with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 27 November 2025

10:00 – 12:30

To be held in the Leckhampton Room, Edward Jenner Court

AGENDA

Time	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/1125	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1125	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/1125	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/1125	Minutes of the meeting held on 25 September 2025	Approve	**Paper**	Chair
	05/1125	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/1125	Questions from the Public	Assurance	Verbal	Chair
10:40	07/1125	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/1125	Report from Chief Executive	Assurance	**Paper**	CEO
PERFORMANCE AND PATIENT EXPERIENCE					
11:00	09/1125	Finance Report	Approve	**Paper**	DoF
11:10	10/1125	Quality Report	Assurance	**Paper**	DoNTQ
11:25 - BREAK (5 minutes)					
11:30	11/1125	Performance and Quality Dashboard	Assurance	**Paper**	DoF/COO
11:45	12/1125	Board Assurance Framework	Assurance	**Paper**	DoCG
11:55	13/1125	Freedom to Speak Up Report	Assurance	**Paper**	FTSU Gdn
GOVERNANCE					
TO NOTE	14/1125	Council of Governor Minutes – Sept 2025	Information	**Paper**	DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:10	15/1125	MHLS Committee (15 Oct)	Information	**Paper**	MHLS Chair
	16/1125	Great Place to Work Committee (21 Oct)	Information	**Paper**	GPTW Chair
	17/1125	Resources Committee (30 Oct)	Information	**Paper**	Resources Chair

Time	Agenda Item	Title	Purpose	Comms	Presenter
	18/1125	Quality Committee (4 Nov)	Information	**Paper**	Quality Chair
	19/1125	ATOS Committee (11 Nov)	Information	**Paper**	ATOS Chair
	20/1125	Audit & Assurance Committee (13 Nov)	Information	**Paper**	A&A Chair
	21/1125	Leadership & Culture Assurance Committee (13 Nov)	Information	**Paper**	LCA Chair
CLOSING BUSINESS					
12:25	22/1125	Any other business	Note	Verbal	Chair
12:30	23/1125	**Date of next Board Meeting:** Thursday, 29 January 2026, 10:00-12:30 in the Leckhampton Room, EJC	Note	Verbal	All

with you, for you

NHS
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NHS Foundation Trust

AGENDA ITEM: 04/1125

MINUTES OF THE TRUST BOARD MEETING

Thursday, 25 September 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
Nicola de Iongh, Non-Executive Director
Rosanna James, Director of Improvement & Partnership
Jason Makepeace, 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:
Laura Bailey, Trust Governor *(MS Teams)*
Jo Crisp, GHC Organisational Development Project Lead
Anna Hilditch, Assistant Trust Secretary
Faisal Khan, Deputy Medical Director
Pam Klus, Senior Community Nurse/Specialist Practitioner District Nurse Student
Bob Lloyd-Smith, Trust Governor *(MS Teams)*
Bren McInerney, Member of the Public
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance
Joanna Watson, Good Governance Institute

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting.

1.2 Apologies were noted from Bilal Lala 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 Nicola Dowdeswell (Physiotherapist) who was in attendance with Vanessa, Sophie and Liam, to present on the MyLife programme, a co-produced lifestyle intervention to support individuals with severe mental illness (SMI) to live well.

3.2 The programme has been led by Nicola and funded by the Research & Development Team. The programme has developed with input from participants, dietetics and psychology.

3.3 Nicola introduced her colleagues, who spoke to the Board about the impact of the programme. Some of the highlights included developing strong connections, better physical health (going to the gym), better relationships with family, meeting new friends, increased knowledge of their medical condition, and a reduction in the medication being taken. The Board heard some powerful quotes, including "I'm not just existing now, I'm living", "I feel motivated", and "I have gone from feeling powerless to empowered". Service user colleagues said that they did still struggle to accept their MH conditions, but the programme offered a safe space to talk about it with people living with the same condition and having the same experiences.

3.4 Nicola Dowdeswell informed the Board that the programme currently only ran in Gloucester, so further work was taking place to look at future funding to develop the training package. She said that it was a 12-week programme, but service users remained part of the community, even after being discharged from MH services, they could still get support if it was needed.

3.5 The Board agreed that this was a very inspiring presentation and clearly highlighted some key benefits for those participants on the programme. The Board thanked Nicola, Vanessa, Sophie and Liam for sharing their stories and showing the Board how important these interventions can be.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 31 July 2025. The minutes were **accepted** as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

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

6. QUESTIONS FROM THE PUBLIC

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

6.2 The questions related to the promotion of the Trust's Charity, and connections with NHS Charities Together.

6.3 Rosanna James 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 In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, Graham Russell said that he 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. Graham said that he was looking forward to visiting more services over the coming months to acknowledge 'Making a Difference' across the trust, emphasising the value of appreciation.

7.3 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 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. 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. Douglas Blair said that he believed the Trust was 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 noted this update and supported the recommendation that further local progress with delivering the 10 Point Plan would be reported via the Great Place to Work Committee to Board.

8.3 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 in 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.

8.4 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 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.

8.5 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 will be undertaken in two phases between August – December, with the submission of plans in December.

8.6 Vicci Livingstone-Thompson noted that the Trust had 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. Vicci said that this was a great achievement, acknowledging the work carried out by the Trust to focus on reasonable adjustments.

8.7 The Board **noted** the update provided and welcomed the new format of the report.

9. FINANCE REPORT

9.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 5. Jason Makepeace confirmed that the financial position was discussed and reviewed in detail at the Resources Committee.

9.2 At month 5 the Trust had 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.

9.3 The 2025/26 capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Net spend to month 5 was £2.210m against a budget of £4.144m. The Capital forecast outturn was anticipated to be in line with plan. Sandra Betney advised that £274k Capital funding had been confirmed for Electric Vehicle Charging Points which would be included in next month's forecast.

9.4 The Trust's agency and off framework agency usage was included in the report, with £1.421m ytd spent on agency staff which is below plan by £0.233m. It was noted that

there were 32 off framework shifts in month 5 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. The Board noted that the Trust spent £8.87m on bank staff which was above plan by £1.404m.

9.5 The Cost Improvement Programme (CIP) has delivered £4.286m of recurring savings against the plan of £3.713m. The target for the year is £10.086m. £2.083m remains unidentified which is a reduction of £0.373m. The non-recurrent savings target is £5.169m all of which has been identified, and of which £2.623m has been delivered.

9.6 The 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%.

9.7 Sandra Betney highlighted the finance related risks within the report, specifically noting the new risk identified in relation to the transfer of services to Gloucestershire County Council. Those risks identified for 2026/27 would start to be added to the report going forward.

9.8 The Board **noted** the month 5 financial position. Graham Russell reflected that GHC was in a relatively positive position, and he thanked Sandra Betney and colleagues for the robust management and oversight.

10. QUALITY DASHBOARD REPORT

10.1 The Board received the Quality Dashboard, which showed the data for August 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 The Board noted that there had been an increase in the number of inpatient falls in August, with no harm falls accounting 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 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. Nicola Hazle advised that the Trust had a low tolerance for reporting which did contribute to the increase of incidents recorded, which was seen as positive. She added that the key was to mobilise patients, and this would in turn bring about risks of falls.

10.3 Positively, there was a reduction in reported incidents of self-harm/self-injurious behaviour and notably in the numbers of restraint incidents and rapid tranquilisation incidents.

10.4 The Board noted that a recent CQC Mental Health inspection had taken place at Mulberry Ward at Charlton Lane, and the report recommended that no action was required. This was extremely positive and provided a good level of assurance about the service.

10.5 The Learning from Deaths Report for Q1 was received and this highlighted that none of the 15 deaths that were reviewed were considered more likely than not to be due to problems in care.

10.6 The Infection Prevention and Control data was included within the dashboard and the Board noted that there had been 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. Nicola Hazle informed the Board that the Trust's Flu campaign was about commence and encouraged all colleagues to get their jab.

10.7 The Board noted that a server issue had prevented automated text messages going out to patients with the link to the FFT survey. Nicola Hazle advised that this had now been resolved but it was likely that there would be a knock on effect in terms of the level of response received during September.

10.8 Steve Alvis was disappointed that the uptake of the HPV vaccination was not quite at threshold. He said that this vaccination was so important in helping to prevent cancer in younger people and he asked if there was anything further that the Trust could do to educate / encourage parents to consent. Nicola Hazle agreed and provided an update on the work already taking place with schools to promote this.

10.9 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 August 2025.

11.2 Sandra Betney highlighted four measures within the 'alert' category of the report which would be followed up by the Resources Committee at its October meeting. Three of these related to length of stay measures, and one to MH Liaison service referrals seen within 2 hours. The Board noted that GHC was part of the Regional Learning Partnership on length of stay.

11.3 The Board noted those measures highlighted in the 'applaud' category of the report for positive recognition. Sandra Betney noted the areas of compliance but added that these had been included within this category due to their sustained, month-on-month compliance which was positive. The report recognised the strong work of the Trust's Memory Assessment Service, noting that 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%).

11.4 Nicola de Iongh asked about morale within the IUC Service. Sarah Branton said that the service was very busy, but morale was ok and the team were proud to see the progress being made and the difference it was making.

11.5 The Board **noted** the Quality and Performance Dashboard Report for August 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. WINTER PLANNING ASSURANCE STATEMENT

12.1 The Board received this report which sought to provide assurance to the Board in relation to the Trust's preparedness and planning for winter 2025/26.

12.2 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.

12.3 Sarah Branton informed the Board that the report summarised and provided assurance on the preparation of the winter plan 25/26 which has been developed in system partnership. The Board Assurance Statement, required as part of the Urgent and Emergency Care Plan for 25/26 covers key areas and this paper had been structured to reflect these.

12.4 The Board noted that the Resources Committee received the Operational Resilience and Capacity Plan (Winter Plan, Board Assurance Statement) at its meeting on 28th August 2025 and this was followed by a further paper circulated to all Committee members on 11th September for comment. The Committee Chair, Chief Operating Officer and Head of Emergency Planning, Preparedness, Resilience and Response then met to review and endorse the Board Assurance Statement to Board.

12.5 The Board noted that a system Quality and Equality Impact Assessment (QEIA) had now been finalised, and a GHC specific QEIA was in development. Sarah Branton advised that this would be completed as we move through the testing phases in September and October 2025. This would ensure that quality and equality impacts have been identified and tested with mitigations in place.

12.6 Sarah Branton added that whilst the Board was being asked to endorse the plan in September 2025, the Operations Directorate would continue to test, iterate and improve the plan throughout Autumn 2025 as we move towards winter.

12.7 On the recommendation of the Resources Committee, the Trust Board endorsed the Winter Plan and approved the Board Assurance Statement for submission to NHS England on or before 30 September 2025.

13. MEDICAL APPRAISAL ANNUAL REPORT

13.1 The Board received the Medical Appraisal and Revalidation Report which provided 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. The report also 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. It was noted that the annual report had been presented to and endorsed by the Great Place to Work Committee on 26th August 2025 for onward Board approval.

13.2 Amjad Uppal presented this report and highlighted 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 was on Bank.

13.3 The Board welcomed this report and recognised that levels have been maintained in the application of appraisal, recording and quality assuring. The Board agreed the content of the report and endorsed the submission of the Statement of Compliance to NHS England, to be signed by the Chair on behalf of the Trust.

14. GUARDIAN OF SAFEWORKING – QUARTER 1 REPORT

14.1 The Board received the Guardian of Safe Working Hours' quarterly report, for assurance and information. This report was also considered at the Great Place to Work Committee in August 2025.

14.2 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.

14.3 This report was noted.

15. TRUST STRATEGY REFRESH: OUR FIVE-YEAR FOCUS

15.1 The purpose of this report was to provide the Board with the final Trust Strategy for 2026-2031 for approval. The refreshed Strategy sets out the intention to build on the progress made since the first 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."

15.2 Rosanna James advised that the paper also described 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.

15.3 In creating this strategy, stakeholder engagement and coproduction has been an ongoing part of the development process since March 2025. Between March-August we have had conversations and analysed survey responses from over 1,200 people. Rosanna James said that the views of our colleagues and stakeholders had greatly influenced our Strategy and the ongoing involvement of them in delivery and shaping how we realise our goals would be a key factor in its successful delivery.

15.4 This engagement has helped to develop 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.

15.5 The Strategy will be kept under review to ensure that it delivers the intended benefits. Rosanna James advised that there was a 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.

15.6 The Board approved the Trust Strategy, and endorsed the approach to communication, delivery and next steps. Graham Russell thanked those colleagues who had led on the development of the refreshed Strategy, and to all those who had contributed through the extensive engagement programme. This strategy was the start of a journey and would give the Trust a new sense of direction and momentum.

16. GREEN PLAN REFRESH

16.1 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, two separate versions (full detail and accessible version) will be designed into public-facing documents working with the Comms Team.

16.2 The Green Plan Refresh includes two goals which are based on NHS carbon footprint targets, and 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. 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.

16.3 The Board noted that progress against linked goals within the Green Plan Refresh would 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 continue to 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.

16.4 Rosanna James advised that Year-1 of Green Plan delivery would 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). It is proposed that 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.

16.5 The Board recognised the great progress that had been made in this area and were pleased to approve the Green Plan Refresh content, specifically the three overarching goals as highlighted.

17. COUNCIL OF GOVERNOR MINUTES – 9 JULY 2025

17.1 The Board **received** and **noted** the minutes of the Council of Governors meeting held on 9th July 2025.

18. BOARD COMMITTEE SUMMARY REPORTS

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

- Audit & Assurance Committee (7 August)
- Great Place to Work Committee (26 August)
- Resources Committee (28 August)
- Quality Committee (2 September)
- Leadership & Culture Assurance Committee (9 September)

18.2 The Audit & Assurance 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, and this had now been embedded into the work plan for the QC.

18.3 External auditors Sumer advised the Audit & Assurance Committee that the handover process between themselves and former external auditors KPMG was yet to commence. However, assurance was provided that this was in hand, and an update would be received at the next Committee meeting in November.

18.4 Rosi Shepherd advised that the Quality Committee had received the Infection Prevention and Control Annual Report at its meeting. This was an excellent report, and it had been shared with Board colleagues in the Reading Room for information.

18.5 Discussions had taken place at the Leadership & Culture Assurance Committee around the engagement proposals for colleagues during November.

19. ANY OTHER BUSINESS

19.1 Graham Russell noted that the Trust's AGM had taken place on Thursday 11th September, and he expressed his thanks to all colleagues who had assisted in the planning and contributions at the meeting.

19.2 Nicola de longh said that she was very pleased to advise that the University of Gloucestershire had climbed 32 places in the annual university league tables.

20. DATE OF NEXT MEETING

20.1 The next meeting would take place on **Thursday, 27 November 2025**.

Annex 1

QUESTIONS FROM THE PUBLIC

QUESTION 1

"How does Gloucestershire Health and Care NHS Foundation Trust promote their charitable arm to the public. What approach does the Trust use to generate awareness of the opportunity, if people wish, to donate to the Trust's charity?"

Bren McInerney

TRUST RESPONSE

Our Charity has recently experienced a period of growth, thanks to support from NHS Charities Together and a development grant we received in 2022. This has enabled us to rebrand the charity, improve our fundraising approach and recruit a Charitable Funds coordinator who now works 3 days per week for the charity. Since being in post, the coordinator has led on raising the profile of the charity both inside and outside the organisation and this is still work in progress. So far, she has successfully set up a Facebook account for the charity, made grant applications to support a number of garden projects, organised fundraising activities at various sites, set up new fundraising online portals and worked with local businesses to encourage them to support us. A corporate pack is in development which should support this further. Recently a fete was held at the Forest of Dean Community Hospital, and this was used as an opportunity to launch a new fundraising group for the Forest with the public. We also continue to work with our Leagues of Friends, who, as independent charities in their own right, do much good work to support our patients and colleagues in community hospitals countywide.

Some of the projects recently funded by GHC charity include a garden development at Charlton Lane Hospital, murals at Hope House and Greyfriars Psychiatric Intensive Care Unit, activities for patients and colleagues and staff welfare items. The charity has also distributed more than £50,000 through a hardship fund for colleagues who are 'in extremis' due to the cost-of-living crisis.

QUESTION 2

"How does Gloucestershire Health and Care NHS Foundation Trust connect with NHS Charities, to further develop and enhance their service provision and experiences for patients, carers, families, and staff, now and for the future."

Bren McInerney

TRUST RESPONSE

Our Charity successfully received grants during Covid from NHS Charities Together and our application for a development grant in 2022 has enabled the charity to grow significantly. We also work closely with Cheltenham and Gloucester Hospitals Charity, who are particularly supporting us with the development of a new female-only garden space at Wotton Lawn Hospital. Our Charitable Funds Coordinator is also building links with other NHS Charities to share best practice and explore new methods for awareness raising and other activities. We also try to involve local businesses – who have made donations towards projects and events. We also promote the charity to colleagues so that they can promote the charity on our behalf, this includes inviting colleagues to participate in fundraising events through Run for Charity. We are always open to conversations with the public, companies (including other charities) and how we can work together.

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 27 November 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
25 Sept 2025	6.3	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.	Trust Secretariat	Nov 2025	Complete	**Complete**

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 2025**

PRESENTED BY: Graham Russell, Trust Chair

AUTHOR: Trust Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

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

The purpose of this report is to

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

Recommendations and decisions required

The Trust Board is asked to:

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

Executive summary

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

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

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified

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 – September and October 2025

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

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

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

2.0 CHAIR'S UPDATE

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

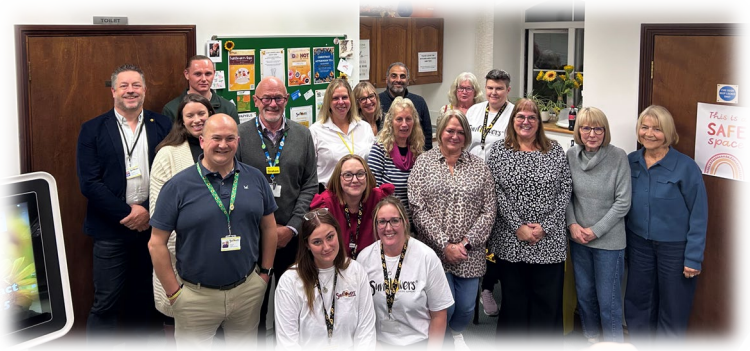
Underpinning the Trust's values, I have four key areas of focus:

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

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

Working together

- It was an honour to speak at **Sunflowers Suicide Support AGM** on 16th October. I shared my thoughts on how our Trust values lived experience and the vital role of the NHS working in partnership with voluntary care sector organisations. Sunflowers support the those bereaved and affected by suicide in Gloucestershire and have a liaison service which provides practical and emotional support.



- The **Bishop of Gloucester, Rt Revd Rachel Treweek** visited our Trust on the morning of 7th November and was given a tour of some of our Gloucester services. Rosi Shepherd, Non-Executive Director and I were delighted to accompany Bishop Rachel to the Homeless Healthcare Team and Complex Homelessness Partnership Support (CHPSS) at Rikenel, Young Adults' Service at the Old Dock Office, Montpelier Unit at Wotton Lawn Hospital and finally Eastgate House where members of the Complex Emotional Needs service, Criminal Justice Liaison and

Community Sentence and Treatments teams shared their experiences. I would personally like to thank all services for taking the time out of their busy schedule to accommodate Bishop Rachel's visit.

- I was delighted to accompany **Cllr Lisa Spivey, Leader of Gloucestershire County Council** on a visit to Hope House Sexual Assault Referral Centre (SARC), Wotton Lawn Hospital and Child and Adolescent Mental Health (CAMHS) at Acorn House on 25th November. During the visit, Cllr Spivey met with colleagues and healthcare professionals. I would like to thank Ava Carpenter, SARC Service and Quality Manager, Becky Anstis, Modern Matron and Diana Scully, Deputy Service Director for taking time out of their busy schedules to accommodate the visit.

- **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

- Regular briefings with the county's MPs continue. The Chief Executive and I met with **MP for Forest of Dean, Matt Bishop** on 3rd October, **MP for North Cotswolds, Sir Geoffrey Clifton Brown** on 17th October, **MP for South Cotswolds**, **Roz Savage** on 23rd October, **MP for Tewkesbury, Cameron Thomas** on 5th November and **MP for Stroud, Dr Simon Opher** on 13th November.

- I chaired a meeting of the **Leadership and Culture Board Assurance Committee** on 13th November. Amongst other items, the committee received an update on the Leadership and Culture programme.

- '**Our GHC Fortnight**' took place over the 10th - 21st November, a Trust wide engagement initiative designed to streamline leadership and culture conversations. Over the two weeks, 17 in-person and 6 virtual sessions including evening and weekend options took place offering colleagues the opportunity to reflect on their experiences, celebrate progress, and contribute to shaping the Leadership & Culture programme and People Strategy refresh. The focus was on honest dialogue about "what it's like to work here" and "what we can do together to make this a great place to work," emphasising that every colleague's voice and personal responsibility is vital in building a positive organisational culture. For teams unable

to attend formal sessions, a conversation toolkit enabled inclusive participation and collective insight gathering, ensuring all teams were able to contribute to next steps.

Respectful and kind

- The long service of colleagues who have worked in the NHS for 20, 30 and 40 years was celebrated at our annual **Long Service Awards** on 6th November. Colleagues gathered at Dowty Sports and Social Club to pay tribute to those who had achieved the significant milestones and given more than two decades of their lives to supporting communities in Gloucestershire and beyond. I had the pleasure of thanking colleagues for everything they had done - collectively those at the event had given more than 850 years of service.

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 **ICT Gloucester Aspen and Saintbridge District Nursing Team** who are based at **Collingwood House** on 23rd October and **Cashes Green Ward at Stroud Hospital** to present their '**Making a Difference**' awards.

Cashes Green Ward

ICT Gloucester Aspen and Saintbridge District Nursing Team

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.

3.0 BOARD UPDATES

- On 15th October, a **Board Seminar session** took place where the topic for discussion was Change and Improvement (QI). The session was led by Rosanna James, Director of Improvement and Partnerships. This informative session discussed the national improvement approach and the role of the Board in embedding improvement into the Trust.

- Following the developmental review of our current Board committee arrangements, an in-person **Board Development session**, facilitated by the Good Governance Institute, took place on 13th November where the outcome of the review was discussed and will feed into future development sessions for Board members

- A **Board Seminar session** took place on 12th November where the topics for discussion were Leadership and Culture led Michelle Hurley-Tyers, Deputy Director of HR & OD and the Learning Disability Pathway including Board Listening and Learning events which was led by Rosanna James, Director of Improvement and Partnerships. Both seminars were constructive and resulting in in depth discussion.

- On 15th October, an **Extraordinary Board** meeting took place where Board colleagues discussed the submission of the Provider Capability Assessment.

- On 5th October I met with Douglas Blair, Chief Executive, Nicola de Iongh, Vice Chair, Lavinia Rowsell, Director of Corporate Governance and Anna Hilditch, Assistant Trust Secretary where we discussed **Non-Executive Director portfolios and transition** ahead of recruitment to two new Non-Executive Directors to the Board. Interviews are scheduled to take place on 17th December, and I will provide an update on the outcome in my January 2026 Board report.

- Sadly, this will be Sumita Hutchison's last Board meeting. Sumita's role as Non-Executive Director comes to an end on 13th January 2026. I would like to personally thank Sumita for all of her hard work and dedication to the Trust and I wish her well for the future.

- On 7th November, we bid a fond farewell to **Jason Makepeace, Non-Executive Director** who left the Trust for pastures new. It was a pleasure to work with Jason.

- On 11th November, I, along with Trust Chairs across England met virtually with **Penny Dash, Chair of NHS England** where we discussed opportunities for reform, the national direction and received key updates.

- A meeting of the **Appointment and Terms of Service Committee** took place on 11th November. Amongst other items, the Committee discussed Executive Director succession planning.

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

4.0 GOVERNOR UPDATES

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

- On 19th November we held our in-person **Council of Governors meeting** where, amongst other items, Governors received a presentation on Child & Adolescent MH Services (CAMHS) and an update on the Working Together Network.

5.0 NHSE PROVIDER CAPABILITY ASSESSMENT

5.1 On Tuesday 26 August, NHS England published *Assessing provider capability – guidance for NHS trust boards*. The guidance sets out how trusts should annually self-assess their capability across six domains:
- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

5.2 These self-assessments would be used by NHSE, alongside other sources of information, to determine each trust's provider capability rating under the NHS oversight framework.

5.3 Following extensive engagement with our Executive Team and Non-Executive colleagues, an extraordinary Board meeting took place on 15th October to review, discuss and confirm the areas of assurance and the levels of compliance applied to each of the criteria and overarching domains. The Board unanimously **approved** the final submission to be submitted to NHSE by the deadline of 22 October 2025, as follows:

Domain	Rating
Strategy, leadership and planning	**Compliant**
Quality of care	**Compliant**
People and culture	**Compliant**
Access and delivery of services	**Compliant**
Productivity and value for money	**Compliant**
Financial performance and oversight	**Compliant**

6.0 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** for the summary of the Non-Executive Directors activity during 1st September to the 31st October 2025.

7.0 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 September – 31st October 2025

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• GGI Webinar • ICS Non-Executive Directors Meeting • Mental Health Act Managers' Forum • Mental Health Bill Webinar • Mental Health Legislation Scrutiny Committee Pre-Meet • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Old Age Psychiatry AAC Panel • Pre Consultant Interview Discussion • Resources Committee Board Self-Assessment • Staff Governor & Non-Executive Directors Meeting	• Board Seminar: Provider Capability Assessment and Change and Improvement (QI) • Mental Health Legislation Scrutiny Committee • Resources Committee • Trust Board: Public and Private
Sumita Hutchison	• Council of Governors Meeting • Diversity Network Pre-Meet • Great Place to Work Agenda Setting Meeting • Great Place to Work Assurance Report Meeting • Great Place to Work Pre-Agenda Setting Meeting • NHS Providers Board Development • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Provider Capability Assessment Meeting • Provider Capability Assessment Meeting	• Great Place to Work Committee • Leadership & Culture Assurance Committee • Trust Board: Public and Private
Nicola de longh	• Aspiring Chairs Programme – Module 4 • Aspiring Chairs Programme – Pathway Group Model • Council of Governors Meeting • GGI Seminar	• Board Seminar: NED Recruitment/Joint Board Development • Board Seminar: Provider Capability Assessment and Change and Improvement (QI)

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Health Overview and Scrutiny Committee • Meeting with Lead Governor • Meeting with Trust Chair • Module 3 Aspiring Chairs NHS Programme • Non-Executive Director Recruitment Proposal • Staff Governor & Non-Executive Directors Meeting	• Nominations and Remuneration Committee • Resources Committee • Trust Annual General Meeting • Trust Board: Public and Private
Vicci Livingstone-Thompson	• Allied Health Professionals Event • Council of Governors Meeting • Diversity Network Meeting • Diversity Network Pre-Meet • Governor Visit to Forest of Dean Community Hospital • Interview panel for Lived Experience Workforce • Meeting with Director of Nursing, Therapies and Quality • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Provider Capability Assessment meeting with Medical Director and Director of Nursing, Therapies and Quality • Staff Governor & Non-Executive Directors Meeting • Working Together Network Meeting	• Board Seminar: NED Recruitment/Joint Board Development • Board Seminar: Provider Capability Assessment and Change and Improvement (QI) • Great Place to Work Committee • Quality Committee • Trust Annual General Meeting • Trust Board: Public and Private
Bilal Lala	• 1:1 with Modern Matron, Wotton Lawn Hospital • AAC Panel Chair • Community Health check-up drop-in at Jama Al-Karim Mosque, Gloucester • Governor visit to Wotton Lawn Hospital • Meeting with Director of HR & OD	• Board Seminar: NED Recruitment/Joint Board Development • Quality Committee • Trust Annual General Meeting

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Jason Makepeace	• AI Ambassador Network • Board Self-Assessment Meeting with Director of Finance • Catch up meeting with Chief Executive • Catch up meeting with Vice Chair • Council of Governors Meeting • Driving Change Data Session • ICB System Resources Committee • Meeting with ICB Resources Chair • Non-Executive Director role potential candidates' informal discussions • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Quality visit to Sexual Health Services • Quarterly Staff Governor Meeting • Resources Committee Agenda Setting Meeting with Director of Finance • Resources Committee Post-Meeting Review	• Board Seminar: NED Recruitment/Joint Board Development • Board Seminar: Provider Capability Assessment and Change and Improvement (QI) • Resources Committee • Trust Annual General Meeting • Trust Board: Public and Private
Rosi Shepherd	• 1:1 with Freedom to Speak Up Lead • 1:1 with Trust Chair • Freedom to Speak Up Away Day • Freedom to Speak Up Champion Network • Gloucestershire ICS NEDs Meeting • Meeting with John Cappock, GHNHSFT Non-Executive Director • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Quality Committee Pre-Meet • Quality Committee Pre-Meet	• Board Seminar: NED Recruitment/Joint Board Development • Board Seminar: Provider Capability Assessment and Change and Improvement (QI) • Leadership & Culture Assurance Committee • Quality Committee • Trust AGM • Trust Board: Public and Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Quality visit to CAMHS • Quality visit to Sexual Health Service • Staff Governor & Non-Executive Directors Meeting	

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AGENDA ITEM: 08/1125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 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

CHIEF EXECUTIVE SERVICE / TEAM VISITS

In October and November, I have completed the following service visits:

- **Forest of Dean – Monday 6 October**
  I hot desked at Colliers Court, dropped in to see colleagues in the Integrated Community Team and received my flu vaccination at the Forest of Dean Community Hospital.

- **Rikenel, Gloucester – Friday 7 November**
  In addition to welcoming the Bishop of Gloucester to a range of service visits, I caught up with colleagues based at the site.

- **Stroud– Wednesday 12 November**
  I visited Stroud Hospital, Weavers Court and Children's Services base as part of the 'Our GHC Fortnight'.

EVENTS

- **AHP Community of Practice meeting – 13 October**
  I joined Allied Health Professions colleagues at their Community of Practice event, held at Dowtys. This was arranged to coincide with national AHPs day (which was on 14 October) and a great opportunity to catch up with colleagues.

CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Alert	**Workforce**	**Resident Doctors Industrial Action**
	By the time of November's Board meeting, the NHS will have undergone the British Medical Association's (BMA) England-wide Resident Doctors industrial action. A verbal update will be provided at the Board. The industrial strike action by Resident Doctors, is planned from Friday 14 November (7am) to Wednesday 19 November (7am). The Trust has worked through its usual well-tested emergency planning and resilience planning processes for strikes in partnership with system colleagues to ensure impacts on patient safety and day to day operations are mitigated wherever possible. Gloucestershire Hospitals NHS Foundation Trust (GHT) made temporary changes to Cheltenham General Hospital's Emergency Department as well as other clinical pathways. To support this, and to illustrate other pathway changes into GHT, a simple action card was provided across the system for referrers and partners, which also included useful points of contact. It is hoped that the government can reach an agreement with the BMA to end the on-going pay and terms and conditions dispute.	
Assure	**Workforce**	**10 Point Plan to Improve Resident Doctors' Working Lives**
	Following the previous Board update on this national 12-week initiative, the Trust completed and submitted its national return on 31 October. Compliance with the 10 Point Plan is being formally incorporated into the oversight regime for 2026/27. The detailed response will be included on the agenda for the December Great Place To Work Committee and will recommend that the Trust takes "substantial assurance" on delivery against the national improvement plan requirements. Dr Amjad Uppal has led on this work with the support of Dr Emma Abbey, Neil Savage, Medical Staffing, Postgraduate Medical Education, Working Well and Workforce.	
Advise	**National/Regional Updates**	**Medium Term Planning Framework**
	On 24 October 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published a Medium Term Planning Framework covering the financial years 2026/27 to 2028/29. This marks a move away from annual financial and delivery planning cycles. The planning framework sets out the refreshed operating model and focuses on the following 8 key areas: • Unleashing local potential to deliver integrated care • Delivering Neighbourhood Health at pace • Shifting from sickness to prevention • Doing digital differently • Transforming the approach quality • Understanding and improving the patient experience • Reconnecting with the workforce, and renewing and strengthening leadership and management	

Advise	• Embedding genomics, life sciences and research The key service deliverables particularly relevant for GHC are: **Community services and primary care:** • Addressing long waits for community services: 78% of activity within 18 weeks in 2026/27; 80% within 18 weeks in 2028/29 'Develop a plan' to eliminate all 52-week waits and 'actively manage' long waits for community services. **Mental health, learning disabilities and autism:** • New targets for those accessing talking therapies - 805,000 courses of NHS talking therapies by the end of 2026/27 (up from 700,000) with a 51% reliable recovery rate (up from 48%) and a 69% reliable improvement rate (up from 67%). 915,000 courses of NHS talking therapies by end of 2028/29 with 53% reliable recovery rate and 71% reliable improvement rate • Expanded coverage of mental health support teams (MSHTs) in schools and colleges, aiming for 77% coverage of operational MSHTs in 2026/27 and 100% coverage in 2029 • Moving towards the elimination of inappropriate out-of-area placements, reducing the number by March 2027 and further reducing or maintaining the number at zero in 2028/29 • Reduce reliance on mental health inpatient care for people with a learning disability and autistic people by 10% in 2028/29 **Workforce:** • Annual limits on bank and agency spend will be set individually for trusts, based on the national target of 30% reduction in agency use in 2026/27 and 10% year on year reduction in spend on bank staffing, working towards zero spend on agency by August 2029 • Ambition to reduce sickness absence rates to the lowest recorded national average level (approximately 4.1%) **Productivity:** • Increase productivity by a minimum of 2% annually (and plan for a 3% community capacity increase) Each Provider Organisation is required to submit their own plan in collaboration with system partners. The first submission is due on the 18 December and will include: • 3-year revenue and 4-year capital plan return

<table>
<tr><td rowspan="3">Advise</td><td>

3-year workforce return
3-year operational performance and activity return
Integrated planning template showing triangulation and alignment of plans
Board assurance statements confirming oversight of process

Plans are expected to be finalised in early February. Full plan submissions will include updated versions of those listed above plus a five-year narrative plan.

In conjunction with the national planning framework, Gloucestershire ICB is developing a Strategic Commissioning Framework for the next 5 years. This will set out the high-level commissioning intent in Gloucestershire across the following 6 areas:

Neighbourhood Health
All Age Mental Health, Neurodivergence, Learning Disabilities and Autism
Urgent Care and Flow
Planned Care & Diagnostic
System Quality
Enabling Functions

These will inform the Provider planning submissions, along with the outcomes of the internal GHC business planning process.
</td></tr>
<tr><td>Workforce | The Wellbeing Line</td></tr>
<tr><td>Sadly, the Gloucestershire Wellbeing Line will be closing in March 2026. The service was set up in 2022 to give confidential psychological support to health and care staff across the county as part of the national response to support staff wellbeing during and after the COVID-19 pandemic. The team also helped create the Health and Wellbeing Champions Network and the Neurodiversity Community of Practice.

The Wellbeing Line has been one of the last remaining hubs from the 40 funded nationally during the pandemic. Since 2023, it has relied on short-term ICS funding, which ends in March 2026. At the same time, the focus has shifted to ensuring wellbeing support is embedded within each organisation’s own offer, so colleagues can access help directly through their employer.</td></tr>
</table>

Advise	The Board will want to express our sincere thanks to the Wellbeing Line team for their dedication and expertise. Their support has been highly valued by colleagues across the system and has made a real difference to people's wellbeing during challenging times. The resources and ideas developed will help shape future wellbeing support across county-wide health and social care organisations. We will share further updates as the closure approaches, and this will include a celebration event to mark its achievements.	
	Workforce	**10 Year Workforce Plan**
	Following publication in the summer of the 10 Year Health Plan for England, a related Workforce Plan is in development and a national consultation closed on 7 November. The government intends to deliver its vision for the NHS workforce through a 10 Year Workforce Plan which will take a different approach to workforce ensuring that: • digital technology and automation frees up clinical time for care • the NHS becomes a modern employer with a new tranche of top-quality leaders • colleagues will be better supported to reach their full professional potential NHS Employers have worked with provider Chief People Officers to develop and submit a consultation response which is summarised below: • The need for further investment to support the introduction of digital and AI initiatives • The importance of apprenticeships at all levels in both clinical and non-clinical roles to attract individuals into the NHS and to ensure they stay by having apprenticeship opportunities along career pathways • Support to create new roles such as in mental health, which will enhance a preventative approach and serve the local community • Having a flexible educator workforce within education institutions and NHS organisations • Entry-level pay must be reviewed to maintain competitiveness against rising statutory minimums and private sector alternatives • Graduate entrants need structured progression • Promotion incentives for Agenda for Change staff must be rebalanced, as narrow pay gaps between bands reduce the financial appeal of taking on more responsibility, undermining motivation and career development • Different pay awards made by different pay bodies can lead to further disagreements and potential strike action • Reforming the NHS Pension Scheme to provide a modernised and inclusive reward offer to all parts of the workforce • The need for a balance of using AI to undertake certain duties within roles, while still offering a range of entry level roles to provide opportunities for the local community to take up a career in the NHS	

	• Offering new ways of multi-professional team working to provide care in the local community, or nearer to home, to enhance patient care • The introduction of the staff standards will ensure that staff experience is a priority within NHS organisations • Reducing occurrences of racism and discrimination, sexual abuse and violence in the NHS from both staff and patients • Having an immigration policy which encourages our international colleagues to flourish and stay in the UK Elements of the above are being factored into the development of the Trust's future new five-year People Strategy, which is expected to come back to the Board in March 2026. A publication date for the 10-Year Workforce Plan is yet to be confirmed.
	Operational **The Sexual Assault Referral Centres** The Sexual Assault Referral Centres (SARC) in Glos and Swindon received a pre-assessment visit from the UK Accreditation Service (UKAS) in early October to support our ongoing progress with compliance against the ISO 15189 standard (related to medical laboratories to ensure the quality of forensic evidence collected). Accreditation is a requirement under the Forensic Services Regulator which came into force this year. The visit was a culmination of a significant amount of work over the last 24 months by a range of colleagues in GHC and our partners First Light (in Swindon) and the OPPC (Office of Police and Crime Commissioners). We are analysing the feedback we gathered during the visit, whilst we await the formal feedback to determine next steps in our progress to accreditation.
Applaud	**Workforce** **Safe Effective Quality Occupational Health Service (SEQOHS) Accreditation** At the end of October, the Trust received confirmation that Working Well had successfully passed its Year 3 SEQOHS annual renewal assessment. SEQOHS is a set of quality standards and a process of accreditation for occupational health services in the UK. It aims to raise the overall standard of care and help purchasers differentiate high quality services from low or poor quality providers. Following external assessment, the SEQOHS assessor provided the following feedback: *"This is an excellent service which has clearly demonstrated good governance and openness in its annual renewal. The service has provided some good evidence of audit plans and has demonstrated diligence on the rare occasions when things have not gone as well as they could have. I would like to congratulate your service for its continued commitment to maintaining SEQOHS standards."* The team have been congratulated for the outcome and have begun working on their next "year five reaccreditation."

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 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 October 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 7 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 7 the Trust has a surplus of £0.091m compared to the ytd plan of a £0.211m deficit.
- 2025/26 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, disposals and IT schemes. Spend to month 7 is £2.344m against a budget of £5.58m.
- The Trust spent £12.518m on bank staff which is above plan by £2.071m.
- The Trust spent £1.741m on agency staff up to month 7, which is below plan. There were 16 off framework shifts, the target is 0.
- Cash at the end of month 7 is £44.681m, which is c.£3m ahead of plan.
- The Board are asked to **approve** the Revised Capital Plan.

Risks associated with meeting the Trust's values

Risks are included within the paper.

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report

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

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AGENDA ITEM: 09.1/1125

Finance Report Month 7

27 November 2025

Presented by **Sandra Betney Director of Finance**

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Overview

- The system plan at 30th April submission was break even and the Trust's plan was break even.
- The Trust has submitted a revised plan to NHSE to reflect approved development funding
- At month 7 the Trust has a surplus of £0.091m compared to the plan of a £0.211m deficit.
- Cash at the end of month 7 is £44.681m, which is above plan by £3m.
- Cost improvement programme has delivered £5.255m of recurring savings against the plan of £5.393m. Target for the year is £10.086m. £1.761m is unidentified which is a reduction of £0.204m.
- Non recurrent savings target is £5.169m all of which is identified, and of which £3.618m is delivered.
- The Trust spent £12.518m on bank staff which is above plan by £2.071m.
- The Trust spent £1.741m ytd on agency staff which is below plan by £0.573m. There were 16 off framework shifts, the target is 0.
- Better Payment Policy shows 95.1% of invoices by value paid within 30 days and 91.6% 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 7 is £2.344m against a plan of £5.58m.
- Capital forecast outturn is anticipated to be in line with plan.
- Trust Board are asked to approve the updated Capital plan which reflects revised disposals.

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GHC Income and Expenditure

	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	315,164	183,657	182,768	(889)
Other operating income	16,590	19,417	11,776	12,538	762
Employee expenses - substantive	(221,705)	(233,665)	(147,361)	(131,945)	15,416
Bank	(17,906)	(17,906)	(970)	(12,518)	(11,548)
Agency	(3,967)	(3,967)	(641)	(1,741)	(1,101)
Operating expenses excluding employee expenses	(73,026)	(78,153)	(46,039)	(49,061)	(3,022)
PDC dividends payable/refundable	(2,781)	(2,781)	(1,622)	(1,622)	0
Finance Income	1,500	2,038	1,385	1,436	51
Finance expenses	(198)	(198)	(113)	(133)	(20)
Surplus/(deficit) before impairments & transfers	**(51)**	**(51)**	**72**	**(278)**	**(351)**
Gains/ (losses) from disposal of assets			0	17	17
Remove capital donations/grants I&E impact	51	51	26	31	5
Surplus/(deficit)	**0**	**0**	**98**	**(231)**	**(329)**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	321	321
Remove net impact of consumables donated from other DHSC bodies	0	0	0		0
Revised Surplus/(deficit)	**0**	**0**	**98**	**91**	**(7)**
WTEs	4762	4756	4756	4746	10

Budget for bank & agency is for specific cost centres, but Plan is for the Trust.

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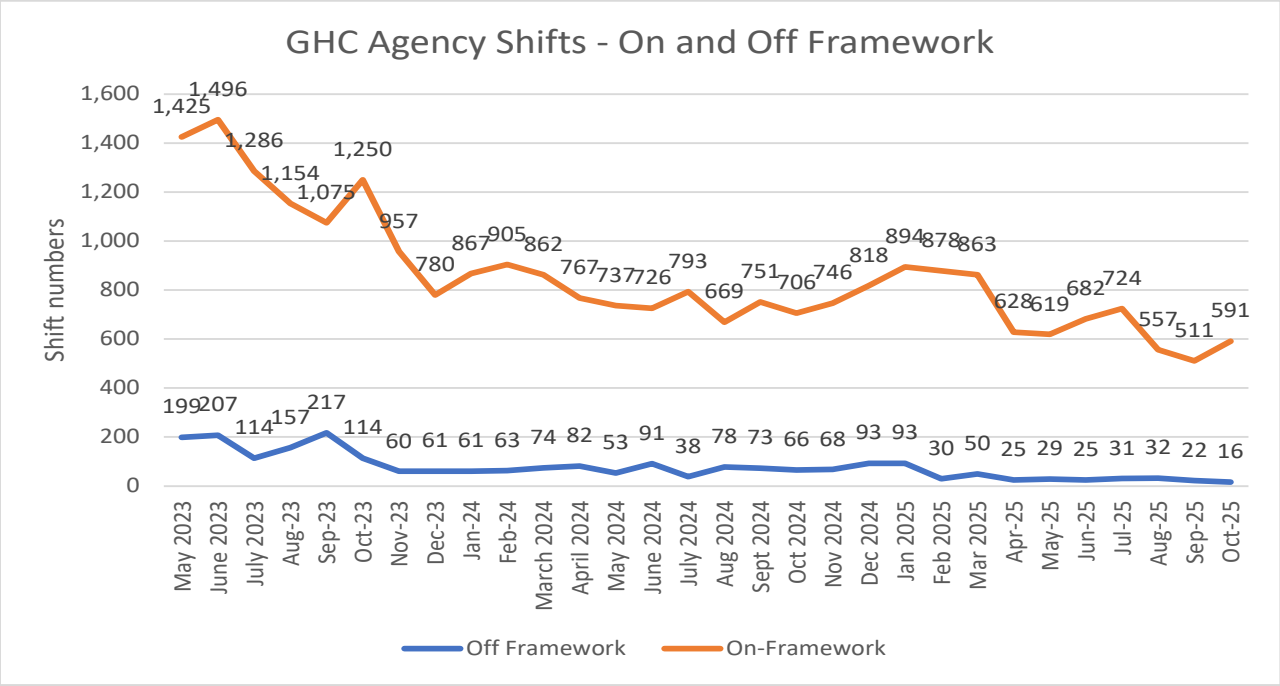
Pay Analysis

Pay analysis month 7						
	Plan WTE Month 7	Budget WTE Month 7	Budget £000s	Actual WTE Month 7	Actual £000s	Actual £ as % of Total £
Substantive	4,354	4,739	147,361	4,319	131,945	90.2%
Bank	348	18	970	397	12,518	8.6%
Agency	46	0	641	30	1,741	1.19%
Total	**4,748**	**4,756**	**148,972**	**4,746**	**146,205**	**100.0%**

- Trust WTE budget 8 higher than plan due to devts

- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- the Trust used 16 off framework agency shifts in October. 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

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	1,784	1,783	(1)	2,578
	Property, plant and equipment: other	117,935	122,466	119,366	115,207	(4,160)	123,447
	Right of use assets	16,438	16,541	16,305	15,783	(522)	15,661
	Receivables:	1,244	1,209	1,224	1,225	2	1,195
	Total non-current assets	**137,361**	**142,480**	**138,679**	**133,998**	**(4,681)**	**142,881**
Current assets	Inventories	444	444	444	443	(1)	443
	NHS receivables	7,409	7,432	7,432	17,657	10,225	7,457
	Non-NHS receivables	9,331	9,349	9,349	7,472	(1,877)	9,372
	Credit Loss Allowances	(1,595)	(1,595)	(1,595)	(1,585)	10	(1,585)
	Property held for Sale	3,123	377	1,732	2,763	1,032	1,368
	Cash and cash equivalents:	41,855	39,359	41,377	44,681	3,304	36,681
	Total current assets	**60,567**	**55,366**	**58,739**	**71,432**	**12,693**	**53,738**
Current liabilities	Trade and other payables: capital	(3,815)	(3,535)	(3,335)	(725)	2,610	(3,725)
	Trade and other payables: non-capital	(26,851)	(26,875)	(27,106)	(30,527)	(3,422)	(27,656)
	Borrowings	(1,514)	(1,514)	(1,514)	(1,482)	32	(1,407)
	Provisions	(8,701)	(8,702)	(8,702)	(6,203)	2,499	(7,203)
	Other liabilities: deferred income including contract liabilities	(1,303)	(1,303)	(1,303)	(11,731)	(10,428)	(1,331)
	Total current liabilities	**(42,184)**	**(41,929)**	**(41,960)**	**(50,669)**	**(8,709)**	**(41,323)**
Non-current liabilities	Borrowings	(14,026)	(14,252)	(13,981)	(13,415)	566	(13,437)
	Provisions	(2,511)	(2,511)	(2,511)	(2,499)	12	(2,499)
	Total net assets employed	**139,206**	**139,154**	**138,966**	**138,847**	**(119)**	**139,360**

Taxpayers Equity	Public dividend capital	132,103	132,103	132,103	132,103	(0)	132,707
	Revaluation reserve	13,790	13,789	13,789	13,692	(97)	13,692
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	(1,046)	(5,498)	(5,685)	(5,446)	239	(5,446)
	Income and expenditure reserve (current ye	(4,399)	0	0	(261)	(261)	(352)
	Total taxpayers' and others' equity	**139,206**	**139,154**	**138,967**	**138,847**	**(120)**	**139,360**

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Cash Flow Summary

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)		40		128	
Add back: Depreciation on donated assets	185		31		61	
Adjusted Operating surplus/(deficit) per I&E	**(4,287)**		**71**		**189**	
Add back: Depreciation on owned assets	11,117		5,632		9,978	
Add back: Depreciation on Right of use assets					0	
Add back: Impairment	4,497		321		321	
(Increase)/Decrease in inventories	(88)		1		1	
(Increase)/Decrease in trade & other receivables	(4,386)		(8,358)		(59)	
Increase/(Decrease) in provisions	154		(2,510)		(1,510)	
Increase/(Decrease) in trade and other payables	(8,506)		3,457		781	
Increase/(Decrease) in other liabilities	217		10,428		28	
Net cash generated from / (used in) operations		(1,283)		9,042		9,730
Cash flows from investing activities						
Interest received	3,072		1,436		2,484	
Interest paid	(9)		(5)		(9)	
Proceeds from Sale of PP&E	1,974		50		1,445	
Purchase of property, plant and equipment	(9,316)		(5,226)		(14,934)	
Assets Held for Sale						
Net cash generated used in investing activities		(4,279)		(3,746)		(11,014)
Cash flows from financing activities						
PDC Dividend Received	227		0		604	
PDC Dividend (Paid)	(2,491)		(1,427)		(2,817)	
Finance lease receipts - Rent	94		60		94	
Finance lease receipts - Interest	(62)		(35)		(59)	
Finance Lease Rental Payments	(1,572)		(943)		(1,521)	
Finance Lease Rental Interest	(213)		(126)		(190)	
		(4,016)		(2,471)	0	(3,889)
Cash and cash equivalents at end of period		41,855		44,680	0	36,682

Liquidity Metric

Month 7

Liquid Working Capital	x 214 days	=	35,935	40.19	days
ytd Operational Expenditure			191,359		

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Capital – Five Year Plan

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	2,477	519	8,500	5,000	3,000	3,000
Backlog Maintenance	1,879	3,381	974	1,393	1,393	1,393	1,400
Buildings - Finance Leases	1,496	615	206	2,050	250	250	250
Vehicle - Finance Leases	250	250	95	250	250	250	250
Other Leases	0	0	0		0	0	
Net Zero Carbon	2,643	3,814	424	1,400	1,800	1,500	1,500
LD Pathway				0	3,000	0	0
Medical Equipment	1,780	751	47	602	930	1,030	1,000
IT							
IT Device and software upgrade	320	0	0	800	900	900	1,200
IT Infrastructure	1,300	1,935	(2)	1,100	1,300	1,300	1,300
Transforming Care Digitally	1,260	1,260	135	790	250	250	250
NHS Net Transition	500			400	0	0	0
Digital Innovation					500	500	500
Patient Portal		**601**		**170**			
Contingency							
Total of Updated Programme	**15,449**	**15,084**	**2,398**	**17,455**	**15,573**	**10,373**	**10,650**
Disposals	(3,265)	(1,449)	(54)	(8,796)	0	0	0
Total CDEL spend	**12,184**	**13,635**	**2,344**	**8,659**	**15,573**	**10,373**	**10,650**

Capital plan revised to reflect re-phasing of disposals

Capital plan agreed at system level

CIP

			Low Risk	Medium Risk	High Risk
Rec / Non rec	**Scheme**	**Target**	**Delivered**	**Identified**	**Unidentified**
Rec	Undelivered 24/25 brought forward	1,942	1,106	747	89
Rec	Efficiency 1.1%	3,189	1,715	1,136	338
Rec	Delivering Value 1.4%	4,001	1,486	1,180	1,334
Rec	Programme Savings	949	949	0	0
Non Rec	Non recurrent savings	5,169	3,618	1,551	0
		15,250	8,875	4,614	1,761
			58%	**30%**	**12%**

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

25/26 potential risks are as set out below:

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	979.03	3	3	0	9
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	1761	4	3	1761	12
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	1761	4	3	1761	12
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	3	2	348.8	6

Risks 391 & 622 are similar risks, but impacts are different. Risk 391 is longer term risk of not delivering recurrent savings whereas 622 is more short-term risk of non delivery in 25/26 which can be mitigated by non-recurring savings but will have significant reputational and Oversight Framework implications

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AGENDA ITEM: 10/1125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 2025**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT OCTOBER 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) Quality Committee 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 to supplement the Integrated Performance Quality Report improvements continues with emphasis being placed on use of definitive language alongside themes and impact with most slides now using the messaging format of "what the data is telling us" and "what we are going to do about it". Following on from this slide authors are now embracing the Alert ,Advise, Assure , Applaud format to direct the audience to key issues within the summary pages.

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 and are developing with metrics being included within the Integrated Performance Report.

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

Appendices:	Quality Dashboard Report – October 2025 Data

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

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QUALITY DASHBOARD 2025/26

Physical Health, Mental Health and Learning Disability Services

Data covering October 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

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

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

Advise

- The safe staffing across Community Hospitals and MH Inpatients has been reviewed and assured by the Deputy Director of Nursing, Therapies and Quality, however, the exception data are not reported in this month's dashboard due to changes in data collection process. There are no concerns to escalate.
- Of 1375 Patient Safety Incidents reported 89% were no or low harm, leaving 153 were moderate harm, severe harm or death
- Of the 9 PSIIs/ Care Reviews that have been open longer than 6 months, 7 are at point of closure and are planned to be taken for sign off at the Executive meeting, with an extended meeting arranged for November 2025 to address the delay.
- The increase in numbers of restraint incidents this month is related to the LD IHOT team supporting with seasonal vaccinations.
- There has been a further decrease in inpatient falls in October with 33 fewer incidents being reported by wards.
- In October BDO have undertaken an audit on trust PSIRF processes - we await the findings and recommendations.

Assure

- We have seen an improved DoC reporting position for incidents initially reported in September. At the last report 37% of the moderate harm and above incidents did not have anything recorded against them for DoC. This has been reduced to 9%. 25% of the incidents in September met Regulation 20 and 66% did not meet regulation 20. Reasons for the incident not meeting Regulation 20 has been provided in 99% of incidents. In 82% of incidents a verbal or written response has been provided which is an improvement.
- Learning From Deaths Report - in Quarter 2, none of the deaths that were reviewed were considered more likely than not to be due to problems in care.
- There has been a reduction in number of overdue actions in Datix from 46 to 27.

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

Advise

- An overview of the progress and risks relating to the Adult Vaccination Programme 2025/26, which commenced 1st October 2025 is provided for information. The program is being monitored and will be reported monthly.
- UKHSA has reported that flu season commenced 1 month early this year, with 3 times as many cases nationally in October as last year. No cases of hospital acquired flu in the Trust in October.
- 1 (COVID-19) outbreak in October was effectively managed and limited nosocomial transmission provides good assurance that IPC policies are being adhered to.
- New risk placed on Trust risk register in Sept, risk 654. The Air Handling Unit (AHU) in Stroud Theatre needs replacing (booked in for Jan 26) but the risk of it failing, and theatre activity needing to be cancelled, has been placed on register. Estates are inspecting and monitoring the AHU on a weekly basis to provide a level of assurance to enable the environment to remain open for usual service delivery.
- The frailty of patients on our community caseloads is being explored with the Rockford frailty score being explored as a possible measure.

Assure

- High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT feedback.

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

Alert

- Year to date, complaints received increased by 66% on 2024/25 data. Of the 49 open complaints 24 relate to IUCS services , themes relate to communication and caller expectations, call back times and disposition e.g. referral to other services.

Advise

- There are 4 complaints with the PHSO, 2 of which are under full investigation (both MH IP/UC) and 2 are at initial review stage.
- The Q1 and Q2 Non-Executive Director (NED) Audit of complaints are included this month and provide **SIGNIFICANT** assurance that overall, the Trust is investigating and responding to complaints appropriately.

CQC DOMAIN ARE SERVICES SAFE - Safeguarding Adults & Children

- Trust Safeguarding activity relates to activity that the Safeguarding Team is directly involved with, such as MASH & MARAC duties, as well as activity emanating from colleagues around the Trust where the Safeguarding Team may not always have a direct role – for instance, the submission of MARFs and Adult Safeguarding referrals.
- Some of the activity is reactive; that is, we are responding to things beyond our control. This includes MASH & MARAC work, child deaths and reviews. However, other work is proactive and demonstrates that colleagues around the Trust are identifying and responding to issues using their Safeguarding knowledge. That includes use of the advice line, Safeguarding escalations for children's cases, MARFs and Adult Safeguarding referrals.

- Things of note
  - No Safeguarding escalations in September or October and a decrease in advice line calls. This does not give us cause for concern and is part of the normal variation reporting pattern.
  - There is a small uplift with Allegation Management cases we have not identified any recurring themes or causes. MARF numbers are coming through the Children's template. These figures are lower when compared to historical data so we will be working to understand whether this indicates that some MARFs are not being recorded on the template. We await data for October.

	Q1	Q2	Jul-25	Aug-25	Sep-25	Oct-25
Number of Safeguarding Escalations (Children)	1	7	5	2	0	0
MARAC - Families screened/researched	393	403	161	122	120	132
MASH - Children & adults researched	4,724	4436	1,752	1,226	1,458	1371
Number of Adult Reviews ongoing	20	24	20	23	24	24
Number of LCSPRs in progress	1	1	1	1	1	1
Number of Rapid Reviews attended	1	1	1	0	0	0
Expected Child Deaths	1	5	2	2	1	0
Unexpected Child Deaths	3	0	0	0	0	1
New Allegation Management cases	5	9	3	5	1	3
Adult Safeguarding Referrals made	132	tbc	57	37	tbc	tbc
MARFs (child referrals) made	n/a	24	8	4	12	tbc
Safeguarding Advice line - Childrens	208	236	102	59	75	54
Safeguarding Advice line - Adults	265	309	122	91	96	78

What is the data telling us (Additional information)?

- Talking Therapies are the biggest user of the Safeguarding advice line which reflects the breadth and depth of the population worked with, and high number of contacts compared with other teams.
- Domestic abuse is the single biggest reason for calls to the advice line, accounting for 20-23% calls in September and October. Safeguarding are working with Talking Therapies in response to their need for more support with managing risk to others / protecting the public and to build confidence in dealing with these types of risks. There is no formal domestic Abuse training within the trust however we are exploring possibilities with system partners.
- This data highlights and further demonstrates the number of calls we receive each month and the majority being domestic abuse related concerns.
- In response to this data, a bespoke domestic abuse training was implemented. This platform was a virtual 3-hour module and has captured over 150 staff over 4 days (September – November). It is too early to reach conclusions, but we will keep this under close review in terms of impact and function.
- Following a locality thematic review there is a recommendation for GHC offer training to all frontline and supporting staff on domestic abuse and how to create safe environments for disclosure and how to support victims if a disclosure is made.
- The recommendations have been shared with practice education and learning and development colleagues where we plan to review and agree our trust position.
- Domestic abuse will need to remain a priority area for services in terms of training and awareness.

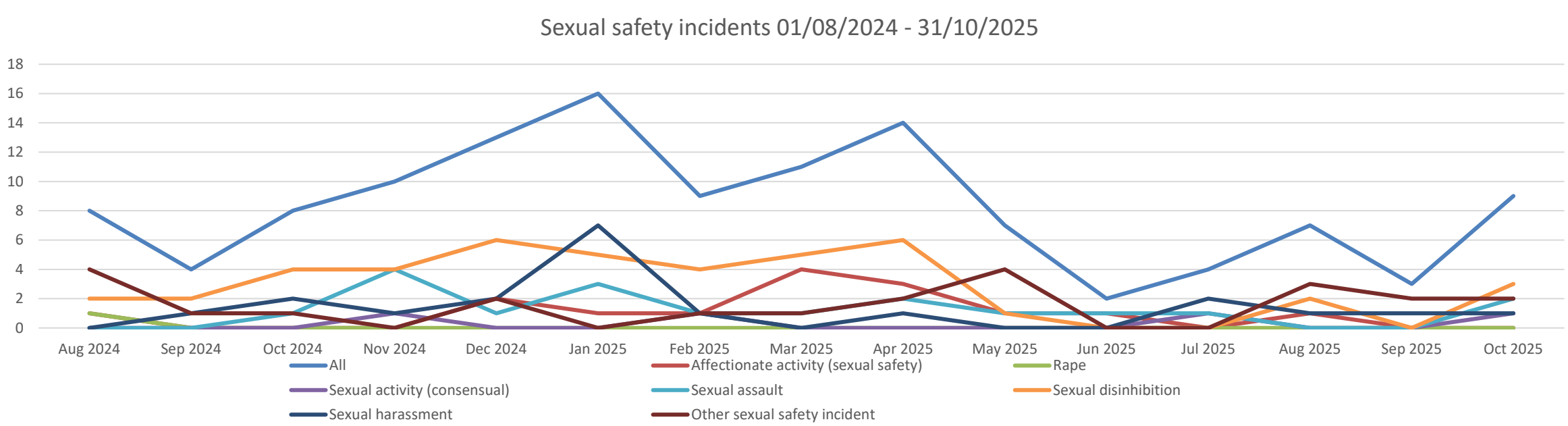
CQC DOMAIN ARE SERVICES SAFE - Safeguarding Adults & Children

- Training compliance remains strong across the Trust with the exception of Level 4 training sessions which are facilitated by GCC. The availability of training places has been escalated to GCC.
- Childrens safeguarding supervision has a minimum requirement of 3x per year. The team deliver 5 x sessions which are delivered per week and whilst attendance is good, compliance remains below expected standard. The team are exploring this, with feedback being sought and captured following every session via a Snap Survey – feedback helps to shape future sessions. We have shared this process with line managers and operational colleagues who are committed to supporting this process.
- Adult safeguarding supervision is not mandatory but encouraged and the Safeguarding Team have been doing more to raise awareness of the offer. We have not yet set any targets ,however this is under review.
- Training and awareness is offered through other forms, including the Learning Lunches & the Safeguarding Monthly focus, which for October was on the topic of “Parental Substance Misuse”.

GHC - Safeguarding Dashboard 2025/26 Training and Supervision Data

	Q1	Q2	Aug-25	Sep-25	Oct-25
TRAINING					
Level 1 – Induction	97%	98%	98%	98%	98%
Level 2 – Think Family	95%	95%	96%	95%	96%
Level 3 – Multi-Agency Child Protection	84%	78%	85%	83%	82%
Level 3 Adult Protection	91%	91%	91%	91%	90%
Level 4 Adult Protection	70%	83%	83%	82%	72%
PREVENT:					
Level 1	99%	99%	98%	99%	99%
Level 2	94%	93%	94%	93%	93%
Level 3	97%	96%	96%	96%	97%
MENTAL CAPACITY ACT:					
Level 1	97%	97%	98%	96%	95%
Level 2	88%	89%	89%	90%	91%
Bespoke MCA Training	19		7	10	3
SAFEGUARDING SUPERVISION					
CHILDREN:					
Group Supervision Sessions	72	60	12	22	28
Group Supervision Compliance	70%	65%	66%	64%	67%
One to One Supervision Sessions	13	11	5	3	13
ADULTS:					
Group Supervision Sessions	0	2	0	0	1
Number of Staff who attended Supervision	0	6	0	0	3
One to One Supervision Sessions	3	12	1	5	1

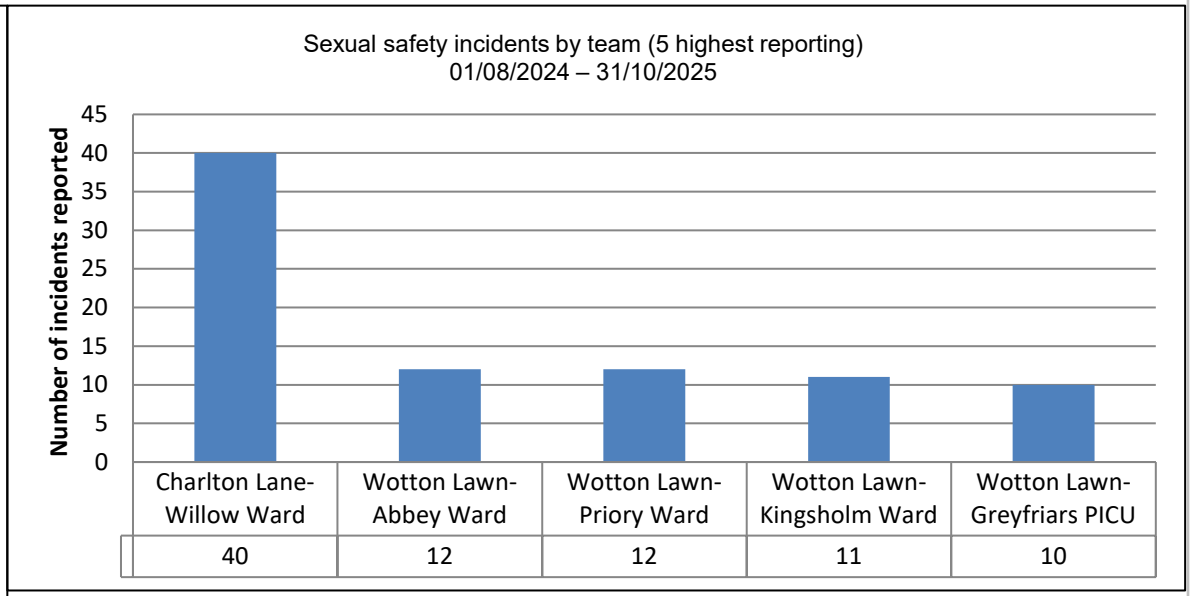
Sexual Safety Incidents



Sexual Safety update:
There were nine recorded sexual safety incidents during October.

- At least 3 were patient towards staff, two were alleged by patients but context/perpetrator unknown
- The incident recorded as consensual, has been fully explored by the clinical teams and guidance given to both parties. Seven of the nine incidents occurred within mental health inpatient settings, one at a community hospital and one in the community

The incidents that occurred in September & October have been handled according to policy and support has been provided to staff and patients where required , any relevant learning will be shared.



Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

	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	1300	1375					
Number of No Harm and Low Harm incidents (including skin integrity)	1112	1325	1244	1282	1198	1139	1222					
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	123	113	98	156	124	161	153					
Patient Safety Investigations												
Number of AARs completed in Month		4	3	4	4	4	2					
Number of New PSII's and Care Reviews declared in month	1	0	2	0	1	2	0					
Number of PSIIs open		5	6	7	7	9	11					
Number of PSIIs closed in month		0	0	0	1	0	0					
Number of Care Reviews open		9	9	8	7	6	6					
Number of Care Reviews closed		1	0	1	0	1	0					
Number of PSIIs and Care reviews open over 6 months		11	11	11	11	10	9					
Number of PSIIs/ Care Reviews planned for Exec sign off (Closure)			6	7	7	6	7					
Family Liaison Practitioners												
Number of patients being supported		1	1	1	1	1	1					
Number of family and friends being supported		7	8	9	8	9	11					
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner		1	1	0	0	0	0					
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AARs/ Care Reviews/ PSIIs)		34	36	36	26	46	27					
PCET		1	0	2	1	0	1					
Alerts/ NICE/ Audit		1	2	1	1	1	1					

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

What is the data telling us?

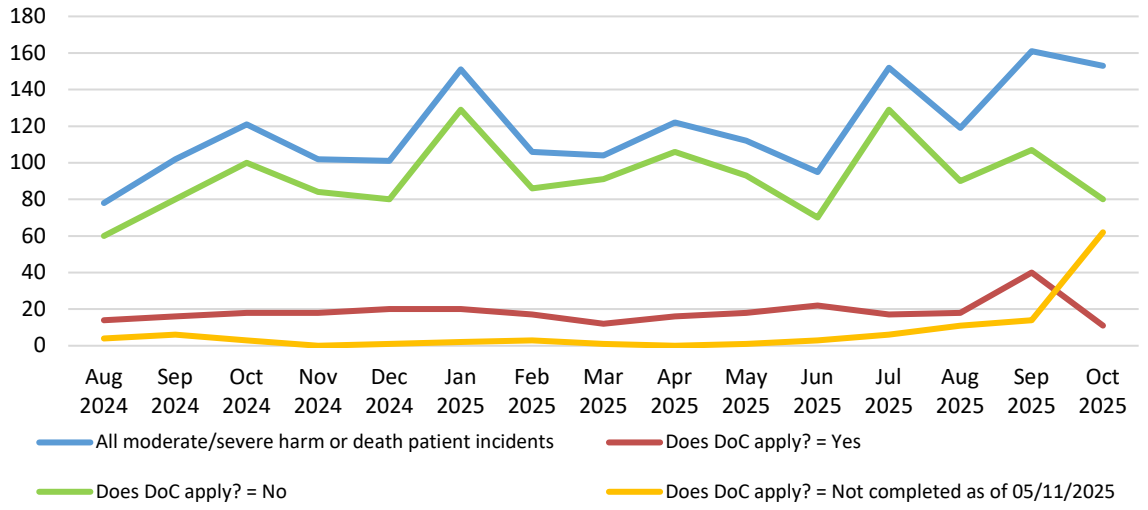
Patient Safety Team:

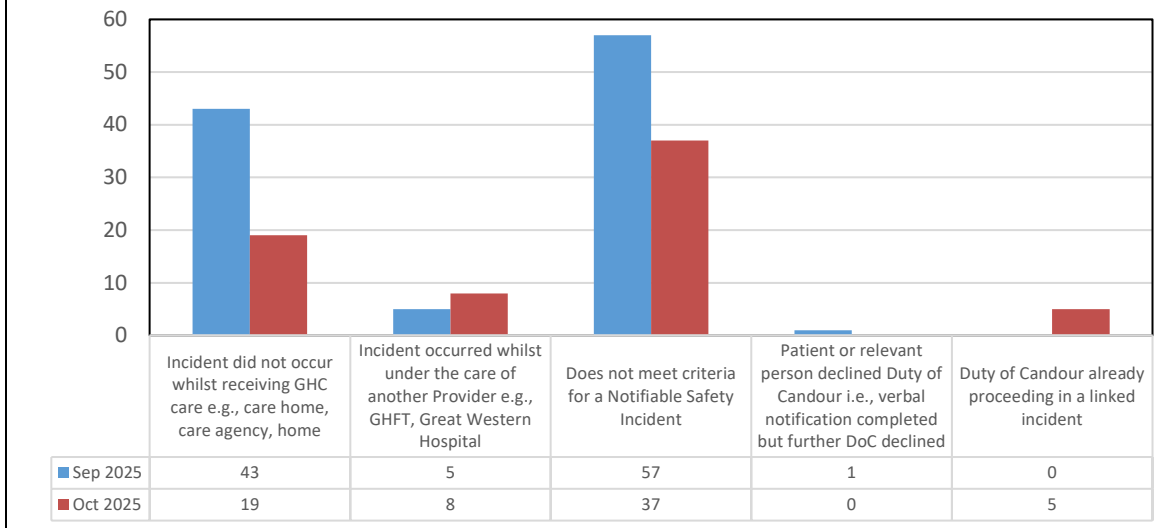
- In October we had a total of 1375 patient safety incidents reported across the trust with 89% being no or low harm, the number of moderate harm incidents has reduced from 12% to 11%.
- There were 2 After Action Reviews completed in October 2025.
- Of the 11 open PSII's or care reviews there are 9 that have been open for longer than 6 months of which 7 are ready for executive sign off. An extended Executive Sign off meeting has been arranged for November 2025 to enable to closure of as many of these as possible.
- We have not opened any new PSIIs in October 2025. However, the cumulative demands year to date on the team are such that staffing capacity is being reviewed.
- There is an increase in the number of families, friends and patients(12) being supported by a Family Liaison Practitioner. This service is predominantly being provided by our Patient Safety Reviewers.
- In October, our internal auditors BDO undertook an audit of the Trust PSIRF processes - we are awaiting the findings.

Learning Assurance:

- The team continue to work closely with action owners to address overdue Datix actions and secure updates or evidence of assurance where available. As a result of this ongoing work, the number of overdue actions has reduced to 29 as of end October. A monthly overview continues to be provided to each Service Director, and the PST team attend the Operational Directorate Business Meeting to present this data and support continuous improvement.
- The team have commenced a benchmarking exercise against the findings of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report 2025. This work involves analysing 12 months of Trust data on reported suspected suicide incidents to identify how our local patterns and trends align with, or differ from, national findings. The aim is to strengthen learning, support targeted quality improvement, and inform future suicide prevention strategies within the Trust.

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

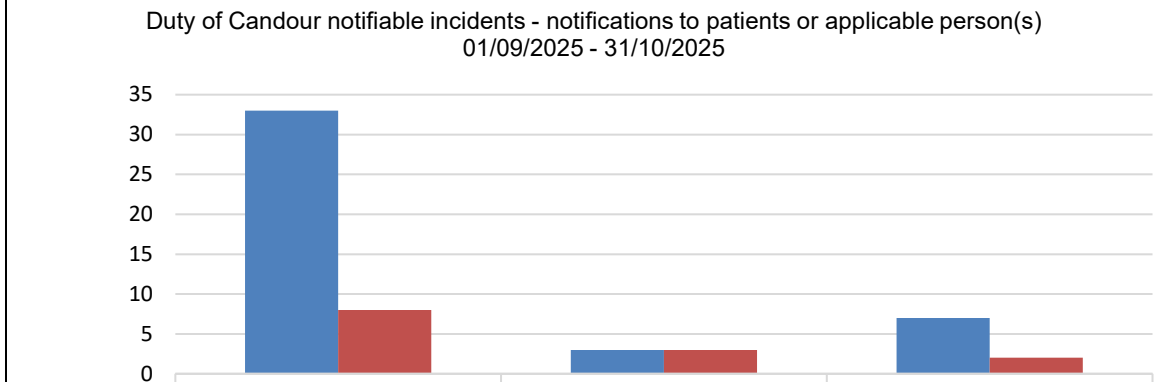




	Incident did not occur whilst receiving GHC care e.g., care home, care agency, home	Incident occurred whilst under the care of another Provider e.g., GHFT, Great Western Hospital	Does not meet criteria for a Notifiable Safety Incident	Patient or relevant person declined Duty of Candour i.e., verbal notification completed but further DoC declined	Duty of Candour already proceeding in a linked incident
Sep 2025	43	5	57	1	0
Oct 2025	19	8	37	0	5

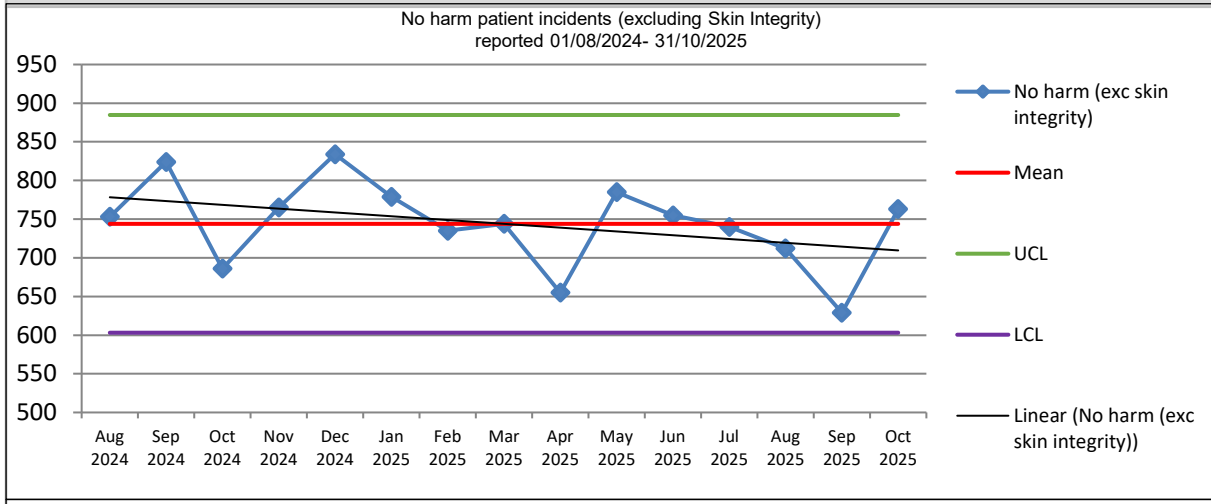
What is the data telling us?

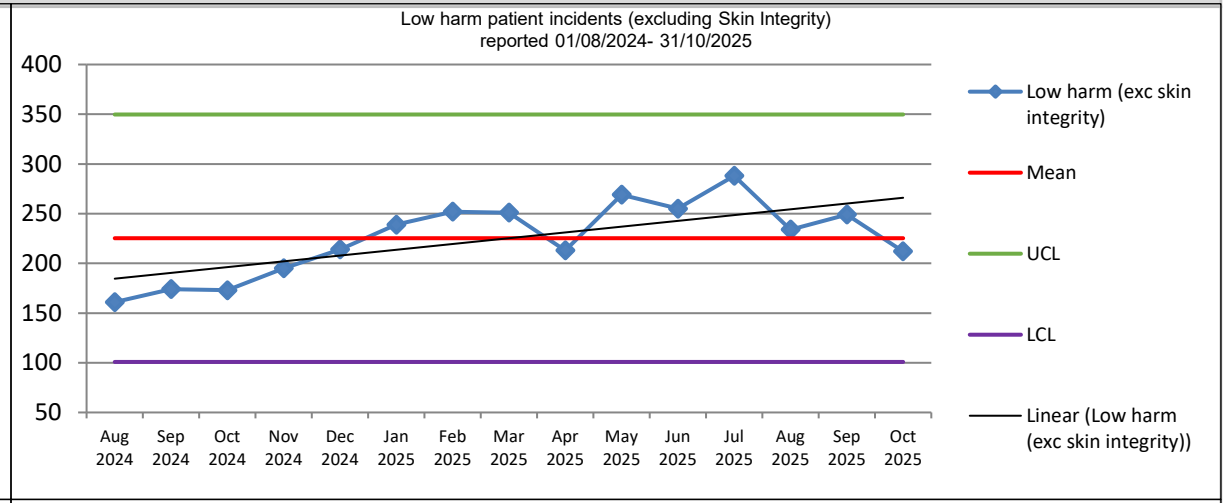
- There has been a decrease in the number of moderate harm and above incidents in October 2025, with them accounting for 11% of all reported incidents, whilst this is above the typical 10% or lower, it is a reduction on the previous month and reflects the variation we see on a month-by-month basis.
- We have seen an improved DoC reporting position for incidents initially reported in September. At the last report 37% of the moderate harm and above incidents did not have anything recorded against them for DoC. This has been reduced to 9%. 25% of the incidents in September met Regulation 20 and 66% did not meet regulation 20. Reasons for the incident not meeting Regulation 20 has been provided in 99% of incidents. In 82% of incidents a verbal or written response has been provided which is an improvement.
- In October, 7% of moderate harm and above incidents have been identified as meeting regulation 20, 52% are felt not to meet regulation 20 and 41% have this section outstanding in Datix. As with previous months we will see an improved position next month when incidents have been 'handled' and PST have followed up.
- We are aware that there can be some confusion regarding DoC so the poster detailing when regulation 20 applies and the criteria to be met will be recirculated on patient safety notice boards.

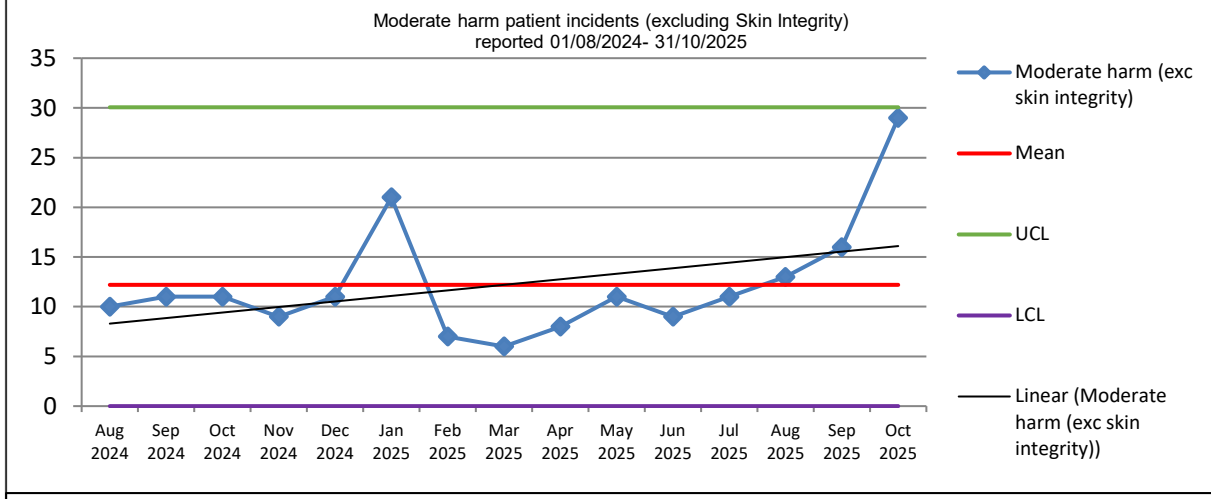


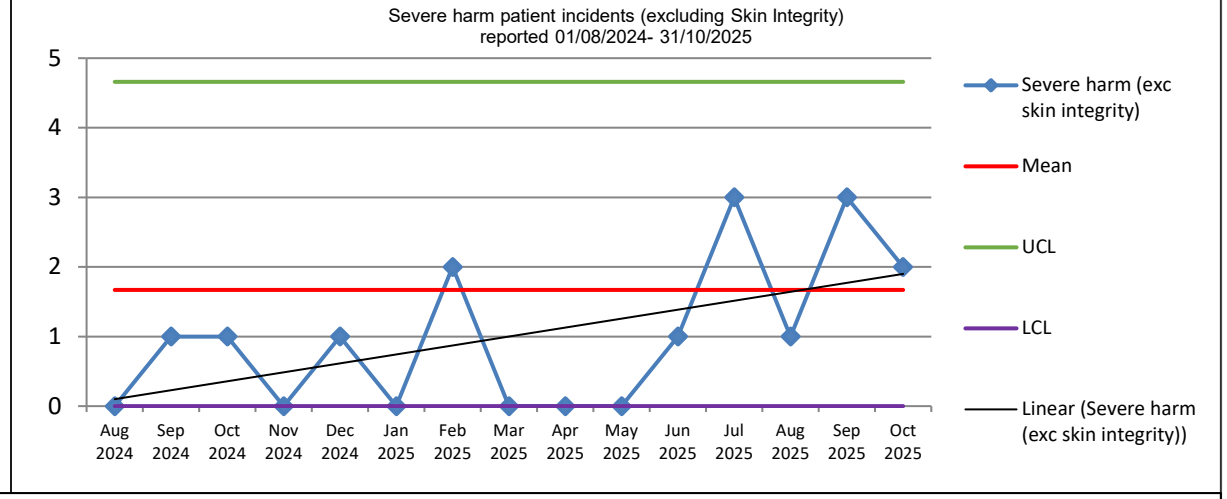
	Verbal notification requirements have been met and documented in clinical record	Written notification requirements have been met, detailed in the Duty of Candour letter and uploaded to the clinical and/or Datix records	Duty of Candour applies but no notifications (either verbal or written) recorded as of 05/11/2025
Sep 2025	33	3	7
Oct 2025	8	3	2

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







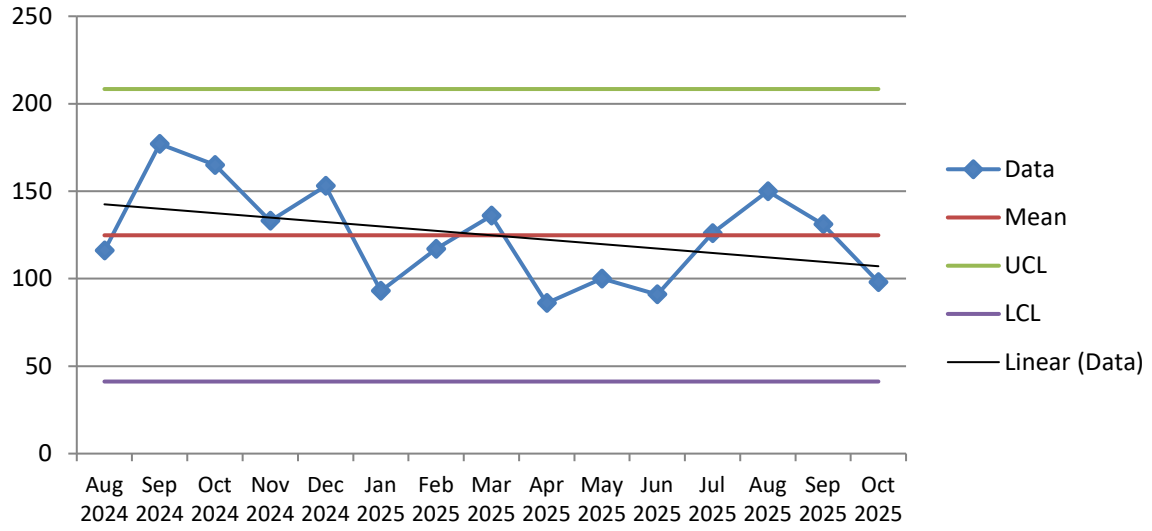


What the data is telling us:

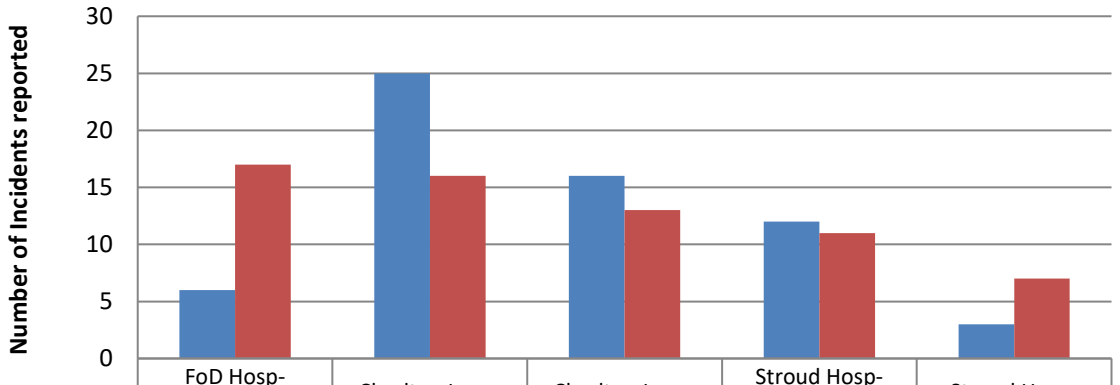
- Whilst there has been an increase in reported incidents since last month, we have observed an increase in no harm and moderate harm incidents but a reduction in low and severe harm incidents.
- The moderate harm incidents are seen across a number of teams and incident categories with Falls (5) and clinical care, treatments and procedures (7) being observed to have the highest figures. There are small number of incidents across 9 further categories. Incidents are being reviewed and handled by clinical teams and Patient Safety Team (Planned activity- 1 x AAR, 1 x Safeguarding Adult Review, 1 x Complaint investigation, 1 x Patient Safety Investigation).
- 2 severe harm incidents were reported; MIIU incident relating to ligature rupture is being reviewed with PST and legal team, CYPS incident shared with colleagues at Bristol Children's Hospital to investigate as incident occurred under their care.
- 5 deaths were reported in October, 1 patient was supported by reablement but found unresponsive, determined appropriate actions was carried out, 1 individual died in a fire - awaiting further information from Fire Service regarding the circumstances before determining next steps, 1 presentation at MIIU with cardiac chest pain, 1 palliative care with ICT, 1 x suspected suicide that will be investigated.

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

All Inpatient falls 01/08/2024-31/10/2025



All Inpatient falls - 5 highest reporting wards 01/09/2025-31/10/2025

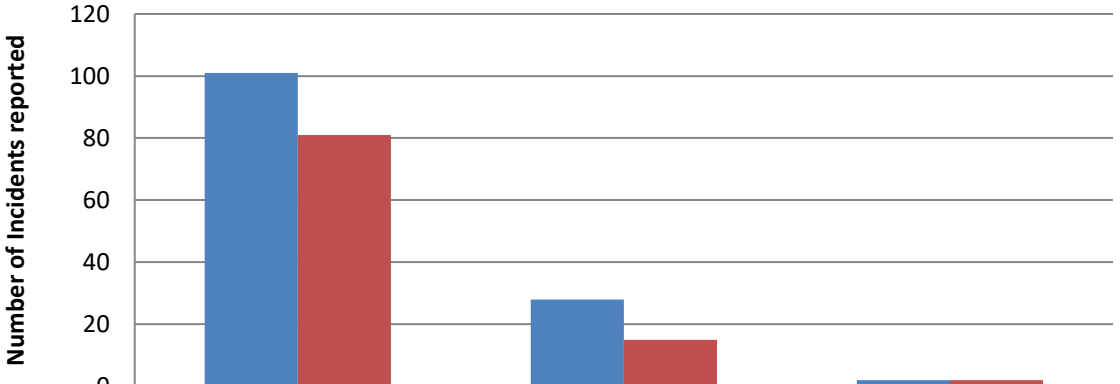


	FoD Hosp-Woodland View Ward	Charlton Lane-Willow Ward	Charlton Lane-Chestnut Ward	Stroud Hosp-Cashes Green Ward	Stroud Hosp-Jubilee Ward
Sep 2025	6	25	16	12	3
Oct 2025	17	16	13	11	7

What is the data telling us?

- There has been a reduction in the number of falls reported in October 2025 (-33) with the fewest falls reported in the last 3 months.
- This trend is observed at Charlton Lane where we often see the highest number of reported falls, there has been a steady reduction in falls since August when there was a total of 88.
- Of the 98 falls reported in the month, 58 individual patients account for all falls, with 20 patients falling on more than one occasion and accounting for 58 of the total falls.
- The 2 moderate harm falls occurred in Community Hospitals; 1 fall was witnessed and 1 unwitnessed. Inpatient falls questionnaires have been completed for both incidents which considers whether appropriate documentation and assessments are in place.
- Any trends and patterns will be analysed in the upcoming Falls Group on 19/11/25.
- The falls lead is currently working with colleagues across the trust, this includes falls templates on our electronic patient records systems, read codes for JUYI and the wording on Care to Learn falls training programme.
- Scoping work regarding falls sensors in our Community Hospitals has been completed and will be shared at the next Falls Group.
- An audit into Active Balance Class/ Otago has been undertaken and findings will be shared when the final report has been completed.

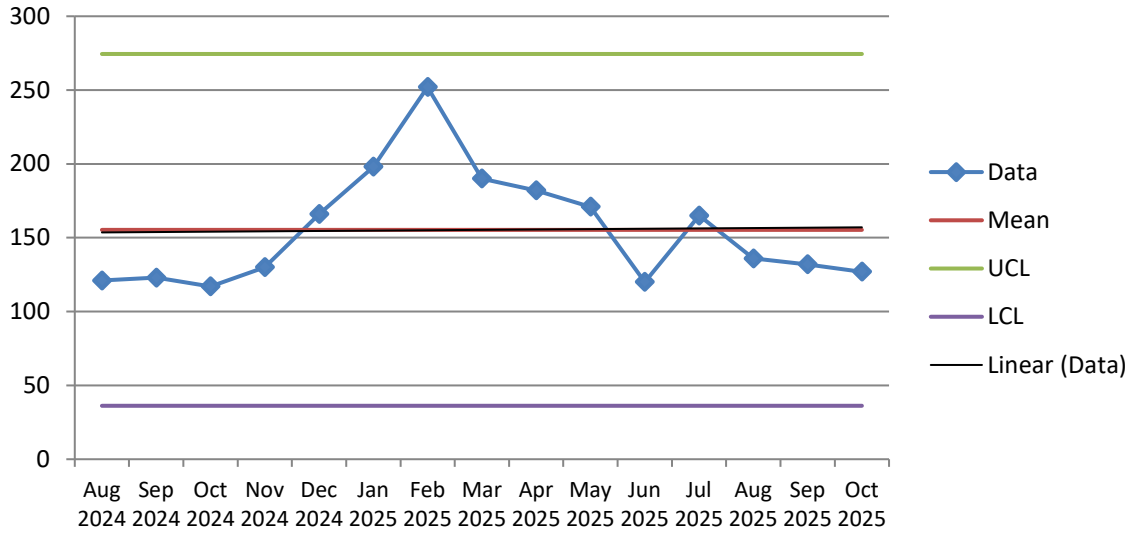
All Inpatient falls by overall severity 01/09/2025-31/10/2025



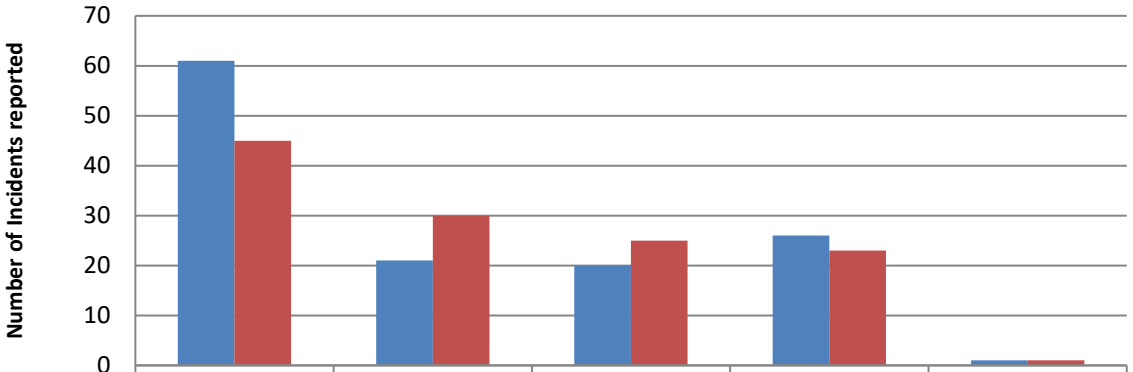
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)
Sep 2025	101	28	2
Oct 2025	81	15	2

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

Self harm or self injurious behaviour (SIB) incidents 01/08/2024 - 31/10/2025



Self harm/self injurious behaviour (SIB) incidents - 5 highest reporting teams
01/09/2025 - 31/10/2025

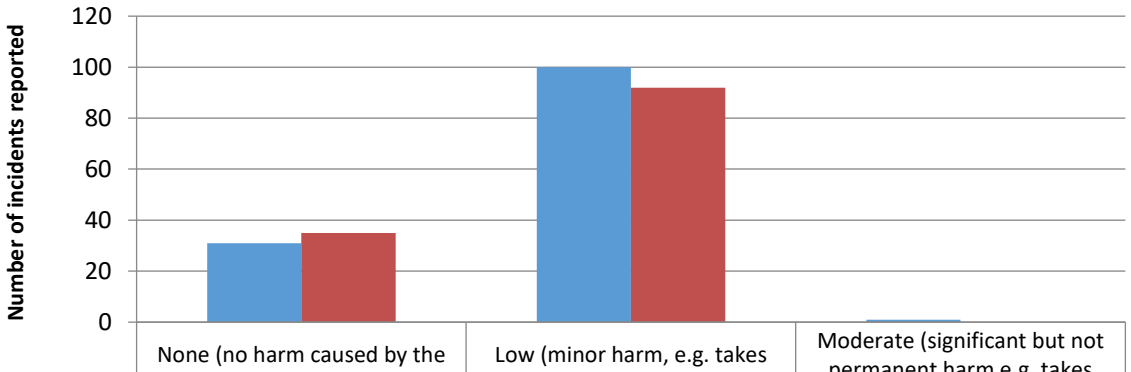


	LD Inpatients - Berkeley House	Wotton Lawn- Abbey Ward	Wotton Lawn- Priory Ward	Wotton Lawn- Dean Ward	Wotton Lawn- Greyfriars PICU
Sep 2025	61	21	20	26	1
Oct 2025	45	30	25	23	1

What is the data telling us?

- We continue to see a reduction in the number of self harm/self injurious behaviour incidents with a slight reduction on the previous month
- The number of incidents is below our 15-month average for the 3rd month in a row.
- All incidents were reported as being no or low harm with 0 moderate harm or above incidents reported.
- 17 individuals account for the 127 incidents, with 4 individuals having 10 or more incidents of self harm during the month.
- 94% of self harm or self injurious incidents have been reviewed for learning and closed by handlers.
- Headbanging remains our most frequently reported self harm or self injurious behaviour at Wotton Lawn with non fixed ligaturing being the 2nd most frequently reported incident type.
- We have appointed a Clinical Development facilitator who will take a lead role in refreshing the Trust suicide prevention strategy.

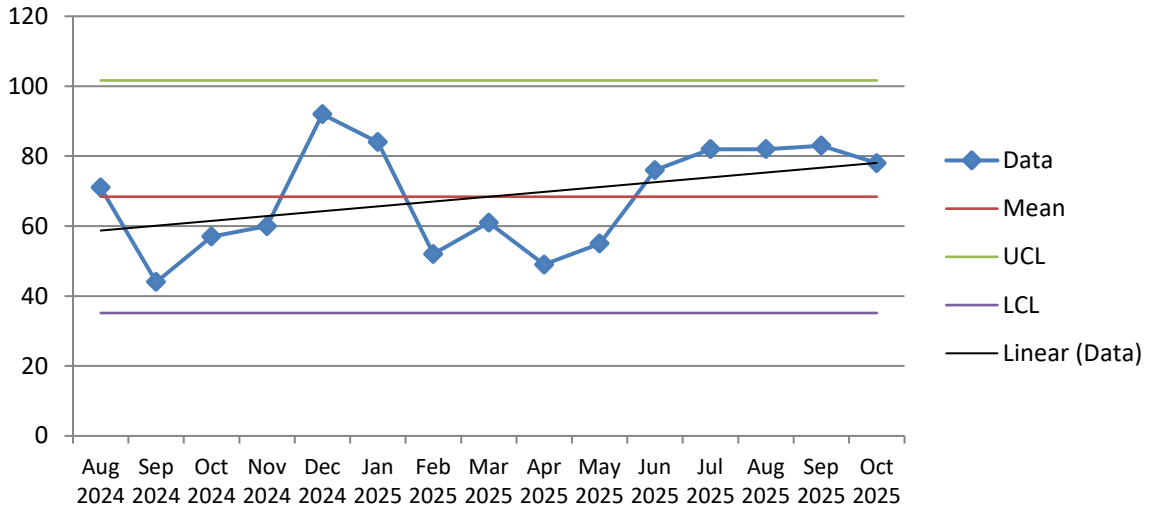
Self harm/self injurious behaviour (SIB) incidents by overall severity
01/09/2025 - 31/10/2025



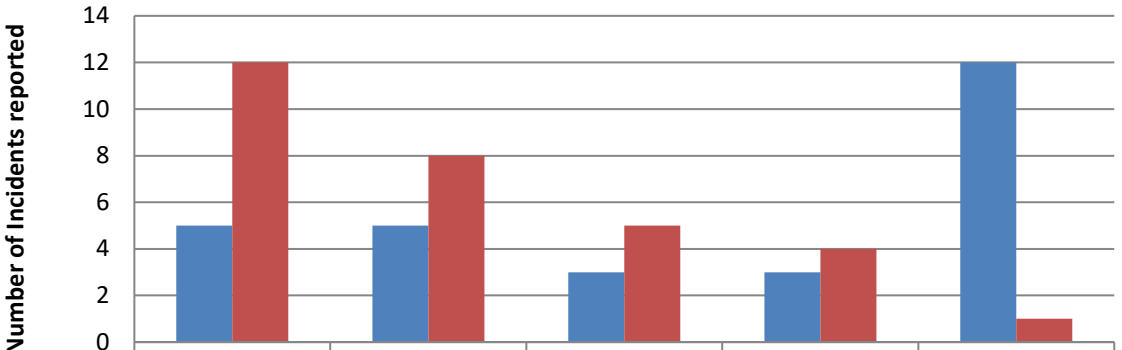
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)
Sep 2025	31	100	1
Oct 2025	35	92	0

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

Clinical care, treatments and procedure incidents 01/08/2024 - 31/10/2025



Clinical care, treatments and procedure incidents – 5 highest reporting teams 01/09/2025 - 31/10/2025

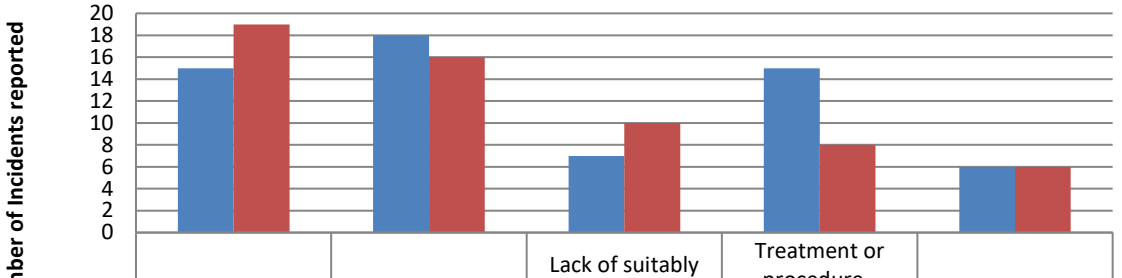


	Eating Disorder Community	Charlton Lane-Willow Ward	Charlton Lane-Chestnut Ward	MH Liaison Acute Hospitals	SALT Adults Physical Health
Sep 2025	5	5	3	3	12
Oct 2025	12	8	5	4	1

What is the data telling us?

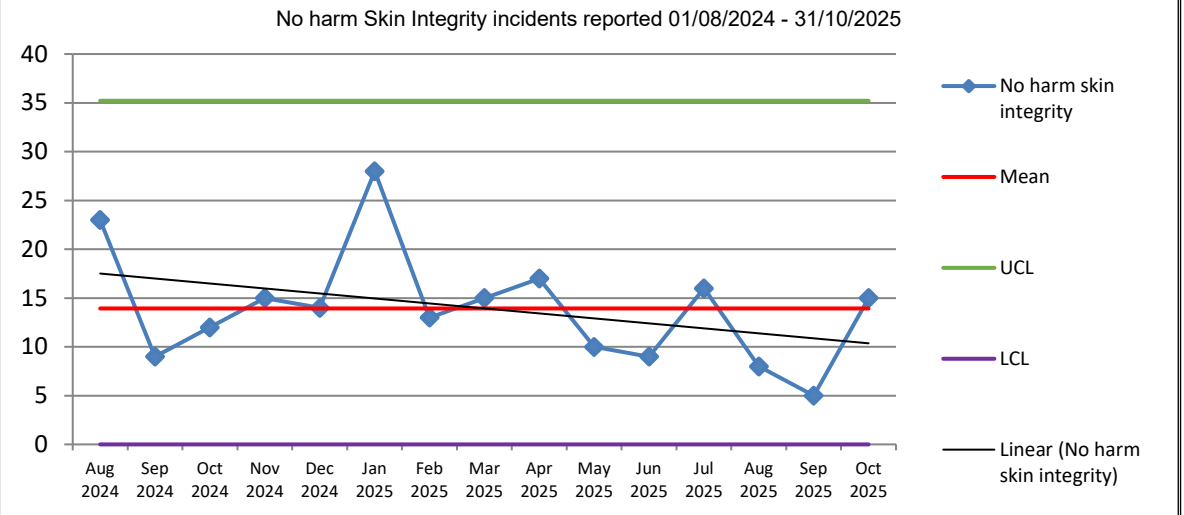
- There has been a slight decrease in the number of incidents reported in this category, with 5 fewer reported in October.
- We continue to see a broad spread of subcategories being reported but the common theme across them is a lack of staff / assessment or delay in providing the treatment of assessment.
- There has been a change in the team reporting this category most frequently, from SALT to Eating Disorder Community.
- The Eating Disorder Service have historically been a low reporter of incidents but there has been an increase this month in this category (+7). The team are currently experiencing significant challenges in staffing which is impacting the provision of support available to patients. A paper has been produced to consider approval for a temporary spend on agency staff to assist with team capacity and the delivery of services. The team have been actively encouraged to report any incidents where patient care may be impacted by staffing provision, the reporting of this on Datix will enable this issue to be monitored.

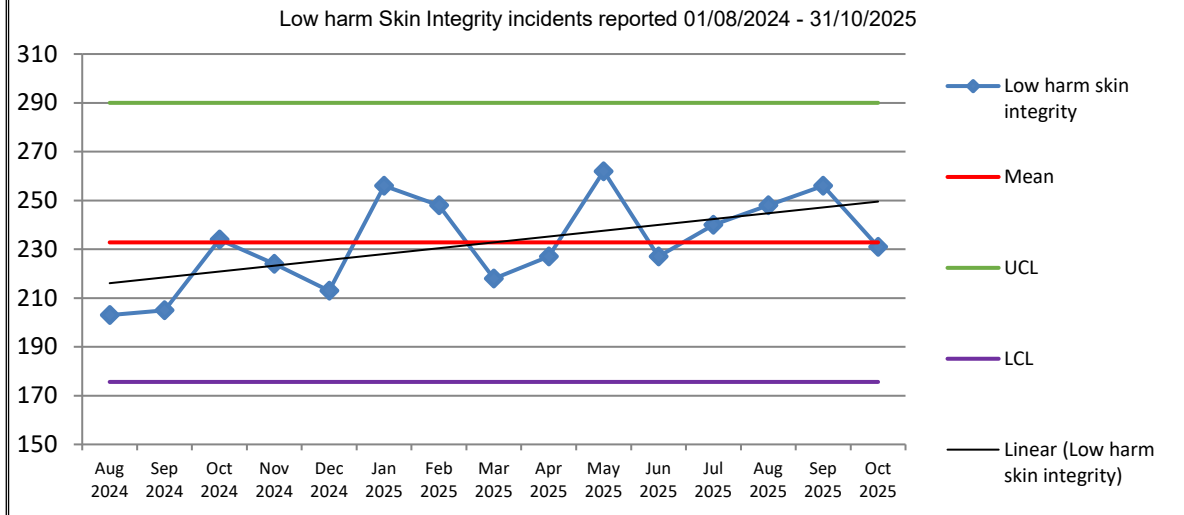
Clinical care, treatments and procedure incidents by top 5 sub categories - 01/09/2025-31/10/2025

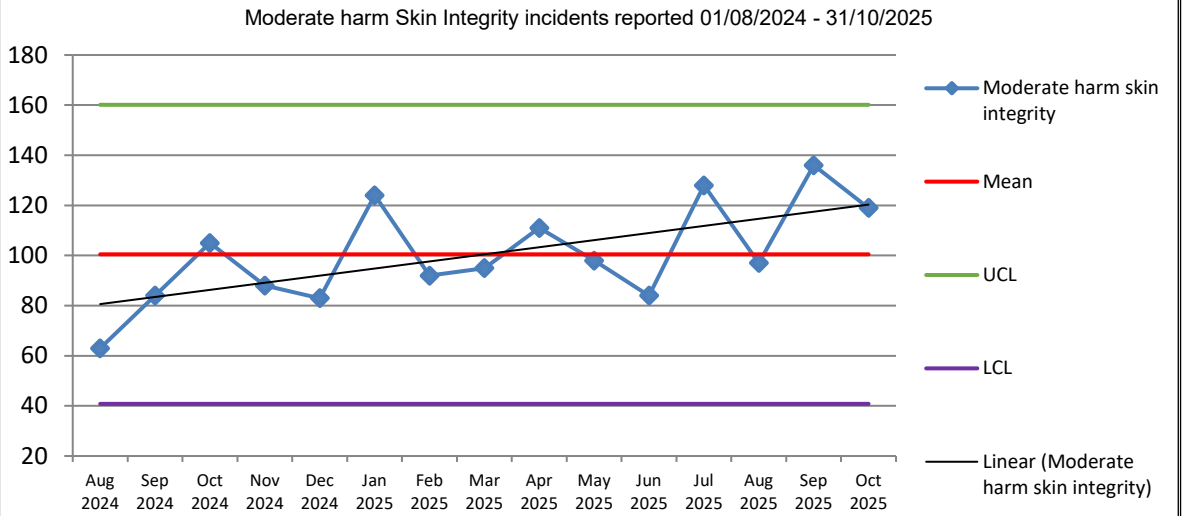


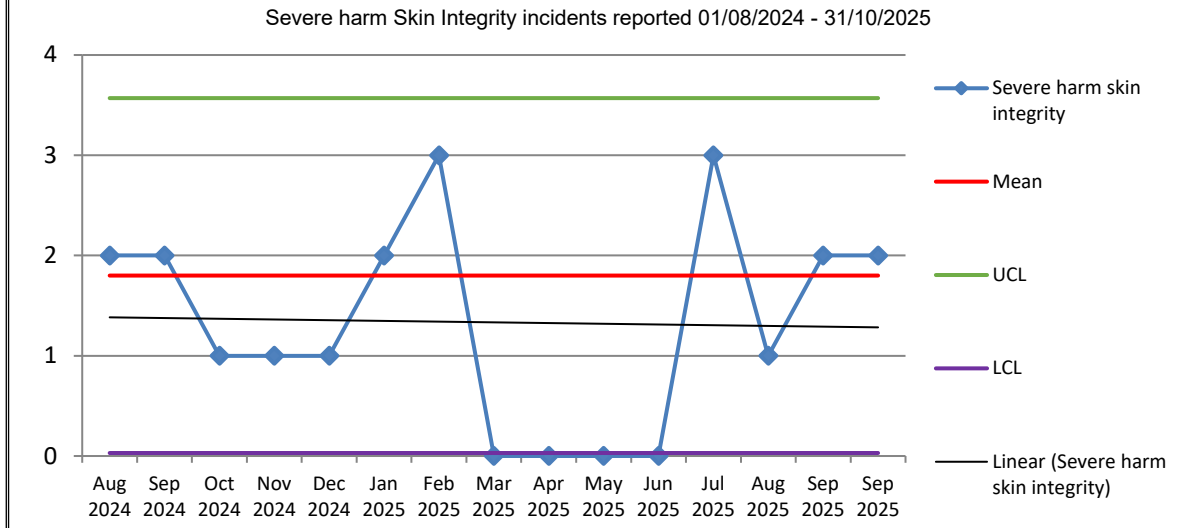
	Assessment - lack of clinical assessment	Treatment or procedure - delay / failure	Lack of suitably trained/skilled staff including lack of carer support	Treatment or procedure - inappropriate / wrong / not clinically indicated	Delay / failure to monitor
Sep 2025	15	18	7	15	6
Oct 2025	19	16	10	8	6

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



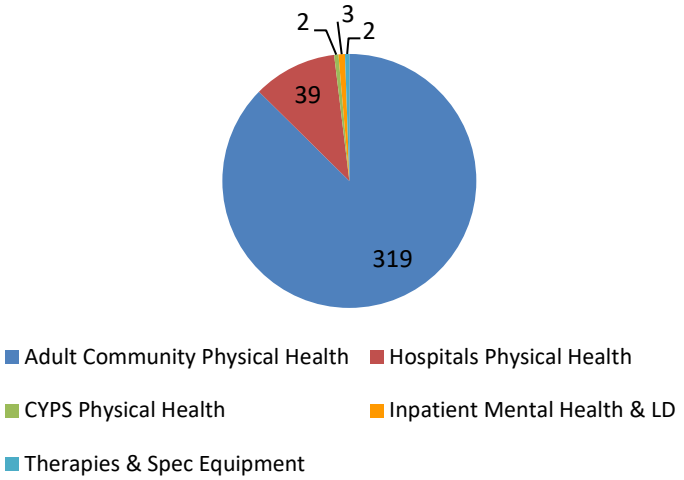




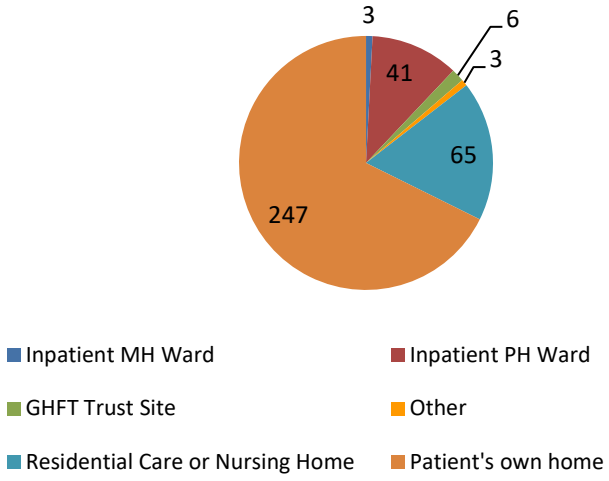


CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

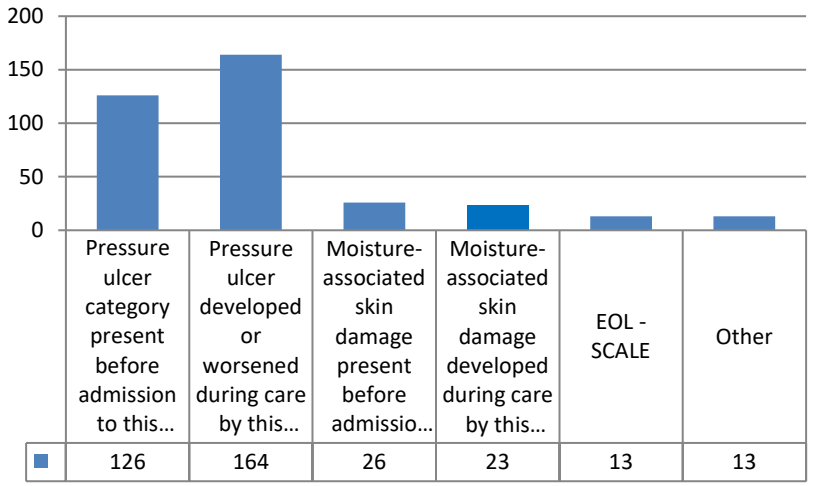
Skin Integrity Incidents by reporting team 01/10/2025-31/10/2025



Skin Integrity Incidents by Patient Location 01/10/2025-31/10/2025



Skin Integrity Incidents by Sub Category 01/10/2025-31/10/2025



	Pressure ulcer category present before admission to this...	Pressure ulcer developed or worsened during care by this...	Moisture-associated skin damage present before admissio...	Moisture-associated skin damage developed during care by this...	EOL - SCALE	Other
■	126	164	26	23	13	13

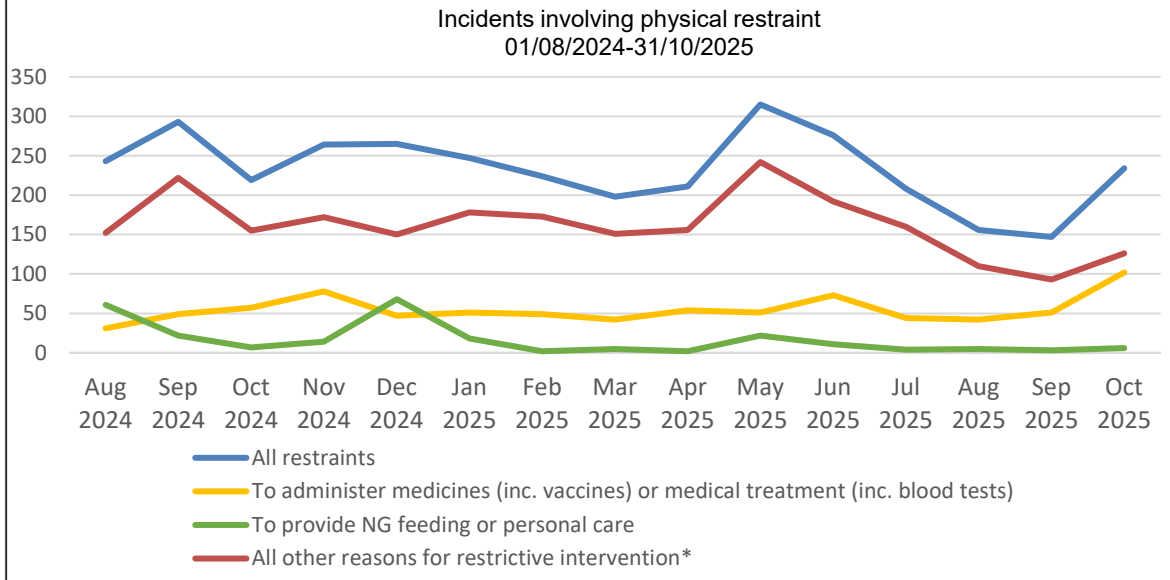
What is the Data telling us?

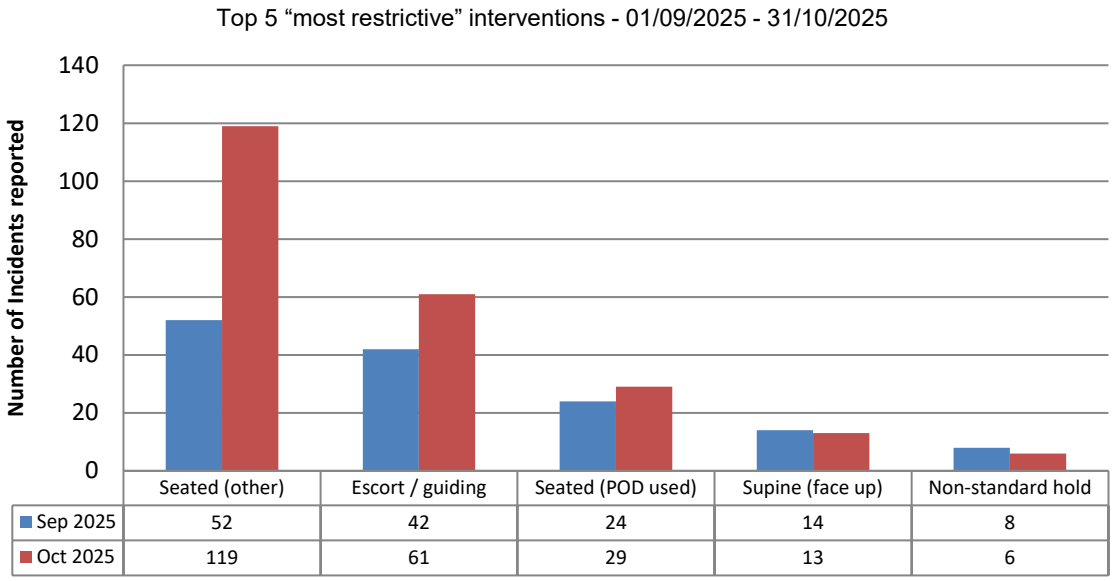
- There has been 367 skin integrity incidents reported across the trust with an increase in no harm incidents and reductions in low and moderate harm incidents.
- 290 of the incidents were reported as pressure ulcers with 126 of these present before admission to our wards or community caseloads.
- 247 of the incidents were for people living in their own home and 65 for those who are living in a residential care, these individuals are visited by our community nurses who are our biggest reporters of this type of incident (87%).
- 44 incidents were reported by our inpatient settings with 3 of these on our inpatient MH wards.
- As detailed in last months report, whilst an inpatient GHC staff have 24-hour visibility of PU's and are able to assess in real time and respond to changes at several points throughout the day, monitor pressure relieving equipment and ensure regular repositioning is undertaken in line with the agreed plan of care. When someone lives in their own home or a care home environment community nurses visit at agreed times (based upon clinical assessment) throughout the week, this may be as little as twice a week and as such are reliant on the patient , their families and care staff to implement the wider agreed plan of care that includes compliance with pressure relieving equipment, repositioning, nutritional intake and hygiene, this is significant and needs to be fully understood when reviewing PU data.

What are we doing about the data?

- The lower limb pre-doppler pathway has been rolled out across all ICTs now. This rules out any red flags for the use of compression. Whilst only a small number of case studies have been considered so far, results from this pathway are positive.
- A follow up audit for the Wound Care app is due to be started in December 2025. Anecdotal feedback from clinical teams is that the improved photographs on the app are enabling quicker decision making around treatment options.

Incidents involving restraint

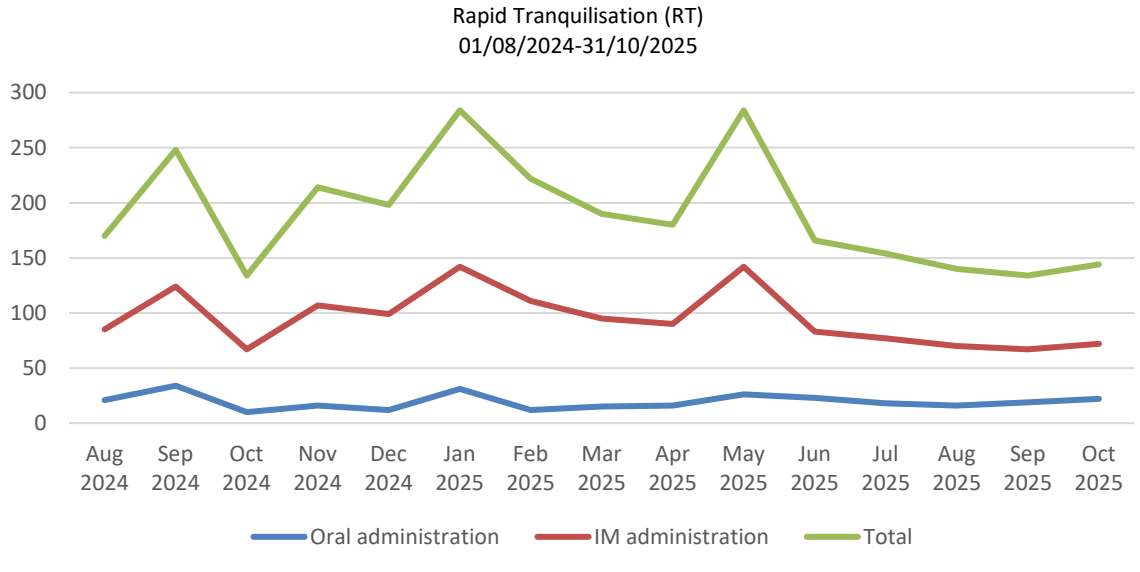




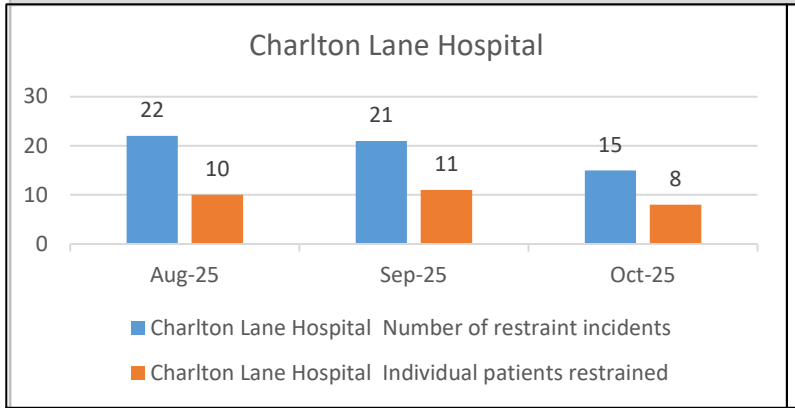
	Seated (other)	Escort / guiding	Seated (POD used)	Supine (face up)	Non-standard hold
Sep 2025	52	42	24	14	8
Oct 2025	119	61	29	13	6

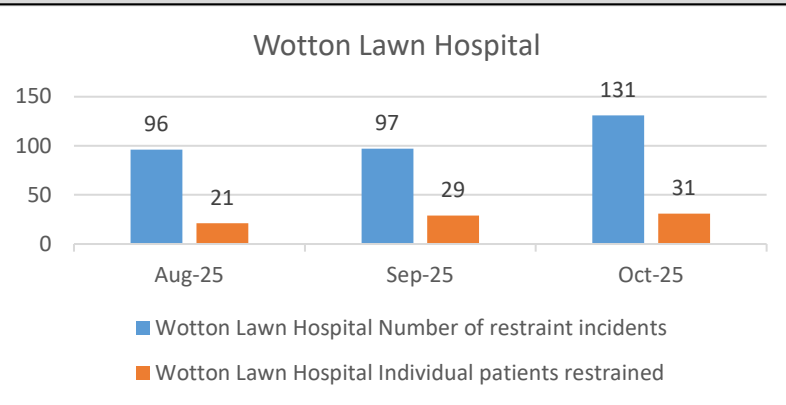
What is the data telling us?

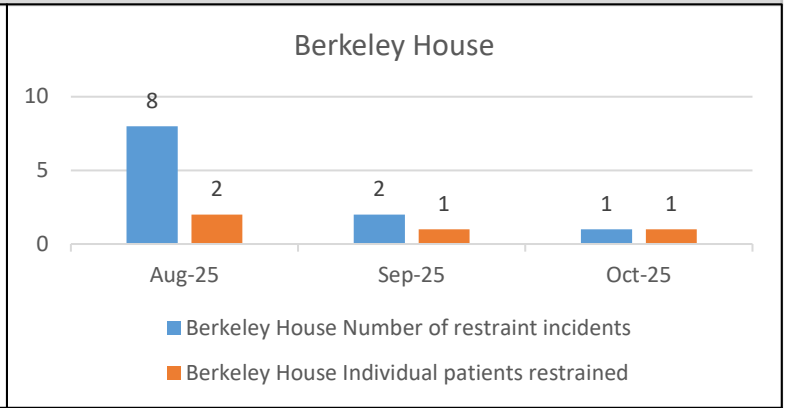
- There has been an increase in incidents relating to physical restraint in October (+87). Seated restrictive interventions remain the most frequently reported type of restraint.
- Both increases are attributed to LD IHOT support around the seasonal vaccine campaign which has now commenced.
- There have been 0 prone restraints in October 2025.
- Our rates of rapid tranquilisation appear to remain consistent with a small increase (+5) on the previous 4 months. The use of rapid tranquilisation and restraint in our inpatient settings remains connected to the individual presentations and needs of the individuals being supported on our wards.
- We continue to see the pattern of a small number of patients being restrained on more than one occasion.
- Our most common reasons for using a restrictive intervention are to lawfully administer medicines or another treatment (102) and to prevent violence to others (69) or harm to themselves (21).

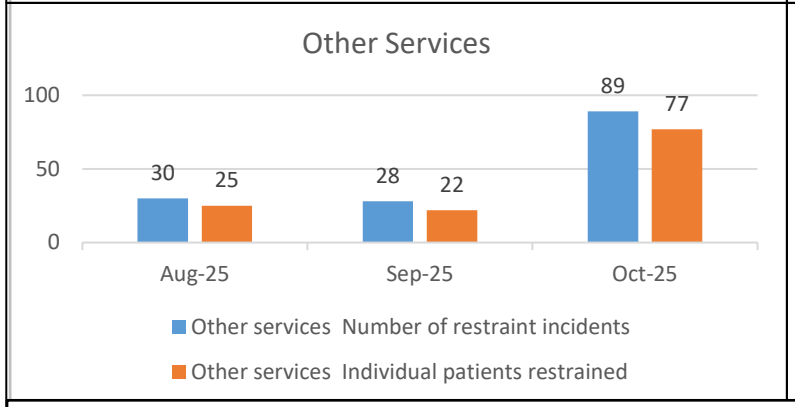


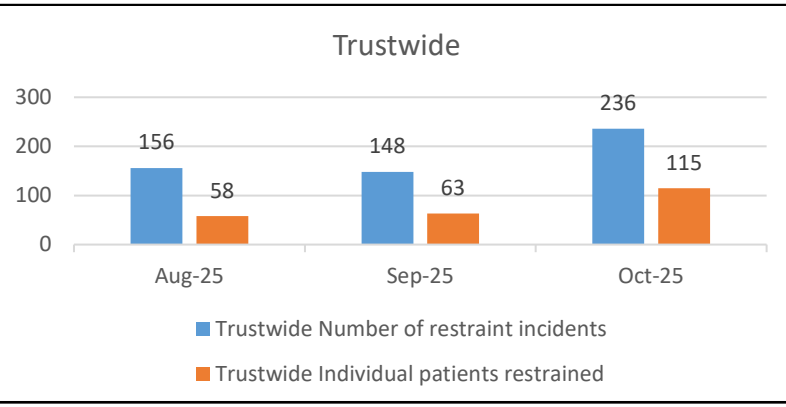
Incidents involving restraint – individual patients restrained

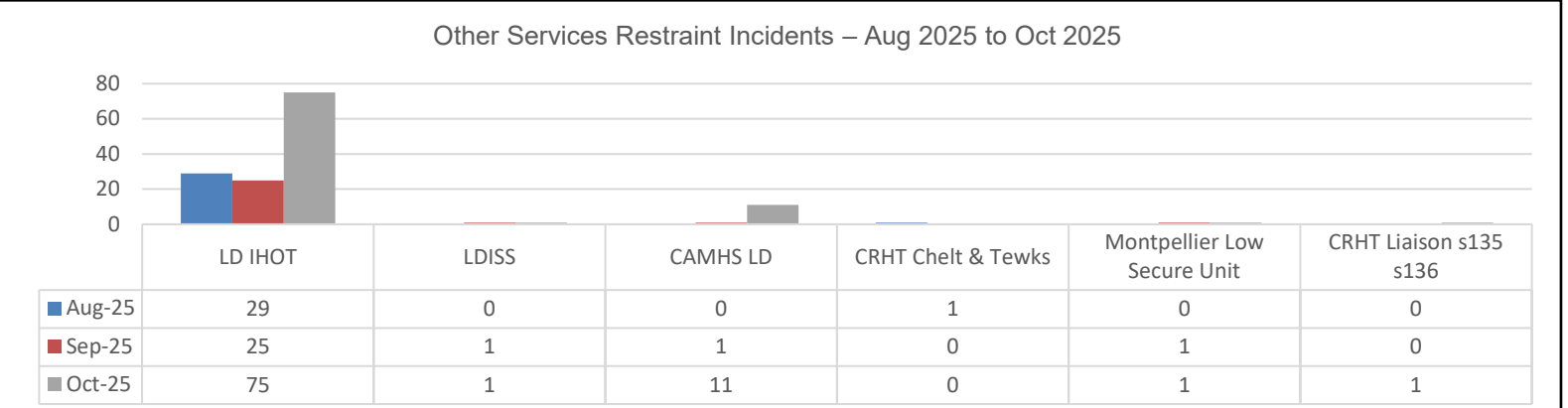












	LD IHOT	LDISS	CAMHS LD	CRHT Chelt & Tewks	Montpellier Low Secure Unit	CRHT Liaison s135 s136
Aug-25	29	0	0	1	0	0
Sep-25	25	1	1	0	1	0
Oct-25	75	1	11	0	1	1

What is the data telling us?

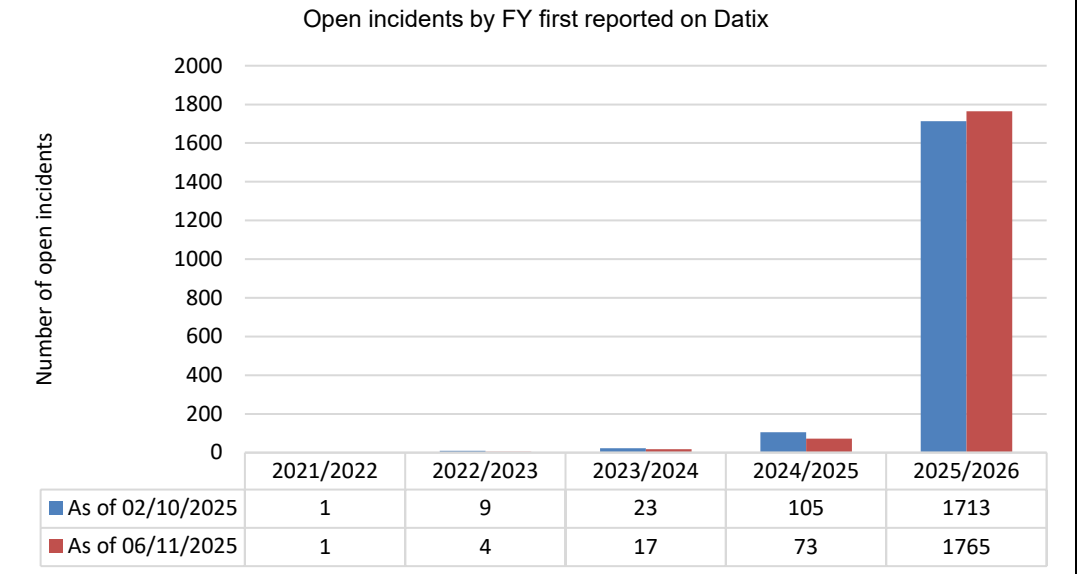
Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints. Looking more widely at other services:

In October 2025 89 restraint incidents were reported across the other services of:

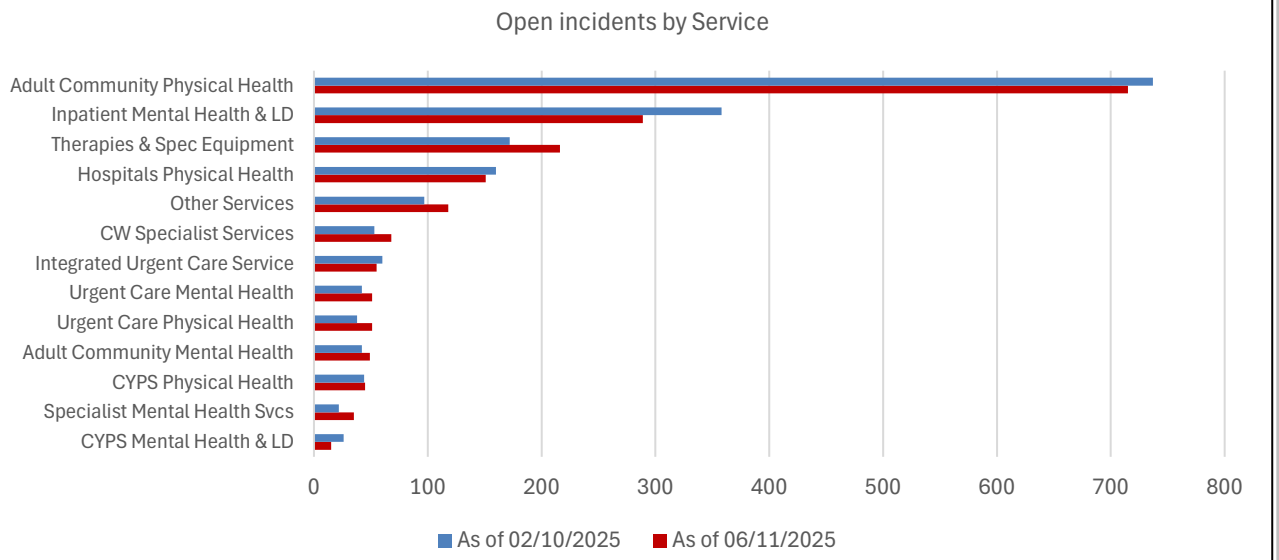
- LD IHOT (75)
- CAMHS LD (11)
- s135 s136 (1)
- LDISS (1)
- Montpellier Unit (1)

These involved 64 patients in LD IHOT, 10 patients in CAMHS LD, 1 patient in CRHT Liaison s135 s136, 1 patient in LDISS and 1 patient in Montpellier Unit.

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



	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
As of 02/10/2025	1	9	23	105	1713
As of 06/11/2025	1	4	17	73	1765



What is the data telling us?

- We continue to see the number of overdue incidents (over 60 days) from previous years steadily reducing following the targeted work carried out in the operations team and all directorates.
- The largest number of overdue incidents is now seen in the Adult Community Physical Health Directorate; it is important to reflect that these services are our highest reporters of incidents and are impacted month on month by the validation process for skin integrity.
- The largest number of open incidents is now seen for our current financial year which would be expected.
- At the time of writing this report there has been an improvement in data with there being a total of 657 overdue incidents, with only 313 in Adult Community Physical Health and 54 for Inpatient Mental Health & LD.

Open incidents (awaiting review/being reviewed) as of 06/11/2025 by FY incident first reported on Datix

	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	Total
Adult Community Physical Health	0	0	0	28	687	715
Inpatient Mental Health & LD	0	0	0	7	282	289
Therapies & Spec Equipment	0	0	0	2	214	216
Hospitals Physical Health	0	0	0	0	151	151
CW Specialist Services	0	0	0	1	67	68
Integrated Urgent Care Service	0	0	0	0	55	55
Urgent Care Physical Health	0	0	0	1	50	51
Urgent Care Mental Health	0	0	0	4	47	51
Adult Community Mental Health	0	0	1	12	36	49
CYPS Physical Health	0	0	0	0	45	45
Specialist Mental Health Svcs	0	0	0	2	33	35
CYPS Mental Health & LD	0	0	0	0	15	15
Other Services	1	4	16	16	81	118
Total	**1**	**4**	**17**	**73**	**1763**	**1858**

Gloucestershire Health and Care
NHS Foundation Trust

Learning From Deaths Report Quarter 2 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 2 Learning From Deaths

During Q2 2025-26 **81** Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died, the table below provides the summary of reported deaths by month:

GHC Patient Deaths reported during Q2 2025/26			
July	August	September	Total
29	29	23	81

During Q2 2025-26 we carried out a total of 12 care record reviews, 10 in our Physical Health Mortality Review Group and 2 in our Mental Health and Learning Disability Mortality Review Group:

Number of comprehensive investigations and care record reviews completed during Q2 2025/26 for deaths occurring in:			
Q4 2024/25	Q1 2025/26	Q2 2025/26	Total
1	7	4	12

Quarter 2- 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 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 and is now used across both the Physical Health Mortality Review Group and Mental Health and Learning Disability Mortality Review Group.
- In Quarter 2 All 12 Care Record Reviews were recorded as:
- Category 1 – Good Practice: A standard that you would accept from yourself, your trainees and your institution.
- There were no concerns raised in the reviews regarding the quality of care provided.

Quarter 1- Case Record Reviews-Mazars Summary

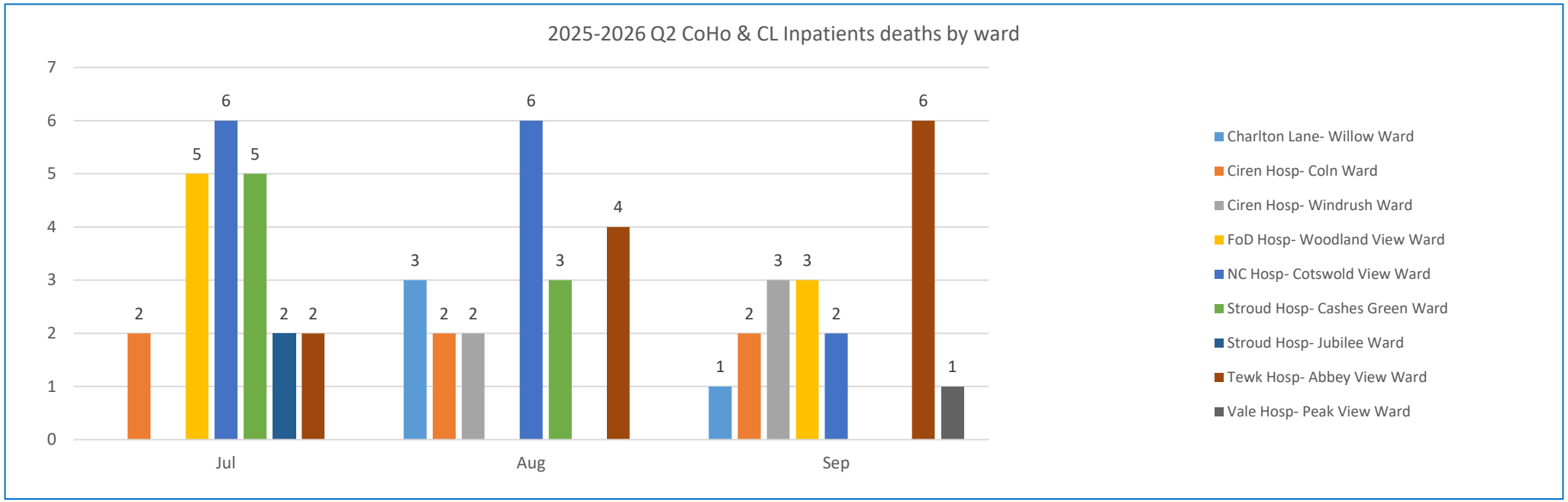
In our Mental Health Mortality Group we use the Mazars Classification of patient deaths. This classification tool considers whether deaths are unexpected or expected or natural or unnatural. Each reviewed case is given a score by the group.

In Quarter 2 there were 2 case record reviews, and the following ratings were given:

Case Record 1:
Cause of death:1a Upper gastrointestinal haemorrhage.1b Bleeding chronic peptic duodenal ulcer.
(UN1) **Unexpected Natural**. '*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.'*

Case Record 2:
Cause of death: Acute COPD
(UN2) **Unexpected Natural**. '*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'*

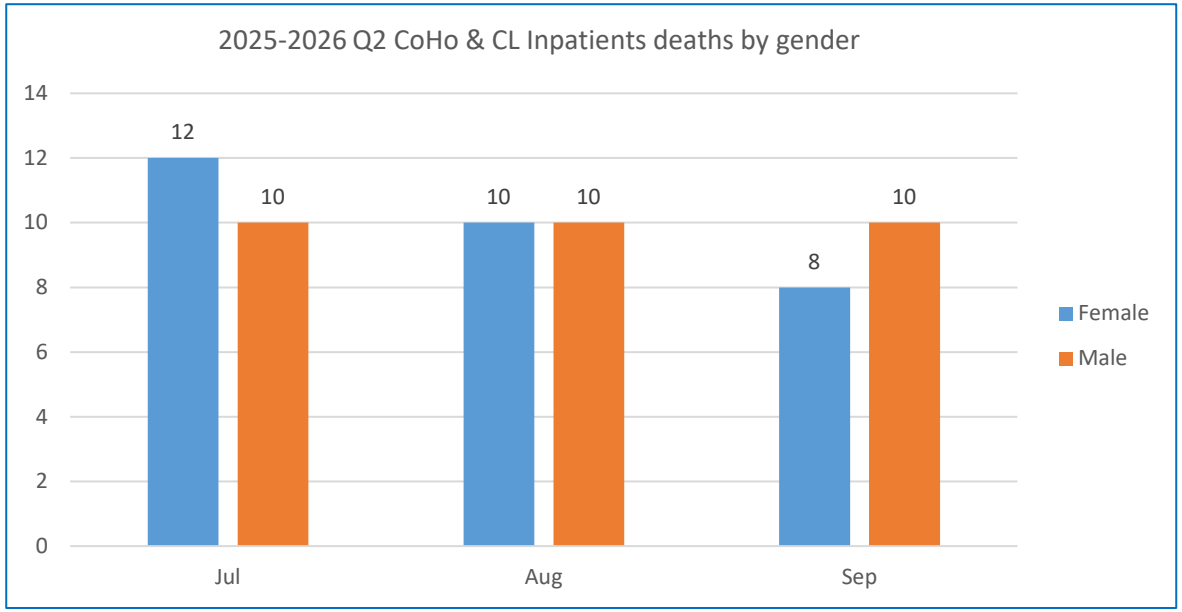
Quarter 2 Community Hospitals and Charlton Lane Hospital Inpatient Deaths by ward

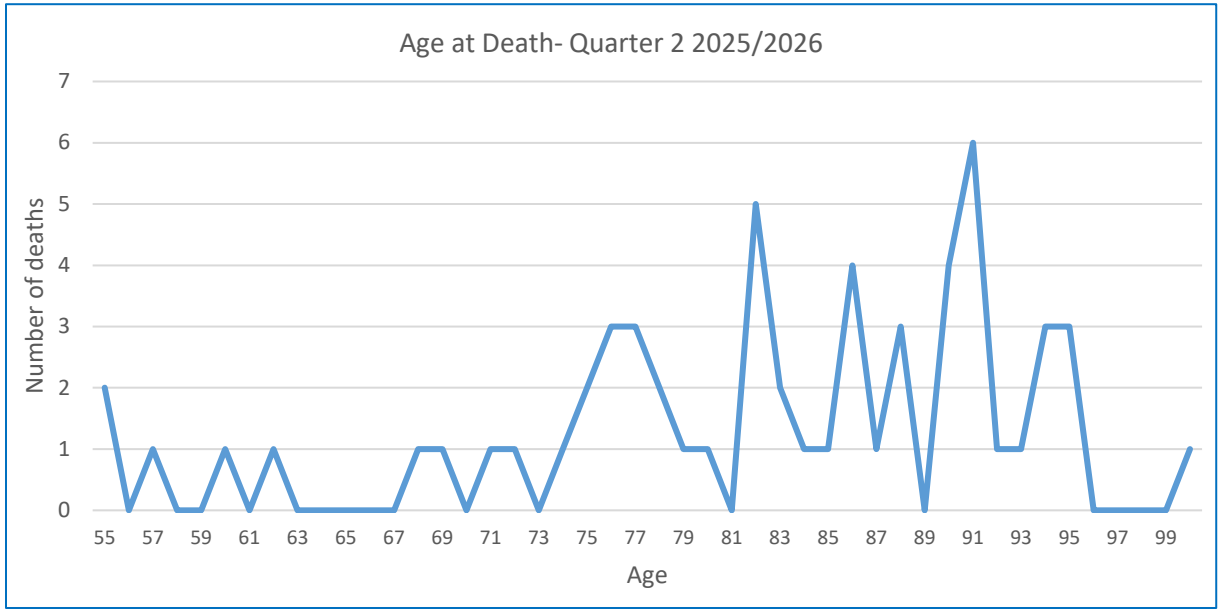


- In Quarter 2 there were 60 deaths reported across our inpatient settings. This figure is broadly similar to Quarter 1 where we saw 61 deaths.
- Whilst there were no deaths reported by Charlton Lane in Quarter 1, we have had 4 deaths reported in Quarter 2.
- Our community hospital sites where we provide direct admissions (Tewkesbury Hospital) and where there is only 1 ward on site are out highest reporters in Quarter 2.
- A meeting is planned with BI colleagues in October 2025 to explore how we can further understand the themes and trends of data relating to admission pathways in Community Hospitals.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 2- Inpatient Deaths by Gender, Age and recorded ethnicity

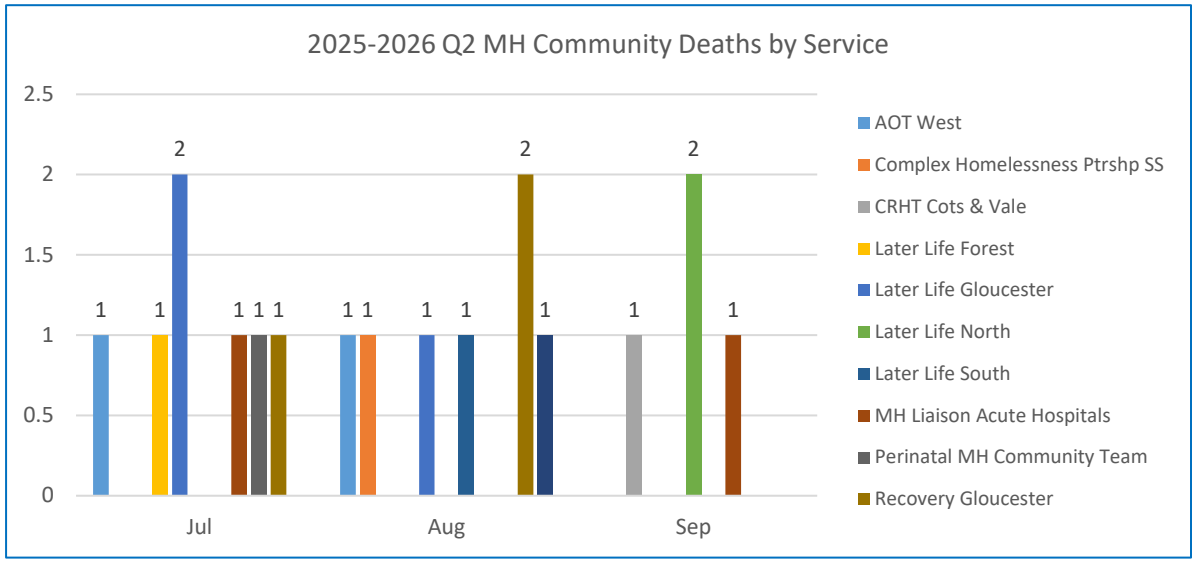




- In Quarter 2, we observe a 50/50 split of inpatient deaths by gender. This is a change of the previous quarter where it was identified that more females had died in our inpatient settings.
- We have included a graph detailing age at death and the largest proportion (37) of the deaths were seen in individuals aged over 80. This would be in line with the Gloucestershire life expectancy at birth (79.8 for males and 83.6 for females)
- Whilst not detailed on a graph above we have continued to observe that individuals have a recorded ethnicity of white or white British.

Gloucestershire Health and Care NHS Foundation Trust

Quarter 2 Deaths reported by Mental Health Services:



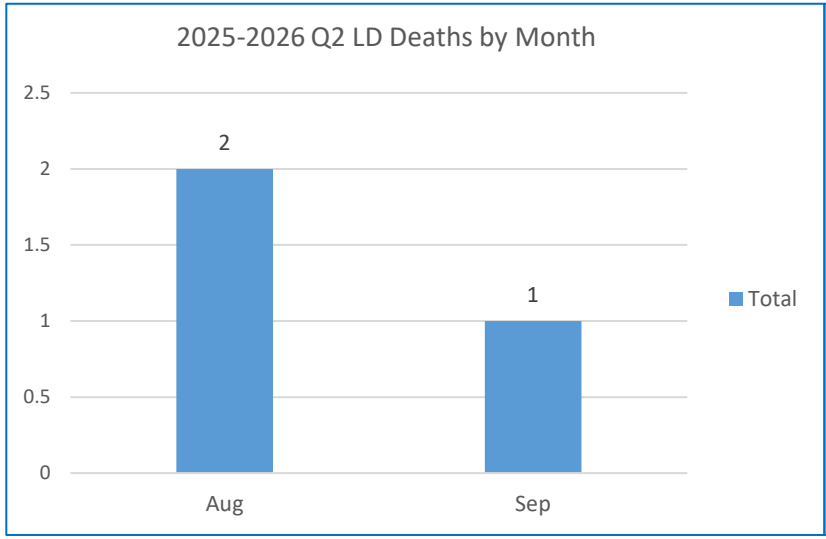
- In Quarter 2 we have seen deaths reported by more teams and services at the trust.
- All deaths reported by wider services are in line with our Learning from deaths scope
- Our Later Life teams continue to be our highest reporters.

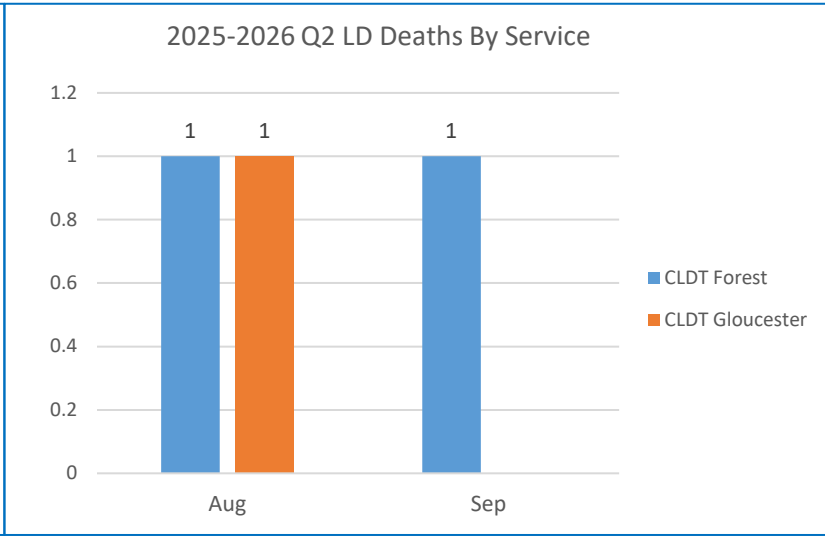
In Quarter 2, there were 9 incidents reported on Datix related to suspected deaths by suicide. Of these it has been determined that:

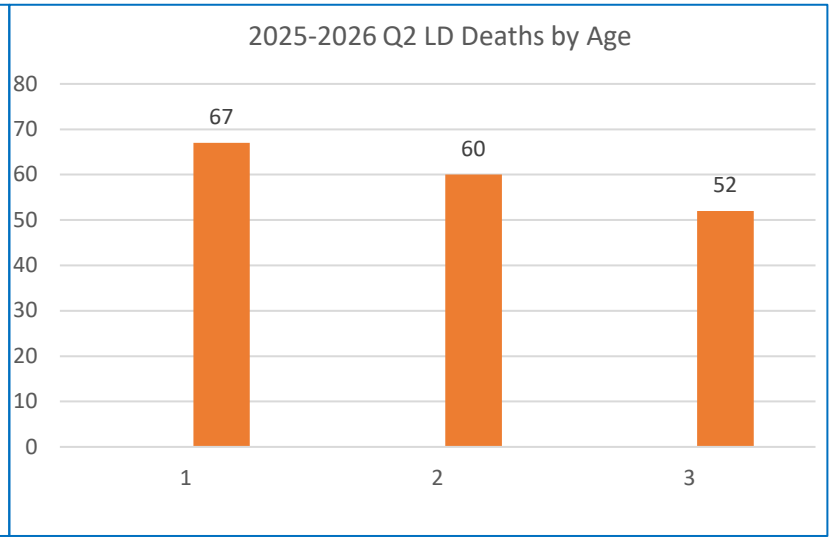
- 4 are being investigated as suspected deaths by suicide via PSIRF processes- PSII
- 2 are being investigated as suspected deaths by suicide via PSIRF processes- AAR
- 1 will be progressed as a multi agency patient safety review by Hereford and Worcester ICB
- 2 were considered as suspected deaths by 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.

Gloucestershire Health and Care NHS Foundation Trust

Learning Disability (LD) Patient deaths per Month







- In Quarter 2 there have been 3 deaths reported by our CLDT services for individuals with a learning disability. This is a 50% reduction on the quarter before.
- We are aware that a further 2 deaths have been referred to the LeDeR programme by wider mental health teams and these are included in the previous data sets in the presentation.
- All individuals were reported as being male with an age range of 52 to 67.

Quarter 2 Themes and Trends from MRG meetings:

- To develop language and sensitive conversations regarding uncertainty with relatives.
- Challenges of ‘feed at risk’ – Requires individualised approach and careful documentation and risk assessment. Staff need to consider capacity and whether this is in best interests or whether the patient is choosing to make an unwise decision.
- Opportunity for explore whether staff who predominantly work nights have been able to access training that is primarily available in the day regarding end of life care and also their involvement in MDT discussions.
- Good examples of collaborative approach between community hospitals and palliative care team.

Additional Developments:

- Gloucestershire ICB through the System Mortality Group has made premature mortality, (under the age of 75 years) in people with severe mental illness (SMI) a focus area. We have contributed to these discussions through a collaborative presentation with public health. Meetings have been arranged with colleagues in BI to further explore ways we use data to understand our mortality position fully.
- We presented the changes made to our Mortality Groups and the positive feedback received from our teams at a recent Patient Safety Specialist Forum. As part of the feedback from teams we are developing a Mortality Newsletter which will enable us to share the learning from mortality reviews directly with them.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Infection Prevention and Control – 2025/26

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	0	1					
Influenza	20		0	0	0	0	0	0	0					
Norovirus	35		10	0	0	0	0	0	0					
COVID-19 HODA	9		10	0	0	0	0	1	4					
COVID-19 HOHA	1		3	0	0	0	0	0	0					
Gram-Negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)	0		0	0	0	0	0	0	0					
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0					
MSSA Bacteraemia	0		0	0	0	0	0	0	0					
Outbreaks	8		1	0	0	0	0	0	1					
Hand Hygiene overall compliance	94%	90%	97%	92%	99%	97%	93%	99%	99%					
Mandatory IPC Training: Clinical	92%	90%			93%	93%	92%	93%	93%					
Mandatory IPC Training: Non-clinical	98%	90%			98%	98%	98%	98%	98%					
Cleanliness FFT "Was the ward clean?"			98%	99%	100%		94%	98%	97%					

Cleanliness – 2025/26

13 Weeks Report

GHC		3rd Party	
Compliant	141	Compliant	23
Non-compliant	3	Non-compliant	0
TOTAL	144	TOTAL	23

FR	Target score	Actual score average	FR	Target score	Actual score average
FR1	98%	98.44%	FR1	98%	N/A
FR2	95%	97.11%	FR2	95%	N/A
FR3	90%	98.46%	FR3	90%	96.75%
FR4	85%	96.94%	FR4	85%	97.41%
Total average score		97.74%	Total average score		97.08%

Infection Prevention Control

- 1 outbreak of hospital acquired COVID-19 in October (Peak View Ward, The Vale) involving 4 patients. Effective management and limited nosocomial transmission provides good assurance that IPC policies are being adhered to.
- UKHSA has reported that flu season commenced 1 month early this year, with 3 times as many cases nationally in October as last year. No cases of hospital acquired flu in the Trust in October.
- TB positive case (staff member), staff contact tracing complete, patient contact tracing in progress. Working in collaboration with UKHSA, Working Well and Gloucestershire TB service
- Good assurance from Hand Hygiene audits, nil returns from Berkeley House (since July 2025) and Cirencester Complex Leg Wound service in October. IPC have contacted BH to offer support.

Cleanliness

- High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT feedback.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Adult Vaccination Programme – 2025/26

IMMFORM – pre-defined staff groups for national (UKHSA/DoH) vaccination reporting purposes ^Additional Intensive Health Outreach Team (IHOT) activity data not available *Vaccines not seasonal

Quality Indicators	Autum/ Winter 2024/25	Spring 2025	Target	Oct	Nov	Dec	Jan	Feb	Mar
Flu - GHC IMMFORM staff	45.8%	-	50.8%	1107 (25.9%)					
Flu - GHC all non-bank staff	48.2%	-	50.8%	1445 (27.6%)					
Flu - Other healthcare staff	373	-		144					
Flu – GHC inpatients	362	-		136					
Flu - Care home residents	27	-		4					
Flu - Housebound	69	-		0					
Covid - GHC IMMFORM staff	32.9%	-	N/A	-	-	-	-	-	-
Covid - Other healthcare staff	279	-	N/A	-	-	-	-	-	-
Covid - GHC inpatients	351	165		95					
Covid – Outreach	74	180		0					
Covid - Care home residents	27	196^		0					
Covid - Housebound	50	5^		0					
DTP - Asylum seekers	-	209*		9					
MMR - Asylum seekers	-	172*		8					
MenACWY - Asylum seekers	-	New		0					

What the data is telling us : Overview of uptake of adult National Vaccinations Programmes (NVP) administered by GHC teams. NVP commenced 01/10/25. Where targets are set, we are on track to achieve them, cumulative staff data for flu uptake is at 43.68% as at 14/11/2025

What are we going to do about it

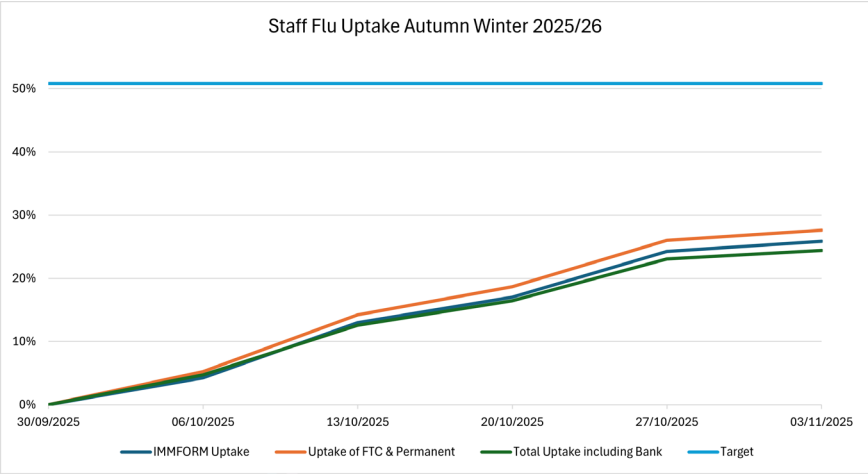
Continue to provide opportunities to increase vaccine uptake for eligible cohorts. Change in delivery model of staff flu vaccination, now there is a much greater reliance on peer vaccinators in teams.

Are there any risks

Uncertainty of commissioning arrangements for Outreach Vaccination and Health Team beyond March 2026. This will have a significant impact/reduction of GHC adult vaccination activity including supporting vaccinations for inpatients and staff.

Vaccination programmes and eligibility criteria 2025/26

Flu 01/10/2025-31/03/2026 – x1 dose over 65s, clinical at-risk groups and GHC staff. National target increase uptake by 5% from 2024/25 Autumn/Winter season among patient facing H&SC staff.
Covid 01/04/25-16/06/25 & 01/10/25-31/01/26 x1 dose over 75s, residents in older adult registered care homes, severely immunosuppressed 6 months+, previously healthcare staff.
Diphtheria, Tetanus & Polio (DTP) national schedule **-** x3 doses 4 weeks apart unknown and/or incomplete vaccination history
Measles, Mumps & Rubella (MMR) national schedule x2 doses 4 weeks apart.
MenACWY (Meningitis & Sepsis) national schedule x1 dose unknown and/or incomplete vaccination history.



Steps to increase staff uptake - peer vaccinators, walk-in clinics various locations across the Trust estate advertised via Comms, flu tab on intranet, staff Facebook group and local advertising.

Quality Dashboard

NHS
Gloucestershire Health and Care

Quality Indicator Q1 and Q2	2024/25	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Endoscopy: cfu (colony forming unit) tolerance levels exceeded				1	1	0	1	0						
Legionella Water Risk Assessments Completed			0	5	0	2	0	0						
Legionella sampling tolerance levels exceeded			0	2	1	2	5	5						
Waste hold inspections			0	0	13	0	0	0						
FFP3 testing compliance: Group 1			-	-	71%	-	-	67%						
FFP3 testing compliance: Group 2			-	-	78%	-	-	78%						
Occ. Health: RIDDOR reports			0	0	0	0	0	0						
Occ. Health: No. contamination injuries			5	3	3	3	3	2						

DECONTAMINATION
- The final rinse water results for the Trust Endoscopy departments exceeded tolerance levels on 1 occasion for 1 week in Q2 (Stroud). Confirmed an anomaly and now resolved with no patient risk identified.
- 2 new washer disinfectors (Springbank and St Pauls dental clinics) passed commissioning phase and are now in use
- Risk 637 closed in August - Stroud endoscopy and strong smell of Peracetic Acid within the Decontamination washroom. Control of Substances Hazardous to Health (COSHH) continues, risk assessments in place and monitored.

WATER SAFETY
- 2 Legionella water risk assessments were completed in Q2 (Southgate Moorings and Wotton Lawn Hospital) in line with national requirements and agreed scheme of works. All recommended actions have been added to the Water Risk Assessment Action Plan. Remedial works is undertaken and overseen by the Water Safety Group that reports to IPC Committee and approved by Authorising Engineer for Water
- Legionella sampling – positive samples detected Charlton Lane Hospital, Greyfriars, Laurel, Montpellier, Stroud and Wotton Lawn Hospital. Remedial work complete and re-samples clear. More sites were sampled Q2 than in Q1 (7 more sites) resulting in an increase in numbers
- Water tank replacement works completed for Cirencester and Vale Hospitals

VENTILATION SAFETY
- New risk placed on Trust risk register in Sept, risk 654. The Air Handling Unit (AHU) in Stroud Theatre needs replacing (booked in for Jan 26) but the risk of it failing, and theatre activity needing to be cancelled, has been placed on register. Estates are inspecting and monitoring the AHU on a weekly basis to provide a level of assurance to enable the environment to remain open for usual service delivery
- Formal Ventilation Safety Group meetings are not yet fully mature; second meeting held in Q2 with further E&F input planned in now that capacity issues have been resolved.

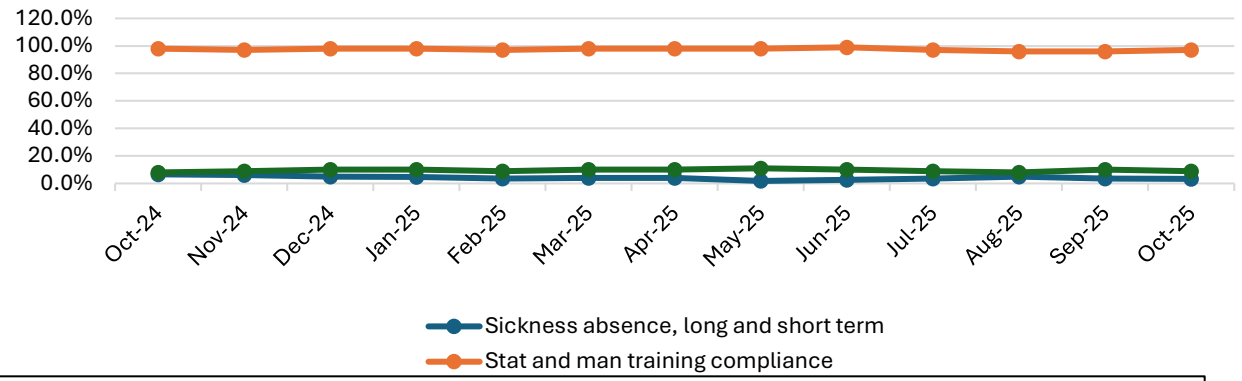
WASTE MANAGEMENT
- Waste Steering Group established, first meeting in Q3. Terms of Reference to be agreed
- Pre Acceptance Audits required for all sites in 2025, currently 30% complete and additional support within E&F has been identified to help complete these
- Recurring issues with general waste contractor, Veolia, including missed collections and broken bins, have been escalated within Veolia.

FFP3
- Physical Health ICTs are ordering 5 respiratory protective hoods to provide additional resilience and mitigate against transmission of respiratory HCIDs that augments those staff who are fit tested.
- Compliance rates show that the current delivery model for FFP3 testing is not sustainable. Improvement will require review of the delivery model and of staff categorisation. Long-term staff absence is having an on-going significant impact on operational delivery. Powered Air Purifying Respiratory Protective Hoods (PAPRHs)/Respiratory Protective Hoods (RPHs) are an alternative to FFP3, there are 51 PAPRH/RPH held across Trust sites

OCCUPATIONAL HEALTH – WORKING WELL
- There are no clear trends in the contamination injuries that occurred during Q2

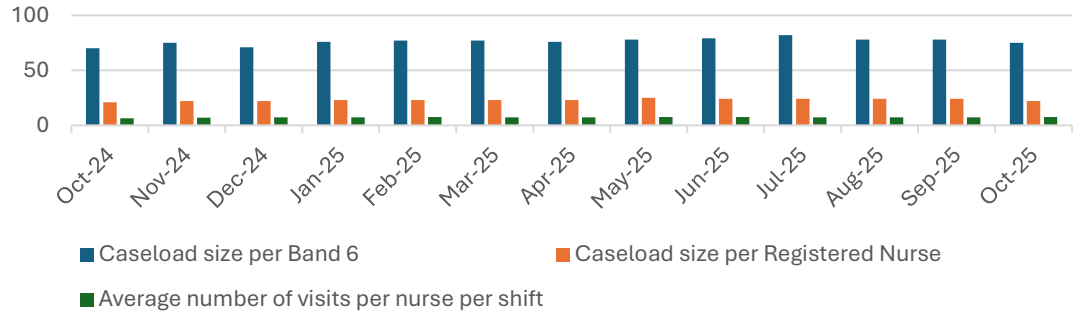
CQC DOMAIN - ARE SERVICES EFFECTIVE? - ICT Community Nursing

Workforce



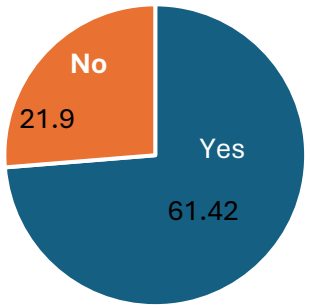
What the data is telling us: the average % rate of sickness continues to be below the threshold ***however*** teams in Forest & Tewkesbury, Cheltenham and Gloucester have experienced higher than the 4% baseline.
What are we doing about this: sense checking the tableau data with the community managers to confirm that reporting processes are feeding into Business Intelligence. Consider a % sickness in different clinical roles as a metric to triangulate senior clinical availability with impact on visits.

Nurse Caseload

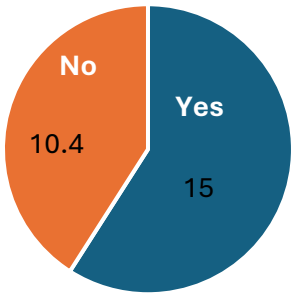


What the data is telling us: the average number of visits per nurse per shift has gone up whilst the average caseload size has dropped slightly this reflects national narrative of complexity and co morbidity on caseloads.
What are we doing about this; monitoring in individual localities, working with BI colleagues to identify data which can highlight complexity for example the ***Rockwood frailty score***.

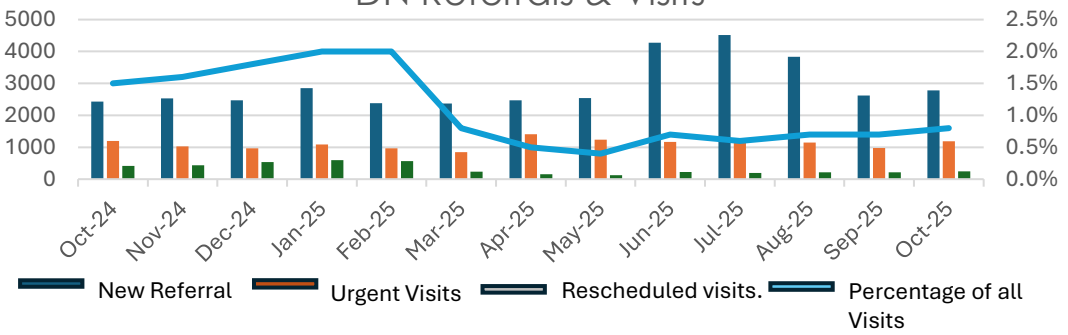
SPQ at B6



SPQ at B7



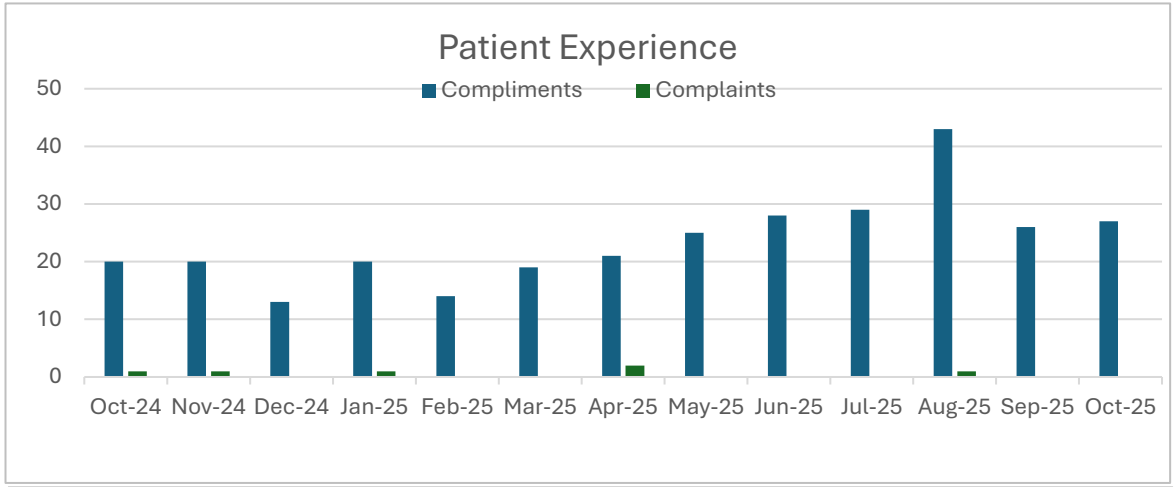
DN Referrals & Visits



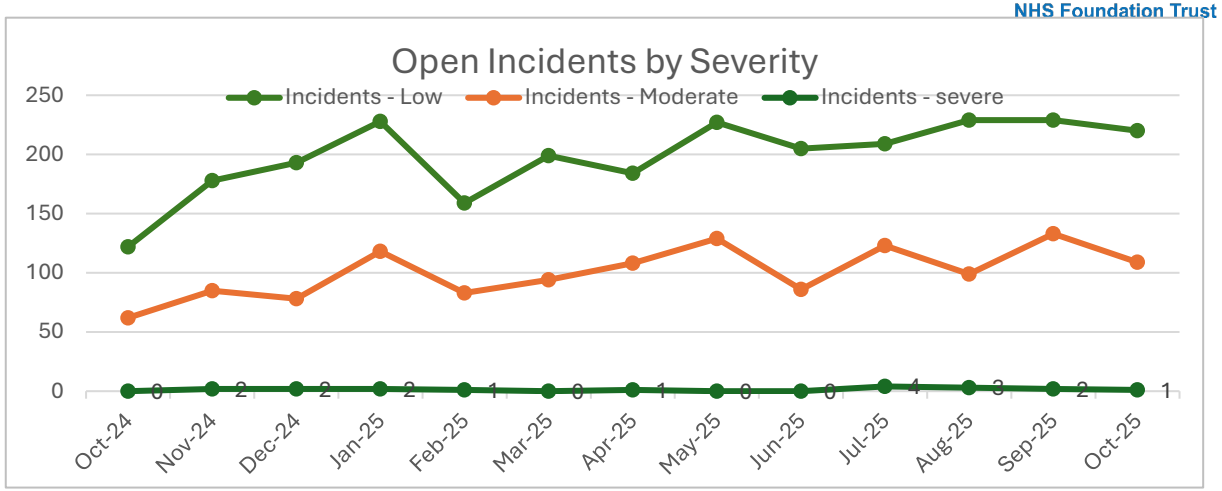
October's data remains static. Workforce planning continues to ensure specialist senior clinician availability in Community Nursing , 5 places will be available on September 2026 intake .

The left axis of the graph shows the number of visits whilst the right axis shows the 3 metrics taken together and illustrated as a % of all visits on all community nursing caseloads. There were 168 more new referrals in October and 206 more requests for urgent visits. There was one more missed visit (11 in total)

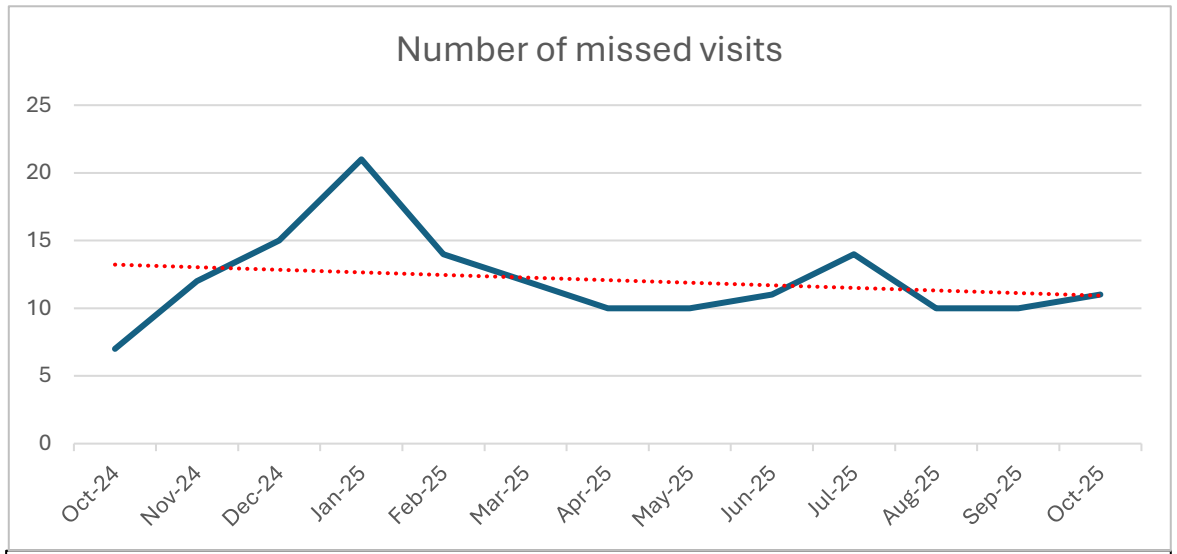
ICT Community Nursing – October 2025



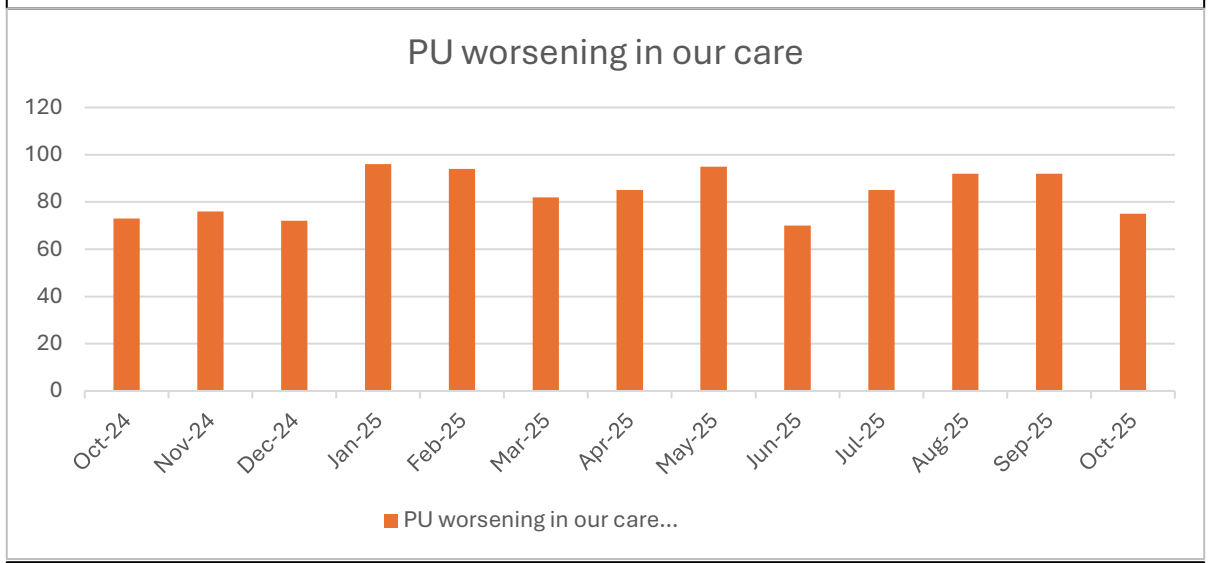
What the data is telling us: we received one more compliment than last month and no complaints.



What the data is telling us: low, moderate and severe incidents have reduced in October, Community Nursing Leads are drawing learning to share across localities following AAR's and using these as a focus for continuous professional development sessions.



What the data is telling us: This is a manual data count recording one more missed visit than last month



What the data is telling us: there were 17 less PU's worsening in our care in October, weekly review and validation is set to commence in November

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

Key Highlights:.

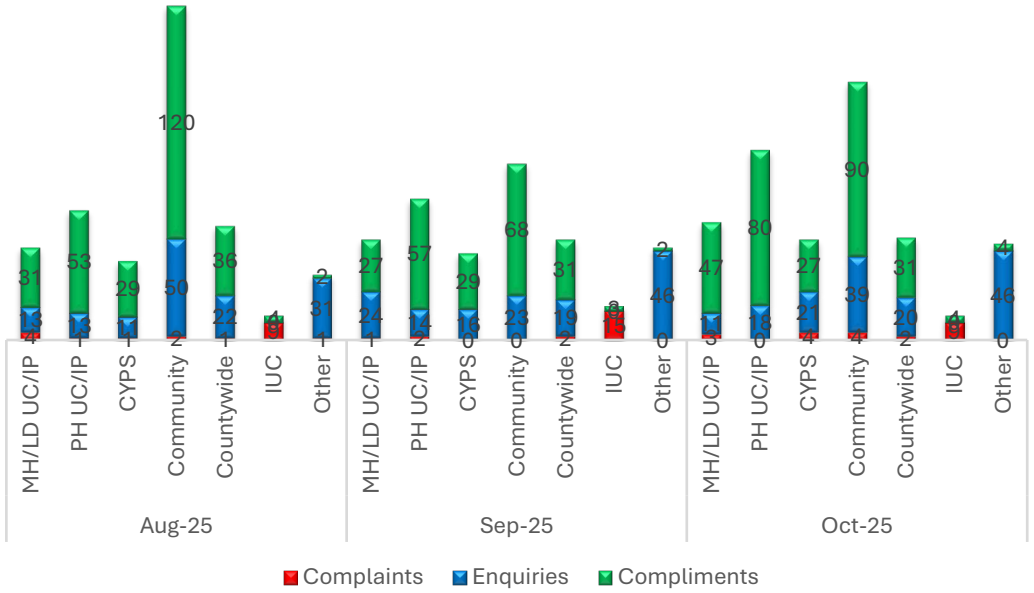
- Complaints received are up 66% YTD on 2024/25 data (78 then against 134 now).
- We continue to see far more compliments than any other type of feedback and directorates now receive a full list of these each month.
- Directorate level data is shared with senior operational leads each month to enable interrogation of service specific feedback.
- High level data is shared at the Ops Governance monthly meeting

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	3	Early resolution:	**3**	11	47
		Closer look:	**0**		
PH urgent care and inpatient	0	Early resolution:	**0**	18	80
		Closer look:	**0**		
CYPS	4	Early resolution:	**4**	21	27
		Closer look:	**0**		
PH/MH/LD Community	4	Early resolution:	**4**	39	90
		Closer look:	**0**		
Countywide	2	Early resolution:	**2**	20	31
		Closer look:	**0**		
IUCS	9	Early resolution:	**9**	0	4
		Closer look:	**0**		
Other	0	Early resolution:	**0**	46	4
		Closer look:	**0**		
Totals	22	Early resolution:	**22**	155	283
		Closer look:	**0**		

Directorate feedback over the past three months



Examples of complaints [as reported] for each directorate:

- MH UC/IP Mother of patient unhappy with the patient's unsafe discharge from the Maxwell Suite.
- CYPS: Mother of patient very unhappy with the postnatal care provided by a health visitor.
- Community: Patient unhappy with comments made by the clinician during her assessment.
- Countywide: Husband of patient very unhappy that the nurse referred them to social services.
- IUCS: Mother of patient unhappy with incorrect advice given by NHS111.

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)

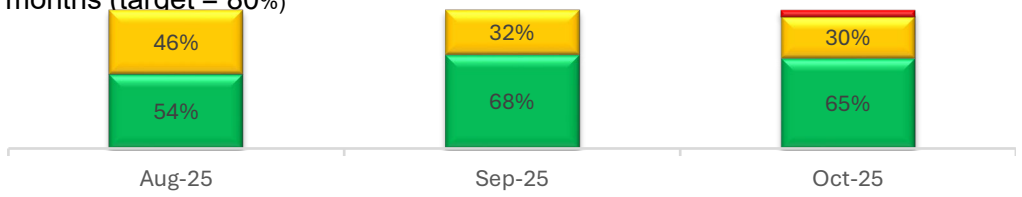
The below table shows all complaints CLOSED this month by outcome and directorate.

These include closer look and early resolution complaints.

Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	0	2	0	0	0	2
PH urgent care, inpatient	0	1	0	0	0	1
CYPS	0	2	2	0	0	4
PH/MH/LD Community	0	0	2	0	0	2
Countywide	0	0	0	0	0	0
IUC	7	1	3	0	0	11
Other	0	0	0	0	0	0
Totals	**7**	**6**	**7**	**0**	**0**	**20**

The below graph shows the length of time taken to close complaints.

This month, 65**%** were closed within three months (target = 50%), 95**%** closed within six months (target = 80%)



	Aug-25	Sep-25	Oct-25
6-12 months	0%	0%	5%
3-6 months	46%	32%	30%
0-3 months	54%	68%	65%

The below table shows some of the upheld COMPLAINT THEMES this month.

Directorate	Upheld themes for complaints closed this month
MH UC/IP (20229)	FPCC need to escalate to clinical team when triaging at night. **Clinical Treatment**
CYPS (19934)	Improved communication needed with regard to resources when young people are waiting for an assessment. **Communication and attitude**
PH UC/IP (20818)	MIIU staff to be reminded about kindness and compassion when speaking to patients. **Values and Behaviours**
IUCS (18946)	Staff need to be reminded what is considered aggressive behaviour before transferring to 5555. **Communication and attitude**

	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	9	12	7	8
Upheld	9	4	6	0

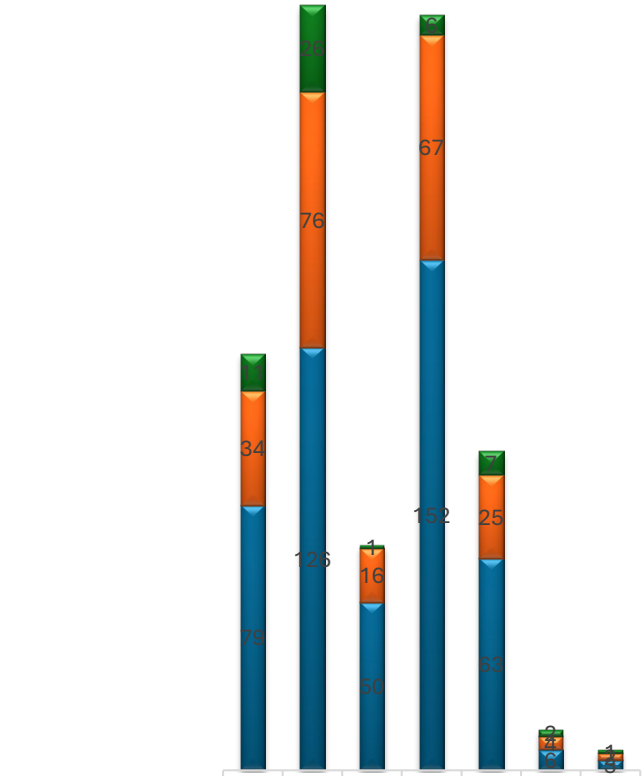
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

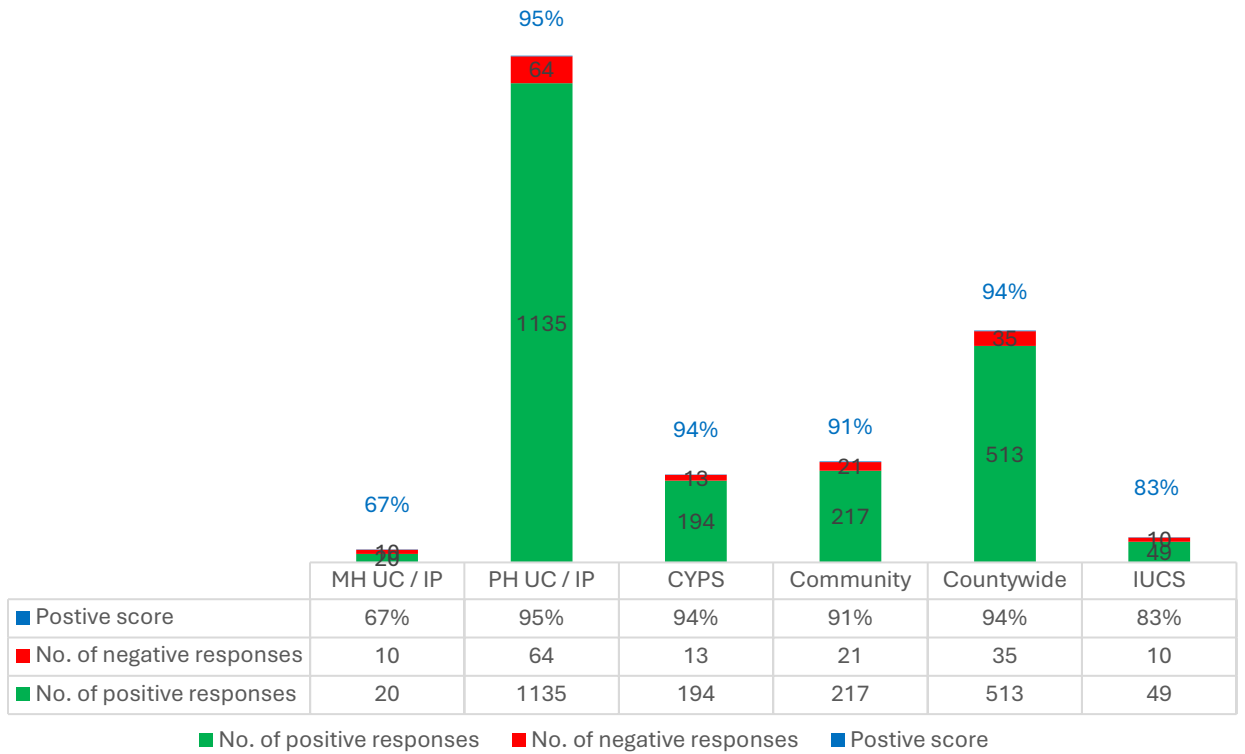
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.
The 283 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.** 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
05/10/2025	21160	Charlton Lane-Willow Ward	Patient's family came to visit and voiced that their loved one appears to be better at coordination (fork and Knife). They also thanked all the staff for all the support given to them and the patient. Really happy with his care.
15/10/2025	21312	CRHT Chelt & Tewks	A carer wanted to pass on his gratitude for support he received last week. He said you are a great and responsive team Thank you
22/10/2025	21514	Stroud Hosp-Cashes Green Ward	I would like to say thank you for looking after my mum on Cashes Green ward recently. She was well looked after and cared for. Staff were attentive, caring and worked hard. We thank you. It was a real community hospital and nursing staff reflected that. Again, thank you. It meant so much.
13/10/2025	21273	Rapid Response	NNP Rhianne Young went above and beyond her own duties on the morning of the 13th/10/2025, assisted with OOH GP for an urgent Home visit to a distress palliative patient who requires end of life medication, but due to the lack of capacity, OOH GP was unable to attend.
27/10/2025	21484	CYPS PH-Childrens SALT	Parent emailed following a triage appointment for their son. "Thank you for making [child's] appointment this morning such a positive and engaging experience for him. We really appreciate the resources you shared".
08/10/2025	21460	CAMHS MH Support Team	Thank you, I am very grateful to everyone I have spoken to today, whether that was via message, phone or email. It has been a really, really hard time and you have all been very lovely and caring. Please make sure your manager knows how wonderful you all are.
07/10/2025	21199	Reablement Stroud	The patient's family met with the team's Progression and Wellbeing Coordinator and wanted her to know that they were very appreciative of Home First and all that they were doing and also spoke very highly of the Reablement Workers.
15/10/2025	21338	LCP Gloucester	A family support worker got in touch with the LCP team as her colleagues from Families First at Shire Hall had fed back how helpful the LCP provision is to their service.
16/10/2025	21340	Sexual Health Integrated ISH	Patient stated that the care he had received from the ISH team & the HA office was excellent & thanked all those involved in his care.
13/10/2025	21309	Falls and Education Service (FAES)	Compliment from patient's son during assessment regarding feeling that he felt listened to.
15/10/2025	21314	IUCS OOH Service	"Wow! What fantastic service. Following a 111 call I was given a doctors appointment at 11.15pm at Cheltenham Out of hours service. Fabulous lady on reception, and great doctor. I was in and out in half and with antibiotics, after being diagnosed with a uti.Thank you for such a great caring service."



	MH UC|IP	PH UC|IP	CYPS	Community	Countywide	IUCS	Other
Other	11	26	1	6	7	2	1
Care | treatment	34	76	16	67	25	4	2
Communication | attitude	79	126	50	152	63	6	3

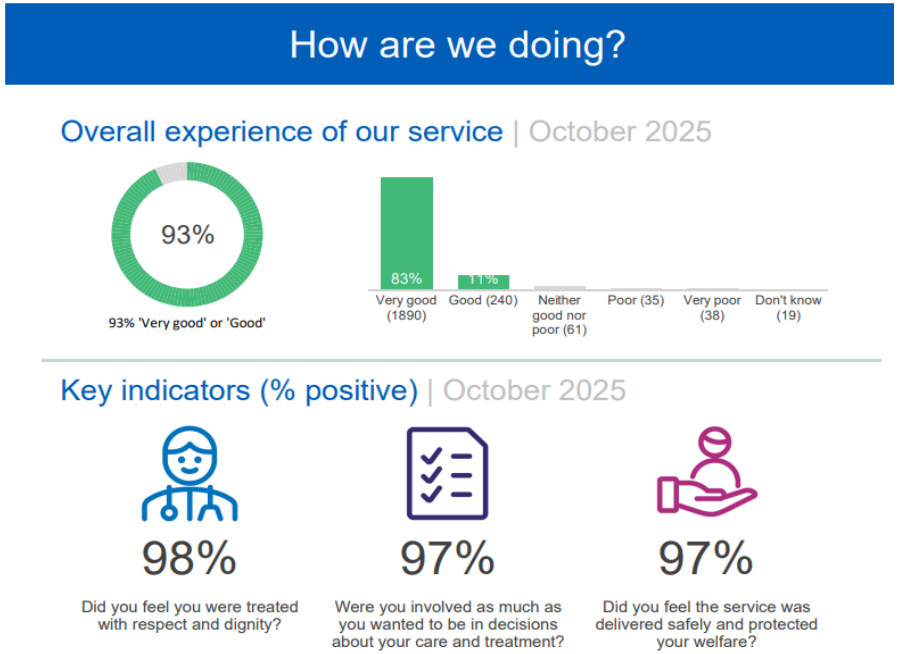
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)



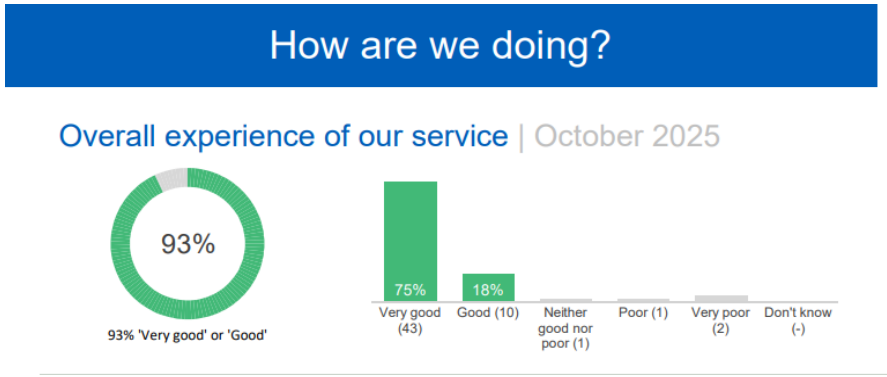
	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
Postive score	67%	95%	94%	91%	94%	83%
No. of negative responses	10	64	13	21	35	10
No. of positive responses	20	1135	194	217	513	49

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

Patient feedback



Carer feedback



Highlights for this month:

- The retrospective send has now completed, with the overall positive experience for the month at 93% which is in line with recent months.
- We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.
- Service users made 4 requests for contact/action through the FFT.
- FFT set up to support new IUC service; there were 59 responses in October 2025 with a positive experience rating of 83%.

ADDENDUM TO QUALITY DASHBOARD

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 2025/26

INTRODUCTION

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

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

PROCESS

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

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q1 2025/26 audit provides **SIGNIFICANT** assurance that overall, the Trust is investigating and responding to complaints appropriately.
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard.

FUTURE AUDITS

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

RECOMMENDATIONS

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

Gloucestershire Health and Care NHS Foundation Trust

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 2025/26

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 [17307] Joint complaint from SWCT regarding the late patient's care from the district nursing team.	**SIGNIFICANT ASSURANCE** • Issues agreed with SWCT – no contact with complainant • Formal response letter was sent slightly late due to line management changes in directorate	**FULL ASSURANCE** • Robust investigation • Good evidence of the support provided to the complainant	**FULL ASSURANCE** • Robust response in which an individual's expectations seem not to match what can realistically be offered	**FULL ASSURANCE** • No learning was identified but appropriate explanations were given	• Limited response given as NHS SW complaints did not obtain level of consent accepted by GHC. • Complaint was not upheld
Complaint 2 [17524] Father of patient unhappy with poor communication from team and having to chase a report and unhappy with wait times for the CAAAS team.	**FULL ASSURANCE** • Complaint was acknowledged appropriately • Response was sent within 3-month KPI	**SIGNIFICANT ASSURANCE** • Thorough investigation giving detailed timeline of events. Full response given to all issues raised.	**FULL ASSURANCE** • Information contained in the response letter was clear but lacked empathy. • Apologies given when mistakes were identified.	**SIGNIFICANT ASSURANCE** • Both services have significant capacity and demand issues and although learning has been identified in connection with communications with the family it is difficult to demonstrate fully how teams can significantly reduce wait list times.	• Complaint upheld due to communication shortfalls with the young persons family.
Complaint 3 [17689] Daughter of patient unhappy with a document written by the SPCA team.	**FULL ASSURANCE** • Daughter of patient did not wish to make a formal complaint, however, as an organisation we felt the serious issue raised needed to be investigated formally. • Response sent well within 3-month KPI	**FULL ASSURANCE** • Thorough investigation conducted into each department. • Very balanced and informed judgements made	**FULL ASSURANCE** • Sensitive letter, with appropriate information sharing and apologies	**FULL ASSURANCE**. • Very clear learning around staff not copying and pasting documentation from another trusts electronic system and referral paperwork not being added to patient's bedside folders.	• Family of patient expressed that the ward was lovely with staff being very caring, empathetic and understanding. • Complaint was upheld

ADDENDUM TO QUALITY DASHBOARD

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q2 2025/26

INTRODUCTION

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

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

PROCESS

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

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q2 2025/26 audit provides **SIGNIFICANT** assurance that overall, the Trust is investigating and responding to complaints appropriately.
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard.

FUTURE AUDITS

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

RECOMMENDATIONS

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

Gloucestershire Health and Care NHS Foundation Trust

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q2 2025/26

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 [18377] Patient unhappy with treatment received from the OT team.	**FULL ASSURANCE** • Delay in agreeing issues due to patient and advocate not responding. • Response letter sent well within time scale.	**FULL ASSURANCE** • Robust investigation substantiated with an appropriate level of evidence. • Outcomes not specifically noted for each issue, however, new template is now being used to address this.	**SIGNIFICANT ASSURANCE** • The letter is informative and clear, though regularly more technical than empathetic in its tone. There are proofing errors, which could undermine empathy and apologies (new proof-reading process now in place).	**SIGNIFICANT ASSURANCE** • Learning was appropriately identified; however, the new template will ensure ownership of all learning actions going forward.	• Complaint was partially upheld. • Consideration of sharing complaints with organisations outside of GHC could be helpful and prevent patients falling through cracks.
Complaint 2 [16834] Patient unhappy with the length of time for a call back from 111 service.	**SIGNIFICANT ASSURANCE** • Complaint received on 10/12/2024 when IUCS processes were still being embedded. Initial confusion regarding acknowledgment responsibilities, now resolved. Issues with accessing inbox added to delays, also resolved.	**FULL ASSURANCE** • The addition of an AAR into the complaint has resulted in a very thorough, robust and thoughtful investigation.	**FULL ASSURANCE** • The letter is extremely well written – sympathetic and clear, in non-technical language, without proofing errors, and with meaningful apologies.	**FULL ASSURANCE** • An AAR into the complaint process has rendered an incredibly valuable learning and improvement cycle.	• This complaint should not have been included in Q2 audit, closed date amended in error by IUC Governance Lead. • Appropriate escalation to AAR by IC24 colleagues. • Significant improvements in the acknowledging of complaints have now been implemented.
Complaint 3 [18143] Patient wishing to complain about her treatment received from the eating disorders team and about a clinician who has now left the Trust.	**FULL ASSURANCE** • Time spent agreeing issues and carefully explaining that we could only investigate issues that had occurred within the last 12 months. • Response letter sent within the 3-month KPI.	**FULL ASSURANCE** • This appears to be a very thorough and well-considered review of the case which has clearly been researched in great detail, including reaching out to colleagues with specific knowledge .	**FULL ASSURANCE** • An exemplary response, which has clearly been considered and conveyed in sensitive language by the investigator and the PCET team.	**FULL ASSURANCE**. • I hope that the complainant finds the letter reassuring and recognises that – as they themselves wrote in correspondence – the focus has been on improving the service for others, as well as reflecting on the patient's own experience.	• Complaint was partially upheld. • Significant consideration carried out with members of the team is reflected in final report to complainant.

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NHS Foundation Trust

AGENDA ITEM: 11/1125

Performance and Quality Dashboard

TO FOLLOW

with you, for you

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NHS Foundation Trust

AGENDA ITEM: 12/1125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 2025**

PRESENTED BY: Lavinia Rowsell, Director of Governance & Trust Secretary

AUTHOR: Lavinia Rowsell, Director of Governance & Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK (BAF)**

If this report cannot be discussed at a public Board meeting, please explain why.	The report has been redacted to remove commercially sensitive information

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

The purpose of this report is to:
Provide assurance to the Trust Board on the management of strategic risks.

Recommendations and decisions required

The Trust Board is asked to:

- **Receive** and **consider** the BAF (Q2 review)
- **Note** the overarching risk profile for the Trust (Page 2, **Appendix 1** BAF)
- **Note** progress towards mitigating strategic risks

Executive summary

Along with the Corporate Risk Register the Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The Board Assurance Framework (BAF) for 2025/26 reflects the Trust's Strategic Aims and Objectives. For the assurance of the Board, throughout the year, the BAF has been reviewed and updated in line with Trust policy with the regular governance touchpoints (Executive risk owners, Executive Team and Governance Committees). The BAF is a dynamic in nature as demonstrated by the changes set out below.

<u>Key changes during Q1/Q2:</u>

- 3 new risks have been added – *Capacity for Change (R7), Health Equity (R10), Strategic Commissioning Partnerships (R11)*
- All target dates have been reviewed and updated.

- Executive Deep Dives into ***Risk 9 Closed Culture*** and ***Risk 7 Capacity for Change*** have taken place resulting in additional mitigating actions being agreed
- Risks and mitigating actions have been cross referenced to the outcome of the Board Self-Assessment. As a result, the committee oversight ***Risk 10 Health Equity*** has been moved to the Resources Committee.
- A summary key changes in Q2 set out on page 2 of **Appendix 1**.

The next steps in the development of the Board Assurance Framework will be considered in the context of the outcome of the recent Committee Development Review.

Risks associated with meeting the Trust's values
Ensuring a BAF is in place which helps to effectively manage Strategic Risks is a core element of the Trust's Risk Management Policy.

Corporate considerations	
Quality Implications	The Trust must have a robust approach to risk management in order to maintain the highest standards of quality care provided to patients. Identification and mitigation of risk is an important tool in being able to manage events that could have an impact.
Resource Implications	There are no financial implications arising from this paper.
Equality Implications	There are no financial implications arising from this paper.

Where has this issue been discussed before?

- Governance Committees, Executive Team, Board / Seminar

Appendices:	Board Assurance Framework Q2 Review

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

BOARD ASSURANCE FRAMEWORK - SUMMARY OF KEY CHANGES IN Q1/Q2

Strategic risks added, removed, changed score

		Score
Closed	*None*	**N/A**
New Risks Added (Q1)	**Risk 7 – Capacity for change –** in response to speed of change and the Trust's ability/capacity to adapt to meet the expectations of the population. **Risk 10 – Health Equity** – separate health inequality from 'demand and capacity' given the focus on this within the strategic plan/objectives **Risk 11 – Strategic Commissioning Partnerships** – to reflect changing external policy environment, NHS reorganisation and importance of maintaining strong relationships with commissioners.	
Movements	*None*	**N/A**

Issues to note

		Score
All Risks	All risks have been reviewed with Executive Leads and action owners and amendments highlighted in Red. All target risks scores have been reviewed and updated.	
Risk 9	*Closed Culture* – In September, the Executive Team undertook a deep dive discussion on the Closed Culture Risk resulting in: • A change to the target risk score (increase in impact). While the impact of the risk is unlikely to reduce the focus of the mitigating actions will be on reducing the likelihood of the risk materialising. • It was acknowledged that whilst closed cultures can occur in any setting, the focus of this risk was on those *settings where our duty of care is greatest.* Wider organisational work on culture being addressed via the Leadership and Culture programme. • Additional mitigating actions including high risk areas will be specified alongside appropriate governance, oversight and monitoring arrangements. This will allow for informed consideration of the scoring of the risk.	**16**

BOARD ASSURANCE FRAMEWORK – HEATMAP – May 2025-April 2026										RISK SCORE				STRATEGIC AIM				Issue to be raised by Exec / Committee Yes /No
Strategic Risk	Risk No	Exec Lead	Last Exec Review	Committee Lead	Last Committee Review	Tolerance	Initial Risk Score	Target Risk Score	Target Date by	Qtr1	Qtr2	Qtr3	Qtr4	Better Health	Great Place to Work	High Quality Care	Sustainability	
Quality Standards	1	Dir. NTQ/MD	Sept 25	Quality		10	12	8	April 26	12	12			✓		✓		
Demand & Capacity	2	COO	Sept 25	Resources		10	12	8	April 26	12	12			✓		✓		
Recruitment, Retention & Development	3	Dir. HR & OD	Sept 25	GPTW		12	16	12	April 26	16	16			✓	✓	✓		
Inclusive Culture	4	Dir. HR & OD	Sept 25	GPTW		10	16	10	April 26	16	16			✓	✓			Yes
Relationships & Partnership Working	5	Dir. I&P	Sept 25	Quality		12	12	10	April 26	12	12			✓				
Funding for Transformation	6	Dir. of Finance	Sept 25	Resources		10	16	09	April 26	12	12			✓		✓		
Capacity for Change	7	CEO	Sept 25	Resources		12	16	12	April 26	16	16			✓	✓	✓	✓	
Cyber	8	Dir. of Finance	Sept 25	Resources		10	12	9	April 26	12	12			✓	✓	✓		
Closed Culture	9	Dir. NTQ	Sept 25	Quality		10	16	8	April 26	16	16			✓	✓	✓		Yes
Health Inclusion	10	Dir. I&P	Sept 25	Resources		10	12	6	April 26	12	12			✓		✓		
Strategic Commissioning Partnerships	11	Dir. I&P	Sept 25	Trust Board		10	16	8	April 26	12	12			✓	✓	✓	✓	

Note: *(1) Click on the Strategic Risk for the link to the individual risks (2) On the Individual risk, click on the Strategic Risk name to take you back to the Heatmap.*

Strategic Aim(s):			• High Quality Care • Better Health	**Executive Leads**	**Date of review**
				Nicola Hazle & Dr Amjad Uppal Dir. NTQ & MD	Sept 2025
RISK ID: 01	**Description:** **QUALITY STANDARDS**		There is a risk that failure to meet Quality Standards will result in harm and poor clinical outcomes for patients / service users and poor patient / service user, carer and staff experience.	**Lead Comm**	**Next review**
Date Risk: Identified/confirmed	Updated May 2025 (this is an ongoing BAF risk from 2019)			Quality	**Jan 2026**
RISK RATING	**Likelihood**	**Impact**	**Overall**	**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*	
Inherent Risk Score:	**3**	**4**	**12**	KPI's/Quality Indicators	
Current Risk Score:	**3**	**4**	**12**		
Target Score:	**2**	**4**	**8**		
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	Recognising its core importance to the work of the Trust this has been confirmed as an area for ongoing monitoring on the BAF since 2019, confirmed May 2025.

Rationale for current score Completed by Lead Executive at each review *(What is the justification for the current risk score):*

Established quality governance structures and processes through to Quality Committee provide partial assurance in relation to delivery of the Quality Strategy as well as the monitoring and response to trends and variability across quality standards and the embedding of learning and improvement; where the majority of indicators are within agreed parameters. There remains further development and improvement required to:

- ➝ Mature the analysis and triangulation of data available to demonstrate impact on clinical harm, safety, quality outcomes and experience.
- ➝ Implement changes to the quality governance structures that support Quality Assurance Group and Quality Committee – incorporating findings from internal audit as received.
- ➝ Progress safer staffing compliance and the reductions in agency staffing use with implementation of inpatient establishment reprofiling and robust governance for safer staffing assurance.
- ➝ Continue the work to reduce closed cultures through triangulation of data from reviews, audits and FTSU alongside the quality priority programme in relation to reducing restrictive practice, pressure ulcers, clinical supervision, clinical risk assessment & management and PSIRF.
- ➝ Maintain progress on actions plans and internal assurance related to regulatory compliance, including the S31 at Berkeley House where there remains enhanced surveillance.
- ➝ Assure on significant service transformation programmes, including the community MH services and integrated urgent care service.
- ➝ Assure on delivery of delegated statutory duties.
- ➝ Maintain progress on action plans and internal assurance related to mental health inpatients, including the culture of care programme (linked to leadership and culture)

In light of ongoing learning in governance following recent patient safety incidents, this risk will be reviewed monthly and updates provided to Exec/Quality Committee.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
SARC Clinical Records (update to be provided at meeting)	490	16	1
Advancing Mental Health Equalities Strategy	**613**	16	**6**

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Current clinical policies, SOPs and clinical procedures	Clinical Policy Review Cycle/Audit (L1)	• Policy Rev Grp • Quality Comm	Monthly Quarterly	Satisfactory	New process now established to identify and escalate risk in out of date policies
2.	Clinical compliance programme including clinical audit, NICE guidance audit, medicines audits	Clinical audit, peer review & self-assessment reporting (L2)	• QAG • Qual Comm • Audit Comm	Annual Per IA plan	Satisfactory	Will be reviewed as part of quality governance structures
3.	Regulatory compliance including self-assessment and peer review, fidelity testing	Compliance Report (L1&L2) NED Quality Visits (L2)	• Mangt Groups • Qual Comm	Monthly Quarterly	Satisfactory	
4.	Effective local clinical governance processes operational teams/services/directorates in place	Clinical Governance Reports (L1&L2)	• Ops Governance • Qual Comm	Monthly Quarterly	Satisfactory	
5.	Patient Safety Framework e.g. Incident reporting, Datix, Service User Experience, Healthwatch etc, Annual Surveys	Quality Reporting (L1&L2)	• Mangt Groups • Qual Comm • Board	Monthly	Satisfactory	Embedding of framework
6.	Safer staffing, Guardian of Safe Working	Performance Report (L2) Survey Outcomes (L3) FTSU Report (L2)	• Mangt Groups • Quality/GPTW Comm	Monthly	Not satisfactory	Self-assessment has identified compliance gaps
7.	Training & professional practice including revalidation and clinical supervision	Training/development compliance reports (L1&L2)	• Qual • Board	Monthly	Satisfactory	Clinical supervision policy under review – consultation stage
8.	CQC Inspections	External report (L3)	• National body	Ad-hoc	Satisfactory	S31 remains – outcome of comprehensive inspection awaited
9.	Freedom To Speak Up Processes	Speaking up reports (L1&L2) Staff survey (L3) Internal Audit (L3)	• GPTW/Board • GPTW/Board • Audit	2x year Annual Per plan	Satisfactory	
10.	Quality Reporting Framework	Quality Reporting including Safeguarding, PCET, Patient Safety (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Gaps in triangulation
11.	Complaints and Compliments processes	Quality Reporting (L1&L2)	• Qual Comm/Brd	Monthly	Satisfactory	
12.	PCREF	Compliance Reporting (L1&L2)	• Qual Comm	TBC	Not Satisfactory	Advisory review has identified gaps in governance and impact

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** **Complete** / **In Progress** **Delayed** / **Not started**
1.	Embed PSIRF Programme	Internal audit scheduled from which action plan will be developed.	MD	**In progress – March 2026**
2.	Integrated Performance and Quality Reporting	In development. Approach/timeline endorsed by Res Comm	DoF/COO/DNTQ	**In progress**
3.	Revised NED quality visit approach in place	Endorsed by NEDs for introduction in October	DNTQ	**Complete**
4.	Clinical supervision policy	Under review – consultation stage	DNTQ	**30 Sept 2025**
5.	Safer Staffing Compliance	Moved to business as usual. Implementation of inpatient establishment reprofiling underway. New governance for safer staffing compliance starting from November. Regional oversight/support in place.	DNTQ	**31 March 2026**
6.	Evaluation and review of Quality Strategy	Scheduled as part of wider review of enabling strategies. Includes nursing strategic framework	DNTQ	**1 April 2026**
7.	Sexual safety action implemented		DNTQ	
8.	Review of quality governance structures	Review quality governance structures underway. internal audit occurring Q2/3 25/26.	DNTQ/MD/COO	**December 2025**
9.	PCREF reviewed and reestablished	Internal advisory review completed. Implementation plan in place. Governance to recommence October/November.	DNTQ	**31 March 2026**
10.	Regulatory preparedness	CQC ongoing as BAU– engagement sessions CQC and providers expected November. FSR (SARC) – pre-assessment for UKAS accreditation in October.	DNTQ	
11.	Review of S31 notice at Berkely House	Application to remove prepared in June. Comprehensive CQC inspection undertaken in July (including review of S31). Outcome awaited.	DoNTQ	**30 Sept 2025**

Levels of Assurance
L1 – Operational
L2 – Board/Committee Oversight
L3 – Independent

Strategic Aim(s):				• High Quality Care • Better Health	**Executive Lead** / Sarah Branton COO; **Date of review** / Sept 2025
RISK ID: 02	**Description:** **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.	**Lead Committee** / Resources; **Next review Date** / **Jan 2026**
Date Risk: Identified/confirmed	May 2025 (refocused from 2023 BAF risk)				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* *As per performance dashboard*
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**5**	**4**	**20**		
Current Risk Score:	**3**	**4**	**12**		
Target Score:	**2**	**4**	**8**		
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	Oct 2023 – risk updated May 2025 – increased focus on impact of risk and health & inequalities moved to separate risk.

Rationale for current score: *Completed by Lead Exec at each review (What is the justification for the current risk score)*

Demand for our services remains high and monitoring to reflect service operation meets the needs of the population continues to be in development. Whilst the majority of services are within national performance expectations it is acknowledged that this is not the case for some services where some KPIs are in exception (e.g CAHMS, Speech and Language Therapy, Neurodiagnostic Services etc), or may be heading that way) and will be kept under review.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
Children's Autism/ADHD Assessment Demand	ID: 232:	16	4
Eating Disorder Medial Resource	ID: 273	16	6
CAMHS Neuro Capability (Medical Resource)	ID: 605	16	9
Community Adult PH Speech/Language Therapy Demand	ID: 638	16	4
SAR Accreditation – Gloucs/Swindon	IDs: 372/487	16	4
General Medicine SLT Capacity	ID 604	15	9

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Contract Management Board	Updates (L1/L2)	• BIMG • Resources	Monthly As required	Satisfactory	
2.	ICS Board	ICS Operating Plan (L2)	• Board	Annual	Satisfactory	
3.	Operational governance arrangements	Performance Reports (L1&L2) IA Report Ops Governance (L3)	• Res /Board • Audit Comm	Monthly Audit Plan	Satisfactory Not Satisfactory	Embedding new structure at Ops Directorate Level
4.	Board and Committee Monitoring	Performance Report (L1&L2)	• Exec / Board	Monthly	Satisfactory	
5.	Business plan – process & monitoring	Business Plan Reports (L2)	• Exec / Board	6 monthly	Satisfactory	
6.	Service User experience (complaints/incidents/feedback)	Quality Account (L2/3) HoSC, (L3) Quality Reporting (L2)	• Qual Comm / Board	Annual Bi-monthly Monthly	Satisfactory Satisfactory Satisfactory	
7.	Winter Planning	Plan/Board Assurance Statement	• Resources	Annual	Satisfactory	

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** **Complete** / **In Progress** **Delayed** / **Not started**
1.	Embed governance changes arising from internal audit – operational and service directorate level	Governance manual agreed. Action plan in place. 3rd cycle of new meetings in place.	COO	**December 2025**
2.	Continue performance report monitoring & deep dives to focus on patient outcomes.	Risk based approach to service/waiting list review. Proposals in place for Quality and Safety Group linked to quality governance review.	COO	**In Progress – 1 April 2026**
3.	Review of level of co-production and engaging EbE in service developments.	Reviewed via transformation programme	COO/DoSP	**1 April 2026**
4.	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS.	Executive	**Ongoing**
5.	Integrated reporting in newly configured performance report	Update provided to Resources Comm. Duplication between quality/performance reports removed.	Executive	**In Progress – 1 April 2026**
6.	Colleague training and development in demand/capacity planning, forecast setting/management	Recent IA on data quality (moderate opinion) supports recommendation re training development	COO	**1 April 2026**
7.	Review of quality governance structures	Review quality governance structures underway. Internal audit in Q3 25/26.	DNTQ/MD/COO	**December 2025**

Levels of Assurance

L1 – Operational, L2 – Board/Committee Oversight, L3 – Independent

Strategic Aim(s):				• Great Place To Work • High Quality Care • Better Health	Executive Lead	Date of review
					Neil Savage Dir. of HR & OD	Sept 2025
RISK ID: 03	**Description:** **COLLEAGUE RECRUITMENT AND RETENTION AND DEVELOPMENT**			There is a risk that we fail to recruit, retain and develop a sustainable workforce, to deliver services in line with our strategic objectives.	**Lead Committee**	**Next Review Date**
					GPTW	Jan 2025
Date Risk: Identified/confirmed	May 2025 in this form				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* • Recruitment KPI's; - Time to Hire - WRES/WDES - Vacancy rate • Staff Survey Results	
RISK RATING	**Likelihood**	**Impact**	**Overall**			
Inherent Risk Score:	**4**	**4**	**16**			
Current Risk Score:	**4**	**4**	**16**			
Target Score:	**3**	**4**	**12**			
TARGET DATE:	**01/04/27**	**Tolerance:**	**12**			

Potential or actual origin of the risk:	2025 risk broadened to include development.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

Many aspects of supply, terms, conditions and competitive remuneration are outside the Trust's immediate control. Although current recruitment and retention feel positive, shortages of nursing, medical, AHP and health care staff (particularly CAMH's, inpatient MH, PH and LD) are being experienced nationally, and the significant decrease in applications to study nursing (particularly Learning Disability field) impact on GHC recruitment. Inpatient establishment reprofiling and service transformation as we embrace new ways of working and delivering care realises a significant risk to recruitment and retention. Strategies to reduce turnover rate have been positive, and benchmark well, however, the rate remains above the NHS England and desired Trust target. We recognise the need to be seen as an employer of choice, to attract and retain a diverse workforce in a competitive environment. This is a particular consideration considering changing demographics, increased demand for services and forecast workforce gaps. The risk incorporates consideration of our ability to invest in our people. Although we strive to ensure staff are welcomed with a comprehensive induction and commit to their training and development, factors including availability of funding, releasing time from care, and external decisions e.g. apprenticeship reforms significantly impact this ambition.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

Controls: (What do we currently have in place to control the risk?)		**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Recruitment and retention strategic framework	Recruitment Activity Reports (L1) Retention Data (L1&2) Exit / Leavers (L1&L2)	• SSOG • GPTW	Monthly Quarterly	Satisfactory Satisfactory	
2.	Partnerships with universities and others e.g. Strategic Workforce Partnership Board & NHSE WT&E/AEI/Provider Joint Network Meeting (WAPN)	Attendance at University events Student placements & conversions to employment (L1&L3) Provider benchmarking (L3) NHS England Graduate Guarantee Data Return (L1)	• GPTW	Yearly	Satisfactory	
3.	Recruitment Policy and SOPs in place	Vacancy Rates (L2) Bank & Agency Usage Rates (L2)	• GPTW • GPTW	Monthly Quarterly	Satisfactory Satisfactory	
4.	Learning & Development Strategic Framework	Staff Survey (L3) Training reports (Care to Learn) Apprenticeship Assurance Report Preceptorship Enrolment Data CPD/Trust Training fund Utilisation (L1&L2)	• GPTW • GPTW/Board • GPTW • WOMAG/GPTW • WOMAG/GPTW	Annual Quarterly Annual Annual Annual	Satisfactory Satisfactory Satisfactory Satisfactory Satisfactory	
5.	Agency reduction plan	Bank and Agency Spend and Fill Rate (L1&L2)	SSOG/GPTW	Monthly/Bi-Monthly	Satisfactory	

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
1.	Recruitment & Retention Framework Review - Secondment opportunities - Itchy Feet (career) conversations - Return to Practice opportunities	Progress report to April GPTW – on track	Dir. HR & OD	**In progress**
2.	People Promise Implementation Plan - Flexible Working Policy	Progress report to June GPTW – on track	Dir. HR & OD	**In progress**
3.	Leadership and Culture Programme Implementation	See progress update via Risk 04.	Dir. HR & OD	**In progress – April 2026**
4.	Safer Staffing Implementation	Recruitment plan being delivered – 50% of band 5 and 6 jobs recruited to and 20% delivered against the plan overall.	Dir NTQ	**In progress**
5.	Strengthening partnerships with HEI's and representatives	Engagement with HEI's - UoW, number of placements required versus capacity available, overcoming	Dir NTQ	**In progress**

		restrictions from geographical location. Implementing graduate guarantee scheme		
6.	Nursing national job matching profiles and job evaluation process review	Self-assessment completed, action plan in place to meet NHSE recommendations	Dir HR & OD	**In progress**

Levels of Assurance
L1 – Operational
L2 – Board/Committee Oversight
L3 – Independent

Strategic Aim(s):				• Great Place To Work • Better Health	Executive Lead	Date of review
					Neil Savage Dir. HR & OD	Sept 2025
Risk ID: 04	**Description:** **INCLUSIVE CULTURE (Internal)**			There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours, which results in negative impacts on retention and recruitment, colleagues experience and engagement, and on our ability to address inequalities in service delivery (access, experience and outcomes). **NB:** It is recognised that there is interrelation between this risk and Risk 9: Closed Culture.	**Lead Committee**	**Next Review Date**
Date Risk: Identified/confirmed	October 2023 (updated from 2022)				GPTW	**Jan 2025**
RISK RATING	**Likelihood**	**Impact**	**Overall**		**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*	
Inherent Risk Score:	**4**	**4**	**16**		• Staff Survey	
Current Risk Score:	**4**	**4**	**16**			
Target Score:	**3**	**2**	**6**			
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**			

Potential or actual origin of the risk:	Updated format for 2023-25 BAF. No change to Risk wording 2025.

Rationale for current score Completed by Lead Executive at each review *(What is the justification for the current risk score):*

The Trust has undertaken several Culture Reviews which have highlighted areas of concern impacting negatively on the workforce and patient care. In particular, areas of concern have been highlighted relating to exclusion, discrimination and a closed culture.

Whilst activity has been undertaken within the Culture and Leadership space and improvements made, feedback from staff (via Staff Survey; Pulse Surveys as well as engagement sessions) suggests further work is needed. If there isn't dedicated work carried out in this space, this will impact on colleague productivity, wellbeing, attraction & retention, and invariably Patient Care and the delivery of the Trust Strategy. This continues to also be a national focus and part of the NHS People Plan. Current workstreams in discovery stage of the cycle. Restorative, Just and Learning, and Leadership workstreams underway. Leadership and culture engagement fortnight planned 10-21 Nov 2025 to share current progress of LCP workstreams and themes from discovery stage – to sense-check assumptions with organisation and key stakeholders. Findings to be brought to LCP Committee in Dec 25 with recommendation for next steps. Measuring the success of the culture and values work remains challenging due to data limitations, work is underway to enhance triangulation of data and strengthen evaluation and insight.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

Controls: (What do we currently have in place to control the risk?)		**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Leadership & Culture Programme	Highlight reports (L1&L2)	Oversight Group/ Assurance Comm	Quarterly 2-monthly	Not Satisfactory	Evaluation methodology Delay in Wooton Lawn workstream
2.	OD & Inclusion Action Plan	OD&I Annual Report (L2) WRES/WDES (L2&3) Patient & Staff Surveys (L3) Diversity Networks (L1&L2) Pay Gap Reporting (L3) WL External Review 2024 (L3) Disability Confident Leader Accreditation (L3) Lead NED (L2) Inclusive Employer Status (L3)	• GPTW • GPTW • Qual/Board • WOMAG & GPTW • Board • Board • Board • Board • Board	Annual Annual Annual Ongoing Annual Ad hoc 3 Yearly Ongoing 3 yearly	TBC Satisfactory Satisfactory Satisfactory Satisfactory Not Satisfactory Satisfactory Satisfactory Satisfactory	
3.	Freedom to Speak Up Action Plan	FTSU Reports (L2) Internal Audit (L3)	• Board • Audit Comm	6 monthly Per plan	Satisfactory Satisfactory	
4.	People Strategy	Progress Reports (L1&L2)	• Management /GPTW	Quarterly	Satisfactory	Review as part of strategy update

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** **Complete** / **In Progress** **Delayed** / **Not started**
1.	Leadership and Culture Programme	Current workstreams in discovery stage of the cycle. Restorative, Just and Learning, and Leadership workstreams underway. Leadership and culture fortnight planned 10-21 Nov 2025 to share current progress of programme and test thinking. To bring to LCP Committee in Dec 25 recommendation for next steps.	Dir. HR & OD	In Progress - April 2026
2.	L&C Wotton Lawn Workstream	Programme delayed. New Sponsor now in place, discussion regarding what the next actions are to progress work. Review of actions undertaken as part of Culture of Care programme to align to LCP.	Dep Dir HR&OD	**April 2026**
3.	Evaluation Strategy with external support from University	Under development. Changes in University has meant that this is on hold; assessing other mechanism for	Head of Leadership &OD	**Not Started**

		evaluation. Metrics to be identified post Discovery stage – Dec 2025.		
4.	People Strategy Review & Update	Engagement has started on Phase 1 of review of current People Strategy; alignment to discovery stage of LCP		**In progress**

Levels of Assurance
L1 – Operational
L2 – Board/Committee Oversight
L3 – Independent

Strategic Aim(s):			• Better Health	**Executive Lead**	**Date of review**
				Rosanna James Dir. Improvement & Partnership	Sept 2025
RISK ID: 05	**Description:** **RELATIONSHIPS AND PARTNERSHIP WORKING**		There is a risk that the Trust does not have the right culture, processes and practices in place to work effectively with our communities (including service users, carers, and voluntary sector partners) impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in health service delivery (access, experience and outcomes).	**Lead Committee**	**Next Review Date**
Date Risk: Identified/confirmed	October 2023 (updated from 2022)			Quality	**Jan 2025**
RISK RATING	**Likelihood**	**Impact**	**Overall**	**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*	
Inherent Risk Score:	**4**	**4**	**16**	• Number of community engagement events (DI&P team) • Number of requests from front line teams for use of experts by experience per quarter	
Current Risk Score:	**3**	**4**	**12**		
Target Score:	**3**	**3**	**9**		
TARGET DATE:	**01/04/27**	**Tolerance:**	**12**		

Potential or actual origin of the risk:	Risk updated 2025 to reinforce that this is a risk that needs to be actioned through organisation wide response.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

Partnership working, co-production and personalised care are central to the Trust's ways of working and approach to transformation. Work is ongoing following the review of the Working Together Committee to take forward this work through a revised approach as the Working Together Network. The new model represents the next iteration of working towards embedding people and communities as partners in driving improvement and decisions.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Partnership team embedded in the communities we serve	Working Together Network Reports (L1&2)	• Board • Qual Comm	Annual Bi-Annual	TBC	Not yet available – new process & KPI's in development
2.	Expert by Experience Programmes (youth & adult)	Report on number of experts, participation requests and areas of engagement (L1)	• Dir. I&P	Monthly	Satisfactory	
3.	Governor Membership & Engagement Strategy	Reports to Council (L2)	• CoG	Quarterly	Satisfactory	
4.	Family & Friends Test Patient Feedback	Quality Report (L2)	• Qual Comm	Monthly	Satisfactory	
5.	Compliments and Complaints Processes	Quality Report L2)	• Qual Comm	Monthly	Satisfactory	
6.	VCS Engagement	Working Together Network Reports (L1&2)	• Board • Qual Comm	Annual Bi-Annual	TBC	Not yet available – new process
7.	VCS Engagement via GHC & System Transformation Portfolios	GHC Transformation Board governance reports Neighbourhood Health Portfolio plans	• SOG • Resources Committee	Bi-Annual	TBC	Not yet available – new process

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Completed / In Progress / Delayed / Not started
1.	Working Together Advisory Network Established	First meeting held June 2025.	Dir I&P	**Complete**
2.	Test the GHC coproduction maturity matrix as a tool to measure co-production	3 test services in progress.	Dir I&P	**In progress (March 2026)**
3.	Personalised Care implementation plan	System Reset approach planned for Sept/ Oct 25 – ICB restructure has paused system approach reset – no timeframe indicated. GHC review to be started.	Dir I&P	**Delayed (date TBC)**
4.	Develop a Working Together Network Youth Voice parallel process	GHC Youth Voice participation programme is established. Draft governance process developed.	Dir I&P	**In progress (Dec 2025)**
5.	Join the "Know Your patch" community events to host conversations about improving GHC services.		Dir I&P	**In progress (March 2026)**
6.	Develop Trust members survey framework		Dir I&P	**Not started (Nov2025)**
7.	Pilot Board Locality 'Study Days' approach	Proposal for themed conversations to be agreed with Board in November Board development session and event planned prior to end of 25/26	Dir I&P	**In progress – March 26**

8.	Performance indicators and measures of success to be developed for 'Partnerships with purpose - deepening our partnerships to deliver great healthcare' as one of 5 focus areas of new strategy.	Strategy approved at Board (25/09/25).	Dir I&P	**April 2026**
9.	Working Together Advisory Network Priorities co-produced	October 2025 meeting to co-produce topics for WTN	Dir I&P	**Dec 2025**

Levels of Assurance: L1 – Operational, L2 – Board/Committee Oversight, L3 – Independent

		Strategic Aim(s):	• High Quality Care • Better Health • Great Place To Work	**Executive Lead**	**Date of review**
				Sandra Betney Director of Finance	Sept 2025
RISK ID: 06	**Description:** **FUNDING FOR TRANSFORMATION**		There is a risk that funding constraints impact the ability of commissioners to commit to long term transformation of services to meet the needs of the populations we serve at the target pace. **NB:** Link to Risk 11 Private Board – Strategic Commissioning Partnerships	**Lead Committee**	**Next Review Date**
				Resources	Jan 2025
Date Risk: Identified/confirmed	2023			**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* - No current KPIs measuring transformation	
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**4**	**16**		
Current Risk Score:	**4**	**3**	**12**		
Target Score:	**3**	**3**	**9**		
TARGET DATE:	**01/04/27**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	Discussion at Risk Session 2025 revised existing risk.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

The Trust's ability to directly influence national funding is limited, but the Trust is active nationally in NHS Providers, the ICS and in community and mental health networks to support understanding of the roles of these services in supporting the population of the community and recognition of the need for their distinct funding. Gloucestershire submitted and achieved a balanced position for 24/25, however the 25/26 financial outlook for the system and the Trust is challenging with system deficit risk sharing arrangements in development. MHIS has been agreed for 25/26 although challenged by reduction in Strategic Development Funds transferring, however some MH Transformation has been recurrently funded. The nature of growing demand for unplanned services impacts on longer term commitment for transformational planning/funding. The impact of the 10-year plan with the additional focus on prevention and community services is still unclear as is the impact of NHS ICB reorganisation. The 'likelihood' of the risk is unlikely to reduce within foreseeable future therefore the focus will be on reducing the impact of the risk through our approach to service transformation withing existing financial constraints.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Active Member NHS Providers	Reports to Board (L2)	• Board	Bi-monthly	Satisfactory	
2.	Membership ICS Strategic Executive	Reports to Board/Exec (L1&2)	• Board/Exec	Monthly	Satisfactory	
3.	Membership of System Resources Comm	Reports to Board/Exec (L1&2)	• Board/Exec	Monthly	Satisfactory	
4.	Membership of ICB	Reports to Board/Exec (L1&2)	• Board/Exec	Monthly	Satisfactory	
5.	ICS pathway planning	Reports to Exec (L1)	• Exec	Quarterly	Satisfactory	
6.	ICS Joint Forward Plan	Reports to Board (L2)	• Board	Annual	Satisfactory	
7.	Funding Allocation Processes	Funding Allocation (L1&2)	• Exec/Board	Annual	Satisfactory	
8.	Commissioner engagement processes	Updates on relationships (L2)	• Board	Annual	Satisfactory	

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** **Complete** / **In Progress** **Delayed** / **Not started**
1.	Continue to work with community and mental health networks	Ongoing	CEO COO	
2.	Continue to be active ICS Partner making best use of Gloucestershire pound	Ongoing	CEO Chair Director of Finance	
3.	Build knowledge base to demonstrate quantifiable results of investment in non-acute services		Director of Finance	
4.	Ongoing contribution to system discussions on how funding is spent / allocated	ICB workshop held on 'how do we/how should we spend our money'.	CEO Director of Finance	**Complete**
5.	Executive to review approach to service transformation with current financial constraints	To be scheduled for Exec Roundtable discussion	Execs	

Levels of Assurance

L1 – Operational

L2 – Board/Committee Oversight

L3 – Independent

Strategic Aim(s):			• High Quality Care • Better Health • Sustainability	**Executive Lead**	**Date of review**
				Douglas Blair CEO	Sept 2025
RISK ID: 07	**Description:** **CAPACITY FOR CHANGE**		There is 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	**Lead Committee**	**Next Review Date**
				Resources Board	Jan 2026
Date Risk: Identified/confirmed	2023 reviewed and 2022 risk maintained			**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* - No specific KPIs	
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**4**	**16**		
Current Risk Score:	**4**	**4**	**16**		
Target Score:	**3**	**3**	**9**		
TARGET DATE:	**01/08/26**	**Tolerance:**	**12**		

Potential or actual origin of the risk:	New risk following risk session February 2025.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

Unprecedented level of change in external policy environment and growing expectations and needs of service users/patients are driving increased focus on the need to do things differently across a broad range of areas at a significantly increased pace against prior levels of transformation achieved by GHC.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
No specific risks on CRR			

Controls: (What do we currently have in place to control the risk?)		**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Strategic Refresh Process	Reports to Board	• Board	Monthly	Satisfactory	Review process
2.	Active Member NHS Providers	Reports to Board (L2)	• Board	Bi-monthly	Satisfactory	
3.	Membership ICS Strategic Executive Meetings	Reports to Board/Exec (L2)	• Exec / Board	Monthly	Satisfactory	
4.	Membership of System Resources Committee	Reports to Board/Exec (L2)	• Exec / Board	Monthly	Satisfactory	
5.	Membership of ICB	Reports to Board/Exec (L2)	• Exec / Board	Monthly	Satisfactory	
6.	ICS pathway planning	Reports to Exec (L2)	• Exec	Quarterly	Satisfactory	
7.	Innovation and Partnership Development	Reports to Exec & Board (L1&2)	• Exec / Board	Quarterly	TBC	
8.	Business Plan	Set & Monitoring (L1&2)	• Exec / Board	Bi-yearly	Satisfactory	

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
1.	Strategic Refresh delivers clarity on future priorities allowing change activities to be delivered within framework.	Strategy approved by Board Sept 25	CEO	**Complete**
2.	Influence external policy environment	CEO representation on national working groups, National Confed etc	CEO	**Ongoing**
3.	Review of enabling strategies undertaken	Methodology agreed by Exec. Key milestones agreed. Plan to build into Board Development schedule.	DI&P	**In progress – May 26 (TBC)**
4.	Business plans linked to strategy and delivery of 5-year plan	Business planning process launched and commenced	DoF/CEO	**In progress - Jan 2026**
5.	Agreed plans in place for delivery of future priorities which reflect best practice/co-production		DI&P	**Not started**
6.	Review of effectiveness of organisational Innovation and Transformation and approaches and governance	Deep dives into transformation programme, project transformation framework in development. Response to QI internal audit	DI&P	**In progress – April 226**
7.	Enabling and empowering senior leaders	TBC		

Levels of Assurance
L1 – Operational
L2 – Board/Committee Oversight
L3 – Independent

Strategic Aim(s):				• High Quality Care • Better Health	**Executive Lead**: Sandra Betney, Director of Finance **Date of review**: Sept 2025
RISK ID: 08	**Description:** **CYBER**			There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data. **Detail Confidential – internal circulation only**	**Lead Committee**: Resources **Next Review Date**: Jan 2026
Date Risk: Identified/confirmed	Originated 2022				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**5**	**20**		
Current Risk Score:	**3**	**4**	**12**		
Target Score:	**2**	**4**	**8**		
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	[redacted]

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

[redacted]

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

[redacted]

Strategic Aim(s):				• High Quality Care • Better Health • Great Place To Work	Executive Lead	Date of review
					Nicola Hazle Dir. NTQ	Sept 2025
RISK ID: 09	**Description:** **CLOSED CULTURE**			There is a risk of closed cultures existing in teams and services across the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm. **NB**. It is recognised that there is interrelation between this risk and Risk 4: Inclusive Culture.	**Lead Committee**	**Next Review Date**
					Quality Board	Jan 2025
Date Risk: Identified/confirmed	2023				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*	
RISK RATING	**Likelihood**	**Impact**	**Overall**		Staff survey Clinical supervision rates FTSU	
Inherent Risk Score:	**4**	**4**	**16**			
Current Risk Score:	**4**	**4**	**16**			
Target Score:	**2**	**~~3~~ 4**	**~~6~~ 8**			
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**			

Potential or actual origin of the risk:	Identified following reflection on Edenfield case, alongside previous and current culture reviews in some services across the Trust. Reviewed and agreed to continue for 2025 BAF.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

The Trust has in place a range of processes to support an open culture, such as Freedom to Speak Up, Civility at Work, options to raise concerns confidentiality or via CEO or Board member, however this is an area where vigilance is required to reduce the likelihood and ensure that staff feel confident to report harm to vulnerable and/or isolated patient groups. Staff survey results for 2024 received and evidence need for ongoing focus on culture. Previous culture reviews and an internal audit in 2023 resulted in greater reporting on closed culture in higher risk areas. Further work to review the approach to identifying and monitoring closed cultures and determining the impact on patient care will be taken forward. The risk is being closely reviewed given, the positive outcome of the recent internal audit, and the establishment of the leadership and culture programme, but has been maintained for 25/26 BAF to ensure improvements are embedded.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Current clinical policies, SOPs and clinical procedures	Clinical Policy Review Cycle/Audit (L1)	• Policy Rev Grp • Quality Comm	Monthly Quarterly	Satisfactory	New process now established to identify and escalate risk in out of date policies
2.	Clinical compliance programme including clinical audit, NICE guidance audit, peer review & self-assessment	Clinical audit, peer review & self-assessment reporting (L2)	• QAG • Qual Comm	Annual	Satisfactory	Will be reviewed as part of quality governance structures
3.	Regulatory compliance including self-assessment and peer review, fidelity testing	Compliance Report (L1&L2)	• Dir. NTQ, COO, • Qual Comm	Monthly Quarterly	Satisfactory	S31 notification at Berkeley House
4.	Effective local clinical governance processes operational teams/services/directorates in place	Clinical Governance Reports (L1&L2)	• Ops Governance • Qual Comm	Monthly Quarterly	Not Satisfactory	Findings of internal audit on Operations governance. Partial assurance from quality governance (BAF 1)
5.	Patient Safety Incident Response Framework e.g. Datix	Quality Reporting (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Embedding of framework
6.	Safer staffing, Guardian of Safe Working	Quality Reporting (L1&L2)	• Quality Comm	Monthly	Not Satisfactory	Self-assessment against Developing Workforce Safeguards shows gaps in compliance
7.	Training & professional practice including revalidation and clinical supervision	Quality Reporting (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Clinical supervision policy under review – consultation stage
8.	Freedom To Speak Up	Speaking up reports (L1&L2) Internal Audit (L3)	• GPTW/Board • Audit	2x year Per plan	Satisfactory	
9.	Leadership & Culture Programme	Highlight reports (L1&L2)	• L&C Comm	Bi-monthly	Not Satisfactory	WL workstream
10.	Staff Feedback Processes	Staff Survey (L3) Pulse Surveys (L3)	• GPTW / Board	Annual Quarterly	Satisfactory	
11.	Quality Reporting Framework	Quality Reporting including Safeguarding, PCET, Patient Safety (L1&L2)	• Qual Comm • Board	Monthly	Not Satisfactory	Partial assurance. Internal audit in Q2/3

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)**	
			Complete	**In Progress**
			Delayed	**Not started**

1.	Improvement Plan Berkeley House	All 5 conditions showing as complete. Application for review of S31 prepared in June. Comprehensive inspection by CQC in July – awaiting report.0	DNTQ	**Complete**
2.	Identification and agreement of areas considered to be of greater inherent risk of closed culture		DNTQ	**Date 01 April 2026**
3.	Actions, governance and oversight arrangements in place for those areas identified.		DNTQ/COO	**Date 01 April 2026**
4.	Regular triangulation of key workforce data for vulnerable or isolated patient groups	Reviewing national work in relation to early warning signs alongside improvements to internal reporting	DNTQ/COO/DOF	**Not started – April 2026**
5.	Clinical supervision policy updated	Under review – consultation stage – expected to Clinical Policy Group November.	DNTQ	**~~Sept~~ Dec 2025**
6.	Leadership and Culture Programme in place	Programme governance established. RJL, Leadership and ED&I workstreams launched	CEO	**In Progress – April 2026**
7.	Review of quality governance structures	Review quality governance structures underway. internal audit in Q2/3 25/26.	DNTQ/ MD/ COO	**December 2025**

Levels of Assurance

L1 – Operational, L2 – Board/Committee Oversight, L3 – Independent

Strategic Aim(s):				• High Quality Care • Better Health	**Executive Lead**: Rosanna James, Dir of Improvement & Partnerships **Date of review**: Sept 2025
RISK ID: 10	**Description:** **HEALTH CARE INCLUSION**			There is a risk that services are designed and operate in such a way that they do not meet the diverse needs of the population resulting in barriers to access and availability, and poor experience and outcomes for individuals, groups, or communities.	**Lead Committee**: Resources **Next Review Date**: **Jan 2026**
Date Risk: Identified/confirmed	2025				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* *To be developed as part of key actions* • Compliance with recording demographic data on EPR
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**4**	**16**		
Current Risk Score:	**3**	**4**	**12**		
Target Score:	**2**	**4**	**8**		
TARGET DATE:	**01/04/27**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	New Risk 2025, focused risk instead of incorporated within other risks.

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

The review of the Working Together Advisory Committee and access data, outcome data and complaints and compliments reporting indicates that this is an active risk with range of actions to be embedded to move further in the journey to Health Care inclusion.

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

Controls: (What do we currently have in place to control the risk?)		**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Quality Reporting Framework	Quality Report (L2) Access (L2) Outcomes (L2)	• Qual Comm • Board	Monthly	TBC	
2.	Staff Composition Monitoring	Performance Report (L2)	• GPTW	Quarterly	TBC	
3.	Working Together Network Development Plans	Reports & Aims & Objectives (L2)	• Qual Comm	Bi yearly	In development	
4.	Feedback Reporting	Complaint & Compliments (L1&2)	• Qual Comm • Board	Monthly	TBC	
5.	Diversity Reporting	WRES, WDES (L1&2) Pay Gap Reporting (L3)	• GPTW • Board	Monthly	Satisfactory	
6.	PCREF	Compliance reports (L2)	• Qual Comm	TBC	Not satisfactory	

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** **Completed** / **In Progress** / **Delayed** / **Not started**
1.	Implement and embed Patient and Carer Race Equalities Framework	BDO advisory review completed. Quality Committee governance oversight confirmed	DNTQ	**In progress (1 April 2026**)
2.	Develop GHC Health Equity framework, including Anchor approach	Anchor progression framework results presented at SLN in July. Engagement on Draft Health Equity goals underway.	Dir I&P	**In progress (Dec 2025)**
3.	Support development of ICS Health Inequality approach	Maturity self-assessment tool draft reviewed – final version completed for organisations to test and ICS Partnership Board review (Jan2026)	Dir I&P	**In progress (March 2026)**
4.	Develop Lived experience workforce framework	PSW Leadership role preferred candidate identified. Co-produced framework content in development	Dir I&P & DNTQ	**In progress – Dec 2025**
5.	Performance indicators and measures of success to be developed for 'Inclusive Healthcare' – one of five focus areas of new strategy.	Strategy approved at Board (25/09/25).	Dir I&P	**1 April 2026**
6.	Training for use of data and analysis	Recent IA on data quality (moderate opinion) supports recommendation re training development	COO	**1 April 2026**

Levels of AssuranceL1 – Operational, L2 – Board/Committee Oversight, L3 – Independent

Strategic Aim(s):				• High Quality Care • Sustainability • Better Health • Great Place To Work	**Executive Lead**: Douglas Blair CEO **Date of review**: Sept 2025
RISK ID: 11	**Description:** **STRATEGIC COMMISSIONING PARTNERSHIPS**			There is a risk that changes in commissioning impact our ability to provide services affecting staffing models, financial sustainability and achievement our strategic objectives and require significant changes to our contract management and delivery monitoring processes. **Confidential – Internal circulation only**	**Lead Committee**: Board **Next Review Date**: Jan 2025
Date Risk: Identified/confirmed	May 2025				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**4**	**16**		
Current Risk Score:	**4**	**3**	**12**		
Target Score:	**3**	**3**	**9**		
TARGET DATE:	**01/04/26**	**Tolerance:**	**10**		

Potential or actual origin of the risk:	[redacted]

Rationale for current score Completed by Lead Exec at each review *(What is the justification for the current risk score):*

[redacted]

Links to Risk Register *(High consequence (16 and above) risks that may impact strategic risks)*

[redacted]

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AGENDA ITEM: 13/1125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 November 2025**

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

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

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

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

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

The purpose of this report is to:

To update the Trust Board, capturing activity of the Freedom to Speak service for Q1&Q2 2025/26.

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

Recommendations and decisions required:

Following consideration by the Great Place to Work Committee at its meeting in October 2025, the Board is asked to **receive, review** and **note** the information and assurance provided in relation to Freedom to Speak Up activity during Q1&Q2 2025/26.

Executive summary

This six-monthly report is an update from the previous report presented to the Trust Board in May 2025, which covers Freedom to Speak Up activity of colleagues speaking up, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

This is a summary of a report presented to the Great Place to Work Committee on 21st October 2025. In addition to the information presented in the report, the Committee considered the interlinked Trust strategic risks of inclusive culture and closed culture in

relation to the Freedom to Speak Up agenda, noting that FTSU is a workstream of the Leadership and Culture Programme.

The thematic reporting for colleagues' safety/wellbeing has increased and the Committee discussed and requested an ongoing focus and greater understanding of this and including the fear of detriment.

The Committee took assurance from the information presented on Freedom to Speak Up activity.

In summary (Q1/Q2 2025/2026)

- This reporting period has seen 45 cases. This is marginally higher than last year's data.
- Anonymous reporting last year had increased to 11.5%, 2024/25 national picture of 11.6%. Nationally the largest percentage change across all themes in the 20250702-Annual-data-report-2425-Publishable.pdf. Anonymous reporting for the first two quarters at GHC is currently at 15%. Of the 7 colleagues that spoke up anonymously, 6 were through the FTSU APP and 1 via phone.
- The thematic reporting is highest in 45% of colleagues concerned about their safety/wellbeing.
- A breakdown in service areas shows an increase in Children's and Young People's and Mental Health Urgent Care and Inpatients.
- In 2024/25 those colleagues that feel they have suffered detriment was just under 10%, against a national picture of 2.9%. Currently for 2025/26 is at 8% although those colleagues that shared a fear of suffering detriment is at 29%. There is currently no national picture for this.
- For those that provided feedback, 80% of colleagues said that they would speak up again.
- V3 of the Freedom to Speak Up APP (application) is being progressed to further enhance experience and ensure records are adhering to the refreshed NHS England guidance.
- Those colleagues that have declared a protected characteristic during this reporting period is 13.33% although there are no current trends to this above data. Disability was the greatest declared disability and 1 colleague declared via the Freedom to Speak Up APP. From April 2025, within the feedback collated three updated questions has now been added to offer further insight. Further barriers to speaking up analysis is needed.
- Looking forward - Following discussion at the last meeting of the Board discussions have taken place with Trusts scoring highly on Questions 20a/b and 25e/f of the NHS Staff Survey. This information will be used to inform future learning and objectives for improvement.
- Colleague voices from the national Freedom to Speak Up week (13-17 October) will be incorporated into the leadership and culture programme.
- The closing down of the National Guardians Office in March 2026, may impact the capacity of experienced Freedom to Speak Up Guardians at local level.

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

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

Where has this issue been discussed before?
• Quality Assurance Group 17th October 2025 • Great Place to Work Committee 21st October 2025

Appendices:	PowerPoint Slide deck Freedom to Speak Up Six Monthly Update.

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

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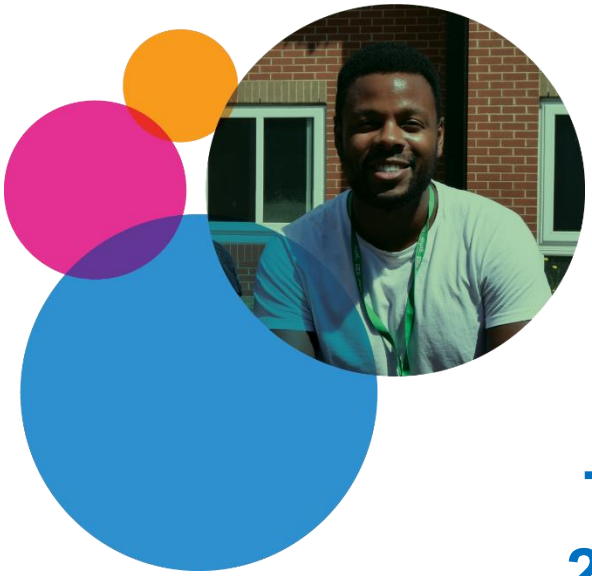

Freedom to Speak Up Update

Trust Public Board
27th November 2025

Freedom to Speak Up Guardian

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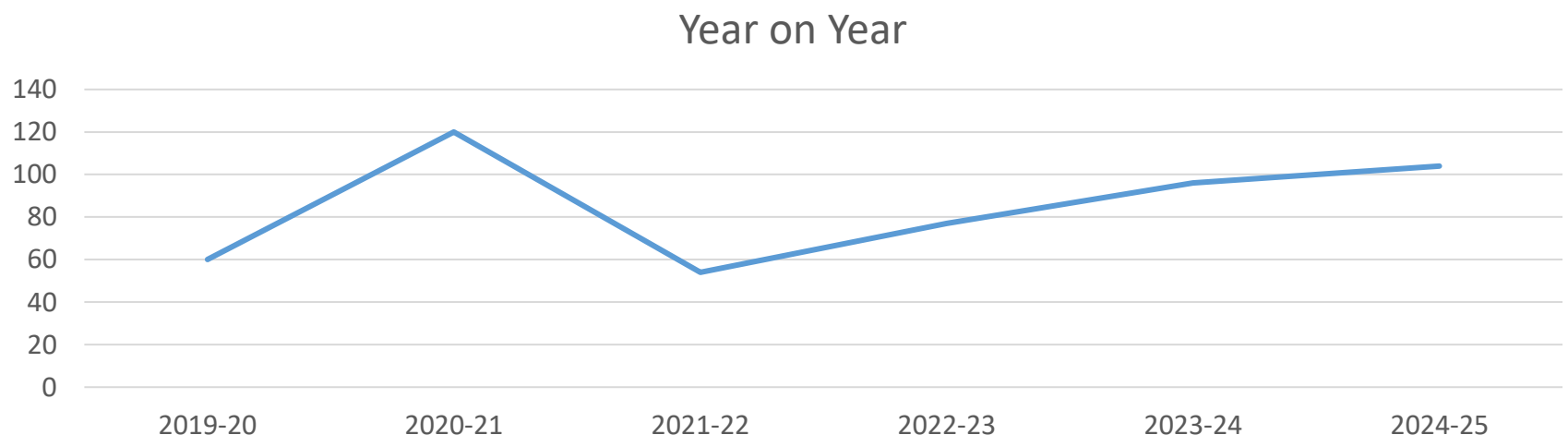
Speaking Up in GHC

Gloucestershire Health and Care
NHS Foundation Trust

Cases raised to the Freedom to Speak Up Guardian

	Number of Cases				
Year	Q1	Q2	Q3	Q4	Total
2024/2025	20	21	26	37	104
2025/2026	20	25			45



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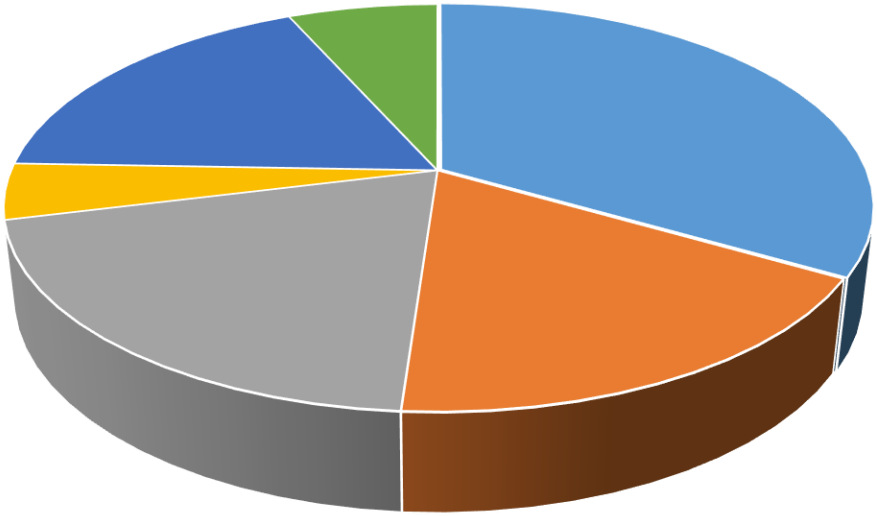
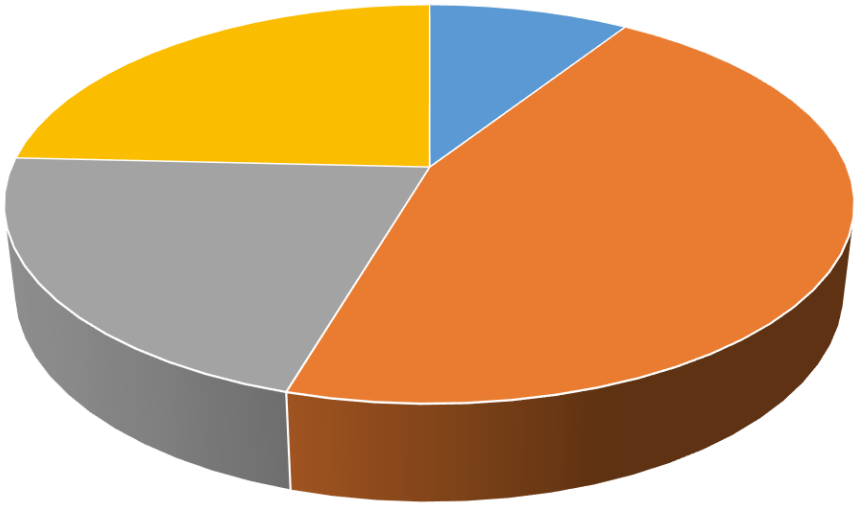
Colleagues Speaking Up – 2025/2026 (Q1/2)

Professional Groups

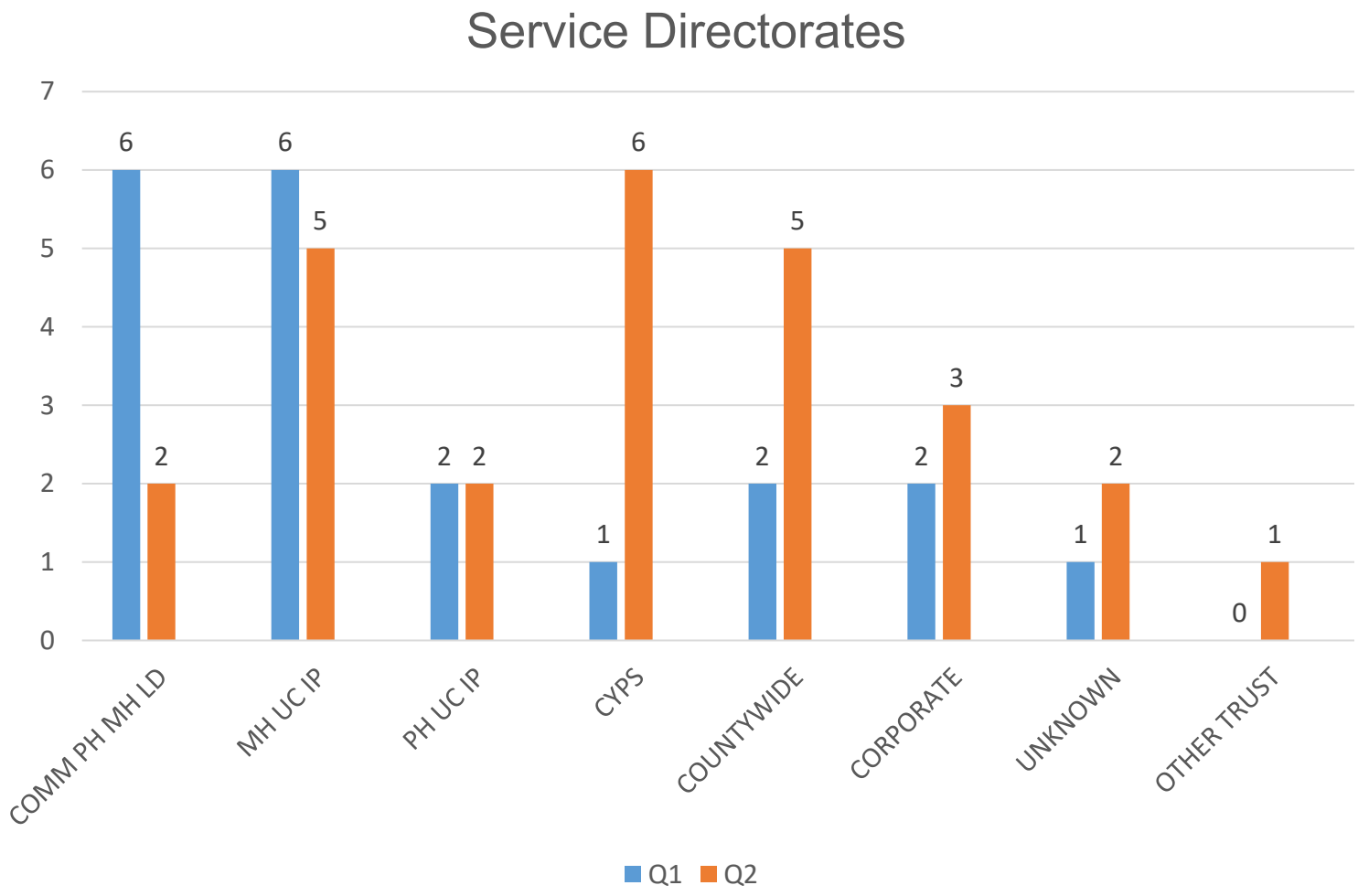


Themes

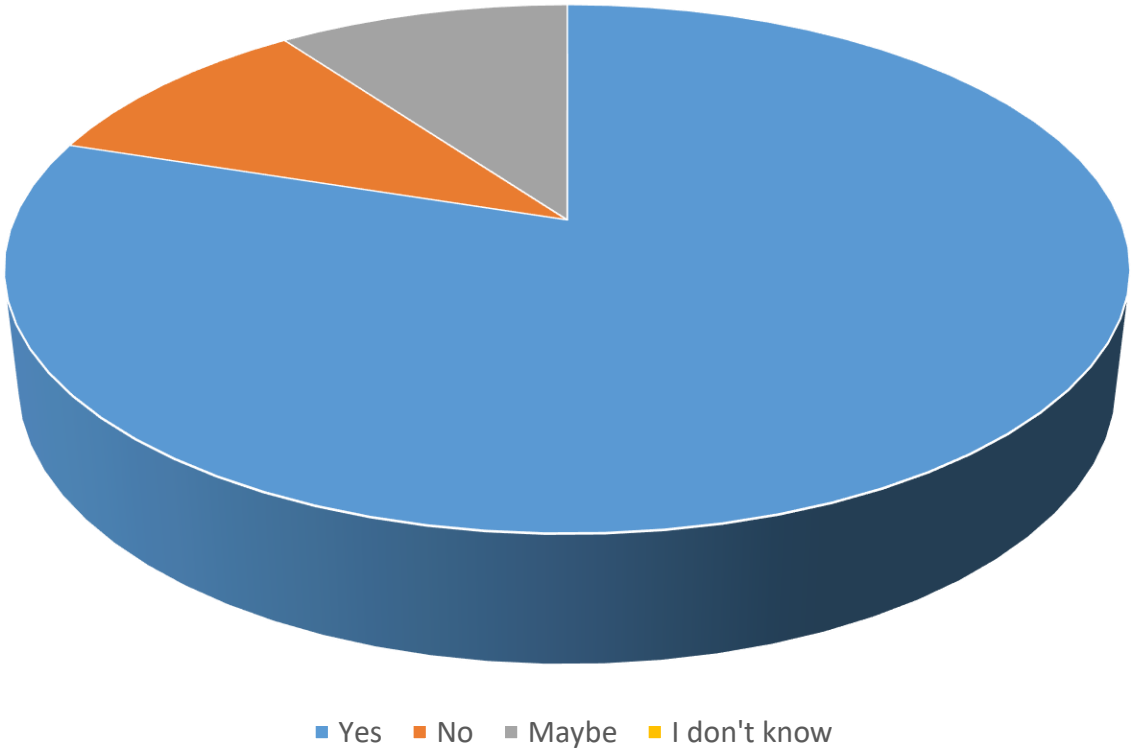


Colleagues Speaking Up

Gloucestershire Health and Care
NHS Foundation Trust



Would you speak up again?



PROACTIVE SPEAKING UP ACTIVITY

- This year's Speak Up Week, 13-17 October 2025, and the theme - Follow Up in Action. A communications plan was in place. A very engaging week.

- Benchmarking and collaborative working has commenced with Berkshire Healthcare NHS Foundation Trust (slides 8/9). This will further support the new objectives being developed.

- Co-production with the Freedom to Speak Up Champion Network which continues to grow, and 37 Champions attended aways days in September 2025 focussing on Sexual Safety.

- Networks - the Guardian is visible with the Chairs for each of the diversity networks including the Internationally Educated Nurses Council and Resident Doctor's Forum.

- Board Guidance Tool - Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. This is used as an ongoing quality statement
- Temporary Staff - FTSU also extends to temporary staff and contractors. The Guardian has links with the local Universities and is a visiting lecturer at both the University of Gloucestershire and the University of Worcester, thereby raising the profile of FTSU and supporting students who may wish to access the service.
- The patient safety learning assurance framework currently under review and FTSU triangulation is to be included.
- Workshops – the Guardian attends various events across the Trust to deliver relevant sessions related to FTSU, behaviours and cultural change. Intelligence from these is fundamental to mapping our culture. These include Creating Psychological Safety and Civility Saves Lives

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NATIONAL UPDATES

- NHS England and the Department of Health and Social Care have confirmed that the role Freedom to Speak Up Guardian will remain part of NHS Standard Contract for 2026/27, providing crucial certainty about the future of the guardian role Freedom to Speak Up Guardian role will remain part of NHS Standard Contract - National Guardian's Office

- Following a collaborative piece of work with Freedom to Speak Up Guardians, Protect, and Andy Noble, Head of Speak Up at NatWest Group, the national team have published detriment guidance for organisations. Detriment guide - National Guardian's Office

- The National Guardian's Office has published the results of the 2025 Freedom to Speak Up Guardian Survey, offering valuable insight into how the role is being delivered across healthcare organisations Strong job satisfaction among guardians despite resource challenges – national survey 2025 - National Guardian's Office

- The National Guardian's Office has published the latest annual speaking up data report. The report, *Culture is a patient safety issue. A summary of Speaking Up to Freedom to Speak Up guardians*, summarises the themes and learning from the speaking up data shared by guardians between1 April 2024 - 31 March 2025. Speaking up annual data report published - National Guardian's Office

- This review published in May 2025 highlights the unique challenges faced by NHS workers trained outside the UK when speaking up. Overseas trained workers - National Guardian's Office. The final speak up review by the National Guardian's Office will focus on temporary workers and to be published by February 2026. Speak Up Review into experiences of temporary workers in the NHS - National Guardian's Office

- Freedom to Speak Up - NHS Transformation Directorate refreshed information governance guidance

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GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 17 September 2025
Via MS Teams

PRESENT:	Graham Russell (Chair)	Kizzy Kukreja	Peter Gardner
	Amy Aitken	Chris Witham	Sarah Nicholson
	Marcia Gallagher	Sarah Waller	Jan Lawry
	Andrew Cotterill	Michelle Kirk	Bob Lloyd-Smith
	Joy Hibbins	Mick Gibbons	Martin Pittaway
	Alicia Wynn	Laura Bailey	David Hindle

IN ATTENDANCE: Douglas Blair, Chief Executive
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Rosanna James, Director of Improvement and Partnerships
Vicci Livingstone-Thompson, Non-Executive Director
Jason Makepeace, Non-Executive Director (from Item 7)
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary
Neil Savage, Director of HR & OD

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Chas Townley, Leighton Lee Pettigrew, Paul Winterbottom, Caroline Goldstein, Penelope Brown, and Tussie Myerson. Apologies had also been received from Non-Executive Directors, Steve Alvis, Rosi Shepherd and Bilal Lala.

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 meeting held on 9 July 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. The output report from the Working Together approach session held with Governors at the May Council meeting had been circulated, and a further update would be provided at the next Council meeting in November.

4.2 The Governor briefing session on the annual report and accounts took place on 27th August and was well attended. Thanks were passed to Sandra Betney (Director of Finance) and Bilal Lala (NED and Chair of Audit Committee) for leading this session.

4.3 There were no further matters arising from the previous meeting not already covered on today's agenda.

5. CHIEF EXECUTIVE'S REPORT

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

5.2 Douglas Blair reported on the Trust's placement in NHS England's oversight framework league tables, noting that the Trust ranked 21st out of 61 non-acute trusts and was segmented at level 2. It was **noted** that this was a good place to be. Douglas explained the limitations of the framework and its reliance on a small set of indicators, noting that further work would be carried out to make the indicators more meaningful. The Council was asked to note that the Trust would be measured each quarter.

5.3 Douglas Blair discussed the implications of the national 10-year plan, including the requirement for five-year delivery plans which have been requested from provider trusts. He **noted** that the Trust was well positioned due to its ongoing strategic refresh.

5.4 An update was provided on the changes to services commissioned by Gloucestershire County Council, which would result in the transfer of certain functions and staff to GCC and other providers. Douglas Blair acknowledged the complexity of this transition and assured governors that detailed work and communications were ongoing with all colleagues affected by the changes.

5.5 The Council were updated on the Trust's Leadership and Culture programme, which continues to focus on sustainable change through deep engagement. Further engagement opportunities were planned to take place during November. Martin Pittaway asked about the number of colleagues that had been engaged in the Trust's Leadership & Culture work to date. Douglas Blair advised that several different types of engagement had been taking place, but the Trust did want to expand its engagement, hence the sessions being planned for November.

5.6 Marcia Gallagher picked up on a national news item around winter strikes and flu, and she asked what the likely impact of this would be on GHC colleagues. Douglas Blair informed the Council that there was a lot of concern nationally about winter and winter preparedness, with a big focus on flu vaccinations. However, in terms of impact on staff, it was **noted** that the Trust was not expecting anything different from the normal ongoing operational pressures. The Governors **noted** that a winter planning report and assurance statement would be presented to the Trust Board at its meeting on 25 September for approval, prior to submission to NHSE.

5.7 Peter Gardner noted that a question had been asked at the Governor pre-meeting about mileage rate reductions. Douglas Blair explained that this related to the national Agenda for Change rates. Nationally, the guidance is to reduce mileage rates over 3500 miles. During the fuel crisis, GHC had taken the local decision to take away the requirement to drop the rate after 3500 miles. However, now that fuel prices have levelled out, the Trust has made the decision to revert back to national guidelines. Neil Savage advised that colleagues had been made aware of this

position, and that the rates were reviewed two times a year nationally by the NHS Staff Council.

6. CHAIR'S REPORT

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

6.2 Graham Russell reflected on the recent AGM which took place on 11 September, noting its positive tone and the importance of using past performance as a springboard for future improvement. The Governors **noted** that the recording of the meeting and the Annual Report and Accounts 2024/25 were available on the Trust's website.

6.3 Graham Russell emphasised the importance of meeting with local partners and other organisations by way of establishing productive relationships. He highlighted recent engagement with external stakeholders, including Councillor Ian Dobie (Chair of HOSC), Lisa Spivey (Leader of Gloucestershire County Council), and Bishop Rachel, focusing on health inequalities and partnership working.

6.4 Graham spoke about the monthly "Making a Difference" awards, which celebrate outstanding contributions from staff. The monthly winners would go forward to be considered for the annual awards. It was **noted** that Staff Governors had been invited to sit as part of the monthly judging panel for these awards, which was welcomed.

6.5 The Council **noted** that a meeting of the Nominations and Remuneration Committee would be taking place immediately after today's Council meeting. Committee members would be considering the recruitment of a new Non-Executive Director to succeed Sumita Hutchison when her term ends in January 2026.

7. TRUST STRATEGY REFRESH (2025–2031)

7.1 Rosanna James attended the meeting to present the Council with the refreshed Trust Strategy.

7.2 Rosanna emphasised the co-produced nature of the strategy, which incorporated over 1,200 pieces of feedback from staff, the public, and partners. The strategy was structured around five focus areas: Connecting services and neighbourhoods, Supporting children and young people, Enhancing community urgent care, Promoting inclusive healthcare, and Building purposeful partnerships. Rosanna explained that the content of the strategy was different from the previous version, but it continued to reflect the Trust's key values and was in line with the national 10-year plan. She said that the strategy provided a clear direction of what the Trust wants to achieve.

7.3 Chris Witham said that it was great to see the extensive consultation that had taken place with a wide range of stakeholders. He asked about the references within the strategy to Digital and IT and said that it was important to be clear about the differences. Chris also asked about the use of AI and how that may be incorporated moving forward. Rosanna James said that the Trust would position itself as being

open to evaluating opportunities associated with AI, however, ensuring the safety and security of patients and patient data was key. The Trust had a Transforming Care Digitally programme already underway and the Trust would be reflecting on progress with this and how it feeds into the 10-year plan.

7.4 Alicia Wynn **noted** the reference to the enabling strategies. Rosanna James advised that these were already in place but would now undergo a refresh to fully align them once the overarching strategy was approved. The enabling strategies provided the granular detail of how specific things would be delivered such as Digital, People, Quality and the Green Plan.

7.5 David Hindle suggested that the format of the strategy could be changed to include bullet points, no long sentences, more spacing etc to make it easier to view. Rosanna James confirmed that the Communications Team would carry out a review of the final strategy and ensure that this was presented in a more accessible format once ready for publication.

7.6 Kizzy Kukreja said that this was an excellent and exciting piece of work. She asked how the final 5 focus areas within the strategy were agreed. Rosanna James said that it was very much an iterative process, and the Trust had listened, engaged and tested this with different groups.

7.7 The Governors thanked Rosanna and colleagues for the work that had gone in to developing the new Trust Strategy. It was **noted** that this would be presented at the Trust Board meeting in September for final approval.

8. IMPACTFUL ROLES FOR PATIENT ADVOCACY - PRESENTATION

8.1 Katie Parker-Roberts (Deputy Service Director – Performance and Development, Community Hospitals and Urgent Care), Emma Wright (Onward Care Lead), and Amy Lister (Ward Manager) were in attendance to present on the roles of discharge co-ordinators and ward assistants in community hospitals.

8.2 Colleagues described the wide-ranging responsibilities of discharge coordinators, including liaising with families, MDTs, and external partners, and facilitating safe and timely discharges. Ward assistants were praised for their multi-faceted contributions, including supporting clinical staff, engaging patients in activities, and enhancing the ward environment. Examples were shared of personalised care and patient engagement, including knitting projects and quiz sessions.

8.3 Sarah Waller had carried out a Governor visit to Cirencester Hospital and said that colleagues there had raised an issue about social care integration and the ability for social care and health to access each other's clinical systems. Katie Parker-Roberts advised that this had now been resolved with social care colleagues now having access to SystmOne. She added that social care colleagues also regularly participated in MDT meetings which had improved communication.

8.4 The Governors welcomed the presentation which highlighted the valuable role played by colleagues across the Trust, and the impact that these roles can have on patient wellbeing and improving length of stay.

9. GOVERNOR DASHBOARD AND HOLDING TO ACCOUNT

9.1 The Council of Governors received the Governor Dashboard for information and assurance. The purpose of the Governor Dashboard is to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board and ensuring that people that use our services are receiving the best possible care. The dashboard was **noted**.

9.2 Sumita Hutchison provided highlights from the **Great Place to Work Committee**, noting that the last meeting had taken place on 26 August.

- 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". Sumita advised that the Committee discussed the WRES and WDES alongside the Leadership and Culture work, and also received an update on equality, diversity and inclusion and the work of the diversity networks in place across the Trust.
- 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. The Committee discussed the Workforce Implications of the NHS 10-year plan.
- The Committee received the Workforce Performance Report which showed a robust performance in key areas with good metrics. Sumita said that this provided good assurance that the Trust compared well when benchmarked with other organisations, and that data was monitored and action taken where necessary.
- Sumita informed the Governors that the Trust had received confirmation that it had been reaccredited as a Disability Confident Leader employer, the top accreditation level available which was excellent.
- The GPTW Committee had 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. Sumita Hutchison said that this was an uplifting story, and Chris shared some helpful learning for the future around being more responsive to change. Positively, the Council **noted** that the Trust was awarded its Veteran Aware reaccreditation in June 2025.

9.3 Jason Makepeace provided highlights from the **Resources Committee**, **noting** that the last meeting had taken place on 28 August.

- 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). Jason **noted**

that the Winter Planning Board assurance statement would be presented to the September Trust Board for approval before being submitted to NHSE.

- The Committee received and endorsed the Draft Green Plan Refresh, noting the final version would be received by the Trust Board for formal approval. Jason said that the current draft largely remained the same as the previous version, but included the addition of a new overarching goal, which recognised the importance of embedding sustainability into service delivery and the Trust's core operational processes.
- The Committee received and welcomed the Transforming Care Digitally (TCD) Programme highlight report. Assurance was received that the key milestones had been delivered and that the TCD was mapped against the Trust's 10-year plan to identify deliverables and future alignment.
- 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. Jason Makepeace **noted** this was a significant achievement in the current circumstances.
- The Committee received an update on the system finance position and underlying position. While GHC's financial position is conforming to plan, the 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. Jason advised the Council that the Resources Committee would continue to monitor this position closely.

10. GOVERNOR ENGAGEMENT UPDATE

10.1 Governors were invited to share any comments, reflections or feedback from recent engagement activities that they wished to make all Governors aware of.

10.2 Peter Gardner raised awareness of Carers Rights Day and offered to share the details of planned events with the Trust Secretariat. It was **noted** that these events would be picked up as part of the Partnership Team's monthly engagement schedule.

10.3 Vicci Livingstone-Thompson and Marcia Gallagher highlighted the success of the recent Forest Community Hospital fete. This had been a fantastic event, attended by Trust colleagues and members of the community, and had raised funds for the Trust's new Forest Health Services charity.

10.4 Governors expressed their thanks for the ongoing schedule of Governor visits, noting that they found these very useful and informative.

11. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

11.1 The Council received and **noted** this report which provided an update on changes to the membership of the Council of Governors and an update on progress with any upcoming Governor elections.

11.2 Anna Hilditch confirmed that there were no current or forthcoming elections scheduled. The list of governors and term dates was provided for information.

Graham Russell welcomed the continuation of Alicia Wynn's term as Appointed Governor for Young Gloucestershire.

11.3 Peter Gardner raised the need to progress membership pop-up stands, particularly at Cirencester Hospital. Anna Hilditch confirmed that dates were being finalised and would be shared as soon as possible.

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

12. GOVERNOR QUESTIONS LOG

12.1 The Governor Questions Log is presented at each Council meeting, and any questions received between meetings are presented in full, alongside the response for Governors' information. Questions included on the log can be questions received by Governors from constituents, or directly from Governors seeking specific assurance on a topic not due to be covered at a normal Council meeting.

12.2 It was **noted** that two new questions had been received since the last formal meeting in July, and the full questions and responses were presented within the paper.

13. ANY OTHER BUSINESS

13.1 Joy Hibbins raised a query regarding the recent patient incident at Wotton Lawn. Douglas Blair confirmed that while individual cases are not reported to governors, broader assurance on patient safety and learning can be provided. David Hindle requested further information on how the Trust learns from incidents and complaints. Douglas Blair confirmed that a session could be arranged to explore this in more detail. **ACTION**

14. DATE OF NEXT MEETING

14.1 The next Council of Governors meeting will be held on Wednesday, 19 November 2025, at 10.30 – 1.00pm at Churchdown Community Centre, followed by lunch and networking until 1.45pm.

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
17/9/25	13.1	Governor session on patient safety processes and learning from incidents to be arranged and a date communicated out to all Governors inviting attendance	**Complete.** Session scheduled for Friday 5th December at 3.30pm. Date emailed out to Governors inviting attendance.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 27 NOVEMBER 2025**
COMMITTEE:	**MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE (MHLS) – 15 OCTOBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, Chair of Committee

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

The Committee received the Mental Health Act (MHA) Reforms Update. GHC's Task and Finish group had been reinstated, with Integrated Care Board (ICB) engagement. As well as the implications of the Reforms with regards to resources and future recruitment, there was concern about the scope and scale of the programme and the need for a central resource to manage this. The Committee **agreed** that the Board should be alerted to this risk. Although timelines had not yet been confirmed, the MHA Reforms were likely to pass through Parliament by the end of the year.

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

It was **agreed** that there was a need to strengthen the governance and reporting routes into the MHLS Committee. A number of reports were received where it was not clear how onward action and monitoring would be carried out. This would be picked up for discussion outside of the meeting.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the review of Mental Capacity Act (MCA) Practice, Deprivation of Liberty Safeguards (DoLS) Applications and Liberty Protection Safeguards (LPS) Report, which provided assurance on the work being undertaken to monitor and improve practice across the Trust. Clear audit reports and associated action plans were in place to ensure ongoing monitoring.

The Committee received the outcome of recent audits on four of the MHA Policies (MHA Information Policy, Renewal of Detention & Extension of Community Treatment Orders (CTO), CTO Concerns of Family, and Audit of Timing of Hearings). Good compliance was demonstrated against a number of policies, however, further work was required to look at those areas where slower progress was being made. The Committee **agreed** that this would be referred back to the Mental Health Operational Group for oversight and

monitoring, and to **review** how to progress the necessary improvement actions to see increased compliance.

The Committee received the quarter 1 and Quarter 2 Approved Mental Health Professional (AMHP) Service Reports. Areas highlighted to the Committee included workforce data, referrals, and transport.

APPROVALS: Decisions and Approvals made by the Committee

The Committee received and **ratified** the revised Mental Health Information Policy, noting that no significant changes had been made.

RISK UPDATE

The Committee **noted** the risks on the Corporate Risk Register of which the Committee has oversight of:

- Risk ID 180 – Mental Health Act (MHA) Changes

This was discussed in detail during the meeting.

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

The Committee were advised that a CQC MH Inspection was carried out on Mulberry Ward at Charlton Lane, and the inspection had generated no recommendations for action, which offered good assurance.

The Committee **noted** the positive impact of the work taking place on improving the Mental Capacity Act (MCA) compliance across the Trust, with a recent re-audit of Berkeley House MCA practice seeing compliance improving significantly from 17% to 84%.

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

- Annual MH Act Activity Report
- CQC Mental Health Act Round Up

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 27 NOVEMBER 2025**
COMMITTEE:	**GREAT PLACE TO WORK COMMITTEE (GPTW) 21 OCTOBER 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

Freedom to Speak Up (FTSU) detriment, creating a safe culture. More people reporting anonymously, link to the Board Assurance Framework (BAF) re barriers to raising concerns and internal culture. Risk 4 inclusion data, risk 3.

The Committee received the six-monthly Freedom to Speak Up Report, which highlighted an increase in the number of colleagues reporting anonymously and that this was linked to the fear of detriment. It was raised that this linked with the Board Assurance Framework risks barriers to raising concerns and internal culture.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the National Workforce Policy Update, in which a number of updates were provided on national policies.

The Committee was informed that a Ten Point Plan to improve the lives of resident doctors had been published which laid out some non-negotiable actions targeting longstanding issues affecting resident doctor working conditions and support. An update on the progress and outcomes would be received at a future Committee meeting.

It was reported the government had issued a call for evidence to support the national Ten-Year Workforce Plan. The plan aims to create a sustainable workforce which is fit for the future. The government was looking for examples of best practice and innovation, which could be scaled to meet the Ten-Year Health Plan ambitions, as well as feedback on their research and modelling. Individual responses were encouraged.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee was assured that FTSU processes were in place and were in line with national guidance. Speaking Up processes would continue to be developed and the ambition was for FTSU to align with the top performing trust, Berkshire Healthcare.

FTSU – speaking up processes align with national guidance, continue to develop positive FTSU culture. Ambition for FTSU service to align with the top performing trust (Berkshire healthcare).

The Performance Report – Workforce Key Performance Indicators (KPIs), was received, and the Committee **noted** the report as an adequate level of assurance of the Trust's workforce performance measures or that appropriate service action plans were being developed to address areas requiring improvement. Highlights from the report included turnover across the Trust remained stable, and a growth across workforce was being seen. A slight increase in sickness rate was noted; however, this was in line with seasonal trends in cold and flu.

An update on the People Strategy was provided and well received by the Committee. It was **noted** that the template is a dynamic tool and would continue to evolve, incorporating workforce metrics to provide a more comprehensive overview of progress in delivering the strategic intent to be a 'Great Place to Work.'

APPROVALS: Decisions and Approvals made by the Committee

The Committee received and **endorsed** the Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES) update and action plan for publication 31 October 2025.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report for quarter two, which provided information and assurance in respect of the management of the corporate and strategic risks for which the Committee has oversight. The following risks were highlighted and discussed:

- Risk three – Recruitment and Retention – scoring 16
- Risk four – Internal Culture – scoring 16

The Committee discussed using the new BANI (Brittle, Anxious, Nonlinear, Incomprehensible) model as the new framework when looking at risks.

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

The Committee was informed that the Trust had been confirmed as a joint finalist in the Nursing Times Workforce Awards, for the collaborative work on developing the level 7 Preceptorship for Healthcare Practice module. Sylvia Jellyman and Rehana Begum were congratulated for their involvement with this. The winner would be announced 26 November 2025.

An open, frank, and constructive engagement session was held on the People Strategy Refresh.

ITEMS RECEIVED: The following items were received and discussed at the meeting
The following Summary Reports were **received** and **noted**: • ICS People Function • JNCF • Workforce Management Group

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/1125

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 27 November 2025**
COMMITTEE:	**RESOURCES COMMITTEE – 30 OCTOBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Deputy 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 was informed of the requirement to implement NHS Connect, which involved the migration of the Trust's email accounts to nhs.net, and the impact that this would have on the Trust.

The Committee received the Performance and Quality Dashboard Report and were alerted to the following measures which required follow up:

- N37 - Community Public Health (PH): Children & Young People (CYP) Community Services waiting list % seen within 52 weeks
- O02 - Adult Speech and Language Therapy (ASLT) - % routine referrals treated within 18 Weeks
- O08 – Musculoskeletal (MSK) Physiotherapy - % routine treated within 18 Weeks

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

The Committee received the Emergency Preparedness Resilience & Response (EPRR) Report and were advised of the next steps for Business Continuity Plans, which involved a new process being developed to ensure greater visibility to senior management and a process to escalate to the executive if required.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report for month 6 and was informed that the Trust was reporting a surplus for this period and cash at the end of month 6 was in line with the plan.

The Committee **noted** that the Integrated Urgent Care Service (IUCS) had been ranked top nationwide for their 111 service.

The Committee received the Business Planning Report for quarter 2 and **noted** that 69% of milestones have been completed and a further 30% have been part achieved leaving only 1% not achieved.

The Committee received the Integrated Business Planning and Budget Setting Process 2026/27 and noted the initial review of the operational plan would take place at a Board Development session scheduled for 11th December 2025. The draft submission would be submitted to NHSE 18th December 2025. The Resources Committee would receive an update at its meeting scheduled for 8th January 2026 and Board approval would take place in March 2026.

The Committee was assured by the work achieved in progressing the Trusts EPPR.

The Cyber Security Assurance Report was received and the Committee **agreed** to not change the risk score as the trust's controls and mitigations remained strong.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** the projects and workstreams set out in the new delivery plan for the Green Plan Refresh 2025-28.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee discussed Cyber Security throughout the meeting and **agreed** to not change the risk score (as recorded above).

The Committee was informed that *risk 372 – SARC Building Accreditation* was significantly above the tolerable risk appetite with a score of 16 on the register.

The Committee **noted** that additional SARC related risks (*303 and 607*) remained above tolerance levels. These were acknowledged as linked to staffing and estate pressures. The Committee recognised that these were not reflective of service performance but of resource limitations.

The Committee was informed that that *risk 10 – Health Inclusion/Equity* had been transferred from the Quality Committee to the Resources Committee for oversight.

The Committee **agreed** that deep dives on BAF risks would be scheduled into the Committee's work plan.

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

The Committee received the Property Portfolio Plan and acknowledged the progress made.

The Committee received the Green Plan and congratulated teams for their work and achievements towards sustainability.

ITEMS RECEIVED: The following items were received and discussed at the meeting
The Committee **received** and **noted** the Service Development Report and the following Summary Reports from management groups: • Business Intelligence Management Group • Capital Management Group • Community Mental Health Transformation • Digital Group • Strategic Oversight Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 27 NOVEMBER 2025**
COMMITTEE:	**QUALITY COMMITTEE – 4 NOVEMBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Rosi Shepherd, Chair of Committee

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

The Committee discussed risk due to pressures in Community Nursing and was informed that an improvement plan is being developed, as well as a longer-term model to understand potential delay related harm. This work may have positive learning to be shared with other services with waiting lists.

The Committee was advised about patient safety risk within the Adult Speech and Language Therapy (SALT) service and the current position in terms of improvement plan. Oversight will be undertaken by the Quality Assurance Group (QAG) and escalated to committee by exception.

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

A deep dive in to Complex Emotional Needs (CEN) was shared with the Committee, and assurance of transformation work being done and developed was shared. It was noted that the service is not available across the whole county and that there is potential to reduce service user inpatient stays if the service could be expanded.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee discussed and questioned on a range of matters within the Quality Dashboard Report, including allegations management in safeguarding and duty of candour, and complaints.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the Annual Safeguarding Report *(copy available to Board members in the Reading Room on Diligent)* but **requested** an increased focus on impact and outcomes in future reports.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Risk Reporting had moved to the beginning of the meeting to support the connection of agenda items and associated discussions to the BAF risks not just the ones allocated to the Committee going forward.

The Corporate Risk Register was received and the Committee discussed the governance of the risks and acknowledged work to do around the timeliness and management of these. It was **agreed** that the risks would be reviewed in more detail in a future Board seminar session.

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

A service improvement story was shared with the Committee on the Quality impacts of service transformation in children's speech and language therapy. The Committee acknowledged the work of the service, recognising quality improvement and how the team owned this. The co-production element was particularly praised.

The Medical Education Report was positively received, which highlighted the potential opportunity to increase resident doctors.

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

The QAG Summary Report was received.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 27 November 2025**
COMMITTEE:	**APPOINTMENTS AND TERMS OF SERVICE COMMITTEE (ATOS) 11 NOVEMBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Graham Russell, Trust Chair

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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

Nothing to report.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **received** a report providing an update on the current Trust position for Executive Director succession planning. The Committee last reviewed Executive succession planning and its related approach in November 2024. The latest review analysed the readiness of GHC's internal talent pool across three critical categories:

1. Immediate Interim Readiness
2. Substantive Readiness
3. Future Readiness (2-3 Years)

This report was welcomed, and the Committee thanked the Chief Executive for the assessment.

The Committee **received** the outcome of the 2025/26 interim performance reviews of the Chief Executive and Executive Directors. The reports provided a mid-year summary of performance against agreed objectives. The Committee thanked colleagues for carrying out the reviews, and for providing very helpful summaries for consideration. The ATOS Committee wished to express their thanks to the Executive Team for their continued hard work and commitment.

APPROVALS: Decisions and Approvals made by the Committee

There were no items received for approval.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding
Nothing to report.

ITEMS RECEIVED: The following items were received and discussed at the meeting
• Chief Executive Interim Performance Review • Executive Directors Interim Performance Review • Review of Executive Directors succession planning

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 27 November 2025**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 13 NOVEMBER 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Bilal Lala, Chair of Committee

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

None.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the Counter Fraud, Bribery and Corruption Secondary Employment Policy Compliance Report, which identified a lack of compliance with the Trust's secondary employment policy. An action plan was in place which included a review and relaunch of the policy and consideration of risks.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received and **noted** the Internal Audit Progress Report, noting that good progress was being made against the delivery of the 2025/26 internal audit plan.

The Committee received and **considered** the following internal audits:

- Temporary Staffing: substantial for design opinion and moderate for effectiveness.
- Working Well: limited for design opinion and moderate for effectiveness.
- Risk Maturity: (advisory review report) current maturity of the Trust's risk management process was rated as 'defined' with a target of 'mature'.

The Committee received and **noted** the Internal Audit Follow Up Report, noting positive progress in implementing recommendations made in internal audits undertaken in 2024/25 and 2025/26.

The Committee received the External Audit indicative timetable and **noted** that a new reporting date had been proposed by NHSE, which required appropriate planning by the Trust and Sumer (External Auditors). Assurance was provided that this was in hand.

The Counter Fraud, Bribery and Corruption Progress Report was received and **noted**.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the amendments to the Trust's Counter Fraud, Bribery and Corruption Policy V4, to incorporate The Economic Crime and Corporate Transparency Act 2023 which became effective from 1 September 2025.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Corporate Risk Register and **noted** there were 44 reportable risks as defined by the Trust's risk appetite on the register. The Committee **noted** development in risk management processes since the last meeting (including publication of new guidance on minimum risk review periods and setting target risks scores) and that these aligned with the recommendations from the risk maturity audit.

The Committee received the Board Assurance Framework (BAF) and it was **noted** that the development of the framework would be considered in the context of the outcome of the recent Committee Development Review.

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

The Committee **noted** the progress made post September month end, in early October and early November, with the collection of c£2m from GHFT, settling current and overdue debts reported within the Finance Compliance Report.

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

- The Counter Fraud Summary of Investigations was **noted**.
- The Trust's proposed approach to accounting for the introduction of NHS Connect O365 shared tenant arrangements was **endorsed**.
- An ICO referral was **noted.**
- Committee effectiveness review approach was **noted**.
- Committee 2025/26 Workplan was **noted**.
- The following reports from management groups were **noted**:
  - BEME Management Group
  - Health, Safety and Security Group
  - Information Governance Group
  - Risk Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 27 NOVEMBER 2025**
COMMITTEE:	**LEADERSHIP & CULTURE ASSURANCE COMMITTEE – 13 NOVEMBER 2025**
AUTHOR:	Trust Secretariat
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

Nothing to report.

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

Nothing to report.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received an update on the 'Our GHC Fortnight' (10-21 November) that had been initiated across the Trust, allowing for enhanced engagement with colleagues. The Committee **noted** the programme of activity associated with the fortnight and the differing routes through which colleagues could participate.

The feedback/insights received from the Fortnight, and the intelligence gained from the workstreams so far, would inform the next phase of the programme and which would move from the 'discovery' to the 'delivery' phase.

As the programme moved to the delivery phase, a review of the programme approach would be undertaken with the importance of coproduction and colleague engagement highlighted by Committee Members. It was proposed that the next Leadership and Culture Assurance Committee take place in late January / early February 2026, to review the outcomes of the fortnight and consider next steps.

The future assurance arrangements for the programme including the role of and lifespan of the Assurance Committee would also be reviewed at the next meeting.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE
The Committee **noted** the key risk for the Programme was regarding the capacity for workstream volunteers being able to engage in the required work, as it may not be sustainable for them to do alongside their usual day-to-day work roles. It was **noted** that a review of the workstreams approach was required.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding
The Committee recognised the progress made and the implementation of Fortnight event engagement sessions.

ITEMS RECEIVED: The following items were received and discussed at the meeting
The Committee **noted** the Workstream Highlights Report.