with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING - PUBLIC SESSION

Thursday, 29 January 2026

10:00 – 12:05

The Leckhampton Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0126	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0126	Declarations of interest	Assurance	Verbal	Chair
~~**10:05**~~	~~03/0126~~	~~Patient Story Presentation~~	~~Assurance~~	~~Verbal~~	~~MD~~
10:05	04/0126	Draft Minutes of the meeting held on 27 November 2025	**Approve**	**PAPER**	Chair
	05/0126	Matters arising and Action Log	Assurance	**PAPER**	Chair
10:05	06/0126	Questions from the Public	Assurance	Verbal	Chair
10:10	07/0126	Report from the Chair	Assurance	**PAPER**	Chair
10:25	08/0126	Report from Chief Executive	Assurance	**PAPER**	CEO
PERFORMANCE AND PATIENT EXPERIENCE					
10:40	09/0126	Finance Report M9	**Approve**	**PAPER**	DoF
10:50	10/0126	Quality Dashboard Report	Assurance	**PAPER**	DoNTQ
11:10	11/0126	Performance and Quality Report M9	Assurance	**PAPER**	DoF
11:30 – BREAK - 10 Minutes					
11:40	12/0126	Safer Staffing (Governance Statement and workforce plan)	**Approve**	**PAPER**	DoNTQ
STRATEGIC ISSUES					
11:50	13/0126	Sustainability: Carbon Footprint and Green Plan Delivery Report	Assurance	**PAPER**	DoIP
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS (REPORTING BY EXCEPTION)					
TO NOTE	14/0126	Great Place to Work Committee held 16 December 2025	Information	**PAPER**	GPTW Chair
TO NOTE	15/0126	Charitable Funds Committee held 19 December 2025	Information	**PAPER**	CF Chair
TO NOTE	16/0126	Resources Committee held 8 January 2026	Information	**PAPER**	Resources Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
TO NOTE	17/0126	Quality Committee held 13 January 2026	Information	**PAPER**	Quality Chair
TO NOTE	18/0126	Mental Health Legislation Scrutiny Committee held 14 January 2026	Information	**PAPER**	MHLS Chair
CLOSING BUSINESS					
12:05	19/0126	Any other business	Note	Verbal	Chair
	20/0126	**Dates of future 2026 Trust Board Meetings** to be held in the Leckhampton Room, EJC • Thursday 26th March • Thursday 28th May • Thursday 30th July • Thursday 24th September • Thursday 26th November			

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AGENDA ITEM: 04/0126

MINUTES OF THE TRUST BOARD MEETING

Thursday, 27 November 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
Rosanna James, Director of Improvement & Partnership
Bilal Lala, Non-Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Rosi Shepherd, Non-Executive Director
Amjad Uppal, Medical Director

IN ATTENDANCE:
Ben Argo, Lead Governor, UHBW NHS Foundation Trust
Dr Richard Dean, Trust Governor *(MS Teams)*
Anna Hilditch, Assistant Trust Secretary
Nicola de Iongh, Non-Executive Director *(MS Teams)*
Cathia Jenainati, Associate Non-Executive Director *(MS Teams)*
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting.

1.2 Apologies were noted from Vicci Livingstone-Thompson.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest. Rosi Shepherd reminded the Board that she was the Chief Nursing Officer at BNSSG ICB.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Hannah to the meeting who shared her story and experience of using the Trust's Individual Placement and Support (IPS) service. Hannah was joined by Lisa Bailey (Employment Specialist), and Vicky Vacara (IPS Service Manager).

3.2 The presentation highlighted the integration of employment specialists into clinical teams, the importance of ongoing support for individuals entering employment, and the positive impact of employment on mental health recovery. Hannah shared her personal experiences, including the challenges she faced in returning to work after periods of ill health, the value of tailored support, and the positive impact of

employment on recovery and self-esteem. Hannah informed the Board that thanks to the IPS Team and Lisa, she was now on her employment journey, and she felt extremely grateful for all the help she had received in achieving her goals at a pace that felt both comfortable and achievable.

3.3 Lisa Bailey said that employers were often anxious about taking on new staff and there was still stigma and discrimination around mental health conditions. The IPS Service was therefore a vital link in building those strong relationships with employers. Lisa advised that the service did have targets to meet but this was proving challenging at the current time due to a lack of jobs available. However, more work was taking place to continue to promote the IPS service and working with patients to encourage more referrals into the service.

3.4 Douglas Blair said that the Board would be considering the implications and opportunities arising from the NHS 10-year plan later in the meeting and noted that services such as the IPS service would be a key part of realising that plan.

3.5 The Board thanked Hannah for her courage in speaking about her experiences, and to Vicky and Lisa for facilitating.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 25 September 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 Hate Crime Incidents and Overseas Staff Turnover.

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

7. REPORT FROM THE CHAIR

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

7.2 The Chair reported on recent visits and engagement with community and partner organisations, including time spent with Bishop Rachel and local council leaders.

7.3 Graham Russell informed the Board that the long service of colleagues who have worked in the NHS for 20, 30 and 40 years was celebrated at the annual GHC 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. Graham said that he had the pleasure of thanking colleagues for everything they had done, noting that collectively those at the event had given more than 850 years of service. Graham Russell informed the Board that Louise Moss, Deputy Director of Corporate Governance had been unable to attend the event, but he wanted to acknowledge her 20 years of service.

7.4 Bilal Lala noted the visits that had taken place with Bishop Rachel and asked whether there were any plans to carry out similar visits with any other religious leaders. Graham Russell said that there was nothing scheduled currently but he welcomed the reflective challenge.

7.5 The Board **noted** the report, and the assurance provided.

8. REPORT FROM CHIEF EXECUTIVE

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

8.2 Douglas Blair advised that the Trust completed and submitted its *10 Point Plan to Improve Resident Doctors' Working Lives* 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.

8.3 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. The Board noted that this marks a move away from annual financial and delivery planning cycles. The planning framework sets out the refreshed operating model and focuses on 8 key areas, which were highlighted within the report.

8.4 At the end of October, the Trust received confirmation that Working Well had successfully passed its Year 3 SEQOHS (Safe Effective Quality Occupational Health Service) 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. Douglas Blair said that the team had been congratulated on the outcome and they have begun working on their next "year five reaccreditation."

8.5 Steve Alvis asked whether there was any update on the ongoing industrial action regarding the phlebotomists at GHFT, and whether this was having an impact on GHC services. Assurance was provided that this was having minimal impact on Trust services.

8.6 Sumita Hutchison noted the reference in the report to the closure of the Gloucestershire Wellbeing Line 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. 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. Sumita Hutchison sought assurance as to whether the Trust had plans in place to safely absorb the service. Neil Savage said that a full update would be presented to the next GPTW Committee in December. The Trust wouldn't be able to provide a like for like provision; however, the Trust has good provision for colleagues already in place through Working Well, Talking Well and ViVup.

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 7. The financial position was discussed and reviewed in detail at the Resources Committee.

9.2 At month 7 the Trust had a surplus of £0.091m compared to the plan of a £0.211m deficit. Cash at the end of month 7 was £44.681m, which was £3m 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 7 was £2.344m against a budget of £5.58m. The capital plan was behind schedule, due to delays in planning phases for certain projects and slippage in IT projects, however, it was anticipated that the full capital allocation would be utilised by year-end.

9.4 The Trust's agency and off framework agency usage was included in the report, with £1.741m ytd spent on agency staff which is below plan by £0.573m. It was noted that there were 16 off framework shifts in month 7 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 £12.518m on bank staff which was above plan by £2.071m.

9.5 The Cost Improvement Programme (CIP) has delivered £5.255m of recurring savings against the plan of £5.393m. The target for the year is £10.086m. £1.761m remains unidentified which is a reduction of £0.204m. The non-recurrent savings

target is £5.169m all of which has been identified, and of which £3.618m has been delivered.

9.6 The 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%.

9.7 The Board approved the changes to the capital programme, noting that the revised plan reflected revisions to phasing of buildings, disposals and IT schemes.

9.8 The Board agreed to delegate authority to the Resources Committee to review and sign off the variation to the heat pump business case.

9.9 The Board **noted** the month 7 financial position and was assured that, despite ongoing pressures, the Trust remains in a stable financial position with appropriate plans in place to address challenges.

10. QUALITY DASHBOARD REPORT

10.1 The Board received the Quality Dashboard, which showed the data for October 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. This report also included the Quarter 2 Learning from Deaths data, and the NED Audit of Complaints, which provided significant assurance that overall, the Trust is investigating and responding to complaints appropriately.

10.2 In October 2025, 1,375 patient safety incidents were reported, with 89% resulting in no or low harm. Moderate harm incidents accounted for 11%, a reduction from the previous month. There were 2 severe harm incidents and 5 deaths reported, and assurance was received that all incidents had been reviewed appropriately. There had been a further reduction in the number of reported Falls on inpatient wards, marking the lowest number in three months. Restraint incidents had increased but this related to the LD IHOT team supporting with seasonal vaccinations. Overdue actions in Datix reduced from 46 to 27.

10.3 There were no Safeguarding escalations in September or October and a decrease in advice line calls. Nicola Hazle advised that this does not give us cause for concern and was part of the normal variation reporting pattern. Safeguarding 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.

10.4 An Infection Prevention and Control dashboard was now included in the Quality report and this demonstrated that high standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT feedback.

10.5 Year to date, the number of complaints received had increased by 66% on 2024/25 data. Of the 49 open complaints 24 relate to IUCS services, with themes relating to communication and caller expectations, call back times and disposition e.g. referral to other services. The Trust recorded 283 compliments in October.

10.6 An overview of the progress and risks relating to the Adult Vaccination Programme 2025/26, which commenced 1st October 2025 was provided for information, and would continue to be reported monthly. Nicola Hazle advised that the Trust was tracking above the previous year in relation to staff uptake of the flu vaccination, but more work was needed to encourage colleagues to have the jab.

10.7 The Board noted that a new risk had been placed on the Trust risk register in relation to the need to replace the Air Handling Unit (AHU) in Stroud Theatre. The risk related to the AHU failing, and theatre activity needing to be cancelled. Sandra Betney queried this risk, and whether it was a GHC risk, or GHT. Nicola Hazle agreed to review and confirm the status of this.

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

11. QUALITY AND PERFORMANCE DASHBOARD

11.1 Sandra Betney and Sarah Branton 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 October 2025.

11.2 The Board was alerted to *N22: Mental Health: Number of people accessing Individual Placement and Support (IPS)*, noting that this was a newly introduced indicator that would be considered for further monitoring at the Resources Committee in December 2025.

11.3 The Board authorised the Business Intelligence Monitoring Group (BIMG) endorsement from operational services to (i) reposition three Physical Health Length of Stay (LoS) indicators from the Board Source into the Operational source, and (ii) authorise two Mental Health LoS indicators to adopt National methodology and introduce locally agreed interim improvement milestones

11.4 Areas of positive performance for the period included:

- Child and Adolescent Mental Health Services Learning Disability Referral to Assessment in 4 weeks – 100% met against an 80% target.
- Rapid Response key performance indicators were all met and the service is overperforming to meet their annual target.

11.5 The Board **noted** the Quality and Performance Dashboard Report for October 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. BOARD ASSURANCE FRAMEWORK

12.1 The Board received the Quarter 2 Board Assurance Framework (BAF). The BAF for 2025/26 reflects the Trust's Strategic Aims and Objectives and has been reviewed and updated throughout the year in line with Trust policy with the regular governance touchpoints (Executive risk owners, Executive Team and Governance Committees).

12.2 Lavinia Rowsell presented the key changes to the BAF made during quarters 1 and 2. This included the addition of 3 new risks – Capacity for Change (R7), Health Equity (R10), and Strategic Commissioning Partnerships (R11). All target dates had 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.

12.3 The Board **noted** that the next steps in the development of the Board Assurance Framework would be considered in the context of the outcome of the recent Committee Development Review.

12.4 Graham Russell asked for Executive reflection as to how people felt about the scale and complexity of the risks and whether the BAF represented those risks that colleagues were aware of. There was general agreement that the BAF reflected the current risk environment and supported effective governance.

12.5 The Board **noted** the quarter 2 review of the BAF, and the overarching risk profile for the Trust.

13. FREEDOM TO SPEAK UP – 6 MONTHLY REPORT

13.1 The purpose of this report was to provide an update to the Trust Board on Freedom to Speak Up service activity for Quarter 1 and Quarter 2 2025/26.

13.2 Sonia Pearcey, Freedom to Speak Up (FTSU) Guardian informed the Board that a fuller report was presented to the Great Place to Work Committee on 21st October 2025. In addition to the information presented in the Board report, the Committee had 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. Sonia Pearcey advised that the thematic reporting for colleagues' safety/wellbeing has increased and the GPTW Committee discussed and requested an ongoing focus and greater understanding of this, including the fear of detriment.

13.3 In terms of an overview, the Board **noted** that this reporting period had seen 45 cases. This was marginally higher than last year's data. Anonymous reporting last year had increased to 11.5%, against a national picture of 11.6%. 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.

Sonia Pearcey informed the Board that the Trust was making it easier for colleagues to report anonymously.

13.4 In 2024/25 those colleagues that felt they had suffered detriment from speaking up was just under 10%, against a national picture of 2.9%. Currently for 2025/26 this was at 8%. For those that provided feedback, 80% of colleagues said that they would speak up again. Board colleagues **agreed** that it would be helpful to see the breakdown of those 20% of colleagues who would not choose to speak up again.

13.5 Sonia Pearcey provided some national updates within the report and flagged the closing down of the National Guardians Office in March 2026, noting that this may impact the capacity of experienced Freedom to Speak Up Guardians at a local level.

13.6 The Board thanked Sonia Pearcey for this report, noting the rich and diverse information included within it.

14. COUNCIL OF GOVERNOR MINUTES

14.1 The Board **received** and **noted** the minutes of the Council of Governors meeting held on 17th September 2025.

15. BOARD COMMITTEE SUMMARY REPORTS

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

- MHLS Committee (15 Oct)
- Great Place to Work Committee (21 Oct)
- Resources Committee (30 Oct)
- Quality Committee (4 Nov)
- ATOS Committee (11 Nov)
- Audit & Assurance Committee (13 Nov)
- Leadership & Culture Assurance Committee (13 Nov)

15.2 Steve Alvis advised that the MHLS Committee had 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%.

15.3 Sandra Betney highlighted the “Alert” within the Resources Committee summary in relation to NHS Connect. The Committee had been informed of the requirement to implement NHS Connect, which would involve the migration of the Trust’s email accounts to nhs.net, and the significant impact that this would have on the Trust.

15.4 The Board **noted** that the Quality Committee had received a deep dive into the Complex Emotional Needs (CEN) service, and assurance of the transformation work being carried out and developed was shared. A service improvement story was also 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.

16. ANY OTHER BUSINESS

16.1 Graham Russell expressed his thanks to all Board colleagues for their continued work and efforts.

16.2 Graham Russell led the Board in recognising and appreciating the contributions of Sumita Hutchison (Non-Executive Director) and Lavinia Rowsell (Director of Corporate Governance & Trust Secretary), who would be leaving the Trust over the coming weeks.

17. DATE OF NEXT MEETING

17.1 The next meeting would take place on **Thursday, 29 January 2026**.

Annex 1

QUESTIONS FROM THE PUBLIC

QUESTION 1

"What assurance and re-assurance does Gloucestershire Health and Care NHS Foundation Trust have that any hate crime, between staff to staff, staff to patient, patient to staff is, or is not, increasing. What measure(s) and evidence does the Trust have/use to have this assurance and reassurance?

Bren McInerney

TRUST RESPONSE

The Trust seeks its assurance through two main routes. Firstly, incidents are regularly reported and overseen by the Trust's Health, Safety and Security Management Group and the Local Security Management Service (LSMS). In terms of racist or hate crime incidents i.e. Patient to Staff, Public to Staff and Staff to Staff incidents 132 were reported during the period of November 2023 to October 2024, compared with 156 in the same period 2024 to 2025. While this represents an increase over the previous year, the LSMS have highlighted that a high number of these incidents are caused by a small number of patients, particularly in in-patient settings, and that the overarching figures remain relatively consistent with previous years.

Secondly, the Trust oversees colleagues' reported experience of harassment, bullying or abuse (which may or may not be on the grounds of racism or other protected characteristics) via the annual NHS staff survey. This is reported to and overseen by the Board's Great Place To Work Committee (GPTW) and included in the Trust's annual Workforce Race Equality Standard (WRES) report. This measures by ethnicity the percentage of staff experiencing (a) harassment, bullying or abuse from patients, relatives or the public in the last 12 months, (b) harassment, bullying or abuse from staff in the last 12 months, and (c) discrimination at work from manager / team leader or other colleagues in the last 12 months. For all three categories colleagues with non-white ethnicity reported reductions in abuse in 2024 compared with 2023. The next data for 2025 will be available in February/March 2026.

Finally, in terms of measures, the Trust has recently commenced a review of its Anti-Abuse Road Map and related guidance for managers and colleagues. This is a widely publicised poster, guidance and resource pack to support colleagues with how to report and get support when they received any type of abuse, including racism and hate crimes. This was originally implemented early in 2024. The refresh will be relaunched early in 2026 following completion of the current consultation with operations, trade unions, the LSMS, Human Resources and Equality, Diversity and Inclusion colleagues alongside the Race and Cultural Awareness Staff Network. The Diversity Network has also recently discussed experiences of incident via its Diversity Network.

QUESTION 2

Is there any indication that overseas staff coming to work in the Trust are leaving in high/higher numbers than the Trust may/has experienced one year ago?"

Bren McInerney

TRUST RESPONSE

No there isn't. The Trust monitors employee turnover via the Board's Great Place to Work Committee and operationally via the Workforce Management Group. We review leaver and turnover report and consider whether there are differentials in turnover between professional groups and also with respect to Internationally Educated colleagues in comparison with local appointees. From our most recent review at the end of October 2025, retention of International Recruits remains very high with low turnover 2.17% (2022), 4.49% (2023), 3.49% (2024) and 3.49% (2025 year to date). This compares to a turnover rate of between 10 and 11% across the Trust. We continue to keep this under close scrutiny, with targeted "Itchy Feet" conversations and engagement via the International Nurses Council.

Neil Savage
Director of HR & OD

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 29 January 2026

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

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
27 Nov 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	January 2026	Complete	**Complete**

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29th January 2026**

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 – November – December 2025

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

REPORT FROM THE CHAIR

1. INTRODUCTION AND PURPOSE

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

2. CHAIR'S UPDATE

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

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

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

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

Working together

- Along with the Director of Improvement and Partnerships, I met with Christina Line, Chief Executive of **The Nelson Trust** on 3rd December. The Nelson Trust is a UK charity supporting people facing disadvantage.

- I, along with Dame Jane Cummings, Non-Executive Director and Deputy Chair of NHS Gloucestershire visited **Stroud General Hospital** on 18th December where we met with colleagues from **Cashes Green Ward** and discussed the position on discharges.

- **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.

- Along with the Director of Improvement and Partnerships, Associate Director of Estates, Facilities and Medical Equipment and Head of Sustainability, I met with **Dr Simon Opher MP** on 7th January where we had an informative discussion on sustainability within the Trust.

- I joined a meeting of the **NHS Confederation** all member Chairs group on 12th January where we had the opportunity to discuss matters of mutual importance.

Always improving

- On 13th January, I joined the hybrid **Working Together Network** at Churchdown Community Centre. The session was well attended both in person and virtually. At the session we heard from Matthew McKensie on the National Ethnic Mental Health Carer Forum and Ismail Kholwadia on Focal Elements on Faith. A presentation on the Trusts introduction to the Patient Carer Race Equality Framework (PCREF) was also received. The next network meeting takes place on 2nd April and will focus on personalised care.

- '**Our GHC Fortnight**' (November 10th – 21st) engaged 359 colleagues and 24 teams across 14 sites - generating insights now shaping the People Strategy and informing the Leadership and Culture Programme (LCP). These insights and themes will be validated and refined through stakeholder engagement in January and February, commencing with Senior Leadership Network on 20th January, to inform the final People Strategy and the implementation of the next phase of the LCP. The newly drafted People Strategy will be presented to Board in March 2026 which will encompass the LCP as a key programme that will support the delivery of GHC's People ambitions to enable the delivery of the new Trust Strategy.

Respectful and kind

- I participated in the judging panel for the **Better Care Together Awards** on 15th January. There were more than 240 nominations across the eight categories, and the panel spent a whole day at Churchdown Community Centre carefully considering and choosing a shortlist of 3 entries per category. The panel felt that the standard of nominations was incredibly high, and it was very difficult to shortlist some categories. We hope that the final shortlist reflects the breadth and depth of our services, and we look forward to the awards event itself, on 15th April at Hatherley Manor Hotel.

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 **Windrush Ward** who are based at **Cirencester Hospital** on 13th January and the **Mental Health Liaison Service** at **Beacon House** on 22nd January to present their '**Making a Difference**' awards.

Windrush Ward

Beacon House

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. I look forward to visiting more services over the coming months to acknowledge 'Making a Difference' across the trust.

- On 6th January, Vicci Livingstone-Thompson and I visited the **Individual Placement and Support Service** (IPS) where with met with Vicky Vacara, IPS Employment Specialist and colleagues within the team. We had the opportunity to discuss the service and the eight principles of IPS. I would like to take this opportunity to thank Vicky and her team for taking time out of their busy schedule to meet with myself and Vicci.

3. BOARD UPDATES

- A **Board Seminar session** took place on 11th December where the topic for discussion was **People Enabling Strategies** and was led by Michelle Hurley-Tyers, Deputy Director of HR & OD and Rehana Begum, Senior OD Consultant. This session focused on shaping the future including a discussion on strategy shaping.

- Following the developmental review undertaken by the Good Governance Institute (GGI) of our current Board committee arrangements, a **Board Seminar session**, led by Douglas Blair, Chief Executive, took place on 21st January where the development needs of the Trust were discussed. The outcome from the GGI review will feed into future development sessions for Board members.

- On 11th December, an **Extraordinary Board** meeting took place where Board colleagues discussed the national planning framework and the timeline for planning returns.

- 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.

- On 20th January, Douglas Blair and I attended a Board-to-Board meeting with **NHS Bristol, North Somerset, South Gloucestershire ICB cluster** (BNSSG ICB). Amongst other items, we discussed the direction of travel for the two ICB Boards in the cluster.

4. GOVERNOR UPDATES

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

- The recruitment for two new **Non-Executive Directors** concluded on 17th December. Following a rigorous recruitment process overseen by our Governors' Nominations and Remuneration Committee, I am delighted to advise that Debbie Forster and Karen Clements have been appointed. I am sure you will join me in welcoming Debbie and Karen to the Trust. Debbie will commence in post on 26th January and Karen will join us on 2nd March.

- An **extraordinary Council of Governors** meeting took place on 19th December where the appointment for two Non-Executive Directors was approved.

- On 22nd January we held our in-person **Council of Governors Development Session** which primarily focussed on Business Planning and Governor/member engagement. Governors also received an update from Douglas Blair, Chief Executive on key developments within the Trust.

- An informative **Governor session** took place on the 5th December where the session focussed on **Patient Safety and Learning from Incidents**. The session was led by the Medical Director, Associate Director of Patient Safety, Quality & Clinical Compliance and the Head of Patient Safety and Learning.

5. NED ACTIVITY

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

See **Appendix 1** for the summary of the Non-Executive Directors activity during 1st November to the 31st December 2025.

6. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1 - Non-Executive Directors (NEDs) – Summary of Activity 1st November – 31st December 2025

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• Council of Governors Meeting • Mental Health Act Managers Forum • NHS Providers Webinar • Non-Executive Directors Meeting • Quarterly Staff Governor and Non-Executive Directors Meeting • Webinar: Mental Health Bill	• Board Development: Enabling Strategies • Board Development: GGI Board Development Outcomes • Board Seminar: Leadership & Culture and Learning Disabilities Pathway • Quality Committee • Trust Board: Public & Private
Sumita Hutchison	• Diversity Network Agenda Discussion • GHC Diversity Network • Great Place to Work Committee Assurance Report • Great Place to Work Pre-Agenda Meeting • Non-Executive Directors Meeting • Patient Carer Race Equality Framework (PCREF) Meeting with Rosi Shepherd, Director of Nursing, Therapies and Quality & Director of HR & OD • Quarterly Staff Governor Meeting • Workforce discussion with Chair of Great Place to Work & Resources Committees	• ATOS Committee • Audit & Assurance Committee • Board Development: Enabling Strategies • Board Development: GGI Board Development Outcomes • Board Seminar: Leadership & Culture and Learning Disabilities Pathway • Great Place to Work Committee • Leadership & Culture Assurance Committee
Nicola de longh	• Aspiring Chairs Meeting with NHS England Regional Director • Aspiring Chairs Pathway Group Meeting • Informal Health Overview and Scrutiny Committee • Non-Executive Director Interviews	• ATOS Committee • Board Development: Enabling Strategies • Board Development: GGI Board Development Outcomes • Board Seminar: Leadership & Culture and Learning Disabilities Pathway

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Non-Executive Director Portfolio and Transition Meeting • Quarterly Staff Governor and Non-Executive Directors Meeting • Resources Committee Preparation	• Great Place to Work Committee • Trust Board: Public & Private
Vicci Livingstone-Thompson	• Quarterly Staff Governor and Non-Executive Directors Meeting • Council of Governors Meeting • All Age Board for Mental Health, Neurodivergence and Learning Disabilities • Non-Executive Directors Meeting • Meeting with Senior Organisational Development Consultant	• ATOS Committee • Board Development: Enabling Strategies • Board Development: GGI Board Development Outcomes • Board Seminar: Leadership & Culture and Learning Disabilities Pathway • Charitable Funds Committee • Great Place to Work Committee
Bilal Lala	• Workforce discussion with Chair of Great Place to Work & Resources Committees • Audit & Assurance Committee Assurance Report Meeting • Council of Governors Meeting • Non-Executive Directors Meeting • Panel Interview for Director of Corporate Governance • Non-Executive Director Recruitment Board Focus Group • Non-Executive Directors Meeting • 1:1 with Director of Finance in advance of Audit & Assurance Committee • Monthly 1:1 with Director of Finance	• ATOS Meeting • Audit & Assurance Committee • Board Development: Enabling Strategies • Board Development: GGI Board Development Outcomes • Board Seminar: Leadership & Culture and Learning Disability Pathway • Great Place to Work Committee • Quality Committee, including separate private committee members only meeting • Trust Board: Public & Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Rosi Shepherd	• 1:1 with Director of Nursing, Therapies and Quality • Governor Session: Patient Safety and Learning from Incidents • Leadership & Culture Engagement Event • Meeting with Sumita Hutchison • NHS Gloucestershire System Quality Committee Meeting • NHS Providers Conference • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Quality Committee Assurance Report • Visit to Montpellier Unit, Wotton Lawn Hospital • Visit to services with the Trust Chair and Bishop Rachel	• Board Development: GGI Board Development Outcomes • Quality Committee • Audit & Assurance Committee • Board Development: Enabling Strategies • Board Seminar: Leadership & Culture and Learning Disabilities Pathway • Leadership & Culture Committee • Trust Board: Public & Private

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

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 Overview

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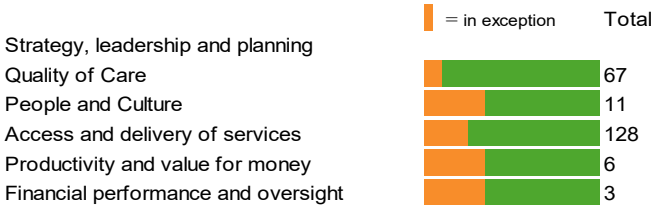
NHS Gloucestershire Health and Care NHS Foundation Trust

Strategic Update

Focus Areas	Update
Connecting services in neighbourhoods	Participating in national community of practice with GP Collaborative and VCS partners.
Children and young people	Early work to explore new model of care in Gloucestershire for highest mental health needs
Community urgent care	Strong focus on community urgent care included in system portfolio change plans
Inclusive healthcare	Work in progress on new Trust health inequalities framework, aiming to align with national guidance
Partnerships with purpose	Third meeting of Working Together Network in January, focusing on race equity.

Performance Indicators Overview

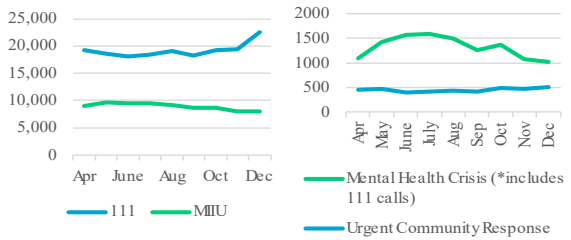


NHS Oversight Framework - 2025/26

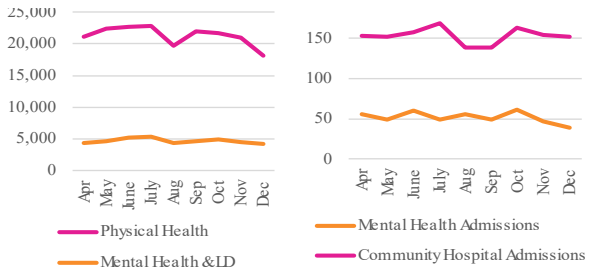
	Q1	Q2	Q3	Q4
Score	2.18	2.23		
Segment	2	2		
Ranking	21/61	20/61		

Service Demand Trends

Urgent Care demand (all age)

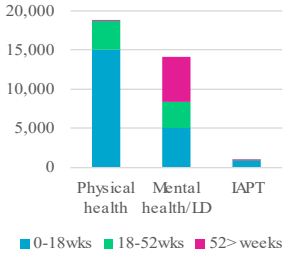


Planned Care Referrals (all age)

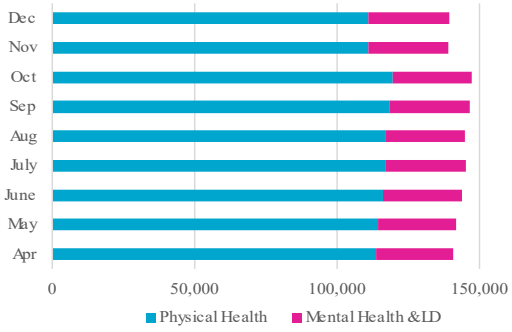


Service Capacity

Total Waiting for Treatment



Caseload



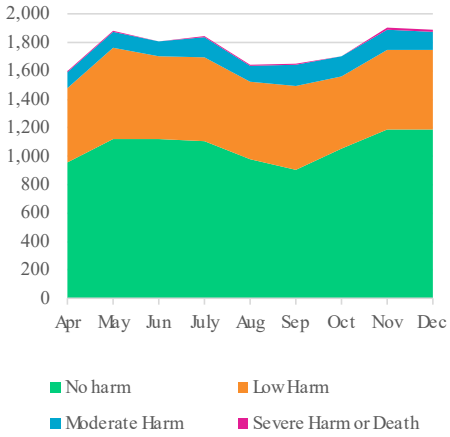
Strategic Risks - Board Assurance Framework

	Target	Q1	Q2	Q3	Q4
Quality standards	8	12	12		
Demand & Capacity	8	12	12		
Recruitment, retention and development	12	16	16		
Inclusive culture	10	16	16		
Relationships and partnership	10	12	12		
Funding for transformation	9	12	12		
Capacity for change	12	16	16		
Cyber	9	12	12		
Closed culture	8	16	16		
Health inclusion	6	12	12		
Strategic commissioning	8	12	12		

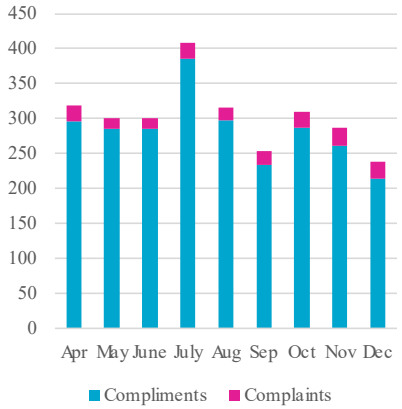
Chief Executive Overview

Quality and experience headlines

Incidents



Compliments and complaints



Patient Feedback (Dec 25)

Overall Experience

93%
Very good or Good

Respect and Dignity

98%
Positive

Involvement in decisions

96%
Positive

Safety and welfare

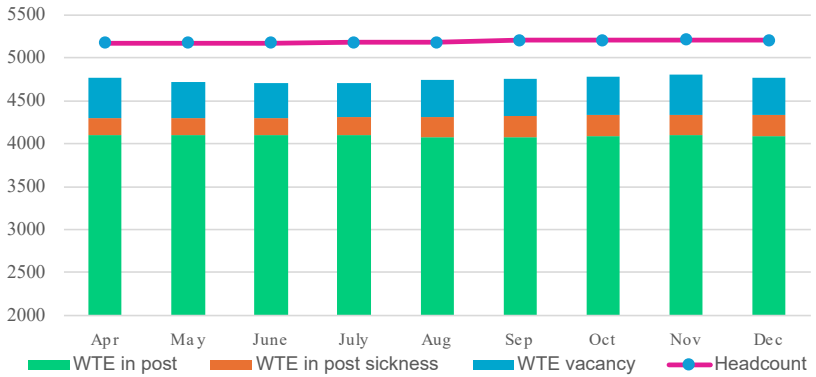
97%
Positive

Finance headlines

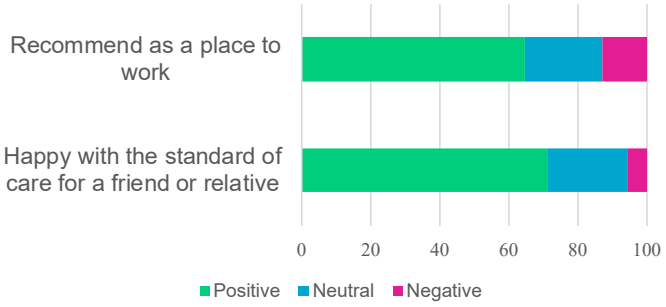
Month 9 2025/26

Income & Expenditure Performance	£0.084m surplus
Cost improvement savings of	£5.62m
Capital expenditure	£4.569m 37% of full year plan

Our people



Colleague voice: Pulse Survey (Q2)



CHIEF EXECUTIVE SERVICE / TEAM VISITS AND EVENTS

Service Visits in December and January	• **Dental team away day, 3 December 2025.** I was pleased to be invited to speak at the start of an away day for our dental team, spending time to explain the Trust's strategy and priorities and engaging in a thoughtful question and answer session. • **Tewkesbury Hospital, 23 December 2025**. A walkaround of all departments within the hospital, thanks to everyone who took time to speak to me. • **Avon House, Tewkesbury, 23 December 2025.** I dropped in to Avon House as an impromptu visit. This was my first visit since some significant refurbishment works, which have greatly improved the working environment. • **Stonehouse Health Centre, 7 January 2026.** This is one of a few Trust sites that I hadn't visited before as it acts as a local base for integrated community team colleagues. • **Redwood House, Beeches Green, Stroud, 7 January 2026.** I was pleased to make my first visit to Redwood House, as I wanted to see the good quality facilities at this site. • **Tyndale Day Centre, Dursley, 7 January 2026**. My first visit to this small base, where I met therapist colleagues at the end of a meeting that had been held there. • **Vale Hospital, Dursley, 7 January 2026**. It was good to see colleagues from across the hospital, both colleagues that I had spent time with before, and new introductions. • **Pullman Place, Gloucester, 16 January 2026**. I hot desked with the Perinatal team in the morning, taking the opportunity to check in with colleagues across the site also.
Events to note	• **Health and Overview Scrutiny informal meeting, 2 December 2025, Pullman Place.** This has become an annual session at which members of the committee can spend time getting to know some of our services in more detail. Thanks to colleagues from the learning disability team and the Individual Placement and Support Service – for talking about their services. • **Southwest Mental Health Chief Executives, 5 December 2025, Taunton**. Southwest Provider Collaborative business, including time with NHS England colleagues discussing future commissioning intentions. • **Opening of University of Gloucestershire City Campus, Gloucester, 16 January 2026**. I attended the official opening and saw some of the new facilities in this refurbished former Debenhams building. • **Meeting of ICB Boards (BNSSSG and Gloucestershire), 20 January 2026**. Time spent on priorities in creating the new clustered ICB covering both areas. • **NHS Leadership Event, 27 January 2026, London**. National meeting of NHS leaders to discuss priorities for the forthcoming financial year.

CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Advise	Workforce	Resident Doctors Exception Reporting Reform Update

The DHSC has recently agreed forthcoming reforms to the Exception Reporting (ER) requirements for Doctors and Dentists in Training (Resident Doctors) under the 2016 Terms and Conditions of Service. These changes need to be implemented in February 2026 and are a significant contractual reform designed to improve safety, ensure fair compensation, and streamline the reporting process in four main areas:

- Processing and Sign-Off
- Compensation Choice
- Reporting Timescale and
- System Access

The new framework also introduces contractual penalties and significantly enhances the monitoring role of the Guardian of Safe Working Hours (GoSWH). For example, there are new financial penalties, with fines being introduced for system failures and data breaches.

While the Great Place to Work Committee has received an update on this, three elements are important to bring to the Board's attention. These include:

- That the GoSWH role retains oversight of all reports to identify trends and patterns of unsafe working.
- A new requirement that the GoSWH must oversee quarterly surveys of access/completion breaches, information breaches, and actual/threatened detriment experienced by doctors related to exception reporting.
- New Board Reporting: There are additional board reporting requirements to a standardised national template. These will be brought in later in 2026.

GHC's Medical Education and HR/Medical Workforce teams are working on readiness and future progress, and compliance reports will be brought to the Great Place to Work Committee.

Advise	Operational	System Wide Learning Disability Pathway Review

Between April and October 2025, GHC Learning Disability teams have been involved in a comprehensive system-wide assessment of local NHS learning disability services, to evaluate how effectively the current Gloucestershire model meets the needs of people with learning disabilities and their families. The review combined quantitative data on service use, admissions, and workforce capacity with qualitative insights from stakeholders, including families of service users, carers, clinicians, VCSE partners, care providers and GCC. Overall, the review engaged with over 150 stakeholders in the project groups and workshops and modelled expected future demand.

Early on in the process, the stakeholders involved set a guiding vision for the work - *People with learning Disabilities will lead gloriously ordinary lives in their community. Where needed, care and support will be available in the right time, right place and by the right person.*

Throughout December, we have been engaged in a system-wide governance process to agree next steps. This has included discussions with the Integrated Care Board (ICB), Gloucestershire County Council and NHS England. December's ICB Board approved several recommendations to progress to Health Overview Scrutiny Committee (HOSC) on 27January 2026 for their views and endorsement, including:

- Community investment is required to address gaps in benchmarked workforce levels, deliver pathway improvement's identified by the review and respond to rising complexity and modelled demographic growth. A minimum requirement of £1m investment has been identified.
- A dedicated stand-alone learning disabilities inpatient unit will not be part of long-term commissioning plans in Gloucestershire.
- The ICB will lead a due diligence process in the coming months to determine the long-term inpatient options for people with learning disabilities.
- A co-production approach, involving people with lived experience and the voluntary sector, alongside health professionals and commissioners, has been endorsed for continuing pathway development, leading to a Full Business Case (FBC) in 2026 to finalise amendments to the pathway.

Advise	Board Reporting Update	Chief Executive Overview report
	This report includes, for the first time, a high level overview of a range of indicators as a 'Chief Executive's Overview'. This is not designed to be an alternative to the performance dashboard and exception reporting presented to the Board. Instead, it is designed to draw out some of the broader trends and context in which the organisation is operating in a way that is not always obvious from the more detailed reports about individual performance metrics.	
	National/Regional Updates	**National Cost Collection 2024/25**
	The National Cost Collection results for 24/25 have been published onto NHSE's public website. There is a National Schedule of NHS Costs showing national average cost by service type calculated by dividing total cost by activity and a National Cost Collection Index which displays relative cost difference between NHS providers. Results for 2024/25 for GHC show a National Cost Index of 112 (100 is the national average). This metric feeds into the National Oversight Framework score and is deemed to be a measure of efficiency. The score takes no input from outcomes, experience or safety of services. Full results were presented to the Resources Committee earlier in the month. The data gained from the national cost collection does provide useful cost and service insights into productivity and performance as well as detailed information at patient level. This analysis will be available in a few months.	
	Workforce	**Update on Actions to Prevent Sexual Misconduct in the NHS**
	In early December 2025, NHSE published a new letter update on actions to prevent sexual misconduct in the NHS. In summary, the letter: • Launches new training for investigators of sexual misconduct for trusts in England – 2 people professionals from each trust will be invited to take part in the training from March • Asks all providers to review their chaperoning policies to ensure they are in line with new principles on chaperoning published this month • Sets the expectation that providers should build a pool of doctor/dental investigators who are trained in sexual misconduct investigations • Asks providers to strongly consider review groups for allegations that may include a sexual dimension • Reminds providers to make a referral to DBS if someone has been removed from work/clinical duties due to concern about conduct • Clarifies that – even where an investigation needs to consider "training" aspects to allegations with resident doctors – if there is a clear sexual element to an allegation it is very likely to need to require a conduct process • Urges providers to liaise with their police liaison officer about where employer investigations can still continue, even where the police are conducting their own investigations	

Advise	• Asks all trusts and ICBs to respond to a fresh audit of actions by Monday 2nd February The letter brings the measures that have already been asked of trusts and ICBs to all primary care providers too, who are also being asked to sign up to the charter and complete a new self-assurance checklist against the charter. NHSE will be following up with ICBs to provide additional support to their providers and check-in on progress. The Great Place To Work Committee was updated on this workstream in its December meeting and the Trust's revised Sexual Misconduct Policy, guidance and action cards were launched last Autumn. Specialist training has been provided in 2025 to HR and Organisational Development colleagues as well as Freedom To Speak Up Champions.	
Assure	**National/Regional Updates**	**NHS Oversight Framework and League Tables**
	As summarised above, the latest results of the NHS Oversight Framework for 2025/26 for quarter 2 of 2025/26, were published on 11 December. The Trust was placed in segment 2 and ranked 20 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.	
Applaud	**Operational**	**Response to Winter Demands**
	All teams are responding well to seasonal challenges, in particular: Our School Aged Immunisations Service vaccinated an additional 4000 young people during the 2025 flu season, compared to previous years. In total across the 14-week delivery period, the service vaccinated 67,109 young people, achieving a 74% uptake against national targets of 50% for secondary schools and 60% for primary schools. As well as visiting 287 primary schools and 78 secondary schools, the service provided 15 community clinics and 5 home visits. The majority of vaccines are delivered via nasal spray, however injectable vaccines were delivered in primary and secondary schools for the first time with 798 injectable flu vaccines delivered. The service does a fantastic job in keeping our young people protected against flu and preventing the spread to their families, neighbours and carers. The Integrated Urgent Care service experienced exceptionally high demand over the Christmas and New Year period, with call volumes exceeding forecast levels. Their busiest day during the festive season saw them take 1500 calls (compared to 900 on a standard day). Throughout December, more than 20,000 calls were received. Additional resources were deployed to support the service and manage the surge in demand, both within IUCS and across the wider system. The service continues to plan for further improvements and developments as part of system plans.	

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AGENDA ITEM: 09/0126

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st December 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 9 position.

Executive summary

- The system plan at 30th April was break even and the Trust's plan was break even
- At month 9 the Trust has a surplus of £0.084m compared to the ytd plan of a £0.151m deficit
- 25/26 Capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Revised capital plan reflects revisions to phasing of Buildings, Disposals and IT schemes. Spend to month 9 is £4.569m against a plan of £9.24m
- The Trust spent £15.81m on bank staff which is above plan by £2.38m.
- The Trust spent £2.161m on agency staff up to month 9, which is below plan. There were 13 off framework shifts, the target is 0.
- Cash at the end of month 9 is £45.197m, which is c.£4.4m ahead of plan.

Risks associated with meeting the Trust's values

Risks included within the paper

Corporate considerations	
Quality Implications	

Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report

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

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Finance Report Month 9

29 January 2026

Presented by **Sandra Betney Director of Finance**

Overview

- The system plan at 30th April submission was break even and the Trust's plan was break even.
- At month 9 the Trust has a surplus of £0.084m compared to the plan of a £0.151m deficit.
- Cash at the end of month 9 is £45.197m, which is above plan by £4.4m.
- Cost improvement programme has delivered £5.62m of recurring savings against the plan of £7.075m. Target for the year is £10.086m. £1.653m is unidentified.
- Non recurrent savings target is £5.169m all of which is identified, and of which £4.91m is delivered.
- The Trust spent £15.81m on bank staff which is above plan by £2.38m.
- The Trust spent £2.161m ytd on agency staff which is below plan by £0.815m. There were 13 off framework shifts, the target is 0.
- Better Payment Policy shows 95.6% of invoices by value paid within 30 days and 92.0% 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 9 is £4.569m against a plan of £9.24m.
- Capital forecast outturn is anticipated to be in line with revised plan.
- Five year capital plan is yet to be finalised
- A business case for the potential lease of rooms within Coleford Health Centre will be presented to the March Board meeting if the value exceeds the Chief Executive authorisation level

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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	236,010	236,351	340
Other operating income	16,590	19,417	15,050	16,047	997
Employee expenses - substantive	(221,705)	(233,665)	(189,897)	(169,804)	20,093
Bank	(17,906)	(17,906)	(1,351)	(15,810)	(14,459)
Agency	(3,967)	(3,967)	(570)	(2,161)	(1,590)
Operating expenses excluding employee expenses	(73,026)	(78,153)	(58,879)	(64,665)	(5,787)
PDC dividends payable/refundable	(2,781)	(2,781)	(2,086)	(2,086)	0
Finance Income	1,500	2,038	1,808	1,853	46
Finance expenses	(198)	(198)	(145)	(169)	(24)
Surplus/(deficit) before impairments & transfers	**(51)**	**(51)**	**(60)**	**(444)**	**(385)**
Gains/ (losses) from disposal of assets			0	17	17
Remove capital donations/grants I&E impact	51	51	39	39	0
Surplus/(deficit)	**0**	**0**	**(20)**	**(388)**	**(368)**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	471	471
Remove net impact of consumables donated from other DHSC bodies	0	0	0		0
Revised Surplus/(deficit)	**0**	**0**	**(20)**	**84**	**104**
WTEs	4762	4822	4822	4702	120

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

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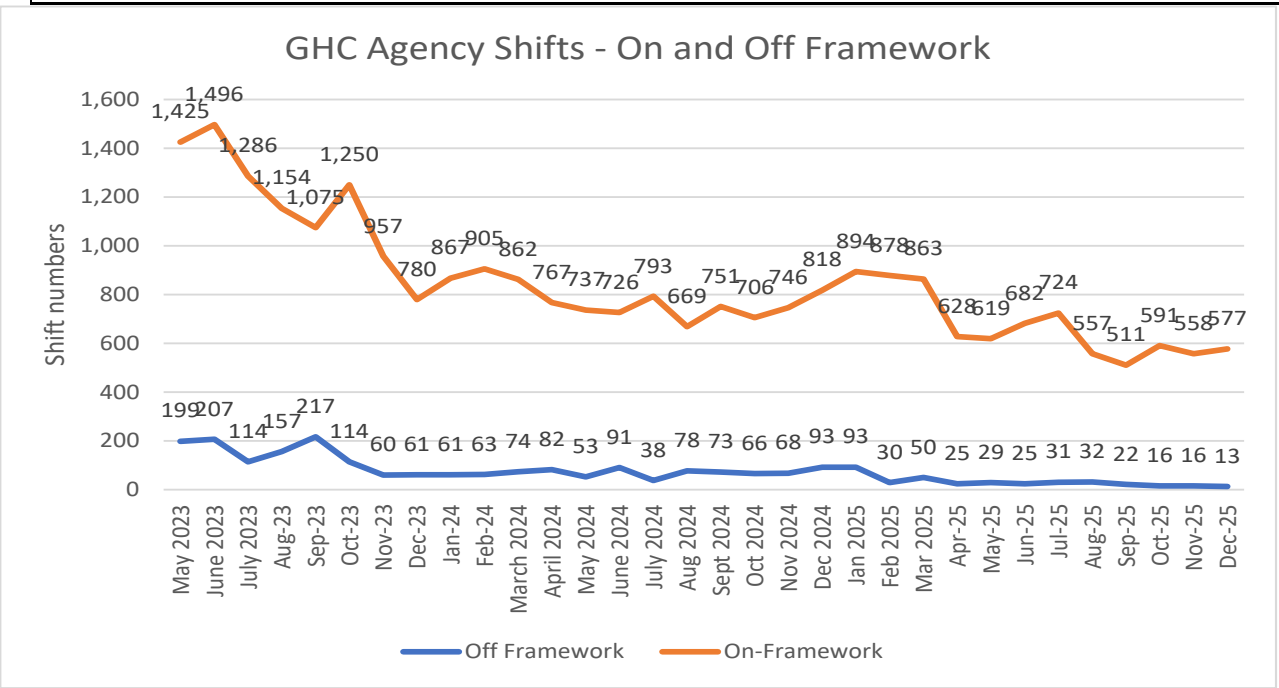
Pay Analysis

Pay analysis month 9						
	Plan WTE Month 9	Budget WTE Month 9	Budget £000s	Actual WTE Month 9	Actual £000s	Actual £ as % of Total £
Substantive	4,368	4,804	189,897	4,326	169,804	90.4%
Bank	341	18	1,351	347	15,810	8.4%
Agency	43	0	570	28	2,161	1.15%
Total	**4,752**	**4,822**	**191,818**	**4,702**	**187,775**	**100.0%**

- Trust WTE budget 70 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 13 off framework agency shifts in December. 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	2,230	2,253	23	2,316
	Property, plant and equipment: other	117,935	122,466	120,607	115,560	(5,047)	124,702
	Right of use assets	16,438	16,541	16,621	15,509	(1,112)	15,660
	Receivables:	1,244	1,209	1,218	1,221	3	1,193
	Total non-current assets	**137,361**	**142,480**	**140,676**	**134,543**	**(6,133)**	**143,871**
Current assets	Inventories	444	444	444	443	(1)	443
	NHS receivables	7,409	7,432	7,432	9,793	2,361	8,793
	Non-NHS receivables	9,331	9,349	9,349	8,112	(1,237)	7,612
	Credit Loss Allowances	(1,595)	(1,595)	(1,595)	(1,919)	(324)	(1,919)
	Property held for Sale	3,123	377	1,732	2,513	782	1,118
	Cash and cash equivalents:	41,855	39,359	40,797	45,197	4,400	39,815
	Total current assets	**60,567**	**55,366**	**58,159**	**64,140**	**5,981**	**55,863**
Current liabilities	Trade and other payables: capital	(3,815)	(3,535)	(3,903)	(1,607)	2,296	(4,107)
	Trade and other payables: non-capital	(26,851)	(26,875)	(27,570)	(32,362)	(4,792)	(30,761)
	Borrowings	(1,514)	(1,514)	(1,514)	(1,484)	30	(1,409)
	Provisions	(8,701)	(8,702)	(8,702)	(6,470)	2,232	(6,870)
	Other liabilities: deferred income including contract liabilities	(1,303)	(1,303)	(1,303)	(2,453)	(1,150)	(1,453)
	Total current liabilities	**(42,184)**	**(41,929)**	**(42,992)**	**(44,376)**	**(1,384)**	**(44,600)**
Non-current liabilities	Borrowings	(14,026)	(14,252)	(14,314)	(13,226)	1,087	(13,447)
	Provisions	(2,511)	(2,511)	(2,511)	(2,500)	11	(2,500)
	Total net assets employed	**139,206**	**139,154**	**139,019**	**138,581**	**(438)**	**139,187**

Taxpayers Equity	Public dividend capital	132,103	132,103	132,103	132,103	(0)	132,972
	Revaluation reserve	13,790	13,789	13,789	13,592	(197)	13,592
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	(1,046)	(5,498)	(5,633)	(5,446)	187	(5,446)
	Income and expenditure reserve (current ye	(4,399)	0	0	(427)	(427)	(690)
	Total taxpayers' and others' equity	**139,206**	**139,154**	**139,019**	**138,581**	**(438)**	**139,187**

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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)		(60)		(19)	
Add back: Depreciation on donated assets	185		35		70	
Adjusted Operating surplus/(deficit) per I&E	**(4,287)**		**(25)**		**51**	
Add back: Depreciation on owned assets	11,117		6,446		9,969	
Add back: Depreciation on Right of use assets					0	
Add back: Impairment	4,497		471		471	
(Increase)/Decrease in inventories	(88)		1		1	
(Increase)/Decrease in trade & other receivables	(4,386)		(10,421)		218	
Increase/(Decrease) in provisions	154		(2,407)		(1,407)	
Increase/(Decrease) in trade and other payables	(8,506)		5,892		3,216	
Increase/(Decrease) in other liabilities	217		9,189		189	
Net cash generated from / (used in) operations		**(1,283)**		**9,147**		**12,709**
Cash flows from investing activities						
Interest received	3,072		1,632		2,484	
Interest paid	(9)		(6)		(34)	
Proceeds from Sale of PP&E	1,974		50		1,445	
Purchase of property, plant and equipment	(9,316)		(5,963)		(15,196)	
Assets Held for Sale						
Net cash generated used in investing activities		**(4,279)**		**(4,287)**		**(11,301)**
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		67		94	
Finance lease receipts - Interest	(62)		(40)		(59)	
Finance Lease Rental Payments	(1,572)		(1,059)		(1,521)	
Finance Lease Rental Interest	(213)		(143)		(190)	
		(4,016)		**(2,602)**	**0**	**(3,889)**
Cash and cash equivalents at end of period		**41,855**		**44,113**	**0**	**39,374**

Liquidity Metric

			Month 9		
Liquid Working Capital	x 275 days	=	26,174	29.09	days
ytd Operational Expenditure			247,391		

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Capital – Five Year Plan

Capital Plan	Plan	Revised Plan	Actuals	Plan	Plan	Plan	Plan	Plan
£000s	2025/26	2025/26	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Land and Buildings								
Buildings	4,021	1,418	555	5,199	11,750	4,086	2,888	2,888
Backlog Maintenance	1,879	3,791	1,120	1,896	1,393	1,393	1,400	1,400
Buildings - Finance Leases	1,496	615	206	227	600	2,450	382	382
Vehicle - Finance Leases	250	612	117	50	250	250	250	250
Other Leases	0	0	115	0	0	0		
Net Zero Carbon	2,643	4,624	1,550	1,712	1,650	1,650	1,650	1,650
Medical Equipment	1,780	1,504	193	740	630	1,200	1,200	1,200
Unallocated				0				
				0				
IT								
IT Devices	320	600	0	200	900	900	1,200	1,200
IT Infrastructure	1,300	1,671	87	1,640	1,250	680	1,310	1,310
WAN/LAN				0		1,530	400	400
Transforming Care Digitally	1,260	734	635	1,230	250	0	0	
NHS Net Transition	500	300		334	0	0	0	
Digital Innovation		0		0	430	540	590	590
Data Centres/Servers		0		0	840	40	220	220
Patient Portal		601		256				
Space Management Toolkit (Estates)		200		0				
Contingency								
		0						
Total of Updated Programme	**15,449**	**16,671**	**4,579**	**13,484**	**19,943**	**14,719**	**11,490**	**11,490**
Disposals	(3,265)	(1,454)	(54)	(1,565)	(4,200)	(1,176)	(1,450)	
Total CDEL spend	**12,184**	**15,217**	**4,525**	**11,919**	**15,743**	**13,543**	**10,040**	**11,490**
Funded by;								
Anticipated System CDEL	**12,184**	**12,184**		**8,916**	**9,352**	**9,528**	**9,750**	**11,490**
PDC		**869**						**0**
Additional CDEL		**2,164**		**1,395**				**0**
	0							
CDEL Shortfall / (under commitment)	**0**	**(0)**		**1,608**	**6,391**	**4,015**	**290**	**0**

CIP

	£000's	Low Risk	Medium Risk	High Risk
Scheme	**Target**	**Delivered**	**Identified**	**Unidentified**
Undelivered 24/25 brought forward	1,947	1,108	670	169
Efficiency 1.1%	3,189	1,836	1,016	337
Delivering Value 1.4%	4,001	1,727	1,194	1,147
Programme Savings	949	949	0	0
Non recurrent savings	5,169	4,910	259	0
	15,255	10,531	3,139	1,653
		69.0%	**20.6%**	**10.8%**

- Identified scheme delivery is split £1.7m delivery in 25/26 and £1.4m in 26/27

- 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

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Risks

25/26 potential risks are as set out below:

- Risks 390 and 648 concerning the impact of System wide overspends have been removed following updates to the System's forecast position for 25/26 which indicate a break even position
- A detailed list of risks for 26/27 have been included in the budget setting paper

Risks 25/26	Mitigations	Risk Value	Likelihood	Impact	Recurring	Mitigated Risk Score
There is a risk that GHC does not fully identify 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	1653	4	3	1653	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	1653	4	3	1653	12
[illegible] delivered until 26/27 leading to a deterioration in the finance position	Alternative savings identified. Monitor CIP delivery and Finance position. Monitor forecasts	1428	2	3	1428	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: 10/0126

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT 29th JANUARY 2026 DECEMBER 2025 DATA**

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

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

The purpose of this report is to:

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

Recommendations and decisions required.

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

Executive summary

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

Quality reporting improvement:

- The data to support safe staffing is contained within the Dashboard and this is taken from the information that appears on a monthly basis published on our Website. We undertake benchmarking against National Indicators noting that there is a time lag on the publication of the National Data. Development of the Quality Dashboard to supplement the Integrated Performance Quality Report improvements continues.
- For ease of reading the Executive Summary now shows headlines sorted within the Alert, Advise, Assure and Applaud layout only, and not further segregated into the Safe, Effective and Caring domains.

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.

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:	AI-10.1/0126 Quality Dashboard Report – December 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 December 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

Alert, Advise, Assure, Applaud

Alert

- Our current year total of moderate harm, severe harm and incidents relating to death are now above or consistent with the final year total of 2024/2025 with 3 months left of this year. The increase in overall incidents seen during 2025/2026 is already near to/ exceeded the 2024/25 total with December being the month with the highest number of reported incidents. This is reflective of winter pressures in addition to the known impact of an increase in the number of services to the trust and a high reporting culture. There is an increase in moderate harm and above incidents with assurance that all these incidents receive greater oversight including Duty of Candour consideration and the application of a learning response if indicated.

- Year to date, complaints received have increased 50% on 2024/25 data.

- The increase in reporting activity across all quality governance teams is not showing in terms of impact on compliance with timeliness standards but is impacting on pressures felt by staff across these teams. This has been escalated to Executive Directors at Quality Assurance Group and support for teams, demand and capacity and timeliness of governance are being closely monitored.

- There is Executive oversight in place on the pressures across community nursing services, where an improvement plan is in place.

Advise

- Total of 1576 Patient Safety Incidents reported of which 1432 were no or low harm,144 were moderate harm, severe harm or death. In month we have seen:
    - An increase in sexual safety incidents reported
    - Decrease in the number of restraint incidents this month
    - A decrease in inpatient falls in December, follow an overall downward trend over last 15 months
    - An increase in the number of incidents relating to self-harm and self-injurious behaviour
    - A total of 379 skin integrity incidents reported across the trust with an observed decreases in no, low and moderate harm incidents

- There has been an increase in unexpected child deaths in December. There are no trends identified across these deaths, or immediate concerns relating to the delivery of care our services.

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

Alert, Advise, Assure, Applaud

Assure

- We have reviewed our DOC position for incidents reported in November 2025 which has improved validation of the position noting that incidents reported in December may still be awaiting handling and confirmation of harm level.
- The safe staffing across Community Hospitals and MH Inpatients has been reviewed and assured by the Deputy Director of Nursing, Therapies and Quality. Our fill rates remain good.
- There has been a delay in bringing through the report for the most recent NED Quality Visits. This has been a timing issue that has now been addressed, supported by attendance at January's Non-Executive Director Meeting.

Applaud

- The Datix Team received positive feedback via thumbs up Friday.
- Gloucestershire as a system was commended in a national report by the Kings Fund, recognised as an exemplar during the pandemic for vaccine delivery .
- Gloucestershire ICB are currently top of the regional tables for both Flu and Covid vaccine delivery.

Safeguarding December 25

What is the data telling us?

This table summarises the responsive Safeguarding work carried out by the Safeguarding team. Those in the system such as involvement in multi agency activity (MASH, MARAC, reviews, and child death process) and those responding internally (advice line, escalations, Allegation Management).

- There is no imminent digital solution to track the referral activity related to MARFs and Adult Safeguarding referrals made by Trust colleagues to the local authority. This is reflected on the risk register. The situation is mitigated by the weekly MASH multi agency audit and attendance at monthly meetings. The Safeguarding team are assured there are no quality issues arising from referrals.
- There is an increase in unexpected child deaths in Q3, with 4 occurring in December. There are no trends identified across these deaths, or immediate concerns relating to the delivery of care our services. The safeguarding team support colleagues who nay be involved in external led reviews.

	Q1	Q2	Oct-25	Nov-25	Dec-25	Q3
Number of Safeguarding Escalations	1	7	0	1	0	1
MARAC - Families screened/researched	393	403	132	133	126	391
MASH - Children & adults researched	4,724	4,436	1,371	1,449	1,327	4,147
Number of Adult Reviews ongoing	20	24	24	25	25	25
Number of LCSPRs in progress	1	1	1	1	1	1
Number of Rapid Reviews attended	1	1	0	0	1	1
Expected Child Deaths	1	5	0	0	0	0
Unexpected Child Deaths	3	0	1	0	4	5
New Allegation Management cases	5	9	3	1	1	5
Adult Safeguarding Referrals made	132	n/a	n/a	n/a	n/a	n/a
MARFs (child referrals) made	n/a	24	n/a	n/a	n/a	n/a
Safeguarding Advice line - Childrens	208	236	54	83	59	196
Safeguarding Advice line - Adults	265	309	78	99	67	244

Safeguarding December 25

Training is the foundation of good Safeguarding practice, and this slide shows solid training compliance across all training.

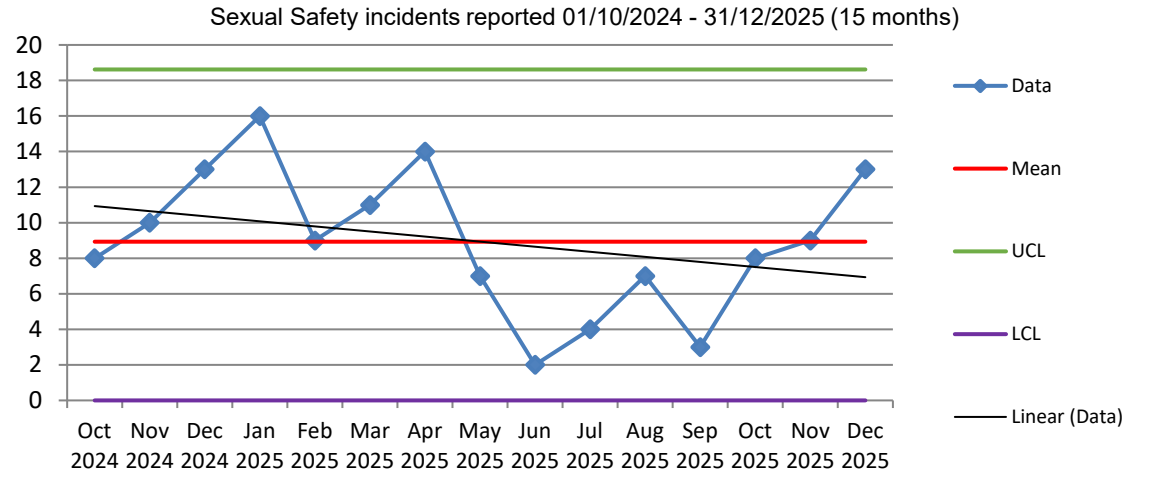
- The exception is Level 4 training. This is facilitated by GCC for there are more limited training places available. It equates to 8 colleagues who are overdue and all have been made aware of the next available courses in March.
- Clinical staff working with children need to attend children's safeguarding supervision 4x per year. For Adults attendance at safeguarding supervision is good practice but not a requirement.
- Compliance for Children's Safeguarding supervision remains low compared to the target compliance of 90%. 5 x sessions are delivered per week, are generally full with a max 8 participants. A recording issue in the training system has been identified for which there is currently no solution identified. There is planned work to review Children's Safeguarding supervision arrangements which is intended to target eligible colleagues better and improve compliance.
- For Adult Safeguarding supervision different models have been offered over the years with limited impact so part of the barrier is deemed to be that supervision is not mandatory within Adult Safeguarding. Feedback shows that some colleagues will use the advice line in place of formal supervision, although colleagues who contact the advice line with an Adult Safeguarding query are routinely offered supervision.

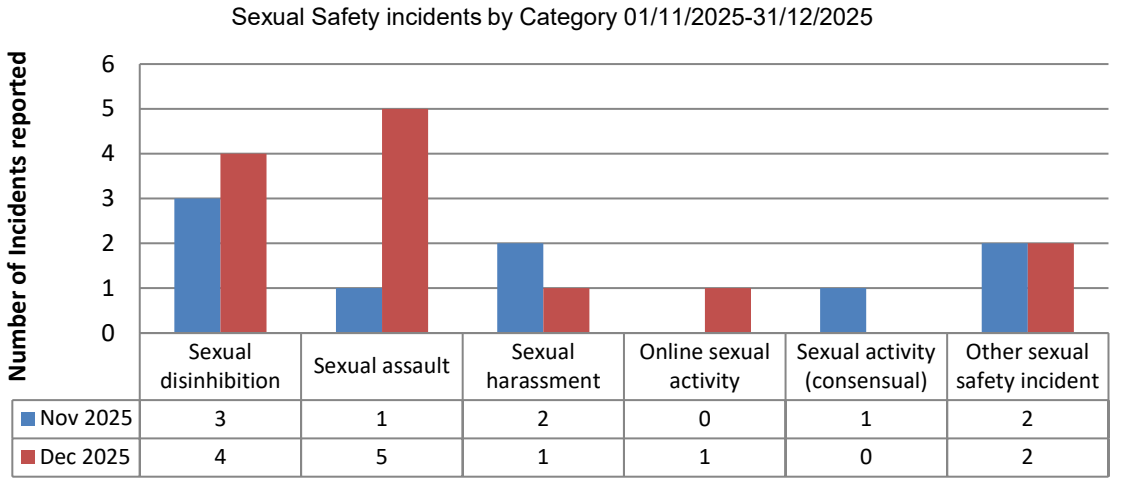
TRAINING	Q1	Q2	Oct-25	Nov-25	Dec-25	Q3
Level 1 – Induction	97%	98%	987%	98%	98%	98%
Level 2 – Think Family	95%	95%	96%	95%	96%	96%
Level 3 – Multi-Agency Child Protection	84%	78%	82%	82%	82%	82%
Level 3 Adult Protection	91%	91%	90%	90%	91%	90%
Level 4 Adult Protection	70%	83%	72%	72%	69%	71%
PREVENT:						
Level 1	99%	99%	99%	99%	99%	99%
Level 2	94%	93%	93%	93%	94%	93%
Level 3	97%	96%	97%	97%	97%	97%
MENTAL CAPACITY ACT:						
Level 1	97%	97%	95%	96%	96%	96%
Level 2	88%	89%	91%	92%	92%	92%
SAFEGUARDING SUPERVISION CHILDREN:						
Group Supervision Sessions	72	60	28	22	16	66
Group Supervision Compliance	70%	65%	67%	67%	67%	67%
One to One Supervision Sessions	13	11	13	9	5	27
ADULTS:						
Group Supervision Sessions	0	2	1	0	0	1
Number of Staff who attended Supervision	0	6	3	0	0	3
One to One Supervision Sessions	3	12	1	2	2	5

Safeguarding December 25

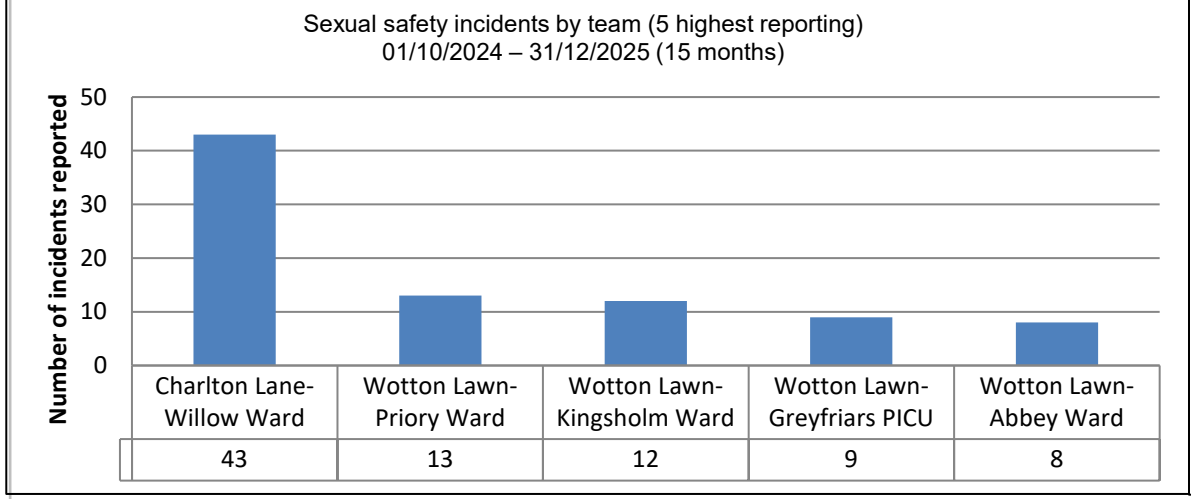
- Analysis of the Safeguarding advice line continues to show that Talking Therapies is the most frequent caller with 34 calls during December. Other teams calling include Health Visiting (13 calls), Young Minds Matter (9), Sexual Health (8), School Nursing (7) and Community Nursing (7). A wide spread of teams also made calls although these were less than 5 each and so have not been individually specified.
- Domestic abuse remains the single most common reason for calls to the advice line, accounting for 32 of the 126 calls received by the service in December. Neglect remains the second most common identifiable reason for calls (12) although calls logged as 'other' account for 21 calls. For the second month in a row there have been calls relating to MCA (4) which is welcomed.
- Work is continuing to review the advice line & identify possible enhancements to both the way colleagues interact with the advice line and the collection of data, to hopefully provide greater insight and analysis.
- The sexual safety data continues to be reported by inpatient services with notably limited reporting across community services. The Safeguarding Team has contacted other Trusts to understand their approaches to raising awareness and improve reporting on Sexual Safety to develop our approach further.
- The Trust received a letter during December from NHS England providing an update on actions to prevent Sexual Misconduct in the NHS. Assurance is given that there is further work planned across HR, NTQ and medical directorate with oversight by GPTW Committee.
- A launch event for Gloucestershire's Tackling Domestic Abuse Strategy (2025-28) took place in December. The strategy's vision is:
    - *Early intervention and prevention to stop abuse before it escalates*
    - *Support for victims and survivors that is accessible, consistent, and trauma-informed*
    - *Strong partnership working across agencies to ensure no one falls through the cracks*

Sexual Safety Incidents

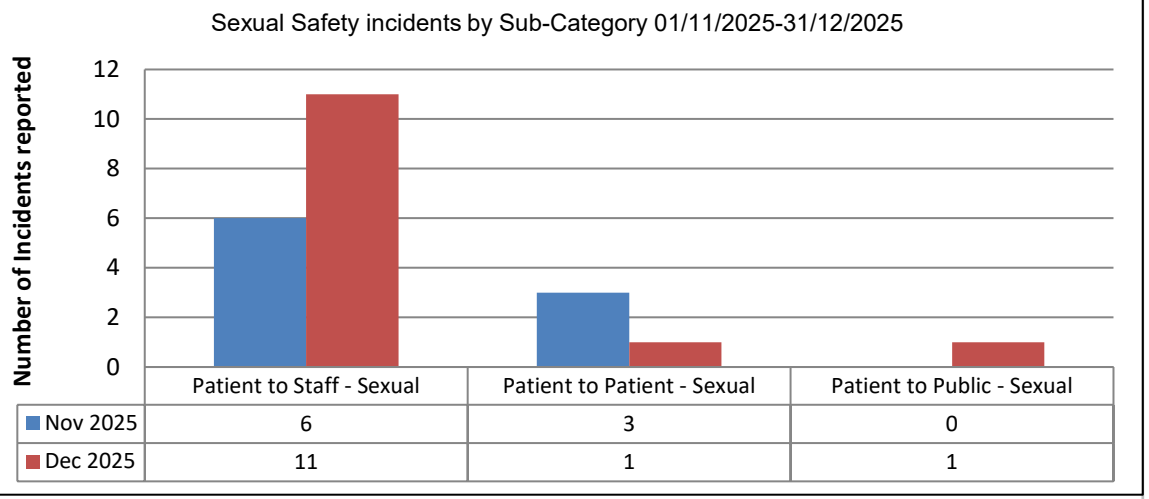




	Sexual disinhibition	Sexual assault	Sexual harassment	Online sexual activity	Sexual activity (consensual)	Other sexual safety incident
Nov 2025	3	1	2	0	1	2
Dec 2025	4	5	1	1	0	2



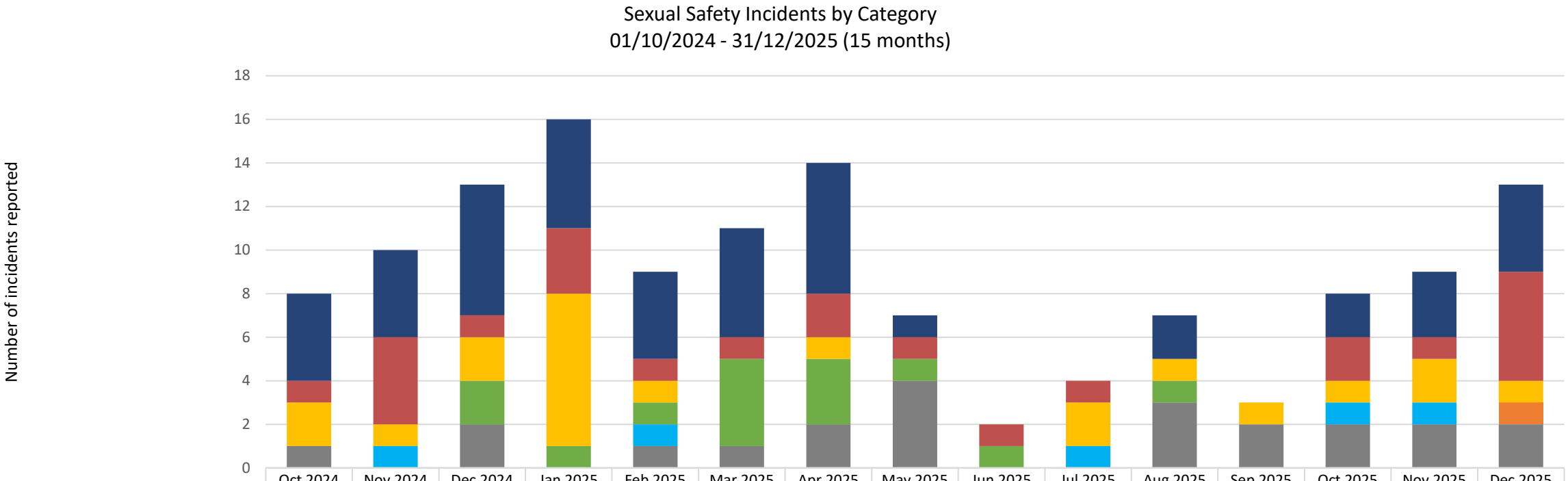
Charlton Lane-Willow Ward	Wotton Lawn-Priory Ward	Wotton Lawn-Kingsholm Ward	Wotton Lawn-Greyfriars PICU	Wotton Lawn-Abbey Ward
43	13	12	9	8



	Patient to Staff - Sexual	Patient to Patient - Sexual	Patient to Public - Sexual
Nov 2025	6	3	0
Dec 2025	11	1	1

Sexual Safety incidents increased from 9 in November to 13 in December. All of the incidents were rated as 'no harm'. On that basis, none met the criteria for Reg 20 Duty of Candour. However, all incidents have been handled according to policy and support has been provided to staff and patients where required, any relevant learning will be shared

Sexual Safety Incidents



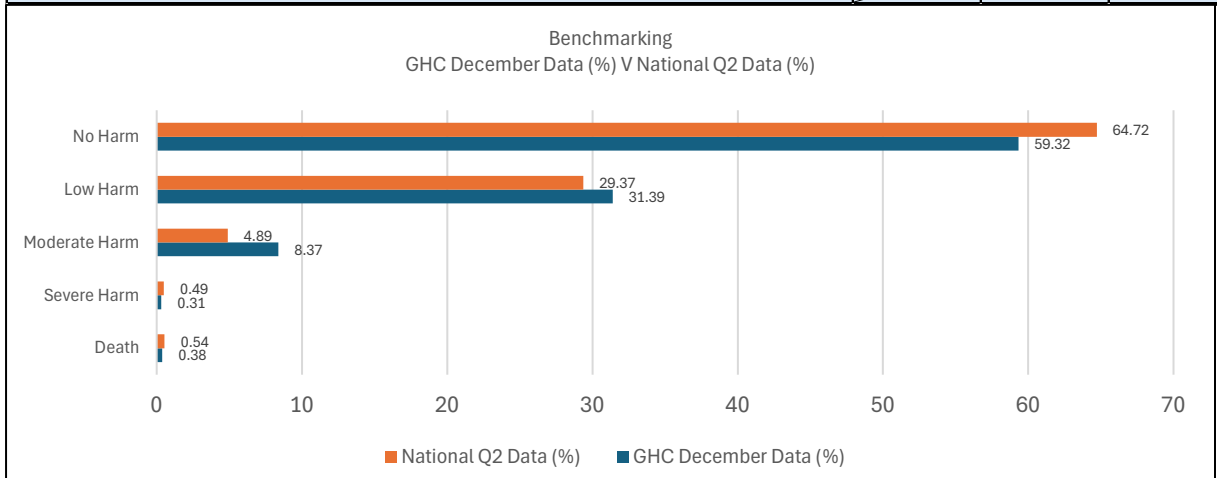
	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Sexual disinhibition	4	4	6	5	4	5	6	1	0	0	2	0	2	3	4
Sexual assault	1	4	1	3	1	1	2	1	1	1	0	0	2	1	5
Sexual harassment	2	1	2	7	1	0	1	0	0	2	1	1	1	2	1
Affectionate activity (sexual safety)	0	0	2	1	1	4	3	1	1	0	1	0	0	0	0
Sexual activity (consensual)	0	1	0	0	1	0	0	0	0	1	0	0	1	1	0
Online sexual activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other sexual safety incident	1	0	2	0	1	1	2	4	0	0	3	2	2	2	2

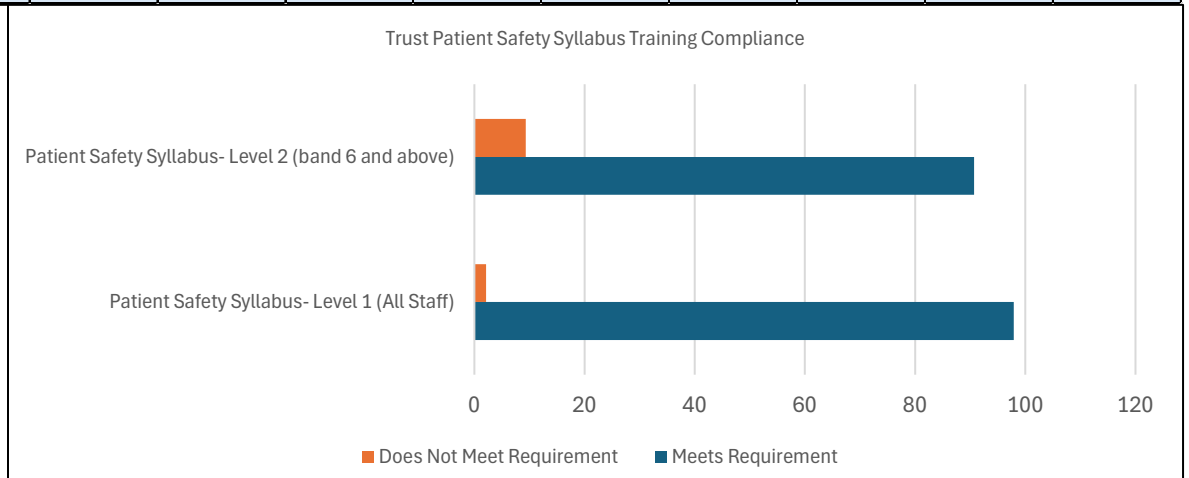
The rise in December's figures includes six incidents on a mental health inpatient ward, five of which were connected and have been addressed through clinical care planning, with appropriate reporting to police and supervision for staff. All staff have had supervision.

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	1234	1439	1341	1436	1321	1299	1373	1574	1576			
Number of No Harm and Low Harm incidents (including skin integrity)	1113	1326	1246	1285	1203	1147	1229	1423	1432			
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	121	113	95	151	118	152	144	151	144			
Patient Safety Investgations												
Number of AARs completed in Month		4	3	4	4	4	2	4	3			
Number of New PSII's and Care Reviews declared in month	1	0	2	0	1	2	0	3	0			
Number of PSII's open		5	6	7	7	9	11	11	11			
Number of PSII's closed in month		0	0	0	1	0	0	2	0			
Number of Care Reviews open		9	9	8	7	6	6	3	3			
Number of Care Reviews closed		1	0	1	0	1	0	3	0			
Number of PSII's and Care reviews open over 6 months		11	11	11	11	10	9	6	6			
Number of PSII's/ Care Reviews planned for Exec sign off (Closure)			6	7	7	6	7	1	1			
Family Liaison Practitioners												
Number of patients being supported		1	1	1	1	1	1	0	0			
Number of family and friends being supported		7	8	9	8	9	11	13	14			
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner		1	1	0	0	0	0	0	0			
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AAR's/ Care Reviews/ PSII's)		34	36	36	26	46	27	25	37			
PCET		1	0	2	1	0	1	5	15			
Alerts/ NICE/ Audit		1	2	1	1	1	1	1	1			





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

What is the data telling us?

Trust Data:

- In December we saw 1576 incidents reported at the trust, and this is our highest number of incidents reported in a single month.
- Our current year total of moderate harm, severe harm and incidents relating to death is already near to/ slightly above the final year total of 2024/2025 with 3 months left of this year. The increase in overall incidents we are seeing in 2025/2026 is multifactorial, including the impact of new services to the trust, ongoing promotion of a positive safety culture and the work undertaken by the Patient Safety Team to improve quality of reporting, including applying accurate harm levels. Whilst an increase in moderate harm and above incidents may raise concerns it is important to reflect that these incidents do receive greater oversight including Duty of Candour consideration and the application of a learning response if indicated.
- We are continuing to use the NHS-England Q2 data to benchmark our monthly harm incident data. Whilst this allows us to draw a basic comparison it is important to note that this data is not validated and only considers physical harm, so there is caution in drawing reliable or meaningful conclusions. We do continue to observe that compared to national figures we have a higher percentage of low and moderate harm incidents but fewer no harm, severe harm and incidents relating to death at the trust. We have had fewer moderate harm incidents in December 2025 compared to the previous month, placing us in a slightly improved position against the national data. There continues to be no emerging themes or trends in the moderate harm incidents, as the 14 incidents were across 6 incident categories and 12 teams.

Patient Safety Team:

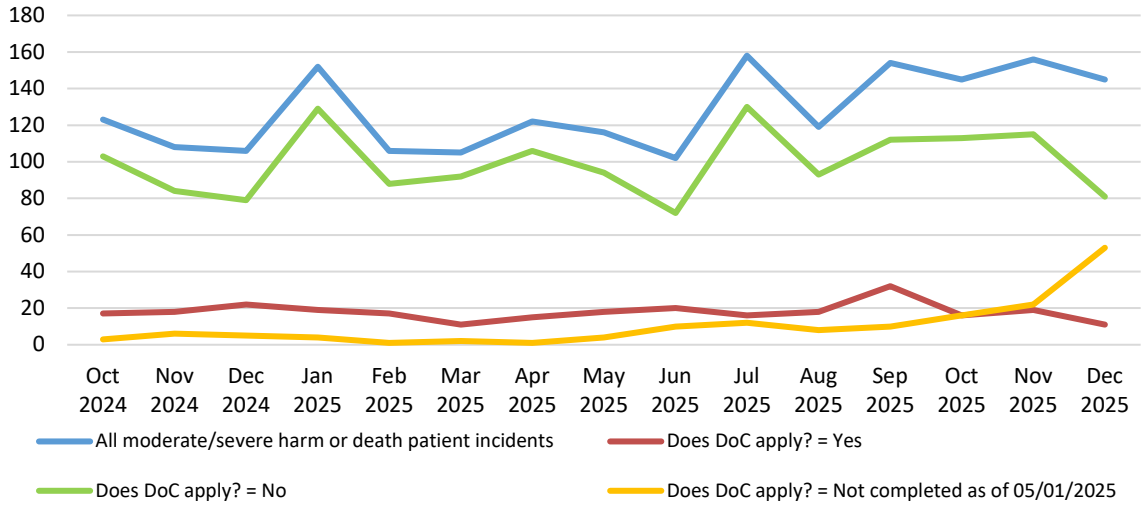
- There were 3 After Action Reviews completed in December 2025 with a further 5 already planned in for January 2026.
- 6 PSIIs/ Care Reviews have been open longer than 6 months. These delays are caused by a combination of factors including capacity for an allocated reviewer, arranging family meetings when it suits a family best and internal review meetings around colleagues' availability. Of the 6 reports over 6 months; 1 draft report is with the family, 2 reports are being edited following internal review meetings, 2 have an internal review meetings planned, 1 will go to the next Executive Sign off Group.
- 0 PSIIs and Care reviews were closed in December 2025.
- We did not declare any new PSII’s in December 2025 however we have 2 there are still awaiting allocation. These incidents occurred in November 2025.
- We continue to draw upon some bank resource to assist with capacity in the PST but there are limitations to available resource as staff must meet the strict requirements outlined in PSIRF for reviewers.
- We are experiencing an increase in incident handling and requirements for learning events in line with the observed increase in reporting of moderate and above incidents and the challenges being experienced in teams across the trust.
- There has been another increase in the number of families being supported by a Family Liaison Practitioner, this is now at 14.
- We have received the draft PSIRF audit and are preparing the management responses. This will be presented by the auditors to Audit committee in January.

Learning Assurance- NED Quality Visits:

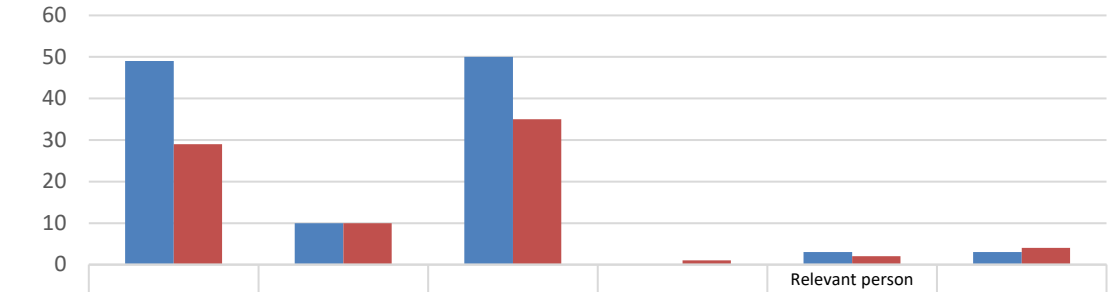
- A list of clinical teams willing to engage in visits have been shared with the Non-Executive Directors and are in the process of confirming suitable dates for these visits to take place.
- Attendance at the Non-Executive Directors' meeting on 22 January will provide an informal introduction and initial engagement.
- The next report will be brough in Q4.

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

Does Duty of Candour apply? - 01/10/2024 to 31/12/2025



Reason Duty of Candour does not apply 01/11/2025 - 31/12/2025



	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	Relevant person unknown e.g. patients with advanced dementia or who lack capacity, or following a death, and no known NOK/relevant person	Reason not completed as of 05/01/2026
Nov-25	49	10	50	0	3	3
Dec-25	29	10	35	1	2	4

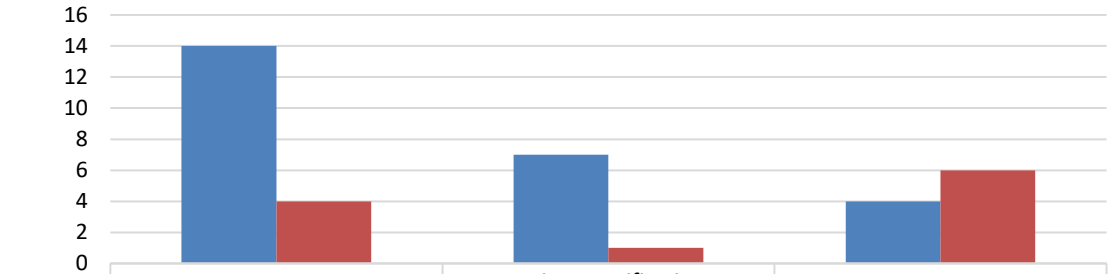
What is the data telling us?

We have revised our DOC data for incidents reported in November 2025 to improve the data validation in December. As a result:

- There are 12 fewer moderate harm incidents seen in November's data, these have been regraded as lower harm levels.
- Our previous data showed that we were waiting to understand if DoC applied in 37% of incidents reported, this figure has now fallen to 14%. This reduction is due to the incidents having been appropriately handled and follow up by the PST.
- It has identified that DoC regulation 20 did not apply in 74% of incidents in November and a reason for this has been provided in 97% of incidents.
- DoC regulation 20 applied in 12% of incidents, we are still awaiting confirmation of the notification provided in 4 incidents, but these will not be closed by the PST until this has been provided.

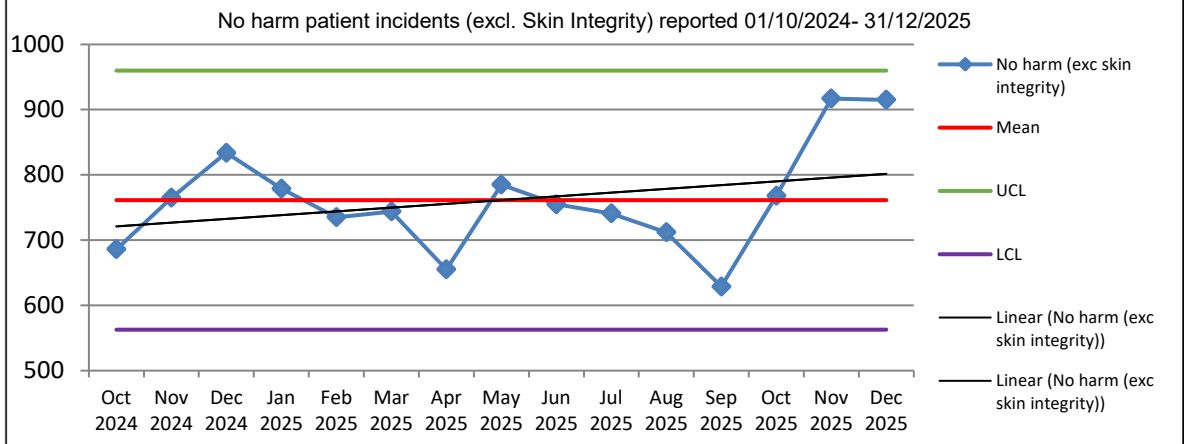
Whilst we see an improved position each month, we have identified that there are a small number of incidents that are still outstanding completion. We will undertake a targeted piece of work to review these.

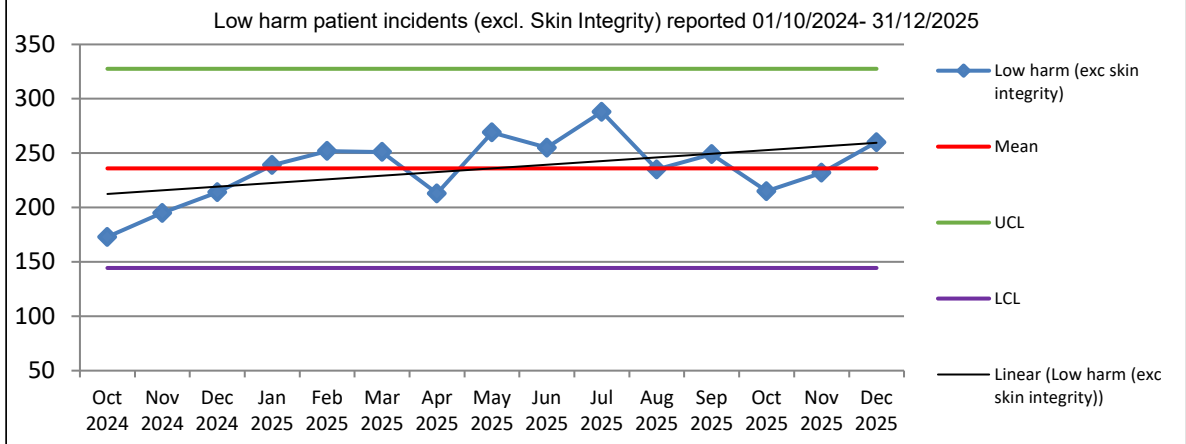
Duty of Candour notifiable incidents - notifications to patients or applicable person(s) 01/11/2025 - 31/12/2025

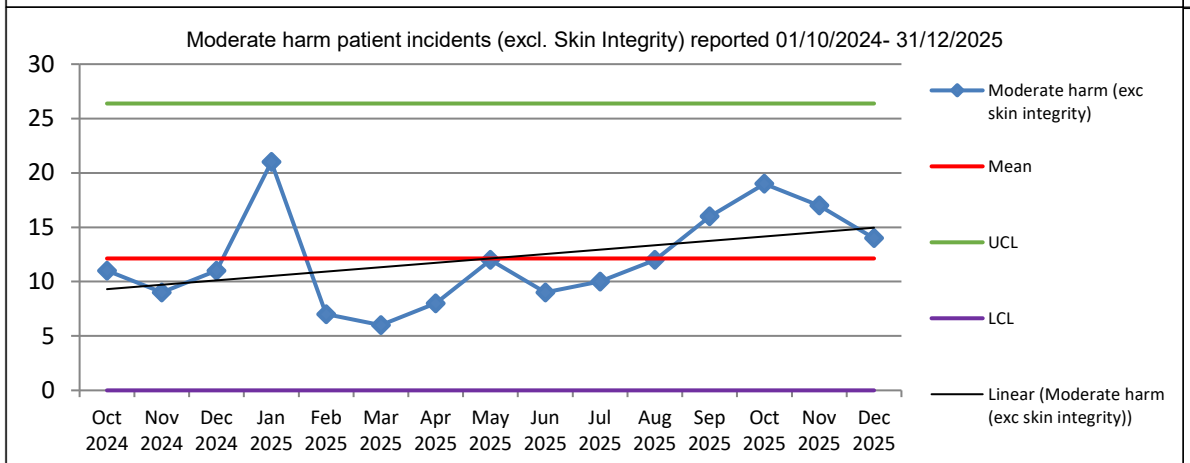


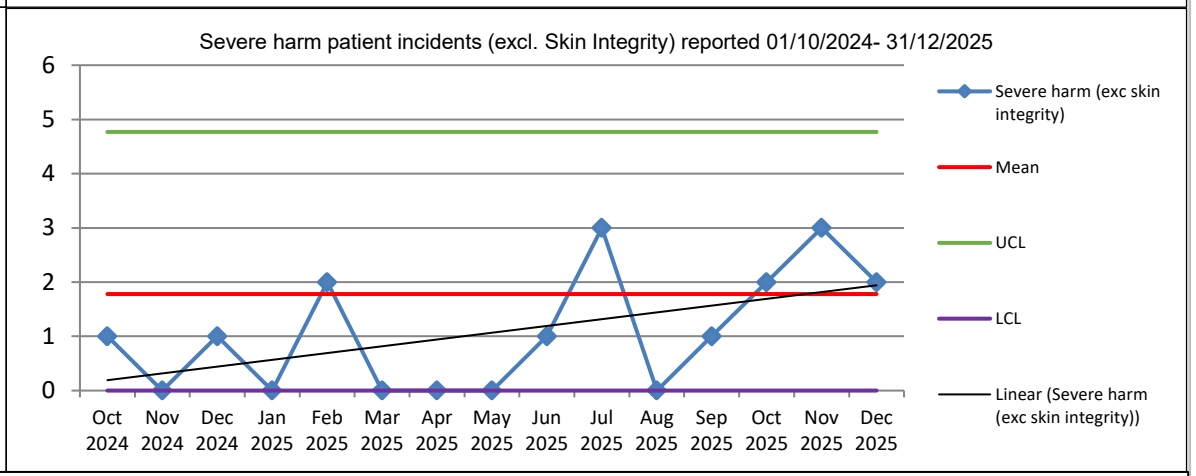
	Verbal notification requirements have been met and documented in clinical record	Written notification requirements have been met, detailed in the Duty of Candour letter and uploaded to the clinical and/or Datix records	Duty of Candour applies but no notifications (either verbal or written) recorded as of 02/12/2025
Nov-25	14	7	4
Dec-25	4	1	6

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







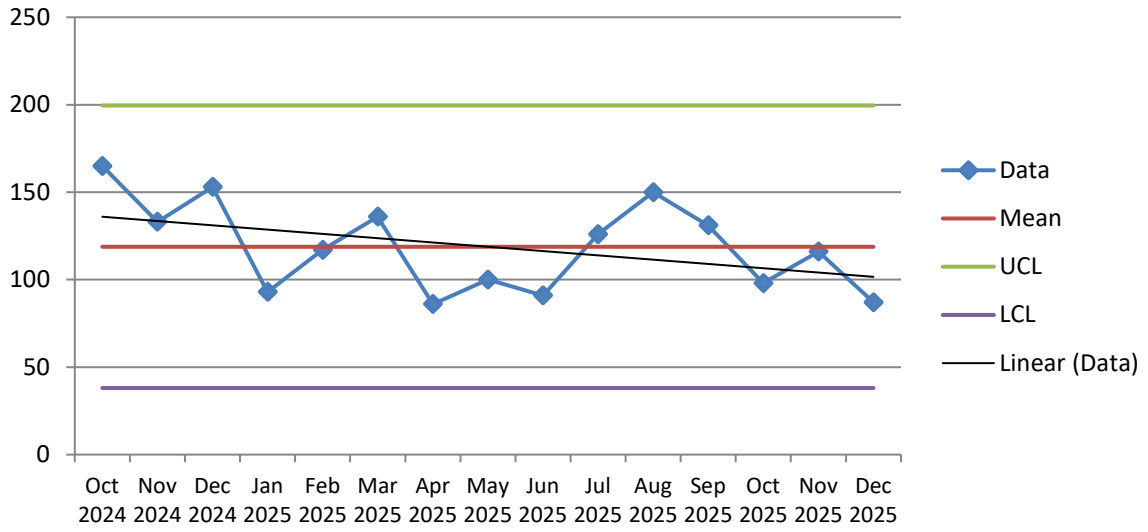


What is the data telling us?

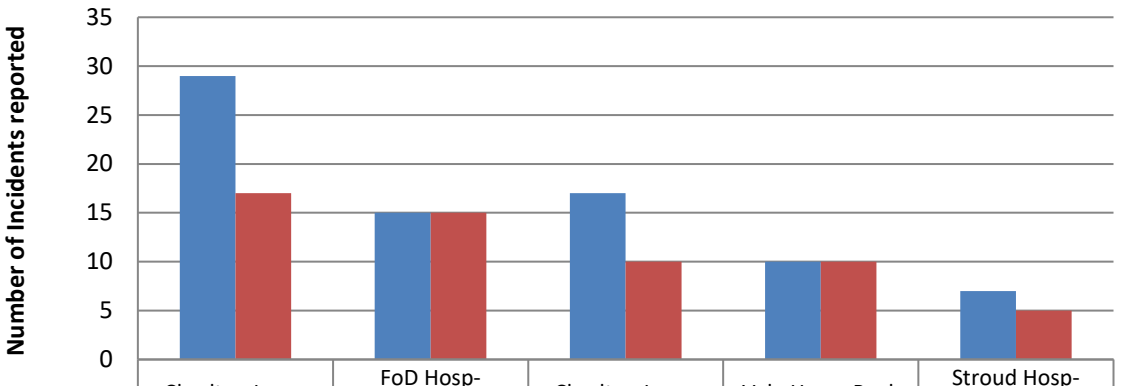
- Whilst December saw the highest number of incidents reported this was only an increase of 2 incidents on the previous month. The number of no harm incidents remained consistent with the previous month with an increase in low harm incidents but reductions in moderate and severe harm incidents. . There are no emerging themes or trends as the activity from our moderate harm incidents as the 14 incidents were across 6 incident categories and 12 teams.
- 1 severe harm incident relates to fall on a community hospital inpatient ward which is under review and the 2nd incident has been shared with GHFT for review as this falls under their regulated activity.
- There were 6 deaths reported in December - 2 were suspected suicides and 4 were unexpected. These are being reviewed in line with usual processes.

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

All Inpatient falls 01/10/2024-31/12/2025



All Inpatient falls - 5 highest reporting wards 01/11/2025-31/12/2025



	Charlton Lane-Willow Ward	FoD Hosp-Woodland View Ward	Charlton Lane-Chestnut Ward	Vale Hosp- Peak View Ward	Stroud Hosp-Cashes Green Ward
Nov 2025	29	15	17	10	7
Dec 2025	17	15	10	10	5

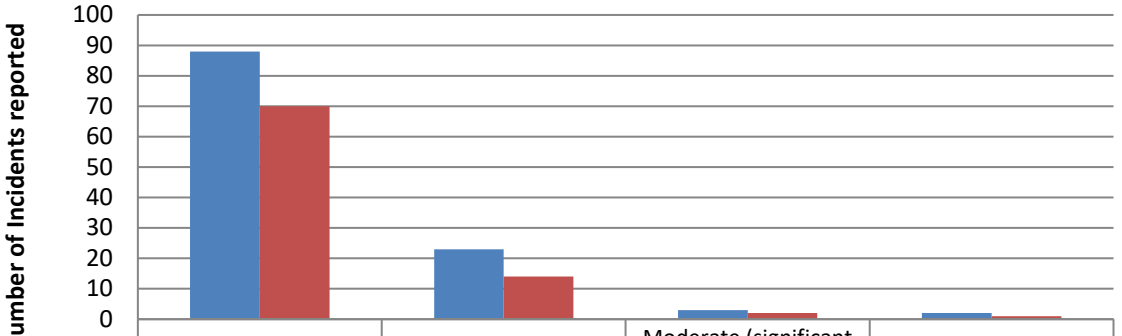
What is the data telling us:

- We continue to see a downward trend in the number of falls incidents reported in our inpatient settings.
- In December, 87 incidents were reported which is a reduction of 29 on the previous months data. The is the second lowest figure of falls in the last 15 months.
- 97% of the falls were no or low harm falls.
- The remaining 3% of falls are being initially being reviewed utilising our inpatient falls risk mitigation tool. If assurance is not provided via this tool we will undertake a further learning response.

What are we doing about the data:

- A review of incident data has identified a trend indicating that a proportion of falls on Woodland View Ward occur between 4 and 8pm. In response, a review of current practices will be undertaken.
- Scoping work has been completed in the community hospitals in relation to the use of fall sensors. Charlton Lane Hospital is currently trialling new floor sensors, with the intention of rolling these out across the hospital. The Falls Group has identified that a range of sensor options would be beneficial.

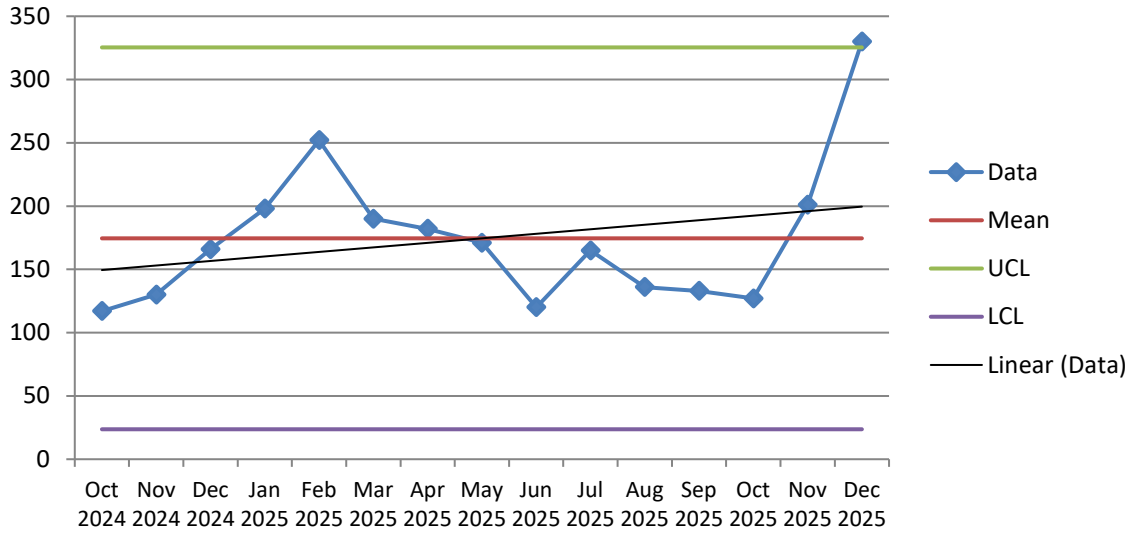
All Inpatient falls by overall severity 01/11/2025-31/12/2025



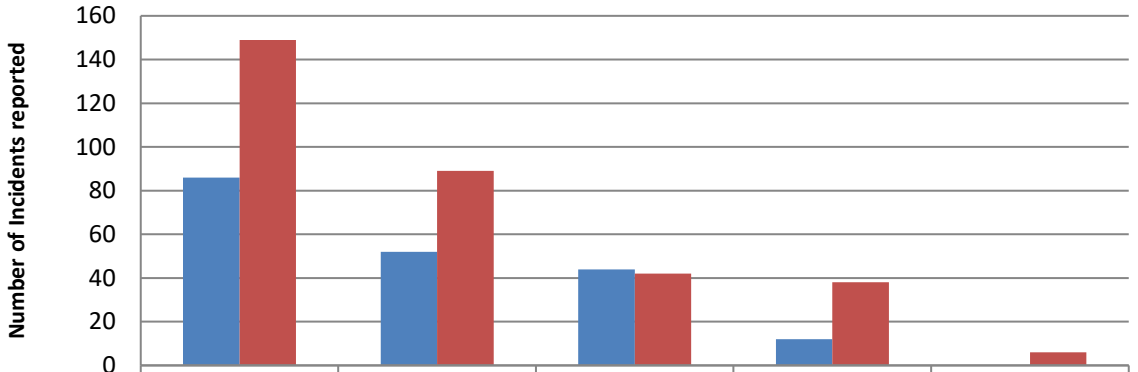
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)
Nov 2025	88	23	3	2
Dec 2025	70	14	2	1

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

Self harm or self injurious behaviour (SIB) incidents 01/10/2024 - 31/12/2025



Self harm/self injurious behaviour (SIB) incidents - 5 highest reporting teams
01/11/2025 - 31/12/2025

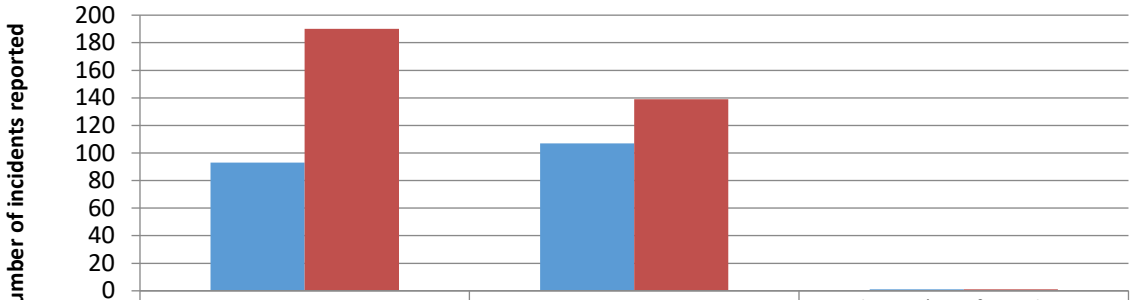


	Wotton Lawn- Priory Ward	Wotton Lawn- Abbey Ward	LD Inpatients - Berkeley House	Wotton Lawn- Dean Ward	Wotton Lawn- Greyfriars PICU
Nov 2025	86	52	44	12	0
Dec 2025	149	89	42	38	6

What is the data telling us?

- There has been a notable increase in the number of incidents reported in December 2025 with a total of 330 incidents reported. These incidents have involved 24 patients, with 12 individuals accounting for 94% of incidents. These 12 individuals have had 10 or more incidents of self-harm or self-injurious behaviour in the month.
- Last month we observed an increase in ligature incidents, for December 99 of the 330 reported incidents in this category were related to ligatures being tied with 6 being reported as fixed ligatures. In line with our revised ligature management processes a dynamic risk assessment was undertaken regarding the known fixed ligature point and we are assured that the outcome of this has been shared with Wotton Lawn staff and appropriate support is in place for teams.
- Whilst there has been 99 incident reports relating to ligatures, the Datix system allows staff to report more than 1 ligature incident on the form taking the figure to 158 ligature incidents.
- The increase in incidents continues to reflect the patient population at Wotton Lawn with several individuals experiencing distress and having complex emotional needs.
- It is important to reflect that whilst there has been an increase in reporting in this category, 99.7% of incidents have been no or low harm.

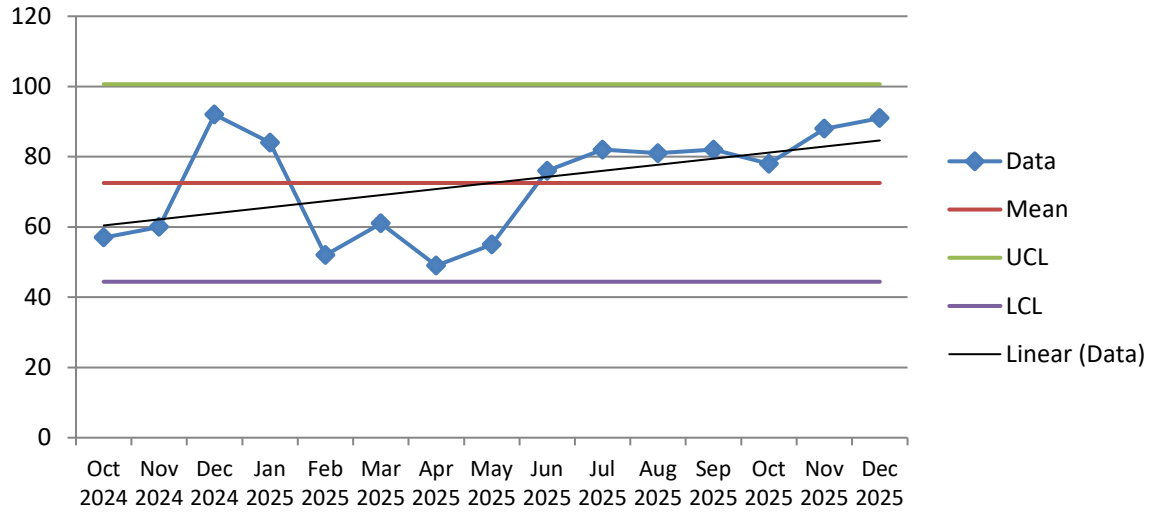
Self harm/self injurious behaviour (SIB) incidents by overall severity
01/11/2025 - 31/12/2025



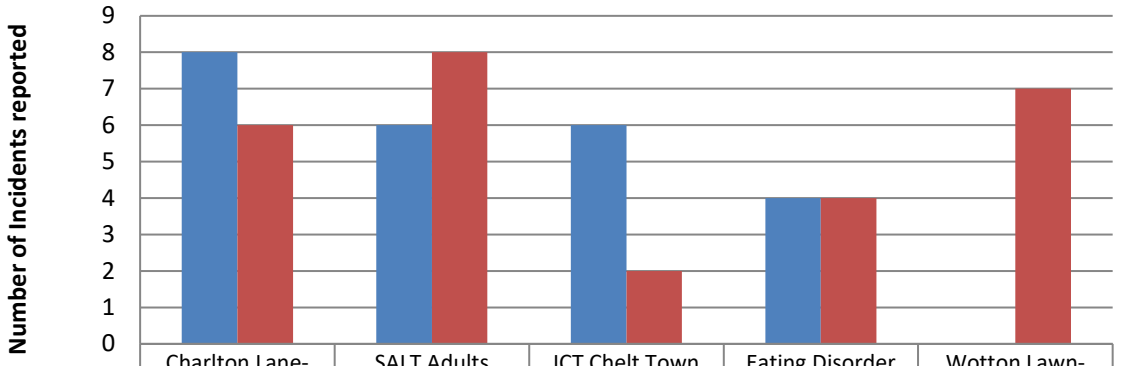
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)
Nov 2025	93	107	1
Dec 2025	190	139	1

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

Clinical care, treatments and procedure incidents 01/10/2024 - 31/12/2025



Clinical care, treatments and procedure incidents – 5 highest reporting teams 01/11/2025 - 31/12/2025



	Charlton Lane-Willow Ward	SALT Adults Physical Health	ICT Chelt Town Centre DN	Eating Disorder Community	Wotton Lawn-ECT Suite
Nov 2025	8	6	6	4	0
Dec 2025	6	8	2	4	7

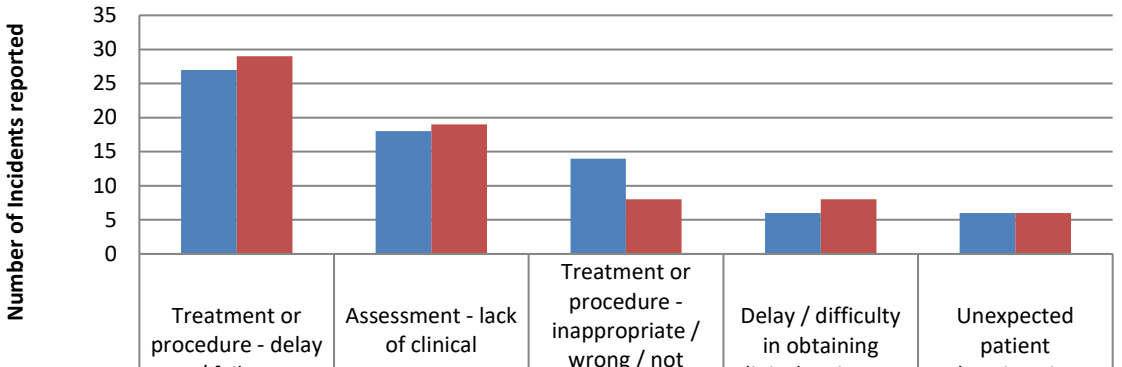
What is the data telling us:

- In December we had 91 incidents reported in this category and whilst the graph on the right shows the top 5 reporting teams it is important to note that this category has been used by 42 teams this month.
- This category is predominantly being used to report both GHC and other organisations delays in treatment and procedures by teams.
- We have observed an increase *in ECT suite incidents in December. This is due to 7 patients* having ECT treatment cancellations “due to staff shortages, namely the lack of an ODP”. In December these were reported as 7 separate incidents however in previous months just 1 incident has been reported for multiple patients. All incidents have been reviewed by the nominated handler, and a successful recruitment programme has been undertaken to mitigate the risk of this happening again in the future.
- 95.6% of these incidents were no or low harm, where moderate or severe harm has been reported this will be managed as per PST processes.

What are we doing about the data:

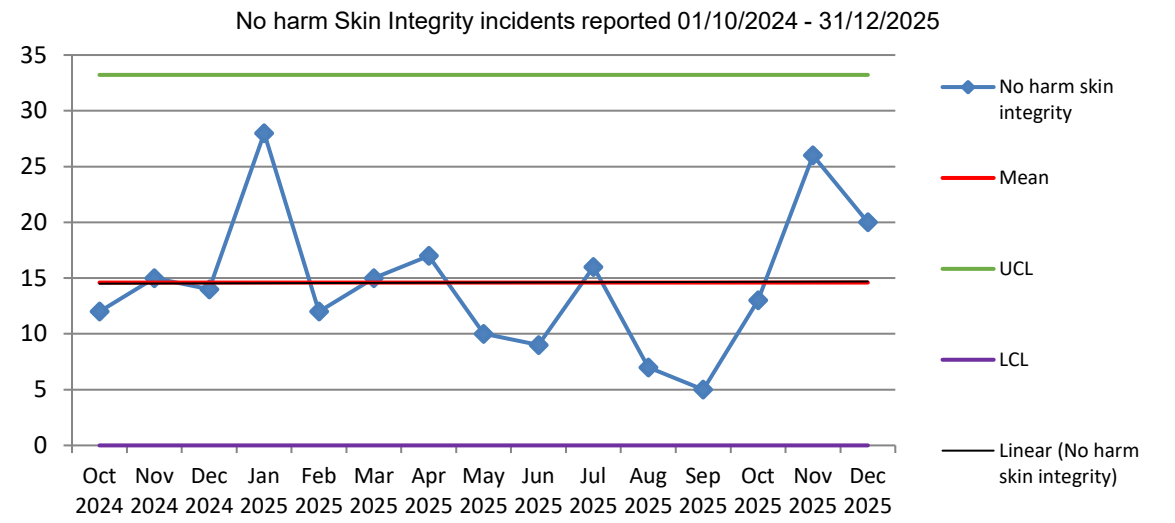
- We have recognised in previous reports that this category overlaps other category types and themes of incidents may be spread across multiple categories. We have identified that this was due to National Reporting Learning System (NRLS) reporting which is no longer in place. The Datix team will be undertaking a piece of work to consolidate the categories to improve in our reporting and data analysis.

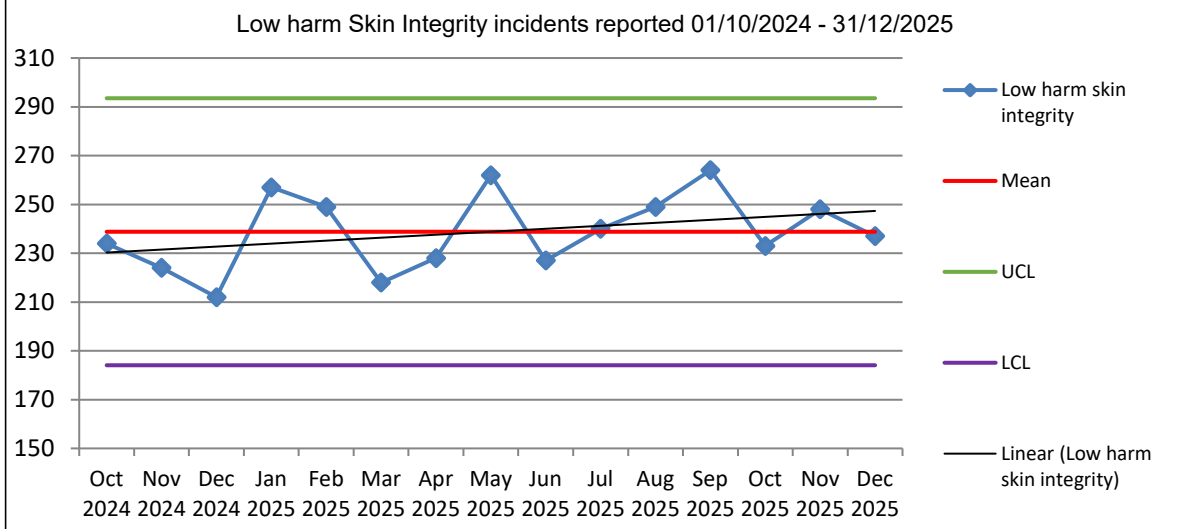
Clinical care, treatments and procedure incidents by top 5 sub categories - 01/11/2025-31/12/2025

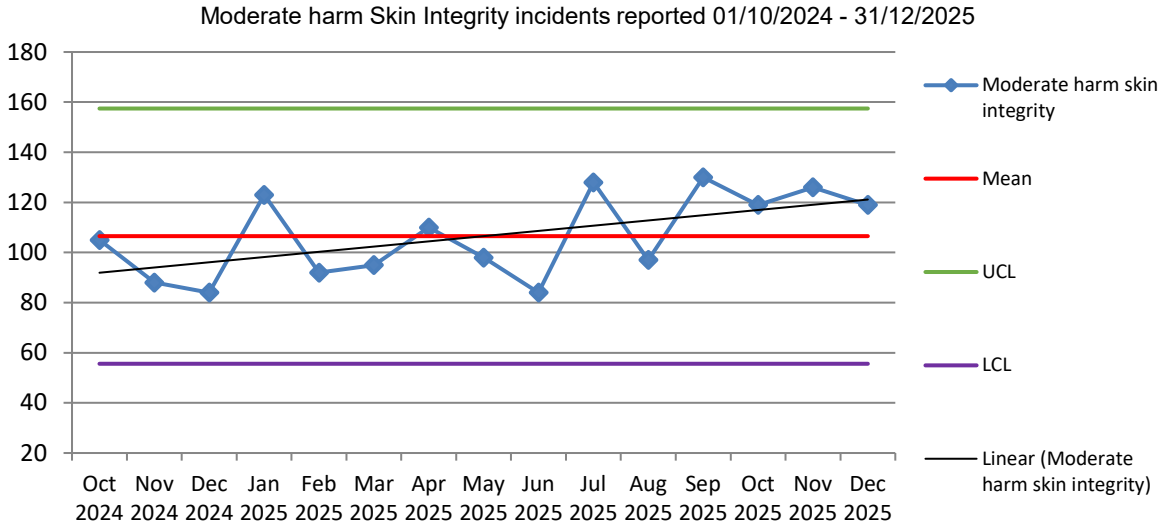


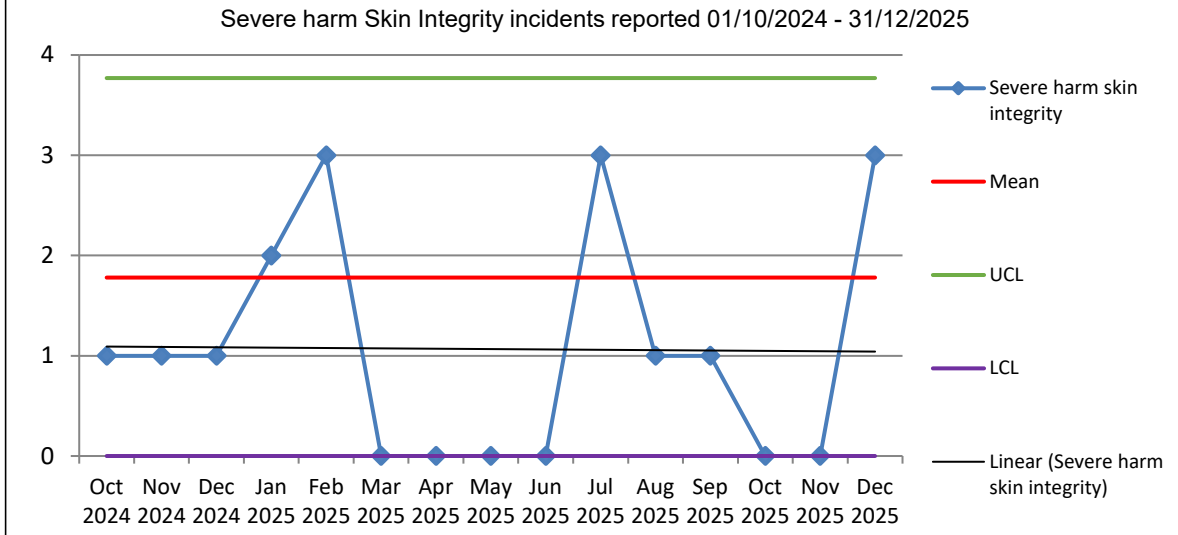
	Treatment or procedure - delay / failure	Assessment - lack of clinical assessment	Treatment or procedure - inappropriate / wrong / not clinically indicated	Delay / difficulty in obtaining clinical assistance	Unexpected patient deterioration
Nov 2025	27	18	14	6	6
Dec 2025	29	19	8	8	6

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



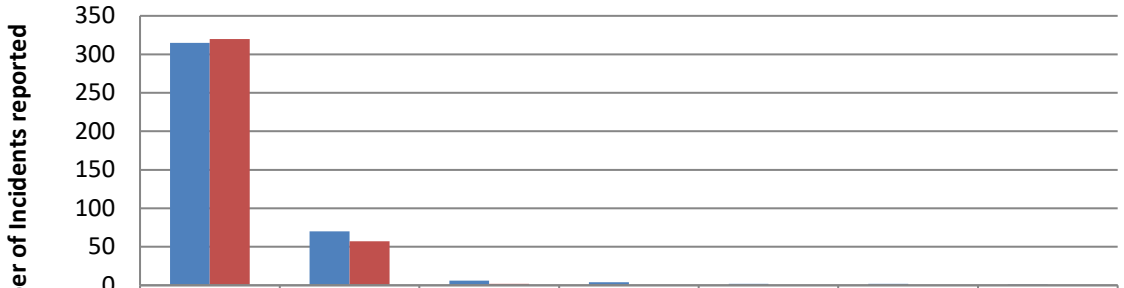






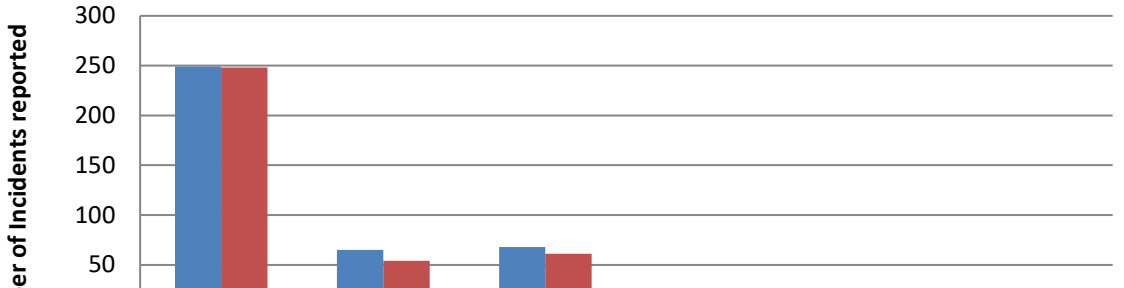
CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data – Skin Integrity

Skin Integrity incidents by Service Type
01/11/2025 - 31/12/2025



	Adult Community Physical Health	Hospitals Physical Health	Inpatient Mental Health & LD	Adult Comm Mgmt & Admin	CW Specialist Services	CYPS Physical Health	Urgent Care Physical Health
Nov 2025	315	70	6	4	2	2	1
Dec 2025	320	57	2	0	0	0	0

Skin Integrity Incidents by Patient Location
01/11/2025 - 31/12/2025

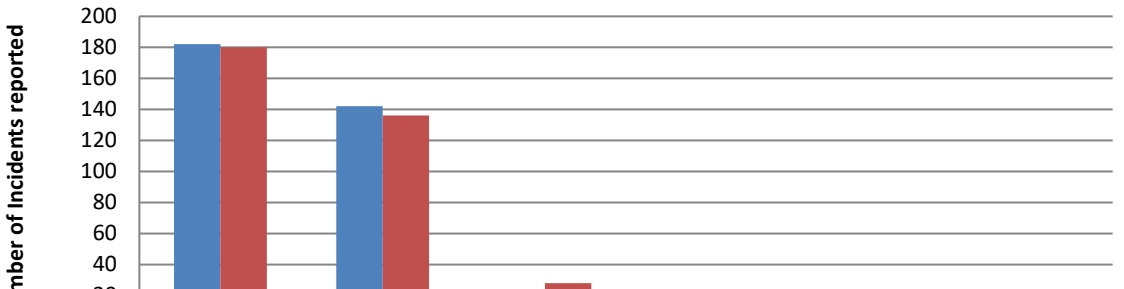


	Patient's own home	Residential care or Nursing home	Community Hospital Ward	GHFT Acute Hospital	MH Inpatient Ward	Other
Nov 2025	249	65	68	8	6	4
Dec 2025	248	54	61	12	2	2

What is the data telling us:

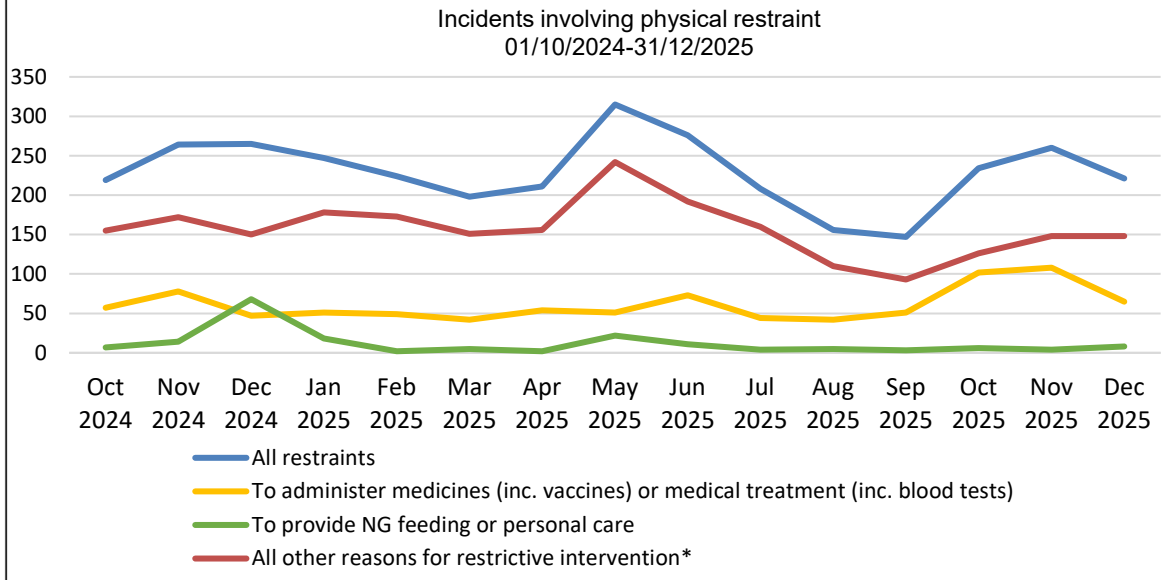
- There were a total of 379 skin integrity incidents reported across the trust with an observed reductions in no harm, low harm and moderate harm incidents. There were 3 severe harm incidents reported in the month.
- 288 individuals were connected to these incidents with 60 individuals having 2 or more skin integrity incidents reported. They account for 39% of all reported skin integrity incidents.
- 316 of these incidents were reported as pressure ulcers (all categories), with 43% (36) being present before admission to the trust.
- 65% of skin integrity incidents were for individuals living in their own home and a further 14% for individuals in residential or nursing homes.
- 16% of skin integrity incidents occurred within our inpatient settings.
- There is Executive oversight in place on the pressures across community nursing services, daily management assurance and the development of an improvement plan. A verbal update on these pressures was provided by the Chief Operating Officer to recent Resources Committee and Quality Committees. This is reflected in a new risk coming onto the risk register with an anticipated score of 16.

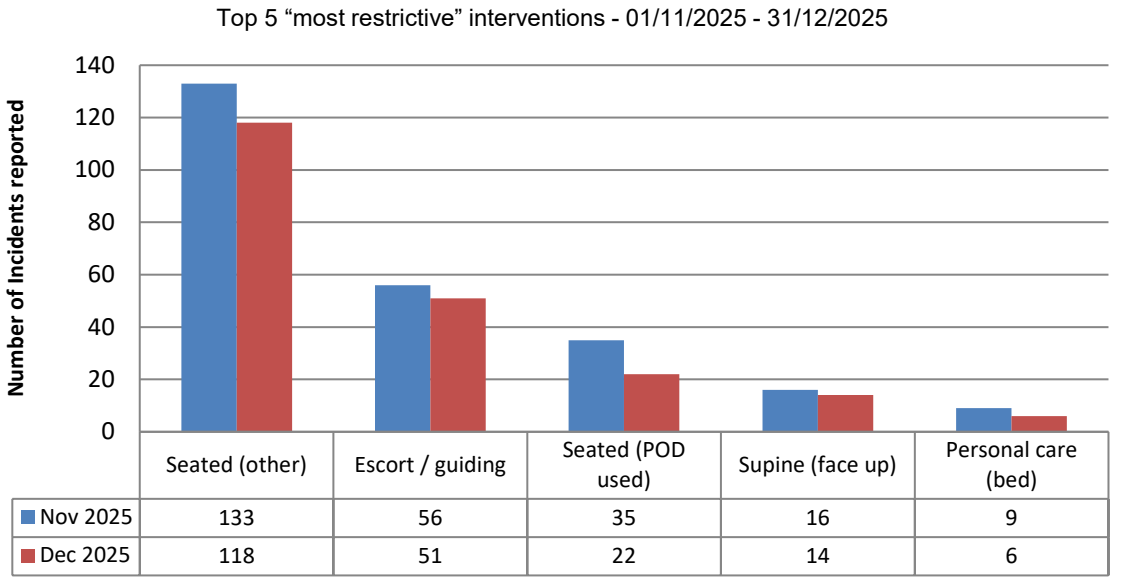
Skin Integrity Incidents by Sub-categories (grouped)
01/11/2025-31/12/2025



	PU developed or worsened during care by this Trust	PU present before admission to this Trust	MASD developed during care by this Trust	MASD present before admission to this Trust	EOL - SCALE	Other
Nov 2025	182	142	21	11	20	24
Dec 2025	180	136	28	12	7	16

Incidents involving restraint

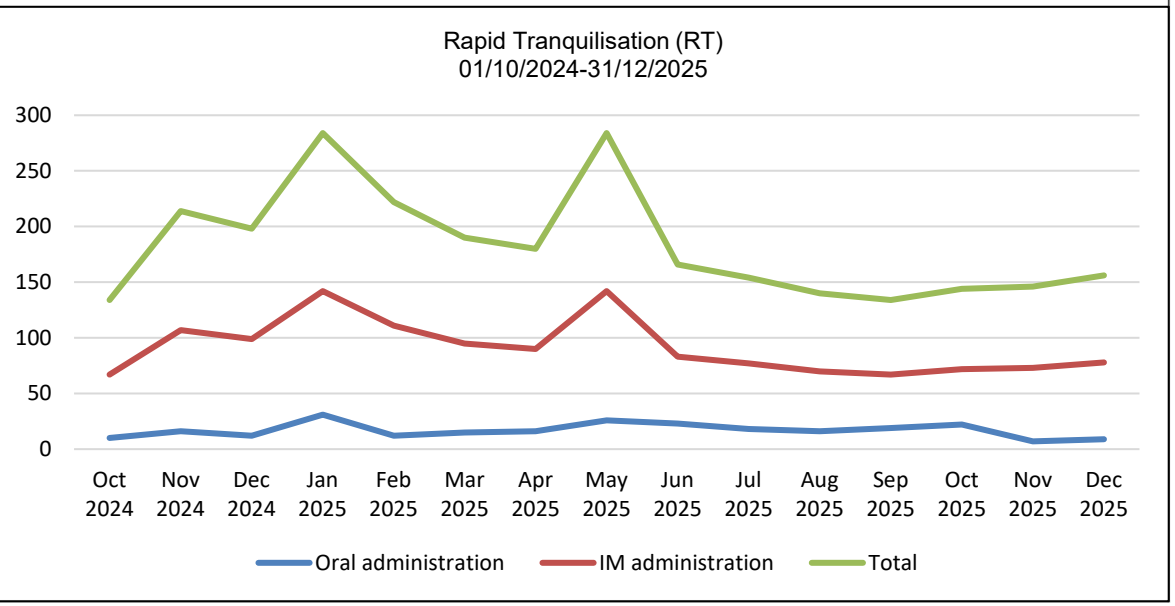




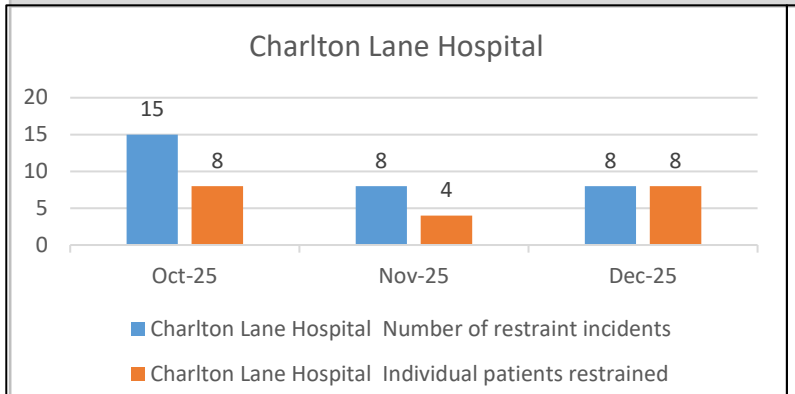
	Seated (other)	Escort / guiding	Seated (POD used)	Supine (face up)	Personal care (bed)
Nov 2025	133	56	35	16	9
Dec 2025	118	51	22	14	6

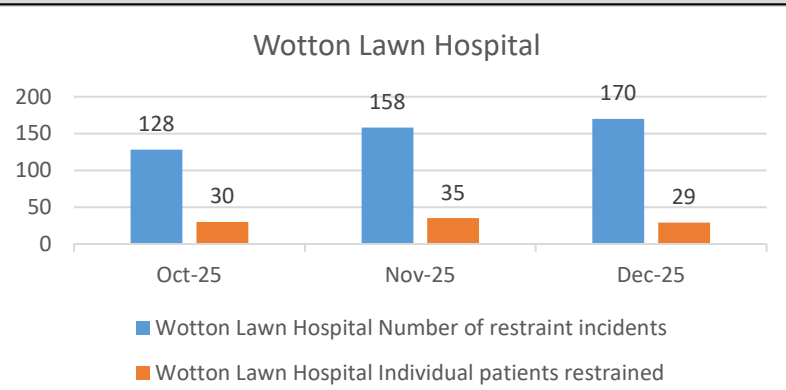
What is the data telling us:

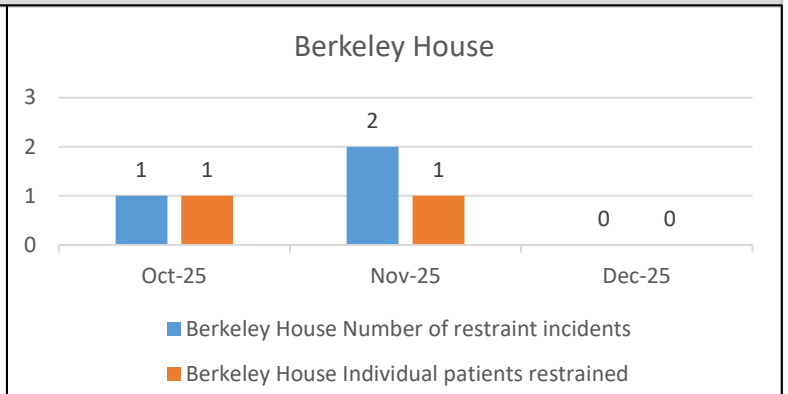
- In December there were a total of 221 incidents involving physical restraint at the trust. This is a slight reduction in the last 3 months. This reduction was expected in line with the end of the seasonal vaccine programme.
- Whilst we may expect to see a correlation between our levels of self harm and restrictive interventions, our data on Datix does not provide this information accurately enough as staff can choose to report as 1 incident or 2 different incidents. There were a total of just 20 incidents where both categories were selected. There is work underway with BI colleagues to understand how data can be more meaningfully brought together in tableau dashboards to provide greater understanding and assurance.
- We continue to see that preventing violence to others, preventing harm to themselves and the lawful administration of medication as the main reasons for restrictive interventions.
- Our figures relating to rapid tranquilisation remain consistent with previous 6 months.
- We continue to see the pattern of seated restrictive interventions and escort/ guiding being our most frequently reported type of intervention. These are lesser restrictive interventions.

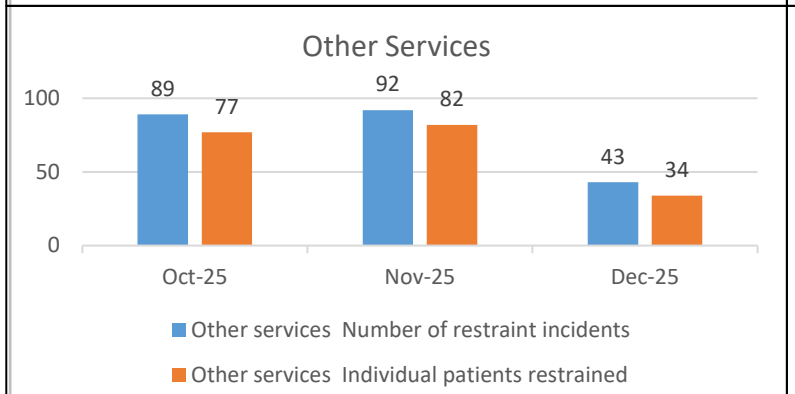


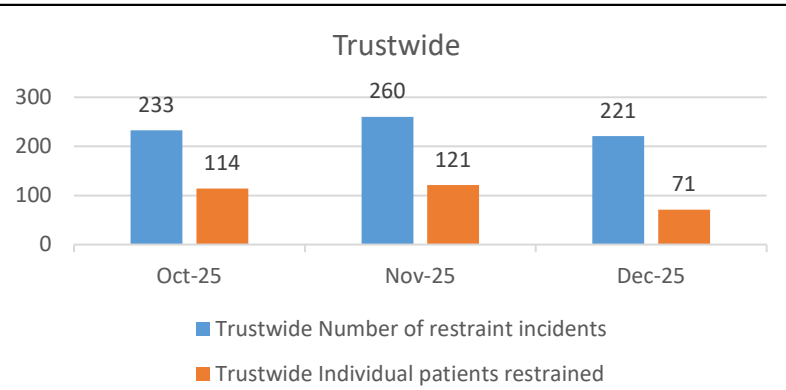
Incidents involving restraint – individual patients restrained

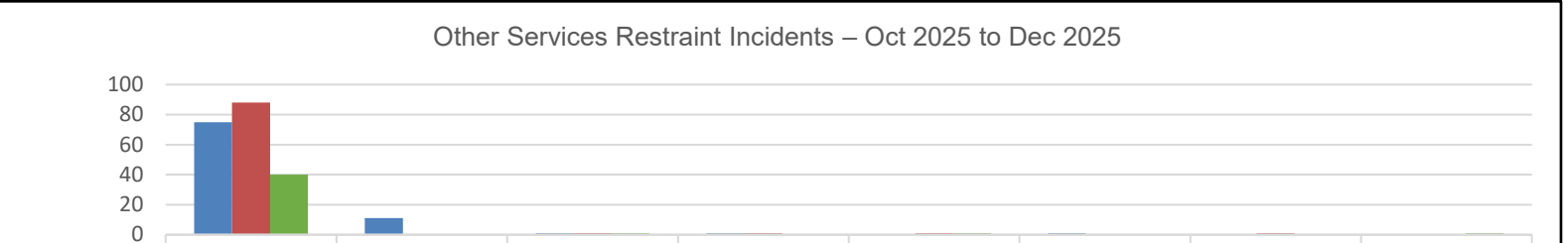












	LD IHOT	CAMHS Learning Disability	CRHT Liaison s135 s136	CRHT West Glos	LDISS	Montpellier Low Secure Unit	MH Community Physio	Recovery Gloucester
Oct 2025	75	11	1	1	0	1	0	0
Nov 2025	88	0	1	1	1	0	1	0
Dec 2025	40	0	1	0	1	0	0	1

What is the data telling us?

In December 2025 43 restraint incident were reported across the other services of:

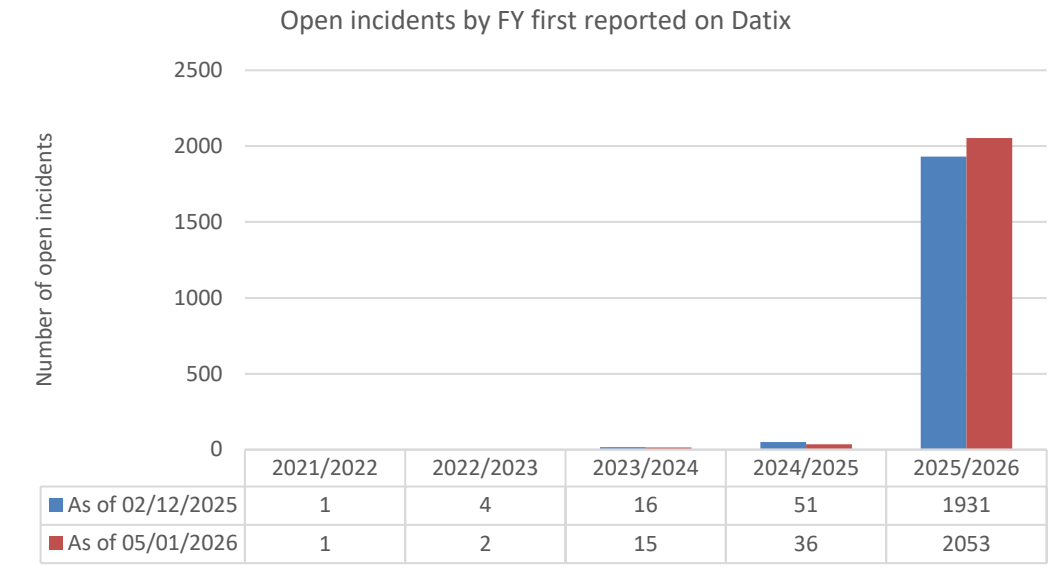
- LD IHOT (40),
- Recovery Gloucester (1),
- CRHT Liaison s135 s136 (1)
- LDISS (1).

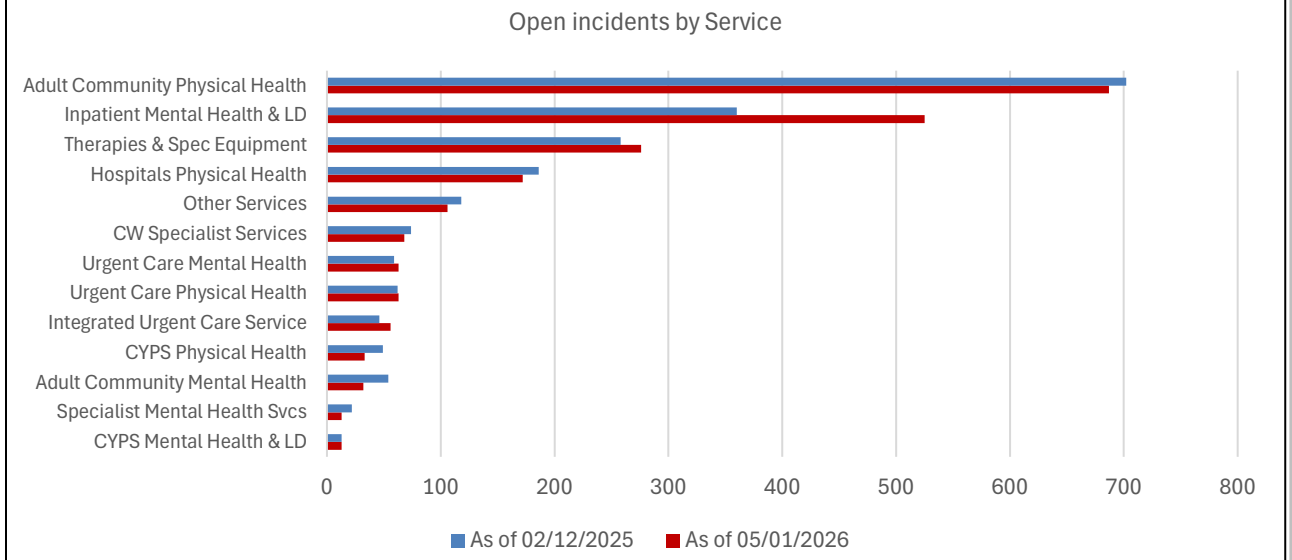
These involved:

- 31 patients in LD IHOT,
- 1 patients in Recovery Gloucester,
- 1 patient in CRHT Liaison s135 s136
- 1 patient in LDISS.

In December we have seen the predicted reduction in reported incidents by our LDIHOT due to the completion of seasonal vaccines.

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





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 continue to be seen in the Adult Community Physical Health Directorate; it is important to reflect that these services are our highest reporters of incidents, and we are aware that there are ongoing challenges with capacity and demand for our ICT nursing teams which will be impacting their ability to review and close incidents. Opportunities to support colleagues in closing these incidents are being explored.
- The Datix team have now also introduced monthly reminders where incidents do remain open.

Open incidents (awaiting review/being reviewed) as of 05/01/2026 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	3	684	687
Inpatient Mental Health & LD	0	0	0	5	520	525
Therapies & Spec Equipment	0	0	0	1	275	276
Hospitals Physical Health	0	0	0	0	172	172
CW Specialist Services	0	0	0	1	67	68
Urgent Care Mental Health	0	0	0	4	59	63
Urgent Care Physical Health	0	0	0	1	62	63
Integrated Urgent Care Service	0	0	0	0	56	56
CYPS Physical Health	0	0	0	0	33	33
Adult Community Mental Health	0	0	0	4	28	32
Specialist Mental Health Svcs	0	0	0	1	12	13
CYPS Mental Health & LD	0	0	0	0	13	13
Other Services	1	2	15	16	72	106
Total	**1**	**2**	**15**	**36**	**2053**	**2107**

Safe Staffing – Mental Health & LD and Physical Health Inpatient Data

The Deputy Director of NTQ chairs a monthly assurance meeting to review all inpatient Nursing workforce staffing reports in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing as set out by NHSE. The meeting seeks assurance that arrangements are in place to safely staff our inpatient wards with the right number of Nurses with the right skills, at the right time. Our rota fill rates are good which means most scheduled shifts have the required staff in place, so staffing gaps are minimal. Our CHPPD (care hours per patient per day) for September (as reported in national tables) reports the Trusts position is 8.2 against a peer value of 10.6, this places us in the lower half of Trusts across England for CHPPD within the Model Hospital (NHS benchmarking tool that allows trusts to compare their performance against peers). In essence Staffing levels are being filled as planned, but the amount of nursing care time per patient is lower than most comparable trusts, which could indicate efficiency or potential pressure on staff. However, this metric does not recognise the care that is provided by other members of the multi-disciplinary team such as Therapists, Exercise and Activity practitioners and therefore needs to be triangulated with other data and information sources to fully understand. This work is planned within the Trust as the wider safe staffing work matures. Whilst acknowledging that we have utilised bank and agency to support short term absence, our Heads of Profession have maintained oversight of services and the increase in falls and self injury have no correlation with this use and largely reflect increase in acuity and patient complexity.

Mental Health & LD					
Ward	**Average fill rate - Registered Nurses/Midwives (%)**	**Average fill rate - Non-registered Nurses/Midwives (care staff) (%)**	**Average fill rate - Registered Nurses/Midwives (care staff) (%)**	**Average fill rate - Non-registered Nurses/Midwives (care staff) (%)**	**CHPPD (Care Hours per patient per day) overall**
	Day	Day	Night	Night	
Dean Ward	89	125	100	252	10.4
Abbey Ward	100	205	95	352	9.2
Priory Ward	101	208	113	319	9.2
Kingsholm Ward	99	122	92	139	7.8
Montpellier	106	111	105	97	11.6
PICU/Greyfriars Ward	94	127	105	135	15.9
Willow Ward	101	104	100	101	9.4
Chestnut Ward	106	100	100	103	7.4
Mulberry Ward	100	98	100	102	6.4
Laurel House	102	96	90	100	5.7
Honeybourne Unit	98	104	100	103	5.8
Berkeley House	50	136	102	127	78.8

Physical Health					
Ward	**Average fill rate - Registered Nurses/Midwives (%)**	**Average fill rate - Non-registered Nurses/Midwives (care staff) (%)**	**Average fill rate - Registered Nurses/Midwives (care staff) (%)**	**Average fill rate - Non-registered Nurses/Midwives (care staff) (%)**	**CHPPD (Care Hours per patient per day) overall**
	Day	Day	Night	Night	
Coln (Cirencester)	88	93	102	88	7.9
Windrush (Cirencester)	-	-	-	-	-
Thames (Cirencester)	103	97	100	102	19.8
Forest Of Dean Community Hospital	115	100	111	110	8.2
North Cotswolds	102	101	94	113	8.2
Cashes Green (Stroud)	105	103	100	123	6.3
Jubilee (Stroud)	111	109	108	126	9.8
Abbey View (Tewkesbury)	107	94	108	135	9.2
Peak View (Vale)	97	107	101	126	10.4

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	2	1			
Influenza	20		0	0	0	0	0	0	0	0	1			
Norovirus	35		10	0	0	0	0	0	0	8	0			
COVID-19 HODA	9		10	0	0	0	0	1	4	0	2			
COVID-19 HOHA	1		3	0	0	0	0	0	0	0	0			
Gram-Negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)	0		0	0	0	0	0	0	0	0	0			
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0			
MSSA Bacteraemia	0		0	0	0	0	0	0	0	0	0			
Outbreaks	8		1	0	0	0	0	0	1	1	0			
Hand Hygiene overall compliance	94%	90%	97%	92%	99%	97%	93%	99%	99%	96%	99%			
Mandatory IPC Training: Clinical	92%	90%			93%	93%	92%	93%	93%	94%	93%			
Mandatory IPC Training: Non-clinical	98%	90%			98%	98%	98%	98%	98%	98%	98%			
Cleanliness FFT "Was the ward clean?"			98%	99%	100%		94%	98%	97%	95%	100%			

Cleanliness – 2025/26

06/10/25 – 29/12/25

13 Weeks Report

GHC		3rd Party	
Compliant	156	Compliant	25
Non-compliant	0	Non-compliant	0
TOTAL	156	TOTAL	25

FR	Target score	Actual score average	FR	Target score	Actual score average
FR1	98%	99.17%	FR1	98%	N/A
FR2	95%	98.33%	FR2	95%	N/A
FR3	90%	98.38%	FR3	90%	95.98%
FR4	85%	97.48%	FR4	85%	94.75%
Total average score		98.34%	Total average score		95.36%

INFECTION PREVENTION CONTROL

- No outbreaks in December. The cases of COVID-19 were on different wards (1 case on Coln Ward, Cirencester and 1 on Cashes Green Ward, Stroud). *C.diff* case was on Woodland View Ward (Forest of Dean) where the patient tested positive for *C.diff* following transfer from GHNHSFT. Effective management and limited nosocomial transmission provides good assurance that IPC policies are being adhered to
- Flu rates nationally remain higher than last year, 1 case of hospital acquired flu in the Trust in December
- Good assurance from Hand Hygiene audits, audits received from all areas in December
- Universal masking in some areas of GHC is in place, IPC review on a weekly/ad-hoc basis, as of now remains in place

CLEANLINESS

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

Quality Dashboard

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. Reported figures are cumulative.

NHS Gloucestershire Health and Care NHS Foundation Trust

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%)	2035 (47.3%)	2219 (51.6%)			
Flu - GHC all non-bank staff	48.2%	-	50.8%	1445 (27.6%)	2550 (48.5%)	2767 (52.6%)			
Flu - Other healthcare staff	373	-		144	212	227			
Flu – GHC inpatients	362	-		136	175	208			
Flu - Care home residents	27	-		4	13	13			
Flu - Housebound	69	-		0	0	35			
Covid - GHC IMMFORM staff	32.9%	-	N/A	-	-	-	-	-	-
Covid - Other healthcare staff	279	-	N/A	-	-	-	-	-	-
Covid - GHC inpatients	351	165		95	110	135			
Covid – Outreach	74	180		0	35	57			
Covid - Care home residents	27	196^		0	2	2			
Covid - Housebound	50	5^		0	0	36			
DTP - Asylum seekers	-	209*		9	23	23			
MMR - Asylum seekers	-	172*		8	20	20			
MenACWY - Asylum seekers	-	New		0	0	0			

National Average	56.88% Covid	52.74% Flu
SW Region Average	66.98%	61.50%
NHS Bath And North East Somerset, Swindon And Wiltshire Integrated Care Board	69.11%	62.92%
NHS Bristol, North Somerset And South Gloucestershire Integrated Care Board	67.41%	58.56%
NHS Cornwall And The Isles Of Scilly Integrated Care Board	64.49%	58.41%
NHS Devon Integrated Care Board	66.96%	61.67%
NHS Dorset Integrated Care Board	66.30%	60.48%
NHS Gloucestershire Integrated Care Board	69.02%	64.73%
NHS Somerset Integrated Care Board	64.97%	64.36%

What the data is telling us
Overview of uptake of GHC staff for flu vaccines and summary of National Vaccinations Programmes (NVPs) administered by GHC teams. Seasonal flu and Covid NVPs commenced 01/10/25.

What are we going to do about it
Continue to provide opportunities to increase vaccine uptake for eligible cohorts.

Are there any risks
Uncertainty of commissioning arrangements for Outreach Vaccination and Health Team beyond August 2026. This will have a significant impact/reduction of GHC adult vaccination activity including supporting vaccinations for inpatients and staff.
Change in delivery model of staff flu vaccination, now there is a much greater reliance on peer vaccinators in teams.

King's Fund Report – Approaches to vaccine delivery: Learning from Gloucestershire ICB's Covid-19 vaccine programme, Dec 2025. Gloucestershire was held up as being exemplar for vaccine delivery during the pandemic. The key learning points were:

- Vaccines were delivered locally through GP-led networks and community venues by GHC OVHT, instead of mass-vaccination centres (access was easier, more trusted and more convenient)
- Real-time data helped spot gaps in uptake and guide outreach
- Tailored outreach services, such as pop-up clinics and mobile 'jab vans', along with targeted support and messaging, helped to reach more hesitant groups
- Flexibility and learning from what worked helped adapt delivery

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)
Please note, following year-end data cleanse, some figures may have moved between categories.

	Reporting Level	Threshold	2024/25 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		27,696	2,328	2,509	2,158	1,936	1,213	1,794	2,283	1,885	1,863				17,969	Including 35 responses from carers (86% positive response)
% of respondents indicating a positive experience of our services	N - T	95%	93%	92%	94%	93%	93%	92%	93%	93%	92%	93%				93%	
Number of compliments received in month	L - R		2,830	256	270	256	346	275	217	283	227	227				2,357	As reported on last day of the month, noting compliments can be added retrospectively
Number of enquiries (other contacts) received in month	L - R		1,724	120	128	128	141	140	143	155	136	136				1,227	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		204	23	14	14	22	19	20	22	26	25				185	1 x MHUC/IP, 3 x CYPS, 4 x Community, 2 x CW, 15 x IUC,
Of complaints received in month, how many were early resolution complaints	L - R			23	14	14	21	19	20	22	26	25				184	
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			64	56	47	52	57	47	49	58	57					
Percentage of complaints acknowledged within 3 working days	N - T	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			26	22	23	18	13	31	20	19	25				197	2 x MHUC/IP, 1 x PHUC/IP, 3 x CYPS, 2 x Comm (MH), 3 x CW, 13 x IUCS. 1 x Operational Flow.
Number of complaints closed within 3 months	L - I			23	17	13	11	7	21	13	14	21				140	
Number of re-opened complaints (not all opened within month)	L- R			3	2	2	1	2	3	2	2	2					1 x CYPS, 1 x IUCS.
Number of external reviews (not all opened within month)	L - R			3	6	4	3	4	4	4	4	4					3 x MH UC/IP (including 1 x possible joint LGO) and 1 x CYPS.

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

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

Key Highlights:.

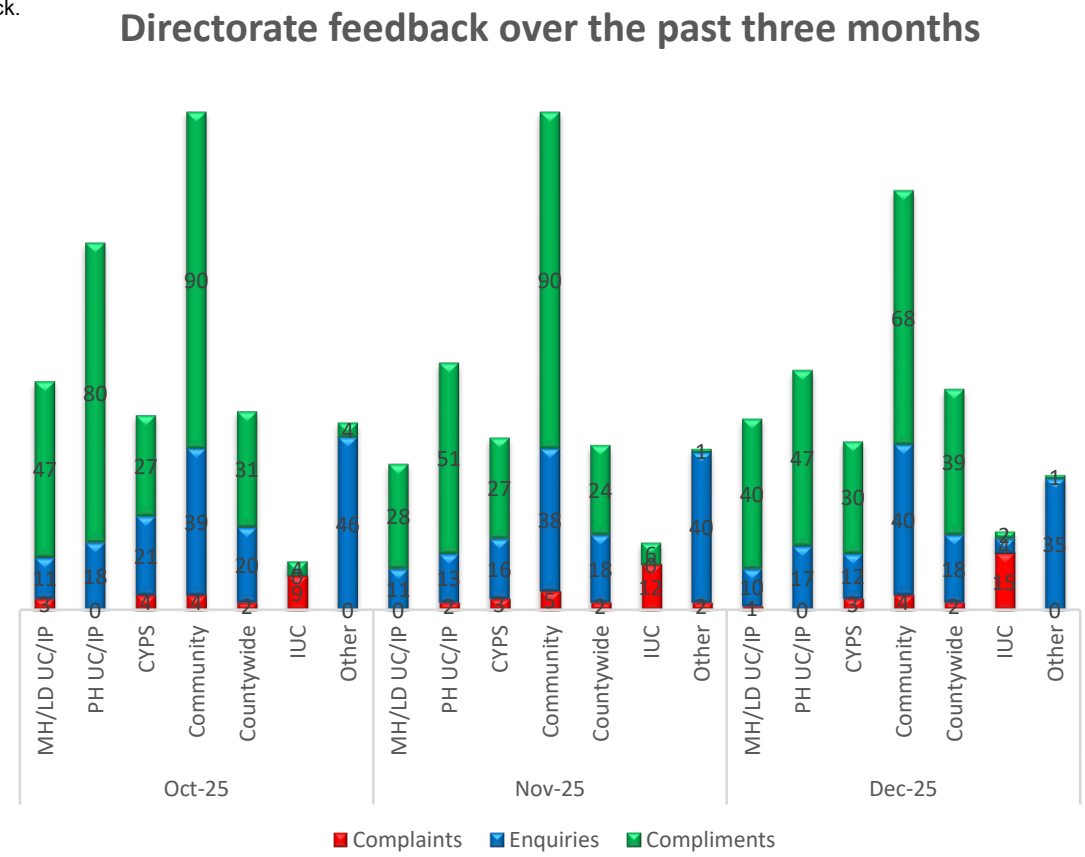
- Complaints received are up 50% YTD on 2024/25 data (124 then against 185 now). This is coming down due to one-year anniversary of IUCS, which accounts for disproportionate number of complaints.
- We continue to see far more compliments than any other type of feedback and directorates now receive a 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	1	Early resolution:	**1**	10	40
		Closer look:	**0**		
PH urgent care and inpatient	0	Early resolution:	**0**	17	47
		Closer look:	**0**		
CYPS	3	Early resolution:	**3**	12	30
		Closer look:	**0**		
PH/MH/LD Community	4	Early resolution:	**4**	40	68
		Closer look:	**0**		
Countywide	2	Early resolution:	**2**	18	39
		Closer look:	**0**		
IUCS	15	Early resolution:	**15**	4	2
		Closer look:	**0**		
Other	0	Early resolution:	**0**	35	1
		Closer look:	**0**		
Totals	25	Early resolution:	**25**	136	227
		Closer look:	**0**		

Examples of complaints [as reported] for each directorate:

- MH UC/IP: Friend of patient unhappy that she was expected to stop patient from self harming and was prevented from leaving the building.
- CYPS: Mother of patient unhappy that a data breach occurred.
- Community: Patient very unhappy with the poor amount of care and support she has received for her mental health.
- Countywide: Patient unhappy that she has just found out that she was fitted with the wrong coil 10 years ago.
- IUCS: Patient unhappy with the attitude of a call handler.



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)

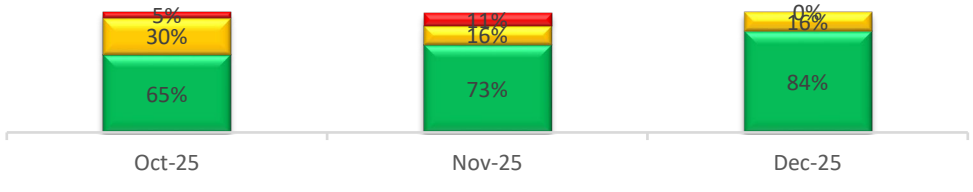
The below table shows all complaints CLOSED this month by outcome and directorate.
These include closer look and early resolution complaints.

Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	1	1	0	0	0	2
PH urgent care, inpatient	0	0	0	0	1	1
CYPS	0	0	3	0	0	3
PH/MH/LD Community	1	0	1	0	0	2
Countywide	0	0	2	0	1	3
IUC	7	2	1	1	2	13
Other	0	0	1	0	0	1
Totals	**9**	**3**	**8**	**1**	**4**	**25**

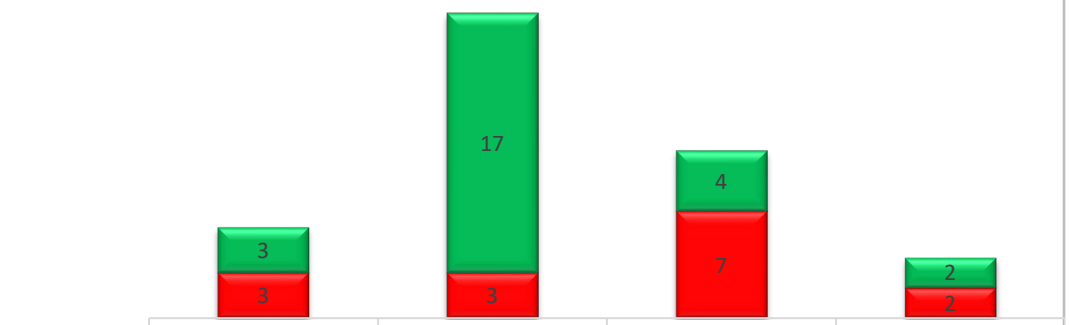
The below table shows some of the upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
MH UC/IP (20936)	Breach of confidentiality when family members raising concerns about a patient. **Values & behaviours**
Community (21209)	Miscommunication and missed opportunities to provide follow up support. **Communication and attitude**
IUCS (21389)	Health advisors should inform patients to contact GP surgery directly when there are no slots available. **Access to treatment or drugs**
IUCS (20703)	Patient unhappy with lack of support or warnings of side effects from the medication given from an OOH GP. **Communication**

The below graph shows the length of time taken to close complaints.
This month, 84**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)
NB: There are 8 x complaints OPEN longer than 3 months



	Oct-25	Nov-25	Dec-25
6-12 months	5%	11%	0%
3-6 months	30%	16%	16%
0-3 months	65%	73%	84%

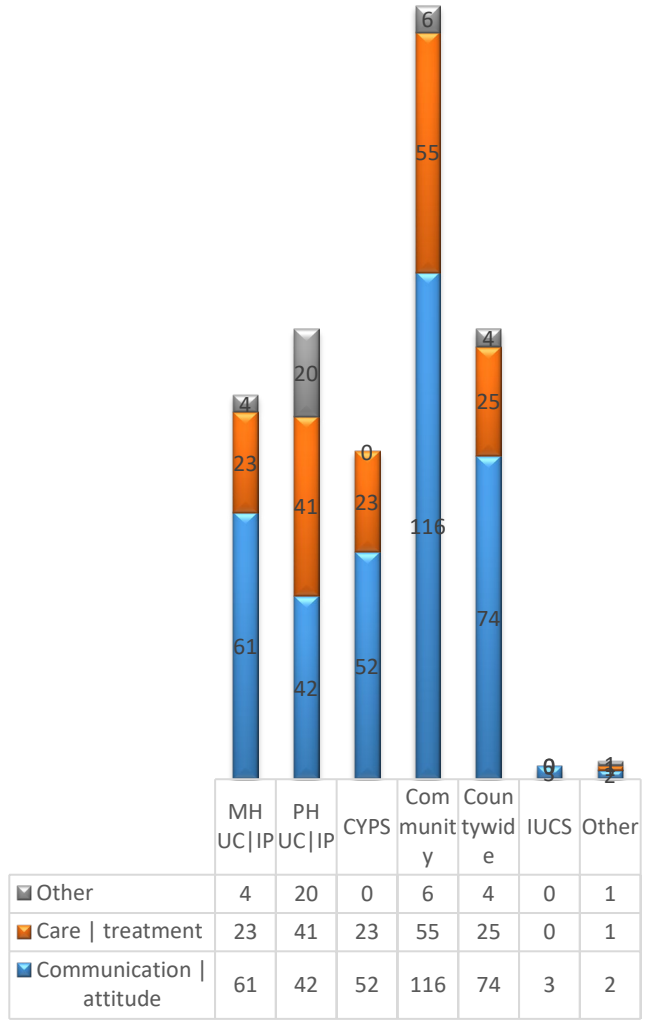


	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	3	17	4	2
Upheld	3	3	7	2

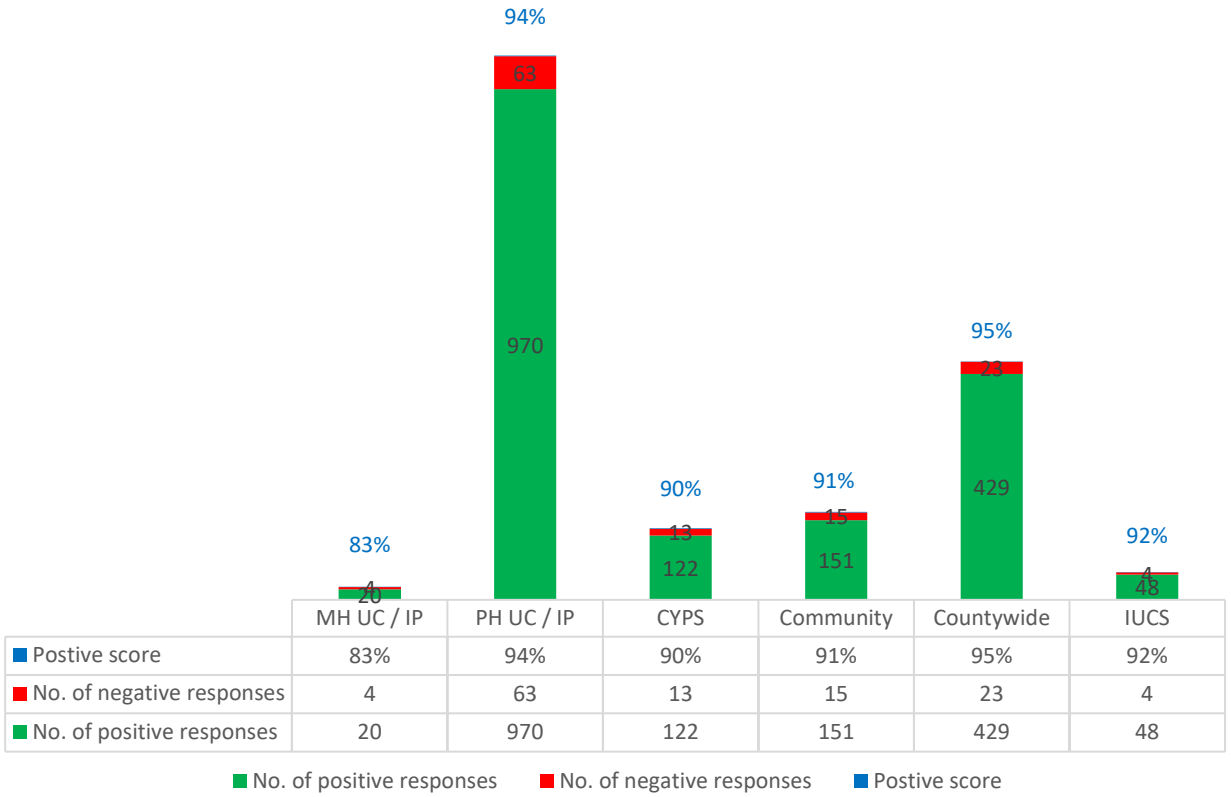
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

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 227 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
16/12/2025	22253	Charlton Lane-Mulberry Ward	This is my first time ever being admitted to an NHS hospital, and I must say it is better than all private stays I have ever had before. Everyone has been amazing, The staff are so helpful.
29/12/2025	22385	MH Contact Centre	During a call the patient shared how amazing the team have been and wanted to thank everyone for the support provided to him
05/12/2025	22092	Tewk Hosp-Abbey View Ward	We would like to thank you so much for the care shown and support for the family during the last few weeks of life.
12/12/2025	22336	IV Therapy Services	"Thank You Card: Thank you all very much to the Home Intravenous Antibiotic Therapy Team. You are all amazing, very kind and do a wonderful job. Thank you also for being so helpful and supportive."
02/12/2025	22033	CYPS PH-ELSEC	"Thank you so much. It was really great to meet you and thank you for being so patient and encouraging with our children. Your input will be very helpful and much appreciated.
09/12/2025	22138	CYPS PH-Childrens SALT	"A parent replied to some advice offered with the following: 'I thank you again for taking the time to reply to me. I appreciate the way you have always understood Xs needs and am very grateful for it.'"
12/12/2025	22214	ICT Cotswold South 1 DN	Routine visit to patient. Patient stated that the last nurse that visited was very kind & caring, and had a gentle approach, which he stated was very reassuring.
23/12/2025	22357	Talking Therapies - North	"Received a thank you card and handmade gift from client at final session. Client reported that the sessions had changed her life, that she no longer feels a 'stupid old woman' and that she would recommend the service to anyone."
31/12/2025	22408	MSK Physio	How brilliant the physio is, very thorough and helpful
04/12/2025	22066	Podiatry	"Thank you for all the trouble i have caused because of my hole! you have been amazing with your expertise and patience "



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

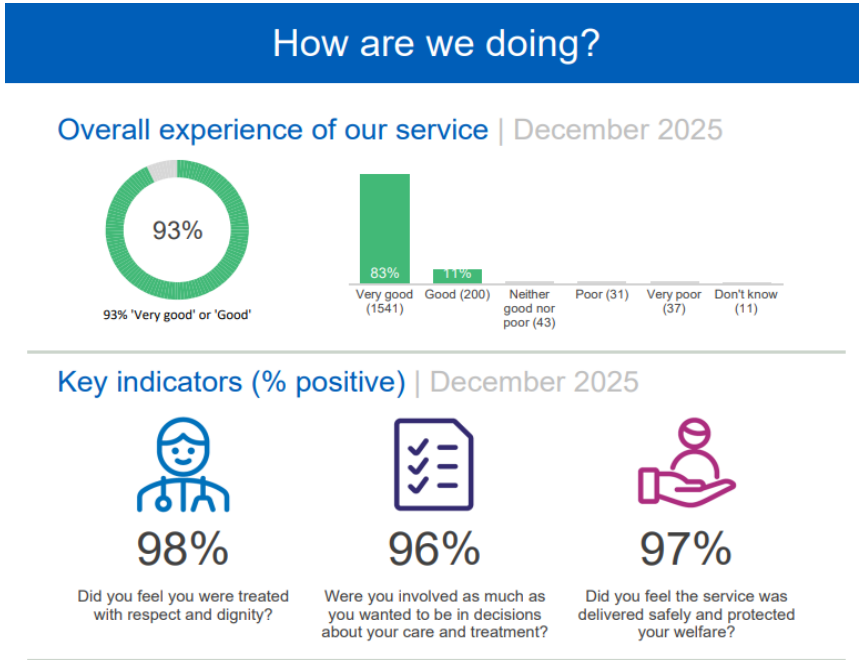


	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
Postive score	83%	94%	90%	91%	95%	92%
No. of negative responses	4	63	13	15	23	4
No. of positive responses	20	970	122	151	429	48

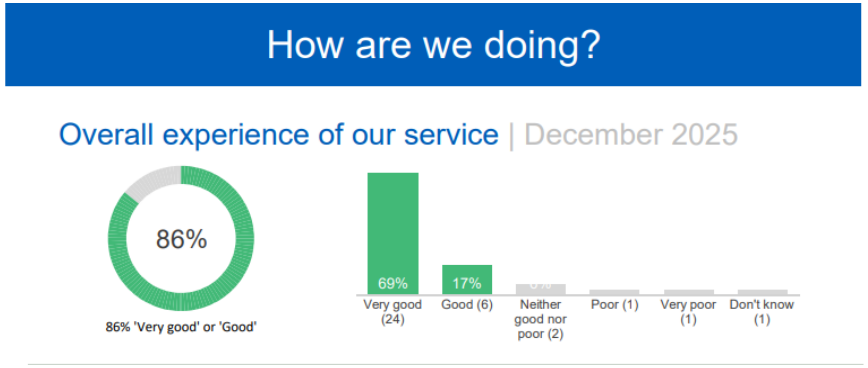
Highlights for this month:

- 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 7 requests for contact/action through the FFT.
- FFT set up to support new IUC service; there were 52 responses in December 2025 with a positive experience rating of 92%.

Patient feedback



Carer feedback



AGENDA ITEM: 11/0325

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **QUALITY AND PERFORMANCE DASHBOARD DECEMBER M9 2025-26**

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

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

The purpose of this report is to

This quality and performance dashboard provides a high-level view of performance and quality indicators in exception across the organisation. Activity covers the period to the end of December (Month 9, 2025/26). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Service led Operational & Governance reports are presented to the operational performance & risk meetings and more widely accounts for indicators in exception and outline service-level improvement plans including forecasts and risk assessments. Data quality progress will be more formally monitored through the Patient Records Quality Group which updates the Business Intelligence Management Group (BIMG).

Recommendations and decisions required

The Trust Board is asked to:

NOTE the Quality and Performance Dashboard Report for December 2025/26 and acknowledge that appropriate service improvement action plans are being developed *or* are in place, to address areas requiring improvement, within Operational governance processes (Advise and Assure sections).

Executive summary

Business Intelligence Updates

- 1 new KPI has been implemented for the period. 12 are planned to go live in January 2025, with a further 27 before the end of Quarter 4.
- A new "Domain" proposal paper (to align to NHSE Insightful Board guidance and Trust self-assessment) has been agreed by the Resources Committee and will proceed through the Great Place to Work and Quality Committees in Q4. The intention is to use this new structure for a new-look integrated dashboard in 2026/27.

Performance Update
The performance dashboard indicators are presented from page 2 within the Board's current four source format (*to note, the fifth Operational source is only presented to the Resources Committee - but the source is reviewed at BIMG for each period*). The Dashboard offers a lighter commentary format however detailed narrative is reviewed across wider governance processes for all indicators across all Source areas.

Alert (to matters that may require attention)
There are no new indicators being alerted to Board for the period.

Advise (areas of ongoing monitoring or development)
The following indicators are already being closely monitored by operational governance with support from business partner functions. The Board are advised to support that scrutiny continues for these specific indicators until recovery can be assured:

- **N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice** – *narrative on page 3 with forecasted recovery in Q1 2026.*
- **N37 - Community PH: CYP Community Services Waiting List % seen within 52 weeks - (*Service exclusions applied)*** – *narrative on page 3.* Gradual improvements anticipated with recovery milestones to be set. Performance will be scrutinised closely in BIMG in February, offering support to set recovery dates.
- **N45 - IUCS - Average speed to answer calls (in seconds) (KPI 2)** – *narrative on page 4. This incorporates N44 and N46. Performance is expected to recover after the winter surge period*.
- **N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)** – *narrative on page 4, slighted behind the initially predicted recovery plan to achieve 40-50% by April 2026 due to winder surge period.*
- **L21 - MH Liaison - number of routine referrals seen within 24 hours (ICS portfolio)** – *narrative on page 7, forecasted recovery remains in development.*
- **B18 MH Acute Inpatients – Percentage of discharge within LoS threshold (26days)** – *narrative on page 11, new interim recovery milestones being introduced from January 2026 (reporting in February) alongside update of measure.*
- **B20 MH Older Adult Inpatients – Percentage of discharge within LoS threshold (70days)** – *narrative on page 11, new interim recovery milestones being introduced from January 2026 (reporting in February) alongside update of measure.*

Assure
There are no indicators having previously been identified as areas for closer monitoring to Alert or Advise that are delivering to plan for the period.

The Board are assured that these measures are monitored within the Quality Committee:
- **N13 - Number of E.Coli Bloodstream Infections** – *narrative on page 3.*
- **B17 - Total number of pressure ulcers developed or worsened during care by this Trust** – *narrative on page 10.*

Applaud
Areas of positive performance for the period include (but are not limited to):

- All indicators within the **Specialised Commissioning Source** which are compliant for the period. This includes **Health Visiting (S02-S10)** and **School age flu immunisations (S01, S11-S19)** which have surpassed the national target, with an increased uptake across all age groups.
- **N53 - Proportion of callers allocated the first service type offered by Directory of Service (KPI 7)** – This indicator is compliant for its third consecutive period.

Risks associated with meeting the Trust's values
Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operationally owned Service led Improvement Plan which outlines any quality impact, risk(s) and mitigation(s) will be monitored through the Operational Performance and Risk Group.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality-of-care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service works alongside other Corporate service areas to provide the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting such as the DQMI indicators.

Where has this issue been discussed before?	Service Directorate Ops Sessions, Directorate wide Performance and Risk meeting on 21/01/2026 and BIMG on 15/01/2026

Appendices:	

Report authorised by: Sandra Betney Sharon Buckley & Emma Webber	**Title:** Director of Finance Deputy Chief Operations Officers

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Snapshot Month
December

Quality & Performance Dashboard Report

Aligned for the period to the end December 2025 (month 9)

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

In support of these indicators, monthly Operational Performance & Risk summaries (with improvement plans, risk reviews, action planning and improvement forecasts if appropriate) are presented by Service Directors within Operational governance (Business, Performance and Risk) meetings. Some services are considering interim milestone proposals which are aligned to their improvement plans and these will move through BIMG for ratification before Resources Committee authorisation.

Quality & Performance Dashboard Summary

The Dashboard itself (on pages 2-12) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are all underperforming against their targets and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods in line with the Trust's Performance Management Framework. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online data platform (Tableau). All services are using this tool, alongside their operational reporting portfolios to monitor wider performance with the support of corporate business partnering functions.

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate and in response to significant, ongoing and wide-reaching performance issues, performance improvement plans are held at Directorate level to outline the risks, mitigation and actions.

Business Intelligence Summary Update

- Intensive work continues to progress the KPI workplan, with *N69: "PH: % of bed days occupied by patients when they are ready to be discharged*" having gone live within the dashboard portfolio for January. Alongside 7 in-development KPIs, this now sees 144 measures reported, with 12 further go-lives planned for January and 27 for the remainder of Q4. There are 6 planned for 2026/27 to deliver 210 KPIs in total across the portfolio. *13 KPIs are awaiting input from stakeholders and as yet haven't an agreed go-live date.*
- A new "Domain" proposal paper (to align to NHSE Insightful Board guidance and Trust self-assessment) has been agreed by the Resources Committee and will proceed through the Great Place to Work and Quality Committees in Q4. The intention is to use this new structure for a new-look integrated dashboard in 2026/27.
- NHSEngland Medium Term Planning remained a focused priority through Quarter 3.

National Contracted Source

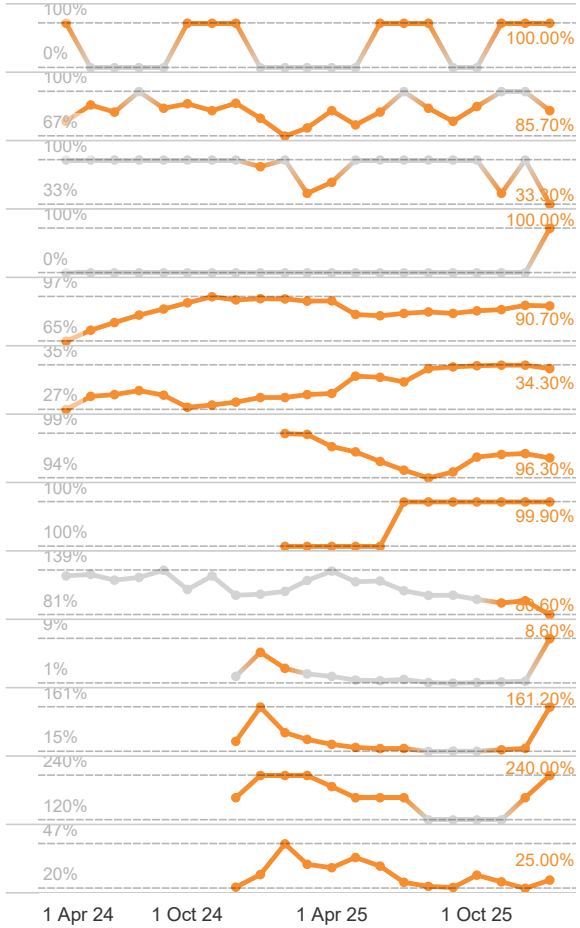
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National level as agreed by a national commissioner.

		DECEMBER
N02	Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only	100.0% / 0.0%
N11	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	85.7% / 95.0%
N12	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	33.3% / 95.0%
N13	Number of E.Coli Bloodstream Infections	100.0% / 0.0%
N22	Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)	90.7% / 100.0%
N25	Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice	34.3% / 50.0%
N37	Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)	96.3% / 100.0%
N38	Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)	99.9% / 100.0%
N43	NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)	80.6% / 100.0%
N44	IUCS - Proportion of calls abandoned (KPI 1)	8.6% / 3.0%
N45	IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)	161.2% / 20.0%
N46	IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)	240.0% / 120.0%
N67	IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)	25.0% / 90.0%



<u>Performance Thresholds not being achieved in Month</u> - *Note all indicators have been in exception previously in the last twelve months except N13.*

N02 - Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only
One fracture case transfered from GHT before being transfered back to GHT - treated with antibiotics in GHT.

Narrative continued on next page...

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

Risk: 645. Actions: A deep dive of all patient cases, over the last eight months has been undertaken, with no clear identifiable actions to be taken to improve performance. Initial results appear to be due to patient choice, rather than service capacity and delivery issues. The one patient this exception related to, has now been seen. Proposed Eating Disorder Service Review Project - Case for Change presented to the Mental Health and Learning Disability Programme Board in January 2026.

N12 - Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week

Forecast for recovery: Due to low numbers and element of patient choice, it is unlikely performance will be be consistently met. Actions: Further review of the patient cases has identified that performance for the period related to one patient due to difficulty in making contact but they have now been seen. The other exception was a data entry error and has now been resolved.

N13 - Number of E.Coli Bloodstream Infections

One case became unwell whilst in GHC and transferred to ED GRH where blood cultures were taken and confirmed E.Coli. This is a Community Onset Healthcare associated, but as the patient was actually an inpatient in GHC and as GHC don't take blood cultures the case will not be atributed to GHC.

N22 - Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)

Risk: 656. Forecast for recovery: Quarter 1 2028/29 dependent on funding being agreed, associated recruitment and generation of primary care referrrals. Actions: Recruitment commenced to facilitate expansion. Onoing liaison with ICB in respect of funding to support further recruitment to posts. Expanding into primary care. Exploring communications and media to advertise. Raising profile of service with the Job Centre and other professional groups.

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

Forecast for Recovery: Quarter 1, 2026. Performance above National average and the denominator includes services that are diagnostic only and don't record outcomes. Perinatal actions: Performance against this KPI is impacted by the transition from the previous outcome measure (Core10) to the new measure (Dialog). Assurance mechanism in place to ensure that an outcome measure is completed at start and end of an episode of care. Tableau report availble to identify in month exceptions which is supporting a deep dive into non compliant cases. Perinatal specific performance expected to improve once reports configured in the system. Children's actions: Recovery plan led by champions from Core CAMHS, Young Minds Matter and Young Adults. Team feedback sought regarding recording process, online training dates January/ February, development work on processes for collection routine outcome measures on hold until virtual assistant is live as this will enable collection via text messages and web chat functions.

N37 - Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)

The service is currently non-compliant as 79 children are waiting over 52 weeks for Speech and Language Therapy (73) and Occupational Therapy (6). Safety is being maintained through adherence to the Long Waiter Standard Operating Process, robust referral screening and prioritisation, regular clinical review of long waiters, and ongoing access to advice, training, digital resources, and patient informed follow up pathways. A service transformation programme is focused on reducing waits at both referral and treatment stages. While performance is expected to remain similar in the short term, gradual improvement is forecast, with updated milestones to be reviewed in the new year once the new delivery models are embedded. Performance and Risk Meeting in December 2025, received a detailed presentation from the Speech and Language Therapy Service Manager and new forecast modelling is being prepared for the Occupational Therapy Service.

Narrative continued on next page...

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N38 - Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)
Actions: Waiting list review processes in place. Speech and Language Therapy Service: Processes in place to discharge two patients, three have now been seen. Two patients remain and appointments have been scheduled in January 2026.

N43 - NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)
The target for this KPI is set as a cumulative figure across the year, whilst the target was not met for this period, the service continues to be ahead of the cumulative target (5,473 against a plan of 5,212) in December 2025.

N44 - IUCS - Proportion of calls abandoned (KPI 1)
Forecast for recovery: Performance is expected to return to target after the winter surge period. Actions: During extreme winter pressures, experienced nationally across urgent care, the priority is harm reduction, patient safety and workforce resilience. Recovery expected as winter pressures ease and call volumes stabilise.

N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)
Please see narrative above for KPI N44

N46 - IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)
Please see narrative above for KPI N44

N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)
Risk: 628 and 629. Forecast for recovery: Previously reported 7 week recovery programme in place to meet 40-50% by March 2026. Winter pressures and surge are still apparent so may not realise sustainable improvement trajectory. Actions: Enacting surge plans when call-back breaches increase. Rapid triage and clinical prioritisation across pathway. Focus on 111 clinical queue, targeting call-backs within 20 minutes. Escalation and pathway allocation to reduce risk. Dashboards in place. Weekly scrutiny of recovery plan through GHC/IC24 operational leadership collaboration.

Specialised Commissioning Source

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

National or regional level indicators as agreed by a commissioner.

All Performance Thresholds were achieved for the period.

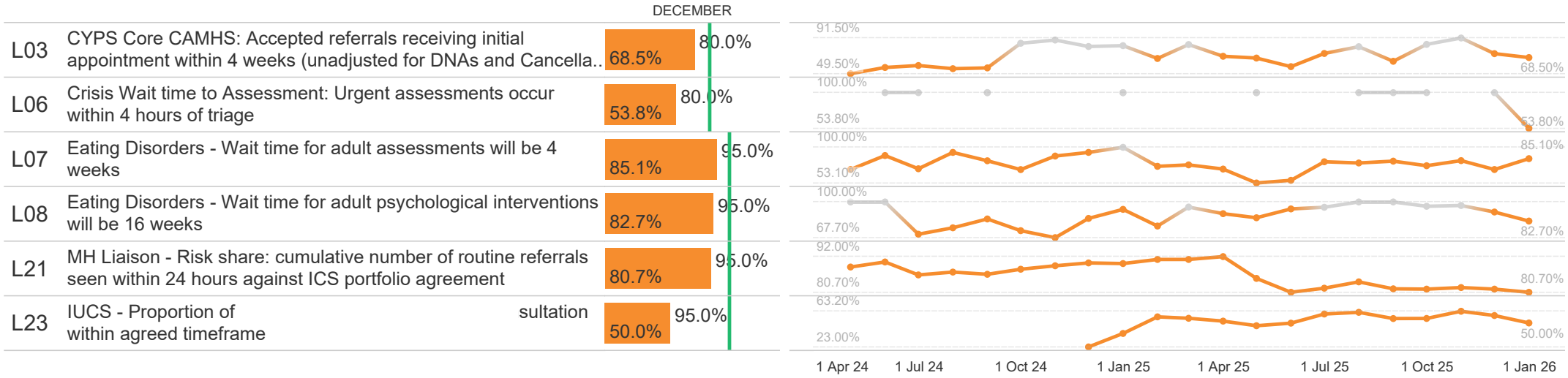
ICS Agreed Source

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

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



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

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
Linked Risk: 165. Forecast for recovery: Under review as unlikely to recover in February 2026 as previously reported. Actions: Greater number of assessments offered in January to address the backlog. Increased regular capacity for assessments, additional weekend assessment clinic, workshop to explore joined up system front door options secheduled end of January (commissioner led).

L06 - Crisis Wait time to Assessment: Urgent assessments occur within 4 hours of triage
Methodology to present the true urgency of the request is now outdated, due to the introduction of 111 IVR and the complexity of recording. Proposal to replace L05 (1hour) & L06 (4hours) to align to NHS Oversight Framework meaning a new 24hour and 4 hour triage scale. Clinical systems team have built the new referral urgency definitions and now Commissioner agreement is being sought to decommission old measures. The start date for the new recording process for the new indicators will be in place by the end of the financial year.

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
Forecast for recovery: Due to low numbers and element of patient choice it is unlikely this KPI can be consistently met. Actions: Review of each patient case completed which demonstrates the service have offered a variety of appointments where capacity allows and made reasonable adjustments where approriate. Capacity issues impacted on one patient being seen outside of four weeks. Two cases were due to patient choice. All patients have been seen.

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L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks
Risk: 645. Forecast for recovery: Due to low numbers, it is unlikely this KPI can be consistently met. Actions: a deep dive of patient cases complete, the exceptions related to; two patients due to complexity, one due to clinician capacity, one due to patient choice. Staffing issues resolved. Proposed Eating Disorder Service Review Project - Case for Change presented to the Mental Health and Learning Disability Programme Board January 2026.

L21 - MH Liaison - Risk share: cumulative number of routine referrals seen within 24 hours
Forecast for recovery: Proposal to update KPI to monitor a count of referrals (as a number) of those referred and not %, however awaiting clarity of whether this will remain a 2026/27 risk share item. If removed, likely to monitor an alternative, similar measure internally. Actions: Review referral process to eliminate those who are not medically fit for review (NMFFR) or do not attend (DNA). Liaison with Clinical Systems Team to capture NMFFR and DNAs.

L23 - IUCS - Proportion of HCP calls that receive clinical consultation within agreed timeframe
This is a subset of N67 IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4) that only examines HCPs calling 111 who require a call back (rather than all calls). *Please see narrative for KPI N67.*

Board Focus Source

with you, for you

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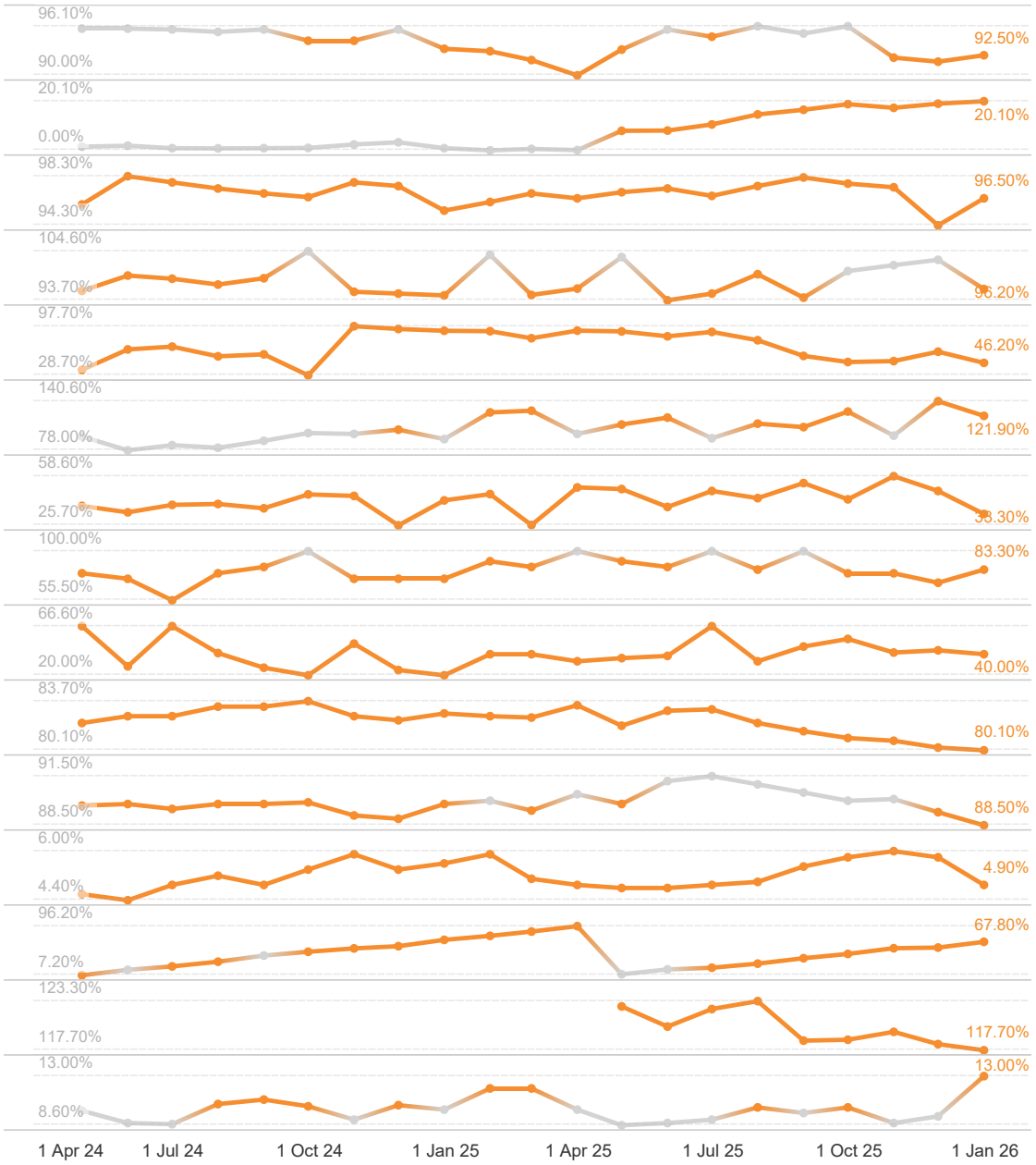
KPI Summary

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

		DECEMBER
B01	Care Programme Approach - formal review within12 months	92.5% / 95.0%
B02	Nationally reported - Delayed Discharges (Including Non Health)	20.1% / 7.5%
B05	Bed Occupancy Rate – Physical Health	96.5% / 92.0%
B11	Safer Staffing Fill Rate - Community Hospitals	96.2% / 100.0%
B13	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	46.2% / 99.0%
B17	Total number of pressure ulcers developed or worsened during care by this Trust	121.9% / 100.0%
B18	MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)	33.3% / 95.0%
B19	MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days)	83.3% / 95.0%
B20	MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)	40.0% / 95.0%
B28	% (All Active Assignments including Bank) Staff with completed Appraisals (exclusion..	80.1% / 90.0%
B29	% (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions..	88.5% / 90.0%
B30	Sickness absence average % - including non-working days (Joint Forward plan)	4.9% / 4.0%
B32	Cumulative Leave	67.8% / 75.0%
B44	Bank spend reductions (Joint Forward plan)	117.7% / 100.0%
B52	PH CATU Inpatients Average Length of Stay (Days. Not a percentage)	13.0% / 10.0%



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

B01 - Care Programme Approach - formal review within12 months
Forecast for recovery: February 2026. Actions: A report outlining overdue and due CPAs sent to operational leads to plan reviews. Discussions ongoing with colleagues within Nursing, Therapies and Quality Directorate regarding proposal to replace CPA review with "My Care Plan".

B02 - Nationally reported - Delayed Discharges (Including Non Health)
Linked risk: 196. Forecast for recovery: in development to identify the criteria for clinically ready for discharge as opposed to delayed discharge. Actions: Action cards relating to criteria to identify patients who are clinically ready for discharge to be re-shared, due to inconsistency in reporting. Discussions in place with Clinical Systems to align the clinically ready for discharge criteria within the clinical system. Once in place clinicians can report accurately and the Business Intelligence Team will support the extraction and reporting for this indicator. Some patients were delayed due non availability of housing sector support over the Christmas period.

B05 - Bed Occupancy Rate – Physical Health
Forecast for recovery: Not agreed due to significant demand for community hospital beds within the county. Milestones are in place to recover length of stay. Work to support reducing the demand is required for pathway one. Actions: Continued work with flow partners to reduce average length of stay. Delay related harm programme in place, bed function discussions as part of future planning and temporary tests of change programme, introducing new roles such as ward assessments to support bed changeover frequency.

B11 - Safer Staffing Fill Rate - Community Hospitals
Forecast for recovery: To be determined as dependent on timeline for inpatient establishment reprofiling. Actions: Inpatient Establishment Reprofiling programme, organisational change process for training and development facilitators (full effect from March), optimal absence management, centralised rostering to support best roster approach, review to ensure all roles are included as appropriate. Ongoing discussions in the monthly safer staffing group with Deputy Director of Nursing.

B13 - Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
Linked risk: 660. Forecast for Recovery: In development. Actions: Discussions ongoing with commissioners in respect of sub contracting arrangements for Echocardiograms. Breaches shared monthly with system partners, and weekly escalation process in place. Additional staff have been recruited to address the backlog of echocardiograms. For patients who are waiting, GPs are encouraged to notify the team of any changes/outcome of any new blood test to enable the Heart Failure Team to reprioritise and expedite the echocardiogram as necessary, or esclate to Cardiology Consultants.

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

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

Narrative continued on next page...

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

B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)
Linked risk: 196. Forecast for recovery: Expecting to meet 54 days by April 2026 with new interim milestones to begin in January 2026. Committee to note that average length of stay was impacted as expected due to patient discharge who had an extended length of stay. Actions: Reviewed length of stay data, recognised variation in length of stay for extended length of stays. Agreed proposal for 12-week rolling average in reporting to provide greater allowance for extended length of stays with cleaner methodology. This is demonstrating a gradual reduction without the spikes when long stayers are discharged. Implementing mental health inpatient transformation programme, reinstated multi agency discharge event. Peer review of length of stays at 31 days. Learning improvement network (NHS England led) development programme application made and £25,000 approved. Thematic review of admissions ongoing. Review of interactive whiteboards, daily ward huddle at Wotton Lawn Hospital. Identify daily nursing requirements.

B19 - MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days)
Linked risk: 196. Forecast for recovery: 45 days by end of quarter 3. 40 days by end of quarter 4 with new interim milestones to begin in January 2026. Actions: Reviewed length of stay data and 12 week rolling average. Review of national criteria for delivery of Psychiatric Intensive Care Units (PICU). Review of acute admissions which may be extending PICU length of stay. Implementing mental health inpatient transformation programme, review of interactive whiteboards, daily ward huddle at Wotton Lawn Hospital. Local improvement network development programme initiation. Team working to make discharge arrangments for a patient who has had an extended length of stay.

B20 - MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)
Linked risk: 196. Forecast for recovery: 100 days by end of quarter 3. 90 days by end of quarter 4. Actions: Reviewed length of stay data, including variation in length of stay for extended length of stays. Agreed proposal for 12-week rolling average in reporting as provides a greater allowance for extended length of stay in determining trajectory. Implementing mental health inpatient transformation programme. Reinstate multi agency discharge event (Charlton Lane Hospital complete). Learning improvement network (NHS England led) development programme. Thematic review of admissions. Peer review at 70 days (median functional). Team working to make discharge arrangements for a patient who has had an extended length of stay.

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for December has dropped slightly to 80.0%, compared to a threshold of 90%, although the figure is expected to rise slightly again due to delayed data entry, performance is outside normal variation. November performance rose from 79.2% to 80.3% and was below expected variation. The Performance is following the same seasonal pattern that has been seen for the last couple of years. The appraisal performance figure includes Bank Staff.

The Trust are currently exploring the CPD/ Appraisal benchmarking for Bank staff and will make appropriate recommendations following this, therefore reporting on this may change accordingly. This paper will go through the appropriate governance processes before a final decision is made.

B29 - % (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions applied)
Performance figures for December, excluding Bank staff, remains static at 88.4%, just under the performance threshold of 90%, although the figure is expected to rise slightly due to delayed data entry (November's performance rose from 88.0% to 89.3%). Performance is within normal variation and has been steady at around 89.8% for the last 25 months.

Narrative continued on next page...

Continued from last page...

B30 - Sickness absence average % (Joint Forward plan)
The sickness absence rate for December 2025 is reported at 4.9% at the time of publication. However, this figure cannot be confirmed yet, as the data from the e-rostering system (Allocate) is not yet available. Once this data is incorporated, the absence rate is expected to rise to 6.0%. This continues to follow the seasonal trend of the last few years and is within expected variation.

B32 - Cumulative Leave
The predicted Cumulative Leave Taken Percentage for December 2025 is approximately 65.9%, which is below the target threshold of 75% for this point of the year. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until mid-January. The estimated % for December once the data from Allocate has been included is expected to be 70.0%, still below the threshold.

B44 - Bank spend reductions (Joint Forward plan)
The Trust is required to make a year on year spend reduction of 10% on bank costs, this is a challenge for 25/26 due to the late addition of the IUCS in November 2024, so the Trust didn't have a full year of costs to create the baseline. As of December, the Trust was 17% above the Bank spend for the same period last year. For agency spend, the Trust are on track to achieve the year on year 30% reduction.

B52 - PH CATU Inpatients Average Length of Stay (Days. Not a percentage)
Forecast for recovery: To be determined as dependent on pathway change options and actions. Actions: Internal review to understand contract variation and draft service specification. Exploring causation of extended average length of stay. It is anticipated the new step-up beds will reduce the inappropriate admission to CATU - awaiting system decision.

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 12/0126

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

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

AUTHOR: Hannah Williams, Deputy Director of Nursing, Therapies and Quality

SUBJECT: **ANNUAL SAFE STAFFING ASSURANCE STATEMENT**

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

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

The purpose of this report is to:

This paper is presented to the Trust Board to provide formal annual assurance that arrangements are in place to support safe staffing across the inpatient services in the Trust. While detailed safe staffing information is reviewed routinely through the Quality Committee, the Board retains overall accountability for ensuring that the organisation has effective processes to plan, monitor and respond to staffing risks.

Recommendations and decisions required

The Trust Board is asked to:
Approve the Annual Safe Staffing Assurance Statement and note that more detailed safe staffing reporting is received routinely by the Quality Committee, with escalation through established governance routes.

Executive summary

This paper is presented to the Trust Board to provide formal annual assurance that arrangements are in place to support safe staffing across the inpatient services in the Trust. Safe staffing reporting and oversight takes place routinely through our operational and quality governance structures in addition to daily scrutiny by relevant colleagues.

Whilst specific safe staffing data and information will be reviewed routinely through the Quality Committee, the Board retains overall accountability for ensuring that the organisation has effective processes to plan, monitor and respond to staffing risks.

This annual assurance statement acts as the Board level confirmation that safe staffing reporting and escalation have been maintained through the year, and that the Trust approach remains broadly aligned with national guidance on safe and effective staffing and transparency expectations, noting that the Trust seeks to improve its maturity with

safe staffing governance as referenced within the safe staffing paper presented to Board in July 2025.

Key points

- Safe staffing metrics (including planned versus actual staffing, staffing risks and mitigations) are reviewed routinely by a monthly safe staffing assurance group.
- Escalation routes exist for staffing risks that may impact patient safety, service delivery or staff wellbeing, including Executive review and Board visibility where required.
- This paper provides annual Board level assurance and supports the Trust's wider governance and assurance framework, including the Annual Governance Statement.

Risks associated with meeting the Trust's values

The principal risks relating to staffing include the impact of workforce shortages on patient safety, quality and experience, and the potential for increased pressure on staff wellbeing. The Trust's controls include routine monitoring, escalation and mitigation planning, and ongoing workforce planning actions. Quality Committee scrutiny provides ongoing assurance, with Board oversight retained through this annual statement and exception reporting when required.

Corporate Considerations	
Quality Implications	Positive. Supports Board assurance and oversight of safer staffing governance arrangements.
Resource Implications	None arising directly from this assurance statement. Staffing pressures and mitigations are considered through routine governance.
Equality Implications	No adverse impact identified. Safer staffing oversight supports safe, equitable care across services.

Where has this issue been discussed before?

- Trust Board July 2025
- Bi-monthly Quality Committee
- Monthly safe staffing assurance meeting

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

Acronyms used within this report	
CNSST	Community Nursing Safer Staffing Tool
CHPPD	Care Hours Per Patient Day
CQC	Care Quality Commission
ETOC	Enhanced Therapeutic observations of Care
GHC	Gloucestershire Health and Care NHS Foundation Trust
MHOST	Mental Health Optimal Staffing Tool
NHSE	NHS England
NQB	National Quality Board (in NHS England)
PSIRF	Patient Safety Incident Reporting Framework
SCNT	Safer Nursing Care Tool

ANNUAL SAFE STAFFING ASSURANCE STATEMENT

1.0 INTRODUCTION

Gloucestershire Health and Care NHS Trust is committed to delivering safe, effective and compassionate care to the people of Gloucestershire. Ensuring that we have enough suitably skilled and experienced staff is fundamental to patient safety and service quality. This paper describes how the Trust meets its responsibilities in relation to safe staffing in inpatient settings, in line with the Care Quality Commission (CQC) fundamental standards and NHS England (NHSE) guidance.

The Trust Board discussed and approved plans to reprofile inpatient ward establishments during Q4 2024/25 with this work being delivered during 2025/26. NHS Trusts are mandated to have a considered and planned position on safe staffing numbers in inpatient settings and there is a requirement for Trusts to report on this regularly and for Trust Boards to consider the position (National Quality Board 2016). There is strong evidence that all three domains of quality of care - safety, experience, clinical effectiveness - are positively affected by having the right number of staff, of the right type, at the right time. Patient experience, and ultimately patient recovery and health outcomes will be enhanced by continuity of care, which is achieved by a consistent workforce on inpatient wards. The balance between a substantive workforce and staffing levels that are filled by temporary staff (bank and agency) is an important consideration for NHS Trusts and their Boards. Safe Staffing is one identified mitigation within the Trust Board Assurance Framework (BAF 1).

2.0 OUR STATUTORY AND REGULATORY RESPONSIBILITIES

GHC recognises its duties under:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, particularly Regulation 18 (Staffing)
- The CQC fundamental standards, which require providers to deploy sufficient numbers of competent staff to keep people safe
- NHS England's expectations on safe, effective workforce planning and deployment, specifically:
    - The National Quality Board (NQB) Safe sustainable and productive staffing guidance in 2016 which supports "NHS providers to deliver the right staff, with the right skills, in the right place at the right time."

And

    - Developing Workforce Safeguards (2018) sets out a regulatory framework of 14 recommendations to support trusts in making informed decisions relating to safe staffing practice and implementation of the NQB guidance.

The Trust is committed to ensuring that staffing arrangements protect patients from avoidable harm and support high-quality, person-centred care.

3.0 OUR APPROACH TO SAFE STAFFING

Safe staffing sits within the Trust Quality and Operational governance structures. Our approach reflects CQC expectation that providers have:

- Clear leadership and accountability for staffing decisions
- Systems to identify and manage workforce risks
- A culture of openness, learning and continuous improvement

The Trust applies a triangulated approach to staffing, combining data, professional judgement and quality intelligence (incident and experience) to inform decision-making.
Whilst significant work across all levels of the organisation has taken place this year, our arrangements to Safe Staffing are likely to be more developed than some NHS Trusts, but undoubtedly with more that can be improved.
Currently it is our inpatient services that are subject to the use of recognised evidence-based tools that support the identification of safe staffing levels. This is led by the national prioritisation to develop inpatient tools for acute (inpatient) physical health care adult nursing (the Safer Nursing Care Tool - SNCT) followed by acute (inpatient) mental health adult nursing (Mental Health Optimal Staffing Tool - MHOST).
In Q3 2025/26, we completed and submitted the NHSE safe staffing self-assessment tool to the NHSE South West regional Nursing Team. This was a national requirement for all NHS Trusts. It was noted from the regional Nursing Team, that whilst GHC had adopted the fundamental components of Safe Staffing principles and met our statutory reporting requirements, there were opportunities to enhance this further. The self-assessment identified that we were compliant in 4 domains, partially compliant in 7 domains and non-compliant in 1 domain. Improvement work undertaken in response to this includes:

- Review of escalation processes and reporting – **In progress with further work to embed and mature, timescale end Q4 2025/26**

- Review of Trust wide Safe Staffing Policy- **In progress with further work to embed and mature, timescale end of Q4 2025/26**

- Strengthen monthly governance arrangements that more clearly demonstrates triangulation of staffing data with incident and experience data, senior professional clinical review and challenge alongside identifying learning opportunities – **In progress with further work to embed and mature timescale end of Q4 2025/26**

- Include CHPPD data within the monthly published submission to NHSE – **Completed**

We have committed to repeating the NHSE self-assessment during Q4 2025/26 and ahead of our next scheduled meeting with the regional Nursing team.

3.1 How We Establish Safe Staffing Levels

Staffing levels across all inpatient areas are determined using a combination of:

- Evidence-based workforce planning tools appropriate to each service area (specifically MHOST and SNCT)
- NHS England guidance on workforce planning and safe deployment
- Professional judgement from senior clinicians and service leads
- Analysis of activity, acuity and complexity
- Quality and safety indicators, including incidents, safeguarding concerns and patient outcomes

This approach aligns with NHSE expectations that staffing decisions are evidence-based and responsive to changing service needs.

3.2 Real-Time Monitoring and Escalation

In line with CQC expectations for effective risk management, the Trust maintains good operational oversight of staffing through:

- Daily review of actual vs planned staffing levels at team and service level as reported on the daily Trust wide operational meeting at 9am
- Real-time escalation processes when staffing falls below planned levels
- Senior clinical oversight to assess and manage risk to patient safety
- Immediate mitigation actions, including redeployment and temporary staffing where necessary

These arrangements ensure that emerging risks are identified early providing an opportunity for them to be addressed promptly.

4.0 GOVERNANCE, LEADERSHIP AND BOARD OVERSIGHT

Safe staffing is a standing component of the Trust governance framework, supporting compliance against CQC Well-led domain. A review of the Trust safe staffing policy and our reporting and escalation processes is the opportunity to ensure there is good alignment within our framework.

The monthly safe staffing assurance meeting chaired by Deputy Director of Nursing, Therapies and Quality formally reviews and seeks assurance that the previous month's staffing data has met planned requirements, reviews professional judgement decisions and seeks to assure safety through triangulate with available patient safety and patient experience data. Historically our practice of reporting focused on where staffing exceeded expected levels. The new meeting takes a more comprehensive and considered review to understand the impact to patients and colleagues when actual staffing levels have been over or under planned establishment, the registered to unregistered staffing ratios, the availability of therapy staff, the use of temporary staffing and other mitigations that are put in place to minimise harm. The meeting has identified and tested occasions where staffing was not optimal - from which learning is shared - but has not identified that harm has directly occurred as a result of an actual shift not meeting its planned establishment.

From this meeting, a monthly submission and publication on the Trust website of safe staffing data is made in line with NHSE requirements. A summary version is included in the quality dashboard report of the Director of Nursing, Therapies and Quality to assure to Quality Committee and Board. Through shared membership, this Safer Staffing Meeting connects with the monthly Sustainable Staffing Oversight Group which reports to Board via the Great Place to Work Committee. This demonstrating Executive accountability for workforce and patient safety.

4.1 Managing Workforce Pressures

The Trust acknowledges the ongoing national and local workforce challenges affecting health and care services. In line with NHSE expectations, we have in place:

- Workforce risk assessments and escalation processes
- Business continuity and surge planning for periods of increased demand
- Flexible deployment and new ways of working to maximise available capacity
- Careful and proportionate use of bank and agency staff to maintain safety

These measures promote continuity of safe services while long-term workforce solutions are implemented.

4.2 Learning, Openness and Continuous Improvement in safe staffing

In line with CQC emphasis on learning organisations, the Trust actively seeks intelligence from:

- Patient feedback and experience
- Staff surveys and engagement
- Freedom to Speak Up (F2SU) and Direct 2 Douglas
- Incident reporting and subsequent safety reviews in line with Patient Safety Incident Reporting Framework (PSIRF)
- National guidance and peer benchmarking

In addition, the Trust is:

- One of a small number of Mental Health Trusts who have been selected to be part of the national review into MHOST, this work is due to complete at the end of Quarter 4 2025/26.
- Participation in the 3rd wave of the national Enhanced Therapeutic Observations of Care (ETOC) implementation. Our work commenced in Quarter 3 of 2025/26 and will continue in Quarter 1 and Quarter 2 of 2026/27
- During Quarter 3 2025/26, the national team launched the licence for NHS Trusts to use a tool for adult community physical health nursing (CNSST). We have signed up and been accepted for a licence following further work for our community nursing staff to complete the prescribed mandatory training. We are engaged with the national team who are leading implementation and it will become incorporated into our policy, governance and assurance processes.

5.0 CONCLUSION

Gloucestershire Health and Care NHS Board can take assurance that safe staffing governance has improved and continues to do so. Further maturity is in progress and will be assessed in line with NHSE guidance by the end of the financial year. The Trust has leadership, governance and operational systems in place to support safe staffing in accordance with CQC fundamental standards and NHS England guidance, noting the identified areas of planned future work. While workforce challenges remain, the Trust is committed to continuous improvement and to ensuring that staffing levels support safe, high-quality and compassionate care for the people of Gloucestershire.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2026**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: James Powell, Head of Sustainability

SUBJECT: **2024/25 CARBON FOOTPRINT REPORT**

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

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

The purpose of this report is to:

To provide:

- An annual sustainability update to the Trust Board which includes the Trust carbon footprint metrics for FY 2024/25
- Updated delivery against the GHC's first Green Plan (2022-2025)

Recommendations and decisions required

The Trust Board is asked to:

- **Acknowledge** the positive impact of the 2022/25 Green Plan in reducing our Carbon Footprint in line with NHS net zero targets (28% reduction in carbon emissions vs. 19/20 baseline and above our Trust 25% stretch target).
- **Note** the 28% figure is a marginal deterioration vs. the position reported at September 2025 board (32%), as a result of additional data sources being included in the overall net impact.

Executive summary

Our Carbon Footprint Data is completed in arrears, as we require 12 months of data for completion. The data is then verified by NHS England in Q1/Q2 of the next financial year via the ERIC returns system (Estates Return Information System). This data concludes the outturn in terms of carbon footprint for year 3 of our 2022-2025 Green Plan.

As an update to our 24/25 performance (reported to Board in September 2025), our NHS Carbon Footprint emissions **increased by 5%** compared to the previous year. This is predominantly due to the impact of the temporary boiler house at Wotton Lawn Hospital (the data for this was not available until later in 2025).

Despite this, we have reduced our emissions by 28% compared to our 19/20 baseline **exceeding our target by 3%,** indicating that the Trust is ahead of schedule to reach net zero by 2040.

Due to lead times for the project to install an air source heat pump at Wotton Lawn Hospital, the temporary boiler house will continue to have an impact on our carbon footprint in 25/26 & 26/27; although the air source heat pump at Charlton Lane is due to go live and will offset these emissions to some extent.

Risks associated with meeting the Trust's values

The Goals and Targets set out in this 3-year Green Plan have been fully achieved and therefore presents no risk to meeting the Trusts values.

Corporate Considerations	
Quality Implications	N/A
Resource Implications	N/A
Equality Implications	N/A

Where has this issue been discussed before?

A summary of the Trust carbon footprint was presented as part of the Green Plan Refresh at September 2025 Board meeting.

Appendices:	N/A

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

2024/25 CARBON FOOTPRINT REPORT

1.0 INTRODUCTION

This report provides an overview of our Total, NHS Carbon Footprint and Carbon Footprint Plus emissions for the 24/25 financial year. The Trust's NHS Carbon Footprint includes emissions within the organisation's direct control, such as those from building energy, waste, water, business travel, fleet, inhalers, and anaesthetic gases. The Trust's Carbon Footprint Plus includes our organisation's indirect emissions, which include supply chain, staff commuting, and patient and visitor travel. Combined, these make up GHC's total carbon footprint. Our Carbon Footprint Plus calculations are based on spend (£) rather than the carbon value of items. This means neither year-on-year nor vs baseline figures are comparable.

2.0 TOTAL CARBON FOOTPRINT

In 24/25, our **total** carbon footprint was estimated to be 22,052 tCO_2e, the equivalent of a person flying a return journey from London to Hong Kong 6,300 times. Our NHS carbon footprint accounted for 27% of these emissions, with the remaining 73% attributed to our carbon footprint plus.

The primary contributors to our 24/25 **total** carbon footprint are:

- Supply chain: 45% of our total emissions
- Building energy: 20% of our total emissions
- Commissioned health and care services:13% of our total emissions
- Staff commuting: 11% of our total emissions

3.0 24/25 NHS CARBON FOOTPRINT

Emissions from our NHS Carbon Footprint are publicly reported and are based on accurate data and therefore contribute to our 2040 net zero goal.

In 24/25, our NHS Carbon Footprint was estimated at 6008 tCO_2e and represents a 5% increase over the previous year (23/24), resulting predominantly from the temporary boiler house at Wotton Lawn Hospital and business travel.

Overall, we have seen a 28% reduction from our 19/20 baseline year (Figure 1), meaning we have surpassed our Green Plan Goal of a 25% reduction in our NHS Carbon Footprint emissions by 2025.

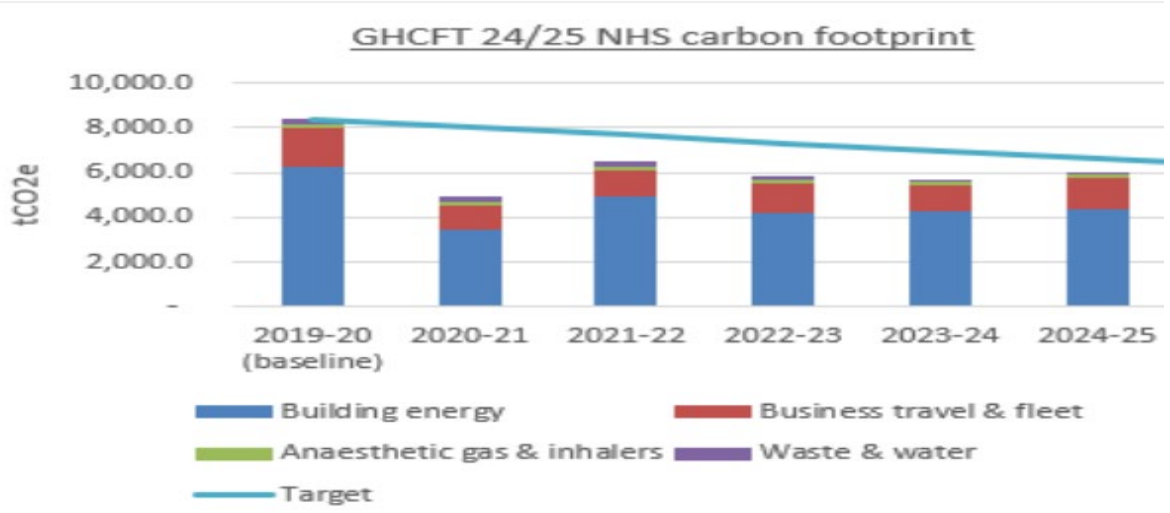

Figure 1: GHC NHS Carbon Footprint 2019-2025

As **Figure 2** demonstrates, building energy from fossil fuels accounts for 44% of these emissions. Other notable categories include electricity and Business Travel.

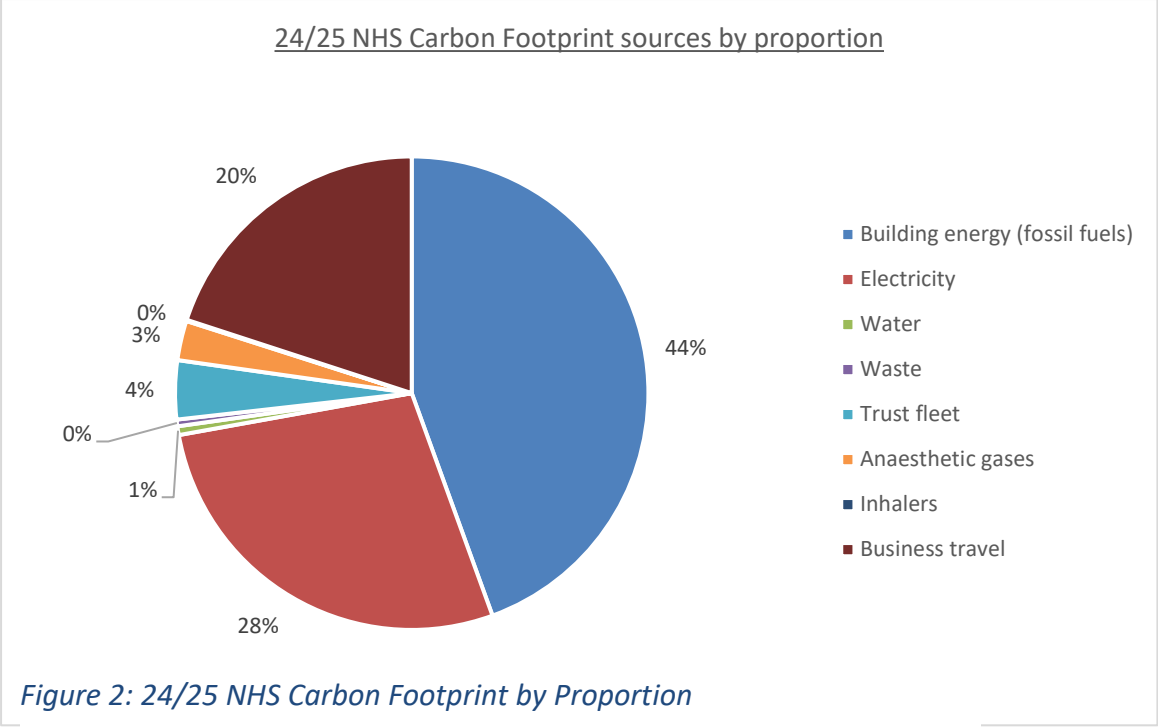

Figure 2: 24/25 NHS Carbon Footprint by Proportion

Key Headlines

Building Energy

Building Energy accounts for 64% of our NHS Carbon Footprint

- **Electricity:** Emissions and consumption increased by 10% compared to the 23/24 financial year. This increase can be attributed to air-source heating systems in the Forest of Dean and to the increased electricity emissions factors for calculating these emissions in 2024.

- **Gas:** emissions decreased by 8% compared to the previous financial year due to the closure of Lydney Hospital.
- **Oil:** increased by 94% compared to the previous financial year due to the temporary boiler house at Wotton Lawn Hospital. Oil emissions will decrease to 0% once the boiler house is removed and replaced with an Air Source Heat Pump. Due to lead times for the project to install an air source heat pump at Wotton Lawn Hospital, the temporary boiler house will continue to have an impact on our carbon footprint in 25/26. It is due to be decommissioned in September 2026. The air source heat pump at Charlton Lane is due to go live and will offset these emissions to some extent.

Waste

- Waste accounts for less than 1% of our NHS Carbon Footprint.
- Emissions from waste decreased by 25% in 24/25 compared to the previous financial year and 81% since our 19/20 baseline.

Business Travel and Fleet

- Business Travel and Fleet account for 24% of our NHS Carbon Footprint
- Business Travel emissions increased by 26% compared to the previous financial year but have decreased by 16% since our 19/20 baseline.
- The total number of business travel miles increased by 29% compared to the previous financial year, a decrease of 10.5% compared to our 19/20 baseline.
- This means we did not achieve our 20% reduction target in vehicle miles set within our Green Plan. We are working with the business travel team to address the sharp increase in vehicle mileage within this financial year. A pilot is in progress (2025/26) trialling e-bikes for clinical teams as an alternative form of transport.
- Trust Fleet Emissions increased by 1% compared to the previous financial year but have decreased by 10% compared to the 19/20 baseline year. 0.8% of our fleet is electric.

4.0 24/25 CARBON FOOTPRINT PLUS

In 24/25, our carbon footprint plus was estimated to be 16,045 tCO_2e, or 74% of our total carbon footprint. This represents a 22% reduction compared to our baseline year and a 6% decrease in the previous financial year.

Whilst we report these figures, our Green Plan does not contain a carbon footprint or total carbon footprint reduction target, as our Carbon Footprint Plus calculations are based on spend (£) rather than the carbon value of items. This means neither year-on-year nor vs baseline figures are comparable.

This is a national challenge, and NHS England is working to provide accurate carbon footprint plus data, though no release date has been announced.

As Figure 3 demonstrates, the supply chain makes up 62% of these emissions.

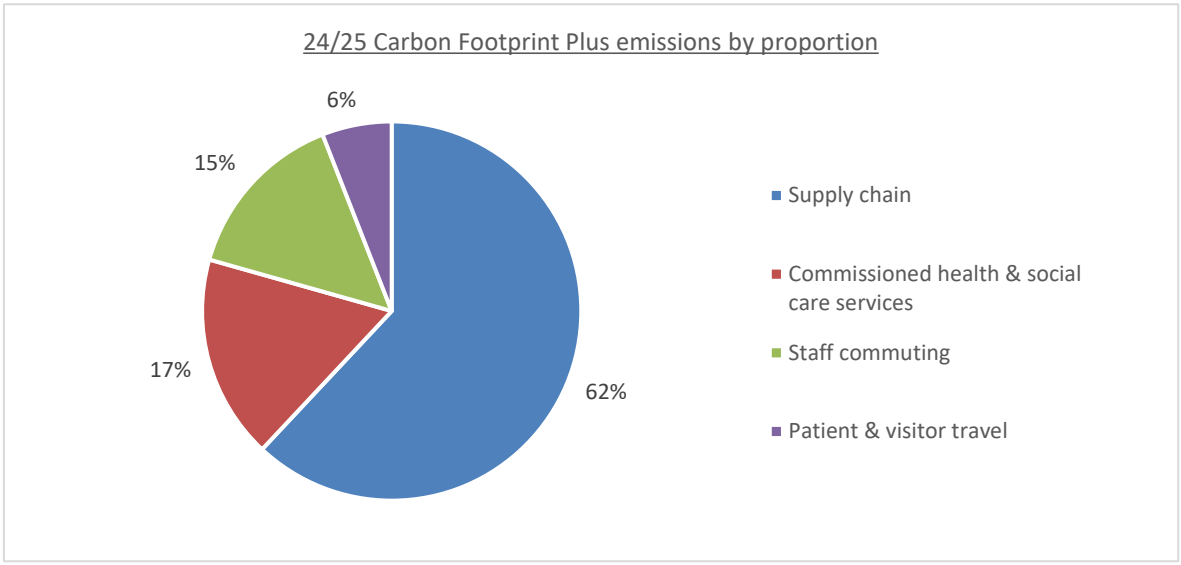

Figure 3: 24/25 Carbon Footprint Plus Emissions by Proportion

Key Headlines

Supply Chain

- Medical and surgical equipment is the leading source of supply chain emissions, accounting for 24% of the supply chain total emissions
- Emissions increased by 4% and spending increased by 11% compared to the previous year

Staff Travel

- 2% reduction in staff commuting compared to the 22/23 financial year and an estimated 10% reduction against or 19/20 baseline

Patient and Visitor Travel

- 2% decrease in patient and visitor travel emissions compared to the 22/23 financial year

For Staff Travel /Patient Travel, the current methodology relies on the Health Outcomes for Travel Tool (HOTT) based on predictions for the year 24/25. To ensure accuracy, future estimates for staff commuting will be based on staff surveys, whereas patient/visitor travel will be based on actual patient numbers.

5.0 GREEN PLAN DELIVERY

This carbon report concludes the 2022-2025 Green Plan, in which we set an overarching target to reduce our NHS Carbon Footprint emissions by 25%. We have exceeded this goal, achieving a 28% reduction.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 JANUARY 2026**
COMMITTEE:	**GPTW COMMITTEE – 15 December 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Sumita Hutchison, Chair of Committee

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

The Committee was informed of national changes to mileage rates following the biannual review and was advised that revised lower rates would be implemented from 1st January 2026 for all Agenda for Change staff.

The Committee was informed of changes to Exception Reporting for Resident Doctors under the 2016 Terms and conditions of Service and recent reforms. Exception reporting is the formal mechanism for Resident Doctors (formerly junior doctors), to flag when their working day varies from their agreed work schedule. The changes were due to be implemented from February 2026 and were **noted** as a significant contractual reform designed to improve safety, ensure fair compensation, and streamline the reporting process.

The Committee received an update on the Violence Prevention and Reduction Standard, and an update on Sexual Safety and was assured that work was underway and that the policies had been updated. Further work would be progressed, including the Risk Register narrative being updated to include sexual safety.

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

The Committee was advised that the British Medical Association Resident Doctors' Committee announced that resident doctors in England would stage a further five-day strike over pay from 17th to 22nd December 2025; and that the Trust has commenced its well-rehearsed business continuity / organisational resilience planning to ensure that services would be adequately prepared and staffed to cover the period safely.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Guardian of Safe Working Report for Resident Doctors and **noted** the assurance provided.

The progress on 10-Point Plan to improve Resident Doctors' working lives was well received by the Committee; this presented an update on the Trust's progress with implementing the plan.

The Committee received and noted the Medical Education Report, which provided a comprehensive account of the medical education activity for the previous year, and key plans for the coming year.

The following Strategic Framework updates were received by the Committee; Recruitment and Retention, Learning and Development, and Health and Wellbeing. Assurance was provided on each Framework, and it was noted that further related work on Equality Diversity and Inclusion (EDI) was required. The Committee also noted the need for a more detailed understanding of the quality aspects of the frameworks. This would be considered as part of the People Strategy review.

The Working Well Annual Assurance Report was received and **noted** by the Committee. The Committee received and **noted** the Workforce Performance Report, which included additional details on recruitment and retention; and noted the assurance provided.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

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

A Staff Story on 'Training and Development, Career Journey' was shared with the Committee, which highlighted the value of good leadership and investment in people's career opportunities and the impact that this has on retention and experience of being at work.

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

A verbal update on Leadership and Culture was provided, and it was **noted** that analysis from the 2-week Fortnight would be received by the Committee in the new year.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15/0126

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 JANUARY 2026**
COMMITTEE:	**CHARITABLE FUNDS COMMITTEE – 19 December 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Vicci Livingstone-Thompson, Vice Chair of Committee

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

Nothing to report.

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

The Committee was advised of a £2k underspend for the Big health day 2024/25. Reasons for this were sought, noting the Committee was content for the Trust's portion to be returned to the general charitable fund, subject to appropriate partner discussions and financial advice.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report and **noted** that the charitable funds balance stood at £350k.

The Committee received an update on bid approvals made since the previous Committee meeting in June 2025 and **noted** 21 bids had been approved with a total value of £17k. 23 bids remained outstanding with the total value of £28k.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** (via correspondence) the establishment of the Charity Advisory Group.

The Committee received an update on the League of friends and **approved** the proposed communication plan.

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

ITEMS RECEIVED: The following items were received and discussed at the meeting
A verbal update was provided on the Five year Plan – GHC Charity.

with you, for you

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NHS Foundation Trust

AGENDA ITEM: 16/0126

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 JANUARY 2026**
COMMITTEE:	**RESOURCES COMMITTEE – 8 January 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Nicola de Iongh, 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 alerted that measure *N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage (KPI 2)* was being actively monitored and performance is expected to recover after the winter surge period. Call volumes would be monitored against forecasts and the health advisor roster fit for call answering capacity would also be reviewed.

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

A verbal update was provided on the Learning Disabilities Adult pathway review that has taken place between April and November 2025. The Committee was informed that the ICB (Integrated Care Board) Board in December, had endorsed a revised Learning Disabilities pathway and that this would include additional investment into Community Services to meet demographic growth and patient complexity, with reduced reliance on in-patient admissions. A full business case was being progressed for approval in May 2026. It was **noted** that the review was undertaken with a co-production approach with user groups, individuals with lived experience, and key stakeholders including GHCNHSFT and the ICB.

The Committee was informed that a new risk on digital and data literacy had been added to the Board Assurance Framework (BAF).

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report for the month 8 period and was assured by the Trust's financial position. The issue regarding the Capital Plan was **noted** by the Committee.

The Committee received the Quality and Performance Dashboard Report for month 8 and **noted** that appropriate service improvement action plans were developed or were in place to address areas requiring improvement, within Operational governance processes.

The Committee received the Operational Plan, Business Planning and Budget Setting update.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the proposal for 6 new domains to be included in the Quality and Performance Dashboard. These domains will be shared with Board and will be embedded into the improved reporting work, with KPIs being allocated across committees to ensure clear accountability.

The Committee **approved** the cost variation proposed for the Wotton Lawn Hospital and Greyfriars Unit decarbonisation scheme

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

The Committee acknowledged the co-production element of the Learning Disabilities pathway redesign.

The Committee applauded the progress of Transforming Care Digitally and the benefits shared.

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

The Committee received and **noted** the following:

- Service Development Report
- National Cost Collection submission
- 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 – 29 JANUARY 2026**
COMMITTEE:	**QUALITY COMMITTEE – 13 January 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Rosi Shepherd, Chair of Committee

IT IS TO BE NOTED – THE MEETING WAS IMPACTED BY CONNECTIVITY ISSUES ON MICROSOFT TEAMS THROUGHOUT

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 a briefing on the regulatory arrangements of the two Sexual Assault Referral Centres (SARC) delivered by the Trust in Gloucestershire and Swindon. Both services are non-compliant with IOS accreditation requirements; reflective of the current national position for all SARC services. The Committee tested the action plan presented and took assurance that it was working to both services being accredited within 2026/27 The Committee tested the risks and mitigations and **endorsed** the score of 16 as reflective of the current position.

The Committee was alerted to the services that have been experiencing pressures during winter. A specific update was provided related to Community Nursing Teams which related to high sickness. The Committee took assurance from the Executive oversight of the response and the improvement plan in place. The risk on the risk register is under review.

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

The Committee was advised that there was an increased number of complaints and patient safety incidents for the reporting period and that this would continue to be monitored. The Committee was advised of the resulting pressures to allocate and complete investigations in a timely manner.

The Committee was assured by the Director of Nursing, Therapies and Quality that the violence and aggression being experienced by the workforce is being looked at in conjunction with the HR and OD directorate as part of work related to the new Violence Prevention Standards. The Director of Nursing, Therapies and Quality is progressing this with the Director of HR and OD to agree reporting to the most relevant committee.

Prescribing cost issues were noted and agreed to be investigated further to understand if this was an issue. It was suggested this be referred to the Resources Committee.

The Committee receipted a letter from NHS England regarding antimicrobial resistance (AMR) and Infection Prevention Control (IPC) and **recommended** a future Board Seminar session be held to address.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received, questioned and was assured by the Quality Dashboard Report.

The Committee received an update on the Patient and Carer Race Equality Framework (PCREF) and on the progress made in terms of governance in place.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** the risk 613 (regarding PCREF) remaining at a score of 16 whilst the improvement plan progresses, given the limited impact that can yet be evidenced.

The Committee **endorsed** the risks relating to SARC remain at score of 16.

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

The Committee applauded the Service Improvement Story from the Perinatal Mental Health team and the QI work carried out, particularly noting the engagement with the South Asian community through collaboration with the trust's outreach workers.

The Committee recognised the exemplary management of IPC (infection prevention control) outbreaks over winter and the achievement of the stretch target in relation to the uptake of flu vaccinations by frontline staff. This was **noted** to be in the context of national recognition for the successful vaccine approach by Gloucestershire system.

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

The Committee **received** and **noted** the:

- Quality Assurance Group Summary Reports.
- Research and Development Annual Report.
- Suicide Prevention Strategy update, noting that this was not discussed due to time pressures at the meeting.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0126

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 29 JANUARY 2026**
COMMITTEE:	**MHLS COMMITTEE – 14 January 2026**
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 was informed of an increasing number of Deprivation of Liberty Safeguards (DoLS) referrals and staff were taking appropriate action. The Committee was alerted that the local authority was experiencing delays in assessments. This was also the case with other local authorities.

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

The Committee awaited the code of practice and further guidance for the Mental Health Act and was advised that a Programme Group would be re-established to be able to draw together the project initiation document to understand the size and the scope.

The Committee was advised that the implications of delayed Mental Health Act assessments as a consequence of the unavailability of section 12 doctors would be reviewed.

ASSURE: Inform the Board where positive assurance has been achieved

The Receipt and Scrutiny of Mental Health Act documents was received, and assurance was provided that the audit of a random selection of AMHP applications had identified no errors.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

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

The Committee was informed of the positive outcome of a recent CQC inspection of Willow Ward, Charlton Lane Hospital.

The AMHP Report received showed a decrease in transport delays.

The review of training for Mental Health Act, (MHA) Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) showed the Trust had achieved 90%.

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

A verbal update on the Mental Health Act Reforms was provided.

The Committee **received** and **noted:**

- Mental Health Legislation Operational Group update
- Minutes of the Mental Health Act Manager Forum held on the 4 December 2025