



Gloucestershire Health and Care
NHS Foundation Trust



Annual Report and Accounts

2025-2026

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**Gloucestershire Health and Care NHS Foundation Trust
Annual Report and Accounts 2025/26**

**Presented to Parliament pursuant to Schedule 7,
paragraph 25(4) (a) of the National Health Service Act 2006.**

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This is us: Gloucestershire Health and Care NHS Foundation Trust

Welcome to our Annual Report, where you will find information about who we are and what we have done throughout 2025/26



Get involved

Find out more about our Trust at: www.ghc.nhs.uk

You can also keep in touch with us through our social media channels:



GlosHealthNHS



GlosHealthNHS



GlosHealthNHS

Join us!

As a Trust member, you can help shape strategy and the way services are run. To become a member of the Trust, visit www.ghc.nhs.uk/membership or call 0300 421 7146.

Our registered address is: Gloucestershire Health and Care NHS Foundation Trust, Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, GL3 4AW.

You can also contact us by telephone on **0300 421 8100**

Welcome from Trust Chair, Graham Russell, and Chief Executive, Douglas Blair



As we look back over 2025/26, there is a lot for everyone in Gloucestershire Health and Care NHS Foundation Trust to be proud of.

Highlights include:

- Achieving the highest uptake in the South West for flu vaccinations for children and young people
- Celebrating the first anniversary of our Integrated Urgent Care Service, which has demonstrated its vital role in supporting the county's urgent care needs
- Seeing our Complex Homelessness Partnership Support Service (CHPSS) team win accolades for the support given to people experiencing homelessness and complex needs including mental health, physical health, and substance misuse
- Another good set of responses to the Community Mental Health Survey with all scores better than or as expected
- The launch of our 'Five Year Focus', setting out our priorities and ambitions to shape better health and care services across Gloucestershire over the next five years
- Our results in the national NHS Staff Survey – which compared well across the NHS, performing best in the South West across a number of themes, while still showing room for ongoing improvements.
- Achieving our financial targets and ending the year in surplus.

This all demonstrates a big effort on behalf of everyone within the Trust, as well as the support we receive from our partners. Alongside this selection of achievements, 2025/26 has also been a year of change, high demand on services and challenges. The health and care system is changing, with Integrated Care Boards becoming strategic commissioners operating on larger geographies; this has an impact on the way our Trust will need to work too. During 2025/26, we were sad to be preparing to say goodbye to social care services before their transfer to Gloucestershire County Council during 2026.

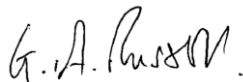
We are also very aware that not all our services are managing to respond to high levels of demand, with some waiting times longer than they should be. Improving this by changing how we work is a key focus, as well as ensuring that our Trust learns, adapts and improves when we do not get things right.

Looking ahead, we have some major plans. These include transforming our Learning Disability and Community Mental Health Services, as well as key estates projects such as significant investment in the Cirencester Hospital site. Another area of focus will be our work on the Patient and Carer Race Equality Framework (PCREF) which will include us publishing a bold anti racist statement which has been co-produced with our communities, and increased focus on inclusive healthcare in order to reduce the gap of access, experience and

outcomes. We will also be finalising and launching our strategies for People, Digital, Estates, Quality and Research and Innovation.

We will also be working in a provider partnership with Gloucestershire GP Collaborative and Gloucestershire Hospitals NHS Foundation Trust to tackle three key areas - improving support for older people living with frailty and dementia, transforming care for people with multiple long-term conditions and expanding community mental health and crisis care for people of all ages. This is part of responding to the enhanced role of healthcare providers in leading the transformation of services.

Finally, it just remains for us to share a huge thank you to everyone who works in the Trust, volunteers, Experts by Experience and partners for your support. Together we're delivering better health, high quality care, sustainable services and creating a great place to work, together.



Graham Russell, Trust Chair



Douglas Blair, Chief Executive

18 June 2026

Performance Report

About Us

Gloucestershire Health and Care NHS Foundation Trust provide joined-up services for people of all ages with physical health, mental health and learning disability needs. Our services cover the whole of Gloucestershire. We work out of health centres and children's centres, community venues such as libraries or schools as well as in people's own homes. We also provide services from our community hospitals, our two specialist mental health hospitals, and our inpatient recovery and learning disability units.

Our Five-Year Focus for 2026 to 2031 can be read in full on our website. It sets out:

Our purpose

Helping you live your best life by
delivering great healthcare.

Our goals

Better Health

Work together to improve the health of all people in Gloucestershire.



High Quality Care

Inclusive and timely access, great experiences, and better outcomes.



Great Place to Work

Be the place where people enjoy working, learning and building a career.



Sustainable Services

Great value services for healthier people, stronger communities, and a greener world.



Our focus areas



Connecting services in neighbourhoods

Working together for better local health



Children and young people

Helping children thrive and build resilience for a healthier future



Community urgent care

Helping people manage urgent healthcare needs and stay well



Inclusive healthcare

Reducing the gap of access, experience and outcomes



Partnerships with purpose

Deepening our partnerships to deliver great healthcare

Our 'With you, for you' Way of Working

We will design, deliver and improve all our services, guided by what matters most...

- Getting the **basics** right: safe, accessible, effective, and timely
- Working **with people**, not just for them
- **Joining up** healthcare across services
- Helping people **stay well** and in control
- Making the most of everyone's **skills and experience**
- Making good **use of resources**
- Using **technology and new ideas**
- Making healthcare as **local** as possible

Our Values

Our Values are our guiding principles and underpin everything we do.

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

Foundation Trust Status

As a Foundation Trust, we are a not-for-profit, public benefit corporation. NHS Foundation Trusts are accountable to their local population.

We work with our members, people who use our services, carers and local organisations to gather feedback and advice. This feedback helps us develop a range of comprehensive services that meet the needs of our local communities and make continued improvements in all that we do.

Our People

We employ more than 6,000 colleagues (including colleagues available for temporary work as part of our bank). We also work in partnership with a wide range of commissioners, collaborators and our colleagues across the health and social care community.

As an NHS foundation trust, we are accountable to the local people, who help ensure local ownership and control of their NHS and the services we provide. More than 8,200 members (including colleague members) influence our activities, both directly by contacting the Trust and through locally elected representatives who form our Council of Governors.

Our services

Our services are provided according to core NHS principles - free care, based on need and not on someone's ability to pay.

We provide assessment, support, treatment and advice on a wide range of mental health, physical health and learning disability conditions. We do this in a variety of ways, through telephone support, appointments in a healthcare facility, in public buildings including schools, and within inpatient services. We provide a comprehensive range of services for people of all ages for physical health, mental health and learning disability needs.



Stay Well

Health promotion and prevention of illness - immunisations, health checks, monitoring of conditions, diagnostics, lifestyle advice, and early interventions.



Get urgent care

When you need help, fast and close to home - Minor Injury and Illness Units, Rapid Response, Mental Health Crisis, Sexual Assault Referral Centre, and Integrated Urgent Care.



Get treatment

Care for short term and ongoing conditions - specialist services, specialist dentistry, talking therapies, inpatient care, and minor procedures.



Recover

Helping you feel stronger and more independent - physical and mental health rehabilitation, therapies, psychological support, and community hospital services.



Live Well

Supporting you with long term conditions - community teams, equipment services, complex care, children's community nursing and therapies.

Our Partnerships

We work with many partners, both locally and nationally in supporting our communities. Our partnership work includes:

- Our systemwide partnerships through the Integrated Care System, including the network of Integrated Locality Partnerships and Primary Care Networks
- Locality Community Partnerships, formed through Community Mental Health Transformation, offering holistic support to people with serious mental illness in partnership with the voluntary, community and social enterprise sector
- Our Integrated Urgent Care Service includes IC24, who provide NHS111 services
- Our Sexual Assault Referral Centre for Gloucestershire, Swindon and Wiltshire which is provided in partnership with First Light, providing medical care, emotional and psychological support, and practical help to anyone who has been raped or sexually assaulted
- Homeless Health Care services have a well-established network of partner organisations that help deliver holistic care to meet individual needs. Some examples include close working with Gloucestershire Action for Refugees and Asylum Seekers (GARAS), P3 and Via
- Working Well, our occupational health service provides services to our own employees as well as to those of other NHS Trusts in Gloucestershire, and to other public and private organisations.
- Our Gloucestershire-based Individual Placement and Support (IPS) Employment Services provide vocational opportunities and promote social inclusion for people recovering from mental ill health.
- We also provide Criminal Justice Liaison Services in Gloucestershire alongside the Youth Support Team and the Nelson Trust.
- Our research team is mainly funded by the National Institute for Health Research (NIHR) which works with educational providers, hospitals and commercial companies to promote research studies. The team receives additional income from commercial partners to undertake additional research that is not fully funded by the NIHR.

We are currently operating in two provider collaboratives – The South West Provider Collaborative hosted by Devon Partnership NHS Foundation Trust covers Adult Secure/Learning Disability and perinatal services and the Thames Valley Provider Collaborative in the South East hosted by Oxford Health NHS Foundation Trust providing Children and Adolescent Mental Health/Eating Disorders services.

In March 2026, our Trust agreed to work in close partnership with our partners in the Gloucestershire GP Collaborative and Gloucestershire Hospitals NHS Foundation Trust as part of the Gloucestershire Provider Partnership, which will be taking the lead in transforming health services for three specific focus areas over the next few years. We will act as one system, bringing together our colleagues, funding and expertise to deliver shared priorities.

These priorities are:

- supporting people's health in their local communities
- improving urgent and emergency care
- strengthening mental health services

Going concern

After making enquiries, the directors have a reasonable expectation that Gloucestershire Health and Care NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing these accounts.

Performance Report – Analysis

As an NHS Foundation Trust, our performance is measured in a variety of ways, including the ratings we are given by NHS England. We report on a number of local safety and quality standards agreed with commissioners. We are also inspected by our regulator, the Care Quality Commission. In addition to these operational performance measures, we also constantly undertake our own quality assurance reviews and audits across all services.

Financial performance

During 2025/26, our main commissioner was NHS Gloucestershire Integrated Care Board (ICB) with whom we agreed to provide clinical care and treatment through block contracts.

We also hold contracts with commissioners in our surrounding region and a contract with an NHS Provider Collaborative for low secure mental health inpatient care.

Our 2025/26 Statement of Comprehensive income can be found on page 99.

The following table summarises the Trust's Statement of Comprehensive Income for the past two years:

	2025/26 (£000s)	2024/25 (£000s)
Operating income	357,821	331,546
Operating expenditure	-356,530	-336,063
Net Finance Costs	-698	167
Other gains/(losses)	147	-32
(Deficit) / Surplus	740	-4,382

As detailed above, our operating expenditure in 2025/26 totalled £356,530,000 of which staff costs accounted for £269,269,000 or 75.5% of our operating expenditure.

The Trust had a financial plan of break even and we achieved a financial performance surplus of £2,013k excluding impairments.

Although our accounts report a surplus of £740k, our reported financial performance reported to NHSE is a surplus of £2,013k. The reason for this is that our performance position excludes the impact of impairments. The impairments (in this instance) relate to the reduction in the value of property during the year which is calculated through valuation at year end. Although we are required to account for this movement as affecting our overall surplus/

deficit is it not caused by the day to day management of the organisation. The table following shows the reconciliation between the two numbers which also includes other technical adjustments:

Adjusted Financial Performance	2025/26 (£000s)	2024/25 (£000s)
	£000s	£000s
Deficit for the year	740	- 4,382
Before consolidation of Charity	37	-
Add back all I&E impairments / (reversals)	1,183	4,497
Surplus / (deficit) before impairments and transfers	1,960	115
Remove capital donations / grants I&E impact	52	185
Remove net impact of DHSC centrally procured inventories	1	27
Adjusted financial performance surplus / (deficit)	2,013	327

Our full annual accounts can be found at page 98.

Efficiency savings

During 2025/26 Gloucestershire Health and Care NHS Foundation Trust planned to deliver £10.086m of recurring efficiency savings. This comprised a 2.0% national efficiency requirement and additional savings to meet cost pressures and service development requests. The Trust delivered £5.783m of recurrent savings with a further £2.952m identified for delivery in 2026/27. Over the year, we delivered total savings of £15.255m against a total expenditure of £356m.

The key financial aim for 2026/27 is for Gloucestershire Health and Care NHSFT to be in financial balance. The Trust has submitted a balanced financial plan position for each of the next three years. In 2026/27 the Trust has an agreed capital plan to spend £13.313m, net of disposals, to invest in Net Zero Carbon schemes, medical equipment and IT infrastructure, and to make further improvements to our buildings.

Cost allocation and charging requirements

The Directors confirm that Gloucestershire Health and Care NHS Foundation Trust complies with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Income disclosure

The Directors confirm that Gloucestershire Health and Care NHS Foundation Trust has met the requirement that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Post balance sheet events

There are no material post balance sheet events to report.

Public Sector Payment Policy

The Trust operates its 'Public Sector Payment Policy' in line with the Government's 'Prompt Payment policy' administered by Crown Commercial Services and the Cabinet Office. This states that the target for all Government bodies is to pay all 'valid, undisputed invoices' within 30 days. The cumulative Public Sector Payment Policy (PSPP) performance for the Trust for the financial year 2025/26 was 95.4% paid within 30 days.

The figures, including a split between NHS and Non-NHS payments, is reported on a monthly basis.

This table sets out our payment record for the year, broken down by NHS and non-NHS payments.

Better payment practice code	31/03/2026 Number	31/03/2026 £'000
Non NHS		
Total bills paid in the year	28,484	191,176
Total bills paid within target	26,239	183,371
Percentage of bills paid within target	92.1%	95.9%
NHS		
Total bills paid in the year	663	11,723
Total bills paid within target	577	10,145
Percentage of bills paid within target	87.0%	86.5%
Total		
Total bills paid in the year	29,147	202,899
Total bills paid within target	26,816	193,516
Percentage of bills paid within target	92.0%	95.4%

The Trust paid no interest under the Late Payment of Commercial Debts (Interest) Act 1998.

Counter fraud

Our robust and effective Counter Fraud Service demonstrates our commitment to ensuring that public money is not defrauded. This helps make sure that NHS funds are used for patient care and services. Over the year, Gloucestershire Local Counter Fraud Service (LCFS) has assisted us in reducing opportunities for fraud and corruption to an absolute minimum.

It has also helped to increase liaison with other government, public and private organisations, and the national and regional offices of NHS Counter Fraud Authority to improve the impact of our counter fraud activity. We continue to encourage colleagues to report any concerns to the LCFS about potential fraud and corruption or areas of high fraud risk. The LCFS then

takes appropriate action and pursues appropriate sanctions. The outcome of this activity is reported to act as a deterrent to others.

Well-Led

The Trust has a continuous self-assessment programme which includes scrutiny of how well-led the Trust is. This includes evaluation by services about themselves and is based around the Care Quality Commission's Key Lines of Enquiry. During 2022/23 our Trust received a comprehensive inspection by the Care Quality Commission, which included a Well-Led inspection. Our Trust was rated 'Good'.

There is a Trust improvement focus on health and wellbeing; engagement, response rates and embedding our values and behaviours; communications around responding to and acting upon feedback from colleagues and people who use our services; and improving our leadership and management skills. Data quality oversight is provided through a governance structure which includes the Trust's Resources Committee, Business Intelligence Management Group and operationally led Performance and Finance meetings.

Inclusion

Our Five-Year Focus for 2026 to 2031 aims to help people live well by providing great care.

We provide health services for everyone – from newborn babies to older adults.

Some of the health challenges we know about:

- Gloucestershire has one of the fastest-growing older populations, especially people aged over 85
- More people have one or more long-term condition like dementia, diabetes, frailty, breathing and heart problems
- Health is worse for people on low incomes, from minority groups, who have a learning disability or mental illness
- People living in rural areas find it more difficult to get support
- More young people and adults are asking for mental health support
- High blood pressure, smoking, poor diet, and obesity are the main things leading to many preventable illnesses

Our goals and focus areas are aimed at addressing these challenges, with a particular priority placed on increasing the equity of healthcare. There is more information on our work to address Health Inequalities on page 22.

We also focus heavily on inclusion within the organisation, with our soon to be published People Strategy including key focus areas such as leadership and culture, and creating a safe, inclusive and healthy workplace. See page 92 for further details on this.

Task force on climate-related financial disclosures (TFCD)

NHS England's NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the TFCD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM

Treasury's TFCD aligned disclosure guidance for public sector annual reports. TFCD recommended disclosures are as interpreted and adapted for the public sector by the HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TFCD requirements as these are computed nationally by NHS England.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

The **governance arrangements** and resource requirements to deliver the Trust's sustainability agenda have developed in recent years. We have a dedicated sustainability team, led by the Head of Sustainability which sits within the portfolio of the Director of Improvement and Partnerships. Sustainability expertise is also reflected in our non-executive skill set at Board level. The delivery of our Green Plan is a key transformation programme within the Trust, overseen by a Sustainability Programme Board.

The Trust Board is responsible for the delivery of the Trust's Strategy which includes Sustainable Services as one of four strategic goals. Our annual business planning process directly links business planning objectives to the overarching sustainable services strategic goal. The Resources Committee receives twice yearly reports setting out progress against the Trust's Green Plan and the linked goals within this, with an annual report received by the Board detailing overall progress against agreed targets and reflecting the Trust's carbon footprint. The Trust's carbon footprint for 2024/25 (and comparison with prior years) is set out below in the Sustainability section of this report.

This year we completed the refresh of our Trust Green Plan and following sign off by the Trust Board in September 2025, have published this to set out our future ambitions for the years 2025-2028. This is in line with the recommendations and principles set out in the revised National Green Plan guidance issued by NHSE in February 2025. The Trust actively participates in the ICS Green Plan Steering Groups and national groups.

A local risks and issues log is held by our sustainability team feeding into the Sustainability Programme Board where risks are considered and escalated as appropriate through our Corporate Risk Register. Climate-related risks are identified via operational teams e.g. our Emergency Preparedness Resilience and Response (EPRR). All sustainability / climate-related risks are identified, assessed and managed in line with the Trust's Risk Management Policy (see page 83 of annual governance statement).

During the summer of 2025, the Trust participated in a Gloucestershire wide Climate Risk and Vulnerability Assessment exercise, commissioned by Climate Leadership Gloucestershire. Bringing together partners from across the county, this was a collaborative review and assessment process with statutory bodies, Voluntary Community and Social Enterprise (VCSE) and commercial business partners to explore the risks associated with climate change for Gloucestershire, its population, infrastructure, public services and commercial activities. The review also considered the capacity of organisations across the county to adapt to climate risks, and to understand what work was already in train. The output of this was a comprehensive report that is being utilised by the Trust to inform its strategic, operational and estates resilience planning in relation to climate risk management and adaptations.

Key metrics and targets for 2025-28 are set out in the Trust's Green Plan across nine areas of focus (which expands on the four pillars of the Trust's first Green Plan). These are as follows: Workforce and Systems Leadership, Sustainable Models of Care, Digital Transformation, Medicines, Travel and Transport, Estates and Facilities, Supply Chain and Procurement, Food and Nutrition, Climate Adaption and Greenspace and Biodiversity.

Our Green Plan goals reflect local ambitions in the context of national targets and commitments. Progress is monitored quarterly through our Sustainability Programme Board, reported twice a year to the Resources Committee and culminates in a comprehensive annual report to the Board, which includes updated Direct Carbon Footprint and Carbon Footprint Plus data to show year on year progress, as well as improvements against our Green Plan baseline, Financial Year 2018/19.

Environmental Sustainability

This report outlines Gloucestershire Health and Care NHS Foundation Trust's carbon impact for the 2024/25 financial year. This is reported one year in arrears due to the timing of Estates Returns Information Collection (ERIC) return, which is a key data component of our carbon footprint.

In 2024/25, we entered the final year of our three-year Green Plan, which aims to reduce our NHS Carbon Footprint emissions by 25% by the end of the 2024/25 financial year. Meeting this target will ensure we remain on track to support the national ambition for the NHS to achieve net zero by 2040.

We are pleased to announce we have exceeded this target, reducing our NHS Carbon Footprint (for direct emissions) by 28% compared to our 2019/20 baseline. You can find more information in the 'NHS Carbon Footprint' Section of this report.

Our Carbon Impact

Our total carbon impact for 2024/25 was estimated at 22,052 tCO₂e, equivalent to a person taking 6,300 round-trip flights from London to Hong Kong.

Our total Carbon Footprint (includes direct and indirect emissions) and we have decreased this by 3% compared to the previous financial year resulting in a total reduction of 24% compared to our 2019/20 baseline.

Our total carbon impact is divided into two categories:

- NHS Carbon Footprint includes emissions under our direct control, such as utilities, fleet and anaesthetic gases.
- Carbon Footprint Plus includes indirect emissions beyond our control, such as supply chain, colleague and service user travel and commissioned health and social care services.

Our NHS Carbon Footprint represents 27% of our total emissions, with the remaining 73% represented by our Carbon Footprint Plus.

NHS Carbon Footprint

In 2024/25, our NHS Carbon Footprint was 6,008 tCO₂e, accounting for 27% of our total carbon impact. The main contributors (Figure 1) were building energy (44%), electricity (28%) and business travel (20%).

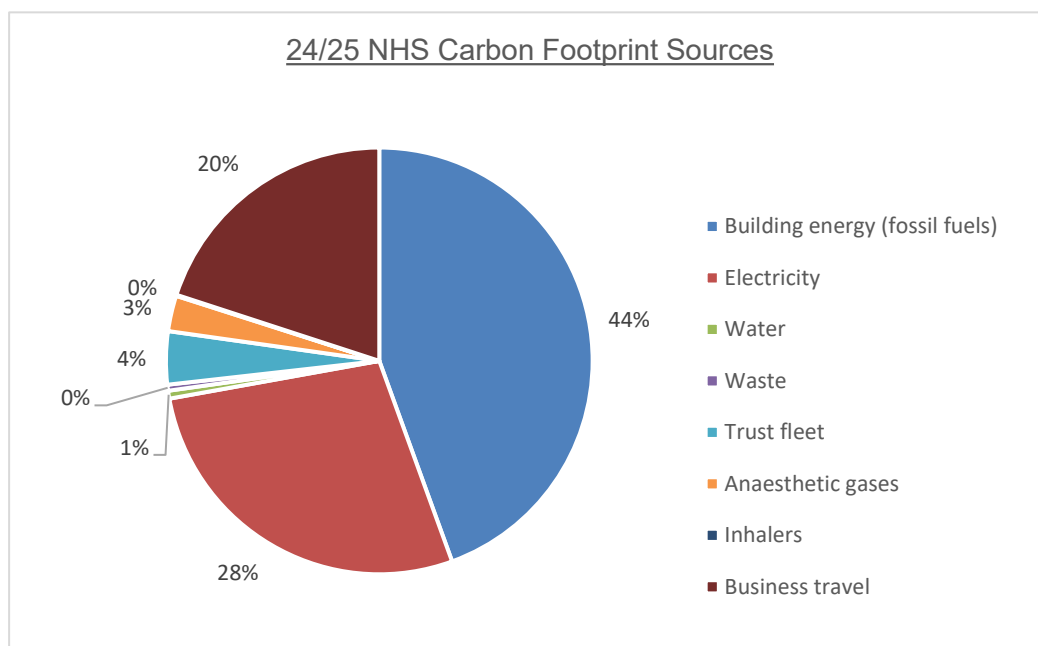


Figure 1: GHC's Direct Carbon Footprint by Source

Our NHS Carbon Footprint emissions increased by 5% from the previous financial year (Table 1). This is a direct result of us needing to use a temporary oil-powered boiler house at Wotton Lawn Hospital, increased electricity emissions factors and an increase in business travel mileage.

Despite this, we have seen a 28% reduction from our 19/20 baseline year. Meaning we have surpassed our Green Plan Goal of a 25% reduction in our NHS Carbon Footprint emissions by 24/25 (against a 19/20 baseline).

NHS Carbon Footprint category	tCO ₂ e						Annual % change	% change from baseline (19/20)
	19/20	20/21	21/22	22/23	23/24	24/25		
Building energy (Gas and Heating Oil)	4,166	2,014	3,166	2,852	2,746	2,671	-3%	-36%
Electricity	2,090	1,423	1,758	1,358	1,516	1,665	+10%	-20%
Anaesthetic gases	*162	**162	**162	**162	**162	**162	0%	0%
Inhalers	*7	**6	**5	**5	**5	***5	0%	-31%
Trust fleet	269	214	256	250	240	241	+1%	-10%
Water	106	114	43	30	57	36	-37%	66%

Waste	117	141	195	59	27	27	0%	-81%
Business travel	1,433	867	941	1,090	954	1,201	+26%	-16%
Total NHS Carbon Footprint	8,350	4,940	6,526	5,807	5,707	6,008	+ 5%	-28%

*GHC Emissions taken from the Greener NHS Dashboard

** Based on 19/20 emissions data from the Greener NHS Dashboard. Data will be updated once available.

*** Based on 21/22 emissions from the Greener NHS Dashboard. Data will be updated once available.

Table 1: 24/25 direct carbon footprint

Carbon Footprint Plus

In 24/25, our Carbon Footprint Plus was estimated to be 16,045 tCO₂e and is responsible for 73% of our Total Carbon Footprint. The main contributors (Figure 3) were supply chain (62%), commissioned health and care services (17%) and staff commuting (15%).

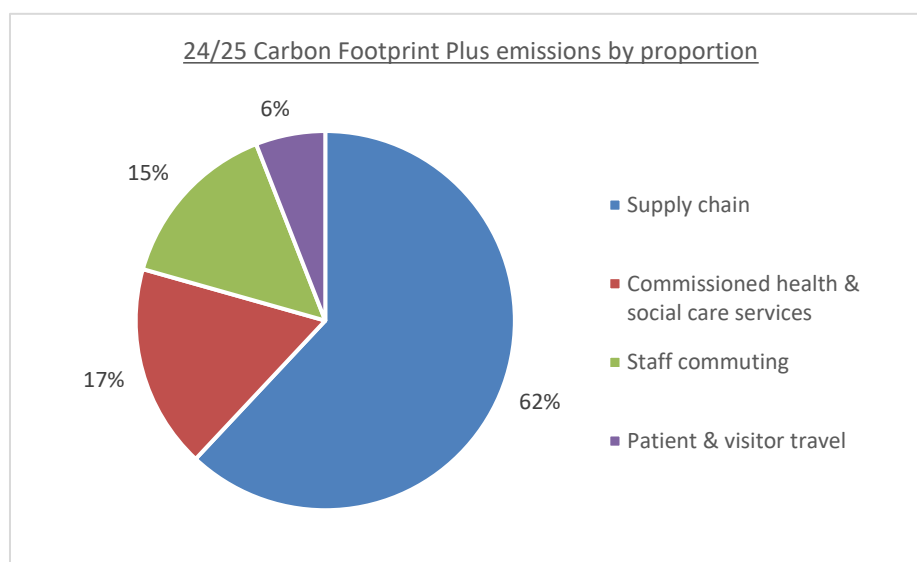


Figure 3: GHC's carbon footprint plus by proportion

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

Looking Ahead

NHS England mandated that all Trusts should refresh their Green Plans in the 2025/26 financial year, in line with new guidance. This new Green Plan will cover the period until the 2027/28 financial year.

This will be publicly available on the Trust's website.

Health Inequalities Statement

This Health Inequalities Statement sets out how the Trust has identified, analysed and acted on health inequalities in line with NHS England's Statement on Information on Health Inequalities, fulfilling our duty under section 13SA of the NHS Act 2006.

It provides an overview of how the Trust has acted consistently with NHS England's expectations on the collection, analysis, use and publication of health inequalities information, and how this has informed service improvement and decision-making during 2025/26.

What do we mean?

Here are some definitions for the terms used in this report.

Health inequalities: Unfair and avoidable differences in health between people and groups in society.

Health equity: Giving everyone a fair chance to live a healthy life by removing barriers that can lead to unequal health outcomes.

Healthcare inequalities: Unfair and avoidable differences in people's access to, experience of, or outcomes from healthcare. These are often linked to factors such as where people live, income, ethnicity, disability, education, or social circumstances.

Core20PLUS5: The NHS approach to reducing healthcare inequalities, focusing action on:

- Core 20% – the most deprived 20% of the population
- PLUS – locally identified population groups experiencing poorer access, experience or outcomes
- 5 – five national clinical priority areas for adults and children

In Gloucestershire, PLUS groups include people from minority ethnic communities, people with learning disabilities, autistic people, people with severe mental illness, people living in rural areas and inclusion health groups.

Inclusion Health: People who are socially excluded or marginalised and experience multiple, overlapping risk factors. This may include people experiencing homelessness, Gypsy, Roma and Traveller communities, refugees and asylum seekers, people in contact with the criminal justice system and care leavers.

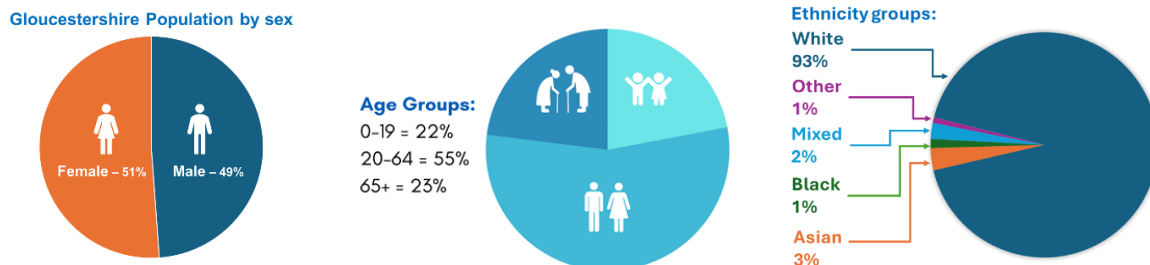
Intersectionality: The way multiple factors, such as ethnicity, socioeconomic status and disability, combine to shape people's health outcomes and experiences of care.

Disaggregating data: Breaking health data down into smaller groups (for example by age, sex, ethnicity, disability, postcode or deprivation) to identify differences that can be hidden within population averages.

Understanding our Population and Health Inequalities

This section sets out who lives in Gloucestershire, the key causes of health inequality, and how the Trust uses population health intelligence to understand needs which are not being met.

Gloucestershire has a population of nearly **670,000 people**. The information charts show the estimated Gloucestershire population by sex, age, and ethnicity.



(Data source - Office for National Statistics 2023 review estimates – rounded figures)

Population health data shows that overall health outcomes in Gloucestershire are better than the national average. But this is not experienced equally. Key causes of health inequalities include:

- A rapidly growing population of people aged over 80. This increases demand for health and care services and means the number of people living with multiple long-term conditions is high.
- Areas of high deprivation, particularly in parts of Gloucester, Cheltenham, Tewkesbury and the Forest of Dean.
- A mainly rural population, which means deprivation can be hidden and people struggle to access services because of distance, travel costs, and lack of access to digital technology.
- One in seven children living in low-income households.
- Persistent inequalities for people with severe mental illness, learning disabilities and autistic people, people from minority ethnic communities and inclusion health groups.

To understand health inequalities the Trust uses a range of information, including:

- Integrated Care Board (ICB) population health analysis and system data
- Local public health intelligence, including the Joint Strategic Needs Assessment and the Gloucestershire Health Inequalities Dashboard - [Health Inequalities Dashboard | Inform Gloucestershire](#)
- Trust activity, access and outcome data
- Patient and carer feedback, engagement activity, community groups and forums, and case studies.

Quantitative data (numbers) helps us understand *what* is happening, while qualitative insight (people's experiences) help us understand *why*. Together these provide a more complete understanding of population health and inequality.

People often experience multiple, intersecting drivers of inequality – such as housing, finance, genetics, education, culture - and healthcare is only one factor influencing a person's health and wellbeing. However, these factors directly affect how people access our services, their experience of care, and their outcomes. Understanding unwanted or unfair variation within our services is critical to effective action to reduce healthcare inequality and is explored further in the next section.

Understanding healthcare access, experience and outcomes

The Trust provides community physical health, mental health, learning disability and autism services to people of all ages across Gloucestershire. We work as part of the One Gloucestershire Integrated Care System and in partnership with other statutory providers including health, education, social care, ambulance, policing, and with voluntary, charity and social enterprise organisations and community groups. We share and discuss population health data, service delivery information, and insights to identify gaps and find new ways of working together to meet people's needs as much as we can.

Reducing variation in access, experience and outcomes is central to addressing healthcare inequalities. The Trust contributes directly and indirectly to reports against the national Core20PLUS5 priority clinical areas across both adult and children's services, reflecting the breadth of its commissioned activity.

Clinical domains GHC contribute to directly and in-directly

CORE20PLUS5 - Adults			Core20PLUS5 - Children		
	Direct	Indirect		Direct	In-direct
Maternity			Asthma		
Mental health	☒		Diabetes		
Respiratory disease		☒	Epilepsy		
Cancer			Oral Health		☒
Hypertension (high blood pressure) case finding		☒	Mental health	☒	
Smoking		☒	SEND, LD & A	☒	
Vaccines		☒			
Learning Disability & Autism (LD&A)	☒				

Please note: **Smoking** is a national priority because it positively impacts all five key clinical areas. **SEND** (Special Educational Needs and Disabilities), **learning disabilities and autism** were added to the NHS Health Inequalities Statement Measurement Framework (2025) under Core20PLUS5 (adults and children) because strong national evidence showed large, avoidable inequalities in access, experience and outcomes in these areas. **Vaccines** were added because they can have a big impact on reducing preventable harm.

System level data produced by Gloucestershire ICB, indicates variation across priority populations, particularly for people living in the most deprived areas, people with severe mental illness, people with learning disabilities and autistic people, people from minority ethnic communities and inclusion health groups. However, incomplete and inconsistent recording of ethnicity and other characteristics limits the Trust's ability to fully understand and quantify variation at a service level. As a result, insight into inequalities for some groups continues to rely heavily on qualitative evidence, including patient and carer feedback,

community engagement activities, and shared intelligence from other provider organisations and groups.

While Trust services routinely monitor performance measures such as waiting times, length of stay and outcomes, the use of disaggregated data to identify inequality and inform improvement is inconsistent. This is influenced by data quality challenges and differing levels of confidence and capability across the workforce.

As a mental health provider, the Trust has reinvigorated our approach to implementation of the **Patient and Carer Race Equality Framework (PCREF)** across adult and children's services. This includes a focus on strengthening leadership, governance, data quality, and co-production with patients, carers and communities, to improve people's experiences and outcomes when accessing our services.

Data Quality and Improvement

The Trust recognises that high-quality, complete and accurate data is essential to understanding and reducing health inequalities. To support this, we have established a data quality policy to promote data quality best practice across the organisation in an aim to deliver high quality health and care.

During the year, we have identified data quality challenges, including but not limited to:

- Recording of ethnicity and other demographic characteristics
- Recording of 'not stated/not known'
- Consistency of data across services and pathways

The Trust has established work plans to improve data quality as a key enabler in identifying and addressing health inequalities. Business Intelligence Services support this through data visualisation and exception reporting, enabling services to prioritise action and improve data completeness.

Improving ethnicity data quality remains a priority, including completeness and 'not stated/not known' recording. An agreed approach with Gloucestershire ICB has resulted in improved performance, with the Trust now **exceeding the national average across all national datasets**. The Trust believes it can further improve its Mental Health Services Data Set (MHSDS) performance, and some targeted clinical system alignment is expected to improve this further in 2026/27. Significant improvement has been demonstrated in 2025/26 within the Community Services Data Set (CSDS), where ethnicity data completeness increased from 71% to **92%**.

Progress is overseen by a Patient Record Quality Group led by operational services, providing assurance and oversight of data quality priorities that support the Trust's approach to reducing health inequalities.

The table shows latest completeness of ethnicity recording across national datasets:

Dataset Name	Latest GHC performance (Dec 25)	National Published average (Dec 25)
Admitted Patient Care (APC)	100%	87.7%
Community Services Data Set (CSDS)	91.9%	70.9%

Emergency Care Data Set (ECDS)	93.3%	86.8%
Talking Therapies Data Set (IAPT)	99.7%	94.2%
Mental Health Services Data Set (MHSDS)	76%	69%
Data Quality Maturity Index Total Score	92.9%	70.3%

The **Accessible Information Standard (AIS)** is an NHS requirement that makes sure people can **get information and communicate with NHS services in ways that work for them**. For example, by providing information in easy read, large print, audio, email, Braille, or by arranging communication support such as a British Sign Language (BSL) interpreter.

It applies to people who have a disability, impairment or sensory loss and helps to reduce health inequalities by ensuring people can:

- understand their care and treatment
- make informed decisions
- access services independently and safely

Meeting the Accessible Information Standard helps us meet our legal duties under the Equality Act 2010. NHS England updated the Accessible Information Standard in 2025. While the core requirements remain the same, the updated guidance strengthens expectations around reviewing people's communication needs, organisational accountability, and consistent delivery of accessible information, supporting action to reduce health inequalities.

We asked our internal auditors to complete a review of our compliance against the new expectations. Initial feedback suggests that there are areas for improvement to ensure we meet the new guidance. Our next steps are to develop and publish improvement actions.

Action Taken to Address Health Inequalities

During 2025/26, the Trust has taken targeted action to reduce health inequalities across community physical health, mental health, and learning disability services for adult and children's services. A few examples include:

The Big Health Day 2025 – Promoting health and wellbeing



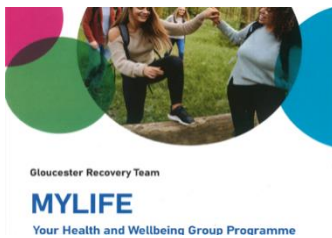
GHC coordinates this annual event for people with learning disabilities, people who are autistic, those with sensory impairment, mental health needs, or long-term health conditions. The event offers sport, wellbeing activities, and social connection, wellbeing and lifestyle advice and support, free health checks and points of contact. In 2025 it was attended by over 1600 people and included 12 inclusive activities, 120 stalls and displays offering advice and support, a range of health checks and points of contact, with over 130 health checks completed.

Community Health Checks – Rurality, inclusion health, and marginalisation



In 2025-26 the Outreach Vaccination and Health Team provided pop-up events in community venues, delivering 1400+ health checks (blood pressure and health advice) with an average of 12% onward referrals and appointments for screening or treatment made on the day. These events target communities experiencing health inequalities, such as the Gypsy, Roma and Traveller communities, refugees and asylum seekers, people from ethnic minorities, and rural communities, including farming.

Co-produced Lifestyle Programme – Severe Mental Illness



MY Life is a co-produced 12-week lifestyle programme for people with Severe Mental Illness. Working in partnership with Freedom Leisure in Gloucester, people try exercise, build a community of peers, have education around health and wellbeing, and set personal goals. Due to the success of the programme there is now a peer-led “step-down” offering graduates support to continue independent exercise and maintain social contacts.

Working together for better healthcare – Learning Disabilities



Together with people with lived experience, families, carers and partner organisations we are co-designing a better care pathway for people with learning disabilities. The focus is on prevention, earlier support and helping people access mainstream services with the right reasonable adjustments and specialist support. The aim is to improve physical health, strengthen crisis support, reduce hospital admissions and help people with learning disabilities stay well at home.

Improving outcomes through translation – Minority Ethnic Communities



In the area of Gloucester around 72 languages and dialects are known to be spoken. Children and Young People Speech and Language Services have improved access to early support to preschool and reception aged children by translating material. This includes a Language Exposure Questionnaire translated into over 30 languages and creation of a multi-lingual advice and myth busting video for settings and parents. The material also encourages families to embrace their home language to support cultural identity.

Health Literacy is a barrier to support – other health inequalities



Around one in six people find health information hard to understand, and the average UK reading age is 9–11. Using a health literacy approach, the School Nursing team identified that some parents struggled to complete fluid and stool charts. As a result, children were less likely to access support and were often re-referred later with anxiety or wellbeing concerns. This showed the issue was accessibility, not non-compliance, leading to a review of the materials.

Tackling disproportionate detentions – Mental Health and Inclusion Health



The Child and Adolescent Mental Health Service Outreach team reviewed children detained on section 136 of the Mental Health Act during the period of April 2025-December 2025. This showed that children who have typically experienced the social care system were detained more often. They are now working with partners including the Police and Children's Social Care to support system change and find new ways of working.

Note: Section 136 allows police officers to remove individuals from public places to a place of safety if they appear to have a mental disorder and are at risk of harm to themselves or others.

Impact and Learning

The Trust recognises that demonstrating measurable, system-wide impact on health inequalities takes time and requires consistent, high-quality data and cultural change. Much of the work in 2025/26 has focused on understanding where we have gaps and strengthening foundations. Learning from work undertaken to date highlights that:

- **Co-produced and community-based approaches improve engagement and trust**, particularly for groups less likely to access traditional services.
- **Health literacy and accessibility are significant barriers**, and assumptions about understanding can lead to unmet need and delayed support.
- **High-quality data is essential**, but incomplete recording and variable confidence in using disaggregated data limit the Trust's ability to fully identify and monitor inequality.
- **Approaches to addressing health inequalities are not yet consistent or embedded across all services**. This was reinforced through the One Gloucestershire Health Inequalities Self-Assessment completed by the Senior Leaders Network, which identified gaps in organisational culture, consistency, and confidence.
- **Sustained leadership and cultural change are essential enablers of progress**. Continued senior leadership commitment, including delivery of the Patient and Carer Race Equality Framework (PCREF), will be critical to embedding equity into everyday practice and reducing inequalities in access, experience and outcomes.

At this stage, it is too early to demonstrate sustained, system-wide impact on health inequalities. As data quality, capability and consistency improve, the Trust will be better placed to evidence impact over time.

Governance, Oversight and Leadership

Health inequalities are a core component of the Trust's strategic and operational approach. The Trust's named executive lead for health inequalities is the Director of Improvement and Partnerships, providing senior leadership and accountability.

Health inequalities information is reported through established Trust governance structures, and it is our ambition to increasingly embed within service planning, quality improvement and performance discussions. This includes oversight of data quality, progress against Core20PLUS5 priorities, responding to learning and delivery of targeted improvement actions.

As part of the Trust's Health Equity Approach, further work is underway to strengthen routine reporting measures and metrics to support consistent Board-level oversight. This includes a range of self-assessment tools that contribute to understanding system progress that we will aim to complete at least every two years in line with our One Gloucestershire approach or as suggested by NHS England guidance. This ensures that action to reduce health inequalities is systematic, evidence-led and aligned with the Trust's statutory equality duties.

Looking Ahead

In 2026/27, the Trust will build on this work by:

- Finalising and embedding the Trust's Health Equity Approach, setting out clear principles, priorities and delivery expectations.
- Publishing an annual Health Equity report to increase transparency and accountability.
- Further embedding health inequalities considerations into service design, improvement and transformation activity.
- Further development of the PCREF implementation and development of our commitment to be an anti-racist organisation.
- Continuing to improve the completeness, quality and use of data to identify and address inequalities.
- Strengthening partnership working across One Gloucestershire to support joined-up, system-wide action.
- Maintaining a clear focus on Core20PLUS5 priority populations.
- Develop new ways to ensure the Board understands and is responsive to population health needs and inequalities, using learning to drive continuous improvement and inform decision making.
- Further strengthening the data recording and confidence agenda through the Transforming Care Digitally (TCD) programme. Digital Literacy and Data Confidence projects will support the workforce to record high-quality data consistently, enabling more effective identification of inequality and targeted improvement action.
- Develop and publish an improvement action plan to ensure we are compliant with Accessible Information Standards by March 2027.

This will ensure that reducing health inequalities remains integral to how the Trust delivers safe, effective and equitable services.

Future investment

Changes in demographics, demand, awareness, national guidance and targets, the introduction of new technologies and our work with our partners, mean we must remain flexible and adaptable. Delivering against our financial plan while maintaining and enhancing the care we provide will be essential yet demanding. Our commitment to our service users, carers, colleagues, partners and communities remains at the forefront of everything we do. We will continue to invest in what we need to do and what is best for the people we serve, while ensuring that we are responsible and careful with our necessary spending.

Future performance and risks

The year ahead will undoubtedly challenge us. However, we have historically shown our ability to meet challenges, adapt and work with our partners to ensure that we continue to meet the demands placed upon us and continue to focus on our main aim – provision of high-quality services and support to our communities.

We are aware that we face risks in achieving our strategic goals. We will continue to monitor and assess those risks and include them in our risk register and Board Assurance Framework, which is reported and discussed regularly at our Trust Board. These risks are shared with most, if not all, of our colleagues across the NHS and we have detailed plans in place to respond to and mitigate these risks. Further information on this is within our Annual Governance Statement. This Performance Report has been approved by the directors of Gloucestershire Health and Care NHS Foundation Trust.



Douglas Blair
Chief Executive

18 June 2026

Accountability Report

Our operating expenses in 2025/26 totalled £356,530,000 of which staff costs accounted for £269,269,000 or 75.5% of our operating expenses.

The Trust had a financial plan of break even and we achieved a financial performance surplus of £2,013k excluding impairments.

Although our accounts report a surplus of £740k, our reported financial performance reported to NHSE is a surplus of £2,013k. The reason for this is that our performance position excludes the impact of impairments. The impairments (in this instance) relate to the reduction in the value of property during the year which is calculated through valuation at year end. Although we are required to account for this movement as affecting our overall surplus/deficit it is not caused by the day-to-day management of the organisation. The table following shows the reconciliation between the two numbers which also includes other technical adjustments:

Adjusted Financial Performance	2025/26 (£000s)	2024/25 (£000s)	
	£000s	-	£000s
Deficit for the year	740	-	4,382
Before consolidation of Charity	37		-
Add back all I&E impairments / (reversals)	1,183		4,497
Surplus / (deficit) before impairments and transfers	1,960		115
Remove capital donations / grants I&E impact	52		185
Remove net impact of DHSC centrally procured inventories	1		27
Adjusted financial performance surplus / (deficit)	2,013		327

Our full annual accounts can be found at page 98.

Charitable Funds (GHC Charity)

The Trust's Charitable Funds enable people to have experiences which are not part of core NHS spending. They enhance patient care, user and carer support and colleague welfare and amenities. They are also used to improve the working environment and facilities at all of the Trust sites.

Our Charitable Funds are registered with the Charities Commission, and our Charity Number is 1096480.

Directors' responsibilities

The Directors confirm that, so far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Accounting policies for pensions and other retirement benefits are set out in note 1.6 to the accounts, and details of senior employees' remuneration can be found in the Trust's Remuneration Report.

Income disclosures

As per Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), we can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The impact of the provision of other income is not material on the provision of goods and services for the purposes of the health services in England.

Membership constituencies and eligibility requirements

Our members support us in appointing a Council of Governors.

Public constituencies

Members of our public constituency must live in England or Wales, be aged 11 or older and not eligible to become a member of our staff constituency. Six of our public constituencies are based in the city, borough and district councils of Gloucestershire. The seventh constituency is Greater England and Wales.

Staff constituency

Members of the staff constituency are individuals who are employed by the Trust under a contract of employment. There are three classes:

- Medical, Dental and Nursing staff
- Health and Social Care Professional staff
- Management, Administrative and Other staff

The Trust provides automatic membership of the staff constituency.

Membership data

Constituency	As at 31 March 2025	As at 31 March 2026
Public	3224	3284
Staff	4882	4957

Public Membership data by constituency as at 31 March 2026

Cheltenham	522
Cotswolds	268
Forest of Dean	333
Gloucester	724
Stroud	533
Tewkesbury	354
Greater England and Wales	550

Become a member

If you are interested in helping to shape local NHS services, join us:

- Telephone: 0300 421 7142
- Email: members@ghc.nhs.uk
- Web: www.ghc.nhs.uk/membership

Patient and Carer Experience Team (PCET) Annual Report 2025/26

Overview

In line with other teams across our Trust, 2025/26 was a busy and challenging year for our Patient and Carer Experience Team.

Complaint data was up, however, enquiries and enquiries transferred remained largely the same. Overall, contacts to the team increased significantly and the issues raised were increasingly complex with satisfactory resolution harder to achieve.

It is important to note that the Trust again received more compliments than any other type of feedback over the past year (in green below).

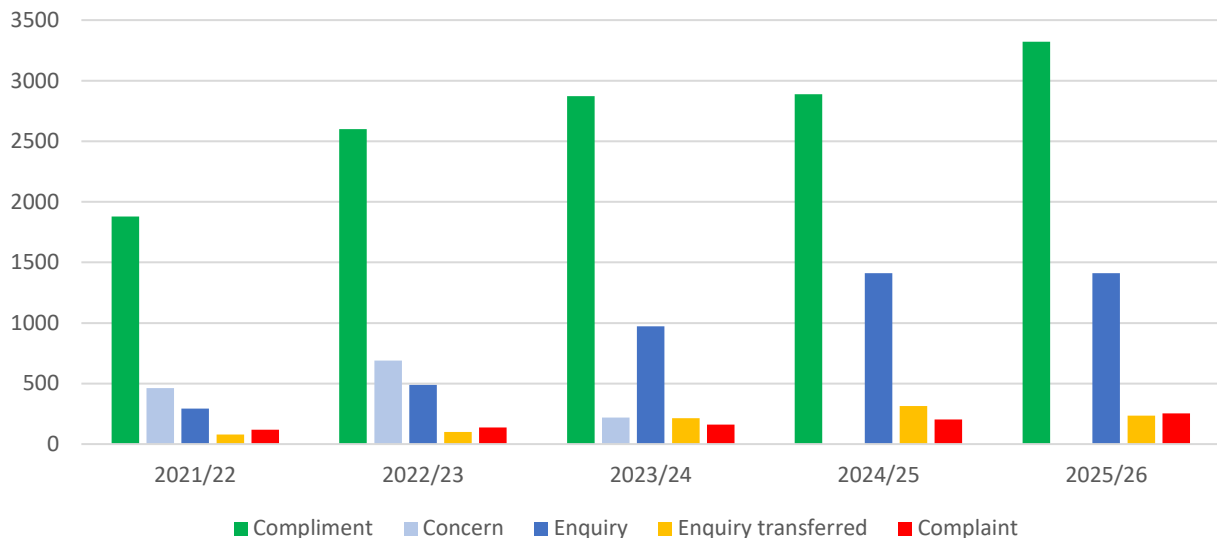


Fig. 1: Patient and Carer Experience data over the past five years.

Enquiries and Complaints Data

Analysis of the 2025/26 data shows that there was a **24.5%** increase in the number of complaints received (**254**) recorded by PCET against 2024/25 figures (204). This increase is largely a reflection that 2025/26 was the first full year in which the high volume Integrated Urgent Care service was part of the Trust's services. Enquiries remained the same (**1,410**) as last year. Contacts requiring a response from another organisation (enquiries transferred) were down (**234**) against 2024/25 (314).

Overall, there was a 1.5% decrease (**1,898**) in the combined number of contacts requiring action during 2025/26 compared to 2024/25 (1,928).

This is largely due to the reduction in enquiries transferred to another organisation.

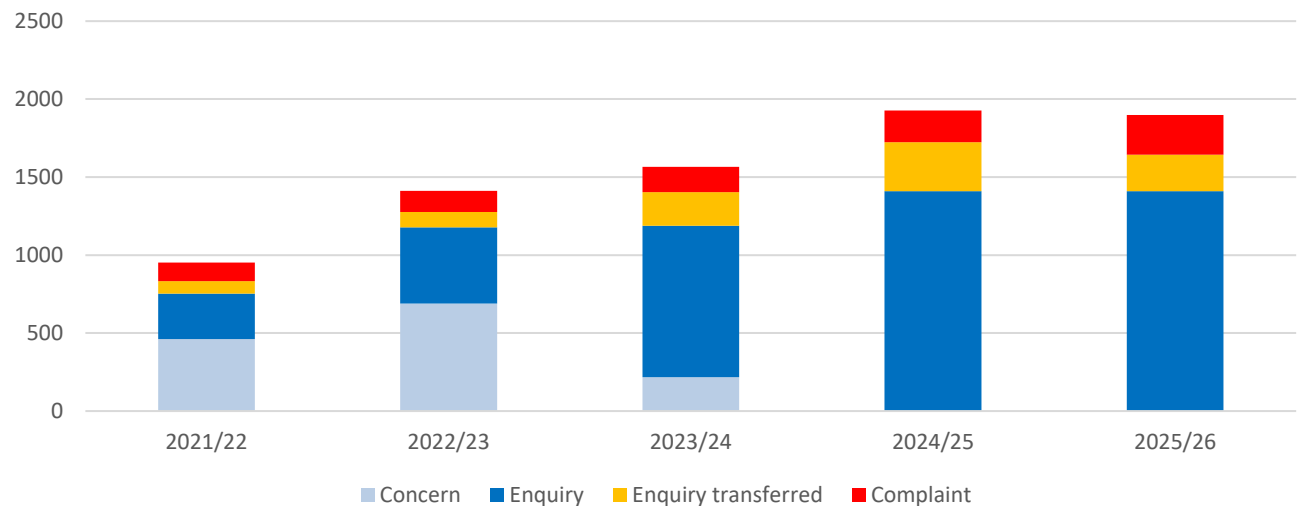


Fig. 2: Increase in combined number of contacts (complaints, enquiries and enquiries transferred) over time.

Over the past year, the prevailing complaint issues related to care and treatment (228), of which 49 were upheld. Overall, there were 403 complaint issues of which 200 were upheld.

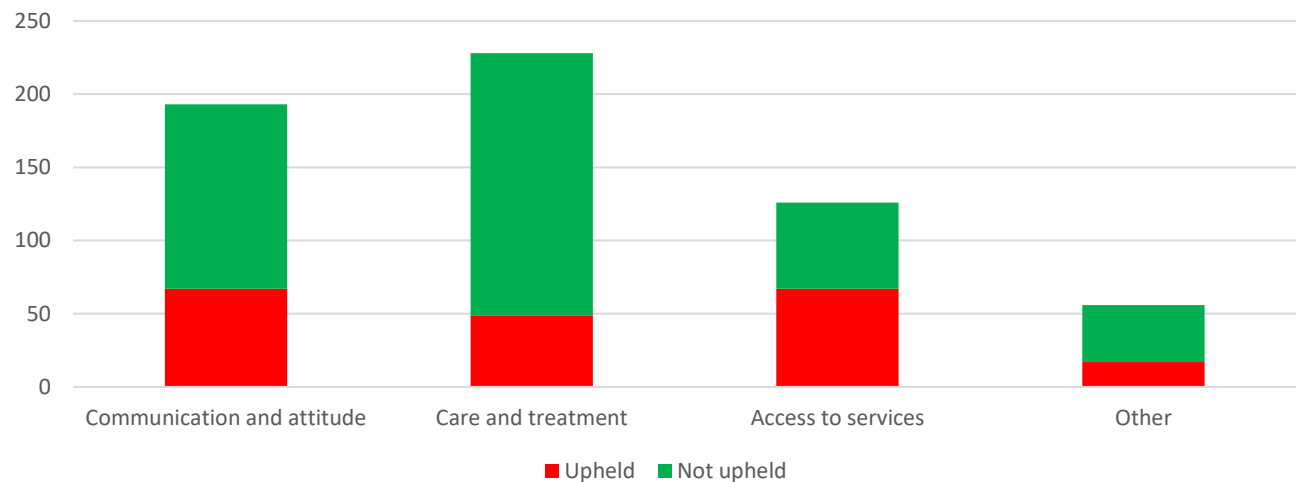


Fig. 3: Breakdown of complaint themes over the year by upheld/not upheld. Individual complaints typically include multiple issues; as such, the number of complaint issues is significantly larger than the number of complaints.

These themes cut across all directorates; however, a deeper dive into the data highlighted the most common issues raised within each directorate. These are listed below.

Adult Community Physical Health, Mental Health and Learning Disabilities: Access and waiting times, discharge and continuity of support, perceived communication difficulties, assessment outcome challenges.

Children and Young People Services: Access thresholds and waiting times, ADHD/ASC assessment pathways, discharge decisions, perceived lack of communication with parents.

Countywide: Appointment delays, discharge decisions, perceived poor communication of outcomes, staff behaviour in sensitive contexts.

Integrated Urgent Care Service: Delayed/missed callbacks, perceived poor quality of advice, reported navigation failures, perceived lack of empathy.

Mental Health Urgent Care and Inpatients: Discharge decisions, perceived attitude of staff during crisis, feeling unsafe/safeguarding, reported lack of information at critical moments.

Physical Health Urgent Care and Inpatients: Waiting times and flow, capacity related closures, perceived staff attitude, transfer/referral confusion.

We continue to report PCET data by directorate, sharing this with senior leads each month for wider oversight and learning via operational governance channels. High level data is presented/discussed at the monthly Operational Governance Business Meeting, Quality Assurance Group and included in the monthly Quality Dashboard.

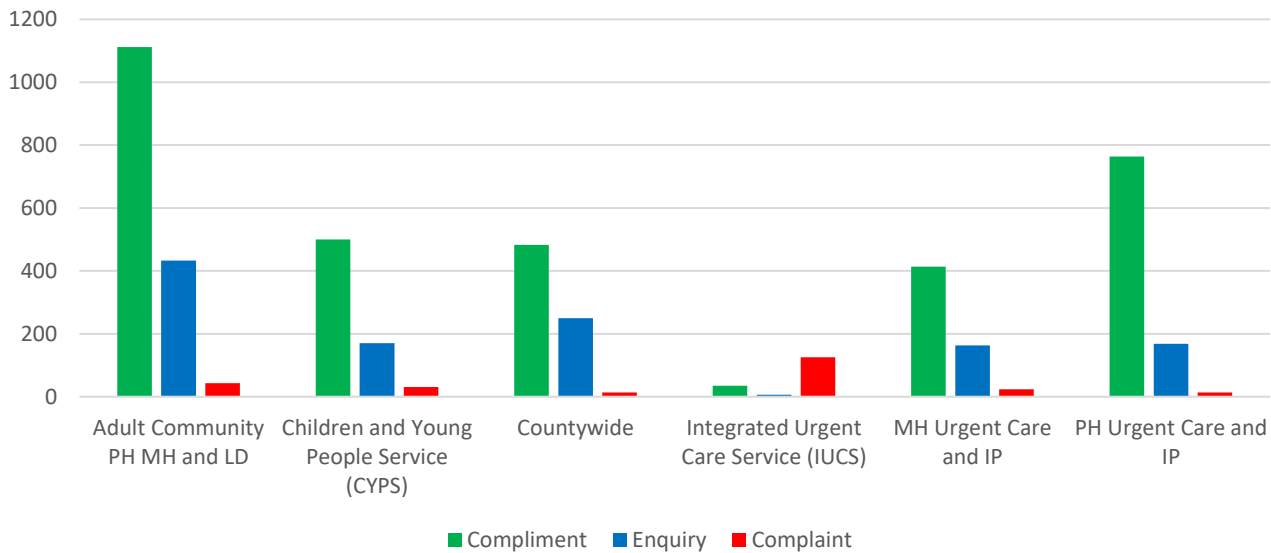


Fig. 4: Breakdown of compliments, complaints and enquiries by operational directorate for 2025/26.

It is important to note that we encourage resolution at local level, empowering teams to provide open and honest answers as soon as possible. We want to create a positive environment in which feedback is welcomed, and any issues are resolved at the earliest opportunity. As such, many enquiries and complaints are managed outside PCET; however, this does not preclude patients and carers from subsequently raising a complaint via the Trust’s formal processes.

PCET provides independent advocacy information, signposting service users to POhWER if they need additional support to make a complaint. As a Trust we also recognise the important role of the Parliamentary Health Services Ombudsman (PHSO) in resolving complaints where the Trust has been unable to do so locally. During 2025/26, the PHSO has considered 12 cases relating to the Trust. Of these, 4 remain under primary investigation and 7 have been closed with no further action required. The remaining case is under formal investigation and relates to a complaint we referred to the Ombudsman under Section 10 of the Health Service Commissioners Act 1993.

Responsiveness

In 2025/26, we met the national three-day requirement for responding to complaints (100%) up from 99% last year and back in line with previous years.

Despite significant efforts by colleagues, our responsiveness to complaints has declined slightly. Over the last 12 months, **72%** of complaints were closed within 0-3 months (down from 77% in 2024/25) and **26%** of complaints closed within 3-6 months (down from 33%). Additionally, **2%** of complaints closed within 6-12 months. Whilst this data set is within our target Key Performance Indicator framework, this is not in line with our ambition to provide a swift resolution for patients and carers (and colleagues).

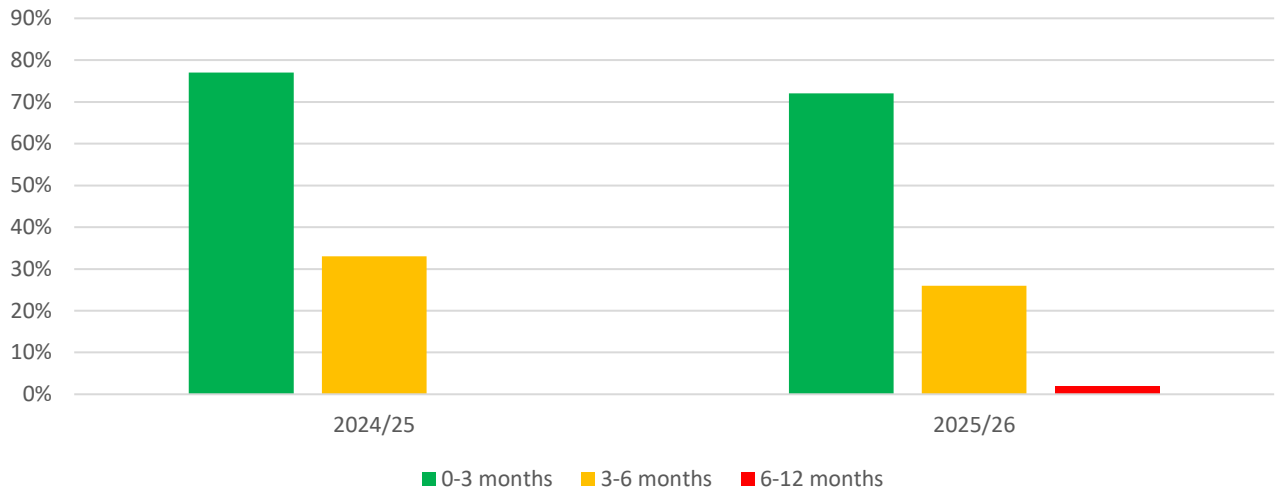


Fig. 5: Breakdown of complaints closed by timeframe over the past two years.

Compliments Data

The number of compliments **recorded** in 2025/26 (**3321**) represents a **17.3%** increase on 2024/25 figures (2,830). Compliments can be added retrospectively, so these numbers may not reflect data previously reported via monthly governance channels. We also acknowledge that teams receive much more positive feedback but do not always record it due to operational challenges. We continue to celebrate good practice as a further opportunity to learn and share compliments data with senior directorate leads each month.

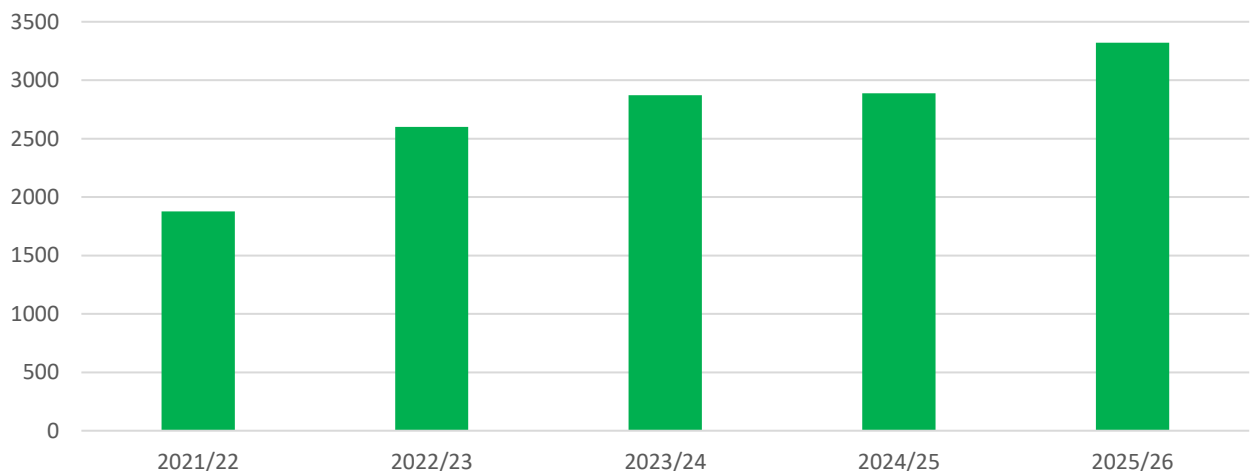


Fig. 6: Number of recorded compliments over time.

The dominant themes in compliments, consistent over the data set are:

- Kindness, compassion, empathy
- Feeling listened to and believed
- Professionalism and expertise
- Colleagues going “above and beyond”
- Emotional support during crises, bereavement, or end-of-life care
- Teamwork and calm environments
- Practical problem-solving

Learning Opportunities Group

We continue to meet informally with Trust colleagues every other week to discuss any emerging themes and hot spots. Where further investigation or learning is noted, a nominated member of the group will discuss with relevant colleagues to determine the potential impact and share further details to drive improvement/mitigate risk.

Patient Advice and Liaison Service (PALS) Visits

We continue to attend Wotton Lawn Hospital and Charlton Lane Hospitals each month. These visits provide patients with an opportunity to share feedback about their experiences. Due to increased demand/decreased capacity in the team, we have completed fewer visits this year (**27**) and have been unable to roll out our offer to further services as planned. In 2026/27, we hope to extend the scope of our PALS outreach to include those services we do not typically hear from via other routes.

NHS Friends and Family Test (FFT)

Many of our patients receive the FFT automatically when discharged from one of our services; however, some services use other methodologies for gaining FFT feedback due to the complexities of their patient groups. Paper surveys, electronic links and QR codes are all available to services on request. We are also working with colleagues to explore new ways in which to increase responses and share the FFT data with teams and via internal governance channels each month.

In 2025/26, we received **25,404** FFT responses (**9.7%** down on the previous year). The percentage of responders reporting an overall positive experience was at **93%** (based on the percentage of people who stated that the service was 'very good' or 'good'). A server error in late July 2025 caused the automatic push notifications for SMS messages to stop. This was resolved in September 2025 and the backlog of surveys was subsequently sent; however, it is likely that this will have impacted the total number of responses to the FFT.

	Total Responses	% Positive Responses
2021/22	16,816	94%
2022/23	20,256	94%
2023/24	30,365	94%
2024/25	28,151	93%
2025/26	25,404	93%

Fig. 7: FFT responses received by the Trust over the past 5 years.

Information around how we compare to other community providers can be found here: [NHS England » Friends and Family Test data](#)

You Said, We Did

During 2025/26, we trialled several 'You Said, We Did' boards to improve the visibility and highlight the value of feedback. Whilst the initial response was positive, more work is required to ensure that the boards are updated regularly to support patient and carer engagement. Over the next year, we plan to work with teams to understand and overcome the barriers to showcasing what we have learned and how we have implemented positive change from listening to the experiences of patients and carers.

National Mental Health Community Patient Survey

The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patient feedback.

In 2025, the final response rate for the Trust was **23.89%** (280 responses). **58.9%** of respondents identified as female and **41.1%** identified as male. **91.1%** of respondents reported that their ethnicity as white and **52.4%** noted their religion as Christian.

The Trust scored better than most Trusts for 13 questions and scored about the same in relation to 22 questions. The Trust did not score lower than the national average for any question.

Section	Score	Benchmark
Section 1: Support while waiting	6.5	About the same
Section 2: Mental health team	6.9	About the same
Section 3: Your care	7	About the same
Section 4: Medication	7.5	About the same
Section 5: Psychological therapies	8.7	About the same
Section 6: Crisis care support	5.6	About the same
Section 7: Crisis care access	7	About the same
Section 8: Support with other areas of life	4.5	Somewhat better
Section 9: Support in accessing care	5	About the same
Section 10: Respect, dignity and compassion	8.5	Somewhat better
Section 11: Overall experience	7.4	Somewhat better
Section 12: Feedback	4	Better

Fig. 8: CQC scores by section of the CQC Community Mental Health Survey 2025.

We are working collaboratively with experts by experience and operational colleagues to develop an action plan that identifies opportunities to improve our services for patients and carers in Gloucestershire.

The National Landscape

10 Year Plan

We recognise that proposed changes to NHS England and NHS Gloucestershire Integrated Care Board (ICB) will see more feedback funnelled directly through the Trust, which will have

a significant impact on PCET capacity and operational resources. We also acknowledge the work required to align our processes with the Trust's organisational restructure and look forward to working with colleagues to establish a robust framework that will provide a positive experience for everyone involved.

Dash Report (Dr Penny Dash)

Published in July 2025, Dr Penny Dash's review focuses on patient safety across the health and care landscape, however, patient experience and quality of care are rightly highlighted in her report. Specifically, the review found that 'the current system for complaints and concerns is confusing and may lack responsiveness'. We remain committed to ensuring patients and carers know how to provide feedback and recognise the importance of co-design in refining our processes to align with local and national guidance.

You can read Dr Dash' full report here: [Review of patient safety across the health and care landscape - GOV.UK](#)

Experience of Care Framework

NHS England has recently updated the 2018 patient experience improvement self-assessment in line with strategic policy and following feedback from providers. Trusts have been asked to complete this voluntary self-assessment tool to improve outcomes and experiences for people using services, unpaid carers, colleagues, volunteers and communities.

Noting demand and capacity challenges across the Trust, this was not progressed in 2025/26; however, the establishment of a review group to provide a broad range of perspectives in relation to the self-assessment will be prioritised over the next year. The self-assessment tool focuses on five key areas:

- Leadership
- Organisational culture
- Collecting feedback
- Analysis feedback
- Learning for improvement

You can find more information about the Experience of Care Framework here: [NHS England » Experience of care improvement self-assessment](#)

Thank you

Thank you to everyone across the Trust for your help and support with resolving issues for patients and carers over the past year. We recognise the significant impact this has on your time, and we are enormously grateful for your support.

Accountability

The Code of Governance for NHS Provider Trusts

Governance is the system by which the Trust is directed and controlled to achieve its objectives and meet the necessary standards of accountability and probity. The Trust has adopted its own governance framework which requires Governors, Directors and colleagues to have regard for recognised standards of conduct including the overarching objectives and principles of the NHS, the seven Nolan Principles, the NHS Constitution and the Code of governance for NHS provider trusts. The Code of Governance was published in October 2022 and has been applicable since 1 April 2023.

Board of Directors

Our Board of Directors provides leadership and helps drive overall trust performance, ensuring accountability to Governors and our members.

The Board is legally responsible for the strategic and day-to-day operational management of the Trust, our policies and our services. It maintains a scheme of delegation giving authority to Directors and others within certain limits to carry out actions required under financial procedures and the Mental Health Act.

Members of the Board

About our Independent Non-Executive Directors

Graham Russell – Trust Chair

Graham Russell is Chair of the Trust. Prior to becoming Chair, Graham was Vice Chair having been appointed as a Non-Executive Director in 2016. Graham is also Chair of Brunelcare which is a charity based in Bristol providing person-centred housing, care and support. He was formerly Chair of Elim Housing Association and Chair of Second Step, a mental health charity.

Prior to this, Graham spent 10 years as an expert advisor to the Organisation for Economic Co-operation and Development (OECD), four years as executive director at the Commission for Rural Communities and a decade in a number of senior roles at Business in the Community, whose founding patron is His Majesty The King.

Nicola de longh – Senior Independent Non-Executive Director / Vice Chair

Nicola joined the GHC Board in July 2022 and was appointed as Vice Chair and Senior Independent Director in June 2024. She is also Chair of Council at the University of Gloucestershire, where she has led major initiatives in institutional transformation, governance development and local regeneration, including the strategic purchase of the former Debenhams building in Gloucester City Centre and the recruitment of a new Vice-Chancellor. She also serves as Chair of the Committee of University Chairs, representing and supporting university chairs across the UK to strengthen governance and influence policy through ongoing engagement with regulators and government.

Alongside her NHS and higher education leadership roles, Nicola is Senior Independent Director of Connexus Homes, a rural social housing association. She also advises on the appointment of magistrates in the South West.

Previously, Nicola chaired the Premier Miton Responsible UK Equity Investment Fund Reference Committee and served as a trustee for a mental health charity. Prior to that, she

worked internationally in senior roles in organisational change, strategy and leadership development, including as Global Programme and Change Manager at Zurich Insurance Group and as an independent consultant to major corporations across Europe.

Nicola holds an MBA from the Open University, a Diploma in Human Resources from the University of Gloucestershire, and a BA (Hons) in French and Russian from the University of Bristol.

Nicola is the Chair of the Charitable Funds Committee, and Vice Chair of the Resources Committee.

Dr Stephen Alvis – Independent Non-Executive Director

Stephen was a GP in Gloucestershire for the 32 years; first with the Uley practice and then with the Cam and Uley Family Practice following a merger of two surgeries in 2013.

He chaired the Stroud and Berkeley Vale Primary Care Group and has served as Treasurer on the Gloucestershire Local Medical Committee, working in liaison with the clinical commissioning group on specific projects.

A graduate of Bristol University, Stephen had junior doctor roles in Cheltenham, Exeter, Bristol, Weston-Super-Mare, Milton Keynes and Aylesbury, before his GP training in Buckingham. He retired from general practice in October 2019.

Stephen joined the Trust as an Associate Non-Executive Director in January 2020, subsequently appointed as a Non-Executive Director from 19 November 2020. Stephen is Vice Chair of the Quality Committee and Chair of the Mental Health Legislation Scrutiny Committee. Stephen is also the Chair of the MH Act Managers Forum.

Bilal Lala – Independent Non-Executive Director

Bilal is an FCCA qualified accountant who is also a Non-Executive Director of Bristol Energy Cooperative, with prior non-executive experience with the local NHS acute trust, as well as broader experience through private sector pensions related chair and trustee roles.

Bilal started his working life in high street banking, before graduating as a mature student, thereafter, professionally qualifying whilst working for Chubb Electronic Security during the 1990s. Subsequently, the majority of Bilal's career has been spent in senior finance roles working for large national and multi-national outsourcing companies, spanning amongst others rail, highways, waste, energy (including renewables), EV charging and property technology offerings, servicing both the public and private sectors, and culminated in his last role, prior to retirement in June 2023, as Divisional Finance Director with Equans UK & Ireland.

Bilal's personal interest in the NHS stems, in part, from his children, three of whom have pursued careers in healthcare, two being doctors, the third being an optometrist; with all three now working for the NHS.

Bilal chairs the Audit and Assurance Committee.

Vicci Livingstone-Thompson – Independent Non-Executive Director (from 1 May 2025)

Vicci is the Chief Executive Officer of Inclusion Gloucestershire, a user-led organisation working to further inclusion and champion the voice of people facing disabling barriers across Gloucestershire and beyond. Vicci has a career history in senior leadership within the charity disability sector in Gloucestershire and is passionate about empowering people to play the leading role in managing their health and wellbeing and advocating for community-based preventative care and support.

Vicci, who was awarded a British Empire Medal (BEM) for services to mental health and people with disabilities in Gloucestershire in the King's New Year Honours List in 2024, was also named one of the 100 most influential disabled people in the UK on the Shaw Trust Disability Power 100 list in 2022. She is also a trustee of the National Disabled People's Organisation, Disability Rights UK, and local charity Active Impact, which champions inclusion for disabled children and young people.

Vicci Livingstone-Thompson joined the Trust as an Associate Non-Executive Director in 2023 and was subsequently appointed as a Non-Executive Director from 1 May 2025. Vicci is Vice Chair of the Great Place to Work Committee and Chair of the Trust's Diversity Network.

Debbie Forster MBE – Independent Non-Executive Director (from 26 January 2026)

Debbie Forster MBE has a background in technology, skills, innovation and inclusion. She is a Board Member and Chair of Diversity Committee at the Institute of Coding, as well as a member of the UK Government's Digital Skills Council.

Debbie has Non-Executive experience with the Lending Standards Board, Temenos (a Swiss technology company), and the British Council and has been a member of the UK Government's National Cyber Advisory Board, Money and Pensions Service Advisory Board and Digital Economy Forum.

Debbie's most recent role as Chief Executive was with Tech Talent Charter, where she worked between 2017 and 2024 and earlier in her career, she spent five years as CEO of Apps for Good (a technology education charity). In 2019 Debbie was recognised as the Most Influential Woman in UK IT in 2019, by Computer Weekly magazine and was awarded an MBE for services to Digital Technology.

Debbie is the Chair of the Resources Committee.

Karen Clements - Independent Non-Executive Director (from 2 March 2026)

Karen Clements served as a Non-Executive Director with NHS Gloucestershire Integrated Care Board and brings extensive senior leadership experience spanning more than 35 years across the insurance, banking and commercial real estate sectors. She has over two decades of experience in strategic business planning and delivery, with a strong track record in identifying opportunities for improvement, setting clear strategic direction and delivering sustainable organisational change.

Karen also brings significant practical experience in improving employee engagement and securing the commitment of colleagues to deliver meaningful change. She will bring this strong people-focused approach to her role as Chair of the Trust's Great Place to Work Committee.

Associate Non-Executive Directors (Non-Voting)

Cathia Jenainati – Associate Non-Executive Director

Dr Cathia Jenainati is Professor of Gender and Leadership, and the Head of the School of Business, Computing and Social Sciences at the University of Gloucestershire (UoG). Prior to her appointment at UoG, Cathia was the Dean of the School of Arts and Sciences at the Lebanese American University (2019-2023) and worked across the US and the Middle East.

From 2003-2019 Cathia was at the University of Warwick (UoW) where she occupied various roles, culminating in the Foundation of the School for Cross-Faculty studies in 2015 where she was appointed as Founding Head of School. Cathia founded the Global Sustainable Development (GSD) unit at UoW and oversaw the establishment of the Research Institute for

GSD. She also founded the Liberal Arts program which is predicated on the pillars of Social Justice, Gender Equity and Sustainability.

She is a certified coach who is committed to supporting individuals from under-represented communities during their leadership journey.

Non-Executive Director Changes in 2025/26

During the year the Trust welcomed a number of new Non-Executive Directors, but also said farewell to the following colleagues:

Jason Makepeace (Non-Executive Director) – 7 November 2025 – *Resignation*

Sumita Hutchison (Non-Executive Director) – 13 January 2026 – *End of Final Term*

Rosi Shepherd (Non-Executive Director) - 6 February 2026 – *Resignation*

About our Executive Directors

Douglas Blair – Chief Executive

Douglas started as Chief Executive in April 2023. He joined the NHS in 2006, with Primary Care Trust, Strategic Health Authority and NHS England roles before being appointed as Director of Community Services at Great Western Hospitals NHS Foundation Trust in 2014 and then Managing Director of Wiltshire Health and Care LLP in 2016.

Prior to his time in the NHS, he was a civil servant, having been accepted into the Civil Service Fast Stream in 1998. His government roles included homelessness policy, rural policy, the Scottish Cabinet secretariat and the reform and transformation of the prosecution service in Scotland. His first career was as a sound engineer, working for EMI at Abbey Road Studios.

Sandra Betney – Director of Finance and Deputy Chief Executive

Sandra's responsibilities include estates, facilities, business planning, financial and contract management as well as leadership of the finance, procurement, business intelligence and digital services.

Sandra was the co-chair of the Trust's Women's Leadership Network during the financial year, a role which will pass to Nicola Hazle, Director of Nursing Therapies and Quality on Sandra's retirement in summer 2026.

A qualified accountant, Sandra began her accountancy career in Housing Associations. She joined the NHS in 1993 and has held high profile roles in finance and procurement within health authorities, mental health and community trusts, and the NHS Information Authority.

Neil Savage – Director of Human Resources & Organisational Development

Neil has been the Trust's Director of HR and Organisational Development since 2016.

Prior to this, he was Director of HR Transformation, leading on the HR integration of Birmingham Children's and Birmingham Women's NHS Foundation Trusts after a period as the Women's Trust's Interim Chief Executive and a four-year tenure as Chief Operating Officer. Before this, he was Director of Workforce & Organisational Development. Neil also previously worked for Gloucestershire Hospitals NHS Foundation Trust as Assistant HR Director and Acting Director of HR & Organisational Development. He has worked in other HR roles in acute, mental health, learning disabilities and community services. A Chartered Fellow of the CIPD, Neil was the winner of the Health Education England West Midlands' "Inspirational Leader of the Year" award in 2015 and was shortlisted as a national finalist in

2016. He is currently the South West employers' representative on the national NHS Staff Council and the Co-Chair of the South West Regional Social Partnership Forum.

Dr Amjad Uppal – Medical Director

Amjad completed his undergraduate medical training in 1995 and subsequently worked in Primary Care and General Medicine before specialising in Psychiatry. He completed his core and specialist training in Gloucestershire in the Severn Deanery. He is on the GMC Specialist Register with accreditation in General Adult Psychiatry and an endorsement in Rehabilitation Psychiatry.

Amjad's first appointment as Consultant was with the Cheltenham Crisis and Home Treatment Team from January 2010 to July 2013. In August 2013 he was appointed as Consultant to the Gloucester Assertive Outreach Team.

Amjad has a keen interest in medical education and management. He served as Postgraduate Tutor and Inpatient Medical Lead from November 2010 to August 2013, Director of Medical Education from August 2013 to November 2017 and was appointed as Medical Director at 2gether NHS Foundation Trust in December 2017. He became Medical Director for Gloucestershire Health and Care NHS Foundation Trust in October 2019. He continues with his clinical role as Consultant to the Gloucester Assertive Outreach Team.

Amjad is also the 'Caldicott Guardian' and 'Responsible Officer' in the Trust.

He was elected to Fellowship of the Royal College of Psychiatrists in November 2021.

Rosanna James - Director of Improvement and Partnerships

Rosanna lives in Gloucestershire and previously worked within the Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS) as a Programme Director for an ICS wide transformation programme focused on improving care for older people.

Her work involved bringing together health and social care partners, alongside the VCSE sector, to redesign acute and community care models. The programme aimed to strengthen system flow and maximise opportunities for older people to maintain their independence through Home First-focused, integrated care options. Before working in the ICS, Rosanna spent eight years at North Bristol NHS Trust as Deputy Chief Operating Officer across both elective and emergency care portfolios, having originally begun her NHS career as a Graduate Management Trainee. Rosanna has a strong commitment to co production and meaningful patient engagement, ensuring that transformation and service design are shaped by lived experience and deliver real improvements for the communities she serves.

Outside her NHS roles, she has been closely involved with initiatives supporting families and young people. She chaired the Baby Bank Network in Bristol until April 2025 and is currently a Trustee at Home Start Stroud and Gloucester.

Sarah Branton – Chief Operating Officer

Sarah has been a registered Social Worker since 1998. She specialised in mental health as an Approved Social Worker and trained in a number of psychological therapies. Sarah joined us from Avon and Wiltshire NHS Partnership Mental Health (AWP) Trust where she was the Deputy Chief Operating Officer. She led the organisation through multiple complex situations as gold commander for Covid, industrial action and critical incidents.

Sarah has an interest in leadership. She completed the NHS Leadership Academy Award in Executive Healthcare Leadership (Nye Bevan) and has taught on compassionate leadership. She is an experienced coach and mentor. She is also committed to systems thinking and

working across organisations to build shared purpose and deliver services close to communities.

Nicola Hazle – Director of Nursing, Therapies and Quality

Nicola has 25 years of experience as a registered mental health nurse and joined the Trust in June 2024 from her previous role as Health and Care Professional Director within Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board.

Prior to this she was Clinical Director in Avon & Wiltshire Mental Health Partnership NHS Trust and has worked in a range of nursing, senior nursing and management roles in mental health and community organisations across the NHS. Nicola holds a Lay Advisory Panel Member (voluntary) role with the College of Optometrists and has previously worked as a bank Mental Health Inspector for the Care Quality Commission and as a Fitness to Practice Registrant Panel Member with the Nursing and Midwifery Council.

Attendance by Non-Executive Directors and Directors

Terms of reference define membership for each Board committee. The Chair and Chief Executive by virtue of office may attend all meetings (except the Audit Committee).

The number of meetings and individual attendances at those meetings are detailed in the following table. Board members who are “members” of a particular committee, as per the Terms of Reference, and therefore expected to attend are highlighted. All Board members can attend any meeting, and ad hoc attendance is also recorded.

Attendance at Trust Board and Board Committees by Non-Executive and Executive Members from 1 APRIL 2025 – 31 MARCH 2026									
Name and position	Council of Governors	Board	Resources	Audit & Assurance	Quality	Mental Health Legislation Scrutiny	Charitable Funds	ATOS	Great Place to Work
Total of Meetings Held	8*	6	6	5	6	3	3	4	6
Graham Russell, Trust Chair ⁱ	8	6	1					2	
Steve Alvis, Non-Executive Director	4	4	4		5	3		3	
Sumita Hutchison, Non-Executive Director ⁱⁱ	1/4	3/4		4/4		0/2		1/2	5/5
Nicola de longh, Non-Executive Director	3	4	6				1	3	4
Bilal Lala, Non-Executive Director	3	5		5	5			3	1
Jason Makepeace, Non-Executive Director ⁱⁱⁱ	3/3	2/3	4/4	2/3			1/1	1/1	
Rosi Shepherd, Non-Executive Director ^{iv}	1/5	5/5		2/5	5/5			1/2	
Vicci Livingstone-Thompson, Non-Executive Director	6	5		2	4		3	2	3
Debbie Forster, Non-Executive Director ^v	0/1	2/2	1/1	1/1			1/1	2/2	1
Karen Clements, Non-Executive Director ^{vi}	1/1	0/1		0/0				0/0	0/0
Cathia Jenainati, Associate Non-Executive Director	1	2							
Douglas Blair, Chief Executive Officer ¹	6	6		2				4	
Sandra Betney, Director of Finance/Dep. Chief Executive		6	6	5			0		
Sarah Branton, Chief Operating Officer		6	4	1	5	2			6
Nicola Hazle, Director of Nursing, Therapies & Quality	2	5		2	6				4
Rosanna James, Director of Improvement and Partnerships	2	5	5	1			3		
Neil Savage, Director of HR & Organisational Development	1	6	5	2			1	4	6
Dr Amjad Uppal, Medical Director	1	5		1	6	2			3
Lavinia Rowsell, Director of Corporate Governance & Trust Secretary ^{vii}	3/4	3/4	3	4/4	3				3
Helen Child, Director of Corporate Governance & Trust Secretary ⁸	1/1	1/1		0/0					

	Member of a Committee/Board as stated in the terms of reference.
	Left the Trust / role in year (see footnotes)
	Joined the Trust in the year (see footnotes)

* There were 8 Council of Governor meetings during the year (4 full Council meetings, 2 development sessions and 2 extraordinary meetings).

¹ The Chair and Chief Executive are Ex officio members of all Board Committees, except Audit. Attendance at Board Committees is therefore optional or by invitation only.

² Left the Trust 13th January 2026

³ Left the Trust 7th November 2025

⁴ Left the Trust 6th February 2026

⁵ Joined the Trust 26th January 2026

⁶ Joined the Trust 2nd March 2026

⁷ Left the Trust 2nd January 2026

⁸ Joined the Trust 2nd March 2026

Board Committees

Audit and Assurance Committee

All Non-Executive Directors, except the Trust Chair, are members of the Audit and Assurance Committee. Bilal Lala chairs the Committee. The role of the Audit and Assurance Committee is to provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities, both generally and in support of the Annual Governance Statement.

There were five meetings of the Audit and Assurance Committee held in the reporting period. The Committee's agenda is structured so as to enable consideration of significant issues throughout the year. Standing agenda items include:

Internal Audit: BDO LLP is the Trust's Internal Audit provider. The Committee has commissioned from BDO a full audit programme based upon risk as identified by the Board Assurance Framework and received regular reports on the outcomes and actions completed. Where appropriate, the findings of these audits were also reported to other Committees in order for action plans to be developed and their timely implementation monitored. A number of these audits were specifically requested by the Committee in order to scrutinise known areas of risk.

External Audit: Sumer is the Trust's External Audit provider. Each year the Committee approves an External Audit plan setting out the timetable for the audit of the annual accounts. The Committee also receives at each meeting a summary of any additional significant risks identified through the planned audit work, as well as a summary of significant risk, regulatory and health sector developments which are pertinent to the work of the Trust.

Financial Reporting: The Committee receives a number of reports through the year on significant financial issues such as losses and special payments and valuation of intangible assets. In accordance with International Financial Reporting Standards the Committee also receives the 'Going Concern' report enabling the Trust to make and document a rigorous assessment of whether the Trust is a going concern when preparing its annual financial statements. In reviewing and approving the financial statements, the Committee also reviews any changes to accounting policies, and receives a report outlining factors which the Committee must take into account in order to satisfy itself that no material misstatements have been made in the accounts, and providing assurance that sufficient controls exist for the Committee to be assured that the Annual Accounts present an accurate assessment of the Trust's financial position, and the External Auditor can rely on the information contained within the Letter of Representation.

Counter Fraud Reporting: The Committee approves a Counter Fraud Plan each year and receives reports on Counter Fraud activity at each meeting.

Appointment and Terms of Service Committee

The Appointment and Terms of Service (ATOS) Committee is chaired by the Trust Chair and has a membership of all Non-Executive Directors. In the absence of the Chair, the Vice Chair of the Trust will lead the meeting. The Committee's role is to advise the Board on the appointment, remuneration and terms of service and performance of the Chief Executive and Executive Directors of the Board. This also includes Very Senior Managers (VSMs are defined by NHS Employers as 'other senior managers with Board level responsibility'). It also ensures there are appropriate arrangements for the consideration and management of succession planning.

During the year the committee met 5 times and considered:

- The new national VSM pay framework and guidance
- The appointment and terms and conditions for a new Director of Finance
- The performance of each Executive Director and the Chief Executive
- Executive Director and Chief Executive remuneration
- Succession planning for Executive Directors

Appointment

Appointment of new Non-Executive Directors is for an initial period of three years subject to earlier termination or extension and is governed by the terms of the Trust's Constitution and the Standing Orders for the Council of Governors and Board of Directors. Appointment of both Executive and Non-Executive Directors is subject to candidates satisfying the requirements for Fit and Proper Persons; Directors, as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Directors must continue to satisfy these requirements during the term of their appointment.

Reappointments

Non-Executive Directors are eligible for reappointment at the end of their initial period of office in accordance with the Trust's Constitution, but they have no absolute right to be reappointed. Decisions about reappointment of Non-Executive Directors are made by the Council of Governors.

In reaching a decision, in addition to having regard to the appraised performance of the individual, the Council of Governors will consider the performance of the Trust, the make-up of the Board of Directors in terms of skills, diversity and geographical representation, the Board dynamics and the effectiveness of its team working.

The full term of office for a Non-Executive Director is six years. However, the Trust's Constitution does include a clause stating that, in exceptional circumstances, a Non-Executive Director may be reappointed for further term(s) of 1 year, up to a maximum of 3 consecutive years in total. Any proposed reappointment under this clause shall be subject to annual re-appointment, rigorous review and a satisfactory appraisal carried out in accordance with procedures which the Council of Governors has approved.

Termination of Appointment

Our Constitution sets out the following circumstances in which the appointment of a Non-Executive Director may be terminated by the Trust:

- Removal from the Board of Directors being approved by 75% of members of the Council of Governors at a general meeting of the Council of Governors
- The Non-Executive Director being adjudged bankrupt or their estate being sequestrated and (in either case) not being discharged
- The Non-Executive Director making a composition or arrangement with, or granting a trust deed for, their creditors and not having been discharged in respect of it
- Within the past five years, the Non-Executive Director having been convicted in the British Isles of any offence for which a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed
- The Non-Executive Director being a person whose tenure of office as a Chair or as a member or director of a health service body having been terminated on the grounds that the appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest
- The Non-Executive Director being a person who is undergoing a period of disqualification from a statutory health or social care register. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement.

- The Non-Executive Director having within the previous two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body.
- The Non-Executive Director being subject to a director's disqualification order made under the Company Directors Disqualification Act 1986.
- The Non-Executive Director being a person who is the subject of an Order pursuant to the Sexual Offences Act 2003 or any subsequent legislation.
- The Non-Executive Director ceasing to be a public member of the Trust.
- The Non-Executive Director being or becoming a Governor of the Trust

If the Council of Governors is of the opinion that it is no longer in the interests of the National Health Service that a Non-Executive Director continue to hold office then, subject to the provisions of the Trust's Constitution, their appointment may be terminated. The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the National Health Service that a Non-Executive Director continues in office:

- If an annual appraisal or sequence of appraisals is unsatisfactory
- If the Non-Executive Director loses the confidence of the public or local community in a substantial way
- If the Non-Executive Director fails to deliver work against agreed targets incorporated within their annual objectives
- If there is a terminal breakdown in essential relationships, for example between the Chair and Chief Executive, or between a Non-Executive Director and the other directors.

The above list is not intended to be exhaustive or definitive. The Council of Governors will consider each case on its merits, taking all relevant factors into account.

Balance of the Board and appraisal

The Board reviews its effectiveness after each meeting, and through developmental workshops throughout the year. These build on similar performance evaluations carried out during previous years. Board Committees' objectives and Terms of Reference are reviewed annually, and Committee membership is regularly reviewed to take account of any new Non-Executive Directors joining the Board, and to ensure that Non-Executive Directors' skills and knowledge are being put to all reasonable use. It is the Trust Chair's responsibility to ensure Committee and Board membership is revitalised when appropriate. The balance of skills on the Board is considered when appointing replacements, thus ensuring that the Board's mix of skills, knowledge and experience remains appropriate for the current and future requirements of the Trust.

Except where people join the Board late in the financial year, all Board members have a performance appraisal during the year involving input from colleagues and, when appropriate, Governors and others to provide insight into effectiveness and to identify learning and development opportunities. The results of the appraisals of the Executive Directors have been shared in summary with the Appointments and Terms of Service Committee of the Board of Directors. Similar arrangements have been followed for the summary of Non-Executive and Chair appraisals to be given to the Nominations and Remuneration Committee of the Council of Governors. Each Board member has individual development and performance targets for the coming year, and it is the responsibility of the Trust Chair to ensure that the results of Directors' performance appraisals are acted upon.

Board Remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.6 of the accounts.

Details of senior employees' remuneration can be found in page 55 of the Remuneration Report; and details of company directorships and other significant interests held by Directors or Governors which may conflict with their management responsibilities are set out in note 48 of the accounts.

Directors' Statement as to Disclosure to the Auditors

The Directors confirm that so far as they are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps that they ought to have taken as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Going Concern

After making enquiries, the Directors have a reasonable expectation that Gloucestershire Health and Care NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Council of Governors

Our Council of Governors consists of public, staff, and appointed Governors from the local authority and partner organisations.

Governors are an essential link between our membership and the Board of Directors. They help ensure that the Trust hears everyone's views.

Public and staff Governors are elected by members of their own constituency using the single transferable vote system.

The following elections took place during 2025/26 for public and staff governor positions.

Constituency	Vacant Posts	Candidates	Total Votes Cast	Turnout
May 2025				
Public: Stroud	1	Mick Gibbons	Reappointed Unopposed	
Public: Cotswolds	1	David Hindle	Appointed Unopposed	
Staff: Medical, Dental & Nursing	1	Caroline Goldstein* Andrew Telford	Eligible Voters: 1584 Valid votes cast: 187	11.8%

* Elected

The appointment term of all Governors is three years. Governors can stand for two terms. Local authority Governors may hold office for as long as they remain a local authority councillor.

Council of Governors by constituency and current vacancies		
Category of Governor	Total number of Governors	Vacancies as of 31 March 2026
Public constituencies		
Cheltenham	2	0
Cotswolds	2	0
Forest of Dean	2	0
Gloucester	2	1
Stroud	2	0
Tewkesbury	2	0

Greater England & Wales	1	0
Staff constituencies		
Medical, Dental and Nursing	3	0
Health and Social Care Professionals	2	1
Management, administrative and other staff	2	0
Appointed Governors		
Gloucestershire County Council	1	0
Young Gloucestershire	1	0
Healthwatch Gloucestershire	1	0
Inclusion Gloucestershire	1	0
Total	24	2

The Council of Governors has three primary roles:

- to hold the Non-Executive Directors to account for the performance of the Board; and
- to represent the interests of the Trust's stakeholders in the governance of the organisation; and
- to communicate the key messages of the Trust to the electorate and appointing bodies.

The duties and powers of Governors are defined within the constitution and include:

- Reviewing and providing advice and comments to the Board of Directors on any strategic plans
- Developing and approving a membership strategy, including feeding information back to their constituencies and stakeholder organisations
- Appointing or removing the Chair and the Non-Executive Directors
- Deciding the remuneration and allowances of the Chair and Non-Executive Directors
- Appointing or removing the Trust's auditors
- Receiving and reviewing the annual accounts, any report of the auditor on the accounts and the Trust's annual report
- Holding the Non-Executive Directors to account for the performance of the Board
- Approving an appointment by the Non-Executive Directors of the Chief Executive
- Enforcing standards of conduct for Governors
- Such other responsibilities as the Board of Directors and Council of Governors may agree

The following table shows the composition of the Council of Governors during the reporting period, listing names, appointment dates and length of service. The following also shows the number of Council of Governor meetings attended by Governors during the reporting period. Attendance by Board members at Council of Governors meetings is detailed elsewhere in this report.

Constituency	Number of Constituency Governors	Name of Governor	Date of appointment/ Nomination (Date of reappointment) (<i>resignation date</i>)	Council of Governor Meeting Attendance
Elected Public Governors				
Cheltenham Borough Council	2	Tussie Myerson	September 2024	5/8
		Joy Hibbins	February 2025	3/8
Cotswold District Council	2	Jenny Hincks ²	July 2019 (July 2022) July 2025	1/2
		Peter Gardner	September 2023	8/8
		David Hindle	July 2025	5/6
Forest District Council	2	Chris Witham	Sept 2020 (Sept 2023)	8/8
		Marcia Gallagher	September 2024	6/8
Gloucester City Council	2	Penelope Brown ¹	January 2023 March 2026	3/7
		Leighton-Lee Pettigrew	February 2025	3/8
Stroud District Council	2	Mick Gibbons	July 2022	7/8
		Jan Lawry	February 2025	5/8
Tewkesbury Borough Council	2	Laura Bailey	January 2021 (Dec 2023)	3/8
		Chas Townley	January 2023	2/8

Greater England & Wales	1	Sarah Waller CBE	September 2024	8/8
Elected Staff Governors				
Medical Dental and Nursing	3	Kizzy Kukreja	January 2021 (Dec 2023)	6/8
		Paul Winterbottom	September 2021 (Sept 2024)	2/8
		Caroline Goldstein	July 2025	3/6
Health and Social Care Professionals	2	Sarah Nicholson ²	Mar 2020 (Mar 2023) March 2026	7/8
		Michelle Kirk	September 2024	6/8
Management, Administrative and Other	2	Amy Aitken	September 2024	7/8
		Martin Pittaway	September 2024	5/8
Gloucestershire County Council	1	Richard Dean	November 2025	1/4
Young Gloucestershire	1	Alicia Wynn	September 2022	7/8
Healthwatch Gloucestershire	1	Bob Lloyd-Smith	January 2023	7/8
Inclusion Gloucestershire	1	Andrew Cotterill	September 2023	3/8

¹ Resignation

² End of Final Term

How Governors work with Directors and Members

Meetings of the Council of Governors and Board of Directors are both presided over by the Chair of the Trust or, in their absence, the Deputy Chair of the Board of Directors.

It is the Chair's role to ensure there is a positive working relationship between the Council of Governors and the Board of Directors. The constitution provides for the sharing of responsibilities, and this is supported by standing orders for each forum. The Trust has a formal process for the resolution of disputes between the two bodies if required but use of this process has not been necessary to date. Directors' duties are set out in a scheme of delegation.

Both Non-Executive and Executive Directors have attended Council of Governors meetings to present information and to seek Governors' views. Non-Executive Directors are regular attendees at the Council. The Council of Governors was consulted as part of the Trust's business planning process, and their views were taken into account when developing the new Trust Strategy. Individual Non-Executive Directors provide assurance to the Council of Governors on areas relevant to their roles as Committee Chairs, as part of the Council of Governors' responsibility to hold the Non-Executive Directors to account for the performance of the Board. The Chair informs the Council of Governors of the work of the Board through regular correspondence to Governors and the presentation of reports at meetings.

There were 8 Council of Governor meetings during the year (4 full Council meetings, 2 development sessions and 2 extraordinary meetings).

Business conducted at the Council of Governor meetings during 2025/26 included the receipt of the Governor Dashboard which provides a high-level overview of performance and quality measures, a review of the NHS Staff Survey results, engagement in the development of the Trust's quality priorities, and formal receipt of the Annual Report 2024/25. The Council received a number of presentations during the year providing information on the Integrated Urgent Care Service (IUCS), the Trust's Working Together approach, the Trust Strategy refresh and Children and Young People's Services. During 2025/26 the Council continued its Governor Ways of Working review, looking at how the Trust can optimise the contribution and value of Governors.

During 2025/26, at the recommendation of the Nominations and Remuneration Committee, the Council also approved the appointment of 3 new Non-Executive Directors, received and endorsed recommendations around the proposed recruitment process for a further Non-Executive Director, and approved a remuneration increase for Non-Executive Directors and the Trust Chair.

Two Governor Development sessions took place. The first session took place in July 2025 and was a joint Board and Governor session focusing on the implications of the new NHS 10-year Plan and engagement with the Trust strategy refresh. The second session took place in January 2026 and was a joint Governor and Non-Executive Director session

focussing on the Annual Business Planning Process and embedding of the new Five-Year Trust Strategy.

The Chief Executive regularly attends Council of Governor meetings and provides presentations on current and future developments for the Trust. Some Governors have attended Board of Directors meetings as observers and the Chair keeps the Board informed of the issues dealt with at the Council of Governors. The minutes of Council meetings are included on the agenda of the Board of Directors.

Members are informed of changes and proposals through a newsletter and invited to comment and make suggestions.

Nominations and Remuneration Committee

The Nominations and Remuneration Committee is a committee of the Council of Governors which advises the Council on the appointment, dismissal, remuneration and terms of service of the Chair and Non-Executive Directors of the Board. The Committee is normally chaired by the Trust Chair, unless they must be excluded from the meeting due to the business being conducted. In this instance the Deputy Trust Chair, or Lead Governor, will oversee the meeting.

The committee has delegated authority to manage and oversee the recruitment and appraisal processes for the Chair and Non-Executive Directors on behalf of the Council.

In 2025/26 the Committee oversaw the recruitment processes for four Non-Executive Director positions, with 3 new NEDs appointed during 2025/26. The Committee received the outcome of the 2024/25 annual appraisals of the Non-Executive Directors and Chair, and the process for future appraisals was agreed. The Committee also considered national guidance and benchmarking data in making a recommendation to the full Council with regard to an increase in Non-Executive Director and Chair remuneration.

The Nominations and Remuneration Committee met 6 times during the reporting period.

As at 31 March 2026, our Lead Governor is Chris Witham (Public Governor) who was appointed by the Governors from 1 January 2021. The Council of Governors endorsed the creation of a formal Deputy Lead Governor position in September 2022. Peter Gardner (Public Governor) was appointed as the Deputy from 13 March 2024. In addition to deputising for the Lead Governor, this role will include a particular focus on our membership and engagement agenda.

Register of Governors' and Directors' interests

Our Trust hospitality register, register of Directors' interests and register of Governors' interests, are available on our Trust website at www.ghc.nhs.uk or by contacting the Trust Secretary at Trust.Secretary@ghc.nhs.uk.

Remuneration Report

Annual Statement on Remuneration

The Trust's Appointments and Terms of Service Committee (AToS) has received the delegated responsibility from the Board of Directors to review and set the remuneration and terms of service of the Chief Executive and the Executive Directors.

All other senior managers are covered by the national Agenda for Change, or, in the case of medical managers, Consultant terms and conditions of service. The Trust policy has been for all colleagues who are not board members to be employed on national or equivalent terms and conditions of employment. The AToS Committee is chaired by the Trust Chair and has a membership of all Non-Executive Directors. In the absence of the Chair, the Vice Chair of the Trust, leads the meeting.

The Committee has reviewed Chief Executive and Executive Director performance and succession planning over the year. During 2025/26 it has also overseen the recruitment campaigns to appoint a new Director of Finance, following a planned retirement, and for a Chief Operating Officer, following a career move.

Remuneration for Executive Directors is agreed through an established evaluation process which complies with the national Very Senior Manager (VSM) Pay Framework and related remuneration guidance from NHS England. The remuneration package does not include any Performance Related Pay scheme and has no additional other pay or non-pay benefits which are outside standard terms and conditions that apply to the majority of colleagues employed within the Trust e.g. NHS Pension Scheme, annual leave, sick pay etc. In view of this and compliance with the VSM Pay Framework, no future policy table is included in this report.

Decisions which the Committee takes on the salary and terms of conditions of service of its Chief Executive and Executive Directors are informed by reviews that take into account the wider labour market, the scope of responsibilities, performance, best practice, NHS Providers' annual remuneration survey and benchmarking, and compliance with the NHS England VSM Pay Framework. The Committee also considers the awards for other staff groups as required, through, for example, the NHS Pay Review Body (NHSPRB). During the year, following the Government's acceptance of the Senior Salaries Review Body (SSRB) recommendations, the Committee agreed to apply the Government's recommended award to VSM in the NHS, which equated with a 3.25% pay increase for 2025/26 from 1st April 2025, in a way that was consistent with the new VSM pay framework. The Committee operates in line with the Trust's commitment to equality, diversity and inclusion.

For all other senior managers, performance is managed in accordance with our appraisal policy and Agenda for Change pay progression requirements, both of which are aligned with national terms and conditions of service and agreed locally with our Staff Side trades unions representatives.

The appraisal process for Executive Directors and senior managers employed on Agenda for Change terms ensures that objectives for everyone are regularly reviewed and aligned to the Trust strategy and business needs.

For senior managers on Agenda for Change terms and conditions under the Trust's Pay Progression Policy, pay steps may be withheld if levels of performance are not maintained.

The Committee receives an annual report on the performance of the Chief Executive and Executive Directors from the Chair and Chief Executive respectively. This follows the assessment of the appraisal objectives for each member of the Board that are agreed for each financial year.

The Chief Executive and Executive Directors are employed on substantive contracts of employment. The current Chief Executive's contract and those of our Executive Team are subject to six months' written notice from either party to minimise the risk from loss of senior management capacity at this level, while recruitment processes take place. None of the contracts for the Chief Executive or Board Directors contains clauses specifying termination payments which are more than contractual obligations. Contractual occupational redundancy terms are as per Section 16 of the Agenda for Change NHS Terms and Conditions of Service Handbook.

Senior managers on Agenda for Change terms and conditions are employed on substantive contracts subject to three months' written notice by the individual and statutory notice by the Trust. No contract contains clauses specifying termination payments which are in excess of contractual obligations.

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State. Therefore, it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. Further details can be found in note 10 of our annual accounts.

Salary and Benefits of Board Members 2025/26

Single Total Figure Table

		a	b	c	d	e	Total
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	Pension related benefits ⁽¹⁾ (bands of £2,500)	 (bands of £5,000)
Name and Title	Year	£0	£0	£0	£0	£0	£0
Non Executive Directors							
Graham Russell	2025/26	45-50	700	0	0	0	45-50
Chair (from 01/05/24)	2024/25	40-45	800	0	0	0	45-50
Dr Stephen Alvis	2025/26	15-20	400	0	0	0	15-20
	2024/25	10-15	200	0	0	0	10-15
Nicola de longh	2025/26	15-20	0	0	0	0	15-20
	2024/25	15-20	0	0	0	0	15-20
Bilal Lala	2025/26	15-20	200	0	0	0	15-20
	2024/25	10-15	100	0	0	0	10-15
Vicci Livingstone-Thompson	2025/26	10-15	100	0	0	0	10-15
(from 01/05/25 - previously Associate NED)	2024/25	10-15	100	0	0	0	10-15
Debbie Forster	2025/26	00-05	0	0	0	0	00-05
(from 26/01/26)	2024/25	0	0	0	0	0	0
Karen Clements	2025/26	00-05	0	0	0	0	00-05
(from 02/03/26)	2024/25	0	0	0	0	0	0
Sumita Hutchison	2025/26	10-15	100	0	0	0	10-15
(end 13/01/26)	2024/25	10-15	200	0	0	0	10-15
Rosi Shepherd	2025/26	10-15	0	0	0	0	10-15
(end 06/02/26)	2024/25	00-05	0	0	0	0	00-05
Jason Makepeace	2025/26	05-10	0	0	0	0	05-10
(end 31/10/25)	2024/25	10-15	0	0	0	0	10-15
Associate Non Executive Directors							
Dr Cathia Jenainati ⁽²⁾	2025/26	0	0	0	0	0	0
	2024/25	0	0	0	0	0	0

Executive Directors							
Douglas Blair ⁽¹⁾⁽⁴⁾ Chief Executive	2025/26	195-200	15000	0	0	152.5-155	365-370
	2024/25	175-180	17300	0	0	7.5-10	200-205
Sandra Betney Director of Finance/Deputy Chief Executive	2025/26	170-175	0	0	0	62.5-65	235-240
	2024/25	165-170	0	0	0	17.5-20	185-190
Amjad Uppal ⁽²⁾⁽⁴⁾ Medical Director	2025/26	220-225	8100	0	0	50-52.5	280-285
	2024/25	215-220	12100	0	0	75-77.5	300-305
Sarah Branton Chief Operating Officer (from 04/11/24)	2025/26	135-140	0	0	0	95-97.5	230-235
	2024/25	50-55	0	0	0	0	50-55
Neil Savage Director of HR & Organisational Development	2025/26	140-145	100	0	0	55-57.5	195-200
	2024/25	135-140	0	0	0	15-17.5	150-155
Nicola Hazle ⁽⁴⁾ Director of Nursing, Therapies & Quality (From 03/06/24)	2025/26	125-130	11800	0	0	37.5-40	175-180
	2024/25	100-105	0	0	0	115-117.5	220-225
Rosanna James Director of Improvement and Partnerships (From 04/11/24)	2025/26	135-140	0	0	0	30-32.5	165-170
	2024/25	50-55	0	0	0	0	50-55
Senior Manager							
Helen Child Director of Corporate Governance (from 02/03/26)	2025/26	05-10	0	0	0	0-2.5	10-15
	2024/25	0	0	0	0	0	0
Lavinia Rowsell ⁽⁴⁾ Director of Corporate Governance/Trust Secretary (to 05/01/26)	2025/26	80-85	3900	0	0	15-17.5	100-105
	2024/25	105-110	0	0	0	27.5-30	130-135

- (1) These figures include the effects of back pay relating to the previous year (2024/25), which was paid as part of an 'earn back' provision. This contractual provision was removed during 2025/26 as it was no longer a requirement in the new Very Senior Manager pay framework.
- (2) The post of Medical Director is a split role with 12 programmed activities (PAs). Dr Uppal has 8 PAs for his Medical Director (MD) role and 4 PAs for his Consultant Psychiatrist (Clinical) role. Dr Uppal has additional roles of Caldicott Guardian and Responsible Officer in the Trust. From Gloucestershire Health and Care NHSFT he received remuneration, including salary sacrifice, of £165–170k for his Medical Director role, and remuneration of £60–65k for his clinical work during 2025–26.
- (3) Dr Cathia Jenainati holds an Associate Non-Exec Director post with the appointee nominated by the University of Gloucestershire with the key objective of enhancing joint working between the Trust and the University. The appointee remains employed by the University at all times during the appointment. As such the appointment is an honorary unpaid position but the Trust will reimburse reasonable expenses.
- (4) Expense payments (taxable), includes Salary Sacrifice amounts when applicable.
- (5) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Pension Entitlement of Senior Managers – Pension Benefits

Name and Title	Real Increase in Accrued Pension during current financial year	Real Increase in Lump Sum during Current Financial Year	Accrued Pension as at 31 March 2026	Accrued Lump Sum as at 31 March 2026	CETV as at 31 March 2025	CETV as at 31 March 2026	Real Increase in CETV during current Financial Year	Employers contribution to stakeholder pension
	Bands of £2500	Bands of £2500	Bands of £5000	Bands of £5000	£000	£000	£000	£00
Douglas Blair - Chief Executive	7.5–10	12.5–15	65–70	160–165	1,237	1,431	149	-
Sandra Betney - Director of Finance/Deputy Chief Executive	2.5–5	2.5–5	75–80	185–190	1,692	1,825	84	-
Amjad Uppal - Medical Director	2.5–5	-	65–70	150–155	1,443	1,551	58	-
Sarah Branton - Chief Operating Officer	5–7.5	7.5–10	45–50	115–120	894	1,020	94	-
Neil Savage - Director of HR & Organisational Development	2.5–5	0–2.5	60–65	155–160	1,388	1,498	69	-
Nicola Hazle - Director of Nursing, Therapies & Quality	2.5–5	0–2.5	40–45	100–105	772	836	35	-
Rosanna James - Director of Improvement and Partnerships	0–2.5	2.5–5	35–40	75–80	595	653	31	-
Helen Child - Director of Corporate Governance (from 02/03/26)	0–2.5	-	0–5	-	-	2	1	-
Lavinia Rowsell - Director of Corporate Governance/Trust Secretary (to 05/01/26)	0–2.5	-	10–15	-	153	184	11	-

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

Median Pay

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

There has been no change to the highest paid director during the year with the Medical Director being the highest paid director in 2024/25 and 2025/26. The banded remuneration of the highest-paid director in Gloucestershire Health and Care Foundation Trust in the financial year 2025-26 was £220,000 to £225,000 (2024-25, £215,000 to £220,000). This is a change between years of 2.3%.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration bands in 2025-2026 was from band £10,000 - £15,000 to band £220,000 - £225,000 (band £10,000 - £15,000 to band £215,000 - £220,000 for 2024/25.) The percentage change in average employee

remuneration (based on total for all employees divided by full time equivalent number of employees) between years is 6.6%. The Trust has used actual spend and WTE numbers for calculating the average employee remuneration, except for agency staff where an estimate of the number of wtes has been derived from the costs and invoices received.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2025/26	25th percentile	Median	75th percentile
Salary component of pay	23,601	31,973	43,768
Total pay and benefits excluding pension benefits	25,497	31,518	52,143
Pay and benefits excluding pension: pay ratio for highest paid	9: 1	7: 1	5: 1

2024/25	25th percentile	Median	75th percentile
Salary component of pay	22,562	31,434	41,054
Total pay and benefits excluding pension benefits	22,403	29,116	42,056
Pay and benefits excluding pension: pay ratio for highest paid	10:1	7:1	5:1

Governors

Governors do not receive remuneration but are paid reasonable expenses in order to perform their role. During the reporting period, Governor expenses totalled £438. In 2024/25, Governor expenses totalled £161.28.

Directors

In 2025/26, 17 directors claimed expenses totalling £9,779. In 2024/25, 19 Directors claimed expenses totalling £12,434.

The above information has been audited.



Douglas Blair
Chief Executive

18 June 2026

GHC Colleagues

On 31 March 2026, we employed 6,306 people across a variety of professions, including doctors, dentists, nurses, Allied Health Professionals, social workers and support roles.

Our colleagues are categorised as follows:

Permanent employees	4,957
Bank staff	1,039
Others (fixed term temporary staff and locums)	310

The following table provides a breakdown of the number and percentage of **female and male colleagues**:

Board Members	Employees	Percentage
Female	8*	60%
Male	6	40%

*excluding Associate NED

Senior Clinicians/Manager (Band 8c and above) (Excludes Executives, bank staff, temporary staff and locums)	Employees	Percentage
Female	118	61%
Male	77	39%

Total staff (Up to Band 8b) (Permanent staff only)	Employees	Percentage
Female	4,249	84%
Male	816	16%

Sickness absence and turnover data

Data items: The Electronic Staff Record (ESR) does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of Full Time Equivalent (FTE)-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Average FTE 2025/6	Adjusted FTE days lost to Cabinet office definitions	Average sick days per FTE	FTE days available	FTE days recorded sickness absence
a	b	c	d	e
4,328.7	51,612.46	11.92	1,579,993.1	83,726.88

$a=d/365$

$b=e/365*225$

$c=e/d*225$

and d and e are from the ESR Data Warehouse

Please see the link to the NHS Digital publication series on NHS Workforce Statistics for information on staff turnover. The link can be found here: [NHS workforce statistics - NHS Digital](#)

Staff Costs

	Group			
	Permanent	Other	2025/26	2024/25
	£000	£000	Total £000	Total £000
Salaries and wages	198,228	-	198,228	184,294
Social security costs	25,355	-	25,355	18,640
Apprenticeship levy	974	-	974	806
Employer's contributions to NHS pension scheme	41,990	-	41,990	38,688
Pension cost - other	-	104	104	121
Temporary staff	-	2,618	2,618	5,123
Total gross staff costs	266,547	2,722	269,269	247,672

Average number of employees (WTE basis)

	Group			
	Permanent	Other	2025/26	2024/25
	Number	Number	Total Number	Total Number
Medical and dental	138	24	163	137
Administration and estates	1,101	37	1,138	1,135
Healthcare assistants and other support staff	1,011	172	1,183	1,165
Nursing, midwifery and health visiting staff	1,323	128	1,451	1,433
Nursing, midwifery and health visiting learners	13	-	13	14
Scientific, therapeutic and technical staff	748	19	766	736
Total average numbers	4,333	380	4,713	4,619

Of which:

Number of employees (WTE) engaged on capital projects	-	-	-	-
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Reporting of compensation schemes - exit packages 2025/26

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	3	-	3
£10,000 - £25,000	4	-	4
£25,001 - 50,000	4	-	4
Total number of exit packages by type	11	-	11
Total cost (£)	£228,000	£0	£228,000

Reporting of compensation schemes - exit packages 2024/25

One exit package was agreed in 2024/25 which was under £10,000 for a TUPE redundancy payment

Equal Opportunities

We continue to meet our responsibilities as part of the Public Sector Equality Duty (PSED) that are outlined in the Equality Act 2010. As part of GHC's ongoing commitment to Equality, Diversity and Inclusion the Trust has a dedicated Equality, Diversity and Inclusion Lead, based within the Organisational Development (OD) and Leadership Development Team. The postholder works closely with our Freedom to Speak Up Lead, Health and Wellbeing programmes and represents the Trust in ICS activity across Gloucestershire and more widely within the South West.

Our Director of Human Resources and Organisational Development ensures that equality and diversity is represented at all levels of our organisation including at Board level. We work within the parameters of the NHS Equality Delivery System and recognise the diversity of the community we serve, making every effort to engage with communities to ensure high quality care is received by all.

We have implemented both the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES). These are tools to identify gaps in the work experiences of colleagues from ethnic minorities or those who identify as disabled. We review the related data regularly and take actions where we can improve. In support of our ambitions on equality, diversity and inclusion outlined in our Diversity and Inclusion Policy which was developed in partnership with our trades unions.

The Trust has a breadth of systems in place to enable anyone who may experience discriminatory or other forms of unacceptable behaviour to seek support and resolution. These include our "Freedom to Speak Up Guardian" and a cohort of champions, and "Direct to Douglas". The Trust Diversity Network is well established, with the support of a range of specialist networks that focus on supporting and providing a voice for minorities such as our Race and Cultural Awareness Network, Disability Awareness Network, LGBTQI+ Rainbow Network, Veterans' Group, as well as a dedicated Women's Leadership Network. Through the overarching Diversity Network and these additional networks, we are working to ensure all colleagues have a strong voice, feel valued and supported and that key Trust decisions are informed by lived experience and developed in collaboration. Additionally, in 2024, we launched our Internationally Educated Nurses Council, to provide a listening, support and engagement forum for colleagues who trained in other countries. We also launched a new Anti-abuse Roadmap and resources alongside rolling out cultural competency training.

Alongside the afore-mentioned feedback routes, indicators within the Staff Survey, Pulse Surveys, the quarterly Staff Friends and Family Test, WRES and WDES inform the actions we take to address inequality and poor experience. We are proud to maintain our Disability Confident Leader status and pride ourselves on ensuring all reasonable adjustments are made to the work environment to enable colleagues to remain in work and prosper. Our

values-based and candidate centred recruitment processes supports candidates to perform to the best of their ability throughout their recruitment journey.

We have complied with the national Gender Pay Gap reporting requirements and have an associated action plan to address the issues identified. The reports and associated data have been published on our website here: [Equality, Diversity and Inclusion > Glos Health & Care NHS Foundation Trust](#). At the same time, we complete Disability and Ethnicity Pay Gap reports and have related action plans for progressing these.

From a training perspective, we provide Equal Opportunities in our on-boarding induction process, provide access to Equality and Diversity and Human Rights e-learning with high completion compliance, Recruitment training with a focus on EDI requirements and good practice, alongside the provision of additional specialist training from our Social Inclusion Team.

Our Leadership and Culture Programme has completed its Discovery Phase in 2025/26 and activities will now be aligned with implementation programmes flowing from our new People Strategy.

Health and Wellbeing

Working Well is our occupational health service. The service promotes, monitors and helps improve the health and wellbeing of people in work – both within our Trust and for a variety of external public and private sector organisations. Working Well is accredited fully to the 'Safe Effective Quality Occupational Health Service' (SEQOHS) national quality standards set by the Faculty of Occupational Medicine. This accreditation provides independent and impartial recognition that Working Well has objectively demonstrated its competence, as defined by the SEQOHS standards, to a team of trained assessors.

The service offers independent advice both to managers and employees, which includes guidance on how to support people to stay in work, how to return to work safely following a period of absence, as well as assessments of the health risks associated with the workplace. The team also supports colleagues with advice and guidance regarding vaccination and other requirements.

The service has a Talking Well team of counsellors and therapists who provide face to face and virtual support for all GHC colleagues, volunteers and family members. Our counselling services provide a wide range of services from Integrative Counselling, Acceptance and Commitment Therapy, Compassion Focused Therapy, Cognitive Behaviour Therapy and Eye Movement Desensitisation and Reprocessing.

Working Well continues supporting our annual flu vaccination programme. Working Well has a specialist proactive physiotherapy team that provides specialist occupational health physiotherapy advice and guidance to teams and individuals across the Trust. Working Well also provides a rapid access physiotherapy treatment service to ensure our people receive timely support for musculoskeletal issues.

Through VIVUP, our Employee Assistance programme, we provide additional 24/7 telephone counselling service for all colleagues. Additionally, there is enhanced psychological support, a comprehensive intranet section signposting colleagues to support, alongside health and wellbeing newsletters, a salary finance scheme, and investment in colleague rest areas, including outdoor seating for colleagues to be able to take restful breaks away from their work environment.

Engagement

Colleagues have access to information and are able to contribute views through a number of different communication mechanisms. Our Chief Executive records a weekly message, which is shared Trustwide, and offers “Direct to Douglas” as an engagement opportunity for colleagues. Our weekly colleague e-bulletin is called “Indi-to-go”, and we provide two-way monthly Open Forums, which enable a flow of key information to and from their teams and which are hosted by Directors.

We also publish comprehensive news updates, policies and other information of relevance and interest to colleagues on Indigo – our intranet, which also enables discussion forums. There are a number of other Trust-wide gatherings, such as our Senior Leadership Network and Exec Plus, which act as an opportunity for leaders to be keep up to date with each other and shape key developments. These forums support the development of new ideas whilst providing an opportunity for leaders across the Trust to feedback on the issues that concern them; working together to co-produce solutions.

Our Foundation Trust elected Staff Governors meet regularly with board directors and members of the Corporate Governance team to ensure good engagement, involvement and communications. We also enable colleagues to feedback their views on a range of subjects through regular surveys and the quarterly national Pulse Survey. We have an established staff Facebook group, with a membership of circa 1600 colleagues.

We work in partnership with non-medical trade union (Staff Side) colleagues through the formal Joint Negotiation and Consultative Forum, which meets bi-monthly. With medical colleagues we meet regularly through the Joint Local Negotiating Committee. In addition, we encourage participation from Staff Side representatives, and colleagues at all levels from across the Trust. These mechanisms are used to consult with colleagues, share Trust performance, seek feedback, to review and create workforce policies and procedures, as well as co-developing initiatives.

Staff Side representatives, including Safety and Equality Representatives, meet regularly with managers to discuss, monitor and share a range of information on health and safety; health and wellbeing; and other related workplace health issues. We also work closely with our Local Counter Fraud Service to ensure policies and procedures are “fraud proofed”. The service provides regular briefings, training and refreshers to colleagues to maintain fraud awareness and best practice.

Speaking Up

We actively promote a speaking up culture, through our Freedom to Speak Up Guardian, who works closely with the National Guardian's Office, reporting regularly to the Trust's Board of Directors.

We firmly believe that to improve safety and make our Trust a great place to work, we need a culture that places less emphasis on blame when things go wrong and more importance on transparency and learning from mistakes.

Our Freedom to Speak Up Guardian is supported by an extensive champions network following The National Guardian's Office guidance. This sets out principles for the development and support of Freedom to Speak Up Champion networks. Engagement and training continue to refresh, raise awareness and promote the value of speaking up and support and signpost colleagues.

Reward and Recognition

The Trust runs annual GHC Awards, to celebrate the outstanding commitment, dedication, care, compassion and expertise of our colleagues. We also hold regular Long Service Awards to highlight the long service of colleagues who have worked for the NHS for 20, 30, 40 or 50 years.

During 2025, as part of our People Promise programme, we introduced monthly Making A Difference Awards, recognising the added value teams made to patients, service users, carers, family, visitors, and other teams.

In addition, several teams and services hold their own award events.

The Apprenticeship and Widening Participation Team co-ordinated National Apprenticeship Week 2026 including awards for apprentices, and new for this year T-Level student of the year and their mentors. Many teams, including Estates and Facilities, present 'Employee of the Month/Quarter' awards. We also promote regional and national awards such as the NHS Excellence Awards and regularly submit nominations.

The Trust actively celebrates national profession days such as International Nurses Day, with promotional campaigns to highlight and thank individuals who consistently make a difference to the communities we serve.

Staff Survey and Friends and Family Recommendations

Commentary

In 2025, 2,643 colleagues completed the National NHS Staff Survey representing a 51% response rate broadly in line with the sector median. That level of participation reflects a genuine and ongoing commitment among our people to share their experiences and shape how we improve.

The results come at a significant moment for the Trust, 2025 has been a year of considerable change - organisational, operational and strategic. Colleagues have navigated system-wide

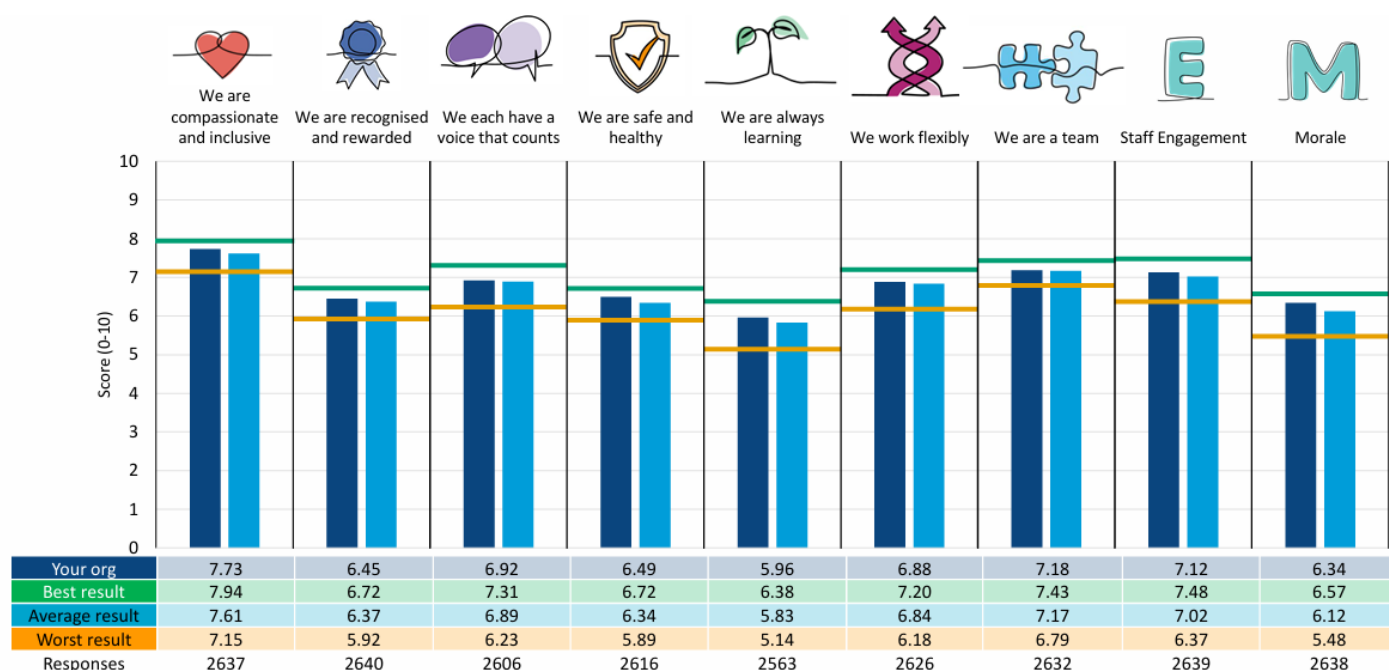
integration, transformation programmes and ongoing workforce pressures, while continuing to deliver compassionate care.

We compare our performance with a group of similar NHS organisations, mental health, learning disability and community providers, which allows for benchmarking in terms of where we stand nationally and regionally. GHC performs at or above the national sector average across all nine People Promise elements and themes, a consistent position we have held across the past three survey cycles. Regionally, the picture is even stronger, within our South West benchmarking group of similar NHS organisations, GHC reports the highest scores for both Staff Engagement and Morale and ranks among the top performers across seven of the nine People Promise domains. Overall, colleagues rated the Trust the top performing NHS provider employer amongst all South West NHS Provider Trusts.

Summary of performance

The 2025 NHS Staff Survey continues to use the People Promise as the basis for measuring experience, with the two additional themes of Staff Engagement and Staff Morale. All scores referenced below are weighted (as per the national methodology), ensuring comparability with other Trusts.

The Trust's scores for 2025 People Promise themes were all above the sector average ratings and are detailed below:



Staff Friend and Family Tests

Two indicators stand out as among our strongest results, and the most meaningful: how many colleagues would recommend GHC as a place to work, and how many would recommend us as a place to receive care. For both areas, the Trust's performs above the sector, regional and national average.

69.8%

would recommend GHC as a place to work

Sector average: 62.4% | +7.4 percentage points above sector

75.7%

would recommend GHC as a place for care

Sector average: 64.3% | +11.5 percentage points above sector

Three-Year Performance

There has been gradual and minor reduction in ratings across several People promise indicators over the past 3 years, including compassionate and inclusive, recognised and rewarded, a voice that counts, we are always learning and we are a team. We are committed to reverse that direction of travel through the focused priorities set out in our forthcoming People Strategy 2026–2031.

People Promise /Theme	2023	2024	2025
We are compassionate and inclusive	7.80	7.75	7.73
We are recognised and rewarded	6.53	6.48	6.45
We each have a voice that counts	7.11	7.00	6.92
We are safe and healthy	6.51	6.49	6.49
We are always learning	6.05	6.05	5.96
We work flexibly	6.83	6.83	6.88
We are a team	7.23	7.21	7.18
Staff Engagement	7.27	7.18	7.12
Staff Morale	6.38	6.35	6.34

Where We Perform Well

Colleagues continue to rate the Trust positively across the People Promise themes, with scores remaining consistently above the sector average:

- Compassionate & Inclusive Culture (7.73) — one of our most enduring strengths, and significantly above the national average
- Teamworking (7.18) — reflecting the strong local team identity that colleagues consistently describe
- Flexible Working (6.88) — above average and improving year on year
- Diversity & Equality (sub-score 8.71) — among the highest scores in our results

Emerging Themes – Where we will focus

Four areas stand out as requiring focused attention from the 2025 staff survey. These areas of focus have also been identified as part of a wider data analysis exercise carried out to inform the refresh of the Trust's People Strategy. The areas of focus are:

- **Wellbeing, Capacity and Burnout**

While the Trust is rated well in comparison with the sector benchmark and wider NHS providers, too many colleagues tell us that work regularly feels overwhelming. Conflicting demands on time, difficulty switching off, and a sense that there are never quite enough hours or people to do the job well. Through our People Strategy theme *A Safe, Inclusive and Healthy Workplace*, we have committed to prioritising the health and wellbeing of every colleague and actively managing workloads so everyone can do their best work.

- **Voice, Psychological Safety and Raising Concerns**

Colleagues need to feel genuinely safe to speak up about concerns for patients, about their own experience, and about things that aren't working. This year's survey shows that while the Trust benchmarks well in comparison with peers and the wider NHS, not all colleagues feel that confidence, and that fewer people believe the organisation will act on what they raise. Through our People Strategy theme *Great Leadership and Culture*, we have committed to strengthening staff voice, meaningful involvement in decision-making, and fostering a culture where we learn from experience and continuously improve.

- **Learning, Development and Career Progression**

Colleagues want to grow and they want meaningful conversations about their development, fair access to learning opportunities, and a sense that there is a future for them at GHC. The survey tells us we are not yet communicating sufficiently about the breadth of offers not are we delivering consistently enough. Through our People Strategy theme *A Workforce Fit for the Future*, we have committed to creating clear pathways for colleagues to develop and grow their careers, whilst investing in the development and training of line managers who make that possible day to day.

- **Alignment Between Values and Perceived Organisational Action**

GHC has strong values, and colleagues recognise these and regularly discuss them. What the survey reflects is a growing question about whether what we say always matches what we do, and whether concerns raised are always genuinely heard and acted upon. Through our People Strategy theme *Great Leadership and Culture*, we have committed to growing leaders at every level who live and model our values, and to fostering a culture where actions consistently reflect what we stand for.

Our Commitment from the Survey Feedback

Our refreshed People Strategy 2026–2031, being launched in quarter 1 of 2026, will provide the strategic framework for how we address these focus areas and build on the feedback our colleagues have shared through the survey. Rather than treating the survey as a separate workstream, our response will be embedded within the strategy, joined up, sustained and resourced.

Alongside the organisation-wide approach, each service area is identifying its own two to three local priorities, giving colleagues a stake in how their team responds.

Progress against plans and key performance indicators will be overseen by Executive Directors, the Workforce and Organisation Management Group and the Board's Great Place to Work Committee throughout the following year.

Expenditure on consultancy

In 2025/26 our consultancy cost totalled £0k. During 2024/25 our consultancy cost totalled £26k.

Political Donations

The Trust does not make political donations.

Off-payroll engagements/arrangements

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater	
Number of existing engagements as of 31 March 2026	4
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	1
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	2

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2026	0
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in scope of IR35 *	0
Subject to off-payroll legislation and determined as outof-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	20

Exit packages

We are required to publish information on our use of exit packages during the year, with comparative tables for the previous year.

Reporting of compensation schemes - exit packages 2025/26

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	3	-	3
£10,000 - £25,000	4	-	4
£25,001 - 50,000	4	-	4
Total number of exit packages by type	11	-	11
Total cost (£)	£228,000	£0	£228,000

In 2025/26 following the closure of a service 3 employees had exit packages agreed under NHS redundancy term and conditions. When another service was transferred to us, 8 employees had exit packages agreed under TUPE guidance.

Reporting of compensation schemes - exit packages 2024/25

One exit package was agreed in 2024/25 which was under £10,000 for a TUPE redundancy payment

One exit package was agreed in 2024/25 which was under £10,000 for a TUPE redundancy payment.

Early retirements due to ill health

During 2025/26 there were 3 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £72k (£201k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Compliance with the Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts (the Code of Governance) was published in October 2022 and has been applicable since 1 April 2023.

The Code of Governance sets out a common overarching framework for the corporate governance of NHS providers (being NHS Trusts and NHS Foundation Trusts), reflecting developments in UK corporate governance and the development of Integrated Care Systems. Providers must comply with each of the provisions of the code or, where appropriate, explain in each case why the provider has departed from the code.

NHS Foundation Trusts are required to provide some disclosures in their annual report to meet the requirements of the Code of Governance. Schedule A of the Code of Governance summarises the relevant provisions in the document.

The table below replicates schedule A to the Code of Governance to list the required disclosures. It also includes some requirements not listed in schedule A to the Code of Governance but are required by the Foundation Trust Annual Reporting Manual.

Reference	Code of Governance requirement	Trust response
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Strategically the board has agreed 5 focus areas for 2026-2031: Neighbourhood Health, Children's and Young People, Urgent Community Care, Inclusive Healthcare and Purposeful Partnerships. The Trust have formed a Provider Partnership with Gloucestershire GP Collaborative, and Gloucestershire Hospitals NHS Foundation Trust to deliver on the transformation priorities in the Gloucestershire 5 Year Population Health and Strategic Commissioning Plan. The partnership will deliver on three flagship areas: older people living with frailty and dementia, transforming care for people with multiple long-term conditions and expanding community mental health and crisis care for people of all ages to deliver the ambitions of the national Neighbourhood Health Framework. Our colleagues in Gloucestershire County Council are also recognised as key delivery partners to the partnership, alongside a commitment to work with the wider VCSE sector across Gloucestershire. Neighbourhood working inherently requires collaborative delivery with other providers, supporting the board's duty to address shared challenges through partnerships and provider collaboratives. This model is also a core mechanism through which a trust contributes to the priorities of the ICP, ICB and place-based partnerships. Neighbourhood teams operationalise system objectives such as tackling inequalities, improving population health, supporting flow and reducing demand. By working seamlessly with primary care, social care and the voluntary sector, neighbourhood health

		demonstrates how the trust aligns its strategy with wider system ambitions. We are active members of the six geographically defined Integrated Locality Partnership (ILP) forums and have participated in the approach to take forward Integrated Neighbourhood Teams in conjunction with our Primary Care Networks (PCN). The Trust took on delegated responsibility for the delivery of the Community Mental Health Transformation programme. We now support three locality community partnerships covering the six ILP's working alongside 16 PCN's and a range of voluntary sector organisations across the county. We are currently operating effectively in two MH provider collaboratives – The South West Provider collaborative hosted by Devon Partnership NHS FT covers Adult Secure/Learning Disability and perinatal services and the Thames Valley Provider Collaborative in the South-East hosted by Oxford Health NHS Trust providing Children and Adolescent Mental Health/Eating Disorders services. The Board reviews the opportunities and risks associated through clear tender assessment processes and via our business planning processes with all risks captured and reviewed, through operational and clinical governance, feeding the Strategic level risks captured under the Board Assurance Framework.
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	The Board assesses and monitors culture via the Great Place to Work Committee. The committee oversees delivery of the People Strategy and colleague health and wellbeing. In its overseeing, it utilises the annual Staff Survey, quarterly Pulse Surveys, Friends and Family Tests, plus ad hoc engagement and surveys alongside action plans. Additionally, 6-monthly Freedom to Speak Up Guardian and Guardian of Safe Working reports and actions are reviewed. In response to a previously reported rise in experiences of discrimination in a previous year's Staff Survey, the Trust established a leadership and culture programme in 2025 to focus on improving our culture, leadership and to tackle racial and other forms of discrimination. A short-term Board Assurance Committee to oversee this work commenced in April 2025. Survey results in 2025 showed reduced discrimination at work from patients and service users, their relatives or other members of the public, and from managers and team leader or other colleagues compared with 2024. The Trust continues to deliver, develop and invest in a wide range of health and wellbeing resources

		through its Working Well and Talking Well services alongside an Employee Assistance Programme.
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	The Trust is committed to working in partnership and co-producing services with the people who use our services, stakeholders and partners. Our Working Together Plan (2021-2026), due for review in 2026, outlines the GHC approach to how we listen to, involve, and work with people and communities we serve. The Working Together Network was launched in October 2025 as the primary mechanisms to drive forward the Working Together Plan. The Network continues to report directly to the Trust Board to advise, influence and organise activities to achieve the Trust's strategic goal to embed a culture of working together. The network seeks to develop and improve how the Trust listens, understands, and responds to the voice of the people and communities we serve with an emphasis on promoting healthcare equity. To achieve this we are co-developing and testing several new approaches, including: Board community insight event – a locality based listening event to promote learning about local assets, population health and healthcare inequity co-delivered local people and community groups; service-based co-production self-assessment tool; improving communication and feedback loops using a network of networks; actively involving Trust governors and members. Significant transformation programmes (e.g. Community Mental Health Transformation) have a Partnership Board that oversees the delivery of the objectives of the programme and also a Patient Representation Action Board whose membership comprises of individuals who have used our services and is hosted by Inclusion Gloucestershire to provide an independent voice into our transformation programme. Key partnerships and collaborations include; • Gloucestershire Provider Partnership • 6 district level Integrated Locality Partnerships • 2 regional provider collaboratives • Delivery of specific services in sub-contract/partnership arrangements e.g. sexual health delivered with First Light • Significant Transformation activities including redesign of Adult LD pathways with co-production approach involving people with Lived Experience
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to	This information can be found on page 41 of the Annual Report.

	impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance	This information can be found on page 47 of the Annual Report.
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	The Trust's Scheme of Delegation sets out the roles and responsibilities of the Board of Directors, its Committees, the Council of Governors and executive management. Any disputes between the Board and the Council are resolved in accordance with the procedure set out in the Trust's constitution. Details of how the Board and the Council of Governors operate are given in pages 51 of this Annual Report.
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	This information can be found on page 72 of the Annual Report.
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee	The role of the Governors' Nominations & Remuneration Committee (For Non-Executive Director terms and conditions) can be found on page 54 of the Annual Report. This includes a summary of the work that has taken place in

	should be set out in publicly available written terms of reference.	2025/26. The TOR for the Committee are available on request and are presented at a public Council of Governors meeting, papers for which are available on the website.
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	This information can be found on page 41 of the Annual Report.
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	An External Well Led Review was conducted in May 2022. The process is currently underway to secure a provider for our next Review, planned for Q1 or Q2 2026/27.
C 4.13	The annual report should describe the work of the nominations committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives - the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served - the gender balance of senior management and their direct reports.	The role of the Trust's Appointments and Terms of Service Committee (For Executive Director terms and conditions) can be found on page 55 of the Annual Report. This includes a summary of the work that has taken place in 2025/26.
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	A joint Board and Governor development session took place in July 2025 as part of the extensive engagement on the Trust Strategy refresh. Feedback from Governors was considered in developing the final version of the document (published September 2025). A Governor and NED session also took place in January 2026 to provide comment on the process and content of the Trust's annual business plan, on behalf of the Trust's members, public, and key stakeholders.
D 2.4	The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed	This information can be found on page 48 of the Annual Report.

	• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	This information can be found in our Accountability Report which starts on page 31 of the Annual Report.
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	This information can be found in our Accountability Report which starts on page 31 of the Annual Report..
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	This information can be found in our Accountability Report which starts on page 31 of the Annual Report.
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare	This information can be found on page 105 of the Annual Report.
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report	This information can be found on page 55 of the Annual Report.

	should include a statement as to whether or not the director will retain such earnings.	
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	This information can be found on page 51 of the Annual Report.
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	This information can be found on page 51 of the Annual Report and is available on the Trust's website.
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations	All Board members can attend Council of Governor meetings, and NEDs are required attendees. Two joint development sessions take place each year with the NEDs and Council. Our NEDs have a lead for each locality and our public Governors from that locality are encouraged to link in with them to discuss matters of mutual interest. Executive Directors regularly attend Council meetings to provide reports of interest and were also part of a joint Board session with Governors in July 2025 as part of the Trust Strategy refresh.
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not relevant. This power has not been exercised.

Gloucestershire Health and Care NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis.



Douglas Blair
Chief Executive

18 June 2026

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- b) considering financial override which may limit a segment to be no better than 3
- c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
- d) capability assessments which consider the organisation's leadership and governance.

The Trust ended the year with a segmentation rating of 2 under NHS England's National Oversight Framework.

This segmentation information is the Trust's position as at June 2026.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables. The Trust is included on the acute / ambulance / non-acute hospital trust dashboard.

Statement of Chief Executive's Responsibilities as the Accounting NHS Officer of Gloucestershire Health and Care NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Gloucestershire Health and Care NHS Foundation Trust to prepare for each financial year a Statement of Accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Gloucestershire Health and Care NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year. In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Douglas Blair, Chief Executive

Date: 18 June 2026

Annual Governance Statement

For the period 1 April 2025 – 31 March 2026

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks of the achievement of the policies, aims and objectives of Gloucestershire Health and Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gloucestershire Health and Care NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts.

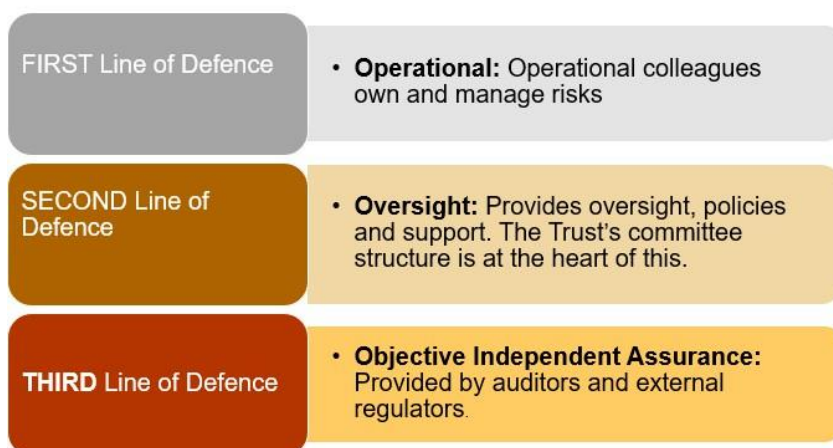
Capacity to handle risk

The Trust has a dynamic and proactive approach to risk management. The Risk Management approach supports timely identification, assessment, mitigation and management of both clinical and non-clinical risk to the achievement of the operational and strategic objectives of the Trust. It explains that risk management is everyone's responsibility.

Risk is regularly reviewed at all levels within the Trust with oversight provided from a named Executive Director and assurance provided via the Trust's governance committee structure. The Trust has in place policies and procedures designed to ensure the safety of colleagues and people who use our services, supported by a suite of statutory and mandatory training.

The Trust operates a three lines of defence model for managing risk:

Lines of Defence



The Risk and Control Framework

Identification, evaluation and control of risk

Risk management principles and practical risk management arrangements, including the duties of relevant committees, directors, managers, clinicians, specialist advisors and individual employees, are set out in the Trust's Risk Management framework. All colleagues are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust and as professionals working to professional codes of conduct. The Board promotes a culture of openness in reporting without fear of unwarranted repercussions. The framework is underpinned by procedures, guidance documentation and training resources that contribute to the management and control of risk including the risk and incident reporting arrangements via Datix.

The Risk Management framework sets out a process for the assessment and prioritisation of risks and the level at which risks must be escalated and ensures that mitigating actions are in place and working. The framework is kept under regular review and updated as necessary to reflect good practice and changes in practice externally and lessons learned and feedback received. The Board ensures an appropriate level of independent assurance is provided on the whole process of risk identification, evaluation, transfer and control.

Identification and assessment

All colleagues within the Trust are trained to enable them to identify and raise a risk. Risks may be identified via the following:

- Direct observation of or identification of risks in the workplace
- Board and Committees
- Internal risk assessments
- Trends in incidents and concerns
- Counter Fraud
- Internal audit
- Emergency preparedness and Health and Safety routes

Assessment and treatment

- NHS National Patient Safety Agency (NPSA) matrix adopted for assessing and analysing risk
- All risks recorded via Datix
- Risk owners lead the design of controls, consideration of transfers and mitigations to manage risk to acceptable level

Managing and monitoring supporting control, mitigation and learning from good practice

- Regular review by risk owner and directorate risk lead
- Risk Manager review
- Monthly review via directorate governance groups
- Oversight by Executive Lead
- Quarterly review via Risk Management Group and Executive Team
- Quarterly review via Audit and Assurance and other Trust Governance Committees
- Board oversight of the overall Risk Management operation
- Communication through the governance framework of good practice identified through risk management processes

Where appropriate risk transfer via insurance or contractual arrangements is considered. The Trust participates in the NHS Resolution Scheme to cover clinical negligence claims and public liability.

Mechanisms are in place for engaging with partner organisations to ensure information on key risks is regularly exchanged, including within the Gloucestershire Integrated Care Board (ICB), and Gloucestershire County Council. Whenever possible and appropriate the Trust works jointly with these partners to manage risks. The Audit Committee Chairs of the main system provider partners of the ICB are members of the ICB Audit Committee to support joint understanding and oversight of system risks.

Risk appetite and the Board Assurance Framework

The Board has set its Risk Appetite in line with good practice guidance following comprehensive consideration by the Board. The Risk Appetite is kept under ongoing review and informs the management of Risk through the organisation both within the Corporate Risk Registers and the Board Assurance Framework. The Risk Appetite was last comprehensively reviewed and updated in September 2023. A review of this has been undertaken in 2026, with revisions agreed by the Board in May 2026.

The NHS Foundation Trust Code of Governance sets out the responsibility of the Trust to maintain a sound risk management system and determine the nature and extent of the risks it is willing to take in order to achieve its strategic objectives. The Board Assurance Framework (BAF) is the principal document that identifies, captures, and monitors the ongoing risks to the implementation and achievement of the strategic objectives of the Trust. It sets out the controls and assurances in relation to those risks identified.

Strategic risks are identified by Directors and are aligned to the Trust's outline strategic objectives. Each risk will have a nominated Executive Lead and will be assigned to Board or a Board Committees for consideration to provide appropriate visibility, monitoring and assurance. The BAF is used to drive the agendas and areas of focus of the Board and its committees. The development and maintenance of the BAF is the responsibility of the Director of Corporate Governance (Company Secretary).

As at the end of March 2026 there were 11 risks on the BAF as follows:

Risk Title	Score	(Likelihood x Impact)
Quality Standards	9	3x3
Demand and Capacity	12	4x3
Recruitment and Retention & Development	9	3x3
Inclusive Culture	12	3x4
Relationships & Partnership Working	9	3x3
Funding for Transformation	12	4x3
Capacity for Change	16	4x4
Cyber	12	3x4
Closed Culture	12	3x4
Health Inclusion	12	3x4
Strategic Commissioning Partnerships	12	3x4

Sustainability Risks remain under ongoing review and scrutiny.

On 31 March there was one risk on the BAF with a risk rating of High (16). This is shown below along with key mitigations:

Risk	Mitigations	Assessment
There is a risk that the Trust is unable to adapt in an agile manner to the rapidly changing policy environment and needs and expectations of the population resulting in opportunities for improvement being missed or delayed impacting on the quality services provided.	• Strategic Refresh delivers clarity on future priorities allowing change activities to be delivered within framework. • Influence external policy environment • Review of enabling strategies undertaken • Business plans linked to strategy and delivery of 5-year plan • Agreed plans in place for delivery of future priorities which reflect best practice/co-production • Review of effectiveness of organisational Innovation and Transformation and approaches and governance • Operational restructure • Enabling and empowering senior leaders	Range of work to progress these mitigations is ongoing through the Trust. Strategy approved by Board Sept 25 and being progressed. Methodology agreed by Executives. Key milestones agreed. These are being built into Board Development schedule. Business planning process ongoing. Deep dives into transformation programme are ongoing and the project transformation framework is undergoing development. Internal Audit work in quarter 1 of 2026 supported this review process. New leadership arrangements recognising COO's coming departure in development.

Performance Information

The Trust's Business Intelligence (BI) Team supports Operational and Corporate services with information reports that identify data quality risks and provide service performance insight to inform decision and assurance. The Business Information Management Group (BIMG) meets regularly to consider the performance of the organisation across all aspects of data activity to ensure that services are delivered to the highest possible standards for patients and service users. Various Clinical System User Groups provide forums to engage with users and ensure that data quality issues and training needs arising from the use of the Electronic Patient Record Systems can be tackled consistently across all Trust services.

In performing this function, the BIMG engages with senior leaders, stakeholders and information user groups who utilise information reporting systems data to identify risk, resolution and inform clinical and management decisions. It ensures that systems are in place through an integrated business platform (Tableau) for the effective performance management of contracts and services, and to support continuous improvement and service development.

BIMG acts as an assurance function to the Trust's Resources Committee and provides a forum for escalation of risks and issues that have not been resolved at a service delivery level. The performance reports produced by the BI service are subject to robust challenge from management and the Board.

To support this, Service Directors and managers meet regularly with their respective teams to discuss any performance, finance and quality concerns to inform the corporate awareness to developing risks and identify potential issues. These are through a combination of monthly Business Meetings and monthly Performance & Risk meetings at both a Directorate and Service Group level. Review meetings are held regularly with commissioning colleagues to provide assurance, offering early warning of any potential quality or performance issues, and seek joint solutions where appropriate. Collectively this ensures accurate reporting to the Trust Board against local and national operational and contractual targets.

Quality Governance

The Trust has robust arrangements in place to monitor and improve the safety, experience and effectiveness of care provided to those who use our services.

The Board is supported in identifying risks to quality through the work of its committees, notably the Quality Committee which reviews quality matters on a bi-monthly basis supported by a monthly management meeting, which undertakes detailed scrutiny of safety and quality issues and provides onward assurance. The Audit and Assurance Committee also consider quality and the governance processes, supported by a programme of internal audits.

Aspects of quality which are considered higher risk are included in the clinical audit and assurance programme, with action plans arising from these audits being monitored by the appropriate committee to ensure implementation and delivery of the intended outcome.

Board agendas include standing items relating to quality, including reports on Patient Safety and Serious Incidents, Learning from Deaths, and the Quality Report. A comprehensive monthly performance dashboard provides timely monitoring information on all quality targets, and data

assurance processes are in place to ensure that quality information presented to the Board is robust. The Quality Committee and Board receive regular updates on safe staffing levels in inpatient wards.

The Board takes an active leadership role in quality to promote a quality-focused culture throughout the Trust, and Non-Executive Directors participate in a programme of service/quality visits. Executive Directors visit clinical and non-clinical sites regularly.

The Medical Director and Director of Nursing, Therapies and Quality take the executive lead for quality and for assessing Quality Impact Assessments in respect of cost improvement programmes and service change to ensure any adverse quality and safety impacts are mitigated. The Director of Nursing, Therapies and Quality is the lead Executive for service experience and complaints. The organisation is structured to enable quality accountability in appointed Clinical Directors, Heads of Profession, and Lead Nurses. A Quality Management Team provides support in embedding this quality culture and ensuring that learning is captured from complaints, incidents and other initiatives.

The Trust actively engages with patients, colleagues and other key stakeholders on quality; the Quality Report and public Board papers are publicly available, shared with stakeholders and feedback is encouraged and provided within the Annual Quality Report. The Board receives a 'service user story' at each meeting in public, providing an opportunity for the Board to hear first-hand service users' experience of the Trust's services. The Council of Governors' agenda also includes regular items on services and quality issues.

The Trust is committed to comprehensive stakeholder engagement, as is set out within this statement, to improve and shape our services. Regular surveys of service users inform the quality debate and help to ensure quality of service.

CQC Registration

Assurance on compliance with CQC registration requirements is reported and monitored regularly through governance structures within the Nursing and Therapies Directorate reporting to the Quality Committee which in turn reports to Board. Regular quality and performance reports, the Quality Account and exception reporting are presented to Board to ensure that Directors are informed of key quality issues relating to patient experience, patient safety and clinical effectiveness.

The last CQC Core and Well-Led inspections were undertaken in April and May 2022, resulting in an overall rating of "Good". All actions from this inspection have been completed and in Q3 of 2024 the Trust's Quality Team undertook fidelity checking process to ensure that all actions have been embedded in clinical practice areas.

In October 2023 Berkeley House, our ward for People with Learning Difficulties and Autism, received an Inadequate rating and the Trust was also issued with a Section 31 notice. The service was reinspected in July 2025, and we await the final report due to an extended period of factual accuracy with CQC.

During 2025/26 the CQC continued to complete Mental Health Act visits to mental health and learning disability wards – one Learning Disability ward as part of an overall CQC inspection, and two Older Age Adults wards. Overall, feedback has been very positive, with the older age adult wards having no areas for improvement identified and their exemplary practice noted.

The Trust has a rolling programme of self-assessment for all services in the Trust to determine their regulatory compliance and preparedness, including whether they are Well-Led under the CQC and NHS England well-led framework. These are supplemented by internal peer reviews.

The Trust is prepared that a CQC inspection of core services and a subsequent Well-Led inspection could occur during 2026/27 and preparatory work for this continues with particular focus on areas that have not been inspected for some time.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The next external well-led review of leadership and governance will take place in 2026/27.

Data security risk and information governance

The Trust maintains systems and processes to ensure that all information, but particularly person-identifiable information, is kept safe, accurate and only shared with appropriate authority and lawfulness. The Trust has appointed, at Board level, a Caldicott Guardian and a Senior Information Risk Owner to oversee this. A detailed Annual Report on our Information Governance processes, produced by our Senior Information Risk Owner is available on our website.

The Trust actively encourages the reporting of information governance incidents and near misses. These are investigated internally where it is appropriate to do so, and incident trends and themes are reported to and reviewed by the Information Governance Group.

There were three information governance incidents during 2025/2026 which met the criteria for reporting to the Information Commissioner's Office (ICO). The required steps advised were taken.

We are currently on target to achieve compliance with the Data Security Protection Toolkit 'Standards Met', by the end of June 2026 for our annual submission.

Principal risks to compliance with the NHS Foundation Trust Condition 4 (Foundation Trust Governance)

Compliance with the NHS Foundation Trust Condition 4 requires trusts to 'apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate as a supplier of healthcare services.'

The principal risks of non-compliance are that the Trust's governance structures, and reporting lines are not sufficiently focussed to enable an appropriate level of oversight of the Trust's operations, management and control.

The Trust has actions and processes in place to manage and mitigate these risks.

- (i) The Trust's governance structures are subject to regular review to ensure that they remain fit for purpose and to maintain compliance with relevant legislation, licence conditions and good practice. Committee membership and responsibilities are regularly reviewed and revised where necessary to ensure continued oversight of performance standards.

- (ii) The Trust has a Scheme of Delegation which outlines matters that must be reserved for the Board of Directors and those that may be delegated to a committee of the Board or Executive Director. Each committee of the Board is chaired by a Non-Executive Director and has at least two other Non-Executive members who provide scrutiny and rigorous challenge regarding performance. Performance reporting to the Board and its committees includes indicators relating to statutory and regulatory requirements. Each committee has terms of reference which are reviewed annually.
- (iii) The Trust's Annual Governance Statement also provides assurance to the Board that risks to compliance with the terms of its licence are being appropriately addressed. Before signing off its Annual Governance Statement, the Audit and Assurance Committee, in line with its delegated responsibilities from the Board receives and reviews a detailed report summarising the evidence upon which the Board might rely in making each individual declaration within the Annual Governance Statement. The Board also considers reports it has received through the year and takes account of the work undertaken through the year by its committees in assessing the Trust's performance, overseeing compliance with relevant legislation, and ensuring the efficient, effective and economic operation of the Trust.
- (iv) The Council of Governors provides a further layer of governance to monitor compliance with the license by holding the Trust's Non-Executive Directors to account for the performance of the Board. This is done by focusing on the activities of the Non-Executive Directors in their role as the Chair of one of the Board's Committees and gaining assurance on the operation of the Committees in providing challenge, triangulating information, and obtaining assurances which are passed on to the Trust Board. The Council receives regular training to support this. Over the last year it has received a range of training and development to support its core functions. Additionally new Governors are invited to attend the NHS Providers GovernWell Core Skills course as part of induction.

Involvement and Engagement

The Trust aims to involve service users, carers, members, the local community and colleagues in matters that affect them and to ensure the manner of their participation will enhance their own confidence that the Trust and its employees will always act professionally and listen to and take account of their views. The Trust has an established membership and a Council of Governors which represents the interests of constituents and members of the public. This is further enhanced by the Working Together Network. The Trust has developed a Working Together Strategy which will improve still further its communication and engagement with stakeholders. The Trust is also a member of both the regional and local Gloucestershire Social Partnership Fora, which provides an established route for regional and local health and social care employers to engage with and involve local and regional trades unions.

The Duty of Candour is considered in all the Trust's serious incident investigations, and service users and their families and carers are included in this process to ensure that their perspective is considered. Service users, families and carers are provided with feedback on conclusion of each investigation. The Trust is a participant in the Triangle of Care programme, a national scheme bringing carers, service users and professionals together to offer support to adult and young carers.

In line with other NHS employers, the Trust undertakes an annual staff survey. Up to this year we have achieved year on year improvements in response rates, 61% for 2024 compared with 58% in 2023 and 55% in 2022. For 2025 we received a response rate of 51%, participation reflected a wider trend across England of declining response rates. For the 4th year of Bank data, we achieved a response rate of 23% against 31% for 2024, 22.5% for 2023 and 23.4% in 2022. The outcomes of the surveys are reviewed by Board and action plans to address issues raised are approved and monitored through the year by the relevant Board Committee. Alongside the annual staff survey, the Staff Friends and Family Test has become firmly embedded as a regular quarterly check to determine staff attitudes on the Trust as a provider of care, and as a place to work. Regular NHS Pulse Surveys, alongside ad hoc health and wellbeing surveys are also undertaken.

The Trust is committed to fostering and promoting a culture of openness in which all colleagues are encouraged to speaking up without fear of suffering detriment. The Freedom to Speak Up Policy describes the various routes that colleagues can use to speak up. Formal and informal routes through which concerns can be raised in confidence are promoted by our Freedom to Speak Up Guardian, supported by a visible network of champions.

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The national NHS EDI Improvement Plan, the Workforce Disability and Race Equality Standards (WDES/WRES) and the Trust's Diversity and Inclusion Policy, provide a basis for ensuring the Trust meets its obligations under the Public Sector Equality Duty (PSED) and the Equality Act 2010.

The Trust undertakes Equality Impact Assessments (EIAs) on all policies, practices, activities, services and cost improvement programmes. Using EIAs, the Trust can make informed choices, reasonable adjustments or mitigate risks, to ensure people have fair and appropriate access to high quality care and are not disadvantaged due to protected characteristics. The Trust publishes an annual Equalities Report containing its pay gap reporting. The Trust encourages applications from under-represented groups for election as a Governor or appointment as a Non-Executive Director, as well as in other areas of under-representation.

Human Rights control measures are monitored by the Mental Health Legislation Scrutiny Committee through scrutiny of Key Performance Indicators regarding the Mental Health Act, Deprivation of Liberty Safeguards and Mental Capacity Act, and by scrutinising audits of compliance with requirements to ensure patients and their carers are informed and aware of their rights.

Carbon Reduction

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In 2020, Sustainability was identified as one of the Trust's 4 strategic aims, with the commitment to reduce our carbon footprint. Following national guidance in 2021, our first 3-year Green Plan

was board-approved in 2022, setting a target to reduce our NHS Carbon Footprint by 25% by the end of the 2025/26 financial year (against a 2019/20 baseline). Over this period, the Trust exceeded its ambition, achieving a 28% reduction in our NHS Carbon Footprint.

In 2025, The Trust worked with system partners to co-produce a Climate Vulnerability Risk Assessment (CRVA), with actions to be embedded into existing governance and processes, including emergency planning & resilience, service delivery, and the Trust's estates strategy. A national mandate also required all Trusts to refresh their green plans, with an increased focus on net zero clinical transformation. Following two board development sessions to assess our environmental maturity, our new Green Plan was board-approved in September 2025.

Our new Green Plan sets an overarching target to reduce our carbon footprint by 50% by 2028 (against a 19/20 baseline) and to embed sustainability into all applicable Trust processes. Over the next 12 months, priorities will focus on net zero clinical transformation and governance to ensure sustainability is embedded into Trust processes.

Progress against the Green Plan is overseen by the Resources Committee (bi-annually) and Board (Annually) to ensure that the Trust is on track to deliver National NHS Net Zero targets.

Workforce Strategy and Planning

The Trust's five-year People Strategy (2021-2026) came to the end of its lifespan in Quarter 4 2025/26. A new People Strategy has been in development during 2025/26 and was signed off by the Board in May 2026. The new strategy is aligned to national, regional and local needs and what matters most to our colleagues. It will be regularly reviewed in light of the emerging new provider, regional and national workforce Target Operating Model, alongside the national 10-year Workforce Plan expected to be published later in 2026.

The Great Place to Work Committee has continued to receive progress updates with respect to the delivery requirements of the 2021/26 strategy, ensuring that it has remained fit for purpose and aligned with national requirements and changing needs. Regular updates have also been provided to the Committee on the three additional enabling frameworks and their action plans – Health and Wellbeing, Learning and Development, and Recruitment & Retention.

Recruitment within specific professions and services remains a national and local challenge and this is reflected in the related Board Assurance Framework risk which is regularly reviewed by the Great Place to Work Committee and the Board of Directors. Taking account of NHSE guidelines for 'Safer Staffing and Developing Workforce Safeguards', during 2025 we reviewed and improved inpatient staffing levels, putting into place related recruitment and retention actions to further improve quality and mitigate workforce risks and challenges, particularly in terms of temporary staffing costs.

In line with our values, we will continue to listen and work in partnership with colleagues as well as stakeholders, patients, carers and communities.

Our approach to workforce planning relies on the output of focused operational modelling, completed for a number of strategic and transformational priorities across our integrated physical and mental health services. It also includes ensuring that Trust workforce plans align with known commissioning and financial expectations operational planning submissions. We

continue to work with partners across the Integrated Care System (ICS) to identify opportunities for education, training, and the development of new roles and new ways of working.

Our governance structure integrates finance, workforce and performance considerations at Board level, supported by its assurance committees which meet bi-monthly and consider planning and assurance regarding the affordability, capacity, capability and transformation of the workforce. The Great Place to Work Committee receives workforce key performance indicators (KPIs), including staff survey, pulse survey, and friends and family test ratings. The Quality Committee also considers workforce in relation to the safety and quality of our service delivery to our patients including safer staffing, clinical supervision, appraisal and training.

Our approach to workforce has been recognised by the achievement of key standards and awards including the Armed Forces Covenant, Veteran Aware, the Mindful Employer Charter, and Safe, Effective, Quality Occupational Health Service (SEQOHS) reaccreditation in 2025.

Within the Gloucestershire Integrated Care System (ICS), workforce plans and issues are shared and discussed through the One Gloucestershire People Board and the ICB People Committee, although these fora are expected to change during 2026/27.

NHS Pension Scheme

As an employer with employees entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Conflicts of Interest

A policy is in place to enable the Trust and its colleagues to manage conflicts of interest, this is in line with the guidance issued by NHS England in 2017 and includes provisions relating to interests, gifts and hospitality. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for the Board and the register for other colleagues is available on request.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has processes designed to ensure the economy, efficiency and effectiveness of the use of resources. These include:

- Monthly monitoring by the Resources Committee or Board of Trust performance in relation to financial performance and associated risk ratios, training and attendance targets, resource usage and the delivery of national and local target trajectories.
- The use of reference cost benchmarks for service review and economic improvement
- The use of Patient Level Information and Costing to enable the Trust to understand better its cost structure, improve the potential for benchmarking, and inform cost improvement programmes
- The use of internal audit to review the efficiency and effectiveness of corporate business processes

- All relevant NICE guidelines are monitored, and baseline reviews are completed to provide assurance our services are in line with the recommendations”
- Service and pathway redesign within the Trust’s services

The Executive has responsibility for overseeing the day-to-day operations of the Trust and for ensuring that resources are used efficiently, effectively and economically.

At a strategic level, the Resources Committee receives assurance on the efficient, economic and effective use of resources and provides onward assurance on these matters to the Board through its bi-monthly summary report.

Internal Audit conducts a review of the Trust’s internal control systems and processes as part of an annually agreed audit plan. This review encompasses consideration and assessment of the flow through the organisation of information pertaining to risk and assurance. It provides independent assurance that systems are in place, are appropriate, and can be evidenced by a range of documents available within the organisation. Internal audits have reviewed the governance arrangements within the organisation over a range of financial and other functions to ensure assurance that there is an appropriate and robust approach to the use of resources.

The Gloucestershire Health and Care team represents its biggest resource and accounts for its highest expenditure. The Trust is committed to maximising safe staffing, and, wherever possible, minimising expenditure on agency colleagues. In delivering its commitments, it has an established Sustainable Staffing Oversight Group led by the Director of HR and OD, working with colleagues from Operations, Workforce Systems, Recruitment, Finance and Nursing, Quality and Therapy teams.

The Trust ended the year with a segmentation rating of 2 under NHS England’s National Oversight Framework.

Data Quality and Governance

The Trust has built on its clinical data quality arrangements and put in place the following actions to support data quality:

- We have aligned our performance monitoring tools and data warehousing to facilitate the needs of a progressive, integrated health and care organisation
- Data quality oversight is provided through a governance structure which includes the Trust’s Resources Committee, Business Intelligence Management Group (BIMG) and operationally led Performance & Finance meetings, Business meetings and a Patient Record Quality Group. Collectively these raise the profile of performance and data quality amongst operational leaders and educates them in how to get the most from the Business Intelligence tools and visualisations available
- Data quality is owned by operational service directors and supported through Business Intelligence (BI) business partnering
- We have progressed our automated suite of internal data quality reporting tools to support daily monitoring and early warning notifications so operational managers can observe and are alerted to any identified data quality gaps
- An integrated, single infrastructure platform has been developed that brings many data sources together into one place and has been rolled out to all inpatient and community teams across mental health, learning disability and physical health

- Patient Tracking Lists have been expanded to provide an overview of all clients within the service detailing waiting times from the referral to treatment and then waiting times between appointments

Service level performance scrutiny will continue through focused Service Recovery Action Plans, reviewing all aspects of service performance and data quality focusing on demand, capacity, outcomes and risk.

The Trust has processes in place to ensure that data is used to inform reporting and decision making and are subject to a system of internal control and validation. Internal and external reporting requirements have been critically assessed, and data provision is reviewed regularly. Data is used to populate a Quality and Performance Dashboard which is reviewed by Executives, the Resources Committee, Service Directorates and the Trust Board, subjected to appropriate levels of challenge, and used to inform strategic and operational decision making and monitor performance. The Quality and Performance Dashboard contain information about performance in relation to national and local targets and contractual obligations including waiting times, quality targets, internal 'stretch' performance targets and other internal performance measures regarding finance and human resources.

Financial and performance data are subject to scrutiny and challenge by the Resources Committee and the Audit and Assurance Committee, in order to provide assurance to the Board. Non-Executive Directors chairing these Committees will request further clarification and assurance in the event that information initially presented is unclear.

A Clinical Systems User Group, which covers all clinical systems is in place and provides a forum to ensure that data quality issues arising from the use of the Electronic Patient Record System can be tackled consistently across all Trust services

Mechanisms are in place to ensure that colleagues have the knowledge, competencies and capacity for their roles in relation to data quality. Managers monitor competencies and development needs through the annual appraisal process and ensure that colleagues have access to appropriate training opportunities. The Trust has training programmes in place to ensure colleagues have the capacity and skills for effective collection, recording and analysis of data. Clinical System training is provided to all appropriate colleagues, and support materials are available on a dedicated intranet page. Individual colleagues have their own training records and are responsible for identifying their own individual skill requirements in relation to data quality.

Review of effectiveness

In accordance with NHS Internal Audit Standards, the Head of Internal Audit provides an annual opinion, based on and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control, and governance processes. This is achieved through a risk-based plan of work, agreed with management, and approved by the Audit and Assurance Committee.

At each meeting, the Audit and Assurance Committee review the internal audit recommendations and the progress made against each of these recommendations by management, ensuring that any gaps in control are responded to. These recommendations are also scrutinised by other Board committees where relevant.

Audits are classified in relation to Design Opinion and Design Effectiveness with the levels of assurance defined as substantial, moderate, limited. Recommendations are classified as high, medium or low risk as appropriate. 6 high risk findings were reported overall, across the internal audit programme. The Trust's Audit and Assurance Committee continue to monitor progress, to provide assurance that improvements to these processes have been progressed and embedded.

Assurance ratings in internal audit reports

Audit	Design	Effectiveness
Data Quality 24/25	Moderate	Moderate
Quality Improvement 24/25	Moderate	Moderate
PCREF	N/A	N/A
Working Well Occupational Health	Limited	Moderate
Temporary Staff & E-rostering	Significant	Moderate
Risk Maturity	N/A	N/A
Infection & Prevention Control	Moderate	Moderate
Quality Governance NTQ	Moderate	Moderate
Key Financial Systems – Budgetary Control	Moderate	Moderate
PSIRF	Moderate	Limited
Cyber Security (procurement)	June 26	
Accessibility Information Standards	Limited	Moderate
Data Security and Protection Toolkit	Very low risk/high confidence	

Head of Internal Audit opinion 2025/2026

Overall, we provide the opinion that GHC's risk management, control and governance processes are **generally satisfactory with improvements required in some areas**.

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The assurance framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

Conclusion

The Trust firmly believes that it has comprehensive and robust governance processes in place. No significant internal control issues have been identified.



Douglas Blair, Chief Executive

18 June 2026

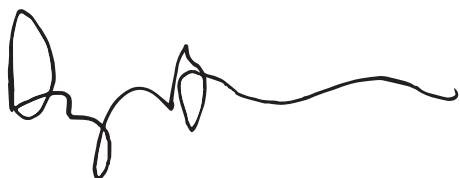
Foreword to the accounts

Gloucestershire Health and Care NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Gloucestershire Health and Care NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Gloucestershire Health and Care NHS Foundation Trust provided mental health services and physical health services to the population of Gloucestershire.

Signed

A handwritten signature in black ink, appearing to read 'Douglas Blair', with a long horizontal flourish extending to the right.

Douglas Blair
Chief Executive
18 June 2026

Consolidated Statement of Comprehensive Income

	Note	Group	
		2025/26 £000	2024/25 £000
Operating income from patient care activities	3	336,016	310,348
Other operating income	4	21,805	21,198
Operating expenses	7,9	(356,530)	(336,063)
Operating surplus / (deficit) from continuing operations		1,291	(4,517)
Finance income	11	2,415	3,133
Finance expenses	12	(309)	(306)
PDC dividends payable		(2,804)	(2,660)
Net finance costs		(698)	167
Other gains / (losses)	13	147	(32)
Surplus / (deficit) for the year from continuing operations		740	(4,382)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(138)	(256)
Revaluations	21	4,591	2,065
Total other comprehensive income for the period		4,453	1,809
Total comprehensive income / (expense) for the period		5,193	(2,573)
Surplus / (deficit) for the period attributable to:			
Non-controlling interest, and		-	-
Gloucestershire Health and Care NHS Foundation Trust		740	(4,382)
Total		740	(4,382)
Total comprehensive income / (expense) for the period attributable to:			
Non-controlling interest, and		-	-
Gloucestershire Health and Care NHS Foundation Trust		5,193	(2,573)
Total		5,193	(2,573)

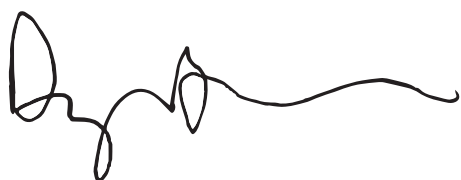
The accompanying notes form part of these financial statements.

Statements of Financial Position

	Note	Group		Trust	
		31 March	31 March	31 March	31 March
		2026	2025	2026	2025
		£000	£000	£000	£000
Non-current assets					
Intangible assets	16	2,466	1,745	2,466	1,745
Property, plant and equipment	18	125,253	118,084	125,253	117,934
Right of use assets	22	15,798	16,439	15,798	16,439
Receivables	29	721	1,244	721	1,244
Total non-current assets		144,238	137,512	144,238	137,362
Current assets					
Inventories	28	384	444	384	444
Receivables	29	15,152	15,192	15,139	15,186
Non-current assets held for sale	32.1	4,965	3,123	2,215	3,123
Cash and cash equivalents	33	41,494	42,091	41,303	41,855
Total current assets		61,995	60,850	59,041	60,608
Current liabilities					
Trade and other payables	34	(35,381)	(30,713)	(35,376)	(30,708)
Borrowings	36	(1,469)	(1,514)	(1,469)	(1,514)
Provisions	38	(7,334)	(8,702)	(7,334)	(8,702)
Other liabilities	35	(426)	(1,303)	(426)	(1,303)
Total current liabilities		(44,610)	(42,232)	(44,605)	(42,227)
Total assets less current liabilities		161,623	156,130	158,674	155,743
Non-current liabilities					
Borrowings	36	(13,514)	(14,026)	(13,514)	(14,026)
Provisions	38	(2,454)	(2,511)	(2,454)	(2,511)
Total non-current liabilities		(15,968)	(16,537)	(15,968)	(16,537)
Total assets employed		145,655	139,593	142,706	139,206
Financed by					
Public dividend capital		132,972	132,103	132,972	132,103
Revaluation reserve		14,203	13,789	14,203	13,789
Other reserves		(1,241)	(1,241)	(1,241)	(1,241)
Income and expenditure reserve		(3,228)	(5,445)	(3,228)	(5,445)
Charitable fund reserves	27	2,949	387	-	-
Total taxpayers' equity		145,655	139,593	142,706	139,206

The notes on pages 1 to 51 form part of these accounts.

Signed



Douglas Blair
Chief Executive
18 June 2026

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserves £000	Other reserves* £000	Income and expenditure reserves £000	Charitable fund reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	132,103	13,789	(1,241)	(5,445)	387	139,593
Surplus / (deficit) for the year	-	-	-	778	(38)	740
Impairments	-	(138)	-	-	-	(138)
Revaluations	-	1,991	-	-	-	1,991
Revaluations and impairments - charitable fund assets	-	-	-	-	2,600	2,600
Transfer to retained earnings on disposal of assets	-	(1,439)	-	1,439	-	-
Public dividend capital received	869	-	-	-	-	869
Taxpayers' and others' equity at 31 March 2026	132,972	14,203	(1,241)	(3,228)	2,949	145,655

Other results* (£1,241k) is the result from two different transactions £1,157k and (£2,398k) detailed below.

* £1,157k; When the 2gether NHS Foundation Trust was originally established the Statutory Instrument that confirmed the Public Dividend Capital was incorrect. As advised by the Department of Health and Social Care, the element which had been missed off was classified as 'other reserves'.

* (£2,398k); When the Gloucestershire Care Services NHS Trust merged with 2gether NHS Foundation Trust in October 2019 other reserves in respect of donated assets included on the Trust's balance sheet were merged into Gloucestershire Health and Care NHS Foundation Trust.

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserves £000	Other reserves* £000	Income and expenditure reserves £000	Charitable fund reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	131,876	13,821	(1,241)	(2,887)	370	141,939
Surplus / (deficit) for the year	-	-	-	(4,399)	17	(4,382)
Other transfers between reserves	-	(1,841)	-	1,841	-	-
Impairments	-	(256)	-	-	-	(256)
Revaluations	-	2,065	-	-	-	2,065
Public dividend capital received	227	-	-	-	-	227
Taxpayers' and others' equity at 31 March 2025	132,103	13,789	(1,241)	(5,445)	387	139,593

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves* £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 – brought forward	132,103	13,789	(1,241)	(5,445)	139,206
Surplus / (deficit) for the year	-	-	-	778	778
Impairments	-	(138)	-	-	(138)
Revaluations	-	1,991	-	-	1,991
Transfer to retained earnings on disposal of assets	-	(1,439)	-	1,439	-
Public dividend capital received	869	-	-	-	869
Taxpayers' and others' equity at 31 March 2026	132,972	14,203	(1,241)	(3,228)	142,706

Other results* (£1,241k) is the result from two different transactions £1,157k and (£2,398k) detailed below.

* £1,157k; When the 2gether NHS Foundation Trust was originally established the Statutory Instrument that confirmed the Public Dividend Capital was incorrect. As advised by the Department of Health and Social Care, the element which had been missed off was classified as 'other reserves'.

* (£2,398k); When the Gloucestershire Care Services NHS Trust merged with 2gether NHS Foundation Trust in October 2019 other reserves in respect of donated assets included on the Trust's balance sheet were merged into Gloucestershire Health and Care NHS Foundation Trust.

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves* £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 – brought forward	131,876	13,821	(1,241)	(2,887)	141,569
Surplus / (deficit) for the year	-	-	-	(4,399)	(4,399)
Other transfers between reserves	-	(1,841)	-	1,841	-
Impairments	-	(256)	-	-	(256)
Revaluations	-	2,065	-	-	2,065
Public dividend capital received	227	-	-	-	227
Taxpayers' and others' equity at 31 March 2025	132,103	13,789	(1,241)	(5,445)	139,206

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

£1,157k; When the 2gether NHS Foundation Trust was originally established the Statutory Instrument that confirmed the Public Dividend Capital was incorrect. As advised by the Department of Health and Social Care, the element which had been missed off was classified as 'other reserves'.

(£2,398k); When the Gloucestershire Care Services NHS Trust merged with 2gether NHS Foundation Trust in October 2019 other reserves in respect of donated assets included on the Trust's balance sheet were merged into Gloucestershire Health and Care NHS Foundation Trust.

Merger reserve

This legacy reserve reflects balances formed on previous mergers of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted, unrestricted and revaluation reserve; a breakdown is provided in note 48.

Non-controlling interest reserve

This reserve represents the amount of equity a consolidated subsidiary that is not attributable directly or indirectly to the Trust.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		1,291	(4,517)	1,329	(4,534)
Non-cash income and expense:					
Depreciation and amortisation	7.1	9,862	11,302	9,862	11,302
Net impairments	8	1,183	4,497	1,183	4,497
(Increase) / decrease in receivables and other assets		57	(4,428)	57	(4,428)
(Increase) / decrease in inventories		60	(88)	60	(88)
Increase / (decrease) in payables and other liabilities		4,367	(8,264)	4,367	(8,264)
Increase / (decrease) in provisions		(1,519)	154	(1,519)	154
Movements in charitable fund working capital		(7)	(4)	-	-
Other movements in operating cash flows		-	(10)	-	(10)
Net cash flows from / (used in) operating activities		15,294	(1,358)	15,339	(1,371)
Cash flows from investing activities					
Interest received		2,356	3,072	2,356	3,072
Purchase of intangible assets		(1,509)	(741)	(1,509)	(741)
Purchase of PPE and investment property		(14,020)	(8,563)	(14,020)	(8,563)
Sales of PPE and investment property		930	1,974	930	1,974
Finance lease receipts (principal and interest)		97	94	97	94
Net cash flows from / (used in) investing activities		(12,146)	(4,164)	(12,146)	(4,164)
Cash flows from financing activities					
Public dividend capital received		869	227	869	227
Capital element of lease liability repayments		(1,582)	(1,567)	(1,582)	(1,567)
Interest paid on lease liability repayments		(215)	(212)	(215)	(212)
PDC dividend (paid) / refunded		(2,817)	(2,491)	(2,817)	(2,491)
Net cash flows from / (used in) financing activities		(3,745)	(4,043)	(3,745)	(4,043)
Increase / (decrease) in cash and cash equivalents		(597)	(9,565)	(552)	(9,578)
Cash and cash equivalents at 1 April					
Cash and cash equivalents at 31 March	33	41,494	42,091	41,303	41,855
		(597)	(9,565)	(552)	(9,578)

The accompanying notes form part of these financial statements.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate Trustee to Gloucestershire Health and Care NHS charitable fund, registration number 1096480. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The Trust has no subsidiaries.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg, share dividends are received by the Trust from the associate.

The Trust has no associates.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

The Trust has no joint ventures.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The Trust has no joint operations.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods / services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of the Trust's service contracts measure the delivery of the service on a monthly basis so that the Trust can receive regular income and cashflows across the financial year.

Revenue from NHS contracts

The main source of income for the Trust is contracts with the commissioners for health care services. Funded envelopes are set as Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or support service functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Property Revaluations are undertaken by DVS Property Services (DVS) an arm of 'The Valuation Office Agency' which is an Executive Agency of HM Revenues and Customs.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

The property valuations are carried out primarily on the basis of Depreciated Replacement Cost (DRC) for specialised operational property (e.g. NHS patient treatment facilities) and Existing Use Value (EUV) for non-specialised operational property. The value of land for existing use purposes is assessed at EVU. For non-operational land including surplus land, the valuations are carried out at Market Value.

The MEA approach incorporates the Building Cost Information Service Index to determine an increase or decrease in building costs which impact on the asset valuation.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 18.1.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Right of Use assets (capitalised projects on leased properties) are carried at current value in existing use.

The carrying values of Property Plant & Equipment (PPE) are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

The costs arising from financing the construction of PPE are not capitalised but are charged to the Statement of Comprehensive Income (SOCl) in the year to which they relate.

All impairments resulting from price changes are charged to the SOCl. If the balance on the revaluation reserve is less than the impairment the difference is taken to SOCl.

The valuation has been undertaken having regard to IFRS as applied to the UK public sector and in accordance with HM Treasury guidance. The Trust has valued its land and buildings at fair value – non-specialised assets at existing use value and specialised operation assets at depreciated replacement cost

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust does not have any Private Finance Initiative and Local Improvement Finance Trust (LIFT) transactions.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	80
Plant and machinery	5	15
Transport equipment	5	7
Information technology	3	10
Furniture and fittings	5	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	3	5
Software licences	3	5

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

Note 1.12 Investment properties

The Trust has no Investment properties.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are assessed for Receivable invoices, Debit balances on Payables Accounts where we no longer use the supplier, and for Road Traffic Act transactions.

Expected credit losses are determined for transactions over 90 days, except for transactions with other NHS bodies which are not normally recognised as expected credit losses.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability. The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 38.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 39 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 39.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

The Trust has determined that it has no corporation tax liability as it does not carry out any applicable commercial activities..

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.23 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.26 Transfers of functions [to / from] [other NHS bodies / local government bodies]

For functions that have been transferred to the Trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements – The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £86.7m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £86.7m at 31 March 2026.

The Trusts expects the impact to be material, but the likely impact is currently not quantified.

Note 1.29 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The Trust believes the use of the Modern Equivalent Asset (MEA) basis to value land and buildings to fair value is the methodology with least risk of material uncertainty.

The underlying principle is that the valuation of land and buildings should reflect the extent of estate required for the provision of the same service as already provided by the existing estate. With service delivery requirements evolving, this requires the Trust to consider whether the existing buildings and sites are optimal in terms of number and size.

The fundamental principle is that the hypothetical buyer of a Modern Equivalent Asset would purchase the least expensive site that would be suitable and appropriate for its proposed use. If the Trust were starting with a “clean sheet”, the Modern Equivalent Asset aligned to service delivery could be different to the current layout in terms of buildings configuration and the number of sites. The Trust is responsible for providing the requirements of the optimised site to the Trust's Valuer.

For the initial application of IFRS 16, where formal contract documentation wasn't explicit, available or existed, IFRS 16 lease liabilities were calculated using current lease payments and term. For peppercorn leases rental rates for their vicinity.

Note 1.30 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

With regard to valuing provisions the methodology to determine best estimate differs according to the class of provision.

Annual leave carry forwards are only approved under exceptional circumstances whereby staff are unable to take the full annual leave allowance. The maximum carry forward is 5 working days apart from those with accrued balances arising from maternity or sick leave. Outstanding leave was valued at each individual's pay rate.

The annual leave year for medical staff is determined by start date in post and their annual leave carry forward was costed at the appropriate average pay scale based on the number of days left at 31st March 2026.

Note 2 Operating Segments

Note 2.1 Operating Segments

The Trust Board has determined that it only has one reportable segment. All services delivered by the Trust are as an NHS Community Services Provider or Mental Health Services Provider and over 85% of Income is earned through contracts with NHS Gloucestershire Intergrated Care Board.

Note 2.2. Going Concern and Liquidity Risk

The Trust's business activities, together with the factors likely to affect its future development, performance and position are set out in the Strategic Report. In addition, notes 1 to 51 to the financial statements include the Trust's policies and processes for managing its capital; its financial risk management objectives; details of its financial instruments; and its exposures to credit risk and liquidity risk.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation Trust will continue to be provided by the public sector for the foreseeable. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Note 2.3 Discontinued Operations

There were no discontinued services or operations in 2025/26 or 2024/25.

In 2026/27 the Trust will be discontinuing some Section work, Social Care and Occupational Therapy Services which will be transferring to Gloucestershire County Council. The contract is worth c£15m per year and employs c103 Whole Time Equivalents.

Note 2.4 Business combinations involving the Trust and another entity within the Whole of Government Accounts (WGA) boundary

There were no new business combinations involving the Trust and another entity within the Whole of Government Accounts (WGA) boundary in 2025/26 or 2024/25.

Note 2.5 New Operations

In November 2024 the Trust started to provide a new service to the Gloucestershire population. The Integrated Urgent Care Service provides 111 phone services, Out of Hours and a Clinical Assessment Service. The contract was worth £10.5m per year and employs 28 Whole Time Equivalents.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Mental health services		
Income from commissioners under API contracts*	155,267	144,184
Services delivered under a mental health collaborative	5,727	3,485
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	1,589	1,555
Community services		
Income from commissioners under API contracts*	155,267	144,183
Income from other sources (e.g. local authorities)	1,595	1,575
All services		
National pay award central funding***	-	127
Additional pension contribution central funding**	16,571	15,239
Other clinical income	-	-
Total income from activities	336,016	310,348

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26 £000	2024/25 £000
Income from patient care activities received from:		
NHS England	23,312	21,642
Integrated care boards	300,858	279,641
Other NHS providers	5,749	3,503
Local authorities	4,501	3,986
Injury cost recovery scheme	186	167
Non NHS: other	1,410	1,409
Total income from activities	336,016	310,348
Of which:		
Related to continuing operations	336,016	310,348
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26 £000	2024/25 £000
Income recognised this year	-	-

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total income £000
Research and development	427	-	427	496	-	496
Education and training	7,205	679	7,884	6,965	614	7,579
Non-patient care services to other bodies	12,937	-	12,937	11,744	-	11,744
Charitable and other contributions to expenditure	-	269	269	-	966	966
Revenue from finance leases	-	16	16	-	19	19
Charitable fund incoming resources	-	67	67	-	82	82
Other income	206	-	206	309	3	312
Total other operating income	20,775	1,031	21,805	19,514	1,684	21,198

Of which:

Related to continuing operations	21,805	21,198
Related to discontinued operations	-	-

There are no partially completed contracts where the Trust does not recognise the revenue until the completion of the full performance obligation. Instead the Trust only has contracts that recognises revenue as work is undertaken.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2026 £000	31 March 2025 £000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	-	-

Note 5.3 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	-	-
Income from services not designated as commissioner requested services	336,016	310,348
Total	336,016	310,348

Note 5.4 Profits and losses on disposal of property, plant and equipment

In 2025/26 the Trust sold 2 Buildings which had a total net book value of £148k and £600k. The sales were completed in February and March 2026 and the sales proceeds were £155k and £725k resulting in a gain on sale of £7k and £125k. The Trust also disposed of an item of equipment with a net book value of £33k and sales proceeds of £49k in the year resulting in a gain of £16k. Additionally there was a termination of a Lessor finance lease in year which resulted in a loss on disposal of £2k.

In 2024/25 the Trust sold land which had a net book value of £2,000k. The sale was completed in December 2024 and the sales proceeds were £1,974k resulting in a loss of £26k. The Trust also disposed of an item of equipment for zero proceeds in March 2025 resulting in a loss of £5k.

Note 5.5 Fees and charges (Group)

The Trust have no material income from charges to service users

Note 6 Operating leases - Gloucestershire Health and Care NHS Foundation Trust as lessor

Gloucestershire Health and Care NHS Foundation Trust has no income generated in operating lease agreements where Gloucestershire Health and Care NHS Foundation Trust is the lessor.

Note 7.1 Operating expenses (Group)

	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	20	20
Purchase of healthcare from non-NHS and non-DHSC bodies	18,033	10,524
Purchase of social care	12,778	12,266
Staff and executive directors costs	266,424	245,444
Remuneration of non-executive directors	147	170
Supplies and services – clinical (excluding drugs costs)	9,951	10,417
Supplies and services – general	4,854	4,265
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,232	4,777
Consultancy costs	0	26
Establishment	4,156	3,877
Premises	13,883	17,854
Transport (including patient travel)	2,793	2,947
Depreciation on property, plant and equipment	9,065	10,688
Amortisation on intangible assets	797	614
Net impairments	1,183	4,497
Movement in credit loss allowance: contract receivables / contract assets	(234)	411
Increase / (decrease) in other provisions	(265)	(471)
Change in provisions discount rate(s)	(111)	-
Fees payable to the external auditor		
audit services- statutory audit	196	182
Internal audit costs*	87	77
Clinical negligence	1,115	1,490
Legal fees	417	496
Insurance (as a policy holder)	315	280
Research and development	435	433
Education and training	3,751	3,861
Expenditure on short term leases	35	76
Redundancy	579	6
Car parking and security	123	116
Hospitality	1	3
Losses, ex gratia and special payments	6	5
Other services, eg external payroll	857	1,076
Other NHS charitable fund resources expended	103	63
Other**	(197)	(427)
Total	356,530	336,063
Of which:		
Related to continuing operations	356,530	336,063
Related to discontinued operations	-	-

* Audit services – statutory audit fee is £162k excluding VAT. (£150.0k in 2024/25)

** The 2024/25 credit is for the reversal of prior year accruals which were higher than needed.

Note 7.2 Other auditor remuneration (Group)

	2025/26 £000	2024/25 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	-	-

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £162k (2024/25: £1,000k).

Note 8 Impairment of assets (Group & Trust)

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss as a result of catastrophe	-	-
Changes in market price	1,183	4,497
Total net impairments charged to operating surplus / deficit	1,183	4,497
Impairments charged to the revaluation reserve	138	256
Total net impairments	1,321	4,753

Further details in note 21 Revaluations of property, plant and equipment

Note 9 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	198,228	184,294
Social security costs	25,355	18,640
Apprenticeship levy	974	806
Employer's contributions to NHS pensions	41,990	38,688
Pension cost - other	104	121
Temporary staff (including agency)	2,618	5,123
Total gross staff costs	269,269	247,672
Recoveries in respect of seconded staff	-	-
Total staff costs	269,269	247,672
Of which		
Costs capitalised as part of assets	-	-

The Trust has contributed £175k to pension schemes in respect of directors in 2025/26 (£162k in 2024/25). None of the directors have benefits accruing under money purchase schemes or non NHS pension schemes. No advances or credits have been made to directors by the Trust, nor have any guarantees been entered into on their behalf.

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 3 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £72k (£201k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	Total	Total
	£000	£000
Interest on bank accounts	2,356	3,072
Interest income on finance leases	59	61
Total finance income	2,415	3,133

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	Total	Total
	£000	£000
Interest expense:		
Interest on lease obligations	215	212
Interest on late payment of commercial debt	-	-
Total interest expense	215	212
Unwinding of discount on provisions	94	85
Other finance costs	-	9
Total finance costs	309	306

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	Total	Total
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses) (Group)

	2025/26 Total £000	2024/25 Total £000
Gains on disposal of assets	149	-
Losses on disposal of assets	(2)	(32)
Total gains / (losses) on disposal of assets	147	(32)
Other gains / (losses)	-	-
Total other gains / (losses)	147	(32)

In 2025/26 the Trust sold 2 Buildings which had a total net book value of £148k and £600k. The sales were completed in February and March 2026 and the sales proceeds were £155k and £725k resulting in a gain on sale of £7k and £125k. The Trust also disposed of an item of equipment with a net book value of £33k and sales proceeds of £49k in the year resulting in a gain of £16k. additionally there was a termination of a Lessor finance lease in year which resulted in a loss on disposal of £2k.

In 2024/25 the Trust sold land which had a net book value of £2,000k. The sale was completed in December 2024 and the sales proceeds were £1,974k resulting in a loss of £26k. The Trust also disposed of an item of equipment for zero proceeds in March 2025 resulting in a loss of £5k.

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's surplus/(deficit) for the period was £0.8 million (2024/25: £(4.4) million). The Trust's total comprehensive income/(expense) for the period was £2.6 million (2024/25: £(2.6) million).

Note 15 Discontinued operations (Group)

There were no discontinued operations in 2025/26 and 2024/25.

In 2026/27 the Trust will be discontinuing some Social work, Social Care and Occupational Therapy Services which will be transferring to Gloucestershire County Council. The contract is worth c£15m per year and employs c103 Whole Time Equivalents.

Note 16.1 Intangible assets – 2025/26

Group	Software licences £000	Internally generated information technology £000	Total £000
Cost at 1 April 2025 – brought forward *	7,572	1,130	8,702
Additions	1,509	-	1,509
Reclassifications	9	-	9
Cost at 31 March 2026	9,090	1,130	10,220
Amortisation at 1 April 2025 – brought forward	5,827	1,130	6,957
Provided during the year	797	-	797
Amortisation at 31 March 2026	6,624	1,130	7,754
Net book value at 31 March 2026	2,466	-	2,466
Net book value at 1 April 2025	1,745	-	1,745

Note 16.2 Intangible assets – 2024/25

Group	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2024 – as previously stated	6,939	1,253	8,192
Additions	741	-	741
Disposals / derecognition	(108)	(123)	(231)
Valuation / gross cost at 31 March 2025	7,572	1,130	8,702
Amortisation at 1 April 2024 – as previously stated	5,321	1,253	6,574
Provided during the year	614	-	614
Disposals / derecognition	(108)	(123)	(231)
Amortisation at 31 March 2025	5,827	1,130	6,957
Net book value at 31 March 2025	1,745	-	1,745
Net book value at 1 April 2024	1,618	-	1,618

Note 17.1 Intangible assets – 2025/26

Trust	Software licences £000	Internally generated information technology £000	Total £000
Cost at 1 April 2025 – brought forward *	7,572	1,130	8,702
Additions	1,509	–	1,509
Reclassifications	9	–	9
Cost at 31 March 2026	9,090	1,130	10,220
Amortisation at 1 April 2025 – brought forward	5,827	1,130	6,957
Provided during the year	797	–	797
Amortisation at 31 March 2026	6,624	1,130	7,754
Net book value at 31 March 2026	2,466	–	2,466
Net book value at 1 April 2025	1,745	–	1,745

Note 17.2 Intangible assets – 2024/25

Trust	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2024 – as previously stated	6,939	1,253	8,192
Additions	741	–	741
Disposals / derecognition	(108)	(123)	(231)
Valuation / gross cost at 31 March 2025	7,572	1,130	8,702
Amortisation at 1 April 2024 – as previously stated	5,321	1,253	6,574
Provided during the year	614	–	614
Disposals / derecognition	(108)	(123)	(231)
Amortisation at 31 March 2025	5,827	1,130	6,957
Net book value at 31 March 2025	1,745	–	1,745
Net book value at 1 April 2024	1,618	–	1,618

Note 18.1 Property, plant and equipment – 2025/26

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Valuation / gross cost at 1 April 2025 – brought forward	4,809	104,581	7,205	17,527	531	16,357	8,293	150	159,453
Additions	-	485	13,457	-	-	-	-	-	13,942
Impairments	-	(162)	-	-	-	-	-	-	(162)
Revaluations	53	1,938	-	-	-	-	-	2,600	4,591
Reclassifications	(14)	2,779	(9,465)	2,952	448	1,393	1,898	-	(9)
Transfers to / from assets held for sale	(34)	(994)	-	-	-	-	-	(2,750)	(3,778)
Disposals / derecognition	(10)	-	-	(41)	-	-	-	-	(51)
Valuation/gross cost at 31 March 2026	4,804	108,627	11,197	20,438	979	17,750	10,191	-	173,986
Accumulated depreciation at 1 April 2025 – brought forward	-	19,176	-	8,396	309	11,188	2,300	-	41,369
Provided during the year	-	3,115	-	1,349	67	2,162	706	-	7,399
Transfers to / from assets held for sale	-	(27)	-	-	-	-	-	-	(27)
Disposals / derecognition	-	-	-	(8)	-	-	-	-	(8)
Accumulated depreciation at 31 March 2026	-	22,264	-	9,737	376	13,350	3,006	-	48,733
Net book value at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	-	125,253
Net book value at 1 April 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	150	118,084

Note 18.2 Property, plant and equipment – 2024/25

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Valuation / gross cost Valuation / gross cost at 1 April 2024 – as previously stated	4,050	84,775	29,690	16,733	387	27,992	6,550	150	170,327
Additions	-	689	9,653	-	-	-	-	-	10,342
Impairments	(167)	(4,586)	-	-	-	-	-	-	(4,753)
Revaluations	217	1,848	-	-	-	-	-	-	2,065
Reclassifications	709	24,177	(32,138)	3,684	144	1,051	2,373	-	-
Transfers to / from assets held for sale	-	(120)	-	-	-	-	-	-	(120)
Disposals / derecognition	-	(2,202)	-	(2,890)	-	(12,686)	(630)	-	(18,408)
Valuation/gross cost at 31 March 2025	4,809	104,581	7,205	17,527	531	16,357	8,293	150	159,453
Accumulated depreciation at 1 April 2024 – as previously stated	-	15,732	-	10,000	247	21,418	2,379	-	49,776
Provided during the year	-	4,691	-	1,281	62	2,456	551	-	9,041
Transfers to / from assets held for sale	-	(22)	-	-	-	-	-	-	(22)
Disposals / derecognition	-	(1,225)	-	(2,885)	-	(12,686)	(630)	-	(17,426)
Accumulated depreciation at 31 March 2025	-	19,176	-	8,396	309	11,188	2,300	-	41,369
Net book value at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	150	118,084
Net book value at 1 April 2024	4,050	69,043	29,690	6,733	140	6,574	4,171	150	120,551

Note 18.3 Property, plant and equipment financing – 31 March 2026

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Owned – purchased	4,804	85,696	11,197	10,655	603	4,400	7,185	-	124,540
Owned – donated / granted	-	667	-	46	-	-	-	-	713
NBV total at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	-	125,253

Note 18.4 Property, plant and equipment financing – 31 March 2025

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Owned – purchased	4,809	84,657	7,205	9,079	222	5,169	5,993	150	117,284
Owned – donated / granted	-	748	-	52	-	-	-	-	800
NBV total at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	150	118,084

Note 18.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) – 31 March 2026

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Subject to an operating lease	-	-	-	-	-	-	-	-	-
Not subject to an operating lease	4,804	86,363	11,197	10,701	603	4,400	7,185	-	125,253
NBV total at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	-	125,253

Note 18.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) – 31 March 2026

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Charitable PPE assets £000	Total £000
Subject to an operating lease	-	-	-	-	-	-	-	-	-
Not subject to an operating lease	4,809	85,405	7,205	9,131	222	5,169	5,993	150	118,084
NBV total at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	150	118,084

Note 19.1 Property, plant and equipment – 2025/26

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Valuation / gross cost at 1 April 2025 – brought forward	4,809	104,581	7,205	17,527	531	16,357	8,293	159,303
Additions	-	485	13,457	-	-	-	-	13,942
Impairments	-	(162)	-	-	-	-	-	(162)
Revaluations	53	1,938	-	-	-	-	-	1,991
Reclassifications	(14)	2,779	(9,465)	2,952	448	1,393	1,898	(9)
Transfers to / from assets held for sale	(34)	(994)	-	-	-	-	-	(1,028)
Disposals / derecognition	(10)	-	-	(41)	-	-	-	(51)
Valuation / gross cost at 31 March 2026	4,804	108,627	11,197	20,438	979	17,750	10,191	173,986
Accumulated depreciation at 1 April 2025 – brought forward	-	19,176	-	8,396	309	11,188	2,300	41,369
Provided during the year	-	3,115	-	1,349	67	2,162	706	7,399
Transfers to / from assets held for sale	-	(27)	-	-	-	-	-	(27)
Disposals / derecognition	-	-	-	(8)	-	-	-	(8)
Accumulated depreciation at 31 March 2026	-	22,264	-	9,737	376	13,350	3,006	48,733
Net book value at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	125,253
Net book value at 1 April 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	117,934

Note 19.2 Property, plant and equipment – 2024/25

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Valuation / gross cost at 1 April 2024 – as previously stated	4,050	84,775	29,690	16,733	387	27,992	6,550	170,177
Additions	-	689	9,653	-	-	-	-	10,342
Impairments	(167)	(4,586)	-	-	-	-	-	(4,753)
Revaluations	217	1,848	-	-	-	-	-	2,065
Reclassifications	709	24,177	(32,138)	3,684	144	1,051	2,373	-
Transfers to / from assets held for sale	-	(120)	-	-	-	-	-	(120)
Disposals / derecognition	-	(2,202)	-	(2,890)	-	(12,686)	(630)	(18,408)
Valuation/gross cost at 31 March 2025	4,809	104,581	7,205	17,527	531	16,357	8,293	159,303
Accumulated depreciation at 1 April 2024 – as previously stated	-	15,732	-	10,000	247	21,418	2,379	49,776
Provided during the year	-	4,691	-	1,281	62	2,456	551	9,041
Transfers to / from assets held for sale	-	(22)	-	-	-	-	-	(22)
Disposals / derecognition	-	(1,225)	-	(2,885)	-	(12,686)	(630)	(17,426)
Accumulated depreciation at 31 March 2025	-	19,176	-	8,396	309	11,188	2,300	41,369
Net book value at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	117,934
Net book value at 1 April 2024	4,050	69,043	29,690	6,733	140	6,574	4,171	120,401

Note 19.3 Property, plant and equipment financing – 31 March 2026

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Owned – purchased	4,804	85,696	11,197	10,655	603	4,400	7,185	124,540
Owned – donated / granted	-	667	-	46	-	-	-	713
Total net book value at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	125,253

Note 19.4 Property, plant and equipment financing – 31 March 2025

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Owned – purchased	4,809	84,657	7,205	9,079	222	5,169	5,993	117,134
Owned – donated / granted	-	748	-	52	-	-	-	800
Total net book value at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	117,934

Note 19.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) – 31 March 2026

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Subject to an operating lease	-	-	-	-	-	-	-	-
Not subject to an operating lease	4,804	86,363	11,197	10,701	603	4,400	7,185	125,253
Total net book value at 31 March 2026	4,804	86,363	11,197	10,701	603	4,400	7,185	125,253

Note 19.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) – 31 March 2025

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total £000
Subject to an operating lease	-	-	-	-	-	-	-	-
Not subject to an operating lease	4,809	85,405	7,205	9,131	222	5,169	5,993	117,934
Total net book value at 31 March 2025	4,809	85,405	7,205	9,131	222	5,169	5,993	117,934

Note 20 Donations of property, plant and equipment

There were no donations of equipment to the Trust in 2025/26 (£0k in 2024/25).

Note 21 Revaluations of property, plant and equipment

	Group		Trust	
	March 31 2026 £000	March 31 2025 £000	March 31 2026 £000	March 31 2025 £000
DVS Property Services (DVS) desktop review of the Trust's operational land and buildings	941	(2,688)	941	(2,688)
Assets held for Sale Valuations (Trust)	(271)	-	(271)	-
Assets held for Sale Valuations (Charity / Group)	2,600	-	-	-
Total revaluations	3,270	(2,688)	670	(2,688)
Revaluation movements				
Revaluation Reserve (Trust)	1,991	2,065	1,991	2,065
Revaluation Reserve (Charity /Group)	2,600	-	-	-
Impairments to operating surplus / deficit (Trust)	(1,183)	(4,497)	(1,183)	(4,497)
Impairments charged to revaluation reserve (Trust)	(138)	(256)	(138)	(256)
Total revaluations movements	3,270	(2,688)	670	(2,688)

Note 22 Leases - Gloucestershire Health and Care NHS Foundation Trust as a lessee

A breakdown of the types of leases the Trust holds is shown in Note 22.1 Right of use assets - 2025/26

Note 22.1 Right of use assets - 2025/26

Group	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
				£000
Valuation / gross cost at 1 April 2025 - brought forward	20,022	608	20,630	4,414
Additions	-	160	160	-
Remeasurements of the lease liability	876	-	876	(13)
Disposals / derecognition	-	(24)	(24)	-
Valuation / gross cost at 31 March 2026	20,898	744	21,642	4,401
Accumulated depreciation at 1 April 2025 - brought forward	3,988	203	4,191	1,332
Provided during the year	1,497	169	1,666	415
Disposals / derecognition	-	(13)	(13)	-
Accumulated depreciation at 31 March 2026	5,485	359	5,844	1,747
Net book value at 31 March 2026	15,413	385	15,798	2,654
Net book value at 1 April 2025	16,034	405	16,439	3,082
Net book value of right of use assets leased from other NHS providers	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	2,654	-	2,654	2,654

Note 22.2 Right of use assets - 2024/25

Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which:
				leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	19,967	518	20,485	4,414
Additions	502	226	728	-
Disposals / derecognition	(447)	(136)	(583)	-
Valuation / gross cost at 31 March 2025	20,022	608	20,630	4,414
Accumulated depreciation at 1 April 2024 - brought forward	2,939	188	3,127	884
Provided during the year	1,496	151	1,647	448
Disposals / derecognition	(447)	(136)	(583)	-
Accumulated depreciation at 31 March 2025	3,988	203	4,191	1,332
Net book value at 31 March 2025	16,034	405	16,439	3,082
Net book value at 1 April 2024	17,028	330	17,358	3,530
Net book value of right of use assets leased from other NHS providers	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	3,082	-	3,082	3,082

Note 22.3 Right of use assets - 2025/26

Group	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which:
				leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025 - brought forward	20,022	608	20,630	4,414
Additions	-	160	160	-
Remeasurements of the lease liability	876	-	876	(13)
Disposals / derecognition	-	(24)	(24)	-
Valuation / gross cost at 31 March 2026	20,898	744	21,642	4,401
Accumulated depreciation at 1 April 2025 - brought forward	3,988	203	4,191	1,332
Provided during the year	1,497	169	1,666	415
Disposals / derecognition	-	(13)	(13)	-
Accumulated depreciation at 31 March 2026	5,485	359	5,844	1,747
Net book value at 31 March 2026	15,413	385	15,798	2,654
Net book value at 1 April 2025	16,034	405	16,439	3,082
Net book value of right of use assets leased from other NHS providers	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	2,654	-	2,654	2,654

Note 22.4 Right of use assets - 2024/25

Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which:
				leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	19,967	518	20,485	4,414
Additions	502	226	728	-
Disposals / derecognition	(447)	(136)	(583)	-
Valuation / gross cost at 31 March 2025	20,022	608	20,630	4,414
Accumulated depreciation at 1 April 2024 - brought forward	2,939	188	3,127	884
Provided during the year	1,496	151	1,647	448
Disposals / derecognition	(447)	(136)	(583)	-
Accumulated depreciation at 31 March 2025	3,988	203	4,191	1,332
Net book value at 31 March 2025	16,034	405	16,439	3,082
Net book value at 1 April 2024	17,028	330	17,358	3,530
Net book value of right of use assets leased from other NHS providers	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	3,082	-	3,082	3,082

Note 22.5 Revaluations of right of use assets

No revaluations for right of use assets that have taken place in 2025/26 or 2024/25.

Note 22.6 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 36.1.

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Carrying value at 1 April	15,540	16,379	15,540	16,379
Lease additions	160	728	160	728
Lease liability remeasurements	876	-	876	-
Interest charge arising in year	215	212	215	212
Early terminations	(11)	-	(11)	-
Lease payments (cash outflows)	(1,797)	(1,779)	(1,797)	(1,779)
Carrying value at 31 March	14,983	15,540	14,983	15,540

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 22.7 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
		Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:
	Total	31 March	Total	31 March
	2026	2026	2026	2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,667	456	1,667	456
- later than one year and not later than five years;	5,857	1,520	5,857	1,520
- later than five years.	8,720	740	8,720	740
Total gross future lease payments	16,244	2,716	16,244	2,716
Finance charges allocated to future periods	(1,261)	(82)	(1,261)	(82)
Net lease liabilities at 31 March 2026	14,983	2,634	14,983	2,634
Of which:				
Leased from other NHS providers	-	-	-	-
Leased from other DHSC group bodies	-	2,634	-	2,634

Note 22.8 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
		Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:
	Total	31 March	Total	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,712	462	1,712	462
- later than one year and not later than five years;	5,988	1,602	5,988	1,602
- later than five years.	9,204	1,120	9,204	1,120
Total gross future lease payments	16,904	3,184	16,904	3,184
Finance charges allocated to future periods	(1,364)	(107)	(1,364)	(107)
Net finance lease liabilities at 31 March 2025	15,540	3,077	15,540	3,077
Of which:				
Leased from other NHS providers	-	-	-	-
Leased from other DHSC group bodies	-	3,077	-	3,077

Note 22.9 Leases – other information

The Trust has no sale and leaseback transactions or restrictions or covenants imposed by leases.

Note 23 Investment Property

The Trust has no Investment Properties

Note 24 Investments in associates and joint ventures

The Trust has no investments in associates and joint ventures

Note 25 Other investments / financial assets (non-current)

The Trust has no Other Investments or financial assets

Note 25.1 Other investments / financial assets (current)

The Trust has no Other Investments or financial assets.

Note 26 Disclosure of interests in other entities

The Trust has no interests in other entities

Note 27 Analysis of charitable fund reserves

Gloucestershire Health and Care NHS Foundation Trust Charitable Fund, registration number 1096480, has been consolidated into the Group accounts.

	31 March 2026 £000	31 March 2025 £000
Unrestricted funds:		
Unrestricted income funds	99	144
Revaluation reserve *	2,600	-
Restricted funds:		
Endowment funds	-	-
Other restricted income funds	250	243
	<u>2,949</u>	<u>387</u>

* During 2025/26 the Trust's charity revalued a piece of land it owns and the increase in value is shown in the revaluation reserve. The land is currently shown as an asset held for sale.

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 28 Inventories

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Consumables	384	444	384	444
Total inventories	384	444	384	444
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £2,246k (2024/25: £2,077k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 29.1 Receivables

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Contract receivables	12,604	13,924	12,604	13,924
Allowance for impaired contract receivables / assets	(1,351)	(1,595)	(1,351)	(1,595)
Prepayments (non-PFI)	1,807	1,636	1,807	1,636
Finance lease receivables	25	35	25	35
VAT receivable	1,219	1,083	1,219	1,083
Other receivables	835	103	835	103
NHS charitable funds receivables	13	6	-	-
Total current receivables	15,152	15,192	15,139	15,186
Non-current				
Finance lease receivables	553	1,056	553	1,056
Other receivables	168	188	168	188
Total non-current receivables	721	1,244	721	1,244
Of which receivable from NHS and DHSC group bodies:				
Current	9,080	9,068	9,080	9,068
Non-current	721	1,244	721	1,244

Note 29.2 Allowances for credit losses – 2025/26

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April 2025 – brought forward	1,595	1,595
New allowances arising	334	334
Reversals of allowances	(568)	(568)
Utilisation of allowances (write offs)	(10)	(10)
Allowances as at 31 March 2026	1,351	1,351

Note 29.3 Allowances for credit losses – 2024/25

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2024 – as previously stated	1,565	1,565
New allowances arising	411	411
Utilisation of allowances (write offs)	(381)	(381)
Allowances as at 31 Mar 2025	1,595	1,595

Note 29.4 Exposure to credit risk

The majority of the Trust's income comes from contracts with other public sector bodies. The Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

Note 30 Finance leases (Gloucestershire Health and Care NHS Foundation Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Gloucestershire Health and Care NHS Foundation Trust is the lessor.

Note 30.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Finance lease receivables at 1 April	1,091	836	1,091	836
Additions	10	977	10	977
Interest arising (unwinding of discount)	59	61	59	61
Lease receipts (cash payments received)	(97)	(94)	(97)	(94)
Derecognition due to early termination	(485)	(689)	(485)	(689)
Finance lease receivables at 31 March	578	1,091	578	1,091

For many years the Trust has had had three leases with other local NHS foundations Trusts which have been informally treated as rental agreements. After discussion with our NHS counterbodies it has been agreed that the nature of each agreement should be treated as a finance lease and these leases were treated as new finance leases in 2022/23. Two of these leases ended 31st March 2024 and the leases were renegotiated for five years starting from 1st April 2024.

In 2025/26 the Trust negotiated a new lease with a local NHS foundations Trusts leases for three years.

Note 30.2 Finance lease receivables maturity analysis as at 31 March 2026

	Group		Trust	
		Of which: leased from DHSC group		Of which: leased from DHSC group bodies
	Total 31 March 2026 £000	31 March 2026 £000	Total 31 March 2026 £000	31 March 2026 £000
Undiscounted future lease receipts receivable in:				
not later than one year;	25	25	25	25
later than one year and not later than two years;	20	20	20	20
later than two years and not later than three years;	20	20	20	20
later than three years and not later than four years;	1	1	1	1
later than four years and not later than five years;	1	1	1	1
later than five years.	140	140	140	140
Total future finance lease payments to be received	207	207	207	207
Estimated value of unguaranteed residual interest	371	371	371	371
Unearned interest income	-	-	-	-
Allowance for uncollectable lease payments	-	-	-	-
Net investment in lease (net lease receivable)	578	578	578	578
of which:				
Leased to other NHS providers	-	578	-	578

Note 30.3 Finance lease receivables maturity analysis as at 31 March 2025

	Group		Trust	
		Of which: leased from DHSC group		Of which: leased from DHSC group bodies
	Total		Total	
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Undiscounted future lease receipts				
receivable in:				
not later than one year;	35	35	35	35
later than one year and not later than two years;	37	37	37	37
later than two years and not later than three years;	39	39	39	39
later than three years and not later than four years;	42	42	42	42
later than four years and not later than five years;	1	1	1	1
later than five years.	141	141	141	141
Total future finance lease payments to be received	295	295	295	295
Estimated value of unguaranteed residual interest	796	796	796	796
Unearned interest income	-	-	-	-
Allowance for uncollectable lease payments	-	-	-	-
Net investment in lease (net lease receivable)	1,091	1,091	1,091	1,091
of which:				
Leased to other NHS providers	-	1,091	-	1,091

Note 30.4 Assets derecognised under finance leases with other DHSC group bodies

None of the four assets leased to other DHSC group bodies under finance leases are material.

Note 31 Other assets

The Trust has no Other assets

Note 32.1 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	3,123	5,025	3,123	5,025
Assets classified as available for sale in the year	3,751	98	1,001	98
Assets sold in year	(750)	(2,000)	(750)	(2,000)
Impairment of assets held for sale	(1,159)	-	(1,159)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	<u>4,965</u>	<u>3,123</u>	<u>2,215</u>	<u>3,123</u>

During 2025/26 the overall value of assets held for sale increased by £1,842k from £3,123k to £4,965k. The increase is due to three Trust assets transferring to assets held for sale increasing the value by £1,001k, two assets being sold in the year reducing the value by £750k and the impairment to market value of three assets reducing the value by £1,159k.

In addition, in 2025/26 the Trust's charity transferred an asset valued at £2,750k into assets held for sale.

During 2024/25 one asset with a total value of £98k was transferred to assets held for sale. One asset within assets held for sale was sold during the year value £2,000k resulting in an overall reduction in assets held for sale of £1,902k.

Note 32.2 Liabilities in disposal groups

The Trust has no Liabilities in disposal groups in 2025/26 or 2024/25.

Note 33.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	42,091	51,656	41,855	51,433
Net change in year	(597)	(9,565)	(552)	(9,578)
At 31 March	41,494	42,091	41,303	41,855
Broken down into:				
Cash at commercial banks and in hand	214	259	23	23
Cash with the Government Banking Service	41,280	41,832	41,280	41,832
Total cash and cash equivalents as in SoFP	41,494	42,091	41,303	41,855

Note 33.2 Third party assets held by the Trust

Gloucestershire Health and Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026	31 March 2025
	£000	£000
Bank balances	63	69
Total third party assets	63	69

Note 34.1 Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Trade payables	8,507	4,685	8,507	4,685
Capital payables	3,270	3,833	3,270	3,833
Accruals	14,563	14,126	14,563	14,126
Social security costs	2,796	2,219	2,796	2,219
Other taxes payable	2,241	2,155	2,241	2,155
PDC dividend payable	23	36	23	36
Pension contributions payable	3,513	3,296	3,513	3,296
Other payables	463	358	463	358
NHS charitable funds: trade and other payables	5	5	-	-
Total current trade and other payables	35,381	30,713	35,376	30,708
Non-current				
Trade payables	-	-	-	-
Capital payables	-	-	-	-
Accruals	-	-	-	-
Total non-current trade and other payables	-	-	-	-
Of which payables from NHS and DHSC group bodies:				
Current	1,440	1,373	1,440	1,373
Non-current	-	-	-	-

Note 34.2 Better Payment Practice code

	2025/26 number	2025/26 £000	2024/25 number	2025/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	28,484	191,176	31,834	171,420
Total non-NHS trade invoices paid within target	26,239	183,371	27,580	160,350
Percentage of non-NHS trade invoices paid within target	92.1%	95.9%	86.6%	93.5%
NHS Payables				
Total NHS trade invoices paid in the year	663	11,723	656	11,509
Total NHS trade invoices paid within target	577	10,145	473	8,056
Percentage of NHS trade invoices paid within target	87.0%	86.5%	72.1%	70.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 34.3 Early retirements in NHS payables above

The payables note above includes no amounts in relation to early retirements.

Note 35 Other liabilities

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	426	1,303	426	1,303
Total other current liabilities	426	1,303	426	1,303

Note 36.1 Borrowings

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Lease liabilities	1,469	1,514	1,469	1,514
Total current borrowings	1,469	1,514	1,469	1,514
Non-current				
Lease liabilities	13,514	14,026	13,514	14,026
Total non-current borrowings	13,514	14,026	13,514	14,026

Note 36.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2025	15,540	15,540
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,582)	(1,582)
Financing cash flows - payments of interest	(215)	(215)
Non-cash movements:		
Additions	160	160
Lease liability remeasurements	876	876
Application of effective interest rate	215	215
Early terminations	(11)	(11)
Carrying value at 31 March 2026	14,983	14,983
Group - 2024/25	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2024	16,379	16,379
Financing cash flows - payments and receipts of principal	(1,567)	(1,567)
Financing cash flows - payments of interest	(212)	(212)
Non-cash movements:		
Additions	728	728
Application of effective interest rate	212	212
Carrying value at 31 March 2025	15,540	15,540

Note 36.3 Reconciliation of liabilities arising from financing activities (Trust)

Trust - 2025/26	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2025	15,540	15,540
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,582)	(1,582)
Financing cash flows - payments of interest	(215)	(215)
Non-cash movements:		
Additions	160	160
Lease liability remeasurements	876	876
Application of effective interest rate	215	215
Early terminations	(11)	(11)
Carrying value at 31 March 2026	14,983	14,983
Trust - 2024/25	Lease liabilities	Total
	£000	£000
Carrying value at 1 April 2024	16,379	16,379
Financing cash flows - payments and receipts of principal	(1,567)	(1,567)
Financing cash flows - payments of interest	(212)	(212)
Non-cash movements:		
Additions	728	728
Application of effective interest rate	212	212
Carrying value at 31 March 2025	15,540	15,540

Note 37.1 Other financial liabilities

The Trust has no Other Financial liabilities.

Note 38.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions:		Legal claims	Redundancy	Other	Total
	injury benefits					
	£000		£000	£000	£000	£000
At 1 April 2025	200		601	95	10,317	11,213
Change in the discount rate	-		-	-	(124)	(124)
Arising during the year	-		577	854	3,500	4,931
Utilised during the year	(16)		(25)	-	(998)	(1,039)
Reversed unused	-		(223)	(95)	(4,980)	(5,298)
Unwinding of discount	-		-	-	105	105
At 31 March 2026	184		930	854	7,820	9,788
Expected timing of cash flows:						
- not later than one year;	16		882	854	5,582	7,334
- later than one year and not later than five years;	80		3	-	10	93
- later than five years.	88		45	-	2,228	2,361
Total	184		930	854	7,820	9,788

The provisions of £9,787k includes £1,017k Potential repayment when HMRC's Software VAT review is finalised, £833k Employment Tribunal Cases, £2,069k Potential finance lease dilapidations, £1,222k. Provider Collaborative, £769k Operations Restructure Programme and £2,230k International Recruitment/Sponsorship.

Note 38.2 Provisions for liabilities and charges analysis (Trust)

Group	Pensions:				Total
	injury benefits	Legal claims	Redundancy	Other	
	£000	£000	£000	£000	£000
At 1 April 2025	200	601	95	10,317	11,213
Change in the discount rate	-	-	-	(124)	(124)
Arising during the year	-	577	854	3,500	4,931
Utilised during the year	(16)	(25)	-	(998)	(1,039)
Reversed unused	-	(223)	(95)	(4,980)	(5,298)
Unwinding of discount	-	-	-	105	105
At 31 March 2026	184	930	854	7,820	9,788
Expected timing of cash flows:					
- not later than one year;	16	882	854	5,582	7,334
- later than one year and not later than five years;	80	3	-	10	93
- later than five years.	88	45	-	2,228	2,361
Total	184	930	854	7,820	9,788

Note 38.3 Clinical negligence liabilities

At 31 March 2026, £2,818k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Health and Care NHS Foundation Trust (31 March 2025: £2,558k).

Note 39 Contingent assets and liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Value of contingent liabilities				
NHS Resolution legal claims	(13)	(6)	(13)	(6)
Gross value of contingent liabilities	(13)	(6)	(13)	(6)
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	(13)	(6)	(13)	(6)
Net value of contingent assets	-	-		

Note 40 Contractual capital commitments

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	1,278	1,536	1,278	1,536
Total	1,278	1,536	1,278	1,536

Note 41 Other financial commitments

The group / Trust has no non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement).

Note 42 Defined benefit pension schemes

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation. The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Local Government Pension Scheme (LGPS)

As part of the S75 Integrated Services arrangements, the Trust employs staff who were TUPEd from Gloucestershire County Council. As part of the TUPE transfer, former local authority staff could elect to remain in the LGPS. The LGPS is a defined benefit statutory scheme administered by the County Council in accordance with the LGPS (Benefits, Membership and Contributions) Regulations 2007; the LGPS (Administration) Regulations 2008 and the LGPS (Transitional Provisions) Regulations 2008. It is contracted out of the State Second Pension.

During the financial period 1 April 2025 to 31 March 2026, the Trust's pension contributions totalled £40k and employees' contributions totalled £11k.

Key Assumptions in actuarial valuation of assets and liabilities

	31 March 2026	31 March 2025
	%	%
Pension Increase Rate	3.00%	2.80%
Salary Increase Rate	3.50%	3.30%
Discount Rate	6.20%	5.80%

The fair value of employer assets of the whole fund as at 31 March 2026 is as shown below:

	31 March 2026		31 March 2025	
	£000s	%	£000s	%
Assets				
Private Equity	322	3%	302	3%
Real Estate	893	8%	834	8%
Investment Funds & Unit Trusts	9,763	88%	9,263	88%
Derivatives	49	0%	8	0%
Cash and Cash Equivalents	248	1%	139	1%
	<u>11,275</u>	<u>100%</u>	<u>10,546</u>	<u>100%</u>

Note 42.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Present value of the defined benefit obligation at 1 April	(5,693)	(6,495)	(5,693)	(6,495)
Current service cost	(36)	(65)	(36)	(65)
Interest cost	(323)	(307)	(323)	(307)
Contribution by plan participants	(11)	(16)	(11)	(16)
Remeasurement of the net defined benefit (liability) / asset:	(324)	915	(324)	915
Benefits paid	<u>308</u>	<u>275</u>	<u>308</u>	<u>275</u>
Present value of the defined benefit obligation at 31 March	<u>(6,079)</u>	<u>(5,693)</u>	<u>(6,079)</u>	<u>(5,693)</u>
Plan assets at fair value at 1 April	10,546	10,292	10,546	10,292
Interest income	604	489	604	489
Remeasurement of the net defined benefit (liability) / asset:	(64)	-	(64)	-
- Return on plan assets	446	(34)	446	(34)
Contributions by the employer	40	58	40	58
Contributions by the plan participants	11	18	11	16
Benefits paid	<u>(308)</u>	<u>(275)</u>	<u>(308)</u>	<u>(275)</u>
Plan assets at fair value at 31 March	<u>11,275</u>	<u>10,546</u>	<u>11,275</u>	<u>10,546</u>
Plan surplus / (deficit) at 31 March	<u>5,196</u>	<u>4,853</u>	<u>5,196</u>	<u>4,853</u>

The in year increase in attributable net assets has not been reflected in the accounts of the Trust. The Trust elected at 31/3/16 not to show the value of any attributable surplus pension scheme assets on its balance sheet as there is no scenario where these would become the property of the Trust.

Note 43 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has no PFI LIFT or other service concession arrangements

Note 44 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no PFI LIFT or other service concession arrangements

Note 45 Financial instruments

Note 45.1 Financial risk management

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies, to which the reporting standards mainly apply.

The Trust's treasury management operations are carried out by the Finance Department, within parameters formally defined within the Trust's Standing Financial Instructions and policies agreed by a committee of the Board. Trust treasury activity is subject to review by the Trust's internal auditor.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency fluctuations.

Interest rate risk

The Trust invests in fixed term money market deposits with the National Loans Fund only as all other banking institutions are now not part of the Government Banking Scheme as such penalties arise on such investments. Investments are for period of three months only. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies. The Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses and capital disposals. The Trust is not, therefore, exposed to significant liquidity risks.

Note 45.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets

Cash and cash equivalents

Consolidated NHS Charitable fund financial assets

Total at 31 March 2026

Held at amortised cost £000	Total book value £000
12,833	12,833
41,303	41,303
204	204
54,340	54,340

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets

Cash and cash equivalents

Consolidated NHS Charitable fund financial assets

Total at 31 March 2025

Held at amortised cost £000	Total book value £000
12,367	12,367
41,855	41,855
242	242
54,464	54,464

Note 45.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets

Cash and cash equivalents

Total at 31 March 2026

Held at amortised cost £000	Total book value £000
12,833	12,833
41,303	41,303
54,136	54,136

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets

Cash and cash equivalents

Total at 31 March 2025

Held at amortised cost £000	Total book value £000
12,367	12,367
41,855	41,855
54,222	54,222

Note 45.4 Carrying values of financial liabilities (Group)

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2026		
Obligations under leases	14,983	14,983
Trade and other payables excluding non financial liabilities	26,080	26,080
Consolidated NHS charitable fund financial liabilities	-	-
Total at 31 March 2026	41,063	41,063

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2025		
Obligations under leases	15,540	15,540
Trade and other payables excluding non financial liabilities	21,818	21,818
Consolidated NHS charitable fund financial liabilities	5	5
Total at 31 March 2025	37,363	37,363

Note 45.5 Carrying values of financial liabilities (Trust)

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2026		
Obligations under leases	14,983	14,983
Trade and other payables excluding non financial liabilities	26,080	26,080
Total at 31 March 2026	41,063	41,063

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2025		
Obligations under leases	15,540	15,540
Trade and other payables excluding non financial liabilities	21,818	21,818
Total at 31 March 2025	37,358	37,358

Note 45.6 Fair values of financial assets and liabilities

For all categories of the Trust's financial liabilities the book values are equal to the fair values.

Note 45.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
In one year or less	27,747	23,535	27,747	23,530
In more than one year but not more than five years	5,857	5,988	5,857	5,988
In more than five years	8,720	9,204	8,720	9,204
Total	42,324	38,727	42,324	38,722

Note 46 Losses and special payments

	2025/26		2024/25	
Group and Trust	Total	Total value	Total	Total value
	number of	of cases	number of	of cases
	cases	of cases	cases	of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	3	54	27
Fruitless payments and constructive losses	1	26	-	-
Bad debts and claims abandoned	64	10	5	106
Total losses	103	69	59	133
Special payments				
Ex-gratia payments	4	1	12	5
Total special payments	4	1	12	5
Total losses and special payments	107	70	71	138
Compensations payments received.				

Note 47 Gifts

The Trust has not given any material gifts to an individual or to another organisation.

Note 48 Related parties

Gloucestershire Health and Care NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

Gloucestershire Health and Care NHS Foundation Trust is under the control of the Department of Health and Social Care, and have material transactions with NHS England, NHS Gloucestershire ICB and Gloucestershire Hospitals NHS Foundation Trust.

The Trust has had a number of material transactions other government departments and other central and local government bodies within the public sector such as Gloucestershire County Council, NHS Pension Scheme and HM Revenue and Customs.

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

A Non-Executive Director, Nicola de longh, is Chair of the University of Gloucestershire Council.

Associate Non-Executive Director, Dr Cathia Jenainati, is an employee of the University of Gloucestershire and is an appointee nominated by the University of Gloucestershire.

In 2025/26 the Trust spent £95,239 with the University of Gloucestershire.

An Associate Non-Executive Director, Vicci Livingstone-Thompson, is Chief Executive of Inclusion Gloucestershire. In 2025/26 the Trust spent £2,505 with Inclusion Gloucestershire.

During the year none of the members of the Council of Governors have undertaken any material transactions with the Trust.

Joy Hibbins is a Public Governor and is the Chief Executive of Suicide Crisis, a national charity. The Trust had no financial transactions with this organisation.

Jan Lawry is a Public Governor and is the Chair of Age UK Gloucestershire. The Trust had no financial transactions with this organisation.

Dr Paul Winterbottom, a Consultant Psychiatrist in our Learning Disabilities service, is a Staff Governor. Dr Winterbottom is also the Chair and Trustee Gloucestershire Young Carers, and a Trustee/Director with Kingshill House Trust. The Trust have no financial transactions with these organisations.

The Council of Governors has four Appointed Governors:

Cllr Dr Richard Dean is the Gloucestershire County Council appointed governor where is a County Councillor. The Trust spent £17,916,324 in 2025/26 with Gloucestershire County Council.

Bob Lloyd-Smith is the Healthwatch Gloucestershire Appointed Governor. He is also a Trustee with the Gloucestershire Rural Community Council. The Trust have no financial transactions with Healthwatch Gloucestershire and spent £41,483 in 2025/26 with Gloucestershire Rural Community Council.

Alicia Wynn is the Young Gloucestershire Appointed Governor where she is Chief Operations Officer. The Trust had no financial transactions with this organisation.

Andrew Cotterill is the Inclusion Gloucestershire Appointed Governor where is he is the Deputy Chair and Treasurer. In 2025/26 the Trust spent £2,502 with Inclusion Gloucestershire.

Trustees, officers and key management staff of Gloucestershire Health and Care NHS Trust Charities are members of the Board of Gloucestershire Health and Care NHS Foundation Trust or its employees. During 2025/26 (and 2024/25) none of the trustees or members of key management staff or parties related to them undertook any material transactions with the Gloucestershire Health and Care NHS Trust Charities. The executive and non-executive Directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as a corporate Trustee in managing the charitable funds.

Note 48 Related parties (continued)

The Trust is the corporate Trustee to Gloucestershire Health and Care NHS charitable fund, registration number 1096480. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

	31 March 26 £000	31 March 25 £000	
Charity's statement of financial activities / SoCI			
Operating income	67	82	
Cash donations and other cash expenditure	(103)	(63)	
Audit fee (payable to external auditor)	(2)	(2)	
Total operating expenditure	(105)	(65)	
Net (outgoing) / incoming resources before other recognised gains and losses	(38)	17	
Net movement in funds	(38)	17	
	31 March 26 £000	31 March 25 £000	31 March 24 £000
From charity's balance sheet / statement of financial position			
Non-current assets			
Property, plant and equipment	-	150	150
Total non-current assets	-	150	150
Current assets			
Receivables	13	6	1
Non-current assets for sale and assets in disposal groups	2,750	-	-
Cash and cash equivalents	191	236	223
Total current assets	2,954	242	224
Current liabilities			
Trade and other payables	(5)	(5)	(4)
Total current liabilities	(5)	(5)	(4)
Net assets	2,949	387	370
Funds of the charity			
Restricted funds:	250	243	225
Unrestricted funds:	99	144	145
Revaluation Reserve	2,600	-	-
Total current trade and other payables	2,949	387	370

Note 49 Transfers by absorption

There are no Transfers by absorption in 2025/26 or 2024/25.

Note 50 Prior period adjustments

There were no Prior Period adjustments in 2025/26 or 2024/25.

Note 51 Events after the reporting date

There are no Events after the Balance Sheet Date that need reporting.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

Opinion on financial statements

We have audited the financial statements of Gloucestershire Health and Care NHS Foundation Trust (the Trust) for the year ended 31 March 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs), and as interpreted and adapted by the 2025-26 Government Financial Reporting Manual as contained in the Department of Health and Social Care, Group Accounting Manual 2025-26, and the NHS Foundation Trust Annual Reporting Manual 2025-26 issued by NHS England.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Gloucestershire Health and Care NHS Foundation Trust as at 31 March 2026 and of its expenditure and income for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care, Group Accounting Manual 2025-26; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration Report and Staff Report

We have also audited the information in the Remuneration Report and Staff Report that is described in those reports as having been audited.

In our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025-26.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in this regard.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice we report to you if:

- in our opinion, the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with our knowledge acquired in the course of the audit; or
- we refer a matter to the regulator under Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accounting Officer of the Trust, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Our procedures included the following:

- inquiring of management, the Trust's head of internal audit, the Trust's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements for any special payments;
- discussing among the engagement team and involving relevant internal specialists, including regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, expenditure recognition around year end and posting of unusual journals;

- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. Relevant laws and regulations identified include VAT legislation, PAYE legislation, the DHSC Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and legal advisors concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantively testing increased samples of income and expenditure around year end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at:

<https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Auditor's other responsibilities

As set out in the 'Other matters on which we report by exception' section of our report there are certain other matters which we are required to report by exception.

We have nothing to report in respect of these matters.

Delay in respect of certificate of completion of the Audit

As required by Auditor Guidance Note 07, we cannot formally conclude the audit and issue an audit certificate, as confirmation is yet to be issued from the NAO that the audit of the Department of Health & Social Care is complete. We will issue our audit certificate under a separate cover when this has been completed. This will close out the audit.

Use of our report

This report is made solely to the Council of Governors of Gloucestershire Health and Care NHS Foundation Trust, as a body, in accordance with Schedule 10 of the National Health Service Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Council of Governors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.



Brian Clerkin (Senior Statutory Auditor)

For and on behalf of

Sumer NI Auditco Limited

Registered Auditors

4th Floor Glendinning House

6 Murray Street

Belfast

BT1 6DN

Date: 25 June 2026

Quality Report

The Trust has produced a quality account for 2025/26 with engagement of stakeholders. The report has been published on our website.

Contact Us

If you would like to contact the Trust you can:

Write to: Trust Secretary, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester GL3 4AW

Email: trustsecretary@ghc.nhs.uk

Tel: 0300 421 7111

Communicating with Governors

Members of the Trust may contact Governors via:

Email: trustsecretary@ghc.nhs.uk

Writing to: Freepost RLYA-XAKR-HABZ, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester GL3 4AW

Telephone: The Deputy Trust Secretary on 0300 421 7111

There is also a feedback form on the Trust website at www.ghc.nhs.uk

Information in other languages/formats

If you would like the Annual Report in large print, Braille, audio cassette tape or another language please telephone 0300 421 7146 or email us at ghccomms@ghc.nhs.uk.

List of acronyms

AMHP	Approved Mental Health Professional
ARM	Annual Reporting Manual
ATOS	Appointment and Terms of Service Committee
BAF	Board Assurance Framework
BI	Business Intelligence
BREEAM	Building Research Establishment Environmental Assessment Method
CEO	Chief Executive Officer
COO	Chief Operating Officer
CQC	Care Quality Commission
CQUIN	Care Quality Initiative
DHSC	Department of Health and Social Care
EDI	Equality, Diversity and Inclusion
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Returns Information Collection
ESR	Electronic Staff Record
EV	Electric Vehicle
FCCA	Fellow of Chartered Certified Accountants
FFT	Friends and Family Test
FT	Foundation Trust
GARAS	Gloucestershire Action for Refugees and Asylum Seekers
GHC	Gloucestershire Health and Care
GMC	General Medical Council
GP	General Practitioner
HR	Human Resources
ICB	Integrated Care Board
ICS	Integrated Care System
ILP	Integrated Locality Partnership
IPC	Infection Prevention and Control
IT	Information Technology
IUCS	Integrated Urgent Care Service
IV	Intravenous Therapy
LCFS	Local Counter Fraud Service
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MHA	Mental Health Act
MIU	Minor Injury and Illness Unit
MS Teams	Microsoft Teams
NED	Non-Executive Director
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OD	Organisational Development
NPSA	National Patient Safety Alerts
PALS	Patient Advice and Liaison Service
PCET	Patient and Carer Experience Team
PCREF	Patient, Carer Race Equality Forum
PHSO	Parliamentary Health Service Ombudsman
PLICS	Patient Level Information and Costing System
SCAAS	Social Communication and Autism Assessment Service
SEQOHS	Safe, Effective, Quality Occupational Health Service accreditation
SRO	Senior Responsible Officer
TFCD	Task Force on Climate Related Disclosures
TUPE	Transfer of Undertakings Protection of Employment
TOR	Terms of Reference
VCSE	Voluntary Community Social Enterprise
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
QI	Quality Improvement
QR	Quick Response

