with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 25 September 2025

10:00 – 13:00

To be held in the Leckhampton Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0925	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0925	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/0925	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/0925	Minutes of the meeting held on 31st July 2025	Approve	**Paper**	Chair
	05/0925	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0925	Questions from the Public	Assurance	Verbal	Chair
10:40	07/0925	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/0925	Report from Chief Executive	Assurance	**Paper**	CEO
BREAK – 11:05 (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:15	09/0925	Finance Report	Approve	**Paper**	DoF
11:30	10/0925	Quality Report M5	Assurance	**Paper**	DoNTQ
11:45	11/0925	Performance and Quality Dashboard M5	Assurance	**Paper**	DoF / COO
12:00	12/0925	Winter Planning – Board Assurance Statement	Approve	**Paper**	COO
12:10	13/0925	Medical Staffing Assurance: 13.1 - Medical Appraisal Annual Report 13.2 - Guardian of Safe Working Report	Endorse Assurance	**Paper**	MD
BREAK – 12.20 (5 minutes)					
STRATEGIC					
12:25	14/0925	Trust Strategy Refresh	Approve	**Paper**	DoIP
12:40	15/0925	Green Plan Refresh	Approve	**Paper**	DoIP
GOVERNANCE					
TO NOTE	16/0925	Council of Governor Minutes – 9 July 2025	Information	**Paper**	DoCG

TIME	Agenda Item	Title	Purpose	Comms	Presenter
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:50	17/0925	Audit & Assurance Committee (7 Aug)	Information	**Paper**	Audit Chair
	18/0925	Great Place to Work Committee (26 Aug)	Information	**Paper**	GPTW Chair
	19/0925	Resources Committee (28 Aug)	Information	**Paper**	Res. Chair
	20/0925	Quality Committee (2 Sept) • Infection Prevention & Control Annual Report *(Reading Room)*	Information	**Paper**	Quality Chair
	21/0925	Leadership & Culture Assurance Committee (9 Sept)	Information	**Paper**	Chair
CLOSING BUSINESS					
1:00	22/0925	Any other business	Note	Verbal	Chair
	23/0925	**Dates of future Board Meetings 2025** • Thursday, 27th November	Note	Verbal	All

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AGENDA ITEM: 04/0925

MINUTES OF THE TRUST BOARD MEETING

Thursday, 31 July 2025
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sarah Branton, Chief Operating Officer
Nicola Hazle, Director of Nursing, Therapies and Quality
Sumita Hutchison, Non-Executive Director
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Non-Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Rosi Shepherd, Non-Executive Director
Amjad Uppal, Medical Director

IN ATTENDANCE:
Des Gorman, Deputy Director of Improvement & Partnership
Anna Hilditch, Assistant Trust Secretary
Lowri Jones, Team Manager – Criminal Justice Liaison Service
Bren McInerney, Member of the Public
Kate Nelmes, Head of Communications
Sonia Pearcey, FTSU Guardian

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting.

1.2 Apologies were noted from Rosanna James, Nicola de Iongh, Jason Makepeace, Lavinia Rowsell and Cathia Jenainati.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Julie to the meeting, who was accompanied by Vron Rufus, Karen Currie, and Anna Kearney from the Community Neurology Service.

3.2 Julie had a stroke in July 2024 and was an inpatient at Frenchay Brain Injury Rehabilitation Unit (BIRU) for 3 months prior to coming home and being supported by the Community Neurology Service (CNS). Julie had significant weakness on her left side affecting her walking and ability to manage everyday tasks independently. The stroke also affected her cognition, in particular her attention and had a significant impact on her psychological wellbeing due to her loss of independence and role as a mother and Wife.

3.3 Julie was very goal focussed on her approach to rehabilitation and Physiotherapy and Occupational Therapy supported her to improve independence at home, but also around access to the community and strategies to support cognition. Julie's therapy goals focused on increasing her independence with walking and reducing her reliance on a walking aid. Julie also wanted to be more independent with personal activities of daily living, such as washing and dressing and kitchen activities.

3.4 Julie shared with the Board how she built her confidence and self-efficacy during her time with the CNS, achieving many of her goals. Julie said that the CNS colleagues treated her with respect, listened to her and she was treated like an adult which was so important.

3.5 The Board was pleased to hear that the CNS had now been made permanent, with recurrent funding to be received for the service to continue.

3.6 In terms of learning points, Julie suggested that more timely joined up MDT support would be helpful, and improved collaborative working with other agencies prior to coming home to provide greater support and smoother transition. Julie said that she would like to see improved information about the CNS for people coming out of hospital. She said that it was a fantastic team, and people need to know that they exist and to understand what support will be available to them as they transition from hospital to the home environment.

3.7 The Board thanked Julie for attending and speaking about her experience and congratulated her on the huge progress she had made. It was great to hear about the positive impact the CNS had had, noting that it was so important for people to keep motivated whilst in recovery and having the Team's support to keep going had made a huge difference to Julie.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 29 May 2025. The minutes were **accepted** as a true and accurate record of the meeting, subject to the following amendments:

- Nicola de longh, NED, was present at the meeting.
- 13.2 - The year-end financial position was a surplus of £0.31m, not £0.13m as noted.

5. MATTERS ARISING AND ACTION LOG

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

6. QUESTIONS FROM THE PUBLIC

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

6.2 The first question asked what assurance the Board sought that colleagues are able to take the necessary breaks whilst at work. The second question related to the opportunities to be made available for current staff who are in training roles/placements at the Trust, and approaches to the recruitment of new staff.

6.3 Neil Savage provided a verbal response to the questions. Both questions and the full responses would be shared with Bren McInerney following the meeting and would also be added as an annex to the minutes for future record. **ACTION**

7. REPORT FROM THE CHAIR

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

7.2 Graham Russell said that the Trust put a huge emphasis on Board development, and at the start of the year, the Board **agreed** the following priorities for its 2024/25 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). 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.

7.3 The Trust's Big Health Day took place 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. Graham Russell expressed his thanks to Dominika Lipska-Rosecka, Big Health Day Event Lead Co-Ordinator from the Partnership Team for her hard work and dedication in making it such a spectacular and inclusive event. Vicci Livingstone-Thompson noted that this was the first year that the coordination of the Big Health Day had transitioned over to the Partnership Team and she asked whether there was any learning to be taken from the event. Des Gorman said that colleagues were currently evaluating the event and the model used, and a report would be presented at a future Executive Meeting.

7.4 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 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 of July. We will work with partners to mitigate avoidable disruption and impact for colleagues and Gloucestershire people during transition.

8.3 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.

8.4 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'. There are a wide range of proposals and the plan is long term in its focus. On 10 July, Douglas Blair 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.

8.5 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 five 'segments' which indicate relative performance. 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.

8.6 Douglas Blair also highlighted a number of personal and team achievements within his report, including apprenticeships, awards and service reaccreditation. The Board was pleased to note that a letter of congratulations had been received confirming the approval of the 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.

8.7 On 2 July, Douglas Blair 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. Sumita Hutchison asked whether there were any reflections for GHC from this event. Douglas Blair said that there would be some follow through for the

Leadership & Culture programme, and Tania Hamilton (GHC Equality Diversity and Inclusion Lead) was coordinating an event in August to seek feedback. The Trust's Diversity Network would also be fully engaged.

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

9. FINANCE REPORT

9.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 3.

9.2 Sandra Betney informed the Board that the final accounts were approved at the Audit & Assurance Committee on 19th June and submitted on 30th June 2025. There were no amendments to the year-end position of a performance surplus of £0.31m.

9.3 At month 3, the Trust had a surplus of £0.018m compared to the plan of a £0.198m deficit.

9.4 The 2025/26 capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. It was reported the spend at month 3 was £1.376m against a budget of £2.266m. The cash position at the end of month 3 was £40.371m, which was £0.583m below plan. Sandra Betney advised that NHS receivables, invoices outstanding, disposals etc could all affect the Trust's cash position, but she said that she had no concerns about this area currently.

9.5 The Trust's agency and off framework agency usage was included in the report, with £0.953 spent on agency staff in month 3 which was below plan by £0.04m. It was noted that there were 25 off framework shifts in month 3 against a target of 0. The Board acknowledged the huge amount of work carried out to reduce off-framework agency usage, noting that an action plan was in place to focus in on those services where this off-framework is being requested with the aim of reducing this further.

9.6 The Cost Improvement Programme (CIP) has delivered £3.559m of recurring savings against the plan of £2.033m. The target for the year is £10.086m. £5.406m was currently unidentified. The non-recurrent savings target is £5.189m all of which has been identified, and of which £1.126m has been delivered.

9.7 The 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%.

9.8 The Board **noted** the month 3 position and **approved** the Revised Capital plan that included changes to planned expenditure and has 2 property disposals deferred to 2026/27.

10. QUALITY DASHBOARD REPORT

10.1 The Board received the Quality Dashboard, which showed the data for June 2025 and provided a summary assurance update on the progress and achievement of quality priorities and indicators across the Trust's Physical Health, Mental Health, and Learning Disability services. The report had been developed and now

presented data to the Board under the key headings of Alert, Advise, Assure and Applaud to assist with identifying key focus areas.

10.2 In relation to Alerts, the Board noted that a Prevention of Future Death (PFD) notice was issued on 26th June 2025 regarding MH crisis team staffing provision and the Trust was preparing a response to the coroner. Fidelity Testing has been undertaken into a prevention of future death that was issued in 2024 to understand if learning has been embedded at Wotton Lawn. Additional assurance was required in 3 of the 5 areas, and actions have been identified for completion in August. Nicola Hazle advised that an increase in the number of PFD notices was being seen nationally.

10.3 Positively, a further reduction in the number of overdue Datix incidents from 2024/25 was being reported, down from 701 to 393. The Trust does continue to see high levels of reporting of incidents which is encouraged as demonstrating our promotion of an open and transparent learning culture.

10.4 Bilal Lala noted that compliance with children's safeguarding supervision training had dropped to 66% in June, from 75% in May and he asked what was being done to improve this position. Nicola Hazle advised that work was taking place to identify the reasons for this drop and assured the Board that ongoing liaison between the Safeguarding team and Operational colleagues to increase rates was continuing.

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

11. QUALITY AND PERFORMANCE DASHBOARD

11.1 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 June 2025.

11.2 The Board **noted** that Service led Operational & Governance reports are presented to the operational governance and risk meeting, the first meeting of which was held in June and more widely accounts for performance indicators in exception and outline service-level improvement plans including forecasts.

11.3 Sandra Betney highlighted four measures within the 'alert' category of the report which would be followed up by the Resources Committee at its August meeting.

11.4 The Board **noted** those measures highlighted in the 'applaud' category of the report for positive recognition. These included:

- L03 CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations) – The Board noted that there had been a significant improvement in compliant cases this month and recovery was anticipated by the end of July.
- Integrated Urgent Care Services (IUCS) are driving continued performance improvements across many of their indicators with improvement plans in place. Particular attention is celebrated with the important Category 3 and 4 ambulance and Excess Treatment Costs (ETC) validation metrics which are performing well beyond compliance.

- The Board **noted** that all Wheelchair service measures, such as routine, priority referrals assessed and equipment delivery for adults and under 18s, were now compliant and meeting target.

11.5 Although not directly within the quality and performance dashboard yet, the Board was informed that all locally monitored key performance indicators (KPIs) for Dental & Sexual Health Services were presenting compliant positions across Sexual Health, the Sexual Assault Referral Centre, the Community Dental Specialist and Intermediate Minor Oral Surgery (IMOS) Services. This covered treatment and referral to book waits, HIV (Human Immunodeficiency Virus) testing offers and response times.

11.6 Bilal Lala noted L24 IUCS – OOH IUC Home Visit within 2 Hours – Urgent, where performance was reported at 29.6% against a target of 95%. Sarah Branton said that not all measures were relevant to GHC. Contract variation was being discussed in response to the new national KPI publication and GHC are expecting 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. The Board was assured that all proposed changes to the measures would be presented through BIMG and the Resources Committee for transparency.

11.7 Sumita Hutchison noted the amount of information received, and she asked what the Board should be looking at or focused on. Douglas Blair said that a Board development session was scheduled for the coming month where the Board would spend time focusing on this, and the development of integrated reporting.

11.8 The Board **noted** the Quality and Performance Dashboard Report for June 2025 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.

12. SAFE STAFFING UPDATE

12.1 The Board received this report which provided an update 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.

12.2 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).

12.3 This update paper to the Board sought 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

12.4 The Board **noted** 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. Regular oversight and scrutiny of safe staffing would take place at the Quality Committee.

13. MODERN SLAVERY STATEMENT

13.1 The purpose of this report was to present the Board with the Trusts' statement on Modern Slavery, for approval and reconfirmation. 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.

13.2 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.

13.3 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 was now presented to the Trust Board for approval.

13.4 The Board **noted** 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 **approved** the statement for publication on the Trust website.

14. AUDIT AND ASSURANCE COMMITTEE ANNUAL REPORT

14.1 The Board received the annual report of the Audit and Assurance Committee for 2024/2025. The report provided 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 provided an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement.

14.2 The Board received this report, noting that no issues had been highlighted as areas of concern, and that the Committee had operated in line with its terms of reference to meet the functions delegated to it by the Board.

15. COUNCIL OF GOVERNOR MINUTES – 14 MAY 2025

15.1 The Board **received** and **noted** the minutes of the Council of Governors meeting held on 14th May 2025.

16. BOARD COMMITTEE SUMMARY REPORTS

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

- Charitable Funds Committee (18 June)
- Audit & Assurance Committee (19 June)
- Great Place to Work Committee (24 June)
- Resources Committee (25 June)
- Quality Committee (8 July)
- Appointments and Terms of Service Committee (17 July)

16.2 The Audit & Assurance 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.

16.3 The Audit & Assurance Committee also 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 recommended 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 Board **endorsed** this self-certification.

16.4 The Resources Committee received, reviewed and approved the Wotton Lawn/Greyfriars decarbonisation scheme. Due to the SFI approval limits, the Committee was given delegated responsibility to approve this scheme on behalf of the Board.

17. ANY OTHER BUSINESS

17.1 There was no other business.

18. DATE OF NEXT MEETING

18.1 The next meeting would take place on **Thursday, 25 September 2025**.

Annex 1
QUESTIONS FROM THE PUBLIC

QUESTION 1

"What assurance, and reassurance does the Gloucestershire Health and Care NHS Foundation Trust board seek and have that staff are able to take the necessary breaks whilst at work? What process(s) are in place, and being implemented, to ensure staff are able to take a break and what evidence and robust measures are in place to ensure this is happening?

What is the expectation(s) of, for example Team Managers, but not just Team Managers in the Trust, when staff may/do report concern(s) on breaches/repeated breaches to not having a break in their workplace?

Bren McInerney

TRUST RESPONSE

The Trust has several mechanisms in place to support and monitor staff access to rest breaks during their shifts:

- **Local Implementation Practices:** At the team level, local processes are encouraged to support break compliance. For example, break times may be recorded on whiteboards to ensure visibility and accountability. The nurse in charge or team lead holds responsibility for ensuring all colleagues are afforded their breaks and for monitoring the fairness and safety of break distribution. A buddy system is often used to facilitate cover during breaks.
- **Local Induction:** Within the onboarding Handbook and Checklist “Day One in the Workplace Overview” that new appointees complete and sign off with their recruiting managers, these highlights what the local arrangement are for meal and rest break arrangements.
- **Roster System Monitoring:** The Healthroster system (which is used by colleagues to allocate their working patterns/shifts) is configured to flag instances where a colleague has not taken the minimum 20-minute break during a shift exceeding six hours. Breaks are embedded into the roster planning, and managers are expected to stagger break times to maintain safe staffing levels while ensuring colleagues can rest.
- **Policy Framework:** The Trust’s Working Hours Policy clearly outlines the statutory entitlements for breaks. Staff working more than six hours are entitled to a minimum 20-minute uninterrupted break. In practice, colleagues normally have longer periods allocated. Additionally, the policy stipulates a minimum of 11 hours of rest between shifts and at least one full day off every seven days, or two days off within a 14-day period. Again, the Healthroster system has a system of rules in place to oversee this. The Leave Policy also reminds colleagues and their line managers of the importance of regularly taking their full annual leave through the year, as rest and recuperation outside normal working hours are as equally as important.
- **Regular Communications and Signposting:** reminders and good practice for ensuring rest periods and breaks are highlighted in communication briefings and intranet wellbeing resources such as the “Looking after your teams and colleagues” on Indigo.
- **Operational Flexibility and Support:** While high acuity or emergency situations may occasionally delay breaks, the Trust is committed to ensuring that time is given back or

additional rest is provided where breaks are missed. This is sometimes referred to as "compensatory rest" and reflects a flexible and compassionate approach to operational realities while maintaining a focus on staff wellbeing.

- **Escalation Routes:** while the expectation is that colleagues and their managers should be fully able to locally resolve rest period issues, if this is not the case, it can be escalated to their senior manager, to a member of the Health and Wellbeing Champion Network, to a local trade union / health and safety representative, to Freedom To Speak Up or via Direct to Douglas for resolution.

Neil Savage
Director of Human Resources & Organisational Development

QUESTION 2

"What opportunities will be made available for current to staff who are in training roles/placements at Gloucestershire Health and Care NHS Foundation Trust. What approaches to recruitment of new staff will Gloucestershire Health and Care NHS Foundation Trust adopt going forward in the changing NHS landscape?

Bren McInerney

TRUST RESPONSE

Gloucestershire Health and Care NHS Foundation Trust is committed to nurturing talent and supporting the development of staff in training roles and placements, while also evolving its recruitment strategies to meet the demands of a changing NHS landscape.

Opportunities for Staff in Training Roles and Placements:

The Trust offers a wide range of structured development pathways for colleagues in training roles, including:

- **Apprenticeships:** Colleagues can access over 30 apprenticeships, covering both clinical and non-clinical disciplines. These programmes are designed to support career progression and are delivered through a blend of workplace learning, simulation, and academic study
- **Work Experience and T-Level Placements:** In collaboration with local education providers, the Trust supports T-Level industry placements and work experience opportunities, offering hands-on exposure to healthcare environments and professional mentoring
- **Care To Learn:** The Trust's learning management platform provides free access to all colleagues, including those in training roles, to a wide range of clinical and non-clinical learning programmes and courses, self-directed and bookable learning. Access to wider learning programmes and accredited learning is also made available via the free e-Learning for Health hub and other national resources.
- **Continuing Professional Development (CPD):** the Trust spends circa £700k per annum on CPD training for nurses and AHPs. A proportion of this is allocated to those in role training and upskilling programmes.
- **Support Structures:** Staff in training roles are supported by dedicated teams, including line managers, workplace mentors, and the Apprenticeship and Widening Access Team, ensuring a high-quality learning experience and integration into the workforce

Future Recruitment Approaches:
In response to the evolving NHS workforce landscape, the Trust is adopting innovative and inclusive recruitment strategies, including:

- **Widening Participation Initiatives:** Targeted outreach to underrepresented groups and partnerships with schools, colleges, and community organisations to attract diverse talent.
- **Flexible Entry Routes:** Expansion of apprenticeship and trainee programmes to provide alternative pathways into healthcare careers, reducing barriers to entry.
- **Digital Recruitment Tools:** Enhanced use of digital platforms and social media to reach broader audiences and streamline recruitment processes.
- **Retention-Focused Recruitment:** Emphasis on values-based recruitment and career development opportunities to attract candidates who are aligned with the Trust's culture and long-term vision.
- **Industry Placement Coordination**: The Trust, GHT and NHS Gloucestershire ICB have successfully secured funding for the new Industry Placement Coordination Officer (IPCO) role for the county. This marks a significant milestone in our commitment to expanding high-quality T-Level industry placements across the health and care system. Over the past two years, our system-wide T-Level network has grown, with placements increasing across clinical and non-clinical pathways. This success has been driven by strong collaboration with our system partners, local colleges, discretionary effort from our teams, and a shared vision to build a sustainable talent pipeline for the future workforce. The new IPCO role will be pivotal in:

  - Scaling placement capacity across NHS, social care, primary care, and voluntary sector partners.
  - Driving strategic alignment between T-Level courses and workforce needs through gap analysis and action planning.
  - Supporting students and staff with tailored mentoring, induction frameworks, and feedback mechanisms.
  - Promoting T-Level pathways to young people, parents, and employers, including myth-busting campaigns and success stories.
  - Embedding T-Levels into workforce planning, helping address staffing pressures and inequalities.

  The IPCO will work closely with the providers and the ICS Careers Engagement and Outreach Team, which has already engaged over 25,000 students this academic year. Together, they will promote T-Level opportunities and support progression into apprenticeships and entry-level roles, particularly in areas with high vacancy rates such as social care and primary care. This role will also align with the Widening Access Demonstrator programme ensuring synergy across widening participation, recruitment, and education workstreams.

These approaches reflect the Trust's commitment to building a resilient, skilled, and compassionate workforce that can meet the needs of the communities it serves.

Neil Savage
Director of Human Resources & Organisational Development

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 25 September 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	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	November 2025	To be included in the next 6-monthly update report to the Board. Due November 2025.	**On Track**
31 July 2025	14.5	Formal responses to Public Questions to be sent to Bren McInerney following the meeting and attached as an annex to the meeting minutes for the record.	Neil Savage / Trust Secretariat	July 2025	Complete.	**Complete**

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

PRESENTED BY: Graham Russell, Trust Chair

AUTHOR: Trust Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

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

The purpose of this report is to

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

Recommendations and decisions required

The Board is asked to:

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

Executive summary

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

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

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified

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 – July and August 2025 **Appendix 2** Integrated Board Reporting Framework

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

- I was delighted to accompany **Cllr Iain Dobie, new Chair of Gloucestershire County Council's Health Overview and Scrutiny Committee** on a visit to Forest of Dean Community Hospital and Charlton Lane Hospital on 2nd September. During his visit, Cllr Dobie met with hospital colleagues, healthcare professionals, and patients and had the opportunity to view hospital facilities. I would like to thank Matrons Kate Harper and Brad Watkins for taking time out of their busy schedule to accommodate the visit.

Forest of Dean Community Hospital

Charlton Lane Hospital

- The **Chair of Gloucestershire Hospitals NHSFT**, **Deborah Evans** and I continue to meet on a regular basis where we have the opportunity to discuss matters of mutual interest.

Always improving

- I chaired a meeting of the **Leadership and Culture Board Assurance Committee** on 9th September. Discovery work continues across each of the Leadership and Culture workstreams.

Respectful and kind

- Although unable to attend myself, the **Forest of Dean Community Hospital Summer Fete** took place on 16th August where funds were raised to support staff and patient wellbeing. Everyone was welcome to attend the event which I understand was lively and good fun.

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 the **Perinatal MH Community Team** who are based at **Pullman Place** on 9th September to present their '**Making a Difference**' award.

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 to acknowledge 'Making a Difference' across the trust.

3. BOARD UPDATES

- The **developmental review of our current Board committee arrangements** continues. As reported in my last report to Board, 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 outcome will feed into our ongoing board development programme.

- On 12th August, a **Board Seminar session** took place where the topic for discussion was **Governance Development and Integrated Reporting**. The session was led by Douglas Blair, Chief Executive and Sandra Betney, Director of Finance. This informative session discussed 'Insightful Board' guidance related to Board reporting, proposed an overarching framework for reporting and reviewed all aspects of the framework including overall implementation and timings. See Appendix 2 to view the Integrated Board Reporting Framework and timescales for implementation. This framework will be considered in the context of the outcome and any recommendations arising from the developmental review of Trust Board Committee governance arrangements which is currently underway – due to report in October 2025.

- A face-to-face **Board Development session** took place on 21st August where the topic for discussion was the **Trust Strategy refresh**. The session, which was led by Rosanna James, Director of Improvement and Partnership, focused on the priorities of the Trust and the 10-year plan.

- On 3rd September I met with Nicola de Iongh, Vice Chair, Neil Savage, Director of HR & OD and Lavinia Rowsell, Director of Corporate Governance and Anna Hilditch, Assistant Trust Secretary where we discussed **NED recruitment** proposals ahead of presentation at the Board Seminar on 11th September.

- A **Board Seminar** session took place on 11th September where recruitment to the role of NED was discussed. During the summer, a full Board skills and experience audit was undertaken, and the seminar was an opportunity to review the audit and consider next steps for recruitment. A future joint Board Development opportunity with Gloucestershire Hospitals NHS Foundation Trust (GHNFT), focussing on innovation and transformation in the context of the 10 year plan was also considered.

- The **Trust's AGM** took place on 11th September. This was a virtual event which provided a review of last year and an account of our quality and financial position as well as a review by our Lead Governor, Chris Witham. There was an opportunity to ask questions of the Council of Governors and the Board.

- 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.

- A meeting of the **Nominations and Remuneration Committee** took place on 17th September where proposals for NED recruitment were discussed along with a review of the Committee Terms of Reference and Trust Chair Remuneration.

- On 17th September a **Council of Governors meeting** took place where Governors, amongst other items, received an update on the Trust Strategy refresh.

- A briefing session took place on 27th August where Governors had the opportunity to learn more about the **Trust annual report and accounts.** The session was led by Sandra Betney, Director of Finance and Bilal Lala, NED and Chair of Audit and Assurance Committee.

- Our **programme of visits to sites for Trust Governors** continues to progress with visits taking place at Wotton Lawn Hospital on 11th September and Forest of Dean Community Hospital on 29th September. 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 regularly active, attending meetings in person and virtually across the Trust and where possible visiting services.

See **Appendix 1** (page 7), for the summary of the Non-Executive Directors activity during the 1st of July to the 29th August 2025.

6. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1 - Non-Executive Directors (NEDs) – Summary of Activity 1st July – 29th August 2025

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• 2 x MHAM Personal Development Reviews • GGI NET Zero Webinar • GGI/GHC meeting re MHLSC • Gloucestershire ICS NEDs Network Meeting • Interviews for Consultant Occupational Health Consultant • NHS Confederation Quarterly Non-Executive Directors Forum • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Quality visit to CYPS Occupational Therapy Service	• Appointments and Terms of Service Committee • Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Joint Board & Council of Governors Development Session: Strategy Refresh • Quality Committee • Resources Committee • Trust Board: Public & Private
Sumita Hutchison	• Non-Executive Directors Meeting • Great Place to Work Agenda Planning Meeting • Meeting with Executive Assistant to Director of HR and OD • Great Place to Work Pre-Meet • Meeting with Jason Makepeace and Bilal Lala • Great Place to Work Assurance Report Meeting	• Appointments and Terms of Service Committee • Audit and Assurance Committee • Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Great Place to Work Committee • Trust Board: Public & Private
Nicola de longh	• BDS Pre-Meet with Director of Director of Improvement and Partnerships • Governor Visit to Charlton Lane Hospital • Meeting with Director of HR & OD and Director of Corporate Governance • Non-Executive Directors Meeting	• Appointments and Terms of Service Committee • Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Great Place to Work Committee • Joint Board & Council of Governors Development Session: Strategy Refresh • Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Vicci Livingstone-Thompson	• Disability Awareness Network • Gloucestershire ICS NEDs Network Meeting • Meeting regarding Working Together Network • Meeting with Will Chapman regarding ICB AGM • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Quality visit to Assertive Outreach Team • Race and Cultural Awareness Network • Working Together Network Debrief	• Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Joint Board & Council of Governors Development Session: Strategy Refresh • Quality Committee • Trust Board: Public & Private
Bilal Lala	• 1:1 with Counter Fraud Lead • Audit and Assurance and Resources Committee Chairs Catch Up • Audit and Assurance Committee Assurance Report Meeting • Audit and Assurance Committee reflections discussion with Director of Corporate Governance • Governor Session: Annual Report and Accounts • Meeting with GGI • Meeting with Sumita Hutchison and Jason Makepeace • Non-Executive Directors Meeting • Quality visit to Dental Services	• Appointments and Terms of Service Committee • Audit and Assurance Committee • Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Joint Board & Council of Governors Development Session: Strategy Refresh • Quality Committee • Trust Board: Public & Private
Jason Makepeace	• Audit and Assurance and Resources Committee Chairs Catch Up • Making a Difference Award Meeting • Meeting with Gerry Gogarty, Blood and Transplant Service • Meeting with GGI • Meeting with Sarah Sharp, Community Manager, Gloucester Integrated Community Team • Meeting with Sumita Hutchison and Bilal Lala • NHS Gloucestershire System Resource Committee • Non-Executive Directors Meeting	• Appointments and Terms of Service Committee • Audit and Assurance Committee • Board Development Strategic Away Day • Board Development: Strategy Refresh - focus priorities/test of 10-year plan • Board Seminar: Governance Development and Integrated Reporting • Joint Board & Council of Governors Development Session: Strategy Refresh

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Non-Executive Directors Meeting • Quality Visit to Stroud ICT • Resources Committee Agenda Setting Meeting	

Rosi Shepherd	Quality Committee Pre-Meet Quality Committee Assurance Meeting Non-Executive Directors Meeting Meeting with Becky Parish Meeting with Medical Director Meeting with Chief Operating Officer Freedom to Speak Up Training Visit to Young Minds Matter Visit to CAMHS Outreach/Crisis Team Meeting with GGI 1:1 with Freedom to Speak Up Champion Visit to School Nursing Service Visit to Forest of Dean Community Hospital Visit to Young Adults Service Visit to CAMHS LD Service Non-Executive Directors Meeting NHS Gloucestershire System Quality Committee	Board Development Strategic Away Day Quality Committee Trust Board: Public & Private Audit and Assurance Committee Board Seminar: Governance Development and Integrated Reporting Board Development: Strategy Refresh - focus priorities/test of 10-year plan

Appendix 2

Integrated Board Reporting Framework

Chief Executive Overview NEW developing, launch at either November or January Board

- New part of Chief Executive report to Board
- A fixed set of high level information showing the current overview and trends (demand, progress against strategy, key areas of delivery, financial headlines, workforce headlines, quality/experience headlines) + our status on NHS Oversight Framework
- Provides integrated view of overarching context but NOT to be used as an alternative performance dashboard

Committee Highlight Reports IN PLACE

- Alert/Assure/Advise/ Applaud format
- Identifying need for cross committee coordination/referral
- Includes visible link to BAF risks being overseen by Committee

Highlight Reports from Executive Team

- By exception, further essential information/ description that relates to a dashboard indicator/s, but not duplicating
- Make connection to Committee Assurance where issue is being reported due to timing. **Three elements**:

- **Chief Executive/Executive Report REVISING September Board**
  - National policy updates/changes
  - Will include Alert/Assure/Advise/Applaud structure for wider information/issues not being reported by other means (related to Operations, Workforce, Digital, Estates, Improvement and Partnerships)
- **Finance Report IN PLACE**
- **Quality Report REVISING (changes as indicators transition to dashboard)**

Integrated Dashboard REVISING

- **All new indicators integrated by 31 March**
- **Domains changed by November Board**
- Organised into domains (reviewed in light of Insightful Board guidance)
- Exception reporting (exceptions include extent of variability as well as absolute thresholds)
- Brief narrative on what is in place when off plan (does not need to also be covered in Executive Team reports, unless adding more detail)
- Content to be increased over time
- Design/presentational improvements over time – more info-graphical style

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 September 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.

Recommendations and decisions required

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

Executive Summary

See purpose section.

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

Report authorised by:	**Title:**
Douglas Blair	Chief Executive Officer

1. CHIEF EXECUTIVE SERVICE / TEAM VISITS

In August and September, I have completed the following service visits:

- **North Cotswold Hospital – 6 August**

  I spent the day at North Cotswold Hospital on 6 August and took the opportunity to catch up with colleagues across the site.

- **St Pauls Medical Centre/ Brownhill Centre, Cheltenham – 12 September**

  In the afternoon I dropped in for an impromptu walkaround with teams, providing an opportunity to catch up with some colleagues from our dental team, Mental Health Intermediate Care Team and Eating Disorders team.

- **Gloucester Integrated Community Team – 18 September**

  I started the day hot desking at Collingwood House, providing a brief opportunity to see community team colleagues at the start of their shifts.

2. EVENTS

FTSU Champions Away Day – 4 & 11 September

I was pleased to welcome our Freedom to Speak Up champions to an away day, which was held twice in September. It was good to reinforce the vital role that our Champions play in encouraging colleagues to speak up about issues of concern.

NHS Leadership Event – 16 September

I attended the latest NHS leadership event in London on 16 September. The topics focused on the immediate priority areas in terms of delivering the 10 year plan, with some initial thinking developed by working groups over the summary being tested with the large group of leaders. The session also included a Question and Answer session with the Secretary of State for Health and Social Care.

Falls Awareness Week – Strong and Steady - 18 September

I was pleased to be put through my paces, alongside the Director of Nursing, Therapies and Quality and Medical Director, in a series of balance and strength exercises to highlight Falls Awareness Week. The team were out and about in Gloucestershire during the week and received a great response from members of the public.

South West Exercise Medical Endeavour – 19-21 September

Gloucestershire Health and Care has entered two teams, out of a total of 16 from NHS Trusts across the South West, for this annual event, which is organised by 243 Multi-Role Medical Regiment and is designed to promote good collaboration between the armed forces and the NHS. The event has not taken place at the time of writing, but I have been persuaded by colleagues to take part in the exercise itself, helping (or hindering) one of our two teams.

3. CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Alert	None	
Assure	Workforce	**Getting The Basics Right for Resident Doctors**

On the 28 August 2025, NHS England wrote to provider trusts launching a new national 10 Point Plan to improve resident doctors' working lives. This plan sets out clear expectations for NHS England and providers, with a 12-week delivery window for initial actions and further milestones extending into 2026. A summary of the 10 Point Plan is listed below:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating
7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours
8. Resident doctors should receive reimbursement of course related expenses as soon as possible
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

Dr Amjad Uppal, Medical Director, is the lead executive for this work and is being supported by Neil Savage, Director of HR and OD. An initial meeting has been held resulting with a task and finish group being set up, to include our current resident doctor representatives and key colleagues.

We believe the Trust is meeting the majority of the points within the 10-point plan already, due to ongoing collaborative work by the resident doctor reps, medical staffing and the medical education team over the last few years. The task and finish group will identify any outstanding areas so that an action plan can be in place well before the deadline.

The Board is asked to note this update and support the recommendation that further local progress with delivering the 10 Point Plan will be reported via the Great Place to Work Committee to Board.

Assure	National/ Regional Update	**NHS Oversight Framework and League Tables**
	The first results of the new NHS Oversight Framework for 2025/26 were published on 9 September 2025. The framework introduces a segmentation model for providers, categorising them from Segment 1 (high performing) to Segment 5 (most challenged), based on indicators across six domains with organisations to be granted greater autonomy. The segmentation data and performance dashboards are publicly available. For quarter 1 of 2025/26, the Trust was placed segment 2 and ranked 21 out of 61 of 'non-acute' trusts. The framework is dynamic and is based on relative performance on a small number of indicators, so it is expected that rankings and segmentation could significantly change quarter by quarter.	
	National/ Regional Update	**Board Assessment of Organisational Capability**
	NHS England has launched a new Provider Capability Assessment process as part of the NHS Oversight Framework. This initiative complements existing NOF segmentation by providing a more holistic view of provider performance, focusing on governance, oversight, and Board capability. Organisations are required to complete a self-assessment, aligned with themes from The Insightful Board guidance, by 22 October 2025. The Trust is progressing its assessment to meet the October deadline noting that, due to the scheduling of meetings, the final outcome will not be formally reported to Board in public until the November meeting. The assessment will be reviewed by regional oversight teams, triangulated with delivery track records and third-party intelligence, and used to inform segmentation. The process is intended to support continuous improvement and strengthen internal assurance and as such, ongoing review will be embedded within the workplans of Board Committees.	
	Digital	**NHS Digital Maturity Assessment**
	The NHS Digital Maturity Assessment is a national NHS England initiative to evaluate the digital capabilities of healthcare providers. It serves as a foundational tool to support long-term digital transformation and allows organisations to: • Assess their readiness, capabilities, and infrastructure for digital integration • Identify strengths and gaps in digital service provision • Align digital strategies with core business objectives and patient care outcomes. The self-assessment is structured around a framework and has been run for 3 years, although significant changes each year makes the results hard to compare. The assessment defines seven dimensions of digital excellence and each section is scored from 1 to 5, 5 being the highest score and 1 being the lowest. This year, GHC scored itself as an overall average 2.1. The South West has an average across all provider Trusts of 2.1 (the national average is 2.4).	

	We are reviewing the results to identify quick wins over the next year, including work on safe practice and sustainability, and ensuring the Digital maturity is factored into our renewed Digital strategy in in 2026. A fuller update will be provided to the Resources Committee in October.	
Advise	Workforce	**Nursing national job matching profiles, Agenda for Change non-pay deal recommendations & NHS Job Evaluation**
	Part of the Agenda for Change (AfC) non-pay deal agreed between the government and trade unions earlier this year included a focus on job evaluation. NHS England wrote to Trusts in August to remind colleagues of the importance of ensuring staff receive the correct pay for the work they are asked to do and asked employers to prepare for and prioritise work following publication of the NHS Staff Council updated Job Evaluation profiles for nursing and midwifery and accompanying guidance in June 2025. **NHS England will launch a Job Evaluation data collection exercise in phases with providers beginning Autumn 2025**. This will include: • An **initial readiness assessment** will ask Trusts to confirm that they have appointed a board-level SRO or sponsor to oversee the JE process, and that senior leaders are aware of the updated nursing and midwifery profiles and have read and understood the supporting communications and guidance. • **Collection of key workforce metrics** focused initially on the nursing and midwifery workforce JE profiles and activity monitoring. • **A future NHS England audit** against the NHS Staff Council assessment of job evaluation practices. Providers will be asked to conduct this assessment in partnership with local trade unions. NHS England plan to launch the JE practices audit Autumn-Winter 2025, with no clear date yet given. Further updates and detailed papers will be provided to the Great Place to Work Committee, and Board where necessary, when more dates and details have been received. The Director of Human Resources and Organisational Development will be the SRO and oversee the action plan delivery and will be taking a report to Executives in October.	
	Workforce	**Widening access -- Gloucestershire NHS recruitment drive to support working-class communities**
	As part of implementation of the 10 year plan, the government has launched a scheme to get 1,000 working class people on the health and social care career ladder, supporting the NHS to continue to recruit from the communities it serves. Parts of Gloucestershire will receive funding to support those worst affected by unemployment, including young people not in education or training, young carers and care leavers.	

Advise	Locally, Barton and Tredworth, Kingsholm and Wotton, Moreland and Westgate, St Marks and St Pauls, and Cinderford will benefit from the scheme - with an aim to get unemployed young people, care leavers and young carers in the areas into work. Circa £490K is being made available to fund a Widening Access Demonstrator (WAD) project. The project will start later in 2025 and aims to support at least 100 individuals into work experience, volunteering or education, with a minimum of 12 participants being expected to move into paid employment by March 2026.	
	Workforce	**Freedom to Speak Up changes**
	On the 13th August, following the Publication of the Patient Safety Landscape Review, NHS England wrote to all Trusts to reaffirm *the vital role that Freedom to Speak Up Guardians continue to play across the NHS*. The letter highlighted that Guardians *are instrumental in ensuring that staff voices are heard that patients are protected from harm, and in supporting the development of safer, fairer, and more transparent healthcare systems.* Importantly, as outlined in the recommendations of the review, the functions of the National Guardian's Office will be transferred to NHS England. Until such time, the Office will remain the primary support and main point of contact for Guardians. Additionally, it was confirmed that Freedom to Speak Up, and the Guardians role, will be incorporated into the NHS Standard Contract for 2026/27. NHS England will assume responsibility for leading this work from 2026/27 onwards.	
	National / Regional Update	**NHS Planning Framework**
	The planning framework for the NHS was published in August 2025 and supports the development of integrated five-year plans (2026/27 to 2030/31) that are aligned with the Ten-Year Health Plan (10YHP). It marks a shift from annual cycles to a rolling, strategic, and collaborative planning model across the NHS. Detailed 1-year plans are to be submitted at both provider organisation and system level and 5-year organisation plans together with neighbourhood health plans will be the core outputs of integrated local planning processes. Core planning activities to be undertaken in two phases between August – December, with submission of plans in December. **Key Principles** 1. Outcome-focused: Deliver measurable improvements in health outcomes for patients and value for taxpayers. Involve patients, carers and communities to ensure plans are responsive to local needs. 2. Accountable and transparent: Clear governance and oversight, alignment with strategic objectives at organization, place and system level. 3. Evidence-based: Use robust analytics and modelling.	

<table>
<tr><td rowspan="3">Advise</td><td colspan="2">4. Multidisciplinary: Involve finance, workforce, performance and clinical teams; ensure those responsible for delivery have shaped plan content.
5. Credible and deliverable: Plans are ambitious but realistic with mitigation strategies for risk. Robust triangulation between finance, performance, workforce and quality.

Roles and Responsibilities
National: Set strategy, develop tools, and support capability building.
Regions: Coordinate cross-system planning and assure responses.
ICBs: Lead system strategy, commissioning, and coordination.
Providers: Develop strategic, operational, and financial plans with clinical leadership.

Boards: More active moving beyond final plan endorsement to direction setting, reviewing drafts and constructive challenge of assumptions. Accountable for plan development and delivery, ensuring alignment with system strategy and national ambitions.</td></tr>
<tr><td>System Update</td><td>Changes related to social care services provided on behalf of Gloucestershire County Council services</td></tr>
<tr><td colspan="2">The Trust has received formal notice from Gloucestershire County Council and the Integrated Care Board of the need to end the provision of Mental Health Social Care Services, Mental Health Supported Accommodation, Occupational Therapy and Reablement services, which are provided on behalf of Gloucestershire County Council. The implementation of these changes, which will involve the transfer of employment for some colleagues is being worked through in detail.</td></tr>
<tr><td rowspan="2">Applaud</td><td>Workforce</td><td>Apprenticeships</td></tr>
<tr><td colspan="2">Congratulations on the achievements of our apprentices who have recently successfully completed their apprenticeship.

Level 3 – Senior Healthcare Support Worker:
• Bobbie-Jo Sparson; Jen Codell; Amy Gibson; Hannah Parish; Naomi Larner; Molly Hale

14 completed Level 5 Student Nursing Associate including;
• Katie Gibbs; Oyewalye Oloyede; Becky Ellis; Mark Skelton; Mandy Rawlings; Aimee Stafford; Nicola Stewart

5 completed Level 6 Top Up Nursing including:
• Faye Rickaby; Becky Sears</td></tr>
</table>

Applaud	Workforce	**Disability Confident Leader Reaccreditation**
	The Trust has received confirmation that following a recent external review and reassessment, it has been reaccredited as a Disability Confident Leader employer, the top accreditation level available. The scheme was designed by the government as a continuous learning journey, encouraging employers to evolve and improve with every step. It replaced the previous Disability Two Ticks model. It is not about achieving a static level of the scheme, and it does not mean the Trust has everything right. Importantly, we know from case outcomes and reviews, alongside our work with the Disability Awareness Network, that we have much still to do, particularly with how we deal more swiftly and effectively with reasonable adjustments.	
	Estates	**NHS Charge Point Accelerator Scheme**
	The Trust has been successful in securing a grant of £274k as part of the £8m NHS charge point accelerator scheme to increase the number of Electric Vehicle Charge Points on Trust sites during this financial year. This grant will support the purchase and installation of 21 additional dual charger units (i.e. 42 charge points) across Brownhills, Colliers Court, Cleeve House, Collingwood House, Pullman Place and Southgate Moorings as well as Wotton Lawn, Stroud, Vale, Cirencester & Tewkesbury Hospitals.	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09/0925

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st August 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 5 position.
- **APPROVE** the Revised Capital Plan.

Executive summary

- The system plan at 30th April was break even and the Trust's plan was break-even.
- At month 5 the Trust has a surplus of £0.089m compared to the ytd plan of a £0.232m deficit.
- 25/26 Capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Revised capital plan reflects revisions to phasing of Buildings and Lease schemes. Spend to month 5 is £2.21m against a budget of £4.144m
- The Trust spent £8.87m on bank staff which is above plan by £1.404m.
- The Trust spent £1.421m on agency staff up to month 5, which is below plan. There were 32 off framework shifts, the target is 0.
- Cash at the end of month 5 is £45.108m, which is £2.554m ahead of plan.
- The 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:	AI-09.1/0925 - Finance Report (Month5)

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

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NHS Foundation Trust

AGENDA ITEM: 09.1/0925

FINANCE REPORT
Month 5

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

Overview

- The system plan at 30th April submission was break even and the Trust's plan was break even.
- At month 5 the Trust has a surplus of £0.089m compared to the plan of a £0.232m deficit.
- Cash at the end of month 5 is £45.108m, which is £2.554m above plan.
- Cost improvement programme has delivered £4.286m of recurring savings against the plan of £3.713m. Target for the year is £10.086m. £2.083m is unidentified which is a reduction of £0.373m.
- Non recurrent savings target is £5.169m all of which is identified, and of which £2.623m is delivered.
- The Trust spent £8.87m on bank staff which is above plan by £1.404m.
- The Trust spent £1.421m ytd on agency staff which is below plan by £0.233m. There were 32 off framework shifts, the target is 0.
- Better Payment Policy shows 95.4% of invoices by value paid within 30 days and 91.5% by number of invoices, the national target is 95%.
- 25/26 Capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Net spend to month 5 is £2.210m against a budget of £4.144m.
- Capital forecast outturn is anticipated to be in line with plan.
- £274k Capital funding confirmed for Electric Vehicle Charging Points which will be in next months forecast.
- Resources Committee are asked to approve the updated Capital plan.

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	311,176	131,104	130,632	(472)
Other operating income	16,590	18,501	8,157	8,838	681
Employee expenses - substantive	(221,705)	(230,851)	(105,077)	(94,174)	10,903
Bank	(17,906)	(17,906)	(965)	(8,870)	(7,905)
Agency	(3,967)	(3,967)	(528)	(1,421)	(893)
Operating expenses excluding employee expenses	(73,026)	(75,526)	(32,399)	(34,763)	(2,364)
PDC dividends payable/refundable	(2,781)	(2,781)	(1,159)	(1,159)	0
Finance Income	1,500	1,500	998	1,063	65
Finance expenses	(198)	(198)	(79)	(97)	(18)
Surplus/(deficit) before impairments & transfers	**(51)**	**(51)**	**52**	**50**	**(1)**
Gains/ (losses) from disposal of assets			0	17	17
Remove capital donations/grants I&E impact	51	51	22		(22)
Surplus/(deficit)	**0**	**(0)**	**73**	**67**	**(7)**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	22	22
Remove net impact of consumables donated from other DHSC bodies	0	0	0		0
Revised Surplus/(deficit)	**0**	**(0)**	**73**	**89**	**15**
WTEs	4762	4860	4860	4734	126

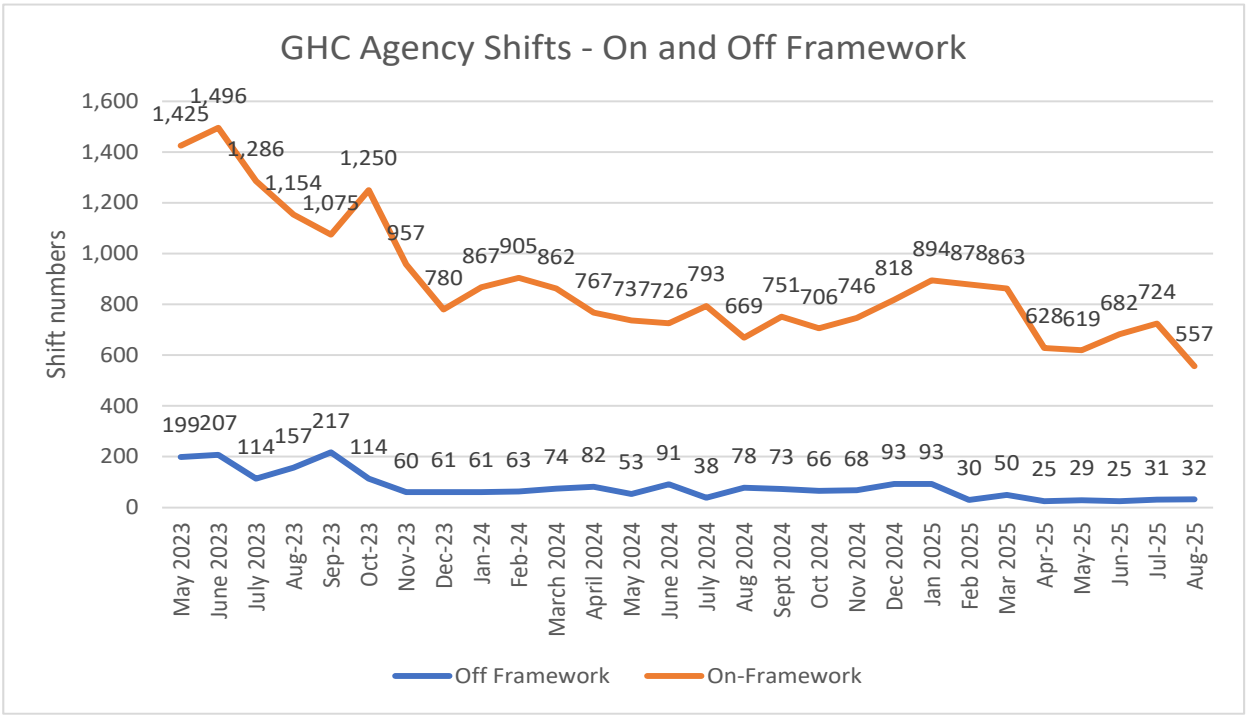
Revised plan submitted to NHSE at month 4, no changes to plan in month 5.
Budget for bank & agency is for specific cost centres but Plan is for the Trust.

Pay Analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 5						
	Plan WTE Month 5	Budget WTE Month 5	Budget £000s	Actual WTE Month 5	Actual £000s	Actual £ as % of Total £
Substantive	4,340	4,846	105,077	4,297	94,174	90.1%
Bank	356	14	965	399	8,870	8.5%
Agency	49	0	528	37	1,421	**1.36%**
Total	**4,744**	**4,860**	**106,571**	**4,734**	**104,465**	**100.0%**

- Trust WTE budget 126 higher than plan due to devts
- substantive budget includes negative budgets for CIP not yet identified (£1.974m@mth 5, £4.74m full year)
- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- the Trust used 32 off framework agency shifts in August. The target is 0.



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

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Balance Sheet

NHS
Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2024/25	2025/26				2025/26
		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	1,745	2,264	1,658	1,742	84	2,330
	Property, plant and equipment: other	117,935	122,466	118,727	116,513	(2,214)	122,122
	Right of use assets	16,438	16,541	16,529	16,040	(489)	15,635
	Receivables:	1,244	1,209	1,229	1,240	11	1,211
	Total non-current assets	**137,361**	**142,480**	**138,144**	**135,536**	**(2,608)**	**141,299**
Current assets	Inventories	444	444	444	443	(1)	443
	NHS receivables	7,409	7,432	7,432	13,020	5,588	7,420
	Non-NHS receivables	9,331	9,349	9,349	7,243	(2,106)	9,243
	Credit Loss Allowances	(1,595)	(1,595)	(1,595)	(1,586)	9	(1,586)
	Property held for Sale	3,123	377	2,328	3,123	795	1,377
	Cash and cash equivalents:	41,855	39,359	42,554	45,108	2,554	40,941
	Total current assets	**60,567**	**55,366**	**60,512**	**67,352**	**6,840**	**57,840**
Current liabilities	Trade and other payables: capital	(3,815)	(3,535)	(3,456)	(840)	2,616	(3,840)
	Trade and other payables: non-capital	(26,851)	(26,875)	(28,033)	(34,881)	(6,848)	(29,222)
	Borrowings	(1,514)	(1,514)	(1,514)	(1,505)	9	(1,430)
	Provisions	(8,701)	(8,702)	(8,702)	(7,014)	1,688	(8,014)
	Other liabilities: deferred income including contract liabilities	(1,303)	(1,303)	(1,303)	(3,223)	(1,920)	(1,323)
	Total current liabilities	**(42,184)**	**(41,929)**	**(43,008)**	**(47,463)**	**(4,455)**	**(43,829)**
Non-current liabilities	Borrowings	(14,026)	(14,252)	(14,183)	(13,647)	536	(13,375)
	Provisions	(2,511)	(2,511)	(2,511)	(2,506)	5	(2,506)
	Total net assets employed	**139,206**	**139,154**	**138,954**	**139,273**	**319**	**139,429**

Taxpayers Equity	Public dividend capital	132,103	132,103	132,103	132,103	(0)	132,377
	Revaluation reserve	13,790	13,789	13,789	13,790	1	13,790
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	1	(1,241)
	Income and expenditure reserve	(1,046)	(5,498)	(5,698)	(5,446)	252	(5,446)
	Income and expenditure reserve (current ye	(4,399)	0	0	67	67	(51)
	Total taxpayers' and others' equity	**139,206**	**139,154**	**138,953**	**139,273**	**320**	**139,429**

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)		509		396	
Add back: Depreciation on donated assets	185		22		66	
Adjusted Operating surplus/(deficit) per I&E	**(4,287)**		**531**		**461**	
Add back: Depreciation on owned assets	11,117		4,031		9,876	
Add back: Depreciation on Right of use assets					0	
Add back: Impairment	4,497				0	
(Increase)/Decrease in inventories	(88)		1		1	
(Increase)/Decrease in trade & other receivables	(4,386)		(3,491)		109	
Increase/(Decrease) in provisions	154		(1,973)		(693)	
Increase/(Decrease) in trade and other payables	(8,506)		6,847		2,347	
Increase/(Decrease) in other liabilities	217		1,920		20	
Net cash generated from / (used in) operations		**(1,283)**		**7,866**		**12,122**
Cash flows from investing activities						
Interest received	3,072		1,075		2,513	
Interest paid	(9)		(4)		(5)	
Proceeds from Sale of PP&E	1,974		50		2,100	
Purchase of property, plant and equipment	(9,316)		(4,983)		(13,460)	
Assets Held for Sale						
Net cash generated used in investing activities		**(4,279)**		**(3,862)**		**(8,852)**
Cash flows from financing activities						
PDC Dividend Received	227		0		274	
PDC Dividend (Paid)	(2,491)		0		(2,781)	
Finance lease receipts - Rent	94		32		94	
Finance lease receipts - Interest	(62)		(20)		(59)	
Finance Lease Rental Payments	(1,572)		(671)		(1,521)	
Finance Lease Rental Interest	(213)		(91)		(190)	
		(4,016)		**(750)**	**0**	**(4,183)**
Cash and cash equivalents at end of period		**41,855**		**45,108**	**0**	**40,942**

Liquidity Metric			Month 5		Forecast Outturn
Liquid Working Capital	x 153 days	=	27,004	30.28 days	24.74
ytd Operational Expenditure			136,430		

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

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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	2,405	505	8,500	5,000	3,000	3,000
Backlog Maintenance	1,879	2,146	566	1,393	1,393	1,393	1,400
Buildings - Finance Leases	1,496	579	206	2,050	250	250	250
Vehicle - Finance Leases	250	250	88	250	250	250	250
Other Leases	0	0	0		0	0	
Net Zero Carbon	2,643	4,156	766	1,400	1,800	1,500	1,500
LD Pathway				0	3,000	0	0
Medical Equipment	1,780	563	24	602	930	1,030	1,000
IT							
IT Device and software upgrade	320	0	0	800	900	900	1,200
IT Infrastructure	1,300	1,620	1	1,100	1,300	1,300	1,300
Transforming Care Digitally	1,260	1,260	107	790	250	250	250
NHS Net Transition	500	300		400	0	0	0
Digital Innovation					500	500	500
Patient Portal		**601**		**170**			
Contingency		**300**					
Total of Updated Programme	**15,449**	**14,180**	**2,264**	**17,455**	**15,573**	**10,373**	**10,650**
Disposals	(3,265)	(1,943)	(54)	(8,531)	0	0	0
Total CDEL spend	**12,184**	**12,237**	**2,210**	**8,924**	**15,573**	**10,373**	**10,650**
Funded by;							
Anticipated System CDEL	**12,184**	**12,184**		**12,259**	**12,573**	**10,373**	**10,650**

Capital plan revised to reflect re-phasing of Buildings and Leases schemes.
Variance to plan is expenditure under spend net of delay in disposals.

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Cost Improvement Programme (CIP)

Gloucestershire Health and Care NHS Foundation Trust

			Low Risk	Medium Risk	High Risk
Rec / Non rec	Scheme	Target	Delivered	Identified	Unidentified
Rec	Undelivered 24/25 brought forward	1,947	985	873	89
Rec	Efficiency 1.1%	3,189	1,194	1,498	497
Rec	Delivering Value 1.4%	4,001	1,158	1,345	1,497
Rec	Programme Savings	949	949	0	0
Non Rec	Non recurrent savings	5,169	2,623	2,546	0
		15,255	6,909	6,262	2,083
			45%	**41%**	**14%**

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:

2025/26 pay award risk has been removed

Risks 25/26	Mitigations	Risk Value	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	2083	4	4	2083	16
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	2083	4	4	2083	16
There is a risk that System wide CIP schemes do not deliver and the Trust receive a share of the shortfall through the Deficit Risk Share agreement. (648)	Support system partners to deliver the savings or identify alternatives. Identify non recurring savings withn the Trust as cover	348.8	4	2	348.8	8
Risks 26/27	**Mitigations**	**Risk Value £000s**	**Likelihood**	**Impact**	**Recurring**	**Mitigated Risk Score**
Transfer of services to Gloucestershire County Council could lead to the Trust losing less expenditure than income	Discussions with GCC. Review of service provision	750	4	3	750	12

Risks 391 & 622 are similar risks, but the impacts are different.
Risk 391 is longer term risk of not delivering recurrent savings whereas Risk 622 is more of 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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REPORT TO: **TRUST BOARD PUBLIC SESSION 25th SEPTEMBER 2025**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT – AUGUST 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 are asked to **RECEIVE, DISCUSS,** and take assurance from the Quality Dashboard.

Executive summary

This dashboard provides an overview of the Trust's Quality activities for 2025/26. This report is produced monthly for Operational Delivery and Quality Governance Forums, Quality Committee and Trust Board.

Quality reporting improvement:

- The development of the Quality Dashboard is to supplement the developing Integrated Performance Quality Report. Improvements to graphical representation and the narrative assurance is continuing within the Quality Dashboard with emphasis being placed on themes and impact.

- 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 August.

- We have fulfilled the requirements of the S31 Notification at Berkeley House and have been providing monthly updates in a prescribed template.

Quality issues for priority development:

- The datasets in the Dashboard are developing to reflect the statutory responsibilities and duties of the Trust towards quality. This is in addition to other sections that assure against the quality priorities of the Quality Strategy.
- Improvement to the governance arrangements of safer staffing will give greater assurance.
- The Patient Carer and Experience Team intend to introduce mechanisms to identify where patient and carer experience data is less heard.

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 Learning from Deaths – Quality Committee

Appendices:	Quality Dashboard Report – August 2025 Data

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10.1 /0925

QUALITY DASHBOARD 2025/26

Physical Health, Mental Health and Learning Disability Services

Data covering August 2025

This reports brings together quality focused performance, activity and developments to fulfil statutory duties, national and local contractual requirements and areas of internal priority. Certain data sets are the same/aligned to the Integrated Quality and Performance Report that goes to Resources Committee

Feedback on the content of this report is welcomed and should be directed to
Nicola Hazle, Director of Nursing, Therapies and Quality

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

Advise

- Consistent total number of patient safety incidents reports and the ratio of these that were moderate or severe harm. These led to a consistent level of PSIIs and Care Reviews opened and After Action Reviews completed in month. No change in reporting categories identified.
- The impact of the Patient Safety Team oversight on Duty of Candour notification is included and showing improved completion of these processes in month. The Patient Safety Team are following up the 8 incidents where the notification has not been provided. For those incidents where DoC doesn't apply there is a high compliance with providing the reason.
- Thematically, August has seen an increase in reported falls. There has been a reduction in reported incidents of self harm/self injurious behaviour and notably in the numbers of restraint incidents and rapid tranquilisation incidents.

Assure

- The Learning from Deaths Report for Q1 is included and has been reviewed and assured by Quality Committee for assurance. None of the 15 deaths that were reviewed were considered more likely than not to be due to problems in care.
- We continue to a reduction in open and overdue incidents; the largest reduction in the Inpatient Mental Health and LD Directorate and for the financial year 2024/2025.

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

Alert

- The safe staffing across Community Hospitals and MH Inpatients has been reviewed and assured by the Director of Nursing, Therapies and Quality. The exception codes are not reported in this month's dashboard due to changes in data collection process, this will resume next month.

Assure

- Infection Prevention and Control - No outbreaks or hospital acquired transmission in August, providing good assurance that no nosocomial transmission took place and adherence to IPC policies. High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT feedback

Applaud

- Community Nursing received 43 compliments in August. Two teams have been notified they have been awarded the *Making a Difference Award.*

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

Alert

- A server issue prevented automated SMS FFT survey distribution in month. This is being investigated to establish the cause and whether retrospective send is possible.

Advise

- 54% of complaints were closed within 3 months (down from 61% last month) of which 5 out of 6 IUCS complaints closed in month breached this KPI.
- There were 8 communication issues upheld this month.

Applaud

- Carer feedback increased to 96% positive.

CQC DOMAIN ARE SERVICES SAFE - Safeguarding Adults & Children

- The Safeguarding Group have no escalations to indicate we have not met our statutory duties in relation to our safeguarding responsibilities.
- Escalations refers to escalations at level 2 - the point where the Safeguarding Team is required to become involved. The new Children's template (introduced in July) will provide more insight into the extent of escalations at Level 1.
- Overall MASH activity is higher than last year due to the introduction of DVPMs (Daily Police Vulnerability Meetings) just over a year ago. The reduction in August data mirrors last year and reflects the summer holidays.
- The notable increase in Allegation Management cases during August to five, includes one of which involved LADO oversight. This increased activity generates considerable work with 20 allegation management meetings held.
- For August, the Adult Safeguarding team found most common topics for referral were psychological/emotional abuse (18), neglect (17), self neglect (15) and domestic abuse (14).
- There were two expected child deaths in August with no unexpected deaths.

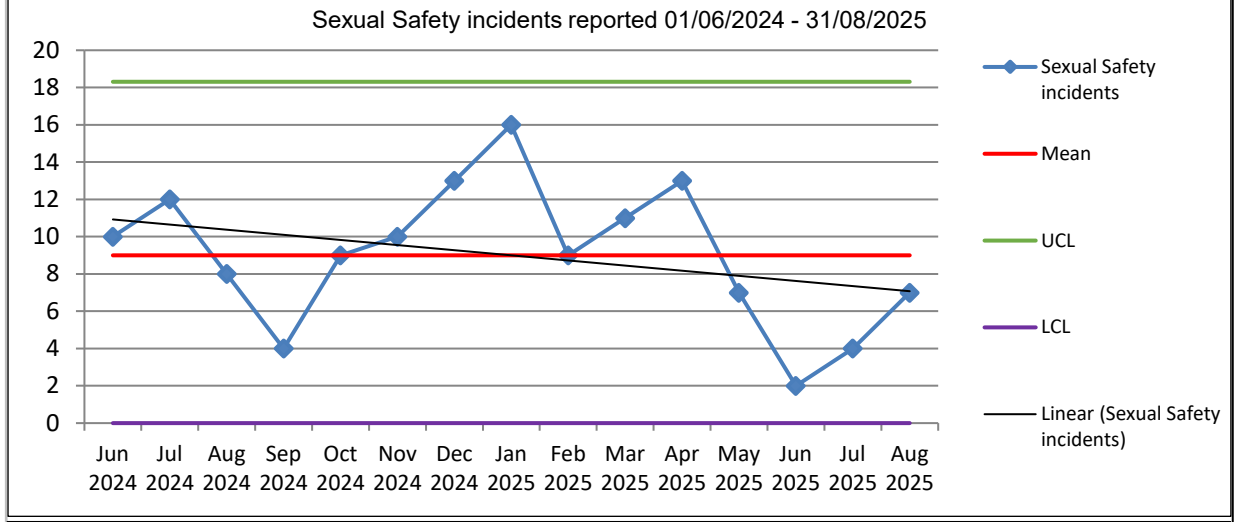
	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25
Escalations	0	1	0	1	2	1
MARAC families screened / researched	130	143	120	393	161	122
MASH children & adults researched	1601	1533	1590	4724	1752	1226
Number of adult reviews ongoing	18	20	22	22	23	24
Number of LCSPRs in progress	1	1	1	1	1	1
Number of Rapid Reviews attended	0	0	1	1	1	0
Expected child deaths	0	1	0	1	2	2
Unexpected child deaths	1	2	0	3	0	0
New Allegation Management cases	1	3	1	5	1	5
Adult Safeguarding referrals submitted to LA	40	32	60	132	57	tbc
MARFs submitted to LA	*	*	*	*	*	*
Safeguarding advice line calls - children	36	94	78	208	102	59
Safeguarding advice line calls - adults	44	119	102	265	122	91

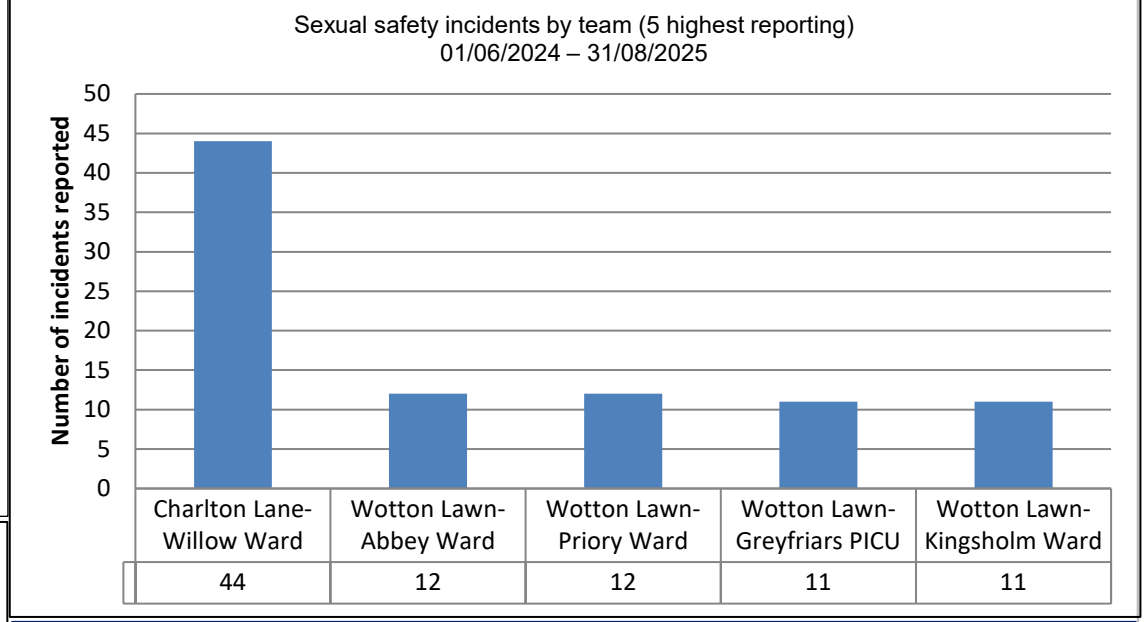
CQC DOMAIN ARE SERVICES SAFE - Safeguarding

- The two areas of note in training are Level 3 Multi Agency Child protection compliance which bounced back from 67% in July to 85% in August (closer to its typical level) and the Level 4 Adult Protection which has remained at 83% for two months after being below 80% since August last year.
- Mental Capacity Act training is a vital part of ensuring we fully meet the statutory requirements of the Act, and this is covered by risk 416. There is some evidence of improved MCA practice within the Trust.
- While high training compliance is good to note, the Safeguarding Team is exploring how we evidence that training is leading to improved practice.
- The Children's Safeguarding Team are designing 'Bitesize' learning for different Safeguarding topics. These will include a presentation on MS Teams for all staff, discussion at Safeguarding Champions Forums, with the presentation to be uploaded to the Safeguarding intranet pages for easy access to all. Themes will be identified via practitioner's requests in supervision and themes from the advice line.
- The Safeguarding Team has reached out to Talking Therapies to offer Safeguarding Supervision with an adult & child safeguarding practitioner once a fortnight in response to their high contact. Named leads are meeting with Talking Therapies early in September.

TRAINING	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25
Level 1 Induction	97%	97%	97%	97%	97%	98%
Level 2 Think Family	95%	96%	95%	95%	95%	96%
Level 3 Multi Agency Child Protection	84%	84%	84%	84%	67%	85%
Level 3 Adult Protection	91%	91%	89%	91%	90%	91%
Level 4 Adult Protection	77%	67%	65%	70%	83%	83%
PREVENT:						
Level 1	99%	99%	99%	99%	99%	98%
Level 2	93%	94%	94%	94%	93%	94%
Level 3	97%	97%	97%	97%	96%	96%
MENTAL CAPACITY ACT:						
Level 1	97%	97%	95%	97%	98%	98%
Level 2	82%	83%	86%	84%	87%	89%

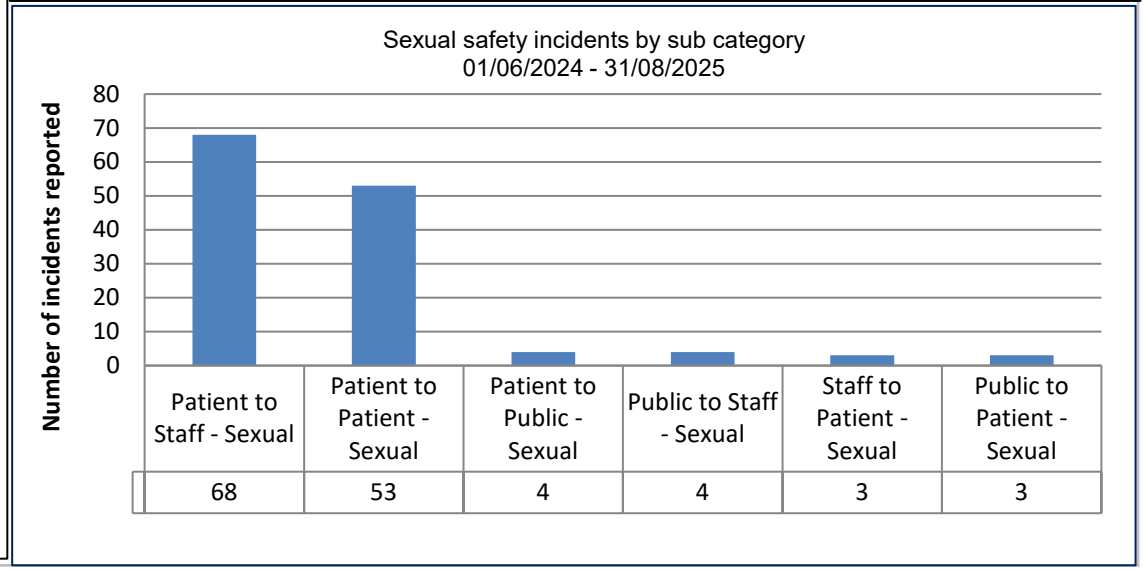
CQC DOMAIN ARE SERVICES SAFE – Safeguarding - Sexual Safety





Sexual Safety update:

There were five recorded sexual safety incidents during August - two were within the community, two were at Wotton Lawn Hospital and one at Cirencester Community Hospital. The data displays a downward trend over time despite their being spikes in occurrence due to differing patient cohorts. The incidents that occurred in August have been handled according to policy and support has been provided to staff and patients where required. Relevant learning will be shared.



CQC DOMAIN ARE SERVICES SAFE - Patient Safety Incident Data

	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Patient Safety Incidents												
Total number of Patient Safety Incidents	1235	1438	1342	1438	1332							
Number of No Harm and Low Harm incidents (including skin integrity)	1112	1325	1244	1282	1198							
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	123	113	98	156	124							
Patient Safety Investgations												
Number of AARs completed in Month		4	3	4	4							
Number of New PSII's and Care Reviews declared in month	1	0	2	0	1							
Number of PSII's open		5	6	7	7							
Number of PSII's closed in month		0	0	0	1							
Number of Care Reviews open		9	9	8	7							
Number of Care Reviews closed		1	0	1	0							
Number of PSII's and Care reviews open over 6 months		11	11	11	11							
Number of PSII's/ Care Reviews planned for Exec sign off (Closure)			6	7	7							
Family Liaison Practitioners												
Number of patients being supported		1	1	1	1							
Number of family and friends being supported		7	8	9	8							
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner		1	1	0	0							
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AAR's/ Care Reviews/ PSII's		34	36	36	26							
PCET		1	0	2	1							
Alerts/ NICE/ Audit		1	2	1	1							

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

What is the data telling us:

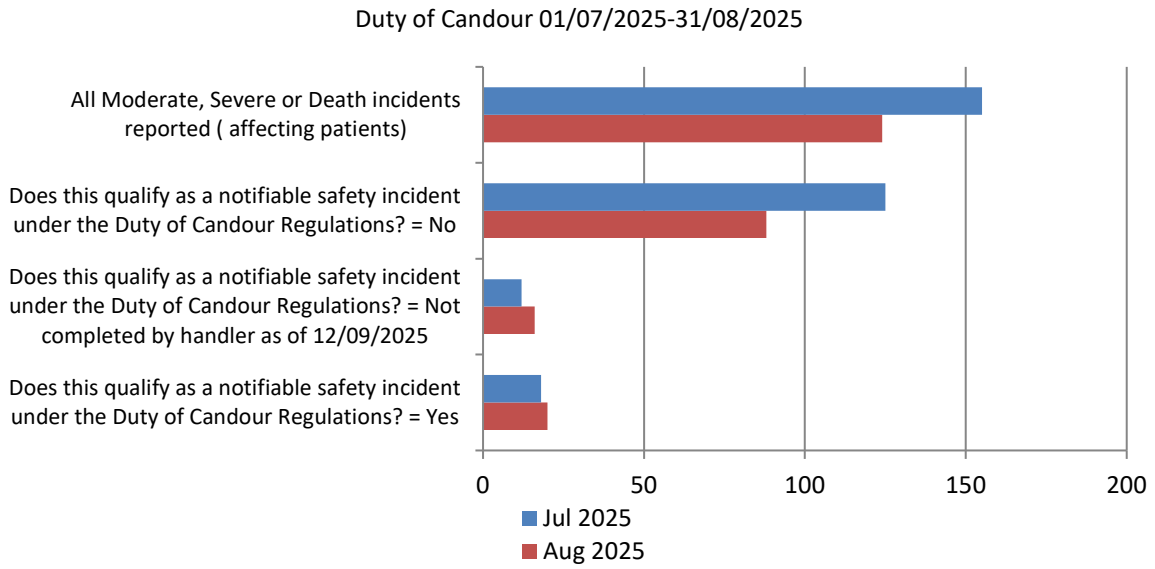
Patient Safety Team:

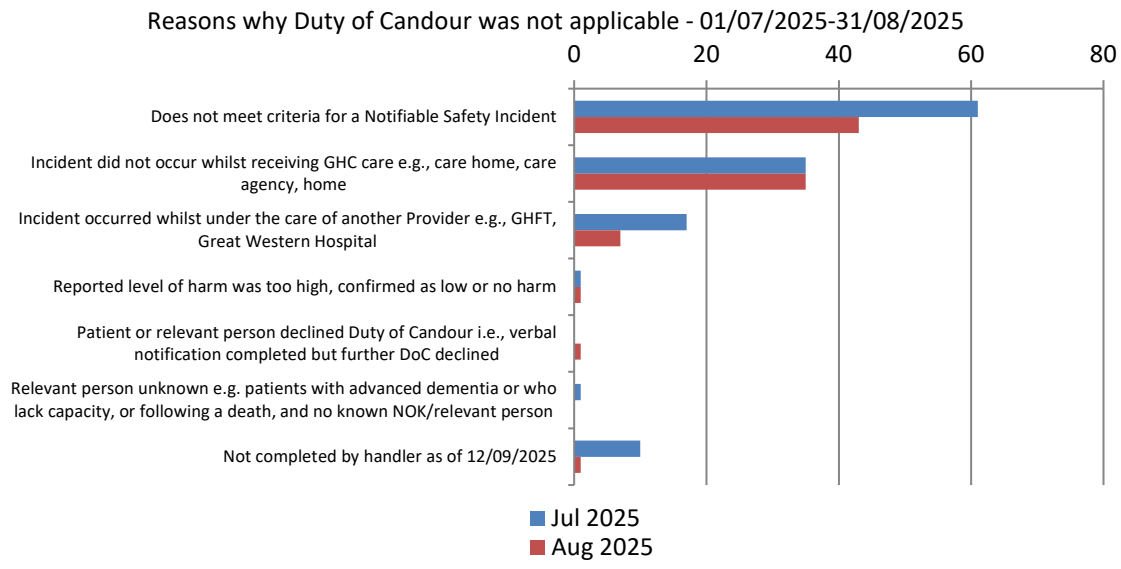
- We continue to see proportionate learning events undertaken on incidents reported with 4 After Action Reviews occurring in August 2025.
- There remain 11 PSIIs/ Care Reviews which have been open longer than 6 months, 7 of these are now at point of closure and are planned to be taken for sign off at the Executive meetings and to planned meetings with families. It is difficult to provide clear timeframes regarding the closure of these investigations are they are reliant on a number of variables, including engaging with families in a way and at a time that suits them best, which may take several weeks or months. This engagement is a key component of PSIRF. The Executive Sign Off Meeting is held monthly and has capacity for a limited number of reports each time due to the depth of discussion required. Reports can be required to wait for an allocated slot on a future agenda.
- Whilst the numbers of families and friends being supported by Family Liaison Practitioners (FLP) remains static, that engagement with an FLP is the choice of the family, and some do not choose to take up this offer. The team are proactive in explaining and offering this support.

Learning Assurance:

- The Learning Assurance Team actively monitors open and overdue actions with action owners and notify operations through a monthly Directorate Report. Data relating to overdue actions is now included in the data table. There has been a reduction in the number of overdue actions between July and August.
- The Learning Assurance Team reviewed the implementation and embedded improvement from an action plan related to a Prevention of Future Death (PFD) Order issued in May 2024 after the death from choking at Wotton Lawn Hospital. Four areas were identified as requiring further focus and the action plan updated to reflect this. Timescales for the actions are between September and November 2025 and further fidelity testing will be undertaken then.
- The Learning Assurance Team is undertaking a fidelity test of the processes and procedures related to absconding/ AWOL (absent without leave) across inpatient mental health services over a period of two months and how this is reflected within in the clinical record. This work was identified following the review of a no harm incident highlighted by safeguarding colleagues. Findings will be shared with Matrons.

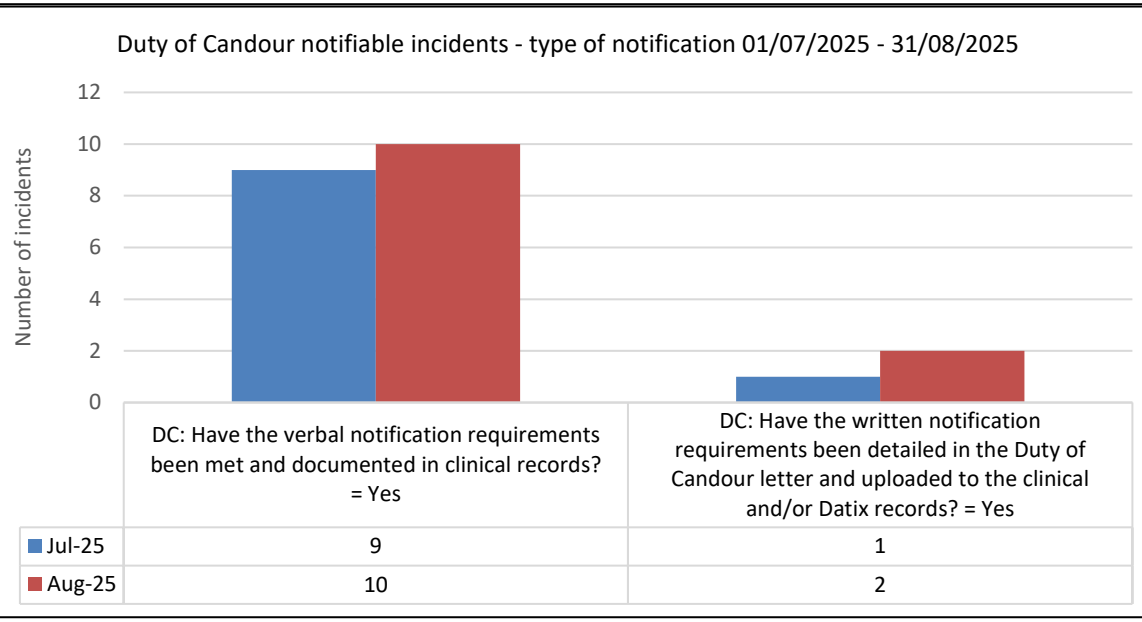
CQC DOMAIN - ARE SERVICES SAFE? - Duty of Candour (DoC)



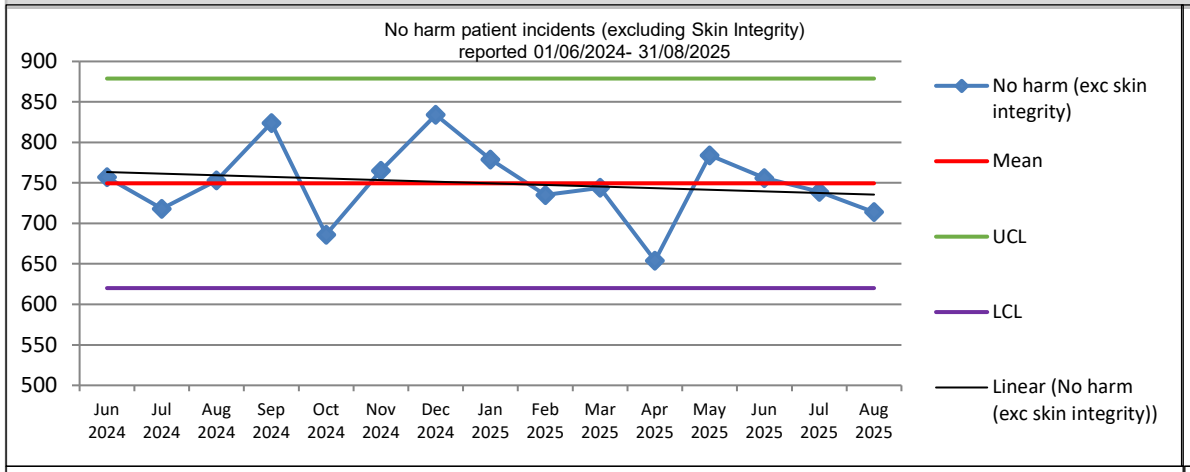


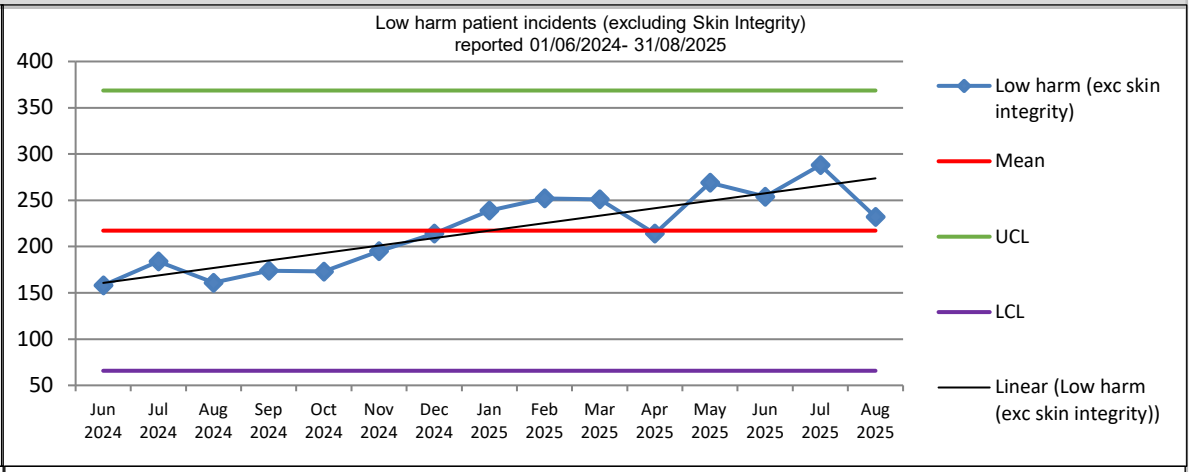
What is the data telling us:

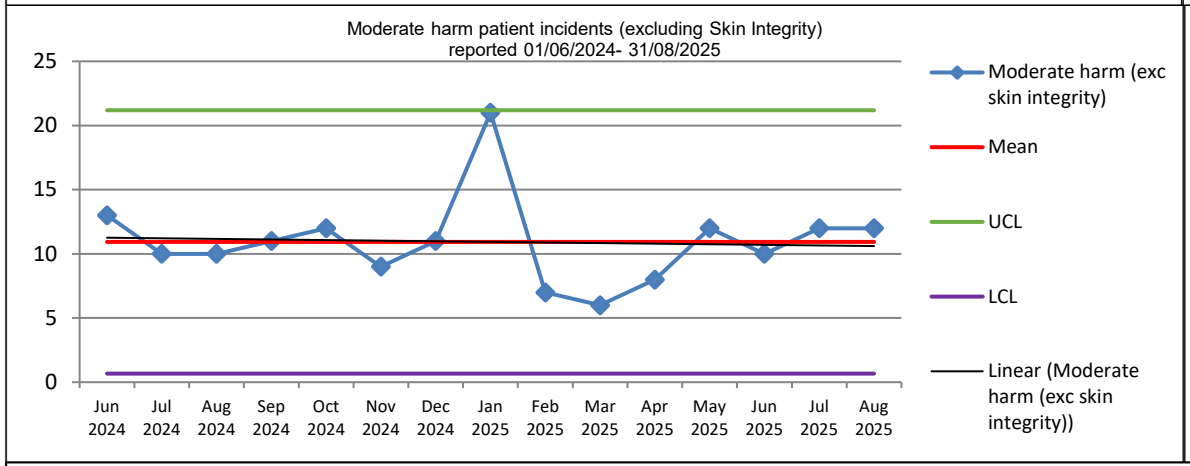
- There is an improved position in the completion of DoC reviews for July; a further 34 incidents have been reviewed and are not found to meet criteria for a notifiable safety incident, and one notification has been issued where DoC notification does apply. There remain 8 incidents where the type of notification has not been completed on Datix.
- In August, 20 incidents initially identified as meeting DoC regulations; 10 with a verbal notification provided, 2 with a written notification. There are that 8 remain outstanding.
- In August where it has been deemed that the incident does not meet DoC, a reason has been provided for 87 out of 88 incidents. This demonstrates the impact of the Patient Safety Team following up with handlers to ensure that the type of notification is recorded and reason why DoC does to apply to provide further assurance.

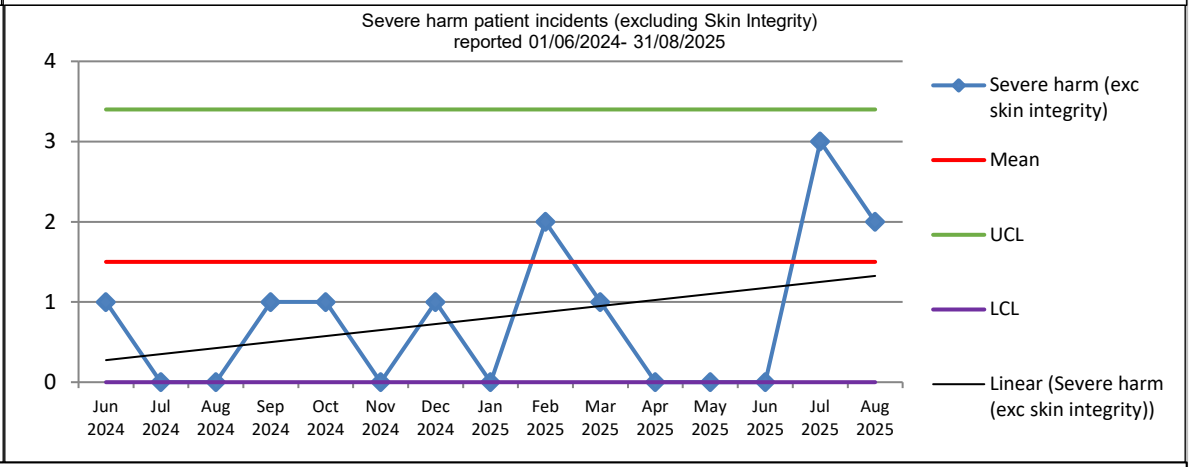


CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data







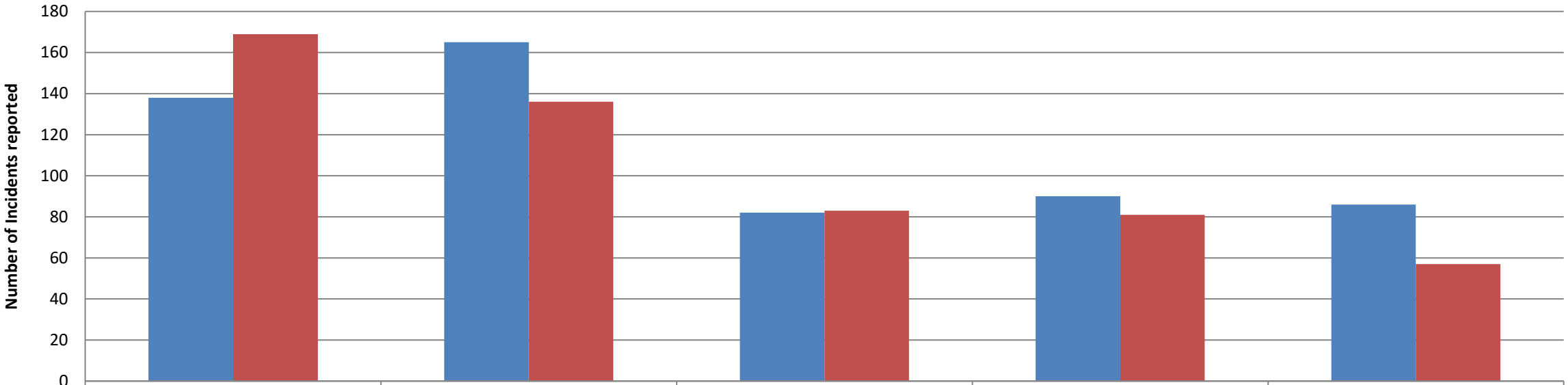


What is the data telling us:

- In August we have seen a reduction in the number of no harm, low harm and severe harm incidents reported. The number of moderate harm incidents has remained stable.
- There were 8 deaths reported in August across the Trust of these; 2 will be recategorized and reviewed via Mortality review processes as they had been recorded on the incorrect Datix module. One was a death by natural causes in an ICT team and closed. Two are awaiting confirmation of cause of death to agree next steps. One incident related to a road traffic accident and will be closed. One has a professionals meeting arranged to discuss feedback for GP colleagues and one will be progressed to a PSII as it is related to a suspected suicide.

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

Top 5 categories of all patient incidents (excluding PU & RI) – 01/07/2025-31/08/2025

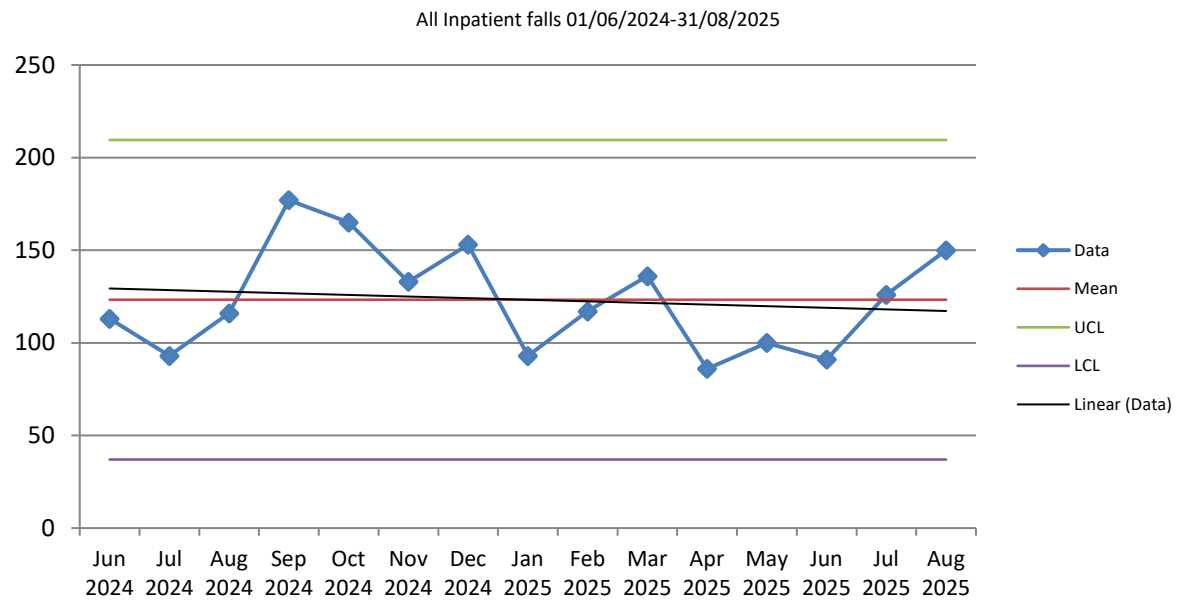


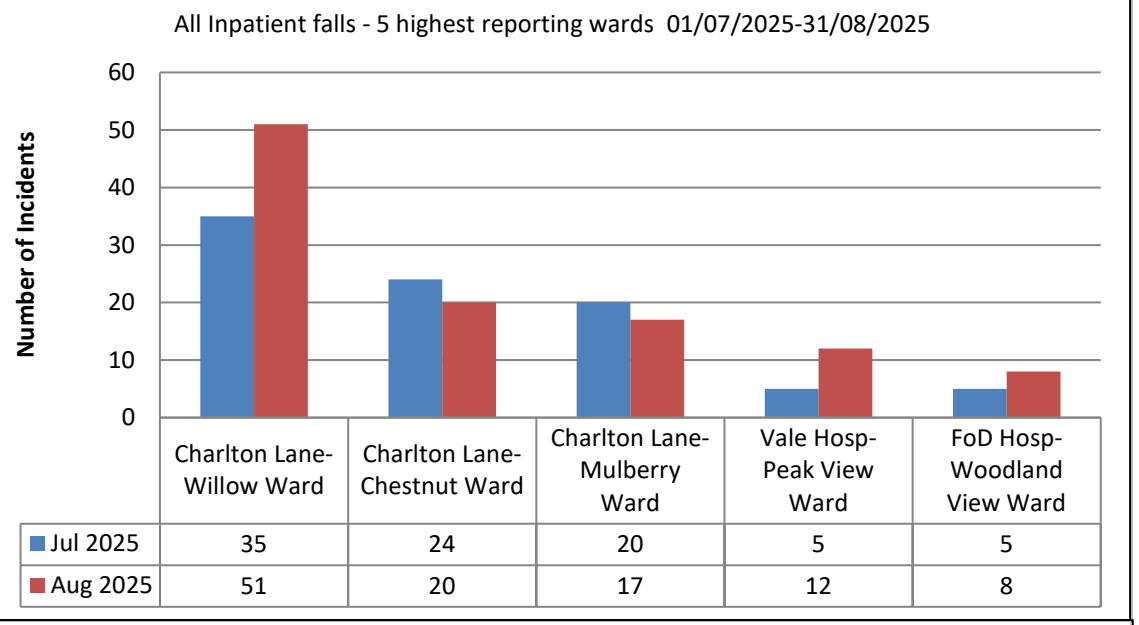
	Falls (including slips & trips)	Self harm / self-injurious behaviour (SIB)	Clinical care, treatments and procedures	Appointments, follow-ups and referrals	Medication incidents
Jul 2025	138	165	82	90	86
Aug 2025	169	136	83	81	57

What is the data telling us:

- In August we continue to see consistency in our top reporting categories. There has been variation with regards to the numbers of incidents reported in each category with an observed increase in falls.
- The data above excludes restrictive interventions and skin integrity incidents which have continue to have focused data provided in the dashboard, we have this month included additional data for
    - Self Harm/ Self Injurious behaviour
    - Falls
    - Clinical Care, treatments and procedures

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

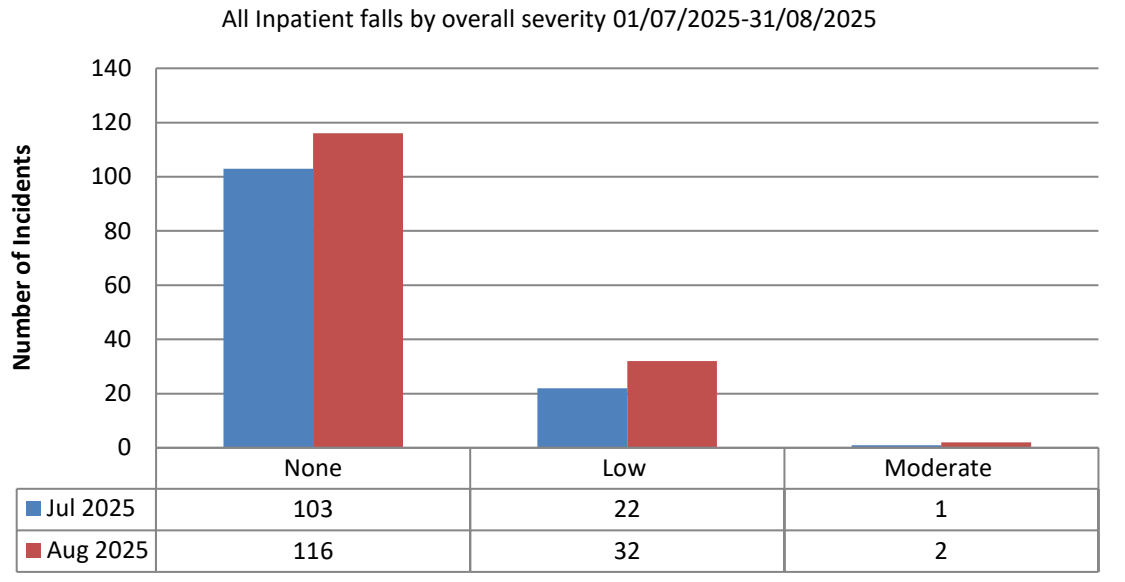




	Charlton Lane-Willow Ward	Charlton Lane-Chestnut Ward	Charlton Lane-Mulberry Ward	Vale Hosp-Peak View Ward	FoD Hosp-Woodland View Ward
Jul 2025	35	24	20	5	5
Aug 2025	51	20	17	12	8

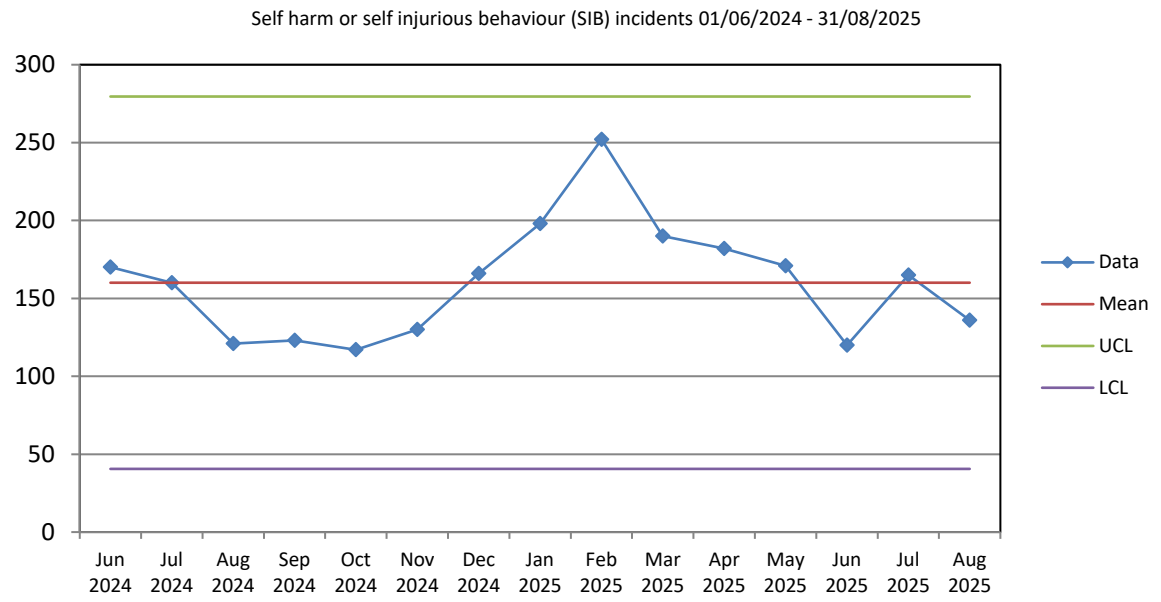
What is the data telling us?

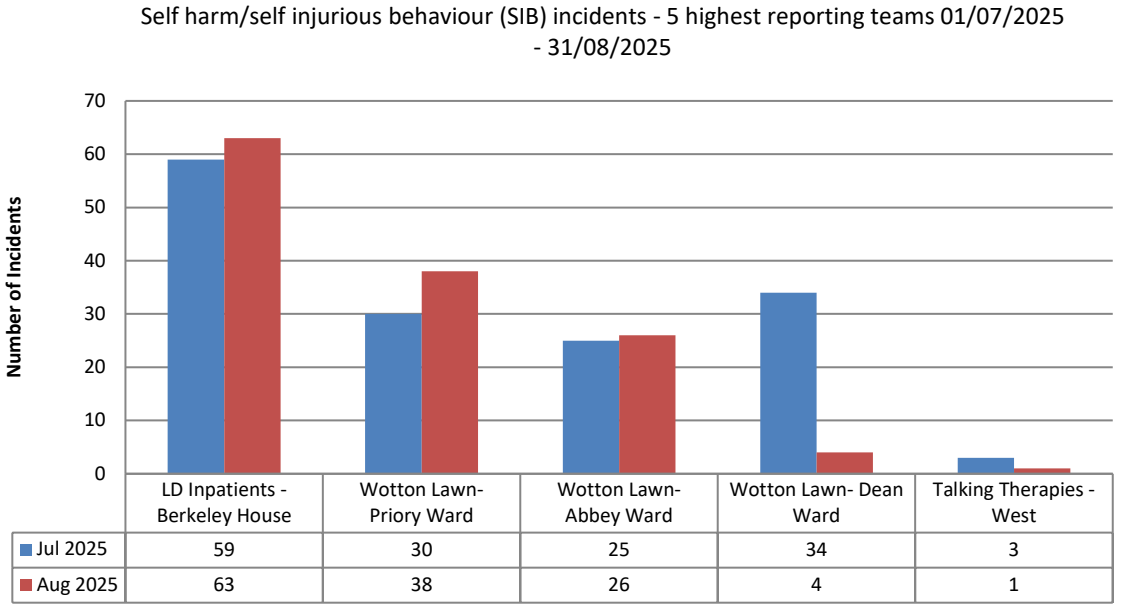
- There has been an increase in the number of inpatient falls in August, this being the highest total in the last 8 months. No harm falls account for 77% of reported incidents, 21% low harm and 2% moderate harm. There were no severe harm or falls resulting in death.
- Charlton Lane Hospital accounts for the most falls, with 23 patients having 88 falls; of which 87 were no or low harm falls and 1 moderate harm fall. The majority occur on Willow Ward that treats dementia/organic illness. The Matron reviews all falls monthly and completes a mid-month falls huddle. These reviews consider the cause and clinical presentation of the individuals at the time to identify where any changes in care can be made to mitigate risk. There do not appear to be any clear themes for these falls with clinical details demonstrating individual factors for each patient.
- Across the Community Hospitals, Peak View Ward had an increase in falls; 5 individual patients fell in the month with 1 individual having 6 incidents (1 in the previous month). As with CLH all falls in Community Hospitals are reviewed by a registered senior staff member who seeks to identify any contributing factor or changes in care plans to mitigate any risk.
- The 2 moderate harm falls had an Inpatient Falls Questionnaire was completed and reviewed by the Patient Safety Team. Neither had gaps in clinical and risk assessments so there was no requirement for an AAR or PSI. In both incidents staff met the requirements of Duty of Candour



	None	Low	Moderate
Jul 2025	103	22	1
Aug 2025	116	32	2

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data – Self harm/Self injurious behaviour

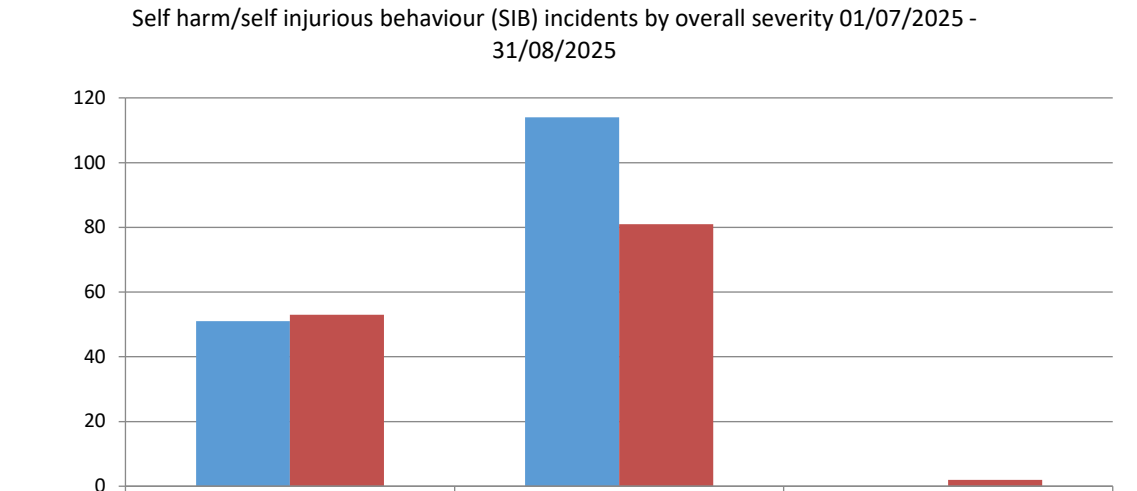




	LD Inpatients - Berkeley House	Wotton Lawn- Priory Ward	Wotton Lawn- Abbey Ward	Wotton Lawn- Dean Ward	Talking Therapies - West
Jul 2025	59	30	25	34	3
Aug 2025	63	38	26	4	1

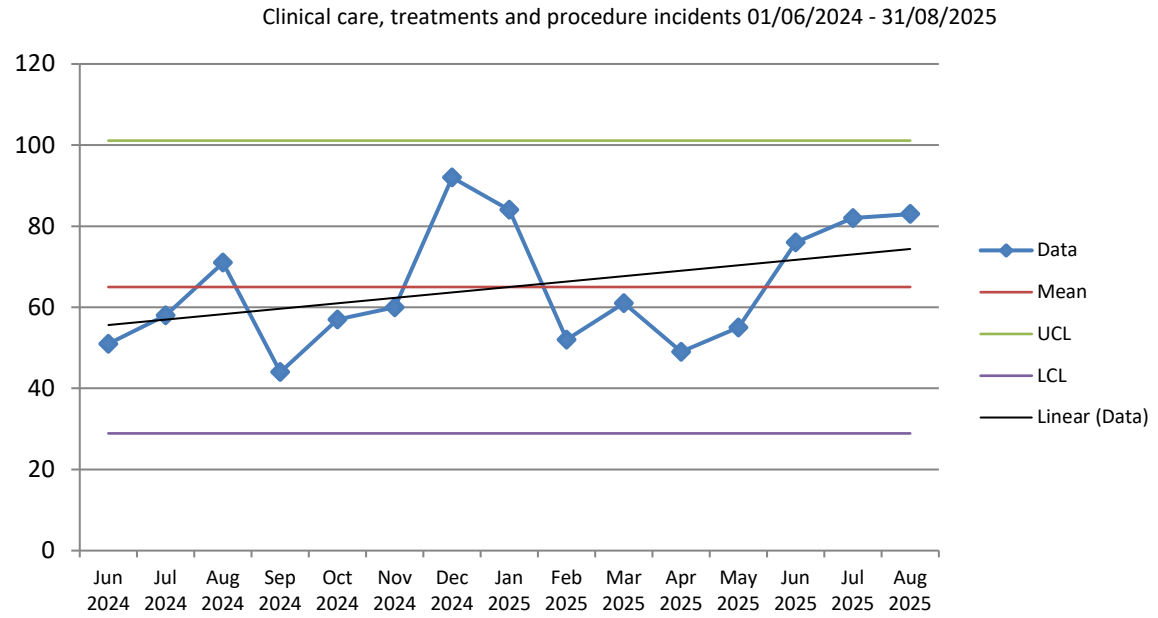
What is the data telling us:

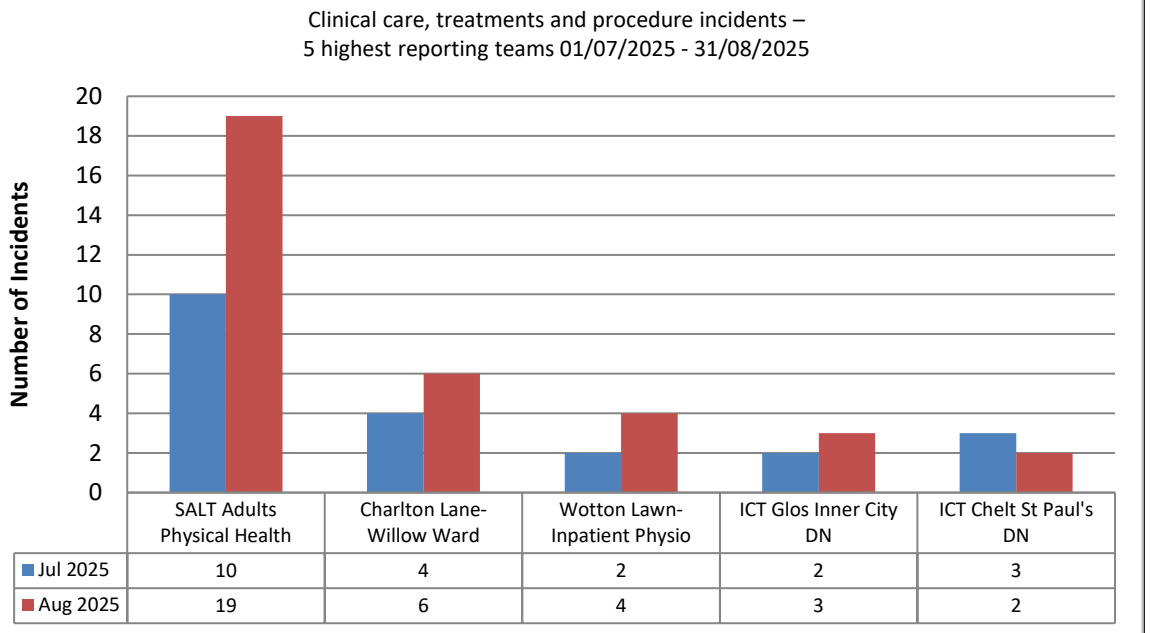
- There is an observed reduction in the number of self harm/ self injurious behaviour incidents. No and low harm incidents account for 98.5% of the reported incidents with 2 moderate harm incidents reported.
- Wards at Wotton Lawn and Berkeley House account for the highest reported incidents.
- Berkeley House have detailed care plans and communication strategies in place. The team report a link of these incidents with transition towards discharge.
- A similar pattern of a small number of individuals accounting for many of the incidents continues to be observed in MH inpatient settings. The 2 moderate harm incidents relate to 1 individual who is transitioning towards discharge, these incidents have been appropriately reviewed and professional DoC provided where relevant.
- The MH Inpatient Governance meeting identified that a small number of individuals account for many of the reported incidents with headbanging the most frequently reported method of self injurious behaviour. It is however important to note that whilst headbanging is the most frequently reported type of self-injurious behaviour that there has been a marked reduction since February 2025 with a peak of over 160 incidents to 47 in August.



	None	Low	Moderate
Jul 2025	51	114	0
Aug 2025	53	81	2

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data – Clinical care, treatments and procedures

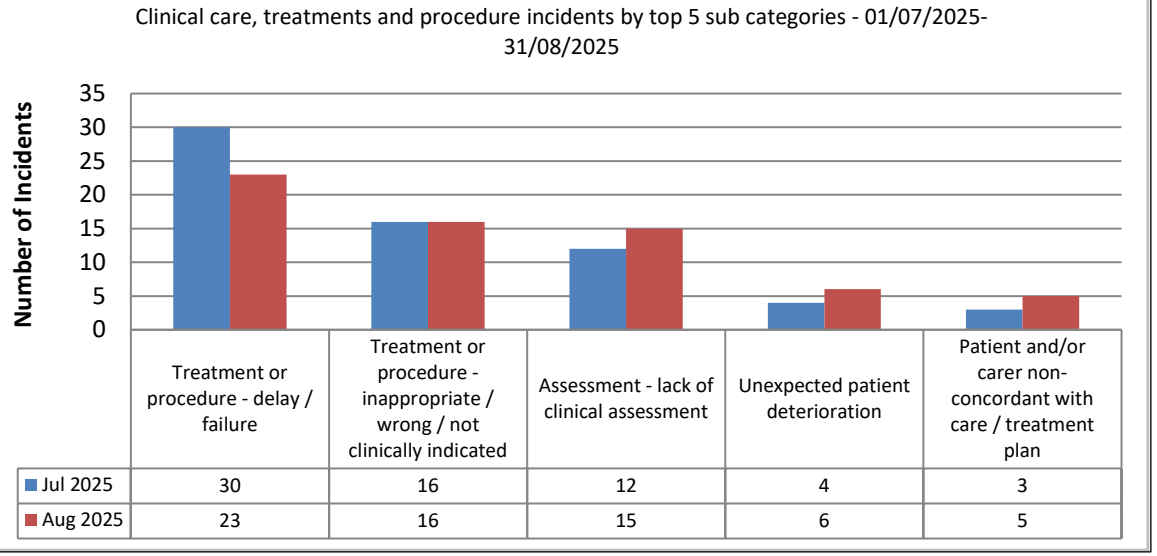




	SALT Adults Physical Health	Charlton Lane-Willow Ward	Wotton Lawn-Inpatient Physio	ICT Glos Inner City DN	ICT Chelt St Paul's DN
Jul 2025	10	4	2	2	3
Aug 2025	19	6	4	3	2

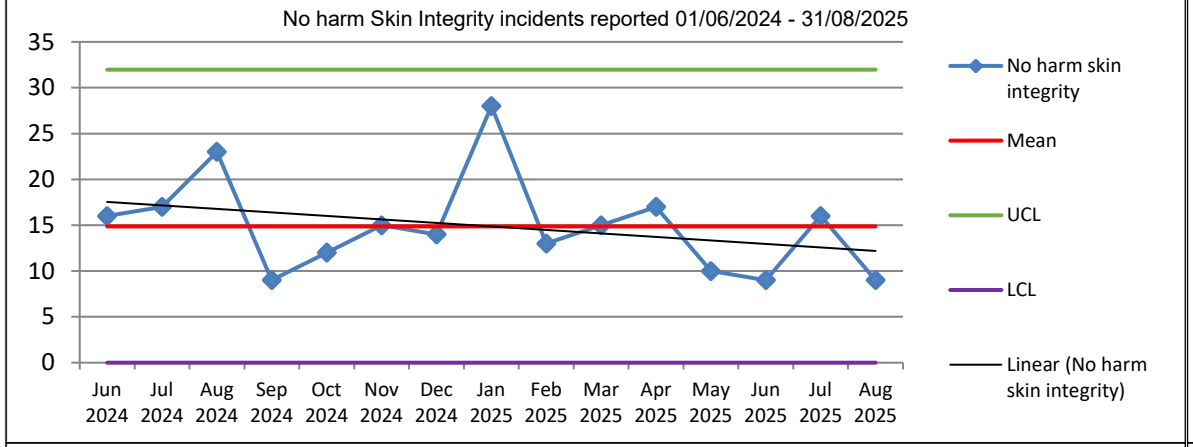
What is the data telling us:

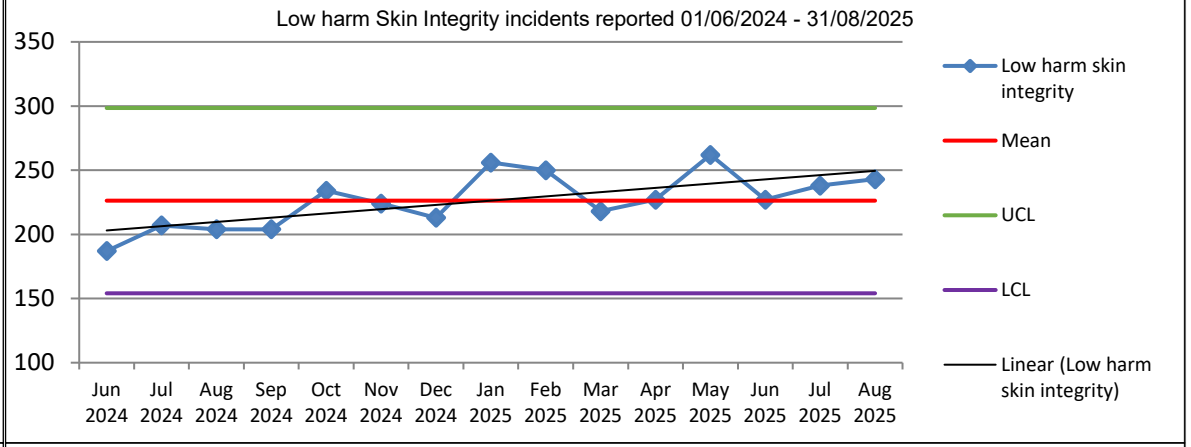
- SALT Adults Physical Health continue to be the highest reporter (22%) in this category with other teams at the Trust reporting single figures of incidents in this category.
- The most frequently reported sub-category remains as delay in treatment or procedures.
- In August 62% of incidents were no harm, 32% low harm, 5% moderate harm and 1% severe harm incident.
- The severe harm incident was related to support the SALT service provide to specific patients at GHFT, this incident will be reviewed by the team, and any identified learning will be incorporated into the existing service plan.

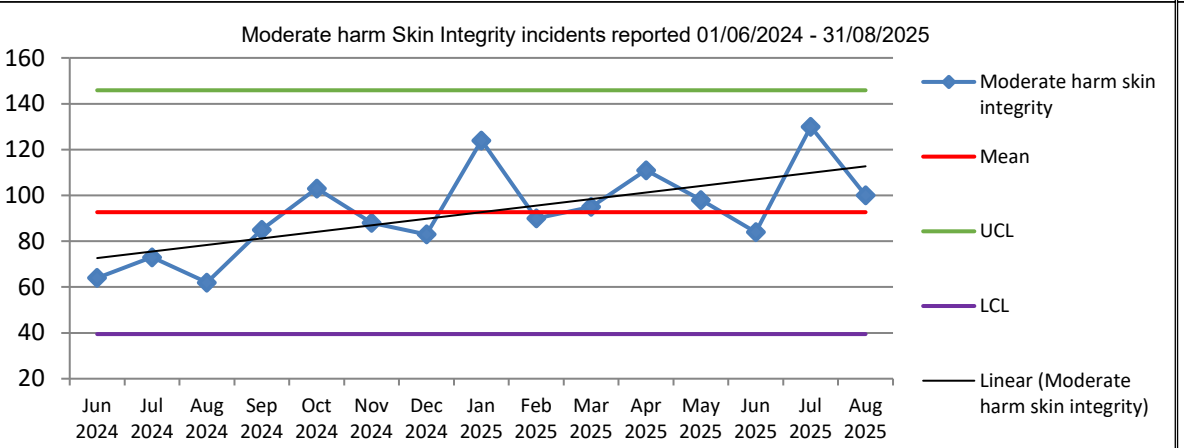


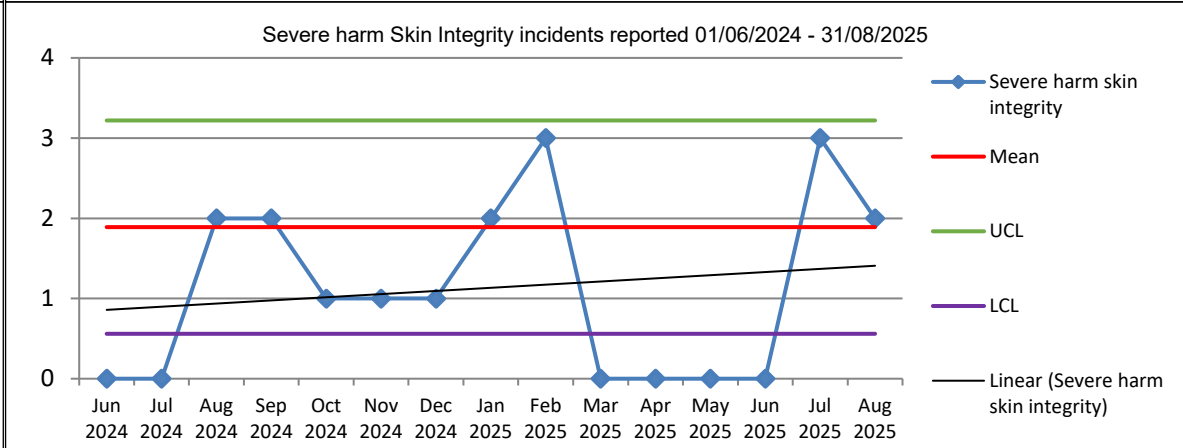
	Treatment or procedure - delay / failure	Treatment or procedure - inappropriate / wrong / not clinically indicated	Assessment - lack of clinical assessment	Unexpected patient deterioration	Patient and/or carer non-concordant with care / treatment plan
Jul 2025	30	16	12	4	3
Aug 2025	23	16	15	6	5

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





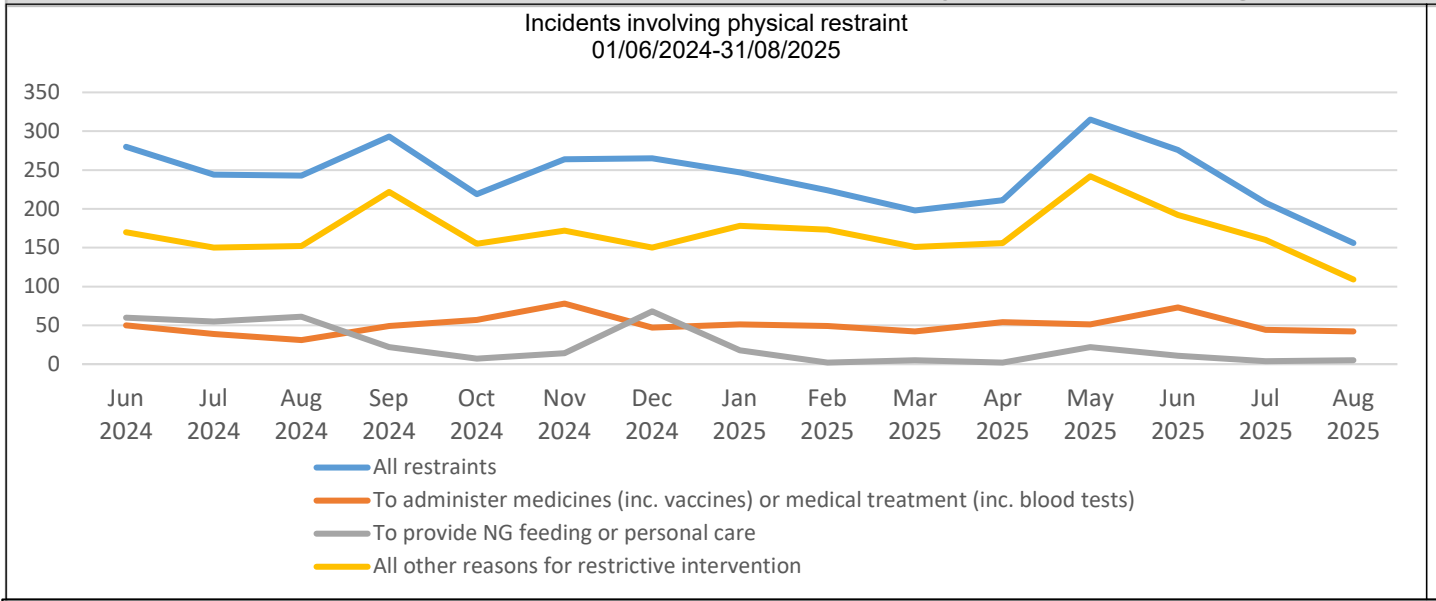


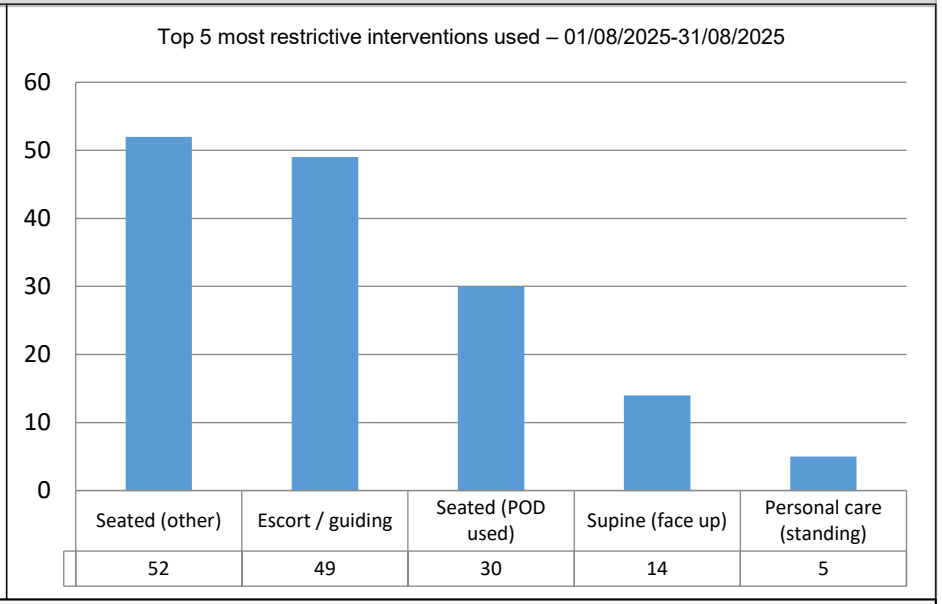


Key Highlights from skin integrity incidents:

- Variation remains in the numbers and harm level of skin integrity incidents each month. No, low and severe categories have seen a reduction, with a slight increase (+5) in moderate harm incidents. All moderate and above skin integrity incidents are reviewed using a Pressure Ulcer Questionnaire (PUQ). The Patient Safety Team scrutinise all completed questionnaires to ensure all learning has been identified and that there are no gaps in assessments or processes before the incident is closed.
- There is a 2 year Tissue Viability Quality Plan in place (to support skin integrity as a quality priority) which is currently meeting all set targets. Tissue Viability Specialists are identifying discreet pieces of pilot work for Category 1 and 2 Pressure Ulcers; these incidents are most commonly reported as no and low harm incidents.

CQC DOMAIN - ARE SERVICES SAFE? Patient Safety Data - Reducing Restrictive Practice (RRP) (Use of Force Act 2018)



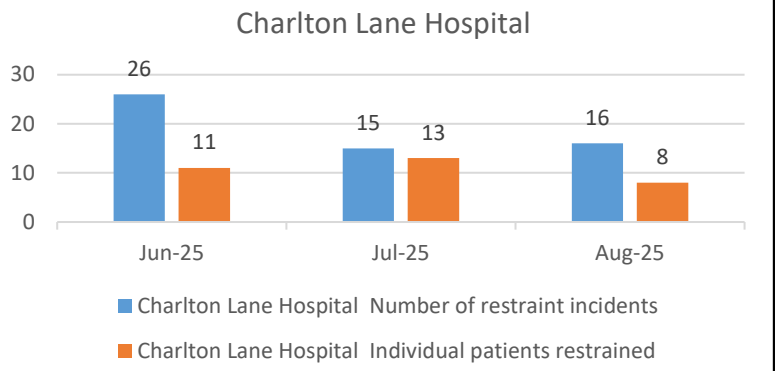


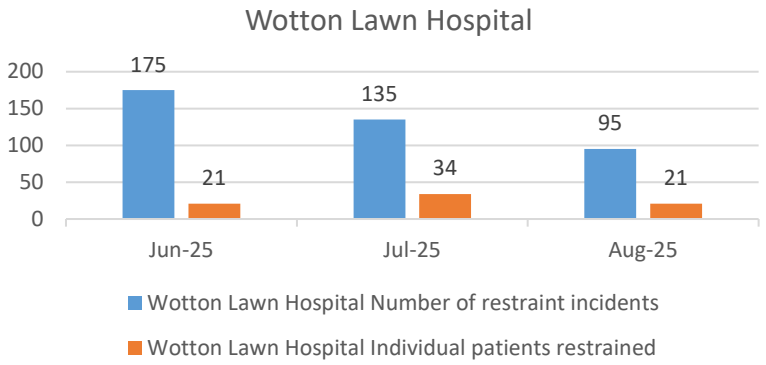
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous 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.*

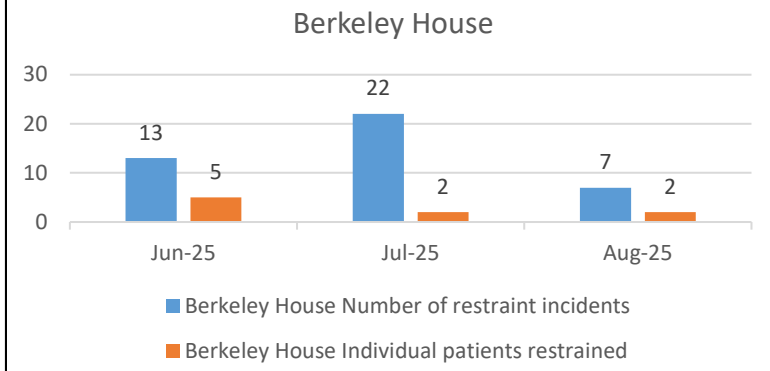
What is the data telling us:

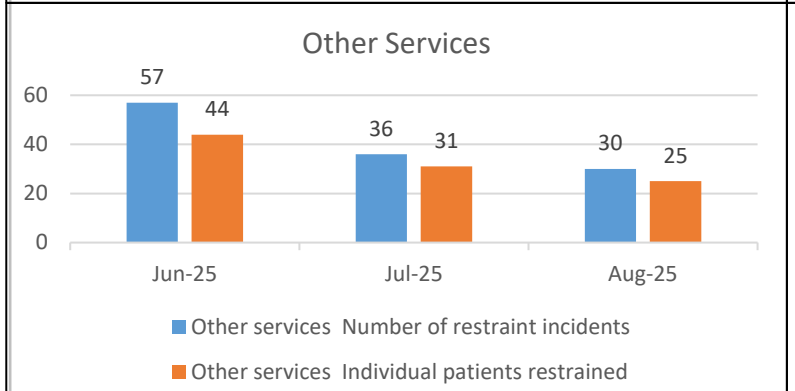
- August is showing a total number of restraints below what has historically been seen as a consistent range of 200-300 incidents per month. At 156 this is the lowest figure in 15 months. Whilst these figures will be related to the changes in the patient population month to month, there has been an observed decrease in the number of incidents of headbanging in month, restrictive interventions such as the use of seated holds are frequently used to reduce harm from headbanging so there is a likely correlation between the two.
- The type of intervention determine the level of restriction; with 52 restraints seated, 49 were for guiding or escort and 30 were seated using the POD. The use of supine restraint decreased to 14 incidents in August 2025. There was one prone (face down) restraint recorded at Wotton Lawn where the individual put themselves into the prone position in the pod whilst staff were attempting des-escalation, a review assures there was no airway hindrance
- The most common reported reasons for a restrictive intervention were to prevent a patient being violent to others (56), to lawfully administer medicines or medical treatment (42) and to prevent the patients causing serious intentional harm to themselves (16).
- There were 70 incidents relating to the use of Rapid Tranquilisation; either by oral administration (16) or IM administration (54). This is lowest reported figure since October 2024.

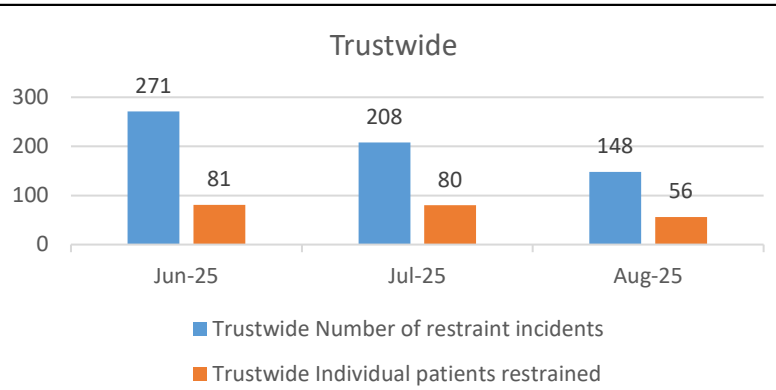
CQC DOMAIN – ARE SERVICES SAFE? Patient Safety Incidents – RRP – individual patients restrained





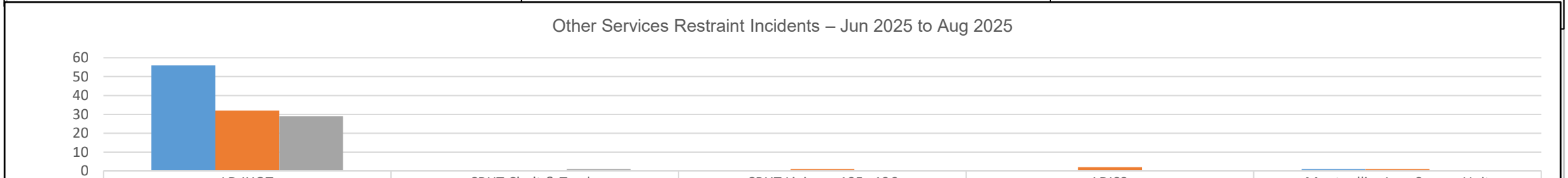






Mental health and learning disability inpatient services continue to be the settings where individual patients are more likely to have the highest frequence of restraints. Looking at other services:

In August 2025 30 restraint incidents were reported across the other services and involved 25 patients. LD IHOT restraints continue to be in support of clinical support and phlebotomy. We expect to see increases in reporting as part of this team's work in supporting patients to access flu vaccinations.



	LD IHOT	CRHT Chelt & Tewks	CRHT Liaison s135 s136	LDISS	Montpellier Low Secure Unit
Jun-25	56	0	0	0	1
Jul-25	32	0	1	2	1
Aug-25	29	1	0	0	0

Learning From Deaths Report Quarter 1 2025-2026

Purpose of report:

The report is based on the Learning from Deaths framework issued by NHS-England which states that trusts must collect and publish, via quarterly public board papers, information on:

- number of deaths in their care
- number of deaths subject to case record review (desktop review of case notes using a structured method)
- number of deaths investigated under the Serious Incident framework (now PSII's)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

In order to meet the requirements above the trust holds 2 Mortality Review Groups each month:

- Physical Health Mortality Review Group
- Mental Health and Learning Disability Mortality Review Group

We have chosen to include additional information relating to observations in data, themes and feedback from the Medical examiner to provide additional assurance to the trust.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 1 (Q1) Learning From Deaths

During Q1 2025-26 **91** Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

GHC Patient Deaths reported during Q1 2025/26			
April	May	June	Total
27	31	33	91

Community Hospitals + Charlton Lane Inpatients: 61 Mental Health Community: 24 Learning Disability Teams : 6
(Figures exclude Memory Management, CYPS, Child Deaths)

During Q1 2025-26 there were 15 care record reviews discussed in the Review Groups, 14 of these were undertaken as part of the Trust Mortality Review Processes with an additional case being presented by LeDeR. The LeDeR case will not be included in figures regarding rating scales on subsequent slides.

Number of comprehensive investigations and care record reviews completed during Q1 2025/26 for deaths occurring in:			
Q3 2024/25	Q4 2024/25	Q1 2025/25	Total
1	10	4	15

Quarter 1- Case Record Reviews-National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Summary

As part of our Mortality Review Groups (MRG) 2 grading systems are used, NCEPOD and Mazars.

The NCEPOD grading system (below) is used to summarise the assessment of quality of care provided for the cases which are presented. The grading is agreed by attendees at the group. Historically this grading system has only be used as part of our Physical Health MRG, however in Q2 this will be introduced for all cases.

The table below summarises the grading of cases in Q1:

	NCEPOD Categories 2025/26	Q1
1	Good practice: a standard that you would accept from yourself, your trainees and your institution	7
2	Room for improvement: aspects of clinical care that could have been better	1
3	Room for improvement: aspects of organisational care that could have been better	0
4	Room for improvement: aspects of both clinical and organisational care that could have been better	0
5	Less than satisfactory: several aspects of clinical and/or organisational care that were below that you would accept from yourself, your trainees and your institution.	0
6	Insufficient data/information in the case notes to assess the quality of care	0

7 out of the 8 cases were rated as being good practice, where a case has been determined to have room for improvement teams have identified actions for improvement. This largely relates to improved training opportunities for staff and would not have impacted patient care.

Quarter 1- Case Record Reviews-Mazars Summary

In our Mental Health Mortality Groups we use the Mazars Classification of patient deaths which was developed following their report into Southern Health NHS Foundation Trust (2015). This classification tool considers whether deaths are unexpected or expected or natural or unnatural. Each reviewed case is given a score by the group. Quarter 1 ratings are detailed below:

Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These would not be investigated but could be included in a mortality review of early deaths amongst service users.	
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and, in some cases, would benefit from further investigation	2
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.	
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed, and some may need an investigation.	4
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause, but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated	
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating	

All deaths which were reviewed were considered natural, however several of them were unexpected in Quarter 1. The causes of death included spontaneous intracerebral haemorrhage, Pulmonary thrombo-embolism and a stroke.

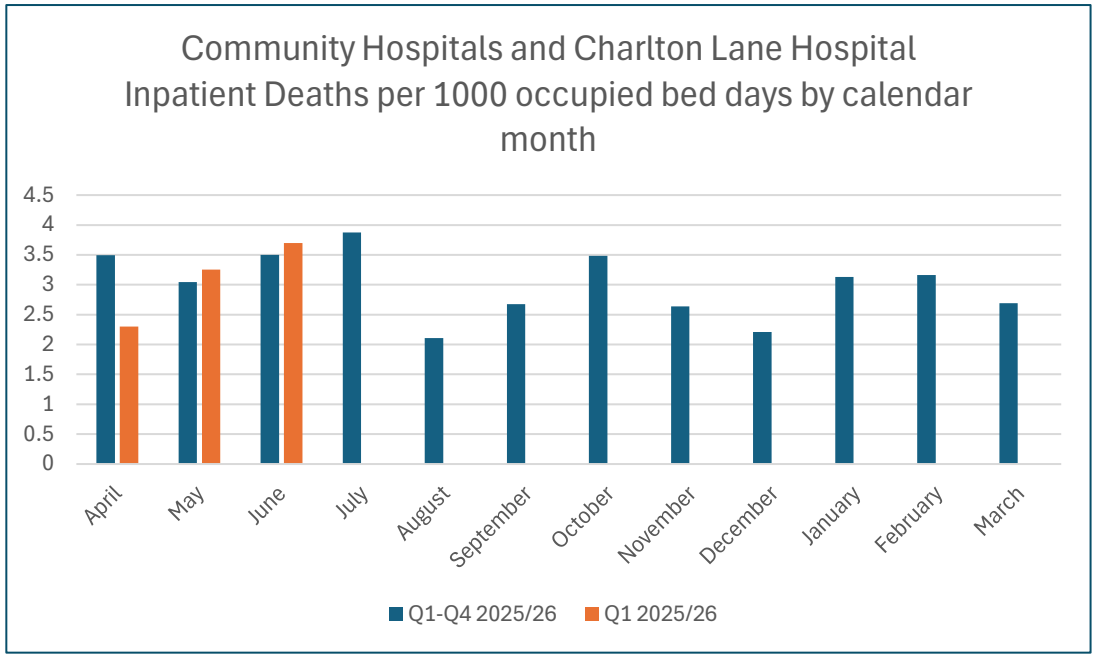
In Quarter 1, none of the 15 deaths that were reviewed were considered more likely than not to be due to problems in care.

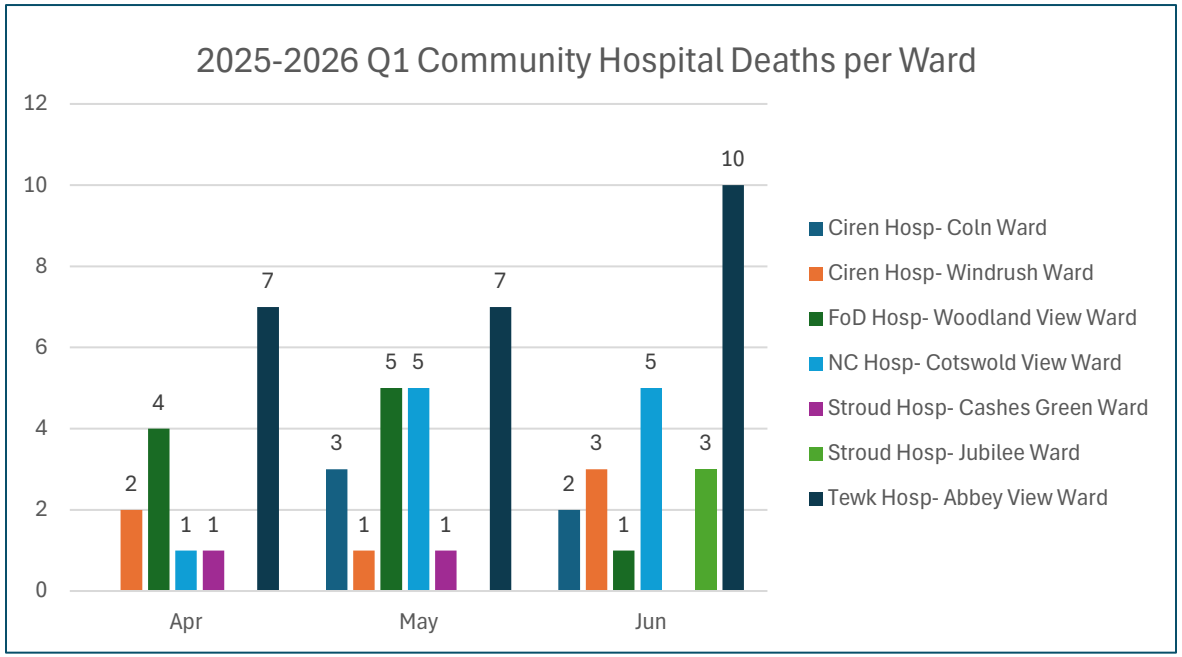
Gloucestershire Health and Care NHS Foundation Trust

Quarter 1 Referrals the Trust has made to the Medical Examiner Service

1.	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024-25 YTD
Number of deaths generating MCCD resolved with the input of the ME service													
Number	63												
Number of times a MCCD is rejected by Registrar and reason this occurs	0												
Number of referrals to the Coronial Service													
Number	3 1 x asbestos related and 2 x fall related.												
Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)	0												

Quarter 1 Community Hospitals and Charlton Lane Hospital Inpatient Death Rate per Month (Data from Mortality Datix submissions)

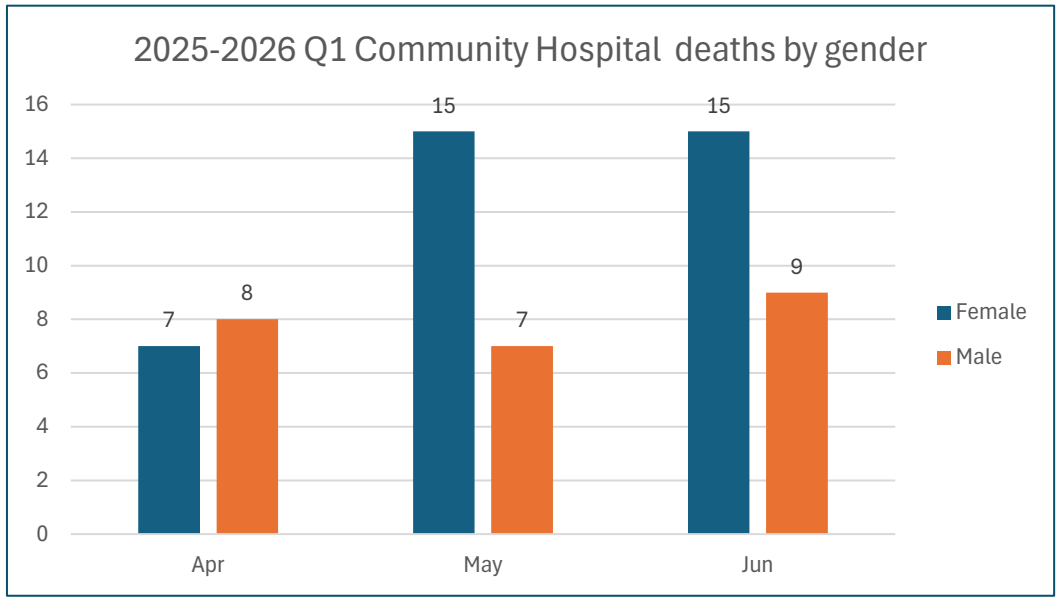


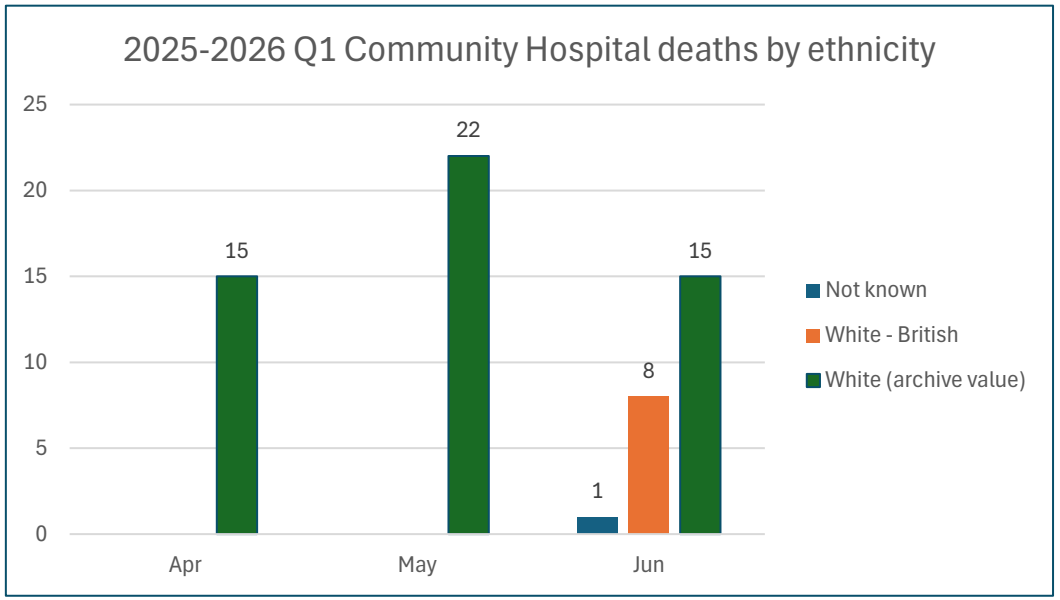


- In Quarter 1 there were no deaths reported at Charlton Lane Hospital.
- All deaths observed in the graphs above were on Community Hospital Sites, the highest number of deaths were seen on Abbey View ward at Tewkesbury Hospital where direct admissions are accepted from the community, patients are frequently admitted for end-of-life care.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 1- Deaths Gender and Ethnicity

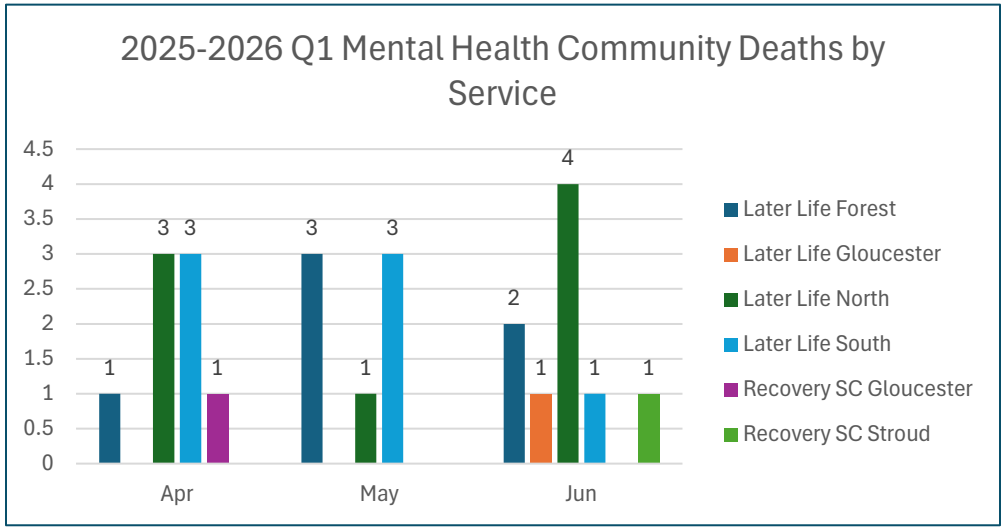




- In Quarter 1, 61% of deaths were for females and 39% male.
- We continue to observe that most people have a recorded ethnicity of white or white British which likely reflects the population who are admitted into our Community Hospitals.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 1 Deaths reported by Mental Health Services:



As with the previous Quarter the largest number of deaths reported under our mortality processes are by our Later Life teams with 2 further deaths reported by our Recovery Teams.

Quarter 1 Deaths reported by Mental Health Services- Unexpected Death/ Suspected Suicide

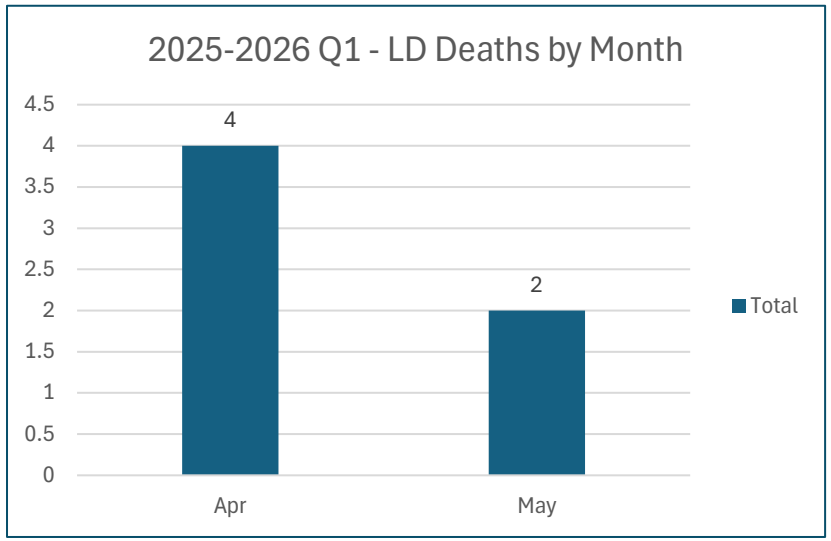
(Data from Datix Incident submissions)

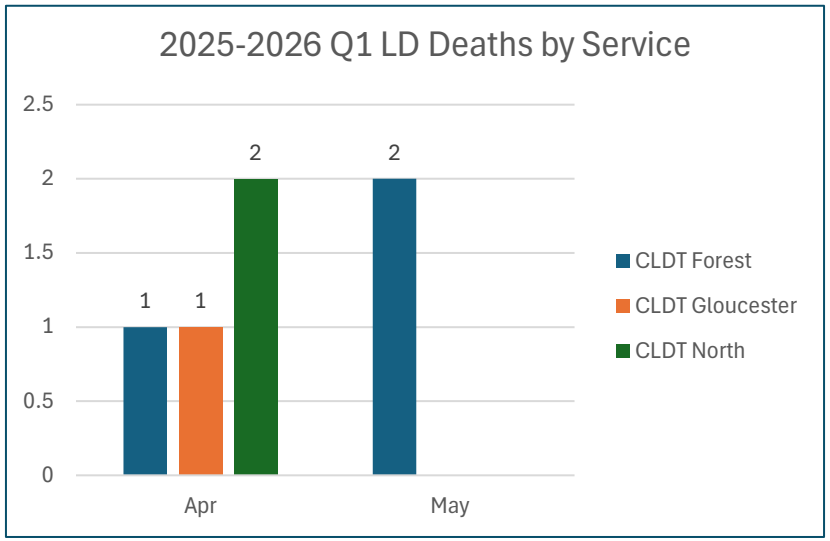
In Quarter 1, there were 7 incidents reported on Datix related to unexpected deaths or suspected deaths by suicide. Of these it has been determined that:

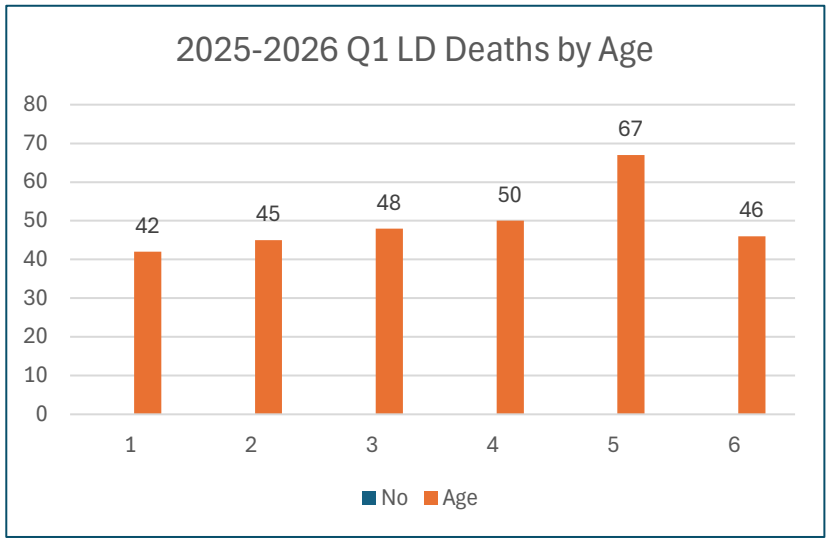
- 3 have or are being investigated as suspected deaths by suicide via PSIRF processes
- 2 were considered as suspected deaths by suicide and have been reviewed in line with our processes but have not met the criteria for further review due to limited involvement by our services.
- 2 are as a result of natural causes and have subsequently been closed.

Gloucestershire Health and Care NHS Foundation Trust

Learning Disability (LD) Patient deaths per Month







- In Quarter 1 there were a total of 6 Learning Disability deaths reported by trust teams.
- All are confirmed as being referred to LeDeR for their standardised review and we await the learning from these.
- Of the 6 deaths 4 were male and 2 were female.
- The age range of those who died was between 42 and 67, we share deaths by age as nationally there are concerns that individuals with a Learning Disability die earlier than the general population.
- In Q1, the Gloucestershire LeDeR programme presented 1 case to our MRG to enable wider discussion and consideration, this was the first time that this had occurred and was found to be valuable by all participants.
- We are awaiting Q1 learning on a page from LeDeR and will distribute these via Patient Safety Noticeboards.

Quarter 1 Themes and Trends from MRG meetings:

- Lack of information provided by other trusts when discharging to GHC needs to be logged on Datix so themes can be identified and targeted.

- At end-of-life staff need to recognise the careful balance that is required when involving families in decision making as for some this may feel like an added burden.

- Where patients do not wish to be involved in decision making, this guidance is available: https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/circumstances-that-affect-the-decision-making-process-continued-1#if-a-patient-doesnt-want-to-be-involved-in-making-a-decision-90C84F315010457895A6AA28D2757E3C

- To listen to patients and support them to make their own choices – not for staff to take over even if they feel it's in their best interests. Staff need to remain mindful of thresholds for Best Interests Decision-Making processes: https://intranet.ghc.nhs.uk/page/24364?SearchId=3246217&marketplace-error=fb510d68-92f9-459a-a5a1-dbe601451aa5&marketplace-service=microsoft

- Value of LeDeR case being presented and discussed alongside trust case reviews

- Social Stories are available to people who are open to learning disability teams that require a medical procedure.

CQC DOMAIN - ARE SERVICES SAFE? - Infection Prevention Control

Quality Indicator	2024/25	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C. *difficile* (toxin positive) HOHA	5	14	0	1	1	1	0							
Influenza	20		0	0	0	0	0							
Norovirus	35		10	0	0	0	0							
COVID-19 HODA	9		10	0	0	0	0							
COVID-19 HOHA	1		3	0	0	0	0							
Gram-Negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)	0		0	0	0	0	0							
MRSA Bacteraemia	0	0	0	0	0	0	0							
MSSA Bacteraemia	0		0	0	0	0	0							
Outbreaks	8		1	0	0	0	0							
Hand Hygiene overall compliance	94%	90%	97%	92%	99%	97%	93%							
Mandatory IPC Training: Clinical	92%	85%			93%	93%	92%							
Mandatory IPC Training: Non-clinical	98%	85%			98%	98%	98%							
Cleanliness FFT "Was the ward clean?"			98%	99%	100%		94%							

Cleanliness – 2025/26

13 Weeks Report

GHC		3rd Party	
Compliant	147	Compliant	21
Non-compliant	5	Non-compliant	1
TOTAL	152	TOTAL	22

FR	Target score	Actual score average	FR	Target score	Actual score average
FR1	98%	98.98%	FR1	98%	N/A
FR2	95%	98.32%	FR2	95%	N/A
FR3	90%	97.88%	FR3	90%	96.83%
FR4	85%	97.27%	FR4	85%	96.51%
Total average score		98.11%	Total average score		96.67%

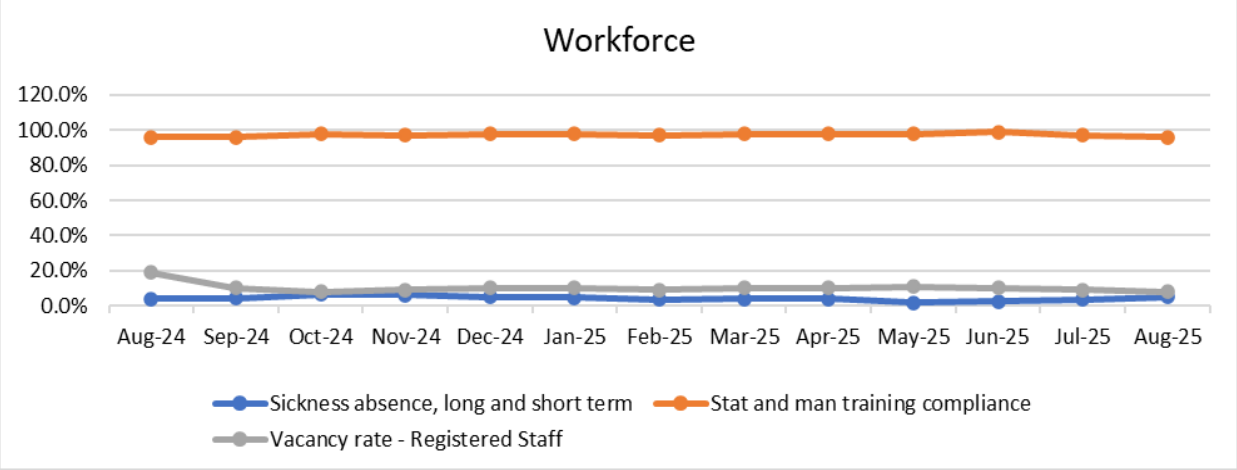
INFECTION PREVENTION CONTROL

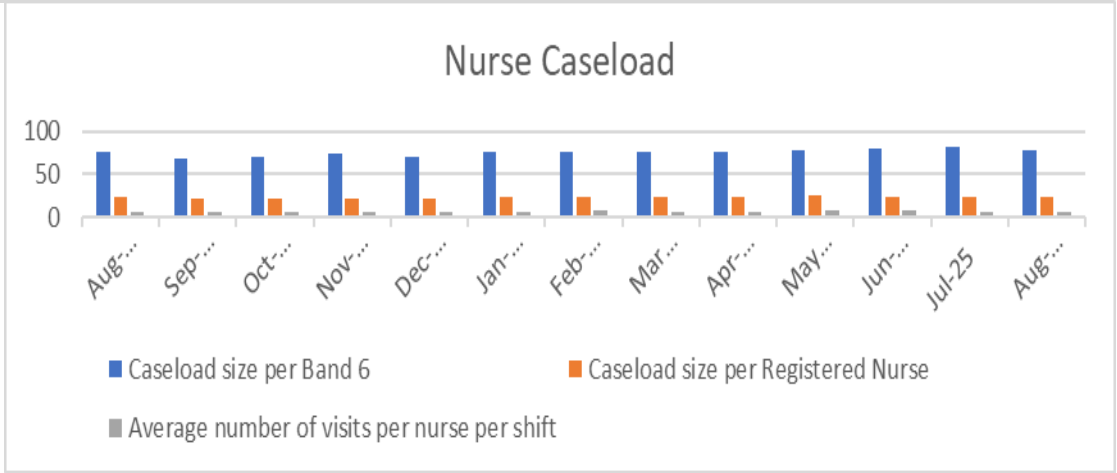
- No outbreaks or hospital acquired transmission in August, providing good assurance that no nosocomial transmission took place and IPC policies are being adhered to
- TB positive case (staff member) at Forest of Dean Hospital, staff and patient contact tracing taking place. Working in collaboration with UKHSA, Working Well and Gloucestershire TB service
- Good assurance from Hand Hygiene audits, nil returns from Berkeley House, Cashes Green ward (Stroud Hospital) and Mulberry ward (Charlton Lane Hospital)

CLEANLINESS

- High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT feedback, with no outbreaks or hospital acquired transmission in August.

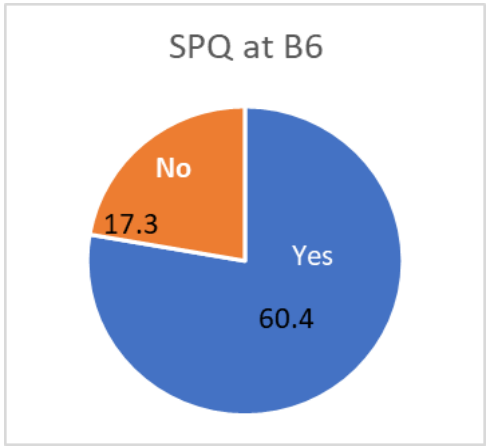
CQC DOMAIN - ARE SERVICES EFFECTIVE? - ICT Community Nursing

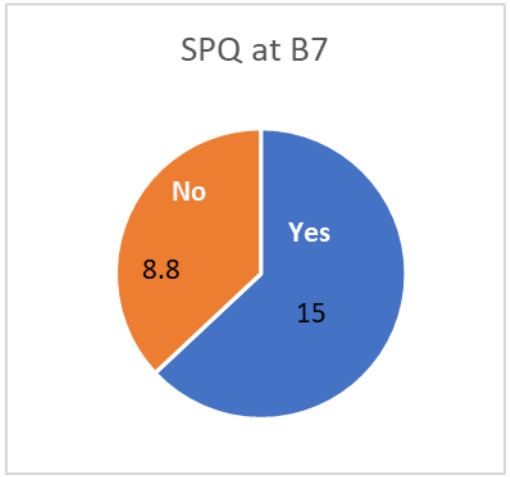




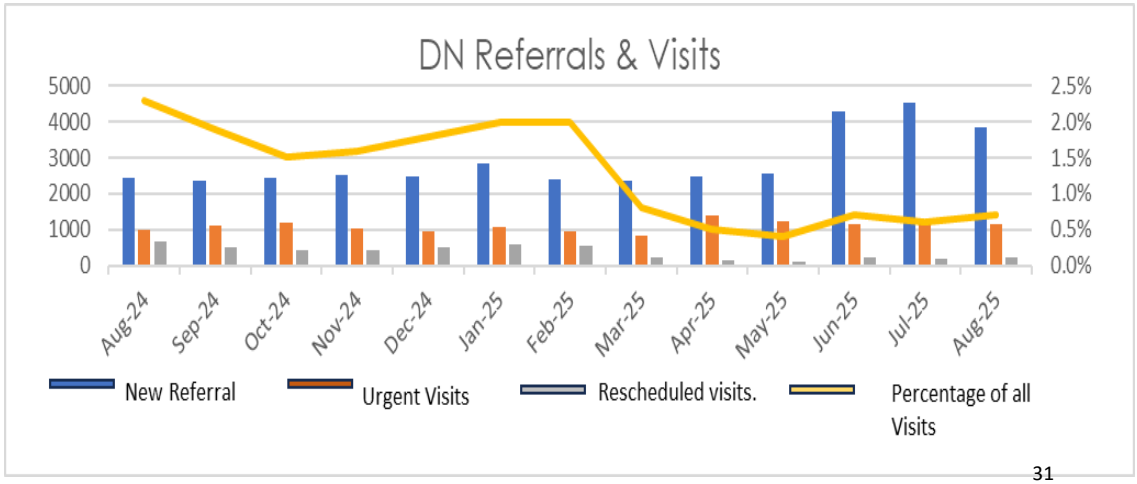
What the data is telling us: the average sickness in community nursing teams increased to 4.9. Only 1 out of the 5 localities reported sickness above 4%.This locality's' numbers have increased to 10.2% in August and cross support continues, triangulation with referrals, visits and increasing numbers of Datix reports again highlights the service is under stress.

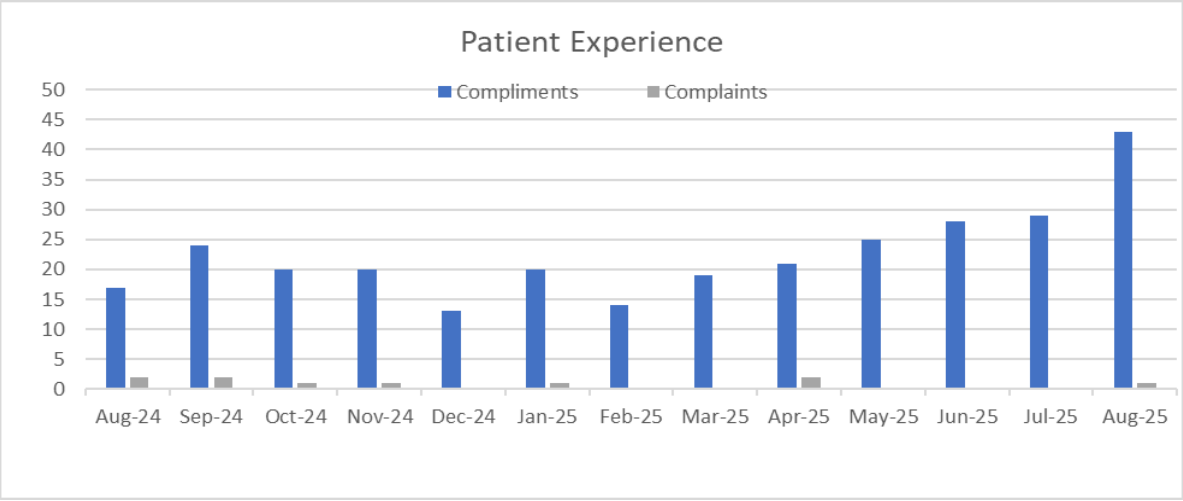
The numbers of SPQ qualified nurses in Community nursing teams shows variation which is being sense checked with operational teams to confirm accuracy.



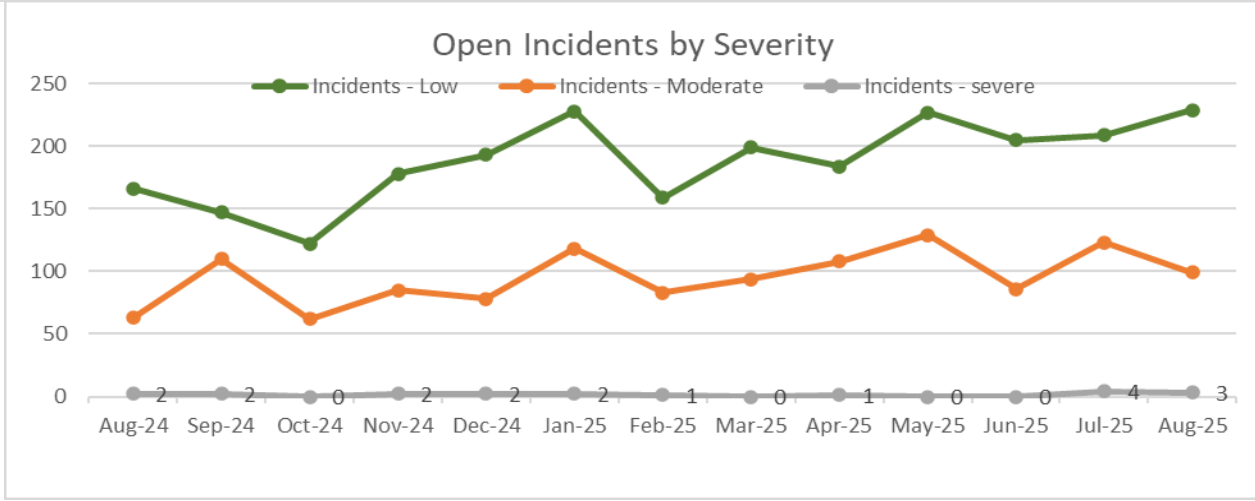


What the data is telling us*: caseload data* shows little change from last month; there isn't a clear correlation to the workforce data graph however the increase in sickness levels is reflected in ***DN referral & visits*** below which gives more understanding of the impact on patients and community teams

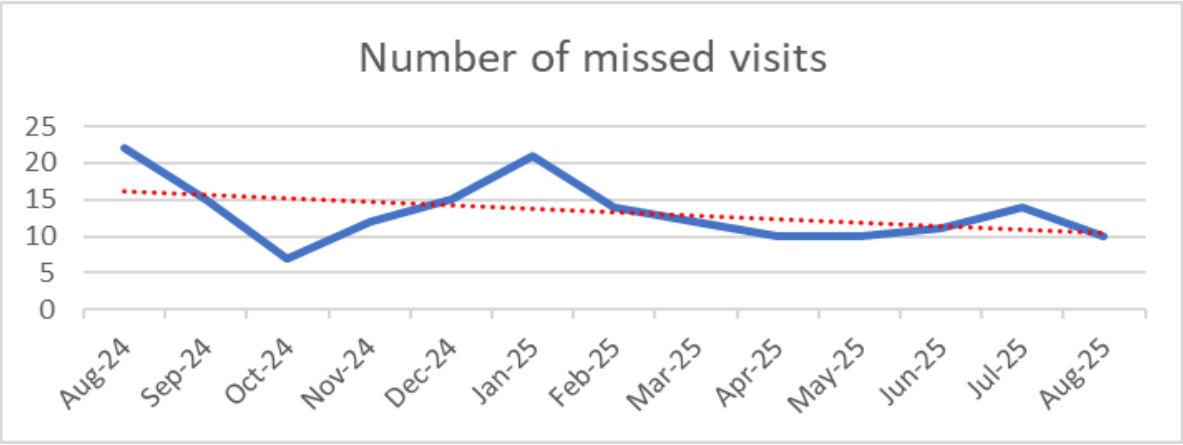




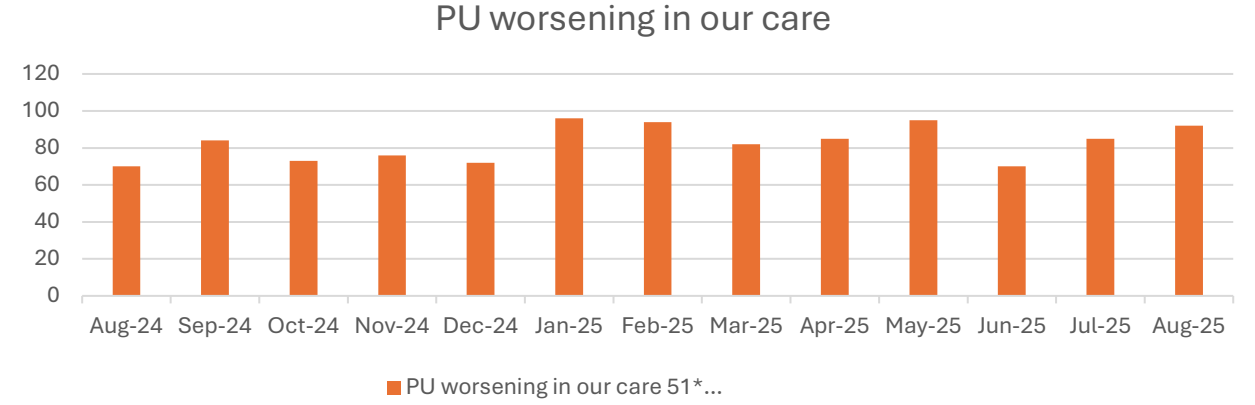
What the data is telling us: community nursing has received 43 compliments in August. 2 teams have been notified they have been awarded the ***making a difference award,*** well done Community Nursing.



What the data is telling us: overall the incidence of low harms is increasing with moderate and severe declining in August. A focus on medication incidents reported by community nursing is being undertaken as a deep dive in September.



What the data is telling us: the number of reported missed visits had reduced in August, a difficult metric to obtain because it is a manual count. A focus on the next 2 months as caseloads are reviewed will be useful in interpreting if the sickness levels and rescheduled visits have been identified through datix.



What the data is telling us: the Datix reports of low harm PU's continue to rise in line with increased incidence**.** The QI project looking at cat 1 & 2's is commencing their first PDSA this autumn which will enable locality breakdown and data to understand if the implementation is successful.

CQC DOMAIN - ARE SERVICES EFFECTIVE? Regulatory Compliance - Section 31 Notification Berkeley House

Assurance Category (Based on our learning assurance framework)	October 23 Total conditions	October 24 Total conditions	July 25 Total conditions
	5	5	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:

The CQC carried out a comprehensive inspection of Berkeley Houe during July, which included a review of the conditions of the Section 31 restriction. We continue to provide monthly submissions against the restriction whilst it is in place.

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

- =Improve quality of sleep on ward
- + Falls Assessment Education Service reducing DNAs
- + MSKAPS 2 week referral to appointment target
- MSK 2 week referral to appointment target

Training data August 2025:
33 Silver (current trained taken from Care to Learn, GHFT or GHC silver trained) –0.7% workforce
786 Bronze (current trained taken from Care to Learn) - 16% workforce
2030 Pocket QI, total trained overtime

- = (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
- = Why do certain demographics access MSK physiotherapy in Forest of Dean?
- =(s) Catheter Trauma - increase knowledge and how to prevent and manage

- = 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
- =(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
- = Recording ethnicity in SystemOne
- = Culture of Care Abbey Ward
- = Personalised Care Programme
- = Adverse events pathway

- = Culture of Care - Dean Ward
- = Culture of Care - Kingsholm Ward
- = Culture of Care – Priory Ward
- = IPS Project
- = Increasing the time between incidents of severe constipation needing a proactive response in CLH
- = 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
- = (s) CYPS SLT waiting list
- = 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.
- = Inadequate and not optimised bone protection

- = Inequities in the Mental Health Act - Greyfriars
- =(G) Improving access to ECT in WLH and community
- ↑ School nursing - Supporting Primary Schools with High Health Needs
- ↑ People Promise - Learning from Leavers

- 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.

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

Directorate	No of improvement work supported by QI Hub (includes projects from Lifecyle and others)
Countywide	10
MH Hospitals and UC	10
PH Hospitals and UC	3
Adult MH/PH/LD Community	16
CYPs	15
Corporate	12
Total: 66	33

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

Key Highlights:.

- Complaints received are up 76.9% YTD on 2024/25 data (52 then against 92 now).
- 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.

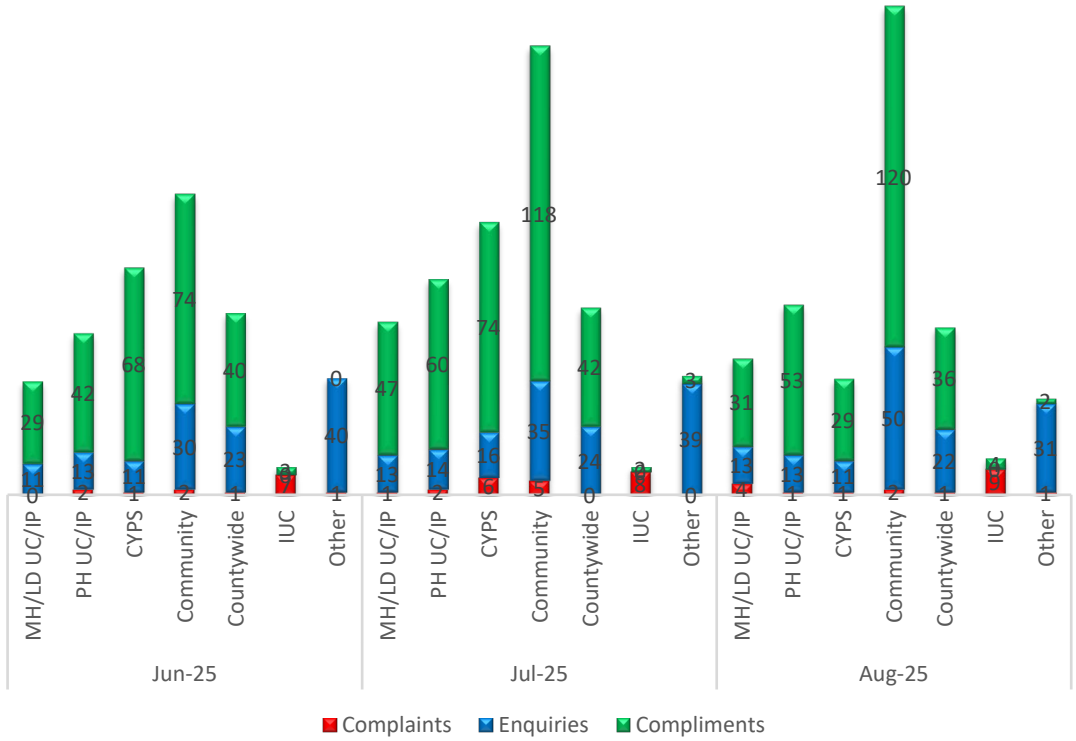
This table shows all reported PCET data received this month by type and directorate
It is important to note that this is a snapshot and does not consider directorate size/footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	4	Early resolution:	**4**	13	31
		Closer look:	**0**		
PH urgent care and inpatient	1	Early resolution:	**1**	13	53
		Closer look:	**0**		
CYPS	1	Early resolution:	**1**	11	29
		Closer look:	**0**		
PH/MH/LD Community	2	Early resolution:	**2**	50	120
		Closer look:	**0**		
Countywide	1	Early resolution:	**1**	22	36
		Closer look:	**0**		
IUCS	9	Early resolution:	**9**	0	4
		Closer look:	**0**		
Other	1	Early resolution:	**1**	31	2
		Closer look:	**0**		
Totals	19	Early resolution:	**19**	140	275
		Closer look:	**0**		

Examples of complaints [as reported] for each directorate:

- MH UC/IP: Patient not happy with medication withdrawal and felt manipulated by the team.
- PH UC/IP: Patient complaining x-rays were not undertaken as part of the investigations and raised concerns that a previous Achilles tendon rupture.
- CYPS: Mother of patient wishing to complain regarding the continuing and unacceptable failure to provide the patient with the urgent mental health care she desperately needs.
- Community: : Patient requesting an investigation regarding the recent contact he has had with the team.
- IUCS: Patient unhappy with an OOH doctor's attitude and felt she was not interested and in a rush to get out of there.

Directorate feedback over the past three months



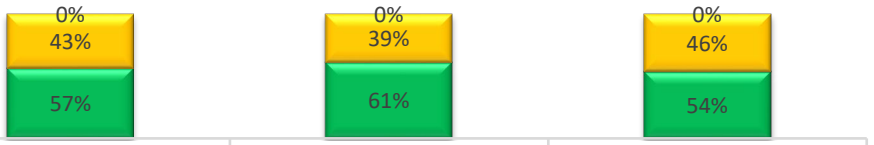
The above graph shows feedback by type and directorate over the past three months.
Whilst we continue to welcome complaints as an opportunity to improve our services, it is important to recognise good practice across all directorates.

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	0	0	0	0
PH urgent care, inpatient	0	0	1	0	1	2
CYPS	1	1	0	0	0	2
PH/MH/LD Community	0	1	0	0	0	1
Countywide	0	0	0	0	0	0
IUC	2	1	3	0	0	6
Other	1	0	1	0	0	2
Totals	**4**	**3**	**5**	**0**	**1**	**13**

The below graph shows the length of time taken to close complaints.
This month, 54**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)

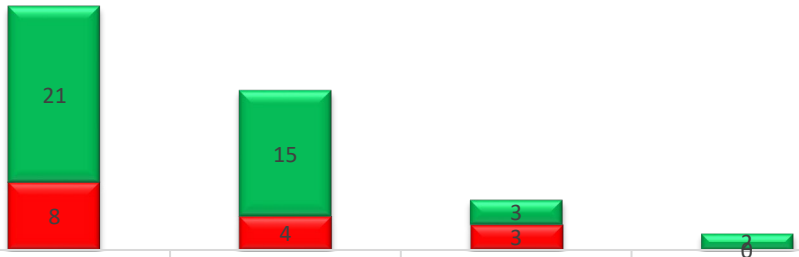


	Jun-25	Jul-25	Aug-25
6-12 months	0%	0%	0%
3-6 months	43%	39%	46%
0-3 months	57%	61%	54%

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 (18377)	Patient waited too long for appt, contracts with outside organisations altered to reflect this. **Wait times**
CYPS (18728)	Continued work and improvements around Language that Cares. **Communication and attitude**
IUCS (18498)	Patient complained about the attitude of the clinician. **Communication and attitude**
0ther (Patient Flow)(19363)	Patient was not supported to arrange transport and access to their home. **Admission and discharge**

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



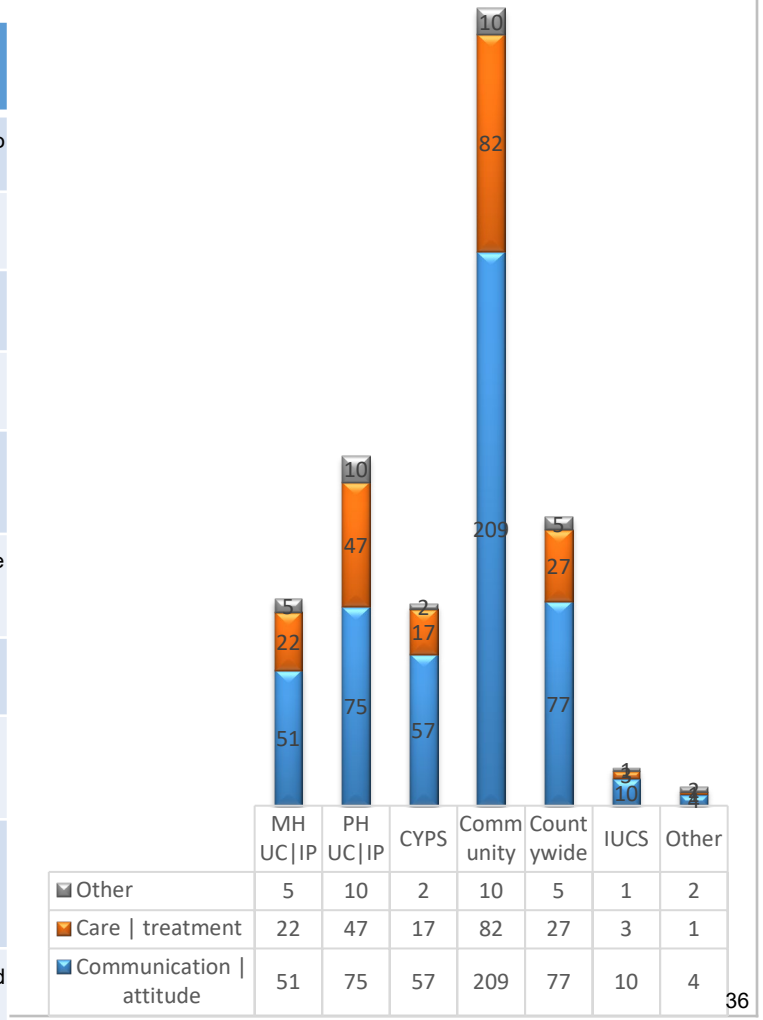
	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	21	15	3	2
Upheld	8	4	3	0

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

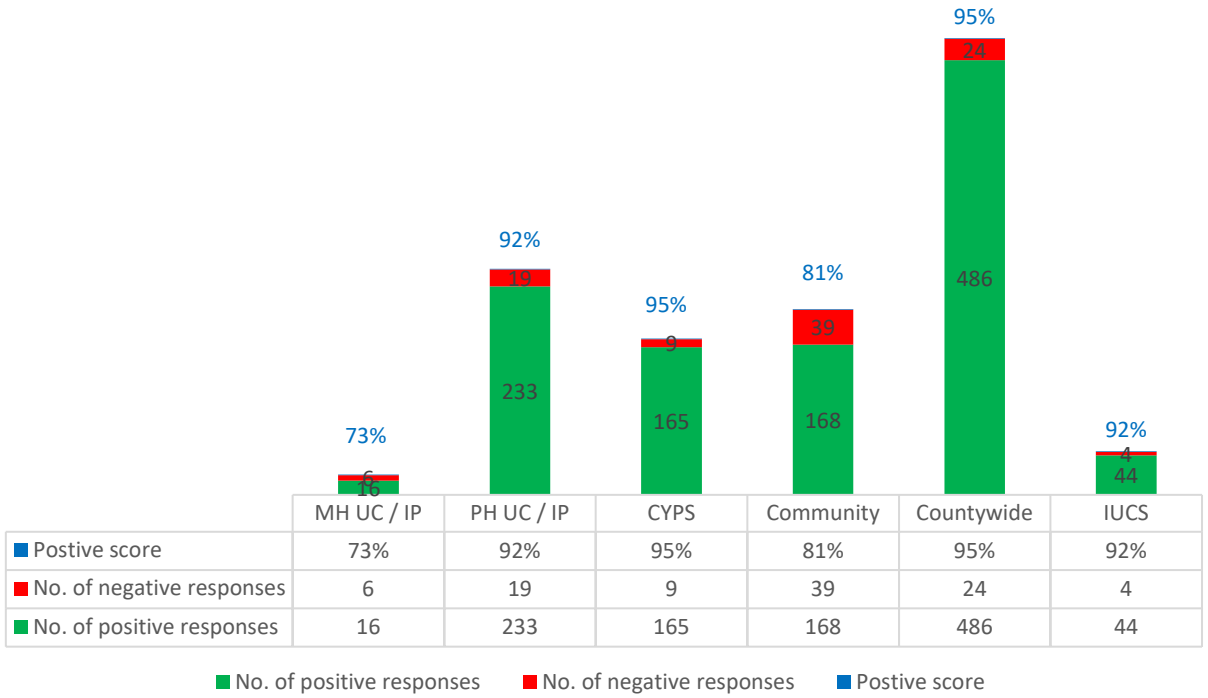
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The 275 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.** It is very likely that more compliments were received but not recorded, therefore, not reported; this is due to operational challenges in some teams.

Date	ID	Team	Compliment
08/08/2025	20405	MH IP Rehab-Laurel	Laurel House staff were complimented on how well they support patients to reach their full potential and re integration back into the community.
14/08/2025	20421	MH Contact Centre	Email received from MHICT nurse who reported a patient complimented staff at FPCC and how invaluable that support is for him.
26/08/2025	20607	NC Hosp-Cotswold View Ward	"Our heartfelt thanks for all your care compassion and kindness you have shown our mum. To overcome the operation at her age would not have been possible if it wasn't for you all. You really are a credit to the hospital"
02/08/2025	20218	MIiU- Vale Hosp	"Patient was delighted with her care. The patient has attended a few times over the last couple of weeks. The patient wanted to highlight the professionalism/caring/kindness of Scott."
22/08/2025	20609	CYPS/PH-Immunisation Team	"Email received following home visit. Huge thanks - they were brilliant with him. I really appreciate being able to arrange it by email too, it makes a big difference. All best wishes,"
21/08/2025	20574	Reablement Cotswolds	"Thank you very much to getting the legs back to where they should be. They are not red any more they are nice & pink & were looking amazing compared to what they were looking like. Chris advised that the nurse said that she wished that she could have her at all her patients. "
12/08/2025	20375	ICT Cotswold South OT	"I just don't know how you do your job - and so amazingly! You were a lifeline for me."
05/08/2025	20272	Early Stroke Discharge ESD	Patient informed Physiotherapist that he has been extremely pleased with the service received and wanted to thank all who have been involved in his care. He said everyone who visited was very professional and kind.
08/08/2025	20323	Sexual Assault Referral SARC	Thank you and your team for helping me. You've done so much in so little time and I appreciate that.
01/08/2025	20234	IUCS OOH Service	The parents of a patient said how lovely the OOH Dr was at GRH base - very caring, took his time and listened, very impressed with the service received and wanted to say thank you.



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



	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
Postive score	73%	92%	95%	81%	95%	92%
No. of negative responses	6	19	9	39	24	4
No. of positive responses	16	233	165	168	486	44

Highlights for this month:

- An issue with the server has prevented automated SMS messages going out (under investigation)
- The overall positive experience rating is 92% which is slightly down on 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 6 requests for contact/action through the FFT.
- FFT set up to support new IUC service; there were 48 responses in August 2025 with a positive experience rating of 92%.

Patient feedback

Carer feedback

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **QUALITY & PERFORMANCE DASHBOARD AUGUST 2025/26 (M5)**

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 provides a high-level view of performance and quality indicators in exception across the organisation. Activity covers the period to the end of August (Month 5, 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 meetings and more widely accounts for performance indicators in exception and outline service-level improvement plans including forecasts and risk assessments. Data quality progress will be more formally monitored through the Patient Records Quality Group which updates the Business Intelligence Management Group (BIMG).

Recommendations and decisions required
The Board are asked to:

- **NOTE** the Quality and Performance Dashboard Report for August 2025/ 26 and acknowledge that appropriate service improvement action plans are being developed *or* are in place to address areas requiring improvement, within Operational governance processes.
- **CONSIDER** follow-up by Resources Committee for the 9 indicators highlighted (Alert and Advise).

Executive summary

Business Intelligence Update
Improvements continue within operational governance mechanisms with a second Service Directorate layer of governance set to begin in October. In addition, there was an Exec roundtable held in August 2025 which re-examined the overarching reporting framework for the Trust and reaffirmed the current commitment to complete the agreed KPI portfolio updates within 2025. This also intends to align all KPIs within the new NHSE Insightful Board guidance domains to offer an alternative lens. Around 80 indicator updates or new

introductions are currently being developed alongside a further set of new quality indicators which are being considered for inclusion. When completed in April 2026, the quality and performance dashboard will then be reflective of all latest national and local KPI developments. A proposal for this was agreed in Resources Committee in August 2025 and a full schedule was brought to Resources Committee in October, post endorsement by BIMG.

Performance Update
The performance dashboard indicators are presented from page 2 within the Board's current four source format (*to note, the fifth 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 lighter commentary format however detailed narrative is reviewed across wider governance processes for all indicators across all source areas.

Alert (to matters that may require attention)
The Board are alerted to these measures and are asked to consider them for follow-up within the Resources Committee in October 2025:

- **L20 MH Liaison – cumulative number of urgent referrals seen within 2hours (ICS portfolio)** – *narrative on page 7*
- **B18 MH Acute Inpatients – Percentage of discharge within LoS threshold (26days)** – *narrative on page 11*
- **B20 MH Older Adult Inpatients – Percentage of discharge within LoS threshold (70days)** – *narrative on page 12*
- **B51 PH Core Bed Inpatient Average Length of Stay (in days)** – *narrative on page 12*

Advise (areas of ongoing monitoring or development)
The following indicators are already being closely monitored by operational services with support of business partner functions (which include KPIs recommended for follow-up by the July 2025 Trust Board. The Board are advised to consider the continuation of follow-up within the Resources Committee for these specific indicators in October 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 3*
- **N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)** – *narrative on page 3*
- **L06 - Crisis Wait time to Assessment: Urgent assessments occur within 4 hours of triage** – *this indicator is compliant for the period*
- **L19 Ensure that reviews of new short or long-term packages take place within 8 weeks of commencement** – *narrative on page 7*
- **L21 - MH Liaison - number of routine referrals seen within 24 hours (ICS portfolio)** – *narrative on page 7*

Assure
The new interim milestones process are delivering to plan for these two indicators:

- **B52 PH CATU Inpatients Average Length of Stay (days)**
- **B53 PH Stroke Inpatients Average Length of Stay (days)**

Applaud

Example areas of positive performance for the period include (but are not limited to):

- **N45 (IUCS) Average speed to answer calls (seconds)** – *second month of sustained compliance.*
- **O21 Paediatric Physiotherapy - % treated within 4 weeks for urgent referrals** – *second month of sustained compliance.*
- **O22 Paediatric Physiotherapy - % treated within 18 weeks for routine referrals** – *second month of sustained compliance.*
- **Recognising the strong work of the Trust's Memory Assessment Service***, the Gloucestershire dementia diagnosis rate is now at 66%, second in the South West and very close to the total number of people that NHS England estimates are living with a form of the disease (66.7%).*

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.

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.
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 Directorate Business Meeting on 11/09/2025, Performance and Risk meeting on 16/09/2025 and BIMG on 18/09/2025

Appendices:	*None*

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

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Snapshot Month
August

Quality & Performance Dashboard Report

Aligned for the period to the end August 2025 (month 5)

In line with the Quality & Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents performance indicators from four indicator 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 governance and reviewed within the Business Intelligence Management Groups (BIMG).

In support of these indicators, monthly Operational Performance & Risk summaries (with improvement plans, risk reviews, action planning and improvement forecasts if appropriate) are presented by Service Directors within Operational governance meetings. Some services are considering 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 is for Physical Health inpatient length of stay which has now been implemented.

Quality & Performance Dashboard Summary

The Dashboard itself (on pages 2-12) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are all underperforming against their targets 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 in line with the Trust's Performance Management Framework. 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 with the support of corporate business partnering functions.

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

The new Operational governance process is becoming established and a second tier of business partnering and service directorate level meetings are being setup to further strengthen the process. A 2025/26 plan to implement all the required changes and updates to the Trust's KPI portfolio has now been constructed with four new indicators for August 2025. A further 3 planned for implementation in September and 47 more across 2025/26.

The new NHSE Oversight Framework (NOF) tool was published in September 2025 scoring the Trust at Level 2 in the top 25% of similar Trusts. The measures within this framework are to be incorporated within the performance dashboard, alongside operational planning measures.

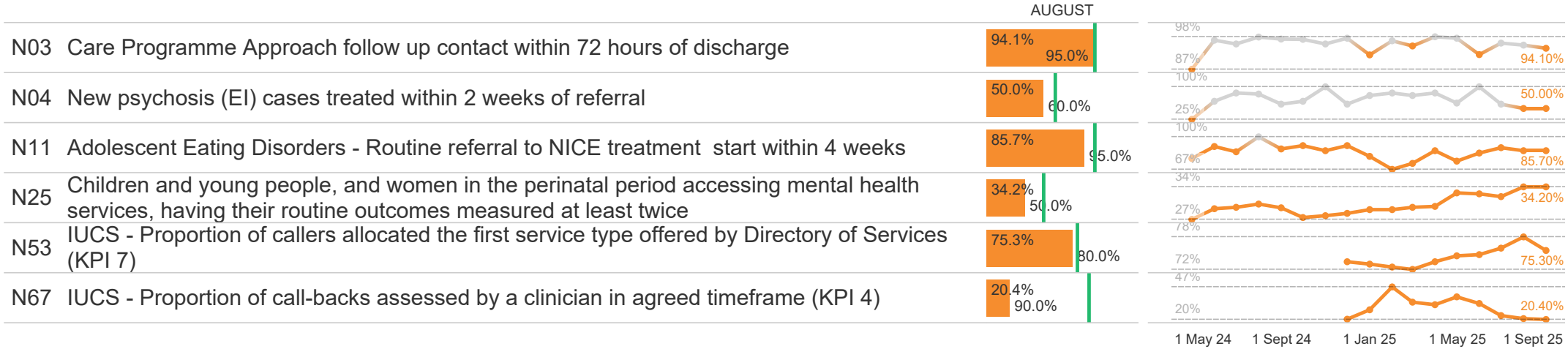
National Contracted Source

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 N51 were in exception last month.*

N03 - Care Programme Approach follow up contact within 72 hours of discharge
<u>Recovery Forecast:</u> December 2025.
<u>Actions:</u> Daily breach alerts, liaising with inpatient teams to ensure discharge processes are followed, communication with mental health community teams regarding follow up requirements. Meeting with community mental health services. All patients are confirmed as safe and have been followed up.

N04 - New psychosis (EI) cases treated within 2 weeks of referral
<u>Forecast for Recovery:</u> October 2025 (may see decrease due to recent localised change in reporting).
<u>Actions:</u> Assessment rotas in place and shared across localities when referrals at higher level. Assertive engagement with patients to engage in initial assessments. Work with Clinical Systems/ other teams to rectify data entry issues. Robust annual leave allocation process. Deputy Service Director ensuring that all patients are now in the service.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
<u>Forecast for Recovery:</u> Immediate.
<u>Actions:</u> Related to one case as the patient was out of the country. Service to link in with other eating disorder teams across the country to explore how this indicator is met in October 2025.

Narrative continued on next page...

Continued from last page...

N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice

Forecast for Recovery: Quarter 1 2026 (*due to being a rolling year KPI*).

Actions: Performance against this KPI is impacted by the transition from the previous outcome measure (Core 10) to the new one (Dialog). Assurance mechanism in place to ensure that an outcome measure is completed at start and end of an episode of care. Tableau report now available to identify in month exceptions to support a deep dive into all non compliant cases. Joint work between directorates to agree target rates.

CYPS specific Actions: Lead Nurse with Children's Service is leading a "Routine Outcome Measures (ROM)" project group with a focus to improve the clinical use of ROMs to measure impact and progress. Various initiatives in place such as ROMs focus month and additional training. Input required from BI regarding reporting ROMS for diagnostic services. ROMs training delivered to clinicians/ managers/ clinical supervisors. From September 2025 clinicians and medical staff to review caseloads and complete ROMs for each open case (if clinically appropriate). BI to support ability to report on patient rated experience measures or parent specific ROMs, including building reports for teams to see ‘reliable improvement’, ‘reliable deterioration’ and ‘no change’.

N53 - IUCS - Proportion of callers allocated the first service type offered by Directory of Services (KPI 7)

Forecast for Recovery: The forecast for compliance *was* July 2025. Currently 4.7% away.

Actions: Comprehensive recovery plan is in place and progressing well. Training/ Coaching Review, E Learning for Pharmacy First, top of the Directory of Services learning week and drop in training sessions, mandatory selection pharmacy dashboard.

N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)

Linked Risk: 628/ 629.

Forecast for Recovery: A forecast improvement plan is in development as July 2025 was the first month of reviewing this metric. The service will be developing milestones.

Actions: Monitoring in real time, IUCS is developing dashboards and escalation triggers, work progressing to review clinical demand and workforce distribution across the pathway, work progressing to select top of the directory of services to support the most appropriate outcome for the patient.

Specialised Commissioning Source

with you, for you

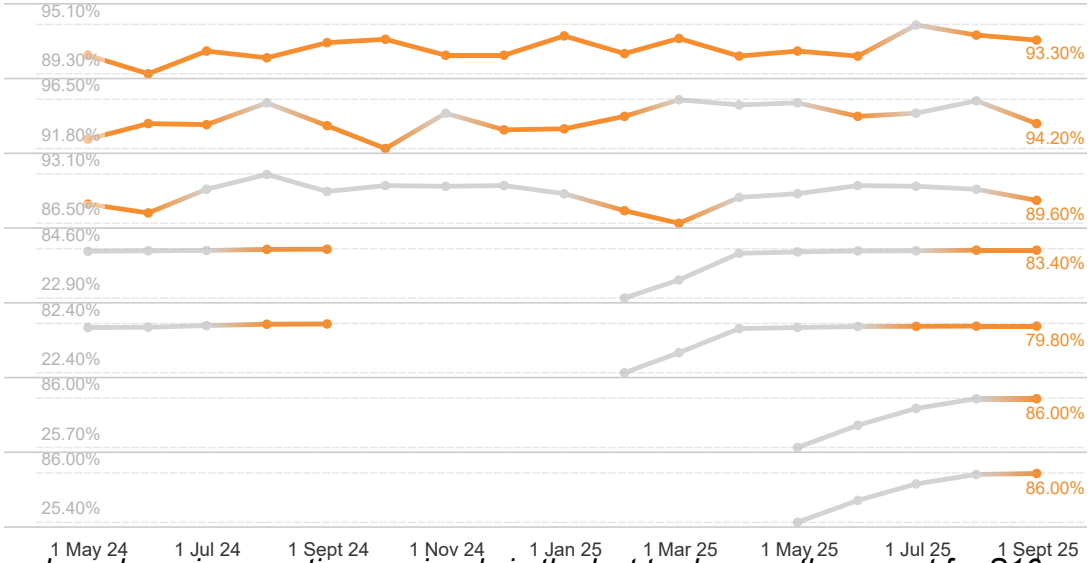
NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

National or regional level indicators as agreed by a commissioner.

		AUGUST	
S02	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	93.3%	95.0%
S03	% of children who received a 6-8 weeks review	94.2%	95.0%
S04	% of children who received a 9-12 month review by the time they turned 12 months	89.6%	90.0%
S12	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	83.4%	90.0%
S15	HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1	79.8%	90.0%
S16	MenACWY (Meningitis) coverage for all children in school year 9	86.0%	90.0%
S17	Td/IPV (Diphtheria, tetanus and inactivated poliomyelitis) coverage for all children in scho..	86.0%	90.0%



<u>Performance Thresholds not being achieved in Month</u> - *Note these indicators have been in exception previously in the last twelve months except for S16 and S17.*

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
<u>Forecast for recovery:</u> Unable to predict due to variability of cases in Neonatal Intensive Care Unit and family choice.
<u>Action:</u> Team Leads and Heads of Service are sharing locality specific performance data with individual teams. Tableau report in development to highlight those that need to be booked, or about to breach.

S03 - % of children who received a 6-8 weeks review
<u>Forecast for recovery:</u> Unable to forecast due to family choice.
<u>Action:</u> Data entry issues also identified and Team Leads/ Heads of Service are leading discussions within the teams.

S04 - % of children who received a 9-12 month review by the time they turned 12 months
<u>Forecast for recovery:</u> Unable to forecast due to family choice.
<u>Action:</u> Data entry issues also identified and Team Leads/ Heads of Service are leading discussions within the teams.

Narrative continued on next page...

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S12 - HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
The School Age Immunisation Service continues to be a strong provider and whilst they have sustained delivery, they have not been able to meet the 90% key performance indicator due to variation in the cohort sizes between the GHC service cohort and Child Health information Service (CHIS) (which is the service responsible for collating immunisation and screening data into a single child health record). To fall in line with reporting, all data now flows through CHIS, but there continues to be cohort discrepancies. As a result, national reporting will show a drop in uptake. Other areas are also experiencing this variation, so the teams are connecting and working with NHS England and CHIS, to resolve these cohort issues prior to the new programmes starting in January 2026.

Combined Narrative for:
S15 - HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1
S16 - MenACWY (Meningitis) coverage for all children in school year 9
S17 - Td/IPV (Diphtheria, tetanus and inactivated poliomyelitis) coverage for all children in school year 9
These key performance indicators could not be met due to consent not being given to receive the immunisation. Ongoing work with Child Health Information Service and Integrated Care System to understand the wider issues.

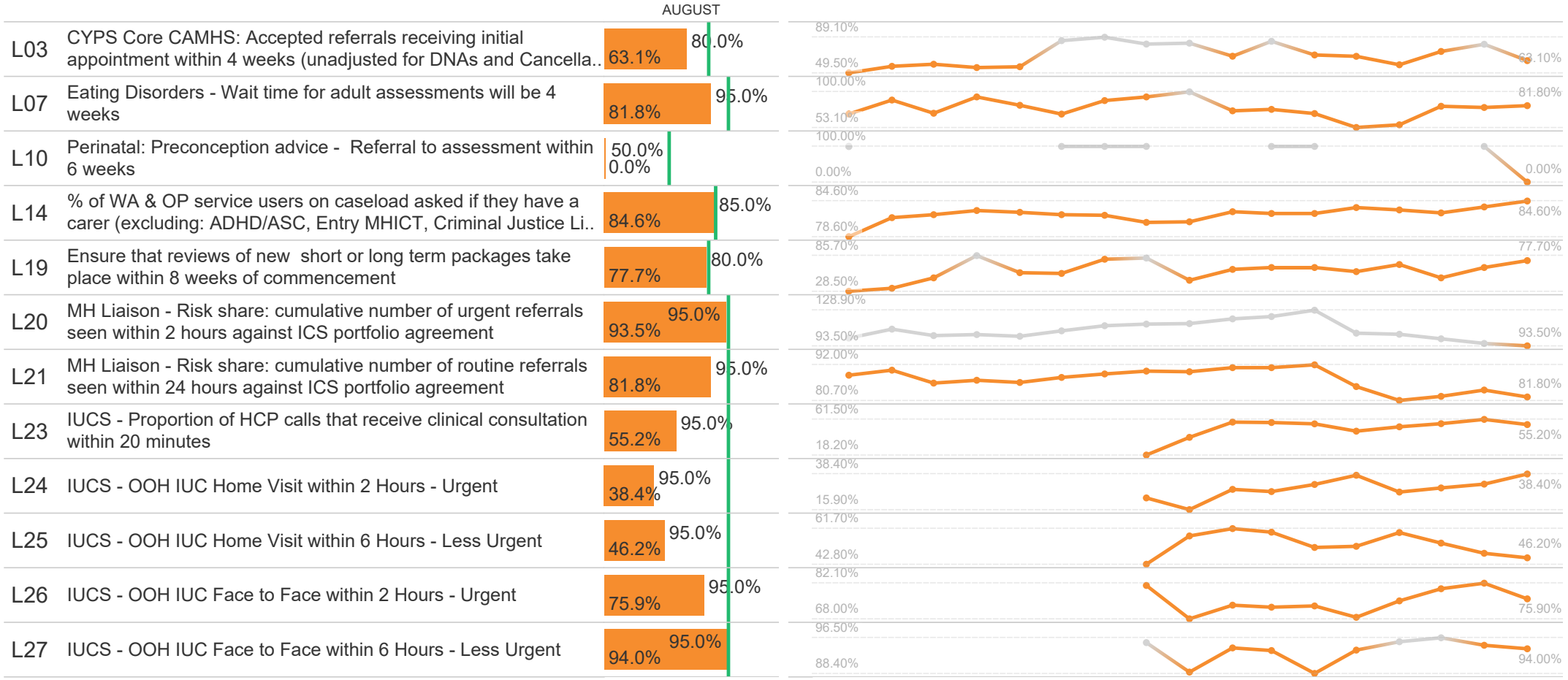
ICS Agreed Source

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 with the exception of L10 and L20 which isn't usually in exception.*

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)

Linked risk: 165

Forecast for recovery: In May 2025 the forecast for recovery was July 2025 and achieved. Key performance indicator not met in August 2025 so new actions identified and forecast in development.

Narrative continued on next page.....

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Actions: Exploring 2-way text messages to improve communication around appointment times, giving longer notice for families and increased ease to cancel early. Reviewing the rota to explore increased single assessments slots, to improve capacity. Standard paragraph to be added to appointment letters, highlighting did not attend rates and discharge impacting services. Exploring with Administrative Team to work on filling the 'late booking' slots. Weekend clinic appointments in place.

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
Actions: Service continues to offer a variety of appointments where capacity allows and making reasonable adjustments where approriate. 3 of the 4 patients have been seen (on day 29). Service to link in with other eating disorder teams across the country to explore how this indicator is met in October 2025.

L10 - Perinatal: Preconception advice - Referral to assessment within 6 weeks
Actions: One non-compliant case due to patient choice to cancel their appointment. Patient was seen in week seven.

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)
Forecast for Recovery: Previous forecast was September 2025, revised to October 2025.
Actions: Deep dive of indicator completed and identified areas to support focussed recovery approach. Operational Leads and Team Managers reviewed processes in place to identify actions required. Plan to be formulated to ensure ongoing compliance. Support offered from Carer Ambassador from the Nursing, Therapy and Quality Directorate. Identified services outside of the directorate are included in this KPI which is being explored.

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
Linked risk: 483
Forecast for Recovery: September 2025
Actions: Social Care Lead continues to scrutinise each package that is due for review within month. Reviews to be undertaken by liaising with all care professionals involved in the person's care (Care co-ordinator, Social Worker, Care Provider). Team managers to identify processes to ensure reviews do not get missed in the event of staff absence.

Combined narrative for:
L20 - MH Liaison - Risk share: cumulative number of urgent referrals seen within 2 hours against ICS portfolio agreement
L21 - MH Liaison - Risk share: cumulative number of routine referrals seen within 24 hours against ICS portfolio agreement
Recovery Forecast: December 2025
Actions: Liaison with Mental Health Liaison Service, determine the data quality, review workforce, activity, demand and capacity to achieve indicator. Meeting to be led by Operations with corporate colleagues by end of September 2025.

L23 - IUCS - Proportion of HCP calls that receive clinical consultation within 20 minutes
This KPI is under review due to the National KPI 4 (N67) 'Proportion of call-backs assessed by a clinician in agreed timeframe' (90% target).
Actions: Improvement plan in place, monitoring in real time, service developing dashboards and escalation triggers, review clinical demand and workforce distribution across the pathway, continue work to select top of the directory of services to support the most appropriate outcome for the patient.

Narrative continued on next page...

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Combined narrative for:
L24 - IUCS - OOH IUC Home Visit within 2 Hours - Urgent
L25 - IUCS - OOH IUC Home Visit within 6 Hours - Less Urgent
L26 - IUCS - OOH IUC Face to Face within 2 Hours - Urgent
L27 - IUCS - OOH IUC Face to Face within 6 Hours - Less Urgent

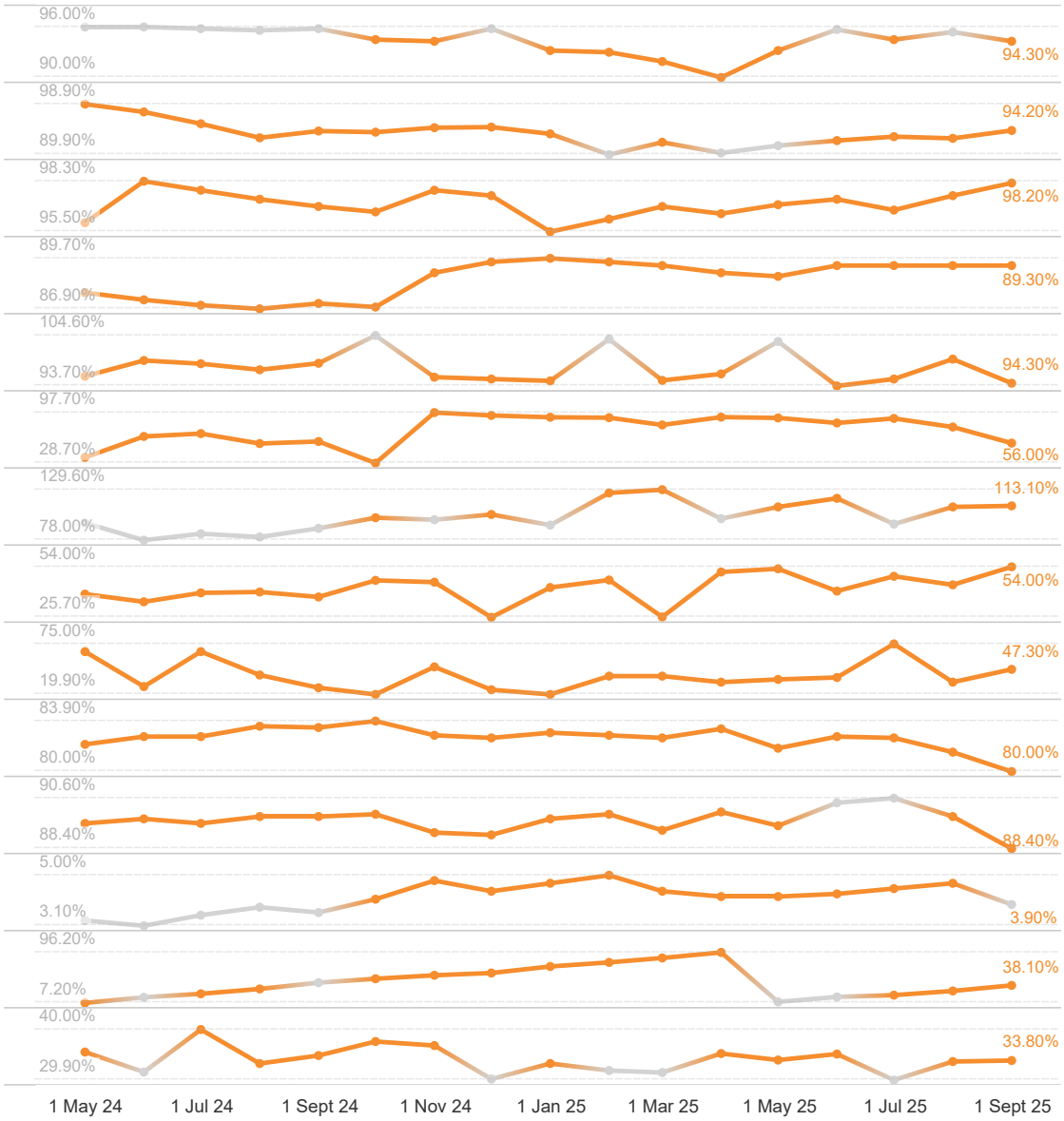
Due to the CAS (Clinical Assessment Service) First model implemented in the Integrated Urgent Care (IUC) Service, these key performance indicators do not reflect the operational processes associated with the data capture. The current proposal is to remove this indicator local quality requirements. A new local indicator will be introduced to capture the speed in which patients are assessed in an IUC Treatment Centre, or in their own residence.

Board Focus Source

KPI Summary

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

		AUGUST	
B01	Care Programme Approach - formal review within12 months	94.3%	95.0%
B04	Bed Occupancy Mental Health Units	94.2%	92.0%
B05	Bed Occupancy Rate – Physical Health	98.2%	92.0%
B08	Improved Data Quality and Reporting - Data Quality Maturity Index	89.3%	90.0%
B11	Safer Staffing Fill Rate - Community Hospitals	94.3%	100.0%
B13	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	56.0%	99.0%
B17	Total number of pressure ulcers developed or worsened during care by this Trust	113.1%	100.0%
B18	MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)	54.0%	95.0%
B20	MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)	47.3%	95.0%
B28	% (All Active Assignments including Bank) Staff with completed Appraisals (exclusion..	80.0%	90.0%
B29	% (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions..	88.4%	90.0%
B30	Sickness absence average % (Joint Forward plan)	3.9%	4.0%
B32	Cumulative Leave	38.1%	41.7%
B51	PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)	33.8%	33.0%



Narrative on next page...

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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.*

B01 - Care Programme Approach - formal review within12 months
Forecast for Recovery: November 2025
Actions: Deputy Service Director leading operational leads to review outdated CPA. Access given to Tableau report to identify individual Care Co-Ordinator records. Reports circulated to teams (now including those with breaches outside the community directorate) which indicate patient reviews in 1-2 months. Deputy Service Director meeting to consider if review of "My Care Plan" is a more suitable clinical option for monitoring as CPA no longer in the NHS Contract (since August 2022).

B04 - Bed Occupancy Mental Health Units
See narrative and work in relation to length of stays B18 and B20.

B05 - Bed Occupancy Rate – Physical Health
Linked risk: 406
Forecast for recovery: Milestones in place to recover length of stay as approved at Resources Committee, August 2025.
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.

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:

- CSDS: Community services data set 92.6 % (previous month 91.5%)
Activity location Type is at 87.6% which has increased from 75.7% in July, with 11k appointments recorded without a location type (decreased from 21k last month). Configuration changes to the system have been made with the field now being mandatory this should be visible in national reports in the coming months. Language recording is at 58.5% but above the national average of 33.5%.
To note - Consultation Mechanism is at 82.7% (above national average) due to a SystmOne configuration issue in recording mechanism against DNA's and cancelled appointments – this has been raised with the system supplier.
- ECDS: Emergency care data set 75.9% (previous month 74.5%)
Compliance is below average on 10 KPIs. The clinical systems team have created a new assessment form to collect all required fields, which was rolled out in Quarter 3, but the dataset has yet to see a marked improvement to compliance. Service led review is in progress.
- APC: Admitted patient care data set 100% (previous month 100%)
- IAPT: Talking Therapies data set 99.8% (no change from previous month)
- MHSDS: Mental Health services data set 91.5% (previous month 90.6%)

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

Narrative continued on next page...

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B11 - Safer Staffing Fill Rate - Community Hospitals
Linked risk: 624
Forecast for recovery: dependent on timeline for inpatient establishment reprofiling (IER) programme. IER delivery and recruitment provision aim to stablilise within 4 months.
Actions: IER 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). Meeting planned with Nursing, Therapy and Quality Team to explore the reporting targets.

B13 - Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
Forecast for Recovery: In development.
Actions: Discussions ongoing with commissioners in respect of sub contracting arrangements for Echocardiograms. Situation background assessment recommendation (SBAR) paper is in development to support further discussions.

B17 - Total number of pressure ulcers developed or worsened during care by this Trust
August 2025 data has not been fully validated so Pressure Ulcer (PU) classification is likely to alter after review. It should be acknowledged that there are factors such as patient compliance and equipment availability that can result in an increase in reported PU's. Physiological tissue changes experienced at a persons end of life may also result in a PU developing and therefore the number of EoL patients across the Trust should also be considered when analysing this data.

A Quality deep dive review of community nursing was presented to Quality Committee by HOP community Nursing & DSD ICT in January 25. It was requested to review the approach to reporting data, rather than a focus on PU incidence, this has been agreed and is now being presented to QAG and Quality Committee in this new format.

In August there were 102 pressure ulcers developed or worsened whilst receiving care by GHC (in July there were 104) compared to a threshold of 91. Performance is within normal variation.

There is a nationally recognised risk of incidence and prevalence of pressure ulcers. Increases in reported category 1 and 2 pressure ulcers corresponds to increases in caseload referrals in community nursing, but the data has not been triangulated. Tissue Viability specialists and Community Nursing colleagues have commenced a Quality Improvement (QI) project in March to explore the reasons behind this and understand how different approaches may reduce occurrence. QI tools will be used and a PDSA method employed.

Wording for the current risk, 114 – rating 9, is under review to reflect factors that adversely impact mitigation.

B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)
Linked risk: 196
Forecast for recovery: intermin milestones to be proposed September/October 2025.
Actions: Review of daily meetings, internal escalation process review, therapies review underway to closer align with the wards and work in an integrated model, Supporting Discharge Team aligned to wards/case study review quarter 3, trajectory setting with Business Intelligence Team against national benchmarking data.
Future planned work: Herefordshire and Worcestershire Health and Care NHS Trust on 26 September 2025 to gather good practice/innovations. Quality Improvement Scoping (deep dive opportunities). Review length of stay National Benchmarking, provider assessment framework 60 day baseline required. Regional learning improvement network - focus is on reducing length of stay through quality improvement , first project group set up in October 2025.

Narrative continued on next page...

Continued from last page...

B20 - MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)
Linked risk: 196
Forecast for recovery: interim milestones to be proposed September/October 2025.

Actions: Data review of challenges to extended length of stay, review of meetings, review of escalation internal/external processes, therapies review underway to closer align with the wards and work in an integrated model, Social Work team based within hospital, Supported Discharge Co-ordinator specifically for Charlton Lane Hospital to support reablement/home first.
Future planned work: Focussed work on admission avoidance for those with a diagnosis of dementia being led by Service Director for Community Services. Visit planned for Herefordshire and Worcestershire Health and Care NHS Trust on 26 September 2025 to gather good practice/innovations.

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for August has dropped slightly to 80.0%, compared to a threshold of 90%, although the figure is expected to rise slightly again due to delayed data entry, performance is outside normal variation. July performance rose from 80.4% to 81.4% and was within normal variation. The Performance is following the same seasonal pattern that has been seen for the last couple of years.

B29 - % (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions applied)
Performance figures for August, excluding Bank staff, remains static at 88.4%, just under the performance threshold of 90%, although the figure is expected to rise slightly due to delayed data entry (July's performance rose from 88.6% to 89.8%). Performance is within normal variation and has been steady at around 89.5% for the last 25 months.

B30 - Sickness absence average % (Joint Forward plan)
The sickness absence rate for August 2025 has been retrospectively updated to include the e-rostering system (Allocate) data and performance is at 5.1% which is above normal variation (it was 3.7% without). This continues to follow the seasonal trend of the last few years.

B32 - Cumulative Leave
The predicted Cumulative Leave Taken Percentage for August 2025 is approximately 40%, which is slightly below the target threshold of 42%. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until mid-September. Currently, the reported rate for August stands at 38.1%, but this figure does not yet include data from Allocate.

B51 - PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)
Linked risk: 406
Forecast for recovery: Interim milestones agreed (32 by October 25, 30 by April 26), in place as approved by Resources Committee August 2025. To be reviewed in December 2025 as part of ongoing system transformation work and bed modelling.
Actions: Delay Related Harm workshop booked with colleagues across the system, 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 addtion 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. Reviewing the impact following changes to continuing health care.

REPORT TO: **TRUST BOARD PUBLIC SESSION**

PRESENTED BY: Sarah Branton, Chief Operating Officer

AUTHOR: Chief Operating Officer

SUBJECT: **WINTER PLANNING 2025/26**

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 assurance to the Board in relation to the Trust's preparedness and planning for winter 2025/26.

Recommendations and decisions required

On the recommendation of the Resources Committee, the Trust Board is asked to **ENDORSE** the Winter Plan and approve the Board Assurance Statement (**Appendix A**) for submission to NHS England on or before 30 September 2025.

Executive summary

The Trust Winter Plan serves to provide strategic oversight of the delivery of care over Winter 25/26. NHS England published the Urgent & Emergency Care Plan for 2025/26 in June 2025. This document has been reviewed to ensure that the required actions and focus areas are contained within the Winter Plan

The report, originally prepared for Resources Committee, summarises and provides assurance on the preparation of the winter plan 25/26 which has been developed in system partnership.

The Board Assurance Statement (**Appendix A**), required as part of the Urgent and Emergency Care Plan for 25/26 covers key areas and this paper has been structured to reflect these.

While the Board is asked to endorse the plan in September 2025, the Operations Directorate will continue to test, iterate and improve the plan throughout Autumn 2025 as we move towards winter.

Risks associated with meeting the Trust's values
Board Assurance Framework Risk 02: Demand and Capacity – There is a risk that the number of people being referred to services exceeds capacity to be responsive, resulting in poor experience and delays to timely access and provision of effective treatments and interventions

Corporate considerations	
Quality Implications	Any quality implications will be reviewed through the QEIA process.
Resource Implications	None identified at this stage
Equality Implications	None identified at this stage

Where has this issue been discussed before?
Resources Committee 28 August 2025 Ref: Operational Resilience and Capacity Plan (Winter Plan, Board Assurance Statement) Quality Committee 2 September 2025 Ref: Annual Flu Plan 25/26, Infection Prevention and Control Annual Report Extraordinary Resources Committee 16 September 2025 – paper circulated to all Committee members 11 September for comment. Chair, Chief Operating Officer and Head of Emergency Planning, Preparedness, Resilience and Response met to review and endorse Board Assurance Statement to Board

Appendices:	A: Board Assurance Statement

Report authorised by:	**Title:**
Sarah Branton	Chief Operating Officer

WINTER PLANNING 2025/26

1.0 INTRODUCTION

This document provides an overview of Gloucestershire Health and Care NHS FT (GHC) preparation for winter pressures, both internally and in support of the wider Urgent and Emergency Care (UEC) system. The Board Assurance Statement is included in **Appendix A** which the Board is asked to endorse.

This document is supported by the GHC Winter Escalation Plan 25/26 which contains the operational detail.

NHS England wrote to all NHS Trusts on 14 July 2025 to request the following:

1. Develop an organisational winter plan, completing a draft by the end of August.
2. Ensure preparatory actions, including staff vaccination programmes, were in progress now; and to,
3. Stress test draft winter plans by participating in an NHS England hosted exercise in September; and,
4. Following the exercise, sign off plans using the relevant Board Assurance Statement.

The Board Assurance Statement (**Appendix A**) covers the following areas:

- Governance
- Plan content and delivery
- Prevention – flu vaccination uptake for frontline staff
- Capacity
- Infection Prevention and Control
- Leadership
- Specific Actions for Mental Health Trusts

This paper is structured to enable the Board to easily identify the areas above.

2.0 GOVERNANCE

The Trust's Chief Operating Officer (COO) is the Executive accountable for delivery of services and is the Accountable Emergency Officer.

The Operations Directorate maintains daily oversight of services with a particular focus on services critical to UEC flow through the winter period. This is in the form of a daily internal Teams meeting. Internal mechanisms are in place for escalation via the Operational Governance Structure with the Chief Operating Officer reporting into Resources Committee and Board to update as required.

In terms of governance within the system, the Operations Directorate attends daily Operational Oversight and Flow meetings. The Deputy Chief Operating Officers attend the system weekly Tactical Escalation Group which may stand up additional meetings as required through winter and may escalate to the system Strategic Escalation Group (SEG). The Chief Operating Officer sits as a member of SEG.

2.1 Senior Decision Makers

The Trust has in place senior decision-making processes 24/7. During the normal working day, this will be the Chief Operating Officer (COO), Deputy COOs or Service Directors. Outside of these hours, this is available through the Executive On-Call rota, supported by Physical Health, Mental Health, and IUCS On-Call managers.

These rotas are confirmed as being in place, covering throughout winter until March 2026.

During times of pressure, rotas are bolstered; or supported by an Incident Management Team.

The Trust also has rotas for Consultants and Resident Doctors within mental health and access to out of hour GPs for Community Hospitals.

2.2 Quality and Equality Impact Assessment

A Quality and Equality Impact Assessment is in development. It is proposed that this is completed as we move through the testing phases in September and October 2025. This will ensure that quality and equality impacts have been identified and tested with mitigations in place. It is proposed that the QEIA moves through the usual governance structure within the Trust (Improving Care Group and Quality Assurance Group) to be reviewed at Quality Committee on 4 November 2025.

2.3 System Development and Testing

Following winter 24/25 the Trust held an internal debrief which identified a range of recommendations. These were then fed into a system debrief on 12th February 2025.

The key learning for GHC was to review Operational Escalation Level (OPEL) actions, ensure they are aligned with the system and increase internal awareness. These actions have been incorporated into this winter plan.

The Winter Plan has been developed in partnership with system colleagues including Integrated Care Board, Gloucester Hospitals Foundation Trust and Gloucestershire County Council. It has been developed and scrutinised in the Tactical Escalation Group (TEG) with the joint system plan presented to the Strategic Executive Group on the 21 August 2025. With further iterations via TEG, it is due to be presented to the Strategic Escalation Group (SEG) week commencing 8 September 2025.

The Trust, alongside system colleagues, attended a regional winter planning event on 29 July 2025 and a South West Ambulance (SWASFT) lead event on 3 September 2025. Again, alongside system partners, the Trust is involved in a National Winter exercise on 10 September 2025 and is taking part in a System Stress Test of the winter plan on 17 October 2025.

The learning from these events will be incorporated into iterative development of the Trust winter plan and the system winter plan. The Emergency Preparedness Planning and Resilience team will then host an internal winter workshop for managers and lead clinicians in October 2025.

3.0 PLAN CONTENT and DELIVERY

The Winter plan encompasses a range of documents which when brought together demonstrate the Trust preparedness. The Operations Directorate hold business continuity plans and standing operating procedures that support the Trust's response to surges in demand in all Service Directorates including the urgent care system, all year round.

3.1 Preparation

As part of usual management practices, rotas have been reviewed and are reviewed throughout the winter period. Capacity will be reviewed across community services dynamically and flexed to support clinical need. Rosters are published 12 weeks in advance with early and proactive escalation to bank and framework agencies. Critical gaps will be escalated in line with normal processes. During periods of additionally high demand the process for approval of resilience shifts over and above the funded establishments is enacted.

Clinical teams identify people with additional vulnerabilities and capture this in the clinical record. The purpose of this is to ensure that during times of additional pressure, teams are able to quickly identify those with priority need.

As part of the preparation, Service Directorates have identified critical areas to strengthen ahead of winter. Actions in response to this include improving ways of working between teams to increase resilience or aligning additional management to ensure a daily focus on activity and flow.

Finally, and linked to the UEC system portfolio, colleagues have worked together across the system to map the UEC preventing admission and enabling discharge pathways to identify opportunities to streamline ahead of winter by reducing duplication.

3.2 Surge Modelling

The Trust receives the UKHSA weekly briefing which indicates the progression of viruses and winter illnesses through winter and provides a prediction of likely periods of surge. The Trust is also working with Public Health to gather intelligence particularly in relation to predicted surge in respiratory illness and paediatric illnesses. Our areas of pressure during these times are into our services in the UEC pathway and therefore our winter plan has focussed on these services to ensure surge capability and actions in response.

As a system partner in the Tactical Escalation Group we review previous years spikes to predict likely times of surge and actions required in response.

3.3 Operating Pressures Escalation Levels (OPEL)

These are a set of levels (1 to 4) which are used to manage short term operational pressures such as patient flow. NHS England has issued OPEL levels for Community and Mental Health providers which the Trust has now adopted with OPEL action cards for ease of reference in escalation. As per our learning from the 24/25 winter debrief, the action cards have been reviewed and communicated. The

internal winter workshop in October 2025 will further communicate and test the OPEL action cards.

OPEL levels are monitored daily in internal and system calls, as described in section 2.0. An example of an OPEL action card can be found in **Appendix B.**

Whilst winter plans and OPEL escalation actions provide much mitigation, in the event of a declared major incident or significant disruption to critical services, the *Maintaining Essential Services Through Redeployment* process may be enacted.

3.4 Flu Plan

The Trust is working to deliver at least 5% improvement on last year's flu vaccination rate for frontline staff by the start of the flu season. The staff flu vaccination programme is planned. This includes bookable appointments at Working Well, walk-in vaccination sessions at various locations across the Trust estate and an established peer vaccinator programme. Staff vaccination sessions are advertised via the Trust internet, staff social media channels e.g. Facebook, global emails, posters displayed at local service level, team meetings, handovers etc. The Outreach Vaccination and Health Team (OVHT) also offer patients flu and Covid vaccines to patients who are eligible during an admission.

The Annual Flu Plan 25/26 was reviewed at the Trust Quality Committee 2 September 2025.

3.5 Infection Prevention and Control (IPC)

Policies and procedures across all areas of the Trust are current and in line with National Guidance. We have clear guidance in place with regards to direct admissions to our Community Hospitals for those who may be flu or covid positive utilising our single room estate. Where clinically indicated patient cohorting is planned in line with the Trusts outbreak management guidance. The IPC team work daily with the Trust's flow team to mitigate nosocomial transmission.

A **patient cohorting plan** including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.

Fit testing has taken place for all relevant staff groups with the outcome recorded on the Electronic Staff Record, and all relevant **PPE** stock and flow is in place for periods of high demand.

The Infection Prevention and Control Annual Report 24/25 was reviewed at Trust Quality Committee on 2 September 2025. While this reviewed the work of the previous year, the quality of this report and the work of the IPC team, was noted by Committee with support to continue with this level of responsiveness and delivery into the coming winter.

3.6 Specific Actions for Mental Health Trusts

As with all services, our all-age urgent mental health helplines, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, all have business continuity plans in place. Rosters are published 12 weeks in advance,

and any gaps are proactively filled. The Trust has a clinical on call rota for consultants and a 24/7 rota for Approved Mental Health Professionals to ensure coverage of senior clinical decision makers.

The Trust has a management on call rota specific to mental health ensuring availability of senior decision making from this specialism.

Our psychiatric hospitals have a nursing rota to ensure senior clinical decision making from experienced psychiatric nurses.

In preparation for winter, our community mental health teams and crisis teams are identifying people who frequently access urgent care services as well as all high-risk patients to ensure that they have an up-to-date crisis and relapse plan in place.

3.7 Childhood Vaccination Offer

The School Aged Immunisation Team have confirmed flu vaccination dates with all schools within Gloucestershire. As part of our planning process, we review the data from the previous year and schedule lower uptake schools earlier within the season to enable us to maximise uptake.

3.8 Targeted Local Campaigns

The Outreach Vaccination and Health Team (OVHT) hold community-based pop-up health events at various locations across the county offering basic health checks, health conversations including information about vaccination campaigns and sign posting to local services to support the national Making Every Contact Count (MECC) agenda. The OVHT also hold community-based pop-up Covid vaccination clinics at various locations across the county.

3.9 Emergency Preparedness

In addition to the above, the Trust has a Major Incident Plan which details the Command and Control arrangements which could be put in place if a serious issue arises. This includes the declaration of a Business Continuity, Critical or Major Incident and the Chief Operating Officer is the Accountable Emergency Officer.

This plan dovetails with the Local Health Resilience Partnerships Health Community Response Plan which sets out how partners will work together during a crisis.

In relation to **adverse weather** – the Trust has an Emergency Preparedness, Resilience and Response (EPRR) Winter Plan which details the arrangements in place to support services in periods of adverse weather. For example, 4x4 vehicle arrangements.

The Trust also has a winter severe weather plan which outlines how critical services will be maintained in the event of severe weather, such as snow and flooding alongside service level business continuity plans.

The severe weather plan will be considered at the EPRR Forum and signed off by the Chief Operating Officer, in line with previous years.

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Y	
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Y	QEIA is in development as Trust continues testing
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Y	
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	Y	10 September 2025 ICS Stress test 17 October 2025.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Y	
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Y	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Y	
The Board has reviewed its 4 and 12 hours, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	N/A	

Provider CEO name	Date	Provider Chair name	Date
Douglas Blair		Graham Russell	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5-percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Y	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Y	
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Y	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	N/A	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Y	
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Y	
8. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Y	

Checklist		Confirmed (Yes / No)	Additional comments or qualifications (optional)
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Y	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Y	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Y	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Y	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13/0925

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Emma Abbey, Chair of Medical Appraisal Committee

SUBJECT: **MEDICAL APPRAISAL ANNUAL REPORT**

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:

The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services by medical practitioners with a connection to this designated body.

It provides assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required:

1) That the Board **accept** and **endorse** the Medical Appraisal Annual Report and:

- **Recognise** that levels have been maintained in the application of appraisal, recording and quality assuring and that this has occurred without significant additional funding.
- **Recognise** that the figures for engagement in appraisal reflect a snapshot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the revalidation statistics provided.
- **Recognise** that there are a number of exceptions/reasons for non-compliance that contribute to a compliance point of less than 100%.
- **Recognise** that effective appraisal has supported timely and appropriate revalidation for all doctors to date.
- **Recognise** that good employment practice with regard to recruitment is supporting safe practice.
- **Recognise** that locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.
- To **note** in particular the assurance for NHS England in section 13 that the Trust meets requirements.

2) That the Board **agrees** the content and submission of the Statement of Compliance to NHS England and that this is signed by the Chair on behalf of the Trust (section 13 page 9-19).

3) The covering paper and annual report has been presented to and endorsed by the Great Place to Work Committee on the 26th August 2025 for onward Board approval.

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures demonstrate that of the 110 doctors requiring appraisal during the 2024-25 appraisal year 97 (88%) were compliant as of 1st April 2025 (this is an increase on the previous year). Of the 13 doctors who were non-compliant; 5 (4.5%) had acceptable reasons (3 being new starters; 1 on maternity leave and 1 due to the appraiser's availability). The 8 (7.5%) without a reason were overdue by two months or less except for one who is on Bank.
- Doctors' revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and is necessary to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and both consultant and SAS level doctors. A new lay member, Andrea Foden, an MHA Manager, has joined the group to provide lay oversight.
- This report does not include Dental staff as they are not subject to these GMC regulations.

Risks associated with meeting the Trust's values

There are significant risks both to quality, safety and reputation of failure to implement revalidation and annual appraisal effectively.

Corporate considerations	
Quality Implications	Appraisal contributes to patient safety.
Resource Implications	Continuing use of administrative and managerial time with clinician input to revalidation process.
Equality Implications	The annual appraisal monitoring process addresses equalities issues.

Where in the Trust has this been discussed before?
Medical Appraisal Committee, 14th May 2025 Great Place to Work Committee, 26th August 2025

Appendices:	N/A

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

Explanation of acronyms used:	SARD – Strengthened Appraisal & Revalidation Database MAC – Medical Appraisal Committee

Annual Medical Appraisal Board Report

Appraisal year:	**1st April 2024 – 31st March 2025**
Author:	**Dr Emma Abbey** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Great Place to Work Committee**

1. Executive summary

Of the 110 doctors requiring appraisal during the 2024-25 appraisal year 97 (88%) were compliant as of 1st April 2025; this is an increase on the previous year (79% at end of Q4 2024).

In addition, there are another approximate 130 doctors who are employed by GHC in a sessional or bank capacity but not under our 'designated body'.

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaged in and completed a standardised medical appraisal. Since then, the MAC has focussed on improving the quality of medical appraisals undertaken in the organisation.

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to the Trust Board through the Quality Committee and the Quality Assurance Group that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019, with future visits expected on a 5-year cycle.

2. Purpose of the paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board through the Great Place to Work Committee over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisals over a five-year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of 'fitness to practise' to the GMC for revalidation.

4. Governance arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to maintain robust systems for the recruitment, training, support and performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the Trust.

The MAC comprises of the Medical Director/Responsible Officer, Revalidation Officer, a separate chair, the Director of Medical Education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical and sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative, and a lay representative.

The MAC convenes quarterly; this includes a year-end half-day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee reviews the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review of the current terms of reference for the MAC
- Review of the membership of the MAC
- Completion of the annual quality assurance audit. The April 2025 audit covered all appraisals completed from 1st April 2024 to 31st March 2025
- Continued review of the currently active medical appraisers list
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisals

Alongside these new and ongoing developments, the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline and refresher training for medical appraisers (provision is determined by current need); monitor training compliance and output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved appraiser within a 2-year cycle; and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job plans are completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency of compliance monitoring and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends a firm reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged. A process for escalation to the GMC if non-engagement continues is also in place.

Priorities for the MAC for the next year include further refinement of the number and nature of active qualified medical appraisers within the organisation, in line with the

increase in doctor numbers and natural turnover of appraisers. The committee have sourced an easy read patient feedback form for 360-degree feedback as clinicians from certain sub-specialities had previously identified this as being a barrier to collecting patient feedback.

5. Medical appraisal

5.1. Appraisal and revalidation performance data

Of the 110 doctors requiring appraisal during the 2024-25 appraisal year 97 (88%) were compliant as of 1st April 2025; this is an increase on the previous year (79% at end of Q4 2024).

In 2018-19 the 'appraisal year' was introduced (1 April to 31 March). This aims to prevent slippage of appraisal date, and expects that each appraisee will have one completed appraisal per appraisal year unless authorised by the RO.

Of the 13 doctors who were non-compliant; 5 (4.5%) had acceptable reasons (3 being new starters; 1 due to appraiser being sick/availability; 1 retuning from maternity leave). The 8 (7.5%) without a reason were all overdue by less than two months except for one who is on bank.

The SARD JV system for monitoring compliance does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see **Appendix A.**

5.2. Appraisers

There are currently 16 trained medical appraisers within the establishment of non-training grade doctors. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

During the appraisal year 2024-25, we have sadly lost one of our very experienced appraisers to retirement, and another has felt unable to continue in the role due to work pressures. These remain on the list currently but are winding down their appraiser commitments. One new appraiser has started during the year, and another will do so shortly. There have also been some periods of sick leave for our established appraisers, which have required reallocation at short notice.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in 2014 and enforced in 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually. Appraisers who consistently do small numbers are asked whether they wish to continue in this role.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers and are actively seeking ways to facilitate non-psychiatrists becoming appraisers.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom GHC has a prescribed connection. Some appraisals are undertaken for colleagues working outside GHC, in retirement or within other roles such as the Deanery.

5.3. Quality assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; whose purpose is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities. A comparator report is received each year from NHS England, which allows the Trust to benchmark itself against other trusts. As GHC is small compared to other Trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall, the Trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all core standards; scoring highest for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and few suggestions made for improvement, mainly concerning HR procedures (since enacted). Many areas of good practice were noted including the overriding focus on quality of medical appraisals, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement which result from the annual quality assurance audit. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

As RO/Deputy RO the Medical Director and/or Deputy Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this, as below:

5.3.1. Support for appraisers

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within annual appraiser support forums, existing consultant CPD (Continuing Professional Development) peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

5.3.2. Feedback from appraisees

Appraisee feedback forms are automatically generated by SARD JV and sent to appraisees after all completed appraisals. Return rates are high. Completed returns are screened by the Medical Director's office and reviewed quarterly by the MAC. Any concerning feedback is followed up individually by the MAC chair in order to address potential problems in a timely manner. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and considered comparable).

94 appraiser feedback questionnaires for 19 appraisers who completed 102 online appraisals between 01 Apr 2024 and 31 Mar 2025. This is a return rate of 92%.

5.3.3. Automatic uploading of complaints and anonymised SI reports

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of the appraisal process.

5.3.4. Annual quality assurance audit

The annual medical appraisal quality assurance audit was conducted in May 2025 by all members of the MAC, using a nationally recognised medical appraisal QA tool (the Excellence Tool).

11 (10% of all) completed appraisal summaries were randomly selected for audit. Consent was sought from individual appraisees; none declined. Following discussion at last year's audit, this year each appraisal was audited by two independent MAC members. Results were reviewed and an action plan developed, including:

- Preparation of a comprehensive audit report
- Dissemination of key learning points to all appraisers and appraisees and
- Individualised feedback provided to appraisers

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool had returned to the previous year's level of 20/22 indicating a sustained high standard of appraisal documentation. Since the 2022-23 audit we have included a question of whether form A has been uploaded to SARD and discussed at appraisal. Form A is a summary of the appraisee's job plan and is recommended by NHSE to be used in appraisal. Its use is now increasing by appraisees and appraisers.

SARD JV has informed the MAC of its intention to develop its own audit tool, based on the ASPAT, which will be able to automate a lot of the data gathering currently done by this audit. The committee will consider this once it is available, a previous trial of the ASPAT tool in 2019 found that the Excellence Tool still provided better scrutiny of appraisal than ASPAT.

The audit will be repeated annually.

Please refer to **Appendix B.**

5.4. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD JV portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

5.5. Lay participation in medical appraisal

We were sorry that Ivars Reynolds, an experienced member of the Mental Health Managers Review Panels who served as a lay member of the MAC for several years, let us know in summer 2024 that he would be standing down. A rigorous recruitment and interview process was carried out in autumn 2024, and Anthea Foden, also a member of the Mental Health Managers Review Panels, has now taken up the role of Lay Rep on the MAC.

5.6. Clinical governance

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5-year revalidation cycle. This is greater than the national minimum standard (one completed cycle per 5 years) but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the Trust adheres to.

6. Revalidation recommendations

During the last year 25 revalidation recommendations were due; positive recommendations were made for 17 of these (68%), and 2 were deferred within the same financial year (12%) and 4 (16%) were deferred to the new financial year 25/26. 2 left before their revalidation was due (4%).

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as statutory and mandatory training compliance or completion of a multi-source feedback exercise.

See **Appendix C** for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at Gloucestershire Health and Care NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. All pre-employment checks for substantive doctors are completed before employment is started. These checks include:

- Occupational health clearance, including any night working
- Identity verification
- Qualifications
- Right to work
- Disclosure and Barring Service (DBS) enhanced level checks
- References from two line-managers over the last two years
- Medical Practice Transfer Form (information from previous Medical Director)

Please see appendix E.

8. Monitoring performance

The performance of doctors is monitored through the combination of perspectives provided by the following source materials and processes:

- ❖ Initial design of job description and person specification
- ❖ Effective recruitment and selection processes
- ❖ Job planning
- ❖ Peer group membership and attendance

- Appraisal
- Monitoring of serious incidents, complaints and compliments
- Participation in supervision
- Activity data
- Participation in continuing professional development (CPD)
- Completion of statutory and mandatory training
- Diary monitoring exercises
- Attendance/sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, clinicians and managers. Most also constitute areas that are considered as part of the appraisal process.

Please refer to **Appendix D.**

9. Responding to concerns and remediation

The policy on the 'Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners' provides a framework that interprets national policy and best practice for local delivery.

No doctors are currently in receipt of input within the framework provided by this policy.

Please refer to **Appendix D.**

10. Risk and issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year. This is largely due to the improved engagement of doctors achieved over recent years and also to the ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD JV software.

However, the sensitivity of the monitoring system, which allows no latitude in completion date before a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This impacts on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue, and one further expanded on in the Pearson review.

The scope of work that a doctor can undertake is determined by and determines their CPD and continuing medical education (CME) requirements. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective actions, improvement plan and next steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust Medical Appraisal Policy was reviewed during the appraisal year 21-22. There was a further review with minor updates made in 2024. Priorities for the MAC for the next year include further refinement of the number and nature of active qualified medical appraisers within the organisation, particularly in under-represented groups such as non-psychiatrists; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed annual appraisal are not eligible for routine pay progression; Gloucestershire Health and Care NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Committee is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

- Recognise the support provided to Appraisal and Revalidation within GHC through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this designated body to be appraised; however, there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of appraisals, appraiser performance, maintenance of appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.
- Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence.
- To note in particular the assurance in section 13 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. NHSE Statement of compliance

1A – General

The board/executive management team of Gloucestershire Health and Care NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None
Comments:	Dr Uppal is appointed as Responsible Officer, and a deputy is in place.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the Responsible Officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	Yes, this is maintained by Medical Director's office
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None
Comments:	The Medical Appraisal Policy was reviewed and minor updates made in 2024.
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	The annual medical appraisal quality assurance audit was conducted in April 2025 for the appraisal year 24-25 by the Medical Appraisal Committee (MAC).
Action for next year:	The audit is repeated annually by the MAC.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None
Comments:	A process is in place and this is actively monitored by the Medical Directorate team.
Action for next year	Continue with current provision

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC license to practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None
Comments:	Except those where there is an accepted reason agreed by the RO.
Action for next year:	Continue with current practice

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	None
Comments:	Yes, a full record of non-compliance and reasons for exemption is maintained by the Medical Directorate Team.
Action for next year:	Continue with current practice

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	None
Comments:	The Medical Appraisal Policy was reviewed and minor updates made in 2024.
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	None
Comments:	Appraiser numbers are regularly monitored by the MAC, and a recommendation made as to minimum and maximum number of appraisals undertaken per year for appraisers
Action for next year:	Continue with current practice

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	None
Comments:	10% appraisals audited annually for quality control, plus the first 3 appraisals by any new appraiser. Appraisers are monitored for attendance at update training. Feedback is

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	sought from appraisees and followed up by the MAC chair.
Action for next year:	Continue with current practice.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None.
Comments:	Annual audit of 10% appraisals, and the first 3 appraisals done by each new appraiser. This considers whether the appraisal has covered (at appropriate depth) scope of work, progress towards previous year's PDP, and a SMART PDP for next year which reflects the trust's aims and objectives. It considers whether appropriate challenge and support has been present, and whether the doctor is on course for successful revalidation.
Action for next year:	Continue with current practice

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the 'fitness to practice' of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None.
Comments:	A thorough system is in place with the Medical Directorate Team.
Action for next year:	Continue with current practice.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None.
Comments:	Doctors are informed at regular intervals of the status of their revalidation and what recommendation will be made. If a recommendation other than positive is made the doctor would be fully informed as to the reasons for this.
Action for next year:	Continue with current practice.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None.
Comments:	The appraisal system combined with job planning is an effective means of delivering effective clinical governance for doctors.
Action for next year:	Continue with current practice.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None.
Comments:	A thorough system is in place with the Medical Directorate Team.
Action for next year:	Continue with current practice.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None.
Comments:	A thorough system is in place with the Medical Directorate Team.
Action for next year:	Continue with current practice

1D(iv) There is a process established for responding to concerns about a medical practitioner's 'fitness to practice', which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and 'fitness to practice' concerns.

Action from last year:	None.
Comments:	A thorough system is in place with the Medical Directorate Team and supported by a current responding to concerns policy.
Action for next year:	Continue with current practice.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None.
Comments:	An annual report to the Board provides quality assurance regarding concerns.
Action for next year:	Continue with current practice.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None.
Comments:	Yes.
Action for next year:	Continue with current practice.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	None.
Comments:	Yes.
Action for next year:	Continue with current practice.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	None
Comments:	The chair of the MAC and the RO attend biannual "RO Network meetings" covering the SW region, where cases are discussed and relevant updates are shared. Information is then disseminated via email. The MAC chair also attends NHSE updates where changes to policy are shared.
Action for next year:	Continue with current practice

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None
Comments:	Induction to the trust is multidisciplinary and the same for all healthcare professionals joining the trust. Appraisal for non-doctors is captured on one unified system for all health professionals in the trust, using the same set of documentation. Compliance with appraisal and supervision is regularly monitored.
Action for next year:	Continue with current practice, continuing to review this against the Messenger Report guidance.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None.
Comments:	A thorough process is in place within Medical Staffing and HR.
Action for next year:	Continue with current practice.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None
Comments:	The appraisal and supervision system aims to support staff to develop their potential.

	Further incentives for excellence include the "better care together awards", where staff are nominated for making a difference, always improving, being respectful and kind, working together, tackling inequalities, outstanding achievement, and sustainability. Degree apprenticeships are offered internally to staff showing potential to develop their careers towards professional registration.
Action for next year:	Continue current practice.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity, and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None
Comments:	All staff in any kind of managerial position complete equality and diversity training. Our Chief Executive has brought in a method of contacting him directly and confidentially about any concerns. This is called "Direct to Douglas" and is an ican on all trust computers. It is alongside other methods of raising issues, including our Freedom to Speak Up Guardian network, via line managers, Staffside, Staff Forums, Bite Sized Briefing and more.
Action for next year:	Continue current practice

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None
Comments:	Champions in place across the workplace: • Health and wellbeing champions • Freedom to speak up champion • Guardian of Safe Working
Action for next year:	Continue current practice

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Action from last year:	None
Comments:	Every doctor is encouraged to seek 360 feedback from patients and relatives twice per revalidation cycle. Information about revalidation available in leaflet format at all trust premises. Formal complaints procedure via the Patient Experience Team; all complaints are uploaded by the RO office to the doctor's appraisal portfolio to ensure transparency.
Action for next year:	Continue current practice.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None
Comments:	All staff conducting investigations into complaints are regularly updated in equality and diversity training.
Action for next year:	Continue current practice

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None.
Comments:	Yes, the Medical Director attends network meetings and peer review programmes. Our appraisal lead attends the appraisal lead meetings when possible.
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2025	99

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions

is as recorded in the table below.

Total number of appraisals completed	97
Total number of appraisals approved missed	5
Total number of unapproved missed	8

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	23
Total number of late recommendations	0
Total number of positive recommendations	17
Total number of deferrals made	6
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	
Total number of trained case managers	
Total number of new concerns registered	
Total number of concerns processes completed	
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	
Total number of doctors referred to GMC	

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	93
Number of new employment checks completed before commencement of employment	93

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Actions still outstanding
None
Current issues
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Gloucestershire Health and Care NHS Foundation Trust

Name:	Graham Russell
Role:	Chair
Signed:	
Date:	

Appendix A - Audit of all missed or incomplete appraisals (as of 1st April 2025)

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	2
New starter more than 3 months from appraisal due date	1
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	1
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	1
Appraisal outputs not signed off by appraiser within 28 days	1
Lack of time of appraiser	0
Other appraiser factors (not known)	6
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe) Waiting for appraisal to be undertaken by different designated body and evidence provided.	0
Total	13
NB. Dentists employed by the Trust are currently subject to different monitoring arrangements and not included in the figures on this page.	

Appendix B - Quality assurance audit of appraisal outputs using the Excellence Tool

		Frequency (% in brackets)		
Number	**Criterion** (following scrutiny of the appraisal summary, score 0-2 for each criteria)	absent	room for improvement	well done
1	Includes whole scope of work?	0	2 (9%)	20 (91%)
2	Free from bias?	0	0	22 (100%)
3	Challenging & supportive?	0	5 (23%)	17 (77%)
4	Exceptions explained?	0	0	22 (100%)
5	Reviews & reflects?	1 (5%)	2 (9%)	19 (86%)
6	Review of previous PDP?	1 (5%)	3 (14%)	18 (82%)
7	Encourages excellence?	0	2 (9%)	20 (91%)
8	Gaps identified?	0	4 (18%)	18 (82%)
9	SMART PDP?	0	5 (23%)	17 (77%)
10	Relevant PDP?	0	5 (23%)	17 (77%)
11	Form A	1 (5%)	2 (9%)	19 (86%)

Appendix C - Audit of revalidation recommendations

Revalidation recommendations between 1st April 2024 to 31st March 2025	
Recommendations completed on time (within the GMC recommendation window)	25
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	25
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	n/a
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other – (late due to Staff unplanned absence)	
Describe other – Trust was in negotiations with Doctor and GMC	
TOTAL [sum of (late) + (missed)]	0

Appendix D - Audit of concerns about a doctor's practice
(1st April 24 to 31st March 25)

Please note this does not include information about dentists.

Concerns about a doctor's practice	High level[2]	Medium level[4]	Low level[4]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	0	3	2	5
Capability concerns (as the primary category) in the last 12 months	0	0	0	5
Conduct concerns (as the primary category) in the last 12 months	0	3	1	
Health concerns (as the primary category) in the last 12 months	0	0	1	
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2025 who have undergone formal remediation between 1 April 2024 and 31 March 2025 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	n/a
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practise procedures between 1 April and 31 March	2
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NHS Resolution assessments performed	0

Appendix E - Audit of recruitment and engagement background checks (1st April 2024 to 31st March 2025)

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	6
Temporary employed doctors	5
Temporary employed doctors who became substantive	0
Locums brought in to the designated body through a locum agency	0
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	82
Other: Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	
TOTAL	93

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)?

NB. MPIT forms from previous designated body

These forms provide information from previous Responsible Officer. This form is not required for all new doctors employed, i.e. trainees who are then appointed, bank staff, those under a different designated body, overseas etc.

*Includes some staff who were TUPE transferred from other provider.

	Total	Identity check	GMC issues	GMC conditions or undertakings	On-going investigations	DBS	2 references	Last RO	Reference from last RO	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Unresolved performance concerns
Permanent employed doctors	6*	6	0	0	0	3*	3*	2	2	0	0	3*	6	6	0
Temporary employed doctors	5	5	0	0	0	5	5	1	1	0	0	5	5	5	0
Temporary employed doctors who became substantive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Locums brought in to the designated body through a locum agency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Locums brought in to the designated body through 'Staff Bank' arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctors on Performers Lists	82	82	0	0	0	82*	82*	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc.)															
Total	93	93				90*	90*								

For Providers of healthcare i.e. hospital trusts – **use of locum doctors:**

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	0				
Medicine	0	156			156
Psychiatry	6.5	452	809		1261
Obstetrics/Gynaecology	1			25	25
Accident and Emergency	0				
Anaesthetics	0				
Radiology	0				
Pathology	0				
Total in designated body (Includes all doctors, not just those with a prescribed connection)	8.11	608	809	25	1442

Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	0				
3 days to one week	0				
1 week to 1 month	0				
1-3 months	0				
3-6 months	3	3	3	N/A	0
6-12 months	3	3	3	N/A	0
More than 12 months	6	6	6	N/A	0
Total	12	12	12	NA as most in post still	0

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Sally Morgan, Guardian of Safe Working Hours

SUBJECT: **GUARDIAN OF SAFE WORKING HOURS (**GoSWH)
Q1 2025/26 REPORT

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:

It was agreed in the 2016 national negotiations that all NHS Trusts employing trainees (resident doctors) were required to appoint a 'Guardian of Safe Working Hours' in order to work with resident doctors to ensure safe working practices during their training.

As part of that agreement, the Guardian of Safe Working Hours is required to provide quarterly reports to the Trust Board for assurance and information. This report is being presented to the Trust Board following consideration at the Great Place to Work Committee. We are required to use a national template.

Further information about role and requirements can be seen under point 1 – Introduction/Context.

Recommendations and decisions required

The Trust Board is asked to:

1. **Note** the report from the Guardian of Safe Working Hours.
2. **Note** ongoing issues are being addressed.
3. **Note** the historical open reports will be closed following agreement between trainees, the Guardian and DME.

Executive summary

- The exception reporting process is part of the new resident Doctors Contract to enable them to raise and resolve issues with their working hours and training.

- The Guardian's Quarterly report summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.

- The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered, and their working hours are complaint with the Terms and Conditions of Service (TCS).

Risks associated with meeting the Trust's values

- Providing suitable and safe training placements for resident doctors is essential for the Trust in terms of reputation and developing workforce.

- This data is monitored by CQC and NHS England.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Great Place to Work Committee – 26th August 2025

Appendices:	A. Quarterly Report

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

GUARDIAN OF SAFE WORKING

1.0 INTRODUCTION / CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for resident doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (Resident doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the resident doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Great Place to Work Committee and Board or equivalent body that doctors' working hours are safe.

1.3 The work of the Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by NHS England. These measures should ensure the safety of doctors and therefore of patients.

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is well established in the Trust now.

1.5 The Guardian's Quarterly Report, as required by the resident doctor's contract, is intended to provide the Trust's Board with an evidence-based report on the working hours and practices of resident doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2.0 REPORTS

2.1 These reports are made using the nationally agreed template. Please refer to the specific report for details on the exception reports made and actions taken.

2.2 Recent GOSWH report between the period of April to June 2025 submitted (Q1).

2.3 12 exception reports in this period, 11 relating to hours worked, 1 related to pattern of working. One exception report identified an immediate patient safety concern when an on-call resident doctor was late to turn up for a shift requiring the previous resident doctor to stay on late.

2.4 Outcomes agreed: 1x payment (for the immediate safety concern), the rest were TOIL.

2.5 There are ongoing challenges resulting in delays in exception reports being closed.

2.6 From 12 September 2025, significant reforms to exception reporting for resident doctors on the 2016 contract in England will come into effect. These changes aim to simplify processes, enhance doctor wellbeing, and ensure compliance with new legislative requirements.

2.7 Changes have been made in terms of exception reporting, enforcement measures and strict timelines are recommended with onboarding, submission window, processing time and time off in lieu (TOIL).

2.8 New reform would have an impact on medical staffing time, potential for increased fines, rolling fines and financial penalties for employers.

3.0 APPOINTMENT OF GUARDIAN OF SAFE WORKING HOURS

Dr Sally Morgan has been the Guardian of Safe Working Hours from July 2020.

4.0 EXCEPTION REPORTING REFORMS & IMPLICATIONS FOR GHC

4.1 These changes will apply to all resident doctors under the 2016 TCS in England, and any resident doctors to whom Trusts have given access to under the current system. Employers are encouraged to extend this to academic trainees, public health trainees, armed forces trainees, and locally employed doctors.

4.2 Key dates:

By 12 September 2025: Full implementation deadline for all employers – however as final details have not yet been shared with organisations it is possible this deadline may change.

From February 2026: Faster processing times (7-day deadlines), and all fines set at £500.
From August 2027: Formal national evaluation of reforms begins.

4.3 Key changes to exception reporting:

Simplified Exception Reporting: Introduction of a streamlined exception reporting form.

Direct Reporting Lines: Exception reports will be submitted directly to HR and the Guardian of Safe Working Hours, removing the need for supervisor approval.

Enforcement Measures: Trusts may face fines for non-compliance, including delays in onboarding doctors, slow processing of exception reports, or sharing report details with individuals not authorised to see them.

Strict Timelines:

Onboarding: Doctors must be onboarded onto an exception reporting system within 7 days of commencing work

Submission Window: Doctors have up to 28 days to submit an exception report

(can be greater if outside their control).

Processing Time: Reports must be processed within 10 days of submission.

Time Off In Lieu (TOIL): Needs to be arranged within 10 days (but not taken)

4.4 **Implications for GHC:**

Capacity - Impact on medical staffing time.

Financial - Potential for increased exception reporting and payment requests and for more fines.

All residents must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following ER, except when a breach of safe working hours mandates the award of TOIL. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents' consent. Additional hours reports go to HR and the GoSWH, not the supervisor.

Doctors' clinical judgement around working additional hours will not be challenged. Window to submit an exception report increased to 28 days.

Rolling fines for Employers who fail to onboard residents onto an ER system within 14 days of starting work.

Financial penalties for employers who breach new confidentiality processes for ER Data.

Changes to GoSWH reporting format – The GoSWH's quarterly reports (including annual summary reports) will be standardised to a national template co-produced in guidance to allow central data processing. Reports to be shared with national stakeholders, the LNC and also be available to the public.

Guardian of Safe Working Hours Report Part 1

- **Reporting time period April 2025 – June 2025.**
- GoSWH – Dr Sally Morgan.
- **Number of mental health resident doctors** 56 doctors in training posts during this time period (14 HTs, 9 CT3s , 10 CT2s, 5 CT1s, 4 GP trainees, 7 FY2s, 7 FY1s).
- **34 on call shifts had a resident doctor gap due to sickness.**
- 29 shifts were covered by our own resident doctors acting as locums and 5 by specialty doctors in our bank. There were no incidents of Higher Residents or Consultants having to step down during this time period.
- **There was a Resident Doctors Forum held on 27 June 2025 .**
- The **GoSWH webpage** on the intranet to provide information about GoSWH and exception reporting is now up and running.
- GoSWH continues to work with Modern Matrons from WLH and CLC to ensure adequate resident doctor office and rest spaces at both sites to take into account the increase in the numbers of residents.

Guardian of Safe Working Hours Report Part II

- **12 exception reports** in this time period, 11 relating to hours worked, 1 related to pattern of working. One exception report identified an **immediate patient safety concern** when an on-call resident doctor was late to turn up for a shift requiring the previous resident doctor to stay on late.
- 1 of the exception reports was created in error after a resident doctor who had moved posts reported to the wrong rota.
- Only 1 of the exception reports raised was by a Higher Resident about the hours worked on the non resident on call rota. This did not constitute a breach. The work schedule review about this rota appears to have been effective in reducing exception reporting.
- **Outcomes agreed** : 1 x payment (for the immediate safety concern), the rest were TOIL.
- **There are ongoing challenges resulting in delays in exception reports being closed** due to resident doctors and supervisors not completing the initial review meeting on Allocate in a timely way to document the agreed outcome.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/0925

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: Des Gorman, Deputy Director of Improvement and Partnerships

SUBJECT: **OUR FIVE-YEAR FOCUS: A STRATEGIC PLAN FOR BETTER HEALTHCARE SERVICES ACROSS GLOUCESTERSHIRE**

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 the Board with the final Trust Strategy for 2026-2031 for approval and confirmation of publication and communication with colleagues and stakeholders.

Recommendations and decisions required

Trust Board are asked to:

- **Approve** the final Strategy, confirming the Focus areas of the Trust for the next 5 years: Connecting services in local neighbourhoods, Children and Young People, Community Urgent Care, Inclusive Healthcare and Partnerships with Purpose.
- **Endorse** the approach to communication, delivery and next steps.

Executive summary

This paper presents the refreshed Gloucestershire Health and Care Foundation Trust (GHC) Strategy that sets out the Trust intention to build on the progress made since the 1st GHC Strategy 2021-2026 and identifies key strategic areas of focus for the Trust over the next 5 years to achieve our Trust Purpose "Helping you live your best life, through delivering great Healthcare," as well as the approach to designing, delivering and improving services under "Our ways of Working."

The paper also describes how we will align the Trust goals and Focus Areas through the Business Planning process for 2026/7 and the medium-term planning arrangements (launched in September's Planning Framework for the NHS in England) as well as recognising our contribution to delivery of the NHS 10-year plan.

In creating this strategy, stakeholder engagement and coproduction has been an ongoing part of the development process since March 2025. This has helped us develop our focus areas:

- Connecting Services in Local Neighbourhoods
- Children and Young people
- Community Urgent care
- Inclusive Healthcare
- Partnerships With Purpose

The Strategy will be kept under review to ensure that it delivers the intended benefits. We acknowledge the need for an iterative approach to the development of detailed change ideas and directorate plans, in order to ensure objectives, remain achievable, in light of the changes taking place at a national, regional and local NHS policy and organisational level and to align our resource requirements.

Risks associated with meeting the Trust's values

The development of the new Strategy is mitigation against BAF 7

- A risk that the Trust is unable to adapt in an agile manner to the rapidly changing policy environment and needs and expectations of the population resulting in opportunities for improvement being missed or delayed impacting on the quality services provided."

The development of Focus areas (1) Partnerships with Purpose & (2) Inclusive Healthcare under the new Strategy are mitigations for BAF 5 - Relationships and Partnership working and BAF 10 – Health Equity respectively.

Corporate considerations -	
Quality Implications	N/a
Resource Implications	Following approval of the Strategy the Trust will use its business planning process to manage the resource allocation and re-prioritisation associated with delivery
Equality Implications	The Trust will ensure any new programmes of work and/ or directorate business plans follow Trust EQIA processes

Where has this issue been discussed before?
Iterations of the Strategy have been developed directly with colleagues, patients, partners and the board over the last 6 months. The approach to the Strategy engagement process was agreed by the Board in May 25.

Appendices:	

Report authorised by:	Title:
Rosanna James	Director of Improvement and Partnerships

TRUST STRATEGY REFRESH

1. BACKGROUND AND CONTEXT

As we approached the final year of the current Gloucestershire Health and Care (GHC) Strategy, the Trust Board agreed that the Trust should enter a period of engagement and co-production to test our Strategic Framework and provide greater clarity on our strategic priorities for the next five years.

A six-month engagement programme took place from April to September 2025. During the programme the Trust tested reflections on our purpose, values and behaviours, how we want to work together (both with colleagues and with external partners and the public) and potential key areas of focus over the next 5 years. The publication of Government's 10 Year Health Plan for England in July 2025 enabled us to test in our engagement discussions that there was clear alignment between our emerging areas of focus and the three fundamental shifts launched in the 10-year plan.

In August 2025 NHS England also published a new national planning framework that sets out new responsibilities for provider trusts and Integrated care Boards. This Framework sets out the key role and responsibilities for ICBs, Providers, Regions and National Organisations in the planning process. ICBs are required to lead the system level strategic planning and set overall system Strategy to inform allocation of resources, to improve population health through outcomes-based commissioning and to ensure equitable access to healthcare.

For GHC, this presents both challenges and opportunities in contracting, strategic partnership development, and influencing system-wide priorities. Central government policy may evolve during the lifecycle of our Strategy, and the creation of a new ICB cluster arrangement could result in a change in strategic emphasis. Our five focus areas will not change over the next 5 years, but we will remain agile, with governance and planning mechanisms that allow us to respond and adapt effectively within the priorities we have set out. Long-term financial sustainability is also critical and features as part of our Sustainability goal. Our Strategy will be underpinned by robust financial planning that reprioritises resources and potentially supports additional investment in transformation, workforce development, and digital innovation where necessary to achieve our goals.

2. ENGAGEMENT AND CO-PRODUCTION

To help shape our five-year focus and in line with our Trust value of "Working Together", we listened to people across Gloucestershire — including people who use our services, local communities, our colleagues, and the organisations we work alongside. Between March-August we have had conversations and analysed survey responses from over 1,200 people. The views of our colleagues and stakeholders have greatly influenced our Strategy and the ongoing involvement of them in delivery and shaping how we realise our goals will be a key factor in its successful delivery. We also included information and insights we've collected over time and from different sources:

- Feedback, complaints and comments.
- NHS staff survey results
- Healthcare reports, including Healthwatch, Inclusion Gloucestershire, Black Lives Matter, People Panel, and Joining up Insights Gloucestershire
- Information and insights shared by providers and community groups about local healthcare issues.
- Gloucestershire's Joint Strategic Needs Assessment helped us understand our population health needs and inequalities.
- NHS 10-year plan 'Fit for the Future' – published July 2025

Alongside information to shape the five focus areas, we heard some important messages that feature in the content and approach of our Strategy:

- We don't always get the basics of healthcare right.
- People expect joined up care.
- We need to include the experience of colleagues as part of healthcare planning.
- Communication needs to be clear and use everyday language – 'not NHS speak'.
- The way we organise services sometimes makes it hard for people to get the healthcare they need, and we should be deliberate in our attempts to improve healthcare equity
- Saying 'Community Services' doesn't make what we do or don't do clear – the public struggle to differentiate at times between our services, general practice and services provided by other NHS Trusts.

These messages have particularly shaped the 'Our ways of working' component of our Strategic Plan (set out in Section 3). Our ways of working will be used to test and inform our transformation and improvement approaches to ensure that our ongoing design, delivery and improvement of services is guided by some specifics on how we do things in GHC. They also provide a guidance framework for day-to-day service delivery.

3. OUR FIVE-YEAR FOCUS: A STRATEGIC PLAN FOR BETTER HEALTHCARE SERVICES ACROSS GLOUCESTERSHIRE

Our public facing materials start with descriptions about "Who we are" then summarise in a plan on a page format:

- Our purpose & goals ("Why we are here"),
- Our focus areas ("What we will do") and,
- Our ways of working and enabling Strategies ("How we will do it")

.. all of which are underpinned by the Values of the Trust: Working Together, Always Improving, Respectful and Kind, Making a Difference. Finally, there is more detailed content on each of the five areas of focus *(* please note, the final look and format of the focus areas and "Who we are" are under development with the Comms team).*

Exec Plus Amendments

Strategy Refresh

Rosanna James, Director of Improvement and Partnerships

We provide 96 different types of community health services, including mental health and learning disabilities, and work in partnership with GPs, Gloucestershire Hospitals in Cheltenham and Gloucester, local authority, education, community groups, and the voluntary and charity sector.

Gloucestershire has more older people than many other places in England and by 2043, the number of people aged **85 or over** in Gloucestershire is expected to increase by **84%** . This means more people may need help with long-term illnesses, memory problems like dementia.

The number of people with learning disabilities in Gloucestershire is similar to the rest of the country. But more people are being diagnosed now, so more support will be needed in the future.

More young people and adults are also asking for help with their mental health. This shows that people are starting to understand how important it is to get help early.

In Gloucestershire, people don't all live the same number of years in good health (health life expectancy). Some areas are better off than others. People who live in poorer areas can expect to live about **11 years less** than those in wealthier areas.

In the next few years, Gloucestershire's health services will need to work better together. Services need to be fair, easy to use, and ready to help everyone, wherever they live.

In a typical month...

GHC teams travel **300,000** miles

17,000 calls to 111

8,200 attendances at Minor Illness and Injury Centres

85+
SITES

175
PHYSICAL HEALTH BEDS

157
MENTAL HEALTH BEDS

407,720
REFERRALS

1,072,352
CONTACTS

6,295
COLLEAGUES

11,000
ADULTS REFERRED TO TALKING THERAPIES

£340m
BUDGET

58,000
SCHOOL PUPILS COVERED BY YOUNG MINDS MATTER (63% OF COUNTY TOTAL)

There when you need to...

Stay Well

Health promotion and prevention of illness - immunisations, health checks, monitoring of conditions, diagnostics, lifestyle advice, and early interventions.

Get urgent care

When you need help, fast and close to home - Minor Injury and Illness Units, Rapid Response, Mental Health Crisis, Sexual Assault Referral Centre, and Integrated Urgent Care.

Get treatment

Care for short term and ongoing conditions - specialist services, specialist dentistry, talking therapies, inpatient care, and minor procedures.

Recover

Helping you feel stronger and more independent - physical and mental health rehabilitation, therapies, psychological support, and community hospital services.

Live Well

Supporting you with long term conditions - community teams, equipment services, complex care, children's community nursing and therapies.

and much more!

Our Five-Year Focus: our strategic plan for better community health and care services across Gloucestershire

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

WHY WE ARE HERE

Our purpose

Helping you live your best life by delivering great healthcare.

Our goals

Better Health
Work together to improve the health of all people in Gloucestershire.

High Quality Care
Inclusive and timely access, great experiences, and better outcomes.

Great Place to Work
Be the place where people enjoy working, learning and building a career.

Sustainable Services
Great value services for healthier people, stronger communities, and a greener world.

WHAT WE WILL DO

Our focus areas

Connecting services in neighbourhoods
Working together for better local health

Children and young people
Helping children thrive and build resilience for a healthier future

Community urgent care
Helping people manage urgent healthcare needs and stay well

Inclusive healthcare
Reducing the gap of access, experience and outcomes

Partnerships with purpose
Deepening our partnerships to deliver great healthcare

HOW WE WILL DO IT...

Our way of working - with you, for you

We will design, deliver and improve all our services, guided by what matters most...

- Getting the **basics** right: safe, accessible, effective, and timely
- Working **with people**, not just for them
- **Joining up** healthcare across services
- Helping people **stay well** and in control
- Making the most of everyone's **skills and experience**
- Making good **use of resources**
- Using **technology and new ideas**
- Making healthcare as **local** as possible

Helping us deliver
Our enabling strategies–Quality, People, Estates, Digital and Research help us deliver safe, effective, and efficient health and care services

Connecting services in neighbourhoods –working together for better local health

Why is this a focus?

In Gloucestershire, around 1 in 5 people live with multiple long-term health conditions like heart disease, diabetes, mental illness, and frailty—especially as they age. We have one of the fastest-aging populations in England, and about 40% of over-65s experience frailty, meaning they recover less easily from injury, illness or stress and often need more healthcare, emergency and unplanned hospital stays.

No matter your age or health need, services can feel disconnected and hard to use because they often focus on single health issues rather than the whole person. This leads to people being passed between services and missing out on consistent, joined-up care—which can improve health, and reduce hospital visits.

Health is shaped by where people live, not just the care they receive. Communities, frontline teams, and residents understand what works and challenges in local neighbourhoods. Using a 'think local, act personal' approach, we can build on community strengths, reduce inequalities, and deliver better, joined-up care closer to home.

What do we want to do?

- Explore and align our services with Primary Care, Social Care, VCSE, Hospital Care, and Education into neighbourhoods where this makes sense.
- Offer more holistic, personalised care based on what matters to the person.
- Shift from sickness to prevention by helping people get the right support to help them stay well and able to manage their health and wellbeing needs in their local community and avoid unplanned hospital stays.
- Strengthen integrated neighbourhood teams across mental and physical health and learning disability with a focus on continuity of care.
- Support local leadership and co-designed care models.
- We will review how our buildings can better serve communities and be part of co-designing community hubs that offer joined-up, accessible care in locations that work for people.

How are we going to do it?

- Our starting focus is on frailty, due to Gloucestershire's aging population. Over the next five years, we'll expand our care models to support people with multiple conditions across all age groups.
- Test different ways of working in partnership with GPs, social care, local voluntary and community groups to deliver healthcare and support that makes the most of every contact, improves continuity of care and shares information effectively.
- Use data and local insights to understand what each neighbourhood needs, and co-design solutions with residents, partners, and colleagues.
- Equip colleagues with the tools, training, and time to lead local change—supporting them to use broad skills and take positive risks as part of shared decision-making.

> "Have more care available locally rather than having to travel to one of the big hospitals."
> A member of the public

> "I really could have done with better communication as to who did what."
> A member of the public

> "…continue as much independence as possible – avoid inpatient care"
> A member of the public

> "We need to think about our ageing population... start the foundations of building and preparing how our services need to look"
> A colleague

Children and Young People –Helping children thrive and build resilience for a healthier future

Why is this a focus?

In Gloucestershire, like the rest of the country, children's health and wellbeing is getting worse—with more social, physical and mental health problems, longer waits for care, and more young people in crisis.

- 1 in 7 children under 16 live in absolute poverty.
- Absent from school rate has increased to1 in 5 pupils

In the last 5 years, Gloucestershire has seen:

- 500% increase in the number of children needing support in a mental health crisis.
- 600% increase in referrals for eating disorder services.
- The growing number of children and young people trying to access mental health services, speech and language therapy, and for Autistic Spectrum Disorder and ADHD assessment means that GHC is not meeting demand in some of our services, leading to late intervention and increasing complexity. We can not solve the problems that impact the health and wellbeing of children and families alone. This needs to be a system wide approach.

What do we want to do?

- Get the basics of healthcare right. This means making sure children, their families and carers have safe, accessible, effective, and timely healthcare across all mental and physical health, learning disability, and autism services.
- Build services around children and families that are made available in the places children spend most of their time, such as schools and local neighbourhoods.
- Find ways to collaborate to connect health, social care, education, and community groups to provide intensive support in the community as an alternative to hospital admission and as safe step-down service where appropriate.
- Strengthen early intervention by making sure practitioners, education, families, and communities can access the right support and information when it's needed - so children and young people get help before problems grow.

How are we going to do it?

- Expand the youth network to co-design healthcare with children, young people and families.
- Make sure all schools have access to early mental health support through Young Minds Matter.
- Use data to spot and tackle unfair healthcare differences experienced by children and young people and their families.
- Build connectivity within our children's system colleagues to join up information and support plans.
- Work to develop specialist community based mental health care for young people to avoid admission to hospital where possible.
- Use digital tools to make access and communication easier for young people and families.
- Promote a 'Think Family' approach—supporting parents and carers who use adult services.

> "Reduce waiting time…it's confusing where to go and who to talk to whilst waiting"
>
> A youth participant

> "Stopping one size fits all care. I want colleague to "get me". I am much more than my diagnosis"
>
> A youth participant

> "Make language simple – stop making it technical"
>
> A youth participant

> "My mum has to take half a day off work to get me to an appointment… and travels miles..."
>
> A youth participant

Community Urgent Care - Helping people manage urgent health needs and stay well

Why is this a focus?

When a person's health is getting worse because of an injury, illness, or a long-term condition, too many result in an avoidable health crisis, a hospital attendance, admission, or diagnostic testing.

- Access to urgent care is inconsistent—especially for people with mental health problems and learning disability.
- Sometimes an admission is not just about a person's health but includes equipment, social, and care needs.
- Urgent and emergency care services can feel confusing and fragmented

Emergency services are under pressure—and we need strong community alternatives to support people recover from illness or injury, to feel confident and safe about home treatment, or to access support in a local safe place.

What do we want to do?

- Work in partnership with people and services to spot early warning signs and act before urgent or emergency care is needed.
- Grow urgent community healthcare teams for same-day and 2-hour support.
- Strengthen 24/7 crisis for mental health and community learning disability healthcare.
- Work with partners to reduce delays when people are ready to leave hospital and go home.
- Provide alternatives to A&E and hospital stays, including creating safe spaces and step-up care.
- Improve coordination with NHS 111, primary care, ambulance and acute services through our Integrated Urgent Care Service (IUCs) and a new Single Point of Access to help people to the right service.

How are we going to do it?

- Co-ordinate multi-disciplinary urgent proactive response teams
- Support colleagues to respond to complex needs with competency, capability, confidence and compassion.
- Create joined-up urgent care pathways for physical, mental health and learning disability needs.
- Use digital tools for virtual support and expand virtual wards.
- Shape safer, more compassionate crisis care by listening to lived experience.
- Focus on developing joined up and person- centred healthcare planning and self-management at home or in a place where people feel safe to help early intervention.
- Use "what matters to me" conversations to understand people's needs and work alongside carers and families.
- Partnering with VCSE organisations on the mental health crisis pathway.

> "Stop bouncing people between services and shorten wait times, improve continuity and better communication"
>
> A member of the public

> "Provide clearer info about what people can do to help selves"
>
> A member of the public

> "Just knowing that help is there when it's truly needed, without long delays, would make all the difference"
>
> A member of the public

Inclusive healthcare - reducing the gaps for access, experience, and outcomes

Why is this a focus?

In Gloucestershire, the gap between people who have the best and poorest health is getting worse. This includes how long people are likely to live, the health conditions they may experience, and the care that is available to them. People living in poorer areas, ethnic minority groups, vulnerable people, and those living in rural areas often face unfair and avoidable differences in health.

- 20,000 people in Gloucestershire live in England's most deprived areas: their healthy life expectancy is about 11 years lower; higher rates of urgent care; and have more health problems that are avoidable if treated earlier.
- Poverty in rural Gloucestershire can be hidden and has added problems like travel costs, less local services, digital exclusion, and isolation.
- Physical and mental health are closely linked, but support isn't equal.
- National data shows people with a learning disability or Autistic people die about 20–25 years earlier than the general population.

What do we want to do?

- In partnership with Strategic Commissioners develop a stronger understanding of Gloucestershire's population health.
- Work to people with lived experience so that we design better healthcare.
- Identify and close gaps in access, experience and outcomes for people and communities that have barriers to healthcare.
- Personalise care for people with long term conditions and health needs that are complex or involve multiple services e.g. mental health and housing or people with Learning Disabilities and physical health needs.
- Strengthen our role as an anchor institution by using our resources, influence, and partnerships to support local communities, tackle root causes of inequality.
- Create a culture that values diversity and cares for everyone.

How are we going to do it?

- Put our Health Equity Framework plans into action focusing on: Increasing Awareness; Improving Data Quality; and Making Communication Clear and Inclusive.
- Build trust and connections with communities, led by our Working Together Network, to inform, develop, and monitor inclusive practice.
- Develop and put our anti-racist PCREF (Patient and Carer Race Equality Framework) plans into action by working with our local communities.
- Train colleagues in inclusive practice, cultural competence, and trauma-informed care.
- Work with our partners to reduce the risk of digital exclusion and ensure new ways of accessing care don't leave people behind.
- Make our communication clearer using language that people understand.

> "..we need to reach out to under - represented communities and groups across Gloucestershire"
>
> A colleague and carer

> "Communication, communication, communication… at a levels of the NHS in a form that ALL patients can understand"
>
> A member of the public

> "Transport and isolation is a huge issue in the north Cotswolds"
>
> A member of the public

> "LGBT+ patients with severe mental health issues... the current (NHS) pathways are failing both"
>
> A member of the public

Partnerships with purpose –deepening our partnerships to deliver great healthcare

Why is this a focus?

The NHS is under growing pressure, with high demand and limited resources. No single organisation can meet the complex health and care needs of Gloucestershire's population alone. Better health outcomes depend on effective joined-up work across NHS, social care, voluntary, community and education sectors.

Our partners - especially in local government, VCSE and lived experience networks - hold deep insight, trust, and reach into communities.

When we act with shared goals, we can deliver better care, faster support, and stronger communities.

What do we want to do?

- Turn partnerships into practical action that makes care more joined-up, accessible and impactful.
- Deepen collaboration across health, care, VCSE, housing, education and criminal justice
- Develop shared goals and delivery plans that tackle local priorities together
- Build and support partnership teams at neighbourhood, place and system level
- Embed VCSE and lived experience voices into planning and governance
- Share resources, data and insight to improve decision-making
- Design pathways that span mental health, physical health, LD and social care

How are we going to do it?

- Partnering with intent to increase trust, transparency and shared leadership.
- Invest time and resource in building relationships
- Create local delivery partnerships with shared leadership and accountability
- Involve people with lived experience from the start - not after the plan is written
- Develop shared dashboards and outcomes to track impact together
- Where is makes sense, align funding, priorities and colleague development to enable truly joined-up working

> "Join up working throughout the county... healthcare, social care, police and other emergency services all sharing information"
>
> A colleague

> "Get the basics right - listen to people and communities, strengthen relationships with partner organisations, build trust..."
>
> A community partner

> "Better work between different teams and simple for people who need to …work with different teams"
>
> A member of the public

> "In the last year my treatment was hampered by (people) not being able to see inputs from other clinicians or GHC services"
>
> A member of the public

4. IMPLEMENTING OUR STRATEGY

4.1 Alignment with Business and operational planning

Our 2025-2031 Strategy launch aligns well with the launch of our integrated business planning and budget setting process on 24th September and gives us the opportunity to provide clear Strategic context and priorities to the setting of business objectives for 26/27 and our medium-term plans. Our internal planning cycle has been revised to align with the new Planning Framework for the NHS in England that was published on the 13th August 2025. The new Planning Framework sets out core principles and key planning activities including an indicative timeline for development and submission of our Trust Operational Plan by the end of December 2025.

Our refreshed Strategic Goals and Focus Areas will be articulated and discussed as a key component of the business planning launch and have been built into our business planning templates. This will enable us to review and report on the ways in which our business objectives at Directorate level are contributing to the delivery of our Strategy. Being able to report on cross directorate objectives against the Focus Areas also enables identification of opportunities to integrate delivery plans so that we are working across teams to deliver integrated solutions in these areas of high strategic priority, with the share responsibility and ownership that this engenders.

Early consideration is also being given to the development of the metrics, with a renewed focus on outcome measures, that will provide assurance that we are delivering on the aspirations and commitments within our Strategy, and these will be identified within the business plan, together with clear milestone deliverables that will be tracked through our usual process.

4.2 Refresh of the current Enabling Strategies

Our Enabling Strategies are key to the delivery of our Strategic goals. The following Enabling Strategies will be refreshed over the next 6-12 months, with a particular focus on supporting the delivery of business and operational plan objectives that underpin our Focus Areas, as well as a longer view of the roadmap required to deliver the NHS 10-year plan and the ‘three shifts’.

- Quality
- People
- Estates
- Digital
- Research

5. Communicating our Strategy

We will launch the Strategy both inside and outside of the Trust, starting with Senior Leadership Network on 30 September. Following that, we will utilise a wide range of tools including a graphic video to be shared via a global email, a story on our intranet and in Indi-to-go, inclusion in CEO weekly email, and a post on our staff Facebook group. We will then share the Strategy in any relevant gatherings, such as the roadshow (working title ‘Great Place to Work roadshow’) being held in November, our diversity network meetings, and will update wall graphics with our new Vision and

key messages. We will ensure the new Strategy is also promoted in corporate induction sessions for new colleagues.

Externally, we will update our Trust website and share posts on social media. For members we will include a feature in our next membership newsletter and send out a membership e-flyer. In November we have an opportunity to share the Strategy at our next Working Together Network meeting for discussion and enable members to share the link with their networks. A similar approach will be taken with the Youth Voice community of practice, involving experts by experience and a network of health providers, community group, education, and VCSE partners. The Partnership Team attend regular partnership meetings and events representing GHC across the county, such as Integrated Locality Partnership, Partnership Boards, Know Your Patch, and community outreach events. We will use such opportunities to circulate and talk about the Strategy enabling us to reach GP's, Local Authority, social care, education, and VCSE partners along with faith and community leaders and members of the public.

Both the internal and external approach will enable us to understand how the Strategy is received and collect feedback. Blending NHS national and local priorities, views, learning, and experience has enabled us to test ideas and make changes to new features of the Strategy - the five focus areas and the way we work to design, deliver and improve services. We will keep the conversation live to ensure the working version of the Strategy continues to resonate with people; and as we develop the next stage of the Strategy, including implementation plans, success measures, and performance indicators.

6. STRATEGIC DELIVERY

6.1 Setting Clear and Measurable Goals

Delivering the Trust Strategy requires a structured, transparent, and inclusive approach that translates strategic intent into meaningful action across the organisation. This involves setting measurable goals, aligning operational plans, fostering leadership at all levels, and ensuring clear communication throughout the Trust.

The Trust has an established set of Key Performance Indicators (KPIs). Through a comprehensive review of its enabling strategies over the next 12 months alignment of these to the Strategy will take place. KPIs aligned with strategic priorities are monitored regularly to ensure progress. In areas where broader system measures are more appropriate, such as in the focus on Neighbourhood Health, we will agree evaluation criteria with partners and may choose to have ICS wide performance metrics to track the system wide impact vs, activity or performance metrics for GHC alone. We recognise that indicators for partnership working need a focus on qualitative and relational measures and we will co-design this with stakeholders. We started this process with our Executive-Plus session on 15th September 2025. Business planning objectives will be clearly defined and supported by quarterly milestones, enabling directorates to track delivery and adjust as needed. A renewed focus will be placed on outcome measures that reflect the impact on people who use our services, moving beyond activity-based metrics to those that demonstrate improvements in health, independence, and equity.

6.2 Shared Responsibility and Ownership

The delivery of the Strategy will be supported by a distributed leadership model, ensuring that leaders and teams at all levels understand how their work contributes to strategic goals:

- Strategic initiatives will be deliberately prioritised and resourced through workforce and operational planning.
- Quality improvement will be embedded in everyday practice, linked to the development of new National Delivery Frameworks
- Executive Directors will consistently reference strategic goals in meetings and service design conversations.
- Strategic goals and Focus Areas will be used in team and individual appraisals to guide planning and reflection.
- Leadership programmes will support delivery with targeted training in areas such as partnership working, health equity and sustainability.
- Executive Directors will reinforce strategic alignment through day-to-day conversations and meetings, and leaders will dedicate time to strategic initiatives, helping teams understand their role in achieving the Strategy

6.3 Visible re-prioritisation of resources

Resource re-prioritisation will be approached deliberately and transparently, with strategic priorities reflected in workforce plans, transformation programmes, and operational delivery models and management structures. This ensures that the Trust has the capacity and capability to deliver on its ambitions, whilst maintaining its goals on financial sustainability. Transformation and Quality Improvement resources in service of the changes needed to deliver plans associated with the Focus Areas will be adjusted as we enter 2026/27 to deliver the greatest strategic impact for GHC.

6.4 Monitoring

Committees will be with monitoring key data and measures, and the Board will use development sessions to explore strategic priorities in depth. An annual refresh of operational plans will be incorporated into a rolling five-year planning cycle to maintain relevance and responsiveness.

The delivery of Enabling Strategies will be closely monitored through the relevant Board Committees and triangulated with business plan delivery each year to ensure that we are providing the necessary support to the delivery of our Focus Areas and can reallocate resources and review in year prioritisation as required to ensure that we are delivering on our strategic aspirations in a balanced way, across all domains.

7. RECOMMENDATION

The Trust Board are asked to **Approve** the final Strategy, confirming the Focus areas of the Trust for the next 5 years: Connecting services in local neighbourhoods, Children and Young People, Community Urgent Care, Inclusive Healthcare and Partnerships with Purpose and **Endorse** the approach to communication, delivery and next steps.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25th September 2025**

PRESENTED BY: Rosanna James, Director of Improvement and Partnership

AUTHOR: James Powell, Head of Sustainability, Georgia Taylor, Sustainability Project Manager, Nicola Moore, Associate Director of Transformation

SUBJECT: **GREEN PLAN REFRESH – FINAL DRAFT**

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 a final draft copy of the Green Plan Refresh for endorsement from the Trust Board.

Recommendations and decisions required

The Trust Board is asked to:

- **Note –** this final draft was presented to Resources Committee on the **28th August** where Green Plan goals, aims and risks were endorsed.
- **Note –** this is a final draft version of the Green Plan Refresh for 2025-2028.This Word document is for internal use and governance purposes only, it is not intended for public use. The communications team will develop this Word document into a public-facing documents to meet Green Plan guidance and guided by NHS accessible standards. Case studies for some sections are in the process of being finalised by operational leads and will be added to public facing documents.
- **Note:** This Green Plan Refresh meets all national Green Plan Guidance, including the addition of Greenspace and Biodiversity. A separate reporting dashboard for the detailed Green Plan objectives is under development and will be presented to Execs/Resources committee in October 2025.
- **Approve** – Green Plan Refresh content, specifically the three overarching goals (including one new non-carbon-based goal) in section 2.1. and the nationally mandated Aims for each area of focus in sections 2.2.

Executive summary

The Green Plan refresh 2025-2028 is an updated version which builds on the success of our existing Green Plan from 2022-2025. Once the content has been signed off by the

Board on the 25th September 2025, two separate versions (full detail and accessible version) will be designed into a public-facing documents working with the Comms Team.

The Green Plan Refresh includes two goals which are based on NHS carbon footprint targets:

1. NHS carbon footprint to reach net zero by 2040 (direct emissions from estates and travel)
2. NHS carbon footprint plus to reach net zero by 2045 (indirect emissions from supply chain, patient and visitor travel)

A third goal has been introduced which is a non-carbon-based target to recognise our strategic intent to broaden organisational involvement in delivery of the Green Plan.

3 By 2028, we will integrate sustainability into wider Trust service delivery and key governance processes to enhance patient care, make best use of resources and reduce waste.

Wider engagement has taken place with multidisciplinary teams to develop the more detailed objectives, and these are being built into the Green Plan Dashboard, which will be completed for sign-off following the overarching plan in October 2025.

The Green Plan Refresh consists of 9 mandatory areas of focus and 1 optional as per national guidance. Areas of focus are used to improve sustainable development across the NHS which are carbon intensive or have an environmental impact.

<u>Mandatory</u>

- **Workforce and Systems Leadership** (to enable the transition to net zero, the Trust will support their staff and leaders to learn, innovate and embed sustainability into everyday actions).
- **Sustainable Models of Care** (strong clinical leadership of transformation to ensure high-quality, preventative, low carbon care is provided to patients at every stage).
- **Digital Transformation (**prioritise sustainability and low carbon in the procurement, design and management of digital services).
- **Medicines** (building on progress to reduce “point of use” emissions, while improving patient care and reducing waste).
- **Travel and Transport** (decarbonise NHS travel and transport, while also providing cost savings and health benefits).
- **Estates and Facilities** (to seek opportunities across the NHS Estate to reduce emissions and lower costs, while improving energy resilience and patient care).
- **Supply Chain and Procurement** (to embed circular solutions, such as reusable, remanufactured or recycled items where clinically appropriate).
- **Food and Nutrition** (building on current success to deliver high-quality, healthy and sustainable food and minimise waste).
- **Climate Adaption** (resilience and adaption will be built into business continuity and longer-term planning to avoid climate related disruptions and participating in countywide climate vulnerability risk assessment).

Optional

- **Greenspace and Biodiversity** (seek opportunities to enhance Greenspaces that improve health in local communities whilst increasing biodiversity net gain.

Progress against linked goals within the Green Plan Refresh will be monitored through the Green Plan Dashboard and progress of delivery of Green Plan objectives will be governed by the Sustainability Programme Board (SPB). Bi-annual updates will be presented to the Resources Committee to provide assurance that the sustainability programme is on track for delivery, and an annual carbon footprint report will be submitted to the Board to ensure that the Trust is making progress by reducing emissions and is on target for achieving NHS net zero goals.

Year-1 of Green Plan delivery will focus on establishing Clinical leadership and developing a training offer to improve knowledge and integrate sustainability into clinical pathways. This will be underpinned by embedding sustainability into core processes for Quality Improvement, Transformation, and the Quality Equality Impact Assessment (QEIA). This will enable the sustainability team to harness opportunities and realise the potential of environmental, social, and financial (CIP) benefits from improvement and change management projects. Teams leading on projects that optimise sustainability benefits will be considered for a Sustainability Recognition Award.

Risks associated with meeting the Trust's values

- See Risk section
- Reputation – Failure to achieve the mandated targets by NHS England may impact our reputation

Corporate Considerations	
Quality Implications	n/a
Resource Implications	See Risk section re reduction in external funding sources
Equality Implications	n/a

Where has this issue been discussed before?

Board development seminars held on the 4th December 2024 and 15th May 2025.

Please note: the Sustainability Maturity Model used in the session has been updated. This version better aligns with our strategic priorities and introduces a bridging element between efficiency and long-term viability, reflecting the scale of change required to progress between levels. This means the numerical levels have changed but the underlying meaning remains the same.

Appendices:	

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

GREEN PLAN REFRESH 2025-2028 – FINAL DRAFT

SECTION 1
INTRODUCTION, PROGRESS TO DATE AND BACKGROUND

1.1 About Us

Gloucestershire Health and Care NHS Foundation Trust provide joined-up physical health, mental health, learning disability and autism services for all age groups. We employ over 5000 people and provide care throughout Gloucestershire. The majority of our services are provided in people's own homes or community clinics; the Trust also operates 6 community hospitals, as well as inpatient mental health, learning disability, and recovery units.

1.2 Green Plan

Our first 3-year Green Plan launched in 2022 and expired in the 25/26 financial year. This updated version builds upon our progress to date and follows the latest NHS Green Plan Guidance.

Our vision and net zero commitments remain the same, but our goals over the next 3 years have changed to align with new national targets.

Areas of Focus

Previously, we reported progress under 4 priority themes (Net Zero, Sustainable Models of Care, Equity and Procurement and Workforce and Systems Leadership). To improve accessibility and to align with new Green Plan guidance, we have simplified the structure so that each area of focus is a standalone heading.

A flexible Strategy

Previously, we included a detailed list of objectives under each area of focus. In this Green Plan, we have moved these objectives to an internal dashboard. This gives us more flexibility to update our actions as priorities change over time.

Clear Language and Terminology

We have simplified the language in this strategy to make it more accessible and aligned with the national Green Plan Guidance. Where technical terms are necessary, we have included a Glossary in Appendix A to support understanding.

1.3 Introduction

Climate change is primarily caused by rising carbon emissions from burning fossil fuels. This leads to more extreme weather, air pollution and impacts everything, from food systems to healthcare services.

Climate change also impacts our health. Higher temperatures cause more heat-related illnesses. Increased rainfall causes more flooding. Pollution causes poor air quality, which leads to cardiovascular diseases. These challenges impact us all and the NHS.

At the same time, the NHS produces a lot of carbon as we use a lot of resources to keep our health services running 24 hours a day, 365 days a year.

To reduce this, we need to stop adding carbon to the atmosphere, which is known as net zero. The UK has committed to becoming a global leader in tackling climate change, building on the impact of the Industrial Revolution.

This Green Plan sets out how our Trust will reduce our carbon emissions and improve population health. It builds upon our previous Green Plan, reflecting national policy changes and the progress we've already made to date.

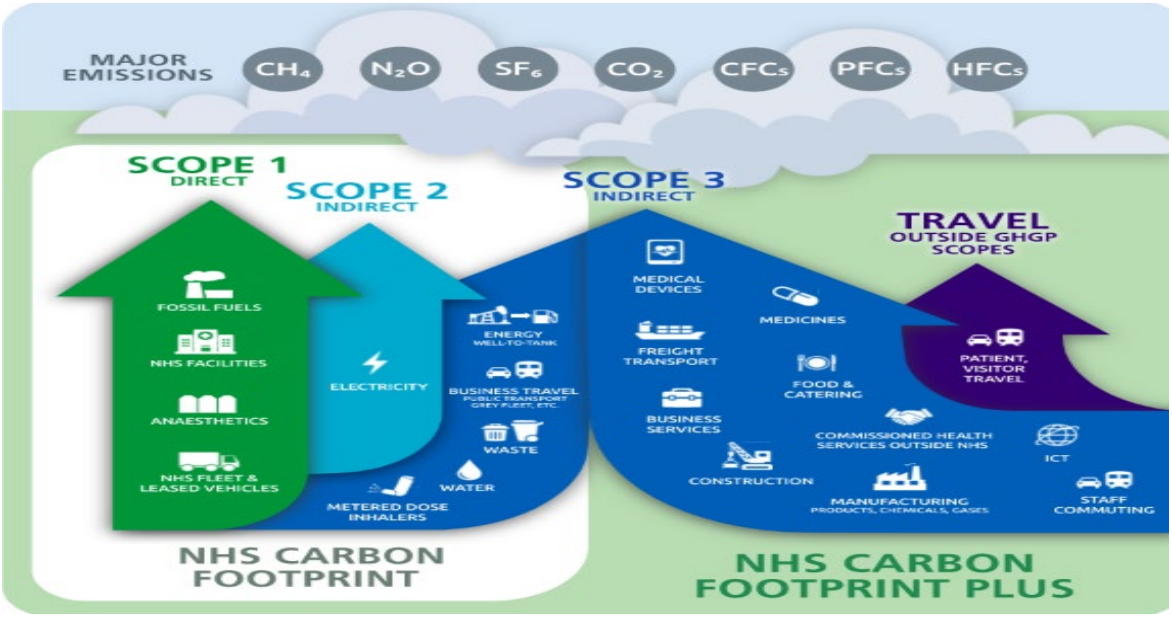
1.4 Delivering a Net Zero NHS

We measure how much carbon is produced by creating a carbon footprint, and this is completed at a global, national, local and organisation level. At a national level, the NHS accounts for 4% of the UK's carbon footprint as we use a lot of resources to keep our healthcare services running 24 hours a day, 365 days a year.

To reduce our carbon footprint, the NHS has committed to two net zero targets:

- NHS Carbon Footprint: to reach net zero by 2040, with an ambition for an 80% reduction in emissions (compared with a 1990 baseline) between 2028 to 2032.
- NHS Carbon Footprint Plus: to reach net zero by 2045, with an ambition for an 80% reduction in emissions (compared with a 1990 baseline) between 2036 and 2039

GHC did not monitor carbon emissions prior to 19/20 and therefore we have used 19/20 as the baseline for all reporting.



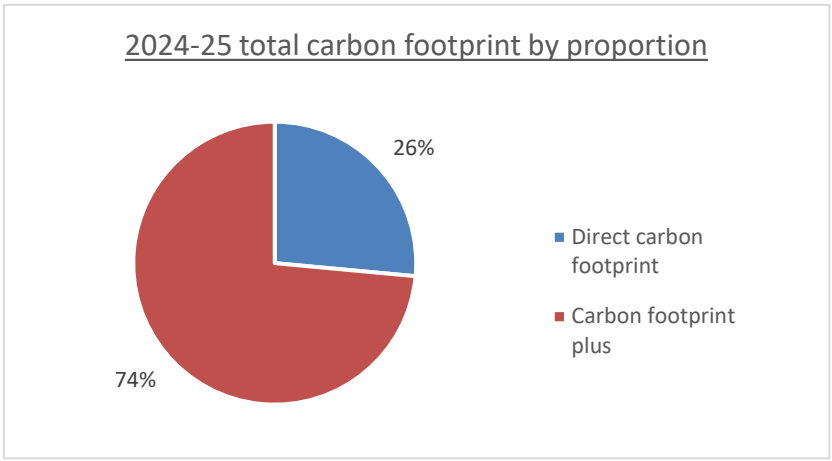
1.5 Our Carbon Impact

We use a lot of carbon to keep our healthcare services running 24 hours a day, 365 days a year.

These carbon emissions fall into two groups:

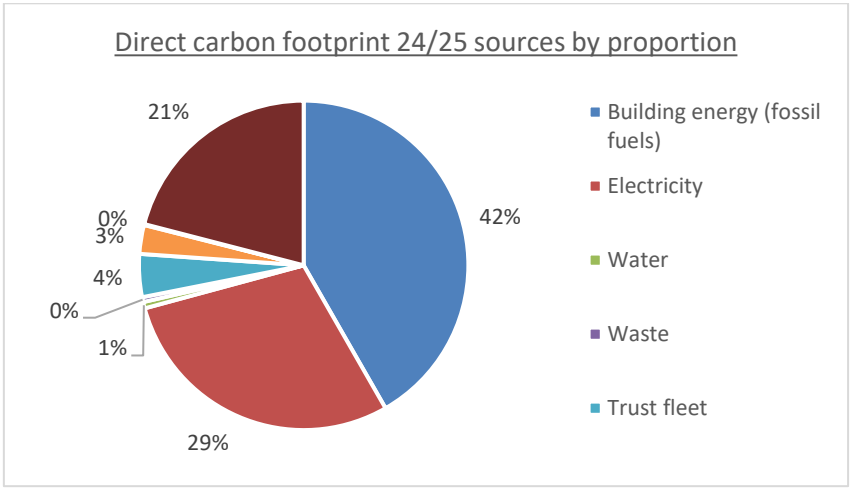
- NHS Carbon Footprint – Emissions we directly control (e.g. Energy use) and are easier to reduce
- Carbon Footprint Plus – Emissions we do not control and can only influence (e.g. Supply chain).

Approximately three-quarters (74%) of our total carbon footprint comes from our carbon footprint plus, with the remaining 26% coming from our NHS Carbon Footprint.



Whilst our NHS Carbon Footprint represents only 26% of our total carbon footprint, we are directly responsible for these emissions and can therefore see the most change.

Building energy from fossil fuels accounts for 42% of our NHS Carbon Footprint and reducing these emissions will remain a priority throughout the lifetime of this strategy.



1.6 Wider Sustainability Impacts

We recognise that achieving net zero will not only reduce carbon, but it will improve people's health, wellbeing and the lives of our local community.

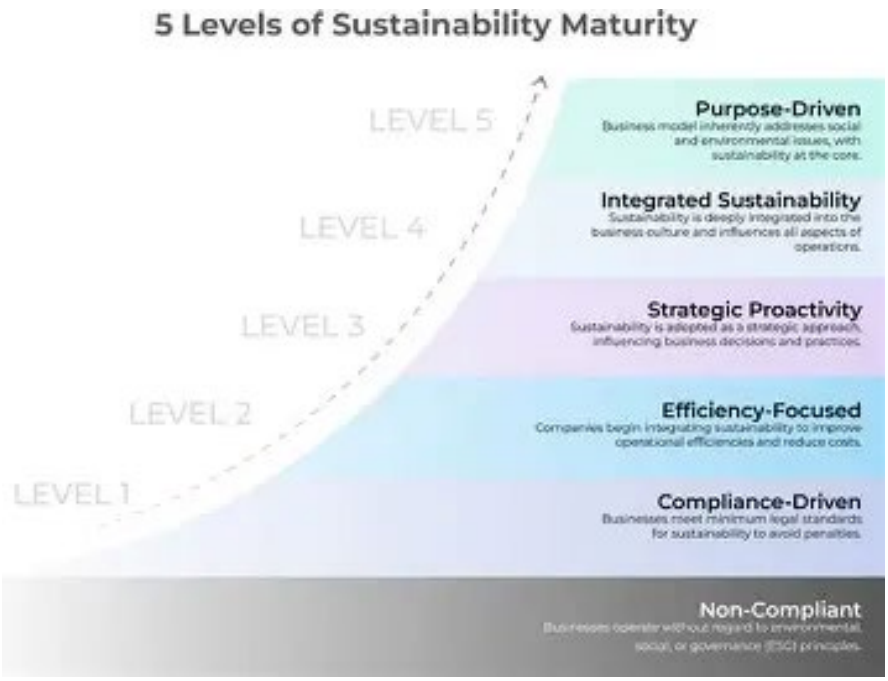
This Green Plan embraces a triple-bottom-line approach, balancing environmental sustainability, social value and financial efficiency. As an anchor institution, we are committed to using our influence and resources to create a positive impact across all three areas – for our staff, patients and the wider population.

1.7 Developing Our Green Plan

The Trust Board is committed to embedding sustainability throughout the organisation. Sustainability has been a core strategic aim of the Trust since 2019 and has remained so in our recent Trust Strategy Refresh for the next 5 years (2026-2031).

As part of this Green Plan development, we held a dedicated Board Development Session. During this session, board committees presented their achievements to date and outlined their ambitions over the next 3 years of this Green Plan.

To support this, we used a Sustainability Maturity Model as a guide to consider the Trust's current position and to guide the Board's ambition. Although some areas are more developed than others, it was agreed that as an organisation, we are currently at Level 2, which focuses on efficiency. Over the lifetime of this strategy, we aim to progress to Level 3, with elements of Level 4 in areas that are more advanced in their sustainability journey. This will be achieved by delivering on the goals and associated aims found within this strategy.



1.8 Green Plan Vision

Our vision for sustainability has not changed from our previous Green Plan:

"Delivering Sustainability through a whole systems approach; going beyond net zero to prevent ill health and reduce dependencies on high carbon care, ensuring better health for all"

The vision was developed by working inclusively with colleagues, people who use our services and experts by lived experience to deliver positive change and lasting benefits.

In developing of our Green Plan, we have aligned with the Trust Values:

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

1.9 Our achievements so far (2022-2025)

Goal 1: To reduce our NHS carbon footprint by 25% (against a 19/20 baseline).

Why did this goal matter?

To reach net zero for our NHS Carbon Footprint by 2040, we set initial targets for 2022-25.

What did we achieve?

We reduced our NHS carbon footprint by *32%* between 2022-2025 (against a 19/20 baseline):

Targets	Financial Year	NHS Carbon Footprint
National Target	2022-23	20%
GHC Stretch Target	2023-24	25%
Target Achieved	2024-25	32% (25% + 7% above GHC stretch target)

Goal 2: We will reach net zero for our Carbon Footprint Plus emissions by 2045

Why did we set this goal?

In line with national NHS targets, we need to reach net zero for our Carbon Footprint Plus by 2045. Aside from our NHS carbon footprint emissions, these emissions are harder to reduce as they are not directly under our control. These emissions come from sources such as the goods and services we purchase, the supply chain and staff, patient and visitor travel. We can only influence these emissions through promoting better procurement practices, supplier engagement and behaviour change across staff groups and service users.

We did not set a specific 3-year target in 2022 for these emissions because the national tool for accurately calculating our carbon footprint plus emissions was still in development.

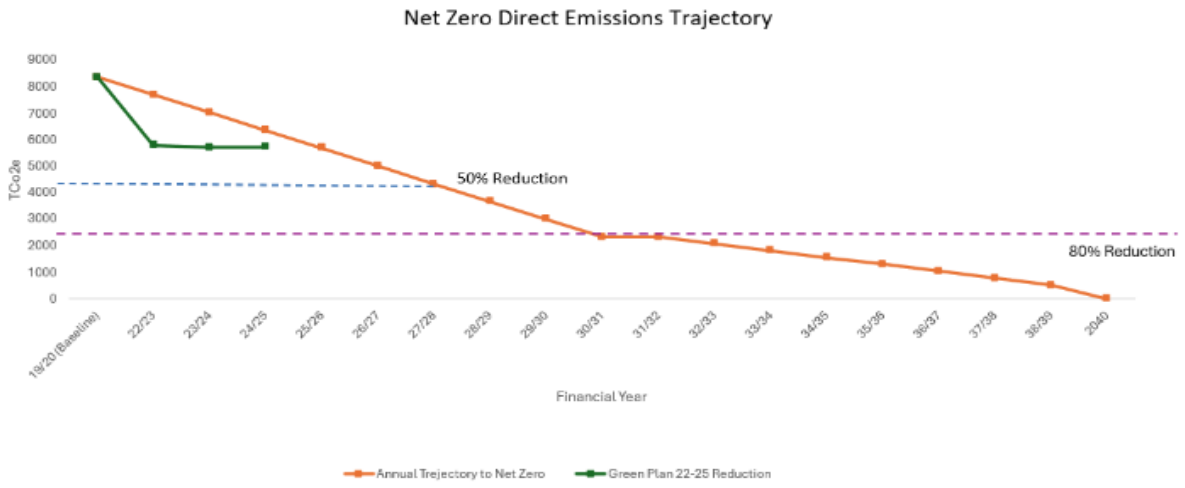
As best practice, we continued to measure our estimated Carbon Footprint Plus emissions internally using other methodologies to ensure our ability to meet the 2045 target.

Financial Year	2019-20 Baseline Year	2020-21	2021-22	2022-23	2023-24	2024-25	% Change from Baseline
Carbon Footprint Plus (tCO2e)	20,607	18,220	18,309	17,026	17,130	15,905	-23%

These emissions are estimated based on spend, carbon cost per UK £, until NHS supply chain has introduced a methodology for reporting our supply chain emissions

What did we achieve?

We have seen a reduction in our Carbon Footprint Plus emissions. However, as the majority of these emissions are estimated based on spend, we will not be reporting these in our final public documents. We will report our Carbon Footprint Plus emissions publicly once the national reporting tool is available.


Net Zero Direct Emissions Trajectory
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
TCo2e
50% Reduction
80% Reduction
19/20 (Baseline)
22/23
23/24
24/25
25/26
26/27
27/28
28/29
29/30
30/31
31/32
32/33
33/34
34/35
35/36
36/37
37/38
38/39
2040
Financial Year
Annual Trejectory to Net Zero
Green Plan 22-25 Reduction

SECTION 2
GREEN PLAN GOALS 2025-2028

2.1 What we want to achieve

We have set three goals that will help us achieve our Trust Green Plan Vision, while also supporting the achievement of the wider NHS net zero targets.

Goal 1:

By 2028, we will reduce our NHS Carbon Footprint by 50% (against a 19/20 baseline)

How does this support our journey to net zero?

Decarbonising our estate, and promoting sustainable modes of travel and transport, will reduce emissions and costs whilst improving the quality of care delivered in mental and physical health settings.

Looking to the future and the national targets to achieve 80% reduction by 2032 vs. 19/20 levels, our assessment is we will be in a good position to make the remaining improvements. This will be by increasing the amount of onsite renewable energy, zero emission fleet and introducing **offsetting measures** such as carbon capture to achieve net zero by 2040, as it is unrealistic to achieve nil emissions.

Goal 2:

We will reach net zero for our Carbon Footprint Plus emissions by 2045

How does this support our journey to net zero?

We will continue to work towards the national goal of net zero by 2045 target for our Carbon Footprint Plus. Similarly to our previous Green Plan (2022-25), we will not be setting a specific, 3-year carbon reduction target due to the delayed publication of national support tools and associated programmes. We will, however, continue to measure and internally report our Carbon Footprint Plus emissions to provide assurance of carbon reduction.

Goal 3: (NEW)

By 2028, we will integrate sustainability into wider Trust service delivery and key governance processes to enhance patient care, make best use of resources and reduce waste.

How does this support our journey to net zero?

Every day, teams across the Trust are making changes that support better care, and many of these also support net zero, even if that's not the primary driver of the change and improvement. By recognising the sustainability benefits across everyday improvements, we can demonstrate that sustainability is an integral part of high-quality care, and this supports the achievement of our longer-term net-zero goals.

2.2 Areas of Focus

The aims listed under each area of focus represent the strategic direction we are committed to over the lifetime of this strategy and are consistent with national guidance for the next three years of our Green Plan.

Behind each aim, we have developed clear objectives, which we will track through our internal Green Plan Dashboard. This approach will allow us to respond flexibly to evolving priorities and funding opportunities, adapt objectives as progress is made or challenges arise, and ensure accountability through regular reporting. We will publish an annual standalone Sustainability Report, summarising our progress and highlighting how our objectives have evolved.

2.2.1 Workforce and Leadership

Why this matters…

We need everyone, from Senior Leaders to frontline staff, to feel supported and inspired to take sustainability action. To do this, we will provide our workforce with the tools and knowledge to embed sustainable practices within their day-to-day activities. By building knowledge and embedding sustainability principles throughout the organisation, we can create a net zero NHS.

Our Progress so far (2022-2025 Green Plan)

Sustainability in Quality Improvement

In 2022, Sustainability was embedded into the Silver Quality Improvement Training. Staff members undertaking projects undertake a module on the importance of sustainable healthcare and learn how to apply knowledge to their existing and any future quality improvement projects.

Sustainability Programme Board

Launched in 2023, the quarterly Sustainability Programme Board oversees the delivery of our Green Plan. Our Net Zero Board Lead chairs the group, and it includes operational leads responsible for achieving the Green Plan's objectives.

Better Care Together Event

In 2024, we hosted the Trust's ever sustainability event, with sustainability leads and over 90 staff members working across the system. Participants were involved in workshops throughout the day to develop their knowledge and understanding of Healthcare Waste, Sustainable Travel, Preventative Healthcare, Anchor Institutions and Eco-linguistics.

Our aims for the next 3 years

- By March 2028, we will review Trust policies and procedures to include updated Green Plan Guidance and sustainability criteria where applicable.
- By March 2028, we will assess our workforce's capability and ensure that all identified staff complete core and specialist sustainability training.

How we will measure success

- Percentage of staff completing core sustainability training

- Percentage of identified key roles that have completed specialist sustainability training
- Completion of a workforce capability and skills assessment for identified staff
- Embedding Sustainability requirements across all aspects of the Trust and Improvement Programmes

2.2.2 Sustainable Models of Care

Why this matters…

How we design and deliver care significantly influences our carbon footprint – from reducing unnecessary travel and hospital admissions to embracing prevention. By rethinking the way care is provided, we can not only reduce emissions but also improve patient outcomes, reduce health inequalities and build a more efficient healthcare system.

Our Progress so far (2022-2025 Green Plan)

School Age Immunisations Project

The School Age Immunisations Team are responsible for delivering vaccines to 91,000 school-aged children across Gloucestershire.

In August 2024, they redesigned their service to increase vaccine uptake and reduce health inequalities in Gloucestershire. To achieve this, they changed their workforce model and replaced paper-based parental consent forms with digital consent forms for the annual Flu Vaccination programme.

By changing the previous care model, they were able to achieve the following benefits:

- **Improved Vaccine intake:** 0.9% increase in flu vaccinations across all schools
- **Eliminated Paper consent forms**: unless requested by schools, parents or carers
- **Reduced Admin time**: 88% reduction in admin triage time, which has allowed the upskilling of existing staff members
- **Reduced Triage Time:** 92% reduction in consent forms requiring clinical triage
- **Parent Satisfaction**: 91% of parents or carers rated the system ‘very good’ or ‘excellent’
- **Health Inequalities**: Time saved through admin efficiencies has enabled the team to target low uptake schools, resulting in a 30% increase in vaccines at one school

Our aims for the next 3 years

➢ By March 2028, we will appoint a Net Zero Clinical Lead to embed and support sustainable clinical practices in at least one of the High-Carbon Specialities listed in the Green Plan Guidance.

- By March 2028, we will identify and deliver at least one Quality Improvement or Transformation Project annually which has measured sustainability benefits to both reduce emissions and enhance the quality of care. `

How we will measure success

- Appointment of Net Zero Clinical Lead for the Trust
- Number of Quality Improvement Projects with a positive impact on Sustainability, year on year, over the life of our plan

2.2.3 Digital Transformation

Why this matters…

We can use digital technology to improve patient access and experience, streamline clinical services and reduce reliance on paper, travel and other resource-intensive processes. These practices will not only save time and improve care but also play a key role in the NHS achieving its net zero targets by reducing emissions and waste.

Our Progress so far (2022-2025 Green Plan)

Digital meal ordering system

In 2023, we launched a Trust-wide digital catering system, which we piloted at Stroud General Hospital. The project aimed to improve patient experience and safety and reduce food waste and time across the organisation.

Previously, patients selected meals via paper forms, which were linked to their bed numbers. These forms were universal, which meant patients saw all meals available and not those linked to their specific dietary needs. If the patient moved wards or was discharged, there was no way of tracking their movements, contributing to food waste and inefficiencies.

With the new system, dietary requirements and care plans are logged digitally upon admission. The Patients can then select meals from the tablet, view imaging and nutrition details, choose portion sizes and only see options that meet their specific needs.

Our aims for the next 3 years

- By March 2028, we will identify and report the sustainability benefits of digitalised care models.

- By March 2028, we will use the results of the Annual Digital Maturity Assessment to identify appropriate sustainability improvement opportunities.

How we will measure success

- Annual completion of the Digital Maturity Assessment
- % increase in the number of services using digital applications that reduce carbon footprint *(*NB to be tested with digital team & seeking input from national team).*

2.2.4 Medicines

Why this matters…

Medicines are responsible for 25% of the NHS's Carbon Footprint Plus, making them one of the biggest contributors to healthcare emissions. Most of these emissions come from the production, use, and disposal of these products. By focusing on Medicine optimisation, we can make sure patients get the right medicines at the right time. This will not only improve patient care, but lower carbon emissions, reduce waste and support NHS net zero ambitions.

Our Progress so far (2022-2025 Green Plan)

[awaiting case study information]

Our aims for the next 3 years

- By March 2028, we will remove nitrous oxide waste from medical gas pipeline systems.
- By March 2028, we will cease the use of desflurane in line with national guidance and only use it when clinically necessary.
- We will continue to support high-quality, low-carbon respiratory care by reducing the volume of high-carbon inhalers and increasing the volume of low-carbon inhalers prescribed (against a 19/20 baseline).
- By March 2028, we will address medicine optimisation opportunities and implement at least one project to improve medicine wastage
- By March 2028, we will complete the RPS Greener Pharmacy Guide and aim for Silver Accreditation

How we will measure success

- Emissions (tCO_2e) and volume (litres) of nitrous oxide by trust
- Reduction (%) of prescribed high carbon inhalers
- Number of non-essential nitrous oxide outlets decommissioned

2.2.5 Travel and Transport

Why this matters…

Due to its high carbon footprint, travel and transport play a crucial role in our net-zero ambitions and are included in both our NHS Carbon Footprint and NHS Carbon Footprint Plus emissions. Not only will reducing these emissions make us more sustainable, but it will also improve air quality and public health.

Our Progress so far (2022-2025 Green Plan)

Installation of Electric Vehicle (EV) Charging Points

We are proud to operate the largest EV charging network in the NHS South West Region, and over the past three years, we have installed a further 5 7kW dual charging points.

We now have 18 charging units across the Trust, which are capable of charging 36 electric vehicles at once. 66% of these are publicly accessible and 33% are for Trust Fleet vehicles only.

Our aims for the next three years

- By December 2026, we will develop and publish a Green Travel Plan to reduce carbon emissions from our fleet, business travel and staff commuting.
- From December 2026, we will only offer zero-emission vehicles through vehicle salary sacrifice schemes.
- From December 2027, all newly leased, hired and purchased Trust Fleet vehicles will be zero emissions.
- By March 2025, we will increase the number of fleet-only electric vehicle charging points to support a net zero fleet.

How we will measure success

- Publication of Sustainable Travel Plan
- Number of Fleet-only EV Charging Points
- Percentage of owned and leased fleet vehicles that are ultra-low emission vehicles (ULEV) and zero-emission vehicles (ZEV)

2.2.6 Estates and Facilities

Why this matters…

The NHS estate and its supporting facilities services contribute 15% towards the total NHS carbon footprint. By removing fossil fuels and improving the efficiency of our estate, our buildings will become more resilient to the effects of climate change and improve the environment in which care is delivered.

Our Progress so far (2022-2025 Green Plan)

The new Forest of Dean Community Hospital opened in April 2024 and is a leading example of a net zero building. It replaced two ageing hospitals that relied on gas and oil heating systems and was designed with patients, sustainability, operational efficiency and long-term value in mind.

Patient Centred Design

- Dementia sensitive by design – ensuring accessibility and safety in line with inclusive design standards
- Nature views from inpatient rooms – promotes wellbeing

Sustainable Design and Construction

- Achieved a BREEAM ‘excellent’ rating – reflecting best practice in building standards

Low Carbon Utilities

- Heating and cooling are delivered through air source heat pumps, eliminating fossil fuel use on-site
- Solar PV panels have been installed to generate renewable electricity and help reduce running costs – it is a net contributor of electricity to the national grid
- Water-efficient toilets

Our aims for the next 3 years

- By March 2028, we will reduce our NHS Carbon Footprint by 50% (against a 19/20 baseline)
- By March 2028, we will develop Heat Decarbonisation Plans and associated business cases for all carbon-intensive sites, identifying and prioritising the phase out of fossil fuel heating systems by 2032
- By December 2026, achieve a 20:20:60 clinical waste segregation target, in line with the Clinical Waste Strategy

How we will measure success

- Percentage of sites with Heat Decarbonisation Plans
- Carbon Footprint reduction from the removal of fossil fuel heating systems

2.6.7 Supply Chain and Procurement

Why this matters…

Supply chain and procurement underpin every aspect of healthcare delivery – medicines, medical equipment, PPE, food, uniforms and cleaning. As a result, it has a high carbon footprint, accounting for an estimated 62% of our carbon footprint plus emissions.

Whilst we do not have direct control of these emissions, we can use our purchasing power to focus on more sustainable procurement practices, including the use of local suppliers to aid social value.

Our Progress so far (2022-2025 Green Plan)

Forest of Dean Hospital

As well as building a sustainable hospital, we also wanted to build a sustainable community by using local businesses to build the hospital where possible.

Over 70% of the suppliers used in the project were based within 30 miles of the hospital site. A significant proportion of these were based in the Forest of Dean itself, helping to reduce transport emissions whilst also investing in nearby businesses.

Single-use plastics in the Catering Department

Since October 2023, we have replaced all single use plastic cups with paper cups and have replaced all plastic cutlery with metal alternatives.

Our aims for the next 3 years

- By March 2028, we will embed the NHS Net Zero Supplier Roadmap into all relevant procurement contracts and support suppliers to use the Evergreen Sustainable Supplier Assessment.
- By December 2026, we will establish a baseline of all high-consumption single-use items used across settings to identify improvement opportunities.

How we will measure success

- Sustainability KPI's in all contracts over £250k
- Increasing Number of Quality Improvement Projects with a positive impact on Sustainability, year on year, over the life of our plan

- Number of single-use items reduced

2.6.8 Food and Nutrition

Why this matters…

The food we produce, purchase and serve across the Trust has an environmental and carbon impact. We can continue to meet the nutritional requirements of people while reducing our carbon emissions through sourcing local, in-season and lower-carbon produce and reducing food waste.

Our Progress so far (2022-2025 Green Plan)

Low-Carbon Meal Plan

In a collaborative effort to improve sustainability and patient choice, our catering team and dieticians created a low-carbon meal plan across the organisation. The primary aim was to reduce the carbon footprint of our food services without compromising on nutritional standards.

Both teams worked alongside our catering supplier to assess the carbon footprint of all meal choices. They replaced the high-carbon, less popular dishes with lower-carbon alternatives that met all nutritional guidelines. This approach enabled us to make impactful changes without compromising patient satisfaction or choice.

As a result, we have seen a 27% reduction in carbon emissions from our meal plans and have increased the variety of meal options offered each week, supporting sustainability, nutrition and patient satisfaction.

Our aims for the next 3 years:

- By March 2028, we will measure food waste in line with Estates Return Information Collection (ERIC) requirements.
- By March 2028, we will reduce food waste by up to 20% across the organisation (against a 23/24 baseline)
- By March 2028, we will review our meal service and prioritise meals that are high in fruits and vegetables and low in heavily processed foods.

How will we measure success

- Percentage reduction in food waste (compared to 19/20 baseline)
- Annual cost savings from food waste reduction
- Total food waste (tonnes)

2.6.9 Climate Adaptation

Why this matters…

Extreme weather events such as heat waves and flooding are happening more often because of climate change. This can disrupt NHS services, through damaging buildings, restricting access and putting pressure on our staff and systems.

We can reduce the impact of this by adapting our buildings, hospital sites and the way we deliver care to protect our patients, staff and services to avoid climate-related service disruptions.

Our Progress so far (2022-2025 Green Plan)

Organisational Resilience following the 2022 Heatwave - [Awaiting Case Study]

Forest of Dean Hospital

As well as designing our Forest of Dean Hospital in a sustainable way and using local suppliers, we also included climate change adaptation features to help reduce the impact of extreme weather events. This includes:

- Sustainable Drainage Systems (SuDS), which help slow and absorb excess rainwater, reducing the likelihood of flooding
- Solar resistant glazing, which creates a more comfortable environment by reducing building temperatures in hot weather and improves visual comfort
- Extra Thick Insulation – To keep the building cooler in extreme heat and warmer in extreme cold

Our aims for the next 3 years:

➢ By March 2027, we will work with wider system partners to develop and publish a joint climate change adaptation plan to address identified vulnerabilities and risks to services and service users.

How we will measure success

- Publication of the joint climate change adaptation plan

2.6.10 Greenspace and Biodiversity

Why this matters

Accessible Greenspace improves wellbeing, supports preventative healthcare measures through physical activity and helps to reduce carbon and improve air quality.

This area of focus goes beyond mandated national guidance, but we have included it as a priority because many of our community hospitals are surrounded by green space. This presents opportunities to enhance these spaces, which will benefit the environment and the health of our communities.

Our Progress so far (2022-2025 Green Plan)

Montpellier Allotment

The Montpellier allotment is a therapeutic space located at our Wotton Lawn Hospital in Gloucester City Centre. It plays a vital role in the rehabilitation and well-being of patients at the Montpellier Low Secure Unit as well as individuals accessing services from across the Trust.

Over the past few years, the half-acre site has been transformed by staff members, volunteers, service users and experts by lived experience. It is now a calm, engaging space where people can take part in meaningful therapeutic activities that support both their physical and mental health.

The allotment features:

- A Koi carp pond
- A bird aviary, housing quails and finches
- A wildlife point with a levelled viewing platform
- A nature reserve, utilising existing woodland and the introduction of native trees and vegetation
- A free-range chicken paddock which rehomes battery hens
- Raised beds for growing and cultivating food
- A purpose-built log cabin with a living room, kitchen, pizza oven and toilet facilities
- Working beehives to support biodiversity

Regular sessions held at the allotment include:

- Horticulture courses and gardening therapy
- Creative writing sessions, reading groups and mindfulness sessions
- Animal care and birdwatching classes
- Cooking classes using freshly grown produce

Many individual care plans include the use of the allotment, giving individuals the chance to enjoy time outdoors through purposeful, supported activities, either independently or supported by staff as part of their recovery and reintegration into the community.

The redevelopment of the allotment has received significant attention and Media coverage, including being officially opened by HRH Princess Anne in 2023 and the Log Cabin being opened by BBC Countryfile presenter Adam Henson. Many local businesses have donated books, tools and time to support its development.

A Montpellier Allotment Group Working Party has been set up to ensure this space continues to grow and support recovery for years to come.

Our aims for the next 3 years

- By March 2027, we will develop and publish a Greenspace and Biodiversity Strategy
- By March 2028, we will implement at least one Greenspace and biodiversity project to support patient recovery and overall health and wellbeing.

How we will measure success

- Development and publication of the Greenspace and Biodiversity Strategy
- Increase in the number of accessible green spaces across our Trust Sites

SECTION 3

GOVERNANCE, DELIVERY RISKS AND FINANCE

3.1 Governance and Reporting

We have a well-established and robust governance and reporting structure to provide oversight and assurance around the delivery of this Green Plan.

Trust Board
Progress against the Green Plan, and our carbon footprint will be reported annually to the Trust Board.

Resources Committee
Progress against the Green Plan, and our carbon footprint will be reported biannually to Resources Committee.

Strategic Oversight Group (SOG)
SOG meets bimonthly to provide Executive oversight of our portfolio of major operational transformation programmes. SOG receives summary reports of

Sustainability Programme Board (SPB)
The Sustainability Programme Board meets every quarter oversees the delivery of our Green Plan. Our Net Zero Board Lead chairs the group, and it includes operational leads responsible for achieving the Green Plan's objectives.

Project Groups
Responsible for the delivery of individual sustainability schemes, or workstreams within wider transformation projects.

Wider staff networks
These special interest groups (such as staff allotments) are run exclusively by staff and support the implementation of the Green Plan but have no formal reporting structure.

3.2 Risks

There are risks which could impact the delivery of this Green Plan. These risks will be monitored through the Sustainability Programme Board throughout the lifetime of this strategy, with escalation through to Board level where appropriate. We recognise that there are factors that may impact our carbon footprint but fall outside the scope of this strategy. This includes artificial intelligence. As AI is a new and emerging tool, we are unable to foresee its full environmental impact but will continue to seek guidance from NHS Sustainability colleagues and networks on how to respond appropriately.

Risk and Description	Mitigation	Likelihood	Impact	Risk Score
Organisational scale and associated utility costs may impact our Carbon Footprint target. The size and complexity of our organisation, combined with increases in utility costs may limit the ability to reach our Carbon Footprint targets.	Measure carbon footprint annually, work with energy suppliers to ensure the best value contracts, prioritise fast return energy upgrades across the estate.	3	3	9
Loss of external funding The withdrawal of external heat decarbonisation schemes (e.g. PSDS) could limit the Trust's ability to reduce our Carbon Footprint emissions.	Creation of a financial plan based on available internal capital and balanced with the availability of external funding sources.	4	2	8
Changes to National methodology may increase our Carbon Footprint Plus emissions. Planned improvements to the national Carbon Footprint Plus emissions calculator will change from a spend-based to an activity-based. This could result in an increase in emissions at both a national and Trust level.	The exclusion of a 3-year Carbon Footprint Plus emissions target, proactively communicate methodology changes to the Board.	3	3	9
Insufficient workforce capacity to deliver Green Plan Targets Current capacity of both the Sustainability Team and the wider workforce may be inadequate to effectively implement and achieve the targets outlined in the Green Plan.	Completion of a workforce capability assessment, upskilling of staff, and dedicated programmed activity time where appropriate.	3	4	12
Equity and accessibility risks associated with the mandated transition to electric-only salary sacrifice vehicle schemes. The mandated removal of petrol and diesel vehicles from the staff benefits salary sacrifice scheme may reduce participation amongst lower-banded staff. This will not impact our Carbon Footprint or Carbon Footprint Plus emissions but has wider sustainability considerations relating to equity and staff benefit offers.	Negotiate with the current vehicle provider to ensure a range of accessible electric vehicles and benchmark best practice from other Trust's that have already implemented this mandated target.	3	3	9

3.3 Financial Resources

Achieving the NHS' net zero ambitions will require significant upfront financial investment, particularly across our estate. Reaching net zero for our NHS Carbon Footprint by 2040 will depend on major upgrades to our existing buildings and infrastructure. Whilst these upgrades lead to long-term cost savings and a reduction in emissions, these schemes require a large upfront financial investment.

To date, we have successfully secured Government Grant funding through the Public Sector Decarbonisation Scheme (PSDS). These grants cover most of the costs, and we only fund a proportion of this. We have been awarded this funding twice, and most recently for the installation of air source heating at Charlton Lane Hospital, which will be completed by the end of 2025.

Following the Government's 2025 spending review, it was announced that there will be no further grant funding available when the current funding phase ends in 2028. Whilst developing this strategy, no announcements of alternative funding schemes have been made. This presents a risk to our net zero journey, and long-term consideration will need to be given to capital investments associated with the estate, in particular, replacement of heating systems and refurbishments.

We will continue to consider the level of resources we have internally to respond to this Trust wide agenda. Re-investment into both the Team and wider sustainability schemes from some of the financial gains achieved because of resource efficiency projects will be considered on a case-by-case basis. This will also enable us to invest into other projects which bring limited financial benefit, but which will deliver wider environmental or social value (e.g., Greenspace and Biodiversity Projects). The detailed objectives and schemes in our Green Plan Dashboard, will be adjusted annually to reflect the amount of available capital and resourcing, and this is a risk that may impact the pace and scale of progress across the lifetime of this strategy.

3.4 Summary

Achieving our vision will not be easy and we have made an intentional and challenging commitment to go beyond net zero and improve our services and the wider health and wellbeing of our service users, communities and workforce.

Building on the success of our 2022-2025 Green Plan, we believe that by delivering this updated strategy, we will make a positive difference and achieve the goals and aims we have set. To ensure accountability, we will publish an annual standalone Sustainability Report, which will detail our progress against the goals and aims set out in this strategy. Where significant national policy or legislative changes are made, or any new guidance published we will update this strategy accordingly.

Appendix 1 - Glossary (to be finalised in public version)

We have purposely made this strategy clear and easy to read. However, some words cannot be altered because they have specific meanings that we cannot change.

We have added a glossary below to help explain these terms and make the strategy easier to understand.

**[requires definitions and additional words or phrases to be added]*

Area of Focus

Anchor Institution

Net Zero

Carbon Footprint

Climate Change

NHS Carbon Footprint

NHS Carbon Footprint Plus

Triple Bottom Line

Social Value

Heat Decarbonisation Plan

Ultra Low Emission Vehicles (ULEV)

Zero Emissions Vehicles (ZEV)

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 9th July 2025
At Trust HQ, Edward Jenner Court

PRESENT:

Graham Russell (Chair)
Amy Aitken
Sarah Nicholson
Bob Lloyd-Smith
Mick Gibbons
Alicia Wynn
Kizzy Kukreja
Penelope Brown
Sarah Waller
Leighton Pettigrew
Martin Pittaway
David Hindle
Peter Gardner
Chris Witham
Jan Lawry
Joy Hibbins
Tussie Myerson

IN ATTENDANCE:

Steve Alvis, Non-Executive Director
Douglas Blair, Chief Executive
Nicola Hazle, Director of Nursing, Therapies and Quality
Anna Hilditch, Assistant Trust Secretary
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Non-Executive Director
Rosanna James, Director of Improvement & Partnership
Cathia Jenainati, Associate Non-Executive Director
Jason Makepeace, Non-Executive Director
Lavinia Rowsell, Director of Corporate Governance
Neil Savage, Director of HR & OD
Amjad Uppal, Medical Director

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Marcia Gallagher, Andrew Cotterill, Michelle Kirk, Chas Townley, Paul Winterbottom, Caroline Goldstein and Laura Bailey. Apologies had also been received from Non-Executive Directors Nicola de Iongh, Rosi Shepherd and Sumita Hutchison.

1.2 Graham Russell formally welcomed everyone to the meeting. The recent Governor elections had now completed, and the Council welcomed two new Governors, David Hindle (Public Governor: Cotswolds) and Caroline Goldstein (Staff Governor: Medical Dental & Nursing). Graham Russell advised that Mick Gibbons (Public Governor: Stroud) had also been successfully reappointed for a second term. All terms had officially commenced on 1 July 2025.

1.3 On behalf of the Council, Graham Russell expressed his thanks to Jenny Hincks who came to the end of her final term on the Council on 30 June. Jenny had served 2 full terms as a Public Governor representing the Cotswolds.

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 14 May 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. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

5.1 Chris Witham presented this report which provided a summary of the business conducted by the Nominations and Remuneration Committee. The Council was asked to note that due to absence, the business at the meeting scheduled for 26 June was conducted via correspondence, in line with the Trust's Standing Orders. Committee members received the reports for the meeting, and confirmed via email that these had been received, reviewed and supported.

5.2 The focus of the business related to the outcome of the 2024/25 appraisals for the Trust Chair and Non-Executive Directors.

NED APPRAISALS 2024/25

5.3 Appraisal meetings for all NEDs took place during April and May 2025 with the Trust Chair. In advance of each meeting, NEDs were asked to undertake a self-review focusing on their achievements over the past year and previously agreed objectives. Following the meeting, a summary of the discussion, proposed objectives and development plans were shared with each NED and signed off by both parties.

5.4 Appraisals were completed for Sumita Hutchison, Steve Alvis, Jason Makepeace, Bilal Lala and Nicola de Iongh. A light touch appraisal was carried out for Rosi Shepherd (appointed 6 January 2025) and Vicci Livingstone-Thompson (appointed 1 May 2025). Objectives for all NEDs have been agreed and signed off.

5.5 The Nominations and Remuneration Committee received individual summaries from each of the appraisal meetings. Committee members confirmed via email that they had received and noted the positive outcome of this year's NED appraisal process and agreed to report formally to the full Council of Governors that this information was received and noted.

CHAIR APPRAISAL 2024/25

5.6 The report received by the Committee set out the process that had been followed for the Chair appraisal which was in line with the "Framework for conducting annual appraisals of NHS provider chairs" guidance issued by NHSE in February 2024 (revised March 2024). The report summarised key themes emerging from feedback

received from stakeholders, summarised the outcome of the appraisal discussion and set out next steps in finalising the appraisal documentation in advance of submission to NHS England. All feedback received was anonymised and collated by the Senior Independent Director (Nicola de Iongh) who led the appraisal discussion with the Trust Chair at their meeting on 9th April 2025.

5.7 The Nominations and Remuneration Committee received this report and noted the positive outcome of this year's Chair appraisal. It was agreed to report formally to the full Council of Governors that this information was received and noted.

5.8 The Chair appraisal report was submitted to NHS England on 30 June 2025, with full Nominations and Remuneration Committee support.

5.9 On behalf of the Council, Chris Witham thanked Graham Russell and Nicola de Iongh for conducting the annual appraisal process, which had been thorough and robust. Thanks, were also given to the NEDs who had all demonstrated their continued efforts, hard work and positive contributions over the past year.

6. ANNUAL REPORT AND ACCOUNTS 2024/25 – FORMAL RECEIPT

6.1 The purpose of this report was to present the Council of Governors with the final draft Annual Report and Accounts 2024/25, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".

6.2 The Council **noted** that the Annual Report would be Laid before parliament during July and would be formally presented at the Trust's AGM taking place on Thursday 11th September 2025.

6.3 As in previous years a briefing session would been arranged for Governors to learn more about the Annual Report and Accounts, with the session led by Bilal Lala (Chair of Audit & Assurance Committee), Sandra Betney (Director of Finance) and a representative from the External Auditors. This session would be scheduled to take place in August, and the date would be shared with all Governors once confirmed. **ACTION**

6.4 Penelope Brown asked whether there had been any comment or adjustments to the accounts from the External Auditors this year. Douglas Blair had attended the Audit & Assurance Committee where the Annual Report and Accounts were received and approved and provided assurance that these had been given a clean bill of health by the External Auditors.

6.5 David Hindle asked whether the Trust would be producing a summary of the annual report, or an easy read version to make it more accessible. It was noted that the Trust's Communications Team would be looking at this in more detail, and like previous years the Trust would be producing a short film to accompany the written report, setting out the key highlights in a bitesize format.

6.6 The Council of Governors formally received the Annual Report and Accounts 2024/25.

7. ANY OTHER BUSINESS

7.1 There was no other business.

8. DATE OF NEXT MEETING

8.1 The next Council of Governors meeting would take place on:
Wednesday, 17th September at 13:00 – 15:30 via MS Teams.

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.	**Complete** Output report shared alongside papers for the Sept 2025 meeting, for information.
	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.	**Complete** Standing agenda item to be added from Nov 2025.
9 July 2025	6.3	Governor briefing session on the Annual Report and Accounts to be set up and the date communicated out inviting attendance.	**Complete** Session took place on 27 August 2025.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 25 SEPTEMBER 2025**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 7 AUGUST 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Lavinia Rowsell, Executive Lead 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 and discussed the Patient and Carer Race Equality Framework (PCREF) Advisory Report, from BDO, setting out the Trust's compliance against national organisational competencies – partially or non-compliant against 16 actions – and the associated workplan. Governance oversight will be provided by the Quality Committee on behalf of the Board. The wider links with the Leadership and Culture programme were noted.

ADVISE: Advise of areas of ongoing monitoring or development

External auditors Sumer advised the Committee that the handover process between themselves and former external auditors KPMG was yet to commence. Assurance was provided that this was in hand, and an update would be received at the next Committee meeting.

ASSURE: Inform the Board where positive assurance has been achieved

An update on contaminated theatre sets was received, which provided assurance that the previously discussed issues had been resolved.

The Committee received the Data Quality Internal Audit Report, which scored moderate for both design and effectiveness opinion; with four moderate findings.

The Committee received the Data Improvement Internal Audit Report, which scored moderate for both design and effectiveness opinion; with three moderate findings.
The Committee received the Counter Fraud, Bribery and Corruption Progress Report and the Counter Fraud Functional Standard Return 2024-25 noting that the Trust was rated green against 11 of the 12 components. The positive progress of work was noted.

The Committee received the Finance Compliance Report and noted the good progress made on staff overpayments.

The Committee received the Health and Safety and Security Annual Report and noted the key achievements, developments, and areas of assurance.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved the proposed amendments to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD).

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the new Board Assurance Framework (BAF) which reflected the Trust's Strategic Aims and Objectives and quarter 1 review. The new format, which was created in response to feedback received from Board Members, was welcomed.

The Committee received the Corporate Risk Register and was informed that a new risk relating to PCREF would be added.

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

The Internal audit Follow Up Report was received, and the Committee was informed of the good progress made, including the closure of all actions from the 2023/24 Consultant Job Planning Internal Audit.

The Committee was informed of the positive changes made to the culture around Health and Safety audits, which were welcomed by colleagues and thanked the team for their efforts.

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

Cyber Security Assurance Report.

The Summary Reports are from the following groups:

- BEME Management Group
- Health & Safety & Security Management Group
- Information Governance Group
- Risk Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 25 SEPTEMBER 2025**
COMMITTEE:	**GREAT PLACE TO WORK (GPTW) COMMITTEE – 26 August 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Sumita Hutchison, Chair of Committee

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

The Committee received the national workforce update which summarised some of the key developments, issues and horizon scanning relating to the national and regional workforce and people agenda affecting or expected to affect the Trust. Key items presented to the Committee included:

- 2025/26 National Pay & Pay Structure Reform
- Amendments to the Employment Rights Bill.
- Freedom to Speak Up Changes
- Workforce Implications of the 10-year plan

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the Trust's 2025 annual Workforce Disability Equality Scheme (WDES) and Workforce Race Equality Scheme (WRES) Data and Action Planning approach for 2025/26. This was an opportunity for colleagues to reflect on the data and to seek comments and acknowledgement in readiness for publication by 31 October 2025. A final report would be presented back for sign off in October. The Committee discussed the data within the report and stressed the importance of moving thinking from this simply being an "annual submission" to making it more mainstream and embedding it into "every day and everyone".

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Self-Assessment Update & Closure Report (NHSE Retention Toolkit for Nurses). As part of NHS England's transformation under the Fit for the Future: 10 Year Health Plan for England, the Retention self-assessment tool has been renamed the Staff Experience assessment tool. The purpose of the tool is to help organisations identify strengths and areas for improvement, using this insight to develop and implement evidence-based retention improvement plans. The Committee **noted** the great progress that had been made and thanked colleagues for the work conducted.

The Committee received the Workforce Performance Report which showed a robust performance in key areas with good metrics. The Committee was assured that the Trust compared well when benchmarked with other organisations.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **received** and **endorsed** the Medical Appraisal Annual Report, and Guardian of Safe Working quarterly report, both of which would be presented in full at the September Trust Board for approval and noting.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **received** and **noted** the Risk Report for quarter one, and the Board Assurance Framework, noting the 2 risks that the GPTW Committee has oversight for and the associated controls and mitigations in place:

Risk ID	Risk Title	Current Score
Risk 3:	Recruitment and Retention	**16**
Risk 4:	Internal Culture	**16**

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

The Trust has received confirmation that following a recent external review and reassessment, it has been reaccredited as a Disability Confident Leader employer, the top accreditation level available.

The Committee welcomed Chris to the meeting for the Staff Story, who spoke openly about his experiences, and the challenges he has faced in moving from the military into civilian life. Chris was complementary about the GHC recruitment team on his positive onboarding journey, stating that he was treated like a person, not a statistic. This was an uplifting story, and Chris shared some helpful learning for the future. Positively, the Trust was awarded its Veteran Aware reaccreditation in June 2025.

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

The Committee **noted** that an evidence-based strategic review of GHC's health and wellbeing offers was underway, looking to identify what offers work well, where there may be gaps in provision, and where there may be future opportunities for development. The completed Review would be presented back to the Committee in December.

As part of the national workforce update, a number of national leader's articles / blogs were flagged to Committee members. The following was strongly recommended:

- From Burnout To Belief: Reflections On Reforming The NHS From Within | The King's Fund

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust PUBLIC Board – 25 SEPTEMBER 2025**
COMMITTEE:	**RESOURCES COMMITTEE – 28 AUGUST 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

System finance position: The Committee received an update on the system position and underlying position. While GHC's financial position is conforming to plan (see 'Assure' below), the Director of Finance will alert the next Board meeting that national guidance on operational planning will change business planning and budget setting timescales for the Trust, with an associated negative impact on the time and resilience of colleagues over the next 3-6 months.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the proposed updates to the 2025/26 Key Performance Indicator (KPI) portfolio. A substantial number of services now have action plans in place to ensure they can meet and maintain targets.

The Committee received the draft Winter Plan (see 'Applaud' below) and noted further final changes would be required before approval ahead of the next Board. Since Resources Committee, the Winter Plan has been presented at Quality Committee. COO, EPRR Lead and Resources Chair have met ahead of September Board, to review plan readiness and complete the Board assurance form to simplify approval at that meeting.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report for the month 4 period and **noted** the Trust's underlying position, the Committee was informed that (at month 4) the Trust had a small operating surplus, ahead of a small plan deficit.

The Committee received the Quality and Performance Dashboard Report for the month 4 period and acknowledged that appropriate service improvement action plans were being developed or were in place to address areas requiring improvement, alongside Ops governance. The indicators which would be followed up by Trust Board were highlighted.

The Business Planning Report was received, which set out the progress made in achieving the business planning objectives for quarter 1. The report informed that 66% of

milestones had been completed and a further 33% had been part achieved. Resources Committee noted this was a significant achievement in the current circumstances.

The Committee received the positive Service Development Report, which provided an update on the Trust's service development activities and income streams.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the latest endorsed updates to the Trust's KPI portfolio for 2025/26.

The Committee **approved** the submission of the Trust's NHS Premises Assurance Model (PAM) self-assessment.

The Committee **approved** the Draft Green Plan Refresh, noting the final version would be received by the Trust Board for formal approval.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report for quarter 1 and discussed *risk 8 – cyber,* **noting** that there had been no movement in the risk, specifically the likelihood and impact; and that this was not being impacted by mitigations in place.

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

The Committee received the Operational Resilience and Capacity Plan (Winter Planning & Board Assurance Statement 2025/26) and recognised the significant improvement in comparison with the previous version (2024/25).

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

The Committee received and welcomed the Transforming Care Digitally Programme highlight report.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 25 SEPTEMBER 2025**
COMMITTEE:	**QUALITY COMMITTEE – 2 SEPTEMBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Rosi Shepherd, Chair of Committee

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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee was advised of the regulatory risk regarding record keeping and that this was not where it needed to be, and was informed mechanisms were in place to address this.

It was reported that the CQC had undertaken a comprehensive inspection of Berkeley House. Feedback was awaited. The Committee **noted** that no initial immediate concerns have been raised and that the Section 31 Notice remained in place.

The Committee was informed, in regard to LeDeR, the ICB had provided assurance of local mitigation for the current year, whilst awaiting for national clarity for the upcoming year.

The Committee is currently actively reflecting about where it is regarding effectiveness and delivery for the next year, recognising active governance evolution.

ASSURE: Inform the Board where positive assurance has been achieved

The Patient & Carer Experience Team (PCET) and the Safeguarding Service shared their Service improvement Story with the Committee, which emphasised the importance of how services work together across the Trust to provide good quality patient care.

The Committee received the Annual Flu Plan 2025/26 and **noted** that there is a plan in place to achieve at least a 5-percentage point improvement on last year's flu vaccination rate for frontline staff, by the start of flu season. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions. The Committee was further informed that fit testing had taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of

high demand. A patient cohorting plan, including risk-based escalation is also in place and understood by site management teams, ready to be activated as needed.

The Committee received a presentation from the Crisis Team, which provided assurance on the Trust's benchmarking position.

The Committee received an update on the AHP Assurance Statement, which provided the bi-annual update on the Trust's quality priorities.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the Annual Flu Plan 2025/26.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the quarter 1 Risk Report and noted there were 20 confirmed corporate risks scoring 12 or above for which the committee has either sole or shared oversight responsibility for.

The Committee received the Board Assurance Framework and **noted** the Committee had oversight for 4 risks, which were detailed in the report.

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

The Committee received the Infection and Prevention Control Annual Report, which was well received and **noted** the strong position and the further work planned focusing on Community Teams. The report would further be shared with the Trust Board *(included in reading Room on Diligent).*

The Committee **noted** the improvements made by the Crisis team, noting the 48-hour follow-ups, low admission rates, good call handling, and the high referral acceptance rate.

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

The Committee received for information and review, an update on the following BDO Internal Audit Reports:

- Infection Prevention Control Audit
- Non-Medical Prescribers Audit
- Patient and Carer Race Equality Framework (PCREF) Advisory Report
- Patient Safety Incident Reporting Framework Audit
- Quality Governance Audit

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 25 September 2025**
COMMITTEE:	**LEADERSHIP AND CULTURE ASSURANCE COMMITTEE – 09 September 2025**
AUTHOR:	Programme Manager – Leadership and Culture Programme
PRESENTED BY:	Graham Russell, 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

None.

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

Programme Methodology and Approach: The overall approach to the programme has been the subject of discussion and reflection by the Oversight Group, and this was reported to the Committee. It is acknowledged that the non-linear, discovery-led approach creates a tension between urgency to act and the intentionally slower pace of deeper discovery. The Committee were satisfied that the programme approach is best suited to sustainable and long term change, particularly when coupled with clarity on the timelines for the different phases.

Communications and Engagement Planning: A trust-wide engagement initiative is in development for November. It is designed to clarify the programme's purpose, promote inclusivity, provide further opportunities for engagement and cross-organisational dialogue as part of the discovery phase.

Programme Risk – Programme Resources: The Committee were advised on risks relating to changes to programme resources, both relating to a forthcoming change of programme manager and in relation to specific streams of work. The focus in relation to programme resources would be on achieving a smooth handover. In relation to specific streams of work, gaps in capacity had affected the pace of work but gaps were now being filled.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received an update on each active stream.

APPROVALS: Decisions and Approvals made by the Committee

No formal decisions or approvals were required or made at this meeting.

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
Programme Update (Discovery Phase – Year 1): Focused on strategic realignment, tensions within engagement and delivery, and the evolving programme methodology. **Executive Reflections:** Contributions from programme leaders and executive sponsors on managing ambiguity, discomfort, and readiness for transition. **Evaluation and Strategic Integration:** Discussion of how outcomes will be assessed and aligned with organisational goals. **Communications and Engagement Strategy:** An outline of the upcoming November engagement initiative was shared, emphasising visibility, accessibility, and cross-workstream collaboration.