with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 30 July 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	01/0726	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0726	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/0726	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/0726	Minutes of the meeting held on 28th May 2026	Approve	**Paper**	Chair
	05/0726	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0726	Questions from the Public	Assurance	Verbal	Chair
10:40	07/0726	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/0726	Report from Chief Executive	Assurance	**Paper**	CEO
STRATEGIC					
11:00	09/0726	Estates and Facilities Strategy	Approve	**Paper**	DoF
BREAK – 11.15am (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:25	10/0726	Finance Report	Assurance	**Paper**	DoF
11:35	11/0726	Quality Dashboard Report M3	Assurance	**Paper**	DoNTQ
11:50	12/0726	Quality and Performance Dashboard Report M3	Assurance	**Paper**	DoIP
12:05	13/0726	Guardian of Safe Working Hours Q4	Assurance	**Paper**	MD
12:15	14/0726	Working Together Annual Report 2025/26	Endorse	**Paper**	DoIP
GOVERNANCE					
12:25	15/0726	Modern Slavery Statement – Annual reconfirmation	Endorse	**Paper**	DoCG
12:35	16/0726	Audit & Assurance Committee Annual Report	Assurance	**Paper**	Audit Chair
TO NOTE	17/0726	Council of Governor Minutes - 14 May 2026	Information	**Paper**	DoCG

TIME	Agenda Item	Title	Purpose	Comms	Presenter
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:40	18/0726	Charitable Funds Committee (10 June)	Information	**Paper**	CF Chair
	19/0726	Audit & Assurance Committee (18 June) • Provider Licence Self-Certification	Endorse	**Paper**	Audit Chair
	20/0726	Resources Committee (25 June) • Digital Strategy 2026-2031	Information	**Paper**	Res. Chair
	21/0726	Great Place to Work Committee (30 June)	Information	**Paper**	GPTW Chair
	22/0726	Quality Committee (7 July) • GHC Quality Report 2025/26	Information	**Paper**	Quality Chair
	23/0726	ATOS Committee (9 July)	Information	**Paper**	Chair
	24/0726	Mental Health Legislation Scrutiny Committee (15 July)	Information	**Paper**	MHLS Chair
CLOSING BUSINESS					
13:00	25/0726	Any other business	Note	Verbal	Chair
	26/0726	**Dates of future Board Meetings 2026** • Thursday, 1st October • Thursday, 26th November	Note	Verbal	All

with you, for you

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AGENDA ITEM: 04/0726

MINUTES OF THE TRUST BOARD MEETING

Thursday, 28 May 2026
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Helen Blanchard, Non-Executive Director
Sarah Branton, Chief Operating Officer
Karen Clements, Non-Executive Director
Debbie Forster, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Bilal Lala, Non-Executive Director *(MS Teams)*
Vicci Livingstone-Thompson, Non- Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Amjad Uppal, Medical Director

IN ATTENDANCE:
Olesya Atkinson, GHC - Observing
Nick Boor, GHC – Observing *(MS Teams)*
Helen Child, Director of Corporate Governance
Des Gorman, Deputy Director of Improvement & Partnership
Katie Hartwright, Transition Director
Anna Hilditch, Deputy Trust Secretary
Esther Mitchell, GHC - Observing
Farzana Mohammed, External – Observing (MS Teams)
Kate Nelmes, Head of Communications
Sonia Pearcey, FTSU Guardian
Danielle Simons, GHC - Observing
Hannah Williams, Deputy Director of Nursing, Therapies and Quality

1. WELCOME AND APOLOGIES

1.1 Apologies were noted from Steve Alvis, Rosanna James, Nicola Hazle and Cathia Jenainati.

1.2 The Board welcomed new Non-Executive Director Helen Blanchard to her first Board meeting. Helen had commenced in post on 25th May 2026.

1.3 The Board also welcomed Katie Hartwright, who had joined the Trust for a 6 month fixed term period as Transition Director.

2. DECLARATIONS OF INTEREST

2.1 Nicola de Iongh informed the Board that she had accepted a role as a non-executive director with Ecctis, starting on 1st June, for an initial period of 36 months. Ecctis is an Employee Owned Trust based in Cheltenham who specialise in helping institutions, governments and employers understand how international qualifications compare against those in the UK.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Jordan to the meeting, who was joined by Rachel Andrews (Health Visitor) who spoke about her experiences and the use of Video Interaction Guidance (VIG).

3.2 Rachel introduced the story, and explained that Video Interaction Guidance (VIG) is a strength-based intervention aimed at enhancing communication and attunement between parents and children by micro analysing video footage of their interactions. The process is highly individualised, focusing on the specific needs and goals of each client, and is supported by robust research.

3.3 Jordan described her struggles with guilt over not being able to breastfeed her second child, the impact on her mental health, and challenges with self-care. She recounted how VIG, combined with emotional well-being visits and CBT (Cognitive Behavioural Therapy), helped her address depression and anxiety, leading to improved self-appreciation and reduced feelings of guilt.

3.4 The VIG intervention with Jordan involved five cycles of video consultations and emotional well-being activities. Through reviewing video snippets, Jordan was able to recognise positive interactions with her child, which increased her confidence as a mother and helped her trust her own choices, resulting in decreased anxiety and depression.

3.5 Jordan discussed the difficulties she faced in accessing counselling and perinatal mental health services, noting that she was initially declined for certain referrals and only learned about VIG through a health visitor. Rachel Andrews highlighted the challenge of high referral thresholds and the need for more permanent funding for VIG, emphasising its preventative value.

3.6 In response to questions, Jordan explained that the benefits of VIG were gradual, with small moments in video reviews helping her see her strengths as a parent. She emphasised the importance of being asked what she wanted to achieve and the value of seeing herself through another's perspective, which was not possible through CBT alone.

3.7 The Board thanked Jordan for attending and sharing her positive story.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 26 March 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 Three questions had been received in advance of the meeting from Bren McInerney. The questions and responses were shared with Board members and read out at the meeting. A formal written response would be sent to Bren McInerney following the meeting, and a record of both the questions and responses would be included in the meeting minutes for the record.

7. PEOPLE STRATEGY 2026-2031

7.1 The Board welcomed Michelle Hurley-Tyers (Deputy Director of People) who was 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.

7.2 The People Directorate had led a comprehensive refresh of the GHC People Strategy over 9 months, developed in direct response to what our colleagues have told us and aligned to our Trust Five-Year Focus and national NHS priorities. The Strategy had incorporated the feedback from the Great Place to Work committee and previous Board sessions. Karen Clements, Chair of the GPTW Committee confirmed that the Committee had robustly reviewed and carried out deep dives as part of the People Strategy development, and she said that she was happy to see that the comments and feedback had fed through to the final version.

7.3 The Board discussed the balance between top-down and bottom-up inputs, the integration with NHS and local plans, and the need for clear measurement and prioritisation.

7.4 Debbie Forster asked what colleagues felt were the biggest opportunities that had been identified as part of the Strategy, and also any potential challenges. Neil Savage said that he was excited about the digital aspects, which would be a huge enabler. Michelle Hurley-Tyers agreed, adding that there was a real opportunity for teams to work differently. It was agreed that capacity and the careful sequencing of initiatives would need to be considered by way of potential challenges.

7.5 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. There was also an acknowledgement in relation to the responsiveness to the feedback that the team had received.

7.6 The Board **noted** the additional activity undertaken on the refreshed People Strategy since the last Board Meeting in March 2026 and was happy to **approve** the newly revised GHC People Strategy 2026-2031.

8. ANTI-RACISM STATEMENT AND PCREF ACTION PLAN

8.1 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.

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

8.3 A Board Development Day held in April 2026, provided an 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 the Anti-Racist Intent Statement and the PCREF Action Plan at Trust Board is a public commitment of the organisation to the expectations of the Framework, following which both will be published on the Trust's public facing website.

8.4 Douglas Blair presented the co-produced Anti-Racist Statement and Year 1 Patient Carer Race Equality Framework (PCREF) Action Plan to the Board. He advised that both documents were developed through extensive co-production, and set out stretch ambitions for reducing structural inequities in service delivery and internal behaviours, with a focus on both immediate actions and longer-term goals.

8.5 The Board discussed the challenges in implementing the PCREF, such as the need for dedicated resources, the risk of actions becoming compliance exercises, and the importance of understanding root causes of inequity. Feedback included suggestions to clarify language around co-production, to ensure ambitions were sufficiently challenging, and to improve the alignment between ambitions and action plan items. The Board agreed to make these adjustments and to focus on both behavioural and structural aspects of inequity.

8.6 Graham Russell thanked Douglas Blair for presenting this item, noting that this was a whole Board responsibility. Thanks, were also given to Nicola Hazle for her Executive leadership of PCREF and the progress that had been made over the past year to invigorate the Trust's approach. The Board emphasised the need for regular updates, transparent communication, and integration of the action plan into performance and assurance frameworks. There was a need for communications to be accessible and impactful, ensuring that all staff understand and engage with the anti-racist agenda.

8.7 The Board **approved** the Trust Anti-Racist Intent Statement, subject to some suggested amendments. The Board also approved the Trust PCREF Action Plan, noting that both documents would be published on the Trust's public facing website.

9. RISK APPETITE STATEMENT 2026/27

9.1 Helen Child presented the Risk Appetite Statement, which set out the Board's tolerance for different types of risk, including governance, transformation, and

regulatory compliance. The document was intended to guide risk management across the organisation and inform decision-making at all levels.

9.2 Board members discussed the need to make the risk appetite statement accessible and meaningful for operational colleagues, emphasising that it should guide real-world decisions rather than remain a technical document. Suggestions included explicit references to health and safety and clearer communication of expectations.

9.3 A question was raised about how risk appetite informs investment and innovation. Sandra Betney suggested that whilst the statement sets parameters, actual investment decisions are constrained by budget structures and capital availability. The Board agreed that the statement should encourage innovation and provide permission to take calculated risks.

9.4 The Board **approved** the Risk Appetite Statement, with a commitment to further develop tools and communications to ensure effective application throughout the organisation.

10. BOARD ASSURANCE FRAMEWORK

10.1 Helen Child presented the Board Assurance Framework (BAF) for 2025/26, which reflected the Trust's Strategic Aims and Objectives. The BAF had been reviewed by individual Executive owners throughout the year, as well as being presented quarterly to the relevant Board Committees, and was presented to the Board for assurance of actions in place to control risks.

10.2 A summary of the key changes and items for the attention of the Board were set out in the report, and in summary, in the year under review no new risks had been added or removed, and all risk scores (including inherent, current, and target) had been reviewed in line with the Trust's risk scoring methodology. This had 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.

10.3 The Board was asked to **note** that *Risk 6: Funding for Transformation,* had remained static with a current score of 12 all year. It had reached its target of 12, however, this was above risk appetite (10). It was agreed that further discussion was required as to whether the Board would tolerate the risk outside of appetite and it was noted that this had been referred to the Resources Committee for review.

10.4 A request was made that future BAF reports include reference to the Risk title alongside the numbering in the cover report, for ease of reference. **ACTION**

11. QUALITY AND PERFORMANCE DASHBOARD

11.1 Sandra Betney and Sarah Branton presented the Quality & Performance Dashboard, which provided a high-level view of performance and quality indicators in exception across the organisation for the period to the end of April 2026.

11.2 One new KPI (Key Performance Indicator), had gone live in the dashboard in April 2026. There were also 24 KPIs being monitored within the Development Source of the dashboard portfolio, awaiting authorisation from owners to go-live. This would bring the overall indicator number to 176, with a further 18 in development for Q1 and across 2026/27.

11.3 Sandra Betney advised that the 2026/27 NHS Oversight Framework (NOF) was expected in May 2026 and a summary would be provided at the Resources Committee as part of the dashboard in June 2026. An evaluation of performance for likely 2026/27 MH indicators was underway, and those NOF measure IDs currently in exception were highlighted within the dashboard.

11.4 The Board was alerted to three eating disorder service measures which were now in exception. Indicator N71 - *MH: Average Length of Stay for Patients in Older Adult Acute Mental Health Bed* was also flagged to the Board, noting that long length of stay discharges were impacting performance. This target was expected as a new 2026/27 NOF measure, so more work was needed to address this. Sarah Branton advised that weekly line by line reviews were carried out to assess what it was that was preventing people from being discharged.

11.5 Sarah Branton highlighted indicator N69 - *PH Percentage of bed days occupied by patients when they are ready to be discharged*. This indicator was now in exception due to a change in recording process enacted in March 2026. This had previously been flagged to the Board, so the increase had been expected.

11.6 The Board **noted** the increase in mental health out of area placements. Sarah Branton advised that further discussion would be taking place at the June Resources Committee to look at additional measures that could be put in place to manage this position.

11.7 Karen Clements **noted** the increase in complexity of people being admitted to the community hospitals. Sarah Branton said that this did make the position more challenging and more work was needed to fully understand admissions and the need for more complex discharge packages.

11.8 The Board **noted** the Quality and Performance Dashboard Report for April 2026/27 and acknowledged that appropriate service improvement action plans were being developed or were in place to address areas requiring improvement, within Operational governance processes.

12. QUALITY DASHBOARD REPORT

12.1 The Board received the Quality Dashboard, which showed the data for April 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.

12.2 Hannah Williams advised that the number of reported falls continued 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 had for the third month in a row followed a reduced reporting pattern, which may be indicative of coming out of winter pressures.

12.3 The Board was pleased to **note** that in response to a longstanding recommendation, Safeguarding practitioners have now planned, designed and implemented domestic abuse training for Trust staff facilitated by Gloucestershire Domestic Abuse Support.

12.4 Hannah Williams highlighted the increase in self-harm incidents, specifically at Wotton Lawn, with an increase of 35 incidents reported on the previous month's data. It was noted that all incidents had been reported as no or low harm. Priory Ward accounted 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. Hannah Williams said that further analysis of this data was being carried out.

12.5 Hannah Williams advised that the Learning from Deaths Report (LFD) (Quarter 4) was presented to the Quality Committee in May, which took assurance that none of the deaths that were reviewed were considered more likely than not to be due to problems in care.

12.6 Amjad Uppal referenced the data around Patient Safety Incident Reviews. It was noted that 10 PSIIs/ Care Reviews had been open longer than 6 months, with 3 exceeding 12 months. Amjad advised that he was 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.

12.7 Karen Clements noted the incident data and the current escalation pressures in the community nursing teams which were resulting in delays in the validation of incidents related to pressure ulcers. Hannah Williams informed the Board that an improvement plan was now in place, and this position was expected to resolve by next month.

12.8 Bilal Lala said that despite still meeting target, it was disappointing to see that the Friends and Family test scores had dropped to 90% in April, which was the lowest positivity rate recorded. Bilal Lala also noted the IUCS pilot process (launched on 1st April and led by IC24) which had reduced the number of complaints requiring GHC action by more than 50%. He said that this appeared to be a positive step, however, he sought assurance that the Trust would not lose oversight of complaints and key themes arising from the IUCS service. Hannah Williams offered assurance that GHC would still have full oversight of all complaints received.

13. FINANCE REPORT

13.1 The Board received the Finance Report, which provided an update on the financial position of the Trust at month 1. The financial position was discussed and reviewed in detail at the Resources Committee in April.

13.2 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 had a surplus of £0.004m, in line with the plan. Cash at the end of month 1 was £37.167m, which was £3.5 below plan.

13.3 The cost improvement programme had delivered £2.941m of recurring savings through budget setting. The target for the year is £14.459m. £7.047m is unidentified (39.23%). The Non recurrent savings target is £3.475m of which £0.103m has been delivered. All savings have been identified. Bilal Lala asked whether CIP delivery was in line with previous years, and whether additional actions were required to increase the identification of recurrent savings. Sandra Betney informed the Board that a detailed analysis was due to be presented back to the Resources Committee in June, with oversight at the weekly Executive Team meetings.

13.4 The 2026/27 Capital plan is £16.208m with £2.895m of disposals leaving a net £13.313m programme. After disposals net spend to month 1 was (£0.737m) against a budget of (£0.242m).

13.5 The Trust's agency and off framework agency usage was included in the report, with £0.209m on agency staff in month 1, against the plan of £0.202m. There were 4 off framework shifts 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 £1.142m on bank staff in month 1, against the plan of £1.391m.

13.6 The 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%.

13.7 As reported to the Resources Committee in April, a business case outlining the transfer of Edward Jenner Court from NHS Property Service would be presented at the July Board meeting (subject to adequate information being received from NHSPS). It was noted that the Cirencester Hospital redevelopment business case was planned to be presented to the Resources Committee in October and the Trust Board in November.

13.8 The Board **noted** the month 1 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. The Board also **approved** the updated Capital plan.

14. FREEDOM TO SPEAK UP (FTSU) REPORT

14.1 The Board welcomed Sonia Pearcey, FTSU Guardian to the meeting who presented the Freedom to Speak Up report, providing information and assurance in relation to Freedom to Speak Up activity during 2025/26 and the forward-looking plans.

14.2 Sonia Pearcey reported that most concerns raised through Freedom to Speak Up related to interpersonal and behavioural issues rather than patient safety, a trend consistent with local comparators. The Board discussed the need to shift the focus towards more patient safety and quality concerns, ensuring that FTSU did not become an alternative HR route. An FTSU Board seminar would be taking place in June where this would be reviewed further.

14.3 Neil Savage described plans to train more mediators to resolve issues earlier and reduce reliance on formal grievance processes. The Board discussed the importance of accountability and ensuring that concerns are addressed effectively across the organisation.

14.4 The report highlighted the impact on colleagues who raise concerns, especially as cases progress to formal stages. The Board acknowledged the need to support staff through the process and to learn from organisations with strong speaking-up cultures.

14.5 Sonia Pearcey advised that a review had been carried out of the scores received around Speaking Up within the NHS Staff Survey 2025, which included an analysis of the free-text comments received. Of the four speaking up related questions within the Staff Survey, all show reduced confidence and were collectively responsible for the fall in the theme score. Key issues include reduced confidence that the organisation will address concerns, a lower sense of psychological safety, reduced perception that the organisation acts on patient/service user concerns and lower confidence around reporting violent incidents. These themes are closely linked to staff wellbeing, patient safety, retention, and organisational culture.

14.6 The Board thanked Sonia Pearcey for this report, noting that further discussion would take place at the scheduled June Board seminar session.

15. REPORT FROM THE CHAIR

15.1 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.

15.2 Graham Russell reported on recent visits and engagement with community and partner organisations. In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, Graham said it was a real privilege to visit the Children in Care Team (Rikenel) and the Gloucester Reablement Team (Collingwood House) on 14th April to present their 'Making a Difference' awards.

15.3 The annual Trust awards took place at Hatherley Manor Hotel on 15th 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. Graham Russell said that this was a fantastic celebration with teams and services represented from across the county, and from a huge range of services and specialities.

15.4 Alongside other Board colleagues, Graham Russell had the pleasure of attending the Volunteer and Experts by Experience Thank You Tea Party Celebration on 6th May. Graham said that this was a simply marvellous occasion to thank and celebrate the difference made by Experts by Experience and volunteers, noting that the Trust is a better organisation because of their contribution, and we improve through their insights, lived experience, and engagement.

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

16. REPORT FROM CHIEF EXECUTIVE

16.1 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.

16.2 The CEO Overview was **noted**, setting out key financial, quality and performance headlines.

16.3 The Board **noted** that the Trust was continuing 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. Douglas Blair advised that this 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.

16.4 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.

16.5 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 1st 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, the Trust will also temporarily

disregard the 3,500 mileage cap during April, May and June 2026 in advance of the national changes.

16.6 The Board **noted** the updates provided.

17. SENIOR INFORMATION RISK OWNER (SIRO) REPORT 2025/26

17.1 The Board received the SIRO report 2025/26 which provided assurance to the Board on the effectiveness of controls for Information Governance (IG), data protection and confidentiality, and to document the Trust's compliance with legislative and regulatory requirements. This report had also been received and discussed at the Audit & Assurance Committee on 14th May.

17.2 The Board **noted** that there continues to be an impact on the IG activity as the Trust continues to move forward with new ways of working, embracing 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).

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

17.4 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.

17.5 The Board received and **endorsed** this annual report, noting that the role of SIRO had now transferred to Rosanna James as part of the Executive portfolio review.

18. USE OF THE TRUST SEAL 2025/26

18.1 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.

18.2 In 2025/26, the Seal was used on 9 occasions. The Board received the register of sealed documents, which reflected the number of property disposals that had taken place during the year.

19. COUNCIL OF GOVERNOR MINUTES

19.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 17 March 2026.

20. BOARD COMMITTEE SUMMARY REPORTS

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

- Mental Health Legislation Scrutiny Committee (15 April)

- Great Place to Work Committee (28 April)
- Resources Committee (30 April)
- Quality Committee (5 May)
- Audit & Assurance Committee (14 May)

21. ANY OTHER BUSINESS

21.1 There was no other business.

22. DATE OF NEXT MEETING

22.1 The next meeting would take place on **Thursday, 30 July 2026**

QUESTIONS FROM THE PUBLIC

QUESTION 1

Does Gloucestershire Health and Care NHS Foundation Trust believe it is a) institutionally racist b) structurally racist? How and when has/could this this be communicated to the public in Gloucestershire, along with the appropriate evidence?

Bren McInerney

TRUST RESPONSE

The question of whether the NHS is institutionally or structurally racist is complex and widely debated. So far, there is not a single, universally agreed definition or diagnostic test for institutional or structural racism, and different people and organisations reach different conclusions based on interpretation of the evidence.

However, what can be stated with confidence, is that there is clear and well-documented evidence of persistent inequalities in both health outcomes and workforce experience for people from ethnically diverse backgrounds within the NHS.

We do know that service users from some ethnic minority groups experience poorer health outcomes and sometimes inequitable access to certain services. There are also inequalities related to other protected characteristics, for example, for disabled and Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) people. Many of these longstanding disparities are recognised nationally and are part of the reason for nationally driven programmes such as the Patient and Carer Race Equality Framework (PCREF) and the clinical service elements of the Equality Delivery System (EDS).

Additionally, within the NHS workforce locally and across England, annually published data from the Workforce Race Equality Standard (WRES) shows consistent differences in experience between White colleagues and colleagues from minority ethnic backgrounds. Examples of these differences can include lower likelihood of entering senior roles, higher likelihood of experiencing discrimination, and disparities in disciplinary processes. Again, for workforce, additional frameworks, such as the previously mentioned EDS, the People Promise and wider equality, diversity and inclusion policies, exist precisely because these inequalities have been identified and evidenced as requiring sustained remedial action.

While the existence of these frameworks does not in itself label the NHS as institutionally or structurally racist, it does clearly indicate that national and local system-wide patterns of inequality exist and need to be addressed at an organisational and structural level.

As a Board, we acknowledge that there are inequalities and that racism is a real and evidenced experience for many. We take our responsibilities in acknowledging this seriously, and we are taking targeted actions to reduce disparities and experiences of racism and to make sure that services and our workplaces are equitable, inclusive, and fair for all. We do recognise that some colleagues and service users experience these inequalities as systemic and deeply embedded. That perspective is understandable and needs to inform how we respond. At the same time, there is also a shared commitment across the whole of the NHS to improving fairness and tackling discrimination in all its forms. The PCREF update and the forthcoming WRES submission and action plan coming later this year are some of the ways we are tackling this.

QUESTION 2

How can Gloucestershire Health and Care NHS Foundation Trust better address the need for the expansion of acronyms in their publicly facing board papers so all the publicly facing board papers are inclusive and transparent to all?

Bren McInerney

TRUST RESPONSE

We recognise that the use of acronyms and technical language can make it more difficult for people to read and relate to our papers and discussions, particularly when meetings are held in public. While Board meetings are held in public and are not public meetings in the sense of open participation, we remain committed to ensuring that the information we share is as accessible and transparent as possible.

We are actively working to reduce our reliance on acronyms and, where they are necessary, to ensure that they are clearly explained within our papers. We have asked report authors to define terms on first use and to use plain English wherever possible. However, as you have noted, some acronyms do occasionally still appear without explanation, and we acknowledge that this is an area where we need to continue to improve.

Your feedback is helpful in reminding us of the importance of this, and we will continue to review and strengthen our approach so that our papers can be more easily understood by all who wish to follow our work.

QUESTION 3

How many, and what percentage of the Gloucestershire Health and Care NHS Foundation Trust staff have had racial bystander training? If so, how has the impact of this training been measured to address racial inequities?

Bren McInerney

TRUST RESPONSE

99.1% of Trust colleagues have completed Equality and Diversity and Human Rights - Level 1 training. This mandatory training includes sections on recognising and tackling health and workplace inequalities, as well as “How to challenge prejudice, discrimination, and unfairness.” This latter section includes topics of allyship and how not to be a passive bystander. Additionally, Trust colleagues have participated in the One Inclusive Gloucestershire Collaborative with Integrated Care System partners during 2024 and 2025. This included 109 colleagues attending three allyship training programme cohorts. Future allyship and bystander training options are being reviewed regionally and with system partners, and the Trust’s refreshed People Strategy continues with the prioritised theme and workstream of equality, diversity, and inclusion (EDI). This will require regular review and development of training offers.

Whilst training is important, we recognise that training itself will not resolve racism in the Trust as this requires a cultural, behavioural shift but it is part of our journey to get there.

Our PCREF action plan includes a training target for colleagues in our Mental Health services as this remains the initial focus of work on PCREF. We welcome the separate suggestion of having quarterly targets and will incorporate this into the work of the PCREF steering group which will work up an action plan in more detail.

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 30 July 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
28 May 2026	10.4	Future BAF reports to include reference to the Risk title alongside the numbering in the cover report, for ease of reference	Helen Child	July 2026	Risk Management Team advised of request, with change to be reflected in future reports.	**Complete**

QUESTIONS FROM THE PUBLIC

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30th July 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 – May – June 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. On 18th June, along with the Chief Executive, I met with Kevin McNamara, Chief Executive and Deborah Evans, Chair of **Gloucestershire Hospital NHSFT** where we had the opportunity to discuss matters of mutual interest.

- On 2nd June, I along with **Chairs from NHS Bristol, North Somerset, South Gloucestershire and Gloucestershire ICB** met with **Dr Jeff Farrar**, cluster Chair where we discussed matters of mutual interest.

- I was invited by **Dame Gill Morgan** to attend the **South West Regional Chairs Meeting** on 25th June. The aim of the session was to bring together all Provider, ICB, Community Interest and Health Innovation Chairs for an engaging and meaningful discussion about collaborative and effective working in the future.

- Along with the Chief Executive, I attended the **NHS Confederation Conference** in Manchester on 10th June. The conference was an opportunity to hear from a range of national speakers and to share good practice.

- On 17th June, I was delighted to attend **The Rt Revd Rachel Treweek, The Bishop of Gloucester** Garden Party. The gathering was an opportunity to network with a range of individuals.

Always improving

- I was invited to attend an exclusive tour of **FutureSim**, University of Gloucestershire's new state-of-the-art simulation facility, located at Oxstalls Campus. FutureSim represents a £2.5 million investment in the future of professional training, bringing together cutting-edge simulation, AI-enabled technology and immersive, real-world environments into one integrated hub. Designed in collaboration with industry partners, the facility provides highly realistic settings that mirror clinical, community and incident scenarios; supporting learners to develop practical skills, confidence and decision-making capabilities before entering practice. FutureSim offers a great opportunity for collaboration between the Trust and University of Gloucestershire.

Respectful and kind

- Unfortunately, **Westley May, Food Service Assistant** at Cirencester Hospital was unable to attend the **annual Trust Awards ceremony** on 15th April to receive his award, and so it was a pleasure for me to meet with Westley at Cirencester Hospital to personally present his award on 4th June. Whilst at the Hospital I was delighted to be able to assist with handing out of refreshments and meeting patients on Thames Ward.

Making a difference

- I had the pleasure of supporting and participating in the **18th Big Health Day** on 11th June at Oxstalls Sports Park. This annual event features accessible activities designed to help people with a disability, a mental health condition, hearing or sensory loss to stay active and healthy. My sincere thanks to Dominika Lipska-Rosecka, Big Health Day Event Lead Co-Ordinator from the Partnership Team and

all other Trust colleagues for all of their hard work and dedication in making the Big Health Day such a spectacular and inclusive event.

- It was an honour to attend and say a few words at the **Macmillan Next Steps Cancer Rehabilitation 10 Year Celebration** on 11th June. The service has grown significantly over the past decade and has made a real difference to patients living with and beyond cancer across Gloucestershire.

- 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 **Talking Therapies North** who are based at **St Paul's Medical Centre, Cheltenham** on 2nd June and **Talking Therapies – Long Term Conditions** based at **Pullman Place** on 21st July to present their '**Making a Difference**' awards.

Talking Therapies – Long Term Conditions

Talking Therapies North

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.

3. BOARD UPDATES

- **NHS FIT AND PROPER PERSON COMPLIANCE**

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

Proper Person Test. A new Fit and Proper Person Test framework was published by NHS England in August 2023.

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

Documentation includes:

- Completion of a self-attestation form by the individual (includes the 'Unfit Person test' and considerations relating to 'Good Character' DBS Check compliance, and professional registration compliance)
- Annual checks against the disqualified directors register, the bankruptcy and insolvency register, the removed charity trustees register and relevant professional register.

The Board is asked to **note** that I reviewed and signed the Annual Submission Form to confirm that the annual checks have been completed and that our Board continues to meet the Fit and Proper Person Test. This completed submission form was submitted to NHS England on 29th June 2026.

- **Co-production Week** took place from 29th June to 3rd July. During the week, the Improvement and Partnership team highlighted an annual awareness campaign to recognise the benefits of working in equal partnership with people using health and social care provision. The week highlighted the power of co-production to design and develop better ways of doing things in Health and Social Care.

- We have recently concluded the recruitment process for our new **Associate Non-Executive Director**. Interviews took place on 16th July and I am delighted to advise that a preferred candidate was identified. The Trust will be carrying out all relevant Fit and Proper Person checks with the aim of our new colleague joining us mid-September.

- A **Speak Up Board Seminar** led by Helen Child, Director of Corporate Governance and Trust Secretary took place on 23rd June. At the seminar, Sonia Pearcey, Freedom to Speak Up Guardian facilitated a productive workshop session. Colleagues focused on speaking up in the well led framework and what this means along with best practice as a Board. We reflected on current challenges and through appreciative enquiry we discussed the actions, innovation, and good ideas to get us where we want to be.

- 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.
- A meeting of the **Appointment and Terms of Service Committee** took place on 9th July. The committee discussed Executive Directors Performance Review for 2025-26 and 2026-27 Objectives along with the Chief Executive Performance and Objectives.

- The Trust have commissioned an **independent developmental Well-Led Review** in line with the Care Quality Commission (CQC) Well-Led framework. The review will be undertaken by an external organisation, **thevaluecircle**, and forms part of our ongoing commitment to continuous improvement, transparency and strong leadership and governance.

  The review will take place over the summer period, commencing shortly after contract award and concluding with presentation of the final report to the Board on 24 September 2026. It will provide an objective and constructive assessment of how effectively the Trust is led and governed, identifying strengths to sustain and areas where further development would support future performance and inspection readiness.

- On 14th July an in-person **Board Development session** took place which focussed on preparation for a well-led review. The purpose of the event was to support a realistic self-assessment against the CQC well-led framework, identify strengths and gaps and to agree priority actions for improvement.

4. GOVERNOR UPDATES

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

- A meeting of the **Nominations and Remuneration Committee** took place on 25th June. Amongst other items, the committee discussed the Chair Appraisal Outcome for 2025/26 and the recruitment processes for a new Trust Chair and Non-Executive Director.

- On 16th July we held our in-person **Council of Governors Development Session** which primarily focussed on the future of governors.

- Our **programme of visits to sites for Trust Governors** continues to progress with a visit taking place at Charlton Lane Hospital on 8th June. 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 May to 30th June 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 May – 30th June 2026

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• 2025/26 Appraisal with Trust Chair • Advisory Appointment Committee • Good Governor Institute Webinar • Governor visit to Cirencester Hospital • Introduction meeting with Helen Blanchard • Mental Health Act Managers' Forum • Mental Health Legislation Scrutiny Committee Action Meeting • Non-Executive Director Informal Meeting • Pre-interview discussion with Dr Almaskati • Pre-Mental Health Legislation Scrutiny Committee meeting regarding Board Assurance Framework	• Board Seminar: Infection Prevention Control and Antimicrobial Stewardship – A Call to Action • Board Seminar: Speak Up • Quality Committee • Resources Committee
Nicola de longh	• Appraisal meeting with Trust Chair • Charitable Funds Assurance Report • Charlton Lane Governor Visit • Chief Operating Officer Board Stakeholders Focus Group • Meeting with Chief Executive • Meeting with Director of Corporate Governance and Trust Secretary • NHS Visit: FutureSim Planning • Non-Executive Directors Informal Meeting	• Audit & Assurance Committee • Charitable Funds Committee • Extraordinary Appointments and Terms of Service Committee • Public and Private Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Vicci Livingstone-Thompson	• Advisory Appointment Committee • Appraisal with Trust Chair • Black Man's Burden Workshop Post Event Debrief • Chief Operating Officer Recruitment Stakeholder Focus Group • Council of Governors Meeting • Discussion with Associate Non-Executive Director candidate • Diversity Network Agenda meeting preparation • Diversity Network Meeting • Experts by Experience and Volunteers Celebration Event • Joint Staff Network Chairs Meeting • Meeting with Associate Director, Organisational Development & Learning and Development and Head of Organisational Development and Leadership • Meeting without management with External & Internal Auditors • Non-Executive Director Informal Meeting • Non-Executive Directors Informal Meeting • Pride Month Workshop	• Audit & Assurance Committee • Board Seminar: Infection Prevention Control and Antimicrobial Stewardship – A Call to Action • Charitable Funds Committee • Great Place to Work Committee • Public and Private Trust Board • Quality Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Bilal Lala	• Appraisal with Trust Chair • 1:1 with Counter Fraud Lead in advance of Audit & Assurance Committee • 1:1 with Director of Finance in advance of Audit & Assurance Committee • 1:1 with Director of HR & OD • Audit & Assurance Committee Assurance Report • Audit & Assurance Pre-Meeting with Director of Finance • Board Assurance Framework Meeting with the Director Nursing, Therapies and Quality, Medical Director and Debbie Forster • Council of Governors Meeting • Meeting without management with External & Internal Auditors • NHS Gloucestershire ICB Audit Committee members briefing • NHS Gloucestershire ICB Audit Committee, parts 1 and 2 • Non-Executive Directors Meeting	• Audit & Assurance Committee • Board Seminar: Infection Prevention Control and Antimicrobial Stewardship – A Call to Action • Board Seminar: Speak Up • Public and Private Trust Board • Quality Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Debbie Forster	• Board Assurance Framework Meeting with the Director Nursing, Therapies and Quality, Medical Director and Bilal Lala • Chief Operating Officer Interviews • Council of Governors Meeting • Meeting Auditors • Meeting with Aaron Matiza/Lesley Moya, Auditors • Meeting with Director of Corporate Governance and Trust Secretary • Meeting with Gloucestershire Rural Community Council • Meeting with Lead Governor • Meeting with Medical Director • Meeting with Trust Chair • NHS Alliance Training • Non-Executive Directors Informal Meeting • Non-Executive Directors Informal Meeting • Non-Executive Directors Informal Meeting • Oliver McGowan Training • Quality Visit to Tewkesbury Community Hospital • Resources Committee Pre-Meeting with Director of Finance	• Audit & Assurance Committee • Audit & Assurance Committee • Board Seminar: Infection Prevention Control and Antimicrobial Stewardship – A Call to Action • Board Seminar: Speak Up • Charitable Funds Committee • Extraordinary Appointments and Terms of Service Committee • Public and Private Trust Board • Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Karen Clements	• Audit & Assurance Committee Pre-Meeting • Big Health Day • Council of Governors Meeting • Experts by Experience and Volunteers Celebration Event • Gloucestershire ICB Farewell Event • Great Place to Work Committee Agenda Setting Meeting • Great Place to Work Committee Operational Risk Review Meeting • Meeting with Freedom to Speak Up Champion • Meeting with Lead Governor • Non-Executive Directors Informal Meeting • Objective Setting Meeting with Trust Chair • Oliver McGowan Training • People Strategy Launch Meeting • People Strategy Review Meeting • Research and Innovation Meeting	• Audit & Assurance Committee • Board Seminar: Infection Prevention Control and Antimicrobial Stewardship – A Call to Action • Board Seminar: Speak Up • Great Place to Work Committee • Public and Private Trust Board
Helen Blanchard	• Black Man's Burden Conference • Corporate Induction • Introduction Meeting with Director of Nursing, Therapies and Quality • Introduction meetings with Helen Child, Neil and Douglas, Rosanna – put titles • Introduction with Lead Governor • Launch of People Strategy	• Board Seminar: Speak Up • Public and Private Trust Board

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 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

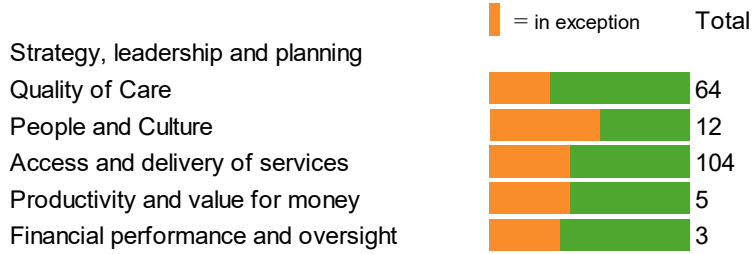
with you, for you

NHS Gloucestershire Health and Care NHS Foundation Trust

Strategic Update

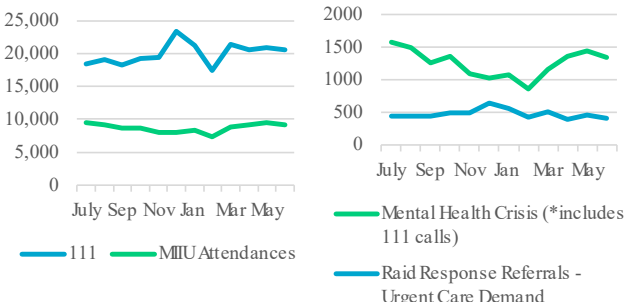
Focus Areas	Update
Connecting services in neighbourhoods	Gllouceste rshire Provider Partnership presented apppriach to ICB cluster/ NHS England learning event
Children and young people	Agreement reached on expansion of safeguarding tem to meet new statutory requirements
Community urgent care	Progress on approach/ detail of Single Point of Access, Care Transfer Hub and Urgent Treatment Centres.
Inclusive healthcare	Working Together Network engaged on prioroities and approach over next 12/24 monhts.
Partnerships with purpose	Glos VCSE Infrastructure Collaborative established, with GHC a core member.

Performance Indicators Overview

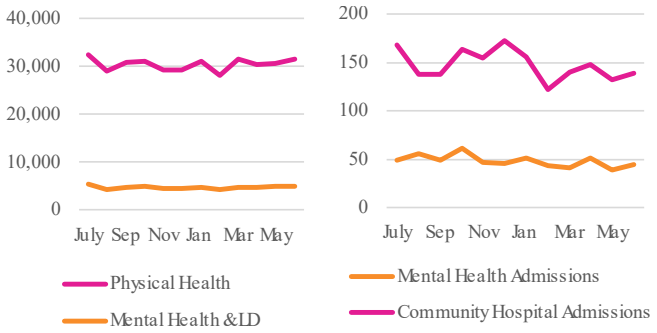


Service Demand Trends

Urgent Care demand (all age)

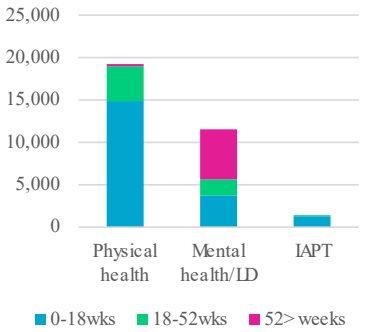


Planned Care Referrals (all age)

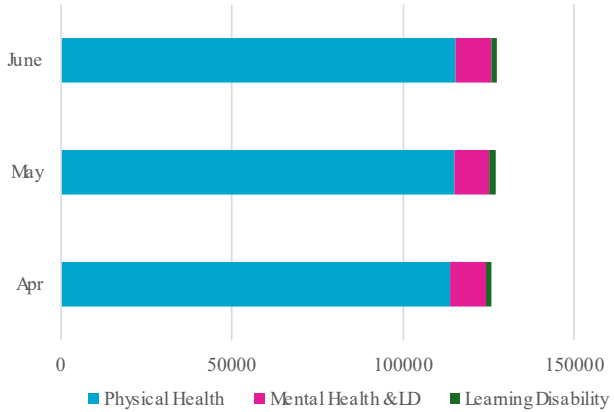


Service Capacity

Total Waiting for Treatment



Caseload



NHS Oversight Framework - 2025/26

	Q1	Q2	Q3	Q4
Score	2.18	2.23	2.32	2.29
Segment	2	2	2	2
Ranking	21/61	20/61	29/61	29/61

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 partnershi	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

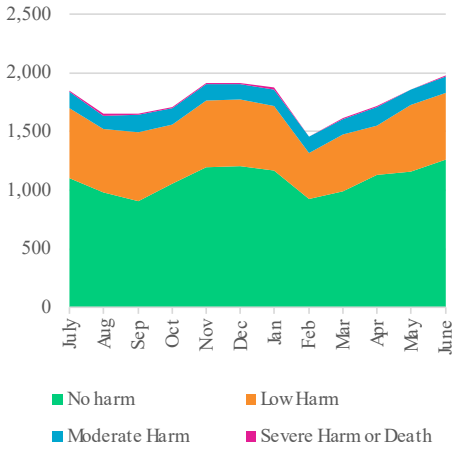
Chief Executive Overview

with you, for you

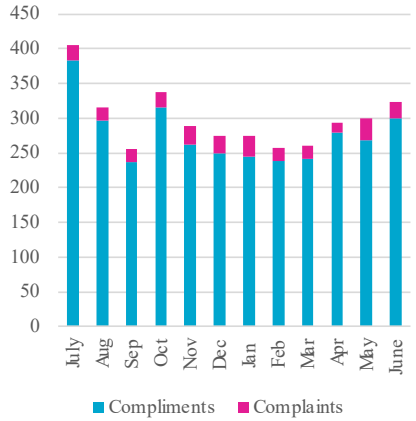
NHS Gloucestershire Health and Care NHS Foundation Trust

Quality and experience headlines

Incidents



Compliments and complaints



Patient Feedback (June 26)

Overall Experience

91%
Very good or Good

Respect and Dignity

98%
Positive

Involvement in decisions

95%
Positive

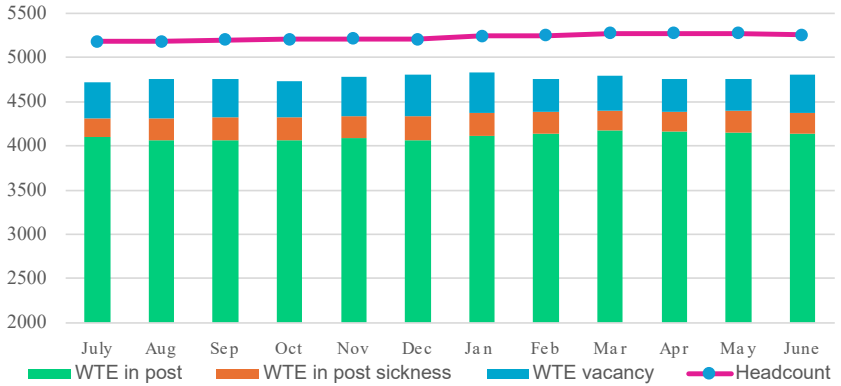
Safety and welfare

96%
Positive

Finance headlines

	Month 3 2026/27	
Income & Expenditure Performance	£0.032m surplus	
Cost improvement savings of	£5.36m	
Capital expenditure	£1.042m	85% of year to date plan

Our people



Colleague voice: People Pulse Survey (Q4 25/26)

Recommend as a place to work	65%
Happy with the standard of care for friend or relative	71%

CHIEF EXECUTIVE SERVICE / TEAM VISITS AND EVENTS

Service Visits in June and July 2026	• **Community Learning Disability Team, Weavers Croft, Stroud, 15 June 2026.** As part of celebrating Learning Disability week, I spent time with the community team, discussing a range of issues. • **Charlton Lane Hospital, Cheltenham, 17 June 2026.** While at the hospital to mark estates and facilities day, I was able to squeeze in some early catch ups with colleagues across the site. • **Tewkesbury Community Hospital, Tewkesbury, 17 June 2026.** While at the hospital to mark estates and facilities day, I had a general walkaround across the whole site. I was particularly pleased to catch up briefly with the theatres team, who reported that the facilities were starting to be used more intensively, as this was a concern on previous visits. • **Cirencester Hospital, 30 June 2026**. I was on site to meet with a local GP to discuss the development of exciting plans for the site. While there, I was able to catch up with colleagues from across the site. • **Gloucester Integrated Community Team, 15 July 2026.** I joined the team as they were taking some time to celebrate and recognise their achievements as an integrated team, before the planned transfer of social care Occupational Therapy to Gloucestershire County Council on 1 August. • **Wotton Lawn, Gloucester, 17 July 2026.** I hot desked at this site in the late afternoon, meeting colleagues while doing so.
Events to note	• **NHS Estates and Facilities Day, 17 June 2026.** I was pleased to be part of marking estates and facilities day this year. I started by participating in routine water testing at Charlton Lane hospital and finished the morning by helping to clean the air handling unit on the roof of Tewkesbury Hospital. • **Neighbourhood health event, Bristol 20 July 2026.** A gathering of colleagues from across the new clustered Integrated Care Board area, together with national NHS England leaders, to discuss and share progress being made on neighbourhood health. I was able, along with colleagues, to speak about the plans for the Gloucestershire Provider Partnership and how this will be a useful mechanism for designing and implementing changes related to neighbourhood health.

CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Assure	Quality	National Audit of Care at the End of Life (NACEL) Audit publication

The National Audit of Care at the End of Life (NACEL) is an annual national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during their last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers. For the first time - in August 2026 - findings from 5 questions in the 2025 audit will be made available to the public on the NACEL website.

The Trust performance exceeded both peer and national averages across many key measures, including pain management, communication, anticipatory prescribing, emotional support, and overall patient and family experience. For two of the five published questions on patient and family feedback, the Trust performs strongly, with 97% (peer 80%, England 78%) of bereaved relatives rating the care provided as good or excellent and 94% (peer 79% England 78%) reporting that adequate pain relief was achieved. These outcomes reflect the commitment of our clinical teams to delivering person-centred care at this important stage of life.

The third published question relates to hospitals with face-to-face specialist palliative care (8 hours a day, 7 days a week) and the Trust is recorded as 0% (peer 36% England 64%). Specialist Palliative Care services are hosted by Gloucestershire Hospitals NHS Foundation Trust. Whilst this face-to-face specialist support is not currently available seven days a week, a 24/7 telephone advice is available to all healthcare professionals in the Trust. The current provision and accessibility of specialist palliative care is known by all system partners and the Integrated Care Board is sighted to the reported position for Gloucestershire in the national audit.

The audit has identified opportunities to strengthen practice. For the other two of the five published questions on documentation, the Trust has improvement work to progress, with 39% (peer 59% England 47%) of patient clinical notes evidencing personalised care planning conversations and 28% (peer 47% England 49%) of patient clinical notes recording the assessment of spiritual, religious and cultural needs of those people who are important to the patient. It is important to note that the Trust is at 48% to the question related to recording the assessment of spiritual, religious and cultural needs of the patient, with 78% of actions being subsequently addressed for those patients. The End-of-Life Quality Improvement Work Plan has already increased targeting training and support to staff, with additional actions identified to improve the templates within clinical records systems and review existing arrangements of our spiritual care resource.

Overall, the audit demonstrates a good quality of end-of-life care across the Trust, noting that where further improvement have been identified there are improvement plans to ensure that patients and families receive high-quality, compassionate care at the end of life

	National Guidance	**Board Assurance relating to Nottingham Maternity Review Findings on Post-Death Care and key actions required following the Fuller Inquiry**
	The Trust received a letter from NHS England on 26 June 2026 in response to the Nottingham Maternity Review findings on post-death care and key actions required following the Fuller Inquiry. The letter serves as a strong reminder of the NHS's responsibility to ensure that all deceased people are cared for with dignity, respect, compassion and security. It also included a requirement for Boards to give assurance on their local position and submit a formal Board Assurance Statement to NHS England by 31 July 2026. In response to the Fuller Report recommendations, the Trust has reviewed its arrangements to ensure that deceased patients continue to be protected from harm and treated with dignity following death. As the Trust does not operate mortuary facilities or body stores within its community hospitals and MH/LD inpatient units, care of the deceased is limited to immediate after-death care while awaiting collection and transfer to the deceased person's chosen funeral director. We have undertaken a review of relevant policies and guidance with a particular focus on safeguarding, dignity and security. Where necessary, changes have been made to ensure our documented approach maintains high standards. As a result, the Trust is able to provide assurance that recommendations from the Fuller Inquiry are met. The letter and Board assurance statement have been made available for Board members to view in Diligent ("Board Assurance Statements" folder).	
Advise	**National Guidance**	**Lord Mann Review**
	Following publication of Lord Mann's national review into antisemitism and wider racism in the NHS, and the Government's acceptance of all recommendations, a summary of the implications for NHS provider trusts is provided below. A full paper and Trust response has been taken to the Executive meeting and the June Great Place to Work Committee. The Review finds that racism, including antisemitism, remains persistent and at times normalised across NHS settings, negatively affecting colleague experience and patient confidence. Muslims and Jewish colleagues and patients continue to face discrimination, and there is inconsistency in organisational responses. More broadly, colleagues are increasingly experiencing racism, abuse and discrimination from patients and the public. The Review calls for a system-wide reset, with stronger leadership, accountability and consistency. It emphasises making tackling racism a core organisational priority, supported by improved data use, clear reporting and investigation processes, and a stronger focus on culture and staff experience. Mandatory training and strengthened organisational capability are also required. As immediate actions, delivered through our People Strategy 2026–2031 and corresponding implementation plans, the Great Place To Work Committee approved the following from the Mann Review: • **Signing up** to the NHS Race and Health Observatory Seven Anti-Racism Principles following consultation with the Race & Cultural Awareness Network (RCAN), the Internationally Educated Nurses Council and local Staff Side representatives	

- **Implementing** the Violence Prevention and Reduction Standard (VPRS), with data capture to monitor improvement with affected groups; governance route through the Great Place to Work Committee. Work has already commenced on this via our new People Strategy Theme 3 - A Safe, Inclusive and Healthy Workplace
- **Implementation of the new NHS Staff Standards** on the experience of racism, in partnership with colleague networks, RCAN and local union representatives
- **Strengthening accountability for racial inclusion through appraisals**, aligned to the **NHS Leadership and Management Framework** launched earlier this month alongside the NHS Staff Standards. Due to the very recent implementation of this and the Staff Standards, the implementation plans for both are yet to be taken through Executives and the Great Place To Work Committee
- **Ensuring Board and senior leaders complete anti-racism training** when the promised NHS England's programme becomes available. Embedding inclusive leadership is a core component of the GHC leadership and management offer
- **Ensuring all colleagues complete the NHS Core Skills Framework EDHR module** (including content on Islamophobia and antisemitism), maintaining 90%+ compliance — monitored through learning and development statutory/mandatory programme and KPIs. NB this is already mandatory in the Trust with 99% compliance
- **Launching an inclusive thinking and practice EDI education offer** — covering protected characteristics, allyship, and inclusive behaviours — to be piloted Q2–4 2026/27
- **Using Staff Survey data on racism experiences to drive service-level action planning**, monitored through the Great Place to Work Committee oversight of the People Strategy implementation and core elements of Staff Survey. This will also include developing bespoke eLearning for PALS and complaints handlers when the expected NHS England guidance is published
- **Undertaking an external review of speaking up** processes within GHC, noting that this is broader than just the formal function of Freedom to Speak Up and includes wider speaking up processes (date to be agreed)

The Committee also noted the Review's clear expectation of board-level accountability, oversight and implementation going forwards.

National Guidance	**EHRC Code of Practice on Single-Sex Spaces & Workplace Facilities Implementation**

Following the Supreme Court ruling clarifying under current law that "sex" under the Equality Act 2010 refers to biological sex, the Equality and Human Rights Commission (EHRC) laid its updated draft Code of Practice for services, public functions and associations before Parliament in May 2026.

The 40-day parliamentary scrutiny period ended on 9 July, and to support the next steps in the process as set out in section 14 of the Equality Act 2006, the EHRC is now issuing the Code in accordance with section 14(8)(a). The Minister for Women and Equalities will now take necessary action to revoke the 2011 Code and bring the new Code into force as statutory guidance. At the point that it comes into force, the ERHC will formally publish the Code. This is expected to be in August 2026.

	Concurrently, NHS England is updating its guidance on hospital accommodation and developing specific frameworks for NHS staff facilities. However, it is unclear when this will be available. The updated code of practice for services, public functions and associations can be read here and wider information is available here. The Resources and Great Place to Work Committees will be apprised of progress against next steps for GHC in Q3.
	Operational **Organisational Redesign** Our new service group structure commenced on 1st July. There are three groups: Mental Health and Learning Disability Autism, Community and Urgent, and Children and Young People and Specialist. New Service Group Directors have commenced in their role. The next operational leadership layer of the organisation is now in formal consultation to provide the strength to these groups. We are also working through the detail of how medical and quality functions will align across the remainder of this financial year with these groups. Engagement with senior teams in our medical and quality functions has commenced to create the leadership capacity needed for this change. We are also working to ensure that the service groups will be well supported by corporate colleagues and business partnering. This represents a new way of working and every opportunity will be taken to align future organisational design decisions to this way of working. Underpinning the creation of these groups is significant work on how governance and assurance infrastructure will work in the future, so that we can ensure that our decision making is integrated and as close to services as possible.
	Operational **Gloucestershire County Council Delegated Responsibilities Update** There are four key services affected by this programme, which sees the transfer of services to Gloucestershire County Council. These services include Mental Health Social Work, which transferred on 1st June and the transfer is now considered complete. Supported Accommodation Service has a completion date of 1st September and, aside from a planned novation of contracts, the work for transferring this pathway is largely complete. The other two services, Occupational Therapy and Home First/Reablement require a more involved splitting out of services with some elements being retained by GHC, so are naturally more complex. Occupational Therapy is due to transfer on 1st August. GHC is building an Occupational Therapy and actively recruiting to this now. Home First/Reablement is the most complex service to disaggregate and transfer. Reablement workers, currently embedded into integrated teams but already employees of Gloucestershire County Council, will TUPE to commissioned private providers to deliver the service. This has caused disquiet amongst reablement workers and there is a ballot for strike action through UNISON. As the service does not transfer until 1st September, any industrial action before then will cause system-wide operational disruption that GHC will have a significant role in managing over August. Business continuity plans are being prepared and the system is convening regularly to manage inter-organisational plans. This is against a backdrop of agreeing transition plans, escalation points, additional resource capacity and standing up the new 7-day Home First service within GHC. Existing GHC Home First workers will be eligible to slot into this new service and a Management of Change process is underway to enable this. There is also recruitment activity underway to fill vacancies and a group established to build a bank of workers to manage ebbs and flows in demand.

	Workforce	**Band 5 Nursing Job Evaluation Review**
	The Government previously announced its "Fairer deal for nursing" commitments and specifically referenced an ask in regard to the Band 5 nursing role review for registered nurses (e.g. Registered General Nurse, Registered Mental Health Nurses and Registered Nurses in Learning Disabilities. As a result of this NHS England has requested that all NHS organisations submit a delivery plan by 31 July 2026 setting out how all Band 5 nursing roles will be reviewed by October 2028 in line with updated national nursing job profiles. Board members can find full details about the NHS job evaluation scheme here. It is important to note that under national terms and conditions, job evaluation is a partnership process between management and trade union representatives, and collegiate working will be of prime importance in delivering the nationally required review. Within the Trust, the review will include roles currently occupied by circa 514 Band 5 Nursing covering (430.85 wte). Earlier this month a draft delivery plan was reviewed with staff-side representatives through our Joint Negotiating and Consultative Committee. The plan has subsequently been considered and approved by Executives. The related operational report included identification of risks and mitigations, alongside initial financial modelling of potential costs. Some national funding may be available to assist providers with some up-banding arising out of the review, but the detail on this is currently unclear. As further clarity is reached, this will be factored into financial planning. The plan will be submitted to the NHS England team for review by the end of this month.	
	Workforce	**Transforming People Services (TPS) Programme**
	Following discussion at the May 2026 Board meeting, colleagues are reminded that Transforming People Services programme aims to modernise and transform NHS people services through greater automation, digital self-service, standardised processes and the introduction of a digital front door for HR services, alongside the Future Workforce Solution replacing ESR from 2027 onwards. The South West is one of two accelerator regions, but the detailed Target Operating Model remains under development in consultation with providers. Following on from considerations at the Board meeting in May of our role in the programme and feedback to the regional and national team on the implementation of the South West TPS accelerator programme, some further recent updates are outlined below: • The programme has now completed its National Infrastructure and Service Transformation Authority (NISTA) Gateway Review. This has provided positive feedback on overall programme progress while identifying a small number of recommendations, which are now being taken forward. • DHSC approval has now been received for the Business Case to appoint a national design and regional change partners, and these will be going out to market within the next month, with the aim that the partners will commence working with national and regional teams in the autumn.	

- The regional TPS Board continues to meet with representation from myself and Neil Savage. Neil has also been asked to co-lead the People, Culture and Change TPS workstream.
- Seven senior colleagues within GHC's People Directorate have contributed as subject matter experts to TPS discovery workshops in the past month. On top of the co-lead work for Neil, this has taken a significant investment of time from the team, but allows us to influence the design.

Future updates will be reported to the Great Place to Work Committee.

Estates	**Cirencester Redevelopment Programme**

Cirencester Hospital is the largest site within GHC's portfolio (by both land area and Internal Floor area) and due to its age and changing healthcare requirements, needs modernisation. Four strands of work have been established with oversight from an Assurance Group chaired by the Director of Finance:

Renovate - Short term projects and enhancements
Works progressed include backlog maintenance, plant and infrastructure upgrades, refurbishment works (toilets, Querns House, lifts) and external lighting
Redevelop - Strategic development projects
Exploring the potential for diagnostic upgrades and a c20,000 patient Primary Care Centre on site.
Reprovision - Modernise and reconfigure facilities (with partner organisations)
Investigating the future opportunities around partner services on site – including Theatre, Endoscopy and Diagnostics
Renew - Renewal projects to fit changes in need (GHC)
Refurbishment and new build of premises to deliver GHC services including renewed Inpatients, MIIU, Outpatients and Therapies departments

The renew strand is currently focusing on securing planning approval for an affordable and deliverable scheme. Detailed stakeholder engagement is underway to ensure the modernisation reflects the needs of people who use our services, colleagues, and the wider community. Pre-application submissions to Cotswold District Council will conclude by the end of August with, subject to feedback, the Full Planning Application submitted in Autumn 2026.

Early consideration is being given to the appointment of a main contractor, with procurement options being evaluated to maximise value, minimise risk and support design development. The overall programme is being refined, with construction commencement dependent on planning approval and procurement timelines.

A progress update covering all four strands is scheduled for Capital Management Group in August. This will be followed by a detailed paper to the Executive Team in September ahead of an Outline Business Case (OBC) covering the Renew works to Resources

	Committee in October. Updates in relation to the partnership opportunities under the Reprovision and Redevelop Strands will be scheduled as appropriate.	
	Partnerships	**Gloucestershire Provider Partnership Update**
	The Gloucestershire Provider Partnership (GPP) has moved into its mobilisation phase, with recruitment underway for four senior roles, jointly funded by all partners and governance structures are being agreed with stakeholders outside the immediate partnership. The ICB has produced a baseline data set and dashboard linked to the John Hopkins Population Health model and Data Protection Impact Assessment's will be signed this month.	

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

PRESENTED BY: Kevin Adams, Associate Director of Estates, Facilities & Medical Equipment

AUTHOR: Kevin Adams, Associate Director of Estates, Facilities & Medical Equipment and
Laura Harvey, Assistant Director of Estates, Facilities & Medical Equipment

SUBJECT: **ESTATES AND FACILITIES MANAGEMENT STRATEGY (EFMS)**

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:

- Present the final draft of the Estates and Facilities Management Strategy to the Trust Board for approval.
- Highlight the amendments made following feedback from the May Board meeting.
- Outline the next steps to implementation.

Recommendations and decisions required:

The Trust Board is asked to **NOTE** the amendments relating to feedback received since the May Board meeting and approve the final draft of the strategy.

Executive Summary:

The Trust has been undertaking a refresh of its Estates and Facilities Management (EFM) Strategy since December 2025.

Extensive engagement has informed the development of the strategy, capturing the views of a broad range of stakeholders across the organisation. This has included the Senior Leadership Network, Open Forum, stakeholder surveys, EFM colleague focus groups, operational team meetings and forums, Experts by Experience and Staff side colleagues.

These engagement activities have provided valuable insight into the priorities of our colleagues and the people who use our services, helping to shape and refine our key

EFM strategic themes. The process has also highlighted strong links with supporting Trust strategies, with several common priorities and themes emerging across them.

The proposed strategic themes have been tested and reviewed through a range of stakeholder groups, including the Trust Board, Resources Committee, Executive Plus, operational forums, and the Joint Negotiating and Consultative Forum (JNCF).

The resulting strategy provides a clear framework for the development of our estates and facilities services, ensuring they continue to support the delivery of safe, effective and sustainable healthcare environments that meet the needs of patients, colleagues and communities now and in the future.

Feedback has been supportive of the four themes identified:

- Resource Optimisation
- Environment and Experience
- Accessibility and Inclusivity
- Partnerships and Community
-

Through engagement across these themes EFM has listened to and captured the areas of focus that will drive Trust services forward. By understanding the priorities for services, EFM have aligned the strategy to provide EFM services that will support the Trust in delivering the five key focus areas of the GHC Strategy.

The feedback received from engagement since May Trust Board has refined the strategy and the key changes are highlighted below:

- This strategy encompasses the properties that we own or lease, EFM services and our use of all space and premises countywide. These areas have been clearly defined with specific delivery approaches.
- The strategy highlights the principal areas for improvement, indicating the current position and setting more ambitious expectations for improvement over the next five years.
- Measurement targets and metrics are set out, providing a framework for evaluating progress across these areas.

Next Steps:

- The Communications team will finalise the formatting of the strategy document prior to launch.
- The launch timeline and approach will be agreed to ensure alignment with the Trust's supporting strategies, minimising duplication of launch activities and avoiding information overload for Trust colleagues.
- A range of implementation plans will be developed to deliver the strategy, setting out short, medium and long-term priorities for our EFM services, environments and use of space. The strategy will guide strategic decision making and investment, ensuring that the Trust's estate continues to support the delivery of high quality, sustainable healthcare services.

- Delivery plans will be integrated into the Trust's business planning process, maintaining alignment with organisational priorities and ensuring that interdependencies with supporting strategies are effectively managed.
- Whilst it is acknowledged there was a request to include interim milestones, these have not been incorporated within the strategy document. Interim milestones will form part of future reporting to the Resources Committee.
- The Resources Committee will retain oversight of the delivery of the EFM Strategy through regular updates that will be reported on to the Board.
- Progress against the strategic objectives and associated metrics will be monitored through annual reporting cycles and national assurance returns, including the Premises Assurance Model (PAM), Estates Returns Information Collection (ERIC), and the Patient-Led Assessment of the Care Environment (PLACE).
- Performance against the strategy will be reviewed annually to ensure delivery remains on track and continues to support the organisation's strategic ambitions.

Risks associated with meeting the Trust's values

Corporate considerations	
Quality Implications	A robust Estates and Facilities strategy is key to ensuring we support the Trust strategic goals and deliver specific Estates and Facilities aims. Whilst developing this strategy quality, resource and equality implications have been reflected.
Resource Implications	
Equality Implications	

Where has this issue been discussed before?
- Resource Committee - April 2026 - Trust Board - May 2026 - Various forums during development

Appendices:	None

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

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AGENDA ITEM: 09.1/0725

Estates and Facilities Management (EFM) Strategy 2026 - 2031

Safe spaces. Efficient service.
Supporting the delivery of great healthcare.

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EFM Strategy

The EFM strategy sets out the plan to support delivery of the Trust's strategic objectives, within the national and local context. We have created this plan by talking to our colleagues and partner organisations to ensure that it reflects what matters most to those delivering healthcare and by listening to feedback from people who use our services to ensure our plans are centred.

This strategy sets the direction for:

- ✓ The future of the properties we own and lease
- ✓ EFM services
- ✓ Our use of all spaces/premises countywide

Welcoming, compliant spaces and services to meet the needs of people who use our services, colleagues and communities.

Working **collaboratively** with colleagues across the Trust, partner organisations, voluntary sector and experts with lived experience to ensure our services are accessible and inclusive.

Sustainability at the core of EFM services, focusing on efficient use of resources, supporting social value and reduction of wastage.

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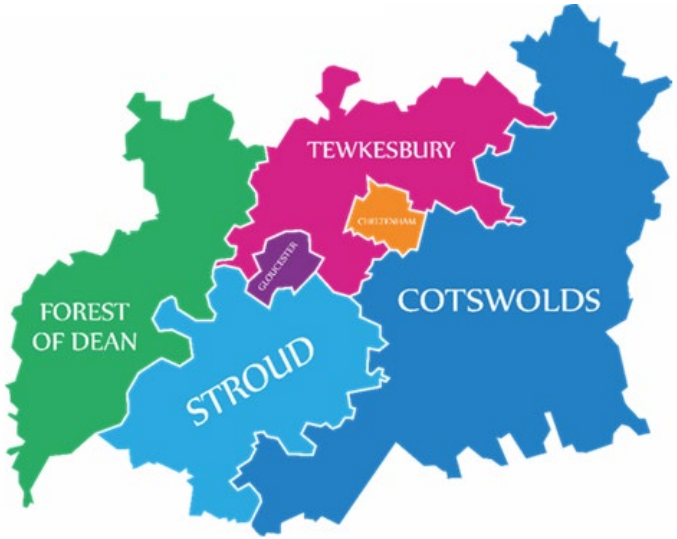
What we do…

- Serve 292k meals
- Complete 14,304 maintenance jobs
- Raise 3,600 purchase orders
- Complete 690 cleaning audits
- Utilise 670,978 pieces of linen
- Support 11,493 medical devices

Where we aim to improve…

- Backlog maintenance £17.9m - maintain focus on reduction to mitigate inflationary pressure.
- Patient Led Assessment of the Care Environment (PLACE) Dementia and disability scores below National average
- 64 Trust properties, including 12 categorised as “tail” - sub-optimal, outdated, not fit for modern care models
- Premises Assurance Model (PAM) positive responses 469 of 590
- Digital Maturity positive responses 25%



Areas of Success

PLACE - Cleanliness
All inpatient sites scored 99.8% or above for cleanliness, placing us among the highest-performing NHS providers nationally.

Estates Maintenance
90% of jobs are resolved within the agreed service level agreement.

Catering
All sites have a 5-star Food Hygiene Rating.

Backlog Maintenance
Total backlog maintenance is £17.9m, benchmarking in lowest 25% of Trusts.

Net Zero
84% of lighting upgraded to LED,
Solar panels generate c1 GWh of power, saving 150T carbon.
Over 80 EV charging points in operation

Areas for Improvement

PLACE - Disability
Results identify disability and dementia related measures as priority areas for improvement, .

Estates Maintenance Feedback
Use of digital software to improve feedback and communications to colleagues reporting jobs.

Catering
13% of patient meals are plant-based, highlighting an opportunity to increase provision.

Space Utilisation
Average clinic utilisation is currently 40% , indicating capacity across the estate.

Waste
Our total waste cost of £839.per tonne benchmarks in the highest 25% of Trusts, indicating scope to improve.

How our Five-Year Focus and Strategies work together

This model sets out how our work is shaped, delivered, and supports our purpose: helping you live your best life by delivering great healthcare.

Our Five-Year Focus (2026-2031) sets out our long-term goals, five areas of focus, our ways of working and our values. These are supported by our five guiding strategies.

Each year, we use a structured business planning process to create clear actions. This allows us to put our long-term priorities into action while also responding to changing national requirements and local needs.

At the same time, we keep learning and improving our services by using data, feedback and experience. We manage large changes through our transformation programmes.

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Our EFM Strategic Themes

Safe spaces. Efficient service.

Supporting the delivery of great healthcare.

Resource Optimisation

Optimise use of our resources, aligning them with strategic priorities, to deliver maximum value.

Environment and Experience

Providing therapeutic, safe, welcoming spaces that enhance the experience and wellbeing of people who use our services , colleagues and visitors.

Accessibility and Inclusivity

Providing inclusive, flexible services for people who use our services , colleagues and visitors.

Partnerships and Community

Working collaboratively with NHS colleagues, system partners, and the voluntary and community sector to deliver high quality estates and facilities that support integrated care and improve outcomes for local populations.

Resource Optimisation - Optimise use of our resources, aligning them with strategic priorities, to deliver maximum value.

Why is this a key theme?

Our five-year focus sets out how we will provide sustainable services to the people of Gloucestershire; to achieve this, we need to make the best use of our resources.

Feedback highlights opportunities to make more effective use of our buildings, increasing use of our space and reduce the size of our estate to achieve best value.

The NHS 10-year plan is a key driver behind this theme, supporting the delivery of the three key shifts will enable us to ensure the organisation is fit for the future. Lord Darzi's report highlights the need to invest in infrastructure and equipment, ensuring our estate is resilient, modern, and capable of meeting population needs.

We will also use technology in our buildings and EFM services to create more efficient and user-friendly spaces. This will help colleagues in their work and support the delivery of high-quality care.

What do we want to do?

- Increase occupancy levels across our sites, to enable rationalisation and release financial resources to reinvest in modern, fit-for-purpose facilities.
- Support teams to work flexibly and share facilities.
- Work in collaboration to broaden access to the Gloucestershire public estate, making the best use of assets and providing the greatest value for the population.
- Optimise our use of technology to improve information management, processes and communication, and how we interact with environments and services to inform and forecast demand.
- Focus on delivering financial and social value, reducing waste reduction through improved use of equipment, supplies and asset utilisation; improved procurement and contract management; evidence-based investment and disposal or repurposing of assets.

How will we do this?

Overarching approach, we will:

- Identify barriers to efficient resource use.
- Develop clear processes and principles that support efficient and appropriate use of resources, working with colleagues to prioritise safety and fitness for purpose.
- Work with Gloucestershire partners to agree collective utilisation of the public sector estate, including improving access to schools and neighbourhood settings for Children and Young People's services.

For our buildings this means:

- Embedding a framework for building and property decisions in line with the Trust property plan.
- Releasing resources through more efficient use of space and equipment, to enable further investment in environments.

For our EFM services this means:

- Defining the requirements to support new ways of working, including cultural changes.
- Exploring options to adopt technological solutions to improve efficiency and effectiveness, including systems to monitor and manage space utilisation and to track medical device lifecycle, location, usage and servicing.

" A balanced holistic approach to sustainability, reducing wastage and ensuring value for money"
Colleague

"Have the right equipment for the job and in the right place"
Colleague

"Simplify room booking for Trust and community space."
Colleague

" Improved links between corporate services, not just at senior level"
Colleague

Environment and Experience – Providing therapeutic, safe, welcoming spaces that enhance the experience and wellbeing of people who use our services, colleagues and visitors.

Why is this a key theme?

Creating spaces where people who use our services and colleagues feel safe, supported and valued is essential to their wellbeing and mental health, aligning with the Trust's Great Place to Work goal and five-year focus.

We are committed to delivering EFM services that where possible exceed required standards; ensuring safe, compliant, fit-for-purpose spaces and services whilst driving continuous improvement.

Key themes from engagement identified implementation of trauma-informed and neurodiverse design principles to support psychological safety; and therapeutic, biophilic design to promote positive experience and greater engagement with healthcare services. Feedback demonstrates that experience of people who use our services is a shared priority across our EFM workforce, with colleagues recognising the important role they play in shaping positive experiences.

As ways of working continue to evolve, needs for workspace and welfare support are changing, requiring flexible and responsive environments that promote a positive experience.

What do we want to do?

- Co-produce plans for change in partnership with the people who use our EFM services to ensure that voices are heard, valued and acted upon.
- Create environments that enable colleagues and people who use our services to feel valued through positive, equitable interactions with our EFM services.
- Ensure that spaces and EFM services meet our on-going commitment to safety and compliance, that they are fit-for-purpose and meet modern healthcare and workplace standards.
- Ensure that our colleagues have access to welfare and supportive workspace, with a focus on our peripatetic workforce.
- Provide creative team meeting and collaboration spaces, to enable innovative thinking and peer support.
- We commit to ensuring that Estates and Facilities colleagues feel recognised and valued as part of wider healthcare teams.

How will we do this?

Overarching approach:

- Improved communication and easy to access information about Trust premises, EFM processes and how to get things done.
- Link with People and Digital to engage with colleagues and experts by experience and agree environmental standards for spaces that meet local needs, supporting quality and equity, ensuring safety and welfare remain a consistent priority.
- Develop feedback loops and opportunities to review and engage, enabling continuous improvement over time.

For our buildings this means:

- Create opportunities for proactive engagement to enable innovative, co-design solutions, create welcoming environments and access to outdoor space.
- On going investment in colleague welfare spaces and environmental improvements, ensuring teams have access to suitable spaces.

For our EFM services this means:

- Ensuring that relevant colleagues are fully engaged in developments in our EFM services, including decisions around food choices, menu planning and cleaning routines.
- Build relationships based on mutual respect and understanding of the professional role that EFM provide in supporting care. Embed learning from areas where this works well.

" Explore options for improving outdoor spaces."
Person who uses our services

"Improve communication and updates"
Colleague

" Entrance should be welcoming and warm, non-clinical with softer surfaces to absorb sound, sensory load is overwhelming."
Expert by Experience

"More informal team spaces, 1:1 rooms, big meeting rooms and parking"
Colleague

"Link nutrition to outcomes, EFM and clinicians to work together."
Colleague

Accessibility and Inclusivity - Providing inclusive, flexible services for people who use our services, colleagues and visitors.

Why is this a theme?

Addressing health inequalities is a core priority within our five-year focus, driving a commitment to improve accessibility and inclusivity of our spaces and EFM services.

This includes targeted efforts to reach communities in areas of deprivation and adapting our environments to meet the needs of an ageing population.

PLACE data, whilst showing improvement across all domains, indicates there is progress to be made on two domains, Disability and Dementia. We have heard how co-production and the voices of those with lived experience are essential in creating more inclusive spaces. Ensuring that we respect the dignity of people who use our services , visitors and colleagues is vital to our success.

The provision of multi-functional, flexible and responsive environments and EFM services will enable us to meet the changing and evolving needs of our organisation and our population.

What do we want to do?

- Remove physical, communication and process barriers, so that people of all abilities, backgrounds and needs can use our spaces and EFM services easily and confidently.
- Co-design spaces and EFM services alongside people with lived experience, people who use our services, colleagues and carers.
- Incorporate the use of technology to increase adaptability of our services.
- Working with communities and partners to offer accessible spaces and services in rural and minority communities.
- Proactively review and embed improvements in accessibility or inclusivity standards and best practice.

How will we do this?

Overarching approach, we will:

- Explore how technology can be used to improve access to buildings and services.
- Create a more flexible approach to engagement and communication considering needs of individuals, using technology where appropriate to do so.
- Build relationships with experts with lived experience and robust feedback loops to ensure effective outcomes.
- Prioritise improvements related to frailty and older age, neurodivergence and children and young people.

For our buildings this means:

- Proactively review our accessibility and inclusivity standards based on lessons learnt from projects, 15 steps, accessibility audits and best practice examples from other Trusts.
- Review existing spaces to understand where and how accessibility improvements can be made.

For our EFM services this means:

- Provide responsive EFM services which enable us to manage shifting priorities and respond effectively to unexpected changes in demand.

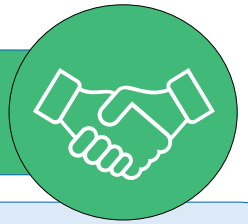
“Clearer signage. Department signage would be easier to read in a bigger font; consider colours that enhance readability. Improve exit signage.”
Expert by Experience

“ Ensure gardens are accessible with ramps where needed.”
Expert by Experience

“ Well maintained hearing loops, with clear sound quality and colleagues that know how they function.”
Expert by Experience

“Increase access to community venues and non-clinical settings; we require a more flexible approach to reach some populations**.”**
Colleague

Partnerships and Community - Working collaboratively with NHS colleagues, system partners, and the voluntary and community sector to deliver high quality Estates and Facilities services that support integrated care and improve outcomes for local populations.



Why is this a key theme?

We will support our Trust services in the development and transition towards Neighbourhood Health Centres, by making sure people can access safe, suitable community buildings where health and care teams can work together.

Building on existing partnerships and helping Trust services work more closely within local neighbourhoods, will enable us to achieve this Trust and NHS strategic priority.

Facilitating ease of access to all sites and spaces used by Trust colleagues and partners and ensuring that they are safe and suitable for the intended use, will be essential to delivery of neighbourhood care.

To deliver our community promise we will support local communities to reduce inequalities, ensuring social value, to enable better health outcomes.

What do we want to do?

- Build stronger relationships with colleagues, system partners and Voluntary Community and Social Enterprise to underpin partnership working in the delivery of Neighbourhood Health Centres.
- Support the delivery of safe, equitable spaces and services by ensuring communities are actively involved in their planning and design, through meaningful engagement and feedback, leading to positive outcomes.
- Deliver proactive and responsive EFM services that anticipate community demand and maintain business continuity preventing disruption to care.
- Engage with community networks and voluntary groups to explore how our spaces and services can support their needs.

How will we do this?

Overarching approach, we will:

- Develop effective communication loops with colleagues, system partners and communities, enabling co-production in support of neighbourhood healthcare and improved access to spaces and services.
- Provide clear process and governance structures to support partnerships and community working and shared use of Trust space and EFM services.
- Supporting access to safe, appropriate and inclusive non-clinical community spaces.
- Embed customer focus approach and develop skills in engagement and co-production.

For our buildings this means:

- Establishing opportunities for community involvement projects.
- Building relationships with communities and breaking down barriers to sharing our premises.
- Continued investment in net zero for cleaner air.

For our EFM services this means:

- Delivery of social value through a community benefit approach to our EFM services.
- Localised procurement and recruitment practice.
- Proactively supporting community care through fleet management, home waste collections and medical device management.

“ Expand on existing partnerships and networks such as the Men’s Shed and Vale Community allotments.”
Colleague

“ Neighbourhood Health is of particular interest, and everyone was keen to see a community voice present within the decision-making processes.”
Community Support Group

“ Develop relationships with schools and colleges through community projects, such as artwork and gardens to help breakdown barriers. ”
Colleague

“ Support community groups to access our facilities.”
Colleague

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EFM 2031

Measure	Premises Quality	Compliance	Quality & Colleague Satisfaction	Resource	Cost Control
Target	Reduction from 64 to c50 freehold or leasehold premises	Premises Assurance Model positive responses increase to >500 EFM Digital Maturity Assurance High Maturity increased to > 50%	Quality benchmarks remain in upper quartile	Clinical space utilisation increased from 40% to 60%	Backlog contained <£20m (Do nothing = £30.7m) Operating cost continue to benchmark in upper quartile
Themes	Resource Optimisation Partnerships & Community	Environment and Experience Accessibility and Inclusivity	Environment and Experience Accessibility and Inclusivity	Resource Optimisation Accessibility and Inclusivity Partnerships & Community	Resource Optimisation
Secondary targets	Improved quality, efficiency and clinical alignment of retained premises All space utilised pre-approved by Health & Safety and Infection Control specialists	Enhanced data quality and evidence based decision making	Improved disability and dementia friendly scores. Improved feedback from colleagues and people who use our services	Improved Space utilisation analytics across all room types Increased our use of technology, where advantageous.	Improved Waste cost benchmarking Adoption of best practice Evidenced learning from others

The future of the properties we own and lease

EFM services

Our use of all spaces/premises countywide

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

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 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 June 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 3 position.

Executive summary

- Final accounts were submitted 25th June 2026, and the year-end performance position for GHC was a surplus of £2.013m.
- The Trust has submitted a revised plan to NHSE to reflect the pay award and approved development funding.
- The Trust's annual plan is a £53k surplus. At month 3 the Trust has a surplus of £0.032m, slightly better than 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 3 is £1.043m against a budget of £1.226m.
- Cash at the end of month 3 is £34.326m, which is £6.4m below plan.
- The Trust spent £4.568m year to date on bank staff, against the plan of £4.174m.
- The Trust spent £0.546m on agency staff, against the plan of £0.606m. There were 42 off framework shifts, the target is 0.
- Lydney Health Centre business case to be presented at September Trust Board.

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-10.1/0726 - Finance M3 Report

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

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AGENDA ITEM: 10.1/0725

Finance Report Month 3

30 July 2026

Presented by **Sandra Betney Director of Finance**

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Overview

- Final accounts were submitted 25th June 2026, and the year end performance position for GHC was a surplus of £2.013m.
- The Trust has submitted a revised plan to NHSE to reflect the pay award and approved development funding.
- The Trust's annual plan is a £53k surplus. At month 3 the Trust has a surplus of £0.032m, slightly better than 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 3 is £1.043m against a budget of £1.226m.
- Cash at the end of month 3 is £34.326m, which is £6.4m below plan.
- Cost improvement programme has delivered £3.881m of recurring savings up to month 3. Target for the year is £14.459m. (£5.144m, 28.68% was unidentified at month 3).
- Non recurrent savings target is £3.475m of which £1.485m is delivered. All has been identified.
- The Trust spent £4.568m ytd on bank staff, against the plan of £4.174m.
- The Trust spent £0.546m on agency staff, against the plan of £0.606m. There were 42 off framework shifts, the target is 0.
- Better Payment Policy shows 94.7% of invoices by value paid within 30 days and 91.7% by number of invoices, the national target is 95%.
- Lydney Health Centre business case to be presented at September Trust Board.

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GHC Income and Expenditure

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	2026/27 Plan	2026/27 Revised Budget	2026/27 Revised budget ytd	2026/27 Actuals ytd	2026/27 Variance
Operating income from patient care activities	309,009	313,370	80,528	80,928	400
Other operating income	18,588	18,816	4,796	4,795	(1)
Employee expenses - substantive	(234,236)	(258,013)	(65,371)	(59,407)	5,963
Bank	(16,697)	(2,039)	(510)	(4,568)	(4,058)
Agency	(2,425)	(0)	(0)	(546)	(546)
Operating expenses excluding employee expenses	(72,189)	(70,323)	(19,033)	(20,884)	(1,851)
PDC dividends payable/refundable	(2,847)	(2,847)	(712)	(712)	0
Finance Income	1,000	1,240	440	504	64
Finance expenses	(203)	(203)	(51)	(52)	(1)
Surplus/(deficit) before impairments & transfers	**0**	**(0)**	**89**	**59**	**(29)**
Gains/ (losses) from disposal of assets			0	(40)	(40)
Remove capital donations/grants I&E impact	53	53	13	13	0
Surplus/(deficit)	**53**	**53**	**102**	**32**	**(69)**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	0	0
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0	0
Revised Surplus/(deficit)	**53**	**53**	**102**	**32**	**(69)**
WTEs	4755	4745	4751	4646	(106)

Budget for bank & agency is for specific cost centres, but Plan is for the Trust. The Operating expenses excluding employee expenses variance of £1.851m includes £0.627m for STAR and £0.608m for Out of County placements.

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GHC Income and Expenditure

Plan movements

	Income £000s	Expenditure £000s
Opening Plan 26/27	328,597	(328,597)
Additions to Plan month 3		
Pay Award		
Pay budgets		(3,295)
Non Pay Travel budget		(187)
Unallocated		(133)
Glos ICB funding	3,120	
Glos CC	165	
NHSE	86	
Aneurin Bevan HB	15	
Ed & Training	28	
GHFT	48	
Other income streams	151	
Glos ICB Developments	1,214	(1,214)
Total Revised Plan at month 3	333,425	(333,425)

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Pay Analysis

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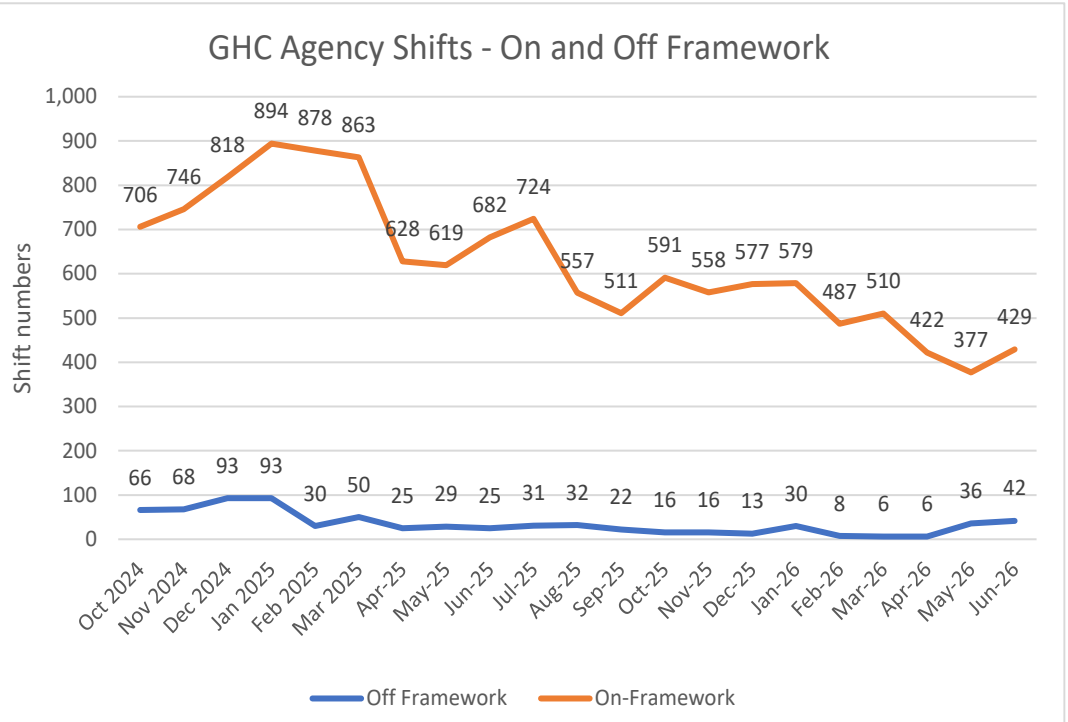
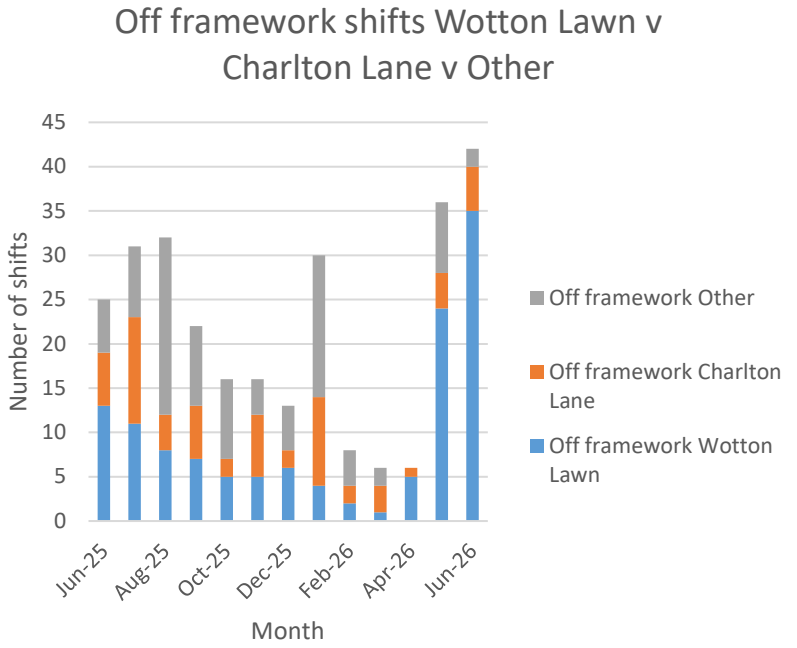
Pay analysis month 3								
	Plan WTE Month 3	Budget WTE Month 3	Actual WTE Month 3	Plan ytd £000s	Budget ytd £000s	Actual ytd £000s	YTD Variance to budget £000s	Actual £ as % of Total £
Substantive	4,386	4,835	4,359	58,559	65,371	59,614	5,756	92.1%
Bank	344	6	263	4,174	510	4,568	(4,058)	7.1%
Agency	22	0	24	606	0	546	(546)	0.84%
Total	4,751	4,841	4,646	63,339	65,880	64,728	1,153	100.0%

- Trust WTE budget 90 higher than plan due to devts
- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- In month 3 the expenditure pay budgets and NHSE plan have been uplifted for the pay award impact
- the Trust used 42 off framework agency shifts in June (33 in May). The target is 0.





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STATEMENT OF FINANCIAL POSITION (all figures £000)		2025/26	2026/27				2026/27
Month 3		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	2,465	2,234	2,296	2,399	104	2,383
	Property, plant and equipment: other	125,254	128,095	124,844	125,162	318	128,224
	Right of use assets	15,797	15,278	15,272	15,388	117	15,371
	Receivables: due from NHS and DHSC group bodies	721	966	993	545	(448)	514
	Receivables: due from non-NHS/DHSC Group bodies		188	188	168	(20)	168
	Total non-current assets	**144,237**	**146,761**	**143,591**	**143,662**	**71**	**146,660**
Current assets	Inventories	385	443	443	385	(58)	385
	NHS receivables	9,224	8,793	8,793	16,422	7,629	9,224
	Non-NHS receivables	7,472	7,612	7,612	9,668	2,056	7,472
	Credit Loss Allowances	(1,351)	(1,919)	(1,919)	(1,343)	576	(1,343)
	Property held for Sale	2,215	1,203	3	1,315	1,312	2,065
	Cash and cash equivalents:	41,303	37,854	40,729	34,303	(6,426)	40,804
	Cash and cash equivalents: commercial / in hand / other		23	0	23	23	23
	Total current assets	**59,247**	**54,009**	**55,661**	**60,773**	**5,112**	**58,630**
Current liabilities	Trade and other payables: capital	(3,270)	(4,295)	(3,318)	(1,674)	1,644	(4,270)
	Trade and other payables: non-capital	(32,313)	(30,753)	(31,465)	(29,941)	1,524	(32,313)
	Borrowings	(1,469)	(1,409)	(1,409)	(1,448)	(39)	(1,469)
	Provisions	(7,333)	(6,870)	(6,870)	(7,508)	(638)	(7,333)
	Other liabilities: incl. deferred income	(426)	(1,453)	(1,453)	(5,991)	(4,538)	(426)
	Total current liabilities	**(44,811)**	**(44,780)**	**(44,515)**	**(46,563)**	**(2,048)**	**(45,811)**
Non-current liabilities	Borrowings	(13,515)	(12,995)	(13,043)	(13,173)	(130)	(13,019)
	Provisions	(2,455)	(2,500)	(2,500)	(1,976)	524	(2,455)
	Total net assets employed	**142,704**	**140,495**	**139,195**	**142,723**	**3,529**	**144,005**
Taxpayers Equity	Public dividend capital	132,972	134,272	132,972	132,972	(0)	134,272
	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	19	19	1
	Total taxpayers' and others' equity	**142,704**	**140,495**	**139,195**	**142,723**	**3,528**	**144,005**

Cash shortfall due to delay in asset disposal and payment of receivables.

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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	40,827	38,264	37,816	37,527
Cash flows from operating activities										
Operating surplus/(deficit)	1,330		319		1,030		1,975	1,950	1,929	1,913
Add back: Depreciation on donated assets	52		13		51		51	51	51	51
Adjusted Operating surplus/(deficit) per I&E	1,383		332		1,081		2,026	2,001	1,980	1,964
Add back: Depreciation on owned assets	9,809		2,496		8,824		9,029	9,600	9,701	10,107
Add back: Depreciation on Right of use assets					1,554		1,415	1,391	1,367	1,151
Add back: Impairment	1,183				0		0	0	0	0
(Increase)/Decrease in inventories	60				0		0	0	0	0
(Increase)/Decrease in trade & other receivables	(148)		(9,613)		(8)		42	43	1	1
Increase/(Decrease) in provisions	(1,519)		(305)		0		0	0	0	0
Increase/(Decrease) in trade and other payables	5,451		(2,877)		0		0	0	0	0
Increase/(Decrease) in other liabilities	(877)		5,565		0		0	0	0	0
Net cash generated from / (used in) operations		15,343		(4,402)		11,451	12,512	13,035	13,049	13,223
Cash flows from investing activities										
Interest received	2,355		490		1,986		958	956	999	999
Interest paid	0				0		(17)	(17)	(17)	(17)
Proceeds from Sale of PP&E	930		860		1,310		2,765	1,176	1,000	0
Purchase of property, plant and equipment	(15,531)		(3,538)		1,750		0	0	0	0
Assets Held for Sale					-13713		(14,283)	(11,155)	(10,896)	(8,956)
Net cash generated used in investing activities		(12,246)		(2,188)		(8,667)	(10,577)	(9,040)	(8,914)	(7,974)
Cash flows from financing activities										
PDC Dividend Received	869		0		1,300		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		28		97		97	96	4	4
Finance lease receipts - Interest	(60)		(15)		(58)		(55)	(52)	(3)	(3)
Interest arising (unwinding of discount)	60		15		58					
Finance Lease Rental Payments	(1,582)		(363)		(1,624)		(1,531)	(1,501)	(1,461)	(1,201)
Finance Lease Rental Interest	(215)		(50)		(186)		(162)	(139)	(117)	(98)
		(3,648)		(386)	0	(3,260)	(4,498)	(4,443)	(4,424)	(4,145)
Cash and cash equivalents at end of period		41,303		34,327	0	40,827	38,264	37,816	37,527	38,631

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Capital – Five Year Plan

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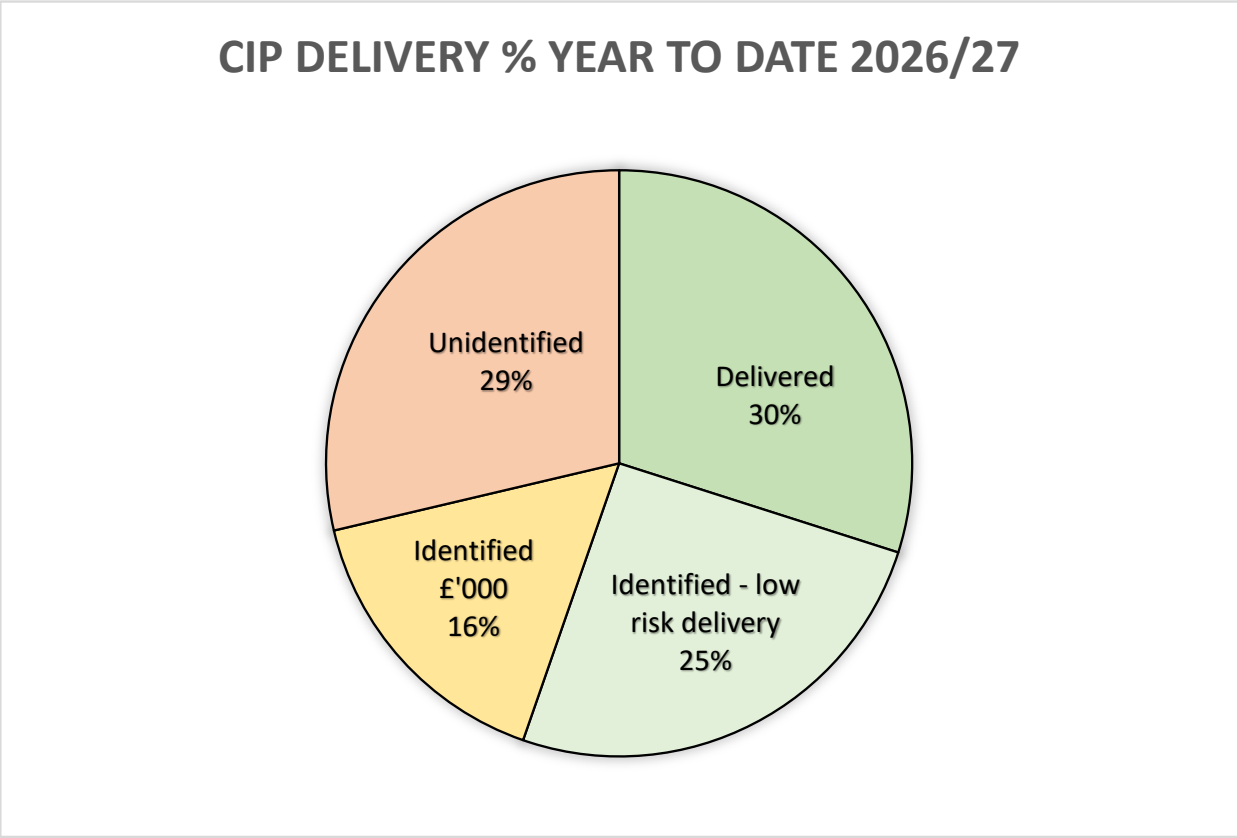
Capital Plan	Plan	Actuals	Plan	Plan	Plan	Plan	Plan
£000s	2026/27	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Land and Buildings							
Buildings	3,871	445	8,250	5,750	2,821	1,636	1,636
Backlog Maintenance	2,451	393	1,393	750	1,400	1,400	1,400
Buildings - Finance Leases	2,458		90	2,115	347	382	382
Vehicle - Purchases / Finance Leases	50	39	250	250	250	250	250
Other Leases	0		0	0	300	0	0
Net Zero Carbon	2,401	744	0	0	1,000	1,000	1,000
Medical Equipment	669	46	630	500	1,200	1,200	1,200
Digital							
IT Devices	200		900	900	1,200	1,200	1,200
IT Infrastructure	1,648	90	1,250	380	1,310	1,310	1,310
WAN/LAN	0		0	1,530	400	400	400
Transforming Care Digitally	1,230	116	250	0	0	0	0
NHS Net Transition	334		0	0	0	0	0
Digital Innovation	0		0	540	590	590	590
Data Centres/Servers	30		840	40	0	0	0
Patient Portal	256	68	0	0	220	220	220
Space Management Toolkit (Estates)	0		0	0	0	0	0
PDC National IT Schemes	1,300		770	765	755	0	0
Unallocated	273						0
Total of Updated Programme	17,171	1,943	14,623	13,520	11,793	9,588	9,588
Disposals	(2,680)	(900)	(2,765)	(1,176)	(1,000)	0	0
Charitable fund donation	(1,750)	0	0	0	0	0	0
Total CDEL spend	12,741	1,043	11,858	12,344	10,793	9,588	9,588
Funded by;							
Anticipated System CDEL	8,916		9,352	9,528	9,750	9,750	9,750
Additional CDEL- Fair Shares Bonus	1,130		0				0
Additional CDEL - 2025/26 Disposals C/Fwd	1,395		0				0
Surplus Spend			2,013				0
PDC National IT Schemes	1,300		380	1,760	0	0	0
Additonal PDC - EVCP/Solar panels							0
CDEL Shortfall / (under commitment)	0		113	1,056	1,043	(162)	(162)

CIP


CIP DELIVERY % YEAR TO DATE 2026/27
Unidentified
29%
Delivered
30%
Identified
£'000
16%
Identified - low
risk delivery
25%

CIP

Summary	Total Target	Delivered	Identified - low risk delivery	Identified £'000	Unidentified
Prior Year(s)	4,304	1,056	980	1,801	467
Efficiency	3,380	1,115	540	420	1,305
Delivering Value	4,877	893	625	566	2,793
Delegated Responsibility	1,044	273	270	82	320
Programme Savings	854	544	50	0	260
Non Recurrent Savings	3,475	1,485	1,990	0	0
Total	**17,934**	**5,366**	**4,454**	**2,869**	**5,144**
Percentage Total		*29.92%*	*24.84%*	*16.00%*	*28.68%*

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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	3,813	4	4	3,813	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.	3,744	4	4	3,744	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	3,066	3	4	3,066	12
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	5,144	3	5	5,144	15
There is a risk that the uplift to the 26/27 contract tariff (1.19%) is insufficient to cover the band 5 job evaluation review as it is unclear how much has been allocated 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	1,184	5	3	1,184	15

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NHSE Early Warning System - Red Flags

NHSE have developed 28 Metrics to identify emerging financial risks. The 6 in exception at month 2:

Category	GHC	Explanation	Calculation	Weighting	Month 2 2026-27	Comments/Actions
			%		Rounded	
Financial Position	YTD provider pay variance to plan	YTD provider pay variance to plan %	-2.24%	2	4	Updated plan to include pay award
	Forecast + Total Risk	FOT + Total Risk % of turnover or allocation	-4.47%	5	4	Identification of CIP
Efficiency	High Risk Efficiency	High risk efficiency FOT as a % of total efficiency plan	37.57%	10	4	Identification of CIP
Cash	Cash metric	Variance on cash after adjusting for revenue position	-13.25%	2	4	Resolve NHS Receivable delays
Workforce	Temporary staffing - Bank	Ytd Bank variance to plan	-6.50%	0.5	3	Wotton Lawn and service pressures
Other	Plan Sign Off Conditions	1. reduce high risk efficiency 2. workforce alignment review	Plan conditions partially achieved inline with expectations	2	3	Identification of CIP
	Raw Score with Override				2	

Intervention Level

Concern category	Concern definition	Intervention category	Nature of Intervention	Typical actions
Level 2	Delivery is likely but not assured	Enhanced monitoring and support	More frequent and in-depth oversight. Supportive, collaborative engagement. Greater focus on assuring delivery assumptions and mitigations.	More detailed monthly assurance, focusing on what needs to be delivered. Targetd deep dives. Informal regional / system finance engagement.

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

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AGENDA ITEM: 11/0725

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT – JUNE 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 Board with a summary assurance update on progress and achievement of indicators across Trust Physical Health, Mental Health, and Learning Disability services.

Recommendations and decisions required.

The 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 2026/27. This report is produced monthly for Operational Delivery and Quality Governance Forums, Quality Committee and Trust Board. Following discussion at QAG this Dashboard moves 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.

- We continue to develop the Quality Dashboard to supplement the Integrated Performance Quality Report and to incorporate any suggestions and recommendations for improvement.

Quality issues for priority development:

- 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?
Quality Assurance Group (QAG)

Appendices:	AI-12.1/0726 - Quality Dashboard Report –June 2026 Data

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

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11.1 /0725

QUALITY DASHBOARD 2026/27

Physical Health, Mental Health and Learning Disability Services

Data covering June 2026

This reports brings together quality focused datasets to fulfil statutory duties, legal requirements and mandated responsibilities. Some of the datasets will align to those within the Integrated Quality and Performance Report that goes to Resources Committee and Great Place to Work Committee.

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

Alert, Advise, Assure, Applaud

Alert

- Data across the dashboard continues to demonstrate the sustained clinical acuity and workforce pressures known at Wotton Lawn Hospital.
- Whilst we are reporting a position of compliance with NHS England (NHSE) /Safe Staffing Guidance in June for our inpatient nursing services, there is partial assurance in relation to the position for the staffing levels at mental health inpatient services, particularly Wotton Lawn Hospital. Fill rates above 100% are indicative of higher levels of clinical acuity and whilst there is assurance that no patient safety incidents were directly attributable to staffing shortfalls, the known gaps in leadership and workforce have led to an increase requirement in bank and agency staffing to ensure safe staffing levels are achieved.
- The variability in staffing from increased temporary staffing use is likely to be having some clinical impact, given the ongoing higher levels of reporting of self-harm and self-injurious behaviour, restraint and rapid tranquillisation. There is increased senior operational and senior clinical presence across the site to support stabilisation.
- As part of the improvement plan at Wotton Lawn Hospital, the Safeguarding Team have commenced a regular presence of member of the team at the site to offer safeguarding supervision and ad hoc consultation and is open to all staff. This will be maintained for at least 3 months alongside other elements of the improvement plan related to safeguarding training and clinical supervision.
- This month only 46% of complaints were closed within 3 months. This is the first time the key performance indicator of 50% has not been achieved. There are also 8% complaints that have not been closed within 6 – 12 months. This is almost entirely down to capacity issues in the Patient Carer Experience Team (PCET) and operations teams in responding to the total volume of activity, where enquiries are also up significantly on 2025/2026 figures.

Alert, Advise, Assure, Applaud

Advise

- During June early incident monitoring by the Patient Safety Team and Operations identified several reported incidents that appeared to indicate a connection between the heat wave and an increase in mortality of individuals known to Community Mental Health Teams. Colleagues rapidly met and immediate actions were agreed in anticipation of ongoing high weather temperatures including raising awareness and providing health related information. The early surveillance information was shared with relevant partners in the system including Public Health.
- The Datix Team continue to make improvements and new developments on the Datix system. Mental Health Inpatient and Children's OT Dashboards have been designed and shared with teams. The team are currently working closely with the risk team to make improvements to the Trust Risk Register.
- In June, the Eating Disorders team have reported 8 incidents where individuals have been assessed as having physical observations outside of expected parameters and have used this category to document that they have escalated for further medical assessment. We have requested that a specific sub-category be added onto Datix to ensure consistency of reporting for these incidents.
- This month the number of positive FFT responses has gone down to 91% reflective of the trend for this year)

Alert, Advise, Assure, Applaud

Assure

- Two NED visits were undertaken in April and May, a summary slide for each visit is contained within this report. At both Tewkesbury Community Hospital and Stroud Crisis team, the visits identified positive team cultures and a commitment to delivering good quality patient care. At Tewkesbury it was identified that further staff engagement about changes in structures and digital innovation may be beneficial

- At an inquest in June 2026, the Coroner highlighted the importance of being able to demonstrate that learning arising from a PSII had been acted upon, with recommendations implemented, embedded into practice, and reviewed for effectiveness. The Coroner was assured by the evidence provided of service improvements and concluded that a Prevention of Future Deaths Report was not required.

- 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 a monthly Enhanced Oversight Group with the Integrated Care Board to monitoring discharge pathways.

- There was 1 case of *C.difficile* on Coln Ward, Cirencester Hospital. Effective management and no nosocomial transmission provides good assurance that IPC policies are being adhered to.

Applaud

- At both Tewkesbury Community Hospital and Stroud Crisis team, the NEDs identified positive team cultures and a commitment to delivering good quality patient care from the NED Quality visits.

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 (MASH, MARAC, reviews, and child death process) and work related to responding internally (advice line, escalations, Allegation Management).

Key points to note are,

- Timescales for the Multi-Agency child protection team (MACPT) project remain tight as it will become a statutory function in April 2027, with the roll out within Gloucestershire being planned for 3rd October 2026. The CYPS Transformation Programme Board meeting agreed the health element of the service would remain in GHC beyond the pilot with a decision with finer details on the commissioning arrangements expected imminently.
- Staffing issues are improving within the Safeguarding Team with the position expected to be fully recovered by the end of July.
- Risk 299 and the availability of safeguarding information on clinical systems continues to challenge. It has been identified that some practitioners were not using the S1 template therefore we have sent out further comms and reminded mangers to request that their staff complete the training on Care 2 Learn. This will also be an agenda item at the Safeguarding Group meeting with managers on 29/07/26.
- There were 5 new cases considered by the allegation (AMM) process in June, with 33 meetings during the month in response to the number of open cases. This activity is often required to occur at short notice and to be fit between existing work to be responsive to information as it is gathered through fact finding.
- The drop in the number of Safeguarding adult reviews to 12 in June is due to the team updating the system and reflects more accurately the number of reviews currently underway. Learning and recommendations are disseminated through the Trust and down to practitioners. A recent notable recommendation was from the Domestic Homicide Reviews that identified GHC would benefit from having their own domestic abuse training and the Safeguarding Team are in the process of rolling this training out.

* show that during that month, no data was collected. All data since the * are newly reported

	Apr-26	May-26	Jun-26	Q1
Number of Safeguarding Escalations	3	1	0	4
MARAC - Families screened/researched	114	137	129	380
MARAC – Children & Adults researched	*	420	438	858
MASH - Children & adults researched	1,402	1.252	1,463	4,117
Number of Adult Reviews ongoing	27	25	12	64
Number of LCSPRs in progress	1	1	1	1
Number of Rapid Reviews attended	0	1	0	1
Expected Child Deaths	0	1	0	1
Unexpected Child Deaths	0	0	1	1
New Allegation Management cases	3	8	5	16
Number of Allegations Management Meetings held this month	14	20	33	67
Adult Safeguarding Referrals made	n/a	n/a	n/a	n/a
MARFs (child referrals) made	n/a	n/a	n/a	n/a
Safeguarding Advice Line Calls - Children	28	42	45	115
Safeguarding Advice Line Calls - Adult	58	54	53	165

Are Services Safe? - Safeguarding

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

- Level 4 adults training has returned to 85% following new training dates becoming available for attendance.
- The drop L3 adults training compliance is being addressed through communications across the Trust to managers as there are dates and spaces available on Care2Learn.
- Compliance with Children's Safeguarding Level 3 training remains static at 86%. Managers across CYPS have received reminders re training requirements. The Gloucestershire Children's Training Partnership (GSCP) continues to provide a variety of training dates, including Saturday sessions.
- Training compliance will be a matter raised and discussed in the next Safeguarding Group meeting at the end of July.

Prevent and MCA training remain strong and stable in compliance.

Safeguarding supervision:

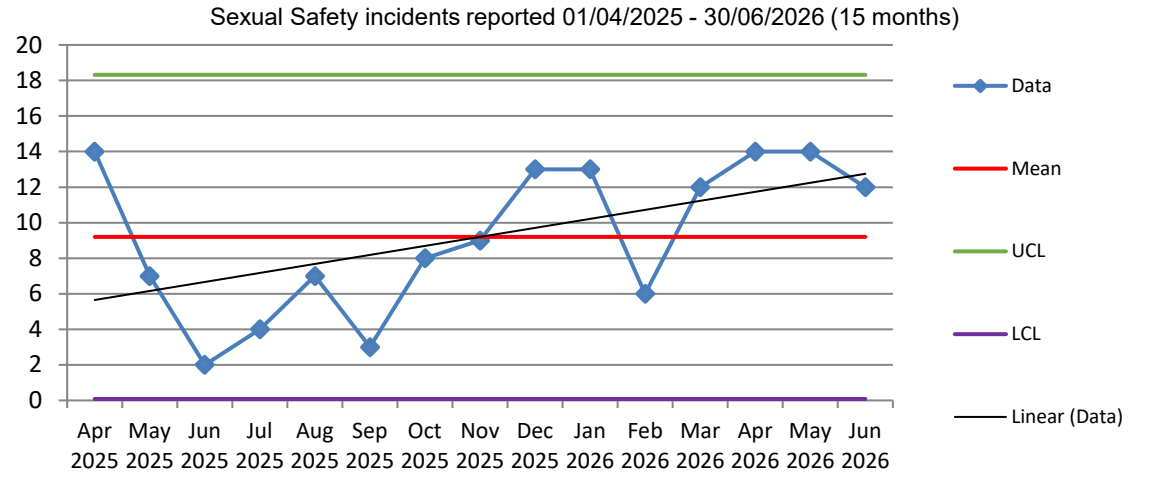
- Children's safeguarding supervision: This is essential to role for those working with under 18s and should occur 3 times a year. Being below target (67%), a deeper dive has evidenced that the recording system cannot record attendance more that every four months and this anomaly impacts compliance. More sessions are being added if there is a waiting list. The timescale to review current supervision arrangements has been extended to end of Quarter 3 due to the recent team capacity.
- Adult safeguarding supervision: Not essential to role but good practice. Five sessions were scheduled but only one session went ahead due to only 2 staff booking on.
- Increased safeguarding team presence at Wotton Lawn Hospital has commenced with the first supervision session having 4 staff attending. Arrangements for the next 6 months are being finalised.

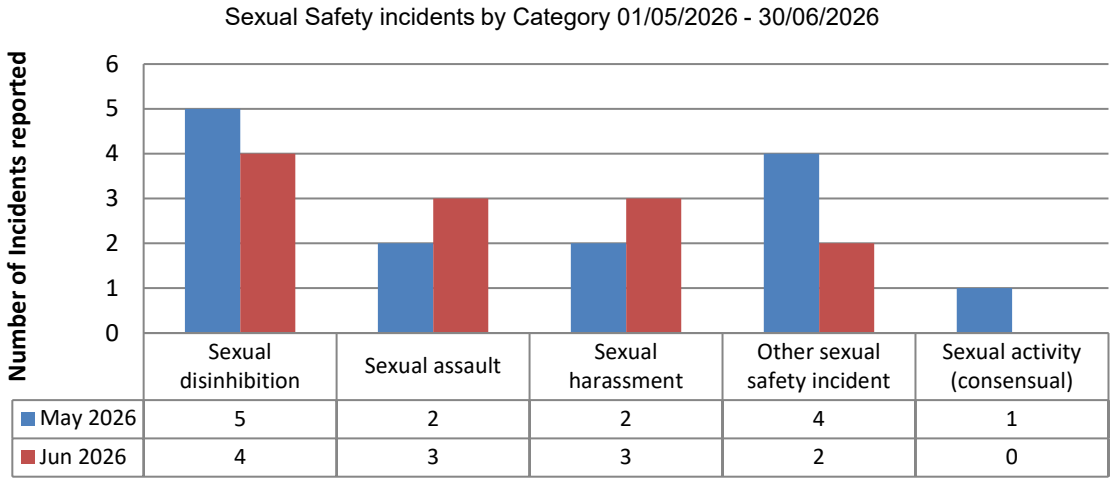
GHC - Safeguarding Dashboard 2026/27
Training and Supervision Data

	Apr-26	May-26	Jun-26	Q1
TRAINING				
Level 1 – Induction	98%	98%	98%	98%
Level 2 – Think Family	96%	96%	97%	96%
Level 3 – Multi-Agency Child Protection	86%	86%	86%	86%
Level 3 Adult Protection	91%	91%	86%	89%
Level 4 - NSPCC Level 4 safeguarding training for named health professionals	*	*	100%	*
Level 4 Adult Protection	83%	67%	85%	89%
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	90%	91%	91%	91%
Bespoke MCA Training	7	5	2	14
SAFEGUARDING SUPERVISION				
CHILDREN:				
Group Supervision Sessions	21	20	22	63
Group Supervision Compliance	69%	67%	67%	68%
One to One Supervision Sessions	6	8	8	22
ADULTS:				
Group Supervision Sessions	2	2	1	4
Number of Staff who attended Supervision	9	6	2	17
One to One Supervision Sessions	1	1	1	3

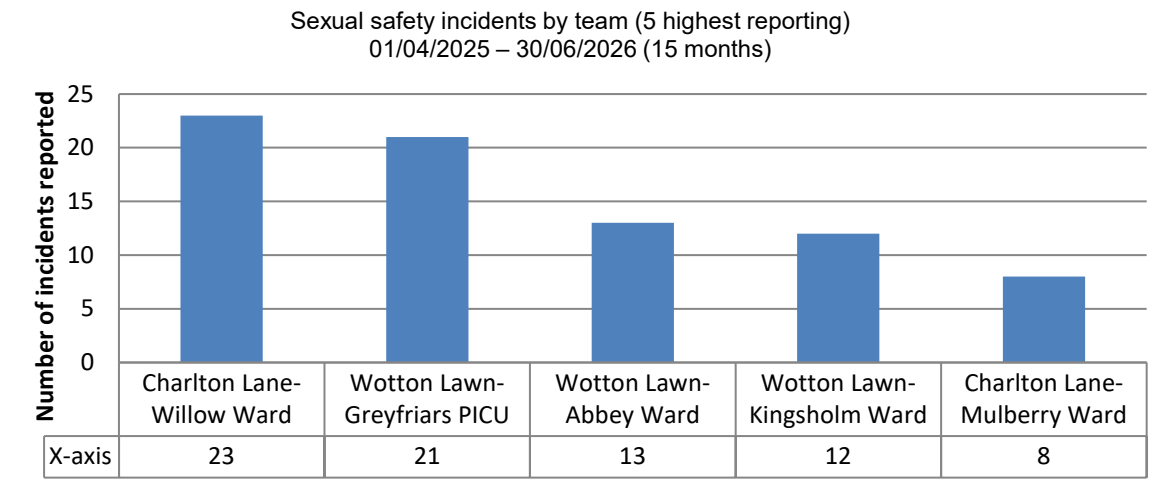
* show that during that month, no data was collected. All data since the * are newly reported

Sexual Safety Incidents

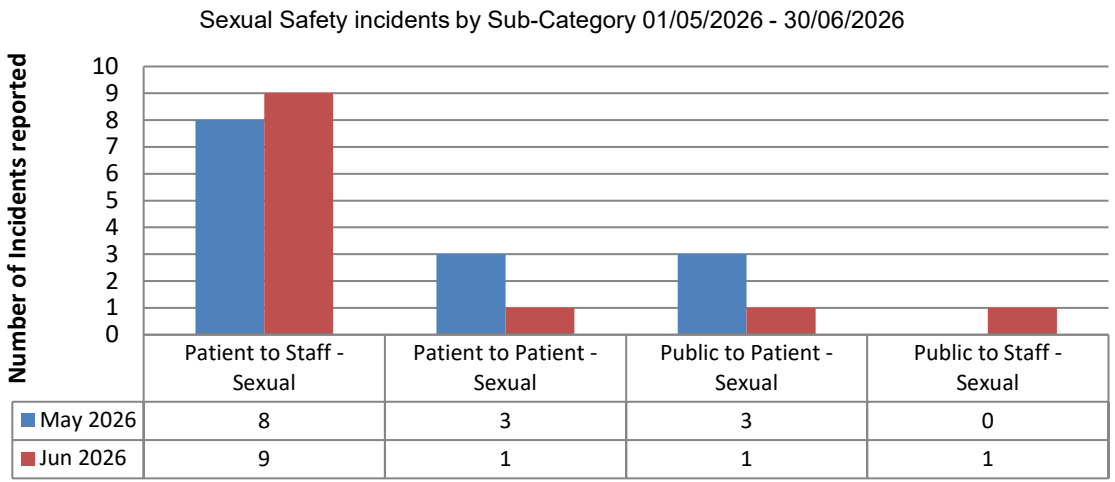




	Sexual disinhibition	Sexual assault	Sexual harassment	Other sexual safety incident	Sexual activity (consensual)
May 2026	5	2	2	4	1
Jun 2026	4	3	3	2	0



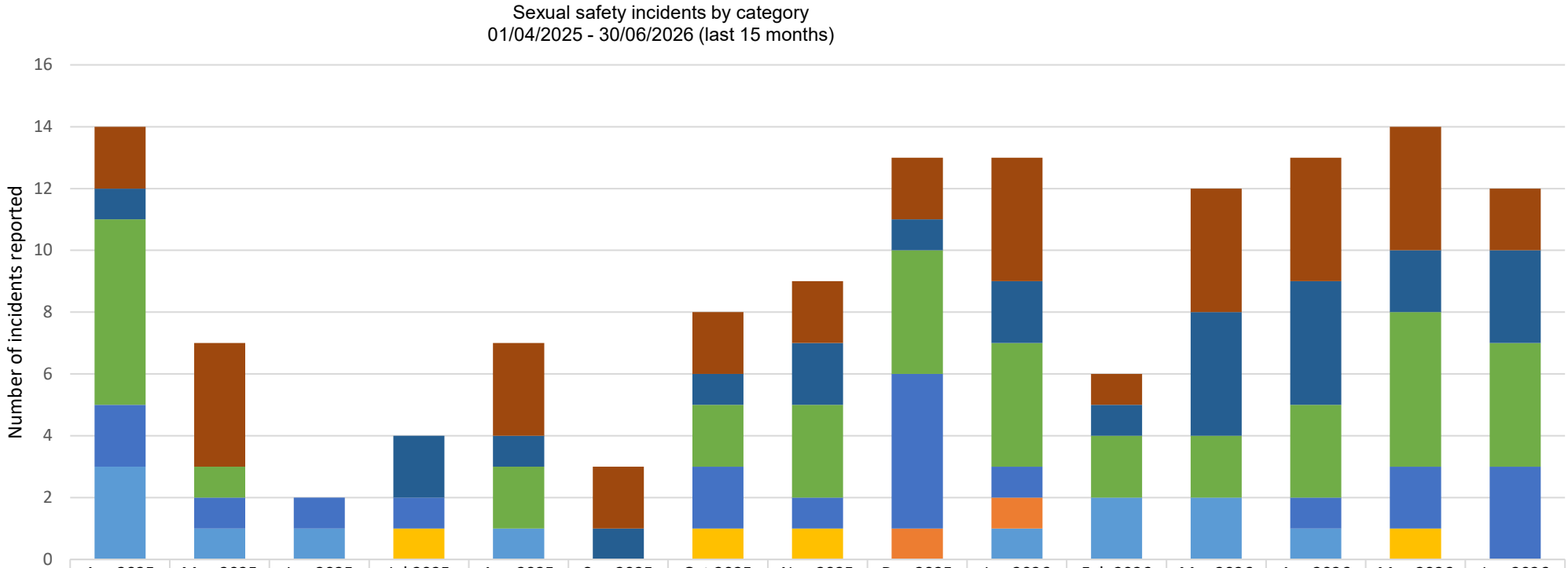
	Charlton Lane-Willow Ward	Wotton Lawn-Greyfriars PICU	Wotton Lawn-Abbey Ward	Wotton Lawn-Kingsholm Ward	Charlton Lane-Mulberry Ward
X-axis	23	21	13	12	8



	Patient to Staff - Sexual	Patient to Patient - Sexual	Public to Patient - Sexual	Public to Staff - Sexual
May 2026	8	3	3	0
Jun 2026	9	1	1	1

All incidents are reviewed as per patient safety policy and appropriate actions have been taken place. Most incidents are reported by inpatient services though this is anticipated to reflect under reporting across the Trust.

Sexual Safety Incidents

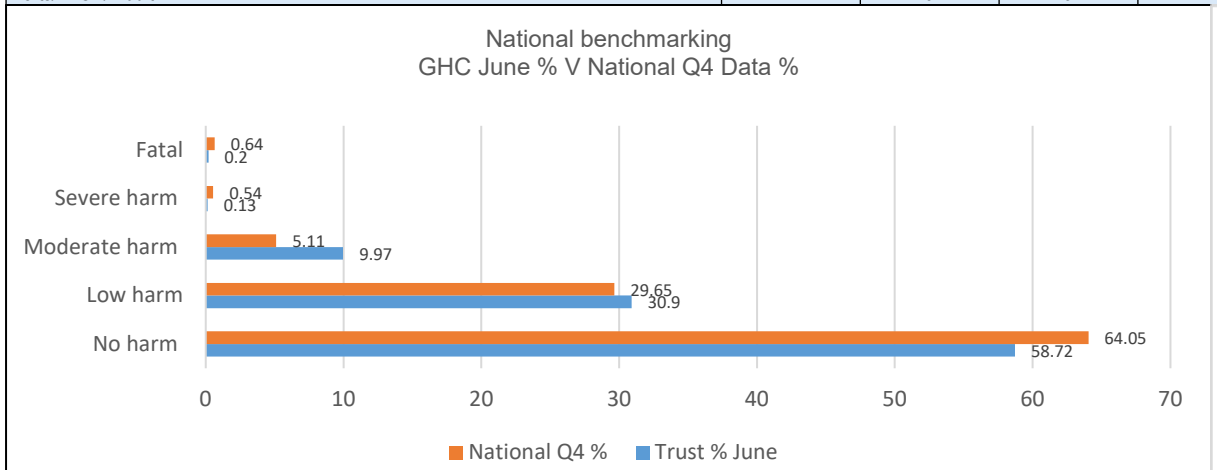


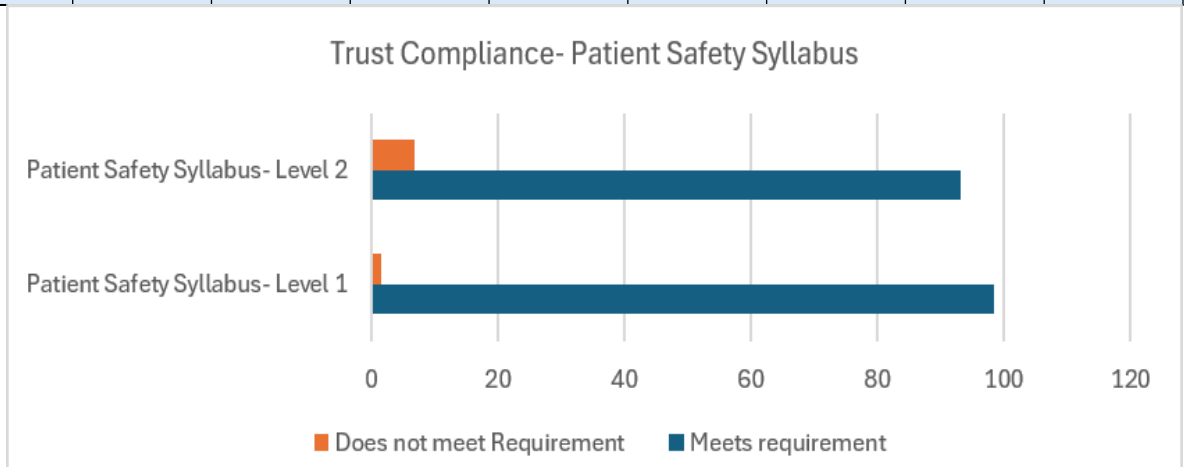
	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Other sexual safety incident	2	4	0	0	3	2	2	2	2	4	1	4	4	4	2
Sexual harassment	1	0	0	2	1	1	1	2	1	2	1	4	4	2	3
Sexual disinhibition	6	1	0	0	2	0	2	3	4	4	2	2	3	5	4
Sexual assault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

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	1384	1454	1524									
Number of No Harm and Low Harm incidents (including skin integrity)	1223	1340	1363									
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	161 (11.6%)	114 (7.8%)	161 (10.6 %)									
Patient Safety Investigations												
Number of AARs completed in Month	2	2	1									
Number of New PSIIs and Care Reviews declared in month	3	1	0									
Number of PSIIs open	14	15	15									
Number of PSIIs closed in month	0	0	0									
Number of Care Reviews open	2	2	2									
Number of Care Reviews closed	0	0	0									
Number of PSIIs and Care reviews open over 6 months	10	13	13									
Number of PSIIs/ Care Reviews planned for Exec sign off (Closure)	0	2	2									
Family Liaison Practitioners												
Number of patients being supported	0	0	0									
Number of family and friends being supported	14	14	14									
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner	0	0	0									
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AARs/ Care Reviews/ PSIIs)	36	30	32									
PCET	24	28	33									
Alerts/ NICE/ Audit	1	3	3									





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

What is the data telling us?

Trust Data:

- The number of reported incidents has increased over quarter 1 to June, where the proportion of no and low harm and moderate+ harm have remain relatively consistent each month.
- Our monthly data is benchmarked against NHS England have published the Q4 National Data. To note where national reporting has seen a slight increase in the overall percentages for moderate harm, severe harm and fatal incidents, our incidents in June have higher percentages in moderate and low harm incidents than this Q4 National data.
- During June early incident monitoring by the Patient Safety Team and Operations identified several reported incidents that appeared to indicate a connection between the heat wave and an increase in mortality of individuals known to Community Mental Health Teams. Colleagues rapidly met and immediate actions were agreed in anticipation of ongoing high weather temperatures including raising awareness and providing health related information and water bottles to individuals with a mental illness or on psychotropic medication, reviews of clinical caseloads by community teams to identify vulnerable patients and ensuring additional support and advice is given to specific vulnerable patient groups and partners supporting them. The early surveillance information was shared with relevant partners in the system including Public Health. The Patient Safety Team has continued to monitor incidents related to providing care in high weather temperatures with actions cards and clinical guidance being reviewed to reflect best practice advice. Across clinical records there has been evidence of increased record keeping that hydration and heat related advice has been given.

Patient Safety Team:

- There was 1 After Action Review completed in June, a further 6 are booked or being planned with clinical teams.
- 13 PSIIs/ Care Reviews have been open longer than 6 months, these do continue to progress along internal governance routes with1 report taken to an extra-ordinary Executive sign off group (rescheduled) and 2 planned for July's Executive sign off group. The factors for the delays are known, and progress of these reviews is monitored in a fortnightly Sitrep meeting. The Patient Safety Team have met with neighbouring patient safety teams to understand their approach in implementing PSIRF, and it has indicated similar pressures in completing the reports in an expected 6-month timeframe.
- 0 PSIIs and Care reviews were closed in June, although 1 report is approved subject to changes and 0 PSII was declared.
- Family Liaison Practitioners continue to offer contact with 14 families; at the present time we are not supporting any patients due to the circumstances of the incidents.
- Our Datix Team continue to make developments on the Datix system; Mental Health Inpatient and Children's OT Dashboards have been designed and shared with teams. The team are currently working closely with the Risk Management Team to make improvements to the Trust Risk Register.
- In May we introduced a question relating to the impact on patient care with the Over roadworks, 0 incidents have yet cited this as a factor.
- From August we intend to share data relating to the activity of the Patient Safety Team that is now being recorded on Datix. In June the Patient Safety Team reviewed and dip sampled and reviewed 27% of incidents despite only 10.6% of incidents meeting the moderate + harm threshold for Patient Safety Team involvement. This triage approach is undertaken to quality check incident reports especially where incidents are recorded as a 'near miss'.

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

Learning Assurance:

- The Learning Assurance team have been engaging with the Group Directors regarding the next NED visits, all have provided a list of teams to connect with.

- Two NED visits were undertaken in April and May, a summary slide for each visit is contained within this report. At both Tewkesbury Community Hospital and Stroud Crisis team, the NED's identified positive team cultures and a commitment to delivering good quality patient care. At Tewkesbury it was identified that further staff engagement about changes in structures and digital innovation may be beneficial

- **Learning from Inquests:** Coroners may consider issuing a Section 28 Prevention of Future Deaths Report where there is concern that risks identified could lead to similar incidents occurring in the future.

- At an inquest in June 2026, the Coroner highlighted the importance of being able to demonstrate that learning arising from a PSII had been acted upon, with recommendations implemented, embedded into practice, and reviewed for effectiveness. The Coroner was assured by the evidence provided of service improvements and concluded that a Prevention of Future Deaths Report was not required.

- This case highlighted the significant scrutiny applied at inquest, with a particular focus on the organisation's ability to evidence that learning has translated into sustained improvements in patient safety. It reinforces the need for robust systems to monitor, assure, and demonstrate the impact of actions arising from PSIIs across the organisation.

NED Quality Visit-Summary

Date of Visit	11 May 2026	Name of NED	Debbie Forster	Team Service	Tewkesbury Community Hospital	Directorate	Community Hospitals and Urgent Care Directorate

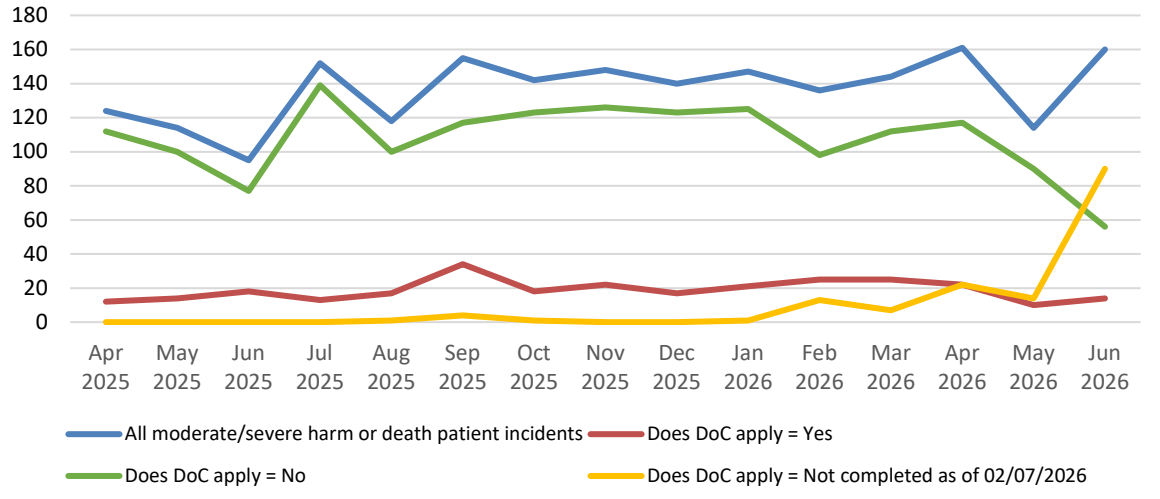
Feedback on Visit

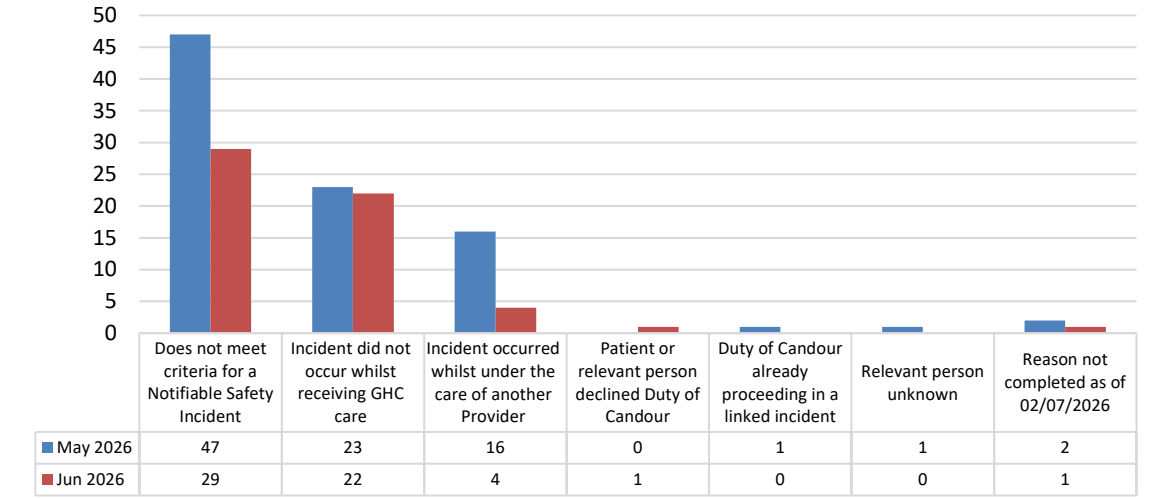
Summary of Positive areas/ Good Practice	• **Welcoming culture and visible leadership:** The hospital had a warm friendly atmosphere, with a close-knit team and a highly visible Hospital Matron whose leadership was evident through regular engagement with staff and clinical areas. • **High quality patient-centred care:** Patients spoke positively about their experiences, and numerous examples demonstrated the team's commitment to compassionate, personalised care, including creative initiates to enhance patient wellbeing. • **Engaged and proud workforce:** Colleagues clearly took pride in their roles , working respectfully together and were open in sharing ideas for service improvement while recognising operational challenges. • **Strong clinical performance:** Performance indicators were excellent, including a 98% compliance with the 4-hour MIIU standard, 100% compliance with VTE and falls risk assessment, and no reported pressure ulcers or Clostridioides difficile infections during the reporting month. • **Positive outlook for service development:** Staff were supportive of forthcoming directorate reorganisation, recognising its potential to improve communication, integration and shared learning between MIIU and NHS 111 services.	Reflections	• **Systems pressures continue to affect service delivery:** Poor advice and inappropriate referrals from NHS 111 and limited social care capacity were identified as significant challenges, contributing to inappropriate attendances, delayed discharges and extended lengths of stay. While these issues are recognised at system level, they continue to have a substantial operational impact. • **Staff are optimistic but want greater engagement:** The directorate reorganisation was viewed positively as an opportunity to improve communication and collaboration between services. However, staff would welcome clearer communication from leadership about future direction of the service and greater involvement in shaping improvements. • **There is strong support for digital innovation:** Staff were enthusiastic about using digital tools, including AI, to reduce administration workload and improve efficiency. They recognised that progress would depend on overcoming barriers such as the use of multiple clinical systems that do not communicate with each other, alongside time and resource constraints.
Agreed Next Steps		**Actions (if required)**	
• None identified	• Strengthen staff engagement and communication by providing clear, consistent updates on the directorate restructuring and creating opportunities for frontline staff to inform service planning. • Explore digital innovation through small –scale AI and digital tool pilots to reduce administration burden, while recognising the limitations of current system complexities. • Maintain momentum in developing site capacity, particularly by maximising the potential of the operating theatre and wider site, building on strong staff engagement and support. • Sustain focus on patient flow by continuing to address the impact of social care capacity constraints through senior oversight and system-wide partnership working.		

NED Quality Visit-Summary

Date of Visit	28 April 2026	Name of NED	Dr Steve Alvis	Team Service	Stroud CRHTT	Directorate	MH & LD Urgent Care and In-Patient
Feedback on Visit							
Summary of Positive areas/ Good Practice	• **Positive team culture and engagement:** the daily morning meeting demonstrated a highly engaged and supportive team culture. All staff actively contributed, were listened to, and appeared comfortable sharing their views, reflecting a collaborative and inclusive working environment. • **Patient-centred care**: Observation of a joint visit by a social worker and nurse highlighted a calm, professional and compassionate approach. The patient and carers ere given ample opportunity to express their concerns, received appropriate reassurance, and were actively involved in agreeing the care plan and follow up arrangements. • **Supportive leadership and staff development:** Staff spoke positively about the support they receive and described having good access to training, learning opportunities and regular updates to support their professional development. • **Workforce**: The service currently operates with 13-hour shifts, typically three shifts per week. It was encouraging to hear that all vacancies had been successfully recruited to, with several new staff awaiting their start dates.			Reflections	• **NHS 111 Option 2**: patients and carers continue to experience anxiety due to long wait times and complex triage processes. Consideration should be given to streamlined access for existing service users. • **Increasing pressure on community services:** Difficulties securing hospital admissions mean more acutely unwell patients are being managed in the community, increasing demand on already stretched resources. • **Operational resilience**: Minor IT connectivity issues with pool vehicles were reported but are being managed effectively, with no significant impact on service delivery.		
Agreed Next Steps				**Actions (if required)**			
• None identified	No Actions Identified						

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



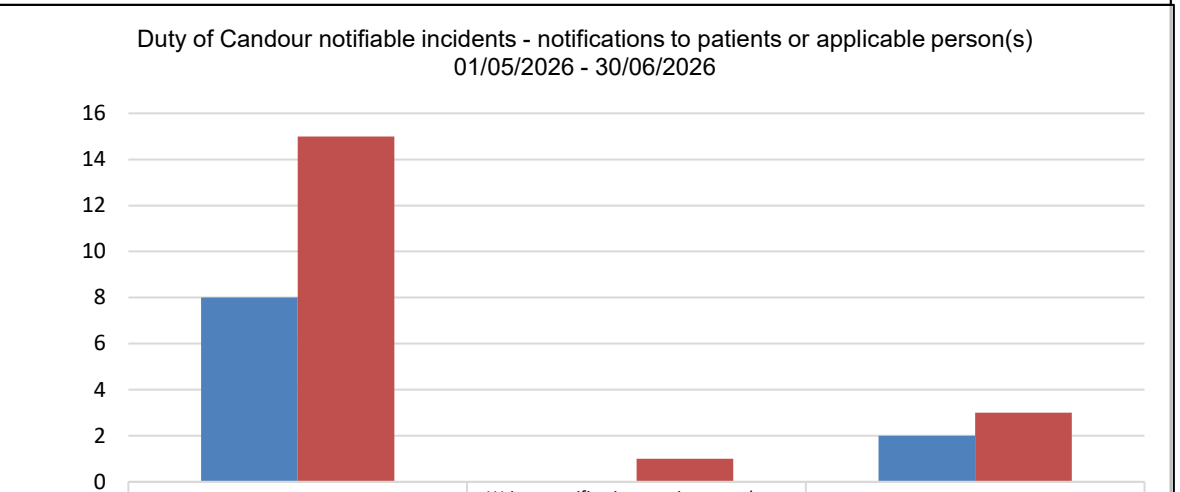


	Does not meet criteria for a Notifiable Safety Incident	Incident did not occur whilst receiving GHC care	Incident occurred whilst under the care of another Provider	Patient or relevant person declined Duty of Candour	Duty of Candour already proceeding in a linked incident	Relevant person unknown	Reason not completed as of 02/07/2026
May 2026	47	23	16	0	1	1	2
Jun 2026	29	22	4	1	0	0	1

What is the data telling us:

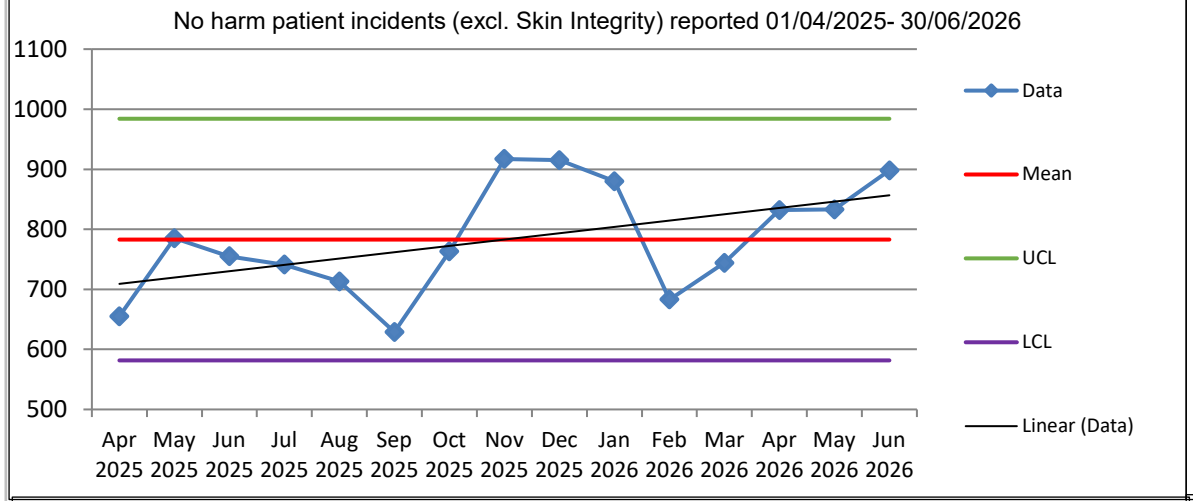
The DOC position for incidents reported in the previous month (May) is now revised and more accurate, noting that incidents reported in the current month (June) may still be awaiting handling and confirmation of harm level:

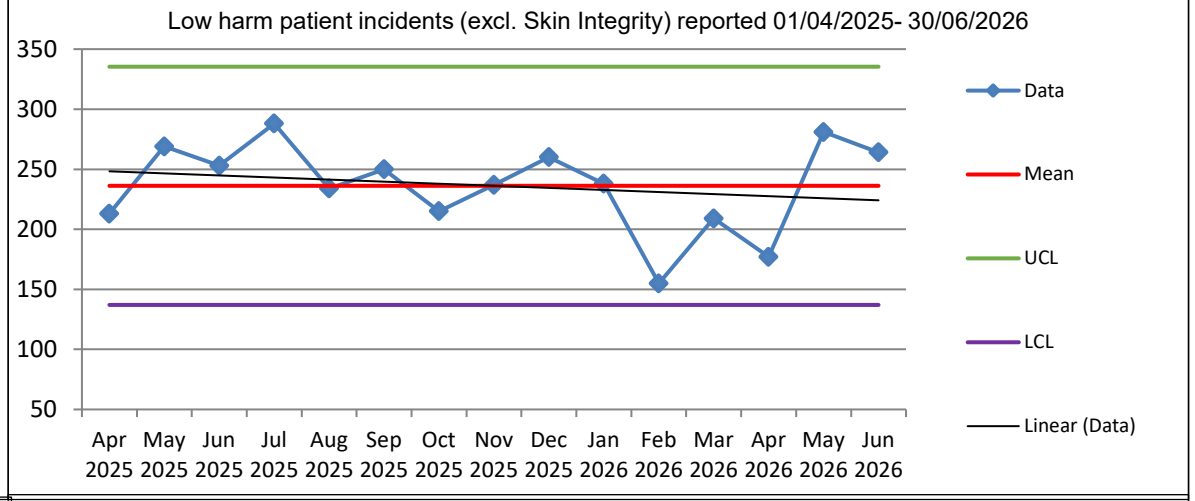
- Following confirmation of harm there are 10 fewer moderate harm or above incidents in the previous month's data.
- We were waiting to understand if DoC applied in 45% of incidents reported, this figure is now at 12%.
- DoC regulation 20 did not apply in 78% of incidents in May and a reason for this has been provided in 98% of incidents.
- DoC regulation 20 applied in 10 incidents; confirmation of the notification provided is awaited in 2 incidents, but these will not be closed by the PST until this is received.
- The most common reasons for DoC not applying is that the incident does not meet the criteria for a notifiable safety incident.
- In line with national guidance a number of these incidents do relate to care provided by neighbouring organisations, so DoC does not apply for our Trust but these organisations are informed by our incident sharing arrangements.

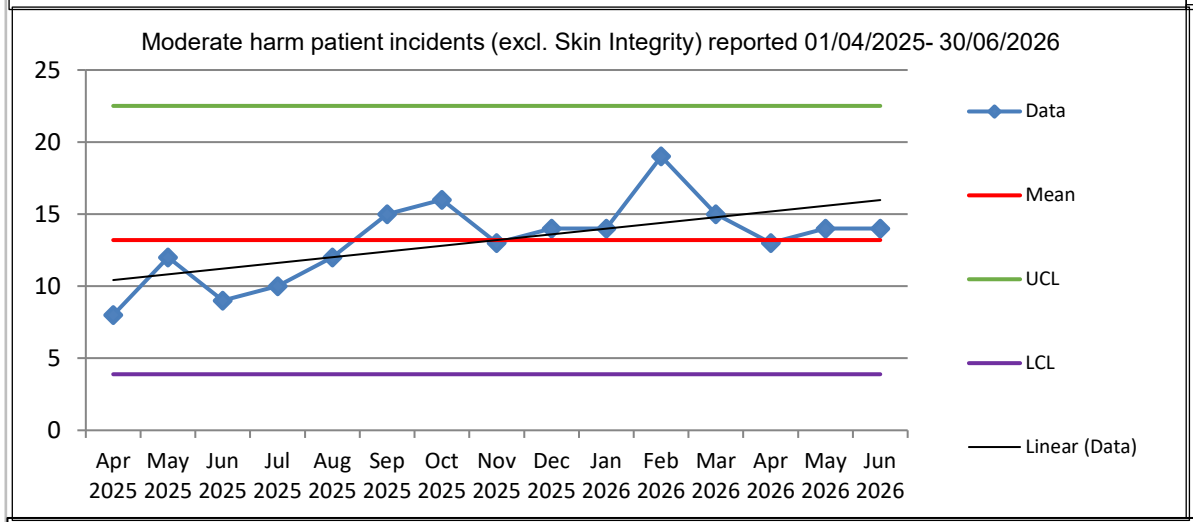


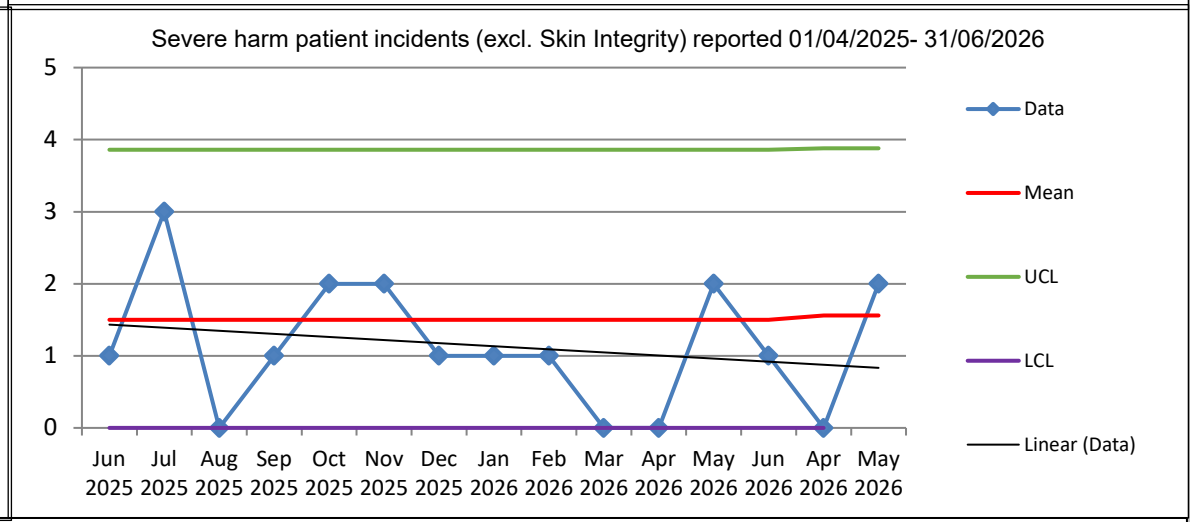
	Verbal notification requirements have been met and documented in clinical record	Written notification requirements have been met, detailed in the Duty of Candour letter and uploaded to the clinical and/or Datix records	Duty of Candour applies but no notifications (either verbal or written) recorded as of 02/07/2026
May-26	8	0	2
Jun-26	15	1	3

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





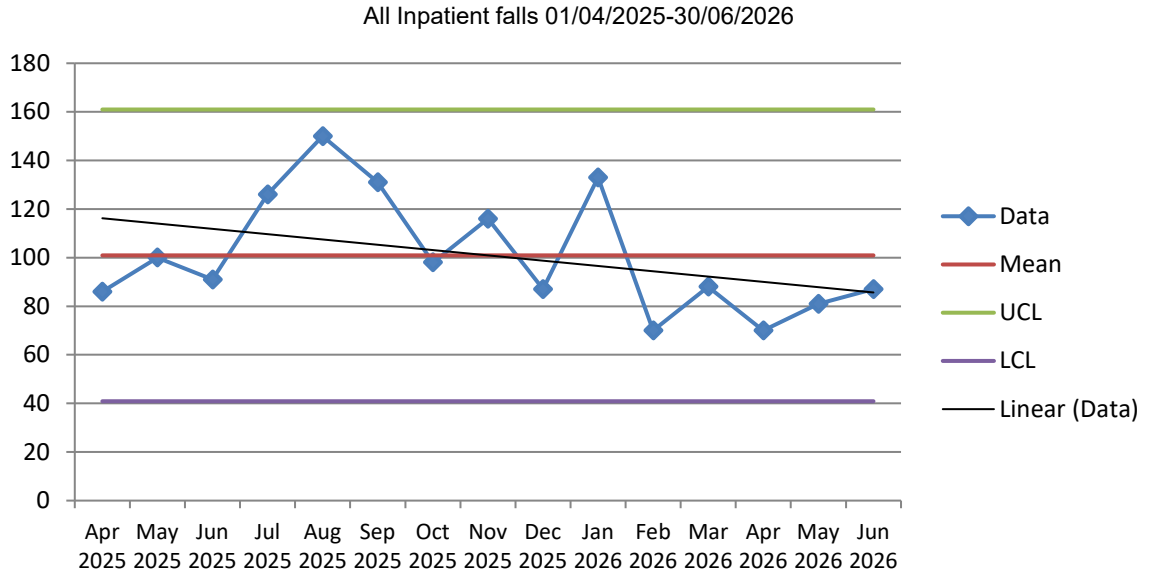


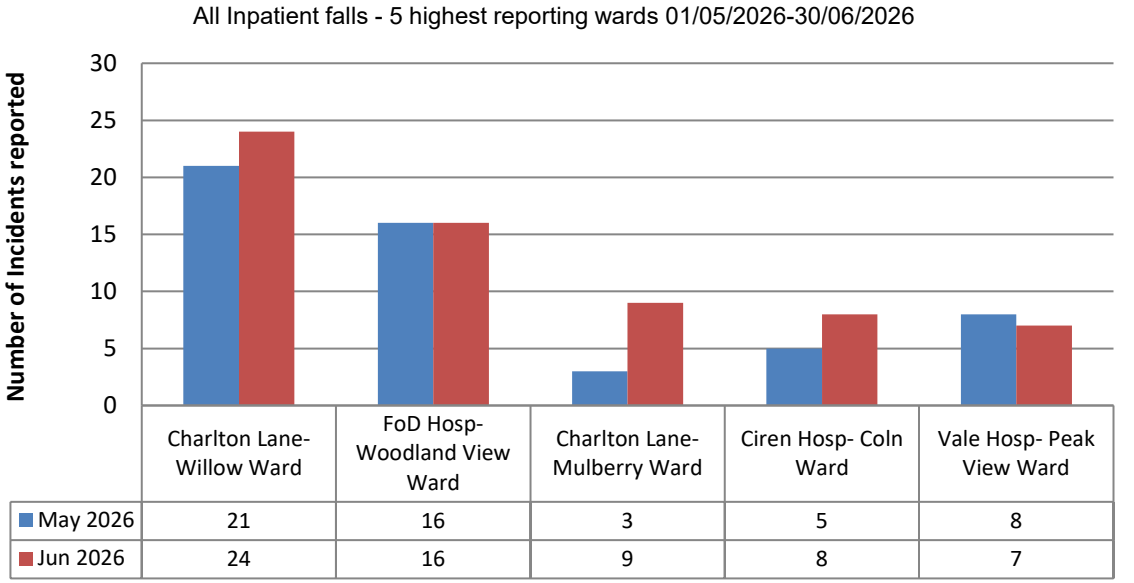


What is the data telling us:

- One severe harm incident relates to the safe management of a patient under the Mental Health Act requiring attendance to the Emergency Department; whilst the incident is attributed to another partner, learning is being taken forward with system partners. The other severe harm incident relates to skin integrity and is a stage 4 pressure ulcer which is being appropriately managed following local clinical review.
- In June, three deaths were reported as incidents, we are awaiting further information from the Coroner on two deaths which will inform if a learning response is required. One death has been considered at Patient Safety Panel with agreement that no further learning response is required due to the level of contact with services.

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

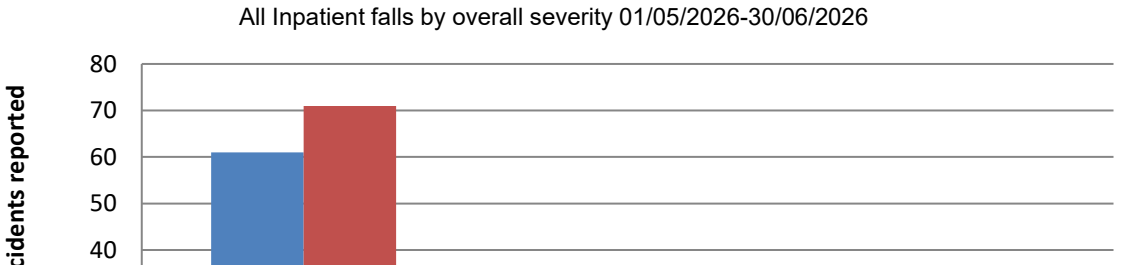




	Charlton Lane-Willow Ward	FoD Hosp-Woodland View Ward	Charlton Lane-Mulberry Ward	Ciren Hosp- Coln Ward	Vale Hosp- Peak View Ward
May 2026	21	16	3	5	8
Jun 2026	24	16	9	8	7

What is the data telling us:

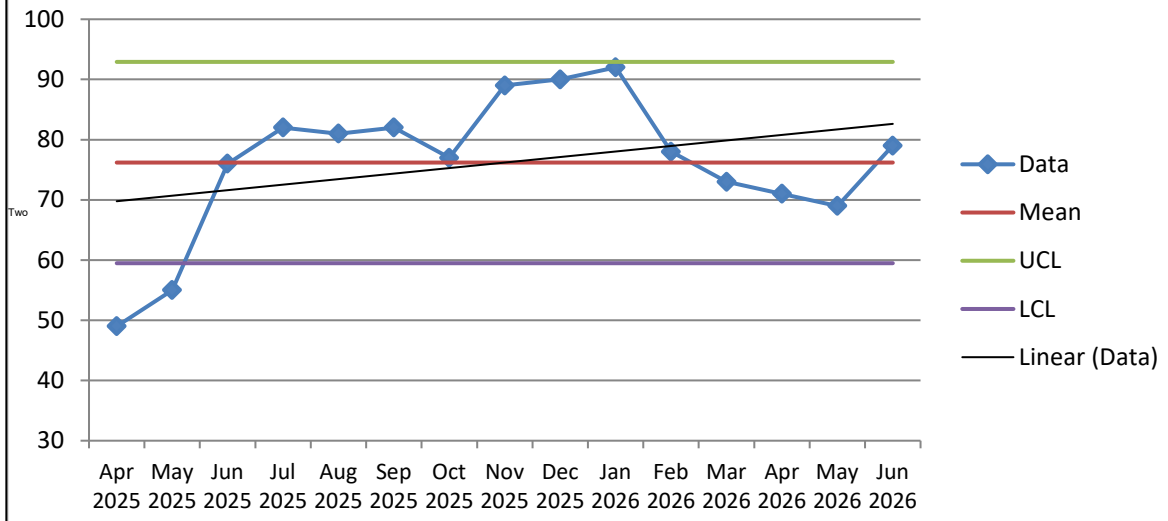
- There were 87 falls reported by our inpatient settings, whilst this is an increase in the previous month, we do continue to see a downward trend in the number of falls over the last 15 months.
- Willow Ward at Charlton Lane Hospital remains our highest reporter of falls across the trust. A monthly review has been undertaken of falls at the site with 16 patients falling, individuals who have had multiple falls have been reviewed with evidence of declining mental health, advancing dementia and poor spatial awareness being some of the contributing factors.
- There has been 1 moderate harm fall this month at Stroud Hospital, Duty of Candour has been completed alongside an inpatient falls questionnaire, this has demonstrated that trust procedures were followed correctly.
- We are showing 97.06% falls assessment compliance across our Community Hospitals.
- A new risk has been raised on the risk register related to the standardisation of a falls assessment template within Electronic Patient Records (EPR) systems. Resolution and action is being taken forward with clinical systems team input.



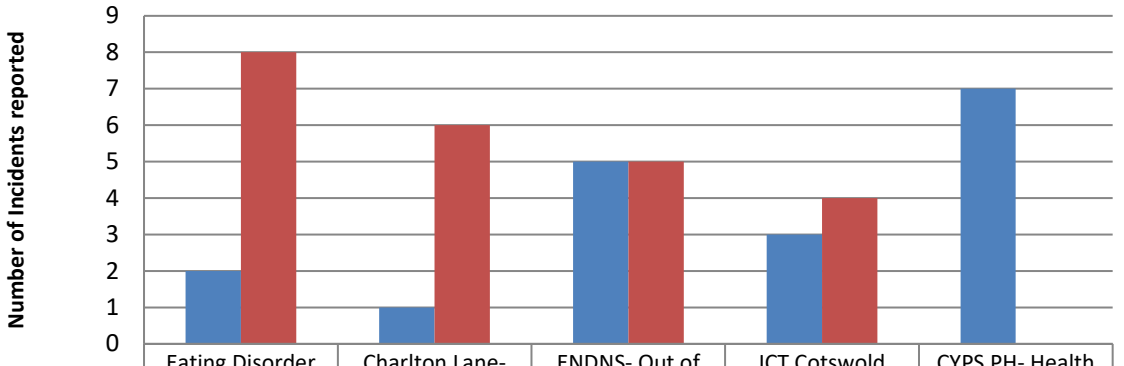
	None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)
May 2026	61	20	0
Jun 2026	71	15	1

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

Clinical care, treatments and procedure incidents 01/04/2025 - 30/06/2026



Clinical care, treatments and procedure incidents – 5 highest reporting teams 01/05/2026 - 30/06/2026

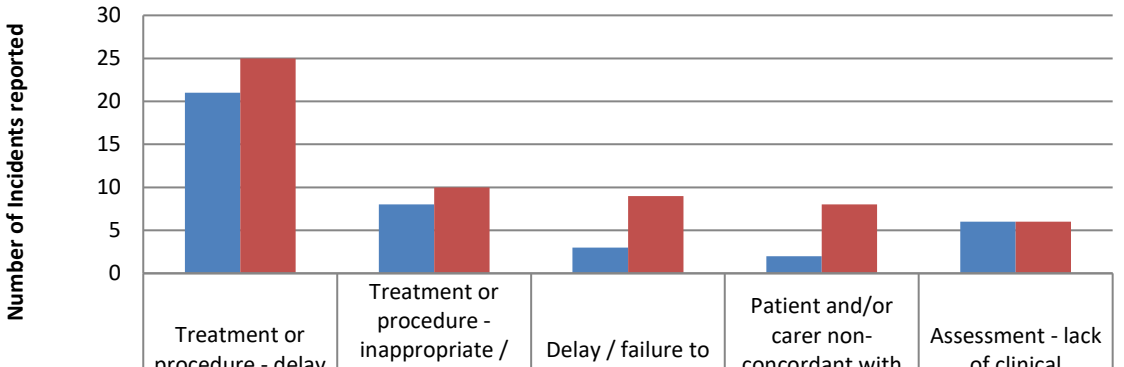


	Eating Disorder Community	Charlton Lane- Willow Ward	ENDNS- Out of Hours DN	ICT Cotswold South 1 DN	CYPS PH- Health Visiting
May 2026	2	1	5	3	7
Jun 2026	8	6	5	4	0

What is the data telling us:

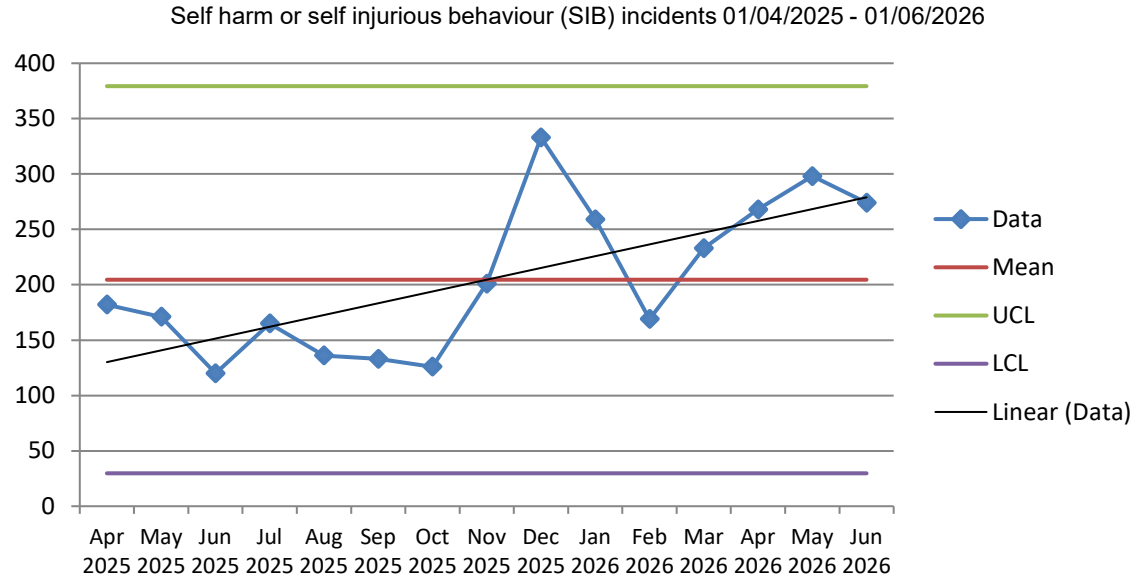
- We have observed a total of 79 incidents in this category in June.
- 38 teams across 24 services have used this category to report an incident. As previously detailed the breadth of the teams using this can make it challenging to draw overarching themes, however it does appear a useful category to identify emerging themes and challenges in individual teams.
- The Eating Disorders team reported 8 incidents when physical observations have been found to be outside of expected parameters. A specific sub-category is to be added onto Datix to improve reporting for these incidents. A significant service review has informed a recently formed transformation programme which includes physical health management. Successful recruitment to a GP and Consultant Psychiatrist will contribute to improved clinical oversight.
- 97% of incidents in this category are categorised as no or low harm incidents. Two moderate harm incidents have been reported, 1 relates to the care provided by another organisation and we are awaiting feedback and 1 is awaiting further review by professional with special knowledge.

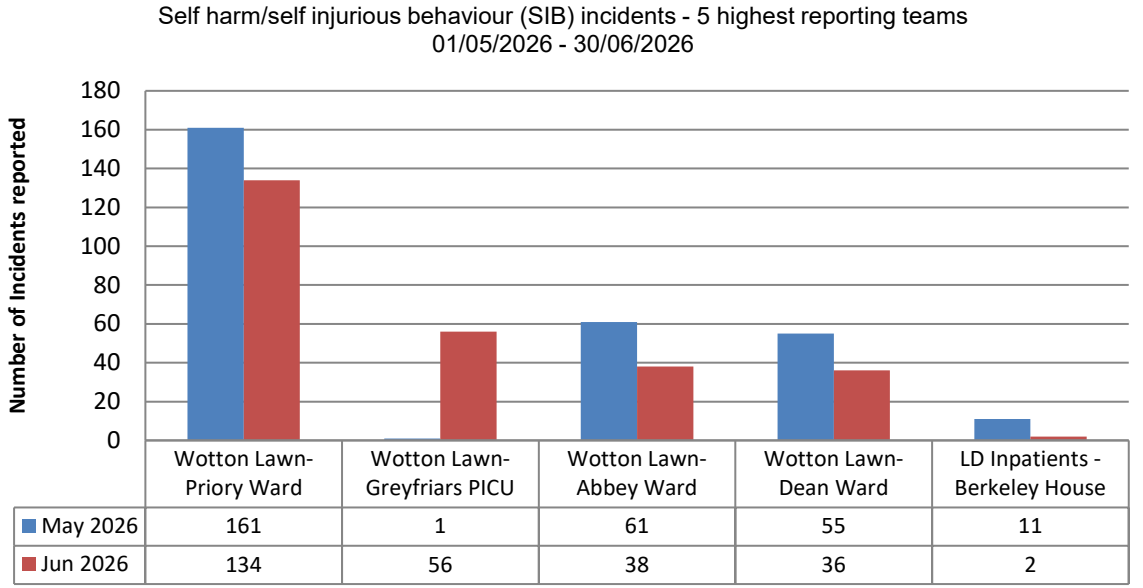
Clinical care, treatments and procedure incidents by top 5 sub categories - 01/05/2026-30/06/2026



	Treatment or procedure - delay / failure	Treatment or procedure - inappropriate / wrong / not clinically indicated	Delay / failure to monitor	Patient and/or carer non-concordant with care / treatment plan	Assessment - lack of clinical assessment
May 2026	21	8	3	2	6
Jun 2026	25	10	9	8	6

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

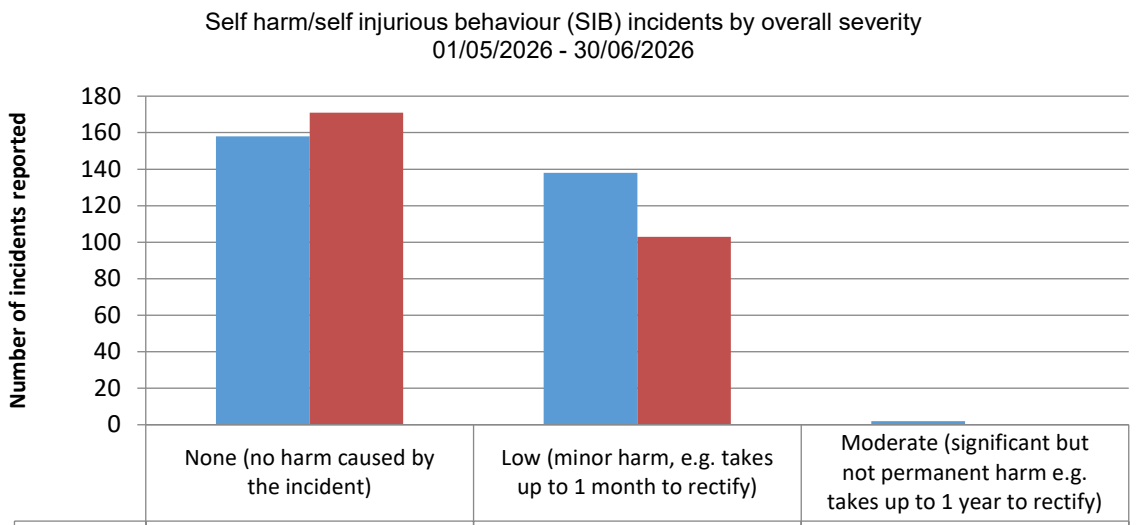




	Wotton Lawn-Priory Ward	Wotton Lawn-Greyfriars PICU	Wotton Lawn-Abbey Ward	Wotton Lawn-Dean Ward	LD Inpatients - Berkeley House
May 2026	161	1	61	55	11
Jun 2026	134	56	38	36	2

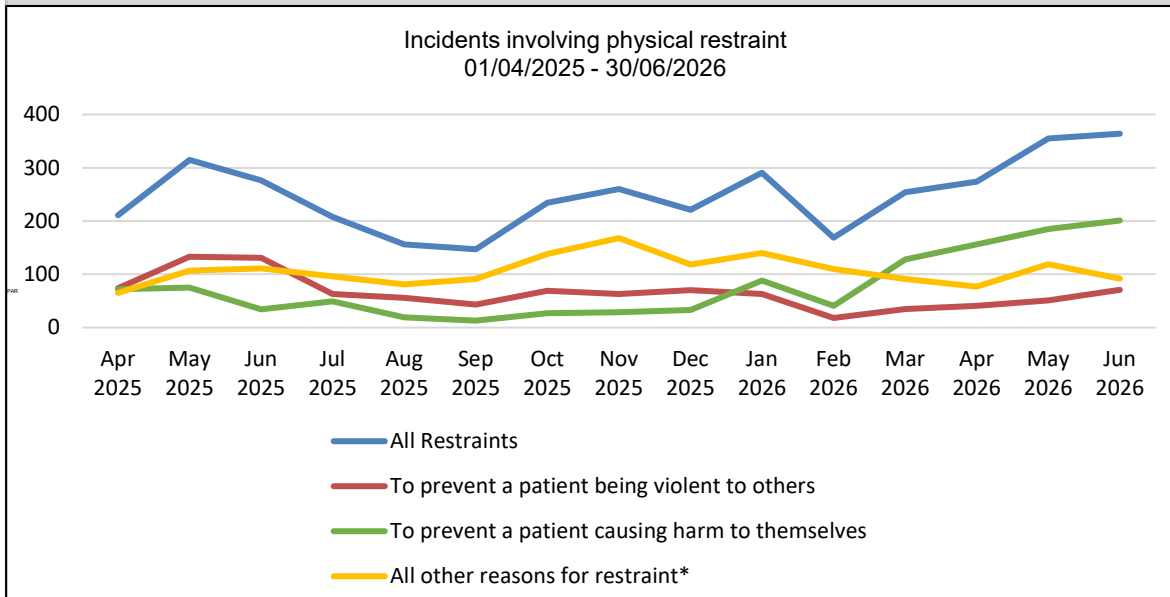
What is the data telling us:

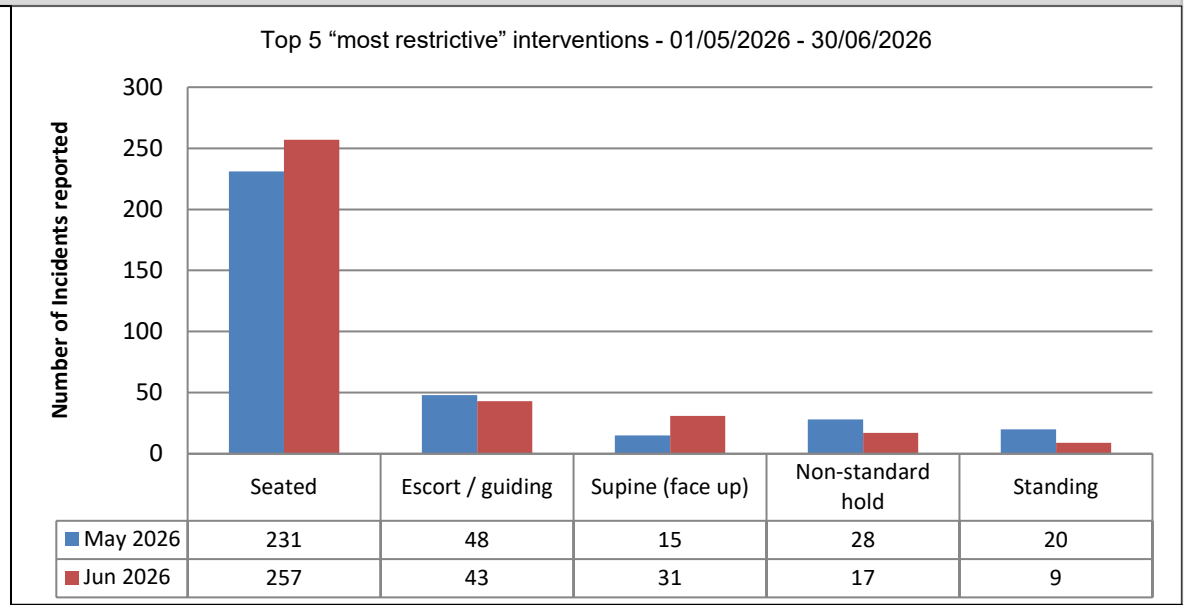
- 274 incidents of self-harm and self-injurious behaviour have been reported across the trust, a reduction of 24 on the previous month. All (100%) were reported as being low or no harm incidents. There have been no moderate or above incidents in this reporting category.
- Wotton Lawn Hospital reports most of these incidents, with Priory Ward as one of the 18 bedded wards accounting for 77% of all incidents.
- Approximately 23 inpatients were involved in incidents of self-harm or self-injurious behaviour with <10 of inpatients accounting for 86% of the reported incidents.
- A training needs analysis under the Wotton Lawn Hospital improvement plan has identified training for staff working with people with complex needs and trauma and this is being arranged. This is in addition to a focus on increasing availability and access to clinical supervision and reflective practice.
- Eight of the incidents occurred outside of inpatient settings and reflect where community teams have been notified of or observed disclosures of self-harm.



	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)
May 2026	158	138	2
Jun 2026	171	103	0

Incidents involving restraint

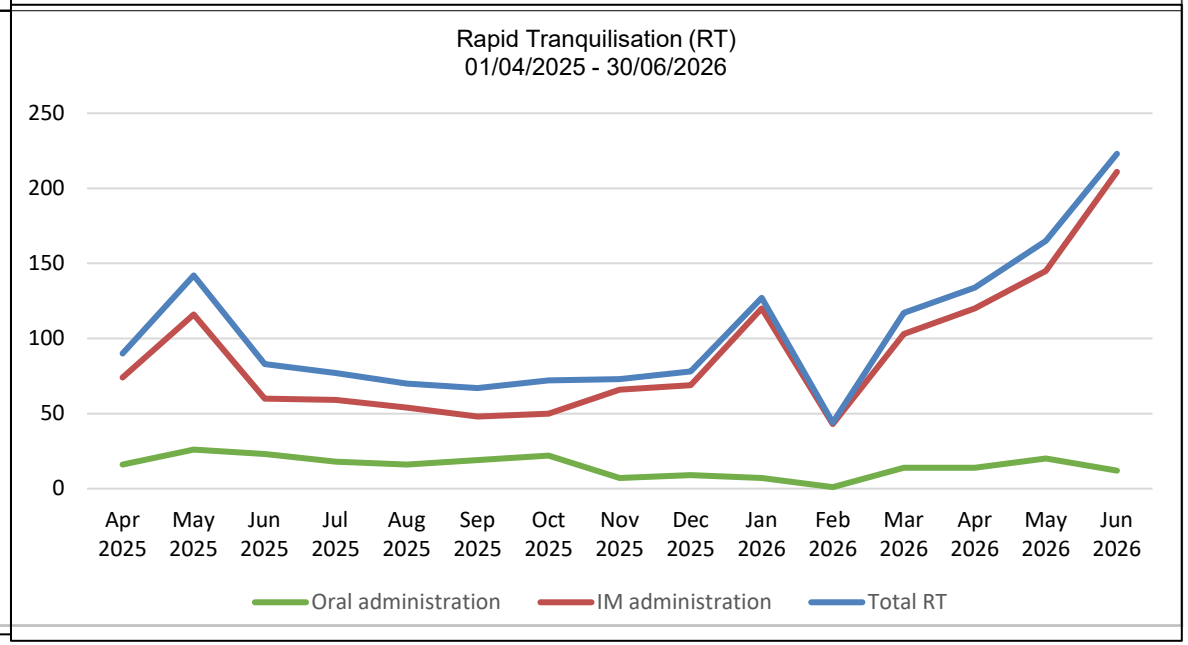




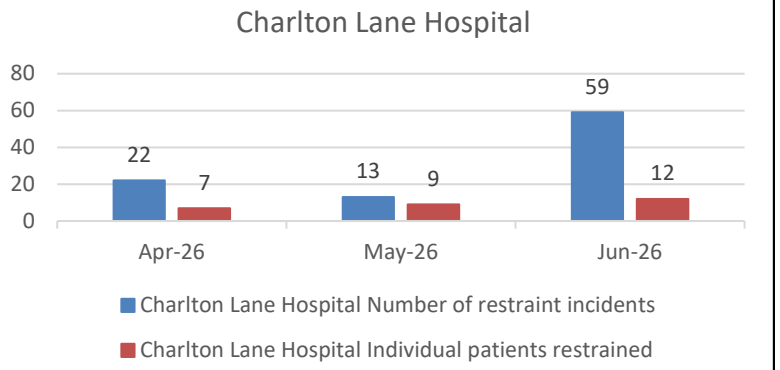
	Seated	Escort / guiding	Supine (face up)	Non-standard hold	Standing
May 2026	231	48	15	28	20
Jun 2026	257	43	31	17	9

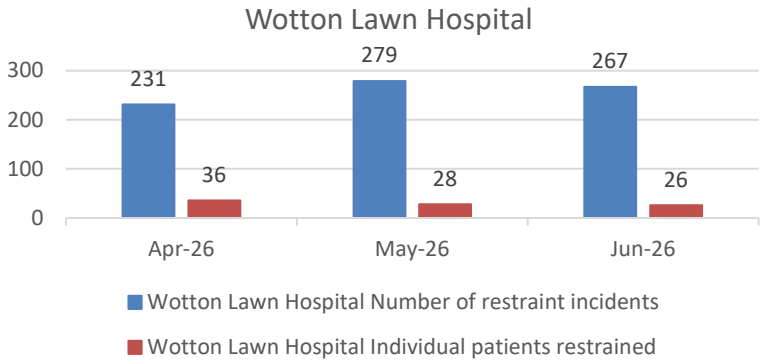
What is the data telling us:

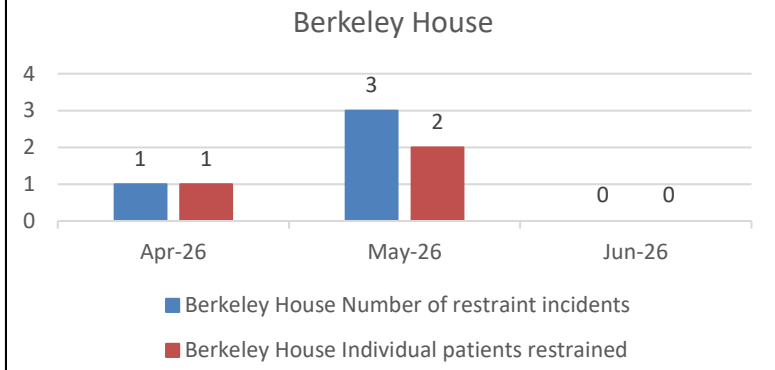
- There has been a slight increase in the number of restraint incidents in June; a month-on-month increase since February 2026 with the rationale for restraints being to prevent harm to themselves and to prevent violence to others.
- Concurrent with restraint incidents is a further increase in Rapid Tranquilisation with 223 reported this month (+58), of which 95% was given via IM. We have seen the biggest increases on Priory Ward and Greyfriars PICU, with a small number (<5) patients having had noticeable increases this month.
- The PARRI (Proactive Approaches Reducing Restrictive Interventions) Team are undertaking audits into records which will be shared with relevant teams when available. The PARRI team have also been contributing into bespoke care plans where non-standard holds have been required for individual patients.
- The increase in LD IHOT recorded restraint in May has reduced; this figure. These interventions have all been planned and in relation to Phlebotomy, Dental or Podiatry procedures.
- An update to the Trust Rapid Tranquilisation policy, approach to training and compliance is being taken to the next Positive and Safe Group.

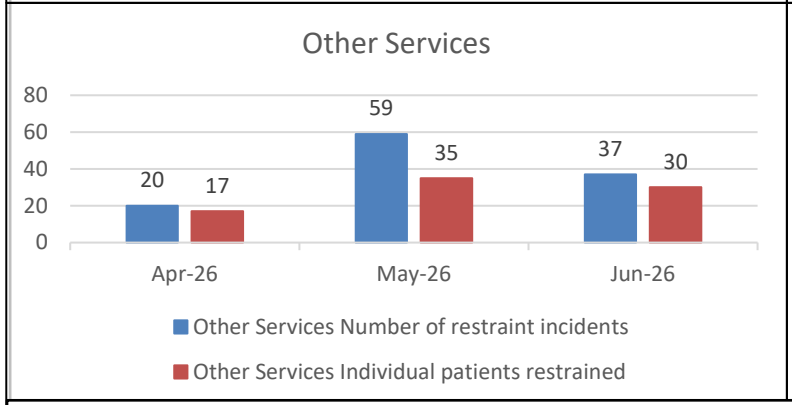


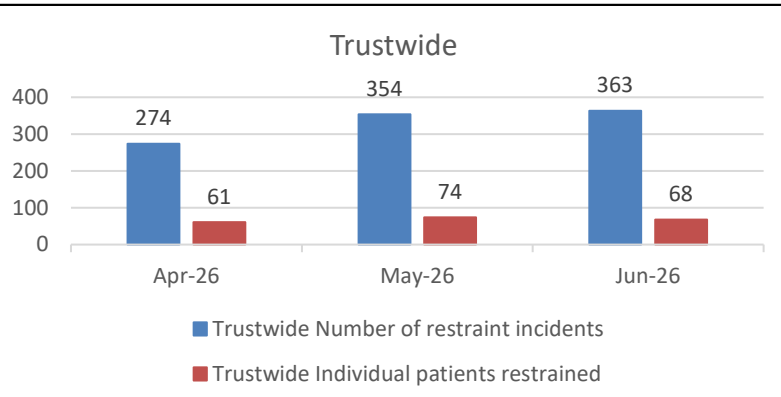
Incidents involving restraint – individual patients restrained







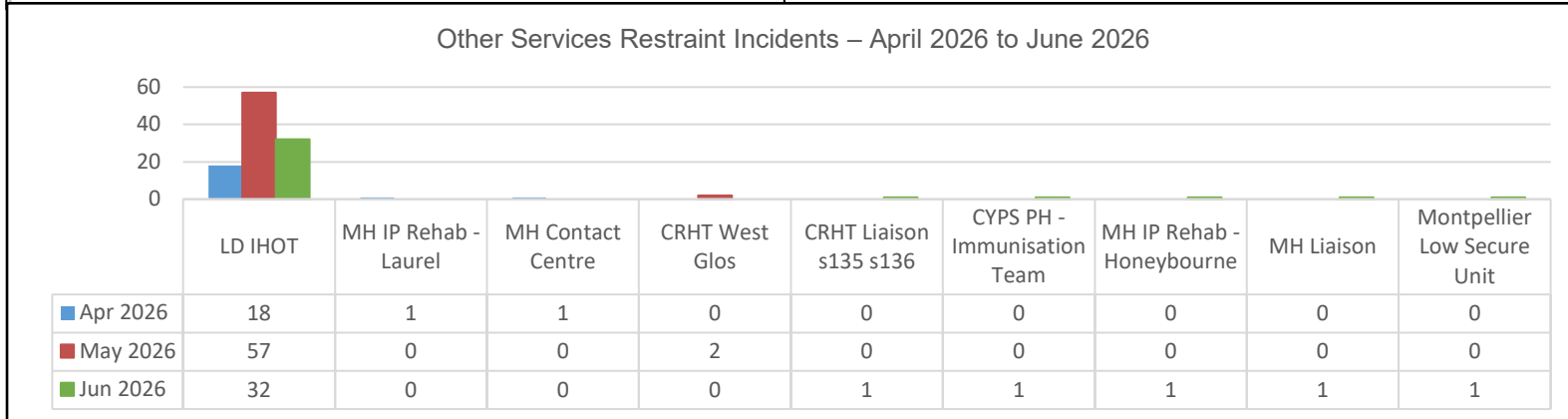




What is the data telling us:

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

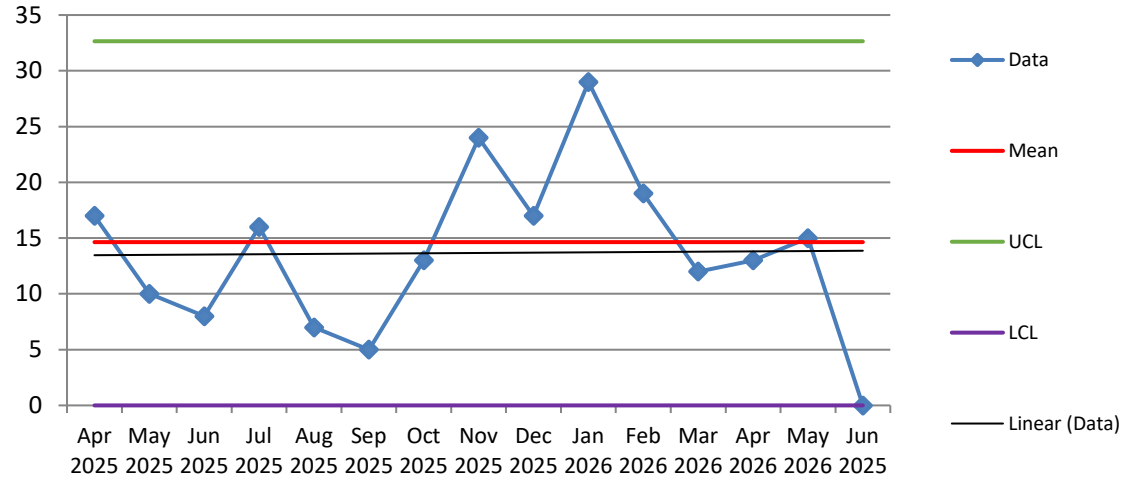
- Learning Disabilities (32)
- CRHT Liaison (1)
- CYPS PH (1)
- Mental Health Rehabilitation (1)
- Mental Health Liaison (1)
- Low Secure Services (1)



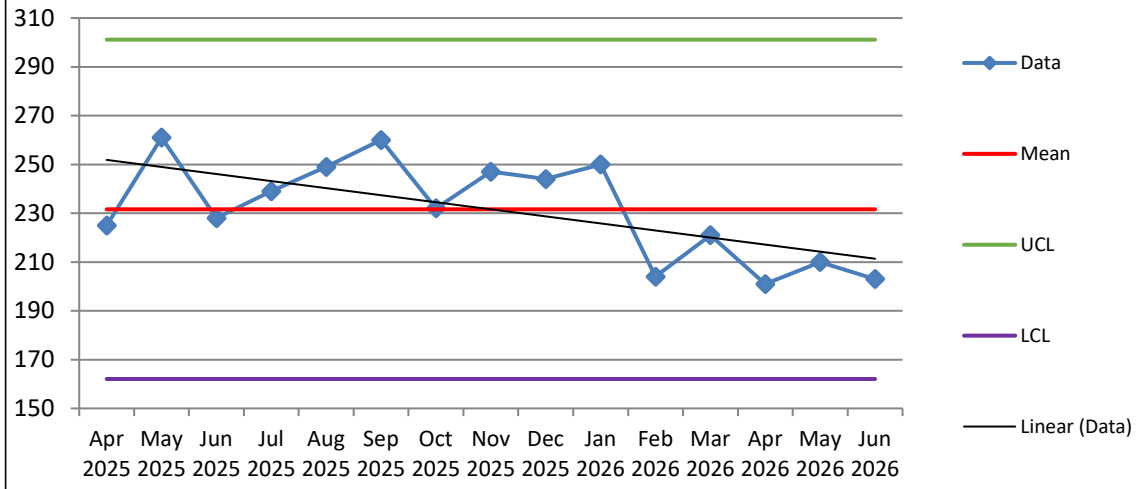
	LD IHOT	MH IP Rehab - Laurel	MH Contact Centre	CRHT West Glos	CRHT Liaison s135 s136	CYPS PH - Immunisation Team	MH IP Rehab - Honeybourne	MH Liaison	Montpellier Low Secure Unit
Apr 2026	18	1	1	0	0	0	0	0	0
May 2026	57	0	0	2	0	0	0	0	0
Jun 2026	32	0	0	0	1	1	1	1	1

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

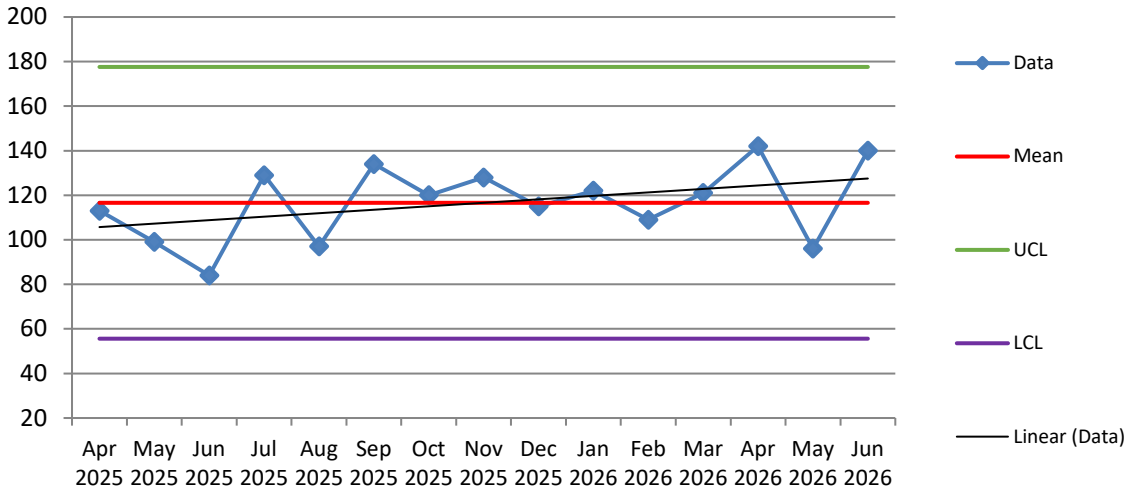
No harm Skin Integrity incidents reported 01/04/2025 - 31/06/2026



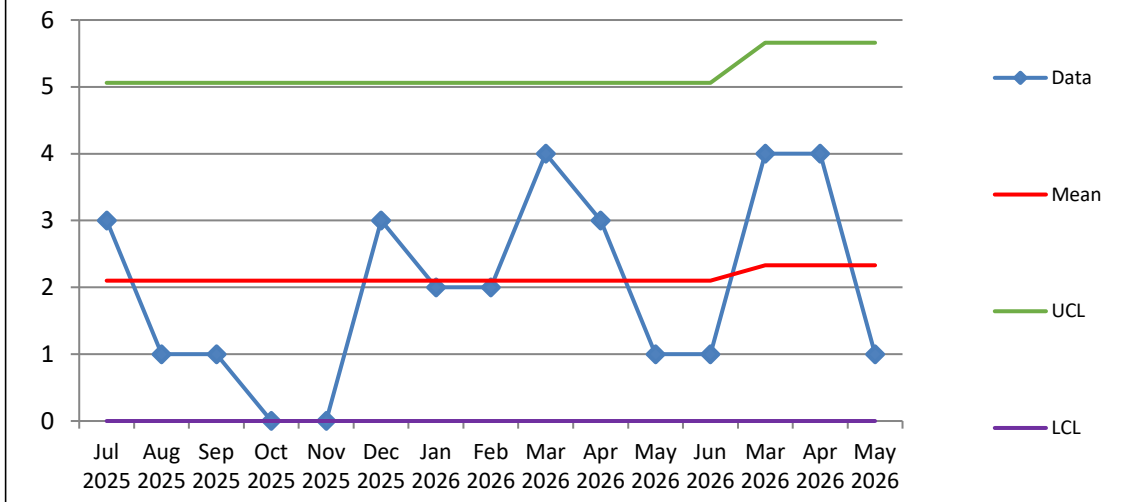
Low harm Skin Integrity incidents reported 01/04/2025 - 30/06/2026



Moderate harm Skin Integrity incidents reported 01/04/2025 - 30/06/2026

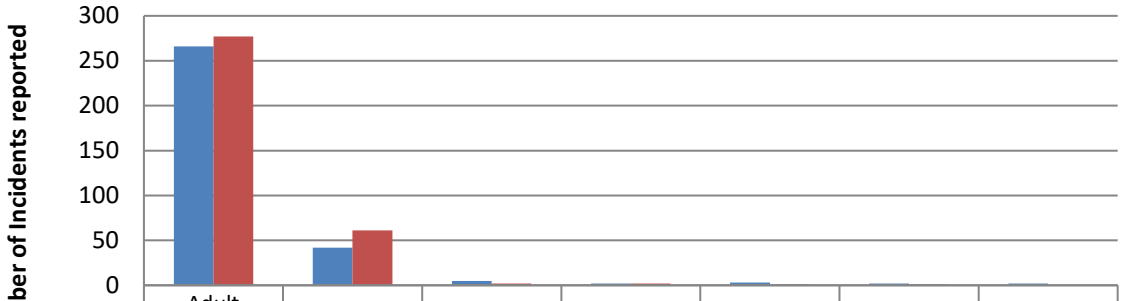


Severe harm Skin Integrity incidents reported 01/04/2025 - 30/06/2026



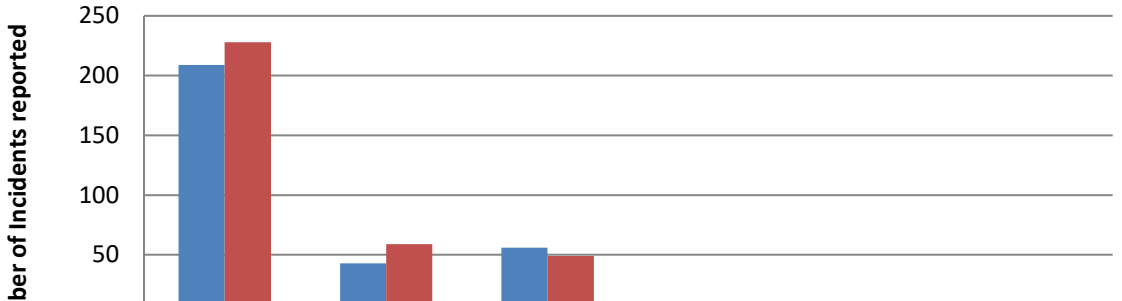
CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

Skin Integrity incidents by Service Type
01/05/2026 - 30/06/2026



	Adult Community Physical Health	Hospitals Physical Health	CW Specialist Services	CYPS Physical Health	Inpatient Mental Health & LD	Urgent Care Physical Health	Other
May 2026	266	42	5	2	3	2	2
Jun 2026	277	61	2	2	1	1	0

Skin Integrity Incidents by Patient Location
01/05/2026 - 30/06/2026

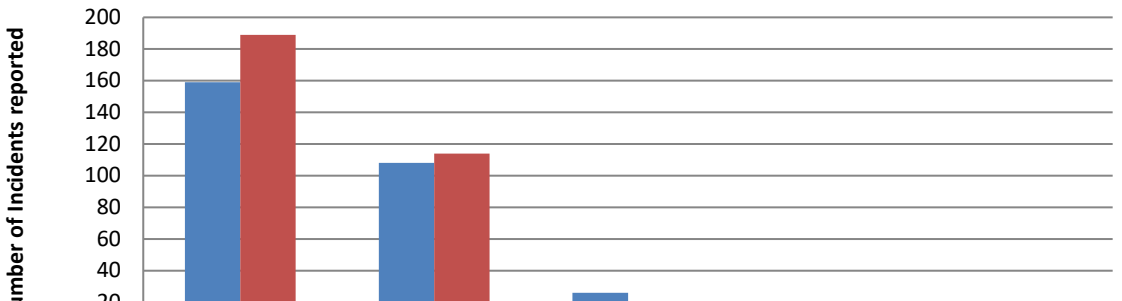


	Patient's own home	Community Hospital Ward	Residential Care or Nursing Home	GHFT Acute Ward	MH Inpatient Ward	Other
May 2026	209	43	56	8	3	3
Jun 2026	228	59	49	6	1	1

What is the data telling us:

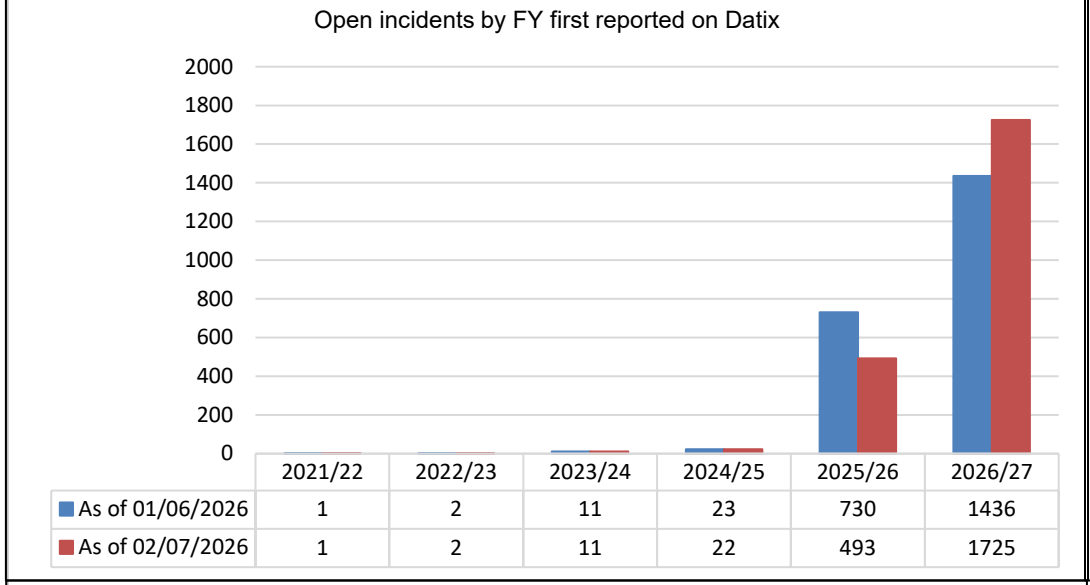
- There were a total of 345 skin integrity incidents reported across the trust with a reduction in low harm incidents, an increase in moderate harm incidents and 1 severe harm incident. As per the change described in last month's report, we have had 0 no harm incidents reported.
- 288 individuals were connected to these incidents with 46 individuals having 2 or more skin integrity incidents reported and accounting for 30% of all reported skin integrity incidents.
- 303 of these incidents were reported as pressure ulcers (all categories), with 33% being present before admission to the trust.
- 66% of skin integrity incidents were for individuals living in their own home and a further 14% for individuals in residential or nursing homes.
- 17% of skin integrity incidents occurred within our inpatient settings.
- Local clinical review processes to all skin integrity incidents maintain good levels of oversight and appropriate clinical responses in care provision.

Skin Integrity Incidents by Sub-categories (grouped)
01/05/2026 - 30/06/2026

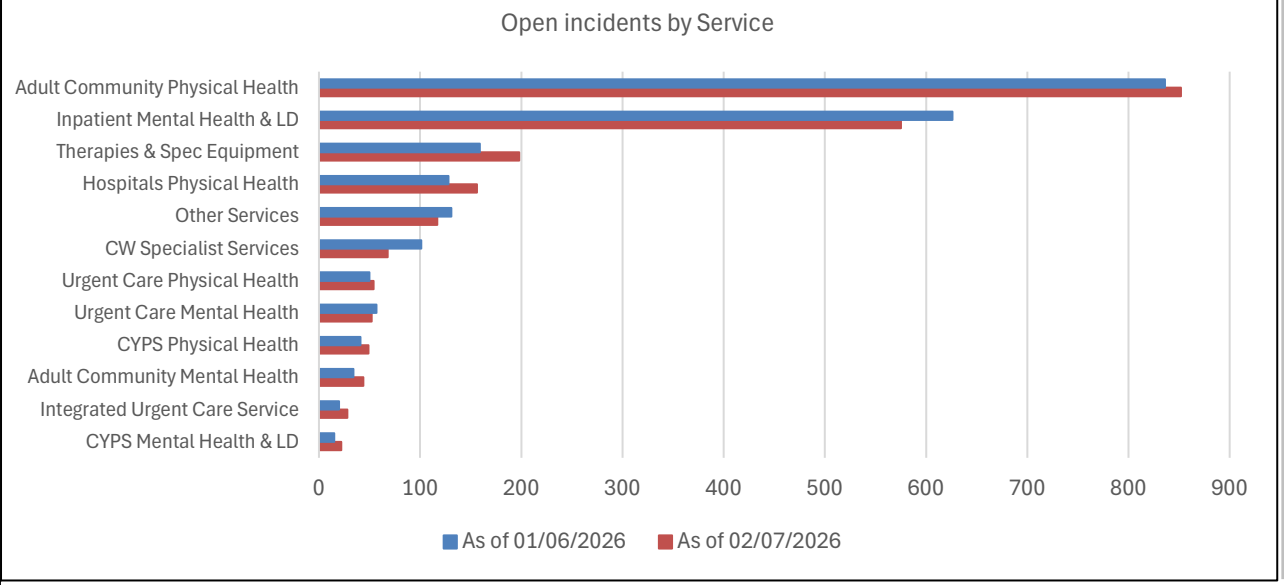


	Pressure ulcer developed or worsened during care by this Trust	Pressure ulcer present before admission to this Trust	MASD developed during care by this Trust	MASD present before admission to this Trust	Other
May 2026	159	108	26	15	14
Jun 2026	189	114	18	14	9

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 01/06/2026	1	2	11	23	730	1436
As of 02/07/2026	1	2	11	22	493	1725



What is the data telling us:

- There is a steady decrease in the number of incidents that were open in the year 2025/2026 with a reduction of 237 in June.
- Where the incidents relate to year prior to 2025/2026, the Patient Safety Team are reaching directly out to teams to request these are reviewed and closed. Several test records used for training were identified which have been closed taking 2023/2024 to 7 incidents. These incidents predominantly relate to corporate teams.
- A number of incidents should remain open from previous financial years where active Patient Safety Incident Investigations are still underway.

Open incidents (awaiting review/being reviewed) as of 02/07/2026 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	261	590	852
Inpatient Mental Health & LD	0	0	0	1	36	538	575
Therapies & Spec Equipment	0	0	0	0	89	109	198
Hospitals Physical Health	0	0	0	0	2	154	156
CW Specialist Services	0	0	0	0	28	40	68
Urgent Care Physical Health	0	0	0	1	3	50	54
Urgent Care Mental Health	0	0	0	2	19	31	52
CYPS Physical Health	0	0	0	0	2	47	49
Adult Community Mental Health	0	0	0	3	10	31	44
Specialist Mental Health Svcs	0	0	0	1	4	33	38
Integrated Urgent Care Service	0	0	0	0	8	20	28
CYPS Mental Health & LD	0	0	0	0	2	20	22
Other	1	2	11	13	29	61	117
Total	1	2	11	22	493	1724	2253

CQC DOMAIN – Are Services Safe - Safe Staffing – Mental Health & LD and Physical Health Inpatient Data

A safe-staffing assurance meeting for our inpatient services across Mental Health, Learning Disabilities, and Physical Health is held on a monthly basis. 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.

Physical Health – Community Hospitals

The community hospitals demonstrated a high level of compliance with safe staffing requirements throughout June 2026**,** with nursing fill rates meeting or exceeding the proposed standard of 92.5% for registered nursing staffing during both day and night shifts. There is strong evidence of effective professional judgement, appropriate escalation processes and triangulation with quality indicators. No patient safety incidents, complaints or adverse outcomes were identified that could be directly attributed to staffing levels.

Staffing Fill Rates Delivered Safely:

Overall staffing achievement was **94.68%:** Registered Nurse (RN) staffing during both day and night shifts met the proposed standard of **92.5%**. Healthcare Support Worker (HCSW) staffing was maintained appropriately and exceeded planned levels where patient acuity required enhanced observation and support. There is clear evidence that ward teams are appropriately escalating concerns when patient acuity increases. Examples included: Additional HCSW capacity provided to support a patient requiring enhanced therapeutic observation at Vale Hospital. Enhanced staffing deployed at North Cotswold Hospital following the opening of escalation beds to support wider system pressures. Additional staffing secured for a highly complex patient at Cashes Green Ward. Ward-level concerns were escalated appropriately, additional shifts were requested, all requests were fulfilled, and patient safety was maintained.

This provides strong assurance that the escalation process is functioning effectively and that staffing decisions are being informed by patient need rather than solely by establishment numbers. One staffing red flag was submitted in error and subsequently reviewed. Assurance was obtained that staff understood the red flag process and recognised the error. This demonstrates increasing staff awareness and utilisation of safe staffing escalation mechanisms.

Review of:

Care Hours Per Patient Day (CHPPD),Incident reporting, Patient safety data, and Patient experience information identified no concerns directly attributable to staffing shortfalls**.** Staffing metrics were consistent with expected levels and national comparators. A small amount of off-framework agency usage (12 hours on Jubilee Ward) was identified. This related to an unplanned sickness absence outside normal hours and the shift was successfully filled, preventing any reduction in staffing levels. An increase in pressure ulcer reporting was noted during June. However, this trend is consistent with seasonal patterns observed during hotter weather. There is also likely contribution from wider system pressures and delayed transfers from acute settings. No evidence was identified linking these incidents to staffing shortages.

Mental Health Inpatient Services

Mental Health inpatient services maintained overall staffing levels above establishment requirements during June, with reported fill rates of approximately 103%**.** However, assurance is moderated by significant workforce pressures associated with ongoing organisational, safeguarding and workforce challenges, particularly affecting Wotton Lawn Hospital. Safe care continued to be delivered, but several workforce risks require ongoing executive oversight. Since May, a combination of staff suspensions, high levels of sickness absence, and annual leave has resulted in significant staffing gaps at WLH, particularly within the nursing workforce across all bands, as well as in key leadership positions. This has included an absence of substantive Matron cover across the site. To maintain safe clinical services, there has been a marked increase in the approval and use of off-framework agency staff, particularly at WLH. This increased reliance on agency staffing has also impacted safer staffing at CLH by reducing the availability of bank staff across both inpatient sites, placing additional pressure on workforce resilience and staffing levels.

CQC DOMAIN – Are Services Safe - Safe Staffing – Mental Health & LD and Physical Health Inpatient Data

Overall Fill Rates Remain Strong:

Staffing fill rates across mental health inpatient services were approximately 103%**,** indicating that services were largely able to maintain planned staffing levels despite significant workforce pressures. The 103% includes registered and nonregistered across days and nights for the whole reporting period. A review of incident reporting identified:

One incident categorised under "lack of suitably trained or skilled staff". Upon Investigation it was confirmed that this related to incorrect use of a hoist sling and training issues rather than staffing numbers. The incident was subsequently closed as a no-harm event. No incidents directly attributable to insufficient staffing levels were identified. Whilst off-framework usage increased, there is evidence that:

Requests are appropriately scrutinised, escalation processes are in place, the rationale for agency utilisation is clearly documented and understood by workforce and operational leads. The group identified that Abbey Ward staffing data does not reflect the temporary reduction in bed numbers. This means some apparent staffing deficits are artefacts of configuration issues rather than actual staffing shortages. The issue is understood and being considered within the interpretation of the data.

Areas of concern

Red flags* continue to be reported from: Laurel House and Honeybourne Unit. Current review suggests that these do not represent unsafe staffing but relate to the way mental health staffing establishments interact with the national red flag criteria. However: Narrative validation requires strengthening and Ward managers require refresher guidance regarding mental health-specific red flags and escalation requirements; this will be actioned in July.

Significant Workforce Pressures continues at Wotton Lawn and there is ongoing workforce instability associated with:

A large-scale Section 42 safeguarding enquiry and associated HR investigations, staff redeployments and restrictions, elevated sickness absence and difficulties onboarding newly recruited staff. There is reduced attractiveness of the service as a recruitment destination during a period of heightened scrutiny. These factors have created substantial workforce gaps which continue to require mitigation through temporary staffing arrangements. Off-framework agency usage increased from 244 hours in May to 299 hours in June**.** The increase is understood and justified in the context of current operational pressures. Nevertheless, reliance on off-framework staffing remains a workforce risk and should continue to receive executive oversight. Enhanced observation hours remain higher than desired. Whilst work is underway to improve data capture and governance oversight, elevated ETOC utilisation may indicate:

Higher patient acuity, Workforce instability, increased use of temporary staff, greater reliance on restrictive interventions.

Senior operational leaders identified a potential relationship between: Reduced availability of substantive staff, Increased temporary staffing reliance, Higher ETOC use, and Increased restrictive practice. This risk is recognised by the leadership team and is being actively monitored.

Despite significant operational and workforce challenges, there is currently no evidence that patient harm has occurred as a direct result of insufficient staffing levels**.** Staffing fill rates remain above planned establishment levels and escalation processes are functioning. However, ongoing workforce pressures, increasing reliance on temporary staffing, elevated enhanced observation activity and the risk of restrictive practice require continued executive oversight. Further strengthening of red flag governance and sustainable workforce solutions remain priorities.

*A red flag **in the context of** safer staffing is an indicator that staffing levels or workforce pressures may be affecting the quality or safety of patient care. Red flags do not necessarily mean that patient harm has occurred, but they signal that care may have been compromised or that there is an increased risk, requiring review and appropriate action.

A high number of red flags over time may indicate that staffing establishments, recruitment, retention, or staff wellbeing require further review, even if serious incidents have not occurred. In mental health settings, red flags are often considered alongside patient acuity, observation requirements, incidents, and the delivery of therapeutic care to provide a fuller picture of staffing safety.

CQC DOMAIN – Are Services Safe - Safer Staffing – Mental Health & LD and Physical Health Inpatient Data

Mental Health & LD	June 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	76	123	84	151	10.5
Dean	85	142	107	176	11.6
Greyfriars	71	147	96	178	16.5
Kingsholm	91	101	103	98	8.5
Montpellier	105	92	97	100	10.2
Priory	94	146	100	151	9.3
Chestnut	80	116	100	199	7.6
Mulberry	89	96	92	100	7.0
Willow	96	95	100	99	9.7
Laurel House	96	110	100	113	6.4
Honeybourne	87	117	100	110	8.1
Berkeley House	45	103	102	91	122.6

Physical Health	May 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)	86	F95	102	97	7.6
Windrush (Cirencester)	-	-	-	-	-
Thames (Cirencester)	106	97	100	104	19.6
Forest Of Dean Community Hospital	101	95	98	102	7.8
North Cotswolds	97	103	98	102	L7.9
Cashes Green (Stroud)	97	113	102	111	7.8
Jubilee (Stroud)	114	114	100	100	8.7
Abbey View (Tewkesbury)	107	100	103	98	9.1
Peak View (Vale)	97	103	102	143	10.4

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	0	1									
Influenza	3		0	0	0									
Norovirus	33		0	0	0									
COVID-19 HODA	17		0	1	0									
COVID-19 HOHA	3		0	0	0									
Gram-Negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)	0	0	0	0	0									
MRSA Bacteraemia	0	0	0	0	0									
MSSA Bacteraemia	0		0	0	0									
Outbreaks	6		1	0	0									
Hand Hygiene overall compliance	97%	90%	90%	93%	99%									
Mandatory IPC Training: Clinical	94%	90%	94%	93%	93%									
Mandatory IPC Training: Non-clinical	98%	90%	98%	99%	98%									
Cleanliness FFT "Was the ward clean?"	98%		100 %	96%	100%									

Cleanliness – 2026/27

30/03/26 – 22/06/26

13 Weeks Report

GHC		3rd Party	
Compliant	142	Compliant	23
Non-compliant	7	Non-compliant	4
TOTAL	149	TOTAL	27

FR	Target score	Actual score average	FR	Target score	Actual score average
FR1	98%	98.95%	FR1	98%	N/A
FR2	95%	97.91%	FR2	95%	N/A
FR3	90%	97.68%	FR3	90%	93.47%
FR4	85%	96.48%	FR4	85%	92.29%
Total average score		97.75%	Total average score		92.88%

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.

CQC DOMAIN – Are Services Safe – Infection Prevention and Control

Infection Prevention Control

- There was one case of *C.difficile* at Cirencester Hospital. Effective management and no nosocomial transmission provides good assurance that IPC policies are being adhered to correctly.
- There remains good assurance from Hand Hygiene audits and mandatory training compliance.
- The IPC team have identified an increase in the number of cases of measles, meningitis and respiratory infections. There is joint working happening between public health and GHFT to ensure there are proactive plans to manage this
- There has been some specific improvement work with the IPC team and wider colleagues to reduce the risk of infections and support with individualised care planning in relation to MRSA.

Cleanliness

- High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit and FFT results.
- High Consequence Infectious disease policy and guidance is being updated in line with new NHSE guidance with PPE.

- There has been recognition of areas of good practice :

    - Tewksbury for decontamination with suspected measles as per action cards and informing the IPC team for reassurance.
    - Wooton Lawn for working with IPC team with some MRSA confirmed cases and indivualised care for patients and education/support for staff.
    - IPC rolling of a trial of sink sticker for hand wash only basins to reduce the risk of infections.
    - IPC attended the Inclusive wound awareness workshop as a system wide project to look at how we support the homeless and IV drug user in skin health
    - The IPC team have identified an increase in the number of cases of measles, meningitis and respiratory infections. There is joint working happening between public health and GHFT to ensure there are proactive plans to manage this

Note: Decontamination, Water and Ventilation Safety, Occupational Health and FFP3 fit testing are reported on a quarterly basis.

- Fit testing team are reduced to 1 P/T tester 3 days a week. In addition, an administrative staff member who supports will also be going on paternity leave. IPC are managing the team service and expectations.
- A letter from the national quality team dated 18 June 2026 was received by all providers in relation to recommendations from the UK Covid-19 Inquiry Module 3 report, which included great assurance on preparedness to protect patients and staff including improved FFP3 mask fit testing. Actions are being taken in response to this letter which will be reviewed by the Trust Infection Prevention Control Committee and an assurance position reported through with the next quarterly report on FFP3 fit testing.

CQC DOMAIN – Are Services Safe - Adult Vaccination Programme – 2026/27 cumulative

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	94	123				
Covid – Outreach	150	200	254	261				
Covid - Care home residents	10	-	-	34				
Covid - Housebound	72	-	20	55				
RSV – GHC inpatients		23	74	107				
DTP - Asylum seekers	167	12	27	35				
MMR - Asylum seekers	143	8	13	16				
MenACWY - Asylum seekers	81	-	-					

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

What the data is telling us

Spring Covid Vaccination Programme ended on 30/06/26. The update of Autumn/ Winter 2025/26 GHC staff flu vaccines and summary of National Vaccinations Programmes (NVPs) administered by GHC teams.

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 has been awarded the Outreach Vaccination Service tender for Gloucestershire 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.

Gloucestershire Health and Care NHS Foundation Trust

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

Please note, following year-end data cleanse, some figures may have moved between categories.

	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	2,618	2,670										7,891	
% of respondents indicating a positive experience of our services	NR	90%	93%	90%	92%	91%										91%	
Number of compliments received in month	LR		3,321	250	240	276										766	
Number of enquiries (other contacts) received in month	LR		1,671	204	197	177										578	
Total number of complaints received in month	NR		254	14	30	22										66	
Total early resolution complaints received in month	LR			12	27	21										60	
Total number of open complaints (not all opened within month)	LR			59	72	70											
% of complaints acknowledged within 3 working days	NT	100%	100%	100%	100%	100%										100%	
Total number of complaints closed in month	LR			21	18	24										63	
Number of complaints closed within 3 months	LT			8	17	11										36	
Number of re-opened complaints (not all opened within month)	LR			4	2	1											
Number of external reviews (not all opened within month)	LR			6	6	4											

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)

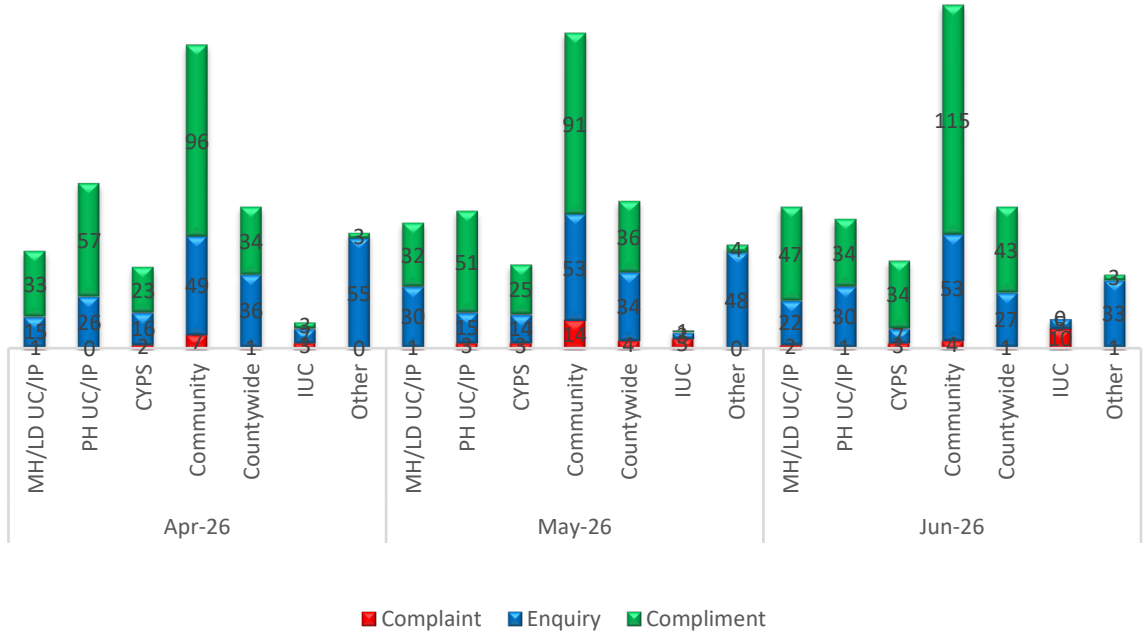
· **Key Highlights:**.

- The IUCS pilot process (launched 1st April and led by IC24) is making some impact and we are working to clear all 2025/26 complaints in July.
- 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	2	Early resolution:	2	22	47
		Closer look:	0		
PH urgent care and inpatient	1	Early resolution:	1	30	34
		Closer look:	0		
CYPS	3	Early resolution:	3	7	34
		Closer look:	0		
PH/MH/LD Community	4	Early resolution:	3	53	115
		Closer look:	1		
Countywide	1	Early resolution:	1	27	43
		Closer look:	0		
IUCS	10	Early resolution:	10	5	0
		Closer look:	0		
Other	1	Early resolution:	1	33	3
		Closer look:	0		
Totals	22	Early resolution:	21	177	276
		Closer look:	1		

This table shows directorate feedback over the past three months



Gloucestershire Health and Care NHS Foundation Trust

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

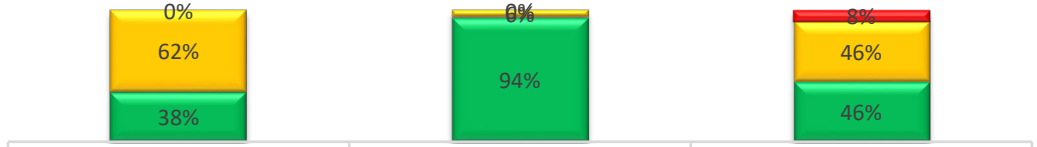
Directorate	Upheld	Partially upheld	Not upheld	No contact	Withdrawn	Other	Total
MH/LD UC/IP	0	2	2	0	0	0	4
PH UC/IP	0	0	2	0	0	0	2
CYPS	0	1	0	0	0	0	1
PH/MH/LD Community	1	1	2	1	1	0	6
Countywide	0	0	0	0	0	1	1
IUCS	3	2	5	0	0	0	10
Other	0	0	0	0	0	0	0
Totals	**4**	**6**	**11**	**1**	**1**	**1**	**24**

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

Directorate	Upheld themes for complaints closed this month
MH/UC/IP (22628)	Patient unsafely titrated medication. **Clinical treatment**
CYPS (24201)	Waiting for an ADHD assessment. **Waiting times**
Community (20395)	Protocol not followed regarding sepsis source information. **Clinical treatment**
IUCS (22958)	Call not managed appropriately. **Communication**
IUCS (22425)	Patient sent to wrong hospital for appointment. **Access to treatment**

The below graph shows the length of time taken to close complaints**.**
This month 46**%** were closed in 3 months (target 50%), 92**%** closed in 6 months (target 80%)

13 complaints breached the three-month target (2 x MH, 2 x Community, 9 x IUCS). Delays are largely due to capacity issues in teams .Of these complaints, there were:2 x 3-4 months, 5 x 4-5 months, 4 x 5-6 months , 1 x 6-7 months, 1 x 10-11 months.



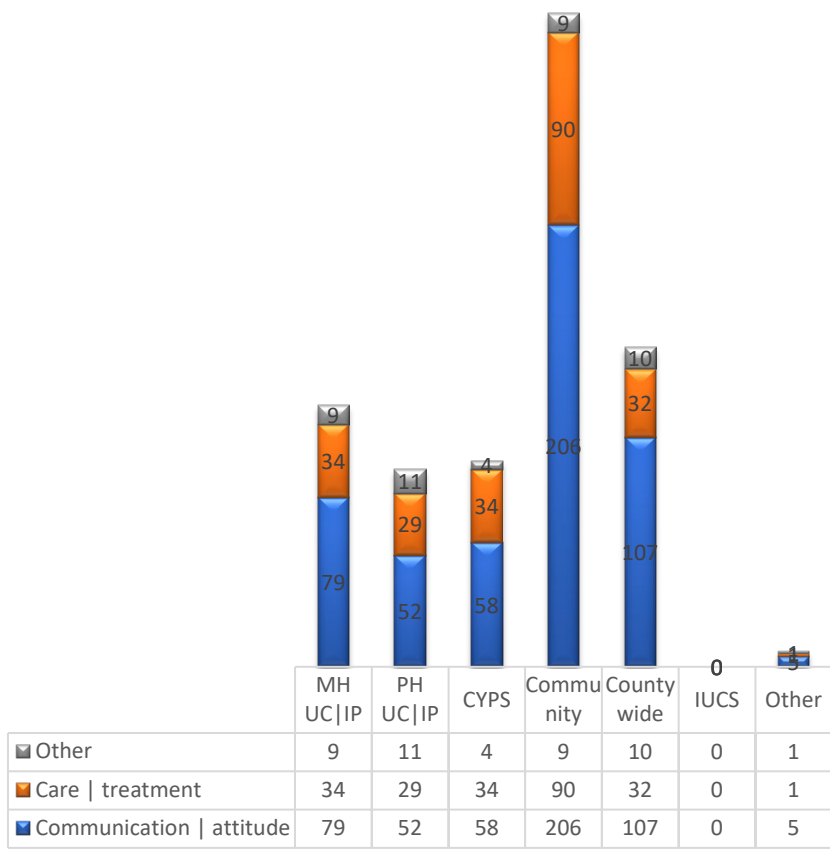
	Apr-26	May-26	Jun-26
6-12 months	0%	0%	8%
3-6 months	62%	6%	46%
0-3 months	38%	94%	46%

	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	7	18	10	2
Upheld	6	4	4	2

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

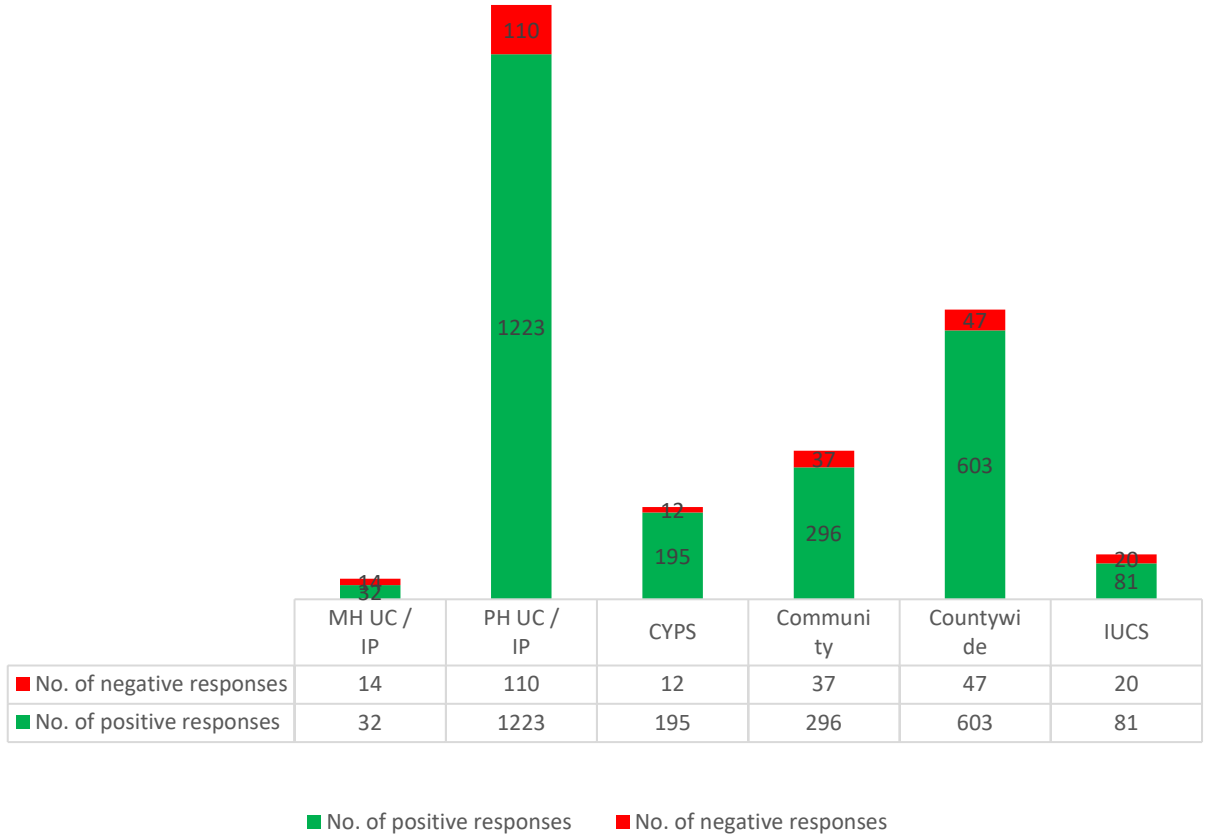
The table below is a sample of compliments RECORDED this month. The chart opposite illustrates the key themes by directorate.
The 276 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.**

ID	Team	Compliment
24939	Recovery Cheltenham	"thank you email from pt's mother to Recovery team staff who were involved with her son. Wonderful team, care, support, kindness and understanding - positively impacting on parents well being too "
24864	ICT Stroud Cotswolds DN	Email from daughter of patient to say thank you for the support given by the Stroud District Nurses for her catheter care. Said all who have attended have been kind and helpful.
25038	Complex Care at Home Cheltenham	"Thanks for all your help and support during the last few months. we really appreciated your support and friendship during a difficult time. All the best, her sons"
24729	Podiatry	podiatrist was fabulous, understanding, professional and attentive. she gave me reassurance and was absolutely fab. Thank you.
24766	CAMHS/VC Infant MH Team	I find the sessions so helpful, it helps me work through what has happened to me and put things into perspective with my son
25044	MIiU- NC Hosp	Review from patient giving the hospital 5*. Says he was seen quickly and staff were superb, friendly and helpful.
25097	FoD Hosp- OPD	Email from patient to say the team who looked after her at FOD Community were lovely and made her feel at ease and were so friendly. Said they are a huge asset to our community.
25161	Charlton Lane- Chestnut Ward	It is a wonderful hospital. They have lovely grounds to sit out in and beautiful and lovely food. All the nurses work hard and good workers.
24728	MH Contact Centre	A patient called in for support an wanted to thank all of the team for helping him, as he feels he wouldn't be here if it wasn't for the support he gets ringing in.

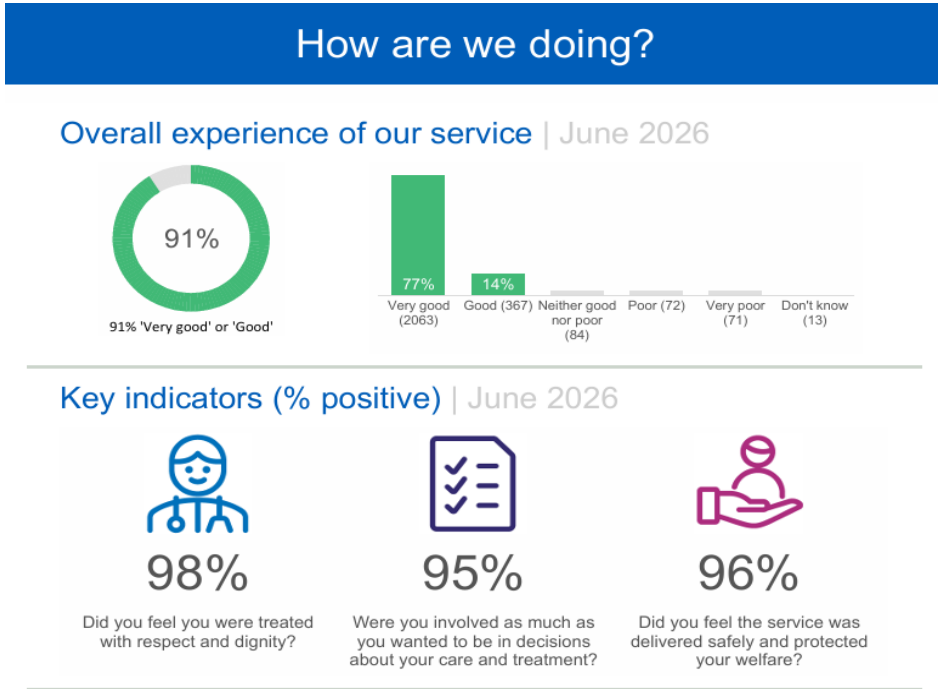


	MH UC|IP	PH UC|IP	CYPS	Community	County wide	IUCS	Other
Other	9	11	4	9	10	0	1
Care | treatment	34	29	34	90	32	0	1
Communication | attitude	79	52	58	206	107	0	5

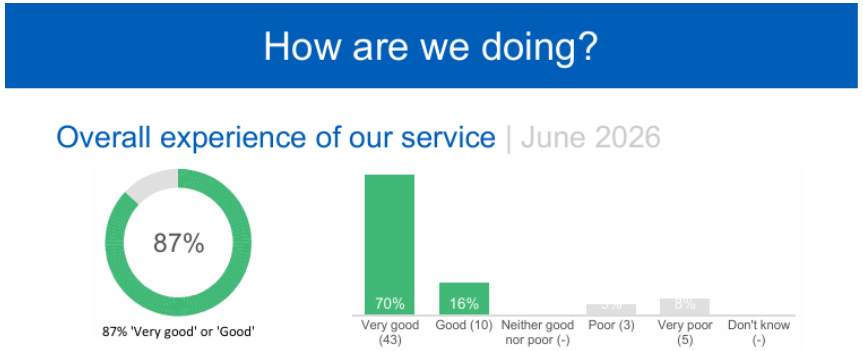
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)



Patient feedback



Carer feedback



Highlights for this month:

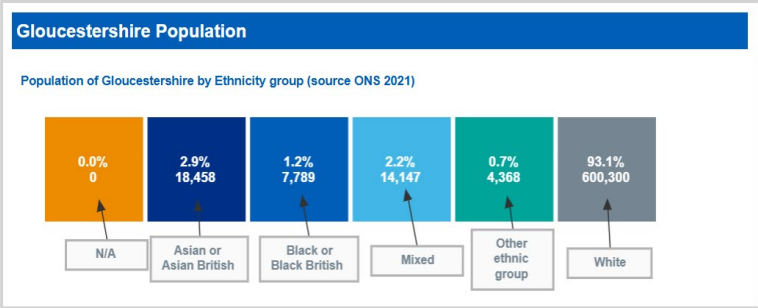
- The overall positive experience for the month is 91%, down from 92% last month.
- Service users made 7 requests for contact/action through the FFT.
- FFT for Out of Hours GP, IUCS received 101 responses (80% positive).
- There were 67 teams (cost centres) who received no FFT responses in June.(Not all cost centres represent a Team).

Patient and Carer Race Equality Framework (PCREF) (High Level Board Slide)

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.

Gloucestershire Population



Ethnicity Recording

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%

Anti-Racist Intent Statement and Action Plan

The co-produced, anti-racist intent statement and action plan were presented to the Board at the end of May 2026 and has been signed off. This is following the work of the PCREF steering groups and two community engagement events in February 2026 and April and an interactive Board development day. The statement has been published on the GHC external website and the intranet.

PCREF National Monitoring

- The number of cases of detention under the Mental Health Act
- Restraint including the type of restraint
- Physical health checks for those adults (18+) with Severe Mental Illness (SMI)
- Deaths in mental health inpatient units
- Suicide rates
- Access rates for CAMHS

Why the need for physical health checks in relation to PCREF?

The most common and severe physical health risks includes Type 2 Diabetes (in some ethnic groups this is up to six times more frequent than the White British population) and Cardiovascular Disease, heart disease and stroke disproportionately affect Black and South Asian individuals. This is frequently tied to higher rates of high blood pressure and underlying socioeconomic deprivation (reference NHS Race ad Health Observatory – Ethnic health inequalities and the NHS)

Why monitor access rates for CAMHS in relation to PCREF?

Key inequalities in access and care pathways suggest that Black children are disproportionately more likely to enter CAMHS via crisis care, social services or the criminal justice system rather than through standard referral by their GP compared to White British children (reference Children's Commissioner, Children's Mental Health Services 2023-2024, May 2025).

Action Plan

One action for our Operational/Clinical colleagues *– please ask the following questions of* ***ALL*** *your patients:*

- *'What is your first language?'*
- *'Do you have a religion, if so what is it?'*
- *'Do you have any cultural needs that I need to be aware of?'*
- *'How would you describe your ethnicity?'*

We are asking these questions so that we can personalize your care to you.

The aim is to reach 95% compliance for Ethnicity recording

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **QUALITY AND PERFORMANCE DASHBOARD June 2026-27 (Month 3)**

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 June (Month 3, 2026/27). 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), although it is on a pause until August whilst it resets its focus and priorities.

Recommendations and decisions required
The Board are asked to:

- **NOTE** the Quality and Performance Dashboard Report for June 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).
- **AGREE** the proposal to reduce the 100% target for B11 (Board Focus) Safer Staffing Fill Rate to 92.5%, to account for registered and non-registered AHP workforce inclusion which do not have mandated backfill requirements (or resourcing). This change has been previously endorsed by the Safer Staffing monthly Assurance Group and BIMG.

EXECUTIVE SUMMARY

Business Intelligence Updates

- The Business Intelligence Service, and its responsibilities now reside within the Improvement & Partnerships portfolio under the leadership of Rosanna James.

- The Trust are still awaiting the technical annex for the NHSE Oversight Framework to understand definitions and methodology for 2026/27. KPIs that apply to GHC will then be developed and introduced into the dashboard. Indicators that are predicted to be within the NOF in some form are indicated in purple within this dashboard, for illustration only.

Performance Update

June is the second month that NHS England's Insightful Board guidance has been adopted in the layout of the Quality and Performance Dashboard. Indicators are now presented from page 2 within a new "Domain" format. The current spread of KPIs across legacy Sources and Domains were presented to the Resources Committee in May 2026.

Board members are reminded that operationally sourced ("O" prefix) indicators are not presented to the Board - but the source is still reviewed and monitored at BIMG and within operational governance each period.

Alert (to matters that may require attention)

There are no additional indicators to alert the Board to for this period.

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:

- **B04 - Bed Occupancy Mental Health Units** – Narrative on page 12.
- **B51 - PH Core Bed Inpatients Average Length of Stay** (Days. Not a percentage) – Narrative on page 5.
- **B53 - PH Stroke Inpatients Average Length of Stay** (Days. Not a percentage) – *narrative on page 5.*
- **L07 – Adult Eating Disorders** - Wait time for adult assessments will be 4 weeks – *narrative on page 5.*
- **L08 – Adult Eating Disorders** - Wait time for adult psychological interventions will be 16 weeks – *narrative on page 5.*
- **N11 – Adolescent Eating Disorders** – Routine referral to NICE treatment starts within 4 weeks – *narrative on page 6.*
- **N25 - Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice** –*Narrative page 18.*
- **N37 - Community PH: CYP Community Services Waiting List % seen within 52 weeks** - (*Service exclusions applied) – Narrative on page 6.*
- **N67 - IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe** (KPI 4) –*Narrative on page 6.*

- **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) – *narrative on page 7.*
- **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) – *Narrative on page 7*.

Assure

Having previously been 'advised' for closer monitoring, the following indicator is within its thresholds for the period:

- **N69 - PH Percentage of bed days occupied by patients when they are ready to be discharged.** Performing at 37.3% against a 40% target although close monitoring will continue.

The following indicators have now been removed from the dashboard:

- **L19 Ensure that reviews of new short or long-term packages take place within 8 weeks of commencement** – due to delegated responsibilities transition to GCC.
- **L21 - MH Liaison - number of routine referrals seen within 24 hours (ICS portfolio) -** superseded by B55, B56 and B57 (not in exception).

Applaud (to areas for recognition)

- **Health visiting** KPIs all met their thresholds for the period, including the % of live births that received a new birth visit within 7-14 days by a health visitor (SO2) which can routinely be challenging due to NICU and family choice.
- **N44 IUCS/ NHS111 Low Abandonment rate** is 1.9%, which is below 3% target, meaning patients are able to access the service quickly. Furthermore, the **Mental Health Response Vehicle** continues to see high 'see and treat' figures (84%). This has been the case despite a rise in demand since its inception in 2024. This means that service users are avoiding having to be conveyed to Emergency Departments.
- **N25 – Outcome measurements.** The perinatal element (O25) achieved compliance at 54.5% against a target of 50% as planned.
- **L03 – CYPS Core CAMHS appt within 4 weeks.** Significant sustained improvements over 6 months has been seen for this KPI. Forecast for full recovery is expected and remains on track for July 2026. Additionally, significant progress is being made on the longest waits for CAMHS Referral to Treatment.

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?	July Service Directorate Ops Sessions, Directorate-wide Performance & Risk meeting on 21/07/2026 and BIMG on 16/07/2026.

Appendices:	*None*

Report authorised by: Rosanna James Sarah Branton Nicola Hazle	**Title:** Director of Improvement & Partnerships Chief Operating Officer Director of Nursing, Therapies & Quality

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Snapshot Month
June

Quality & Performance Dashboard Report

Aligned for the period to the end June 2026 (month 3)

This report presents the Trust's key performance indicators across five new indicator Domains including **Access & delivery of services**, **Financial performance and oversight**, **People & culture**, **Productivity & value for money,** and **Quality of care**. There are currently no indicators held within the **Strategy, Leadership & Planning** domain. The previous sources (*Nationally measured*, *Specialised & Direct Commissioning*, *ICS Agreed, Board Focus,* and *Operational*) are still indicated via the KPI ID subscript. This aligns to NHSEngland Insightful Board guidance. 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 2-15) 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

- The NHS Oversight Framework technical guidance which will outline the final definitions and methodologies for 2026/27 still hasn't been published; therefore there is limited work that can be done to replicate the new 2026/27 measures within this dashboard at this time. Indicators that are currently predicted to be within the NOF in some form are highlighted in purple for illustration only.

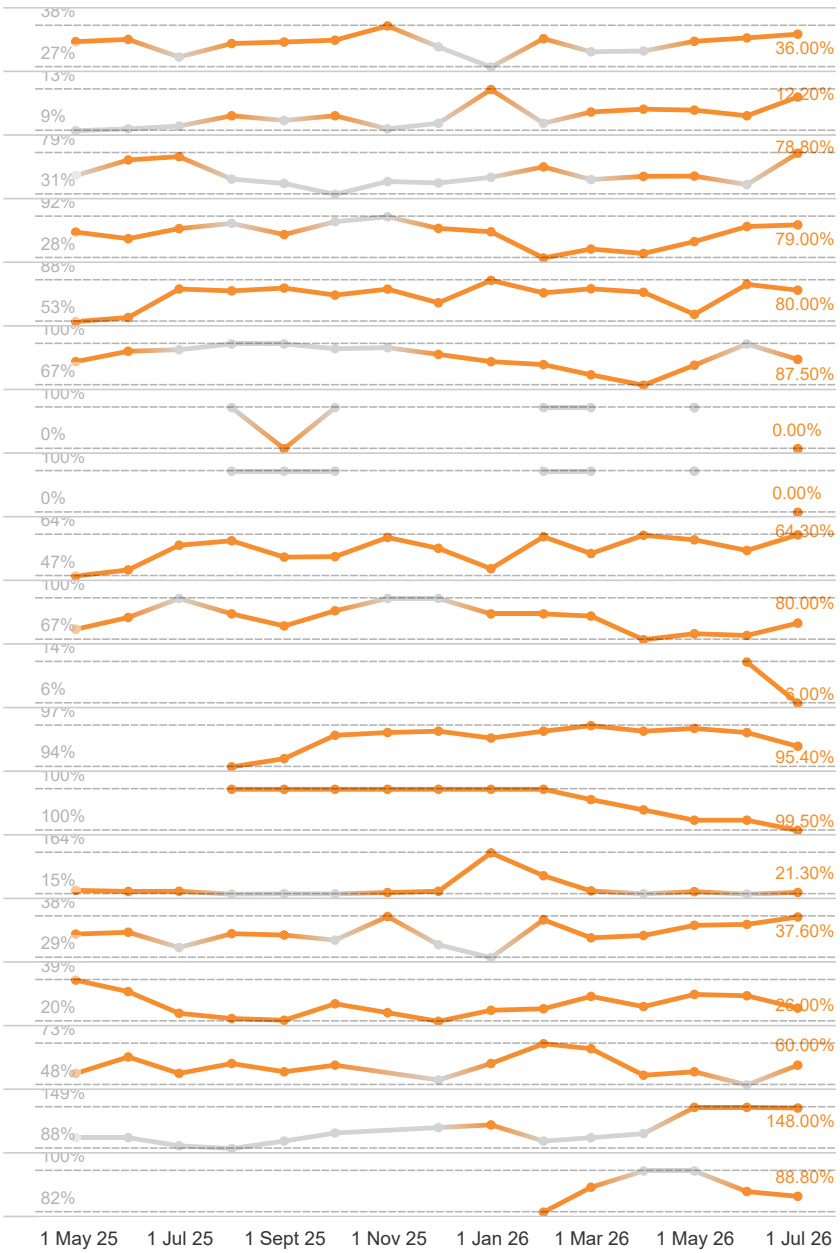
- With 16 new indicators being published in the dashboard for the period, 166 indicators are now reported within this month's KPI dashboard portfolio. 14 are currently being monitored within the development source and 11 new indicators are scheduled to go live before the end of Quarter 2 (with a further 6 in Q3). The full plan will see the portfolio rise to a total of 200 indicators, before any NHS Oversight Framework updates.

- As agreed within the Safer Staffing monthly Assurance Group and endorsed by BIMG, ratify the proposal to recommendation to reduce teh 100% target for B11 Safer Staffing Fill Rate to 92.5%. This will account for registered and non-registered AHP workforce inclusion which do not have mandated backfill resourcing requirements (or resourcing).

Access and Delivery of Services

This domain focuses on how well services are delivered to patients, including access and waiting times. It assesses whether care is timely, responsive and meeting demand effectively.

		JUNE
B51	PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)	36.0% / 30.0%
B52	PH CATU Inpatients Average Length of Stay (Days. Not a percentage)	2.2% / 10.0%
B53	PH Stroke Inpatients Average Length of Stay (Days. Not a percentage)	78.8% / 50.0%
L03	CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)	79.0% / 80.0%
L07	Eating Disorders - Wait time for adult assessments will be 4 weeks	80.0% / 95.0%
L08	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	87.5% / 95.0%
L10	Perinatal: Preconception advice - Referral to assessment within 6 weeks	0.0% / 50.0%
L11	Perinatal: Preconception advice - Referral to assessment within 8 weeks	0.0% / 90.0%
L23	IUCS - Proportion of HCP calls that receive clinical consultation within agreed timeframe	64.3% / 95.0%
N11	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	80.0% / 95.0%
N37	Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)	95.4% / 100.0%
N38	Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)	99.5% / 100.0%
N45	IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)	21.3% / 20.0%
N63	PH Community Hospitals Average Length of Stay (All Beds. Days. Not a percentage)	37.6% / 33.0%
N67	IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)	26.0% / 90.0%
N70	MH: Average length of stay for patients in Adult Acute and PICU MH beds. (NOF & Op Plan E.H.38) (Including leave - rolling 3 months) - Days not a percentage	60.0% / 51.0%
N71	MH: Average length of stay for patients in Older Adult Acute MH beds. (NOF & Op Plan E.H.39) (Including leave - rolling 3 months) - Days not a percentage	148.0% / 119.0%
N16	MH: Number of Out of Area Placements (Inappropriate) Adult Acute, PICU and Older People at the end of the month (Number of Patients. Not a percentage)	6.0% / 2.0%
N72	MH: Percentage of patients (aged 18+) in mental health crisis (Urgent referral) that receive a face-to-face contact within 24 hours (NOF)	88.8% / 95.0%



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Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months except L11.*

B51 - PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)
Risk ID: 406. Forecast for recovery: Interim measures reviewed alongside system transformation work and bed modelling - July 2026 29 days, October 2026 28 days, January 2027 27 days, April 2027 26 days. 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."

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)
Forecast for recovery: unable to determine due to system related variables. Actions: review of internal standard operating procedure completed. Ongoing system work to enable flow from all pathways. Ongoing work with Adult Social Care.

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
Risk: 165. Forecast for recovery: July 2026. Actions: Review of rota process to reflect job plans. Caseload tracker review in place. Reviewing appointment cancellations, did not attends and rebooking approach to identify improvements, weekly review with front door lead for young people awaiting multi agency discussions. Seasonal planning in place to understand increase/decrease of referrals to service.

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
Risk ID: 645. Forecast for recovery: Continued downward trajectory due to ongoing capacity issues. 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. Designing Solutions Project Group being progressed. All exceptions are well understood by the service.

L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeeks
Forecast for recovery: To be determined through Designing Solutions Group. All 3 patients have now been seen and received an assessment. Actions: access to online support from the voluntary care sector. Contact telephone helpline number available for all patients. Ongoing service development within the Designing Solutions Group.

L10 - Perinatal: Preconception advice - Referral to assessment within 6 weeks
The appointment was offered within the timeframe, however this was rearranged in line with the patient's wishes.

L11 - Perinatal: Preconception advice - Referral to assessment within 8 weeks
The appointment was offered within the timeframe, however this was rearranged in line with the patient's wishes.

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.

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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 that 3 cases did not attend their appointments. Designing Solutions Project Group has now commenced. Handover now complete to new senior manager. Highlight report to be presented to the Mental Health and Learning Disability Programme Board in August 2026.

N16 - MH: Number of Out of Area Placements (Inappropriate) Adult Acute, PICU and Older People at the end of the month (Number of Patients. Not a percentage)
Linked risk: 707. Forecast for recovery: improvement anticipated by November 2026. Actions: Stepped up patient flow activity. Looking at block contract to enable quality monitoring/visits. Supporting discharge team are attending multi disciplinary team meetings. Working with community teams to support earlier discharges.

N37 - Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)
There are 66 children waiting over 52 weeks for Occupational Therapy (OT). 47 children waiting over 52 weeks for Speech and Language Therapy (SLT), 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 on the OT waiting list, however further progress is dependent on completion of the Disabled Facilities Grant process.

N45 - IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)
For ongoing monitoring.

N63 - PH Community Hospitals Average Length of Stay (All Beds. 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: Proposed new forecasting is to meet 50% by August 2026. Performance is expected to increase to 54.6% under the agreed adjusted reporting methodology, which is removing validation mapped to 60 minutes, currently in the under 20 mapping. Actions: IC24 recovery activity underway. Bi-weekly tracking in place. Live queue management in place supported by dashboards. Call volumes continuously monitored. Capacity aligned to demand through ongoing review. Detailed review of performance by time of day/ week is underway. 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. Monthly review of incidents, complaints, patient experience and safety data undertaken monthly have not identified any associated patient harm.

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N70 - MH: Average length of stay for patients in Adult Acute and PICU MH beds. (NOF & Op Plan E.H.38) (Including leave - rolling 3 months) - Days not a percentage

Linked risk: 707. Forecast for recovery: Quarter 4. Actions: Weekly admission review meetings. Weekly liaison with system partners for allocation of social workers, with daily escalations in place. Multi agency discharge events focusing on themes/ trends for escalation. Improvement plan in place.

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: Improvement to be seen through quarter 2, with a continuous reduction in bed days. Actions: Weekly admission review meetings. Weekly liaison with system partners for allocation of social workers, with daily esclations in place. Individuals with complex funding package/placement have been escalated. Multi agency discharge events focusing on themes/trends for escalations. Supported Discharge Co-ordinator in place to liaise closely with Bed Manager.

N72 - MH: Percentage of patients (aged 18+) in mental health crisis (Urgent referral) to receive face to face contact within 24 hours

Forecast for recovery: Improvement anticipated August 2026, previously July 2026. Actions: Team managers have met with teams to remind of process for reporting/ recording which has had positive impact. Business Intelligence Team supporting exception reporting to teams for regular review. The patient has been seen and safe.

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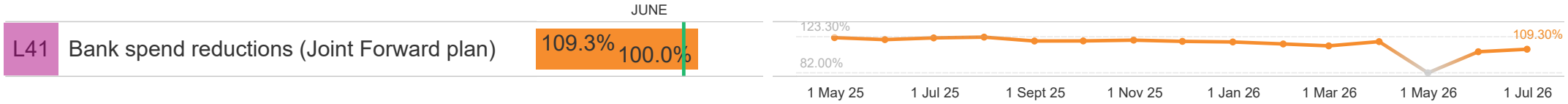
Financial Performance and Oversight

This domain examines how efficiently resources are used to deliver services. It focuses on improving outputs, reducing waste, and maximising value from available capacity.

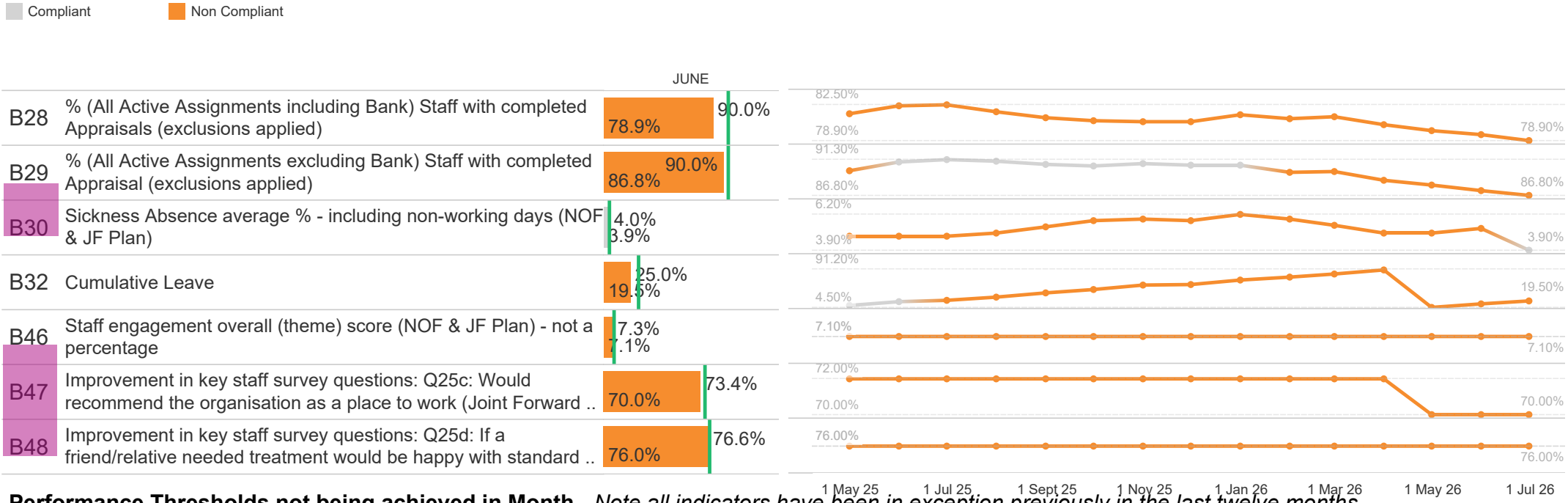


<u>Performance Thresholds not being achieved in Month</u> - *Note this indicator has been in exception previously in the last twelve months.*

L41 - Bank spend reductions (Joint Forward plan)
The Trust is required to make a year on year spend reduction of 10% on Bank costs. As of June, the Trust was 9.3% above the Bank spend Threshold. For Agency spend, the Trust are currently 10.0% below the Threshold.

People and Culture

This domain looks at workforce wellbeing, engagement and organisational culture. It assesses whether staff feel supported, able to speak up, and part of an inclusive and positive working environment.



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

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)
Performance for June is at 78.9%, 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. For comparison, May performance rose from 78.6% to 79.5% 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 June, excluding Bank staff is at 86.8%, just under the performance threshold of 90%, although the figure is expected to rise slightly due to delayed data entry (for comparison, May's performance rose from 86.3% to 87.4%). Performance is outside normal variation and has averaged 89.7% for the last 24 months. Finance are the only directorates meeting the 90% threshold at 92%. Operations are at 88%, HR and Improvement & Partnerships are both at 87%, Nursing, Quality and Therapy are at 79%, the Medical Directorate are at 71% and Corporate Governance are at 66%.

B30 - Sickness absence average % - including non-working days (Joint Forward plan)
The sickness absence rate for June 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 month. Once this data is incorporated, the absence rate is expected to rise to 5.2%. This continues to follow the seasonal trend of the last few years and is within expected variation.

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The Medical Directorate and Improvement and Partnerships were both above the threshold at 4.4%. Nursing, Therapies & Quality sickness absence was at 4.6%. Operations Directorate sickness absence was 5.5% and Human Resources Directorate sickness absence was 7.6%.

B32 - Cumulative Leave
The reported Cumulative Leave Taken Percentage for May 2026 is approximately 19.5%, which is below the target threshold of 25%. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until later in the month. The estimated % for July once the data from Allocate has been included is expected to be 22.8%.

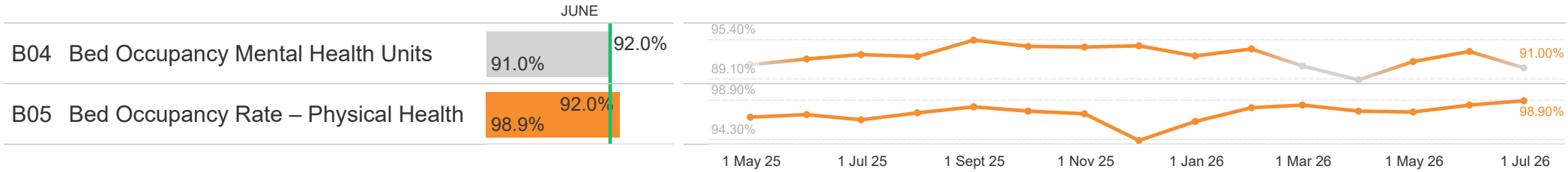
B46 - Staff engagement overall (theme) score (NOF & JF Plan) - not a percentage
The Trust's new five-year People Strategy is focused on creating a Great Place to Work by strengthening staff voice, leadership, inclusion, recognition and employee experience. Key initiatives during 2026/ 27 include leadership development, enhanced staff engagement and feedback mechanisms, improved recognition programmes, strengthened staff networks, and targeted retention support for groups at greater risk of leaving. These actions aim to ensure colleagues feel heard, valued and supported, with insights from staff directly informing organisational priorities. The staff engagement score is targeted to increase from 7.1 to 7.3 by March 2027, with improvements expected to build gradually as the impact of interventions is realised.

B47 - Improvement in key staff survey questions: Q25c: Would recommend the organisation as a place to work (Joint Forward plan)
The Trust's five-year People Strategy seeks to improve employee experience by creating a more supportive, responsive and engaging workplace. During 2026/27, action will focus on responding to staff survey feedback, strengthening communication of improvements, expanding stay conversations, enhancing recognition, and developing a more joined-up approach to listening to staff. These measures are intended to improve staff confidence in the organisation and increase advocacy among employees. The proportion of staff who would recommend the organisation as a place to work is targeted to rise from 70.0% to 73.4% by March 2027.

B48 - Improvement in key staff survey questions: Q25d: If a friend/relative needed treatment would be happy with standard of care provided by the organisation (Joint Forward plan)
Work is ongoing throughout 2026/ 27 to improve staff experience and organisational culture, recognising the link between staff engagement and confidence in patient care. Staff Survey findings are being triangulated with Pulse Survey, Freedom to Speak Up and retention data to inform targeted improvement actions. Directorate-led action plans, enhanced accountability, leadership and management development, and further Freedom to Speak Up initiatives are being progressed to address identified themes. The expected outcome is improved staff confidence in the quality of care delivered by the organisation, with measurable impact anticipated in future Staff Survey results.

Productivity and Value for Money

This domain examines how efficiently resources are used to deliver services. It focuses on improving outputs, reducing waste, and maximising value from available capacity.



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

B04 - Bed Occupancy Rate – Mental Health Units
Although currently presented as compliant for the period, it was not felt that this measure was reflecting the very high demand for services. On investigation this measure incorporates some bed capacity which is currently unavailable through closures or long term leave. A recommendation is progressing through governance routes (and ultimately August's Resources Committee) to exclude these beds from the calculation. This exclusion would make the indicator non-compliant hence the early warning.

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.

Quality of Care

This domain examines whether services are safe, effective and deliver good patient outcomes. It emphasises continuous improvement, patient experience, and reducing harm across services.

		JUNE	
B01	Care Programme Approach - formal review within12 months	84.7% / 95.0%	96.00% / 84.70% / 84.70%
B02	Nationally reported - Delayed Discharges (Including Non Health)	14.8% / 7.5%	20.90% / 8.00% / 14.80%
B11	Safer Staffing Fill Rate - Community Hospitals	94.6% / 100.0%	103.30% / 93.70% / 94.60%
B13	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	23.7% / 99.0%	90.40% / 19.40% / 23.70%
B17	Total number of pressure ulcers developed or worsened during care by this Trust	134.0% / 100.0%	153.80% / 92.30% / 134.00%
B58	Clinical Supervision	69.0% / 90.0%	69.30% / 60.10% / 69.00%
B59	Total number of sexual safety incidents	120.0% / 100.0%	140.00% / 20.00% / 120.00%
B60	Total number of incidents involving rapid tranquilisation (Whole Trust)	285.8% / 100.0%	285.80% / 55.10% / 285.80%
B61	Total number of incidents involving physical restraint (Whole Trust)	183.8% / 100.0%	183.80% / 73.70% / 183.80%
N02	Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only	100.0% / 0.0%	100.00% / 0.00% / 100.00%
N22	Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)	74.1% / 100.0%	91.30% / 72.70% / 74.10%
N25	Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice	36.4% / 50.0%	37.30% / 32.20% / 36.40%
N43	NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)	75.9% / 100.0%	124.50% / 66.70% / 75.90%
S12	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	78.3% / 80.0%	83.40% / 27.30% / 78.30%
S15	HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1	76.0% / 80.0%	79.80% / 23.70% / 76.00%
S16	MenACWY (Meningitis) coverage for all children in school year 9	63.4%	86.00% / 63.40%

S16	MenACWY (Meningitis) coverage for all children in school year 9		65.0%
S17	Td/IPV (Diphtheria, tetanus and inactivated poliomyelitis) coverage for all children in school year 9	62.5%	65.0%

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

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B01 - Care Programme Approach - formal review within 12 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.

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. Additionally, there is a recommendation to reduce the threshold to account for registered and non-registered AHP workforce inclusion.

B13 - Percentage of patients waiting less than 6 weeks from referral for a diagnostic test (Echocardiograms)
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.

B17 - Total number of pressure ulcers developed or worsened during care by this Trust

June 2026 data remains subject to validation and classifications may change following review. There were 122 pressure ulcers reported in June (May: 108) against a threshold of 91, although performance remains within SPC control limits. Increased incidence is associated with rising community nursing caseloads, sustained operational pressures and national trends, alongside factors such as patient compliance, equipment availability and end-of-life care.
June 2026 data remains subject to validation and classifications may change following review. There were 122 pressure ulcers reported in June (May: 108) against a threshold of 91, although performance remains within SPC control limits. Increased incidence is associated with rising community nursing caseloads, sustained operational pressures and national trends, alongside factors such as patient compliance, equipment availability and end-of-life care.

B58 - Clinical Supervision
A Clinical Supervision Improvement Plan is in place to address variation and improve consistency across teams. Current actions include strengthening local management oversight, targeted engagement with services reporting low compliance, clarifying recording and reporting processes, and increasing support for supervisors and supervisees. The intended outcome is improved uptake, recording and assurance of clinical supervision, with incremental improvement expected over the coming months as actions become embedded and are monitored through existing governance and performance arrangements.

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B59 - Total number of sexual safety incidents
There was a reduction of incidents reporting in June from 14 in May. All incidents are reviewed as per patient safety policy and appropriate actions have been taken place. Most incidents are reported by inpatient services though this is anticipated to reflect under reporting across the Trust.

B60 - Total number of incidents involving rapid tranquilisation (Whole Trust)
In line with incidents of physical restraint, the Trust have seen a further increase in Rapid Tranquilisation with 223 reported this month (+58 from May), of which 95% were given via Intra Muscular injection. The Trust have seen the biggest increases on Priory Ward and Greyfriars PICU, with 3 patients having had noticeable increases this month. An update regarding the Trusts Rapid Tranquilisation policy, approach to training and compliance will be provided to the next Positive and Safe Group.

B61 - Total number of incidents involving physical restraint (Whole Trust)
There has been a further increase in the number of restraint incidents in June with a small increase on the previous month (+9). There has been a month-on-month increase since February 2026 the rational for restraints being to prevent harm to themselves and to prevent violence to others.
The PARRI (Proactive Approaches Reducing Restrictive Interventions)Team are currently undertaking audits into records and results will be shared when available. In May the Trust had seen an increase in LD IHOT recorded restraints; this figure has reduced to 32 in June. These have all been planned and in relation to Phlebotomy, Dental or Podiatry procedures.

N02 - Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only
June - One patient transferred to GHT due to deterioration and reported a blood cultures positive result (Sample taken 30/05/26 and came through late after previous update). One HO-HA C.Diff Toxin positive, attributed to Cirencester.

N22 - Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)
Risk: 656. Forecast for recovery: 2028/29 dependent on funding being agreed, associated recruitment and generation of primary care referrals. 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 for perinatal element which was achieved in June 2026. CYPS forecasting for recovery is being further reviewed. 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.

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. 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.

Narrative continued on next page...

...narrative continued from last page...

S12 - HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
Team reviewing uptake daily and undertaken school revisits. Community clinics occurred over May half term. Saturday clinic held 11 July to address missed opportunities. Ongoing liaison with commissioners.

S15 - HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1
See S12 narrative.

S16 - MenACWY (Meningitis) coverage for all children in school year 9
Nationally the target is recognised as ambitious by national and regional commisioners. Vaccinations are offered to all school aged pupils (including those educated at home). Informed consent is required to be able to administer the vaccination. The target was not met in June due to 3 school sessions cancelled due to extreme heat which resulted in school closures. Additional community based clinic undertaken on Saturday 4 July. All cancelled sessions re-booked for July.

S17 - Td/ IPV (Diphtheria, tetanus and inactivated poliomyelitis) coverage for all children in school year 9
See narrative for S16.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Sally Morgan, Guardian of Safe Working Hours

SUBJECT: **GUARDIAN OF SAFE WORKING HOURS (**GoSWH)
Q4 2025/26 REPORT

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

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

The purpose of this report is to:

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

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

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

Recommendations and decisions required

The Trust Board is asked to:

1. **Note** the report from the Guardian of Safe Working Hours.
2. **Note** ongoing issues are being addressed.

Executive summary

- The exception reporting process is part of the new resident Doctors Contract to enable them to raise and resolve issues with their working hours and training.
- The Guardian's Quarterly report summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours

by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.

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

Risks associated with meeting the Trust's values

- Providing suitable and safe training placements for resident doctors is essential for the Trust in terms of reputation and developing workforce.
- This data is monitored by CQC and NHS England.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Great Place to Work Committee – 26TH June 2026

Appendices:	A. Quarterly Report

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

GUARDIAN OF SAFE WORKING HOURS

1.0 INTRODUCTION / CONTEXT

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

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

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

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

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

1.6 From 4 February 2026, the reforms to exception reporting for resident doctors on the 2016 contract in England came into effect. The overriding principle of these changes is to trust doctors to conduct themselves professionally, and to remove previously existing barriers to exception reporting. These changes aim to simplify processes, enhance doctor wellbeing, and ensure compliance with new legislative requirements.

1.7 This report now must now be standardised to meet the national template reporting requirements to allow central data processing.

1.8 Quarterly reports are required to be sent to: JLNC, LNC chair, DHSC/NHS England, NHS England (local office), CQC, GMC and GDC . Quarterly reports must be publicly accessible online within one month after the report has been created

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

1.10 The new reform will have an impact on medical staffing time, potential for increased fines, rolling fines and financial penalties for employers.

2.0 REPORTS

2.1 A) Number of exception reports submitted

Number of exception reports submitted over the last quarter	**27**

B) Categories of exception reports submitted

Type of exception report	Outcome				Number of exception reports
	Pay	TOIL	Penalty/fine	information	
Additional hours – unscheduled early start					0
Additional hours – unscheduled late finish	5	7	0	2 reports were withdrawn	14
Breaches of non-resident on call pattern	0	1	1 = £43.45	Fine for breach of rest period	2
Inability to take contractual breaks	0	0	0	Doctor was emailed by GOSWH to discuss – no response	1
Inadequacy of clinical support					0
Inadequacy of rostered skill mix					0
Raising concerns of suspected non-compliant rota	0	0	0	Flagged for ongoing monitoring	2
Detriment or threat of detriment related to exception reporting					0
Information breach					0
Access and completion resolved in time					0
Access and completion breaches					0
Access and completion test				All doctors were emailed to make them aware of need to exception report. And all new starters were given this information by GOSWH in person at their Induction	9
Other: optional free text box					
Totals	**5**	**8**	**£43.45**		**27**

B2) Immediate Safety Concerns

Number of exception reports that were immediate safety concerns	**0**

B3) Exception reports actioned by Verification Manager

Exception reports reviewed and actioned by Verification Manager	**13** (2 were later withdrawn by doctor)

B4) Exception reports actioned by GoSWH

Exception reports flagged directly to GoSWH.	**5**

B5) Exception reports relating to missed training opportunities

Exception reports relating to missed training opportunities – signed off by Director of Medical Education.	**0**

C) Experiences of actual or threatened detriment

Quarterly survey response rate.	**47%**
Doctors experiencing actual detriment as a result of exception reporting.	**0%**
Doctors feeling that they are not discouraged from exception reporting.	**88%**

D) Withdrawals

Number of exception reports withdrawn over last quarter.	**2**

E) Access to individual doctors' exception reporting data

Number of exception reports disclosures over the last quarter.	**0**

Other optional free text box

The GoSWH attended the Resident Doctor Induction In February 2026 to meet new doctors joining the trust and provided with information about exception exporting. All doctors (existing plus new starters) were emailed to make them aware of the need to submit a test exception report (access and completion test).

There has been a clear increase in exception reporting since the new reforms came into place.

The acting deputy of GoSWH has been contacting some of the doctors who have exception reported to explore reasons for reporting in more detail .

The GoSWH will continue to monitor exception reports and identify trends or patterns which may require work schedule reviews .

There has been a clear increase in the work load for both the GoSWH and Verification Manager as a result of the new process.

F) Work schedule reviews related to exception reporting pattern/instance

Number of work schedule reviews related to exception reporting patterns or instances.	**0**

G) Rota gaps on all shifts over the last quarter

Total number of rota gaps on all shifts over the last quarter.	**26**

Resident Doctors in Training Summary

Category	January	February–March
Total Doctors in Training	56	58
Higher Trainees (HTs)	17 *(incl. 1 on maternity leave)*	20 *(incl. 1 on maternity leave)*
CT3s	11 *(incl. 1 on maternity leave)*	9
CT2s	6	6
CT1s	4	6
GP Trainees	5	4
FY2s	5	5
FY1s	8	8

On-call Shift Gaps and Cover

Metric	Number
Total shifts with gaps	26
Covered by Resident Doctors (locums)	18
Covered by Specialty Doctors (locums)	8

H) Additional information on an ad hoc basis

The Guardian of Safe Working Hours is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant Executive Director, or equivalent, for decision and action, where these have not been addressed at departmental level.

None.

The Guardian of Safe Working Hours is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

None.

3.0 APPOINTMENT OF GUARDIAN OF SAFE WORKING HOURS

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

4.0 EXCEPTION REPORTING REFORMS & IMPLICATIONS FOR GHC

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

4.2 Key dates:

- By 4 February 2026: Full implementation deadline for all employers.
- From August 2027: Formal national evaluation of reforms begins.

4.3 Key changes to exception reporting:

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

Direct Reporting Lines: Exception reports for less than 2 hours additional work will be submitted directly to HR, exception reports relating to missed educational opportunities will be submitted to the Director of Education and all others will be submitted to the Guardian of Safe Working Hours. This removes the need for supervisor approval.

Resident doctors making exception reports relating to additional hours worked will be required to need to provide evidence of time, date and location which will be used to verify their submitted exception report for additional hours worked.

The Guardian of Safe Working Hours retains oversight for all exception reports made which will allow for monitoring of any patterns of exception reporting and consideration of work schedule reviews.

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

Strict Timelines:

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

Submission Window: Doctors have up to 28 days to submit an exception report (can be greater if outside their control).

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

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

4.4 **Implications for GHC:**

Capacity - Impact on medical staffing time.

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

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

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

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

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

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

PRESENTED BY: Rosanna James Director of Improvement and Partnership

AUTHOR: Dominika Lipska-Rosecka, Service Development Manager

SUBJECT: **WORKING TOGETHER ANNUAL REPORT 2025-2026**

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:
The purpose of this report is to provide an overview of progress made in delivering the Working Together approach during 2025-2026, and to demonstrate how involvement, co-production and partnership working have contributed to service improvement and the delivery of the Trust's strategic priorities.

Recommendations and decisions required

The Trust Board is asked to:

- **Note** the progress made in delivering the Working Together activities, including achievements in involvements, co-production and partnership working.
- **Endorse** the Working Together Annual Report 2025-2026.

Executive summary

The Working Together Annual Report 2025-2026 demonstrates the Trust's continued commitment to placing people who use our services, carers, families, communities and partners at the heart of the decision making.

The report outlines progress in delivering the Working Together Plan, highlighting how co-production, community engagement and partnership working have supported the Trust's strategic priorities, strengthened governance, and embedded lived experience, community insight and, importantly, the difference this has made to our services, patient and carer experience across the Trust.

The report also reflects on progress made, identifies areas for continued development, and sets out the priorities for 2026–2027 as the Trust continues to strengthen its Working Together approach and refresh the Working Together Plan in line with the Trust's Five Year Focus. **Please note:** An Easy Read version and a public-facing version, including

additional photographs and visual content will be produced following Board approval to improve accessibility and engagement with people and communities.

Risks associated with meeting the Trust's values
Risk ID 05: Relationships and Partnership Working

There is a risk that the Trust may not fully meet its statutory duty to involve people and communities in decisions about NHS services. This could impact regulatory assurance, including Care Quality Commission assessments, and result in reputational risk.

CURRENT RISK SCORE 9 (Target: 6) – The current score reflects system-wide organisational changes, including the evolving partnership landscape across the ICB, Gloucestershire County Council and emerging provider, primary care and VCSE collaboratives. Additional challenges include inconsistent adoption of co-production across the Trust; increasing demand for involvement activity; and ensuring participation reflects the diversity of Gloucestershire's communities.

MITIGATION: Risk is being mitigated through development of the Working Together Plan (2027-2031); investment in the Working Together Network; Experts by Experience programme; partnership working to deliver community engagement; a new Digital Platform; strengthening approaches to measuring impact; and delivery of the Trust's Five-Year Focus priority, Partnerships with Purpose, which aims to strengthen and mature partnership working including the Provider Partnership and GP Collaborative.

Corporate Considerations	
Quality Implications	Working Together supports continuous quality improvement by ensuring services are designed, delivered and evaluated in partnership with people and communities. The report provides assurance of compliance with statutory duties relating to involvement, equality and co-production, including the NHS Duty to Involve and the Equality Act 2010.
Resource Implications	Delivery of the Working Together approach is supported through existing Trust resources and partnership working. Future priorities will continue to be delivered through a combination of internal resources, co-production and community partnerships.
Equality Implications	Working Together supports the Trust's commitment to reducing health inequalities by improving accessibility, increasing participation from under-represented communities and ensuring diverse voices inform service development and decision-making.

Where has this issue been discussed before?
None

Appendices:	(Page 26) Appendix 1- Working Together Priorities 2026-2027

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

Acronyms used within this report	
GHC	Gloucestershire Health and Care NHS Foundation Trust
CAMHS	Child and Adolescence Mental Health services
ICS	Integrated Care System
VCSE	Voluntary, Community and Social Enterprise
EbE	Experts by Experience
QI	Quality Improvement
ICB	Integrated Care Board
ILP	Integrated Locality Partnerships
MH	Mental Health
PH	Physical Health
LD	Learning Disability

NHS
Gloucestershire Health and Care
NHS Foundation Trust

with you, for you

Working Together Annual Report 2025-2026

Creating Better Health and Care Through Partnership

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

WORKING TOGETHER 2025–2026

At a Glance

NHS
Gloucestershire Health and Care
NHS Foundation Trust

WORKING TOGETHER

50	Long-term co-production projects supported
125	Project involvement activities delivered (across these projects)
200+	Single involvement opportunities delivered
75	Services connected through the Working Together approach

EXPERTS BY EXPERIENCE

228	Active Adult Experts by Experience
22	Youth Voices Experts by Experience
318	People who have participated in the Experts by Experience Programme since its launch
26	Members of the Gloucestershire Children and Young People Community of Practice
3	Language That Cares events delivered

YOUTH VOICES – PARTNER GROUPS INCLUDE

GCC Future Me, GFT, Gloucestershire Hospitals NHS Foundation Trust, Young Influencers, Creative Sustainability, GPSA, Gloucester Youth Group, mentoring organisations and Gloucestershire Children and People Community of Practice.

COMMUNITY ENGAGEMENT & INSIGHTS

205	Community engagement events attended
20,000+	People estimated to have attended community engagement events
90+	VCSE and community partners engaged
25	System engagement meetings attended
	Community Engagement Events Tracker developed

WORKING TOGETHER NETWORK

5 Working Together Network meetings held

Bringing together people with lived experience, staff and partners to share learning, influence priorities and strengthen co-production across the Trust.

INNOVATION & IMPROVEMENT

Co-production Maturity Matrix	In development and testing
Community Insights Framework & Dashboard	In development
Digital Platform Launched to support involvement and co-production	

LOOKING AHEAD

- Review and refresh the Working Together Five-Year Plan
- Strengthen partnership working across the new Integrated Care System footprint and Gloucestershire County Council
- Further develop the Co-production Maturity Matrix
- Continue embedding co-production across all Trust services
- Expand Community Insights to better understand local needs and reduce health inequalities

Working together with people, communities and partners to improve health and wellbeing across Gloucestershire.

1. INTRODUCTION

This report provides an overview of Gloucestershire Health and Care NHS Foundation Trust's **Working Together** activities and achievements during 2025-2026. It demonstrates how people with lived experience, carers, families, communities, colleagues and partner organisations have contributed to shaping, improving and influencing health and care services across the Trust.

The report highlights progress made in delivering our Working Together Plan and demonstrates how co-production, community engagement and partnership working support our commitment to delivering personalised, inclusive and responsive care.

This report includes:

- **Progress and achievements -** overview of the progress and achievements made to support delivery of the Trust's Working Together Plan (2021-2026).
- **Governance, Leadership and Delivery** - how co-production and collaboration support decision making across the Trust.
- **Expert by Experience programmes** - the contribution and impact of adults and young people with lived experience of using our services.
- **Community Engagement and Community Insight** - how we listen to and learn from communities across Gloucestershire.
- **Partnerships with Purpose** - the partnerships and networks that help us improve services and reduce healthcare inequalities.
- **Working Together in Action** - examples and case studies demonstrating how involvement has influenced change.
- **Measuring Impact and Looking Ahead** - the difference Working Together has made and our priorities for 2026-2027.

Throughout the report, we share examples of how the experiences, insights and expertise of people and communities have influenced decisions, strengthened relationships and contributed to service improvement. We also reflect on our progress, identify areas for further development and set out our ambitions for the year ahead.

2. OUR COMMITMENT

At Gloucestershire Health and Care NHS Foundation Trust (**GHC**), we believe the best health and care services are created **with people, not simply for people**. Our **Working Together** approach supports the delivery of our **Five-Year Focus (2026-2031)** - our plan for better community health and care services across Gloucestershire **-** by placing people, carers, families, colleagues, communities and partners at the heart of everything we do.

Working Together is how we involve people and communities in shaping decisions, improving services and influencing the future of health and care across Gloucestershire. By bringing together lived experience, community insight and professional expertise, we can design and deliver care that is more responsive, person-centred and inclusive.

During 2025-2026, we continued to embed Working Together across the Trust, strengthening opportunities for involvement, developing partnerships, and ensuring lived experience informed service improvement and organisational decision-making.

As we look ahead, we remain committed to increasing participation, improving accessibility and inclusion, strengthening partnerships and demonstrating the impact of Working Together across Gloucestershire.

Strategic Alignment
Working Together supports delivery of the Trust's Five-Year Focus by:

- **Putting people first** through meaningful involvement and co-production.
- **Getting the basics right** by listening, learning and acting on feedback.
- **Building Partnerships with Purpose** across health, care, voluntary and community organisations**.**
- **Reducing healthcare inequalities** through improved inclusion, accessibility and representation**.**
- **Using lived experience and community insight** to inform decision-making and service improvement.
- **Supporting continuous improvement** through collaboration, innovation and shared learning.

"Building equity and inclusion in care requires us to work differently. Co-production is about building genuine partnerships based on trust, respect and shared decision-making, where lived experience is valued alongside professional expertise." Rosanna James Director of Improvement and Partnerships

3. THANK YOU

We would like to thank everyone who contributed to Working Together during 2025-2026.

We recognise and are grateful for the contributions of:

- **Experts by Experience**
- **Youth Voices**
- **Carers and families**
- **Working Together Network members**
- **Trust colleagues**
- **Community organisations**
- **Voluntary, Community and Social Enterprise partners**
- **Volunteers**
- **Health and care partners**

Your experiences, expertise and commitment have helped improve services, influence decisions and strengthen relationships across Gloucestershire.

Together, we are creating better health and care for local people.

4. PROGRESS AND ACHIEVEMENTS

4.1 Governance and Leadership

Strong governance and leadership are essential to embedding Working Together across the Trust. During 2025-26 we co-designed and implemented a new Working Together model. This removed committee and reporting processes to enable more workshop-style conversations and information sharing.

We recognise that further work is needed to improve oversight and links with operational and clinical governance structure's and will review the new model's effectiveness during Autumn 2026; ensuring results are considered alongside the organisational restructure.

Looking ahead, we will further develop our Youth Working Together Network to ensure young people's voices are more clearly represented in decision-making.

4.2 The Working Together Plan

The **Working Together Plan (2021-2026)** provided the framework for how the Trust works alongside people, carers, communities, colleagues and partners to influence decisions, improve services and strengthen partnerships. During 2025-2026, we continued to embed co-production across service development, quality improvement, workforce development, recruitment, research and transformation programmes.

As the current plan comes to an end, we are reviewing and refreshing our Working Together Plan for 2027-2031 to align with the **Trust's Five-Year Focus (2026-2031)**. The refreshed plan will build on the progress made to date, strengthen our ambitions for involvement, inclusion and co-production, and provide a clear roadmap for the next phase of delivery.

We will continue to monitor and report on progress, ensuring that lived experience, community insight and partnership working remain central to how we design, deliver and improve services.

What difference did this make?

The Working Together Plan has provided a consistent framework for involvement, co-production and partnership working across the Trust, helping to embed lived experience and community insight into service development, quality improvement and organisational decision-making.

4.3 Delivering the Working Together Plan

The Working Together Network

The Working Together Network provides an important forum for collaboration, shared learning and partnership development.

It creates opportunities to share good practice, discuss emerging priorities, and strengthen relationships across Gloucestershire.

During 2025-2026, the Working Together Network continued to strengthen collaboration between people with lived experience, communities, partners and colleagues.

During the year we:

- Held **5** Working Together Network meetings
- Involved **105** people with lived experience, carers, and members of the public.
- Engaged with approximately **69 partner organisations from across Gloucestershire** – including health, housing, education, local authority, Voluntary, Community and Social Enterprise (VCSE) and community organisations, Healthwatch.
- Promoted county-wide **collaboration and partnership opportunities**.
- Shared **learning, community insights and examples of good practice**.
- Supported greater **understanding and adoption of co-production approaches**.
- Informed the Trust's work through themed discussions on **key strategic priorities**.
- Developed a **parallel Working Together approach for children and young people.**

Throughout the year, Network meetings focused on a range of important topics, including:

- Personalised Care
- Peer Support and Lived Experience

- Patient and Carer Race Equality Framework (PCREF)
- Working Together Principles
- The Trusts Five-Year Focus

What difference did it make?

The Network has strengthened relationships between people with lived experience, communities, partners and colleagues, creating opportunities for collaboration, shared learning and co-production that have influenced service improvement and strategic decision-making across the Trust.

4.4 Celebrating Co-production and Working Together in our Trust

This year marked the introduction of the **Dan Beale-Cocks Co-production Award** as part of the **Trust's Better Care Awards**. The award honours Dan's outstanding contribution as an Expert by Experience and his commitment to championing co-production across Gloucestershire.

The inaugural award was presented by Dan's Family to **Melissa Reed, Consultant Occupational Therapist**, in recognition of her commitment to inclusive practice, partnership working and co-production.

What difference did it make?

Recognising and celebrating good practice has helped raise the profile of co-production across the Trust, encouraging Colleagues and teams to strengthen partnership working and involve people more meaningfully in service improvement.

4.5 Experts by Experience and Volunteers Celebration event

More than 100 Experts by Experience, volunteers and colleagues attended our annual celebration event, hosted by the Trust Chair.

The event recognised and celebrated the invaluable contribution that Experts by Experience and volunteers make across the Trust. It provided an opportunity to:

- Thank participants for their contribution and commitment.

- Share examples of good practice and impact.
- Strengthen relationships between Colleagues, volunteers and people with lived experience.
- Build connections and support networking.
- Celebrate the positive difference that co-production and Working Together make across our services.

What difference did it make?

The event highlighted the importance of partnership working and the value added and significant role that people with lived experience and volunteers play in helping us improve services and outcomes for the communities we serve.

4.6 Experts by Experience (EbyE) Programme

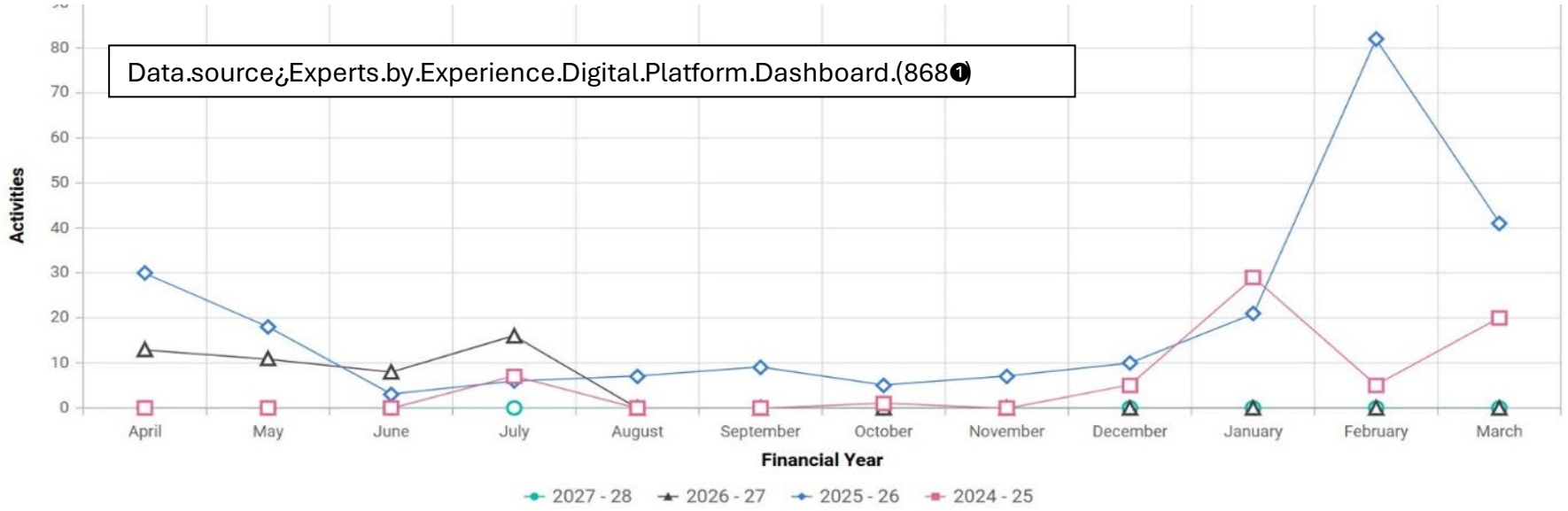
The EbyE Programme is a cornerstone of our Working Together approach. It brings together adults, children and young people with lived experience of using GHC services, and their carers and families. EbyE's influence service improvement, quality improvement, recruitment, education, research and organisational development across the Trust.

During 2025-2026:

- 228 adults were actively involved in the programme.
- 25 new members joined during the year.
- 50 long-term projects were supported.
- 125 project-based involvement opportunities were delivered.

"I never could have imagined just how much the Expert by Experience programme would positively impact me¡It truly has been?and continues to be? literally life changing*ϟ EbyE

Overall, EbyE's contributed to more than **375+** involvement opportunities during 2025-2026. We have seen a continued increase in involvement opportunities over recent years, indicating the growing integration of lived experience across the Trust. This increase coincides with the **launch of the EbyE Digital Platform in 2025**, making it easier for colleagues to identify and involve people with relevant experience. The graph below shows this growth: the blue line represents this reporting year (2025-2026) and shows an increase in the number of activities for nearly every month compared to the pink line (2024-2025). The black line (up to July 2026) shows that this trend is continuing in the current financial year.



Through their involvement, EbyE's helped us to:

- **Co-design and improve services and patient pathways** including **Eating Disorders, Community Mental Health and Stroke Services**, supporting better experiences and more responsive services.
- **Improve patient information and communications**, including reviews of the **Complex Care at Home leaflets, Adult MSK invitation letters, Fatigue leaflets, Talking Therapies website content and the Sexual Health patient portal**, resulting in clearer, plain English resources created that are more accessible and easier for patients and carers to understand.
- **Strengthen recruitment processes** by involving Experts by Experience in interview panels and focus groups for a range of the roles across the Trust: **Non-Executive Directors, Approved Mental Health Practitioners, Clinical Psychologists, Matrons, Service Directors, Strategic Leads.** Their involvement supported values-based recruitment, ensuring appointments of Colleagues committed to compassionate, person-centred care.
- **Co-designed and co-delivered training** on **Learning Disability, mental health, personalised care, wellbeing and workforce development.** This helped strengthen Colleagues understanding of the lived experience, improving confidence, communication and the delivery of more personalised, compassionate care.

- **Increase understanding of healthcare inequalities** through initiatives such as the **My Life Project and the Patient and Carer Race Equality Framework (PCREF),** helping to shape more inclusive and culturally responsive services.
- **Influence strategic decision-making through participation** in the **Working Together Network and by sharing patient stories at Trust Board meetings, community Insight Days**, leading to greater organisational learning, more informed decisions and supporting improvements in service quality, communication and patient experience.
- **Strengthen Quality Improvement (QI) projects**, including **Perinatal Mental Health** through co-production, helping to shape more culturally competent services, strengthen relationships with underrepresented communities and improve equitable access to care. Supported the **Reducing MH Inpatient Length of Stay QI project**, informing service improvements to enhance discharge planning, improve patient flow and deliver a better patient experience.
- **Create more welcoming, accessible and person-centred care environments** using the **15-step challenge NHSE toolkit**. As a result of this work, improvements were made to signage, accessible information in reception areas and the overall patient environment, helping to improve people's experience of care.

What difference did it make?

By involving people with lived experience throughout service development, improvement and decision-making, we have strengthened co-production across the Trust, improved services and communications, increased workforce understanding of patient experiences and ensured that decisions are informed by the people most affected by them.

4.7 Youth Voices

Young people continue to play an important role in shaping services through our Youth Voices Programme. The programme enables young people to contribute their experiences, ideas and perspectives to service development, quality improvement and organisational learning, while helping them build confidence, leadership skills and experience of partnership working.

During 2025-2026

- 22 young people were actively involved as youth experts
- 7 active service projects received Youth Voice input
- 14 Quality Improvement projects were influenced
- 3 Language That Cares events were co-designed and co-delivered

Because of their involvement, young people helped us to:

- Co-design improvements to pathways in **Special Education Needs and Disabilities services (SEND),** supporting more open conservation with children, Young People and families, and strengthening personalised care planning and support.
- Review and improve patient information and communications aimed at children and young people e.g. **discharge letters for Child and Adolescent Mental Health Services (CAMHS)** and **shaping the language used in care records**.
- Improve experiences and outcomes by influencing the language used in therapeutic conversations, communications, training and engagement activities **(e.g. Tree of Life project).**
- Young People's involvement helped services better understand what matters most to Children and Young People, informing our **GHC Five-year Plan**, **strengthening Youth Voice and broadening engagement through the Community of Practice**.

The programme also helps young people build confidence, leadership skills, and experience of partnership working.

What difference did it make?

Youth Voices has strengthened the influence of children and young people within service improvement and decision-making, helping services become more accessible, responsive and relevant to the needs and experiences of younger people.

4.8 Understanding Our Expert by Experience Community

Understanding who participates in our Experts by Experience and Youth Voices programmes helps ensure that the people shaping our services reflect the diverse communities we serve.

We collect demographic information to monitor representation, identify gaps and inform more targeted engagement with under-represented communities. This includes information relating to:

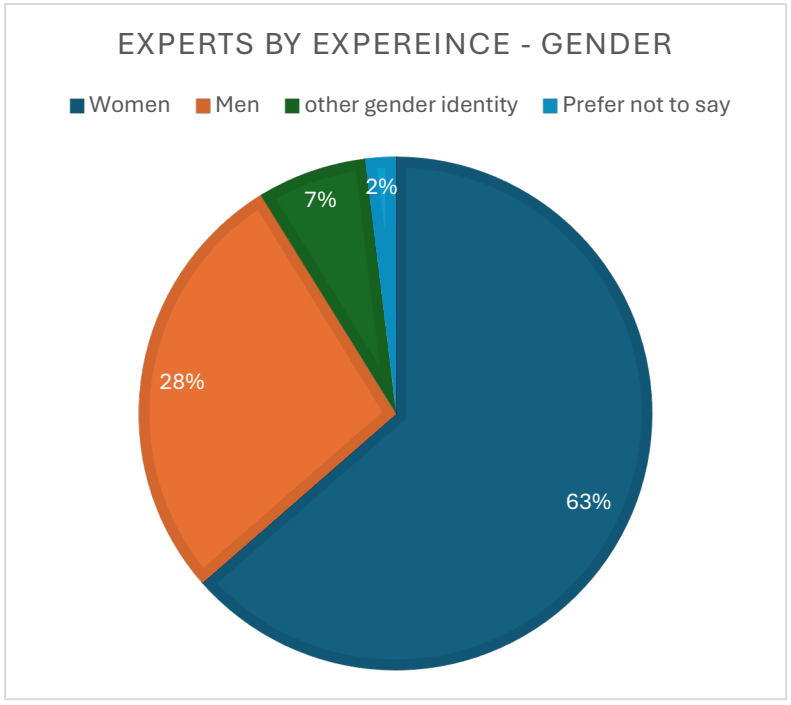
- Age
- Gender
- Ethnicity
- Sexual orientation
- Disability
- Protected characteristics

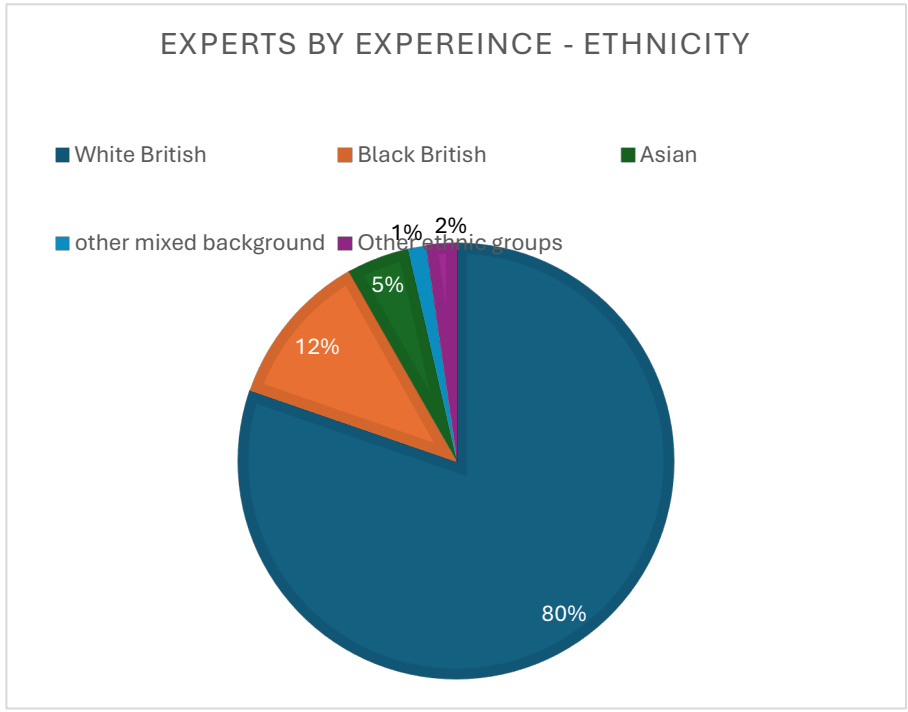
- Faith
- Service and lived experience backgrounds

By comparing programme demographics with Gloucestershire population data, we can assess how representative our involvement activity is and identify opportunities to strengthen equality, diversity and inclusion.

Nearly **670,000 people** live in Gloucestershire, and we remain committed to ensuring opportunities for involvement are accessible to everyone. The charts below show some of our data.

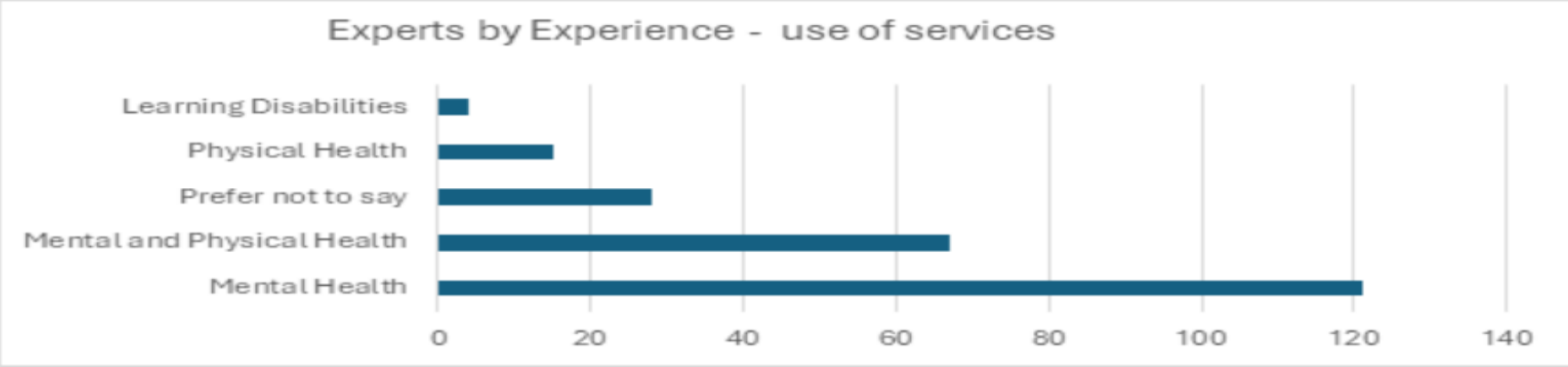
Overall, our **Experts by Experience and Youth Voices communities are broadly representative of the local population** with some minority populations over-represented compared to population data. This is because we continue to focus on engaging people and communities who experience the greatest health inequalities or are traditionally underrepresented in involvement activities.





(Data Source: Experts by Experience demographic monitoring data - GHC Digital Platform Dashboard).

During 2025-2026, the largest proportion of our EbyE's community represented people with experience of mental health services. We also **saw strong representation from people with experience of both mental and physical health services,** together with **people with Learning Disabilities**. This breadth of lived experience enables meaningful co-production across service redesign, quality improvement, research, recruitment, workforce development and transformation programmes throughout the Trust.



What difference did this make?

Understanding the diversity of our EbyE community helps us ensure that a wide range of perspectives informs service improvement and decision-making. It enables us to identify gaps in representation, strengthen engagement with under-represented or marginalised communities and ensure that services are shaped by people with experiences that reflect the communities we serve.

4.9 Community Engagement and Insight

Meaningful engagement helps us understand what matters most to local communities and ensures that services are informed by the experiences, priorities and needs of the people we serve. Throughout 2025-2026, we worked alongside local people, communities, voluntary organisations and partners to strengthen relationships, gather insight and support service improvement across Gloucestershire.

Community engagement also provides opportunities to raise awareness of Trust services, improve health literacy, connect people with support and help communities access advice, screening and preventative health interventions.

Out-Reach

During the year we:

- Attended more than **205 community engagement activities**.
- Worked alongside **90+ community and voluntary organisations**.
- Reached approximately **20,000 people** across Gloucestershire.
- Supported **75 Trust services** through community engagement activity.
- Delivered more than **100 outreach pop-up events** through the Outreach Vaccination and Health Team, providing over **1,400 health checks**, with **12% of people referred directly for further screening or treatment**.

What difference did it make?

- These out-reach activities supported communities experiencing the greatest health inequalities, including Gypsy, Roma and Traveller communities, refugees and asylum seekers, people from ethnic minority backgrounds, rural communities and farm workers.
- Alongside gathering feedback and community insight, these events provided opportunities to promote services, offer health advice, undertake health checks and support people to access care and treatment at an earlier stage.
- These events also provide opportunities to raise awareness of services, improve health literacy, and connect people with appropriate support at an earlier stage.

Community Insight

To strengthen organisational learning, we continue to develop our Community Engagement Events Tracker and Community Insights Dashboard.

These tools help us identify emerging themes, understand community priorities and share learning across services. They also support a more coordinated approach to community insight across Gloucestershire and help inform service improvement, transformation and action to reduce health inequalities.

Turning Insight into Action

Community engagement and lived experience have helped us to:

- Improve understanding of local priorities and challenges through **Partnership Boards and Know Your Patch meetings**.
- Identify barriers to accessing services through **community conversations and outreach events**.
- Inform service redesign, including **Eating Disorder Services and Community Mental Health Transformation**.
- Improve patient communications through **reviews of letters, leaflets, websites and digital applications**.
- Increase accessibility through programmes such as the **Patient and Carer Race Equality Framework (PCREF) and Triangle of Care, 15 steps challenges initiatives**.
- Increase the influence of lived experience voices on strategic decisions through the **Working Together Network, patient stories and Community Insight Events, Lived Experience Community of Practice.**

What difference did it make?

- Community engagement has strengthened relationships with local communities, improved understanding of health inequalities and helped people access information, advice and support. By combining engagement with health promotion and preventative interventions, we have been able to identify unmet need, improve awareness of services and connect people with appropriate care earlier.

4.10 Partnerships with Purpose

Strong partnerships help us improve services, understand community needs and address health inequalities.

During 2025-2026, we worked alongside more than **90 voluntary, community, statutory and system partners** to strengthen relationships, share learning and improve how people and communities influence health and care services.

Our partnership activity spans the county and includes collaboration through:

- Integrated Locality Partnerships
- Know Your Patch meetings
- Gloucestershire County Council Partnership Boards

- VCSE networks
- Rethink locality Mental Health Forums
- Community events and engagement activities
- System-wide programmes and partnerships

These collaborations bring together organisations from health, social care, local government, housing, education, community and voluntary sectors to understand local priorities and coordinate action.

Recent examples include collaborative work within the Matson and Coney Hill communities, where partners worked with local people to co-design solutions that improve health, wellbeing and population health outcomes.

What difference did it make?

- Partnership working has improved communication and collaboration between organisations, strengthened community insight and supported more joined-up, person-centred approaches to improving health and wellbeing across Gloucestershire.
- Helps our teams know about community groups and provide information about support people can access in their local area.

5. WORKING TOGETHER IN ACTION

5.1

Case Study – Working Together with Communities: **Big Health Day 2025**

Big Health Day brings together people with learning disabilities, autistic people, people with sensory impairments, those experiencing mental health challenges and people living with long-term health conditions. The event promotes health, wellbeing and social connection through accessible activities, health advice, information and support.

»It's.been.a.fabulous.day¡.The.Big.Health.Day. event.is.a.fantastic.opportunity.to.network?. connect.with.people.™.communities.and. share.good.practice.across.organisations*. Thank.you.to.everyone.involved.in.organising. that.event*

In 2025:

- **1,600** people attended.
- Over **120 stalls** and displays provided information and support.
- **12 inclusive activities** were delivered.
- More than **130 health checks** were completed.

Why this matters: People with Learning Disabilities experience significant health inequalities and can die up to 20 years earlier than the average life expectancy in Gloucestershire, often due to preventable physical health conditions. People experiencing health inequalities often face barriers accessing healthcare, wellbeing support and preventative services. Events such as Big Health Day create opportunities for earlier intervention, improved health literacy and stronger community connections.

What Difference Did It Make?

- Strengthened relationships and trust between local communities, health and care services and partner organisations.
- Improved awareness of available services and support, helping people access the right support earlier.
- Increased access to health advice, wellbeing information and health checks; over 130 health checks were completed, identifying potential health concerns and signpost people to appropriate services.
- Connected people experiencing health inequalities with local services, support and health improvement opportunities.
-

5.2 Case Study – 15 Steps Challenges

The 15 Steps Challenge is an NHS improvement methodology that explores care environments through the eyes of patients, carers and visitors to identify opportunities for improvement.

The 15 Steps Challenges helps ensure our buildings are welcoming, accessible, safe and patient-centred by incorporating feedback from people with lived experience.

During 2025-2026, 15 steps challenges were completed across:

- **6 Community Hospitals** across Gloucestershire
- **Wotton Lawn Hospital**
- **Southgate Moorings**
- **Pullman Place**

What Difference Did It Make?

- Improvements to external and internal signage, reception areas and accessible information made our services easier to navigate for people with Learning Disabilities, people with Autism, Neurodivergent people and others with additional accessibility needs.
- Strengthened dignity, privacy and comfort by identifying practical environmental changes that enhanced the experience of people using services.
- Helped create environments that better support positive health and care experiences by ensuring that people who use our services directly influenced improvements in our services.

> "Thank you so much for supporting 15 steps challenge with us, as there are some really clear, helpful actions here for us to take forward."...
>
> Zoe Hepburn Clinical Lead for Long Term Conditions, Pulman Place.

5.3 Case study: Youth Voices Influencing Improvement

Tree of Life – Getting Ready for Your First CAMHS (Child and Adolescence Mental Health Services) Appointment

Six young people with lived experience reviewed the Tree of Life activity to explore how it could support children and young people preparing for their first CAMHS appointment.

Participants completed the activity independently before meeting online to discuss their experiences and recommendations. Their feedback highlighted the importance of choice, flexibility and personalised approaches. As a result, the resource was refined to better support the needs of individual young people.

What Difference Did It Make?

- Young people's experiences directly informed service design.
- The resource became more personalised and flexible.
- Services gained a better understanding of what helps young people feel prepared and confident.
- Young people influenced how services engage with children and young people from the earliest stages of care.

> "I nearly didn't reply (when asked to become a Youth Expert) but I am so glad I did. It's allowed me to use my experience to create a positive change. I can now view that experience in a different light. "
>
> From a Youth Expert

5.4 You Said, We Did

We know we can do more to show people how their feedback has influenced decisions and improvements. We want to strengthen how we measure, evidence, and communicate the impact of involvement across our Trust and to the people and communities.

Why This Matters

Closing the feedback loop is a key part of Working Together. People who share their experiences want to know how their views have influenced decisions and improvements.

During 2026-2027, we will aim to strengthen our **You Said, We Did** approach by:

- Developing and testing impact measures.
- Improving governance and reporting arrangements.
- Strengthening how evidence of change is captured.
- Developing and improving ways to feedback to people, communities and partners.

What Difference Will This Make?

A stronger *You Said, We Did* approach will improve transparency, build trust and demonstrate how feedback, engagement and co-production contribute to meaningful change across the Trust.

6. MEASURING IMPACT

Measuring our impact

Working Together is about more than participation. It is about creating meaningful change.

Throughout the year we continued to measure:

- Participation
- Representation
- Inclusion
- Service improvement
- Community reach
- Partnership activity

Alongside quantitative measures, we collected stories, feedback, and case studies to demonstrate the difference Working Together makes across Gloucestershire.

The few examples we have shown demonstrate how we measure our Working Together approach by capturing activity, the insights gained from people and communities, and the impact these contributions have had on improving services, influencing decisions, and supporting better outcomes.

We are continuing to develop more robust measures of impact and outcomes, alongside activity and participation data.

7. LOOKING AHEAD

Building on the progress made during 2025-2026, our priorities for this year are to further embed Working Together across the Trust and continue strengthen a culture where people and communities are genuine partners in shaping and improving our services. We will refresh the Working Together Plan, strengthen co-production, widen participation and outreach with underrepresented communities, improve how we can capture and demonstrate the impact of involvement, and further develop “You Said, We Did” approach. Together, these priorities will support delivery of the Trust’s Five-Year Focus and our ambition to improve health, wellbeing and care outcomes for the people of Gloucestershire.

Appendix 1 provides a summary of the Working Together priorities for 2026-2027.

8. CONCLUSION

The progress made during 2025–2026 demonstrates that the Working Together approach is becoming increasingly embedded across Gloucestershire Health and Care NHS Foundation Trust. You can see more examples of the benefits of co-production in the Trust’s Annual Report 2025/26 statement about how we are tackling health inequalities.

The commitment and contributions of Experts by Experience, carers, colleagues, volunteers, communities and partner organisations have helped shape services, improve experiences and strengthen our culture of involvement, co-production and partnership working.

While significant progress has been made, we recognise that Working Together is an ongoing journey. We remain committed to listening, learning and working alongside the people and communities we serve, ensuring that lived experience and community insight continue to inform decisions, influence improvement and help reduce health inequalities.

Together, we will continue to strengthen partnerships, improve services and deliver better health and care outcomes for the people and communities of Gloucestershire.

Appendix 1


OUR PRIORITIES
FOR 2026–2027
NHS
Gloucestershire Health and Care
NHS Foundation Trust
1
EXPAND EXPERTS BY EXPERIENCE AND YOUTH EXPERT PROGRAMMES
Increase diversity and representation
Grow opportunities for involvement across services
2
DEVELOP THE EXPERTS BY EXPERIENCE DIGITAL PLATFORM
Launch Phase Three – external application for Experts by Experience
Improve usability and accessibility
Strengthen reporting and analytics
3
STRENGTHEN COMMUNITY INSIGHT
Develop the Community Engagement Events Tracker
Embed community insight across planning and decision-making
4
EMBED CO-PRODUCTION
Support all services to use co-production consistently
Further develop and implement the Co-production Maturity Matrix
Embed lived experience across improvement, transformation and quality improvement projects
5
IMPROVE INCLUSION HEALTH
Increase engagement with under-represented communities
Reduce barriers to participation
Improve equitable access and health outcomes
6
BUILD STRONGER PARTNERSHIPS
Strengthen collaboration across the new Gloucestershire Integrated Care System footprint
Continue working with Gloucestershire County Council, VCSE organisations, Primary Care Networks and wider system partners
7
MEASURE WHAT MATTERS
Develop meaningful impact measures
Strengthen dashboards and reporting
Review and refresh the Working Together Five-Year Plan

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

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

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **MODERN SLAVERY TRUST STATEMENT 2025/26**

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

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

The purpose of this report is:

To present the Board with the Trust's proposed statement on Modern Slavery, for approval.

Recommendations and decisions required

The Board is asked to:

- **Note** the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and;
- **Approve** the statement for 2025/26 – noting that this was received and endorsed at the June GPTW Committee.

Executive summary

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

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

The statement has been reviewed for work conducted in 2025/26 to ensure that it remains fit for purpose and compliant with national requirements. The statement was presented to the GPTW Committee for initial review and endorsement, in advance of presentation to the Trust Board for approval.

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

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

Where has this issue been discussed before?
Trust Board / Executive Team – annual reconfirmation paper GPTW Committee – 30 June 2026

Appendices:	None

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

TRUST STATEMENT ON MODERN SLAVERY

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

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

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

2.0 SLAVERY AND HUMAN TRAFFICKING STATEMENT FOR FINANCIAL YEAR 2025/26

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

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

inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since our Trust inception in October 2019.

- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adults Policy", and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites
- Our Trust provides training for all recruiting managers on Safe Recruitment via our online training platform - Care To Learn.
- Our Freedom to Speak Policy for the NHS gives a platform for colleagues to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to all colleagues. This is supplemented by a Freedom to Speak Up application (APP), which guides them through the process of raising concerns, and offers the option to remain anonymous. This app is offered to all workers whether they are substantive or temporary.
- The Procurement Team work on the principle of zero tolerance of modern slavery in our supply chain. Our standard terms and conditions require suppliers to comply with relevant legislation and tender evaluations include Social Economic factors. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation
- We continue to work with our suppliers directly and via partners, such as NHS Supply Chain, to support initiatives related to modern slavery.

3.0 REVIEW OF EFFECTIVENESS

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

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

4.0 RECOMMENDATION

The Board is asked to:

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2026.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0726

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 July 2026**

PRESENTED BY: Helen Child, Director of Governance and Trust Secretary

AUTHOR: Helen Child, Director of Governance and Trust Secretary

SUBJECT: **AUDIT & ASSURANCE ANNUAL REPORT TO THE BOARD 1 APRIL 2025 – 31 MARCH 2026**

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

The purpose of this report is to

Present the Audit and Assurance Committee annual report 2025/26 to the Board.

Recommendations and decisions required

The Trust Board is asked to note the Annual Report 2025/26.

Executive summary

The Audit and Assurance Committee's terms of reference require that:

"*The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board*"

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

The attached report provides an overview of the Committee's work in the last financial year, from 1 April 2025 to 31 March 2026 in sections which reflect the headings of the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues have been highlighted as areas of concern. The Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

Risks associated with meeting the Trust's values

Failure to identify and mitigate corporate and strategic risks may adversely affect the achievement of the Trust's strategic goals.

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

Where has this issue been discussed before?
• Annual Report to Trust Board • Endorsed by Audit & Assurance Committee – June 2026

Appendices:	

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

Gloucestershire Health and Care NHS Foundation Trust

Audit and Assurance Committee Annual Report

1 April 2025 – 31 March 2026

1.0 INTRODUCTION

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

2.0 MEMBERSHIP

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

At least one member of the Committee has recent, relevant financial experience and a relevant financial qualification; in this case, the Chair of the Committee.

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

3.0 MEETINGS AND ATTENDANCE

The Committee met 5 times during the period 1 April 2025 to 31 March 2026, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate. All Non-Executive Directors receive papers and have the opportunity to raise any concerns with the Chair even where they do not attend. Attendance by members at the Committee during the period as follows:

** core members*

Members*	30/04/25	19/06/25	07/08/25	13/11/25	05/02/26
Bilal Lala* (Chair)	Y	Y	Y	Y	Y
Jason Makepeace*	Y	N	Y		
Sumita Hutchison*	Y	Y	Y	Y	
Rosi Shepherd*	N	N	Y	Y	N
Nicola de Iongh					
Vicci Livingstone-Thompson		Y			Y
Steve Alvis*	N				
Debbie Forster*					Y
Karen Clements					

	Not core member of group
	Not in post

4.0 PRINCIPAL REVIEW AREAS

4.1 Governance, Risk Management and Internal Control

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

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

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

The Committee acknowledges the ongoing progress in developing risk management and believes that while adequate systems for risk management are in place, ongoing management focus is required to ensure that risk management matures within the Trust.

4.2 Internal Audit

In completing its work, the Committee places considerable reliance on the work of the Internal Auditors, BDO. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. During the year the Committee reviewed and approved the internal audit plan for 2026/27 and considered the findings of internal audit in relation to work on the following areas aligned to the 2025/26 agreed internal audit plan:

	REPORT FINDINGS	
	Design	Effectiveness
Data Quality 24/25	Moderate	Moderate
Quality Improvement 24/25	Moderate	Moderate
PCREF (advisory)	N/A	N/A
Working Well Occupational Health	Limited	Moderate
Temporary Staff and E-Rostering	Significant	Moderate
Risk Maturity (advisory)	N/A	N/A
Infection and Prevention Control	Moderate	Moderate
Quality Governance NTQ	Moderate	Moderate
Key Financial Systems – Budgetary Control	Moderate	Moderate
Patient Safety Incident Response Framework	Moderate	Limited
Accessibility Information Standards	Limited	Moderate
Data Security and Protection Toolkit	Very Low Risk/High Confidence	

The reviews produced a total of 38 recommendations - 2 low, 32 medium and 4 high risk-rated. In respect of each of these findings the Committee sought and

received assurance on the mitigating actions being taken, following up outstanding actions as necessary and referring issues to other Committees as appropriate in order for progress with action plans to be monitored. Tracking of IA recommendations is reviewed at each meeting.

4.3 External Audit

During the year, the Committee:

- **Received** and **noted** the final audit in respect of the 2025/26 Annual Report Financial Accounts.
- **Reviewed** and **agreed** the external audit plan for 2025/26.
- **Reviewed** and **commented** on the reports prepared by external audit which have kept the Committee appraised of progress against the External Audit Plan.

4.4 Private Meeting with the Auditors

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

4.5 Other Assurance Functions

The Committee received regular Counter Fraud updates, and received Counter Fraud Annual Report for 2025/26 and the Counter Fraud work plan for 2026/27. Throughout the year the Head of Counter Fraud has met with the Committee Chair, Director of Finance and Counter Fraud Champion.

Proactive Counter Fraud exercises were concluded relating to Single Tender Waiver Benchmarking, Secondary Employment Policy Compliance and Conflict of Interest Compliance.

4.6 Compliance Reporting

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

The Committee reviewed the 2025/26 financial statements and annual report at the 18 June 2026 meeting prior to recommending the final accounts for Accounting Officer signature.

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

5.0 OTHER MATTERS

During the year the Committee has:

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

6.0 CONCLUSION

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

Bilal Lala
Chair, Audit and Assurance Committee - June 2026

COUNCIL OF GOVERNORS MEETING

held **Thursday, 14 May 2026**
via MS Teams

PRESENT:	Graham Russell (Chair)	Peter Gardner	Amy Aitken
	Chris Witham	Sarah Waller	Michelle Kirk
	Bob Lloyd-Smith	Jan Lawry	Martin Pittaway
	Alicia Wynn	David Hindle	Andrew Cotterill
	Caroline Goldstein	Joy Hibbins	Marcia Gallagher

IN ATTENDANCE: Douglas Blair, Chief Executive (from Item 8)
Helen Child, Director of Corporate Governance
Karen Clements, Non-Executive Director
Debbie Forster, Non-Executive Director
Anna Hilditch, Deputy Trust Secretary
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Non-Executive Director
Kate Nelmes, Head of Communications
Neil Savage, Director of HR&OD

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Mick Gibbons, Chas Townley, Tussie Myerson, Kizzy Kukreja, Richard Dean, Laura Bailey, Leighton-Lee Pettigrew and Paul Winterbottom. Apologies had also been received from the following Non-Executive Directors: Steve Alvis and Nicola de Iongh.

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 17 March 2026, and the extraordinary meeting held on 1 May, 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 Sarah Waller informed the Council that she had attended the recent Governor visit to Cirencester Hospital. Peter Gardner and Chas Townley also attended, alongside Steve Alvis, NED. Sarah said that they had visited Thames Ward and had the opportunity to speak with colleagues, noting that morale was high which was positive to see. The target length of stay on Thames Ward has more than doubled, allowing patients to be discharged when ready rather than rushed, contributing to positive staff morale and patient outcomes.

5. CHAIR'S REPORT

5.1 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 28th May, and all Governors would receive the papers in advance for information.

5.2 Graham had the pleasure of attending the Volunteer and Experts by Experience Thank You Tea Party Celebration on 6th May. He informed the Council that this was a marvellous occasion to celebrate the difference made by Experts and volunteers, noting that the Trust was a better organisation because of their contributions, insights, and engagement. Andrew Cotterill had also attended the event and agreed with Graham's sentiments, noting that it had been a fantastic event, very well attended and a great networking opportunity.

5.3 The Trust had successfully appointed Helen Blanchard as a Non-Executive Director. Helen would commence in post on 25 May and trust wide communications would be sent out shortly. Graham Russell took the opportunity to thank those colleagues who had participated in the recruitment process.

5.4 The Trust Board has decided to recruit a new Associate Non-Executive Director role to help 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. The Trust is 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 would launch in the week beginning 25th May, and we will be promoting this opportunity throughout our networks. Graham Russell said that he was excited about the chance to bring new perspectives onto the Board and it was agreed that the advert and recruitment pack would be shared with all Governors once ready, with colleagues being encouraged to share these materials across their extensive networks. **ACTION**

5.5 On 23rd April, the Trust's first Board Community Insight Event took place in Northleach. The 'Cotswold' Community Insight Event took place in collaboration with local partners and focussed on Local Population Health data, what matters most to the community and identified key challenges. The event was well attended, and plans will be developed looking to extend the model to urban communities, focusing on underserved populations, with ongoing reflection and adaptation based on feedback. Sarah Waller, Peter Gardner and David Hindle had attended the Insight Event. Sarah Waller expressed her thanks to colleagues for keeping Governors up to date on key issues, and for regularly presenting Governors with service updates, e.g. Children & Young People's Services, noting that this helped gain a good understanding of key services and enabled Governors to engage with people in the community on such matters.

5.6 Since the previous Council meeting there had been no further update in relation to the national direction for councils. However, it was proposed that the July Governor development session would be used to focus on next steps and future models.

5.7 It was noted that the Trust's Annual Quality Account was currently being drafted, in preparation for a final submission date of 30th June. As in previous years, the draft report would be shared with Governors for comment and feedback, and it was hoped that this would be circulated by 25th May.

6. COMMUNITY HOSPITALS DELAY RELATED HARM PROGRAMME

6.1 The Council welcomed Katie Parker-Roberts, Deputy Service Director, who was in attendance to present on the Community Hospitals Delay Related Harm Programme. The presentation would be shared with Governors following the meeting. **ACTION**

6.2 Katie described the shift from performance metrics to a quality-driven approach, emphasising prevention of delay-related harm and quantifiable outcomes such as falls and pressure ulcers. The programme uses data visibility to drive transformation, with changes in discharge ready definitions and benchmarking against national standards, revealing that 40-50% of patients are discharge ready daily.

6.3 Regular system workshops take place involving community hospitals, adult social care, brokerage, and Home First, fostering shared understanding and collaborative problem-solving. Red to Green data tracks discharge delays, with adult social care and family delays identified as major factors; quality dashboards monitor compliance and deep dives are conducted for readmissions and pressure ulcers.

6.4 Temporary tests of change include Thames ward and ring-fenced step-up beds, with ongoing evaluation showing step-up patients have shorter stays and case reviews informing inclusion criteria and staff support.

6.5 Katie set out some of the risks which included high bed occupancy and lack of adult social care data. Next steps would involve further quality improvement, harm data triangulation, and continued system engagement.

6.6 Chris Witham said that this was an excellent piece of work, and he asked about the system-level response to this programme, noting that it could be applied nationally. Katie confirmed that there was good system-wide collaboration and open data sharing. Sarah Waller agreed with the value of sharing this work, noting that it could be of real benefit to other Trusts.

6.7 David Hindle referenced the tests of change and enquired about patient and carer feedback. Katie advised that qualitative feedback was being collected from staff, patients and carers on the test of change and this would all be fed into the evaluation process, alongside the quantitative data.

6.8 Governors thanked Katie Parker-Roberts for providing this update and acknowledged the great work that was taking place.

7. NEIGHBOURHOOD HEALTH STRATEGY AND FRAILTY FOCUS

7.1 The Council welcomed Des Gorman and Julia Bradbury who were in attendance to present a Neighbourhood Health update. The presentation would be shared with Governors following the meeting. **ACTION**

7.2 Des Gorman explained the NHS 10-year plan's three key shifts - hospital to community, sickness to prevention, analogue to digital - and described six core components of neighbourhood health, including population health management and integrated intermediate care.

7.3 Historic challenges such as organisational silos and misaligned incentives were discussed, with the future model emphasising integrated care delivery and outcome-based commissioning.

7.4 Julia Bradbury used a patient story to contrast fragmented, crisis-driven care with coordinated, proactive, and preventative neighbourhood health, highlighting the benefits of integrated teams and personalised care plans.

7.5 In Gloucestershire, the initial focus was on primary care networks, frailty, and dementia, with plans to expand to other cohorts; internal and system workshops are underway to align vision and implementation. Julia described the need for integrated neighbourhood teams, improved information sharing, and community health centres, supported by strategic planning and values-driven goals.

7.6 The Council thanked Des and Julia for attending and presenting this helpful overview of neighbourhood health.

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 Graham Russell invited those Non-Executive colleagues present to provide a brief highlight report of some of the key business received and discussed at the recent round of Board committees.

8.3 **Resources Committee** - Debbie Forster (Committee Chair) said that the Resources Committee had received updates on Finance and business planning, and good assurance on progress with these was received. An in-depth review of the neighbourhood health strategy was received, and the Committee received a draft of the Estates and Facilities Strategy for discussion.

8.4 **Audit & Assurance Committee** – Bilal Lala (Committee Chair) informed the Council that the Audit Committee had received an internal audit report of PSIRF (Patient Safety Incident Response Framework), had reviewed the board assurance framework and corporate risk report and provided feedback on the timelines and deadline for targets. The Financial Overpayments report was received, and the annual report from the Local Counter Fraud service noted.

8.5 **Great Place to Work Committee** – Karen Clements (Committee Chair) advised that the Committee had received a full session on the Trust's People Strategy, looking at

how this links through to the 10-year people plan. The Committee received the staff survey results, noting the key themes and areas for development. The Trust's workforce KPIs report was discussed, and good assurance was received on the Trust's people metrics. The Committee was also updated on potential industrial action and the new national transformation of people services programme.

8.6 **Quality Committee** - Vicci Livingstone-Thompson (Non-Executive Director and Committee Member) noted that the increase in the number of complaints continued to be monitored, particularly related to the IUC Service, however, increases were being seen nationally. The Committee received reports on the Patient and Carer Race Equality Framework (PCREF), an update on Berkeley House, and an update on the safeguarding review at Wotton Lawn.

8.7 Bob Lloyd-Smith asked about the increase in complaints. Bilal Lala 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. 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.

8.8 The Governors asked for an update on IUCS in the next Governor Dashboard, focusing on complaints, the number being received, and the themes. An overview of the service performance measures would also be welcomed. **ACTION**

9. CHIEF EXECUTIVE'S REPORT

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

9.2 A verbal update was provided on the safeguarding review at Wotton Lawn and Douglas advised that the Trust was committed to upholding standards and being transparent. GHC was working collaboratively with partners on the review and ensuring that the necessary support was available for patients, carers and colleagues at Wotton Lawn. The Governors noted the preparations for the upcoming BBC coverage.

9.3 Earlier in the day the Secretary of State for Health had resigned. Douglas said that the Trust would await further details about the potential impact of this.

9.4 Douglas Blair was very pleased to announce the appointment of Katherine Archer as the Trust's new Director of Finance. Katherine would commence in post in July as the successor to Sandra Betney on her retirement from 31 July. The Trust had also successfully recruited a new Chief Operating Officer, and final fit and proper person checks were being carried out before a public announcement of Sarah Branton's successor was made. Douglas confirmed that handover plans were in place for both positions to ensure continuity.

9.5 The Governors were provided with an update on the Provider Partnership Agreement. Douglas Blair advised that a Memorandum of Understanding had now been signed with the Integrated Care Board, GP Collaborative, and Gloucestershire Hospital's Trust to lead service transformation in frailty, long-term conditions,

community mental health, and urgent care. Further updates would be presented back to the Governors in due course.

10. GOVERNOR ENGAGEMENT UPDATE

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

10.2 Peter Gardner informed colleagues that he had attended the Trust's awards ceremony having taken part on the judging panel. He had also attended the previously discussed community insight event in Northleach, and the visit to Cirencester Hospital. Peter said that taking part on the judging panel for the Trust awards had helped him gain valuable insights into staff and service contributions, and encouraged other Governors to take up the opportunities to get more involved.

10.3 Michelle Kirk described attending a group consultation for OT staff facing delegated responsibility changes, and said that the Trust's approach to this had been empathetic and positive, despite being very challenging for the colleagues affected.

11. ANNUAL GOVERNOR DECLARATIONS 2025/26

11.1 The Governors received and noted the Annual Governors Declarations register for 2025/26.

12. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

12.1 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.

12.2 Since the last meeting, Graham Russell said that the Council had said farewell to Sarah Nicholson (Staff Governor) whose final term ended in March. Sarah was a Governor with us for a full period of 6 years and on behalf of the Council, Graham expressed his thanks to Sarah for her valued contributions and engagement in the role.

12.3 The Council was asked to note that Caroline Goldstein (Staff Governor) would be leaving GHC next month and would therefore be required to stand down as a Staff Governor from 31 May 2026. Graham Russell wished Caroline well for the future.

12.4 The Council noted that as at 1 June 2026, there will be three vacant positions on the Council, as follows:

- Public Governor (Gloucester)
- Staff Governor (Health & Social Care Professionals)
- Staff Governor (Medical Dental & Nursing)

Anna Hilditch advised that, at this time, the Trust does not propose to go out for election for these positions and will hold them as vacant. This is in line with the discussions that are taking place nationally about the future of the Council of Governors.

13. GOVERNOR QUESTIONS LOG

13.1 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.

13.2 It was **noted** that no new questions had been received since the last formal meeting held in March 2026.

14. ANY OTHER BUSINESS

14.1 There was no other business.

15. DATE OF NEXT MEETING

15.1 The next Council of Governors meeting would be held on Thursday 16 July 2026.

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
14 May 2026	5.4	Associate NED advert and recruitment pack to be shared with all Governors once ready, with colleagues being encouraged to share these materials across their extensive networks	**Complete**. Circulated on 9th June
	6.1	Community Hospitals Delay Related Harm Programme – presentation to be shared with Governors	**Complete**. Circulated following the meeting on 14th May
	7.1	Neighbourhood Health update - presentation to be shared with Governors	**Complete**. Circulated following the meeting on 14th May
	8.8	Update on IUCS to be included in the next Governor Dashboard, focusing on complaints, key themes and an overview of the service performance measures	Noted for future Governor Dashboard report.

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**CHARITABLE FUNDS COMMITTEE – 10 June 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Nicola de Iongh, Chair of Committee

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

The Committee noted the status of the general fund and raised concerns about the ability to service the Hardship Fund to the same level in future years, without a clear strategy to increase fundraising opportunities.

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

Nothing to report.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received an update on the functioning of the new Charity Advisory Group and were assured by the progress and activities which had taken place.

The Committee received an update on the Hardship Fund and were assured that the allocation had been met and the impact the funds had.

The Committee received an update on the Charitable Funds Co-Ordinator and was assured by the significant fundraising activity being undertaken and the progress made in developing fundraising opportunities and partnerships.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the Annual Report and Accounts subject to completion of an independent review which is due to start week commencing 22nd June 2026.

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

ITEMS RECEIVED: The following items were received and discussed at the meeting
• Bid approvals made since the previous Committee meeting • A verbal update about the status of the Charitable Funds Strategy • An update on the Friends of the Forest Health Services

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 18 June 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Karen Clements, Vice Chair of Committee

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

Nothing to report.

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

The Committee received the Cyber Assurance Report, and whilst assured by the report, the Committee **noted** that cyber security was impacted by weaknesses due to performance by third parties in key areas of cyber and procurement and **noted** that actions were being led by the Executive to strengthen performance.

The Committee **noted** that an Internal Audit on business continuity would commence and that the expected remedial actions would require attention from the Resources Committee.

The Committee discussed how the control environment would be assured and requested board development time to be dedicated to this, together with wider assurance of committee risk management through to the Audit & Assurance Committee and Trust Board.

The Committee reflected on the fact that there are a number of new Non-Executive Directors and agreed that there was the need to ensure that there was a plan to build their understanding of key technical areas.

The Committee received and reviewed the Committee Terms of Reference, the Committee Annual Report and the Committee Work Plan and agreed that these items would be approved outside of the Committee via correspondence due to quoracy issues.

ASSURE: Inform the Board where positive assurance has been achieved

The following items were received, and allowed the Committee to take assurance of the integrity of financial controls and accuracy of the financial reporting for the 2025/26 financial year:

- Internal Audit Annual Report & Head of Internal Audit Opinion
- External Audit Year End Report (ISA260)
- Draft External Audit Annual Report 2025/26
- Draft External Audit Opinion
- Statutory Accounts
- TAC01 CE Confirmation of NHS Improvements Accounts
- Summarisation Schedule Certificate of NHS Improvements Accounts (TACs)
- Letter of Representation

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

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

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved the Final Annual Report and the Final Accounts and Certificates.

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

The Committee was pleased with the Data Security and Protection Toolkit Internal Audit Report and applauded the results of the hard work put in by the digital and information governance teams.

The Committee received the Considerations Prior the Approval of the Annual Accounts and appreciated the format and the content of the report; and **noted** that this would be adopted elsewhere.

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

Due to issues of quoracy the following items were received and **noted** when the Committee was not quorate:

- Internal Audit Progress Report
- Procurement Shared Services Annual Assurance Report

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**RESOURCES COMMITTEE – 25 June 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 **noted** the financial exposure from two areas (Home First and STAR). Absence of confirmed future Home First funding, and impact of STAR and Out of County expenditure over spends.

The Committee was informed that 37.53% of CIP remained unidentified as of month 2 of the financial year.

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

The Committee received the Quality and Performance Report and was advised that the number of pressure ulcers (indicator B17) was above the threshold for the month May, and there is a nationally recognised risk of incidence and prevalence of pressure ulcers.

The Committee **noted** the wide spread of the Wotton Lawn Large Scale Safeguarding Enquiry and the impact on off framework shifts. The committee will visit the stats with this separated out to monitor the individual trajectories.

The Committee received a paper on Board Assurance Framework (BAF) risk 7 – Capacity for Change and the Committee discussed the difference between internal capacity and external pressures. The Committee **noted** that the risk score would remain at 16, with a target of 9. This would be further reviewed in December.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee **noted** that co-streaming good practice was having a positive effect on indicator L21 – Mental Health Risk Share.

The Committee received the National Cost Collection Methodology 2025/26 and the Service Development Report and was assured by the information shared, and thanked finance colleagues for their work.

The Committee received an update on the Transforming Care Digitally Programme and was assured by the progress made.

The Committee received the Green Plan Delivery update and noted that the Trust had achieved a 28% reduction in its NHS Carbon Footprint, which was 3% above target. The Committee received the new delivery plan, which included additional ambitions for active projects.

The Committee **noted** that the Accessible Information Standard **(**AIS) Implementation Plan and an update on Prescribing Costs would be received at the August Committee meeting.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the Digital Strategy 2026-2031.

The Committee **approved** the delivery of the Green Plan.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **noted** that BAF Risk 8 Cyber Security risk score had increased to twenty following server vulnerabilities and the SIEM.

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

The Committee applauded the progress made in the delivery of the Trust's Green Plan.

The Committee applauded Digital Services, who had 90% of calls rated as excellent.

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

The Committee received the NHS Premises Assurance Model (PAM) Annual Assessment.

The Committee received the following summary reports from Management Groups:

- Business Intelligence Management Group
- Capital Management Group
- Digital Group
- Strategic Oversight Group

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AGENDA ITEM: 21.1/0726

Digital Strategy 2026 - 2031

Our plan to become a Digitally Enabled Trust to help you live your best life by delivering great healthcare

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

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Foreword From Simon Christopherson, Clinical Director and Trust Chief Clinical Information Officer

Our new digital strategy sets out how we will use digital to improve care for people in Gloucestershire. We want our services and systems to feel more connected, responsive and empowering for both staff and the people we support.

This strategy is not about technology for its own sake, and neither can we solve every issue. It is about using digital tools, data and new ways of working to make care for people simpler, safer and more joined up. Our aim is to become a Digitally Enabled Trust by giving colleagues reliable tools, access to the information they need, and the confidence to use digital well.

The strategy has been shaped by feedback from colleagues and partners, who told us digital needs to be simpler, more reliable, better connected and more helpful in everyday work. Their views helped define our four priorities: User Experience; Systems, Data and Reporting Integration, Access to Digital Tools and Digital and Data Confidence.

This supports the NHS wider aims of moving from paper to digital, from hospital to community, and from treating illness to preventing it. We have also ensured that the Trust's five-year plan is fully embedded throughout, with its core ambitions reflected in our priorities and delivery approach

This strategy sets a direction that is ambitious about the future we want to create, while remaining realistic about the pace and sequencing required to deliver sustainable change. We are clear about the long-term improvements needed for GHC and our partners, while taking a phased and prioritised approach to implementation.

I am confident about what we can achieve together. By focusing on what matters most and keeping compassion, inclusion and practicality at the centre, digital can help us improve experience, outcomes and everyday working lives across Gloucestershire

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Digital Services in Gloucestershire Health and Care Foundation Trust

with you, for you

Digital Services supports the delivery of health and care to over **6,200 colleagues**, working in over **100 Services** across our **140 sites**

WE PROVIDE SUPPORT FOR APPROXIMATELY **6000** WORKSTATIONS AND OVER **3000** MOBILE PHONES AND TABLETS

OUR CLINICAL SYSTEMS TEAM SUPPORT **5 CLINICAL SYSTEMS**

IN 2025 THERE WERE **92,152** SUPPORT TICKETS LOGGED TO DIGITAL SERVICES

IT OPERATIONS SUPPORT OVER **100 CORPORATE SYSTEMS AND APPLICATIONS**

OUR APPLICATIONS TEAM HAVE DESIGNED AND SUPPORT **29 APPLICATIONS**

OUR BUSINESS INTELLIGENCE TEAM MAINTAIN 2,176 DASHBOARDS INCORPORATING 8,231 VISUALISATIONS

OVER **91%** OF CALLS TO OUR SERVICE DESK WERE RATED AS 'EXCELLENT'

Digital Services is made up of a number of teams, **working together** to provide services across the Trust.

IT Operations
Continually developing, maintaining and supporting an effective, cyber secure, resilient and innovative IT environment

Service Desk
Deployment Team
Server Team
Infrastructure Team
Community Technicians

Business Intelligence
Delivering evidence-based insight and improvements for health and care

The BI team consists of **Data Developers** who process data and **Information Analysts** who interrogate the information provided

Clinical Systems Team
Through our expertise and collaborative, open approach we will develop effective clinical systems that support you to deliver safe and seamless patient care

Development Team
Change Team
Operations & Support (Training)
Registration Authority (RA)

Digital Transformation
Collaborating and empowering our community to deliver digital solutions that will enhance the delivery of care

Project Delivery & Change Management
Applications Development
Digital Support & Engagement Team

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Our Plan to become a Digitally Enabled Trust

Why we need a Digital Strategy

The Digital Strategy is essential to enabling Gloucestershire Health and Care to deliver its long-term ambitions for high-quality, integrated community services. It provides the strategic framework to ensure Digital; data and technology are used to improve outcomes and support more proactive, joined-up models of care.

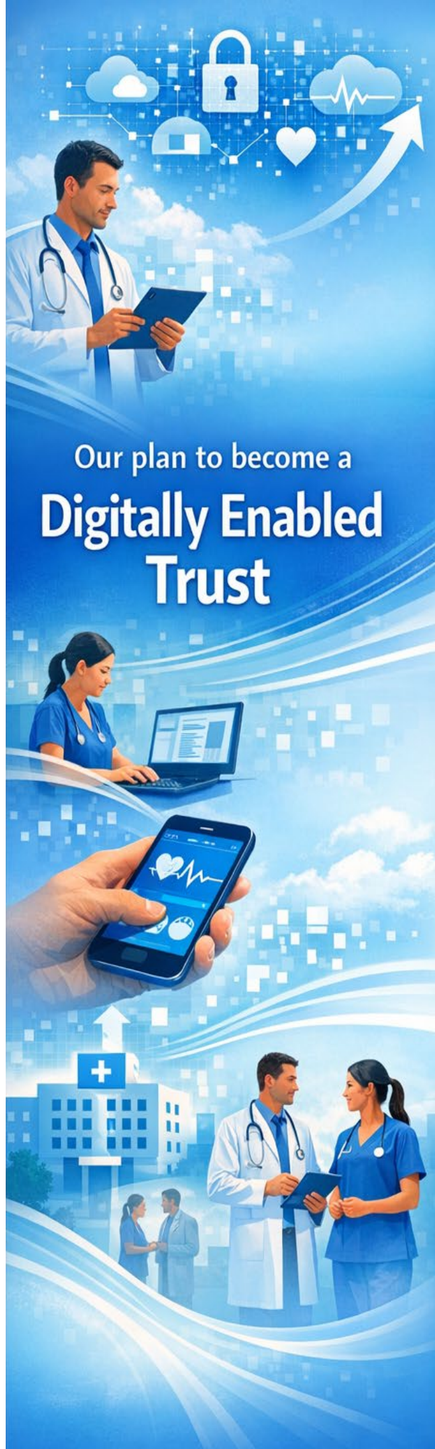
Our approach

We have identified four strategic themes to guide where attention and resource will be directed first. This reflects a deliberate approach to prioritisation, recognising that while the ambition of the strategy is broad, successful delivery depends on being clear about what will have the greatest impact. By making informed choices about where to focus initially, we can build momentum, ensure capacity is used effectively, and create a strong foundation for longer-term transformation.

It is our intention to learn from proven digital approaches across the NHS and beyond. In developing the strategy, we have drawn on established good practice, national direction and local insight. This has helped us create a strategy that is evidence-informed, relevant to our organisation, and focused on delivering meaningful improvement for colleagues, services and the people we support.

Implementing this strategy will mean us being nimble and flexible in accessing funding, always ensuring that our teams have the time and capacity to support implementation, whilst accepting that funding opportunities, policies and system developments may change over time.

While this strategy sets a clear direction for the next five years, a formal mid-point review will be built in to assess progress, ensure continued alignment with organisational priorities, and enable adjustment where required over its lifecycle



Gloucestershire Health and Care
NHS Foundation Trust

How our Five-Year Focus and Strategies work together

This model sets out how our work is shaped, delivered, and supports our purpose: helping you live your best life by delivering great healthcare.

Our Five-Year Focus (2026-2031) sets out our long-term goals, five areas of focus, our ways of working and our values. These are supported by our five guiding strategies.

Each year, we use a structured planning process to create clear actions. This allows us to put our long-term priorities into action while also responding to changing national requirements and local needs.

At the same time, we keep learning and improving our services by using data, feedback and experience. We manage large changes through our transformation programmes.

The highlighted strategy will vary by document – this on focused on our Digital Strategy

Gloucestershire Health and Care
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Our Digital Strategy – Strategic Themes

Access to Digital Tools
Provide teams with reliable, well-supported digital tools by standardising devices, access and roll out AI where its needed most

Digital and Data Confidence
Empower our colleagues to use Trust digital systems and data confidently and consistently by building sustained digital and data confidence

Data, Systems and Reporting Integration
Improve the quality, timeliness, and availability of patient data across systems, integrating data to reduce fragmentation

User Experience
Deliver a consistent digital experience to our service users and colleagues by optimising our systems, workflows, and infrastructure

Enabling access to Digital Tools

Why is this a focus?

Reliable access to the right devices and digital tools enables colleagues to work efficiently and deliver safe, effective care.

This supports **the Trust Strategy** and the **NHS 10 Year Plan** by accelerating the shift from analogue to digital and enabling safer, more consistent care across **neighbourhood settings.**

From **feedback**, we have seen the access to the right tools reduces day-to-day frustration, streamlines tasks, supports point-of-care working, supports accessibility, expedites onboarding and helps colleagues work with confidence.

Overall, this improves how quickly and safely, we can deliver better, high-quality care to patients and helps make GHC a great place to work, ensuring sustainable services by giving colleagues what they need to do their best work.

What do we want to do?

- ✓ Provide access to cyber secure software and hardware that meets the needs of the user
- ✓ Enable a digitally confident and capable workforce, equipped with the skills, knowledge and support needed to use digital and data effectively whilst delivering high-quality care.
- ✓ Harness innovation, including AI and emerging technologies, where there is a clear case to improve efficiency, deliver new ways of working and support better outcomes.
- ✓ Deliver appropriate, dependable and secure digital systems that are designed to meet service needs and support safe, effective working.
- ✓ Implement digital tools in partnership with the people who use them, ensuring systems are shaped through engagement, listening and co-production.
- ✓ Address digital exclusion to ensure that digital transformation improves access rather than widens inequalities

How are we going to do it?

- ➢ Develop a more integrated and standardised digital landscape by consolidating core clinical systems and supporting greater alignment across the ICS
- ➢ Strengthen digital capability through targeted training for 500 colleagues in 26/27 under TCD, plus practical support and accessible guidance.
- ➢ Adopt digital innovation in a focused way to improve efficiency, reduce duplication and support colleagues
- ➢ Embed clinical safety, ethics and accessibility standards in all digital change through clear governance and oversight.
- ➢ Work with colleagues, patients and partners to prioritise, test and measure digital solutions.
- ➢ Design inclusive systems that offer choice, support and accessible alternatives.

> "If we want safer, more consistent care, we have to make digital the easy default – starting with the right access to the right tools"

> "Before adopting new systems/ tools, we need to explore the full extent of what our existing systems do, we probably only use a small part of their overall capability."

> "When tools differ by team or site, it slows us down and makes it harder to cover shifts or work across services"

> "There are so many tools that we could be using that would streamline the administrative side of the clinical work"

Build Digital and Data Confidence

Why is this a focus?

The **NHS 10 Year Plan** depends on a digitally confident workforce to deliver the shift from analogue to digital and enable safer, more joined-up care.

Digital and data confidence is not just workforce development; it is an enabler of transformation. It helps GHC deliver on its **five-year focus** by enabling more connected, inclusive, efficient and high-quality services, while also supporting staff experience and long-term sustainability.

Our engagement **feedback** shows colleagues are keen to build their digital skills, and it also highlights clear opportunities to make our systems more intuitive, so digital tools are used to consistently support day-to-day work.

There is growing recognition that improving confidence must go beyond traditional training; it requires well designed systems, accessible support, and a culture where colleagues feel able to use digital tools safely, effectively and as a routine part of their roles.

What do we want to do?

- ✓ Fully embed digital and data confidence into the wider organisational structure
- ✓ Empower colleagues to build digital confidence through a supportive learning environment and accessible development opportunities
- ✓ Improve data quality by fostering a culture in which data is understood, valued and used to support better care outcomes
- ✓ Equip colleagues with the skills and confidence to use AI and automation practically, safely and with appropriate governance
- ✓ We want to create role-based digital and data training, delivered in ways that are accessible for colleagues
- ✓ Take a planned approach to workforce development so that Digital Services has the capacity, confidence and expertise needed to support both current priorities and future transformation.

How are we going to do it?

- ➢ Work with the People Strategy and teams across the Trust to prioritise digital and data skills development, embedding role-based capability into induction, appraisal, development pathways and ongoing support.
- ➢ Strengthen and expand the Digital Champions network, including Data and AI Champions (targeting 10% of our workforce), to provide local support, promote good practice and respond to emerging needs across the organisation.
- ➢ Work in partnership with colleagues to identify priority pain points, co-design improvements and support delivery through clear communication, training and responsive go-live support.
- ➢ Enable the safe, practical and well-governed adoption of AI by prioritising high-value use cases, across a consolidate number of tools to drive best-value
- ➢ Develop a workforce plan that identifies the skills, roles and training needed across Digital Services

> "Need to change behaviours (not necessarily tools) to ensure quality data input to ensure quality data output."

> "Provide IT training sessions and drops in's and make more basic information available on 'how to

> "Digital is for patients and for staff - do patients know how systems work to access/ book etc - training is not just for staff. Digital confidence for patients may support more effective care.

> "There is plenty of data available to NHS employees, but people do not have the knowledge/confidence in what is available/ how to access it/ why you might use it. Who could support/ help/promote this?

Focus on Data, Systems and Reporting Integration

Why is this a focus?

A digital focus on data systems and reporting integration supports the **NHS 10 Year Plan** by enabling more joined-up, proactive and efficient care. Better-connected systems improve access to information, reduce duplication, and support safer, timelier decisions across services and neighbourhood settings.

Joined-up information supports faster and safer decisions in **Community Urgent Care** and advances **inclusive healthcare** by reducing barriers caused by inconsistent data. It also strengthens **partnerships with purpose** through shared insight and better coordination across adult and children's services; all contributing to the **five-year focus plan**

Feedback shows that fragmented systems create risks across care delivery and operational processes. Our aim is to make integration foundational to all digital systems, aligned with national developments such as the Federated Data Platform, to reduce manual workloads, and provide faster insights for all.

Where appropriate, a single patient record will be an important enabler of safer, more coordinated and more efficient care. We will continue to connect digital systems and join up information with external partners through the shared care record, Joining Up Your Information (JUYI).

What do we want to do?

- ✓ Provide clear guidance on information and reporting sharing
- ✓ Use digital tools that connect with other systems wherever possible, reducing manual copying and workarounds
- ✓ Align our approach with national learning and standards, so our reporting integration work stays up to date and future-ready
- ✓ Enable information to be shared and received in a consistent and safe way across GHC services, at all levels, and into the ICS through new Information Governance Frameworks
- ✓ Build Advanced Analytics & Population Health Capabilities to support research, innovation and service transformation.
- ✓ Ensure the architecture is in place to the deliver AI driven, predictive, system-wide intelligence as the Trust moves forward as part of the 10-year plan
- ✓ Expand the use of the Shared Care Record to support integrated neighbourhood teams, improve information sharing across health and care services

How are we going to do it?

- ➢ Provide clear guidance and support so colleagues can share information safely and confidently within governance and cyber requirements.
- ➢ Work with stakeholders to prioritise and deliver a phased integration roadmap that meets governance and cyber standards and our ambitions for neighbourhood working
- ➢ Align delivery with system and national programmes, responding to external priorities and opportunities as they evolve.
- ➢ Work with ICS partners to prioritise and deliver the Data Sharing Strategy in support of areas such as population health and risk stratification.
- ➢ Build capability in demand forecasting and outcome measurement to support prioritisation and informed decision-making.
- ➢ We will align with wider system digital strategies, supporting shared care records, common information standards and interoperable technologies that create a more connected and coordinated model of care

> "We spend too long chasing updates across teams because the systems don't talk to each other."

> "Common standards make it easier to connect new services quickly and safely across the **system**"

> "It's frustrating that Systems don't link information, especially where there is "core" information required by all clinicians"

> "We need consistent, timely information sharing across organisations to support joined-up care"

Enhance the User Experience

Why is this a focus?

User experience is critical to digital success and adoption. It supports the **NHS 10 Year Plan** shift from analogue to digital by improving access and empowering our patients to interact with their care via digital means.

Enhancing user experience also supports **GHC's five-year focus plan** by making services more accessible, inclusive and connected, helping children, young people and families engage with care, improving neighbourhood working, reducing barriers to access, and strengthening purposeful partnerships.

Feedback tells us that upgrades like better Patient Wi Fi, improved accessibility and system intuitiveness enhance the user experience and adoption part of everyday clinical and operational systems for both our patients and colleagues.

Through user engagement and co-production, we can design services around the needs of patients and colleagues, building trust, improving adoption and supporting high-quality care and better health.

What do we want to do?

- ✓ Initially on planned care pathways, improve how patients access services digitally, making it easier to find information, request support, manage appointments and communicate with care teams
- ✓ Use digital solutions and apps to support more personalised, preventative and proactive care, particularly for people with long-term conditions, mental health needs (especially for children and young people) or complex care requirements
- ✓ Develop inclusive, reliable and user-centred digital tools that are shaped by feedback and aligned to real workflows
- ✓ Enable high-quality remote care that is safe, inclusive and responsive to the needs of people using our services

How are we going to do it?

- ➢ Provide simple, inclusive and consistent digital tools by prioritising the needs of patients and colleagues, working with services to focus on tools that improve communication and coordination.
- ➢ Introduce self-management and digital care planning tools through phased delivery, with clear clinical ownership, robust governance and implementation where they add most value.
- ➢ Expand remote monitoring where this improves care and convenience.
- ➢ Co-design accessible digital solutions in partnership with patients, carers and clinicians, using feedback and insight to prioritise changes and ensure solutions remain practical, inclusive and responsive to need.
- ➢ Embed virtual care models in partnership with clinical teams and system partners
- ➢ Support and integrate clinical service redesign with digital transformation

"If we're serious about equity, we have to assume not everyone can use digital easily — language, confidence, accessibility needs and connectivity all affect the experience"

"There are too many different routes for patients to get help or updates, and it's not always obvious which one is the right place to go."

"We need to do the basics right clear accessible language, up to date information that is easy to update for services"

"Design the technology so it is more user friendly and intuitive.

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Our performance indicators

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2025 **2.1** Average DMA score

Where we are now

Each year, GHC takes part in a **self-assessed** Digital Maturity Assessment (DMA). Each 'pillar' is scored out of **maximum of 5**. Across the Southwest, the average score is 2.2

Over time, we will deliver key elements from this that align both to this strategy and the main Trust Strategy i.e. "getting the basics right" that is aligned with smart foundations.

We will also utilise additional metrics to track progress including:

- Delivery Metrics
- Adoption and user experience
- Impact Metrics

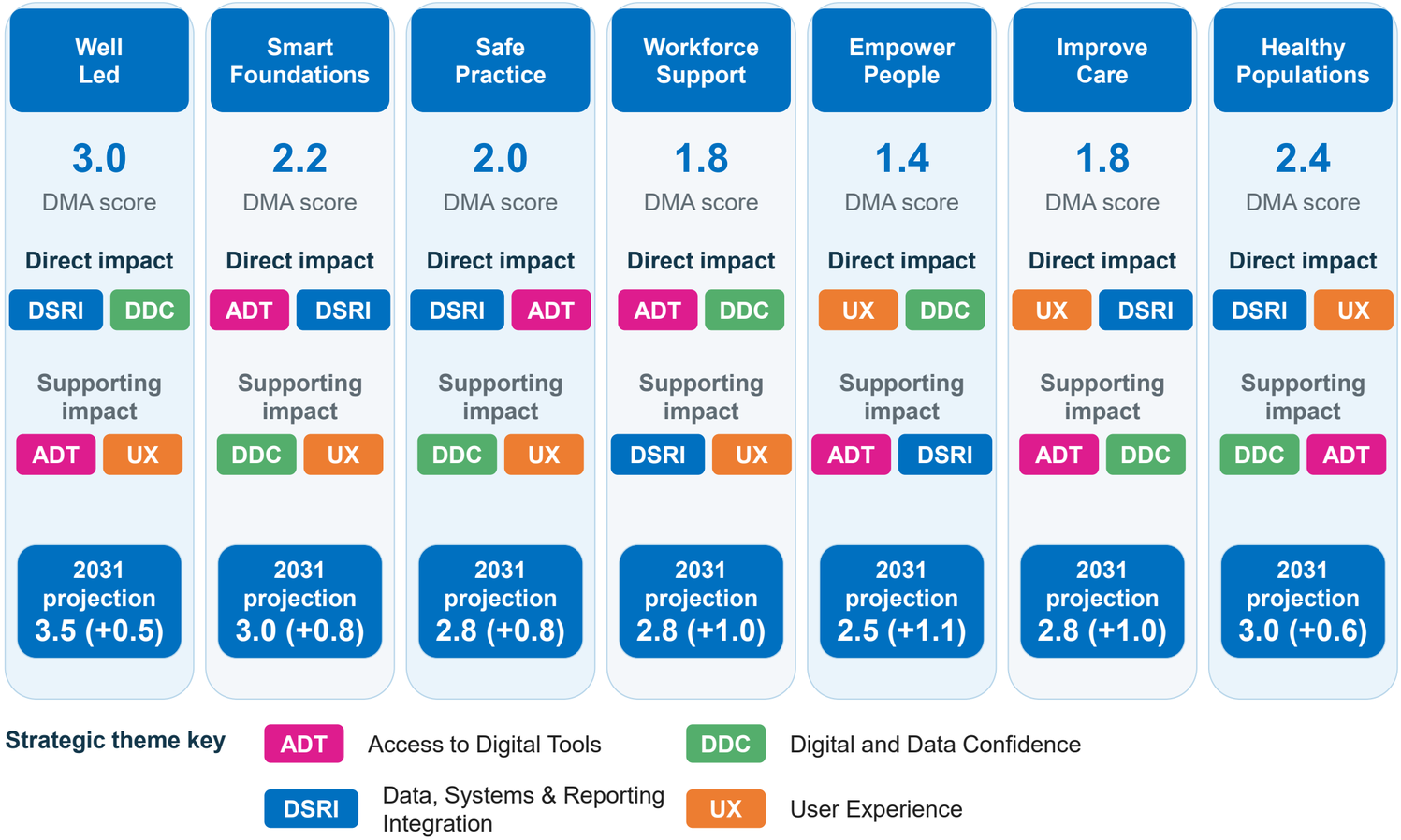
Where we'd like to be

During the lifecycle of this Digital Strategy, our aim is to see an increase on each pillar.

This graphic shows which of our strategic themes meets the DMA pillars. Also shown are our projected scores for each pillar by 2031, based on the successful delivery of this strategy and its themes. This will also be tracked against:

- National Average
- Peer Group Organisations
- Regional comparators

GHC DMA pillar relationship to strategic themes



ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**GREAT PLACE TO WORK (GPTW) COMMITTEE – 30 JUNE 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

Nothing to report.

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

The Committee received the National workforce and people Update for June and were advised that resident doctors have accepted the government's pay deal and industrial action has been called off.

The Committee was informed that the Ockenden report had been received and noted that a detailed paper would be received and discussed at the next Committee meeting, as there would be consequences for the Trust and more widely.

The Committee **noted** that there was a further delay to the Ten-Year Workforce Plan publication date.

The Committee discussed the feedback from the Pulse Survey, which included group sessions held and the insight delivered, and felt that the development of an overarching set of prioritised communications themes for the organisation would be helpful to help colleagues to understand the whole pattern of activity going on, addressing the tactical as well as the strategic. The Committee expressed that this would be a useful topic for a future Board Development session and would require wider committee triangulation.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the 2026 Gender, Ethnicity and Disability Pay Gap Report and were assured by the latest data received and noted the number of improvements. Comments were provided and support given to the pay gap actions recommended in the report.

The Committee received the Performance Report – Workforce KPIs and noted the work undertaken to provide assurance from a variety of sources on the level of genuinely

unfilled medical positions across the Trust, and that this was not adversely impacting patient experience. The Committee is now seeking wider assurance on teams that are outliers in terms of the number of unfilled positions and/or temporary staffing levels and if there is a relationship between staffing levels/staffing mix and sickness, attrition and colleague engagement as measured through our staff surveys.

The Committee received assurance around the actions and activities identified and delivered to address closed culture over the past 5 years, in addition to the work currently underway at Wotton Lawn. The Committee requested the opportunity to reflect further on whether there were softer indicators that could be used as early warning signs in the future.

APPROVALS: Decisions and Approvals made by the Committee

The Committee received the Lord Mann Review and agreed the recommendations shared, with the exception of the specific IHRA definition of antisemitism where engaging with wider networks and further national steer had been requested in light of legal challenges and a related report by United Nations Special Rapporteurs. These needed completed prior to any agreement on definitions.

The Committee recognised the importance of the Trust undertaking a wider speaking up review recognising that this needed to cover the breadth of speaking up routes not just Freedom to Speak Up (FTSU).

The People Strategy Implemented Plan was received and **approved** by the Committee. The Committee commended the work achieved.

The Committee **approved** the Medical Job Planning Policy

The Committee **approved** the People Performance Business Meeting (previously Workforce Management Group - WOMAG) Terms of Reference.

The Committee **approved** the amended Committee Work Plan. Amended committee work plan.

The Committee **endorsed** the Modern Slavery Trust Statement 2025/26 for onward approval by the Trust Board.

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

The Committee applauded the quality of the leadership training developed to support the Organisational Re-Structure, and particularly its flow from the People Strategy.

The Committee welcomed the video which accompanied the launch of the People Strategy, and applauded Nada Baker and Annie Nightingale for producing this.

The Committee applauded the continued reduction of our gender pay gap and reaching a zero median gap for the first time.

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

The Committee received and **noted** the Guardian of Safe Working Hours Report.

The Summary Reports from the following Management Groups:

- Joint Negotiating & Consultative Committee (JNCC)
- Joint Negotiating & Consultative Committee (JNCC) – Medical Staff
- Learning & Development Oversight Group
- Workforce Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**QUALITY COMMITTEE – 7 JULY 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

In relation to enhanced oversight arrangements for quality and safety at Wotton Lawn Hospital, the Committee noted the assurance within the quality dashboard and received a verbal update. The Committee agreed that an assurance report on the service and oversight arrangements would be a standing agenda item from the next Committee.

The Committee received the Research and Innovation Strategy Update and was informed that there had been a 7% funding reduction.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received additional information relating to complaint activity and made a request to extrapolate the data further to assure analysis of complaints, particularly when those for IUCS are separated. This would be received at the next Committee meeting.

A high-level version of the Quality Strategy was shared with the Committee. The Committee was satisfied with the timescale to present a final version to the Committee and Board in September 2026.

The Committee was advised on the progress against the Research and Innovation Strategy.

The Committee discussed ethnicity monitoring to support quality improvement and equality, including clinical supervision.

A verbal update was provided and accepted by the Committee as to the postponement of the Controlled Drugs Assurance Statement, which would be received at the next Committee meeting.

ASSURE: Inform the Board where positive assurance has been achieved

The committee received the Safer Staffing 6 Monthly Assurance Review, and were assured by the information shared.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the Safer Staffing 6 Monthly Assurance Review on behalf of the Board. This is available for Board Members to view in the Reading Room via Diligent.

The Committee **approved** the closure of the Qualities Priorities into business as usual as part of the transition to the new Quality Strategy later in the year.

The Committee formally **approved** the Quality Account.

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

A Service Improvement Story was shared from the Supported Accommodation Service, and the Committee applauded the work achieved, recognising that the service would be transitioning over to Gloucestershire County Council in September 2026.

The Committee applauded the Research and Development team for submissions completed within required timescales, with the Trust recognised for early completion, and that a small amount of funding was received as a result, which will go towards staff wellbeing initiatives.

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

The Committee received and **noted** the Quality Governance Internal Audit revised timescales in the improvement plan.

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Quality Report

2025-2026

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

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

I am pleased to present our Quality Report for 2025 to 2026. This sets out our main activities during the year on meeting our Strategic Goal of 'Quality Care for All' and progress against our 11 quality priorities. On some of these, the planned outcome has been achieved, and ongoing work and monitoring has been absorbed into day-to-day activities of our Trust. On others, we are completing outstanding elements before transferring into day-to-day activities.

Following the publication of 'Our Five-Year Focus', our approach to quality is being refreshed as part of developing a new Quality Strategy to be completed later this year.

Achieving our goal of 'Quality Care for All' cannot be achieved by GHC colleagues alone. We will not get everything right and therefore appreciate feedback from people who use our services and their families. We use this feedback to learn and improve.

I hope the report provides assurance of our focus on continuously improving the quality of our services and our commitment to doing all that we can to support the health and wellbeing of communities across Gloucestershire.

I'd like to thank everyone involved in ensuring that services are safe, delivering high quality care and improving our services throughout the past year – we are fortunate to have skilled and dedicated colleagues supporting the people we serve, working in partnership with others.

If, when reading this report, you would like more information or to get involved in continuing to improve our services, then please contact experience@ghc.nhs.uk.

To the best of my knowledge the information contained in this report is an accurate representation of the year's events.

Kind regards,

Douglas Blair
Chief Executive

What is a Quality Account

- Our Quality Strategy sets out our quality ambitions, strategic goals, priorities, and the approaches we will take to measure our progress. It does not sit in isolation but is one of six integrated enabling strategies delivering **Gloucestershire Health and Care NHS Foundation Trust's (GHC) strategy: 'Our Strategy for the Future 2021-2026'.**
- The **Quality Priorities** originate from the **Quality Strategy** and from areas requiring improvement identified through our own governance assurance processes alongside regional and national agendas.
- The **Quality Account** is a report that is published annually by providers, including the independent sector, and is available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders

Part 2.1: Looking ahead to 2026/27

Quality priorities for improvement 2025/26

The quality priorities agreed in 2023 were designed to be implemented over a multi-year period and were agreed with the Gloucestershire Integrated Care Board (ICB) and ratified by our Governors. They have covered areas of quality improvement taken from the Quality Strategy and are large pieces of work which take time to develop, implement and embed. Quality is a core business priority and central to achieving our strategic ambitions. Aligned to the Trust Quality Strategy, our approach focuses on embedding continuous improvement across all aspects of care and service delivery. By empowering our people to shape culture, improve processes and transform practice, we ensure that quality informs decision-making, drives organisational performance and delivers better outcomes and experiences for the communities we serve.

It is based on the concept that continual improvement towards a quality aim provides better services, increases quality and reduces costs. The Care Quality Commission (CQC) Well Led Inspection in 2022 gave "good" assurance that our governance structures provide a good foundation for growth and are the gateway for our ambitions to be an outstanding provider of healthcare in Gloucestershire.

As we conclude the third and final year of these priorities, we acknowledge that the foundation year and implementation year demonstrated improvements in all our priority areas. We are drawing on these experiences and improvements to embed the work into day-to-day activities and conclude these 11 Priority Focus Areas. Our Quality Strategy is being refreshed in 2026/27 and, as it is launched later in the year, we will be taking a new approach to identifying quality priorities.

The continued support from our Trust Board and Governors has enable us to build on the successes in the previous years, and this reflects our ongoing focus and shining a light on quality within the organisation and channelling improvements which reflect our Trust values.

Part 2.2: Statements relating to the quality of NHS services provided

Review of Services

The purpose of this section of the report is to ensure we have considered the quality of care across all our services, which we undertake through comprehensive reports on all services to the Quality Committee (a committee of the Board).

Between April 2025 and March 2026, Gloucestershire Health and Care NHS Foundation Trust provided or sub-contracted the following NHS health services. Our services are delivered through multidisciplinary and specialist teams. They are:

- One Stop Teams providing care to adults with mental health needs and those with a learning disability.
- Integrated Urgent Care Service (IUCS) including NHS 111 (provided with IC24) and the Minor Injury and Illness Units (MIIUs).
- Intermediate Care Mental Health Services (Primary Care Mental Health Services and Talking Therapies).
- Community Mental Health Recovery Teams and Accommodation Teams.
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services, Eating Disorders, Intensive Health Outreach Team, and the Learning Disability Intensive Support Service & Reablement.
- Inpatient mental health and learning disability care for adults and older adults.
- Community services in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices; district nursing, Integrated Community Team, Rapid Response and podiatry etc
- In-reach services into acute hospitals, nursing and residential homes and social care settings.
- Six community hospitals provide nursing, occupational therapy and physiotherapy in community settings.
- Health visiting, school nursing, occupational therapy and physiotherapy and speech and language therapy services for children
- Other specialist physical health services include sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability, wheelchair assessment and community equipment.

MH & LD Urgent Care and In-Patient Services	PH Urgent care and In-Patient Services	Community PH, MH & LD Services	CYPS Directorate	Countywide Services
Inpatients MH & LD & supporting functions • Wotton Lawn Hospital • Charlton Lane Hospital • MH Inpatient Rehabilitation Laurel House • MH Inpatient Rehabilitation Honeybourne • Montpellier Low Secure Unit • Learning Disabilities Inpatients - Berkeley House • Alexandra Wellbeing House • Crisis Services incl. Mental Health Rapid Response Vehicle (MH RRV) • s136 Maxwell Centre • Mental Health Liaison Team • Criminal Justice Liaison Service • Approved Mental Health Professional (AMPHP) Hub • First Point of Contact Centre • Specialised Community Forensic Team	Inpatients PH & supporting functions • Vale • Tewkesbury + CATU • Stroud • North Cots • Dilke • Lydney • Cirencester Out-patients Depts • Cirencester • North Cots • George Moore Clinic • Fairford • Vale • Tewkesbury • Stroud • Dilke • Lydney Theatre activity (GHFT with GHC staff) • Cirencester + Endoscopy (all GHFT inc staff) • Stroud + Endoscopy • Tewksbury • Minor Injury and Illness Units • Rapid Response and • Intravenous (IV) Therapy Services • Home Assessment Treatment	• Integrated Care Team (ICT) • Assertive Outreach Team (AOT) • Complex Psychological interventions (CPI) Recovery • Later Life • Community Dementia Nurses (+CHST) • Memory Assessment Service • Mental Health ICT – Primary MH Nursing • MHICT (IAPT) • First Contact Practitioner (ARRS) • Eating Disorders • Perinatal • Learning Disability Intensive Support Services (LDISS) and Intensive Home Outreach Team (HOT) • Learning Disabilities Health Facilitation Team • Community Learning Disability Team (CLDT) • Complex Emotional need (CEN) • LD Health Education Team • Gloucestershire Recovery in Psychosis (GRiP) • Integrated Social Care (ISC) • Autistic Spectrum Conditions (ASC) • Attention Deficit-Hyperactivity Disorder (ADHD) • Specialist Treatment and Rehabilitation (STAR) • Individual Placement service (IPS) • Evening and Overnight District Nursing Services	• CAMHS Parenting Support Team • CAMHS LD • CAMHS Interagency Teams (x 3 teams) • CAMHS MHST Young Minds Matter • Core CAMHS and Outreach Paediatric Liaison Team (LTCs) Young Adults (16-25) Team • SCAAT (Social Communication and Autism Assessment Team) - CYPS • CAMHS VCS (x 11 teams) • Children's Community Nursing Team • Children's Complex Care Team • Children's Occupational Therapy Inc. CYPS Home Safety Team • Children's Physiotherapy • CYPS Respiratory Physiotherapy • CYPS Persistent Physical Symptoms (PPS) • Children's Speech and Language Therapy SALT • Immunisation Service • School Nursing Team • Health Visiting Team • Children in Care Team • Wellchild Nurse and Trg	• Long Term Conditions - Heart Failure - Cardiac Rehab - Bone Health - Macmillan - Respiratory – home oxygen - Respiratory – core - Pulmonary Rehab - Adult specialist Respiratory - Diabetes – nursing and education - Long Covid - Dental • Complex Care at Home • Sexual Health – PAS. GUM/HIV • Sexual Health Referral Centre (SARC) • Accommodation • Wheelchair Assessment Service • Integrated Community Equipment Service • Blue Badge • Telecare • Musculoskeletal (MSK) • Musculoskeletal Advanced Practitioner Service (MSKAPS) • First Contact Practitioners (PH) • Lymphoedema • Falls Assessment • Tissue Viability • Homeless healthcare • Complex leg wound/lower limb • Podiatry Services • Speech and Language Therapy Services (SALT) • Early Stroke Discharge (ESD) • *Neurology (Clinical Specialists*

Gloucestershire Health and Care NHS Foundation Trust have reviewed all the data available to them on the quality of care in all these relevant health services.

The income for patient care activities in 2025/26 represents 93.3% of the total income generated by Gloucestershire Health and Care NHS Foundation Trust for 2025/26.

Participation in Clinical Audits and National Confidential Enquiries

National Clinical Audits

During 2025/26, there were 14 national clinical audits which related to mental health and physical health services provided by Gloucestershire Health and Care NHS Foundation Trust.

During this period, Gloucestershire Health and Care NHS Foundation Trust participated in 13 of the national clinical audits.

The national clinical audits that Gloucestershire Health and Care NHS Foundation Trust was eligible for and participated in during 2025/26 are as follows:

National Clinical Audits	Participated Yes/No	Teams
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	No	Bone Health Service has registered to participate in the audit from 1st April 2026
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	Community Hospital Inpatients and Mental Health Inpatients
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	Podiatry Service
National Audit of Cardiac Rehabilitation	Yes	Cardiac Rehabilitation Team
National Audit of Care at the End of Life (NACEL)	Yes	Community Hospital Inpatients
National Audit of Dementia (NAD)	Yes	Memory Assessment Service
National Audit of Eating Disorders (NAED)	Yes	Eating Disorders Service
National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis	Yes	GRIP (Early Intervention in Psychosis) Team
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation Audit	Yes	Pulmonary Rehabilitation Team
Prescribing Observatory for Mental Health (POMH): Improving the quality of valproate prescribing in adult mental health services	Yes	Adult Mental Health Services
Prescribing Observatory for Mental Health (POMH): Use of clozapine	Yes	Adult Mental Health Services

National Clinical Audits	Participated Yes/No	Teams
Prescribing Observatory for Mental Health (POMH): Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	Yes	Older People's Mental Health Services
Sentinel Stroke National Audit Programme (SSNAP)	Yes	The Vale Stroke Unit and Early Supported Discharge Team
UK Parkinson's Audit	Yes	Adult Physiotherapy Team and Adult Speech and Language Therapy Team

The reports of 11 national clinical audits were reviewed by the provider in 2025/26 and below is an example of the actions that Gloucestershire Health and Care NHS Foundation Trust intend to take to improve the quality of healthcare provided:

Audit title	Details of the audit and the actions that were taken as a result of the audit
Prescribing Observatory for Mental Health (POMH) Audit: The Use of Clozapine	The POMH audit on the use of clozapine assesses the safety around prescribing, including the physical health monitoring undertaken for patients prescribed the antipsychotic clozapine. There was good participation in this audit with data collected for over half of the patients who are prescribed clozapine in the trust, these came from many teams. 97% of patients prescribed clozapine long term had been reviewed by a clinician in the past year, and this was commonly a consultant psychiatrist. In keeping with previous local audit results (2024-2025) 95% of patients had their blood pressure and 93% of patients had their body weight recorded at least once during the past year, however rates for measuring plasma lipids and glucose were lower. It should be noted that these tests are not part of the mandatory blood test taken routinely in clozapine clinic via POCHI (Point of Care testing) machines, which can only run a basic Full Blood Count (FBC) test. Any additional tests need to be ordered by clinicians separately. The rates of recording on the primary care Summary Care Record (SCR) list that patients are prescribed clozapine by secondary care slightly improved with 75% now recorded (a quarter were not). This compares with recording rates of 68% in 2022, and 61% in 2023 in local audits. The 2025 improvement is likely to be at least related in part to the improved functionality of JUYI (Joining Up Your Information), the digital care record system for sharing health information in Gloucestershire, which was implemented in 2025. Recommendations: • The new Clozapine Policy should be widely circulated and implemented as this supports the practice standards of this audit. • Similar emphasis and priority should be given to monitoring patients' physical health status (constipation, cardiometabolic parameters and cardiac symptoms) as their FBCs. • Communication with primary care prescribers about patients prescribed clozapine should request that this is added to the patients SCR (and therefore JUYI) if it is not already there.

Audit title	Details of the audit and the actions that were taken as a result of the audit
National Audit of Care at the End of Life	The National Audit of Care at the End of Life (NACEL) assesses the quality and outcomes of care experienced by the dying person and those important to them, during the last admission leading to death. In 2025, the audit consisted of three parts: • Patients' Case note reviews (CNR) • Bereavement survey sent to those who were important to the person who has died • Hospital/site overview The national audit, which has a focus on quality improvement, has identified 10 key indicators / metrics for end-of-life care. The Trust performed well in 6 out of 9 key indicators and scored higher when benchmarked against the peer group of Community Hospitals: • The number of deaths where it was expected that the person would die during the final admission as a proportion of the sample 'all deaths' included in the audit – 96% (England Community Hospitals average 88%) • The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for symptoms likely to occur in the last days of life – 99% (England Community Hospitals average 97%) • The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good – 97% (England Community Hospitals average 90%) • The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way – 97% (England Community Hospitals average 93%) • The proportion of people who died who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the person may die during the final admission – 94% (England Community Hospitals average 93%) • The proportion of people who died with ethnicity documented in their clinical record – 100% (England Community Hospitals average 95%) There are 3 indicators where the Trust's compliance was below the national peer group average: • The proportion of people who died with documented evidence in their clinical records of communication about hydration with those important to the dying person, or a reason recorded why not – 54% (England Community Hospitals average 76%) • The proportion of people who died with documented evidence in their clinical records of an assessment of the emotional/psychological needs of the person, or a reason recorded why not – 71% (England Community Hospitals average 88%) • The proportion of hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week – 0% (England Community Hospitals average 49%) The Integrated Care Board (ICB) commissions Specialist Palliative Care services for the county and currently it only commissions a face-to-face 5-day a week face to face service. It should be noted that there is 24/7 telephone access to Specialist Palliative Care if needed at weekends. These commissioning arrangements are outside the control of the Trust. Recommendations: • Improve the End-of-Life template on the electronic patient record to ensure person-centred, holistic end of life care is planned

Audit title	Details of the audit and the actions that were taken as a result of the audit
	• Training on the End-of-Life template to be provided to staff when the template is ready to go live.

Local clinical audit activity

The reports of 103 local clinical audits were reviewed by Gloucestershire Health and Care NHS Foundation Trust in 2025/26. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of healthcare provided by our services:

Audit title	Details of the audit and the actions that were taken as a result of the audit
Integrated Community Teams Physiotherapy Clinical Record Keeping Audit	The aim of this audit is to establish compliance of record keeping against the Trust's Clinical Record Keeping Policy and the profession-specific standards. Recording of the physiotherapy objective assessment has improved since the previous audit, with all criteria recorded in over 90% of the records reviewed. Since the previous audit, improvements have been made in documenting past medical history, medication and allergies, although further improvements are required. Actions: • Deliver local team training on recording past medical history, medication and allergies • Deliver local team training to reduce the use of abbreviations within clinical records • Increase compliance of outcome measures and goals being set and then reviewed on discharge.
Dental Extraction Audit	The aim of this audit was to ensure that Gloucestershire Health and Care NHS Foundation Trust Community Dental Services are following local policy with regards to dental extractions under local anaesthetic. The overall compliance for this audit was good, with one area identified as requiring improvement: TIME OUT (verbally stated pause to recheck plan). Actions: • Ensure laminated versions of Local Safety Standards for Invasive Procedures (LocSSIPs) pathway are available in all clinics • To deliver team training about the audit and areas of improvement.
Community Hospitals Bed Rails Audit	The aim of this audit is to monitor compliance with the Trust's Policy on Bed Rails Assessment and Safe Use, ensuring all community hospital staff are compliant with the policy and that their documentation is complete and evidence that they are using a clinical reasoning approach to identify if the bed rails should be used or not. Completion of the Bed Rail Clinical Reasoning Tool has increased from 81% in the previous audit, to 94% in this re-audit. The review of bed rail use has also improved in this audit. Evidence that review dates had been agreed and that reviews of bed rail use had happened at the agreed frequency had significantly improved from the previous audit.

Audit title	Details of the audit and the actions that were taken as a result of the audit
	Review dates had been agreed for 95% of patients and reviews of bed rail use happened at the agreed frequency for 93% of patients. Actions: • The audit identified that consideration of actions to mitigate the risks of use of bedrails had reduced in compliance from 89% to 82%. It is recommended that an update for colleagues on the bed rail policy needs to be undertaken to ensure they are aware of all the risks and options for mitigation highlighted to aid their decision making. Colleagues to document on the clinical reasoning tool what options they have considered. • There was a reduction in evidence that the risks of using bed rails / not using bed rails have been communicated to the patient and/or relative/carer, from 89% to 76% in this re-audit. The recommendation is that a decision is made by the inpatient teams on how and where they are going to document the communication. Currently on the clinical reasoning tool there is a tick box for communication with patients and one for best interest decisions. • There was a reduction in the documentation of the assessment of the bed and bed rails from 82% in the previous audit, to 63% in this re-audit. It is standard practice to check all medical equipment before use and if any issues were found with the equipment, then they would report it appropriately. The recommendation is to identify and agree in governance structures the best option for bed rail checks and the process for documenting these checks.

Participation in Clinical Research

Research activity in Gloucestershire Health and Care NHS Foundation Trust in 2025/26

The number of patients receiving relevant health services provided or subcontracted by Gloucestershire Health and Care NHS Foundation Trust in 2025/26 that were recruited during that period to participate in National Institute for Health and Care Research (NIHR) portfolio research approved by a research ethics committee was **128**. No target was set for 2025/26 due to the initiation of a new performance and funding model across the Regional Research Delivery Networks (RDN).

This participation was across **15** different studies in Mental Health, Dementia and Neurodegenerative Diseases and Children clinical areas. This is a decrease on the previous year's total of **181** participants (from 18 studies). The legacy of the COVID-19 pandemic has led to a reduction in recruitment and many other trusts around the country are still seeing lower recruitment in the same way. The need to find new ways of working to avoid infection risks led to many studies being redesigned to work remotely, and this trend has continued as it can prove more efficient and cost effective.

In 2025/26, the Trust registered and approved **21** local projects in the following clinical areas:

- **6** in Mental Health Services
- **4** Eating Disorders
- **2** in Neurology
- **2** in Clinical Pharmacology
- **1** in Diabetes

- **1** in Health Services
- **1** in Musculoskeletal
- **1** in Primary Care
- **1** in Public Health
- **1** in Sexual Health
- **1** in Social Work

Although there is still a focus on mental health studies, the increasing variety in other clinical areas continues to reflect the growing opportunities for taking part in research. A rising proportion of these studies are being led by local teams and students.

The decrease in the number of National Institute for Health and Care Research studies being delivered within the Trust for 2025/26 is due to a combination of factors including a general reduction in portfolio studies available to us via the RDN and a continued reduction in the capacity of the Research Team. Our commercial research portfolio previously provided additional revenue to support a larger team with greater capacity for both NIHR portfolio and local projects. Positively, the increase in service evaluation activity from last year has been maintained, suggesting a stronger research culture across teams & services and/or more awareness of R&D support for such projects.

More detail of the NIHR recruiting studies and the services from which they were recruited is shown in Table 1 below:

Table 1. Recruiting Studies in Gloucestershire Health & Care 2025/26

Short Name	Managing Speciality	IRAS #	Recruitment
Quantitative MRI in the NHS – Memory Clinics / QMIN-MC	Dementia and Neurodegeneration	44742	39
NCISH	Mental Health	5655	14
Mental Health Treatment Requirements (MHTR)	Mental Health	64720	14
National Centre for Mental Health (NCMH)	Mental Health	34524	12
Genetic Links to Anxiety and Depression (GLAD)	Mental Health	40136	8
DIADEM	Dementia and Neurodegeneration	60651	7
Eating Disorders Genetics Initiative V1	Mental Health	41782	7
UK-REACH I-CARE WP4&5	Infection	66339	6
Strengthening programme for ambulant adolescents with cerebral palsy	Children	57227	4
More RESPECT	Mental Health	56541	4
VISION-QUEST	Mental Health	58033	4
PPiP2	Mental Health	18451	3
Stretching programme for ambulant children with cerebral palsy (SPELL)	Children	57141	2
gameChange VR	Mental Health	67294	2
Spatial Inattention Grasping Therapy (SIGHT)	Stroke	58911	2

Funding

Budgets for 2026/27 have been announced and GHC will receive £267,592 compared to £287,733.86 for 2025/26. A new funding model has been initiated across the Research Delivery Networks by the National Institute for Health and Care Research (NIHR) in response to the national review of commercial clinical trials by Lord O'Shaughnessy. The new model puts greater emphasis than ever before on commercial research activity which has resulted in mental health trusts especially being vulnerable to funding cuts – the 3 mental health trusts within our Southwest Central region received funding cuts of 6.5 – 7% for 2026/2027.

In 2025/26 we received additional funding from the Regional Research Delivery Network (RRDN) for two development bids totalling approximately £70,000. These bids supported Allied Health Professionals and Psychological Services staff to become more active and engaged with research, especially NIHR research activities. This support was vital to ensuring the successful delivery of several portfolio studies including those in community mental health, cardiology, children's services, dementia and stroke. No further funding is available from the RDN to support these initiatives through 2026/27.

Additional funding was secured via the NIHR Developing Research Leaders programme, to recruit an AHP lead for 3 years who will deliver on embedding research into AHP professional identities, culture and roles within GHC, across all career stages.

We are also still waiting for confirmation of any Research Capability Funding allocated to GHC. If we qualify for this payment in 2026/27, we expect it to be around £27,000. This funding will support the launch of a new initiative to encourage GHC colleagues to complete their own account research & evaluation projects.

Research Network

Following the restructuring of clinical research networks GHC is part of the Southwest Central Research Delivery Network, which incorporates the same area as the previous network but also stretches south through Dorset to the coast as seen in Figure 1 below.

GHC works with the NIHR and our Regional Research Delivery Network, who are our primary funders. We routinely collaborate with local partners including Gloucestershire Hospitals NHS FT, University of Gloucestershire, Cobalt charity, Health Innovation West of England and wider academic institutions, voluntary and community sector organisations, as well as selected commercial partners.

Fig 1 – New RDN Boundaries

Research Strategy

The GHC Research and Innovation Strategy, which is currently under review, has been agreed by the trust and has been published on the Research Intranet pages HERE. One of the key themes of the strategy is collaboration, and we will be working closely with the Research4Gloucestershire partners throughout 2026/27 to set up systems and process that will support a truly collaborative, systemwide approach to research, development and innovation.

Research4Gloucestershire is a consortium of research active organisations within Gloucestershire, including, GHC, GHT, ICB, University of Gloucestershire, Social Care, General Practice and local authorities. We will continue to review this membership and expand it as appropriate.

Changes to the ICB boundaries offer GHC the exciting opportunity to join Bristol, North Somerset, South Gloucestershire ICB – the #1 ranked ICB in the country for securing research capability funding.

Use of the Commissioning for Quality and Innovations (CQUIN) framework

A proportion of Gloucestershire Health and Care NHS Foundation Trust's income is typically informed by achieving quality improvement and innovation goals agreed between Gloucestershire Health and Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2025/26 CQUIN Schemes were nationally paused with the option to undertake locally agreed schemes. None were agreed for 2025/26.

2025/26 CQUIN Goals

Gloucestershire Health and Care Locally agreed CQUINS.

Goal name	Applicable To
None negotiated for 2026/27	NA

Statements from the Care Quality Commission

CQC registration

Assurance on compliance with CQC registration requirements is reported and monitored regularly through governance structures coordinated by the Nursing and Therapies Directorate and Medical Directorate, which reports to the Quality Committee which in turn reports to Board. Regular quality and performance reports, the Quality Account and exception reporting are presented to ensure that Directors are informed of key quality issues relating to patient experience, patient safety and clinical effectiveness.

The last CQC Core and Well-Led inspections were undertaken in April and May 2022, resulting in an overall rating of "Good". All actions from this inspection have been completed and in Q3 of 2024 the Trust's Quality Team undertook fidelity checking process to ensure that all actions have been embedded in clinical practice areas.

In October 2023 Berkeley House, our ward for People with Learning Difficulties and Autism, received an inadequate rating and the Trust was also issued with a Section 31 notice. The service was reinspected in July 2025, and we await the final report due to an extended period of factual accuracy checking with CQC.

During 2025/26 CQC continued to complete Mental Health Act visits to mental health and learning disability wards – one Learning Disability ward as part of an overall CQC inspection, and two Older Age Adults wards. Overall, feedback has been very positive, with the older age adult wards having no areas for improvement identified and their exemplary practice noted.

In Q4 of 2025/26 concerns related to patient safety at Wotton Lawn Hospital were raised with Gloucestershire County Council Head of Safeguarding and resulted in a Large-Scale Safeguarding Enquiry being established under Section 42 of the Care Act 2014 to assure that patients are appropriately safeguarded against abuse and neglect. A range of partners, including Care Quality Commission are part of the enquiry and the Trust has been proactive in sharing its internal response and assurance with partners.

The Trust has a rolling programme of self-assessment for all services in the Trust to determine their regulatory compliance and preparedness for a service inspection, including whether they are well-led under CQC and NHS England well-led framework.

The Trust is anticipating that CQC inspections of core services and a subsequent well-led inspection could occur during 2026/27 and preparatory work for this continues with particular focus on areas that have not been inspected for some time.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The next external Well-Led review of leadership and governance is scheduled for 2026/27, providing independent assurance of the Trust's leadership and governance arrangements

Data Quality

Robust and reliable data underpins the effective provision of healthcare services both at a delivery and a management level. It is essential for maximising performance, informing service improvements and creating reliable insight to inform decision making. However, to be of use, data needs to be of high quality, timely, comprehensive, and accurately captured.

Gloucestershire Health and Care NHS Foundation Trust (GHC) submitted data at the required quality maturity levels during 2025/26 (based on latest local published position January 2026):

- The patient's valid NHS number was: **99.5%** (97.1% national average) for Emergency Care (ECDS); **100**% (87.2% national average) for Community Services (CSDS), **100%** (50.1% national average) for Mental Health Services (MHSDS) and **100%** (91.9% national average) for Improving Access to Psychological Therapies (IAPT). The Trust is above National data score averages in all areas for NHS Number recording and improved in all areas on the previous year.

- The patient's valid General Medical Practice Code (Patient Registration) was: **99.1%** (97.4% national average) for Emergency Care (ECDS); **100**% (93.9% national average) for Community Services (CSDS), **100%** (71.6% national average) for Mental Health Services (MHSDS) and **100%** (96.2% national average) Improving Access to Psychological Therapies (IAPT). The Trust is above National data score averages in all areas for NHS Number recording and improved in all areas on the previous year.

Overall, the Data Quality Maturity Index (DQMI) Rates for GHC in January 2026 were:

MHSDS94%, IAPT 99.9%, CSDS 99.3%, and ECDS 82.6%. All have improved since the previous year. This contributed to an 92.8% Trust position (89.7% for 2024/25).

Furthermore, the Trust has made the following quality improvements during 2025/26:

- Ongoing quality improvement through an operationally-led Patient Record Quality Group, supported by robust governance and reporting.
- The development of a data quality reporting suite for operational services and enhanced Board-level oversight via the Data Quality Maturity Index (DQMI) within the Trust's quality and performance dashboard.
- Established business intelligence business partnering functions aligned to a developing operational service structure to improve relations and support service delivery management.
- Integrated corporate and clinical service level reporting for all core Physical Health Community and Mental Health and Learning Disability systems.
- Improvements to quality reporting via iterative development of Quality Dashboard
- Initiated a review of quality governance structures and processes, supported by the findings and improvement plan following an internal audit of Quality Governance in Q3 that reported moderate assurance on design and moderate assurance on operational effectiveness.
- National Faster Data Flows (FDF) implementation and feeding data into the NHS Federated Data Platform (FDP).
- Dental system review and replacement system implementation to enable automated reporting in 2026/27.
- Trust health inequalities statement to express how GHC has identified, analysed and acted on health inequalities for 2025/26, and its intentions for 2026/27.

Information Governance

Gloucestershire Health and Care NHS Foundation Trust's (GHC) 2024/ 2025 Data Security and Protection Toolkit (DSPT) submission was an overall score of Standards met. We are expecting to submit a standards met return in June 2026 for the 2025 to 2026 DSPT submission. The Board received an annual report from the Senior Information Risk Owner (SIRO) in May 2026.

Clinical Coding

Gloucestershire Health and Care NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during 2025/2026 by the Audit Commission.

Learning from Deaths

To meet the requirements of the Learning from Deaths framework issues by NHS-England above the trust holds 2 Mortality Review Groups each month:

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

During 2025/26, 374 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died and were considered for review as part of our Mortality Review processes.

	Q1	Q2	Q3	Q4
Number of deaths	91	81	100	102
Number of deaths reviewed	15	12	15	15

As part of our Mortality Review Groups (MRG) 2 grading systems are used, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Mazars.

In our Mental Health Mortality Groups, we use the Mazars Classification of patient deaths which was developed following their report into Southern Health NHS Foundation Trust (2015). This classification tool considers whether deaths are unexpected or expected or natural or unnatural. Each reviewed case is given a score by the group. Our Mazars summary for 2025/26 is below:

Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These would not be investigated but could be included in a mortality review of early deaths amongst service users.	5
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and, in some cases, would benefit from further investigation	1
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.	0
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed, and some may need an investigation.	13
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause, but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated	1
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating	0

The NCEPOD grading system (below) is used to summarise the assessment of quality of care provided for the cases which are presented. Our summary for the year 2025/26 is below:

	NCEPOD Categories 2025/26	
1	Good practice: a standard that you would accept from yourself, your trainees and your institution	31
2	Room for improvement: aspects of clinical care that could have been better	1
3	Room for improvement: aspects of organisational care that could have been better	0
4	Room for improvement: aspects of both clinical and organisational care that could have been better	0
5	Less than satisfactory: several aspects of clinical and/or organisational care that were below that you would accept from yourself, your trainees and your institution.	0
6	Insufficient data/information in the case notes to assess the quality of care	0

Case record reviews are discussed at monthly Mortality Review Group (MRG) meetings chaired by a Clinical Director and Head of Patient Safety and Learning.

Some deaths are reviewed outside of our Mortality Review Groups; these are deaths that are considered under our Patient Safety Incident Response Framework (PSIRF) Policy and Plan where learning responses such as Patient Safety Incident Investigations (PSII) and After-Action Reviews (AAR) are undertaken.

Shared Learning from 2025/26

Learning from incidents and improvement activity is actively shared across the organisation through structured shared learning practice notes, including posters and newsletters disseminated to teams. This is supported by fidelity testing undertaken by the Quality Assurance team to ensure learning is consistently understood, embedded and translated into practice. These processes strengthen organisational learning and provide assurance that improvement actions lead to sustained change.

- Lack of information provided by other trusts when discharging to GHC needs to be logged on Datix so themes can be identified and targeted.
- At end-of-life, colleagues need to recognise the careful balance that is required when involving families in decision making as for some this may feel like an added burden.
- Where patients do not wish to be involved in decision making, guidance is made available.
- To listen to patients and support them to make their own choices – not for colleagues to take over even if they feel it's in their best interests. Colleagues need to remain mindful of thresholds for Best Interests Decision-Making processes.
- Value of LeDeR case being presented and discussed alongside trust case reviews.
- Challenges of 'feed at risk' – Requires individualised approach and careful documentation and risk assessment. Colleagues need to consider capacity and whether this is in best interests or whether the patient is choosing to make an unwise decision.
- Opportunity for exploration whether colleagues who predominantly work nights have been able to access training that is primarily available in the day regarding end-of-life care and also their involvement in MDT discussions.
- Good examples of collaborative approach between community hospitals and palliative care teams.
- Direct contact details of GP surgeries have been shared – to allow for quicker and smoother communication.
- To alleviate organisational system challenges around availability of information, particularly from other Trusts, Community Teams are to have access and training to Clinical Systems such as S1 and Sunrise – this is to be explored and followed up through the digital transition group meetings.
- To develop the language and share ideas of uncertainty with relatives, mindful that these can be challenging, sensitive conversations to have. To take the approach by explaining that the relative is sick enough to die however he/she has not yet died but is in the last months/year of life.

- To note, reinforcement of the process of ReSPECT being guidance and dynamic, senior clinical decision making in the moment remains the priority.
- Raised awareness of encouraging early referrals to the specialist palliative care team for end-of-life patients who have a combination of physical health and mental health challenges
- Teams were encouraged to invite colleagues that had been directly involved in cases to MRG meetings to listen and contribute to the case and for shared learning.

Part 2.3: Mandated core indicators 2025/26 data

There are several mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. **The percentage of patients aged 0-15 years and 16 years and over, readmitted to a hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period.**

	Quarter 1 2025-26	Quarter 2 2025-26	Quarter 3 2025-26	Quarter 4 2025-26
Gloucestershire Health and Care NHS Foundation Trust 0-15 years	0%	0%	0%	0%
Gloucestershire Health and Care NHS Foundation Trust 16 years +	6.67%	3.9%	1.3%	3.7%

Gloucestershire Health and Care NHS Foundation Trust consider that this data is as described for the following reasons:

- The Trust does not have Child and Adolescent inpatient beds.
- Patients with serious mental illness are re-admitted to hospital to prioritise their safety and promote recovery.
- Patients on Community Treatment Orders (CTOs) can be recalled to hospital if there is deterioration in their presentation.

Comparative to last year this showed a reduction in average percentage over the year from 4.25% (2025) to 3.89% (2026).

Gloucestershire Health and Care NHS Foundation Trust have taken the following action to improve (reduce) this percentage, and so by improve the quality of services, by:

- Participating in the National Getting It Right First Time (GIRFT) MENSAT programme, designed to improve patient care by reducing unwarranted variation in services, sharing best practices, and providing data-driven recommendations for service improvement
- Conducting an external review of our Community Mental Health Transformation programme to identify further opportunities for improvement in our community setting
- Continuing to promote a recovery model for people in contact with services.
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

2. **The percentage of staff employed by, or under contract to, the Trust during the reporting period who responded positively to "*If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation*".**

NHS Staff Survey	2021	2022	2023	2024	2025
GHC NHS Foundation Trust	78.42%	73.54%	76.59%	76.14%	76.03%
National Average Score	67.74% (all NHS trusts) 64.93% (MH, LD, Comm trusts)	62.90% (all NHS trusts) 63.77% (MH, LD, Comm trusts)	64.96% (all NHS trusts) 65.13% (MH, LD, Comm trusts)	64.28% (all NHS trusts) 64.84% (MH, LD, Comm trusts)	62.84% (all NHS trusts) 64.45% (MH, LD, Comm trusts)
Worst Trust Score	45.06% (MH, LD, Comm trusts)	40.20% (MH, LD, Comm trusts)	43.61% (MH, LD, Comm trusts)	41.55% (MH, LD, Comm trusts)	44.25% (MH, LD, Comm trusts)
Best Trust Score	82.37% (MH, LD, Comm trusts)	79.63% (MH, LD, Comm trusts)	80.42% (MH, LD, Comm trusts)	79.18% (MH, LD, Comm trusts)	81.28% (MH, LD, Comm trusts)

Whilst the GHC Trust score is less than the previous year, we remain in the top quartile and well above the national average score.

Our People Strategy 2026–2031, 'Creating a Great Place to Work Together for Better Healthcare', was ratified at Gloucestershire Health and Care (GHC) NHS Foundation Trust Board in May 2026 following co-creation with over 9,360 voices. The Strategy sets out four focus areas and 21 'We will' commitments across Great Leadership and Culture; A Workforce Fit for the Future; A Safe, Healthy and Inclusive Workplace; and Working Together, Working Differently.

Part 3: Looking back: a review of quality during 2025/26

Introduction

Quality Priorities 2023-2026:

In support of our overarching quality ambitions our physical, mental health, learning disability, children's and specialist services undertook work relating to the following quality improvement priorities which have been agreed with commissioning bodies. This is to facilitate an ongoing focus on quality for the organisation to improve care for the people we seek to serve in Gloucestershire. The priorities are underpinned by the mandate set out in the Quality Strategy and reflect our 3 Pillars of Quality in terms of Effectiveness, Safety and user Experience.

- Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources.
- Dementia Education - with focus on Increase staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.
- Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on baseline 2021/22 data.
- End of Life Care (EoLC) – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End-of-Life Care decisions.
- Friends and Family Test (FFT) – with a focus of building upon the findings of the 2022/23 CQC Adult Community Mental Health Survey action plan.
- Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.
- Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranquilisation.
- Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.
- Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.
- Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.
- Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.

Good progress against all agreed plans has been demonstrated against each Quality Priority. In relation to Tissue Viability the National Wound Care Strategy (NWCS) is fully embedded and blended model training available. Our Dementia Education programme continues with good training uptake and very positive feedback received in relation to community events held. Falls and restrictive practice are being overseen within the monthly Quality Dashboard where any emerging themes or trends are reported, the actions from the 2022/23 CQC Adult Community Health Action Plan are implemented and the work undertaken on the Zero Suicide Plan 2022/24 is being reviewed to align with the One Gloucestershire Suicide Prevention Strategy 2024/2029. Our learning disability colleagues were trained in positive Behavioural Support (PBS) by April 2025, and the Oliver McGowan training continues throughout the organisation. Work relating to the SEND provision is ongoing as is the focus on achieving the triangle of Care Stage 3 accreditation. GHC EoLC priorities align with NICE Quality Standards for care at the end of life and NHSE personalised care, we have a workforce that is compassionate, confident and competent in delivering personalised end of life care in our hospitals and in the community. The GHC Patient Safety Incident Response Policy and plan were updated and implemented alongside Implementation of the Patient Safety Incident Response Framework (PSIRF).

As this cycle of Quality Priorities concludes, the Trust recognises the strong foundation established through high levels of engagement, delivery and learning across all workstreams. From 2026/27, quality improvement will be driven through a refreshed Quality Strategy and embedded within the Trust's business planning process, ensuring that quality improvement objectives are fully aligned to strategic priorities, operational plans and resource decisions. This integrated approach will strengthen accountability, support delivery at scale and ensure that quality remains a central driver of organisational performance and improvement.

Below are some curated highlights:

Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources.

The implementation plan is split into 4 sections:

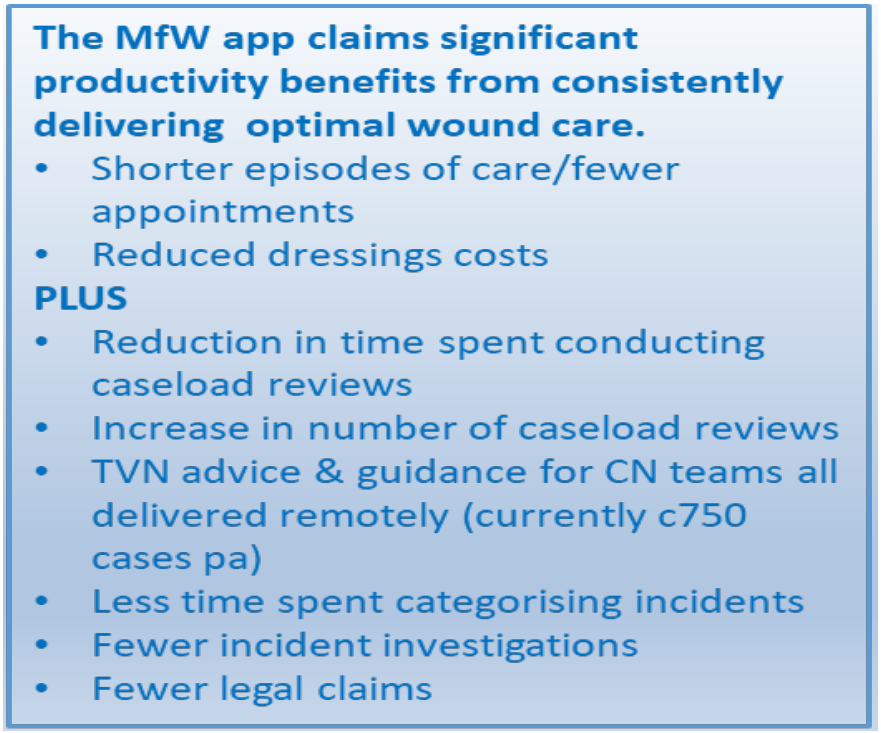
- Implementation of the National Wound Care Strategy (NWCS).
- Refresh and evaluate the delivery of training, education and support available.
- Evaluate and produce a business case for the implementation of a wound care app.
- Evaluate and strengthen links with dietetic services and other services both within GHC and across the system to improve holistic support to patients.

The Journey:

- The National Wound Care Strategy (NWCS) has been fully embraced and embedded within the culture of GHC with links to Tissue Viability Nurse (TVN) colleagues being established in Gloucestershire, Oxford and Bristol. A review of the latest guidance/standards published on the NWCS website was completed and uploaded to the Trust Intranet, with links to the NWCSP videos and training/learning resources being shared to enable learning.

- Training: A blended model of training is available encompassing both Face to Face training and Webinars, the Face-to-Face offers have been made available countywide at multiple locations.

- Wound Care App. A trial of the wound care app was undertaken in one location with a control set up to test the benefits suggested by **healthy.io** who are the provider of the "**Minuteful for Wound**" application. The purpose of the trial was:
    - To determine whether the app improves the quality of wound care
    - To determine the app's usability, impact on service delivery,
    - To evaluate the claim that the cost of the app is recovered through productivity gains.



Trial Methodology

- Trial of the wound care app commenced 17/03/25
- Duration of trial: 9 months (6 months for clinical intervention data)
- Intervention locality, Forest of Dean, allocated 40 full licences.
- Control locality, Stroud, no licences allocated.

- A case control approach was taken, with Forest of Dean as the case and Stroud as the control. Stroud was matched to Forest of Dean based on demographic factors and similar length of stay, total contacts and contact duration.
- Comparison between baseline audit undertaken in February 2025 (before trial started) and follow up audit undertaken December 2025 (nine months into trial)

Conclusion

- The annual licence fee of £960.00 per user per annum equates to over £250,000 pa for use across community nursing.
- There is no measurable cost savings from deployment of the app
- A six-month extension of the trial would cost £20,000.

Links with Dietetic Services.

Network established which GHC actively engage with and ensure representation at all arranged meetings.

The Outcome:

The Wound Care App is not currently progressing due to the initial return on investment outcome. While the app was positively received, the trial did not demonstrate sufficient cost benefit when all factors were considered. Implementation of the National Wound Care Strategy (NWCS) continues in line with national priorities, with all colleagues retaining access to up-to-date guidance and equitable, high-quality training, including those in remote locations.

Next Steps:

The system for oversight and monitoring of Pressure Ulcers is well embedded within routine reporting mechanisms and real time data is available via Tableau (BI reporting system). Oversight occurs via the BI Master Performance Dashboard (quantitative analysis), with a different lens being applied via the Quality Dashboard (qualitative) analysis.

Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.

The implementation plan is split into 5 sections:

- Training.
- Gloucestershire 5 Step Approach.
- Patient Carer Experience.
- System Working with GP Practices.
- Communication.

What we have achieved.

Training

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline in brain function. There are many different causes of dementia and many different types.

In the UK one in 11 people over the age of 65 have dementia and the number of people with dementia is increasing because people are living longer.

GHC lead the Dementia Training and Education Strategy network and host the Dementia Education Team who develop and lead on the ICS wide dementia training offer. All dementia training and education that takes places in Gloucestershire is reported on through the ICS Dementia Training and Education Strategy network meeting which is planned to be held each quarter.

The quality priorities aim is to increase the numbers of staff within GHC who have completed the Tier 1, 2 and 3 training that is available.

Across the ICS, courses remain fully booked and feedback received is always very positive. Please see figures below covering 1st January 2024 - 1st January 2026 for GHC colleagues:

- Dementia Tier 1 Training - 418 completions
- Dementia Tier 2 Training - 51 completions
- Dementia Tier 3 Training – 19 completions

GHC have also supported development of 10 new dementia training films in collaboration across the ICS – these are now published and available.

The videos can be found here:
Dementia - Residential care training films for carers, family and friends - PocketMedic.org
These videos will be imbedded into the existing dementia training programme across Gloucestershire.

The Gloucestershire 5 step Approach

This remains available on GCC Website and training is delivered in the Tier 3 Dementia Link Worker / Dementia Lead programme available across the ICS. There is a planned review of the 5 Step Approach in Q1 2026/27.

Patient/Carer Experience

All incidents that are reported via the Datix Incident Reporting System that mention a person living with a dementia as being are reviewed by a specialist. This has been helpful for oversight and monitoring of any issues / challenges faced and support is offered to clinical teams as required.

The numbers of concerns and complaints raised to the Trust where a person living with a dementia is involved is low and these are subjected to oversight by specialists with support being provided to teams and individuals where required.

Primary Care

Work has been done to update the dementia pages on G-CARE (a shared digital hub across Gloucestershire NHS and partner organisations, providing clinical guidance, education and training resources, and consistent, up-to-date information to support health and social care staff) to ensure that all information is clear and accurate for Primary Care staff, this includes updating the resources available on signs and symptoms and information on young onset dementia. A one-off session was also delivered to the MH ARRS workers covering some GP practices in 2025, with relationships built and team know who to contact if they have any questions / concerns.

Ongoing dementia awareness training available across Primary Care through the ICS Dementia Education Team and also able to access the newly produced dementia training films.

Frailty and Dementia business case was developed by the ICB and now most GP practices have a dedicated GP dementia lead who will be supporting the primary care co diagnosis work that is

planned. This has enabled some focused dementia education for those colleagues and the Frailty Teams that support out across PCN's to increase knowledge and understanding and continue to build stronger relationships.

Community Hospitals

A programme of Dementia Care Mapping (DCM) commenced in July across three cohorts: Cirencester, Stroud, and Forest. This demonstrated strong person-centred practice across all sites. Forward planning is underway to increase the number of staff trained.

Dementia Action

Research shows dementia risk is lowest in people who have healthy behaviours in midlife (aged 40-65) and healthy lifestyles can make it possible to reduce the likelihood of getting dementia by up to one third. Through 2025 we held Dementia Action Day's across the ICS, and these were focused within a different locality each month. This enabled engaging with the public and discussion of dementia risks and risk reduction.

The Dementia Action Day's for 2025 were held as below:

- Saturday 11th January – Gloucester (Eastgate Shopping Centre)
- Wednesday 12th February – Stroud (outside Stroud Library)
- Tuesday 4th March – Tewkesbury
- Saturday 5th April – Cirencester
- Friday 13th June – Chipping Camden
- Saturday 9th August – Newent
- Sunday 21st September – Cheltenham (World Alzheimer's Day)
- Thursday 27th November – Dursley

Next Steps

For 2026, we have marked Dementia Action Week (18th – 24th May) and are scoping our dates for Dementia Action Days and developing our input to ICS Cultural and Diversity Dementia Network. This group is ongoing with all workstreams embedded, meeting quarterly with a clear action plan on what we want to achieve over the next 2 years and has won a Trust award.

End of Life Care (EoLC) – with a focus on patient centred decision, including the extent which the patient, their carers and families wish to be involved in the End-of-Life Care decisions.

The implementation plan is split into 3 sections:

- To be fully assured that patients, their carers and families, are involved as much as they want to be in end-of-life care decisions.
- To Be fully assured that staff are identified and receive training with systems in place for ongoing compliance monitoring.
- To maximise training availability and ensure identification of additional resources where required.

The Journey:

Progress – The NACEL 2023 audit evidenced good compliance that patients, carers and families participated in end-of-life care as much as they wanted to be. A training needs baseline has been established with the aim of Masterclasses being assigned as Essential to Role for certain groups. A review of the training provision and alignment to essential role training identified a shortfall in provision and as number of topics have been requested to become essential to role, this has led to

a wider review of essential to role training and therefore the EoL essential to role proposals are part of that wider review.

The Outcome:

GHC EoLC priorities align with NICE Quality Standards for care at the end of life and NHSE personalised care, we have a workforce that is compassionate, confident and competent in delivering personalised end of life care in our hospitals and in the community therefore benefiting the patients in our care.

Next Steps:

We receive many compliments regarding EOL care but our recording of these is low and we are working hard to support the teams to record these to enable us to share the positive feedback. The number of EOL complaints that we receive is fortunately very low, however, we consider that one complaint is too many as the impact for family and those people important to the patient can lead to significant and ongoing distress and challenges in their bereavement process if there is no resolution. Our work and success in early / local resolution of complaints is important for patients and their loved ones. Early resolution can support people to travel through their bereavement process without the distress and anger that a complaint can bring to them. Going forward we are exploring how we can capture feedback in Realtime to address and resolve any issues or concerns before they have a devastating impact.

Summary

End of Life Care priorities align with NICE and NHSE standards and are supported by a compassionate, capable workforce delivering personalised care across hospital and community settings. We will be exploring way to encourage and expand access to End of Life Care training to ensure consistent knowledge and confidence across the workforce. While complaints remain very low, focus is shifting to improved real-time feedback capture and consistent recording of positive feedback to support early resolution, shared learning, and ongoing quality improvement.

Carers – with a focus on preparing for, achieving and long-term maintenance of the Triangle of Care Stage 3 accreditation.

The Plan:

The implementation plan is split into 4 sections:

- **Mission and vison**
  Continue with an organisational plan that communicates the mission and vision of the project.
- **Mapping**
  Continual live evaluation and remapping of all teams that establishes their current compliance status with level 2 requirements by using a self-assessment methodology.
- **Engagement**
  Continued engagement with all stakeholders.
- **Planning**
  Develop plan on a page and project control methodology.

The Journey:

In 2024 the Carers Trust reaffirmed our 1st and 2nd star status for our work within mental health services and again in 2025 for continued progression within both mental and physical health services. The Carers Trust now gives approval and encouragement for GHC to progress towards the ToC 3rd star accreditation by engaging the principles of ToC with all teams. Progress with the Triangle of care accreditation workstream continues with focus projected on engaging with stakeholders and developing a map of all teams establishing their current compliance status with level 2 requirements by using a self-assessment methodology. This enables a clear picture to be obtained of where resource needs to be directed next year.

The Outcome:

Each year, to retain accreditation, Gloucestershire Health and Care NHS Foundation Trust (GHC) submits an annual report to the Carers Trust providing information regarding progress, key developments and evidencing the compliance of our carer aware practice against the 6 set standards. Key themes include:

- A quarterly Carer Champion Community of Practice where sharing and learning can provide best practice.
- Application of the Trusts Carer Awareness training package to be raised to a mandated platform as essential for role.
- The implementation of a monthly Carers Working Group.
- The Development of the Trust Carers Charter and Young Carers Charter
- Continued delivery of Trust wide Carers Handbook with mental health supplement.
- The implementation of a carer specific Friends and Family Test.
- The development of proactive links with our local Young Carers.
- Monthly support group for GHC colleagues who are carers.
- The development of guidance on the use of common-sense conversations with family and friends to empower staff to feel more empowered and confident to converse with carers and family members.
- Development of a Triangle of Care Maturity Matrix to monitor compliance across the Trust.
- Planned work to develop a digital portal to support recording of the ToC data being collated.

Summary
The Carers Trust complimented the Trust on our ambition, and how we continue to re-affirm and build on our commitment to carers using the Triangle of Care quality improvement framework.

Next Steps:

Evaluate the data collected, alongside responses and recommendations from the Carer Trust to plan the workstream priorities for 2026/7 to visit areas requiring focus and development with focus on Carer Friendly Workplace and The Peoples Promise.

Quality Dashboard

During 2025/26, the Trust has sought to strengthen its approach to quality and performance reporting. The monthly Quality Dashboard is aligned to NHS England's shared single view of quality, supporting the delivery of safe, effective, personalised and equitable care. This approach enables early identification and escalation of quality risks, supports oversight of service improvement and transformation, and provides clear visibility of progress and good practice across the organisation.

The dashboard forms a key role in our emerging quality management system approach and informs a number of forums and committees within the Trust governance structures as well as a vehicle to inform our ongoing quality relationship with our Commissioners, System Partners and our Regulators. It includes a range of information across all our services.

The dashboard provides a monthly overview of our activity split into the Safe, Effective and Caring categories and has an Executive Summary highlighting key points. This year we have been streamlining the data so that the report can sit alongside the main Integrated Performance and Quality Report. The datasets within the quality dashboard have also evolved from a focus on reporting the qualities priorities of our Quality Strategy to covering statutory responsibilities, mandated duties and legal requirements.

There is an organisational appetite to further develop our reporting and governance framework by moving towards greater integration between our assurance mechanisms. The ambition is to enhance the way the Trust thinks, plans and reports and to improve accountability through assurance and scrutiny; it is felt that a better reporting product will drive short and long-term organisational improvement. Therefore, the intention is to move beyond our historical silo approaches of information reporting towards a more comprehensive, holistic assessment of value, quality and performance. There will be a multi-year timeline for achieving the ambition and it will develop not only the reporting and associated governance frameworks of (initially) the Performance and Quality Dashboards, but also, over time, the integration of other corporate reports such as, but not limited to, the Trust's corporate Finance and Workforce reports.

Outreach Vaccination Team (OVHT) 2025/26

The Outreach Vaccination and Health Team (OVHT) support the national immunisation programme by offering vaccinations including Covid and flu to the people of Gloucestershire in five core areas of activity:

- The OVHT hold community-based pop-up sessions in areas with low vaccine uptake and underserved communities offering Covid vaccinations at various locations across the county of Gloucestershire including venues supporting the homeless, food banks, community centres, warm spaces, sports clubs, libraries and village halls. During 2025/2026 Covid vaccination campaigns, 210 vaccines were administered by the team. OVHT also supported primary care when required and administered 100 Covid vaccinations to people who were housebound and/or residents in older adult care homes.

- Support the Covid and flu vaccination campaigns to increase vaccine uptake in vulnerable groups such as inpatients and administered a total of 312 Covid and 224 flu vaccinations to patients admitted to Trust inpatient units. To respond to the national respiratory syncytial virus (RSV) vaccine catch-up campaign, OVHT administered 13 RSV vaccines to inpatients who were eligible. In addition, the team supported the Trust occupational health offer by holding walk-in sessions for staff at various locations across the Trust estate. During the Autumn/Winter 2025/2026 vaccination campaign the OVHT administered 1244 flu vaccinations to staff which accounted for 54% of total GHC staff flu vaccine uptake. Anticipated changes to the model of delivery of the national vaccination programme, means the Trust will expand a trust wide peer vaccinator approach across all services for the provision of staff and inpatient flu and Covid vaccines during the winter campaign for 2026/27.

- Promote the national call for Making Every Contact Count (MECC) in which public facing staff engage with patients, and members of the public as an opportunity to support and encourage or consider change in behavior such as stopping smoking to improve individual people's health and wellbeing. The OVHT offer health care advice including blood pressure checks, sign-post people to free local services and partner organisations at community pop-up vaccination and MECC sessions. During 2025/2026 the team held over 140 MECC sessions at various locations

across the county, with 1717 people having blood pressure checks. Of these, 224 people were referred to for specialist/ primary care review.

- During 2025/2026 OVHT continued to work jointly with system partners to support offering routine vaccinations to refugees and asylum seekers within Gloucestershire. OVHT administered 203 measles, mumps and rubella (MMR) and 259 diphtheria/tetanus and polio (DTP) vaccines to those who had incomplete/unknown vaccination history.

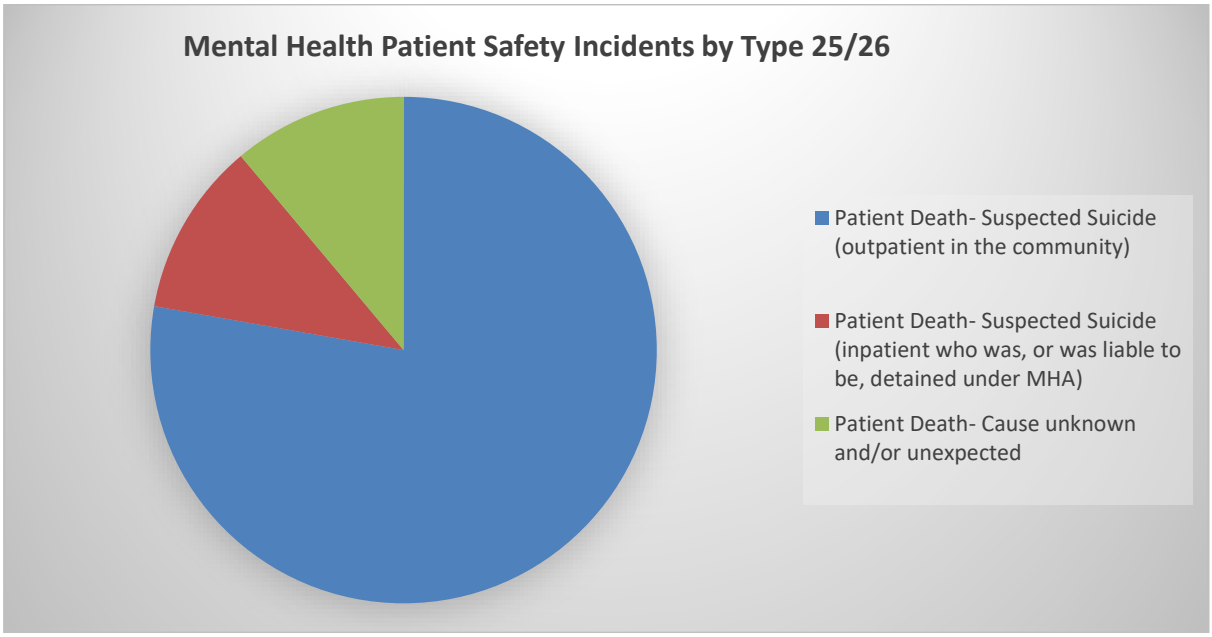
The OVHT tirelessly champion vaccination uptake and outreach within Gloucestershire through ongoing engagement with community leaders/networks and partner organisations and seek innovative ways to expand their reach.

Patient Safety Incidents 2025/26

Mental Health Services

By the end of 2025/26, 9 Patient Safety Incidents (PSIs) were reported by the Trust. The classification of these incidents reported are shown below.

- 7 Patient Death- Suspected Suicide (outpatient in the community)
- 1 Patient Death- Suspected Suicide (inpatient who was, or was liable to be, detained under MHA)
- 1 Patient Death- Cause unknown and/or unexpected



Physical Health Services

For 2025/26, the Trust reported 1 Patient Safety Incident (PSIs).

The classification of this incident was as follows:

- 1 Patient Death- Cause unknown and/or unexpected

All Patient Safety Incidents were investigated by a specialist team of reviewers, all of whom have met the requirements set out by NHSE in their PSIRF guidance around training and competencies.

The role of a Family Liaison Practitioner is currently being met by two members of the Patient Safety Team who are Registered Nurses and hold the necessary skills to undertake compassionate and caring conversations with individuals impacted by patient safety events.

During this financial year the internal auditors BDO undertook an audit into the Trust's implementation of its PSIRF policy, plan and processes. The audit found moderate assurance on design and limited assurance on operational effectiveness and an improvement plan is in place to address the areas of learning and improvement.

The Trust has a dedicated Learning Assurance Team who support learning from safety actions, tracking these through to conclusion and beyond so that GHC can translate that learning into sustained improvements in patient care.

Recognising the emotional demands of this work, the service places a strong emphasis on colleague welfare and self-care. Team members actively support one another through both formal and informal support networks, which provide a space for ongoing communication and peer support.

The Trust continues to share copies of our investigation reports regarding suspected suicides with the Coroner in Gloucestershire to assist with the Coronial investigations.

Physical health care in mental health settings

Gloucestershire Health and Care (GHC) employs a small, specialist team of Nurses and Healthcare Assistants (HCAs) to improve the physical health care of people with mental health conditions and learning disabilities across Gloucestershire.

The service includes two Band 6 Physical Health Nurses working within Older Adult and Working Age Adult inpatient units, who also provide weekly support to the Recovery Units and Berkeley House as required. In addition, the team includes a Band 6 Learning Disability Specialist Screening Nurse (0.3 WTE), a dedicated Treating Tobacco Dependency Team, and two Band 7 Lead Nurses for Improving Physical Health in Mental Health and Learning Disabilities (1.0 WTE job share).

The inpatient Physical Health Nurses deliver hands-on clinical care to patients, alongside providing training and support to mental health colleagues. One of these nurses is due to qualify as a Non-Medical Prescriber later this summer, which will enable her to prescribe appropriate dressings and treatments directly, reducing delays and dependence on medical colleagues.

We were delighted to receive recurrent funding from the Integrated Care Board (ICB) for the Treating Tobacco Dependency Team. This funding has enabled the recruitment of permanent staff and clearly demonstrates Gloucestershire's commitment to the national 10-Year Plan for smoking cessation, which focuses on reducing tobacco-related harm and better integrating smoking cessation support within healthcare services.

The Learning Disability Specialist Screening Nurse has now been in post for just over a year. This role was established to improve uptake of the five national screening programmes—breast screening (mammography), cervical screening (cytology), abdominal aortic aneurysm (AAA) screening, diabetic retinopathy screening, and bowel cancer screening—among people with learning disabilities. The work has been very well received by both service users and care providers.

Earlier this year, a joint initiative with the Gloucestershire charity *Artlift* led to the delivery of three community workshops. These workshops used creative activities to help build confidence in expressing concerns about screening procedures and attending appointments with doctors and nurses. The events were attended by 60 people and culminated in the project being awarded first prize by the South West Group (SWAG) Cancer Alliance.

Freedom to Speak Up

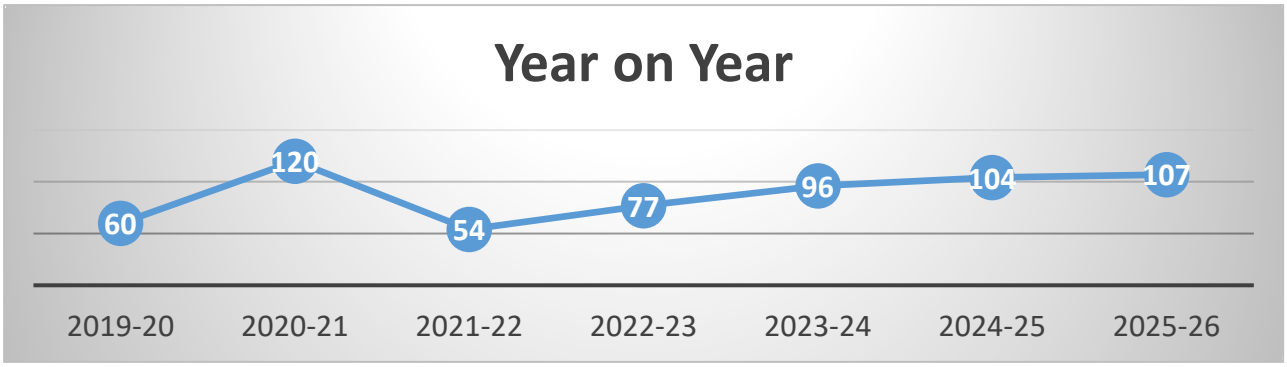
The Trust continues to invest in a full-time Freedom to Speak Up Guardian. The Guardian operates independently, impartially, and objectively on all matters relating to speaking up in the workplace, taking a highly visible leadership role in promoting the culture of speaking up, including trust and confidence in the processes themselves, and promoting learning and improvement. The wider remit is to play a key role in promoting a culture of transparency and safety and assisting the Trust in protecting staff from suffering detriment through their speaking-up experience. We continue to focus on always improving this agenda.

The Freedom to Speak Up Guardian is supported by a network of Champions who promote the Freedom to Speak Up service, offer support to colleagues to gain psychological and/or practical support. The commitment by the Freedom to Speak Up Guardian is to ensure that our champions receive ongoing support and development through sharing successes, challenges, best practice and learning.

Speaking Up processes, in line with national guidance are in place and remain open for colleagues

to speak up, be listened to and follow up action occurs. In summary, in 2025/2026 there was an 3% increase in speaking up cases (104 in total), which follows an 8% increase of speaking up in 2024/2025.

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



Patient safety and quality of care related concerns are much less in number (13%), compared to behaviour related concerns 41%, recognising that 46% of colleagues said that their safety/wellbeing had been impacted. As an organisation, the ambition is to reflect the number of patient safety concerns raised in line with the vision of Freedom to Speak Up, The Francis Review into patient care failings (2013), with the recommendations to improve NHS culture, safety and accountability.

The Freedom to Speak Up Guardian role is part of a much bigger picture, supporting the wider organisational approach to a positive speaking up culture. Those colleagues that have declared a protected characteristic is 13% and this information is used to identify if they experience any differences in their speaking up experience, identifying any barriers and ensuring learning takes place. We use opportunities to reflect on local and national reports these and capture learning, aligned to the NHS England guidance and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer, in our 'Strong Voice' commitment to colleagues. Within the NHS Staff Survey, "We each have a voice that counts" saw its score fall from 7.00 (2024) to 6.92 (2025). Despite this small decline, GHC remains above the national average. The four speaking up related questions (Q20a, 20b, 25e, 25f), do 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. Priority Focus Areas commenced related to Voice, Psychological Safety and Raising Concerns.

Feedback from colleagues who have used the Freedom to Speak Up (FTSU) service remains largely positive, with 82% reporting that they would speak up again. While the majority describe the process as a positive experience, it is recognised that barriers to speaking up remain. Recent feedback has highlighted concerns about the effectiveness and confidentiality of speaking-up processes, consistent with themes identified in the staff survey. We take these concerns seriously and will commission an external review of speaking up in 2026/27 to strengthen confidence, effectiveness and trust in our arrangements. Alongside the FTSU Guardian, FTSU Champions and

day-to-day management routes, colleagues have access to a range of established escalation and resolution mechanisms, including a well-embedded Resolution Process, access to the Senior Independent Director, strong and active colleague diversity networks, and well-established Staff Side representation, with additional advice and advocacy available through professional associations and trade union partners.

Looking forward, in addition to continuing to support colleagues on a day-to-day basis, Freedom to Speak Up is identified as a key enabler within the new People Strategy. A system quality improvement project has been scoped alongside the Freedom to Speak Up Guardian at Gloucestershire Hospitals NHS Foundation Trust, in reducing barriers to speaking up. In GHC, we welcome greater responsibility, accountability and autonomy for embedding effective Freedom to Speak Up arrangements, following the move for oversight to NHS England in July 2026.

Learning from speaking up is fundamental to an open and honest culture and through continued work with our learners and proactive work continues within local universities.

Other options available to colleagues within the Trust include:

Freedom to Speak Up APP is an in-house application available as a safe, anonymous or confidential application to enable colleagues to enter into a conversation to obtain further advice and support. The version 3 APP was launched in April 2026 and will enhance the user and Guardian experience with an enhanced process for case management system and increased governance in place.

Direct to Douglas is a confidential application to share with our Chief Executive any issues colleagues think he should be aware of, give feedback or ask for a response to something they are concerned about. There are also opportunities to make suggestions for improvement.

National indicators 2025/26

		National Threshold	2023-2024 Actual	2024-2025 Actual	2025-2026 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	60%	76.9%	70.1%	73.97%
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -community mental health services (people on CPA)	 NA NA	 77% 81%	 76% 88%	 75% 87%
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	 50% 75% 95%	 52% 99.6% 99.9%	 53.3% 97.4% 99.8%	 51.24% 90.9% 99.8%

4	Admissions to adult facilities of patients under 16 years old.	NA	0	0	0

The data above is mandated within the guidance and there are no statistical variances to report upon.

The table below reports out of area placements for adult mental health services. All out of area placements are monitored by a range of teams to ensure our patients are receiving services which are safe, effective and provide a good experience. Use of out of area placements (typically within the private sector) refers to a situation where a patient is admitted to an inpatient unit outside of their local area because no appropriate bed is available locally. However out of area providers may also have limited capacity or decline to accept a patient when referred.

The aim of the trust is always to eliminate all out of area placements (OAPs) in mental health services for adults in acute care in lieu of local capacity, however in exceptional circumstances use can be operationalised to reduce the risk of harm, ensuring we provide care that has a clear benefit and improve outcomes and is patient centred and in partnership with the patient and their family.

A *'Use of Mental Health Out of Area Beds: In and Out of Hours Protocol'* has been implemented.

To support more local capacity being readily available the Trust has developed a Wotton Lawn Length of stay programme focusing on Mental Health Hospital Flow with community colleagues and system partners. Regular Multi-agency Discharge Events (MADE) are held regularly across working age, older age and recovery units to both enable actions to support patients being discharged but also collating barriers to discharge themes to focus efforts and development to take forward.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year
Average Bed Days	0	26	40	39	36	49	51	140	124	100	20	0	625

CQC Adult Community Mental Health Survey 2025

Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and is an underpinning core value of Gloucestershire Health and Care NHS Foundation trust.

The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patient feedback. For the 2025 survey, Gloucestershire Health and Care NHS Foundation commissioned IQVIA (Quality Health) to carry out this work. The CQC makes comparison with 50 English NHS mental health care providers results of the same survey and the results are published on the CQC website. The CQC requires that all providers of NHS mental health services in England undertake an annual survey of patients in their care.

The CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, CQC will use the results alongside other sources of people's experience data to inform targeted assessment activities.

The Trust scores in comparison with other trusts is detailed below:

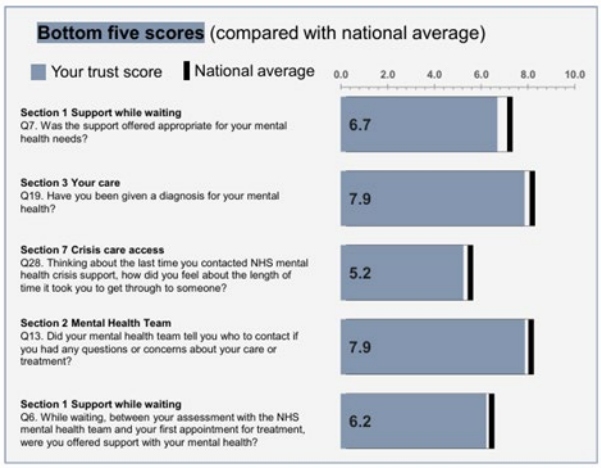
Survey Domain	Score	Rating

Support while waiting	6.5	Same
Mental Health Team	6.9	Same
Your Care	7.0	Same
Medication	7.5	Same
Psychological Therapies	8.7	Same
Crisis Care Support	5.6	Same
Crisis Care Access	7.0	Same
Support with other areas of life	4.5	Somewhat better
Support in accessing care	5.0	Same
Respect, dignity and compassion	8.5	Somewhat better
Overall experience	7.4	Somewhat better
Feedback	4.0	Better

The Trust's response rate was 24% (280 responses). This is above the national average of 19%.

The Trust performed about the same compared with other trusts in 22 of the 34 questions and somewhat better (5) or better (7) than expected in the remaining 12 questions. The Trust did not score worse than expected compared with other Trusts in any of the survey questions.

In relation to our performance relative to the national average, the diagram below indicates the five questions where the Trust scored the highest and lowest in comparison with the national average scores.



Annual NHS Staff Survey and Staff Friends and Family Test 2025/26

The Trust approaches colleague engagement through a breadth of routes. These include via a regular Staff Forum, Board Visits, Staff Stories at the Great Place To Work Committee, Diversity Networks engagement, Internationally Educated Nurses Council, Freedom to Speak Up Champions, Health and Wellbeing Champions, the Joint Negotiation and Consultative Forum, the Joint Local Negotiating Committee, the Resident Doctors Forum, quarterly Pulse Surveys, annual GMC and National Education and Training surveys, annual Staff Survey, ad hoc surveys, discussions and listening groups.

Commentary

In 2025, 2,643 colleagues completed the National NHS Staff Survey representing a 51% response rate broadly in line with the sector median. That level of participation reflects a genuine and ongoing commitment among our people to share their experiences and shape how we improve.

The results come at a significant moment for the Trust, 2025 has been a year of considerable change - organisational, operational and strategic. Colleagues have navigated system-wide integration, transformation programmes and ongoing workforce pressures, while continuing to deliver compassionate care.

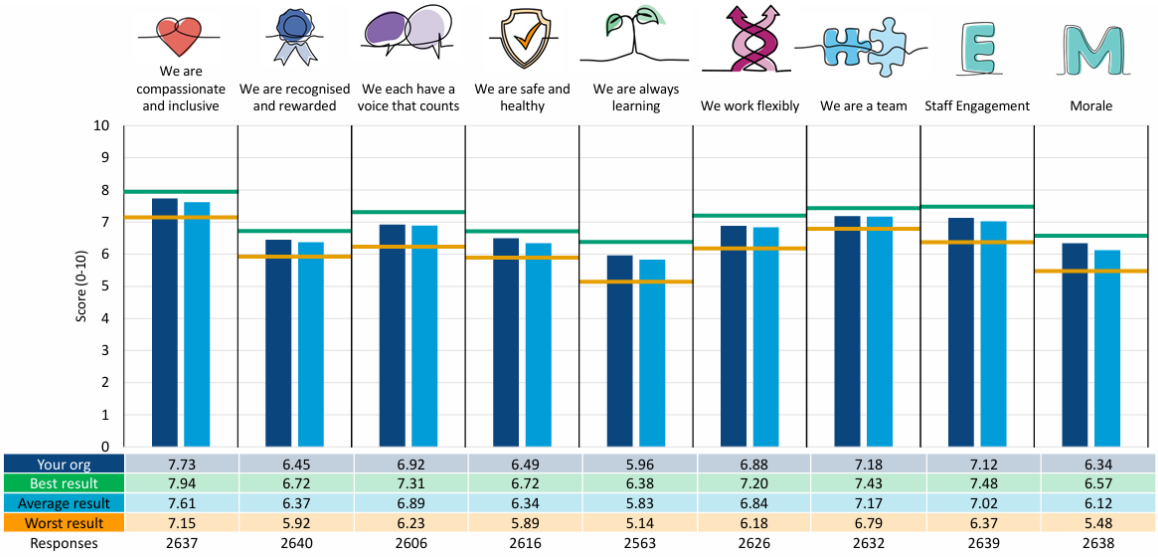
We compare our performance with a group of similar NHS organisations, mental health, learning disability and community providers, which allows for benchmarking in terms of where we stand nationally and regionally. GHC performs at or above the national sector average across all nine People Promise elements and themes, a consistent position we have held across the past three survey cycles. Regionally, the picture is even stronger, within our Southwest benchmarking group of similar NHS organisations, GHC reports the highest scores for both Staff Engagement and Morale and ranks among the top performers across seven of the nine People Promise domains. Overall, staff rated the Trust the top performing NHS provider employer amongst all Southwest NHS provider trusts.

S**ummary of performance**

The 2025 NHS Staff Survey continues to use the People Promise as the basis for measuring experience, with the two additional themes of Staff Engagement and Staff Morale. All scores referenced below are weighted (as per the national methodology), ensuring comparability with other Trusts.

The Trust's scores for 2025 People Promise themes were all above the sector average ratings and are detailed below:

Staff



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.73	6.45	6.92	6.49	5.96	6.88	7.18	7.12	6.34
Best result	7.94	6.72	7.31	6.72	6.38	7.20	7.43	7.48	6.57
Average result	7.61	6.37	6.89	6.34	5.83	6.84	7.17	7.02	6.12
Worst result	7.15	5.92	6.23	5.89	5.14	6.18	6.79	6.37	5.48
Responses	2637	2640	2606	2616	2563	2626	2632	2639	2638

Friend and Family Tests

Two indicators stand out as among our strongest results, and the most meaningful: how many colleagues would recommend GHC as a place to work, and how many would recommend us as a place to receive care. For both areas, the Trust's performs above the sector, regional and national average.

69.8%

would recommend GHC as a place to work

Sector average: 62.4% | +7.4 percentage points above sector

75.7%

would recommend GHC as a place for care

Sector average: 64.3% | +11.5 percentage points above sector

Three-Year Performance

There has been gradual and minor reduction in ratings across several People promise indicators over the past 3 years, including compassionate and inclusive, recognised and rewarded, a voice that counts, we are always learning and we are a team. We are committed to reverse that direction of travel through the focused priorities set out in our forthcoming People Strategy 2026–2031.

People Promise /Theme	2023	2024	2025
We are compassionate and inclusive	7.80	7.75	7.73
We are recognised and rewarded	6.53	6.48	6.45
We each have a voice that counts	7.11	7.00	6.92
We are safe and healthy	6.51	6.49	6.49
We are always learning	6.05	6.05	5.96
We work flexibly	6.83	6.83	6.88

We are a team	7.23	7.21	7.18
Staff Engagement	7.27	7.18	7.12
Staff Morale	6.38	6.35	6.34

Where We Perform Well

Colleagues continue to rate the Trust positively across the People Promise themes, with scores remaining consistently above the sector average:

- Compassionate & Inclusive Culture (7.73) — one of our most enduring strengths, and significantly above the national average
- Teamworking (7.18) — reflecting the strong local team identity that colleagues consistently describe
- Flexible Working (6.88) — above average and improving year on year
- Diversity & Equality (sub-score 8.71) — among the highest scores in our results

Emerging Themes – Where we will focus

Four areas stand out as requiring focused attention from the 2025 staff survey. These areas of focus have also been identified as part of a wider data analysis exercise carried out to inform the refresh of the Trust's People Strategy. The areas of focus are: -

- **Wellbeing, Capacity and Burnout**

While the Trust is rated well in comparison with the sector benchmark and wider NHS providers, too many colleagues tell us that work regularly feels overwhelming. Conflicting demands on time, difficulty switching off, and a sense that there are never quite enough hours or people to do the job well. Through our People Strategy focus area *A Safe, Inclusive and Healthy Workplace*, we have committed to prioritising the health and wellbeing of every colleague and actively managing workloads so everyone can do their best work.

- **Voice, Psychological Safety and Raising Concerns**

Colleagues need to feel genuinely safe to speak up about concerns for patients, about their own experience, and about things that aren't working. This year's survey shows that while the Trust benchmarks well in comparison with peers and the wider NHS, not all colleagues feel that confidence, and that fewer people believe the organisation will act on what they raise. Through our People Strategy focus area *Great Leadership and Culture*, we have committed to strengthening staff voice, meaningful involvement in decision-making, and fostering a culture where we learn from experience and continuously improve**.**

- **Learning, Development and Career Progression**

Colleagues want to grow and they want meaningful conversations about their development, fair access to learning opportunities, and a sense that there is a future for them at GHC. The survey tells us we are not yet communicating sufficiently about the breadth of offers not are we delivering consistently enough. Through our People Strategy focus area *A Workforce Fit for the Future*, we have committed to creating clear pathways for colleagues to develop and grow their careers, whilst investing in the development and training of line managers who make that possible day to day**.**

- **Alignment Between Values and Perceived Organisational Action**

GHC has strong values, and colleagues recognise these and regularly discuss them. What the survey reflects is a growing question about whether what we say always matches what we do, and whether concerns raised are always genuinely heard and acted upon. Through our People Strategy focus area *Great Leadership and Culture*, we have committed to growing leaders at every level who live and model our values, and to fostering a culture where actions consistently reflect what we stand for.

Our Commitment from the Survey Feedback

Our refreshed People Strategy 2026–2031, being launched in quarter 1 2026, will provide the strategic framework for how we address these focus areas and build on the feedback our colleagues have shared through the survey. Rather than treating the survey as a separate workstream, our response is about will be embedded within the strategy — joined up, sustained and resourced.

Alongside the organisation-wide approach, each service area is identifying its own two to three local priorities, giving colleagues a stake in how their team responds.

Progress against plans and key performance indicators will be overseen by Executive Directors, the Workforce and Organisation Management Group and the Board's Great Place to Work Committee throughout the following year.

Staffing in adult and older adult community mental health services

We have continued to invest in our staff and to build our service offer; including that to minority groups, we continue to offer both remote and face to face therapy and are actively looking at how we can offer support to older adults. We have been concentrating significant time on our NHS Talking Therapies to enable them to develop their input to the CMHT Transformation agenda.

Health Inequalities

The strategic focus on our approach to health inequalities has been increased during the year, with 'Inclusive Healthcare' being made one of our five Focus Areas in our strategy 'Five Year Focus 2026 – 2031'. This will bring added attention and action over the five year period.

One area of continuing action are initiatives that run across our learning disability services aimed at tackling the health in equalities that we know many people with learning disabilities face. Here are just a few examples:

Our Health Facilitator continues to chair a multi-agency group looking at how Annual Health checks are run across the county for people with a learning disability; the work of this group has included introducing a pre-health check questionnaire, which is in line with clinical recording systems used by most GPs across the county, as well promoting access to the learning disability register and ensuring that people are invited to / attend for their health checks. Through this group we have also worked closely with the ICB to support surgeries over the past few years who have been struggling to complete their health checks and work conducted by a specialist learning disability nurse to facilitate this has had a big impact. Clinicians from the GHC learning disability service are actively involved in the LeDeR review process and findings from these reviews produce learning for all involved in the care of people with learning disabilities; local and national learning is shared across

our service and more widely. In response to these findings, there is a continued focus on healthy lifestyles and healthy eating.

One of our biggest and most popular initiatives aimed at health inequalities that people will hopefully already be aware of is the Big Health Day, held every year at Plock Court in Gloucester, where health and social care providers (both statutory and voluntary) come together to offer over 120 information stalls alongside interactive and inclusive sports and other attractions. This year is the 18th Big Health Day event, and it took place on June 13th.

Guardian of Safe Working

The Trust has a Consultant and Guardian of Safe Working Hours who provides the Trust Board with quarterly reports about the Trust's performance on junior doctors' rotas and rest periods. These quarterly Board reports summarise all exception reports, work schedule reviews and rota gaps, and provide assurance on compliance with safe working hours by both the Trust and doctors in approved training programs. The purpose of the regular reports is to give assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of Service.

A summary of exception reporting and rota gaps for the year 1st April 2025 to 31st March 2026 is shown below.

Date	No. of reports	Resolutions
April 2025 to June 2025	12	1 payment ,11 were TOIL.
July 2025 to September 2025	9	Toil for all
October 2025 to December 2025	13	TOIL and compensatory rest for all except the breaches where payment was made in addition to fines
January 2026 to March 2026	18 (2 were later withdrawn)	TOIL for 7, payment for 5, 3 for ongoing monitoring, 1 incurred a fine (breach of rest period)

Equality, Diversity and Inclusion

Equality, diversity and inclusion is becoming more visible and embedded into everything we do as a Trust.

Our Trust's five-year focus sets out our ambition to create a Great Place To Work together. We are delivering this through our refreshed People Strategy which sets out how we will make this ambition real. Listening to our colleagues, resulting in four themes; "Great leadership and culture", "A workforce fit for the future", "A safe, inclusive and healthy workplace", and "Working differently, working together".

Our People Strategy continues to set out our pledge as an organisation to support our colleagues to be free from bullying or discrimination at work. Theme 3 of the People Strategy (Equity, Safety and Wellbeing) has resulted in an "Equity, Diversity, Inclusion and Access Implementation Plan" which sets out how we will link our EDIA work with the People and wider Trust strategies.

The 2025 Leadership and Culture Programme brought together existing and new strands of work that focussed on improving our culture, leadership and our determination to tackle racial and other forms of discrimination. The findings from the discovery phase of the this programme have been embedded into the People Strategy, as well as work and plans linked into other culture change work.

Our five diversity networks continue to grow and develop and have participated in a development review to support their growth and strategic direction, leading to a greater Board and decision maker influence.

Work is progressing though the Patient and Carer Race Equality Framework (PCREF) which is NHS England's mandatory anti racism framework to improve mental health services for people from diverse ethnic, racial, and cultural backgrounds and forms part of CQC inspections. Community events have shaped our position and ambition to becoming an anti-racist organisation where we are co-producing an anti-racism statement and commitment to reduce health inequalities for patients and carers where there is racial inequity.

Our 2025/26 Workforce Race and Disability Equality Standards data and action plans, and our Gender Pay Gap report, are published and the actions will align with the EDIA Implementation Plan, referenced above.

In 2025, we have been re-accredited for our Disability Confident Leader Status until August 2028, making strong links of this status with our Workforce Disability work and EDIA Implementation Plan.

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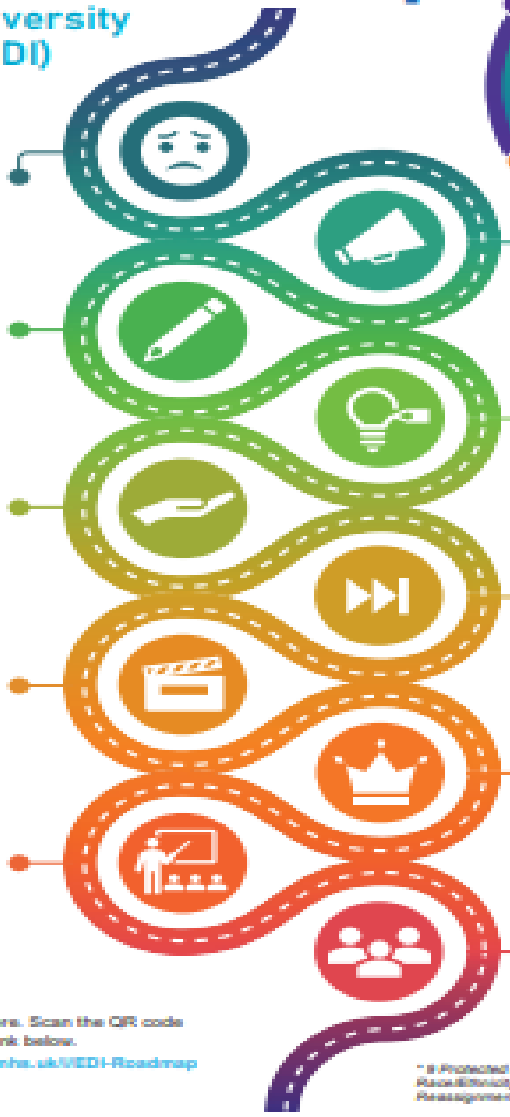
NHS Foundation Trust

Incident Roadmap

GHC Equality, Diversity and Inclusion (EDI) for colleagues

Tackling inequalities and abuse is everyone's business



Abuse
Any type of abuses at work is unacceptable and will be proactively managed.

Record
Your line manager should signpost options, support and help record details to help manage the incident response

Support
Your line manager will offer you support which might include supervision, Working Well, Wellbeing Line

Action
Your manager or service director may (A) warn the abuser, (B) consider the Patient / HR policy, (C) consider withdrawal of non-urgent care or serious disciplinary action

Learning
Build into Corporate and Local Inductions, GHC Handbook, EDI / Leadership Development Training

Report
If you experience abuse on the grounds of a protected characteristic (*see below), you should raise it immediately with your line manager(s) in the first instance

Options
If you feel unable to raise with your line manager(s), raise with HR, Staff Side, FTSU, or via 'Direct To Douglas'. We can do more to tackle abuse and support you when we know who you are

Approach
Your line manager or service director will speak to the perpetrator within one working day with support

Escalate
Line managers should escalate to the Dir. of HR & OD who will ensure (B) and/or (C) above is implemented with the appropriate Trust team(s)

Collaborate
Reflection with Networks, FTSU, HR, ASMS, stakeholders, Board and Senior Leaders

To find out more. Scan the QR code or follow the link below.
Intranet.ghc.nhs.uk/EDI-Roadmap

*9 Protected characteristics: Age, Gender, Disability, Race/Ethnicity, Religion/Belief, Sexual Orientation, Gender Reassignment, Pregnancy/Maternity, Marriage/Civil Partnership

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

Annex 1: Statements from our partners on the Quality Account

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Account for Gloucestershire Health and Care NHS Foundation Trust for 2025/26.

We recognise that the multi-year quality priorities continue to be substantial programmes of work that require sustained effort to fully embed across the organisation. It is positive to see evidence of progress across areas such as patient safety, end of life care and dementia support. In particular, we welcome the continued focus on personalised care, including ensuring that patients, families and carers are involved in decisions to the extent that they wish.

It was also very encouraging to read the overall positive results from 2025 survey of mental health services in England *and* the 2025/26 Staff Survey in what the Trust accepts as being a year of considerable change – organisational, operational and strategic. We note that the Trust identified four areas for focussed attention highlighted in the survey and that these will be addressed in GHC's new People Strategy.

Healthwatch Gloucestershire also welcomes the work undertaken to address health inequalities and improve access to services for underserved communities, including outreach vaccination programmes and targeted work with people with learning disabilities. This is important in ensuring that all voices across Gloucestershire are represented and acted upon. We encourage the Trust to continue strengthening how patient voice is consistently embedded across all services to ensure that feedback is not only collected but clearly demonstrates how it has influenced change ("you said, we did, so what").

It is noted that Berkeley House, GHC's inpatient ward for People with Learning Difficulties and Autism, is still under a Section 31 notice since a CQC Inspection in 2023 having been given a rating of 'Inadequate'. The service was re-inspected in July 2025 but the Trust is still awaiting a final report due to "an extended period of factual accuracy with CQC". The Trust must be eager to resolve this issue and so finalise plans for the future provision for those with Learning Difficulties and Autism.

Healthwatch Gloucestershire values the strong and collaborative relationship we have with the Trust. We appreciate the opportunities to share public feedback through our ongoing engagement, including representation at Council of Governors and involvement in PLACE visits. This enables us to bring real patient experiences into discussions about service improvement. For example, this year we were welcomed into the Integrated Urgent Care Service hub to meet staff and share public feedback. We were surprised that there was not much mentioned about the IUCS in this Quality Account given it is still quite a new and significant service for the Trust.

We congratulate Gloucestershire Health and Care NHS Foundation Trust on the progress made during 2025/26 and look forward to continuing to work together over the coming year to ensure that the voices of patients, carers and the wider community remain at the heart of service design, delivery and improvement.

Gloucestershire Health and Care NHS Foundation Trust Quality Account (Annual Report) 2025-26

As Chair of the Gloucestershire Health Overview and Scrutiny Committee, (HOSC), I welcome and commend this report.

The HOSC comprises county and district councillors who, as democratic representatives of communities across the whole of Gloucestershire, act as "critical friends" in supporting and challenging NHS commissioners and providers - notably the Health and Care Foundation Trust led by Douglas Blair. Douglas has rightly noted that continuous quality improvement depends on feedback from service users, and I would like to take this opportunity to thank Douglas and his staff, not only for engaging directly with HOSC through regular public meetings held at Shire Hall, Gloucester - which can be appropriately robust - but also, proactively, as and when "hot" issues arise between meetings. The HOSC is properly treated as a "stakeholder", speaking for the population with integrity, and ultimately, with goodwill towards the joint project to improve health provision in our county.

This is a time of great changes - in health commissioning, (radical ICB rearrangements), in giving a voice to the patient, (Healthwatch decommissioning), as well as in local government structures. Nevertheless, I am sure that the Gloucestershire Health Overview and Scrutiny Committee will continue to make an important contribution as a "critical friend" to the quality of improvements so impressively set out in this report.

Councillor Iain Dobie
Chair of Gloucestershire Health Overview and Scrutiny Committee (HOSC)

Annex 2: Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, Directors are required to take steps to satisfy themselves that:

- The content of the quality account meets the requirements set out in the NHS Foundation Trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2019/20.

- The content of the quality account is not inconsistent with internal and external sources of information including:

    1. Board minutes and papers for the period April 2025 to March 2026.
    2. Papers relating to quality reported to the Board over the period April 2025 - March 2026.
    3. Feedback from local Healthwatch organisations dated 17th June
    4. Feedback from overview and scrutiny committees dated 17th June
    5. The 2020 CQC national patient survey dated 2025.
    6. The 2020 national NHS staff survey dated March 2025.

- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality Account.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair **Date:**

Douglas Blair
Chief Executive **Date:**

Annex 3: Glossary

BMI	Body Mass Index
CCG	Clinical Commissioning Group
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
ECG	An electrocardiogram (ECG) is a test that is used to check the heart's rhythm and electrical activity.
GHC	Gloucestershire Health and Care NHS Foundation Trust
GRiP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
ICS	Integrated Care System. NHS Partnerships with local councils and others which take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
LeDer	Learning Disabilities Mortality Review. It is a national programme aimed at making improvements to the lives of people with learning disabilities
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every person that uses our services.
NHSI	NHSI is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.

MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant.
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PAM	Patient Activation Measure: This is a tool to measure a patient's skill, knowledge and confidence to manage their long-term conditions.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
ReSPECT	This is a plan created through a conversation between a patient and a healthcare professional which includes their personal priorities for care, particularly for those people who are likely to be nearing the end of their lives.
RiO	This is the name of the electronic system for recording patient care notes and related information within the Trust's mental health services.
ROMs	Routine Outcome Monitoring (ROMs)

SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Account, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
SJR	Structured judgement reviews. A process to effectively review the care received by patients who have died
SystmOne	This is the name of the electronic system for recording patient care notes and related information within the Trust’s physical health services.
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to contact us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Douglas Blair
Chief Executive
Gloucestershire Health & Care NHS Foundation Trust
Edward Jenner Court
1010 Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: GHCComms@ghc.nhs.uk

Other comments, concerns, complaints and compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly.
- Telephoning us on 0300 421 8313.
- Completing our Online Feedback Form at www.ghc.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites.
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient & Carer Experience Team at experience@ghc.nhs.uk
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative formats

If you would like a copy of this report in a different format, please telephone us on 0300 421 7146.

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AGENDA ITEM: 23/0726

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 JULY 2026**
COMMITTEE:	**APPOINTMENTS AND TERMS OF SERVICE COMMITTEE (ATOS) – 9 JULY 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Graham Russell, Trust Chair

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy
Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development
Nothing to report.

ASSURE: Inform the Board where positive assurance has been achieved
The Committee **received** the outcome of the annual review of Executive Director portfolios. The review had been undertaken in discussion with members of the Executive team, individually and collectively and considering recent performance review discussions. The Chief Executive informed the Committee that having undertaken the review, he was satisfied that the outcome accurately represented the current portfolios held by each Executive Director and that the portfolios were appropriately distributed across the team. Committee members welcomed this report. The Committee **received** the outcome of the 2025/26 annual performance reviews of the Chief Executive and Executive Directors following the appraisals carried out during May, June & July 2026. The appraisal process included 360-degree feedback and the exercise was undertaken based on the themes from the Leadership Competency Framework from direct reports and a selection of NEDs. The reports also included the objectives agreed with the Chief Executive and Executive Directors for 2026/27. The Committee thanked colleagues for carrying out such a thorough process, and for providing very helpful summaries for consideration. The ATOS Committee wished to echo the sentiments from the appraisal outcomes and expressed their thanks to the Executive Team for their hard work and achievements over the past year.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **noted** the portfolio change of digital and Business Intelligence which would move into Rosanna James' portfolio, effective from 15th June. The Committee therefore **endorsed** a new job title of Director of Improvement Partnerships & Digital. In line with the newly published People Strategy, the Committee also supported the renaming of Neil Savage's role to Director of People (formerly Director of HR&OD).

The Committee **received** and **approved** its revised Terms of Reference, which had been updated slightly to reflect a change in job titles.

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

Nothing to report.

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

- Chief Executive and Executive Director Remuneration (in line with the VSM Pay Framework)
- Chief Executive Performance
- Committee Workplan
- Executive Directors Performance
- Review of Executive Directors Portfolios
- Terms of Reference Review

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 30 July 2026**
COMMITTEE:	**MHLS COMMITTEE – 15 JULY 2026**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, Chair of Committee

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

The Committee was informed about the new Supreme Court judgement in the Attorney General for Northern Ireland (AGNI) case, resulting in changes to Deprivation of Liberty Safeguards (DoLS) and the training and practice implications. It was **noted** that information is available on the Trust intranet.

It was reported that a higher proportion of patients from ethnic minorities were detained on Community Treatment Orders (CTOs). This is in keeping with the national picture. It was also **noted** that a significant number of patients still had unknown ethnicity recorded.

The Committee received the Mental Health Act Managers (MHAM) Forum update and was informed of concerns raised by 'MHA Managers' relating to the introduction of new arrangements for the preparation of Social Circumstances Reports. The Committee **noted** concerns that reports may be completed by practitioners with limited direct knowledge of the individual concerned and that the new process could result in delays in report completion.

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

It was **noted** that Section 2 detentions had reduced by approximately 35%, Section 3 detentions had increased by 13%, and overall admissions under Sections 2 and 3 combined had reduced by approximately 12%.

The Committee **noted** that the new MHA Programme Board is in the process of being set up and the first workshop is scheduled for August 2026.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the AMHP Report for quarter one and **noted** improvements in transport delays, with one delay reported compared to three in the previous quarter.

The Committee received the CQC and Mental Health Act Round Up and was informed that the recent inspection of Chestnut Ward had one action which related to personalised care plans.

The Committee received the Mental Health Act Activity 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 Corporate Risk Report, which provided information and assurance in respect of risk 180 – MHA Changes for which the committee has the Lead oversight responsibility for. It was confirmed there were no further developments and the Committee would be updated as the national programme progressed.

The Committee queried whether the changes in DoLS legislation should be added to the risk register. This would be reviewed further.

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

The Committee was informed of the positive inspection of Willow Ward, in which no actions were received, and the team was congratulated by the CQC.

The Committee received the MHA Information Policy audit which showed continued high compliance for inpatients, with 98% having a recorded provision of rights and 96% meeting the policy timescales.

The Committee **noted** that there had been a significant improvement for CTO patients, with 100% having a record that rights had been provided and 71% meeting the required review timescales.

The Committee congratulated Jane Higgins and her team on her work achieved in progressing MCA level one and two training.

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

The following items were received and noted by the Committee:

- Mental Health Act Managers' Forum minutes and update
- Mental Health Legislation Operational Group Update