with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 28 May 2026

10:00 – 13:00

To be held in the Leckhampton Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0526	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0526	Declarations of Interest • Annual Board Declarations 2025/26	Assurance	**Paper**	Chair
10:05	03/0526	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/0526	Minutes of the meeting held on 26th March 2025	Approve	**Paper**	Chair
	05/0526	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0526	Questions from the Public	Assurance	Verbal	Chair
STRATEGIC ISSUES					
10:40	07/0526	People Strategy	Approve	**Paper**	DoHR&OD
10:50	08/0526	Anti-racism Statement and PCREF Action Plan	Approve	**Paper**	DoNTQ
11:00	09/0526	Risk Appetite Statement 2026/2027	Approve	**Paper**	DoCG
11:10	10/0526	Board Assurance Framework	Assurance	**Paper**	DoCG
BREAK – 11:20 (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:30	11/0526	Performance and Quality Dashboard Report	Assurance	**Paper**	DoF/COO
11:45	12/0526	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
12:00	13/0526	Finance Report	Approve	**Paper**	DoF
12:10	14/0526	Freedom to Speak Up 6 Monthly Report	Assurance	**Paper**	FTSU Guardian
GOVERNANCE					
12:25	15/0526	Report from the Chair	Assurance	**Paper**	Chair
12:35	16/0526	Report from Chief Executive	Assurance	**Paper**	CEO
12:45	17/0526	Senior Information Risk Owner (SIRO) Report 2025/26	Endorse	**Paper**	DoF

TIME	Agenda Item	Title	Purpose	Comms	Presenter
TO NOTE	18/0526	Use of the Trust Seal 2025/26	Assurance	**Paper**	DoCG
TO NOTE	19/0526	Council of Governor Minutes - 17 March 2026	Information	**Paper**	DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
TO NOTE	20/0526	Mental Health Legislation Scrutiny Committee (15 April)	Information	**Paper**	MHLS Chair
	21/0526	Great Place to Work Committee (28 April)	Information	**Paper**	GPTW Chair
	22/0526	Resources Committee (30 April)	Information	**Paper**	Res. Chair
	23/0526	Quality Committee (5 May)	Information	**Paper**	Quality Chair
	24/0526	Audit & Assurance Committee (14 May)	Information	**Paper**	Audit Chair
CLOSING BUSINESS					
13:00	25/0526	Any other business	Note	Verbal	Chair
	26/0526	**Dates of future Board Meetings 2026** ▪ Thursday, 30th July ▪ Thursday, 24th September ▪ Thursday, 26th November	Note	Verbal	All

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AGENDA ITEM: 02/0526

TRUST BOARD – REGISTER OF DECLARATIONS OF INTERESTS 2025/26

NAME	POSITION	DECLARATION OF INTERESTS
Graham Russell	Trust Chair	Trust Chair of Brunelcare from July 2023 to present.
Nicola de longh	Non-Executive Director Senior Independent Director Vice Chair	Chair of the Board, CUC (Committee of University Chairs) from April 2022 to present..
		Chair of Council, University of Gloucestershire from October 2019 to present.
		Senior Independent Director, Connexus Housing Group from October 2020 to present.
		Director, Honourable Company of Gloucestershire from November 2022 to present.
Debbie Forster	Non-Executive Director (from 26 January 2026)	Director & Co-owner of Novel Design which provides consultancy, coaching & workshops around tech M&E, social entrepreneurship, leadership from 2017 to present.
		Member of UK Government Digital Skills Council which is a uk government advisory board working with DSIT providing advice on digital skills across all sections. From 2024 to present.
		Advisory Board member of Institute of Coding - IOC is a consortium of universities providing training and degrees for computing, AI and digital skills. From 2022 to present.
		Podcast host of Fox Agency - provides research and hosting for a monthly tech podcast - from 2022 to present.
Steve Alvis	Non-Executive Director	Landlord to The Surgery, 42 The Street, Uley, Dursley, Gloucestershire, GL11 5SY - In the process of selling and aiming to complete by end of March 2026.
Karen Clements	Non-Executive Director (from 2 March 2026)	NED - Gloucestershire ICB (resigned position before working for GHCNHSFT).
Bilal Lala	Non-Executive Director	Director of Bilal HL Limited from February 2023 to present.
		Bristol Community Energy Ltd from January 2024 to present.
Vicci Livingstone-Thompson	Non-Executive Director	CEO at Inclusion Gloucestershire - Non financial professional interest / loyalty interest from 2016 to present. Interest declared to colleagues and flagged at relevant meetings. Will absent myself from any conversations which may present a conflict of interest.
		Trustee at Active Impact from 2013 to present. Non financial professional interest/loyalty interest. No current perceived conflict of interest, noted for transparency
		Trustee at Disability Rights UK from 2024 to present. Non-financial preofessional interest. No current perceived conflict of interest, noted for transparency.
		Executive Coach from 2025 to present. Financial Interest. No current perceived conflict of interest, noted for transparency.
Cathia Jenainati	Associate NED (Nominated)	Head of School of Business, Computing and Social Sciences (University of Gloucestershire).
		Executive Dean for Partnerships, Inclusion and Innovation (University of Gloucestershire)
NAME	**POSITION**	**DECLARATION OF INTERESTS**
Douglas Blair	Chief Executive	Member of the Gloucestershire ICB Board (from April 2023 to present)
Sandra Betney	Director of Finance	Nothing to Declare.
Neil Savage	Director of HR&OD	NED of The Fold CIC from January 2025 to present (unpaid)
Rosanna James	Director of Improvement and Partnerships	Non-financial personal interest: Trustee of Homestart Stroud and Gloucester from August 2025 - present (declared interest on GICB register as well. Would step out of any decisions if required in either my role as a Trustee of GHC charity and or, when undertaking GHC Board / Exec business.
Dr Amjad Uppal	Medical Director	Private Clinical Practice from 04.03.26 - 03.03.27 (private clinics are outside of NHS working hours. I use 'time shifting' to make up for any urgent phone calls or emails. This is approved in the job plan.
Sarah Branton	Chief Operating Officer	Nothing to Declare.
Nicola Hazle	Director of Nursing, Quality and Therapies	Working in a voluntary role as a Lay Panel Member with the College of Optometrists from May 2023 to present (will declare as relevant to agendas/matters of potential conflict)
		Interest: Remain as a bank Mental Health Inspector with the Care Quality Commission from November 2023 - November 2025 (would declare as relevant to agendas/matters of potential conflict) - **Now ceased**
Helen Child	Director of Corporate Governance and Trust Secretary	Trustee and Director of Family Society (TA Adoption Focus) from 14 April 2023 to present
		Member of the Legal Advisory Board at Anglia Rusking University (advising on legal course and careers content for ARU) from January 2026 to present

Gloucestershire Health and Care NHS Foundation Trust - **TRUST BOARD REGISTER OF ANNUAL DECLARATIONS 2025-2026**

REGISTER OF DECLARATIONS OF INTEREST - Trust Board 2025-2026								
CHAIR & NEDS	**Graham Russell** Chair	**Bilal Lala** NED	**Debbie Forster** NED	**Karen Clements** NED	**Vicci Livingstone-Thompson** NED	**Nicola de longh** NED	**Steve Alvis** NED	**Cathia Jenainati** Assoc NED
Date received:	20.03.26	17.03.26	17.03.26	29.01.26	19.03.26	25.03.26	06.03.26	20.03.26
Copy on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EXECUTIVE	**Douglas Blair** CEO	**Sandra Betney** DoF/Deputy CEO	**Neil Savage** DoHR&OD	**Dr Amjad Uppal** Medical Director	**Helen Child** Dir of Gov/Trust Sec	**Rosanna James** DoI&P	**Sarah Branton** COO	**Nicola Hazle** DoNTQ
Date received:	20.03.26	06.03.26	05.03.26	04.03.26	04.03.26	20.03.26	23.03.26	09.03.26
Copy on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FIT AND PROPER PERSONS TEST - SELF-ATTESTATION FORM								
CHAIR & NEDS	**Graham Russell**	**Bilal Lala**	**Debbie Forster**	**Karen Clements**	**Vicci Livingstone-Thompson**	**Nicola de longh**	**Steve Alvis**	**Cathia Jenainati**
Date received:	23.03.26	17.03.26	17.03.26	18.03.26	19.03.26	23.03.26	06.03.26	20.03.26
Copy on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EXECUTIVE	**Douglas Blair**	**Sandra Betney**	**Neil Savage**	**Dr Amjad Uppal**	**Helen Child**	**Rosanna James**	**Sarah Branton**	**Nicola Hazle**
Date received:	19.03.26	06.03.26	05.03.26	04.03.26	16.04.26	20.03.26	23.03.26	09.03.26
Copy on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DISQUALIFIED DIRECTOR CHECK								
CHAIR & NEDS	**Graham Russell**	**Bilal Lala**	**Debbie Forster**	**Karen Clements**	**Vicci Livingstone-Thompson**	**Nicola de longh**	**Steve Alvis**	**Cathia Jenainati**
Date actioned:	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26
Reviewer:	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov
EXECUTIVE	**Douglas Blair**	**Sandra Betney**	**Neil Savage**	**Dr Amjad Uppal**	**Helen Child**	**Rosanna James**	**Sarah Branton**	**Nicola Hazle**
Date actioned:	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26
Reviewer:	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov
INSOLVENCY CHECK								
CHAIR & NEDS	**Graham Russell**	**Bilal Lala**	**Debbie Forster**	**Karen Clements**	**Vicci Livingstone-Thompson**	**Nicola de longh**	**Steve Alvis**	**Cathia Jenainati**
Date actioned:	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26	09.03.26
Screen shot on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reviewer:	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov
EXECUTIVE	**Douglas Blair**	**Sandra Betney**	**Neil Savage**	**Dr Amjad Uppal**	**Helen Child**	**Rosanna James**	**Sarah Branton**	**Nicola Hazle**
Date actioned:	09.03.26	**09.03.26**	**09.03.26**	**09.03.26**	**09.03.26**	**09.03.26**	**09.03.26**	**09.03.26**
Screen shot on file:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reviewer:	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov	Stefan Doynov

ADDITIONAL ANNUAL CHECKS	Date Checked	Reviewer	Issues of Concern
No Employment Tribunal Judgements Found	01/05/2026	A Hilditch	No
Not Disqualified as a Charitable Trustee	01/05/2026	A Hilditch	No
Social Media Date Checked *	06/05/2026	A Hilditch	No
Open/Upheld Disciplinary Case	01/05/2026	A Hilditch	No
Open/Upheld Grievance Case	01/05/2026	A Hilditch	No

* Social Media checks carried out - Facebook, Instagram, X, LinkedIn, Google, and YouTube

MINUTES OF THE TRUST BOARD MEETING

Thursday, 26 March 2026
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sarah Branton, Chief Operating Officer
Debbie Forster, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Nicola Hazle, Director of Nursing, Therapies and Quality
Rosanna James, Director of Improvement & Partnership
Bilal Lala, Non-Executive Director *(Until Item 12)*
Vicci Livingstone-Thompson, Non- Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Amjad Uppal, Medical Director

IN ATTENDANCE:
Helen Child, Director of Corporate Governance
Anna Hilditch, Deputy Trust Secretary
Kate Nelmes, Head of Communications
Alastair Penman, External - Observing
Nick Boor, GHC - Observing
Aynslie Evans, GHC - Observing

1. WELCOME AND APOLOGIES

1.1 Apologies were noted from Steve Alvis, Karen Clements and Cathia Jenainati.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

2.2 Vicci Livingstone-Thompson reminded colleagues of her role as CEO of Inclusion Gloucestershire, noting reference to the Voluntary, Community and Social Enterprises (VSCE) partnership within the Chief Executive's report.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Tina Craig and Helen Reid to the meeting, who were in attendance to present Lee's story to the Board. Due to mobility issues, Lee had not been able to attend the meeting in person, but had agreed that a pre-recorded interview with him could be shared.

3.2 Lee is a 57 year old Military veteran who had a below the knee amputation on his left leg following complications with diabetes and arterial disease in May 2024. For the last 18 months, his remaining right foot has also developed diabetic foot disease. Some of the toes became gangrenous and gradually this foot is decaying despite efforts to improve his blood supply via an angioplasty.

3.3 Gangrene can be acutely painful, and Lee was taking a cocktail of pain relief, unable to sleep for more than 2 hours at a time and consequently his quality of life was suffering.

3.4 The Trust started seeing Lee regularly since the start of 2025 and he has been trialling a topical oxygen therapy boot. This is a treatment delivered in the patient's home, all carried out by the patient. Lee wears an inflatable boot and plugs himself into a condensing unit about the size of a mini bar. This pumps oxygen directly into the boot (& over his foot) for 90 mins per day. The aim is that oxygen is delivered directly to the wound bed, with a greater concentration that helps with wound healing & blood vessels.

3.5 Helen Reid informed the Board that since using topical oxygen, Lee initially reduced his pain relief medication by 75% and was able to sleep through the night. Consequently, he has much better sleep and feels he has the energy to do more during the day, and his quality of life has improved considerably. Importantly, the treatment has ultimately achieved wound healing, avoiding further amputation and healthcare interventions at this time.

3.6 This was a great example of collaboration between the patient, GHFT (where the foot clinic is held) and GHC who employ the podiatrists.

3.7 Helen Reid advised that the therapy costs approximately £2,600 per month and typically requires at least three months to assess effectiveness. The cost includes equipment, patient training, and remote monitoring. The Board discussed the potential for in-house delivery, patent restrictions, and the possibility of price reductions with wider adoption. Board members also debated whether the therapy should be reserved as a last resort or considered earlier in the treatment pathway, balancing resource constraints with potential benefits.

3.8 Amjad Uppal reflected on this story and said that it demonstrated the importance of investing in staff attendance at conferences where new technologies and innovation such as this topical oxygen treatment can be identified.

3.9 On behalf of the Board, Graham Russell expressed thanks to Helen Reid and Tina Craig for attending, and to Lee for agreeing to share his story. The importance of capturing and sharing learning from innovation across the Trust and system partners was highlighted.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 29 January 2026. 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 no questions had been received from members of the public.

7. REPORT FROM THE CHAIR

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

7.2 Graham Russell reported on recent visits and engagement with community and partner organisations, as well as a recent visit he had carried out to learning disability team colleagues at Pullman Place.

7.3 Graham Russell had joined the Patient and Carer Race Equality Framework Workshop (PCREF) on 26th February. The event, which took place at Churchdown Community Centre, was an opportunity for Trust colleagues, service users, carers, Experts by Experience and community representatives, to talk about the key elements of PCREF. The Patient and Carer Race Equality Framework is a mandated requirement on all mental health trusts and is an accountability framework that supports organisations to address the mental health inequalities experienced by different racial groups. Graham said that this had been a great event, noting that a second workshop was planned for 1 April.

7.4 A meeting of the Leadership and Culture Assurance Committee had taken place on 12th March, and Graham Russell reported that the organisational-level leadership and culture workstreams would now transition into the refreshed People Strategy 2026–2031. This decision reflects the natural strategic alignment between the two programmes. Insights from the Leadership and Culture Workstream Discovery and the GHC Fortnight had been integral to shaping the four areas of focus in the refreshed People Strategy. The transition ensures that we have a single, coherent framework that is simplified, sustainable, and embedded into business as usual. Assurance would be provided through the Great Place to Work Committee.

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. The Board welcomed the new format of this report.

8.2 The CEO Overview was noted, setting out key financial, quality and performance headlines, and the Board **noted** that the Trust had retained a National Oversight Framework rating of segment 2.

8.3 At the end of January, Professor Meghana Pandit, National Medical Director, who leads the improvement plan for the Department of Health and Social Care (DHSC), wrote to Trusts to say thank you for the progress made with the next steps on the

Resident Doctor 10-point plan. The 10-Point Plan was launched in August 2025, to improve a series of long-standing systemic issues that have negatively affected resident doctors. It is recognised that while there is much more to do, nationally and locally within the Trust, we have a great foundation to build on. Through the Board Champions and the Resident Doctor Peer Leads there is an infrastructure to ensure we maintain focus over the long term. Nationally, the DHSC will continue to report on progress and celebrate providers that are making a real difference to resident doctors' working lives.

8.4 Nicola de Iongh highlighted the strategic risk (Board Assurance Framework) scores for quarter 3 included within the report, noting that this looked to be moving in a positive direction. Douglas Blair agreed, noting that good progress had been made in addressing the relationships and partnerships risk over the past few months.

8.5 NHS England has launched a programme of work for Community and Mental Health providers, which intends to disaggregate historic block contract arrangements in a shift towards activity x price payment mechanisms for 2027/28 contracting (NHS health services only). The programme known as 'Deconstructing the Block' will run through 2026, with providers required to complete submissions by mid-September 2026, to allow for development of recommendations for the 2027/28 payment consultation.

8.6 The report also provided updates on the new Neighbourhood Health Framework, and the Voluntary, Community and Social Enterprise (VCSE) Partnership Model.

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

9. PEOPLE STRATEGY

9.1 The Board welcomed Michelle Hurley-Tyers (Deputy Director of People) and Siwan Purkis (Head of Leadership & Organisational Development) who were in attendance to present the refreshed GHC People Strategy 2026–2031 - the Trust's plan for delivering its Great Place to Work strategic goal and supporting the delivery of its Five-Year Focus.

9.2 The People Directorate had led a comprehensive refresh of the GHC People Strategy over 6 months, developed in direct response to what our colleagues have told us and aligned to our Trust Five-Year Focus and national NHS priorities. Over 9,360 voices and data points across 27 distinct data sources have informed this strategy - including direct colleague engagement through Our GHC Fortnight, Leadership & Culture Programme, NHS Staff Survey 2025, People Pulse, Health and Wellbeing Review, Freedom to Speak Up themes and workforce data. An inductive thematic analysis approach was used to ensure themes emerged from the evidence rather than from pre-determined assumptions.

9.3 The People Strategy is presented as a living document, subject to iterations and adaptations to meet the needs of our workforce and the new national People Plan due to launch in Spring 2026.

9.4 Siwan Purkis advised that a comprehensive engagement approach had been undertaken throughout November to February 2026 including Board Development Sessions, and the Senior Leadership Network. The steer for the People Strategy approach was discussed at the GPTW Committee on 21 October 2025 and feedback given on the 4 draft focus areas on 24 February 2026. The People Strategy was also discussed during the Leadership and Culture Assurance Committee on 12 March 2026.

9.5 The Board expressed its thanks and appreciation to the senior HR team and colleagues across the Trust who had worked to get the strategy to this stage, acknowledging the huge amount of work and engagement that had been carried out.

9.6 The importance of getting this strategy right was emphasised, and Board colleagues provided feedback on areas for further development. This included:

- The Board asked for a clearer and more explicit demonstration of how the People Strategy drives the Trust strategy and five focus areas.
- Board members confirmed they could clearly see the link between what colleagues had said and how this had helped shape the areas of focus. What was less clear, however, was how this strategy ensures that GHC can make the transformational shifts needed to meet the longer-term national direction set out in the 10-year plan.
- The Board requested greater clarity on the current position as a baseline for measuring progress, alongside a clearer articulation of what success will look like.
- The Board asked for closer alignment between the People Strategy and the Digital, Quality, Estates and Facilities and Research strategies.
- Board members requested further clarity on prioritisation and on how the strategy will be delivered.

9.7 It was agreed that further work would be carried out to consider the Board's feedback, with a revised draft to be presented back to the GPTW Committee in April, before then coming back to the Board in May for final approval.

9.8 Nicola Hazle suggested that it would be helpful to find some time at a future Board development session to receive and look at the interdependencies of the supporting strategies.

10. STAFF SURVEY RESULTS 2025

10.1 The purpose of this report was to present the results of the 2025 NHS Staff Survey for Gloucestershire Health and Care NHS Foundation Trust.

10.2 This was GHC's sixth NHS Staff Survey, covering data gathered from colleagues between September and November 2025. The 2025 staff survey results reflect a workforce that remains engaged, motivated and committed to delivering high-quality care. Across all nine People Promise elements and themes, GHC performs at or above the national sector average, with Staff Engagement and Morale both above benchmark. Regionally, GHC is first overall in the Southwest Mental Health,

Learning Disability and Community benchmarking group, achieving the highest Staff Engagement and Morale scores in the region.

10.3 The Board **noted** that the response rate was 51%, a decline from 61% in 2024, consistent with a broader national downward trend. The Trust received 2,643 responses from substantive staff. Staff advocacy for GHC as both an employer and a care provider remains strong and above sector average.

10.4 Those areas that required focused attention were presented to the Board. The People Promise theme 'We each have a voice that counts' showed the only statistically significant decline, with concerns about speaking up and organisational responsiveness evident across several questions. 'We are always learning' remains our lowest-scoring element, with appraisal quality and career development opportunities both areas of weakness. Burnout, workforce capacity and work-related stress, while better than sector average, present as a sustained pressure requiring proactive response.

10.5 Neil Savage advised that these themes were not new signals, noting that they appear consistently across the staff survey, the 'Our GHC Fortnight' engagement in November 2025, and the wider evidence base underpinning the People Strategy refresh. That alignment strengthens confidence that the Trust is identifying the genuine, recurring challenges that matter most to our workforce. Rather than treating these findings as isolated survey responses, the intention is to address them in a coordinated way, joined up through the People Strategy 2026–2031. A phased response is planned from March through to the end of 2026, with the People Strategy launch in April providing the strategic framework for sustained, meaningful action.

10.6 Douglas Blair **noted** that the results were based on a survey conducted 6 months ago so there was a time lag in receiving the responses. Assurance was received that other mechanisms were in place to engage colleagues and triangulate feedback in a timelier fashion, including pulse surveys and engagement forums.

10.7 The Board **agreed** that GHC should be proud of the results, however, the Trust was never complacent and there was always more that could be done. As in previous years, the Trust would focus its attention on those areas where scores were below average, recognising the reduction in response rate this year, and acknowledging that it was important to look at those areas of the Trust where colleagues' voices weren't being heard.

10.8 The Board **noted** the 2025 NHS Staff Survey results and GHC's overall above-sector performance across all nine People Promise elements and themes. The Board recognised the alignment with wider strategic work on Leadership, Culture, and the People Strategy, and supported the phased approach to action planning set out in the report, aligned to the People Strategy 2026–2031.

11. GENDER ETHNICITY AND DISABILITY PAY GAP REPORT

11.1 The purpose of this report was to provide the Board with the Trust's 2025 pay gap reporting following previous reporting via the Great Place to Work Committee. The report analyses pay and bonus differences across key demographic groups to

assist with the identification of any disparities in earnings across the Trust's workforce.

11.2 Neil Savage reported that the headline figure based on all eligible Trust employees and pay schemes indicated that the gender pay gap continues to slowly close, and, that women are paid 11.91% less on average than men against a previous year of 11.99%. Similar assessments can be given in varying degrees to the disability and ethnicity pay gaps.

11.3 The data indicates that in 2025 some 84% (84% also in 2024) of GHC's substantive workforce were women. An analysis would expect to show this is broadly reflected in each of the AfC pay bands, Medical and Dental pay and VSM / Executive Board level pay.

11.4 The Board **noted** section 7.2 of the report which set out the current actions and next steps. Neil Savage advised that reducing the combined Gender, Ethnicity and Disability related pay gaps was a long-term ambition and incremental improvements would only be possible through sustainable actions over time.

11.5 The Board **noted** the latest report, which would be published on the Trust website and the government website by the end of March 2026 deadline. The current and future actions were also noted and supported, with the next pay gap report to be presented to the GPTW Committee in June 2026.

11.6 The Board **agreed** the recommended commitment statement (below), to be published alongside the pay gap data on the Trust and government websites.

"Gloucestershire Health & Care NHS Foundation Trust's Board confirms its commitment to the ongoing monitoring and analysis of its Gender, Disabled and Ethnicity Pay Gap data and to developing and delivering appropriate actions aimed at reducing and eradicating the gaps over time.

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

12. FINANCE REPORT

12.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 11. The financial position was discussed and reviewed in detail at the Resources Committee.

12.2 At month 11 the Trust had a surplus of £0.373m compared to the plan of a £0.050m deficit. Cash at the end of month 11 was £45.535m, which is above plan by £3.9m. The cost improvement programme had delivered £5.62m of recurring savings against the plan of £9.082m. The target for the year is £10.086m. Sandra Betney noted that £1.352m was still unidentified. Vicci Livingstone-Thompson asked whether the unidentified CIP was something that the Board should be concerned about. Sandra Betney advised that this was a risk; however, the level of unidentified CIP

had been steadily reducing and mitigations were in place. The non recurrent savings target is £5.169m all of which has been identified, and of which £7.77m had delivered.

12.3 The 2025/26 capital plan was £15.449m with £3.265m of disposals leaving a net £12.184m programme. Net spend to month 11 was £8.335m against a plan of £12.187m. The capital forecast outturn was anticipated to be in line with plan.

12.4 The Trust's agency and off framework agency usage was included in the report, with £2.497m year to date on agency staff which was below plan by £1.139m. There were 8 off framework shifts in month 11 against the 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 £18.596m on bank staff which was above plan by £2.182m.

12.5 The Better Payment Policy shows 95.4% of invoices by value paid within 30 days and 91.7% by number of invoices, the national target is 95%. Sandra Betney advised that further analysis of this position was planned for the Audit & Assurance Committee and that increased focus was being placed on this.

12.6 The Board **noted** the month 11 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.

13. QUALITY DASHBOARD REPORT

13.1 The Board received the Quality Dashboard, which showed the data for February 2026 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.

13.2 Further work is needed to understand the resource requirements related to allegations management cases that are managed by the Safeguarding Team. The Board noted that there were 2 new cases in February, and there were 25 meetings held. This requires significant capacity of the Safeguarding Team as well as other colleagues involved in the allegations management process.

13.3 The new approach to coordinating NED quality visits is being seen since the changes agreed in Q3. Three quality visits have been scheduled in Q4 - a Community Hospital, the Wellbeing College, and a Community Learning Disability Team – with two already completed. The learning assurance team are working with each of the team leads to develop SMART actions based on the reflections provided by the NEDs. A more detailed report would come to the Quality Committee in May 2026 for assurance.

13.4 In relation to patient safety and PSIRF, the Trust did not declare any new PSIIs in February, and the 2 incidents from November have been allocated and investigations have commenced. Vicci Livingstone-Thompson asked whether there was a reason for the decrease in reported patient safety incidents. Nicola Hazle advised that some incidents were seasonal. It was positive to see the reduction, but

she was mindful that there would be fluctuation so a close eye would be kept on this position.

13.5 Nicola Hazle informed the Board that the Trust was reporting a position of compliance with NHSE/Safe Staffing Guidance in February. Across community hospitals and mental health inpatient services, safe staffing levels were broadly met, with no evidence presented this month of any patient safety incidents, quality concerns, or complaints attributable to staffing shortfalls.

13.6 The March Quality Committee took assurance that the Q3 2025/26 NED Audit of Complaints audit provides significant assurance that overall, the Trust is investigating and responding to complaints appropriately.

13.7 The Board noted that the Trust was continuing communication with the Care Quality Commission (CQC) regarding the inspection report related to Berkeley House. Monthly data continues to be submitted to the CQC under regulation 31 with the Enhanced Oversight Group resumed to monitoring discharge pathways.

13.8 Nicola Hazle advised that the Learning from Deaths Report (LFD) (Quarter 3) was presented to the Quality Committee in March, which took assurance that none of the deaths that were reviewed were considered more likely than not to be due to problems in care.

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

14. QUALITY AND PERFORMANCE DASHBOARD

14.1 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 February 2026.

14.2 Sandra Betney advised that there were 12 KPIs being monitored within the Development Source of the dashboard portfolio, awaiting authorisation from owners to go-live. There were a further 10 KPIs planned for reporting in March 2026. This will bring the overall KPI number to 173, with a further 23 in development for 2026/27. It was noted that the NHS Oversight Framework (NOF) published its Q3 rankings in March with GHC maintaining its level 2 segmentation. An updated framework is expected for 2026/27 and a review of KPIs would be required.

14.3 In terms of Alerts to the Board, 3 indicators were highlighted that had been impacted by the changing workforce and pathways due to GCC Delegated Responsibilities transfers. Assurance was received that these would continue to be closely monitored.

14.4 The Board received and **authorised** two operational directorate performance and risk group's proposals (BIMG ratified) around length of stay, including the introduction of an independent Thames Ward Length of Stay KPI.

14.5 Sarah Branton highlighted some of the key indicators to the Board, and offered reassurance on those areas of ongoing monitoring or development. Indicator N69 -

PH Percentage of bed days occupied by patients when they are ready to be discharged remained compliant, however, Sarah Branton advised that this was likely being under reported due to legacy data capture processes. System configuration improvements have been completed, and work is in progress with the service to more accurately present performance from March 2026. The Board was asked to note that this indicator would likely then present in exception.

14.6 Focusing on the Applaud section of the report, the Board noted indicator O20 - *Paediatric Speech and Language Therapy % treated within 18 weeks for routine referrals*. In July 2025, 1,348 children who had been seen for their first clinical contact counted for the KPI, were waiting over 12 months for their therapy episodes of care to start. At the end of February, only 22 were waiting for therapy to start. This was a very positive improvement, and it was suggested that a service improvement story could be received at a future Resources Committee meeting.

14.7 The Board **noted** the Quality and Performance Dashboard Report for February 2026 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.

15. BUSINESS PLANNING AND BUDGETS

15.1 The Board received the following items:

- The Trust's Annual Business Planning process for 2026/29 and the updated Business Planning Objectives for operational and corporate teams.
- The 5 Year Integrated Delivery Plan narrative, developed in accordance with the NHS England Planning Framework
- The budget setting process and outline budgets for 2026/27.

15.2 Sandra Betney advised that all 3 reports had been presented to the Trust Board at its private session meeting in January for initial sign off. Changes that had been made to the reports since that time were highlighted for Board reference.

15.3 The Board **noted** that the 5 Year Integrated Delivery Plan narrative had been updated; however, the Trust was not required to submit this to NHSE, only the activity reports, and was therefore presented to the Board for information and note.

15.4 Graham Russell noted the extensive discussion and engagement on planning and budgets by the Board and the Resources Committee over the past few months. The Board:

- **Approved** the updated business plan, noting the planned refresh in quarter 1
- **Approved** the revised revenue budgets and capital plan for 26/27, and **ratified** the revised 3-year Financial Plan and the 4-year capital programme submitted on 18th March 2026
- **Noted** the 5 Year Integrated Delivery Plan narrative which had been updated in line with the activity and finance planning submission requirements on the 18th March 2026.

16. GUARDIAN OF SAFE WORKING HOURS REPORT

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

16.2 The Board **noted** this report and the data presented for quarter 3, and was assured by the robust monitoring within the Trust.

17. *CHANGE TO TRUST CONSTITUTION*

17.1 *This item was withdrawn following receipt of updated national guidance. Revised proposals would return to a future Board meeting.*

18. COUNCIL OF GOVERNOR MINUTES

18.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 19 November 2025.

19. BOARD COMMITTEE SUMMARY REPORTS

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

- Audit & Assurance Committee (5 Feb)
- Great Place to Work Committee (24 Feb)
- Resources Committee (26 Feb)
- Quality Committee (3 March)
- Charitable Funds Committee (11 March)

19.2 Debbie Forster had chaired her first meeting of the Resources Committee following her appointment in January. She said that the Committee had received the first viewing of the Trust's Estates Strategy which was very well received, noting that this would now go through a full phase of engagement with colleagues across the Trust before being presented to Trust Board for final approval.

20. ANY OTHER BUSINESS

20.1 Nicola de Iongh expressed her personal thanks to Trust colleagues, noting that a family member had presented at the MIIU in Cirencester recently and she said that the treatment that they had received and the referral into the managing memory service had been great, and demonstrated fantastic collaboration.

21. DATE OF NEXT MEETING

21.1 The next meeting would take place on **Thursday, 28 May 2026**

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 28 May 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
26 March 2026		No actions identified.				

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AGENDA ITEM: 06/0526

QUESTIONS FROM THE PUBLIC

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

PRESENTED BY: Neil Savage, Director of People

Michelle Hurley-Tyers, Deputy Director of People

AUTHORS: Rehana Begum - Associate Director of People – L&D, OD & HR
Siwan Purkis, Head of Organisational Development & Inclusion

SUBJECT: **REFRESHED GHC PEOPLE STRATEGY – 2026-2031**

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

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

The purpose of this report is to:

This paper seeks Board **Approval** of the Refreshed GHC People Strategy 2026–2031 - the Trust's plan for delivering its Great Place to Work strategic goal and supporting the delivery of its Five-Year Focus.

Recommendations and decisions required

The Board is asked to:

- **Note** the additional activity undertaken on the refreshed People Strategy since the last Board Meeting in March 2026
- **Approve & ratify** the newly revised GHC People Strategy 2026-2031

Executive summary

This paper provides a structured response to feedback received, primarily from the previous Board session in March 2026, and sets out how each of the identified areas is being addressed. The background, evidence base, and development approach previously presented to both Committee and Board are not repeated in this paper but remain available within the earlier submissions.

Across the feedback received, consistent themes were identified, including the need for clearer and more accessible language, improved structure, stronger alignment with the Trust's overarching strategy, clearer prioritisation, resolution of content gaps, and a strengthened emphasis on colleague voice. The responses presented in this paper demonstrate how these themes are being addressed, without altering the underlying strategic intent or evidence base.

The approach has been intentionally designed to ensure the strategy remains flexible in the context of ongoing national changes, including the forthcoming NHS England 10-Year Workforce Plan and the Transforming People Services programme. The four focus areas and twenty commitments remain high level to ensure durability and adaptability. Implementation plans that cover 24 workstreams, including evaluation metrics and risk/issues assessment, are currently in development and will be brought to the June GPTW sub-board committee for assurance.

Our People strategy has four themes include:

1. **Great Leadership and Culture**
   Strategic Goal: Continue to develop compassionate, values-led leadership to shape a culture we are all proud of
2. **A Workforce Fit for the Future**
   Strategic Goal: Build a skilled, flexible workforce that delivers high quality care today and is also fit for the future
3. **A Safe, Inclusive & Healthy Workplace**
   Strategic Goal: Create the conditions within the workplace for every colleague to thrive and do their best work
4. **Working Differently, Working Together**
   Strategic Goal: Improve how we work together across the Trust and with our partners to deliver high quality care

Each theme maps directly to what colleagues told us, to our Trust Five-Year Focus and to the priorities of the NHS 10 Year Plan. The strategy takes an evidence-based approach, envisaged to support us to provide a baseline for clear evaluation metrics to assess progress in meeting our Trust Strategic Goals and in particular the Goal of **Great Place to Work:** *Be the Place where People enjoy working; learning and building a career*.
The People Strategy is presented as a living document, subject to iterations and adaptations to meet the needs of our workforce and the new national People Plan due to launch in Spring 2026. It sits alongside our Digital, Estates, Quality and Research strategies, with interdependencies recognised across all four focus areas.

Board **approval** is sought at this meeting, ahead of an organisation-wide launch in June 2026.

Risks associated with meeting the Trust's values

The People Strategy identifies explicitly the core people-related issues and themes we need to address as a Trust to meet our trust strategic aims and objectives.
Key strategic risks aligned to the themes identified include:

- **Great Leadership and Culture**
  There is a risk that inconsistent leadership behaviours, weak cultural alignment, and limited colleague voice result in poor engagement and misalignment between strategy and practice, leading to ineffective decision-making, reduced performance, and reputational damage.
- **A Workforce Fit for the Future**

There is a risk that insufficient workforce capacity, capability gaps, and poor retention compromise the Trust's ability to deliver safe, effective, and sustainable services, leading to quality failures, increased financial pressure, and regulatory intervention. There is also a risk of not being able to optimise the productivity gains for digital from sub-optimal digital skills and capabilities.

- **A Safe, Inclusive & Healthy Workplace**
  There is a risk that inequity in colleague experience, poor wellbeing, or weak safety culture leads to increased sickness absence, disengagement, and failure to identify or manage risks, resulting in avoidable harm and regulatory concern.
- **Working Differently, Working Together**

There is a risk that inefficient systems, poor information flow, and fragmented collaboration within and across organisations lead to delays, duplication, and inconsistent service delivery, limiting the Trust's ability to deliver integrated, neighbourhood-based care.

Corporate considerations	
Quality Implications	• Inconsistent prioritisation of quality and safety • Loss of confidence from colleagues, partners, and regulators • Reduced improvement and transformation capacity • Poorer patient experience and outcomes • Increased regulatory and reputational risk
Resource Implications	• Increased agency reliance and financial risk • Unsafe staffing and reduced service resilience • Reduced colleague availability and productivity • Failure to realise benefits of system working • Reduced organisational grip and pace of delivery
Equality Implications	• Variation in access, quality, and experience for both patients as well as colleagues

Where has this issue been discussed before?
- A comprehensive engagement approach was undertaken within GHC with various stakeholder groups November to February 2026 - Board Development Session 11th December - Senior Leadership Network 20th January 2026. - Leadership and Culture Assurance Committee 12th March 2026. - GPTW Committees on 21 October 2025; 24 February 2026 and 28th April 2026 (endorsement received) - Board of Directors 26 March 2026

Appendices:	**Appendix 1** GHC Our People Strategy Document

Report authorised by:	**Title:**
Neil Savage	Director of Human Resources & Organisation Development

1.0 Introduction

1.1 This paper presents the GHC People Strategy 2026–2031 for Board approval. The strategy has been developed over a period of extensive colleague engagement, evidence analysis and stakeholder testing, and represents the Trust's plan for delivering its Great Place to Work strategic goal and supporting the delivery of the Five-Year Focus.

1.2 The current People Strategy was developed during the COVID Pandemic and responded to the needs at that time. This refreshed strategy responds directly to what our colleagues have told us, to our Trust's strategic ambitions and to the requirements of the NHS 10 Year Plan.

1.3 Board approval is sought at this meeting ahead of a planned organisation-wide launch in June 2026.

2.0 Background

2.1 The NHS is entering a decade of significant change. The NHS 10 Year Plan sets out a fundamental shift in how care is delivered, moving services closer to home, focusing on prevention, reducing health inequalities and making greater use of digital technology. These changes require a workforce that is flexible, skilled, supported, growing and working differently.

2.2 Our Trust Five-Year Focus translates that national ambition, connecting services in neighbourhoods, community urgent care, partnerships with purpose, addressing health inequalities, and supporting children and young people. Delivering on these means we need people who can work across boundaries, operate in community settings and bring diverse perspectives to the care they provide.

2.3 Great Place to Work is one of our four strategic goals and our People Strategy is how we will deliver it. We have listened to our workforce - 9,360 voices and data points across 27 data sources. We know the evidence base is strong, if our people are well, valued and developing they will deliver better health and quality care, therefore our communities, patients and service users benefit.

2.4 Our refreshed People strategy sets out our priorities and commitments, sitting alongside our Digital, Estates, Quality and Research strategies to deliver our Five-Year Focus

3.0. Summary of Board feedback and response

3.1. The Board identified areas of the People Strategy that require strengthening. Each is addressed in turn below.

3.2. **Connection between the People Strategy and Trust Strategy**

3.3. The Board has asked for a clearer and more explicit demonstration of how the People Strategy drives the Trust strategy and five focus areas. A mapping activity undertaken shows more clearly the links to the People Strategy and its specific commitments that align to the five focus areas within the trust strategy. The implementation plans that sit under the strategy are more directly linked to the activities that demonstrate how the focus areas are being enabled and the interdependencies between the various

strategies. The updated version of the People Strategy (Appendix 1) also now shows more clearly the links)

3.4. **Stronger Strategic Narrative**

3.5. Board members confirmed they could clearly see the link between what colleagues had said and how this had helped shape the areas of focus. What was less clear, however, was how this strategy ensures that GHC can make the transformational shifts needed to meet the longer-term national direction set out in the 10-year plan. An additional activity was undertaken to highlight how each of the 4 themes drives the changes needed to meet our longer term national strategic goals. This is represented in the new updated version.

3.6. The NHS 10 Year Plan sets out three fundamental shifts: from hospital to community, from analogue to digital, and from sickness to prevention. The updated version shows explicitly how all four themes and all twenty commitments can be traced directly to what the 10 Year Plan requires for our GHC workforce. The delivery architecture in **diagram 1.** shows how the strategy sits within the broader strategic landscape, shaped simultaneously by national drivers, the Five-Year Focus and colleague feedback.

3.7. Staff experience was a key driver for areas of focus and will be a key driver for year 1 prioritisation however the approach to the People strategy ensured that emerging themes were verified against both national and Trust strategic requirements before finalising any focus area or commitment. The strategy introduction will be strengthened to make this explicit and traceable.

Diagram 1.

3.8. **Clarity on Current state and Future Ambition**

3.9. The Board requested greater clarity on the current position as a baseline for measuring progress, alongside a clearer articulation of what success will look like. We are not yet able to publish a full quantitative measurement framework and doing so before completion of Implementation Plans would risk being misleading. A cultural maturity analysis was completed across the four People Strategy themes. This draws on the Schein organisational culture framework, the NHS People Promise Maturity Index, and West's compassionate leadership model, and is informed by the 27 data sources underpinning the strategy. These scores represent GHC's starting point on a genuine transformation journey. They are intended as honest baselines rather than targets.

3.10. A comprehensive quantitative measurement framework, drawing on NHS Staff Survey engagement scores, sickness absence rates, vacancy rates in priority services, WRES metrics, and People Pulse data, will be developed alongside the Year 1 implementation plan and presented to the GPTW Committee in June 2026. A formal midpoint review is planned for 2028–29, with annual reporting to the Board commencing from Year 1.

3.11. In parallel, work is underway across refreshed strategies to develop a consistent measurement methodology, led and supported by the Improvement and Partnerships function. This will ensure alignment across key strategies and strengthen the longer-term evaluation approach, building on the framework outlined above.

3.12. **Closer collaboration and alignment with wider strategies**

3.13. The Board asked for closer alignment between the People Strategy and the Digital, Quality, Estates and Facilities and Research strategies. The People Strategy is the first enabling strategy to be ratified following the Five-Year Focus and was developed before the other strategies exist in final form. The strategy has been designed to be durable and directional rather than prescriptive so that the four focus areas and twenty commitments can sit alongside whatever form the other strategies take.

3.14. A formal interdependency workshop has been arranged for 28 April 2026 to map business objective links and implementation plan alignment between the People Strategy and the other strategies. Outputs will be incorporated into the Year 1 implementation plan presented to the GPTW Committee in June 2026. The most significant interdependencies between People and Digital on digital confidence, between People and Estates on working environments, and between People and Quality on safety to speak up, learning and improvement have been identified and will be explored in more detail, ensuring interdependencies are mapped to avoid duplication of effort and resource.

3.15. An additional consistency conversation took place in ATOC and a template was agreed. The new updated People Strategy reflected this new template – with consistency in terms of colour, language and alignment following feedback.

3.16. **Clearer prioritisation and clarity of the how**

3.17. Board members requested further clarity on prioritisation and on how the strategy will be delivered. The high-level work plan was developed to set out the key programmes

that will be prioritised, aligned to the Five-Year Focus and integrated with Trust business planning. Some activity will be completed within Year 1, while other initiatives are multi-year programmes, commenced in Year 1 and delivered across Years 2 and 3.

3.18. The People Directorate leads are currently developing operational implementation plans to sit beneath this framework, making Year 1 priorities explicit. There are 7 leads and 24 workstreams. These will set out how the people directorate activity aligns with the Five-Year Focus, responds to the 2025 staff survey feedback and wider colleague feedback and contributes to the delivery of longer-term People Strategy commitments. Together, these elements provide a clear, evidence-based rationale for the allocation of effort and resources. Each programme will have named leads and defined measures of success.

3.19 The updated People Strategy 2026–2031 with the additional activity named above, was presented to the Great Place to Work Committee on 28 April 2026; and the committee endorsed the activities undertaken to meet the Board's feedback. To note – the updated template provided by ATOC was provided after the 28 April 2026 – so this version is different in terms of appearance to the one discussed in the April GPTW sub-board committee – however the content remains the same.

4.0 A framework operating in a changing national context

4.1 The People Strategy has been designed to accommodate significant national change that has not yet materialised. The NHS England 10 Year Workforce Plan has not been published at the time of this paper. When it is published it will set national requirements around workforce supply, training reform, role redesign and digital capability. The strategy's focus area 2 commitments are designed to be consistent with the direction of any credible national workforce plan, with specific targets and timelines to be calibrated once the plan is published.

4.2 The Transforming People Services programme will bring structural and operational change to NHS workforce functions, including potential changes to how HR, OD, recruitment and workforce planning services are configured across the system. The strategy has been designed at the level of focus areas and commitments rather than service delivery structures so that what GHC commits to do for its people is durable, while how the People Directorate is organised to deliver it can adapt as the programme develops.

4.3 Implementation planning will be explicit about which activities are dependent on national planning decisions, and which can proceed regardless, ensuring GHC makes progress without waiting for national clarity that may not arrive on the timetable the strategy requires.

5.0 Conclusion

5.1 Our GHC People Strategy 2026-2031 is grounded in the most comprehensive evidence base the Trust has assembled for a people-focused strategy — 9,360 voices and data points across 27 data sources, analysed rigorously and tested with stakeholders at every level of the organisation.

5.2 It responds directly to what our colleagues have told us, reflects our current organisational reality honestly and sets out a clear and ambitious direction for the next five years. The themes, goal statements and commitments that sit beneath them will support GHC to attract, recruit and retain talented people, build a

supportive and inclusive culture, develop values-led leadership and enable our workforce to deliver outstanding care for the communities of Gloucestershire.

5.3 Approval of this strategy marks the beginning of this work. Delivered well, it will enable GHC to meet its Great Place to Work strategic goal, fulfil the requirements of the NHS 10 Year Plan and ensure our people have what they need to thrive.

5.4 The Board is asked to approve the People Strategy 2026–2031 and support its launch to our organisation in June 2026

6.0 Next Steps

6.1 We invite the Board to note the updated People Strategy, the 4 theme areas, goals and commitment statements and consider the work undertaken to get to these.

6.2 The Board is requested to:

- Approve the GHC People Strategy 2026–2031 as the Trust's people framework for the period 2026 to 2031
- Note The Year 1 implementation plan, including the full measurement framework and team portfolio plans, will be presented to the GPTW Committee at the June 2026 meeting.
- Note the date of the planned organisation-wide launch of June 2026.

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AGENDA ITEM: 07.1/0526

Our People Strategy 2026 - 2031

Creating a Great Place to Work Together for Better Healthcare

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Our People Strategy

Our People Strategy sets out how we will become a great place to work. The four prioritised themes in Our People Strategy are for everyone in the Trust. It is a commitment to **and** by every colleague who works at Gloucestershire Health and Care Foundation Trust.

We have listened widely, looked at the evidence and been honest about where we need to improve collectively. Shaped by 27 data sources and more than 9,360 voices and data points.

Our strategy will help us deliver our Trust Five-Year Focus and the NHS 10 Year Plan: Fit for the Future. We know when we feel supported, valued, included and able to grow, we deliver better health and quality care for the people of Gloucestershire.

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Our People Strategy Themes

Creating a Great Place to Work Together For Better Healthcare

Great Leadership and Culture

Continue to develop compassionate, values-led leadership to shape a culture we are all proud of.

A Workforce Fit for the Future

Build a skilled, flexible workforce that delivers high quality care today and is fit for the future.

A Safe, Inclusive and Healthy Workplace

Create the conditions for every colleague to thrive and do their best work.

Working Differently, Working Together

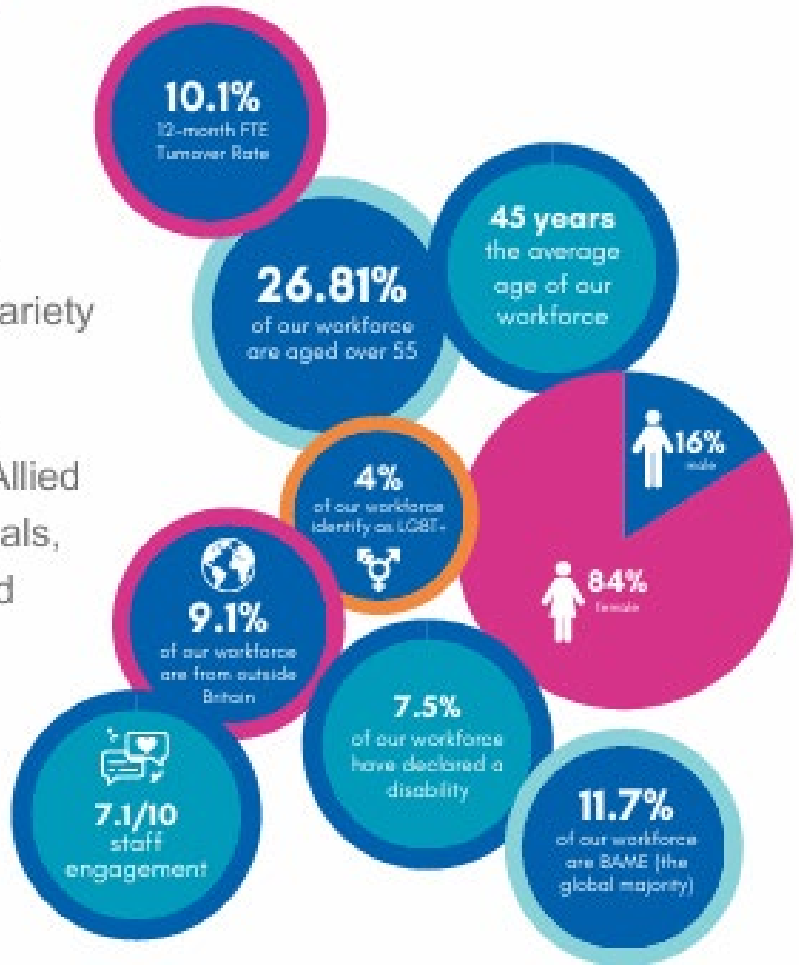
Improve how we work together across the Trust and with our partners to deliver high quality care.

Our Workforce

Total colleagues:
5,263

4,389.53
Whole Time Equivalent

We employ **5,263** people across a variety of professions, including doctors, dentists, nurses, Allied Health Professionals, social workers and support staff.



Supported By Our People Directorate

What we do
The People Directorate is committed to helping make our Trust a great place to work for everyone. We want all colleagues to feel informed about the support available and confident about where to go for help. By working together with colleagues across the Trust, we aim to ensure the support we provide reflects people's needs and experiences

Working alongside Services
Our People business partners work closely with services, understanding what is needed and connecting teams to the right support

Specialist support
Our specialist teams across GHC provide a range of support. This includes; learning and development, professional and practice education, organisational development and inclusion, medical staffing, recruitment, occupational health, wellbeing, workforce information and planning and People Services (formerly HR)

Great Leadership and Culture

Continue to develop compassionate, values-led leadership to shape a culture we are all proud of

Why is this our focus?

Across the information we reviewed, leadership and culture stood out most. Colleagues told us they want leaders who are visible, include them in decisions and help them see the impact of their work. They want to see a stronger culture, clear values and behaviours, they want a voice and better ways to learn and grow together.

Strong leadership based on our values is key to delivering our Five-Year Focus. It will help neighbourhood care work, support us to respond to urgent care needs, build an inclusive culture that fosters research and innovation, helping us to improve how we work with our partners.

The NHS 10 Year Plan calls for accountable leadership, empowered staff and a culture of continuous improvement.

"We need visible and inclusive leadership behaviours"
Colleague

What do we want to do?

We will: -

- Grow leaders at every level who live our values and behaviours
- Support leaders to be visible, inclusive and take responsibility for their actions
- Strengthen colleague voice and involvement in decision-making
- Help leaders to connect their teams to why we are all here and the difference we make
- Foster a culture where we learn from experience, repair relationships and keep improving
- Ensuring that every colleague plays their part

"We need more involvement in change and decision making"
Colleague

How are we going to do it?

- Introduce and use the NHS leadership and management framework
- Review and promote the behaviours that bring our values to life
- Build a coaching and mentoring offer that grows skills within the Trust and with our partners
- Embed a Restorative Just Learning Culture across GHC
- Bring people support closer to services through HR and OD business partnering
- Create more effective and regular ways of listening to colleagues to understand experience and increase invovlement in decisions
- Embed our values at every stage of a colleague's journey at GHC

"My immediate team is supportive however the wider culture could be improved"
Colleague

A Workforce Fit for the Future

Build a skilled, flexible workforce that delivers high quality care today and is fit for the future

Why is this our Focus?

We heard from colleagues that workforce skills and capacity are important. They told us they want to grow, develop and reach their full potential, but high workloads, unclear development pathways and gaps in line management support are getting in the way.

A skilled, sustainable and innovative workforce is essential to deliver neighbourhood care, building joined up teams and meet the growing demand on our services. It helps us attract and keep the right people and grow talent from within our communities.

The NHS 10 Year Plan calls for modern training, more apprenticeships, new roles and a stronger focus on attracting and keeping local people.

"Greater level of staffing required"
Colleague

What do we want to do?

We will: -

- Plan and build a modern workforce that is digitally confident and ready for neighbourhood care
- Recruit and keep the right people and grow talent from within our communities
- Invest in our line managers so they have the support and skills to manage well
- Create clear pathways for colleagues to develop and grow their careers
- Support colleagues to understand their roles, make confident decisions and take ownership of their work

"Upskill staff in digital literacy"
Colleague

How will we do it ?

- Improve workforce planning and systems so we have the right people in the right place at the right time
- Roll out E-Rostering and e-Job Planning to give colleagues and managers better control of workloads
- Use values-based recruitment so we attract the right people
- Grow talent from the communities we serve as part of our community promise
- Expand apprenticeships and open up careers at GHC to more people
- Create clear talent and clinical career pathways so colleagues can grow and progress
- Provide learning and development opportunities that help every colleague reach their full potential, including line management development

"The Trust needs to review the training and CPD opportunities"
Colleague

A Safe, Healthy and Inclusive Workplace

Create the conditions for every colleague to thrive and do their best work

Why is this our focus?

Colleagues told us safety, inclusion and wellbeing are key concerns. They want to feel safe, valued and supported but workload pressures and fairness at work are making this harder. They want to see improvements in equity and overall staff experience.

A safe, inclusive and healthy workplace is essential to our Five-Year Focus. We cannot provide inclusive care if our workforce does not feel included. Supporting wellbeing, managing workloads fairly and building a workforce that reflects our communities will help us achieve this.

The NHS 10 Year Plan calls for fair access to careers, healthy workloads and a diverse workforce.

"Appreciate the focus on wellbeing"
Colleague

What do we want to do?

We will: -

- Advance equity and inclusion through deliberate anti-racism work and challenge discrimination in all areas
- Protect the physical and psychological safety of every colleague and address concerns quickly
- Prioritise the health and wellbeing of every colleague acting early and with care
- Actively manage workloads so every colleague can do their best work
- Ensure every colleague feels valued and recognised for their contribution

"It can be difficult to speak up because you do not want to stand out or be seen as being different"
Colleague

How are we going to do it?

- Deliver a clear equality, diversity and inclusion programme including anti-racism programme, education offers and Staff Network support
- Introduce a Recognition approach so every colleague feels valued for the difference they make
- Strengthen our Occupational Health service with a simple digital way for colleagues to access support quickly
- Put in place Violence Prevention and Reduction Standards to protect the physical safety of every colleague
- Build a colleague wellbeing offer, including colleague treatment services, so everyone can access the right support
- Use inclusive recruitment and positive action to open up volunteering, work experience and apprenticeship opportunities

"I feel there could be greater access to mental health support for staff"
Colleague

Working Together, Working Differently

Improve how we work together across the Trust and with our partners to deliver high quality care

with you, for you

Why is this our focus?

Improving how we work together came through as a strong theme. Colleagues told us that the way we work across teams, how we share information and communicate has a direct impact on their experience and the care they deliver. They want to see improvements in collaborative working, clearer communication, stronger team working, improved systems, processes and working environments.

Working differently and working together is fundamental to our Five-Year Focus. Joined-up neighbourhood care, integrated teams and stronger partnerships with our communities all depend on it. We also know that building the skills to work effectively with external partners is essential.

The NHS 10 Year Plan calls for integrated working and stronger collaboration across the system.

What do we want to do?

We will:

- Make sure every colleague receives clear and honest communication
- Improve our working environments and resources available to our people
- Build strong and connected teams that work well across our services
- Develop the skills our colleagues need to work well with partners and our communities
- Simplify our systems and processes and embrace new ways of working to free up time for care

How are we going to do it?

- Simplify People Services processes and introduce self-service tools so colleagues can get support quickly
- Provide a team development offer that supports teams to work well together
- Build the skills needed to work across the system through leadership development
- Improve communication with colleagues through a clear listening approach, acting on feedback
- Strengthen partnerships with higher education through our community promise work
- Work with our Digital teams to build digital confidence, improve user experience and provide tools that free up time for care
- Work with our Estates & Facilities teams to improve working environments, with a focus on colleague experience and accessibility

"Staff want honest, transparent communication"
Colleague

"Clearer communication to those at the ground level"
Colleague

"I would like to spend more time finding out what other teams do – we work in silo's"
Colleague

Gloucestershire Health and Care
NHS Foundation Trust

How will we measure our progress?

with you, for you

People Strategy 2026–2031

CULTURAL MATURITY
BASELINE SCORE

2.1

out of 5

Average across 4 focus areas

The 2026 Cultural maturity assessment measures how deeply our values, leadership behaviours and ways of working are embedded across GHC. Scores are based on inductive thematic analysis of 27 data sources and 9,360+ voices.

- Leadership & Culture is the **most raised concern** across 23/27 data sources out of all 4 themes
- Workforce Capacity — **highest sub-theme** at 21/27 sources
- All four focus areas sit between **Levels 1.8–2.5** on the maturity scale

*High sub-theme frequency = area of unmet need, not strength.

Metrics

- NHS Staff Survey, Pulse Survey
- WRES/ WDES Data
- Freedom to Speak Up themes
- Key People metrics e.g. ER cases, Exit data
- Risk & Issue Register
- Quality Performance Metrics
- Wellbeing Metrics
- Additional Qualitative data

Cultural Maturity Assessment People Strategy Focus Area Scores

Great Leadership & Culture	Workforce Fit for the Future	Safe, Inclusive & Healthy Workplace	Working Differently, Working Together
2.5/5	2/5	2.2/5	1.8/5
Level 2.5	Level 2	Level 2.2	Level 1.8

Maturity Scale

5 · Embedded / Exemplary
Self-sustaining; behaviours consistently modelled

4 · Embedding / Generative
Measurably embedded; proactively developed

3 · Developing / Proactive
Active programmes; monitored & improving

2 · Aware / Compliance
Acknowledged; some action but inconsistent

1 · Absent / Reactive
Not yet addressed; reactive only

We will use this assessment approach each year to measure our progress

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

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

PRESENTED BY: Douglas Blair, Chief Executive Officer

AUTHOR: Nicola Hazle, Director of Nursing, Therapies and Quality
Gemma Rust, Head of Professional MH and LD Nursing
Ruth Eustace, Clinical Development Practitioner

SUBJECT: **PCREF INTENT STATEMENT AND PCREF ACTION PLAN**

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 Trust Board with Final versions, of the
- Trust Anti-Racist Intent Statement
- Trust PCREF Action Plan for Year 1

Recommendations and decisions required

Trust Board are asked to:

- **APPROVE** the Trust Anti-Racist Intent Statement and publication on the Trust's public facing website
- **APPROVE** the Trust PCREF Action Plan and publication on the Trust's public facing website

Executive Summary

The National Mental Health Act Review (2018) recommended that NHS England develop a framework to address the mental health inequalities experienced by different racial groups. The Patient and Carer Race Equality Framework (PCREF) is an NHS England accountability framework and is a key component of the Advancing Mental Health Equalities Strategy (2020).

As of 1st April 2025, PCREF is mandatory for all mental health trusts in the national standards contract, with associated national reporting. It will become part of Care Quality Commission (CQC) inspections.

An advisory report completed by the internal auditors in Q1 2025/26 assessed and mapped the Trust's position against the three areas of the Patient Carer Race Equality Framework (PCREF) and identified several areas for improvement. Updates to Quality

Committee in January 2026 showed good progress against the timescales set in the improvement plan with planned work during quarter 4 that will enable the trust to be in an improved position for the start of 2026/27.

A Board Development Day in April 2026 provided opportunity for the Board to hear about the engagement with communities and staff in two sessions during Quarter 4 and to contribute to the development of the Trust Anti-Racist Intent Statement.

Approval of this Anti-Racist Intent Statement and its PCREF Action Plan at Trust Board is public commitment of the organisation to the expectations of the Framework, following which both will be published on the Trust's public facing website.

Corporate considerations	
Quality Implications	PCREF is a mandatory requirement for all mental health trusts and will form part of Care Quality Commission (CQC) inspections
Resource Implications	Successful implementation will require identifiable leadership and dedicated capacity alongside input into the work from across all Trust directorates.
Equality Implications	PCREF is an accountability framework to address the mental health inequalities experience by different racial groups. It is a key component of the NHSE Advancing Mental health Equalities Strategy (2020). There should be connectivity to existing Equality, Diversity & Inclusion (EDI) and Equality Delivery System (EDS) work in the Trust.

Where has this issue been discussed before?

1. Executive Meeting – 25/02/2025 – Progress Report on PCREF
2. Quality Committee – 06/05/2025 – PCREF Position Paper
3. Quality Committee – 02/09/2025 - Position Statement: Quality Internal Audits 2025/26
4. Executive Meeting - 24/06/2025 – PCREF Next Steps (including BDO advisory report)
5. Quality Assurance Group – 18/07/2025
6. Audit and Assurance Committee – 07/08/2025
7. Quality Committee – 13/01/2026 – PCREF Progress Update
8. Board Development Day – 23/04/2026 – draft PCREF Anti-Racist Intent Statement
9. Executive Team – 12/05/26 – Draft Anti-Racist Intent Statement and Action Plan

Appendices:	None

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

PCREF INTENT STATEMENT AND PCREF ACTION PLAN

INTRODUCTION

The National Mental Health Act Review (2018) recommended that NHS England develop a framework to address the mental health inequalities experienced by different racial groups. The Patient and Carer Race Equality Framework is an NHSE accountability framework and is a key component of the Advancing Mental Health Equalities Strategy (2020).

As of 1st April 2025, PCREF is mandatory for all mental health trust in the national standards contract, with associated national reporting. It will become part of Care Quality Commission (CQC) inspections.

An advisory report completed by the internal auditors in Q1 2025/26 assessed and mapped the Trust's position against the three areas of the Patient Carer Race Equality Framework (PCREF) - leadership and governance, data and feedback mechanism. It also reviewed the Trust against current CQC PCREF guidance and interim requirements. The dynamic and relational nature of the PCREF framework is such that embedding it into the culture and way of working in the Trust is expected to build over a longer period than the improvement plan.

Progress on the improvement plan was presented to the Quality Committee on 13 January 2026. The update shows good progress against the timescales set for improvement with planned work during quarter 4 that will enable the trust to be in an improved position for the start of 2026/27.

Part of the national contract requirements of implementing the framework, sets an expectation under governance and leadership the Trust will have publicly stated and published its commitment to being an anti-racist organisation, and to have published plans that it intends to deliver the framework through.

In response to this requirement, the PCREF steering group have

- Increased awareness of PCREF across the Trust including engagement at meetings such as Working Together Network, Governors meeting, more frequent Trust communications and a dedicated web page
- Reviewed the data we hold in our incidents, complaints
- Co-ordinated and held two community engagement events during Quarter 4, attended by 39 and 46 colleagues and members of our communities respectively – at Churchdown Community Centre and the Friendship Café.
- Collation of feedback/ further thoughts from attendees, steering group members and wider Trust engagement, e.g. with the Equality Diversity and Inclusion Team in Human Resources and Organisation Development to ensure alignment of messaging on anti-racism.

TRUST ANTI RACIST INTENT STATEMENT

In developing this anti racist intent statement below, collaboration with colleagues in the People Directorate has ensure that this intent statement aligns with the refreshed GHC Trust 'People Strategy' and the Trust 'Values and Behaviours' Statements Who We Are > Glos Health & Care NHS Foundation Trust. One of the commitments in the People Strategy (Focus Area 4 – commitment 1) relates directly to Anti-racism.

Our Anti-Racist Intent Statement 2026

'We will value everyone and their differences by being visibly and vocally anti-racist'.

We acknowledge that racism is experienced daily by our colleagues and the communities we serve.

At Gloucestershire Health and Care NHS Foundation Trust, we commit to listening with humility, learning from lived experiences, and building trust through consistent action because not tolerating racism is not enough.

We will work towards creating safe and inclusive spaces where people feel valued, respected, and able to speak openly without fear.

We will engage in partnership with colleagues, patients, carers - produce change and ensure our services are equitable, inclusive, and responsive to diverse needs.

We will be transparent about our action, our impact and where we need to do better.

We will take meaningful steps to reduce inequity.

We will improve outcomes for All.

Our Board and senior leaders hold named, visible accountability for progress against this plan, and will report transparently on impact. Every member of our workforce shares responsibility for making anti-racism real in their daily practice — in how they treat colleagues, patients and carers, and how they respond when they witness racism.

TRUST PCREF ACTION PLAN

The Trust Action Plan is structured around the PCREF organisational competencies: Cultural Awareness, Staff Knowledge, Partnership Working, Co-Production, Workforce, and Co-Learning - NHS England » Patient and carer race equality framework

This plan supports a shift:

- **From awareness → to action**
- **From statements → to accountability**
- **From doing "for" communities → to working "with" them**
- **From isolated initiatives → to sustained cultural change**

Anti-racism becomes **"how we do things here"**, not an add-on.

Following collation of feedback from sources cited above the below ambitions have been formulated. It is recognised that the ambitions contains both short term and long-term objectives, many may be expressions of a desired future state rather than specific actions. An annual SMART (specific, measurable, attainable, relevant, time based) Action Plan for Year 1 is set out to assist; with recognition that these may seem transactional, they will build over future years to being more relational to deliver the cultural change.

The work of the PCREF Steering Group will be provide regular assurance on progress internally and to share regular updates with our engagement partners and external stakeholders. Table 1 sets out the Year 1 Action Plan for 2026/27. Further work will be undertaken during 2026/27 to set out the action plan for years 2 and 3.

Gloucestershire Health & Care NHS Foundation Trust: PCREF Action Plan

Ambition 1. Cultural Awareness

Purpose: Build a shared understanding of racism, culture, identity, and power across the organisation.

Key Stakeholders: Organisational Development People's Promise/Strategy Team. EDIA. Partnership and Inclusion Team. Transformation/QI Team.

Core Actions

- **Cultural insight** – Conduct a deeper analysis of our diverse populations and their cultural needs to inform education and service design
- **Cultural competence learning** — Provide ongoing education on cultural norms, intersectionality, and lived experience.
- **Shared anti-racist language** —Build confidence and curiosity of colleagues to engage in honest conversations about race and inequity. Make clear that the willingness to learn, listen and reflect matters more than getting language perfect. Provide accessible guidance on language as a resource to reduce barriers to engagement, not a test.
- **Normalising discomfort** — Embed the expectation that difficult conversations are part of safe, inclusive practice.
- **Cultural humility** — Promote humility, curiosity, and openness as everyday behaviours.

Expected Outcomes

- Colleagues recognise that racism can be structural, not only interpersonal.
- Cultural awareness becomes embedded in daily practice, not a one-off training.
- People feel safe to speak up and challenge.

Ambition 2. Colleague Knowledge

Purpose: Ensure all colleagues understand racism, bias, inequity, and their responsibilities. (This will include comms plan).

Core Stakeholders: Training and Development. Comms. HR. Psychological Therapies. FTSU Guardian and Champions. BI. EDIA.

Core Actions

- **Anti-racism training** — As part of a longer-term learning approach, deliver mandatory, ongoing learning on:
    - Unconscious bias
    - Systemic racism
    - Power and privilege
    - Courageous conversation
- **Reflective practice** — Build structured reflection into supervision, appraisals, and team meetings.
- **Practical application** — Move beyond awareness to real-world scenarios, case studies, and role-play.
- **Data confidence** — Training to interpret equity data and understand disparities.

Expected Outcomes

- Colleagues can identify racism at individual, organisational, and systemic levels.
- Colleagues feel more confident challenging racism and supporting colleagues.
- Knowledge translates into consistent, equitable practice.

Ambition 3. Partnership Working

Purpose: Build strong, trusting relationships with communities, grassroots groups, and external partners.

Stakeholders: Partnership and Inclusion Team. Experts by Experience. Spiritual Care Team. Transformation/QI Team. ICB. GCC. VCSE.

Core Actions

- **Community engagement** — Engage regularly with community leaders, grassroots organisations, and racialised groups.
- **Lived experience partnerships** — Value qualitative insight as equal to quantitative data.
- **Shared decision-making** — Ensure communities influence priorities, not just respond to them.
- **Transparency** — Communicate how community input leads to change.

Expected Outcomes

- Trust is strengthened between the organisation and communities.
- Services reflect the needs and experiences of racialised groups.
- Partnerships become long-term, not reactive.

Ambition 4. Workforce

Purpose: Build a fair, inclusive, anti-racist workforce where everyone can thrive.
Stakeholders: HR. Recruitment. EDIA. Learning and Development. Organisational Development. VCSE. FTSU. WW. Psychological Therapies.

Core Actions

- **Equitable recruitment** — Review recruitment, promotion, and progression processes for bias.
- **Leadership accountability** — Embed anti-racist expectations into leadership roles and performance objectives.
- **Safe reporting routes** — Ensure trusted, transparent processes for reporting racism.
- **Support for affected colleagues** — Provide advocacy, wellbeing support, and restorative approaches.
- **Collective responsibility** — Reinforce that anti-racism is everyone's job, not only those most affected. Address the co-creation gap by engaging and including majority-group colleagues in the work.

Expected Outcomes

- Reduced inequities in recruitment, retention, and progression.
- Colleagues feel safe, supported, and valued.
- Leaders model anti-racist behaviours consistently.

Ambition 5. Co-Learning

Purpose: Create a culture of continuous learning, reflection, and improvement.

Core Actions

- **Learning from data** — Use quantitative data and lived experience together to identify inequities, building a set of outcome measure to aid continuous learning and improvement
- **Continuous improvement cycles** — Regularly review progress, evaluate impact, and adjust actions.
- **Sharing learning** — Communicate successes, challenges, and lessons openly.
- **Cross-sector learning** — Learn from other Trusts, community organisations, and national bodies.

Expected Outcomes

- Anti-racism becomes embedded in organisational learning systems.
- Colleagues see progress and understand their role in improvement.
- The organisation remains accountable and transparent.

Ambition 6. Co-Production

Purpose: Work *with* communities, not *for* them.

Core Actions

- **Co-designing services** — Involve service users and colleagues with lived experience in designing policies, pathways, and interventions.
- **Shared ownership** — Ensure co-production is built into governance, not optional.
- **Feedback loops** — Show clearly how feedback has shaped decisions.
- **Safe spaces** — Create brave, psychologically safe spaces for open dialogue.

Expected Outcomes

- Solutions are grounded in lived experience.
- Communities feel valued, not consulted as a formality.

- Co-production becomes the default way of working.

Trust PCREF Action Plan 2026/27 (Year 1)

This Action Plan is an initial proposal for the areas of focus during 2026/27, recognising that further iterations are required through the PCREF Steering Group to ensure it is correctly focused and SMART. Further the PCREF Steering Group will, during 2026/27 develop the Action Plan for Year 2 and Year 3. The Board is asked to give approval for this Year 1 Action Plan on the understanding that it is iterative, and any public facing version will be updated to reflect the changes agreed.

Ambition	Action Number	Action	Due Date
Cultural Awareness	1.	Advertise Cultural Competence e-learning training to all Mental Health and Learning Disability staff with a view of 50% having completed this training in next 12 months	May 2027
Cultural Awareness	2.	Increase communications, raise awareness and engagement with PCREF within GHC by: Intranet page, posters in all patient facing areas, details of how to get involved on intranet, bi-monthly newsletter available on intranet.	Dec 2026
Staff Knowledge	3.	Improve Ethnicity recording across GHC with the aim of <20% patients with 'not stated' across RIO electronic patient recording system.	Dec 2026
Staff Knowledge	4.	Report through Quality Dashboard on how many Trust employees are accessing PCREF Tableau dashboard via Business Intelligence	From June 2026
Partnership	5.	PCREF to be advertised and represented at Big Health Check event in June 2026	June 2026

Further work is planned with the Communications Team to format the Trust Anti Racist Intent Statement and the Trust PCREF Action Plan so that it is accessible and engaging for publication on the Trust website, for internal and external engagement and communications.

CONCLUSION

Quality Committee took assurance in January 2026 that progress of the improvement plan is on track with the timescales as set. Trust PCREF leads have been actively engaged in a wide range of national meetings and forums as well as leading two county focused engagement events with local communities and staff to develop a Trust Anti-Racist Intent Statement and Trust PCREF Action Plan. The final drafts of both are being shared ready for approval today by Trust Board. Approval of these will lead to them being published on the public facing website and will be a further step in achieving compliance with the Leadership and Governance aspect of the Framework.

with you, for you

NHS
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AGENDA ITEM: 09/0526

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

PRESENTED BY: Helen Child, Director of Corporate Governance

AUTHOR: Helen Child, Director of Corporate Governance

SUBJECT: **RISK APPETITE STATEMENT – 2026-2027**

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 seeks Board approval of the revised Risk Appetite statement for 2026-27, based on input from a Board Development workshop in March 2026 and the experience of delivering risk management within the Trust.

It is best practice for risk appetites to be reviewed at least annually to ensure planning and decision-making reflect the Board's up to date assessment of the nature and extent of risks to the organisation achieving its strategic objectives.

Recommendations and decisions required

The Board is asked to:

- **Approve** the risk appetite statement and definitions attached to this paper
- **Approve** the revised risk appetite descriptors within the risk appetite statement.

Executive summary

Drawing on input from a Board workshop in March 2026 and the experience of the Risk Team in delivering risk management within the Trust, the revised risk appetite statement includes several new categories of risk, primarily relating to corporate functions. These have mainly drawn on the categorisation and description from the HM Treasury Orange Book, which represents risk management best practice in the public sector. New and renamed categories are highlighted in the attached document for ease of identification (the highlighting will be removed in the published version).

Some descriptions of risk and opportunity type have also been amended to reflect the input from the Board workshop.

The risk appetite descriptors have been amended in full:

None ➔ Averse
Low ➔ Limited
Moderate ➔ Measured
High ➔ Progressive
Significant ➔ Transformational

This is based on the recommendation from the Board workshop facilitator, whose experience shows that the revised language is more representative of reality and enables a more open discussion of willingness to take transformational decisions. This was positively received at the Board workshop.

The overall aim of the changes is to make the risk appetite statement more descriptive for those who need to use it to score their risks.

Risks associated with meeting the Trust's values

The absence of an up to date and appropriate risk appetite statement compromises the maturity and usability of the Trust's risk management approach.

Corporate Considerations	
Quality Implications	Regulation 17: Good Governance (Health and Social Care Act 2008 regulations, 2014) includes a requirement to put in place systems and process to "assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others". Good governance systems and processes are key elements within the CQC Well Led framework.
Resource Implications	The proposed changes do not create additional resource implications.
Equality Implications	None identified.

Where has this issue been discussed before?

- Board Development Workshop, 14 March 2026
- Executive Team meeting, 19 May 2026

Appendices:	AI-09.1 - Risk Appetite Statement, 2026/2027

Report authorised by: Helen Child	**Title:** Director of Corporate Governance

RISK AND OPPORTUNITIES APPETITE STATEMENT 2026/2027

The purpose of the Risk Appetite Statement is to inform all those responsible for identifying and managing risk at Gloucestershire Health and Care NHS Foundation Trust (GHC) of the context to use when assessing how a risk should be evaluated, mitigated and controlled.

The Risk Appetite Statement provides the Board's appetite for risk taking and appetite thresholds and is mapped against the Trust's Strategic Priorities and core business. The risk appetite for 2026/27 is similar to the previous year. This reflects the challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, and the pace of societal and technological changes. It also reflects the Board's commitment to transformation of services to achieve our strategic purpose; helping our population live their best life by delivering great healthcare.

In relation to Quality and Safety, Service User Experience, Demand and Capacity, Financial, and Data and Digital we will continue to have a measured risk appetite, enabling us to explore opportunities whilst ensuring the breadth and importance of these areas is subject to sufficient oversight. Estates and Facilities has been added, with a measured risk appetite to ensure that our estate is fit for the community we serve and our colleagues who work here.

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

To achieve our aims of providing outstanding care, we have a progressive-risk appetite in our approach to Innovation and Transformation, Meeting Population Needs, Partnerships and Collaboration, and Our People. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships. The digital agenda will underpin innovation and the transformation of services to become more efficient and effective. Whilst we are prepared to accept higher levels of risk to implement changes for longer term benefit, we have a limited appetite in relation to Regulatory (Legal) and Governance risks.

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

The Risk Appetite Statement was approved by the Trust Board on 28 May 2026.

Risk and Opportunity Appetite Themes

Risk Theme	Risk Domains	Appetite Description	Appetite Level	Threshold	Reporting Impact
Quality and Safety	Quality of care. Safety of service users. Safety of the public.	**Risks** arising from inadequate, poorly designed, ineffective or inefficient processes resulting in error or substandard care. There may be impaired patient safety and outcomes, or non-compliance with best practice. **Opportunity:** We will deliver consistently safe and effective care and monitor quality indicators.	Measured	**9**	10 and up
Service User Experience	Complaints. Audit. Loss of public trust. Diversion of funds and attention from service delivery. Media coverage.	**Risks** arising from adverse events, including ethical violations, systemic or repeated failures, poor quality or a lack of innovation. Leading to loss of public trust and/or diversion of funds and resources from service delivery. Complaints made by the public and service users. **Opportunity:** We will learn from feedback and incidents and continuously improve service delivery to enhance patient experience. We will provide confidence in the Trust.	Measured	**9**	10 and up
Innovation and Transformation	Business innovation. Speed of change. Strategy.	**Risks** that change programmes and projects that are not aligned with strategic priorities. Risks arising from identifying and pursuing a strategy which is poorly defined, is based on flawed or inaccurate data or fails to support the delivery of commitments, plans or objectives due to a changing macro-environment (e.g. political, economic, social, technological, environment and legislative change).	Progressive	**12**	15 and up

		Opportunity: We will promote a culture of innovation and evidence-based practice. Support research activity, clinical trials, and the adoption of new technologies and models of care that improve outcomes and efficiency.			
Meeting population need	Health equity. Changing needs and demographics	**Risks** that the services we offer do not adequately meet the needs of the communities we serve, and that we do not adapt quickly enough to emerging needs. Service users may not be able to access services, or services are not appropriate to their needs. **Opportunity:** We will engage with communities and stakeholders to ensure services are equitable, inclusive, and accessible.	Progressive	**12**	15 and up
Demand and capacity	Demand and capacity. Safety of service users. Inspections.	**Risks** that mean we are unable to deliver our services in a timely manner and in an appropriate way. Demand may outweigh capacity. Service users may come to harm or be unable to obtain the appropriate services in a timely manner. **Opportunity:** We will design and deliver services that respond to the evolving health and wellbeing needs of the population. Services will be available to our communities.	Measured	**9**	10 and up
Partnerships and Collaboration	Relationships and Partnership Working.	**Risks** arising from weaknesses in the management of partnerships resulting in poor performance, inefficiency, inequity, or failure to meet organisational objectives. Work may result in using the wrong partners, not having due diligence, and we exclude people.	Progressive	**12**	15 and up

		Opportunity: We will foster collaborative relationships across health, care, education, voluntary, police and community sectors to improve outcomes and efficiency. Support integrated working, shared learning, and joint initiatives that align with strategic goals.			
Our People	Human Resources. Colleague wellbeing Business continuity	**Risks** arising from ineffective leadership and engagement, suboptimal culture, closed culture, or inappropriate behaviours. Industrial action or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance. Risks may result in negative impacts on colleague wellbeing, gaps in staffing, productivity and efficiency. **Opportunity:** We will develop and sustain a skilled, motivated, and resilient workforce. Invest in recruitment, retention, wellbeing, and leadership development to meet current and future service demands, and drive productivity.	Progressive	**12**	15 and up
Financial and Commercial	Finance including claims. Financial impact. Business projects. Procurement and contract management.	**Risks** arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting. Risks include supply chains, contractual requirements, and strategic commissioning partnerships.	Measured	**9**	10 and up

		Opportunity: We will support financial sustainability and stewardship through effective budgeting, resource allocation, and financial governance. Enable strategic investment decisions that align with organisational priorities and long-term value.			
Regulatory (legal)	Statutory duty. Information governance. Inspections. Compliance and regulation.	**Risks** arising or potentially arising from some legal event occurring that results in a liability, a loss, or a failure to take appropriate measures to meet legal, regulatory, or statutory requirements or to protect assets. This includes compliance and regulation, data protection and information governance. Risks arising from a failure to prevent unauthorised or inappropriate access to key systems and assets, including people, platforms, information and resources. **Opportunity:** We will ensure the organisation operates within all legal, regulatory, and statutory frameworks. Maintain rigorous oversight of compliance activities, including inspections and reporting, to uphold public trust and accountability.	Limited	**6**	8 and up
Data and Digital	Cyber. Technology. Service and business interruption. Data Quality	**Risks** arising from a failure to prevent unauthorised and/or inappropriate access to digital systems. This encompasses the subset of cyber security. Risks arising from technology not delivering the expected services due to inadequate or deficient system/process development and performance or inadequate resilience. Risks arising from poor data quality, inadequate data management, loss of information integrity, or failure to use data effectively	Measured	**9**	10 and up

		to support operational, financial, clinical, or strategic decision-making. This includes risks relating to data accuracy, completeness, timeliness, governance, and reporting. **Opportunity:** We will ensure data and information are managed securely, accurately, and consistently to support effective decision-making, regulatory compliance, operational performance, and public trust. We will maintain robust governance, oversight, and assurance processes to protect the integrity, confidentiality, and availability of data assets. We will safeguard digital infrastructure and sensitive data through proactive cyber security measures. Promote awareness, resilience, and rapid response capabilities to mitigate threats and maintain operational continuity.			
Governance	Oversight processes. Inspections. Audit.	**Risks** arising from unclear plans, priorities, authorities and accountabilities, and/or ineffective or disproportionate oversight of decision-making and/or performance. **Opportunity:** We will ensure good governance with clear plans, priorities, oversight and accountability, ensuring the Trust complies with relevant duties.	Limited	**6**	8 and up
Estates and Facilities	Sustainability. Service and business interruption. Colleague wellbeing.	**Risks** arising from the failure to maintain safe, effective, sustainable, and resilient estate and facilities services. This includes risks relating to the condition, security, and maintenance of buildings and infrastructure, environmental sustainability, utilities, workplace safety, colleague wellbeing, and	Measured	**9**	10 and up

		disruption to critical services and operational delivery. **Opportunity:** We will maintain safe and effective estate and facilities management through planned maintenance, business continuity arrangements, sustainability initiatives, and compliance with relevant health and safety standards. We will promote resilient environments that support operational delivery, colleague wellbeing, and high-quality services.			

RISK APPETITE DESCRIPTORS

Appetite Level	Description	Upper Tolerance	Reporting
Averse	We adopt an extremely cautious stance. Any exposure is tolerated only when unavoidable and subject to rigorous controls.	**0**	1 and above
Limited	We take a cautious approach, accepting only lower levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance.	**6**	8 and above
Measured	We are willing to accept moderate risk where there is compelling evidence of benefit and robust mitigation measures in place supported by strong governance.	**9**	10 and above
Progressive	Higher levels of risk are acceptable where benefits are clear, mitigations are robust, and alignment with strategic objectives is maintained.	**12**	15 and above
Transformational	Higher levels of risk are acceptable where the potential benefits are substantial, mitigations are robust, and alignment with long-term strategic objectives is clear.	**15**	16 and above

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10/0526

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

PRESENTED BY: Helen Child, Director of Corporate Governance & Trust Secretary

AUTHOR: Ben Newman, Risk Manager

SUBJECT: **BOARD ASSURANCE FRAMEWORK YEARLY REVIEW**

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

The purpose of this report is to:

Provide assurance to the Board on the management of the Trust's **strategic** risks.

Recommendations and decisions required.

Board is asked to:

- **RECEIVE** and **CONSIDER** the revised BAF.
- **NOTE** the summary of key changes to the BAF (**Appendix 1)**
- **CONSIDER** the overarching risk profile for the Trust.
- **DECISION** on risk 6 to tolerate risk outside of appetite

Executive summary

The Board Assurance Framework (BAF) for 2025/26 reflects the Trust's Strategic Aims and Objectives. The BAF has been reviewed by individual Executive owners throughout the year and is presented to the Board for assurance of actions in place to control risks.

The full BAF can be found in the Heatmap Paper**.** A summary of key changes and items for the attention of the Board are set out in **Appendix 1**. In summary, in the year under review:

- No new risks have been added or removed during the course of the year.
- All risk scores (including inherent, current, and target) have been reviewed in line with the Trust's risk scoring methodology. This has resulted in movement of some scores, while other scores may have changed to reflect the tangible work that has been done to reduce the risk, or factors that may have increased the risk.

A Board Development Seminar on Risk was held on 13 March 2026, and the Risk Appetite Statement for the Trust will be presented to the board in a separate paper.

- Risk 01 fell within appetite but has recently increased to a score of 20.
- Risk 02 has remained static all year with current score of 12.
- Risk 03 has met its target score and is well within appetite threshold. Only 2 mitigating actions remain.
- Risk 04 has reduced over the year but is still outside appetite.
- Risk 05 is now within appetite but still requires work to reach its target.

- Risk 06 has remained static with a current score of 12 all year. It has reached its target of 12 but is above appetite.
- Risk 07 has remained static with an 'extreme' current risk score of 16 all year. It is well above appetite.
- Risk 08 has remained static all year with its current score of 12. The target date has passed.
- Risk 09 did reduce the current score to 12 from 16 but has since returned to 16.
- Risk 10 has remained static all year with its current score of 12.
- Risk 11 has remained static all year with its current score of 12.

A regularly static score can be indicative of a risk that is difficult to control. This can be due to both internal and external factors. It is possible that the controls being used are not appropriate or do not have the required levels of assurance and can be failing. Static risks, can at times, be a warning to pay close attention, especially when the risk is outside of appetite. Risks (risk 6) whereby the reasonable target is outside of appetite should be considered by the board and whether the risk should be 'tolerated' or a review made as to whether other steps can be taken to 'treat' the risk.

Next Steps:

- Continue to control and reduce the risk around our BAF risks, highlighting to committees where appropriate those risks that are requiring extra attention or tolerating.
- Work is ongoing to design and consider a new template for BAF risks in near future. The intention is to give clearer lines of assurance.
- Work is ongoing to introduce a more formal three tier system of risk management with clear distinction between operational, corporate, and strategic risks.

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

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

Where has this issue been discussed before?

- Governance Committees, Executive Team, Board / Seminar

Appendices:	Appendix 1: Summary of key changes

Report authorised by:	**Title:**
Helen Child	Director of Corporate Governance and Trust Secretary

APPENDIX 1

BOARD ASSURANCE FRAMEWORK - SUMMARY OF KEY CHANGES IN Q4

Strategic risks added, removed.

		Score
Closed / Added	None	**N/A**

Movements in risk ratings

			Q1/2/3 Score	Q4 Score
Risk 1		FLUCTUATING - RAISED	12 / 12 / 9	**20**
Risk 3		REDUCED	16 / 16 / 9	**9**
Risk 4		REDUCED	16 / 16 / 12	**12**
Risk 5		REDUCED	12 / 12 / 9	**9**
Risk 9		FLUCTUATING - STATIC	16 / 16 / 12	**16**

Issues to note.

		Score
Risk 01	Had fallen within risk appetite but has recently increased in score. This is due to a range of factors, including work to improve quality governance and issues at Wotton Lawn Hospital which are being investigated by the Trust and initiated the local authority's large-scale safeguarding enquiry.	**20**
Risk 03	Has met its target score and is well within risk appetite threshold. Only 2 mitigating actions remain. When these actions are completed, a review will be required of assurance levels and then a decision will be required on whether to monitor the risk within the BAF elsewhere.	**9**
Risk 06	Has remained static with a current score of 12 all year. It has reached its target score of 12 but is above appetite. There are no more reasonable measures that can be put in place. A decision is required whether to tolerate the risk outside of appetite.	**12**
Risk 07	Has remained static with an 'extreme' current risk score of 16 all year, largely because of the external drivers of the risk, many of which are outside the Trust's ability to control. It is well above appetite.	**16**
Risk 09	Did reduce the current score to 12 from 16 but has since returned to 16. This recognises some of the issues at Wotton Lawn Hospital which are being investigated by the Trust and initiated the local authority's large-scale	**16**

	safeguarding enquiry. An operational iteration of this risk has crystalised into an issue at one location and local action plans have been developed to deal with this appropriately. This remains on the BAF as a risk across the Trust, but the score reflects the increased risk when there is a realised issue in one location.	

BOARD ASSURANCE FRAMEWORK – HEATMAP – May 2025-April 2026										RISK SCORE				STRATEGIC AIM				Issue to be raised by Exec / Committee Yes /No
Strategic Risk	Risk No	Exec Lead	Last Exec Review	Committee Lead	Last Committee Review	Appetite	Initial Risk Score	Target Risk Score	Target Date by	Qtr1	Qtr2	Qtr3	Qtr4	Better Health	Great Place to Work	High Quality Care	Sustainability	
Quality Standards	1	Dir. NTQ/MD	Apr 26	Quality	Q3	10	16	6	April 28	12	12	9	20	✓		✓		N
Demand & Capacity	2	COO	Apr 26	Resources	Q3	10	20	9	April 27	12	12	12	12	✓		✓		N
Recruitment, Retention & Development	3	Dir. HR & OD	Apr 26	GPTW	Q3	12	16	9	April 27	16	16	9	9	✓	✓	✓		N
Inclusive Culture	4	Dir. HR & OD	Apr 26	GPTW	Q3	10	16	6	July 26	16	16	12	12	✓	✓			N
Relationships & Partnership Working	5	Dir. I&P	Apr 26	Quality	Q3	12	12	6	April 27	12	12	9	9			✓		N
Funding for Transformation	6	Dir. of Finance	Jan 26	Resources	Q3	10	20	12	April 27	12	12	12	12	✓	✓	✓		N
Capacity for Change	7	CEO	Apr 26	Resources	Q3	12	20	9	Aug 26	16	16	16	16	✓		✓	✓	N
Cyber	8	Dir. of Finance	Jan 26	Resources	Q3	10	20	8	April 26	12	12	12	12	✓		✓		N
Closed Culture	9	Dir. NTQ	Apr 26	Quality	Q3	10	20	8	April 27	16	16	12	16	✓	✓	✓		N
Health Inclusion	10	Dir. I&P	Apr 26	Resources	Q3	10	16	8	April 27	12	12	12	12	✓		✓		N
Strategic Commissioning Partnerships	11	CEO	Apr 26	Trust Board	Q3	10	16	9	April 27	12	12	12	12	✓	✓	✓	✓	N

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

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Strategic Aim(s):			• High Quality Care • Better Health	**Executive Leads**	**Date of review**
				Nicola Hazle & Dr Amjad Uppal Dir. NTQ & MD	April 2026
RISK ID: 01	**Description:** **QUALITY STANDARDS**		There is a risk that failure to meet Quality Standards will result in harm and poor clinical outcomes for patients / service users and poor patient / service user, carer and staff experience.	**Lead Comm**	**Next review**
				Quality	**June 2026**
Date Risk: Identified/confirmed	Updated May 2025 (this is an ongoing BAF risk from 2019)			**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*	
RISK RATING	**Likelihood**	**Impact**	**Overall**	KPI's/Quality Indicators	
Inherent Risk Score:	**4**	**4**	**16**		
Current Risk Score:	**5**	**4**	**20**		
Target Score:	**2**	**3**	**6**		
TARGET DATE:	**01/04/28**	**Appetite:**	**10**		

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

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

Established quality governance structures and processes provide partial assurance in relation to delivery of the Quality Strategy. This is alongside monitoring and response to trends and variability across quality standards and the embedding of learning and improvement; where most indicators are within agreed parameters. There is further development and improvement required to:

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

In light of ongoing learning in governance following recent patient safety incidents, updates to this risk will be considered monthly.

- Large scale safeguarding enquiry (under section 42 of the Care Act 2014) has commenced at Wotton Lawn in February. Executive overseen programme of improvement is being implemented to address identified concerns related to practice, governance and policy/process.
- The transfer of delegated functions back to GCC has the potential to reduce quality of care during and following transition. There is an Executive overseen programme of work in place to coordinate the transfer of services.

→ New workforce standards in relation to sexual safety and violence prevention reduction standards which create an opportunity to align workforce and clinical approaches

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
SARC Clinical Records	490	16	1
Advancing Mental Health Equalities Strategy	613	16	6
Continued delivery of specific services (such as social care) affected by Delegated Responsibilities functions returning to GCC	663	16	9
Instrumental sallow assessment capacity (FEEs and VFSS)	518	15	6
There is a risk that the ICT Nursing service in GHC is not always able to provide safe and effective nursing care and treatment.	658	16	6
ECHO demand on Heart Failure Service	660	16	8

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
1.	Current clinical policies, SOPs and clinical procedures	Clinical Policy Review Cycle/Audit (L1)	• Policy Rev Grp • Quality Comm	Monthly Quarterly	Satisfactory	New process now established to identify and escalate risk in out of date policies
2.	Clinical compliance programme including clinical audit, NICE guidance audit, medicines audits	Clinical audit, peer review & self-assessment reporting (L2)	• QAG • Qual Comm • Audit Comm	Annual Per IA plan	Not Satisfactory	Under review of quality governance structures. Compliance concerns identified through LSSE enquiry
3.	Regulatory compliance including self-assessment and peer review, fidelity testing	Compliance Report (L1&L2) NED Quality Visits (L2)	• Mangmt Groups • Qual Comm	Monthly Quarterly	Satisfactory	
4.	Effective local clinical governance processes operational teams/services/directorates in place	Clinical Governance Reports (L1&L2)	• Ops Governance • Qual Comm	Monthly Quarterly	Not Satisfactory	New processes being developed for ops and quality governance Compliance concerns identified through LSSE enquiry
5.	Patient Safety Framework e.g. Incident reporting, Datix, Service User Experience, Healthwatch etc, Annual Surveys	Quality Reporting (L1&L2)	• Mangmt Groups • Qual Comm • Board	Monthly	Satisfactory	Embedding of framework
6.	Safer staffing	Performance Report (L2) Survey Outcomes (L3) FTSU Report (L2)	• Mangmt Groups • GPTW Comm	Monthly	Not satisfactory	Self-assessment identified compliance gaps. Good progress made since Q3

						but awaiting region to lead reassessment.
7.	Training & professional practice including revalidation and clinical supervision	Training/development compliance reports (L1&L2)	• Qual • Board	Monthly	Satisfactory	Clinical supervision policy has been published. Trust wide compliance remains c60%. Heads of Profession leading an improvement trajectory
8.	CQC Inspections	External report (L3)	• National body	Ad-hoc	Satisfactory	S31 remains – outcome of comprehensive inspection awaited. CMH visits expected
9.	Staff voice/ staff experience (FTSU, D2D, Staff Survey, WRES/WDES, staff networks)	Speaking up reports (L1&L2) Staff survey (L3) Internal Audit (L3)	• GPTW/Board • GPTW/Board • Audit	2x year Annual Per plan	Satisfactory	
10.	Quality Reporting Framework	Quality Reporting including Safeguarding, PCET, Patient Safety (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Gaps in triangulation
11.	Patient Experience (complaints/FFT etc)	Quality Reporting (L1&L2)	• Qual Comm/Bd	Monthly	Satisfactory	
12.	PCREF	Compliance Reporting (L1&L2)	• Qual Comm	TBC	Not Satisfactory	Action plan addressing gaps from advisory review regarding governance and impact. Making progress but not sufficient impact.
13	Professional frameworks/codes of practice	Annual revalidation report	QAG Board		Satisfactory	Gap in nursing strategic framework - agreed outcomes and recording.

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
1.	Embed PSIRF Programme	Internal audit completed Q3 with action plan approved Feb A&AC. Management plan in place and underway.	MD	**December 2026**
2.	Integrated Performance and Quality Reporting	In development. Approach/timeline endorsed by Resources Committee. Quality domain KPIs expected for 26/27	DoF/COO/DNTQ	**Complete**
3.	Revised NED quality visit approach in place	Endorsed by NEDs. Learning & Assurance team in PST coordinating since Oct 25. Report to Quality Committee Jan 26.	DNTQ	**Complete**
4.	Clinical supervision policy	Under review – consultation stage complete, publish in Q4 25/26 Improvement trajectory being developed.	DNTQ	**Complete**
5.	Safer Staffing Compliance	Moved to business as usual. Implementation of inpatient establishment reprofiling underway. New governance for safer staffing compliance starting from November. Regional oversight/support in place. Still awaiting region led reassessment.	DNTQ	**31 March 2026 - TBC**
6.	Evaluation and refresh of Quality Strategy and Research and Innovation Strategy	Engagement and consultation will start in Q4 25/25. Approval at Quality Committee in July 26. Will include nursing strategic framework.	DNTQ	**31 July 2026 (may extend to 30 September 2026)**
7.	Oversight of national work on sexual safety, restrictive practices, violence and aggression – aligning with workforce standards (reporting to GPTW) as required	Sexual safety reporting via safeguarding aligns to Sexual Safety Charter. DNTQ is Exec Lead. HR led violence and aggression group in response to VPRS (violence prevention standard). DNTQ is Exec Lead. Restrictive Practice policy under review.	DNTQ	**30 June 2026**
8.	Review of quality governance structures	Review quality governance structures underway. Internal audit completed Q3 25/26 – report going to A&AC May 2026. Ongoing work to implement new structures and align with organisational changes.	DNTQ/MD/COO	**December 2026**
9.	PCREF reviewed and reestablished	Leadership in place. Governance recommenced in November 26. Action plan in progress. Significant national focus – liaison and learning opportunities with other trusts in place. Review of progress and risk planned for Q2 and Q3	DNTQ	**31 October 2026**
10.	Regulatory preparedness	CQC preparedness ongoing as BAU but increased activity for some services anticipating visits and for Well Led inspection FSR (SARC) – pre-assessment for UKAS accreditation completed in October. Separate timescale for application agreed for both services during 26/27.	DNTQ	**31 December 2026**
11.	Review of S31 notice at Berkely House	Application to remove prepared in June. Comprehensive CQC inspection undertaken in July (including review of S31). Outcome has been delayed but in progress.	DoNTQ	**30 May 2026**

12.	Response to Sexual Safety and Violence and Aggression	Joint work underway between People and NTQ directorate on these agendas to align approach across clinical and workforce. Clinical sexual safety oversight sat with safeguarding. Workforce sexual safety charter has been published. There is a working group set up to respond to Violence Reduction Prevention Standards	DoNTQ/ DoP	**31 March 2027**

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

Back to top	**Strategic Aim(s):**	• High Quality Care • Better Health	**Executive Lead**	**Date of review**
			Sarah Branton COO	April 2026

RISK ID: 02	**Description:** **DEMAND AND CAPACITY**	There is a risk that the number of people being referred to services exceeds capacity to be responsive, resulting in poor experience and delays to timely access and provision of effective treatments and interventions.	**Lead Committee**	**Next review Date**
			Resources	**June 2026**
Date Risk: Identified/confirmed	May 2025 (refocused from 2023 BAF risk)		**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* *As per performance dashboard*	

RISK RATING	**Likelihood**	**Impact**	**Overall**
Inherent Risk Score:	**5**	**4**	**20**
Current Risk Score:	**4**	**3**	**12**
Target Score:	**3**	**3**	**9**
TARGET DATE:	**01/04/27**	**Appetite:**	**10**

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

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

Demand for our services remains high and monitoring to reflect service operation meets the needs of the population continues to be in development. Whilst the majority of services are within national performance expectations it is acknowledged that this is not the case for some services where some KPIs are in exception (e.g. CAMHS, Speech and Language Therapy, Neurodiagnostic Services etc) or may be heading that way and will be kept under review. The impact of changes in relation to GCC/delegated services is being carefully monitored. We are focussing on specific services and this is where we are making our biggest gains e.g.: Children's Speech and Language, Core CAHMS.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	**Reference**	**Current**	**Target**
General Medicine Speech and Language Therapy Capacity	604	20	10
CYPS Speech & Language Therapy - Routine Wait Times	350	16	16
Meeting contractual agreement for out of hours dental appointments	687	16	8
Continued delivery of specific services (such as social care) affected by Delegated Responsibilities functions returning to GCC	663	16	9
ECHO demand on Heart Failure Service	660	16	8
Community Adult Physical Health Speech and Language Therapy waiting lists	638	16	4
CAMHS Neuro Capacity	605	16	9
Special Allocation Scheme Patients accessing face to face services	680	15	6

There is a risk that the ICT Nursing service in GHC is not always able to provide safe and effective nursing care and treatment.	658	16	6

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

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
9.	Embed governance changes arising from internal audit – operational and service directorate level	Action update provided to auditors. Operations Directorate Governance manual agreed and in next stages of development to reflect Service Groups as these are implemented. Review of agendas/ minutes for each Service Directorate underway.	COO	**1 September 2026**
10.	Continue performance report monitoring & deep dives to focus on patient outcomes.	Internal Audit planned for 26/27 in relation to waiting list management and 'waiting well'	COO	**1 April 2027**
11.	Review of level of co-production and engaging EbE in service developments.	Monitored via transformation programme board	COO/DoSP	**1 April 2027**
12.	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	System Portfolio leadership (UEC, Neighbourhood) to improve flow through urgent services and develop neighbourhood model. Review of Community Mental Health	Executive	**1 September 2026**
13.	Integrated reporting in newly configured performance report	Update provided to Resources Comm. Duplication between quality/performance reports removed. Initial	Executive	**1 April 2027**

		improvements reflected in the report with further development throughout 2027		
14.	Colleague training and development in demand/capacity planning, forecast setting/management	Internal Audit on data quality (moderate opinion) supports recommendation re training development. 'Making Data Count' online training available to senior Operations colleagues. Included in the development plan aligned to the organisational change and creation of Service Groups	COO	**1 April 2027**
15.	Review of quality governance structures	Review quality governance structures underway. Internal audit in Q3 25/26.	DNTQ/MD/COO	**February 2026 - TBC**
16.	Review of Operations directorate structure	Operational Structure work now identified as Organisational change as impact and change is wider than one Directorate. Operational leadership workstream in progress	COO	**1 April 2027**
17.	Data quality audit	Action plan in place following data quality audit.	COO	**30 June 2026**

Levels of Assurance

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

Back to top			**Strategic Aim(s):**	• Great Place To Work • High Quality Care • Better Health	**Executive Lead**: Neil Savage, Dir. of HR & OD **Date of review**: April 2026
RISK ID: 03	**Description:** **COLLEAGUE RECRUITMENT AND RETENTION AND DEVELOPMENT**			There is a risk that we fail to recruit, retain and develop a sustainable workforce to deliver services in line with our strategic objectives.	**Lead Committee**: GPTW **Next Review Date**: June 2026
Date Risk: Identified/confirmed	December 2025 in this form				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month.* • Recruitment KPI's; - Time to Hire - WRES/WDES - Vacancy rate • Staff Survey Results • Retention inc. turnover • Preceptorship Data • Leadership & Culture Programme
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	4	4	16		
Current Risk Score:	3	3	9		
Target Score:	3	3	9		
TARGET DATE:	01/04/27	**Appetite:**	12		

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

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

Many aspects of supply, terms, conditions, immigration regulations, and competitive remuneration are outside the Trust's immediate control. Although current recruitment and retention feel positive (growth of 2.13% Trust wide in the last 12 months), shortages of nursing, medical, AHP and health care staff (particularly CAMH's, inpatient MH, PH and LD) are being experienced nationally, and the general decline in applications to study nursing (particularly Learning Disability field) impact on GHC recruitment.

While inpatient reprofiling and service transformation may pose challenges for recruitment and retention, we have fulfilled our graduate guarantee to NHSE by offering roles to all newly qualified nurses. Preceptorship (mandatory for newly qualified and returning Nurses and AHP) has 60 enrolments (spread over 3 cohorts), 15 have expressed an interest in completing the Level 7 One Gloucestershire Preceptorship Module March 2026 programme currently 18 booked. Strategies to aid the improvement of the recruitment experience have proved positive; time to hire has decreased by 7 working days in the last 12 months (30 to 23), 65% of Trust vacancies are successfully filled in comparison to 49% in 2024 and the satisfaction of candidates and recruiting managers averages at 4.6 out of 5 in our Recruitment Survey.

Strategies to reduce turnover rate have also been positive, and benchmark well (10% 12-month turnover rate), for example directorates investment in HCSW to Registered Nurse career pathways via apprenticeship (4 x Nursing Associate to Registered Nurse via RN Degree Apprenticeship), IEN retention strategies and Itchy Feet conversations. IEN retention strategies and 'Itchy feet' conversations will continue and strengthen through ongoing discovery and scoping of a talent management and retention portfolio, which will now sit within Organisational Development to evolve and strengthen the approach and ensure linkage

with interdependent leadership and culture portfolios. This alignment will ensure the work draws upon the wider data and analysis and insight from the L&C discovery, with further work underway to strengthen the analysis and systematic use of exit data.

Early impact is evidenced by Internationally Educated Nurse retention of 93.2% (compared to 89% Trust average) and 95% retention of those engaged in itchy feet conversations, participants reporting increase clarity, motivation, and engagement. Forward plans include retention initiatives such as OneGlos HCSW event (March 2026)

The Trust turnover rate remains above other Trust's in the Southwest and below national averages. We recognise the need to be seen as an employer of choice, to attract and retain a diverse workforce in a competitive environment, and are engaging in the system activity associated to Widening Access Demonstrator and T-Level (IPCO) projects (current position: 33 GlosCol and Cirencester College T Level students on placement, 2 programme completions, 14 placements secured for 2026. This is a particular consideration considering changing demographics, increased demand for services and forecast workforce gaps. The risk incorporates consideration of our ability to invest in our people. Although we strive to ensure staff are welcomed with a comprehensive induction and commit to their training and development, factors including availability of funding, releasing time from care, and external decisions e.g. apprenticeship reforms significantly impact this ambition.

Following approval of the Trust strategy people directorate have been co-designing the people strategy which is going to board in May for sign-off and approval. The various actions that are now showing as complete below have helped to maintain stability.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
None			

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

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed.** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
18.	Recruitment & Retention Framework Review - Secondment opportunities - Itchy Feet (career) conversations - Return to Practice opportunities	Progress report to April GPTW – on track	Dir. HR & OD	**Delayed – May 2026**
19.	People Promise Implementation Plan - Flexible Working Policy	Progress report to June GPTW – on track	Dir. HR & OD	**Complete – 2025**
20.	Leadership and Culture Programme Implementation	See progress update via Risk 04.	Dir. HR & OD	**Complete – Feb 2026**
21.	Safer Staffing Implementation	Recruitment plan being delivered 100% of band 5 and 6 recruited to plan and 89% of Healthcare Support Workers recruited to plan.	Dir NTQ	**Complete – March 2026**

22.	Strengthening partnerships with HEI's and representatives	- Revised capacity based on NHSE Toolkit, allocated to HEI's. Continue to engage with HEI's to overcome restrictions from geographical location. Implementing graduate guarantee scheme. One Gloucestershire pilot Learner App – live launch 01/26, Participation in NHSE SW pilot of demand / capacity tool 01-02/26.	Dir HR & OD	**In progress – May 2026**
23.	Nursing national job matching profiles and job evaluation process review	Self-assessment completed, action plan in place to meet NHSE recommendations	Dir HR & OD	**Complete – March 2026**

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

<table>
<tr><td colspan="3">Back to top
Strategic Aim(s):</td><td>• Great Place To Work
• Better Health</td><td>Executive Lead
Neil Savage
Dir. HR & OD</td><td>Date of review
April 2026</td></tr>
<tr><td>RISK ID: 04</td><td colspan="2">Description:
INCLUSIVE CULTURE (Internal)</td><td rowspan="6">There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours, which results in negative impacts on retention and recruitment, colleagues experience and engagement, and on our ability to address inequalities in service delivery (access, experience and outcomes).

NB: It is recognised that there is interrelation between this risk and Risk 9: Closed Culture.</td><td>Lead Committee
GPTW</td><td>Next Review Date
June 2026</td></tr>
<tr><td>Date Risk:
Identified/confirmed</td><td colspan="2">October 2023 (updated from 2022)</td><td colspan="2" rowspan="5">Key Performance Indicators: indicate if in exception (in Ex) in last month.

• Staff Survey
• Pulse Surveys
• Leadership & Culture Programme
• Staff Networks
• WRES/WDES</td></tr>
<tr><td>RISK RATING</td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>TARGET DATE:</td><td>01/07/26</td><td>Appetite:</td><td>10</td></tr>
<tr><td colspan="2">Potential or actual origin of the risk:</td><td colspan="4">Updated format for 2023-25 BAF. No change to Risk wording 2025.</td></tr>
<tr><td colspan="6">Rationale for current score Completed by Lead Executive at each review (What is the justification for the current risk score):</td></tr>
<tr><td colspan="6">The Trust has undertaken several Culture Reviews which have highlighted areas of concern impacting negatively on the workforce and patient care. Areas of concern have been highlighted relating to exclusion, discrimination, and a closed culture. Whilst activity has been undertaken within the Culture and Leadership space and improvements made, quantitative and qualitative data collected via the Staff Survey; Pulse Surveys, WRES and WDES reports, staff networks, HR metrics as well as staff engagement sessions suggests further work is needed. If there is not dedicated work carried out in this space, this will impact on colleague productivity, wellbeing, attraction & retention, and invariably Patient Care and the delivery of the Trust Strategy. This continues to also be a national focus and part of the NHS People Plan. Measuring the success of the culture and values work remains challenging due to data limitations, work is underway to enhance triangulation of data and strengthen evaluation and insight.

The Leadership and Culture Programme is in place and a broad programme of engagement delivered in November 25 through the ‘GHC Fortnight’ across the organisation to capture lived experience. The engagement will inform targeted interventions for leadership and culture as well as development of key priorities for the refresh of the Trust people strategy. Progress has also been made in the refresh of the Trust’s People strategy which is a critical lever for strengthening our inclusive culture but risks exist if not fully aligned with leadership and culture activity. To mitigate this, the work is being aligned to ensure that both pieces of work draw on the extensive engagement, discovery, data analysis and triangulation to inform next steps and ensure the leadership and culture programme can act as a key vehicle to deliver a refreshed strategy. Progress and improvement to be monitored through further staff engagement and implementation of leadership and culture discovery recommendations.

Following submission of Peoples Strategy to board and subject to sign off we will need a further review of this BAF risk and the associated target scores etc</td></tr>
</table>

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*			
Key Risks	**Reference**	**Current**	**Target**
None			

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

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed.** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
24.	Leadership and Culture Programme	Current workstreams in discovery stage of the cycle. Restorative, Just and Learning, and Leadership workstreams underway. Leadership and culture fortnight planned 10-21 Nov 2025 to share current progress of programme and test thinking. To bring to	Dir. HR & OD	Complete – Feb 2026

		LCP Committee in Dec 25 recommendation for next steps.		
25.	L&C Wotton Lawn Workstream	Programme delayed. New Sponsor now in place, discussion regarding what the next actions are to progress work. Review of actions undertaken as part of Culture of Care programme to align to LCP.	Dep Dir HR&OD	**June 2026**
26.	Evaluation Strategy with external support from university	Under development. Changes in University has meant that this is on hold; assessing other mechanism for evaluation. Metrics to be identified post Discovery stage – Dec 2025.	Head of Leadership &OD	**Not Started – (awaits update from Rehana)**
27.	People Strategy Review & Update	Engagement has started on Phase 1 of review of current People Strategy; alignment to discovery stage of LCP.		**Completed – May 2026 (just awaiting board)**

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

<table>
<tr><td colspan="2">Back to top
Strategic Aim(s):</td><td colspan="2">• High Quality care</td><td>Executive Lead
Rosanna James
Dir. Improvement & Partnership</td><td>Date of review
April 2026</td></tr>
<tr><td>RISK ID: 05</td><td colspan="3">Description:
RELATIONSHIPS AND PARTNERSHIP WORKING</td><td rowspan="2">There is a risk that the Trust may not fully meet its statutory duty under the Health and Care Act 2022 to involve people and communities in decisions about NHS services.

This could also negatively affect regulatory assurance — including Care Quality Commission assessments (particularly within the Responsive domain) — and expose the Trust to reputational risk.

NB – description now excludes all reference to Personalised Care components, AIS & reasonable adjustment -these are included in Health Inequalities risk BAF10</td><td>Lead Committee
Quality</td><td>Next Review Date
June 2026</td></tr>
<tr><td>Date Risk:
Identified/confirmed</td><td colspan="3">October 2023 (updated from 2022)</td><td colspan="2" rowspan="6">Key Performance Indicators: indicate if in exception (in Ex) in last month
• Number of Youth and Adult Expert by experience registered
• Number of community engagement events (DI&P team).
• Number and type requests from front line teams for use of experts by experience per quarter.
• Number and range of attendees at WTN and associated network for network activities.</td></tr>
<tr><td><u>RISK RATING</u></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td>Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>TARGET DATE:</td><td>01/04/27</td><td>Appetite:</td><td>12</td></tr>
<tr><td colspan="2">Potential or actual origin of the risk:</td><td colspan="4">Risk updated 2025 to reinforce that this is a risk that needs to be actioned through organisation wide response.</td></tr>
<tr><td colspan="6">Rationale for current score Completed by Lead Exec at each review (What is the justification for the current risk score):
There are a number of good and established activities in place that support the Trust's approach to involving public – this includes: many Trust, service and team level delivery, improvement and design activities involving public and experts by experience (EBE); work undertaken by the Partnerships Team to implement the goals and objectives outlined in the GHC Working Together Plan, such as coordinating the EBE programme for children and adults, the new Working Together Network, and working with system partners to deliver community engagement events and gather community insights. We have developed a digital platform to make it easier for services to request involvement activity. The Trust's Five-year plan includes a focus area 'Partnerships with Purpose', specifically to support how we will commit to deepening our partnerships to deliver great healthcare. There are however opportunities to maintain and improve our target score, these include: Strengthen reporting of involvement activity as part of Operational/Quality governance; Continued promotion and feedback form Working Together Network across the trust ; Continued focus to build a Trust-wide culture of coproduction sharing evidence of benefits to service design and improvement; Training is not mandatory for co-production therefore consider access to co-production training and development activities that do not impact on limited resource through exploring system partnering and digital opportunities.</td></tr>
<tr><td colspan="6">Links to Risk Register (High consequence (15 and above) risks that may impact strategic risks)</td></tr>
<tr><td colspan="3">Key Risks</td><td>Reference</td><td>Current</td><td>Target</td></tr>
<tr><td colspan="3">Advancing Mental Health Equalities Strategy</td><td>613</td><td>16</td><td>6</td></tr>
</table>

Continued delivery of specific services (such as social care) affected by Delegated Responsibilities functions returning to GCC	663	16	9

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
28.	Partnerships Team is embedded in the communities we serve and has established relationships with health, care, and voluntary sector system partners	Working Together Reports (L1&2)	• Board • Qual Comm	Annual Bi-Annual	Not Satisfactory	Not yet available – new process & KPI's in development
29.	Expert by Experience Programmes (youth & adult)	Report on number of experts, participation requests and areas of engagement (L1)	• Dir. I&P	Monthly	Satisfactory	
30.	Governor Membership & Engagement Strategy	Reports to Council (L2)	• CoG	Quarterly	Satisfactory	
31.	Family & Friends Test Patient Feedback	Quality Report (L2)	• Qual Comm	Monthly	Satisfactory	
32.	Compliments and Complaints Processes	Quality Report L2)	• Qual Comm	Monthly	Satisfactory	
33.	VCS & Community Engagement via GHC & System Transformation Portfolios	Working Together Network Reports (L1&2) Transformation Board governance reports (L1)	• Board • Qual Comm	Annual Bi-Annual	Not Satisfactory	Not yet available – new process
34.	Working Together Network established	Co-chair report (L1)	• Board	Quarterly	Satisfactory	

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Completed / In Progress / Delayed / Not started
28.	Working Together Network Established	First meeting held June 2025.	Dir I&P	**Complete**
29.	Test the GHC coproduction maturity matrix as a tool to measure co-production	3 test services in progress.	Dir I&P	**In progress - May 2026**
30.	Develop a Working Together Network Youth Voice parallel process	GHC Youth Voice participation programme is established. Draft governance process developed for approval	Dir I&P	**In progress - TBC**
31.	Join the "Know Your patch" community events to host conversations about improving GHC services.	Focus on Gloucestershire city KYP first	Dir I&P	**Complete**
32.	Develop Trust members survey framework	Concept discussed and approved by Governors.	Dir I&P	**Not started - TBC**

33.	Pilot Board Locality 'Study Days' approach	Renamed – Community Insight Events – first event in planning - April 23rd (location: Cotswolds - Rurality & healthcare inequality) in conjunction with a Board development (full day).	Dir I&P	**In progress – April 26**
34.	Performance indicators and measures of success to be developed for 'Partnerships with purpose - deepening our partnerships to deliver great healthcare' as one of 5 focus areas of new strategy.	Strategy approved at Board (25/09/25). New Provider Partnership established March 2026	Dir I&P	**In progress – June 26**
35.	Working Together Network priorities co-produced	Programme of topics for WTN agreed by co-chairs for 4 events during 2026: Racial equality; personalised care; Educational hubs for community support-marginalised communities; Health Inequalities strategic framework;	Dir I&P	**Complete**

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

<table>
<tr><td colspan="3">Back to top
Strategic Aim(s):</td><td colspan="2">• High Quality Care
• Better Health
• Great Place To Work</td><td>Executive Lead
Sandra Betney
Director of Finance</td><td>Date of review
Jan 2026</td></tr>
<tr><td colspan="2">RISK ID: 06</td><td colspan="2">Description:
FUNDING FOR TRANSFORMATION</td><td rowspan="3">There is a risk that funding constraints impact the ability of commissioners to commit to long term transformation of services to meet the needs of the populations we serve at the target pace.

NB: Link to Risk 11 Private Board – Strategic Commissioning Partnerships</td><td>Lead Committee
Resources</td><td>Next Review Date
June 2026</td></tr>
<tr><td colspan="2">Date Risk:
Identified/confirmed</td><td colspan="2">2023</td><td colspan="2" rowspan="2">Key Performance Indicators: indicate if in exception (in Ex) in last month

- No current KPIs measuring transformation</td></tr>
<tr><td>RISK RATING</td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>5</td><td>4</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Current Risk Score:</td><td>4</td><td>3</td><td>12</td><td colspan="2"></td></tr>
<tr><td>Target Score:</td><td>4</td><td>3</td><td>12</td><td colspan="2"></td></tr>
<tr><td>TARGET DATE:</td><td>01/04/27</td><td>Appetite:</td><td>10</td><td colspan="2"></td></tr>
<tr><td colspan="2">Potential or actual origin of the risk:</td><td colspan="5">Discussion at Risk Session 2025 revised existing risk.</td></tr>
<tr><td colspan="7">Rationale for current score Completed by Lead Exec at each review (What is the justification for the current risk score):

The Trust's ability to directly influence national funding is limited, but the Trust is active nationally in NHS Providers, the ICS and in community and mental health networks to support understanding of the roles of these services in supporting the population of the community and recognition of the need for their distinct funding. Gloucestershire submitted and achieved a balanced position for 24/25, however the 25/26 financial outlook for the system and the Trust is challenging with system deficit risk sharing arrangements in development. MHIS has been agreed for 25/26 although challenged by reduction in Strategic Development Funds transferring, however some MH Transformation has been recurrently funded. The nature of growing demand for unplanned services impacts on longer term commitment for transformational planning/funding. The impact of the 10-year plan with the additional focus on prevention and community services is still unclear as is the impact of NHS ICB reorganisation. The scoring for the risk has been reviewed and the inherent and target score changed as the actions required to reduce the score are outside the control of the Trust and unlikely to reduce in the foreseeable future. This reflects changes to the national financial, resulting impact on ICB financial freedoms and the forthcoming impact on ICB clustering arrangements which could result in a reduced focus on Gloucestershire.</td></tr>
<tr><td colspan="7">Links to Risk Register (High consequence (15 and above) risks that may impact strategic risks)</td></tr>
<tr><td colspan="3">Key Risks</td><td colspan="2">Reference</td><td>Current</td><td>Target</td></tr>
<tr><td colspan="3"></td><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="3"></td><td colspan="2"></td><td></td><td></td></tr>
</table>

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

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

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

Back to top **Strategic Aim(s):**			• High Quality Care • Better Health • Sustainability	**Executive Lead** Douglas Blair CEO	**Date of review** April 2026
RISK ID: 07	**Description:** **CAPACITY FOR CHANGE**		There is a risk that the Trust is unable to adapt in an agile manner to the rapidly changing policy environment and needs and expectations of the population resulting in opportunities for improvement being missed or delayed impacting on the quality services provided	**Lead Committee** Resources Board	**Next Review Date** June 2026
Date Risk: Identified/confirmed	2023 reviewed and 2022 risk maintained			**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* - No specific KPIs	
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**5**	**4**	**20**		
Current Risk Score:	**4**	**4**	**16**		
Target Score:	**3**	**3**	**9**		
TARGET DATE:	**01/08/26**	**Appetite:**	**12**		

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

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

Unprecedented level of change in external policy environment and growing expectations and needs of service users/patients are driving increased focus on the need to do things differently across a broad range of areas at a significantly increased pace against prior levels of transformation achieved by GHC. The external environment coupled with a shift to provide a led transformation is driving the need to change our internal service leadership structures. This will bring long-term benefits but potentially compound short-term capacity constraints.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

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

Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*		**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
41.	Strategic Refresh delivers clarity on future priorities allowing change activities to be delivered within framework.	Strategy approved by Board Sept 25	CEO	**Complete**
42.	Review of enabling strategies undertaken	Methodology agreed by Exec. Key milestones agreed. Plan to build into Board Development schedule.	DI&P	**July 2026**
43.	Business plans linked to strategy and delivery of 5-year plan	Business planning process commenced	DoF/CEO	**Complete – March 2026**
44.	Review of effectiveness of organisational Innovation and Transformation and approaches and governance	Deep dives into transformation programme, project transformation framework in development. Response to QI internal audit	DI&P	**April 26**
45.	Organisational restructure	In progress New service groups agreed. Dep COO post recruited to. Additional resource and revised leadership arrangements in place for next phase. Corporate systems hierarchy being changed to reflect service groups by 1st July (milestone).	COO/DOCG	**1 JULY 26 (milestone)**

Levels of Assurance

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

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

Potential or actual origin of the risk:	Risk identified at Board Risk Seminar March 2022. Confirmed ongoing 2023 with additional recognition of risks to service user and colleague data and performance monitoring data. Reconfirmed 2025 with revised risk appetite and tolerance to reflect external threat environment.

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

Technology and data are critical to providing effective care in an increasingly digitised health and social care system. Cyber security, the protection of devices, services and networks and the information on them from theft or damage, is an essential enabler of that care. Cyber security assures the safety of our people, and their families. It is the Trust's responsibility to ensure the cyber security of our services.

The Department for Health and Social Care Cyber Security Strategy to 2030 is clear that in England and internationally, there have been instances where cyber-attacks have caused major disruption to systems and services with significant negative financial operational, patient and public trust consequences. The likelihood of Cyber-attack remains high due to threat of an attack based on 'imminent threat' status from the national cyber security centre, public sector attacks such as the recent ransomware Synnovis attack that led to patient harm and large operational disruption and issue. The Trust continues to make progress against locally controlled cyber objectives within the digital teams' control. However, there are still elements of the System that are in progress that will contribute to reaching tolerable score. Implementation of ICS Cyber tools is in progress but not finalised. ICS Cyber desktop exercise was undertaken in Q1 with a number of actions to improve process and response plans to any incident. ICS cyber strategy signed off with delivery plan in final draft stage. There have been delays in this area because of a lack of resource from the Cyber Team and appropriate project managers to review the roadmap and move strategy forward. Ongoing cyber developments include port access and further work on the pilot of Cynerio a tool that will support identification of vulnerabilities for devices connected to the network. Poor results from recent from Trust phishing exercise and recent Home Office incident impacting on an HR system indicates that this remains an ongoing area for vigilance. Target score is still deemed possible over the longer term, though less likely over short term. The delivery of the cyber strategy and ensuring we are utilising all of the national and local cyber tools well, will more likely ensure the target score of 8 is achievable. The current score is maintaining rather than reducing as there is so much evolving in the cyber world and lots of work being done to keep the fires out.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*			
Key Risks	**Reference**	**Current**	**Target**
Cyber Threat – Phishing	215	15	6

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
51.	IG/Digital policies and procedures	Update cycle in place (L1) Internal Audit (L3)	• IG/Digital Group • Audit/Res	Quarterly Per IA plan	Satisfactory Satisfactory	
52.	Cyber awareness and education	IG/Digital group reporting (L1) Phishing test outcome (L1) Tracking of cyber operational risks Internal Audit (L3)	• IG Group • Digital Group • Resources	Quarterly	Satisfactory	
53.	Anti-Virus & Advanced Threat Protection					
54.	Email Scanning					
55.	Secure Boundary					
56.	Cyber Tools, immutable backups			Annual	Satisfactory	
57.	Cyber Security Operations alert actions			Annual	Satisfactory	
58.	Cyber Essentials Plus certification			Per IA plan	Satisfactory	
59.	IG/Cyber training, development & testing	Compliance Report (L1/2)	• IG Group, Exec • Audit/Res Com	Ongoing	Satisfactory	
60.	Information Governance requirements built into system development processes	IG/Digital Group Reporting (L1)	• IG/Digital Grps • Resources	Ongoing	Satisfactory	
61.	Multi-factorial authentication	Digital Group Reporting (L1)	• IG/Digital Grps	Complete	Satisfactory	
62.	GHC IG reporting framework	Annual SIRO Report (L2)	• Audit/ Board	Annual	Satisfactory	
63.	ICS Cyber Reporting Framework/ Outcome	ICS Cyber Reporting (L1) ICS Security Road Map (L2)	• ICS Digital Grp • Resources	Quarterly	Satisfactory	
64.	ICS Cyber Response Plan - EPPR	Desk Top Exercise (L2)	• Resources	Annual	Satisfactory	Review of outcome/action
65.	DSPT/CAF aligned Toolkit/CAF	Internal Audit (DSPT) (L3)	• IG Group • Audit	Annual	Satisfactory	

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
46.	Review of contractual arrangements to ensure appropriate cyber security elements in place.	Consideration of risk underway. Portfolio on contracts being established prior to reviewing cyber elements	Contracting/ procurement	**TBC**
47.	Action plan as result of EPPR Cyber Deep Dive	Cyber exercise scheduled	AD IT & CS	**TBC**

48.	ICS Cyber Strategy 25/26 and Delivery Plan	Cyber strategy now signed off. Cyber strategy PID for delivery of 25/26 delivery plan in draft	ICS	**March 26 - TBC**
49.	Ensuing ICS cyber team works as effectively as possible in line with SLA	Monthly review meetings. Update of SLA end 25/26.		**TBC**
50.	Ongoing cyber developments include port access and trial for Cynerio	Port control implementation in now complete. Cynerio initial pilot awaiting finalisation.	IT/ ICS Cyber	**TBC**
51.	Windows 11 Rolled out to all Endpoints	Over 90% of devices now updated, final devices now being chased up and escalated to service owners	IT	**Complete**
52.	Introduction of mandatory cyber security training	Agreed as mandatory for all staff by Exec.	IT/HR	**Complete**

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

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Strategic Aim(s):				• High Quality Care • Better Health • Great Place To Work	**Executive Lead**: Nicola Hazle, Dir. NTQ **Date of review**: April 2026
RISK ID: 09	**Description:** **CLOSED CULTURE**			There is a risk of closed cultures existing in services* across the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm. **NB**. It is recognised that there is interrelation between this risk and Risk 4: Inclusive Culture. * as per CQC definition of closed cultures - where people are removed from their communities and may stay for months or years at a time. In these services weak leadership, unskilled/experienced staff and poor engagement with patients and families increase the risks of a closed culture developing	**Lead Committee**: Quality Board **Next Review Date**: June 2026
Date Risk: Identified/confirmed	2023				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month* Staff survey Clinical supervision rates FTSU
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	**4**	**5**	**20**		
Current Risk Score:	**4**	**4**	**16**		
Target Score:	**2**	**4**	**8**		
TARGET DATE:	**01/04/27**	**Appetite:**	**10**		

Potential or actual origin of the risk:	Identified following reflection on Edenfield case in 2023, alongside previous and current culture reviews in some services across the Trust. Reviewed and agreed to continue for 2025 BAF.

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

The Trust has in place a range of processes to support an open culture, such as Freedom to Speak Up, Civility at Work, options to raise concerns confidentiality or via CEO or Board member. This is an area where vigilance is required to reduce the likelihood and ensure that staff feel confident to report harm to vulnerable and/or isolated patient groups. Staff survey results for 2024 received and evidence need for ongoing focus on culture. Previous culture reviews and an internal audit in 2023 resulted in greater reporting on closed culture in higher risk areas. Further work to review the approach to identifying and monitoring closed cultures and determining the impact on patient care will be taken forward. The risk is being closely reviewed given, the positive outcome of the recent internal audit, and the establishment of the leadership and culture programme, but has been maintained for 25/26 BAF to ensure improvements are embedded.
A large-scale safeguarding enquiry (under section 42 of the Care Act 2014) has commenced at Wotton Lawn in February. Executive overseen programme of improvement is being implemented to address identified concerns related to practice, governance and policy/process.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*						
Key Risks				**Reference**	**Current**	**Target**
Advancing Mental Health Equalities Strategy				613	16	6
Controls: (What do we currently have in place to control the risk?)		**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
66.	Current clinical policies, SOPs and clinical procedures	Clinical Policy Review Cycle/Audit (L1)	• Policy Rev Grp • Quality Comm	Monthly Quarterly	Satisfactory	New process now established to identify and escalate risk in out of date policies
67.	Clinical compliance programme including clinical audit, NICE guidance audit, peer review & self-assessment	Clinical audit, peer review & self-assessment reporting (L2)	• QAG • Qual Comm	Annual	Satisfactory	Will be reviewed as part of quality governance structures
68.	Regulatory compliance including self-assessment and peer review, fidelity testing	Compliance Report (L1&L2)	• Dir. NTQ, COO, • Qual Comm	Monthly Quarterly	Satisfactory	S31 notification at Berkeley House
69.	Effective local clinical governance processes operational teams/services/directorates in place	Clinical Governance Reports (L1&L2)	• Ops Governance • Qual Comm	Monthly Quarterly	Not Satisfactory	New processes being developed for ops and quality governance Compliance concerns identified through LSSE enquiry
70.	Patient Safety Incident Response Framework e.g. Datix	Quality Reporting (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Embedding of framework
71.	Safer staffing	Quality Reporting (L1&L2)	• Quality Comm	Monthly	Not Satisfactory	Self-assessment against Developing Workforce Safeguards shows gaps in compliance (same as BAF 1)
72.	Training & professional practice including revalidation and clinical supervision	Quality Reporting (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Clinical supervision policy has been consulted to be published in Q4 25/26
73.	Freedom To Speak Up	Speaking up reports (L1&L2) Internal Audit (L3)	• GPTW/Board • Audit	2x year Per plan	Satisfactory	
74.	Leadership & Culture Programme	Highlight reports (L1&L2)	• L&C Comm	Bi-monthly	Not Satisfactory	WL workstream
75.	Staff Feedback Processes	Staff Survey (L3) Pulse Surveys (L3)	• GPTW / Board	Annual Quarterly	Satisfactory	

76.	Quality Reporting Framework	Quality Reporting including Safeguarding, PCET, Patient Safety (L1&L2)	• Qual Comm • Board	Monthly	Satisfactory	Gaps in triangulation
12.	Patient Carer Race Equality Framework	Compliance Reporting (L1&L2)	• Qual Comm	TBC	Not satisfactory	Advisory review has identified gaps in governance and impact (same as BAF 1)

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
53.	Improvement Plan Berkeley House	All 5 conditions showing as complete. Application for review of S31 prepared in June. Comprehensive inspection by CQC in July – awaiting report.0	DNTQ	Complete
54.	Identification and agreement of areas considered to be of greater inherent risk of closed culture	Agreed by deep dive discussion into BAF 9 during Executive Meeting in Jan 2026. BAF description has been amended to reflect.	DNTQ	Complete
55.	Actions, governance and oversight arrangements in place for those areas identified.	LSSE enquiry at WLH has Executive oversight programme of improvement in place	DNTQ/COO	**30 September 2026**
56.	Regular triangulation of key workforce data for vulnerable or isolated patient groups	Reviewing national work in relation to early warning signs alongside improvements to internal reporting. This is being incorporated into LSSE improvement plan and review of assurance metrics for the service.	DNTQ/COO/DOF	**30 September 2026**
57.	Clinical supervision policy updated	Under review – consultation stage – expected to Clinical Policy Group November. Improvement trajectory being developed.	DNTQ	Complete.
58.	Leadership and Culture Programme in place	Programme governance established. RJL, Leadership and ED&I workstreams launched	CEO/ DOP	**April 2026 TBC**
59.	Review of quality governance structures	Review quality governance structures underway. internal audit in Q2/3 25/2 - report going to A&AC May 2026. Ongoing work to implement new structures and align with organisational changes.	DNTQ/ MD/ COO	**December 2026**
8.	Patient and Carer Race Equality Framework	Action plan from advisory report in progress. Focus on improved governance, evidencing outcomes, comms to staff and engagement with communities. Positive engagement sessions in Q4 regarding Trust antiracist intention and action plan. Review of progress and risk planned for Q2 and Q3	DNTQ	**31 October 2026**
9.	Sec 42	TBC		TBC

Levels of Assurance

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

<table>
<tr><td colspan="2">Back to top
Strategic Aim(s):</td><td colspan="2">• High Quality Care
• Better Health</td><td>Executive Lead
Rosanna James
Dir of Improvement & Partnerships</td><td>Date of review
April 2026</td></tr>
<tr><td>RISK ID: 10</td><td colspan="2">Description:
HEALTH CARE INCLUSION</td><td rowspan="3">There is a risk that GHC services are not meeting the diverse needs of people and communities who experience health inequalities.

This is because services are often designed and operate to meet the needs of a majority population and to make the most of limited financial and workforce resources.

This could result in barriers to access and availability, poor experiences and outcomes for individuals, groups or communities who already experience and are at most risk of avoidable poor health and early death.</td><td>Lead Committee
Resources</td><td>Next Review Date
June 2026</td></tr>
<tr><td>Date Risk:
Identified/confirmed</td><td colspan="2">2025</td><td colspan="2" rowspan="2">Key Performance Indicators: indicate if in exception (in Ex) in last month

To be developed as part of key actions
• Compliance with recording demographic data on EPR
• Accessible Information Standards recording compliance
• Reasonable Adjustment flags and qualitative feedback</td></tr>
<tr><td>RISK RATING</td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td><td colspan="2" rowspan="4"></td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Target Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td>TARGET DATE:</td><td>01/04/27</td><td>Appetite:</td><td>10</td></tr>
<tr><td colspan="2">Potential or actual origin of the risk:</td><td colspan="4">New Risk 2025, focused risk instead of incorporated within other risks.</td></tr>
<tr><td colspan="6">Rationale for current score Completed by Lead Exec at each review (What is the justification for the current risk score):</td></tr>
<tr><td colspan="6">Gloucestershire population health data reflects a national picture showing growing health inequalities – that is unfair, avoidable, and measurable differences in mortality and morbidity. Described in NHS literature as Core20PLUS5, in Gloucestershire this identifies the most disadvantaged 20% of people living in areas of deprivation or poverty (includes areas of Gloucester, Cheltenham, Forest of Dean and Tewkesbury). PLUS people who are Black, Asian, or from ethnic minority groups, people living in rural communities, and those in social inclusion groups such as people with severe mental illness, learning disabilities, or are homeless, sex workers, refugees or asylum seekers who experience health inequalities (See Marmot report and Gloucestershire JSNA).
GHC is commissioned to provided services for several vulnerable groups identified – Mental Health, Learning Disability, and social inclusion groups – and reaches into communities to provide services locally and in people's homes. There are also several examples of transformation and BAU activities aimed at improving healthcare access, experience and outcomes for population cohorts e.g. Big Health Day. The Trust understands having a diverse workforce and using Experts by Experience brings a broader range of perspectives, cultural competence, and understanding of different social, cultural, and faith contexts. This supports more personalised, trauma-informed, and culturally appropriate care, leading to better experiences and outcomes for service users.
Inclusive Healthcare is one of the five focus areas in the new GHC five-year plan. Arguably this work provides a rational for the current score.
However, in the context of widening health inequalities, it is important to identify and address gaps in our current approach. This includes embedding a culture in which health inequalities are routinely considered by all services when assessing performance and implementing quality improvements; strengthening data recording and data quality to better measure access, experience, and outcomes – this includes improving compliance with Accessible Information Standards;</td></tr>
</table>

taking targeted action to identify unmet need and improve services for populations at greatest risk of inequality; and using our influence and resources as a major public sector organisation to support the local economy and address the wider determinants of health.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target

	Controls: (What do we currently have in place to control the risk?)	Source of Assurance and Level* (How do we know if the things we are doing are having an impact?)	Received by	Received	Assurance Rating - Satisfactory - Not Satisfactory	Gaps in Assurance / Controls
77.	Quality Reporting Framework	Quality Report (L2) Access (L2) Outcomes (L2)	• Resources Comm • Qual Comm	Bi Yearly	Not Satisfactory	Reporting Framework in Development
78.	Staff Composition Monitoring	Performance Report (L2)	• GPTW	Quarterly	Satisfactory	
79.	Working Together Network support service & community insights for Health Inequalities	Reports & Aims & Objectives (L2)	• Qual Comm	Bi yearly	Not Satisfactory	In development
80.	Feedback Reporting	Complaint & Compliments (L1&2)	• Qual Comm • Board	Monthly	TBC	TBC
81.	Diversity Reporting	WRES, WDES (L1&2) Pay Gap Reporting (L3)	• GPTW • Board	Monthly	Satisfactory	
82.	PCREF	Compliance reports (L2)	• Qual Comm	Bi yearly	Not satisfactory	Progress underway. impact for people still to be evidenced

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	Update since last reviewed *This should be high level action; the detail of the actions part of regular committee discussions*	Action Owner	Deadline (revised deadline)	
				Completed	In Progress
				Delayed	Not started
60.	Implement and embed Patient and Carer Race Equalities Framework	BDO advisory review completed. Quality Committee governance oversight confirmed. Re-launched Q4 25/26	DNTQ	**In Progress - TBC**	

61.	Develop GHC Health Equity framework, including Anchor approach and performance indicators to measure success	Engagement on Draft Health Equity goals in progress for inclusion in Trust strategies	Dir I&P	**In progress - July 2026**
62.	Support development of ICS Health Inequality approach	Senior Leaders Network completed self-assessment 31/03/26 – results to be reviewed at SLN May for part 2 Health equity engagement. Results for ICS Partnership Board review (May2026 – new date as postponed from Jan)	Dir I&P	**In progress - May2026**
63.	Develop Lived experience workforce framework	Co-produced framework content in development	Dir I&P & DNTQ	**In progress May 2026**
64.	Training for use of data and analysis	Recent Internal Audit on data quality (moderate opinion) supports recommendation re training development. TCD Data Confidence business case agreed at Digital programme Board – roll out date TBC To be delivered as a training programme in 2026	COO	**TBC**
65.	Approval for Health Inequalities Annual Report to enhance the Trust Health Inequalities statement	Health Equity approach presentation to Board April 2026	Dir I&P	**In Progress - TBC**

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

Back to top **Strategic Aim(s):**				• High Quality Care • Sustainability • Better Health • Great Place To Work	**Executive Lead**: Douglas Blair CEO **Date of review**: April 2026
RISK ID: 11	**Description:** **STRATEGIC COMMISSIONING PARTNERSHIPS**			There is a risk that changes in commissioning impact our ability to provide services affecting staffing models, financial sustainability and achievement our strategic objectives and require significant changes to our contract management and delivery monitoring processes. **Confidential – Internal circulation only**	**Lead Committee**: Board **Next Review Date**: June 2026
Date Risk: Identified/confirmed	May 2025				**Key Performance Indicators:** *indicate if in exception (in Ex) in last month*
RISK RATING	**Likelihood**	**Impact**	**Overall**		
Inherent Risk Score:	4	4	16		
Current Risk Score:	3	4	12		
Target Score:	3	3	9		
TARGET DATE:	01/04/27	**Appetite:**	10		

Potential or actual origin of the risk:	Risk developed 2025 in response to external environment relating to GCC commissioning plans and national changes relating to NHSE and ICBs.

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

Developing changes to commissioning – both processes, volumes and types of services by GCC, and changes to the ICBs mean there is significant uncertainty in relation to current services which GHC is commissioned to deliver and future arrangements for strategic commissioning. These will potentially impact significantly on staffing models and strategic objectives. This does not affect services commissioned for 2025/26 but requires negotiation & future planning. ICB clustering arrangements are now in place with further work required to embed working arrangements/relationships. New ICB Executive Team in place across cluster
We are now entering new arrangements with partners and have signed a memorandum of understanding with the ICB to be part of the partnership of health care providers to lead on certain aspects of healthcare transformation.

Links to Risk Register *(High consequence (15 and above) risks that may impact strategic risks)*

Key Risks	Reference	Current	Target
Continued delivery of services affected by Delegated Responsibilities functions returning to GCC	663	16	9
Deliverability of mental health social work under s75 arrangement with GCC	671	12	8

	Controls: (What do we currently have in place to control the risk?)	**Source of Assurance and Level*** (How do we know if the things we are doing are having an impact?)	**Received by**	**Received**	**Assurance Rating** - Satisfactory - Not Satisfactory	**Gaps in Assurance / Controls**
83.	Strategy Refresh process	Reports to Board (L2)	• Board	Monthly	Satisfactory	
84.	Experienced Contracts and Procurement Team in place	Business Plan Reporting (L1&2)	• Exec / Board	6 monthly	Satisfactory	
85.	Relationships with current commissioners	Board Reports (L2) HoSC (L3) Quality Account (L2&3)	• Board	Bi-monthly Bi-monthly Annual	Satisfactory	Strong GCC relationship
86.	Partnerships with other providers (primary care/ GHFT/ GCC services)	Board Reports (L2) HoSC (L3)	• Board	Bi-monthly	Satisfactory	In development

	Mitigation Actions: *What more should we do to address the gaps in Controls and Assurances?*	**Update since last reviewed** *This should be high level action; the detail of the actions part of regular committee discussions*	**Action Owner**	**Deadline (revised deadline)** Complete / In Progress / Delayed / Not started
66.	Strategy refresh	Board strategy sign off - September	CEO	**Complete**
67.	Develop formal partnership arrangement with GP collaborative	We have entered a collective MOU with the ICB alongside the GP collaborative and Gloucestershire Hospitals Trust. Formal provider partnership arrangements and decision-making architecture is being put in place.	Dir I&P	**In progress – 1/7/26**
68.	Explore further partnership working with GHFT	Exec to Exec meeting held. Joint development sessions under consideration. In addition to update above exec to exec meetings continuing.	CEO/Dir I&P	**In progress – June 26**
69.	Build relationships with new GCC Councillors and leadership	Ongoing – meetings with new CEO/Leader. Service visits and informal HOSC held.	CEO/DoIP/Chair	~~**Complete**~~
70.	Build relationships with new ICB commissioning leadership	Good existing relationships with some of the new Exec Team. Further relationship building activity with new colleagues.	CEO/Chair	**In progress – September 26**

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

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AGENDA ITEM: 11/0526

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE & QUALITY DASHBOARD APRIL 2026/27 (M1)**

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 March (Month 1, 2026/27) and end of the financial year. 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 Board are asked to:

- **NOTE** the Quality and Performance Dashboard Report for April 2026/27 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

- One new KPI has gone live in the dashboard in April 2026. There are also 24 KPIs being monitored within the Development Source of the dashboard portfolio, awaiting authorisation from owners to go-live. This will bring the overall indicator number to 176, with a further 18 in development for Q1 and across 2026/27.
- The Trust expects an increasing National focus on the NHS Oversight Framework (NOF) to be published in May, and then the NOF monitoring indicators within the dashboard will be updated. NOF measure IDs in exception are indicated in pink (2025/26) and blue (2026/27) in this dashboard.

Performance Update
The performance dashboard indicators are presented from page 2 within the Board 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).
Alert (to matters that may require attention)
Eating Disorder Services incorporating the following indicators:

- **N11 – Adolescent Eating Disorders – Routine referral to NICE treatment starts within 4 weeks** – *narrative on page 3.*
- **L07 – Adult Eating Disorders - Wait time for adult assessments will be 4 weeks** – *narrative on page 7.*
- **L08 – Adult Eating Disorders - Wait time for adult psychological interventions will be 16 weeks** – *narrative on page 7.*

Mental Health Inpatient Length of Stay:

- **N71 - MH: Average length of stay for patients in Older Acute Mental Health Beds (26/27 Op plan E.H.39) (Including leave - Rolling 3 months) (Days. Not a percentage) –** Long length of stay discharges impacting performance and expected as a new 2026/27 NOF measure. Narrative on page 4. Note N70 (Adult Acute & PICU) is within the Advise section.

Advise (areas of ongoing monitoring or development)
The following indicators have been previously highlighted by Board or its Committees to be scrutinised. They are being closely monitored by operational governance with support from business partner functions. The Board are advised to support continued senior oversight 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** – *forecasted recovery remains for Quarter 1 2026. Narrative page 3.*
- **N37 - Community PH: CYP Community Services Waiting List % seen within 52 weeks - (*Service exclusions applied)*** – *Gradual improvements anticipated with recovery milestones to be set. Safety is maintained. Narrative on page 3.*
- **N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)** – *The initially forecasted recovery plan to achieve 40-50% by April 2026 achieved if ambulance and emergency department validation calls were to be excluded, which is being discussed with Commissioner. Robust actions in place, narrative on page 4.*
- **N69 - PH Percentage of bed days occupied by patients when they are ready to be discharged** – *As predicted, indicator in exception now that recording process change was enacted in March 2026. Narrative on page 4.*
- **N70 - MH: Average length of stay for patients in Adult Acute and PICU Mental Health Beds (26/27 Op plan E.H.38) (Including leave - Rolling 3 months) (Days. Not a percentage) –** *Long length of stay discharges impacting performance. Narrative on page 4.*
- **L21 - MH Liaison - number of routine referrals seen within 24 hours (ICS portfolio)** – *Improvements projected in Quarter 1 2026, alongside indicator update proposals which were ratified at BIMG in May 2026. Page 7 for narrative.*
- **B51 - PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage) –** Thames Ward now excluded however, as expected the improvement target has been a

challenge with current system position, and a high delay related discharge bed base. Robust actions in place. Narrative on page 11.

- **B53 - PH Stroke Inpatients Average Length of Stay (Days. Not a percentage) –** Delay related discharges impacting performance. Narrative on page 11.

Recovery for the following indicators are impacted by service transfer to Gloucestershire County Council, however, quality and safety mitigations are in place

- **L19 Ensure that reviews of new short or long-term packages take place within 8 weeks of commencement** – *narrative on page 7.*

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

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

Where has this issue been discussed before?	May Service Directorate Ops Sessions, Directorate-wide Performance & Risk meeting on 19/04/2026 and BIMG on 21/05/2026.

Appendices:	*None*

Report authorised by: Sandra Betney Sharon Buckley Nicola Hazle	**Title:** Director of Finance & Deputy CEO Deputy Chief Operating Officer Director of Nursing, Therapies and Quality

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Snapshot Month
April

Quality & Performance Dashboard Report

Aligned for the period to the end April 2026 (month 1)

In line with the Quality & Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents performance indicators from four indicator Sources 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

- B54 Thames Ward Length of Stay was the only new indicator for the period. There are 24 indicators prepared in the development Source and leads are being chased to endorse publication in the dashboard for all those that have been available for monitoring for 3 months or more. 12 indicators are due in Quarter 1 2026/27 with 6 more scheduled across 2026/27. This will bring the total KPIs monitored to 194 indicators.
- The 2026/27 NOF Framework is expected in May 2026 and a summary will be provided the Resources Committee as part of the dashboard in June 2026. An evaluation of performance for likely 2026/27 MH indicators is underway. Where known, NOF measure IDs are indicated in pink (2025/26) and blue (2026/27) in this dashboard.
- A review of patient waiting lists and the application of exclusions was reviewed within May's BIMG.
- A proposal for a more formal KPI review guidance document was ratified at BIMG in May 2026.

National Contracted Source

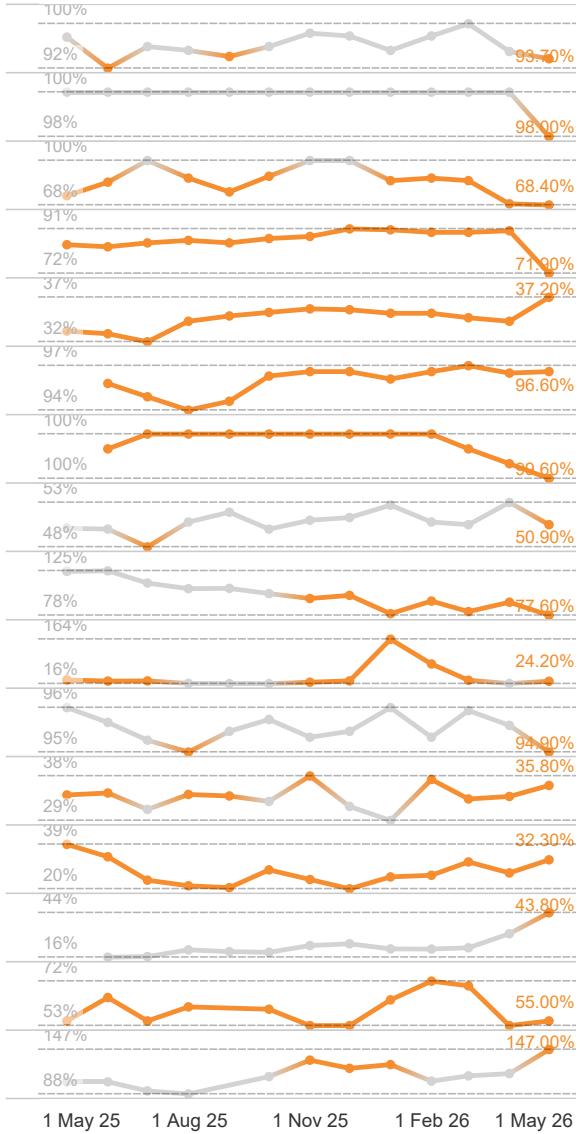
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National level as agreed by a national commissioner.

		APRIL
N03	Care Programme Approach follow up contact within 72 hours of discharge	93.7% / 95.0%
N07	No children under 18 admitted to adult in-patient wards	98.0% / 100.0%
N11	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	68.4% / 95.0%
N22	Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)	71.9% / 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	37.2% / 50.0%
N37	Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)	96.6% / 100.0%
N38	Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)	99.6% / 100.0%
N42	Talking Therapies Reliable recovery rate for those completing a course of treatment and meeting caseness (Op. plan E.A.4a)	50.9% / 51.0%
N43	NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)	77.6% / 100.0%
N45	IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)	24.2% / 20.0%
N51	IUCS - Proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention (KPI 5)	94.9% / 95.0%
N63	PH Community Hospitals Average Length of Stay (All Beds. Days. Not a percentage)	35.8% / 33.0%
N67	IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)	32.3% / 90.0%
N69	PH: Percentage of bed days occupied by patients when they are ready to be discharged - all community hospitals (recording process change from March 2026)	43.8% / 41.0%
N70	MH: Average length of stay for patients in Adult Acute and PICU Mental Health Beds (26/27 Op plan E.H.38) (Including leave - Rolling 3 months) (Days. Not a percentage)	55.0% / 51.0%
N71	MH: Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (26/27 Op plan E.H.39) (Including leave - Rolling 3 months) (Days. Not a percentage)	147.0% / 119.0%



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months except N07 & N69.*

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N03 - Care Programme Approach follow up contact within 72 hours of discharge
Related to three patients. Two patients were followed up within the timescale and recording being amended.

N07 - No children under 18 admitted to adult in-patient wards
No age appropriate provision available and all alternatives were exhausted out of hours. After Action Review requested to identify learning.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
Risk: 645. Actions: A deep dive of the cases undertaken, which identified delayed data entry for 3 cases, which has improved compliance. 1 case had not been offerred treatment options within the threshold due to capacity. Delays in progressing the Eating Disorders Project Group, senior leadership support identified and wider discussions with Nursing, Therapies and Quality Team in place. Report presented to Quality Assurance Group in May 2026.

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. Expanding into primary care. Exploring communications and media to advertise and raise profile within 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: Currently identified as quarter 1, 2026/27. CYPS forecasting for recovery is being further reviewed. Perinatal Actions: Routine outcome measures (ROM) training now part of induction process. An assurance mechanism is in place to ensure that an outcome measure is completed at the start and end of an episode of care. Tableau report is available to identify in month exceptions which is supporting a deep dive into non-compliant cases. Perinatal specific target has improved (43.7%). CYP Actions: Proposal being explored to introduce interim improvement milestones. Improvement plan in place. GHC performance is strong compared to National picture. Progress with ROMS for CAAAS/ADHD medication pathway. Bi-monthly meetings with the National Digital ROMS with CYP special interest group to share best practice.

N37 - Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)
There are 54 children waiting over 52 weeks for Speech and Language Therapy (SLT), and 32 children waiting over 52 weeks for Occupational Therapy (OT). 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.

N38 - Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)
For patients waiting over 52 weeks. Actions include: for Adult Speech and Language Therapy waiting list review processes are in place with actions planned to include scheduling appointments, patient discharges and data entry corrections. 1 patient for musculoskeletal service who has been sent an invite to book letter. 3 patients are identified on the OT waiting list, however further progress is dependent on completion of the Disabled Facilities Grant process.

N42 - Talking Therapies Reliable recovery rate for those completing a course of treatment and meeting caseness (Op. plan E.A.4a)
Performance at 50.9% against a 51% target. No action. See N43 for further service narrative.

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N43 - NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)
New annual target of completed treatments set at 7,598. First month of reporting. Actions: Increased funding to support with active recruitment. Trainees increased to build workforce. Developing National Institute for Health and Care Excellence approved counselling to increase choice. Continue to use Dr Julian to support. Anticipate annual target will be met once additional workforce/ trainees are in place.

N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)
This exception was due to the surge in demand over the Easter weekend period and has now resolved.

N51 - IUCS - Proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention (KPI 5)
Agreed to review position next month.

N63 - PH Community Hospitals Average Length of Stay (All Beds. Performance in days, NOT a percentage).
Risk: 406. Forecast for recovery: Interim measures to be reviewed alongside system transformation work and bed modelling. Actions: Delay related harm programme in place, increased matron capacity and system work. Length of stay review meetings in place. Therapy improvement programme in action with Forest of Dean as an accelerator site and supported by Heads of Profession.

N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)
Risk: 629. Forecast for recovery: Previously reported recovery programme is in place to meet 40-50% and with removal of validation calls, this would be 59.2%, ongoing engagement with local commissioners around this. 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. Weekly review of breaches, no identified patient safety issues.

N69 - PH: Percentage of bed days occupied by patients when they are ready to be discharged - all community hospitals (recording process change from March 2026)
Risk: 406. Forecast for recovery: delay related discharge reduction trajectory modelled on reducing from 40% to 23% over 3 years, currently experiencing 40-50% and revising trajectories on this basis. Actions: Delay related harm programme in place. Ongoing partnership working to help address external causes of dely. Application of national delay related discharge approach. Engaged within system transformation programmes.

N70 - MH Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (26/27 OP Plan E.H.38 - Rolling 3 months (Performance in Days)
Risk:196. Forecast for recovery: KPI aligned to medium term planning guidance to achieve 50 days by March 2027, 49 days by March 2028 and 48 days by March 2029. Actions: 40 day peer review process. Allied Health Professional Lead oversight to support timely assessment of need. Cross team shared safety assessments. Multi agency discharge events. Review of patient flow standard operating procedure. Liaison with Mental Health Lead at Gloucestershire County Council.

N71 - MH: Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (26/27 Op plan E.H.39) (Including leave - Rolling 3 months) (Days. Not a percentage)
Forecast for recovery: Improvements to be seen throughout quarter 2, 2026/27. Actions: 70 day per review process. Liaison with Gloucestershire Council. Multi agency discharge events. Fixed term supported discharge co-ordinator in place. 14 individuals are waiting for system input to support the discharge, ongoing discussions with system partners.

Specialised Commissioning Source

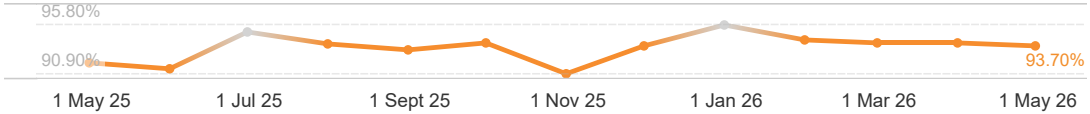
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

National or regional level indicators as agreed by a commissioner.

		APRIL	
S02	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	93.7%	95.0%



Performance Thresholds not being achieved in Month - *Note this indicator has been in exception previously in the last twelve months.*

S02 - % of live births that receive a New Birth Visit within 7-14 days by a Health Visitor
The variability of babies in Neonatal Intensive Care Unit/ family choice impact performance. No action required.

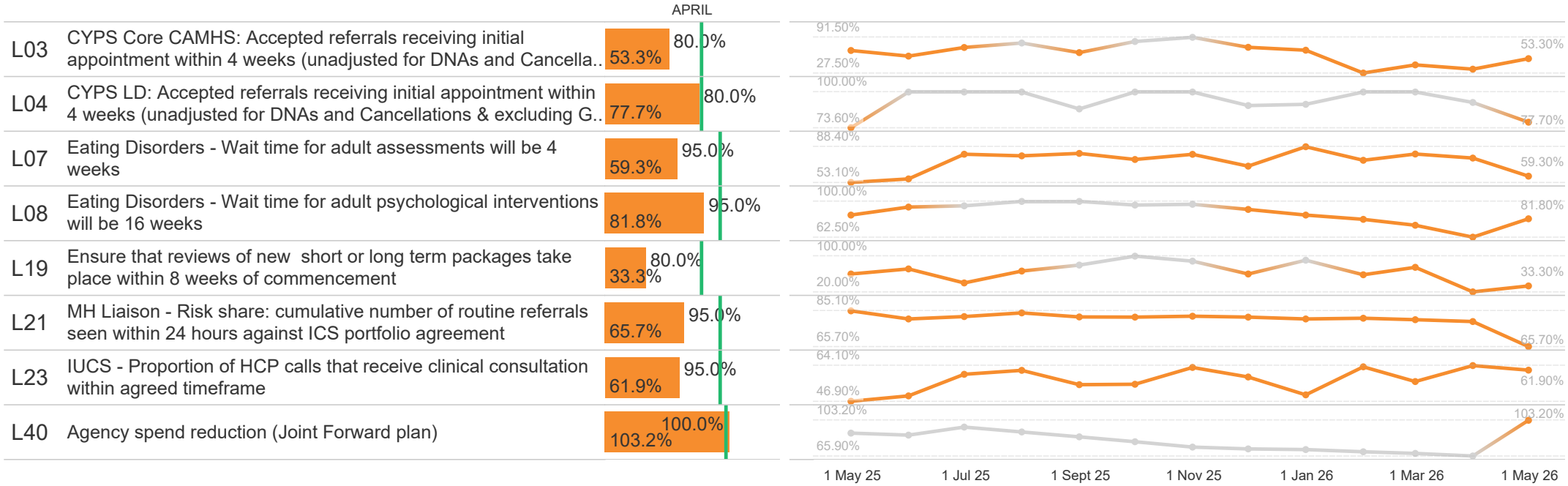
ICS Agreed Source

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

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



<u>Performance Thresholds not being achieved in Month</u> - *Note all indicators have been in exception previously in the last twelve months except L04 & L40.*

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
<u>Risk:</u> 165. <u>Forecast for recovery:</u> Previously identified as June 2026, changed to July 2026, following modelling support from Business Intelligence Team. <u>Actions:</u> Review of rota process to reflect job plans. Caseload tracker review in place. Reviewing appointment cancellations and rebooking approach to identify improvements, weekly review with front door lead for young people awaiting multi agency discussions.

L04 - CYPS LD: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations & excluding Group work)
<u>Forecast for recovery:</u> June 2026. <u>Actions:</u> Related to two cases, both parental choice and appointments now offered. Additional capacity in place to meet assessment demand. Weekly management oversight. Appointments being booked at week 3.

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L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
Risk: 645. Forecast for recovery: Continued downward trajectory due to ongoing capacity issues. Previously, patient choice and low activity numbers can make forecasts unreliable, however in April this was due to capacity within the service and changes to staff allocations for assessments. Actions: All referrals are triaged on receipt and any urgent cases are prioritised. Service exploring options for support/ contact whilst people are waiting. Explored bank and agency which has been unsuccessful. Senior leadership in place from June 2026. Report presented to Quality Assurance Group in May 2026. Physical health monitoring training complete. Dedicated Mental Health Lead Nurse and project support in place. Recruitment process in place for Consultant. Clinical model transformation in development.

L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks
Risk: 645. Actions: All patients triaged and received an assessment. Reviewing numbers of people on the waiting list to establish need and appropriate pathway. People waiting can access support from voluntary care sector organisations (BEAT and FEAST) and can access the helpline number for the Eating Disorder Service for advice. Report presented to Quality Assurance Group in May 2026.

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement.
Risk: 663. Forecast for recovery: Recovery continues to be impacted by the service transferring to Gloucestershire County Council in June 2026, and will not be met prior to the transfer of the service. Mitigations are in place to address the quality and safety of individuals within our care which includes; daily allocation meetings, weekly esclation meetings, weekly workstream meetings that look at caseloads, capacity, demand, supervision, continuing professional development and other aspects of the service, ongoing work to safely decommision the service.

L21 - MH Liaison - Risk share: cumulative number of routine referrals seen within 24 hours
Forecast for recovery: Trajectory changed from April 2026, to quarter 1 2026/27 due to testing and roll out required. Proposal to update the indicator was presented to Operational Performance and Risk in April 2026. This will introduce three KPIs across emergency department, acute hospital, community hospital. Detailed actions presented in May 2026 to Operational Performance and Risk and BIMG for review and approval.

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 for more detail.

L40 - Agency spend reduction (Joint Forward plan)
The Trust is required to make a year on year spend reduction of 30% on Agency costs. As of April, the Trust was 3.2% above the Threshold figure, but 29% below the spend for the same period last year. For Bank spend (L41), the Trust are on track to achieve the year on year 28% reduction.

Board Focus Source

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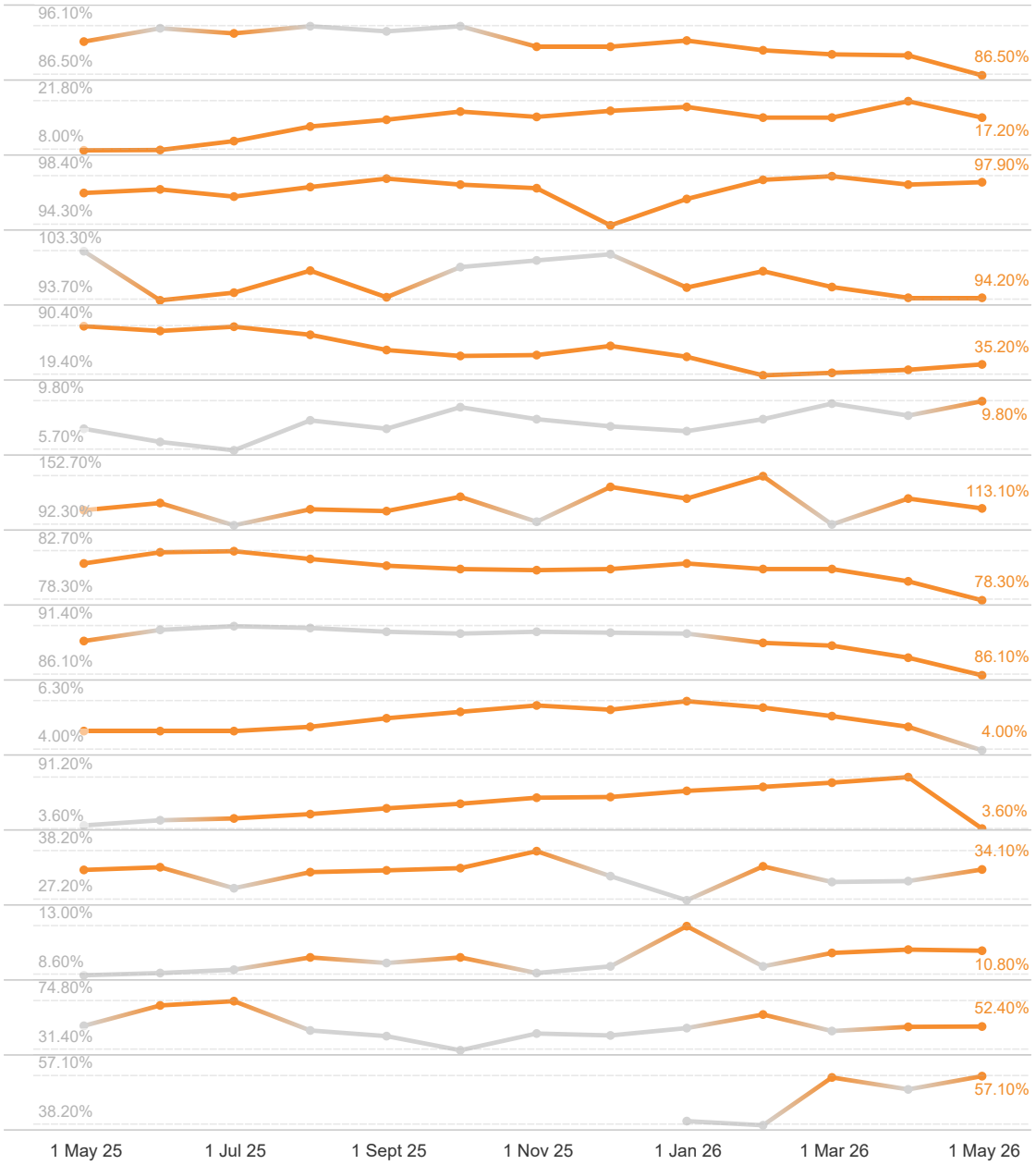
KPI Summary

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

		APRIL
B01	Care Programme Approach - formal review within12 months	86.5% / 95.0%
B02	Nationally reported - Delayed Discharges (Including Non Health)	7.5% / 17.2%
B05	Bed Occupancy Rate – Physical Health	97.9% / 92.0%
B11	Safer Staffing Fill Rate - Community Hospitals	94.2% / 100.0%
B13	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	35.2% / 99.0%
B14	% incidents resulting in moderate harm, severe harm or death	9.8% / 9.6%
B17	Total number of pressure ulcers developed or worsened during care by this Trust	113.1% / 100.0%
B28	% (All Active Assignments including Bank) Staff with completed Appraisals (exclusion..	78.3% / 90.0%
B29	% (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions..	86.1% / 90.0%
B30	Sickness absence average % - including non-working days (Joint Forward plan)	4.0% / 4.0%
B32	Cumulative Leave	3.6% / 3.3%
B51	PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)	34.1% / 30.0%
B52	PH CATU Inpatients Average Length of Stay (Days. Not a percentage)	10.8% / 10.0%
B53	PH Stroke Inpatients Average Length of Stay (Days. Not a percentage)	52.4% / 50.0%
B54	PH Complex (Thames) Inpatients Average Length of Stay (Days. Not a percentage)	57.1% / 54.0%



<u>Performance Thresholds not being achieved in Month</u> - *Note all these indicators have been in exception previously in the last twelve months except B14.*

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B01 - Care Programme Approach - formal review within12 months
Forecast for recovery: Previously February 2026, progressing with "My Care Plan" being embedded within the Assessment and Care Management Policy. Actions: Discussed through Mental Health and Learning Disability Programme Board as scale or required change now understood. Reports outlining overdue CPAs are sent to operational leads to review monthly and ensure formal CPA reviews are booked in.

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: 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 which will support the extraction and reporting for this indicator. Practice notice sent to ward staff to complete estimated date of discharge to support our understanding of predicted length of stay and cross reference this with those who are clinically ready for discharge.

B05 - Bed Occupancy Rate – Physical Health
Forecast for recovery: Not agreed due to significant demand for community hospital beds within the county. 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, increasing wellbeing champion network.

B11 - Safer Staffing Fill Rate - Community Hospitals
Actions: Recruitment to the final vacancies aligned to the Inpatient Establishment Reprofiling programme, optimal absence management, centralised rostering to support best roster approach, review to ensure all roles are included as appropriate. Ongoing discussions are held in the monthly safer staffing group with the Deputy Director of Nursing. Review of seven day working in Forest of Dean hospital completed.

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 are ongoing with Commissioners in respect of sub-contracting arrangements for Echocardiograms. Breaches are shared monthly with system partners, and a weekly escalation process in place. Additional staff have been recruited at the acute hospital 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 escalate to Cardiology Consultants.

B14 - % incidents resulting in moderate harm, severe harm or death
Whilst severe harm and death incident figures are below the national Q3 Patient Safety published data for April, our moderate harm figures are higher. These are largely attributed to skin integrity incidents. Due to the teams being in escalation these incidents have not yet been validated and these figures may change when reviewed.

B17 - Total Number of pressure ulcers developed or worsened during care by this Trust
In April there were 103 pressure ulcers developed or worsened whilst receiving care by GHC (in March there were 114) compared to a threshold of 91. Performance is within SPC control limits. It is of note that data for the period has not been fully validated, therefore 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. In addition, Community nursing which reports the highest number of skin integrity incidents has been in escalation with a risk rating of 16 on the Trust's risk register since January 26 due to sustained operational pressure.

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An internal Quality review advised to review the approach to reporting data, rather than a focus on PU incidence, this has been agreed and is now being presented to Improving Care Group and QAG in this new format.

There is a nationally recognised risk of incidence and prevalence of pressure ulcers. Increases in reported category 1 and 2 pressure ulcers corresponds to increases in caseload referrals in community nursing, but the data has not been triangulated. Tissue Viability specialists and Community Nursing colleagues have commenced a Quality Improvement (QI) project in March to explore the reasons behind this and understand how different approaches may reduce occurrence. QI tools will be used and a PDSA method employed. An overview has been taken to the trust's Improving Care Group for review and next steps. Wording for the current risk, 114 – rating 9, is under review to reflect factors that adversely impact mitigation.

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for April has dropped slightly to 78.3%, 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. March performance rose from 79.5% to 80.1% and was also outside normal variation expected variation. 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 April, excluding Bank staff is at 86.1%, just under the performance threshold of 90%, although the figure is expected to rise slightly due to delayed data entry (March's performance rose from 87.3% to 88.1%). Performance is outside normal variation and has been steady at around 89.9% for the last 25 months.

B30 - Sickness absence average % (Joint Forward plan)
The sickness absence rate for April 2026 is reported at 4.0% at the time of publication. However, this figure cannot be confirmed yet, as the data from the e-rostering system (Allocate) is not available until later in the period. Once this data is incorporated, the absence rate is expected to rise to 5.2%. For comparison, the reported sickness absence rate in March 2025, including e-rostering, was 5.1% compared to a threshold of 4.0% (March was reported as 3.8% without the e-rostering data). 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 April 2026 is approximately 3.6%, which is below the target threshold of 8.3%. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until mid-May. The estimated % for April once the data from Allocate has been included is expected to be 7.9%.

B51 - PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)
Risk ID: 406. Forecast for recovery: Interim measures being reviewed alongside system transformation work and bed modelling.
Actions: Delay related harm programme in place. Increased matron capacity. System work for bariatric equipment. Home first reablement improvement plan in place. Length of stay review meetings. Daily board rounds. Therapy improvement programme in action with Forest of Dean as an accelerator site. Length of stay review meetings in place.

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B52 - PH CATU Inpatients Average Length of Stay (Days. Not a percentage)
Risk ID: 406. Forecast for recovery: to be established following the temporary test of change review, which will report to operational Performance and Risk Meeting in August 2026. Actions: Internal review completed. Evaluation to consider if CATU is now appropriate in light of the step up bed trial. Ongoing work to manage flow through beds.

B53- PH Stroke Inpatients Average Length of Stay (Days. Not a percentage)
Risk 406. Forecast for recovery: To be determined. Actions: Work to reduce long lengths of stay work is well committed to, however is impacted by delay related discharges, which requires system commitment. Indicator also impacted by long stay discharges.

B54 - PH Complex (Thames) Inpatients Average Length of Stay (Days. Not a percentage)
Risk: 406. Forecast for recovery: To be determined. Actions: Delay related harm programme in place. Ongoing work with system partners to improve assessment processes and timescales for completion. Learning to inform test of change data. Metrics flowing to contribute to evaluation mechanisms in June 2026.

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AGENDA ITEM: 12/0526

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT - April 2026 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 Quality Committee with a summary assurance update on progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health, and Learning Disability services.

Recommendations and decisions required.

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

Executive summary

This dashboard provides an overview of the Trust's Quality activities for 2025/26. This report is produced monthly for Operational Delivery and Quality Governance Forums, Quality Committee and Trust Board. Following discussion at QAG this Dashboard will move through the Governance process to Board.

Quality reporting improvement:

- The main issues that are new or may require additional focus are presented in the Executive summary which has been edited to avoid repetition of information/data previously presented.
- Development of the Quality Dashboard to supplement the Integrated Performance Quality Report improvements continues.

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.

- We are working to further streamline data and narratives, and after listening to feedback, to alter and align graphs, where possible, with the Statistical Process Control (SPC) analytical technique which will enable us to have a better understanding of variations.

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?
QAG

Appendices:	Quality Dashboard Report – April 2026 Data

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

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AGENDA ITEM: 12.1/0526

QUALITY DASHBOARD 2025/26

Physical Health, Mental Health and Learning Disability Services

Data covering April 2026

This reports brings together quality focused datasets to fulfil statutory duties, legal requirements and mandated responsibilities. Some of the datasets align to those within 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

Advise

- There is progress reported by the Safeguarding Team against risk 299 on the risk register, where the team are now able to report on numbers of Multi Agency Risk Framework (MARFS) (child referrals) and adult referrals via the System 1 safeguarding template for physical health services. Whilst there remains no digital solution to track these from other clinical systems, a project will be starting soon with the Clinical Systems Team and the Safeguarding Team to review the risk assessment forms on RiO.
- There has been an increased number of anonymised concerns received through Care Quality Commission (CQC) safeguarding and Gloucestershire County Council (GCC) safeguarding routes related to Wotton Lawn Hospital. All have been acknowledged and explored further where the detail of the concern allows.
- Incident reporting shows a higher proportion of moderate harm incidents for April, but this is identified as being compounded by current escalation pressures in the community nursing teams resulting in a delay in validation of incidents related to pressure ulcers. This position is expected to resolve by next month.
- The ratio for the time taken to close complaints has shifted to an increased number taking 3-6 months which aligns with the demand and capacity pressures reported by clinical teams and the Patient and Carer Experience Team.

Executive Summary

Alert, Advise, Assure, Applaud

Assure

- All core safeguarding functions continue to be met and prioritised despite staff shortages within the team.
- The number of reported falls continues to follow a downward trajectory, indicative of the proactive response taken across sites when increases in falls are seen due to clinical acuity and patient presentations. On a similar note, incidents related to care and treatment have for the third month in a row followed a reduced reporting pattern, which may be indicative of coming out of winter pressures.
- We are reporting a position of compliance with NHS England (NHSE) /Safe Staffing Guidance in April. Across community hospitals and mental health inpatient services, safe staffing levels were broadly met, with no evidence presented this month of any patient safety incidents, quality concerns, or complaints attributable to staffing shortfalls.
- Regulatory compliance - the Trust is in ongoing communication with (CQC) regarding the inspection report related to Berkeley House. We continue to submit monthly data to CQC under regulation 31 with the Enhanced Oversight Group resumed to monitoring discharge pathways.
- There was one outbreak in April on Priory Ward, Wotton Lawn Hospital, staff were supported by the Infection Prevention Control (IPC) team during the outbreaks.
- The Learning From Deaths Report (LFD) (Quarter 4) is presented to and provides assurance that , none of the deaths that were reviewed were considered more likely than not to be due to problems in care.

Applaud

- In response to a longstanding recommendation, Safeguarding practitioners, have planned, designed and implemented domestic abuse training for Trust staff facilitated by Gloucestershire Domestic Abuse Support (GDASS).
- Recognition for the Patient and Carer Race Equality Framework (PCREF) Leads and colleagues across the partnerships and improvement directorate and the people directorate for the co-production work to develop our first anti-racist intent statement.

Are Services Safe? - Safeguarding

This table summarises the responsive Safeguarding work carried out by the Safeguarding team. It includes system work such as involvement in multi agency activity, (Multi Agency Safeguarding Hub (MASH), (Multi Agency Risk Assessment Conference) (MARAC), reviews, and child death process) and work related to responding internally (advice line, escalations, Allegation Management).

Key points to note are,

- The Multi-Agency Child Protection Team (MACPT) pilot is halfway through, with timescales set for early June by the Families First Programme Board for decisions regarding future funding and resources to implement the multi-agency model from October 26 (note: national requirements are March 2027). The pilot has relied upon a seconded role from the MASH (Multi Agency Safeguarding Hub) Team, part of the Trust's Safeguarding Team. The Trust's Named Nurse for Safeguarding Children is heavily involved in the evaluation including a MASH Time in Motion study. The Trust is working together with Gloucestershire ICB as the lead agency for the decision on the health role within the model, however due to capacity constraints on the Trust's Safeguarding Team and the on-going evaluation of pilot there will delays to the timescale for the health decision, with contingency options for October go live being worked on.
- There has been some progress in the actions related to risk 299 on the risk register. The Safeguarding Team is now able to monitor the number of MARFS (child referrals) and adult referrals completed by our physical health services from the System 1 safeguarding template. Whilst there remains no digital solution to track these from other clinical systems, a project will be starting soon with clinical systems and the safeguarding team to review the risk assessment forms on RiO. The mitigations for this risk remain in place.
- This progress is also enabling monitoring/reporting on the number of safeguarding escalations in GHC. These occur for open safeguarding cases when a practitioner has any disagreement with another practitioner from the same or different agency, about a child/adult. Escalation is a process to reduce risks to a child/adult and improve the quality of their care by all agencies coming together to work with them. Our reporting of escalations supports assurance that our services are proactively responding to risk identified.
- In relation to the families screened/researched as part of MARAC, the Safeguarding Team are working with the ICB to explore an arrangement that will enable the Police MARAC team to access the NHS Spine to find more of the information they require. This efficiency could improve the timeliness of the MARAC action plans to be uploaded by GHC. Building on this the team are reviewing reporting arrangements for MARAC so that it more closely aligns to how MASH activity is reported as this will be a more accurate reflection of the time and resource required.

	Q4	Feb-26	Mar-26	Apr-26
Number of Safeguarding Escalations	*	*	*	3
MARAC - Families screened/researched	369	100	140	114
MASH - Children & adults researched	4,059	1,327	1,332	1402
Number of Adult Reviews ongoing	25	25	27	27
Number of LCSPRs in progress	1	1	0	1
Number of Rapid Reviews attended	1	0	0	0
Expected Child Deaths	0	0	0	0
Unexpected Child Deaths	3	3	0	0
New Allegation Management cases	6	2	2	3
Number of Allegations Management Meetings held this month	*	*	22	14
Adult Safeguarding Referrals made	n/a	n/a	n/a	3
MARFs (child referrals) made	n/a	n/a	n/a	6
Safeguarding Advice line - Children's	118	43	38	28
Safeguarding Advice line - Adults	154	59	46	58

Are Services Safe? - Safeguarding

Training is the foundation of good safeguarding practice, and April demonstrates strong and sustained compliance across core training, with continued improvement in key areas.

- Level 4 Adult Safeguarding training compliance remains at the planned improvement. This training is targeted to staff undertaking safeguarding enquiries and, as these are coordinated across system partners, the overall organisational risk remains low, with approximately two enquiries per month.
- Children's safeguarding training continues on the trajectory to compliance with Level 3 Children at 86%

Clinical staff working with children are required to attend safeguarding supervision four times annually. Children's safeguarding supervision compliance remains below target (69%), despite the delivery of 21 group sessions in April. Safeguarding team workforce capacity and known recording issues within the training system, continue to impact demonstrable compliance.

Adult safeguarding supervision remains good practice but is not mandated. Adult safeguarding supervision activity has increased, with:

- Group sessions rising to 2 in April, with attendance increasing to 9 staff. Uptake remains variable, with staff often utilising the safeguarding advice line in place of formal supervision and this will form part of the evaluation of the new advice line arrangements.
- Safeguarding practitioners continue to deliver Domestic abuse (DA) training in partnership with GDASS, aligned to Domestic Homicide Review recommendations, representing sustained good practice.

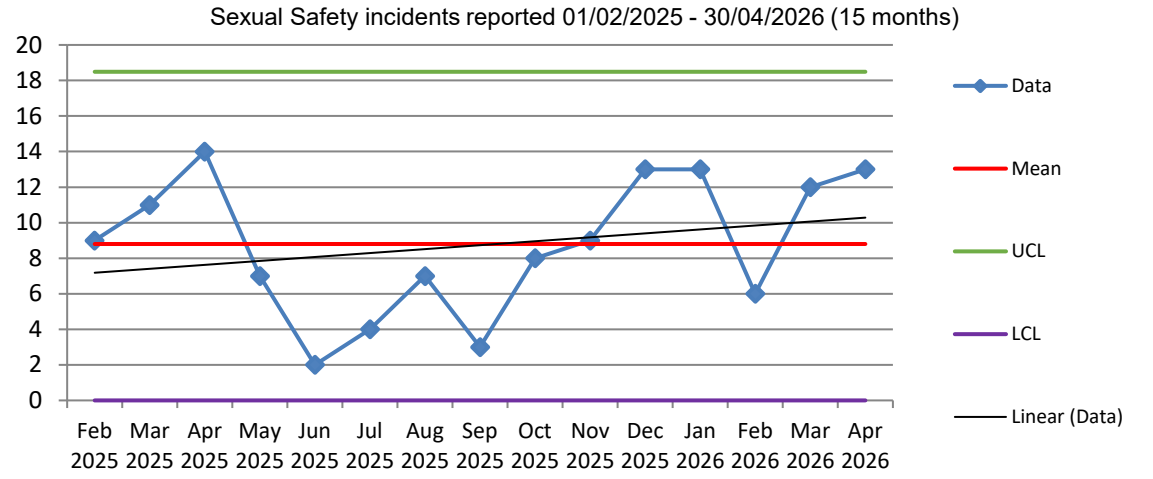
GHC - Safeguarding Dashboard 2026/27 Training and Supervision Data

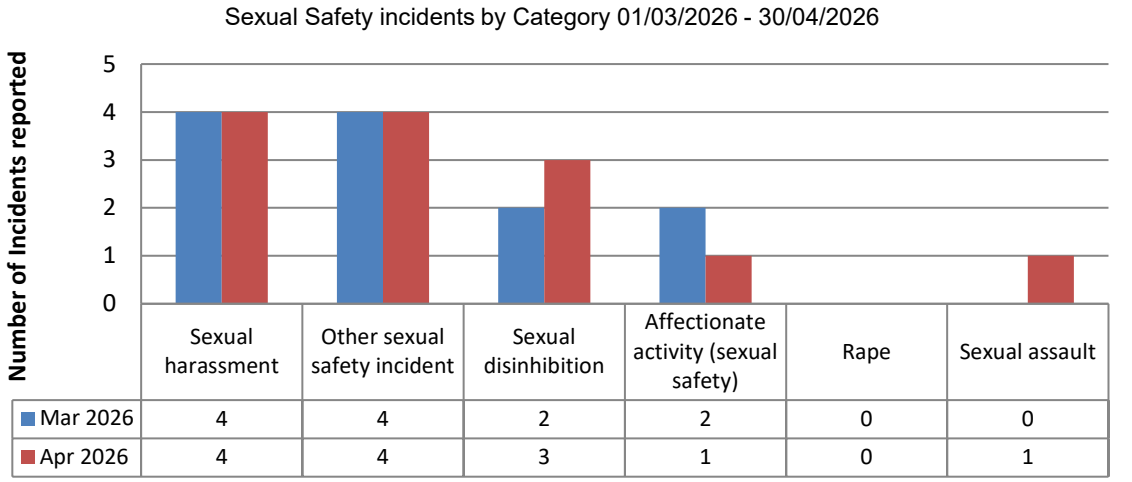
	Q4	Feb-26	Mar-26	Apr-26
TRAINING				
Level 1 – Induction	98%	98%	98%	98%
Level 2 – Think Family	97%	97%	97%	96%
Level 3 – Multi-Agency Child Protection	84%	83%	85%	86%
Level 3 Adult Protection	91%	91%	91%	91%
Level 4 Adult Protection	64%	55%	82%	83%
PREVENT:				
Level 1	99%	99%	99%	99%
Level 2	95%	95%	95%	95%
Level 3	97%	97%	97%	97%
MENTAL CAPACITY ACT:				
Level 1	96%	96%	96%	96%
Level 2	93%	93%	92%	90%
Bespoke MCA Training	12	3	3	7
SAFEGUARDING SUPERVISION				
CHILDREN:				
Group Supervision Sessions	65	20	22	21
Group Supervision Compliance	68%	67%	66%	69%
One to One Supervision Sessions	19	2	7	6
ADULTS:				
Group Supervision Sessions	1	0	0	2
Number of Staff who attended Supervision	3	0	0	9
One to One Supervision Sessions	5	2	1	1

Quality Dashboard

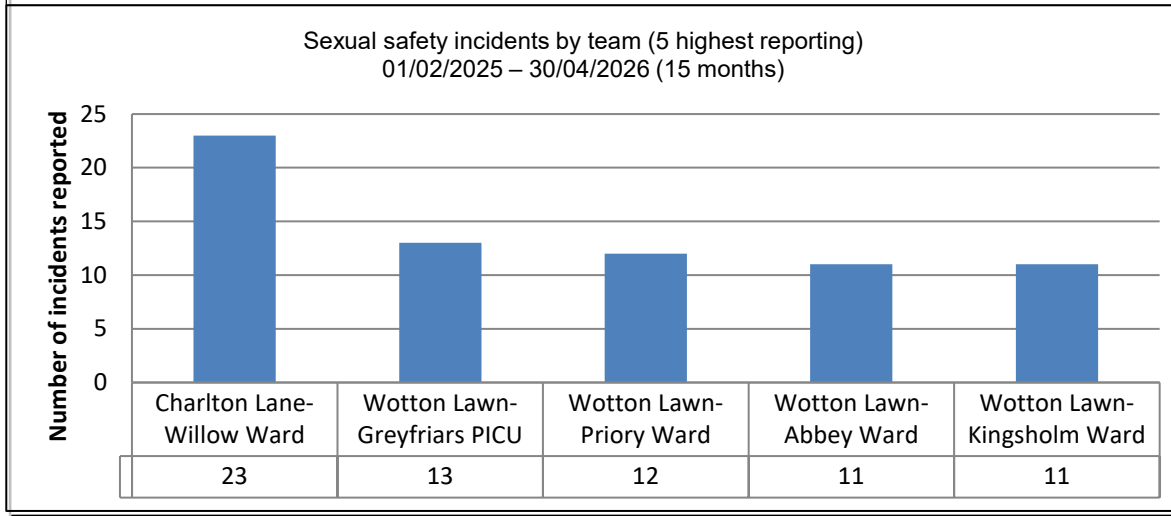
Gloucestershire Health and Care NHS Foundation Trust

Sexual Safety Incidents

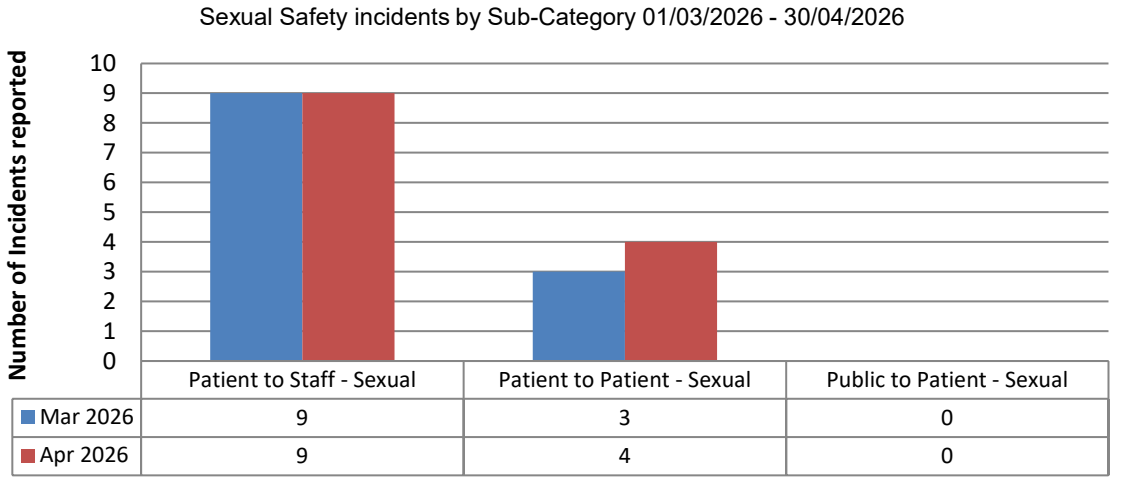




	Sexual harassment	Other sexual safety incident	Sexual disinhibition	Affectionate activity (sexual safety)	Rape	Sexual assault
Mar 2026	4	4	2	2	0	0
Apr 2026	4	4	3	1	0	1



Charlton Lane-Willow Ward	Wotton Lawn-Greyfriars PICU	Wotton Lawn-Priory Ward	Wotton Lawn-Abbey Ward	Wotton Lawn-Kingsholm Ward
23	13	12	11	11

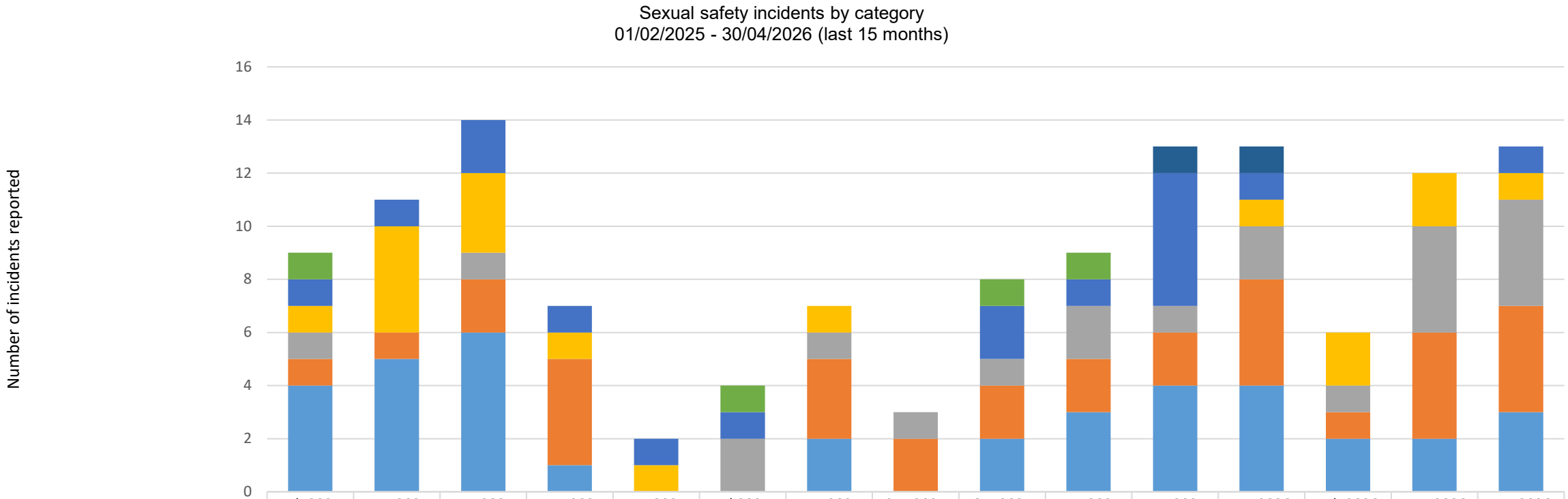


	Patient to Staff - Sexual	Patient to Patient - Sexual	Public to Patient - Sexual
Mar 2026	9	3	0
Apr 2026	9	4	0

Sexual Safety update:

There were 13 sexual incidents during April, consistent with the marginal improvements seen in reporting since 2025/26. All incidents have been dealt with in line with policy and support offered to all involved.

Sexual Safety Incidents

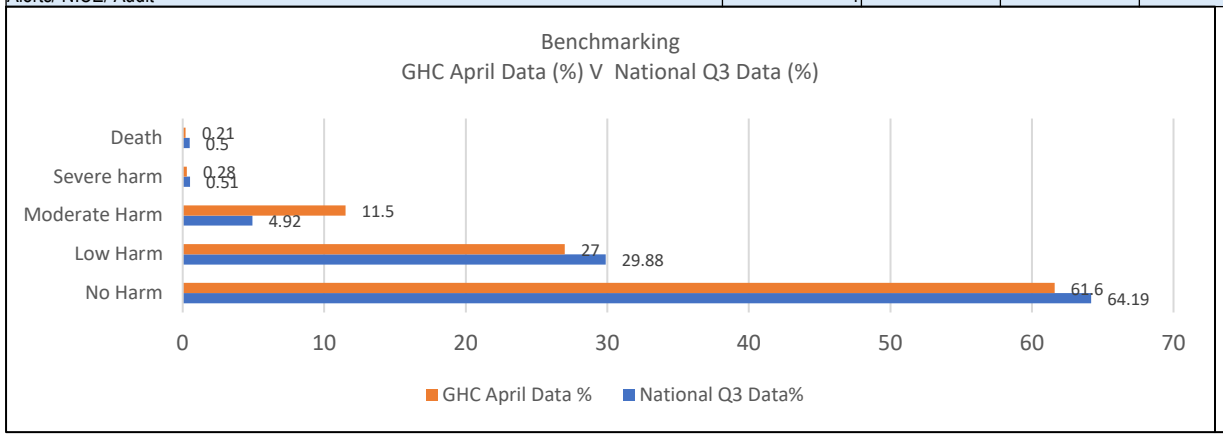


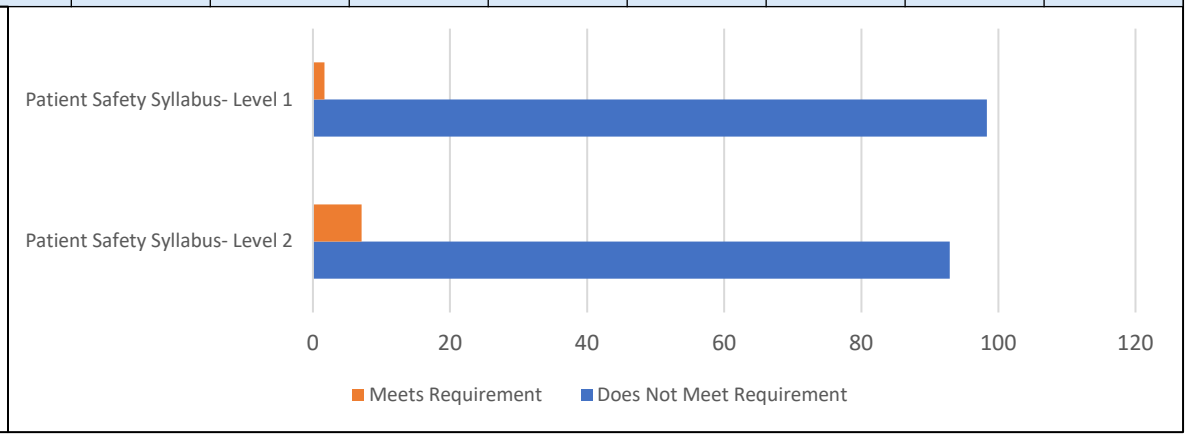
	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Rape	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Online sexual activity	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0
Sexual activity (consensual)	1	0	0	0	0	1	0	0	1	1	0	0	0	0	0
Sexual assault	1	1	2	1	1	1	0	0	2	1	5	1	0	0	1
Affectionate activity (sexual safety)	1	4	3	1	1	0	1	0	0	0	0	1	2	2	1
Sexual harassment	1	0	1	0	0	2	1	1	1	2	1	2	1	4	4
Other sexual safety incident	1	1	2	4	0	0	3	2	2	2	2	4	1	4	4
Sexual disinhibition	4	5	6	1	0	0	2	0	2	3	4	4	2	2	3

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	1385											
Number of No Harm and Low Harm incidents (including skin integrity)	1216											
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	169											
% of incidents reported resulting in moderate harm, severe harm or death (including skin integrity) against the total number of patient safety incidents reported	12.2%											
Patient Safety Investgations												
Number of AARs completed in Month	2											
Number of New PSII's and Care Reviews declared in month	3											
Number of PSII's open	14											
Number of PSII's closed in month	0											
Number of Care Reviews open	2											
Number of Care Reviews closed	0											
Number of PSII's and Care reviews open over 6 months	10											
Number of PSII's/ Care Reviews planned for Exec sign off (Closure)	TBC											
Family Liaison Practitioners												
Number of patients being supported												
Number of family and friends being supported	14											
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner	0											
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AAR's/ Care Reviews/ PSII's)	36											
PCET	24											
Alerts/ NICE/ Audit	1											





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

What is the data telling us?

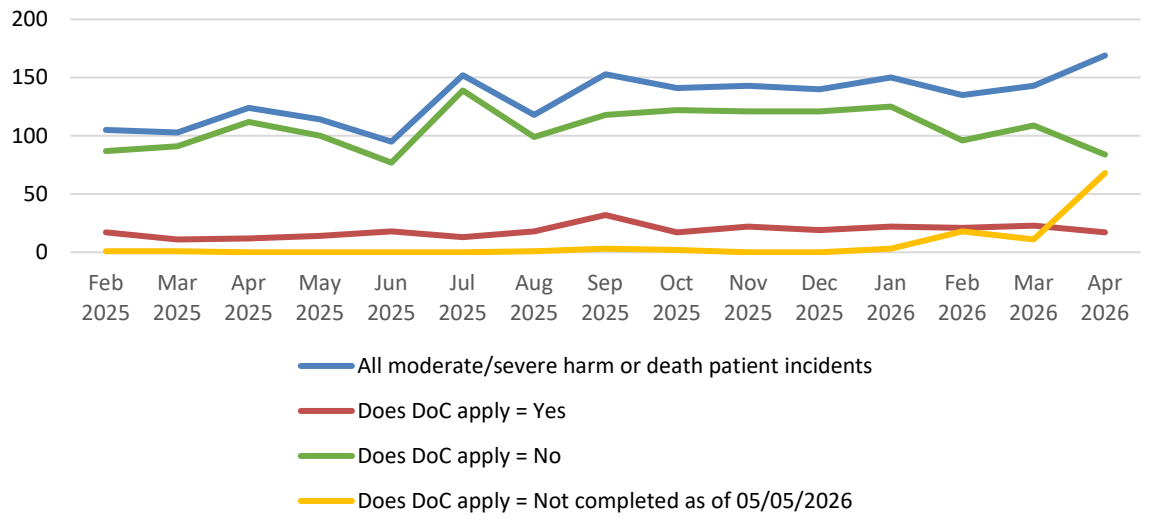
Trust Data:

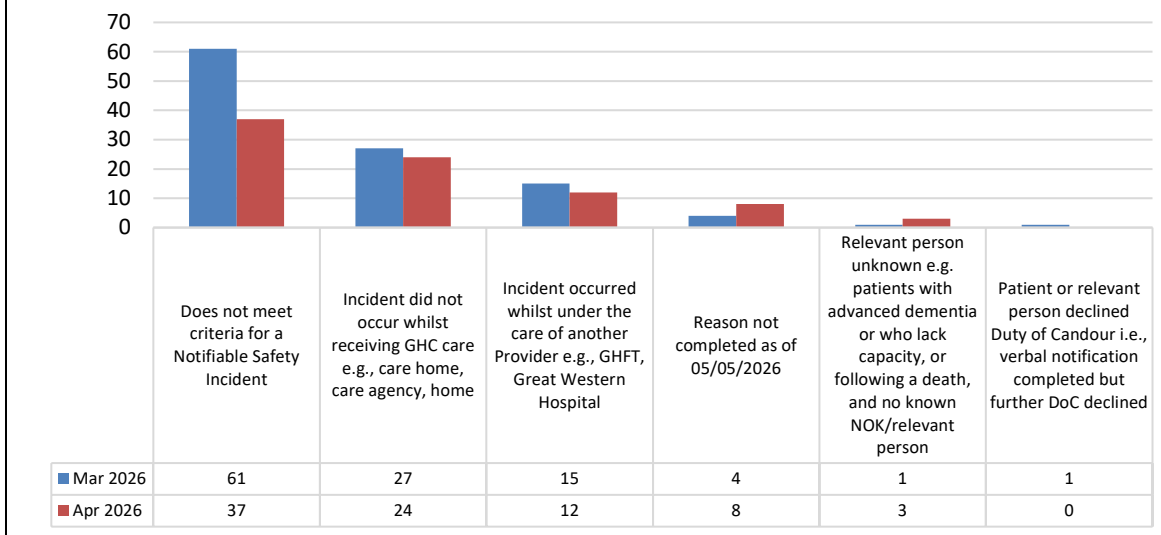
- The 1385 incidents reported in April were broadly in line with the monthly figures seen during 2025/26 (a slight increase on March).
- The recently published national Q3 Patient Safety data is being used to benchmark the Trust's monthly harm incident data against. Whilst this allows us to draw a basic comparison it is important to note that this data is not validated and only considers physical harm, as a result it is not possible to make reliable or meaningful conclusions.
- Comparison then notes we have fewer no harm, low harm, severe harm and death incidents, but more moderate harm incidents. The moderate harm incidents predominantly relate to skin integrity incidents, such that there are an increased number of these that have not been validated during April due to the community nursing teams being in escalation. There is confidence that this situation is not expected to sustain for an extended period and validation once complete is expected to retrospectively change these reported moderate harm incidents for April.

Patient Safety Team:

- There were 2 After Action Reviews (AAR) completed in April, and two are already planned for May.
- No (Patient Safety Incident Investigation) (PSIIs) and Care reviews were closed in April and 3 PSIIs were declared.
- 10 PSIIs/ Care Reviews have been open longer than 6 months, 3 exceed 12 months. The Executive Lead for the Patient Safety Incident Response Framework (PSIRF) is sighted and overseeing the factors contributing to these ongoing delays. The patient safety team continue to explore options for additional capacity, noting the limitations that any staff used meet the strict requirements outlined in PSIRF for reviewers.
- Family Liaison Practitioners (FLP) are offering support to 13 families. All FLP support is now being provided from within the PST Reviewer capacity. The team are developing a family leaflet to explain the PSIRF process to any person or family involved in incident.

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

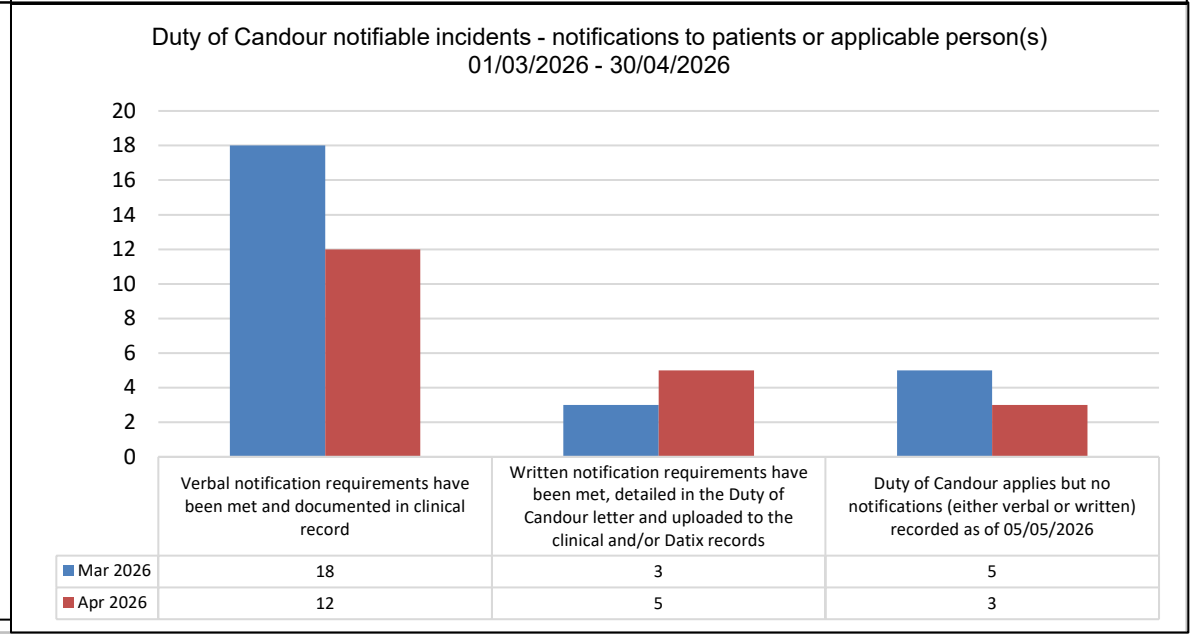




What is the data telling us:

We have reviewed our DoC position for incidents reported in March 2026, the rationale for this is that incidents reported in April may still be awaiting handling and confirmation of harm level:

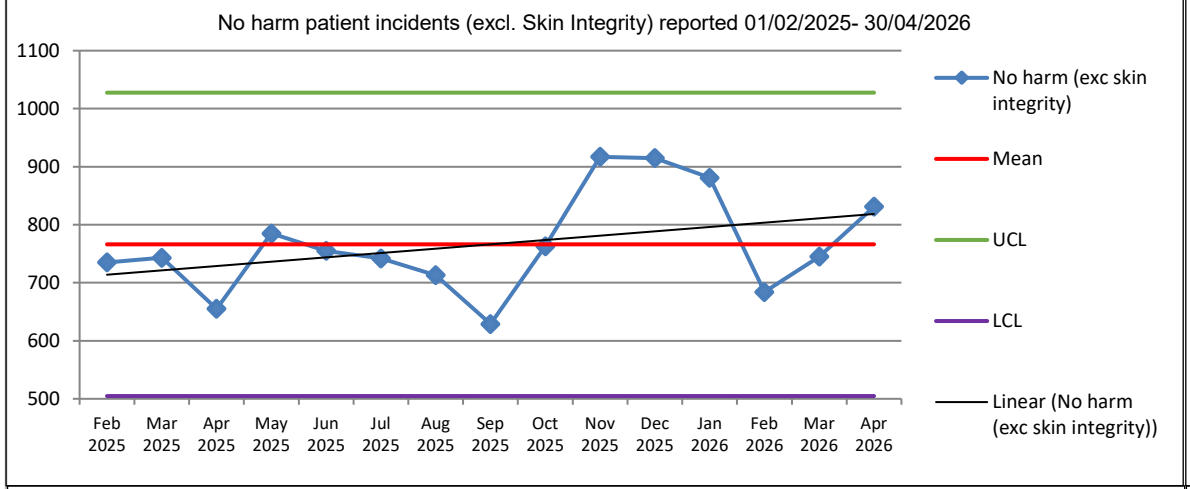
- Following confirmation of harm there are 13 fewer moderate harm incidents in the previous months data (March).
- Our previous data showed that we were waiting to understand if DoC applied in 49.8% of incidents reported, this figure has now fallen to 7.7%.
- It has identified that DoC regulation 20 did not apply in 76% of incidents in February and a reason for this has been provided in 80% of incidents.
- DoC regulation 20 applied in 16% of incidents, we are still awaiting confirmation of the notification provided in 5 incidents, but these will not be closed by the PST until this has been provided.
- The most common reasons for DoC not applying is that the incident does not meet the criteria for a notifiable safety incident and that the incident occurred whilst not under GHC care

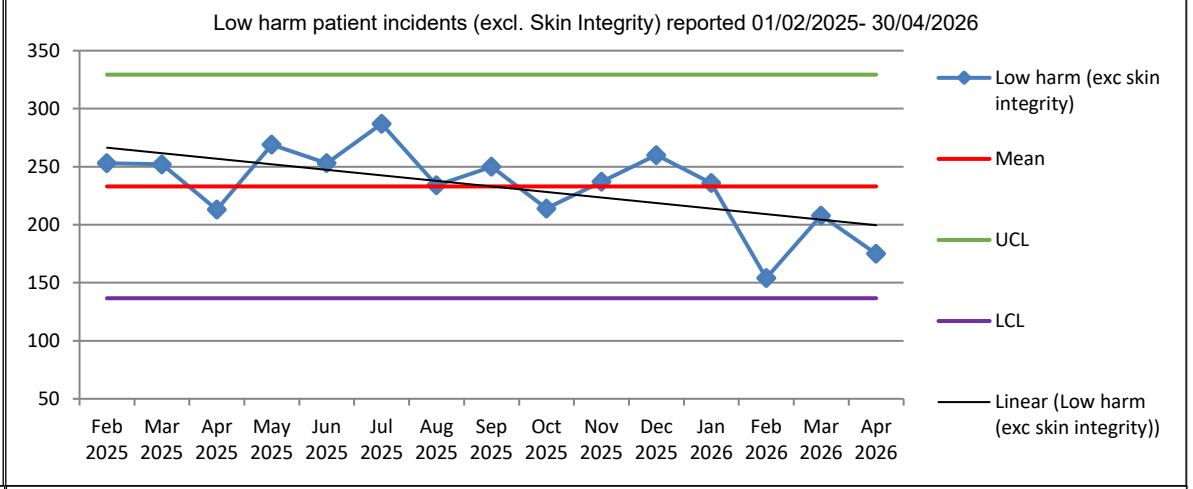


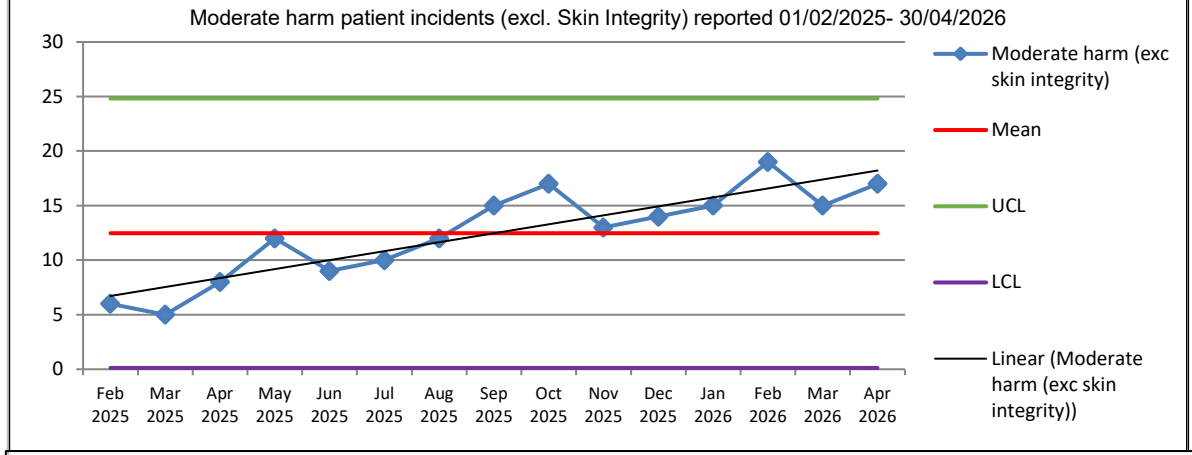
Quality Dashboard

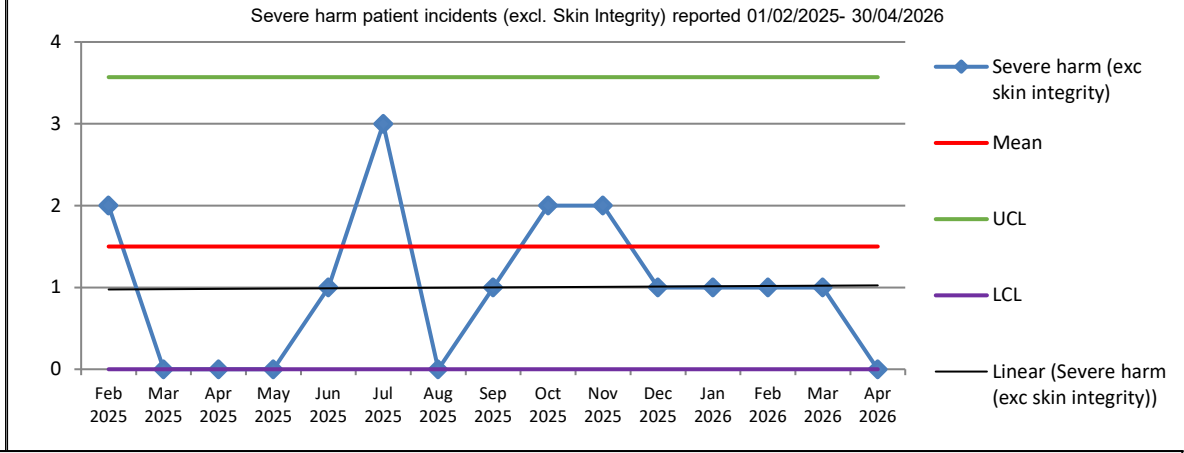
Gloucestershire Health and Care NHS Foundation Trust

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







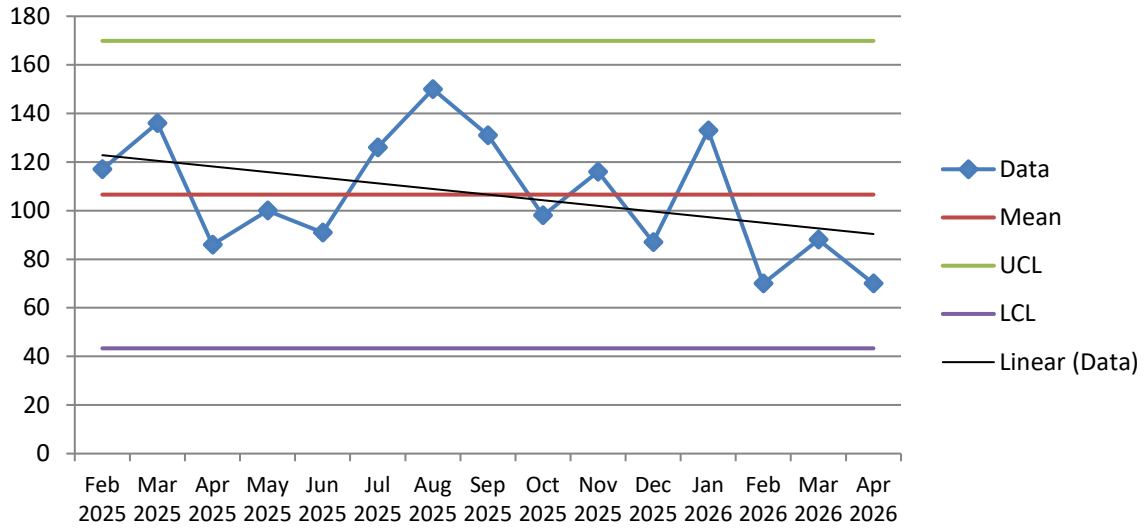


What is the data telling us:

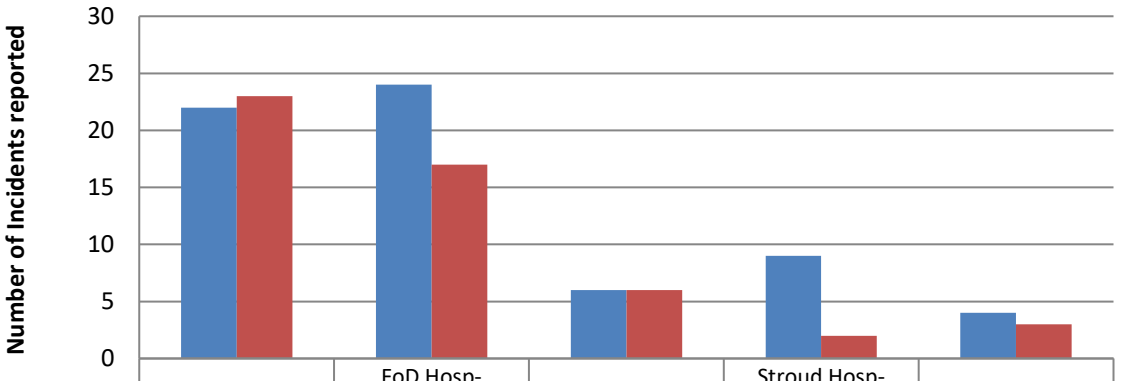
- We continue to observe month by month variation in the number of incidents reported in each harm level. There have been reductions in low harm and severe harm incidents but increases in no harm and moderate harm incidents in April.
- In April 3 deaths were reported by services, 1 relates to delays in the care pathway with another organisation and we are waiting for the information including cause of death for the remaining 2.

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

All Inpatient falls 01/02/2025-30/04/2026



All Inpatient falls - 5 highest reporting wards 01/03/2026-30/04/2026

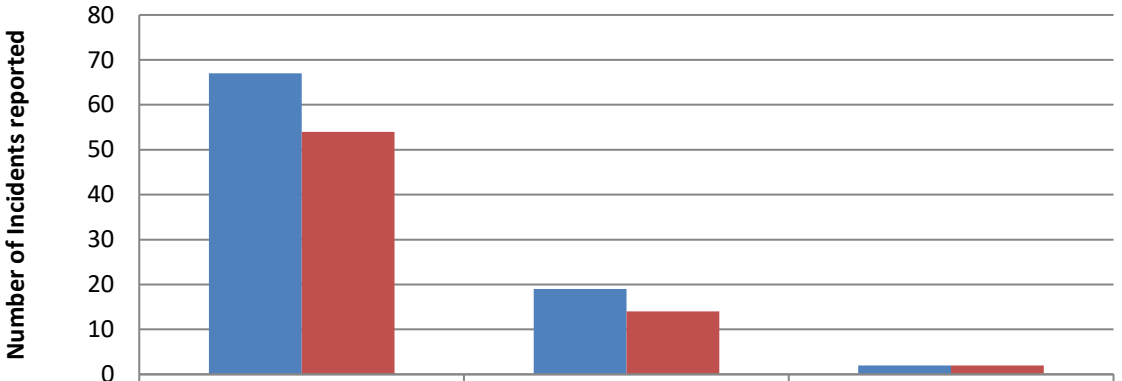


	Charlton Lane-Willow Ward	FoD Hosp-Woodland View Ward	Ciren Hosp- Coln Ward	Stroud Hosp-Cashes Green Ward	Charlton Lane-Chestnut Ward
Mar 2026	22	24	6	9	4
Apr 2026	23	17	6	2	3

What is the data telling us:

- We observe a downward trend with the number of falls across our inpatient setting, with 97% being low or no harm falls.
- Whilst there have been 23 falls on Willow Ward, the Matron reports that Charlton Lane Hospital (CLH) as a whole has for the past 2 months been within the expected baseline for number of falls. With the patient population on Willow Ward, we would expect it to be higher than other areas. We continue to have regular monthly review and mid month huddles to review our falls data and consider what we can do further.
- The reported increase in falls on Woodland View Ward at Forest of Dean Hospital last month has seen a reduction in April to 17. This is likely to reflect the multi disciplinary team meeting held to discuss the incidents and agree appropriate steps in relation to clinical management.

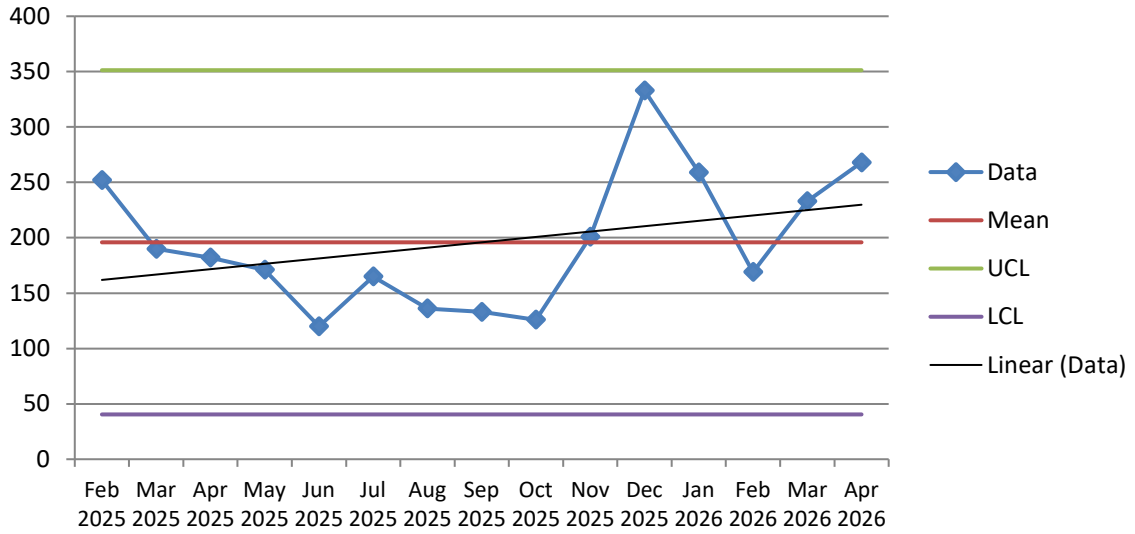
All Inpatient falls by overall severity 01/03/2026-30/04/2026



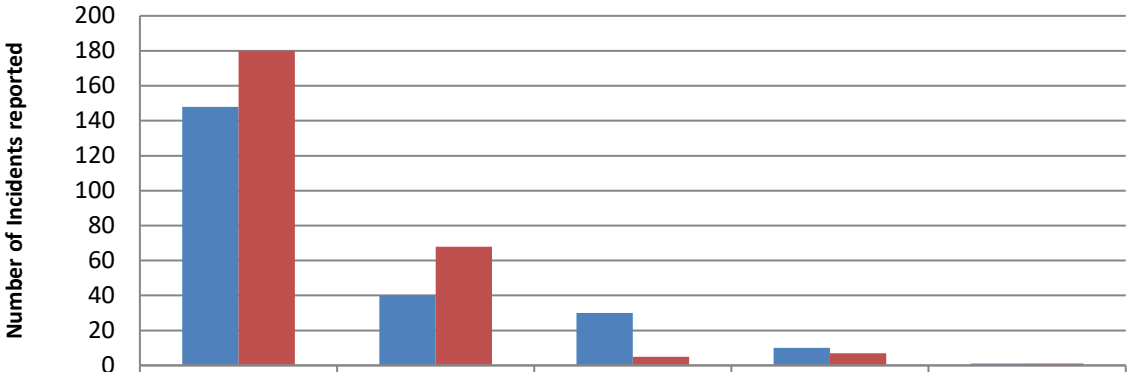
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)
Mar 2026	67	19	2
Apr 2026	54	14	2

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

Self harm or self injurious behaviour (SIB) incidents 01/02/2025 - 30/04/2026



Self harm/self injurious behaviour (SIB) incidents - 5 highest reporting teams
01/03/2026 - 30/04/2026

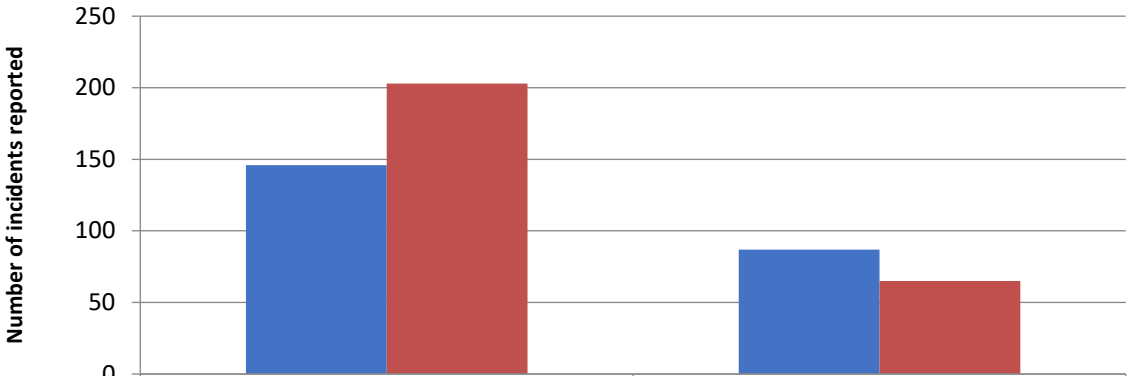


	Wotton Lawn- Priory Ward	Wotton Lawn- Abbey Ward	Wotton Lawn- Dean Ward	LD Inpatients - Berkeley House	CRHT Chelt & Tewks
Mar 2026	148	40	30	10	1
Apr 2026	180	68	5	7	1

What is the data telling is:

- There has been an increase of 35 incidents on the previous month's data, all of which have been reported as no or low harm.
- Priory Ward accounts for 67% of incidents and Abbey Ward 25% of incidents this month.
- A total of 24 patients were involved in the incidents of self harm or self injurious behaviour with 7 having 15 or more incidents reported and accounting for 85.9% of all incidents in this category.

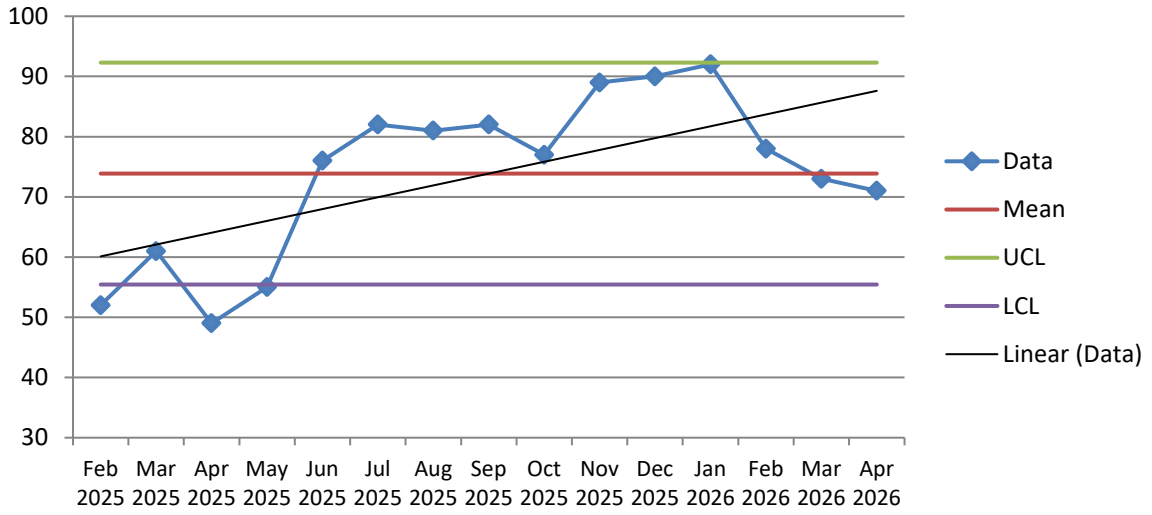
Self harm/self injurious behaviour (SIB) incidents by overall severity
01/03/2026 - 30/04/2026



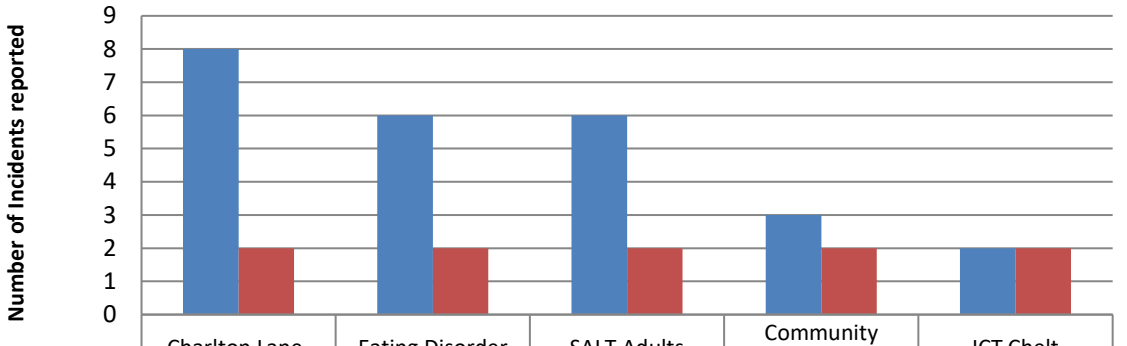
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)
Mar 2026	146	87
Apr 2026	203	65

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

Clinical care, treatments and procedure incidents 01/02/2025 - 30/04/2026



Clinical care, treatments and procedure incidents – 5 highest reporting teams 01/03/2026 - 30/04/2026

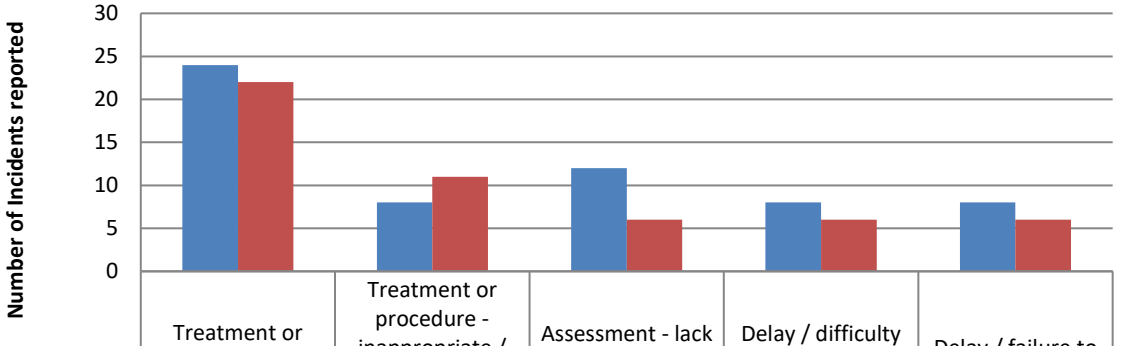


	Charlton Lane-Willow Ward	Eating Disorder Community	SALT Adults Physical Health	Community Neurology Service	ICT Chelt Peripheral DN
Mar 2026	8	6	6	3	2
Apr 2026	2	2	2	2	2

What is the data telling us:

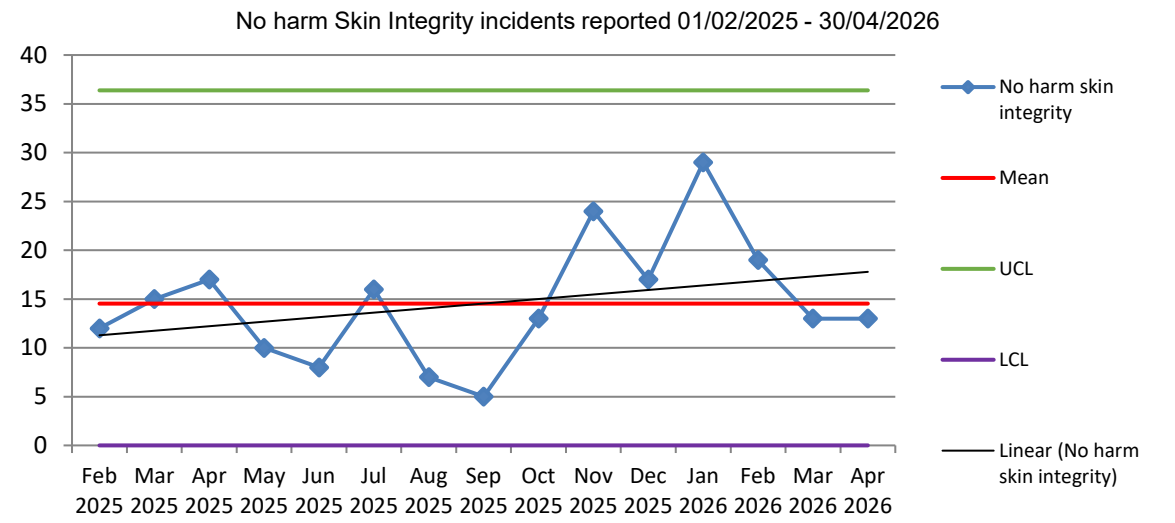
- We have observed a total of 71 incidents in this category for the month of April, with a three-month reducing trend in reporting of this category which aligns with the timing of winter pressures.
- As with previous months, analysis shows a small number of incidents for many teams across the trust, where for April the highest reporting teams recorded 2 incidents.
- At a service level, the highest number of incidents are across our Integrated Community Teams (ICTs), Wotton Lawn Hospital and Minor Injury and Illness Units (MIIUs).
- The most common sub-category remains treatment or procedure - delay or failure, where examples reported this month include a delay in ECT due to staff shortages, out of date equipment, delay or no prescription received from GP, breach of wait in MIIU due to acuity of patients attending and no handover of titration of medication.
- 96% of these incidents were low or no harm incidents.

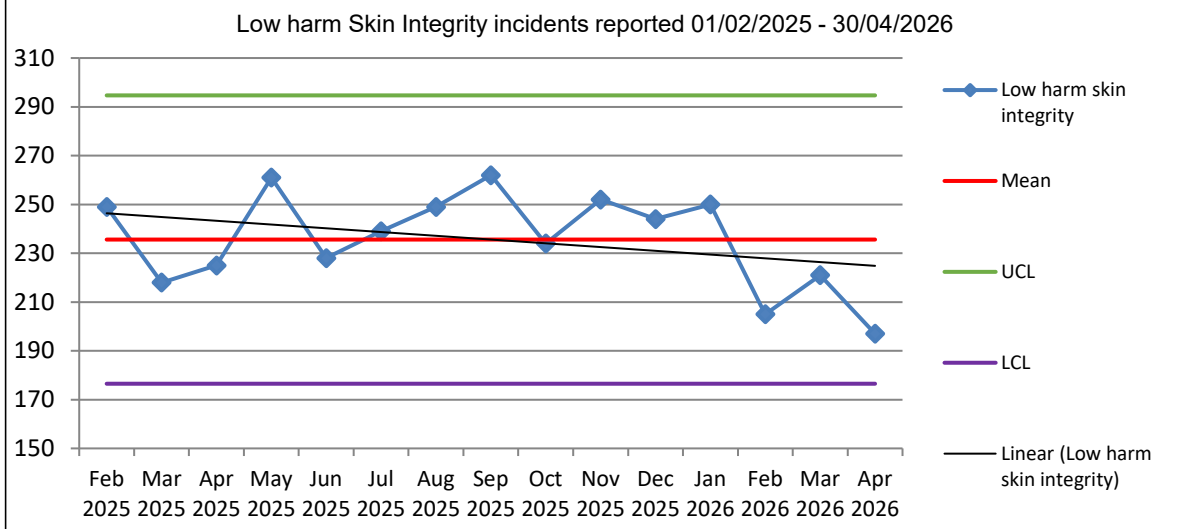
Clinical care, treatments and procedure incidents by top 5 sub categories - 01/03/2026-30/04/2026

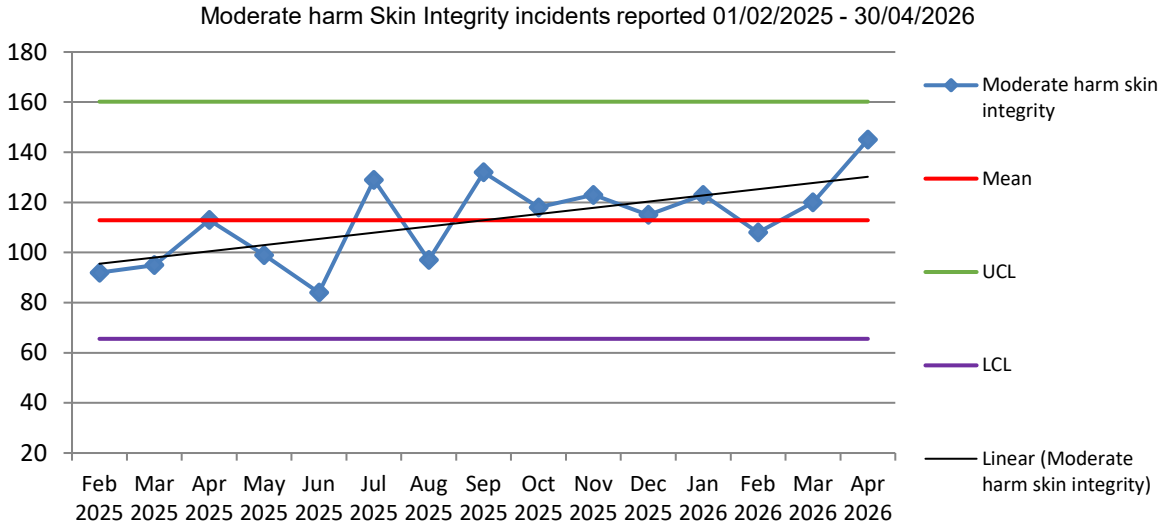


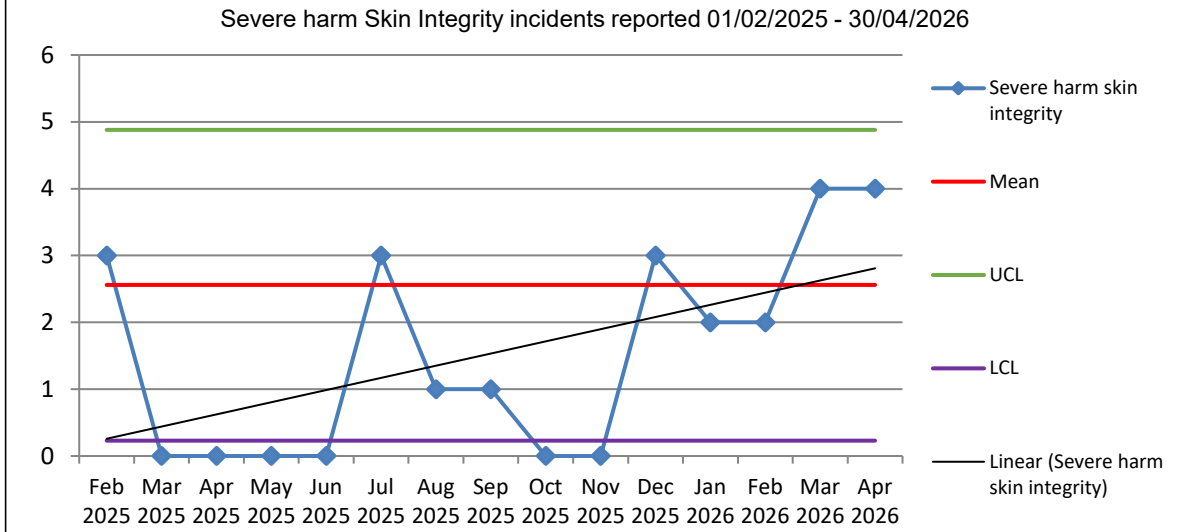
	Treatment or procedure - delay / failure	Treatment or procedure - inappropriate / wrong / not clinically indicated	Assessment - lack of clinical assessment	Delay / difficulty in obtaining clinical assistance	Delay / failure to monitor
Mar 2026	24	8	12	8	8
Apr 2026	22	11	6	6	6

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



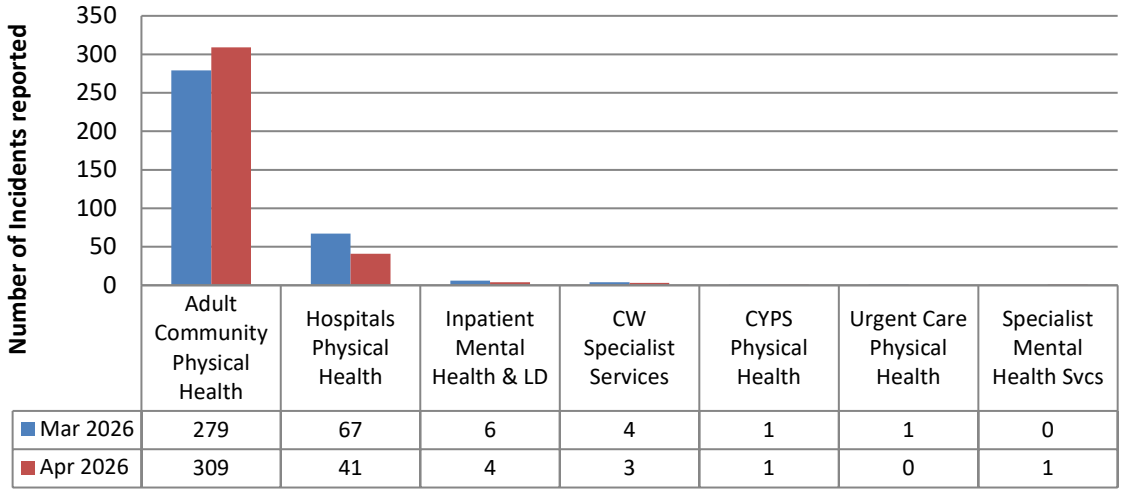






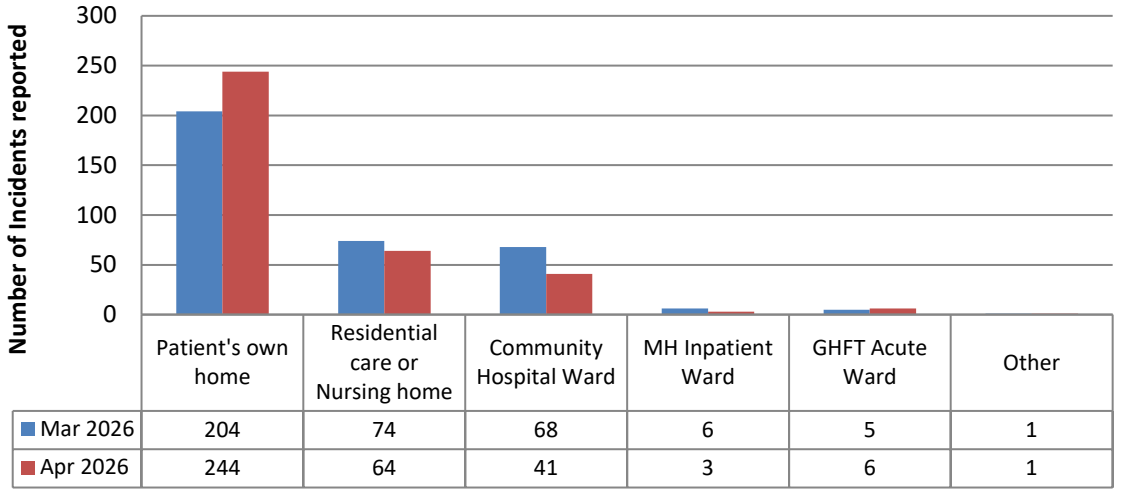
CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

Skin Integrity incidents by Service Type
01/03/2026 - 30/04/2026



	Adult Community Physical Health	Hospitals Physical Health	Inpatient Mental Health & LD	CW Specialist Services	CYPS Physical Health	Urgent Care Physical Health	Specialist Mental Health Svcs
Mar 2026	279	67	6	4	1	1	0
Apr 2026	309	41	4	3	1	0	1

Skin Integrity Incidents by Patient Location
01/03/2026 - 30/04/2026

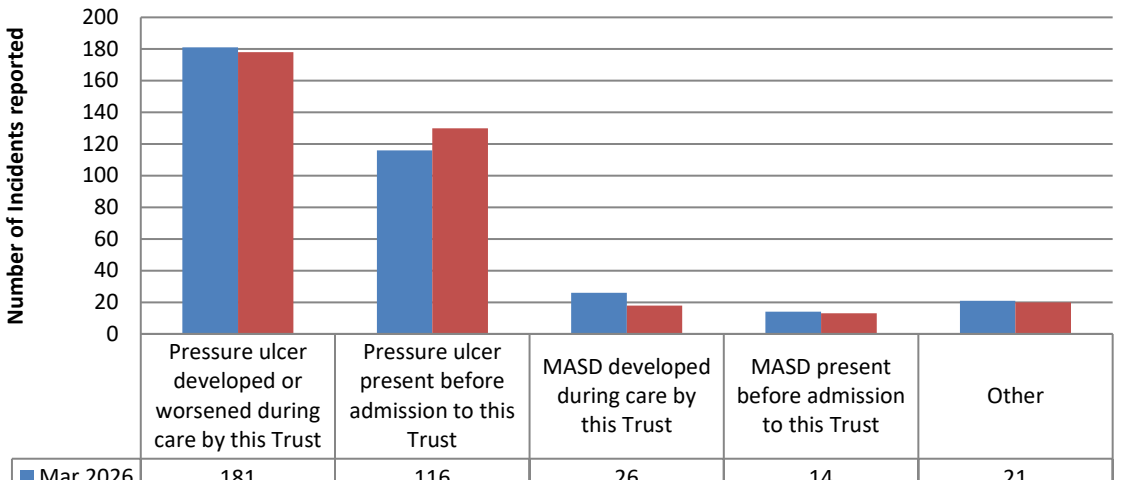


	Patient's own home	Residential care or Nursing home	Community Hospital Ward	MH Inpatient Ward	GHFT Acute Ward	Other
Mar 2026	204	74	68	6	5	1
Apr 2026	244	64	41	3	6	1

What is the data telling us:

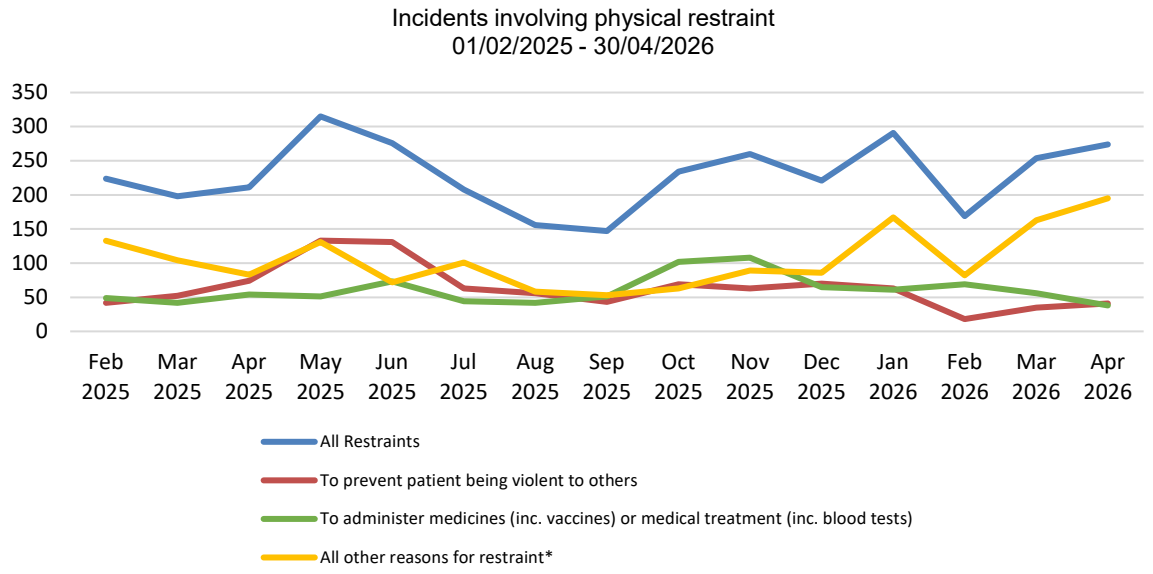
- There were a total of 359 skin integrity incidents reported across the trust with a decrease in low harm incidents, and an increase in moderate harm. Severe harm (4) and no harm incidents are consistent with the previous month's figures.
- 286 individuals were connected to these incidents with 42 individuals having 2 or more skin integrity incidents reported. They account for 32% of all reported skin integrity incidents.
- 308 of these incidents were reported as pressure ulcers (all categories), with 42% being present before admission to the trust.
- 68% of skin integrity incidents were for individuals living in their own home and a further 18% for individuals in residential or nursing homes.
- 12% of skin integrity incidents occurred within our inpatient settings.
- The severe harm incidents relate to worsening pressure ulcers in home care settings.
- Due to escalation and a back log of overdue incidents, the community nursing teams have been delayed in their validation of April's data so the harm levels reported may change retrospectively.

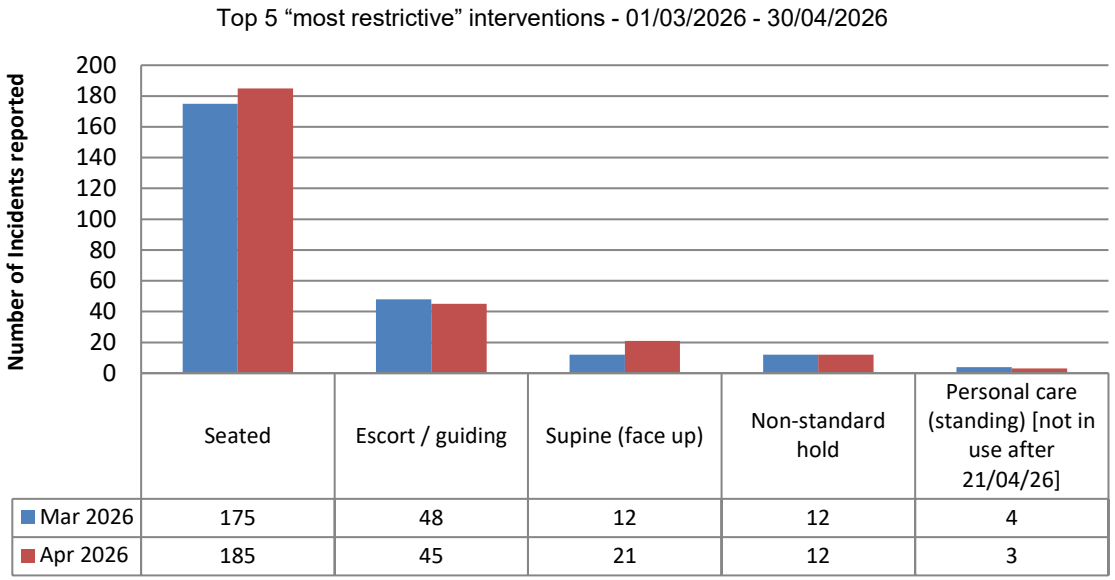
Skin Integrity Incidents by Sub-categories (grouped)
01/03/2026 - 30/04/2026



	Pressure ulcer developed or worsened during care by this Trust	Pressure ulcer present before admission to this Trust	MASD developed during care by this Trust	MASD present before admission to this Trust	Other
Mar 2026	181	116	26	14	21
Apr 2026	178	130	18	13	20

Incidents involving restraint

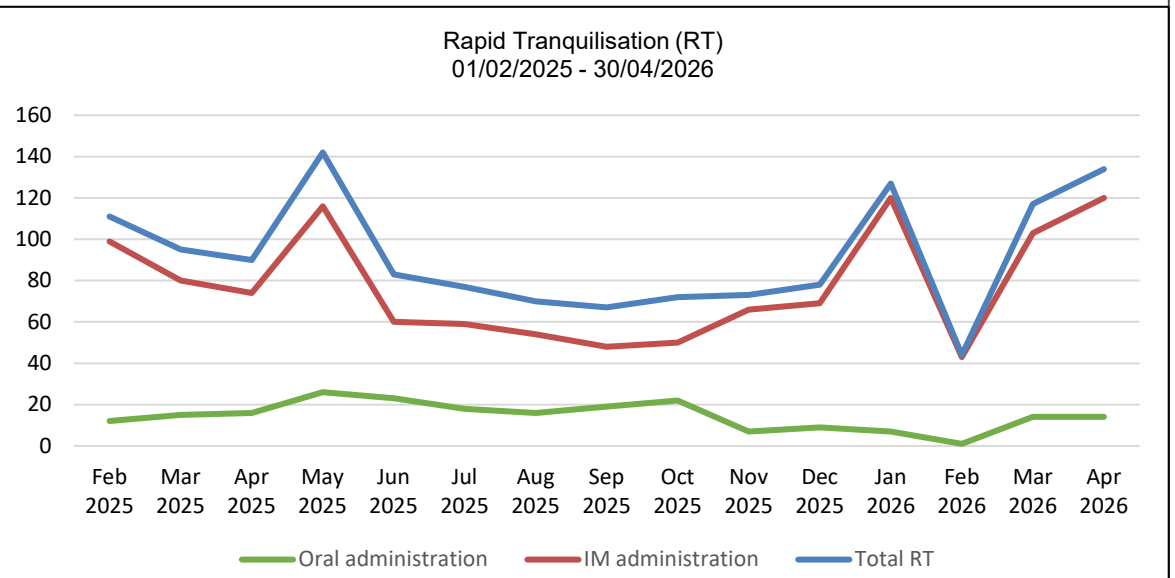




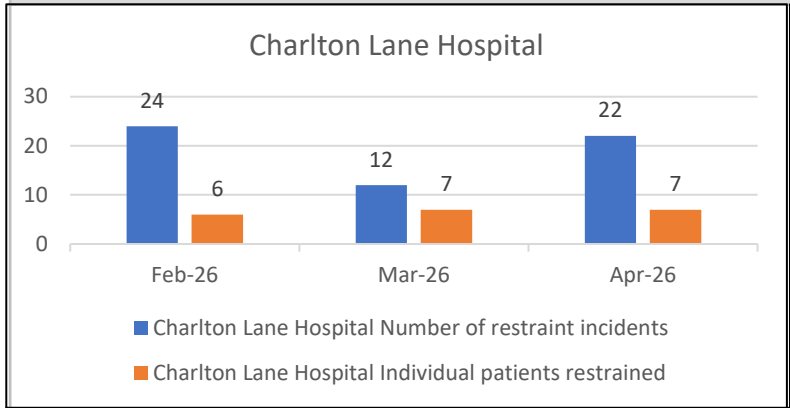
	Seated	Escort / guiding	Supine (face up)	Non-standard hold	Personal care (standing) [not in use after 21/04/26]
Mar 2026	175	48	12	12	4
Apr 2026	185	45	21	12	3

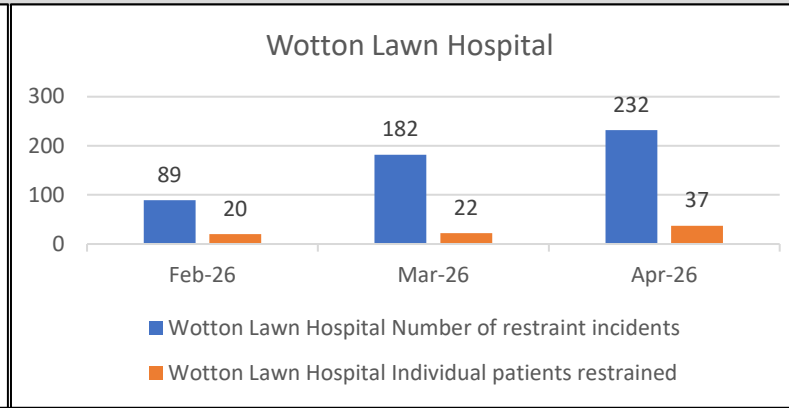
What is the data telling us:

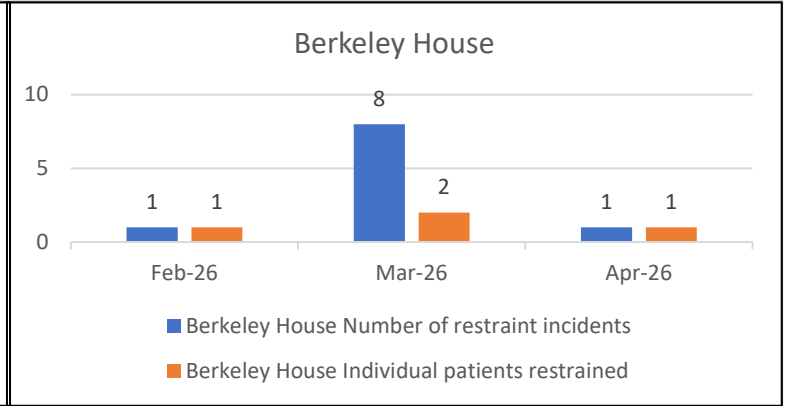
- There has been an increase in incidents relating to physical restraint, with 274 reported across our services.
- This is largely attributed to the presentation and associated needs of individuals within our MH inpatient settings with 37 individuals accounting for 232 incidents at Wotton Lawn hospital.
- Seated and escort/guiding continue to be our most frequently reported type of restricted intervention with a slight increase in seated in this month's data.
- There were 2 incidents of prone restraint in April, both have been reviewed by handlers.
- In correlation with the increase in restraint incidents, we see an increase in rapid tranquilisation with a total of 134 reported, of these 89% were IM Administration.

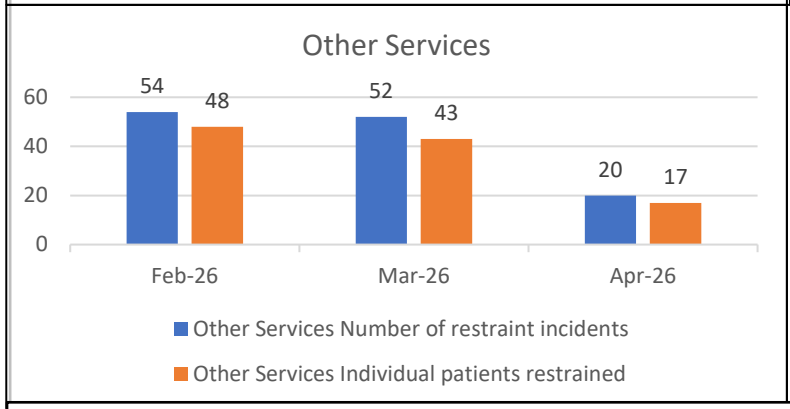


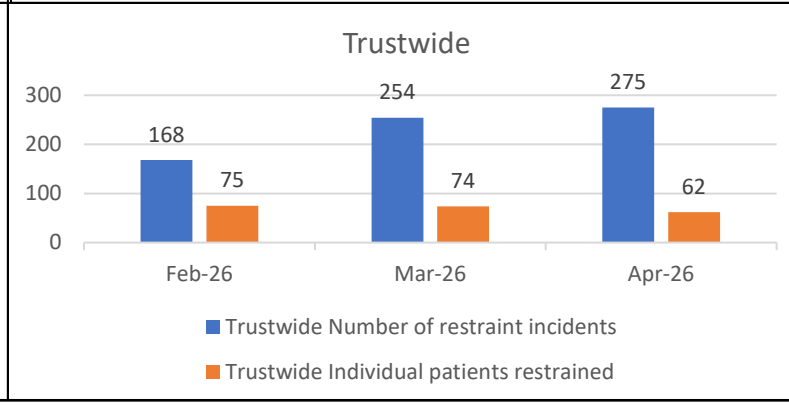
Incidents involving restraint – individual patients restrained

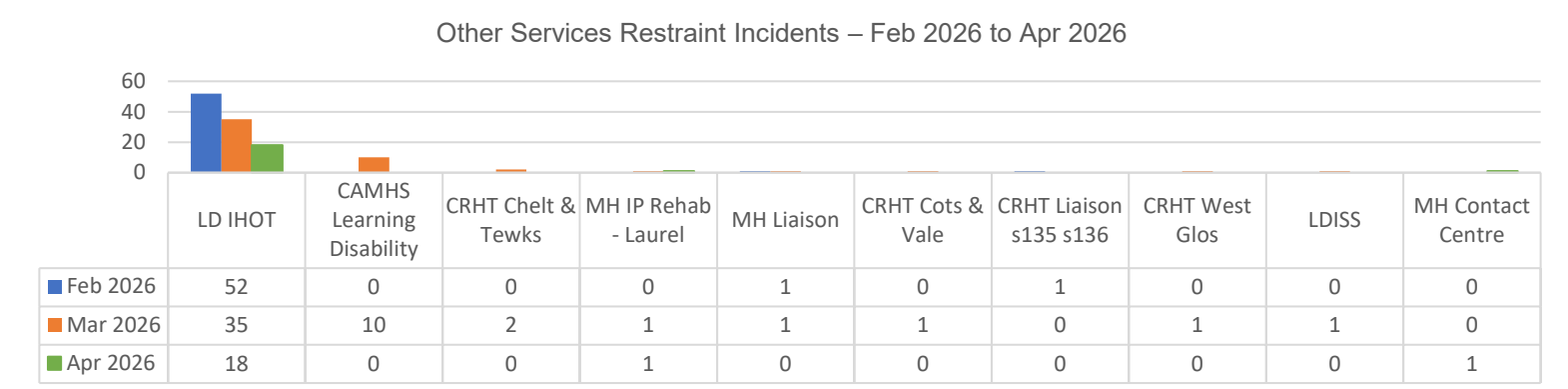












	LD IHOT	CAMHS Learning Disability	CRHT Chelt & Tewks	MH IP Rehab - Laurel	MH Liaison	CRHT Cots & Vale	CRHT Liaison s135 s136	CRHT West Glos	LDISS	MH Contact Centre
Feb 2026	52	0	0	0	1	0	1	0	0	0
Mar 2026	35	10	2	1	1	1	0	1	1	0
Apr 2026	18	0	0	1	0	0	0	0	0	1

What is the data telling us:

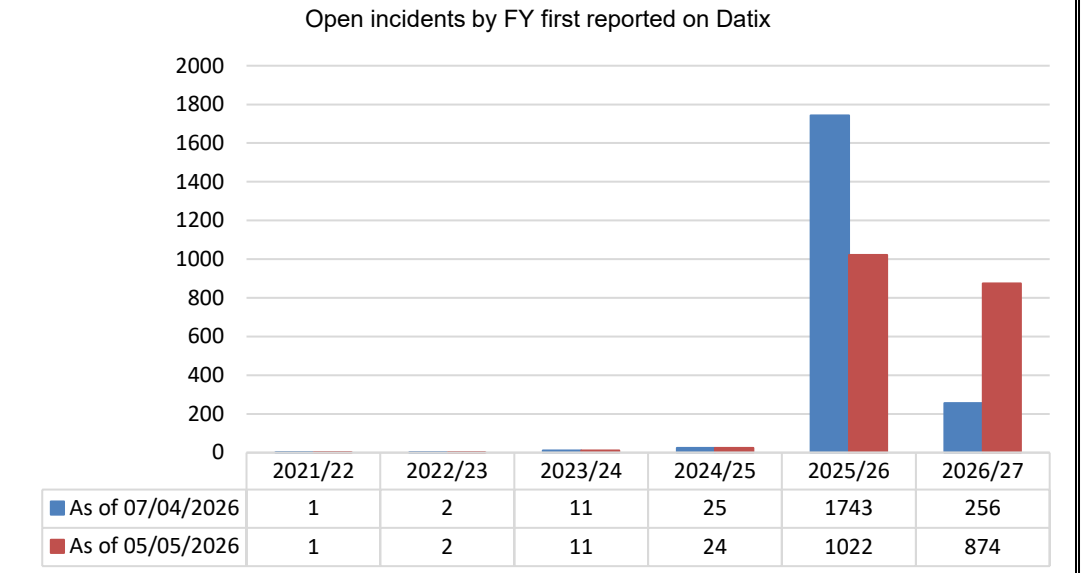
Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints. Looking more widely at other services:

In April 2026 20 restraint incidents were reported across the other services of:

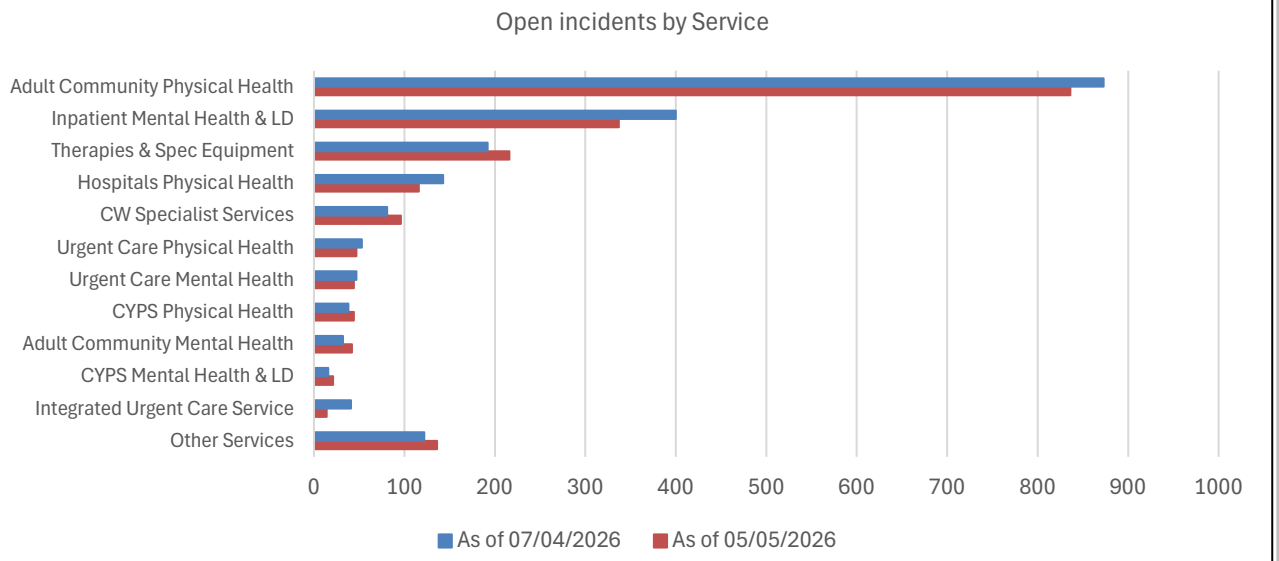
- LD IHOT (Intensive Heath Outreach Team) (18),
- MH IP Rehab – Laurel (1)
- MH Contact Centre (1).

These involved 15 patients in LD IHOT, 1 patient in MH IP Rehab and 1 patient in MH Contact Centre (incident occurred in patient's own home, assigned to MH First Point of Contact Centre).

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



	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
As of 07/04/2026	1	2	11	25	1743	256
As of 05/05/2026	1	2	11	24	1022	874



What is the data telling us?

- We continue to see the number of overdue incidents (over 60 days) from previous years steadily reducing, there has been a reduction over 700 for the financial year 2025/2026.
- The largest number of overdue incidents is in the Adult Community Physical Health Directorate. These services are our highest reporters of incidents and that we are aware that due to escalation pressures that there are challenges in undertaking reviews of incidents. A meeting is planned with ICT leads and PST to discuss this further.
- A growing number of open incidents is being seen for our current financial year 2026/27 which would be expected.

Open incidents (awaiting review/being reviewed) as of 05/05/2026 by FY incident first reported on Datix

	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	2026/2027	Total
Adult Community Physical Health	0	0	0	1	545	290	836(873)
Inpatient Mental Health & LD	0	0	0	1	67	269	337(4000
Therapies & Spec Equipment	0	0	0	1	169	46	216(192)
Hospitals Physical Health	0	0	0	0	26	90	116(143)
CW Specialist Services	0	0	0	1	63	32	96(81)
Urgent Care Physical Health	0	0	0	1	12	34	47(53)
Urgent Care Mental Health	0	0	0	2	29	13	44(47)
CYPS Physical Health	0	0	0	0	18	26	44(38)
Adult Community Mental Health	0	0	0	3	20	19	42(32)
CYPS Mental Health & LD	0	0	0	0	4	17	21
Integrated Urgent Care Service	0	0	0	0	9	5	14(41)
Other Services	1	2	11	14	60	34	122(122)
Total	1	2	11	24	1022	875	1935

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

The Deputy Director of NTQ chairs a monthly safe-staffing assurance meeting for our inpatient services across Mental Health, Learning Disabilities, and Physical Health. This review is undertaken in line with the National Quality Board (NQB) Safe Staffing Standards and NHSE's Developing Workforce Safeguards framework, which require Trusts to demonstrate that staffing establishments, roster deployment, skill mix, and care hours per patient day (CHPPD) metrics support safe and effective care.

Safe Staffing Assurance Summary (April 2026) : The Trust continues to demonstrate measurable improvement in safe staffing**,** aligned with NHSE expectations. There is clear evidence of enhanced workforce stability, reduced reliance on temporary staffing, and strengthened triangulation of staffing and quality data**.**
Patient safety impacts associated with staffing shortfalls remain minimal**,** with effective mitigation in place. However, ongoing risks relating to Registered Nurse (RMN) workforce sustainability, data consistency, and operational pressures within mental health services remain, we have **:**

- Robust triangulation of staffing exceptions with incident data**,** demonstrating predominantly no/low harm and no clear causal link to staffing gaps
- Active operational mitigation, including: Flexible workforce deployment, Use of enhanced HCSW support
- Increasing maturity in exception reporting and red flag monitoring
- Staffing shortfalls (primarily RMN-related) are: Risk-assessed and mitigated locally, Often aligned to reduced bed occupancy or acuity.
- High Health Care Support Worker (HCSW) utilisation reflects enhanced observation needs and patient safety prioritisation

Further work planned within :

- Structural RMN workforce gaps, driving recurrent exceptions
- Inconsistent red flag application, limiting robustness of assurance
- Environmental pressures (e.g. corridor observation, mixed gender flow) increasing staffing demand

Physical Health Services

- Significant improvement in recruitment and fill rates**,** with staffing now largely aligned to establishment
- Minimal agency use, with sustained reduction in off-framework shifts
- Stable quality position with no red flags and no evidence of staffing-related harm
- Effective service model (e.g. Thames Ward) supporting safe cohorting of enhanced care patients
- Variations in fill rates (including overfill) are: Clearly understood and justified (e.g. supernumerary staff, enhanced care)
- Continued focus on optimising bank usage

Further work planned within:

- Data maturity gaps**,** particularly: Limited visibility of professional judgement metrics although reassurance provided that demonstrates they are being used appropriately, opportunities to strengthen triangulation and reporting consistency .

The Trust is demonstrating a clear and positive trajectory in safe staffing, with robust mitigation maintaining patient safety despite ongoing pressures.
While Physical Health services are operating at a consistently safe level**,** Mental Health services require continued focus to achieve sustainable RMN workforce capacity and strengthen assurance processes**.** The staffing and incidents at WLH has been reviewed in light of the enhanced surveillance.

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

Mental Health & LD	April Data				
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	
Abbey	86%	144%	100%	181%	10.0
Dean	79%	109%	100%	118%	9.9
Greyfriars	77%	99%	95%	102%	15.2
Kingsholm	90%	104%	101%	98%	8.7
Montpellier	101%	92%	100%	100%	11.0
Priory	82%	185%	108%	198%	10.8
Chestnut	79%	115%	100%	100%	7.7
Mulberry	94%	96%	98%	98%	7.1
Willow	100%	92%	100%	94%	9.8
Laurel House	104%	101%	98%	100%	6.0
Honeybourne	86%	109%	100%	100%	7.3
Berkeley House	48%	136%	102%	121%	153.5

Physical Health	April Data				
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)	95%	93%	102%	101%	7.9
Windrush (Cirencester)	-	-	-	-	-
Thames (Cirencester)	105%	94%	100%	93%	19.9
Forest Of Dean Community Hospital	97%	102%	118%	104%	8.4
North Cotswolds	98%	100%	96%	107%	8.0
Cashes Green (Stroud)	93%	98%	99%	99%	6.8
Jubilee (Stroud)	112%	105%	97%	98%	9.2
Abbey View (Tewkesbury)	116%	94%	102%	101%	9.4
Peak View (Vale)	98%	97%	95%	105%	9.8

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Infection Prevention and Control – 2026/27

Quality Indicator	2025/26	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C. difficile (toxin positive) HOHA	8	14	0											
Influenza	3		0											
Norovirus	33		0											
COVID-19 HODA	17		0											
COVID-19 HOHA	3		0											
Gram-Negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)	0	0	0											
MRSA Bacteraemia	0	0	0											
MSSA Bacteraemia	0		0											
Outbreaks	6		1											
Hand Hygiene overall compliance	97%	90%												
Mandatory IPC Training: Clinical	94%	90%	94%											
Mandatory IPC Training: Non-clinical	98%	90%	98%											
Cleanliness FFT "Was the ward clean?"	98%		100%											

Cleanliness – 2026/27

02/02/26 – 27/04/26

13 Weeks Report

GHC		3rd Party	
Compliant	137	Compliant	23
Non-compliant	6	Non-compliant	4
TOTAL	143	TOTAL	27

FR	Target score	Actual score average	FR	Target score	Actual score average
FR1	98%	98.96%	FR1	98%	N/A
FR2	95%	97.85%	FR2	95%	N/A
FR3	90%	98.55%	FR3	90%	92.67%
FR4	85%	96.60%	FR4	85%	93.41%
Total average score		97.99%	Total average score		93.04%

Functional Risk (FR) categories (National Standards of Cleanliness 2025) dictate the frequency of cleaning audits and target scores based on risk, e.g. Theatres fit into FR1, OPD into FR4.

Infection Prevention Control

- One outbreak of diarrhoea and vomiting in April on Priory Ward at Wotton Lawn Hospital, 4 cases (organism not identified). Staff were supported by the IPC team during the outbreak,
- Good assurance from Hand Hygiene audits and mandatory training compliance.

Cleanliness

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

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Adult Vaccination Programme – 2026/27

IMMFORM – pre-defined staff groups for national (UKHSA/DoH) vaccination reporting purposes.

Quality Indicators	Autum/ Winter 2025/26	April 2026	May	June	July	August	September	Autumn/ Winter 2026/27
Flu - GHC IMMFORM staff	12,091 (52.2%)	-						
Flu - GHC all non-bank staff	15,174 (53.4%)	-						
Flu - Other healthcare staff	1,320	-						
Flu – GHC inpatients	1,197	-						
Flu - Care home residents	102	-						
Flu - Housebound	146	-						
Covid - GHC inpatients	484	41						
Covid – Outreach	150	200						
Covid - Care home residents	10							
Covid - Housebound	72							
RSV – GHC inpatients		23						
DTP - Asylum seekers	167	12						
MMR - Asylum seekers	143	8						
MenACWY - Asylum seekers	81							

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 uptake of GHC staff flu vaccines Autumn/Winter 2025/26 and summary of National Vaccinations Programmes (NVPs) administered by GHC teams. Spring Covid Vaccination Programme commenced 13/04/26.

What are we going to do about it

Continue to provide opportunities to increase vaccine uptake for eligible cohorts.

Are there any risks

The Trust is engaged in an active regional procurement process which may have implications for the Outreach Vaccination and Health Team.

The change in delivery model of staff flu vaccination programme 2026/27, with a greater reliance on peer vaccinators within teams, remains under review by the Flu Group.

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.

	Type	Aim	2025/26	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2026/27 YTD	Notes
Number of Friends and Family Test Responses Received	NR		25,368	2,603												2,603	Including 48 responses from carers (81% positive)
% of respondents indicating a positive experience of our services	NR	90%	93%	90%												90%	
Number of compliments received in month	LR		3,321	250												250	Compliments can be added retrospectively
Number of enquiries (other contacts) received in month	LR		1,671	204												204	
Total number of complaints received in month	NR		254	14												14	1 MH, 2 CYPS, 7 Community, 1 Countywide, 3 IUCS.
Total early resolution complaints received in month	LR			12												12	
Total number of open complaints (not all opened within month)	LR			59													
% of complaints acknowledged within 3 working days	NT	100%	100%	100%												100%	National requirement
Total number of complaints closed in month	LR			21												21	1 MH, 1 PH, 4 CYPS, 3 Comm, 2 C/W, 10 IUCS.
Number of complaints closed within 3 months	LT			8												8	
Number of re-opened complaints (not all opened within month)	LR			4													1 CYPS, 2 Community, 1 IUCS
Number of external reviews (not all opened within month)	LR			6													4 MH, 1 CYPS, 1 Community

NT: Nationally reported measure with target. **NR**: Nationally reported measure, no target. **LT**: Locally reported measure with internal target. **LR**: Locally reported measure, no target.

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

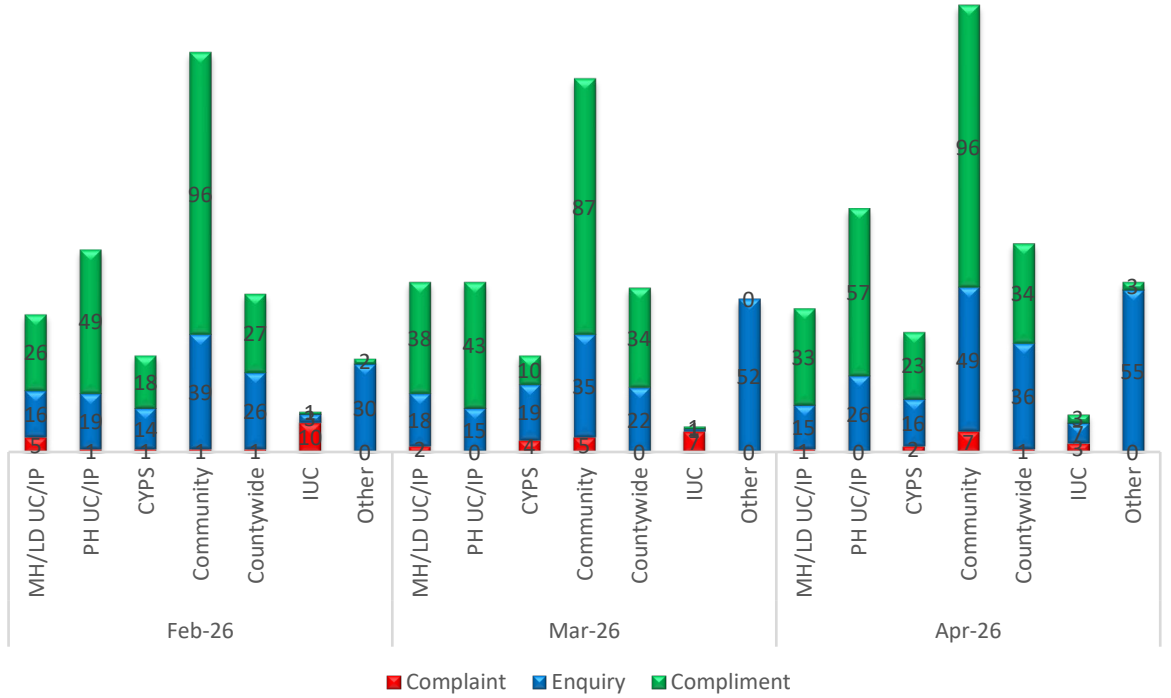
Key Highlights:.

- The IUCS pilot process (launched 1st April and led by IC24) has reduced the number of complaints requiring GHC action by more than 50%.
- We continue to see far more compliments than any other type of feedback and directorates 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

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	1	Early resolution:	**1**	15	33
		Closer look:	**0**		
PH urgent care and inpatient	0	Early resolution:	**0**	26	58
		Closer look:	**0**		
CYPS	2	Early resolution:	**2**	16	23
		Closer look:	**0**		
PH/MH/LD Community	7	Early resolution:	**6**	49	96
		Closer look:	**1**		
Countywide	1	Early resolution:	**1**	36	34
		Closer look:	**0**		
IUCS	3	Early resolution:	**2**	7	3
		Closer look:	**1**		
Other	0	Early resolution:	**0**	55	3
		Closer look:	**0**		
Totals	14	Early resolution:	**12**	204	250
		Closer look:	**2**		

This table shows directorate feedback over the past three months



Quality Dashboard

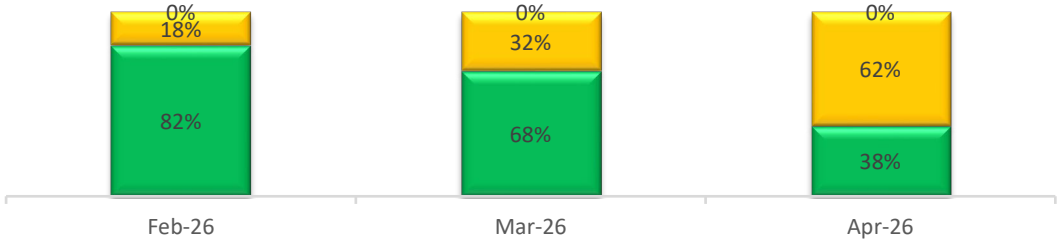
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD UC/IP	0	0	0	0	1	1
PH UC/IP	1	0	0	0	0	1
CYPS	3	1	0	0	0	4
PH/MH/LD Community	0	1	2	0	0	3
Countywide	0	1	1	0	0	2
IUCS	4	3	3	0	0	10
Other	0	0	0	0	0	0
Totals	**8**	**6**	**6**	**0**	**1**	**21**

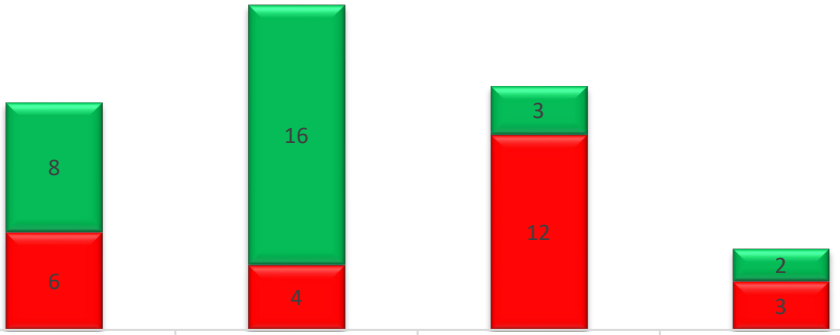
The below table shows some of the upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
CYPS (22681)	Delay in referral to paediatrics. **Appointments**
PH/MH/LD Community (22792)	Concerns ignored re worsening diabetes complications. **Clinical Treatment**
Countywide (22676)	Pain management practice review for high-risk patients undergoing procedures under local anaesthetic. **Trust admin/policies/procedures**
IUCS (20979)	Out of Hours GP arrived unannounced and patient awoke to find him standing over her bed. **Communication**

The below graph shows the length of time taken to close complaints.
This month 38**%** were closed in 3 months (target 50%), 100**%** closed in 6 months (target 80%)



	Feb-26	Mar-26	Apr-26
6-12 months	0%	0%	0%
3-6 months	18%	32%	62%
0-3 months	82%	68%	38%

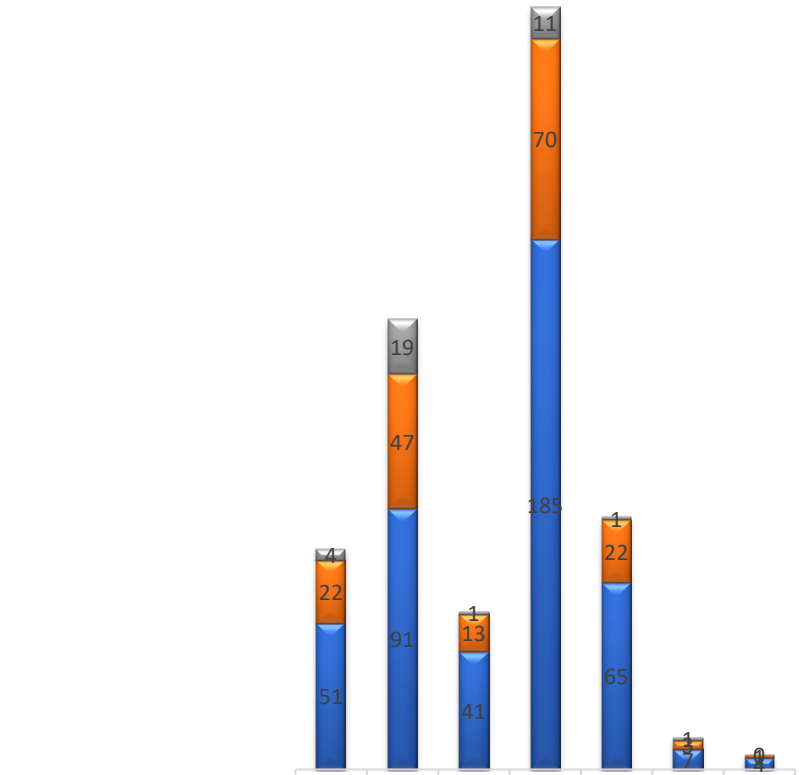


	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	8	16	3	2
Upheld	6	4	12	3

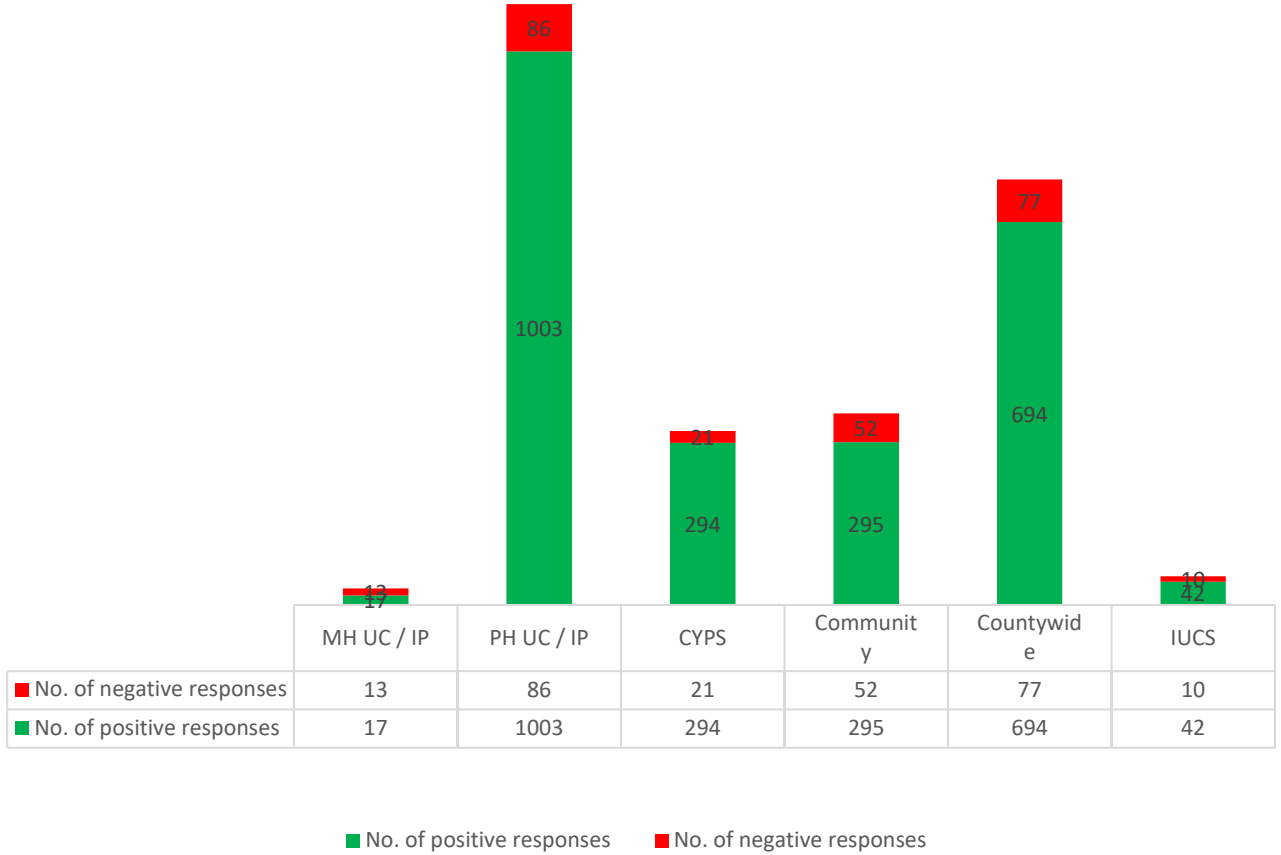
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The table below is a sample of compliments RECORDED this month. The chart opposite illustrates the key themes by directorate.
The 250 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.**

ID	Team	Compliment
24105	MH Contact Centre	Care coordinator for older people's service e-mailed the team advising a patient felt the staff were great and very supportive and finds the calls the beneficial.
24085	Stroud Hosp-Jubilee Ward	A patient was chatting to physios on the ward re: his in-patient experience, in general conversation. He was very complimentary regarding the high standard of care and therapy service he had received since admission to Jubilee ward 'I can't fault it here'.
23764	CAMHS/VC Infant MH Team	"I can't thank you enough, I couldn't have done it without you. I'm so grateful. Our life as a family is completely transformed, we are in such a better place"
24010	ICT Cotswold South 1 DN	Was very complimentary about the DN team, she said the team was "amazing, can't fault the care given".
23612	Sexual Health Preg Adv PAS	The pregnancy Advisory team worked together brilliantly to support a Vulnerable child presenting very late for a TOP to obtain the correct treatment within 1 week of presentation.
24044	IUCS 111 Service	Email from patient re: 111 call she made and that "the call handler was kind, understanding and professional. Patient says she was feeling suicidal and this person saved her life."
24047	Wotton Lawn-Dean Ward	Patient and husband thanked staff for the care and treatment that have been receive when leaving the ward. Afterwards a thank you card has been sent to the ward.
23721	MIiU- Ciren Hosp	"Excellent friendly staff, would recommend anyone to use their services."
23768	Later Life North	"I was looked after very well with kindness and understanding."



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

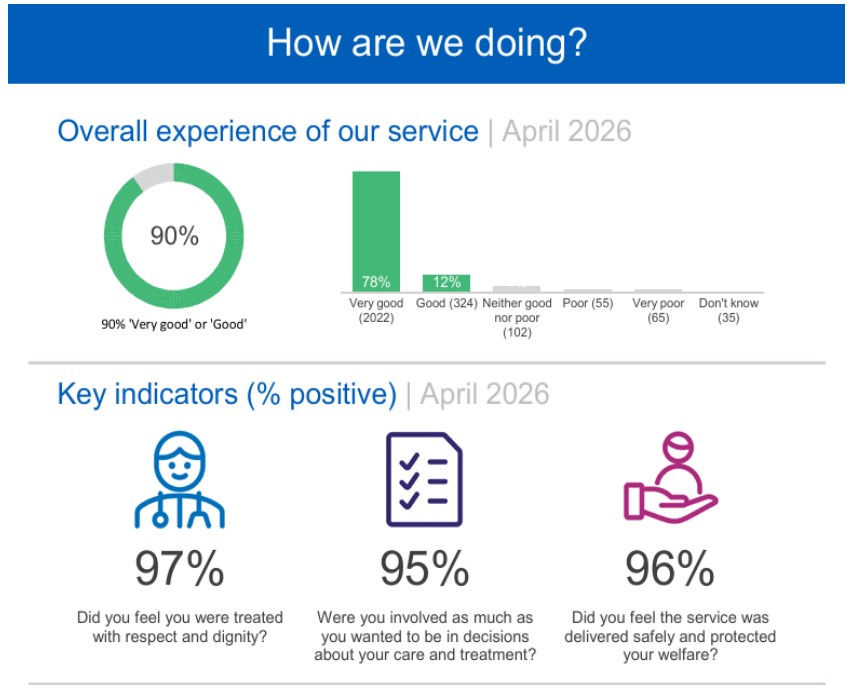


	MH UC / IP	PH UC / IP	CYPS	Community	Countywide	IUCS
No. of negative responses	13	86	21	52	77	10
No. of positive responses	17	1003	294	295	694	42

Highlights for this month:

- The overall positive experience for the month is 90%, which is lowest positivity rate recorded.
- Service users made 13 requests for contact/action through the FFT.
- FFT for Out of Hours GP, IUCS received 52 responses (81% positive).
- There were 77 teams (cost centres) who received no FFT responses in April. There are 235 cost centres in total, these are not all in use and there may be a variety of reason why some cost centres don't have responses each month. E.g. Children Community Complex Care Team have a small number of patients which they survey annually so they would only have responses in one month of a year, the rest will show 0 responses, but this is not a concern.

Patient feedback



Carer feedback

Patient and Carer Race Equality Framework (PCREF)

What is PCREF?
The PCREF is NHS England's first anti-racism framework aimed at improving Mental Health services for individuals from diverse ethnic, racial and cultural Backgrounds. The framework is mandatory and is part of CQC inspections, ensuring that trusts and providers are responsible for addressing racial disparities and improving patient experiences. We are aiming to establish what are the disparities and what is the required action going to be to address this alongside comparing this with national benchmarks.

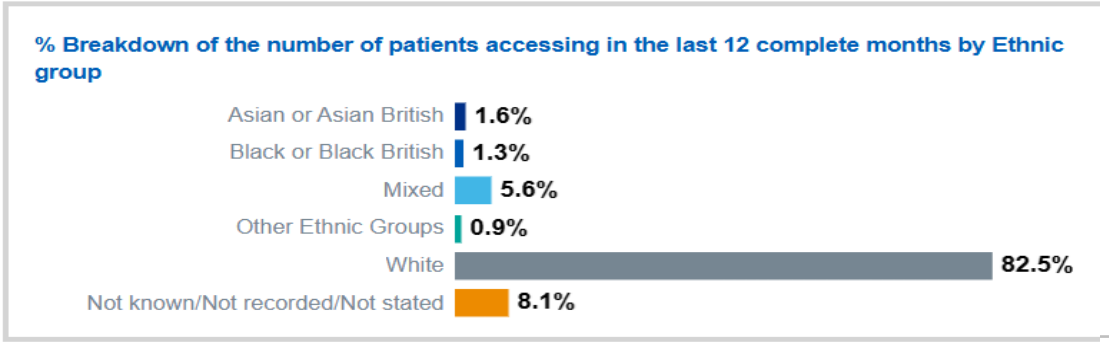
Quality Assurance/BI Dashboard (current data collection. Data correct as of)
Gloucestershire Population

Ethnicity recording compliance (RiO and IAPTus)

	Caseload	Number of ethnicity recorded	Number where ethnicity is not known/not recorded/not stated	Compliance
RiO	23,758	18,738	212	78.9%
IAPTus	4,756	4,687	69	98.5%
Grand Total	28,514	23,425	281	82.2%

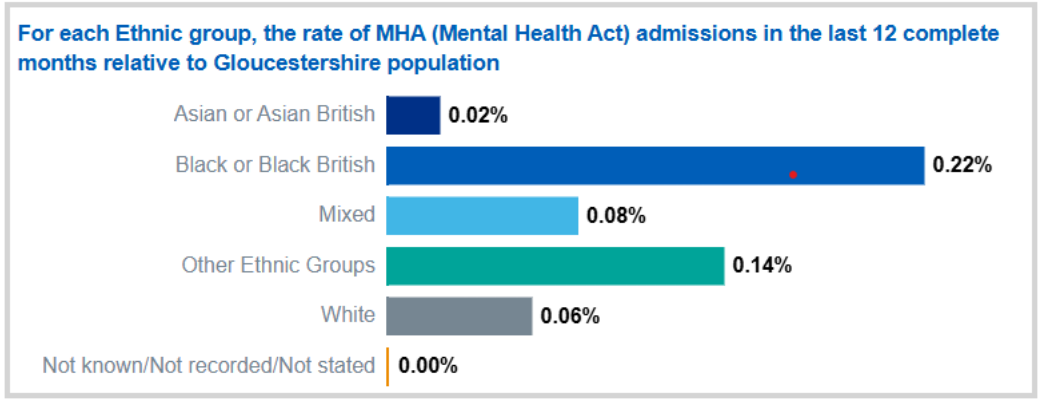
Ethnicity recording shows that the number of patients where their ethnicity is not known is still too high. This will have an impact personalised Care and an inability to track their outcomes and progress. The PCREF Leads will be taking a particular focus on internal communications on recording during Q2 & Q3 to improve.

Access to services – access rates into Child and Adolescent Mental Health Services (CAMHS) – As we know access rates into CAMHS, particularly for those with brown/black skin is less than expected. CAMHS have set up a Culture group to look to Innovative ways to improve access rates for this population of children and young people.



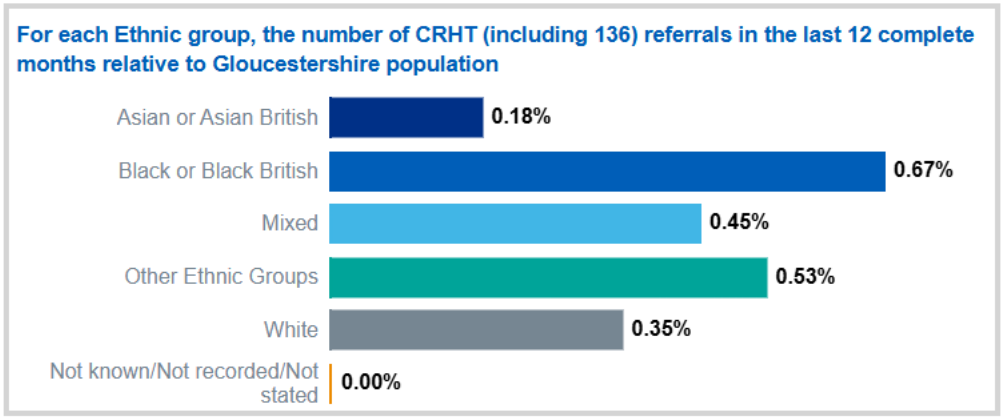
PCREF Data Working Group
From June, we will be starting a data working group in order to look more closely at what the data is telling us and where the gaps are. What questions we need to be asking and how we will know and measure our success as an organisation

Mental Health Act Admissions



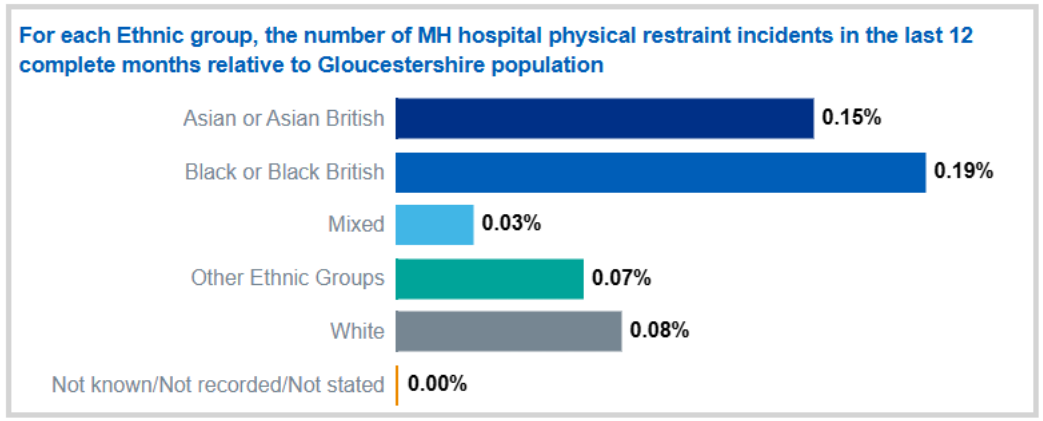
This graph shows that there were 0.22% (17 people) of Black/Black British, 0.02% (4 people) of Asian/Asian British and 0.06% (356 people) of white ethnicity. This raises questions as to whether there could be an issue with timely access to MH services or increased detentions based on ethnicity?

Referrals to CRHTT over the last 12 months



Part of the PCREF Data working group will be to look in more detail about what our Local data is telling us compared to the National picture and highlights areas for action.

Mental Health Hospitals Physical Restraint



This graph show that 0.08% (495 people) of white ethnicity were restrained compared to 0.19% (15 people) of Black/Black British Ethnicity that were restrained. This raises the question whether those from Black/Black British ethnicity are more likely to be restrained, therefore receiving more restrictive practices/care?

Anti-Racist Intent Statement and Action Plan

The co-produced, anti-racist intent statement and action plan are going to Trust Board for approval on 28th May. This is following the work of the PCREF steering group since November, two community engagement events in February and April, and an interactive session at a Board Development day.

With Trust Board approval, this intent statement will be published on the Trust public website and more internal communications to GHC colleagues will follow.

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Appendix One Learning From Deaths Report Quarter 4 2025-2026

Purpose of report:

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

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

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

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

Quarter 4 Learning From Deaths

During Q4 2025-26 **102** Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

GHC Patient Deaths reported during Q4 2025/26			
January	February	March	**Total**
37	32	33	**102**

During Q4 2025-26 there were in total **15** care record reviews
(7 at Physical Health Mortality Review Group & 8 at Mental Health Mortality Review Group)

Number of comprehensive investigations and care record reviews completed during Q4 2025/26 for deaths occurring in:			
Q2 2025/26	Q3 2025/26	Q4 2025/26	**Total**
0	8	7	**15**

This data shows that recent cases are being reviewed as there is no longer a backlog.

A Physical Health meeting in January was cancelled due to hospital system pressures/Christmas annual leave uptake

Quarter 4 Learning From Deaths

Physical Health (CoHo) Care Record Reviews – National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

January – March 2025/26 there were 7 Care Record Reviews

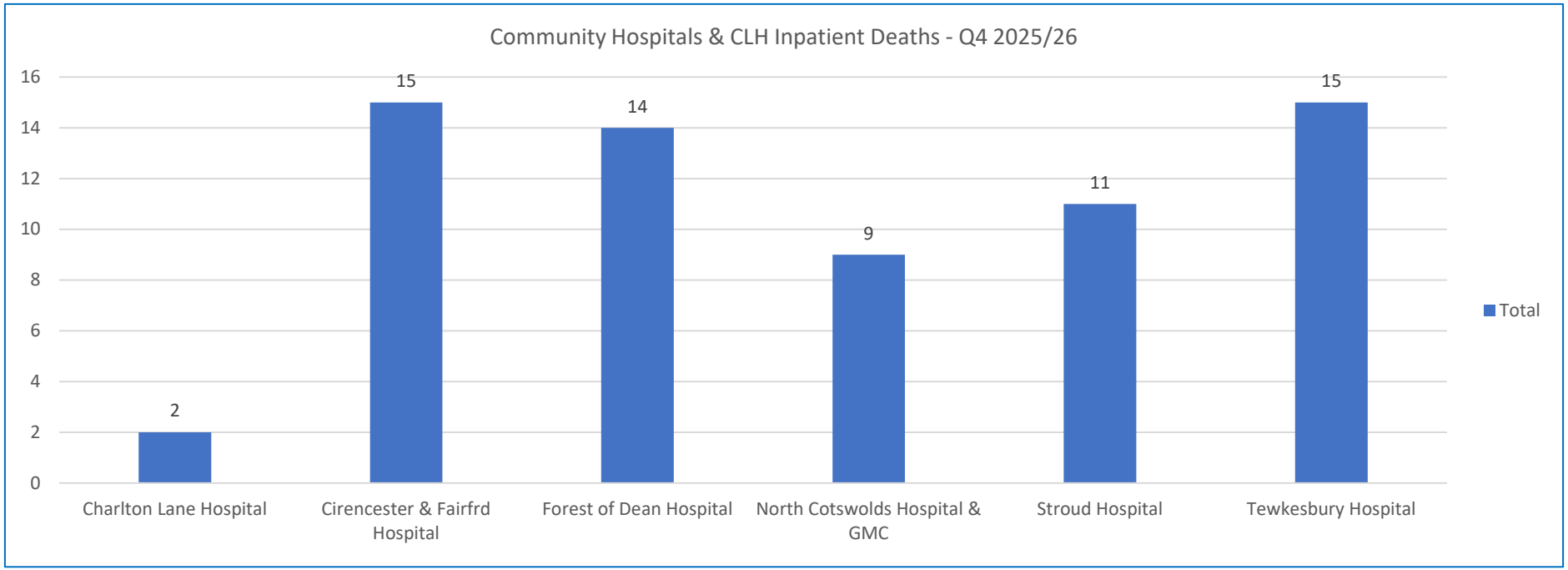
All 7 Care Record Reviews were recorded as Category 1 – Good Practice: A standard that you would accept from yourself, your trainees and your institution.

Mental Health Inpatients/Community - Care Record Reviews – Mazars Criteria

January – March 2025/26 there were 8 Care Record Reviews

3 x Care Reviews	(UN1) **Unexpected Natural**. Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed, and some may need an investigation.
3 x Care Reviews	(EN1) **Expected Natural.** A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
2 x Care Reviews	(EN2) **Expected Natural**. A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated. These deaths should be reviewed and in some cases would benefit from further investigation

Quarter 4 Community Hospitals and Charlton Lane Hospital Inpatient Deaths by ward



- In Quarter 4 there were 66 deaths reported across our Community Hospitals and Charlton Lane Hospital inpatient settings.
- 2 deaths were at Charlton Lane (*Acute mental health inpatient services for people with a level of frailty in combination with their mental health disorder and/or an organic mental health disorder*) and the remaining 64 in our Community Hospitals.
- We continue to see fluctuations in the number of deaths at each site but there has been a reduction in deaths at North Cotswolds Hospital this quarter.
- The meeting has been held with BI colleagues to look at triangulation of data to understand any patterns or trends, with plans to now develop a dashboard of key data.

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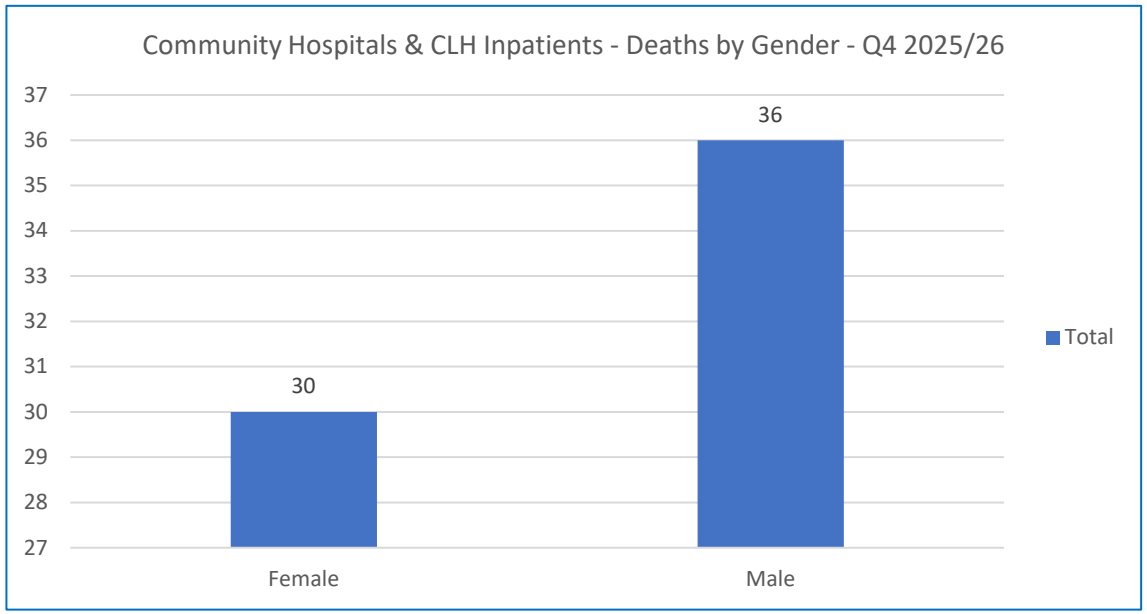
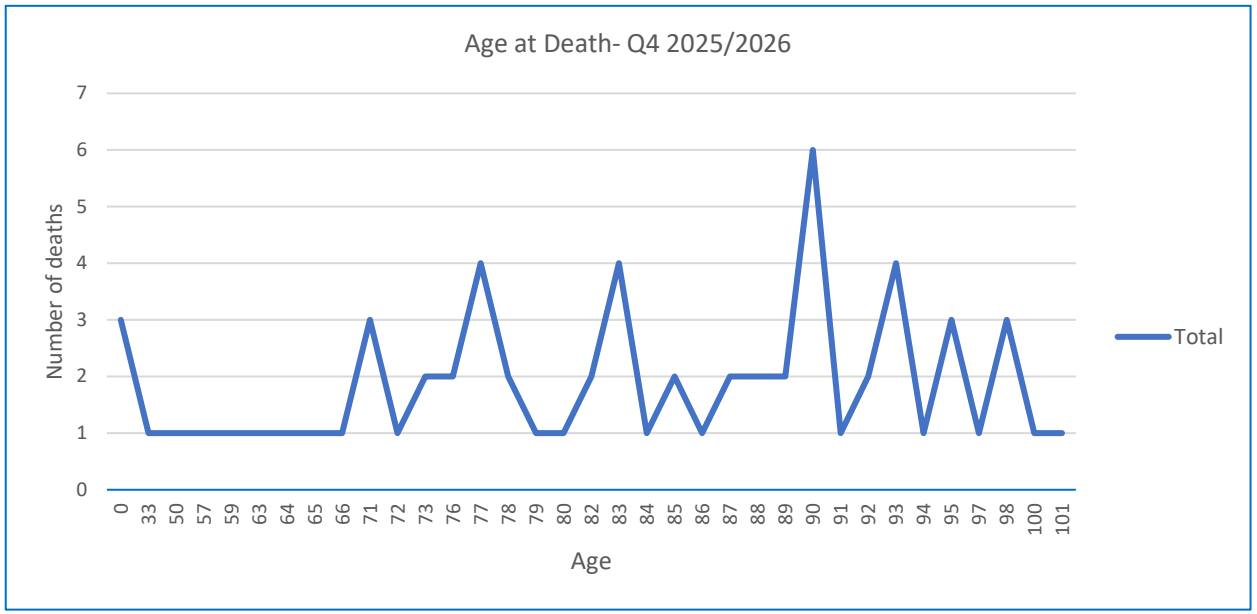
Quarter 4- Inpatient Deaths by Gender and Age





- In Quarter 4, 45.45% of deaths were female and 55.55% were male.
- We continue to observe that the largest percentage of deaths are for individuals aged over 80 (60%). This would be in line with the current Gloucestershire life expectancy at birth (79.8 for males and 83.6 for females).

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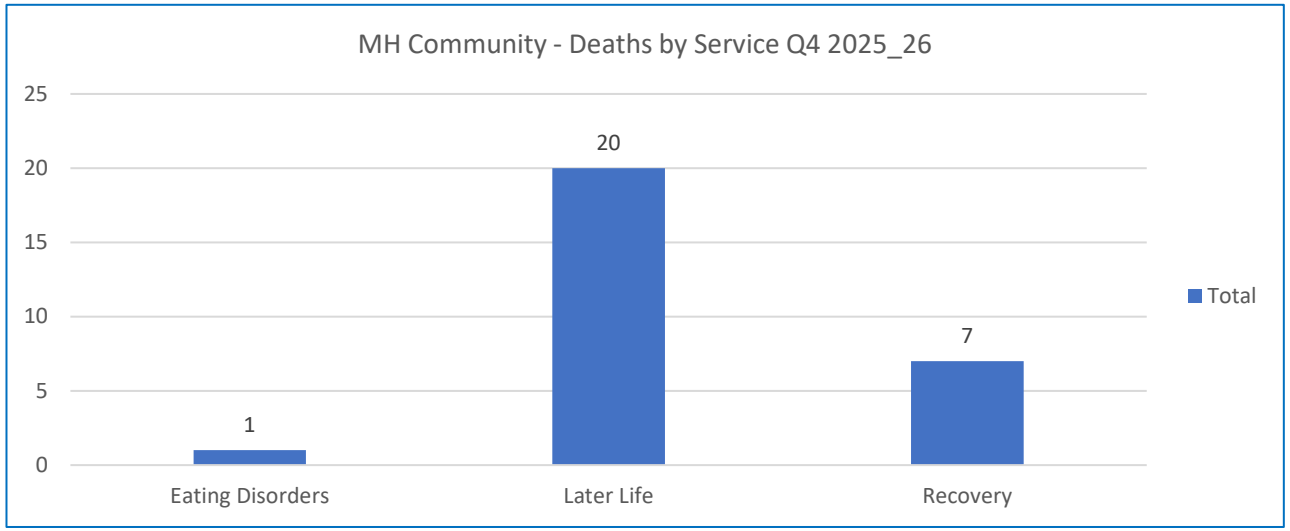
Quarter 4 Deaths reported by Mental Health Services:



- In Quarter 4 we have seen 28 deaths reported by mental health teams and services at the trust.
- Our Later Life teams continue to be our highest reporter of deaths within Mental Health Services which is to be expected.
- 11 individuals under the age of 75 died in the quarter, deaths prior to 75 are considered to be premature mortality.
- The 7 deaths referenced to Recovery teams were reported as Mortality Datix where cause of death references a physical cause.

In Quarter 4, there were 11 incidents reported on Datix related to suspected deaths by suicide. Of these it has been determined that:

- 3 are being reviewed via an After Action Review
- 2 have been reviewed in line with our processes but have not met the criteria for further review due to limited involvement by our services.
- 1 is awaiting toxicology report
- 5 recategorized as mortality reviews when further details received regarding cause of death.

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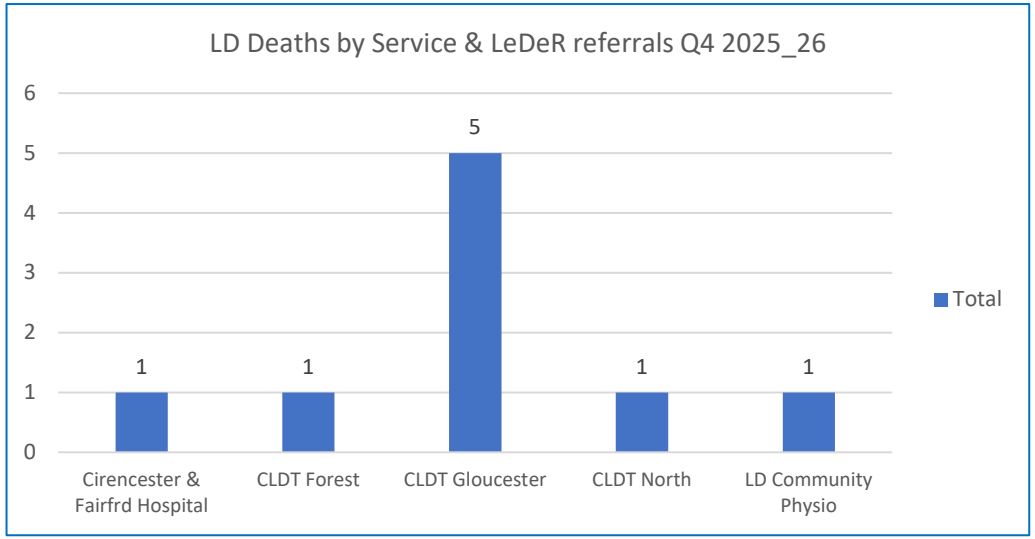
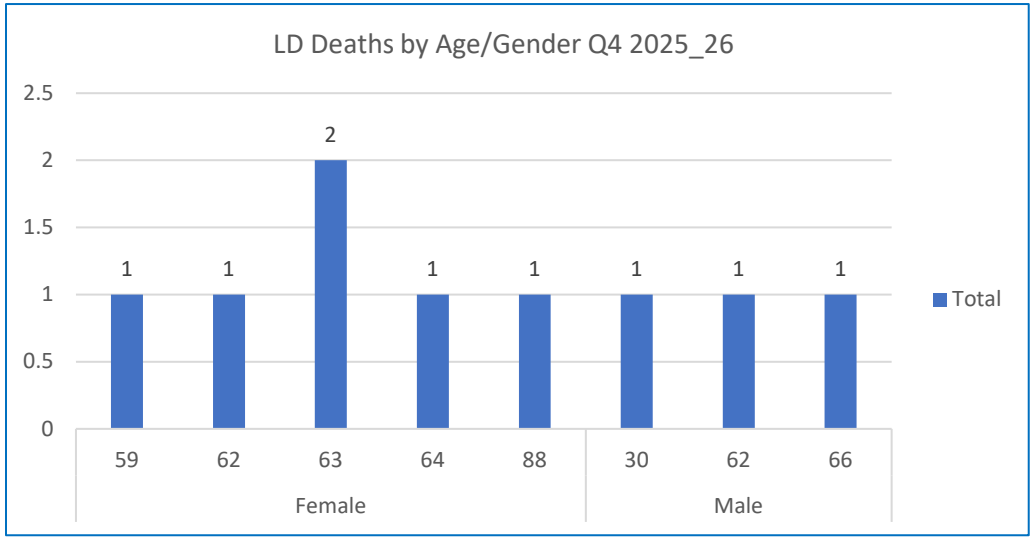
Quarter 4- Learning Disability Deaths





- In Quarter 4 there have been 9 deaths reported by our Community Learning Disability Team's and wider services for individuals with a Learning Disability.
- We have observed 5 deaths for females and 3 for males.

- Age at time of death ranged from 59-66, in 2023-24 Gloucestershire's median age of death was 61.9, in Q4 our median age at time of death was 48.8 although it is important to reflect that this is a small data set.

Quarter 4 Update including Learning, Themes and Trends from Mortality Review Group (MRG) meetings:

- New Clinical Director Community and Urgent Care is in post and supporting Community Hospital MRG
- Learning From Deaths policy was ratified in the May Policy Group Meeting.
- Launch of Mortality Matters Newsletter – first (introductory) draft has been approved and circulated to teams and for the Patient Safety Notice Boards. Future editions will contain more quarterly data, case studies, learning etc.
- A Mortality Intranet Page is being created which will be linked to the Patient Safety Team Intranet Page. This will host information, resources, meeting minutes, templates as well as links to other internal intranet pages and external web sites.
- Junior members of staff that have been directly involved in cases have attended the MRG meetings to listen and contribute to the case and for the shared learning.
- Teams are invited to select cases (via Datix) that they would like to bring to MRG to share for whatever reasons they feel e.g. to celebrate good practice, improvements, learning etc.
- We have seen many examples of excellent care, compassionate and person-centred approaches as well as collaborative working.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th April 2026**

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

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

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

Recommendations and decisions required

The Trust Board is asked to:

- **Note** the month 1 position.
- **Approve** the changes to the Capital Plan

Executive summary

- Draft accounts submitted 27th April 2026, being audited by Sumer N.I. Audited accounts are due 26th June 2026.
- There are no material amendments to the position from the Resource Committee summary in April, and the year-end performance position for GHC was a surplus of £2.013m.
- The Trust's plan is a £53k surplus. At month 1 the Trust has a surplus of £0.004m, in line with the plan.
- 26/27 Capital plan is £16.208m with £2.895m of disposals leaving a net £13.313m programme. After disposals net spend to month 1 is (£0.737m) against a budget of (£0.242m).
- Cash at the end of month 1 is £37.167m, which is £3.5 below plan.
- The Trust spent £1.142m on bank staff in month 1, against the plan of £1.391m.
- The Trust spent £0.209m on agency staff in month 1, against the plan of £0.202m. There were 4 off framework shifts, the target is 0.
- Business case on transfer of Edward Jenner Court (EJC), from Property Services to the Trust to be presented to July Trust Board.

- Cirencester Hospital redevelopment business case to be presented to October Resources Committee and November Trust Board meeting.
- Trust Board is asked to approve the updated Capital plan.

Risks associated with meeting the Trust's values Risks included within the paper	
Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	AI-13.1 - Finance Report

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

Gloucestershire Health and Care
NHS Foundation Trust

with you, for you

AGENDA ITEM: 13.1/0526

Finance Report Month 1

28 May 2026

Presented by **Sandra Betney, Director of Finance**

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Overview

with you, for you

- Draft accounts submitted 27th April 2026, being audited by Sumer N.I. Audited accounts are due 26th June 2026.
- There are no material amendments to the position from the Resource Committee summary in April, and the year end performance position for GHC was a surplus of £2.013m.
- The Trust's annual plan is a £53k surplus. At month 1 the Trust has a surplus of £0.004m, in line with the plan.
- 26/27 Capital plan is £16.208m with £2.895m of disposals leaving a net £13.313m programme. After disposals net spend to month 1 is (£0.737m) against a budget of (£0.242m).
- Cash at the end of month 1 is £37.167m, which is £3.5 below plan.
- Cost improvement programme has delivered £2.941m of recurring savings through budget setting. Target for the year is £14.459m. £7.047m is unidentified (39.23%).
- Non recurrent savings target is £3.475m of which £0.103m is delivered. All has been identified.
- The Trust spent £1.142m on bank staff in month 1, against the plan of £1.391m.
- The Trust spent £0.209m on agency staff in month 1, against the plan of £0.202m. There were 4 off framework shifts, the target is 0.
- Better Payment Policy shows 96.1% of invoices by value paid within 30 days and 93.2% by number of invoices, the national target is 95%.
- As reported to Resource Committee in April a business case outlining the transfer of Edward Jenner Court from NHS Property Service to be presented at the July Board meeting (subject to adequate information being received from NHSPS).
- Cirencester Hospital redevelopment business case is planned to be presented to Resources Committee in October and Trust Board in November.
- Trust Board is asked to approve the updated Capital plan.

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GHC Income and Expenditure

	2026/27 Plan	2026/27 Revised budget ytd	2026/27 Actuals ytd	2026/27 Variance
Operating income from patient care activities	309,009	26,718	27,165	448
Other operating income	18,588	1,528	1,741	213
Employee expenses - substantive	(234,236)	(21,328)	(20,197)	1,130
Bank	(16,697)	(124)	(1,142)	(1,019)
Agency	(2,425)	0	(209)	(209)
Operating expenses excluding employee expenses	(72,189)	(6,623)	(7,274)	(651)
PDC dividends payable/refundable	(2,847)	(237)	(214)	23
Finance Income	1,000	83	189	105
Finance expenses	(203)	(17)	(17)	(0)
Surplus/(deficit) before impairments & transfers	**0**	**(0)**	**40**	**40**
Gains/ (losses) from disposal of assets		0	(40)	(40)
Remove capital donations/grants I&E impact	53	4	4	(0)
Surplus/(deficit)	**53**	**4**	**5**	**0**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	0
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0
Revised Surplus/(deficit)	**53**	**4**	**5**	**0**
WTEs	4755	4741	4651	(90)

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

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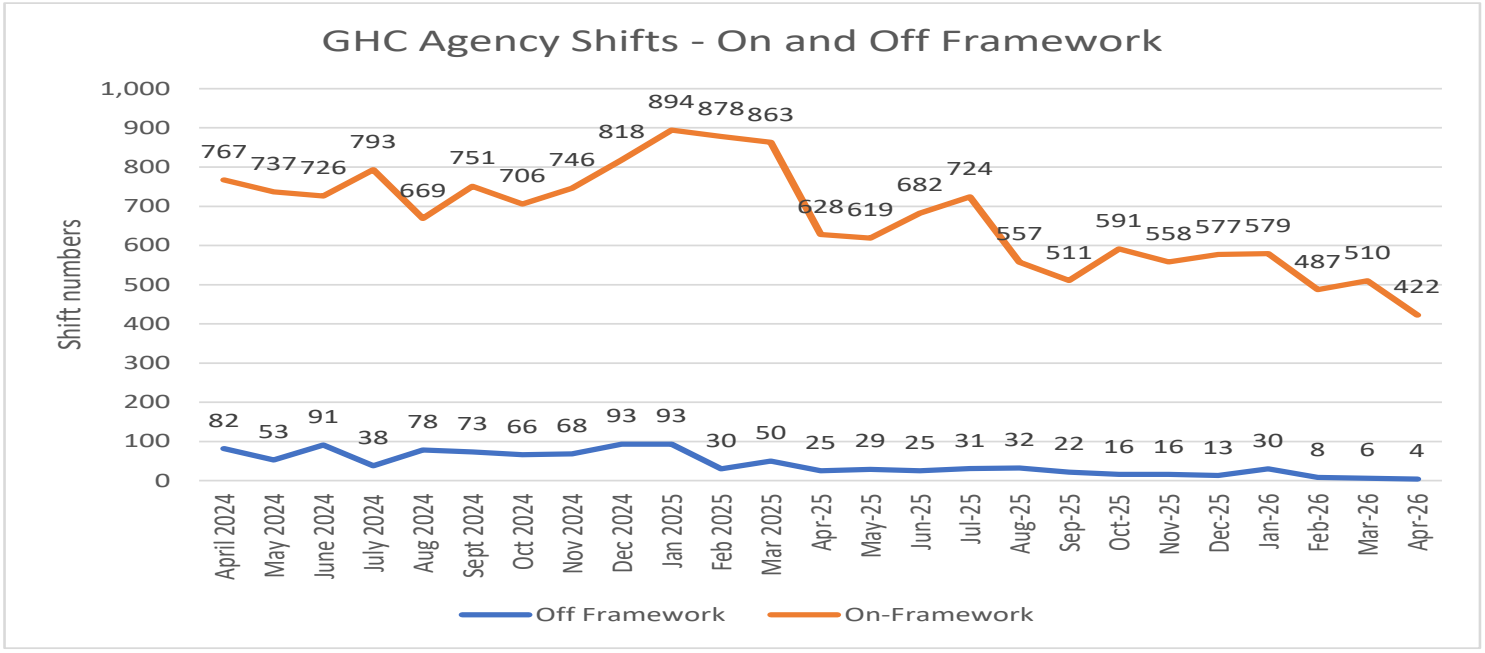
Pay Analysis

Pay analysis month 1							
	Plan WTE Month 1	Budget WTE Month 1	Actual WTE Month 1	Budget ytd £000s	Actual ytd £000s	YTD Variance to budget £000s	Actual £ as % of Total £
Substantive	4,371	4,806	4,380	21,328	20,197	1,130	93.7%
Bank	347	4	251	124	1,142	(1,019)	5.3%
Agency	23	0	20	0	209	(209)	0.97%
Total	**4,741**	**4,809**	**4,651**	**28,726**	**21,548**	**(97)**	**100.0%**

- Trust WTE budget 68 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 4 off framework agency shifts in March. The target is 0.



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Balance Sheet

STATEMENT OF FINANCIAL POSITION (all figures £000)		2025/26	2026/27				2026/27
Month 1		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	2,465	2,234	2,309	2,384	75	2,383
	Property, plant and equipment: other	125,254	128,095	124,392	124,797	405	130,297
	Right of use assets	15,797	15,278	15,531	15,661	130	15,285
	Receivables: due from NHS and DHSC group bodies	721	966	997	546	(451)	515
	Receivables: due from non-NHS/DHSC Group bodies		188	188	168	(20)	168
	Total non-current assets	**144,237**	**146,761**	**143,417**	**143,556**	**139**	**148,648**
Current assets	Inventories	385	443	443	385	(58)	385
	NHS receivables	9,224	8,793	8,793	16,398	7,605	9,898
	Non-NHS receivables	7,472	7,612	7,612	6,364	(1,248)	7,664
	Credit Loss Allowances	(1,351)	(1,919)	(1,919)	(1,343)	576	(1,343)
	Property held for Sale	2,215	1,203	453	1,315	862	0
	Cash and cash equivalents:	41,303	37,854	40,601	37,144	(3,457)	39,305
	Cash and cash equivalents: commercial / in hand / other		23	23	23	0	23
	Total current assets	**59,247**	**54,009**	**56,006**	**60,285**	**4,280**	**55,931**
Current liabilities	Trade and other payables: capital	(3,270)	(4,295)	(3,734)	(1,924)	1,810	(3,734)
	Trade and other payables: non-capital	(32,313)	(30,753)	(30,988)	(31,215)	(227)	(31,001)
	Borrowings	(1,469)	(1,409)	(1,409)	(1,445)	(36)	(1,445)
	Provisions	(7,333)	(6,870)	(6,870)	(7,372)	(502)	(7,372)
	Other liabilities: incl. deferred income	(426)	(1,453)	(1,453)	(3,348)	(1,895)	(1,348)
	Total current liabilities	**(44,811)**	**(44,780)**	**(44,454)**	**(45,305)**	**(851)**	**(44,901)**
Non-current liabilities	Borrowings	(13,515)	(12,995)	(13,272)	(13,380)	(108)	(12,999)
	Provisions	(2,455)	(2,500)	(2,500)	(2,451)	49	(2,451)
	Total net assets employed	**142,704**	**140,495**	**139,196**	**142,705**	**3,508**	**144,228**

Taxpayers Equity	Public dividend capital	132,972	134,272	132,972	132,972	(0)	132,972
	Revaluation reserve	14,202	13,592	13,592	14,202	610	14,202
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	(4,006)	(6,128)	(6,128)	(3,229)	2,899	(3,229)
	Income and expenditure reserve (current ye	778	0	0	0	0	1,523
	Total taxpayers' and others' equity	**142,704**	**140,495**	**139,195**	**142,705**	**3,510**	**144,228**

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Cash Flow Summary

Statement of Cash Flow £000	YEAR END 25/26		ACTUAL 26/27		FULL YEAR FORECAST 26/27		2027/28 Forecast £000s	2028/29 Forecast £000s	2029/30 Forecast £000s	2030/31 Forecast £000s
Cash and cash equivalents at start of period		**41,854**		**41,303**		**41,303**	**39,328**	**33,163**	**30,675**	**29,424**
Cash flows from operating activities										
Operating surplus/(deficit)	1,330		81		3,654		1,975	**1,950**	**1,929**	**1,913**
Add back: Depreciation on donated assets	52		4		53		51	51	51	51
Adjusted Operating surplus/(deficit) per I&E	**1,383**		**85**		**3,707**		**2,026**	**2,001**	**1,980**	**1,964**
Add back: Depreciation on owned assets	9,809				10,376		9,029	9,600	9,701	10,107
Add back: Depreciation on Right of use assets							1,415	1,391	1,367	1,151
Add back: Impairment	1,183		833				0	0	0	0
(Increase)/Decrease in inventories	60				0		0	0	0	0
(Increase)/Decrease in trade & other receivables	(148)		(6,075)		(874)		42	43	1	1
Increase/(Decrease) in provisions	(1,519)		35		35		0	0	0	0
Increase/(Decrease) in trade and other payables	5,451		(1,312)		(1,312)		0	0	0	0
Increase/(Decrease) in other liabilities	(877)		2,922		922		0	0	0	0
Net cash generated from / (used in) operations		**15,343**		**(3,512)**		**12,855**	**12,512**	**13,035**	**13,049**	**13,223**
Cash flows from investing activities										
Interest received	2,355		186		1,000		958	956	999	999
Interest paid	0						(17)	(17)	(17)	(17)
Proceeds from Sale of PP&E	930		860		2,175		2,424	0	0	0
Purchase of property, plant and equipment	(15,531)		(1,509)		(13,444)		(17,544)	(12,019)	(10,858)	(10,858)
Assets Held for Sale							0	0	0	0
Net cash generated used in investing activities		**(12,246)**		**(463)**		**(10,269)**	**(14,179)**	**(11,080)**	**(9,876)**	**(9,876)**
Cash flows from financing activities										
PDC Dividend Received	869		0				**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,817)		0		(2,847)		**(2,847)**	**(2,847)**	**(2,847)**	**(2,847)**
Finance lease receipts - Rent	97		13		97		**97**	**96**	**4**	**4**
Finance lease receipts - Interest	(60)		(5)		(58)		**(55)**	**(52)**	**(3)**	**(3)**
Interest arising (unwinding of discount)	60		5		58					
Finance Lease Rental Payments	(1,582)		(158)		(1,607)		**(1,531)**	**(1,501)**	**(1,461)**	**(1,201)**
Finance Lease Rental Interest	(215)		(17)		(203)		**(162)**	**(139)**	**(117)**	**(98)**
		(3,648)		**(162)**	**0**	**(4,560)**	**(4,498)**	**(4,443)**	**(4,424)**	**(4,145)**
Cash ånd cash equivalents at end of period		**41,303**		**37,167**	**0**	**39,328**	**33,163**	**30,675**	**29,424**	**28,626**

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Capital – Five Year Plan

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Capital Plan	Plan	Revised Plan	Actuals	Plan	Plan	Plan	Plan	Plan
£000s	2026/27	2026/27	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Land and Buildings								
Buildings	4,669	3,871	4	8,250	5,750	2,821	1,636	1,636
Backlog Maintenance	2,041	2,451	7	1,393	750	1,400	1,400	1,400
Buildings - Finance Leases	2,322	2,458		90	2,115	347	382	382
Vehicle - Purchases / Finance Leases	50	50	39	250	250	250	250	250
Other Leases	0	0		0	0	300	0	0
Net Zero Carbon	1,502	2,131	16	0	0	1,000	1,000	1,000
Medical Equipment	**664**	669		630	500	1,200	1,200	1,200
Digital								
IT Devices	200	200		900	900	1,200	1,200	1,200
IT Infrastructure	1,610	1,648	15	1,250	380	1,310	1,310	1,310
WAN/LAN	0	0		0	1,530	400	400	400
Transforming Care Digitally	1,230	1,230	62	250	0	0	0	0
NHS Net Transition	334	334		0	0	0	0	0
Digital Innovation	0	0		0	540	590	590	590
Data Centres/Servers	30	30		840	40	0	0	0
Patient Portal	256	256	19	0	0	220	220	220
Space Management Toolkit (Estates)	0	0		0	0	0	0	0
PDC National IT Schemes	1,300	1,300		770	765	755	0	0
Unallocated	0	493						0
Total of Updated Programme	**16,208**	**17,121**	**163**	**14,623**	**13,520**	**11,793**	**9,588**	**9,588**
Disposals	(2,895)	(2,630)	(900)	(2,765)	(1,176)	(1,000)	0	0
Charitable fund donation		(1,750)	0	0	0	0	0	0
Total CDEL spend	**13,313**	**12,741**	**(737)**	**11,858**	**12,344**	**10,793**	**9,588**	**9,588**
Funded by:								
Anticipated System CDEL	**8,916**	**8,916**		**9,352**	**9,528**	**9,750**	**9,750**	**9,750**
Additional CDEL- Fair Shares Bonus	**1,130**	**1,130**		**0**				**0**
Additional CDEL - 2025/26 Disposals C/Fw	**1,395**	**1,395**		**0**				**0**
Surplus Spend	**1,300**			**2,013**				**0**
PDC National IT Schemes	**0**	**1,300**		**380**	**1,760**	**0**	**0**	**0**
Additonal PDC - EVCP/Solar panels								**0**
CDEL Shortfall / (under commitment)	**572**	**0**		**113**	**1,056**	**1,043**	**(162)**	**(162)**

Capital Plan revised after expenditure, disposals and charitable fund donation all updated. Plan under review to reduce overspend years by identifying additional funding, reduced spend and increased disposals.

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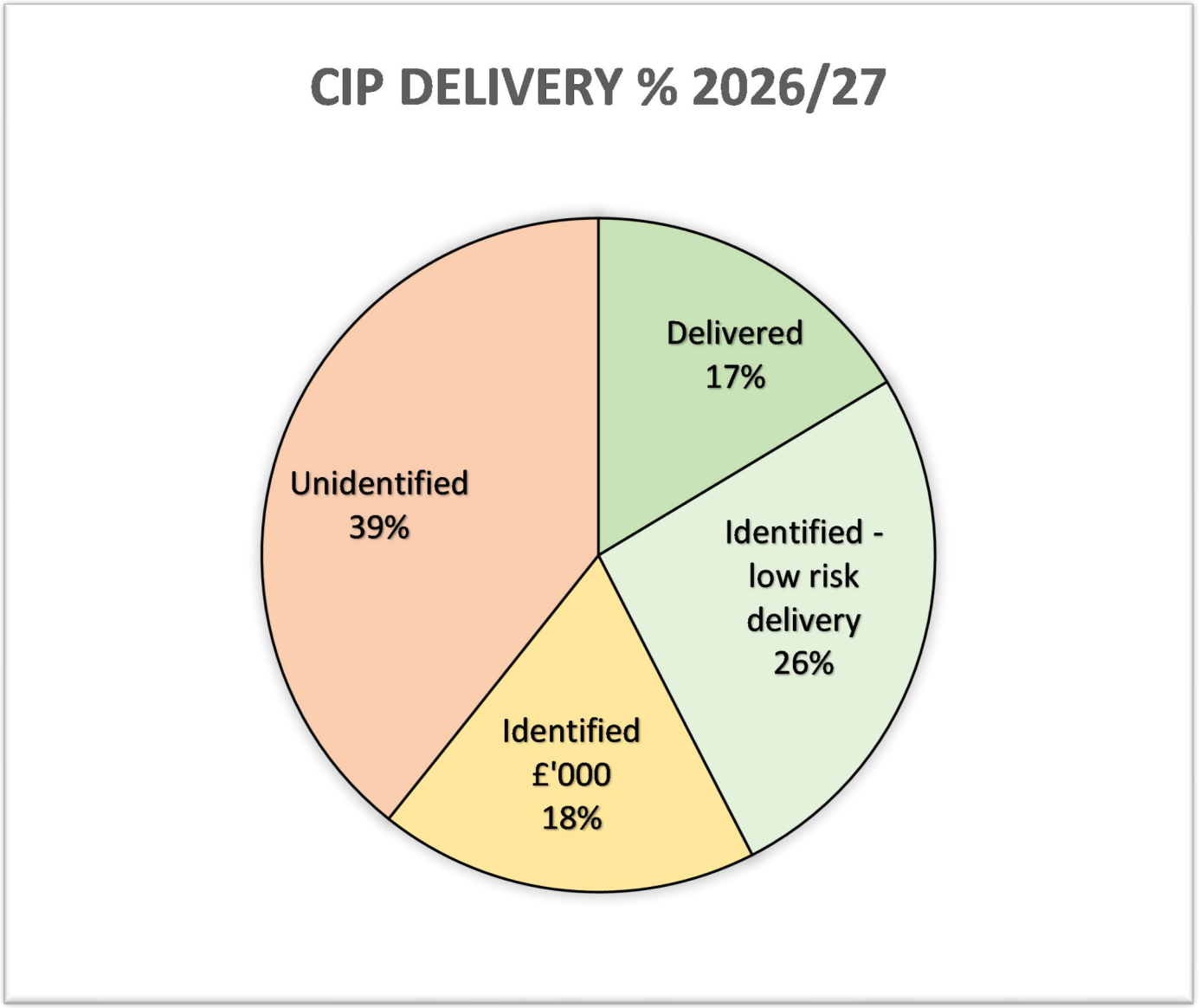
Risks

26/27 risks are set out below:

Risks 26/27	Mitigations	Risk Value £000s	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 (694)	Short term non recurrent savings. Close monitoring by the CIP management board. Longer term identification of new recurrent schemes	3,644	4	4	3,644	16
There is a risk that services do not have the capacity to identify CIP schemes in year resulting in under delivery of RECURRENT in year CIP target (622)	Create dedicated time to review CIP. CIP Management Group to actively manage situation and support directorates if greater support needed. Non recurring savings to offset in year non delivery	3,644	4	4	3,644	16
Specialist Treatment and Rehabilitation costs are greater than budget despite additional funds from commissioner	Continued negotiation with ICB/GCC. Review all costs for each package. Identify additional savings. Management action to review how costs are shared	1,636	3	3	1,636	9
There is a risk that non delivering of the savings target in 26/27 will lead to financial pressure or a deficit in the following year. (695)	Savings programme clearly articulated. Programme of directorate reviews planned. Greater level of monitoring being implemented	3,644	4	4	3,644	16
There is a risk that the uplift to the 26/27 contract tariff (1.19%) is insufficient to cover the pay award, mileage rate changes, band 5 job evaluation review and exception reporting for resident doctors as it is unclear how much has been allocated to each element and guidance is unclear. This could result in a financial cost pressure	Detailed assessment of implications to ensure clear understanding of impact and to allow appropriate mitigations to be sought	934	3	3	934	9

CIP


CIP DELIVERY % 2026/27
Delivered
17%
Identified -
low risk
delivery
26%
Identified
£'000
18%
Unidentified
39%

CIP

Summary	Total Target	Delivered	Identified - low risk delivery	Identified £'000	Unidentified
Prior Year(s)	4,304	1,122	177	2,090	915
Efficiency	3,380	824	181	460	1,915
Delivering Value	4,877	700	597	725	2,855
Delegated Responsibility	1,044	192	0	0	852
Programme Savings	854	0	344	0	510
Non-Recurrent Savings	3,475	103	3,372	0	0
Total	**17,934**	**2,941**	**4,672**	**3,275**	**7,047**
Percentage Total		*16.40%*	*26.05%*	*18.26%*	*39.29%*

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

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

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

AUTHORS: Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian
Kamaldeep Sidhu, Organisational Development and Inclusion Practitioner

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

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

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

The purpose of this report is to:

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

To provide information and assurance to the group that:

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

Recommendations and decisions required:

Following consideration by the Great Place to Work Committee at its meeting in April 2026, the Board is asked to **receive, review** and **note** the information and assurance provided in relation to Freedom to Speak Up activity during 2025/2026 and the looking forward plans.

Executive summary

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

This is a summary of a report presented to the Great Place to Work Committee on 28th April 2026. In addition to the information presented in the report, the Committee considered what future support may be needed alongside the Freedom to Speak Up

Guardian. The Committee noted the prevalence of interpersonal issues raised through Freedom to Speak Up processes, rather than concerns relating to patient safety and quality of care. There was a discussion of how the Trust can ensure Freedom to Speak Up is capturing the patient safety and quality concerns it was established to amplify following the Francis Review into patient care failings (2013). Further discussion of this will be taken forward at a Trust Board seminar in June 2026.

The Committee also commended where improvements can be made across this agenda and took assurance from the information presented on Freedom to Speak Up activity.

In summary (2025/2026)

- Speaking up to the Freedom to Speak Up Guardian continues to increase, and this reporting period shows a further increase although small of 3.85%.

  Patient safety and quality of care related concerns are much fewer in number (13%), compared to behaviour related concerns (41%), recognising that 46% of colleagues said that their safety/wellbeing had been impacted. Notably an increase in Q3 and Q4, potentially due to the decommissioning of the Wellbeing Line.

  Most concerns have been supported through the local and informal route, although some concerns raised have resulted in formal interventions. In many cases speaking up to the Freedom to Speak Up Guardian has enabled colleagues to step back from the workplace, receive appropriate support and achieve positive outcomes.

- Anonymous reporting last year in GHC had increased to 11.5%, against the national picture of 11.6%. For 2025/26 it is similar at 11%, mostly raised through the Freedom to Speak Up Application (APP). No national figure is available currently.

- A breakdown in service areas shows an increase in Children's and Young People's directorate. There has been more visibility by the Freedom to Speak Up Guardian and promotion of positive speaking up within the teams, with a positive recruitment drive for Freedom to Speak Up Champions.

- Those colleagues that feel they have suffered detriment is at 8% although those colleagues that shared a fear of suffering detriment and the futility of speaking up is just under a third at 30%. No national figure is available currently. The fear of suffering detriment is consistent with evidence sources linked to not being heard and/or believed, and the futility that the organisation does not act on concerns. Colleagues described their experiences of suffering detriment as low morale, a breakdown of trust within the team and being treated differently, questioning whether it was right to speak up and did not feel involved in decisions that affect their work. These themes are reflected in the NHS Staff Survey analysis within this paper.

- As professional groups, nurses and administration colleagues are the largest group to speak up this year.

- Those colleagues that have declared a protected characteristic during this reporting period was 13.33% although there are no current trends to this above data. Disability was the most frequent declared characteristic alongside racial groups, not identifying as white. There is an increase in the numbers of colleagues coming forward raising concerns who are neurodivergent.

Within the feedback form relating to colleagues' experiences of speaking up to the Freedom to Speak Up Guardian, three updated questions have been added to offer further insight.

Further analysis of barriers to speaking up is needed, and to understand if a person's protected characteristic is linked to detriment with in GHC, as the case from national evidence drawn from case reviews.

- Version 3 of the Freedom to Speak Up APP was launched in April 2026 and will enhance the user and Guardian experience with an improved process for case management and better governance in place. Version 3 also has live data reporting and records adhering to the refreshed NHS England guidance. Looking forward, the plan is to potentially integrate some reporting through our business intelligence system.

- For those who provided feedback, 82% of colleagues said that they would speak up again. Qualitative feedback remains mainly very positive although negative feedback aligns to the staff survey, linked to the fear of speaking up and detriment, limited outcome /meaningful action and the impact of speaking up on their health and wellbeing.

- The NHS Staff Survey 2025 - Nationally the raising concerns sub-score has fallen to 6.37, which is the sharpest single-year decline the survey has recorded. The survey found six in ten staff feel safe to speak up about anything that concerns them, while just under half (47.6%) believe their organisation would act if they did so. Against that backdrop, it is notable that the number of cases being raised with Freedom to Speak Up Guardians is rising.

  Within GHC, the score for "we each have a voice that counts", fell from 7.00 (2024) to 6.92 (2025). Despite the small decline, GHC remains above the national average. The raising concerns sub-score fell 6.82 → 6.69 (−0.13). GHC remains above national average, but the downward trend is statistically significant. The four speaking up related questions (Q20a, 20b, 25e, 25f), all show reduced confidence and are collectively responsible for the fall in the theme score. Key issues include reduced confidence the organisation will address concerns, lower sense of psychological safety, reduced perception that organisation acts on patient/service-user concerns and lower confidence around reporting violence incidents.

  Analysis of the free-text comments shows, colleagues raised a number of significant and recurring themes relating to psychological safety, confidence to speak up, and trust in organisational response when concerns are raised. While some colleagues describe supportive local environments, there is a clear pattern suggesting that speaking up is not experienced as consistently safe or effective across the Trust. These themes are closely linked to staff wellbeing, patient safety, retention, and organisational culture.

  Key Risks Highlighted from a Freedom to Speak Up and organisational risk perspective, the comments suggest: Undetected or unresolved safety risks (staff and patient), potential under-reporting of serious issues, loss of experienced staff due to lack of trust, perpetuation of cultures where harmful behaviour is normalised.

These risks align with multiple evidence sources, including our GHC Fortnight, People Strategy development and the Freedom to Speak up data, both qualitative and quantitative.

- Further insight into benchmarking has enhanced a learning experience alongside Berkshire Healthcare NHS Foundation Trust, and recently South Coast East Ambulance Service NHS Trust. New objectives for 2026/2027 have been developed to ensure a systematic and open approach to capturing and sharing learning, therefore the experience of those speaking up makes a difference.

  Scoping has begun, for a system wide quality improvement project (2026/2027) alongside the Freedom to Speak Up Guardian at Gloucestershire Hospitals NHS Foundation Trust, aimed at reducing barriers to speaking up. This will include setting best practice, time frames along a defined Freedom to Speak Up process, improve accountability in the organisation in terms of responding to concerns through an escalation pathway. The outcome will be to improve colleague experience, strengthening leadership accountability and responsiveness to concerns, and impact on a desired just and learning culture in reducing harm.

- Nationally, the publication of Dr Penny Dash's the Patient Safety Review Report in July 2025, resulted in plans to close the National Guardians Office in March 2026, although this has been extended. From 1 July, NHS England will assume delivery of some activities previously undertaken by the National Guardians Office, and employers will take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

  On 16 April NHS England published the Future of Freedom to Speak Up across the NHS.

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

Corporate considerations	
Quality Implications	Processes are aligned to the guidance NHSE and the National Guardian's Office embedded in the NHS Contract, renewed for 2026/27. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported. Freedom to Speak Up arrangements are reviewed within the Well Led domain.
Resource Implications	Continued monitoring of the workload and demand on the Freedom to Speak Up service.
Equality Implications	Colleagues have spoken up regarding their experiences of racial discrimination. Colleagues may disclose to the Freedom to Speak Guardian their protected characteristics.

Where has this issue been discussed before?
Great Place to Work Committee 28th April 2026

Appendices:	14.1 - PowerPoint Slide deck Freedom to Speak Up Six Monthly Update.

Report authorised by: Helen Child	**Title:** Director of Corporate Governance and Trust Secretary

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AGENDA ITEM: 14.1/0526

Freedom to Speak Up Update

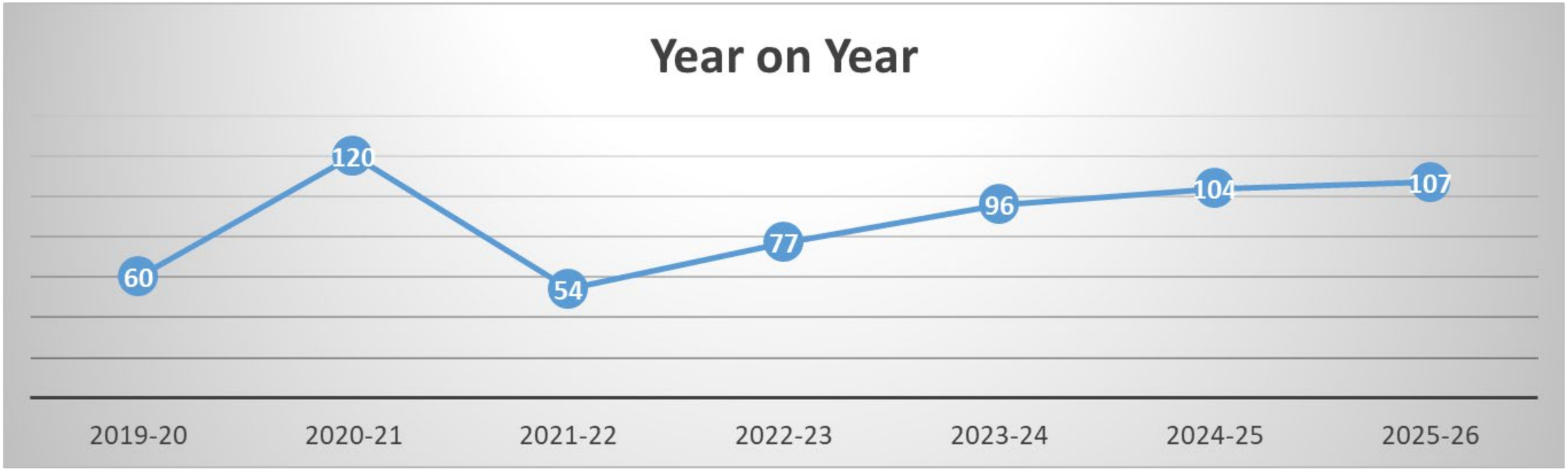
8 May 2026

Presented by **Sonia Pearcey MBE RGN Ambassador for Cultural Change/Freedom to Speak Up Guardian**

Speaking Up in GHC

Cases raised to the Freedom to Speak Up Guardian

	Number of Cases				
Year	Q1	Q2	Q3	Q4	Total
2024/2025	20	21	26	37	104
2025/2026	20	25	27	35	107



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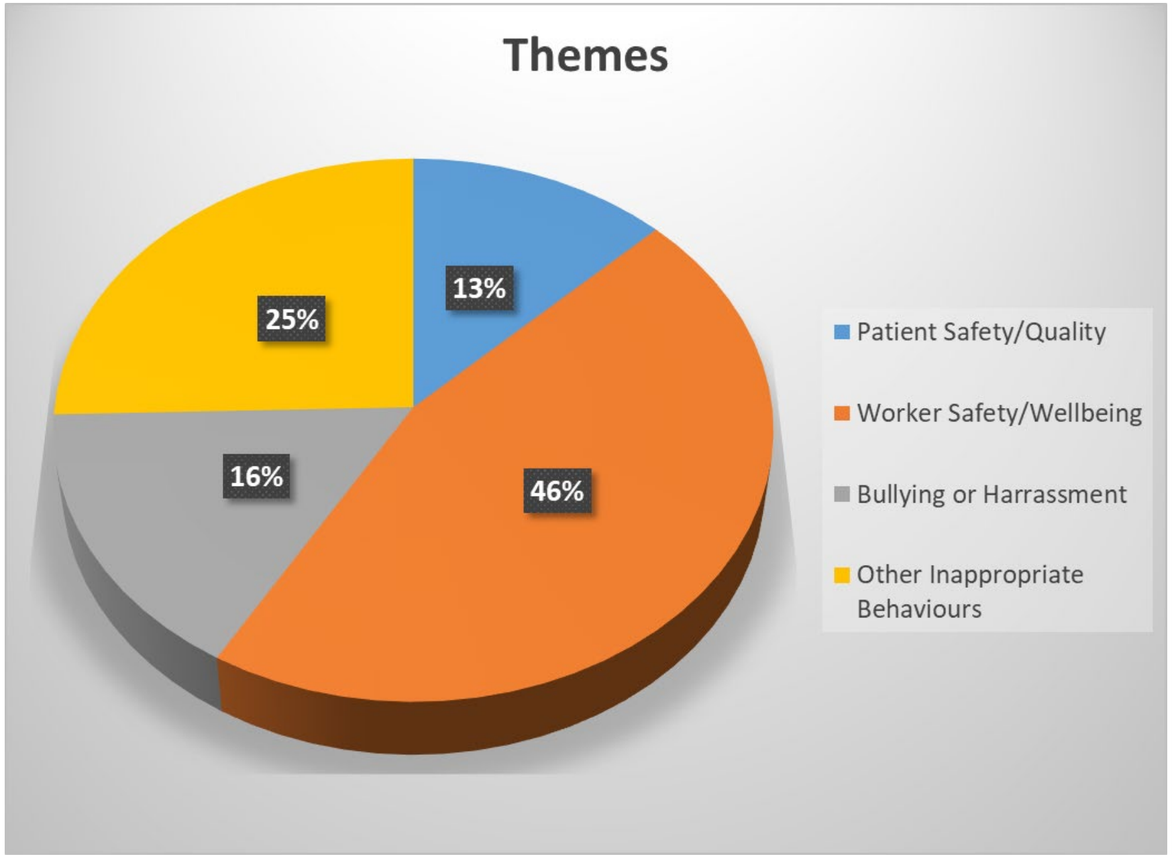
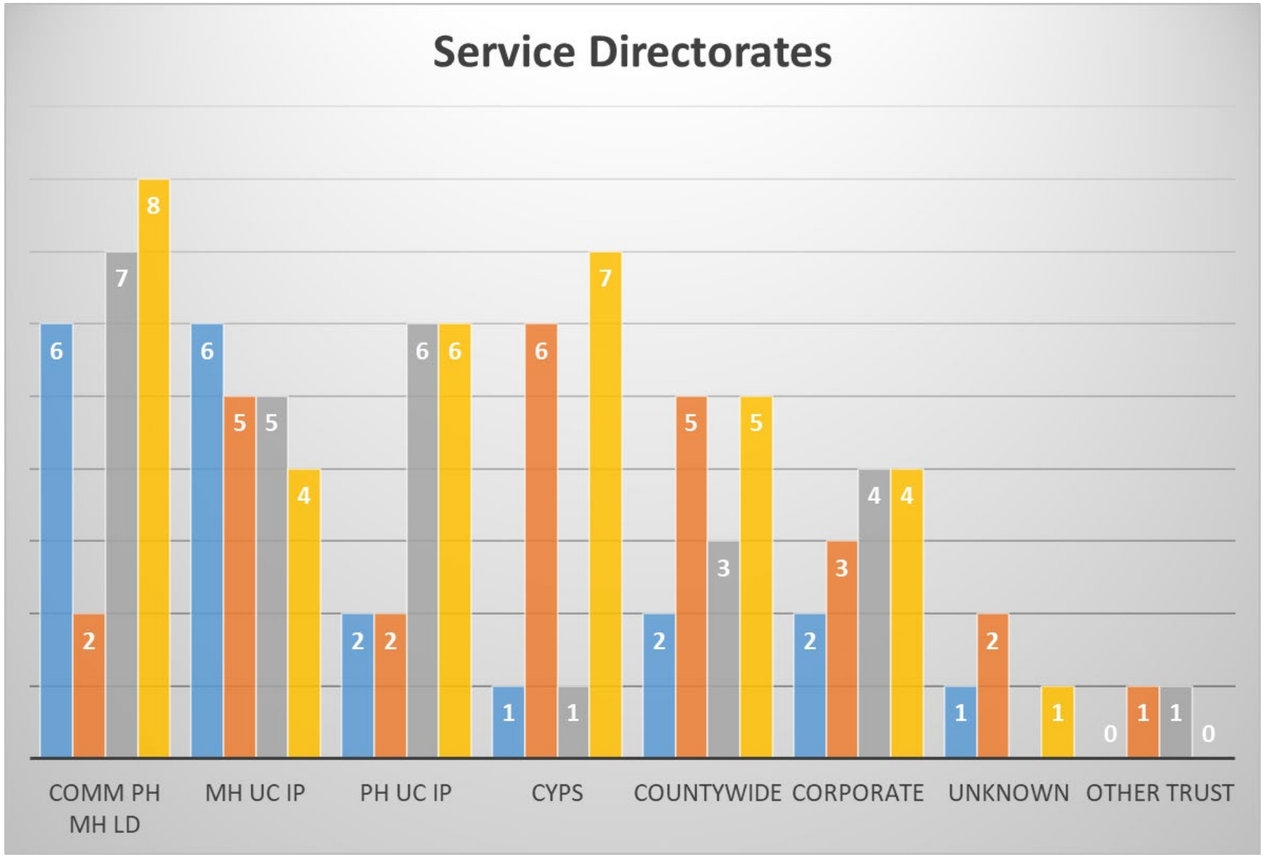
Speaking Up in GHC

Cases raised to the Freedom to Speak Up Guardian





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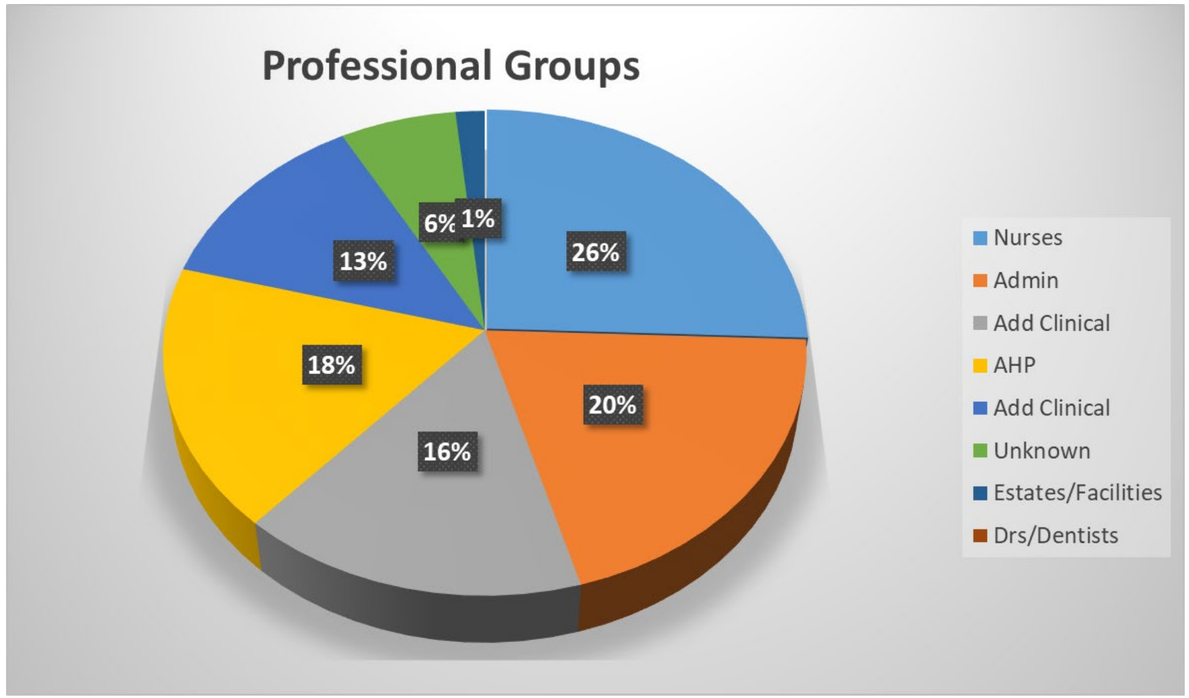
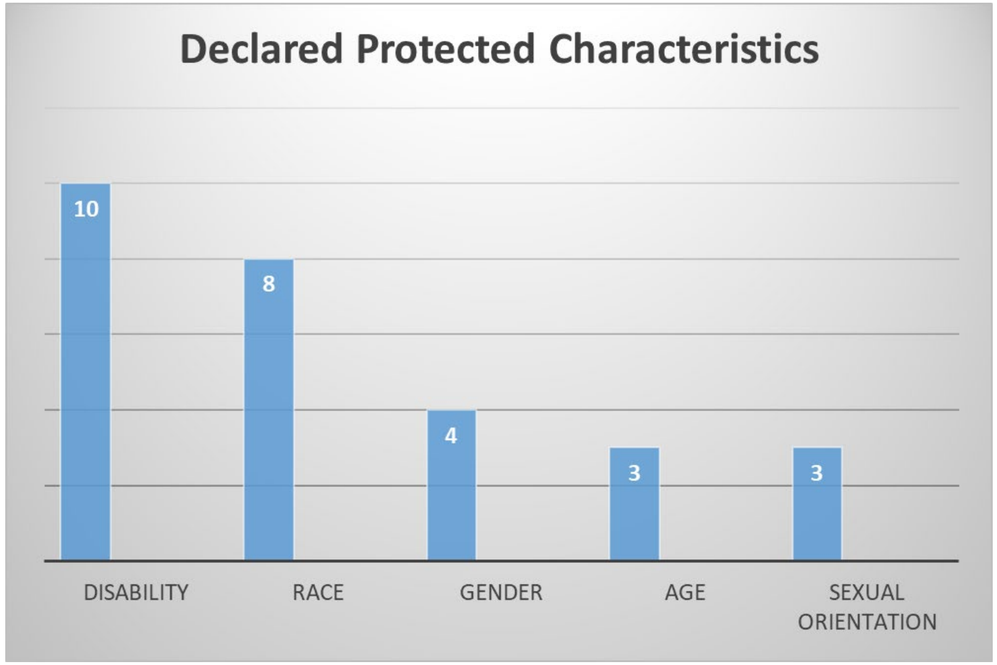
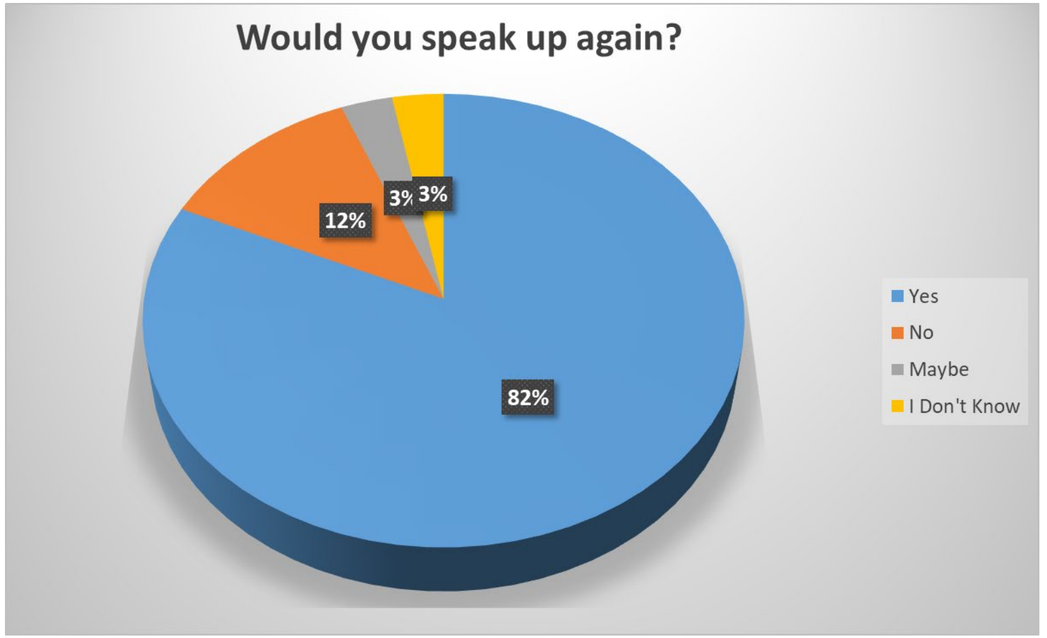
Speaking Up in GHC

Cases raised to the Freedom to Speak Up Guardian







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Speaking Up in GHC

Feedback

- Amazing service. very helpful and quick to respond
- I felt really stuck and distressed by situation at work and speaking up helped clarify what I needed to feel less distressed and work out how to get resolution to issues
- I felt supported by the Guardian to flag my concerns with a clinician's line manager
- Freedom to Speak Up was a really positive experience, I now feel confident should I feel the need to speak up again I can and I will be heard

Speaking Up in GHC

- The FTSU process has been fine, I have been well supported by the Guardian, and I have felt communicated with in a timely and helpful way. The result of me speaking up was a fact-finding exercise, formal investigation and a disciplinary process. These took a considerable amount of time and impacted my emotional wellbeing more than I expected. Overall, I found the whole whistleblowing process really draining and it has a significant impact on my mental health. At present I wouldn't speak up again. If an issue was brought to my attention again, I would encourage that person to speak up or escalate to someone else.

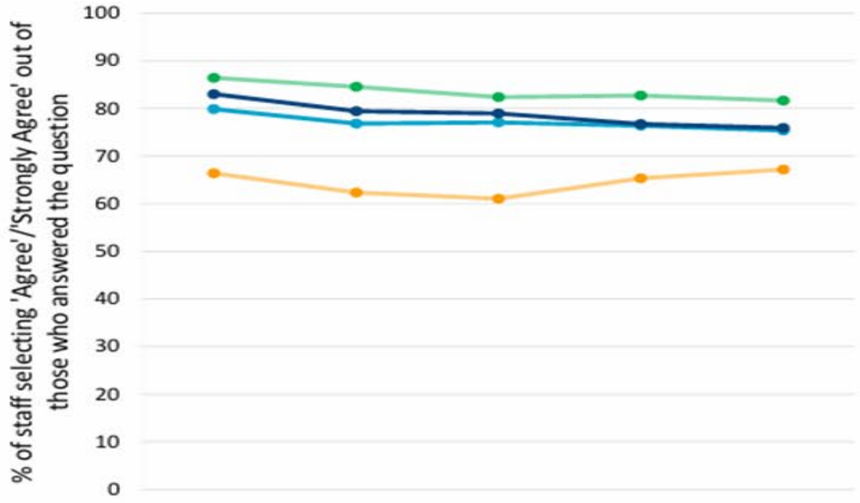
- Many thanks for your time it made me realise what I needed to voice and focus on how I needed to get this across in a way that would make me feel I had a resolution. Our discussion made me think about how I would know I had been heard and had recognition of the impact on me personal and professionally. I was able to raise these points directly with my manager this week. I have not been thinking about work as much at home and have managed to be more positive. Many thanks for your support and hopefully things will continue to improve.

NHS Staff Survey 2025

People Promise elements and theme results – We each have a voice that counts: Raising concerns

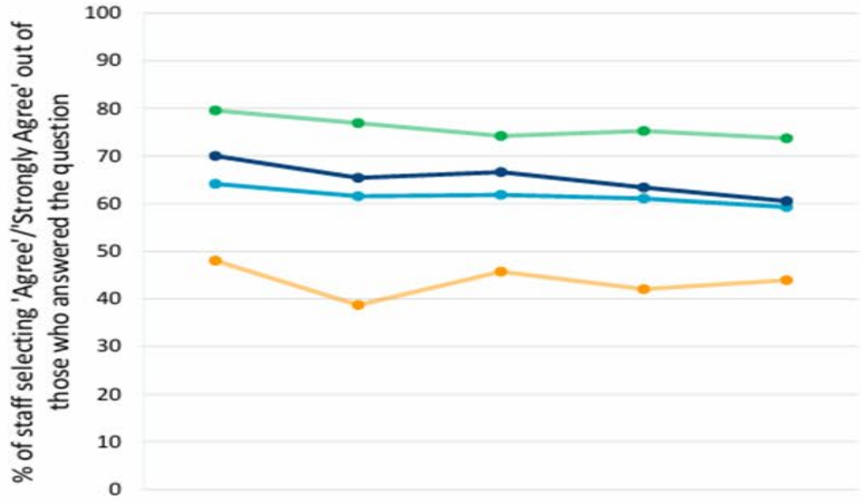
Survey Coordination Centre

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



	2021	2022	2023	2024	2025
Your org	83.00%	79.39%	78.94%	76.71%	75.90%
Best result	86.42%	84.52%	82.35%	82.70%	81.64%
Average result	79.85%	76.83%	77.03%	76.38%	75.37%
Worst result	66.36%	62.35%	61.05%	65.31%	67.17%
Responses	2357	2477	2787	3009	2621

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



	2021	2022	2023	2024	2025
Your org	70.01%	65.44%	66.64%	63.40%	60.53%
Best result	79.56%	76.90%	74.19%	75.29%	73.72%
Average result	64.16%	61.56%	61.87%	61.07%	59.29%
Worst result	48.03%	38.71%	45.71%	42.06%	43.94%
Responses	2349	2467	2781	3002	2612

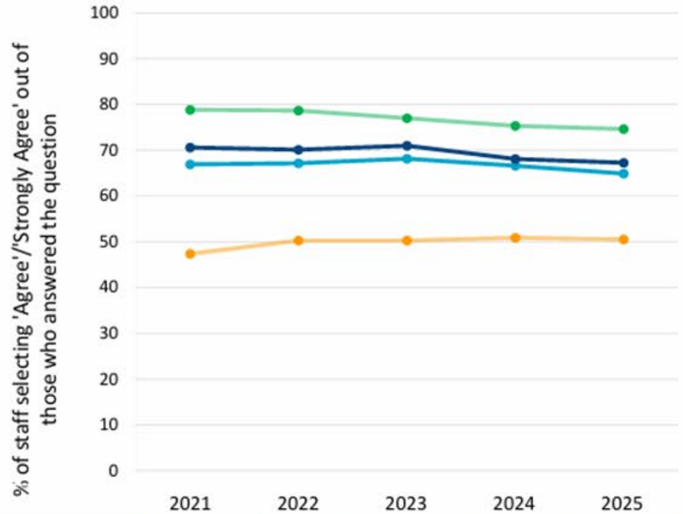
https://www.nhsstaffsurveys.com/results/local-results/

NHS Staff Survey 2025

People Promise elements and theme results – We each have a voice that counts: Raising concerns

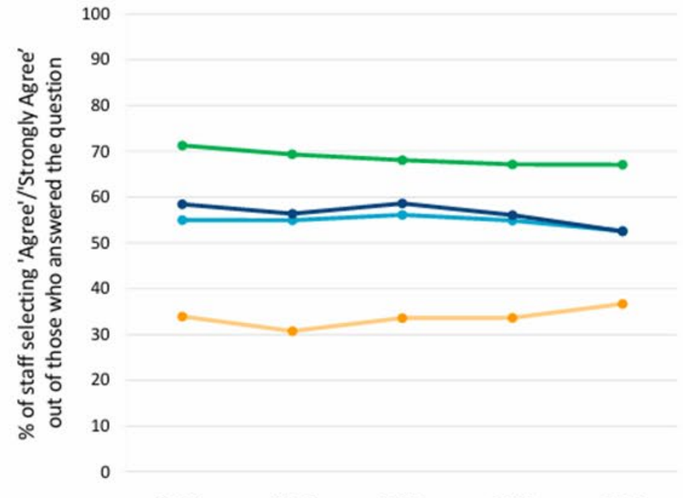
Survey Coordination Centre

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



	2021	2022	2023	2024	2025
Your org	70.61%	70.12%	70.98%	68.08%	67.26%
Best result	78.82%	78.66%	77.01%	75.34%	74.63%
Average result	66.88%	67.15%	68.14%	66.62%	64.89%
Worst result	47.35%	50.28%	50.25%	50.87%	50.51%
Responses	2357	2475	2793	3006	2623

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



	2021	2022	2023	2024	2025
Your org	58.44%	56.39%	58.62%	56.09%	52.51%
Best result	71.30%	69.33%	68.11%	67.14%	67.08%
Average result	55.01%	54.96%	56.13%	54.91%	52.62%
Worst result	33.93%	30.73%	33.57%	33.61%	36.67%
Responses	2354	2480	2792	3002	2618

https://www.nhsstaffsurveys.com/results/local-results/

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Proactive Speaking Up Activity

- Benchmarking and collaborative working alongside Berkshire Healthcare NHS Foundation Trust, recently South Coast East Ambulance Service NHS Trust (linked to quality improvement project) This will further support the objectives for 2026/2027.

- Co-production with the Freedom to Speak Up Champion Network which continues to grow.

- The Freedom to Speak Up APP (application) V3 launched April 2026

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

- Workshops – the Guardian attends various events across the Trust to deliver relevant sessions related to FTSU, behaviours linked to culture change. Support to local universities and temporary staff and contractors.

- Our People Strategy2026-2031, Quality Strategy and the Patient and Carer Race Equality Framework

National Updates

- NHS England » The future of Freedom to Speak Up

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

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

- Annual report laid before Parliament - National Guardian's Office November 2025

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th MAY 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 the 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 – March – April 2026

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

- **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.

- On 16th April, the Chief Executive and I were invited by NHS England to attend an in-person meeting of all **South West Chief Executives and Chairs** where we discussed strategic priorities for 2026/27.

Always improving

- On 1st April, I joined the second **Patient and Carer Race Equality Framework Workshop (PCREF)** at the Friendship Café in Gloucester. The primary aim of the event was to collaboratively identify and agree on the three key priorities for the Trust PCREF action plan for the year ahead. The engagement of key stakeholders to co-produce the Framework is absolutely the best approach and we really value the insights and experience of all contributors. A follow up session will take place in October where progress will be reviewed against the key priorities.

  The Patient and Carer Race Equality Framework is a mandated requirement on all mental health trusts and is an accountability framework that supports organisations to address the mental health inequalities experienced by different racial groups.

Respectful and kind

- Our **annual Trust awards** took place at Hatherley Manor Hotel on 15 April. There were more than 247 nominations across the nine categories and congratulations were given to everyone who was either nominated, shortlisted or ultimately named a winner. A full recording of the awards can be found on our YouTube channel here: https://youtu.be/J8gEiLqELLM?si=6ivp9nA8o7blqwvD

It was a fantastic celebration with teams and services represented from across the county, and from a huge range of services and specialities. The winners in each category were as follows:

Working Together:	Community Neurology Team
Always Improving:	School Aged Immunisation team
Respectful and Kind:	Kate Bowden, Head of Patient and Carer Experience
Making a Difference:	Children in Care team
Rising Star:	Moss Thornton (Expert by Experience)
Outstanding Achievement:	Dr Louise Knowles, Consultant Clinical Psychologist
Team of the Year:	Cheltenham Health Visiting
Valuing our Communities:	Increasing access to perinatal mental health (South Asian women living in Gloucester) project group
Co-Production Award:	Melissa Reed, Consultant Occupational Therapist (presented in memory of Dan Beale-Cocks by his sister Rebecca and son Albie)

- I had the pleasure of attending the **Volunteer and Experts by Experience Thank You Tea Party Celebration** on 6th May. A simply marvellous occasion to celebrate the difference made by Experts by Experience and volunteers. The Trust is a better organisation because of their contribution, and we improve through their insights, lived experience, and engagement. A massive personal 'thank you' from me. The tea party was an opportunity to thank our dedicated Volunteers and Experts by Experience for the valuable contribution they make to our services.

Making a difference

- In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, it was a real privilege to visit the **Children in Care Team** who are based at **Rikenel** and the **Gloucester Reablement Team** who are based at **Collingwood House** on 14th April to present their '**Making a Difference**' awards.

Children in Care Team

Gloucester Reablement Team

Individuals and teams are selected based on the recognition received through various channels, such as the Patient Experience Team or national awards. I look forward to visiting more services over the coming months to acknowledge 'Making a Difference' across the trust.

- I was invited to attend **The Black Mental Health Conference 2026: The Black Man's Burden**, delivered by **Restore Black CIC** in partnership with **Black South West Network** and **Barnwood Trust** on 27th May. The conference addressed the mental health challenges faced by the Black community and brought together mental health professionals, community leaders, educators, NHS representatives, police, housing sector experts, and members of the Black community to examine the systemic issues affecting wellbeing and access to care.

- On 19th May, I met with **Dame Gill Morgan DBE**. Gill was appointed NHS England South West Regional Chair in March and is meeting with all Provider Chairs. The meeting was an opportunity to discuss matters of mutual interest.

3. BOARD UPDATES

- The recruitment for a new **Non-Executive Director** concluded on Thursday 30th April. Following a rigorous recruitment process overseen by our Governors' Nominations and Remuneration Committee, I am delighted to advise that Helen Blanchard has been appointed and will commence in post on 25th May 2026. I am sure you will join me in welcoming Helen into her new role.

- As a Board we have decided to recruit a new **Associate Non-Executive Director** role to help us identify the gaps in our insight into the experience of the diverse communities we serve in Gloucestershire. This remunerated role will be part of the Board team, although not a voting member of the Board. We are specifically looking for people with extensive insight (likely gained through lived experience, work or volunteering) into the experience of racially minoritised communities in Gloucestershire. The recruitment is likely to be launched in the week beginning 25th May, and we will be promoting this opportunity throughout our networks. We are excited about the chance to bring new perspectives onto the Board.

- It has been a pleasure to undertake the **annual appraisals** for the Trust's four Non-Executive Directors with objective setting meetings taking place for two newly appointed Non-Executive Directors. This opportunity for reflection is a valuable experience on both sides. The outcome of the appraisal process will be reported to the July meeting of the Council of Governors. I would like to take this opportunity to thank NEDs for their very impactful contributions.

- On 23rd April an in-person **Board Development session** and our first **Board Community Insight Event** took place in Northleach. The 'Cotswold' Community Insight Event facilitated by Julie Mackie, Head of Partnerships and Gemma Hendzel, Service Development Manager in collaboration with local partners focussed on Local Population Health data, what matters most to the community and identified key challenges. The event was well attended, and I look forward to

the next Insight Community event. The **Board Development session** followed and focussed on Health Equity, our Quality Strategy and the Patient and Carer Race Equality Framework (PCREF).

- A Board Seminar took place on 21st May focussing on **Infection Prevention & Control and Antimicrobial Stewardship (AMS)** led by the Director of Nursing, Therapies and Quality, and the development of our **Research Strategy** led by the Medical Director and our Head of Research, Rob Mullen.

- 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.

- An extraordinary meeting of the **Appointment and Terms of Service Committee** took place on 1st April. The committee discussed recruitment to the roles of Director of Finance and Chief Operating Officer.

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.
- An extraordinary meeting of the **Council of Governors** took place on 1st May where Governors **approved** the appointment of Helen Blanchford as a Non-Executive Director.
- A virtual meeting of the **Council of Governors** took place on 14th May 2026. Amongst other items, Governors received an update on Neighbourhood Health and a presentation on the Community Hospitals Programme – Delay Related Harm.
- Our **programme of visits to sites for Trust Governors** continues to progress with a visit taking place at Cirencester Hospital on 7th May. On 27th May, Richard Dean and I visited the Complex Homeless Partnership Support team. Visits offer Governors the opportunity to see out sites, speak to colleagues and to gain a better understanding of the services we provide. Non-Executive Director colleagues accompany Governors on each of the visits.

5. NED ACTIVITY

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

See **Appendix 1** for the summary of the Non-Executive Directors activity during 1st March to 30th April 2026.

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 March – 30th April 2026

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• Council of Governors Meeting • Good Governance Institute Webinar – The Board as a Good Actor • Mental Health Act Manager Forum • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Pre-interview meeting with Dr Rosemary King • Quality Visit: Stroud Crisis Resolution and Home Treatment Team (CRHTT)	• Appointments and Terms of Service Committee • Board Development: Community Insight Event & Development • Mental Health Legislation Scrutiny Committee • Quality Committee
Nicola de longh	• Council of Governors Meeting • Meeting with Trust Chair • Health Overview and Scrutiny Committee • Non-Executive Directors Meeting • Audit of Complaints • Meeting with Karen Clements • People Strategy Board Paper Discussion • Aspiring Chair Talent Programme • Meeting with Trust Chair and Director of Corporate Governance and Trust Secretary	• Appointments and Terms of Service Committee • Board Development: Community Insight Event & Development • Board Development: Risk Appetite • Charitable Funds Committee • Resources Committee • Trust Board: Public & Private
Vicci Livingstone-Thompson	• Council of Governors Meeting • Director of Finance Recruitment Board Focus Group • Forest Community Learning Disability Team Quality visit • Meeting regarding Staff Networks • Meeting with Deputy Head of Information Governance	• Appointments and Terms of Service Committee • Board Development: Community Insight Event & Development • Charitable Funds Committee • Leadership and Culture Assurance Committee • Quality Committee • Trust Board: Public & Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Meeting with Karen Clements • Non-Executive Director Recruitment • Non-Executive Directors Meeting • Non-Executive Directors Meeting • Patient and Carer Race Equality Framework Community Workshop • Race and Cultural Awareness Network	
Bilal Lala	• Council of Governors Meeting • Director of Finance Candidate Discussions Director of Finance Longlisting Meeting • Non-Executive Directors Meeting	• Board Development: Risk Appetite • Quality Committee • Trust Board: Public (part)
Debbie Forster	• AAC Panel Interview • Better Care Awards Ceremony • Chief Operating Officer Candidate discussions • Director of Finance Interviews • Meeting with the Director of Finance • NHS England Chair & Non-Executive Director Welcome Day • NHS Gloucestershire System Resource Committee Meeting • NHS Providers Non-Executive Director Training • Non-Executive Directors Meeting • Non-Executive Directors Meeting • People Strategy Board paper discussion • Women's Leadership Network	• Appointments and Terms of Service Committee • Board Development: Community Insight Event & Development • Board Development: Risk Appetite • Charitable Funds Committee • Great Place to Work Committee • Resources Committee • Trust Board: Public & Private

Karen Clements	• Audit and Assurance Committee Briefing • Corporate Induction • Council of Governors Meeting • Director of Focus Board Focus Group • Great Place to Work Committee Agenda Setting • Introduction meeting with Debbie Forster • Introduction Meeting with Director of corporate Governance and Trust Secretary • Introduction meeting with Director of Improvement and Partnerships • Introduction meeting with Medical Director • Introduction meeting with Senior Executive PA • Introduction meetings with Chief Executive Director of HR and OD, Director of Nursing Therapies and Quality, Nicola de Iongh, Vicci Livingstone-Thompson • Meeting with Deputy Director of HR and OD • Meeting with Director of Corporate Governance • NHS England Chair & Non-Executive Director Welcome Day • Non-Executive Director Meeting • Non-Executive Director Meeting • Non-Executive Director Recruitment Long-Listing Meeting • People Strategy Board paper discussion • Welcome meeting with Trust Chair	• Appointments and Terms of Service Committee • Board Development: Community Insight Event & Development • Board Development: Risk Appetite • Great Place to Work Committee • Leadership and Culture Assurance Committee

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AGENDA ITEM: 16/0526

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 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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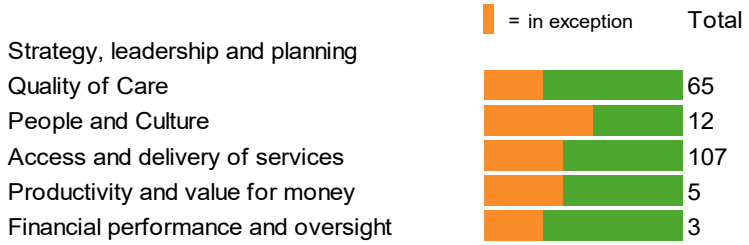
Strategic Update

Focus Areas	Update
Connecting services in neighbourhoods	3 workshops underway with cross system partners to gain alignment on the vision for Neighbourhood health
Children and young people	Engagement in plan for SEND reforms which will lead to investment in clinical 'expert at hand' roles
Community urgent care	Single Point of Access to integrate community based urgent care through to full business case stage
Inclusive healthcare	PCREF anti-racist statement co-produced and for Board approval in May
Partnerships with purpose	Joint resourcing proposal for the new Gloucestershire Provider Partnership agreed

Performance Indicators Overview

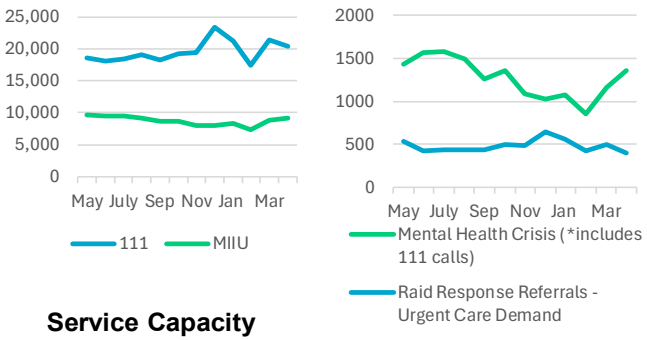


NHS Oversight Framework - 2025/26

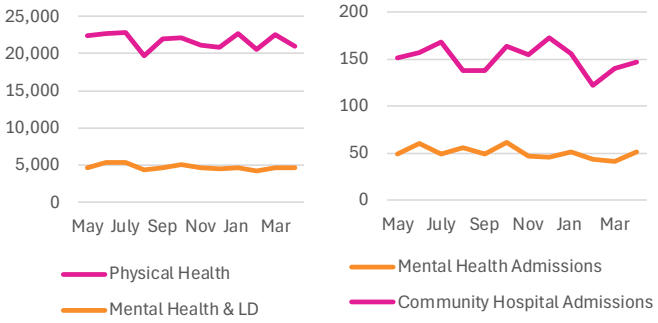
	Q1	Q2	Q3	Q4
Score	2.18	2.23	2.32	
Segment	2	2	2	
Ranking	21/61	20/61	29/61	

Service Demand Trends

Urgent Care demand (all age)

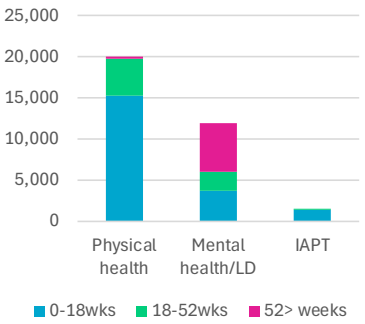


Planned Care Referrals (all age)

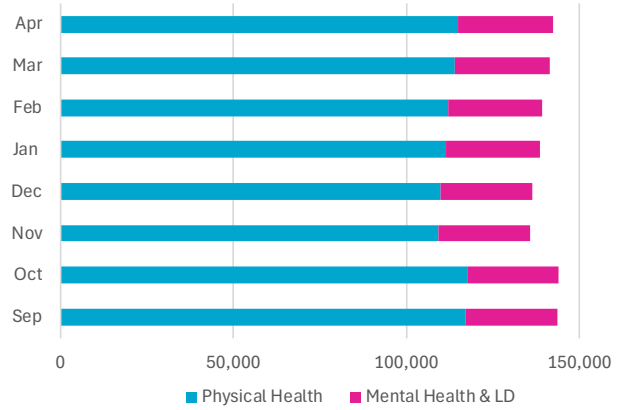


Service Capacity

Total Waiting for Treatment



Caseload



Strategic Risks - Board Assurance Framework

	Target	Quarter 4
Quality standards	6	20
Demand & Capacity	9	12
Recruitment, retention and development	9	9
Inclusive culture	6	12
Relationships and partnership	6	9
Funding for transformation	12	12
Capacity for change	9	16
Cyber	8	12
Closed culture	8	16
Health inclusion	8	12
Strategic commissioning	9	12

Chief Executive Overview

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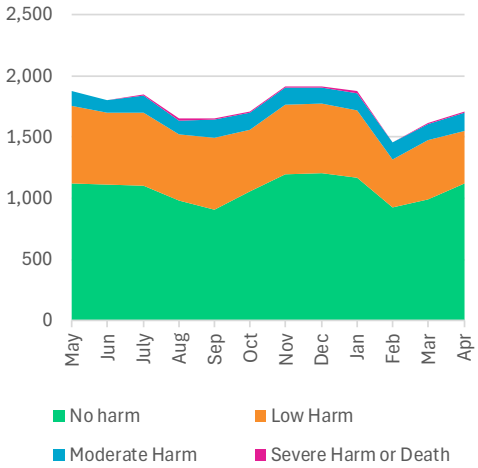
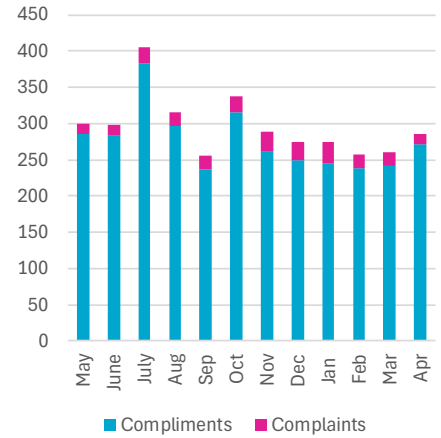
Quality and experience headlines

Incidents



Compliments and complaints



Patient Feedback (Apr 26)

Overall Experience

90% Very good or Good

Respect and Dignity

97% Positive

Involvement in decisions

95% Positive

Safety and welfare

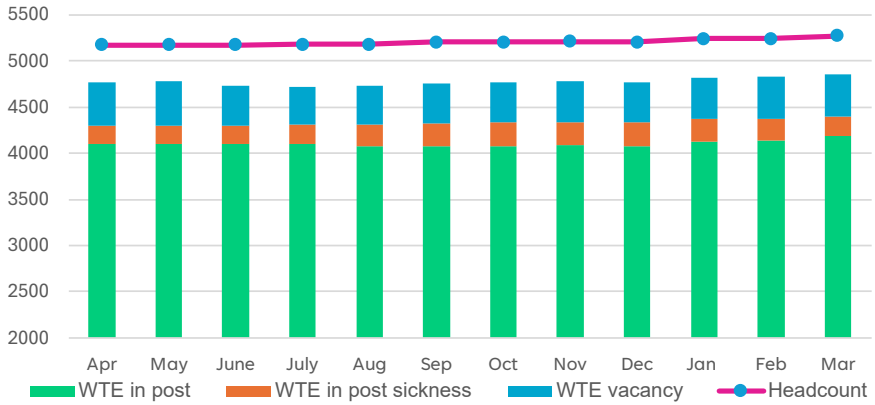
96% Positive

Finance headlines

Month 1 2026/27

Income & Expenditure Performance	£0.004m surplus
Cost improvement savings of	£2.941m
Capital expenditure	£0.163m 6% of full year plan

Our people



Colleague voice: National staff survey (Q3 25/26)

Recommend as a place to work	70%
Happy with the standard of care for friend or relative	76%

CHIEF EXECUTIVE SERVICE / TEAM VISITS AND EVENTS

Service Visits in April and May	• **Wotton Lawn Hospital, Gloucester, 20 April 2026.** An impromptu walkaround across the site during the morning, meeting new colleagues and connecting with others too. • **North Cotswolds Hospital , Moreton in Marsh, 23 April 2026.** A brief early morning return visit to North Cotswolds, where I was pleased to help with the breakfast round on the ward, as well as drop in to see other colleagues. • **Stokes Hay Nurses Base, Churchdown, 8 May 2026.** This was my first visit to see this base, which acts as a base for community nurses. • **Social Care Hub, Invista, Gloucester. 13 May 2026.** This was a planned visit to speak to the team who have been working very hard to keep services running throughout a difficult and stressful process of transferring mental health social work services to Gloucestershire County Council, which will take place on 1 June 2026. • **Cobalt Unit, Cheltenham, 13 May 2026.** I visited the Cobalt Imaging medical charity, who provide a range of diagnostics within and outside of the county and are also partners of the Trust in relation to dementia research.
Events to note	• **PCREF Community Engagement Event, Friendship Café, Gloucester 1 April 2026.** I was pleased to attend the start of this second workshop and be part of discussions. • **GHC Annual Awards, 15 April 2026.** A great afternoon celebrating achievement of individual colleagues and teams. • **National meeting of Mental Health Chief Executives, London, 14 April 2026.** An opportunity to discuss with colleagues the approach being taken to mental health services and improvement at a national level, with Nick Broughton, recently appointed as the national director and Sir Jim Mackey, NHS Chief Executive • **South West NHS Leaders event, Ashton Gate, Bristol, 16 April 2026.** A gathering of Chief Executives and Chairs from across the South West with the NHS England national leadership team. • **Board community insight event, Northleach, 23 April 2026.** A successful event, aimed at increasing insight into the needs of the population in the Cotswolds. • **NHS Leadership event, London, 28 April 2026.** National meeting of Chief Executives and other senior leaders to discuss progress against NHS improvement plans. • **Volunteers and Experts by Experience celebration, Bowden Hall Hotel, Gloucester, 6 May 2026.** See below.

CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Advise	**Operational**	**Intensive and Assertive Business Case**
	GHC and One Gloucestershire ICB have worked together since late 2024 to respond to the CQC and NHSE recommendations following the Nottingham homicides in 2023, undertaking a comprehensive review of the psychosis pathway and in particular Intensive and Assertive services. This work has culminated in a targeted investment proposal, now being considered by our Board prior to submission to commissioners, which reflects a strengthened system-wide approach focused on timely access, continuity, and assertive engagement for people with complex psychosis. The primary purpose of the investment is to improve outcomes for people with psychosis while reducing the risk of harm to patients and the public. It will do this through strengthened community provision, earlier intervention in relapse, improved information sharing, and workforce expansion with specialist expertise in risk management and trauma-informed care. Emphasising prevention over crisis response, the business case embeds learning from public enquiries into routine practice and supports more responsive, coordinated and accountable pathways, aligning clinical quality, patient safety and public protection with the Trust's strategic ambition to deliver safer, more effective mental health services.	
	Quality	**Wotton Lawn Hospital Review**
	We continue to support and engage in the Large Scale Safeguarding Enquiry being coordinated by Gloucestershire County Council regarding Wotton Lawn Hospital. The enquiry attracted media attention during May and there was also a wide range of public comments through social media. The Board has previously been updated that this is related to our own reporting of incidents and investigations into aspects of care at Wotton Lawn Hospital. We continue to work closely with partners in this process, as part of our commitment to learn from when things go wrong while also recognising the positive experiences that many patients tell us about. Our approach to the enquiry is open and transparent, ensuring that we regularly update all stakeholders, including our regulators, colleagues, patients and carers.	

	Operational	**Gloucestershire County Council Delegated Responsibilities Update**
	The programme of transferring services currently delivered on behalf of Gloucestershire County Council back to the Council continues to progress at pace, with key milestone transfers scheduled for Mental Health Social Work on 1 June 2026, Occupational Therapy on 1 August 2026, and Special Accommodation Service and Reablement on 1 September 2026. Significant activity is underway across all service areas, including TUPE processes, transfer of caseloads and waiting lists, service continuity planning, communications, and wider decommissioning activity. Delivery is placing considerable demand not only on operational teams but also on corporate services, including people, digital, clinical systems, business intelligence, and transformation functions. In parallel, development of the future models and required resources for NHS Occupational Therapy and Home First operating models are progressing rapidly. However, compressed timelines for approvals and mobilisation present a key programme risk.	
	Estates	**Cirencester Redevelopment Programme**
	A programme of communication is beginning to update colleagues as well as patients, carers, and other stakeholders about our planned extensive redevelopment programme at Cirencester. This is a significant programme involving upgrading of plant, equipment and structures planned for retention, as well as improvements to underground infrastructure. Benefits for patients will include new ensuite facilities for inpatients, better outpatient clinic space, and improvements to the urgent care provision. It is a complex project - aside from operational considerations, the site has a rich mix of archaeological and ecological factors which will be taken into account. To help us design a facility that meets clinical and patient needs, as well as sustainable solutions and which are sensitive to ecological and archaeological content of the site we have appointed Architects Corstorphine and Wright who have a number of successful health and hospital projects within their portfolio.	
	Partnerships	**Provider Partnership Update**
	The three NHS organisations - Gloucestershire GP Collaborative, Gloucestershire Hospitals NHS Foundation Trust, and Gloucestershire Health and Care NHS Foundation Trust - are progressing the next phase of their partnership through the Gloucestershire Provider Partnership (GPP) to deliver system-wide transformation. The core function of this partnership is to lead and coordinate a population health–driven model of care, focused on neighbourhood working and improved outcomes across mental health, urgent and emergency care, and community and primary care services. Partners have agreed a joint resourcing plan for senior transformation leadership under and will start recruitment in the coming weeks.	

	Workforce	**Changes to Mileage Claim Mechanism and Rates**
	The NHS Staff Council announced in March the introduction of a new mechanism for calculating mileage reimbursement for eligible NHS staff who use their own cars for work. Rates will now be reviewed twice a year (with an increase planned on 1 June 2026) and the mileage threshold (beyond which rates drop) will increase from 3,500 miles to 4,500 miles on 1 July 2026. This is particularly important for GHC colleagues who undertake the most mileage, particularly those who look after patients in rural communities and often travel the furthest for work. In recognition of the recent substantial increases in fuel costs, our Trust will also temporarily disregard the 3,500 mileage cap during April, May and June 2026 in advance of the national changes.	
Applaud	**Recognition and Celebration**	**Experts by Experience "Thank you" event**
	The sun shone as the Trust rolled out the red carpet for our volunteers and Experts by Experience to its regular celebration 'Thank You' event. More than 100 guests were welcomed at Bowden Hall Hotel, in Upton St Leonards, for a light-hearted afternoon tea hosted by Trust Chair Graham Russell and Chief Executive Douglas Blair. There was a tribute and round of applause for Dan Beale-Cocks, expert by experience, patient safety partner and co-chair of the Mental Health and Wellbeing Partnership Board, who sadly died in 2024. Parisa Wasley and Jo Sansom from Macmillan Next Steps talked about the impact of experts by experience on their service, and service user Chris added his own thoughts on the value of providing input. And Peter Beach gave a presentation about the development of Cirencester Hospital Radio, which relies on the dedication, skills and know-how of two dozen volunteers, and which celebrates its 50th anniversary this year. GHC Charity was also represented, as well as Digital Services, which provided info on our Experts by Experience App.	

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

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

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

SUBJECT: **SENIOR INFORMATION RISK OWNER (SIRO) ANNUAL REPORT**

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

This report is provided for:

Decision ☐ Endorsement ☒ Assurance ☒ Information ☐

The purpose of this report is to:

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

Recommendations and decisions required

The Board is asked to:

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

Executive summary

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

It should be noted that the Trust was able to achieve a DSPT submission (self-assessment) of 'met standards' for the 2024/25 year and are expecting to meet standards for 25/26. There were three data breaches that met the threshold for onward reporting to the Information Commissioners Office (ICO).

There continues to be an impact on the IG activity as the Trust continues to move forward with new ways of working, embracing more and more within the digital arena. This has continued to increase the demand for advice and support from the IG team and the IG

Group, with the IG Group approving 16 Data Protection Impact Assessments (DPIA) and 12 Data Sharing Agreements (DSA).

This year there has been an increase in Subject Access Requests (SARs) of 7.7%. The number of Freedom of Information Requests (FOIs) has also seen an increase of 9.8%.

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

Risks associated with meeting the Trust's values

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

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

Where has this issue been discussed before?

The report has been discussed with key contributors and was presented to the Audit & Assurance Committee at its meeting on 14th May.

Appendices:	NA

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

Annual SIRO Report 2025 – 2026

INTRODUCTION

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

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

During 2025/26 the governance model. processes and structures for IG and Records have continued to develop, with the high volumes of activity experienced. The records practices have continued to be developed across the organisation, with the role out of the Electronic Management Document System (EDMS) and will continue to as the physical health records come online later in the year.

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

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

Section 1: Information Governance

Section 2: Clinical Coding and Health Records

Section 3: Data Quality

Section 4: Cyber / Data Security

Key highlights 2025/2026

- The Information Governance Group met six times and approved 16 Data Protection Impact Assessments and 12 sharing agreements to support services;
- The 24/25 final submission for the Data Security and Protection Toolkit was assessed as ‘Met Standards’. The 25/26 is submission is expected to meet the standards;
- There have been three data breaches reported through the Trusts incident reporting system that met the threshold for onward reporting to the Information Commissioners Office (ICO);
- The Trust achieved the 95% target for Data Security and Awareness training, on 19 occasions this year;
- There have not been any significant health records incidents or losses reported; and,

- The EDMS Project has now completed with all mental health records ingested into CITO and live in the RIO EPR, the Physical health element is underway and due to go live in Jun 26 with a final completion date in August 2026.

1.0 INFORMATION GOVERNANCE

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

1.1 Information Governance & Records Team

The team continues to develop and improve their processes in line with findings, activity reporting and feedback. The team have again seen an increase in activity additionally the numbers of complex subject access requests has gone up by over 100%.

The team has delivered operational support, advice, and guidance to colleagues, including attending team meetings. They have also provided bespoke IG and Records training to a number of teams in the year. It also issues quarterly compliance reports to the IG Group.

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

1.2 Information Governance Group

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

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

The IGG has met bimonthly throughout the year.

During 2025/26, the group has:

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

submission for 25/26 and final submission for 24/25;
- Reviewed and approved 16 Data Protection Impact Assessments (DPIA);
- Reviewed and approved 12 Data Sharing Agreements (DSA);
- Engaged with and supported the development of an AI policy for the Trust; and,
- Reviewed and agreed the Trusts training analysis for IG training.

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

1.3 Data Security and Protection Toolkit (DSPT)

The DSPT continues to be aligned with the National Cyber Assurance Framework (CAF), with no material changes. The number of mandatory audited outcomes has increased by one with the Trust selected decreasing by the same amount.

As part of the DSPT's requirement the Trust's must have a number of outcomes audited, the Trust's Internal Auditors, BDO, audited the 2024/25 DSPT submission. The overall risk assessment by BDO was medium, with an overall high level of confidence in the Trust's DSPT submission.

The Trust has submitted their CAF aligned DSPT for 2024/25 submission, in June as met standards. The 2025/26 interim submission was made in December 25, with the final submission to be made in June 26.

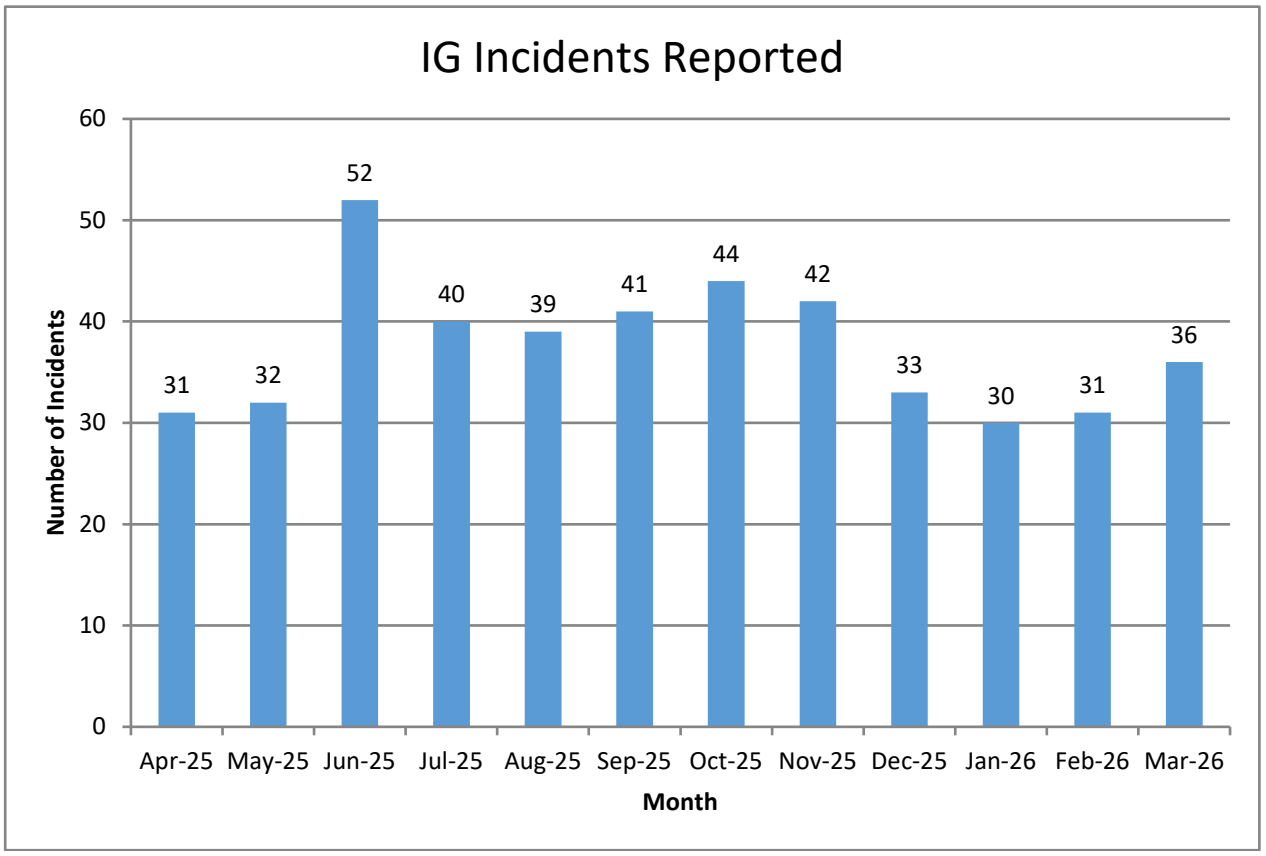
1.4 Breaches and Near Misses

There have been 451 IG incidents reported in year, of which there were three that met the threshold to be referred to the SIRO or Caldicott Guardian for review and consideration of onward reporting to the ICO. All three breaches were report to the ICO.

The below table shows the number of IG Incidents ICO reported incident by year.

	IG Incidents		
Year	**2023/24**	**2024/25**	**2025/26**
Incidents	373	447	451
ICO reports	3	2	3

Below is a graph of reported incidents by month for the last financial year.



There is an increase of 4 incidents compared to the same period in 2024/25. Comparing when breaches occur there is a clear increase in the number of incidents between Sept to Nov and then again in Mar, this was mirrored for the same periods last year. Although there has been learning for teams and individuals following a breach there has been no organisational learning or trends identified.

Targeted training has been provided to teams where there has been an increase of confidential information being posted or emailed to the wrong address. The training centred around best practice simple preventative measures.

1.5 Subject Access Requests (SARs)

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

	Total Requests			Total Over Time Limit		
Requests	**2023/24**	**2024/25**	**2025/26**	**2023/24**	**2024/25**	**2025/26**
SARs	1022	1111	1197	2	11	4

A total of 1,197 SARs were received in 2025/26, up from 1,111 in 2024/25. This represents an increase of 7.7%. The average number of SARs has increased from 21.4 per week in 2024/25 to 22.6 per week in 2024/25.
On occasion, due to size and complexity SARs can take up to three months to process. This is in line with UK GDPR for complex SARs, requestors are advised when this is the case.

In the final quarter, no SARs went over the one-month response time where no extension had been agreed with the requester.

Following the addition of the 111 and Out of Hours (OOH) Services to the Trust's portfolio in 2024/25, a total of 13 SARs (10 x 111 Service, 3 x OOH Service) were received in 2025/26 an increase on 2024/25.

The number of SARs continues to rise, limited data does show the numbers of requests do peak around the holiday periods (Easter, Summer, Christmas). There has been a rise in requests from solicitors, for 'potential' clinical negligence claims in 2024/25 there were 52, in 2025/26 this rose to 63, an increase of 21.1%. For 'potential' personal injury claims in 2024/25 there were 317, in 2025/26 it rose to 364, an increase of 14.8%.

SARs vary considerably both in the size of the records and the time involved to complete. A simple SAR can be 3 to 4 pages may only take 10 - 15 minutes to download and send for approval. More complex SAR may involve downloading several hundred documents, and records of over 2,000 pages (the top five largest requests, by pages, this year were for 4,784, 5,084, 11,980, 17,469 and 21,256), and can take weeks to download, collate, review, redact and send for approval.

During 2025/26, the Team saw a significant increase in the number of requests from current and former employees for copies of their information we hold, in 2024/25 there were only 4 such requests whereas in 2025/26 this has risen by 300% to 16 in 2025/26. Due to the breadth of the requests and the specialist tooling required to extract the data, these are often complex.

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

With the ongoing increase in requests, including the increase in the number of complex requests, the Team have completed a lean review of its SAR process which supports the requirement for a specialised digital SAR tool.

1.6 Freedom of Information Requests (FOIRs)

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

	Total Requests			Total Over Time Limit		
Requests	**2023/24**	**2024/25**	**2025/26**	**2023/24**	**2024/25**	**2025/26**
FOIRs	466	501	550	164	103	155

Despite increasing the amount of data, we make publicly available the number of FOI requests received for the year ending 31st March 2026 has increased by 9.8%.

71.8% of the FOI requests were answered within the statutory timeframe, this represents a decline in compliance from the 2024/25 year. The reasons in part for going over the statutory time limit are varied, but includes the increased complexity of requests, technical difficulties with the tracking tool, delayed internal responses to request.

Additionally, a few complex internal issues has contributed to the poor performance, this has been reported to the IGG and the Audit and Assurance committee. Changes were implemented to bring the work back on track. These changes have resulted in a clear improvement on performance, in the last 2 quarters of the year. Compliance for this period raised to 97%. To support these changes and to maintain compliance the structure of the IG Team has been reviewed, and we are actively recruiting to provide greater resilience and oversight going forward.

It is worth noting with the proliferation of Artificial Intelligence (AI) FOI requests received by the Trust are now covering AI, its use and impact.

The following table breaks down the FOI performance

Total FOIR requests for April 2025/26: 550		
Days Over time	**Number**	**% of FOIRs**
01 - 07	66	12%
08 – 14	41	7.5%
15 +	48	8.7%
Total	155	28.2%
Total FOIs on time	395	71.8%

The digital tool being considered for SARs will also be utilised for FOI's, which will improve transparency, reporting and tracking.

1.7 IG Training

The Trust achieved the 95% target for Data Security and Awareness training in compliance with the DSPT. This was achieved this year on 19 occasions, which is a further improvement from previous years, which was 10. The IGG, IG&R team and SIRO regularly review training statistics and consider ways in which to improve compliance to ensure that good IG practices are embedded across the Trust.

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

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

1.8 Information Asset Registers

The Trust maintains an information asset register that is reviewed with IT and clinical systems regularly along with the IGG periodically. As assets are identified as part of the DPIA process they are added accordingly. The asset register also details the assigned Information Asset Owners (IAO). Work is underway to develop further resources for IAOs to support them in their role.

1.9 Updated media statement in the event of a data breach

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

1.10 **Data Processor update on issues (contractual updates, compliance, and UK GDPR)**

There have been no reported issues raised with or by a processor, in the year.

1.11 **Data Flows**

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

1.12 **IG Risk**

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

Additionally, the board have a moderate appetite for 'information governance' and 'cyber' with an upper risk tolerance score of 10. As a result, these risks rated 11 and above that fall within this category are reported to the Audit and Assurance Committee.

2.0 CLINICAL CODING AND RECORDS

2.1 **Privacy Officer**

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

There have been 46,530 SystmOne privacy officer checks performed between April 2025 and March 2026. 90 resulted in queries being raised with staff as to why patient records were accessed. No concerns have been raised following the responses received from staff.

There have been 11,688 SCR privacy officer checks performed between April 2025 and January 2026. 181 resulted in queries being raised with staff as to why patient records were accessed. No concerns have been raised following the responses received from staff.

There are a further 2,256 Privacy Officer alerts raised between February and March 2026, that have not yet been processed.

2.2 Clinical Coding Report Clinical Coding

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

Mental Health

- The coding team rely upon the Nursing/Doctors Summaries to code episodes, followed by accessing the progress notes;
- When Discharge Summaries are not available, the progress notes are used to determine a diagnosis; and,
- CHKS request uncoded patient lists when required from the IG & Records Team.

Sexual health

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

Rehabilitation

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

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

2.3 Records

The team, supported by Trust bank staff, have processed 500 boxes of physical health records that were stored Trust's storage facility, that were linked to the CITO project, which had moved into Business As Usual (BAU) activity for the record team.

There are about 1347 historic paper records, that predate the Trust, in Iron Mountain. These are requiring a review to consider destruction or retention.

2.4 CITO EDMS Project

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

All Mental Health and Learning Disabilities files have been scanned and are available in CITO, via a click-through from RiO. All Physical Health files are viewable/downloadable from CITO via the Health Records team. We expect a click-through from SystmOne to go-live by June 2026.

The Clinical Systems team continue to work with the system suppliers CIVICA, to troubleshoot and implement functionality that is currently missing from the system, for example the ability to upload video files. CIVICA have given a projected delivery date of August 2026 for these elements.

Key Milestones Planned for 2026:

- Physical Health quality assurance checks complete (April 2026).
- Click-through from SystmOne Go-live (June 2026).
- Update with additional functionality, including ability to upload video files (August 2026).

2.5 Summary of audits which have Data Privacy/Quality Implications

The clinical audit programme has delivered on a varied programme of audits. There have not been any significant issues that have implications on the Trust's compliance with Data Protection Legislation that required raising with the SIRO, Caldicott Guardian and DPO.

3.0 DATA QUALITY

3.1 Policies

The Trust's FOI policy has been reviewed and updated in year, with process procedures being updated to ensure consistency of approach.

The Trusts Information Governance Management System Policy, and Access to Health Records Policy has been reviewed and approved in year.

The IGG has supported the developed of a Trust AI Policy and staff guide.

3.2 Business Continuity / Disaster Recovery

The Trust has an incident response policy that forms the backbone of its disaster recovery and business continuity planning. This policy has been reviewed and incorporated the Trust's essential functions assessment.

There have not been any technical incidents this year that have required teams to utilise their business continuity plans.

3.3 Business Intelligence

The Trust has a progressive infrastructure to deliver integrated reporting for 2026/27. Its data warehouse ingests numerous data tables from various systems including workforce (Electronic Staff Record), risk, incident management service experience (Datix), finance (Centros), training, appraisals, supervision (Care2Learn), e-rostering (Allocate) and its five clinical systems (RiO, SystmOne, Lilie, IAPTus and Systems for Dentists). It also receives data from partner clinical systems such as CLEO. This allows for the triangulation of data sets to inform decision making and further improve patient care.

A single, unified Trust Hierarchy is critical the integration capabilities of data across these systems, and the maintenance of this continues to be paramount to the success of the overall outputs available through a single Business Intelligence (BI) platform Tableau. Combined, this offers all stakeholders a single version of the truth with absolute alignment between National, Regional and Local data. This collectively improves commissioner, operational and corporate confidence in many areas.

Managing numerous corporate and clinical systems brings with it unavoidable data quality issues which can stem from record keeping errors or system configuration complexity. To mitigate this, data quality reports are published and available to all staff which help feed audit and help monitor operational practice to mitigate this issue. The clinical systems and BI team also run starter and refresher user training to maintain a good level of data recording and report monitoring and the Trust's Transforming Care Digitally agenda will further address Data literacy and Digital confidence in 2026/27. BI manage the portfolio of data quality reports, however, it is a combination of the Nursing, Quality and Therapies directorate, the Operations Directorate and Clinical Systems team that monitor compliance and undertake corporate and clinical audits. An operationally led Patient Record Working Group also improves ownership and accountability for data quality within clinical systems.

The Trust currently maintains a full BI reporting suite of information reports that maintains pseudonymised data (through clinical system ID or NHS numbers). The following example is a rare exception that use patient identifiable information, however, such reports are used for direct patient care and clinical monitoring, not research or planning purposes:

- Mental Health Bed Management Report – This Digital Whiteboard (Name and Age) is secure to the bed management team, wards and select senior operational managers to manage patient flow. The report has progressed through a DPIA process.

There are comparable controls to manage access to corporate reports such as financial budget statements (to budget holders and associated management accountants) and HR Workforce reports (Workforce leads). There are always controls in place to manage access to sensitive reports, and although an automated IT owned, Active Directory solution is still being developed, it is currently and satisfactorily managed through a locally BI monitored list of responsible names that is locally maintained. Access to these reports is reviewed annually and tools will be securely archived if no longer required. Named user activity to any of these reports can also be monitored as required.

Although the majority of the Trust's *identifiable* data use is for direct patient care (acceptable) and all planning or development reporting uses *confidential, un-identifiable* data (also acceptable); the Trust does have a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied. The Trust also handles pseudonymised and anonymised data where appropriate, often for ICS but also GHC management needs.

3.4 ESR

There have not been any system or data security issues in year. Data quality audits and reviews continue to be carried out monthly using system reports. There are no emerging themes or trends following these reviews.

3.5 Electronic Patient Records

There have not been any system or data security issues in year. Data quality and template reviews continue to be carried out as part of the transforming care digitally programme.

4.0 CYBER / DATA SECURITY

4.1 Access Controls

The Trust operates a clear process for granting IT and Clinical Systems access to new starters and managing access removal for staff who leave. The leaver process is partially automated and driven by a weekly ESR report provided by the HR Workforce team.

As part of this process, accounts are disabled and relevant data is archived. For staff moving roles, access linked to their previous position is removed to ensure appropriate permissions are maintained.

Over the reporting period, 696 new Active Directory accounts were created and 699 leavers were processed. There is a weekly process in place for inter-organisational moves, following an email sent from the HR Workforce team.
To support account segregation, members of the Digital Services team are issued with a separate privileged Active Directory account for tasks requiring administrative access to GHC devices, including servers, switches, and workstations. Six-monthly audits are carried out to ensure the principle of least privilege is upheld.

4.2 Cyber Report

The Countywide IT Service (CITS) plays a crucial role in managing the cyber response for the Integrated Care System (ICS). CITS ensures that the ICS Digital Executive Steering Group, which includes the Senior Information Risk Owner (SIRO), receives timely cyber security updates. Weekly meetings hosted by GHC focus on reviewing cyber threats, assigning actions to address potential risks.

CITS carries out monthly penetration testing for GHC, identifying vulnerabilities across the Trust's IT systems and devices. The outcomes are reviewed during the weekly GHC Cyber meetings. Alongside this, GHC has engaged an external organisation to perform additional penetration testing, and NHS England conducts monthly external scans using Qualys to assess internet-facing services. Any issues raised are addressed jointly by the GHC IT and ICS Cyber team.

GHC completed an IT Health Check in August 2025 to assess vulnerabilities across devices, accounts, and internal infrastructure. This included both internal and external vulnerability scanning. Results showed improvement compared with previous years, reflecting the team's ongoing efforts. Remediation work is currently 95% completed.

4.3 Data Destruction

IT equipment

There have been no reported issues around data destruction or disposal. The contract is held with Hewlett Packard (HP) and was reviewed October 2025. Devices are collected by HP who in turn issue reports of what has been destroyed, recycled etc. All data is wiped/destroyed to the required standard and a HPEFS Disposal Certificate is provided for each collection.

To date for 2025/26, to date, GHC have has 21 disposal collections with 2,452 assets returned and processed, 632 of these assets were recycled and 1820 remarketed.

To date for 2024/2025 GHC have has 18 disposal collections with 4,512 assets returned and processed, 2398 of these assets were recycled.

Print waste

There have been no reported data issues with the print waste contract or supplier. Additionally, the supplier has not highlighted any data issues.

4.4. Cyber Data Security Risks

The Digital Group manages the cyber security risks for the Trust with oversight provided by the Audit and Assurance Committee.

4.5 Phishing

Phishing remains the number one method by which attackers initiate a cyber-attack, this is evidenced within GHC's own environment.

4.6 Patching

To minimise risk, GHC has implemented a comprehensive defence-in-depth cyber strategy that includes various solutions to mitigate risks.

Images, courtesy of Canvas and Getty images

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 May 2026**

PRESENTED BY: Helen Child, Director of Corporate Governance & Trust Secretary

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL APRIL 2025 – END OF MARCH 2026**

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

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to **NOTE** the use of the Trust seal for the reporting period 1st April 2025 – 31st March 2026.

Executive summary

The Trust's Standing Orders require that the use of the Trust's Seal is reported to the Trust Board at regular intervals. The Common Seal is primarily used to execute legal documents, such as transfers of land and lease agreements.
Since the last report to the Trust Board on **29 May 2025**, the Seal has been used as follows:

- **4 occasions** during **Q1 & Q2 (1 April 2025 – 30 September 2025)**; and
- **5 occasions** during **Q3 & Q4 (1 October 2025 – 31 March 2026)**.

Risks associated with meeting the Trust's values

All actions have been undertaken in line with the Trust Board's Scheme of Delegation. There are no inherent risks to report to the Trust Board arising from the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?
N/A

Appendices:	**Appendix 1** (page 3) Register of Seals 1st April 2025 – 31 March 2026

Report authorised by: Helen Child	**Title:** Director of Corporate Governance/Trust Secretary

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust

REGISTER OF SEALED DOCUMENTS - 1st April 2025 to 31st of March 2026 (9 sealed documents)

Ref No.	Date of sealing	Document No.	GHCNHSFT and Other Parties Involved	Description	Building / Property	Purpose	Seal Applied	No of Seals	Attested signature (1)	Attested signature (2)	Witnessed by	Location of Original Doc.
57/2025	23-Apr-25	ICT 2024 - 200499904	The Joint Contracts Tribunal Ltd 2024 (JCT)	Intermediate Building Contract (IC) Executed as a Deed by the Employer	**Avon House** Green Lane Business Park, Tewkesbury, GL20 8SJ	Ongoing contract work	Yes Page 15	**1**	Douglas Blair (CEO)	Rosanna James (Director of Improvement and Partnership)	Lavinia Rowsell (Trust Secretary)	Estates
58/2025	22-Aug-25	210595175.3 146111.15 Michaelmores HM Land Registry Sellers Title No GR142806	Berkhampstead School (Cheltenham) Trust Ltd	Deed of Variation	**Lexham Lodge** Copt Elm Road, Charlton Kings, Cheltenham, GL53 8AG	Clause 10 on sale agreement to be deleted and replaced	Yes Page 7	**1**	Sandra Betney (Director of Finance & Deputy CEO)	Neil Savage (Director of HR & OD)	Lavinia Rowsell (Trust Secretary)	Estates
59/2025	25-Sep-25	211256538.3 146111.9	New Docs Ltd - Company No. 07298816	Deed of Rectification	**Part of Tewkesbury General Hospital relating to Trinity Church** 38-39 Barton Road, Tewkesbury, GL20 5QL	re development adjacent to Tewkesbury Hospital	Yes Page 7	**1**	Douglas Blair (CEO)	Sandra Betney (Director of Finance & Deputy CEO)	Lavinia Rowsell (Trust Secretary)	Estates
60/2025	25-Sep-25	HM Land Registry TR1 No. GR142807	Art Shape Ltd	HM Land Registry TP1	**Trinity Church,** Barton Street, Tewkesbury, Gloucestershire, GL20 5QL	Transfer of property	Yes No. 13	**1**	Douglas Blair (CEO)	Sandra Betney (Director of Finance & Deputy CEO)	Lavinia Rowsell (Trust Secretary)	Estates
61/2026	03-Nov-25	HM Land Registry TR1 No. GR327043	Retain Property Ltd	HM Land Registry TR1	**Units 4 & 5 Ambrose House** Meteor Court, Barnett Way, Barnwood, Gloucester, GL4 3GG	Transfer of property	Yes No. 12	**1**	Douglas Blair (CEO)	Neil Savage (Director of HR & OD)	Lavinia Rowsell (Trust Secretary)	Estates
62/2025	17-Nov-25	10-107552394-1\362488-26	Wiltshire Council & Hollins Strategic Land LLP	Deed - 106 Engrossment	**South-East side of Park Lane, Malmesbury** (known as Land off Sherston Road, Malmesbury)	Brokenborough Malmesbury Land disposal	Yes Page 74	**1**	Douglas Blair (CEO)	Dr Amjad Uppal (Medical Director)	Lavinia Rowsell (Trust Secretary)	Estates
63/2025	18-Dec-25	HM Land Registry TR1 No. GR160462	Birmingham Independent College Ltd	HM Land Registry TR1	**Dilke Memorial Hospital** Speech House Road, Cinderford, GL14 3HX	Relating to the sale of Dilke Hospital	Yes No. 12	**1**	Douglas Blair (CEO)	Nicola Hazle (Director of Nursing & Quality)	Sarah Lodge (Property Manager)	Estates
64/2025	18-Dec-25	HM Land Registry TR1 No. GR401880	I A Property Investment Ltd	HM Land Registry TR1	**Hatherley Road Day Centre** Hatherley Road, Gloucester, GL1 4PW	Transfer of property	Yes No. 12	**1**	Douglas Blair (CEO)	Nicola Hazle (Director of Nursing & Quality)	Sarah Lodge (Property Manager)	Estates
65/2025	08-Jan-26	HM Land Registry TR1 No. GR166243 and GR166246	Stantonbury (Lydney) Ltd	HM Land Registry TR1	**Lydney Hospital** Grove Road, Lydney, GL15 5JE and **Grove House** 24 Grove Road, Lydney, GL15 5JE	Transfer of property	Yes No.12	**1**	Douglas Blair (CEO)	Sandra Betney (Director of Finance & Deputy CEO)	Sarah Lodge (Property Manager)	Estates

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Tuesday, 17 March 2026
MS Teams

PRESENT:	Graham Russell (Chair)	Peter Gardner	Amy Aitken
	Chris Witham	Sarah Nicholson	Sarah Waller
	Michelle Kirk	Bob Lloyd-Smith	Mick Gibbons
	Martin Pittaway	Alicia Wynn	Laura Bailey
	Tussie Myerson	Caroline Goldstein	Richard Dean
	Joy Hibbins	Marcia Gallagher	Kizzy Kukreja

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Douglas Blair, Chief Executive
Anna Hilditch, Deputy Trust Secretary
Michelle Hurley-Tyers, Deputy Director of HR&OD
Nicola de Iongh, Vice Chair / Senior Independent Director
Karen Clements, Non-Executive Director
Vicci Livingstone-Thompson, Non-Executive Director
Helen Child, Director of Corporate Governance

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Jan Lawry, Chas Townley, David Hindle, Andrew Cotterill, Leighton-Lee Pettigrew and Paul Winterbottom. Apologies had also been received from the following Non-Executive Directors: Bilal Lala and Debbie Forster.

1.2 The Council noted that Penny Brown, Public Governor – Gloucester, had resigned from the Council on 5th March. Colleagues wished Penny well for the future.

1.3 The Council welcomed new Trust colleagues, Karen Clements (Non-Executive Director), Richard Dean (Appointed Governor – Glos. County Council), and Helen Child (Director of Corporate Governance).

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETINGS

3.1 The minutes from the previous Council meeting held on 19 November 2025, and the extraordinary meeting held on 19 December, were received and agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were complete or progressing to plan.

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

5. NOMINATIONS AND REMUNERATION COMMITTEE REPORT

5.1 The purpose of this report was to provide a summary to the Council of Governors of the business conducted at the Nominations and Remuneration Committee meetings held on 11 February (Extraordinary) and 5 March 2026.

5.2 The Committee had received a report setting out the proposed direction of travel for the recruitment of a new non-executive director following the departure of Rosi Shepherd. The Committee noted the proposed skills and experience being sought and supported the immediate commencement of the process to try and secure a new Non-Executive Director (NED) by May 2026. Governors would be invited to participate as part of the recruitment process and dates would be shared in due course.

5.3 The Committee reviewed and supported the process for conducting the Chair and Non-executive Director appraisals for 2025/26.

5.4 A discussion took place at the Committee meeting on 11 February about the future of the Council of Governors. It was noted that this was on the agenda as a separate item for the Council meeting and further discussion would take place at that point.

6. CHAIR'S REPORT

6.1 Graham Russell provided a verbal report to the Council, setting out some of his activity over the past few months. It was noted that his full written report would be presented at the Trust Board meeting on 26th March, and all Governors would receive the papers in advance for information.

6.2 Graham informed the Council that there would be a lot of change on the Board this year, with 2 new NEDs having just joined us and the recruitment for a further vacancy now underway. The Trust was also recruiting for a new Director of Finance, and a new Chief Operating Officer.

6.3 The Council discussed the process and etiquette for governors' service visits. It was noted that the service visits were centrally organised to avoid overwhelming staff and to allow all governors the opportunity to participate. Governors were joined on their visits by either the Chair or one of the NEDs. The schedule of visits for 2026/27 was currently in development and would be shared with all Governors over the coming weeks. Alicia Wynn offered to facilitate visits to Young Gloucestershire for governors and NEDs interested in understanding the partnership working taking place in mental health services for children and young people. **ACTION**

7. CHIEF EXECUTIVE'S REPORT

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

7.2 Douglas Blair provided an update on ICB Clustering and the development of local Strategic Partnerships.

7.3 An update was provided on the temporary service changes at Cirencester Hospital, with Douglas reminding colleagues that the temporary suspension of day surgery at Cirencester was part of a six-month test of change looking to improve utilisation. Governors noted that no other services were affected and that evaluations from the test of change would be used to inform any permanent decisions. Further discussions took place around outpatient space utilisation, the need for a broader review of community hospital roles, and the potential for future site development to better match service needs.

7.4 In response to a question from Marcia Gallagher, Douglas Blair advised that the original plan for a private endoscopy service provider in the Forest of Dean had fallen through and that a viable alternative had not yet been established.

7.5 The Council welcomed Michelle Hurley-Tyers, Deputy Director of Human Resources & Organisational Development, who presented an overview of the 2025 staff survey results. A decline in staff survey response rates was highlighted, which was consistent with national trends, and it was noted that the majority of responses came from white female staff aged 50-55, which may influence the results. The survey showed stable results in most areas, with strengths in inclusion and team culture, but identified areas for improvement around burnout, work-related stress, appraisal, and staff availability, as well as pockets of discrimination and inconsistent psychological safety. Michelle described the ongoing and planned actions, including sharing results with teams, leadership engagement, targeted work on equity and well-being, and the upcoming launch of the people strategy, which incorporated staff survey and GHC Fortnight feedback. Governors raised questions about how staff feedback is acted upon and communicated, with Michelle emphasising the importance of closing the feedback loop, using multiple data sources, and exploring more immediate and engaging feedback mechanisms. Douglas Blair referred to the reduction in response rate this year and advised that GHC was looking at ways of receiving more responsive and dynamic feedback from colleagues. A copy of the presentation received at the meeting would be shared with Governors. **ACTION**

8. GOVERNOR DASHBOARD

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

8.2 Nicola de Iongh (NED) updated on the business on the Resources Committee, noting that the previous meeting had focussed on finance, including system finance, cyber security, business planning, and good discussion and engagement took place around the Trust's Digital and Estates strategies. Nicola de Iongh provided assurance that the Trust's finances were on track at year end.

8.3 Steve Alvis (NED) advised that the Quality Committee had received an excellent deep dive into community hospitals, focusing on delay-related harm, the benefits of step-up beds, and the importance of direct admissions to community hospitals. It

was suggested that this would be a good presentation to bring to a future Council meeting. **ACTION**

8.4 Vicci Livingstone-Thompson (NED) had chaired the February meeting of the Great Place to Work Committee and reported that the Committee had received an update on national workforce policy, approved new KPI domains, had robustly discussed and engaged in the development of the refreshed people strategy, and had reviewed the 2025 gender ethnicity and disability pay gap report.

8.5 Nicola de Iongh advised that the Charitable Funds Committee had approved the establishment of a charity advisory group which aimed to enhance staff input on grant allocation and fund awareness, and the Committee also approved of the refreshed Charitable Fund policy.

8.6 Following a review of the Governor Dashboard, Kizzy Kukreja asked for clarification on the complaints data. Steve Alvis advised that the increase in complaints over the past year was primarily due to the addition of the integrated urgent care service, which brought higher volumes of contacts. However, he added that the increase had slowed, with additional support now in place for the Patient Carer Experience Team. Steve noted that a deeper analysis of complaints, excluding the urgent care service was scheduled for the July meeting of the Quality Committee to better understand underlying themes.

9. CHANGE TO TRUST CONSTITUTION

9.1 Anna Hilditch presented a proposal to amend the Trust constitution in response to national uncertainty about the future of Councils of Governors. It was noted that this had been discussed in detail at the Nominations and Remuneration Committee prior to being received by the Council.

9.2 The NHS 10-year plan suggested Councils of Governors may no longer be required, with powers being removed, but no further guidance had been issued in support of this statement, prompting the need for a pragmatic, flexible approach.

9.3 The proposal would allow for a one-year extension of governor terms under exceptional circumstances, avoiding costly and potentially short-lived recruitment, and maintaining council experience during the transition period.

9.4 Governors discussed the implications and unanimously approved the proposed change for onward presentation to the Trust Board.

10. GOVERNOR ENGAGEMENT UPDATE

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

11. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

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

12. GOVERNOR QUESTIONS LOG

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

12.2 It was noted that four new questions had been received since the last formal meeting in November, as follows:

- *Board Interaction/Engagement with Service Users*
- *Crisis Teams*
- *Sexual Safety Incidents*
- *Wotton Lawn Online Reviews*

13. ANY OTHER BUSINESS

13.1 There was no other business.

14. DATE OF NEXT MEETING

14.1 The next Council of Governors meeting would be held on Thursday 14 May 2026.

15. PRIVATE GOVERNOR BRIEFING

15.1 Douglas Blair briefed governors about a review that was taking place at Wotton Lawn. The review aims to investigate themes and standards of care, involving internal and external partners such as the Safeguarding Team, Integrated Care Board (ICB), and Care Quality Commission (CQC). Douglas Blair agreed to ensure that Governors remained informed as appropriate.

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
17 March 2026	6.3	Governor visiting schedule to be shared once dates confirmed.	First visit to Cirencester took place on 7 May. Further dates currently being confirmed.
	6.3	Governors who would like to take up the opportunity of a visit to Young Glos to let Anna Hilditch know, who would liaise with Alicia Wynn to arrange a visit.	
	7.5	Circulate the staff survey presentation to all governors for reference.	Presentation included alongside paper pack for May meeting
	8.3	Future session for Governors on community hospitals and delay related harm to be scheduled.	Presentation to be received at May CoG meeting

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 28 MAY 2026**
COMMITTEE:	**MHLS COMMITTEE – 15 APRIL 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 subject of delays in Section 136 assessments was discussed, especially overnight. This is due to a variety of reasons, including the lack of availability of Section 12 approved doctors.

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

The Committee received the Annual AMHP Report and was informed that the number of Community Treatment Orders (CTOs) had increased over the past three years. It was noted that this was possibly due to increased morbidity in the county.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Review of Mental Capacity Act Practice (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguard (LPS) Update Report and noted that the new MCA Policy had been approved. The Committee was also assured that work had been completed on Rio to record MCA assessments.

The Committee was informed that the re-audit of the quality of MCA assessment forms had been completed and showed a slight improvement in overall compliance, increasing from 71% to 74%.

It was reported the Berkeley House MCA practice audit had been completed in January 2026, which showed good compliance, noting however, that the sample was very small due to there being only 3 patients within the unit.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK UPDATE

The Committee received the Risk Report for quarter 4 and noted risk 180 – Mental Health Act Changes for which the Committee has oversight for, for which a Programme Group was being set up to mitigate.

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

It was highlighted within the AMHP Report that there had only been 3 instances where SWAST transport had taken over 4 hours to attend during the year.

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

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

- CQC & Mental Health Act Round Up
- MH Legislation Operational Group Update
- MHAM Forum Minutes and Update

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 28 MAY 2026**
COMMITTEE:	**GPTW COMMITTEE – 28 APRIL 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Karen Clements, Chair of Committee

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

The Committee received an update that the British Medical Association (BMA), were initiating a ballot for industrial action on 11 May. This would cover Consultants and Specialist, Associate and Specialty (SAS) doctors. The Committee noted that the risk would be reviewed and updates on developments and any necessary planning would be provided at the next committee meeting.

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

The Committee received a report on Transforming People Services, which was a new operating model for NHS people services. The Committee noted that the nationally approved board pack providing the initial implications for the two 3-year accelerator pilot regions (London and the Southwest). It was recognised that there would be an impact on elements of the Trust's People and OD provision and structures, particularly in 2027/28 and 2028/29. It was also noted that there would also be several opportunities and risks from the delivery of the programme, however it was currently too early to plan for these. Regular updates would be provided to the Committee. It was noted that provider Trust Boards across the pilot regions were asked to consider and confirm support for the programme and to respond on related expectations. This will be covered off via a separate Board paper.

The Committee received and supported the reworked People Strategy Refresh, which outlined how the strategy would support the Trust's 5 strategic focus areas following previous discussions and feedback from the Committee and Trust Board. The Committee noted the clarity provided by the detailed supporting appendices and the proposal of baseline measures.

The Committee received an update on the Staff Survey and noted that the free text analysis provided additional data to inform actions. It was acknowledged that issues shared were sometimes beyond individual resilience and wellbeing and spoke to wider structural and systemic issues, which would require action beyond the People Strategy i.e.: digital, estates, quality and nationally.

The Committee received the Freedom to Speak Up (FTSU) Report and was advised of the lower sense of psychological safety and increase in reporting relating to FTSU psychological safety and inter-personal relationships. It was noted that this would be further reviewed in a scheduled Board Development session.

The Board is advised that the GPTW Committee will carry out a deep dive into risk in light of discussions at the meeting to ensure new threads (psychological safety, burnout, industrial action etc) were being accurately reflected in risk scoring and mitigations.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee was assured by the People Strategy alignment with the Trust Strategy as detailed within the report and the thorough discussions held.

The Committee received the Performance Report – Workforce KPIs and was assured by how the Trust benchmarked against other organisations.

The Committee received assurance on recruitment and vacancies and noted that the overall positive performance was not masking clinical safety issues in in-patient services. The Committee will further discuss whether overall organisational vacancy targets should be considered across all teams at the next meeting.

APPROVALS: Decisions and Approvals made by the Committee

The Committee supported the People Strategy Refresh going to the May 2026 Board.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report for quarter 4, was satisfied by the current ratings and were minded not to support an adjustment currently to the ratings pending a deep dive on People risk.

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

The Committee applauded the data driven approach and the robust and helpful maturity assessment, underpinned by academic evidence, taken in the development of the People Strategy Refresh.

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

The Committee **received** and **noted** the following summary reports from management groups:

- Joint Local Negotiating Committee (JLNC)
- Joint Negotiating and Consultative Committee (JNCF)
- Workforce Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 28 MAY 2026**
COMMITTEE:	**RESOURCES COMMITTEE – 30 APRIL 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Debbie Forster, Chair of Committee

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

The Committee received the Quality and Performance Report and was informed of the following alerts for indicators in exception:

- N70 - MH: Average length of stay for patients in Adult Acute and PICU Mental Health Beds – It was highlighted that discharge plans for patients with extended length of stay would have a detrimental impact on performance.
- B51 - PH Core Bed Inpatients Average Length of Stay – It was noted that Thames Ward would be excluded from the indicator, as agreed previously by the Board. The Committee was informed that from April, the improvement target for CoHo core beds was 30 days, and that this would be a challenge to meet with current system position, and a high delay related discharge bed base.
- B53 - PH Stroke Inpatients Average Length of Stay – It was reported that this KPI was not met in March 2026 due to a long length of stay discharge case. The Committee noted that the KPI would have achieved the threshold without this. The KPI would also be impacted in April, due to a further long stay discharge.
- O31 - Wheelchair Service: Under 18s – The Committee noted that there had been a significant increase in referrals received in March 2026 and that this would affect performance over the upcoming months.
- O53 - MH Older Adult Inpatients Average Length of Stay – The Committee noted that progress had been made in the previous quarter, however the reduction of Mental Health Social Workers (Delegated Responsibilities/ Risk ID 663) was having an early impact.
- N69 - PH Percentage of bed days occupied by patients when they are ready to be discharged – The Committee noted that although the indicator remains compliant, services felt that this this was being under reported due to legacy data capture processes. System configuration improvements had been completed, and work was in progress with the service to more accurately present performance, however the indicator was expected to then present in exception initially.

The Committee was alerted that risk 604, relating to the quality of care of the general medicine and speech and language, was the highest scoring risk on the risk register. It was reported that work was underway to reduce this.

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

The Committee was advised on areas of ongoing monitoring or development within the Quality and Performance Report, which included the following indicators:

- N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice
- N37 - Community PH: CYP Community Services Waiting List % seen within 52 weeks – Gradual improvements anticipated with recovery milestones to be set, it was noted that was being maintained.
- N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4) – it was noted that this was behind the initially forecasted recovery plan to achieve 40-50% by April 2026 due to winder surge period continuation.
- L21 - MH Liaison - number of routine referrals seen within 24 hours (ICS portfolio)
- O02 - Adult SLT % routine referrals treated within 18 Weeks – It was noted the recovery plan had been implemented and appeared to be stabilising performance; an initial recovery date of June 2026 is being reviewed.
- O11 and O12 – ICT Occupational Therapy Services % urgent referrals treated within 2 weeks and % routine referrals treated within 18 weeks – It was reported that an Improvement project was in place with Nursing, Therapies and Quality team.

The Committee received the Strategic Focus Area Update on Neighbourhood Health and was informed of the new national framework and its requirements. The Committee endorsed the approach taken by the Trust for developing the Neighbourhood Health plans internally alongside partners.

The Committee received the Digital Strategy 2026-2031 and welcomed the progress made. Members noted a divergence of views on the level of ambition reflected in the strategy and requested that (in the same way that the People Strategy progressed) a further draft be brought back to a pre-committee working session before the strategy is presented for full approval.

The Committee received the Estates and Facilities Management Strategy and acknowledged that the additional progress made in the accompanying presentation and the stakeholder engagement undertaken. Members requested further development of the future vision for estates, facilities and service delivery environments, and that a revised draft be shared for a pre-committee working session before the strategy is presented for approval.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report and noted the positive performance on the overall month 12 position for the Trust and the progress made towards the Trust's Better Payment Policy, which exceeded the national target.

The Committee received the Business Planning Report and was assured that 98 of the business planning milestones had been achieved or partly achieved in the year.

The Committee received the Service Development Report and noted the assurance provided.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report and Board Assurance Framework for quarter 4. It was reported there were 34 risks currently on the Corporate Risk Register for the Committee's oversight and only risks above the risk appetite were reported.

It was raised that BAF risk 06 – had remained static all year. It was reported the risk had reached its target but was above risk appetite. The Committee agreed to further monitor the risk.

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

Positive performance was reported for the period via the Quality and Performance Report, including; sustained compliance around IUCS Top of the Directory of Services, with notable positive impact in selection of Pharmacy First and Pharmacy Plus, and also improvements regarding to indicators O05 (MSKAPs 5 Urgent treated within 2 weeks), O07 (MSK Physiotherapy % treated within 2 weeks) and (O20 Paediatric Speech and Language Therapy % treated within 18 weeks).

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

The following summary reports from Management Groups were **received:**

- Business Intelligence Management Group
- Capital Management Group
- Digital Group
- Strategic Oversight Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 MAY 2026**
COMMITTEE:	**QUALITY COMMITTEE – 5 MAY 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, 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

The Committee was informed of the 24% increase in complaints received and noted that this was in line with the national pattern. It was reported that this was the first time in the recent years that a lack of resolution within 6 months was being seen. Solutions were being considered, noting capacity issues.

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

Patient Carer Race Equality Framework (PREF) was included in the Quality Dashboard received by the Committee, noting that this was a mandated requirement within the Trust's NHS contract. It was identified as an area which the Committee should focus on.

The Committee received the Quality Assurance Group (QAG) Summary reports and was advised that the CQC drug self-assessment had been completed and showed a compliance of 87%. An improvement plan and annual statement of assurance plan would be received at the next QAG meeting in July.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Draft Quality Accounts, and it was noted they would also be received by the Trust governors.

The Committee received the Triangle of Care annual Report and noted the assurance provided and endorsed the next steps and future objectives.

The Committee received the CQC Community Mental Health Survey and was assured on the results shared and the national comparison. It was noted that an improvement plan was being developed to address areas identified for improvement.

The Committee received the Patient and Carer Experience Team (PCET) Annual Report and was assured by the activity presented.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report and Board Assurance Framework (BAF) for quarter 4. The Committee noted that all risk scores had been reviewed, and changes were noted to BAF risks 01 and 09. It was reported risk 01 had increased from a score of 9 to 20, and risk 09 had increased from a score of 16 to 20. Both increases were due to the largescale safeguarding review.

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

The Service Improvement Story on NHS Talking Therapies and the Long-Term Conditions Pathway was shared, and the Committee congratulated the 100% retention rate in groups highlighted and recognised that partnership working was evident.

The Occupational Therapy Vocational Rehabilitation deep dive was positively received by the Committee and benefits and opportunities were highlighted.

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

A verbal update on Berkeley House was provided.

The Committee **received** the Trust response to the Largescale Safeguarding Enquiry.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 MAY 2026**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 14 MAY 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Bilal Lala, Chair of Committee

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

The Committee received the Accessible Information Standard (AIS) Internal Audit report and noted this received ratings of limited in relation to design and moderate for effectiveness, with one high and four medium priority findings.

The Committee raised concerns regarding lack of formal governance structure to implement the AIS, the absence of implementation plan and incomplete AIS self-assessment framework.

Further concerns were raised regarding interoperability and information sharing across partners, including the lack of AIS functionality within JUYI and uncertainty over future ICB digital development plans.

The Committee noted the risk that the Trust may not achieve full AIS compliance by the target date of March 2027, and it was agreed this be referred to the Resources Committee for ongoing review and assurance.

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

The Committee received the Quality Governance Internal Audit report, which was rated moderate for both design and effectiveness, with three moderate priority findings relating to governance framework, interaction with attendees of the Quality Assurance Group (QAG) and the need for improved documentation in the Positive and Safe Group.

The Internal Audit Follow Up Report was received by the Committee, and it was raised that four actions were overdue, mainly relating to Procurement Shared Services. The Committee would continue to engage with the service.

The Committee discussed the asset valuation reported in the Draft Financial Annual Accounts and raised concern regarding forthcoming changes to International Accounting Standard 16 (IAS16) and the potential significant impact on asset valuations and depreciation charges from1st April 2028.

The Committee received the Trust Compliance Report and were generally assured, however raised concern that some governors had not returned their declarations.

ASSURE: Inform the Board where positive assurance has been achieved

The Internal Audit Draft Annual Report and Head of Head of Internal Audit Opinion for 2025/26 was received, with a '*generally satisfactory with improvements required in some areas'* opinion, noting the final opinion would be provided following the final two internal audits being received at the Committee meeting in June.

The External Audit Progress Report was received, and the Committee was assured that everything was on track. It was noted that this was Sumer's first year working with the Trust.

The Counter Fraud, Bribery and Corruption Progress Report was received, and it was noted that good progress had been made and that the Counter Fraud Functional Standard Return (CFFSR) had been signed off by the Director of Finance and would be reviewed and signed by the Committee Chair prior submission.

The Committee reviewed the Counter Fraud Summary of Investigations and was assured by the progress being made and noted that the pace of identifying issues for investigation had increased.

The Committee endorsed the Going Concern reports for approval by the Trust Board.

The Committee endorsed the Senior Information Risk Owner (SIRO) report for onward approval by Trust Board.

The Committee endorsed the Provider Licence Declaration for approval by the Trust Board.

APPROVALS: Decisions and Approvals made by the Committee

Nothing report.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report for quarter four and noted that there were currently 48 reportable risks as defined by the risk appetite on the risk register.

The Committee discussed attention to be given to the target completion dates and for consideration to be given as to whether trajectories are to be introduced to demonstrate progress.

A discussion was held on the pressures of implementing a range of change within the organisation, which had been demonstrated in several agenda items. It was suggested that this could be reflected in BAF risk 7 (organisational capacity for change).

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

The Committee received the Budgetary Controls Internal Audit Report which highlighted good compliance.

The Single Tender Waiver Benchmarking Report 2024/25 was received, which evidenced that the Trust continued to benchmark favorably. It was noted that this would continue to be monitored with the newly appointed Director of Finance.

The Committee noted Trust ended the year with a £2m surplus, in part due to receipt of national funding.

The Committee received the Annual Finance Compliance Report and noted the excellent progress made with debtors with a 30%/ £2.8m reduction in year.

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

The following items were **received** and **noted** by the Committee:

- Counter Fraud, Bribery and Corruption Work Plan
- Draft Annual Report
- Internal Audit Progress Report
- Summary Reports from the following Management Groups:
  - BEME Management Group
  - Information Governance Group
  - Risk Management Group