

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 1st October 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	01/1026	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1026	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/1026	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/1026	Minutes of the meeting held on 30th July 2026	Approve	Paper	Chair
	05/1026	Matters arising and Action Log	Assurance	Paper	Chair
10:35	06/1026	Questions from the Public	Assurance	Verbal	Chair
10:40	07/1026	Report from the Chair	Assurance	Paper	Chair
10:50	08/1026	Report from Chief Executive	Assurance	Paper	CEO
STRATEGIC					
11:00	09/1026	Quality Strategy	Approve	Paper	DoNTQ
BREAK – 11.10am (10 minutes)					
PERFORMANCE AND PATIENT EXPERIENCE					
11:20	10/1026	Integrated Dashboard	Assurance	Paper	DoDIP
11:35	11/1026	Finance Report	Assurance	Paper	DoF
11:50	12/1026	Quality Report	Assurance	Paper	DoNTQ
12:05	13/1026	Medical Staffing Assurance: 13.1 - Medical Appraisal Annual Report 13.2 - Guardian of Safe Working Report	Endorse Assurance	Paper	MD
GOVERNANCE					
TO NOTE	14/1026	Council of Governor Minutes – 16 July 2026	Information	Paper	DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:40	15/1026	Audit & Assurance Committee (06 Aug)	Information	Paper	Audit Chair
	16/1026	Great Place to Work Committee (25 Aug)	Information	Paper	GPTW Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
	17/1026	Resources Committee (27 Aug) - SW Provider Collaborative - Seasonal Planning Board Assurance Statement	Information	Paper	Res. Chair
	18/1026	Charitable Funds Committee (09 Sept)	Information	Paper	CF Chair
	19/1026	Quality Committee (14 Sept) - Annual IPC Report - Controlled Drugs Assurance Statement	Information	Paper	Quality Chair
CLOSING BUSINESS					
13:00	20/1026	Any other business	Note	Verbal	Chair
	21/1026	Dates of future Board Meetings 2026 Thursday, 26th November	Note	Verbal	All

MINUTES OF THE TRUST BOARD MEETING

Thursday, 30 July 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 longh, Non-Executive Director
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Non-Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Amjad Uppal, Medical Director

IN ATTENDANCE:

Kevin Adams, Head of Estates & Facilities – item 9
Katherine Archer, Director of Finance
Josh Bond, Digital Specialist Inclusion Lead - Item 3
Helen Child, Director of Corporate Governance
Sarah Denley Dufton, CAMHS Outreach - item 3
Jane Hannon, Deputy Chief Operating Officer
Katie Hartwright, Transition Director
Claire Kenny, Board Committee & Membership Officer
Dominika Lipska-Rosecka, Service Development Manager
Bren McInerney, Member of the Public
Kate Nelmes, Head of Communications
Sue Nicholls, The Value Circle (observing)
Tracey Thomas, Associate Non-Executive Director (*MS Teams*)
Maria – item 3

1. WELCOME AND APOLOGIES

- 1.1 The Chair welcomed everyone to the meeting and apologies were noted and received from Cathia Jenainati and Anna Hilditch.

2. DECLARATIONS OF INTEREST

- 2.1 Nothing declared.

3. SERVICE USER STORY PRESENTATION

- 3.1 The Board welcomed Maria to the meeting, who was joined by Josh Bond and Sarah Denley-Dufton, and she spoke about her experience with Children and Mental Health Services (CAMHS) Outreach.

- 3.2 Maria shared that she first came in to contact with CAMHS Outreach during a hospital admission due to a deteriorating eating disorder when she was 16 years old. Following her discharge from hospital, Maria explained how she worked regularly with two CAMHS Outreach clinicians, and when her eating disorder worsened, she was admitted to Marlborough House in Swindon, where she continued to receive support from the CAMHS Outreach team.
- 3.3 Maria continued receiving support from the CAMHS Outreach team and spoke about the transition to adult mental health services once she had turned 18 years old.
- 3.4 The Board heard how Maria had an Adult Recovery Psychiatrist who was involved in her Care Programme Approach meetings and following her discharge, a joint meeting took place, which involved her CAMHS therapist and a clinician from the Tewkesbury Recovery Team.
- 3.5 Maria described her transition process from children's mental health services to adult mental health services, describing what she felt went well. Maria shared that there was no abrupt ending to the relationship which she had built with CAMHS clinicians and that she was able to say goodbye. Maria also explained that the joint meetings at the beginning of her transition were welcomed and helped ease her anxiety, as the transition was done gradually. Maria also felt involved in the process and that her worries were listened to and acknowledged.
- 3.6 Maria reflected further on her experience, and shared areas of the transition which she felt could be improved. She stated that having a clearer explanation of how adult services work would be helpful and suggested a leaflet which explained the differences to the services and what to expect.
- 3.7 Maria also suggested help to build advocacy skills would be welcomed, as the ability to self-advocate does not suddenly happen on your 18th birthday. She spoke about having help to book appointments and having a transition co-ordinator that you are able to contact for an extended period after transitioning to assist with queries, and to also offer support to parents of patients with the transition process.
- 3.8 Maria suggested a transition passport would be useful, which would be personalised for each person.
- 3.9 Amjad Uppal commended Maria's ideas to improve the service and asked if she would like to be involved with the creation of a transition passport. Maria welcomed this suggestion and was keen to be involved in the project.
- 3.10 The Chair spoke about how the transition from children's to adults services could be improved further and suggested a member of the Board attend one of the bi-monthly meetings held by the transition team to gain further knowledge of the service.
- 3.11 The Board thanked Maria for sharing her story and for her insightful suggestions to further improve the service and wished her well for the future.

4. MINUTES OF THE PREVIOUS BOARD MEETING

- 4.1 The Board received the minutes from the previous Board meeting held on 28 May 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 action from the previous meeting was now complete.

6. QUESTIONS FROM THE PUBLIC

- 6.1 None received.

7. REPORT FROM THE CHAIR

- 7.1 The Board received the Report from the Chair, which provided an update on the main activities of the Chair and Non-Executive Directors (NEDs), Council of Governor discussions and Board development as part of the Board's commitment to public accountability and Trust values.
- 7.2 The Chair reported on recent visits and engagement with community and partner organisations and highlighted that he had the pleasure of supporting and participating in the Big Health Day which took place 11 June. The Chair thanked Dominika Lipska-Rosecka for her leadership in the Big Health Day.
- 7.3 Dominika Lipska-Rosecka shared that it was a good opportunity for networking and reported that 1620 people had attended the event.
- 7.4 The Board **noted** the report and the assurance provided.

8. REPORT FROM CHIEF EXECUTIVE & EXECUTIVE TEAM

- 8.1 The Board received the Report from the Chief Executive Officer (CEO) and Executive Team, which provided an update on significant Trust issues not covered elsewhere.
- 8.2 The CEO Overview was **noted**, which set out key financial, quality and performance headlines.
- 8.3 Douglas Blair highlighted the outcomes of the National Audit of Care at the End of Life (NACEL), and reported that the Trust's performance had exceeded both peer and national averages across many key measures, including pain management, communication, anticipatory prescribing, emotional support, and overall patient and family experience; and that overall, the audit demonstrated a good quality of end-of-life care across the Trust, noting that where further improvement was identified there were improvement plans to ensure that patients and families receive high-quality, compassionate care at the end of life. Follow up monitoring would take place via the Quality Assurance Group (QAG) and Quality Committee.

- 8.4 The Board **noted** that the Trust had 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. Douglas Blair reported that the Trust had reviewed its arrangements to ensure that deceased patients continued to be protected from harm and treated with dignity following death, noting that the Trust does not have a mortuary. Douglas Blair informed the Board that a statement would be submitted on behalf of the Board, stating that the Trust was able to provide assurance that the recommendations from the Fuller inquiry were met.
- 8.5 Douglas Blair highlighted the update provided on the delegated responsibilities to Gloucestershire County Council (GCC) and thanked the colleagues who would be transitioning to GCC for their service whilst working for the Trust.
- 8.6 The Board **noted** the update provided on the Organisational Redesign and **noted** that the new Service Group structure commenced 1st July 2026 and that the new Service Group Directors had begun their new roles.
- 8.7 The update on the Cirencester Redevelopment Programme was highlighted, which included an overview of the activities being undertaken, which included four strands of work; renovate, redevelop, reprovision and renew. The Board **noted** that an Assurance Group had been established and this would have oversight of the programme and was chaired by the Director of Finance.
- 8.8 Douglas Blair informed the Board that the Gloucestershire Provider Partnership (GPP) had now moved into its mobilisation phase, with recruitment underway for four senior roles, jointly funded by all partners. Governance structures were being agreed with stakeholders outside the immediate partnership. It was reported that the Integrated Care Board (ICB) had produced a baseline dataset and dashboard linked to the Johns Hopkins Population Health model, and Data Protection Impact Assessments would be signed later in the month.
- 8.9 In response, Nicola de longh welcomed the progress with GPP and suggested the provider partnership be a topic for future Board session.
- 8.10 The Board **noted** the report.

9. ESTATES & FACILITIES STRATEGY

- 9.1 The Board welcomed Kevin Adams to the meeting who shared the Estates and Facilities Management Strategy.
- 9.2 The Board was informed that amendments had been made to the strategy, following feedback received at the May Trust Board meeting and from stakeholders across the Trust. It was **noted** that the version presented would be subject to design amendments before finalisation.
- 9.3 Kevin Adams informed the Board that stakeholder feedback had been supportive of the four strategic themes:
- Resource Optimisation

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

- 9.4 In response, Nicola de longh asked on which areas the Trust needed to focus further to ensure successful delivery of the strategy. Kevin Adams shared that more work needed to be done on culture relating to structure change and behaviours, and also space utilisation across the Trust. This would be reported through to the Resources Committee as part of strategy progress reports.
- 9.5 In response to a question from Steve Alvis, Kevin Adams reported that the Estates and Facilities Team were mindful of the Green Plan in regard to waste management and was doing further work on the frequency of waste collections, working closely with colleagues to improve waste contracts.
- 9.6 Sandra Betney referred to the waste benchmarking data and reported that the Trust was benchmarked as a Mental Health Trust, and not Community, which did not take into account that the majority of waste is generated by community hospitals.
- 9.7 The Board **noted** the amendments relating to feedback received since the May Trust Board meeting and **approved** the strategy.

10. FINANCE REPORT

- 10.1 The Board received the Finance Report, which provided an update on the financial position of the Trust for the period ending 30 June 2026.
- 10.2 Sandra Betney informed the Board that the final accounts for 2025/26 were submitted on 25 June 2026, and the year-end performance position for the Trust was a surplus of £2.013m.
- 10.3 The Board was informed that the annual plan for 2026/27 projected a surplus of £53k and at month three, the Trust had reported a surplus of £32k. It was **noted** that this was slightly better than plan.
- 10.4 Sandra Betney informed the Board that the Trust had submitted a revised plan to NHS England (NHSE), to reflect the pay award and approved development funding.
- 10.5 The Board was informed that the 2026/27 Capital Plan was £16.208m, with £2.895m of disposals leaving a net £13.313m programme; and after disposals the net spend to month three was £1.043m against a budget of £1.226m.
- 10.6 Sandra Betney informed the Board that NHSE had developed 28 metrics to identify emerging financial risks and reported that there were six metrics in exception at month two. These were detailed within the report.
- 10.7 It was **noted** that the Trust was at level two intervention in regard to the NHSE Early Warning System. At level three enhanced monitoring and support would be triggered.

- 10.8 Bilal Lala referred to the Trust's cash position and asked what level of confidence the Trust had that outstanding cash from Gloucestershire County Council (GCC) would be recovered. Sandra Betney shared that assurance was provided from GCC that payments would be processed, but there was still a large amount outstanding.
- 10.9 The Board **noted** the month three position.

11. QUALITY DASHBOARD REPORT MONTH 3

- 11.1 The Board received the Quality Dashboard Report – Month three, which provided a summary assurance update on progress and achievement of indicators across Trust Physical Health, Mental Health, and Learning Disability services.
- 11.2 Nicola Hazle alerted the Board that there was partial assurance in relation to the position for the staffing levels at mental health inpatient services, particularly Wotton Lawn Hospital. It was reported that fill rates above 100% were indicative of higher levels of clinical acuity and whilst there was assurance that no patient safety incidents were directly attributable to staffing shortfalls, the known gaps in leadership and workforce have led to an increased requirement in bank and agency staffing to ensure safe staffing levels are achieved.
- 11.3 The Board was informed that only 46% of complaints had been closed in three months, against a target of 50%. It was noted that this was the first time that the key performance indicator had not been achieved. It was further reported that 8% of complaints had not been closed within 6-12 months and that this was almost entirely due to capacity issues within the Patient Carer Experience Team (PCET) and Operations teams in responding to the total volume of activity, where enquiries were also up significantly in comparison to 2025/26 figures.
- 11.4 Nicola Hazle referred to the advise section of the report, and reported that during June, early incident monitoring by the Patient Safety Team and Operations had 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. The Board was informed that colleagues rapidly met to address this, 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.
- 11.5 Nicola Hazle reported that in June, the Eating Disorders team reported eight incidents where individuals had been assessed as having physical observations outside of expected parameters and had used this category to document that they have escalated for further medical assessment. The Board **noted** that a specific sub-category had been requested to be added onto Datix to ensure consistency of reporting for these incidents.
- 11.6 The Board was informed that two NED visits had been undertaken in April and May and summary slides for each visit were included in the report. Nicola Hazle shared

that visits to both Tewkesbury Community Hospital and Stroud Crisis Team had identified positive team cultures and commitment to delivering good quality patient care. It was also identified that further staff engagement about changes in structures and digital innovation may be beneficial.

- 11.7 Nicola Hazle referred to an inquest in June 2026 and reported that the Coroner had highlighted the importance of being able to demonstrate that learning arising from a Patient Safety Incident Investigation (PSII) had been acted upon, with recommendations implemented, embedded into practice, and reviewed for effectiveness. The Board **noted** that the Coroner was assured by the evidence provided of service improvements and concluded that a Prevention of Future Deaths Report was not required.
- 11.8 The Board **noted** that the Trust was in ongoing communication with CQC regarding the Berkeley House inspection report and that the Trust continued to submit monthly data under regulation 31 with a monthly Enhanced Oversight Group with the Integrated Care Board monitoring discharge pathways.
- 11.9 Nicola Hazle informed the Board that there had been one case of C.difficile on Coln Ward at Cirencester Hospital, and reported that effective management and no nosocomial transmission provided good assurance that Infection Prevention and Control policies were being adhered to.
- 11.10 Helen Blanchard referred to the reduction in the number of positive Friends and Family Test (FFT) responses for the month of June and requested further analysis of this. Nicola Hazle advised that additional narrative would be included in the next dashboard report received at the Quality Committee.
- 11.11 Steve Alvis referred to the new system for Integrated Urgent Care Service (IUCS) complaints and asked what was being done to support the Patient and Carer Experience Team (PCET), with the increased workload. Nicola Hazle reported that the demand was recognised across the Trust and that the IUCS pilot, launched 1 April was beginning to have some traction. Douglas Blair **noted** that the types of enquiries received were often complicated and could involve multiple contacts.
- 11.12 Steve Alvis referred to the Outreach Vaccination Service tender which had been awarded to the Trust and asked about the implications of this. Nicola Hazle reported that discussions had taken place about putting some of the immunisation teams together to align closer with the children's immunisation team. The Board was informed that the Nursing, Therapies and Quality (NTQ) directorate would lead on vaccinations for corporate directorates.
- 11.13 Vicci Livingstone-Thompson referred to the increase in MMR (measles, mumps and rubella) cases and asked if this was unusual and whether it could be an early indicator of a challenge in the winter period. Nicola Hazle reported that the Infection, Prevention and Control (IPC) team would use the data as an early warning and would triangulate with national data.

- 11.14 Bilal Lala raised concern with the reported trendlines for sexual safety, moderate harm and self-harm; and asked what was driving the trends and what was being done to address them.
- 11.15 Amjad Uppal shared that colleagues were getting better at reporting sexual behaviour, and that this may contribute to the increase in the number of incidents reported.
- 11.16 In regard to moderate harm, Nicola Hazle reported that this was indicative of the level of clinical complexity, as well as a spike in the number of people in Community Hospitals.
- 11.17 Nicola Hazle shared that the increase in self-harm was mainly in Wotton Lawn Hospital and more work was being undertaken to address this. Further analysis of trends would be included in future dashboard reports.
- 11.18 The Board **received, discussed,** and took **assurance** from the Quality Dashboard Report.

12. QUALITY & PERFORMANCE DASHBOARD REPORT – MONTH 3

- 12.1 The Board received the Quality and Performance Dashboard Report for month three, which provided a high-level view of performance and quality indicators in exception across the organisation.
- 12.2 The Board was informed that the Business Intelligence Service has moved to the Improvement & Partnerships portfolio under the leadership of Rosanna James.
- 12.3 It was reported that the Trust was still awaiting the technical guidance for the NHSE Oversight Framework (NOF) to understand definitions and methodology for 2026/27. The Board noted that KPIs that apply to the Trust would be developed and introduced into the dashboard once the guidance had been received.
- 12.4 Rosanna James reported that indicators which were expected to be part of the NOF were indicated in purple within the dashboard report for illustration only.
- 12.5 Rosanna James requested the Board's approval 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). It was **noted** that this change had been previously endorsed by the Safer Staffing monthly Assurance Group and BIMG.
- 12.6 The Board **agreed** the above proposal.
- 12.7 Sarah Branton referred to the applaud section of the report and highlighted the significant sustained improvements seen in indicator L03 – CYPS (Children and Young People's Service) Core CAMHS appointments within four weeks.

- 12.8 Indicators N37 – Community PH: Community Services Waiting List % seen within 52 weeks, and indicator N38 – Community PH: Community Services Waiting List % seen within 52 weeks were highlighted to the Board within the advise section of the report and the narrative was **noted**.
- 12.9 Sarah Branton referred to indicator N67 – IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe and reported that this was being closely monitored.
- 12.10 The Board **noted** that the Health Visiting service had met all of their thresholds for the period, and that this was the first time that this had been achieved.
- 12.11 Steve Alvis referred to indicator B13 – Percentage of patients waiting less than 6 weeks from referral for a diagnostic test (Echocardiograms) which had not achieved its performance threshold; and suggested requesting commissioners for other providers. Sarah Branton agreed.
- 12.12 The Board extended its gratitude to all of the teams and services included in the applaud section of the report for their achievements during the reporting period.
- 12.13 The Board **noted** the Quality and Performance Dashboard Report for June 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.

13. GUARDIAN OF SAFE WORKING HOURS Q4

- 13.1 The Board received the Guardian of Safe Working Hours (GoSWH) Report for quarter four, which provided 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.
- 13.2 The Board **noted** the report from the Guardian of Safe working Hours and **noted** that ongoing issues were being addressed.

14. WORKING TOGETHER ANNUAL REPORT 2025/26

- 14.1 The Board received the Working Together Annual Report 2025/26, which provided an overview of progress made in delivering the Working Together approach during 2025-26, and demonstrated how involvement, co-production and partnership working have contributed to service improvement and the delivery of the Trust's strategic priorities.
- 14.2 Rosanna James highlighted that a total of 125 project-based involvement opportunities had been delivered across the Trust in 2025/26 and reported that overall, Experts by Experience (EbyE) had contributed to more than 375 involvement opportunities during the year.

- 14.3 Rosanna James reported that a new digital platform had been introduced for EbyE, which made it easier for colleagues to identify and involve people with relevant experience. This had contributed to the increase in activities for almost every month of the reporting period when compared to the previous year.
- 14.4 Rosanna James highlighted the work achieved with the contribution of Youth Voices and noted the Tree of Life Project, which focused on how to support young people with their first Children and Adolescent Mental Health (CAMHS) appointments.
- 14.5 The priorities for 2026/27 were highlighted, which were detailed in the report across seven key themes.
- 14.6 In response, Vicci Livingstone-Thompson referred the small number of EbyE within Learning Disability (LD) services and commented that this was a huge, missed opportunity. Rosanna James explained that work was focused in a different way with LD services and agreed to discuss further with Vicci Livingstone-Thompson outside of the meeting.
- 14.7 The Board **noted** the progress made in delivering the Working Together activities, including achievements in involvements, co-production and partnership working. It was noted that future iterations of the report would include resource requirements.
- 14.8 The Board **endorsed** the Working Together Annual Report 2025/26.

15. MODERN SLAVERY STATEMENT – ANNUAL RECONFIRMATION

- 15.1 The Board received the Trust's proposed statement on Modern Slavery and **noted** the ongoing work taking place across the Trust to ensure that slavery and human trafficking was not taking place in any of its supply chains, and in any part of its own business.
- 15.2 The Board **approved** the statement for 2025/26 and noted that this had been received and endorsed at the June Great Place to Work (GPTW) Committee.

16. AUDIT & ASSURANCE COMMITTEE ANNUAL REPORT

- 16.1 The Board received the Audit and Assurance Committee Annual Report, which provided 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 provided an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement.
- 16.2 The Board **noted** that no issues had been highlighted as areas of concern, and that the Committee had operated in line with its terms of reference to meet the functions delegated to it by the Board.
- 16.3 The Board **noted** the Annual Report 2025/26.

17. COUNCIL OF GOVERNOR MINUTES - 14 MAY 2026

- 17.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 14 May 2026.

18. BOARD COMMITTEE SUMMARY REPORTS

- 18.1 The Board **received** and **noted** the following summary reports for information and assurance.
- Charitable Funds Committee (10 June 2026)
 - Audit & Assurance Committee (18 June 2026)
 - Resources Committee (25 May 2026)
 - Great Place to Work Committee (30 June 2026)
 - Quality Committee (7 July 2026)
 - Appointments and Terms of Service Committee (ATOS) (9 July 2026)
 - Mental Health Legislation Scrutiny Committee (15 July 2026)

19. ANY OTHER BUSINESS

- 19.1 The Chair **noted** that this was both Sandra Betney and Sarah Branton's last Board meeting and thanked them both for their work and commitment to the Trust.

20. DATE OF NEXT MEETING

- 20.1 The next meeting would take place on **Thursday, 1 October 2026**

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 1st October 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
30 July 2026		No new or unplanned actions identified				

QUESTIONS FROM THE PUBLIC

REPORT TO: TRUST BOARD **PUBLIC SESSION – 1st OCTOBER 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



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

Where has this issue been discussed before?
--

This is a regular update report for the Trust Board.
--

Appendices:	Appendix 1 Non-Executive Director – Summary of Activity – July – August 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 3rd September, 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 11th August, the Chief Executive and I met with **Alex McIntyre, MP for Gloucester** and **Dr Simon Opher, MP for Stroud**. At the meeting we discussed constituent matters of interest.

Always improving

- Along with colleagues from the Integrated Care Board and Regional Chairs, I was invited to discuss the findings of the **Amos and Ockenden reviews** on 10th August. The landmark June 2026 investigations exposed widespread safety failures, cultural toxicity and systematic issues across England's NHS maternity and neonatal services. Both reports highlighted weak triage systems, racial and socioeconomic inequalities in care, defensive hospital cultures and a failure to properly support or listen to women.

Making a difference

- In recognition of the hard work, dedication and 'making a difference' by individuals and services within the Trust, it was a real privilege to visit the **Complex Psychological Interventions South Team** who are based at **St Weavers Croft** in **Stroud** on 19th August to present their '**Making a Difference**' award.



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

3. BOARD UPDATES

- Further to the update I provided in my July report, following relevant Fit and Proper Person checks, I am delighted to advise Tracey Thomas commenced in post on 1st September as our new **Associate Non-Executive Director**. I am sure you will join me in welcoming Tracey to the Trust.
- On 18th November, **Dr Steve Alvis'** term as **Non-Executive Director** comes to an end. During his tenure, Steve has been a valued and committed Non-Executive Director. I would like to take this opportunity to thank Steve for his contribution to the Trust over the years and to wish him all the very best for the future.
- A **Provider Capability Assessment (PCA) Board Seminar** led by Helen Child, Director of Corporate Governance and Trust Secretary took place on 3rd September. At the seminar, the Board agreed the approach for submission of the PCA to NHS England, with the final submission to be received for sign off at our private Board session in October.
- Ahead of the **Board Development Strategic Away Day**, which is scheduled to take place during October, I met virtually with Amy Hart from All Mighty You. Amy

will deliver day one of the Away Day and it was an opportunity for Amy and I to discuss thoughts and outcomes for the day.

- The **Trust's AGM** took place on 17th September. This was a virtual event which provided a review of last year and an account of our quality and financial position as well as a review by our Lead Governor, Chris Witham. There was an opportunity to ask questions of the Council of Governors and the Board.
- The **Non-Executive Directors** and I continue to meet regularly as a group. NED meetings are helpful check-in sessions as well as enabling us to consider future plans, reflect on any changes we need to put in place to support the Executive and to continuously improve the way the Trust operates.
- An extraordinary meeting of the **Appointment and Terms of Service Committee** took place on 1st September.
- As advised in my previous report, the Trust commissioned an **independent developmental Well-Led Review** in line with the Care Quality Commission (CQC) Well-Led framework. The review was undertaken by external organisation **TheValueCircle** and formed part of our ongoing commitment to continuous improvement, transparency and strong leadership and governance.

The review took place over the summer period, and the findings will be presented at Trust Board on 1st October. The report 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 18th August an in-person **Board Development session** took place which focussed on our **Quality Strategy**, led by Sarah Birmingham, Chief Allied Health Professional and **Board and Committee Assurance**, led by Helen Child, Director of Corporate Governance and Trust Secretary. The purpose of the event was to understand how our Quality Strategy supports delivery of our Trust ambition, enabling high-quality care. Following the Good Governance Institute (GGI) **Board and Committee Assurance Effectiveness Review**, which took place during December 2025, the Board revisited the GGI report, mapped assurance flows to committees and to Board, refined the committee referrals processes and understood the Committee role and remit in relation risk management.

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.
- On 16th July we held virtually our **Council of Governors** meeting. At the meeting, Governors received updates on the Trust Strategy Development, Board Committees and key issues and a presentation on 'The Future of Governors: Evolve, Adapt or Replace?'. Our next Council of Governors meeting will take place in person on 19th November.

- Our **programme of visits to sites for Trust Governors** continues to progress. 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 July to 31st August 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 July – 31st August 2026

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	• Council of Governors Development Session • Informal gathering for the retiring Director of Finance • Meeting with Amy Hart ahead of the October Strategic Board Development Session • Non-Executive Director Informal Meeting • Risk discussion with Non-Executive Director colleagues • TheValueCircle Well-Led Review Interview • Tour of FutureSim, Oxstalls Campus	• Appointments and Terms of Service Committee • Audit and Assurance Committee • Board Development: Well-Led Review Preparation & Foundational Strategies Development • Board Development: Well-Led Review Preparation & Foundational Strategies Development • Board Seminar: Quality Strategy and Board Assurance Routes • Mental Health Legislation Scrutiny Committee • Quality Committee • Resources Committee
Nicola de longh	• Catch up meeting with Chief Executive • Meeting with Amy Hart ahead of the October Strategic Board Development Session • Meeting with Chair of Gloucestershire Hospitals NHSFT, Deborah Evans • Meeting with Starfish • Meeting with TheValueCircle regarding Well-Led Review • Non-Executive Director Informal Meeting	• Appointments and Terms of Service Committee • Board Development: Well-Led Review Preparation & Foundational Strategies Development • Board Seminar: Quality Strategy and Board Assurance Routes • Council of Governors Development Session • Great Place to Work Committee • Resources Committee • Trust Board: Public and Private
Vicci Livingstone-Thompson	• Associate Non-Executive Director Shortlisting • Council of Governors Development Session • Introduction meeting with Helen Blanchard	• Appointments and Terms of Service Committee

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Meeting with Amy Hart ahead of the October Strategic Board Development Session • Non-Executive Director Informal Meeting • TheValueCircle Well-Led Review Interview	• Board Development: Quality Strategy and Board Assurance Routes • Board Development: Well-Led Review Preparation & Foundational Strategies Development • Quality Committee
Bilal Lala	• Catch-up with the Director of Corporate Governance and Trust Secretary • Council of Governors Development Session • Pre-Audit and Assurance Committee Meeting with the Risk Manager • Introduction meeting with Helen Blanchard • Associate Non-Executive Director Shortlisting • Associate Non-Executive Director Interview Panel • 1:1 with Counter Fraud Lead in advance of Audit and Assurance Committee • Introduction meeting and 1:1 with the Director of Finance in advance of Audit and Assurance Committee • 1:1 with Debbie Forster in advance of Audit and Assurance Committee • 1:1 with the Deputy Chair of Audit and Assurance Committee in advance of the Committee • 1:1 with the Director of Corporate Governance and Trust Secretary • Audit and Assurance Committee Assurance Report Meeting	• Appointments and Terms of Service Committee • Audit and Assurance Committee • Board Development: Quality Strategy and Board Assurance Routes • Board Development: Well-Led Review Preparation & Foundational Strategies Development • Quality Committee • Trust Board: Public and Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	- Meeting with TheValueCircle regarding Well-Led Review - Meeting with Amy Hart ahead of the October Strategic Board Development Session	
Debbie Forster	- EFM Strategy Meeting with Director of Finance - Handover and introduction meeting with Chief Operating Officer and Deputy Chief Operating Officer - Meeting with Amy Hart ahead of the October Strategic Board Development Session - Meeting with Bilal Lala - Meeting with Helen Blanchard - Meeting with Karen Clements and the Associate Director Workforce Systems & Planning - Meeting with the Associate Director of Transformation - Meeting with the Director of Finance - Meeting with the Risk Manager - Non-Executive Director Informal Meeting - Risk discussion with Non-Executive Director colleagues - TheValueCircle Well-Led Review Interview - Women's Leadership Network	- Appointments and Terms of Service Committee - Audit and Assurance Meeting - Board Development: Quality Strategy and Board Assurance Routes - Board Development: Well-Led Review Preparation & Foundational Strategies Development - Great Place to Work Committee - Resources Committee - Trust Board: Public & Private
Karen Clements	- Council of Governors Development Session - Falls Advice Education Service 10 Year Anniversary - Meeting with Amy Hart ahead of the October Strategic Board Development Session - Meeting with Bilal Lala	- Appointments and Terms of Service Committee - Audit and Assurance Committee - Board Development: Quality Strategy and Board Assurance Routes

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Meeting with Debbie Forster and the Associate Director Workforce Systems & Planning • Meeting with Governor Tussie Myerson • Meeting with Helen Blanchard • Meeting with Neil Savage and the Deputy Director of HR & OD • Meeting with the Director of Digital, Improvement and Partnerships • Non-Executive Director Informal Meeting • Quality visit to Complex Emotional Needs Team • Risk discussion with Non-Executive Director colleagues • TheValueCircle Well-Led Review Interview • Visit to North Cotswold and Cirencester Hospital with Sir Geoffrey Clifton-Brown MP	• Board Development: Well-Led Review Preparation & Foundational Strategies Development • Great Place to Work Committee • Trust Board: Public and Private
Helen Blanchard	• Attendance at NHS Alliance Non-Executive Directors Event • Council of Governors Development Session • Discussion with the Director of Nursing, Therapies and Quality • Discussion with the Medical Director and Director of Nursing, Therapies and Quality • Introduction meeting with Bilal Lala • Introduction meeting with Debbie Forster • Introduction meeting with Karen Clements • Introduction meeting with the Chief Operating Officer • Introduction meeting with the Deputy Director of Business Intelligence	• Audit and Assurance Committee • Great Place to Work Committee • Trust Board: Public and Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	• Introduction meeting with the Director of Finance • Introduction meeting with Vicci Livingstone-Thompson • Introductory meeting with Rosi Shepherd, Chief Nurse, ICB • Meeting with Amy Hart ahead of the October Strategic Board Development Session • Meeting with BDO Internal Auditors • Meeting with the Director of Nursing, Therapies and Quality • Meeting with the Risk Manager • Objective Setting Meeting with the Trust Chair • Oliver McGowan Training • Risk discussion with Non-Executive Director colleagues • Risk Reporting meeting with the Director of Nursing Therapies and the Quality, Risk Manager and Director of Corporate Governance and Trust Secretary	

REPORT TO: TRUST BOARD **PUBLIC** SESSION – 1st October 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: Douglas Blair	Title: Chief Executive Officer
---	--

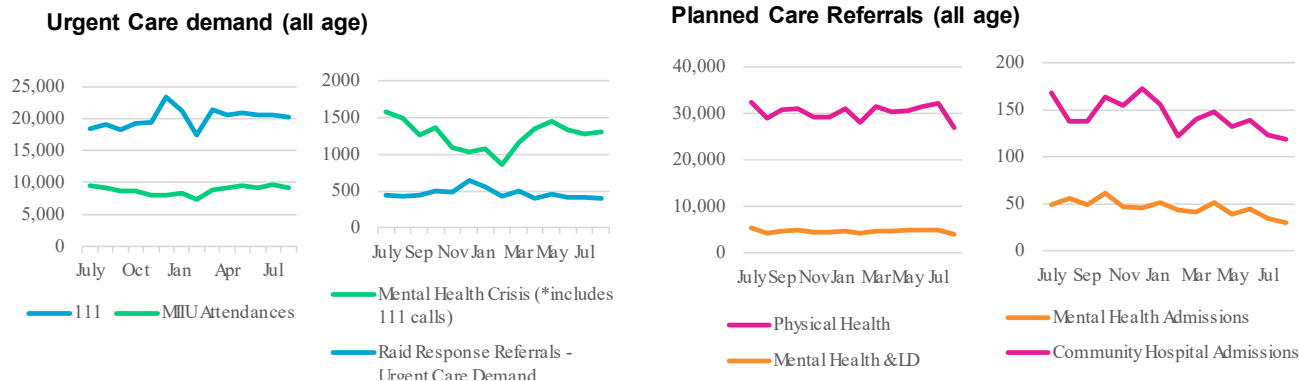
Strategic Update

Focus Areas	Update
 Connecting services in neighbourhoods	Final workshop with partners in Sep to gain alignment to frailty/neighbourhood model
 Children and young people	Proposals being developed for all age ADHD/Autism transformation programme to be discussed in October
 Community urgent care	Due diligence plan for transfer of virtual ward leadership to Gloucestershire Health and Care in 2027
 Inclusive healthcare	Community Promise (anchor institution activity) steering group to commence in October
 Partnerships with purpose	Gloucestershire Provider Partnership setting up in earnest with recruitment to senior programme roles.

Performance Indicators Overview

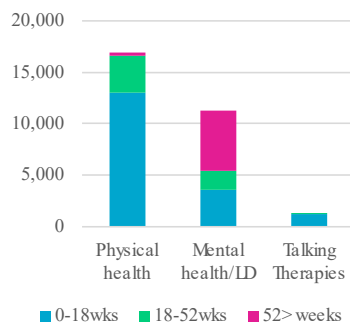
	 = in exception	Total
Strategy, leadership and planning		
Quality of Care		65
People and Culture		12
Access and delivery of services		107
Productivity and value for money		3
Financial performance and oversight		3

Service Demand Trends

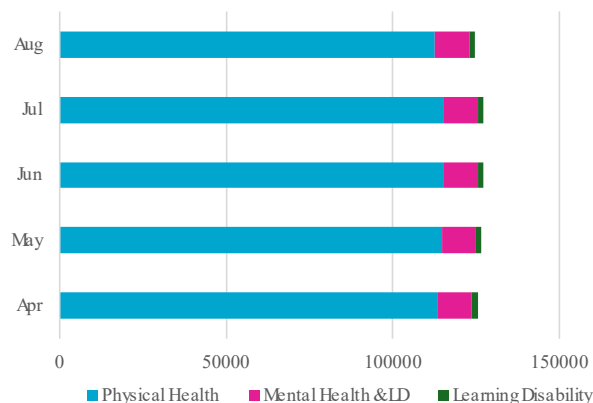


Service Capacity

Total Waiting for Treatment



Caseload



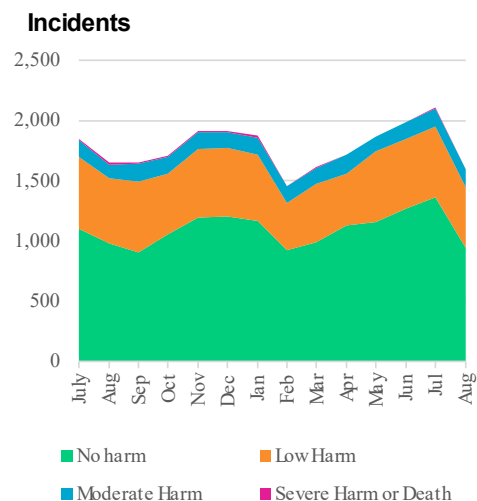
NHS Oversight Framework - 2026/27

	Q1	Q2	Q3	Q4
Score	2.34			
Segment	3			
Ranking	35/58			

Strategic Risks - Board Assurance Framework

	Target	Quarter 1
Quality standards	6	20
Demand & Capacity	9	12
Recruitment, retention and development	9	9
Inclusive culture	6	12
Relationships and partnership	6	9
Funding for transformation	12	9
Capacity for change	9	16
Cyber	8	16
Closed culture	8	16
Health inclusion	8	12
Strategic commissioning	9	12

Quality and experience headlines



Patient Feedback (July 26)

Overall Experience

92%

Very good or Good

Respect and Dignity

98%

Positive

Involvement in decisions

95%

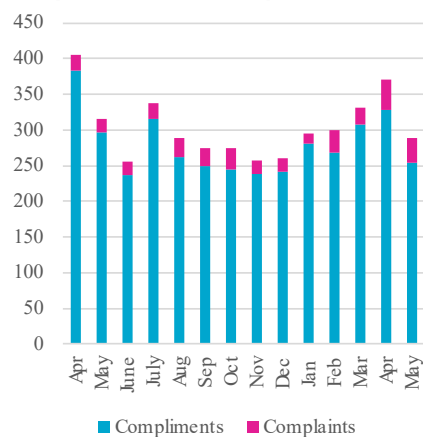
Positive

Safety and welfare

97%

Positive

Compliments and complaints

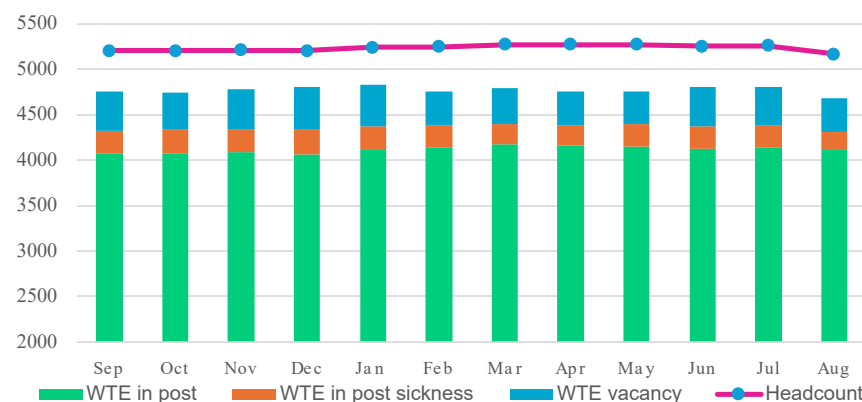


Finance headlines

Month 5 2026/27

Income & Expenditure Performance £0.049m surplus
Cost improvement savings of £7.629m
Capital expenditure £2.06m 35% of year mto date plan

Our people



Colleague voice: Pulse survey (Q1 26/27)

	Colleague Rating	Benchmark Average for Organisation Type
Recommend as a place to work	62%	47%
Happy with standard of care for friends & relatives	67%	56%

CHIEF EXECUTIVE SERVICE / TEAM VISITS AND EVENTS

Service Visits in August and September	• North Cotswolds Hospital, Moreton-in-Marsh, 12 August 2026. I spent the morning at North Cotswolds Hospital, spending time with colleagues from across the site. In particular, I had pre-arranged to spend time with, and thank, our team of volunteer gardeners who do a great job in maintaining and developing the gardens in a number of Trust sites. • George Moore Clinic, Bourton-on-the-Water, 12 August 2026. A brief visit to this base, used by community nursing, school nurses and hosts clinics also. • Cirencester Hospital, 27 August 2026. I was on site to host a visit by Geoffrey Clifton Brown, North Cotswolds MP. While based on the site for the day, I was able to catch up with colleagues from across the site. It was a good reminder of the need for the planned investment to improve the usage and the fabric of the buildings, as it does not match the standard of other sites in our estate. I was pleased to see an area of the oldest and most historic part of the site which has been recently refurbished to a high standard for use by teams. • Rikenel, Gloucester, 4 September 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.
Events to note	• Mental Capacity Act Conference. Shire Hall, 9 September 2026. I was pleased to open this multi-agency conference alongside Jo Walker, Chief Executive of Gloucestershire County Council. It was an opportunity for practitioners across health and social care organisations in Gloucestershire to refresh their understanding of the legal aspects and to share practice learning points.

CHIEF EXECUTIVE AND EXECUTIVE HIGHLIGHT REPORT

Advise	National	New NHS Staff Standards & Leadership & Management Framework
	The launch of the NHS Staff Standards, the NHS Leadership and Management Framework, and the NHS College of Leadership and Management in July 2026 introduce mandated employer standards across six key areas, including health and wellbeing, line management, flexible working, tackling racism, sexual safety, and violence prevention, with performance incorporated into the NHS Oversight Framework. They also establish, for the first time, a single national framework describing effective leadership and management behaviours and expectations across all levels of the NHS. The Trust is well positioned to respond, with the priorities and requirements of the new standards already strongly aligned to the ambitions set out within the People Strategy 2026–2031, particularly Theme 1 (Great Leadership and Culture) and Theme 3 (A Safe, Healthy and Inclusive Workplace). Rather than requiring a separate programme of work, implementation will be delivered through existing strategy workstreams, including leadership development, culture improvement, workforce inclusion, colleague wellbeing, and staff engagement activity. The national framework and standards provide an opportunity to strengthen and accelerate improvements already underway, whilst ensuring compliance with emerging national expectations and assurance requirements. Four required accountable roles have been identified and agreed, alongside a programme of actions to embed the new standards into leadership development, appraisal processes, directorate plans and governance arrangements. Progress will be monitored through established People Strategy governance, with oversight provided through the People Performance Business Meeting and the Great Place to Work Committee. Adopting this approach will ensure the Trust demonstrates compliance with the new national standards, supports improved staff experience and organisational culture, and strengthens performance against key NHS oversight measure. A detailed session to consider the new framework will take place at the October Great Place to Work Committee.	
	National	Thirlwall Inquiry Report and Recommendations
On 15 September 2026, the report from Lady Justice Thirlwall's Inquiry into events at the Countess of Chester Hospital was published. The Inquiry found devastating failure of individuals and the system to act quickly to safeguard babies, and it questions the NHS culture that prevented this from happening. It is a difficult read, and our thoughts are first and foremost with the families affected who have experienced unimaginable loss and pain. The care, safety and safeguarding of all patients is a principal duty of us all, and rightly we have been asked through a letter from NHS England on 21 September 2026, to act and ensure that learning from this Inquiry is translated into action. The national letter sets out five immediate actions to be taken, of which the Executive Team have determined 2 are immediately relevant to the Trust: • Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting • Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to.		

	In light of the proximity to Trust Board today, the Executive Team have agreed several actions in service of having an informed discussion at the public session of Trust Board on 28 November 2026. A paper with the findings and recommendations of the Inquiry, and the immediate actions in the national letter, will determine the position of the trust against each recommendation and action, identifying any gaps and actions to improve. This will be presented to the Executive Team, with a relevant position provided to both Great Place to Work Committee in October and Quality Committee in November, ahead of the Trust Board discussion.	
	National	Organ Donation
	Having received an urgent call to action on organ donation from Professor Francesca Swords and Dr Rommel Ramanan, National Medical Director at the Department of Health and Social Care and NHS England and the Chief Medical Officer at NHS Blood and Transplant respectively, the Trust has shared internal communications championing organ donation. We recognise the importance of organ donation and the positive impact this can have on patient outcomes.	
	Operational	Organisational Redesign
	The Trust is progressing its organisational redesign to deliver services through three Service Groups: Mental Health, Learning Disabilities and Autism (MHLDA), Community and Urgent, and Children and Young People/Specialist, with corporate and quality functions aligned to support delivery. The redesign aims to break down organisational silos, strengthen a more collaborative culture, and increase agility in responding to NHS transformation and service development demands. Service Group Directors are now in post, services, budgets and reporting structures have been aligned, and work is underway to ensure each group has appropriate capacity and resources. Engagement with Nursing Therapies & Quality and Medical directorates is informing proposals for new ways of working, while Corporate Services are reviewing how best to support Service Groups through organisational support, business partnering and strengthened project management approaches. A review of internal governance is also underway to ensure effective assurance and decision-making within the new structure. The changes will be implemented incrementally within existing resources, supported by a comprehensive programme of engagement, communication, organisational development and wellbeing support, as leaders work collaboratively with colleagues to balance the development of the future model with the uncertainty that accompanies organisational change.	
	Operational	Gloucestershire County Council Delegated Responsibilities Update
	The final services to transition back into Gloucestershire County Council under the Delegated Responsibilities programme transferred on 1 September 2026. This marked the conclusion of an extensive programme of work which started in August 2025 when the cabinet at Gloucestershire County Council took the decision to transfer Mental Health Social Work, Supported Accommodation, Social Care Occupational Therapy and Reablement into the County Council again. The Programme has now come to an end.	
	As you are aware this also required that we develop two new services, an Occupational Therapy Service and a standalone Home First Service. The scale of change and development required for the Home First Service is significant, especially within the constraints	

of timescales colleagues have been working to. I am pleased to advise that both new services commenced on 1st September as planned. As would be expected when operationalising new services, there have been challenges in terms of processes and interfaces. Service leads are working collaboratively with GHC and system colleagues to address these. Home First has also experienced capacity constraints in the first few weeks of clinical service delivery however, this is very clearly on an upward trajectory, and we expect this to improve further as newly recruited colleagues commence with the service.

A programme evaluation will be undertaken, initially internally and then jointly with colleagues in GCC. This will utilise the McKinsey 7S methodology and will identify successes and lessons learnt for any future organisational programmes.

We are very grateful to everyone working in those services, and also those who worked on the programme, for ensuring that the transitions were as smooth as possible, and for their continued efforts whilst new processes bed in.

Workforce	Transforming People Services (TPS) Programme
------------------	---

Regional partnership working has commenced to deliver the Transforming People Services South West Accelerator programme, previously reported through the Great Place to Work Committee and the Trust Board. Douglas Blair and Neil Savage continue to represent the Trust on the South West Programme Board. There is considerable engagement from other senior leads in the organisation in a wide range of workshops to inform the programme and modelling.

A region-wide data sharing agreement has been enacted, and provider trusts have completed an initial baseline data collection submission of People Services functions and resources. A South West Outline Business Case is expected to be completed by the end of October. The Outline Business Case will shortly be shared with provider trust Boards, with the Full Business Case being expected to be considered formally by Boards in early 2027.

Workforce	BMA Industrial Action
------------------	------------------------------

The British Medical Association industrial action ballot of Consultant members has now closed, and members voted for future strike action. Of the 35,067 eligible BMA Consultant members, 18,069 (51.53%) voted in the ballot with the following breakdown:

- Yes, in favour of industrial action - 13,695 (75.81%)
- No - 4,369 (24.19%)

As a result of this, the BMA and its membership are seeking significant improvements to working lives and an end to what they describe as “pay erosion.” To this end, the BMA have written to the Government to further pursue a resolution of the dispute through negotiation.

It remains unclear about how this dispute will progress. Ultimately, given the rules relating to industrial action, the BMA would have to take action which could range from work to rule through to full strike within the next 5 months. The Trust’s tried and tested business continuity and emergency planning processes are being stepped up.

	Estates	Cirencester Redevelopment Programme
	Alongside ongoing delivery of backlog maintenance work, we are now pleased to be able to share an update on early plans to redevelop Cirencester Hospital. Whilst the ongoing visioning work and outcome of the two tests of change (relating to Theatre and Beds) will, during 2026, help determine the over-arching longer-term ambitions for the site, there is plenty we can and have progressed in the meantime. Positive engagement with clinical teams, partners and stakeholders has helped to shape proposals that support future service delivery and improved patient and staff environments for GHC services. Current plans include: • Refurbishment and repurposing the Locality Office into a MH/LD hub (replacing Cirencester Memorial Centre) • Creation of a new energy centre replacing the aged infrastructure on site • Plans for the development of a new block to house inpatients, therapies and urgent care services • Plans to refurbish the existing outpatients space Pre-Application discussions with planning colleagues at Cotswold District Council have progressed well with an ambition of submitting a Full Planning Application later this year. Alongside the planning work and visioning conversations, constructive discussions have also been progressed with Primary Health Care partners in Cirencester on the possibilities of supporting primary care services on site in future. This Programme of work is being led by Katherine Archer as Senior Responsible Office, Kev Adams, Associate Director of EFM and Vicki Heselton, Cirencester Redevelopment Programme Manager, with an established Programme structure in place to ensure appropriate oversight. This will include an Assurance Group with Executive representation.	
	Partnerships	Gloucestershire Provider Partnership Update
	The Gloucestershire Provider Partnership (GPP) has continued to make good progress as it moves through its mobilisation phase. All four jointly funded senior leadership appointments have now been made, with one postholder already in place, two further appointments commencing in October and November, and arrangements for the final start date being confirmed. This represents an important milestone in building the leadership capacity required to deliver the partnership's ambitions. Governance arrangements continue to be developed with a wider range of stakeholders, with the inaugural GPP Transformation Board expected to be convened in late October.	

REPORT TO: TRUST BOARD **PUBLIC** SESSION – 1st October 2026

PRESENTED BY: Sarah Birmingham, Chief AHP

AUTHOR: Sarah Birmingham

SUBJECT: QUALITY STRATEGY 2026-2031

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

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

The purpose of this report is to:
To present the Quality Strategy 2026-2031 and associated Implementation Plan for endorsement by the Trust Board.
The paper outlines the implementation approach, governance arrangements, delivery priorities and measures that will support delivery of the strategy over the next five years.

Recommendations and decisions required
The Trust Board is asked to:
Approve the Quality Strategy 2026-2031 and Implementation Plan.

EXECUTIVE SUMMARY
The Quality Strategy 2026-2031 sets out the Trust's approach to delivering safe, effective, personalised and equitable care through four strategic themes: Safe, Effective, Experience and Leadership.
The accompanying Implementation Plan provides the roadmap for delivery through: • A Quality Management Approach (QMA) to support learning, assurance, improvement and decision-making. • A Daily Management System (DMS) to embed quality management in everyday practice. • A Quality Maturity Framework (QMF) to establish a baseline, assess progress and identify improvement priorities. • A phased five-year implementation programme aligned to business planning and organisational priorities.

Implementation will be overseen through existing governance arrangements, with progress reviewed three times annually through the Quality Assurance Group, Quality Committee and Trust Board. The Associate Director of Patient Safety, Quality & Clinical Compliance will act as Senior Responsible Officer for delivery.

Risks associated with meeting the Trust's values

There is a risk that inconsistent implementation of the Quality Strategy, Quality Management Approach and Daily Management System could limit the Trust's ability to fully realise its values and ambition of delivering consistently safe, effective, personalised and equitable care. These risks will be mitigated through leadership oversight, capability development, governance arrangements and routine monitoring of implementation progress.

Corporate Considerations

Quality Implications	The Quality Strategy establishes the framework through which the Trust will improve quality, strengthen governance, embed continuous improvement and support delivery of safe, effective, personalised and equitable care. Successful implementation will enhance organisational learning, improvement capability and quality outcomes across all services.
Resource Implications	Implementation will be delivered through existing resources. External improvement expertise, including the Virginia Mason Institute or a similar partner, may be required to support implementation, with funding arrangements to be agreed through the appropriate governance processes
Equality Implications	The Quality Strategy supports the Trust's commitment to equitable care by promoting personalised care, reducing health inequalities and using quality and population health intelligence to identify and address unwarranted variation in outcomes and experience

Please list any meetings where this has been discussed before

- Quality Assurance Group June 2026
- Board Development Session July 2026
- Quality Committee Sept 2026

Appendices:	Appendix 1 Quality Strategy 2026-2031 Appendix 2 Quality Strategy Implementation Plan
--------------------	--



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

Acronyms used within this report	
QMA	Quality Management Approach
DMS	Daily Management System
QMF	Quality Maturity Framework

QMA	Quality Management Approach
DMS	Daily Management System
QMF	Quality Maturity Framework

Report authorised by: Nicola Hazle	Title: Director of Nursing Therapy and Quality
--	--

Our Quality Strategy 2026 - 2031

We help people live their best life by delivering great healthcare that is consistently safe, effective and personalised, and always provided with kindness, dignity and respect.



Our Quality Strategy 2026-2031

Quality is everyone's responsibility. Our Quality Strategy sets out how we will ensure care is safe, effective, equitable and centred on people's experience, aligning with national priorities for quality while reflecting the needs of our communities. It provides a practical framework to deliver our Trust ambition and five-year priorities, enabling us to fulfil our commitment to high-quality care.

Building on our strengths, this strategy sets out how we will learn from people's experiences, act on feedback, improve what we do and manage risk to deliver better care and outcomes. Our Quality Management Approach brings together learning, assurance, improvement and outcomes, helping us reduce inequalities and provide more joined-up, personalised care.

Our ambition

We help people live their best life by delivering great healthcare that is consistently safe, effective and personalised, and always provided with kindness, dignity and respect.

Our evidence base

Shaped by extensive engagement with colleagues, partners, people and carers, this strategy reflects real experiences, challenges and opportunities for improvement. It draws on over 20 data sources - including workshops, focus groups, surveys and professional governance forums - alongside ongoing discussion across teams, committees and system partners.

Our Quality Strategy Themes

Safe

Safer care through openness and curiosity

Effective

Prevention, partnership and better outcomes

Experience

Personalised, joined-up and equitable care,
with a focus on reducing inequalities

Leadership

Inspirational, influential and accountable

A shared view of Quality Quality

High-quality care is:

- Safe
- Effective
- Positive experience
- Equitable care

Achieved through:

- Strong leadership
- Empowered and skilled teams
- Partnership with people, carers and communities
- Continuous improvement and learning

Together, quality is everyone's responsibility



Safe – Safer care through honesty, curiosity and learning

WHY safety matters

People told us they want care that is safe, honest and reliable.

They want concerns to be listened to, learning to be shared and action taken when things go wrong.

Colleagues told us that when people feel safe to speak up, teams communicate well and learning is encouraged, services become safer and care improves.

Safety is about more than responding when harm occurs. It is about identifying risks early, learning from experience and working together to prevent harm before it happens.

WHAT success looks like

- People receive safe and reliable care.
- Risks are identified and addressed before harm occurs.
- Colleagues, people using services and carers feel confident to speak up and are listened to.
- Learning leads to visible improvements in care.
- Safety improves over time and inequalities reduce.
- Everyone understands their role in delivering safe, high-quality care

HOW we will deliver it

- Build a culture where people feel safe to speak up, share concerns and learn together.
- Turn learning from incidents, feedback, audits and good practice into measurable improvements.
- Use data, technology, lived experience and safety insight to identify risks early and prevent harm.
- Work with neighbourhood teams and partners to support people earlier and closer to home.
- Use a consistent approach to reducing variation and improving safety across all services.
- Strengthen accountability so leaders and teams use quality information to make informed decisions and sustain improvement

“Talking openly about issues helps us learn and improve.”

Colleague

“Open and transparent communication... is essential for good partnership working.”

Stakeholder

“Enable more colleagues to feel able to speak up and contribute.”

Non-Executive Director

Effective – Prevention, partnership and better outcomes

WHY this matters

People told us they want care that works, is based on evidence and fits around their needs.

Colleagues told us they need good information, clear systems and working with others to improve services and outcomes.

By bringing learning, evidence, data and feedback together, we can improve care, reduce differences and help people get the right support at the right time.

Preventing problems, acting early and joining up care helps people stay well for longer and use resources wisely.

WHAT success looks like

- People receive joined-up care that meets their needs.
- Care is based on evidence, learning and best practice.
- Decisions are informed by data, feedback and lived experience.
- Outcomes improve and unwarranted variation reduces.
- Improvement is measurable, sustained and visible.
- We can clearly demonstrate the difference our services make.
- We use research to learn what works, share good ideas, and make sure people get the best possible care

HOW we will achieve it

- Work across neighbourhoods, teams and services so people receive joined-up support at the right time and in the right place.
- Use local health information, evidence and people's experiences to understand needs, improve care and reduce inequalities.
- Focus on preventing problems and acting early so people can stay well and independent for longer.
- Use and share what we learn from research, audits, evaluation and improvement work to keep making care and outcomes better.
- Use results and feedback to see what's working and show the difference our services make.
- Connect learning, assurance, improvement and performance through one shared Quality Management Approach.

“Inclusive Assessments”
Carer

“I can see that what I shared has made a difference.”
Expert by Lived Experience

“Be transparent... promote incidents as opportunities to learn. By talking about them we can be more aware, and we can learn from them”
Colleague

Experience — Personalised, joined-up and equitable care

WHY this matters

People told us they want to be listened to, involved and treated as partners in their care.

People want care that reflects what matters to them, services that work together and fair access to good outcomes for everyone.

Feeling heard and respected builds trust, improves experiences and leads to better outcomes.

Working with people, carers and communities helps us design better services and reduce inequalities.

WHAT we want to achieve

- People feel listened to, respected and involved in decisions about their care.
- Care is personalised around what matters most to each person.
- Carers and families are valued as partners in care.
- People receive joined-up support and do not fall through gaps between services.
- Feedback leads to visible improvements.
- Access, experience and outcomes are more equitable for all communities.

HOW we will achieve it

- Embed personalised care through shared decision-making.
- Involve people, carers and families in service design, improvement and care planning.
- We will show that we understand people's stories by sharing information effectively, acting on what people tell us and demonstrating how this improves care.
- Connect with people and communities whose voices are not always heard and use their experiences to improve care.
- Use quality, workforce and population health data to identify differences in access, experience and outcomes between communities, including racism and discrimination, and take action to reduce these.
- Work with neighbourhoods, communities and partners to provide more joined-up support closer to home.
- Help people build the knowledge, confidence and support they need to manage their health and wellbeing.

"I was involved in decisions, and what mattered to me was taken seriously."

Expert by Lived Experience

"Reassuring, validating transformative"
Carer

"I don't want to have to repeat my story – I would like everyone to work together."

Expert by Lived Experience

Leadership – Inspirational, influential and accountable

WHY leadership matters

People told us they want leaders who are visible, approachable and willing to listen.

They want to feel involved in decisions and confident that concerns will be acted on.

Colleagues told us that strong leadership helps create a culture of openness, learning and improvement where people feel supported to provide high-quality care.

Good leadership brings people together, creates clear accountability and helps teams improve outcomes for the people and communities we serve.

WHAT success looks like

- Leadership is visible, approachable and supportive.
- Colleagues feel empowered to improve services and make a difference.
- Teams have the skills, confidence and support to deliver high-quality care.
- Decisions are informed by evidence, data and lived experience.
- Leadership strengthens quality, safety, experience and outcomes.
- A culture of learning, improvement and accountability is embedded across the Trust.

HOW we will deliver it

- Build compassionate, visible and inclusive leadership at every level.
- Develop leaders with the skills, confidence and support to improve services and lead change
- Promote shared leadership across teams, professions, services, neighbourhoods and partners.
- Create a restorative culture that supports openness, learning, accountability and improvement.
- Support leaders to focus on prevention, reducing inequalities and improving long-term outcomes.
- Create clear development, career and leadership opportunities so colleagues can reach their potential.

“When leaders are visible and approachable, people feel able to speak up.”

Colleague

“When teams feel confident and understand their role, care feels safe.”

Expert by Lived Experience

“Good leadership builds trust, supports learning and helps improve outcomes.”

Non-Executive Director

Our Quality Management Approach

Our **Quality Management Approach** is how we will deliver this strategy.

It provides a **single framework for learning, assurance, improvement and decision-making**, enabling teams to continuously improve care and achieve better outcomes.

Every team will use this approach to understand, improve and assure the quality of care they provide.

We will use research, data and people's experiences to make good decisions and improve care

This is how we work together to improve quality every day.

How We Deliver Quality Through Our Quality Management Approach

A single, integrated approach to plan, deliver, assure and improve care



Our Quality Management Approach

This is how we work together to improve quality

Our Quality Management Approach is how we work together to learn, improve and assure the quality of care we provide

How will we deliver it?

Over the next five years we will achieve this by:

- Create a shared language and approach to quality across the Trust.
- Strengthen leadership and improvement capability at every level.
- Use data, evidence and lived experience to guide improvement.
- Embed quality management through business planning, improvement programmes and everyday practice.

How everyone contributes to quality

Every colleague contributes to quality by:

- Putting people first
- Speaking up and listening
- Using feedback to improve
- Working safely
- Learning and sharing learning
- Taking responsibility for improvement

How will we make it part of how we work?

We will embed the Quality Management Approach by:

- Use simple visual frameworks and tools.
- Embed the approach within existing governance and improvement processes.
- Support leaders and teams to understand their role.
- Develop a common language for quality across the Trust.
- Demonstrate how it helps teams solve real problems and improve care.

Measuring improvement through a Quality Maturity Framework

Understanding where we are and how we improve:

- We will measure our progress through a **Quality Maturity Framework**, establishing a baseline, **identifying strengths and opportunities for improvement**, and tracking progress over time.
- This will help us **understand where we are now, target improvement efforts** and demonstrate progress across the key components of high-quality care.
- By 2031, we aim to demonstrate that **quality, learning and improvement are embedded in everyday practice** across the Trust.

Quality by 2031

Our ambition for quality by 2031

By 2031, quality will be embedded in everything we do through visible leadership, continuous improvement, informed decision-making and strong partnerships with people, carers and communities

We will know we are succeeding when:

- People experience safer, more effective, personalised and equitable care.
- Outcomes improve and unwarranted variation reduces.
- Health inequalities narrow.
- Learning is consistently translated into measurable improvement.
- Colleagues have the confidence and capability to improve care.
- Quality management and improvement are embedded in everyday practice.
- Strategic priorities are delivered and sustained.



Gloucestershire Health and Care
NHS Foundation Trust



Practical tools and Visual resources

CLINICAL LEADERSHIP

Leading quality through **compassion**, **curiosity** and **collaboration**.



— WHAT GOOD LOOKS LIKE —

To safe, effective and personalised care enabled by strong leadership



**STRONG LEADERSHIP
ENABLES SAFE, EFFECTIVE
AND PERSONALISED CARE**



Sets clear
direction and
priorities



Uses data, insight
and evidence to
guide decisions



Supports teams
and builds
capability



Drives improvement
and sustains
change



SAFE



Risks are identified early



Reporting and learning increase



Harm and recurrence reduce



Support others to speak up
and act on concerns



Strong leadership supports safe
decision-making, early risk
identification and a culture of
speaking up



EFFECTIVE



Outcomes improve



Variation reduces



Care is consistent and reliable



Decisions are informed by
data, evidence and outcomes



Strong leadership ensures
evidence-based, outcome-focused
care and drives improvement



EXPERIENCE



Care is personalised



People are involved in decisions



Care is joined up and easy to navigate



Work with carers and families as
partners in care



Strong leadership supports
personalised, coordinated care
and partnership with people
and carers



QUALITY

Through strong leadership and our quality management approach, we deliver consistent, high-quality care that improves outcomes and keeps people's experience at the heart of everything we do.

SAFE | What you need to do to keep people safe



Why this matters



Speaking openly helps us learn and improve



Acting on concerns early helps prevent harm



Good communication helps us work better together



Learning from incidents leads to safer care over time



Clear accountability ensures risks are managed and actions are completed



Everyone has a role in identifying risks, taking action and improving safety every day

EFFECTIVE

Improving care through informed decisions, clinical leadership and continuous improvement

WHAT EFFECTIVE CARE LOOKS LIKE



Informed Decisions

Data, evidence and feedback guide decisions



Clinical Leadership

Direction, accountability and ownership



Sustained Improvement

Improvement is measured, embedded and sustained

HOW WE ACHIEVE IT

1 UNDERSTAND



Use data
Use feedback
Identify variation

2 PRIORITISE



Focus on what matters
Set priorities
Make informed decisions

3 IMPROVE



Take ownership
Test change
Deliver improvement

4 MEASURE



Monitor outcomes
Review impact
Learn what works

5 SUSTAIN



Embed change
Share learning
Spread success

WHAT THIS MEANS



Improved Outcomes



Reduced Variation



Evidence-Based Care



Coordinated Care



Reduced Inequalities



Effective care improves outcomes, reduces variation and ensures people receive evidence-based, coordinated and personalised care.

EXPERIENCE

Listening, involving and working together to deliver personalised, coordinated care

**GOOD CARE
HAPPENS WHEN**



We listen to people
and involve them



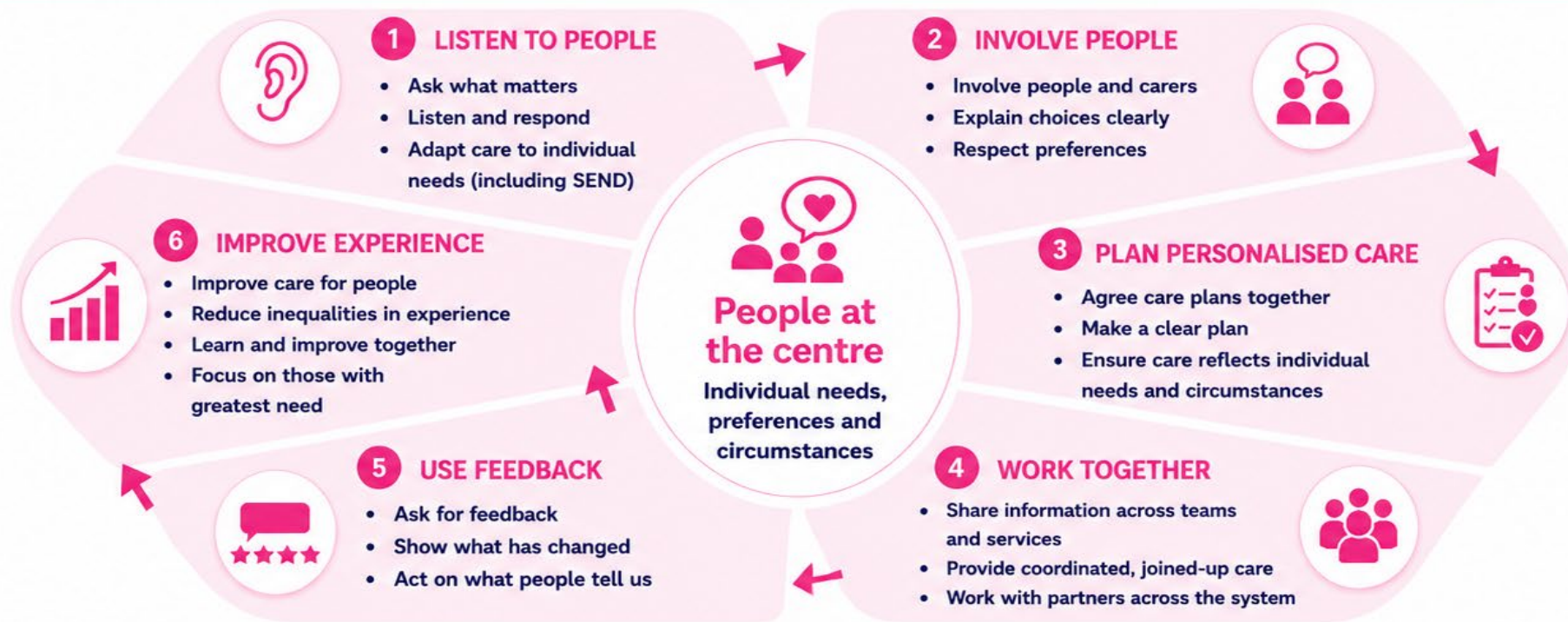
Care is coordinated
and joined up



We act on feedback
and improve



Care is inclusive
and reduces
inequalities



We use feedback, experience and insight to understand what people experience and improve care



Everyone has a role in delivering personalised, coordinated care and improving experience for all people

LEADERSHIP AT GLOUCESTERSHIRE HEALTH AND CARE

What does leadership mean at GHC?

Leadership at Gloucestershire Health and Care is a dynamic process of influencing, guiding and supporting others. It is **compassionate**, **collaborative** and **inclusive**, working with others to achieve a shared goal: **improving patient care and population health** across our system.



CORE PRINCIPLES OF LEADERSHIP AT GHC



COMPASSION AND CARE

Prioritising the health, safety and wellbeing of patients and staff.



INCLUSIVITY

Valuing diverse backgrounds and ensuring a supportive, open culture where everyone's voice is heard.



SHARED PURPOSE

Setting a clear direction that aligns with our values and inspires teams to deliver high-quality services.

EFFECTIVE LEADERSHIP AT GHC CREATES...



Better outcomes for patients and communities



A positive, inclusive and compassionate culture



Safe, high-quality care and good use of resources



Empowered teams that innovate and improve

OUR SHARED VALUES

- Working together
- Respect and dignity
- Compassion
- Commitment to quality
- Everyone counts

THE HEALTHCARE LEADERSHIP AT GHC

The NHS Leadership Academy outlines 9 key behavioural dimensions that define effective leaders.

1



INSPIRING SHARED PURPOSE

Curious about how to improve services and patient care and acting in line with NHS values.

2



LEADING WITH CARE

Showing compassion and valuing others to create a positive and inclusive environment.

3



EVALUATING INFORMATION

Using insight and evidence to make clear, confident and timely decisions.

4



CONNECTING OUR SERVICE

Building strong relationships across teams, services and partners.

5



SHARING THE VISION

Clearly communicating the vision and engaging others in the journey.

6



ENGAGING THE TEAM

Motivating and empowering people to contribute their best every day.

7



HOLDING TO ACCOUNT

Being consistent, fair and transparent in supporting high performance.

8



DEVELOPING CAPABILITY

Coaching and developing others to build skills, confidence and potential.

9



INFLUENCING FOR RESULTS

Working with others and influencing beyond your team to achieve sustainable results.



Leadership at every level.

Everyone has a part to play.

We lead. We care. We improve.



**One
Gloucestershire**
Transforming Care, Transforming Lives

HOW WE MEASURE IMPROVEMENT

Safer care, better outcomes and personalised care—
demonstrated through sustained, measurable improvement



SAFE

We know care is safe when:

A strong safety culture shows:



REPORTING AND LEARNING

- Incident reporting
- Near miss reporting
- Time to report



HARM REDUCTION

- Harm and serious incidents
- Recurrence of incidents
- Time to action



EFFECTIVE

We know care is improving when:



OUTCOMES

- Outcomes improve
- Variation reduces



PERFORMANCE

- Standards met
- Waiting times



DELIVERY

- Actions completed
- Improvements sustained



EXPERIENCE

We know experience is
improving when:



EXPERIENCE

- Experience scores
- Complaints



PERSONALISATION

- Personalised care plans
- Shared decision-making evident



FEEDBACK AND CHANGE

- Feedback leads to visible change
- Coordination improves

CLINICAL LEADERSHIP: CLEAR OWNERSHIP, ACCOUNTABILITY AND RESPONSIBILITY



CLEAR OWNERSHIP

Owned by the right people
at every level



ACCOUNTABILITY

Outcomes are owned with progress
monitored, challenged and reported



RESPONSIBILITY

Teams take action and deliver
the work needed to improve care

Improvement is everyone's business. Together we learn, improve and deliver the best possible care.



How We Know Quality Is Improving



Safe, effective and **personalised** care, enabled by clinical leadership



SAFETY

Risks are identified early.



HIGH-QUALITY CARE

Care is safe, effective and delivered to consistent standards.



OUTCOMES

Outcomes improve and variation in care reduces.



PERSONALISED CARE

People and carers are listened to and involved in decisions.



LEARNING

Feedback drives improvement and learning is shared.



DELIVERY

Actions are completed, sustained and make a difference.



PEOPLE & CULTURE

Everyone feels supported and empowered to improve care.



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

www.ghc.nhs.uk

QUALITY STRATEGY 2026-2031 IMPLEMENTATION PLAN

1.0 PURPOSE

This document provides a handover of the Quality Strategy implementation programme. The strategy has been developed, extensively engaged upon and is ready for launch.

The next phase is focused on implementation, measurement and embedding. The strategy will be delivered through a Trust-wide Quality Management Approach, supported by a Quality Maturity Framework to measure progress and improvement over time.

1.1 Accountability and Leadership

Senior Responsible Officer: Associate Director of Patient Safety, Quality & Clinical Compliance

Executive Oversight: Quality Assurance Group, Quality Committee and Trust Board.

Implementation Partners: Organisational Development, Corporate Governance, Operational and Clinical Leadership Teams, Virginia Mason Institute (where appropriate).

1.2 Current Position

- Quality Strategy developed and ready for launch.
- Extensive stakeholder engagement completed.
- Quality Management Approach identified as the delivery mechanism for the strategy.
- Daily Management System development initiated, with pilot activity planned as part of implementation.
- Quality Maturity Framework identified as the mechanism for measuring progress and improvement.
- Initial implementation priorities agreed for 2026/27.

This document should be used as the primary reference for implementation, reporting and programme oversight during the delivery of the Quality Strategy 2026-2031.

2.0 KEY IMPLEMENTATION PRIORITIES

The key implementation priorities are:

- Launch and socialise the Quality Strategy.
- Develop and test practical tools to support application of the Quality Management Approach (QMA).
- Implement the Daily Management System to embed the QMA in everyday practice.
- Complete a baseline Quality Maturity Assessment.

- Strengthen organisational quality improvement capability.
- Align governance and business planning processes.

3.0 DEFINITION OF SUCCESS

By 2031, quality management, learning, improvement and decision-making will be embedded in everyday practice, supported by capable leaders, empowered teams and a mature quality culture that delivers measurable improvements in quality, experience, outcomes and equity.

4.0 FIVE-YEAR DELIVERY ROADMAP (2026-2031)

The Quality Strategy will be delivered through a phased five-year programme aligned to the Trust's annual business planning cycle.

The programme will focus on building the foundations to implement a quality management approach, embedding improvement and learning systems, integrating quality and operational performance, and developing a mature learning organisation by 2031.

The Quality Management Approach (QMA), underpinned by the Daily Management System (DMS) our approach to embedding quality management in everyday practice and measured through the Quality Maturity Framework (QMF), will provide the framework, infrastructure and assurance required to support delivery of the Quality Strategy.

Year	Phase	Primary Focus	Business Plan Alignment
2026-27	Foundation	Launch strategy, establish QMA, DMS and Quality Maturity Framework	Organisational development, governance, patient safety, CQC readiness
2027-28	Embed	Roll out and embed quality management systems, strengthen improvement capability, and support leaders to drive continuous improvement in partnership with Organisational Development colleagues.	Service planning, organisational restructure and quality governance
2028-29	Improve	Evaluate and continuously improve the Quality Management Approach, Daily Management System and organisational improvement capability	Productivity, effectiveness and reducing variation
2029-30	Integrate	Integrate the Quality Management Approach into business planning and delivery to drive the Trust's strategic priorities and strengthen	Integrated care, prevention and health inequalities

Year	Phase	Primary Focus	Business Plan Alignment
		organisational improvement capability.	
2030-31	Sustain & Innovate	Embed a mature quality culture by strengthening the conditions, capability and leadership needed for continuous improvement, innovation and sustainability.	Long-term sustainability and organisational excellence

5.0 GOVERNANCE, OVERSIGHT AND REPORTING

Progress will be reported through existing governance arrangements and aligned to the annual business planning cycle. Reporting will focus on four areas:

- Delivery of implementation milestones and key deliverables across the four priorities.
- Adoption and embedding of the Quality Management Approach and Daily Management System.
- Organisational progress against the Quality Maturity Framework, including improvement priorities and maturity assessments.
- Demonstration of impact through improved quality, learning, improvement capability, decision-making and delivery of Quality Strategy objectives.

Progress will be reviewed three times annually through existing governance arrangements to assess delivery, organisational maturity, adoption of the Quality Management Approach and Daily Management System, and progress towards the Quality Strategy objectives.

November

- Review implementation progress and delivery milestones
- Confirm emerging quality priorities and risks to inform the development of the following year's business plan

March

- Review Quality Maturity Framework findings
- Agree improvement priorities and quality objectives for incorporation into annual business and operational plans

July

- Annual review of outcomes, benefits realisation and Quality Account priorities
- Progress towards the Quality Strategy ambition and 2031 objectives

This approach aligns with the committee cycle, enabling meaningful review of progress, priorities and outcomes while avoiding unnecessary reporting burden.

The governance structure is listed in the table below:

Role	Suggested Holder
Responsible Executive	Director of Nursing, Therapy & Quality and Chief Medical Officer (through QAG)
Delivery Lead / Senior Responsible Officer	Associate Director of Patient Safety, Quality & Clinical Compliance
Strategic Assurance	Quality Committee
Final Approval / Accountability	Trust Board

6.0 DELIVERY PRIORITIES

The implementation programme is organised around four delivery priorities which translate the Quality Strategy into practice. Together they support engagement across the organisation, adoption of the Quality Management Approach, implementation of the Daily Management System and measurement through the Quality Maturity Framework.

Priority	Aim	Key Deliverables	Key Measure
Strategy Launch & Engagement	Build understanding, ownership and commitment to the Quality Strategy across the Trust and with partners	Communications and engagement plan Leadership briefings and launch resources Stakeholder engagement programme Intranet and digital communications hub Quality Strategy launch campaign	Quality Strategy understood and referenced in organisational planning, improvement and governance activities
Quality Maturity Framework	Measure organisational progress and identify opportunities for improvement across the key components of high-quality care	Quality Maturity Framework Baseline organisational assessment Agreement of maturity domains and assessment methodology Improvement priorities and action plan Annual review process	Organisational baseline established with measurable improvement demonstrated over time
Quality Management Approach (QMA)	Establish a consistent Trust-wide approach to learning, assurance, improvement and decision-making, supported by the Virginia Mason Institute	QMA framework and operating model Governance and accountability framework Integrated dashboard and intelligence framework Review, align and embed the existing improvement framework and standards, ensuring they support the	QMA embedded within governance, improvement and business planning processes

Priority	Aim	Key Deliverables	Key Measure
		Quality Management Approach, daily management and continuous improvement. Leadership guide and implementation roadmap	
Daily Management System (DMS)	Establish a structured approach to embedding quality management in everyday practice."	DMS framework Visual management boards and core metrics Escalation and response processes Governance and reporting arrangements Use the learning from the pilot to develop a plan for rolling out consistent ways of working across the whole Trust	Embed clear accountability and standard ways of working so everyone understands their role in delivering high-quality care through the Quality Management Approach.

The four priorities are designed to work together.

- Priority 1 focuses on engagement and organisational ownership of the Quality Strategy.
- Priority 2 establishes the Quality Maturity Framework to measure progress and identify improvement priorities.
- Priority 3 develops the Quality Management Approach, providing the overarching framework for learning, assurance, improvement and decision-making.
- Priority 4 implements the Daily Management System, which provides the operational infrastructure to embed the Quality Management Approach in everyday practice.

Together these priorities provide the foundations for delivering the Quality Strategy over the next five years

6.1 **PRIORITY 1: Strategy Launch and Communications**

Aim

To build understanding, ownership and commitment to the Quality Strategy across the Trust and with key partners.

Key Deliverables

- Communications and engagement plan.
- Leadership briefing resources.
- Digital and engagement materials.
- Stakeholder engagement programme.
- Quality Strategy launch events and supporting resources

Key Measures

- Quality Strategy formally launched.
- Positive engagement from leaders, colleagues and stakeholders.
- Quality Strategy referenced within governance, improvement and business planning processes.
- Awareness and understanding of the Quality Strategy demonstrated across services.

6.2 PRIORITY 2: Quality Maturity Framework

Aim

To establish an organisational baseline and provide a consistent approach to assessing progress, identifying priorities and measuring improvement across the key components of high-quality care and the Quality Strategy.

Key Deliverables

Quality Maturity Framework

- Baseline organisational assessment
- Agreed maturity domains, descriptors and assessment methodology
- Improvement priorities and action plan
- Maturity assessment and reporting process integrated within governance arrangements
- Annual review and refresh process

Key Measures

- Quality Maturity Framework agreed and implemented
- Organisational baseline established across agreed maturity domains
- Improvement priorities identified and incorporated into organisational delivery plans
- Measurable improvement demonstrated over time through maturity assessments
- Annual maturity review and reporting process embedded within governance arrangements
- Maturity assessment findings routinely used to inform quality planning, improvement and decision-making

6.3 PRIORITY 3: Quality Management Approach (QMA)

Aim

Establish a consistent Trust-wide approach to learning, assurance, improvement and decision-making, supported by the Virginia Mason Institute, and embedded within governance, improvement and business planning processes.

Key Deliverables

QMA framework and operating model

- Governance and accountability framework

- Integrated dashboard and intelligence framework
- Review, align and embed the existing improvement framework and standards to support the QMA, Daily Management System and continuous improvement
- Leadership guide outlining roles, responsibilities and expectations
- Implementation roadmap for Trust-wide adoption

Key Measures

- QMA framework approved and implemented across the organisation
- Governance, improvement and business planning processes aligned to the QMA
- Clear quality accountability and decision-making arrangements established
- Quality intelligence routinely used to support assurance, learning and improvement
- Existing improvement standards and methodology aligned and embedded within the QMA
- Quality Strategy priorities routinely reflected within planning, governance and improvement activity
- QMA embedded within governance, improvement and business planning processes

6.4 **PRIORITY 4: Daily Management System (DMS)**

Daily Management System (DMS) is our approach to embedding quality management in everyday practice

Aim

To establish a consistent approach to everyday management, quality governance, escalation and continuous improvement across the organisation, enabling timely decision-making, learning and delivery of high-quality care.

Key Deliverables

DMS framework

- Visual management boards and core metrics
- Escalation and response processes
- Governance and reporting arrangements
- Pilot evaluation and Trust-wide roll-out plan
- Standard work and leader standard work defined and implemented
- Clear roles, responsibilities and routine practices aligned to the Quality Management Approach

Key Measures

- DMS framework implemented across the organisation
- Standard quality, safety, workforce, experience and improvement measures adopted and routinely reviewed
- Clear ward-to-board and board-to-ward visibility of quality, safety, workforce, experience and improvement priorities
- Agreed standard work and leader standard work embedded across teams and services

- Timely escalation, learning and decision-making embedded in everyday practice
- Clear alignment between operational management, governance and improvement activity
- Colleagues and leaders have a clear understanding of their roles, responsibilities and routine practices in delivering the Quality Management Approach and high-quality care

7.0 IMPLEMENTATION MILESTONES BY MARCH 2027

- Quality Strategy launched across the Trust.
- Organisational quality maturity baseline established.
- Quality Management Approach agreed.
- Daily Management System piloted and evaluated.
- Governance and business planning aligned to the Quality Strategy.
- Year 2 priorities agreed and incorporated into delivery plans

8.0 KEY RISKS AND MITIGATIONS

Risk	Mitigation
Quality Strategy launched but not embedded in practice	Implement the QMA and DMS, supported by leadership engagement, governance and business planning processes
Competing organisational priorities impact delivery	Align implementation with annual business planning, operational priorities and resource allocation processes
Quality Maturity Framework viewed as a compliance exercise rather than an improvement tool	Position the framework as a mechanism for learning, improvement and organisational development.
Inconsistent adoption of the QMA and DMS across services	Pilot, evaluate and refine approaches before phased implementation, supported by leadership and improvement capability development
Improvement capability and improvement culture are not developed consistently across the organisation, resulting in variable adoption, engagement and sustainability of the Quality Management Approach	Targeted improvement training and coaching programme, with improvement capability embedded within OD and leadership development programmes
Insufficient leadership ownership and sponsorship	Maintain Executive, clinical and professional leadership oversight throughout implementation

REPORT TO: TRUST BOARD **PUBLIC SESSION – 1st October 2026**

PRESENTED BY: Rosanna James, Director of Digital, Improvement and Partnerships

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **INTEGRATED DASHBOARD – AUGUST 2026-27 (Month 5)**

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 integrated dashboard provides a high-level view of performance and quality indicators in exception across the organisation. Activity covers the period to the end of August (Month 5, 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 over the Summer whilst it resets its focus and priorities.
--

Recommendations and decisions required The Board are asked to: NOTE the Integrated Dashboard Report for August 2026/27 and acknowledge that appropriate service improvement action plans are being developed <i>or</i> are in place to address areas requiring improvement, within Operational governance processes (Advise and Assure sections).
--

Executive summary

Business Intelligence Updates

The Quarter 1 publication for 2026/27 NHSE Oversight Framework performance has been released. Areas of improvement for the Trust include:

- Percentage of total Children and Young People's mental health waits for help that are over 104 weeks
- Percentage of people discharged from community mental health services with a paired outcome score recorded (adult and older adult)
- Mean length of stay for adult acute and psychiatric intensive care unit patients
- Mean length of stay for older adult acute mental health patients
- Percentage of intermediate care beds occupied by patients without criteria to reside
- Percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking
- Relative cost difference (National Cost Collection Index)
- Percentage of clinical trials set up within 90 days

Performance Update

Indicators in exception for the period are now presented from page 2.

Alert (to matters that may require attention)

MSK services experienced mailbox issues during the NHS connect (nhs.net) migration with previously actioned emails reappearing and duplicating the workload. It has required additional capacity to address the issues and restore mailbox flow, but because the mailbox receives a high volume of referrals daily, it has resulted in a backlog and bottleneck within the referral process. Whilst the issues are being addressed, it is anticipated that the resulting delays will impact **O07 MSK Physiotherapy - % Urgent referrals treated within 2-weeks** for September 2026.

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 Committee 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 5.
- **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.**
- **N69 - PH Percentage of bed days occupied by patients when they are ready to be discharged. – Narrative on page 7.** This indicator has fallen back into exception after being briefly compliant in June.
- **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) & 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.** Average length of stay for the psychiatric intensive care unit (PICU), older adult mental health wards and working age mental health wards will be impacted next month, following the discharge of patients in September, who have experienced an extended length of stay.

Assure

- **N16 & N16a: MH: Number of Out of Area Placements:** A review of out of area mental health inpatient beds is being undertaken. We have seen significant improvements following multidisciplinary action to support people to be closer to home. There is a trajectory in place which introduced progressive interim milestones has been out-performed week on week.

Applaud (to areas for recognition)

- All key performance indicators that relate to the **Wheelchair Services** are compliant for the period, for the first time since June 2025.
- The **Crisis Team** remained compliant for both their 4 hour (N73) and 24 response time (N72), for the second consecutive month.
- The **Mental Health Liaison Services** remain compliant for their 2 hour (B55) and 24 hour response time (B56 CoHo removed). B57 (CoHo only) remains in exception.

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?
August Service Directorate Ops Sessions, Directorate-wide Performance & Risk meeting on 15/09/2026 and BIMG on 17/09/2026.

Appendices:	AI-10.1/1026 – Integrated Dashboard M5
--------------------	--

Report authorised by: Rosanna James Jane Hannon Nicola Hazle	Title: Director of Digital, Improvement & Partnerships Deputy Chief Operating Officer Director of Nursing, Therapies & Quality
--	--

Quality & Performance Dashboard Report

Aligned for the period to the end August 2026 (month 5)



This report presents the Trust's key performance indicators across five 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 although this is being considered. The previous sources (*Nationally measured, Specialised & Direct Commissioning, ICS Agreed, Board Focus*, and *Operational*) are still indicated via the KPI ID prefix. 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

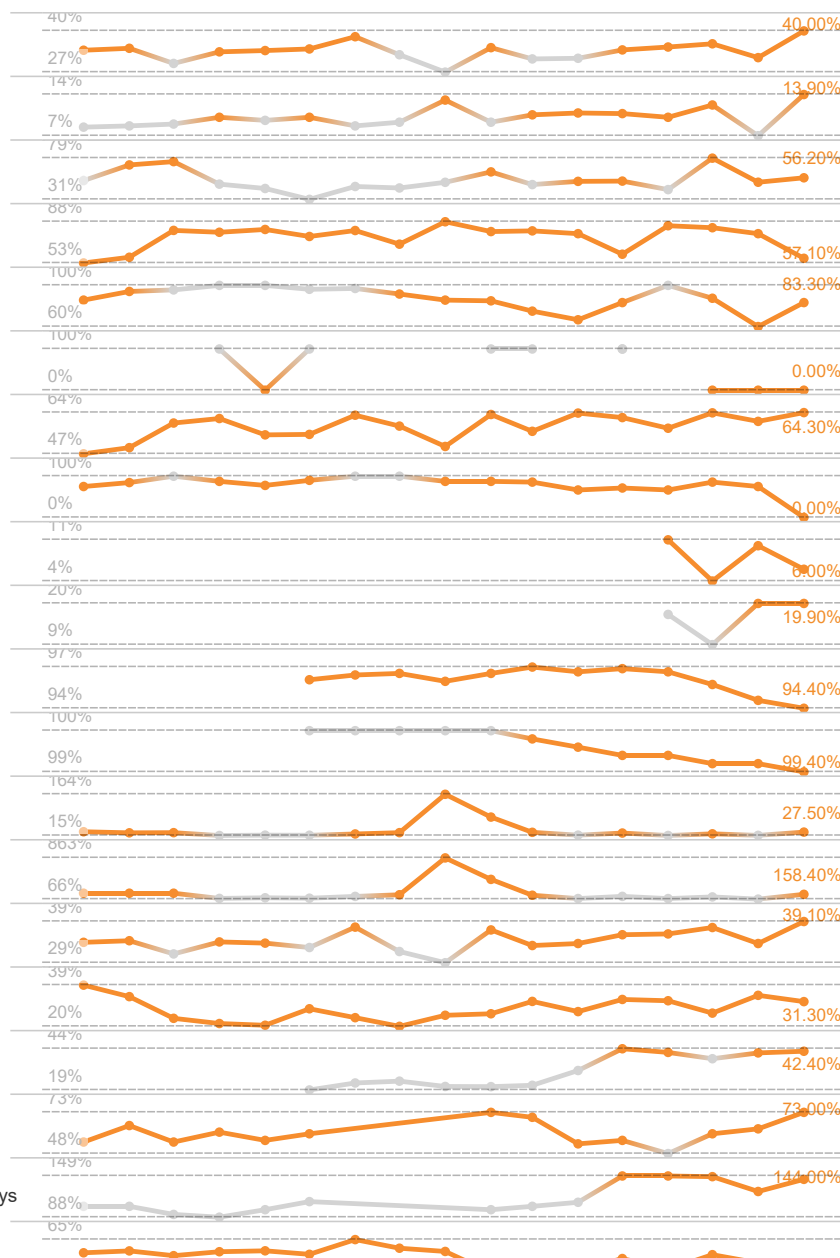
The Dashboard itself ([on pages 2-19](#)) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are all underperforming against their targets and therefore warrant escalation and wider oversight. To note, confirmed data 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

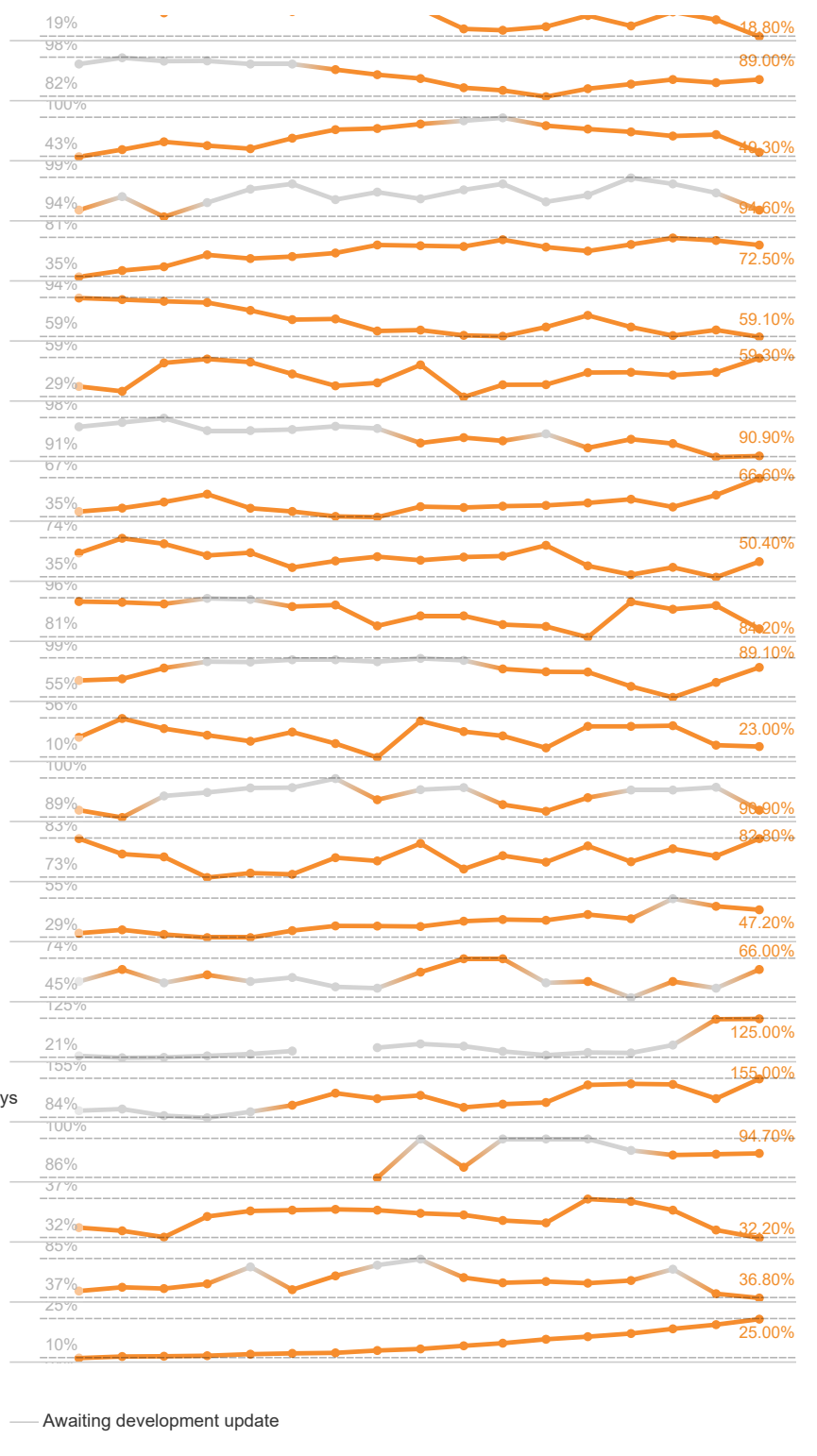
- Quarter 1 performance for the National Oversight Framework (NOF) was published on 15th September, although the latest technical annexe remains unavailable. Areas of improvement focus for the Trust include:
 - % total Children & Young People's mental health waits for help that are over 104 weeks
 - % people discharged from community mental health services with a paired outcome score recorded (adult & older adult)
 - Mean length of stay for adult acute & psychiatric intensive care unit patients
 - Mean length of stay for older adult acute mental health patients
 - % of intermediate care beds occupied by patients without criteria to reside
 - % of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking
 - Relative cost difference (National Cost Collection Index)
 - % of clinical trials set up within 90 days
- 169 indicators remain reported within this month's KPI dashboard portfolio. 16 are currently being monitored within the development source and 17 new indicators are scheduled to go live before the end of 2026/27. The full plan will see the portfolio rise to a total of 202 indicators, before any NOF measures are added.

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.

AUGUST		
B51	PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)	40.0 days 30.0 days
B52	PH CATU Inpatients Average Length of Stay (Days. Not a percentage)	3.9 days 10.0 days
B53	PH Stroke Inpatients Average Length of Stay (Days. Not a percentage)	56.2 days 50.0 days
L07	Eating Disorders - Wait time for adult assessments will be 4 weeks	57.1% 95.0%
L08	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	83.3% 95.0%
L10	Perinatal: Preconception advice - Referral to assessment within 6 weeks	0.0% 50.0%
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	0.0% 95.0%
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 patients 2 patients
N16a	MH: Number of Out of Area Placements (Appropriate and Inappropriate) Adult Acute, PICU and Older People at the end of the month (Number of Patients. Not a percentage)	19.9 patients 17 patients
N37	Community PH: Community Services Waiting List % seen within 52 weeks - CYP: Service exclusions applied (Op. plan E.T.9a)	94.4% 100.0%
N38	Community PH: Community Services Waiting List % seen within 52 weeks - Adult: Service exclusions applied (Op. plan E.T.9b)	99.4% 100.0%
N45	IUCS - Average speed to answer calls (Seconds. Not a percentage) (KPI 2)	27.5 seconds 20.0 seconds
N46	IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)	158 secs 120 secs
N63	PH Community Hospitals Average Length of Stay (All Beds. Days. Not a percentage)	39.1 days 33.0 days
N67	IUCS - Proportion of call-backs assessed by a clinician in agreed timeframe (KPI 4)	31.3% 90.0%
N69	PH: Percentage of beds days occupied by patients when they are ready to be discharged - all community hospitals (NOF & Op Plan E.M.43)	42.4% 39.0%
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	73.0 days 51.0 days
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	144.0 days 118.0 days
O02	Adult Speech and Language Therapy - % routine referrals treated within 18 Weeks	18.8% 95.0%



		95.0%	
O04	Podiatry - % routine referrals treated within 18 Weeks	89.0%	95.0%
O05	MSKAPS - % Urgent treated within 2 Weeks	49.3%	95.0%
O06	MSKAPS - % Routine treated within 18 Weeks	94.6%	95.0%
O07	MSK Physiotherapy - % urgent referrals treated within 2 Weeks	72.5%	95.0%
O08	MSK Physiotherapy - % routine treated within 18 Weeks	59.1%	95.0%
O09	ICT Physiotherapy - % urgent referrals treated within 2 Weeks	59.3%	95.0%
O10	ICT Physiotherapy - % routine referrals treated within 18 Weeks	90.9%	95.0%
O11	ICT Occupational Therapy Services - % urgent referrals treated within 2 Weeks	66.6%	95.0%
O20	Paediatric Speech and Language Therapy - % treated within 18 Weeks for routine referrals	50.4%	95.0%
O21	Paediatric Physiotherapy - % treated within 4 Weeks for urgent referrals	84.2%	95.0%
O22	Paediatric Physiotherapy - % treated within 18 Weeks for routine referrals	89.1%	95.0%
O24	Paediatric Occupational Therapy - % treated within 18 Weeks for routine referrals	23.0%	95.0%
O25	Stroke ESD - Proportion of new patients assessed within 72 hours of notification	90.9%	95.0%
O35	HomeFirst and Reablement - Therapist assessment within 2 days of arriving home	82.8%	95.0%
O50	Percentage of women in the perinatal period accessing MH services having their routine outcomes measured at least twice	47.2%	50.0%
O51	MH Acute Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)	66.0 days	56.0 days
O52	MH PICU Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)	125.0 days	61.0 days
O53	MH Older Adult Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)	155.0 days	90.0 days
O61	SARC – Referrals responded to within 90 minutes or with an appropriate appointment of patient's preference	94.7%	95.0%
O62	% of children and young people accessing community mental health services, having their outcomes recorded at least twice	32.2%	50.0%
O63	MH: Percentage of Autism/ADHD First Assessments under 3 years – Adult	36.8%	70.0%
O64	MH: percentage waiting for autism/ADHD first assessment for over 3 years - adult	25.0%	10.0%
O65	PH Routine IVT % First Contact Within 22 Days	6.4%	95%
O66	PH Urgent IVT % First Contact Within 48 Hours	16.8%	95%

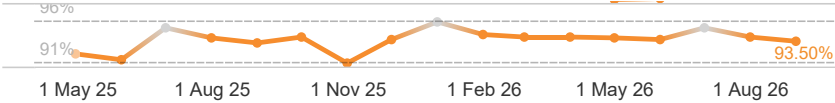


U00 PH Urgent IV I % First Contact within 48 Hours

42.9% / 95%

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

93.5%
95.0%



Narrative continues on next page...

Continued from last page...

Performance Thresholds not being achieved in Month - Note all indicators have been in exception previously in the last twelve months except O06.

B51 - PH Core Bed Inpatients Average Length of Stay (Days. Not a percentage)

Risk ID: 406. Forecast for recovery: Interim milestones are being reviewed alongside system transformation work and bed modelling - July 2026 29 days, October 2026 28 days, January 2027 27 days, April 2027 26 days. Whilst delay related discharge remains challenging, the interim milestones are unachievable within community hospitals. Situation, Background, Assessment and Recommendation produced and will be taken through system governance processes. 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)

Forecast for recovery: Requires temporary test of change evaluation. Actions: Internal review completed summer 2025. Evaluation to consider function in light of the step-up bed trial in summer 2026. Ongoing work to manage flow through of beds as described in B51 above.

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 and outcome being reviewed. Ongoing system work to enable flow from all pathways.

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks

Risk ID: 645. Forecast for recovery: To be developed alongside service redesign plan. Continued downward trajectory due to ongoing capacity issues. Actions: All referrals are triaged on receipt and any urgent cases are prioritised. Discussions with team manager to improve accuracy of recording interventions/appointments. Designing Solutions Project Group has now commenced. Discussions to redesign project to take place in September, with Group Director and Senior Responsible Officer. Next 6 months to focus on service stabilisation, service improvement, quality governance. Next 6-24 months to focus on transformation governance.

L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks

Risk ID: 645 Forecast for recovery: To be developed alongside service redesign plan. Actions: Discussions to redesign project to take place in September, with Group Director and Senior Responsible Officer. Next 6 months to focus on service stabilisation, service improvement, quality governance. Next 6-24 months to focus on transformation governance. Discussions with team management to improve accuracy of recording interventions/appointments. Patients have access to online support from the voluntary care sector. Contact telephone helpline number available for all patients.

L10 - Perinatal: Preconception advice - Referral to assessment within 6 weeks

This refers to one patient. The appointment was offered within the timeframe, however was declined due to patient choice. Appointments are offered flexibly where possible.

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.

Narrative continued on next page...

Continued from last page...

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

Risk: 645. Forecast for recovery: Initial improvements expected by March 2027. Actions: This related to one referral that was not recorded correctly. Discussions with team manager to improve accuracy of recording interventions/appointments. Designing Solutions Project Group has now commenced. Discussions to redesign project to take place in September, with Group Director and Senior Responsible Officer. Next 6 months to focus on service stabilisation, service improvement, quality governance. Next 6-24 months to focus on transformation governance.

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) &

N16a - MH: Number of Out of Area Placements (Appropriate and Inappropriate) Adult Acute, PICU and Older People at the end of the month (Number of Patients. Not a percentage)

Linked risk: 722/ 728. Forecast for recovery: Week on week improvements, ahead of the agreed interim milestones which plan to deliver no more than 5 total placements (N16a) in December. Inappropriate placement (N16) target of 2 to be achieved sooner. Actions: MDT led regular meetings to support people to support people to receive care closer to home. Stepped up patient flow activity. Block contract with system footprint provider to support care closer to home (which meets definition of an appropriate out of area placement under national guidance) . The number of acute placements is now lower than the number of beds closed to support the improvement work. Supporting discharge team are attending multi disciplinary team meetings. Working with community teams to support earlier discharges. Quality visits in place with providers.

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

There are 87 children waiting over 52 weeks for Occupational Therapy (OT). 28 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)

Actions: 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.

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

N46 - IUCS - 95th centile call answer time (Seconds. Not a percentage) (KPI 3)

Working with IC24 to explore this further as previously compliant in July 2026.

N63 - PH Community Hospitals Average Length of Stay (All Beds. Days. Not a percentage)

Risk: 406. Forecast for recovery: 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 at 31%, with 63% under the agreed adjusted reporting methodology, which is removing validation mapped to 60 minutes, currently in the under 20 minute mapping.

Narrative continued on next page...

Continued from last page...

Demand remained steady throughout the month, with weekends consistently carrying the highest daily volumes. Weekends remain challenging and reduce performance overall. Actions: IC24 recovery activity underway. Bi-weekly tracking in place. Live queue management in place supported by dashboards. Call volumes continuously monitored against forecast demand to identify emerging pressures and respond proactively. Capacity aligned to demand through ongoing review. Detailed review of performance by time of day/ week is underway. Review of the workforce model to look at what can be supported through the predicted surge period is underway. Enacting surge plans when call-back breaches increase. Focus on 111 clinical queue, targeting call-backs within 20 minutes. Monthly review of incidents, complaints, patient experience and safety data undertaken monthly have not identified any associated patient harm.

N69 - PH: Percentage of beds days occupied by patients when they are ready to be discharged - all community hospitals (NOF & Op Plan E.M.43)

Forecast for recovery: Trajectory is being revisited due to 40-50% of delay related discharges within community hospital beds. Actions: Delay related harm programme in place. Ongoing partnership work to address external causes of delay. Application of clinically ready for discharge criteria since March 2026, aligning to national reporting. Feeding into system transformation programmes.

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

Forecast for recovery: Quarter 4. Actions: Wotton Lawn Hospital Stabilisation and Improvement Implementation Group has an extensive phased action plan reporting into Executive Oversight Group. 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. Closer working with community teams. It is anticipated that in the short term length of stay will remain escalated as longer stay patients are discharged to appropriate care packages.

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 escalations 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. Focus on length of stay over 90 days. It is anticipated that in the short term length of stay will remain escalated as longer stay patients are discharged to appropriate care packages.

O02 - Adult Speech and Language Therapy - % routine referrals treated within 18 Weeks

Linked Risk: 638 Risk: 518. Forecast for Recovery: Forecasting for recovery is in progress and will be updated. Actions: Operational Pressures Response Plan implemented. Weekly extremis meetings in place to monitor position and priorities. Patient self help information available for those on the waiting list. Dysphagia swallow screen pilot rolled out to multiple care homes due to its success. Swallow screen pilot is being rolled out in community hospitals. Additional staff in place - two days to support voice caseload, one in community. Regular team meetings continue to ensure changes are communicated and enable joint working. Review of the service has been commissioned.

O04 - Podiatry - % routine referrals treated within 18 Weeks

Linked Risk: 491. Forecast for Recovery: Improvement continues to be seen, following data recording improvements as well as increased capacity initiatives. Recovery expected in the new financial year 2027/28, previously October 2026. Date changed as new starters will have settled into role, skill mixing will be in place, invite to book letters will be having a positive impact (this has supported in the past and has worked well to manage MSK waits). Actions: Remote appointments continue to be provided to increase advice, guidance and triage face to face appointments. Saturday clinics offered when staff available. Scoping skill mix to support with capacity for new patient assessments. Implementation of a podiatry steering group has a focus on recovery actions.

Narrative continued on next page...

O05 - MSKAPS - % Urgent treated within 2 Weeks

Forecast for Recovery: Improvement to be seen in September 2026, with recovery identified as October 2026. Actions: Quality improvement change ideas for appointment offers. Urgent criteria adherent with getting it right first time. Demand and capacity modelling continues, including allocated appointment space for triaging and urgent new patient appointments. To develop second advanced physiotherapist in foot and ankle competencies.

O06 - MSKAPS - % Routine treated within 18 Weeks

Compliance expected next month.

O07 - MSK Physiotherapy - % urgent referrals treated within 2 Weeks

Forecast for Recovery: Recovery expected in December 2026. Actions: Improvement plan in place with monthly monitoring meetings. Aligned urgent criteria to getting it right first time (GIRFT) standards. Reviewing urgent criteria and classification with colleagues. Completion of demand and capacity exercise across service sites/specialisms to differentiate need for urgent and routine appointments. Acknowledgement email signposts to self help resources. Protocols issued at point of surgical care to ensure ""safe waiting"". Community assessment days, to emphasise waiting well. Scoping of digital triage and self management apps.

O08 - MSK Physiotherapy - % routine treated within 18 Weeks

Linked Risk: 661. Forecast for Recovery: Anticipated improvement December 2026. Actions: invite to book initiative starting to have an impact on overall waiting list. Additional capacity by reallocating staff to support core MSK work. Increasing capacity with each department to offer focussed new patient days, with one off appointments now embedded into the ledgers. MSK South West cluster working with getting it right first time principles. Community education days in August and planned for September to focus on waiting well and self management. Focus on validating long waits as initial work shows a third of referrals no longer need to access the service.

O09 - ICT Physiotherapy - % urgent referrals treated within 2 Weeks &

O10 - ICT Physiotherapy - % routine referrals treated within 18 Weeks

Forecast for Recovery: Previously reported May 2026. This was not achieved and requires further work to agree a new forecast. Actions: The project in place to address this KPI was formally paused due to the direct and indirect impact of the transfer of delegated responsibilities. A meeting is planned for September 2026 to recommence the work.

O11 - ICT Occupational Therapy Services - % urgent referrals treated within 2 Weeks

Service transitioned to Gloucestershire County Council on 1 August 2026, health OT service in mobilisation. Ongoing review of KPIs required to be reflective of the new service.

O20 - Paediatric Speech and Language Therapy - % treated within 18 Weeks for routine referrals

Linked Risks: 350. Forecast for Recovery: Milestones to be established as the service scope the scale of the challenges and actions required. Business Intelligence Team is supporting forecasting. Actions: Core offer adapted to create capacity. Daily duty line in place to offer support and guidance, long waiter standard operating procedure in place to review referrals waiting more than 24 weeks, robust referral screening and prioritisation process in place, telephone advice line for referrers, training for schools, patient initiated follow up process, service website with advice/guidance/ resources available. Engaged in system work to introduce experts at hand, with recruitment taking place. Oversight of transformation plan at Children Young People Transformation Board, with the aim to reduce waits between assessment and treatment. Focus from March to November 2026 to reduce longest waits.

Narrative continued on next page...

Continued from last page...

O21 - Paediatric Physiotherapy - % treated within 4 Weeks for urgent referrals

Forecast for recovery: Unable to determine due to element of patient/family choice. In August, 14 referrals were delayed due to patient/family choice. Actions: Special school therapists delivered drop in clinics in August as a waiting list recovery initiative. Additional hours offered to part time colleagues as a waiting list recovery initiative.

O22 - Paediatric Physiotherapy - % treated within 18 Weeks for routine referrals

Forecast for recovery: To be determined following trajectory modelling. Actions: Special school therapist delivered drop in clinic in August as a waiting list recovery initiative. Additional hours offered to part time colleagues as a waiting list recovery initiative. Six month cover in place to support staff absences.

O24 - Paediatric Occupational Therapy - % treated within 18 Weeks for routine referrals

Linked Risk: 633. Forecast for recovery: Anticipated forecasting for recovery due end of September 2026 as new job planning and job productivity tools have time to embed. Actions: Recovery milestones being defined within forecasting plan. Recovery plan in place with workforce, caseload and pathway management overview, including weekly targets. Operational Escalation Recovery Plan enacted and has been reviewed end of August 2026, next review end of September 2026. Update to be presented to Quality Assurance Group in October 2026. Oversight of quality and safety impacts, include regular reporting to Improving Care Group and Quality Assurance Group. Daily duty line in place to offer support and guidance. Long waiter standard operating procedure in place to review referrals waiting more than 24 weeks. Questionnaire in development to gain oversight of long waiters outstanding needs. Meeting booked with Health Visiting and SCAAS to discuss pathway options. Operational/Clinical/Heads of Profession working together to support planning and delivery.

O25 - Stroke ESD - Proportion of new patients assessed within 72 hours of notification

The indicator is impacted due to the bank holiday in August. Assurance mechanism in place which addressed the patient referrals immediately the day following the bank holiday.

O35 - HomeFirst and Reablement - Therapist assessment within 2 days of arriving home

The GCC Home First Reablement changes have had a huge impact on colleagues and service delivery through the summer and the impact has been felt across all the Integrated care teams in August. Despite this, in the first 3 weeks of August the average time to first therapy assessment was 2.6 days, which was an improvement from the July average of 3.6 days.

Services have seen an upwards trend in the performance of this KPI since January 2026 despite the impact of the GCC Cabinet Decision. This month was the second highest performance in the past 2 years. The service has performed well despite the operational changes throughout August but September figures are expected to be disrupted as the existing cohort was moved to a new SystmOne unit and not all first visits will be recorded retrospectively for this group. It is unlikely that the service will achieve compliance until they have recruited to their vacancies and the Management of Change process has fully concluded, which will not be until the 1st of November. Seasonal variation has played a large part towards performance for the period; with many of our Therapists required to take leave to support childcare. Routinely, therapists from other parts of the ICT service would be utilised, but August saw the migration of 81 therapists to GCC as part of the delegated responsibility GCC Cabinet decision which meant this was not possible. Therapists and management within the service were also going through their own Management of Change Process regarding the new Home First Service raising anxiety and unease, which had an indirect impact on service delivery. In the new service, leads will be identified for each shift through a three month rota and once all posts are full it is anticipated that this KPI will be met. Full staffing will not be in place (the MoC cohort) until 1st of November 2026, therefore compliance will not be anticipated until December 2026, for January 27 reporting. Full trust support has been asked for across all areas to meet the demands of setting up a new service for the Trust which is where this KPI sits.

Narrative continued on next page...

O51 - MH Acute Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)

See narrative for N70.

O52 - MH PICU Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)

Linked risk: 725. Forecast for recovery: Quarter 4. The indicator was impacted due to the discharge of a patient who had experienced a very long length of stay. Actions: Wotton Lawn Hospital Stabilisation and Improvement Implementation Group has an extensive phased action plan reporting into Executive Oversight Group. 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. Closer working with community teams.

O53 - MH Older Adult Inpatients Average Length of Stay (Excluding leave - Rolling 3 months) (Days. Not a percentage)

See narrative for N71.

O61 - SARC – Referrals responded to within 90 minutes or with an appropriate appointment of patient’s preference

One delay related to examination room availability. The client did not cross any forensic window or medical timeframe. Achieving and sustaining compliance more likely from January 2027 when the building work at Swindon SARC has concluded. This is currently placing additional pressures on Gloucester SARC as it is more than likely the clinical space will be in use.

O62 - % of children and young people accessing community mental health services, having their outcomes recorded at least twice

See N25 for narrative.

O63 - MH: Percentage of Autism/ADHD First Assessments under 3 years – Adult

System transformation being established. GHC taking system programme lead. Further work to ensure good productivity of existing service provision ongoing. Actions: Increase staffing/capacity. Self-referrals and website information. Review of referral forms to support quality of referral information. Regular review and cleansing of waiting list. Exploration of ambient voice technology. Focussed work on DNAs.

O64 - MH: percentage waiting for autism/ADHD first assessment for over 3 years - adult

System transformation being established. GHC taking system programme lead. Further work to ensure good productivity ongoing. Actions: Increase staffing/capacity. Self-referrals and website information. Review of referral forms to support quality of referral information. Regular review and cleansing of waiting list. Focussed work on reducing cancellations and DNAs which include neighbourhood working, increased communication, exploring support for people on the waiting list. Exploration of ambient voice technology.

O65 - PH Routine IVT % First Contact Within 22 Days &

O66 - PH Urgent IVT % First Contact Within 48 Hours

Forecast for recovery: Trajectory modelling underway. New pathway to be in place from 1 October 2026, anticipate this will create capacity across pathways. Actions: Working with ambulatory care colleagues to review pathway, maximising prescribing capacity to reduce delays and maximise clinic opportunities for routine patients. Additional administrative capacity to support waiting list management function into the service. Links to urgent and emergency care transformation programme. Data quality issues being reviewed.

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

The varying number of babies in Neonatal Intensive Care Unit/family choice impact performance. No action required.

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 this indicator has been in exception previously in the last twelve months.

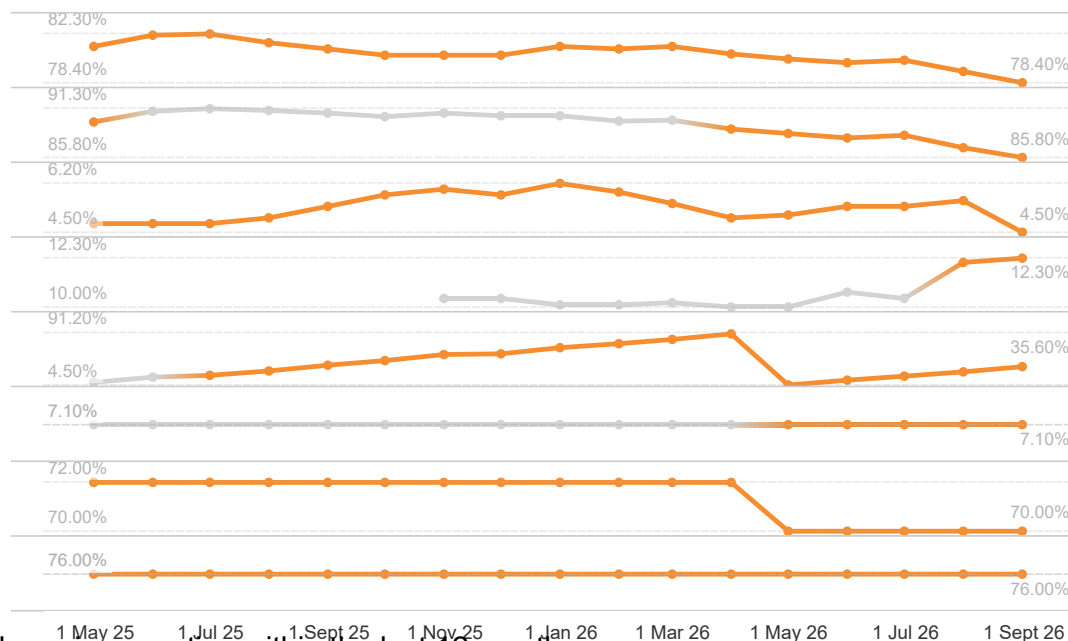
L41 - Bank spend reductions (Joint Forward plan)

The Trust is required to make a year on year spend reduction of 10% on Bank costs. As of August, the Trust was 8.9% above the Bank spend Threshold. For Agency spend, the Trust are currently 7.1% below the Threshold.

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.

Non Compliant

AUGUST		
B28	% (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)	78.4% 90.0%
B29	% (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions applied)	85.8% 90.0%
B30	Sickness Absence average % - including non-working days (NOF & JF Plan)	4.0% 4.5%
B31	Turnover (12 month rolling)	11.0% 12.3%
B32	Cumulative Leave	35.6% 41.7%
B46	Staff engagement overall (theme) score (NOF & JF Plan) - not a percentage	7.3% 7.1%
B47	Improvement in key staff survey questions: Q25c: Would recommend the organisation as a place to work (Joint Forward ..	70.0% 73.4%
B48	Improvement in staff survey questions: Q25d: If a friend or relative needed treatment I would be happy with the standard of..	76.0% 76.6%



Performance Thresholds not being achieved in Month - All indicators have been in exception within the last 12 months.

B28 - % (All Active Assignments including Bank) Staff with completed Appraisals (exclusions applied)

Performance for August is at 78.4%, compared to a threshold of 90%, although the figure is expected to rise slightly again due to delayed data entry, performance is outside normal variation. July performance rose from 78.5% to 79.3% and outside normal variation. The appraisal performance figure includes Bank Staff.

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

B29 - % (All Active Assignments excluding Bank) Staff with completed Appraisal (exclusions applied)

Performance figures for August, excluding Bank staff is at 85.8%, just under the performance threshold of 90%, although the figure is expected to rise slightly due to delayed data entry (July's performance rose from 86.1% to 86.9%). Performance is outside normal variation and has averaged 89.6% for the last 24 months.

Finance is the only directorate meeting the 90% threshold at 91%. Operations and Improvement & Partnerships Directorates were at 87%, the People Directorate are both at 84%, the Medical Directorate are at 74%, Nursing, Quality and Therapy are at 71%, and Corporate Governance are at 61%.

Narrative continued on next page...

Continued from last page...

B30 - Sickness absence average % - including non-working days (Joint Forward plan)

The sickness absence rate for August 2026 is reported at 4.5% 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 mid-August. Once this data is incorporated, the absence rate is expected to rise to 5.7%. The reported sickness absence rate in July 2026, including e-rostering, was 5.6% compared to a threshold of 4.0%. July was reported as 4.2% without the e-rostering data. This continues to follow the seasonal trend of the last few years and is within expected variation.

B31 - Turnover (12 month rolling)

The reported Turnover (12 month rolling) Percentage for August is 12.3% which is above the threshold of 11%. This is due to transfer of 67.04 FTE to another public sector organisation in July 2026. This will have an impact on this KPI for the next 11 months.

B32 - Cumulative Leave

The reported Cumulative Leave Taken Percentage for August 2026 is approximately 35.6%, which is below the 5/12 month target threshold of 41.7%. However, this figure is provisional, as full data from the e-rostering system (Allocate) will not be available until mid-September. The estimated % for August once the data from Allocate has been included is expected to increase to 38.1%.

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.

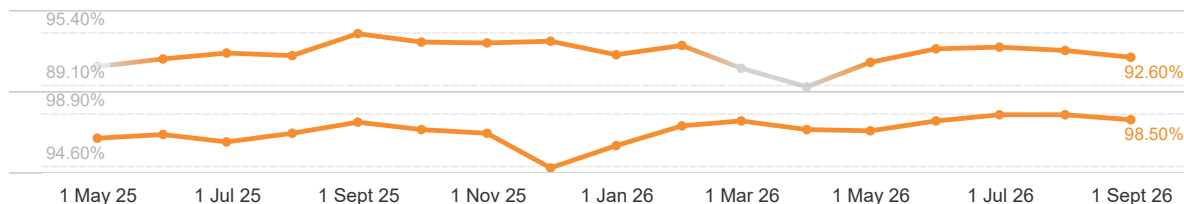
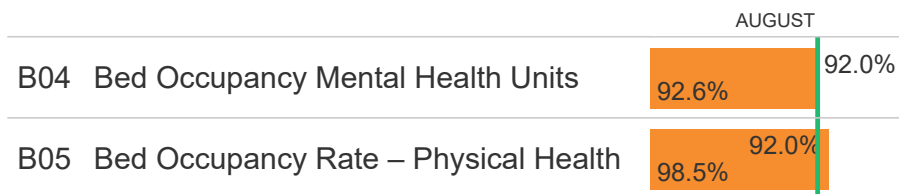
B47 - Improvement in key staff survey questions: Q25c: Would recommend the organisation as a place to work (Joint Forward plan)

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.

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 both of these indicators have been in exception previously in the last twelve months.

B04 - Bed Occupancy Rate – Mental Health Units

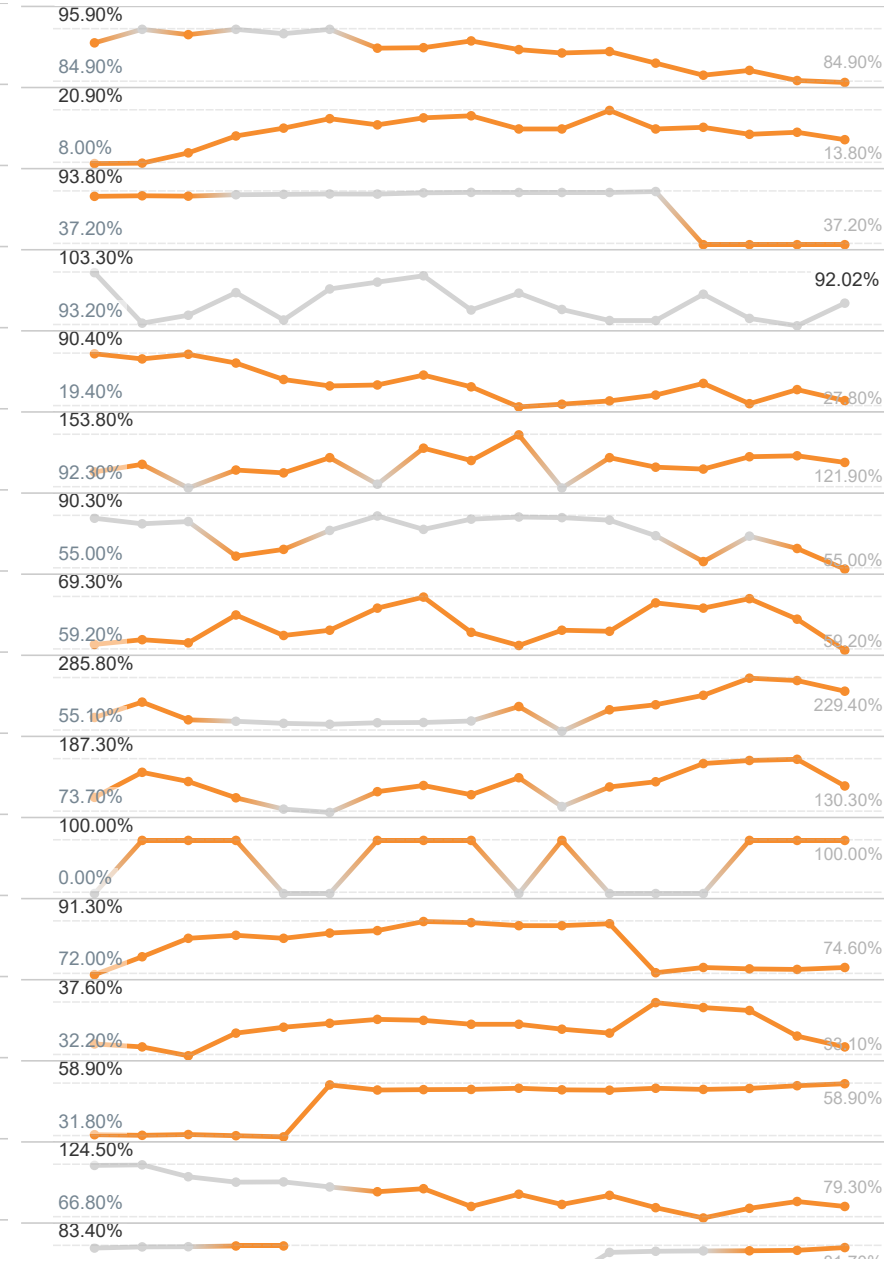
Linked risk: 728. Forecast for recovery: Improvement to be expected through quarter 3, 2026/27. Actions: Length of stay meetings have been established with clinical and social work representatives. Discussions to co-locate key staff. Proposal to remove beds for Berkeley House agreed, which will enable clearer understanding of bed occupancy rates within acute mental health beds, to be reflected next month."

B05 - Bed Occupancy Rate – Physical Health

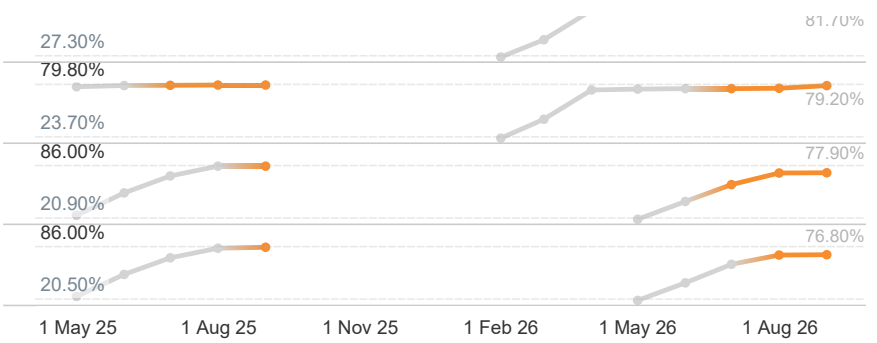
Forecast for recovery: Not agreed due to significant demand for community hospital beds within the county. Work to support reducing the demand is required for pathway one. Actions: Continued work with flow partners to reduce average length of stay. Delay related harm programme in place, bed function discussions as part of future planning and temporary tests of change programme, increasing wellbeing champion network.

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

		AUGUST
B01	Care Programme Approach - formal review within 12 months	84.9% 95.0%
B02	Nationally reported - Delayed Discharges (Including Non Health)	13.8% 7.5%
B08	Improved Data Quality and Reporting - Data Quality Maturity Index (NOF)	37.2% 90.0%
B11	Safer Staffing Fill Rate - Community Hospitals	92.02% 92.5%
B13	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	27.8% 99.0%
B17	Total number of pressure ulcers developed or worsened during care by this Trust	121.9% 100.0%
B57	Routine (CoHo Only) Mental Health Liaison Referrals Seen Within 24 Hours	55.0% 80.0%
B58	Clinical Supervision: % of eligible staff with clinical supervision recorded in the previous 40 days	59.2% 90.0%
B60	Total number of incidents involving rapid tranquilisation (Whole Trust)	229.4% 100.0%
B61	Total number of incidents involving physical restraint (Whole Trust)	130.3% 100.0%
N02	Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only	100.0% 0.0%
N22	Mental Health: Number of people accessing (IPS) Individual Placement and Support (Op. plan E.H.35)	74.6% 100.0%
N25	Children and young people, and women in the perinatal period accessing mental health services, having their routine outcomes measured at least twice	33.1% 50.0%
N32	MH: GHC contribution to - The number of people on the General Practice SMI registers who have received a full, annual physical health assessment in the 1..	58.9% 75.0%
N43	NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)	79.3% 100.0%
S12	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	81.7%



S12	HPV immunisation coverage for girls aged 12/13 years old - Immunisation 1	80.0%	90.0%
S15	HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1	79.2%	90.0%
S16	MenACWY (Meningitis) coverage for all children in school year 9	77.9%	90.0%
S17	Td/IPV (Diphtheria, tetanus and inactivated poliomyelitis) coverage for all children in school year 9	76.8%	90.0%



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

...narrative continued from last page...

B01 - Care Programme Approach - formal review within 12 months

Forecast for recovery: New forecast confirmed as quarter 3, 2026/27. Actions: Progressing with "My Care Plan" being embedded within the Assessment and Care Management Policy and exploring new KPI with colleagues within the Nursing, Therapies and Quality Directorate. Actions: Reports outlining overdue CPAs are sent to operational leads to review monthly and ensure formal CPA reviews are booked in. Increased focus on "My Care Plan".

B02 - Nationally reported - Delayed Discharges (Including Non Health)

Linked risk: 728 (196 closed to expand risk narrative related to Wotton Lawn Hospital). Actions: Focus on bed management related to the temporary reduction of beds at Wotton Lawn Hospital. Focus on patient flow, both for working age and older adults over the last few months is improving delayed discharges through improved system partnerships and establishing clear escalation routes.

B11 - Safer Staffing Fill Rate - Community Hospitals

Performance was at 92.02% for August 2026. AHP has contributed to more than 7.5% ((7.98%)) during the period which was the estimated AHP impact on the metric when the target was recently reviewed. Nursing registered and non-registered fill rate in August is at 98.6%, even though this is below 100%, the Care Hours Per Patient Per Day (CHPPD) is within the expected range for each ward and therefore there are no concerns for the overall performance level or this indicator at this time

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. Weekly reconciliation of waiting list information 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

August 2026 data remains subject to validation and classifications may change following review. There were 111 pressure ulcers reported in August (July: 118) 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. Additionally, recent sustained high temperatures and associated dehydration has contributed to an increase in pressure ulcers. A review is being undertaken to understand the impact of deferred care due to workforce challenges in ICT localities to see if this could be driving a small increase.

B57 - Routine (CoHo Only) Mental Health Liaison Referrals Seen Within 24 Hours

Forecast for recovery: To be determined following a review of data, to understand specific referral information, breach reasons and timelines. Actions: Reviewing service provision in relation to the model and resource. Data quality issues identified and will be addressed.

B58 - Clinical Supervision

Reported professional supervision compliance continues to be impacted by three key factors:

1. Reporting issues where completed professional supervision is not always reflected accurately within compliance reports.
2. Recording issues, with some colleagues not fully aware of the correct process for recording professional supervision. As a result, supervision may be taking place but is not consistently captured within reporting mechanisms.

Narrative continued on next page...

...narrative continued from last page...

3. Data flow issues from Totara since 23 August, affecting the visibility and reporting of supervision activity. Heads of Profession are actively addressing these issues through targeted communication, clarification of recording requirements, local oversight and validation of compliance data.

In addition, Heads of Profession have been asked to:

1. Strengthen understanding of professional supervision requirements and compliance expectations within their professions, recognising the limitations of current reporting arrangements which do not routinely report by profession.
2. Identify teams and services with compliance below 90%, implement targeted improvement actions and monitor progress through professional governance arrangements.
3. Include professional supervision compliance as a standing agenda item within Professional Governance Meetings to support regular oversight and escalation of risks.
4. Review supervisor capacity, identifying gaps, risks and actions required to support sustainable supervision arrangements.

While improving compliance remains a priority, current work is focused on ensuring supervision activity is both undertaken and accurately recorded, enabling a more reliable assessment of compliance and professional assurance across services.

B60 - Total number of incidents involving rapid tranquilisation (Whole Trust)

There has been a further decrease in incidents in August. This is a similar pattern with regards to the physical restraint incidents, and this is to be expected. Work around improving training compliance for rapid tranquilisation is ongoing. The Head of Profession is due to present at Learning and Development Oversight Group to ensure that this training is essential for role for HCA's employed in inpatient MH settings recognising their key role in post rapid tranquilisation monitoring. This will continue to be monitored and reported through Positive and Safe Group.

B61 - Total number of incidents involving physical restraint (Whole Trust)

There has been a further decrease in incidents in August and the number of individuals restrained. This is primarily within WLH, and contributory factors are the temporary reduction of beds, a change in patient cohort because of discharges and a reduction in the use of agency staff leading to more experienced and substantive staff and less use of physical restraint. There are training days planned for September and October to include all aspects of restrictive intervention to continue to address and improve on the relatively high levels of physical restraint required.

N02 - Minimise rates of C. Diff (Clostridioides Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only

2 C.diff positive HOHA cases. One case is isolated but does not require treatment. The other case is isolated and commenced on treatment. Both cases will be closely monitored until fully recovered.

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 and associated recruitment and generation of primary care referrals. Actions: Additional three employment specialists recruited. Expanded into primary care, Forest, Cheltenham and Gloucester. Exploring communications and media to advertise and raise profile within job centre and other professional groups.

Narrative continued on next page...

...narrative continued from last page...

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

Forecast for Recovery: Perinatal element impacted by staffing challenges in August 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 strong compared to national picture. Progress with ROMS for CAAAS/ADHD medication pathway. Use of ROMs within Children in Care. Bi-monthly meetings with the National Digital ROMS with CYP special interest group to share best practice. New outcome measure CGAS identified and request is with Clinical Systems Team. Perinatal Actions: Service are revisiting the assurance mechanism in place to ensure that outcome measures are completed at the start/end of an episode of care.

This KPI will need to be further developed to count discharges only, to meet the new 2026/27 national NHS Oversight Framework monitoring. This would also remove the need for perinatal monitoring within the KPI. However perinatal could, if required, be maintained through operational KPI monitoring. When the updated view is understood, a fuller paper will proceed through operational governance forums with a recommendation for the appropriate updates to the Trust Resources Committee later in the year. Chris, please can you let Dominic, Jane and I know what the timelines for the KPI development are for this?

N32 - MH: GHC contribution to - The number of people on the General Practice SMI registers who have received a full, annual physical health assessment in the 12 months to the end of the period

Forecast for recovery: Quarter 4, 2026/27. Actions: Teams reminded of importance of full completion of the APHC forms to ensure they are valid. Annual physical health check clinics implemented within Recovery Team. Review data on team by team basis including non Recovery Teams. Establish areas where there are gaps and identify/implement pathways. Some patients refuse to complete all elements of assessment and this results in a nil return. We are doing further work to understand the impact of this.

N43 - NHS Talking Therapies proportion of adults and older adults receiving a course of treatment (Op. plan E.A.4b)

Forecast for recovery: In development. 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.

S12 - HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1 &

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

Team reviewing uptake daily and undertaken school revisits. Community clinics continued to be held during the summer holidays.

S16 - MenACWY (Meningitis) coverage for all children in school year 9 &

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

Nationally the target is recognised as ambitious by national and regional commissioners. Vaccinations are offered to all school aged pupils (including those educated at home). Informed consent is required to be able to administer the vaccination. Community clinics continued to be held during the summer holidays.

REPORT TO: TRUST BOARD **PUBLIC SESSION – 1st OCTOBER 2026**

PRESENTED BY: Katherine Archer, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st August 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 5 position.

Executive summary

- The Trust's annual plan is a £0.053m surplus. At month 5 the Trust has a surplus of £0.049m, slightly better than the year-to-date plan of a £0.022m surplus.
- 26/27 Capital plan included £16.208m of expenditure and £2.895m of disposals. After disposals net spend to month 5 is £2.066m against a budget of £5.877m due to slippage in schemes such as the provision of a new training facility, and in concluding the EJC transfer.
- Cash at the end of month 5 is £39.988m, which is in line with plan.
- The Trust spent £7.585m ytd on bank staff, against the plan of £6.963m.
- The Trust spent £0.94m on agency staff, against the plan of £1.011m. There were 18 off framework shifts, the target is 0.

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-11.1/1026 Finance Report
--------------------	-----------------------------

Report authorised by: Katherine Archer	Title: Director of Finance and Deputy CEO
--	---



Gloucestershire Health and Care
NHS Foundation Trust



AGENDA ITEM: 11.1/1026

Finance Report Month 5

1 October 2026

Presented by

Stephen Andrews, Deputy Director of Finance

Overview

- The Trust's annual plan is a £0.053m surplus. At month 5 the Trust has a surplus of £0.049m, slightly better than the year-to-date plan of a £0.022m surplus.
- 26/27 Capital plan included £16.208m of expenditure and £2.895m of disposals. After disposals net spend to month 5 is £2.066m against a budget of £5.877m due to slippage in schemes such as the provision of a new training facility, and in concluding the EJC transfer.
- Cash at the end of month 5 is £39.988m, which is in line with plan.
- Cost improvement programme has delivered £5.645m of recurring savings up to month 5. Target for the year is £14.459m. (£4.454m, 24.83% is unidentified at month 5).
- Non recurrent savings target is £3.475m of which £1.984m is delivered. All has been identified.
- Operating Income is over plan by £3.7m due to additional Community Care income (offset by expenditure) and additional development income.
- Pay spend is under plan by £0.362m including a bank cost over spend of £0.622m and agency cost under spend of £0.071m. There were 18 off framework shifts, the target is 0.
- Non pay over spend of £3.985m is driven by Out of County Admissions, Specialist Treatment and Rehabilitation (STAR) demand costs and Community Care costs (offset by income).
- Better Payment Policy shows 94.4% of invoices by value paid within 30 days and 91.4% by number of invoices, the national target is 95%.

GHC Income and Expenditure

	2026/27	2026/27	2026/27	2026/27	2026/27
	Revised Plan	Revised Plan ytd	Actuals ytd	Variance	Forecast
	£000s	£000s	£000s	£000s	£000s
Operating income from patient care activities	313,500	130,624	134,350	3,726	315,973
Other operating income	18,684	7,786	8,556	770	19,797
Employee expenses - substantive	(240,909)	(100,379)	(99,467)	912	(237,362)
Bank	(16,712)	(6,963)	(7,585)	(622)	(17,948)
Agency	(2,425)	(1,011)	(940)	71	(2,425)
PAY SUB TOTAL	(260,046)	(108,353)	(107,991)	362	(257,735)
Operating expenses excluding employee expenses	(70,328)	(29,303)	(34,396)	(5,093)	(76,989)
PDC dividends payable/refundable	(2,847)	(1,186)	(1,186)	(0)	(2,847)
Finance Income	1,240	517	817	300	2,044
Finance expenses	(203)	(85)	(86)	(1)	(203)
Surplus/(deficit) before impairments & transfers	0	0	65	65	40
Gains/ (losses) from disposal of assets			(38)	(38)	(40)
Remove capital donations/grants I&E impact	53	22	22	(0)	53
Surplus/(deficit)	53	22	49	27	53
Adjust (gains)/losses on transfers by absorption/impairments	0		0	0	
Remove net impact of consumables donated from other DHSC bodies	0		0	0	
Revised Surplus/(deficit)	53	22	49	27	53
WTEs	4755	4752	4601	(151)	4,654

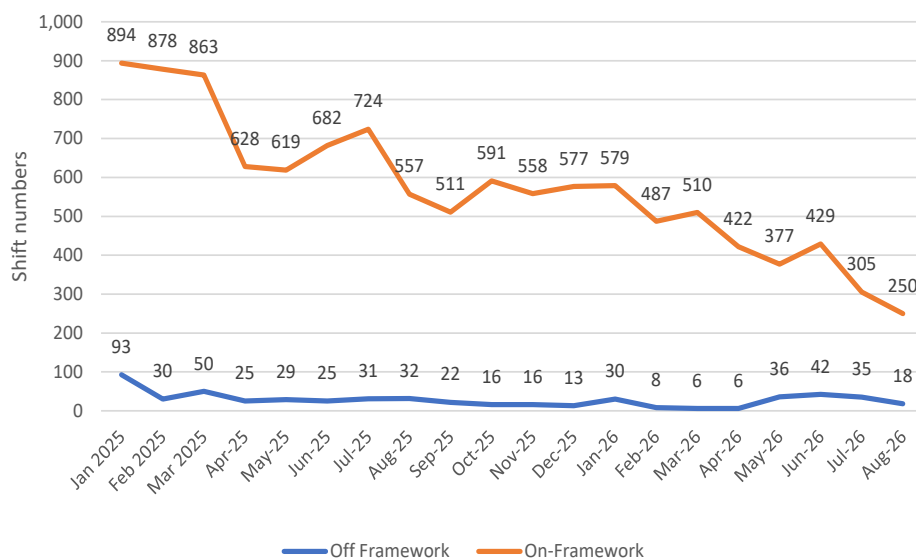
Budget for bank & agency is for specific cost centres, but Plan is for the Trust.

Pay analysis Month 5

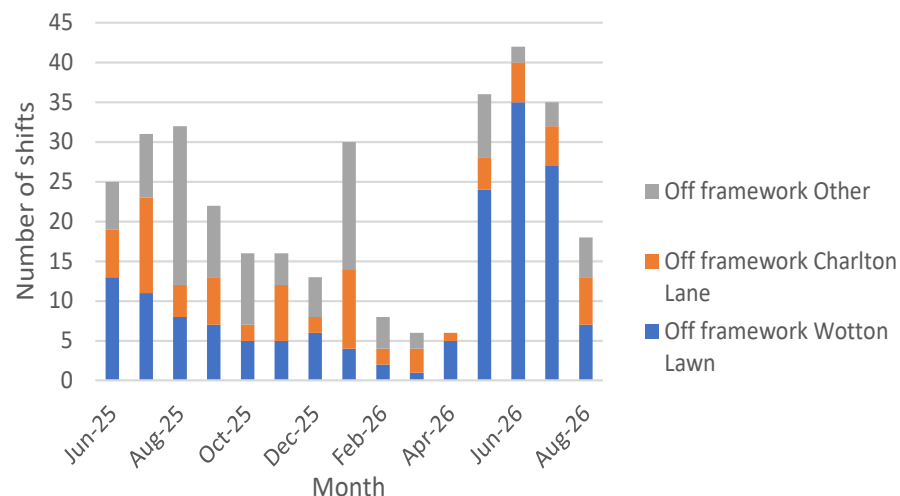
	Plan WTE Month 5	Budget WTE Month 5	Actual WTE Month 5	Revised Plan ytd £000s	Actual ytd £000s	YTD Variance to plan £000s	Actual £ as % of Total £
Substantive	4,401	4,811	4,314	100,379	99,467	912	92.1%
Bank	338	7	271	6,963	7,585	(622)	7.0%
Agency	21	0	16	1,011	940	71	0.87%
Total	4,760	4,818	4,601	108,353	107,991	361	100.0%

- Trust WTE budget 58 higher than plan due to developments
- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- the Trust used 18 off framework agency shifts in Aug (35 in July). The target is 0.

GHC Agency Shifts - On and Off Framework



Off framework shifts Wotton Lawn v Charlton Lane v Other



Balance Sheet

STATEMENT OF FINANCIAL POSITION (all figures £000)		2025/26	2026/27				2026/27
		Actual	NHSE Plan	YTD revised plan	YTD Actual	Variance	Full Year Forecast
Month 5							
Non-current assets	Intangible assets	2,465	2,234	2,282	2,230	(52)	2,384
	Property, plant and equipment: other	125,254	128,095	126,144	125,156	(988)	127,360
	Right of use assets	15,797	15,278	17,028	14,915	(2,112)	15,584
	Receivables: due from NHS and DHSC group bodies	721	966	986	542	(445)	503
	Receivables: due from non-NHS/DHSC Group bodies	0	188	188	168	(20)	168
	Total non-current assets	144,237	146,761	146,628	143,011	(3,617)	145,999
Current assets	Inventories	385	443	443	385	(58)	385
	NHS receivables	9,224	8,793	8,793	8,444	(349)	8,444
	Non-NHS receivables	7,472	7,612	7,612	9,224	1,612	7,224
	Credit Loss Allowances	(1,351)	(1,919)	(1,919)	(1,237)	682	(1,237)
	Property held for Sale	2,215	1,203	3	1,315	1,312	2,065
	Cash and cash equivalents:	41,303	37,854	40,004	39,965	(39)	42,322
	Cash and cash equivalents: commercial / in hand / other		23	0	23	23	23
	Total current assets	59,247	54,009	54,936	58,119	3,182	59,225
Current liabilities	Trade and other payables: capital	(3,270)	(4,295)	(3,458)	(1,913)	1,545	(3,913)
	Trade and other payables: non-capital	(32,313)	(30,753)	(31,939)	(31,007)	932	(31,821)
	Borrowings	(1,469)	(1,409)	(1,409)	(1,431)	(22)	(1,431)
	Provisions	(7,333)	(6,870)	(6,870)	(7,945)	(1,075)	(7,945)
	Other liabilities: incl. deferred income	(426)	(1,453)	(1,453)	(1,440)	13	(1,440)
	Total current liabilities	(44,811)	(44,780)	(45,129)	(43,736)	1,393	(46,550)
Non-current liabilities	Borrowings	(13,515)	(12,995)	(14,740)	(12,690)	2,050	(12,637)
	Provisions	(2,455)	(2,500)	(2,500)	(1,973)	527	(1,973)
Total net assets employed		142,704	140,495	139,195	142,730	3,536	144,064

Taxpayers Equity	Public dividend capital	132,972	134,272	132,972	132,972	(0)	134,332
	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 year)	778	0	0	26	26	(0)
	Total taxpayers' and others' equity	142,704	140,495	139,195	142,730	3,535	144,064

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	42,345	38,264	37,816	37,527
Cash flows from operating activities										
Operating surplus/(deficit)	1,330		520		1,050		1,975	1,950	1,929	1,913
Add back: Depreciation on donated assets	52		22		53		51	51	51	51
Adjusted Operating surplus/(deficit) per I&E	1,383		542		1,103		2,026	2,001	1,980	1,964
Add back: Depreciation on owned assets	9,809		4,191		10,376		9,029	9,600	9,701	10,107
Add back: Depreciation on Right of use assets							1,415	1,391	1,367	1,151
Add back: Impairment	1,183				0		0	0	0	0
(Increase)/Decrease in inventories	60				0		0	0	0	0
(Increase)/Decrease in trade & other receivables	(148)		(1,298)		759		42	43	1	1
Increase/(Decrease) in provisions	(1,519)		128		130		0	0	0	0
Increase/(Decrease) in trade and other payables	5,451		(2,286)		(285)		0	0	0	0
Increase/(Decrease) in other liabilities	(877)		1,014		1,014		0	0	0	0
Net cash generated from / (used in) operations		15,343		2,290		13,097	12,512	13,035	13,049	13,223
Cash flows from investing activities										
Interest received	2,355		795		2,044		958	956	999	999
Interest paid	0						(17)	(17)	(17)	(17)
Proceeds from Sale of PP&E	930		862		1,312		2,765	1,176	1,000	0
Purchase of property, plant and equipment	(15,531)		(4,557)		(12,007)		(15,801)	(11,155)	(10,896)	(8,956)
Assets Held for Sale										
Net cash generated used in investing activities		(12,246)		(2,901)		(8,652)	(12,095)	(9,040)	(8,914)	(7,974)
Cash flows from financing activities										
PDC Dividend Received	869		0		1,360		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		40		97		97	96	4	4
Finance lease receipts - Interest	(60)		(22)		(58)		(55)	(52)	(3)	(3)
Interest arising (unwinding of discount)	60		22		58					
Finance Lease Rental Payments	(1,582)		(660)		(1,810)		(1,531)	(1,501)	(1,461)	(1,201)
Finance Lease Rental Interest	(215)		(83)		(203)		(162)	(139)	(117)	(98)
		(3,648)		(703)	0	(3,403)	(4,498)	(4,443)	(4,424)	(4,145)
Cash and cash equivalents at end of period		41,303		39,989	0	42,345	38,264	37,816	37,527	38,631

Capital- Five-Year Plan

Capital Plan	Plan	Plan YTD	Actuals	Plan	Plan	Plan	Plan	Plan
£000s	2026/27	2026/27	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Land and Buildings								
Buildings	3,871	1,711	886	8,250	5,750	2,821	1,636	1,636
Backlog Maintenance	2,451	839	583	1,393	750	1,400	1,400	1,400
Buildings - Finance Leases	2,458	2,015	(234)	90	2,115	347	382	382
Vehicle - Purchases / Finance Leases	50	0	39	250	250	250	250	250
Other Leases	0	0		0	0	300	0	0
Net Zero Carbon	2,401	1,034	1,251	0	0	1,000	1,000	1,000
Medical Equipment	669	269	46	630	500	1,200	1,200	1,200
Digital								
IT Devices	200	0		900	900	1,200	1,200	1,200
IT Infrastructure	1,648	268	30	1,250	380	1,310	1,310	1,310
WAN/LAN	0			0	1,530	400	400	400
Transforming Care Digitally	1,230	571	156	250	0	0	0	0
NHS Net Transition	334	139	85	0	0	0	0	0
Digital Innovation	0	0		0	540	590	590	590
Data Centres/Servers	30	0		840	40	0	0	0
Patient Portal	256	206	124	0	0	220	220	220
Space Management Toolkit (Estates)	0	0		0	0	0	0	0
PDC National IT Schemes	1,300	521		770	765	755	0	0
Unallocated	273							0
Total of Updated Programme	17,171	7,573	2,966	14,623	13,520	11,793	9,588	9,588
Disposals	(2,680)	(1,695)	(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	5,878	2,066	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
Additional PDC - EVCP/Solar panels								0
CDEL Shortfall / (under commitment)	0			113	1,056	1,043	(162)	(162)

CIP

Summary	Total Target	Delivered	Identified - low risk to delivery	Identified £'000	Unidentified
Prior Year(s)	4,304	1,519	812	1,531	442
Efficiency	3,380	1,411	396	326	1,247
Delivering Value	4,877	1,462	60	753	2,602
Delegated Responsibility	1,044	445	223	214	163
Programme Savings	854	808	46	0	0
Non Recurrent Savings	3,475	1,984	1,491	0	0
Total	17,934	7,628	3,028	2,823	4,454
<i>Percentage Total</i>		42.54%	16.89%	15.74%	24.83%

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

CIP

Sub-Directorate	Total Target	Delivered	Identified - low risk to delivery	Identified £'000	Unidentified
Adult Community PH MH & LD	4,566	537	1,003	1,130	1,897
Children & Young People (CYPS)	784	313	0	471	0
Countywide	1,236	403	123	323	388
Finance	1,557	1,172	315	0	71
Board	222	222	0	0	0
People	385	97	0	288	0
Improvement & Partnerships	51	51	0	0	0
Integrated Urgent Care	269	269	0	0	0
Medical	1,381	370	14	24	973
MH Urgent Care & IP	1,514	322	37	203	952
Nursing, Therapies & Quality	573	0	0	337	236
Operational Management	88	40	0	48	0
PH Urgent Care & IP	979	1,041	0	0	(62)
Programme Savings	854	808	46	0	0
Non recurrent savings	3,475	1,984	1,491	0	0
Total	17,934	7,628	3,028	2,823	4,454
		42.54%	16.89%	15.74%	24.83%

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

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	1,777	4	3	1,777	12
There is a risk that services do not have the capacity to identify CIP schemes in year resulting in under delivery of RECURRENT in year CIP target (622)	Create dedicated time to review CIP. CIP Management Group to actively manage situation and support directorates if greater support needed.	3,397	4	4	3,397	16
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	4,454	3	5	4,454	15
There is a risk that the uplift to the 26/27 contract tariff (1.24%) 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 (756)	Detailed assessment of implications to ensure clear understanding of impact and to allow appropriate mitigations to be sought	1,184	4	3	1,184	12



with you, for you



Gloucestershire Health and Care
NHS Foundation Trust



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

REPORT TO: TRUST BOARD **PUBLIC SESSION - 1st October 2026**

PRESENTED BY: Nicola Hazle Director of Nursing Therapy and Quality

AUTHOR: Sarah Birmingham – Chief Allied Health Professional

SUBJECT: **QUALITY DASHBOARD REPORT – AUGUST 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:

This report provides an overview of quality, safety, patient experience and governance indicators across Gloucestershire Health and Care NHS Foundation Trust.

It supports the Board in discharging its responsibilities for quality assurance, patient safety, safeguarding, clinical effectiveness, patient experience and regulatory compliance.

Recommendations and decisions required

The Trust Board is asked to:

- **Receive** the Quality Dashboard for August 2026.
- **Note** the areas of alert and ongoing monitoring.
- **Take assurance** from the quality, safety and patient experience indicators presented.
- **Support** actions being taken to improve complaint timeliness and investigation closure rates.

EXECUTIVE SUMMARY

The August Quality Dashboard provides assurance that quality and safety remain stable across the Trust. Positive performance continues to be demonstrated in patient experience, safeguarding activity, infection prevention and control, and safe staffing, alongside reductions in self-harm, falls and restrictive interventions. Board attention is required in relation to workforce pressures affecting patient safety investigation timeliness, and ongoing registered nurse staffing pressures within rehabilitation services.

Improvement work continues to strengthen sexual safety reporting, ethnicity data quality and organisational learning. Overall, the report provides assurance that identified risks are being actively managed and targeted improvement actions are in place.

Risks associated with meeting the Trust's values

Failure to address safeguarding supervision compliance, investigation timeliness, workforce sustainability, sexual safety reporting and ethnicity data quality may impact the Trust's ability to demonstrate its values of working together, continuous improvement, respect and inclusion, and making a positive difference to patient outcomes and experience.

Corporate Considerations

Quality Implications	The August Quality Dashboard provides assurance that quality and safety remain stable across the Trust, with positive patient experience, strong infection prevention and control performance, and reductions in several key patient safety indicators. Areas requiring continued improvement include safeguarding supervision compliance, patient safety investigation timeliness, sexual safety reporting and ethnicity data quality.
Resource Implications	Existing workforce pressures within the Patient Safety Team and ongoing nursing staffing challenges within rehabilitation services continue to require management attention. Delivery of recovery plans, workforce reviews and improvement programmes will need to be supported within available resources and existing governance arrangements.
Equality Implications	The report highlights limitations in ethnicity data quality, which restrict the Trust's ability to fully assess variation in access, experience and outcomes across different population groups. Improvement work through the Patient and Carer Race Equality Framework (PCREF) remains a priority to strengthen assurance regarding equitable care and outcomes.

Please list any meetings where this has been discussed before

Quality Assurance Group September 2026

Appendices:

AI-12.1/1026 - Appendix 1 Quality Dashboard

Acronyms used within this report

AAR	After Action Review
AM	Allegation Management
ATP	Adenosine Triphosphate
CAMPI	Catheter Associated Medical Pressure Injury
CAS	Clinical Assessment Service
CHPPD	Care Hours Per Patient Day
CPE	Carbapenemase Producing Enterobacterales
CRHT	Crisis Resolution and Home Treatment Team
CYPS	Children and Young People's Services
DoC	Duty of Candour
EPR	Electronic Patient Record
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observation and Care
FFT	Friends and Family Test
FFP3	Filtering Face Piece 3 Respirator
GCC	Gloucestershire County Council
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT t	Gloucestershire Hospitals NHS Foundation Trust
HCID	High Consequence Infectious Disease
HCSW	Healthcare Support Worker
HOHA	Hospital Onset Healthcare Associated
HODA	Hospital Onset Definite Association
ICP	Integrated Care Plan
IPC	Infection Prevention and Control
IUCS	Integrated Urgent Care Service
LCSPR	Local Child Safeguarding Practice Review
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDRO	Multi-Drug Resistant Organism
MH	Mental Health
MHA	Mental Health Act
MIIU	Minor Injury and Illness Unit
MMR	Measles, Mumps and Rubella Vaccine
MRSA	Methicillin-Resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-Sensitive <i>Staphylococcus aureus</i>
NED	Non-Executive Director
NHSE	NHS England
PAPRH	Powered Air Purifying Respiratory Protective Hood
PCET	Patient and Carer Experience Team
PCREF	Patient and Carer Race Equality Framework
PFD	Prevention of Future Deaths
PSII	Patient Safety Incident Investigation
PST	Patient Safety Team
QAG	Quality Assurance Group
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RN	Registered Nurse

RPH RSV SMI SWARM WLH	Respiratory Protective Hood Respiratory Syncytial Virus Severe Mental Illness Shallow Water Acoustics in a Random Medium Wotton Lawn Hospital
-----------------------------------	---

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

QUALITY DASHBOARD 2026/27

Physical Health, Mental Health and Learning Disability Services

Data covering August 2026

This report 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, which is presented 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

- Workforce pressures within the Patient Safety Team continue to impact the timely completion of investigations. Executive oversight and recovery plans remain in place to support delivery of organisational learning and reduce the backlog of open investigations
- Persistent registered nurse staffing red flags within rehabilitation services remain under active review. Whilst no staffing-related patient harm has been found, workforce establishment reviews are being undertaken to assure future sustainability and safety

Advise

- Safeguarding supervision compliance within children's services remains below expected levels, creating a risk that opportunities for professional reflection, challenge and learning are reduced. Recovery actions are in progress.
- As there is no nationally recognised safe staffing methodology for Minor Injury and Illness Units (MIIUs) this is creating a challenge in evidencing safe staffing decisions against an agreed benchmark. Workforce modelling work is continuing with oversight by the Safer Staffing Governance Group.
- Sexual safety reporting reduced during August; however, the Trust is not assuming risk has reduced and recognises that under-reporting remains a potential concern. Further work is underway to strengthen reporting culture, oversight and analysis.
- Current ethnicity data limitations continue to restrict the Trust's ability to fully assess variation in access, experience and outcomes across ethnic groups. Improvement work through PCREF remains a priority.

Alert, Advise, Assure, Applaud

Assure

- Statutory safeguarding responsibilities continue to be delivered effectively, supported by strong engagement in multi-agency safeguarding arrangements and reviews.
- Mental Health, Learning Disability and Physical Health inpatient services remained within safe staffing parameters during August, with no evidence of staffing-related patient harm.
- Infection Prevention and Control indicators remain strong, with no outbreaks, high levels of hand hygiene compliance and effective management of infection risks.
- Patient experience remains positive, with 91% of respondents reporting a positive experience and complaints acknowledged within required timeframes.
- The Learning From Deaths Report (LFD) (Quarter 4) is presented in Appendix One and provides assurance that, none of the deaths that were reviewed were considered more likely than not to be due to problems in care.
- Reductions have been observed across several key patient safety indicators, including self-harm, falls and restrictive practice, suggesting quality improvement initiatives are having a positive impact.
- Whilst pressures in the Patient Carer Experience Team (PCET) remain, there is a notable number of complaints closed in August which has improved the timeliness position comparatively in the earlier part of the year, with close monitoring of the position remaining in place.

Applaud

- Improvement is beginning to be seen in safeguarding documentation compliance following targeted interventions and staff engagement.
- IPC and cleanliness standards remain consistently strong across Trust services, providing one of the Trust's strongest areas of quality assurance.
- Services are continuing to strengthen ethnicity recording and data quality to support future understanding of inequalities in access, experience and outcomes.

Are Services Safe? - Safeguarding

The safeguarding dashboard demonstrates continued delivery of statutory safeguarding responsibilities and active engagement with multi-agency processes across the system. Several indicators show stable performance, particularly in relation to MASH activity, safeguarding advice line usage, and ongoing review processes. There is also evidence of improvement in the use of safeguarding documentation within adult services following targeted interventions

A notable improvement has been seen in the use of the adult safeguarding template, increasing from 17 uses in July to 50 in August, representing a near threefold increase. This suggests that recent communications, reminders and training interventions are beginning to have a positive impact. The children's template continues to be consistently utilised, with usage increasing by just over 5% from 1,794 to 1,887 over the same period. MARAC activity reduced during August:

- Families screened/researched decreased from 154 to 106.
- Children and adults researched decreased from 540 to 342.

The narrative attributes this reduction to the school holiday period, which is a plausible explanation and consistent with historical seasonal variation.

MASH activity remained comparatively stable:

- July: 1,209
- August: 1,203

This suggests that underlying safeguarding demand remains significant despite reduced MARAC volumes.

Seven new allegation management (AM) cases were received during August, compared with two in July. The increase reflects activity within established safeguarding processes and does not indicate a significant change in safeguarding risk. Appropriate governance and oversight arrangements remain in place

Due to the confidential nature of the AM process, detail will not be provided here, however themes and trends are routinely monitored and there are ongoing conversations with Trust governance colleagues in regard to more detailed reporting, analysis and assurance to Board.

	Q1	Jun-26	Jul-26	Aug-26
Number of Safeguarding Escalations	4	0	0	1
MARAC - Families screened/researched	380	129	154	106
MARAC – Children & Adults researched	858	438	540	342
MASH - Children & adults researched	4,117	1,463	1,209	1,203
Number of Adult Reviews ongoing	64	12	12	12
Number of LCSPRs in progress	1	1	1	1
Number of Rapid Reviews attended	1	0	0	0
Expected Child Deaths	1	0	4	2
Unexpected Child Deaths	1	1	1	1
New Allegation Management cases	16	5	2	7
Number of Allegations Management Meetings held this month	67	33	22	26
Number of times SystmOne Safeguarding Template is used for Adults	*	*	17	50
Number of times SystmOne Safeguarding Template is used for Children	*	*	1,794	1887
Safeguarding Advice Line Calls - Children	115	45	59	51
Safeguarding Advice Line Calls - Adult	165	53	70	61

*data not available

Are Services Safe? - Safeguarding

- **High and sustained compliance** for Level 1 and Level 2 safeguarding training, consistently achieving 97-99%.
- **Prevent training compliance remains strong** across all levels (94-99%), indicating good organisational preparedness in relation to Prevent responsibilities.
- **Mental Capacity Act training remains stable**, with Level 1 at 96% and Level 2 at 89%.
- **Level 3 Adult Protection compliance has improved** from 86% in June to 89% in August.
- **Named Professional Level 4 safeguarding training remains fully compliant (100%)**, providing assurance that key safeguarding leadership roles remain appropriately trained.

Whilst most safeguarding training metrics remain above or close to organisational targets, compliance decreases as training becomes more specialist.

- Level 3 Child Protection training remains static at **87%**.
- Level 4 Adult Protection compliance remains significantly below expected levels at **71%**, despite a small improvement from 69% in July.

Children's safeguarding supervision compliance has reduced from **68% to 65%**, remaining substantially below the expected level for an essential to role requirement. Discussions with service care group colleagues will be held to explore opportunities for improved compliance

Children's safeguarding supervision compliance remains below the expected standard at 65%. Whilst there is no evidence that statutory safeguarding duties are not being fulfilled, reduced supervision may limit opportunities for professional reflection, challenge and learning. Targeted actions with operational leaders are underway to improve compliance and recording arrangements. Progress will continue to be monitored through established governance processes.

No Trust wide adult group supervision sessions were held during August as safeguarding staff provided safeguarding supervision to WLH teams as part of the improvement plan. Whilst adult safeguarding supervision is not deemed mandatory, the reduction in activity will be closely monitored to ensure opportunities for learning, reflection and professional challenge remain available.

GHC - Safeguarding Dashboard 2026/27

Training and Supervision Data

	Q1	Jun-26	Jul-26	Aug-26
TRAINING				
Level 1 – Induction	98%	98%	98%	98%
Level 2 – Think Family	96%	97%	97%	97%
Level 3 – Multi-Agency Child Protection	86%	86%	87%	87%
Level 3 Adult Protection	89%	86%	90%	89%
Level 4 - NSPCC Level 4 safeguarding training for named health professionals	*	100%	100%	100%
Level 4 Adult Protection	89%	85%	69%	71%
PREVENT:				
Level 1	99%	99%	99%	99%
Level 2	95%	95%	95%	94%
Level 3	97%	97%	97%	97%
MENTAL CAPACITY ACT:				
Level 1	96%	96%	96%	96%
Level 2	91%	91%	90%	89%
Bespoke MCA Training	14	2	6	Tbc
SAFEGUARDING SUPERVISION				
CHILDREN:				
Group Supervision Sessions	63	22	19	17
Group Supervision Compliance	68%	67%	67%	65%
One to One Supervision Sessions	22	8	7	6
ADULTS:				
Group Supervision Sessions	4	1	1	0
Number of Staff who attended Supervision	17	2	5	0
One to One Supervision Sessions	3	1	1	3

Sexual Safety Incidents



Sexual Safety update:

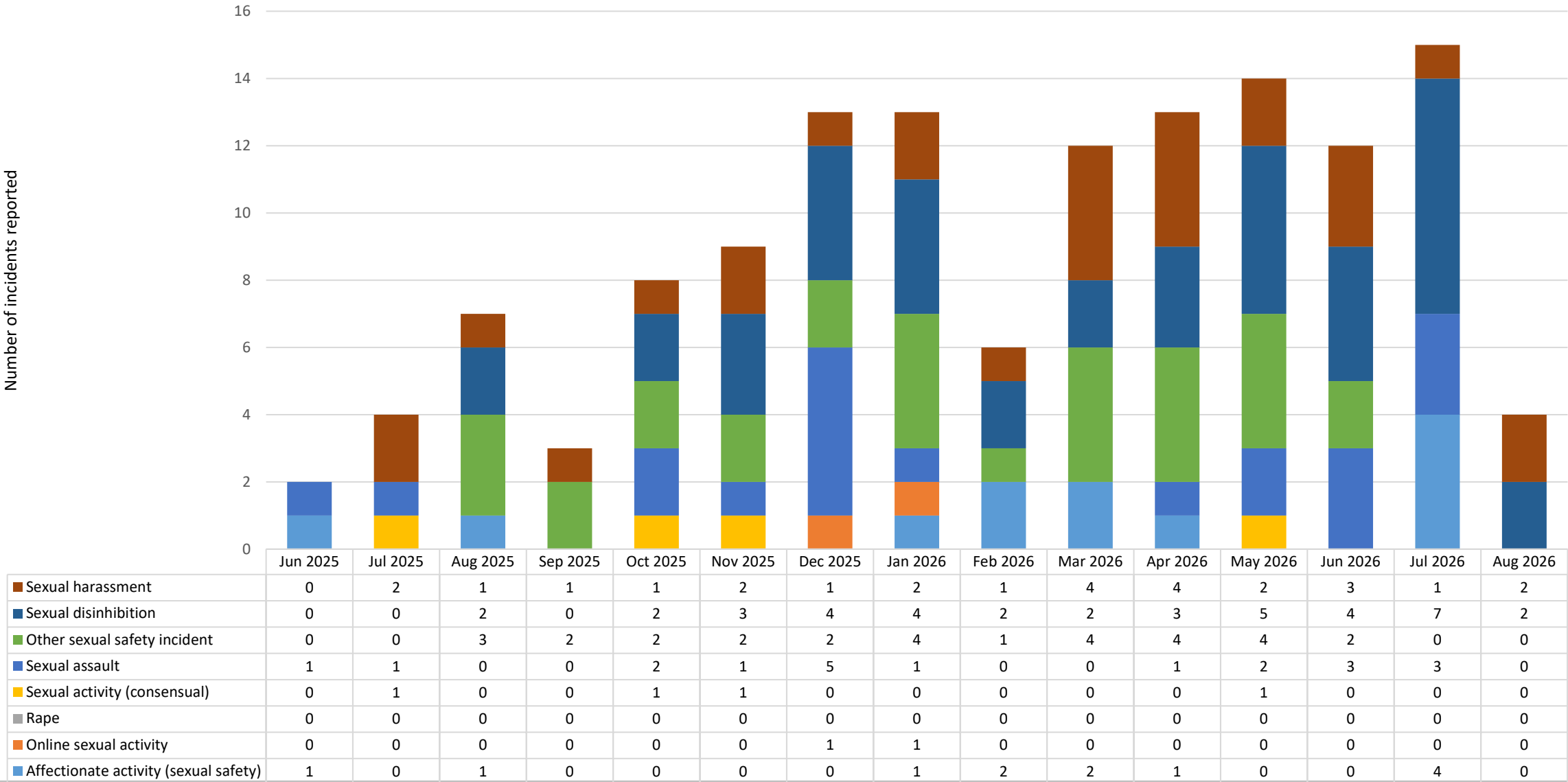
There has been a reduction in sexual safety incidents reported from 15 in July to 4 in August ,the four incidents reported were two of sexual harassment in the community (patient to staff) and two instances of sexual disinhibition from patients. While reported incidents reduced from 15 in July to 4 in August, the Trust is not assuming that underlying risk has reduced. Under-reporting remains a recognised concern and work continues to strengthen reporting culture, staff awareness and organisational oversight.

Sexual Safety Incidents

- The Safeguarding Team provide oversight of all reported sexual safety concerns, including incidents involving patient-to-patient, patient-to-staff and staff-to-patient behaviours. Allegations involving members of staff are managed in accordance with the Trust's Allegations Management Process and relevant safeguarding, workforce and disciplinary procedures. Incidents involving staff-to-staff sexual misconduct are managed in line with the Trust's Sexual Misconduct Policy and NHS England guidance.
- All incidents are reviewed to identify themes, trends and emerging risks. Learning from incidents is used to implement preventative measures, strengthen organisational safeguards, inform workforce education and training, and ensure that appropriate support is available to those affected.
- To date, analysis has not identified any patterns, trends or themes, however further work is programmed going into Q3 to further refine the analysis. This work has and will continue to be presented, discussed and matured within the Trust wide Safeguarding group, chaired by the Deputy Director of Nursing Therapies & Quality.
- Whilst reported sexual safety incidents remain low in comparison with overall Trust activity, under-reporting remains a significant risk. Feedback from colleagues, particularly those working in community settings, indicates that some unwanted, inappropriate and/or harmful sexual behaviours may not always be formally reported. This may reflect the normalisation of such behaviours and highlights the importance of promoting a culture in which colleagues feel safe, supported and confident to speak up and report concerns –this will be aligned closely with the People Directorate and work on sexual misconduct in the workplace.
- The Safeguarding Team will be establishing a multidisciplinary Sexual Safety Working Group to strengthen organisational oversight, improve reporting arrangements and support the development of a mature sexual safety dashboard. The group will work collaboratively across patient-facing services, Trust sexual safety champions, partner organisations and peer Trusts to share learning, benchmark practice and support continuous improvement in sexual safety arrangements.
- The Safeguarding Team has increased their presence at WLH through a programme of scheduled engagement sessions and informal drop-in opportunities for colleagues. These sessions promote awareness of sexual safety, reinforce the Trust's zero-tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours, improve understanding of reporting pathways and support colleagues to raise concerns with confidence.

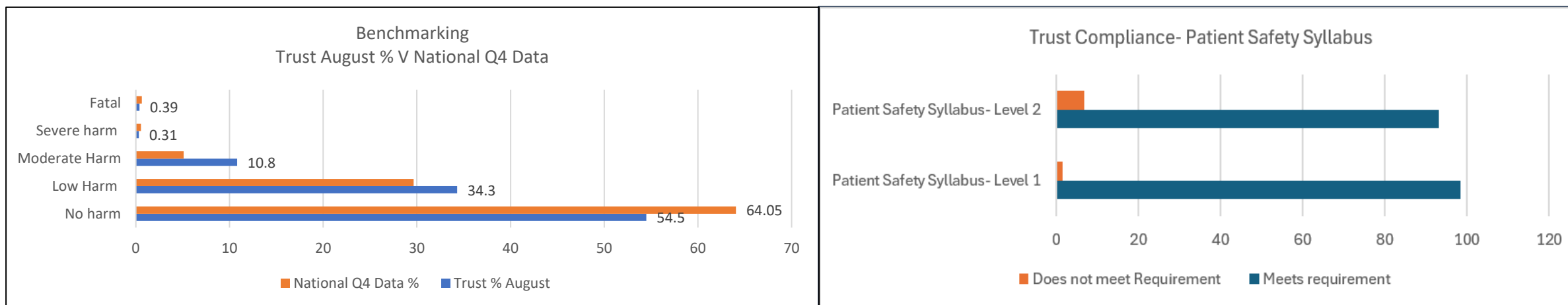
Sexual Safety Incidents

Sexual safety incidents by category
01/06/2025 - 31/08/2026 (last 15 months)



	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Patient Safety Incidents												
Total number of Patient Safety Incidents	1383	1454	1510	1609	1265							
Number of No Harm and Low Harm incidents (including skin integrity)	1219	1338	1364	1453	1117							
Number of incidents reported as resulting in moderate harm, severe harm or death (including skin integrity)	164 (11.8%)	116(7.9%)	146 (9.7%)	156(9.7%)	148(11.6%)							
Patient Safety Investigations												
Number of AARs completed in Month	2	2	1	2	2							
Number of New PSII's and Care Reviews declared in month	3	1	0	1	2							
Number of PSII's open	14	15	15	15	16*							
Number of PSII's closed in month	0	0	0	0	0							
Number of Care Reviews open	2	2	2	2	2*							
Number of Care Reviews closed	0	0	0	0	0							
Number of PSII's and Care reviews open over 6 months	10	13	13	13	13							
Number of PSII's/ Care Reviews planned for Exec sign off (Closure)	0	2	2	2	3							
Family Liaison Practitioners												
Number of patients being supported	0	0	0	0	0							
Number of family and friends being supported	14	14	14	14	14							
Regulation 28- Prevention of Future of Deaths (PFD's)												
Number issued by Coroner	0	0	0	0	0							
Learning Assurance- Monitoring of Overdue Actions												
Incidents (AAR's/ Care Reviews/ PSII's)	36	30	32	31	40							
PCET	24	28	33	66	33							
Alerts/ NICE/ Audit	1	3	3	8	8							

* References 3 reports that are agreed subject to changes



Trust Data:

- In August there were 1265 incidents reported at the trust, this is a reduction of approximately 28% on the previous month. Whilst this figure is significantly lower it does fall within the upper and lower figures that we have seen over the last 15 months.
- It is important to note that whilst our overall total number of incidents has reduced, our percentage of moderate harm and above incidents has increased in the month. However many of these incidents still require handling and we typically see this percentage fall the following month and is part of our Duty of Candour monitoring and assurance.
- We have again compared our monthly figures against Q4 National Data, we continue to report higher percentages in moderate and low harm incidents and lower numbers of no harm, severe harm and fatal incidents. Our position against national figures remains consistent, we expect to compare next month's figures against soon to be published Q1 Data.

Data and Reporting:

- The graphs contained within the Patient Safety slides is presented differently this month as the data has been taken from newly developed Tableau dashboards.
- We have noted that the data relating to overdue incident differs from previously reported information and we have made the decision not to include this data whilst we work through this to ensure accuracy.

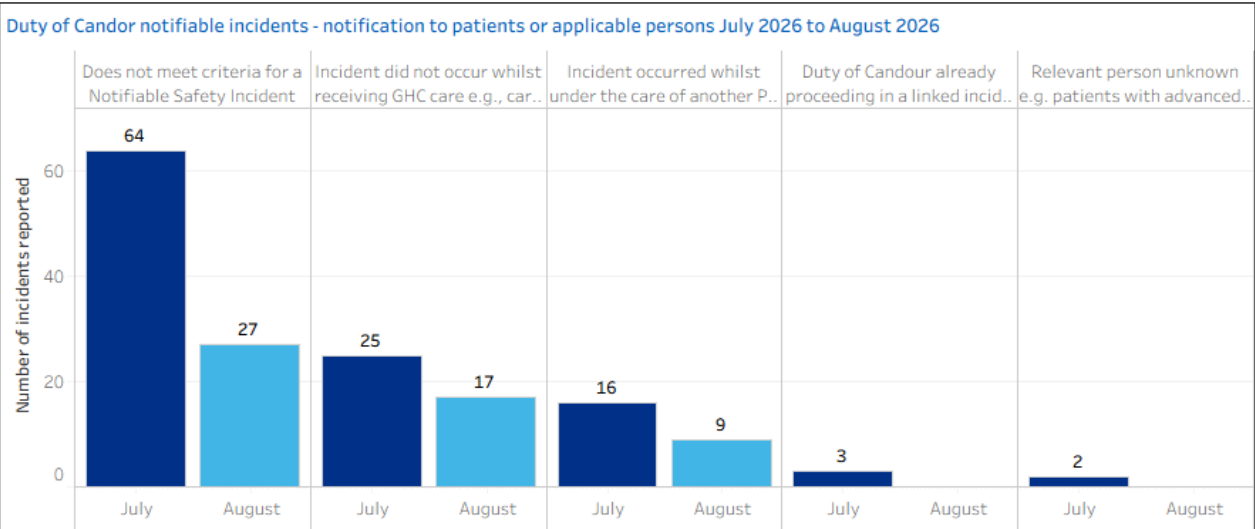
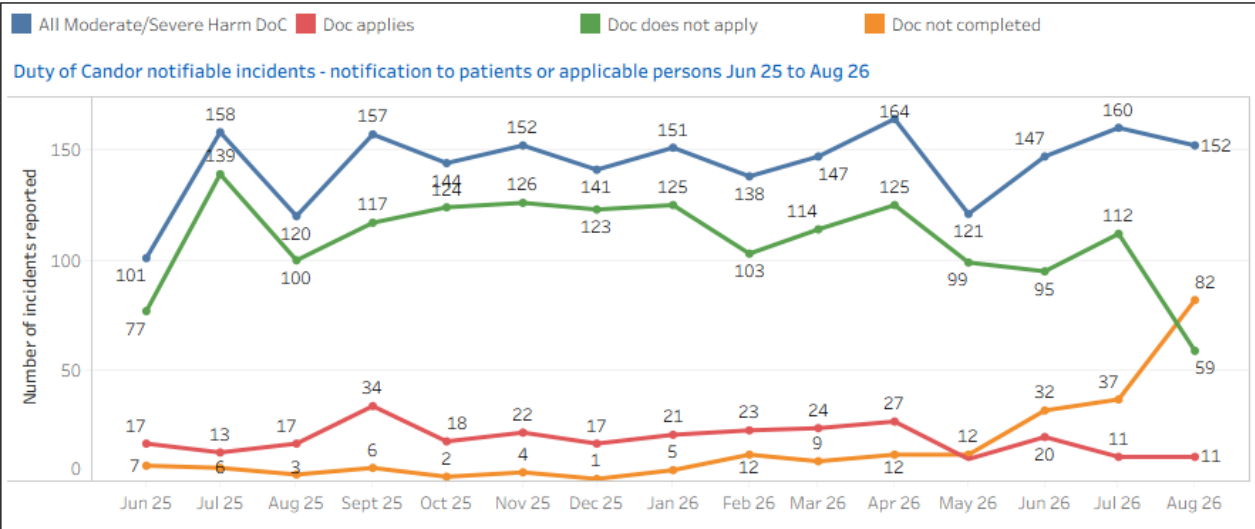
Patient Safety Team:

- The Patient Safety Team continues to experience high levels of absence (4.73 wte out of 12.98 wte) with the largest proportion of this absence from the reviewer capacity. This is particularly impacting timeliness and completion of learning reviews (AARs and PSIRFs), Family Liaison support and follow up of Duty of Candour where this has not been completed on Datix. The team are prioritising workload on a week-to-week basis and continuing to utilise support from bank colleagues and the wider NTQ directorate where they meet the training requirements of PSIRF.
- There were 2 After Action Reviews completed in August, a further 7 are booked or being planned with clinical teams.
- We declared 2 new PSIRFs in August but these are unallocated and we await further conversations with NHS-E in September regarding the PSIRF declared in July.
- Seventeen PSIRFs and Care Reviews remain open, of which thirteen have exceeded six months. Executive oversight remains in place. Recovery plans focus on increasing investigation capacity, completing reviews, implementing learning and ensuring compliance with PSIRF requirements. Whilst timeliness remains a concern, cases continue to be actively progressed according to risk and priority
- In line with the principles of PSIRF in August the PST read and sampled 33.75% of incidents reaching out to handlers where required, 19 risk mitigation tools completed by clinical teams were reviewed for assurance and 21 incidents were directly shared with other organisations for further investigation and learning.
- Workforce pressures within the Patient Safety Team are affecting investigation timeliness, case closure and learning implementation. Although patient safety risks continue to be effectively prioritised, the growing backlog of investigations and overdue actions presents a risk that organisational learning is not being embedded at the pace expected under PSIRF principle

Learning Assurance:

- The NED quality visit programme continues to provide additional assurance regarding service quality, patient experience and implementation of learning. A comprehensive report on findings and themes will be presented to the November Quality Committee.

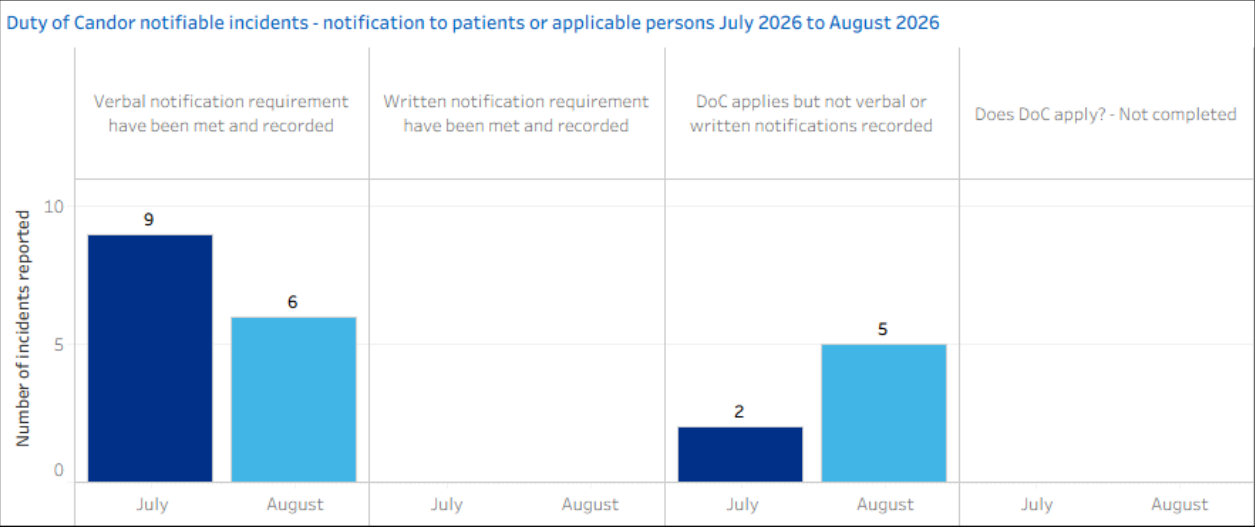
Sub Directorate
All



What is the data telling us:

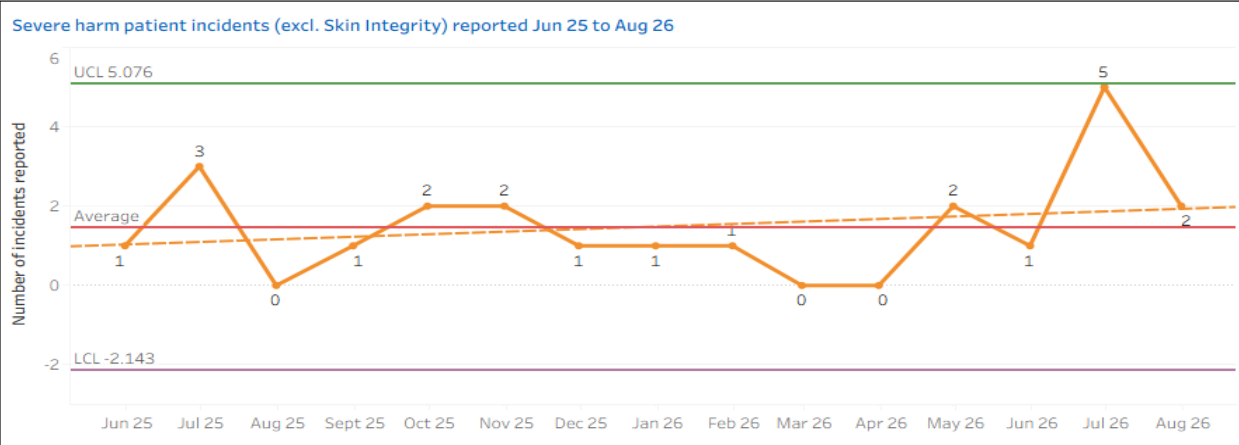
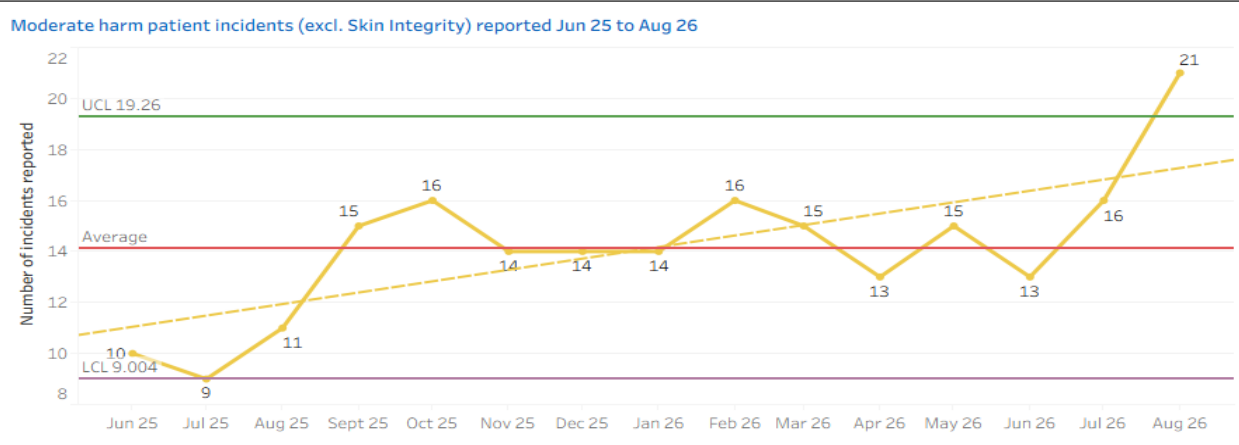
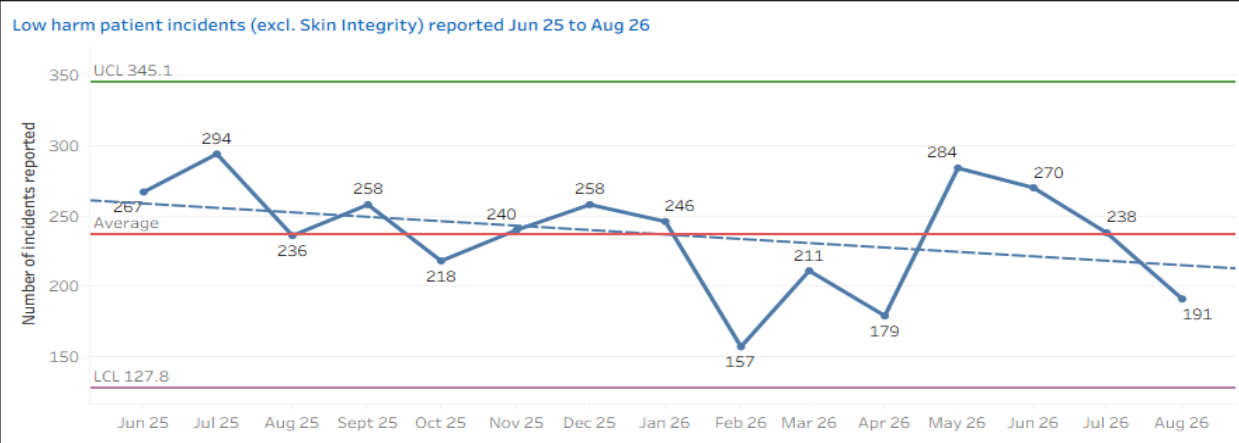
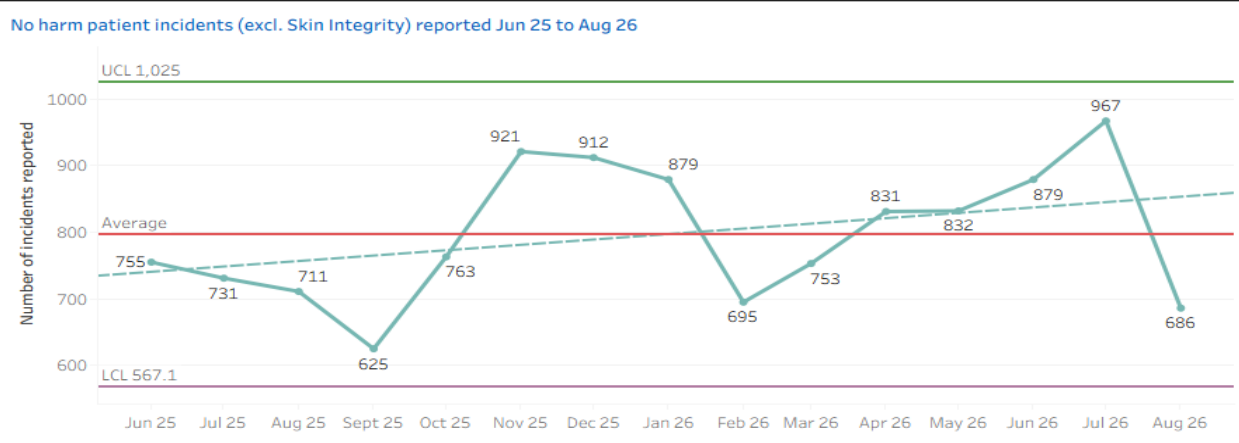
We have reviewed our DoC position for incidents reported in July 2026. The rationale for this is that incidents reported in August may still be awaiting handling and confirmation of harm level. July's data now shows:

- Whilst 23% of incidents remain awaiting Duty of Candour determination, this represents improvement from 44% previously. The Patient Safety Team continues to monitor compliance and ensure regulatory requirements are met prior to incident closure
- DoC regulation 20 did not apply in 70% of incidents and a reason for this has been provided in 98% of those incidents.
- DoC regulation 20 did apply in 11 incidents, we are awaiting confirmation of the notification provided in 2 incidents.
- In line with national guidance where these incidents relate to care provided by neighbouring organisations, DoC does not apply for our Trust, but these organisations are informed by our incident sharing arrangements.
- There has been a relatively stable trend in relation to Duty of Candour, where the PST had been proactively emailing where DoC had not been completed ahead of handling there is not capacity to do this. They will however ensure that this is in place before final closure of an incident to provide assurance.



CQC Domain - Are Services Safe? - Patient Safety Incident Data - Severity

Sub Directorate
All

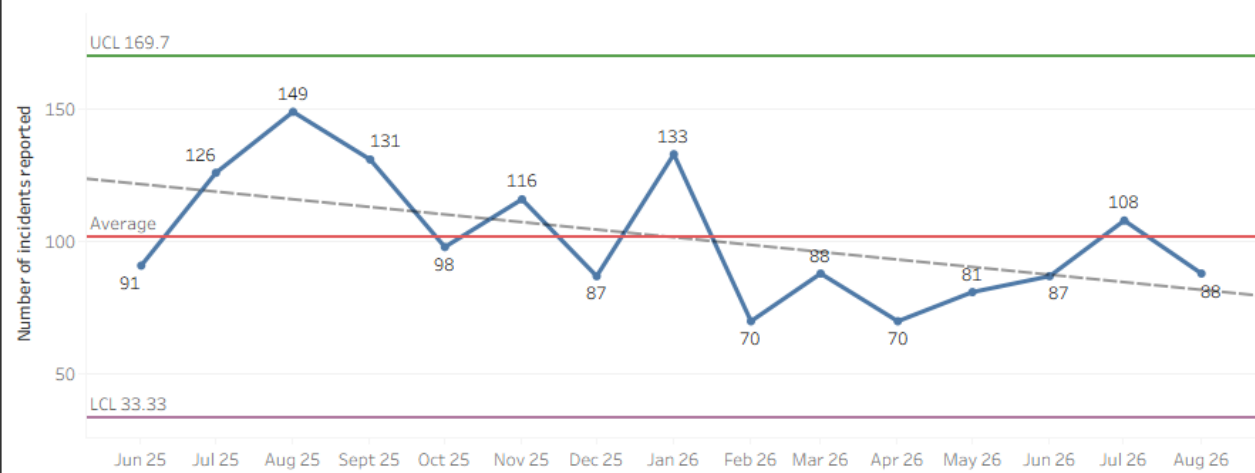


What is the data telling us:

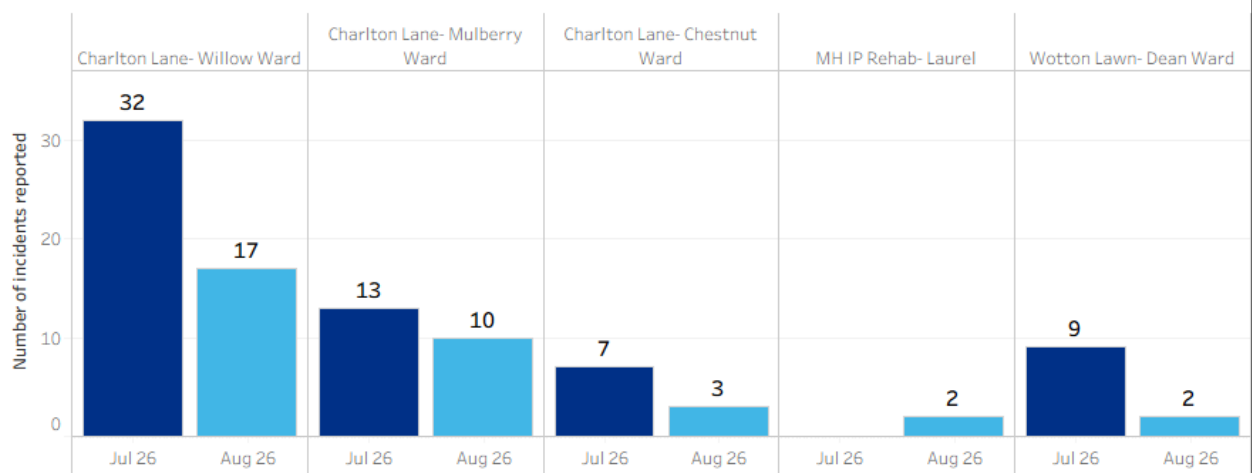
- We have seen reductions in our no harm and low harm incidents across the trust this month, with an increase in moderate harm incidents. On the live Datix system, this figure is lower suggesting that after handling our actual moderate harm incidents is lower (15). A number of these moderate harm relate to the care provided by other organisations and have been appropriately shared with them directly. We have also seen 3 incidents to highlight the lack of SLT provision in Department of Critical Care at GHFT. This is a known risk.
- In July we had 4 deaths, we are awaiting further information to determine next steps on 2 of these, 1 will be progressed as an After-Action Review and 1 was closed with no further action as the individual had been referred but was not open to services at the time of their death. All appropriate actions relating to the referral had been taken.

Sub Directorate
All

All patient falls Jun 25 to Aug 26



All patient falls - 5 highest reporting wards



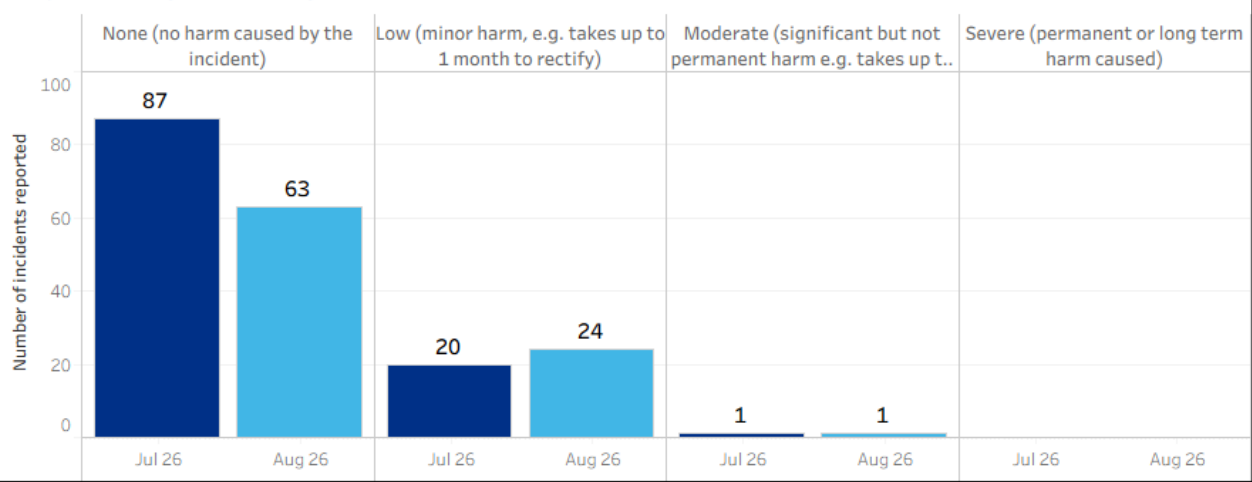
What is the data telling us:

- In July we have observed a reduction in falls in our inpatient settings with a total of 88 falls.
- The wards at Charlton Lane Hospital continue to be our highest reporter of falls, but this is to be expected due to the needs and presentation of the individuals in these settings. Assurance is provided through multidisciplinary falls huddles on site.

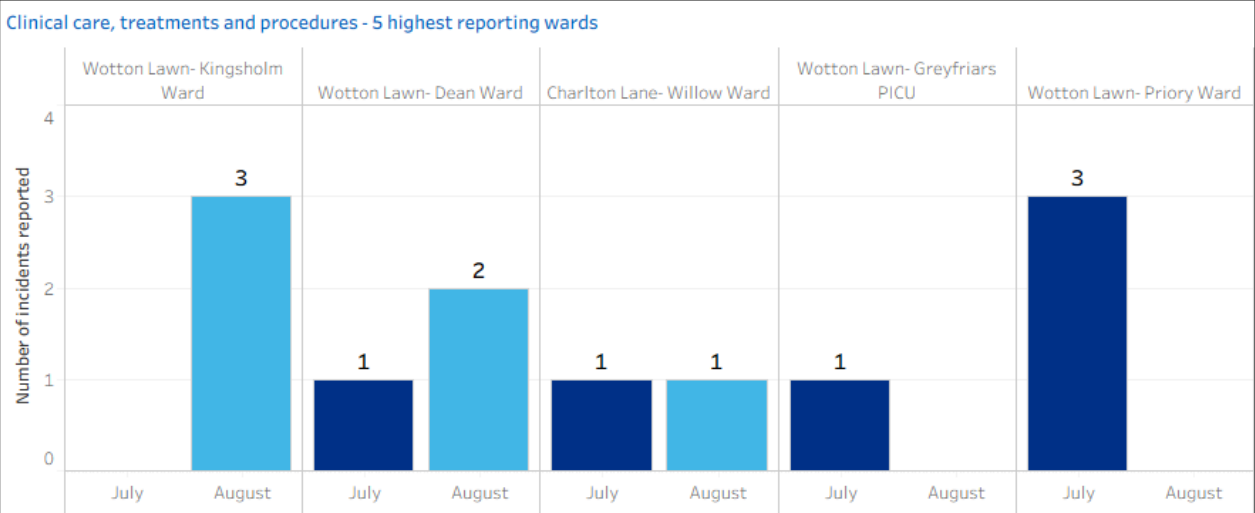
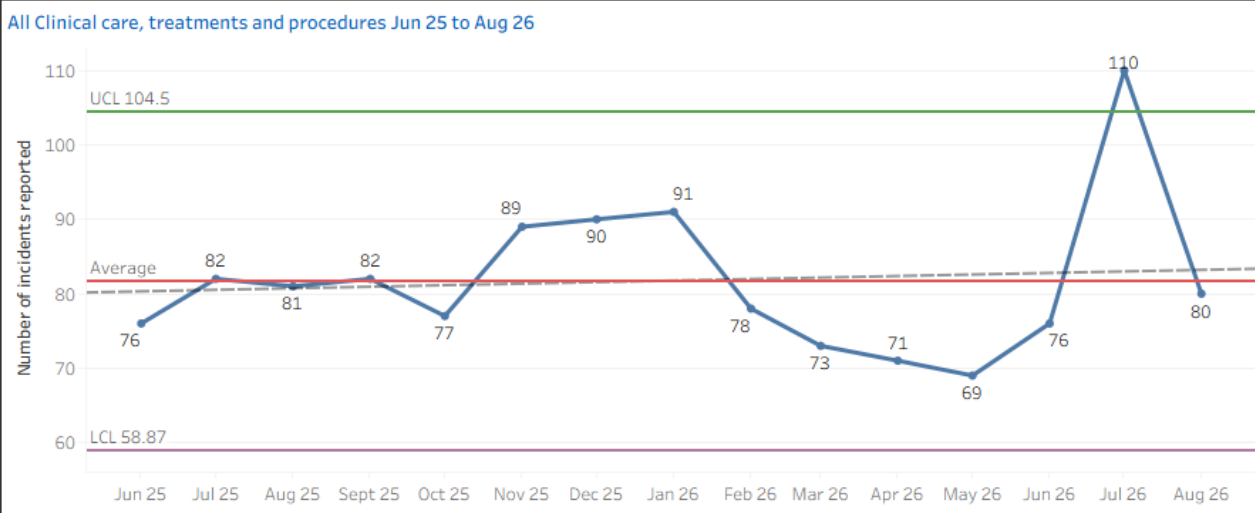
Updates from Falls Lead:

- We had previously observed an increase in falls at the Forest of Dean Hospital; the team have been undertaking targeted work considering the times people were mostly likely to fall. Figures suggest that the implemented changes have made a positive difference.
- An ongoing risk relating to falls documentation within the Electronic Patient Record is under active management. No significant patient harm has been attributed to this issue, and existing controls continue pending implementation of the planned EPR enhancement in October 2026.
- Following the disaggregation of the Occupational Therapy service to GCC, pathways have been reviewed to ensure that our services can access urgent support.

All Inpatient falls by overall severity

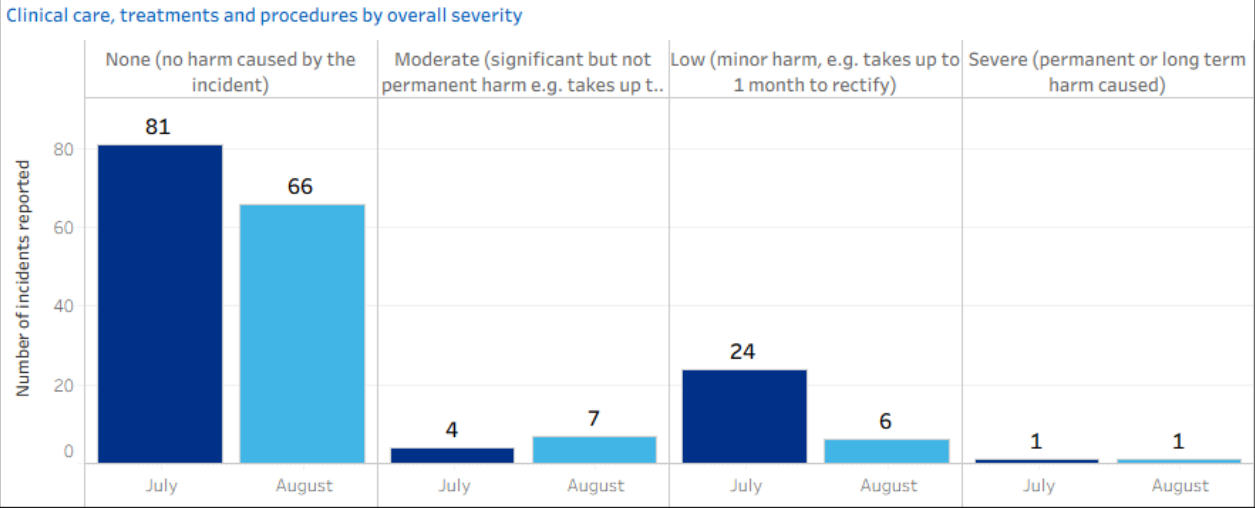


Sub Directorate
All



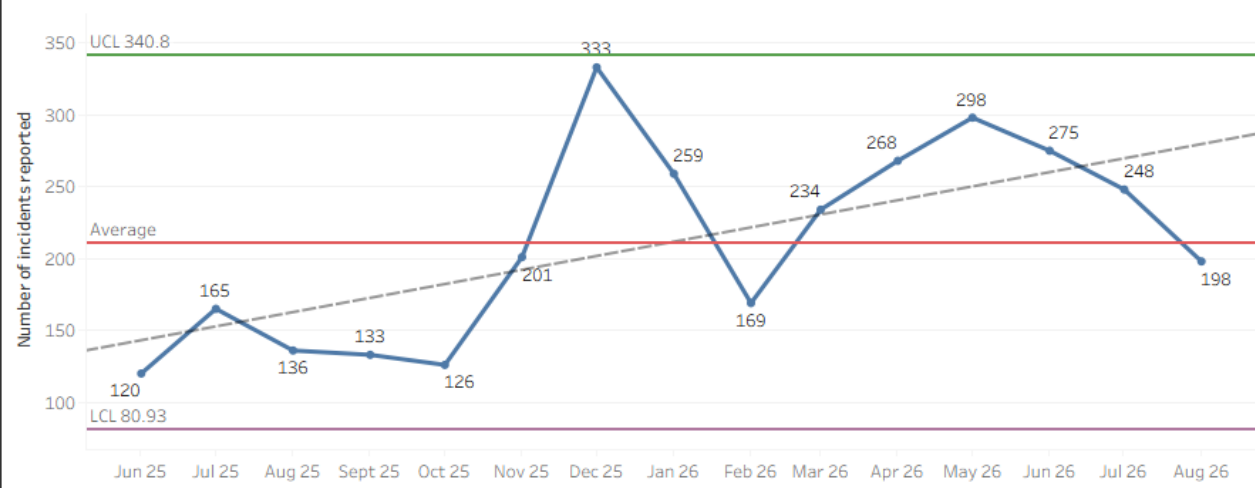
What is the data telling us:

- Incidents relating to clinical care, treatments and procedures have fallen to 80 after the increase in July 2026. 66 patients were connected to the 80 incidents.
- The 1 severe harm incident was related to the administration of medication by another provider, this remains under review whilst assurance is sought regarding any learning that they have identified.
- Whilst we have the top 5 reporting wards on the slide, it is important to note that ordinarily we report top reporting teams as this category is more widely used outside of wards.
- This month our top reporting services were ICT's (23), MIU's (16) and Eating Disorders (8).
- We have continued to see our MIU's using this category to report unsafe staffing, there is no national benchmarking data on expected team size, the data being gathered will be used inform next steps and establish local safer staffing guidance specifically for these services.
- Clinical risks identified through incident reporting continue to be reviewed through local governance processes. Services are required to demonstrate implementation of risk mitigation and learning actions, with oversight provided through care group governance arrangements.

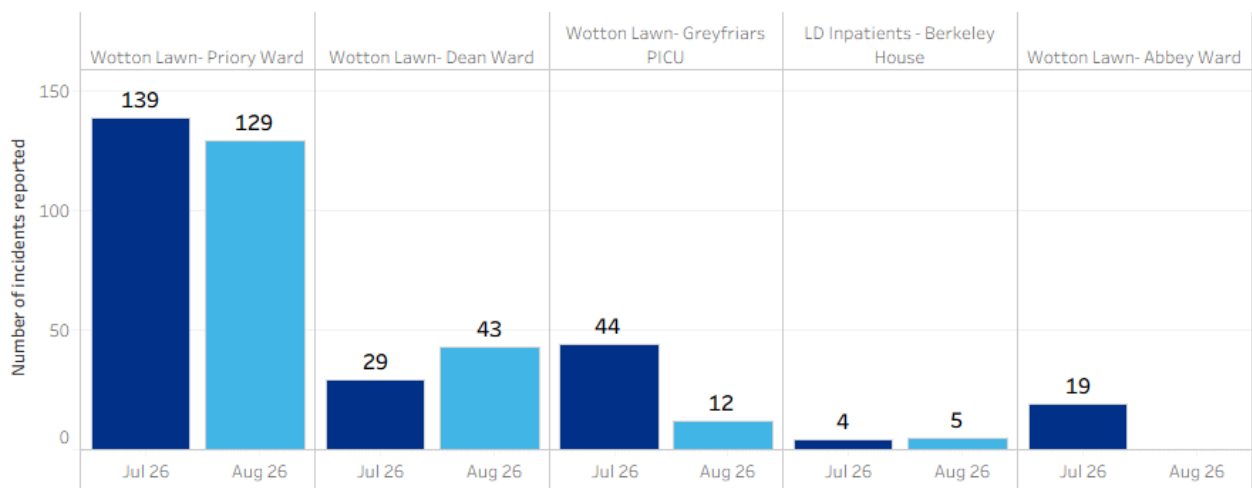


Sub Directorate
All

All Self harm / self-injurious behaviour (SIB) Jun 25 to Aug 26



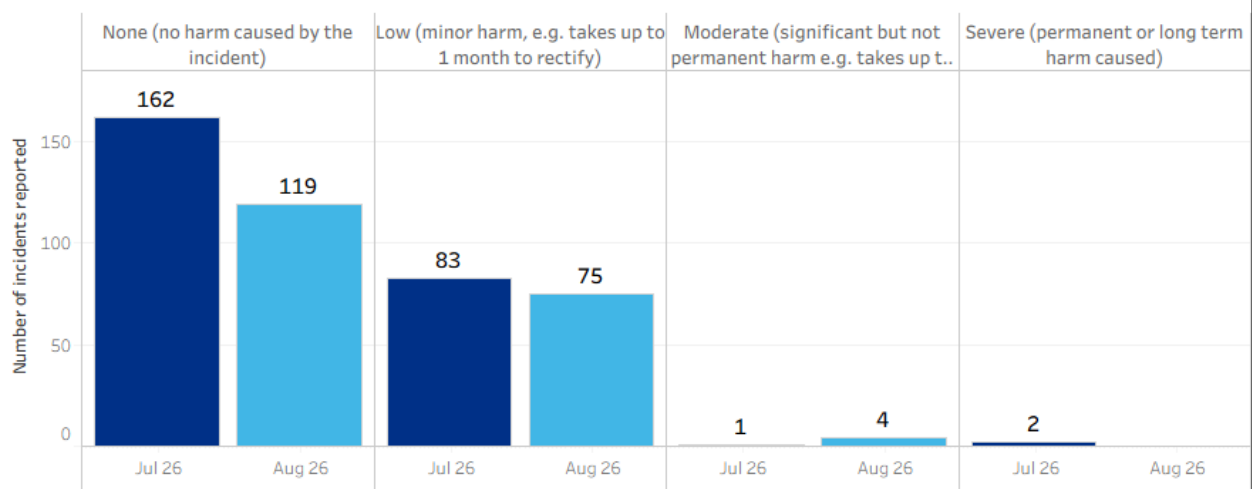
Self harm / self-injurious behaviour (SIB) - 5 highest reporting wards



What is the data telling us:

- There has been a reduction in the number of self harm incidents reported across the trust in August 2026. In July 30 individuals self-harmed whereas in August this was 22.
- Contributory factors include the temporary reduction in bed capacity at Wotton Lawn Hospital (WLH), improved patient flow, earlier discharge planning, strengthened partnership working with social care to reduce delays, and enhanced care planning supported by the Stabilisation Lead.
- We observe that Priory ward continues to have the highest number of incidents of self harm at the trust with lower figures observed on Dean Ward.
- A number of actions are underway at WLH including planned training sessions in September and October, one of which focuses on personalisation of notes and care plans. It is expected that there will be deep dives into records following these sessions to ensure that learning and practice has been embedded. A multi-disciplinary self harm huddle is due to commence in October 2026.

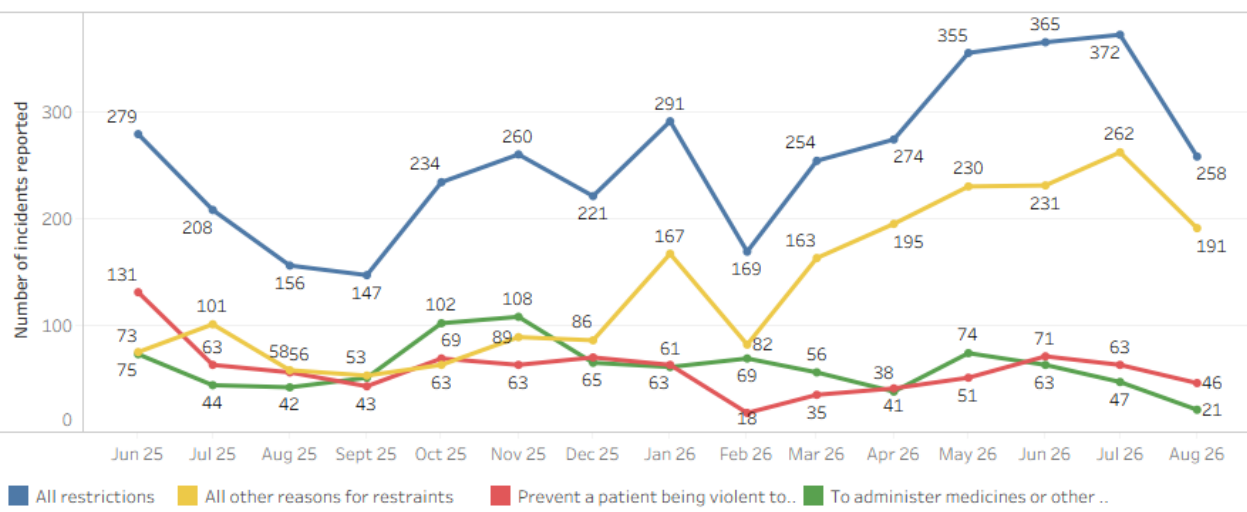
Self harm / self-injurious behaviour (SIB) by overall severity



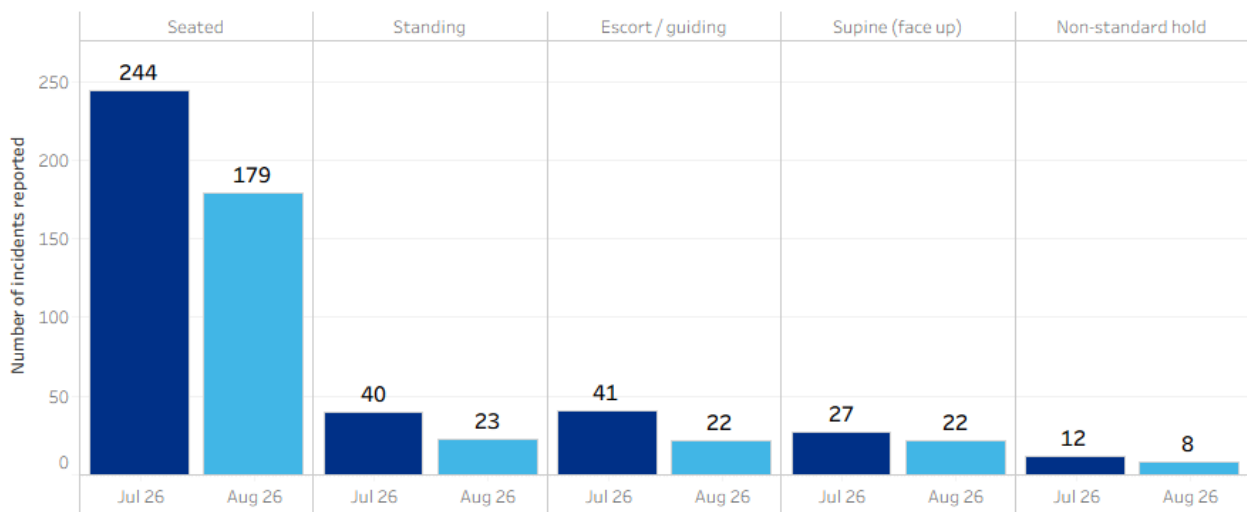
Incidents Involving Restraint

Sub Directorate
All

Incidents involving physical restraint Jun 25 to Aug 26



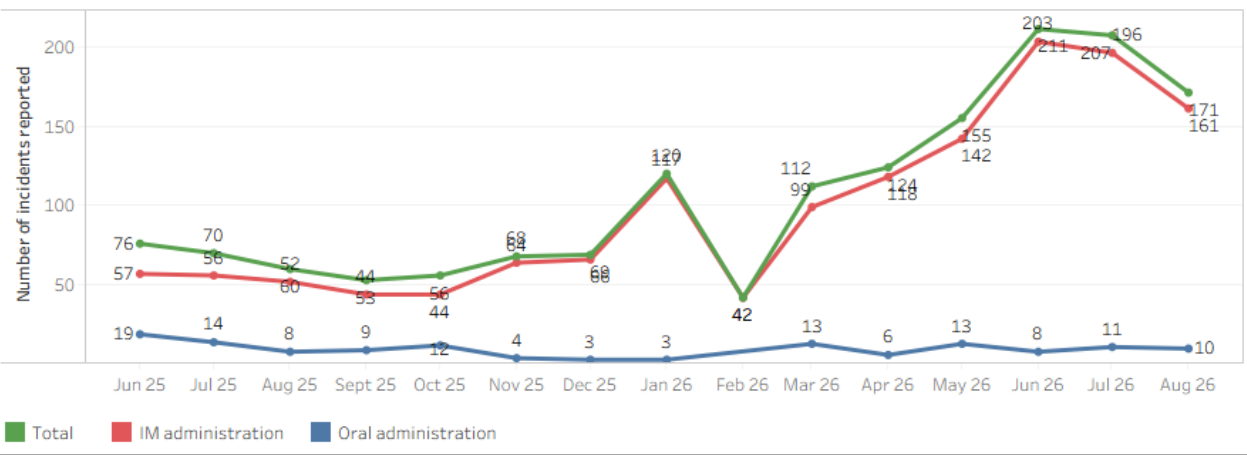
Top 5 "most restrictive" interventions



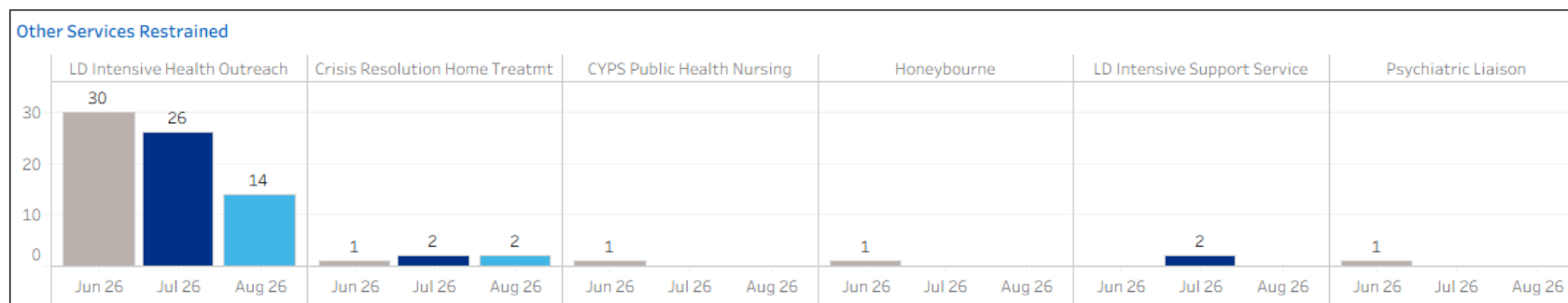
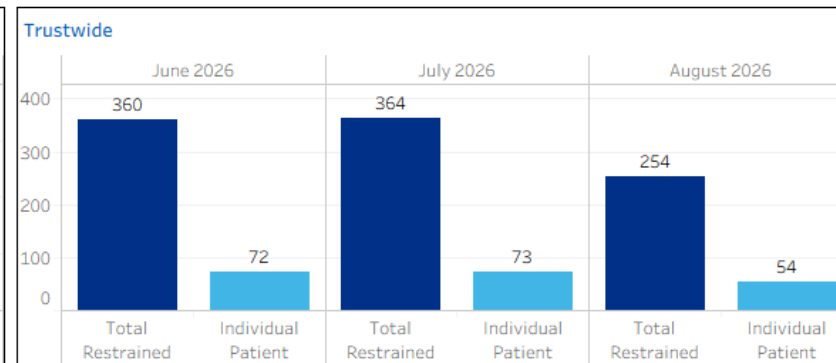
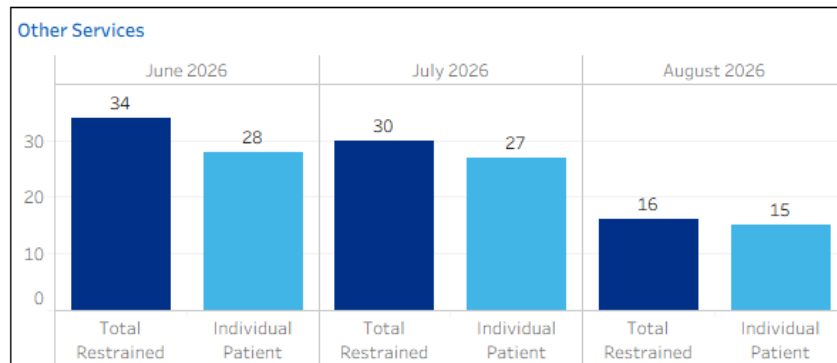
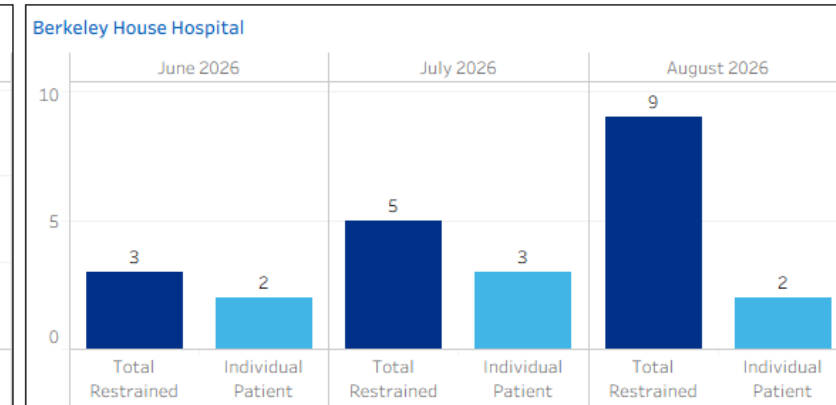
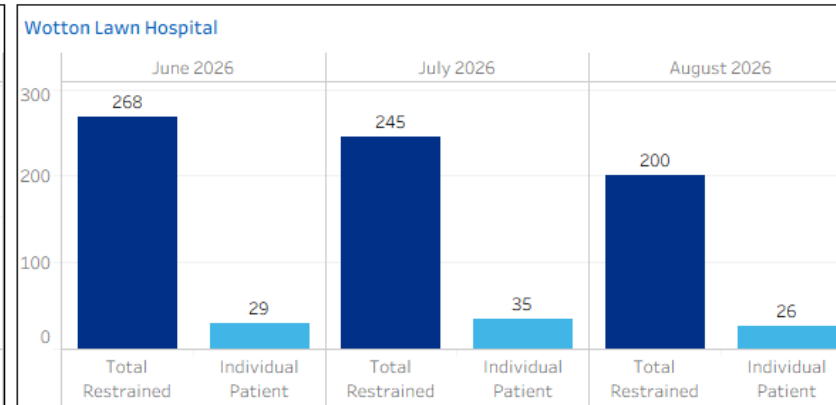
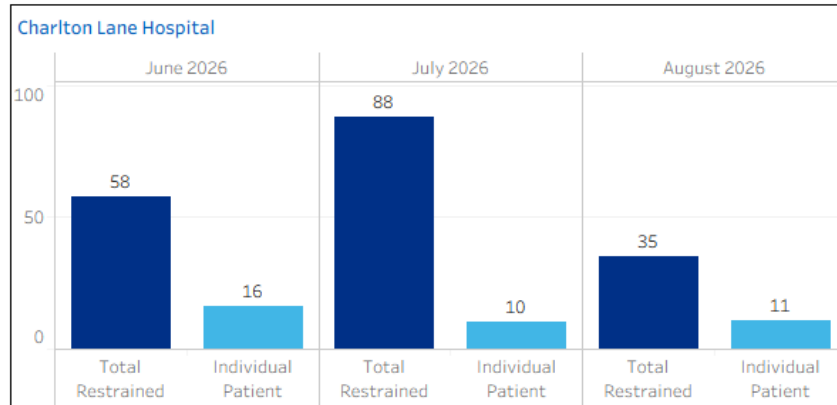
What is the data telling us:

- Trust wide there has been an overall reduction in the number of incidents of restraint and the individual patients restrained (see next slide). Seated continues to be the most frequently used restrictive intervention
- Contributory factors include; temporary reduction of beds at Wotton Lawn Hospital, discharge of patients who had previously had high levels of restraint and a reduction in agency staff on wards meaning that there are more substantive experienced staff on site and supporting patients.
- Training Days are planned for staff at Wotton Lawn Hospital in September/October and practice around aspects of restrictive interventions are included.
- A similar pattern is seen in regard to rapid tranquilisation with figures falling on the previous 2 months. Work around training compliance and rapid tranquilisation is ongoing, with further exploration being given to the role of Health Care Assistant (HCA) in supporting post rapid tranquilisation monitoring. Progress is being monitored via the Positive and Safe Group.

Rapid Tranquilisation (RT) Jun 25 to Aug 26



Incidents Involving Restraint - Individual Patients Restrained



What is the data telling us:

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

In August 2026 restraint incidents were reported across the other services of

LD IHOT (14)

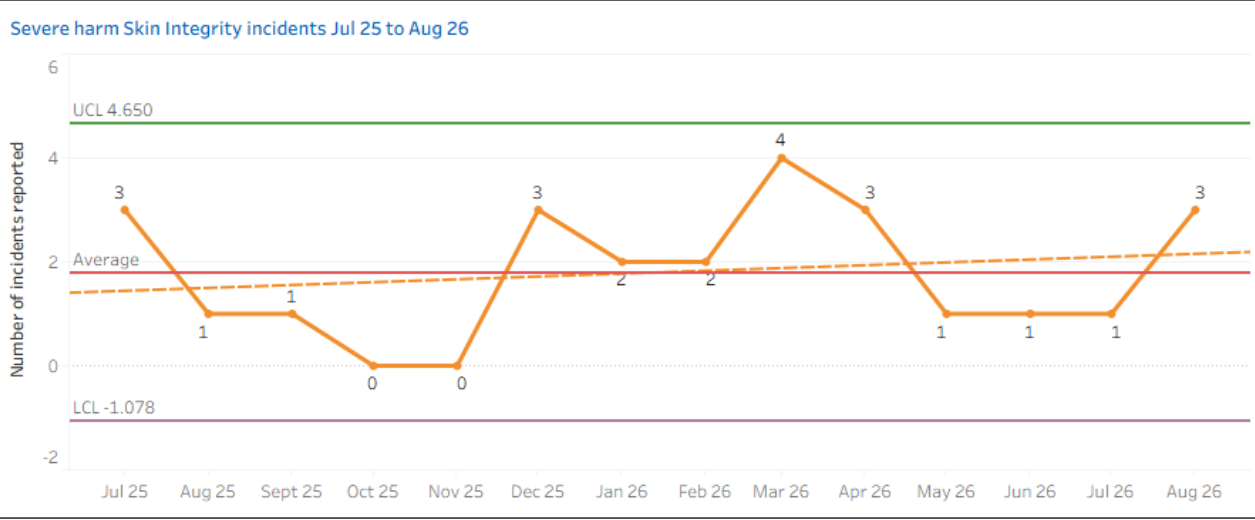
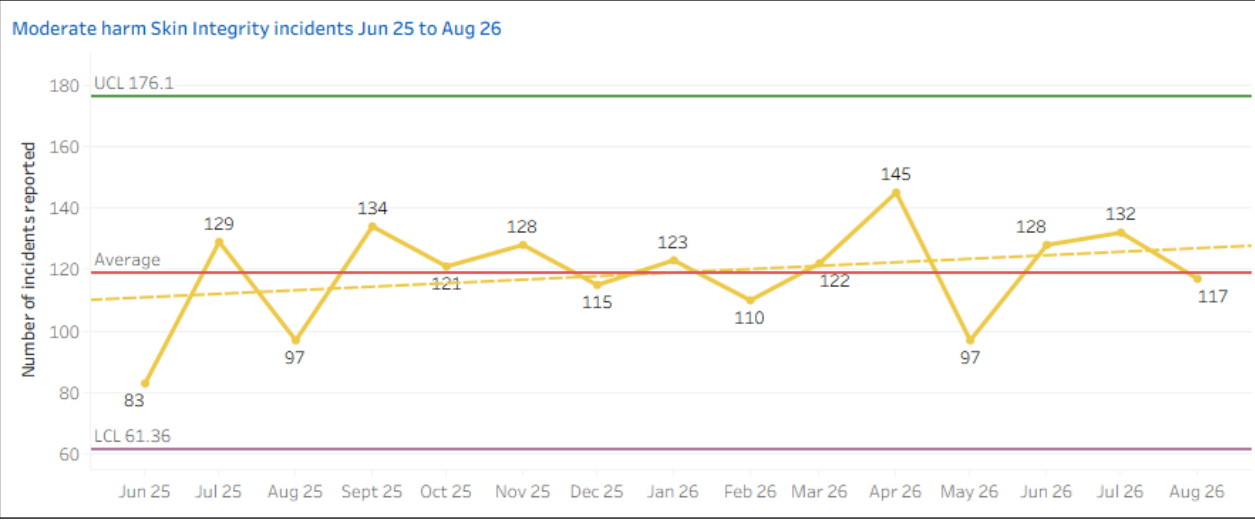
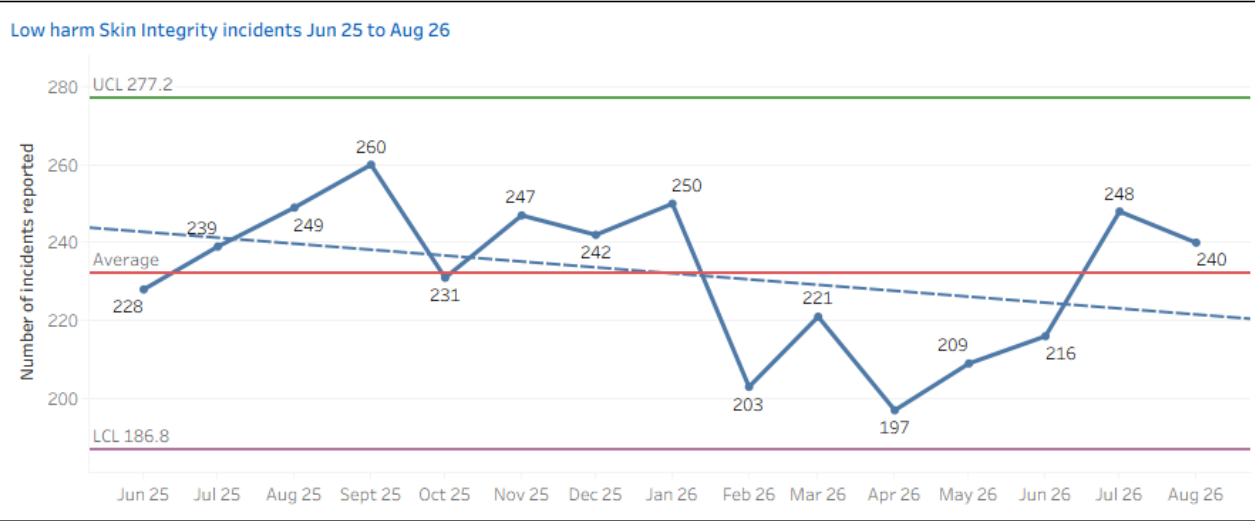
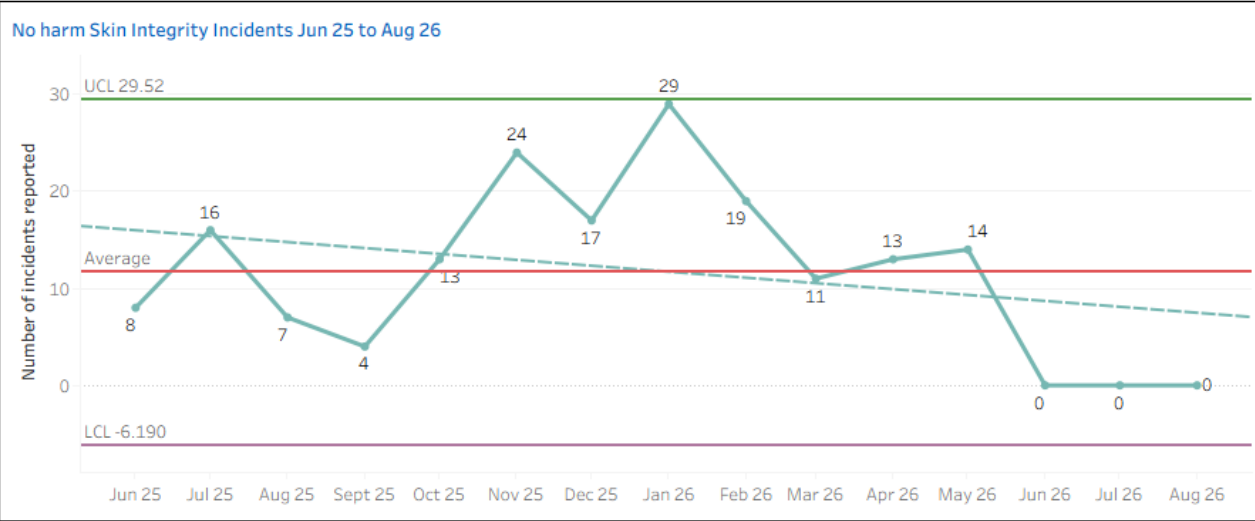
CRHT (2)

It is forecast to expect LD IHOT restraints to increase as we move into the seasonal vaccination programme.

Collectively, the trends reported across falls, self-harm and restrictive interventions demonstrate improvement across several high-risk patient safety indicators. Evidence suggests that targeted quality improvement activity, stabilisation initiatives and enhanced multidisciplinary oversight are contributing positively to outcomes, whilst ongoing monitoring will ensure that these improvements are sustained.

CQC Domain - Are Services Safe? - Patient Safety Incident Data - Severity Skin Integrity Incidents

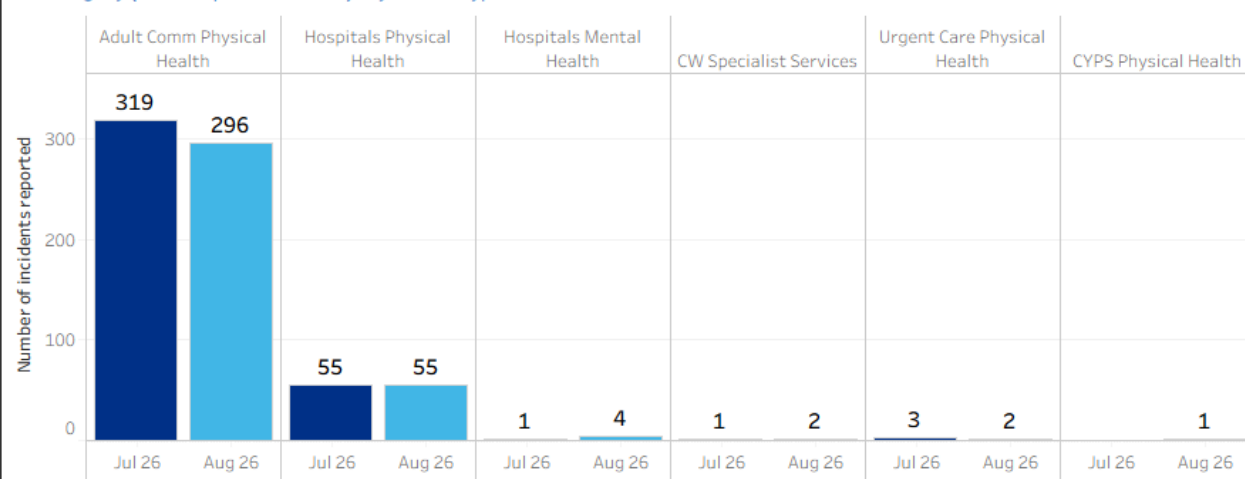
Sub Directorate
All



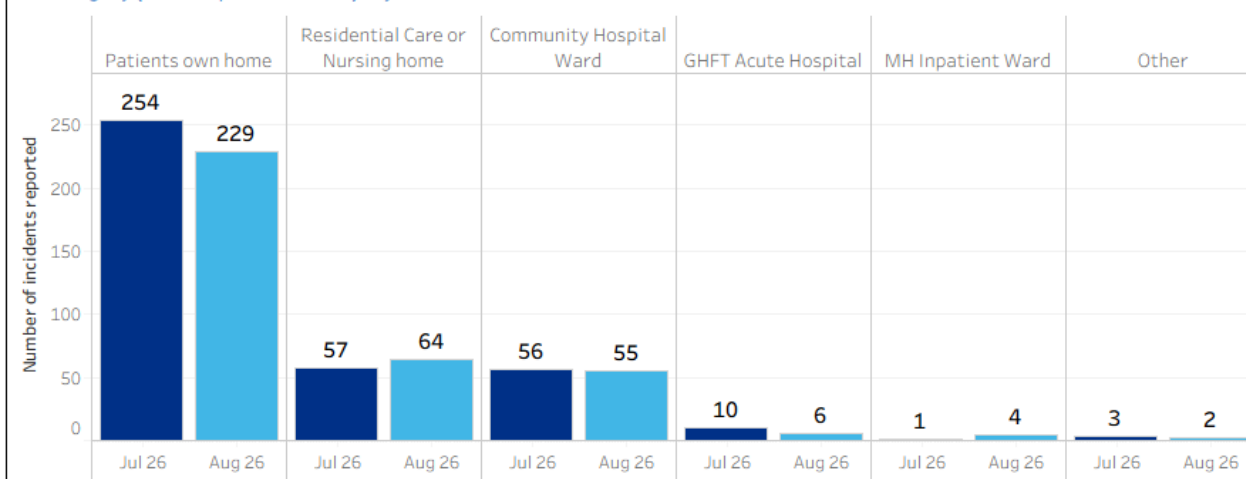
CQC Domain - Are Services Safe? - Patient Safety Incident Data - Skin Integrity Incidents

Sub Directorate
All

Skin integrity (includes pressure ulcers) - by Service Type



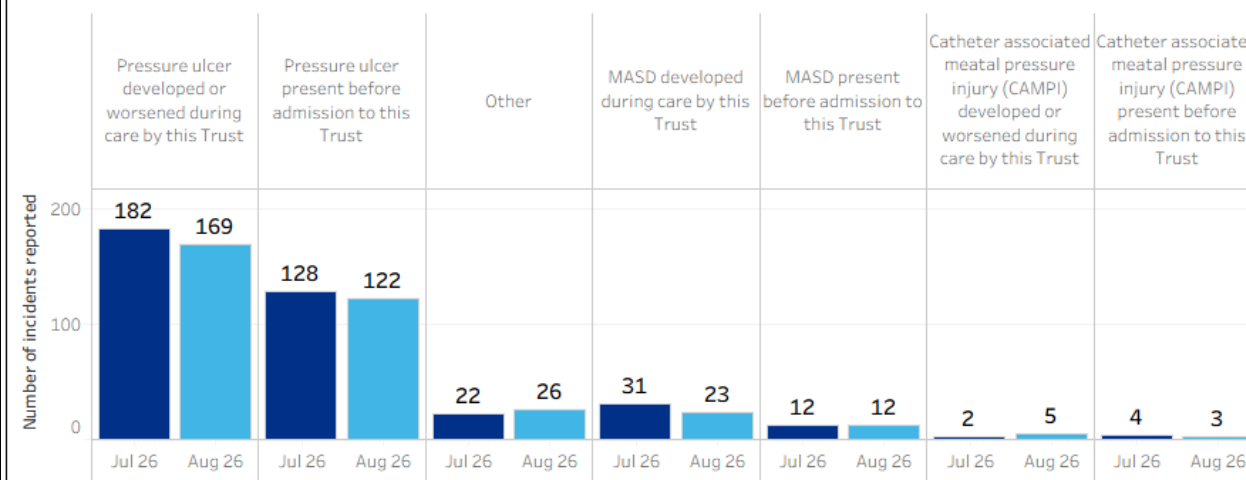
Skin integrity (includes pressure ulcers) - by Patient Location



What is the data telling us:

- There were a total of 360 skin integrity incidents reported across the trust with a decrease in low and moderate harm incidents and 3 severe harm incidents. At the time of providing narrative for the slides there are now 2 severe harm incidents after handling, 1 requires the completion of the CAMPI questionnaire and the other was related to skin integrity prior to admission to the trust and has been appropriately reviewed and closed.
- As per the previous report we have had 0 no harm incidents reported and this provides assurance that staff are reporting incidents as per guidance and expectations.
- 291 individuals were connected to these incidents with 51 individuals having 2 or more skin integrity incidents reported. They account for 33.8% of all reported skin integrity incidents.
- 291 of these incidents were reported as pressure ulcers (all categories), with 41.9% being present before admission to the trust.
- 63.6% of skin integrity incidents were for individuals living in their own home and a further 17.7% for individuals in residential or nursing homes.
- 15.2% of skin integrity incidents occurred within our inpatient settings.

Skin integrity (includes pressure ulcers) - by Sub-category (grouped)



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 monthly. 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.

Mental Health Inpatient Services

Overall, Mental Health inpatient services remained within expected safe staffing parameters during August. Staffing pressures were evident in some areas, particularly related to sickness absence, enhanced observation requirements and the temporary reduction in bed capacity at Wotton Lawn Hospital, but risks were mitigated through workforce redeployment, senior clinical support and approved escalation processes. No staffing-related DATIX incidents or adverse outcomes were identified.

Staffing Fill Rates

- Several wards reported staffing fill rates above 100%, most notably Dean Ward (119%), reflecting a combination of enhanced observation demand, sickness management and redeployment of staff following the temporary reduction in bed capacity (Abbey Ward).
- Increased use of Healthcare Support Workers was used to offset Registered Nurse shortages where clinically appropriate.
- Enhanced care requirements, including multiple patients requiring one-to-one observations, were significant contributors to increased staffing demand.

Care Hours Per Patient Day (CHPPD)

- CHPPD metrics remained broadly consistent with expected service models and patient acuity.
- PICU staffing levels at Greyfriars remained appropriately higher than other inpatient areas which aligns with expected clinical acuity.
- Variations within rehabilitation units were identified but are believed to reflect changes in patient acuity and enhanced observation requirements rather than structural staffing concerns. Further validation was requested.

Workforce Escalation Processes

- Seven off-framework staffing requests were approved during the month, predominantly to maintain registered nurse cover.
- No evidence was presented that any denied requests resulted in adverse impact on patient safety, patient experience or staff wellbeing.

Quality and Safety Indicators

- No DATIX incidents were reported under the category relating to insufficient suitably skilled staff.
- No evidence emerged from patient experience, safety monitoring or workforce metrics indicating deterioration in quality of care attributable to staffing levels.

• Staffing risks remain subject to routine review through the Trust's safer staffing governance framework and are triangulated against patient safety, patient experience and workforce indicators. No evidence of staffing-related patient harm was identified during August

CQC DOMAIN – Are Services Safe - Safe Staffing – Mental Health & LD and Physical Health Inpatient Data**Persistent Registered Nurse Red Flags in Rehabilitation Services**

A total of 46 red flags were reported, concentrated within Laurel House and Honeybourne. The recurring issue relates to shifts operating with fewer than two registered nurses. While these episodes were reviewed and mitigated through proximity working and cross-cover arrangements, the frequency suggests a potential mismatch between current establishments and expected staffing standards. Whilst no patient safety incidents or patient harm have been directly attributed to these red flags, the recurring nature of the concern requires continued Board oversight and will inform planned establishment reviews

Impact on Professional Leadership Functions

At Greyfriars, Band 6 sickness absence has required senior clinical staff to provide operational ward cover. Although patient-facing staffing requirements have been maintained, there is a recognised risk that supervisory and governance activities such as:

- Clinical supervision
- Appraisals
- Mandatory training oversight
- Quality assurance activities may be delayed.

This reflects a recognised NHSE safer staffing consideration whereby safe numbers are maintained at the expense of wider quality and governance functions.

Establishment Review Required

Both rehabilitation services and recovery units have been identified as priority areas for establishment review during Quarter 3. Existing red flags and service transformation plans suggest current establishments may require reassessment against patient need and future service models.

2. Community Hospitals**Nurse Staffing Fill Rates**

- Registered Nurse and Healthcare Support Worker fill rates remained within expected organisational thresholds.
- Overall staffing performance was positive across most sites.
- Apparent underperformance at some sites was mitigated by wider multidisciplinary support available within those environments.

Enhanced Observation Requirements

Additional staffing resource was deployed at The Vale to support enhanced supervision requirements. This demonstrates appropriate dynamic staffing management based on patient acuity rather than reliance solely on planned establishment numbers.

Workforce escalation processes

- No significant off-framework staffing concerns were identified during August.
- No evidence was presented of compromised patient care resulting from staffing shortages.

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

Review of patient experience and quality data identified:

- No nursing staffing-related concerns
- No evidence of harm associated with staffing numbers
- No concerns regarding effectiveness, safety or patient experience linked to nurse staffing levels.

Risk Assessment: Low to Moderate

No immediate patient safety concerns identified, but future integrated workforce reporting should continue monitoring this area.

Data Quality and Timeliness

Minor discrepancies continue to occur due to delays in final roster validation, particularly affecting Tewkesbury data. This is understood to be an administrative timing issue rather than a staffing concern.

3. Minor Injury and Illness Units (MIUs)

This month we included MIU leadership into the monthly safe staffing meetings, this follows discussion at QAG regarding the emerging work of moving towards an urgent treatment centre model. Unlike inpatient services, there is currently no nationally recognised safe staffing tool, benchmark or agreed minimum staffing standard to support local staffing decisions. Leaders expressed concern that current arrangements rely heavily on professional judgment without a robust evidence-based staffing framework. However, it is widely acknowledged within the internationally published literature, that professional judgement is often the one approach that is the most reliable and accurate. Staffing levels are largely historic and there is now an opportunity to refresh these staffing levels, including appropriate skill mix alongside an analysis of activity, changing system landscape and triangulation of established data reporting, eg patients safety and PCET data.

Future work planned by the service group includes:

- Workforce review and analysis of outcomes
 - Review of established data sources including AAR's and PSII's
 - Working towards an urgent treatment centre model including associated workforce modelling
 - Review of any risks associated with the current staffing model- currently none identified
-
- In addition to operational governance reporting, the safe staffing monthly assurance group will receive regular updates and monitor this development in line with NHSE safe staffing requirements

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

Mental Health & LD1	August Data					Physical Health	July 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	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			Day	Day	Night	Night	
Abbey						Coln (Cirencester)	83	97	102	98	7.4
Dean	76	135	98	151	10.9	Windrush (Cirencester)	-	-	-	-	-
Greyfriars	75	122	95	146	15.1	Thames (Cirencester)	99	100	100	100	19.0
Kingsholm	88	127	105	129	9.7	Forest Of Dean Community Hospital	95	93	100	101	7.8
Montpellier	113	104	97	106	14.6	North Cotswolds	97	100	94	101	7.8
Priory	96	145	103	235	10.5	Cashes Green (Stroud)	93	104	103	102	6.9
Chestnut	79	116	100	100	7.4	Jubilee (Stroud)	108	95	100	100	8.5
Mulberry	90	97	95	96	6.9	Abbey View (Tewkesbury)	103	96	100	99	8.8
Willow	94	91	103	97	9.4	Peak View (Vale)	100	96	96	101	9.8
Laurel House	89	114	100	100	5.8						
Honeybourne	95	144	100	126	8.7						
Berkeley House	48	78	100	74	102.9						

Quality Dashboard

Infection Prevention and Control – 2026/27

Quality Indicator	2025/26	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<i>C.difficile</i> (toxin positive) HOHA	8	14	0	0	1	3	2							
Influenza	3		0	0	0	0	0							
Norovirus	33		0	0	0	0	0							
COVID-19 HODA	17		0	1	0	0	0							
COVID-19 HOHA	3		0	0	0	0	0							
Gram-Negative bloodstream infections (<i>Escherichia coli</i> , <i>Klebsiella spp</i> , <i>Pseudomonas aeruginosa</i>)	0	0	0	0	0	0	0							
MRSA Bacteraemia	0	0	0	0	0	0	0							
MSSA Bacteraemia	0		0	0	0	0	0							
Outbreaks	6		1	0	0	0	0							
Hand Hygiene overall compliance	97%	90%	90%	93%	99%	99%	98%							
Mandatory IPC Training: Clinical	94%	90%	94%	93%	93%	93%	93%							
Mandatory IPC Training: Non-clinical	98%	90%	98%	99%	98%	98%	97%							
Cleanliness FFT "Was the ward clean?"	98%		100%	96%	100%	96%	96%							

Cleanliness – 2026/27

01/06/26 – 24/08/26

13 Weeks Report													
GHC						3rd Party							
Compliant					138	Compliant					25		
Non-compliant					3	Non-compliant					2		
					TOTAL	141					TOTAL	27	
FR	Target score		Actual score average				FR	Target score		Actual score average			
FR1		98%			99.41%		FR1		98%			N/A	
FR2		95%			97.77%		FR2		95%			N/A	
FR3		90%			97.83%		FR3		90%			95.90%	
FR4		85%			96.80%		FR4		85%			95.66%	
Total average score					97.95%		Total average score					95.78%	

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 were a total of 2 cases of *C.difficile* across Cashes Green Ward (Stroud) and Cotswold View Ward (North Cotswold 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.

Cleanliness

- High standards of cleanliness continue to be maintained across all Trust sites as evidenced in the cleanliness audit, Adenosine Triphosphate (ATP) swabbing and FFT results.
- All cleanliness audits below 100% are given rectification sheets so that all failures can be addressed. This is usually done within 2 days of the audit being signed off, paper copies are kept on site.
- All registered sites maintain the highest rating score of 5 during Environmental Health Audits. IPC and cleanliness indicators continue to demonstrate one of the most consistent areas of organisational assurance, with strong audit performance, training compliance and effective outbreak prevention arrangements
- IPC and cleanliness indicators continue to represent one of the Trust's strongest areas of assurance, with sustained compliance, effective outbreak prevention arrangements and no indication of deterioration in performance.

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	122	-		
DTP - Asylum seekers	167	12	27	35	43	45		
MMR - Asylum seekers	143	8	13	16	22	22		
MenACWY - Asylum seekers	81	-	-	-	-	-		

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

- The school age immunisation team and Outreach Vaccination Health Team are active in the provision of the flu vaccine to children and pregnant ladies and from 1 October 2026 availability will extend to GHC staff and eligible inpatients.
- There is a 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.

NHS Foundation Trust

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)

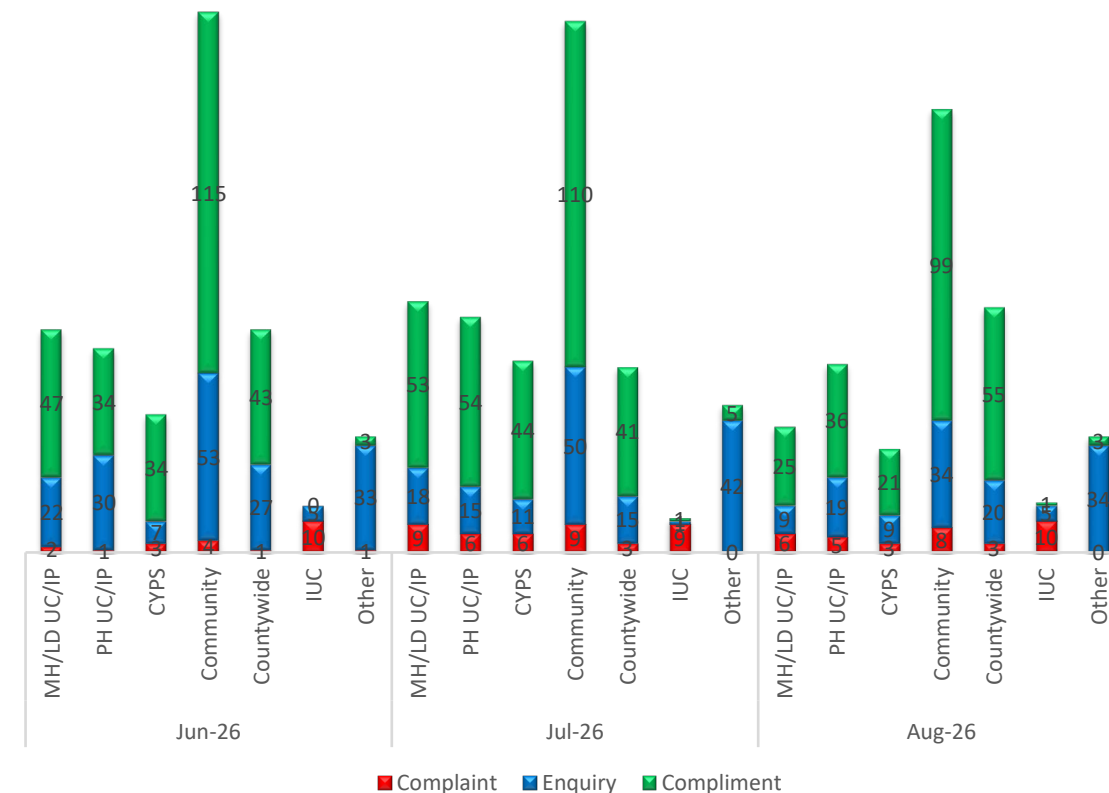
Key Highlights:

- IUCS contacts (around 18k a month) continue to impact complaint data, despite mitigations in place.
- 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	6	Early resolution:	9	25
		Closer look:		
PH urgent care and inpatient	5	Early resolution:	19	36
		Closer look:		
CYPs	3	Early resolution:	9	21
		Closer look:		
PH/MH/LD Community	8	Early resolution:	34	99
		Closer look:		
Countywide	3	Early resolution:	20	55
		Closer look:		
IUCS	10	Early resolution:	5	1
		Closer look:		
Other	0	Early resolution:	34	3
		Closer look:		
Totals	35	Early resolution:	130	240
		Closer look:		

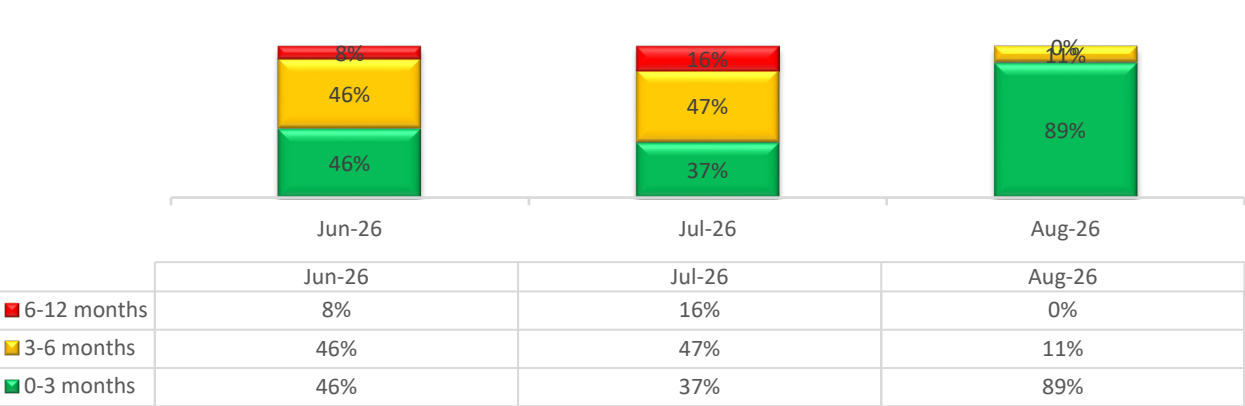
This table shows directorate feedback over the past three months



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

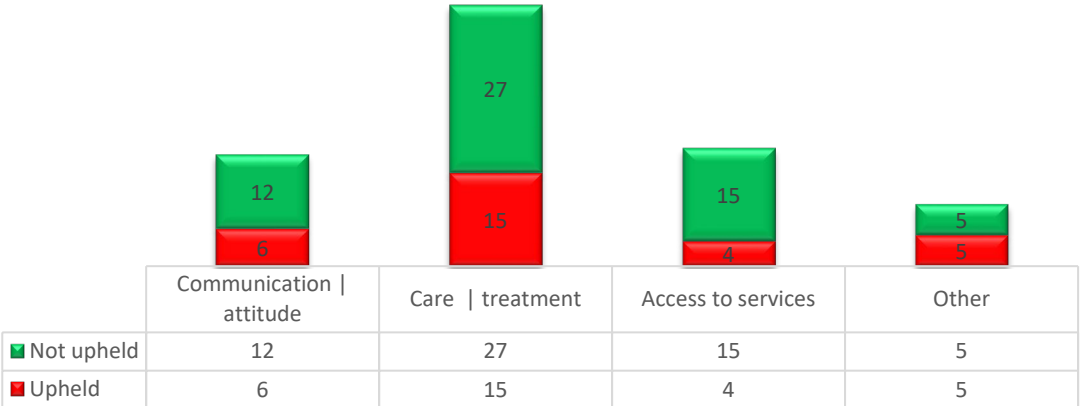
Directorate	Upheld	Partially upheld	Not upheld	No contact	Withdrawn	Other	Total
MH/LD UC/IP	1	0	1	2	1	2	7
PH UC/IP	0	1	2	0	0	0	3
CYPS	3	2	2	1	0	1	9
PH/MH/LD Community	0	7	2	5	0	0	14
Countywide	0	1	1	1	0	0	3
IUCS	1	0	0	0	0	0	1
Other	0	0	0	0	0	0	0
Totals	5	11	8	9	1	3	37

The below graph shows the length of time taken to close complaints.
This month 89% were closed in 3 months (target 50%), 100% closed in 6 months (target 80%)



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 (25804)	Call handler repeatedly asked if drunk despite MS explanation given for slurred speech. Communication
PH/UC/IP (24692)	Triage notes not read before consultation. Clinical treatment
CYPS (25444)	Length of time for an LOT assessment. Access to services
Community (24263)	Cancellation and delay in appointments. Access to services
Countywide (24388)	Patient unhappy with inaccuracies in report after accident at gym. Trust admin/policies



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



■ No. of positive responses ■ No. of negative responses

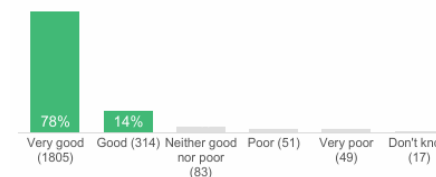
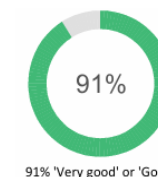
Highlights for this month:

- Overall positive experience for the month is 91%, which is average for this year.
- Service users made 16 requests for contact/action through the FFT.
- FFT for Out of Hours GP, IUCS received 45 responses (87% positive).
- There were 65 teams (cost centres) who received no FFT responses in August.

Patient feedback

How are we doing?

Overall experience of our service | August 2026



Key indicators (% positive) | August 2026



97%

Did you feel you were treated with respect and dignity?



95%

Were you involved as much as you wanted to be in decisions about your care and treatment?



96%

Did you feel the service was delivered safely and protected your welfare?

Carer feedback

How are we doing?

Overall experience of our service | August 2026

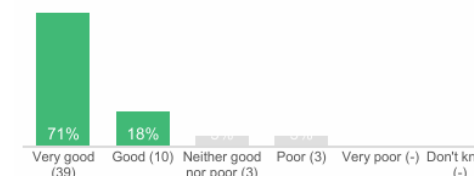
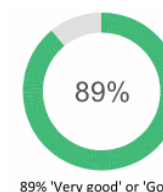


Table below shows 1-4 of the 6 monitoring requirements (5 and 6 are covered in overall summary)

National Monitoring	2025/26	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
The number of patients detained under the MHA by ethnicity										
White		18	24							
Asian/Asian British		1	0							
Black/Black British		2	1							
Mixed		3	1							
Other		0	0							
Not Stated/Not Recorded/Not Known		5	1							
The number of incidents of Restraint (Physical, Oral and IM) by Ethnicity										
Physical Restraint										
White		60	41							
Asian/Asian British		0	0							
Black/Black British		3	15							
Mixed		2	0							
Other		0	0							
Not Stated/Not Recorded/Not Known		274	184							
Physical Health Checks for patients 18+ with an SMI										
AOT		11	79%							
Recovery		88	76%							
Total % compliance over last 12months		77%	76%							
Access rates for CAMHS (number of patients accessing CAMHS by ethnicity)										
Ethnicity										
White		1626	1284							
Asian/Asian British		32	29							
Black/Black British		21	14							
Mixed		102	86							
Other		15	15							
Not Stated/Not Recorded/Not Known		134	91							
Ethnicity Recording (GHC monitoring requirement. Has at least 1 attendance)										
RIO			87.5%							
IAPTUS			98.3%							
Total Compliance			90.4%							

Summary:

Alert Current data is incomplete, particularly around ethnicity recording. To improve reporting accuracy, this month's compliance figures only include patients who have attended at least one appointment, as ethnicity information is best captured during patient engagement. Accurate ethnicity recording across all teams is essential and remains a top priority for the PCREF programme to enable meaningful analysis of access, experience and outcomes.

Key Metrics

- **Mental Health Inpatient Deaths:** Reported only when a patient death occurs; otherwise, this measure will not feature in monthly reporting.
- **Suicide Rate:** Between 2022 and 2024, the rate was **10 deaths per 10,000 population**. This will be updated when 2025 data becomes available.

Assure The PCREF Data Working Group is reviewing data quality gaps and exploring what current data patterns are indicating. In October, the group will focus on patient and carer feedback mechanisms.

Applaud The ADHD and ASC Service has implemented two quick improvements to increase ethnicity recording:

- Adding an ethnicity question to the annual physical health check form.
- Adding an ethnicity question to the Non-Medical Prescriber (NMP) assessment form.

The impact of these changes, particularly on recording compliance, will be reviewed in December and learning shared with other mental health services.

Current findings primarily reflect limitations in data completeness rather than evidence of inequality. Whilst no significant adverse patterns have currently been identified, improved ethnicity recording remains essential to strengthen assurance regarding equitable access, experience and outcomes across all communities. Improvement work continues through the PCREF programme and Data Working Group

Aim: reliable ethnicity data that supports analysis of variation in access, experience and outcomes

Measure	Aug 2026 baseline	Dec 2026 milestone	Mar 2027 target
Valid ethnicity recorded in RIO	87.5%	≥95%	≥97%
Valid ethnicity recorded in IAPTUS	98.3%	Maintain ≥98%	Maintain ≥98%
Overall recording completeness	90.4%	≥95%	≥97%
Services below 95% completeness	Baseline tbc in October	50% reduction	No service below 95%
“Not stated/not known” records	Baseline tbc in October	25% reduction	50% reduction

Expected reporting improvements

A monthly dashboard is expected from January 2027 and will provide:

- % Ethnic reporting completeness by directorate/group
- Analysis through trends and exceptions against agreed targets
- Analysis of access, experience and outcomes where data is sufficiently complete
- Named lead and action for each area below target

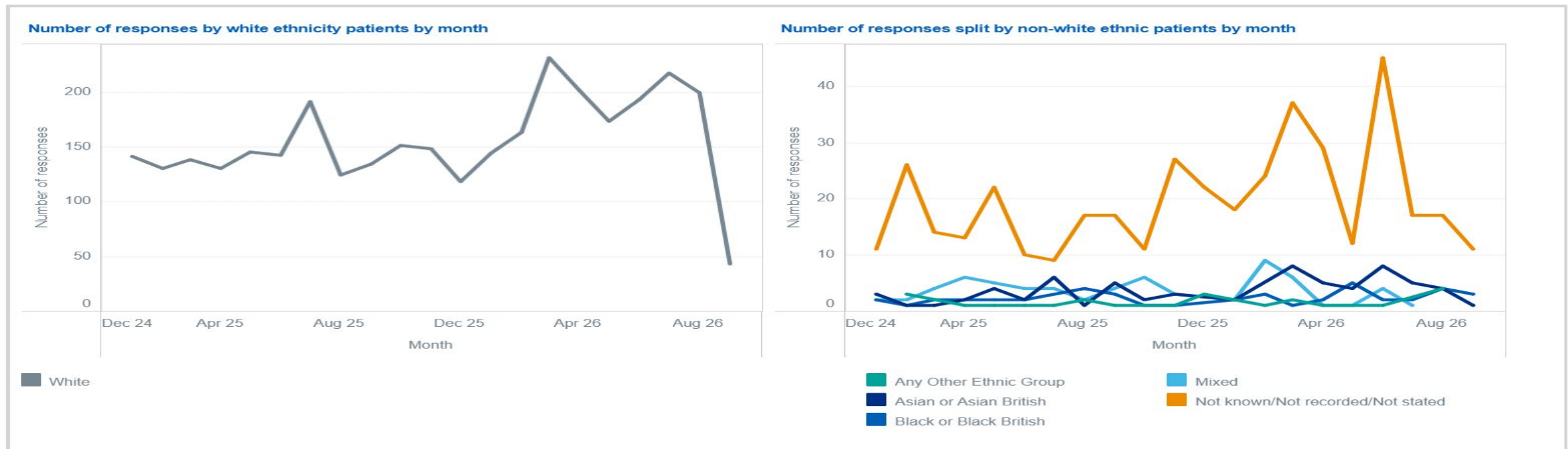
Milestones and accountability

When	Improvement activity	Evidence of progress	Accountability
October 2026	Confirm definitions and service-level baselines. Identify the largest recording gaps.	Agreed baseline and exception report	Data Working Group
November 2026	Support teams below 95%. Confirm who asks, records and updates ethnicity information.	Directorate actions and named leads	Service Directors/Operational leads
December 2026	Review changes to physical health check ‘healthy lifestyle form’ by clinical systems.	First milestone report	PCREF Steering Group
January 2027	Introduce monthly exception reporting and follow-up of incomplete records.	Service-level trends and actions	Directorates and BI
March 2027	Review target achievement and agree improvement action for any service below standard.	Quarter-end assurance report	PCREF Steering Group

Patient and Carer Race Equality Framework (PCREF) – Feedback Mechanism

The Friends and Family Test (FFT) is an important tool that supports the Trust's core principle that patients and carers should be easily able to give feedback about their experience, providing important insight into how we can improve our services and people. This ongoing feedback mechanism also collects demographic data, including ethnicity and gender. Monthly FFT reports are shared through established governance channels, and the Trust is considering ways in which to analyse this data in more detail.

Current patient and carer feedback data demonstrates low response rates from some ethnic minority groups, limiting the ability to draw reliable conclusions regarding experience and engagement. Work through the PCREF Data Working Group will focus on improving the reach, representativeness and analysis of feedback mechanisms to ensure the voices of all communities are reflected within future reporting and service improvement activity.



The graph above shows the response number for the Friends and Family Test (FFT) since Dec 2024.

In the month of August we had the following responses broken down by ethnicity. White - 199, Asian/Asian British – 4, Black/Black British – 4, Mixed – 0, Not Known/Not Recorded/Not Stated – 17. This data will be reviewed in October's PCREF data working group and thought will be given on how we can improve feedback from patients and carers from all ethnic groups.

Appendix 1

Learning From Deaths Report Quarter 4 2025-2026

During Q1 2026-27 **83** Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

GHC Patient Deaths reported during Q1 2026/27			
April	May	June	Total
34	18	31	83

(49 Community Hospital, 3 Charlton Lane Inpatients, 24 Mental Health Community Settings, 7 Learning Disability Community Teams)

During Q1 2026-27 there were in total 16 care record reviews (8 in Physical Health Mortality Group and 8 in Mental Health Mortality Group)

Number of comprehensive investigations and care record reviews completed during Q1 2026/27 for deaths occurring in:					
Q2 2025/26	Q3 2025/26		Q4 2025/26	Q1 2026/27	Total
0	0		13	3	16

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	
1 Good Practice	A standard that you would accept from yourself, your trainees and your institution
2 Room for improvement	Aspects of clinical care that could have been better
3 Room for improvement	Aspects of organisational care that could have been better
4 Room for improvement	Aspects of both clinical and organisational care that could have been better
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
6 Insufficient data/information in the case notes to assess the quality of care	

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

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

April – June 2026/27 there were 8 Care Record Reviews

All 8 Care Record Reviews were recorded as Category 1 – Good Practice: A standard that you would accept from yourself, your trainees and your institution.

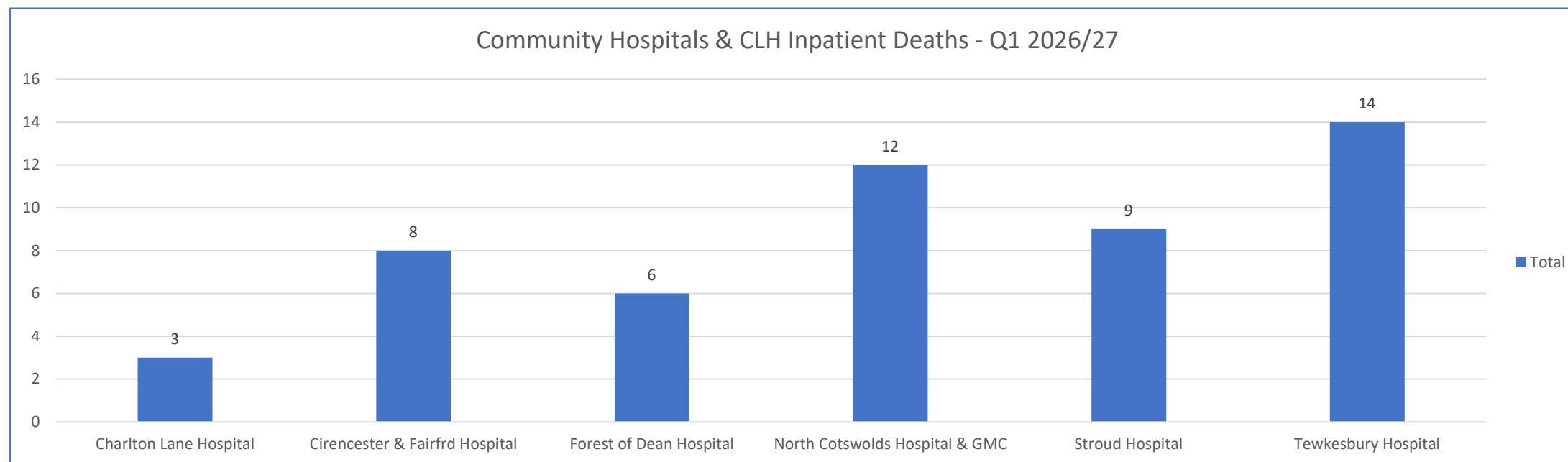
Mental Health Inpatients/Community - Care Record Reviews – Mazars/NCEPOD Criteria

April – June 2026/27 there were 8 Care Record Reviews

Care Review	Mazars: UN1	NCEPOD: 1
Care Review	Mazars: UN1	NCEPOD: 4
Care Review	Mazars: EN1	NCEPOD: 1
Care Review	Mazars: No scoring as review led to AAR	NCEPOD: No scoring as review led to AAR
Case Review	Mazars: UN1	NCEPOD: 3
Case Review	Mazars: UN1	NCEPOD: 1
Case Review	Mazars: UN2	NCEPOD: 4
Case Review	Mazars: EN1	NCEPOD: 1

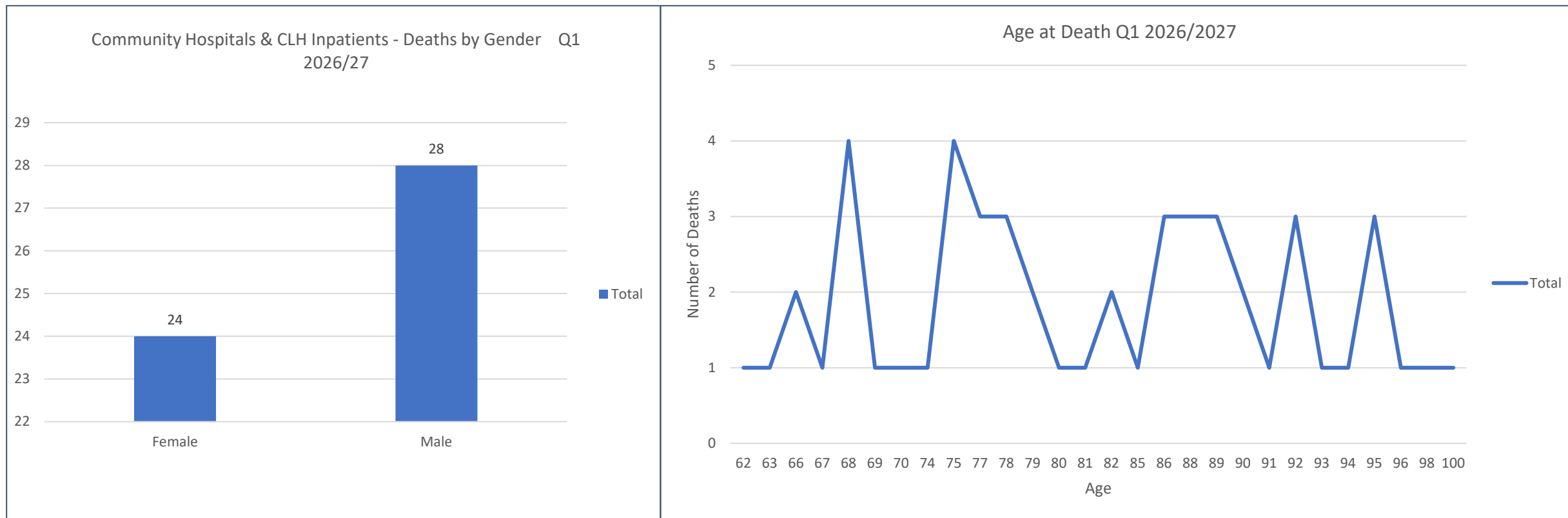
Where a NCEPOD score is not 1, information is contained within the minutes and on Datix detailing the reasons and any proposed actions. Due to the sensitive nature of this full information is not contained within this report.

Quarter 1 Community Hospitals and Charlton Lane Hospital Inpatient Deaths by ward



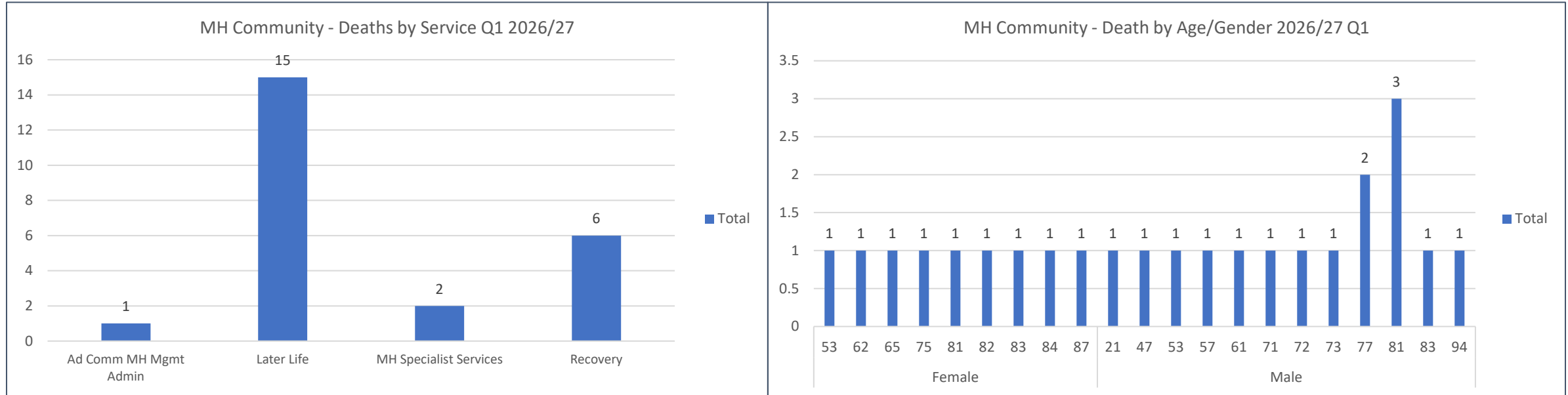
- In Quarter 1 there were 52 deaths reported across our Community hospitals' and Charlton Lane Hospital inpatient settings.
- 3 deaths were at Charlton Lane (*Acute mental health inpatient services for people with a level of frailty in combination with their mental health disorder and /or an organic mental health disorder*) and the remaining 49 in our Community Hospitals.
- The number of deaths per month ranged from 16 to 20, with April seeing the largest number.

Quarter 1- Inpatient Deaths by Gender and Age

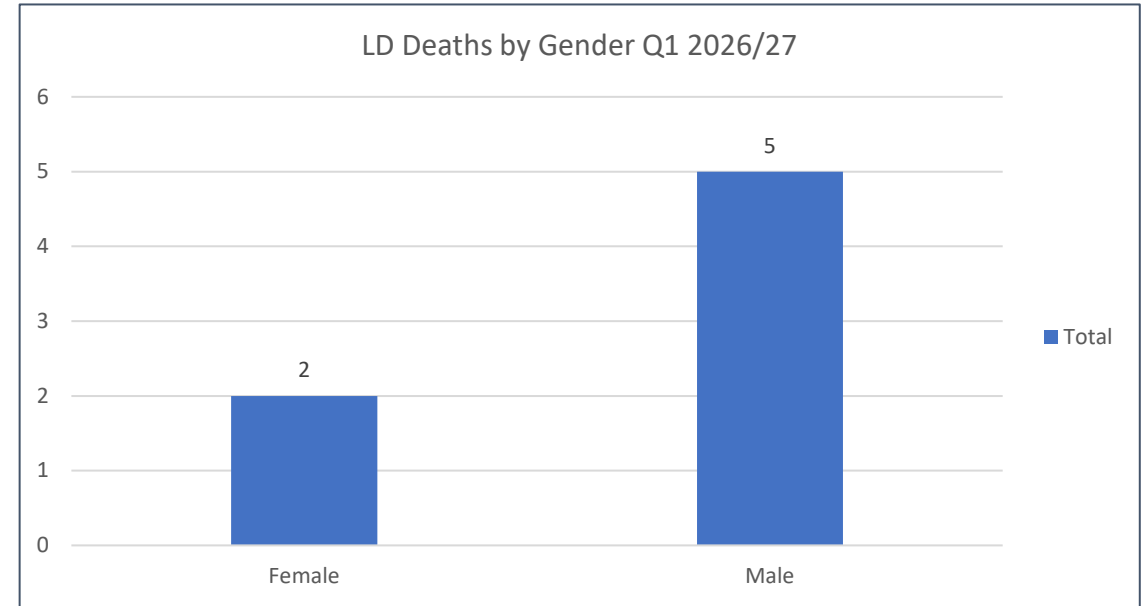
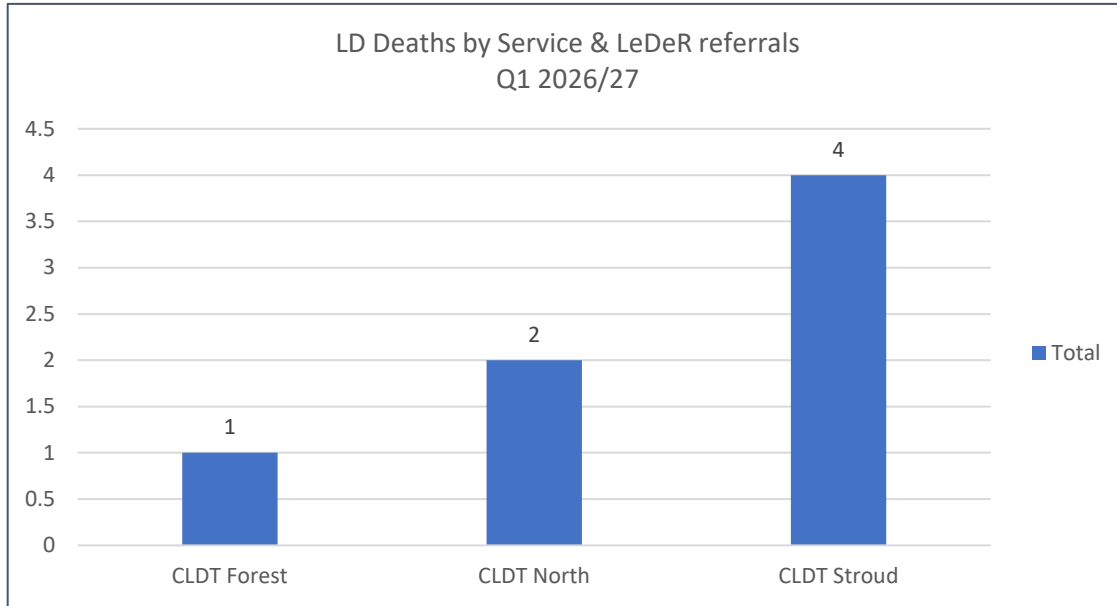


- In Quarter 1, 46% of deaths were female and 54% were male. This pattern reflects the previous quarter where we observed more males died in our inpatient settings.
- We continue to observe that the largest percentage of deaths are for individuals aged over 80. Although in Quarter 1 we have seen this figure has dropped to 54% from 60% in the previous quarter. 19% of our deaths were in individuals aged under 70, 27% aged 70-79, 27% aged 80-89 and 27% aged 90+.

Quarter 1 Deaths reported by Mental Health Services:



- In Quarter 1 we have seen 24 deaths reported by mental health teams and services at the trust, this is 4 fewer than the previous quarter.
- Our Later Life teams continue to be our highest reporter of deaths within Mental Health Services which is to be expected.
- 13 of the deaths were in April, 1 in May and 10 in June. 66% of later life deaths occurred in April.
- 37.5% of deaths were females and 62.5% were male.
- 11 individuals under the age of 75 died in the quarter, deaths prior to 75 are considered to be premature mortality.
- The 6 deaths referenced to Recovery teams were reported as Mortality Datix's where cause of death references a physical cause. Causes of death are typically observed to be respiratory or cardiac in nature.
- There were 3 deaths reported on our incident module by our Mental health services, 1 has required no further action as care was provided as expected, 1 will be a PSII and 1 is still awaiting information from the coroner (toxicology).



- In Quarter 1 there have been 7 deaths reported by our CLDT and wider services for individuals with a Learning Disability. All deaths have been reported to LeDeR.
- We have observed 5 deaths for males and 2 deaths for females; this is a change on the previous quarter where we observed more deaths in females.
- Age at time of death ranged from 56-83, in 2023-24 Gloucestershire's median age of death was 61.9, in Q1 our median age at time of death was 66.2 which is an increase in age on the previous quarters data. As previously stated this is however a small set of data.

Quarter 1 Update including Learning, Themes and Trends from MRG meetings:

- We continue to see examples of our inpatient settings working closely with families around end-of-life care:
 - We have observed examples of collaborative team working, effective communication, information sharing and decision making in a complex case which will act as a model in future similar cases.
 - Transfer of patients between hospitals to ensure family could see their loved one as they could not drive.
 - Inpatient teams are regularly asking for cases to be discussed at Mortality group and identify this via the datix submission, this can be to share good practice, areas for improvement or wider learning.
- Clarification provided that Ryles Tubes these can be done in a Community Hospitals but on a case-by-case basis; they would be managed in a personalised care way. There is a care plan for patients which can be individualised but focuses on the management of an existing Ryles tube that is either on free drainage or needs aspirating
- Acknowledgement of the challenges that can sometimes occur in engaging people with Physical Health Checks, Discussed potential of a 'grab bag' for care coordinators at Pullman place to enable them to carry these out where situation allows. This is an area of focus within the meeting and has contributed to the NCEPOD scores of 4 seen on previous slides.
- The importance of all our trust services being aware of how to contact one another, eg mental health colleagues knowing how to contact District Nursing colleagues

AGENDA ITEM: 13/1026

REPORT TO: TRUST BOARD **PUBLIC SESSION – 1st OCTOBER 2026**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Emma Abbey, Chair of Medical Appraisal Committee

SUBJECT: **MEDICAL APPRAISAL AND JOB PLAN ANNUAL REPORT**

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

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

The purpose of this report is to: The Medical Appraisal, Revalidation and Job Plan Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services by medical practitioners with a connection to this designated body. It provides assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required: 1) That the Board ACCEPT and ENDORSE the Medical Appraisal and Job Plan Annual Report and: • Recognise that levels have been maintained in the application of appraisal and job plan recording and quality assuring, and that this has occurred without significant additional funding. • Recognise that the figures for engagement in appraisal and job plan reflect a snapshot at one point in the year and that the Trust will continue to achieve appraisal and job plans consistent with the provision of safe medical services on an annual basis supported by the revalidation statistics provided. • Recognise that there are a number of exceptions/reasons for non-compliance that contribute to a compliance point of less than 100%. • Recognise that effective appraisal has supported timely and appropriate revalidation for all doctors to date. • Recognise that good employment practice with regard to recruitment is supporting safe practice.

- Recognise that locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.
- To note in particular the assurance for NHS England in section 14 that the Trust meets requirements.

2) That the Board agrees the content and submission of the Statement of Compliance to NHS England and that this is signed by the Chair on behalf of the Trust (section 14 page 11-21).

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures demonstrate that of the 111 doctors requiring appraisal during the 2025-26 appraisal year 99 (89%) were compliant as of 1st April 2026 (this is an increase on the previous year).
- Of the 12 doctors who were non-compliant; 7 (6.5%) had acceptable reasons (3 being new starters; 1 for health reasons, 3 due to appraiser being availability. Of the 5 (4.5%) non-compliant without a reason, 3 had been done by the time of the meeting, and the remaining 2 were all overdue by less than two months.
- Doctors' revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and is necessary to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and both consultant and SAS level doctors. Andrea Foden, MHA Manager, is part of the group to provide lay oversight.
- This report does not include Dental staff as they are not subject to these GMC regulations.
- This report includes a one-page summary from the Job Plan Compliance Committee as recommended by the Trust's internal auditors, BDO (page 10).

Risks associated with meeting the Trust's values

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

Corporate considerations

Quality Implications	Appraisal contributes to patient safety.
Resource Implications	Continuing use of administrative and managerial time with clinician input to revalidation process.

Equality Implications	The annual appraisal monitoring process addresses equalities issues.
-----------------------	--

Where in the Trust has this been discussed before?
- Medical Appraisal Committee, 13th May 2026 - Great Place to Work Committee, 25th August 2026

Appendices:	N/A
--------------------	-----

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

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

ANNUAL MEDICAL APPRAISAL & JOB PLAN BOARD REPORT

Appraisal year:	1 st April 2025 – 31 st March 2026
Author:	Dr Emma Abbey <i>On behalf of Medical Appraisal Committee</i>
Prepared for:	Trust Board via Great Place to Work Committee

1. EXECUTIVE SUMMARY

Of the 111 doctors requiring appraisal during the 2025-26 appraisal year 99 (89%) were compliant as of 1st April 2026; this is an increase on the previous year (88% at end of Q4 2025).

In addition, there are another approximate 260 doctors who are employed by GHC in a sessional or bank capacity but not under our 'designated body'.

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

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to the Trust Board through the Quality Committee and the Quality Assurance Group that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019; a visit was planned for summer 2025 but was cancelled by NHS England.

2. PURPOSE OF THE PAPER

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

3. BACKGROUND

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

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

4. GOVERNANCE ARRANGEMENTS

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

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

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

Key outputs from the MAC during the last year include:

- Review of the current terms of reference for the MAC
- Review of the membership of the MAC
- Completion of the annual quality assurance audit. The April 2026 audit covered all appraisals completed from 1st April 2025 to 31st March 2026
- Continued review of the currently active medical appraisers list
- Provision of a training course for new appraisers, which was attended by 9 GHC employees (consultants and higher trainees) and one doctor from Herefordshire & Worcestershire Health & Care NHS Trust
- Recruitment of 3 new appraisers, of whom two have already started appraising.
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisals
- Training sessions for new starters to SARD provided by Dr Abbey

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

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job plans are



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency of compliance monitoring and hence maintaining the overall high compliance rates seen since its introduction.

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

Priorities for the MAC for the next year include further refinement of the number and nature of active qualified medical appraisers within the organisation, in line with the increase in doctor numbers and natural turnover of appraisers. The committee have sourced an easy read patient feedback form for 360-degree feedback as clinicians from certain sub-specialities had previously identified this as being a barrier to collecting patient feedback.

5. MEDICAL APPRAISAL

5.1. Appraisal and revalidation performance data

Of the 111 doctors requiring appraisal during the 2025-26 appraisal year 99 (89%) were compliant as of 1st April 2026; this is an increase on the previous year (88% at end of Q4 2025).

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

Of the 12 doctors who were non-compliant; 7 (6.5%) had acceptable reasons (3 being new starters; 1 for health reasons, 3 due to appraiser being availability. Of the 5 (4.5%) non-compliant without a reason, 3 had been done by the time of the meeting, and the remaining 2 were all overdue by less than two months.

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

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

For further details see **Appendix A**.



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

5.2. Appraisers

There are currently 21 trained medical appraisers within the establishment of non-training grade doctors, although one of these is relinquishing the role. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

During the appraisal year 2025-26, a “new appraisers” course was organised which ran on 14 May 2026. Following this, 3 new appraisers have been appointed, and have already started appraising. A further appraiser will be starting on her return from maternity leave in 2027. One appraiser whose regular work pressures affected their ability to offer appraisals is now winding down their appraiser commitments. There have again been some periods of sick leave for our established appraisers, which have required reallocation at short notice.

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

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

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

5.3. Quality assurance

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

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



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

quality assurance audit. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

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

5.3.1. Support for appraisers

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

5.3.2. Feedback from appraisees

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

83 appraiser feedback questionnaires were received for 20 appraisers who completed 96 online appraisals between 01 Apr 2025 and 31 Mar 2026. This is a return rate of 86%, which is a slight decrease from 2025 (92%).

5.3.3. Automatic uploading of complaints and anonymised SI reports

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of the appraisal process. Appraisees can also approach the RO office directly to request information about any incidents in which they have been named.

5.3.4. Annual quality assurance audit

The annual medical appraisal quality assurance audit was conducted in May 2026 by all members of the MAC, using a nationally recognised medical appraisal QA tool (the Excellence Tool).

15 (16% of all) completed appraisal summaries were selected for audit – this includes 10% of appraisals plus the first three appraisals of each new appraiser. Consent was sought from individual appraisees; none declined. Each appraisal was audited by two independent MAC members. Results were reviewed and an action plan developed, including:

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

- Individualised feedback provided to appraisers

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool was 41/44, which was an improvement from the previous year (40/44) indicating a sustained high standard of appraisal documentation. Since the 2022-23 audit we have included a question of whether form A has been uploaded to SARD and discussed at appraisal. Form A is a summary of the appraisee's job plan and is recommended by NHSE to be used in appraisal. Its use is now increasing by appraisees and appraisers.

In January 2025 the appraisal documentation collated by SARD was streamlined, and we believe this has positively impacted the capture of appraisal outputs in the summaries from appraisers. Of particular note, out of the 38 points dropped in total, 16 were due to the job plan summary (form A). This has been a specific learning point this year and the MAC have altered the requirement for form A within SARD, in order to reduce the chance that it is forgotten in the appraisal process.

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

The audit will be repeated annually.

Please refer to **Appendix B**.

5.4. Access, security and confidentiality

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

5.5. Lay participation in medical appraisal

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

5.6. Clinical governance

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



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

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

6. REVALIDATION RECOMMENDATIONS

During the last year 9 revalidation recommendations were due; positive recommendations were made for 5 of these (56%), and 1 was deferred within the same financial year (11%) and 2 (22%) were deferred to the new financial year 25/26; all deferrals were subsequently recommended. 1 left before their revalidation was due (11%).

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

7. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

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

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

Please see **Appendix E**.

8. MONITORING PERFORMANCE

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

- ❖ Initial design of job description and person specification
- ❖ Effective recruitment and selection processes
- ❖ Job planning
- ❖ Peer group membership and attendance
- ❖ Appraisal
- ❖ Monitoring of serious incidents, complaints and compliments
- ❖ Participation in supervision
- ❖ Activity data



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

- ❖ Participation in continuing professional development (CPD)
- ❖ Completion of statutory and mandatory training
- ❖ Diary monitoring exercises
- ❖ Attendance/sickness absence

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

Please refer to **Appendix D**.

9. Responding to concerns and remediation

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

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

Please refer to **Appendix D**.

10. RISK AND ISSUES

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

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

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

Recruits from outside the UK have not taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue, and one further expanded on in the Pearson review. The scope of work that a doctor can undertake is determined by and determines their CPD and continuing medical education (CME) requirements. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

11. CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS

The MAC will continue to review its work plan against the terms of reference annually. The Trust Medical Appraisal Policy was reviewed during the appraisal year 21-22. There was a further review with minor updates made in 2024. Priorities for the MAC for the next year include consolidation of our new appraisers and retention of the existing group; and continuing focus on moving beyond compliance towards further quality improvement.

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

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

12. RECOMMENDATIONS

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

- ❖ Recognise the support provided to Appraisal and Revalidation within GHC through the use of SARD JV and the engagement of clinicians in this.
- ❖ Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- ❖ Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this designated body to be appraised; however, there will be exceptions which will reduce the overall figure.
- ❖ Appropriate processes are in place for the review of appraisals, appraiser performance, maintenance of appraisal capacity and the quality of appraisals.
- ❖ Employment checks are undertaken consistent with national standards and best practice.
- ❖ Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence.
- ❖ To note in particular the assurance in section 14 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. JOB PLAN COMPLIANCE COMMITTEE ANNUAL REPORT

13.1 Background

Job planning is a professional and contractual obligation for doctors and employers. Regular review of the efficient and effective use of doctor time is critical to modern



healthcare delivery. Since 1991 it has been a contractual requirement for all doctors to have a job plan, which is agreed and reviewed annually.

The Trust's internal auditors, BDO conducted an audit in 23/24, and the Job Plan Compliance Committee (JPCC) and this annual report were some of the recommendations from that audit.

13.2 Policy

The Trust implemented a new job plan policy in October 2022. The purpose of this policy is to set out clear guidance on doctors' job planning in a way that supports transparency and consistency of approach across all care pathways. This was reviewed and updated in September 2025.

13.3 Job Plan Compliance Committee (JPCC)

The JPCC started in November 2024, the purpose of the group is to:

- i) Oversee the process of job planning of all licensed non-training grade doctors employed within the trust
- ii) Develop and oversee policy, process and training to support effective job planning within the trust
- iii) To act as a point of mediation and escalation for the job plan process

13.4 Compliance Figures at 31st March 2026

No of consultants eligible for job planning	67
No of consultants with a signed job plan	60 / 89.5%
No of SAS doctors eligible for job planning	27
No of SAS doctors with a signed job plan	21 / 78%

14. NHSE STATEMENT OF COMPLIANCE

1A – General

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

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

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



with you, for you

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

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

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

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

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

Action from last year:	None
Comments:	The Medical Appraisal Policy was reviewed and minor updates made in 2026; waiting for approval from LNC.
Action for next year:	None

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

Action from last year:	None
Comments:	The annual medical appraisal quality assurance audit was conducted in May 2026 for the appraisal year 25-26 by the Medical Appraisal Committee (MAC).
Action for next year:	The audit is repeated annually by the MAC

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

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

1B – Appraisal

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

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

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

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

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

Action from last year:	None
Comments:	The Medical Appraisal Policy was reviewed and minor updates made in 2026; waiting for approval from LNC.
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

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

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

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

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

	the MAC chair.
Action for next year:	Continue with current practice.

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

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

1C – Recommendations to the GMC

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

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

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

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

1D – Medical governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1E – Employment Checks

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

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

1F – Organisational Culture

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

Action from last year:	None
Comments:	The appraisal and supervision system aims to support staff to develop their potential. Further incentives for excellence include the “better care together awards”, where staff are nominated for making a difference, always improving, being respectful and kind, working together, tackling inequalities, outstanding achievement, and sustainability. Degree apprenticeships are offered internally to staff showing potential to develop their careers towards professional registration.
Action for next year:	Continue current practice.

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

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

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of



whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

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

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

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

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

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

1G – Calibration and networking

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

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



with you, for you

SECTION 2 – METRICS

Gloucestershire Health and Care

NHS Foundation Trust

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	111
Total number of appraisals completed	99
Total number of appraisals approved missed	7
Total number of unapproved missed	5
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	8
Total number of late recommendations	0
Total number of positive recommendations	5
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	1 (left)
Total number of trained case investigators	21
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer ²	2 (25/26) +2 c/f
Total number of concerns processes completed	2 (25/26) +1 c/f
Longest duration of concerns process of those open on 31 March (working days)	186
Median duration of concerns processes closed (working days) ³ (current year cases closed)	174.5
Total number of doctors excluded/suspended during the period	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

Total number of doctors referred to GMC	0 (plus 1 from 24/25)
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	n/a
Total number of new doctors joining the organisation	20 + 9 GPs
Total number of new employment checks completed before commencement of employment	20 + 9 GPs
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld ⁴	ongoing

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

SECTION 3 – SUMMARY AND OVERALL COMMENTARY

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

General review of actions since last Board report

- 1) New appraiser course has been held and has resulted in 3 new appraisers starting, with another pending.
- 2) Form A documentation has been reviewed to improve reporting
- 3) SARD streamlining has now pulled through to all active appraisals, and is resulting in improved documentation as seen in the audit output
- 4) Annual audit has shown maintenance of a high standard of medical appraisal.

Actions still outstanding

None.

Current issues

- 1) Continued need to maintain numbers of appraisers in an increasing medical workforce

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- 1) Maintain appraiser numbers to accommodate increasing medical workforce
- 2) Annual audit of appraisal standard
- 3) Ongoing oversight of any feedback which is less than positive.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

SECTION 4 – STATEMENT OF COMPLIANCE

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

Signed on behalf of the designated body

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

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

Name:	Graham Russell
Role:	Chair
Signed:	
Date:	

Name of the person completing this form:	Karen Small
Email address:	Karen.small4@nhs.net



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

APPENDIX A - Audit of all missed or incomplete appraisals (as of 1st April 2026)

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	
New starter more than 3 months from appraisal due date	3
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	1
Lack of engagement of doctor	
Other doctor factors	5
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	2
Other appraiser factors (not known)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe) Waiting for appraisal to be undertaken by different designated body and evidence provided.	
Total	
NB. Dentists employed by the Trust are currently subject to different monitoring arrangements and not included in the figures on this page.	



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

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

		Frequency		
Number	Criterion (following scrutiny of the appraisal summary, score 0-2 for each criteria)	absent	room for improvement	well done
1	Includes whole scope of work?	0	2	28
2	Free from bias?	0	0	30
3	Challenging & supportive?	0	1	29
4	Exceptions explained?	0	0	30
5	Reviews & reflects?	0	3	27
6	Review of previous PDP?	1	6	23
7	Encourages excellence?	0	0	30
8	Gaps identified?	0	2	28
9	SMART PDP?	0	4	26
10	Relevant PDP?	0	2	28
11	Form A	3	10	17



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

APPENDIX C - Audit of revalidation recommendations

Revalidation recommendations between 1st April 2025 to 31 st March 2026	
Recommendations completed on time (within the GMC recommendation window)	8
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	8
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	n/a
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other – (late due to Staff unplanned absence)	
Describe other – Trust was in negotiations with Doctor and GMC	
TOTAL [sum of (late) + (missed)]	0



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

APPENDIX D - Audit of concerns about a doctor's practice (1st April 25 to 31st March 26)

Please note this does not include information about dentists as not subject to GMC regulations.

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

⁵ http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf



Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	n/a
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practise procedures between 1 April and 31 March	2 (c/f)



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment	
Number of NHS Resolution assessments performed	2 (new) 2 (c/f)

APPENDIX E - Audit of recruitment and engagement background checks (1st April 2025 to 31st March 2026)

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	14
Temporary employed doctors	5
Temporary employed doctors who became substantive	0
Locums brought in to the designated body through a locum agency	1
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	9
Other: Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	
TOTAL	29

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

NB. MPIT forms from previous designated body

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

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

	Total	Identity check	GMC issues	GMC conditions or undertakings	On-going investigations	Last RO	Reference from last RO	Local conditions or undertakings	Revalidation due date	Appraisal due date	Unresolved performance concerns
Permanent employed doctors	14	14	0	0	0	14	5	0	14	14	0
Temporary employed doctors	5	5	0	0	0	5	3	0	5	5	0
Temporary employed doctors who became substantive											
Locums brought in to the designated body through a locum agency	1*	1	0	0	0	1	1	0	1	1	0
Locums brought in to the designated body through 'Staff Bank' arrangements											

Doctors on Performers Lists (not on DB)	9	9	0	-	-	-	-	-	-	-	-
Other (independent contractors, practising privileges, members, registrants, etc.)											
Total	29	29	0	0	0	20	9	0	20	20	0

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

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

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

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine	Flexible	536* (GP not in DB)	0	0	536 (GP not in DB)
Psychiatry	As of end of March this was 8 WTE	764	992	0	1756
Obstetrics/Gynaecology					

Accident and Emergency					
Anaesthetics					
Radiology					
Pathology					
Total in designated body (Includes all doctors, not just those with a prescribed connection)		764	992	0	1756

Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months	1*	1	1	1 Harshini	
3-6 months	4	4	4	2 NA Mahbouba + Olasupo	
6-12 months	2	2	2	1 NA Second Olukoya	
More than 12 months	2	2	2	NA	NA
Total	9	9	9		

***During this time there were 27 GP's working via agency for IUCS**

REPORT TO: TRUST BOARD **PUBLIC SESSION – 1st October 2026**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Sally Morgan, Guardian of Safe Working Hours

SUBJECT: **GUARDIAN OF SAFE WORKING HOURS (GoSWH)
Q1 2026/27 REPORT**

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

This report is provided for:

Decision ☐

Endorsement ☐

Assurance ☒

Information ☒

The purpose of this report is to:

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

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

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

Recommendations and decisions required

The Trust Board is asked to:

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

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 compliant 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 - 25th August 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' 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	51 + 11 successful test reports + 62
---	--------------------------------------

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	18	27	10 (6 for exceeding shift length and 4 for breach of rest period between shifts)	4 ERs occurred a double fine (shift length and rest breaches) 2 ERs occurred a fine for breach of shift length only 1 ER was withdrawn	47
Breaches of non-resident on call pattern	1	0	1 (breach of rest period)	3 ERs made (1 for breach of rest and 2 for hours – 1 of hours ER later withdrawn)	3
Inability to take contractual breaks					0
Inadequacy of clinical support					0
Inadequacy of rostered skill mix					0
Raising concerns of suspected non-compliant rota					0
Detriment or threat of detriment related to exception reporting					0
Information breach					0

Type of exception report	Outcome				Number of exception reports
	Pay	TOIL	Penalty/fine	information	
Access and completion resolved in time					0
Access and completion breaches					0
Access and completion test				All new starters were given this information by GOSWH in person at their Induction	11
Other: Exception reports relating to missed training opportunities				Signed off by DME	1
Total	19	27	11		51 + 11 tests = 62

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	47
---	----

B4) Exception reports actioned by GOSWH

Exception reports flagged directly to GOSWH	3
---	---

B5) Exception reports relating to missed training opportunities

Exception reports relating to missed training opportunities – signed off by Director of Medical Education	1
---	---

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 and the Verification Manager attended the Resident Doctor Induction In April 2026 to meet new doctors joining the trust and provided with information about exception exporting. All new starters were made 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.

A work schedule review is planned for the resident doctors which cover Wotton Lawn Hospital and Charlton Lane Centre as the majority of breaches and fines have come as a result of this area of their work.

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	18
---	----

Resident Doctors in Training Summary

Category	April to June	
Total Doctors in Training	56	
Higher Trainees (HTs)	20 (<i>incl. 1 on maternity leave and 1 out of area placement</i>)	
CT3s	9	
CT2s	6	
CT1s	6	
GP Trainees	4	
FY2s	6	
FY1s	7	

On-call Shift Gaps and Cover

Metric	Number
Total shifts with gaps	18
Covered by Resident Doctors (locums)	10
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.

Guardian of Safeworking Hours Board Report Part 1

- Reporting time period April 2026 –2026 – new rotation began in April
- GoSWH – Dr Sally Morgan

Resident Doctors in Training Summary

Category	April to June	
Total Doctors in Training	56	
Higher Trainees (HTs)	20 (<i>incl. 1 on maternity leave and 1 out of area placement</i>)	
CT3s	9	
CT2s	6	
CT1s	6	
GP Trainees	4	
FY2s	6	
FY1s	7	

On-call Shift Gaps and Cover

Metric	Number
Total shifts with gaps	18
Covered by Resident Doctors (locums)	10
Covered by Specialty Doctors (locums)	8

Guardian of Safeworking Hours Board Report Part II

- GoSWH and the Verification Manager attended the **Resident Doctor Induction** in April 2026 to meet new doctors joining the trust and provided information about exception exporting and to make them aware of the need to submit a test exception report (access and completion test)
- **62 exception reports made , 11 of which were successful access and completion tests.**
- 47 unscheduled late finishes (1 was later withdrawn) , 4 of these ERs occurred a double fine (for breach of shift length and rest breaches) and 2 ERs occurred a fine for breach of shift length only .
- 3 ERs were made for breaches of non resident on call pattern , 1 for breach of rest period which incurred a fine and 2 for breach of hours (1 of these was later withdrawn).
- 1 exception report was made for missed educational opportunities.
- 3 were actioned by GOSWH, 47 were actioned by the Verification Manager , 1 was actioned by the DME.
- **Outcomes agreed : 27 x TOIL , 19 x payment, 11 x fines.**
- **No exception reports were made regarding disclosures/breach of confidentiality.**
- **A survey regarding experiences of actual or threatened detriment** had a response rate of 47%. Of those that responded, 0% reported experiencing actual or threatened detriment and 88% reported feeling that they are not discouraged from exception reporting.
- The acting deputy GOSWH has been contacting some of the doctors who have exception reported to explore reasons for reporting in more detail .
- **Junior Doctors Forum held virtually on 22nd May 2026.**
- **Wellbeing Day held on 12 June 2026.**

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Thursday 16 July 2026
At Trust HQ, Edward Jenner Court

PRESENT:

Graham Russell (Chair)	Kizzy Kukreja	Peter Gardner
Andrew Cotterill	Chris Witham	Chas Townley
Jan Lawry	Tussie Myerson	Alicia Wynn
David Hindle		

IN ATTENDANCE:

- Steve Alvis, Non-Executive Director
- Helen Blanchard, Non-Executive Director
- Helen Child, Director of Corporate Governance
- Karen Clements, Non-Executive Director
- Anna Hilditch, Deputy Trust Secretary
- Nicola de longh, Non-Executive Director
- Bilal Lala, Non-Executive Director
- Vicci Livingstone-Thompson, Non-Executive Director
- Julie Mackie, Head of Partnerships
- Neil Savage, Director of HR & OD

1. WELCOMES AND APOLOGIES

- 1.1 Apologies had been received from the following Governors: Amy Aitken, Marcia Gallagher, Bob Lloyd-Smith, Michelle Kirk, Leighton Pettigrew, Joy Hibbins, Sarah Waller, Martin Pittaway, Paul Winterbottom, and Laura Bailey. Apologies had also been received from Debbie Forster and Cathia Jenainati.
- 1.2 Graham Russell welcomed Helen Blanchard to her first Council meeting following her appointment as a Non-Executive Director on 25 May 2026.
- 1.3 On behalf of the Council, Graham Russell expressed his thanks to Mick Gibbons, Public Governor for Stroud, who had made the decision to resign from his Governor position in June 2026. Mick had served 4 years as a Public Governor, and his contributions during that time had been most valued, in particular as a member of the Nominations and Remuneration Committee. Governors agreed that Mick's insights, challenge and experience would be missed on the Council.
- 1.4 Graham Russell also advised that Michelle Kirk, Staff Governor for Health & Social Care Professionals would be stepping down from her position on 31st July. Michelle's role would be transferring to the local authority as part of recent changes, which would mean that she would no longer be eligible to continue as a Staff Governor for GHC. Michelle had sent apologies for the meeting due to leave commitments, but Governor colleagues thanked her for her contributions and wished her well for the future.

2. DECLARATIONS OF INTEREST

- 2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETINGS

- 3.1 The minutes from the previous Council meetings held on 14 May 2026 were received and **agreed** as a correct record.

4. MATTERS ARISING AND ACTION POINTS

- 4.1 The actions from the previous meetings were complete or progressing to plan.
- 4.2 There were no matters arising from the previous meeting not already covered on today's agenda.

5. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY

- 5.1 Chris Witham presented this report which provided a summary of the business conducted by the Nominations and Remuneration Committee at their meeting on 25th June 2026.
- 5.2 The Committee received a report setting out the proposed process and provisional timeline for the recruitment of a new Trust Chair, noting that Graham Russell's term of office would come to an end on 1 May 2027. The Committee **noted** the rationale for starting the Chair recruitment process ahead of the usual timeline, noting that this was intended to avoid complications from anticipated changes in NHS governance. The Chair recruitment was planned to commence in September, allowing sufficient time for preparation and ensuring the process was not rushed. The Nominations and Remuneration Committee supported the proposed process and timeline, noted the job description, for onward consultation and engagement with internal and external partners, supported the proposed remuneration range, and agreed to the Director of Corporate Governance and the Director of HR and OD proceeding with recruitment on the outlined basis.
- 5.3 The Committee also received a report setting out the proposed process and provisional timeline for the recruitment of a new Non-Executive Director, noting that Steve Alvis's final term would come to an end on 18 November 2026. The Committee **noted** the importance of recruiting a NED with a background in primary care to succeed Steve Alvis, whose networks and experience as a former GP have been highly valued, especially given the trust's increasing partnership with the GP collaborative and neighbourhood working. The Committee endorsed the direction of travel in relation to the recruitment of a new NED, noting that further engagement would take place with Board members to agree the specific skills and experience being sought for this post. Further details on timelines would be shared once finalised.
- 5.4 The Committee received the outcome of the recent NED appraisals, **noting** that these were completed on time, with positive conversations and outcomes for those appraised. Appraisals took place for Steve Alvis (Chair of Mental Health Legislation Scrutiny and Vice Chair of Quality Committee), Bilal Lala (Chair of Audit Committee), Nicola de longh (Senior Independent Director, Vice Chair and Chair of Charitable Funds Committee, Vice Chair of Resources Committee) and Vicci Livingstone-Thompson (Vice Chair of Great Place to Work Committee, Health & Wellbeing Champion, Diversity Network Chair). Debbie Forster joined the Trust on 24 January, and Karen Clements on 2 March, so both colleagues received a light touch appraisal with the Chair for the 2025/26 period, to help identify objectives for the year ahead. Helen Blanchard, who commenced on 25 May 2026 had also met with the Chair to agree objectives for 2026/27. The Committee **noted** the positive outcome of this year's NED appraisals, and **agreed** to report formally to the full Council that this information was received and noted.
- 5.5 The Committee received the outcome of the Trust Chair appraisal for 2025/26. Committee members received the completed annual appraisal submission for NHSE, which would be submitted by 30th June. This summarised the key themes arising from the stakeholder

feedback, including highlighted areas of strength and identified opportunities to increase impact and effectiveness. The report also included Graham Russell's summary of self-reflection on the multisource stakeholder assessment outcomes. The Committee received and **noted** the objectives that had been agreed for 2026/27. The Committee **noted** the positive outcome of this year's Chair appraisal, and **agreed** to report formally to the full Council that this information was received and **noted**.

6. ANNUAL REPORT AND ACCOUNTS 2025/26 – FORMAL RECEIPT

- 6.1 The purpose of this report was to present the Council of Governors with the final draft Annual Report and Accounts 2025/26, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".
- 6.2 The Council **noted** that the Annual Report would be Laid before parliament during July and would be formally presented at the Trust's AGM taking place on Thursday 17th September 2026.
- 6.3 Governors were advised that the Audit & Assurance Committee received and approved the Annual Report and Accounts at its June meeting, and assurance was provided that these had been given a clean bill of health by the External Auditors.
- 6.4 Colleagues asked whether the Trust would be producing a summary of the annual report, or an easy read version to make it more accessible. It was **noted** that the Trust would be producing a short film to accompany the written report, setting out the key highlights in an accessible format.
- 6.5 Andrew Cotterill said that he had read the report and was pleased that he recognised the key developments and achievements set out within it.
- 6.6 Helen Child informed the Council that this was the first year's audit with the new External Auditors, Sumer NI. She said that they had been very diligent and thorough, and had carried out a comprehensive review of the accounts and annual report.
- 6.7 Colleagues expressed thanks to Bilal Lala, Chair of the Audit & Assurance Committee for his robust scrutiny and for steering the Committee through the accounts sign off procedure.
- 6.8 The Council of Governors **formally received** the Annual Report and Accounts 2025/26.

7. ANY OTHER BUSINESS

- 7.1 The Council **noted** that the interviews for the new Associate NED position would be taking place later that afternoon. Graham Russell said that over 40 applications had been received, and 4 strong candidates had been invited for interview.
- 7.2 Graham Russell informed the Governors that Katherine Archer would be commencing in post at the end of July as the Trust's new Director of Finance. Dominic Gardener had been appointed as the new Chief Operating Officer, and he would join the Trust from 1 September.

8. DATE OF NEXT MEETING

- 8.1 The next Council of Governors meeting would take place on Tuesday 15th September at 10:30 13:00 via MS Teams.

ASSURANCE REPORT TO BOARD

REPORT TO:	TRUST PUBLIC BOARD – 1 ST OCTOBER 2026
COMMITTEE:	AUDIT & ASSURANCE COMMITTEE – 6 AUGUST 2026
AUTHOR:	Trust Secretariat
PRESENTED BY:	Bilal Lala, Chair of Committee

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

The Committee discussed the Committer Referral and Triangulation Log and **agreed** that the process and communications for this required further review.

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

The Committee received and considered the Infection Governance Compliance internal audit report and **noted** that this was considered moderate for design and limited for effectiveness, with three high risk priority findings.

The Committee received and considered the Key Financial Systems (Journals) internal audit report and noted that this was considered limited for design and moderate for effectiveness, with one high risk priority findings, and one medium risk finding.

The Committee was assured that whilst there were areas for improvement, the associated risks and controls were being managed

The Committee received the Internal Audit Follow Up Report and expressed concerns regarding the delayed progress with the Infection Prevention and Control, and the Non-Medical Prescribing Internal Audit recommendations. Assurance was obtained though internal auditors BDO that the expectation was for full disclosure to be received at the next Committee meeting in November. Further scrutiny and oversight on both reports was referred to the Quality Committee.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Counter Fraud, Bribery and Corruptions Summary of Investigations, which provided new, closed and live actions with associated context.

The Committee was informed that that the Memorandum of Understanding (MoU) with Gloucestershire Constabulary regarding out-of-court disposals had been refreshed to

support a timelier resolution of appropriate fraud cases, recognising significant delays within the criminal justice system.

The Finance Compliance Report was received by the Committee, and assurance was provided that although there continued to be overdue debt, good progress was being made on moving things forward to effect collection in due course, particularly from Gloucestershire County Council (GCC).

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the internal audit recommendation to pause the planned internal audit on Partnership Working, following discussions with management, as it was considered more appropriate for the work to be undertaken internally rather than through Internal Audit. It was **noted** that an alternative would be tabled at the November Committee meeting.

The Committee **approved** the proposed amendment to the Scheme of Delegation, which reflected the Trust's operational restructuring by recognising new Service Group Director roles alongside existing Service Director titles until a full review of the governance documents could be completed; and also the revised approval thresholds for the disposal of equipment assets, including a new category for items valued between £55 and £5k aligning these arrangements with the Trust's capital asset controls.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee reviewed and discussed the Board Assurance Framework and the Corporate Risk Register, extending discussion into the operational risks to explore emerging common themes. A further discussion to explore the identified BAF risks in consideration by the wider Board would take place through a Board development session, with discussion around the lack of movement in scores, which would indicate a lack of progress in actions to mitigate risks.

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

The Committee applauded Counter Fraud, Bribery and Corruption teams on their work and relationship with Gloucestershire Constabulary to improve the conditional caution process.

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

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

- BDO Progress Report
- Counter Fraud Summary of Investigations



with you, for you



Gloucestershire Health and Care

NHS Foundation Trust

- Counter Fraud, Bribery and Corruption Annual Report
- Counter Fraud, Bribery and Corruption Progress Report
- External Audit Annual Report
- Functional Standard Return 2025-26
- Summary Reports from the following Management Groups:
 - Risk Management Group
 - Information Governance Group
 - BEME Management Group

ASSURANCE REPORT TO BOARD

REPORT TO:	TRUST PUBLIC BOARD – 1 OCTOBER 2026
COMMITTEE:	GPTW COMMITTEE – 25 AUGUST 2026
AUTHOR:	Trust Secretariat
PRESENTED BY:	Karen Clements, Chair of Committee

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

The Committee was informed that the British Medical Association had balloted members regarding industrial strike action, and members had voted in support for future strike action. The Trust has commenced its usual business continuity planning processes should a strike get called.

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

An update was received on the band 5 nursing job evaluation programme and it was reported that updates on the 18-month programme and the delivery impacts on resources and colleague satisfaction would be required at future meetings.

It was **agreed** that the impacts from Transforming People Services (TPS) needed wider resolution. The Committee was informed that a regional data sharing agreement had been enacted, and baseline data collection had been submitted to the TPS Programme team to inform the South West Outline Business Case, which was expected in October 2026; and the time and resource commitment was significantly higher than previously alluded to from the national and regional teams in the May 2026 Board report.

The Committee received an update on NHS Staff Standards and was informed that the national implementation tool had been published week commencing 24 August. An initial delivery plan for the Trust has been **reviewed** and **approved**, **noting** that the Committee will have a deeper dive on this in the October meeting, focusing particularly on how it can be incorporated in existing People Strategy work streams.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received reasonable assurance that the Trust was incorporating the new national Leadership and Management Framework into the local leadership and development programmes.

The Committee received assurance that the People Strategy Implementation was progressing to plan during quarter one.

The Committee received the Medical Appraisal and Job Plan Annual Report, which provided assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that were required to undertake this work.

The Committee received the enhanced Performance Report and **noted** the reported adequate level of assurance of the Trust's workforce performance measures or that appropriate service action plans were being developed to address areas requiring improvement.

The Committee received an update on Reasonable Adjustments in the Workplace and was **assured** by the current approach and work undertaken by the Task and Finish Group.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** GHC's approach to embedding the NHS Staff Standards within the People Strategy work streams and directorate implementation plans.

The Committee **endorsed** the Medical Appraisal and Job Plan Annual Report, for onward presentation at the Trust Board.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Risk Report for quarter 1 and a wider discussion was held about whether some of the corporate risks were isolated or systemic and whether some were issues rather than risks. It was **agreed** GPTW Committee and Resources Committee be brought together on actions being taken in regard to risk 729 relating to Wotton Lawn.

The Committee **recognised** that further development was needed on wording on corporate risks to make clearer whether risks were micro or macro.

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

The Committee thanked Lisa Bradley, Community Dental Services Manager, for the honesty of the staff story shared and the tenacity shown by the leadership of the team in driving improvement and the quality of training implementation to support them following the Dentistry Culture Review.

The Committee applauded the progress made in delivering high-quality communication and engagement work in the face of external pressure on People Strategy implementation work.

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

The Committee received and **noted** the Guardian of Safe Working Report.

The Committee **noted** the following summary reports from Management Groups:

- Joint Negotiating and Consultative Committee (JNCF)
- Learning & Development Oversight Group (LDOG)
- People Performance Business Meeting (PPBM)
- Sustainable Staffing Oversight Group (SSOG)

ASSURANCE REPORT TO BOARD

REPORT TO:	TRUST PUBLIC BOARD – 1 OCTOBER 2026
COMMITTEE:	RESOURCES COMMITTEE – 27 AUGUST 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

A verbal update was provided on the Pregnancy Advisory Service, which due to staff absences, had temporarily extended its existing contingency arrangement of diverting some activity, including terminations, to established independent providers. It was **noted** that the CQC and partners had been informed and an QEIA had been completed and agreed through the Executive team.

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

The Committee **noted** that the Cost Improvement Programme (CIP) savings reported in the Finance Report were appropriate and were advised that the reporting had been enhanced to show the split between delivered, identified and unidentified savings, with delivered savings continuing to increase. It was reported that £4.778m (26.64%) of the £14.459m annual recurring savings target remains unidentified at month 4. The Trust remained on a trajectory towards reducing unidentified savings to no more than 20% by the end of September, although further work was required.

The Committee received the Quality and Performance Report and **agreed** the proposal to exclude Berkeley House activity from B04 Mental Health Unit Bed Occupancy **noting** that the unit currently only had one patient and that the beds were not expected to be required for returning patients.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Finance Report for month four and **noted** that the year-to-date financial position was ahead of plan, with a surplus of £50k. It was **noted** that the cash position had improved during July, although it remained approximately £4m behind plan. Further improvement was anticipated through ongoing discussions, particularly with Gloucestershire County Council (GCC) with outstanding invoices.

The Committee received an update on the Accessible Information Standard (AIS) Implementation, which had been referred from the Audit and Assurance Committee; the Data & Digital workstream is Red, and the paper itself describes full compliance by June

2027 as unlikely due to pressures from external software constraints, but these were being mitigated. The Committee were assured by the significant progress made. The Committee received an update paper on Organisational Capacity and were **assured** by the update provided.

The Committee received an update on the Home First Service and were **assured** by the significant progress made in establishing the service, including extensive recruitment, the introduction of bank capacity and close working with system partners to address patient flow and discharge arrangements.

The Committee received an update on Occupational Therapy and **noted** the successful transfer of Adult Social Care Occupational Therapy (ASC OT) services to Gloucestershire County Council (GCC), which was completed on 1 August (88 staff TUPE'd, over 2,500 cases transferred within 10 days).

BAF Risk 6 (Funding for Transformation): Reduced from 12 to 9 following the Provider Partnership MOU.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** the South West Provider Collaborative business case on behalf of the Board.

The Committee **accepted** the Board Assurance Statement on Winter Planning 2026/27 on behalf of the Board.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received and considered the Board Assurance Framework (BAF) for quarter one and **noted** the new template being trialled.

The Committee received the Corporate Risk Register and **noted** the introduction of key performance indicators (KPIs) within the register and the report.

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

Adult Social Care Occupational Therapy transfer delivered smoothly at scale — 88 staff and over 2,500 cases transitioned within 10 days.

Gloucestershire ICS was the only system in the South West not to declare a Critical Incident last winter.

Berkeley House's improved CQC rating and the removal of regulatory restrictions.

L03 (CYPS Core CAMHS): accepted referrals receiving an initial appointment within 4 weeks — KPI achieved this quarter.

N72 (mental health crisis face-to-face contact within 24 hours): 100% achieved.

N71 (older adult mental health average length of stay): improved from 148 days in June to 126 days in July.

IUCS call handling remained compliant even through heatwave-driven demand surges.

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

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

- Service Development Report
- Business Planning Report for quarter one
- Good Governance Institute (GGI) Effectiveness Review and Actions.
- The Summary Reports of the following Management Groups:
 - Digital Group
 - Capital Management Group
 - Business Intelligence Management Group
 - Strategic Oversight Group

ASSURANCE REPORT TO BOARD

REPORT TO:	TRUST PUBLIC BOARD – 1 October 2026
COMMITTEE:	CHARITABLE FUNDS COMMITTEE – 9 SEPTEMBER 2026
AUTHOR:	Trust Secretariat
PRESENTED BY:	Nicola de longh, Chair of Committee

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

The Committee received an update on the charity's financial position.

Current financial projections indicate that, without a successful diversification of income streams and growth in fundraising income, the charity will be unable to sustain the Hardship Fund and wider charitable activities at levels comparable to those delivered in 2025/26.

A new Fundraising plan for 26/27 was **approved** at the meeting.

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

The Committee received an update on purchases funded by League of Friends for each of the community hospitals during the period July 2025 to end of June 2026.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received an update on Charity Strategy Engagement, including the proposed direction, purpose and six strategic priorities; and **agreed** that these were appropriate.

The Committee **noted** that the vision was for a healthier Gloucestershire, where communities, businesses, volunteers and NHS colleagues work together to improve health, wellbeing and care; and the purpose was to connect local generosity with opportunities to improve health, wellbeing and care beyond NHS-funded provision. The Committee **supported** this.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** the Fundraising Plan 2026-27 and the exploration of corporate partnerships and other long-term fundraising opportunities to support sustainable growth in charitable income.

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

Nothing to report.

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

No other items were received.

ASSURANCE REPORT TO BOARD

REPORT TO:	TRUST PUBLIC BOARD – 1 OCTOBER 2026
COMMITTEE:	QUALITY COMMITTEE – 14 SEPTEMBER 2026
AUTHOR:	Trust Secretariat
PRESENTED BY:	Helen Blanchard, Chair of Committee

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

The Committee was informed of the continuing concern in relation to responding to IUCS complaints and the concerns raised relating to capacity and potential resource issues.

The Committee was advised that 13 of 17 Patient Safety Incident Investigations (PSIIs) and care reviews had been open for in excess of six months and that further work was required to understand the delays and improve timeliness.

The Committee received the Trust's Flu Vaccination Plan for 2026/27 and discussed the potential risk associated with changing the delivery model to a peer vaccinator led model, and the trajectory for uptake.

The Committee received the Controlled Drugs Annual Report and discussed the new risk identified relating to the safe and effective prescribing of controlled drugs and a broader piece of work to bring together with the recommendations from the Non-Medical Prescribing internal audit. ([Board Reading Room](#))

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

The Committee received an update on the Patient Carer Race Equality Framework (PCREF) and raised that the impact on access remained limited. It was agreed that further work was required and more cultural change needed to happen in order to get to a better position, including further work on what measures are required.

The Committee was advised that an update on Clinical Supervision would be received at the November Committee meeting.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received an update on the Wotton Lawn Hospital position and received partial assurance that early signs of impact were being seen but inconsistently, and that further work on the mitigations and improvement were in place.

The Committee received an update on the Berkeley House position which provided assurance that safe and quality care continued to be provided to those patients who remain open and under the care of Berkeley House.

The Committee **noted** the positive findings from the National Audit of Care at the End of Life (NACEL) which was included in the Reading Room on Diligent for Committee members to access.

The Committee received the Infection Prevention and Control Annual Report and noted the good level of assurance provided. It was agreed that this would be added to the Reading Room on Diligent for all Board members to access.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** that appropriate action was identified to address the three breaches of legal requirements identified by the CQC in its service report relating to Berkeley House, supported by evidence of improvement and an appropriate response from the Trust.

The Committee **endorsed** the Infection Prevention and Control Annual Report.

The Committee **endorsed** the Quality Strategy 2026-31; the strategic approach being taken and the implementation plan.

The Committee **endorsed** the flu vaccination programme plan for 2026/27.

The Committee **endorsed** that the Patient and Carer Race Equality Framework (PCREF) Risk 613 remaining at a score of 16 whilst the improvement plan progresses given the limited impact that can yet be evidenced.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **noted** that the Quality Standards risk score remained at 20 and further consideration would be given to this.

The Committee discussed further work on how the Quality Standards BAF risk links to the opportunities through Quality Strategy as it comes in to effect, and how the gaps in assurance and areas requiring further improvement are incorporated into the Quality Committee work plan.

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

The Committee received a Staff Story from the Infection Prevention and Control team and applauded the work achieved.

The Committee applauded the work achieved in progressing the Quality Strategy 2026/31. The Committee recognised and applauded the comprehensive and collaborative work highlighted in the Infection Prevention and Control Annual Report ([Board Reading Room](#)).

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

The Committee received the Quality Assurance Group (QAG) Summary Reports from the meetings held in July and August 2026.