Board of Directors

Thursday 12 November 2026, 09:00 - 12:30

Lecture Hall, Redwood Education Centre, Gloucester

Agenda

09:00 - 09:00 (0 min)

Agenda

00.00_ AGENDA Public Board Nov 26.pdf (2 pages)

09:00 - 09:00 (0 min)

1. Chair's welcome and introduction

09:00 - 09:00 (0 min)

2. Apologies for absence

09:00 - 09:00 (0 min)

3. Declarations of interest (pertaining to agenda)

09:00 - 09:00 (0 min)

4. Minutes of previous meeting - 10 September 2026

04.00_Minutes September Public Board.pdf (17 pages)

09:00 - 09:00 (0 min)

5. Matters arising

09:00 - 09:00 (0 min)

6. Questions from the public

09:00 - 09:00 (0 min)

7. Patient Story - Maternity and Neonatal Voices Partnership

09:00 - 09:00 (0 min)

8. Chair's Report

Deborah Evans

08.00_ Chairs report for Nov Board.v3.pdf (3 pages)

09:00 - 09:00 (0 min)

9. Chief Executive's Report

Kevin McNamara

09.00_CEO Report - Nov Board.pdf (5 pages)

09:00 - 09:00 (0 min)

10. Community Birth Team and Community Maternity Services: Implementation Update

Matt Holdaway

10.00_Community Births team update - Nov 26.pdf (6 pages)

09:00 - 09:00

11. NHS Maternity Ten Point Plan: Progress Update and Board Assurance

0 min

- 11.00_Maternity 10 point plan Update Nov 2026.pdf (11 pages)
- 11.01_Copy of Appendix 1 GHT 10 Point Plan Benchmarking Tool with Region Comments.pdf (22 pages)

09:00 - 09:00
0 min

12. Audit & Assurance Committee Report

Shawn Smith

- 12.00_Audit Committee Assurance Report.pdf (4 pages)

09:00 - 09:00
0 min

13. Combined Risk Management Report

Kerry Rogers

- 13.00_Strategic and Corporate Risk Report.pdf (11 pages)

09:00 - 09:00
0 min

14. Finance and Resources Committee Report

Jaki Meekings Davis

- 14.00_Finance and Resources Committee Assurance Report.pdf (3 pages)

09:00 - 09:00
0 min

15. Second Half Recovery - Performance and Finance

Karen Johnson, Alan Sheward

- 15.00_Finance H2 - Forecast and Recovery (003) v2.pdf (2 pages)
- 15.01_M6 Forecast Trust Board.pdf (7 pages)

09:00 - 09:00
0 min

16. Quality and Performance Committee Report

Sam Foster

- 16.00_Quality & Performance Committee Assurance Report.pdf (4 pages)

16.1. Thirwall Report Response

Matt Holdaway

- 16.01_Thirlwall board presentation final.pdf (16 pages)

09:00 - 09:00
0 min

17. Integrated Performance Report

Alan Sheward, Karen Johnson, Matt Holdaway, Mark Pietroni, Caroline Julien

- 17.00_IPR - C- November 2026.pdf (5 pages)
- 17.01_September 2026 IPR.pdf (53 pages)

09:00 - 09:00
0 min

18. Learning from Deaths Report

Mark Pietroni

- 18.00_Learning from Death's Report - APPROVED.pdf (12 pages)
- 18.01_Appendix 1 - Deaths Outside SJR Process.pdf (2 pages)

09:00 - 09:00
0 min

19. Winter Plan Update

Alan Sheward

- 19.00_Winter Plan update.pdf (5 pages)

09:00 - 09:00
0 min

20. People, Place and Partnership Committee Report

Vareta Bryan

20.00_People & Partnership Committee Assurance Report.pdf (4 pages)

09:00 - 09:00
0 min

21. Equality, Diversity and Inclusion Programme Update

Deborah Tunnell

21.00_EDI and Staff Experience Development Report - Public Board.pdf (8 pages)

09:00 - 09:00
0 min

22. Any other business

09:00 - 09:00
0 min

23. Governor observations

Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 12 November 2026 at 09.00 to 13.00

Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital

AGENDA

REF	ITEM	PURPOSE	PAPER	TIME
1.	**Chair's welcome and introduction**	Information		09.00
2.	**Apologies for absence**	Information		
3.	**Declarations of interest (pertaining to agenda)**	Approval		
4.	**Minutes of previous meeting** 10 September 2026	Approval		09.03
5.	**Matters arising**	Assurance		
6.	**Questions from the public**	Information		09.10
7.	**Patient Story – Maternity and Neonatal Voices Partnership**	Information		09.15
8.	**Chair's report** *Deborah Evans-Chair*	Information	Yes	09.35
9.	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	09.45
	MATERNITY			
10.	**Community Birth Team and Community Maternity Services: Implementation Update** *Matt Holdaway, Chief Nurse & Director of Quality, Zita Martinez, Director of Midwifery*	Assurance	No	09.50
11.	**NHS Maternity Ten Point Plan: Progress Update and Board Assurance**	Assurance	Yes	10.00
	GOVERNANCE			
12.	**Audit & Assurance Committee Report** *Shawn Smith, Non-Executive Director*	Assurance	Yes	10.15
13.	**Combined Risk Management Report** • **Corporate Risks** • **Board Assurance Framework** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	10.25
	FINANCE			
14.	**Finance and Resources Committee Report** *Jaki Meekings Davis, Non-Executive Director*	Assurance	Yes	10.35
15.	**Finance H2 Forecast and Recovery** *Karen Johnson, Director of Finance*	Assurance	Yes	10.45
	BREAK 11.10			
	QUALITY AND PERFORMANCE			
16.	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Yes	11.25

	to include: Thirlwall Report Response *Matt Holdaway, Chief Nurse*			
17.	**Integrated Performance Report** *Al Sheward-Chief Operating Officer, Karen Johnson-Director of Finance, Matt Holdaway-Chief Nurse, Mark Pietroni-Medical Director, Caroline Julien-Chief People Officer*	Assurance	Yes	11.35
18.	**Learning from Deaths Report** *Mark Pietroni, Medical Director*	Assurance	Yes	12.05
19.	**Winter Plan Update** *Al Sheward, Chief Operating Officer*		Yes	12.15
	PEOPLE			
20.	**People, Place and Partnership Committee Report** *Vareta Bryan, Non-Executive Director*	Assurance	Yes	12.25
21.	**Equality, Diversity and Inclusion Programme Update** *Debbie Tunnell, Deputy Director for People*	Assurance	Yes	12.35
22.	**Any other business**	Information		12.45
23.	**Governor observations**	Information		12.50
	Date and time of next meeting: Thursday 14 January 2027 09.00 Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital	Information		

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Minutes of the Public Board of Directors' Meeting
10 September 2026, 09:00 -12.30
Redwood Education Centre, Gloucester Royal Hospital

Present	Deborah Evans	Chair, Non-Executive Director
	Vareta Bryan	Non-Executive Director
	Will Cleary-Gray	Director of Improvement and Delivery
	Sam Foster	Non-Executive Director
	Matt Holdaway	Chief Nurse and Director of Quality
	Karen Johnson	Director of Finance
	Caroline Julien	Chief People Officer
	Kevin McNamara	Chief Executive Officer
	Jaki Meekings-Davis	Non-Executive Director
	John Noble	Non-Executive Director
	Lee Pester	Chief Digital Information Officer
	Mark Pietroni	Medical Director and Director of Safety
	Kerry Rogers	Director of Integrated Governance
	Shawn Smith	Non-Executive Director
	Al Sheward	Chief Operating Officer
	Kerry Rogers	Director of Integrated Governance
	Raj Kakar-Clayton	Associate Non-Executive
	Kaye Law	Gloucestershire Managed Services Chair/Associate Non-Executive
Attending	James Brown	Director of Engagement, Involvement and Communications
	Sarah Favell	Trust Secretary
	Zita Martinez	Director of Midwifery
	Colette Townsend	Integrated Midwife
	Ebashi Nobuichi, Emma Veitch, Sarah Mather	Surgery and CSSD team
Apologies	Marie-Annick Gournet	Non-Executive Director
	Sally Moyle	Non-Executive Director
Observers		
Governors	Andrea Holder, Helen Bowen	
Public	Two	

Ref	Item
1	**Chair's welcome and introduction**
	Deborah Evans, Chair, opened the meeting, welcoming all members of the public and governors in attendance.
2	**Apologies for absence**
	Apologies were noted as above.
3	**Declarations of interest**
	There were no declarations of interest in respect of agenda items.

4	**Minutes of previous meeting : 16 July 2026**
	The Board reviewed the minutes of the previous meeting. **RESOLVED:** The minutes of the meeting held on 16 July 2026 were APPROVED, as a true and accurate record.
5	**Matters arising**
	The Board noted the updates to the Matters Arising and APPROVED the closed items and the removal of action/item 13/July.
6	**Questions from the public**
	There were no questions from the public.
7	**Staff Story**
	The Board heard from Ebashi Nobuichi and Emma Veitch about the challenges faced by both theatre staff and colleagues within the Central Sterile Services Department (a department managed by Gloucestershire Managed Services) over the last year as the teams faced issues with equipment failures alongside the impact of external factors, including extreme weather and national shortage of cement. The presenters spoke of the stress, fatigue and anxiety felt by members of the department and the concerns of registered colleagues. Foremost in their focus was the impact on patient care as a result through cancellations. They set out the work that had been done on the improvement journey and the importance of frequent, open and transparent communications between the respective teams in rebuilding confidence, alongside both psychological and senior management support for both teams. They acknowledged the improvements made with refreshed processes and escalation routes largely embedded in everyday practice. They spoke of an improvement in morale and were proud of their continued prioritisation of patient safety. Sam Foster, Non-Executive Director, commended the teams on the work done and the powerful presentation provided to the Board. Matt Holdaway, Chief Nurse, expressed his thanks to the team for providing a presentation which made a complex matter easier to understand but which highlighted the importance of relationships and the work underway to ensure continued mindfulness of the respective demands on and priorities of the teams involved. Deborah Evans, Chair, closed the session by expressing her thanks to both the theatre team and colleagues within Gloucestershire Managed Services who had done a huge amount of work to support colleagues.
8	**Chair's Report** *Deborah Evans, Chair*
	Deborah Evans presented her report which provided information about her activities as Chair of the Trust since the last Board meeting in July. The report was taken as read. Following recent media commentary on the sad death of Professor Jason Arday, she invited reflection on how the Trust supported leaders who experienced personal attack, including where racism or misunderstanding of neurodivergence was a factor, and on the importance of applying employee investigation processes fairly, compassionately and sensitively.

	The Board noted the programme of site visits, staff and volunteer engagement, meetings with Members of Parliament and system partners, and the launch of the Gloucestershire Advanced Research Innovation Hub. The Chair outlined the ongoing work to consider future arrangements for patient and community involvement in light of the provisions within the NHS Bill setting out the dissolution of the Council of Governors in its statutory form. It was confirmed that the Trust wished to retain the valued contribution of current governors whilst strengthening lived experience, community insight and involvement in service development. This would be the focus of the joint Non-Executive Director and Governor workshop scheduled for 15 October 2026. **RESOLVED:** The Board NOTED the report.
9	**Chief Executive's Report** *Kevin McNamara, Chief Executive*
	Kevin McNamara presented his report, which was taken as read. The Board welcomed the Care Quality Commission recent inspection report findings, which recognised improvement in leadership, culture and governance, with the Well-Led rating moving from Requires Improvement to Good. Maternity at Gloucestershire Royal Hospital had improved from Inadequate to Requires Improvement and Stroud Maternity Hospital from Requires Improvement to Good. The Board recognised the validation of colleagues' efforts but also noted that several services remained rated 'Requires Improvement' and agreed that the focus must remain on sustained improvement and patient experience rather than the ratings alone. The Board considered the implications of the local government reorganisation (with developments since the report was drafted which would have implications for the Trust), the Adult Inpatient Survey and the possibility of consultant industrial action. Positive survey findings on kindness, compassion, dignity, privacy and confidence in clinical staff were welcomed, while discharge communication and involvement remained an area requiring improvement. Kevin McNamara highlighted the work on the new Department of Critical Care, commenting on the impact of recent extreme weather on the aged Trust estate and the work being undertaken to develop a permanent seasonal plan, addressing issues that will arise during periods of hot weather, as well as the more traditional Winter plan. He commented on the positive news that planning permission had now been granted for the Cancer Centre, a project supported by the Big Cancer Appeal. This centre would offer modern clinical and treatment spaces for the benefit of oncology patients. It was recognised that the building work would impact other services, particularly ophthalmology, and work was ongoing to find an alternative location for those services. As a final point Kevin McNamara highlighted the ongoing remedial work on the Subject Access Request process, recognising the challenges faced by the Trust as a result of the increased volume and complexity of requests, often drafted with the use of AI technology. Oversight of the improvement programme was both a focus for the digital senior leadership team and both Audit Committee and Finance and Resource Committee. This work was relevant to the Board's focus on how responsive the Trust was, alongside the ongoing improvement in complaints management. It was noted that there would be a future board discussion on what does a responsive organisation look like.

	John Noble, Non-Executive Director, sought assurance as to the Trust's resilience to future extreme weather, noting the estates infrastructure challenges. Kevin McNamara confirmed that this was an ongoing area of focus and was being worked through as part of the Estates Strategy. Al Sheward, Chief Operating Officer, confirmed that Gloucestershire Managed Services had commenced work, including key surveys, to understand the extent of the issues, including backlog. Areas of focus included the air-handling units. External expertise had been sought from the Department of Health and a complex programme of works was planned, which would be overseen by the Trust's Contract Management Group. **RESOLVED**: The Board NOTED the report.
10	**Maternity Services Regulatory Compliance Report (section 31 Notice)** *Matt Holdaway, Chief Nurse and Director of Quality and Zita Martinez, Director of Midwifery*
	Matt Holdaway introduced the report, welcoming Zita Martinez, Director of Midwifery, to her first public board meeting since joining the Trust. It was acknowledged that the report was a standing item before the Board and a key element of the continued focus on maternity services. It was confirmed that the report was also shared with the Care Quality Commission on a monthly basis and was reviewed internally by both the Perinatal Delivery Group and Quality and Performance Committee. The report provided an update on progress/compliance against the s31 Enforcement Notice issued in May 2024. It was confirmed that the Care Quality Commission's inspection report published on 27 August 2026 rated maternity services as 'Requires Improvement' and provided external evidence of progress. One separate regulatory breach relating to medicines management required an action plan and was being managed through the agreed regulatory response. The Report confirmed that the Trust continued to self-assess that all eight CQC Section 31 conditions had been met but noted that the conditions would remain in place until a re-inspection by the Care Quality Commission and removal of the conditions was confirmed. The Service confirmed its confidence to proceed with the process for seeking removal of the conditions. It was anticipated that there would be a full inspection by the Care Quality Commission before Christmas. It was confirmed that the Service, in particular the senior team, were continuing to test that the improvements were truly embedded and confirmed that there was confidence in the oversight provided. Shawn Smith, Non-Executive Director, welcomed the positive developments and the planned re-inspection. He also noted the recent External Audit Annual Report which had removed maternity services regulatory compliance as an identified 'significant weakness'. **RESOLVED:** The Board: • NOTED the publication of the Care Quality Commission maternity inspection report (27 August 2026) which rated maternity services as 'Requires Improvement' (previously inadequate). The Board noted the one regulatory breach within the report, relating to medicines management and NOTED the submission of the required action plan. • NOTED the Trust's self-assessment that all eight Section 31 conditions continued to be met and that submission of the condition removal applications would proceed under the Board's delegated authority. • NOTED Care Quality Committee's intention to undertake a further inspection and the preparatory review being led by the Director of Midwifery.

11	**Perinatal Quality Oversight Report (Quarter 1)** *Matt Holdaway, Chief Nurse & Director of Quality and Zita Martinez, Director of Midwifery*
	The Board received the Quarter 1 Perinatal Quality Oversight Model report. The overall position provided developing assurance. Positive controls included one-to-one care in labour, high consultant attendance in eligible complex situations, established mortality review arrangements, strengthened triangulation of incidents and family feedback, and no neonatal unit or cot closures, workforce-related neonatal transfers, maternity safety alerts, coroners' reports or Regulation 28 reports during the quarter. Deborah Evans, Chair, welcomed the clarity provided on workforce risks. Zita Martinez, Director of Midwifery, confirmed that overall, there was evidence of progress but there remained areas of challenge, as identified within the report. Those areas included workforce sustainability, training compliance, neonatal staffing, obstetric theatre and recovery capacity, service-user voice, equitable communication and data quality. Midwifery fill rates reduced to 87% in June, and 45 staffing red flags were recorded in the quarter. Whilst it was noted that the Service had recruited 14 midwives, current gaps were requiring agency cover with consequent impact on the stability of the service. Obstetric roster gaps were largely covered, but reliance on internal cover indicated limited resilience. Neonatal nursing fill rates remained at 70%, Qualified in Specialty compliance was 57%, and neonatal medical night-cover gaps continued. The Board noted assurance from the Director of Midwifery that whilst the Service was safe, it was recognised that the mitigations in place did not resolve the underlying workforce risk. It was confirmed that training oversight had strengthened through frequent trajectory monitoring and recovery planning through a multi-disciplinary approach, with good engagement from the Obstetric lead as medical workforce training remained an area of challenge. Maternity and Neonatal Voices Partnership involvement with thematic reviews, including health inequalities, and involvement with wards and staff was continuing to improve. Deborah Evans, Chair, acknowledged the assurance provided within the report and by the overview provided by the Director of Midwifery but asked that future reports provide the Board with the strategic context for the granular workforce risks. Mark Pietroni, Medical Director, acknowledged the fragility of the obstetric workforce, with the numbers providing very little resilience. Whilst it was recognised that capacity and recruitment was a national issue there was recognition that this needed to be a recruitment focus for the Trust. The Board also discussed some of the likely recommendations from the Thirlwall Inquiry, with the report due to be issued shortly after the meeting. It was noted that there would be a detailed report to the Board on the Trust's planned response. In the context of the workforce risks identified there was a discussion regarding the resourcing of services to meet demand, to include both reallocation of existing resource and recruitment. It was noted that there was an ongoing consultation exercise in respect of the provision of community maternity services with updates to come to a future board meeting.

	RESOLVED: The Board: • NOTED the Quarter 1 perinatal quality oversight position and noted that assurance was continuing to develop across the principal workforce, capacity and training risks. • ENDORSED continued executive oversight of the identified recovery plans. • REQUESTED a Quarter 2 update demonstrating sustained improvement, including validated training compliance, workforce and capacity trajectories, improved data quality and evidence that learning had been embedded. • SUPPORTED further consideration of sustainable workforce, theatre capacity, recovery capacity and digital reporting solutions
11A	**Maternity and Neo-natal 10-Point Plan Assurance Process**
	The Board considered the national 10 Point Plan baseline assessment presented by Zita Martinez Director of Midwifery (supported by Collette Townsend, Integrated Midwife Lead). This was provided for Board scrutiny in advance of a fuller review by Quality and Performance Committee in advance of formal submission (by 25 September). It was confirmed that this process was a benchmarking exercise for an evolving piece of work. In summarising the report it was confirmed that, of 26 deliverables, 12 were assessed compliant and 14 partially compliant, with none assessed as non-compliant. The separate maternity triage benchmark showed 58 of 77 applicable standards fully in place, 17 partially in place and one not in place. It was noted that this was a useful tool in the Service's improvement journey, providing an accurate assessment of current status, identification of priorities and ensuring effective oversight. Key areas of focus continue to be workforce plan and maternity alongside the emerging area of health inequalities. With dedicated Health Inequality resource becoming available the Service would be working to respond to both national targets and local priorities. Deborah Evans, Chair, commented that she would welcome a focus on alcohol alongside smoking indicators Board members discussed the requirements for board oversight of the Maternity Incentive Scheme Year 8 and assurance as to achieving compliance. It was confirmed that the Service was reasonably confident as to the quality of the evidence collated and that it met the extensive guidance provided. It was confirmed that a further report would be brought to both Quality and Performance Committee and Board prior to submission. This would include an update on workforce investment as this required board oversight. **RESOLVED:** The Board: • NOTED the national requirements set out in the NHS England Maternity and Neonatal 10 Point Plan assurance process. • APPROVED the Trust's baseline assurance assessment for submission to the NHS England regional team by 25 September 2026. • APPROVED the completed maternity triage benchmarking assessment and associated 12-month improvement plan. • CONFIRMED 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 CONFIRMED executive oversight of the 14 partially compliant deliverables.

	• NOTED that the 10 Point Plan assessment contained no non-compliant deliverables, while the separate triage benchmark contained one standard rated not in place relating to the dynamic staffing model. • REQUIRED progress, residual risks and evidence of impact to be monitored through the Quality and Performance Committee and reported to the Trust Board before the December 2026 return. • NOTED that the approved Board minute and evidence of successful regional submission must be retained. • AGREED that any material risks to delivery, regulatory compliance or patient safety would be escalated through the Integrated Care Board and NHS England regional routes as required.
12	**Integrated Governance update including updates on legal, regulatory and policy** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers introduced the report as a horizon-scanning and learning paper rather than a complete source of assurance. The Board considered the cumulative effect of regulatory and policy change across maternity, workforce standards, leadership, neighbourhood health, digital prescribing, patient voice, the NHS Bill and patient safety reform. The discussion focused on the need to test whether strategic intent, formal assurance and frontline reality were aligned. Members supported the “True for Us” approach as a means of applying external learning without presuming that the same failures existed locally. Particular themes included psychological safety, leadership visibility, organisational curiosity, the risk that repeated findings became normalised, and the importance of completing actions arising from audits, inspections and risk assessments. The Board considered how future Provider Capability Assessment work and Committee work programmes could provide evidence that the Trust recognised emerging concerns early, triangulated intelligence and verified that completed actions had achieved their intended outcome. The Committee Chairs’ meeting would consider how relevant themes should be reflected in assurance activity. **RESOLVED:** The Board: • NOTED and considered the content of the report and satisfied itself that appropriate arrangements were in place to respond to emerging regulatory expectations. • CONSIDERED the implications of the external learning and "True for Us" sections, particularly regarding organisational culture, psychological safety and visibility of frontline concerns. • RECOGNISED that the Committee Chairs' meeting would reflect on relevant themes within future work programmes and assurance activities where appropriate
13	**Combined Risk Management Report** • **Corporate Risks** • **Board Assurance Framework** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers presented the integrated view of the Trust Risk Register and Board Assurance Framework.

	The Trust had 552 active risks and overall exposure reduced slightly, but the profile remained highly challenged. Extreme and high-rated risks related to Emergency Department overcrowding and corridor care, fire safety and ageing infrastructure, critical workforce shortages, maternity, cyber security and core IT resilience. The Board recognised the close alignment between operational risks and the principal strategic risks. The Board received reasonable assurance that risk identification, ownership, escalation and committee oversight were established. However, assurance was weakened by overdue reviews and actions. Twenty-five per cent of risks were overdue for review and 338 of 659 open actions were overdue. Members regarded the 51% overdue-action rate, including long-outstanding safeguarding actions, as a material governance concern and supported continued targeted executive escalation. The Board noted that no material reduction had occurred in the strategic risk scores covered by the report, despite improvements in financial reporting, workforce controls, quality governance, cyber assurance, health and safety governance and estates planning. Members recognised that stronger governance did not automatically reduce residual risk where sustainable improvement depended on multi-year investment, workforce capacity and organisational change. The proposed Research, Innovation and Genomics strategic risk was considered. The risk addressed failure to develop, integrate and scale research, innovation, digital transformation and genomics safely and equitably. The Board considered the need for clearer divisional accountability, innovation and artificial intelligence governance, workforce capability, partnership development, equity data and evaluation methodology. **RESOLVED:** The Board: • NOTED the integrated position of the Trust Risk Register and Board Assurance Framework. • TOOK REASONABLE ASSURANCE that strategic and operational risks continued to be subject to defined executive ownership, active management and committee oversight. • NOTED that no material reduction in the strategic risk scores covered by the report had been identified, notwithstanding evidence of strengthening controls and assurance in several areas. • SUPPORTED continued executive focus on the management of extreme-rated risks, the timely completion of overdue reviews and actions, and evidence that controls were having the intended impact. • APPROVED the proposed Research, Innovation and Genomics strategic risk and the intention to consider its formal inclusion within the Board Assurance Framework.
14	**Chief People Officer's Insights Report** *Caroline Julien, Chief People Officer*
	Caroline Julien, Chief People Officer, presented a summary of current national workforce reform within the NHS and wider. This included developments in NHS Staff Standards, Leadership and Management Framework, nursing job evaluation, workforce inclusion,

	Transforming People Services, NHS PeoplePortal and the Employment Rights Act 2025. It was confirmed that the Trust had commenced a gap analysis including ensuring appropriate governance arrangements and a delivery model. The Board noted that these developments represented a shift towards nationally monitored expectations, with stronger Board accountability for performance in this arena. Oversight would continue through the People, Place and Partnership Committee but with renewed emphasis that activity monitoring alone would not be sufficient and the Board would want to be assured through clear delivery plans, measurable outcomes, milestones, risks, mitigations and evidence of impact. Vareta Bryan, Non-Executive Director, welcomed the shift of focus from activity to impact/outcomes for staff. Karen Johnson, Director of Finance, commented on the ongoing transformation review of corporate support services, particularly People services. It was acknowledged that the outline business case would be brought to future meetings for Board oversight. It was recognised that this programme of work could cause anxiety for impacted staff and the need to support staff during this period would be a primary focus of any delivery plan. In response to a question from Raj Kakar-Clayton, Associate Non-Executive, it was confirmed that the communications team would be closely involved in supporting the programme led by the People and Organisational Development team. It was acknowledged that these programmes would place significant demand on capacity within the team. The Board discussed elements of the report focused on culture; racism, discrimination, sexual safety, speaking up and leadership capability as connected patient-safety and workforce-sustainability issues. It also noted the required organisational response to the Employment Rights Act, the ongoing Transforming People Services programme. Caroline Julien observed that it would be important to evaluate the impact of various equality, diversity and inclusion initiatives to ensure that the most impactful programmes were supported. **RESOLVED:** The Board: • NOTED the scale and significance of the national workforce reforms and their implications for Board oversight, assurance and organisational readiness. • SUPPORTED oversight of the individual programmes through the People, Place & Partnership Committee, with regular reporting, targeted deep dives and escalation to Board where required. • ENDORSED alignment of these programmes with the Trust's workforce, culture, inclusion, digital, productivity and transformation priorities. • NOTED that further updates would be brought to the Board as national requirements, implementation plans and local risks become clearer.
15	**Guardian of Safe Working Annual Report** *Shyam Bhakthavalsala, Guardian of Safe Working*
	The Board received the annual report for 1 April 2025 to 31 March 2026. A total of 262 exception reports had been logged, with no fines levied. It was noted that in the decade since the reporting had been introduced the Trust had seen a reduction in reporting as rosters became compliant.

	The Board noted five reports identified as immediate safety concerns and discussed themes relating to working hours, educational opportunity and service support. There was a discussion as to the impact of the change in national rules from 4 February 2026. Whilst it was recognised the changes, which included the removal of the educational supervisor role in the process, had addressed doctors' concerns regarding confidentiality of reporting, it had increased the administrative burden on the Guardian and supporting team. The report also highlighted substantial bank and agency expenditure and the difference between funded vacancies and actual rota gaps arising from sickness or leave. The impact on the accuracy of the reporting data caused by the transition of platforms was acknowledged but it was anticipated that future monitoring would be more efficient and consistent. **RESOLVED:** The Board: • NOTED and took positive assurance from the Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training.
16	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director* • Infection Prevention and Control Annual Report • Safeguarding Annual Report
	Sam Foster presented the Committee's report from 30 July 2026 confirming the Committee's focus remained on both maternity and those services under mandated support. The Board noted improving maternity governance and continued self-assessed compliance with the eight Section 31 conditions, but significant residual risk in Maternity Incentive Scheme Year 8 compliance, workforce resilience, neonatal staffing, training and safeguarding capacity. It was confirmed that the Maternal Deaths Review was closed following completion of all relevant actions. It was anticipated that the Neo-natal review would close imminently. Trauma and Orthopaedics and Cardiology remained under mandated support. The Committee had received partial assurance on Trauma and Orthopaedics, with improvement activity in place but continuing risk an number of areas. Cardiology remained subject to enhanced oversight pending the formal Royal College report and evidence that the single improvement plan was delivering sustained change. The Board noted deteriorated June performance across urgent and emergency care, referral to treatment, diagnostics and cancer, with system flow, limited discharge capacity, diagnostic bottlenecks and heat-related estate disruption acting impacting performance. Positive assurance was received from the Infection Prevention and Control and Safeguarding Annual Reports, strengthened maternity leadership and closure of the maternal death action plan. The Board discussed the increasing focus on health inequalities as a key strand in progressing the Trust's strategic objective in respect of the patient voice. **RESOLVED:** The Board NOTED the report and in particular the approval, under delegated authority of the Infection Prevention and Control Annual Report 2025/26, which will now be published on the Trust website.
17	**Integrated Performance Report**

	Al Sheward-Chief Operating Officer, Karen Johnson- Director of Finance, Matt Holdaway-Chief Nurse, Mark Pietroni-Medical Director, Caroline Julien-Chief People Officer
	The Board reviewed performance for July 2026. Urgent and emergency care had improved, with Type 1 four-hour performance at 66.1%, 12-hour performance at 93.5%, paediatric performance at 85.2% and average ambulance handover at 18 minutes which represented a sustained improvement. Members welcomed the improvement but noted that performance remained below the required standard and gains were vulnerable to deterioration in discharge, staffing and capacity. Flow and discharge remained the principal operational risk. Discharge-ready patients and delays beyond 21 days had increased, and post-discharge-ready length of stay had deteriorated. It was noted that this had continued during August. Of particular concern was the average time for system partners to achieve Pathway 1 discharges, with an average 12 day delay in achieving discharge to community partners. This was having an impact on patients with notable delay related harm including patients requiring conversion from pathway 1 to pathway 2 discharge. Kevin McNamara confirmed that this issue was the subject of extensive discussions at CEO level across the system with a focus on the impact of the new pathway measures being led by Gloucestershire Health & Care NHS Foundation Trust from 1 September. It was noted that initial indicators, as at the date of the meeting, were showing early signs of an improving picture. Referral to Treatment performance reduced to 71.7% following waiting-list validation. Long waits increased, with risk concentrated in Orthopaedics, Spinal Surgery, Gynaecology and gastrointestinal services. Diagnostic performance deteriorated, mainly because heat and humidity disrupted MRI capacity and wider impact on the Estate. It was noted that the Orthopaedics service remained in mandated support, but it was anticipated that the move to focus on elective spinal at Cheltenham site and urgent surgery at the Gloucester site would make a positive impact. Cancer performance was noted to have stabilized but remained below standard: 62-day performance was 70.4%, Faster Diagnosis performance was 74.7% and 188 patients waited more than 62 days as at 2 August. Histopathology turnaround, outpatient capacity and treatment capacity remained key constraints, but it was anticipated that the diagnostic position would continue to improve as the heatwave impacts over the summer months receded. It was confirmed that histopathology recovery would be a key focus during Quarter 4. John Noble, Non-Executive Director, sought assurance on the recovery work priorities for cancer performance. Al Sheward, Chief Operating Officer, provided details of the recovery programme, with increased oversight, which had been in place since August and which would remain a focus during Quarter 3. The Board discussed in more detail the system-wide approach to address the delays in achieving the discharge to community services of patients no longer requiring acute hospital care, particularly discharge to Pathway 1 (discharge to home with support). This included the need for system partners to consider the resourcing of this service, including transparency of data sharing between providers to support system change and efficiency, with the Provider Partnership undertaking an increased role in this context. It was confirmed that this remained a primary focus for the Trust Executive team. Matt Holdaway confirmed that quality metrics were broadly stable. Complaints timeliness remained an area of focus with timeliness of responses still not at acceptable levels. It was

confirmed that the improvement programme would be a focus for Quarter 3. Patient experience scores had fallen, particularly for Gloucestershire Royal Hospital Emergency Department and the postnatal ward. The latter was being addressed with a Perinatal Improvement Plan being brought to the Perinatal Delivery Group. The plan was very positive and had been designed with input from service users. Patient Advice and Liaison Service (PALS) demand remained high, but it was acknowledged that staffing challenges had resolved during August and improvements in turnaround were expected.

Mark Pietroni, Medical Director, commented on the Complaints improvement programme with the team fully recruited. It was noted that there had been an increase in complaints relating to Corporate Services, in particular timeliness of Subject Access Request responses with the team implementing an improvement programme which was reported to both Finance and Resource Committee and Audit Committee. It was noted that the Summary Hospital-level Mortality Indicator continued to improve with the Trust being within the 10 top performing UK trusts.

Sam Foster, Non-Executive Director, commented on the remedial work within the complaints team and encouraged a move away from a focus on process towards a triangulation of data to identify areas of specific risk. She also suggested liaising with the Parliamentary & Health Service Ombudsman for advice on local early resolution approaches at ward level to ensure patients felt heard at the time, not many months later. Mark Pietroni indicated that would be a possible piece of work once the new complaints framework was embedded with Deborah Evans, Chair, suggesting a pilot approach may be appropriate.

<u>Workforce</u>
Workforce performance remained pressured. Appraisal compliance had fallen to 79%, sickness absence remained above expectation. Caroline Julien, Chief People Officer, confirmed there was work to be done on ensuring accurate data as to the causes of absence. It was recognised that there was a lack of descriptors available for mental health reasons for absence compared to physical health. It was recognised this would impact on the Trust's ability to identify the correct drivers for absence which in turn impacted support resource provided to individuals.

Agency and bank spend exceeded the NHS England caps. Job-plan compliance was 74%. The Board noted the need for stronger accountability, improved recording, e-rostering, targeted sickness analysis, grip and control over temporary staffing and completion of job plans.

<u>Finance</u>

Karen Johnson, Director of Finance, presented the Month 4 financial position, and confirmed it was broadly in line with plan, but the position remained fragile with Month 5 showing signs of stress. Financial Sustainability Programme delivery was slightly ahead year to date but continued to depend on non-recurrent savings, with a £6.2m unidentified gap and risk that recurrent delivery would not meet the full-year requirement. It was noted that capital expenditure was £6.6m behind plan which was of concern at the half-year point. The capital team had been asked to report to the senior executive team on the slippage against forecast and planned corrective actions. This would be brought to a future board meeting for scrutiny.

	It was also noted that the reduction in temporary staffing costs was not reducing at a rate which would achieve compliance with NHS England caps but it was acknowledged that there had been significant improvements in agency spend. It was confirmed that there would be a meeting with NHS England in October regarding the 6month/half-year position to consider the Trust's recovery forecast. It was noted that the Trust was ranked first in the region for productivity growth. **RESOLVED:** the board: • NOTED the contents of the integrated performance report. • NOTED the identified areas of improvement and deterioration and RECEIVED ASSURANCE regarding the actions being taken in response to performance changes.
18	**Appraisal Revalidation Report** *Mark Pietroni, Medical Director & Director of Safety*
	Mark Pietroni, Medical Director, presented the annual designated body report and statement of compliance. The Board received assurance that medical appraisal and revalidation arrangements were operating effectively, supported by trained deputy Responsible Officers, appraisal quality assurance, appraiser support groups and regular Revalidation Oversight Group meetings. The Board noted continuing improvement needs. The updated Appraisal and Revalidation Policy required final ratification and upload. It was confirmed that work to improve the triangulation of complaints, clinical incident and claims information and evidence submitted at appraisal continued. It was noted that this currently relied on individual disclosure within the appraisal documentation, but work was being undertaken to look at digital information sources alongside inclusion of 'soft intelligence' from Patient Advice and Liaison Service (PALS). Further appraiser recruitment and training of two new deputy Responsible Officers were planned. The Board considered the metrics and the need to maintain fairness, consistency, inclusion and appropriate oversight of conduct and performance concerns. It was satisfied that the report supported the required annual submission, subject to completion of the formal sign-off. **RESOLVED:** The Board: • APPROVED the submission to NHS England as set out in Annex A: Illustrative Designated Body Annual Board Report and Statement of Compliance for Gloucestershire Hospitals NHS Foundation Trust.
19	**Winter planning 2026/27 – Board Assurance Report** *Al Sheward, Chief Operating Officer*
	Al Sheward, Chief Operating Officer, presented the Trust's Winter Plan for 2026/27, supported by a draft Board Assurance Statement and Equality Quality Impact Assessment for the Board to review. A power point presentation was provided. He confirmed that last year's response to Winter had provided the Trust with a better understanding of the pressures and effective management measure. During preparations

	for Winter 2026/27 the divisional teams had continued to demonstrate areas of sustained improvement, with a focus on clinical flow across the Trust throughout the year. The Board were referred to the Winter Plan document and the accompanying Board Assurance Statement and Impact Assessment. It was confirmed that the current self-assessment, subject to the regional stress-testing exercise (16th September), was of full assurance across all domains. It was acknowledged that resilience still depended heavily on discharge, internal flow, workforce and completion of remaining assurance actions but there was confidence as to the assessment and the key controls in place to monitor performance against the required domains. The Board confirmed its commitment there would be no return to corridor care for post-admission patients. Work continued to eliminate the need for occasional corridor-care within the Emergency Department. The Board also discussed staff issues including management of annual leave during pressure periods, vaccination rates and mental health/welfare support for the teams. In addition, the Board considered the impact of rates of RSV (Respiratory Syncytial Virus) on the paediatric Emergency Department and wards, acknowledging that there was evidence of correlation between infection rates and areas of deprivation. The question was posed whether there was to be a targeted focus on this issue by community health partners. The Board were assured that there was a comprehensive and credible winter plan with clear operational controls and effective governance arrangements but did query whether there was value in considering further discussions with system partners regarding the impact of delayed discharge, both potential harm to patients and overcrowding, with consequent impact on performance. To facilitate this reflection and discussion with system colleagues it was suggested that the Executive Team may want to consider further, before submission of the Board Assurance Statement, whether assurance for the discharge domain was currently partial, rather than full. It was acknowledged that final assurance was still dependent on completion of the regional winter exercise, local stress testing, vaccination recording arrangements, QEIA completion and final sign-off before submission. **RESOLVED:** The Board: • Was ASSURED that the Winter Plan 2026/27 addressed the national Board Assurance Statement requirements. • ASSURED itself that all frontline vaccination activity will be recorded on the appropriate systems. • NOTED the current self-assessment of Full Assurance across all applicable domains but confirmed that this would be reviewed further by the Chief Executive Officer, Chair and Chief Operating Officer, with delegated authority to sign-off the Assurance Statement on behalf of the Board within the required time period.
20	**Green Plan** *Will Cleary-Gray, Director of Improvement and Delivery and Jen Cleary, Head of Sustainability*
	Will Cleary-Gray presented the Green Plan for Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services. The plan set the route towards net zero for directly controlled emissions by 2040 and indirect emissions by 2045, while embedding

	sustainability as a golden thread across clinical care, workforce, digital transformation, estates, medicines, travel, procurement, food, adaptation and partnerships. The Board welcomed the 23% reduction in direct carbon emissions over the previous plan period and the 5.4% reduction in 2025/26. However, members noted that further actions and funding were still required to reach the interim trajectory and long-term targets. The Board discussed the need for measurable annual objectives, stronger integration with estate resilience and clinical transformation, and explicit links to health inequalities and climate adaptation. The Board recognised that heatwaves, poor air quality and infrastructure fragility were current patient-safety and operational risks rather than distant environmental issues. Governance through the Climate Emergency Response Leadership Group, Finance and Resources Committee, Gloucestershire Managed Services Board and annual reporting would be required to demonstrate delivery and impact. Non-Executive Directors commented positively on both the quality and accessibility of the Report and encouraged the Service to consider how to ensure it was communicated to staff but also to consider, for future reports, how to harness the interest of the local community in issues impacting sustainability as our patients and local population had a role to play alongside staff. **RESOLVED:** The Board: • APPROVED the Green Plan 2026-2030, accepting the aims, targets and focus on green sustainability over the next five years.
21	**Finance and Resource Committee Report** *Jaki Meekings-Davis, Non-Executive Director*
	Jaki Meekings Davis presented the Committee report from July 2026. The Board noted as Alert items the continuing concern regarding the procurement element of the new finance and procurement system, where implementation had slipped with associated governance and potential fraud risk. The Committee also identified insufficient estate asset data, with only half of assets recorded in enough detail to support future investment decisions and had approved development of a business case for a comprehensive survey. Other areas of focus highlighted to the Board were performance against both the Financial Sustainability and estates capital spend targets. **RESOLVED:** The Board NOTED the report for assurance.
22	**Any other business**
	There was no further business for discussion.
23	**Governor observations**
	Andrea Holder spoke on behalf of the governors, noting the Staff Story with a governor visit to the Service planned for the new year. She also acknowledged the uncertainty caused by the proposed removal of the statutory functions of the Council of Governors in the NHS Bill and the proposed local government restructure.
Close: 13.00 **Date and time of next meeting:** *Thursday 12th November, 09.00 to 12.30* *Lecture Hall, Redwood Education Centre,*	

Gloucestershire Royal Hospital

Actions/Decisions			
Item	**Action**	**Lead / Due Date**	**Update**
20/July	**Integrated Performance Report** 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 **November 2026**	
26/May	Executives to consider bringing a report equivalent to the Nursing Safer Staffing Report for non-nursing staff groups to People and Organisational Development Committee (6 monthly) and Board (annually). Initial focus to be on medical workforce	Medical Director / Chief Nurse / Chief People Officer **November 2026**	
13/Sept	Add the approved Research, Innovation and Genomics strategic risk to the Board Assurance Framework and establish the associated assurance route.	Trust Secretary **November 2026**	
18/Sept	Revalidation Report - Complete formal sign-off and submission of the Designated Body Annual Board Report and Statement of Compliance.	Medical Director/Trust Secretary **30 September 2026**	COMPLETE

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12 November 2026
Report title	Chairs report to November'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 September 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	✓

Digital first	✓

Main Report

1. Purpose

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

2. Non Executive Director changes

This Board meeting is the last for Marie Anick Gournet who finishes her second full term as a non-executive director at the end of November 2026. I have previously thanked her for her various roles which have included chairing People and Organisational Development Committee, and previously the Charitable Funds Committee, being the NED link for Freedom to Speak up and the BME network and playing a full role in Board meetings and Board development sessions. It is also fitting that Marie Annick led a session for us in Black History month on Reparative Justice which attracted colleagues locally and as far afield as Sheffield. Thank you for all your contributions, Marie Annick.

At the time of writing, we are in the process of recruiting a replacement for Marie Annick.

Sam Foster has also announced that due to changing professional commitments she won't be able to stand for a second three year term as a Non-Executive Director when her first term finishes in April 2027. We will be looking to replace her through an open, competitive process.

3. Visits and ambassadorial activities.

I have been active in visits as ever. Some highlights are below:

- Our Chief Executive and I ran a session for new Chief Executives drawn from across the country on the Chair / CEO relationship

- I shadowed a volunteer at Hatherley ward, our stroke rehabilitation unit. This person started as a volunteer on Tivoli ward and subsequently secured a Healthcare Assistant role there but still wanted to continue as a volunteer so is also working on Hatherley ward.
- The Governor / Non Executive Director visits have included the liver unit at Cheltenham General Hospital.
- Our most recent Quality and Performance Committee Deep Dive covered End of Life Care and Oncology. The dedication of colleagues in these teams, the challenges caused by the workforce shortage in Consultant Oncologists and the impact of poor estates were the stand out images on this visit.
- Sam Foster and I visited the Trauma Assessment Unit and the Surgical Assessment Unit at Gloucester Royal Hospital. The range of issues we discussed with colleagues included availability and timeliness of scans, medical cover, waiting times and pain relief.

Highlight from ambassadorial activities and networking meetings include:

- The Bristol, North Somerset and South Gloucestershire (BNSSG) chairs' forum with Jeff Farrar, BNSSG ICB Chair; the South West Chairs meeting with Dame Gill Morgan, South West Regional Chair
- Health Overview and Scrutiny Committee – which included updates from the Trust on Winter Planning and Maternity Services.
- A meeting with Kaye M Fox and Gloucestershire Managed Services (GMS) colleagues to learn more about their outreach inclusion opportunities for young disabled people, people who have recently arrived in the UK and apprenticeships. It illustrated that the Trust and GMS have much to learn from each other.
- Our Postgraduate Medical Education Conference with keynote speaker Dame Jane Dacre who spoke about the national Medical Education and Training review and its implications for us. Raj Kakar Clayton who is our Associate NED with a lead on resident doctors accompanied me and we enjoyed a presentation about the "Bone Phone" initiative to provide an interactive and supportive induction for new orthopaedic resident doctors in our Emergency Departments.
- The Quality Improvement (QI) Academy graduation presentations, which included two interesting QI projects in cardiology and an outstanding one about improving throughput for nephrostomy patients by changing their pain relief regime.

4. Recommendation

The board is asked to note this report

Enclosures: None

FOI: Public

Chief Executive Report to Board – Nov 2026

1 Patient Experience & Voice

1.1 Health Bill 2026

The Health Bill 2026 represents a significant change to the way the NHS in England is organised. Key proposals include the abolition of NHS England, changes to integrated care boards and NHS foundation trusts, new patient-safety arrangements and the creation of a Single Patient Record, intended to make patient information available across healthcare settings and directly to patients. The Bill completed its Commons stages on 8 September and received its Second Reading in the House of Lords on 13 October 2026.

There has been a significant development in relation to Healthwatch. On 28 October, the Government announced that it will no longer proceed with plans to abolish Healthwatch England and local Healthwatch organisations. Instead, Healthwatch will be retained and strengthened, with a greater role in identifying recurring concerns and ensuring patient and public experience informs improvements in quality, safety and care. The change maintains an independent route for patient and community voice as wider NHS structures are reformed.

The Bill also strengthens the focus on involving patients and the public when services are developed or changed. Parliament is considering whether this should go further, with patients and service users involved earlier in co-designing and shaping services, rather than only being consulted once proposals have been developed.

For the Trust, the developing legislation reinforces the importance of early and meaningful involvement of patients, communities and partners when services are being developed or changed. At this stage, we have not identified a change in the Bill that establishes a new threshold for when NHS providers must undertake formal public consultation on service change.

The legislation also has implications for Foundation Trust governance and Governors as wider accountability arrangements change. We are reviewing our own local arrangements to ensure our approach to public involvement is enhanced with updates to the Board in due course.

1.2 ICB merger and wider system changes

NHS England has confirmed that the majority of planned Integrated Care Board (ICB) mergers will not proceed in April 2027 as previously anticipated, while the Government considers future devolution, local government and strategic authority arrangements. The intention nationally is to allow future ICB boundaries to align more closely with those wider public-sector arrangements. In comparable areas, future ICB footprints are expected to be determined following further consultation during 2027, with changes expected from April 2028.

Locally, this means that the planned formal merger of NHS Gloucestershire ICB and NHS Bristol, North Somerset and South Gloucestershire ICB will not proceed in 2027. However, the two organisations will continue the closer working already established through their cluster arrangements.

1.3 Local government reorganisation and devolution

On 29 October, the Government set out the next steps for local government reorganisation in Gloucestershire. Following a review, the Government has withdrawn the decisions announced in July and is now expected to confirm a single unitary council for Gloucestershire. A final decision will be announced before Christmas, following a further opportunity for local views to be considered.

If confirmed, elections to the new council would take place in May 2028, with the new authority formally established in April 2029. Elections to Cotswold, Forest of Dean and Tewkesbury councils will meanwhile go ahead on existing boundaries in May 2027.

There has been no further announcement on wider devolution for Gloucestershire, and the county was not included in the Government's devolution announcements alongside the Budget on 28 October. Local council leaders have said they will continue to make the case for a devolution deal for Gloucestershire.

1.4 Consultant Doctors Industrial Action

The British Medical Association (BMA) has announced two days of industrial action by consultant doctors in England, beginning at 06:59 on 25 November 2026. During the action, consultants will provide emergency care only, known as "Christmas Day cover", which is likely to cause disruption to routine and planned services.

The action follows a national ballot in which 76% of participating BMA consultant members voted in favour of industrial action, on a turnout of just over 51%. The dispute relates to pay and working conditions, including proposals to reduce the standard working week from 40 to 35 hours, increased recognition and payment for out-of-hours work, and changes to pension arrangements.

The Trust is activating its established industrial action planning arrangements, drawing on learning from previous periods of industrial action. The priority will be to maintain patient safety and urgent and emergency care while minimising disruption to planned services wherever possible.

The action nevertheless presents a significant operational risk. The move to emergency-only consultant cover is likely to affect planned care and elective activity and could consequently impact waiting-list recovery and wider productivity and improvement plans. The Trust will continue to monitor national discussions between the Government and BMA alongside detailed local planning ahead of the strike action.

1.5 Homes births and Cheltenham Birth Centre

The Trust has confirmed the next steps in restoring and strengthening community birth choices across Gloucestershire, through the introduction of a new countywide Community Birth Team.

From 4 January 2027, home birth services will restart across Gloucestershire and the new Community Birth Team will begin providing labour and birth care at Stroud Maternity. Women will continue to be able to choose Stroud for their birth. Cheltenham Birth Centre will reopen from 1 February 2027, restoring another important choice for women and families.

The Community Birth Team will operate 24 hours a day, seven days a week, working flexibly to support births at home, Stroud Maternity and Cheltenham Birth Centre. The new approach has been designed to provide a safer, more reliable and sustainable service, supported by additional recruitment, training and new staffing arrangements.

Implementation will be phased to support a safe transition to the new model. The Trust will closely monitor staffing, safety, activity, outcomes and the experiences of women and families as the service is introduced, so that any early issues can be identified and addressed.

2 People, Culture and Leadership

2.1 Protecting patient information and health records

There has been increased national and regional scrutiny of inappropriate access to patient records, following a number of high-profile cases in which NHS staff have accessed confidential information

without a legitimate work-related reason. Some cases have resulted in staff being dismissed and have prompted wider concern from the Information Commissioner and National Data Guardian about the protection of patient information.

NHS England has subsequently strengthened its guidance to NHS organisations, calling for a zero-tolerance approach to unauthorised, inappropriate or unjustifiable access to patient information. The national position is clear that accessing a patient's records without a legitimate work-related reason is unlawful, can seriously undermine patient and public confidence and, in almost all circumstances, should be considered gross misconduct. Consequences can include disciplinary action or dismissal, referral to professional regulators and potentially criminal investigation.

In response, the Trust is running a staff awareness campaign to reinforce the national guidance and colleagues' individual responsibilities when accessing patient records.

2.2 Staff car parking group

Car parking remains a significant practical challenge for many colleagues, particularly those working shifts, out of hours or across different sites. Some of these car parking challenges have been compounded by a range of essential estates work that has taken place over the summer which has impacted the availability of spaces. Listening to concerns raised by staff, the Trust has established a Staff Parking Task and Finish Group, bringing together colleagues from a cross-section of services to share their experiences and identify practical improvements.

The group has highlighted issues including availability of spaces for later shifts and community teams, personal safety, permits and penalty notices, the impact of building works on parking capacity, and the cost and practicality of alternative travel arrangements. These have now been brought together into a single improvement plan.

A number of practical actions are being progressed, including reviewing out-of-hours parking at both Gloucestershire Royal and Cheltenham General Hospitals, identifying opportunities to return spaces currently affected by building works, improving lighting, safety and accessibility, addressing problems with permits and the parking app, and exploring better park-and-ride, public transport and rail options.

Some changes are already being implemented. From 28 October, a car park next to Medical Records at Gloucestershire Royal Hospital became a dedicated Shift Worker Permit holder car park, following the loss of the previous shift-worker car park to enable development of the new Department of Critical Care.

While the underlying shortage of parking, particularly at Cheltenham, cannot be resolved quickly, the work is providing a more coordinated way of listening to colleagues, identifying achievable improvements and acting quickly where changes can be made. The group will continue to oversee delivery of the improvement plan and identify further opportunities to improve colleagues' experience of travelling to and from work.

2.3 Inclusive recruitment

The Trust is strengthening its approach to fair and inclusive recruitment through the introduction of trained Inclusion Advocates on interview panels.

Inclusion Advocates will be full members of recruitment panels, participating in candidate assessment and decision-making alongside other panel members. Their role is to provide an additional level of assurance that candidates are assessed fairly, consistently and against agreed criteria, while helping panels recognise and challenge potential bias or inappropriate assumptions.

The approach is being introduced in phases, with Inclusion Advocates initially supporting recruitment to Band 7 roles and above. Colleagues from all staff groups, professions and

backgrounds can become advocates, subject to completing tailored training covering inclusive recruitment, conscious and unconscious bias, constructive challenge and objective, evidence-based decision-making.

The aim is intended to embed inclusion more consistently into recruitment practice and support the Trust's wider commitment to creating a diverse and inclusive workforce. Recruitment decisions remain the collective responsibility of the interview panel, with Inclusion Advocates providing additional challenge and assurance rather than holding a separate decision-making role.

3 Quality, Performance and Safety

3.1 New national guidance on single-sex facilities and accommodation

On 15 October 2026, NHS England published revised national guidance on single-sex hospital accommodation and staff facilities. The guidance follows the Equality and Human Rights Commission's statutory Code of Practice and requires NHS organisations to review their local policies, practices and facilities.

For patient accommodation, the guidance states that, to maintain accommodation as single sex under the Equality Act 2010, trans people and others with the protected characteristic of gender reassignment should be accommodated in line with their biological sex. It also makes clear that clinical need must continue to be met and that privacy, dignity and safety must be maintained for all patients.

The guidance also covers staff facilities, including toilets, changing, washing and showering facilities, and recommends that organisations review current provision and consider arrangements for lockable single-occupancy facilities. This may have practical and estates implications for NHS organisations.

The Trust has established a task and finish group to coordinate its response. The group will assess current arrangements across clinical services, workforce policies, estates and facilities, governance, digital systems and communications. This will enable the Trust to understand the practical implications of the guidance and identify any changes required.

Implementation is a complex and sensitive issue. The Trust's approach will be guided by the law and national NHS guidance, while maintaining our commitment to safe, compassionate and respectful care and workplaces for everyone. Appropriate support is available for colleagues who may be affected by the changes.

4. Digital

4.1 Increasing cyber risks

The cyber-security threat facing the NHS continues to increase, with vulnerabilities being exploited increasingly quickly. During the reporting period, the Trust responded to a critical vulnerability affecting some of its technology, following evidence of attempted exploitation against NHS organisations, including the Trust. Although no compromise was identified, attempts to exploit the vulnerability began very shortly after it became known, demonstrating how quickly cyber threats can move from identification to active attack and the limited time available to put protective measures in place.

On 22 October 2026, the Trust responded to a global cyber-security incident affecting websites and organisations internationally, including NHS organisations. The incident prompted an immediate review of the Trust's digital systems, websites and third-party services.

The Trust's main public website and staff intranet were assessed with our website supplier and confirmed as very low risk, as they do not use the technology affected by the vulnerability. Both continued to operate normally.

As a precaution, a small number of separately hosted websites, including the Careers and Cotswold Neurology websites, were temporarily suspended while further checks were completed. At the time of the update, no issues had been identified with these sites.

4.2 Nursing Documentation 2.0

Nursing Documentation 2.0 is a redesign of nursing documentation within the Trust's Electronic Patient Record (EPR), including the introduction of Workflow Manager. This gives nurses a clearer view of the assessments and documentation that need to be completed, while aiming to reduce duplication and make documentation simpler and more consistent.

Early monitoring shows improved completion of important assessments when patients are admitted, including falls, nutrition, pressure ulcer and infection prevention assessments. Completing these more consistently helps clinical teams identify risks earlier and ensures important information is available to those caring for patients.

Staff have adapted well to the new approach, with only a small number of minor issues identified and resolved since it was introduced. Formal measures of the impact on staff workload and experience will form part of the ongoing evaluation of benefits.

Dashboards are also being updated to provide real-time monitoring of key safety assessments. This will help teams identify whether assessments are being completed when they should be and whether improvements are being sustained.
This work forms part of the Trust's wider programme to improve and optimise the EPR.

Following approval of the EPR optimisation business case, further work will now be undertaken to improve how the system supports clinical care, staff experience, patient safety and operational efficiency. This will include detailed engagement with clinical teams and relevant suppliers.

Taken together, this work is intended to protect patient information, strengthen the resilience of clinical services and make digital systems safer and easier for colleagues to use.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Date of Meeting	12 November 2026
Report title	Community Birth Team and Community Maternity Services: Implementation Update
Sponsoring Director/Author	Matt Holdaway, Chief Nurse and Director of Quality Mark Pietroni, Medical Director and Director of Safety Nicola Moore, Deputy Director of Midwifery Zita Martinez, Director of Midwifery

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

Executive Summary

This paper updates the Trust Board on implementation of the dedicated countywide Community Birth Team, following formal staff consultation. The team will operate 24 hours a day, seven days a week, supporting birth at home, at Stroud Maternity Hospital and, following reopening, at Cheltenham Birth Centre. Staff will be deployed according to where community births are taking place rather than permanently based at each location. Women will continue to be able to choose Stroud for their birth, and community maternity services will continue to be provided from Stroud.

Home birth services and the new Community Birth Team arrangements at Stroud are scheduled to begin on 4 January 2027, followed by reopening of Cheltenham Birth Centre on 1 February 2027. The Trust is confident that the 4 January 2027 start date is achievable. The revised timetable allows completion of recruitment, training, safe rotas, caseload transfer and estates preparations. Each phase remains subject to confirmation of workforce, training, clinical governance, estates and operational readiness. The Board is asked to note progress, the phased implementation plan and arrangements for monitoring safety, reliability and experience, and to agree ownership of the final go/no-go decision for each phase.

Recommendations:

The Board is asked to:
NOTE
• progress in establishing the countywide Community Birth Team and the intended benefits for safe, sustainable community birth choice;
• the scheduled restoration of home births and introduction of the new Stroud staffing arrangements on 4 January 2027, followed by reopening of Cheltenham Birth Centre on 1 February 2027;
• that women will continue to be able to choose Stroud Maternity Hospital for birth and that community maternity services will continue from Stroud;
• that implementation remains subject to confirmation of readiness for each phase and that safety, activity and experience will be monitored through maternity governance.
AGREE that the Chief Nurse and Director of Quality will hold accountability for the final go/no-go decision for each implementation phase, subject to confirmation of readiness.

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

Impact on any Strategic Risks?

SR1 - Inability to deliver safe and effective services against regulatory and statutory requirements
The Community Birth Team is intended to address workforce fragility and improve the safety, sustainability and reliability of community birth services. Implementation depends on sufficient staffing and skills mix, completed training, escalation arrangements and suitable facilities, with readiness confirmed before each phase begins.

Implications on:	
Equality, Diversity and Inclusion	The model aims to restore community birth choice across Gloucestershire and support personalised care reflecting women's preferences and clinical needs. Feedback from women, families, staff and stakeholders will inform implementation.

Health Inequalities	The countywide approach is intended to address inconsistency and inequity in community maternity provision. Restoring home births and reopening Cheltenham, while maintaining Stroud as a place of birth, will broaden available choices. Any improvement in access or experience will need to be demonstrated through monitoring rather than assumed from implementation alone.
Finance and Resource	Delivery requires recruitment, training, safe staffing rotas, caseload transfer and estates preparations at Cheltenham Birth Centre. The model aims to make better use of the available workforce across community birth settings. No additional funding is required or requested through this paper.
Regulation/Legal	Formal staff consultation has taken place. Implementation prioritises safe, sustainable care, supported by clinical governance and escalation arrangements, with readiness confirmed before each phase.
CQC-Key line of enquiry	The plan supports safe staffing, personalised care, service responsiveness and listening to women, families and staff, relevant to safe, effective, caring, responsive and well-led services.
Green Plan	Implications of countywide staff deployment and use of community facilities remain to be assessed.

Main Report

1. Purpose and background

This paper provides the Trust Board with a high-level update on the Community Birth Team implementation plan and the phased restoration of community birth choices across Gloucestershire.

The programme was established to address longstanding workforce fragility, inconsistency and inequity in community maternity provision. Its aim is to provide safe, sustainable midwifery-led care and choice of birth setting, restoring home birth services and reopening Cheltenham Birth Centre while maintaining Stroud Maternity Hospital as a place of birth.

2. Case for change

Home birth services were suspended in October 2025 following staff concerns about the safety and sustainability of the previous on-call arrangements. Before suspension, workforce pressures and difficulty filling shifts caused frequent short-notice disruption. Concerns also included staff fatigue and wellbeing, lone working and adequate rest periods. Reinstating the previous arrangements was therefore not considered a sustainable or reliable solution.

Cheltenham Birth Centre has remained closed since 2022 because it could not be staffed reliably and safely. Although maternity recruitment has improved, a separate permanently staffed service was not considered sustainable. At Stroud, the review identified low labour and birth activity and

opportunities to deploy the available workforce differently. Stroud nevertheless remains an important part of the community maternity offer, and women will continue to be able to choose to give birth there.

3. Community Birth Team model

Following formal staff consultation and consideration of feedback, the Trust has progressed a dedicated countywide Community Birth Team operating 24 hours a day, seven days a week. The team will support home births across Gloucestershire and births at Stroud Maternity Hospital and, following reopening, at Cheltenham Birth Centre. Staff will be deployed according to where community births are taking place rather than permanently based at each individual location.

Care will be planned with each woman, taking account of her preferences, clinical needs and the support required for safe care. The team will work flexibly across community birth settings, with clear escalation arrangements when demand exceeds available capacity or additional clinical support is required. The intended benefits are greater resilience and reliability alongside restoration of community birth choice; these benefits will need to be demonstrated as the service becomes established.

At Stroud, labour and birth care will be provided by the new Community Birth Team from 4 January 2027, subject to readiness confirmation. Women will retain the choice to give birth at Stroud and community maternity services will continue from the site. The model also provides opportunities to develop more structured antenatal and diagnostic clinics and make better use of Stroud for maternity care; these are opportunities rather than confirmed additional services in this update.

3.1 Continuity of care

The Community Birth Team will work alongside existing community midwifery teams. Women planning a community birth early in pregnancy will receive care through the dedicated team during pregnancy and birth. Women choosing community birth later can transfer their care to the team or remain with their existing community midwife, with the Community Birth Team supporting labour and birth. This supports continuity through a dedicated team while preserving individual choice; it does not guarantee care from the same midwife throughout. The wider maternity birth offer remains available.

4. Implementation timetable and readiness

Home birth services across Gloucestershire and the new Community Birth Team staffing arrangements at Stroud are scheduled to begin on 4 January 2027. The Trust is confident that this start date is achievable. Cheltenham Birth Centre is scheduled to reopen on 1 February 2027. Each phase remains subject to the Trust confirming that the necessary workforce, training, clinical governance, estates and operational arrangements are in place to support safe and sustainable delivery. Readiness approval will be required before each phase, supported by evidence of safe rota cover, current clinical competence, emergency transfer and escalation arrangements, equipment and facilities readiness, and mitigation of the risks that led to the original suspension. It is proposed that ownership of the final go/no-go decision for each phase is agreed by the Board. Any unresolved readiness concerns or material changes to the timetable will need to be escalated through Trust governance before implementation proceeds.

From 3rd November 2026, women will be able to discuss with their midwife plans for a home birth on or after 4 January 2027, where appropriate. The phased approach will first restore home births and introduce the new Stroud arrangements, before extending the model to Cheltenham.

Further new members of the team are expected to come into post during January. These additional starters are not required for the launch of home birth services and the new Stroud arrangements on 4 January 2027, but will strengthen the team ahead of Cheltenham Birth Centre's reopening on 1 February 2027. Staff must complete the required training and orientation before undertaking that work. January will also allow the initial arrangements to become established and the remaining estates preparations at Cheltenham Birth Centre to be completed.

The Trust recognises that women and families hoping to use Cheltenham may be disappointed by the later reopening, particularly given the length of closure. The February timetable is intended to allow the necessary staffing, training and facilities to be in place before births resume.

5. Revised timetable and implementation dependencies

Implementation was previously planned by the end of autumn 2026. The revised timetable allows additional time for recruitment and onboarding, training, safe staffing rotas, caseload transfer and estates preparations. The Trust recognises that women and families have waited longer than anticipated; the priority remains a safe, reliable and sustainable service.

6. Safety, monitoring and engagement

Staffing, activity and outcomes will continue to be monitored through maternity governance as the service becomes established. Staffing and skills mix must support personalised care, with escalation arrangements when demand exceeds available capacity or further clinical support is required. Monitoring will need to establish whether the model delivers the intended improvements in reliability, sustainability and choice.

A coordinated communications and engagement plan supports phased implementation. Staff communication about the change has taken place, including a verbal briefing with the Community Matron and Director of Midwifery on 3 November 2026. Planned stakeholder briefings, accessible public information and updates will explain the model, implementation dates and how women can discuss community birth preferences. Communications will continue through the January introduction and preparations for Cheltenham's reopening on 1 February 2027. The Trust will continue to listen to women and families, maternity staff and stakeholders, particularly in the early months, so that questions and feedback inform communications and ongoing service development.

7. Risks and Board assurance

The main implementation risks are delays in completing workforce, training, caseload transfer, operational or estates preparations, and demand exceeding available capacity across community settings. The phased timetable, readiness requirements and escalation arrangements are intended to manage these risks.

Clear communication and continued engagement are important for women and families awaiting the restoration of community birth choices. The Board is asked to note progress and the phased plan, and to agree ownership of the final go/no-go decision for each implementation phase. Each phase will proceed only once the Trust is assured that the required arrangements are in place.

Monitoring will assess whether the model delivers the intended improvements in safety, reliability, sustainability and experience.

Enclosures
None.
FOI: *Public*

Report to Trust Board

Date of Meeting	12 November 2026
Report title	Maternity and Neonatal 10 Point Plan: Board Assurance November 2026 Update
Sponsoring Director/Authors	Matt Holdaway, Chief Nurse and Director of Quality Mark Pietroni, Medical Director and Director of Safety Joint Executive Sponsors, with shared Board-level accountability for maternity and neonatal safety, quality, experience and improvement. Zita Martinez, Director of Midwifery Nicola Moore, Deputy Director of Midwifery Sarah Ashwood, Perinatal Governance Lead Midwife (Supported by Suzie Cro, Director of Quality Governance)

Purpose (confirm the appropriate box)

For approval	For discussion	For information
x		

Executive Summary

Purpose of the report

The Board is asked to review and endorse the Submission B position at 31 October 2026, set out in Appendix 1. This is the November progress position, not the final submission position: further evidence and assurance will continue to be gathered and scrutinised before the NHS England Maternity and Neonatal 10 Point Plan progress return is submitted by 31 December 2026. The appropriate governance route for final review and approval will be agreed with the Chair and Trust Secretary.

ALERT
Full compliance is not yet evidenced. Of 26 deliverables, nine are Completed at baseline, two are Complete/Green and 15 remain In progress/Amber.

Workforce sustainability is the principal delivery risk. Further investment is required across midwifery, neonatal medical and neonatal nursing workforce to support sustainable staffing and safe service delivery. Funding and implementation of the required workforce plans are not yet evidenced as complete. Interim staffing arrangements, acuity monitoring and escalation mitigate current pressures but do not replace sustainable funded capacity.

Health inequalities: Further evidence is required to demonstrate outcomes and experience analysis by ethnicity and deprivation, data limitations, and the response and impact arising from identified variation.

Further evidence is required to demonstrate consistent PSIRF application across maternity and neonatal services and how learning from complaints informs improvement, although PSIRF is considered embedded. Complaints recovery and learning remain under established governance oversight. Evidence must demonstrate the recovery trajectory, timely responses and early resolution, supported by thematic learning through the Listening and Learning Group and the 12-month complaints deep dive in progress. It must also demonstrate named family contacts, timely communication, compassionate debriefs and early senior-manager candour.

Post-death care assurance remains pending finalisation of the Annual Mortuary Report, this report must evidence continuing oversight, retrospective incident-review findings and outstanding work, national/audit action progress, risks, mitigations and accountable owners.

ADVISE

The enhanced Quarter 2 Perinatal Quality Oversight Report and Perinatal Workforce Report will provide evidence of progress against the relevant 10 Point Plan requirements through established Maternity Incentive Scheme reporting arrangements. They will be scrutinised through the Perinatal Delivery Group and Quality and Performance Committee during November, alongside mortuary assurance planned for committee consideration on 26 November. Evidence available through these processes before submission will inform the final December position.

Continue to gather and validate outstanding evidence and ensure that it is subject to appropriate governance scrutiny before submission. The Chief Nurse and Medical Director may validate evidence and make non-material amendments. As there is no scheduled Board meeting in December, the appropriate governance route for final review and approval of Submission B will be agreed with the Chair and Trust Secretary and may include an extraordinary Board meeting. Any material changes will require further Board approval before submission. Final approval and submission records will be retained.

ASSURE

Joint Chief Nurse and Medical Director accountability is established. The September baseline was submitted by 25 September and reviewed by NHS England South West, whose assessment was communicated on 16 October: nine compliant, 17 partially compliant and none non-compliant. This historical regional assessment remains distinct from current Trust delivery ratings. Overall assurance remains Moderate: controls are generally sound, with exceptions and incomplete compliance, evidence gaps and material workforce dependencies. Assurance is available over accountability, reporting and specified completed requirements, but not full implementation or sustained improvement across all requirements.

Validate supporting evidence and test whether controls are operating effectively through executive and committee scrutiny. Evidence available ahead of the December submission will bring together workforce, safety, outcomes, experience and inequalities to demonstrate what has changed, the effectiveness of interim controls, remaining gaps and required corrective actions.

APPLAUD
Additional September Board evidence supports the Trust's Complete/Green assessments for requirements 9.1 and 9.2: triage audit/reporting and Board oversight. This strengthens evidence of those requirements, rather than demonstrating newly delivered improvement since September. It does not establish full triage compliance: the audit reported 75% compliance and Amber service-delivery confidence.

Sustain triage scrutiny and supporting records, continue staffing, timeliness, data and equity improvements, and test their impact.

Board focus
Review and endorse the current progress position, confirm joint executive accountability and require timely workforce investment decisions and action delivery. Ensure outstanding evidence is appropriately scrutinised and that the final approval route is confirmed ahead of submission by 31 December 2026. Maintain committee scrutiny and immediate escalation of significant risks.

Previously considered by	Director of Midwifery

Recommendations:

The Board is asked to:

- **NOTE** the Moderate assurance position, incomplete compliance and regional feedback.
- **ENDORSE** the Submission B position as at 31 October 2026, recognising that further evidence and assurance will be gathered and scrutinised ahead of final submission.
- **CONFIRM** joint executive accountability and accountable delivery of outstanding actions.
- **REQUIRE** timely decisions and implementation plans for the investment required across midwifery, neonatal medical and neonatal nursing workforce.
- **AGREE** continued committee scrutiny and immediate escalation of significant risks.
- **AGREE** that the appropriate governance route for final review and approval before submission will be confirmed with the Chair and Trust Secretary and may include an extraordinary Board meeting.
- **AUTHORISE** the Chief Nurse and Medical Director to validate evidence and make non-material amendments only. Material changes require further extraordinary Board approval before submission.

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

Impact on any Strategic Risks?

SR1 - Inability to deliver safe and effective services against regulatory and statutory requirements The report supports mitigation of SR1 through Board oversight of delivery, risk and improvement. Assurance remains Moderate, with residual risks in workforce capacity and funding, inequalities, family engagement, learning impact and post-death care. Sustainable risk reduction depends on funded workforce plans, completion of outstanding actions and evidence of their effectiveness.	
Implications on:	
Equality, Diversity and Inclusion	Assurance must demonstrate inclusive engagement and accessible communication, particularly for communities experiencing poorer outcomes or barriers to care.
Health Inequalities	Improvement must respond to variation in outcomes and experience by ethnicity and deprivation, with clear actions and evidence of impact.
Finance and Resource	No financial approval is sought in this paper. Sustainable delivery requires appropriate investment across midwifery, neonatal medical and neonatal nursing workforce, supported by clear implementation plans, recruitment and skill-mix recovery.
Regulation/Legal	Board-approved Submission B is due by 31 December 2026. Material changes require Board approval; approval and submission records must be retained, with significant concerns escalated through ICB and regional routes.
CQC-Key line of enquiry	Relevant to safe care, safeguarding, learning, governance, sustainability, equitable access and involvement.
Green Plan	No direct impact identified.
Main Report	

1. Background and national context

NHS England’s letter of 12 August 2026 established the Maternity and Neonatal 10 Point Plan assurance process following the Amos and Ockenden reviews. Delivery of the urgent actions remains the immediate national priority.

The process is intended to evidence progress through existing governance and assurance, using Board and committee papers, minutes, dashboards and relevant Maternity Incentive Scheme Year 8 evidence, without creating additional reporting burdens.

2. National requirements for Board assurance

The September baseline and December progress return are separate assessments requiring Board approval. At the point of the November Board, work remains in progress and further evidence will continue to be gathered ahead of the December submission.

Further evidence, including Q2 reporting and the biannual staffing paper, will be considered through the Trust's established governance processes, including scrutiny at Quality and Performance Committee during November. The final review and approval route for Submission B remains to be agreed with the Chair and Trust Secretary because there is no scheduled Board meeting in December. This may include an extraordinary Board meeting to enable the updated evidence and assurance arising from this scrutiny to be considered before submission.

The Chief Nurse and Medical Director may validate evidence and make non-material amendments only. Any material changes to the position will require further Board approval before submission, through the governance route agreed with the Chair and Trust Secretary. Non-material amendments will be recorded in a change log.

The return and supporting evidence will be submitted to NHS England South West via Futures by 31 December 2026. Final checks will confirm rating consistency, accessible evidence, approved decisions and the named executive signatory. January reports will remain recorded as planned, not completed. Approval and submission records will be retained.

3. Key areas requiring local oversight

Board oversight should continue to focus on outcomes and experience, clinical audit, inequalities, workforce sustainability and 24/7 service safety, and compassionate responses to incidents and complaints, including evidence that learning is translated into improvement. This includes continued scrutiny of triage quality and performance and delivery of the 12-month improvement plan, alongside family communication and engagement, mortuary governance and implementation of national post-death care recommendations.

4. Maternity triage benchmarking assurance

Appendix 1 assesses 9.1 and 9.2 as Complete/Green, supported by additional September Board evidence demonstrating completion and regional reporting of the triage audit and Board oversight of triage quality and performance. The Trust confirms that the triage materials formed part of the submission made by 25 September 2026, with the regional email of 16 October confirming receipt and review of the baseline and supporting evidence. The correspondence and Board scrutiny records will be retained as evidence.

The Green assessment relates specifically to these requirements and does not indicate full implementation of the national specification. The audit reported 75% overall compliance and Amber service-delivery confidence. Ongoing assurance will therefore continue through governance, including waiting, assessment and review times, redeployment, delays, outcomes and inequalities, with outstanding metric and equity actions monitored to completion.

5. Summary baseline position from reporting template

The tables distinguish September baseline compliance from Submission B delivery status. Historical Trust and regional ratings remain unchanged; current completion does not constitute a revised regional assessment.

Trust baseline self-assessment: September 2026

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

Formal NHS England South-West regional review

Regional assessment communicated: 16 October 2026

Compliant	Partially compliant	Non-compliant	Total
9 34.6%	17 65.4%	0	**26**

The regional review assessed 2.3, 8.1 and 8.2 as partially compliant. All three remain In progress/Amber in Submission B, requiring stronger evidence of inequalities analysis and response, consistent PSIRF implementation and family communication, and complaints learning and impact. Relevant Q2 evidence available before submission will be considered through established governance processes and inform the final December assessment.

Submission B delivery position at the stated 31 October 2026 evidence cut-off

Completed at baseline	Complete / Green	In progress / Amber	Total
9	2	15	**26**

Overall assurance remains Moderate: controls are generally established, but 15 deliverables remain Amber.

The current assessment reflects the position on 31 October 2026 and recognises that further work and evidence remain outstanding ahead of the December submission. Further evidence will continue to be gathered and considered through established governance processes during November and December, including the Quarter 2 Perinatal Quality Oversight Report, Perinatal Workforce Report and mortuary assurance. This will enable appropriate scrutiny and challenge before the final position is determined.

As there is no scheduled Board meeting in December, the appropriate governance route for final review and approval of Submission B will be agreed with the Chair and Trust Secretary. This may include an extraordinary Board meeting to ensure that the updated evidence and assurance can be considered, and the final position approved before submission to NHS England by 31 December 2026.

6. Action-level assurance summary

The table summarises progress against each action, comparing the regional baseline assessment with the current assurance position in Appendix 1. It highlights outstanding requirements and key assurance dates to support Board scrutiny of delivery, risks and next steps.

January 2027 Board reports are planned assurance checkpoints, not completed December actions. Interim controls and action delivery will continue; underlying completion dates must be confirmed separately.

10 Point Plan action	Regional baseline position	Summary assurance position
1. Martha's Rule	Compliant	Completed at baseline: rollout commenced across the mother-and-baby pathway, supported by an operational procedure, patient information and a single 24/7 rapid review number.
2. Listening, outcomes, experience and audit	Mixed: two compliant, one partially compliant	2.1 and 2.2 are Completed at baseline; 2.3 remains In progress/Amber. Complete outcomes and experience analysis by ethnicity and deprivation, including limitations, response and impact, requires further evidence. Relevant Q2 evidence available before the December submission will be considered through the established governance process.
3. Dual Board-level accountability	Mixed: one compliant, one partially compliant	3.1 is Completed at baseline; 3.2 remains In progress/Amber. September Director of Midwifery attendance is confirmed, but relevant Clinical Directors did not attend. Evidence November maternity/neonatal participation and ongoing deputy arrangements through Board minutes.
4. Amos into Action	Not stated in this paper	Nationally led initiative. The Trust will support the national programme, engage with the staff listening exercise as required, and review any resulting findings and recommendations to identify relevant local actions and learning.
5. Inequalities	Partially compliant	All three requirements remain In progress/Amber. Verify programme-launch attendance and agree multidisciplinary staff release. Full six-monthly inequalities review and the Maternal Care Bundle plan remain in progress, with evidence available before submission considered through the established governance process. Bundle implementation remains targeted for March 2027.
6. 24/7 safety and responsiveness	Mixed: one compliant, six partially compliant	6.1 is Completed at baseline; 6.2–6.7 remain In progress/Amber. Outstanding evidence covers funding and delivery decisions, QIS recovery, the live locum register, trained anaesthetic-assistant availability and the full deployment review. Midwifery funding commitment is required by 23 December 2026. Neonatal funding and the associated delivery timetable remain outstanding. Relevant Q2 evidence available before submission will inform the final assessment. .

10 Point Plan action	Regional baseline position	Summary assurance position
7. Homebirth services	Compliant	Completed at baseline: Board scrutiny of the homebirth position is established. Continue oversight of risks, mitigations and restoration planning with regional engagement.
8. Incidents, complaints and concerns	Three partially compliant following regional review	All three requirements remain In progress/Amber. Evidence consistent PSIRF implementation, neonatal coverage, learning impact, named family contacts, completed communications and compassionate debriefs, and early senior-manager candour. Urgent complaints recovery continues; learning must not await final response closure. Relevant Q2 evidence available before submission will inform the final assessment, with urgent complaints recovery and learning continuing through established governance.
9. Maternity triage	Mixed: one compliant, two partially compliant	The September Board pack supports 9.1 and 9.2 as Complete/Green; 9.3 was completed at baseline. This confirms audit/reporting and Board oversight, not full service compliance. Staffing, timeliness, data and equity improvements remain under oversight.
10. Post-death care	Mixed: one compliant, one partially compliant	10.1 is Completed at baseline; 10.2 remains In progress/Amber. The final Annual Mortuary Report is scheduled for Q&P consideration on 26 November 2026. Evidence and scrutiny available before submission will inform the final December assessment. Retrospective-review completion and action closure require final evidence; draft material will not be relied upon.

7. Trust response and governance route

The 15 Amber deliverables will be managed through a single action plan, with named executive and operational leads, completion dates, evidence requirements and escalation thresholds. These action-level details are not set out in this paper and remain subject to the confirmation described in section 9. Significant concerns will be escalated to the Board, ICB and region. Complaints recovery, workforce decisions and safety mitigations will continue within their required timescales.

The Trust will use its established Maternity Incentive Scheme reporting arrangements to evidence progress against the 10 Point Plan. The Quarter 2 Perinatal Quality Oversight Report and Perinatal Workforce Report are being enhanced to address the relevant requirements, supporting the wider evidence log across all deliverables. Relevant evidence will undergo scrutiny through the Perinatal Delivery Group and Quality and Performance Committee during November, with further evidence considered through established governance arrangements ahead of the December submission.

The enhanced reports will bring together workforce, safety, outcomes, experience and inequalities evidence to demonstrate what has changed, whether interim controls are effective and where delivery remains at risk. Committee scrutiny will identify unresolved concerns, corrective actions and any decisions or escalation required.

Evidence and scrutiny available before submission will inform the final December return, alongside the regional feedback of 16 October. As there is no scheduled Board meeting in December, the appropriate governance route for final review and approval will be agreed with the Chair and Trust Secretary and may include an extraordinary Board meeting. This will ensure that any material changes and the updated assurance position can be considered and approved before submission by 31 December 2026. Subsequent Board reporting will provide ongoing oversight and will not form part of the evidence supporting the December submission.

8. Risks, gaps and mitigations

Workforce sustainability remains the principal delivery risk. Further investment is required across midwifery, neonatal medical and neonatal nursing workforce to support sustainable staffing and delivery of safe services. Funding and implementation of the required workforce plans are not yet evidenced as complete, with further decisions, implementation plans and timescales required. Interim staffing arrangements, acuity monitoring and escalation mitigate current pressures but do not replace sustainable funded capacity.

Other residual risks concern inequalities, triage, workforce controls, complaints, family communication and post-death care. September reporting identified some experience improvement-plan actions as Red pending refresh; these are distinct from the Submission B delivery ratings and the current position requires confirmation. Named owners, completion dates and evidence of impact are required, with interim monitoring and escalation continuing. Further evidence and assurance available before the December submission will be considered through established governance processes and reflected in the final Submission B position.

9. Next steps

Before and following the November Board: Confirm the evidence cut-off, named signatory, action owners and completion dates. Validate Board attendance evidence, confirm consistency with the regional feedback communicated on 16 October 2026, and exclude draft mortuary material. Sustain triage reporting and monitor outstanding metric improvements through established governance arrangements.

Ahead of submission: Continue to gather and scrutinise outstanding evidence through the established governance process. Confirm the required investment and delivery plans across midwifery, neonatal medical and neonatal nursing workforce, and add the final Mortuary Report and associated scrutiny records following committee consideration, where available.

Final approval and submission: The appropriate governance route for final review and approval will be agreed with the Chair and Trust Secretary and may include an extraordinary Board meeting. Any material changes and the final assurance position will require appropriate approval before the return is submitted via Futures by 31 December 2026. Approval and submission records will be retained.

Subsequent oversight: The submitted position, outstanding actions, residual risks and evidence of impact will continue to be monitored through established governance arrangements. Any reporting after 31 December will provide ongoing assurance and will not form part of the evidence supporting the December return**.**

Enclosures
Enclosure 1: Appendix 1 GHT 10 Point Plan Benchmarking Tool with Region Comments.xlsx, including historical Submission A, current Submission B and the supporting evidence log.
FOI: *Public*

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

Name of trust or organisation: GHT
Report prepared by: Nicola Moore
Report date: 12-nov-26
Reporting period covered: Sept- Dec 2026

Baseline Assessment			Summary by Action - Baseline		Compliance			
Key Metrics			Action	Total	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
Compliance	0. Not applicable	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
	1. Non-compliant	0	3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
	2. Partially compliant	14	5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	3	0
	3. Compliant	12	6. Ensuring 24/7 safety and responsiveness of services	7	0	0	6	1
Regional Match	Regional match - Yes	23	7. Trust review of homebirth services	2	0	0	0	2
	Regional match - No	3	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

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-p s separate to the tab 2. Progress Report submission.

Report signed off by Trust Board (named Exec): Kevin McNamara

Trust Board sign off date: Board Meeting 10 September 2026 2026-09-03_13-59-17_FINAL-Boardbook_epmSvac.pdf

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	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
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-05, EV-12, EV-13, EV-07	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 Swingler.
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 ≥80% 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 ≥80% 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 April–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 April–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 not the complete strategic review required by this deliverable.
7. Trust review of homebirth services						
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.
8. Responding to incidents, complaints and concerns with humanity and candour						
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 clearer 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/MNISA, 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.
9. Deliver safe and effective triage in maternity services						
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.
10. Post death care						
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 overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Partially compliant	EV-03, EV-04, EV-17	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. The incident review is in progress to be submitted 18 September 2026.	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/MNVP 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 *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)
Completed at baseline					
Completed at baseline					
Completed at baseline					
In progress	Amber	EV-19, EV-20	Progress is demonstrated by the additional September Board evidence, not assessed in Submission A (EV-19, pp.31–34; EV-20). It includes targeted MNVP engagement with under-represented communities, service-user experience themes and interpreter/accessibility findings with planned improvement actions. This strengthens the assurance available at baseline and provides further evidence relevant to the region's feedback. Regional review on 19 October assessed 2.3 as partially compliant, stating that evidence of the inequalities response could be strengthened and there was no reference to experience. Further work is required to demonstrate a complete analysis of outcomes and experience by ethnicity and deprivation, data limitations, and the actions and impact arising from identified variation. The planned Health Inequalities Dashboard and Q2 PQOM presentation to Trust Board on 14 January 2027 is the next assurance checkpoint; receipt and scrutiny remain pending. The displayed Compliant rating is the original September Trust baseline, not a new current or regional compliance assessment.	Address regional feedback through the planned dashboard and Q2 PQOM reporting: include both outcomes and experience by ethnicity and deprivation, data limitations, the response to identified variation, named action owners, dates and impact measures. Retain Board/committee scrutiny, decisions and follow-through. Maintain interim oversight; record January Board reporting as planned in the December return.	14 January 2027: Health Inequalities Dashboard and Q2 PQOM to Trust Board; confirm explicit coverage of 2.3 feedback.
Completed at baseline					

In progress	Amber	September 2026 Board minutes	The Director of Midwifery attended the September 2026 Trust Board; the relevant Clinical Directors did not attend. The Director of Midwifery and Clinical Director intend to attend the November Trust Board. Their planned attendance and participation have not yet been evidenced by meeting minutes; maternity and neonatal clinical representation should be confirmed. September Board minutes will be provided; evidence reference pending.	Confirm the planned attendance of the Director of Midwifery and Clinical Director at the November Trust Board, ensuring appropriate maternity and neonatal clinical representation when perinatal matters are discussed. Retain minutes demonstrating attendance and participation. Confirm ongoing attendance and deputy arrangements for future relevant Board meetings. Add September and November minutes to the Evidence Log when available.	12 nov 2026
In progress	Amber	EV-17, EV-18	NHS England South West has confirmed that the Perinatal Equity and Anti-Discrimination Programme is due to start at the beginning of 2027/28. Trust representation at the launch on 3 November 2026 at 10:00 is confirmed. At the November Board paper evidence cut-off, launch attendance and the detailed multidisciplinary participation and protected staff-release plan are not yet evidenced. November Board agreement is sought to develop the plan following the launch and present it to 14 January 2027 Trust Board. This is a proposed governance arrangement, not an approved or completed action.	November Board is asked to note the regional timetable and confirmed launch representation; agree development of a multidisciplinary participation and protected staff-release/backfill plan following the launch, for presentation to 14 January 2027 Trust Board; and agree an accountable lead and interim governance route to monitor preparation and escalate risks. Retain launch attendance and learning, confirm allocated places and programme start date, and develop named nominations, resource requirements and milestones. November Board should also agree how material updates will be reviewed and approved before the 31 December 2026 national submission, consistently with Trust governance and the requirement for Board approval. Retain the Board decision and subsequent plan as evidence when available.	3 Nov 2026: launch. 12 Nov 2026: proposed Board agreement. 31 Dec 2026: national progress submission. 14 January 2027: proposed plan to Board. Programme start: beginning of 2027/28.
In progress	Amber	EV-11, EV-12, EV-13, EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). The Perinatal Health Inequalities Dashboard is live (EV-11). Earlier Board records evidence inequalities scrutiny, including OASI improvement work and a requested MBRRACE-UK briefing (EV-12, EV-13). September Board received further equity intelligence in Q1 PQOM (EV-19, pp.31–34; EV-20), including targeted MNVP outreach, interpreter-access and recording gaps, and planned Listening and Learning Group actions. Primary language was not recorded for 109 of 1,598 bookings. This counts as supporting evidence of Board equity reporting, but does not demonstrate a completed six-monthly review of the full inequalities dashboard, trends by ethnicity and deprivation, agreed actions and subsequent impact assessment. The Trust plans to present the Health Inequalities Dashboard alongside the planned Q2 Perinatal Quality Oversight Report at 14 January 2027 Trust Board. This replaces the previously recorded November presentation target; presentation and resulting Board decisions remain pending.	Present the Health Inequalities Dashboard alongside the planned Q2 Perinatal Quality Oversight Report at 14 January 2027 Trust Board. Include dated trend analysis by ethnicity and deprivation, data limitations and progress against previous actions. Seek Board scrutiny and agreement of actions with named owners, due dates and impact measures; retain the report and minutes, and confirm the next six-monthly review date. Maintain interim governance oversight and escalate material inequalities risks. The 31 December 2026 progress return should report this as a planned January action, not completed Board assurance.	14 January 2027: dashboard and planned Q2 PQOM to Trust Board. 31 December 2026: national return to record the outstanding January action.

In progress	Amber	EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). Trust Board received an element-level Maternal Care Bundle implementation update on 10 September 2026 (EV-19, pp.37–38; EV-20). VTE: referral self-assessment and an initial LMWH audit in place; early-prescribing pathways under ICB review. Pre-hospital/acute care: MEWS in maternity and ED, ambulance pre-alert and referral action card in place; Trust-wide rollout, guideline alignment, signage and referral processes require further work. Epilepsy: initial benchmarking showed 49% compliance; MDT review planned. Mental health: benchmarking completed but self-administered screening, standardised follow-up assessment, additional appointment time and experience-feedback arrangements remain incomplete. Haemorrhage: PPH/ROTEM guidelines and weekly review of bleeds of 2 litres or more in place; 94% reviewed within 28 days, with guideline additions and audits outstanding. Overall benchmarking was described as underway, expected by 1 September 2026; its completion is not confirmed by this extract. Full implementation was reported on trajectory for March 2027. The September reported position is additional evidence for this Submission B assessment; subsequent action delivery and specific Board decisions remain to be evidenced. The Trust Board is planned to receive the implementation plan to complete the Maternal Care Bundle by March 2027 alongside the next Q2 Perinatal Quality Oversight Report, due to Board on 14 January 2027. Receipt, scrutiny and decisions on that plan remain pending.	Present the Maternal Care Bundle implementation plan, with a March 2027 completion target, to 14 January 2027 Trust Board alongside the next Q2 Perinatal Quality Oversight Report. Include completed benchmarking, element-level actions, named owners, resource requirements, milestones and residual risks. Retain Board scrutiny, decisions and subsequent action tracking; maintain interim oversight of delivery risks. The 31 December 2026 national progress return should record the January plan presentation as outstanding, not completed.	14 January 2027: implementation plan and Q2 PQOM to Trust Board. March 2027: full implementation target. 31 December 2026: national progress submission.
Completed at baseline					
In progress	Amber	EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). September Trust Board received the Q1 PQOM locum audit (EV-19, pp.13–14; EV-20, PDF pp.143–144). All locum doctors reviewed met national and local requirements for short-term obstetric and gynaecology locum working; labour ward consultant cover was maintained at 100%, with most rota gaps covered through internal or approved external locums. This supports certification and locum governance, but does not explicitly demonstrate the continuously updated Trust-specific database of all short-term locums (≤2 weeks) on tier 2/3 obstetric rotas. The updated position is planned to come to 14 January 2027 Trust Board within the Q2 Perinatal Quality Oversight Report; Board receipt and review remain pending.	Include the updated locum assurance position in the Q2 Perinatal Quality Oversight Report to 14 January 2027 Trust Board. Explicitly confirm the live Trust-specific register covers all short-term tier 2/3 obstetric locums, its responsible owner and updating arrangements, with evidence of certification and pre-engagement checks. Retain the register/audit and Board scrutiny, decisions and follow-up. Maintain interim oversight of locum controls; the 31 December 2026 return should describe the January reporting action as outstanding, not completed assurance.	14 January 2027: updated locum assurance in Q2 PQOM to Trust Board. 31 December 2026: national progress submission.
In progress	Amber	EV-19, EV-20, EV-22, EV-25	Progress since Submission A: September Board received neonatal workforce reporting (EV-19, EV-20). Detailed neonatal and integrated workforce plans were subsequently submitted to Q&P on 29 October 2026, with onward reporting planned through the Board 4A report (Trust-confirmed; EV-22, EV-25). The plan is informed by BAPM standards, the 2020 neonatal nursing workforce calculator and professional judgement, and covers nursing, medical, advanced-practice, outreach and multidisciplinary requirements. The neonatal appendix reports 6.10 WTE consultants against a 7.00 WTE minimum, with weekend-cover and other capacity gaps. This strengthens planning assurance but does not demonstrate that the full establishment requirement is met. Committee decisions, recruitment, QIS recovery and delivery remain to be evidenced. The Q2 assurance update is planned for Board on 14 January 2027.	Include the updated neonatal nursing and medical workforce plan in the Q2 Perinatal Quality Oversight Report to 14 January 2027 Trust Board. Demonstrate alignment with BAPM standards for the unit designation and the 2020 neonatal nursing workforce calculator, and explicitly assess whether the full 6.3 requirement is met. Set out current vacancies, recruitment starts, rota cover, nurse-to-baby ratios and QIS recovery, with accountable leads and dated milestones. Retain October Q&P minutes/decisions and the Board 4A report; distinguish submission and safety/quality endorsement from implementation. Maintain interim oversight and escalation of workforce risks. The 31 December 2026 return should record January reporting as a planned action, not completed assurance.	14 January 2027: neonatal workforce assurance and plan within Q2 PQOM to Trust Board. 31 December 2026: national progress submission.

In progress	Amber	EV-19, EV-20, EV-22, EV-23, EV-24	Progress since Submission A: September Board received evidence of a completed workforce review and workforce proposal (EV-19, EV-20). The detailed midwifery plan, December 2025 Birthrate Plus report and integrated workforce requirements were submitted to Q&P on 29 October 2026, with onward Board 4A reporting planned (Trust-confirmed; EV-22–EV-24). The proposal applies a 26% uplift and professional judgement to reflect local acuity, service needs and training requirements. This demonstrates further plan development and formal governance progression, not achievement of the full establishment requirement. Q&P decisions, alignment of the establishment and implementation remain to be evidenced.	Confirm the outcome of Trust Leadership Team consideration and the midwifery workforce plan. Demonstrate alignment of the clinical and specialist establishment and ward deployment to the 2025 Birthrate Plus review, including documented Director/Head of Midwifery professional judgement on adjustments and training uplift. Explicitly assess whether the full 6.4 requirement is met. Record current establishment gaps, accountable leads and delivery milestones. Monitor the Q2 Birthrate Plus recording recovery and integrated workforce reporting actions, retaining governance decisions and evidence of implementation. Present the required assurance paper and supporting evidence to Trust Board on 14 January 2027. Confirm accountable leads and completion dates for underlying actions; the Board reporting date is not confirmation that every action will be complete. Retain October Q&P minutes/decisions and the Board 4A report; distinguish submission and safety/quality endorsement from implementation. Maintain interim oversight and escalation of workforce risks.	14 January 2027: Board assurance update. Confirm interim workforce-plan milestones, underlying action completion dates and accountable leads.
In progress	Amber	EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). September Board Q1 PQOM reports that obstetric anaesthetic cover is consistently maintained through prioritisation of the obstetric on-call rota, supporting emergency theatre access, planned Caesarean delivery and escalation (EV-19, p.15; EV-20, PDF p.145). It identifies the rota as a key dependency and recommends considering any additional out-of-hours anaesthetic tier within wider capacity and workforce planning. This supports anaesthetic workforce oversight but does not explicitly evidence 24/7 duty anaesthetist availability against ACSA 1.7.2.1 or trained anaesthetic-assistant availability 24/7 against ACSA 1.3.1.2. The outstanding assistant-cover assurance gap is not closed by this report.	Retain the existing duty-anaesthetist rota/audit evidence and obtain updated direct assurance of 24/7 availability against ACSA 1.7.2.1. Obtain the trained anaesthetic-assistant rota, competency/training evidence and availability audit against ACSA 1.3.1.2, identifying gaps, mitigations, accountable leads and completion dates. Consider out-of-hours capacity requirements through the wider workforce plan and report assurance and exceptions through governance. Present the required assurance paper and supporting evidence to Trust Board on 14 January 2027. Confirm accountable leads and completion dates for underlying actions; the Board reporting date is not confirmation that every action will be complete.	14 January 2027: required assurance paper to Trust Board. Underlying action completion dates and accountable leads to confirm.
In progress	Amber	EV-19, EV-20, EV-22, EV-23, EV-25	Progress since Submission A: September Board received integrated reporting of workforce, acuity, capacity and escalation risks (EV-19, EV-20). Detailed maternity and neonatal workforce plans were submitted to Q&P on 29 October 2026, with onward Board 4A reporting planned (Trust-confirmed; EV-22, EV-23, EV-25). The paper sets out risks, interim mitigations and monitoring of required, in-post and deployable workforce. This strengthens cross-service planning and oversight. It does not establish implementation or effectiveness of every mitigation; the committee decision and Board 4A report remain to be evidenced. Q2 reporting to Board on 14 January 2027 will update delivery, pressures, escalation and impact, with interim governance oversight continuing.	Present updated integrated workforce, acuity, service-pressure and escalation assurance in the Q2 Perinatal Quality Oversight Report to Trust Board on 14 January 2027. Include validated workforce/acuity trends, recruitment and capacity trajectories, actions addressing local gaps and cross-service working, and evidence that mitigations are effective. Retain Board scrutiny, decisions, escalation and follow-through. Maintain interim oversight and escalation of persistent capacity or safety risks. The 31 December 2026 national return should record January reporting as an outstanding planned action, not completed assurance. Retain October Q&P minutes/decisions and the Board 4A report; distinguish submission and safety/quality endorsement from implementation.	14 January 2027: Q2 PQOM to Trust Board. 31 December 2026: national progress submission.
In progress	Amber	EV-08, EV-19, EV-20, EV-22, EV-23, EV-25	Progress since Submission A: existing workforce reporting describes operational deployment during staffing pressure (EV-08), and September Board received further workforce-planning evidence (EV-19, EV-20). October plans submitted to Q&P include specialist capacity, skill mix, recruitment and neonatal redeployment options, with planned onward Board 4A reporting (Trust-confirmed; EV-22, EV-23, EV-25). These strengthen resource-planning evidence but do not alone confirm completion of the full 6.7 review: redirection of non-frontline roles, training and resilience when specialist staff are unavailable, and assessment of redeployment impact. A resource-deployment review report remains planned for Board on 14 January 2027; completed review findings and decisions are pending.	Complete and present an internal resource-deployment review report to Trust Board on 14 January 2027. Address whether non-frontline roles can be redirected to strengthen service provision; education, training and cover arrangements when specialist bereavement and infant-feeding staff are unavailable; and the safety and service impact of redeployment across maternity and neonatal services. Include findings, risks, mitigations, named owners, resource decisions and delivery dates. Retain Board scrutiny, decisions and subsequent action tracking; maintain interim risk oversight. The 31 December 2026 return should record January reporting as a planned action, not a completed review. Retain October Q&P minutes/decisions and the Board 4A report; distinguish submission and safety/quality endorsement from implementation.	14 January 2027: internal resource-deployment review report to Trust Board. 31 December 2026: national progress submission.
Completed at baseline					
Completed at baseline					

In progress	Amber	EV-19, EV-20, EV-16	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). Regional position (19 October 2026): Partially compliant — further evidence requested that PSIRF is embedded. September Trust baseline: Compliant. Trust progress and response: The Trust confirms that PSIRF is embedded in maternity services. The perinatal governance framework defines the arrangements (EV-16), and the September Q1 PQOM demonstrates processes operating in practice (EV-19, pp.23–28; EV-20, PDF pp.153–158): triangulation of review findings, learning shared through the July Bereavement newsletter and fetal-monitoring training, action-review and quoracy arrangements, and parental-engagement tracking. Regional review on 19 October assessed 8.1 as partially compliant and requested evidence of embedded implementation. This is an evidence-assurance difference, not confirmation that PSIRF is absent from maternity. Further evidence of consistent implementation, completed family communications and learning impact will be provided in the next Q2 report. As 8.1 covers both maternity and neonatal services, the neonatal implementation position should also be explicitly evidenced.	Provide the response to regional feedback in the Q2 Perinatal Quality Oversight Report to Trust Board on 14 January 2027. Substantiate the Trust's confirmed maternity implementation with completed learning-response examples tracing family involvement, communication of findings, actions, changes in practice and impact evaluation. Explicitly evidence the neonatal position. Include updated action and family-engagement trackers, relevant approved documents, audit findings and follow-through on Q1 outstanding actions. Retain Board scrutiny and decisions; maintain interim oversight and describe January reporting as planned in the 31 December 2026 return.	14 January 2027: Q2 report with further PSIRF implementation and learning-impact evidence to Trust Board. 31 December 2026: national progress submission.
In progress	Amber	EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). Regional position (19 October 2026): Partially compliant — complaint timeliness identified as an urgent priority, with concern about timely implementation of learning and demonstration of impact. September Trust baseline: Compliant. Trust progress and response: Regional review on 19 October assessed 8.2 as partially compliant and identified complaint-response timeliness as an urgent priority, with concern about timely action on learning and demonstration of impact. September Board Q1 PQOM (EV-19, pp.25–34; EV-20, PDF pp.155–164) provides evidence of thematic review and planned complaint-related learning actions, including pain-related learning briefs, communication audits and the proposed Listening and Learning Group. It does not confirm completion or measurable impact of these planned actions. The maternity experience improvement plan was Red-rated pending refresh. Delayed complaint responses do not alone establish absence of learning; further evidence is needed to show that learning and safety actions are identified and implemented promptly, without waiting for final complaint closure. The updated timeliness recovery and learning-impact position will be included in Q2 PQOM to Trust Board on 14 January 2027.	Address complaint-response timeliness as an urgent priority and agree a recovery plan with named owners, deadlines, backlog oversight and escalation. Ensure learning and safety actions do not await the final complaint response; trace examples from complaint/theme identification through action, change in practice and impact evaluation, including dates. Provide evidence of completed learning briefs, communication audits and Listening and Learning Group activity, together with current response timeliness and service-user feedback. Present progress and response to regional feedback within Q2 PQOM to Trust Board on 14 January 2027, retaining scrutiny, decisions and follow-through. January reporting is an assurance checkpoint, not the start of urgent action; maintain interim governance oversight. Record January reporting as outstanding in the 31 December 2026 return.	14 January 2027: updated complaints and learning assurance, including response to regional assessment, within Q2 PQOM to Trust Board. 31 December 2026: national progress submission.
In progress	Amber	EV-19, EV-20	September Board papers assessed as additional evidence for Submission B (not assessed in Submission A). September Board Q1 PQOM provides examples of learning taking place (EV-19, pp.23–28; EV-20, PDF pp.153–158). Learning from a case where a partogram was not used was shared in the July 2026 Bereavement newsletter. A case involving CTG interpretation and escalation led to a supportive conversation, individualised learning and inclusion in fetal-monitoring training. Review findings were triangulated with incidents, complaints, claims, audits and family feedback; a parental engagement tracker was in place to oversee contact, follow-up offers and sharing of outcomes. These demonstrate learning activity and strengthened engagement processes, but do not establish that all affected families received completed compassionate debriefs, a named key contact or early senior-manager candour. Communication of review outcomes and action closure remained outstanding; a review of Q1 duty-of-candour/debrief cases was due 30 September 2026. Subsequent completion and sustained learning impact require evidence	Retain the July Bereavement newsletter, training materials and dissemination/attendance records as evidence of learning already shared. Obtain the completed Q1 duty-of-candour/debrief review and current parental engagement tracker showing offers, completed discussions, communication of findings and follow-up, including exceptions. Make named-family-contact and early senior-manager candour responsibilities explicit; evidence staff preparation for compassionate debriefing. Confirm delivery of September-dated learning actions and evaluate whether learning changed practice through follow-up audit and family feedback. Report outstanding actions and learning impact through perinatal governance and Board assurance. Present the required assurance paper and supporting evidence to Trust Board on 14 January 2027. Confirm accountable leads and completion dates for underlying actions; the Board reporting date is not confirmation that every action will be complete.	14 January 2027: required assurance paper to Trust Board. Underlying action completion dates and accountable leads to confirm.

Complete	Green	EV-01, EV-06, EV-20	Submission B assessment: the triage audit-and-reporting requirement is assessed as met. The completed audit and benchmarking position, including staffing and clinical-capacity gaps and an improvement plan, were received by September Trust Board. The Trust confirms that the September Board pack containing the audit was included in the evidence pack sent to regional NHS England. September Board evidence is assessed here as additional assurance not incorporated in Submission A. Green relates to completion and reporting of the audit, not full implementation of all triage standards: the audit reported 75% overall compliance and Amber service-delivery confidence. Regional submission is confirmed by the Trust; the transmission/receipt record has not been supplied here.	Retain the regional submission/receipt record with the evidence pack and September Board minutes showing scrutiny and decisions. Continue delivery and monitoring of the audit improvement plan, including staffing, clinical capacity, timeliness and equity actions; escalate residual service risks through established governance. Keep completion of the audit-and-reporting requirement distinct from the wider triage implementation programme.	Audit received by Trust Board on 10 September 2026 and shared with regional NHS England (Trust-confirmed; submission date/reference to retain). Ongoing improvement-plan milestones monitored through governance.
Complete	Green	EV-06, EV-20	Submission B assessment: the Board oversight and reporting requirement in 9.2 is assessed as met using the additional September Board evidence, not assessed in Submission A. September Board received the triage assurance and benchmarking position (EV-20, PDF pp.64–65,109,127–130; related audit EV-06). All Principle 10 data-and-measurement standards were reported as fully evidenced, including collection and review of triage metrics, demographic information and governance arrangements; quarterly reports from September and monthly PQOM reporting were documented. Green reflects achievement of this oversight requirement, not completion of every triage service improvement. Ongoing reporting will monitor outstanding triage improvements and escalate risks. The September Partially compliant baseline is preserved.	Sustain monthly PQOM and quarterly triage reporting and retain Board scrutiny, decisions and follow-through. Ensure reports explicitly cover all measures named in 9.2: waiting, assessment and review times, redeployment, delays, outcomes and inequalities. Track outstanding selected-metric, experience-of-delay and equity actions with owners, dates and impact measures. Keep wider service-implementation risks distinct from achievement of the Board oversight requirement, while escalating risks that could undermine sustained reporting.	Monthly PQOM and quarterly triage reporting from September 2026; confirm due dates for outstanding metric, delay-experience and equity actions.
Completed at baseline					
Completed at baseline					
In progress	Amber		The Annual Mortuary Report is being prepared for Quality and Performance Committee on 26 November 2026, with onward reporting to Trust Board on 14 January 2027. This demonstrates progress in preparation and the planned governance route only. The draft is not being submitted as supporting evidence and is not relied on here to substantiate completion of the retrospective incident review or closure of national/audit actions. The final report will be provided as evidence only after it has been received by Q&P. Committee and Board receipt, scrutiny and decisions remain pending.	Finalise the Annual Mortuary Report for Q&P on 26 November 2026 and onward presentation to Trust Board on 14 January 2027. Following Q&P consideration, add the final report and relevant minutes to the Evidence Log and reference them in Submission B. The final report should evidence continuing oversight, the retrospective incident-review position, national/audit action progress, current risks, mitigations and accountable owners. Maintain interim oversight and escalation; ensure the December return reflects evidence available and appropriately approved at submission, without presenting January Board reporting as completed.	26 November 2026: planned Q&P receipt of final Annual Mortuary Report. 14 January 2027: planned Trust Board presentation. 31 December 2026: national progress submission.

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 identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	9,1	benchmarking document	Maternity Triage: Board-Level Audit and Assurance Report in Response to the NHS England System Letter prepared for executive review	13.08.2026	Collette Townsend		Paper to the Executive Led Perinatal Delivery Group which was to accomapy the assessment to Board.	Adequate
EV-02	1, 2, 3, 5, 6,	Committee assurance rep	Initial assurance position and proposed re	08 jul 2026	Matt Holdaway, Ch	Attached file: Report_to_PDG 08.07.	PDG paper provides the Trust positic	Adequate
EV-03	10.1, 10.2	Board assurance statemer	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	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
EV-04	10.1, 10.2	Chief Executive covering l	CEO Covering Letter - Mortuary Oversight 31 July 2026 and email receipt of submission	2026-07-31T00:00:00.000Z	Kevin McNamara, Chief Executive	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	Strong
EV-05	2.1, 2.2, 2.3	Published Trust Board pap	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	https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf	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.	Strong

EV-06	9.1, 9.2, 9.3	Board-level audit and assu	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	Supplied attachment: 07. Triage Assurance Board paper for PDG.pdf; scheduled for Trust Board in Sept 2026 https://www.gloshospitals.nhs.uk/media/documents/2026-09-03_13-59-17_FINAL-Boardbook_epmSvac.pdf	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. Update for Submission B: Trust confirms September Board receipt and that the September Board pack containing the completed audit was shared in the regional evidence pack. Specific Board decisions and the regional transmission/receipt record should be retained; these records have not been supplied here.	Strong
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	Supplied attachment: 08. Quarterly PQOM - Q1 2026 Final for PDG.pdf; scheduled for Trust Board agenda on 12 September 2026 Link https://www.gloshospitals.nhs.uk/media/documents/2026-09-03_13-59-17_FINAL-Boardbook_epmSvac.pdf	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
EV-08	6.1, 6.2, 6.3	Six-monthly integrated wo	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	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

EV-09	1,1	Public patient information	Martha's Rule – Gloucestershire Hospitals NHS Foundation Trust	Accessed 14 Aug 2026	Gloucestershire Hospitals NHS Foundation Trust	https://www.gloshospitals.nhs.uk/your-visit/staying-us/during-your-stay/marthas-rule/	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
EV-10	1,1	Patient communication pa	Martha's Rule maternity easy-read guide, maternity leaflet and maternity poster	Reviewed 14 Aug 2026	Gloucestershire Hospitals NHS Foundation Trust	Link to website https://www.gloshospitals.nhs.uk/your-visit/staying-us/during-your-stay/marthas-rule/ - Supplied attachments Marthas_Rule_ADULT_easy_read_A4-compressed-maternity.docx; Marthas_Rule_ADULT_leaflet_A4_Editable-maternity.pdf; 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
EV-11	2.3, 5.2	Internal data dashboard	Perinatal Health Inequalities Dashboard	Confirmed 14 Aug 2026	Gloucestershire Hospitals NHS Foundation Trust	https://ghtreporting.glos.nhs.uk/dashboard/perinatal-health-inequalities-dashboard	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
EV-12	2.2, 2.3, 6.6	Published Trust Board mir	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	https://www.gloshospitals.nhs.uk/media/documents/July_2026_FINAL-Boardbook.pdf	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.	Strong

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	https://www.gloshospitals.nhs.uk/media/documents/2026-05-07_10-21-36_FINAL-Boardbook.pdf	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.	Strong
EV-14	3,1	CQC engagement present	GHNHSFT Maternity Services Deep Dive – CQC Engagement Meeting	27.07.2026	Kevin McNamara, Chief Executive; Chief Nurse and Medical Director; maternity leadership team	Supplied attachment: GHNHSFT_Maternity Services CQC Enagagement 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
EV-15	1,1	Standard operating proced	Maternity Call for Concern – implementing Martha's Rule	Issued 01 Apr 2025	Zoe Robinson; Maternity Department; approved by Clinical Effectiveness Assurance Group	Supplied attachment: SOP_Worries_and_Concerns_Maternity_-_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

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	Supplied attachment: 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
EV-17	5,1	NHSE regional programme information	Information slides for Participants_v2.pptx	Date not stated; receipt date to confirm	NHS England regional team (sender confirmed by Trust)	Supplied attachment: Information slides for Participants_v2.pptx	Slides 5–7 describe programme delivery, participant groups and indicative intake timeframes. Senior leaders: up to 7 per site, with up to 2 additional implementation leads; guideline/governance leads: 2 per site covering maternity and neonatal; clinical leaders: 8–14 places according to Trust birth numbers. Training includes 2 in-person days for each group and action learning sets. Supports participation and staff-release planning, but does not establish this Trust's intake date, nominations, approved release/backfill, attendance or completion. Retain in an externally accessible evidence location.	Limited
EV-18	5,1	NHSE regional email	Regional clarification: Perinatal Equity and Anti-Discrimination Programme timetable and launch event	Email date not supplied	Rachael Glasson, Deputy Regional Chief Midwife & Improvement Lead, NHS England – South West	Email text supplied by Trust; retain original regional email in externally accessible evidence repository	Following regional review of the 10 Point Plan submissions, the sender confirms the programme is due to start at the beginning of 2027/28 and refers to slide 6 for expected participants. Launch event: 3 November at 10:00; year interpreted as 2026 from the November 2026 reporting context. Invitation sent to Directors/Heads of Midwifery; contact the regional generic inbox if missing. Supports regional timing and preparation requirements, not Trust nominations, staff-release approval, attendance or completion.	Adequate

EV-19	2.1, 2.2, 2.3, 5.3, 6.3, 6.6, 8.1, 8.2, 8.3, 5.2, 6.2, 6.4, 6.5, 6.7	September Trust Board PQOM report	Perinatal Quality Oversight Model Report – Quarter 1 (April–June 2026 data); September Board version	10 sep 2026	Matt Holdaway, Chief Nurse and Director of Quality; Sarah Ashwood; Zita Martinez; Suzie Cro; Perinatal Team	Supplied attachment: 11.00_Quarterly PQOM - Q1 2026 2.pdf; retain Board copy in externally accessible evidence repository	Submission B of the Q1 PQOM received by September Trust Board, as confirmed by the Trust and corroborated by EV-20 (agenda item 11; PQOM from PDF page 131). Cover specifies 10 September 2026; Trust confirms Board receipt. Related to EV-07, but this supplied Board version must not be counted as independent corroboration or new post-baseline activity. Pages 1–3: developing assurance and Q2 evidence required. Pages 15–16: neonatal rota gaps, nursing fill 70%, QIS 57%, vacancies 13.73 WTE. Pages 23–28: review/learning, parental engagement tracker, outstanding communication and action closure; learning actions due 30 September. Pages 29–34: experience plan risks, planned Listening and Learning Group, MNVP outreach and interpreter data limitations; not a complete ethnicity/deprivation outcomes analysis. Pages 37–38: incomplete Maternal Care Bundle benchmarking, epilepsy 49%, mental-health gaps, March 2027 trajectory. Does not establish Board decisions, attendance, post-September completion or response	Strong

EV-20	2.1, 2.2, 2.3, 5.3, 6.3, 6.6, 8.1, 8.2, 8.3, 5.2, 6.2, 6.4, 6.5, 6.7, 9.2, 9.1	September public Trust Board pack	FINAL Boardbook – 10 September 2026	10 sep 2026	Gloucestershire Hospitals NHS Foundation Trust; Trust Board	Supplied attachment: 2026-09-03_13-59-17_FINAL-Boardbook_epmSvac Sept 2026.pdf	Counts as supporting evidence for Submission B of September Board reporting and oversight. Trust confirms the report was seen by Board. PDF page 1: agenda item 11 lists PQOM and the 10-point plan (11a). PDF page 61: 10 Point Plan Board Assurance Update. PDF page 131 onwards: Q1 PQOM covering April–June 2026. Read with EV-19 for detailed assurance, gaps and actions. The pack corroborates inclusion in the Board reporting route; the same PQOM should not be counted as a separate independent clinical dataset. September meeting minutes remain the source for specific decisions and attendance. Updated evidence is needed only to substantiate subsequent action delivery/current position. For 9.1, the Trust confirms this Board pack, including the completed triage audit/benchmarking, formed part of the evidence pack sent to regional NHS England. Submission date and transmission/receipt reference have not been supplied here.	Strong
EV-21		Working draft — not submission evidence	Mortuary and Care After Death Annual Assurance Report 2025/26 — draft	Draft; not yet received by Q&P	Professor Mark Pietroni (sponsor); report authors	Working attachment only — do not include in regional evidence submission	Reviewed solely to establish that report preparation is underway. Not cited as supporting evidence for Submission B. Replace with the final report and governance receipt details only after Q&P consideration, as instructed by the Trust.	Limited
EV-22	6.3, 6.4, 6.6, 6.7	October Q&P workforce evidence	17.00_Perinatal Workfroce Plan- QPC October 2026 V3.pdf	Submitted to Q&P 29 October 2026 (Trust-confirmed)	Chief Nurse; Medical Director; Director of Midwifery / perinatal workforce leads	Supplied attachment: 17.00_Perinatal Workfroce Plan-QPC October 2026 V3.pdf	October Q&P workforce requirements paper: safety/quality approval sought. Describes maternity and neonatal workforce requirements, risks, interim mitigations and proposed delivery arrangements. Trust confirms submission to October Q&P and planned onward 4A reporting to Board. Committee decisions/minutes and final Board 4A report not supplied; submission is not assumed approval or implementation.	Adequate

EV-23	6.3, 6.4, 6.6, 6.7	October Q&P workforce evidence	17.01_Appendix 1 - Glos Midwifery Workforce Plan QPC October 2026 (1).pdf	Submitted to Q&P 29 October 2026 (Trust-confirmed)	Chief Nurse; Medical Director; Director of Midwifery / perinatal workforce leads	Supplied attachment: 17.01_Appendix 1 - Glos Midwifery Workforce Plan QPC October 2026 (1).pdf	Detailed midwifery workforce plan, applying December 2025 Birthrate Plus and professional judgement, including 26% uplift, service/skill-mix and specialist capacity proposals. This supports planning, not achievement of the full establishment requirement. Trust confirms submission to October Q&P and planned onward 4A reporting to Board. Committee decisions/minutes and final Board 4A report not supplied; submission is not assumed approval or implementation.	Adequate
EV-24	6,4	October Q&P workforce evidence	17.02_Appendix 2 - Glos Midwifery BR plus report December 2025.pdf	01.12.2025	Chief Nurse; Medical Director; Director of Midwifery / perinatal workforce leads	Supplied attachment: 17.02_Appendix 2 - Glos Midwifery BR plus report December 2025.pdf	December 2025 Birthrate Plus baseline: required 283.74 WTE versus an existing establishment of 281.05 WTE at 21% uplift, deficit 2.69 WTE. This baseline comparison does not represent the full later locally adjusted workforce requirement. Trust confirms submission to October Q&P and planned onward 4A reporting to Board. Committee decisions/minutes and final Board 4A report not supplied; submission is not assumed approval or implementation.	Adequate
EV-25	6.3, 6.6, 6.7	October Q&P workforce evidence	17.03_Appendix 3 - Neonatal workforce paper August 2026.pdf	Submitted to Q&P 29 October 2026 (Trust-confirmed)	Chief Nurse; Medical Director; Director of Midwifery / perinatal workforce leads	Supplied attachment: 17.03_Appendix 3 - Neonatal workforce paper August 2026.pdf	Neonatal nursing, medical, advanced-practice, outreach, AHP and infant-feeding plan. Reports consultant establishment 6.10 WTE versus 7.00 minimum and weekend-cover gaps. Proposals are not completed recruitment or achievement of the full establishment requirement. Trust confirms submission to October Q&P and planned onward 4A reporting to Board. Committee decisions/minutes and final Board 4A report not supplied; submission is not assumed approval or implementation.	Adequate
EV-26								
EV-27								
EV-28								
EV-29								
EV-30								

Action		Deliverable	Suggested evidence
Action 1	1,1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	▪ 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.
Action 2	2,1	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?	▪ Analytical reports
	2,2	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?	▪ Board report and minutes
	2,3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	▪ Board report and minutes ▪ Quarterly MIS thematic report
Action 3	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?	▪ Board ToR ▪ Job plans
	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 discussed?	▪ Job plans ▪ Minutes of Executive board meetings
Action 5	5,1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	▪ Board report and minutes
	5,2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	▪ Board report ▪ Quarterly MIS thematic report ▪ Equity dashboard reports ▪ Core20PLUS5 reporting ▪ Maternity equity action plans
	5,3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	▪ Maternal Care Bundle implementation plans. ▪ Board Report ▪ MIS return
Action 6	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 ≥80% consultant presence in defined acute care situations?	▪ Workforce plan ▪ Biannual workforce papers ▪ Staff experience survey ▪ Cappuccini-style assurance exercise
	6,2	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)*	▪ Database
	6,3	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)*	▪ Workforce plan ▪ Biannual workforce papers ▪ BAPM workforce standards compliance ▪ Staff experience survey
	6,4	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)*	▪ BR+ review and workforce plan ▪ Biannual workforce papers ▪ Staff experience survey
	6,5	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?	▪ Workforce plan ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
	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?	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
	6,7	Has the trust board undertaken a review of internal resource deployment, including co sideration 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.	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
Action 7	7,1	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?	▪ Board report and minutes
	7,2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	▪ Correspondence
Action 8	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?	▪ Board report and minutes ▪ A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services ▪ PSIRF implementation within Maternity and Neonatal Services, governance and review processes. ▪ Process for sharing outcomes and learning from PSIRF reviews with women and families. ▪ Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	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?	▪ Board report and minutes ▪ Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. ▪ Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	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?	▪ Board report and minutes ▪ Debrief guidance ▪ Education and Training for Staff involved in debriefing women and families
Action 9	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?	▪ Triage Benchmarking tool completed template
	9,2	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?	▪ Board paper
	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?	▪ Plan and progress reports
Action 10	10,1	Board assurance statement completed and submitted by 31 July 2026	▪ Assurance statement
	10,2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	▪Board Report ▪Review report

BOARD DRAFT • ALIGNMENT REVIEW

Compared with DRAFT Board 10 point plan Nov 2026.docx • Review 3 November 2026 • Source assessments preserved

Conclusion: numerical alignment confirmed; resolve date, timetable, funding-deadline and evidence/approval traceability before finalisation.

Measure	Workbook	Draft	Check
Deliverables	26	26	Matches
Completed at baseline	9	9	Matches
Complete / Green	2	2	Matches
In progress / Amber	15	15	Matches
Trust baseline compliant	12	12	Matches
Regional baseline compliant	9	9	Matches

RECONCILIATION & APPROVAL CHECKLIST • recommendations, not evidence of completed action

ID	Priority	Draft / workbook reference	Finding	Recommended resolution	Evidence / confirmation required
R01	Resolve before approval	Draft executive summary; §§5,7,9 / B rows 13,33,34; EV-19	Draft says regional feedback communicated 16 October; workbook repeatedly describes regional review on 19 October. Ratings agree, dates do not.	Use the source correspondence to distinguish assessment date from communication date. Reconcile narrative and evidence-log wording; do not overwrite historical ratings.	Dated regional correspondence; record both dates if valid.
R02	Resolve before approval	Draft executive summary; §§2,5–7 / B rows 13,19–28,33–35	Draft anticipates enhanced Q2/workforce scrutiny in November before submission. Workbook specifies 14 January 2027 Board checkpoints. These can coexist, but pre-submission papers, dates and outputs are not yet traceable.	State the November/December committee timetable separately from the 14 January Board timetable. Only received, scrutinised and appropriately approved evidence can support the December assessment.	Committee agenda, final paper versions, receipt dates, minutes and final approval route.
R03	Resolve before approval	Draft §6 action 6 / B row 25; EV-22–EV-24	Draft specifies midwifery funding commitment by 23 December 2026. This deadline is not recorded in the workbook action or evidence-log notes; neonatal funding dates remain outstanding.	Confirm authority and source for 23 December. If retained, add the funding-decision milestone and accountable lead to 6.4; keep it distinct from recruitment, implementation and January assurance.	Underlying workforce decision/request and dated funding milestone; neonatal decision timetable.
R04	Resolve before approval	Draft §4 / B row 37; EV-06, EV-20	Draft states triage materials were submitted by 25 September and that the 16 October email confirms receipt/review. Workbook records Trust-confirmed submission but says transmission/receipt reference was not supplied.	Retain the correspondence and submission manifest showing triage inclusion, then update evidence references. Until retained, label the specific submission timing and coverage as Trust-confirmed, not independently verified.	Regional email, transmission record and evidence-pack contents; September minutes.
R05	Resolve before approval	Draft purpose; recommendations; §9 / B D3:D4; Summary C38:C39	Draft endorses a 31 October snapshot, but workbook header gives a proposed November sign-off and broad Sept–Dec period. Named-executive field currently says Trust CEO rather than a named signatory.	Record assessment cut-off 31 October, proposed Board consideration 12 November and final approval/submission as distinct stages. Populate actual named executive and approval date only when confirmed.	Confirmed executive signatory, Board decision and final approval/submission record.
R06	Clarify drafting	Draft §2 compared with executive summary and §7	Section 2 names Quality and Safety Committee; other sections and workbook use Quality and Performance Committee (Q&P).	Confirm the correct committee title and use it consistently, or explicitly explain separate committee roles.	Trust governance route / relevant committee agendas.
R07	Strengthen Board decision	Draft recommendations and §6 action 5 / B row 18	Workbook asks November Board to agree PEADP multidisciplinary participation, protected release/backfill planning, a lead and interim governance, with plan to January Board. Main draft recommendations only give broad accountability wording.	Add an explicit decision on PEADP preparation and staff-release planning, or clearly cross-refer to the decisions sought in Appendix 1. Do not imply attendance or release is already achieved.	Launch attendance record after 3 November; agreed lead, release/backfill plan and Board decision.
R08	Strengthen action control	Draft §7 / all 15 Amber rows	Draft proposes a single action plan with named executive/operational leads, completion dates and escalation thresholds. Workbook narratives identify required actions but do not consistently supply these fields; January reporting dates are not completion dates.	Implement a controlled action tracker covering all 15 Amber deliverables, with leads, underlying milestones, interim controls, evidence, impact measures and escalation thresholds.	Approved populated tracker and governance review records; do not substitute a generic January deadline.
R09	Evidence housekeeping	Draft §2 final checks / Evidence log EV-01, EV-07, EV-11, EV-21	Evidence log still has accessibility/receipt details to resolve: EV-01 location blank, internal EV-11 needs an externally accessible extract, EV-07 notes Board 12 September versus EV-19/20 10 September. EV-21 is explicitly draft-only.	Verify source dates and locations; clarify EV-07 relationship to EV-19 rather than count it as independent corroboration. Keep draft EV-21 excluded until replaced by the final report after Q&P.	Externally accessible controlled evidence pack; final mortuary report and 26 November scrutiny when available.
R10	Preserve assurance distinction	Draft §§4,5,8 / B rows 34,37–38	Draft correctly separates two Green triage requirements from 75% triage implementation and Amber delivery confidence, and distinguishes historical experience-plan Red actions from current Submission B Amber ratings.	Retain these caveats. Confirm current experience-plan action risks and interim controls; do not infer that absence of Red deliverables means absence of service risk.	Current experience tracker, triage improvement tracker and risk/escalation records.

Scope: document-to-workbook consistency review only. Referenced emails, minutes and underlying attachments were not supplied for independent re-validation.

DELIVERABLE CHECK • ALL 26 REQUIREMENTS

Historical baseline and current delivery status are distinct • all nine action groups covered • detail keyed to Board Draft Review checklist

Deliverable	Trust baseline	Submission B status	Review outcome	Draft reference	Requirement-specific review
1,1	Compliant	Completed at baseline	Aligned	Draft §6 action 1	Rollout commenced, not universal completion. Maintain current SOP, communications and monitoring.
2,1	Compliant	Completed at baseline	Aligned	Draft §6 action 2	Monthly collection/analysis remains completed at baseline; sustain source intelligence and governance cycle.
2,2	Compliant	Completed at baseline	Aligned	Draft §6 action 2	Baseline reporting remains complete; retain published reports, scrutiny, decisions and impact tracking.
2,3	Compliant	In progress / Amber	Clarify timing/date	Draft §§5–6; R01–R02	Regional partial compliance and Amber agree. Explicit outcomes AND experience by ethnicity/deprivation, data limitations, response and impact remain required; January Board is planned.
3,1	Compliant	Completed at baseline	Aligned	Draft sponsors; §6 action 3	Shared Chief Nurse/Medical Director accountability agrees with baseline; confirmation is not new establishment.
3,2	Partially compliant	In progress / Amber	Aligned; evidence pending	Draft §6 action 3	September DoM attendance confirmed, Clinical Directors absent; November maternity/neonatal attendance and participation need minutes and deputy arrangements.
5,1	Partially compliant	In progress / Amber	Strengthen decision	Draft §6 action 5; R07	Programme start 2027/28; launch representation is not completed participation. Agree lead, multidisciplinary nominations and protected release/backfill; January plan remains proposed.
5,2	Partially compliant	In progress / Amber	Clarify timing	Draft §6 action 5; R02	Live dashboard and September equity intelligence do not alone evidence full six-monthly trend review, decisions and impact. Separate pre-submission scrutiny from January Board.
5,3	Partially compliant	In progress / Amber	Aligned; clarify timing	Draft §6 action 5; R02	March 2027 implementation target agrees; benchmarking and element-level actions remain incomplete. January plan presentation is not implementation.
6,1	Compliant	Completed at baseline	Aligned	Draft §6 action 6	Acute-care consultant-presence requirement remains completed at baseline; sustain monitoring.
6,2	Partially compliant	In progress / Amber	Aligned; evidence pending	Draft §6 action 6	Locum audit compliance does not establish a continuously updated Trust-specific tier 2/3 short-term locum register; owner and update controls required.
6,3	Partially compliant	In progress / Amber	Aligned; funding pending	Draft §§6,8; R02–R03	Neonatal plan submitted to October Q&P is not funded implementation. EV-25 reports 6.10 WTE consultants versus 7.00 minimum; retain decisions, nursing/QIS trajectory and milestones.
6,4	Partially compliant	In progress / Amber	Confirm added deadline	Draft §6 action 6; R03	Midwifery funding and implementation gap agrees. Verify 23 December funding deadline; BR+ baseline deficit is not the full later 26%-uplift requirement.
6,5	Partially compliant	In progress / Amber	Aligned; evidence pending	Draft §6 action 6	Explicit 24/7 duty-anaesthetist AND trained anaesthetic-assistant availability/competence assurance still needed, with gaps and mitigations.
6,6	Partially compliant	In progress / Amber	Aligned; impact pending	Draft §§6–8	Integrated workforce, acuity and escalation reporting supports planning; Q&P submission alone does not establish mitigation effectiveness or elimination of siloed working.
6,7	Partially compliant	In progress / Amber	Aligned; review pending	Draft §6 action 6	Full review must address non-frontline redirection, specialist absence training/cover and redeployment impact. Planned January review is not a completed December action.
7,1	Compliant	Completed at baseline	Aligned	Draft §6 action 7	Keep baseline achievement; continue safety/quality oversight and restoration planning rather than imply every future change is complete.
7,2	Compliant	Completed at baseline	Aligned	Draft §6 action 7	Baseline regional sharing remains achieved; maintain current risk, mitigation and agreed-timescale oversight.
8,1	Compliant	In progress / Amber	Aligned; date/evidence pending	Draft §§5–6; R01	Trust-confirmed maternity PSIRF embedding is distinct from regional evidence gap. Explicit neonatal implementation, family communication and learning impact still required.
8,2	Compliant	In progress / Amber	Aligned; urgent action	Draft §§5–8; R01,R10	Complaints timeliness recovery is urgent; learning must not await closure. Retain dated learning-to-impact examples and confirm current experience-plan Red action position.
8,3	Partially compliant	In progress / Amber	Aligned; evidence pending	Draft §6 action 8	Learning examples/engagement tracker do not prove every family has key contact, completed debrief and early senior-manager candour. Obtain completed case review and follow-through.
9,1	Partially compliant	Complete / Green	Rating aligned; receipt pending	Draft §§4,6; R04	Complete/Green is scoped to audit/reporting, not full triage compliance. Retain regional submission/receipt and Board scrutiny records for stronger draft wording.
9,2	Partially compliant	Complete / Green	Aligned; sustain oversight	Draft §§4,6	Complete/Green oversight agrees. Sustain all named time, redeployment, delay, outcome and inequality measures; keep wider triage improvement risks visible.
9,3	Compliant	Completed at baseline	Aligned	Draft §6 action 9	On-track improvement requirement remains completed at baseline; maintain 12-month plan monitoring without claiming full service implementation.
10,1	Compliant	Completed at baseline	Aligned	Draft §6 action 10	July assurance-statement requirement remains completed at baseline, separate from continuing oversight requirement.
10,2	Partially compliant	In progress / Amber	Aligned; final evidence pending	Draft §§6,9; R09	Final mortuary report planned for Q&P 26 November, Board 14 January. Draft excluded; retrospective incident review and action closure remain unsubstantiated until final evidence/scrutiny.

BOARD PAPER • ALIGNMENT WORDING

Paste-ready amendments to DRAFT Board 10 point plan Nov 2026.docx • attached Word source unchanged • 14 January-linked deliverables covered

Draft location	Amendment	Paste-ready wording	Workbook basis / qualification
Executive summary — ADVISE	Replace paragraph	The enhanced Quarter 2 Perinatal Quality Oversight Report and associated workforce assurance are planned for Trust Board on 14 January 2027. Interim evidence will continue to be gathered and scrutinised through established perinatal and Quality and Performance Committee governance before the 31 December 2026 submission. The final Annual Mortuary Report is planned for Quality and Performance Committee on 26 November 2026, with onward presentation to Trust Board on 14 January 2027. Only evidence available, scrutinised and appropriately approved before submission will support the December assessment: January Board receipt and decisions remain outstanding.	Submission B rows 13, 19–28, 33–35, 42. Do not imply confirmed November Q2 scrutiny without agendas and final papers.
Recommendations	Add recommendation	NOTE the planned Trust Board assurance checkpoint on 14 January 2027 and REQUIRE continued interim oversight, named accountable leads and separate completion dates for underlying actions. AGREE development of the multidisciplinary Perinatal Equity and Anti-Discrimination Programme participation and protected staff-release/backfill plan following the launch, for presentation to that Board, with an accountable lead and interim governance route. Confirm how material updates will be reviewed and approved before the national submission on 31 December 2026.	Submission B row 18 and January action rows. Proposed decisions, not approvals already obtained.
Section 2 — national requirements	Replace paragraph beginning Further evidence	Further evidence will be considered through established perinatal governance and the Quality and Performance Committee ahead of the December submission. The enhanced Q2 Perinatal Quality Oversight Report and associated workforce assurance are planned for Trust Board on 14 January 2027; this is distinct from pre-submission evidence scrutiny. As there is no scheduled Board meeting in December, the final review and approval route for Submission B will be agreed with the Chair and Trust Secretary and may include an extraordinary Board meeting. Any material changes require further Board approval before submission.	Use Quality and Performance Committee consistently. Retain section 2 safeguards on non-material amendments, accessibility and submission.
Section 5 — regional response paragraph	Replace paragraph after regional ratings	The regional review assessed 2.3, 8.1 and 8.2 as partially compliant. All three remain In progress/Amber in Submission B. Further inequalities analysis and response, PSIRF implementation and family communication, and complaints learning and impact evidence are planned within Q2 reporting to Trust Board on 14 January 2027. Validated evidence available and appropriately approved before submission may inform the December assessment; January receipt and scrutiny will remain recorded as outstanding.	Submission B rows 13, 33, 34. Preserve historical ratings.
Section 5 — overall assurance	Replace paragraph beginning The current assessment	The current assessment reflects the position at 31 October 2026. Evidence gathering, action delivery and interim scrutiny will continue during November and December. The final Annual Mortuary Report is planned for Quality and Performance Committee on 26 November 2026. Q2 perinatal reporting, associated workforce assurance and onward mortuary reporting are planned for Trust Board on 14 January 2027. The December return will reflect evidence available and appropriately approved at submission and will identify outstanding January reporting separately.	Do not present January Board assurance as achieved before 31 December.
Section 6 — introductory January sentence	Replace sentence	Trust Board reporting on 14 January 2027 is a planned assurance checkpoint, not evidence of completed December actions or confirmation that every underlying action will be complete. Named accountable leads, interim controls and action-specific completion dates must be confirmed separately.	All 14 January-linked deliverables.
Section 6 — action 2	Replace assurance cell	2.1 and 2.2 are Completed at baseline; 2.3 remains In progress/Amber. Further analysis of outcomes and experience by ethnicity and deprivation, data limitations, the response and impact is required. The Health Inequalities Dashboard and Q2 Perinatal Quality Oversight Report are planned for Trust Board on 14 January 2027. Maintain interim oversight and describe January Board reporting as outstanding in the December return.	Submission B row 13.
Section 6 — action 5	Replace assurance cell	All three requirements remain In progress/Amber. Confirm launch attendance and develop the multidisciplinary participation and protected staff-release/backfill plan for proposed presentation to Trust Board on 14 January 2027; programme commencement is expected at the beginning of 2027/28. The full six-monthly Health Inequalities Dashboard review and Maternal Care Bundle implementation plan are also planned for that Board alongside Q2 reporting. Bundle implementation remains targeted for March 2027. January presentations and decisions remain outstanding at the December submission.	Submission B rows 18–20. Launch representation is not completed participation.
Section 6 — action 6	Replace assurance cell	6.1 is Completed at baseline; 6.2–6.7 remain In progress/Amber. Q2 locum-register, neonatal workforce and integrated workforce/acuity assurance, midwifery establishment assurance, direct 24/7 anaesthetic and trained-assistant assurance, and the full internal resource-deployment review are planned for Trust Board on 14 January 2027. Funding decisions, implementation, accountable leads and underlying completion dates remain to be evidenced or confirmed separately. Continue interim risk oversight; January Board reporting is not completed December assurance.	Submission B rows 23–28. The draft's 23 December midwifery funding deadline is not substantiated in the workbook; confirm its source before reinstating as a separate milestone.
Section 6 — action 8	Replace assurance cell	All three requirements remain In progress/Amber. Further evidence of maternity and neonatal PSIRF implementation, learning impact, named family contacts, completed communications and compassionate debriefs, and early senior-manager candour is required. Q2 PSIRF and complaints assurance, and the required supporting family-communication/debrief assurance, are planned for Trust Board on 14 January 2027. Urgent complaints recovery and safety learning continue now and must not await January reporting or final complaint closure. Record January reporting as outstanding in the December return.	Submission B rows 33–35.
Section 6 — action 10	Replace assurance cell	10.1 is Completed at baseline; 10.2 remains In progress/Amber. The final Annual Mortuary Report is planned for Quality and Performance Committee on 26 November 2026, with onward Trust Board presentation on 14 January 2027. Add the final report and committee scrutiny records to the Evidence Log after committee receipt. Retrospective incident-review completion and national/audit action closure require final evidence; draft material and planned January Board scrutiny must not be relied upon as completed December assurance.	Submission B row 42.
Section 7 — reporting and governance	Replace paragraphs beginning The Trust will use and The enhanced reports	The Trust will use established Maternity Incentive Scheme reporting and perinatal governance arrangements to evidence progress. Interim evidence and risks will be scrutinised through the Perinatal Delivery Group and Quality and Performance Committee ahead of submission. Enhanced Q2 perinatal reporting and associated workforce assurance are planned for Trust Board on 14 January 2027, bringing together workforce, safety, outcomes, experience and inequalities, effectiveness of interim controls and residual delivery risks. The final Annual Mortuary Report is planned for committee consideration on 26 November 2026 and onward Board presentation on 14 January 2027. Only evidence available and appropriately approved before 31 December may support the December return.	Retain final approval arrangements in section 7. Committee agendas and papers must substantiate any more specific pre-submission timetable.
Section 9 — subsequent oversight	Replace final paragraph	On 14 January 2027, Trust Board is planned to receive Q2 perinatal assurance, the Health Inequalities Dashboard, Maternal Care Bundle implementation plan, workforce and resource-deployment assurance, further incident/complaints/family-communication evidence and the Annual Mortuary Report. The PEADP participation and protected staff-release plan is proposed for presentation at the same meeting. Board scrutiny will review the submitted position, outstanding actions, residual risks and evidence of impact. This reporting is ongoing assurance and cannot retrospectively substantiate the December submission.	14 deliverables: 2.3, 5.1–5.3, 6.2–6.7, 8.1–8.3, 10.2.
Across draft — other dates and evidence claims	Resolve rather than silently change	Keep the 31 October 2026 assessment cut-off, proposed 12 November Board consideration and final approval/submission as separate stages. Confirm the regional source correspondence: the draft uses 16 October communication, while the workbook records 19 October review; retain both only if their distinct meanings are substantiated. Retain the triage submission/receipt record and evidence-pack contents before presenting specific dates and coverage as independently evidenced. Confirm the source and authority for any 23 December midwifery funding decision milestone.	Board Draft Review R01, R03–R05. No source correspondence or funding authority supplied with this draft.

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 12 November 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Audit and Assurance Committee held on 8 September 2026
Board member lead(s)		Shawn Smith, Non-Executive Director (Chair)
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

- To present an update to the Board of Directors from the quorate Audit and Assurance Committee meeting held on 8 September 2026.
- The Committee reviewed internal and external audit, counter-fraud, risk management, the Board Assurance Framework, information governance, policies and key financial governance matters, providing assurance on the adequacy and effectiveness of governance, risk management, internal control and financial reporting arrangements

Key points

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

- **Internal Audit Report -Recruitment controls** received limited assurance for operational effectiveness. Significant weaknesses were identified in pre-engagement checks and accountability for off-payroll workers, the completeness of the off-payroll register, agency identity checks and recruitment records. An urgent risk assessment and multi-stakeholder action plan were required, with progress, to return to Committee in November. Chief People Officer aware.
- **Internal Audit Report - Gloucestershire Managed Services materials management** received limited assurance for both control design and operational effectiveness, with three high-priority and one medium-priority finding. The service lacked effective governance, effective inventory controls and an inventory management system, and relied heavily on manual processes and one key individual. Action plan to be monitored by Audit Committee but consider alternative sources of oversight.

- **Risk action delivery** - remained subject to limited assurance, with more than half of actions overdue. Policy governance also remained at limited assurance, with just under 30% of policies overdue. The Committee required clearer reporting on the oldest or highest-priority overdue risks and on risks whose ratings had increased.
- **Subject Access Request -** performance remained below organisational standards, creating continuing regulatory, reputational and patient experience risk. Although recovery had begun to reduce the backlog and oldest cases, assurance remained moderate pending sustained compliance. Separate reports to Board and to Finance and Resource Committee have provided assurance as to action plan.
- **Sixteen single tender waivers -** with a reported value of £1.52 million, had been approved between June and August 2026. The Committee considered the volume high and required stronger forward planning, particularly for repeated echocardiography arrangements.

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

- **Internal Audit Report - Referral to treatment data quality** provided moderate assurance over design and operational effectiveness. One high and one medium-priority finding was identified. This was the result of various factors; including a reduction in audits due to a decrease of approximately 40% in the pathway access team from the previous establishment without a reduction in workload. Members welcomed the potential offered by the use of AI. Audit to be referred to Quality and Performance Committee for ongoing monitoring of actions.
- **Four internal audit actions** from 2025/26 remained overdue, relating to PSIRF, conflicts of interest and two mortuary controls. Physical works for the mortuary controls had been commissioned, while the conflicts action was addressed through approval of the refreshed policy (September meeting).
- **The Board Assurance Framework** continued to provide reasonable assurance, but strategic risk scores had not materially reduced. The Committee requested continuing evidence that controls produce measurable and sustainable risk reduction.
- **The Secondary Employment Policy** remained subject to completion of consultation and approval. The Committee asked that the route be accelerated, and that intellectual property provisions be checked against the research and innovation policy.
- The revised **capital approval** arrangements were supported to assist in reducing the approval timeline to assist efficient capital delivery.

ASSURE: inform the board where positive assurance has been received

- **External audit** confirmed that the Trust and group audit cycle had concluded, and the accounts had been laid before Parliament. The Gloucestershire Managed Services and Charity audits remained in progress, with completion planned by the end of September 2026.
- **Internal audit plan** delivery was progressing well. The Committee approved two risk-based amendments: replacing business continuity planning with private practice cardiology and refocusing infection prevention and control work on surgical site infection.
- **Counter Fraud Functional Standard Return** achieved a green rating. Collaborative fraud intelligence arrangements with Gloucestershire Constabulary were developing with information governance involvement.
- The refreshed **Managing Conflicts of Interest Policy** strengthened annual declarations, nil returns, manager accountability, mitigation and breach escalation. Completion of the

annual declaration process had materially improved, with no substantive employees failing to complete an annual declaration. It was recognised that a qualitative audit was needed as to the substance of the declarations – a process which will include line management review.
- The Committee considered that the Board Assurance Framework appropriately captured the Trust's principal strategic risks and approved the new strategic risk relating to research, innovation and genomics.

APPROVALS: decisions made by the Committee

- Approved two amendments to the 2026/27 internal audit plan.
- Approved Strategic Risk 11 relating to research, innovation and genomics, recognising that the risk remained developing and required further consideration of clinical integration, artificial intelligence, and consistent adoption and evaluation.
- Approved in principle the refreshed Managing Conflicts of Interest Policy, subject to replacing 'want to' with 'need to' in the relevant declaration wording and completion of the Corporate Board approval route.
- Supported and recommended to the Board amendments to charitable funds delegations within the Standing Financial Instructions and Scheme of Delegation, including a £10,000 charitable award approval threshold.
- Approved revised financial approval thresholds for capital projects and supported their incorporation into the Standing Financial Instructions and Scheme of Delegation, with continuing Finance and Resources Committee and Board oversight and review of effectiveness.
- Approved the write-off of 141 invoices with a total of £19,692.75 and noted three ex gratia payments totalling £2,080.

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	x
People, culture and leadership	x
Quality, safety and delivery	x
Digital first	x

Board assurance framework

BAF reference	The Committee considered the full Board Assurance Framework and approved Strategic Risk 11

Risks discussed

Principle risks:
Off-payroll, agency and recruitment control weaknesses, including potential patient safety, safeguarding, digital access and fraud risks; referral to treatment data quality and reduced validation capacity; overdue risk actions, overdue reviews and policy compliance; subject access request statutory compliance and operating model; materials management and inventory controls; repeated single tender waivers; strategic risk reduction; secondary employment controls; and charitable funds and capital delegation arrangements

Recommendations

- TAKE ASSURANCE from the Committee's work and conclusions.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12 November 2026
Report title	Strategic and Operational Risk Management Report
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Sarah Favell, Trust Secretary and Lee Troake, Head of Corporate Risk, Health and Safety

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

Executive Summary

This report brings together the Board Assurance Framework (BAF), the Trust Risk Register (TRR) and assurance on the effectiveness of the wider risk management system. Its purpose is to give the Board a single view of the Trust risk profile, test whether exposure remains consistent with risk appetite and tolerance, and demonstrate how risks are scrutinised through the governance architecture.

Overall assurance is REASONABLE. Strategic risks are identified, owned and routed through designated Board Committees, with the Audit and Assurance Committee overseeing the effectiveness of the framework as a whole. However, assurance is constrained by persistent high exposure, overdue actions, reliance on capital and recurrent financial improvement, and inconsistent evidence that controls are producing sustained risk reduction.

The report deliberately excludes routine operational detail. Appendix 1 is limited to TRR risks currently rated 16 or above. The full TRR remains available through management and committee routes.

Reporting cycle: Three times each year

Previously considered by	.

Recommendations:

- **SUPPORT** the relevance of the universal strategic and operational risk profile, including the concentration of TRR risks rated 16 or above taking reasonable assurance that principal risks are scrutinised through the governance architecture.
- **NOTE** the Audit and Assurance Committee's oversight of system effectiveness.
- **SUPPORT** continuation of thematic deep dives through the Risk Management Group, with material learning routed to Executive and Board Committees and reflected in the BAF, investment priorities and business cycles.

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?
This report relates directly to all strategic risks within the Board Assurance Framework. The report supports Board oversight of whether risks remain within appetite and tolerance, whether controls and management actions are effective, and whether further intervention or escalation is required.

Implications on:	
Equality, Diversity and Inclusion	No direct adverse impact has been identified. Effective risk management should support equitable access, experience and outcomes. Risk owners are expected to consider equality impacts when developing controls, actions and service responses.
Health Inequalities	Several strategic and operational risks, including those relating to access, capacity, workforce, digital provision and patient engagement, may disproportionately affect people experiencing health inequalities. Relevant mitigating actions should therefore be informed by population health and inequalities evidence.
Finance and Resource	Financial sustainability remains the highest-rated strategic risk, while delivery of risk-reduction plans is dependent on recurrent financial improvement, capital investment, workforce capacity and effective

	prioritisation of resources. Where exposure cannot be reduced within existing resources or delegated authority, escalation will be required.
Regulation/Legal	Effective risk management is integral to the Board's responsibilities for internal control, statutory compliance and organisational assurance. The report identifies continuing exposure relating to quality and safety, health and safety, estates, fire safety, cyber security and other regulatory requirements.
CQC-Key line of enquiry	The report is principally relevant to the Well-led key question, particularly governance, risk management and assurance. It also supports assurance under Safe, Effective and Responsive where strategic and operational risks may affect patient safety, quality, access and service delivery.
Green Plan	No specific direct impact has been identified.

Main Report

1. Purpose and Board-level scope

The Board receives this integrated report three times each year to maintain a universal view of risk across strategy and operations. It is not intended to replicate the detailed scrutiny undertaken by management forums or Board Committees. It brings forward the matters needed by the Board to discharge its responsibilities for risk appetite, strategic resilience, internal control and organisational assurance.

2. Governance architecture and lines of assurance

How assurance reaches the Board

Management ownership. Operational and divisional teams own, control, review and escalate risks and are accountable for delivering mitigating actions. Executive routes should ensure that material exceptions, dependencies and delays are visible and acted upon.
Risk Management Group. The Group challenges the quality and coherence of operational risk information, identifies cumulative and cross-cutting themes, commissions deep dives and tests whether risk intelligence is shaping priorities and decisions.
Lead Board Committees. Committees scrutinise the strategic risks within their remit, challenge trajectory, controls and assurance gaps, and provide explicit assurance or escalation to the Board. They do not replace management accountability.
Audit and Assurance Committee. The Committee oversees the design and effectiveness of the BAF and the risk management system as a whole, including whether critical controls are being tested rather than merely recorded.

Board of Directors. The Board sets risk appetite, considers aggregate exposure and interdependencies, and determines whether the Trust is operating within its strategic risk profile or whether further intervention is required.

3. Overall assurance judgement

REASONABLE ASSURANCE

The Trust has an established and functioning risk management system. Principal strategic and operational risks are identified, owned and subject to defined management and Committee oversight. Management responses are in place for the highest-rated risks, although delivery is not uniformly on track and sustained reduction remains dependent on capital, workforce capacity, recurrent financial improvement and completion of longstanding actions.

Assurance is reasonable rather than substantial. The principal limitations are the continued level of high and extreme risk exposure, overdue risk and incident actions, and inconsistent evidence that critical controls are operating effectively and producing sustained improvement. These limitations are being addressed through prioritised management action, strengthened exception reporting, thematic deep dives and developing control-effectiveness testing, with oversight through the Risk Management Group, lead Board Committees and the Audit and Assurance Committee.

What supports the judgement

- **Risk visibility and ownership are established.** Strategic and operational risks have named owners, controls and actions, although the aggregate profile can still obscure cumulative or systemic exposure.
- **Governance routes are defined.** Strategic risks are allocated to lead Committees and the BAF is a standing item for the Audit and Assurance Committee.
- **Review discipline is improving.** Overdue risk reviews had reduced to 82 by October 2026, but timeliness remains variable and some high-rated risks require more current review.
- **Action delivery remains the clearest weakness.** Overdue risk actions reduced to 28%, but 46% of incident actions remained overdue. Management recovery is therefore focused on the oldest and highest-impact actions, with exceptions monitored through the relevant quality, Executive and risk governance routes.
- **Risk movement is mixed.** More risk ratings reduced than increased during the period, but increases in infrastructure, service capacity and funding dependency demonstrate continuing material exposure.
- **Control assurance needs to mature.** The next stage is to test whether critical controls are appropriately designed, operating consistently and changing outcomes, rather than relying on the existence of controls and actions as evidence of effectiveness.

4. Strategic risk profile

The Board Assurance Framework (BAF) is more coherent and actively scrutinised, but stronger governance has not yet consistently translated into sustainable reductions in strategic exposure. Several risks remain above target and outside the Trust's preferred level of exposure.

- **Financial sustainability, SR4: 25 against a long-term target of 5.** This remains the highest strategic exposure. The risk is stable at an unacceptable level and sustained reduction depends on delivery of recurrent recovery and improved financial control.

- **Digital infrastructure and cyber, SR6: 20 against 12.** Exposure remains high. Unsupported systems, resilience, supplier assurance and recovery testing remain material gaps, with oversight through the relevant Executive and Committee routes.
- **Digital transformation and culture, SR7: 20 against 10.** Strategy and leadership have strengthened, but the operating model, workforce, funding and benefits realisation remain incomplete.
- **Performance and delivery, SR5: 16 against 9.** The reduction from 25 is positive, but the risk remains above target and dependent on sustained improvement in demand, capacity, flow and delivery.
- **Estates, SR8, and health and safety, SR9: both 16.** Governance routes and visibility have improved. Backlog, asset information, fire, ventilation, asbestos compliance and capital dependency continue to limit assurance.
- **Workforce sustainability, culture and retention, SR2 and SR3: 15 and 16.** The risks are being consolidated to improve coherence. This is a redesign of the risk architecture and must not be interpreted as reduced exposure.
- **Safe and effective services, SR1: 12 against 6.** External assurance has improved, but open requirements, overdue actions and complaints performance constrain assurance.
- **Patient and stakeholder engagement, SR10: 4 against 3, and research, innovation and genomics, SR11: 9 against 6.** These risks are lower rated, but their scope and interfaces with patient voice, inequalities, digital and artificial intelligence continue to be refined.

Management plans are in place for each strategic risk and are overseen through the designated lead Committee. Delivery is not uniformly on track. The principal constraints to further reduction are recurrent financial recovery, capital availability, specialist workforce capacity, digital resilience and completion of longstanding actions. Where delivery materially deviates from plan, the relevant Committee is expected to challenge the recovery response and escalate any matter requiring Board intervention.

Board interpretation

- Financial sustainability and both digital risks remain the most significant Board exposures.
- The improvement in estates and performance risks is positive but remains dependent on sustained delivery.
- Workforce risk consolidation is a redesign of the risk architecture.
- Cross-cutting dependencies include capital, recurrent savings, specialist workforce capacity, transformation delivery and timely completion of mitigating actions.

5. Operational risk profile and material exceptions

Across all registers there are 536 active risks. The TRR contains 35 risks, of which 25 are currently rated 16 or above and are included in Appendix 1. The concentration of highest-rated risks is in quality and operational delivery, estates and infrastructure, digital and cyber resilience, and specialist workforce capacity.

- **Urgent and emergency care and flow.** Overcrowding, corridor care and delayed assessment remain rated up to 20. Assurance depends on triangulation with patient harm, flow, workforce and operational recovery evidence.
- **Estates and infrastructure.** Tower Block, soil stack, fire safety, air handling units, MRI and critical IT environments remain rated 16 to 20. Long-term capital dependency and reliance on temporary controls constrain assurance.

- **Digital and cyber.** Cyber vulnerabilities and the resilience of critical infrastructure remain rated 20. Board assurance should continue to include recovery testing, unsupported systems and supplier dependencies.
- **Workforce and service fragility.** Critical Care, anesthetics, oncology, maternity and other specialist services remain highly exposed. Workforce plans must be demonstrably connected to service sustainability and quality outcomes.
- **Maternity and women's services.** Several risks remain rated 16, including triage, obstetric workforce and ultrasound capacity. Committee assurance should remain linked to quality, workforce and improvement evidence.

Risk appetite and tolerance. Several strategic and operational risks remain above target and are likely to be outside the Board's preferred tolerance. Continued exposure is being managed through defined controls and recovery actions, but sustained reduction remains dependent on capital investment, workforce capacity, recurrent financial improvement and delivery of transformation plans. Where exposure cannot be reduced within existing resources or delegated authority, the matter will be escalated through the relevant Committee for Board consideration.

Movement and action delivery

During September and October, 18 risk ratings reduced and 8 increased. Positive movement included the Diabetic Eye Screening workforce risk reducing from 20 to 6. Material increases included the GRH Tower Block estate risk and specialist weight-management capacity, both increasing to 20, and capital availability and pathology programme funding increasing to 15. These movements reinforce that aggregate risk volume alone is not a sufficient measure of organisational exposure.
There are 271 overdue actions from 959 open risk actions (28%), improved from 51% previously. However, 156 of 340 incident actions are overdue (46%). This remains a material limitation because delayed actions weaken confidence that lessons and agreed mitigations are being implemented at the required pace. Management attention is being prioritised towards the oldest and highest-impact actions, with exceptions followed through the Risk Management Group and relevant quality and Executive governance routes. The next report will provide the continuing trajectory and identify any areas where recovery is not progressing sufficiently or requires escalation.

6. Deep dives: testing risk against organisational reality

The Chair of the Risk Management Group commissioned a programme of thematic risk deep dives as a new development in the Group's approach to organisational risk oversight. The programme commenced with a deep dive into Estates risk, selected because of the scale, age and interdependency of the risks concerned, their reliance on capital and other resources, and the potential disconnect between identified risk, timely decision-making and the allocation of resources.

The introduction of deep dives is intended to move the Risk Management Group beyond reviewing the quality and currency of individual risk records. Their purpose is to test whether the collective risk profile reflects organisational reality; whether risks that share common causes or dependencies are being considered together; whether controls address the underlying causes of exposure; and whether risk intelligence is sufficiently influencing operational decisions, investment choices and organisational priorities.

This is particularly important where risks have been known for a prolonged period, remain dependent on interim controls or cannot be reduced without decisions on capital, workforce or

other resources. In these circumstances, the existence of a risk on a register does not, in itself, provide assurance that the exposure is being managed effectively.

The Estates deep dive provided the first practical test of this approach. It considered whether the individual risks recorded across the organisation, when viewed collectively and alongside wider evidence, presented a complete and coherent picture of the Trust's infrastructure exposure. It also examined whether the significance and cumulative effect of those risks had been reflected sufficiently in the timing of decisions, investment priorities and resource allocation.
The programme will continue through the Risk Management Group, using proportionate thematic reviews to identify systemic issues, test the effectiveness of controls and determine whether management responses are capable of reducing exposure. Material findings will be routed through the relevant Executive and Board Committee arrangements and, where appropriate, reflected in the Board Assurance Framework, Trust Risk Register, investment priorities and organisational business cycle.

Estates deep dive:

The Estates deep dive identified 73 active estates and facilities risks, with five then escalated to the TRR. It found good visibility of individual failures and statutory concerns, but limited assurance that the collective profile fully represented ageing infrastructure, backlog maintenance, cumulative exposure and capital dependency. Some risks had remained open for more than ten years and relied on interim controls. The important learning is that risk identification alone is not enough: the system must connect risk intelligence to timely decisions, investment choices and demonstrable reduction in exposure.

7. Audit and Assurance Committee oversight of system effectiveness

The Audit and Assurance Committee receives the Board Assurance Framework as a standing item and provides oversight of the effectiveness of the risk management framework as a whole. This complements, rather than duplicates, the detailed scrutiny of individual strategic risks by designated Committees.

- **BAF design and completeness: reasonable assurance.** Challenge will continue on strategic coverage, interdependencies and changes to the risk architecture.
- **Risk management process: reasonable assurance.** The immediate focus is continued reduction in overdue reviews and stronger exception reporting.
- **Action delivery and learning: limited assurance.** The oldest and highest-impact actions require prioritised recovery and evidence that implementation has changed practice or reduced risk.
- **Control effectiveness: developing assurance.** Testing will increasingly examine design, consistent operation and impact of critical controls for the highest-rated risks.
- **Deep dives and thematic assurance: developing.** Triangulation will be used to test whether registers reflect organisational reality and whether material findings influence management action and investment decisions.

The Risk Management Group's key message to the Board is that the framework is maturing, but improved reporting, completed activity or lower scores should not be treated as proof of reduced risk without supporting evidence of effective controls, improved outcomes and sustained reduction in exposure. This is endorsed by the Audit and Assurance Committee's conclusions, as reflected in meeting minutes

Management response and escalation. For each material assurance gap, the responsible Executive and risk owner are expected to maintain a recovery response, delivery milestones and evidence of impact. Progress and exceptions are monitored through the Risk Management Group and relevant Executive and Board Committee routes. Matters will be escalated where actions are materially off track, critical controls cannot be evidenced as effective, or exposure remains outside tolerance and cannot be reduced within existing authority or resources.

8. Trust Leadership Team focus

- Risk appetite: whether financial, digital, estates, workforce and operational exposure remains within the Board's stated tolerance, and what explicit action is required where it does not.
- Control effectiveness: whether the highest risks have reliable evidence that critical controls are operating, including recovery testing and independent assurance where appropriate.
- Action delivery: whether longstanding and high-priority actions are being completed at pace, particularly incident actions.
- Investment and prioritisation: whether capital, workforce and transformation choices are demonstrably aligned to relative risk exposure.
- Governance impact: whether information reaching Board and Committees reflects the actual strategic and operational risk profile, including cumulative and cross-cutting risks.

9. Conclusion

The integrated view provides reasonable assurance that the Trust has an established and functioning risk management system. Principal strategic and operational risks are visible, owned and subject to defined management, Executive and Committee oversight. The governance architecture provides appropriate routes for detailed scrutiny, system-level assurance through the Audit and Assurance Committee, and escalation to the Board where exposure, delivery or control effectiveness requires its attention.

The system continues to mature. The next stage is to strengthen the connection between risk identification, timely decision-making and the allocation of resources; improve the consistency with which the effectiveness of critical controls is evidenced; and ensure that longstanding or cross-cutting risks receive sufficient organisational focus. The programme of thematic deep dives commissioned through the Risk Management Group is an important part of that development.

The continued presence of high and extreme risks should not, in itself, be interpreted as evidence that the risk management system is ineffective. Several of the Trust's most significant risks arise from longstanding infrastructure, workforce, financial and capacity pressures that cannot be resolved immediately or through risk-management processes alone. The relevant assurance question is whether those risks are understood, actively managed, supported by credible plans and controls, and escalated where exposure cannot be reduced within existing resources or delegated authority.

There remain areas requiring further improvement, particularly the completion of overdue actions and the consistent testing of control effectiveness. These are recognised limitations within a maturing system and are being addressed through strengthened exception reporting,

management follow-up, thematic deep dives and oversight through the relevant governance routes. The Board can therefore take reasonable assurance that the Trust's principal risks are being managed through an established governance framework, while noting that further work is required to demonstrate sustained reductions in exposure and whether management responses are delivering the intended impact.
Enclosures
FOI: Public

Appendix 1: Trust Risk Register risks rated 16 or above

This appendix is intentionally limited to the highest-rated current TRR risks. The full register remains available through the established management and Committee assurance routes. Scores reflect the source report position for November 2026.

ID	Risk summary	Division	Risk type	Current	Target
266	Delayed assessment and treatment arising from poor Emergency Department flow	Medical	Quality, Safety & Delivery	16	6
293	Inability to provide the Pharmacy Manufacturing Service because of department closure	Diagnostics and Specialties	Quality, Safety & Delivery	16	3
333	Delayed glaucoma follow-up because of insufficient workforce	Surgical	People, Culture and Leadership	16	6
425	Financial and operational impact of ageing and ineffective theatre AHUs	Corporate	Estates and Facilities	16	6
458	Inadequate Critical Care bed base, estate and facilities at GRH	Surgical	Estates and Facilities	16	1
490	Harm to pregnant women and babies due to delayed triage review and treatment	Women's and Children's	Quality, Safety & Delivery	16	6
746	Unsafe or lower-quality maternity service due to insufficient Consultant Obstetricians	Women's and Children's	Quality, Safety & Delivery	16	5

ID	Risk summary	Division	Risk type	Current	Target
751	Failure to provide a safe, high-quality maternity ultrasound service	Women's and Children's	Quality, Safety & Delivery	16	3
764	Reduced quality and poorer outcomes in the fractured neck of femur pathway	Surgical	Quality, Safety & Delivery	16	8
850	Oncology workplace stress due to consultant workforce and workload imbalance	Diagnostics and Specialties	People, Culture and Leadership	16	2
911	Reduced quality of care due to insufficient anaesthetic workforce	Surgical	Quality, Safety & Delivery	16	4
1016	Reduced service quality due to insufficient Critical Care consultant workforce	Surgical	Quality, Safety & Delivery	16	4
1060	Poor outcomes in pregnancy due to diabetes management and guidance	Women's and Children's	Quality, Safety & Delivery	16	4
1143	Inability to provide home birth safely across Gloucestershire	Women's and Children's	Quality, Safety & Delivery	16	3
347	Closure of GRH Tower wards following catastrophic soil stack failure	Corporate	Quality, Safety & Delivery	20	5
363	Statutory intervention arising from non-compliant fire safety infrastructure	Corporate	Brilliant Basics	20	6
401	Failure of core IT infrastructure caused by environmental hazards	Corporate	Digital First	20	3
426	Patient harm in the Emergency Department Minors area due to overcrowding and staffing	Medical	Quality, Safety & Delivery	20	4
600	Patient harm and disruption from recurrent failures in SSD and theatres	Surgical	Quality, Safety & Delivery	20	3

ID	Risk summary	Division	Risk type	Current	Target
1096	Compromise of the digital environment through cyber vulnerabilities	Corporate	Digital First	20	6
1112	MRI scanner breakdown due to insufficient AHU capacity at CGH	Diagnostics and Specialties	Estates and Facilities	20	4
1142	Failure of the GRH Tower Block estate	Corporate	Estates and Facilities	20	8
1185	Critical staffing shortages in Critical Care non-consultant medical and ACCP workforce	Surgical	People, Culture and Leadership	20	8
1202	Patient harm from corridor care in the GRH Emergency Department	Medical	Quality, Safety & Delivery	20	4
1243	Delays to specialist weight-management assessment and treatment	Diagnostics and Specialties	Quality, Safety & Delivery	20	9

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 12 November 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 22nd September 2026
Board member lead(s)		Committee Chair: Jaki Meekings Davis Executive Directors: Karen Johnson, Director of Finance Al Sheward, Chief Operating Officer Kerry Rogers, Director of Integrated Governance Will Cleary Gray, Director of Improvement Delivery Lee Pester, Chief Digital and Information Officer Deborah Evans, Trust Chair (part) John Noble, Non Executive Director Shawn Smith, Non Executive Director
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	✓
	Discussion	✓
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the Finance and Resources Committee held on 22nd September 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.

- **Delivery Capacity across a number of corporate disciplines -** The nature of service provision is changing; the outsourced data centre, new MES contracts such as Pathology, moves towards a new EPR, future financing of digital investments. Collectively, these represent a challenge to the manner in which corporate services, in particular Procurement and Contract Management, are delivered, The Committee has requested a prospective view of future requirements to reflect these pressing changes/new ways of working.

- **Financial Position including in year delivery of Financial Sustainability Programme/Financial Recovery** – The Committee noted that the Month 5 revenue position was on track and the Financial Sustainability Programme was slightly ahead of plan. Following adoption of a Recovery Plan, a break even position is forecast for the year. However, there remained an unidentified gap of £14m in red/unidentified schemes in the Sustainability plan which needs to be recovered in the remaining six months and will require prompt decisions re the Workforce programme in order to access the system cost of change funding. This will require Board level input.
- **Assurance levels around the delivery of the Capital Programme and Department of Critical Care –** following a review, the Committee was advised that there was insufficient assurance around delivery of the Capital programme – confidence levels were low around progress and financial implications and the risk level was assessed as medium to high. Any unspent capital monies are lost at the year end. A number of significant problems affecting delivery of the new Department of Critical Care (DCC) were explored in a separate meeting with Board members and an update will be made at the meeting.
- **Five Year Capital Programme Plan –** a draft programme had been prepared in order to assess the size and nature of challenges ahead. National funding/CDEL allocations will not be sufficient to meet the "Must Do" schemes and no provision had been possible for schemes supporting moves out of secondary care. Additional changes to leasing rather than purchasing assets – through Managed Equipment Services (MES) or Digital developments – add a further uncertainty to both capital and revenue planning. To be reviewed as plans progress but initial indications are for an extremely tight planning round.

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

- **Cyber security –** The risk rating for cyber remains at 20 in order to reflect the heightened national cyber threat and continuing infrastructure risks rather than any deterioration in the Trust's core controls. There has been a sustained and measurable improvement in the Trust's cyber security position.
- **Digital Programme –** The planned implementation of the Data Centre relocation scheme is high risk due to problems encountered with BT/Open Reach. This is a national issue. Agreed that the matter be escalated as a priority with the risks to NHS cyber security articulated.
- **New Finance System –** The target implementation has been agreed as April 2027. This is a high risk programme – the Committee sought assurance that adequate resources are available to oversee implementation and go/no go criteria and gateways are in place with Digital input.
- **Pathology MES Outline Business Case –** the draft Business Case was presented to the Committee. This is a large (approximately £150m) and complex case with implementation not due until 2031. The final decision will be a matter for the full Board and a briefing session for the Board is to be arranged prior to decision making.

ASSURE: inform the board where positive assurance has been received

- **Subject Access Requests –** This was a follow up report following a deterioration in SAR performance. It detailed actions taken to date, recent improvements in completion rates and additional staff appointed to cope with what has been a significant increase in number and complexity of enquiries. The Committee acknowledged the improvements, increased digitisation of the service and levels of assurance. Further work re the long term prospects and resources required for this and similar services to be undertaken.

- **Annual Debt Report –** The level of debt outstanding has reduced by £9m and the corresponding bad debt provision by £3.5m as a consequence of settling a small number of long standing issues.

APPLAUD

- **Cyber Security –** The Trust ranks 127/467 in national rankings of overall cyber security which offers assurance.
- **Delivery of Digital Systems –** Ten "go lives" have been delivered to date in 26/27 with a further 6 planned before the year end – a significant programme of transformation.

APPROVALS: decisions made by the Committee

- Please insert

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, assurance around capital programme delivery, continued cyber threats and digital infrastructure risks, uncertainty around future funding routes for digital investments, procurement and transformation capability and capacity, adequacy of national capital and CDEL allocations in future years and delivery of the Department of Critical Care.

Recommendations

The Board of Directors is asked to take **assurance** from the report, note the matters escalated for attention, and note the approvals made by the Committee.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Date of Meeting	12 November 2026
Report title	Trust Forecast and Recovery Plan
Sponsoring Director/Author	Karen Johnson, Director of Finance

Purpose (confirm the appropriate box)		
For approval	**For discussion**	**For assurance**
		✓

Executive Summary

This report outlines the 2026/27 financial forecast and recovery plan, its dependencies and emerging risks.

The unmitigated forecast position is £14.3m deficit. This is based on our actual spend adjusted by any one off changes that have happened or that are intended to happen during the financial year. This position has operational ownership sign off and has been scrutinised and challenged.

A financial recovery plan has been developed to mitigate the £14.3m forecast deficit. A combination of divisional actions and financial reviews has led to the production of a mitigated forecast that contains some high risk assumptions. The high risk mitigated forecast is £5.576m deficit.

Further mitigations have been identified by the executive team to improve the forecast to a breakeven position. These include a review of spend committed against central reserves and additional income from GICB related to RTT delivery. These mitigations carry a level of risk that will be managed on a monthly basis by the executive team.

Previously considered by	Finance & Resources Committee on 27/10/26

Recommendations:

The Board is asked to:

- note that the Trust is facing an unmitigated forecast deficit of £14m in 26/27 if no recovery action is taken.
- note the recovery actions that are being put in place to forecast a breakeven position.

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

Impact on any Strategic Risks?
This report outlines that we are forecasting to deliver the Control Total. (risk 1053).

Implications on:	
Equality, Diversity and Inclusion	*Not assessed*
Health Inequalities	*Not assessed*
Finance and Resource	This report provides an update on the forecast and recovery plan for 2026/27.
Regulation/Legal	This reports provides an update that the Trust is forecasting to deliver the NHSE requirement to breakeven.
CQC-Key line of enquiry	The report aligns to multiple CQC key lines of enquiry by demonstrating that the Trust is forecasting to deliver against planned targets and is managing the associated risk and mitigations.
Green Plan	*Not assessed*

Main Report
The forecast and recovery report is provided in a separate slide pack.
Enclosures: Slide pack
None
FOI: Partly Confidential

Trust Forecast and Recovery Plan

Trust Board

Background to the 26/27 position

For 2026/27 the NHSE guidance outlined the **requirement** for each NHS Trust and ICB to deliver an agreed **breakeven financial position.**

- There was also a requirement that organisations **move towards underlying financial balance** over the planning period

In order to deliver this the Trust planned to deliver c**£52m of financial sustainability** schemes covering:

- Cost pressure mitigation
- Business as usual savings activities
- Transformational savings

During the first part of the year we have been reporting the financial position in line with its phased deficit plan.

This has been clearly articulated that this position is predicated on the **use of non-recurrent benefits** and the **early advancement** of financial sustainability schemes.

- This early advancement means that year to date undelivered has been temporarily covered but must be recovered later in the year.

- Through reporting it has been highlighted that there is a **material risk to delivering the financial position** primarily due to:
  - gaps in identifying sustainability schemes,
  - Non delivery from high risks schemes
  - Non containment of cost pressures identified at the planning stage

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Forecast Position – high level

The unmitigated forecast position is £14.3m deficit. This is based on our actual spend adjusted by any one off changes that have happened or that are intended to happen during the financial year. This position has operational ownership sign off and has been scrutinised and challenged.

The forecast position includes non recurrent benefits of £5.7m. **Without these benefits, the forecast would be £20m deficit.**

The 2026/27 position includes c.£10m underperformance on activity which is being supported non recurrently by the GICB block adjustment. Without this, the deficit would be c.£30m deficit.

Forecast Driver	£000
FSP Gap	5,973
FSP Red	6,161
Industrial Action	715
Divisional cost pressures	4,032
Tariff drugs	1,172
Variable activity underperformance (OOA/spec comm)	2,097
Reserves & balance sheet review	- 1,857
Capital charges benefit	- 4,000
Total	**14,293**

Non Recurrent Benefits in Forecast	£000
Provision release	- 4,000
Accruals review	- 1,696
Total Non Recurrent benefits	- 5,696
Position excluding non recurrent benefits	**19,989**

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Recovery plan to achieve breakeven

A financial recovery plan has been developed to mitigate the £14.3m forecast deficit.

A combination of divisional actions and financial reviews has led to the production of a mitigated forecast that contains some high risk assumptions.

The high risk mitigated forecast is £5.576m deficit.

Further mitigations have been identified by the executive team to **improve the forecast to a breakeven position**.

These include a review of spend committed against central reserves and additional income from GICB related to RTT delivery. These mitigations carry a level of risk that will be managed on a monthly basis by the executive team.

GHFT Forecast Variance to Plan 26/27	£000 Forecast Deficit
Month 5 forecast (do nothing)	14,293
Medium risk mitigations	
Nursing Review and vacancy controls	-282
Rebates and reclaims	-208
Review of balance sheet	-1,710
Review of reserves and other measures	-1,540
Medium risk mitigations	-3,740
High risk mitigations	
Divisional reviews	-947
Divisions aiming to breakeven	-1,060
Recovery of income underperformance	-2,422
Other	-548
High risk mitigations	-4,977
Total mitigations	-8,717
Mitigated forecast variance (high risk)	5,576
Further mitigations	
Review of reserves	-1,200
Benefit from NHSE 25/26 carry forward	-145
Corporate spend reductions	-531
Review of overheads	-667
Funding linked to RTT delivery	-1,600
Other recovery options	-1,433
	-5,576
Updated high risk forecast if all mitigations materialise	0

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What needs to be true in order to achieve breakeven

- Delivery of the recovery plan, updated monthly and reported to the Executive team and Finance and Resources Committee to ensure progress against the plan and where further risks materialise, they are known and acted upon at pace
- Delivery of the operational plans - monthly reporting to ensure RTT is delivered
- Continue to hold divisions and corporate teams to account on their year end position through the accountability framework
- Continue to push the transformation projects to ensure delivery happens next year if not earlier
- Continue to focus on financial sustainability schemes that can be moved at pace and brought into this financial year
- Reduce discharge ready dates to keep flow and where possible close capacity

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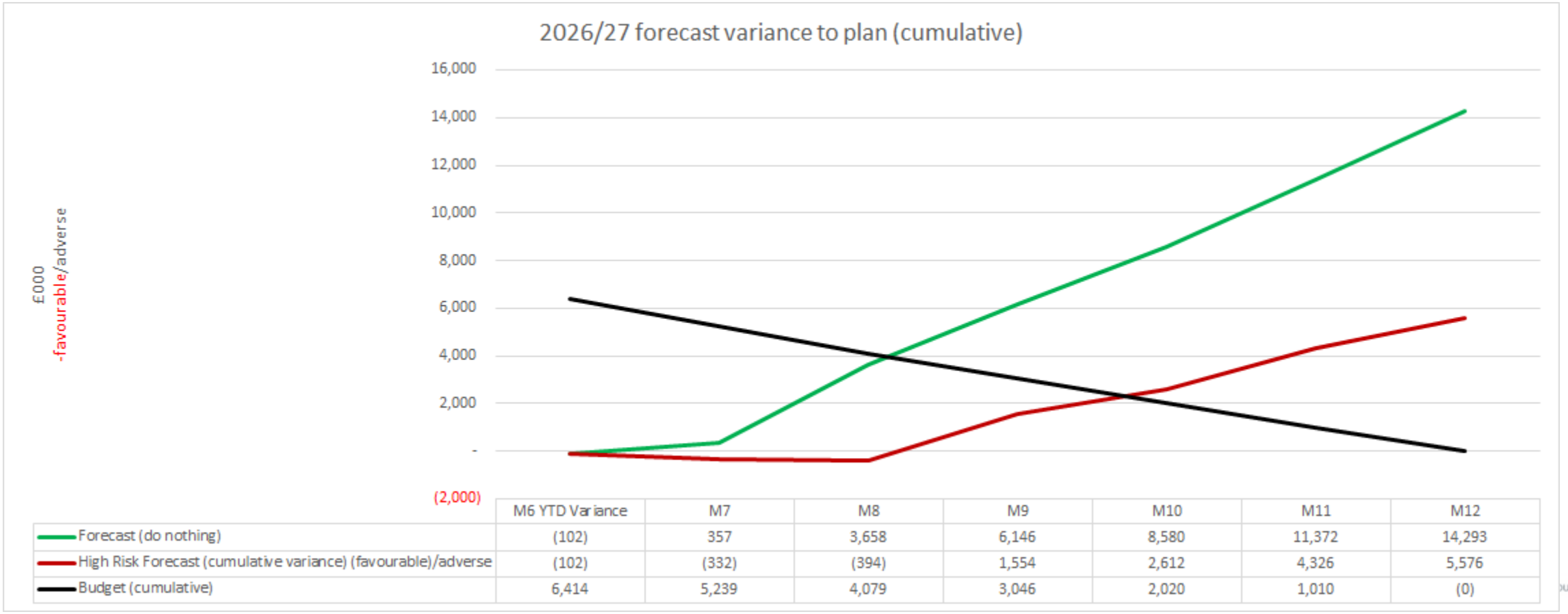
Risks to the plan

- Inability to reduce discharge ready dates which will have an impact on flow and capacity
- Delivery of financial sustainability plans that are rated as medium risk (c.£3.4m)
- Delivery of RTT which will mean inability to access additional funding (£1.6m)
- Recovery of API income underperformance with out of area commissioners (c.£2.4m)
- Supplier penalties associated with the Critical Care (DCC) project (c.£400k.)

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Updated forecast run rate (cumulative variance)

If no action is taken, the Group will begin to deviate from plan in M7. If mitigating actions materialise, this will enable the position to be managed until M9 when the Group will deviate from plan by c£1.5m, increasing each month until the end of the financial year.



	M6 YTD Variance	M7	M8	M9	M10	M11	M12
Forecast (do nothing)	(102)	357	3,658	6,146	8,580	11,372	14,293
High Risk Forecast (cumulative variance) (favourable)/adverse	(102)	(332)	(394)	1,554	2,612	4,326	5,576
Budget (cumulative)	6,414	5,239	4,079	3,046	2,020	1,010	(0)

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 12 November 2026

Title		ADVISE, ALERT and ASSURE Report of the Quality and Performance Committee meetings held on 24 September and 29 October 2026
Board member lead(s)		Sam Foster, Non-Executive Director (Chair); Vareta Bryan, Non-Executive Director (Acting Chair for October)
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

To present an update to the Board of Directors from the quorate Quality and Performance Committee meetings held on 24 September and 29 October 2026.

The Committee reviewed quality, safety and operational performance, including urgent and emergency care, winter preparedness, elective, diagnostic and cancer recovery, patient safety, complaints, regulatory compliance, maternity and neonatal services, patient experience, infection prevention and control, mortality and the Board Assurance Framework.

Key points

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

Urgent and Emergency Care, Flow and Corridor Care - Four-hour performance deteriorated, with whole-hospital flow and delayed discharge remaining the principal constraints. Approximately 130 patients were awaiting Pathway 1 discharge in October, with waits of 10 to 11 days against the national expectation of 24 to 48 hours. Corridor care remained persistent within the Emergency Department, with approximately 21 patients each day spending more than 45 minutes in a corridor or other inappropriate area. Older and frail patients were disproportionately affected. Monthly written assurance reporting will continue throughout winter.

Complaints Capacity and Timeliness - Complaint demand increased by 23% year on year to 1,323. Timeliness remained at 38% against the 95% target, with insufficient central capacity and a significant backlog, including complaints linked to coronial inquests. A demand and

capacity review is due by 30 November and a resourced recovery trajectory by 31 December 2026.

Patient Safety and Clinical Pathways - A third ophthalmology never event within 12 months was reported. Although no harm was identified, the Committee requires evidence that immediate and wider improvement actions are embedded and effective. Delayed glaucoma follow-up presents a risk of sight loss. Patient Safety Incident Response Framework timeliness and Duty of Candour compliance remained below the required level.

Maternity and Regulatory Risk - Maternity scanning capacity remains fragile and requires a sustainable, funded solution, a firm delivery date and effective interim controls. CQC regulatory breaches and Section 31 maternity conditions remain under active oversight.

HM Coroner: A Prevention of Future Deaths response is due by 25 November and will be brought to November Committee meeting.

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

Thirlwall Inquiry Response - The Committee noted the significant Trust-wide implications of the Inquiry's recommendations, including requirements for strengthened safeguarding, Board-level monitoring of deaths of children and babies, escalation of concerning trends and tighter controls within neonatal services. A single Trust-wide gap analysis and action plan is being developed, with QPC providing ongoing scrutiny of implementation and assurance on impact

Elective, Cancer and Diagnostic Recovery - RTT performance stabilised and the Trust retained an ambition to achieve 75% by December, but over-52-week waits increased and recovery assurance for trauma and orthopaedics and spinal services remained limited. Cancer 62-day performance improved but remained below standard. Diagnostic performance improved across 10 of 14 modalities. Echocardiography waiting lists reduced substantially, but a validated and costed recovery plan is required to demonstrate sustainability.

Improvement Impact and Sustainability - The Committee repeatedly requested that reports distinguish activity from impact, provide numbers alongside percentages, identify named owners and milestones, and demonstrate whether controls are effective and sustained. Benefits from Clinical Vision of Flow improvement work have not yet been consistently sustained.

Assurance Framework and Risk - Strategic Risks 1 and 5 were reviewed and approved for inclusion in the Board Assurance Framework. Strategic Risk 5 will be reconsidered in November in light of cancer performance. Work is under way to standardise assurance terminology and strengthen strategic, exception-based reporting.

Patient Experience and Health Inequalities - Patient feedback was predominantly positive, but communication, waiting, access, discharge and complaints responsiveness require improvement. People with disabilities and long-term conditions reported poorer experience, and deprived communities were underrepresented in routine feedback.

ASSURE: inform the board where positive assurance has been received

Mortality and Learning from Deaths - Overall mortality remained within the expected range and actual deaths continued to fall. No material concerns had been identified from current statistical alerts and bereaved-family experience had recovered.

Infection Prevention, Falls and Pressure Ulcers - Healthcare-associated infection improvement trajectories for C. difficile, E. coli and Klebsiella were exceeded, with strong regional benchmarking. Falls and pressure-ulcer performance improved. Sterile-services

performance improved, with no cancellations attributable to sterile services in September and 100% wet-set performance.

Maternity and Neonatal Services - Neonatal training compliance recovered to above 90% across all staff groups. Recruitment secured additional Band 5 and experienced **midwifery** capacity, maternity safety indicators remained positive, and the maternity complaints backlog reduced substantially**.**

Patient Experience and Pathway Innovation - Nearly 130,000 patient ratings were received, with care widely described as kind, compassionate and professional. Changes to the paediatric MRI pathway, including use of a simulator, reduced the need for sedation and general anaesthesia.

Diagnostics and Cardiology Improvement - The echocardiography waiting list reduced from more than 3,000 to approximately 1,500, with a material reduction in forecast breaches. Progress was also reported against the Cardiology improvement programme, subject to continued oversight.

APPROVALS: decisions made by the Committee

ENDORSED the Winter Plan 2026/27 and associated Board Assurance Statement.

APPROVED Strategic Risks 1 and 5 for inclusion in the Board Assurance Framework, with a further review of Strategic Risk 5 in November.

ENDORSED the maternity and neonatal workforce plans on safety and quality grounds and their progression through the formal business-case and financial-governance process.

SUPPORTED publication of the Patient Experience Annual Report, subject to verification of factual updates.

AGREED monthly written assurance reporting on corridor care and flow throughout winter.

APPLAUDED recovery of neonatal training compliance; reductions in falls, pressure ulcers and maternity complaints; strong infection prevention benchmarking; improved sterile-services performance; paediatric MRI pathway innovation; and the emphasis on kind, compassionate and professional care reflected in patient feedback.

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	x
People, culture and leadership	x
Quality, safety and delivery	x
Digital first	x

Board assurance framework

BAF reference	Strategic Risk 1 - Quality; Strategic Risk 5 - Delivery. Mixed / limited assurance overall, with positive assurance in the areas identified above and continued oversight of material risks and recovery trajectories.

Risks discussed

Principal risks: urgent and emergency care and corridor care; delayed discharge and system flow; elective, diagnostic and cancer recovery; complaints capacity and timeliness; patient-safety learning and Duty of Candour; ophthalmology never events and glaucoma follow-up; deteriorating patients and sepsis; maternity and neonatal workforce and scanning capacity; infection prevention, water safety and estate constraints; regulatory compliance; Cardiology improvement; medicines management; patient experience and health inequalities.

Recommendations

TAKE ASSURANCE from the Committee’s work and conclusions; NOTE the material alerts and areas of limited assurance requiring sustained Executive and Board oversight; and NOTE the positive assurance and achievements highlighted in the report.

Thirlwall Inquiry

Board development session

October 2026

What the Inquiry examined

- Events at the Countess of Chester Hospital between 2015 and 2018
- The experiences of families
- The actions of clinicians, managers, executives and the Board
- How concerns were raised, understood and acted upon
- Whether governance, scrutiny and regulation protected babies

The Inquiry did not reconsider the criminal convictions or court evidence.

The central lessons

The neonatal unit is the case study. The failures were organisational.

Weak signals were not joined

Deaths, collapses, clinical concerns and other information were considered separately.

Safeguarding was misunderstood

Suspicion of deliberate harm should have triggered protective action.

Governance did not protect

Committees, reviews and external scrutiny did not produce timely action.

Speaking up met resistance

Clinical concerns became entangled with relationships and grievance processes.

Families were not kept informed

Parents were not told promptly about concerns and reviews.

Patient safety must come before certainty, reputation or organisational comfort.

The 17 recommendations

Grouped into five practical areas. The following slides set out all recommendations.

Protect and respond	Recommendations 4, 8, 9 and 10
Detect patterns earlier	Recommendations 6, 7, 11 and 12
Secure care environments	Recommendations 1 and 2
Strengthen accountability	Recommendations 13, 14 and 15
Make learning stick	Recommendations 3, 5, 16 and 17

Secure care environments

Recommendations 1 and 2

1 Cot-space cameras

All cots and incubators in neonatal units should have baby monitors with secure livestreaming so parents can observe their baby remotely. Funding should be centrally managed and ring-fenced. NHS England should publish an implementation roadmap by 31 March 2027.

2 Insulin controls

Use digital access controls to restrict insulin to authorised people and record access. All neonatal units must meet the Getting It Right First Time safe-insulin requirements by 31 March 2027. Until biometric access is in place, Trusts should install closed-circuit television focused on insulin storage, retaining recordings for at least 28 days. National laboratory guidance on insulin and C-peptide testing should be mandatory.

Protect and respond

Recommendations 4, 8, 9 and 10

4	**Safeguarding and contracts**	All Trusts must provide role-appropriate safeguarding training to all staff and Board members, including Non-Executive Directors. Training must cover concerns or suspicions that staff may have caused deliberate harm. By March 2027, employment, bank and agency contracts must require compliance with safeguarding guidance and the Suspicion of Deliberate Harm Protocol.
8	**Sudden unexpected death**	NHS England must immediately tell neonatal Trusts that the sudden unexpected death in infancy and childhood process applies to babies who die suddenly and unexpectedly without leaving hospital. Trusts must draw this to relevant staff and the Board within seven days. Revised national guidance is due by 31 March 2027.
9	**Suspicion of deliberate harm**	By 31 March 2027, NHS England must issue a one-page protocol and short guidance. Good-faith concerns must be acted on immediately; the responder's personal belief is irrelevant. Protecting patients, usually by moving or suspending the person while investigating, is a neutral act. Safeguarding processes must be followed and Trusts must embed the protocol.
10	**Independent expert panel**	The Department of Health and Social Care should seriously consider a multidisciplinary national panel able to conduct swift, independent technical investigations when concerns emerge about an individual and patient harm.

Detect patterns earlier

Recommendations 6, 7, 11 and 12

6 Board monitoring of deaths

By 31 March 2027, all hospital Trusts must have effective mechanisms for Board-level monitoring of all deaths of children and babies, and a clear, predetermined route to senior management for escalating concerning data trends or patterns.

7 National mortality reporting

Hospitals with a neonatal unit should name and train a lead reporter to enter data at least weekly and review real-time Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom information. Unless immediate action is required, the lead reporter should advise the Board at least every six months about alerts, investigations and action plans.

11 Medical examiners

By 31 March 2027, the National Medical Examiner should issue a one-page process for neonatal deaths. Medical examiners should ask directly about harm or safeguarding concerns, have access to neonatal expertise and record the details of clinicians who cared for the baby where concerns arise. The system should be reviewed in 2027.

12 Specialist pathology

The Department of Health and Social Care and NHS England must ensure that 37 doctors are in paediatric and perinatal pathology training posts by June 2033, with the incentive scheme funded until that level is reached.

Strengthen accountability

Recommendations 13, 14 and 15

13 Managers

The Department of Health and Social Care and NHS England must establish a barring system for all managers by September 2027, review it in 2030 and consider full statutory regulation by September 2032. Senior-manager moves must not conceal capability or misconduct concerns. Managers should have an individual duty of candour and an explicit patients-first standard.

14 Care Quality Commission

The Care Quality Commission should inspect hospital departments without notice, using at least two current practising specialists. Inspectors must establish what is happening in practice, test whether processes are effective and focus on whether patients are safe rather than whether a process exists.

15 Parliamentary scrutiny

The House of Commons Health and Social Care Committee should rigorously and consistently review the Care Quality Commission's performance, initially every year and later every three years or at another frequency determined by the Committee.

Make learning stick

Recommendations 3, 5, 16 and 17

3	**Bereavement care**	The National Bereavement Care Pathway for neonatal death should be implemented nationally and in every Trust by 31 August 2027.
5	**Joined-up digital systems**	By 31 March 2027, NHS England must provide a clear, timed route to harmonising NHS computer systems by December 2028, supported by a mandatory interoperability standard so neonatal data can be entered once, reviewed promptly and monitored continuously.
16	**National speaking-up oversight**	The functions of the National Guardian's Office should transfer to the Parliamentary and Health Service Ombudsman. The Ombudsman should be able to investigate inadequate handling of whistleblowing and help whistleblowers by referring concerns and overseeing the response.
17	**Implementation audit**	The National Audit Office should be given responsibility and funding to audit implementation of recommendations from statutory inquiries into NHS bodies, beginning by September 2027.

Who is responsible?

Some actions are local, some national, and some depend on both.

Provider Trusts

- Insulin access and interim closed-circuit television
- Bereavement pathway
- Safeguarding training and contracts
- Board oversight of child deaths
- Mortality reporting
- Sudden unexpected death and deliberate-harm arrangements

Shared responsibility

- Cot-camera roadmap and local Implementation
- Digital interoperability and local readiness
- Medical examiner guidance and local practice
- National manager framework and local checks

Mainly national

- Independent expert panel
- Pathology workforce
- Manager barring framework
- Care Quality Commission inspection model
- Speaking-up oversight
- National Audit Office implementation audit

National dependency is not a reason to wait where a local risk is already known.

Key dates

Now	Identify immediate safety gaps and confirm ownership
30 November 2026	Interim closed-circuit television for neonatal insulin storage
31 March 2027	Most immediate national and provider requirements, including mortality oversight, escalation and insulin controls
August to September 2027	Bereavement pathway, manager barring framework and National Audit Office audit function
December 2028 onwards	Digital interoperability by December 2028; pathology workforce milestone in June 2033

What the Board is explicitly required to do

- All Trusts must provide safeguarding training to Board members, including Non-Executive Directors. The training should include how to deal with concerns and suspicions about deliberate harm caused by staff.
- By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies.
- By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.
- Where data requires immediate action, a report should be made to the Medical Director and the Board immediately.
- Otherwise, the lead reporter should report to Trust Boards at least every six months and advise whether alerts or a need for investigation have arisen, and what investigation or action plan is in place.

Where the debate has focused

Cameras and monitoring

Questions about privacy, consent, information governance, cost and whether technology could substitute for leadership and culture.

Regulation of managers

Support for stronger accountability, alongside questions about due process, bureaucracy, recruitment and candour.

Learning and individual accountability

How to examine system factors without avoiding action where an individual's conduct, capability or candour may have contributed to harm.

Deliverability

Dependence on funding, digital infrastructure, specialist workforce and national guidance.

Support for staff who raise concerns

Whether staff can raise patient-safety concerns without fear of career detriment, and whether the proposed national oversight arrangements will provide effective help and follow-up.

Sustained implementation

Whether recommendations will lead to demonstrable, lasting change rather than short-term compliance.

What Lady Justice Thirlwall said about “no blame”

> ***“The move towards a ‘no blame’ culture in the NHS, starting in 2000, was a mistake.”***

Her explanation

- Focusing on system faults, while omitting individual responsibility or blame, meant difficult conversations about conduct were avoided.
- Lady Justice Thirlwall concluded that this undermined patient safety.
- Her stated starting point is patient safety, with behaviour and accountability addressed alongside learning from systems.

Board implication: a learning response should not prevent judgement or action where conduct, capability, candour or safeguarding duties are in question.

Our organisational approach

- One whole-Trust programme, not a Women and Children's response
- One consolidated gap analysis and action plan
- Executive sponsorship and a named operational lead for each action
- Local ownership through clinical divisions and corporate functions
- Executive oversight, Quality Delivery Group coordination, Quality and Performance Committee scrutiny and Board visibility
- Staff engagement, Freedom to Speak Up input and active testing of what is "true for us"
- Clear evidence of completion and, importantly, evidence of impact

Three questions for the Board

Questions for Board discussion

1. Could similar events happen here?

Where might the organisation remain vulnerable, despite the governance and controls currently in place?

2. What would convince us that our response to Thirlwall is making care safer?

What would patients, families and staff experience differently, and how would we test that beyond completed actions and reassuring reports?

3. Where is our culture helping or hindering?

Can colleagues challenge senior people safely, while the organisation holds learning, compassion and accountability together?

Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Date of Meeting	12th November 2026
Report title	Integrated Performance Report (IPR)
Sponsoring Director/Author	Chief Operating Officer (COO) Chief Medical Officer (CMO) Chief Nurse (CN) Chief People Officer (CPO) Director of Finance (DoF)

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

Executive Summary	
Previously considered by	- Trust Leadership Team (TLT) - Divisional Executive Reviews

Recommendations:

- To note the contents of the Integrated Performance Report (IPR)
- Assess improvements and deteriorations including assurance on actions to respond to performance changes.

Strategic Aims (tick as appropriate)	
Patient experience and voice	✓

People, culture and leadership	✓
Quality, safety and delivery	✓
Digital first	

Impact on any Strategic Risks?

Implications on:	
Equality, Diversity and Inclusion	Performance is monitored across protected characteristics and patient groups to identify and address unwarranted variation in access, experience and outcomes.
Health Inequalities	The report highlights variation in access, waiting times and outcomes; recovery actions should prioritise groups and communities experiencing the greatest disadvantage.
Finance and resource	Delivery of recovery plans requires careful management of workforce, capacity and productivity within the agreed financial envelope.
Regulation/Legal	Performance is monitored against relevant NHS constitutional standards, statutory duties and regulatory requirements, with exceptions escalated through established governance.
CQC-Key line of enquiry	Relevant to the CQC domains of Safe, Effective, Caring, Responsive and Well-led, particularly access, flow, quality, safety and leadership oversight.
Green Plan	Recovery actions should consider environmental impact, including travel, estates, procurement and efficient use of resources, in line with the Trust Green Plan.

Main Report
Performance September performance remained under pressure across urgent and emergency care, elective recovery, diagnostics and cancer. Although Referral to Treatment performance, diagnostic performance, histopathology turnaround and 62-day cancer performance improved, flow and discharge pressures increased, and several key standards remained off trajectory.

Urgent and Emergency Care
Type 1 four-hour performance deteriorated to 61.83% against the 78% standard, while 12-hour performance fell to 89%. Admitted performance reduced to 42% and non-admitted performance to 66%. Priorities remain admitted flow, time to clinician, workforce recruitment and ambulance handovers.

System Flow and Discharge
Emergency length of stay remained broadly stable but waits for a decision to admit rose again from the summer low. Simple discharges showed some recovery; however, total discharge-ready volumes, delays exceeding 21 days and length of stay after being discharge-ready increased, requiring continued Trust and system escalation.

Planned Care — Referral to Treatment
Referral to Treatment 18-week performance improved slightly to 70.86% in September from 70.02% in August. Total incomplete pathways stabilised at around 68,000, with the submitted position expected to be around 71%. The main pressures remain in Orthopaedics and Spinal Surgery, Gynaecology and gastrointestinal services.
The 45-week cohort increased to 965 and 52-week waits to 52. Orthopaedics and Spinal Surgery account for 33 of the 52-week breaches, with further pressure in Gynaecology. Recovery remains focused on independent-sector capacity, theatre utilisation and H2 productivity plans, with equity cohorts reviewed through weekly governance.

Diagnostics
Diagnostic performance improved by 1.97 percentage points in September, with 10 of 14 modalities reducing breaches. MRI, echocardiography, cystoscopy and urodynamics deteriorated during the month. MRI recovery is likely to extend beyond December because the fourth scanner at Cheltenham General Hospital remains unavailable.
Additional endoscopy and echocardiography capacity is supporting recovery. Histopathology 10-day turnaround improved to 56.2% from 53.8% in August, despite the highest monthly specimen volume to date. Recruitment delays, sickness absence and reduced dissection capacity remain key risks.

Cancer
The 62-day position improved to 65.8% in September from 61.6% in August, but remained below the 85% standard. Treatment capacity and diagnostic delays remain most significant in Urology, Gynaecology and Lower Gastrointestinal pathways, with continued deterioration in Gynaecology and Head and Neck.
Faster Diagnosis Standard performance reduced slightly to 74.0% from 74.2% in August and was 5.8 percentage points below plan. First outpatient appointment and histopathology constraints continue, with Gynaecology and Skin the main drivers of underperformance. Lower Gastrointestinal performance improved above plan to 82.4%.
The 62-day backlog reduced to 180 at 27 September, with emerging improvement in Lower Gastrointestinal, Skin, Head and Neck, and Gynaecology, but it is not yet on a sustainable recovery trajectory. Additional capacity, targeted diagnostic action and stronger specialty and tertiary-provider oversight remain in place. The September position remains subject to validation.

Quality and Safety

Quality performance was mixed during September. Overall falls remained at the improved rate of 4.7 per 1,000 bed-days, no Category 3 pressure ulcers were reported, mortality remained within expected limits and mixed-sex accommodation breaches reduced to 23. However, one

inpatient fall resulted in a fractured neck of femur, reinforcing the continued focus on preventing serious harm.

Patient experience remained variable. Friends and Family Test performance was 91.4%, with lower scores particularly evident in GRH Emergency Department and Maternity. PALS achieved a 78% five-day closure rate, although demand remains high, with access to appointments and communication continuing as key themes.

Patient safety learning-response timeliness remains an area of concern, with on-time completion of Patient Safety Incident Investigations reducing to 58%. Implementation of the Quality Governance Framework and strengthened leadership within the Patient Safety Team are intended to improve capacity, accountability and oversight.

Complaints recovery continues with weekly executive oversight. Timeliness improved to 38% but remains significantly below the 95% standard, with aged complaints presenting an ongoing quality, experience and reputational risk. Recovery remains focused on the oldest and highest-risk complaints, stronger divisional ownership and implementation of the New Complaints Framework

Finance
At month 6, the year-to-date position is a £6.3m deficit, which is £99k favourable to plan. The favourable position has been achieved through non-recurrent balance-sheet benefits that offset a shortfall in Financial Sustainability Programme delivery. The delivery risk is beginning to materialise, particularly in relation to recurrent savings.

Areas of focus for the forthcoming months include delivery of the recovery plan, monitoring monthly run rates and implementing actions to remain on track.

Workforce
The workforce section highlights continuing deterioration or sustained pressure across a small number of core people metrics that require close monitoring. In particular, the current reporting period focuses on appraisal compliance, sickness absence, use of temporary staffing (bank and agency), and job-planning compliance.

Although 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.

Enclosures

Integrated Performance Report (IPR)

I confirm that I have personally reviewed and approved the final version of this paper. I am satisfied that it is factually accurate, proportionate, clearly written, appropriately focused on the Board or Committee role, and explicit about the decision, assurance or discussion required.

Integrated Performance Report

September 2026

- Operational Performance
- Quality & Safety
- Use of Resources
- Workforce

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Statistical Process Control Chart Guidance



Where a metric shows improvement and enters special-cause variation, it will be moved to Watch Measures and removed from the main 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.

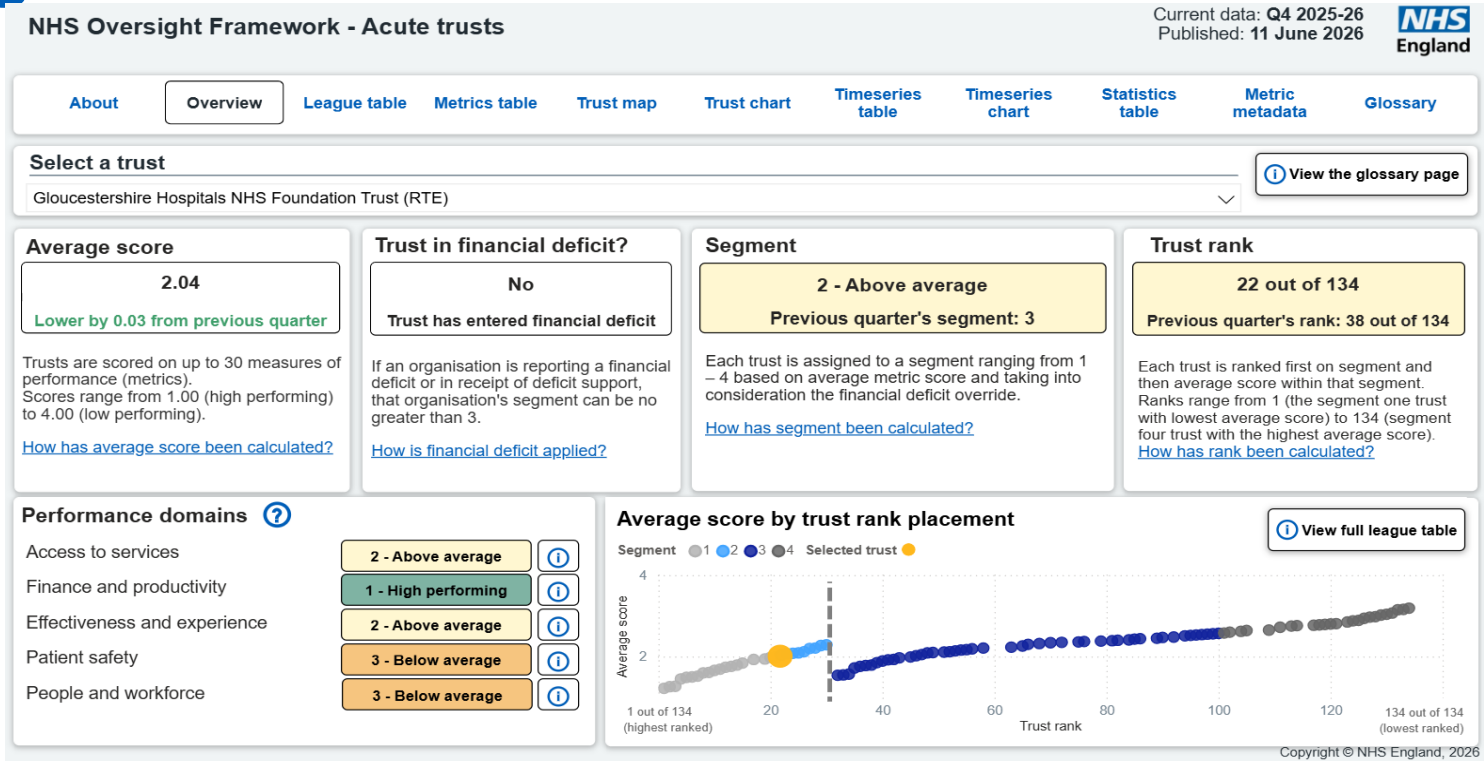
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Operational Performance Metrics

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National Oversight Framework Segment

This information is calculated nationally on a quarterly basis



National Oversight Framework Metrics

Segment Drivers

Domain	Description	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Access to services	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	>80%	76.5%	75.3%	70.2%	57.5%	68.4%	75.8%	74.0%	76.6%	75.2%	74.5%	74.1%	73.9%
	Percentage of patients treated for cancer within 62 days of referral	>75%	77.5%	76.1%	78.7%	84.0%	76.3%	74.0%	71.7%	75.1%	68.9%	69.4%	70.8%	66.6%
	Percentage of patients waiting over 52 weeks for elective treatment	0.00%	0.04%	0.05%	0.05%	0.03%	0.02%	0.01%	0.03%	0.02%	0.02%	0.03%	0.05%	0.08%
	Percentage of patients waiting over 52 weeks for community services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	>92%	69.38%	70.00%	69.27%	68.51%	71.74%	74.55%	73.99%	74.51%	73.56%	72.05%	72.00%	70.33%
	Difference between planned and actual 18 week performance								1.31%	1.29%	-0.27%	-2.40%	-4.89%	-5.20%
	Percentage of emergency department attendances admitted, transferred or discharged within four hours	>78%	62.93%	64.17%	64.13%	60.29%	62.73%	64.57%	64.93%	63.85%	62.32%	66.36%	64.82%	0.00%
	Percentage of emergency department attendances spending over 12 hours in the department	<2%	8.79%	10.06%	10.00%	12.19%	10.37%	9.38%	9.26%	10.35%	11.45%	6.49%	8.30%	10.94%
Effectiveness and experience	Average number of days from discharge ready date to actual discharge date (including zero days)		0.8	0.7	0.7	0.8	0.7	0.6	0.6	0.8	0.8	0.9	0.8	N/A
	Summary Hospital-level Mortality Indicator		1.0098	0.993	0.980	0.9568	0.944	0.927	0.911	0.901	0.902	0.903	0.909	0.908
	CQC inpatient survey satisfaction rate		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Analytical Highlights

The Trust has risen to Segment 2 under the National Health Service Oversight Framework, driven by sustained underperformance in Accident and Emergency access, elective backlog growth, and workforce gaps.

Referral to Treatment metrics for August onwards are taken from internal reporting while publication through national statistics is still in progress.

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Watch Measures

		Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Elective Care	Short notice (within 72h) cancellation rate – total	*<9%*	12.4%	↑ 11.0%	→ 11.0%	↑ 10.6%	↓ 11.4%	↑ 9.6%	↓ 10.7%	↑ 10.2%	↓ 12.4%	↓ 14.0%	↑ 11.8%	↑ 11.6%
	Same Day Non-Clinical Cancellations		74	↑ 68	↑ 38	↓ 53	↑ 50	↓ 56	↓ 59	↓ 63	↓ 89	↓ 117	↑ 73	↓ 80
	Cancellations not rebooked within 28 days	*0*	28	↑ 16	↑ 14	↑ 9	↓ 13	↑ 5	↓ 12	↑ 9	↓ 10	↓ 40	↑ 10	↓ 24
	Angiogram Waiting List Position		220	↑ 216	↓ 232	↓ 250	↓ 255	↑ 237	↓ 263	↑ 254	↑ 245	↑ 227	↓ 235	↑ 203
Flow	G&A Occupancy - CGH	*92%*	87%	↓ 86%	↑ 89%	↑ 91%	↓ 90%	↑ 92%	→ 92%	↓ 91%	↓ 90%	→ 90%	↑ 91%	↑ 92%
	G&A Occupancy - GRH	*92%*	95%	→ 95%	↓ 94%	↑ 97%	→ 97%	↓ 96%	↑ 97%	→ 97%	↓ 96%	↓ 95%	↑ 96%	→ 96%
Safe Care	VTE assessment completed - excluding short stay (%)	*95%*	92.9%	↑ 93.9%	↓ 93.4%	↓ 92.7%	↓ 92.0%	↑ 92.9%	↓ 91.9%	↑ 92.2%	↑ 93.6%	↓ 91.1%	↑ 92.7%	↑ 93.2%
	Number of Category 2 pressure ulcers acquired as inpatient		24	↑ 11	↓ 15	→ 15	↑ 6	↓ 12	↑ 9	↓ 14	↑ 12	↑ 6	↓ 7	↓ 14
	Smoking Status Compliance (%)	*95%*	98.56%	↓98.16%	↓98.04%	↓97.96%	↓97.56%	↑98.45%	↓98.28%	↓97.83%	↓97.81%	↓97.74%	↑97.80%	↓96.74%
	Severe Harm from Patient Medication Errors	*0*	0	→ 0	→ 0	↓ 1	↑ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0

GRH: Gloucestershire Royal Hospital. CGH: Cheltenham General Hospital. VTE: venous thromboembolism. h: hours.

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Urgent and Emergency Care: Performance

(Standard: a minimum of 78% of patients seen within 4 hours by March 2026)

Analytical Highlights:

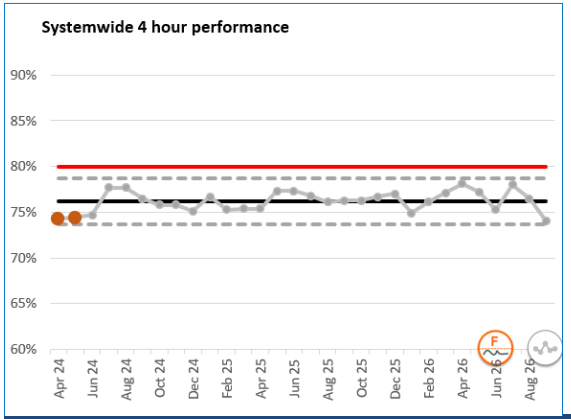
Type 1 4-hour performance deteriorated in September to 61.83%, primarily driven by the impact of a challenging August bank holiday on flow.
12-hour performance likewise fell, from 92.42% in August to 89% in September – just below the average of 89.5%.

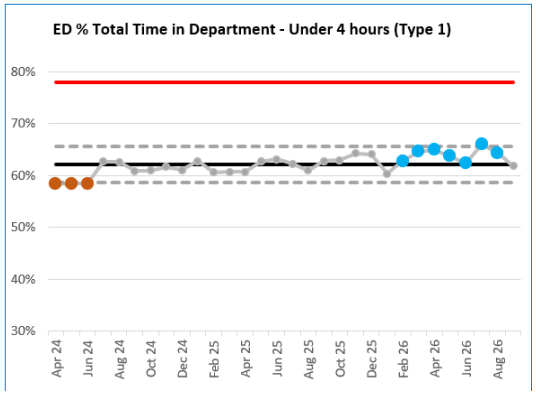
Areas for Concern:

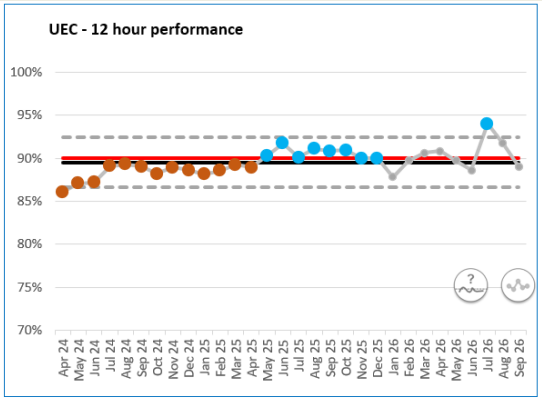
Performance remains below the required operational standard across the key 4-hour measures.
Time to clinician continues to require targeted focus as part of the wider improvement programme.

Learning & Improvement:

Recruitment remains a key improvement lever, including nursing and medical roles. A focused action plan is in place to support improvements across Cheltenham General Hospital Emergency Department, Paediatrics and Minors, including sub-specialist appointments and increased operational presence at Cheltenham General Hospital.







Actions

Continue delivery of the Cheltenham General Hospital Emergency Department, Paediatrics and Minors action plan, with emphasis on operational grip, workforce recruitment and reduction in time to clinician.

4-hour performance taken from the Urgent and Emergency Care MSitAE submission, 05/10/2026.

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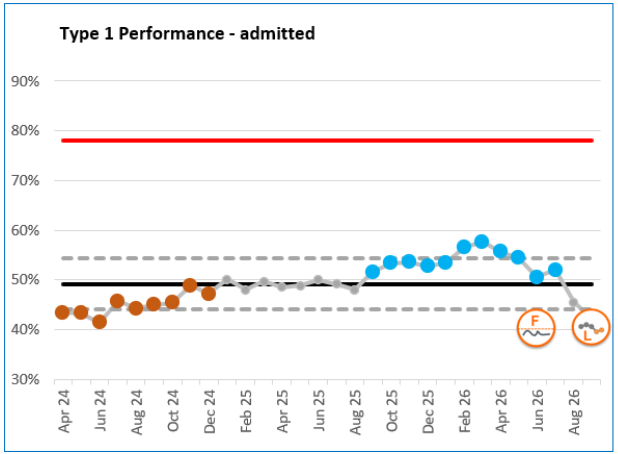
Urgent and Emergency Care: Performance

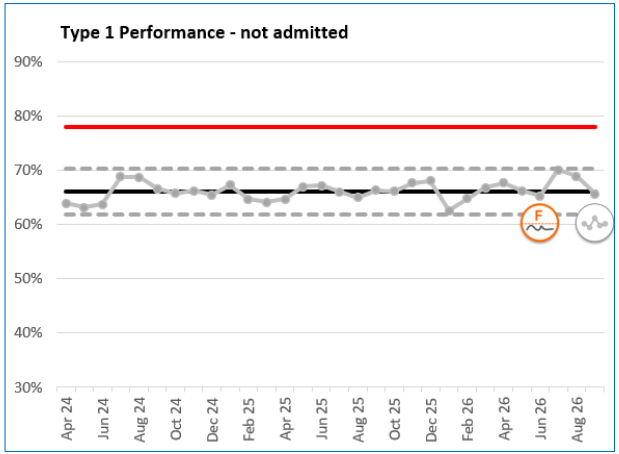
(Standard: a minimum of 78% of patients seen within 4 hours by March 2026)

Analytical Highlights:
Non-admitted performance demonstrated a small deterioration, from 69% to 66%.
Admitted performance fell from 46% in August to 42% in September.

Areas for Concern:
Both admitted and non-admitted pathways remain below the operational standard. The admitted pathway remains the greater area of concern, following a significant deterioration in August's position.

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

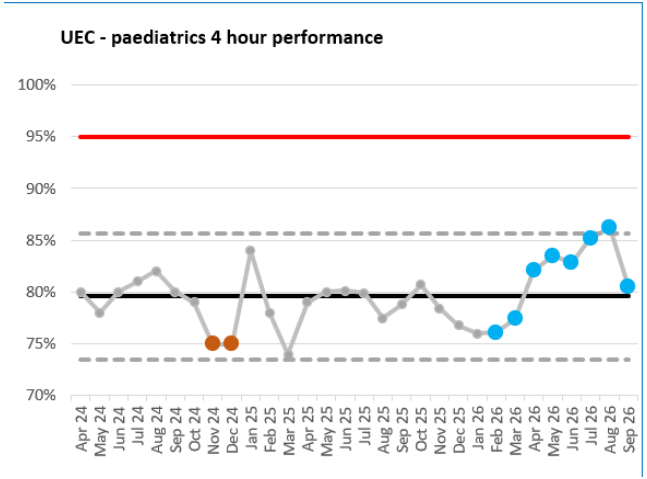
Maintain delivery of the Cheltenham General Hospital Emergency Department, Paediatrics and Minors action plan, with particular focus on admitted pathway flow, time to clinician and operational presence at Cheltenham General Hospital.

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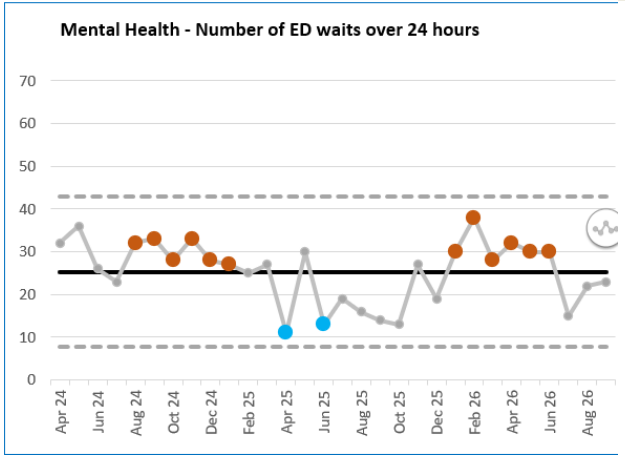
Urgent and Emergency Care: Performance (Standard: a minimum of 78% of patients seen within 4 hours by March 2026)

Analytical Highlights:
Paediatric 4-hour performance fell significantly, from 86.2% in August to 80.5% in September.
The number of mental health patients waiting more than 24 hours in the department rose from 22 to 23. However, when adjusted for the number of attendances, this is a relative increase of only 0.4% (1.56 breaches per 1,000 attendances versus 1.55).

Areas for Concern:
Paediatric performance remains below the 95% standard set out in the MTP framework, with the improvements demonstrated over the previous six months now reversed.



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.

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Average Handover Time — 65% of offloads to be completed within 15 minutes of arrival

Analytical Highlights:

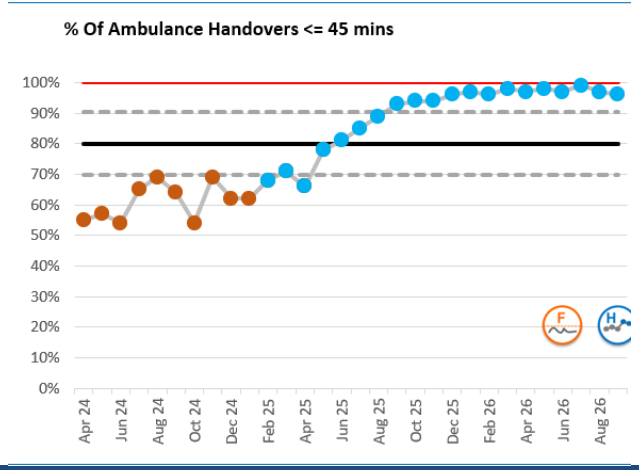
Despite challenging conditions, ambulance handovers remained broadly consistent, rising from an average of 20 minutes to 22 minutes—7 minutes above the 15-minute standard.

The proportion of handovers completed within 15 minutes fell to 38%, falling from a peak of 50% in July.

In September, 4% of handovers exceeded 45 minutes.

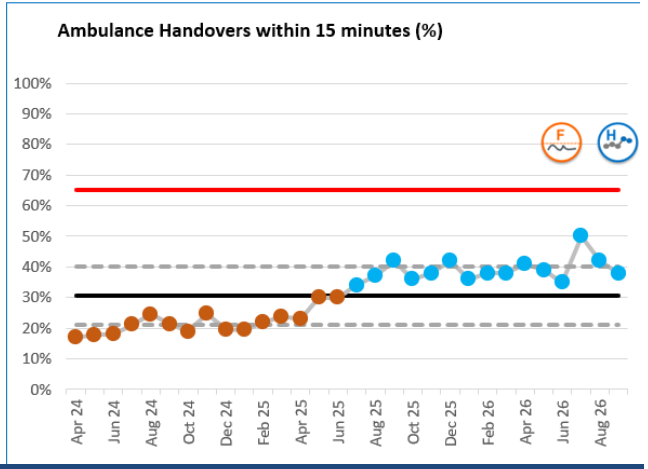
Areas for Concern:

Following pressure caused by the August bank holiday weekend, performance has slipped against standard and remains below the 15-minute standard.



Learning & Improvement:

Further assurance is required that patients are being offloaded promptly into appropriate non-Emergency Department 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.

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Referral to Treatment Performance and First outpatient

Patients treated and outpatient waiters with a first appointment within 18 weeks.

Analytical Highlights:

Referral to Treatment 18-week performance for September was 70.86%, showing a small increase from August (70.02%).

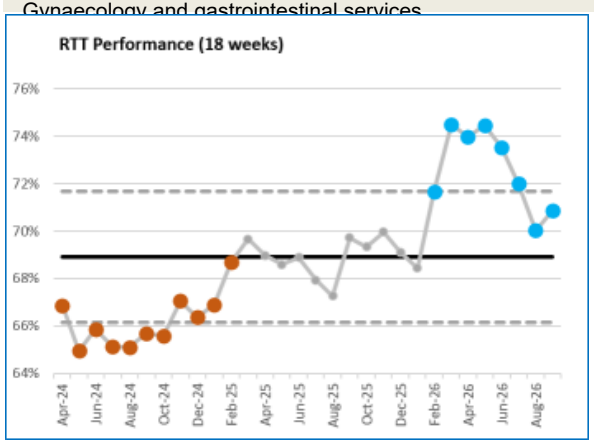
First outpatient appointment performance within 18 weeks has shown a 0.19 percentage-point increase from August, with 16.26% having a first appointment within 18 weeks.

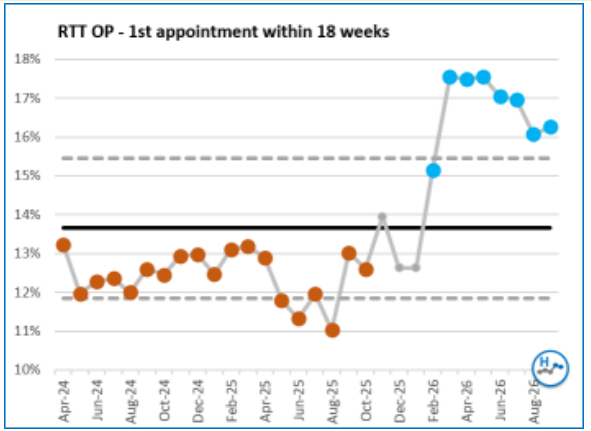
Areas for Concern:

Referral to Treatment performance has improved slightly, with a submitted position of around 71% expected. The total incomplete pathway count has stabilised at around 68,000. The number waiting over 18 weeks is expected to be similar to August. Key challenges remain in Orthopaedics/Spines, Gynaecology and gastrointestinal services.

Learning & Improvement:

Further focus is needed on waits for first appointments and on median waiting times. Services are reviewing opportunities to convert follow-ups to new appointments, overbook in line with did not attend rates and improve utilisation.





Actions

- Focus continues on the most challenged services of Orthopaedics/Spines.
- Neurology will continue to use Cotswold Neurology—around 300 patients are to be IPT'd.
- Data quality action plan paused given some stability secured with Total Incompletes around 68,000.
- Second half of the financial year planning is under way, with an ambition to increase Referral to Treatment performance to 75% by the end of December, focusing on productivity opportunities.
- Focus on first outpatient appointment bookings during October and November.

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Referral to Treatment Equality, Diversity and Inclusion Groups:

Referral to Treatment waiters with learning disabilities and Armed Forces Clinical Commissioning Group (13Q)

Analytical Highlights:

The British Armed Forces cohort (13Q) has shown a slight increase in the number waiting 18+ weeks for treatment to 17 pathways, up from 15 in August.
Of those waiting 18+ weeks for treatment, the average wait is 30 weeks. The longest wait is 51 weeks.

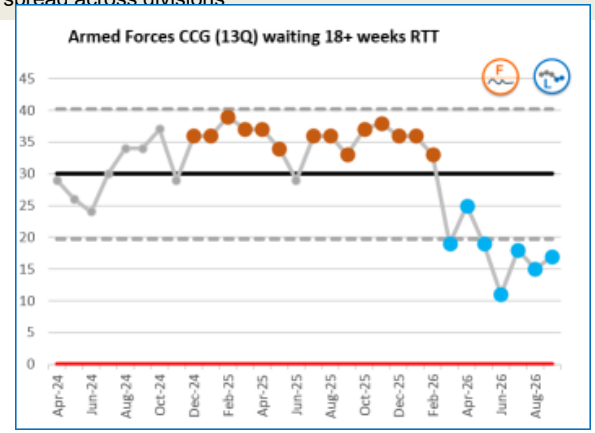
The number awaiting treatment with learning disabilities has increased for the third consecutive month, to 64. Of those waiting 18+ weeks, the average wait is 28 weeks. The longest wait is 50 weeks.

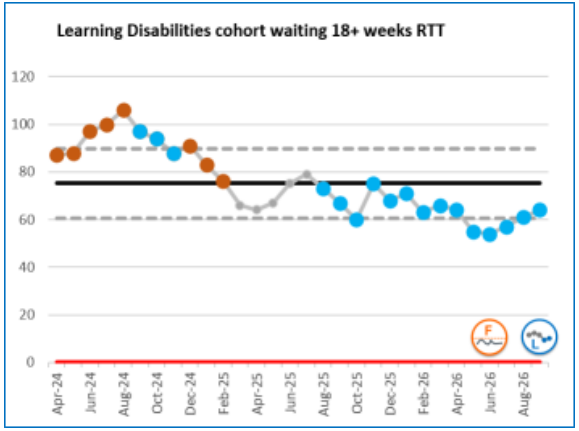
Areas for Concern:

None. Ear, Nose and Throat and Orthopaedics have zero patients waiting over 18 weeks. The national requirement is currently being met. Other specialties with waits over 18 weeks are static, with 60% of patients dated for October or November. No individual specialty is a particular concern, with patients spread across divisions.

Learning & Improvement:

Increased visibility for learning disabilities Referral to Treatment reporting for specialties and integration into weekly Referral to Treatment governance.





Actions

1) Services continue to be advised of requirements to achieve zero 18-week breaches.
2) Focus will remain on serving British Armed Forces personnel.
3) Further promote the timely treatment of patients with learning disabilities and review progress through meetings such as Check and Challenge and Long Waiters.

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Elective: Referral to Treatment 45- and 52-Week Waits

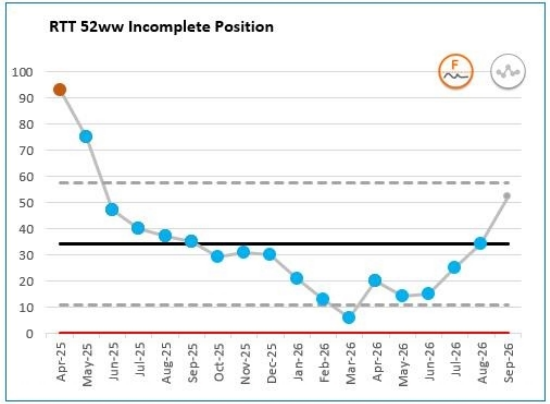
Analytical Highlights:

The 45-week waiting cohort increased again during September, reaching 953 pathways. Although this cohort has shown consecutive growth, the rate is slowing down. The largest cohort is Trauma and Orthopaedics, with 266 pathways, and a further 162 in spinal surgery.

Similarly, the 52-week cohort remains above the target of 0 and has grown since August. Of the 52 patients waiting, 12 have activity booked in October.

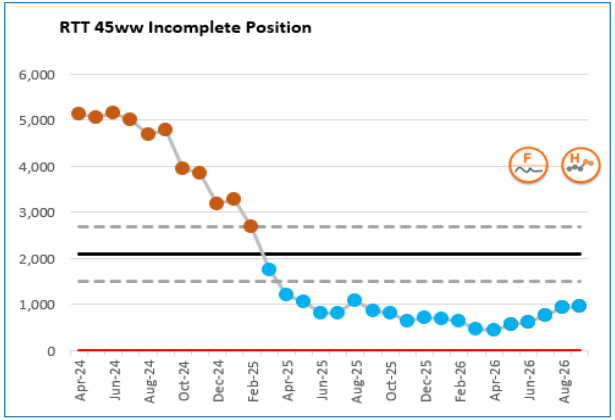
Areas for Concern:

There were 52 confirmed 52-week breaches. Surgery had 34: 33 in Orthopaedics/Spines and one in Ear, Nose and Throat. Women's and Children's had 14: 13 in Gynaecology and one in Gynae-Oncology. Medicine had four breaches: two in Dermatology and two in Rheumatology. The 45-week cohort also increased from 934 in August to 953 in September.



Learning & Improvement:

Learning will be identified through RCAs, pathway reviews and demand-and-capacity analysis.



Actions

Continue using ISPs where appropriate, particularly for Orthopaedics and Neurology.
Refocus on maximising theatre utilisation.
Second half of the financial year planning focusing on productivity gains.

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Cancer: Percentage of Patients Seen within 62 Days (Standard: 85%)

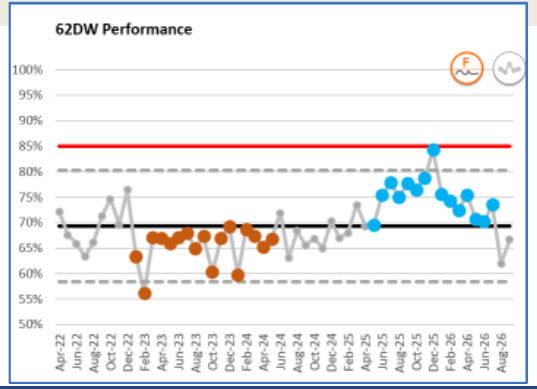
Analytical Highlights:

62-day performance improved in September to 65.8% compared to 61.6% in August.

Recovery plans appear to be having an impact but remain constrained by diagnostic delays and treatment capacity pressures across key tumour sites.

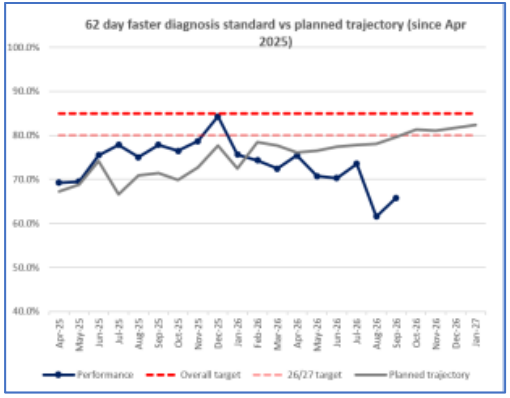
Areas for Concern:

The principal risks remain treatment capacity in Urology, Gynaecology and Lower gastrointestinal, alongside delays in diagnostic reporting, pathway progression and clinical decision-making.
Urology remains unstable, while Gynaecology and Head & Neck continue to deteriorate. Patients are still being booked beyond their 62-day breach dates in some pathways, demonstrating that agreed recovery processes are not yet providing assurance on redressing issues.



Learning & Improvement:

Additional capacity alone will not deliver recovery unless it is translated quickly into booked activity and reduced patient waiting times.
Recovery actions require regular updates and oversight.



Actions

1. Additional diagnostic and treatment capacity deployed in priority tumour sites (Dermatology, Gynae-Oncology, fine-needle aspiration).
2. Directors of Operations present specialty recovery plans through strengthened weekly cancer governance and DOps reporting.
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. A 'Fresh Eyes' review across divisions has been instigated.

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Cancer: Faster Diagnosis Standard (28-day): performance against trajectory

Standard (80%): Improve performance against the 28-day Faster Diagnosis Standard to the 80% ambition by March 2026

Analytical Highlights:

Faster Diagnosis Standard performance fell slightly to 74.0% in September compared to 74.2% in August.

Performance is 5.8% below planned position in September.

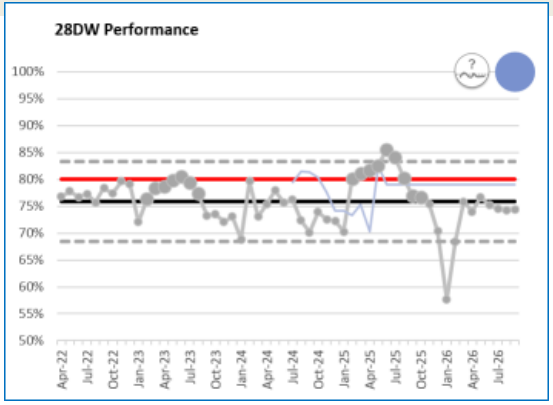
Gynae and Skin specialties appear to be significant drivers of the below planned position. This could be due to active backlog clearance as backlog is falling for both specialties.

Lower gastrointestinal is above plan for the first time in 6 months at 82.4%.

Areas for Concern:

First outpatient capacity remains constrained across Head & Neck, Dermatology, Urology, Colorectal, Gynaecology and Oncology pathways.

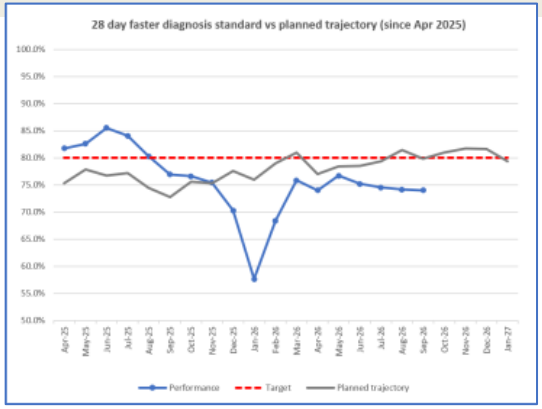
Histopathology turnaround times continue to impact timely diagnosis, particularly within Gynaecology, Breast, Head & Neck and Colorectal services.



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 the lowest confidence in delivery and has a significant impact on the aggregate Trust-wide position. Organisational focus is therefore on supporting an accelerated improvement plan.

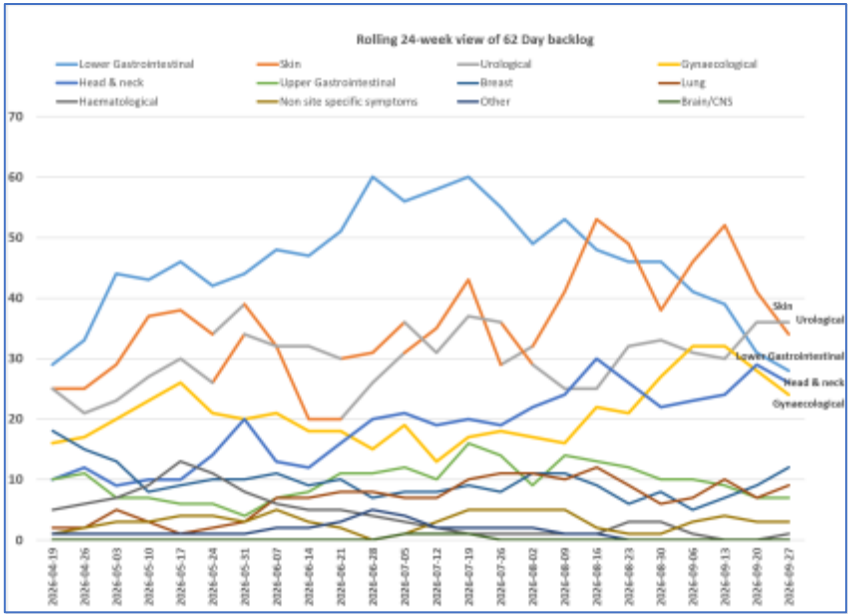


Actions

1. Increase first outpatient capacity in priority tumour sites.
2. Review the baseline against BPTP implementation by tumour site to target delivery support.
3. Continue weekly oversight of the skin pathway.
4. Reduce histopathology turnaround times in priority pathways.
5. Escalate diagnostic bottlenecks through cancer recovery governance.

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Cancer 62-Day Backlog Position



Analytical Highlights:

Backlog data show the position at the end of the week (for the past 24 weeks) for two-week wait referrals that have waited over 62 days. The position as of 27/09 was 180.
Lower gastrointestinal, Skin, Head & Neck and Gynae show a steady reduction in the past 3-4 weeks.

Areas for Concern:

- The backlog is not yet on a sustainable recovery trajectory, although signs of a downward trend are emerging in Lower gastrointestinal and Gynaecology.
- Persistent constraints include theatre and outpatient capacity, incomplete pathway actions, delayed clinical decisions and dependencies on tertiary providers.
- Histopathology remains inconsistent because of embedded issues.

Learning & Improvement:

Targeted recovery actions in Lower gastrointestinal have demonstrated improvement; however, Skin, Head & Neck, Gynaecology and Colorectal continue to be constrained by capacity and diagnostic delays, with Urology deteriorating again. 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 gastrointestinal, whilst weekly specialty red, amber and green 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.
3. Continue outsourcing and insourcing in Skin, Endoscopy and Histopathology, and explore artificial intelligence options across pathways.

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Cancer Waiting Times Performance: Last 3 Months

Please note: the September position is awaiting validation.

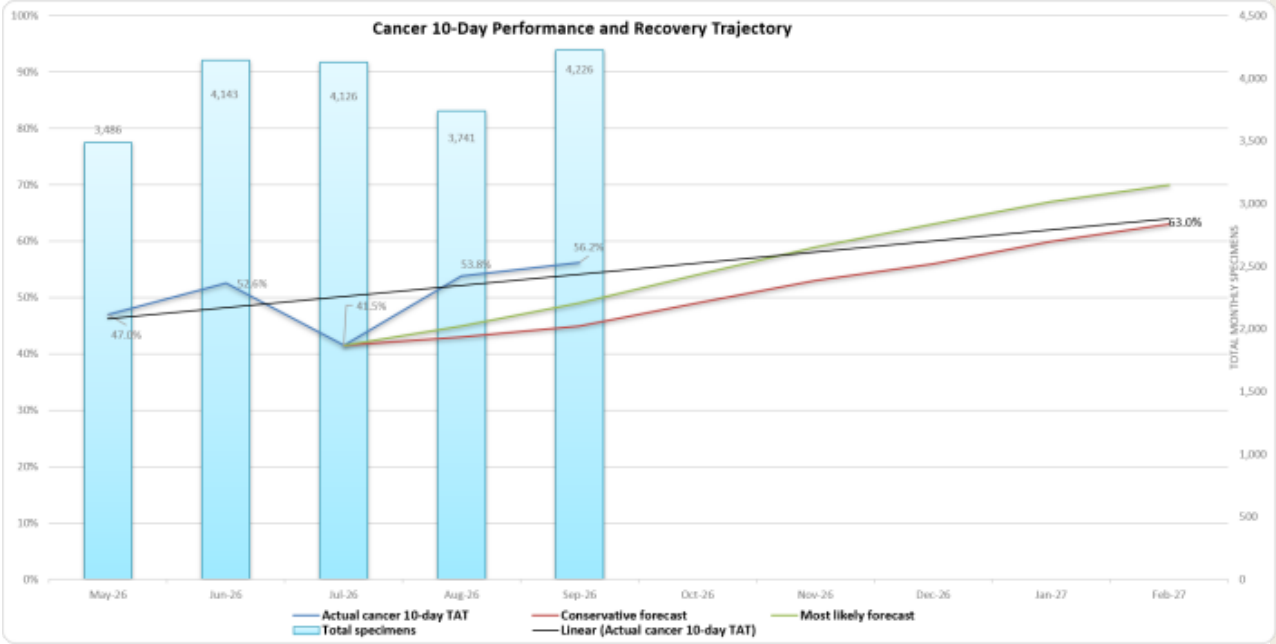
CWT Metrics – 3 prev. months position (excluding Breast. Symptomatic referrals)

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26	Jul-26	Aug-26	Sep-26
Acute leukaemia										100.0%	100.0%	
Brain/CNS	100.0%	90.0%	100.0%	62.5%	100.0%	75.0%	100.0%	100.0%	100.0%		50.0%	100.0%
Breast	47.5%	88.0%	12.2%	85.0%	92.2%	89.8%	94.4%	91.6%	86.8%	72.8%	64.1%	81.4%
Gynaecological	61.7%	59.6%	61.9%	49.7%	41.9%	41.2%	93.1%	89.7%	83.3%	76.7%	55.0%	52.6%
Haematological	100.0%	92.3%	60.0%	36.4%	37.5%	80.0%	100.0%	98.2%	96.2%	78.9%	68.8%	52.9%
Head & neck	71.4%	88.2%	78.8%	74.6%	70.7%	81.3%	100.0%	94.3%	81.5%	39.1%	51.3%	45.5%
Lower GI	77.2%	88.5%	90.8%	69.7%	75.5%	82.4%	92.7%	96.2%	79.1%	63.9%	41.5%	31.8%
Lung	89.5%	100.0%	95.0%	96.0%	100.0%	84.0%	89.4%	84.4%	85.4%	55.0%	37.5%	55.0%
Other		100.0%		0.0%	100.0%		87.5%	100.0%	100.0%	75.0%	66.7%	50.0%
Sarcomas							100.0%			100.0%		
Skin	61.3%	54.6%	57.5%	72.0%	64.6%	57.3%	87.9%	75.3%	76.9%	86.1%	78.3%	64.7%
Non site specific symp	87.9%	43.5%	29.8%	41.9%	55.2%	27.3%						
Testicular	100.0%	84.6%	100.0%	77.8%	69.2%	90.9%					100.0%	
Upper GI	89.5%	96.8%	97.9%	91.3%	90.4%	95.0%	98.3%	98.5%	97.1%	86.4%	71.7%	75.0%
Urological	90.8%	91.8%	91.4%	57.1%	60.0%	56.7%	94.1%	95.7%	88.5%	64.2%	56.0%	70.6%
Trust Total	69.4%	79.2%	65.5%	73.6%	73.6%	73.3%	93.8%	91.8%	86.9%	73.6%	62.0%	66.6%

2WW: two-week wait. FDS: Faster Diagnosis Standard.

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Histopathology 10-Day Reporting



Analytical Highlights:

There was another month of incremental improvement. The 10-day turnaround time for cancer specimens rose to 56.2%, from 53.8% in August and a July low of 41%. September recorded the highest monthly specimen volume to date. Actual performance is following the recovery trajectory agreed in CDG and remains on track for the conservative forecast by February 2027. Staffing resilience improved slightly in September across the laboratory, administrative hub and consultant workforce.

IBEX (artificial intelligence reporting) is live for prostate biopsies; benefits data are being monitored through the working group.

The block backlog remains manageable; however, a challenge is emerging in dissection (the front end of the pathway) because of sickness and reduced staffing.

Areas for Concern:

Acute sickness: locum biomedical scientist, weekend medical laboratory assistant and laboratory GM.

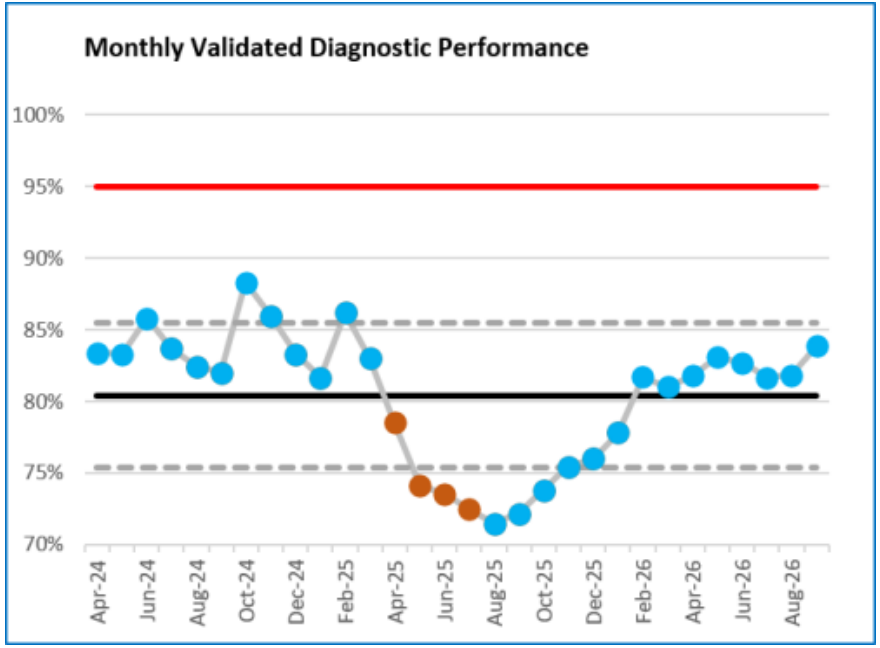
Long-term sickness: dissection lead and two administrative staff.

Recruitment slippage: three Band 3 staff start in November, a one-month delay. The Band 5 biomedical scientist post has been readvertised, with a two-month delay following a visa issue.

Executive VCP approval for locum biomedical scientist and maternity-leave consultant cover is scheduled for the executive panel on 16/10.

Additional dissection space remains out of action; remedial work is in progress.

Diagnostics: Performance Trend



Analytical Highlights:

Performance increased by 1.97% from August. This is mainly due to growth in the waiting list, with most additional pathways waiting less than 6 weeks. Of the 14 modalities, 10 have reported a reduction in breaches from August.

Areas for Concern:

Four modalities have deteriorated in-month (magnetic resonance imaging, Echo, Cystoscopy, Urodynamics).

Magnetic resonance imaging position has deteriorated as the continued impact of the heatwave and humidity is felt. The recovery trajectory is likely to extend beyond December because the fourth magnetic resonance imaging scanner remains unavailable at Cheltenham General Hospital.

Learning & Improvement:

Endoscopy modalities continue to improve due to insourcing activity, totalling a breach reduction of 263. In September, most modalities improved performance compared with August.

Cystoscopy recovery must accelerate to reduce the breach position.

Actions

- Magnetic resonance imaging—complete the paper proposing a mobile imaging unit to compensate for the long-term air handling unit issue affecting the Siemens magnetic resonance imaging scanner at Cheltenham General Hospital.
- Flexible cystoscopy—focused recovery planning is required to address long-standing non-compliance.

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Diagnostics: Performance Trend

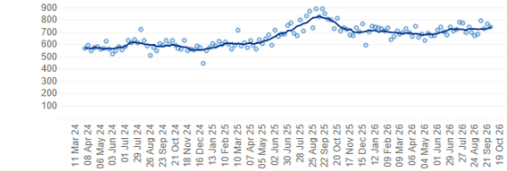
Modality	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Audiology - Audiology Assessments	99.66%	99.65%	99.88%	100.00%	99.80%	99.60%	99.07%	99.09%	97.87%	98.50%	97.76%	98.99%
Barium Enema	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.73%	72.97%	82.73%	100.00%
Cardiology - echocardiography	23.41%	26.52%	30.78%	28.52%	41.82%	28.15%	34.36%	54.65%	44.77%	43.80%	44.69%	45.77%
Colonoscopy	51.27%	50.60%	48.91%	50.00%	53.16%	53.35%	49.91%	49.18%	51.43%	59.93%	62.36%	75.98%
Computed Tomography	89.11%	87.28%	87.07%	88.64%	92.64%	93.44%	94.60%	95.34%	92.83%	92.61%	94.63%	96.95%
Cystoscopy	32.75%	36.93%	39.83%	41.96%	46.20%	58.65%	73.46%	63.38%	66.52%	65.56%	73.89%	71.30%
DEXA Scan	100.00%	99.82%	100.00%	100.00%	100.00%	99.18%	100.00%	100.00%	99.45%	99.82%	99.45%	100.00%
Flexi sigmoidoscopy	41.69%	38.54%	37.40%	47.55%	52.76%	52.18%	51.06%	55.69%	59.10%	68.16%	58.97%	78.17%
Gastroscopy	71.75%	73.81%	73.77%	82.48%	82.23%	84.31%	80.09%	70.10%	71.56%	68.58%	76.48%	83.84%
Magnetic Resonance Imaging	99.10%	97.84%	99.11%	99.02%	99.45%	99.03%	99.38%	99.03%	90.58%	84.09%	80.85%	75.38%
Neurophysiology - peripheral neurophysiology	62.28%	75.14%	59.76%	69.67%	75.80%	75.16%	79.84%	78.48%	68.94%	76.42%	77.17%	76.74%
Non-obstetric ultrasound	99.64%	99.91%	99.63%	99.36%	98.21%	96.67%	94.36%	95.41%	96.34%	94.27%	92.04%	92.28%
Respiratory physiology - sleep studies	96.27%	99.22%	91.69%	82.23%	96.30%	93.01%	95.49%	93.71%	82.44%	87.88%	71.18%	94.49%
Urodynamics - pressures & flows	100.00%	100.00%	91.67%	100.00%	100.00%	100.00%	87.50%	92.59%	92.31%	100.00%	95.38%	90.99%

MRI: magnetic resonance imaging. CT: computed tomography. ECG: electrocardiography. Echo: echocardiography.

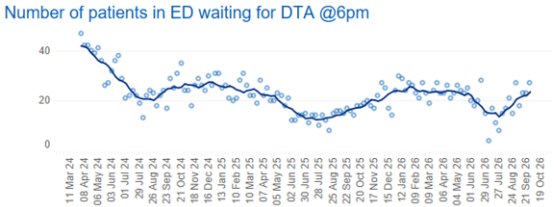
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Flow Summary

Simple discharges (Non OCT) (incld moves to discharge lounge)

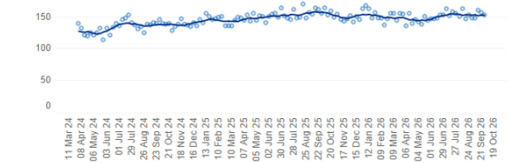


Number of patients in ED waiting for DTA @6pm

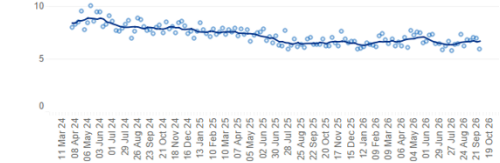


OCT: Onward Care Team. ED: Emergency Department. DTA: decision to admit. LOS: length of stay.

Emergency Admissions



Average LOS for Emergency (excld maternity)



Analytical Highlights:

- Emergency length of stay remains below early-2024 levels and broadly stable in the latest period.
- Emergency Department patients waiting for decision to admit at 6 pm have risen again from the summer low, reversing the recent improvement.
- Simple discharges show a recent recovery, remaining above 2024 levels but below the 2025 peak.
- Emergency admissions remain around the upper part of the historic range, with sustained demand.

Areas for Concern:

- The rebound in decision to admit waits shows renewed pressure at the front door despite broadly stable emergency length of stay.
- The recent rise in simple discharges has not yet restored the strongest 2025 levels.
- Weekly variation remains substantial, so recent discharge gains need to persist.
- Sustained admissions leave limited scope for weaker discharge performance.

Learning & Improvement:

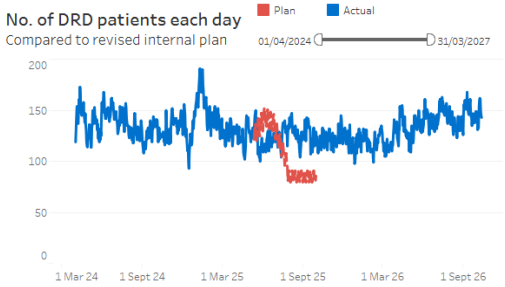
- Review the decision to admit rebound alongside discharge timing and admissions to identify the causes.
- Support the recent discharge recovery through early identification, criteria-led discharge and discharge lounge use.
- Track decision to admit and emergency length of stay together, as their latest trends differ.
- Use Same Day Emergency Care and admission-avoidance pathways on high-demand days, reviewing their impact on flow.

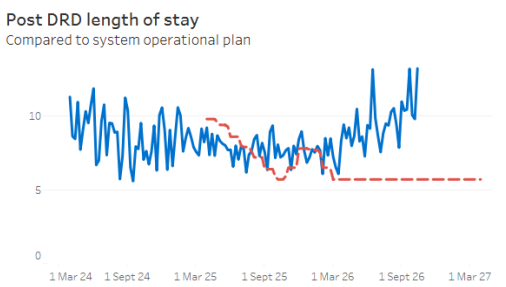
Actions

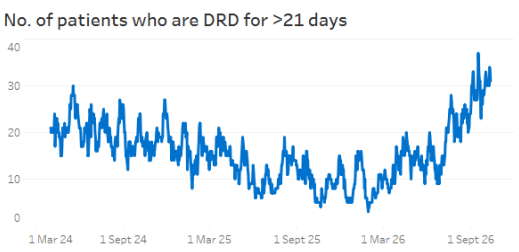
- Investigate the renewed rise in 6 pm decision to admit waits through daily review of admissions, bed availability and discharge timing.
- Sustain the recovery in simple discharges through criteria-led discharge, discharge lounge use and ward-level expected-discharge reviews.
- Track decision to admit and emergency length of stay weekly, using Clinical Vision of Flow workstreams to coordinate front-door and discharge actions.

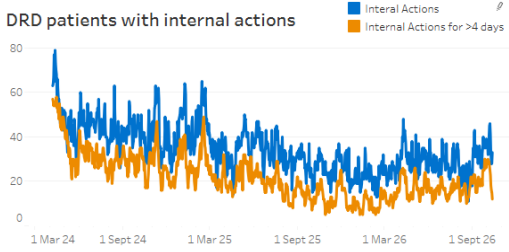
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Discharge-Ready Summary









Analytical Highlights:

- Total DRD patients have risen from the lower levels seen in late 2025 and early 2026.
- The over-21-day cohort has risen sharply and now sits at the highest end of the series.
- Post-DRD length of stay has increased markedly, with recent peaks well above the operational plan.
- Internal-action cases remain below early-2024 levels but have increased from their recent lows.

Areas for Concern:

- Rising DRD numbers and longer delays point to worsening discharge performance across several measures.
- The growth in patients delayed over 21 days requires urgent review of unresolved barriers.
- The recent rise in internal-action cases means the response must address hospital processes as well as external capacity.

Learning & Improvement:

- Clear the longest delays while preventing newly discharge-ready patients from joining that cohort.
- Review internal and external barriers together, with a named owner for each unresolved action.
- Use case-level evidence to identify which pathways drive the rise in post-DRD length of stay.

Actions

- Review total DRD and post-DRD length of stay weekly, quantifying changes and the gap to the applicable plans.
- Prioritise over-21-day cases and the longest post-DRD stays through daily system escalation.
- Review rising internal-action cases alongside pathway 1 starts and pathway 2 capacity, assigning owners to barriers.
- Escalate unresolved hospital and system constraints, tracking whether actions reduce delay.

Delay-Related Harm Summary

Analytical Highlights:

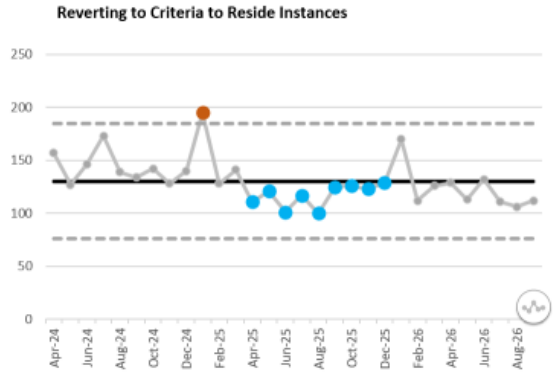
- Latest deaths with a discharge-ready period are above the centre line but below the upper control limit.
- Recent death counts remain within the displayed control limits, without a clear sustained rise.
- Reversions to criteria to reside remain below the centre line after the January 2026 peak, with a small latest increase.

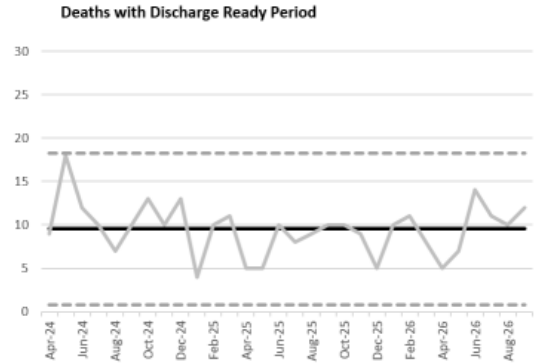
Areas for Concern:

- Recent death counts sit above the centre line and need review.
- Counts alone cannot establish whether delay caused harm.
- Lower reversion counts do not rule out harm in individual cases.

Learning & Improvement:

- Combine Statistical Process Control monitoring with review of delayed patients.
- Test whether delay contributed to each death or reversion.
- Link case-review findings to specific discharge actions.





Actions

- Review recent deaths with a discharge-ready period and reversions, including the latest increases.
- Compare case findings with DRD volume and post-DRD length of stay to identify patients at risk.
- Prioritise review of the longest delays and escalate unresolved care or discharge barriers.
- Use case-review learning to direct pathway actions, then monitor counts and outcomes over time.

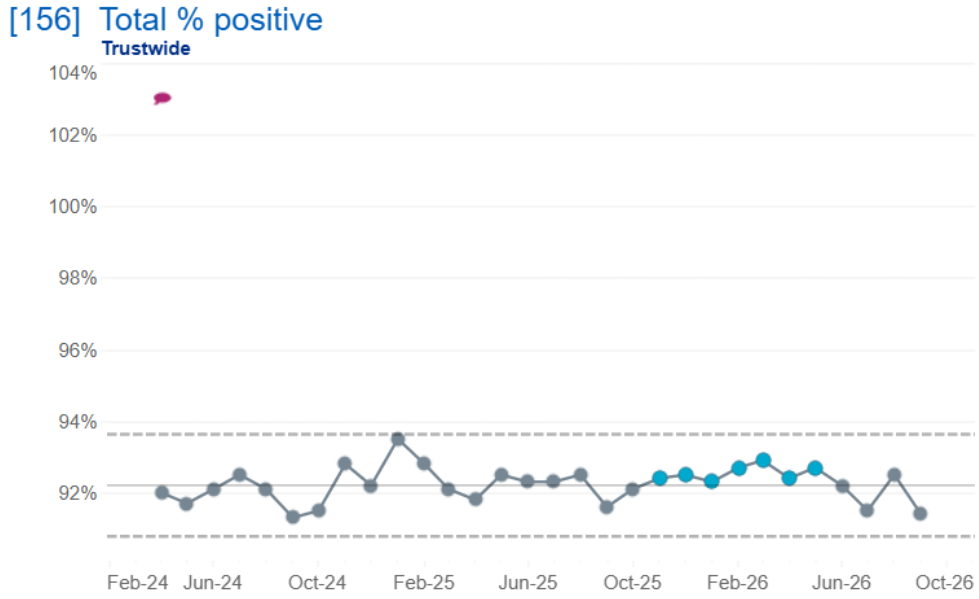
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Quality Metrics

(Safety, experience and effectiveness)

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Quality of Care: Friends and Family Test Positive Response



Quality Highlights:

- Friends and Family Test positive score has decreased to a below-average position.
- A decrease across three care types has driven this.
- Gloucestershire Royal Hospital Emergency Department has seen a significant decrease in score to only 63% positive.

Areas for Concern:

- Gloucestershire Royal Hospital Emergency Department and the maternity ward remain the lowest-scoring areas; the Same Day Emergency Care score has also decreased.

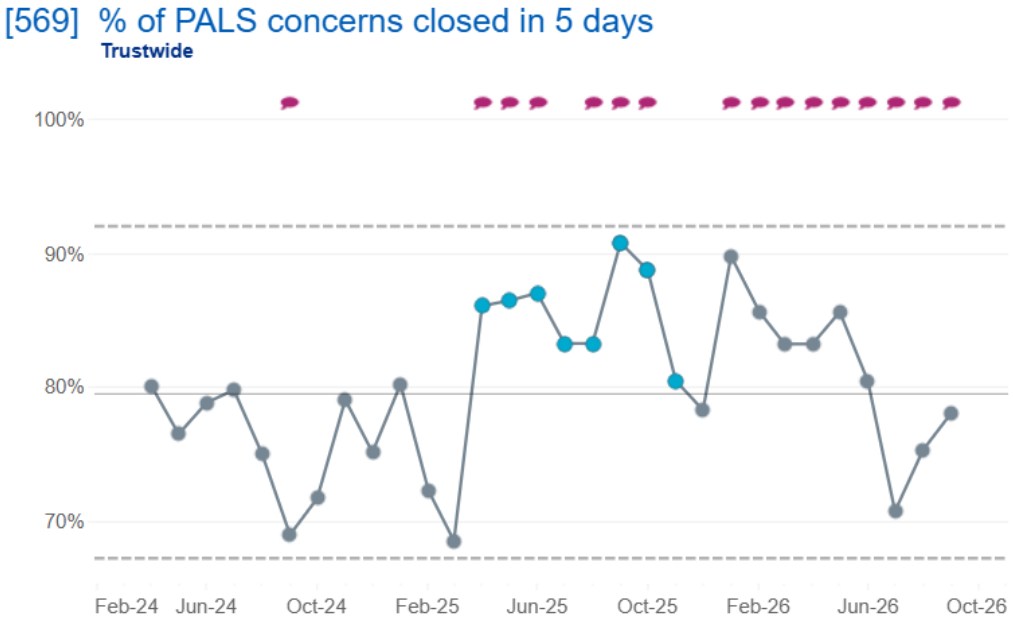
Learning & Improvement:

Patient experience data is now reported monthly to divisions, with most areas now discussing it as part of their quality governance arrangements.

Actions

- Improved reporting is ongoing with divisions, strengthening quality governance and a specific focus on patient experience linked to Trust strategy.
- The Patient Experience Team will work with Maternity and Emergency Department leads to support experience improvement in areas regularly experiencing lower scores.
- The Care Quality Commission National Inpatient Survey report was published on 26 August 2026, so further triangulation is being undertaken.
- Work is ongoing with business intelligence 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.
- A review of outpatient experiences was discussed at the Outpatient Transformation Board to support improvement.

Patient Advice and Liaison Service



Quality Highlights:

- Closure rate further recovered to the target (75%) at 78%.
- A total of 364 cases were closed in September, of which 284 were closed within five working days.
- The number of cases relating to Access to Health Records improved during the month.

Areas for Concern:

- The volume of cases remains relatively high and increased further to 391. This figure is expected to increase again in October.
- The increasing volume and complexity of cases is causing significant pressure and negative impact on staff wellbeing.
- Specialties with high numbers of cases include Trauma and Orthopaedics, Emergency Department, Gynaecology, Ear, Nose and Throat, Neurology. Ongoing themes are availability of appointments and communication with patients.

Learning & Improvement:

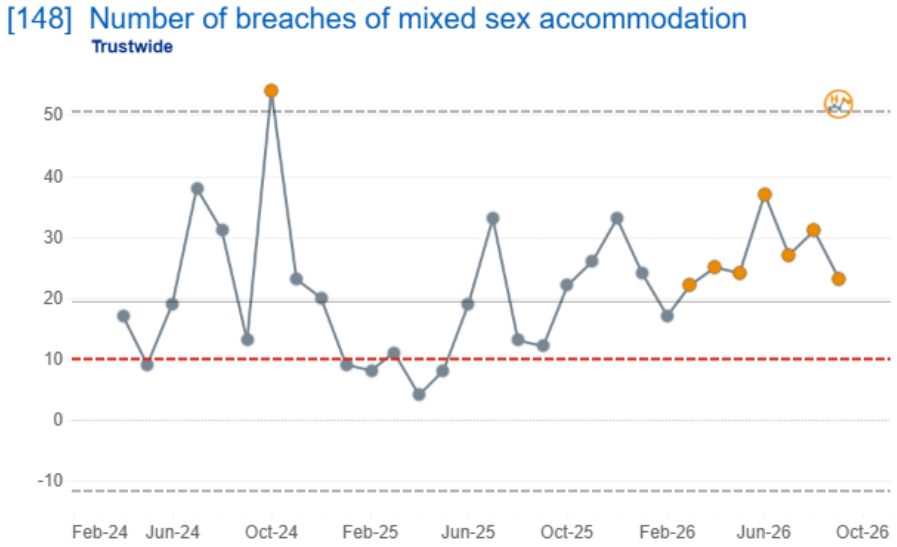
- A sustained position in line with the key performance indicator is anticipated; however, this will depend on volume. Tested escalation processes are now available to support when needed.
- Regular adjustments to processes, including access to the service, triage of cases and escalation of ongoing concerns, continue.

Actions

- Escalation has occurred in areas experiencing the highest number of concerns.
- Recruitment is under way for the Head of Complaints and Patient Advice and Liaison Service post.
- Access to the service has been adjusted, including closure of the drop-in service and management of telephone calls outside core service hours. Webpages have been updated.
- Quality concerns relating to ongoing pressure have been added as risk reference 1128.

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Patient Care: Mixed-Sex Breaches



Analytical Highlights:

Mixed-sex accommodation breaches have increased further over recent months, with the latest position at approximately **37 breaches**, exceeding both the expected tolerance level and recent historical performance. The increase reflects sustained operational pressures and a deterioration from the lower breach levels achieved previously.

Areas for Concern:

Breaches have remained above tolerance for several consecutive months, indicating a recurring issue rather than isolated exceptions. Delays in transferring patients from Critical Care and Recovery areas continue to be a significant contributing factor. The current trajectory presents ongoing risks to patient privacy, dignity and experience.

Learning & Improvement:

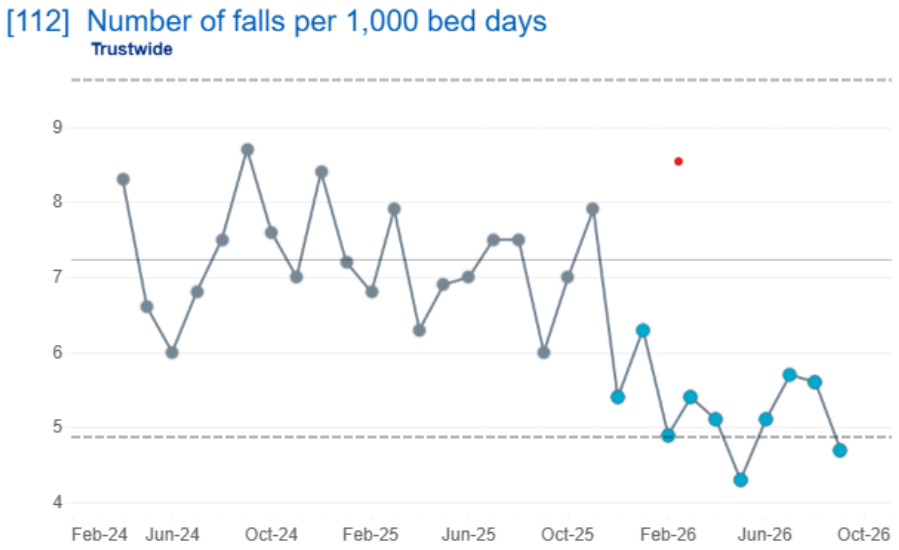
The lower breach rates achieved during early 2025 demonstrate that improvement is achievable. Further analysis is required to identify the operational conditions, patient flow factors and escalation processes associated with that improvement and to ensure they are applied consistently across the Trust.

Actions

- Continue daily review of breaches through site management calls and operational flow meetings.
- Monitor progress through operational and quality governance structures, with the aim of returning performance consistently below the agreed tolerance level.

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Safety Priority: Patient Falls



Quality Highlights:
The number of falls within the Trust was 4.7 per 1,000 bed-days and the reduction we have seen over almost a year is being sustained.

Areas for Concern:
Harm sustained from a fall is an area of concern, especially fractures such as hip fractures and head injuries.

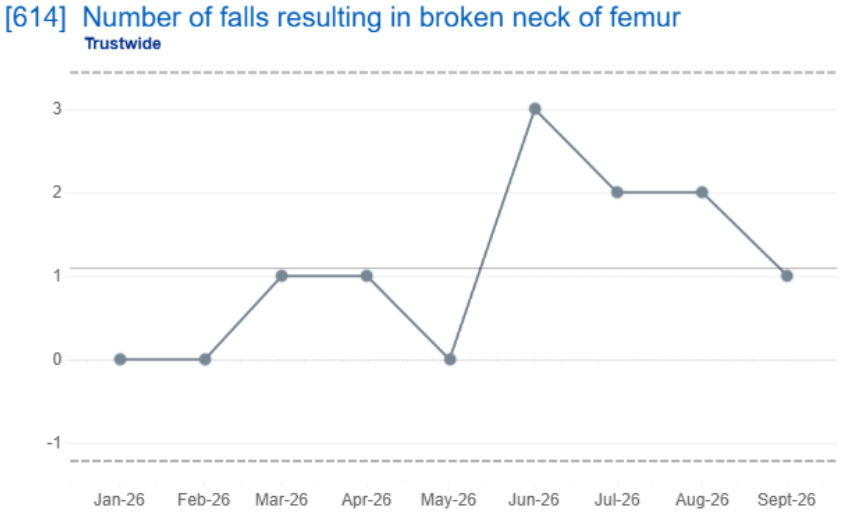
Learning & Improvement:
Regular training sessions are provided to ward based staff including ward clerks and domestics who are well placed to identify environmental risks.

Actions

Our falls overall have stabilised at a lower historical rate we are exploring the reasons for this. There is a correlation with the commencement of the Enhanced Care Team and sustained improvement which we seeking to understand in more detail so that we can further build on the improvements. The link worker role is set to be re-launched.

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Safety Priority: Patient Falls



Quality Highlight:

Following a fall in hospital, one patient experienced a fractured neck of femur requiring surgery, significant event that has caused a prolonged hospital stay and distress.

Areas for Concern:

Generally, falls with serious harm remain low. Our main concern are patients sustaining head injuries.

Learning & Improvement:

As falls resulting in hip fracture have improved and our falls overall have stabilised at a lower historical rate we are exploring the reasons for this. There is a correlation with the commencement of the Enhanced Care Team and sustained improvement which we seeking to understand in more detail.

Actions

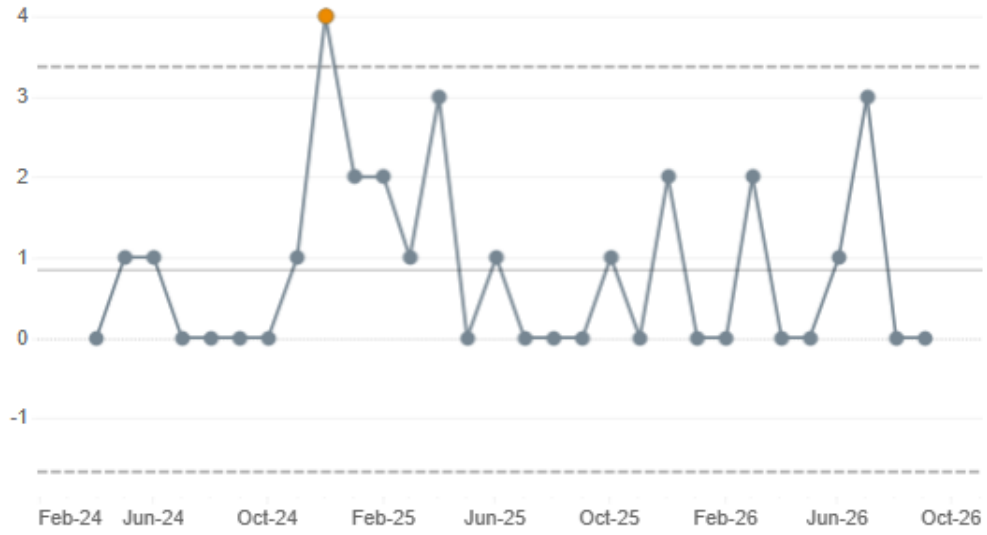
We have a Falls Review Panel that meets every week to ensure all learning is extracted on a themed basis from any incidents, patients sustaining a fracture will have their case reviewed as part of this approach. The popular training package is being updated to include more information on the risk of more severe head injuries in patients receiving anti-coagulants.

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Safety Priority: Category 3 Pressure Ulcers

[267] Number of category 3 pressure ulcers acquired as in-patient

Trustwide



Quality Highlights:

There were no cases of category 3 pressure ulcers recorded.

Areas for Concern:

Incidence remains low with device related category 3 pressure ulcers over bony prominences such as the nasal bridge being a particular area for improvement.

Learning & Improvement:

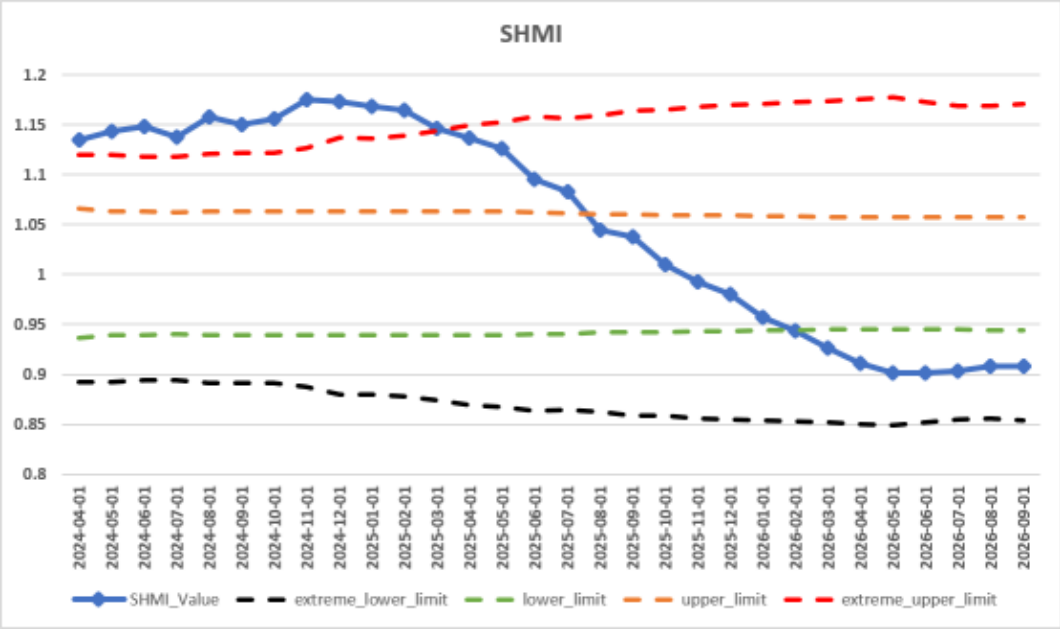
Focus on device related injuries in respiratory and critical care, although incidence remains low.

Actions

A specialist review is carried out following identification of category 3,2 or unstageable pressure ulcers to prevent deterioration. Maintaining access to specilaist equipment and risk assessment using the new PURPOSE-T tool now available on electronic patient record.

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Mortality – Summary Hospital-level Mortality Indicator National Data



Quality Highlights:

National Health Service Digital Summary Hospital-level Mortality Indicator published on 10/9/26 (data covering May 2025–April 2026) = 0.91, showing a plateau after a sustained downward trend from the 2024 peak.

Areas for Concern:

Ongoing monitoring of Summary Hospital-level Mortality Indicator without remedial coding

Clinical audits guided by mortality alerts (business as usual)

- Currently this includes aspiration pneumonia/sepsis

Emergency Department delay-related harm

Contribution of Same Day Emergency Care spells to Summary Hospital-level Mortality Indicator position – national data upload changes planned for April 2027.

Learning & Improvement:

Mortality alerts continue to guide clinical audit priorities, including aspiration pneumonia, sepsis and Emergency Department delay-related harm.

Actions

Continue monitoring Summary Hospital-level Mortality Indicator and mortality alerts through Hospital Mortality Group, maintain audit oversight, and progress the sepsis improvement workstream.

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Patient Safety Incident Response Framework Learning Responses

Highlights:

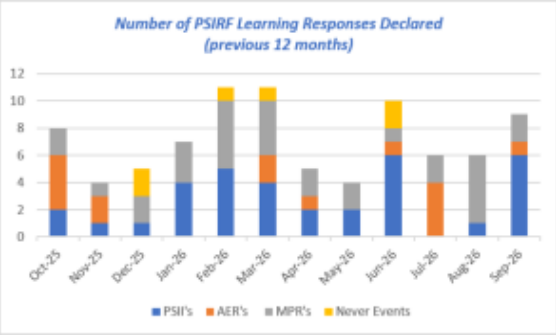
Eighty-six patient safety incidents
have required review through a Patient Safety Incident Investigation, After Event Review or Multi-Professional Review in the last 12 months—an average of 7.16 per month.

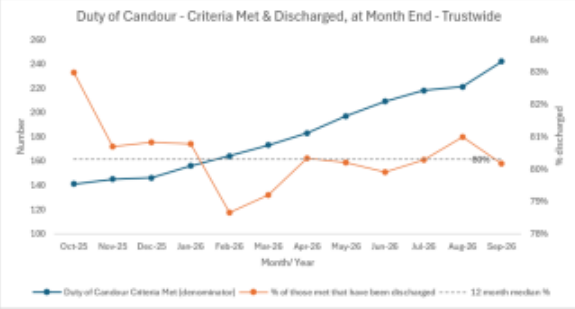
Areas for Concern:

Median on-time performance for Patient Safety Incident Investigations decreased to 58%; After Event Reviews remained at 67% and Multi-Professional Reviews at 69%. The median Duty of Candour discharge rate at month-end decreased marginally to 80%.

Learning & Improvement:

Resource and capacity within divisions and the Patient Safety Team will be addressed through the implementation of the Quality Governance Framework. The substantive Associate Director of Safety & Learning has been appointed.







PSII: Patient Safety Incident Investigation. AER: After Event Review. MPR: Multi-Professional Review.

Actions

Resource: implement the Quality Governance Framework.
Never Events: a thematic analysis was completed and shared with the Trust Board. Learning responses are prioritised and are being completed within the required timeframes.

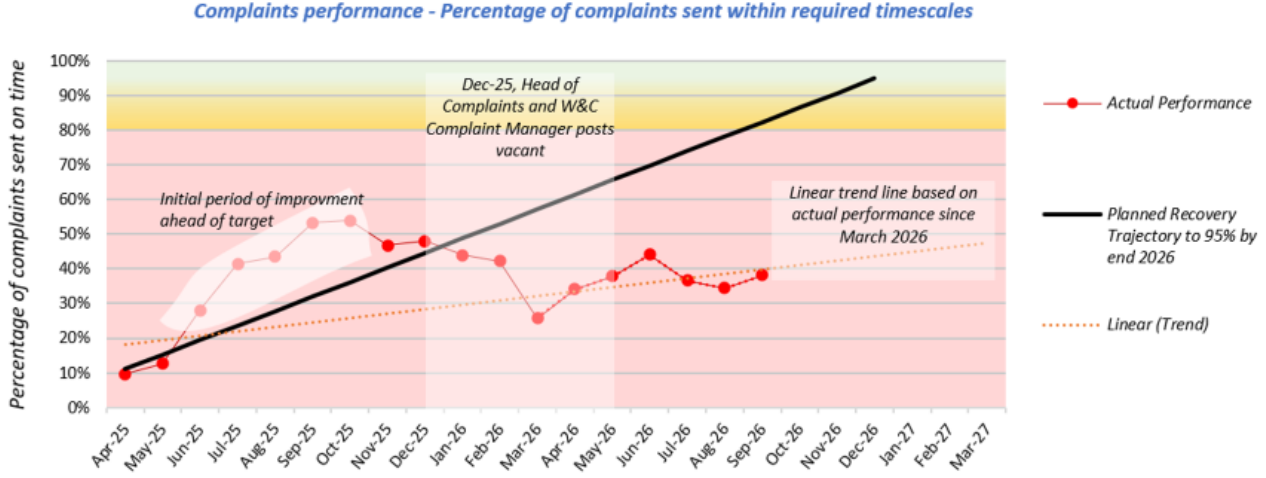
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Complaint Performance

Quality Highlights: September saw continued delivery of the complaints recovery programme, with sustained focus on reducing the backlog of aged complaints and strengthening divisional ownership of complaint responses. Interim leadership arrangements have been stabilised and implementation of the New Complaint Framework has recommenced, providing the foundation for longer-term improvement.

Areas for Concern: Complaint timeliness remains significantly below the Trust standard and aged complaints continue to represent the principal quality, experience and reputational risk. Demand remains high and workforce resilience within the service continues to be challenged by the complexity of complaints and the requirement to recover historic backlog alongside incoming activity.

.



Learning & Improvement: **Sustainable** improvement depends on increasing divisional accountability for complaint investigation and response, reducing reliance on the central Complaints Team and embedding the New Complaint Framework. Early evidence suggests that strengthened executive oversight and specialty ownership are improving organisational grip, but continued focus will be required to achieve sustained recovery.

Actions

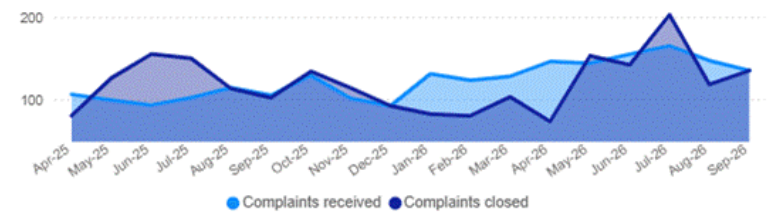
- Continue delivery of the Complaint Improvement Programme with weekly executive oversight.
- Implement the New Complaint Framework across all divisions, strengthening accountability for quality and timeliness of responses.
- Prioritise closure of the oldest and highest-risk complaints and monitor recovery against agreed trajectories.
- Complete recruitment to substantive leadership posts and improve workforce resilience within the Complaints and Patient Advice and Liaison Service service.
- Continue monthly reporting on timeliness, backlog reduction, quality of responses and complainant experience.

Complaint Performance (September 2026)

Complaints Activity and Performance Targets

YearMonth	Received	Total Closed	Due for closure	Closed within due date	% closed on time
Sep-26	135	135	146	56	38%

Complaints received vs Complaints closed

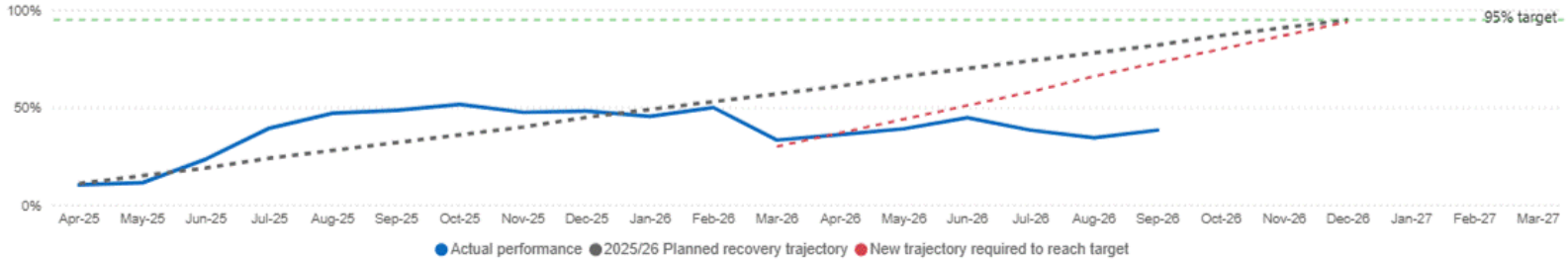


Complaints Received, Closed, and Due - by Division

Division	Received	Total Closed	Due for closure	Closed within due date	Closed within due date (on time)
Corporate	15	17	17	10	59%
Diagnostics and Speci...	2	8	10		
Gloucestershire Mana...		2			
Medical	59	49	52	27	52%
Surgical	43	40	42	16	38%
Virtual Ward Hub	1				
Women's and Children's	15	19	25	3	12%
Total	**135**	**135**	**146**	**56**	**38%**

Complaints Performance - Trustwide

Percentage of complaints closed on time within due date and projected recovery trajectory



Risk Management Performance

Analytical Highlights:

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. The risk exposure is generally reducing over time.

Areas for Concern:

16% of risks remain overdue. The Medical Division is the least compliant with 25% overdue. However, the Corporate Division has improved from 22% to 14% overdue. Both Surgery and Gloucestershire Managed Services have a green red, amber and green this month at 10%. Overdue actions remain a persistent issue.

Learning & Improvement:

A deep dive into Estates risks at Risk Management Group in October promoted a discussion on the effective use of the risk register and how it reflects reality. Further deep dives will be considered, potentially into workforce risks.

D&S: Diagnostics and Specialities. W&C: Women's and Children's.



- Overdue actions on risks

	No. overdue	Total open	% overdue	Change since last month
Corporate	20	133	15%	↓
Medical	47	84	56%	↑
Surgical	34	97	35%	↓
D&S	29	127	23%	↓
W&C	5	84	6%	↓
GMS	3	72	4%	↑
Total	138	597	23%	↓

- Overdue actions on incidents

	No. overdue	Total open	% overdue	Change since last month
Corporate	13	32	40%	↑
Medical	42	87	48%	↓
Surgical	24	36	67%	↑
D&S	9	53	17%	↓
W&C	41	157	26%	↓
GMS	0	2	0%	↓
Total	129	367	35%	↓

Actions

Divisional leadership to continue targeted engagement with risk owners responsible for the highest numbers of overdue reviews and actions. Escalate concerns regarding long-overdue risk reviews and actions.

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Use of Resources Metrics

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Financial Metrics

Highlights

The Month 6 revenue position is a £6.3m deficit which is £99k favourable to plan. Financial Sustainability Programme has delivered £18.7m which is £1.1m behind plan. Capital spend is £19.3m, which is £5.4m behind plan.

Areas of concern

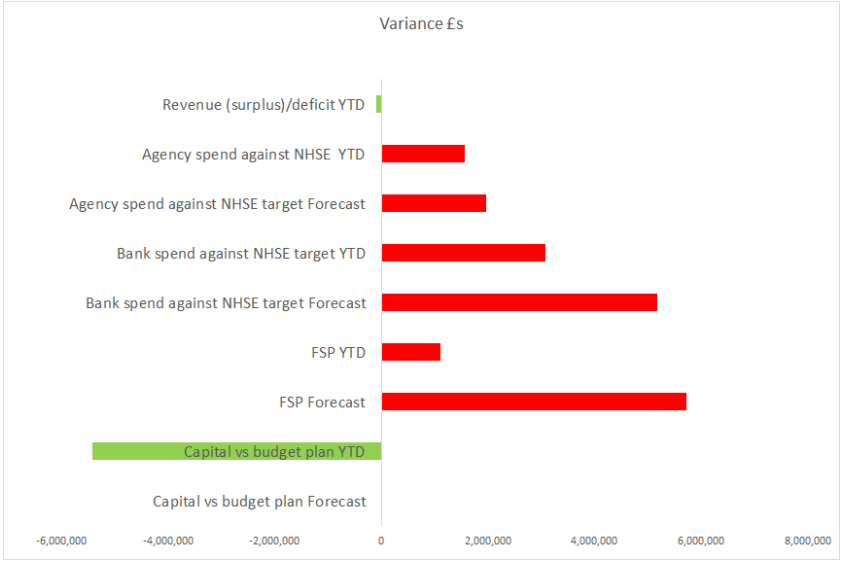
Month 6 is the first month in which the Trust is reporting Financial Sustainability Programme delivery below plan. This, combined with divisional cost pressures, means that the Trust is facing a forecast deficit if no action is taken.

Looking forward

The Trust has developed a robust recovery plan and must now focus on delivery to mitigate a potential deficit in 2026/27.

GMS: Gloucestershire Managed Services. YTD: year to date. FY: financial year.

2026/27Financial Overview	Plan £000s	Actual £000s	Variance £000s	Metric Calculation	Score (1 Best) (4 Worst)
Financial Metrics					
Revenue (surplus)/deficit YTD	6,410	6,311	(99)	0.0%	1
Agency spend against NHSE YTD	2,716	4,278	1,562	57.5%	4
Agency spend against NHSE target Forecast	5,389	7,352	1,963	36.4%	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%	1.4%	0.4%	1.4%	4
Bank spend against NHSE target YTD	16,522	19,607	3,085	18.7%	4
Bank spend against NHSE target Forecast	33,090	38,261	5,171	15.6%	4
Bank spend as % of total pay bill YTD	6.0%	7.1%	1.0%	7.1%	4
Bank spend as % of total pay bill Forecast	6.1%	7.0%	0.9%	7.0%	4
FSP YTD	(19,768)	(18,662)	1,106	5.6%	4
FSP Forecast	(52,345)	(46,617)	5,728	10.9%	4
Capital vs budget plan YTD	24,725	19,303	(5,422)	-21.9%	1
Capital vs budget plan Forecast	62,376	62,376	0	0.0%	1
	Days/%	Days/%	Days/%		
Nos days operating cash	5	20	15	-100.0%	1
BPP - nos invoices paid in 30 days	95%	94%	-1%	1.1%	4



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National Health Service England National Health Service Oversight Framework Score based on variation from plan. (1.00 = on plan or better, 2.00 = below 0.5% adverse variance, 3.00 = between 0.5% and 1% adverse variance, 4.00 = beyond 1% adverse variance)

Director of Finance Summary

Month 6 Overview

The Month 6 year-to-date position is a £6.3m deficit, which is £99k favourable to plan. The planned deficit is £6.4m.
The variance is driven mainly by:

- Financial Sustainability Programme £1.1m behind plan
- Industrial Action £0.7m (April)
- Release of balance sheet benefits (£1.5m)

Looking Ahead

The month 6 position is favourable to plan but remains a deficit. The favourable position has been achieved through non-recurrent balance-sheet benefits which are offsetting a shortfall in Financial Sustainability Programme delivery. The Financial Sustainability Programme delivery risk is beginning to materialise, particularly the delivery of recurrent savings.

Areas of focus for forthcoming months

- Delivery of the recovery plan which will include monitoring monthly run rates and actions to keep on track.
- Review of all vacancies
- Strengthening of workforce controls
- Reduce temporary staffing costs

Month 6 Revenue Position

Highlights

The Month 6 revenue position is £99k favourable to plan. The release of balance-sheet benefit is offsetting Financial Sustainability Programme underperformance against plan and industrial action incurred in Month 1.

Areas of concern

Financial Sustainability Programme has underdelivered by £1.1m. This is the first time this year that an under-delivery has been reported. This is due to a delay in transformation schemes progressing.

Looking forward

The underlying position for the Trust is a £66.5m deficit which assumes full delivery of 26/27 recurrent Financial Sustainability Programme. This is at risk, with the current gap on recurrent schemes being £9.2m.

GMS: Gloucestershire Managed Services. YTD: year to date. FY: financial year. SLA: Service Level Agreement. EBITDA: earnings before interest, tax, depreciation and amortisation. IFRIC: International Financial Reporting Interpretations Committee.

YTD Month 6 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	807,700	403,596	403,020	(576)	0	0	0	0	807,700	403,596	403,020	(576)
PP Overseas and RTA Income	8,520	3,761	3,151	(609)	0	0	0	0	8,520	3,761	3,151	(609)
Other Income from Patient Activities	10,560	5,359	5,925	566	0	0	0	0	16,875	8,138	9,077	939
Operating Income	45,898	23,256	24,796	1,539	94,935	47,467	52,915	5,448	40,363	20,395	24,636	4,240
Total Income	**872,679**	**435,972**	**436,892**	**920**	**94,935**	**47,467**	**52,915**	**5,448**	**873,459**	**435,890**	**439,884**	**3,994**
Substantive	(490,833)	(247,059)	(239,310)	7,749	(32,805)	(16,402)	(14,514)	1,888	(505,872)	(254,254)	(253,775)	479
Bank	(20,294)	(10,158)	(11,833)	(1,675)	(14)	(7)	(28)	(21)	(21,041)	(10,502)	(11,861)	(1,359)
Agency	(2,605)	(1,303)	(3,189)	(1,886)	0	0	(1,089)	(1,089)	(5,389)	(2,694)	(4,278)	(1,584)
Locum	(12,049)	(6,034)	(7,746)	(1,712)	0	0	0	0	(12,049)	(6,034)	(7,746)	(1,712)
Total Pay	(525,781)	(264,554)	(262,079)	2,476	(32,819)	(16,410)	(15,631)	779	(544,351)	(273,484)	(277,660)	(4,176)
Drugs	(112,094)	(55,747)	(55,726)	20	(0)	(0)	(6)	(6)	(112,094)	(55,747)	(55,732)	15
Clinical Supplies	(47,590)	(22,178)	(23,551)	(1,373)	(8,828)	(4,414)	(8,970)	(4,556)	(56,417)	(26,592)	(32,521)	(5,929)
Other Non-Pay	(179,483)	(96,646)	(98,803)	(2,157)	(51,021)	(25,511)	(27,258)	(1,748)	(150,187)	(81,328)	(76,174)	5,154
Total Non Pay	(339,167)	(174,571)	(178,081)	(3,510)	(59,849)	(29,924)	(36,234)	(6,309)	(318,699)	(163,666)	(164,427)	(761)
Total Expenditure	**(864,949)**	**(439,125)**	**(440,159)**	**(1,034)**	**(92,668)**	**(46,334)**	**(51,864)**	**(5,530)**	**(863,050)**	**(437,150)**	**(442,087)**	**(4,937)**
EBITDA	7,730	(3,153)	(3,267)	(114)	2,267	1,133	1,051	(83)	10,409	(1,260)	(2,203)	(943)
EBITDA %age	0.9%	(0.7%)	(0.7%)	(12.4%)	2.4%	2.4%	2.0%	(1.5%)	1.2%	(0.3%)	(0.5%)	23.6%
Non-Operating Costs	(8,680)	(4,421)	(3,780)	641	(2,267)	(1,133)	(1,051)	83	(11,359)	(6,310)	(4,842)	1,468
Surplus / (Deficit)	(950)	(7,574)	(7,047)	527	(0)	(0)	0	0	(950)	(7,570)	(7,045)	525
Donated Asset, IFRIC & Salix Grant Adjustment	950	1,160	734	(426)	0	0	0	0	950	1,160	734	(426)
Adjusted Surplus / (Deficit)	(0)	(6,410)	(6,311)	99	(0)	(0)	0	0	0	(6,410)	(6,311)	99

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Month 6 Financial Sustainability Programme

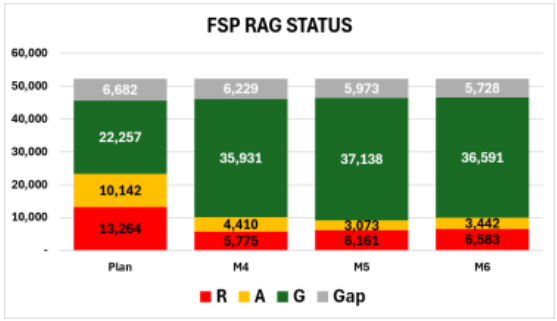
Year to date delivery
Year to date delivery is £18.6m against a plan of £19.8m.
Forecast delivery is £46.6m (89%) against a plan of £52.3m. The unidentified gap has reduced slightly to £5.7m (11%).

Divisions are currently above plan; however, a large proportion of this is non-recurrent.

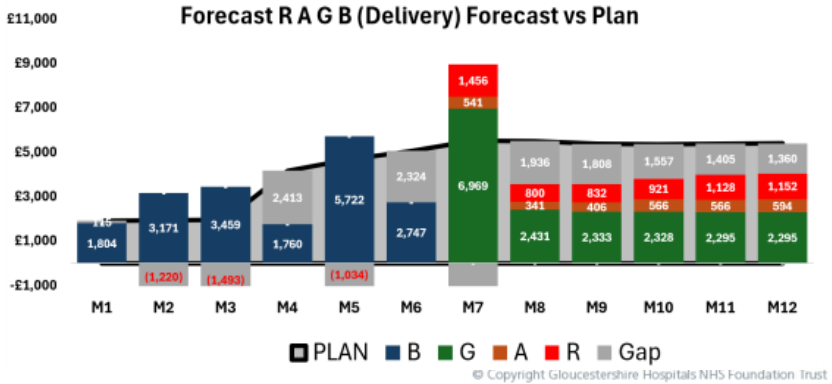
Forecast
Full year forecast assumes that the cost pressure Financial Sustainability Programme of £13.8M will deliver approximately £11.9m of which £1.3m is rated high risk (red). This is being regularly reviewed as there is a risk that mitigations have not been identified and that this will not be delivered in full.

The forecast assumes that transformation schemes will deliver to plan. There remains a gap of £5.7m.

Total Programme	Full Year			YTD		
	Plan	Forecast	B/(W) vs Plan	Plan	Actual	B/(W) vs Plan
Total Recurrent	39,258	30,040	(9,219)	15,995	10,454	(5,541)
Total Non-Recurrent	13,086	16,577	3,491	3,773	8,208	4,435
Total Schemes	**52,345**	**46,617**	**(5,728)**	**19,768**	**18,662**	**(1,107)**



FSP: Financial Sustainability Programme. YTD: year to date. FY: financial year.



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Productivity (Month 12 25/26)

	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
BNSSG Acutes	2.4%	3.9%	**1.4%**	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
BSW Acutes	0.5%	3.6%	**3.0%**	-0.1%	1.6%	**1.7%**		3	
CORNWALL Acute	-2.4%	-2.6%	**-0.2%**	0.1%	-0.6%	**-0.8%**	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
DEVON Acutes	2.0%	5.0%	**2.9%**	0.5%	1.4%	**0.9%**		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
DORSET Acutes	3.2%	2.2%	**-1.0%**	2.4%	-0.1%	**-2.5%**		7	
GLOUCS Acute	-0.6%	5.3%	**5.9%**	0.9%	-0.3%	**-1.3%**	1	1	24 / 134
SOMERSET Acute	0.6%	4.1%	**3.5%**	0.3%	0.2%	**-0.1%**	3	2	52 / 134
SOUTH WEST REGION Acutes	1.4%	3.6%	**2.2%**	1.4%	3.6%	**2.2%**			5
NATIONAL Acutes	0.2%	2.7%	**2.5%**	0.2%	2.7%	**2.5%**			

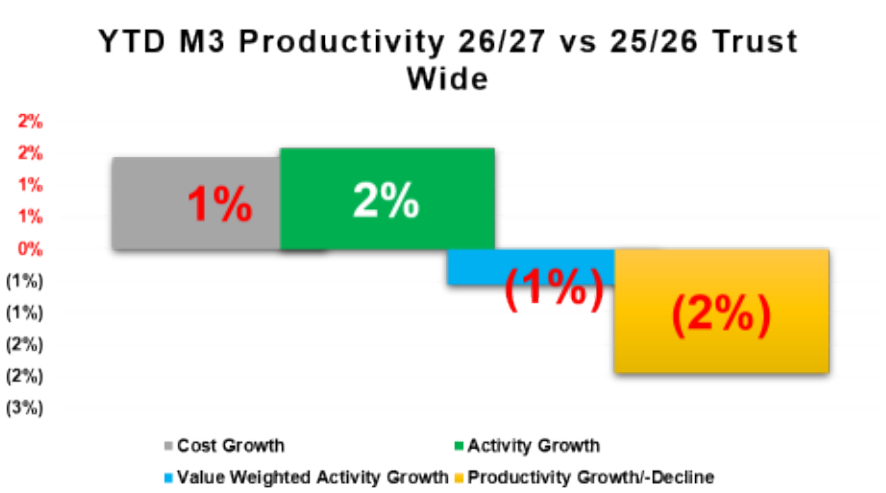
The latest position from the South West Productivity Network (Month 12 25/26) shows Gloucestershire Hospitals National Health Service Foundation Trust as still ranking first in the region for productivity growth, stating a 5.9% implied productivity growth, a reduction from the 7.1% reported at Month 11. However, this is comfortably above the national acute average of 2.5%. Gloucestershire Hospitals National Health Service Foundation Trust ranks 24th nationally out of 134 trusts.

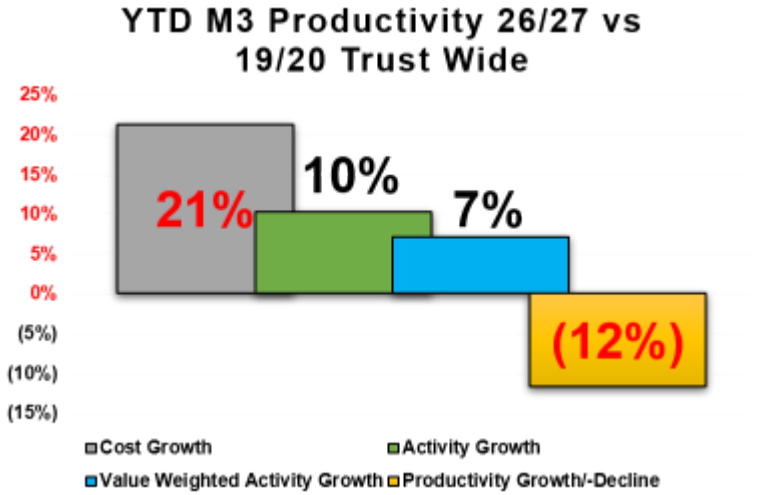
Regionally, only RUH Bath has shown a significant positive increase in productivity from Month 11.

GHFT: Gloucestershire Hospitals National Health Service Foundation Trust. FY: financial year. YTD: year to date.

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Productivity (Month 1 to Month 3 26/27)





While awaiting the official publication of 2026/27 Month 3 data from the South West Productivity Network, we have produced internal reporting to indicate expected performance for the period. The analysis above shows a 2% productivity reduction when comparing 2026/27 Month 3 year to date with 2025/26 Month 3 year to date. Nationally, a 2% year-on-year productivity gain is expected. Compared with the previous slide, this demonstrates the difficulty of sustaining productivity gains after the significant improvement achieved in 2025/26.

When comparing 2026/27 Month 3 year to date with 2019/20 Month 3 year to date, productivity is 12% lower. The national expectation is for trusts to return to pre-pandemic productivity levels. The main driver is cost growth (adjusted for inflation) exceeding weighted activity gains: we are delivering more activity, but its value has not risen in proportion to the cost of delivery. Initial regional indications suggest that productivity is challenging for all acute providers this year.

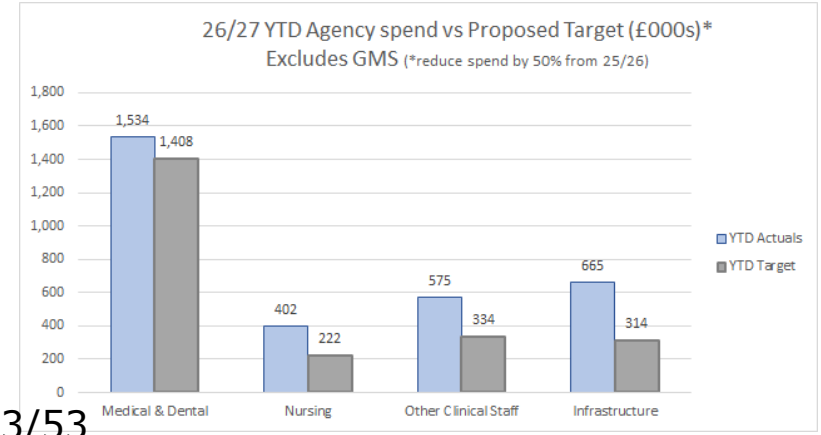
Agency Staffing – Spend

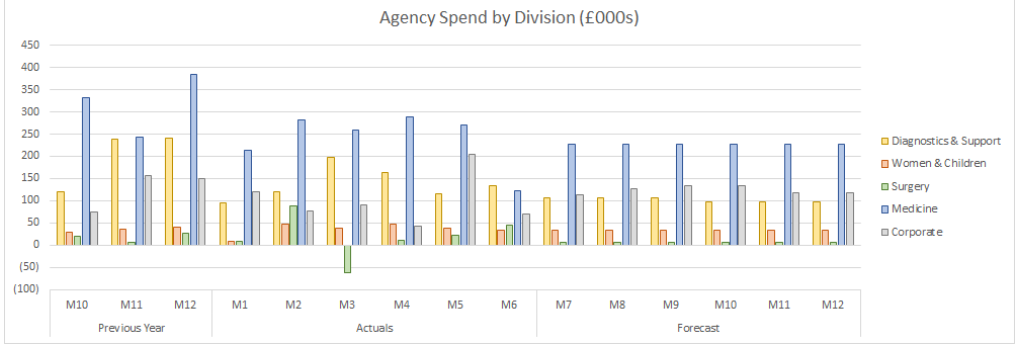
National Health Service England has set a target for Gloucestershire Hospitals National Health Service Foundation Trust to reduce agency spend to £5,391k in 2026/27. The Group needs to reduce spend by approximately 50% from £10,469k last year to be able to meet the target.

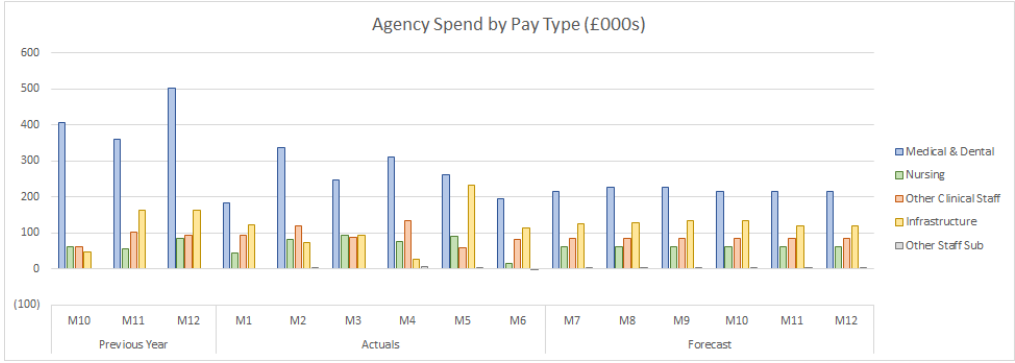
Month 6 spend for the Trust has reduced by £247k from prior month because infrastructure costs within Corporate were particularly high last month.

Month 6 year to date spend is £4.3m, which is £1m lower than last year but £1.5m above the National Health Service England target. If no action is taken, full-year spend will be approximately £7.4m. This is £3.1m lower than last year but £2m above National Health Service England target.

Agency Spend	M1-M6 25/26	M1-M6 26/27	(Reduction) /Increase	(Reduction) /Increase	Full Year 25/26	Forecast 26/27	(Reduction) /Increase	(Reduction) /Increase
	£000	£000	£000	%	£000	£000	£000	%
Medical & Dental	2,734	1,534	(1,200)	-44%	5,684	2,846	(2,837)	-50%
Nursing	431	402	(29)	-7%	856	767	(89)	-10%
Other Clinical Staff	649	575	(74)	-11%	1,255	1,077	(178)	-14%
Infrastructure	611	665	54	9%	1,461	1,462	1	0%
GMS	882	1,103	221	25%	1,213	1,200	(13)	-1%
Total	5,306	4,278	(1,028)	-19%	10,469	7,352	(3,117)	-30%



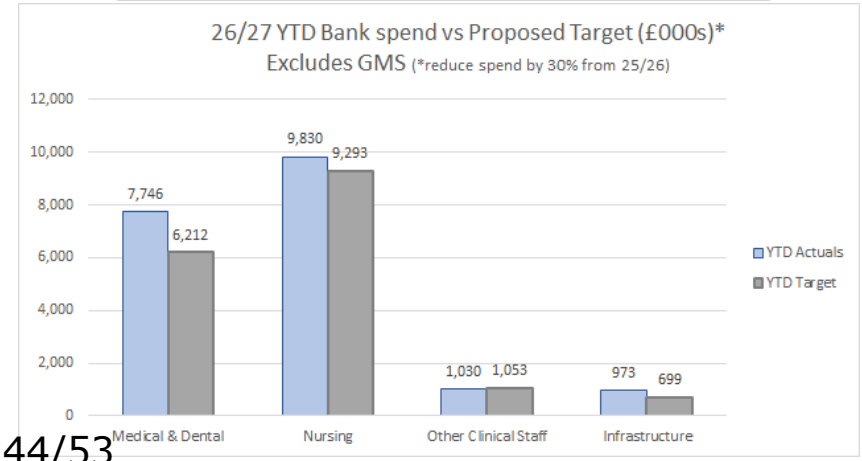


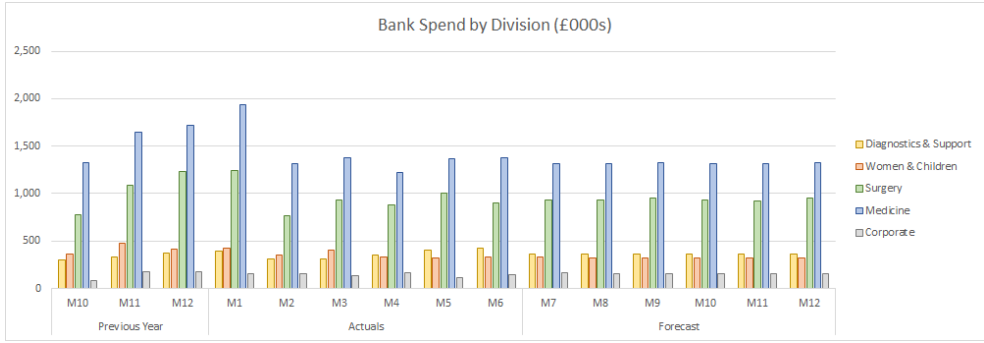


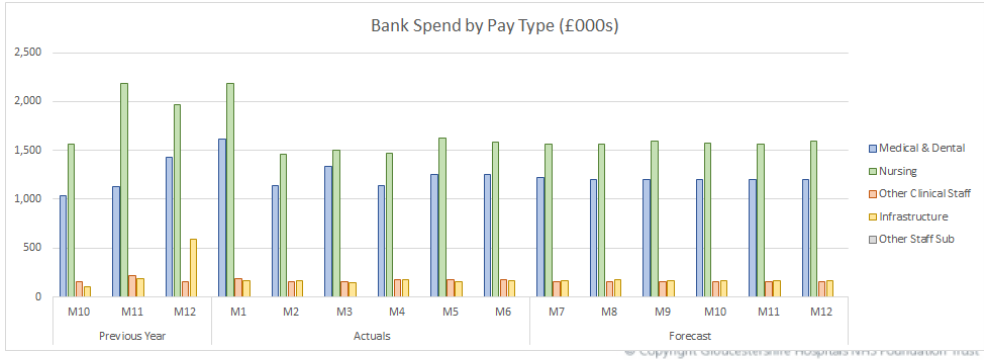
Bank Staffing – Spend

The Group needs to reduce spend by approximately 30% from £45,968k last year to £33,090k to be able to meet the National Health Service England target.
Month 6 spend is broadly in line with prior month, with the main movement due to a reduction in nursing bank of £40k.
Month 6 year to date spend is £19.6m, which is £4.6m lower than last year but still £3m above the National Health Service England 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 National Health Service England target.

Bank Spend	M1-M6 25/26	M1-M6 26/27	(Reduction) /Increase	(Reduction) /Increase	Full Year 25/26	Forecast 26/27	(Reduction) /Increase	(Reduction) /Increase
	£000	£000	£000	%	£000	£000	£000	%
Medical & Dental	8,628	7,746	(882)	-10%	16,625	14,964	(1,661)	-10%
Nursing	12,907	9,830	(3,077)	-24%	24,187	19,273	(4,914)	-20%
Other Clinical Staff	1,463	1,030	(433)	-30%	2,621	1,988	(633)	-24%
Infrastructure	971	973	2	0%	2,316	1,988	(328)	-14%
GMS	200	28	(172)	-86%	218	48	(170)	-78%
Total	24,169	19,607	(4,562)	-19%	45,968	38,261	(7,707)	-17%







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Month 6 Capital Position

Highlights

As of the end of September (Month 6), year to date expenditure on the Trust capital programme totalled £19.3m, against a planned spend of £24.7m, equating to a variance of £5.4m behind plan.

Capital Programme £000s	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	2,904	1,702	1,202	7,277	7,277	(0)
MEDICAL EQUIPMENT	1,065	1,329	(264)	5,630	6,251	(621)
ESTATES	15,737	11,736	4,001	25,207	27,592	(2,385)
CORPORATE	0	(293)	293	67	(293)	360
OVERCOMMITMENT OF PROGRAMME	0	0	0	0	0	0
Total Charge against Capital Allocation (incl. IFRS 16)	**19,706**	**14,474**	**5,232**	**38,181**	**40,827**	**(2,646)**
NAT PROG: ESTATES SAFETY	3,248	3,979	(731)	12,000	12,000	(0)
NAT PROG: CONST STANDARDS	1,246	297	949	10,614	10,614	0
IFRIC 12	273	273	0	546	546	0
DONATIONS VIA CHARITABLE FUNDS	252	281	(29)	1,035	1,035	0
Total Expenditure against Additional Funding	**5,019**	**4,830**	**189**	**24,195**	**24,195**	**(0)**
Gross Capital Spend Total	**24,725**	**19,304**	**5,421**	**62,376**	**65,023**	**(2,647)**
Less Donations and Grants Received	(252)	(281)	29	(1,035)	(1,035)	(0)
Less PFI Capital (IFRIC12)	(273)	(273)	0	(546)	(546)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	183	183	0	366	366	0
Total Capital Departmental Expenditure Limit (CDEL)	**24,383**	**18,933**	**5,450**	**61,161**	**63,808**	**(2,647)**

YTD: year to date. M6: Month 6.

Analysis

Spend on system capital-funded projects year to date totals £14.5m versus a planned spend of £19.7m, resulting in a **variance of £5.2m behind plan** driven by:

- **Estates position is £4.0m behind plan**: primarily driven by Department of Critical Care and Prescott Ward refurbishment, where expenditure has been incurred more slowly than was assumed within the planned spending profile.
- **Digital position is £1.2m behind plan**: almost all projects are currently behind the original phased expenditure profile year to date. Although it is still expected that the allocation will be spent in full, this will depend on an acceleration in spending. Progress has been made in removing barriers affecting a number of digital projects, including approval of waivers required to progress electronic patient record optimisation work.

The Trust is reporting a **forecast overcommitment of £2.6m** against the available allocation:

- The Estates forecast is driving the Trust's overall overcommitment. At present, there is a **forecast overspend** in this area versus the available allocation of **£3.0m**; several major programmes continue to show substantial variance against their allocation including a **£0.6m adverse variance on medical equipment enabling work projects**.
- Whilst confidence in the forecast has increased since Month 5, delivery remains subject to several significant risks, with approximately **£6m of Estates expenditure currently assessed as either medium or high risk**.
- In addition, the current forecast **does not include £2.6m of additional spend for the Department of Critical Care programme; this is a significant further risk to the estates programme allocation that has been excluded pending further investigation into the drivers of this risk and likelihood of it materialising. Proactive dialogue with the Council planners has taken place with a positive outcome that could bring a decision forward by two months, to mid-November or early December.**

*The commentary is based on the gross capital spend. The position against Capital Departmental Expenditure Limit differs as per the table, in that adjustments are made for donations, grants and International Financial Reporting Interpretations Committee 12 spend.

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Workforce

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PWR Provider Workforce Return

Workforce Performance Indicators

Workforce Highlights:

- Sickness absence has risen slightly.
- While bank usage remains below plan, it has risen since July. Agency usage remains significantly above plan.

Areas for Concern:

- High agency usage is being driven by Gloucestershire Managed Services, but the Trust's usage is also not improving.
- Appraisal compliance has drifted down to 79% and continues to be below target.

Learning & Improvement:

- Maintain the focus on temporary staffing reductions in the multi-year plan.
- Spending caps for temporary staffing have been set as part of the multi-year plan, requiring significant reductions each year.

KPI (Trust)	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Turnover (Headcount)	11%	8.03%	8.73%	8.48%	8.47%	8.57%	8.52%	8.65%	8.99%	8.73%	8.65%	8.39%	8.13%
Vacancy	8%	6.87%	6.96%	7.29%	7.09%	7.37%	7.95%	7.06%	7.91%	8.02%	8.27%	7.30%	6.94%
Sickness	4%	4.41%	4.43%	4.47%	4.47%	4.54%	4.55%	4.57%	4.62%	4.60%	4.61%	4.64%	
Appraisal	90%	83%	82%	83%	82%	82%	84%	82%	81%	80%	79%	82%	79%
Essential Training	90%	90%	90%	91%	91%	91%	91%	90%	90%	90%	89%	90%	90%

		Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Bank WTE	Medium Term Plan	509.92	511.41	518.04	521.41	524.79	496.7	501.69	505.01	510.58	495.82	499.15	493.35
	Actual (PWR)	562.63	470.88	436.94	469.46	500.51	485.41						
	Difference	52.71	-40.53	-81.10	-51.95	-24.28	-11.29						
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	83.94	87.37						
	Difference	23.18	16.26	62.10	60.96	53.05	56.89						

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 affected, for example, by short-term changes in non-recurrent funding.

- Establishment is updated on Electronic Staff Record from the Ledger.
- Sickness absence is reported 1 month in arrears, as it is not all uploaded to Electronic Staff Record until around the 20th of each month (in line with payroll processes).

Workforce: Sickness Absence

D&S: Diagnostics and Specialities.

Workforce Highlights:

Overall Trust absence is 0.2% higher than in the previous 12 months.

Mental health continues to be the largest proportion of absence reasons across all staff groups except Medical and Dental, where respiratory absence is 2.6% higher.

Areas for Concern:

Add Prof staff show the sharpest deterioration, from 3.1% to 5.0%, an increase of 1.9%. Healthcare Scientists also increased by 1%, while Estates and Ancillary increased by 1.3%. Additional Clinical Services has a 6.5% absence rate across 1,263 whole-time equivalent, whereas Estates and Ancillary reports 6.2% across 33 whole-time equivalent, representing a smaller staffing impact. Women's and Children's is the clearest divisional pressure point, at 5.2% compared with 4.6% across the Trust. Nursing and Midwifery absence within that division is 6.3%.

Learning & Improvement:

Reporting focus to be developed to optimise data insights from Health Rota (Medical) and Optima (Agenda for Change) rostering to fully integrate with business intelligence dashboard capabilities. Key to this is rollout of medical e-rostering across the Trust, which may result in higher reported absence rates, based on experience of rollouts in 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	7454.63	4.4%	4.6%	0.2%		4.4%	4.6%	4.7%	4.6%	5.2%	27.1%	18.0%	14.9%	9.4%	4.1%
Add Prof Scientific & Tech	238.94	3.1%	5.0%	1.9%		*	3.6%	10.0%	7.6%	*	23.9%	14.5%	12.1%	6.6%	0.9%
Additional Clinical Services	1304.66	6.5%	6.5%	-0.1%		5.9%	6.7%	5.7%	7.4%	5.6%	24.0%	21.7%	14.0%	10.7%	5.2%
Administrative and Clerical	1536.40	4.3%	4.7%	0.5%		4.4%	4.7%	5.6%	5.5%	5.1%	30.6%	16.9%	14.8%	7.8%	2.3%
Allied Health Professionals	471.09	3.0%	3.5%	0.5%		*	3.4%	*	4.1%	*	29.1%	19.3%	19.4%	13.0%	5.2%
Estates and Ancilliary	31.00	4.9%	6.2%	1.3%		*	6.8%	*	*	*	26.0%	36.3%	4.4%	4.9%	0.0%
Healthcare Scientists	268.31	3.1%	4.1%	1.0%		*	4.3%	4.6%	3.4%	*	20.1%	14.2%	25.3%	10.7%	5.8%
Medical and Dental	1115.10	2.2%	1.9%	-0.3%		2.6%	1.7%	2.4%	1.7%	1.1%	13.4%	5.8%	13.5%	6.9%	0.5%
Nursing & Midwifery	2489.15	4.8%	5.0%	0.2%		4.5%	5.6%	4.9%	4.3%	6.3%	29.9%	18.5%	14.9%	9.8%	5.0%

Actions

- Health Roster (optima) enables real-time visibility of absence triggers and reports to individuals on absence levels.
- Review S10 Stress and Anxiety and secondary reasons to target interventions.
- Manager capability is supported through bespoke divisional training and fortnightly live case-management sessions with People Development.
- Continue dedicated wellbeing support in Women's and Children's, considering workforce profile, family-friendly policies and flexible retirement.
- The sickness taskforce is now established to provide a concise overview of organisation-wide sickness work, aligned with the Workforce Sustainability Programme. Maintain long-term absence processes and focus on short-term absence reporting.
- Perkbox is now in place with an enhanced Employee Assistance Programme offer. Continue wellbeing interventions with Organisational Development and the Wellbeing Team.
- Review the occupational health contract and interventions to support musculoskeletal illness.

Workforce: Appraisal

Analytical Highlights:

Trust-wide appraisal compliance has returned to 79% this month, with 223 more staff marked as non-compliant. All divisions have seen a decrease of 2–5% apart from Corporate which remains at 75%. Although Women's and Children's has decreased by 5%, the largest contributor to the organisational decline is the drop in Diagnostics and Specialities (because of its larger workforce), resulting in an overall Trust drop of 0.75% from Diagnostics and Specialities alone.

Although Estates and Ancillary recorded a 21% decline this month, its workforce of 56 means this represents 23 non-compliant staff. By contrast, the 8% decrease in the medical workforce represents 90 staff, leaving more than 200 medical staff non-compliant. Medical Staff and Nursing and Midwifery Registered Staff Groups contribute to 2%+ of the overall Trust decline.

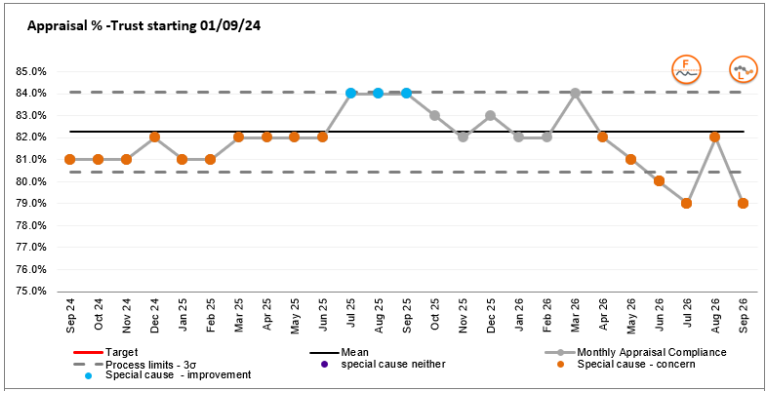
It should be noted that staff on long-term sickness absence (28 days+), maternity/paternity leave, and Gloucestershire Managed Services staff are not included in the Trust's appraisal compliance key performance indicator. As of 31 August, 197 staff are on long-term sickness absence, and 261 are on maternity/paternity leave.

Areas for Concern:

- Trust-wide compliance remains below the national target.
- Variation in performance across divisions remains significant, with compliance swinging significantly in the smaller workforce groups (Staff or Division).
- Seven service lines remain below 70% compliance, although only one has deteriorated this month.

Learning & Improvement:

- Improvement activity introduced in August continues to be monitored for its effectiveness, with a new investigation into the impact of multiple assignments on compliance.
- The effect of training on service-line compliance is being evaluated to ensure we understand its validity as a mechanism of targeted support.



Breakdown by Division

Division / Date	30-Sep-26
Corporate Division	75%
Diagnostic & Specialty Division	80%
Medicine Division	80%
Surgery Division	80%
Women & Children Division	81%
GHT Total	79%

Breakdown by Staff Group

Staff Group / Date	30-Sep-26
Add Prof Scientific and Technic	86%
Additional Clinical Services	83%
Administrative and Clerical	73%
Allied Health Professionals	72%
Estates and Ancillary	60%
Healthcare Scientists	80%
Medical Staff - Consultants	83%
Medical Staff - SAS	84%
All Medical Staff	83%
Nursing and Midwifery Registered	82%
GHT Total	79%

Actions

Refocus recovery plans on the areas contributing most to Trust-wide non-compliance, using workforce numbers alongside percentages.
Complete the appraisal training impact review, linking attendance to subsequent appraisal activity and coverage of Electronic Staff Record supervisors/managers.
Review implementation of the agreed move towards manager-led Electronic Staff Record recording, confirming supervisor access and arrangements for staff who cannot use the standard route.

Workforce: Bank

Workforce Highlights:

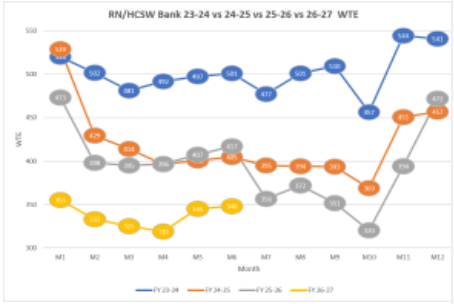
- The Trust has seen an increase in temporary registered nurse/healthcare support worker staffing of 3 whole-time equivalent (from Month 5 345 to Month 6 348 whole-time equivalent).
- This follows the pattern of Month 6 being higher than Month 5 in previous years.
- In comparison with Month 6 of the 2025/26 financial year, there has been a decrease of 69 registered nurse/healthcare support worker whole-time equivalent.
- **Medicine** is the highest user of bank and locum staff.
- The top three users in Month 6 are Emergency Department, Acute and Care of the Elderly. All three have reduced temporary staffing use compared to Month 5.
- **Emergency Department** (81 to 80 whole-time equivalent), **Care of the Elderly** (33 to 24 whole-time equivalent), Acute (41 to 39 whole-time equivalent)
- A year-on-year whole-time equivalent comparison of registered nurse/healthcare support worker temporary staffing use shows the improvements achieved throughout the financial year.

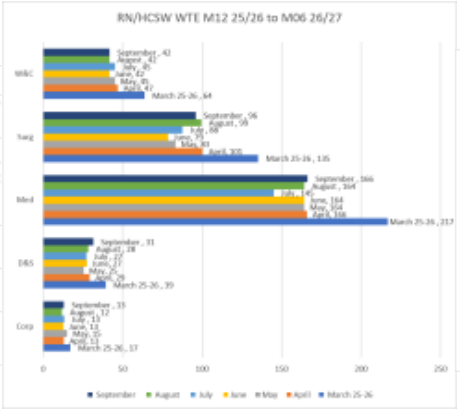
Areas for Concern or Highlight

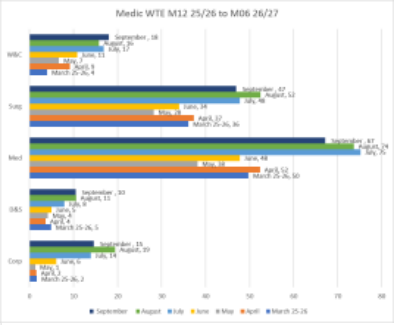
- Overall whole-time equivalent and spe bank staff are above the 2026/27 targe
- Month 6 registered nurse/healthcare support worker bank use is lower in 2026/27 than in 2025/26, although it ha increased from Month 5.

Learning & Improvement:

- As the trends in whole-time equivalent use for 2023/24, 2024/25 and 2025/26 are broadly similar, it is reasonable to assume that Month 7 2026/27 will also see a similar whole-time equivalent use.
- Month 7 will be a pivotal month to track whether bank use drops as in previous years.
- Acute Medicine has been switching from agency to locum use.







D&S: Diagnostics and Specialities. W&C: Women's and Children's. RN: registered nurse. HCSW: healthcare support worker.

Actions

- Continued scrutiny and redesign of Nurse & healthcare support worker rosters, reducing agency and bank use through tightened authorisation procedures and an accurate reflection of the whole-time equivalent-funded position.
- Recruit effectively to key vacancies that are driving high clinical staffing use or expenditure.
- Continue scrutinising bank and agency use through Grip & Control meetings.
- Implement the e-rostering solution for the medical workforce to reduce temporary staffing use.

Workforce: Agency

Workforce Highlights:

Registered Nurse

- The Trust has seen a decrease in temporary registered nurse agency staffing over the last 3 financial years. Average use fell from 88 whole-time equivalent in 2023/24 to 9 whole-time equivalent in 2025/26.
- Month 1 and Month 6 of this year are following a similar average use to that of 25/26.
- **Women's and Children's is the highest user of agency, for the 2nd month in a row.**

Medical & Dental

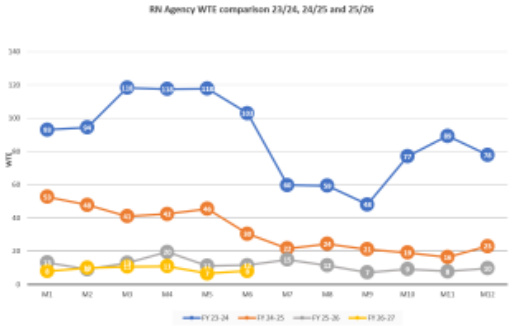
- Medicine is the highest user of agency staff in Month 6.
- The top three agency users in Month 6 are Obstetrics, Acute and Care of the Elderly.
- Comparing the same month in 2025/26 shows a 7 whole-time equivalent reduction in agency use.
- Surgery has not used agency staff for the last 7 months (Month 12–Month 6).

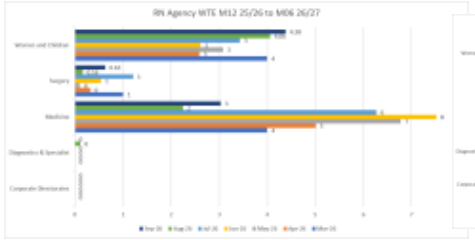
Areas for Concern:

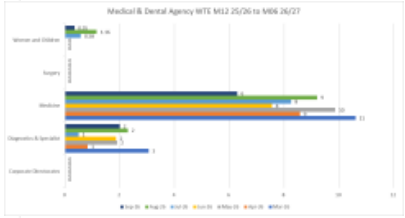
- Overall whole-time equivalent and spend on agency staffing have not yet met the Trust's 50% reduction target at Month 6.
- On-the-day sickness is the biggest driver of high-cost agency use for registered nurses.
- Women's and Children's registered nurse agency use is increasing and there is also medical agency use in the division. Obstetrics is now the highest agency user in the Trust.

Learning & Improvement:

- **Registered nurses —** As the trend for whole-time equivalent agency use in financial year 25-26 and Month 1-Month 6 use is broadly similar, it is reasonable to assume that Month 7 2026/27 will also see a similar whole-time equivalent use.
- **Medical & Dental** – Grip & control meetings are strengthening workforce planning by bringing focus to exit strategies and support measures to reduce reliance on agency staff. All agency workers are to get an exit plan, run-out date or substantive recruitment plan
- **Medicine—since Month 2, agency use has reduced by more than 7 whole-time equivalent.**







D&S: Diagnostics and Specialities. W&C: Women's and Children's. RN: registered nurse. HCSW: healthcare support worker.

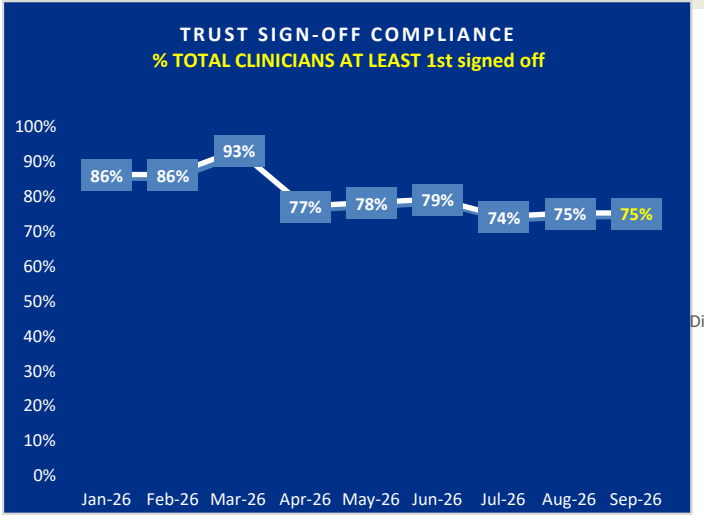
Actions

- Continued scrutiny and redesign of Nurse & healthcare support worker rosters, reducing agency and bank use through tightened authorisation procedures and an accurate reflection of the whole-time equivalent-funded position.
- Recruit effectively to key vacancies that are driving high clinical staffing use or expenditure.
- Continue scrutinising bank and agency use through Grip & Control meetings.
- Implement the e-rostering solution for the medical workforce to reduce temporary staffing use.

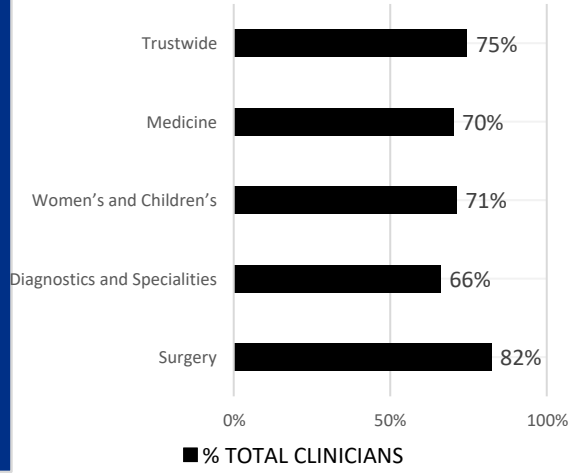
Job Plan Compliance *(Target: 95% job plan sign-offs by 31 March 2027)*

Workforce Highlights:

- Job planning is currently included in Provider Workforce Return reporting and is also a National Health Service 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 year's National Health Service England target was 95% sign-off by 31 March 2026; the Trust reached 93%, two percentage points short.
- Compliance fell from 93% to 77% in April and to 75% in September 2026. The initial drop followed the annual republication of about 25% of Trust job plans.



% Division JOB PLANs that are at least 1st SIGNED-OFF – Sept. 2026



Areas for Concern:

Since data submissions have been required for job planning metrics, the definitions and requirements have changed frequently. However, this report aligns with the most recent National Health Service England Provider Workforce Return 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 for September 2026 cover a Trust total of 598 clinicians (495 consultants and 103 SAS doctors).

Learning & Improvement:

- The last National Health Service England target for Consultant and SAS job plans was for 95% of Trust job plans to be at least first signed off by 31 March 2026. We managed to reach 93%, *just 2% shy of that goal.* We expect this target to remain for this new financial year. The current goal is to build on the work that achieved this result and meet subsequent milestones on time.

- Plans are also underway to switch the job planning software from ALLOCATE to HEALTHROTA. This is expected to improve the job-planning process, job-plan sign-off rates and 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 Speciality Directors, Clinical Leads, unit managers, Chiefs and other job planning stakeholders trust-wide.
- The Job Planning department continues to actively support clinicians and Leads with the process.

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Thank you

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Report to Trust Board

Date of Meeting	12 November 2026
Report title	Learning from Deaths Report (Q3 and Q4 2025/26)
Sponsoring Director/Author	Mark Pietroni, Medical Director and Director of Safety Jo Mason-Higgins, Acting Associate Director of Safety

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

Executive Summary

Alert

- Prolonged waits and overcrowding in the Emergency Department remain the most significant clinical concern affecting mortality.
- Healthcare Evaluation Data identified one red and three amber mortality alerts. These are statistical screening signals that prompt review; they do not, in themselves, demonstrate poor care or confirm excess mortality, and can be influenced by small case numbers and normal variation. Septicaemia was higher than expected nationally; aspiration pneumonia, dementia and two cardiology conditions also remain under review, while the Trust's overall mortality remained within the expected range.
- Bereaved family experience deteriorated in quarter three compared with quarter two: positive and exceptional feedback reduced by 8 percentage points and negative feedback increased by 5 percentage points. The Surgical Division had the largest deterioration, with positive feedback reducing by 29 percentage points. This position improved in quarter four, when Trust-wide positive and exceptional feedback increased from 78% to 83% and negative feedback reduced from 6% to 5%.
- External reviews of deaths of people with a learning disability or autistic people have taken up to one year, delaying learning and reducing assurance about timely oversight.

Advise

- The Board is asked to note recurring learning about clinical ownership, diagnostic and referral pathways, urgent result communication, electronic record reliability, end-of-life care, medication safety and the effect of operational pressure.

- Specialty leads will complete reviews of the identified mortality signals and report findings, actions and monitoring measures to the Hospital Mortality Group by 31 December 2026. The Medical Director will seek a recovery plan for delayed external reviews and report progress to the Quality and Performance Committee by 31 December 2026.
- The Thirlwall recommendations have an executive lead, the Chief Nurse, and a Task and Finish Group will commence on 22 October 2026 to drive the improvement work. Reporting arrangements will be confirmed by the Group.

Assure

- At March 2026, the Trust's twelve-month Summary Hospital-level Mortality Indicator was 0.91, equivalent to 91 deaths for every 100 expected deaths. It remained within the expected range, actual deaths continued to fall and there were no overall excess deaths.
- The structured judgement review dashboard now calculates the expected number of reviews at specialty level and reports completion and care-quality ratings over a rolling twelve-month period, improving the reliability and focus of oversight.
- Eleven patient safety investigations concerning patients who died were completed by the Patient Safety Team. Improvement or action plans were created and monitored by the Safety Executive Review Group, with evidence reviewed and assurance provided before closure during the reporting period.

Applaud

- Bereaved family experience recovered in quarter four following the quarter three deterioration: positive and exceptional feedback increased by 5 percentage points, from 78% to 83%, while negative feedback reduced by 1 percentage point, from 6% to 5%. Of 559 feedback records, 463 (83%) were positive or exceptional.
- Diagnostics and Specialties recorded the strongest quarter four improvement, with positive and exceptional feedback increasing by 21% and no negative Oncology feedback. Families continued to praise compassionate care, kindness, dignity and staff support.

Assurance opinion: Moderate assurance. The Board can take reasonable assurance that mortality remains within the expected range, deaths are identified and reviewed through established governance processes, bereaved family experience improved in quarter four, and learning from completed patient safety investigations has been implemented and assured through to closure. Assurance is not substantial because urgent and emergency care pressures persist, several mortality signals remain under review, completion of structured judgement reviews requires continued divisional and specialty oversight, and delays in external reviews of deaths of people with a learning disability or autistic people limit timely learning.

Previously considered by	Hospital Mortality Group and Quality and Performance Committee (October 2026)

Recommendations:

1. NOTE the moderate assurance opinion.
2. NOTE the issues and AGREE actions and timescales set out in the executive summary.

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?
Board Assurance Framework risk: Quality, Safety and Delivery

Implications on:	
Equality, Diversity and Inclusion	No Major changes
Health Inequalities	Development in Progress
Finance and Resource	No current impact
Regulation/Legal	The report ensures compliance with the National Guidance on Learning from Deaths.
Care Quality Commission key lines of enquiry	SAFE AND WELL-LED
Green Plan	No Impact

Main Report

LEARNING FROM DEATHS REPORT: 1 OCTOBER 2025 TO 31 MARCH 2026

1. Purpose and scope

This report provides assurance of the governance systems in place for reviewing deaths and demonstrated compliance with the National Guidance on Learning from Deaths. It summarises mortality, bereaved family feedback, structured judgement reviews, reviews of deaths of people

with a learning disability or autistic people, and learning from completed patient safety responses. Deaths that fall outside of the SJR process are confirmed in ***Appendix One***. All matters requiring Board awareness or decision are included in the executive summary.

2. Mortality overview

At the end of March 2026, the Trust's rolling twelve-month Summary Hospital-level Mortality Indicator was 0.91, equivalent to 91 deaths for every 100 expected deaths. The indicator had risen slightly in the latest month but remained comfortably within the expected range. Actual deaths continued to fall, crude mortality reduced and there were no overall excess deaths. Mortality increased by 0.16 at Gloucestershire Royal Hospital and by 1.89 at Cheltenham General Hospital. Death within thirty days of discharge increased by 1.44 at Gloucestershire Royal Hospital and by 4.98 at Cheltenham General Hospital; the Cheltenham change was concentrated in Oncology. These movements remain within the expected range but continue to be monitored.

Healthcare Evaluation Data showed one red and three amber diagnostic-group alerts. National data identified septicaemia as higher than expected. A clinical audit of cases clustered in April 2025 has been completed and an improvement plan is in progress; prompts for the Sepsis Six care bundle have been added to the electronic prescribing system to support earlier recognition and treatment. Aspiration pneumonia remained above expected levels and is under review by the lead allied health professional, including assessment of speech and language therapy provision. Dementia has alerted periodically over several years; improvement work is focused on avoiding unnecessary admission, making best use of frailty assessment, reducing bed moves and prioritising transfer from the Emergency Department. A cancer alert involved 18 cases and was assessed as sensitive to small monthly changes, with no clinical concern identified. Two cardiology conditions were also above expected levels and remain subject to specialty governance review.

Coding indicators provide further assurance: invalid primary diagnosis codes and symptom codes were below the national rate, indicating generally good coding quality. Coding depth was below the national average but remained within the expected range. Palliative care recording was also below the national rate and remains an area for improvement. Overall, the mortality position is within expected limits; prolonged waits and overcrowding in the Emergency Department remain the principal clinical risk.

3. Bereaved family feedback

The Bereavement and Medical Examiner Service recorded **1,063 items of feedback** across quarter three and quarter four. Feedback deteriorated in quarter three compared with quarter two, but recovered in quarter four. Trust-wide positive or exceptional feedback increased by 5 percentage points, from **78% in quarter three to 83% in quarter four**, while negative feedback reduced by 1 percentage point, from **6% to 5%**. This quarter four improvement provides positive assurance, although recurring concerns continue to require action and monitoring.

Trust-wide feedback	Quarter three	Quarter four
Total feedback	504	559
Exceptional	185	191
Positive	207	272

Positive or exceptional	**392 (78%)**	**463 (83%)**
Mixed or neutral	82 (16%)	67 (12%)
Negative	**30 (6%)**	**29 (5%)**

Division	Quarter three position	Quarter four movement	Assurance message
Medicine	Positive and exceptional feedback reduced by 3%; negative feedback increased by 4% (comparison with Q2)	Positive and exceptional feedback increased by 4%; negative feedback remained at 4%	Recovery is evident, with continued focus required on care, communication and end-of-life experience.
Surgery	Largest deterioration: positive feedback reduced by 29% and negative feedback increased by 9%. (comparison with Q2)	Positive and exceptional feedback increased by 8%; negative feedback reduced by 4%.	Quarter four improvement is positive.
Diagnostics and Specialties	Positive feedback reduced by 11% and negative feedback increased by 5%. (comparison with Q2)	Positive and exceptional feedback increased by 21%; negative feedback reduced by 5%.	Strongest recovery. All 23 Oncology responses were positive or exceptional.

What families valued	Recurring concerns	Overall assurance
• Compassionate and excellent care • Kindness and dignity • Support for patients and families	• Communication with families • Clinical care and safety • Delays, transfers and discharge • Privacy and dignity at the end of life	Quarter four recovery provides positive assurance that experience improved after the quarter three decline. Moderate assurance remains appropriate because recurring concerns require continued action and monitoring. Themes and trends from family and carer feedback are shared with the End of Life Group.

4. Structured Judgment Review

The input of the Bereavement Team continues to add huge value to our process. They continue to ensure all deaths are recorded in real time.

All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through individual speciality and divisional processes. The main learning from Structured Judgement Reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality. Divisional learning is presented to Hospital Mortality Group (HMG) on a rolling basis. Presentations are available for review, as required

All specialties receive individual monthly data on Structured Judgement Review (SJR) performance and report to Hospital Mortality Group (HMG) on a rolling basis where performance is reviewed. Most SJRs are undertaken within 2 months. 19.6% (Q3) and 19.0% (Q4) were reviewed via SJR; three deaths were identified as complaints

The following provides mortality data from 1st October 2025 to 31st March 2026. Between Q3 and Q4, deaths selected for SJR review fell slightly from 110 to 107. The proportion selected with family concerns reduced from 27.3% to 23.4%, while most cases in both quarters had no family concerns identified at selection. These figures describe the cases selected for review, rather than the review findings.

SJR Metrics - Trust Overall Position
Reporting Period 2025/26 - Q3 (Single Quarter)

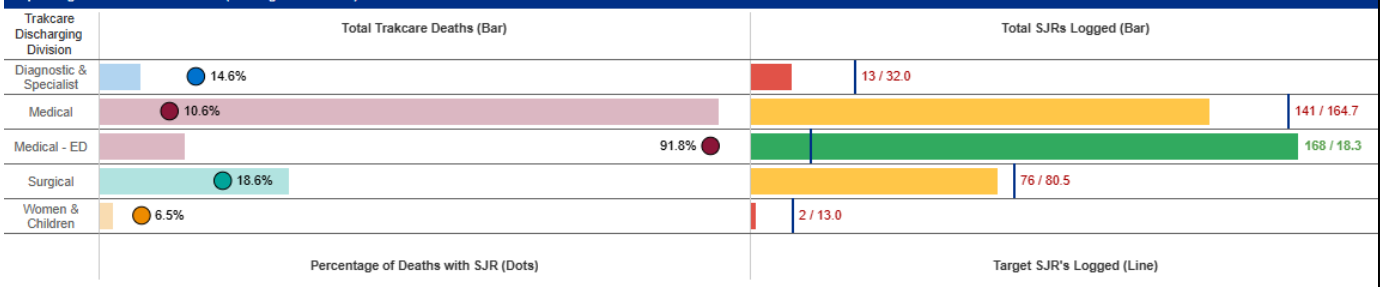
	Deaths as Harm complaints		Deaths Selected for Review with Concerns		Deaths Selected for Review with NO Concerns		Total Deaths Selected for SJR review	
Trust Overall Position	1	0.9%	30	27.3%	80	72.7%	110	21.7%

SJR Metrics - Trust Overall Position
Reporting Period 2025/26 - Q4 (Single Quarter)

	Deaths as Harm complaints		Deaths Selected for Review with Concerns		Deaths Selected for Review with NO Concerns		Total Deaths Selected for SJR review	
Trust Overall Position	2	1.9%	25	23.4%	82	76.6%	107	19.0%

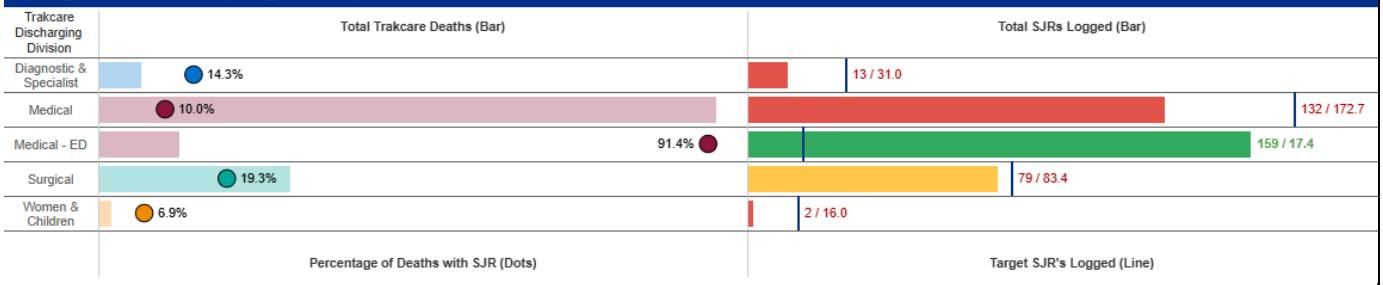
The data below shows completion against targets overall, by division or by specialty, and should be viewed over a rolling 12-month period. The target is 10% of deaths or 10 reviews, whichever is higher. Where there are fewer than 10 deaths, all deaths should be reviewed. The improved methodology adds together each specialty's expected reviews, rather than applying 10% to the combined total, giving a more accurate overall target.

Total Trakcare Deaths in Period	Percentage of Trak Deaths with SJR	Total SJR Recorded	Target SJR Recorded	Total Specialties with Deaths	Specialties Above Target
2,036	19.6%	400	308.5	29	7



Quarter 3

Total Trakcare Deaths in Period	Percentage of Trak Deaths with SJR	Total SJR Recorded	Target SJR Recorded	Total Specialties with Deaths	Specialties Above Target
2,022	19.0%	385	320.5	31	7



Quarter 4

Feedback on progress is provided to the Hospital Mortality Group. The SJR approach is embedded within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

No deaths were escalated to harm review panels following SJR. Three complaints, in the reporting period, related to care/treatment concerns in the episode of care leading to the death. The chart below shows a breakdown by SJR trigger types and care scores for Quarter 4.



5. Reviews of deaths of people with a learning disability or autistic people

All deaths of people with a confirmed learning disability or autism are reported for an external review under the national Learning from Lives and Deaths programme. Death numbers are usually low, averaging one or two each month, although there can be marked variation between quarters. The Trust Learning Disability Team supports the review process by helping reviewers interpret hospital records, including where a person received care from the Trust but died in another setting.

External review provides an important source of independent learning and assurance, but the process is not sufficiently timely. Reviews require engagement with families and carers, consideration of professional records and completion of an independent report before consideration by the quality assurance panel. Earlier reports described a usual delay of at least six months; some current reviews have taken up to one year. This limits timely feedback to families and services and reduces the opportunity to act promptly on learning.

The usefulness of completed reviews can also be restricted where family consent is not provided to share identifiable feedback with the staff involved. The quality assurance panel has therefore considered how learning can be shared proportionately without disclosing information that families have not agreed may be shared. This remains important to ensure that independent review results in learning at service level while respecting family choice and confidentiality.

Previous reviews and family feedback have highlighted the need for appropriate environments, including access to side rooms where possible because busy bays can be distressing for some

people with a learning disability or autism. Families have consistently valued support from Learning Disability Liaison Nurses, palliative care teams and bereavement services. These positive elements provide assurance about specialist and compassionate support, while constraints in the physical environment and delays in external review remain limitations.

The Medical Director will seek a recovery plan and delivery timescale from the Integrated Care Board for outstanding reviews and report progress to the Quality and Performance Committee by 31 December 2026. The assurance sought is that reviews are completed more promptly, learning is shared appropriately and actions arising from reviews are connected to Trust mortality and improvement governance.

A completed learning response involving a person with a learning disability identified prolonged Emergency Department care, atypical presentation of pain, unclear clinical ownership, limited access to an appropriate assessment space and insufficient escalation. Learning has been linked to twelve-hour escalation, communication between specialties, end-of-life improvement work and multidisciplinary mortality review.

6. Learning from completed Patient Safety Learning Responses

Eleven patient safety reviews, concerning deceased patients, were completed by the Patient Safety Team and closed during the reporting period. Each investigation identified learning and resulted in an improvement or action plan. The Safety Experience and Review Group monitored delivery of these plans, reviewed the evidence of completion and provided assurance before approving closure. The individual summaries below therefore describe investigations for which the identified learning has been acted upon and the associated improvement or action plans have been assured through to closure.

Case	Investigation summary, learning implemented and assurance
Missed opportunity to provide optimal end-of-life care	A patient with a learning disability remained in the Emergency Department for almost 48 hours and died while awaiting a ward bed. The review identified atypical pain presentation, unclear clinical ownership, poor coordination between teams and failure to escalate the lack of a suitable assessment space. Learning has strengthened escalation for patients awaiting admission for more than 12 hours, communication between specialty and Emergency Department teams, end-of-life improvement work and multidisciplinary mortality learning. This provides assurance that the specific care and escalation gaps have been identified and incorporated into improvement work.
Pseudomonas aeruginosa bloodstream infection	Microbiological typing linked the patient's infection to contaminated shower water. The review identified weaknesses in water-safety communication, risk assessment, sampling, flushing, maintenance, documentation and audit. A written water-safety scheme, more reliable testing and maintenance, staff competency requirements and joint oversight through the Water Safety

	Group have been established or strengthened. Longer-term actions remain monitored through the Water Safety Group and the related Trust risk.
Delay in diagnosis and treatment of cholangiocarcinoma	An abnormality reported on ultrasound was not sufficiently prominent and was easier to overlook, contributing to diagnosis approximately eight to ten months later. Earlier treatment might have extended survival, although cure was considered unlikely. Learning has led to clearer presentation of sonographer concerns, an agreed reporting procedure, report spot checks, stronger sharing of new clinic correspondence and joint governance review across Radiology and Gastroenterology.
Anticoagulation and antiplatelet treatment before recognition of severe thrombocytopenia	Repeated platelet results were reported as unreliable, but this was not communicated prominently enough to support recognition of bleeding risk before anticoagulant and antiplatelet treatment. The review found that the cumulative treatment was likely to have increased the risk of intracranial bleeding. Learning includes review of the acute coronary syndrome policy, clearer electronic warning of unreliable platelet results, consideration of prescribing alerts and stronger diagnostic review when test results and the clinical picture do not align.
Delay to medical review and treatment	A patient remained physically present in the Emergency Department but was recorded electronically as having left, making the patient invisible to the medical team. The patient went approximately 36 hours without routine observations or treatment for the underlying condition. Learning has strengthened reconciliation of electronic status with patients present, escalation when a patient cannot be located, two-hourly checks, review of retrospective record changes and audit of alcohol-withdrawal monitoring.
Management of a patient with chest pain	A welfare call was not made after the patient left before review, a later opportunity for senior assessment was missed, and an electronic chest pain referral failed without the referrer knowing. This resulted in 26 days without planned follow-up or treatment. Learning has strengthened welfare-call practice, Emergency Department and chest-pain guidance, discharge summaries and immediate confirmation that electronic referrals have been submitted and received.
Oxycodone toxicity during end-of-life care	An opioid-naive patient developed signs consistent with opioid toxicity after regular subcutaneous oxycodone was prescribed outside the anticipatory medication order set. Pain assessment was not consistently recorded and recognition was complicated by the patient's underlying

	condition. Learning has strengthened use of safer prescribing pathways, pain assessment, access to end-of-life training and resources, local clinical champions and staff confidence to question prescriptions irrespective of hierarchy.
Delayed biopsy and communication of urgent results	An urgent biopsy request was entered through the wrong route and was not visible on the pending list. Subsequent results continued to be attributed to a consultant who was not overseeing the pathway. The review did not conclude that earlier detection would have prevented the death. Learning has strengthened referral coding, clinical ownership across specialties, communication with Radiology, leave cover and resilient acknowledgement of urgent results.
Emergency response based on outdated pregnancy information	Electronic records incorrectly indicated an ongoing pregnancy, leading the team to undertake an emergency procedure in accordance with the information available. The procedure did not impede resuscitation and was not related to the death. Learning has improved closure and visibility of pregnancy records, work on interoperability between systems, neonatal equipment checks and multidisciplinary simulation for this emergency response.
Missed pneumothorax following Emergency Department attendance	A pneumothorax visible on initial imaging was not identified and the patient was discharged. Diagnostic momentum, cognitive bias, operational pressure and limitations in the imaging pathway may have narrowed the clinical focus. Learning has been shared with the external reporting provider and through relevant governance forums, linked to the Emergency Department flow risk and supported by continued review of compliance with the National Early Warning Score observations.
Delay to wide local excision following malignant melanoma	A wide local excision agreed by the multidisciplinary team was not booked, resulting in a delay of approximately seven months. The review did not establish that the delay caused later metastatic disease, but found that decisions were not reliably recorded and tracked to completion. Learning has led to review of the multidisciplinary process, identification of any other affected patients, audit of completed actions and development of prospective tracking.

7. Actions

Action	Owner and timescale

Complete current reviews of the identified mortality signals and confirm findings, improvement actions and monitoring measures.	Specialty leads; reporting to the Hospital Mortality Group.
Obtain a recovery plan for delayed external reviews of deaths of people with a learning disability or autistic people.	Safeguarding leads/Medical Director, reporting to the Hospital Mortality Group
Review the End-of-Life Group workplan and ensure that improvement workstreams are in place to address themes and trends identified through family feedback.	Associate Director of Safety and Learning with End-of-Life Group leads.

8. Conclusion

The overall mortality position and established review routes support moderate assurance. The remaining gaps concern operational pressure, timely completion of external reviews, unresolved mortality signals and evidence that learning actions are embedded and sustained. These matters will continue to be monitored through established governance, with exceptions reported to the Quality and Performance Committee.

Appendices: Appendix One – Deaths outside of the SJR Process

Freedom of Information status: Public; no patient-identifiable information.

Appendix One

Deaths outside the SJR Process

	Oct-Dec 23	Jan-Mar 24	April – June 24	Jul-Sept 2024	Oct-Dec 2024	Jan-March 2025	April – June 2025	July to Sept 2025	Oct-Dec 2025	Jan-March 2026
SB >24 wks	5	5	6	2	9	3	4	5	2	3
NND >24 wks Born at GRH/Died GRH	1	1	1	0	0	2	0	1	0	3
NND <24 wks Born at GRH/Died GRH	3	0	1*	2* (x1 TOP)	0	3	1*	1	2	1
NND >24 wks Born & Died Elsewhere	0	0	0	1	1	0	0	2	0	0
NND <24 wks Born & Died Elsewhere	0	0	0	0	1	0	0	0	0	0
NND >24 wks Born GRH & Died Elsewhere	1	1	0	1	0	1	0	1	0	0
NND <24 wks Born GRH & Died Elsewhere	0	0	0	0	0	0	0	0	0	0
Post Neonatal death	1**	1	0	1	0	0	0	0	0	0

Deaths by Special Type	Oct-Dec 23	Jan to March 24	April-June 24	Jul-Sept 2024	Oct-Dec 2024	Jan-March 2025	Apr-June 2025	July – Sept 2025	Oct-Dec 2025	Jan-March 2026

Maternal Deaths (MBBRACE)	0	0	0	0	1	0	0	0	0	0
SI/PSIRF Learning Response Deaths ***Figures represent number of learning response action plans (relating to patient deaths) closed in reporting period.**	8*	7*	6*	3*	4	6	13	5	7	4
Learning Difficulties Mortality Review (inpatient deaths)	4	6	11	4	11	4	6	4	TBC	TBC

- * NND under 24 weeks noted but not required to be reported through MBRRACE.

Gloucestershire Hospitals NHS Foundation Trust

Report to Trust Board of Directors

Winter Plan Update — November 2026

Meeting / report	12 November 2026 — Winter Plan 2026/27 update
Sponsor / author	**Sponsor:** Al Sheward — Deputy Chief Executive and Chief Operating Officer **Author:** David Taylor — Interim Deputy Chief Operating Officer, Urgent and Emergency Care and Hospital Flow

Purpose: Discussion, information and assurance; not approval.

Executive Summary

Assure: Urgent Treatment Centre (UTC) phase 1 is operational, vaccination is underway and Exercise Goldfinch is complete. Discharge Lounge extensions and January therapy deployment remain planned. Assurance is partial pending confirmed readiness and sustained system flow.

Advise: Priorities are front-door assessment, discharge, workforce resilience, infection control and urgent elective and cancer care. Fortnightly reviews and Operational Pressures Escalation Levels (OPEL) guide delivery. The activity predictor informs capacity planning; national infection scenarios are not local forecasts.

Alert: Outstanding dependencies include festive cover, delayed Urology developments, reliable flow data, cohorting and seven-day discharge across Pathways 1–3, community capacity and system surge arrangements.

The Integrated Care Board (ICB) winter stress test is scheduled for 9 November 2026.

Previously considered by	Winter Planning Task and Finish Group; Divisional Operational Assurance Group; Urgent Care and Flow Improvement Board; Trust Leadership Team (TLT); Quality and Performance Committee (QPC), 29 October 2026.

Recommendations:

The Board is asked to:

- **NOTE** delivery progress and regional comparisons.
- **RECOGNISE** partial assurance pending workforce, pathway, data and system-flow readiness.
- **SUPPORT** outstanding actions and escalation through OneGloucestershire governance.
- **RECEIVE** monthly Quality and Performance Committee assurance on winter preparedness

Strategic Aims (tick as appropriate)	
Patient experience and voice	✓

People, culture and leadership	✓
Quality, safety and delivery	✓
Digital first	

Impact on any Strategic Risks?
Mitigates risks to patient safety, urgent care, capacity, workforce, infection control, estates and elective and cancer delivery. Residual risk remains during sustained extreme pressure.

Implications	
Equality and health inequalities	Monitor differential impacts; target vaccination, community response and home-first care using population risk intelligence.
Finance and resources	Use existing capacity; additional resources require financial approval and operational benefit.
Regulation and assurance	Supports NHS England winter requirements, OPEL, emergency preparedness and infection-control duties; aligns with Care Quality Commission (CQC) Safe, Responsive and Well-led domains.
Green Plan	Same-day and home-based care reduce travel and inpatient resource use; no material adverse impact identified.

Main Report

1. Purpose
This report updates the Board on Winter Plan delivery and residual risks at the end of October. The plan runs from 1 November 2026 to 31 March 2027, focusing on Christmas, New Year and early January. Fortnightly Winter Preparedness Incident Management Teams (IMTs) bring together divisions, corporate services and Gloucestershire Managed Services (GMS).

2. Assurance position
Assurance remains partial. Divisional actions have owners and deadlines, but final festive rotas and leadership cover require confirmation following the week commencing 2 November deadline. Risks include sickness, temporary staffing, magnetic resonance imaging (MRI) resilience, system flow and care-home infection prevention and control (IPC) support. GMS has provided staffing and estate assurance; IMTs will verify remaining readiness.

3. Winter implementation and key controls
Medicine

- UTC phase 1 and long-stay reviews are operational. Dedicated paediatric emergency department (ED) cover and rapid assessment are delayed to mid-November.
- NHS England South West has provided £327,000 for overnight staffing and front-door streaming. Twelve-hour frailty and management cover is confirmed for implementation before peak winter.

Surgery
Critical care winter plans and trauma oversight are in place. Surgical Assessment Unit arrangements and elective flexibility are being finalised. Urology Assessment Unit opening has moved to mid-December, with further delay possible.

Diagnostics and Specialties
Discharge Lounge hours of 06:00–20:30 are planned for 21–24 and 29–31 December and 4–8 January; additional therapy support is planned for 4–15 January. Pharmacy, diagnostics and urgent interventional radiology arrangements remain under finalisation.

Women's and Children's
Paediatric Assessment Unit expansion has been tested and can be activated as needed. Additional community outpatient and primary care respiratory provision is in place.

Command and Control
- Operational, flow and incident hubs are co-located. Care Transfer Hub and Pathways 1–3 delivery depend on partner capacity.
- Exercise Goldfinch and severe-weather Emergency Preparedness, Resilience and Response (EPRR) exercises are complete; the ICB stress test is on 9 November.
- The revised escalation policy goes to TLT in November, covering ED, mental health, stroke and frailty. Corridor-care guidance and staff action cards are being trialled.

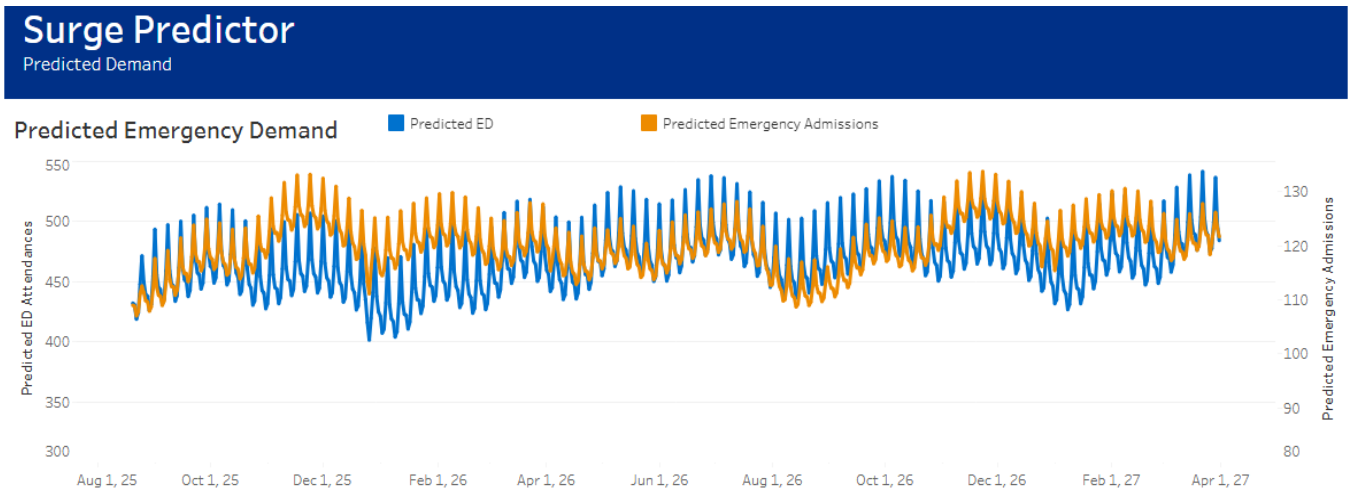
GMS
- GMS confirms round-the-clock festive domestic, portering and security cover; estate maintenance and winter preparation are underway.

4. Predicted activity and capacity
Overall, we compare quite favourably with the Southwest. Several of the core flow measures place Gloucestershire amongst the best-performing providers in the region. - The strengths are non-elective length of stay, discharge before midday and discharge-ready-date performance, where Gloucestershire ranks 1st on the six-week averages. - We are also performing above the regional average on both four-hour measures, despite relatively high activity. Gloucestershire has the second-highest all-type A&E attendance volume in the region, at 5,316 per week. - The main comparative weaknesses are weekend discharge and 21+ day stays. The latter is particularly important because Gloucestershire has experienced the largest year-on-year deterioration in the region, +4.2 percentage points. - 12-hour waits and corridor care remain significant, although these absolute-volume rankings need some caution because larger providers naturally generate larger numbers. - There is a positive signal on ambulance handovers: Gloucestershire's six-week position is strong, and the report forecasts an 86% reduction in >45-minute handovers, the strongest projected improvement in the Southwest.

Measure	Gloucestershire	South West	Approx. SW rank	Position
Ambulance handovers >45 mins	**4.9%**	18.6%	**2nd / 11**	□ Very strong
A&E 4-hour, all types	**73.7%**	70.0%	**4th / 11**	□ Above region
A&E 4-hour, Type 1	**60.6%**	57.5%	**4th / 11**	□ Above region
Non-elective length of stay	**6.3 days**	7.6 days	**1st / 11**	□ Best
Discharged before midday	**26.8%**	20.4%	**1st / 11**	□ Best
Discharged before 5pm	**77.4%**	67.9%	**2nd / 11**	□ Very strong
Discharge-ready date on time	**92.6%**	85.6%	**1st / 11**	□ Best
12+ hour waits	**334/week**	2,912/week region total	**9th / 11***	◍ High absolute volume

Bed occupancy	**91.8%**	93.8%	**4th / 11**	□ Better than region
21+ day stays	**18.7%**	17.8%	**8th / 11**	🟤 Below region
Weekend discharge	**52.1%**	56.5%	**9th / 11**	🟤 Weak
Corridor care	**27/day**	230/day region total	**8th / 11***	🟤 High absolute volume

The predictor below informs daily attendance, admission, occupancy and discharge planning. Earlier and increased discharges, supported by planned lounge extensions and therapy deployment, aim to release capacity before Christmas and sustain it into January.

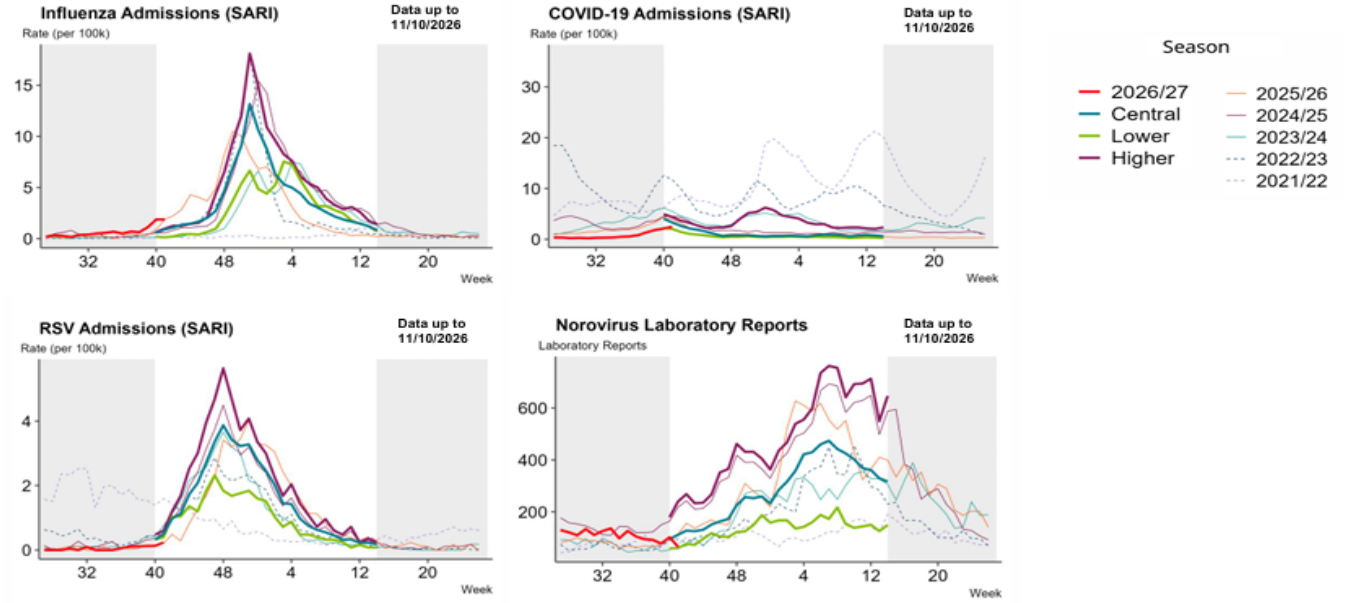


The November–December discharge sprint aims for 80% occupancy before Christmas. The 9 November stress test will examine extending that ambition to 1 January, rather than 24 December alone, to protect capacity for the January peak.

5. Predicted infection rates and Infection, Prevention and Control readiness

Current 2026/27 flu picture

National influenza impact is expected around the four-season average, but peak timing remains uncertain. The illustrative combined peak of influenza, COVID-19, respiratory syncytial virus (RSV) and norovirus is around 6,000 occupied beds daily: a planning scenario, not a forecast. It assumes approximately 75% vaccination uptake in people aged 65 and over.



Red line: latest England 2026/27 data; comparisons: central, lower- and higher-impact scenarios and previous years.

What Gloucestershire Hospitals NHS Foundation Trust (GHFT) is seeing

Respiratory admissions and outbreaks eased in late October but remained above seasonal levels. Point-of-care testing (POCT) began in late September, earlier than last year; national respiratory surveillance engagement has restarted.

Enhanced personal protective equipment (PPE) stocks, monitoring and seven-day IPC outbreak support are in place. Outstanding requirements are norovirus testing validation, filtering face piece class 3 (FFP3) respirator fit testing, cohorting and testing coverage. Universal masking preparations remain conditional. The care-home IPC support gap risks transmission and additional hospital conveyances.

Vaccination

By October's end, 4,455 flu vaccinations had been delivered. Clinics run 1 October–14 December with roving provision. Staff uptake is being calculated for the next IMT against the ambition to exceed 67%.

6. Outstanding actions before peak winter

- Confirm service readiness, festive rotas and leadership cover; monitor sickness risks.
- Complete the 9 November stress test and escalate partner capacity and surge gaps.
- Establish daily system discharge oversight to reduce stays beyond the discharge-ready date (DRD).
- Agree the 80% occupancy bed base, discharge contribution and partner capacity.
- Implement exercise learning and action cards; test outbreak, cohorting and testing arrangements.

7. Conclusion

Assurance remains partial until readiness and sustained system discharge are evidenced. Internal measures cannot resolve seven-day Pathways 1–3, community capacity and surge gaps alone. Partner commitments, clear ownership and escalation through system governance are essential to reduce delayed discharge, ED waits and ambulance handovers.

8. Recommendations to the Trust Board

The Trust Board is asked to:

- **NOTE** Winter Plan delivery and regional comparisons.
- **RECOGNISE** partial assurance pending workforce, pathway, data and discharge readiness.
- **SUPPORT** section 6 actions, accountable ownership and OneGloucestershire escalation.
- **RECEIVE** monthly QPC assurance on delivery, safety, activity against forecast, infection-related capacity loss and exceptions.

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 12 November 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the People, Place and Partnerships Committee held on 15 September 2026
Board member lead(s)		Vareta Bryan, Non-Executive Director (Chair)
Written by		Committee Chair and Trust Secretary
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

- To present an update to the Board of Directors from the quorate People, Place and Partnerships Committee meeting held on 15 September 2026.
- The Committee reviewed workforce sustainability and transformation, staff experience, equality and inclusion, resident doctors' working arrangements, employee relations, consultant recruitment, workforce risks, internal audit and development of the Committee's place and partnership remit.

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.

- **Internal Audit Report - Recruitment controls:** The recruitment audit received limited assurance, principally due to weaknesses in checks for agency and off-payroll workers and identity checking in clinical areas. An immediate task-and-finish group and rapid risk assessment had been established, with progress to be reported to the Audit and Assurance Committee and this Committee.
- **Specialist workforce capacity and operational impact:** Significant residual risks remained in specialist and hard-to-fill groups, particularly within Diagnostic Specialties and Surgery. The Committee highlighted the relationship with operational performance, including cancer performance, and requested clearer articulation of controls, impact and required action.
- **Workforce inequalities:** The annual equality report identified continuing inequalities in workforce experience, career progression, recognition and pay. Clear priorities, timescales and evidence of sustained improvement are required, alongside preparation for mandatory ethnicity and disability pay-gap reporting from April 2027.

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

- **Workforce Sustainability Programme:** The reset programme brings together workforce planning, attraction, retention, deployment, affordability, productivity, digital transformation and workforce data. It must demonstrate benefits for patient care, service strategy, staff wellbeing and community benefit, rather than being understood solely as workforce reduction.
- **People and OD delivery and Staff Experience frameworks:** The Committee supported both developing frameworks but requested clearer timelines, measurable outcomes, plain English communication and stronger ownership across operational and corporate directorates.
- **Employee relations:** Delays remained in disciplinary cases because of limited trained investigating-officer capacity and difficulties securing management time. The report was received as a progress update rather than assurance, and a future report will be expected to demonstrate impact.
- **Consultant recruitment:** Further work was required on shortlisting, values and inclusion assessment, structured scoring, panel training and reasonable adjustments. The revised procedure will be consulted upon with the Local Negotiating Committee before returning for approval.
- **Board Assurance Framework:** The Committee supported development of a single combined workforce strategic risk. The final proposal will return to the Committee before recommendation to the Board.
- **Place and partnership remit:** The Committee supported further development of its terms of reference, membership, delegations and work plan. The remit must remain focused, avoid duplication and provide clear oversight of a manageable number of priorities.

ASSURE: inform the board where positive assurance has been received

- **Integrated workforce oversight:** The refreshed programme will include defined milestones, benefits, key performance indicators, risks and executive oversight. An integrated monitoring report is being developed covering establishment, vacancies, sickness, retention, temporary staffing, workforce plans and productivity.
- **Staff Survey governance:** The 2025 improvement programme was closing, with actions continuing through divisional people boards and established governance. Findings had been reviewed at Trust, divisional, service-line and team level and triangulated with wider evidence.
- **Resident doctor exception reporting:** The common rostering and reporting platform had improved visibility and enabled potentially unsafe rota arrangements to be identified for follow-up. No patient harm had been identified and quarterly Committee monitoring and annual Board reporting will continue.
- **Employee relations oversight:** High-risk cases were subject to monthly confirm-and-challenge review and additional HR resource had been agreed to address investigation capacity.
- **Audit follow-up:** The performance appraisal audit remained on track. The Committee welcomed a 12-month effectiveness review to test whether previous recommendations and controls remain embedded.

- **Workforce risk management:** Active workforce risks had reduced from 59 to 44 since January 2026, with most remaining risks stable or improving.

APPROVALS: decisions made by the Committee

- No formal approvals were made at this meeting. The Committee supported further development of the combined workforce strategic risk and revised place and partnership governance arrangements, both of which will return through the appropriate approval route.

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	SR02 and SR03. The Committee supported further development of a single combined workforce strategic risk before recommendation to the Board.

Risks discussed

Principal risks: Workforce sustainability, affordability and capacity; specialist and hard-to-fill workforce gaps; staff experience, wellbeing and organisational culture; workforce transformation and service stability; equality of experience, progression and pay; resident doctor rota safety and reliance on locums; employee relations delays; recruitment control weaknesses; consultant recruitment fairness and inclusion; and governance of the developing place and partnership remit.

Recommendations

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- **NOTE** the assurance provided in this report.

- **NOTE** that the combined workforce strategic risk and revised place and partnership governance arrangements remain under development and will return through the appropriate governance routes.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12 November 2026
Report title	Equality, Diversity and Inclusion Development within the Staff Experience Framework
Sponsoring Director: **Authors:**	Caroline Julien: Chief People Officer Maria Smith: Associate Director for Organisational Development, Culture and People Development

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

Executive Summary

This paper provides an update on how equality, diversity and inclusion development is being brought together within the Staff Experience Framework and the wider Staff Experience and Equality, Diversity and Inclusion Plan.

The Staff Experience Framework sets out the shared vision and principles for the experience the Trust wants to create for all colleagues. The Staff Experience Programme translates this into coordinated action through six workstreams. The Inclusion, Belonging and Staff Voice workstream provides the organisational home for the Trust's equality, diversity and inclusion programme of work.

The approach aims to embed equality, diversity and inclusion in how the Trust leads, listens, makes decisions and improves staff experience, rather than treating it as a separate set of activities. Current development focuses on strengthening Staff Networks, establishing a shared Trust-wide approach to inclusive leadership, improving how staff voice leads to visible action, clarifying organisational expectations and unacceptable behaviours, and developing an integrated evidence base to understand staff experience and inequality.

The Board supported by the Trust Leadership Team, provides strategic leadership and set organisational expectations. The Staff Experience Committee oversees and challenges delivery of the programme. The People and Organisational Development Delivery Group coordinates wider delivery across People and Organisational Development services and addresses cross-service dependencies. The People, Place and Partnership Committee receives assurance on progress, outcomes, inequalities and significant risks.

Assurance remains developmental. Governance is clearer, but the integrated baseline, outcome measures, project ownership, milestones and evidence of sustained impact are still being established through the Staff Experience and Equality, Diversity and Inclusion Plan. Until

the baseline is complete, the Trust does not yet have a sufficiently integrated evidence base to describe the full scale and pattern of inequalities across every aspect of staff experience. The next phase will move the work from programme design into implementation and measurable improvement. Future reporting will show progress against the agreed baseline and measures, including whether inequalities are narrowing, staff experience is improving, colleagues feel a stronger sense of belonging and psychological safety, confidence in speaking up increases, and staff voice demonstrably influences organisational decisions and action.	
Previously considered by	None

Recommendations:
The Board is asked to: **NOTE** the update on EDI development within the Staff Experience Framework and the Inclusion, Belonging and Staff Voice workstream. No decision, approval or endorsement is requested.

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

Impact on any Strategic Risks?
Board Assurance Framework Strategic Risk: **People Culture and Leadership** If we fail to attract, develop, engage and retain a skilled, diverse, compassionate and high-performing workforce, supported by effective leadership, culture and workforce systems, it may adversely impact patient safety, quality of care, operational performance, financial sustainability and delivery of the Trust's strategic objectives.

Implications on:	
Equality, Diversity and Inclusion	This paper directly supports the Trust's approach to equality, equity, diversity, inclusion and belonging, including leadership accountability and reducing inequalities in workforce experience.
Health Inequalities	The Staff Experience Programme supports a more inclusive workforce culture and strengthens the Trust's ability to

	understand how workforce experience, inclusion and inequality may affect the delivery and experience of care.
Finance and Resource	Delivery will primarily be through existing Board, leadership, Staff Experience and Organisational Development arrangements. The programme governance process will identify any additional resource requirements.
Regulation/Legal	Supports compliance with the Equality Act 2010, the Public Sector Equality Duty and relevant NHS workforce expectations. Specific actions will continue to be reviewed through appropriate legal and governance routes.
CQC-Key line of enquiry	Care Quality Commission Well-Led domain - culture, leadership, staff experience, equality, diversity and inclusion, and Freedom to Speak Up.
Green Plan	No direct implications identified.

Main Report

1. Purpose of the report
This paper provides an update on the Trust's evolving approach to Equality, Diversity and Inclusion (EDI) within the Staff Experience Framework. It explains how development with the Board, the Trust Leadership Team and Staff Networks is being connected through the Inclusion, Belonging and Staff Voice workstream, incorporated into the wider Staff Experience Framework and Programme, and governed by the Staff Experience Committee.
The paper is for information. It does not ask the Board to approve, support or endorse a proposed approach.

2. How the work fits within the Staff Experience Framework
The Staff Experience Framework defines a good staff experience across our Trust. The Staff Experience Programme delivers it through coordinated action, clear accountability, and impact measures. The Staff Experience Committee oversees progress, provides assurance and challenge, and drives meaningful, sustainable improvements. Members include Staff Network chairs, workstream leads, divisional colleagues, and staff side.



Within this structure, the Inclusion, Belonging and Staff Voice workstream coordinates EDI development and ensures that inclusion, belonging and staff voice are connected to leadership practice, organisational improvement and assurance rather than operating as a separate programme.

Component	Role within the approach
Board	Sets organisational culture and provides strategic oversight and accountability
Trust Leadership Team	Translates organisational expectations into executive, divisional and operational leadership practice
Staff Networks	Provide lived-experience insight, challenge, connection and partnership in shaping improvement
Inclusion, Belonging and Staff Voice workstream	Coordinates development, identifies priorities, connects staff voice to action and monitors delivery
Staff Experience Committee	Oversees delivery of the Staff Experience Programme, monitoring progress, outcomes, risks and dependencies across its workstreams and ensuring staff voice informs improvement
People & OD Delivery Group	Connects the work of the Staff Experience Programme with wider People and OD priorities, coordinating activity across Divisions, addressing cross-service dependencies and escalating issues that cannot be resolved through the programme.
People, Place and Partnership Committee	Receives assurance on delivery, outcomes, inequalities and areas requiring escalation.

3. Current areas of development

The workstream is bringing together several connected projects and areas of development. The focus is on moving from broad EDI and staff experience ambitions to clear organisational expectations, practical action and measurable improvement.

- **Staff Network Reset, Refresh and Relaunch:** Strengthen Networks' purpose, sustainability and influence by supporting Chairs, clarifying executive sponsorship and how Networks work with the organisation, and creating clearer routes for staff insight and lived experience to shape decisions and improvement.
- **Trust-wide inclusive leadership:** Develop a shared Trust-wide approach to inclusive leadership, with clear expectations appropriate to different leadership roles and levels. Further detail is set out in section 4.
- **Integrated staff experience and equality evidence:** Combine workforce equality measures, Staff Survey and employee relations data, speaking-up themes, recruitment, progression, retention, sickness, exit information and qualitative insight. Build a fuller picture of differing staff experiences and where action is needed. This approach is reflected in the current Board paper.
- **Outcome and inequality measures:** Track changes in staff experience, not just activity, including belonging, respect, psychological safety, confidence to speak up, line management experience, and workforce inequalities.
- **Accountability and governance:** Bring this work into one Staff Experience Programme with defined projects, owners, measures, milestones and reporting through the Staff Experience Committee and People and OD governance. Review progress, risks, inequalities and impact together.

4. Development of the Trust-wide inclusive leadership approach
The Board, Trust Leadership Team, divisional leaders, managers, Staff Networks, staff-side representatives, and wider staff are developing a Trust-wide inclusive leadership approach. It will establish clear, consistent expectations for inclusive leadership at all levels, while recognising that responsibilities will differ by role and level of leadership.

The approach will bring together Board and senior leadership development, the Staff Networks Reset, Refresh and Relaunch work, engagement with staff and staff-side representatives, and evidence on staff experience and equality. This will create one coherent Trust-wide approach, rather than a series of separate equality, diversity and inclusion activities.

For the Board, the work will consider its role as the Trust's culture setter and how it demonstrates that responsibility in practice. This will include how Board members:

- model inclusive leadership;
- use equality and staff experience evidence in decision-making;
- listen and respond to staff voice;
- understand differences in workforce experience; and
- hold the organisation to account for progress and outcomes.

The approach will translate these principles into practical expectations for leaders and managers at Trust, divisional and team levels. The Inclusion, Belonging and Staff Voice workstream and the Staff Experience Committee will oversee development and implementation, with wider coordination through the People and Organisational Development Delivery Group and assurance through the People, Place and Partnership Committee.

5. Staff Networks and meaningful staff voice
Staff Networks are central to the Inclusion, Belonging and Staff Voice workstream. Development focuses on strengthening their purpose, sustainability, leadership, sponsorship,

and influence. The intention is not only to increase opportunities for staff to speak, but also to create a clearer pathway from lived experience and insight to action, learning and assurance. Create staff-led communities to drive creativity and ambition across the organisation.

The programme will therefore monitor whether issues raised through Staff Networks and other staff voice routes have named owners, receive timely responses, and lead to visible feedback or improvement, and ensure the networks are supported and enabled to enact change.

6. Organisational expectations and red lines
The Trust already has policies, professional standards, values and legal duties that govern workplace behaviour. This work will not create a new set of rules. It will bring greater clarity and consistency to the behaviours and conduct that the Trust will not normalise or leave unchallenged, regardless of role or seniority.

These behaviours include unlawful discrimination, bullying, harassment, victimisation, sexual misconduct, retaliation against people who speak up, deliberate exclusion from opportunities or decisions, and repeated behaviour that undermines dignity or physical or psychological safety. The organisational expectations will be developed and tested with leaders, staff, Staff Networks, staff-side representatives, and relevant People, professional, policy and experts. They will be informed by existing Trust policies, employment and equality law, Freedom to Speak Up arrangements, and the principles of a just and restorative culture.

The work will clarify:

- how unacceptable behaviour is recognised;
- the routes through which staff can raise concerns;
- how concerns are assessed, responded to and escalated;
- the support and protection available to affected staff and people who speak up;
- how consistency and fairness will be monitored; and
- how recurring themes and learning will be identified and acted upon.

Concerns will be managed through the appropriate Trust process, taking into account evidence, seriousness, context and behavioural patterns. A just, restorative approach will continue to challenge unacceptable conduct. The Trust will ensure concerns are addressed promptly, fairly and consistently; those raising them are supported and protected; recurring patterns are addressed; and learning drives visible change. The Trust will monitor delivery through the Inclusion, Belonging and Staff Voice workstream and through Staff Experience governance. Evidence will include response timeliness and consistency; themes from employee relations cases and Freedom to Speak Up concerns; staff feedback; repeat or systemic issues; and changes in staff confidence and psychological safety.

7. Evidence, outcomes and assurance
The programme is creating a single view of staff experience and inequality, drawing on workforce demographics and equality indicators, Staff Survey results, recruitment and progression, employee relations, sickness, retention and exit data, speaking-up themes, Staff Network insights and qualitative accounts.

The baseline will identify where workforce experience differs between staff groups and where inequalities require targeted action. Until this baseline is complete, the Trust does not yet have a sufficiently integrated evidence base to describe the full scale or pattern of inequalities across all aspects of staff experience. Completing the baseline will enable priorities, targeted actions and measures of improvement to be established on a clearer evidence base.

Measures will track whether staff experience improves and inequalities narrow, including belonging, respect, psychological safety, confidence in speaking up and line management, recruitment and progression, disciplinary and retention patterns, consistent People processes, and evidence that staff input shapes decisions and action.

Assurance is developing. The governance and programme structure are clearer, but the baselines, trajectories, ownership, milestones and evidence of sustained impact remain incomplete. These gaps will be addressed through the Staff Experience and Equality, Diversity and Inclusion Plan, with progress and exceptions reported through the Staff Experience Committee and the People and OD Delivery Group.

8. Next steps
The next phase will move the work from programme design into implementation and measurable improvement. Priorities are to:

Complete the baseline activity
Complete the initial staff experience and equality baseline and identify priority inequalities, variations in experience and areas requiring targeted action.

Establish ownership, measures and milestones
Confirm project ownership, outcome measures, milestones and reporting arrangements through the Staff Experience Programme.

Develop the inclusive leadership approach
Develop and test the Trust-wide inclusive leadership approach with the Board, Trust Leadership Team, divisional leaders, managers, Staff Networks, staff-side representatives and wider staff.

Strengthen Staff Networks and staff voice
Progress the Staff Networks Reset, Refresh and Relaunch work and strengthen the route from staff insight and lived experience to organisational decisions, action and feedback.

Clarify organisational expectations
Develop organisational expectations and arrangements for recognising, raising and responding to unacceptable behaviour through the appropriate policy, legal, professional and governance routes.

Establish routine assurance reporting
Introduce routine reporting of outcomes, inequalities, risks, milestones and evidence of impact through the Staff Experience Committee and the People and OD Delivery Group.

Future reports will show progress against the baseline and agreed measures. This will include whether:

- Identified inequalities are narrowing;
- Staff feel a stronger sense of belonging, respect and psychological safety;
- Confidence in raising concerns and speaking up is improving;
- Staff experience differs between workforce groups;
- People processes are being applied fairly and consistently;
- Staff voice is influencing decisions and improvement;
- Concerns and recurring patterns are leading to learning and action; and
- Agreed projects and milestones are being delivered.

Milestone dates will be included once they have been formally agreed through the programme's governance arrangements.

Enclosures: None.
FOI: N/A