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NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 29 May 2025

10:00 – 13:00

To be held in the Leckhampton Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0525	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0525	Declarations of Interest • Annual Board Declarations 2024/25	Assurance	**Paper**	Chair
10:05	03/0525	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/0525	Minutes of the meeting held on 27th March 2025	Approve	**Paper**	Chair
	05/0525	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0525	Questions from the Public	Assurance	Verbal	Chair
10:40	07/0525	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/0525	Report from Chief Executive	Assurance	**Paper**	CEO
STRATEGIC ISSUES (11:00)					
11:00	09/0525	Trust Strategy Refresh - Engagement	Assurance	**Paper**	DoIP
11:10	10/0525	Proposed Strategic Risks and Risk Appetite Statement 2025/2026	Approve	**Paper**	DoCG
11:20	11/0525	Freedom to Speak Up 6 Monthly Report	Assurance	**Paper**	FTSU Gdn
11:30	12/0525	Intensive and Assertive Community Treatment Action Plan Update	Approve	**Paper**	MD
BREAK – 11:40 (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:50	13/0525	Finance Report	Assurance	**Paper**	DoF
12:00	14/0525	Quality Dashboard Report M1	Assurance	**Paper**	DoNTQ
12:15	15/0525	Quality and Performance Dashboard Report M1	Assurance	**Paper**	DoF
GOVERNANCE					
12:30	16/0525	SIRO Report 2024/25	Endorse	**Paper**	DoF

TIME	Agenda Item	Title	Purpose	Comms	Presenter
12:35	17/0525	Standing Orders Review	Endorse	**Paper**	DoCG
12:45	18/0525	Use of the Trust Seal 2024/25	Assurance	**Paper**	DoCG
TO NOTE	19/0525	Council of Governor Minutes - 19 March 2025	Information	**Paper**	DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:50	20/0525	Mental Health Legislation Scrutiny Committee (8 April)	Information	**Paper**	MHLS Chair
	21/0525	Resources Committee (24 April)	Information	**Paper**	Res. Chair
	22/0525	Great Place to Work Committee (29 April)	Information	**Paper**	GPTW Chair
	23/0525	Audit & Assurance Committee (30 April)	Information	**Paper**	Audit Chair
	24/0525	Quality Committee (6 May)	Information	**Paper**	Quality Chair
CLOSING BUSINESS					
13:00	25/0525	Any other business	Note	Verbal	Chair
	26/0525	**Dates of future Board Meetings 2025** ▪ Thursday, 31st July ▪ Thursday, 25th September ▪ Thursday, 27th November	Note	Verbal	All

TRUST BOARD: REGISTER OF DECLARATIONS OF INTERESTS 2024/25

NAME	POSITION	DECLARATION OF INTERESTS
Graham Russell	Chair	• Chair, Brunelcare (current).
Nicola de longh	NED/Senior Independent Director/Vice Chair	• Chair of the Board, CUC (Committee of University Chairs) (April 2022 - current). • Chair of Council, University of Gloucestershire (October 2019 - current). • Senior Independent Director, Connexus Housing Group (Sept 2020 - current). • Director, Honourable Company of Gloucestershire (Nov 2022 - current). • Chair, Premier Miton Responsible UK Investment Fund Committee of Reference (Feb 2019/October 2021 – March 2025). • Trustee, Gloucestershire Counselling Service (Jan 2016 – Feb 2024). • Owner/Director, Deiongh consulting Ltd (closed).
Jan Marriott	NED *(up to 31st March 2025)*	• Co-Chair Glos Learning Disability Partnership Board (2010 - current). • Co-Chair Glos Mental Health & Wellbeing Partnership Board (2015 - current). • Co-Chair, Glos Physical Disability and Sensory Impairment Partnership Board (2018 - current). • Chair, Prime Foundation Charitable Trust (2015 - current). • Trustee, Crossroads Gloucestershire (Dec 2020 - current). • Independent Supporter (2017 – current).
Steve Alvis	NED	• Landlord of building leased to The Cam and Uley Family Practice - The Surgery, 42 The Street, Uley, Dursley, Gloucestershire GL11 5SY (2016 - current).
Sumita Hutchison	NED	• NED, RUH Bath (Sept 2019 - current). • Media Manager, Conscious Planet - Volunteer Role (December 2021 - current). • Board of Trustees for Avon Wildlife Trust (current). • Organisations and PR Co-ordinator for Europe for Save Soil (current). • Governor on Bristol Grammar School (current). • West of England Nature Partnership (current).
Bilal Lala	NED	• Director, Bilal HL Ltd (Feb 2023 – current).

NAME	POSITION	DECLARATION OF INTERESTS
Jason Makepeace	NED	Financial interest: • Employed as Director of Design, UK, by Gingko Bioworks Inc (via a UK umbrella company, Velocity Ltd). Ginkgo Bioworks and its subsidiary Ginkgo Biosecurity provide biotechnology services for governments and pharmaceutical companies, amongst others (1 May 2024 – 1 March 2025). • Ginkgo Bioworks has recently received a contract from UKHSA to develop health and biology security services for HM Government, which I will be involved in delivering (1 May 2024 – 1 March 2025). • At the time of this declaration, there is no perceived conflict of interest. This financial interest is noted for transparency (1 May 2024 – 1 March 2025). Non-financial professional interest: ▪ Co-opted as an independent non-executive director of Royal Agricultural University. RAU is a small specialist university focused on teaching and researching subjects including food and biology security, amongst others (1 Feb 2022 up to 9 years (3 terms). ▪ RAU regularly bids for local, national and international funding, including from Gloucestershire CC (1 Feb 2022 up to 9 years (3 terms).
Rosi Shepherd	NED	• Chief Nursing Officer BNSSG ICB (Jan 2025 – current). • Chair of Members Balcarras Multi Academy Trust (Jan 2025 – current). • Family members employed at Spa Medica (Jan 2025 – current).
Cathia Jenainati	Associate NED	• Nothing to Declare.
Vicci Livingstone-Thompson	Associate NED	• CEO of Inclusion Gloucestershire. Loyalty and Professional Interest (financial and non-financial) – employed by an organisation that may deliver some projects commissioned by GHC. Current projects are CMHT Engagement (2016 - current). • Trustee of Active Impact. Loyalty and Non-Financial Professional Interest – trustee of a charity that is not currently but may at some point deliver projects commissioned by GHC (2013 - current)
Douglas Blair	Chief Executive	• Member of the Gloucestershire ICB Board (April 2023 - current)
Sandra Betney	Director of Finance	• Nothing to Declare.
Neil Savage	Director of HR&OD	• Associate Director of The Fold CIC (1 Dec 2023 – current).

NAME	POSITION	DECLARATION OF INTERESTS
Rosanna James	Director of Improvement and Partnerships	Chair of Baby Bank Network, Bristol based registered Charity (April 2023 – April 2025).
Dr Amjad Uppal	Medical Director	Private Clinical Practice.
Sarah Branton	Chief Operating Officer	Nothing to Declare.
Nicola Hazle	Director of Nursing, Quality and Therapies	• Working in a voluntary role as a Lay Panel Member with the College of Optometrists (May 2023 – current) • Remains employed as a bank Mental Health Inspector with Care Quality Commission (November 2024 – current).
Lavinia Rowsell	Director of Corporate Governance and Trust Secretary	Nothing to Declare.

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AGENDA ITEM: 04/0525

MINUTES OF THE TRUST BOARD MEETING

Thursday, 27 March 2025
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sarah Branton, Chief Operating Officer
Nicola Hazle, Director of Nursing, Therapies & Quality
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Rosanna James, Director of Improvement & Partnership
Cathia Jenainati, Associate Non-Executive Director (via MS Teams)
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jason Makepeace, Non-Executive Director
Jan Marriott, Non-Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Rosi Shepherd, Non-Executive Director
Amjad Uppal, Medical Director

IN ATTENDANCE:
Joy Hibbins, Public Governor (via MS Teams)
Anna Hilditch, Assistant Trust Secretary
Louise Moss, Assistant Director of Corporate Governance
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary
Catherine Sunderland, Trainee Registrar (shadowing Amjad Uppal)

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. No apologies had been received.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 Graham Russell informed the Board that unfortunately there would not be a service user story received at today's meeting. The patient who had been lined up to present was unwell. Further work would take place to ensure that a contingency could be put in place in future as it was agreed that hearing the experiences of our service users was most valuable. In the meantime, Graham Russell passed on his best wishes to the patient for a speedy recovery.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 23 January 2025. The minutes were **accepted** as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board **noted** that the actions from the previous meeting were now complete or progressing to plan.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board noted that two questions had been received in advance of the meeting.

6.2 The first question had been received from Bren McInerney and related to how the Trust could better interact, engage and include Trust Members. Rosanna James provided a verbal response, and the full written response would be sent directly to Bren McInerney following the meeting.

6.3 The second question had been received from Joy Hibbins and related to Trust attendance at Coroner inquests. Amjad Uppal provided a verbal response, and the full written response would be sent directly to Joy Hibbins following the meeting.

6.4 The Board **noted** that the full questions and responses would be included as an annex to the meeting minutes, for the record. **ACTION**

7. REPORT FROM THE CHAIR

7.1 The Board received the Report from the Chair, which provided an update on the Chair's main activities and those of the Non-Executive Directors (NEDs), Council of Governor discussions and Board development as part of the Board's commitment to public accountability and Trust values.

7.2 Graham Russell opened his report by recognising the contributions of Jan Marriott, Non-Executive Director who would come to the end of her final term on 31st March. Graham said that Jan had been an amazing colleague who had contributed so much to health and wellbeing in Gloucestershire. Her passion for collaborative working; the important contribution of the voluntary sector; and the huge value of co-production with service users had shone through. On behalf of the Board, Graham Russell thanked Jan for all of her hard work and dedication to the Trust and wished her well for the future.

7.3 The Board was asked to note that the Council of Governors had met on 19 March and had formally **approved** the reappointment of Nicola de longh for a second term.

7.4 Graham Russell said that there was a considerable amount of change in the NHS currently, and he said that his thoughts were with colleagues in the system and how these changes may impact upon them. He reiterated the need for the Board to continue to live the Trust's values at this challenging time.

7.5 The results of the national Staff Survey had now been published and GHC had performed well, being recognised as the top performer in the south west of colleagues recommending the Trust as a place to work. Graham Russell expressed his thanks to colleagues for taking the time to complete the survey and make their voices heard. However, in line with the Trust's value of "always improving", more work would be carried out to focus on those areas of the survey results where improvements were required. A more detailed update would be presented later in the meeting.

7.6 The Board **noted** the report and the assurance provided.

8. REPORT FROM CHIEF EXECUTIVE

8.1 The Board received the Report from the Chief Executive which provided an update on significant Trust issues not covered elsewhere on the Board agenda, as well as on his activities and those of the Executive Team.

8.2 As referenced by Graham Russell, Douglas Blair confirmed that there had been a sequence of national announcements in recent weeks relating to the reduction in size, and subsequently the abolition of, NHS England as the national leadership of the NHS is reshaped and integrated back into the Department of Health and Social Care. Alongside this, a requirement for Integrated Care Boards to reduce their running costs by 50% was announced. Douglas Blair had attended a national meeting of NHS Chairs and Chief Executives on 13 March 2025 at which the incoming transitional Chief Executive of the NHS, Sir Jim Mackey, set out priorities for the year ahead. This included some specific requirements for provider NHS Trusts to demonstrate increased productivity and reduce any growth of corporate resources. As an organisation, Douglas advised that GHC has had a strong focus on planning for, and delivering, recurrent cost improvement over recent years. This has included not increasing our clinical and non-clinical workforce beyond any increases linked to agreed, commissioned service expansion. This means that, while we will be part of national and local initiatives focused on reducing the cost base of the NHS, we enter into this period with strong foundations. In terms of the financial challenges related to planning for 2025-26, the Trust is working closely with system partners in Gloucestershire to identify the route to a plan which delivers on the main operational requirements and is also financially balanced.

8.3 The Trust's overarching strategy "Our Strategy for the Future 2021 – 2026: Better Care Together" was approved in 2021. Our four values underpin our mission: working together, always improving, respectful and kind, making a difference. This is further supported by our strategic aims which focus on our staff, our patients, our partners and our impact on the environment; enabling our vision to be an integrated mental health, learning disabilities and physical health community provider "Working together to provide outstanding care." In March 2025, the Trust embarked on a 6-month engagement plan to review and refresh our existing Strategy, which will take account of the local and national influences shaping our organisation to provide a clear set of strategic objectives, for the next 5 years (Sept 2025 – Sept 2030), clearly demonstrating how our clinical and operational model will focus on prevention & early intervention; improved health and wellbeing outcomes; and outstanding care. Douglas Blair said that community-based transformation will be at the heart of the new NHS 10-year plan to be released in May 2025 and we understand that to deliver

the Gloucestershire ICS 3 pillars we need to collaborate with our partners and work in different ways with the communities we serve, to provide joined up, patient centred care for our population. The report set out the timeline for the Strategic refresh, and a number of Board and wider engagement sessions had been proposed as part of this engagement exercise phase.

8.4 Within his report, Douglas Blair wished to recognise Trust colleagues on recent awards and achievements. This included congratulations to those colleagues who had recently successfully completed their apprenticeships with the Trust.

8.5 The Board was informed that GHC's facilities teams across the Trust were named in a report published in the Health Service Journal which placed our Trust second in the national league table for cleanliness - scoring a fantastic 99.99%. The data came from the latest PLACE assessments - Patient-Led Assessment of the Care Environment. It was noted that GHC's facilities service was an in-house service, rather than being outsourced. Sandra Betney said that reviews of estates and facilities benchmarking data and PLACE results had taken place and the Trust continued to come out at low cost and very high quality. The Board expressed its thanks to all facilities colleagues for achieving this performance.

8.6 The Board **noted** the update provided.

9. NATIONAL STAFF SURVEY RESULTS 2024

9.1 The purpose of this report was to present the 2024 NHS Staff Survey results.

9.2 This is the Trust's fifth single Staff Survey feedback report, covering data gathered from colleagues between September and November 2024.

9.3 The Survey results present a generally positive view of how colleagues rate the Trust as their employer and Neil Savage said that the Trust should be proud of the results. However, the overall ratings, with some exceptions, could be interpreted as representing a "steady state" rather than a notable increasing or reducing rating. Neil Savage advised that further analysis against the recently released national and regional benchmarking will be crucial in developing our response and action plan.

9.4 Some of the key headlines from this year's results included:

- Year on year response rate improvements, with 61% received for 2024 compared with 58% in 2023
- Above sector average scores across seven People Promise Themes.
- At an individual question level, ratings for 17 were in the top 20% range. 82 were rated in the intermediate 60% zone and 9 were in the bottom 20%, compared with similar organisations surveyed.
- In comparison with last year, 85% questions showed no significant movement, 13% showed significant reduction and 2% significant improvement.
- For Staff Engagement and Morale, results reduced very slightly for both but remained well above sector average.
- Positively, colleagues reporting that they (1) often think about leaving this organisation, (2) are looking for another job in next 12 months and thinking about

leaving, and (3) who say that as soon as they can find another job, they will leave, have all reduced.

9.5 In terms of south west regional benchmarking, the Trust came 1st overall for recommending as a place to work and as a place to receive treatment, and 2nd overall for all staff survey themes ratings combined.

9.6 The results also provide helpful signposting to areas to prioritise for improvement over the coming year. Thematic areas of focus will shortly be drawn up following consideration and engagement through planned Staff Survey listening events; Senior Leadership Network (SLN), operational management groups and committees, Staff Side and Diversity Networks. Suggested prioritised areas for focus in 2025/26 are:

- Discrimination, harassment and violence
- Health and wellbeing
- Colleague engagement
- Speaking up
- Managing conflicting demands
- Teamwork
- Improving clinical supervision

9.7 Sumita Hutchison stressed the importance of looking at hotspots and heatmaps, and advised that the GPTW Committee would be focusing on this via a deep dive at their next meeting in April.

9.8 Sandra Betney said that she welcomed this report, noting the great analysis that had been carried out. The importance of recognising the need for different actions for different teams was noted.

9.9 In terms of the focus on improving clinical supervision, Neil Savage said that it was felt this related to recording issues, training and time pressures on colleagues. Sarah Branton said that improvements in clinical supervision could be seen via the performance report and agreed that further training for colleagues to understand what could be recorded as clinical supervision would be helpful.

9.10 Graham Russell concluded this item by recognising that there were areas where the Trust needed to improve, however, he offered his congratulations to colleagues for what was a very good result, and one that the Trust could be proud of.

10. GENDER ETHNICITY AND DISABILITY PAY GAP REPORT

10.1 The purpose of this report was to inform the Board of the 2024 combined gender, ethnicity and disability pay gaps across Gloucestershire Health & Care NHS Foundation Trust, outline next steps and actions, and to seek agreement on a written equalities' commitment. The Board noted that the Executive Team and the Great Place to Work Committee had also discussed and approved in principle the proposed actions set out in the report for the Board's consideration.

10.2 Neil Savage advised that GHC's People Strategy makes a key strategic commitment to equality, diversity and inclusion. In agreeing this, the Board has previously committed to being "*a fair organisation that celebrates diversity and ensures real*

equality and inclusion. People will be able to bring their hearts to work, free from bullying or discrimination." Reducing, and ultimately removing, the pay gaps is a key element to operationally delivering on this commitment, alongside the Trust's aspirations and actions on the Workforce Race and Disability Equality Schemes.

10.3 Neil Savage noted that the past year's data generally presents a modest improving picture on the gender pay gap for the Trust, however, it also shows that there is much more to do to reach desired equity, particularly for disabled colleagues. The Trust has a *people with disabilities* workforce population of 8%, however, the local population profile shows that the percentage of population of people with disabilities within our area of coverage is 16.8%. Vicci Livingstone-Thompson noted this low level of reporting and suggested that the Trust had a real opportunity to explore issues such as psychological safety in terms of colleagues feeling able to report disabilities.

10.4 Neil Savage informed the Board that the sequence of reporting for this report going forward would change, with the aim of presenting it through key networks and staff groups for engagement before presenting up to the GPTW Committee and Trust Board, meaning that the valuable insights and feedback from colleagues could be included.

10.5 Rosi Shepherd joined Board colleagues in welcoming the inclusion in the report of ethnicity and disability reporting. She noted the proposed actions in place, however, she suggested that some of the issues were societal, and not down to the employer, and it was important that this continue to be recognised. Neil Savage said that a further session was planned for the GPTW Committee in June to focus in on the detail and to look at what big shifts could be made, taking into account good practice from other Trusts.

10.6 To comply with related national requirements, the Trust needs to reconsider its statement of commitment to reducing the pay gap. The GPTW Committee therefore recommended that the Board of Directors endorse the detailed statement of intent, as follows:
"Gloucestershire Health & Care NHS Foundation Trust's Board of Directors confirms its commitment to the ongoing monitoring and analysis of its Gender, Disabled and Ethnicity Pay Gap data and to developing the appropriate actions aimed at reducing and eradicating the gaps over time.

Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove pay gaps."

10.7 The Board welcomed this report and agreed in principle to the proposed actions set out. The Board also approved the publication of this report on the Trust website, submission of the data to the government website, and approved the statement of intent as set out above.

11. BUSINESS PLAN 2025/26

11.1 The purpose of this report was to set out the Trust Annual Business Planning process for 2025/26 and the proposed Business Planning Objectives for operational and corporate teams.

11.2 The business planning process was launched in September last year to support Directorates and Teams in developing their business planning objectives for 2025/26 and beyond. The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by our four strategic aims. The report also set out the known national and local priorities that have informed the business planning objectives and the proposed new schemes for investment.

11.3 The Board was asked to note that a business planning refresh is proposed in quarter 1 of 2025/26 to ensure the business plan is updated to include any system changes and any outcomes from the system portfolio work and the 10 Year Health Plan requirements when known. Sandra Betney noted that the business planning process did align with the system planning timelines, so she was hopeful that it did reflect the system position accurately.

11.4 The key risks to delivering the Business Plan for 2025/26 had been identified and were presented within the report. This year the quality assurance process identified a potential capacity constraint within the clinical systems team resources which requires further prioritisation. The business plan will be refreshed quarterly allowing resources to be flexed where possible.

11.5 The report also included a delivery forecast and overview of the key achievements for the Trust business plan for 2024/25. There were 190 objectives at the beginning of 2024/25. Performance was monitored throughout the year by a quarterly online self-assessment of progress and monthly exception report. There were 687 milestones for delivery by the end of the year and as it currently stood only 8 (1%) of the business plan milestones would not be achieved in year. The Board congratulated colleagues on this fantastic achievement.

11.6 Nicola de Iongh noted the bubble charts included within the report which represented the balance of business planning objectives for each team/directorate for each of our four strategic aims. She said that the 'Better Health' theme had the least number of objectives, and she asked whether there was more we could do in this area. Sandra Betney noted that the Better Health theme was often a secondary consideration to the main strategic driver for High Quality Care objectives which is not recorded within the business planning template but could still deliver a better health benefit. In short, there may be fewer, but they could have a big impact.

11.7 The Board **approved** the business planning objectives identified for 2025/26, noting the planned refresh in quarter 1. Quarterly monitoring of the business plan and progress was reported through the Resources Committee.

12. BUDGET SETTING 2025/26

12.1 The purpose of this report was to present the Board with budget setting process for 2025/26, and the budgets proposed and how they have been prepared in order to meet this annual obligation under the Standing Financial Instructions.

12.2 The report highlighted the links with the NHSE planning, contracting and business planning processes and sets out risks and opportunities within the financial control totals that have been set for each directorate.

12.3 Sandra Betney advised that budget setting for 2025/26 has been completed alongside the compilation of the Gloucestershire ICS financial plan for 2025/26. The Trust has continued to conduct its own thorough process to develop a set of budgets that reflect the business plan of the Trust, and has fed these proposals into the wider system discussions. The Trust's proposed budgets reflect a detailed bottom-up approach that dovetails with the plans and objectives of the Trust for 2025/26.

12.4 As part of the ICS process for finalising the system plan for 2025/26 all organisations budget proposals have been subject to scrutiny and review. Included in the Trust's position are the actions that the Trust has agreed to undertake, and these bring the Trust to a proposed budget position of a break-even position. There remains a risk that these system amendments are not transacted in the way the Trust has assumed leading to further adjustments to the budgets.

12.5 The Trust has set Whole Time equivalent (WTE) budgets as part of the budget setting process and articulated how WTEs have moved from April 2024 through to April 2025. The Trust's plans reflect the drive to reduce bank and agency spend and ensure that non-clinical WTEs are carefully controlled. Additional WTE budget has been included for Inpatient Establishment Reprofiling.

12.6 In order to deliver the proposed plan, recurrent cost improvement schemes of £10.086m are required. In addition, significant non-recurrent savings of £5.169m will be delivered to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 60% (£9.127m) of the total savings target has been delivered or identified.

12.7 A capital expenditure plan of £15.449m, and £3.265m disposals, are proposed for 25/26. There are a number of capital disposals planned for 25/26, and bids have been received for two of these sites already, and a number of other sites are being actively marketed for disposal. The Capital Management Group has agreed the priorities for next year and the main focus of the programme will be investment in net zero carbon schemes £3.3m, improvements to IT Infrastructure £1.3m, progression of the Transforming Care Digitally programme and the continuing reduction in backlog maintenance. The system has a confirmed capital CDEL of £53.117m for 25/26 and has a balanced programme incorporating all essentials requirements of each organisation.

12.8 Sandra Betney highlighted the potential risks in the proposed budget, and these were clearly set out within the report.

12.9 Jason Makepeace informed the Board that regular reports had been received at the Resources Committee over the past 6 months, with members having had the opportunity to discuss and provide challenge on the developing financial position.

12.10 Steve Alvis referenced the Trust investment in net zero carbon schemes and asked about funding for solar panels. Sandra Betney said that the Trust had put itself forward for free solar panel funding, however, if this was not received it was the intention to go ahead and progress this regardless.

12.11 The Board noted the budget setting process and linkages with business planning, approved the revenue budgets and capital plan for 25/26, approved in principle the 5-year capital programme, and **approved** the inpatient establishment reprofiled proposed budgets. The risks associated with the proposed budgets for 2025/26 were also noted.

12.12 The Board expressed its thanks to Sandra Betney and the wider finance team for the hard work in preparing the budgets.

13. FINANCE REPORT

13.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 11.

13.2 At month 11 the Trust had a surplus of £0.178m compared to a plan of £0.034m. The forecast year-end surplus was £0.296m.

13.3 The 2024/25 Capital plan was £10.704m with £4m of disposals leaving a net £6.704m programme. Spend to month 11 was £5.035m against a year-to-date budget of £8.335m. Cash at the end of month 11 was £52.292m, an increase of £7.32m due to a reduction in NHS receivables.

13.4 It was reported the Cost Improvement Programme had delivered £5.465m of recurring savings at month 11 compared to plan of £6.585m. The target for the year is £7.319m of which £1.334m is currently unidentified. £6.841m of non-recurring savings have been delivered at month 11 against a plan of £5.537m. The target for the year was £5.661m, and has therefore been fully delivered.

13.5 The Trust spent £4.772m on agency staff up to month 11. This equates to 2.14% of total pay compared to the agency ceiling of 3.2%. There were 29 off framework agency shifts in February.

13.6 The Board was asked to note that the Coleford Health Centre lease business case was expected for the May Board. However, discussions would be taking place to confirm this timeline and to see whether this would be delegated to the Resources Committee for approval.

13.7 As recommended within the report, the Board formally **approved** the accuracy and robustness of the capital forecast as submitted including the charge against capital allocations, the impact of IFRS 16, and the total CDEL charge.

13.8 The Trust Board **noted** the month 11 financial position. It was agreed that this was a very clear report, and Trust performance remained stable. Jason Makepeace confirmed that the Resources Committee carried out robust oversight and scrutiny of the Trust's financial position and he was assured by the Trust's current position.

14. QUALITY DASHBOARD REPORT

14.1 Nicola Hazle introduced the Quality Dashboard Report (February data), which provided a summary assurance update on progress and achievement of quality priorities and indicators across the Trust's Physical Health, Mental Health and Learning Disability services.

14.2 Key areas highlighted to the Board included safeguarding improvements, an update on skin integrity incidents, restrictive practice and rapid tranquilisation incidents, sexual safety, and Guardian of Safe working activity.

14.3 The Board noted that the vacancy levels at Berkeley House remained high, currently at 30.1%. Nicola Hazle informed the Board that the unit did have a number of vacancies, however, bank staff were in place to support the service, and there was assurance about the level of clinical knowledge, noting that training and supervision compliance at the unit was high. This continued to be monitored closely.

14.4 Rosi Shepherd said that she had carried out a recent visit to Wotton Lawn and she had seen and received very positive news on recruitment and retention. She said that this was a real boost to morale and meant that there was the ability to focus on the development of staff at the unit.

14.5 The Board noted the increase in complaints received, which were attributable to the new IUCS service. Sarah Branton advised that this was a new service, which had increased the contacts with the Trust by approx. 16,000 patients each month. The service was continuing to monitor activity, but time was needed to be able to understand what "normal" would look like.

14.6 The Board **received, noted** and **discussed** the February 2025 Quality Dashboard.

15. QUALITY AND PERFORMANCE DASHBOARD

15.1 Sandra Betney presented the Quality & Performance Dashboard, which provided a high-level view of performance and quality indicators in exception across the organisation for the period to the end of February (Month 11 2024/25).

15.2 This month's Quality & Performance Dashboard for Board continued to offer a lighter commentary format; however, members were assured that a detailed exception narrative was reviewed within the Business Intelligence Management Group (BIMG).

15.3 The Board **noted** those indicators that were in exception for the period within the nationally measured, specialised and directly commissioned, ICS agreed, and Board Focus domains. The Board was asked to note that the Integrated Urgent Care Service (IUCS) indicators were now incorporated within the relevant national and locally agreed domains. Performance improvement plans for those indicators in

exception were received and considered at the Business Intelligence Management Group (BIMG).

15.4 Sarah Branton highlighted the key areas from the report for the Board's attention.

15.5 *Adolescent Eating Disorders routine referral to NICE treatment start within 4 weeks/Adolescent Eating Disorders urgent referral to NICE treatment* – recovery plans have been discussed at the March 2025 BIMG meeting. An internal six-month service efficiency process has commenced, with a number of risk mitigations in place. A recruitment plan is in place with interview and start dates set against each vacancy. The triage process was under review in partnership with VCSE.

15.6 *72 hour follow up (N03)* – target was achieved in February 2025. A Learning event was held with key stakeholders to understand why this measure had not been met previously. A clear process, which includes visual aids has been agreed to ensure patients are followed up. Daily reviews of this measure are now undertaken to ensure appropriate follow up.

15.7 *Length of stay in mental health inpatient settings (B18 – B22).* A number of processes have already been put in place, including purpose of admission and red to green. This work will follow a clinically led quality improvement approach to engage with staff/services, identify ideas and agree the outcomes required to improve this measure.

15.8 *Podiatry (routine referrals is 82.3% against 95%), (O04) (risk 491).* Recovery plan in place which includes effective triage, advice and guidance and recruitment including apprenticeship pipeline. Trajectory for recovery is August 2025.

15.9 *MSK Physiotherapy and Podiatry* - Community appointment days being trialled. These provide a comprehensive range of MSK services, including assessments, advice, health promotion, rehabilitation, community and voluntary sector support, all in a non-medicalised environment. The aim is to move beyond a focus on individual health conditions by focusing on what matters to each individual and give people the tools to manage their own health. The plan is to see up to 300 patients per day with significant reductions in follow ups and high satisfaction from patients and staff alike. Trial events are due to take place in Stroud and Cirencester by the middle of April with a robust evaluation planned to establish the impact on performance and patient satisfaction.

15.10 *Core CAMHS treatment (no current KPI)* - A recovery plan is in place. Data analysis demonstrates improvements in very long waits. The trajectory was originally March 2025, a new trajectory is being determined. Actions in progress are additional demand and capacity work, clear job planning for clinicians, balancing capacity between assessment and treatment.

15.11 *Montpellier Ward* – A "Bored Board", has been created with service users to listen to their feedback. This has led to improvements in ward environment and service user experience.

15.12 *Open Access Therapeutic Service* – in partnership with Kingfisher Treasure Seekers. This is a peer therapy group for people with complex emotional needs. The review of our first year shows that for those who have attended, a 28% reduction in GP attendances and a 62% reduction in contact with crisis teams.

15.13 The Board **noted** the Performance Dashboard and the assurance provided.

16. BOARD COMMITTEE TERMS OF REFERENCE (TOR) REVIEW

16.1 The Trust carries out an annual committee evaluation/self-assessment of performance which is considered good practice. Alongside this, a full review of the Committee terms of reference is carried out to take account of the outcome of the evaluation and to update in line with best practice. Some minor changes to the TOR have been made following this review.

16.2 An additional point in relation to seeking assurance around the use of Quality Equality Impact Assessments (QEIA) has been inserted into all Board level governance Committees. This was in response to a recommendation from the 2024 BDO internal audit on EDI.

16.3 Those TOR that have been reviewed as part of this cycle include:

- Great Place to Work Committee
- Charitable Funds Committee
- Resources Committee
- Quality Committee
- Audit & Assurance Committee
- Mental Health Legislation Scrutiny Committee

16.4 The Audit & Assurance Committee reviewed its TOR at its meeting on 6th February. Some more significant changes were proposed, and these were presented in full to the Board for approval.

16.5 The Board was asked to note that a wider review of the Committee ways of working, to include a full review of membership and attendance, would be carried out during 2025/26. Any subsequent changes to the TOR as a result of this would be brought back to the Board, if required.

16.6 The Board **endorsed** the proposed revisions to the TOR for the Board Committees, as highlighted within the report.

17. WORKING TOGETHER ADVISORY COMMITTEE REVIEW

17.1 The purpose of this report was to present the Board with an update of engagement to review and co-design the next iteration of the GHC Working Together Advisory Committee (WTAC) which includes a proposal for a new name, purpose, structure and function.

17.2 Following recommendations from the WTAC meeting on 25th July 2024, the Board agreed with a proposal to pause the committee group to enable a comprehensive review of the purpose, function, and membership. A robust engagement approach

was followed to co-create and agree preferences for model design, functions and features. Participants agreed that the current Working Together Plan, vision, aims and goals remain relevant, with annual measurable objectives to be developed further and to reflect the new features identified.

17.3 The refreshed working together model proposed seeks to build on the components that were working well, make improvements to shortfalls, and introduce new features to strengthen GHC's co-production approach. Key features to note included:

- New name: Working Together Network
- The new model represents a next iteration working towards involving more people and communities as partners in driving improvement and decisions.
- Change to leadership, quoracy, & reporting. A joint chair (GHC Director of I&P and Expert by Experience) will present an annual report against objectives.
- Development of new community out-reach and GHC in-reach features that will be developed into objectives and tasks.
- Development of a parallel process and governance for the GHC Youth Voice participation programme.

17.4 The Board strongly supported the proposals set out in the report. The Board formally endorsed the disestablishment of the existing Working Together Advisory Committee to be replaced by a Working Together Network, and endorsed the recommended changes to the name, purpose, reporting, membership, and functions. The Board endorsed the recommendation to develop a parallel process for a Youth Voice approach, and endorsed the use of the Trust Strategy Refresh process in 25/26 to provide a clearer mandate for co-production and the need to further explore performance metrics and cost implications.

18. BOARD COMMITTEE SUMMARY REPORTS

18.1 The Board **received** and **noted** the following summary reports for information and assurance.

- Audit & Assurance Committee (6 February)
- Great Place to Work Committee (25 February)
- Resources Committee (26 February)
- Quality Committee (4 March)
- Charitable Funds Committee (12 March)

19. ANY OTHER BUSINESS

19.1 There was no other business.

20. DATE OF NEXT MEETING

20.1 The next meeting would take place on **Thursday, 29 May 2025**.

Annex 1

Questions from the Public

Question 1

"How would/could NHS Gloucestershire Health and Care NHS Foundation Trust better interact and include the Foundation Trust Members in their work/awareness of services of the Trust. What would the Trust see as the benefits and challenges of inviting NHS Gloucestershire Health and Care NHS Foundation Trust Foundation Trust members to internal events (as has been the case in the past) to share their work/meet the Trust's teams in person, and further maximise the insights and assets within all the Foundation Trust Members?"

Bren McInerney

Trust Response

Thank you for your question Bren. We do recognise that since Covid, the Trust has not hosted events specifically for Trust Members to come along and to meet with teams and services. Our Council of Governors' Membership & Engagement Committee has explored the possibility of hosting locality specific events, however, on surveying our Members there was little appetite for this form of event. Our Trust members are made aware of larger events, such as our Better Care Together events, and the Big Health Day, and we encourage attendance at our AGM each year.

A workstream to look at Membership is currently underway via our Council of Governors, looking at how we engage with Members (newsletters, invitations to participate in surveys), and how our Governors can get out and meet with Members in their relevant constituencies. Our Partnerships Team issue a monthly schedule of events and this is shared with our Governors to provide an opportunity for them to participate. New Membership materials have been produced, and we are considering whether to carry out an official re-launch, reiterating the importance and aim of Membership to our existing Public Members.

It is timely to have received this question in advance of today's meeting as we will be receiving a paper later on our agenda looking at our Working Together Approach. We know community-based transformation is at the heart of the 10-year plan to be released in May 2025. We understand that to deliver the Gloucestershire Integrated Care System strategy we need to collaborate with our partners and work in different ways with the communities we serve, and our Trust Members, to provide joined up patient centred care for our population. Our Working Together Plan (2021-2026) outlines the GHC approach to how we listen to, involve, and work with people and communities, and one of the key aims is to include everyone by making it easy for people to have their say, get feedback and be involved in ways that suit them.

We are hoping that once the new Working Together approach starts to move forward, we will see a real improvement in how we can utilise our Trust Members, how we can use their knowledge, expertise, and personal experiences to shape our thinking. The Trust knows how valuable it is to have an engaged Membership, and we are very much looking forward to working with our Council of Governor colleagues to see how this can be developed over the coming year.

Rosanna James
Director of Improvement and Partnership

Question 2

"This question is asked in the context of recognising the devastating impact on staff of the death of a patient, but in recognition of the importance of what is learned by attending the inquests of patients. Will the Trust ensure that someone from the Trust always attends an inquest when a patient under their care takes their own life? This can be anyone from the Trust (for example a manager who was not involved in the care of the patient). This question is being asked in the context of my attending an Article 2 inquest (late last year) into the death of a patient of Wotton Lawn psychiatric hospital. The coroner did not require any witnesses to attend in person. As a result, there was no one from the Trust at the inquest."

Despite the fact that the coroner intended that all evidence/witness statements were pre-prepared and that he would simply read extracts from them, a family member disclosed further evidence orally when the coroner asked (at the end of the inquest) if the family had any questions. As a result of this disclosure, the family member was asked by the coroner to take the witness stand. On the witness stand she gave important testimony and evidence which the coroner had not included until that moment.

As there was no one from the Trust present at the inquest (nor anyone representing the Trust), there was no one to hear that new evidence.

In terms of learning from patient deaths, all the evidence provided at inquests is important. This means hearing every word spoken in oral evidence at inquests.

Having a representative from the Trust at patient inquests is also important as a mark of respect for each patient who dies and out of respect for their family members who attend the inquest. I would consider this essential.

Joy Hibbins

Trust Response

The Trust engages fully with the Coroner's Office during their investigation of a death, via the internal Legal Services Team. The Team works hard to ensure that the Coroner is provided with sufficient evidence within the witness statements provided by Trust colleagues in the event of a death, so that they can make their determinations where possible without a full hearing.

The Legal Services Team will attend hearings when the Trust has been named as an Interested Party and staff members have been called to give evidence (either factual or regarding learning and assurance). The Team do not attend inquests where witnesses have not been called, so as to not create unnecessary complications in the coronial process, cause upset to the bereaved family members, and to ensure that the Trusts resources are used appropriately.

The Trust is aware of all non-attended inquests that take place and contacts the Coroner's Office within 48 hours to request the conclusions made. The conclusions are then disseminated to the relevant teams within the Trust for awareness and learning to take place.

The Trust offer to meet with family members at any stage to explain the findings of the review, and to hear challenge and any additional information that the family may wish to share. We are keen to maximise any learning and would welcome conversations with family members before or after the Coroner's inquest.

Dr Amjad Uppal
Medical Director

AGENDA ITEM: 05/0525

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 29 May 2025

- Action completed (items will be reported once as complete and then removed from the log).
- Action deferred once, but there is evidence that work is now progressing towards completion.
- Action on track for delivery within agreed original timeframe.
- Action deferred more than once.

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
27 March 2025	6	Formal written responses to Public Questions to be sent to those colleagues who had submitted them	Trust Secretariat	May 2025	Complete. Full responses sent by email on 28 March 2025	
		Public Questions and formal responses to be included as an annex to meeting minutes	Trust Secretariat	May 2025	Complete. Attached as an annex to the minutes of the meeting held on 27 March	

QUESTIONS FROM THE PUBLIC

QUESTION 1

"What work is NHS Gloucestershire Health and Care NHS Foundation Trust undertaking to examine, and act, on identified racial pay disparity, at all levels, for staff from Black Asian and Minority Ethnic backgrounds. What assurance and re assurance is brought to the board executive committees/board with the necessary evidence and measures"

Bren McInerney

TRUST RESPONSE

In 2024/25, as part of the Trust's EDI workplans we implemented a new combined gender, disability and ethnicity (race) pay gap report to better understand the issues and address the gaps. The Trust has previously reported annually on the gender pay gap, taking a series of remedial actions, with the gender pay gap subsequently reducing over the reporting periods, from 18.63% in 2020 to 11.99% in 2024.

For assurance and governance, the first combined pay gap report was taken to the Great Place to Work Committee in January 2025 and subsequently received and approved at the Board of Directors' public meeting in March 2025. The report has also been shared with the Women's Leadership Network and is shortly being discussed with the Diversity Network. The Great Place to Work Committee will also be further reviewing pay gap reporting at its next meeting in June 2025.

A number of actions are being taken forward to tackle the pay gap including positive action in areas of underrepresentation, Reciprocal Mentoring, and sponsorship of colleagues on current and future Global Majority, Ready Now and Developing Aspirant Leaders (DAL) programmes which support ethnic minority colleagues aspiring towards leadership roles.

As part of the Board's consideration, it signed up to the following statement:

"Gloucestershire Health & Care NHS Foundation Trust's Board of Directors confirms its commitment to the ongoing monitoring and analysis of its Gender, Disabled and Ethnicity Pay Gap data and to developing the appropriate actions aimed at reducing and eradicating the gaps over time. Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove pay gaps."

For clarity, as part of our response, we think it's important to highlight that the "pay gap" is a different to "equal pay" as this point is sometimes misunderstood when considering equal pay and pay gaps. While it is unlawful to pay people unequally on the grounds of a protected characteristic, the gender, ethnicity and disability pay gaps show the difference in the average (or mean) pay between men and women, disabled and non-disabled, white and ethnic minorities in the workforce. The Equality Act 2010 is the main legislation that prohibits discrimination in the workplace and wider society. While this Act is most associated with

gender pay equality, it also prohibits direct and indirect discrimination based on race, which includes colour, nationality, and ethnic or national origins. Although the Act does not have a specific "equal pay" clause for race (as it does for gender), pay disparities based on race can be challenged under the provisions for direct or indirect racial discrimination. Currently under UK law, gender is the only legally mandated formal pay gap reporting requirement for employers. However, this is changing. Earlier in 2025, the government launched a consultation on extending mandatory pay gap reporting to include:

- Ethnicity pay gaps, and
- Disability pay gaps

These changes are part of the proposed Equality (Race and Disability) Bill, which if enacted, would apply to employers with 250+ employees, and mandate a framework like gender pay gap reporting.

Neil Savage
Director of HR & OD

QUESTION 2

"With the announcement by NHS England on the resource reductions for Trusts, what is in place, what is being added to, in order to support the wellbeing of all staff during this difficult time. How does the Trust know, with all the support being offered, that staff are choosing to take up this support offer/this is the right support offer(s)?"

Bren McInerney

TRUST RESPONSE

The Trust continues to prioritise the provision of health and well-being support. We also recognise the need to continually develop and review our support offers. To this end, the Great Place To Work Committee annually oversees performance against the Trust's Health and Well-being Strategic Framework.

The related key support provided is outlined below.

The Trust supports its staff in having a healthy work-life balance and encourages them to take their full entitlement within the current leave year. This and other core principles are enshrined in our Annual Leave policy.

Working Well provides significant support to colleagues and is accredited as a Safe Effective Quality Occupational Health Service (SEQOHS). This is an accreditation scheme developed by the Faculty of Occupational Medicine to set and maintain high standards in occupational health services. Working Well also includes a "Talking Well" service which provides a range of counsellors and cognitive behaviour therapists readily available to support colleagues with a number of issues, ranging from work stress, to loss, relationship problems, trauma, bereavement, abuse, feelings of low mood or anxiety, managing pain and long-term health conditions.

As part of the wider ICS, the Trust hosts The Wellbeing Line. This provides confidential mental health and wellbeing support for Trust teams and colleagues, as well as to anyone working more widely in health and social care in Gloucestershire.

The Trust also provides colleagues with free access to the VIVUP Employee Assistance Programme, which amongst other things includes 24/7 counselling. This is supplemented where necessary by access to Practitioner Health, a free, confidential NHS service that provides mental health and addiction support specifically for health and care professionals.

Additionally, a range of training and guidance is provided to managers to help them best look after their teams and colleagues and to protect wellbeing.

Uptake, delivery and KPIs for the above services are provided to the Workforce Management Group and reported into the Board's Great Place To Work Committee.

Colleagues rate the Trust's delivery of health and well-being support through satisfaction surveys, Pulse surveys and the annual Staff Survey. In the latest Staff Survey, colleagues rated the Trust second highest on health, safety and well-being amongst 21 provider organisations in the South West.

Neil Savage
Director of HR & OD

QUESTION 3

"I am deeply concerned on the additional pressures placed, even more so now, and why our leaders ensure they keep well. What formal and informal approaches do all board members adopt to check in on each other and ensure board members, are resting, recovering, and having a holiday?"

Bren McInerney

TRUST RESPONSE

There are a range of formal and informal approaches adopted by Board members to check in on each other and ensure board members are prioritising rest, recuperation, and holidays. These include regular 121s, supervision and appraisals, which include health and wellbeing discussions, and, where appropriate through wellbeing objectives.

Neil Savage
Director of HR & OD

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Graham Russell, Trust Chair

AUTHOR: Trust Chair

SUBJECT: **REPORT FROM THE CHAIR**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to

This report updates the Board and members of public on the Chair's main activities and those of the Non-Executive Directors (NEDs), Council of Governor discussions and Board development as part of the Board's commitment to public accountability and Trust values.

Recommendations and decisions required

The Board is asked to:

- **NOTE** the report and the assurance provided.

Executive summary

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board development – including updates on Non-Executive Directors
- Governor activities – including updates on Governors

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**Appendix 1** Non-Executive Director – Summary of Activity March and April 2025

Report authorised by: Graham Russell	**Title:** Trust Chair

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

This report informs the Board and members of the public of the key points arising from the Council of Governors and members' discussions, Board development and the Chair's and Non-Executive Directors most significant activities.

2.0 CHAIR'S UPDATE

I have been out and about meeting colleagues and service users. I have also met with stakeholders and partner organisations.

Underpinning the Trust's values, I have four key areas of focus:

- **Working together**
- **Always improving**
- **Respectful and kind**
- **Making a difference**

The values of the organisation provide us with the platform to be ambitious and impactful both for the benefit of the people and communities we serve and also for our colleagues across the Trust. My update to the Board is structured in line with these four areas.

Working together

- The Chief Executive and I met with **Deborah Evans, Chair** and **Kevin McNamara, Chief Executive of the Gloucestershire Hospitals NHSFT** on 9th April where we discussed matters of mutual interest.

- Our **Better Care Together Awards** were held at Hatherley Manor Hotel, near Gloucester, on Wednesday 9 April. More than 130 colleagues gathered to celebrate the occasion, which followed a record number of nominations - 238 in total!

  It was a privilege to be able to celebrate not only everyone who attended but everyone who was nominated. The real winners, though, are the people of Gloucestershire, who benefit from our colleagues' hard work and dedication every day so it's fantastic to have an opportunity to say a big thank you to everyone.

  The overall winners were:

Working Together:	Wheelchair Assessment Service
Always Improving:	Vale Stroke Rehab Botulinum Toxin injection service
Respectful and Kind:	Mohammed Moolla, Service Desk Analyst
Making a Difference:	Alex Shingler, Ward Assistant, Cirencester Hospital
Rising Star ★:	Emilie Morgan-Moody, Mental Health Nurse, CAMHS
Outstanding Achievement 🏆:	Chris Stock, Expert by Experience
Valuing our Communities:	Children and Young People's Mental Health Navigation Hub
Team of the Year:	Gloucester Inner City District Nursing Team

- The **Chair of the Gloucestershire Hospitals NHSFT, Deborah Evans** and I continue to meet on a regular basis along with quarterly meetings with **Dame Gill Morgan, Chair of NHS Gloucestershire** where we have the opportunity discuss mutual mattes of interest.

Always improving

- Following the recent Working Together Advisory Committee Workshops and the outcomes from the workshop presented at March Board, although unable to attend personally, the first **Working Together Network** will take place in person on 25th June. Working together is important to the Trust as we recognise the essential role it plays in supporting our responsibility to improve health equity, deliver quality services, and contribute to wider determinants of health in Gloucestershire.

Respectful and kind

- The **Leadership and Culture Assurance Committee** met for the first time on 24th April and discussed its role in overseeing the Leadership and Culture Programme, which aims to unify and strengthen both existing and new initiatives to improve leadership, organisational culture and also to tackle discrimination.

  The Committee acknowledged that the Leadership and Culture Programme was in its development phase and that assurance would be sought from the oversight group overseeing the progress of the programme.

  The Committee would receive assurance from the relevant workstreams which would focus on different elements of the programme and agreed to meet on a bi-monthly basis, or as and when deemed necessary.

  The Committee will provide assurance to the Trust Board on the overarching delivery of the Leadership and Culture programme ensuring that the programme is comprehensive, delivered on time and informing cultural change. The Committee is established for an initial period of 12 months with possible extension following which oversight will revert to the appropriate Board governance committees.

Making a difference

- On 12th May, in recognition of **International Nurses Day**, I had the pleasure of visiting Charlton Lane Hospital where I met with Brad Watkins, Matron and members of the nursing team.

- In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, I was delighted to visit George Moore Community Clinic District Nursing Team on 15th May and CAMHS Young Adults service on 27th May to present their '**Making a Difference**' awards. Individuals and teams are selected based on the recognition received through various channels, such as the Patient Experience Team or national awards. Award winners will also be included in the nominations for the Better Care Together Awards, Making a Difference category for 2026. Awards will be presented on a monthly basis and I look forward to visiting more services over the coming months in order to acknowledge 'Making a Difference' across the trust.

3.0 BOARD UPDATES

- The recruitment for a new **Non-Executive Director** concluded on Friday 4th April. Following a rigorous recruitment process overseen by our Governors' Nominations and Remuneration Committee, I am delighted to advise that Vicci Livingstone-Thompson has been appointed and commenced in post on 1st May

2025. As you will be aware, Vicci was previously appointed as a developmental Associate NED in March 2023. I am sure you will join me in welcoming Vicci into her new role.

- On 3rd April, a **Board Development session** took place where the topic for discussion was the **Leadership and Culture Programme**. This face-to-face session was led by Michelle Hurley-Tyers, Deputy Director of HR & OD and focussed on the role of the Board, the Leadership and Culture Assurance Committee and Board Development alignment.

- I have dedicated a significant proportion of my time throughout April and May preparing and undertaking **annual appraisals** for the Trust's seven Non-Executive Directors. This opportunity for reflection is a valuable experience on both sides. The outcome of the appraisal process will be reported to the July meeting of the Council of Governors. I would like to take this opportunity to thank NEDs for their very impactful contributions.

- The Non-Executive Directors and I continue to meet regularly as a group. NED meetings are helpful check-in sessions as well as enabling us to consider future plans, reflect on any changes we need to put in place to support the Executive and to continuously improve the way the Trust operates.

4.0 GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham**, where matters relating to our Council of Governors are discussed including agenda planning, governor elections and membership engagement.

- A meeting of the **Nominations and Remuneration Committee** took place on 1st May. The committee discussed and received assurance the NED (Board) annual declarations including Fit and Proper Persons (FPPT) for 2024/25 and the Annual Governor Declarations had been carried out. The committee also endorsed the review of the Standing Orders. On 8th April, an **extraordinary** meeting took place where the committee approved the appointment of Vicci Livingstone-Thomson as Non-Executive Director.

- On 10th April, an **extraordinary Council of Governors meeting** took place where Governors approved the appointment of Vicci Livingstone-Thompson as Non-Executive Director. At their face-to-face meeting which took place on 14th May, Governors received an update from the Chief Executive on key events and, amongst other items, received very informative presentations on the Integrated Urgent Care Service (IUCS) and the GHC Working Together Network Engagement. Governors were also invited to meet with the Director of HR & OD to look at the Staff Survey results in more detail and to hear about the key themes and actions in place.

- Nominations for our Governor elections opened on 1st May for **Staff Governor**: Medical, Dental & Nursing (reserved for qualified nurse), and **Public Governors**: Stroud and Cotswolds. The deadline for nominations closed on 19th May and I will provide a further update on the outcome in my July Board report.

- A **Staff Governor meeting** took place on 13th May. At the meeting Governors and Non-Executive Directors had the opportunity to discuss the outline of the role and purpose of the meeting.

- Our **programme of visits to sites for Trust Governors** continues to progress with visits taking place at Cirencester Hospital on 25th April and Stroud General Hospital on 6th May. These visits offer Governors the opportunity to see our sites, speak to colleagues and to gain a better understanding of the services we provide. Non-Executive Director colleagues accompany Governors on each of the visits.

5.0 NED ACTIVITY

The Non-Executive Directors continue to be very active, attending meetings in person and virtually across the Trust and where possible visiting services.

See **Appendix 1** for the summary of the Non-Executive Directors activity for March and April 2025.

6.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Appendix 1

Non-Executive Director – Summary of Activity 1st March – 30 April 2025

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	MHAM Personal Development Review Chair Appraisal Meeting with Senior Independent Director 2 x MHAM Personal Development Reviews Meeting with Chair Introductory meeting with Rosi Shepherd MHLSC Pre-Meet Council of Governors Meeting Non-Executive Directors Meeting MHAM Forum Gloucestershire ICS NEDs Meeting Audit of Complaints discussion with Bilal Lala and Jason Makepeace Meeting with Chief Operating Officer GGI NEDs Board Meeting Webinar Non-Executive Directors Meeting Governor Visit to Cirencester Hospital Catch up meeting with Director of Nursing, Therapies and Quality Appraisal with Chair GGI Webinar	Quality Committee Board Seminar: Well Led Trust Board: Public Trust Board: Private x 2 Board Development: Leadership & Culture Programme MHLS Committee Resources Committee Quality Committee
Sumita Hutchison	Chair Appraisal Meeting with Senior Independent Director Great Place to Work Committee follow up meeting with Director of Corporate Governance 1:1 with Chair Gloucestershire ICS NEDs Meeting Great Place to Work Committee Agenda Setting Meeting Great Place to Work Committee Assurance Report Meeting Meeting with Internal and External Auditors Meeting with Director of Improvement & Partnerships Diversity Network Pre-meet	Board Development: Strategic Development Board Seminar: Well Led Trust Board: Public Trust Board: Private x 2 Board Development: Leadership & Culture Programme Leadership & Culture Committee Great Place to Work Committee Audit & Assurance Meeting

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Non-Executive Directors Meeting Quality visit to Children's Community Nursing Service Pre-meet for Sustainability Board Session	
Nicola de longh	Meeting with Director of Partnerships and Improvement Chair Appraisal Meetings Meeting with Jason Makepeace Non-Executive Director Shortlisting Meeting Aspiring Chairs Event Enhanced Study Day Extraordinary Council of Governors Meeting Chair Objective Setting Meeting Aspiring Chair Feedback Meeting Non-Executive Directors Meeting Meeting with Director of HR & OD Aspiring Chair Event	Board Development: Strategic Development Nominations and Remuneration Committee Charitable Funds Committee Board Seminar: Well Led Trust Board: Public Trust Board: Private x 2 Board Development: Leadership & Culture Programme Nominations and Remuneration Committee Resources Committee Great Place to Work Committee
Jan Marriott	Working Together Advisory Committee Survey Feedback Meeting Chair Appraisal Meeting with Senior Independent Director 1:1 Director of Partnerships and Improvement Introductory meeting with Rosi Shepherd Council of Governors Meeting Non-Executive Directors Meeting Quality Assurance Group Meeting Meeting with Director of Partnerships and Improvement and Sara Ryan Meeting with Expert by Experience and Family	Board Development: Strategic Development Quality Committee Board Seminar: Well Led Trust Board: Public Trust Board: Private x 2
Vicci Livingstone-Thompson	Council of Governors Meeting Non-Executive Directors Meeting Appraisal meeting with Chair Introduction Meeting with Rosi Shepherd Disability Awareness Network Council of Governors Meeting Quality Visit to Forest of Dean MIIU Catch up with Director of Nursing, Therapies and Quality	Board Development: Strategic Development Quality Committee Charitable Funds Committee Board Seminar: Well Led Trust Board: Public Trust Board: Private x 2 Board Development: Leadership & Culture Programme

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Non-Executive Directors Meeting	
Bilal Lala	NHS Gloucestershire ICB Audit Committee Part 1 and Part 2 Introduction meeting with Lead Governor Non-Executive Directors Meeting Chair Appraisal Meeting with Senior Independent Director Council of Governors Meeting Audit of Complaints discussion with Jason Makepeace and Steve Alvis HFMA Audit Committee Conference Meeting with Internal and External Auditors Audit & Assurance Pre-Meet with Director of Finance Audit & Assurance Committee Assurance Report Meeting Meeting with new External Auditor Non-Executive Directors Meeting Meeting with Freedom to Speak Up Ambassador Quality visit to Children's Community Nursing Service Meeting with Counter Fraud Lead Audit & Assurance and Resources Committee Chair Catch Up	Board Development: Strategic Development Board Seminar: Well Led Quality Committee Trust Board: Public Trust Board: Private x 2 Audit & Assurance Committee
Jason Makepeace	Introductory meeting with Rosi Shepherd NHS Gloucestershire System Resources Committee Council of Governors Meeting Non-Executive Directors Meeting Gloucestershire ICS NEDs Meeting Audit of Complaints discussion with Bilal Lala and Steve Alvis Meeting with Chief Operating Officer Stroud Locality Governor/Non-Executive Director Introductions 1:1 with Vice Chair Resources Committee Assurance Report Meeting Meeting with Internal and External Auditors Resources Committee Agenda Setting Meeting Meeting with new External Auditors	Board Development: Strategic Development Trust Board: Public Trust Board: Private x 2 Board Development: Leadership & Culture Programme Resources Committee Audit & Assurance Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Introduction meeting with Jan Lawry, Governor 1:1 with Rosi Shepherd NHS England Chair & NED Welcome Day Meeting with Sally Scales, NHS England Audit & Assurance and Resources Committee Chair Catch Up	
Rosi Shepherd	Council of Governors Meeting Non-Executive Directors Meeting Quality Visit to Wotton Lawn Hospital Introduction meeting with Steve Alvis Introduction meeting with Vicci Livingstone-Thompson Introduction meeting with Director of HR & OD Gloucestershire ICS NEDs Meeting Meeting with Director of Nursing, Therapies and Quality and Medical Director Quality Committee Agenda Planning NHS England Chair & NED Welcome Day Quality Assurance Group Meeting NHS Gloucestershire System Quality Committee Freedom to Speak Up Champion Network Meeting Non-Executive Directors Meeting	Board Development: Strategic Development Board Seminar: Well Led Quality Committee Trust Board: Public Trust Board: Private x 2 Leadership & Culture Committee

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Douglas Blair, Chief Executive Officer

AUTHOR: Chief Executive Officer

SUBJECT: **REPORT FROM THE CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ **Assurance ☒** **Information ☒**

The purpose of this report is to

Update the Board on significant Trust issues not covered elsewhere as well as on my activities and those of the Executive Team.

Recommendations and decisions required

The Trust Board is asked to **NOTE** the report.

Executive Summary

The report summarises the activities of the Chief Executive (CEO) and the Executive Team and the key areas of focus since the last Board meeting, including:

- Chief Executive Overview
- System Updates
- National / Regional Updates
- Events
- Achievements / Awards

Risks associated with meeting the Trust's values

None identified.

Corporate considerations	
Quality Implications	Any implications are referenced in the report
Resource Implications	Any implications are referenced in the report
Equality Implications	None identified

Where has this issue been discussed before?
N/A

Appendices:	

Report authorised by:	Title:
Douglas Blair	Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE OVERVIEW

1.1 Chief Executive – Service/Team Visits

In April & May, I have completed the following service visits:

- **Southgate Moorings**, Gloucester – on 1 April I visited Southgate Moorings where I joined the Pulmonary Rehabilitation team, who were presenting as part of an external accreditation visit. It was good to learn more about the service and support the evidence being presented.

- **Wotton Lawn Hospital, Gloucester** – I spent the morning of Tuesday 8 April at Wotton Lawn Hospital and had the opportunity to speak to colleagues there.

- **South West Regional Freedom to Speak Up Guardian Network Meeting** – I spent time with the network of Freedom to Speak Up Guardians from across the South West region, as they were meeting in Cheltenham. This was an opportunity to discuss some of our approaches to speaking up in our Trust, and other GHC colleagues presented also.

- **Tewkesbury Hospital** - I was pleased to visit Tewkesbury Hospital on 28 April where I spent time with the Theatres team, speaking with other colleagues and sitting in on a ward Monday morning review meeting.

- **Cirencester Memorial Centre & Cirencester Hospital** – I visited Cirencester Memorial Centre on 2 May, and spent time on the Cirencester Hospital site, connecting with colleagues across the broad range of services.

2.0 SYSTEM UPDATES

2.1 Model Integrated Care Board Blueprint

A 'Model Integrated Care Board Blueprint' was published on 2 May, as part of the implementation of changes to the role, function and costs of Integrated Care Boards. The blueprint emphasises the role expected of Integrated Care Boards in future, centred around strategic commissioning and management of contracts. It also identifies existing functions which could be suitable for transfer to regional teams or local providers.

Integrated Care Boards are required to submit a plan for performing the functions set out in the blueprint within a newly calculated running cost cap by 31 May 2025, with an expectation of cost reductions by Quarter 3, 2025-26. The process for formulating this plan includes the extent to which Integrated Care Boards work together to deliver functions. Gloucestershire ICB has confirmed that the provisional view is for Gloucestershire to cluster with Bristol, North Somerset and South Gloucestershire Integrated Care Board.

2.2 Corporate Costs Reduction for Provider Trusts

As part of the nationally announced NHS efficiencies, provider Trusts are expected to reduce 50% of growth in corporate costs during 2025-2026. This target has been set by comparing the benchmarked costs with the submitted position for each Trust in 2018-2019. In GHC's case, this is the aggregate of the two predecessor Trusts. This comparison was carried out nationally for all Trusts, and the results shared in April 2025. This showed that GHC should aim to reduce £999k of benchmarked costs during 2025/2026. It is important to note that the benchmark categories do not contain the totality of corporate costs, nor do they comprehensively exclude patient facing services costs. According to the nationally produced information, the Trust has one of the lowest percentages of growth of these types of costs compared to other Trusts. The vast majority of this growth will be linked to expansion of services. For GHC, the national target will be delivered as part of our ongoing programme of cost improvement plans, rather than with specific additional actions. There will be national monitoring of achievement against this target and any proposals for exclusion of specific benchmarked costs.

3.0 NATIONAL / REGIONAL UPDATES

3.1 NHS Performance Assessment Framework

A new NHS Performance Assessment Framework is currently being consulted on, with the proposed framework published on 12 May 2025. This will update the approach to segmentation of providers and Integrated Care Board, with each placed in a segment from 1 to 4 based on its performance against short and medium-term NHS priorities, with an additional segment 5 for those in most need of support. The segmentation decisions will be based solely on performance, rather than taking into account an assessment of capability. Providers will also not have their scores adjusted to reflect wider system performance. Any organisation reporting a financial deficit is limited to segment 3 (but may still be placed in segment 4 or 5). The new version has a reduced set of indicators, mostly focused on short term delivery rather than long term outcomes. In addition to common indicators relating to areas such as staff sickness, financial performance, productivity and colleague engagement, the indicators particular relevant to GHC include indicators relating to mental health acute inpatient length of stay, 52 week Referral to Treatment for community services, Children and Young People mental health access rate, CQC community mental health survey satisfaction rate, restrictive intervention rate, Crisis response and Urgent Community Response.

3.1.1 Digital Staff Passport programme to end

It was announced on the 15 April 2025 that the national Digital Staff Passport (DSP) programme has been deprioritised. As part of the wider NHS England (NHSE) integration with DHSC, a review of all national programmes has taken place, and it was decided that this programme should be stopped.

The DSP had been designed to provide colleagues ("the end user") moving across the NHS with verified credentials. Those credentials would then be owned and passed by the end user between NHS organisations to help them with the onboarding journey when they move to a new organisation. It aimed to significantly reduce recruitment

delays, duplication and improve movement generally, particularly for doctors in training and those on rotational programmes.

The national programme team and local leads are disappointed by this news but will continue to work to ensure that staff can move between NHS organisations with as little friction as possible. The efforts that have gone into developing and using the latest technology to create reusable digital employment checks will be shared so NHS organisations are able to benefit from learnings to date.

3.1.2 **Statutory and Mandatory Training Memorandum of Understanding**

From the 1 May 2025, NHS colleagues will no longer need to repeat training when they move between NHS organisations, resulting in greater efficiency and improved colleague experience. These initiatives are expected to help organisations across the whole of the NHS to release up to 200,000 days of staff time during the next financial year.

As the Trust has already aligned training with the national Core Skills Framework and made significant additional improvements, we are not expecting to gain further time and productivity gains, as these have already been made.

3.1.3 **Increases to Visa fees announced and other immigration policy changes**

The Home Office has announced increases to immigration and nationality fees. These changes were operational on 9th April 2025 and will see immigration and nationality fees increased by 7% too. Other changes include:

- Care providers in England seeking to recruit a new worker from overseas, or those switching from another visa route, will have to first provide proof that they have attempted to recruit a worker resident in England.

- The minimum salary threshold for skilled workers will increase to £12.82 per hour or £25,000 per annum, from £23,200. This means entry-level Band 3 Healthcare Support Worker roles will no longer meet the salary threshold for international sponsorship unless they are at the top step point of £25,674. The Trust has immediately added to adverts that we are now unable to sponsor band 3 salary due to the updated government salary requirement.

3.1.4 **Oliver McGowan Training**

The Oliver McGowan Mandatory Training on Learning Disability is the government's preferred and recommended training for health and social care staff who work with autistic people and people with a learning disability.

Further national funding has been agreed for 2025/26 to continue to deliver this critical training across the NHS. The new funding will be allocated to systems and / or providers on a headcount basis. Providers and / or systems must reach 30% of staff trained or more for Tier 1 training to access the funding. Both Tier 1 and Tier 2 must be compliant to get further additional funding.

Current national performance by region is detailed in the table below.

Regional Progress Against 30% Staff Trained Target as at December 2024

	Headcount	Registered Staff Trained	Percentage of Registered Staff Trained	Total Staff Trained Including Unregistered	Percentage of Total Staff Trained
North East and Yorkshire	288,764	12,192	4.22%	15,605	5.40%
North West	212,623	2,914	1.37%	3,801	1.79%
Midlands	325,068	43,966	13.53%	53,722	16.53%
East of England	150,451	22,318	14.83%	25,577	17.00%
South East	221416	5,728	2.59%	8,481	3.83%
South West	178286	45,481	25.51%	47,948	26.89%
London	269,706	8,010	2.97%	8,010	2.97%
Total	**1,646,314**	**140,609**	**8.54%**	**163,144**	**9.91%**

GHC's position in relation to Tier One training is currently at 39.31% for Gloucestershire which is strong compared to other systems and regional rates.

3.2 New Board Member Appraisal Framework

On 1 April 2025, a new Board Member Appraisal Framework for all Chairs, Chief Executives, Executive Directors and Non-executive Directors was launched. The framework was produced in response to the Messenger Review recommendations and wider stakeholder feedback, including that regarding the existing Chair Appraisal Framework, which it replaces.

This new framework incorporates the 6 domains of the leadership competency framework into a single approach for all executive and non-executive roles and aligns with the fit and proper person test (FPPT) framework. The 6 domains are:

- Working together for patients
- Compassion
- Respect and dignity
- Improving lives
- Commitment to quality of care
- Everyone counts

The framework establishes clear expectations and enhances consistency in standards for Board-level appraisals across the NHS, with the flexibility to adapt the process depending on whether the appraisee is an executive or non-executive director and enabling integration into local policies.

Organisations have the option of either incorporating the framework principles into existing local processes or to use the processes and editable forms provided.

Trust colleagues are reviewing GHC's approach against the framework and will be agreeing our local approach respectively through the Appointment and Terms of Service Committee and the Nominations and Remuneration Committee.

3.3 Very Senior Manager (VSM) Framework

On the 15th of May 2025, NHS England (NHSE) published a new Very Senior Managers (VSM) pay framework and supporting documents, jointly produced by NHSE and the Department of Health and Social Care. It puts all VSMs (Chief Executives, Directors that report to Chief Executives, and all other designated VSMs) across all NHS organisations (ICBs, NHS trusts and NHS Foundation trusts) onto the same remuneration ranges for the first time. It seeks to strengthen the link for Directors and VSMs in terms of reward and performance outcomes, increasing transparency and offering better flexibility to attract talented candidates to the most challenging senior roles in the NHS. Key points include the following:

- Compliance is expected by all providers but is not mandatory. Where an organisation does not comply, they must explain their reasons in their annual report and accounts on a "comply or explain" basis.
- Local remuneration committees remain responsible for setting VSM employment terms and salaries within the applicable remuneration ranges (which depend on turnover for provider trusts). It advises that VSM remuneration should be based on specific organisational circumstances and the complexity of the role.
- NHSE approval will be required for all NHS trust and NHS foundation trust salaries above £170,000.
- The earn back provision (the withholding of 10% of basic salary pending an annual performance review) no longer applies.
- It allows that a pay premium of up to 10% of base salary may be awarded if a VSM takes on additional responsibilities, works across multiple organisations, or performs exceptionally well.
- It also permits an individual's annual VSM pay award to be withheld if they are subject to internal performance management processes (conduct or capability) and/or unreasonably fail to meet appraisal objectives.
- Annual pay awards will be withheld for all VSMs of organisations in the recovery support programme. However, so that VSMs are not discouraged from moving to challenged NHS organisations, this won't apply if they have been in role for less than two years and there will be a 15% salary incentive that will apply for a period of up to 24 months.

In terms of next steps for the Trust, the Appointment and Terms of Service Committee (which is our local remuneration committee), will be reviewing its remuneration strategy and local contracts against the new framework and will determine what it needs to do differently going forwards.

Finally, it is worthwhile noting that the new VSM framework is just one part of a wider package of NHS reforms proposed by the government. For NHS leaders and managers, this includes the introduction of professional standards and regulation, and a package or training and development provided by the establishment of a national College of Executive and Clinical Leadership.

4.0 EVENTS

4.1 NHS Leadership Event – 29 April

I attended the NHS Leadership Event on 29 April 2025, a national Chief Executive's meeting, where as well as updates on some of the recent announcements about NHS England, Integrated Care Boards and resetting the NHS finances, there was also a chance to receive an update about likely content of the 10 Year Plan, which is now expected to be published in July 2025. Themes and direction of travel around boosting prevention and focusing in particular on what more can happen in the NHS in community settings remain at the heart of thinking.

4.2 Gloucestershire Leadership Conference – 10 April.

I was involved in a Gloucestershire Leadership Conference on 10 April, at which a wide range of leaders from across Gloucestershire gathered to discuss longer term vision for the county. This is part of a sequence of events designed to increase coordination and sharing across the public sector.

5.0 ACHIEVEMENTS / AWARDS

5.1 Apprenticeships

Congratulations on the achievements of our apprentices who have recently successfully completed their apprenticeship:

- Faye Shelley – Level 5 Operational/Departmental Manager
- Amanda Brookes – Level 5 Operational/Departmental Manager
- Sue Williams – Level 5 Operational/Departmental Manager
- Kelly May – Level 3 Business Administrator

5.2 Positive Community Mental Health Survey Results for GHC Trust

The latest results of the annual Care Quality Commission Community Mental Health Survey were published on 3 April 2025 and the Trust is highlighted as one of only four organisations in England performing 'better than expected'.

Nationally, the survey summarises the experiences of people who used NHS mental health services between 1st April 2024 and 31st May 2024. The survey asked people questions about how their care and treatment was organised, planned and reviewed, as well as crisis care, support and wellbeing, and overall evaluations of their care.

6.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: Des Gorman, Deputy Director of Improvement and Partnerships

SUBJECT: **OUR TRUST STRATEGY REFRESH 2025 - ENGAGEMENT APPROACH**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☑ Assurance ☐ Information ☐

The purpose of this report is to

This paper presents to the Trust Board the proposed Engagement approach under the 2025 Strategic Refresh.

Recommendations and decisions required

Trust Board is asked to **ENDORSE** the engagement approach.

Executive Summary

This paper sets out the internal and external engagement approach for the GHC Strategic Refresh that began in March 2025.

It also outlines the enabling strategies are to be refreshed in Q3 & 4 2025/26 with further engagement in the coming weeks led by DI&P to agree the proposed approach.

Risks associated with meeting the Trust's values

None – the work programme proposed would align with our Trust Values.

Corporate considerations	
Quality Implications	X
Resource Implications	X
Equality Implications	X

Report authorised by:	**Title:**
Rosanna James	Director of Improvement and Partnership

OUR TRUST STRATEGY REFRESH 2025 - ENGAGEMENT APPROACH

INTRODUCTION

1. Gloucestershire Health and Care NHSFTs 5-year Strategic Framework was developed following the merger of 2gether and GCS and published in 2021.

2. As we approach the final year of the current strategy, the Trust Board has reviewed the framework, alongside local and national priorities and agreed that the Trust should launch a period of engagement and co-production to refresh the strategic framework, to guide its priorities during the next five years.

3. Key decisions from the March 2025 Board development session include:

   - the Board reaffirmed our Values, Vision and Mission (i.e. no planned changes)
   - a recommitment to being an integrated Physical Health, Mental Health and Learning Disabilities provider organisation and pursuing the benefits we believe this provides our population
   - support to co-produce the Strategy refresh with internal teams, partners and those who we provide services for, so that it is meaningful and we are clear on the measures of successful delivery of our Aims
   - asked the Trust to consider whether development of Clinical and Operational Models and/ or Design Principles would be meaningful to guide our longer-term plans
   - agreed that outcome focused measurement must be tested and designed with teams as part of the strategy refresh, so the Trust is clear on the measures of success and can demonstrate these to commissioners, the wider ICS and the Gloucestershire population
   - acknowledging that our Aims were still valid as overarching statements of intent, proposed an update of our existing *Strategic Aims* to reflect 3 high priority themes: **Neighbourhood transformation; Proactive and Preventative Services and Partnership and Co-production** noting a high degree of expected alignment with forth-coming NHS 10-year plan
   - the Enabling Strategic Plans that support the delivery of our overarching refreshed strategy:
     - Quality
     - Estates
     - Digital
     - People
     - Research & Innovation

     To be reviewed in Quarters 3 & 4 and updated as required, to ensure they are aligned and continue to support the refreshed Strategic Aims.

GHC Strategy refresh

ENGAGEMENT APPROACH

4. A four-month engagement programme is currently taking place running throughout April to July 2025. We are testing out the proposed aims with Trust colleagues, ICS partners, governors, members, service users and communities.

5. We are seeking strong clinical engagement in the process to understand the principles that could underpin our service delivery and collaborative ways of working that are core to our Trust values.

6. The programme is seeking input from all levels across the Trust workforce and so far, 100 colleagues have been engaged in discussions around the aims and principles at Board Development session, Exec “plus” and Senior Leaderships Network meeting. The feedback so far is already helping shape wider engagement narrative and language.

7. Broader engagement sessions will take place:
   - at formal directorate and team meetings in May and June, as well as Medical Directorate and NTQ professional forums
   - during July and August, we are meeting with some key services to explore key service objectives for their business plan refresh beginning in September in the context of the outputs of the strategic refresh
   - at our new Working Together Network in June - including attendance from the Voluntary sector, Experts by Lived Experience, HealthWatch, Governors, ICS and GHC Colleagues and people using Trust services
   - Council of Governor's meetings – we will run workshops to engage on all elements of refresh and update on progress and explore opportunities for Governor's to support feedback from their own networks and locality-based communities
   - engaging with colleague's side reps via the JNCF
   - drop-in sessions at our sites to engage front line colleagues and wider corporate teams; as well as opportunities to engage directly with the Improvement and Partnerships Directorate at their convenience (email queries, feedback forms and intranet page content)

- and utilising our Partnership Team attendance at community events across the county, such as our annual Big Health Day in June - at which we expect up to 1000+ members of the public, volunteers, local businesses, and University of Gloucestershire to attend.

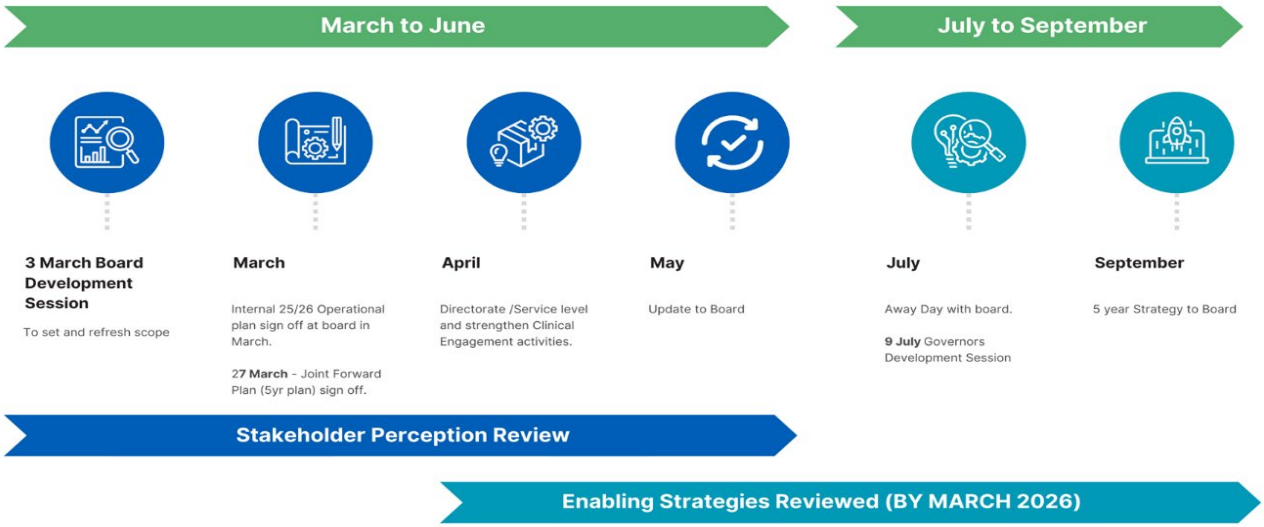
8. This approach is designed to ensure that it resonates with people across Gloucestershire and ensures our language and terminology for the Strategic Framework is clear and meaningful. We will conduct a perception review using a survey approach with wider system partners as part of the engagement process.

Drop-in sessions			
SITE:	**DATE**	**TIME**	**ROOM BOOKED**
Rikenel, Montpellier, Gloucester, GL1 1LY	2nd June	1000-1130	Meeting room 5
FoD ICTs, Colliers Court, GL14 2QA	9th June	1000-1200	Training room
Weavers Croft, Field Road, Stroud, GL5 2HZ	9th June	1400-1600	Main meeting room
Tewkesbury Hospital, GL20 5GJ	11th June	1400-1600	Conference Room
Cirencester Hospital, GL7 1UY	16th June	1000-1200	Seminar Room
Charlton Lane Hospital, Charlton Lane, GL53 9DZ	17th June	1400-1600	Conference Room 2

- *Two additional drop-in sessions via MST to follow later in June*

9. In July a further session will be held with Trust Board members to review feedback and outputs from the engagement approach to date and agree content for production of refreshed strategy through August, with planned submission to Trust Board in September 2025.

Strategy Refresh Timeline:



FOLLOW ON WORK (PHASE 2)

10. Enabling strategic plans that support the delivery of our overarching refreshed strategy will be reviewed in Quarters 3 & 4 and updated as required to ensure they are aligned and continue to support the refreshed Strategic Aims.

11. Refinement of the measures of success, including the baseline position and ambition for achievement over the next five years will also form part of the process in Q3 and Q4

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10/0525

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Lavinia Rowsell-Director of Corporate Governance / Trust Secretary

AUTHOR: Lavinia Rowsell-Director of Corporate Governance / Trust Secretary

SUBJECT: **PROPOSED STRATEGIC RISKS AND RISK APPETITE STATEMENT 2025/2026**

If this report cannot be discussed at a public Board meeting, please explain why.	*N/A*

This report is provided for:
Decision ☒ Endorsement ☐ Assurance ☐ Information ☐

The purpose of this report is to:
To present for agreement the proposed strategic risks and risk appetite statement 2025/2026.

Recommendations and decisions required
The Board is asked to:

- **AGREE** the proposed Strategic Risks that will form the basis of the Board Assurance Framework for 2025/2026
- **APPROVE** the proposed strategic risks and risk appetite statement for 2025/2026
- **NOTE** that the full BAF will be developed with Executive owners of the coming weeks

Executive summary

The Strategic Risks for the Trust are those risks that if realised could prevent the Trust achieving its strategic objectives. These risks are set by the Board and form the basis of the Board Assurance Framework which is reviewed quarterly at the Board Governance Committees.

The proposed strategic risks have been developed following the Board Risk session and feedback provided in the questionnaire undertaken as part of the BAF review work. The resulting risks include some minor rewordings of previous risks, the combination of previous risks and some new risks which have been proposed and agreed by the Executive Team. The identified Executive Lead for each risk will work with the Governance Team to review/develop the Board Assurance Framework to ensure the link between assurances and the Board and Committee workplans are clear.

Risk Appetite can be summarised as the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives. The Risk appetite

statement and levels have been updated in the context of the new strategic risks. Whilst there have been minor updates to the text, the main change to bring to your attention is the change in risk appetite in relation to 'cyber' from low to moderate. Progress continues to be made in protecting the Trust from Cyber-attack however the external environment means that the threat continues to evolve and is likely to remain indefinitely and therefore the likelihood of the risk will remain high. Given the Trust's Strategic Objectives will be reviewed in summer 2025, and that there is volatility in the sector, the updated BAF ad Risk Appetite will be reviewed again in September 2025 and May 2026.

Risks associated with meeting the Trust's values

Corporate Considerations	
Quality Implications	Ensuring the correct BAF risks is key to supporting the quality agenda.
Resource Implications	Ensuring the correct BAF risks is key to supporting effective resource allocation.
Equality Implications	Ensuring the correct BAF risks is key to supporting effective work towards reducing inequalities.

Where has this issue been discussed before?
Ongoing Executive and Board.

Appendices:	Appendix 1 – Proposed Strategic Risks 2025/2026 Appendix 2 – Risk Appetite Statement

Report authorised by: Lavinia Rowsell	**Title:** Director of Corporate Governance & Trust Secretary

APPENDIX 1

PROPOSED STRATEGIC RISKS – 2025/2026

V4 (20/05/25)

	Proposed Risks May 2025	Change	Exec Lead	Committee	Q1 Score (L v I)	Upper tolerance
1.	**Quality Standards:** There is a risk that failure to meet Quality Standards will result in harm and poor clinical outcomes for patients / service users and poor patient/service user, carer and staff experience.	**Existing risk** - reworded	Nicola Hazle /Amjad Uppal	Quality	12 (3x4)	10
2.	**Demand and Capacity:** There is a risk that the number of people being referred to services exceeds capacity to be responsive, resulting in poor experience and delays to timely access and provision of effective treatments and interventions	**Existing risk -** reworded	Sarah Branton	Resources	12 (3x4)	10
3.	**Colleague Recruitment & Retention and Development:** There is a risk that we fail to recruit, retain and develop a sustainable workforce to deliver services in line with our strategic objectives.	**Existing Risks**	Neil Savage	GPTW	16 (4x4)	12
4.	**Inclusive Culture:** There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes).	**Existing Risk**	Neil Savage	GPTW	16 (4x4)	10

	Proposed Risks May 2025	Change	Exec Lead	Committee	Q1 Score (L v I)	Upper tolerance
5.	**Relationships and Partnership Working:** There is a risk that the Trust does not have the right culture, processes and practices in place to work effectively with our communities (including service users, carers, and voluntary sector partners) impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in health service delivery (access, experience and outcomes).	**Existing Risk -** reworded	Rosanna James	Quality	12 (3x4)	12
6.	**Funding for Transformation:** There is a risk that funding constraints impact the ability of commissioners to commit to long term transformation of services to meet the needs of the populations we serve at the target pace.	**Existing Risk -** reworded	Sandra Betney	Resources	12 (4x3)	9
7.	**Speed of Change:** There is a risk that the Trust's speed of improvement, innovation and transformation is not sufficient to respond the rapidly changing policy environment and needs and expectations of the population.	**New Risk**	Douglas Blair	Resources/ Board	16 (4x4)	12
8.	**Cyber:** There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data.	**Existing risk**	Sandra Betney	Resources	12 (3X4)	10
9.	**Closed Culture:** There is a risk of closed cultures existing in teams and services across the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm.	**Existing Risk**	Nicola Hazle	Quality	16 (4X4)	10

	Proposed Risks May 2025	Change	Exec Lead	Committee	Q1 Score (L v I)	Upper tolerance
10.	**Health Equity:** There is a risk that services are designed and operate in such a way that they do not meet the diverse needs of the population resulting in barriers to access and availability, and poor experience and outcomes for individuals, groups, or communities.	**New Risk**	Rosanna James	Quality	12 (3X4)	10
11.	**Strategic Commissioning Partnerships:** There is a risk that changes in commissioning impact our ability to provide services affecting staffing models, financial sustainability and achievement our strategic objectives and require significant changes to our contract management and delivery monitoring processes.	**New Risk**	Rosanna James / Douglas Blair	Resources/ Board	16 (4X4)	10

Note: Consideration of sustainability risk to take place as part of Green Plan refresh discussions.

Appendix 2

PROPOSED RISK APPETITE STATEMENT 2025/2026

The purpose of the Risk Appetite Statement is to inform all those responsible for identifying and managing risk at GHC of the context to use when assessing how a risk should be evaluated.

The risk appetite, set by the Board of Gloucestershire Health and Care NHS Foundation Trust is necessarily more open than in previous years. This reflects the unprecedented challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, the pace of societal and technological changes and the ongoing climate crisis. During this time of change we will continue to protect the Quality and Safety of Care and minimise risks that may have a detrimental effect on the Service User Experience and the experience of those supporting them (classified as a moderate risk appetite).

In relation to Organisational Culture, Meeting Population Needs, and Finance we will continue to have a moderate risk appetite, enabling us to explore opportunities whilst ensuring the breadth and importance of these areas is subject to sufficient oversight.

We acknowledge that service capacity continues to be a challenge across our healthcare system. Transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We will support our people to adapt and thrive during change. Investment decisions will reflect our ambition to provide outstanding physical and mental health care and learning disability services for the people of Gloucestershire, putting the person at the heart of our services focusing on *personalised care* from the perspective of '*what matters to you'* rather than '*what is the matter with you'*.

To achieve our aims of providing outstanding care, we have a high-risk appetite in our approach to Innovation, Transformation; Partnership and Collaborative Working and Workforce. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships. The digital agenda will underpin innovation and the transformation of services to become more efficient and effective. Whilst we are prepared to accept higher levels of risk to implement changes for longer term benefit, we have a moderate appetite in relation to Cyber Security and low in relation to Compliance and Regulation.

The Risk Appetite Statement provides the Board's appetite for risk taking and tolerances and is mapped against the Strategic Priorities. This clear understanding of the Board's tolerances and appetite for risk taking is necessary to steer and influence the development of appropriate risk mitigation controls.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite. Where this is the case, it is proposed that these decisions will be referred to the Board.

The Risk Appetite Statement was approved by the Board on May 2025 (TBC).

Risk Appetite Themes

Risk Theme	Risks within this Theme	Appetite Level	Tolerance	Reporting Impact
Quality and Safety of Care & Service User Experience	Quality and Standards	Moderate	10	11 and up
Innovation and Transformation (including AI)	Speed of Change	High	12	13 and up
Meeting Population Needs	Demand and Capacity Health Equity	Moderate	10	11 and up
Partnership and Collaboration	Relationships and Partnership Working	High	12	13 and up
Workforce	Colleague Recruitment & Retention & Development	High	12	13 and up
Finance	Funding for Transformation Strategic Commissioning Partnerships	Moderate	10	11 and up
Culture	Internal Culture Closed Culture	Moderate	10	11 and up
Compliance and Regulation		Low	6	7 and up
Cyber	Cyber	Moderate	Proposed 10	11 and up

REPORT TO: **TRUST BOARD PUBLIC SESSION - 29 May 2025**

PRESENTED BY: Sonia Pearcey, Ambassador for Cultural Change & Freedom To Speak Up Guardian

AUTHOR: Sonia Pearcey, Ambassador for Cultural Change & Freedom To Speak Up Guardian

SUBJECT: **FREEDOM TO SPEAK UP GUARDIAN SIX MONTHLY UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to:

To update the Trust Board on activity of the Freedom to Speak service for 2024/25.

To provide assurance to the Trust Board that:

- Speaking Up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs
- Speaking Up processes are in line with national guidance
- Continued progress in raising the bar in embedding our positive speaking up culture.

Recommendations and decisions required:

Following consideration by the Great Place to Work Committee at its meeting in April 2025, the Board is asked to **receive, review** and **note** the information and assurance provided in relation to Freedom to Speak Up activity during 2024/25.

Executive summary

This six-monthly update report is an update from the previous report presented to the Trust Board in November 2024, which covers Freedom to Speak Up activity of colleagues speaking up, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian. The report also provides year end data for 2024/2025.

This is a summary of a report presented to the Great Place to Work Committee on 29th April 2025 and was considered in context of the People Strategy and information from the NHS staff survey. At the request of the Chair of GPTW, additional benchmarking information has been included. The Committee took assurance from the information

presented on Freedom to Speak Up activity.

In summary, in 2024/2025:

- There was an 8% increase in speaking up cases (104 in total), this follows a 25% increase of speaking up in 2023/24.
- Anonymous reporting increased to 11.5% from 3% (2023/24 national picture of 9.5%). Reasons behind this are being explored and considered in the context of the staff survey results highlighted below.
- 89% of colleagues speaking up would use the service again.
- Colleagues that feel they have suffered detriment is just under 10% (up from 7% 2023/2024) against a national picture of 4%.
- 14% of colleagues speaking up have declared a protected characteristic although there are no current trends to this above data. From April 2025, within the feedback collated three updated questions has now been added to offer further insight.
- Within the NHS Staff Survey 2024 - *We each have a voice that counts* (2nd in the region), a slight decline from 7.12 in 2023 to 7.00 for 2024. Organisationally the four speaking up questions have also slightly declined year on year. Nationally this year's results have also plateaued in confidence to speak up. The Freedom to Speak Up sub-score remains unchanged at 6.45 compared to 6.46 in 2023.
- The Freedom to Speak Up APP (application) V2 was launched in March 2025, and will enhance the user and Guardian experience with a case management system and increased governance in place.

Looking forward, in addition to continuing to support colleagues on a day to day basis, Speaking Up is identified as a key workstream in the Leadership and Culture programme with the aim of supporting all colleagues to feel safe and confident to speak up, encouraging leaders to take the opportunity to learn and improve from those who speak up.

Risks associated with meeting the Trust's values
All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	Processes are aligned to the guidance NHE/I and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported. Freedom to Speak Up arrangements are reviewed within the Well Led domain. NHS contract (2016/17) the requirement of a Freedom to Speak Up Guardian.
Resource Implications	Continued monitoring of the workload and demand on the Freedom to Speak Up service.

Equality Implications	Colleagues have spoken up regarding their experiences of racial discrimination. Colleagues disclose to the Freedom to Speak Guardian their protected characteristics.

Where has this issue been discussed before?
Workforce Management Group 5th March 2025 Quality Assurance Group 17th April 2025 Great Place to Work Committee 29th April 2025

Appendices:	AI-11.1/0525 - PowerPoint Slide deck Freedom to Speak Up Six Monthly Update.

Report authorised by:	**Title:**
Lavinia Rowsell	Director of Corporate Governance / Trust Secretary

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AGENDA ITEM: 11.1/0525

Freedom to Speak Up Update

Public Trust Board

29th May 2025

Freedom to Speak Up Guardian

Freedom to Speak Up Champion

working together | always improving | respectful and kind | making a difference

Speaking Up in GHC

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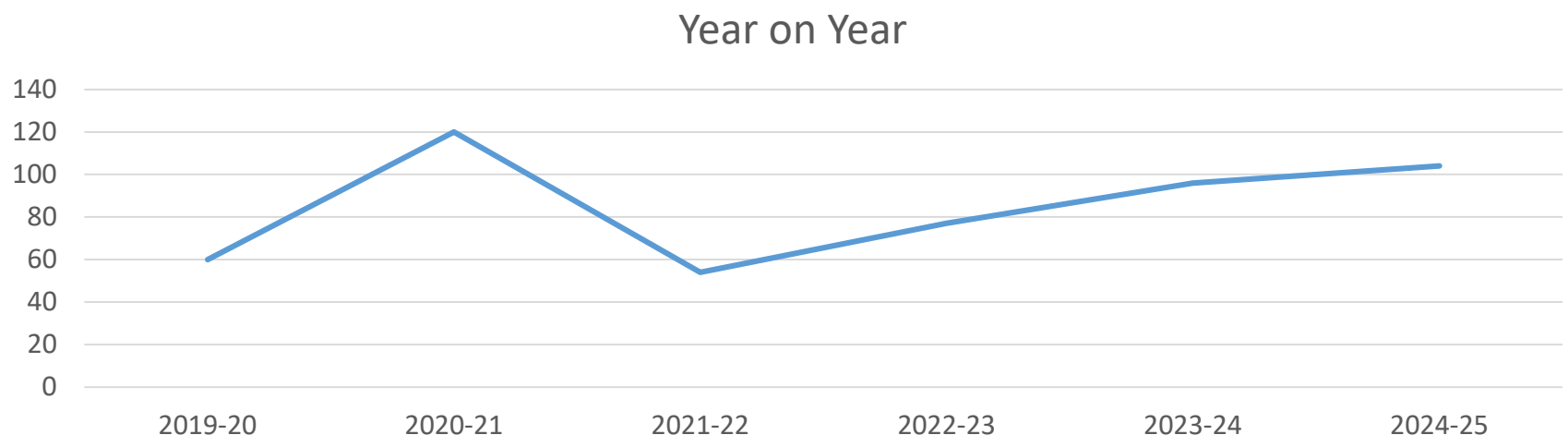
Cases raised to the Freedom to Speak Up Guardian

	Number of Cases				
Year	Q1	Q2	Q3	Q4	Total
2024/2025	20	21	26	37	104
2023/2024	23	16	23	34	96



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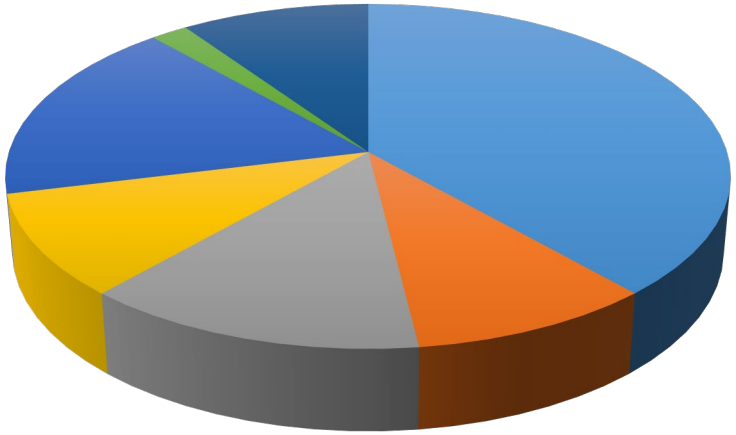
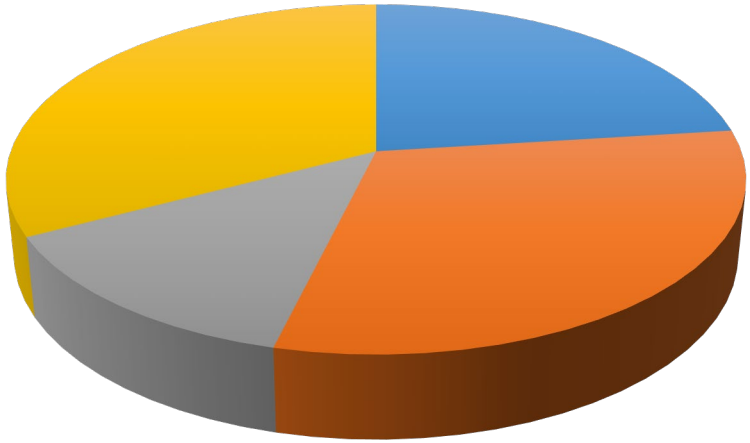
Colleagues Speaking Up – 2024/2025

Professional Groups %



Nurses
AHPs
Add Clinical
E&F
Admin
Medical/Dental
Unknown

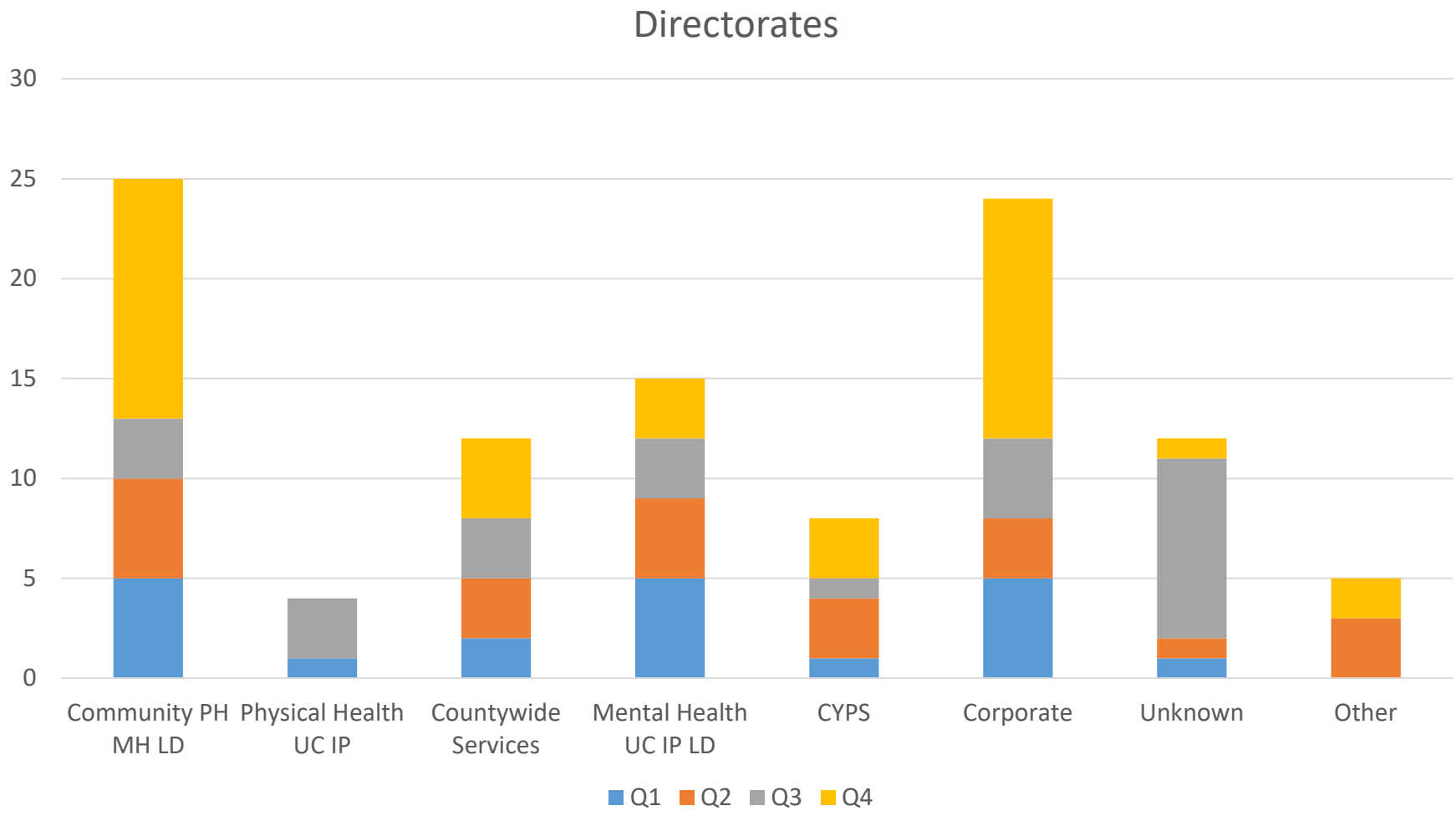
Themes %



Patient Safety/Quality
Inappropriate Behaviors
Bullying and/or Harrassment
Worker Safety/Wellbeing

Colleagues Speaking Up

Gloucestershire Health and Care
NHS Foundation Trust



CURRENT PROACTIVE SPEAKING UP ACTIVITY

- Several proactive projects and initiatives which incorporate FTSU and aim to create a culture of psychological safety to benefit both colleagues and service users Civility Saves Lives - Interact (ghc.nhs.uk)
- Bespoke Directorate/Team workshops to review Staff Survey data and speaking up activity, behaviours and cultural change.
- Specific workstream in Trust Leadership and Culture Programme on Speaking Up
- Networks - the Guardian is visible with the Chairs for each of the diversity networks including the Internationally Educated Nurses Council and Resident Doctor's Forum.
- Temporary Staff - FTSU also extends to temporary staff and contractors. The Guardian has educational links throughout the county

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Staff Survey 2024

We each have a voice that counts

Score 7.0 ↑

This is just below our score for 2023 (7.1). However above average score for our sector was 7.0

Sector Benchmark

↑ Better

⟷ Average

↓ Below

Raising Concerns

76.7% feel they can raise concerns about unsafe clinical practice *(78.9%)*

↓

63.6% feel that the their organisation would address these concerns *(67%)*

68.2% feel safe to speak up about concerns within the organisation *(71.1%)*

↓

56.4% feel that their organisation would address these concerns *(58.8%)*

‘Listening to the Silence - What does the Staff Survey tell us about speaking up in the NHS?’ published July 2024

Fear and futility data sets from the 2023 NHS Staff Survey to compare against the 2024 data.

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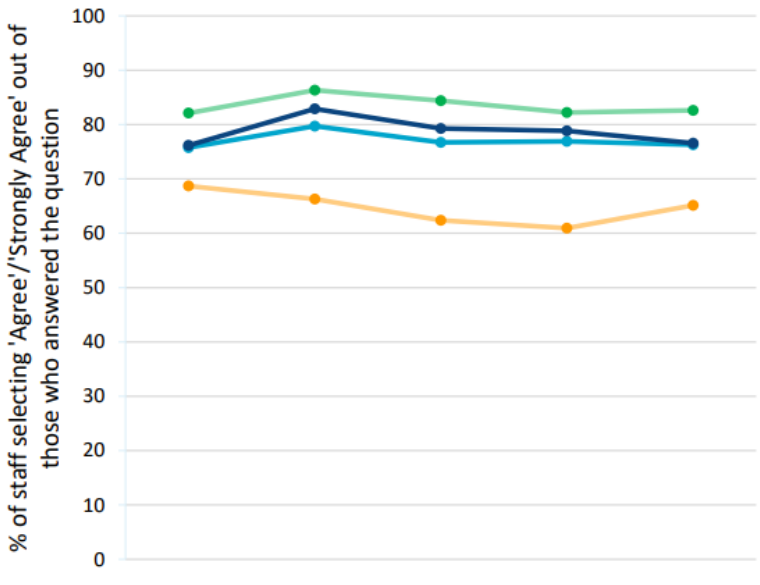
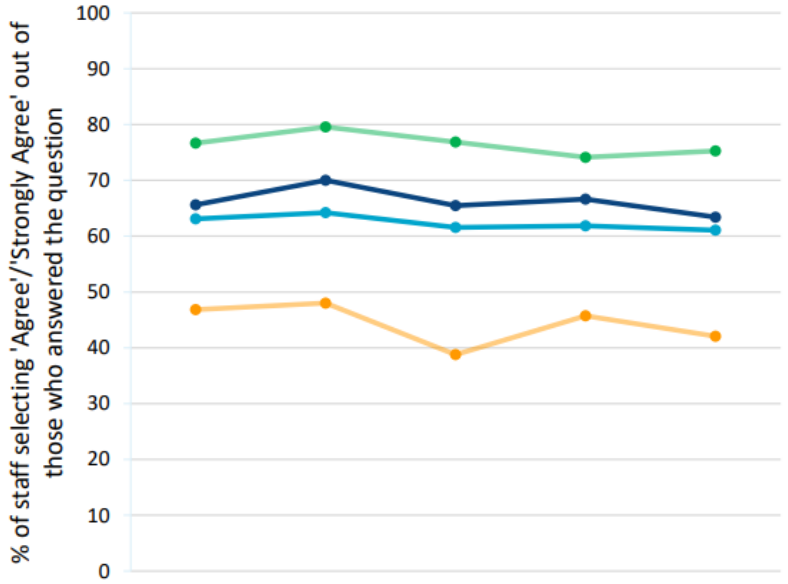
Staff Survey 2024

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2020	2021	2022	2023	2024
Your org	76.16%	82.89%	79.26%	78.82%	76.56%
Best result	82.10%	86.32%	84.40%	82.22%	82.61%
Average result	75.76%	79.72%	76.72%	76.90%	76.27%
Worst result	68.68%	66.30%	62.38%	60.93%	65.14%
Responses	2011	2357	2477	2787	3009

Q20b I am confident that my organisation would address my concern.



	2020	2021	2022	2023	2024
Your org	65.60%	70.01%	65.48%	66.65%	63.41%
Best result	76.65%	79.56%	76.86%	74.13%	75.27%
Average result	63.13%	64.21%	61.55%	61.84%	61.06%
Worst result	46.86%	48.01%	38.77%	45.73%	42.06%
Responses	2006	2349	2467	2781	3002

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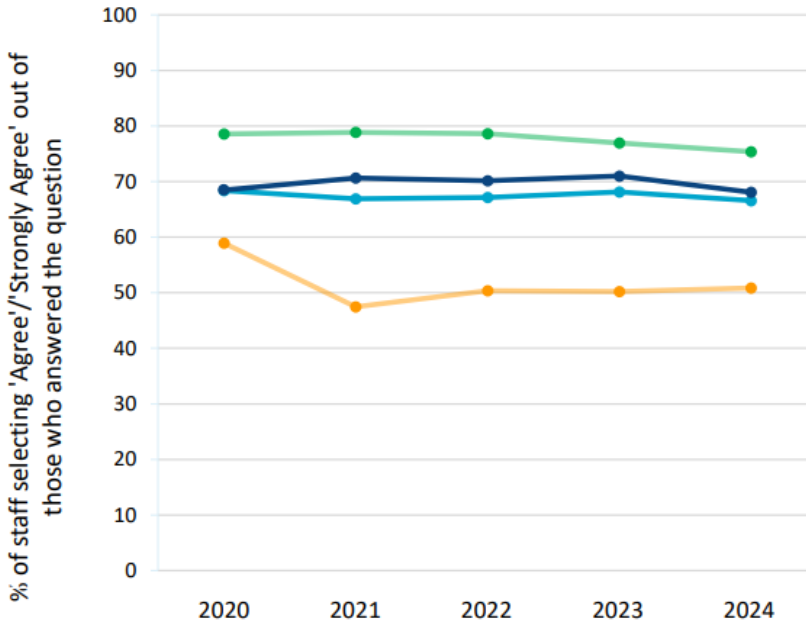
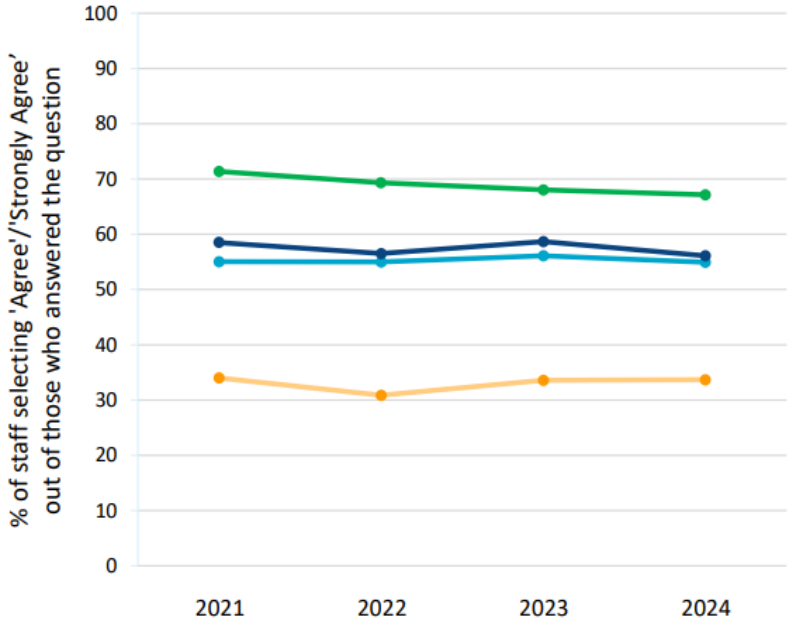
Q25e I feel safe to speak up about anything that concern in this organisation.



	2020	2021	2022	2023	2024
Your org	68.49%	70.62%	70.15%	71.00%	68.07%
Best result	78.55%	78.85%	78.61%	76.93%	75.37%
Average result	68.38%	66.88%	67.13%	68.13%	66.58%
Worst result	58.92%	47.46%	50.35%	50.21%	50.87%
Responses	2006	2357	2475	2793	3006

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024
Your org	58.49%	56.50%	58.67%	56.11%
Best result	71.37%	69.31%	68.05%	67.15%
Average result	55.04%	55.00%	56.11%	54.93%
Worst result	34.00%	30.87%	33.60%	33.65%
Responses	2354	2480	2792	3002

Benchmarking - Top comparators across the four questions

Q20a - I would feel secure raising concerns about unsafe clinical practice	%
Mersey Care NHS Foundation Trust	84.55
Midlands Partnership University NHS Foundation Trust	82.40
Lincolnshire Partnership NHS Foundation Trust	81.60
Gloucestershire Health and Care NHS FT	76.56

Q20b - I am confident that my organisation would address my concern	
Berkshire Healthcare NHS Foundation Trust	75.27
Solent NHS Trust	73.28
Midlands Partnership University NHS Foundation Trust	69.73
Gloucestershire Health and Care NHS FT	63.41

Top comparators across the four questions

Q25e - I feel safe to speak up about anything that concerns me in this organisation	%
Berkshire Healthcare NHS Foundation Trust	75.37
Midlands Partnership University NHS Foundation Trust	74.39
Solent NHS Trust	74.38
Gloucestershire Health and Care NHS FT	68.07

Q25f - If I spoke up about something that concerned me I am confident my organisation would address my concern	%
Berkshire Healthcare NHS Foundation Trust	67.15
Midlands Partnership University NHS Foundation Trust	65.28
Solent NHS Trust	64.49
Gloucestershire Health and Care NHS FT	56.11

NATIONAL UPDATES

- In 2024, NHS England published their cultural review of ambulance trusts following a review by the National Guardian's Office found that the culture in ambulance trusts was having a negative impact on workers' ability to speak up. Progress has been made against the recommendations Listening to Workers - a review of progress - National Guardian's Office.
  The FTSU Guardian has been supporting the Sexual Safety work

- Board Guidance Tool - Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool.
  Ongoing document as a quality statement

- Updated guidance for NEDS

- Detriment guide - National Guardian's Office

  Following a collaborative piece of work with Freedom to Speak Up Guardians, Protect, and Andy Noble, Head of Speak Up at NatWest Group, the national team have published detriment guidance for organisations.

- Strengthening our foundations: why the review of the universal job description matters - National Guardian's Office

  A framework to support leaders, organisations, and guardians alike, to clarify expectations, standardise recruitment, and ensure the role is understood, supported, and effective within organisations.

- Overseas trained workers - National Guardian's Office

  This review highlights the unique challenges faced by NHS workers trained outside the UK when speaking up.

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AGENDA ITEM: 12/0525

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHORS: Andrew Telford (GHC) and Sadie Trout (ICB)

SUBJECT: **INTENSIVE AND ASSERTIVE COMMUNITY MENTAL HEALTH ACTION PLAN UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☒ Endorsement ☒ Assurance ☒ Information ☒

The purpose of this report is to:

To update the Board on progress and next steps in relation to the Intensive and Assertive Community Mental Health Treatment Review led by the Integrated Care Board, supported by GHC Operational Leads.

Following feedback from GHC and ICB Boards, the final action plan submission will be made to NHSE by the end of June 2025.

Recommendations and decisions required

The Trust Board is asked to:
- **NOTE** the update provided
- **ENDORSE** the submission of the action plan to NHSE by the end of June 2025

Executive Summary

The attached paper is presented jointly to the ICB Gloucestershire Public Board (28 May 2025) and Trust Board (29 May 2025). It provides a further update to the opportunities and next steps outlined in the November 2024 Board Paper, in line with the NHSE Intensive & Assertive Community Mental Health review governance. The Action Plan Development and Programme are a shared GHC and ICB responsibility as specified by NHSE National Guidance (July 2024).

Following the multiple homicides in Nottingham 2023 by Valdo Calocane, CQC made several recommendations to improve services and safety across mental health teams and organisations. During 2024/25 ICBs and provider NHS Trusts were required by NHS England (NHSE) to 'review their community services by Q2 2024/25 to ensure that they

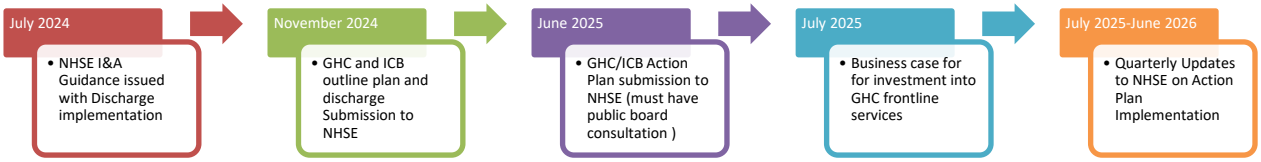
have clear policies and practice in place for patients with serious mental illness, who require intensive and assertive community treatment and follow-up but where engagement is a challenge.' The ICB and GHC worked together and completed a self-assessment using the ICB Maturity Index Self-Assessment Tool and the outcomes and system opportunities were shared with NHSE in September 2024 and considered by Trust Board in November 2024. Since this submission a multidisciplinary task and finish group has been working to develop a detailed action plan, built on clinical and operational service review and in line with CQC and NHSE principles, to ensure our local psychosis pathway meets the needs of this patient cohort and responds to the opportunities identified within current service provision.

Safety is a key consideration in completing the review. The system has confirmed that DNAs (did not attends) are never exclusively used as a reason for discharge from care for this vulnerable patient group. As per national guidance the ICB and GHC NHS Trust rapidly checked that existing service polices and practice and confirmed this with NHSE regional mental health colleagues. The system has now produced a comprehensive action plan that addresses any areas identified as areas for improvement.

Expected Outcomes:

1. Improved response times for Intensive & Assertive patient group (measured from re-referral).
2. Improved Patient Satisfaction (Measured using DIALOG).
3. Reduced length of in-patient stay for this cohort of patients.

Timeline and next steps:



The action plan implementation is subject to the necessary investment in GHC frontline services managed via the agreed business planning process during early 2025/2026.

Risks associated with meeting the Trust's values

The following risks are currently on the Trust's Risk Register:

- There is insufficient robustness in our psychosis care pathway to minimise future serious incidents involving this patient group.

- There is insufficient workforce to deliver the intensity and expertise required to safely manage people with psychosis who do not wish to engage with services.

- The Dartmouth Fidelity Scale and ICB Maturity Index Self-Assessment Tool are based on 1990's frameworks and will not provide sufficient improvement detail for a Transformed CMHT service.

Corporate considerations	
Quality Implications	The paper outlines the next steps to engage with those with lived experience and the wider public. The draft action plan summary has been shared with the Adult Mental Health and Neurodiversity Clinical Programme Group and updates shared with our local Mental Health & Wellbeing Partnership Board. The Task & Finish Group has been working with AOT colleagues to identify people with lived experience of psychosis who may wish to engage with work programme and next steps have been agreed to work with the partner led mental health lived experience group, MHELO.
Resource Implications	The paper summarises the key improvements and next steps identified in the action plan. During the 2024/2025 NHSE submission the ICB and GHC prioritised mitigations, actions and assessed financial impact, considering the potential additional resource i.e., workforce and investment in training. No additional funding has been made available to the system for this work (as part of SDF of core allocation) and so investment has been identified as part of the system MHIS process to support additional clinical, medical and leadership roles.
Equality Implications	The review highlights the need to ensure whole population data is available to support the self-assessment tool. We are aware that our current caseload ethnicity profile is not in keeping with our community population profile. Initial work has been started within the Community Mental Health Transformation Team and will be prioritised as part of our local embedding of our neighbourhood teams. Assertive outreach teams are often tasked with minimising potential harms including harms to the individual and to others within the local community. Clinical decision making requires balancing each of these to find an optimal solution. Development of the action plan therefore considers the impacts of our psychosis pathway, service delivery and balancing safety, with a person's Human Rights.

Where has this issue been discussed before?
GHC Board and ICB Public Boards November 2024. ICB Board 28th May 2025.

Appendices:	None

Report authorised by: Amjad Uppal	**Title:** Medical Director

Glossary of Terms	Explanation or clarification of abbreviations in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

1.0 BACKGROUND

NHSE required all ICBs and provider NHS Trusts to review their community services by Q2 2024/25 to ensure that they had clear policies, practice, and right care provision in place for patients with serious mental illness, who require intensive community treatment and follow-up particularly where engagement is a challenge. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely to present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

The collaborative approach by a multi-disciplinary task and finish group, including a range of system colleagues from across commissioning, community mental health teams, specialist services and including clinical and operational leaders, has provided a broad, honest and open review of intensive and assertive mental health community provision provided by GHC across the county. In Q4 2024/25 the system submitted an overview of the areas for improvement and a draft outline action plan and work has been ongoing to develop and implement these changes.

2.0 KEY THEMES FROM TASK & FINISH REVIEW

To recap, the Intensive & Assertive Task and Finish Group completed the self-assessment over several workshops, overall, the initial self-assessment provided assurance that the cohort (outlined above) were well managed and able to support the complexities of treating people with severe and enduring mental illness, with no concerns or significant issues identified with regards to safety or quality of care. The table below provides a summary of findings:

Identified Strengths	Identified Opportunities
Dedicated AOT in place across county	Improving Interfaces across pathways and between services
Assessment Risk Assessment & Care Planning Met Criteria	Local Community Demographics
Community Rehabilitation Offer	Intervene more quickly and prevent relapse
Improving Recruitment Picture	Diversity Profile
Relevant Criteria in Place in Policy & Pathways	Discharge Processes
	Embedding Lived Experience

In February 25, clinical leaders from the Task & Finish Group completed the Dartmouth Assertive Community Treatment Scale (DACTS) across each of our AO teams (North, South, West), which outlines fidelity to the National Service Framework view of Assertive Outreach. As noted in the risks, the model is 35 years old and so 100% compliance would be of concern given the progression in delivery of care, however our localised template mitigated some of this risk. Overall, there was little variation of scoring across the 3 teams, and the overall fidelity score was 65%. Key opportunities noted were:

- Consideration of a more flexible approach to providing intensive and assertive approach i.e. number of contacts with patient driven by need not time, deployment of other team members dependent on the needs of the service, team flow to support caseload sizes.
- An aligned service with two functions: an intensive and a rehabilitative function. Opportunities to bring teams/functions together i.e. Specialist Rehabilitation, Assertive Outreach and our out of county placements team.
- Information sharing between teams – improving referrals and discharge interfaces.
- VCSE support offers and interface with GHC services – including vocational and accommodation.
- Proactive involvement of patient's families/carers in planning and delivery of care. Work with teams and people who use our services to develop Peer Support Worker roles across community mental health services. Invite carers and service users to be experts by experience.
- Require clear strategy on engagement: clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge.
- A no wrong door approach – likely cohort will present outside of secondary care services. Rapid and direct access back into the Intensive and Assertive team for people previously on the caseload (or meeting the criteria for psychosis with engagement issues)
- Enhance robust risk assessment – staff are adequately supported through training to manage the often-high ongoing risks this client group present.
- Comprehensive training offer – training for support workers and role consistency across all teams to ensure we are using this resource effectively to improve health and care outcomes for people on the caseload, improving training in psychological interventions.
- The DACT tool does not distinguish the services offered to racialised and ethnic minority backgrounds. Further work needs to be done on who is currently accessing services and identifying and engaging with population groups who are not.

2.1 Action Plan Priorities and NHSE I&A Principles

Following the system submission of review findings and noted areas of opportunity, the national team have developed a set of Intensive and Assertive Community Mental Health principles. The Task & Finish group have mapped the action plan against these mandated and/or suggested criteria. An overview of priorities is provided below:

ICBs & Trusts Must Ensure	Action Plan Summary
NHSE Principle: Everyone should have a coproduced and personalised care and treatment plan	
• Reviewed minimum every 6 months • Suitably trained key worker remains in contact with individual throughout period of non-engagement. • Use of depot is carefully considered and used as part of wider treatment plan (including access to psychological therapies, social intervention, and practical support). • Responsive to coexisting needs i.e. substance misuse and links with support services.	*ICB Maturity Matrix and DACT Reviews acknowledged that personalised care and treatment plans were a current strength across AO and Recovery Teams.*
	Explore opportunities within current recommissioned Substance Misuse Services i.e. flexibility of offer with challenging to engage, access and equity.
	Amalgamate Assessment Care Management Policy include review of discharge protocol and development of Opt- in process for rapid and direct re-access to services.
	Undertake focused pathway review and consider interventions for drug induced psychosis, particularly where the pathway crosses organisations.
NHSE Principle: Engaging families, carers and support workers is essential	
• Establish formal process for engaging families at critical decision-making points – care planning, safety, and risk management. • Implement review and update confidentiality policies. • Implement feedback mechanisms to assess impact of family engagement efforts. • Ensure all family engagement policies and processes align with PCREF.	Formalise protocol in Standard Operating Procedure to ensure multi agency and lived experience representation (including carer/families) supported by a coproduction approach.
NHSE Principle: Seamless care between community and inpatient settings is a core component of intensive and assertive community treatment.	
• Joint care planning meetings – inpatient and community teams. • Key workers provide relevant clinical insights to inpatient teams – reducing need for repeated assessment. • Clinical Review Panel or Escalation Forum established. • Ensure views of all care givers are considered in long term care planning.	Our aim is to provide a 'Flexible Assertive Community Treatment Team.' This will be an integration of existing teams (Assertive Outreach, Specialist Rehabilitation, Specialist Out of County) with the ability to 'in reach' to services such as Recovery and Forensic Teams when a person's health becomes a concern. (N.B. The operation and level of integration and is yet to be confirmed how that will be

ICBs & Trusts Must Ensure	Action Plan Summary
	configured, and necessary service specifications be developed).
	Implementation of Flexible Assertive Community Team approach would include development of MDT review approach including stratification of patients.
	Review the positive aspects of the 'care co-ordination' role to define and develop assertive interventions to include structured case management.
NHSE Principle: Ensuring the right workforce with appropriate skills and competencies, is essential for delivering high quality care	
• Appropriate staff, necessary skills. • Comprehensive training, regular supervision and support. • Confidence in application of legal frameworks i.e. s117, MHA, CTOs. • Establish Peer Support Programme.	Completion of workforce skills and training audit across community mental health teams in line with ongoing work led by GHC Clinical Forum.
	Develop training protocol re delivery clinical conversations – i.e. structured visits, goal-based discussions (DIALOG) and agree principles regarding team approaches to staff skill mix i.e. considered whenever there is a vacancy.
	Scope and implement Peer Support Worker role.
	Develop and embed arrangements for ongoing supervision i.e. community mental health team & AO such as motivational interviewing training, CBT programme, family work.
	Review s117 policy and consider practical application of discharge from s117.
NHSE Principle: Intensive and Assertive Community Mental Health treatments are embedded across community teams with robust governance.	
• Local expertise and data – improving risk identification. • Limited staff caseloads. • Establish multiagency forums to review cases. • Ensure local serious incident policies comply PSIRF.	Introduction of Engagement Score (ORES), continued care planning based on DIALOG and when indicated PANNS all recorded routinely and captured in EPR (RiO).
	Develop clinical criterion to ensure clear oversight of patient cohort

ICBs & Trusts Must Ensure	Action Plan Summary
	profile. Implement I&A live dashboard based on clinical criterion (using elements above) that can alert team(s) to change in risk factors and every person who is discharged (that has met the criterion during their current clinical episode.)
	Take steps to ensure routine recording of service user, family/carer protected characteristics, focusing on ethnicity, to support development of robust patient cohort profile.
NHSE Principle: Effective information sharing and collaboration between system partners are essential to delivering coordinated care.	
• Inter-agency governance group to share information. • Multiagency case discussion is embedded in care planning and noted in EPR. • Clear protocols for timely multiagency data sharing. • Improve interoperability to ensure timely sharing of clinical and risk related information across care settings.	Development of I&A live dashboard (as noted above.)
	Implementation of Flexible Assertive Community Team – considering interface with multiagency partners.
	Develop opportunities to share data via JUYI and comms approach with partners.
	Link to development of CMH VCSE Forums across the county, led by Rethink.
NHSE Principle: Ensure patient safety and reduce risk of serious harm.	
• Coproduced, formulation-based risk assessment – personalised relapse signature and actions to support staying safe and well.	Consider options for out of hours assertive support – AOT does not currently have an OOH offer.
• Monitor early warning signs and implement appropriate interventions.	Implement a rapid re-access process directly to the Intensive and Assertive team that can be triggered by the service user, health professional or friends and family (noting the nature of the illness this may be without the service users consent)

3.0 NEXT STEPS

The ICB and GHC will submit a further update of the Intensive & Assertive Community Mental Health Action Plan to regional NHSE colleagues in Q1 25/26. The Task and Finish Group will continue to meet and oversee the delivery of the actions and implementation timeline, led by the appointed Clinical Lead.

Immediate prioritisation of actions has been completed and following completion of the DACT Review and team engagement, our immediate next steps will be the scoping and development of the I&A Live Dashboard. This will require some improvements and changes to clinical recording and reporting and further insights into our patient profile will develop over time, however an immediate digital resolution to ensure a real time, multiagency risk escalation and alert system is a priority.

Concurrently we will also continue to engage people with lived experience of psychosis (specifically those who have been challenging to engage) and their families/carers to consider the interventions and improvements proposed in the action plan and provide opportunities to give regular insight and feedback into any service developments or proposals.

Whilst the review has indicated several areas of opportunity and development need, most improvements can be delivered within existing workforce and resource. However, the system has supported investment into additional medical resource within AOT and specialist rehab functions that will support the implementation of the FACT model, a more robust MDT approach and improved interfaces between teams.

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13/0525

REPORT TO: **TRUST PUBLIC BOARD SESSION – 29th May 2025**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy CEO

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th April 2025**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Trust Board is asked to **NOTE** the month 1 position.

Executive summary

- There are no material amendments to the position from the Resource Committee summary in April, and the year-end performance for GHC was a surplus of £0.31m
- Draft accounts submitted 25th April 2025, being audited by KPMG. Audited accounts are due 30th June 2025
- The system plan at 30th April was break even and the Trust's plan was break even
- At month 1 the Trust has a surplus of £0.002m compared to the plan of a £0.073m deficit
- 25/26 Capital plan is £15.449m with £3.265m of disposals leaving a net £12.184m programme. Spend to month 1 is £0.210m against a budget of £0.548m
- The Trust spent £0.297m on agency staff in month 1. This equates to 1.35% of total pay. There were 25 off framework shifts, the target is 0.
- Cash at the end of month 1 is £45.025m, £3.3m above plan

Risks associated with meeting the Trust's values
Risks included within the paper

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices	Finance Report M1

Report authorised by: Sandra Betney	**Title:** Director of Finance and Deputy CEO

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AGENDA ITEM: 13.1/0525

Finance Report
Month 1

working together | always improving | respectful and kind | making a difference

Overview

- Draft accounts submitted 25th April 2025, being audited by KPMG. Audited accounts are due 30th June 2025.
- There are no material amendments to the position from the Resource Committee summary in April, and the year end performance position for GHC was a surplus of £0.31m.
- The system plan at 30th April was break even and the Trust's plan was break even.
- At month 1 the Trust has a surplus of £0.002m compared to the plan of a £0.073m deficit.
- 25/26 Capital plan is £15.449m with £3.265m of disposals leaving a net £12.184m programme. Spend to month 1 is £0.210m against a budget of £0.548m.
- Cash at the end of month 1 is £45.025m, which is £3.3m above plan.
- Cost improvement programme has delivered £2.956m of recurring savings through budget setting. Target for the year is £10.086m. £5.156m is unidentified.
- Non recurrent savings target is £5.189m of which £0.257m is delivered. Only £0.042m remains unidentified.
- The Trust spent £0.297m on agency staff in month 1. This equates to 1.35% of total pay. There were 25 off framework shifts, the target is 0.
- Better Payment Policy shows 95.1% of invoices by value paid within 30 days, the national target is 95% and 92.5% by number of invoices.
- Lydney Health Centre business case is not finalised for May Board and the scheme is under review.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

	2025/26 Plan	2025/26 Revised budget ytd	2025/26 Actuals ytd	2025/26 Variance
Operating income from patient care activities	301,442	26,492	26,831	339
Other operating income	16,590	1,412	1,654	242
Employee expenses - substantive	(221,705)	(21,461)	(19,801)	1,660
Bank	(17,906)	(209)	(1,831)	(1,622)
Agency	(3,967)	(121)	(297)	(176)
Operating expenses excluding employee expenses	(73,026)	(6,065)	(6,543)	(478)
PDC dividends payable/refundable	(2,781)	(232)	(232)	(0)
Finance Income	1,500	125	233	108
Finance expenses	(198)	(16)	(17)	(1)
Surplus/(deficit) before impairments & transfers	**(51)**	**(74)**	**(2)**	**72**
Gains/ (losses) from disposal of assets				0
Remove capital donations/grants I&E impact	51	4	4	0
Surplus/(deficit)	**0**	**(70)**	**2**	**72**
Adjust (gains)/losses on transfers by absorption/impairments	0	0		0
Remove net impact of consumables donated from other DHSC bodies	0	0		0
Revised Surplus/(deficit)	**0**	**(70)**	**2**	**72**
WTEs	4761.63	4766	4708	58

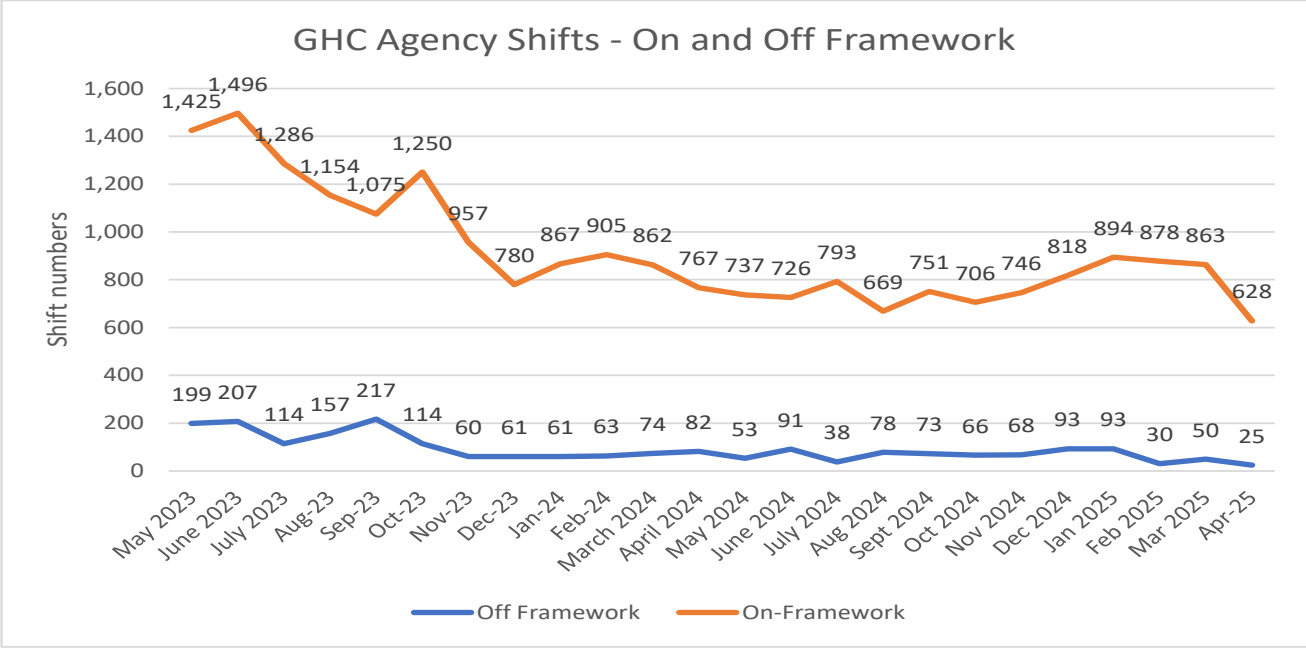
Budget for bank & agency is only for specific schemes but Plan is forecast for the whole Trust.

Pay Analysis

Gloucestershire Health and Care NHS Foundation Trust

Pay analysis month 1						
	Plan WTE Month 1	Budget WTE Month 1	Budget £000s	Actual WTE Month 1	Actual £000s	Actual £ as % of Total £
Substantive	4,310	4,750	21,461	4,302	19,801	90.3%
Bank	370	16	209	370	1,831	8.4%
Agency	55	0	121	36	297	**1.35%**
Total	**4,734**	**4,766**	**21,791**	**4,708**	**21,929**	**100.0%**

- Trust WTE budget 32 higher than plan due to devts
- substantive costs include employers contribution of nationally funded pension costs of 9.4% (£15.2m)
- substantive budget includes negative budgets for CIP not yet identified (£0.513k@mth1, £6.2m full year)
- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- the Trust used 25 off framework agency shifts in April. The target is 0.
- 1.35% of pay bill spent on agency year to date.



Off framework – Trust has action plan to reduce. Focus is on last few key areas still using off framework.

Balance Sheet

NHS
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NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2024/25	2025/26				2025/26
		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	1,745	2,264	1,684	1,686	2	2,205
	Property, plant and equipment: other	117,935	122,466	117,851	117,529	(322)	122,061
	Right of use assets	16,438	16,541	16,302	16,311	9	16,413
	Receivables:	1,244	1,209	1,241	1,237	(5)	1,202
	Total non-current assets	**137,361**	**142,480**	**137,078**	**136,763**	**(315)**	**141,881**
Current assets	Inventories	444	444	444	444	0	444
	NHS receivables	7,409	7,432	7,432	9,996	2,564	7,432
	Non-NHS receivables	9,331	9,349	10,619	9,135	(1,484)	9,135
	Credit Loss Allowances	(1,595)	(1,595)	(1,595)	(1,595)	0	(1,595)
	Property held for Sale	3,123	377	3,123	3,123	0	377
	Cash and cash equivalents:	41,855	39,359	41,698	45,025	3,327	42,650
	Total current assets	**60,567**	**55,366**	**61,721**	**66,128**	**4,407**	**58,442**
Current liabilities	Trade and other payables: capital	(3,815)	(3,535)	(3,381)	(2,203)	1,178	(3,535)
	Trade and other payables: non-capital	(26,851)	(26,875)	(28,377)	(32,423)	(4,046)	(29,583)
	Borrowings	(1,514)	(1,514)	(1,514)	(1,506)	8	(1,506)
	Provisions	(8,701)	(8,702)	(8,702)	(8,636)	66	(8,636)
	Other liabilities: deferred income including contract liabilities	(1,303)	(1,303)	(1,303)	(2,537)	(1,234)	(1,303)
	Total current liabilities	**(42,184)**	**(41,929)**	**(43,277)**	**(47,304)**	**(4,027)**	**(44,562)**
Non-current liabilities	Borrowings	(14,026)	(14,252)	(13,880)	(13,875)	5	(14,101)
	Provisions	(2,511)	(2,511)	(2,511)	(2,508)	3	(2,508)
	Total net assets employed	**139,206**	**139,154**	**139,132**	**139,204**	**72**	**139,153**

Taxpayers Equity	Public dividend capital	132,103	132,103	132,103	132,103	(0)	132,103
	Revaluation reserve	13,790	13,789	13,789	13,790	1	13,790
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	(1,046)	(5,498)	(5,520)	(5,446)	74	(5,446)
	Income and expenditure reserve (current ye	(4,399)	0	0	(2)	(2)	(53)
	Total taxpayers' and others' equity	**139,206**	**139,154**	**139,132**	**139,204**	**73**	**139,153**

Cash Flow Summary

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 24/25		ACTUAL 25/26	
Cash and cash equivalents at start of period		**51,433**		**41,855**
Cash flows from operating activities				
Operating surplus/(deficit)	(4,473)		18	
Add back: Depreciation on donated assets	185		4	
Adjusted Operating surplus/(deficit) per I&E	**(4,287)**		**22**	
Add back: Depreciation on owned assets	11,117		799	
Add back: Depreciation on Right of use assets				
Add back: Impairment	4,497			
(Increase)/Decrease in inventories	-88			
(Increase)/Decrease in trade & other receivables	(4,386)		(2,348)	
Increase/(Decrease) in provisions	154		(69)	
Increase/(Decrease) in trade and other payables	(8,506)		5,316	
Increase/(Decrease) in other liabilities	217		1,234	
Net cash generated from / (used in) operations		**(1,283)**		**4,953**
Cash flows from investing activities				
Interest received	3,072		230	
Interest paid	(9)		(0)	
Proceeds from Sale of PP&E	1,974		0	
Purchase of property, plant and equipment	(9,316)		(1,835)	
Assets Held for Sale				
Net cash generated used in investing activities		**(4,279)**		**(1,605)**
Cash flows from financing activities				
PDC Dividend Received	227		0	
PDC Dividend (Paid)	(2,491)		0	
Finance lease receipts - Rent	94		12	
Finance lease receipts - Interest	(62)		(5)	
Finance Lease Rental Payments	(1,572)		(167)	
Finance Lease Rental Interest	(213)		(18)	
		(4,016)		**(178)**
Cash and cash equivalents at end of period		**41,855**		**45,025**

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Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Plan	Actuals	Plan	Plan	Plan	Plan
£000s	**2025/26**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Land and Buildings						
Buildings	1,929	8	8,500	5,000	3,000	3,000
Backlog Maintenance	4,059	18	1,393	1,393	1,393	1,400
Buildings - Finance Leases	1,496	0	1,900	250	250	250
Vehicle - Finance Leases	250	8	250	250	250	250
Other Leases	0	0		0	0	
Net Zero Carbon	2,643	0	1,400	1,800	1,500	1,500
LD Pathway			3,000	0	0	0
Medical Equipment	1,780	0	602	930	1,030	1,000
IT						
IT Device and software upgrade	320	0	800	900	900	1,200
IT Infrastructure	820	1	1,300	1,300	1,300	1,300
Transforming Care Digitally	1,260	177	790	250	250	250
NHS Net Transition			0	0	0	0
Digital Innovation				500	500	500
Sub Total	**14,557**	**212**	**19,935**	**12,573**	**10,373**	**10,650**
Forest of Dean	0	0	0	0	0	0
Total of Updated Programme	**14,557**	**212**	**19,935**	**12,573**	**10,373**	**10,650**
Disposals	(3,265)	0	(7,176)	0	0	0
Total CDEL spend	**11,292**	**212**	**12,759**	**12,573**	**10,373**	**10,650**
Funded by;						
Anticipated System CDEL	**12,184**		**12,759**	**12,573**	**10,373**	**10,650**

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Risks

Gloucestershire Health and Care
NHS Foundation Trust

25/26 potential risks are as set out below:

Risks from budget setting but risks below score of 9 are not shown, but are still monitored.

Risks 25/26	Mitigations	Risk Value £000s	Recurring	Mitigated Risk Score
Forecast overspends in System partners lead to Trust incurring deficit risk share amount that affects financial position (390)	Continued negotiation with system partners. Review all costs. Identify additional savings. Peer review of system partners	1744	1744	12
There is a risk that GHC does not fully deliver recurrent CIP savings in year, resulting in GHC not achieving its financial targets (391)	Non recurrent savings. Close monitoring by the CIP management board	3500	3500	12
25/26 pay award is under funded once final value is agreed causing a cost pressure	Detailed assessment of implications to ensure clear understanding of impact and to allow appropriate mitigations to be sought	800	800	12
There is a risk that services do not have the capacity to identify CIP schemes in year resulting in under delivery of in year CIP target	create dedicated time to review CIP. CIP Management Group to actively manage situation and support directorates if greater support needed	5198	5156	12

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CIP

			Low Risk	Medium Risk	High Risk
Rec / Non rec	Scheme	Target	Delivered	Identified	Unidentified
Rec	Efficiency 1.1%	3,189	1,107	571	1,511
Rec	Delivering Value 1.4%	4,001	214	1,066	2,721
Rec	Undelivered 24/25 brought forward	1,947	477	594	876
Rec	Programme Savings	949	901	0	48
Non Rec	Non recurrent savings	5,169	257	4,869	43
		15,255	2,956	7,101	5,198
			19%	**47%**	**34%**

NHSE reporting has a more complex categorisation of schemes which splits identified and unidentified schemes into their stages of development.

For national reporting even delivered schemes are considered to carry a low level of risk.

AGENDA ITEM: 14/0525

REPORT TO: **TRUST BOARD PUBLIC SESSION 29th MAY**

PRESENTED BY: Nicola Hazle, Director of Nursing, Therapies and Quality

AUTHOR: Jane Stewart, CQC Compliance Manager, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT – April 2025 DATA**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to:

To provide the Gloucestershire Health & Care NHS Foundation Trust (GHC) Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health, and Learning Disability services.

Recommendations and decisions required.

The Trust Board are asked to **RECEIVE, DISCUSS** and take assurance from the Quality Dashboard.

Executive summary

This dashboard provides an overview of the Trust's Quality activities for April 2025. This report is produced monthly for Trust Board, Quality Committee, Operational Delivery and Governance Forums for assurance.

Quality issues showing positive improvement:

- The development of the integrated performance report continues with quality narrative being seen within the BI reports alongside the removal of duplicated data and improvements to graphical representation taking place within the Quality Dashboard.
- Progress continues to be made to improve safeguarding performance involving The Safeguarding Team linking in with Gloucestershire County Council (GCC) to attend two-weekly Multi Agency Provider meetings. This will enable colleagues to share & hear soft intelligence about providers that interface with our teams/services.

- The Q4 Learning from Deaths report is included in this Dashboard .During Q4 2024-25, 84 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died. 14 care record reviews were completed, none of these reviews identified problems in the care provided to the patients.

- Analysis work concentrating on special cause variations and themes rather than individual events continues to be developed within Patient Safety narratives.

- The Q4 Guardians of Safe Working report is included this month and there were 3 exception reports recorded in this time period. No immediate patient safety concerns were identified.

- Focused work continues with regard to the closure of open incidents on Datix, concentrating on length of time an incident is open for . Although numbers remain high data has been provided to Directorates and a live dashboard has been developed by the Datix Team.

- The Non-Executive Director (NED) Audit of complaints provides significant assurance that overall, the Trust is investigating and responding to complaints appropriately and positive feedback has been received as a result of the NEDS Quality visits.

- Good progress is being made towards the achievement of the Quality Priority objectives which carry forward to 2025-26.

Quality issues for priority development:

- The majority of complaints received within GHC continue to relate to care and treatment in the IUCS. However, with regards to the service, we must ensure there is context to the numbers as it is one of our biggest services, if not the largest in contacts each month. The complaint conversion rate is incredibly small for a service such as this at less than 1 in 1000. However, we are fully aware that this has been a significant impact to the organisation and we are working to look at how we can collectively resolve complaints.

Risks associated with meeting the Trust's values.
Specific initiatives or requirements that are not being achieved are highlighted in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality outcomes this provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us

	monitor the plans we have in place to transform our services and celebrates our successes.
Resource Implications	Improving and maintaining quality is core Trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee/Public Board.

Appendices:	Quality Dashboard Report – March 2025 Data

Report authorised by: Nicola Hazle	**Title:** Director of Nursing, Therapies and Quality

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AGENDA ITEM: 14.1/0525

QUALITY DASHBOARD 2024/25

Physical Health, Mental Health and Learning Disability Services

Data covering April 2025

This Quality Dashboard reports quality focused performance, activity and developments regarding key quality measures and priorities for 2024/25. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to Nicola Hazle, Director of Nursing, Therapies and Quality (NTQ).

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

Are our services SAFE? Advise, Assure, Alert, Applaud

- Advise : The Safeguarding Team have linked in with Gloucestershire County Council (GCC) to attend two-weekly Multi Agency Provider meetings. This will enable colleagues to share & hear soft intelligence about providers that interface with our teams/services.
- Advise : 89% of Trust services are compliant with Safeguarding training.
- Assure : During Q4 2024-25, 84 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died. 14 care record reviews were completed and none of these reviews identified problems in the care provided to the patients.
- Advise : In April 2025 there were a total of 1235 patient incidents reported , one new Patient Safety Incident Investigation and one After Action Review (AAR) . We reported zero HoHa C:Diff and MRSA Bacteraemia.
- Advise : RT has seen a further reduction and there is consistent local and Behavioural Support Team review and oversight
- Advise : Whilst the numbers of open incidents on Datix awaiting review is high, the impact of work with Operations in recent months is evident.

Are our services EFFECTIVE? Advise, Assure, Alert, Applaud

- Assure : We continue to submit monthly updates in regarding the S31 restriction on Berkeley House, and the feedback recognises the sustainability of the improvements that have been made. To support the section 31 application and BAF 9 on 'closed culture' the next iteration of the dashboard will include a focused update on the restrictions and summary of the evidence provided each month to the CQC.

- Assure : The safe staffing across Community Hospitals and MH Inpatients has been reviewed and assured by the Director of Nursing, Therapies and Quality.

- Assure : Guardians of Safe Working (GoSWH) Report Q4 : There were 3 exception reports in this time period, 2 relating to hours worked, 1 relating to pattern of work. No immediate patient safety concerns were identified. Following the recent work schedule review for the Higher Residents on call , a new pattern of working whilst non resident on call started in mid January 2025.

Are our services CARING? Advise, Assure, Alert, Applaud

- Assure : 92% of Friends and Family Test (FFT) respondents reported a positive experience. Across the Trust there were 2328 FFT responses last month.
- Advise : 23 formal complaints were received in April, with 14 of these relating to the IUC. FFT set up to support new IUC service; there were 49 responses in April 2025 with a positive experience rating of 90%. 88% of complaints were closed within 3 months and 100% of complaints being closed within six months (against targets of 50% and 80% respectively). Three complaints were re-opened in April and the PCET continue to work collaboratively with patients and carers to ensure post-complaint actions are completed.
- Assure : The Q4 Non-Executive Directors (NED) audit provides SIGNIFICANT assurance that overall, the Trust is investigating and responding to complaints appropriately.
- Advise : Positive feedback was received in relation to NED Quality Visits colleagues and full details are detailed in Appendix One

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Summary
Trust Safeguarding Data – April 25

- *There is assurance that Safeguarding activity, which is a Trust priority function, is closely monitored and is being delivered as per the requirements of the Gloucestershire Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation.* ***, therefore. full assurance is given that the Trust is fulfilling all its statutory Safeguarding duties.*** *Safeguarding children and adults is a key element of the assessment and care management processes for staff and there are arrangements in place to monitor and provide assurance that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.*

Highlights:

Progress is being made to further improve performance and therefore increase patient safety & our Safeguarding response, examples of this are detailed below**:**

- 89% of Trust services are rated as compliant with Safeguarding training. Compliance with children's safeguarding supervision increased from 66% in March to 70% in April against a 90% targets.. Work continues with Ops colleagues to increase rates and meet Trust targets in both areas.
- The Safeguarding Focus newsletter in April was on the subject of MARAC, and there was a Safeguarding Learning Lunch focusing on online safety in April.
- The team is increasing its focus on Domestic Abuse, and practitioners with expertise in both Children's and Adult Safeguarding have been identified to act as DA links. Plans to progress DA work within the Trust are being made.
- The team has now linked in with GCC to attend two-weekly Multi Agency Provider meetings. This will enable colleagues to share & hear soft intelligence about providers of concern.
- Work continues month on month in relation to MCA / DoLS compliance.

Challenges/risks:

- Risk 298 – In relation to the data we receive from the Local Authority regarding Trust Safeguarding referrals, we continue to seek more thorough data to allow better analysis. To this end, a meeting is taking place with the Head of Safeguarding at GCC in May to try to progress.
- Risk 299 – Work continues towards the introduction of the new Children's Safeguarding template on Systm1. Testing with practitioners takes place on 9th June and the Clinical Systems team are working on the training to support rollout. With this being a partial solution we will continue to explore other potential mitigations.
- Risk 416 – while good work continues towards the MCA action plan, we continue to support colleagues around the Trust to implement good practice.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 4 Learning From Deaths Summary

During Q4 2024-25 **84** Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

- January 30
- February 30
- March 24

- In Q4 2024-25 there were 14 care record reviews undertaken across Inpatient and Mental Health Mortality Review Groups (MRG) with appropriate learning identified. None of these reviews identified problems in the care provided to the patients.

Community Hospitals and Charlton Lane Deaths	Deaths reported by Mental Health Services- Unexpected Death/ Suspected Suicide
• During Q4 2024/5 there were 58 deaths in Community Hospitals (CH) and Charlton Lane Hospital (CLH) combined. • 100% of deaths reported by our Community Hospitals and Charlton Lane Wards had gender coded and of those deaths 53% of those were male and 47% female. • Of the 58 deaths, approximately 95% were coded as being white, 4% coded as ethnicity not known and for 1% no code was entered. • In Quarter 4 there were 57 pieces of feedback from the Medical Examiner Service, 91% of families expressed no concerns or provided positive comments, 5% provided comments suggesting concerns and 4% had no comments (No next of kin or family unable to comment).	In Quarter 4 there were 11 incidents reported on Datix related to unexpected deaths or suspected suicides of these it has been determined that: • 3 have or are being investigated as suspected suicides via PSIRF processes • 3 have been confirmed as natural causes by Coroner • 1 has been confirmed as death due to acute alcohol toxicity and will be reviewed via MRG process. • 1 death is unknown or unexpected and internal process on hold due to police involvement • 3 reported incidents were rejected and resubmitted via Mortality Datix process

Gloucestershire Health and Care NHS Foundation Trust

Quarter 4 Learning From Deaths Summary Continued

Learning Disability Deaths

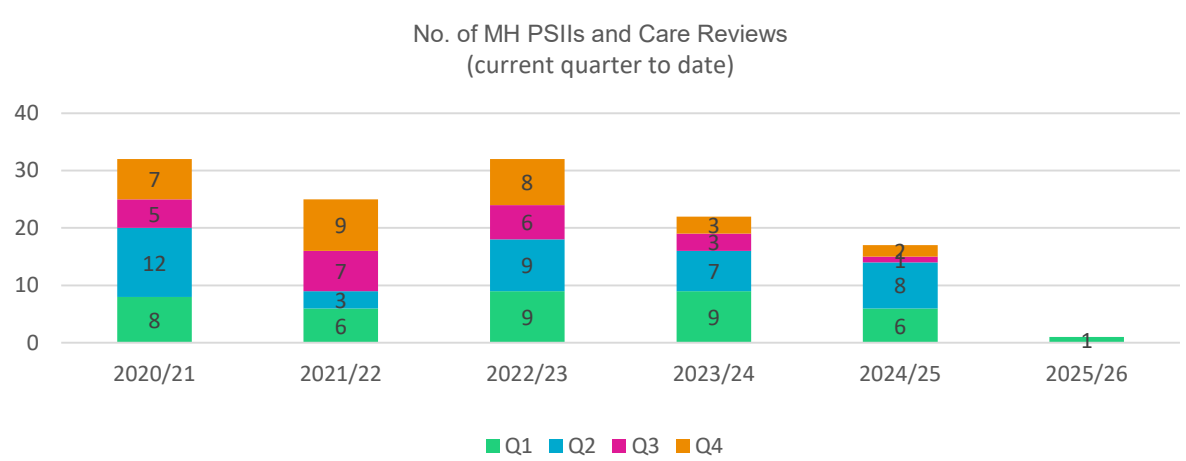
- In Q4 there were 3 deaths reported for individuals open to the Learning Disability caseloads. This is 3 fewer than Q3 and 3 fewer than Q4 2023-2024.
- 2 of the individuals were known CLDT in Gloucester and 1 in Stroud.
- During 2024-2025 there were a total 15 deaths of patients open to the Learning Disability caseloads. In the previous year 2023-2024 there were 19 LD caseload deaths in total.
- 100% of deaths have been referred to LeDeR for Review
- Of the 3 deaths in Q4; 2 were male and 1 was female
- All had a recorded ethnicity of White- British
- Ages ranged from 60-76, 2 of the individuals were younger that the median age of death of 62.9 for people with a learning disability.
- [Median age taken from https://www.kcl.ac.uk/news/2022-leder-report-into-the-avoidable-deaths-of-people-with-learning-disabilities]
- LeDeR Gloucestershire share 5 learning on a page documents that will be shared via learning assurance boards

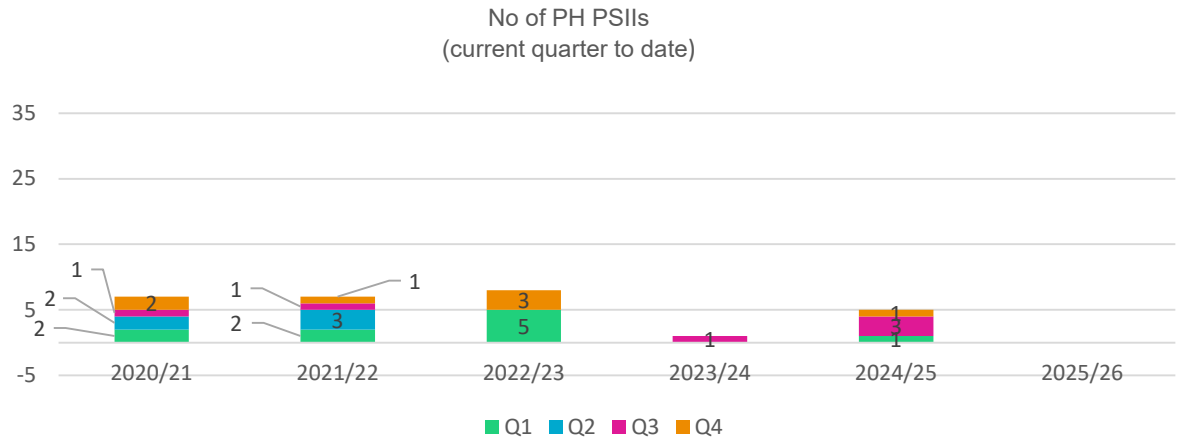
Plans for 2025-2026 for Mortality Review Groups:

- Pilot a standardised template for presentations at Mortality Review Groups to ensure a consistent approach across services with an explanation of the process to support staff who are attending.
- Introduction of a new meeting agenda for Mortality Review Groups with a greater emphasis on capturing learning and ensuring that actions are SMART.
- Review of the Learning from Deaths Policy in line with proposed changes to the Mortality Review Groups.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Response

New Patient Safety Incident Investigations (PSIIs) and Care Reviews





What is the data telling us?

- In 24/25 there was a total of 17 PSII's (including Care reviews) undertaken for Mental Health Services and 5 for Physical Health Services. 15 remain open.
- Summary of the 15 open investigations made up of (4 PSII's, 1 Thematic Review, 10 care reviews):
    - 2 planned to be signed off at Executive Patient Safety Group in May 2025
    - 5 reports have pending dates for review panel
    - 5 are still ongoing investigations
    - 2 to be discussed with families
    - 1 is being amended by chair of panel meeting
    - 9 of the reports are expected to be shared with coroner
    - 9 have been open longer that 6 months

- So far in Q1 of 25/26 1 PSII has been reported and is under review.

CQC DOMAIN - ARE SERVICES SAFE? – Serious Incidents and Embedded Learning

After Action Reviews:

- In April 2025, 1 AAR was completed by the Patient Safety Team which related to a serious self harm on Priory Ward at Wotton Lawn Hospital.
- At the time of writing this report there are 5 AAR's planned for May 2025.

Learning Assurance Activity:

- In April, the Learning Assurance Team met with two clinical teams who had recently completed audits, to review their action plans and ensure that the actions are SMART and provide clear assurance that learning has been effectively implemented and embedded.
- We observed the 'Essential to Role' training (CoHo's) provided by the Training and Development Facilitator following a learning / quality visit to Stroud Community Hospital last year as the majority of the training encapsulated the findings from national Prevention of Future Deaths recommendations.
- We continue developing and distributing monthly directorate slides to each Service Director, providing a comprehensive summary of After-Action reviews conducted during the month and highlighting any new or overdue actions.

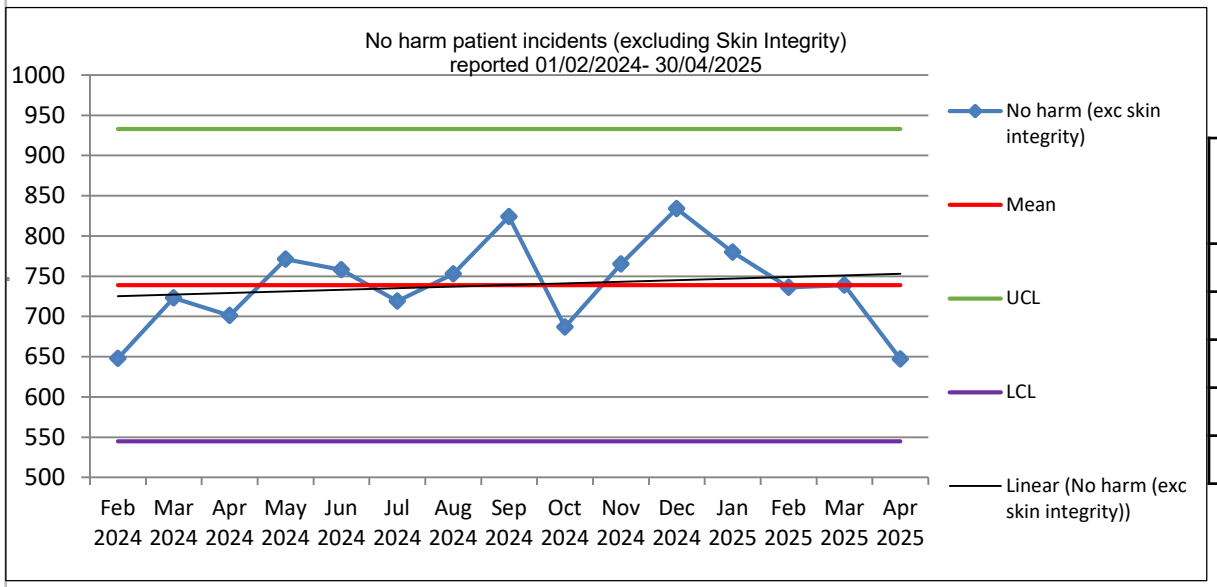
Duty of Candour:

- In future reports will include our compliance with Duty of Candour Regulations,
- As a trust we currently undertake a 6 monthly audit on Duty of Candour but recognise that a more regular update will provide greater assurance and identify if and where there are any challenges relating to this.

Infection Prevention and Control.

- In April there were zero MRSA Bacteraemia and zero CoHO C.Difficile infections.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data- No harm Incidents



Top 5 Reporting Themes	Total	Compared to last month
Restrictive Interventions,	160	↑
Violence and aggression to staff (SIRS)	126	↑
Falls (including slips and trips)	85	↓
Self-harm/ Self injurious behaviour	66	↓
Medication incidents	58	↓

What is the data telling us?

- April 2025 saw the lowest number of low harm incidents (647) in the last 15 months.
- Top 5 reporting themes remain consistent although there was a reduction in 3 categories.
- Increase in reported no harm restrictive interventions (See restrictive intervention slide) and violence and aggression to staff incidents.
- The largest proportion of low harm incidents relating to violence and aggression to staff occur within inpatient settings (Mental health, learning disabilities and physical health) and a small number in community teams. With the exception of 5 incidents, they have all been reviewed and closed.

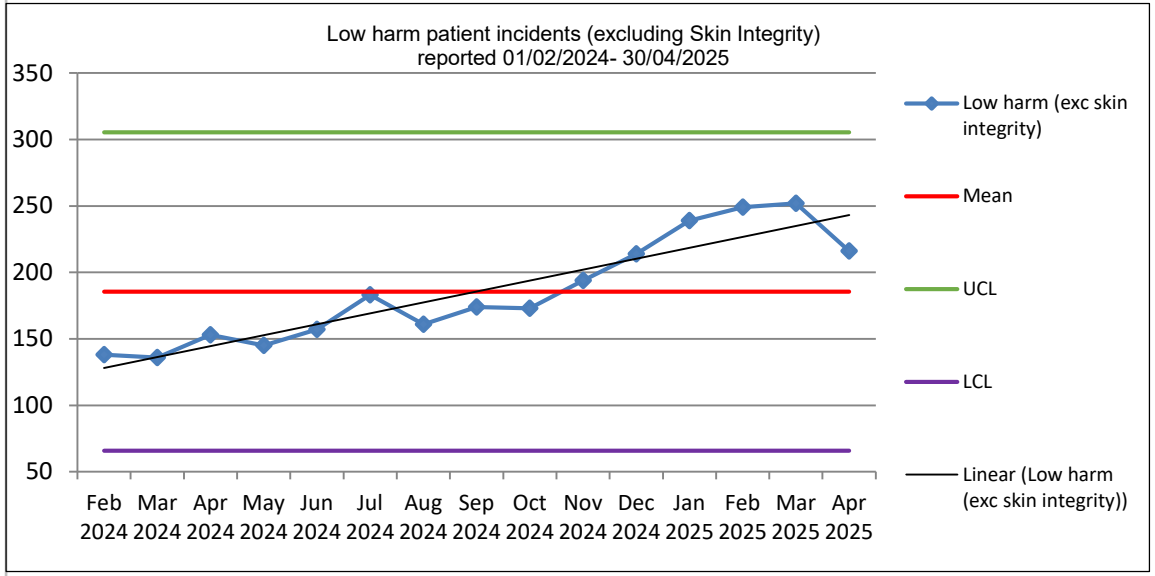
What are the risks/impacts for clinical quality and patient safety?

- The reporting of no harm incidents enables the trust to track trends and patterns of incidents and promotes an open culture of learning.

What are we doing about it?

- Clinical teams are responsible for reviewing and closing no harm incidents and can highlights any incidents to the Patient Safety Team that may require a learning response tool such as an AAR.
- The Patient Safety Team aim to review 10% of no harm incidents for assurance that they are being assessed at the right level of harm and to identify any potential themes and trends.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data- Low harm Incidents



Top 5 Reporting Themes	Total	Compared to last month
Self-harm/ Self injurious behaviour	115	↑
Violence and aggression to staff (SIRS)	53	↓
Falls (including slips and trips)	21	↓
Appointments, follow-ups and referrals	18	↓
Restrictive Interventions	17	↓

What is the data telling us:

- 216 Low harm incidents were reported
- April 2025 saw a reduction in the overall number of low harm incidents, following a period of steady increases from December 2024.
- The top 5 reporting themes remain consistent, however there had been a reduction in 4 of the categories from the previous month.
- There had been an increase in the number of incidents of self harm/ self injurious behaviour incidents from the previous month.
- A large proportion of self harm/ self injurious behaviour incidents are related to a small number of individuals in our inpatient settings.

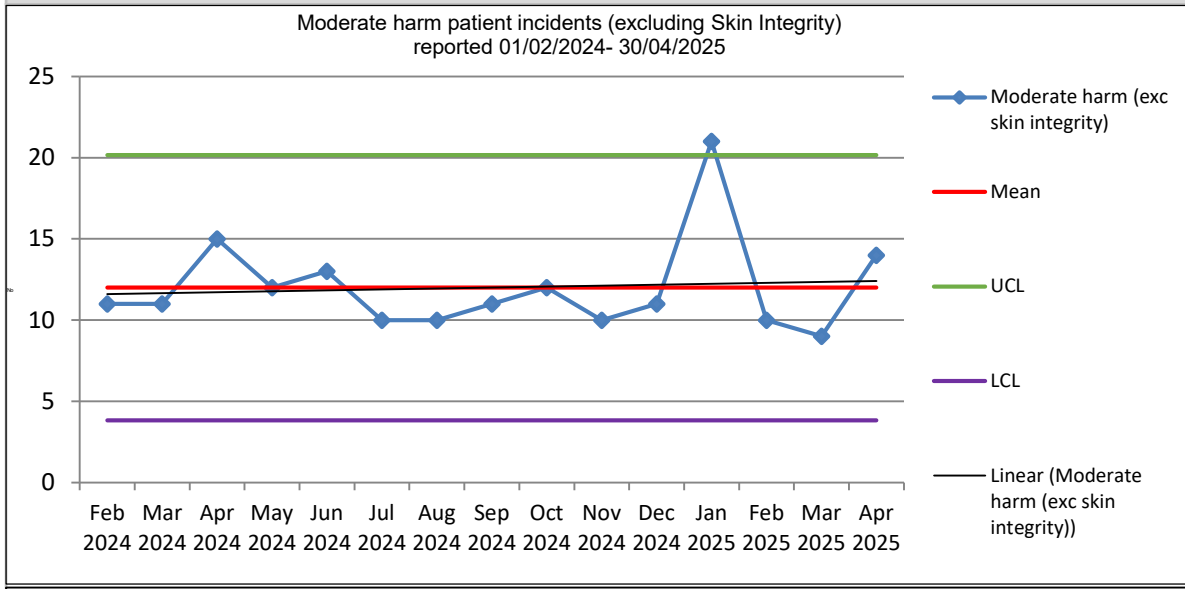
What are the risks/impacts for clinical quality and patient safety?

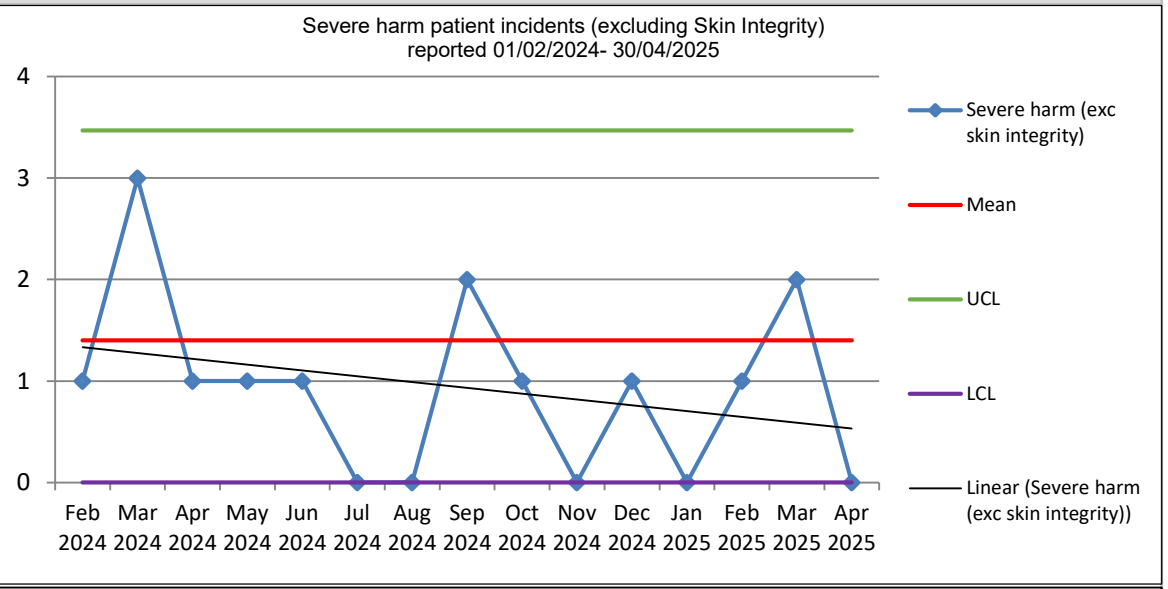
- The reporting of low harm incidents enables the trust to track trends and patterns of incidents and promotes an open culture of learning. The monitoring of low harm incidents may also prevent more significant harm incidents occurring.

What are we doing about it?

- Clinical teams are responsible for reviewing and closing no harm incidents and can highlights any incidents to the Patient Safety Team that may require a learning response tool such as an AAR.
- The Patient Safety Team aim to review 10% of no harm incidents for assurance that they are being assessed at the right level of harm and to identify any potential themes and trends.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data- Moderate and Severe harm incidents





Moderate harm Incidents- What is the data telling us?

- In April 2025, 14 moderate harm incidents were reported.
- As with previous months, a variety of incident types accounted for these including;
  - Admission - delay, failure or errors,
  - no trust bed available,
  - Treatment or procedure - delay / failure, Delay / failure to monitor,
  - Difficult or no access to IT systems,
  - Medical emergency,
  - Patient and/or carer non-concordant with care / treatment plan
  - Safeguarding concerns.
- There was no clear pattern around teams reporting moderate harm incidents.

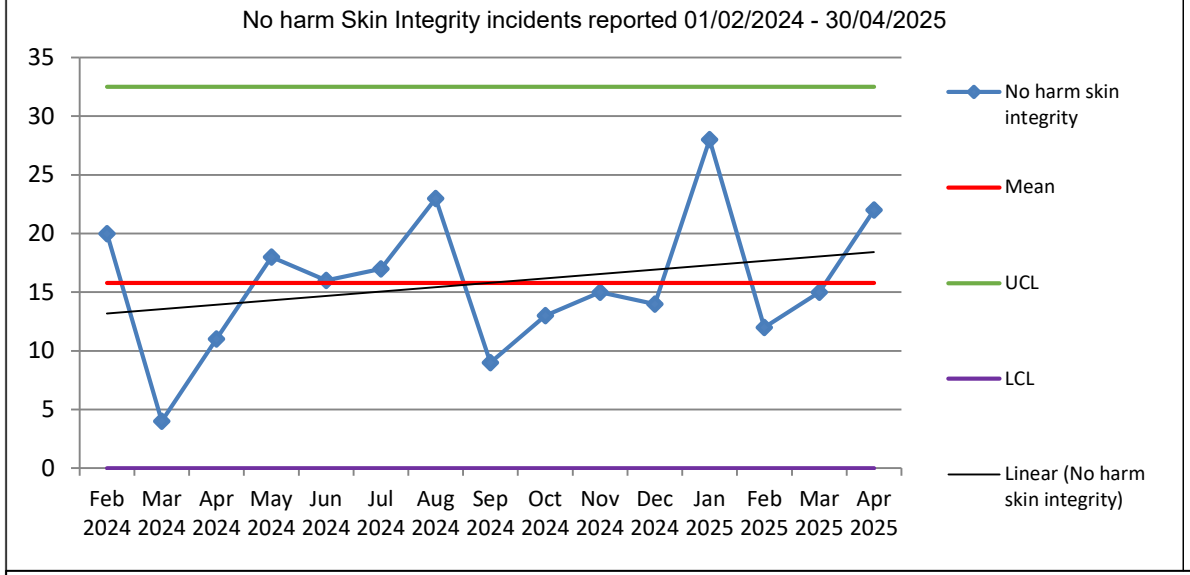
What are we doing about it?

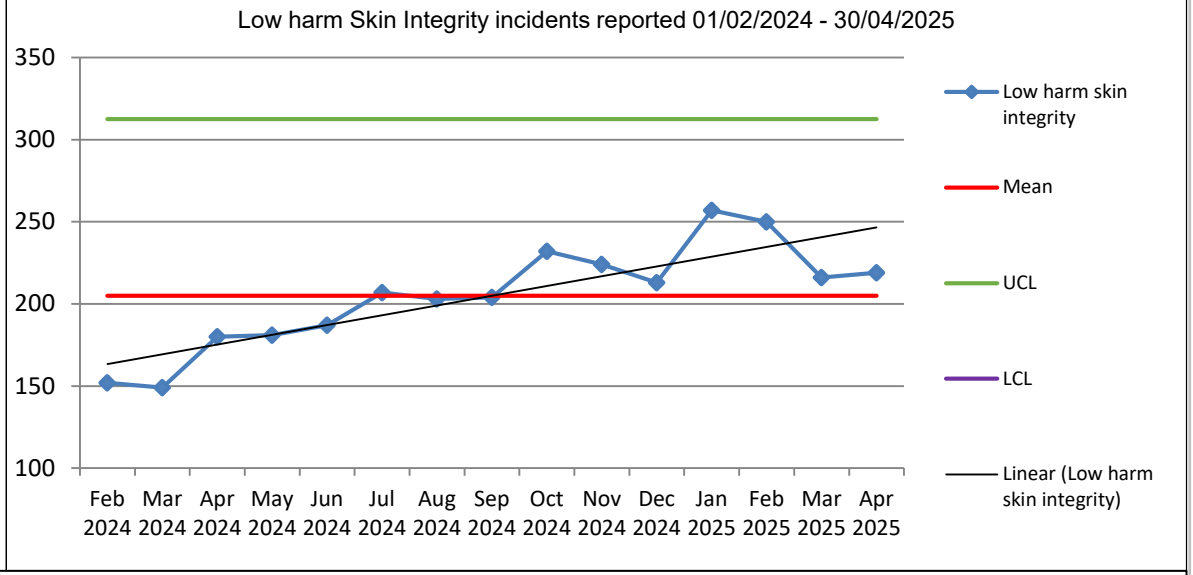
- All moderate harm incidents and above are reviewed by the Patient Safety Team to ensure that harm level is appropriately reported and to understand whether a learning response tool (PSII or AAR) is indicated to help identify any areas of learning and then subsequent recommendations and action plans.

Severe harm incidents- what is the data telling us?

- There were 0 severe harm incidents reported in April 2025.
- Across the last 15 months there have been 5 months including this one when no severe harm incidents have been reported.
- There appears to be an overall downward trend of severe harm incidents at the trust.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

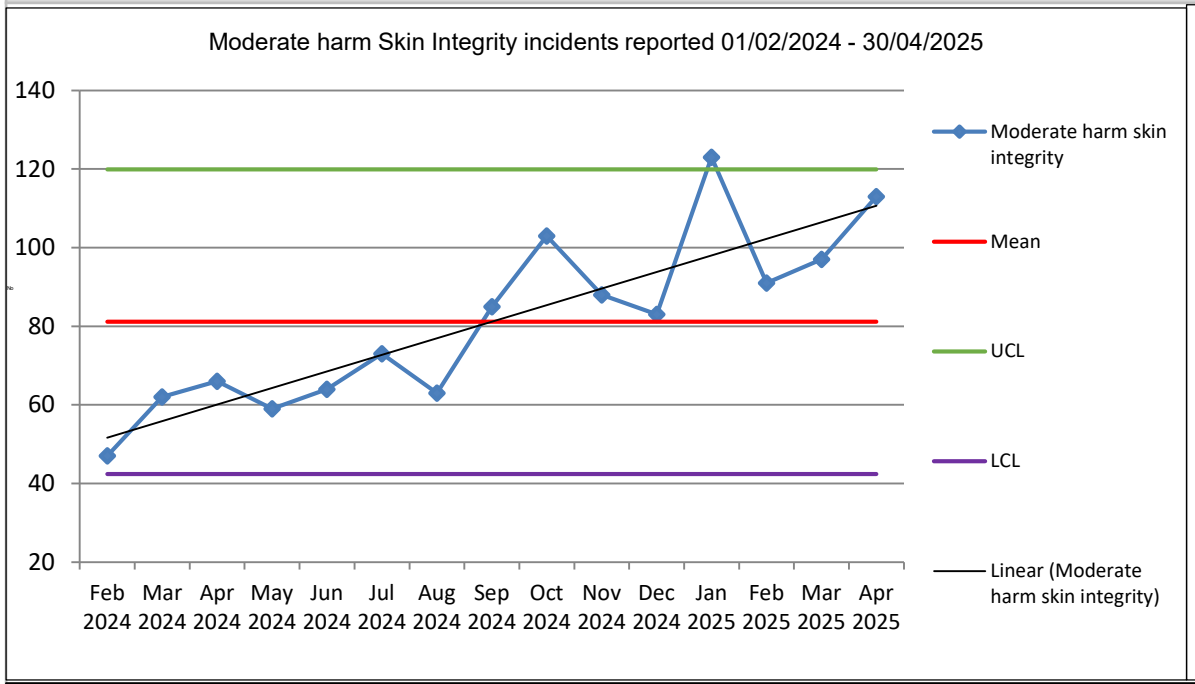


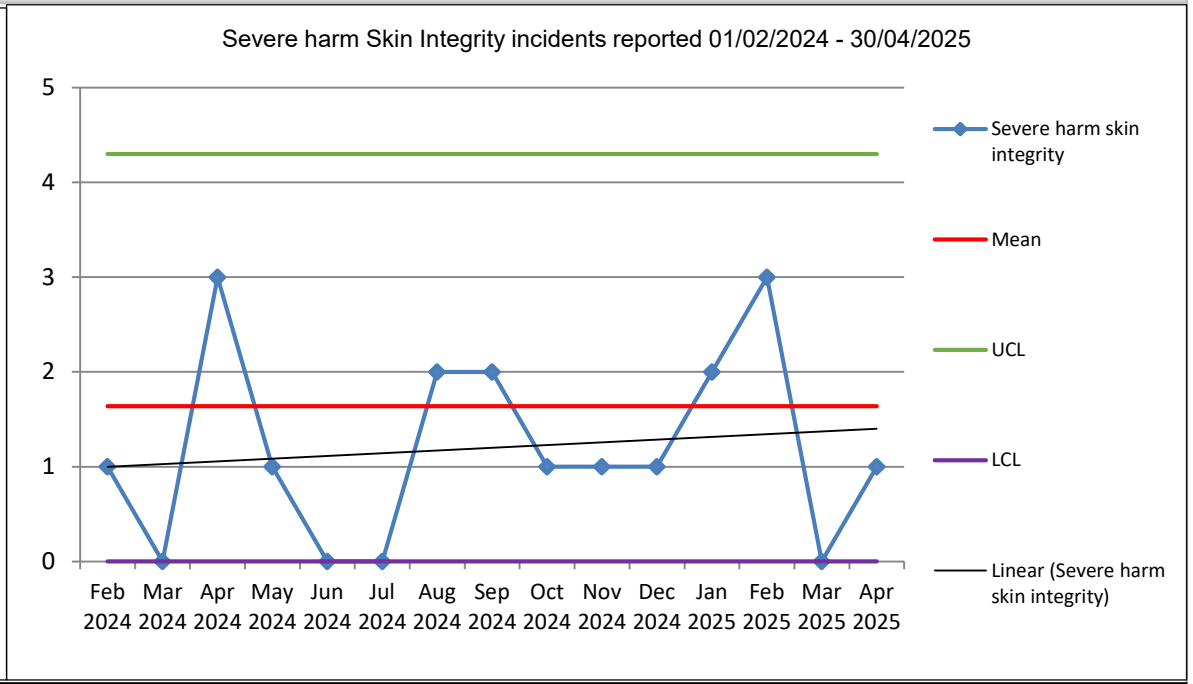


What is the data telling us?

- There were a total of 22 no harm incidents and 219 low harm incidents related to skin integrity in April 2025.
- There was an increase in the number of reported incidents on the previous month in both harm categories, but both were below the highest total we have seen in the previous 15 months.
- ICT's and Community Hospitals continue to be our largest reporter of low and no harm skin integrity incidents.
- 276 of the total skin integrity incidents (across all harm levels) were for individuals living in their own home, residential home or nursing home.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

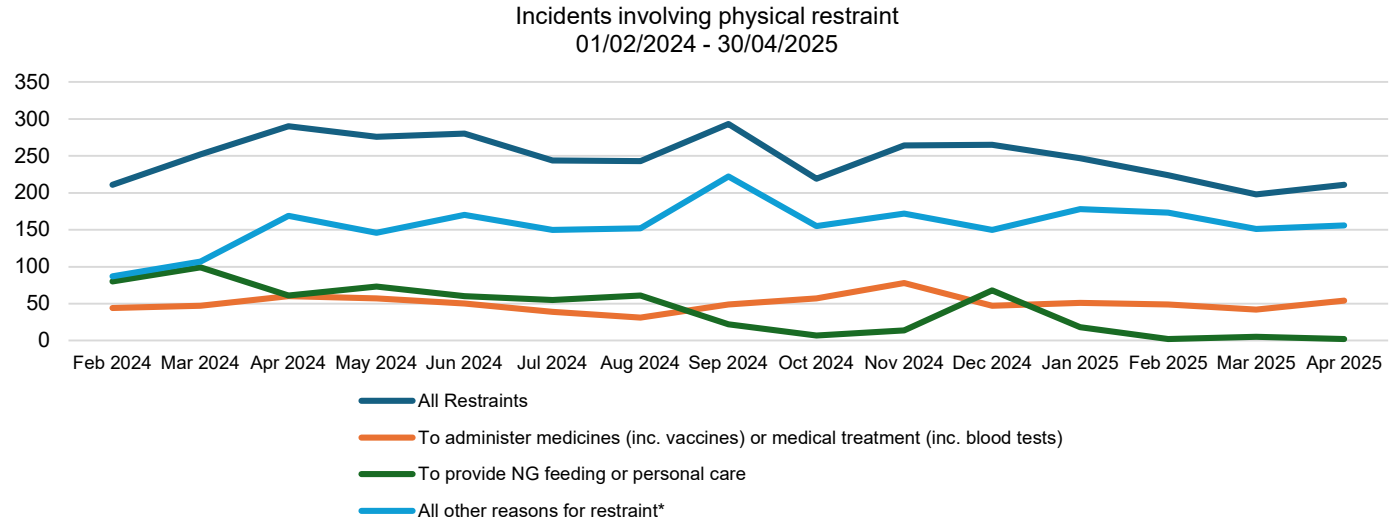


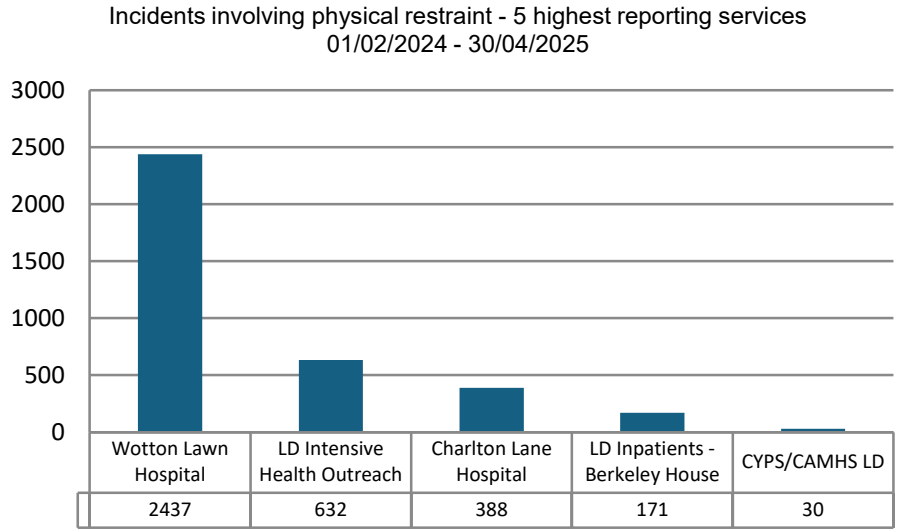


What is the data telling us?

- 113 Moderate skin harm integrity incidents were reported in April 2025; this is the 2nd highest total in the last 15 months.
- There was 1 severe harm skin integrity incident reported in April 2025, at the time of writing the report this appears to have been recategorized to a lower harm level.
- ICT teams continue to report the largest number of moderate skin integrity incidents and again this likely reflects the population that they support in community settings.

Restrictive Interventions (RI)





*Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous behaviour, Undertake a search of the patient's clothing or property to ensure the safety of others, Prevent the patient absconding from lawful custody & Other/Not Known.

What is the data telling us:

- The overall number of incidents involving physical restraint has been consistently in a range between 200-300 per month since February 2024, and this remained the case in April 2025.
- 69% of physical restraints were seated, 20% were standing or escort, 6% were supine (face up) and 5% used other positions in April 2025. No prone (face down) restraints were recorded in April 2025.
- Use of Rapid Tranquilisation (RT), which had risen to 144 incidents in January 2025, has fallen to 95 in March 2025 and 90 in April 2025. This relates to specific patients at Wotton Lawn Hospital, and their specific care plans, but will be kept under review. Low levels of RT were reported at Charlton Lane (7 incidents) in April 2025.
- Restraints to facilitate NG feeds have reduced significantly, from a range of 50-60 per month between November 2023 and August 2024, to 18 incidents in January 2025 and 0 incidents in April 2025. This is the result of changes in patient population at Wotton Lawn Hospital.
- Weekly RI reports indicate that a large proportion of RI weekly interventions at Wotton Lawn Hospital (between 48-60%) are attributed to a small number of patients presenting with distressed responses.

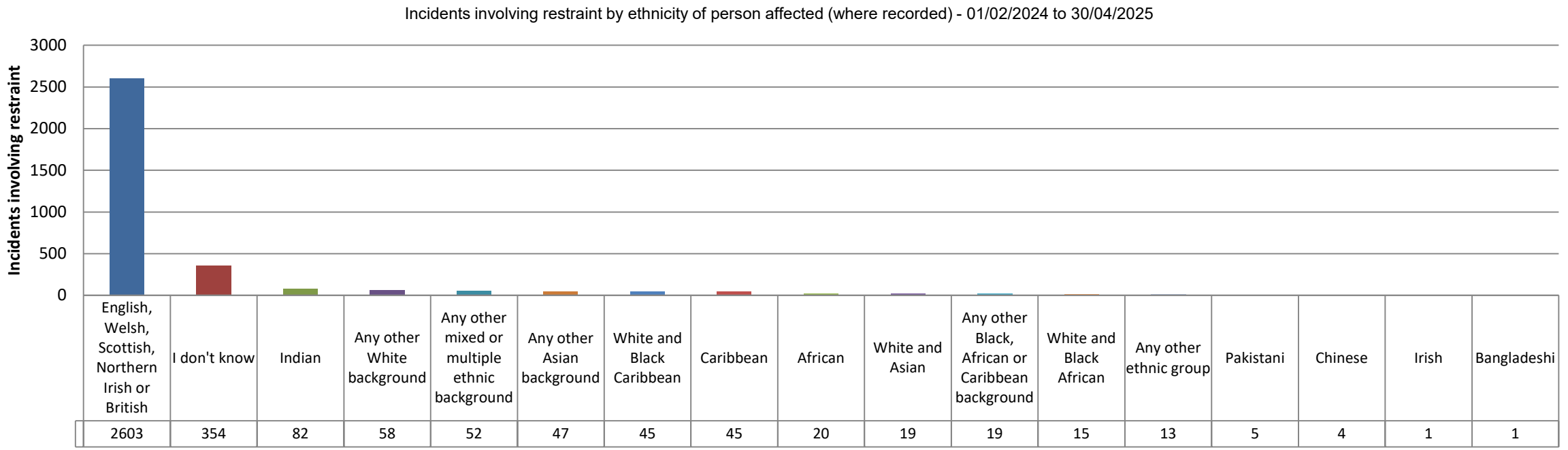
What are the risks/impacts for clinical quality and patient safety?

- It is recognised that RI can have a significant impact on a person's mental health, physical health, and their emotional wellbeing, and could even amount to a breach of their human rights. As a Trust we should ensure that any RI is lawful, for a legitimate aim and the least restrictive way of meeting that aim.

What are we doing about it?

- All incidents related to restrictive interventions are reviewed by the Behaviour and Support Training team and a weekly summary provided to managers to ensure that we are meeting our duties as a Trust.

Incidents involving restraint-Ethnicity Categories



English, Welsh, Scottish, Northern Irish or British	I don't know	Indian	Any other White background	Any other mixed or multiple ethnic background	Any other Asian background	White and Black Caribbean	Caribbean	African	White and Asian	Any other Black, African or Caribbean background	White and Black African	Any other ethnic group	Pakistani	Chinese	Irish	Bangladeshi
2603	354	82	58	52	47	45	45	20	19	19	15	13	5	4	1	1

What is the data telling us:

- Demographic information is included in the weekly review by the Behaviour and Support Training Team. The graph above shows the overall total of RI by ethnicity categories as recorded on LFPSE system (via Datix) and not from patient record systems.
- Data indicates that there are been more incidents of restraint for individuals who are ‘English, Welsh, Scottish, Northern Irish or British’ than any other ethnic category.

What are the risks/impacts for clinical quality and patient safety?

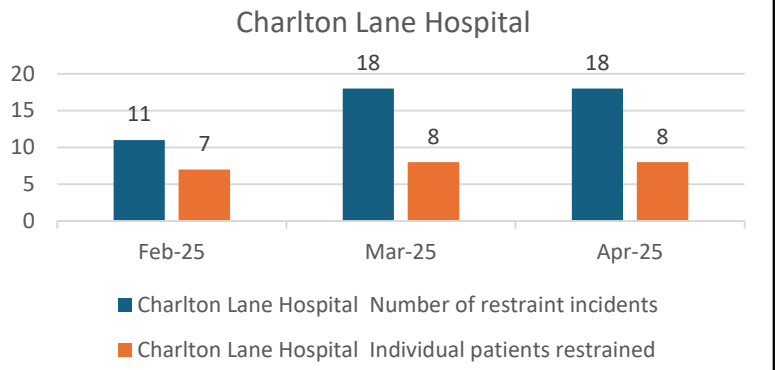
- It is important to reflect that this data is purely a count of incidents and has not been compared to local population or ward population data to understand whether there is any pattern of disproportionate RI for any ethnicity category.

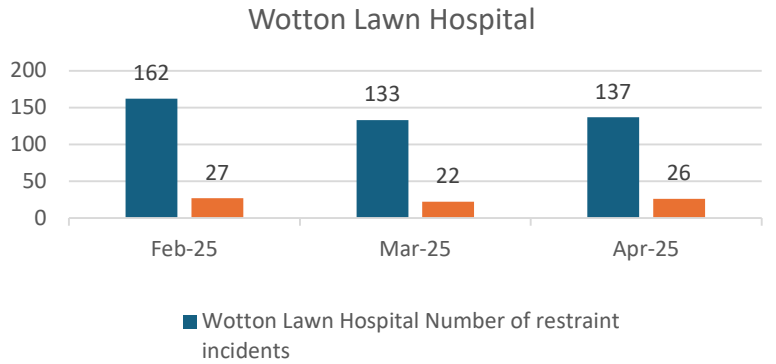
What are we doing about it?

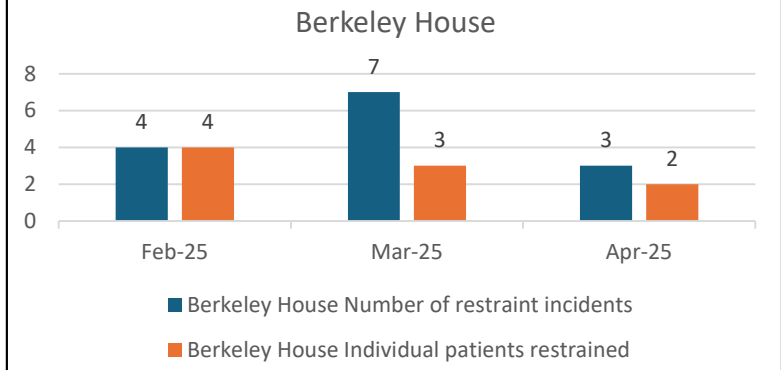
- To provide data around RI and patient demographics accurately there would need to be work to ensure that there is good data quality with no missing demographic information.

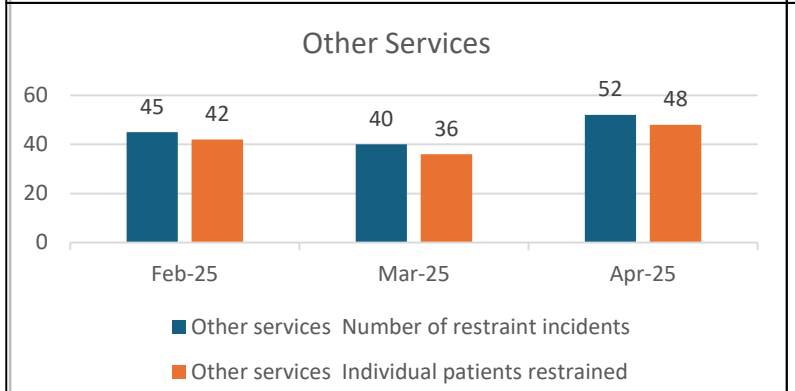
Ethnicity categories above are those provided by NHS England in the Learn from Patient Safety Events (LFPSE) system.

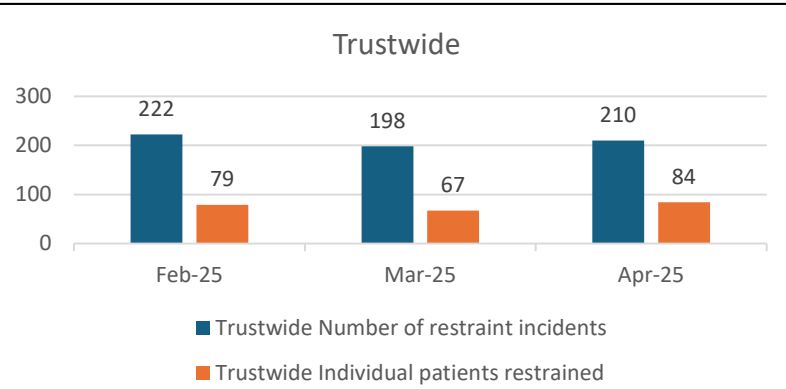
Incidents involving restraint – individual patients restrained

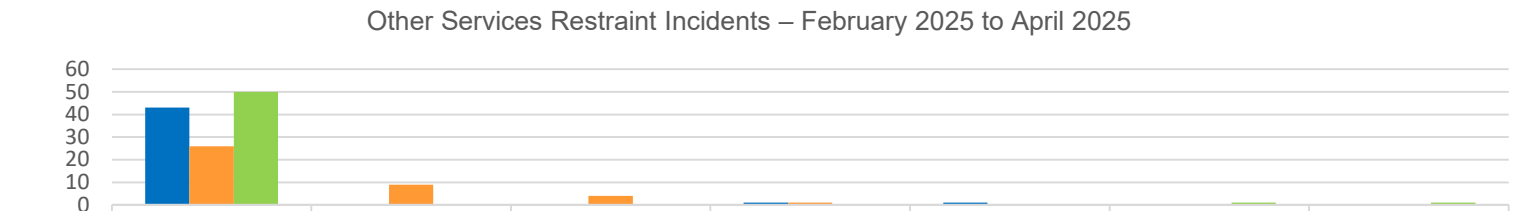












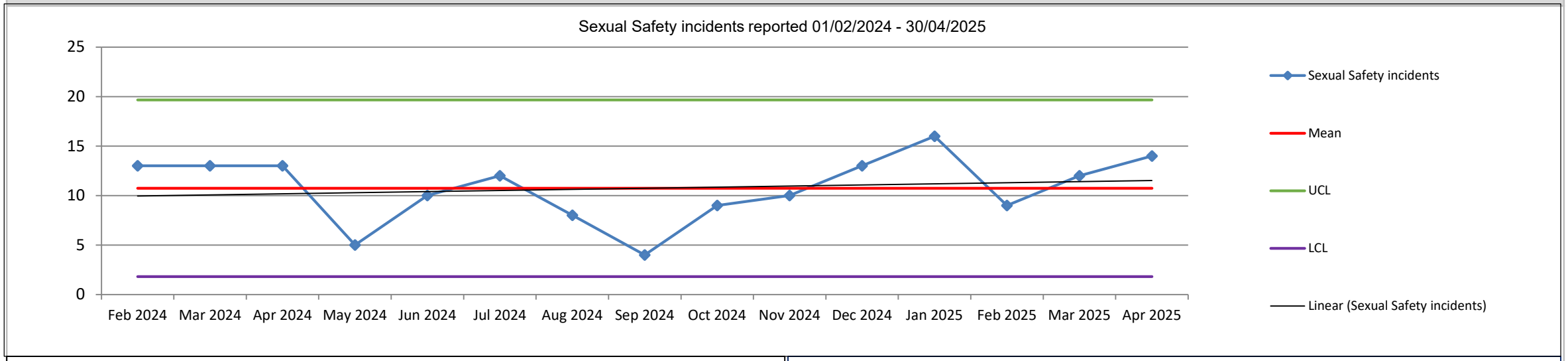
	LD IHOT	CAMHS Learning Disability	CRHT Liaison s135 s136	Montpellier Low Secure Unit	CAMHS/VC Youth Justice SP	CRHT Cotswold and Vale	LDISS
Feb-25	43	0	0	1	1	0	0
Mar-25	26	9	4	1	0	0	0
Apr-25	50	0	0	0	0	1	1

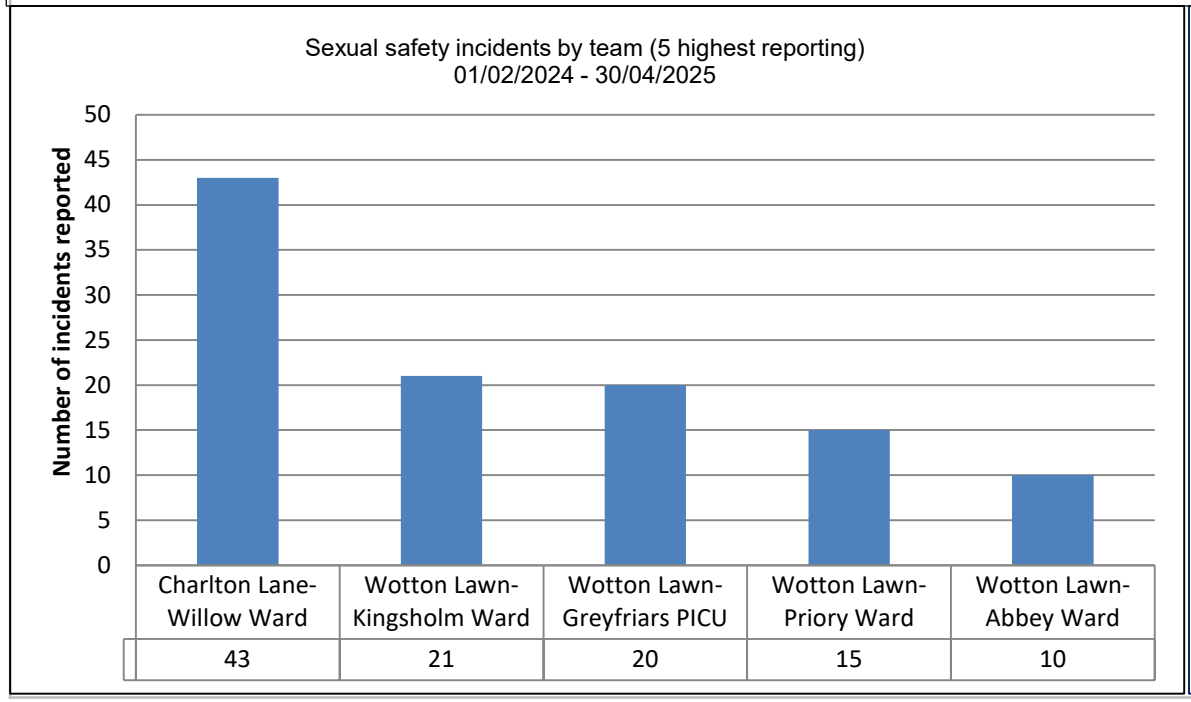
Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints. Looking more widely at other services:

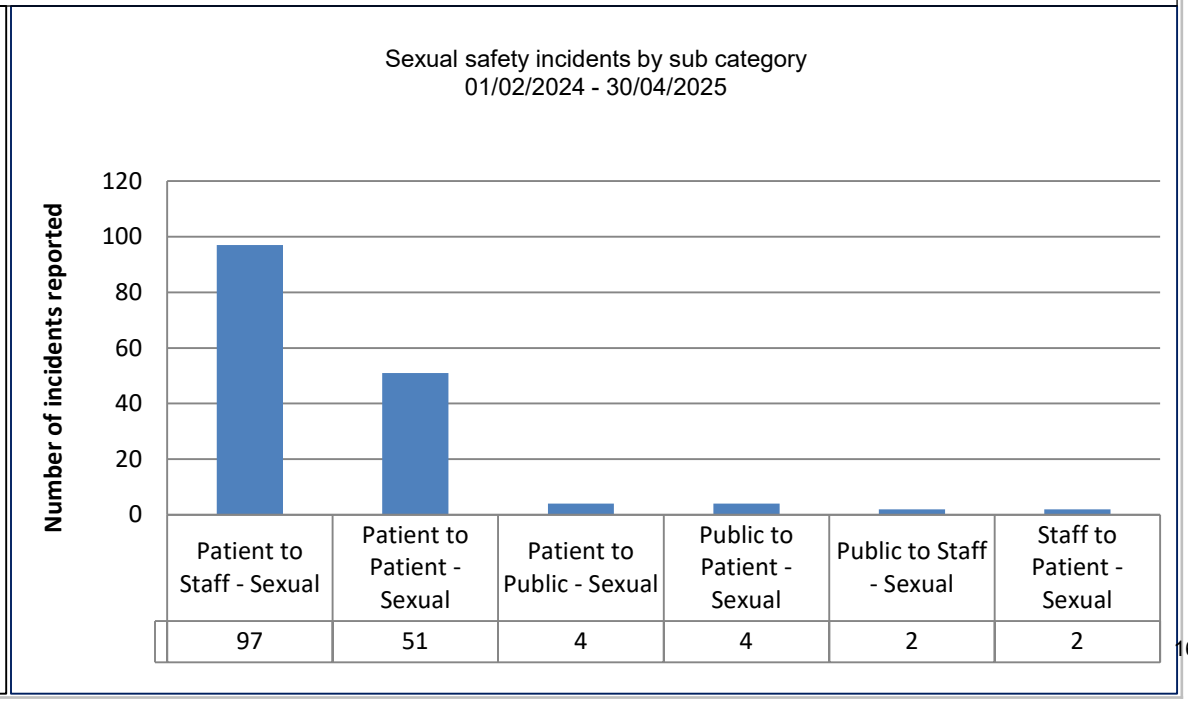
In April 2025 52 restraint incidents were reported across the other services of LD IHOT (50), CRHT Cotswold and Vale (1), LDISS (1). These involved 46 patients in LD IHOT, 1 patient in CRHT Cotswold and Vale and 1 patient in LDISS.

All LD IHOT restraint incidents are reviewed on a weekly basis and were in support of care interventions

Sexual Safety Incident Data







Sexual Safety Incident Analysis

What is the data telling us?

- 13 sexual safety incidents were reported.
- 12 incidents occurred in clinical settings.
- 90% occurring in mental health inpatient areas, and 10% in a physical health teams.
- Wotton Lawn Hospital reported 2 incidents.
- Charlton Lane Hospital reported 9 incident.
- Willow Ward remains the most consistent reporter of sexual safety incidents in GHC.
- Male inpatients continue to be the most reported (83%) alleged perpetrators of sexual incidents on female staff, and occasionally female inpatients.
- 90% of all reported incidents this month resulted in no harm, and zero incidents connect with reported AWOL or Restrictive Practice.

What are the risks/impacts for clinical quality and patient safety?

- In April there were no sexual safety incidents reported by lone workers, this staff group is likely to account for our largest group working with individuals in community and clinic settings. It is unclear whether there have been 0 incidents or whether staff have not reported when they have occurred.

What are we doing about it?

- Sexual safety champion leads are being identified at Wotton Lawn Hospital as a result of benchmarking against the Sexual Safety Collaborative standards.

Additional information:

- A Freedom of Information request was completed this month regarding Sexual safety.

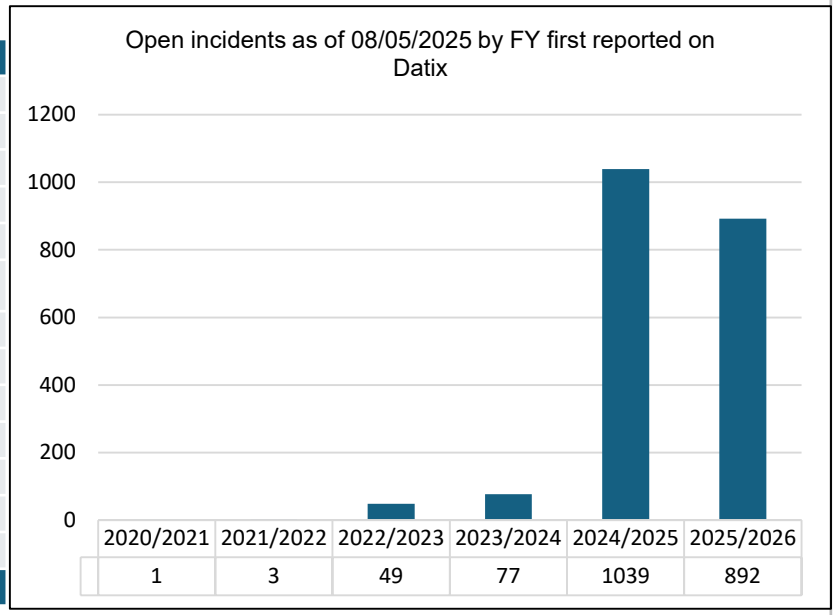
- Use of the term ‘Affectionate Activity’ was raised at previous QAG, update as follows :

    - *Affectionate activity (Glossary page 80):* Acts of physical intimacy with another person that are intended to display affection, such as kissing, hugging, hand-holding or non-sexual touching. A recipient of these affectionate behaviours may or may not have consented to these acts of intimacy. Affectionate activity is not always sexually motivated, but people can still feel uncomfortable if they have not consented.
    - It was decided to include this as a reporting category on Datix as behaviour may escalate and become sexual, and there would be an incident reporting trail.
    - It was felt to be important in differentiating from more sexualised behaviours, acknowledging that nonsexual touching could still create uncomfortable feelings.

Incidents awaiting review and confirmation of level of harm

Open incidents (awaiting review/being reviewed) as of 08/05/25 by FY incident first reported on Datix

	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	Total
Inpatient Mental Health & LD	0	0	8	6	367	308	**689**
Adult Community Physical Health	0	0	2	7	276	263	**548**
Community Hospitals PH	0	0	0	1	48	111	**160**
Therapies & Spec Equip	0	0	1	6	60	45	**112**
Adult Community Mental Health	0	1	23	21	43	14	**102**
Urgent Care Physical Health	0	0	0	1	66	30	**97**
CW Specialist Services	0	0	0	1	25	31	**57**
Urgent Care Mental Health	0	1	2	2	32	19	**56**
Integrated Urgent Care Service	0	0	0	0	38	15	**53**
Specialist Mental Health Svcs	0	0	8	4	24	7	**43**
CYPS Physical Health	0	0	0	0	14	15	**29**
CYPS Mental Health & LD	0	0	0	0	7	10	**17**
Other Services	1	1	5	28	39	24	**98**
Total	**1**	**3**	**49**	**77**	**1039**	**892**	**2061**



What is the data telling us?

- There are a total of 2061 open incidents on Datix that are awaiting review or are being reviewed.
- A total of 1,169 open incidents are from previous reporting years.
- 2024/2025 has the largest number of open incidents which is not unexpected given that this reporting year has just ended.
- Inpatient Mental Health and Learning Disability teams and Adult Community Physical Health Teams have the most open incidents.

What are the risks/impacts for clinical quality and patient safety?

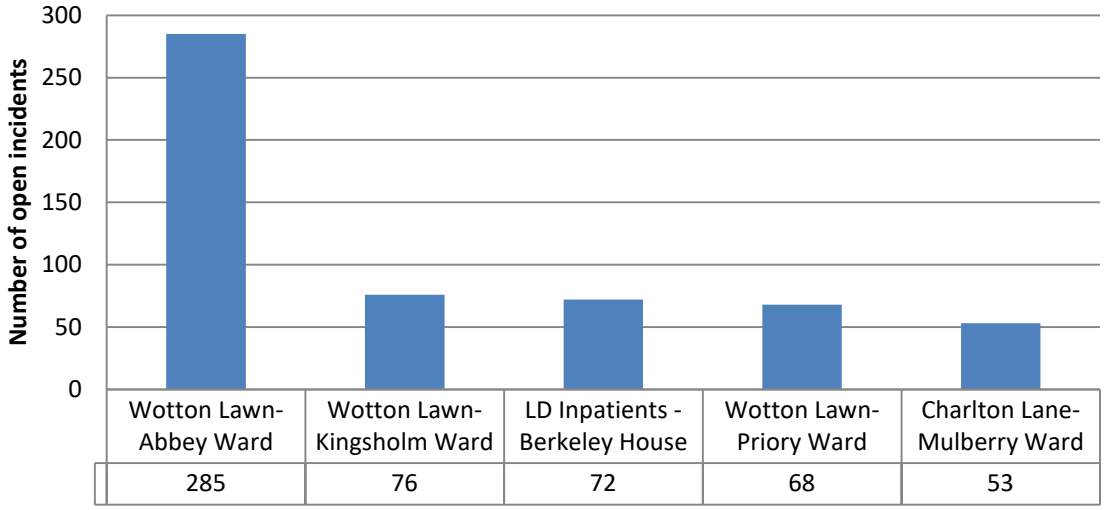
- Open incidents that have not been reviewed or are being reviewed at a much later date will not have any potential learning identified to prevent reoccurrence of the incident or a more significant incident.

What are we doing about it?

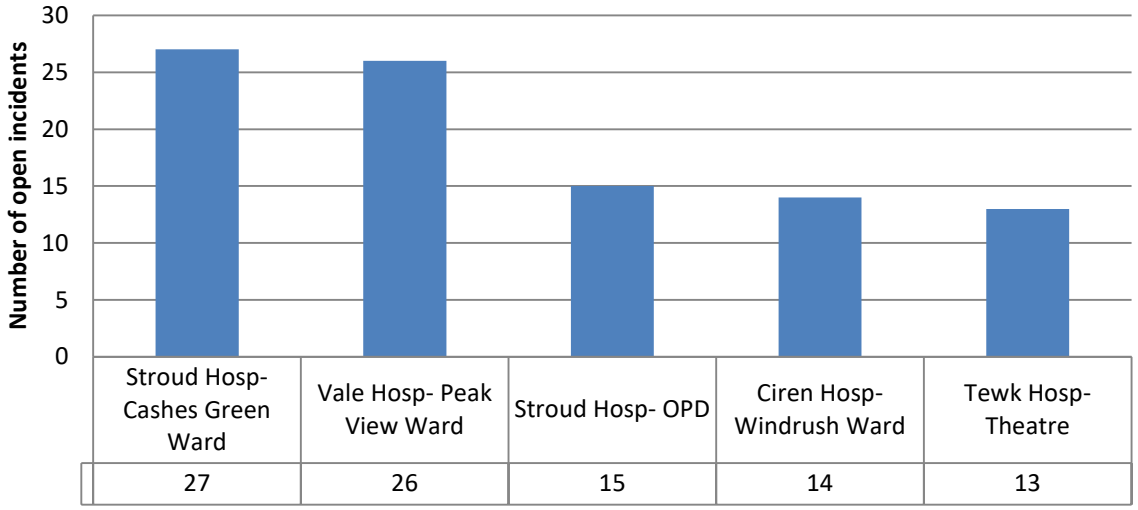
- Data has previously been provided in a spreadsheet to Directorates; a live dashboard has been developed by Datix Team which will be discussed in the future at Directorate Business meeting.

Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway

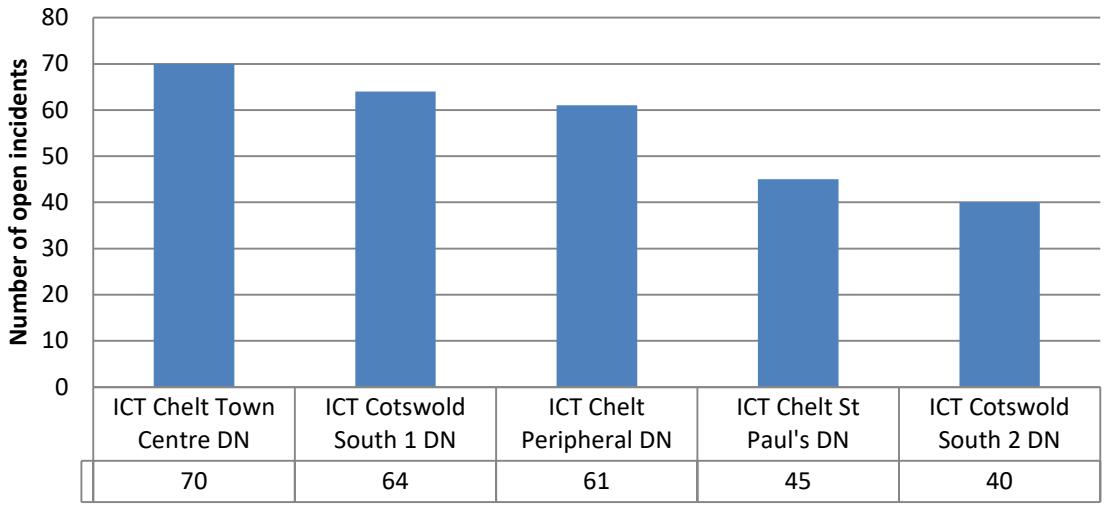
MH/LD inpatient wards/units (Top 5) –
Open incidents (awaiting review / being reviewed) as of 08/05/2025



Community hospitals (Top 5) –
Open incidents (awaiting review / being reviewed) as of 08/05/2025



ICT teams (Top 5) –
Open incidents (awaiting review / being reviewed) as of 08/05/2025

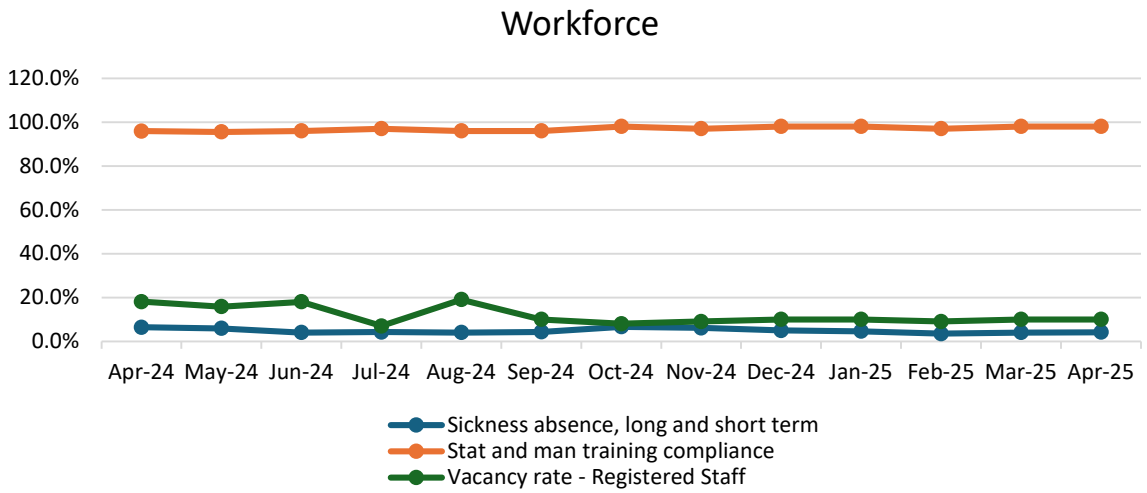


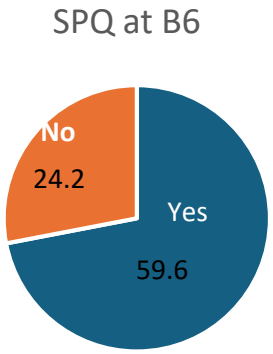
The Datix incident reporting system captures reported incidents and requires managers to review the incident and allocate the correct level of harm and overall severity.

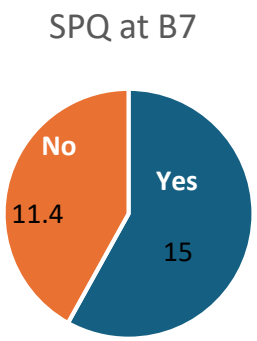
The total number of open incidents (awaiting review / being reviewed) that had yet to be closed was 2061 as of 08/05/2025, this is a decrease of 373 since 04/03/2025 (2434). Of these:

- 1582 were incidents affecting patients, an increase of 302 since 04/03/2025 (1884)
- 356 were incidents affecting staff, a decrease of 58 since 04/03/2025 (414)
- 18 were incidents affecting visitors, a decrease of 7 since 04/03/2025 (25)
- 105 were incidents affecting the Trust, a decrease of 6 since 04/03/2025 (111)

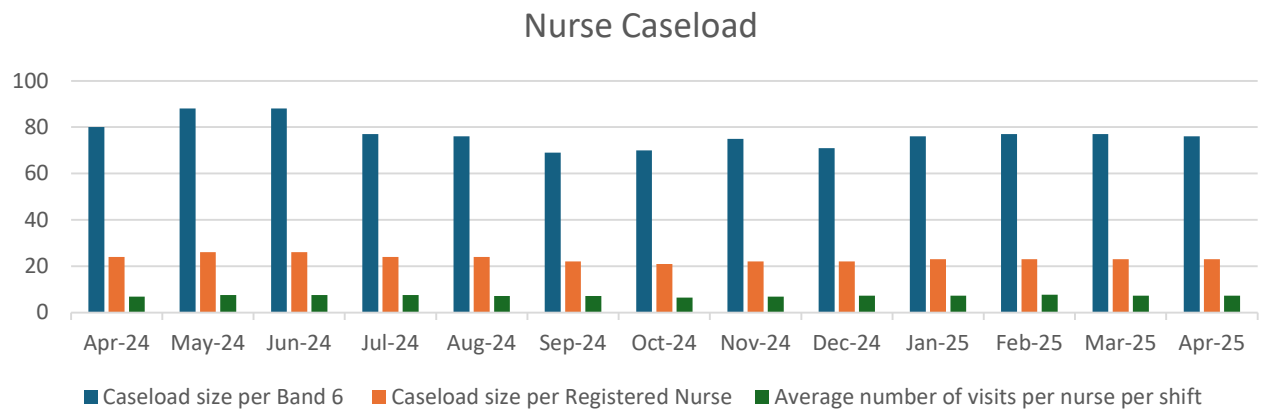
ICT Community Nursing Workforce - April 2025

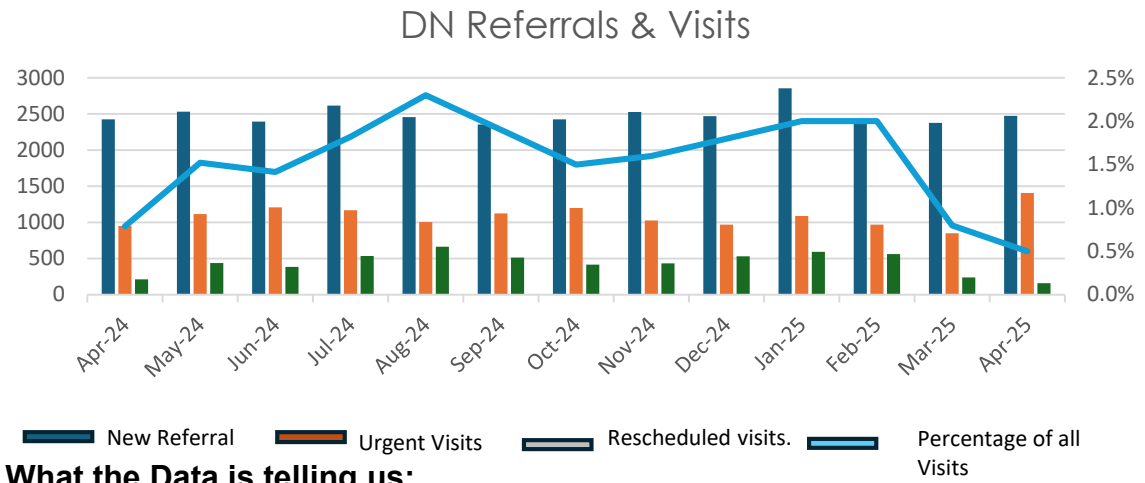






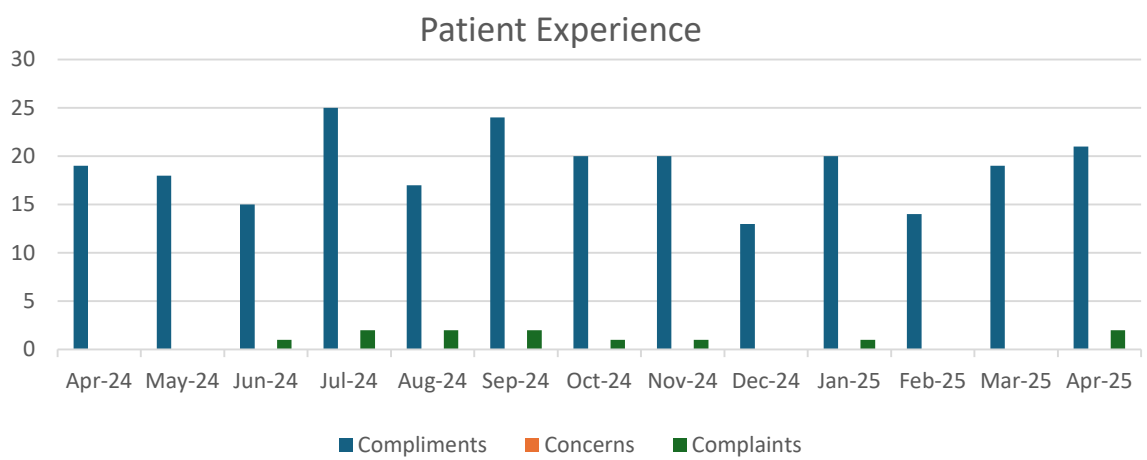
What the Data is telling us:
The continued Operational & NTQ Directorate's support for the Specialist Practice Qualification in District Nursing supports the increased complexity of patients now being admitted to community nursing caseloads.

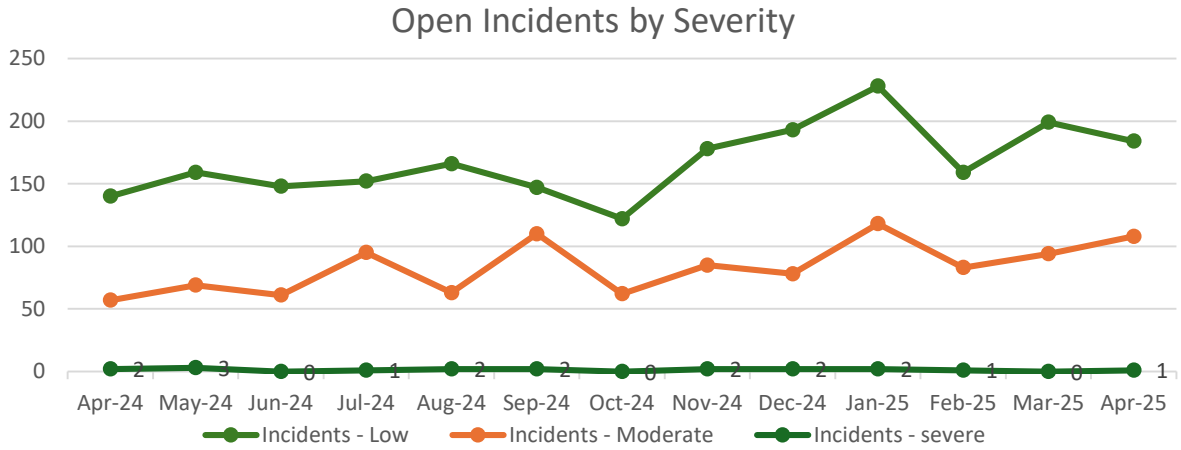




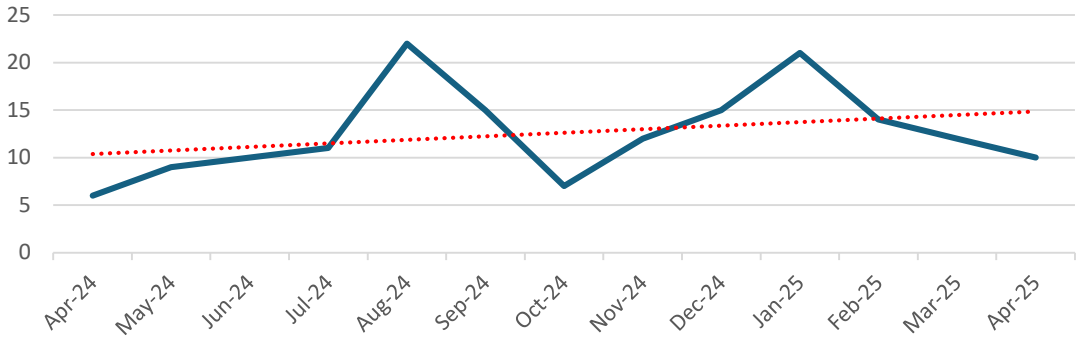
What the Data is telling us:
New referrals continue to rise in April as do urgent visit requests, our data supports nationally reported evidence around nurse morale and retention. The data shows that rescheduled and missed visits have decreased which confirms the changes in process introduced by the operational teams are beginning to have an impact and this work continues.

ICT Community Nursing – April 2025

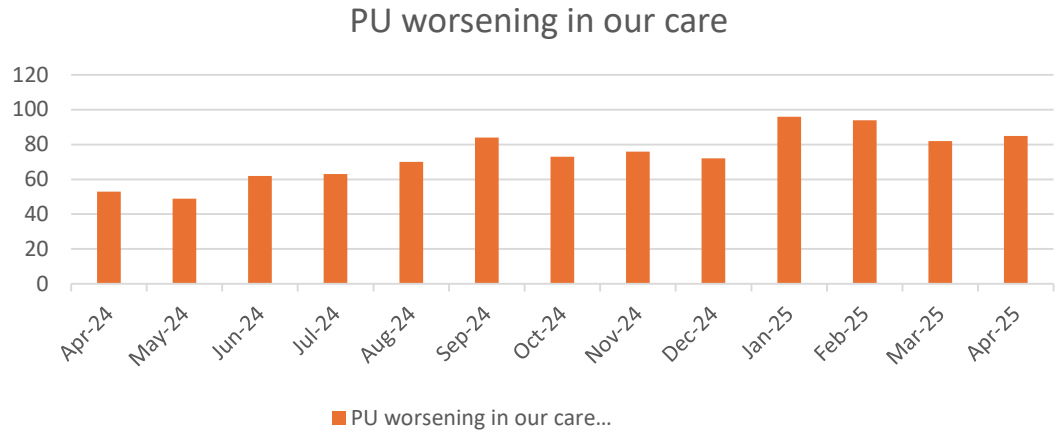




What the Data is telling us:
The upward trajectory of compliments correlates with recent success for ICT Community Nurses in the Cotswolds who have been recognised by GHC as "making a difference" the complaints are being investigated and will move through the GHC process, governance and learning.



What the Data is telling us:
There has been a steady decrease in the number of missed visits which is likely due to the detailed review undertaken in the locality reporting the highest, who have introduced a new system with support to mitigate the risk.



There are two current projects in progress which will improve our understanding of the data in this area. The ***minuteful for wounds app*** being trialled in the Forest ICT community nursing teams and a quality improvement project led by TVN's working in collaboration with ICT community nursing in Stroud & Gloucester to understand category 1 & 2 pressure ulcer incidence.

CQC DOMAIN - ARE SERVICES EFFECTIVE

Safe Staffing Inpatient data April 2025	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	0	0	7.5	1	0	0	0	0	0	0
Abbey	22.5	3	17.5	2	0	0	0	0	0	0
Priory	30	4	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	0	0	45	5	0	0	0	0	0	0
Greyfriars	62.5	8	0	0	0	0	0	0	0	0
Willow	0	0	30	4	0	0	0	0	0	0
Chestnut	10	1	22.5	3	0	0	0	0	0	0
Mulberry	0	0	7.5	1	0	0	0	0	0	0
Laurel	30	3	15	2	0	0	0	0	0	0
Honeybourne	60	8	0	0	0	0	0	0	0	0
Berkeley House	0	0	60	8	0	0	0	0	0	0
Total In Hours/Exceptions	215	27	205	26	0	0	0	0	0	0

	Code 1	Min Staff numbers met – skill mix non-compliant but met needs of patients
	Code 2	Min staff numbers not compliant but met needs of patients
	Code 3	Min staff numbers met – skill mix non – compliant and did not meet needs of patients
	Code 4	Min staff numbers not compliant and did not meet needs of patients
	Code 5	Other

Key highlights:

The Director of Nursing, Therapies and Quality (NTQ) reviews safe staffing reports every month ahead of submission to NHS England (NHSE). This acts as a rolling review of safe staffing and is informing a detailed Trustwide safe staffing review in line with NHSE guidance. This includes staffing data for Community Hospitals which is reported within the Performance Dashboard. We have cross refenced highest exceptions with patient safety and patient experience data with no adverse trends being noted. Honeybourne and Greyfriars have reported the highest code 1 exception levels .The Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Honeybourne were attributed to shortages of HCA.s on early and late shifts and Greyfriars ward was mainly attributed to RN shortages on late shifts. There is currently no data being reported in the QDB for our Com Hospitals; this data for April has been reviewed and assured by the DON and we are working on it's inclusion in a reportable format

Quality Dashboard

Quality Improvement Hub Support along the Improvement Lifecycle

1. New improvement opportunity/concept/idea

- National mandate
- New service bid
- GHC Strategic priority
- ICS/CCG mandate
- Colleagues
- Service users/Carers
- Quality Issue

2. Improvement idea scoping

- What is it
- Why are we doing it
- What are the benefits/risks
- Is the problem clear, understood and agreed
- Is there data

3. Improvement idea initiated

- Stakeholder mapping
- Tools to understand the problem
- Baseline data
- Early team tasks
- Life QI

4. Improvement idea testing – e.g.: PDSAs

- Using the Model for Improvement to test change ideas
- Data to show towards progress and inform next steps

5. Improvement idea sustained & implemented

- Evidence of sustained improvement through data
- Ongoing quality control & assurance agreed

- = Number of ECGs successfully signed with a Bazett QTc
- = Assistance with Voice patient service within SLT
- = Colonoscopy procedure
- =(s)Improving housing support planning
- for the supported accommodation service within mental health
- =(s) Catheter Trauma - increase knowledge and how to prevent and manage
- = Overgranulation
- =To develop an effective pathway for people experiencing At Risk Mental State pathway
- + (G) Over use of continence pads
- + (s)Understanding the Barriers to completing Silver QI
- + (G) Over use of continence pads
- + Falls assessment and education service care home pathway
- +Why do certain demographics access MSK physiotherapy in Forest of Dean?
- + Shared decision making in MSKAPS

- = Culture of Care Abbey Ward
- = CYPS collaborative information library
- = (s)(G) TTO (Tablets To Take Out) from inpatient settings in physical health units
- =(s) Guidance on treatment of hyponatraemia and hypernatremia in the community
- = (s)Making improvement part of everyday conversations in CYPs directorate
- = OAMH Loss dementia pathway
- ↑(s) Digital Front Door process
- ↑ CAMHS Screen Use Project

- = MH inpatient and urgent care flow pathway mapping
- = (s) (G) Improving the number of patients receiving their depots in primary care
- = Paper Care Certificate Workbooks
- = Clinical System Team Model
- =(s) Sexual health triage capacity and improving patient access
- = Culture of Care - Priory Ward
- = Team nursing on Abbey Ward, WLH
- = (s) The Vale Stroke Unit
- = Getting feedback from patients about MHA assessment
- = Inadequate and not optimised bone protection
- = (s) Streamlining triage process for adult SLT
- = ASC waiting list project
- =(s) Pressure ulcers
- = Reducing non attendance in outpatient clinic services
- = STOMP guidelines
- = (s) (G) Local and national AAC pathways for children who may benefit from AAC

- = Dental Services – medical history form
- = Culture of Care - Dean Ward
- = Culture of Care - Kingsholm Ward
- = IPS Project
- =Improving self-referral form for MSK physiotherapy
- = Inequities in the Mental Health Act - Greyfriars
- = Increasing the time between incidents of severe constipation needing a proactive response in CLH
- = Toilet training - improving outcomes for children
- = Measuring effectiveness of new OATS service
- = Improving health inequalities in school age immunisation
- = (s) Gloves off - reducing PPE glove waste
- = Paired ROMs compliance – Outreach Team
- = Paired ROMs compliance – Vulnerable Children's Team
- = Paired ROMs compliance – Young Adults team
- = Paired ROMs compliance –CORE CAMHs South
- = Paired ROMs compliance –CORE CAMHs North
- = (G) Improving access to ECT in WLH and community
- = School nursing - Supporting Primary Schools with High Health Needs
- = (s) CYPS SLT waiting list
- = People Promise - Learning from Leavers
- = (S) (G)Contamination issues with surgical instruments
- = Improving the process for offering SLT placements to T-level students
- ↑ Improving access for mothers from ethnic minority into perinatal service
- =(G) Developing a process for Observed Practice within AHPs
- ↑ Adverse events pathway

- ↑ School nursing mental health pathway and resources
- ↑ CYPS SLT Selective Mutism Project

Key:
+ new to tracker
= no movement
↑ moved forwards
↓ moved backwards
*Restarted
(s) Silver project
(G Gold coach)

Directorate	No of improvement work supported by QI Hub (includes projects from Lifecyle and others)
Countywide	10
MH Hospitals and UC	15
PH Hospitals and UC	6
Adult MH/PH/LD Community	14
CYPs	18
Corporate	11
Total: 74	

- The Quality Improvement Hub is a dedicated Trust team of subject matter experts whose primary aim is to provide leadership to the organisation in the field of improvement science. The team seek to support the experts – the people who use our services and those that deliver them, to understand problems identified and the associated data, find change ideas, test them out at small scale, upscale as appropriate and make them sustainable using proven methodology.
- This update provides a brief overview of the Trust QI training programme- with its intention to ensure that a QI approach is embedded across the whole organisation by;
    1. Providing a complete range of training packages that demonstrate learning outcomes in alignment with the Kirkpatrick Evaluation Framework
    2. It also shows the active QI projects recorded on Life QI- the system the trust utilises to capture and share QI activity.

Training data April 2025:
33 Silver (current trained taken from Care to Learn, GHFT or GHC silver trained) –0.7% workforce
758 Bronze (current trained taken from Care to Learn) - 16% workforce
1077 Pocket QI, total trained overtime – 22% workforce

Gloucestershire Health and Care
NHS Foundation Trust

Guardian of Safeworking Hours Committee Report Part 1

Reporting time period January 2025 – March 2025

GoSWH – Dr Sally Morgan

Number of mental health doctors in training (Resident Doctors) 52 doctors in training posts during this time period (14 HTs, 7 CT3s , 8 CT2s, 5 CT1s, 4 GP trainees, 7 FY2s, 7 FY1s). New rotation started in February.

24 on call shifts had a Resident Doctor gap due to sickness or other reasons such as gaps from part time doctors

15 shifts were covered by our own Resident Doctors acting as locums.

7 shifts covered by trust Specialty Doctors acting as locums.

1 shift was covered by a Higher Trainee stepping down

1 shift was covered by a Consultant stepping down.

Junior Residents Forum held virtually on 10 February 2025.

Gloucestershire Health and Care
NHS Foundation Trust

Guardian of Safeworking Hours Committee Report Part II

3 exception reports in this time period, 2 relating to hours worked, 1 relating to pattern of work. No immediate patient safety concerns identified. One of the exception report related to hours worked occurred when a Resident Doctor stayed on to cover a last-minute night shift gap on the rota due to sickness.

Outcomes agreed : 2 x TOIL , 1 x payment.

Following the recent **work schedule review** for the Higher Residents on call , a new pattern of working whilst non resident on call started in mid January . (Due to their specific terms and conditions, a protected break whilst on non-resident on call is required). Following a review of pattern and amount of work undertaken on call, the quietest time of the night was chosen for this break - 2am to 7am. This allows the Higher Resident their required break, with minimal impact on the Consultant on call at the time.

GoSWH attended the **Resident Doctor Induction** In February 2025 to meet new doctors joining the trust.

Another successful Resident Doctors Wellbeing Day took place on 24 January 2025 and was well attended with excellent feedback. A further Wellbeing Day is being planned for later in 2025.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

Please note, following year-end data cleanse, some figures may have moved between categories.

	Reporting Level	Threshold	2024/25 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		27,696	2,328												2,328	Including 30 responses from carers (90% positive response)
% of respondents indicating a positive experience of our services	N - T	95%	93%	92%												92%	This is the second consecutive month the positive response rate has dipped to 92%
Number of compliments received in month	L - R		2,830	256												256	As reported on last day of the month, noting compliments can be added retrospectively
Number of enquiries (other contacts) received in month	L - R		1,724	120												120	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		204	23												23	1 x MHUC/IP,2 x PHUC/IP, 2 x CYPS, 4 x Comm (2 x MH, 2 x PH), 14 x IUC
Of complaints received in month, how many were early resolution complaints	L - R			23												23	
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			64													
Percentage of complaints acknowledged within 3 working days	N - T	100%	99%	100%												100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			26												26	Out of the 26 closed complaints, 1 was withdrawn, 2 were resolved through LRM,1 was redirected to PPG (previous IUCS provider) and 1 was managed by DDoN and Chief AHP
Number of complaints closed within 3 months	L - I			23												23	
Number of re-opened complaints (not all opened within month)	L- R			3													
Number of external reviews (not all opened within month)	L - R			3													

N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

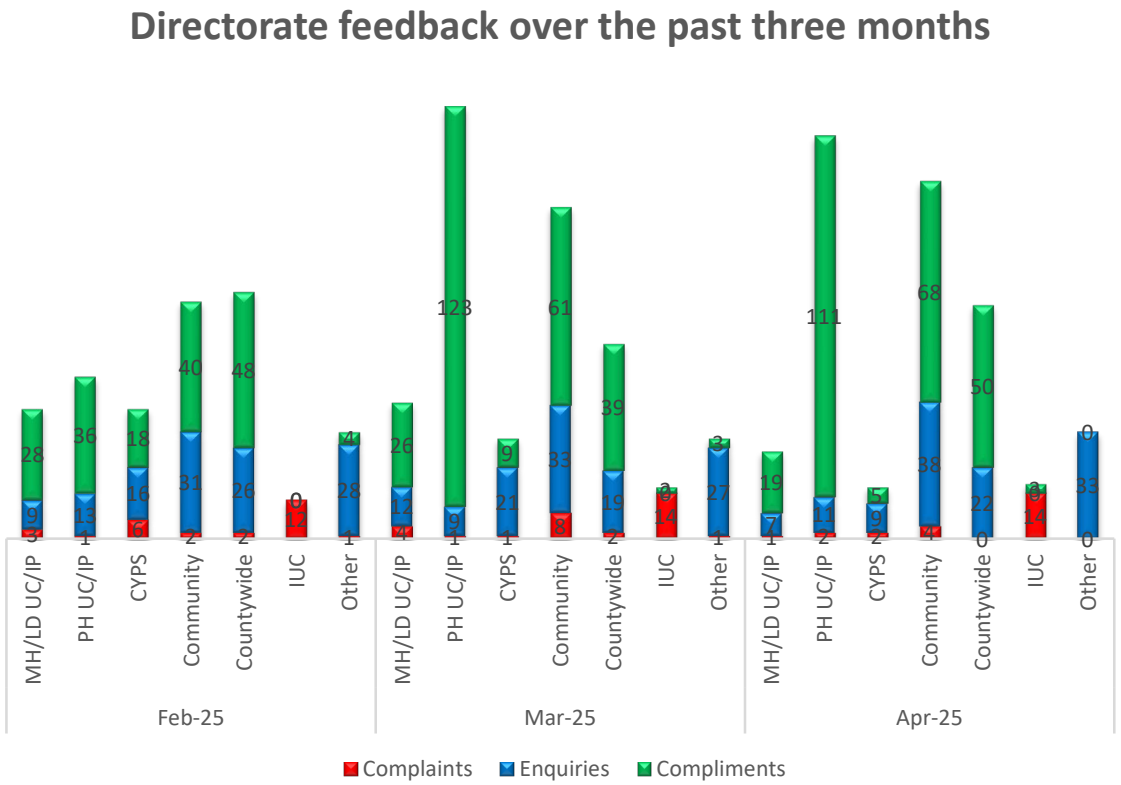
Key Highlights:.

- We continue to see far more compliments than any other type of feedback and directorates now receive a full list of these each month.
- Directorate level data is shared with senior operational leads each month to enable interrogation of service specific feedback; this time is also used to discuss ongoing investigations and emerging themes/learning.

This table shows all reported PCET data received this month by type and directorate

It is important to note that this is a snapshot and does not consider directorate size/footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	1	Early resolution:	**1**	7	19
		Closer look:	**0**		
PH urgent care and inpatient	2	Early resolution:	**2**	11	111
		Closer look:	**0**		
CYPS	2	Early resolution:	**2**	9	5
		Closer look:	**0**		
PH/MH/LD Community	4	Early resolution:	**4**	38	68
		Closer look:	**0**		
Countywide	0	Early resolution:	**0**	22	50
		Closer look:	**0**		
IUCS	14	Early resolution:	**14**	0	3
		Closer look:	**0**		
Other	0	Early resolution:	**0**	33	0
		Closer look:	**0**		
Totals	23	Early resolution:	**23**	120	256
		Closer look:	**0**		



The above graph shows feedback by type and directorate over the past three months.
Whilst we continue to welcome complaints as an opportunity to improve our services, it is important to recognise good practice across all directorates.

Examples of complaints [as reported] for each directorate:

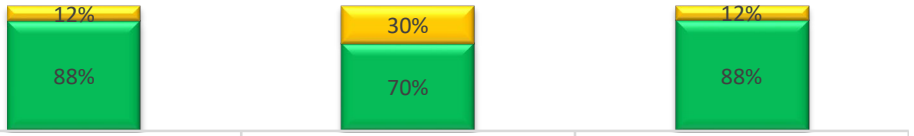
- MH UC/IP: Patient's father is unhappy with care and behaviour of staff and is unhappy with PCET response.
- PH UC/IP: Son of patient unhappy with the way he was spoken to by a member of staff.
- CYPS: Mother of patient very unhappy with treatment received from the team.
- IUCS: Patient unhappy with process and attitude of NHS111 clinician.
- Community: Patient queried why a diagnosis made by Psychiatry UK is not accepted by our Recovery Team.

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The below table shows all complaints CLOSED this month by outcome and directorate.
These include closer look and early resolution complaints.

Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	0	0	1	0	1	2
PH urgent care, inpatient	0	0	0	0	0	0
CYPS	0	0	2	1	0	3
PH/MH/LD Community	0	1	1	0	1	3
Countywide	0	0	2	0	0	2
IUC	8	1	4	0	1	14
Other	1	0	0	0	1	2
Totals	**9**	**2**	**10**	**1**	**4**	**26**

The below graph shows the length of time taken to close complaints.
This month, 88**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)

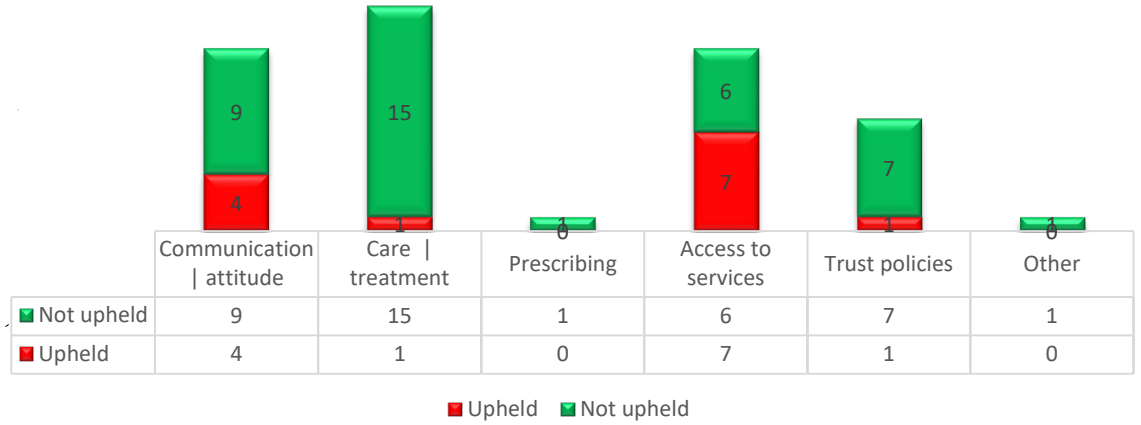


	Feb-25	Mar-25	Apr-25
7-12 months	0%	0%	0%
4-6 months	12%	30%	12%
1-3 months	88%	70%	88%

The below table shows some of the upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
PH UC/IP (17689)	Referral documentation should not be added to patient's end of bed folders. **Trust admin/policies/procedures**
Community (16591)	Patient was not assessed within 18-week target period. **Access to services**
IUCS (17643)	Length of time for call back. **Access to Services**
IUCS (17875)	Patient unhappy with attitude of call handler **Communication**

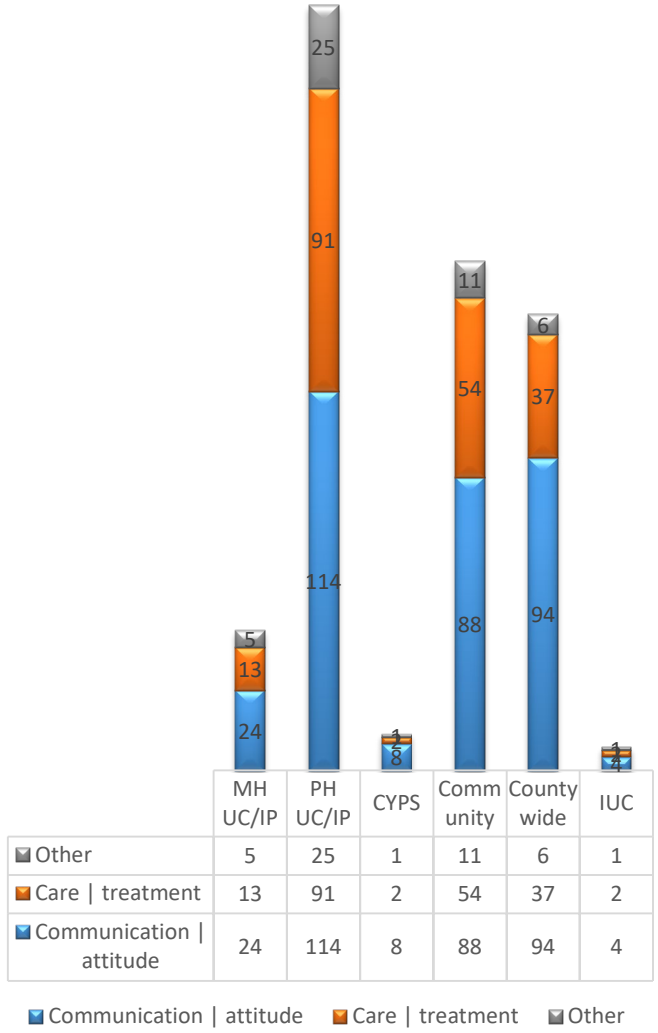
The chart below shows the themes highlighted in all complaints closed over the past month



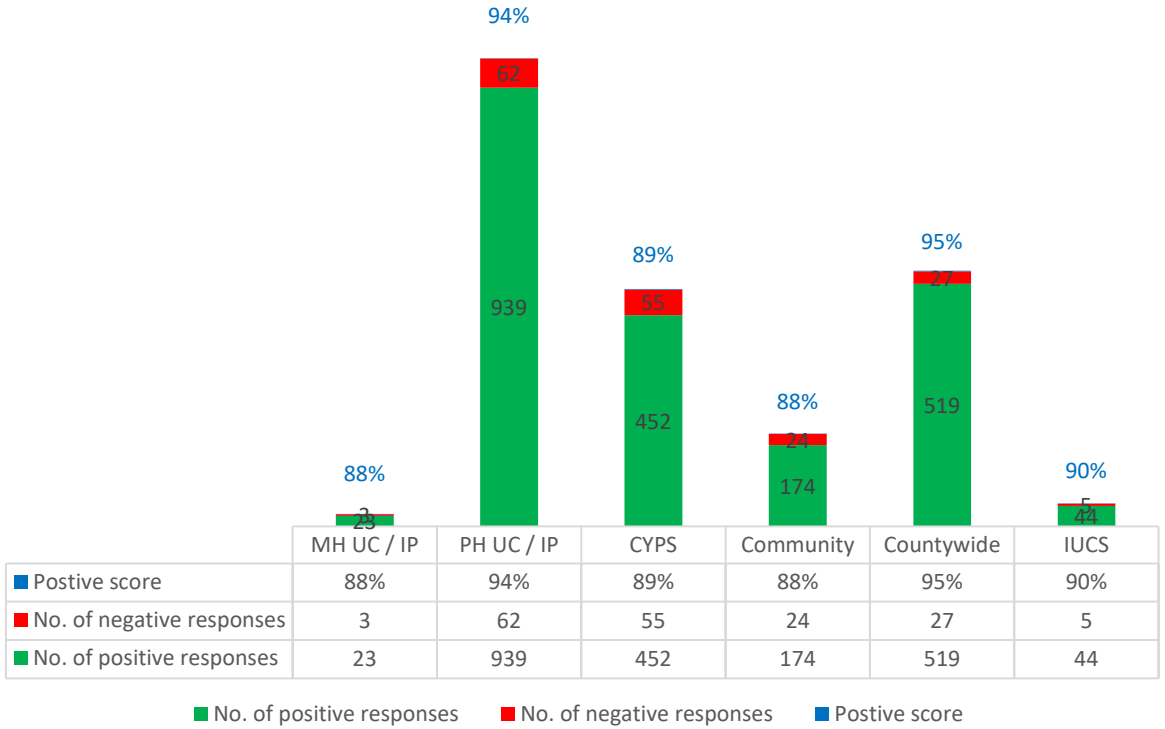
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.
The 256 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.** It is very likely that more compliments were received but not recorded, therefore, not reported; this is due to operational challenges in some teams.

Date	ID	Team	Compliment
23/04/2025	18650	Charlton Lane-Mulberry Ward	We would like to say a huge thank you for all your care, support and kindness. You really are a fantastic team.
25/04/2025	18700	Stroud Hosp-Cashes Green Ward	"Thank You Card & goodies. To the Wonderful Staff on Cashes Green Ward. Thank you all for looking after Iris and us as a family. Especially thanks to the Staff who looked after mum when she got difficult and non compliant when frustrated. We appreciate the care you've delivered so professionally including kitchen staff and domestics for your kindness. Thank you all.“
17/04/2025	181622	CYPS/PH-Health Visiting	"A compliment sent to a VIG Practitioner after she sent her closing letter as her work with the family is now complete. "thank you so much for the work we did together. It was such a valuable experience and I'll cherish the write up and photographs you sent""
04/04/2025	18389	ICT Glos Physio	Partner of patient telephoned to say thank you, she was very impressed by your whole assessment, knowledge and plan to get him motivated and she wanted to say she wants to compliment the service.
25/04/2025	18709	Recovery Tewkesbury	Just want to say a huge thank you, you've both been absolutely amazing. You are both incredible ladies and we are so lucky to have met you. We wish you both all the best
03/04/2025	18371	SALT Adults Physical Health	Thank you card and box of biscuits - Thank you for all your support and help over these last few months. Keep up the good work
22/04/2025	18626	Complex Care at Home Glos	"Patient told myself and my colleague, I am sure you have wings but I just cant see them "
25/04/2025	18712	IUCS OOH Service	HCA from Rapid Response praised how well one of IUCS's Coordinators spoke to patients on the phone - calm and patiently .
11/04/2025	18514	Perinatal MH Community Team	"Birth Without Fear course Myth busting and asking questions was brilliant. Tour of the hospital very helpful."



CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)



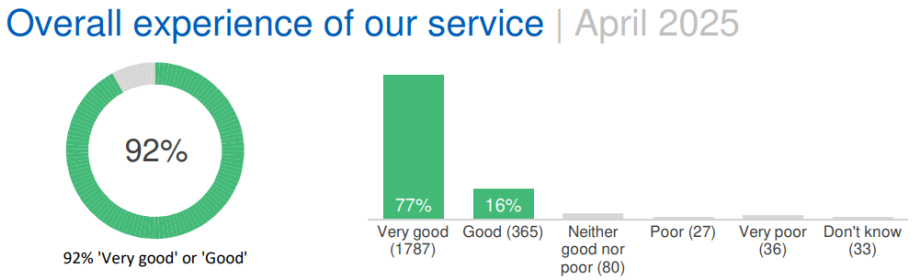
	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
Postive score	88%	94%	89%	88%	95%	90%
No. of negative responses	3	62	55	24	27	5
No. of positive responses	23	939	452	174	519	44

No. of positive responses No. of negative responses Postive score

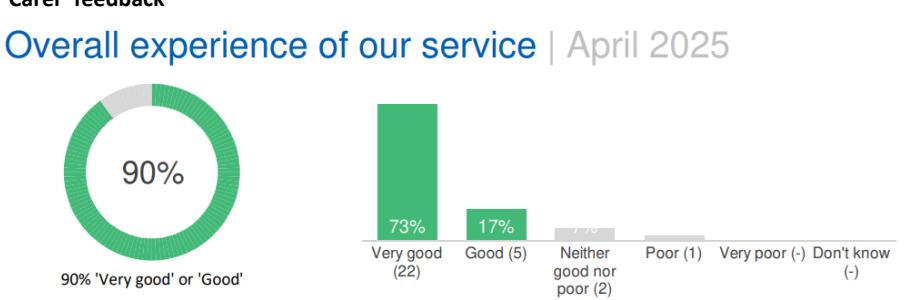
Highlights for this month:

- The overall positive experience rating is 92% which is line with recent data but lower than the yearly average.
- We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.
- Evaluation of 'You Said, We Did' Boards pilot completed in Q4 for initial PCET review.
- Service users made 12 requests for contact/action through the FFT.
- FFT set up to support new IUC service; there were 49 responses in April 2025 with a positive experience rating of 90%.

Patient feedback



Carer feedback



ADDENDUM TO QUALITY DASHBOARD

ARE SERVICES CARING? Non-Executive Director audit of complaints Q4 2024/25

INTRODUCTION

The agreed aim of the audit is to provide assurance that standards of complaint management are being met in relation to the following aspects:

- The timeliness of the complaint response process
- The quality of the investigation and whether it addresses the issues raised by the complainant
- The accessibility, style and tone of the response letter
- The learning and actions identified as a result

PROCESS

- Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide the auditor with copies of the initial complaint letter, the investigation report, and the final response letter.
- Having studied the files, the auditor completes sections 2-4
- The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q4 2024/25 audit provides **SIGNIFICANT** assurance that overall, the Trust is investigating and responding to complaints appropriately.
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To note the assurances provided regarding the Trust's management of complaints

ARE SERVICES CARING? Non-Executive Director audit of complaints Q4 2024/25

	Time scale of response	Quality of investigation	Accessibility and tone of letter	Learning actions identified	Comments
Complaint 1 Mother of patient still unhappy with lack of communication to her and is unhappy that the ward are discharging the patient. Complaint not upheld	**SIGNIFICANT ASSURANCE** • Appropriate clarification of issues via email but not confirmed again in acknowledgement letter. • Formal response letter sent slightly late due to emergency leave taken by investigator mid-way through process.	**SIGNIFICANT ASSURANCE** • Each issue responded to • No judgement provided in two cases where opinion differed. • Learning action is vague, not time specific and there is no owner allocated.	**SIGNIFICANT ASSURANCE** • Response focuses on impact felt by complainant (mother) not patient. • No consent, so only able to provide limited response to complainant. • Learning identified in the investigation but not shared in the letter.	**SIGNIFICANT ASSURANCE** • Learning was identified but no owner allocated and details were not included in the letter. • The learning summary was completed but it is unclear who will take actions forward.	• Complaint outcomes are currently determined by PCET at the end of the process and reported via QAG/QC/Board. • Learning summaries are completed by PCET, based on the investigation, and are shared with SDs/DSDs to action with teams. The Trust's Learning Assurance Lead also receives a copy. • We recognise there is work to do in both the above areas.
Complaint 2 Patient complaining about the lack of contact from the NHS111 Clinical Assessment Service (CAS). Complaint upheld	**SIGNIFICANT ASSURANCE** • Complaint was acknowledged late due to confusion regarding new relationship with IC24, providers of NHS111 in Gloucestershire and did not include advocacy details (now resolved). • Response was shared within agreed timeframe.	**FULL ASSURANCE** • Investigation undertaken by IC24. • Clear and transparent review of what happened, and learning identified (already in place). • Investigation turned around quickly.	**SIGNIFICANT ASSURANCE** • The response acknowledges the distress caused and apologises appropriately. • A change to the process is to prevent such uncertainty in the future is explained. • The expression 'comfort calling' could be taken as patronising by some	**FULL ASSURANCE** • Learning identified and in place.	• NHS111 complaints are now acknowledged by GHC and investigated by IC24. Response letters are written by GHC and signed off by both IC24 and GHC. • NHS111 complaints do not currently include a learning summary, however, the data is shared with the SD each month to embed learning
Complaint 3 Mother of patient wishing to raise a complaint concerning the proposed care plan for the patient - escalated from enquiry. Not upheld	**FULL ASSURANCE** • Appropriate clarification of issues via email but not confirmed again in acknowledgement letter, however, this was appropriate in this instance. • Formal response letter sent within agreed timeframe.	**FULL ASSURANCE** • This complaint appears to have been well handled by the team and investigator. • Care taken to ensure the complainant felt heard and all issues investigated properly.	**FULL ASSURANCE** • Whilst the complainant was likely frustrated by the outcome, the response was full and complete. • Signposting and support offered.	**FULL ASSURANCE**. • Consideration was given to whether there was learning to be extracted, however, none was identified.	• Initially reviewed as an enquiry (16881) and the patient's treatment plan was reviewed and agreed as appropriate. • Increasing number of complaints from parents who believe only CAMHS can help their child.

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Appendix One

Non-Executive Directors Quality Visits Q4 2024/25

January to March 2025

Living our Trust's Values: making a difference (Q4, 2024/25 visits)

Positive feedback from NED colleagues (as described in visit reports):

Forest of Dean Minor Injury and illness Unit [MIiU]
I was told there is lots of peer support …and that the team and culture were great. Staff told me they have annual PDRs and regular catch ups.

Memory Assessment Service [MAS]
I was introduced to the friendly and welcoming team by the administrator in the calm atmosphere of an open plan office with plenty of activity, but also easy liaison between team members. The Team supports each other and share experience and knowledge – the less experienced staff are supported well by colleagues. The Team members all seemed relaxed and approachable. They cross refer to each other and share ideas.

Visit outcomes update from completed visits in Q4, 2024/25

Service	Recommendations/questions	Progress	Status
Gloucestershire Wheelchair Assessment Service **[GWAS]**	The team continue to consider feedback options and how they can gather more patient feedback, and track this over time to look at changes in opinion.	GWAS would like patient input on service development and will consider this during their away day at the end of February 2025.	**Being taken forward by the service**
	There is an issue with wheelchair storage relating to mould and batteries breaking in the cold – the recommendation was to look at estates and see whether there is a storage option for wheelchairs that is less vulnerable to the weather.	Space was needed as more people have come to work at the Independent Living Centre (ILC), so wheelchair storage has moved to a shipping container. While it would be good to look at the estate to identify a storage option for wheelchairs that is less vulnerable to the weather, it is important that the team have quick access to stored items so somewhere off site may cause different issues.	**Closed**
	The team link in more with the Allied Health Professionals Community for networking, shared learning and support	GWAS is based at the ILC so has regular contact with Cheltenham ICT and ESD, however without specific joint working GWAS does not have the opportunity to link with other teams. Other ways the team link in with the wider trust is via supervision with the Head of Profession for Occupational Therapy (OT), attending governance meetings, and joining OT networking days. The team welcome any other suggestions for building networks across the Trust.	**Service lead to support wider engagement of colleagues across the Trust**

Visit outcomes update from completed visits in Q4, 2024/25

Service	Recommendations/questions	Progress	Status
First Point of Contact Centre **[FPCC]**	With the extension of the service and increased numbers of colleagues the room can be quite noisy. Could the partitions be improved to improve both confidentiality and the level of noise?	The Health and Safety Lead has visited FPCC's base and is due to return to consider extending the noise cancelling boards.	**Closed**
	Could we reach out to the Can-Do service to identify any potential to work more closely?	The Connect and Offload (CandO) service is offered by Rethink Mental Illness, and our patients can be signposted there for support. There is now a CandO card on each desk in the FPCC to remind staff to signpost patients where appropriate.	**Closed**
	Should we be identifying opportunities for some integration and joint working with the new IUCS in recognition of the Trust commitment to integration of MH and physical health? There may be learning from both.	The FPCC manager has plans to visit IUCS with a reciprocal visit to FPCC to seek opportunities for closer working.	**Closed**
	I was told that communications with the public re the MH 111 were led nationally. It was felt that a lot of the public are still not aware of the new service and now that the service is better staffed perhaps, we should be doing more locally?	Although 111 is led nationally, the public do appear to be aware the mental health support may be accessed via 111 – calls are now around 600 per month which is an increase from its previous 200 calls per month.	**Closed**
	The partnership working with the police continues to be beneficial although it never became as integrated as was hoped.	Partnership working with police is proving beneficial – police will talk to mental health staff regarding s136 decision making, or ask general questions, and in return can share information regarding risk. With the introduction of Right Care Right Place (RCRP), police no longer routinely conduct welfare checks, however, there is a shift towards working more closely with SWAST and the new band 7 posts will be working in the ambulance response vehicle.	**Closed**

Visit outcomes update from completed visits in Q4, 2024/25

Service	Recommendations/questions	Progress	Status
Community Neurology Service **[CNS]**	The team are keen to learn and adapt and are open to addressing areas of unmet need – hopefully, the vacant Band 3 posts can be filled soon. I anticipate that the current Service evaluation will be favourable, but the Team may need some Executive level support to ensure that appropriate recurrent funding is provided.	The service evaluation was received positively and is awaiting final sign off, currently being supported by Execs. The posts were originally funded for twelve months and when recurring funding is secured, two of the four posts will be four-year apprenticeships (one OT, one physio). The two remaining posts are currently filled by one full time and one 0.6 staff member.	**Closed**
	I would recommend reviewing the parking and transport arrangements for this busy clinical team.	The team have been allocated two spaces at EJC which has helped.	**Closed**
	I would recommend that a discussion takes place with Commissioners regarding Functional Neurological Disorder. The Team would be quite capable of managing this difficult disorder but would need additional clinicians	The team have done a fantastic job of supporting these patients within the remit of OT and physio – discussions with commissioners are ongoing.	**Closed**

Visit outcomes update from completed visits in Q3, 2024/25

Service	Recommendations/questions	Progress	Status
Children's Autism and ADHD Assessment Service **[CAAAS]** [Formerly SCAAS]	The waiting list is impacted by several factors including the amalgamation of others' waiting lists into CAAAS, and the (welcome) reduction in stigma / growth in awareness. Is reducing the number of children on the waiting list the right KPI for this service, or could it be the number of ADOS assessments per month, or overall waiting time for diagnosis?	This feedback has been shared with the Trusts COO, MD and DoN and will be included as part of the wider conversations and T&F group that is being led by the Deputy MD.	**Ongoing work within the Trust**
Service	**Recommendations/questions**	**Progress**	**Status**
Social Care Hub	Visited on 21st January 2025 – awaiting report		awaiting report

Visit outcomes update from completed visits in Q3, 2024/25

Service	Recommendations/questions	Progress	Status
Forest of Dean Minor Injury and illness Unit [MIiU]	All staff that I spoke to mentioned that the team were tired or drained, and morale was lower since the move to the new hospital: • The issue is increased volume and acuity of patients, some of whom treat the MIIU like an Emergency Department. • 88 patients were seen on Monday by 3 practitioners. Ideally practitioners should see 2 patients an hour, so this was much higher. • People with chest pains should be attending ED, not MIIU, but the service sees people with chest pains most days. • The service takes clinical risk due to the capacity of other services. For example, ambulance waiting times mean that patients are often transported to the Emergency Department in Gloucester in a relative's car, where they would have previously been transported by ambulance.	• When I asked what would help with the volume of patients, it was felt that three long day practitioners rather than 2 long day and one standard day would help. However, there isn't the budget. • I wondered whether more far-reaching public comms about this would help, noting that some has already happened.	**Being taken forward by the service**
	It was felt that the budget was challenging and didn't mirror other units of the same size. Given the concerns around amount of practitioner resource available with increased patient volume and acuity, do we need to be benchmarking amount of resource available against demand?	A staffing review was completed approximately two years ago by the Matrons for the service however a lot has changed since then and it no longer reflects the unit's caseload. A further staffing review would be welcomed.	**Being taken forward by the service**

Visit outcomes update from completed visits in Q3, 2024/25

Service	Recommendations/questions	Progress	Status
Memory Assessment Service **[MAS]**	The current wait times and ICB review provide scope for possible changes. It is important not to lose the high Quality that is evident in the current Service. Until recently a coffee van was located outside which was welcomed by all colleagues with access to it. Unfortunately, this is no longer available, connected with insufficient tendering/standards. As a result, this has left the colleagues with no access to a coffee facility. If the van is not to return, a substitute in the form of a machine would be very welcome – particularly considering recent evidence of the health benefits of a morning coffee.	It would be good if the Team had access to a good coffee machine or visiting service. Also access to a breakout room would be most welcome.	**Being taken forward by the service**
	The current wait times and ICB review provide scope for possible changes, possibly identifying people presenting with more advanced cognitive impairment in primary care. However, it is important not to lose the high Quality that is evident in the current Service.	A more efficient way of increasing memory assessments could be to ask the Care Home Service to be involved in assessments to help form diagnoses. It is possible that this may decrease crises developing in Care Homes.	**Being taken forward by the service**
	It would be saving clinical time if the clinic letters could be generated more automatically from the clinical system. This would free clinician time to perform more assessments.	Could Clinical Systems offer support with this?	**Being taken forward by the service and clinical systems.**

Visit outcomes update from completed visits in Q4, 2024/25

Service	Recommendations/questions	Progress	Status
Montpellier Unit	Visit postponed until April 2025 – awaiting report		awaiting report
Service	**Recommendations/questions**	**Progress**	**Status**
Children's Community Nursing Team	Visited on 28th April 2025 – awaiting report		awaiting report
Service	**Recommendations/questions**	**Progress**	**Status**
Wotton Lawn Hospital	Visit planned for April 2025 – awaiting report		awaiting report

Appendix Two

Quality Dashboard Development

(for information only)

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Summarised timescales for development of the dashboard, current ownership of slides and any proposed developments agreed through Quality Committee.

Slide	Description	Ambitions for slide	Timescale (by end)	Slide Owner
0-2	Cover and Exec Summary	To remain. Following the 4 A format.	N/A	Jane Stewart
3	Safeguarding Highlights and Challenges	New style development slides were presented at QAG in March. The focus included, What the data tells us, Risks and Key Actions. Alternative data sets were suggested to provide a more informative data flow concentrating on statutory actions and will be presented back to QAG.	June 25	Paul Gray
4 to 18	Patient Safety Data	Redrafted to concentrate on thematic findings over time rather than reporting on actual data and events notably concentrating on Tissue Viability and Falls over time and using SPC charts to track themes and trends. Introduction of new slides this month re Tissue Viability. New IPC slides in development.to appear by exception. IPC zero return in summary.	May 25	Nicola Mills
19-20	District Nursing Data	Remain – Development required to include What the data tells us, Risks and Key Actions	June 25	Nancy Farr
	Closed Culture	Removed going forward from April Data submission . Situation will be triangulated and monitored with option to re introduce if required.	Mar 25	James Wright
21	Safe Staffing	This slide needs to remain to fulfil statutory reporting requirements and is part of the BAF. Development work on safe staffing reporting to be completed by a workstream within the safe staffing programme..	Nov 25	Nicola Hazle
22 - 26	PCET	To recognise pockets within the organisation where the patients' voices are not being heard and to shift away from presenting actual monthly data to themes reviews and trend analysis for both complaints and compliments. NEDS audit and Quality Visits to continue or be reported separately.	Nov 25	Kate Bowden
27	QI Information	Re draft in progress to show the “what effect is this having” and what happens next elements of work streams – how they impact upon quality. Initial re draft of slides complete with further development being progressed to be approved at QC or QAG.	June 25	Tanya Stacey
	Long Length of stay MH and CoHo	Removed, as captured in the integrated report under Board Domain.	Complete	Jane Stewart

Appendix Three

Summary of Quality Priorities 2022-2025

(for information only)

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Priority	Description	Status in 2024/2025
1	• Tissue Viability (TVN) - with a focus on reducing performance through improvement in the recognition, reporting, and clinical management of chronic wounds.	Good progress being made to meet the purpose and objectives of the workstreams so far , which will all carry forward to the close of 25-26 financial year in line with the lifespan of the current Quality Strategy. A high level summary of highlights/challenges encountered so far will be requested from workstream leads along with a precis narrating what this means for patients and next steps which will present to June QAG and June Quality Committee.
2	• Dementia Education - with focus on Increase staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.	
3	• Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on 2021/22 data.	
4	• End of Life Care (EoLC) – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End of Life Care decisions.	
5	• Friends and Family Test (FFT) – with a focus of building upon the findings of the 22/23 CQC Adult Community Mental Health Survey action plan.	
6	• Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.	
7	• Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranqulisation.	
8	• Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.	
9	• Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.	
10	• Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.	
11	• Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.	

AGENDA ITEM: 15/0525

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy CEO

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **QUALITY & PERFORMANCE DASHBOARD APRIL 2024/ 25 (MONTH 1)**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to

This quality and performance dashboard report provides a high-level view of performance and quality indicators in exception across the organisation. Activity covers the period to the end of April (Month 1 2025/26). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Service led Operational & Governance reports are presented to the operational governance forums and more widely account for performance indicators in exception and outline service-level improvement plans. Data quality progress will be more formally monitored through the Patient Records Quality Group.

Recommendations and decisions required

The Trust Board are asked to:

- **NOTE** the Quality and Performance Dashboard Report for April 2025/26 as a **significant level of assurance** that the Trust's performance measures are being met or,
- **ACCEPT** that appropriate service improvement action plans are being developed or are in place to address areas requiring improvement and are being managed through operational governance mechanisms and,
- **CONSIDER** referrals to the Resources Committee for further improvement plan follow-up.

EXECUTIVE SUMMARY

Business Intelligence Update

Business Intelligence summary updates are presented on page 1 highlighting progress being made within operational governance mechanisms and integrated report

Performance Update

The performance dashboard indicators are presented from page 4 within the Board's four domain format (*to note, the Operational Domain is only presented to the Resources Committee – not the Board - but the domain is reviewed at BIMG for each period*).

The Board's Performance Dashboard offers a light commentary format however members can be **assured** detailed exception narrative is reviewed within BIMG and across wider governance processes for all indicators for all domain areas. A new summary outline is presented below which incorporates the Trust's Chief Operating Officer and wider Exec perspective:

Advise:

Finally, these measures are referenced for information only:

- 'Venous thromboembolism (VTE) Risk Assessments' (N15) is an indicator in exception but only through data quality issues which have been resolved and will retrospectively deliver indicator compliance
- A few of the IUCS measures are not relevant to Gloucestershire (N56, N57 & N58) and an update to the National indicators for 2025/26 should remove those that don't fit Gloucestershire's local model
- 'CYPS Core CAMHS initial appointment waits' (L03) & 'CYPS LD initial appointment waits' (L04) have improvement plans in place. However, L04 has seen a significant improvement in April 2025 from the last period
- 'IUCS HCP calls within 20minutes' (L23) where prioritisation improvement work is underway
- Six indicators L24-L29 for IUCS are in exception but due to underreporting through intended surge protocols
- B17 'MH Acute Inpatients Length of Stay (LoS)' (B17) is within normal variation in April 2025, however, it is presented for context, in line with the other LoS exceptions alerted within the Board Focus domain (above).
- 'Care Programme Approach - formal review within 12 months' (B01) which although rebounded slightly in April 2025, remains in exception for the fifth successive month.
- Eating Disorders (N11, L07, L08). Improvement Plan in place which includes: skill mix review, treatment caseload review, increasing group cognitive behavioural therapy sessions, revised triage protocol, review of MDT process. Current forecast for improvement is November 2025.
- Rapid Response – the second overnight team is now established in the rapid response service and there is increased activity throughout the 24-hour period.
- IV Therapy – additional clinics were stood up in during April to respond to an increase in activity and ensure ongoing timely access to the service.
- B26 MIIU % seen and discharged within 4 hours, 98.1% against 95% target. Closure rate for April 2025 was 7.71%. These are consistent rates despite a significant increase in numbers attending (April 2024 7700 attendances, April 2025 9000 attendances). Directorate has worked closely with MIIU staff to review the process

relating to closures with a view to further improving the closure rate. Further development is required with intention to make changes and test over the summer period.

Assure:

- O07 - Musculoskeletal (MSK) Physiotherapy urgent two-week referral to treatment (RTT). Performance has declined for the urgent RTT since December 2024 (80% to 34.8%). Improvement plan is in place with actions including: weekly data cleansing, proactive recruitment in specialist areas, reviewing patient appointment contacts, triage criteria and process review, urgent criteria review and implementation, increase urgent capacity. The forecast for recovery is August 2025.
- O08 - MSK routine 18 week (93.4% against 95%), improvement actions include: scrutiny of waiting list, recruitment, demand and capacity by site to reduce variation, further community assessment days. This service is part of the job planning pilot with an aim to reduce variation in productivity. The forecast for recovery is August 2025.
- B18 – mental health acute inpatients % of discharges within length of stay threshold 26 days. 52.9% against a target of 95%. As reported last month, an improvement plan is in place. Next steps are to agree a forecast and milestones.
- O19 and 020 - Children and Young People Speech and Language Therapy 4-week RTT and 18-week RTT. As previously reported, the service has been working to process map current pathway to identify opportunities to manage demand within capacity. First phase of work is complete which will now enable development of a reworked model to match demand and capacity. Second phase is to write the pathway and take through quality governance for assurance. Once complete and in implementation a forecast for recovery will be set.
- N53 – proportion of callers allocated the first service type offered by the directory of services (73.4 % against 80%). Collaborative recovery plan in place with the Integrated Urgent Care Service and IC24 involving pharmacy first. There are early signs of improving performance to improve the pharmacy directory of services compliance. Next steps are to agree a forecast and milestones.

Alert:

The Board are alerted to these measures within the report and are asked to consider them for follow-up within the Resources Committee in June 2025:

- 'Routine outcome measurements for Children, young people and women in the perinatal period' (N25) is incrementally improving however is still shy of its target.
- Five inpatient 'Length of Stay (LoS)' indicators were in exception for the period; B19 MH PICU, B20 MH Older Adult, B23 PH, B24 PH CATU and B25 PH Stroke Rehab (Vale). These will carry increased scrutiny in 2025/26 as they are due to be formally monitored through a soon to be published 'NHS England Performance Assurance Framework' (NPAF).
- O23 and O24 Children and Young People Occupational Therapy – early prediction of a dip in performance through the summer due to team vacancies, sickness and other human resources related issues. Service implementing business continuity plan to identify priority need – in particular those requiring intervention within 4 weeks. Improvement plan in development with anticipated forecast of KPI achievement in December 2025.

- O30 – Wheelchair Service (under 18s) 18-week RTT (92% target). Currently at 86.8% against 92% target. Early prediction of a dip in performance through the summer (as seen last summer), due to patient/carer choice (school holidays and children move out of county to be at home) but plan to recover in the same way in September.
- B01 – Care Programme Approach formal review within 12 months (95% target, currently 90%). Improvement plan in place. Forecast for recovery was initially May 2025, this has been reviewed and the forecast for recovery is now September 2025.

Applause:

These two measures are compliant and not in exception but are highlighted for positive recognition:

- Improvement and compliance in the Proportion of calls abandoned (N44) and
- High performance with two indicators which monitors the calls that initially are given an ambulance disposition (N51) or ETC disposition (N52) that receive remote clinical intervention
- O04 Podiatry % routine referrals treated within 18 weeks has been consistently met.
- N03 Care Programme Approach: follow up contact within 72 hours of discharge was consistently met.
- Children and Young People Service initiative: listening with fascination events. Regular teams' sessions to present different services with the purpose of skill sharing/developing awareness across the directorate.

Furthermore, and although below target, the Board are also asked to recognise these measures within the dashboard as areas of positive areas of improving practice.

- Many IUCS are showing strong and sustained improvements in performance, such as average speed to answer calls (N45 & N46) and call backs (N48 & N49)
- The number of patients waiting reduces in eating disorder services (L07 & N11)

Risks associated with meeting the Trust's values

Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operationally owned Service led Improvement Plan which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality-of-care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided. Data quality measures are included in the dashboard and will be monitored through the Clinical Records Quality Group.
Resource Implications	The Business Intelligence Service works alongside other Corporate service areas to provide the support to operational services to ensure the robust review of performance data and co-ordination of the combined corporate performance dashboard and its narrative.

Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before? BIMG on 15 May 2025

Appendices:	

Report authorised by: Sandra Betney	**Title:** Director of Finance and Deputy CEO

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Snapshot Month
April

Quality & Performance Dashboard Report

Aligned for the period to the end April 2025 (month 1)

In line with the Quality & Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents performance indicators across four domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and **Board Focus** domains. The (fifth) **Operational** domain is only presented to Resources Committee (not Board) however is always reviewed within the monthly Business Intelligence Management Group (BIMG). **Integrated Urgent Care Service** (IUCS) KPIs are now presented within the relevant National and Locally Agreed domains.

In support of these metrics a monthly Operational Performance & Governance summary (with action planning, where appropriate) is routinely presented to the Business Intelligence Management Group (BIMG) alongside specific service level improvement plans. Examples over the last few months include Perinatal, Eating Disorders, Occupational Therapy, CYPS & Adult SaLT, CYPS Physio, Community PH (ICT and Podiatry) and MH Social Work. An operationally led Patient Record Quality Group reports into BIMG.

Quality & Performance Dashboard Summary

The Dashboard itself (on pages 2-10) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online server version of this Tableau report. All services are using this tool, alongside their operational reporting portfolios to monitor wider performance.

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate and in response to significant, ongoing and wide-reaching performance issues a single performance improvement plan is held at Directorate level to outline the risks, mitigation and actions. Areas of note are presented at the end of the report on page 11 entitled 'Performance to note'. This section acknowledges either positive progress, possible areas for close monitoring, methodology or data quality updates, or offer context to wider indicators that may be in exception.

Business Intelligence Summary Update

Work continues in support of an improvement in operational governance within the Trust, alongside development plans for improved integrated reporting. The Performance Management Framework and Trust KPI Portfolio have been reviewed and updates proposed to support the aforementioned agendas.

All intended services now have service line reports deployed within Tableau, allowing for a single navigation to a range of clinical and corporate reporting measures and metrics. The few remaining community services are some of those in transformation programmes.

National Contracted Domain

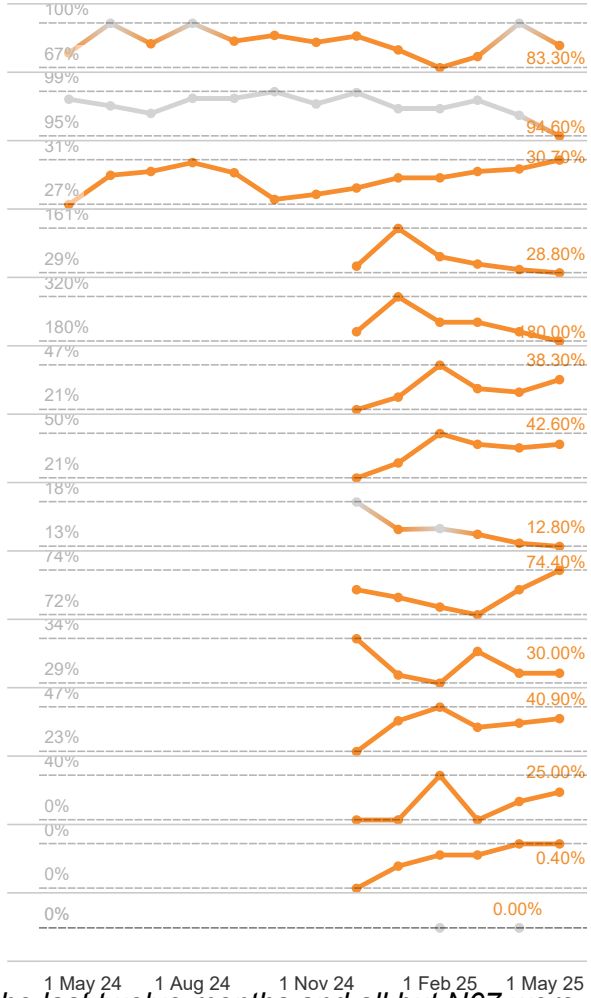
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National Contract Domain

		APRIL
N11	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	83.3% / 95.0%
N15	VTE Risk Assessment - % of inpatients with assessment completed	94.6% / 95.0%
N25	Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice	30.7% / 50.0%
N45	IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)	28.8% seconds / 20.0% seconds
N46	IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)	180.0% seconds / 120.0% seconds
N48	IUCS - Proportion of call backs assessed by a clinician in agreed timeframe under 20 minutes (KPI 5a)	38.3% / 90.0%
N49	IUCS - Proportion of call backs assessed by a clinician in agreed timeframe over 20 minutes (KPI 5b)	42.6% / 90.0%
N50	IUCS - Proportion of callers recommended self-care at the end of clinical input (KPI 6)	2.8% / 15.0%
N53	IUCS - Proportion of callers allocated the first service type offered by Directory of Services (KPI 9)	74.4% / 80.0%
N54	IUCS - Proportion of calls where the caller was booked into a GP practice or GP access hub (calls where DoS selection was GP practice or GP access hub) (KPI 10)	30.0% / 75.0%
N55	IUCS - Proportion of calls where the caller was booked into an IUC Treatment Service or home residence (calls where DoS selection was IUC Treatment Service) (KPI 11)	40.9% / 70.0%
N56	IUCS - Proportion of calls where the caller was booked into a UTC (calls where DoS selection was UTC) (KPI 12)	25.0% / 70.0%
N57	IUCS - Proportion of calls where caller given a booked time slot with a Type 1 or 2 Emergency Department (calls where DoS selection was Type 1 or 2 Emergency Department) (KPI 13)	0.4% / 70.0%
N58	IUCS - Proportion of calls where the caller was booked into a Same Day Emergency Care (SDEC) service (calls where DoS selection was SDEC) (KPI 14)	0.0%



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months and all but N07 were in exception last month.*

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks

April performance is reported at 83.3% against a performance threshold of 95.0%. There was 1 patient not treated within 4 weeks in April out of 6. Statistical process control is not used for this KPI due to the small number of cases.

Narrative continued on next page...

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The service continues to focus on offering all routine adolescent patients an assessment within 28 days of the referral. In most instances the clinicians leading the assessment can provide treatment to then enable patient and families to progress with a plan until the patient is assigned a clinician for continued treatment.

At the end of April there were 33 routine adolescent patients with an assessment completed that were waiting for treatment to commence. A decrease from March at 38.

In the latest national data (MHSDS) for December 2024 to February 2025, GHC achieved 70.0%, which is lower than the England average of 76.1%. Eating Disorder indicators have a Service Improvement Plan and are on the Performance Governance Tracker. This is on the risk register ID 149 (Score 16).

N15 - VTE Risk Assessment - % of inpatients with assessment completed
VTE Risk Assessment is reporting as non compliant due to data quality issues with recording of VTE assessments. Updates have since been made on SystmOne, and with the removal of the exceptions with data quality issues VTE risk assessment completion for April would become compliant at 96%.

N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice.
April performance is reported at 30.7% against a performance threshold of 50%. There were 257 non-compliant cases out of 371. This is a slight increase in performance compared to 30% in March 2025. SPC is not used for this KPI as it is cumulative across the year.

N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)
Average speed to answer calls in April is non-compliant at 28.8 seconds against threshold of 20 seconds. However, this is a fourth consecutive improvement from 39 seconds in March, 55 seconds in February, 77 seconds in January and 161 seconds in December.

The periods of longest calls have been identified and the service are aiming to undertake an audit. Pre-GHC contract in Gloucestershire April 2024 average speed was 100 seconds.

N46 - IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)
The 95th centile call answer time for April is non-compliant at 180 seconds against a 120 second threshold, an improvement from 210 seconds in February.

The periods of longest calls have been identified and the service are aiming to undertake an audit. Pre-GHC contract Gloucestershire April 2024 95th centile call answer time was 545 seconds.

N48 - IUCS - Proportion of call backs assessed by a clinician in agreed timeframe under 20 minutes (KPI 5a)
Call backs assessed in under 20 minute timeframe is non-compliant for April at 38.3% against a threshold of 90%, an improvement from 30.9% in March.

The service are continuing to investigate performance for patient call backs. Pre-GHC contract Gloucestershire April 2024 performance was 29%.

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N49 - IUCS - Proportion of call backs assessed by a clinician in agreed timeframe over 20 minutes (KPI 5b)
Call backs assessed in over 20 minute timeframe is non-compliant for April at 42.6% against a threshold of 90%, an improvement from 40.3% in March. Pre GHC contract Gloucestershire April 2024 performance was 81%. The service are continuing to investigate performance for patient call backs.

Non-CAS calls have been identified as the main contributor for longer callback times in agreed timeframes over 20 minutes and further investigations are taking place for the causes of this.

N50 - IUCS - Proportion of callers recommended self-care at the end of clinical input (KPI 6)
Proportion of callers recommended self-care for April is non-compliant at 12.8% against a threshold of 15% (March was 13.2%).

Non-CAS calls have been identified as the main contributor for low recommendations of self-care and an improvement plan is in place with IC24. Pre-GHC contract Gloucestershire April 2024 performance was 5%.

N53 - IUCS - Proportion of callers allocated the first service type offered by Directory of Services (KPI 9)
Allocation of first DoS (directory of services) selection is non-compliant for April at 74.4% against a threshold of 80% (March was 73.4%). Pre-GHC contract Gloucestershire April 2024 performance was 77%.

There is a collaborative recovery plan in place with IC24 involving pharmacy first. This aims to improve compliance with pharmacy DoS selections.

N54 - IUCS - Proportion of calls where the caller was booked into a GP practice or GP access hub (calls where DoS selection was GP practice or GP access hub) (KPI 10)
GP DoS booking performance is non-compliant for April at 30% against 75% threshold (March was also 32%). Work continues with ICB primary care leads regarding availability of bookable slots. Pre-GHC contract Gloucestershire March 2024 performance was 51%.

Many slots with Gloucestershire Health Access Centre (GHAC) follow an intended process of booking via phone call due to efficiency rather than through DoS selection and are therefore not accounted for in this KPI which only accounts for bookings via DoS.

N55 - IUCS - Proportion of calls where the caller was booked into an IUC Treatment Service or home residence (calls where DoS selection was IUC Treatment Service) (KPI 11)
IUC Treatment Service (OOH service) is non-compliant for April at 40.9% against a 70% threshold (March was 38.4%). This performance is under reported due to recording changes whilst following intended surge protocols, wherein patients are streamed to OOH outside of the DoS selection booking process. These patients are still overseen by the CAS clinician to determine if presentation is appropriate for a face to face OOH appointment.

Pre-GHC contract Gloucestershire March 2024 performance was 6%, however they did not book OOH appointments via the DoS.

N56 - IUCS - Proportion of calls where the caller was booked into a UTC (calls where DoS selection was UTC) (KPI 12)
UTC (urgent treatment centre) booking KPI not currently relevant to Gloucestershire as our MIIUs are not classified as UTCs. See KPI O38 (12a) for MIIU DoS bookings. Small numbers shown are out of county patients booked into UTCs in their home counties.

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N57 - IUCS - Proportion of calls where caller given a booked time slot with a Type 1 or 2 Emergency Department (calls where DoS selection was Type 1 or 2 Emergency Department) (KPI 13)
ED (emergency department) booking KPI not currently relevant to Gloucestershire as ED slots are not booked in our system. System development needed to be able to book ED.

This KPI is currently measuring against patients with a final disposition as recommended to attend ED but only compliant if they are booked. The small numbers shown as compliant are from out of county calls where they do book ED.

N58 - IUCS - Proportion of calls where the caller was booked into a Same Day Emergency Care (SDEC) service (calls where DoS selection was SDEC) (KPI 14)
SDEC booking not currently relevant to our system as SDEC is not a DoS option. Plan for SDEC to be an available DoS option in the future. Small numbers of patients will exist from out of county calls.

Specialised Commissioning Domain

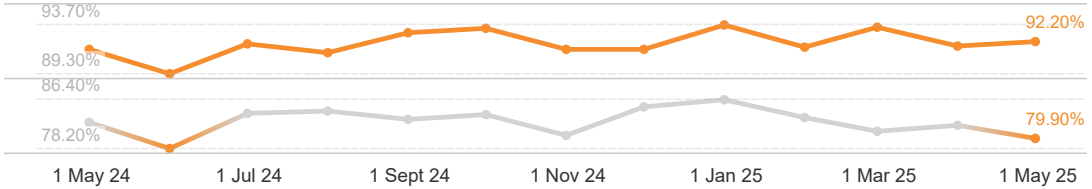
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

Specialised Commissioning Domain

		APRIL	
S02	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	92.2%	95.0%
S10	% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks	79.9%	80.0%



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months.*

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
Performance in April is 92.2% (March was 91.8%) compared to a threshold of 95.0% with 38 out of 491 babies not seen within 14 days. Performance is within normal variation.

S10 - % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks
Performance in April is 79.9% (March was 82.0%) compared to a threshold of 80.0% with 65 out of 324 mothers not continuing to breastfeed at 8 weeks. Performance is within normal variation.

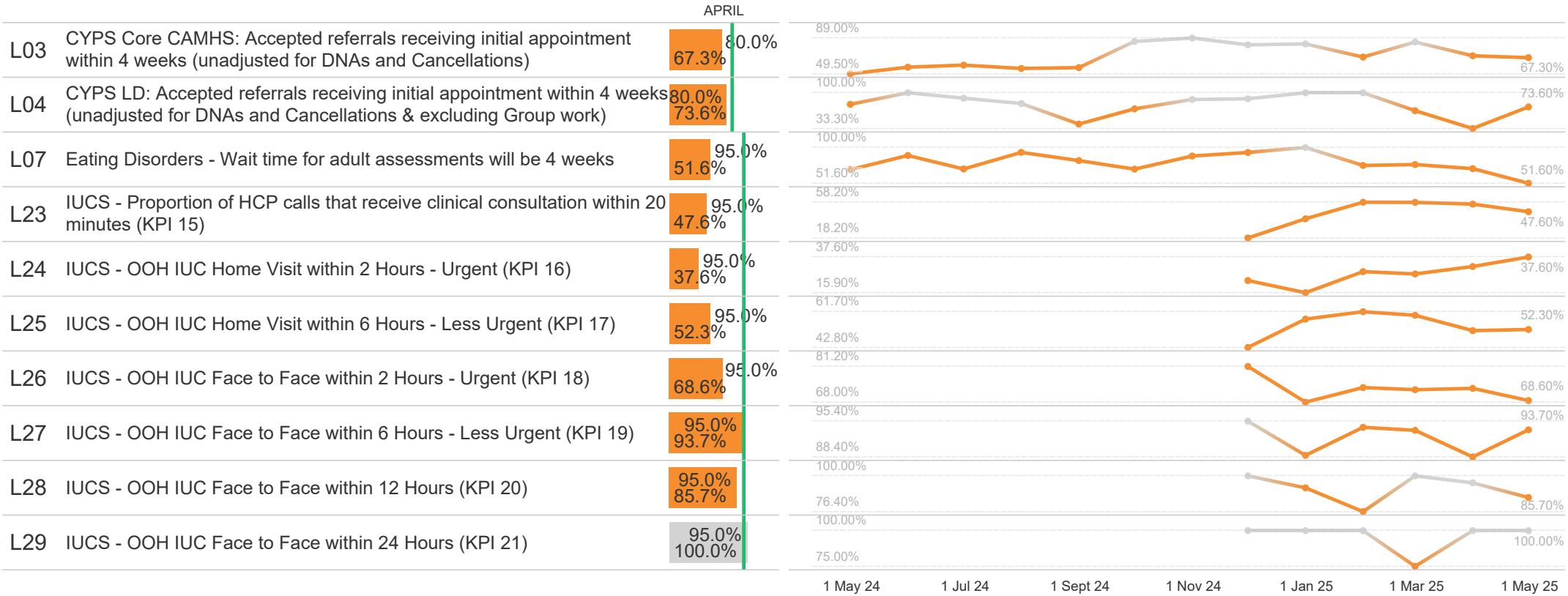
ICS Agreed Domain

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

ICS Agreed Domain



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months.*

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
April performance is reported at 67.3% against a performance threshold of 80%. There were 33 non-compliant cases out of 101. This is a decrease in performance compared to 69.4% in March 2025.

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L04 - CYPS LD: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations & excluding Group work)
April performance is reported at 73.6% against a performance threshold of 80%. There were 5 non-compliant cases out of 19. This is an increase in performance compared to 33.3% in March 2025. Numbers are too few to use SPC with this indicator. Recovery is improving and expected to meet compliance target levels in May 2025.

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
April performance is reported at 51.6% against a 95.0% threshold. There were 15 patients not assessed within 4 weeks in April out of 31. Statistical process control is not used for this KPI as performance is too variable.

Due to the length of time patients have been on the waiting list, performance is expected to be below the threshold. The number of adults waiting for assessment at the end of April was 59, a decrease from March at 79. All attempts are made to offer patients an assessment within 4 weeks.

This set of indicators has a service improvement plan and is on the performance governance tracker. This is on the risk register ID 149 (score 16).

L23 - IUCS - Proportion of HCP calls that receive clinical consultation within 20 minutes (KPI 15)
HCP calls receiving clinical consultation is non-compliant for April at 47.6% against a threshold of 95% (March was 56.1%).

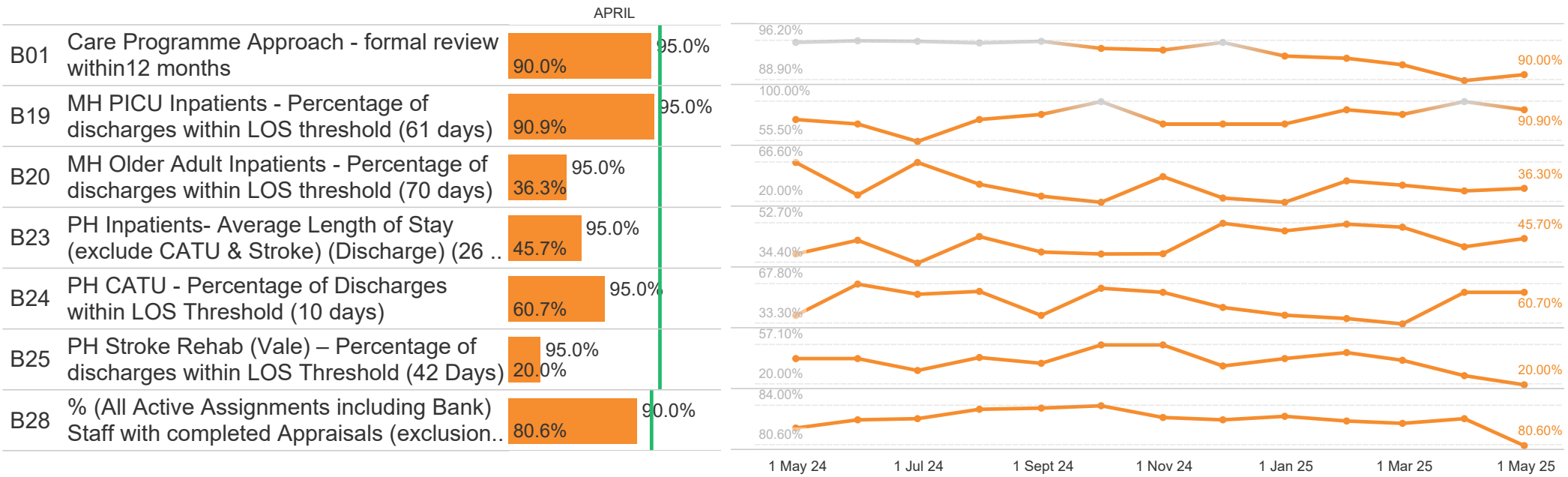
Work is ongoing in the service focussing on appropriate prioritisation of clinician call backs. A renewed clinical priority listing has been shared with all GPs in the service and guidance for the OOH co-ordinators has been distributed.

L24 - IUCS - OOH IUC Home Visit within 2 Hours - Urgent (KPI 16)
L25 - IUCS - OOH IUC Home Visit within 6 Hours - Less Urgent (KPI 17)
L26 - IUCS - OOH IUC Face to Face within 2 Hours - Urgent (KPI 18)
L27 - IUCS - OOH IUC Face to Face within 6 Hours - Less Urgent (KPI 19)
L28 - IUCS - OOH IUC Face to Face within 12 Hours (KPI 20)
L29 - IUCS - OOH IUC Face to Face within 24 Hours (KPI 21)
All these indicators are currently underreported due to recording changes whilst following intended surge protocols, wherein patients are streamed to OOH outside of the DoS selection booking process. These patients are still overseen by the CAS clinician to determine if presentation is appropriate for a face to face OOH appointment. Discussions ongoing with ICB regarding appropriate KPI.

Board Focus Domain

KPI Breakdown

Board Focus Domain



<u>Performance Thresholds not being achieved in Month</u> - *Note all these indicators have been in exception previously in the last twelve months.*

B01 - Care Programme Approach - formal review within 12 months
April performance is reported at 90.0% against a performance threshold of 95.0%. There were 85 referrals reviewed after 12 months in April. Performance is a low outlier and outside of normal variation.

Most of the patients that were reviewed after 12 months are within the Recovery teams.

B19 - MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days)
In April performance was 90.9% against a 95% target (March was 100%). Of the 11 patients whose PICU ward stay ended in April, 1 exceeded the 61 day threshold. The average LOS for PICU was 24.8 days (Mar was 27.4 days). The patient who exceeded 61 days had a length of stay of 78 days (Mar averaged 27.4).

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B20 - MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)
In April performance was 36.4% against a 95% target (March was 33.3%). Of the 11 patients whose Older Adult ward stay ended in April, 7 exceeded the 70 day threshold. The average LOS for a Older Adult wards was 92.5 days (Mar was 101.8 days). For the patients who exceeded 70 days the average length of stay was 127.3 days. (Mar was 141 days).

B23 - PH Inpatients- Average Length of Stay (exclude CATU & Stroke) (Discharge)
Average community hospital length of stay (LoS) discharges within 26 days excluding stroke and CATU is non compliant for April at 45.7% but remains within normal variation. Average LoS for April 34.5 days.

19% of beddays were lost to patients who were Discharge Ready (DR). On average 6.5 days were added per length of stay due to DR. If patients were able to be discharged when they were clinically ready the average LOS would be 28 days.

B24 - PH CATU - Percentage of Discharges within LOS Threshold (10 days)
Performance in April was 60.7% (March was 62.5%); of the 19 patients discharged from a community hospital stay, who spent time in a CATU bed, 11 exceeded the CATU length of stay threshold of 10 days. For the patients who exceeded 10 days the average length of stay of these patients was 15 days. (Mar was 17.4). Average length of stay for all patients was 8.6 days.

8.1% of beddays were lost to patients who were Discharge Ready (DR). On average 0.7 days were added per length of stay due to DR. If patients were able to be discharged when they were clinically ready the average LOS would be 7.9 days.

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
This KPI line is currently under review. For data verified by the service: performance in April was 20% (March was 16.7), the average LOS for a stroke rehab patient was 53 days, compared to the threshold of 42 days, (March was 60.3 days). Of the 5 stroke rehab patients discharged from a community hospital stay, 4 exceeded the length of stay threshold of 42 days.

13.6% of beddays were lost to patients being Discharge Ready (DR). On average this equates to 7.2 days DR for all patients. If patients were able to be discharged when they were clinically ready the average LOS would be 45.8 days.

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for April, including bank staff, has dropped slightly to 80.6%, compared to a threshold of 90%, although the figure is expected to rise slightly due to delayed data entry the performance is outside normal variation. There has been a steady drop in performance since September which follows the same seasonal pattern at this time of the year that has been seen for the last couple of years.

Quality & Performance highlights to note

Positive performance areas

The following three performance indicators are not in exception but are highlighted for note as positive performance areas:

- **N44 - Proportion of calls abandoned (KPI 1)**

Abandoned calls is within compliance for April at 1.9% against a threshold of 3%, a continued improvement (March was 2.5%). Pre GHC contract in Gloucestershire April 2024 performance was 4%.

- **N51 - Proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention (KPI 7)**

Category 3 and 4 ambulance validation continues to perform well beyond compliance at 96.4% for April against a threshold of 85%. This KPI holds significant importance due to its system-wide contribution, particularly SWAST. Pre-GHC contract Gloucestershire April 2024 performance was 82%

- **N52 - Proportion of calls initially given an ETC disposition that receive remote clinical intervention (KPI 8)**

ETC (Emergency Treatment Centre) validation is compliant for April at 82.2% against a local threshold of 75%. This performance is well beyond the national threshold which is set at 50%. Pre-GHC contract Gloucestershire April 2024 performance was 89%.

The following performance indicator is not in exception but is **highlighted for note as a performance area that requires closer monitoring** for the months ahead, alongside the formally escalated Length of Stay indicators:

- **B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)**

In April performance was 52.9% against a 95% target (March was 51.1%). Of the 34 patients whose Adult Acute ward stay ended in March, 15 exceeded the 26 day threshold. The average LOS for Adult Acute wards was 39 days (March was 51.8 days). For the patients who exceeded 26 days the average length of stay was 70.3 days. (Mar was 97.3). The maximum continuous LOS on an Adult Acute Ward was 213 days. Performance is within expected variation.

BI currently have an enquiry open with the national team around the calculation of ward stay length of stays within the national dashboards. Within the Trust patients are moved between wards of the same bed type for clinical reasons on a regular basis, the KPI calculation takes this into account and only includes a patient once they are discharged or transferred to a ward of a different bed type. The national calculation is based on discharges and ward transfers no matter if a patient is moved to a ward of the same bed type, therefore the number of ward stays is greater than those in the KPI and the average LOS is less.

REPORT TO: **TRUST BOARD PUBLIC SESSION - 29 MAY 2025**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy Chief Executive Officer

AUTHOR: Paul Griffith-Williams, Head of Information Governance & Records and Data Protection Officer.

SUBJECT: **SIRO ANNUAL REPORT**

If this report cannot be discussed at a public Board meeting, please explain why.	*NA*

This report is provided for:
Decision ☐ Endorsement ☒ Assurance ☒ Information ☐

The purpose of this report is to:

To provide the Board assurance on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

Recommendations and decisions required

The Board is asked to:

- Take **assurance** that the Trust has effective systems and processes in place to maintain the security of information; and,
- **Endorse** the report.

Executive summary

The Senior Information Risk Owner (SIRO) is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provides assurance on practice, progress and developments around Information Governance (IG), Clinical Coding and Records, Data Quality and Cyber/Data Security.

It should be noted that the Trust was able to achieve a DSPT submission (self-assessment) of 'exceeded standards' for the 2023/24 year and are on target to meet standards for 24/25. There were no data breaches that met the threshold for onward reporting to the Information Commissioners Office (ICO). The ICO did, however, receive two complaints, the ICO accepted the Trusts responses, and no further action was taken.

There continues to be an impact on the IG activity as the Trust continues to move forward with new ways of working, embracing more and more within the digital arena. This has

continued to increase the demand for advice and support from the IG team and the IG Group, with the IG Group approving 25 Data Protection Impact Assessments (DPIA) and 10 Data Sharing Agreements (DSA).

This year there has been an increase in Subject Access Requests (SARs) of 8.7%. The number of Freedom of Information Requests (FOIs) received until 31st March 2025 has also seen an increase of 7.5%.

Cyber security continues to be a very real risk to the Trust, with IT reviewing cyber threats at weekly meetings. Phishing attacks continue to be a top three cyber risk for the Trust, with the Trust experiencing 1500 phishing email per day an increase of 25%.

Risks associated with meeting the Trust's values

- IG and cyber breaches can result in the disclosure of sensitive patient and staff information;
- IG and cyber breaches can result in significant financial penalties and have a negative impact on the Trust's reputation if breaches occur; and,
- IG and cyber breaches can result in a negative impact on patient care.

Corporate considerations	
Quality Implications	*Ensures the quality of information available to deliver patient care.*
Resource Implications	*Can result in financial penalties if IG breaches occur.*
Equality Implications	

Where has this issue been discussed before?

The report has been discussed with key contributors. The report has also been considered at the Trust's IG Group, the Audit and Assurance Committee and the with the SIRO.

Appendices:	NA

Report authorised by: Sandra Betney	**Title:** Director of Finance & Deputy Chief Executive

Annual SIRO Report
2024 – 2025

INTRODUCTION

Welcome to the annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report is to provide assurance to the Board on the effectiveness of controls for Information Governance (IG), data protection, confidentiality and cyber resilience. This assurance is provided by the SIRO who has responsibility for information risks and information assets.

The role of SIRO is well established in GHC. The SIRO advocates at Board for relevant control and safety measures to manage and reduce information and security risks in controlling or processing the data the Trust holds. Ensuring effective use of resource, relevant Board commitment, execution of tasks and appropriate communication to all staff of the measures in place. The aim is to create a culture in which information is valued as an asset and information risk is managed in a realistic and effective manner within the legislative frameworks.

During 2024/25 the governance model. processes and structures for IG and Records have continued to develop, with the high volumes of activity experienced. The records practices have continued to be developed across the organisation, with the conclusion of the of the Electronic Management Document System (EDMS) project, which brought the historic paper records digitally into the Trust's two main Electronic Patient Records (EPR).

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with national guidance and legislation whilst also achieving an ability to ensure operational effectiveness.

Recognising the breadth of the legislation, the SIRO report is divided into four sections:

Section 1: Information Governance

Section 2: Clinical Coding and Health Records

Section 3: Data Quality

Section 4: Cyber / Data Security

Key highlights 2024/2025

- The Information Governance Group met six times and approved 25 Data Protection Impact Assessments to support services;
- The 23/24 final submission for the Data Security and Protection Toolkit was assessed as 'Exceeded Standards'. The 24/25 is submission is expected to meet the standards;
- There have been no data breaches reported through the Trusts incident reporting system, however, the threshold for onward reporting to the Information Commissioners Office (ICO) was not met;
- 2 complaint notifications were received from the ICO, with the Trust reviews identifying a number of improvements;

- The Trust achieved the 95% target for Data Security and Awareness training, on 10 occasions this year;
- There have not been any significant health records incidents or losses reported; and,
- The EDMS Project has now completed and all mental health records have been ingested into CITO, with Physical health to follow shortly in 2025.

1.0 INFORMATION GOVERNANCE

The IG Group (IGG) has maintained scrutiny and assurance for the confidentiality, integrity, availability and security of the data we control and utilise. Whilst continuing to review and approve DPIAs and sharing agreements, as part of that.

1.1 Information Governance & Records Team

The IG&R team continues to develop and embed processes and support the development of new colleagues within the team. As part of improving the resilience of the records the establishment has been reviewed, following and temporary inclusion of a records supervisor role, and the supervisor post has now been added to establishment for the records team.

The IG&R team has delivered operational support, advice, and guidance to colleagues, including attending team meetings to provide support following specific issues identified. It also issues quarterly compliance reports to the IG Group.

The Head of service also provides the Data Protection Officer (DPO) role and supporting the Trust's compliance with data protection legislation and best practice. The DPO also represents the Trust's information governance interests at the ICS level. The DPO is an active member of the Gloucestershire Information Governance Group, the Southwest Strategic Information Governance Network and the National NHSE DPO forum.

1.2 Information Governance Group

The IGG is chaired by the Director of Corporate Governance, with the SIRO, Caldicott Guardian and DPO as key members. The IGG's role is to guide the strategic direction of IG within the Trust, ensure IG compliance, support best practice and ensure that all Trust information is:

- Confidential and Secure;
- Of High Quality;
- Relevant and Timely; and,
- Processed Lawfully, Transparently and Fairly.

The IGG has met bimonthly throughout the year.

During 2024/2025, the group has:

- Set a work plan for the group to formalise and focus activity;
- Reviewed the asset register and the assigned asset owners;
- Reviewed the data flows;
- Reviewed and approved the Data Security & Protection Toolkit (DSPT) interim

submission for 24/25 and final submission for 23/24;
- Reviewed and approved 25 Data Protection Impact Assessments (DPIA);
- Reviewed and approved 10 Data Sharing Agreements (DSA); and,
- Reviewed and agreed the Trusts training analysis for IG training.

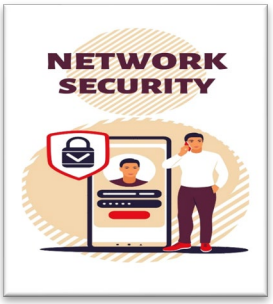
The IGG reports to the Audit and Assurance Committee, a Committee of the Board. This ensures the Board is kept suitably aware of issues and progress being made.

1.3 Data Security and Protection Toolkit (DSPT)

This year NHS England (NHSE) has moved the DSPT to be aligned with the National Cyber Assurance Framework (CAF). The IG Group was briefed on the impacts of these changes, which are expected to be quite considerable.

The Trust's 23/24 final DSPT submission was made on time and assessed as 'exceeded standards'.

As part of the DSPT's requirement the Trust's Internal Auditors, BDO, audited the 23/24 DSPT submission. The Audit covered all 10 data standards and involved a total of 13 assertions. The overall risk assessment by BDO was medium, with an overall high level of confidence in the Trust's DSPT submission.



The Trust has submitted the new CAF aligned DSPT 24/25 interim baseline submission, within the required timescales. The 24/25 final submission will be made in June 25 and is expected to meet standards.

1.4 Breaches and Near Misses

There have been 447 IG incidents reported in year of which none which met the threshold for referred to the SIRO or Caldicott Guardian for review and consideration of onward reporting to the ICO.

There were no breaches to report to the ICO within the year.

Two complaint notifications were, however, received from the ICO which are summarised as follows:

1 A Subject Access Request (SAR) was not disclosed within the statutory period.

SAR Review

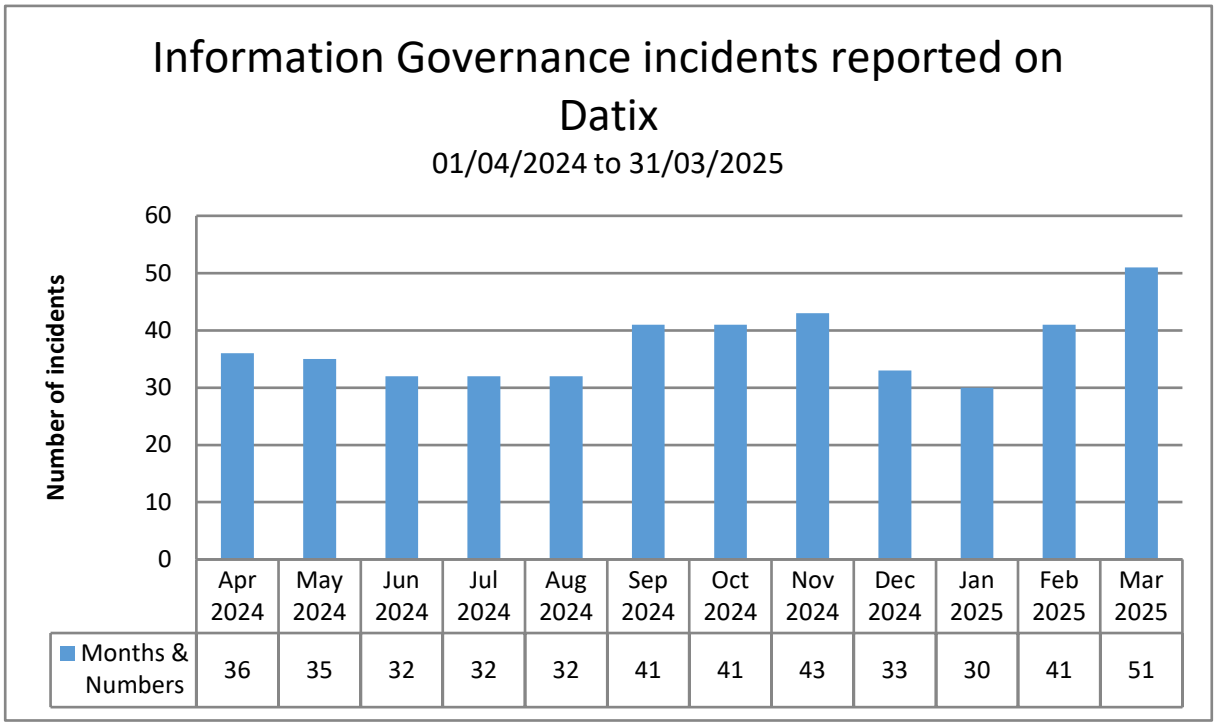
The DPO reviewed of the SAR and the process against the ICO guidance. The processes were found to be in line with the ICO guidance. Weekly reporting did not specially include SARs that went over the statutory period, this has now been included. There is a clear escalation process for the SAR team should they need support with finalising SAR responses. The action taken and assurance was reported to the IGG and the ICO.

2 The Trust failed to make an appropriate FOI disclosure and to carry out a review.

FOI Review

The DPO acknowledged and carried out the review. The review found that we had not provided a complaint response and had not taken appropriate action following a request for a review. This was rectified by the DPO and an apology issued. This was reported also reported to the ICO.

Below is a report on incidents by month for the last financial year taken from Datix.



There is an increase of 74 incidents from 2024/25, which was 373 for the same period in 2023/24. There is no apparent pattern to when there are incidents or incident type. Although there has been learning for teams and individuals from breaches there has been no organisational learning or trends identified.

1.5 Subject Access Requests (SARs) and Freedom of Information Requests (FOIRs)

The following table sets out comparison of activity data for the current and previous years.

	Total Requests			Total Over Time Limit		
Requests	**2022/23**	**2023/24**	**2024/25**	**2022/23**	**2023/24**	**2024/25**
FOIRs	398	466	501	35	164	103
SARs	974	1022	1111	7	2	11

Subject Access Requests

A total of 1,111 SARs were received in 2024/25, up from 1,022 in 2023/24. This represents an increase of 8.7%. The average number of SARs has increased from 19.7 per week in 2023/24 to 21.4 per week in 2024/25.

On occasion, due to size and complexity SARs can take up to three months to process. This is in line with UK GDPR for complex SARs, requestors are advised when this is the case.

In the final quarter, one SAR went over the one-month response time where no extension had been agreed with the requester. This was disclosed two days over the deadline, due to an administrative error, an apology was issues. Additionally, one complex SAR exceeded the extended three-month deadline by 41 days. This was due to the number of documents across multiple teams, however, at every stage the requester was kept updated.

2024/25 saw the addition of the 111 and Out of Hours (OOH) services to the Trust's portfolio. It is anticipated the new service will likely increase the number of SARs in 2025/26.

The number of SARs continues to rise, and although there is still only limited data, the number of requests appear to peak around holiday periods (Easter, Summer, Christmas).

There has been a rise in requests from solicitors, for 'potential' clinical negligence claims in 2023/24 there were 39, in 2024/25 this rose to 52, an increase of 33.3%. For 'potential' personal injury claims in 2023/24 there were 253, in 2024/25 it rose to 317, an increase of 25.3%.

SARs vary considerably both in the size of the records and the time involved to complete. A simple SAR can be 3 to 4 pages may only take 10 - 15 minutes to download and send for approval. More complex SAR may involve downloading several hundred documents, and records over 2,000 pages (the largest request this year to date had 7,913 pages), and can take weeks to download and send for approval.

It is worthwhile remembering that it is not only the time of the Records Team that is used in the turnaround of SARs; Clinicians approving records for disclosure also invest considerable time.

With the ongoing increase in requests, the complexity and time involved in complex SARs the IG and Records Team are planning a lean review of the SAR process with a view to the purchase of a specialised SAR tool.

Freedom of Information

The number of FOI requests received until 31st March 2025 has increased by 7.5%.

79.5% of the FOI requests were answered within the statutory timeframe, this does represent an improvement from the previous year. The reasons for going over the statutory time limit have varied from complexity to authorisation of the request.

The IG team has reviewed the Trust's FOI publication scheme against guidance issued by the ICO. With the Trust's communications team, changes were made to the FOI request and publications page to align with the ICO guidance, improving the Trust compliance.

An independent review was carried out of the Trusts FOI responses in 2024/25. The report identified a high number of issues of non-compliance and made some clear recommendations for improvement. The report has been shared with the IG Group.

Breakdown of the days over time

Total FOIR requests for April 2024/25: 501		
Days Over time	**Number**	**% of FOIRs**
21 – 25	41	8.1%
26 – 46	53	10.5%
47 +	9	1.7%
Total	103	20.5%
Total FOIs on time	398	79.5%

The tool being explored for SARs will also be utilised for FOI's.

1.6 IG Training

The Trust achieved the 95% target for Data Security and Awareness training in compliance with the DSPT. This was achieved this year on 10 occasions, which is a huge improvement from previous years. The IGG, IG&R team and SIRO regularly review training statistics and consider ways in which to improve compliance to ensure that good IG practices are embedded across the Trust.

The SIRO, Caldicott Guardian and the DPO have undertaken their annual update training specific to their roles in line with the IG training needs analysis. Trust Board Members undertake annual IG training.

The training needs analysis has been updated in line with new guidance and presented to the IGG for reviewed and approval.

1.7 Summary of DPIAs completed and any high risks identified

The IG Group has reviewed and approved 25 DPIAs, 2024/25. There has not been any residual high-risk processing identified that needed onward reporting to the ICO.

1.8 Information Asset Registers

The Trust maintains an information asset register that is reviewed with IT and clinical systems regularly along with the IGG periodically. As assets are identified as part of the DPIA process they are added accordingly. The asset register also details the assigned Information Asset Owners (IAO). Further work is underway to embed the role of IAO and the Information Asset Assistant within the Trust.

1.9 **Updated media statement in the event of a data breach**

The Trust has a prepared a base media statement that was drafted in conjunction with the Head of Communications, the statement has been shared with the IGG.

1.10 **Data Processor update on any issues, contractual updates on compliance with UK GDPR**

There have been no reported issues raised with or by a processor, or UK GDPR compliance concerns.

The IGG has reviewed and approved 10 data sharing or processing agreements in year.

1.11 **Data Flows**

The Trust maintains a list of its data flows, the flows are updated by the IG team following DPIA and sharing agreements reviewed and approved in year. The IGG has reviewed the flows register twice this year and agreed that all known flows were identified and mapped.

The Trust flows is also being reviewed as part of the review of our approach to Information Assets and Asset Owners.

1.12 **IG Risk**

IGG manages information governance risks on behalf of the organisations, reporting to the Audit and Assurance Committee. As part of its annual review of Risk Appetite, the Trust Board agreed that it had a 'low risk' appetite for risks relating to information security (cyber and information governance) with an upper risk tolerance score of 6. As a result, all risks rated 7 and above that fall within this category are reported to the Audit and Assurance Committee quarterly for review as the responsible Board Governance Committee.

2.0 CLINICAL CODING AND RECORDS

2.1 **Privacy Officer**

Privacy officer checks are performed across SystmOne and RIO EPRs to ensure staff do not access patient records without a valid reason. At times clinicians and administrators are required to access patient records, including after the patient has been discharged, are presented with access challenge, where they must enter a valid reason. Privacy officer checks verify those reasons monthly.

There have been 47,033 SystmOne privacy officer checks performed between April 2024 and March 2025. 84 resulted in queries being raised with staff as to why patient records were accessed. No concerns have been raised following the responses received from staff.

There have been 10,016 SCR privacy officer checks performed between April 2024 and March 2025. 455 resulted in queries being raised with staff as to why patient records were accessed. No concerns have been raised following the responses received from staff.

2.2 Clinical Coding Report Clinical Coding

Finished completed episodes for coding are outsourced to CHKS Limited who review episodes across GHC services and ensure they are coded correctly. All clinical coders are fully trained Accredited Clinical Coders and have attended a clinical coding standards course, regular three yearly refresher training and specialty workshops.

Mental Health

- The coding team rely upon the Nursing/Doctors Summaries to code episodes, followed by accessing the progress notes;
- When Discharge Summaries are not available, the progress notes are used to determine a diagnosis; and,
- Patient lists are sent to coding on a two-weekly basis.

Sexual health

- Coders access clinic lists on Lillie to code all Sexual Health activity;
- There are issues with coding sexual health episodes, where proformas or sexual reproductive health activity data sets (SRHAD) are not available. Coding reports are sent to Hope House identifying missing documentation, and once rectified the clinical coding for these episodes is completed at a later date; and,
- There is a longstanding issue regarding clinical codes not being available for use in the Lillie system. The full ICD 10 and OPCS classifications are not available for use by the coder. Episodes are therefore only coded using the codes available and there is a significant risk that episodes are not being coded to national standards.

Rehabilitation

- Episodes that require coding appear on an uncoded report on SystmOne, which the coder can access when needed;
- In the first instance the coding team use the Doctors Discharge Summaries to code, followed by accessing the patient's journal. When a Discharge Summary is not available only information from the patients' journal is used;
- On rare occasions some episodes are unable to be coded. This is due data quality or insufficient data in the patient's journal (the journal is the narrative of the patient's care in the clinical record). On these occasions the episode details are sent to Clinical Systems to rectify; and,
- GHC have requested CHKS complete all the clinical coding of the patient episodes from the previous month by the 10th working day of the following month. CHKS are working towards achieving this with the resource they have working on this Contract.

All the above issues have all been highlighted to the relevant teams in GHC and the coding team continue to work with GHC on improving coding.

2.3 Health Records

There are approximately 500 boxes of physical health records remaining to be processed at the Trust's storage facility, that are being processed as Business As Usual (BAU).

A team of records officers are working through these. Additional resource from the staff bank has expedited this task. The estimated completion date is May 2025.

All records found to be outside of their legal retention period will be destroyed. A small number, which are close to the end of their retention period, will be returned to crown storage. The remaining records will then be manually scanned and uploaded to CITO by the Health Records team as BAU.

Additionally, there are about 1347 historic paper records, that predate the Trust in Iron Mountain. The records team have, drawn back 215 boxes and reviewed for destruction or retention.

2.4 CITO EDMS Project

Deployment of the CITO EDMS to the Trust's Mental Health, Physical Health and corporate teams, involves the digitisation of the historical paper health records, currently stored in Crown commercial storage.

The EDMS team has now been disbanded, in line with the budget and timeline for project delivery. All remaining Health Records work has been handed over to the BAU for the Health Records team. All Mental Health and Learning Disabilities files have been scanned and are available in CITO, via a click-through from RiO. We expect all Physical Health files to be available on CITO, via a click-through from SystmOne, by March 2025.

The Clinical Systems team continue to work with the system suppliers (CIVICA) to troubleshoot and implement functionality that is currently missing from the system, for example the ability to upload video files. CIVICA have given a projected delivery date of April 2025 for these elements.

Key Milestones Planned for 2025:

- Physical Health files available on CITO (February 2025)
- Physical Health quality assurance checks complete (February 2025)
- Click-through from SystmOne Go-live (March 2025)
- Update with additional functionality, including ability to upload video files (April 2025)

2.5 Summary of audits which have Data Privacy/Quality Implications

The clinical audit programme has delivered on a varied programme of audits. There were 154 national and locally agreed clinical audits.

The programme for 23/24 is under review and capacity is being created in the team to support a number of clinical interest audit requests. The outputs of the audits enable us to benchmark a range of quality indicators, share good practice and identify areas for improvement. We monitor the progress of the audit programme through a group of well-established governance and reporting structures which forms part of our Quality Management System. The team reports findings into the Regulatory Compliance Group, Improving Care Group and the Quality Assurance Committee. The audit team have strong links with the Quality Improvement Hub and have supported a number of

improvement programmes over the year. The audit team ensure there is a consistent approach to data management and reporting utilising the SNAP digital audit software.

The embedding learning function has been enhanced during the year and the quality team has been testing actions through the fidelity testing process. A structure of assessment using quantitative and qualitative approaches to test the embedded nature of actions arising from a number of learning vehicles has been established. Activity is tracked using the Datix system. Any significant issues that have implications on the Trust's compliance with Data Protection Legislation will be raised with the SIRO, Caldicott Guardian and DPO, there have not been any issues raised.

3.0 DATA QUALITY

3.1 Policies

The Trust's FOI policy has been reviewed and updated in year. The recommendations from the independent review were implemented within either the FOI policy or the revised FOI Standard Operating Procedure. Both were both presented to and approved by the IG Group. These changes continue to bed in.

The Data Quality policy has also been reviewed and updated accordingly in year.

3.2 Business Continuity / Disaster Recovery

The Trust has an incident response policy that forms the backbone of its disaster recovery and business continuity planning. This policy has been reviewed and incorporated the Trust's essential functions assessment.

There have not been any technical incidents this year that have required teams to utilise their business continuity plans.

3.3 Business Intelligence

During the last year, the Trust has established the required infrastructure to deliver integrated reporting for 2025. Its data warehouse now includes multiple data tables from various systems including workforce (Electronic Staff Record), risk, incident management service experience (Datix), finance (Centros), training, appraisals, supervision (Care2Learn), e-rostering (Allocate) and its five clinical systems (RiO, SystmOne, Lilie, IAPTus and Dental). It also digests data from partner clinical systems such as CLEO.

A single Trust Hierarchy underpins the integration capabilities of data across these systems, and the maintenance of this continues to be paramount to the success of the overall outputs available through a single Business Intelligence (BI) platform Tableau. Combined, this offers all stakeholders a single version of the truth with absolute alignment between National, Regional and Local data. This collectively improves commissioner, operational and corporate confidence in many areas.

Managing numerous corporate and clinical systems brings with it unavoidable data quality issues which can stem from record keeping errors or system configuration complexity. To mitigate this, data quality reports are published and available to all staff

which help feed audit and help monitor operational practice to mitigate this issue. The clinical systems and BI team also run starter and refresher user training to maintain a good level of data recording and report monitoring and the Trust's Transforming Care Digitally agenda will further address Data and Digital literacy in 2025/26. BI manage the portfolio of data quality reports; however, it is a combination of the Nursing, Quality and Therapies directorate, the Operations Directorate and Clinical Systems that monitor compliance and undertake corporate and clinical audits. A recently established and operationally led Patient Record Working Group also improves ownership and accountability for data quality within clinical systems.

The Trust currently maintains a full BI reporting suite of information reports that maintains pseudonymised data (through clinical system ID or NHS numbers) with the following exceptions that use patient identifiable information, however these are used for direct patient care and clinical monitoring, not research or planning purposes:

- Bed Management Report - Digital Whiteboard (Name and Age) Secure to bed management team, wards and select senior operational managers to manage patient flow which went through a DPIA process;
- Secure to appropriate operational management leads;
- There are comparable controls to manage access to corporate reports such as financial budget statements (to budget holders and associated management accountants) and HR Workforce reports (Workforce leads).

There are controls in place to manage access to these reports, and although an automated IT owned, Active Directory solution remains in development it is currently managed through a locally BI managed list of responsible names that is locally managed and maintained. All reports themselves are reviewed annually for use and will be securely archived if no longer required. Access to any of these reports can also be monitored as required.

Although the majority of the Trust's *identifiable* data use is for direct patient care (acceptable) and any planning or development reporting uses *confidential, un-identifiable* data (also acceptable); the Trust does have a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied. The Trust also handles pseudonymised and anonymised data where appropriate, often for ICS but also GHC management needs.

3.4 ESR

There have not been any system or data security issues in year. Data quality audits and reviews continue to be carried out monthly using system reports. There are no emerging themes or trends following these reviews.

4.0 CYBER / DATA SECURITY

4.1 Access Controls

The Trust follows a well-defined procedure for granting access to our IT and Clinical Systems for new employees and managing access for departing staff.

Active Directory (AD) Audits monitor and analyse activity within the Trusts AD environment, in line with industry regulations.

The Trust utilises Multi Factor Authentication and has a number of tools to protect and monitor for suspicious activity.

4.2 Cyber Report

The Countywide IT Service (CITS) manages the cyber response for the Integrated Care System (ICS). CITS ensures that the ICS Digital Executive Steering Group, which includes the Senior Information Risk Owner (SIRO), receives timely cyber security updates. Cyber threats are monitored weekly and assigns actions to address potential risks. Threats are identified through various assured channels.

CITS conducts regular penetration testing for GHC, these findings are discussed during weekly Cyber meeting. Additionally, GHC engages an external organisation for penetration testing and a full NHS penetration testing to scan externally facing links. The infrastructure and Cyber Team addressing any concerns.

GHC undertook an IT Health Check assessment in 2024 – 2025. The results were reviewed and remediations were undertaken.

An external penetration test is planned for GHC's external facing infrastructure.

4.3 Data Destruction

<u>IT equipment</u>

There have been no reported issues around data destruction or disposal. All data is wiped/destroyed to the required standard and a HPEFS Disposal Certificate is provided for each collection.

To date for 2024/2025 GHC have has 18 disposal collections with 4,512 assets returned and processed, 2398 of these assets were recycled.

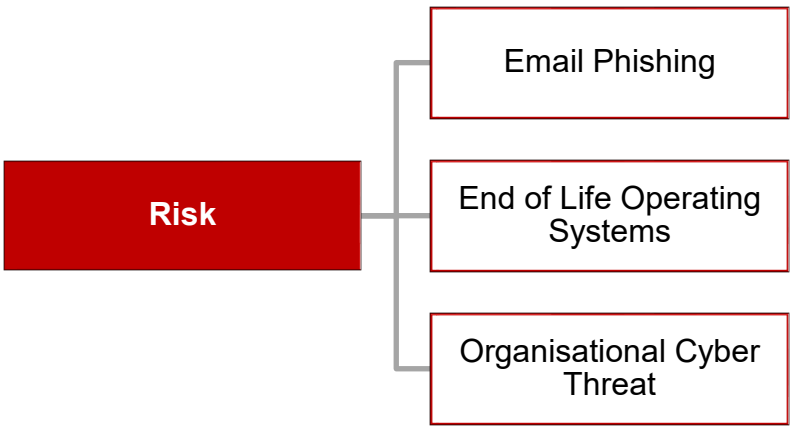
<u>Print waste</u>

There have been no reported data issues with the print waste contract or supplier. Additionally, the supplier has not highlighted any data issues.

4.4. Cyber Data Security Risks

The Digital Group manages the cyber security risks for the Trust with oversight provided by the Audit and Assurance Committee.

The top three risks are currently:



4.5 Phishing

Phishing remains the number one method by which attackers initiate a cyber-attack, this is evidenced within GHC's own environment where on average 1,500 known phishing emails are sent to GHC staff daily.

Around 36% of all data breaches involve a phishing attack, with industry research reporting that healthcare and retail workers are more likely to fall victim to a cyber-attack attempt.

The Trust has several technological measures to protect against cyber-attacks, however attackers are increasingly relying on users. As part of the Trust's response plan and to help protect against phishing attacks we carry out phishing simulations. The results and recommendations falling out of the simulation are reported to and managed through the Digital Group.

4.6 Patching

To minimise risk, GHC has implemented a comprehensive defence-in-depth cyber strategy that includes various solutions to mitigate risks, including a regular patching regime.

Images, courtesy of Canvas and Getty images

REPORT TO: **TRUST BOARD PUBLIC SESSION - 29 MAY 2025**

PRESENTED BY: Lavinia Rowsell, Director of Corporate Governance/Trust Secretary

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **STANDING ORDERS REVIEW - 2025**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☑ Assurance ☑ Information ☐

The purpose of this report is to

Present the Board with the updated Standing Orders for the Practice and Procedure of the Board of Directors, and the Standing Orders for the Practice and Procedure of the Council of Governors.

Recommendations and decisions required

On the recommendation of the Audit and Assurance Committee, the Board is asked to note that a review of the Standing Orders has been carried out, and to **ENDORSE** the proposed changes. The Standing Orders for the Council of Governors were reviewed and supported by the Council at its meeting in May.

Executive summary

High standards of corporate and personal conduct are essential in the NHS. NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

The Trust currently has two sets of Standing Orders, one setting out the practice and procedure of the Board of Directors, and the second setting out the practice of our Council of Governors. Both sets of Standing Orders were created and approved alongside the suite of governance documents as part of the merger in 2019, with a desk top review undertaken when the Trust's Constitution was updated in December 2022.

A full review of the Standing Orders has now been carried out and both sets are presented to the Board for endorsement.

A number of minor points have been updated throughout the Standing Orders, to include job titles, and references to national bodies and guidance. Gender neutral language has

also been used throughout. The Board is asked to note the more substantial changes that have been made to the Standing Orders, as follows:

- SO 5.3 (3.44) – New section added on e-governance and the ability for decisions to be made by way of a written resolution *(in both sets of SOs)*
- SO 5.6 – Section updated to make clear that the Scheme of Delegation shall be considered, approved and reviewed by the Audit & Assurance Committee, on behalf of the Trust Board *(Board)*
- SO 7.6 – Use of the Trust Seal section updated to now include explicit guidance on the circumstances when the Seal should be applied *(Board)*
- SO 8 (7) – Standards of Business Conduct – sections now included within the Standing Orders, previously referenced within the Constitution *(in both sets of SOs)*

The Board is asked to note that SO8 (SO7) "Standards of Business Conduct" has moved into the Standing Orders as recommended by the Trust's solicitors who had carried out a full review of the Constitution in 2022. This is in line with other NHS Trusts and is seen as good practice, noting that the Standing Orders reflect the working practice of the Trust and how we operate. Any changes to the Standing Orders can also be made with Board or Council of Governor approval, rather than requiring a full constitutional change.

The review of the Standing Orders did identify some minor areas of non-compliance and areas where current practice will need to be strengthened to ensure compliance going forward. Examples include the publication of Council of Governor agendas on the Trust website, and clarity on those Directors authorised as signatories in relation to the use of the Trust Seal. Discussions have already taken place with the relevant teams to update internal procedures accordingly.

Other than those key points highlighted above, there have been no further material changes to the Standing Orders that colleagues need to be aware of.

A light touch review of the Standing Orders will be carried out annually, alongside the Constitution. A full review of all governance documents will be carried out every 3 years.

Risks associated with meeting the Trust's values

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. It is therefore important that the Standing Orders remain fit for purpose and are reviewed at regular intervals.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
The Standing Orders for the Practice and Procedure of the Council of Governors have also been presented to and endorsed by the Nominations and Remuneration Committee,

and the Council of Governors in May 2025. Both sets of Standing Orders were presented to and endorsed by the Audit & Assurance Committee at its meeting on 30 April.

Appendices:	Full versions of the Standing Orders for the Practice and Procedure of the Board of Directors and Standing Orders for the Practice and Procedure of the Council of Governors are available in the **Diligent Reading Room** with a summary of the key changes attached as **Appendix 1**.

Report authorised by: Lavinia Rowsell	**Title:** Director of Corporate Governance & Trust Secretary

2025 REVIEW OF STANDING ORDERS FOR TRUST BOARD AND COUNCIL OF GOVERNORS

SUBSTANTIVE CHANGES

NEW TEXT IN YELLOW

1.0 E-GOVERNANCE

1.1 The following new section added to both documents on e-governance and the ability for decisions to be made by way of a written resolution.

Board of Directors section 5.3/ Council of Governors section 3.44

Where agreed by the Chair and the Lead Governor, decisions may also be made by way of a written resolution. In such cases the document or issue in need of review should be sent to Governors and the Council of Governors should have a specified number of days to register their approval via email or other means to the Trust Secretary. The document should not require extensive discussion, although the Council of Governors may choose to ask specific questions to the document author. The email will need to clearly specify the approval that is sought. A document or issue will be considered approved when three-quarters of the Council of Governors has approved it. As in a Council meeting, the Chair shall have the casting vote in the event of an evenly split vote. Notice of all decisions taken by written resolution will be reported to the following formal Council of Governors meeting.

2.0 STANDARDS OF BUSINESS CONDUCT

2.1 Standards of Business Conduct – sections now included within the Standing Orders, previously referenced within the Constitution *(in both sets of SOs)*

Board of Directors section 8/ Council of Governors section 7

Interest of officers in contracts (Board only)

1. *Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any pecuniary interest, direct or indirect, shall declare their interest by giving notice in writing of such fact to the Trust Secretary as soon as practicable.*

2. *An officer should also declare to the Trust Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.*

3. *The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.*

Canvassing of and recommendations by directors in relation to appointments

4. *Canvassing of directors of the Trust Board or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.*

5. *Directors of the Trust Board shall not solicit for any person any appointment with the Trust or recommend any person for such appointment; but this paragraph shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.*

6. *Informal discussions outside appointments panels or committees, whether solicited or unsolicited, and which are not part of the formal recruitment process (other than genuine requests for information about the organisation by a prospective employee, or participation in discussion groups) must be declared to the panel or committee.*

Relatives of directors or officers

7. *Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.*

8. *The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.*

9. *On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office in the Trust.*

3.0 USE OF TRUST SEAL

3.1 Use of the Trust Seal section updated to now include explicit guidance on the circumstances when the Seal should be applied *(Board of Directors – S.O 7.6)*

Custody of Seal, Sealing of Documents and signature of documents

1. *The common seal of the Trust shall be kept by the Trust Secretary in a secure place.*

2. *Where it is necessary that a document shall be sealed, the seal shall be affixed*

in the presence of two executive directors duly authorised by the Chief Executive, ~~not also from the originating department~~, and shall be attested by them.

3. *An entry of every sealing will be made and numbered consecutively in a register provided for that purpose. A report of all sealings will be made to the Board bi-annually. The report will detail the seal number, the description of the document and date of sealing.*

4. *Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any executive director.*

5. *In land transactions, the signing of certain supporting documents may be delegated to managers as set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).*

6. *The following contracts should have the seal applied:*
   a) *All contracts for the purchase/lease of land and/or building;*
   b) *All contracts for capital works exceeding £1,000,000;*
   c) *Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the whole-life value exceeds or is expected to exceed £10,000,000, except for contracts within the Group; and*
   d) *Any contract where the other party requests a seal.*

4.0 DELEGATIONS

4.1 Section updated to make clear that the Scheme of Delegation shall be **considered, approved** and **reviewed** by the Audit & Assurance Committee, on behalf of the Trust Board *(SO 5.6 - Board of Directors).*

The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Audit & Assurance Committee, on behalf of the Trust Board. The Chief Executive (or delegated officer) may periodically propose amendments to the Scheme of Delegation which shall be considered and approved by the Audit & Assurance Committee, as delegated by the Trust Board.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0525

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 May 2025**

PRESENTED BY: Lavinia Rowsell, Director of Corporate Governance / Trust Secretary

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**
1ST APRIL 2024 – 31ST MARCH 2025

This report is provided for:			
Decision ☐	Endorsement ☐	Assurance ☐	Information ☑

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to **NOTE** the use of the Trust seal for the reporting period 1st April 2024 – 31st March 2025.

Executive summary

The Trust's Standing Orders require that the use of the Trust's Seal, be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements. Since the last report to the Board on the 30 May 2024, the seal has been used 3 times during Q1 & Q2 (1st April 2024 – 31 September 2024) and 8 times during Q3 & Q4 (1st October 2024 – 31 March 2025).

Risks associated with meeting the Trust's values

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?

Appendices:	**Appendix 1** (pages 3-4) Register of Seals (Q1-Q4 1st April 2024 – 31st March 2025)

Report authorised by: Lavinia Rowsell	**Title:** Director of Corporate Governance/Trust Secretary

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust
Register of Seals Q1 - Q4 (1st April 2024 – 31st March 2025) (Seal usage x 11)

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
50/2024	16 Sept 2024	**Deed of Grant of Rights and Plan 1 and Plan 2** *(both plans sealed alongside the Deed)* Between Metro MRI Ltd and GHCNHSFT *relating to Ermin House, Horton Road, Gloucester, GL1 3PX*	1	Douglas Blair CEO	Sandra Betney Director of Finance & Deputy CEO	Lavinia Rowsell Trust Secretary	16 Sept 2024
51/2024	18 December 2024	**TR1 HM Land Registry** re GR243453 and GR477233 Between GHCNHSFT and Bromford Housing Association Ltd *Ref: Holly House, West Lodge Driver, Gloucester, GL4 4QH*	1	Neil Savage Director of HR & OD	Rosanna James Director of	Lavinia Rowsell Trust Secretary	18 Dec 2024
52/2025	23 January 2025	**Lease plus Plan 1 and Plan 2** *(both plans sealed alongside the Lease)* Between GHCNHSFT and Swindon and Gloucestershire Mind Ltd relating to *Ref: 29-31 Alexandra Road, Gloucester, GL1 3DR*	1	Douglas Blair CEO	Sandra Betney Director of Finance & Deputy CEO	Lavinia Rowsell Trust Secret	23 Jan 2025
53/2025	31 Jan 2025	**Agreement** Between Cotswold Energy Group Ltd and GHCNHSFT and Constellia Public Ltd in relation to the design, construction and completion of heat pumps at *Charlton Lane Hospital, Charlton Lane, Cheltenham*	1	Douglas Blair CEO	Neil Savage Director of HR & OD	Lavinia Rowsell Trust Secretary	31 January 2025
54/2025	31 Jan 2025	**Building Contract** Between Constellia Public Ltd, Cotswold Energy Group Ltd and GHCNHSFT Re incorporating and amending the JCT intermediate Building Contract with	1	Douglas Blair CEO	Neil Savage Director of HR & OD	Lavinia Rowsell Trust Secretary	31 January 2025

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
		Contractor's design, 2016 Edition (ICD) re design, construction and completion of heat pumps at *Charlton Lane Hospital, Charlton Lane, Cheltenham*					
55/2025	31 Jan 2025	**Contractor Warranty to Authority** Between Cotswold Energy Group Ltd, GHCNHSFT and Constellia Public Ltd Ref: in relation to the design, construction and completion of heat pumps at *Charlton Lane Hospital, Charlton Lane, Cheltenham*	1	Douglas Blair CEO	Neil Savage Director of HR & OD	Lavinia Rowsell Trust Secretary	31 January 2025
56/2025	04 March 2025	**Renewal Lease** by reference to an existing lease Between Invista Textiles (UK) Ltd and GHCNHSFT re new lease granted *ref Invista Car Park, Brockworth*	1	Douglas Blair CEO	Sandra Betney Director of Finance & Deputy CEO	Lavinia Rowsell Trust Secretary	04 March 2025

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 19 March 2025
Via MS Teams

PRESENT:

Graham Russell (Chair)	Kizzy Kukreja	Peter Gardner
Amy Aitken	Penelope Brown	Mick Gibbons
Chris Witham	Sarah Nicholson	Tussie Myerson
Jenny Hincks	Martin Pittaway	Marcia Gallagher
Sarah Waller	Joy Hibbins	Jan Lawry
Leighton Lee Pettigrew		

IN ATTENDANCE:
Steve Alvis, Non-Executive Director
Douglas Blair, Chief Executive
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director (from Item 9)
Rosanna James, Director of Improvement and Partnerships
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jason Makepeace, Non-Executive Director (from Item 9)
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Director of Corporate Governance (from Item 9)
Neil Savage, Director of HR & OD
Rosi Shepherd, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Bob Lloyd-Smith, Andrew Cotterill, Paul Winterbottom, Michelle Kirk, Alicia Wynn, Chas Townley and Laura Bailey. Apologies had also been received from Nicola de Iongh, Non-Executive Director.

1.2 Following the recent Governor elections, Graham Russell said that the Trust was very pleased to welcome its newly appointed Governors who commenced in post on 17th February:

- Jan Lawry (Public Governor: Stroud)
- Joy Hibbins (Public Governor: Cheltenham)
- Leighton-Lee Pettigrew (Public Governor: Gloucester)

1.3 Colleagues also welcomed two new Board members to their first Council meeting - Rosi Shepherd (Non-Executive Director) and Rosanna James (Director of Improvement and Partnerships).

1.4 Graham Russell noted that since the previous meeting, the Trust had officially said goodbye to 3 Governors. Steve Lydon (Stroud) had not been reappointed during the recent election round, Cath Fern (Staff: Nursing) had left her position with the Trust and was no longer eligible to stand as a Governor, and Rebecca Halifax (Appointed: Glos CC) had stood down from her nominated role as Appointed Governor. The

Council joined Graham Russell in expressing their thanks and best wishes to all colleagues.

1.5 The Council also noted that this would be Jan Marriott's final Council meeting as she would be coming to the end of her final term as a Non-Executive Director on 31 March. Colleagues expressed their huge thanks to Jan for her contributions and engagement with the Governors.

2. DECLARATIONS OF INTEREST

2.1 Marcia Gallagher declared a conflict of interest in relation to the NED Remuneration paper coming up on today's agenda. This paper was recommending an increase in NED remuneration, to be back paid to 1 April 2024. Marcia was a NED until 30 June 2024 and would therefore have an interest in the decision to be made. It was agreed that Marcia would refrain from any vote on this matter.

3. MINUTES OF THE PREVIOUS MEETINGS

3.1 The minutes from the previous Council meeting held on 13th November were received and agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meetings were complete or progressing to plan.

4.2 Sarah Waller noted that the Governors had requested that the data for both staff vacancy rates and turnover be included within the Governor Dashboard report and asked that future reports ensure that this information was provided. **ACTION**

5. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

5.1 Chris Witham presented this report which provided a summary of the business conducted at the Nominations and Remuneration Committee meetings held on 8th January and 6th March 2025.

5.2 Chris Witham opened the report by echoing Graham Russell's earlier thanks to Jan Marriott, Non-Executive Director, noting that she was passionate, engaged and had been an excellent colleague.

5.3 The Committee had received a report setting out a recommendation for the reappointment of Nicola de Iongh, Non-Executive Director, for a further term of 3 years. Nicola's first term of office would end on 13th July 2025 and, as set out in the Trust Constitution, she was eligible to be re-appointed for a further 3 years. Nicola was a valued and experienced Non-Executive Director who had the confidence of fellow Directors on the Board. Nicola is the Trust's Deputy Chair and Senior Independent Director. Nicola is also Chair of the Charitable Funds Committee, Vice Chair of the Resources Committee and Vice Chair of the Great Place to Work Committee. The Committee noted that Nicola was fully compliant with the Trust's Fit and Proper Persons checks, has a good attendance record and had received a positive appraisal

for 2023/24. The Nominations and Remuneration Committee supported and endorsed the recommendation for reappointment, and the full Council of Governors was therefore asked to **approve** the reappointment of Nicola de Iongh, Non-Executive Director for a further term of 3 years, commencing on 14th July 2025. Unanimous approval was received.

5.4 The Committee had received a verbal update on the status of the NED recruitment process that was taking place to fill the vacancy that would arise following Jan Marriott's departure. It was noted that the post closed for applications on 26th February, and a total of 52 applications had been received. An initial review of applications had taken place in advance of the longlisting meeting scheduled for 13th March, where a final decision would be made on those applications to be progressed. The interview date had been scheduled for 25th March, however, it was proposed that this date be used for the Trust Chair and Lead Governor to meet with the longlisted candidates, with the aim of shortlisting down to 4-5 candidates who would go forward for final interview. A new interview date would therefore be sought. Committee members were supportive of the suggested way forward, and agreed that it was fantastic to have received so much interest in the post.

5.5 The Nominations and Remuneration Committee also received and endorsed the proposed process and timeline for the Chair and Non-Executive Director appraisals for 2024/25.

6. NON-EXECUTIVE DIRECTOR REMUNERATION

6.1 The purpose of this report was to present the Council of Governors with a recommendation, from the Nominations and Remuneration Committee, regarding an uplift to Non-Executive Director Remuneration. Graham Russell presented this report to the Council.

6.2 The Nominations and Remuneration Committee is required to review remuneration and terms of service for NEDs at least annually, taking into account the performance of individuals specifically, and the organisation generally, and to make related recommendations to the Council for decision. Previously, following the merger in October 2019, the Committee considered NED remuneration against (1) perceived increased responsibilities within the larger post-merger organisation, (2) the then new national NHSE remuneration framework, and, (3) benchmarking data, and made recommendations accordingly. Following the Committee's recommendations, the Council agreed that NED remuneration would be maintained at the 2019 level for three years (to October 2022) and then reviewed thereafter in light of benchmarking, national guidance and any other related circumstances.

6.3 The position was reviewed by the Committee in 2022/23, and it was agreed to re-table an updated paper to a future meeting to include additional benchmarking and a clearer picture of additional responsibilities in light of the formation of the Integrated Care Board (ICB). Following this review and a recommendation from Ingrid Barker, the then Chair, further consideration was put on hold pending resolution of the NHS pay strike dispute, alongside an expected further national update on the remuneration

framework. The former was resolved in Summer 2024, but the latter remains "imminent" but with no confirmed publication date.

6.4 This has meant that NEDs have received no remuneration uplift since 2019, against the backdrop of both increasing inflation and clinical and non-clinical employees receiving annual pay awards over each of the following years. From an analysis of the national benchmarking data, the GHC NED remuneration rate was now uncompetitive with Gloucestershire partner organisations' equivalent roles, and was also below both the "all Non-Acute FT" group and the "Medium Sized Non-Acute" group basic and total remuneration rates.

6.5 Graham Russell said that given the latest benchmarking, strong NED performance, and significant inflationary increases over the past 5 years, the Nominations and Remuneration Committee was therefore recommending to the Council that NED remuneration be increased by 5.5% from 1st April 2024. This would take NED remuneration from £14,000 to £14,770 (i.e. an increase of £770 p.a.) and would recognise the circumstances listed above and provide a modest remuneration increase in line with benchmarks and wider NHS colleagues.

6.6 The Council of Governors **approved** an increase to NED remuneration to £14,770 per annum, to be backdated to 1 April 2024. This would be subject to annual review by the Committee.

6.7 Graham Russell took this opportunity to thank his NED colleagues for their valuable contributions.

7. CHAIR'S REPORT

7.1 Graham Russell provided a brief verbal report to the Council, setting out some of his activity over the past few months.

7.2 Graham highlighted the value of visiting services and he had the opportunity to visit the Brain Injury Team who are based at Gloucestershire Royal Hospital. He said that this was a great example of integrated working, with a real multi-disciplinary team approach.

7.3 Graham also had the pleasure of meeting with colleagues from Art Shape, a not-for-profit organisation who engage people in art to improve their health and wellbeing. Graham said that it was important to learn more about local charities and organisations in the county and how the Trust can work with them to support people.

7.4 Graham Russell extended the invitation to Governors to get in touch with him at any time if they wished to meet up.

8. CHIEF EXECUTIVE'S REPORT

8.1 The Council welcomed Douglas Blair, CEO to the meeting who provided a report on key matters to the Governors, including the publication of the national Staff Survey Results and an update on the Trust Strategy Refresh. Douglas informed the Council

that a lot of work was taking place both internally at GHC and with system partners to look at operational and financial planning for 2025/26, so it was a very busy time on the run up to year end.

8.2 The report set out the key headlines from the 2024 Staff Survey Results. Douglas Blair said that he was really pleased to see that the Trust's response rate had increased again this year, with 61% of colleagues participating in the survey. The majority of scores were above average, and across the seven NHS 'People Promises' scores, 6 scored significantly better than the sector scores for similar organisations surveyed. The score for colleagues recommending GHC as a place to work was in the top 10 nationally, and was the top ranked score received in the southwest region. Douglas Blair advised that the Trust Board would receive a full report at its meeting on 27 March and work was already underway to review underlying themes and messaging. He said that it was very important to reinforce the message that GHC was performing well, however, in line with our Trust values, we are always seeking to improve and those areas where scores were lower would be explored in more detail to look at improvements that could be put in place.

8.3 At the Council meeting in November, Governors were presented with the proposals for taking forward the Trust Strategy refresh. The Trust's overarching strategy "Our Strategy for the Future 2021 – 2026: Better Care Together" was approved in 2021. Our four values underpin our mission: working together, always improving, respectful and kind, making a difference. This is further supported by our strategic aims which focus on our staff, our patients, our partners and our impact on the environment; enabling our vision to be an integrated mental health, learning disabilities and physical health community provider "Working together to provide outstanding care." In March 2025, the Trust embarked on a 6-month engagement plan to review and refresh our existing Strategy, which will take account of the local and national influences shaping our organisation to provide a clear set of strategic objectives, for the next 5 years (Sept 2025 – Sept 2030), clearly demonstrating how our clinical and operational model will focus on prevention & early intervention; improved health and wellbeing outcomes; and outstanding care. Douglas Blair said that community-based transformation will be at the heart of the new NHS 10-year plan to be released in May 2025 and we understand that to deliver the Gloucestershire ICS 3 pillars we need to collaborate with our partners and work in different ways with the communities we serve, to provide joined up, patient centred care for our population. The report set out the timeline for the Strategic refresh, and it was noted that a joint Governor / Board development session would be taking place on 9th July as part of the engagement exercise.

8.4 Douglas Blair provided a verbal update on the IUCS which had launched in November 2024. This was a significant service and Douglas said that colleagues had worked incredibly hard to get the service up and running. It was agreed that the Service Director for the IUCS would be invited to present a full update to the Council at the next meeting in May, looking at how the first 6 months of operation had gone, some of the key statistics, and the challenges and opportunities. **ACTION**

8.5 Following on from previous discussions at the Council around the utilization of Community Hospitals, Douglas Blair advised that discussions had been taken forward with system partners as part of the annual planning process, and helpful meetings had also taken place with colleagues at Gloucestershire Hospital's Trust to progress this.

8.6 Sarah Waller referred back to the Staff Survey results and she asked what the Trust's top focus areas would be. Douglas Blair advised that this was still being worked through, however, from initial reviews there would be a real focus on colleagues experiencing discrimination (age/gender/race) and also on the value of the current appraisal system. With regards to the issue of discrimination, the Trust had already established a Leadership & Culture Programme to focus specifically on this area, with a Board assurance Committee now in place to ensure robust Board level oversight.

8.7 Kizzy Kukreja asked whether the volume of calls received by the IUCS was in line with what had been expected. Douglas Blair said that it had been very busy and was in the upper range of expectations. He said that it had been somewhat challenging, especially having taken on the service at the start of the winter period.

8.8 Tussie Myerson asked whether there were any plans to improve the communication with the public, such as the use of social media, around NHS 111, encouraging people to use it and being clear about how and when it should be used. Jenny Hincks asked whether there was clear signposting for the public on the use of pharmacies, and whether "Pharmacy 1st" was an option as part of the standard call algorithm. It was suggested that these questions could be helpfully asked at the next meeting when colleagues from the IUCS (Integrated Urgent Care Service), would be in attendance to explore further.

Lavinia Rowsell, Jason Makepeace and Sumita Hutchison joined the meeting

9. WAYS OF WORKING

9.1 Anna Hilditch provided an update on the progress made to date on the refreshed Ways of Working and Membership proposals. This included:

- The rolling programme of monthly Governor/Non-Executive Director (NED) visits to community hospitals / inpatient units has now been reinstated and the schedule issued to all Governors inviting attendance
- Non-Executive Director, Public Governor and Partnership Team locality links now in place and introductions made
- Trust engagement events schedule shared with all Governors inviting attendance
- New membership leaflet produced and Membership pages on Trust website updated to reflect new messaging.
- Governor pop-up stand Pilot at community hospitals being planned for April / May – new pull up banners and signposting guidance for Governors being prepared
- Governor pages on website being developed and all Governors will shortly receive a request to provide personal statements for adding to the site

9.2 Governors were asked to note that this year's Big Health Day would be taking place at Oxstalls Tennis Centre on Friday 13th June. This was a great opportunity for Governors to host a stand and promote Trust membership, as well as networking with colleagues from a range of organisations across the county. A space would be booked for a Governor and Membership stand, and Governors would be contacted in due course to look at developing a schedule for attendance on the day. **ACTION**

10. GOVERNOR DASHBOARD

10.1 The Council of Governors received the Governor Dashboard for information and assurance. The purpose of the Governor Dashboard is to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board and ensuring that people that use our services are receiving the best possible care.

10.2 As requested earlier in the meeting, the dashboard would be updated to reinstate the metric for staff vacancy rate, as well as staff turnover. Assurance was given to the Governors that the full range of workforce performance metrics were presented to and scrutinised regularly at the Great Place to Work Committee. It was noted that the Performance Report was received and considered at the last committee meeting in February and this provided strong workforce KPI scores and demonstrated positive benchmarking when compared to other similar organisations.

10.3 Vicci Livingstone-Thompson referred to the Public Membership statistics within the dashboard and said that she would welcome seeing the ethnicity data presented as a percentage of the county population within future reports. **ACTION**

10.4 Marcia Gallagher noted that the number of open complaints had increased significantly, and she queried the reason for this. It was noted that this related to this increase in complaints being received in the period. Since 'go-live' in November 2024, the Trust had received 53 complaints about the new Integrated Urgent Care Service (IUCS). These have mostly been around waiting time for a clinician call back. There had been a slight dip in February, however, the sheer volume of contacts into NHS111 suggests that this trend will continue. Further information would be presented as part of the IUCS presentation at the next meeting.

10.5 Sarah Waller said that she would welcome the definition of what was now classed as a complaint, or inquiry. This was provided in the MS Teams Chat function at the meeting, as follows:

- Inquiry: the act of seeking information or asking questions. It can be a general request for information about services, procedures, or any other aspect of healthcare. Inquiries are typically informal and do not necessarily indicate dissatisfaction.
- Complaint: a formal expression of dissatisfaction or concern about the quality of care or services received. Complaints are usually more structured and require a formal response from the NHS. They can be about any matter reasonably connected with the exercise of NHS services.

10.6 The Council **noted** the content of the Dashboard report.

11. BOARD COMMITTEE UPDATES

11.1 As part of the Governor role in holding the Non-Executive Directors to account for the performance of the Board, this section of the meeting provided an opportunity for the

Governors to hear directly from the NEDs about the business conducted at the recent round of Board Committee meetings, and for them to provide questioning and challenge.

Audit & Assurance Committee – 6 February

11.2 Bilal Lala (Chair of the Audit & Assurance Committee) highlighted the following items to the Council:

- The Committee received the Procurement and Contract management Internal Audit and noted that this was scored moderate by design and limited for design effectiveness. In terms of classification, the Governors noted that audits could be classed as limited, moderate or substantial. Moderate meant that the area was compliant; however, areas for improvement and further review had been identified. Penelope Brown asked what the main issues were with the Procurement Audit, and the awarding of "limited". Bilal Lala said that there had not been an SLA in place until the end of the year (shared service hosted by Gloucestershire Hospitals Trust), there had been recruitment challenges into the service, and contract renewals had been identified as being overdue. Assurance was given that all internal audit reports had associated action plans in place to address the recommendations arising, and these were overseen by the A&A Committee.
- The Finance Compliance Report was received and assurance was provided, noting the improvement made with the overall level of debt and age profile with a marked reduction with long overdue. This was due to proactive intervention by the finance team.
- The Committee received the Board Assurance Framework and Risk Report for quarter three. The change in ownership for the BAF risk 9: Cyber Risk from the Audit and Assurance Committee to the Resources Committee was noted. The Committee would receive an update on cyber assurance 6 monthly from the Resources Committee. Sarah Waller asked about risk allocation. Bilal Lala said that the A&A Committee had overall responsibility for risk; however, risks were discussed at all levels of the organisation, and each of the Board Committees received a risk report setting out those risks allocated to them for review and oversight.

Great Place to Work Committee – 25 February

11.3 Sumita Hutchison (Chair of the GPTW Committee) highlighted the following items to the Council:

- The Committee received the BDO Internal Audit Report on Performance Appraisals and discussed the key findings and how they triangulate with the staff survey results. Sumita informed the Council that the Trust's compliance rate with appraisals was good, however, more was needed to look at the value that colleagues felt appraisals brought and whether they actually helped people to do their jobs. Kizzy Kukreja asked how the Trust was looking to make these more valuable. Sumita Hutchison said that a dedicated group had been set up to review the findings from this audit report and an action plan had been produced with the aim of making the process more engaging, rather than a tick box exercise. She said that this could perhaps be discussed further at the next Staff Governors and NEDs meeting. **ACTION**

- A powerful staff story on reasonable workplace adjustments for disabilities was presented to the Committee and following the Committee discussion, it was agreed a task and finish group would be established to develop the documentation on the process for colleagues seeking reasonable adjustments within the workplace.
- The Committee received the embargoed Staff Survey Results for 2024 and would review this further in a thematic way at the next Committee meeting. As highlighted earlier in the meeting, the headlines from the staff survey results were positive and GHC was performing well but it was important to drill down into those areas where scores were lower.

Resources Committee – 26 February

11.4 Jason Makepeace (Chair of the Resources Committee) highlighted the following items to the Council:

- The Committee received and noted the Cyber Security Assurance Report, noting that cyber risks were being appropriately managed with gaps in assurance noted.
- A full presentation was received on the Annual Operating Plan update ahead of being received by the Trust Board in March. The Budget Setting 2025/26 update was also received and noted ahead of Board approval in March. Jason informed the Council that it was an especially busy time on the run up to year end and the Resources Committee had discussed the capacity issues around planning and financial compliance.
- The Committee received the Performance Report for month 10. Jason Makepeace said that important discussions were taking place to look at the quality of data that the Trust holds and how we use that data across the Trust.

Quality Committee – 4 March

11.5 Jan Marriott (Chair of the Quality Committee) highlighted the following items to the Council:

- The Committee received assurance from the Crisis Services briefing received and further discussions on Crisis Services was scheduled to be received by the Committee in July. Jan advised that Crisis services was an area of improvement seen via the annual Community MH Patient Survey, and the Committee had heard about the work taking place with the call centres, and the new NHS 111 “press 2” for mental health support. Joy Hibbins said that this was a real area of interest for her and offered her support as part of any future work.
- The Committee received and noted the Medical Education Annual Report and was informed that even though it had been a challenging year in terms of delivering high quality medical education and training, the Trust had had a very successful year. The Trust remained in the top ten highest ranked NHS Trusts in England and Wales in terms of Resident Doctor and Trainer Satisfaction.

12. QUALITY ACCOUNT UPDATE

12.1 The Council welcomed Jane Stewart, CQC Compliance Manager, to the meeting. The purpose of this item was to present the proposed timeline for this year’s Quality Account sign off and to provide information and detail in relation to the Quality Account

and how the related Quality Priorities are established and agreed, and how progress is monitored.

12.2 Jane Stewart presented the headline detail regarding the Trust's Quality Priorities and advised that the Quality Priorities originate from the Quality Strategy. Our Quality Strategy sets out our quality ambitions, strategic goals, priorities, and the approaches we will take to measure our progress. It does not sit in isolation but is one of six integrated enabling strategies delivering the Trust's Strategy. By developing this Quality Strategy, we are making clear our commitment and approach to empower the people at the heart of our services. Our colleagues will have the freedom, skills, tools and resources to work in partnership with the people we serve to improve and innovate safely towards defined quality goals.

12.3 Each year the Trust must produce and publish on our website the organisational Quality Account by 30th June. The Quality Account reflects the Trust progress on delivering its quality strategy and meeting its national and local quality requirements. The Quality Priorities and their progress towards targets form an essential mandated part of the Quality Account and as such are used as a template for the preparation of this document which is a requirement of the Health and Social Care Act 2012.

12.4 The Council noted the proposed timeline and noted that a draft of the Quality Account would be made available to all Governors to see and comment upon, before progressing to Trust Board at the end of May for sign off.

12.5 A copy of the presentation, which included reference to the 11 quality priorities would be shared with Governors following the meeting. **ACTION**

13. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

13.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with any upcoming Governor elections.

13.2 It was noted that a further round of Governor elections would commence in early May for one Staff Governor Position (Medical Dental & Nursing – *reserved for Qualified nurses*) and two Public Governor positions (Stroud and Cotswolds).

14. GOVERNOR QUESTIONS LOG

14.1 The Governor Questions Log is presented at each Council meeting, and any questions received between meetings are presented in full, alongside the response for Governors' information.

14.2 It was **noted** that no new questions had been received since the last formal meeting in November.

15. ANY OTHER BUSINESS

15.1 There was no other business.

16. DATE OF NEXT MEETING

16.1 The next Council of Governors meeting would take place on Wednesday 14th May at 10.30 – 1.00pm at Churchdown Community Centre. It was noted that an extraordinary Council meeting would be required in the interim to approve the Non-Executive Director appointment, and a date for this meeting would be shared with all Governors once the recruitment timeline had been confirmed.

17. PRIVATE SESSION BUSINESS

17.1 The Council of Governors received the minutes from the private Council of Governor meetings held on 13 November 2024 and 31 January 2025. Both sets of minutes were **accepted** as a correct record. There were no matters arising.

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
13 Nov 2024	10.3	A future service presentation for Governors on the Sexual Assault referral Centre (SARC) service to be considered.	**Ongoing**. Added to future presentation schedule.
19 Mar 2025	4.2	Data for both staff vacancy rates and turnover be included within the Governor Dashboard report	**Complete.** Data now included in report
	8.4	Service Director for the IUCS to be invited to present a full update to the Council at the next meeting in May	**Complete.** On agenda for May Council meeting
	9.2	Governors would be contacted to look at developing a schedule for attendance at the Big Health Day on 13 June	**Complete.** Booking for stand now confirmed and Membership Officer emailed Governors on 8 May seeking involvement.
	10.3	Ethnicity data within the Public Membership stats report to be presented as a percentage of the county population within future reports	**Complete**. Data now included in report.
	11.3	Discussion about appraisals and how these can be made more valuable to colleagues rather than a tick box exercise to be scheduled for future Staff Governor/NEDs meeting.	**Complete.** Scheduled for agenda for 13 May meeting.
	12.5	A copy of the Quality Account presentation, with the 11 quality priorities would be shared with Governors following the meeting	**Complete.** Emailed out with papers for May meeting.

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 20/0525

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 MAY 2025**
COMMITTEE:	**MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE (MHLS) - 8 APRIL 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, Chair of Committee

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

The Committee received the Mental Health Act (MHA) Reforms Update, and was informed that this would carry recruitment issues and that it was unknown what resources would be received.

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

The Committee received the Annual Approved Mental Health Professional (AMHP) Service Report and was informed of the issues with delays in conveyancing and the use of private conveyancing. It was **noted** that this was included on the Trust's Risk Register.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Review of Mental Capacity Act (MCA) Practice, DoLS Applications and LPS Report and noted the assurance provided in the completion of the MCA audit and also the MCA practice in Berkeley House learning disability inpatient unit audit.

The Committee received the Annual AMHP Service Report and noted there had been a reduction in compulsory admissions, which was at 593, compared to 599 in 2023/24 and 663 in 2022/23.

APPROVALS: Decisions and Approvals made by the Committee

The Committee received the Mental Health Act Managers (MHAM) Forum update, and **approved** the proposed changes to the MHA Managers training profile.

RISK UPDATE

The Committee was informed of the below risks on the Corporate Risk Register of which the Committee has oversight of:

- Risk ID 180 – Mental Health Act Changes
- Risk ID 424 – Conveyance under the Mental Health Act (s6 (1)) - gap in secure transport commissioning
- Risk ID 375 – MHA – Patient Detention Timescales

All above risks were discussed throughout the meeting.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The Committee congratulated Jane Higgins and her MCA Champions on the significant improvements to the audits which had been carried out, noting that the MCA audit had improved from 21% to 74% compliance; and the MCA practice in Berkeley House learning disability inpatient unit had improved from 17% to 84% compliance.

The Committee noted the high capacity and retention of the AMHP workforce in Gloucestershire from the first workforce plan in May 2024, which was especially high in comparison to nationally, included in the Annual AMHP Service Report.

ITEMS RECEIVED: The following items were received and discussed at the meeting

- CQC Mental Health Act Round Up

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 MAY 2025**
COMMITTEE:	**RESOURCES COMMITTEE – 24 APRIL 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Jason Makepeace, Chair of Committee

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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee **received** the Cyber Security Assurance Report, which included highlights from a recent national cyber incidents review and was informed that the level of risk was increasing nationally. The Committee reviewed and supported the mitigation plan.

The Committee **received** the Estates Strategy Update, and was informed of the current process for reviewing the plans for the Trust's estate property by property; and also, the planned refresh of the strategy for completion March 2026.

The Transforming Care Digitally (TCD) highlight report was presented to the Committee and it was raised that the availability to support could be significantly more limited than previously forecast.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** the Finance Report for month 12 and **noted** the end of year position for the Trust.

The Committee **received** the Performance Report and **noted** that improvements were being made with the Integrated Urgent Care Services (IUCS) across many of the measures.

The Committee **received** and **noted** the Service Development Report.
The Committee was assured on the progress made on the implementation of the Transforming Care Digitally Programme.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **received** the quarter 4 risk reporting and the below risks were highlighted:

Highest Scoring Risks				
Risk ID	Title	Risk Score	Direction of Travel	Lead Executive
149	Eating Disorders Service clinician capacity	16	⇔	Chief Operating Officer
180	Mental Health Act Changes - Clinician Workloads & Financial Impact	16	⇔	Medical Director
232	Lengthening waiting times for CAMHS Neurodevelopmental Assessment Delivery	16	⇑	Chief Operating Officer
346	Estate - Berkeley House	16	⇔	Chief Operating Officer, Director of Finance & Deputy CEO
350	The Impact of CYPS Speech & Language Therapy Wait Times	16	⇔	Chief Operating Officer
372	SARC Building and Accreditation	16	⇑	Chief Operating Officer
509	IUCS Clinical Assessment Service - patient safety risk in the CAS clinical queue	16	⇔	Chief Operating Officer
605 - New	CAMHS Neuro Capacity	16	⇔	Medical Director, Chief Operating Officer

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The Committee **received** the Business Planning Report for quarter 4 and celebrated that 99% of the high impact objectives had either been achieved or part achieved for the financial year.

The Committee **received** the Green Plan Strategy Progress Report and celebrated the over achievement in decarbonising the Trust's estate by reducing emissions from building energy use.

ITEMS RECEIVED: The following items were received and discussed at the meeting

The following Summary Reports were received:

- Business Intelligence Management Group
- Capital Management Group
- Community Mental Health Transformation
- Digital Group
- Strategic Oversight Group

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AGENDA ITEM: 22/0525

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 MAY 2025**
COMMITTEE:	**GREAT PLACE TO WORK COMMITTEE (GPTW) – 29 April 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Sumita Hutchison, Chair of Committee

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

The Committee **received** the National Workforce Policy Update and was informed that the national Digital Staff Passport programme had been discontinued. It was reported that the programme team and local leads were disappointed by this news, but would continue to ensure staff were able to move between NHS organisations with as little friction as possible, noting that the removal of support and funding would reduce deliverability. The report also outlined the national NHS Nursing Profiles refresh which would require a related internal project to be initiated from summer 2025.

The Committee was informed that the Leadership and Development Oversight Group had now been established to optimise the Trust's approach to Statutory and Mandatory, and Essential To Role training, and would report to the GPTW Committee.

The Committee **received** the Freedom to Speak Up Report and it was reported that anonymous reporting had increased to 11.5% from 3%.

It was further reported that the speaking up data for the organisation had also seen a slight decline year on year, therefore there is the risk that colleagues will not feel safe to speak up about patient safety. The Committee was informed that *we each have a voice that counts* score had slightly declined, from 7.12 in 2023 to 7.00 for 2024 in the Staff Survey. Nationally this year's results have plateaued in confidence to speak up, but conversely achieved the 2nd highest provider trust staff rating in the South West. The Freedom to Speak Up sub-score remained unchanged at 6.45 compared to 6.46 in 2023.

ADVISE: Advise of areas of ongoing monitoring or development

The Staff Survey – Deep Dive was provided and the Committee would be overseeing the development and delivery of the action plan. An in-depth discussion took place and feedback was received relating to priorities across the Trust.

The Committee **received** the Addressing Sexual Safety and Sexual Misconduct Report and agreed to receive regular future reports within the Performance Report.

The Committee discussed the management of change review with the Staff Side representative present at the meeting and **agreed** this would receive ongoing Committee monitoring.

ASSURE: Inform the Board where positive assurance has been achieved

Nothing to report.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **received** the quarter 4 risk review and **noted** the following risks for which the Committee has oversight of:

		Score
Risk 3	*Recruitment and Retention*	**12**
Risk 4	*Internal Culture*	**16**
Risk 9	*Closed Culture*	**16**
Risk 10	*Workforce Transformation*	**12**

The Committee **received** the Board Assurance Framework (BAF) and **noted** that a full review was underway and would be shared with Board members in advance of consideration at May Trust Board.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The Committee **received** the Performance Report – Workforce KPIs and the new format received positive feedback. A good discussion was held regarding the turnover and vacancy rates across the Trust, both of which were reported below 10% indicating good staff retention.

The Committee **received** the People Strategy Update Report and **noted** the assurance provided on the development of this.

A Staff Story on the Developing Aspirant Leaders (DAL) Programme was shared and the Committee congratulated Dupe Ogunfeitimi on the positive work which she had achieved.

ITEMS RECEIVED: The following items were received and discussed at the meeting

The Committee **received** and **noted** the update provided on Integrated Reporting. The following Summary Reports were **received:**

- ICS People Function
- Joint Negotiating & Consultative Forum
- Learning & Development Oversight Group
- Workforce Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 MAY 2025**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 30 APRIL 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Bilal Lala, Chair of Committee

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

Nothing to report.

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

The Committee **received** the internal audit report on Non-medical Prescribers and **noted** this was scored moderate by design and limited for design effectiveness.

The Committee **received** an update report on the Freedom of Information compliance following a recent complaint and subsequent review.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** the Internal Audit Report and Head of Internal Audit Opinion for 2024/2025. The internal auditor's opinion was that they were able to provide ***moderate assurance*** *that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.*

The Committee **noted** progress made by the Trust in implementing prior year internal audit recommendations, and the request to complete one overdue action relating to consultant job planning.

The Committee **received** three reports relating to Counter Fraud, Bribery and Corruption, which provided assurance on the overall counter fraud functions, including the proposed annual workplan for the year ahead and the draft annual report for 2024/2025.

The Committee **received** and **reviewed** the draft annual accounts and annual report for 2024/25. The report and accounts were being audited by the external auditors, KPMG, and would be presented to the Committee for sign-off in June 2025.

The Trust Compliance Report was **received**, which provided assurance that the required Trust registers were held and maintained in line with statutory requirements and good practice.

The Committee **received** the Board Committee Effectiveness Reviews, which provided a summary of the positive outcome from the Annual Board Committee evaluation process and identified areas for development.

APPROVALS: Decisions and Approvals made by the Committee

The Internal Audit Plan 2025/26 – 2027/28 was **received** and **approved.**

The Counter Fraud, Bribery and Corruption Annual Report was **received** and **approved**, subject to the attachment of a Counter Fraud Functional Standard Return (CFFSR) as required by the NHS Counter Fraud Authority (NHSCFA).

The Committee **received** the Review of the Standing Orders and **endorsed** the proposed changes for onward presentation to the Trust Board and Council of Governors respectively - for final sign off in May 2025.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **received** and **considered** the Board Assurance Framework, and **received**, **noted** and **discussed** the Corporate Risk Register, and **supported** the recommendation of the Risk Management Group to extend the current risk policy review date to 1 January 2026.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The improvement in prompt payment and reduction in debtors was recognised in the Annual Finance Compliance Report .

The Committee celebrated the progress made in closing out internal audit actions throughout the year within the target deadlines (in relation to the Internal Audit Follow Up Report).

The Committee received the Annual SIRO Report which reported that the Trust had achieved the 95% target for Data Security and Awareness training, on 10 occasions during the year.

ITEMS RECEIVED: The following items were received and discussed at the meeting

Guidance from the Internal Auditors on NHS Green Plan 2025 was **received** and would be used to inform the Trust plan.

The External Audit Progress and Technical Update Report, and the External Audit Draft Plan 2024/25 was **received** and **noted.**

Summary reports from the following management groups: Risk Management Group, Information Governance Group, BEME Management Group.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 MAY 2025**
COMMITTEE:	**QUALITY COMMITTEE – 6 MAY 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Rosi Shepherd, Chair of Committee

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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee **received** a presentation on the ADHD Assessment and Treatment Pathway which highlighted challenges in recruitment and waiting times. The Committee was informed that the System had made the recent decision to adopt the Portsmouth Neuro Profiling Approach and requested the Committee's support in doing so, noting that this was a long-term programme of work.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** and **noted** the Quality Dashboard Report, which provided a summary assurance update on the progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health, and Learning Disability services.

The Committee **received** an update on the Integrated Urgent Care Service (IUCS) Quality Arrangements, which showed evidence of strong performance and a positive impact in the System; and raised awareness of the key areas of focus with the requirement to link in to the urgent emergency care pathway.

The Committee **received** the Triangle of Care Annual Report, which provided a briefing regarding the facilitation of carer aware practice across the Trust through the implementation of the Triangle of Care. The Committee **noted** that good feedback had been received following submission to the Carers Trust and the action plan which was in place. The Quality Committee fully supported the work taking place across the Trust and recognised the huge contribution made by carers.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **received** the Risk Report for quarter 4 and **noted** there had been no changes to the risk scores presented. Assurance was received in regards to the circumstances in Sexual Assault Referral Centre (SARC) risks which were linked to work around the accreditation of the service.

The Committee **noted** that a full review of the Board Assurance Framework (BAF) was currently underway with the proposed addition for 2025/26 of a specific risk relating to strategic commissioning partnerships.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

Nothing to report.

ITEMS RECEIVED: The following items were received and discussed at the meeting

A verbal position statement was provided on the Intensive Assertive Outreach Team Position in relation to the submission to NHSE, noting that the full submission would be received by the Trust Board in May 2025.

- The Clinical Issues Report was **received** and **noted.**
- The Patient & Carer Race Equality Framework **(**PCREF) Progress Report was **received** and **noted.**
- The Quality Assurance Group (QAG) Summary Report was **received** and **noted.**
- The Quality Account 2024/25 was **received** and **noted.**