with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 31 July 2025

10:00 – 12:30

To be held in the Leckhampton Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0725	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0725	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/0725	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/0725	Minutes of the meeting held on 29th May 2025	Approve	**Paper**	Chair
	05/0725	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0725	Questions from the Public	Assurance	Verbal	Chair
10:40	07/0725	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/0725	Report from Chief Executive	Assurance	**Paper**	CEO
BREAK – 11:05 (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:15	09/0725	Finance Report	Approve	**Paper**	DoF
11:25	10/0725	Quality Report M3	Assurance	**Paper**	DoNTQ
11:45	11/0725	Quality and Performance Dashboard Report M3	Assurance	**Paper**	DoF
12:05	12/0725	Safe Staffing Update	Assurance	**Paper**	DoNTQ
GOVERNANCE					
12:15	13/0725	Modern Slavery Statement – Annual reconfirmation	Endorse	**Paper**	Dep. DoCG
12:20	14/0725	Audit & Assurance Committee Annual Report	Assurance	**Paper**	Audit Chair
TO NOTE	15/0725	Council of Governor Minutes - 14 May 2025	Information	**Paper**	Dep. DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:25	16/0725	Charitable Funds Committee (18 June)	Information	**Paper**	CF Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
	17/0725	Audit & Assurance Committee (19 June) • Provider Licence Self-Certification	Endorse	**Paper**	Audit Chair
	18/0725	Great Place to Work Committee (24 June)	Information	**Paper**	GPTW Chair
	19/0725	Resources Committee (25 June)	Information	**Paper**	Res. Chair
	20/0725	Quality Committee (8 July)	Information	**Paper**	Quality Chair
	21/0725	ATOS Committee (17 July)	Information	**Paper**	Chair
CLOSING BUSINESS					
12:30	22/0725	Any other business • Board Delegation – Public Sector Decarbonisation Scheme	Note	Verbal	Chair
	23/0725	**Dates of future Board Meetings 2025** • Thursday, 25th September • Thursday, 27th November	Note	Verbal	All

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NHS Foundation Trust

AGENDA ITEM: 04/0725

MINUTES OF THE TRUST BOARD MEETING

Thursday, 29 May 2025
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sarah Branton, Chief Operating Officer
Rosanna James, Director of Improvement & Partnership
Cathia Jenainati, Associate Non-Executive Director (via MS Teams)
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, 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
Hannah Williams, Deputy Director of Nursing, Therapies and Quality

IN ATTENDANCE:
Jodie Bennet, Deputy Professional Head of Physiotherapy
Shane Hillam, Public (online attendee)
Claire Kenny, Board Committee & Membership Officer (Minutes)
Bob Lloyd Smith, Trust Governor (online attendee)
Bren McInerney, Member of the Public (online attendee)
Louise Moss, Assistant Director of Corporate Governance
Tussie Myerson, Trust Governor
Kate Nelmes, Head of Communications
Ben Newman, Risk Manager
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary
Sonia Pearcey, FTSU Guardian
Angela Stonham, Respiratory Nurse, GHC (online attendee)
Nii Wallace-Davies, Business Development Director, IESO

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting.

1.2 Apologies were noted from Steve Alvis, Nicola Hazle and Sumita Hutchison.

2. DECLARATIONS OF INTEREST

2.1 Vicci Livingstone-Thompson declared her involvement with the Oliver McGowen training programme.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Toby to the meeting, who was accompanied by Lloyd Andrews, Physiotherapy and Health and Exercise Team Manager.

3.2 Toby shared his powerful and inspiring story about his experiences with admissions to adolescent units and working age units for his mental health, in particular his admission to Wotton Lawn Hospital from July 2022 to March 2024.

3.3 Toby shared that he had first been admitted to mental health services at 14 years old and back then he had unfortunately not found it a positive experience, however when he was admitted in July 2022 following a self-harm injury to his leg, which required extensive input and coordination of Therapy and Nursing care due to him being unable to walk, his experience with mental health services improved and became a positive one.

3.4 Toby shared how when he was first admitted he had refused treatment and care and experienced a high level of pain and discomfort. He felt reluctant to engage and felt that refusing treatment was the only thing that he had control over. Toby shared that the turning point for him, was when he met Lloyd Andrews who listened to Toby and positively engaged with him patiently and effectively. Lloyd worked with Toby to produce a physio plan together, which involved goal and achievement sheets, which made Toby feel proud of his progress and accomplishments.

3.5 Toby shared that he was now able to walk and had a greater quality of life thanks to Lloyd and his team, for which he was thankful for and appreciated Lloyd's engagement and commitment. Toby was discharged from Wotton Lawn in 2024 and shared that he was now volunteering with the Trust's mental health and learning disability teams and was looking in to becoming an Expert by Experience.

3.6 In response to Toby's story, Amjad Uppal asked if there was anything that could have been done differently to make his journey easier. Toby shared that at the start of his journey he did not have any hope, so therefore came across as defiant to staff, he shared that it was important for staff to understand this and that it was not just patients being difficult. Toby further shared, in regard to restrictive intervention and restraints, that in some cases once restraints were administered, he was often left on his own and that this made him feel angry and resentful to the staff. Hannah Williams shared that this feedback would be communicated with teams.

3.7 The Board thanked Toby for sharing his positive story and wished him good luck in his future and his career aspirations.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 27 March 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 three questions had been received in advance of the meeting.

6.2 The first question had been received from Bren McInerney and related to work being undertaken by the Trust to examine and act on identified racial pay disparity, at all levels, for staff from Black Asian and Minority Ethnic backgrounds. Neil Savage provided a written response which was included in the Board papers for the meeting.

6.3 The second question had also been received from Bren McInerney and queried what was in place, and what was being added to in order to support the wellbeing of all staff following the announcement by NHS England on the resource reductions for Trusts. Neil Savage provided a written response, which was included in the Board papers for the meeting, and Hannah Williams added the work that the Trust was undertaking regarding culture and leadership would also have a positive influence on the wellbeing of Trust colleagues.

6.4 The final question was also received from Bren McInerney, which expressed concerns for the additional pressures placed on the Trust's senior colleagues and asked what formal and informal approaches were in place to ensure that Board members were 'checked in' on and were resting, recovering, and having a holiday. Neil Savage shared his written response within the Board papers.

6.5 The Chair invited any further questions from Members of Public present at the meeting. The following question was asked by Nii Wallace-Davies. *Whilst recognising that there is great work going on in the Talking Therapies service on waiting time for access to service, the nationally published data shows that in March 71% of cases waited between 28-90 days from treatment to start with 26% waiting over 90 days. The overall trend in the last 6 months shows gradual fluctuation but largely the same. Are there any plans in place to support the services with improving those waits to treatment and is the Trust open to support from national providers of Talking Therapies to address waiting times?* An initial response was provided by the Chief Executive who confirmed that the Trust's approach was in line with the national framework and that a balance between volume and performance had been struck. A fuller response would be provided outside the meeting, noting that the Trust had not yet had the opportunity to review the data referenced in the question. **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 activities as part of the Board's commitment to public accountability and Trust values.

7.2 Graham Russell highlighted recent events he had attended and shared he had the pleasure of attending the Better Care Together Awards in April which recognised the great work of colleagues across the Trust. He had also attended, Charlton Lane Hospital on International Nurses Day, where he met with the nursing team.

7.3 The Board was informed of the newly established 'Making a Difference' awards, where Trust colleagues and service users are able to nominate individuals or teams to receive a special recognition from the Board. Graham Russell shared that he was delighted to present the award to George Moore Community Clinic District Nursing Team on 15th May and CAMHS Young Adults service on 27th May. The awards would be presented on a monthly basis, and it was noted the shortlisting had begun for June.

7.4 Nicola de Iongh suggested the nominees for the award be circulated to Board members, as well as the winners (of the Making a Difference) award for recognition. **ACTION**

7.5 Graham Russell shared that the NED annual appraisals were underway and that the outcome of the process would be shared with the Council of Governors in July. Graham Russell thanked all NED colleagues for their involvement and the passionate and impactful contributions.

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 Douglas Blair highlighted the update provided on the Corporate Cost Reduction for Provider Trusts, which was part of the nationally announced NHS efficiencies. This required provider Trusts being expected to reduce 50% of growth in corporate costs during 2025-2026.

8.3 The Board was informed that the new NHS Performance Assessment Framework was currently being consulted on following the new proposed framework being published on 12 May 2025. An update on this was included in the report.

8.4 Nicola de Iongh referred to the increase in UK Visa fees and other immigration policy changes (included in the report) and asked if there was any indication of the potential impact on international colleagues working for the Trust and if this was being built into the ongoing work ensuring that everyone who works for the Trust feels welcome. Neil Savage responded that the impact of the changes were being actively reviewed by the Executive Team and that work was underway to support colleagues who were affected by the changes to ensure that colleagues felt welcome by the Trust.

8.5 Vicci Livingstone-Thompson further asked if this would be a significant risk going forward and for further information on how many people within the Trust would be affected. Neil Savage shared that approximately 200 colleagues had visas, and HR was aware of the individuals likely to be affected, and further work would be progressed in relation to this over the upcoming months. Further updates would be provided to the Great Place to Work Committee.

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

9. TRUST STRATEGY REFRESH – ENGAGEMENT

9.1 The Board received the Our Trust Strategy Refresh 2025 report, which provided the proposed engagement approach under the 2025 strategic refresh.

9.2 Rosanna James shared that the approach would ensure engagement was sought from colleagues and service users of the Trust, and would also meet local partners and patient needs, as well as the wider communities.

9.3 Rosanna James informed the Board that a four-month engagement programme was currently taking place, and the proposed aims would be tested with Trust colleagues, ICS partners, governors, members, service users and communities. Strong clinical engagement would also be sought with professionals.

9.4 New ways of connecting with governors would be explored and support provided to enable them to link in with their constituents.

9.5 The Board was informed that drop-in sessions had been organised across the Trust's different sites, where colleagues would be invited to engage with the Improvement and Partnerships Directorate. The dates for the drop-in sessions were included in the report.

9.6 Rosanna James reported that a log was being kept of who was engaging and what feedback was received. This would be received by the Board at its next meeting in July. **ACTION**

9.7 Nicola de Iongh asked what the response had been from early engagement sessions and Rosanna James shared that the Trust values still resonated with teams and that there was strong support received for co-production.

9.8 Graham Russell asked how responses were sought from people that did not usually respond to ensure that all voices were heard. Rosanna James shared that engagement was sought through the Partnerships Team requesting representation. It was also noted that the new Working Together Network would be launched in June 2025 and that this would be co-chaired by Experts with Lived Experience.

9.9 The Board **endorsed** the engagement approach.

10. PROPOSED STRATEGIC RISKS AND RISK APPETITE STATEMENT 2025/2026

10.1 The Board received the Proposed Strategic Risks and Risk Appetite Statement 2025/2026.

10.2 Lavinia Rowsell informed the Board that the proposed risks were developed from the risk focused workshop attended by the Board and highlighted the table included in the report, which set out the proposed Strategic Risks that would form the basis of the Trust's Board Assurance Framework for 2025/2026.

10.3 The Board was informed of two new risks (Speed of Change and Strategic Commissioning Partnerships), which reflected the recent NHS policy changes and changes to NHS architecture.

10.4 Lavinia Rowsell informed the Board that the risk appetite statement and levels had been updated in the context of the new strategic risks, and highlighted the main change was in relation to 'cyber' which had moved from low to moderate. The Board was informed that progress continued to be made in protecting the Trust from Cyber-attacks, however the external environment meant that the threat continued to evolve and that this was likely to remain indefinitely, and therefore the likelihood of the risk would remain high. It was noted that once the new Trust Strategy was in place, the risk appetite would be re-visited.

10.5 The Board was informed that the next stage would involve working closely with the executive team to ensure the involvement with the Board Assurance Framework (BAF) and Committee work plans.

10.6 Cathia Jenainati referred to the increased risk relating to cyber and suggested considering conversations to enhance cyber security with the universities etc.

10.7 The Board:

- **Agreed** the proposed Strategic Risks that would form the basis of the Board Assurance Framework for 2025/2026
- **Approved** the risk appetite statement for 2025/2026
- **Noted** that the full BAF would be developed with Executive owners in the coming weeks

11. FREEDOM TO SPEAK UP 6 MONTHLY REPORT

11.1 Sonia Pearcey joined the meeting and presented the Freedom to Speak Up 6 Monthly Report, which provided an update on the Freedom to Speak Up service for 2024/25.

11.2 Sonia Pearcey informed the Board that there had been an increase in anonymous reporting in 2024/25, with an increase from 3% to 11.5%. The reasons for this were being explored and it was noted that it could be indictive of a core speaking up culture. It was further reported that the questions in the Staff Survey relating to Speaking Up had also seen a slight decline for the year 2024/25.

11.3 Nicola de Iongh confirmed that the increase in anonymous reporting was also discussed at the GPTW Committee, where similar questions had been raised regarding the figures.

11.4 The report included how the Trust benchmarked against other Trusts in relation to the four FTSU questions in the Staff Survey. Rosi Shepherd supported the inclusion of the benchmarking data and asked if the Trust had linked up with the Trust's mentioned to share learning and best practice. Sonia Pearcey confirmed that this was the case, and meetings had been arranged to meet with those Trust's that had performed well against the FTSU questions.

11.5 Rosi Shepherd further enquired how the data in the report triangulated with the quality and performance metrics. Douglas Blair reported that work was underway to develop an Executive Heatmap that would bring together key metrics and soft intelligence which would support triangulation.

11.6 Sandra Betney requested further information on the breakdown within the 'corporate' category given the diversity of teams within that directorate. **ACTION**

11.7 Sonia Pearcey noted that Trust colleagues did have access to an anonymous reporting app, which not all trusts had, which would also contribute to the increase in the number of anonymous reporting.

11.8 Graham Russell referred to the question in the staff survey; *Q20b - I am confident that my organisation would address my concern;* which indicated that over 30% of Trust colleagues would not feel confident and asked how this could be addressed. Sonia Pearcey shared that sessions were being held with services to try to understand this better and that this would also be progressed via the Leadership and Culture work.

11.9 The issue of 'futility' was discussed in this context. Cathia Jenainati suggested more research be done into what people expect as a resolution to concerns raised, as the resolution may not always be as wanted and referred to a trial carried out by Oxford where people's expectations were re-shaped. Sandra Betney suggested that more could be done to share anonymized past examples of speaking up to demonstrate where resolution has been achieved.

11.10 The Board **received, reviewed** and **noted** the information and assurance provided in relation to Freedom to Speak Up activity during 2024/25, noting that this had also been received and fully considered by the GPTW Committee at its meeting in April 2025.

12. INTENSIVE AND ASSERTIVE COMMUNITY TREATMENT ACTION PLAN UPDATE

12.1 The Board received the Intensive and Assertive Community Treatment Action Plan, which provided an update 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.

12.2 The Board was informed that the final action plan would be submitted to NHSE by the end of June 2025, following feedback from the Trust Board and the ICB Board.

12.3 It was noted that the action plan was received and discussed by the ICB Board the previous day.

12.4 The principle was that DNAs (did not attends) were never used exclusively as a reason to discharge a patient from care in the case of the vulnerable patient group. This was per national guidance and required the Trust and the ICB to check existing policies and practice and confirm with NHSE regional mental health colleagues.

12.5 A comprehensive action plan had been produced which identified areas for improvement, with the main aim to develop a Flexible Assertive Community Team approach with the ability to reach services. It was noted that the action plan implementation was subject to the necessary investment in GHC frontline services managed via the agreed business planning process.

12.6 The Board **noted** the update provided and **endorsed** the submission of the action plan to NHSE by the end of June 2025.

13. FINANCE REPORT

13.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 1.

13.2 Sandra Betney informed the Board that there were no material amendments to the position reported to the Resources Committee in April 2025 and that the year-end position was a surplus of £0.13m.

13.3 The Board was informed that the draft accounts had been submitted and were being audited by External Auditors KPMG. The audited accounts were due to be submitted 30th June 2025.

13.4 Sandra Betney reported that at month 1, the Trust had a small surplus of £0.002m, compared to a plan of £0.073m deficit. This was as expected.

13.5 A challenging capital plan was noted by the Board with the 2025/26 capital plan being £15.449m with £3.265m of disposals. It was reported the spend at month 1 was £0.210m against the budget of £0.548m.

13.6 The Trust's agency and off framework agency usage was included in the report, and it was noted that there were 25 off framework shifts in month 1 against a target of 0.

13.7 Sandra Betney highlighted the 2025/26 potential risks which were scored above 9 in the report and it was noted that two of these related to the Cost Improvement Programme (CIP).

13.8 A breakdown of CIP was included in the report, and it was noted that the CIP Management Group had reviewed and discussed the CIP delivery for the Trust.

13.9 The positive cash position at end of month 1 of £45.025m, £3.3m above plan was noted. In response to a question from the Chair, Sandra Betney confirmed that there would be limited opportunity to generate further cash due to current system financial arrangements.

13.10 The Board **noted** the month 1 position.

14. QUALITY DASHBOARD REPORT

14.1 The Board received the Quality Dashboard, which showed the data for April 2025 and provided a summary assurance update on the progress and achievement of

quality priorities and indicators across Trust's Physical Health, Mental Health, and Learning Disability services.

14.2 The Board noted the inclusion of the quarter 4 Learning from Deaths report, the quarter 4 Guardian of safe Working report and the Non-Executive Director (NED) Audit of Complaints.

14.3 The Board noted that 89% of Trust services were now compliant with safeguarding training and that Hannah Williams, Deputy Director Nursing, Therapies and Quality had asked teams to identify specific support required and whether this poses as a risk.

14.4 In regard to the Learning from Deaths report, it was reported that the Medical Examiner had shared that there were no concerns identified in the care record reviews and that none of the reviews had identified problems in the care provided to patients.

14.5 Hannah Williams reported there had been a further reduction in restrictive interventions in April and Toby's message during the Service User Story would be shared with the Learning and Support team. **ACTION.**

14.6 Hannah Williams informed the Board that at its next meeting the Board would receive an update on the progress of the application to remove the section 31 restriction on Berkeley House. **ACTION**

14.7 Hannah Williams referred to the complaints received and shared that the majority related to the care and treatment in the Integrated Urgent Care Service and reported that although the number of complaints seemed large, the conversion rate was small for the service with less than 1 in 1000 as the service was large. It was noted that this was below the national average. Assurance was provided that the process by which complaints could be collectively resolved was being reviewed and work was progressing on this.

14.8 Rosi Shepherd referred to the Sexual Safety data and narrative included in the report and asked for consideration to be given to the language used and also how it was determined that behaviour was deemed *affectionate*. Hannah Williams shared that the language used was as per the reporter's definition of harm and shared that the mechanics of this would be further reviewed.

14.9 Rosi Shepherd referred to the information included regarding missed visits and requested further information as to the consequence for patients, and also further benchmarking data. **ACTION.**

14.10 It was noted that work was ongoing to review the Quality Dashboard to develop the presentation and improve triangulation.

14.11 The Board **received, noted** and **discussed** the Quality Dashboard report.

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 April 2025.

15.2 Sandra Betney highlighted the measures in the 'alert' category of the report which would be followed up by the Resources Committee at its June meeting.

15.3 Sandra Betney highlighted the areas showing high performance in the 'applaud' category of the report for positive recognition.

15.4 The Board was informed that where there were performance issues, these would be worked through with Nursing, Therapies and Quality (NTQ) colleagues to review the linkage with quality and risk.

15.5 Sarah Branton reported that the IUCS performance was improving and that work was underway to further understand the flow, and work with partners was progressing to further improve the service.

15.6 Bilal Lala referred to indicator *O07- Musculoskeletal (MSK) Physiotherapy urgent two-week referral to treatment (RTT)* and asked if the issues could have been foreseen. Sarah Branton shared that the forecasted recovery was August 2025 and agreed to check the number of patients/ appointments affected. **ACTION.**

15.7 The Board **noted** the Quality and Performance Dashboard Report for April 2025/26 as a significant level of assurance that the Trust's performance measures were being met or, **accepted** that appropriate service improvement action plans were being developed or were in place to address areas requiring improvement and were being managed through operational governance mechanisms.

16. SIRO ANNUAL REPORT 2024/25

16.1 The Board received the SIRO Annual Report, which provided assurance on the effectiveness of controls for Information Governance, data protection and confidentiality and to also document the Trust's compliance with legislative and regulatory requirements.

16.2 Sandra Betney shared that the Trust was able to achieve a DSPT submission (self-assessment) of 'exceeded standards' for the 2023/24 year and was on target to meet standards for 24/25.

16.3 It was reported that there had been no incidents in the year, but two complaints were received. The ICO accepted the Trust's responses to these, and no further actions were taken.

16.4 It was **noted** that the Trust was consistently achieving the 95% target for Data Security and Awareness training, and this had been achieved on ten occasions in year.

16.5 The Board was **assured** that the Trust has effective systems and processes in place to maintain the security of information; and **endorsed** the report.

17. STANDING ORDERS REVIEW

17.1 The Board received the Standing Orders Review for 2025, which provided 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.

17.2 On the recommendation of the Audit and Assurance Committee, the Board **noted** that a review of the Standing Orders was carried out, and **endorsed** the proposed changes. It was further noted that the Standing Orders for the Council of Governors were reviewed and supported by the Council at its meeting in May.

18. USE OF THE TRUST SEAL 2024/25

18.1 The Board received the update on the Use of the Trust Seal 2024/25, which provided information on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

18.2 The Board **noted** the use of the Trust seal for the reporting period 1st April 2024 – 31st March 2025.

19. COUNCIL OF GOVERNOR MINUTES - 19 MARCH 2025

19.1 The Board **received** and **noted** the minutes of the Council Governor meeting held 19th March 2025.

20. BOARD COMMITTEE SUMMARY REPORTS

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

- Mental Health Legislation Scrutiny Committee (8 April)
- Resources Committee (24 April) and noted the achievements made in the Trust's Green Plan in decarbonising the Trust's estate by reducing emissions from building energy use.
- Great Place to Work Committee (29 April)
- Audit & Assurance Committee (30 April) and noted the internal audit report on Non-medical Prescribers was received and scored moderate by design and limited for design effectiveness
- Quality Committee (6 May)
- Charitable Funds Committee (12 March)

21. ANY OTHER BUSINESS

21.1 There was no other business.

22. DATE OF NEXT MEETING

22.1 The next meeting would take place on **Thursday, 31 July 2025**.

Annex 1

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 well-being 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

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AGENDA ITEM: 05/0725

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 31 July 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
29 May 2025	6.5	A fuller response to be provided outside the meeting, to the question asked by Nii Wallace-Davies.	Douglas Blair	July 2025	Full response provided.	**Complete**
29 May 2025	7.4	Nominees for the 'Making a Difference' award be circulated to Board members, as well as the winners for recognition.	Communications Team	July 2025	Action noted and information will be shared with all Board members accordingly.	**Complete**
29 May 2025	9.6	Rosanna James reported that a log was being kept of who was engaging and what feedback was received (for the Trust Strategy Refresh). This would be received by the Board at its next meeting in July.	Rosanna James	July 2025	This was presented at the Board and Governor development session on 9 July. The Board will be updated on progress at the next Board Development session scheduled 21st August.	**Complete**
29 May 2025	11.6	Sandra Betney requested further information on the breakdown within the 'corporate' category (within the Freedom to Speak Up Report) given the diversity of teams within that directorate.	Sonia Pearcey	Nov 2025	To be included in next 6 monthly update report to Board – due Nov 2025.	**On Track**
29 May 2025	14.5	Toby's message regarding restrictive practice during the Service User Story would be shared with the Learning and Support team.	Hannah Williams	July 2025	Shared with Learning and Development as requested.	**Complete**

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
29 May 2025	14.6	An update on the progress of the application to remove the section 31 restriction on Berkeley House to be received at the next Board meeting.	Hannah Williams / Nicola Hazle	July 2025	An update on the application to remove the section 31 restriction on Berkeley House will be provided in the Clinical Issues report to private Board.	**Complete**
29 May 2025	14.9	Further information as to the consequence for patients, and also further benchmarking data in relation to missed visits to be included in the next report to Board.	Hannah Williams / Nicola Hazle	July 2025	The community nursing slides continue to evolve, when validated national benchmarking data is available this will also be included in the slides.	**Complete**
29 May 2025	15.6	Sarah Branton shared that the forecast recovery for indicator *O07- Musculoskeletal (MSK) Physiotherapy urgent two-week referral to treatment (RTT)* was August 2025 and agreed to check the number of patients/ appointments affected	Sarah Branton	July 2025	Full response provided and available in Reading Room for Board members. Verbal update to be provided at the July Board meeting as part of the Performance Report.	**Complete**

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 July 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 Trust 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 – May and June 2025

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

REPORT FROM THE CHAIR

1. 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. 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 7th June marked the first anniversary of the opening of **Forest of Dean Community Hospital** and to mark the occasion, Matron, Kate Harper and I met with the wider team and reflected on the past twelve months. Along with tea and cake, thank you cards were handed out to acknowledge the teams and to recognise their hard work.

- Along with the Chief Executive, I recently attended the **NHS Confederation Expo** in Manchester. The conference was an opportunity to hear from a range of national speakers and to share good practice.

- To mark the **150th Anniversary** of **Stroud General Hospital**, I was thrilled to be invited to a celebratory service on 6th July at the nearby Holy Trinity Church. The service was well attended by hospital colleagues, the League of Friends, Simon Opher MP, and Bishop Rachel Treweek. Stroud General Hospital colleagues and Stroud League of Friends are holding a series of events over the anniversary year to celebrate the history behind the 150 years of the Hospital.

- Along with the Chief Executive and Director of Improvement and Partnerships, I attended the County Council's **Health Overview & Scrutiny Committee** on 15th July. The meeting primarily focussed on NHS Gloucestershire Integrated Care System and NHS Gloucestershire Integrated Care Board.

- To highlight some of the amazing work carried out by our Estates and Facilities colleagues, it was a pleasure to participate in the **National Healthcare Estates and Facilities Day** on 18th June where I met with colleagues at Rikenel and helped serve refreshments to patients and met with colleagues at Stroud General Hospital. The day recognises the role of the Estates and Facilities workforce and is a day to invite all to reflect on the work undertaken by these professions and the value this gives to patients and colleagues. I was really impressed with the energy and enthusiasm shown by colleagues to maintain really high standards.

- I visited **Coln Ward** at Cirencester Hospital on 2nd July where I joined in Wimbledon tennis themed activities. I spent time with Alex Shingler, Ward Assistant and Karen Fawcett, Ward Manager.

- A meeting of the **Appointments and Terms of Service Committee** took place on 17th July. At the meeting, amongst other items, members discussed Executive Director and Chief Executive performance and remuneration.

- Along with the Chief Executive, I attended the **Friends and Family Garden Party** on 4th July at the Montpellier Unit, Wotton Lawn Hospital. It was a lovely afternoon, and the sun shone.

- The **Chair of 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 to discuss matters of mutual interest.

- On 9th July, I was delighted to join colleagues at **Mary Hutton's career celebration**. Mary retires as Chief Executive of NHS Gloucestershire Integrated Care Board after 14 years in Gloucestershire.

- The Chief Executive and I welcomed recently elected **Councillor Lisa Spivey**, **Leader** and recently appointed **Jo Walker, Chief Executive** of **Gloucestershire County Council** to Trust Headquarters on 10th July where we discussed matters of mutual interest.

- I recently met with Kari Gerstheimer, Chief Executive and Founder of **Access Social Care**. Access Social Care provides free legal advice to people with social care needs, helping to achieve a better quality of live. It was great to meet with Kari and hear about future plans.

- On 18th July, I was delighted to attend **The Rt Revd Rachel Treweek, The Bishop of Gloucester** Garden Party. The gathering was an opportunity to network with a range of individuals.

- **Tewkesbury MP, Cameron Thomas** recently visited Tewkesbury Community Hospital where Matron, Julie Ellery and I gave a guided tour. During his visit, Cameron met hospital colleagues, healthcare professionals, patients on Abbeyview Ward and the short-stay Community Assessment and Treatment Unit (CATU). He also visited the Minor Illness and Injuries Unit and Theatre to find out more about how the hospital operates and the services provided.

Always improving

- Although unable to attend for the whole event, I joined colleagues at the **Community Mental Health Transformation Celebration and Vision Day** on 4th June. The event highlighted the outstanding work achieved within the Community Mental Health Directorate as part of the Trust transformation programme and beyond.

- The **Working Together Network** was officially launched on 25 June 2025 in our Trust, following several months of collaborative engagement and co-design approach to work together with people and communities. The hybrid launch event brought together over 40 participants, including our GHC Colleagues, Experts by Experience and representatives from our Gloucestershire partner organisations.

  The session focused on sharing the journey so far and the approach we will be taking to working together, followed by time for relationship building, establishing inclusive and equitable partnership working principles, and setting a shared vision for future collaboration. Co-chaired by Jacky Martel, Marta Hall, Experts by Experience and Rosanna James, Director of Improvement and Partnership.

  The event marked a significant step toward embedding co-production, support to address health inequalities, and ensuring community voices are central in shaping our services. Time was also spent exploring our strategy refresher session, gathering initial feedback on our direction of travel. There was a clear recognition that further engagement is needed to strengthen this work and ensure this is aligned with the NHS 10-year plan priorities and ambitions.

  We are looking forward to hosting further Working Together Network meetings and developing a more localised approach where we will continue to be listening and gathering insights from people and communities, partners to inform, transform and shape our services and create better experiences for people together.

- I was delighted to join colleagues to celebrate the permanent funding of the **Community Neurology Service** which was initially set up in November 2023 as a 12-month pilot project providing rehabilitation across the county for people living with neurological conditions. Permanent funding is a really positive outcome for the people of Gloucestershire.

Respectful and kind

- I had the pleasure of joining colleagues and allies at the face-to-face **GHC Rainbow Network Meeting** which took place on 4th June. Although unable to attend for the whole meeting, it was great to meet with colleagues and allies who, in a safe space, were able to share, learn and support each other.

Making a difference

- In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, I was delighted to visit **Mulberry Ward** at Charlton Lane Hospital on 17th June and **Cotswold View Ward** at North Cotswold Hospital on 24th June 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. I look forward to visiting more services over the coming months in order to acknowledge 'Making a Difference' across the trust.

North Cotswold Hospital

Charlton Lane Hospital

- I had the pleasure of supporting and participating in the **Big Health and Wellbeing Day** on 13th June at Oxstalls Sports Park. This annual event features accessible activities designed to help people with a disability, a mental health condition, hearing or sensory loss to stay active and healthy. My sincere thanks to Dominika Lipska-Rosecka, Big Health Day Event Lead Co-Ordinator from the Partnership Team for all of her hard work and dedication in making the Big Health Day such a spectacular and inclusive event.

3. BOARD UPDATES

- **NHS FIT AND PROPER PERSON COMPLIANCE**

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 place a duty on all NHS providers not to appoint an individual as a Director, or performing the "functions of, or functions equivalent or similar to the functions of a director", or allow a person to continue in the role, if they do not meet, or cease to meet, the requirements as set out in the Regulations in relation to the **Fit and Proper Person Test**. A new Fit and Proper Person Test framework was published by NHS England in August 2023.

The Trust is responsible for ensuring that relevant individuals continue to meet the Fit and Proper Person Test. This is done through an annual review which is aligned with appraisal dates to ensure that outcomes are available for reference at individual appraisals.

Documentation includes:

- Completion of a self-attestation form by the individual (includes the 'Unfit Person test' and considerations relating to 'Good Character', DBS Check compliance, and professional registration compliance)

- Annual checks against the disqualified directors register, the bankruptcy and insolvency register, the removed charity trustees register and relevant professional register.

The Board is asked to **note** that I reviewed and signed the Annual Submission Form to confirm that the annual checks have been completed and that our Board continues to meet the Fit and Proper Person Test. This completed submission form was submitted to NHS England on 30th June 2025.

- We have commissioned a **developmental review of our current Board committee arrangements** to ensure that they are fit for the future. The review will consider and set out recommendations for improvement/development in relation to the current governance structure, meeting mechanics, and meeting dynamics and development. The review will commence in August and include observations of the forthcoming round of governance committees. The outcome will feed into our ongoing board development programme.

- At the start of the year, the Board agreed the following priorities for its 2024/2025 **board development programme**: Refreshing our Strategy, The Board's role in Leadership and Culture and being a Well Led Board in Action (Good to Outstanding).

- On 17th June, a **Board Development session** took place where the topic for discussion was the Trust Strategy refresh. The session was led by Rosanna James, Director of Improvement and Partnership. During the session Rosanna provided feedback following recent engagement events and steps for moving forward.

- A **strategic Board away day** took place on 30th June and 1st July. The purpose of this session was to consider the development of the Trust's strategy in the context of changes in national policy. This was followed on the 9 July 2025 by a joint Board/Council of Governors session where we considered the Trust Strategy in the context of the recently published 10-year plan. We are in the process of reviewing the outputs from these and other engagement sessions in advance of the Board signing off the Trust Strategy and its meeting in September 2025.

- I joined the **NHS Providers Non-Executive Directors Network** on 23rd July which was an opportunity to connect with peers from across the country. We reflected on recent sector developments, engaged with senior leaders and shared insights and learning.

- 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. 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.

- The Trust commenced its nomination process for **Staff Governor**: Medical, Dental & Nursing (reserved for qualified nurse), and **Public Governors**: Stroud and Cotswolds and following recent elections, I am very pleased to welcome Caroline Goldstein representing Medical, Dental & Nursing colleagues, David Hindle, Public Governor for Cotswolds and Mick Gibbons Public Governor for Stroud who has been re-elected for a second term. Caroline and David joined us on 1st July and by way of an introduction, I look forward to meeting with them shortly. I would like to thank **Jenny Hincks**, **Public Governor** representing the Cotswolds who has come to the end of her final term. Jenny has been on the Council for 6 years and we would like to thank her for her support and contribution to the Council during that time.

- On 9th July we held our in-person joint **Board and Council of Governors meeting** where part of the meeting was dedicated to an update on the 10-year plan and the Trust Strategy refresh.

- Our **programme of visits to sites for Trust Governors** continues to progress with visits taking place at North Cotswold Hospital on 24th June, Tewkesbury Community Hospital on 27th June and Charlton Lane Hospital on 29th July. 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. 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 May and June 2025.

6. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity 1st May – 30 June 2025

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• Appraisal with Trust Chair • Catch Up Meeting with Vicci Livingstone-Thompson • Mental Health Act Managers' Forum • Community Neurology Service Celebration • Non-Executive Directors Meeting	Quality Committee Board Seminar: Sustainability and Strategy Refresh Progress Update Board Development: Trust Strategy Board Strategic Away Day
Sumita Hutchison	• GHC Diversity Network • Quarterly Staff Governor meeting with Non-Executive Directors • Council of Governors Meeting • Non-Executive Directors Meeting • Appraisal with Trust Chair • HFMA Webinar: Governance and Financial Accountability • Great Place to Work Committee Agenda Setting Meeting • HFMA Webinar: Driving value and efficiency: utilising patient level costing data (PLICs) • HFMA Webinar: Building effective partnerships: the NED and executive team dynamic • Catch Up Meeting with Director of HR & OD • Private Meeting with Internal & External Auditors • Great Place to Work Committee Assurance Report • Non-Executive Directors Meeting • Catch Up Meeting with Rosi Shepherd • HFMA Webinar: Navigating financial recovery in the NHS: understanding cost improvement plans (CIPs)	Board Seminar: Sustainability and Strategy Refresh Progress Update Board Briefing Board Development: Trust Strategy Audit & Assurance Committee Great Place to Work Committee Leadership & Culture Assurance Committee
Nicola de longh	• Appraisal with Trust Chair • Aspiring Chairs Meeting	Nomination and Remuneration Committee Board Seminar: Sustainability and Strategy Refresh Progress Update

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Board Long-Term Strategy/Vision Session • Disruptive Collective Pathway Group Meeting • Non-Executive Directors Meeting	Trust Board Public Trust Board Private Board Briefing Board Development: Trust Strategy Resources Committee Board Strategic Away Day
Vicci Livingstone-Thompson	Council of Governors Meeting • Sustainability Seminar Prep Meeting with Director of HR & OD and Sumita Hutchison • Quarterly Staff Governor meeting with Non-Executive Directors • NED Role Discussion and Catch Up Meeting with Director of Corporate Governance and Trust Secretary • Non-Executive Directors Meeting • Prep Meeting Ahead of AAC Panel • AAC Panel • Private Meeting with Internal and External Auditors • GHC Working Together Network Launch • Meeting with Lead Governor • Big Health Day • Community Neurology Service Celebration • Non-Executive Directors Meeting	Board Seminar: Sustainability and Strategy Refresh Progress Update Trust Board Public Trust Board Private Board Briefing Audit & Assurance Committee Board Strategic Away Day
Bilal Lala	• Meeting with Deputy Director of Nursing and Quality • Briefing Meeting for NHS Gloucestershire Audit Committee Members • Meeting with Internal Auditor • Introduction meeting with Risk Manager • Board Seminar Prep Meeting with Director of Corporate Governance • Quarterly Staff Governor Meeting with Non-Executive Directors • Meeting with Locality Inclusion Lead and Locality Governor	Quality Committee Trust Board Public Trust Board Private Board Briefing Charitable Funds Committee Audit & Assurance Committee Board Development: Trust Strategy Board Strategic Away Day

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Non-Executive Directors Meeting • Meeting with Director of Nursing, Therapies and Quality • Meeting with Counter Fraud Lead • Appraisal with Trust Chair • Audit & Assurance Committee Catch up with Director of Corporate Governance • NHS Gloucestershire Audit Committee Part 1 and 2 • Private meeting with Internal and Externa Auditors • Audit & Assurance Report meeting • Audit & Assurance and Resources Committee Chair Catch Up • Non-Executive Directors Meeting • Community Neurology Service Celebration • 1:1 with Medical Director	
Jason Makepeace	• NHS Gloucestershire System Resources Committee • Governor Visit to Stroud General Hospital • Catch Up Meeting with Trust Chair • Catch Up Meeting with Joanna Coast, Gloucester ICB Resources Committee Chair • Appraisal with Trust Chair • Quarterly Staff Governor Meeting with Non-Executive Directors • Council of Governors Meeting • Meeting with Lead Governor • Resources Committee Performance Dashboard Meeting • Non-Executive Directors Meeting • Data Commons in Gloucestershire Meeting • Catch Up Meeting with Director of Improvement and Partnership • AAC Panel Briefing with Medical Director • AAC Consultant Panel Interviews • Catch Up with Staff Governor	Board Seminar: Sustainability and Strategy Refresh Progress Update Trust Board Public Trust Board Private Board Briefing Charitable Funds Committee Board Development: Trust Strategy Audit & Assurance Committee Board Resources Committee Board Strategic Away Day

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Resources Committee Agenda Setting Meeting • AsapGlos Website discussion • NHS Providers NHS Quality for NEDs Training • NHS Confederation Expedition • Big Health Day • Meeting with Chief Executive • Board Long-Term Strategy/Vision Session • Private Meeting with Internal and External Auditors • Catch Up Meeting with Jaimie Roylance • Audit & Assurance and Resources Committee Chairs Meeting • Access Social Care Community Expansion Event • Catch Up Meeting with Sumita Hutchison • Community Neurology Service Celebration • Non-Executive Directors Meeting • Catch Up meeting with Dominic Hardisty	
Rosi Shepherd	• Catch Up Meeting with Sumita Hutchison • Community Engagement Event Marking Windrush Day • GHC Diversity Network • Governor Visit to Tewkesbury Hospital • IUCS Meeting with IUCS Programme Director • NHS Gloucestershire System Quality Committee • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Objective Setting Meeting with Trust Chair • Quality Committee Agenda Planning Meeting • Quality Committee Pre-Meeting with Director of Nursing, Therapies and Quality • Quarterly Staff Governor Meeting	Board Briefing Board Seminar: Sustainability and Strategy Refresh Progress Update Board Strategic Away Day Leadership & Culture Assurance Committee Quality Committee Trust Board Private Trust Board Public

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AGENDA ITEM: 08/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 July 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 June & July, I have completed the following visits:

- **Community Mental Health Transformation Reflection and Vision Away Day – 4 June**
  I was pleased to be able to spend some time at the Community Mental Health Transformation Reflection and Vision Day at Churchdown Community Centre. The event highlighted the progress made in the last few years on community mental health services, but also the challenges ahead and work we need to continue to really embed the new ways of working and help more people.

- **GHC Rainbow Network – 4 June**
  On 4 June, I was also able to spend some time with our Rainbow Network. It was good to see colleagues there meeting face to face, focusing on helping to make our Trust a great place to work.

- **National Estates & Facilities Day – 18 June**
  I spent the morning of 18 June at Cirencester Hospital on a visit to mark National Estates and Facilities Day. Following a tea round on Windrush Ward, I helped out with some decorating to show my appreciation for all Estates and Facilities colleagues across the Trust.

- **GHC Race and Culture Awareness Network Celebrating Windrush - 19 June**
  On 19 June, we marked Windrush Day with some celebrations to recognise the contribution of the Windrush generation.

- **Montpellier Unit - Friends and Family Event - 4 July**
  On 4 July, I attended a Garden Party for the Friends and Family Event at Montpellier Unit (in Gloucester). This was an opportunity for the friends and family of patients to spend time with them and is one of various events hosted at Montpellier Unit throughout the year.

- **Councillor Iain Dobie visit to Wotton Lawn Hospital, Gloucester – 14 July**
  On 14 July, I met with Councillor Iain Dobie, the Chair of the Health and Overview Scrutiny Committee, for a visit to Wotton Lawn Hospital. Councillor Dobie was given a tour of the facilities, and we discussed the services provided there and gave an introduction to our Trust.

2.0 SYSTEM UPDATES

2.1 Gloucestershire County Council Proposals relating to Adult Social Care Operating Model and Delegated Functions

On 14 July, Gloucestershire County Council published a Cabinet paper outlining proposals relating to a move towards a new operating model for adult social care in the county and, as part of this, some proposals to change the approach to some functions which are currently delegated by the County Council to Gloucestershire Health and Care. The Cabinet paper contained proposals to end the delegation of some of these functions and transfer responsibility for delivery back to the County Council itself. The functions in scope are mental health social work, social care occupational therapy and reablement services. The decision to proceed was publicised in a media release on the 23rd July. We will work with partners to mitigate avoidable disruption and impact for colleagues and Gloucestershire people during transition.

2.2 Approach to neighbourhood health in Gloucestershire

In advance of the publication of the 10 Year Plan, I co-presented to an Integrated Care Board Development session on 18 June with Emma Crutchlow, GP member of the ICB Board and one of the leaders of the newly established Gloucestershire GP Collaborative, taking stock of the approach to neighbourhood working in Gloucestershire. We emphasised the importance of taking a partnership approach to ongoing developments, building on existing examples and achieving an appropriate balance between local initiative and consistency of approach over broader geographies. Given the strong focus on neighbourhood health in the 10 Year Plan, we continue to work in close partnership with colleagues in the GP collaborative, social care, Gloucestershire Hospitals NHS Foundation Trust and the voluntary sector to make progress on the approach to neighbourhood health in Gloucestershire.

2.3 Integrated Care Board Clustering

Confirmation has been received that the proposed clustering of Gloucestershire Integrated Care Board (ICB) with Bristol, North Somerset and South Gloucestershire ICB has been approved by NHS England. The next immediate step is for a single Chair and Chief Executive to be appointed for the new cluster as the two organisations plan further on combining functions.

3.0 NATIONAL / REGIONAL UPDATES

3.1 Publication of 10 Year Plan

The launch of the 10 Year Plan took place on Thursday 3 July with some key highlights that will impact on our Trust and our services. More detail will be provided in the coming weeks and months on how the changes will be delivered, particularly the emphasis placed on moving to a ‘Neighbourhood Health Service’.

The key messages communicated so far centre around the three shifts:

- **From hospital to community**; transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home.

- **From analogue to digital;** creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide.

- **From sickness to prevention;** shifting to preventative healthcare by making healthy choices easier—banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families.

There are a wide range of proposals and the plan is long term in its focus. On 10 July, I attended an NHS Leadership Event which focussed on the 10 Year Plan and involved colleagues regionally and nationally. Further work on the detail of initial priorities will be worked through over the Summer, with the intention being to clarify the approach and priorities for implementation in September 2025.

3.2 NHS Oversight Framework

The final version of the revised NHS Oversight Framework was published by NHS England on 26 June 2025. In line with the proposed framework that was consulted on, the framework includes a reduced set of indicators and following five 'segments' which indicate relative performance:

Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or, The organisation is a challenged provider where NHS England has identified significant concerns.

It is expected that the segmentation will be accompanied by publicly available league tables also. The first full quarter of information (Q1) will be available by September 2025.

4.0 EVENTS

4.1 Gloucestershire's Volunteer Awards 2025 – 5 June

On 5 June I attended the Gloucestershire's Volunteer Awards evening. This was the second year of the awards, and it was good to attend, support and hear of the fantastic contribution of volunteers across Gloucestershire in multiple different ways.

4.2 NHS ConfedExpo 2025 – 11 & 12 June

I spent a couple of days in Manchester for the national NHS Confederation event which took place on 11 & 12 June. The latest thinking around the NHS from the Department of Health and Social Care, NHS England and other Trusts was shared and it was a good opportunity to share ideas, input views and also get a sense of what formed part of the NHS 10 Year Plan which has since been released.

4.3 Big Health Day – 13 June

On 13 June, I attended the Big Health Day which is an inclusive event which encourages individuals with disabilities, sensory loss or mental health support needs to participate in sport, physical exercise and social activities and to engage with services and organisations which can provide support. This was the 17th year that this event has been held.

4.4 Anti-racist Leadership Practice in Action – 2 July

On 2 July, I attended a conference at Kingsholm Stadium in Gloucester to talk about anti-racist leadership. This was for organisations across the integrated care system, and GHC was well represented by people in a wide range of roles. This ties in well with some of the focus of our Leadership and Culture programme.

5.0 ACHIEVEMENTS / AWARDS

5.1 Apprenticeships

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

• Martyn Price	Level 7 Systems Thinking Practitioner	Pass
• Bilal Odhiambo	Level 3 Business Administrator	Pass
• Michelle Bevan	Level 6 Chartered Manager	Distinction
• Hannah Darby	Level 5 Operational/Departmental Manager	Distinction

5.2 Veteran Aware Trust – one-year review approved

I am pleased to report that we received a letter of congratulations confirming the approval of our Trust's VCHA (Veterans Covenant Healthcare Alliance) 1 Year Review, demonstrating our Trust's ongoing work to continue to be a 'Veteran Aware' organisation. The VCHA team will remain in contact with and encourage our Trust to continue our efforts to improve services for our Armed Forces Community. Our Trust will undertake a 3-year reaccreditation due in May 2027.

5.3 Pulmonary Rehabilitation Service achieves PRSAS accreditation

A huge congratulations to our Pulmonary Rehabilitation (PR) Service on achieving the Royal College of Physicians Pulmonary Rehabilitation Services Accreditation.

This national accreditation provides independent and impartial recognition that the service demonstrates high levels of quality against established standards. Accreditation is recommended in the NHS England commissioning standards and supported by the Care Quality Commission.

The Pulmonary Rehabilitation team has worked relentlessly for over a year, reviewing and updating processes and working through a programme of service and quality improvements. The final hurdle was an on-site visit from the PR Services Accreditation Scheme (SAS) assessors when, after a presentation, the assessors visited PR classes where they talked to patients.

5.4 Complex Emotional Needs Service takes top spot at national conference

Our Complex Emotional Needs Service won the poster presentation at the British and Irish Group for the Study of Personality Disorder (BIGSPD) in early June.

The presentation, one of 42 entries, offered an evaluation of the Frequent Engagement Response Network (FERN), which aims to improve the response for people in acute mental health crises who are at high risk of self-injury or suicide.

FERN is unique in the UK, and involves co-production of individual, trauma-informed, easy to access and psychologically informed response plans which detail what a person might need at times of distress. The evaluation over 18 months shows reduced levels of arrest, restriction or detention under the Mental Health Act, and greater engagement with services.

The project is being led by Assistant Psychologist Tegan Elliott-Todd and Clinical Psychologist Dr Laura Price, who also created the winning presentation.

6.0 CONCLUSION AND RECOMMENDATIONS

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

with you, for you

NHS
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NHS Foundation Trust

AGENDA ITEM: 09/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 July 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 June 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 3 position.
- **APPROVE** the Revised Capital Plan.

Executive summary

- Final accounts were approved at the 19th June Audit Committee and submitted on 30th June 2025. There were no amendments to the year-end position of a performance surplus of £0.31m.
- The system plan at 30th April was break even and the Trust's plan was break even
- At month 3 the Trust has a surplus of £0.018m compared to the ytd plan of a £0.198m deficit.
- 25/26 Capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Revised plan has deferred 2 property disposals to 26/27. Spend to month 3 is £1.377m against a budget of £2.266m
- The Trust spent £0.953m on agency staff up to month 3, which is below plan. This equates to 1.52% of total pay. There were 25 off framework shifts, the target is 0.
- Cash at the end of month 3 is £40.371m, slightly behind plan.
- Board are asked to approve the Revised Capital 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 M3

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

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09.1/0725

Finance Report
Month 3

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

Overview

- Final accounts were approved at the 19th June Audit Committee and submitted on 30th June 2025.
- There were no amendments to the year end position of a performance surplus of £0.31m.
- The system plan at 30th April submission was break even and the Trust's plan was break even.
- The Trust has submitted a revised plan to NHSE to reflect approved development funding.
- At month 3 the Trust has a surplus of £0.018m compared to the plan of a £0.198m deficit.
- 25/26 Capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Spend to month 3 is £1.376m against a budget of £2.266m.
- Cash at the end of month 3 is £40.371m, which is £0.583m below plan.
- Cost improvement programme has delivered £3.559m of recurring savings against the plan of £2.033m. Target for the year is £10.086m. £5.406m is unidentified.
- Non recurrent savings target is £5.189m all of which is identified, and of which £1.126m is delivered.
- The Trust spent £0.953 on agency staff in month 3 which is below plan by £0.04m. There were 25 off framework shifts, the target is 0.
- Better Payment Policy shows 95.9% of invoices by value paid within 30 days and 90.7% by number of invoices, the national target is 95%.
- Board are asked to approve the Revised Capital plan that includes changes to planned expenditure and has 2 property disposals deferred to 26/27.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

	2025/26 Plan	2025/26 Revised Plan	2025/26 Revised budget ytd	2025/26 Actuals ytd	2025/26 Variance
Operating income from patient care activities	301,442	306,442	77,318	77,683	365
Other operating income	16,590	16,590	4,490	5,023	533
Employee expenses - substantive	(221,705)	(226,705)	(61,807)	(56,109)	5,697
Bank	(17,906)	(17,906)	(553)	(5,483)	(4,931)
Agency	(3,967)	(3,967)	(352)	(953)	(602)
Operating expenses excluding employee expenses	(73,026)	(73,026)	(19,178)	(20,066)	(888)
PDC dividends payable/refundable	(2,781)	(2,781)	(695)	(695)	0
Finance Income	1,500	1,500	647	655	8
Finance expenses	(198)	(198)	(47)	(57)	(9)
Surplus/(deficit) before impairments & transfers	**(51)**	**(51)**	**(178)**	**(4)**	**174**
Gains/ (losses) from disposal of assets			0	8	8
Remove capital donations/grants I&E impact	51	51	13	13	0
Surplus/(deficit)	**0**	**0**	**(164)**	**18**	**182**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0		0
Remove net impact of consumables donated from other DHSC bodies	0	0	0		0
Revised Surplus/(deficit)	**0**	**0**	**(164)**	**18**	**182**
WTEs	4762	4782	4782	4669	113

Revised plan submitted to NHSE to reflect funded developments. £5m added to I & E.
Budget for bank & agency is only for specific schemes but Plan is forecast for the whole Trust

Gloucestershire Health and Care
NHS Foundation Trust

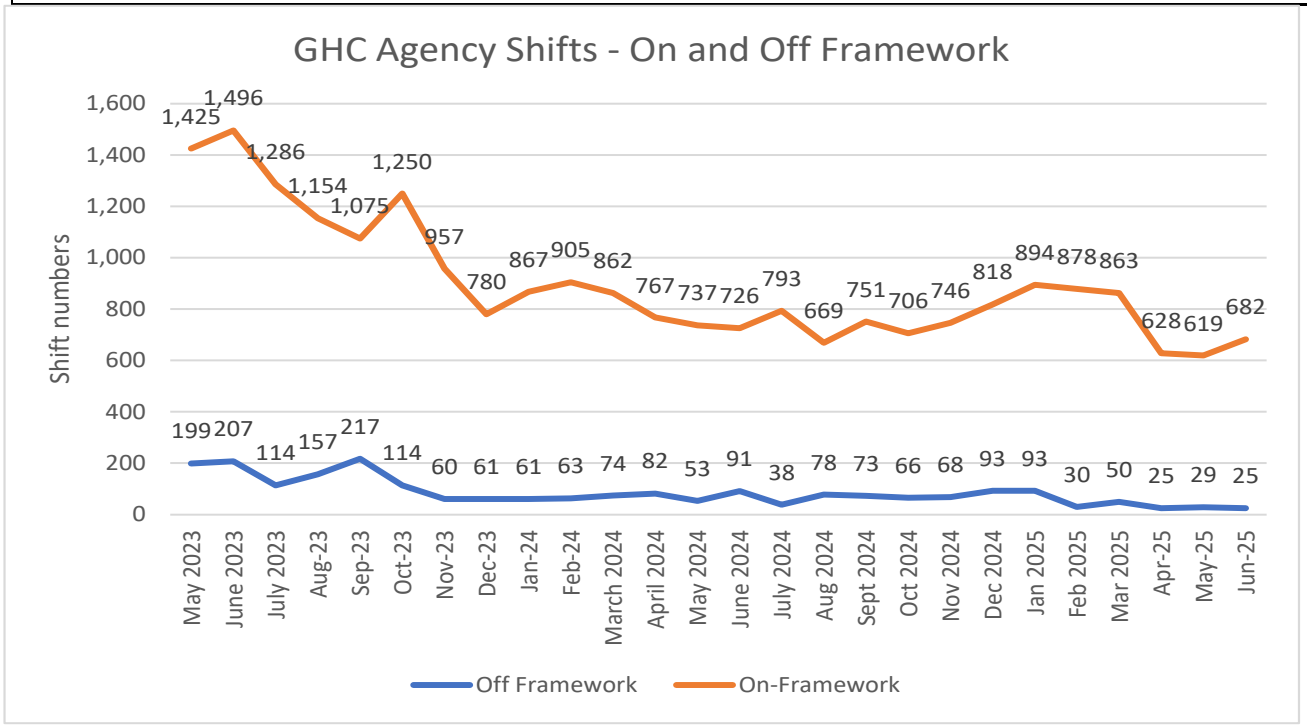
GHC Income and Expenditure Plan movements

Shown in Plan as;			Additions to Plan month 3	£000's
Income	Expenditure			
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	CMHT	2,346
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-031 Crisis offer (all age)	500
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-032 MH Act Compliance	100
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-033 ECT	112
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-034 CAMHS Neuro	40
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-045 CIC Residential Homes Support	153
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-051 Right Care Right Person (MHIS)	109
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-021 Wellbeing Line 25/26 (6 Month Ext)	192
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-040 CYPS Weight Management 25/26	118
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-046 Community Neurological Service	40
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-015 Priorities Process 24/25 - Special School Nursing	123
Operating income from patient care activities	Employee expenses - substantive	Glos ICB	2526-008 Health Video Interaction Guidance	66
Operating income from patient care activities	Employee expenses - substantive	NHSE	Covid - Outreach Service	312
Operating income from patient care activities	Employee expenses - substantive	NHSE	HJ - INCS - 3yr CYP Funding	237
Operating income from patient care activities	Employee expenses - substantive	NHSE	Spec Comm variable activity	551
			Total	**5,000**

Pay Analysis

Pay analysis month 3						
	Plan WTE Month 3	Budget WTE Month 3	Budget £000s	Actual WTE Month 3	Actual £000s	Actual £ as % of Total £
Substantive	4,324	4,769	61,807	4,290	56,109	89.7%
Bank	363	14	553	336	5,483	8.8%
Agency	52	0	352	44	953	**1.52%**
Total	**4,739**	**4,782**	**62,711**	**4,669**	**62,546**	**100.0%**

- Trust WTE budget 43 higher than plan due to devts
- substantive budget includes negative budgets for CIP not yet identified (£1.55m@mth 3, £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 June. The target is 0.
- 1.52% 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.

with you, for you

Balance Sheet

NHS
Gloucestershire Health and Care

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	1,622	1,801	179	2,264
	Property, plant and equipment: other	117,935	122,466	117,523	117,165	(358)	122,433
	Right of use assets	16,438	16,541	16,753	16,076	(677)	16,540
	Receivables:	1,244	1,209	1,235	1,231	(4)	1,207
	Total non-current assets	**137,361**	**142,480**	**137,134**	**136,273**	**(860)**	**142,444**
Current assets	Inventories	444	444	444	444	0	444
	NHS receivables	7,409	7,432	7,432	16,659	9,227	7,459
	Non-NHS receivables	9,331	9,349	13,159	6,776	(6,383)	9,276
	Credit Loss Allowances	(1,595)	(1,595)	(1,595)	(1,588)	7	(1,588)
	Property held for Sale	3,123	377	3,123	3,123	0	1,377
	Cash and cash equivalents:	41,855	39,359	40,953	40,371	(583)	38,017
	Total current assets	**60,567**	**55,366**	**63,516**	**65,784**	**2,268**	**54,984**
Current liabilities	Trade and other payables: capital	(3,815)	(3,535)	(1,826)	(1,068)	758	(3,535)
	Trade and other payables: non-capital	(26,851)	(26,875)	(31,380)	(30,116)	1,264	(26,581)
	Borrowings	(1,514)	(1,514)	(1,514)	(1,510)	4	(1,510)
	Provisions	(8,701)	(8,702)	(8,702)	(7,528)	1,174	(8,528)
	Other liabilities: deferred income including contract liabilities	(1,303)	(1,303)	(1,303)	(6,399)	(5,096)	(1,399)
	Total current liabilities	**(42,184)**	**(41,929)**	**(44,725)**	**(46,621)**	**(1,897)**	**(41,553)**
Non-current liabilities	Borrowings	(14,026)	(14,252)	(14,419)	(13,718)	701	(14,256)
	Provisions	(2,511)	(2,511)	(2,511)	(2,509)	2	(2,509)
	Total net assets employed	**139,206**	**139,154**	**138,995**	**139,210**	**215**	**139,111**

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)	(5,656)	(5,446)	210	(5,446)
	Income and expenditure reserve (current ye	(4,399)	0	0	4	4	(95)
	Total taxpayers' and others' equity	**139,206**	**139,154**	**138,996**	**139,210**	**214**	**139,111**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 24/25		ACTUAL 25/26		FULL YEAR FORECAST 25/26	
Cash and cash equivalents at start of period		**51,433**		**41,855**		**41,855**
Cash flows from operating activities						
Operating surplus/(deficit)	(4,473)		94		1,392	
Add back: Depreciation on donated assets	185		13		52	
Adjusted Operating surplus/(deficit) per I&E	**(4,287)**		**107**		**1,444**	
Add back: Depreciation on owned assets	11,117		2,406		9,890	
Add back: Depreciation on Right of use assets					0	
Add back: Impairment	4,497				0	
(Increase)/Decrease in inventories	(88)				0	
(Increase)/Decrease in trade & other receivables	(4,386)		(6,659)		41	
Increase/(Decrease) in provisions	154		(1,176)		(176)	
Increase/(Decrease) in trade and other payables	(8,506)		2,546		(294)	
Increase/(Decrease) in other liabilities	217		5,096		96	
Net cash generated from / (used in) operations		**(1,283)**		**2,319**		**11,001**
Cash flows from investing activities						
Interest received	3,072		652		1,500	
Interest paid	(9)		(1)		(9)	
Proceeds from Sale of PP&E	1,974		41		2,100	
Purchase of property, plant and equipment	(9,316)		(4,098)		(13,972)	
Assets Held for Sale						
Net cash generated used in investing activities		**(4,279)**		**(3,405)**		**(10,381)**
Cash flows from financing activities						
PDC Dividend Received	227		0		0	
PDC Dividend (Paid)	(2,491)		0		(2,781)	
Finance lease receipts - Rent	94		27		94	
Finance lease receipts - Interest	(62)		(15)		(59)	
Finance Lease Rental Payments	(1,572)		(356)		(1,521)	
Finance Lease Rental Interest	(213)		(54)		(190)	
		(4,016)		**(398)**	**0**	**(4,457)**
Cash and cash equivalents at end of period		**41,855**		**40,371**	**0**	**38,017**

Liquidity Metric

Liquid Working Capital	x 91 days	=	29,967	33.69 days
ytd Operational Expenditure			80,946	

Liquid Working Capital = Current Assets less Current Trade Creditors, Capital Creditors & Borrowings

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Plan	Revised Plan	Actuals	Plan	Plan	Plan	Plan
£000s	**2025/26**	**2025/26**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Land and Buildings							
Buildings	4,021	3,185	378	8,500	5,000	3,000	3,000
Backlog Maintenance	1,879	2,251	438	1,393	1,393	1,393	1,400
Buildings - Finance Leases	1,496	1,496	0	1,900	250	250	250
Vehicle - Finance Leases	250	250	44	250	250	250	250
Other Leases	0	0	0		0	0	
Net Zero Carbon	2,643	4,061	620	1,400	1,800	1,500	1,500
LD Pathway				3,000	0	0	0
Medical Equipment	1,780	493	(15)	602	930	1,030	1,000
IT							
IT Device and software upgrade	320	0	0	800	900	900	1,200
IT Infrastructure	1,300	2,120	(79)	1,300	1,300	1,300	1,300
Transforming Care Digitally	1,260	1,260	(9)	790	250	250	250
NHS Net Transition	500			0	0	0	0
Digital Innovation					500	500	500
Contingency							
Total of Updated Programme	**15,449**	**15,116**	**1,376**	**19,935**	**12,573**	**10,373**	**10,650**
Disposals	(3,265)	(1,943)	0	(8,531)	0	0	0
Total CDEL spend	**12,184**	**13,173**	**1,376**	**11,404**	**12,573**	**10,373**	**10,650**
Funded by;							
Anticipated System CDEL	**12,184**	**12,349**		**12,259**	**12,573**	**10,373**	**10,650**

- **Revised** Plan reflects 2 property disposals moved from 25/26 to 26/27, one of which the Resources Committee approved in June, and increases to Net Zero Carbon and Backlog Maint. (Fire Compartmentation) scheme costs.
- Leases - Risk of potential slippage in buildings leases.

CIP (Cost Improvement Programme)

			Low Risk	Medium Risk	High Risk
Rec / Non rec	Scheme	Target	Delivered	Identified	Unidentified
Rec	Efficiency 1.1%	3,189	847	402	1,940
Rec	Delivering Value 1.4%	4,001	818	401	2,782
Rec	Undelivered 24/25 brought forward	1,944	801	507	636
Rec	Programme Savings	949	901	0	48
Non Rec	Non recurrent savings	5,169	1,126	4,043	0
		15,252	4,493	5,353	5,406
			29%	**35%**	**35%**

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 still carry a low level of risk.

Risks

Gloucestershire Health and Care
NHS Foundation Trust

2025/26 potential risks are as set out below:

Risks from budget setting but risks with a score below 9 are not shown, but are still monitored

Risks 25/26	Mitigations	Risk Value £000s	Likelihood	Impact	Recurring	Mitigated Risk Score
Forecast overspends in System partners might lead to Trust incurring additional costs that affects financial position (390)	Continued negotiation with system partners. Review all costs. Identify additional savings. Peer review of system partners	2992	3	4	0	12
There is a risk that GHC does not fully deliver recurrent CIP savings, resulting in GHC not achieving its future financial targets and the underlying position worsening (391)	Short term non recurrent savings. Close monitoring by the CIP management board. Longer term identification of new recurrent schemes	5406	4	4	5406	16
25/26 pay award is under funded once final value is agreed causing a cost pressure (621)	Detailed assessment of implications to ensure clear understanding of impact and to allow appropriate mitigations to be sought	100	2	1	100	2
There is a risk that services do not have the capacity to identify CIP schemes in year resulting in under delivery of RECURRENT in year CIP target (622)	create dedicated time to review CIP. CIP Management Group to actively manage situation and support directorates if greater support needed. Non recurring savings to offset in year non delivery	5406	4	4	5406	16

Risks 2 & 4 are similar risks but impacts are different.
Risk 2 is longer term risk of not delivering recurrent risks whereas 4 is more a short term risk of non delivery in 25/26 which can be mitigated by non recurring savings but will have significant reputational and Oversight Framework implications.

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AGENDA ITEM: 10/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 July 2025**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT – JUNE 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:

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 is 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 2025. This report is produced monthly for Trust Board, Quality Committee, Operational Delivery and Governance Forums for assurance.

Quality issues showing positive improvement:

- Focused work continues with regard to the closure of open incidents on Datix, concentrating on length of time an incident is open for, and reductions continue in June.

- We have met all the requirements of the S31 notice and have been providing monthly updates in a prescribed template for 20 months. To support an application to the CQC for the removal of restrictions against the registration for Berkeley House we

have fidelity tested the standards through a peer review inspection with the ICB on 8th July. Feedback from the peer review was positive and good evidence to reflect improvements which we have shared with the CQC.

Quality issues for priority development:

- PSII and Care Review open longer that 6 months. The delays in completion were due to team capacity. We have a recovery plan to address the backlog by September.

- As we move through the year we need to now develop mechanisms for identifying any potential "silent voices" within the Patient Carer and Experience arena ,and expand safe staffing progress within the slides presented.

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 – June 2025 Data

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

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11.1/0725

QUALITY DASHBOARD 2024/25

Physical Health, Mental Health and Learning Disability Services

Data covering June 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

Alert

- PFD issued on 26th June 2025 regarding MH crisis team staffing provision - Trust is preparing response to Coroner.
- 12 incidents were considered to meet Duty of Candour regulations - 6 remain under review and delayed whilst we validated the pressure ulcer level of harm. This will be resolved by the end of July.
- Fidelity Testing has been undertaken into a PFD that was issued in 2024 to understand if learning has been embedded at Wotton Lawn. Additional assurance required in 3 of the 5 areas, actions identified and due to complete in August.

Advise

- 11 out of the 14 PSII's/ Care reviews have been open longer than 6 months, 6 of these are ready for closure via Executive PSG. (Planned for dates in July and August). The 5 remaining investigations, the team are working towards closure; 3 internal reviews are being planned, 2 family meetings are being arranged following internal review meetings. The delays in completion were due to team capacity. We have a recovery plan to address the backlog by September.
- Reduction in numbers of restraint incidents in month from 315 to 276.
- Planned review of Reduction of Ligature Risk Policy and benchmarking our systems and processes with Dorset Partnership Trust.

Applaud

- Further reduction in number of overdue Datix incidents from 24/25 down from 701 to 393.
- We continue to see high levels of reporting of incidents demonstrating our promotion of an open and transparent learning culture.

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

Assure

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

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

Assure

- 93% of Friends and Family Test (FFT) respondents reported a positive experience. Across the Trust there were 2158 FFT responses last month.

Advise

- 14 formal complaints were received in June, with 7 of these relating to the IUC. For the IUC in June ; there were 44 responses with a positive experience rating of 91%. The overall positive experience rating for the Trust is 98% which is an improvement from the last 2 months.
- 57% of complaints were closed within 3 months and 100% of complaints being closed within six months (against targets of 50% and 80% respectively). Two complaints were re-opened and the PCET continue to work collaboratively with patients and carers to ensure post-complaint actions are completed.

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

Assure

- We have met all the requirements of the S31 notice and have been providing monthly updates in a prescribed template for 20 months. To support an application to the CQC for the removal of restrictions against the registration for Berkeley House we have fidelity tested the standards through a peer review inspection with the ICB on 8th July. Feedback from the peer review was positive and good evidence to reflect improvements which we have shared with the CQC.

with you, for you

Summary
Trust Safeguarding Data – June 25

NHS
Gloucestershire Health and Care
NHS Foundation Trust

- 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 were rated as compliant with Safeguarding training in June, the same as in May. Compliance with children's safeguarding supervision dropped to 66% in June, from 75% in May. While it is not immediately clear why this is, ongoing liaison between the Safeguarding team and Ops colleagues to increase rates is continuing.
- The Safeguarding Focus newsletter in May was on the subject of trauma informed care, with the Safeguarding Learning Lunch focusing on the Adult Escalation policy.
- A shared GDASS offer with Crisis Teams & First Point of Contact Teams commenced in June and continues until August. Dates have been confirmed for September to October 2025 to capture staff including Admin, Receptionists, Clinical, Non-Clinical based at Wotton Lawn Hospital. All training is 3 hours and face to face.
- Progress has been made towards completion of the MCA workplan during June. This includes the completion and sign-off (at CPG) of guidance for children's services around children and decision making; the drafting of public facing leaflets explaining MCA, LPAs and deputyship and DoLS; the CoHo MCA practice compliance re-audit has been completed and draft report written, with overall compliance going up from 84% to 89%; training re: supported decision making and Best interest was delivered to Berkeley House staff on 30/06/2025.

Challenges/risks:

- Risk 298 – Analysis of Adult referral data is shortly to start which will give some insight into quality assurance, although it will only cover a small proportion of referrals. Children's referral data remains unavailable forr the time being, and the longer-term position won't be clear until the Local Authority's Front Door project has been completed (no date currently known). All internal mitigations are being explored.
- Risk 299 – Work continues towards the introduction of the new Children's Safeguarding template on Systm1 (planned for July)
- Risk 416 – Good work continues towards the MCA action plan to improve practice around the Trust as noted above, however we remain exposed where practice is not compliant.

Key Safeguarding Data – June 25

- This slide will highlight some key data points relating to Trust Safeguarding activity, with contextual narrative

- **Safeguarding Advice Line calls reduced to 180 in June, from 213 in May**. Analysis of the advice line has shown that Talking Therapies accounts for a third of calls to the Advice Line, although there continues to be a wide range of services using it. Around a third of all calls related to domestic abuse, with the next highest subject being neglect / acts of omission (around a sixth of all calls).

- **The number of Allegations Management cases reduced from 3 in May to 1 in June**. There were, however, six Allegations Management meetings during June for ongoing cases as well as the new case.

- **Adult Safeguarding referrals made by Trust colleagues to the Local Authority nearly doubled from 32 in May to 60 in June**. Of this 60, 17 related to self neglect concerns, 15 to domestic abuse, 9 to neglect (organisational abuse) and 7 to financial / material abuse.

- **We have no available figures for Children's referrals**, due to difficulties obtaining the data – this is captured in Risk 298 on the Trust's Risk Register. The introduction of the Children's template (Systm1) in July is anticipated to mitigate this risk to some degree, and communications will be reissued to remind colleagues of the need to inform the Safeguarding team each time a referral is made.

- **Safeguarding training compliance is generally good**. Compliance figures for Levels 1, 2 & 3 (Adult Protection) are at 97%, 95% & 89% respectively. Level 3 Multi Agency Child Protection is at 84%. Adults' Level 4 training remains low at 65%, although this is due to GCC not being able to host sufficient training sessions. While new sessions have been added to Care to Learn, this will not provide an immediate impact. We are exploring with the ICB whether there are alternative courses available that meet the Level 4 outcomes.

- **There were two sexual safety incidents in June, down from seven in May.** One of these occurred at Wotton Lawn, and the other at Charlton Lane, and both were classified as no harm incidents. The Wotton Lawn incident was categorised as 'other sexual safety' and related to a patient talking in a sexual manner regarding a nurse while the Charlton Lane incident was categorised as 'affectionate activity' – patients kissing.

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

GHC - Safeguarding Dashboard 2025/26 Children's Safeguarding Data

	Q4	Apr-25	May-25	Jun-25	Q1	Additional Information
SAFEGUARDING ACTIVITY						
Advice Line Calls	223	36	94	78	208	Good steady use of the Safeguarding Advice Line continues.
Multi-Agency Request for Service Forms submitted to MASH	151	-	-	-	-	The Local Authority are unable to provide referral data and current GHC clinical systems are unable to accurately capture referral figures. This is a documented risk – Risk 298. An action plan is underway to address this. Safeguarding Referral data is captured via the Safeguarding Notifications Inbox as a mitigation until a digital solution is in place. Original target date of Nov 2023 has not been met however, work on the template has increased and good progress is being made. The safeguarding children's audit has been commenced which will be looking.
Number of Safeguarding Escalations	3	0	1	0	1	This confirms new Safeguarding escalations at Level 2 and above.
CHILD DEATH NOTIFICATIONS						
Expected	3	0	1	0	1	Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	0	1	2	0	3	Gloucestershire Child Death Overview Process is followed for each unexpected death.
RAPID REVIEWS/LCSPR'S						
Number of Serious Incident notifications made by LA	1	0	0	1	1	
Number of Rapid Reviews attended	1	0	0	1	1	
Number of LCSPR's in progress	3	1	1	1	1	
MASH HEALTH TEAM ACTIVITY						
Children researched/info shared	4,326	1,558	1,435	1,484	4,477	
Adults researched/info shared	301	43	98	106	247	The introduction of the PDVM has placed significant pressure on the MASH team, increasing it's workload significantly, the MASH team are only researching adults where there is a clear need to do so. This is not a negative thing, in fact demonstrated appropriate information sharing.
MASH urgent strategy meetings attended	83	22	21	26	69	
Demographic information sharing	286	99	77	87	263	MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data. As of 1st September MASH are having to push back demographic requests which is why there is a reduced number of requests for September
AUDITS						
Single Agency	2	1	1	0	2	
Multi-Agency sub group activity	2	1	1	1	3	
UNDER 18'S ADMISSIONS						
Number of under 18's admitted to Adult MH Wards	1	0	0	0	0	
Number of under 18's assessed under S.136 of the MHA 83/07	5	3	1	8	12	
OTHER WORKSTREAMS						
Allegations management – number of referrals to/from the LADO	6	1	3	1	5	This is now a combined figure. All LADO issues come under GHC's Allegations Management policy, but not all Allegations Management issues come under the LADO process (LADO is only involved with cases involving colleagues who come into contact with U18s during the course of their work)

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

GHC - Safeguarding Dashboard 202/26 Adults safeguarding Data	Q4	Apr-25	May-25	Jun-25	Q1	Additional Information
SAFEGUARDING ACTIVITY						
Contacts to GHC advice Line	252	44	119	102	265	Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Continued good use of the Advice Line.
Safeguarding Referrals made to GCC	113	40	32	60	132	
CASE REVIEWS						
New Safeguarding Adult Reviews/Domestic Homicide Reviews	4	0	2	2	4	
Number of Reviews ongoing	18	18	18	20	20	Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs). Several reviews are in the final stages of sign off.
Action Plans Ongoing	5	5	5	5	5	This includes single and multi agency action plans
MAPPA						
Level 2 Meetings Held	16	*	*	*	14	Data reported quarterly.
Level 2 Meetings Attended	14	*	*	*	14	Data reported quarterly.
Level 3 Meetings Held	6	*	*	*	4	Data reported quarterly.
Level 3 Meetings Attended	6	*	*	*	4	Data reported quarterly.
PREVENT						
Number of Prevent Referrals Made	0	0	0	0	0	0 Prevent concern raised with the police.
Information requests received & completed from Police/Channel	6	1	0	2	3	100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC						
Families screened/researched	424	130	143	120	393	Continued high level of MARAC activity. Minor variation in month.
No.of children open to MH Services	47	23	17	12	52	Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected minor variation in month. Unable to obtain Aug data due to problems with spreadsheet.
No.of victims open to MH Services	62	14	18	25	57	Highlights the link between the impact of domestic abuse on victims mental health. Expected minor variation in month. Unable to obtain Aug data due to problems with spreadsheet.
No.of perpetrators open to MH Services	56	15	18	17	50	Identifies the number of perpetrators open to MH services. Expected minor variation in month. Unable to obtain Aug data due to problems with spreadsheet.
Un-uploaded MARAC Action Plans	18	10	112	0	0	MARAC Action Plans are uploaded to clinical records of all related parties. They contain detail of the Domestic Abuse incident and agreed multi agency action plan.
DOLS - No. of referrals for standard authorisation from:						
Mental Health Services Total	1	3	1	1	5	
Mental Health Services Authorised	0	0	0	0	0	
Physical Health Services Total	49	27	25	17	69	14 waiting assessment, 3 closed – 1 regained capacity and 2 passed away
Physical Health Services Authorised	0	0	0	0	0	
AUDITS						
Single Agency - Safeguarding Related	0	0	0	0	0	
Multi Agency Sub - Group Related	2	0	1	0	1	
OTHER WORKSTREAMS						
Allegations management - use of PiPoT guidance						Please see slide 1 for combined data..

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

GHC - Safeguarding Dashboard 2025/26 Training and Supervision Data

	Q4	Apr-25	May-25	Jun-25	Q1	Additional Information
TRAINING						
Level 1 – Induction	97%	97%	97%	97%	97%	Consistent month on month compliance level
Level 2 – Think Family	93%	95%	96%	95%	95%	Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	83%	84%	84%	84%	84%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	91%	91%	91%	89%	91%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 4 Adult Protection	69%	77%	67%	65%	70%	The low compliance is due to the Local Authority not being able to host this training. There are two courses available currently, in September 25 and March 26, so it will be some time before this compliance increases. Options for alternative courses is being explored with the ICB.
PREVENT:						
Level 1	99%	99%	99%	99%	99%	Continued high level of compliance with Level 1 Prevent Training
Level 2	93%	93%	94%	94%	94%	Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	97%	97%	97%	97%	97%	Improving picture of compliance with Level 3 PREVENT training
MENTAL CAPACITY ACT:						
Level 1	97%	97%	97%	95%	97%	New item to the dashboard. Level 1 MCA training is an online package, mandatory for all clinical staff who work with adults.
Level 2	86%	82%	83%	98%	88%	
Bespoke MCA Training	56	7	7	5	19	
SAFEGUARDING SUPERVISION						
CHILDREN:						
Group Supervision Sessions	70	24	23	25	72	Clinical staff working with children need to attend this supervision 3x per year. 5 x sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to shape future sessions.
Group Supervision Compliance	67%	70%	75%	66%	70%	In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' on staff Care to Learn Training Profiles. Operational line managers are responsible for monitoring individual staff member compliance. A piece of work is underway to breakdown compliance at team level for targeted work to address low compliance rates. Alongside this a scoping activity is underway to consider developing a new model of Safeguarding Supervision, development will include consultation with operational teams and a review of the different supervision needs of the target audience.
One to One Supervision Sessions	24	3	5	5	13	121 Supervision is available to all upon request. The uptake for 121 supervision is poor. Practitioners are made aware of this facility in their Group supervision sessions, in training and on the advice line.
ADULTS:						
Group Supervision Sessions	0	0	0	0	0	A new offer/model of Adult Safeguarding Supervision has been developed to address poor attendance and engagement with supervision. This is now beginning to be rolled out across teams and localities
Number of Staff who attended Supervision	0	0	0	0	0	
One to One Supervision Sessions	3	0	2	1	3	121 Supervision is available to all upon request.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Data

	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Patient Safety Incidents												
Total number of Patient Safety Incidents	1235	1439	1341									
Number of No Harm and Low Harm incidents (including skin integrity)	1110	1322	1231									
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	125	129	110									
Patient Safety Investgations												
Number of AARs completed in Month		4	3									
Number of New PSII's and Care Reviews declared in month	1	0	2									
Number of PSII's open		5	5									
Number of PSII's closed in month		0	0									
Number of Care Reviews open		9	9									
Number of Care Reviews closed		1	0									
Number of PSII's and Care reviews open over 6 months		11	11									
Number of PSII's/ Care Reviews planned for Exec sign off (Closure)			6									
Family Liaison Practitioners												
Number of patients being supported		1	1									
Number of family and friends being supported		7	8									

What is the data telling us?

- We continue to see high levels of reporting with approximately 91% of incidents being no or low harm incidents.
- The Patient Safety Team continue to utilise proportionate learning responses with 3 AAR's being carried out in June 2025. There are a further 4 planned AARs in July for incidents that occurred in later in June.
- We continue to have a number of PSII's/ Care Reviews which have been open longer than 6 months, 6 of these are now at point of closure and are planned to be taken for sign off at the Executive meetings in July and August 2025. For the 5 remaining investigations the team are working through the process towards closure; 2 internal reviews are being planned, 2 family meetings are being arranged following internal review meetings. The delays in completion were due to previous staff absences, now that the team is back to expected staffing numbers the number of overdue investigations is expected to reduce over coming months.
- For 1 investigation the team are liaising with family and their advocate regarding how to progress the investigation in line with their needs. This incident is not subject to a Coronial process.
- A PSII has also been undertaken by IC24 into an aspect of care that they are subcontracted by the Trust to undertake as part of our IUCS service. Service Director and Head of Patient Safety are arranging a meeting with IUCS to ensure that the report meets Trust standards.

CQC DOMAIN - ARE SERVICES SAFE? – Regulation 28- Prevention of Future Deaths Reports (PFD's)

New PFD's:

PFD issued on 26th June 2025 raising the following concerns:

- That staff capacity of the mental health crisis team of Gloucestershire Health and Care NHS Foundation Trust will dictate whether a patient is assessed on the same day when their clinical needs demand they are.
- That the Trust will not make any enquiries as to additional resources when their local Crisis Team has no capacity.
- It is important to note that the Trust provided evidence that there is a process in place for bringing in more staff when needed and that there was no evidence indicating that we did not make enquiries to seek additional resources. A robust and clear response with be provided to the Coroner by 21st August 2025.

Updates on issued PFD's:

PFD issued on 08/05/2025 naming both the trust and the Department of Health and Social Care. The PFD matters of concern were that there appear to be insufficient beds available in psychiatric units to meet patient demand.

- The Trust have provided a response to the Coroner

The Learning Assurance Team have fidelity tested the action plan that was written following a PFD issued on 21/02/2024 regarding a choking incident in 2022 on Greyfriars Ward. Additional work/evidence required for L3 resus training compliance, risk assessment following physical health emergency and monitoring of attendance of paramedics on site. Action plan being developed with site Matron.

What is the data telling us?

PFDs are an increasingly utilised tool in inquests, by which a coroner can draw attention to matters for which action could be taken to prevent future deaths. In 2023, the number of PFDs issued by coroners increased to 569 reports, in comparison to 418 reports in 2022. In 2024, the number of PFD's issued by the coroner was 713, that's a 25% increase compared to 2023, and we can only expect that the figure will again likely increase in 2025.

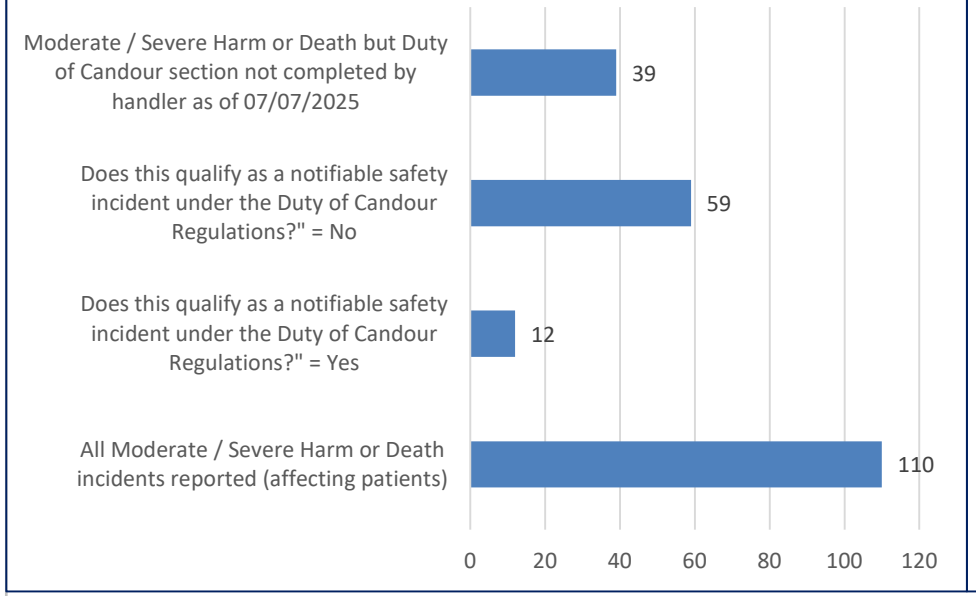
The Coroner has no power to compel the recipient of a PFD report to respond and there is no oversight mechanism. However, the Chief Coroner for England and Wales, Her Honour Judge Alexia Durran, issued the following statement at an Insights Panel on 09 September 2024:

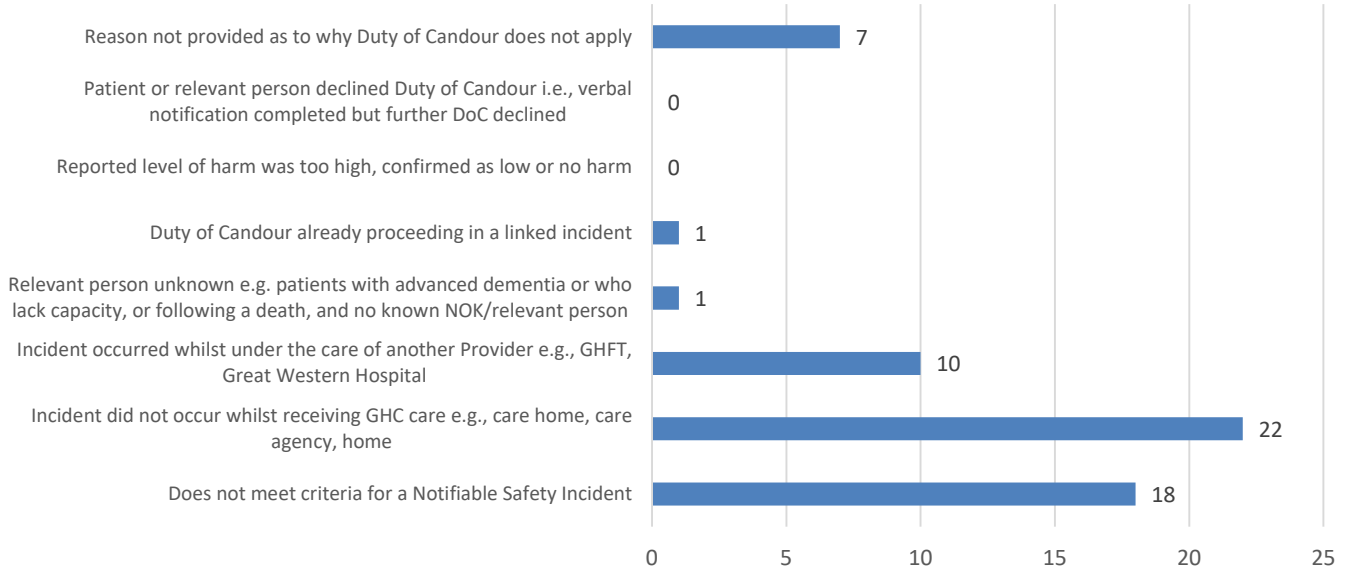
"I have decided to publish a list of those organisations who do not respond [to a PFD report]. That will be a badge of dishonour. It seems to me that if the Chief Coroner has to publish a prevention of future death report and any response, then if a response is not forthcoming this should be clear. So no longer will there be any suggestion that responses have not been uploaded [to the Chief Coroners website]. Going forward it will be clear that no response has been provided rather than simply an absence of response."

As of 01 January 2025, the Chief Coroner will now publicly note any failure to respond to a PFD report, placing the organisation on a publicly accessible list (Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary). This list functions as a "*badge of dishonour*", highlighting the organisations that have not engaged with the process.

Coroners are increasingly using PFD reports as a tool to address systemic issues that contribute to deaths. This is partly due to increased awareness of the reports and their potential impact, as well as guidance from the Her Honour Judge Alexia Durran emphasising their importance. Because of this, we are likely to see an increase in PFDs being issued nationally to all healthcare providers.

CQC DOMAIN - ARE SERVICES SAFE? – Duty of Candour (DoC)





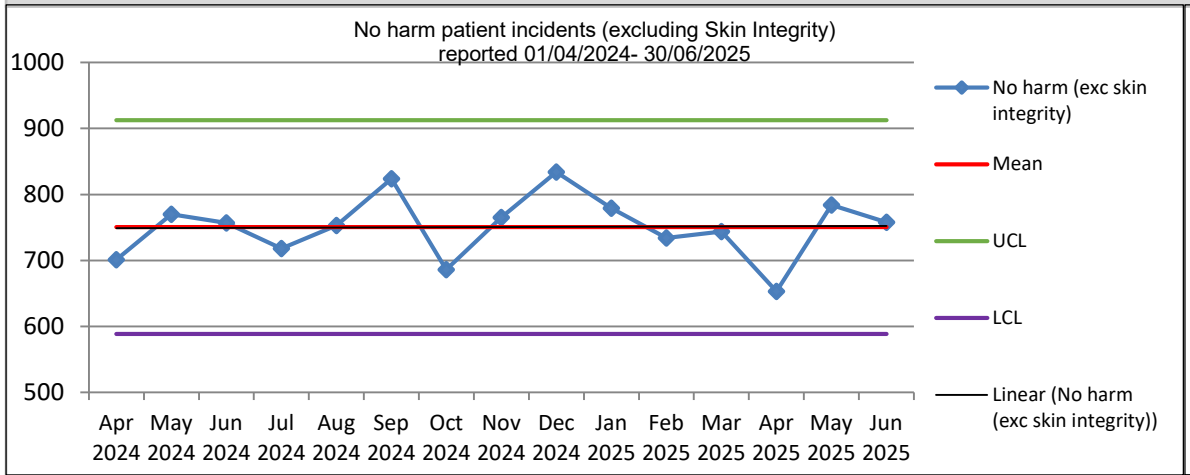
What is the data telling us?

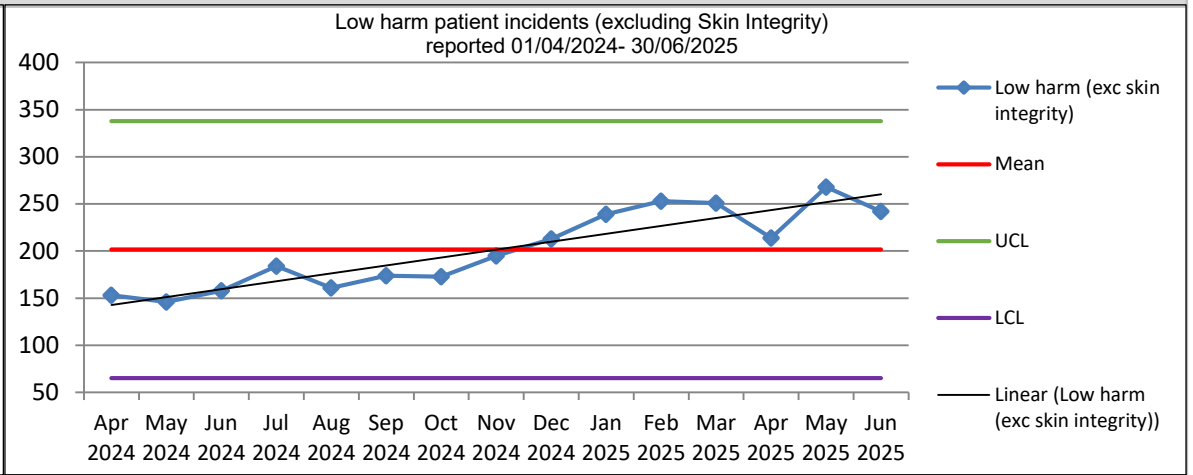
- In June there were 110 moderate harm incidents reported across the trust, of these 12 were considered to meet Duty of Candour regulations.
- Of the 12, 1 written correspondence has been sent and uploaded to records and 5 verbal notifications were met and recorded.

What are we doing about it?

- The Patient Safety Team are reviewing any incidents where it has been indicated that Duty of Candour applies but a verbal or written notification has not been issued to ensure that we have fulfilled our requirements.
- Where it has been identified that the DoC section has not been completed (39), these incidents are awaiting review/being reviewed by the handler. It is important to note that reported skin integrity incidents account for these incidents are these will be reviewed to ensure that the initial harm level is accurate which will contribute to whether DoC is applicable.
- The intention is that activity relating to DoC will be reported to QAG monthly providing greater assurance that we are meeting our responsibilities.

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





Top 5 Reporting Themes- No Harm	Total	Compared to last month
Restrictive Interventions	236	↓
Violence and Aggression to Staff (SIRS)	117	↑
Falls (including slips and trips)	89	↑
Medication Incidents	83	↑
Clinical care, treatments and procedures	52	*new into top 5

Top 5 Reporting Themes- Low harm	Total	Compared to last month
Self harm / self-injurious behaviour (SIB)	96	↓
Violence and aggression to staff (SIRS)	51	↓
Falls (including slips & trips)	37	↑
Appointments, follow-ups and referrals	19	↓
Clinical care, treatments and procedures	19	*New into top 5

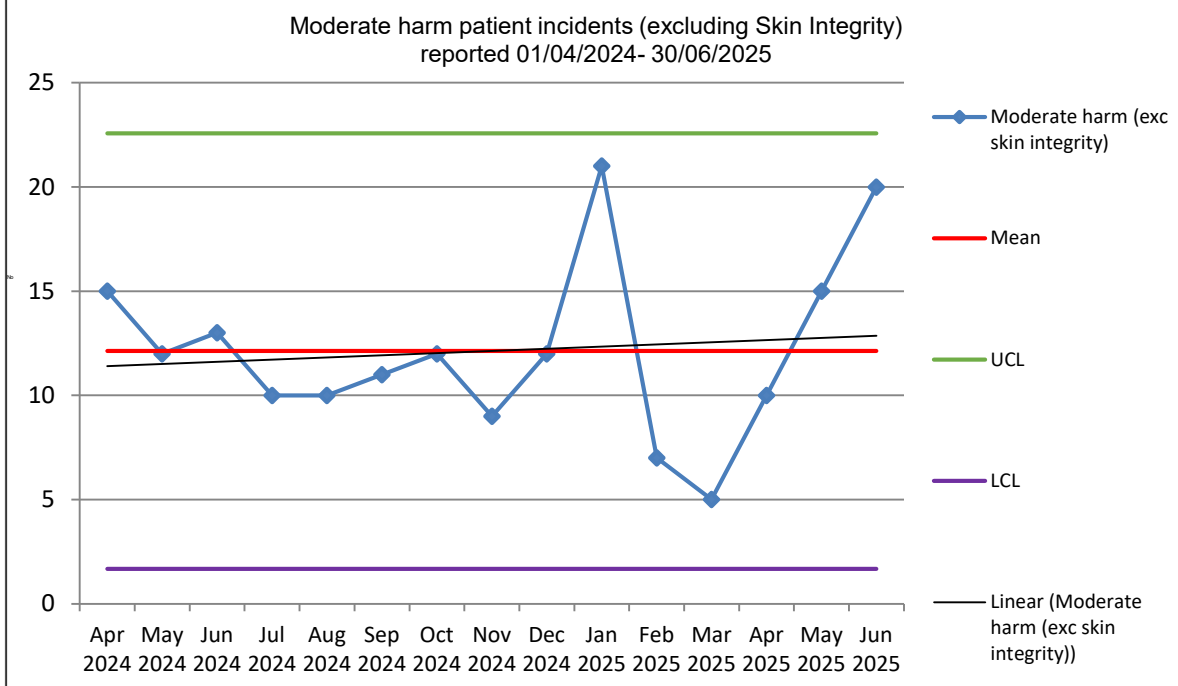
What is the data telling us?

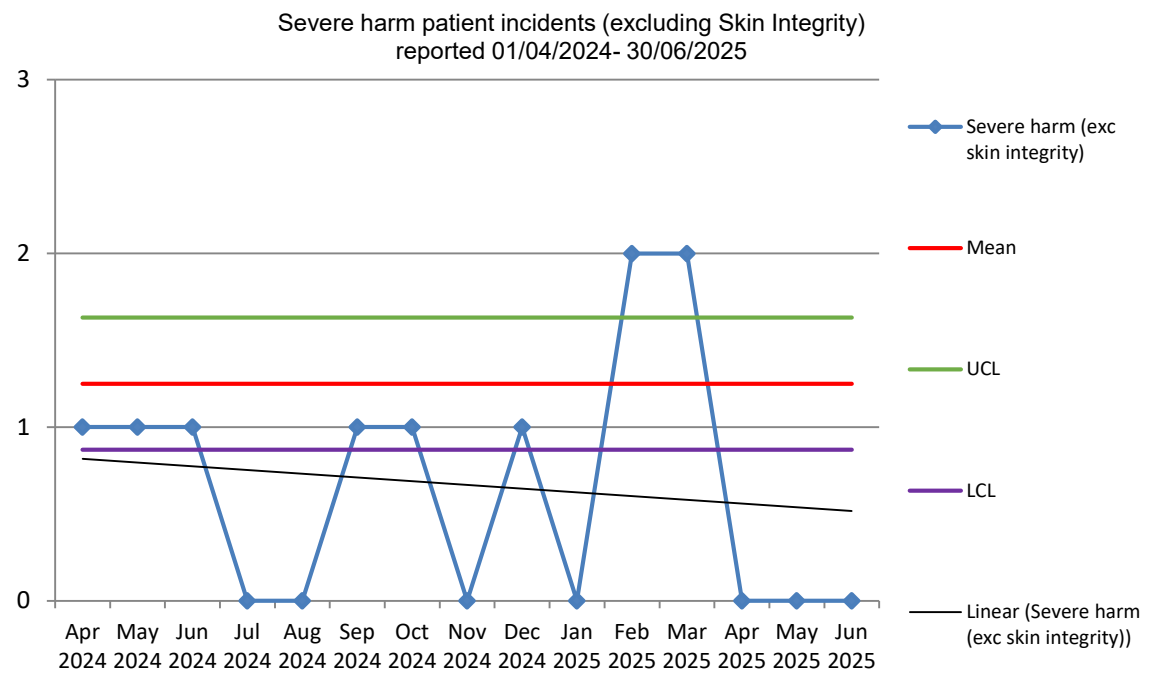
- The top reporting themes remain consistent with the previous month, with slight increases and decreases across categories. We continue see Restrictive Interventions as our most reported no harm incident type and self harm/ self injurious behaviour as our most reported low harm incident type.
- In May 2025, we did observe an increase in the number of incidents related to AWOL, absconding and missing patients, this figure has reduced to 37 from 62 in June. This reduction is largely related to the discharge of a patient to a specialist unit.
- Whilst Violence and Aggression toward staff have been included on this report, these incidents are monitored, and assurance is provided via the Health & Safety and Security Management Group Meeting (Propose- that this category is removed from future QAG reports)
- Clinical care, treatments and procedures incidents are observed withing both no and low harm incidents this month. This category covers a number of teams and sub-categories including lack of assessment, delays, patient non-concordance, breach of policy, inappropriate treatment. It may be beneficial to include a detailed slide of these incidents in future QAG reports to assist in identification of any potential themes or trends.

What are we doing about it?

- The Professional Head of Community Nursing is proactively monitoring and reviewing no harm/low harm to identify any trends or patterns. Where appropriate AAR's are being arranged in conjunction with the Patient Safety Team to identify wider learning to prevent more moderate and above incidents from occurring.
- Undertaking a review of the Trust ligature policies and liaising with the trust in Dorset regarding what they have put in place to manage ligature events that may be relevant to us.
- Patient Safety Team exploring resources that allow us to benchmark our incident figures against similar trusts given the ongoing data quality issues with LFPSE

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





What is the data telling us?

- There were 20 moderate harm incidents reported in June 2025, as with previous months these were observed to be across several reporting categories (13) with no clear themes.
- All moderate harm fall incidents (3) have been reviewed with learning identified by handler or use of appropriate learning tool.
- All moderate harm medication incidents (3) are under review by handler.
- All incidents related to clinical care, treatments and procedures (3) are being reviewed by handler or advice has been provided by Patient Safety Team to handler regarding harm level.

What is the data telling us?

- The graph indicates that there have been 0 severe harm incidents in June.
- We are aware of 1 unexpected community death in June that was not reported until July 2025. This is currently being managed through Patient Safety processes.

Quality Dashboard

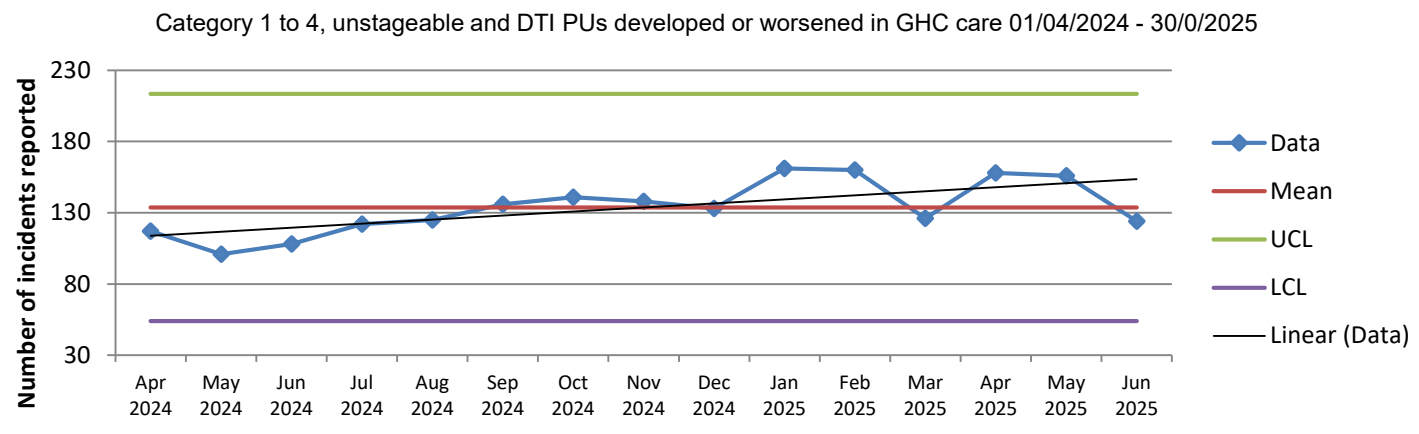
Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

	Reporting Level	Threshold	2024/25 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2025/26 YTD	R A G	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	98%	95%	96.5%	97%										96.5%	G		
N02 - Minimise rates of C. Diff (Clostridium Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only	N	14	5	0	1	1										2	G		
Number of MRSA Bacteraemia	N	0	0	0	0	0										0	N/A		
PU Data threshold removed therefore no longer RAG rated – in line with revised national guidance.																			
Total number of pressure ulcers developed or worsened within our care.	L - R		1567	158	156	124*										438			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		1010	95	102	77*										274			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		61	11	9	4*										24			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		23	1	0	1*										2			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		475	50	45	42*										137			

ADDITIONAL INFORMATION - Health Care Acquired Infections (HCAI) & Pressure Ulcers (PU)

HCAI: There was 1 HOHA Clostridium Difficile (C.Diff) in June. No MRSA infections recorded in June. Note our ICB threshold has been set at 14 for the year.



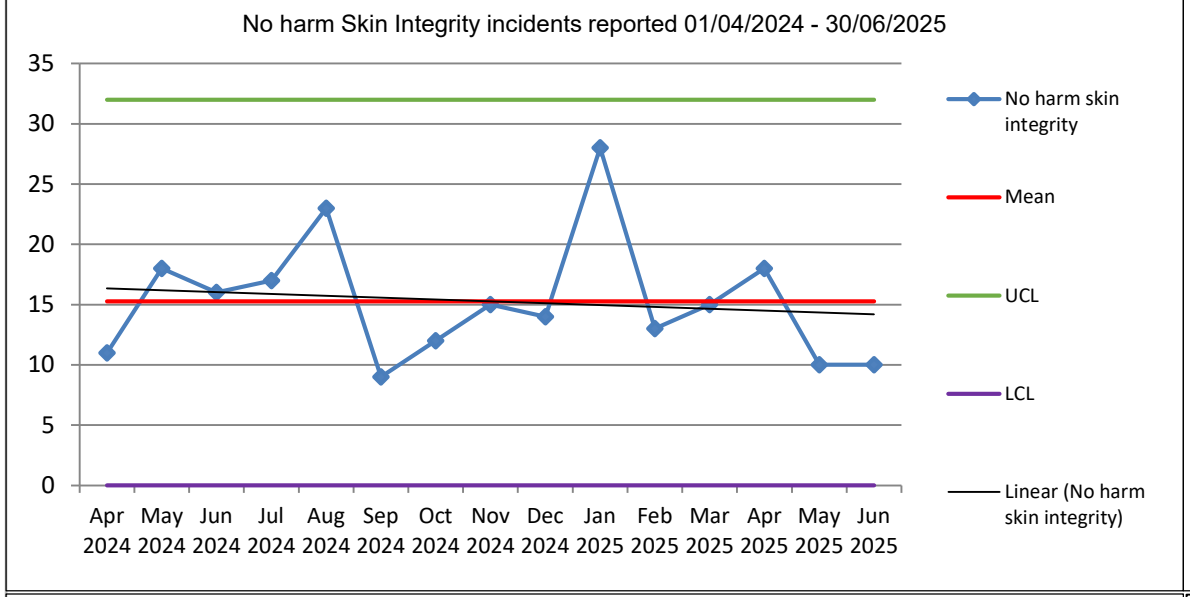
Pressure Ulcers:

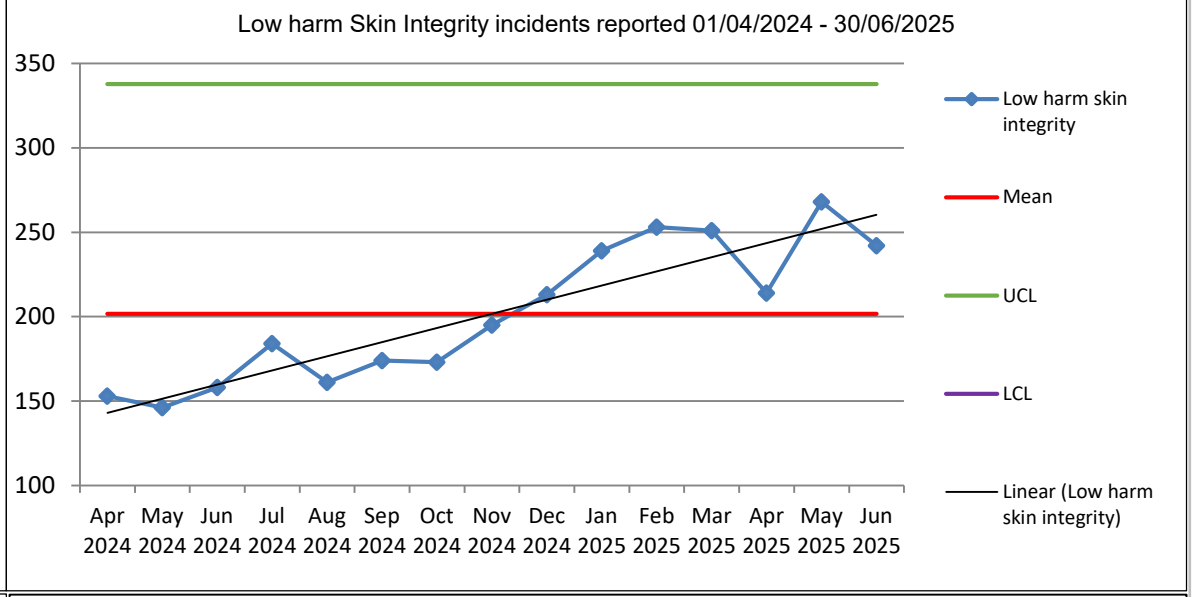
All cat 3, 4 & unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

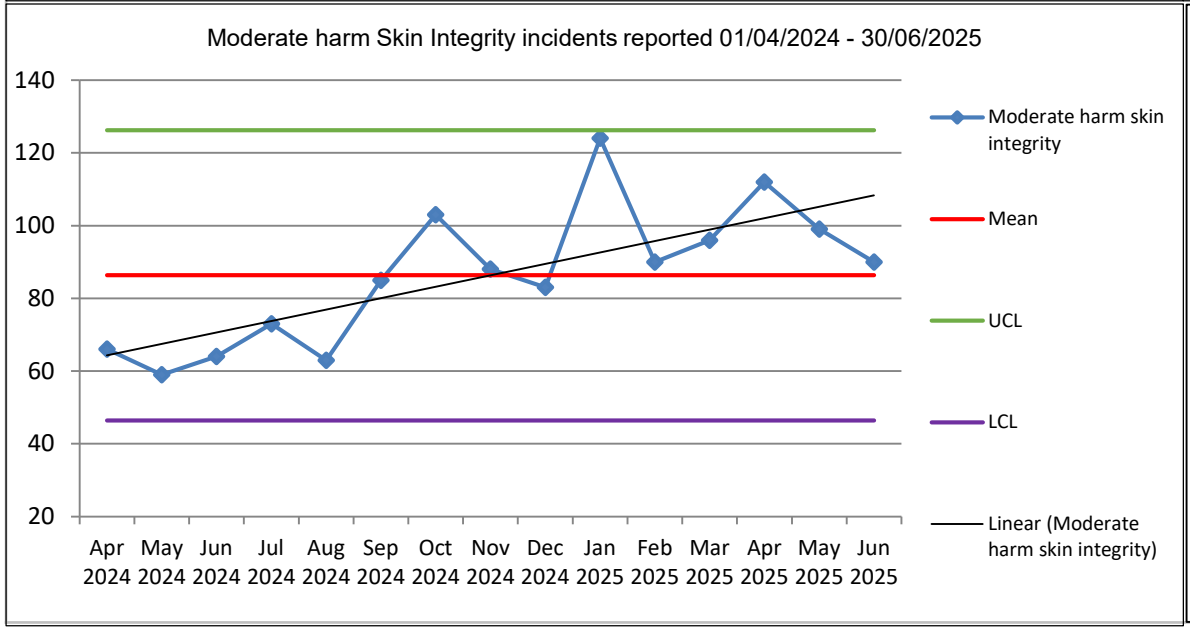
*June 2025 data has not been fully validated so PU classification may alter after review. 51.61% of category 1 to 4, unstageable and DTI PUs developed or worsened in GHC care, and reported in June 2025, had been reviewed and closed by 04/07/2025.

The highest incidents are reported within the ICT nursing teams who have robust monitoring processes, such as PU tracker and oversight by community nursing leads within the ICT. This data / oversight allows the teams to look for themes and support learning and implement change. For the most accurate data, clinicians are requested to report promptly.

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



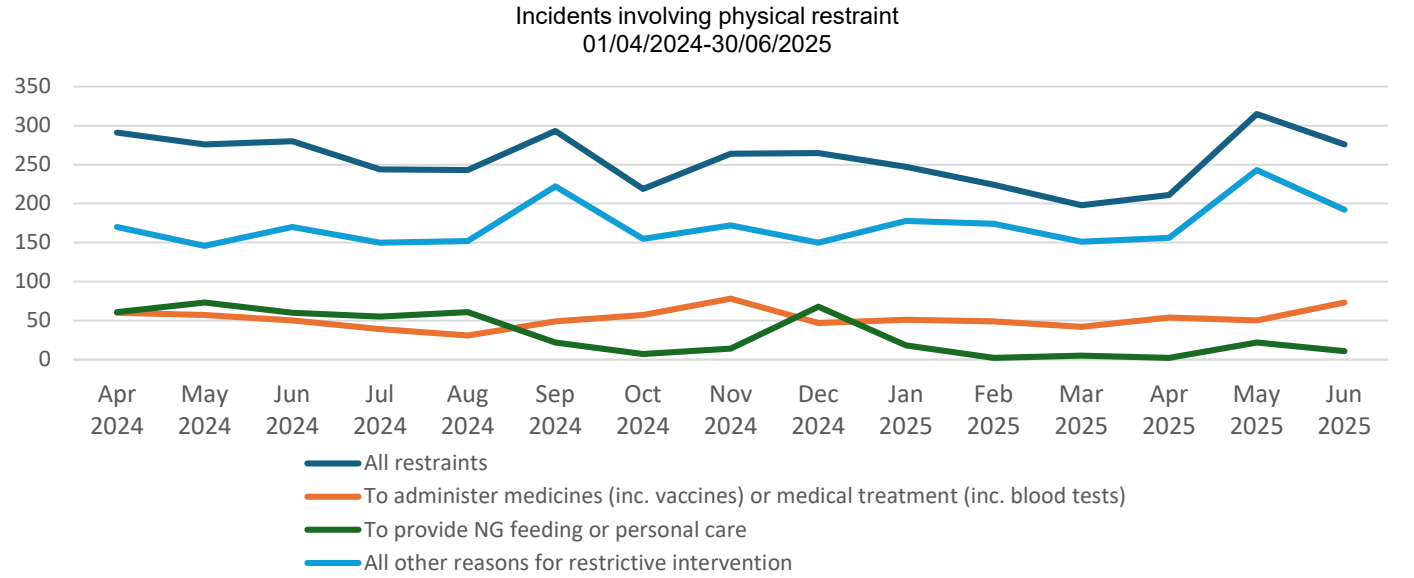


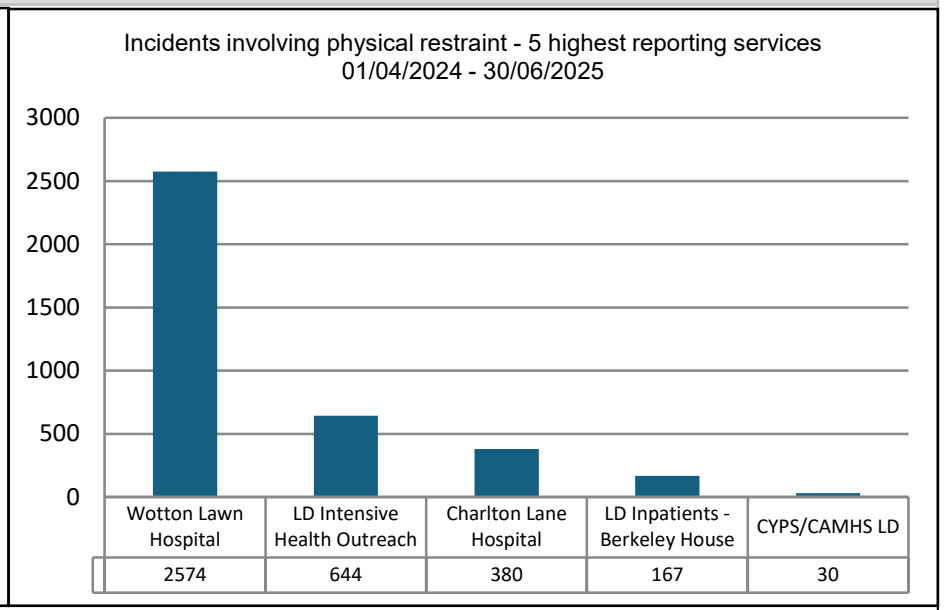


What is the data telling us?

- We continue to see a slightly downward trajectory of no harm, low harm and moderate harm skin integrity incidents, there were 0 severe harm incidents reported in June for the 3rd month in a row.
- There are several projects and initiatives specifically looking at skin integrity underway at the trust including:
  - QI project with Tissue Viability Team and District Nurses, results will be fed back to ICG.
  - Wound Care App Trial in Forest of Dean- Data and case studies are currently being pulled together to be shared wider.
  - Development of a pre doppler pathway which will exclude red flags and enable District Nurses to use compression sooner.
  - We have also been supporting the countywide approach to pressure ulcers but this appears on hold due to the changes with the ICB.

Incidents involving restraint



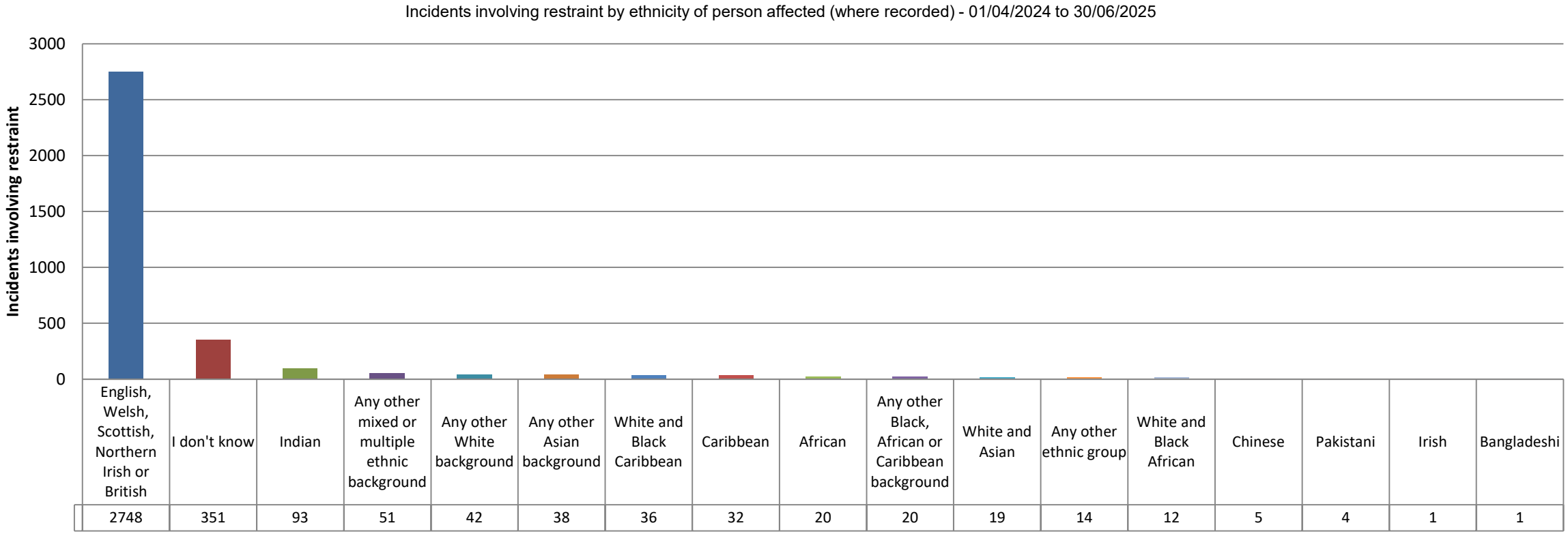


*Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous 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 had been consistently in a range between 200-300 per month since March 2024. This increased to 315 in May 2025 and has since fallen to 276 in June 2025.
- 68% of physical restraints were seated, 12% were standing or escort, 10% were supine (face up) and 10% used other positions in June 2025. Use of supine restraint increased from 14 incidents in May to 29 incidents in June 2025. Increases were seen at Wotton Lawn Hospital (11 to 17 incidents), LD IHOT Team (1 to 8 incidents) and Berkeley House (0 to 4 incidents) between May and June 2025.
- 2 (0.72%) prone (face down) restraints were recorded in June 2025. In both of these situations the patient had placed themselves into the prone position on the floor prior to staff entering the room.
- Use of Rapid Tranquilisation (RT), which had risen to 142 incidents in May 2025, has fallen to 83 incidents in June 2025. This primarily 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 Hospital (4 incidents), Berkeley House (1 incident) and Montpellier Unit (1 incident) in June 2025.
- Restraints to facilitate personal care have increased from 2 in April 2025, to 22 in May 2025 and 11 in June 2025. This is due to the need to facilitate personal care for patients currently at Charlton Lane Hospital.
- All IHOT interventions have been to facilitate Phlebotomy, dental procedure or in support of a clinical procedure.
- There were no recorded episodes of harm to patients because of a Physical Intervention.

Incidents involving restraint- Ethnicity



English, Welsh, Scottish, Northern Irish or British	I don't know	Indian	Any other mixed or multiple ethnic background	Any other White background	Any other Asian background	White and Black Caribbean	Caribbean	African	Any other Black, African or Caribbean background	White and Asian	Any other ethnic group	White and Black African	Chinese	Pakistani	Irish	Bangladeshi
2748	351	93	51	42	38	36	32	20	20	19	14	12	5	4	1	1

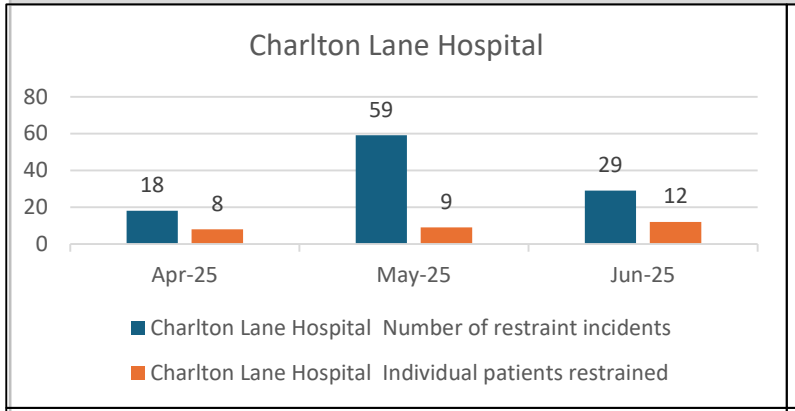
What is the data telling us?

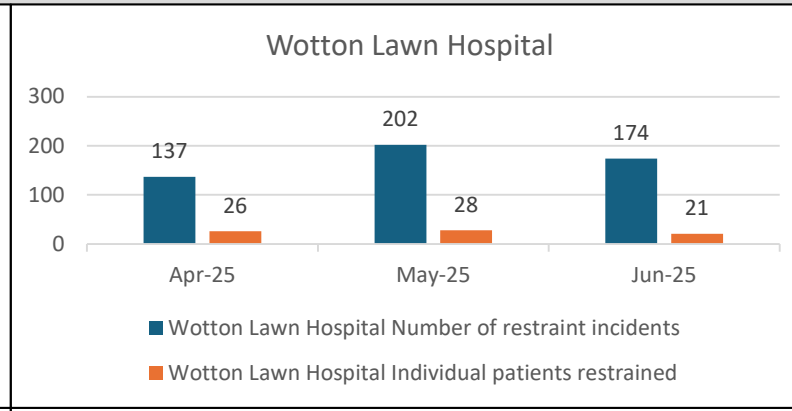
- This data reflects the Ethnicity categories provided by NHS England in the Learn from Patient Safety Events (LFPSE) system and not the national census data around ethnicity hence the different categorisation. This ethnicity code is inputted by the staff member at the time of reporting the incident.

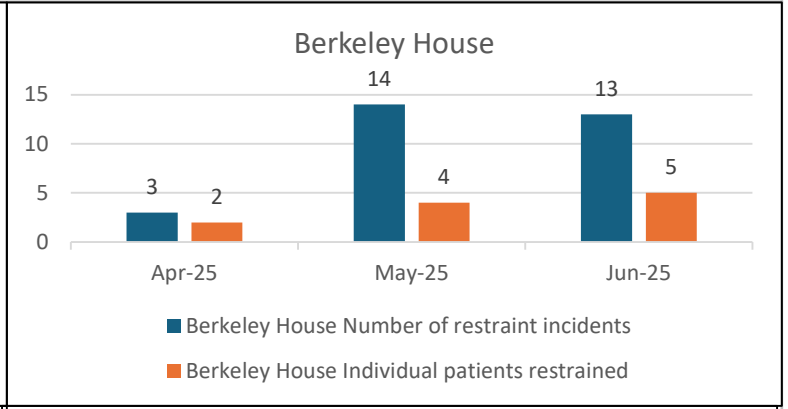
What are we doing about it?

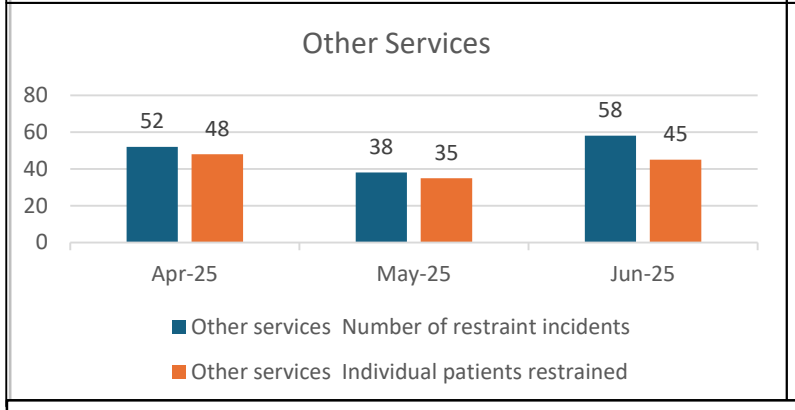
- There is currently improvement work underway to ensure that accurate ethnicity codes are documented in clinical systems for patients.
- There are early conversations between Datix team and BI team to understand whether data can be pulled through in line with national census data to allow for greater monitoring and assurance around incidents and ethnicity particularly those relating to restrictive interventions.

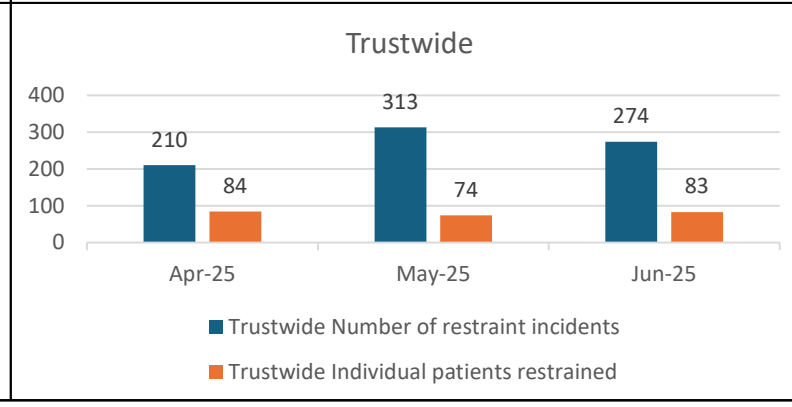
Incidents involving restraint – individual patients restrained

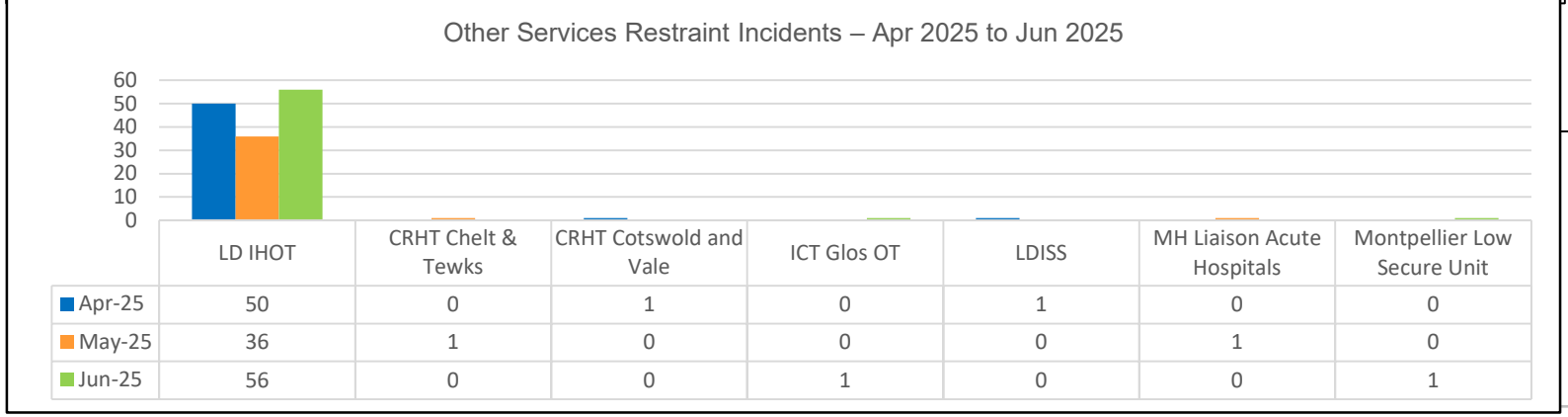












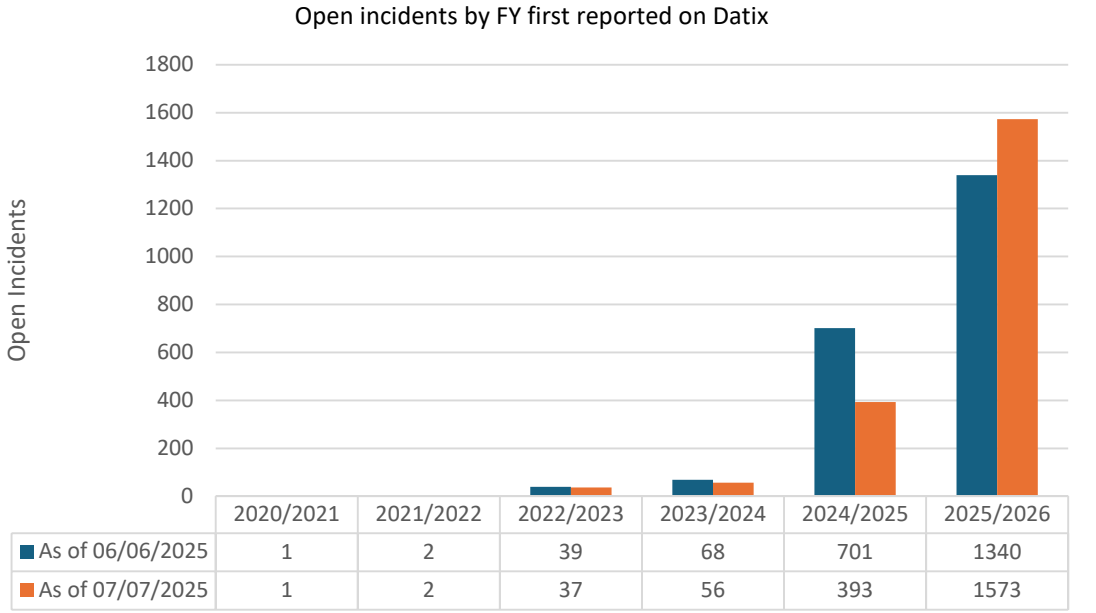
	LD IHOT	CRHT Chelt & Tewks	CRHT Cotswold and Vale	ICT Glos OT	LDISS	MH Liaison Acute Hospitals	Montpellier Low Secure Unit
Apr-25	50	0	1	0	1	0	0
May-25	36	1	0	0	0	1	0
Jun-25	56	0	0	1	0	0	1

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:

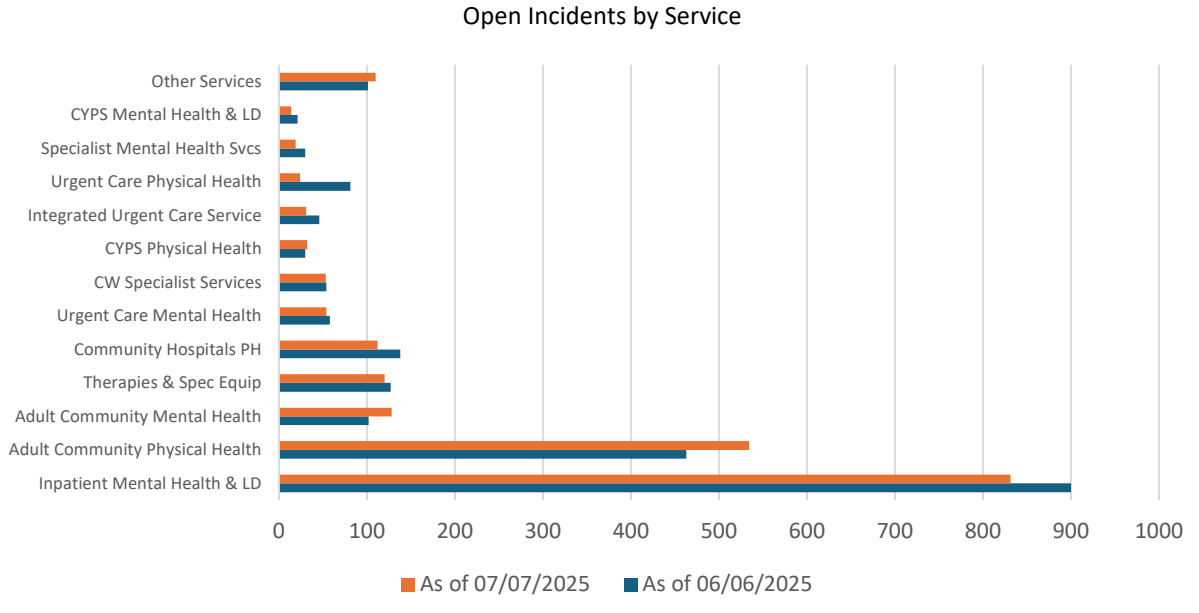
In June 2025 58 restraint incidents were reported across the other services of LD IHOT (56), ICT Glos OT (1) and Montpellier Unit (1). These involved 43 patients in LD IHOT, 1 patient in ICT Glos OT and 1 patient in Montpellier Unit.

The intervention in ICT Glos OT was a non-standard hold to support a patient to remain standing during assessment for outdoor mobility after knee gave way and then assist in transfer to chair.

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



	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
As of 06/06/2025	1	2	39	68	701	1340
As of 07/07/2025	1	2	37	56	393	1573



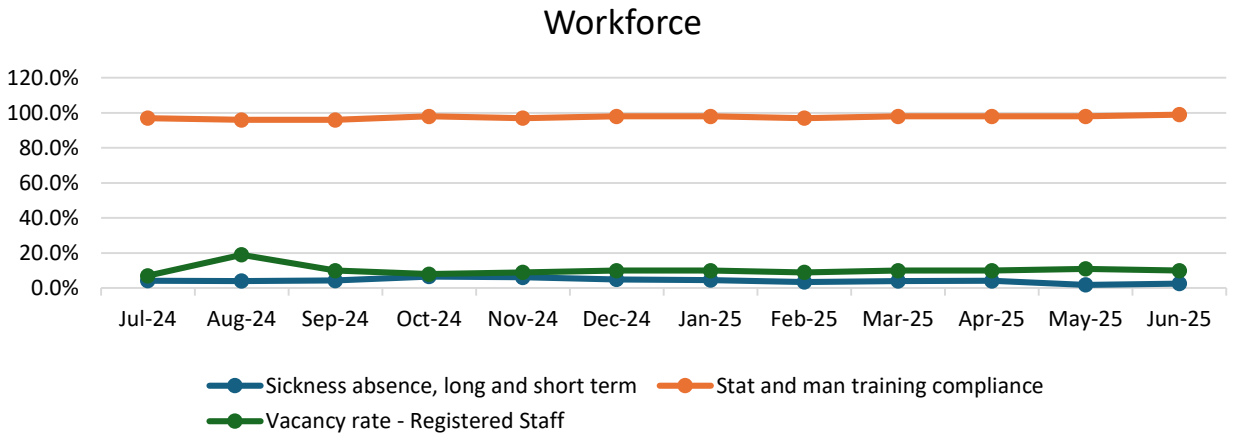
What is the data telling us?

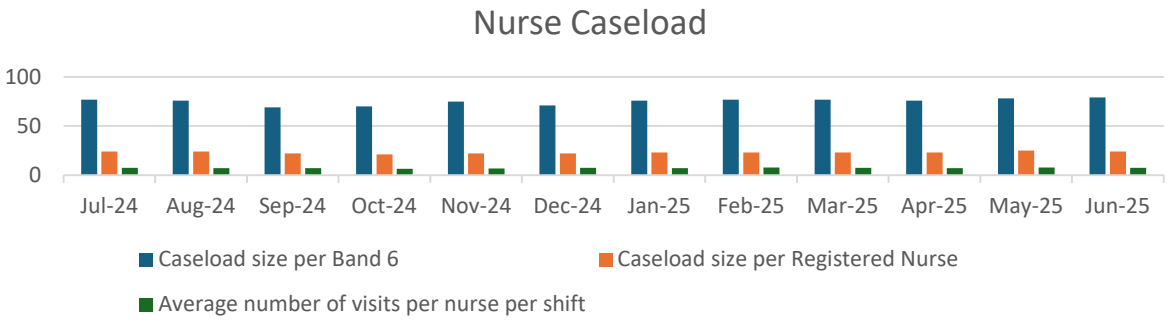
- There are observed overall reductions in the number of open incidents by financial year with the exception of 2025/2026. The largest reduction in overdue incidents can be seen for the 2024/2025 financial year.
- The reduction in overdue incidents reflects the increased monitoring and commitment of colleagues in services and operations.
- The increase in incidents for 2025/2026 is expected as this is our current reporting year and will include the addition of recent incidents.

What are we doing about it?

- Dashboard remains available operations team to monitor open incidents and liaise with colleagues in services where there are overdue incidents. Datix team produce weekly reports where increased monitoring may be required.
- Bank nurse has employed to review all outstanding incidents related individual who had been inpatient at Wotton lawn at time of self injurious incident. When completed this will close approximately 174 incidents by the end of July.
- Patient Safety Team are reviewing any moderate and above incidents that have been allocated for closure.

ICT Community Nursing Workforce - June 2025

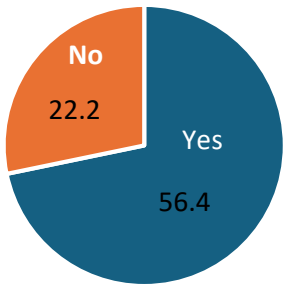




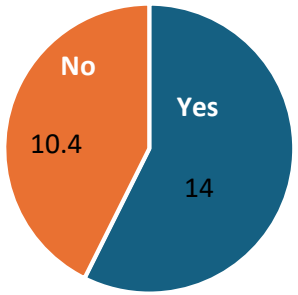
What the data is telling us: a focus on individual locality sickness has identified figures for Cheltenham ICT Community Nursing have a 6.19% which is 2.19% above the target. All other ICT Community Nursing teams are below the 4% threshold. The SPQ chart on slide 2 illustrate this data. Factoring in all the other quality dashboard metrics supports the need to further cross support Cheltenham ICT.

What the data is telling us: there is little change in the average caseload size and visits per nurse per shift, however the next graph highlights how a different data set can highlight operational pressures.

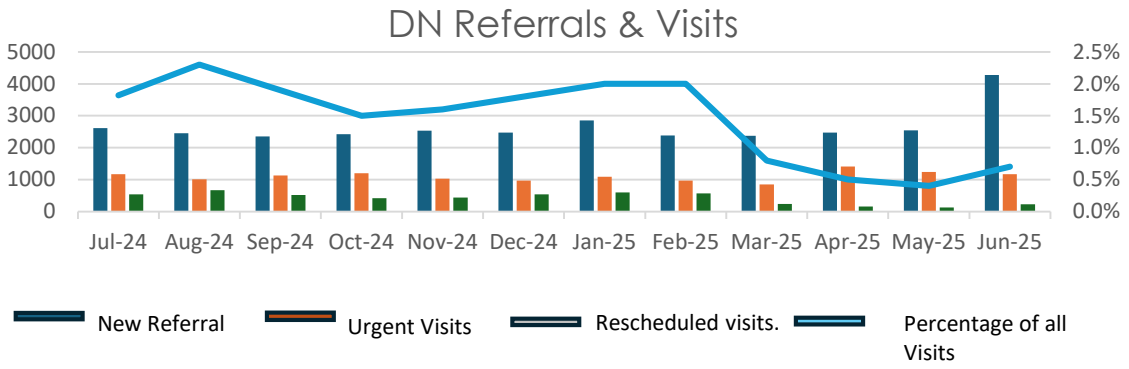
SPQ at B6



SPQ at B7

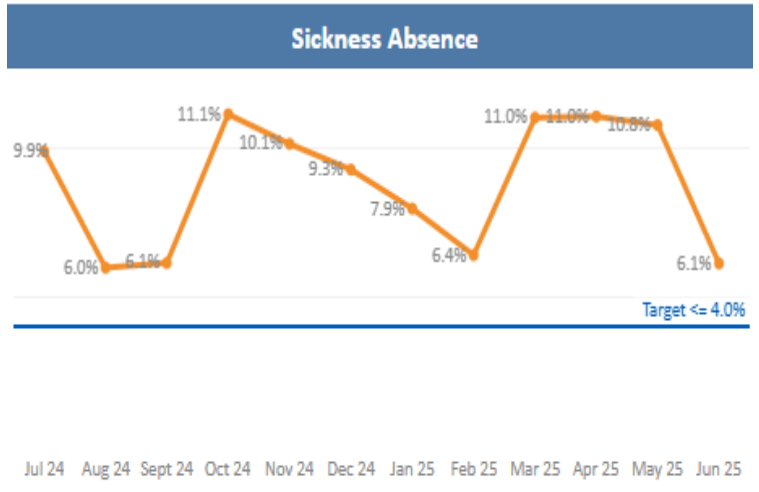


What the data tells us: there is slight changes this month explained by SPQ qualified nurses leaving or joining the ICT teams.

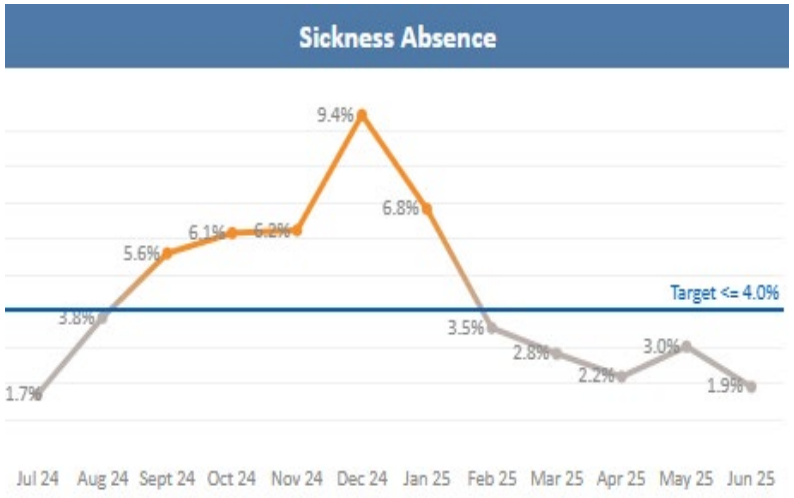


What the data is telling us: there was an increase of 1732 new referrals into ICT community Nursing countywide.

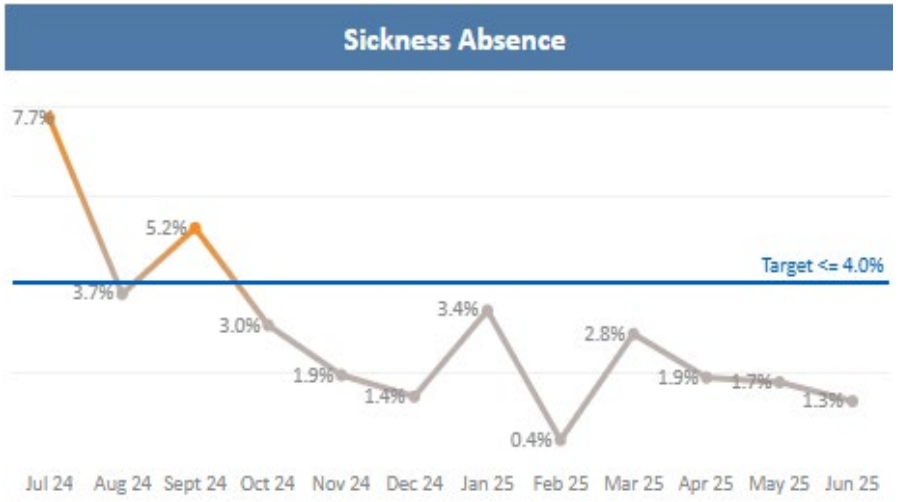
Cheltenham ICT Community Nursing



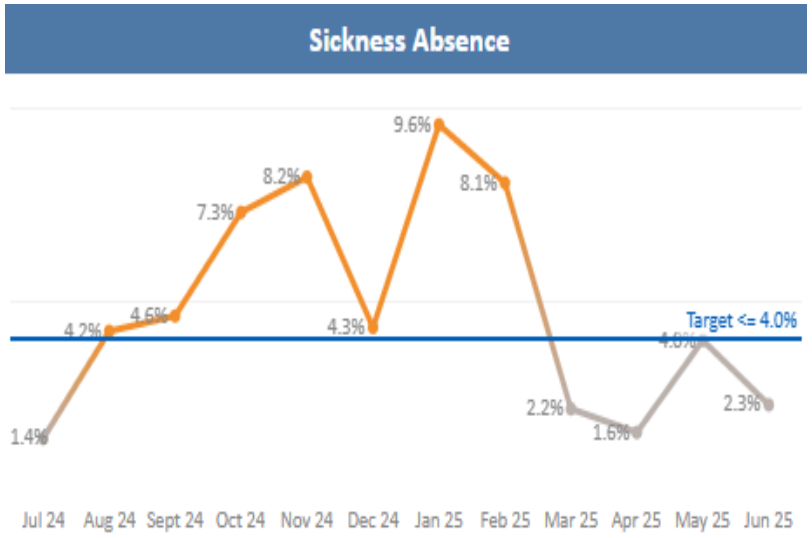
Cotswolds ICT Community Nursing.



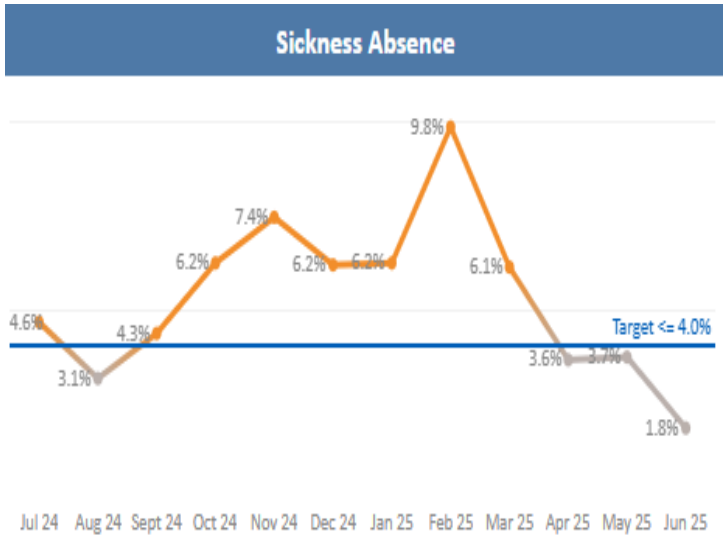
Stroud ICT Community Nursing



Forest & TNS ICT Community Nursing

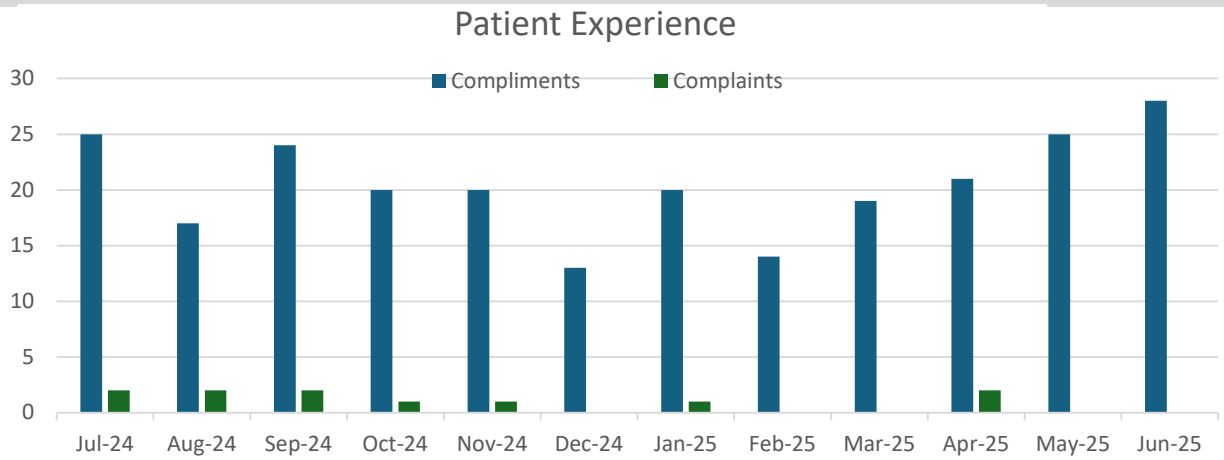


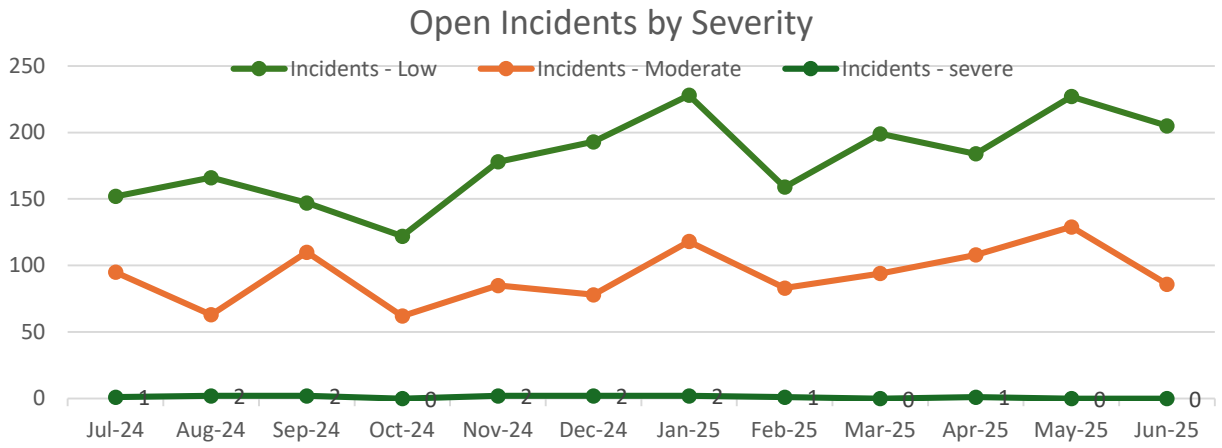
Gloucester ICT Community Nursing



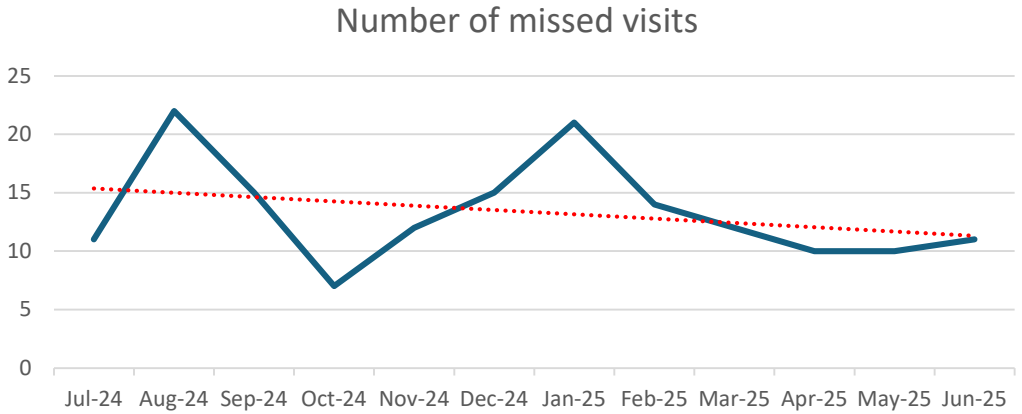
What is this telling us: Data accessed from Tableau to further examine and inform as taking an average across the 5 localities can mask operational challenges in one locality.

ICT Community Nursing – June 2025

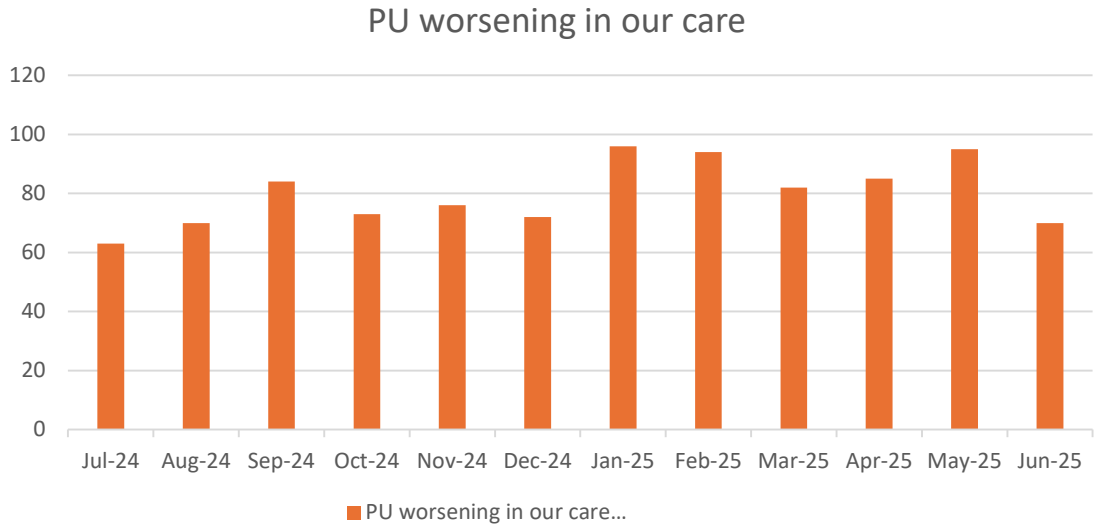




What the data is telling us: ICT Community Nursing has received 3 more compliments this month and no complaints.



What the data is telling us: despite all the highlighted pressures of increased referrals and sickness the number of missed visits reduced in April & May however June shows a slight increase (1) which we continue to monitor.



What the data is telling us: there is a decrease of 25 PU's worsening in our care from last month. Triangulation of this data across localities for September in support of the wound care app pilot in the Forest ICT Community Nurse team will be presented.

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE
Safe Staffing Inpatient data June 2025

Ward Name	Code 1		Code 2		Code 3		Code 4		Code 5	
	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	7.5	1	0	0	0	0	0	0	0	0
Abbey	45	5	45	4	0	0	0	0	0	0
Priory	105	14	15	1	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	7.5	1	22.5	3	0	0	0	0	0	0
Greyfriars	30	4	30	4	0	0	0	0	0	0
Willow	7.5	1	45	6	0	0	0	0	0	0
Chestnut	32.5	4	22.5	3	0	0	0	0	0	0
Mulberry	0	0	30	4	0	0	0	0	0	0
Laurel	75	10	0	0	0	0	0	0	0	0
Honeybourne	150	20	0	0	0	0	0	0	0	0
Berkeley House	0	0	15	2	0	0	0	0	0	0
Total In Hours/Exceptions	460	60	225	27	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 Priory Ward 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 Priory ward was attributed to RN shortages on early and late shifts. Willow Ward reported the highest number of code 2 exceptions due to HCA's on late shifts. There is currently no data being reported in the QDB for our Com Hospitals; this data for June 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

NHS Gloucestershire Health and Care Trust

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

- = (G) Over use of continence pads
- = Shared decision making in MSKAPS
- =Improve quality of sleep on ward
- + Personalised Care Programme

- = Culture of Care Abbey Ward
- = (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 LoS dementia pathway
- = Why do certain demographics access MSK physiotherapy in Forest of Dean?
- ↑(s) Catheter Trauma - increase knowledge and how to prevent and manage
- ↑ Recording ethnicity in SystemOne

- = Falls assessment and education service care home pathway
- = (s) (G) Improving the number of patients receiving their depots in primary care
- = Paper Care Certificate Workbooks
- =(s) Sexual health triage capacity and improving patient access
- = (s) The Vale Stroke Unit
- = Getting feedback from patients about MHA assessment
- = (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
- = Improving the adult SLT referral and triage process
- = BCG Immunisations
- = CAMHS Screen Use Project
- =(s) Digital Front Door process
- = (s)Improving housing support planning
- for the supported accommodation service within mental health
- ↑ Assistance with Voice patient service within SLT
- ↑ To develop an effective pathway for people experiencing At Risk Mental State pathway
- ↑ Overgranulation
- ↑ (s)Understanding the Barriers to completing Silver QI

- = Culture of Care - Dean Ward
- = Culture of Care - Kingsholm Ward
- = Culture of Care – Priory Ward
- = IPS Project
- =Improving self-referral form for MSK physiotherapy
- = 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
- = Improve access and experience of the perinatal pathway for South Asian women during the perinatal period.
- =(G) Developing a process for Observed Practice within AHPs
- = Adverse events pathway
- ↑ Inadequate and not optimised bone protection

- ↑ Inequities in the Mental Health Act - Greyfriars

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

- 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 June 2025:
33 Silver (current trained taken from Care to Learn, GHFT or GHC silver trained) –0.7% workforce
787 Bronze (current trained taken from Care to Learn) - 16.1% workforce
2024 Pocket QI, total trained overtime

Directorate	No of improvement work supported by QI Hub (includes projects from Lifecyle and others)
Countywide	8
MH Hospitals and UC	11
PH Hospitals and UC	5
Adult MH/PH/LD Community	14
CYPs	17
Corporate	12
Total: 67	

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	2,509	2,158										6,995	Including 31 responses from carers (84% positive response)
% of respondents indicating a positive experience of our services	N - T	95%	93%	92%	94%	93%										93%	
Number of compliments received in month	L - R		2,830	256	270	256										782	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	128	128										376	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		204	23	14	14										51	2 x PHUC/IP, 1 x CYPS, 2 x Comm (2 x MH), 1 x Countywide, 7 x IUC and 1 x Patient Flow
Of complaints received in month, how many were early resolution complaints	L - R			23	14	14										51	
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			64	56	47											
Percentage of complaints acknowledged within 3 working days	N - T	100%	99%	100%	100%	100%										100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			26	22	23										71	
Number of complaints closed within 3 months	L - I			23	17	13										53	
Number of re-opened complaints (not all opened within month)	L- R			3	2	2											Both in Community directorate (1 x PH and 1 x MH)
Number of external reviews (not all opened within month)	L - R			3	6	4											2 x MH UC/IP and 2 x Community (2 x MH)

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

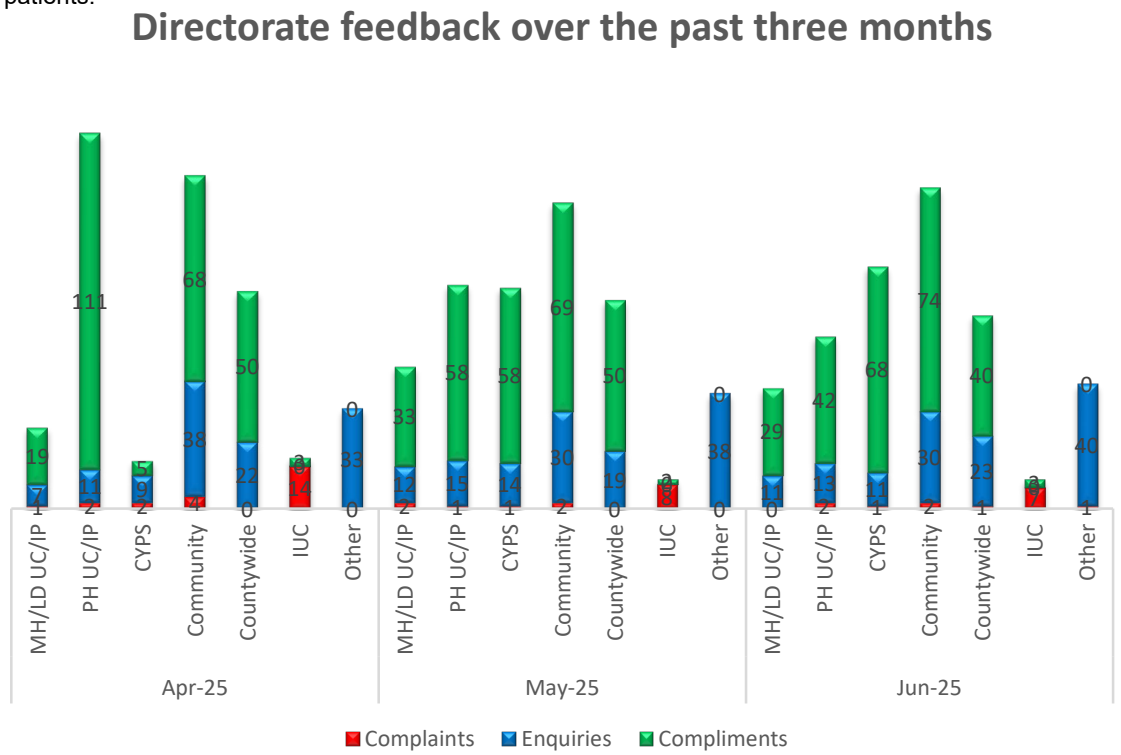
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

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 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	0	Early resolution:	**0**	11	29
		Closer look:	**0**		
PH urgent care and inpatient	2	Early resolution:	**2**	13	42
		Closer look:	**0**		
CYPS	1	Early resolution:	**1**	11	68
		Closer look:	**0**		
PH/MH/LD Community	2	Early resolution:	**2**	30	74
		Closer look:	**0**		
Countywide	1	Early resolution:	**1**	23	40
		Closer look:	**0**		
IUCS	7	Early resolution:	**7**	0	3
		Closer look:	**0**		
Other	1	Early resolution:	**1**	40	0
		Closer look:	**0**		
Totals	14	Early resolution:	**14**	128	256
		Closer look:	**0**		



Examples of complaints [as reported] for each directorate:

- PH UC/IP: Mother of patient unhappy and wishing to put in a complaint about lack of knowledge of interception, pain perception difference and how to communicate with autistic people.
- CYPS: Mother of patient wishing to place a formal complaint regarding the team's care.
- Countywide: Carer for patient unhappy that the patient's wheelchair was missing a part.
- IUCS: Mother of patient unhappy that they requested an out of hours GP appointment and the person they saw was not a GP and could not help.

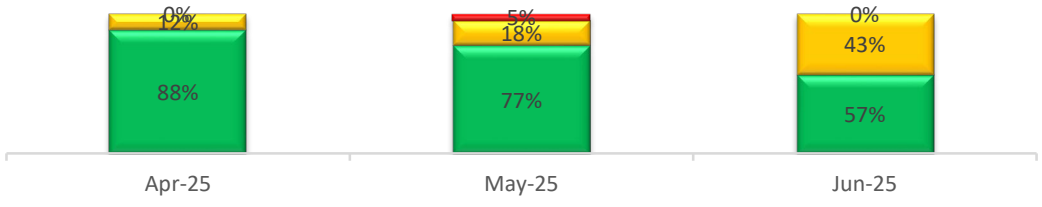
The above graph shows feedback by type and directorate over the past three months.
Whilst we continue to welcome complaints as an opportunity to improve our services, it is important to recognise good practice across all directorates.

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	2	0	0	2
PH urgent care, inpatient	0	0	0	0	0	0
CYPS	0	0	2	0	0	2
PH/MH/LD Community	1	1	1	0	0	3
Countywide	0	1	0	0	0	1
IUC	11	2	2	0	0	15
Other	0	0	0	0	0	0
Totals	**12**	**4**	**7**	**0**	**0**	**23**

The below graph shows the length of time taken to close complaints.
This month, 57**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)

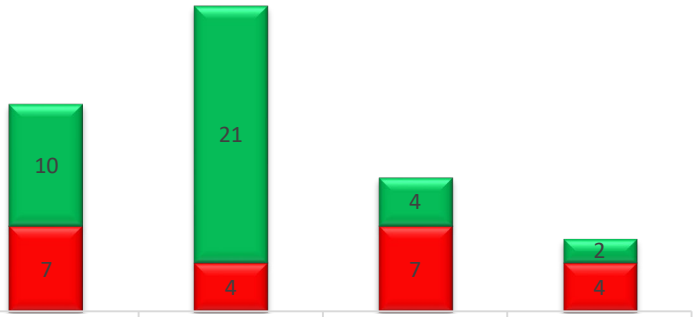


	Apr-25	May-25	Jun-25
Series3	0%	5%	0%
3-6 months	12%	18%	43%
0-3 months	88%	77%	57%

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
Community (19260)	Patient unhappy with inaccuracies in his health records. **Trust admin/policies/procedures including patient record management**
IUCS (17433)	Father of patient very unhappy with attitude of clinician **Communication**
IUCS (18680)	Patient unhappy with process and attitude of NHS111 clinician. **Communication**
Countywide (17291	Care provided fell short of what should be expected. **Clinical treatment**

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



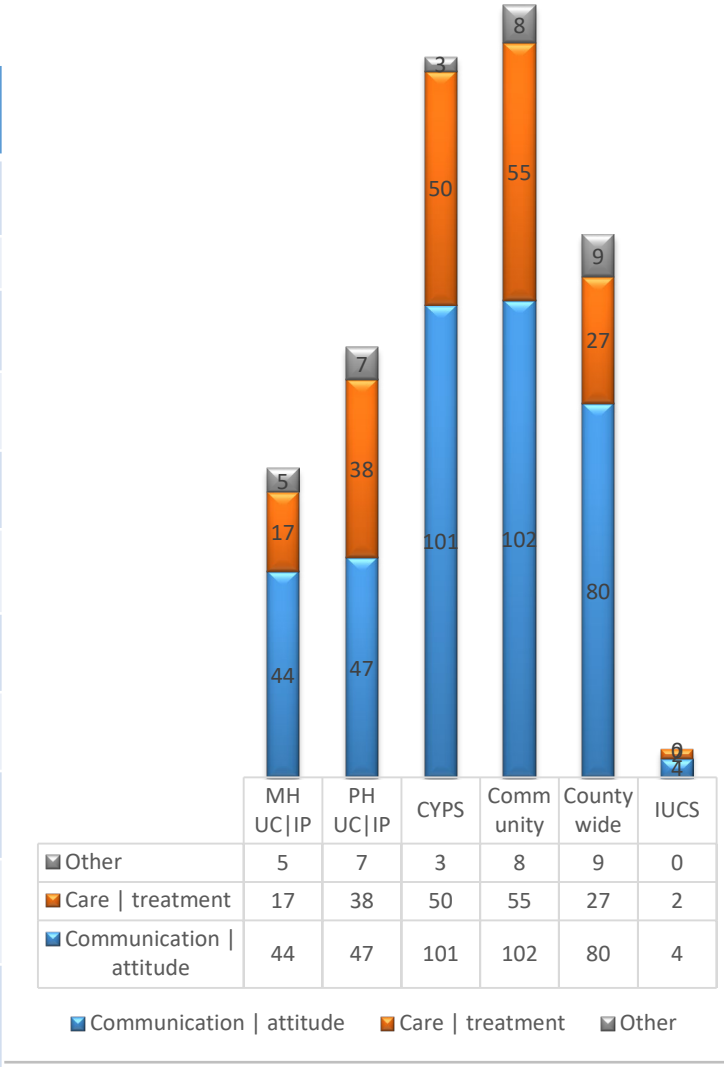
	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	10	21	4	2
Upheld	7	4	7	4

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

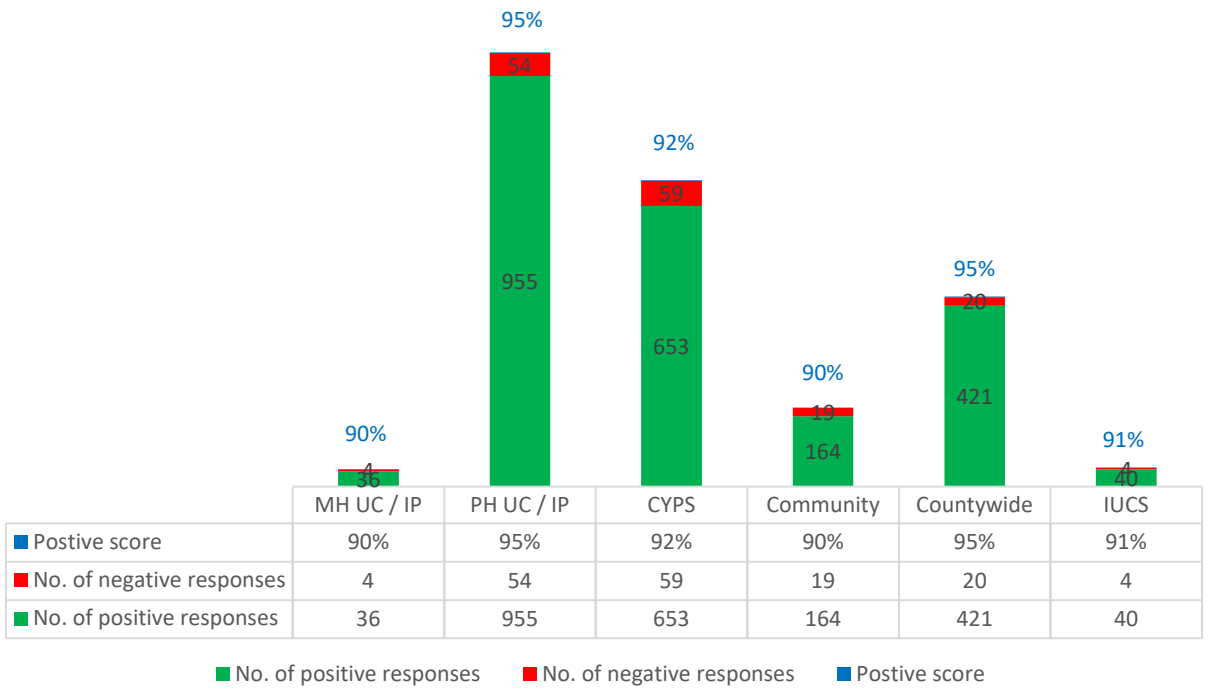
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

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

Date	ID	Team	Compliment
09/06/2025	19480	Wotton Lawn-Inpatient OT	"You have all been so kind and supportive. I particularly enjoyed the therapeutic allotment sessions"
05/06/2025	19312	CRHT Liaison s135 s136	Patient had shared with Police how helpful his earlier calls with CRHTT had been in reducing his distress
11/06/2025	19399	NC Hosp-Cotswold View Ward	I love it here , lovely atmosphere , really kind and understanding staff. I've even enjoyed the hospital food.
13/06/2025	19420	Stroud Hosp-Cashes Green Ward	" Thank You Card To ALL the Staff on Cashes Green Ward. Thank you so much for looking after our mum with such care and tenderness. We appreciate all the kindness and laughter from the moment she arrived to her discharge.
13/06/2025	19623	CAMHS MH Support Team	"I can't thank you enough for how quickly your service picked him up to offer the support that you have provided so far. We are all really grateful and to us you are all worth your weight in gold! "
10/06/2025	19444	CYPS/PH-Community Nursing	"text received by one of the CCN team from parents' As parents, we really appreciated everyone's amazing support and advice'"
19/06/2025	19511	ICT Cotswold South OT	I will never forget the support you gave us over the last two years of their life. Continue to help people in the way that you do. Your kindness radiates – you are definitely in the right job
18/06/2025	19483	Recovery SC Stroud	Patient expressed their gratefulness for the support they received from their Care Coordinator which they described as fantastic.
18/06/2025	19488	MSK Physio	Patient pleased with the service received by clinician. Wished to compliment on the way that the consultations were carried out and the advice given by him.
18/06/2025	19496	Wheelchair Assessment Service	Expressed satisfaction of smooth service delivery and comfortability of the wheelchair parts received. Very happy with the whole communication process.
28/06/2025	19651	IUCS OOH Service	Patient finished appt and came to reception desk and stated' that Dr Padmini was very good and they wanted it noted'.



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

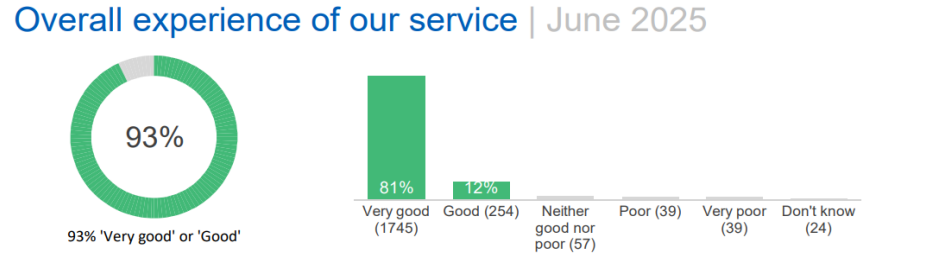


	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
Postive score	90%	95%	92%	90%	95%	91%
No. of negative responses	4	54	59	19	20	4
No. of positive responses	36	955	653	164	421	40

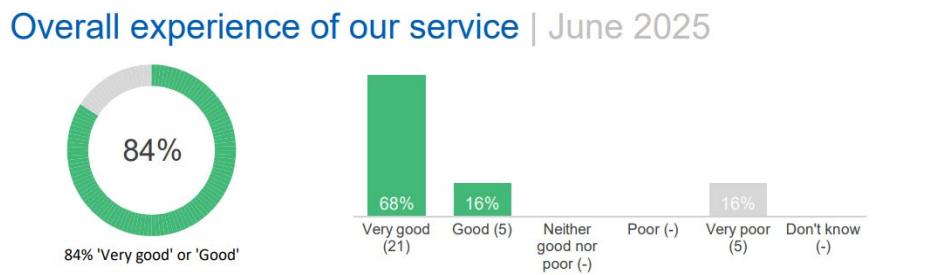
Highlights for this month:

- The overall positive experience rating is 93% which is down from last month but in line with recent months.
- 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 1 request for contact/action through the FFT.
- FFT set up to support new IUC service; there were 28 responses in June 2025 with a positive experience rating of 75%.
- We are reviewing the requirement for pre-paid envelopes, including an EQIA and cost per response analysis

Patient feedback



Carer feedback



CQC DOMAIN - ARE SERVICES RESPONSIVE? Berkeley House Section 31 update

Assurance Category (Based on our learning assurance framework)	October 23 Total conditions 5	October 24 Total conditions 5	July 25 Total conditions 5
Can demonstrate a sustained improvement	**0**	**2** (standard no 4 & 5	**5** (standard 1, 2, 3, 4 & 5)
Action complete, tested and embedded	**0**	**1** (standard no 3)	**0**
Action complete but not yet tested	**5** (standard 1, 2, 3, 4 & 5)	**2** (standard 1& 2)	**0**
Action significantly progressed	0	0	0
Action commenced	0	0	0
Insufficient evidence to support action progress / action incomplete / not yet commenced	0	0	0

Standard No	Standard description
1	Provide an individualised report of the legal and clinical rationale for the restrictions imposed on each service user, along with the plan to reduce these restrictions to the minimum.
2	Must review and provide an updated Behavioural Analysis Plan for each service user.
3	Must ensure that all CCTV observations of service users are undertaken safely, as per the providers policy.
4	Must not admit any new service user to Berkeley House without the prior written agreement of the Care Quality Commission.
5	Must provide monthly updates and assurance on the conditions outlined within this Notice of Decision by the last Tuesday of each month.

Update:

We have met all the requirements of the S31 notice and have been providing monthly updates in a prescribed template for 20 months. To support the application to the CQC for the removal of restriction against the S31 notice we will fidelity test the standards and provide the evidence to the regulator that we have sustained improvement in the 5 areas above.

We have consistently achieved standard 4 & 5 and the CQC are assured by the information we have shared monthly. At the request of the CQC we have scaled down the amount of information being shared each month and this took effect from Dec 24. We completed a mock CQC visit on the 8th July with representation from ICB colleagues.

Additional assurance:

During the period of the S31 restriction we have completed the BDO audit 'Barriers To Raising Concerns (Oct 24), noting all recommendations now complete & supported a Quality Network Learning Disability Peer Review (Jan 25).
Discharge activity – 2 discharges completed, and active discharge activity is planned from June through to August 2025 . Planning permission and NHSE funding secured for the last inpatient, likely discharge April 26.
Tri concordant LD Pathway review started in May 25.

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
0-3	Cover and Exec Summary	To remain. Following the 4 A format.	N/A	Jane Stewart
5 - 8	Safeguarding Highlights and Challenges	A safeguarding summary report was presented at QAG in June and these highlights are included this month along with the complete data set for assurance and to provide a comprehensive data flow alongside a summary of statutory actions.	July 25	Paul Gray
9 - 20	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. IPC.to appear by exception. IPC zero return in summary.	May 25	Nicola Mills
22 - 24	District Nursing Data	May alternate going forward with other slides such as IPC and Meds Management.	July 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
24	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
26-- 30	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
17	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 QAG.	Aug 25	Tanya Stacey
	Long Length of stay MH and CoHo	Removed, as captured in the integrated report under Board Domain.	Complete	Jane Stewart

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 JULY 2025**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **QUALITY & PERFORMANCE DASHBOARD – JUNE 2025/26 (M3)**

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 June (Month 3, 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 and risk meeting which was held for the first time in June and more widely accounts for performance indicators in exception and outline service-level improvement plans including forecasts. Data quality progress is formally monitored through the Patient Records Quality Group which updates the Business Intelligence Management Group (BIMG).

Recommendations and decisions required

The Trust Board is asked to:

- **NOTE** the Quality and Performance Dashboard Report for June 2025/26 as a **significant level of assurance** that the Trust's performance measures are being met and,
- **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.

Executive summary

Business Intelligence Update

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

Performance Update

The performance dashboard indicators are presented from page 2 within the Board's four source format (*to note, the Operational source is only presented to the Resources Committee – not the Board - but the source 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 across wider governance processes for all indicators for all source areas. The Trust's Executive perspective is now incorporated into individual metric narrative.

Alert

The Board are alerted to these four measures within the report and are asked to consider them for follow-up within the appropriate Committees in August 2025:

- N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice – narrative on page 2
- L19 Ensure that reviews of new short or long-term packages take place within 8 weeks of commencement – narrative on page 6
- L21 MH Liaison – number of routine referrals seen within 24 hours – narrative on page 6
- B11 Safer Staffing Fill Rate – narrative on page 9

Assure

Please be assured that items recommended for follow-up by the Trust Board in May 2025 (based on M1 April 2025 performance) were discussed within the Resources Committee in June 2025. Further assurance is provided through this month's narrative for the following indicators whereby appropriate actions and improvement planning is in place or in development.

- N42 - Talking Therapies Reliable recovery rate for those completing a course of treatment and meeting caseness – narrative on page 2
- L07 & L08 Adult Eating Disorder service waits – narrative on page 6
- L14 % of service users asked if they have a carer – narrative on page 6
- B01 - Care Programme Approach - formal review within 12 months – page 9
- B08 Data Quality Maturity Index – narrative on page 9
- Length of stay rates across MH PICU Inpatients B19, MH Older Adult Inpatients B20, Community hospital average length of stay B23, PH CATU B24 and Stroke rehabilitation B25 and Bed occupancy levels B04 and B05 – narrative on page 9 and 10.

Applaud

The following performance indicators are highlighted for specific celebration as positive performance areas and recognition of team excellence for the period:

- L03 CYPS Core CAMHS – narrative page 5.
- Integrated Urgent Care Services are driving continued performance improvements across many of their indicators (such as N45, N46, N53 and L26) with improvement plans in place (such as N67) – narrative on pages 2, 3 & 6. Particular attention is

celebrated with the important Category 3 and 4 ambulance and ETC validation metrics which are performing well beyond compliance (N52 and N68) and therefore not in the dashboard. All IUCS Indicators are being reviewed in response to National KPI changes (now only 7), which informing agreement to reposition or retire other measures, particularly those that never fitted the Gloucestershire delivery model.

- Wheelchair service routine, priority referrals assessed and equipment delivery for adults and under 18s (O27, O28, O29, O30, O31 and O32)
- All measures are in compliance for the period.
- CYPS Health Visiting (S02, S03, S04, S05, S06, S08, S09 and S10)
- The service presented compliance for the period for all its measures covering new birth visits, breastfeeding visits and child reviews.
- CYPS School Nursing (S14 & S15) – narrative page 4.
- Dental & Sexual Health Services. Although not directly within the quality and performance dashboard yet, all locally monitored KPIs were presenting compliant positions across Sexual Health, the Sexual Assault Referral Centre, the Community Dental Specialist and IMOS Services. This covered treatment and referral to book waits, HIV testing offers and response times.

Advise

Finally, these measures are referenced for information and to note only:

- *N02 Minimise rates of C. Diff – narrative on page 2*
- *N11 Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks – narrative on page 2*
- *B16 % medication incidents resulting in moderate, severe harm or death on page 9*
- *B28 and B29 Appraisals, B30 Sickness absence and B32 Cumulative leave – narrative on pages 10 and 11*
- *B50 Number of never events – narrative on page 11*

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 the Operational Performance and Risk Group. Risk are linked where appropriate.

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 is also monitored through the Patient Record Quality Working 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 performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting such as the DQMI indicators.

Where has this issue been discussed before?
Operational Governance and Risk meeting on 22/07/2025 and BIMG on 17/07/2025

Appendices:	Quality and Performance Dashboard Report M3

Report authorised by:	**Title:**
Sandra Betney Sarah Branton	Director of Finance and Deputy CEO Chief Operating Officer

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
June

AGENDA ITEM: 10.1/0725

Quality & Performance Dashboard Report

Aligned for the period to the end June 2025 (month 3)

In line with the Quality & Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents performance indicators from four Sources (*formally called "Domains"*) including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and **Board Focus**. The (fifth) **Operational** Source is only presented to Resources Committee (not Board) however is always received within monthly Operational Performance and Risk Meetings and reviewed within the Business Intelligence Management Groups (BIMG).

In support of these indicators, monthly Operational Performance & Risk summaries (with improvement plans, action planning and improvement forecasts where appropriate) are presented to the Operational Performance and Risk Meetings. Some services are formally negotiating interim milestone proposals which are aligned to their improvement plans and these will move through BIMG for ratification before Resources Committee authorisation. The first of which will be PH Community Inpatient Lengths of Stay.

Quality & Performance Dashboard Summary

The Dashboard itself (on pages 2-11) 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 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, performance improvement plans are held at Directorate level to outline the risks, mitigation and actions.

Business Intelligence Summary Update

July is the second month for a new Operational governance process which has initiated a new Operations Directorate Performance and Risk Meeting. Consistent Service Directorate level Business, Finance, Performance and Risk Meetings are still to be established over the Summer to further facilitate this process and accountability for the Quality and Performance Dashboard, and further embed corporate business partnerships.

Early access to a provisional NHSE Oversight Framework tool has been provided to the Trust to comment and contribute feedback before a formal release of the tool is published later in the Summer, likely to be the end of August 2025. The measures within this framework will be incorporated within the performance dashboard when methodology is published and developed.

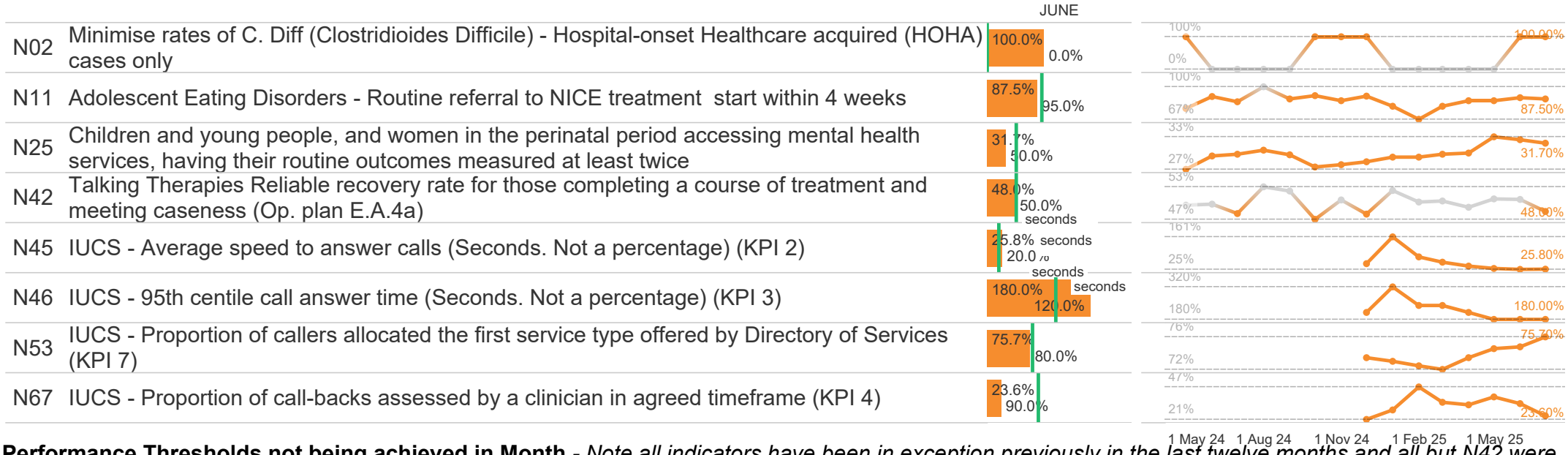
National Contracted Source

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National level as agreed by a national commissioner.



<u>Performance Thresholds not being achieved in Month</u> - *Note all indicators have been in exception previously in the last twelve months and all but N42 were in exception last month.*

N02 Minimise rates of C. Diff - Hospital-onset Healthcare Acquired (HOHA) cases only
Related to a single case which was transferred from GHT following critical care stay where they were treated with antibiotics.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
Related to single case who was unable to commence treatment as they required support from CAMHS. Patient assessed once clinically appropriate.

N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice
This is a new KPI. Discussions continue across two directorates to review their contributions and agree improvement actions.

N42 - Talking Therapies Reliable recovery rate for those completing a course of treatment and meeting caseness (Op. plan E.A.4a)
<u>Actions:</u> Workstreams in place focused on effectiveness, productivity, clinical and management supervision processes. Reviews of clinical outcomes to support development plans. <u>Forecast for Recovery: August 2025</u>

Narrative continued on next page...

Continued from last page...

N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)
Actions: Audit tool to review June's performance to identify peak times/ identify causes for delays. Audit findings to be reviewed to identify recurring issues and identify actions for rota changes or staff training. Forecast for Recovery: Significant improvements noted since the service launch and nearing compliance. Benchmarking year on year is showing significant improvement.

N46 - IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)
Actions: Audit tool to review June's performance to support the formulation of a forecast for improvement. Audit findings to be reviewed to identify recurring issues and identify actions for rota changes or staff training. Forecast for Recovery: Significant improvements already noted since the service launch and nearing compliance. Benchmarking year on year is showing significant improvement.

N53 - IUCS - Proportion of callers allocated the first service type offered by Directory of Services (KPI 7)
Actions: Continue to see improvements. Comprehensive recovery plan in place Forecast for Recovery: July 2025.

N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)
Actions: IUCS developing dashboards and escalation triggers. Work progressing to review clinical demand and workforce distribution across the pathway. Maximise appropriate pathways to select top of the DOS to support the most appropriate outcome for the patient**.** Forecast for Recovery: Forecast recovery improvement plan in development; this is the first month of reviewing this metric. Aim to improve over the next 12 weeks. Linked Risk: 628/ 629

Specialised Commissioning Source

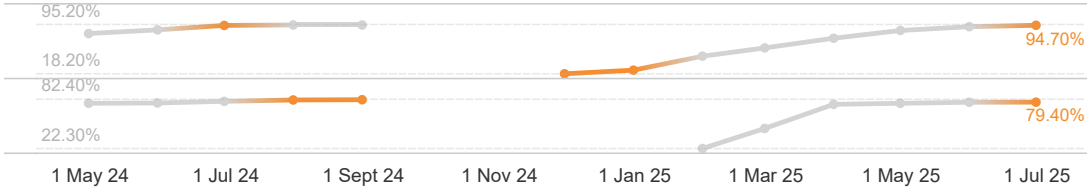
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

National or regional level indicators as agreed by a commissioner.

		JUNE	
S14	Percentage of children in Year 6 with height and weight recorded	94.7%	95.0%
S15	HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1	79.4%	80.0%



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

S14 - % of children in Year 6 with height and weight recorded
Forecast: Assurance provided that performance will achieve its target at end of academic year.

S15 - HPV Immunisation coverage for boys aged 12/ 13 years old (Years 8&9) Immunisation 1
Forecast: Assurance provided that performance will achieve its target at end of academic year.

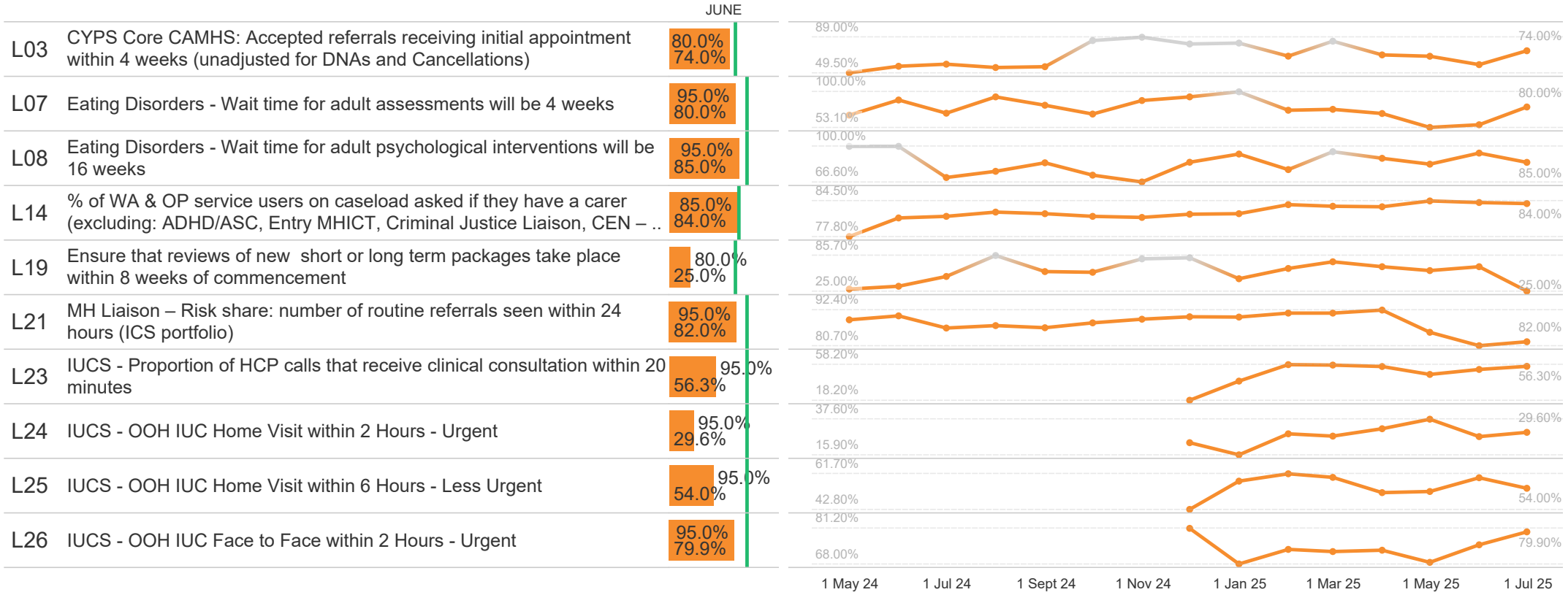
ICS Agreed Source

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

Local (L) level objectives as agreed with a Commissioner at an ICS level.



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

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
Significant improvement in compliant cases this month. Recovery anticipated by end of July as forecast.

Narrative continued on next page...

Continued from last page...

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
Actions: All 7 non-compliant cases were due to patient choice. Processes are in place to support patient engagement with treatment. Forecast for Recovery: Not required as capacity in service to meet the target. Linked Service Risk: 149

L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks
Actions: Six month focus on service underway to introduce initiatives to address the backlog and include developing a group cognitive behavioural therapy offer to commence in September 2025. Long waiters focus for full re-triage/ review. Forecast for Recovery: Six-month focus to develop an improvement plan/ recovery timeline. Linked Risk: 149

L14 - % of WA & OP service users on caseload asked if they have a carer (excluding: ADHD/ASC, Entry MHICT, Criminal Justice Liaison, CEN – High Intensity Users)
Actions: Process in place to remind care co-ordinators, with significant improvement seen. Team meetings and clinical forum in place to refocus with staff. Forecast for Recovery: September 2025.

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
Actions: System recording and configuration issues are being reported. The period's performance related to four cases with actions being taken to track manually in the interim to ensure close monitoring. Forecast for Recovery: To be agreed.

L21 - MH Liaison - Risk share: number of routine referrals seen within 24 hours (ICS portfolio).
Actions: In discovery phase to understand dip in performance and development relevant actions. Forecast for Recovery: December 2025 to be confirmed

Commentary for IUCS indicators L23, L24, L25 and L26:
Contract variation is being discussed in response to new National KPI publication. GHC are expecting the monitoring to reduce significantly through the retirement of unsuitable measures for the Gloucestershire model, and updates to reposition some remaining measures within either the ICS Agreed or Operational source sections of the dashboard.

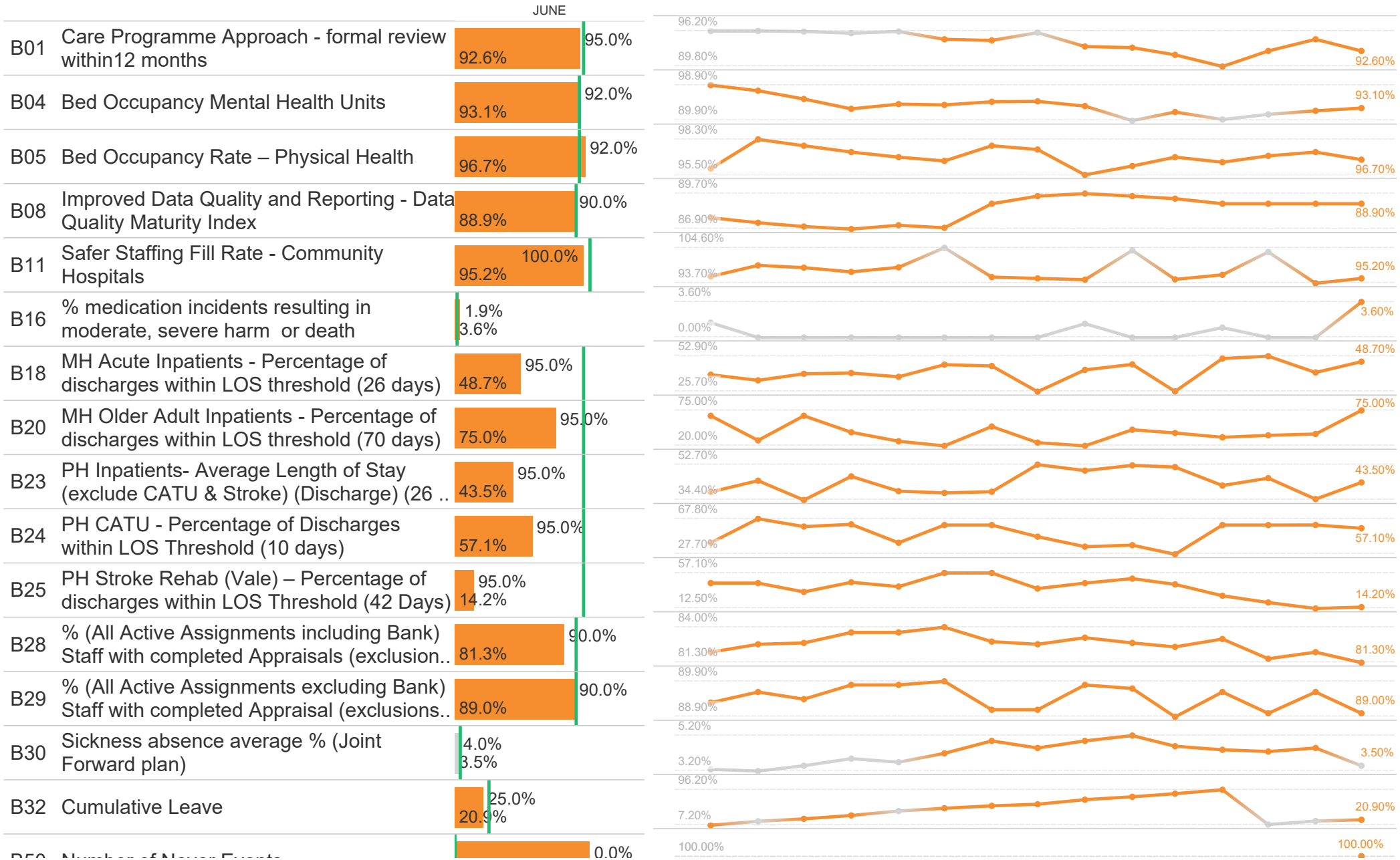
Board Focus Source

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

KPI Breakdown

Executive monitors over a longer period in line with Trust priorities.



B50 Number of Never Events

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Performance Thresholds not being achieved in Month - *Note all these indicators have been in exception previously in the last twelve months with the exception of B16 & B50.*

B01 - Care Programme Approach - Formal review within 12 months
Actions: Implemented reminder process for teams. My Care Plan in place which allows for a far more meaningful, patient-centred approach rather than a CPA review checklist. CPA in the process of being phased out as we focus on risk and assessment. Close working with Business Intelligence to review application of KPI to each referral. Working with Nursing, Therapies and Quality Team to explore solutions. Forecast for Recovery: October 2025.

B04 - Bed Occupancy Mental Health Units
Please reference narrative and activities in relation to relevant length of stay indicators.

B05 - Bed Occupancy Rate – Physical Health
Please reference narrative and activities in relation to relevant length of stay indicators.

B08 - Improved Data Quality and Reporting - Data Quality Maturity Index
The latest performance is 89.3% against a performance threshold of 90%. Performance is within normal variation. This indicator is an amalgamation of Data quality performance across national data sets.

The operationally led Patient Record Quality Governance Forum are monitoring updates and action plans and this group reports into BIMG.

B11 - Safer Staffing Fill Rate - Community Hospitals
Actions: IER (Inpatient Establishment Reprofiling) programme, removal of the core shift, organisational change process for training and development facilitators, optimal sickness and absence management, centralised rostering to support best roster approach, review to ensure all roles included (previously not all HRA roles included) which may account for the reduced percentage in May. Forecast for Recovery: Dependent on timeline for IER programme but IER delivery and recruitment provision aim to stabilise within 4 months. Linked Risk: 624

B16 - % medication incidents resulting in moderate, severe harm or death
There were 3 medication errors recorded in June out of 83 where the level of harm was moderate or higher. The is 3.8% compared to a threshold of 2.0%

With retrospective updates to level of harm and responsible organisation for all cases, the KPI percentage for June would be 0%.

B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)
Actions: Daily board rounds including red to green, weekly line by line, review top 10 longest length of stays, therapies review underway to closer align with the wards and work in an integrated model, alternate pathways work underway via the Alexandra Wellbeing Service and through the Recovery Unit work with Assertive Outreach Team. MoC commenced with the Supporting Discharge Team to closer align with the wards with a view to proactively working to support discharges. Co-ordinators allocation to wards commence 11 August 2025. Review with Kingsholm Leadership Team and subsequent meeting with Quality Improvement; awaiting allocation of resource. Forecast for Recovery: Milestones in development. Future planned work: Visit to Lancashire and Cumbria NHS Foundation Trust 10 September 2025. Quality Improvement Scoping (deep dive opportunities) and Review LOS National Benchmarking. Linked Risk: 196.

Narrative continued on next page...

B20 - MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)
Actions: Data review of challenges to extended length of stay, daily board rounds including red to green, weekly line by line, therapies review underway to closer align with the wards and work in an integrated model, social work team based within hospital. Forecast for Recovery: Milestones in development. Future planned work: Focussed work on admission avoidance for those with a diagnosis of dementia being led by Service Director for Community Services. Visit to Lancashire and Cumbria NHS Foundation Trust with a view to gathering good practice and innovations. Linked Risk: 196.

B23 - PH Inpatients- Average Length of Stay (exclude CATU & Stroke) (Discharge) (26 days)
Actions: Delay related harm programme in place, increased Matron capacity for the service system work on bariatric equipment provision in place, common use equipment procured, adult social care improvement trajectory in agreement (quarterly improvement plan), home first reablement improvement plan in place (optimal handed care), length of stay review meetings in place in addition to Multi Disciplinary Team/Tuesday flow calls/daily board rounds, therapy improvement programme in action with Forest of Dean as an accelerator site supported with the Heads of Professions. Forecast for Recovery: Proposed interim measures; aiming to recover to sub 32 by 1 October 2025, sub 30 by 1 April 2025 with a review in December 2025 as part of ongoing system transformation work and bed modelling. Linked Risk: 406.

B24 - PH CATU - Percentage of Discharges within LOS Threshold (10 days)
Actions: Internal review in operation looking at compliance to contract variation and draft service specification. Exploring causation of extended average length of stay reported as the number of people needing P2 transfer and delays waiting for a bed. Forecast for recovery: To be confirmed. *Linked Risk: 406*

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
Actions: system discussion regarding use of the stroke beds as an escalation approach to reduce waiting time for Vale beds – agreement awaited, and working with partners. Delay related harm programme in place, system stroke pathway review underway, increase Matron capacity for the site, review of incidents – notably those relating to medication errors underway, system work on bariatric equipment provision in place and some common use equipment procured, adult social care improvement trajectory in agreement (quarterly improvement plan), home first reablement improvement plan in place (optimal handed care), length of stay review meetings with Deputy Service Director in place in addition to multidisciplinary team/Tuesday flow calls/daily Board rounds. Proposed interim milestones: Aiming to recover to sub 55 by 1 October 2025, sub 50 by 1 January 2026 and then review. Linked Risk: 625

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for May has dropped slightly to 81.3%, compared to a threshold of 90%, although the figure is expected to rise. 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 that has been seen for the last couple of years. The appraisal performance figure includes Bank Staff.

B29 - % (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions applied) follows a similar trend to B28 although presents closer to compliance at 89% against a 90% target.

B30 - Sickness absence average % (Joint Forward plan)
The predicted sickness absence rate for June 2025 is approximately 4.5%. However, this figure cannot be confirmed yet, as the data from the e-rostering system (Allocate) is not available until mid-July. The current reported rate for June stands at 3.4%, which does not include the Allocate data. Once this data is incorporated, the absence rate is expected to rise to 4.5%, which is within the normal variation and slightly above the 4% threshold.

Narrative continued on next page...

Continued from last page...

B32 - Cumulative Leave
This indicator transitioned from manual data collection to an automated reporting process for the first time this month. The predicted Cumulative Leave Taken Percentage for June 2025 (end of Q1) is approximately 25%, aligning with the target threshold of 25%. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until mid-July.

B50 - Number of Never Events
1 never event was recorded in June by the Forest District Nursing team. However, the responsible organisation is recorded as GHFT, and therefore it is not a GHC incident.

The KPI methodology will be reviewed with the Patient Safety team to only include incidents where GHC is the responsible organisation.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 July 2025**

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

AUTHOR: Andrew Paterson, Strategic Project Manager
Hannah Williams, Deputy Director of NTQ

SUBJECT: **UPDATE: SAFE STAFFING COMPLIANCE**

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

This report is provided for: *(please click on the relevant box)*			
Decision ☐	Endorsement ☐	Assurance ☒	Information ☒

The purpose of this report is to:

This paper provides an update to the Board on progress of the safe staffing project group, including the implementation of reprofiled inpatient ward establishments, and how this is moving towards alignment with national Safe Staffing guidance.

Recommendations and decisions required

The Trust Board is asked to **NOTE** the progress and further areas of focus that will improve our governance, assurance and compliance with national safe staffing guidance, to deliver high quality inpatient care.

EXECUTIVE SUMMARY

- NHS Trusts are mandated to have a considered and planned position on safe staffing numbers in inpatient settings and there is a requirement for Trusts to report on this regularly and for Trust Boards to consider the position (National Quality Board 2016).
- This update paper to the Board seeks to provide a position on:
  - Progress on the review of reporting and governance of safe staffing in the Trust, such that it aligns and is compliant with national guidance and reporting arrangements
  - The intention to implement Enhanced Therapeutic Observations of Care (ETOC) in the latter part of 2025/26, such that it aligns and is compliant with national guidance and reporting requirement.
  - Progress in implementation of the reprofiling of inpatient ward establishments.

Risks associated with meeting the Trust's values
The Trust must fulfil the mandated requirements for considered position on safe staffing – failure may risk clinical safety, regulatory compliance and reputation. There is a risk that failure to implement this as culture change misses the opportunity for transforming ways of working across the Trust's inpatient services, which could impact the appropriate deployment of workforce.

Corporate Considerations	
Quality Implications	Significant quality benefits are expected from implementing ETOC. There will be improved quality assurance through compliance with national safe staffing guidance.
Resource Implications	Across the work related to safe staffing there is expectations to improve deployment of workforce.
Equality Implications	Transformed ways of working across inpatient services should influence experience and outcomes which should improve length of stay, flow and access.

Please list any meetings where this has been discussed before
Trust Board Private Session 23rd January 2025

Appendices:	N/A

Acronyms used within this report	
ETOC	Enhanced Therapeutic Observations of Care

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

TRUST BOARD UPDATE: SAFE STAFFING COMPLIANCE

1.0 INTRODUCTION

This paper provides an update to the Board on progress of the safer staffing project group, including the implementation of reprofiled inpatient ward establishments, that aligns to national Safe Staffing guidance.

The Trust Board discussed and approved plans to reprofile inpatient ward establishments during Q4 2024/25 with this work being delivered during 2025/26. NHS Trusts are mandated to have a considered and planned position on safe staffing numbers in inpatient settings and there is a requirement for Trusts to report on this regularly and for Trust Boards to consider the position (National Quality Board 2016).

There is strong evidence that all three domains of quality of care - safety, experience, clinical effectiveness - are positively affected by having the right number of staff, of the right type, at the right time. Patient experience, and ultimately patient recovery and health outcomes will be enhanced by continuity of care, which is achieved by a consistent workforce on inpatient wards. The balance between a substantive workforce and staffing levels that are filled by temporary staff (bank and agency) must be an important consideration for NHS Trusts and their Boards.
This update paper to the Board seeks to provide assurance of:

- Progress on the review of reporting and governance of safe staffing in the Trust, such that it aligns and is compliant with national guidance and reporting arrangements
- The intention to implement Enhanced Therapeutic Observations of Care (ETOC) in the latter part of 2025/26, such that it aligns and is compliant with national guidance and reporting requirement.
- Progress in implementation of the reprofiling of inpatient ward establishments.

2.0 SAFE, SUSTAINABLE PRODUCTIVE STAFFING - REPORTING AND GOVERNANCE

The National Quality Board (NQB) produced Safe sustainable and productive staffing guidance in 2016 to support “NHS providers to deliver the right staff, with the right skills, in the right place at the right time.” This guidance includes 10 expectations within a framework to support decisions about staffing that put patients first.
The guidance sets out the key principles and tools for trust boards to monitor safe staffing using quality impact measures of staffing and the determination of care hours per patient day (CHPPD) and triangulating with staffing decisions (right staff, right skills, right place and time).

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Developing Workforce Safeguards (2018) sets out a regulatory framework of 14 recommendations to support trusts in making informed decisions relating to safe staffing practice and implementation of the NQB guidance. There are regulatory requirements to report safe staffing compliance through the Single Operating Framework (SOF) and Trust annual governance statements; regulation 18 of The Health and Social Care Act (2018) also sets out the requirements on providers to meet Care Quality Commission (CQC) standards.

A dedicated workstream has met regularly since the start of 2025/26, chaired by the Head of Nursing for Mental Health and Learning Disabilities, with the initial scope:

- To maximise the use of the systems in place that determine staffing levels and assurance across community hospitals and mental health inpatient services.
- To ensure appropriate structures through to Trust Board for governance, oversight and assurance of safe staffing.
- To ensure the robustness of internal reporting and assurance through to Trust Board, including mandatory reporting to NHS England.
- To fulfil national reporting requirements that focus on care hours per patient day (CHPPD) experience and status of staff employment.

To date the workstream has made progress on:

Maximising the use of safe staffing systems including consistent use of the professional judgement and red flag functions by registered nursing staff	Five training sessions put on in Q1 with a further nine sessions in August with focus on mental health inpatient services Further work underway to capture competence/compliance with using system and ensuring training offer is sustainable for future workforce
Ensure appropriate structures for governance, oversight and assurance of safe staffing	A review of the existing Roster Policy has been completed. New Standard Operating Procedure drafted that will cover the expected local processes. Further work underway to finalise governance through operations to DON for approval and reporting through to Quality Committee and Trust Board.

In June 2025, the workstream completed a self-assessment of compliance against the recommendations of the Developing Workforce Safeguards which found we are compliant against 4 of the twelve recommendations and partial compliant with the remaining eight. The terms of reference of the workstream are being refreshed to align to the work required to achieve compliance. This work will be led by the Nursing Heads of Profession alongside Operations and BI colleagues.

Best practice in other provider trusts in relation to safe staffing reporting and assurance will form part of the work with the intention of having this in place for the annual statement on safe staffing being made at the January 2026 Board meeting.

3.0 ENHANCED THERAPEUTIC OBSERVATIONS OF CARE (ETOC)

Enhanced Therapeutic Observation and Care (ETOC), often referred to as enhanced care, enhanced therapeutic observations, 1:1s or specialling, is an intervention which contributes to safe and effective care of patients. The intervention should promote recovery and preserve dignity. Typically, ETOC is undertaken by a Healthcare Support Worker (HCSW), Registered Nurse (RN) or a Registered Mental Health Nurse (RMN) (NHS England 2024).
The use of observation presents both opportunities and challenges for NHS Trusts with regards to:

- The culture of clinical practice, including their frequency of use and the potential for unwarranted restriction for patients.
- The quality of care provided within the observation – the extent to which eyesight is maintained whilst undertaking a genuinely therapeutic activity or is simply a supervisory observation.
- The tendency nationally for ETOC to be dependent on bank and agency staff – this goes against continuity of care and ETOC being more than a supervisory arrangement. It is recognised that ETOC should be a responsibility for substantive staff.
- Governance and reporting of observation which are prescribed at a ward level.

A national programme for Enhanced Therapeutic Observations of Care was launched in 2024 providing opportunity for trusts to implement a patient-centred, intervention orientated approach to meeting enhanced care needs that will improve outcomes and experience. By informing the professional related to the interventions and care to meet patient need, ETOC influences decisions on staffing, and as such contributes to the assurance of compliance with NQB guidance for safe staffing. The national programme operates in 90-day improvement cohorts, and we have requested to participate in Cohort 3 that is expected to start in September.

Whilst participation in the national ETOC programme is not mandated, national reporting against staffing levels related to ETOC is required as part of the national service contract 2025/26. The trust is submitting a return but with caveats regarding data quality as our return is based upon historic categories used on Health Roster. It has been agreed that the term "ETOC" will be introduced as a staffing reason category concurrently with the implementation of Enhanced Therapeutic Observation of Care in the trust and associated policy, procedures and training.

Currently ETOCs are not being specifically recorded in the Trust monitoring of bank and agency use although, with caveat, we can use the category "1:1 clinical care" as a proxy for this.

The Deputy Director of Nursing, Therapies and Quality is leading the implementation of ETOC which is anticipated to start in Q3 2025/26 to align with the intended opportunity to be part of cohort 3 of the national programme. Key known milestones identified to date are set out below.

<table>
<tr><th>Quarter 2 2025/6</th><th>Quarter 3 2025/6</th><th>Quarter 4 2025/6</th></tr>
<tr><td rowspan="2">ETOC self-assessment process (using an NHSE tool) to be undertaken providing an accurate baseline for all inpatient areas to inform the introduction of effective ETOC.

ETOC workstream membership to be established</td><td>The Trust will join national ETOC Cohort 3 taking advantage of sharing learning with other Trusts and making full use of central support.</td><td rowspan="3">Full implementation of Trust ETOC policy across all inpatient wards and use of the ETOC code in reporting.</td></tr>
<tr><td>Nursing will work with the Trust Quality Improvement Team in cycles of improvement to develop a therapeutic offering for ETOCs</td></tr>
<tr><td colspan="2">Developing an ETOC policy and SOP which defines an ETOC and introducing a new ETOC code for reporting but only to record against this once the policy is in place</td></tr>
</table>

In response to the increased national focus on the quality improvements seen from the implementation of ETOC, within Gloucestershire this has become an area of interest in the Quality Transformation Portfolio to enable shared system learning with

Gloucestershire Hospitals NHS Foundation Trust who implemented their ETOC programme some 18 months ago.

4.0 IMPLEMENTATION OF INPATIENT WARD ESTABLISHMENT REPROFILING

Operational and Workforce directorates undertook a significant amount of work during Q4 2024/25 in anticipation of being able to respond promptly at the start of 2025/26. This was to ensure that any recruitment to the reprofiled establishments took advantage of the anticipated interest by qualifying student nurses, which has been seen in the high numbers and high quality of applications received to the B5 advertisements (219 for mental health and 372 for community hospitals).

Separate processes have been undertaken by the Community Hospitals and Mental Health Inpatient Services, and both are on track with their respective timescales. Both have initiated with recruitment to registered nurse posts with advertising for health care support worker posts expected to start in August. The overall on track position against plan for registered nursing post recruitment is based on 19.47 WTE offered posts against a plan for 24.9 WTE posts.

Achievements noted through the process include the promotion of three of our internationally educated nurses to B6 posts during the recruitment. The recruitment approach taken to recruit to multiple posts via one advertisement has been successful and noted to have eased the workload for recruiting managers and the recruitment team.

5.0 GOVERNANCE

The changing emphasis on the workstreams related to the wider safe staffing agenda requires a review of the governance and reporting arrangements for the existing Project Board. Similarly, the terms of reference of the project board will be reviewed in line with those of the workstreams.

Quality Committee will retain primary responsibility for oversight and assurance related to safe staffing, with reporting to Great Place to Work Committee as required. The frequency of reporting by the Safe Staffing Project Board to the Quality Assurance Group and Sustainable Staffing Oversight Group is to be finalised. Further work to finalise the dataset/dashboard for reporting assurance on safe staffing and ETOC will determine how this aligns with the active development of integrated reporting.

6.0 REFERENCES

National Quality Board July 2016 Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time -Safe sustainable and productive staffing

NHS Improvement October 2018 Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing

NHS England » Enhanced Therapeutic Observations and Care programme

REPORT TO: **TRUST PUBLIC BOARD MEETING – 31 July 2025**

PRESENTED BY: Louise Moss, Deputy Director of Corporate Governance

AUTHOR: Louise Moss, Deputy Director of Corporate Governance

SUBJECT: **MODERN SLAVERY TRUST STATEMENT**

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 Trusts' statement on Modern Slavery, for approval and reconfirmation.

Recommendations and decisions required

The Board is asked to:

- **Note** the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and;
- **Approve** the statement for publication on the Trust website.

Executive summary

There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act). The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements.

Ongoing assurance had been received from relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams that combatting and eradicating modern slavery is built in as business-as-usual work.

The statement has been reviewed for 2024/25 to ensure that it remains fit for purpose and compliant with national requirements. The statement has been presented to the Executive Team for initial review and is now presented to the Trust Board for approval.

Risks associated with meeting the Trust's values
The Trust has statutory duties and responsibilities under the Modern Slavery Act 2015 and failure to update the statement would be a breach of these.

Corporate considerations	
Quality Implications	Failure to meet and fulfil duties related to modern slavery could impact on ethical and reputational risk.
Resource Implications	Human Resources. Identification and eradication of modern slavery links to Outstanding Care (for patients), Compassionate Workforce (through safeguarding and training) and effective estate (linked to the human and socio-economic elements of the supply chain).
Equality Implications	Applicable to the extent of providing public, patient and staff assurance about the Trust's practices and to ensuring patients suspected of being subjected to modern slavery are provided with the appropriate care, support and protection.

Where has this issue been discussed before?
Executive Meeting (22 July 2025)

Appendices:	

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

TRUST STATEMENT ON MODERN SLAVERY

1.0 WE FULLY SUPPORT THE GOVERNMENT'S OBJECTIVES TO ERADICATE MODERN SLAVERY AND HUMAN TRAFFICKING

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHCNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

2.0 SLAVERY AND HUMAN TRAFFICKING STATEMENT FOR FINANCIAL YEAR 2024/25

During the last financial year, the Trust took, and continues to take, the following steps to ensure that slavery and human trafficking is not taking place:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. These checks are regularly reviewed and comply with the six national NHS Employment Checks Standards. The checks ensure that we can be confident, before staff commence duties, that they have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation
- Our equality and diversity, grievance, respect and dignity at work for staff policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since our Trust inception in October 2019.

- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adult at Risk Policy", and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff. This is supplemented by an anonymous and confidential Work In Confidence engagement, dialogue and reporting platform offered to all employees and workers whether they are substantive or temporary.
- The Procurement Team work on the principle of zero tolerance of modern slavery in our supply chain. Our standard terms and conditions require suppliers to comply with relevant legislation and tender evaluations include Social Economic factors. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation
- We continue to work with our suppliers directly and via partners, such as NHS Supply Chain, to support initiatives related to modern slavery.

3.0 REVIEW OF EFFECTIVENESS

The Trust will continue to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Embed Social Value best practice into commercial processes which will achieve improved Social Value awareness and compliance across all our commercial activities
- Impact assess all new or reviewed policies for diversity and inclusion compliance

4.0 RECOMMENDATION

The Board are asked to **APPROVE** this statement, for publication on the Trust's website.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2025.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION - 31 July 2025**

PRESENTED BY: Bilal Lala, Chair, Audit and Assurance Committee

AUTHOR: Lavinia Rowsell, Director of Governance and Trust Secretary

SUBJECT: **AUDIT & ASSURANCE COMMITTEE ANNUAL REPORT TO THE BOARD - 1 APRIL 2024 – 31 MARCH 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 to the Board the annual report of the Audit and Assurance Committee for 2024/2025.

Recommendations and decisions required

The Trust Board is asked to **NOTE** the Committee's Annual Report 2024/25.

Executive summary

The Committee's terms of reference require that: "*The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board*"

"*The Committee will report to the Board annually on its work in support of the Annual Governance Statement*."

The attached report provides an overview of the Committee's work in the last financial year, from 1 April 2024 to 31 March 2025 in sections which reflect the headings of the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues have been highlighted as areas of concern. The Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

Risks associated with meeting the Trust's values
Failure to identify and mitigate corporate and strategic risks may adversely affect the achievement of the Trust's strategic goals.

Corporate considerations	
Quality Implications	Effective management of risk provides assurance that patient services are being delivered safely.
Resource Implications	None other than those identified in the report.
Equality Implications	None other than those identified in the report.

Where has this issue been discussed before?
N/A

Appendices:	

Report authorised by:	**Title:**
Bilal Lala	Chair, Audit and Assurance Committee/Non-Executive Director

AUDIT AND ASSURANCE COMMITTEE ANNUAL REPORT

1 April 2024 – 31 March 2025

1.0 INTRODUCTION

In accordance with best practice and good governance, the Committee produces an annual report for the year setting out how it has met its terms of reference during the financial year.

2.0 MEMBERSHIP

All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair, with four NEDs as core members. This membership enables the Committee to triangulate information and assurance received at other key Board Committees, each of which is chaired by a member of the Audit and Assurance Committee.

A number of officers (or their delegates) are in regular attendance at meetings. These include the Director of Finance, the Director of Governance/Trust Secretary, Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers (including the Data Protection Officer and Assistant Director of Digital Services) attend at the request of the Committee, for example where further information is required on actions and/or issues being raised through an Internal Audit report.

3.0 MEETINGS AND ATTENDANCE

The Committee met 5 times during the period 1 April 2024 to 31 March 2025, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate. All Non-Executive Directors receive papers and have the opportunity to raise any concerns with the Chair even where they do not attend.

Attendance by members at the Committee during the period as follows:

** core members*

Members*	09/05/24	17/06/24	08/08/24	21/11/24	06/02/25
Marcia Gallagher (Chair to 30/06/24) *	Y	Y			
Bilal Lala* (Chair from 1/07/24)		Y	Y	Y	Y
Jan Marriott*	Y	Y	Y	Y	Y
Jason Makepeace*		Y	Y	Y	Y
Sumita Hutchison* (member from 08/08)	Y		Y	Y	Y
Rosi Shepherd*					N
Steve Alvis*	N				
	Not core member of group				

4.0 PRINCIPAL REVIEW AREAS

4.1 Governance, Risk Management and Internal Control

The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances.

The Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, with regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement.

The Committee reviewed the Corporate Risk Register and the Board Assurance Framework at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored.

The Committee acknowledges the progress made in year in relation to risk management, in particular the increased focus on risk appetite, and believes that while adequate systems for risk management are in place, ongoing management focus is required to ensure that risk management continues to be embedded within the Trust.

During the year it was agreed that oversight governance oversight of cyber assurance activities would transfer from the Audit and Assurance Committee to the Resources Committee and terms of reference were amended accordingly.

4.2 Internal Audit

In completing its work, the Committee places considerable reliance on the work of the Internal Auditors, BDO. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. During the year the Committee reviewed and approved the internal audit plan for 2025/26 and considered the findings of internal audit in relation to work on the following areas aligned to the 2024/2025 agreed internal audit plan:

	REPORT FINDINGS	
	Design	Effectiveness
Agency Spend	Moderate	Substantial
Health and Wellbeing	Moderate	Moderate
Safeguarding Children	Moderate	Moderate
Procurement and Contracts	Moderate	Limited
Directorate Governance	Limited	Moderate
Barriers to Raising Concerns – follow up	N/A	N/A
Performance Appraisals	Moderate	Moderate
Non-Medical Prescribing	Moderate	Limited
Key Financial Systems – Payroll	Moderate	Moderate
Data Security and Protection Toolkit	High Risk/High Confidence	

The reviews produced a total of 32 recommendations - 4 low, 22 medium and 6 high risk-rated. In respect of each of these findings the Committee sought and received assurance on the mitigating actions being taken, following up outstanding actions as necessary and referring issues to other Committees as appropriate in order for progress with action plans to be monitored. Tracking of IA recommendations is reviewed at each meeting.

4.3 External Audit

During the year, the Committee:

- **Received** and **noted** the final audit in respect of the 2024/2025 Annual Report Financial Accounts.
- **Reviewed** and **agreed** the external audit plan for 2024/25.
- **Reviewed** and **commented** on the reports prepared by external audit which have kept the Committee appraised of progress against the External Audit Plan.

4.4 Private Meeting with the Auditors

The Committee met privately with internal and external auditors during the period. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that have been established.

4.5 Other Assurance Functions

The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2024/25 and the Counter Fraud work plan for 2024/25. Throughout the year the Head of Counter Fraud has met with the Committee Chair, Director of Finance and Counter Fraud Champion.

Proactive Counter Fraud exercises were concluded relating to Single Tender Waiver Benchmarking and National Procurement.

4.6 Compliance Reporting

The Committee has received finance compliance reports at each meeting and an annual compliance report. This includes information on losses and special payments, aged debtors and breaches in SFIs.

The Committee reviewed the 2024/25 financial statements and annual report at the 19 June 2025 meeting prior to recommending the final accounts for Accounting Officer signature.

The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the auditors had not identified any significant weaknesses in systems of accounting and financial control.

5.0 OTHER MATTERS

During the year the Committee has:

- Undertaken an effectiveness review

- Reviewed its terms of reference
- Compiled an annual report to the Board

6.0 CONCLUSION

The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit and Assurance Committee and at other Committees chaired by members of the Audit and Assurance Committee, have enabled the Audit and Assurance Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Bilal Lala
Chair, Audit and Assurance Committee - June 2025

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Held on Wednesday, 14 May 2025
at Churchdown Community Centre

PRESENT:

Graham Russell (Chair)	Kizzy Kukreja	Peter Gardner
Amy Aitken	Penelope Brown	Chris Witham
Sarah Nicholson	Marcia Gallagher	Sarah Waller
Jan Lawry	Andrew Cotterill	Paul Winterbottom
Bob Lloyd-Smith	Michelle Kirk	Chas Townley Leighton Lee
Pettigrew		

IN ATTENDANCE:
Douglas Blair, Chief Executive
Nicola Hazle, Director of Nursing, Therapies and Quality
Anna Hilditch, Assistant Trust Secretary
Vicci Livingstone-Thompson, Non-Executive Director
Jason Makepeace, Non-Executive Director
Lavinia Rowsell, Director of Corporate Governance
Rob Shipley, Public Governor, Black Country NHS Trust (Observing)

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Joy Hibbins, Mick Gibbons, Martin Pittaway, Jenny Hincks, Tussie Myerson, Alicia Wynn, and Laura Bailey. Apologies had also been received from Non-Executive Directors Nicola de Iongh, Steve Alvis, Rosi Shepherd, Sumita Hutchison, and Bilal Lala.

1.2 Graham Russell formally welcomed Vicci Livingstone-Thompson to her first Council meeting in her new role of Non-Executive Director.

1.3 Graham Russell informed the Council that Monday 12th May had been International Nurses Day, and the Trust had organised a number of events to celebrate the fantastic contributions of nurses. He also wished to recognise the contribution of those Internationally Educated Nurses working across the Trust who added real value to teams and services.

1.4 It was with sadness that the Council was informed of the passing of Vincy Rijo, a nurse working at Stroud Hospital. Vincy came to the UK in 2023 as an international nurse. She was joined by her husband and three young daughters. Vincy sadly passed away on 7th May at home in India, after a courageous battle with stomach cancer. Graham Russell held a moments silence for reflection.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETINGS

3.1 The minutes from the previous Council meetings held on 19 March and 10 April 2025 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 There were no matters arising from the previous meeting not already covered on today's agenda.

5. CHIEF EXECUTIVE'S REPORT

5.1 The Council welcomed Douglas Blair, CEO to the meeting who provided a report on key matters to the Governors.

5.2 In March, there was a sequence of national announcements 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.

5.3 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.

5.4 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. The process for formulating this plan includes the extent to which Integrated Care Boards work together to deliver functions. The provisional view is for Gloucestershire ICB to cluster with Bristol, North Somerset and South Gloucestershire Integrated Care Board. Douglas Blair said that discussions would continue to develop the necessary plans, but he said that it was important that this was managed sensitively noting the impact on ICB colleagues locally who would be affected by these changes.

5.5 As part of the nationally announced NHS efficiencies, provider Trusts are expected to reduce 50% of growth in corporate costs during 2025-2026. Douglas Blair noted that GHC would need to continue to ensure that it uses its resources effectively and suggested that the national target would be delivered as part of the Trust's 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.

5.6 Douglas Blair advised that the Trust Strategy refresh work was now underway, with a programme of engagement in place. A joint Board and Governor session was scheduled for 9th July to review this.

5.7 Marcia Gallagher noted the earlier point about the clustering of ICBs, noting the likely clustering of Gloucestershire with BNSSG ICB. She asked about the impact of this, given the size of the area, and whether Gloucestershire would lose out. Douglas Blair advised that there was a lot of work required to progress these discussions and the finer details but assured the Council that regular updates would be provided at each stage of the process.

6. CHAIR'S REPORT

6.1 Graham Russell provided a verbal report to the Council, setting out some of his activity over the past few months.

6.2 The Trust's 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. Graham Russell said that it was a privilege to be able to celebrate not only everyone who attended but everyone who was nominated.

6.3 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 Leadership and Culture Programme was in its development phase and assurance would be sought from the oversight group overseeing the progress of the programme. The Committee has been established for an initial period of 12 months with possible extension following which oversight will revert to the appropriate Board governance committees. Graham Russell highlighted the importance of this programme for the Trust and colleagues, **noting** the alignment with the Trust's values, specifically Respectful and Kind.

6.4 As mentioned in the earlier CEO report, Graham Russell made reference to the Trust Strategy refresh. GHC's Strategy was published in 2021, and 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. The Board have reaffirmed our Values, Vision and Mission, and have proposed an update of our existing Strategic Aims which will hopefully align with forth-coming NHS 10-year plan. Some of the key themes include shifts from Hospital to Community, Analogue to Digital, and Treatment to Prevention. Chris Witham highlighted the implications of the move to digital, and the considerations required around both equipment and the upskilling of staff. The Council noted that a number of GHC's Clinical Systems Team were qualified nurses or AHPs, which would help in developing appropriate training and support for teams across the Trust. Sarah Waller noted that one of the main themes of the NHS 10-year plan would be the shift of the NHS towards working better in people's neighbourhoods and she asked whether there was a clear understanding of what the definition for this was. Douglas Blair said that GHC would be working closely with partners to review this in detail as there was a need to have collective agreement as a system.

6.5 Graham Russell highlighted some of the visits he had carried over the past month, and once again invited Governors to get in touch if they wished to accompany him on any of these, or to meet up for a coffee and a chat.

7. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

7.1 Chris Witham presented this report which provided a summary of the business conducted at the Nominations and Remuneration Committee meeting held on 1 May 2025.

7.2 Key items of business received at the Committee included the receipt of both the Trust Board and Governor annual declarations, including compliance with the Fit and Proper Person regulations. These papers provided assurance to the Committee that all relevant checks had been carried out, and that no areas of concern were identified.

7.3 The Nominations and Remuneration Committee also endorsed the proposed changes to the Standing Orders for onward presentation to the full Council of Governors. These would be received as an agenda item later in today's Council meeting for sign off.

8. WORKING TOGETHER NETWORK ENGAGEMENT

8.1 The Council welcomed Julie Mackie, Head of Partnerships to the meeting who was in attendance to present the Governors with the Trust's proposed Working Together Network Approach.

8.2 We know community-based transformation is at the heart of the 10-year plan to be released in May 2025, and 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, to provide joined up patient centred care for our population. This is why it is important that we continuously improve our GHC working together approach.

8.3 GHC's Working Together Plan was developed and published in 2021. The ambition is to have a Trust-wide culture of working together with the people and communities we serve. Our aims are to:

- Inspire each other by working together to make improvements that matter and make a difference to everyone we serve
- Include everyone by making it easy for all people and communities to have their say, get feedback and be involved in ways that suit them.

8.4 Julie Mackie said that the ambition, aims and goals of the plan were still relevant, and provided the Council with the background to the Working Together Advisory Committee (WTAC) which had been set up to oversee the delivery of the plan.

8.5 The WTAC had been paused in 2024, and a number of workshops took place with GHC colleagues, experts by experience and partner organisations to look at refocusing the Trust's approach. The result was the establishment of the Working Together Network – a people participation forum that contributes to GHC decisions, advises, & connects. Julie Mackie presented a slide to the Governors which set out those areas that will be maintained, those areas requiring further improvement, and the new features to be developed to support this. One of the areas for improvement was how the Trust effectively uses Governors in representing local communities.

8.6 The launch of the new Working Together Network would be taking place on Wednesday 25th June, and an invite was extended to all Governors to attend and participate. It was **noted** that 4 Governors were already involved due to attending the WTAC previously.

8.7 Julie Mackie set out some questions for the Governors to reflect upon, as follows:

- What do you think about the proposal to further develop the role of Public Governors to support our Working Together approach?
- Any concerns, ideas, or considerations?
- What support do we need to develop or offer to help you?

Governors provided comments via sticky notes which were passed back to Julie Mackie at the end of the session. Julie Mackie informed the Council that she would collate the feedback received and a report would be provided back to the full Council in due course, addressing the points received. It was also hoped that these would be used to feed in as part of the new Network launch. **ACTION**

8.8 The Governors thanked Julie for attending the meeting and agreed that it would be helpful to receive regular updates on the work taking place at future Council meetings. **ACTION**

9. INTEGRATED URGENT CARE SERVICE (IUCS) UPDATE

9.1 The Council of Governors welcomed Holly Smith, Service Director, and Gavin Harrison, Service Operations Manager, who were in attendance to provide the Council with an overview and update on the launch of the new Integrated Urgent Care Service.

9.2 The service launched on 19th November 2024, and includes:

- NHS 111 – telephone and online support
- A new Clinical Assessment Service (CAS) giving the public access to general and specialist clinical advice
- An out of hours face to face service – Clinicians seeing people in person either at a local hospital/treatment centre or in their own homes

9.3 The presentation provided Governors with further detail about the Trust's partner, IC24, an overview of the Gloucestershire IUCS and the patient journey, as well as the number of people now employed by the service, location and operating times.

9.4 In terms of activity, the Council noted that telephone activity had averaged 16,000 contacts each month since January 2025. Some key targets and performance indicators had been set for the service, and included areas such as average speed to answer, % of calls abandoned, and calls assessed by a clinician. There had been a significant improvement in year-on-year data – meaning that patients can access the service quicker and more efficiently. Further improvements were highlighted and included calling Health Care Practitioners (HCPs) back quicker and the use of the top of the Directory of Services.

9.5 In terms of reported incidents and complaints, the Governors received the key themes from these, such as delays and wait time for call back, and disagreement on outcomes. Holly Smith noted that Governors had picked up at a previous meeting that the total number of complaints received by GHC had increased following the launch of the service. She noted that there were between 15-17k new contacts per month to the IUCS, and the conversion to complaints worked out as less than 1 in 1000 people.

9.6 Chris Witham said that there had been some great improvements seen in the service provided, and it was reassuring to see such robust governance processes in place. He noted that most of the key measured outcomes related to system partners, e.g. reduction in SWAST call outs, and lower A&E admissions. Going forward he said that it would be helpful to look at some of the benefits to GHC.

9.7 Bob Lloyd-Smith said that it was pleasing to see the level of positive feedback that had been received on the service, and he asked whether it was possible for Governors to see the feedback received. It was noted that thematic feedback was included within the Governor Dashboard report, and some of the specific feedback and complaints received were also included.

9.8 Penelope Brown made reference to her own experience of using the telephone service and suggested that the automated message relayed regarding the NHS111 website could be strengthened, as she personally would use the online service if it could offer the same service.

9.9 Marcia Gallagher noted those people in MH crisis, and the ability to call NHS111, and "press 2" for mental health support. She asked whether people were aware of this service, and also whether the calls were answered or transferred to an answerphone. Holly Smith said that a campaign was being launched nationally to improve awareness of this service. There was still a need to link teams up but calls would be routed through to the Trust's First Point of Contact Centre.

9.10 Sarah Nicholson noted the staffing levels of the service highlighted within the presentation and asked how many call handlers were in post. Holly Smith said that there were 51WTE and this meant that the service could adapt to seasonal variation. Sarah Nicholson raised a point on behalf of Joy Hibbins who was unable to be present at the meeting. Joy had asked about call handlers and whether they worked predominantly from home. She had asked this

question regarding the wellbeing of colleagues, noting that they can receive some challenging or distressing phone calls, and there was concern that they were not in a setting with support available to them. Holly Smith advised that all call handlers had access to a "surge button" which they could push at any time and a senior clinician would be able to join the call to offer any necessary support.

9.11 Sarah Waller had participated in a recent Governor visit to Cirencester Hospital and she mentioned that a member of staff had commented on the IUCS and that the algorithm tended to refer people to MIIUs rather than Pharmacy 1st. Holly Smith confirmed that a Task and Finish Group had already been set up with the MIIUs to look at this, as it had been identified as an area for improvement.

9.12 Graham Russell expressed his thanks to Holly and Gavin for attending and providing the Council with this IUCS overview. It was great to see the positive feedback being received on the service, noting it had only been operating for 6 months. Some areas for development had been acknowledged and work was already underway to progress this.

10. GOVERNOR DASHBOARD AND HOLDING TO ACCOUNT

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 The Council **noted** the content of the Dashboard report.

11. STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL

11.1 The purpose of this report was to present the Council with the updated Standing Orders for the Practice and Procedure of the Council of Governors.

11.2 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.

11.3 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.

11.4 A full review of the Standing Orders had been carried out and the Standing Orders for the practice and procedure of the CoG were presented for approval. As highlighted earlier in the meeting, a review of the document was also carried out by the Nominations and Remuneration Committee on 1st May.

11.5 The report set out those areas where substantial changes had been made, alongside a number of minor changes that had been made throughout the document, to include job titles, and references to national bodies and guidance. Gender neutral language has also been used throughout.

11.6 A light touch review of the Standing Orders will be carried out annually, alongside the Trust Constitution to ensure that they remain fit for purpose. A full review of all governance documents will be carried out every 3 years.

11.7 The Council of Governors **approved** the proposed changes to the Standing Orders, for onward presentation to the Trust Board for final sign off at their meeting in May 2025. It was **noted** that the Board would also **receive** the updated Standing Orders for the practice and procedure of the Board of Directors at their meeting.

12. GOVERNOR ANNUAL DECLARATIONS 2024/25

12.1 The Council of Governors received the Annual Governor Declarations log. This included all declarations of interests and confirmed compliance with the Fit and Proper Person test and Governor Code of Conduct. The log had been reviewed at the Nominations and Remuneration Committee on 1 May, and there were no issues of concern to note.

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 the nominations had opened on 1 May for one Staff Governor Position (Medical Dental & Nursing – *reserved for Qualified nurses*) and two Public Governor positions (Stroud and Cotswolds). Nominations would close on 19th May.

13.3 The Trust still has a vacant Appointed Governor position for Gloucestershire County Council, and contact has been made with Democratic Services at the Council to seek an update on progress with a nomination.

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. Questions included on the log can be questions received by Governors from constituents, or directly from Governors seeking specific assurance on a topic not due to be covered at a normal Council meeting.

14.2 It was **noted** that no new questions had been received since the last formal meeting in March.

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 9th July at 1.00 – 3.30pm. This would consist of a short formal meeting, followed by a Joint Board and Governor development session focussing on the Trust Strategy Refresh.

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
14 May 2025	8.7	Collated feedback and output report from the Working Together Network approach presentation to be shared with all Governors	
	8.8	Consideration to be given to having a new standing agenda item to provide Governors with a regular update on developments with the WT Network	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0725

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**CHARITABLE FUNDS COMMITTEE – 18 JUNE 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Nicola de Iongh, Chair of Committee *(meeting Chaired by Jason Makepeace, Deputy Chair)*

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 Bid Approvals and Commitments Report which provided details of the number of bids and value of bids approved with outstanding commitments. There were currently 16 bids for charitable funds that had been approved but not yet spent, with a total value of £49,225.53. More information on these bids would be included in future reports, noting that some applications had been approved back in 2023.

In relation to the Hardship Fund, the Committee noted that £10.4k had been spent out of a potential £25k budget this year. The uptake had been good but there was a need for continued communication and reminders as applications did reduce overtime, with colleagues potentially forgetting that this was available for them. Further consideration would be given to this.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received a report on the direction the GHC Charity would take over the next 5 years. The Committee agreed clearer guidance was needed on bidding and regular requests, as well as a broader review of the purpose of the Charity, and how staff can fundraise on the Charity's behalf. An updated report will be presented back to the Committee at its next meeting in September.

The Committee received an update on the purchases funded by the League of Friends for each of the community hospitals during the period January to June 2025. It was agreed that a review of the processes in place around LoF purchases would be carried out, and further work to re-establish regular engagement with LoF colleagues would also be explored.

The Committee received a verbal update on progress with the sale of the Brokenborough land.

APPROVALS: Decisions and Approvals made by the Committee

The Charitable Funds Committee **approved** a bid for £8,000 which related to bike storage in the Forest of Dean. The Committee was content to support this bid; however, a query was raised as to whether there were any opportunities to seek grant funding for such initiatives, for example, Sports England in this instance. Further awareness of this would be considered for future bids.

The Committee **endorsed** the establishment of a Charitable Funds expenses budget of £250, to cover day-to-day incidentals for the GHC Charity fundraising events.

The Committee **approved** the Gloucestershire Health & Care NHS Foundation Trust Charities Annual Report and Accounts for the financial year ending 31st March 2025, subject to completion of independent review which was due to start week commencing 30th June 2025.

The Committee **approved** the plans in place for the establishment and launch of the Friends of Forest Health Services.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The Committee received an update on the current cost-of-living impact and the ongoing measures in place by the Trust and other ICS partners to support colleagues and service users. The report provided an update on the uptake of the Hardship Fund, which was launched at the start of 2025, following Committee approval in December 2024. The Committee welcomed the update, noting that the provision of the Hardship Fund was such a kind and caring initiative that sat alongside the Trust's values, and it was positive to read about the ways the Trust had been able to support colleagues who may be experiencing financial challenges.

ITEMS RECEIVED: The following items were received and discussed at the meeting

- Bids Approvals made since the previous Committee meeting & Commitments
- Brokenborough Update
- Charitable Funds Annual Report & Accounts 2024-25
- Charitable Funds Committee work plan
- Charitable Funds Expenses Budget
- Five Year Plan – GHC Charity
- Friends of the Forest Health Services Update
- Hardship Funds Update Report
- League of Friends – 6 Monthly Update

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**AUDIT AND ASSURANCE COMMITTEE – 19 June 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 and considered the Annual Report from Procurement Shared Services (PSS) noting that it had been a challenging year with changes to the market and rising prices and staff vacancies. The Committee **noted** the report and the improvements that had taken place, however agreed that it provided only a level of assurance on the service provided by PSS to the Trust with further work required.

ASSURE: Inform the Board where positive assurance has been achieved

Internal Audit: The Committee **received** the final 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.

The following internal audit reports were considered:

- Key Financial Systems – Payroll: moderate for both design opinion and effectiveness
- Data Security and Protection Toolkit: The assessment of the 12 outcomes found that for 8 outcomes the rating aligned with the Trust's self-assessment. This was viewed as a positive outcome with a high level of confidence in the veracity of the Data Security and Protection Toolkit (DSPT) self-assessment.

External Audit: The Committee **received** the External Audit report for 2024/2025 and **noted** that an **unqualified opinion** had been issued on the Trust's accounts, meaning that it was believed that the accounts were a true and fair view of the financial position of the Trust.

APPROVALS: Decisions and Approvals made by the Committee

Final Annual Report and Accounts: The Committee **received** and **approved** on behalf of the Board for signing the Final Annual Report and Accounts for 2024/2025 and required certificates and returns.

Self-Certification – NHS Provider Licence COS7: The Committee **received** the Self-Certification – NHS Provider Licence (COS7), for endorsement, which formed part of the oversight arrangements for the NHS and set out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, both now and in the future.

The Committee **recommends** that the Board self-certifies against the statement detailed in section 3a (of the paper): *"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."*

The full paper is available in the Diligent reading room for Board Member review.

Committee's Annual Report to the Board: The Committee **endorsed** the annual report for 2024/2025 for presentation to the Board.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

Not applicable for this meeting.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The Committee recognised the work of the Finance Team in supporting the external audit process and positive outcome. The Committee thanked KPMG for their work with the Trust noting that it was their last external audit.

ITEMS RECEIVED: The following items were received and discussed at the meeting

- **Noted** the External Audit Annual Report and ISA260 Report
- **Approved** the considerations prior to the approval of the accounts.
- **Approved** the Annual Committee Workplan 2025/26.

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AGENDA ITEM: 18/0725

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**GREAT PLACE TO WORK (GPTW) COMMITTEE – 24 June 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** an update on the Nursing and Midwifery National Job Matching Profiles and was informed that national guidelines had now been published on the 3 June 2025. There would be a future requirement of the GPTW Committee and the Board to gain assurance from Internal Auditors on the policy, procedure and approach for this and whether there is any learning or improvement going forward.

The New NHS Very Senior Managers (VSM) Pay Framework and Guidance, was published by NHS England and it was reported this would be picked up in the Appointments and Terms of Service (ATOS) Committee.

The Committee **received** an update on apprenticeships and widening participation and it was informed that funding would no longer be received for level 7 apprenticeships from December 31st 2025. This had been added to the Integrated Care System (ICS) Risk Register and would now be added to the Trust Risk Register too.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee **received** the 2024 Staff Survey Progress Report and People Pulse Survey Results. Delivery on the action plan was **noted** and that further improvements were required to increase response rates to the People Pulse, by OD, communications, and service directorates being more proactive.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee was **assured** that the Staff Survey action plan was being delivered, and the delivery of further actions was scheduled in the upcoming months.

The Committee **noted** the improvement in the scores of the People Pulse Survey since the previous survey.

The Committee **received** the Gender, Disability and Ethnicity Pay Gap Report 2025 and noted the enhanced reporting facilities available, that there had been a recent Women's Leadership Network engagement session, and that there was a need for further

engagement with the Disability Awareness Network and the Race and Culture Awareness Network on the disability and ethnicity pay gap.

The Committee **received** the Performance Report which showed strong performance in key areas with good metrics and that the Trust generally compared well when benchmarked with other organisations. Areas for continual improvement were also highlighted, which included the pay gap and the high leaver rates for bands one to four.

APPROVALS: Decisions and Approvals made by the Committee

No approvals were made.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The routine risk report was not received at this meeting due to the reporting cycle; however, the Committee identified the following risks for escalation during the meeting:

- NHS temporary staffing and level 7 apprenticeship funding.
- The increase in immigration and visa fees
- The Continuing Professional Development funding (for nurses and AHPs) would be lost if not spent in the allocated period.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

It was shared that the Trust's Pride Week CPD session was positively received and was well attended by Trust Board members.

Jade Ajetunmobi shared a project closure report presentation on the People Promise and the related positive work achieved. The Committee thanked her for the progress made and recognised her hard work.

ITEMS RECEIVED: The following items were received and discussed at the meeting

Summary Reports from the following Management Group Meetings:

- Joint Local Negotiating Committee
- Joint Negotiating & Consultative Forum
- Learning & Development Oversight Group
- Workforce Management Group

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AGENDA ITEM: 19/0725

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**RESOURCES COMMITTEE – 25 JUNE 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

The Committee **received** the Quality and Performance Report for month 2, and the length of stay activity was highlighted. Further focus on this would be led by Sarah Branton, Chief Operating Officer and the Operational Team, to improve the length of stay across all inpatient settings, in order to achieve national expectations.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee **received** the Wotton Lawn and Greyfriars de-carbonisation Scheme and alongside the approval (of the scheme) and **agreed** to review the optimisation of decarbonisation works aligned to the Trust's Green Plan and the next round of public sector decarbonisation funding.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** the Finance Report for month 2 and was **assured** that there were no material amendments to the year-end finance position from the Resource Committee summary in April, and the year-end performance for the Trust was a performance surplus of £0.31m.

The Committee **received** the Quality and Performance Report, which provided a high-level view of performance and quality indicators in exception across the organisation.

The Committee **received** the National Cost Collection Methodology and was assured by the costing methodology set out in the paper.

The Committee **received** the Cyber Security Assurance Report and requested further alignments be included in the paper for future meetings.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the:

- Cash Management Framework.
- Corporate Benchmarking Return
- Wotton Lawn and Greyfriars de-Carbonisation Scheme

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The routine Risk Report was not received at this meeting in line with the reporting cycle.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

The following Key Performance Indicator (KPI) achievements were highlighted in the Quality and Performance Report:

O12 – ICT Occupational Therapy routine referral to treatment 18 weeks
Since January 2025 consistent performance was met. In January 2024 the mean waiting time was 2.6 months, in May 2025 the mean waiting time was 1.4 weeks.

L04 – CAMHS Learning Disabilities referral to assessment within 4 weeks
Since March 2025 improved performance following additional capacity in the initial assessment clinic, which has contributed to improvement.

N51 – IUCS proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention.
The compliant KPI indicates a high proportion of lower acuity ambulance calls are being safely managed through remote clinical intervention. Improving patient care by providing timely and appropriate treatment.

ITEMS RECEIVED: The following items were received and discussed at the meeting

The Committee **received** and **noted** the Service Development Report.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**QUALITY COMMITTEE – 8 JULY 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

The Committee held a confidential pre-meeting to discuss a recent Patient Safety Incident. This would be reported to the Private Trust Board due to confidentiality.

The Committee was informed that the Executive team were aware of compliance issues relating to record keeping.

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

The Committee continue to make progress with Quality reporting and are sighted on ensuring that the Quality Dashboard report is right in order to enable future improvements on patient safety, and also checking, monitoring and oversight.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** the CQC Community Mental Health Survey, which provided a summary of the results from 2024 and areas for focus. The Committee **noted** that this was a positive report and that the Trust compared highly nationally. The report included a great example of a simple change about communicating with patients which significantly improved the scores.

The Committee **received** the Quality Assurance Group Summary Reports, which highlighted assurance on alerts which were raised and discussed at the meetings held in May and June 2025.

APPROVALS: Decisions and Approvals made by the Committee

No approvals were made.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The routine Risk Report was not received at this meeting in line with the reporting cycle.

There were no new risks identified for escalation to Board during the open Committee meeting.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding

A presentation was shared by the Podiatry Team on *Stimulan – topical antibiotic beads.* This was the first Service Improvement Story received by the Committee and it demonstrated benefits, innovative practice and potential cost savings and aligned to the NHS 10-year plan.

The Committee **received** a summary of the winners and highly commended nominations from the Better Care Together Awards 2025.

ITEMS RECEIVED: The following items were received and discussed at the meeting

No other items were received.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 JULY 2025**
COMMITTEE:	**APPOINTMENTS AND TERMS OF SERVICE COMMITTEE (ATOS) – 17 JULY 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Graham Russell, Trust Chair

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

In May 2025, NHS England published the revised NHS Very Senior Managers (VSM) Pay Framework. The Committee **received** a report setting out the key changes and the implications these may have for GHC. The report summarised the main factors for the Committee's attention. The Committee **agreed** in principle with the key policy decisions, **noting** that these would be developed and incorporated into the Trust's Remuneration Policy, a revised version of which would be presented back at the next meeting for endorsement.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** the outcome of the annual review of Executive Director portfolios. The review had been undertaken in discussion with members of the Executive team, individually and collectively and considering recent performance review discussions. The Chief Executive informed the Committee that having undertaken the review, he was satisfied that the outcome accurately represented the current portfolios held by each Executive Director and that the portfolios were appropriately distributed across the team. Committee members welcomed this report.

The Committee **received** the outcome of the 2024/25 annual performance reviews of the Chief Executive and Executive Directors following the appraisals carried out during May, June & July 2025. The appraisal process had been developed further this year to include 360-degree feedback. The feedback exercise was undertaken based on the themes from the Leadership Competency Framework from direct reports and a selection of NEDs. The Committee welcomed this inclusion. The reports also included the objectives agreed with the Chief Executive and Executive Directors for 2025/26. The Committee thanked colleagues for carrying out such a thorough process, and for providing very helpful summaries for consideration. The ATOS Committee wished to echo the sentiments from

the appraisal outcomes and expressed their thanks to the Executive Team for their hard work and achievements over the past year.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **received** and **approved** its revised Terms of Reference, which had been updated slightly to reflect the newly published VSM Pay Framework.

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

- Chief Executive Performance
- Chief Executive Remuneration
- Committee Workplan
- Executive Director Remuneration
- Executive Directors Performance
- Remuneration Policy Review
- Review of Executive Directors Portfolios
- Terms of Reference Review
- VSM Pay Framework and Guidance and implications