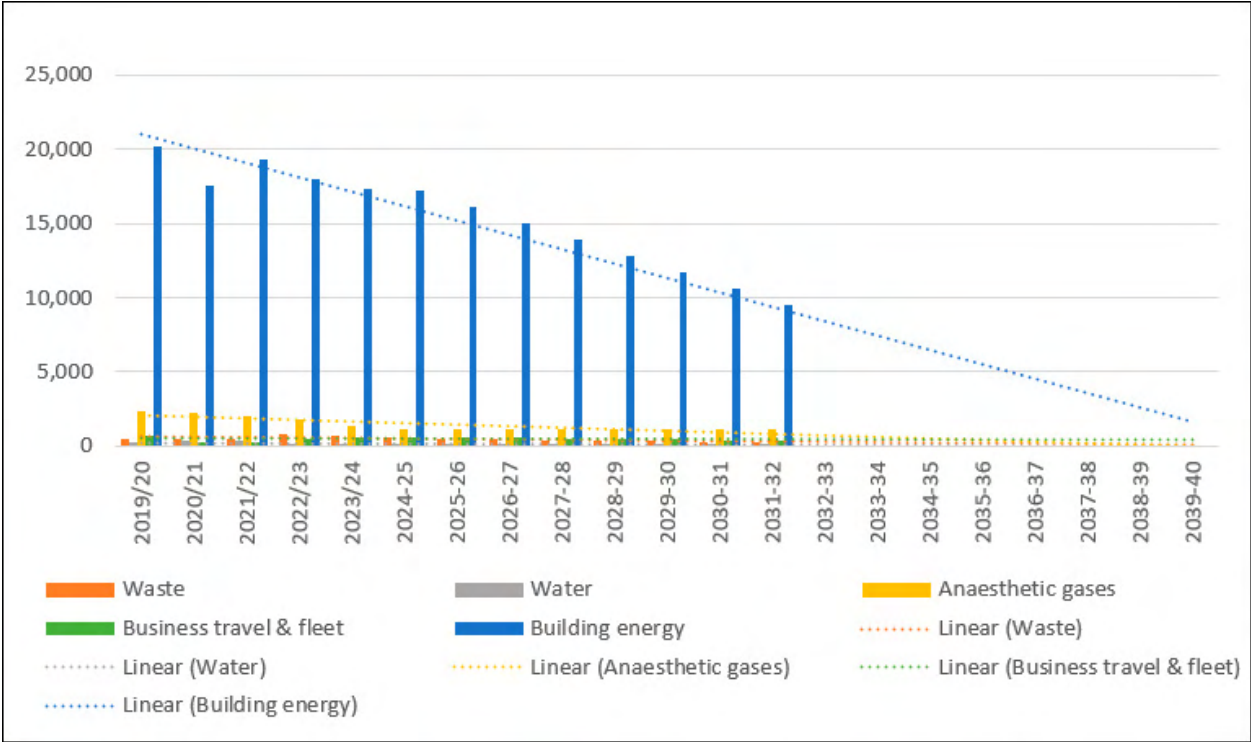


Figure 1: Carbon Footprint tCO2e showing trend to interim target 2032 and net zero 2040 – consumption data 2025-26

## Interim Carbon Footprint Targets

To be on track to reach net zero by 2040, the NHS set an interim target of at least 47% reduction on the 2019-20 baseline by 2031-32. For GHFT this means carbon emissions for building energy, waste, water, anaesthetic gas and business travel and fleet need to be:

| Baseline        | Actual  | Target  |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| 2019-20         | 2025-26 | 2026-27 | 2027-28 | 2028-29 | 2029-30 | 2030-31 | 2031-32 |
| 24,038          | 18,490  | 17,290  | 16,092  | 14,892  | 13,694  | 12,494  | 11,298  |
| All tonnes CO2e |         |         |         |         |         |         |         |

Many of the actions described within this plan will help progress towards these interim targets, but further actions and funding still need to be identified for GHFT to achieve net zero carbon footprint by 2040.

# Carbon Footprint Plus

The Greener NHS has calculated an estimated carbon footprint for every hospital trust using a baseline of 2019/20. To reach net zero by 2045 on the Carbon Footprint Plus (emissions we influence) trusts must reduce their emissions by 73% by 2036-38. Much of their data is from expenditure-based estimates, with some data from our annual Estates Return Information Collection and this has all been used to generate an estimate of total carbon emissions. Their data does differ from ours in some areas, but their data is very useful in showing the scale and overall carbon emission reductions that we must achieve.

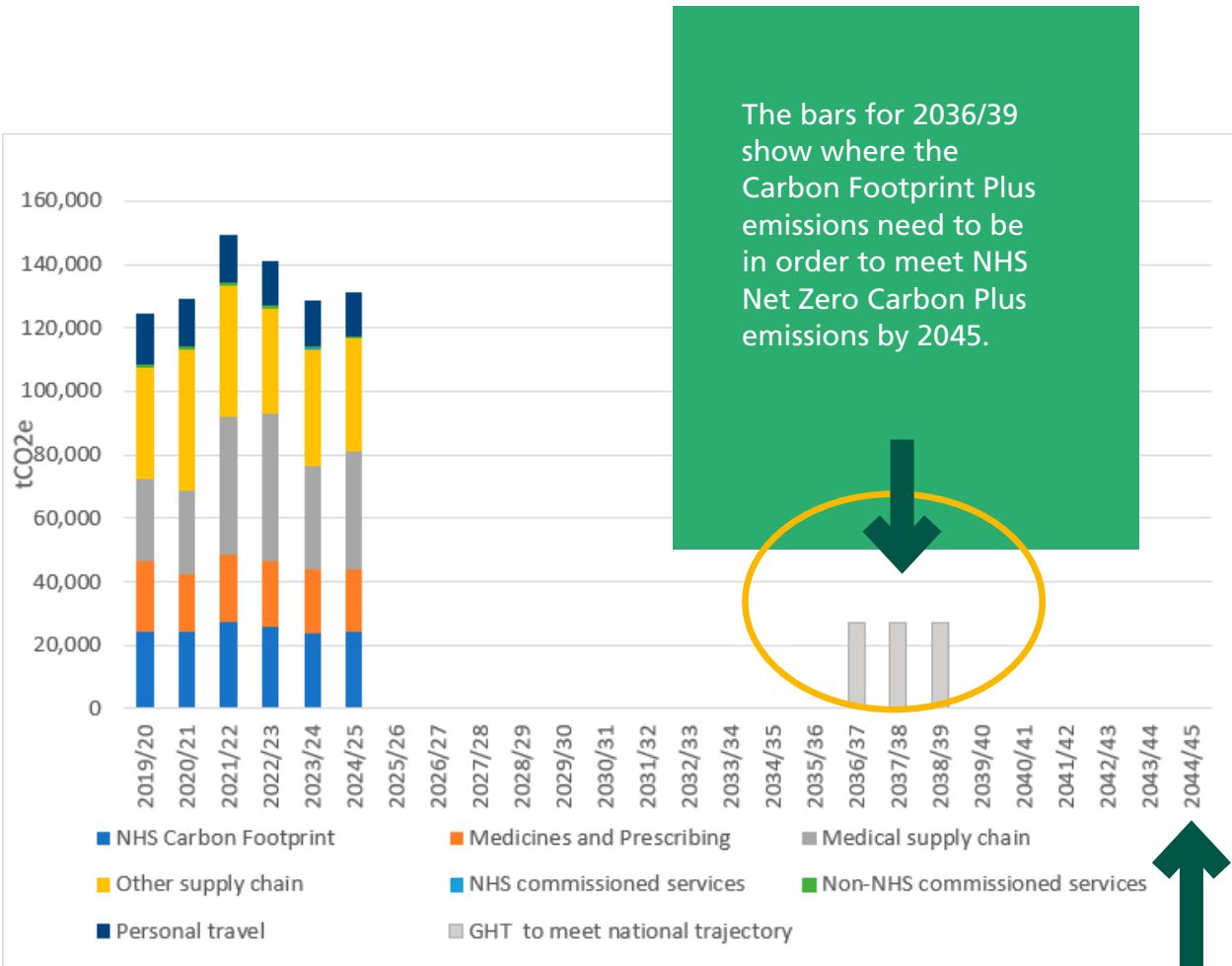


Figure 2: GHFT Carbon Footprint Plus 2019-25 estimated tCO2e (data from Greener NHS Analytics May 2026)

# Building on our Last Green Plan

Since launching our first Green Plan in 2021 we have made meaningful progress in embedding sustainability into our daily operations. We have taken important steps to reduce emissions, improve resource efficiency, engage staff, and build climate resilience across our estate and services. Key highlights are summarised below.

| Area of focus                | Action Taken                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Workforce and Leadership     | We have implemented a network of green champions across the organisation                                                                                                                                                                                                                                                                                                                                                                                                    |
| Clinical Transformation      | A Central Destruction Unit was installed in GRH Birth Unit to capture exhaled Entonox gas from birthing mothers. Entonox has global warming potential 265 times more than CO2 and creates a workforce health risk due to long term and regular exposure. ‘Cracking’ splits Entonox back to nitrogen and oxygen nullifying environmental impacts and reducing workforce risk. This should save 500tCO2e per annum and removes risk to clinical staff from long term exposure |
| Digital Transformation       | Increase in digital systems reducing reliance on paper. From 2021-25 a 22.5% increase in telemedicine. Adoption of the Ecosia search engine. Approved and commenced delivery of Trust Data Centre Migration programme                                                                                                                                                                                                                                                       |
| Medicines                    | We have achieved significant reductions in nitrous oxide and Entonox emissions within GHFT, worked with ICS partners and countywide clinicians to switch patients away from meter-dose inhalers                                                                                                                                                                                                                                                                             |
| Travel and Transport         | From April 2025 to March 2026 there were a total of 254,802 passengers on our shuttle bus, of which 179,309 were NHS staff and the other 75,493 public. The shuttle bus covered 146,851 miles                                                                                                                                                                                                                                                                               |
| Estates and Facilities       | The Trust was successful in bidding for two phases of the Public Sector Decarbonisation Scheme. Combined, both projects should contribute to a 3,105tCO2e reduction in scope 1 and 2 emissions                                                                                                                                                                                                                                                                              |
| Supply Chain and Procurement | All procurements now include a minimum 10% evaluation weighting for net zero and social value weighting in procurements, including defined KPIs                                                                                                                                                                                                                                                                                                                             |
| Food and Nutrition           | Food waste recycling has been implemented for in-patient meals across our sites and in catering retail outlets                                                                                                                                                                                                                                                                                                                                                              |
| Adaptation                   | The Trust has participated in the countywide climate risk and vulnerability assessment. This provides an evidence base to understand the key climate risks, demonstrating their impact, likelihood and overall risk posed by climate change                                                                                                                                                                                                                                 |



## Annual Green Sustainability Improvement Objectives

We have agreed to set two annual improvement objectives for the whole Trust, one strategic and one operational / cross-cutting. These will be managed by the Climate Emergency Response Leadership group, but all areas of the Trust will participate, especially in the operational / cross cutting objective.

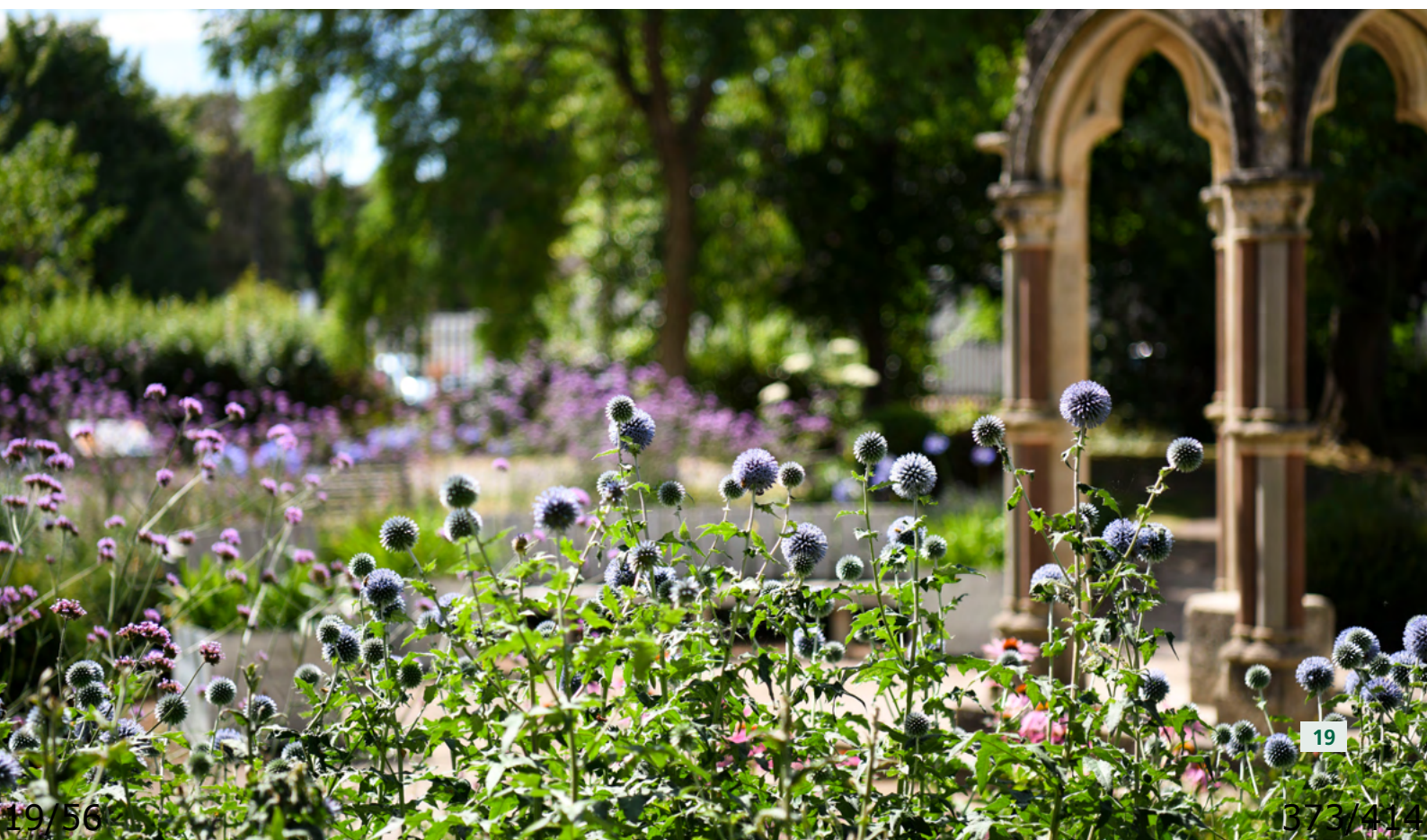
For 2026-27 we will focus on:

### Strategic

Development of electric vehicle charging infrastructure to enable the transition of the fleet to 90% low or zero carbon emission vehicles by 2027/28.

### Operational / cross-cutting:

Paper reduction  
Focusing on reduction in printers  
Postage and paper  
Increasing use of digital channels





# Workforce & Leadership

## Why This Matters

A sustainable healthcare future is reliant on strong leadership and an empowered workforce. We need everyone, from senior leaders to frontline staff, to feel supported and inspired to take sustainability action. Sustainability should be a core consideration across all departments and functions, incorporated into both operational and long-term planning. We aim to encourage and support all staff to improve sustainability in their workplace and provide them with the tools and knowledge to enable them to do this.

As an anchor institution, we can leverage our economic and social influence to support local communities. This includes creating employment opportunities for disadvantaged groups, prioritising local suppliers, and fostering volunteering programs. Sustainability is linked to tackling health inequalities, recognising that environmental and social factors significantly impact population health outcomes

Achievements so far  
(2021-2025)

→

Implemented a network of green champions across the organisation.

→

Carbon foot printing and energy training delivered to staff on the Gold Quality Improvement programme.

→

Climate Emergency Response Leadership group monitors and leads on sustainability.



## Our Aims for the Next 5 Years:

| Action                                                                                                                                                                                                                                         | Measurement                                 | Delivery     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------|
| Strengthen workforce ownership and engagement via communications and use of organisational development methods (e.g. facilitation, networks and communities of practice), reinforcing principle that sustainability is part of everyone’s role | Staff engagement in sustainability activity | 2026 onwards |

| Action                                                                                                                                                                                                                                  | Measurement                                                           | Delivery     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------|
| Embed sustainable ways of working into culture change. Use organisational development interventions to normalise low-carbon, efficient and digital ways of working, linking to wellbeing and health equity                              | Staff engagement in sustainability activity                           | 2026 onwards |
| Use sustainability prompts in culture reviews and service redesign so that sustainability impacts are considered at the outset                                                                                                          | Staff engagement in sustainability activity                           | 2026 onwards |
| Use sustainability prompts in culture reviews and service redesign so that sustainability impacts are considered at the outset                                                                                                          | Implementation of sustainability prompts                              | 2026 onwards |
| Include sustainability in all future job descriptions and annual appraisals to acknowledge that all staff have a part to play in meeting the sustainability and Net Zero goals                                                          | Number of job descriptions and appraisals that include sustainability | 2026 onwards |
| Relaunch Green Champions and Green Council                                                                                                                                                                                              | Number of Green Champions                                             | 2026 onwards |
| Explore and create Trust-wide (including Board level) sustainability training                                                                                                                                                           | % Staff completing training                                           | 2026 onwards |
| Develop staff wellbeing initiatives that link to being in nature, promote social interaction etc. e.g. by volunteering                                                                                                                  | Number of staff participating in initiatives                          | 2026 onwards |
| Install a Greenhouse on site and use as base for associated gardens / green-space social club run by Volunteers; promoting social interaction, being in nature, taking breaks from work, and healthy nutrition. To be funded by charity | Number of participants                                                | 2027 onwards |

# Net Zero Clinical Transformation

## Why This Matters

Disease prevention, healthy lifestyle, care closer to home and digital low carbon care are all priorities identified in the NHS long term plan that will have a positive impact on the planet. All clinical decisions and care delivery should include environmental considerations and waste reduction. Sustainable healthcare models prioritise the health of individuals, communities, and the planet.

By integrating principles of environmental stewardship, social equity, and economic viability, these models aim to create a more resilient and efficient healthcare system. Sustainable models of healthcare are an inherent part of delivering value for health and care systems.

The recently launched Trust Strategy clearly articulates the vision to deliver the best care for everyone. Central to this is a renewed focus on:

- Delivering core services as an acute and specialist hospital provider; and
- Working effectively as a system partner to deliver joined up, integrated care for the people of Gloucestershire.

A fundamental principle underpinning the strategy is the need to get the basics right across all services as an essential foundation for achieving the Trust’s vision.



## Achievements so far (2021-2025)

### Achievements

- A grant from the Trust's sustainability fund provided a gas flow meter to measure CO2 use during colonoscopy. We have demonstrated CO2 emissions are reduced by 87% with judicious CO2 use and adoption of a CO2 valve which helps to reduce passive CO2 waste.
- Central Destruction Unit installed in GRH Birth Unit to capture exhaled Entonox gas from birthing mothers, saving 500 tCO2e per annum.
- NHS NetZero InSites grant awarded for Greenhand – the development of a streamlined, greener carpal tunnel pathway. The project should provide better patient outcomes and an anticipated 80% reduction in CO2e from each surgery. The Trust has agreed to fund the Greenhand pathway as Business as Usual in 2026 and the Research, Innovation and Genomics Team are to begin work on a grant application for Greenhand Community to widen access to and the impact of the Greenhand initiative.
- The Research, Innovation and Genomics team have signed a memorandum of understanding with the University of Gloucestershire for the development of healthcare based AI programmes over the next two years. These should deliver sustainability benefits and carbon reduction.

Our Aims for the Next 5 Years:

| Action                                                                                                                                                                                            | Measurement                                  | Delivery     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------|
| Identify a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance                                                         | Appointment of clinical lead                 | 2026 onwards |
| The Trust has placed a strategic emphasis on planned care, urgent and emergency care, cancer services and maternity care. We will identify carbon reduction opportunities within these areas      | Emissions reduction                          | 2026 onwards |
| Align practices within theatres to the Royal College of Surgeons Green Theatres Checklist                                                                                                         | Completion of checklist                      | 2026 onwards |
| Reduce use of single use items within theatres e.g. with introduction of UV light decontamination units and reusable warmed blankets                                                              | Reduction in number of single use items      | 2026 onwards |
| Consultants and theatre teams to conduct regular review of surgical instrument trays to remove unnecessary items, reduce tray sizes and reduce demand on Sterile Services                         | Number of instruments removed                | 2026 onwards |
| Strengthening the Trust’s role as an anchor institution, aligned to Health and Wellbeing Board and ICB Strategies                                                                                 | Completion of actions on relevant strategies | 2026 onwards |
| Transition to digital-first, clinically prioritised urgent and emergency care, utilising AI to support remote triage and monitoring, ensuring ambulance responses and hospital flow are optimised | Successful introduction of AI support        | By 2030      |

| Action                                                                                                                                                                      | Measurement                                                                        | Delivery     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------|
| Reduce single-use gloves and gown use by 25% by 2030                                                                                                                        | Reduction in number of single use items                                            | By 2030      |
| Continued application for Research and Innovation grants to develop greener models of care e.g. from National Institute of Health and Care Research and NHS NetZero InSites | Number of applications-increase year on year.<br>Number of successful applications | 2026 onwards |
| Embed digital and AI into Research and Innovation projects led by the Research, Innovation and Genomic team                                                                 | Number of new projects opened. Number of publications                              | 2026 onwards |
| Establish a Green Innovation Challenge programme for the development of services and pathways which deliver sustainable benefits and carbon reduction                       | Carbon reduction.<br>Number of publications                                        | 2026 onwards |
| Complete the Green Radiotherapy Framework as championed by the Royal College of Radiologists                                                                                | Award of bronze, silver or gold                                                    | 2026         |

# Digital Transformation

## Why This Matters

Digital transformation plays a crucial role in advancing sustainable healthcare by reducing carbon emissions, improving operational efficiency and supporting high quality patient care. As a key enabler within our Five Year Strategy, digital technology allows us to redesign pathways, improve patient access and experience, and reduce reliance on paper, travel, and energy intensive on site infrastructure. There are opportunities to reduce the travel burden for our patients through the use of digital pathways. Our approach focuses on using digital wisely — prioritising clinical benefit while supporting the NHS Net Zero ambition through reduced emissions, waste and estate impact.

### Achievements so far (2021-2025)

- Reduced paper use across the Trust through the increase in digital systems which reduce reliance on paper.
- In this period there has been a 22.5% increase in the use of telemedicine reducing unnecessary patient and staff travel.
- Approved and commenced delivery of the Trust Data Centre Migration Programme, transitioning from ageing, energy intensive on premises facilities to a modern hybrid cloud hosting model aligned with NHS England's Cloud First strategy and Net Zero commitments. This will significantly reduce power consumption, cooling demand and carbon emissions associated with legacy estate based infrastructure.
- Strengthened digital governance and planning through the Digital Maturity Assessment, enabling sustainability considerations to be embedded into core digital decision making and prioritisation.

Our Aims for the Next 5 Years:

| Action                                                                                                                                                                                                                                                                                                                                                                                                                                    | Measurement                                                                                                                              | Delivery     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| Maximise the benefits of digital transformation to reduce emissions and improve patient care, including reducing paper use and expanding virtual pathways where clinically appropriate                                                                                                                                                                                                                                                    | <div>→ % of outpatient activity delivered via Digital</div> <div>→ Reduction in paper usage year on year</div>                           | 2026 onwards |
| Complete the transition of Trust data centres to a hybrid cloud hosting model, decommissioning legacy on site infrastructure and reducing energy and cooling demand across the estate                                                                                                                                                                                                                                                     | <div>→ Successful migration of in scope systems</div> <div>→ Decommissioning of on premises data centre equipment</div>                  | 2026–2028    |
| <div>Embed sustainability into digital services delivery through the Digital Maturity Assessment, including:</div> <div>→ circular and low carbon IT hardware management (longer device life, refurbishments, power down policies), reviewing recycling arrangements</div> <div>→ data minimisation, deduplication and archiving – reviewing back up policies</div> <div>→ working with suppliers aligned to NHS Net Zero ambitions</div> | <div>→ Number of sustainability actions completed from the assessment</div> <div>→ Reduction in end user device energy consumption</div> | 2026 onwards |
| Increase use of cloud based clinical and corporate systems to reduce reliance on estate bound infrastructure and enable more flexible, resilient working                                                                                                                                                                                                                                                                                  | <div>→ % of systems hosted in cloud or accredited off site environments</div>                                                            | 2026–2031    |



| Action                                                                                                                                                    | Measurement                                                                                                                           | Delivery     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------|
| Expand digital outpatient and remote monitoring pathways where clinically appropriate to reduce repeat hospital attendance                                | <div>→ Reduced avoidable follow up appointments</div> <div>→ Patient travel reductions (proxy measures)</div>                         | 2027 onwards |
| Improve data and information lifecycle management to reduce storage growth, energy use and duplication while maintaining safety and regulatory compliance | <div>→ Volume of archived or retired datasets</div> <div>→ Improved data quality metrics</div> <div>→ Reduction in stored paper</div> | 2026 onwards |
| Ensure future digital procurements explicitly consider whole life carbon impact, hosting model and energy efficiency                                      | <div>→ Sustainability criteria embedded in procurement evaluations</div>                                                              | 2026 onwards |

# Medicines

## Why This Matters

Medicines Optimisation is a vital component in the pursuit of sustainable healthcare systems. It focuses on ensuring that patients receive the most appropriate medications, at the correct doses, and at the right times, thereby maximising therapeutic outcomes and minimising waste. It also aims to ensure patients can access the medicines they need as close to home as possible.

The production and use of medications, inhalers, and anaesthetic drugs contribute significantly to our indirect carbon footprint due to the waste generated from packaging, the manufacturing processes, disposal of unused drugs, and the release of pollutants into the air.

Around 25% of NHS carbon emissions are from medicines. Most of these emissions result from the manufacture, procurement, transport and use of medicines (20%), with the remaining 5% specifically from inhalers (3%) and anaesthetic gases (2%).

Achievements

→ We have achieved significant reductions in nitrous oxide and Entonox emissions within GHFT

| Year    | Nitrous Oxide (tonnes CO2e) | Entonox (tonnes CO2e) | Total CO2e (tonnes CO2e) |
|---------|-----------------------------|-----------------------|--------------------------|
| 2019-20 | ~800                        | ~1400                 | ~2200                    |
| 2020-21 | ~700                        | ~1350                 | ~2050                    |
| 2021-22 | ~550                        | ~1400                 | ~1950                    |
| 2022-23 | ~350                        | ~1400                 | ~1750                    |
| 2023-24 | ~100                        | ~1250                 | ~1350                    |
| 2024-25 | ~50                         | ~850                  | ~900                     |

Figure 3: GHFT Nitrous oxide and Entonox tonnes CO2e

Achievements

→ Working with ICS colleagues, Gloucestershire has made significant reductions in carbon emissions from inhalers. GHFT has been involved in a multi-disciplinary team quality improvement programme, which promotes the use of environmentally sustainable inhaler choices amongst prescribing staff and has made sustainability a key feature of our countywide information leaflets [Asthma inhaler guidelines](#) and [COPD inhaler guidelines](#).

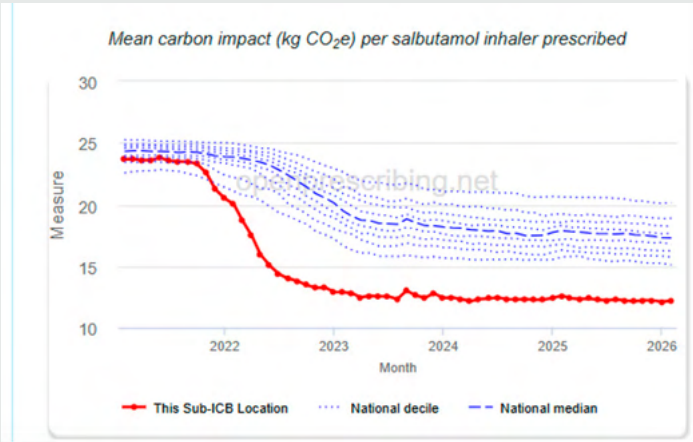


Figure 4: Prescribing of Metered Dose Inhaler (MDI) as a proportion of all inhalers, (excluding salbutamol)

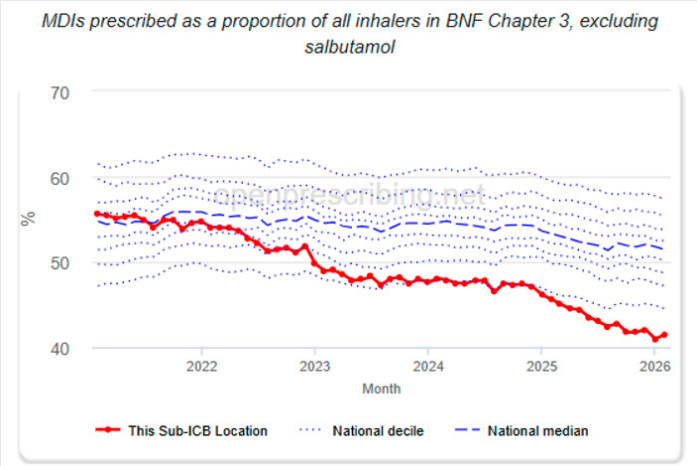


Figure 5: [Non-salbutamol MDI vs DPI prescribing](#) – Gloucestershire

Our Aims for the Next 5 Years:

| Action                                                                                                                                                                                                                                | Measurement                                                                         | Delivery     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------|
| Reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the <a href="#">updated nitrous oxide waste mitigation toolkit</a>                                                         | % reduction in waste                                                                | March 2027   |
| Review use of Entonox across the Trust e.g. in Endoscopy                                                                                                                                                                              | Volume of Entonox                                                                   | March 2028   |
| Reducing over ordering in wards and theatres will mean less waste requiring fewer medicines transported, and stored, resulting in reduction in incineration of expired waste, which will reduce carbon emissions across the lifecycle | Measure items / frequency of orders                                                 | March 2027   |
| Improve medicines reconciliation at admission and discharge, improving use of patients own medication                                                                                                                                 | % MedRec on admission & community pharmacy Discharge Medicines Service at discharge | 2026 onwards |
| Expand pharmacy attendance of ward rounds to prevent duplication and unnecessary prescribing                                                                                                                                          | % pharmacy attendances                                                              | March 2027   |
| Reducing unnecessary IV administration improving IV to-oral switches                                                                                                                                                                  | % IV to Oral                                                                        | March 2027   |
| Switching from MDIs (metered dose inhalers) to DPIs (dry powder inhalers) which are lower Carbon Clinical Alternatives                                                                                                                | % MDI to DPIs                                                                       | March 2027   |

Our Aims for the Next 5 Years:

|                                                                                                            |                                                              |            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------|
| Deprescribing and Optimising High Risk Medicines reducing polypharmacy and preventing avoidable admissions | Measuring items deprescribed & medication related admissions | March 2028 |
| Improving Disposal and Recycling Pathways                                                                  | Measure waste & recycled items                               | March 2028 |
| Introduce inhaler recycling schemes                                                                        |                                                              |            |
| Improve segregation of pharmaceutical waste                                                                |                                                              |            |
| Reduce incineration by preventing unnecessary returns                                                      |                                                              |            |

# Travel and Transport

## Why This Matters

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS. Fossil fuel-based transport is a significant contributor to poor air quality. Poor air quality is the largest environmental risk to public health in the UK (<https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution>) as long-term exposure to air pollution can cause chronic conditions such as cardiovascular and respiratory disease as well as lung cancer. Short-term exposure can also affect lung function, exacerbate asthma, and give rise to increases in respiratory and cardiovascular hospital admissions and mortality.

GHFT / GMS operates 58 vehicles within our fleets, and during 2025-26 the fleets covered 831,257 miles generating 209 tCO2e. There are currently no Ultra-Low or Zero Emission Vehicles within our fleets due to a lack of charging infrastructure. Increasing the proportion of these vehicles will be a priority for us over the next 3-years, in line with the requirements set out in the [NHS Net Zero Travel and Transport Strategy](#).

Active transport such as walking, cycling, or taking public transport have multiple

health and environmental benefits. We have some influence on staff and patient travel and will prioritise simple but effective approaches to creating modal shift such as ensuring we provide secure, covered cycle parking and Cycle to Work schemes for staff. Collaborative work with the ICB and the Local Authority will be used to support these goals.

Achievements so far  
(2021-2025)

→

From November 2021 to March 2026 our Trust shuttle bus carried a total of 1.06 million passengers, of which 73% were NHS staff and the 27% public.

→

EV feasibility study conducted by Cenex across the ICS will help inform development of EV charging within the Trust.

Our Aims for the Next 5 Years:

| Action                                                                                                                          | Measurement                                                    | Delivery           |
|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------|
| We will develop and publish a Green Travel Plan to reduce carbon emissions from our fleets, business travel and staff commuting | Publication of plan                                            | Dec 2026           |
| All new vehicles owned and leased by GHFT will be zero emission                                                                 | Number of zero emission vehicles                               | From December 2027 |
| Offer only zero-emission vehicles through vehicle salary sacrifice schemes                                                      | Vehicles offered on salary sacrifice scheme                    | From December 2026 |
| Introduce electric vehicle charging points for fleet vehicles                                                                   | Number of electric vehicle charging points                     | 2026-2028          |
| Introduce electric vehicle charging points for staff and public vehicles                                                        | Number of electric vehicle charging points                     | 2027-2030          |
| Improvements to cycle storage and cycle changing facilities for staff                                                           | Number of secure bike shed spaces                              | From summer 2026   |
| Review of all fleet vehicles and route optimisation study                                                                       | Number of vehicles removed from fleet and reduction in mileage | Dec 2026           |

# Estate and Facilities

## Why This Matters

Emissions relating to the estates and facilities services span both the NHS Carbon Footprint and the NHS Carbon Footprint Plus, accounting for c.15% of the NHS Carbon Footprint. By reducing reliance on fossil fuels and improving the efficiency of our estate, our buildings will become more resilient to the effects of climate change and improve the environment in which care is delivered.

Research has also shown that green spaces on health care sites can have the following benefits:

- Help reduce stress and enable patients to summon inner healing resources.
- Provide staff with a needed retreat from the stress of work.
- Provide a relaxed setting for patient/visitor interaction away from the hospital interior.

For the Trust and our partners, this also presents an opportunity to educate communities about the benefits of nature for health and encourage people to engage with green spaces.

| Achievements so far (2021-2025)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>→ Trees have been planted across our estate, including in large planters made by Men In Sheds – a group that make and repair, supporting local projects, whilst improving wellbeing and reducing loneliness.</li><li>→ Installation of the Forget-Me-Not Garden at GRH.</li><li>→ Upgrades to the building management systems in theatres and other critical spaces (including Radiopharmacy and Sterile Services) to improve energy efficiency and controllability, as well as Pathology heating in GRH upgraded to plate heat exchangers.</li></ul> | <ul style="list-style-type: none"><li>→ Annual programme of steam trap replacements to reduce steam inefficiency on both sites.</li><li>→ Ongoing project to replace orange (infectious) clinical waste bins with new tiger (offensive / non-infectious clinical) waste bins. Cost savings related to disposal and over 50t carbon savings.</li><li>→ The Trust was successful in two phases of the Public Sector Decarbonisation Scheme. This funding enabled the installation of air source heat pumps, solar panels and a new façade and window replacements to the Tower Block. Combined, both projects should contribute to a 3,105 tCO2e reduction in scope 1 and 2 emissions.</li></ul> |



## Our Aims for the Next 5 Years:

| Goal                                                                                                                                                                       | Measurement                                                                          | Delivery                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------|
| We will develop a Heat Decarbonisation Plan and associated business cases for all sites, identifying and prioritising the phase out of fossil fuel heating systems by 2032 | Percentage of sites with Heat Decarbonisation Plans                                  | March 2028                                                    |
| Remove oil-fired primary heating system in main Estates building GRH                                                                                                       | Replacement of oil-fired boiler with low carbon heating system                       | 2028                                                          |
| Disposal of surplus land & buildings, including leases, will be within a planned programme with disposals linked to social value & sustainability where possible           | Scored via the Sustainability weightings criteria for disposal of buildings and land | Ongoing                                                       |
| Improve building fabric, heating systems, smart lighting etc. across the estate                                                                                            | Reduction in building energy consumption                                             | 2026 onwards                                                  |
| Use digital transformation to Increase energy monitoring, deploy smart building technologies and improve maintenance and asset optimisation systems                        | Better knowledge of systems enabling efficiency and reduction                        | 2026 onwards                                                  |
| By December 2026, achieve a 20:20:60 clinical waste segregation target, in line with the Clinical Waste Strategy                                                           | Percentage split of incineration: orange: offensive waste for Trust                  | December 2026                                                 |
| Progress the feasibility study to understand the potential for a geothermal heat system for CGH and GRH                                                                    | Feasibility study complete                                                           | December 2026                                                 |
| Introduce ISO14001 (Environmental Management System) for new back-up generators. This will be expanded to cover all environmental aspects for GMS services                 | Certification to ISO 14001                                                           | 2026 for generators<br>2030 for other aspects of GMS services |

| Goal                                                                                                                                                                                                                                 | Measurement                                                                         | Delivery     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------|
| Increase percentage of waste sent for recycling                                                                                                                                                                                      | Percentage increase in recycling                                                    | 2026 onwards |
| Continue to identify leaks, review flushing regimes and reduce inefficient use of water across the estate                                                                                                                            | Annual reduction in water consumption (m3)                                          | 2026 onwards |
| Introduce new electronic stock management and receipting systems, to improve stock control and reduce paper use                                                                                                                      | Stock management system in place and decrease in paper use                          | 2027         |
| Use the NHS Net Zero Building Standard (2023) to support the development of sustainable, resilient and energy efficient buildings                                                                                                    | Completed whole life cycle carbon assessment for each relevant project              | 2026 onwards |
| Identify opportunities that support both mitigation and adaptation, and that improve estates resilience to heat, flooding and other climate impacts                                                                                  | Actions taken and reduction of risk                                                 | 2027         |
| Biodiversity Net Gain (BNG) may be required as part of planning permission. Develop and maintain information on ecology, habitat management, biodiversity metric calculations, BNG plans and monitoring arrangements for Trust sites | Development of information. Report on BNG within Trust annual sustainability report | 2026 onwards |
| Further development of green space and habitat management to improve patient and staff environments through access to green space                                                                                                    | Improvement to green spaces                                                         | 2026 onwards |

# Supply chain and procurement

## Why This Matters

The supply chain represents a significant proportion of the Trust's total carbon footprint. Although the Trust does not directly control supplier emissions, procurement decisions significantly influence environmental, social and economic outcomes across the lifecycle of purchased goods and services.

Across the NHS, supply chain emissions account for more than 60% of the total carbon footprint, making supplier engagement essential to achieving net zero. The NHS Net Zero Supplier Roadmap sets binding milestones for all suppliers between 2022 and 2030, including requirements for carbon reduction plans and global emissions reporting.

Effective sustainable procurement also helps reduce waste, encourage circular economy practices, improve resilience, reduce environmental harm, strengthen modern slavery compliance and generate meaningful social value. The Procurement Act 2023 reinforces these priorities by requiring contracting authorities to consider public benefit in all procurements and enabling broader consideration of environmental and social outcomes through the new Most Advantageous Tender duty.

### Achievements so far (2021-2025)

Under the previous Green Plan, the Trust embedded a number of sustainability practices into procurement activity. Key achievements include:

- A minimum 10% evaluation weighting for net zero and social value is applied to all procurements, consistent with NHS England's national requirement introduced in 2022.
- All relevant procurements include Carbon Reduction Plan (CRP) requirements for high value contracts (£5 million and above), in line with Procurement Policy Note 006 (previously PPN 06/21).
- Net zero commitment requirements have been incorporated into lower value procurements above threshold.
- Work with major suppliers has begun to increase sustainability performance, in line with commitments from the previous Green Plan.
- Whole life costing principles and sustainable food procurement standards (Government Buying Standards) began to be embedded.

These represent strong foundational steps, and work continues to ensure these are captured and reported within the Atamis contract register.



# National policy drivers

The following national policies will shape the Trust’s procurement strategy during 2025–2030.

## NHS Net Zero Supplier Roadmap

In addition to the existing minimum 10% percent social value weighting and Carbon Reduction Plans required for contracts above £5 million from 2023 and all new procurements from 2024.

- All suppliers must report global Scope 1, 2 and 3 emissions from April 2027.
- Product-level carbon footprinting required from 2028.

## Procurement Act 2023

- New Most Advantageous Tender test enables consideration of environmental and social value.
- Mandatory public benefit duty.
- At least three KPIs, including sustainability KPIs, must be set and reported annually for contracts above £5m.
- New transparency notices and digital reporting obligations.

## TOMs (Themes, Outcomes and Measures) Framework (Open Access)

Provides a free set of standardised, evidence-based measures for social value, widely used across the public sector. Which Procurement are adopting for all competed activity and all direct awards above the relevant legal thresholds.

## Procurement Policy Notes (PPN)

- PPN 002 (2025) updated Social Value Model: mandatory for central government, influencing wider NHS procurement.
- PPN 006 (2025) Carbon Reduction Plans for large contracts, aligning with NHS rules.
- PPN 009 (2025) tackling modern slavery, strengthening risk assessment and mandatory exclusion grounds.
- PPN 016 (2025) Carbon Reduction Contract Schedule providing optional terms to embed decarbonisation into contracts.

## NHS England Green Plan Guidance (2025)

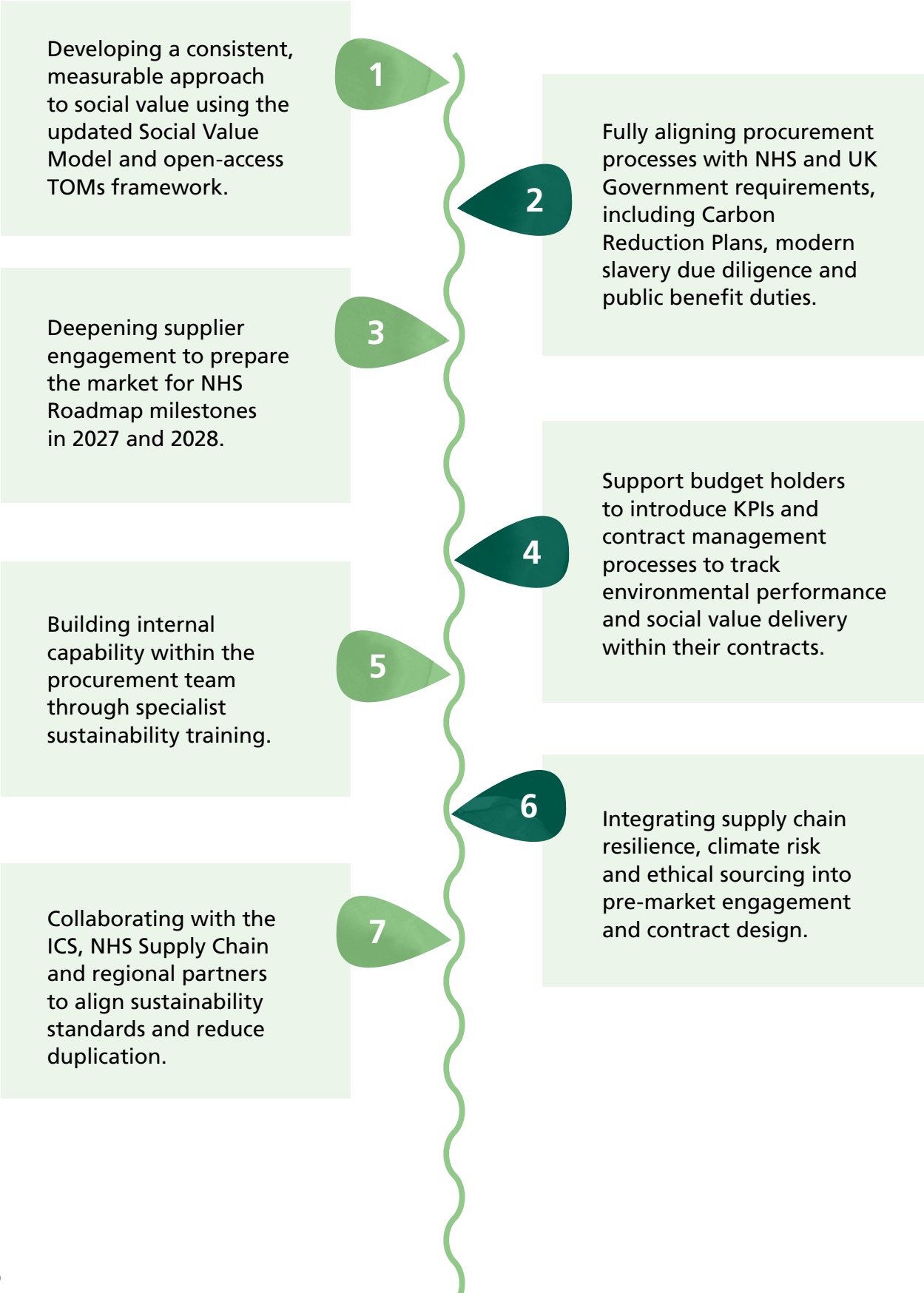
Trust plans must include SMART actions, KPIs, annual reporting and governance oversight across all focus areas, including procurement. Procurement teams are specifically listed among staff groups requiring specialist sustainability training.

## Evergreen Sustainable Supplier Assessment

The national maturity self-assessment tool became mandatory for all NHS Supply Chain tenders, with suppliers required to meet Level 1 from April 2026.

# Our Aims for the Next 5 Years:

During the next five years the Trust will significantly strengthen the sustainability performance of its procurement and supply chain by:



Actions

| Actions                                                                                                      | Delivery          |
|--------------------------------------------------------------------------------------------------------------|-------------------|
| Require compliant Carbon Reduction Plans for all relevant procurements, with annual supplier updates         | From June 2026    |
| Implement the Evergreen Supplier Assessment for all categories where proportionate                           | From April 2026   |
| Introduce contract-specific carbon reduction clauses (based on Procurement Planning Note 016) where relevant | From October 2025 |
| Reduce single-use product reliance in partnership with clinical teams                                        | 2026 onwards      |
| Adopt TOMs-based metrics for social value measurement                                                        | From June 2026    |
| Strengthen modern slavery due diligence in line with Procurement Planning Note 009                           | From June 2025    |
| Provide specialist sustainability training for procurement staff                                             | From June 2026    |

Key Performance Indicators (KPIs)

- Percentage of suppliers with Evergreen Level 1 or above.
- Carbon reduction delivered through contract-specific measures.
- Measurable social value delivered using TOMs or Social Value Model metrics.
- Number of modern slavery risk assessments completed and remediated.

## Supplier engagement and monitoring

**The Trust will implement a supplier engagement programme aligned to NHS England guidance and the Net Zero Supplier Roadmap. This includes:**

- Supplier briefings on Carbon Reduction Plan requirements, Evergreen milestones and product-level carbon expectations.
- Working with NHS Supply Chain to understand supplier readiness and market risks.
- Use of KPIs to monitor supplier performance for contracts over £5m, as mandated by the Procurement Act.
- Collaborative improvement plans for high-impact suppliers.
- Quarterly horizon scanning to identify supply chain climate, geopolitical and ethical risks.

## Social value and sustainability alignment

**The Trust will use the updated Social Value Model and Open-Access TOMs framework to ensure measurable and transparent social value commitments.**

This supports the Government's strategic missions and NHS sustainability priorities.

Social value priorities include:

- Employment, training and skills opportunities for local and disadvantaged groups.
- Environmental improvements and reduced carbon emissions.
- Supporting local SMEs and VCSEs.
- Community wellbeing initiatives.
- Ethical supply chain practices including modern slavery prevention.

## Modern slavery and ethical sourcing

**The Trust will adopt enhanced due diligence and monitoring aligned with:**

- **PPN 009** tackling modern slavery (2025 update).
- Updated Modern Slavery Act transparency guidance (2025).

Activities will include:

- Supplier modern slavery risk assessments.
- Supply chain mapping for high-risk categories.
- Clear escalation, remediation and reporting processes.
- Training for procurement staff and contract managers.

## Waste, circular economy and single-use reduction

**Procurement will support waste reduction by:**

- Encouraging reuse and remanufacturing.
- Reducing packaging and unnecessary disposables.
- Driving adoption of circular economy models where clinically safe to do so.
- Using procurement levers to align with Trust-wide waste and resources initiatives.

These commitments reinforce the achievements of the previous Green Plan and build on national strategies.

## Governance and reporting

Procurement sustainability performance will be embedded in the Green Plan governance framework, including:

- Quarterly reporting to the Green Plan Delivery Board and Climate Emergency Response Leadership Group.
- Reporting through the Procurement Bi-Annual Assurance Report.



## Links to other Green Plan sections

### Supply chain and procurement activity directly supports:

- Net zero clinical transformation (reduction in high-carbon clinical products).
- Estates and facilities (sustainable materials, waste contracts, energy-related procurements).
- Travel and transport (low-emission fleet procurement).
- Workforce and leadership (staff skills, training and culture).
- Digital transformation (sustainable IT procurement).
- Adaptation (resilient supply chains).

## Dependencies

### Delivery of this section depends on:

- Close collaboration with the ICS procurement community.
- Engagement with NHS Supply Chain programmes and Evergreen requirements.
- Support from Finance, Estates, Digital, Clinical and Sustainability teams.

# Food and Nutrition

## Why This Matters

Food and catering services are estimated to contribute around 6% of the NHS Carbon Footprint Plus. Sustainable food and nutrition are therefore essential components of a greener healthcare system. By prioritising locally sourced, seasonal and plant-based options where appropriate, we can reduce the environmental impact of our food services and help improve the health and wellbeing of patients and staff. Minimising food waste and optimising our procurement will also help lower our carbon emissions as well as generating financial savings.

**Achievements so far  
(2021-2025)**

- Food waste recycling for patient meals at GRH and in GMS catering outlets. Being introduced for CGH patient meals.
- Regular review of all menus.

Our Aims for the Next 5 Years:

| Goal                                                                                                                                                                                               | Measurement                                                         | Delivery                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------|
| We will measure food waste in line with Estates Return Information Collection (ERIC) requirements and reduce waste across the organisation                                                         | Percentage reduction in food waste (compared to 19/20 baseline)     | March 2028                                |
| Consider opportunities to make menus healthier and lower carbon by supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods                     | Proportion of locally sourced and whole food offered on our menus   | March 2028                                |
| Increase number of local suppliers for food – reducing food miles, supporting local economy, landscape, green space etc.                                                                           | Number of local suppliers                                           | As contracts become available for renewal |
| Roll-out of Electronic Meal Ordering System across all wards. Will improve patient satisfaction, order accuracy and inventory control                                                              | Reduction in food waste                                             | 2026                                      |
| Investigate opportunities to process own food waste on sites and create own compost                                                                                                                | Completion of review and installation of biodigester if appropriate | December 2027                             |
| Development and implementation of the GHFT Nutrition and Hydration Strategy 2026-31, including actions on food production, addressing health inequalities and providing sustainable snack options. | Successful project outcomes                                         | 2031                                      |

# Adaptation

## Why This Matters

The Trust has fed into a [Climate Risk and Vulnerability Assessment \(CRVA\)](#) commissioned by Climate Leadership Gloucestershire (CLG). The CRVA 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 highlights and scores climate related risks for sectors such as health, built environment, infrastructure and business. The hazards considered are high temperatures, drought, flooding (surface water and river), storms and high winds.

**The report makes suggested actions and for health lists the following as priority:**

- Behavioural guidance for staff and patients during extreme weather
- Climate adaptation education for health professionals aligning with national guidance

**The impact on the delivery of health and care services in Gloucestershire will see:**

- Risks to hospital estate, supply chains, transport, and public health
- Increased pressure on the system caused by heatwaves, pests, diseases, heat exposure and extreme weather events
- Widening of health inequalities as vulnerable people and places are disproportionately affected by climate change

### Achievements so far (2021-2025)

- Key risks and opportunities identified through CRVA
- Heatwave plan in place

Our Aims for the Next 5 Years:

| Goal                                                                                                                                                                                                                                                      | Measurement                                                      | Delivery         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------|
| Comply with the adaptation provisions within the <a href="#">NHS Core Standards for emergency preparedness, resilience and response (EPRR)</a> and the <a href="#">NHS Standard Contract</a> to support business continuity during adverse weather events | Compliance with standards                                        | Ongoing          |
| Follow the recommendations and actions highlighted within the CRVA report for GHFT sites                                                                                                                                                                  | Number of actions implemented                                    | From August 2026 |
| Work in conjunction with CLG/ICS partners to take actions highlighted within the CRVA report for countywide areas                                                                                                                                         | Number of actions implemented                                    | From August 2026 |
| Ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government’s Adverse Weather and Health Plan                                                                                          | Communications plan in place                                     | Ongoing          |
| Complete Climate Change Risk Assessment                                                                                                                                                                                                                   | Assessment and associated action plan                            | March 2027       |
| Integrate climate adaptation and mitigation into all site development and planning                                                                                                                                                                        | Referenced in appropriate documents                              | 2027             |
| Participate in the CLG/ICS community engagement programme for adaptation                                                                                                                                                                                  | Communications plan in place                                     | Ongoing          |
| Conduct assessments with each division to assess how climate change e.g. excessive heat or flooding, will affect their key services and establish mitigation measures                                                                                     | Number of completed assessments and mitigation measures in place | 2027             |

# Governance and Assurance

## Why This Matters

As highlighted in the GHFT Five-Year Strategy, sustainability is embedded in our governance structures, with Board-level oversight ensuring that environmental and social considerations inform strategic decisions. Clear leadership is essential to ensure we will deliver the commitments in this Green Plan.

The Trust Director of Improvement and Delivery is the lead executive director for sustainability.

The Climate Emergency Response Leadership group makes key decisions, considers strategy and oversees progress towards net zero carbon by 2040. Group membership includes the GMS Managing Director, Director of Capital and Strategic Assets, Head of Procurement, Portfolio Director of Estates and Facilities, Head of Sustainability, Head of Energy Management, Communications Manager, Associate Pharmacy Director and clinical consultants representing areas such as endoscopy and theatres/anaesthesia.

**Clear reporting is required to monitor progress and ensure actions are delivered, including but not limited to:**

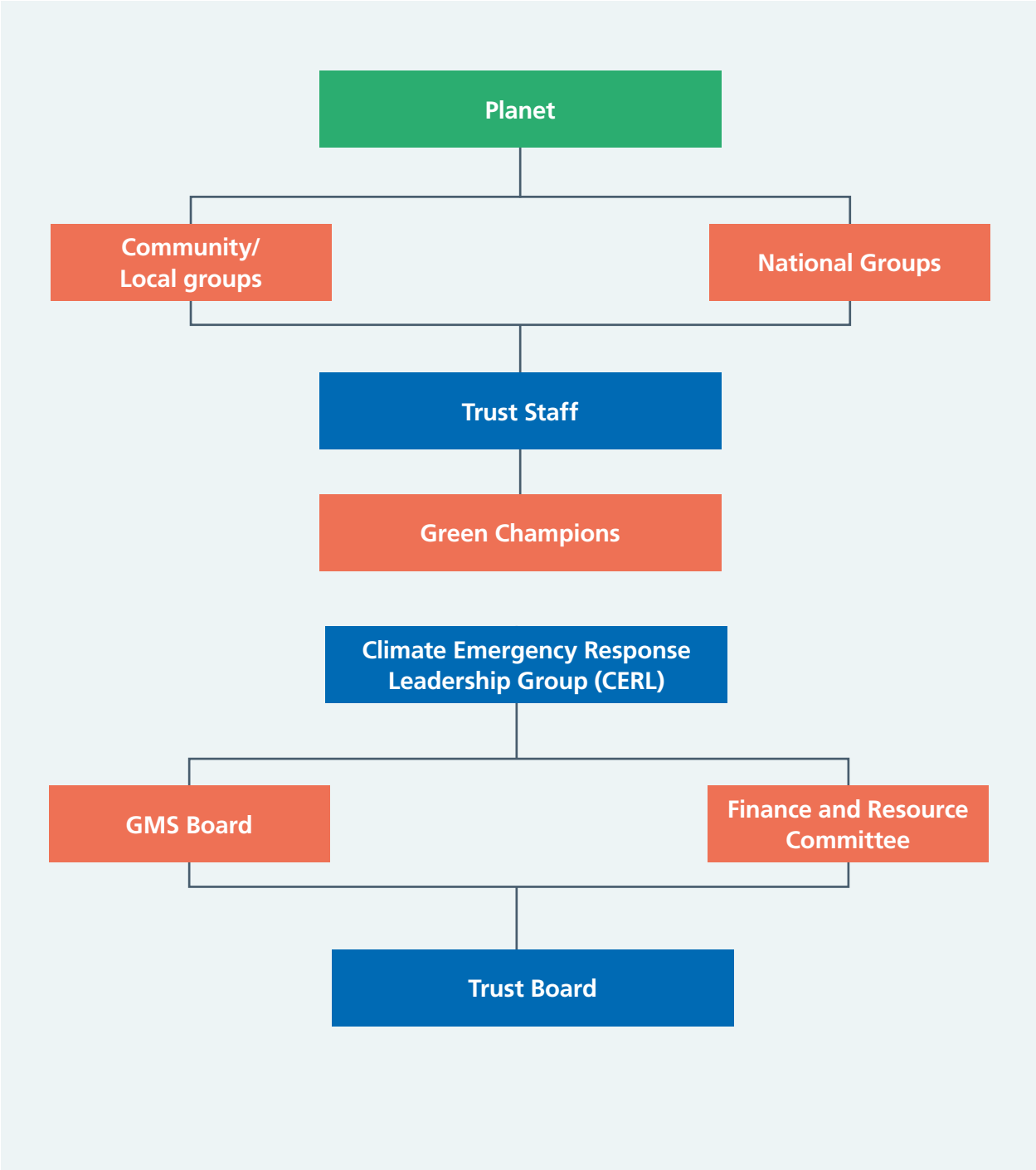
→ **GHFT Annual Report:** includes a brief outline of sustainability achievement and records how the Trust has prepared its climate-related financial disclosures in alignment with the Task Force on Climate-related Financial Disclosures (TCFD) framework, as adopted within the NHS England Annual Reporting Manual 2025/26.

→ **GMS Annual Report:** includes a brief outline of sustainability achievements within the GMS service areas.

→ **Sustainability Annual Report:** a full report detailing carbon emissions for scope 1 and 2, and part of scope 3 (waste, water and business travel), progress towards targets, key sustainability achievements that year and key actions for the forthcoming year.

→ **ERIC (Estates Return Information Collection):** mandatory data return for all NHS trusts, provides benchmarking information for estates and facilities related data.

→ **Progress Reports:** internal bi-annual report produced for Finance and Resource Committee and GMS Board, and monthly data / reports on waste, water and energy and associated carbon emissions.



# Risk Management

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 corporate 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.

All risks identified will impact on the Trust's achievement of its strategic objectives. Climate-linked risks such as overheating and poor ventilation 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 outages). The assessment of these is 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.

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. This 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.



# Conclusion

This Green Plan 2026-2030 provides a clear framework for how Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services will contribute to the NHS ambition of achieving net zero while continuing to deliver safe, effective and compassionate care. Sustainability is not a separate programme of work; it is integral to our mission of improving health outcomes, reducing inequalities, making best use of resources and ensuring that our services remain resilient for future generations.

Over the lifetime of this plan, we will continue to embed sustainability into decision-making across our clinical services, workforce, estates, procurement, digital transformation and partnerships. We will monitor progress through robust governance arrangements, transparent reporting and measurable objectives, ensuring that delivery remains focused, accountable and aligned to national NHS requirements.

We recognise that achieving our ambitions will require collaboration across every part of our organisation and beyond. Success depends on the commitment and innovation of our staff, the support of our patients and communities, and the active engagement of our partners, suppliers and wider Integrated Care System. By working together, we can create lasting environmental, social and economic benefits for the people of Gloucestershire.

As one of Gloucestershire's largest employers and public sector organisations, we are committed to using our influence as an anchor institution to support healthier, fairer and more sustainable communities. Through this Green Plan, we will play our part in tackling climate change, strengthening community resilience and improving the health and wellbeing of current and future generations.

The challenge ahead is significant, but so too is the opportunity. Every action, no matter how small, contributes to a more sustainable future. Together, we can ensure that our actions remain green, fair and affordable, creating a healthcare system that is fit for the future and a healthier environment for all.

# References

[Clean Air Hospital Framework. Global Action Plan and Great Ormond Street Hospital for Children NHS Foundation Trust, 2019](#)

[Climate Change Act, 2008](#)

[Delivering a 'Net Zero' NHS, NHS 2020](#)

[Government Buying Standards 2017, Department for Environment, Food and Rural Affairs](#)

[The impact of climate change on public health. The Climate Coalition, 2021](#)

[NHS Long Term Plan, NHS 2019](#)

[Public Sector \(Social Value\) Act, 2012](#)

Modern Slavery Act guidance 2025

CRVA

NHS Core Standards for emergency preparedness

NHS Standard Contract

Government Adverse Weather and Health Plan

[Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014–2020. NHS England 2014](#)

[United Nations Brundtland Report, 1987 – World Commission on Environment and Development](#)

[GHFT Our five year strategy: 2025-2030](#)

GMS 5-Year Strategic Plan 2025-2030

[NHS Net Zero Building Standard 2023](#)

[NHS Net Zero Travel and Transport Strategy 2023](#)

Clinical waste strategy

Procurement Act 2023

[NHS Net Zero Supplier Roadmap 2021](#)

[UK Health Security Agency Adverse Weather and Health Plan 2026](#)

[Public Health England Health Matters: air pollution 2018](#)

[NHS Clinical Waste Strategy 2023](#)

[Home Office Transparency in Supply Chains \(TISC\) Statutory guidance 2025 \(Modern Slavery Act\) guidance 2025](#)

[NHS Standard Contract 2026](#)

[NHS Core Standards for Emergency Preparedness](#)

[Climate Leadership Gloucestershire Climate Risk Vulnerability Assessment 2025](#)

[Green Plan 2021-2025 GHFT and GMS](#)

# Glossary

**Active Travel:** Walking, cycling or using some other physically active way to travel. Can include public transport if you walk or cycle etc. to the bus stop or railway station

**Adaptation:** Processes which adjust our infrastructure and system so we can continue to operate effectively as the climate changes

**Anchor Institution:** Large, public sector organisation whose long-term sustainability is tied to the wellbeing of the population it serves

**Biodiversity Net Gain (BNG):** ensures a development has a measurably positive impact on biodiversity

**Business Mileage:** Mileage travelled by staff in their own cars whilst on Trust business. Mileage costs are reimbursed via travel claims

**Carbon Emissions / Carbon Footprint:** Amount of carbon dioxide released to atmosphere by an organisation or individual as a result of their activities

**CGH:** Cheltenham General Hospital

**CHP:** Combined Heat and Power unit

**Climate Leadership Gloucestershire:** comprised of all seven Gloucestershire councils, NHS, nature and academia partners, all working together to address local climate challenges

**Climate Change:** A change in global or regional climate patterns and attributed largely to the increased levels of atmospheric carbon dioxide produced by the use of fossil fuels

**CO<sub>2</sub>:** Carbon dioxide is the most prevalent of the greenhouse gases

**CO<sub>2</sub>e:** Carbon dioxide equivalent. For simplicity of reporting the mass of each GHG gas is commonly translated into CO<sub>2</sub>e so that the total impact from all sources can be summed to one figure

**Environmental Management System (EMS):** structured framework to help organisations monitor, control and continuously improve their environmental performance whilst ensuring compliance with regulations and reducing impacts

**ERIC:** Estates Return Information Collection. Annual data submission enables analysis of estates and facilities information

**EV:** Electric vehicles and associated EV Chargers

**Evergreen Sustainable Supplier Assessment:** is an online tool which enables suppliers to engage and align with the NHS net zero and sustainability ambitions, including those set out in the NHS net zero supplier roadmap

**GHNHSFT (the Trust):** Gloucestershire Hospitals NHS Foundation Trust

**GHG:** Greenhouse Gases (GHG) include carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons and sulphur hexafluoride

**GMS:** Gloucestershire Managed Services. A wholly owned subsidiary company providing estates and facilities services to GHNHSFT

**Green Champions:** A network of GHNHSFT and GMS staff who take sustainable actions and projects within their work area

**Green Plan:** Sustainability strategy

**Greener NHS:** National NHS programme to deliver NHS target on net zero emissions by 2040 / 2045

**Grey Fleet:** Staff vehicles which are used on Trust business

**GRH:** Gloucestershire Royal Hospital

**Health Inequalities:** Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society

**Integrated Care System (ICS):** The partnerships between the organisations which provide health and social care in the area - 'One Gloucestershire'.

**One Gloucestershire:** Integrated Care System for Gloucestershire

**NHS Fleet:** Vehicles owned or leased directly by the Trust

**PFI:** Private Finance Initiative used to fund major capital projects. Part of the GRH site and the multistorey car park are PFI schemes

**PSDS:** Public Sector Decarbonisation Scheme. A series of grants to public sector bodies for infrastructure works which will reduce carbon emissions

**SMART:** goals and adjectives must be Specific, Measurable, Achievable, Relevant and Timely

**Sustainability:** "Meeting the needs of today without compromising the ability of future generations to meet their needs" (United Nations Brundtland Report 1987)

**Travel Plan:** A package of actions that will promote safe, healthy and sustainable travel options

**Ultra-low Emission Vehicle (ULEV):** ULEV is any vehicle that uses low carbon technologies and emits less than 75g of CO<sub>2</sub>/km

**VCSE:** Voluntary, Community and Social Enterprise

**Whole Life Cost (WLC):** Also known as Life Cycle Cost. A calculation to establish the spend profile (cost) of a product or service over its anticipated life span

**Zero Emission Vehicle (ZEV):** ZEV is any vehicle that emits no exhaust gas from the onboard source of power





# Alert, Advise and Assure Report to the Board of Directors Meeting held on 10 September 2026

| Title                           |            | ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 28 July 2026                                                                                                                                          |
|---------------------------------|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Board member lead(s)            |            | Committee Chair: Jaki Meekings Davis<br>Executive Directors:<br>Steve Perkins, Director of Operational Finance<br>Al Sheward, Chief Operating Officer<br>Kerry Rogers, Director of Integrated Governance<br>Kevin McNamara, Chief Executive Officer |
| Written by                      |            | Committee Chair                                                                                                                                                                                                                                     |
| Confidentiality                 |            | None                                                                                                                                                                                                                                                |
| Requires<br>Tick as appropriate | Approval   |                                                                                                                                                                                                                                                     |
|                                 | Assurance  | ✓                                                                                                                                                                                                                                                   |
|                                 | Discussion | ✓                                                                                                                                                                                                                                                   |
|                                 | Note       |                                                                                                                                                                                                                                                     |

## Purpose of report

To present an update to the Board of Directors from the meeting of the Finance and Resources Committee held on 28 July 2026. The meeting was quorate.

This committee meets monthly and is attended by members of the Board and senior managers.

## Key points

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

- **Finance System update** – The Committee remained concerned about the procurement element of the new finance and procurement system. This significant weakness (previously reported) creates a governance and potential fraud risk. A solution has been agreed but the implementation date will now slip to either January or April 2027. Confirmation of the date, remaining risks and audit implications to be reported in September.
- **Capital and Estate infrastructure** – The Committee noted concerns raised at Contract Management Group (and previous discussions) regarding the adequacy of the information base upon which decisions about resource allocation would need to be made in coming

months/years. Existing Estate Asset Registers record only 50% of assets in sufficient detail to support informed decision making. Approval was given for the preparation of a business case for a comprehensive asset survey.

- **Financial Position including Financial Sustainability Programme** – The Committee noted that the Month 3 revenue position was on track and that the Financial Sustainability Programme was slightly ahead of plan. However, there remained an unidentified gap of £14m in red/unidentified schemes in the Sustainability plan which would need to be recovered in the remaining nine months. The September meeting would receive details of the revised structure of the FSP team, greater granularity around delivery dates and details of the outcome of the KPMG supported plan – including scheme timelines, complexity and delivery risk. Other emerging risks included the Band 5 regrading initiative, unplanned costs of temporary staffing and heatwaves and the impact of changes planned by Gloucestershire County Council re Reablement Services.

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

- **Estates Capital Delivery and Resourcing** - This report addressed the problems encountered in recent years around delivery of the capital programme and recommended a future operating model and resource implications. The Committee welcomed and approved the approach IN PRINCIPLE subject to the final arrangements addressing governance, Human Resources implications (between the Trust and GMS) and ensuring flexibility as capital resources fluctuated year on year.
- **Balance Sheet Health** – an improved set of balance sheet metrics was considered. This is to be produced on a quarterly basis. Strength of the balance sheet is heavily dependent upon delivery of the Financial Sustainability Programme. The Committee approved a request to NHSE for £9.1m capital cash support required as a consequence of a reduced level of depreciation cash. The Committee discussed the importance of the longer term Financial Strategy encompassing a timetable for improvement on Balance Sheet metrics.
- **CSSD performance and stability**- a 65 point action plan has been agreed and 55 actions completed. Improvement in recent performance was noted although it is too early to be confident about whether this is to be the new norm. Regular reporting to continue.

#### **ASSURE: inform the board where positive assurance has been received**

- **National Cost Collection – Costing Submission** – The Committee received assurance that the submission had been completed in line with NHSE guidance and reconciled to the annual accounts.
- **Financial Well Led Checklist** - The Committee received a positive update on the completion of the extensive “to do” list resulting from the review. A number of significant items have progressed from amber to green status but some of the amber/red items cannot improve until estates opportunities can be realised. This matter is covered elsewhere in this report.
- **Contract Management Group Exception report** – The Committee was assured that this group was running well and offered moderate assurance re the management of the GMS contract. Key areas of focus are asset management registers and CSSD (see separate points), impact of periods of extreme heat, emerging cost pressures and improvements still required in contractual management between the two organisations. Risks are understood and actively managed.

- **Estates Strategy Programme** – The Committee noted progress in this and associated workstreams including the programme for engaging with clinical and other strategies in advance of the draft Strategy in Autumn. A high level Gantt chart is to be produced, capturing the complex interrelationships and decision points.

## APPLAUD

- **Sustainability Annual Report** – The Committee approved this positive report which supports the shorter version included within the Trust's Annual Report. Trust carbon had reduced by 5.4% compared to the previous year and energy use has also reduced as a consequence of work to the Tower block façade, double glazing and pipework lagging. Progress was also made in waste disposal, reduced usage of anaesthetic gases and Entonox capture. The forward looking Green Plan will be presented to the Board in September and will include details of alignment with clinical and other strategies, embedding this agenda into "business as usual" and staff engagement.

## APPROVALS: decisions made by the Committee

- The Committee APPROVED the summary overview of the 2025/26 National Cost Collection submission by Gloucestershire Hospitals NHS Foundation Trust.
- The Committee APPROVED submission of a capital cash support request to NHSE.
- The Committee APPROVED the GMS Financial Budget for 2026-27.
- The Committee APPROVED the progression of a business case for a comprehensive estate asset survey, recognising its importance in providing future assurance over safety-critical assets, statutory compliance and capital planning.
- The Committee APPROVED:
  - The proposed Strategic Estates and GMS Capital Delivery workforce models and phased recruitment programmes to support implementation of the future operating model, reduce long-term reliance on temporary resources, strengthen organisational resilience and improve value for money.
  - The revenue and capital investment required to implement the future operating model and deliver the Capital Delivery Improvement Programme, including associated advisory support, digital portfolio management systems and workforce development costs.
  - The increase in capital-funded resourcing investment from the current baseline of £1.035m per annum to £3.85m in 2026/27, reducing to approximately £3.2m per annum over the following three years, to be accommodated within the overall approved capital programme with no increase in total capital allocation.
  - The ring-fencing of forecast recurrent revenue benefits generated through the programme, estimated at £226k in Year 1, reducing to £164k by Year 4, to support delivery of the Capital Delivery Improvement Programme (CDIP), associated advisory support, digital portfolio management capability and workforce training.
  - The recurrent reduction in the GMS Unitary Payment of £403k per annum, with the resulting benefit allocated to the Estates Transformation Programme and/or Strategic Estates Financial Sustainability Plan (FSP) savings target.
  - The consequential increase in dividend income arising from the revised funding model, estimated at £152k in Year 1 and reducing to £111k by Year 4.
- The Committee received the Electronic Patient Record (EPR) Optimisation Programme Business Case and APPROVED option 2, £2.0m capital for T0 delivery (phased £1.3m FY26/27 + £0.7m FY27/28) via blended Programme Management layer.
- The Committee received the Business Case for point of care blood gas testing equipment and APPROVED the preferred option to replace two of the seven FBC analysers and both



haematinics analysers. The Committee APPROVED the procurement of an interim contract via the NHS Supply Chain Pathology Managed Services Framework for a two-year term, with the option to extend for up to two additional one-year periods.

- The Committee APPROVED a recommendation to award a seven year call off Managed Service contract to Werfen via the NHS Supply Chain Pathology Managed Services Framework (2023/S 000-028831) for the provision of a Point of Care Blood Gas Service to Gloucester Royal Hospital and Cheltenham General Hospital, in full compliance with UK procurement regulations and NHS England guidance.

## Implications

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

## Board assurance framework

|               |                        |
|---------------|------------------------|
| BAF reference | SR04, SR06, SR07, SR08 |
|---------------|------------------------|

## Risks discussed

|                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The Committee discussed the following risks: in year and longer term financial sustainability, temporary workforce and divisional financial pressures, capital programme delivery capacity, timing of the installation of the new finance system, inadequacy of existing asset registers, pressures arising from periods of extreme heat, CSSD quality concerns and arrangements for improved co-ordination of non NHS contracts. |
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## Recommendations

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| The Board of Directors is asked to take <b>assurance</b> from the report, note the matters escalated for attention, and note the approvals made by the Committee. |
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