Meeting of Group Board of Directors of NBT and UHBW held in Public
on Tuesday, 12 May 2026, 10.00 to 13.00
at The Park Centre, Daventry Road, Knowle West, Bristol BS4 1DQ

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
Preliminary Business				
1.	Apologies for Absence	Information	Group Chair	10:00 (30 mins)
2.	Declarations of Interest	Information	Group Chair	
3.	Patient Story	Information	NBT Head of Patient Experience	
4.	Minutes of the Last Meeting held on 10 March 2026	Approval	Group Chair	10:30 (5 mins)
5.	Matters Arising and Action Log	Approval	Group Chair	
6.	Questions from the Public	Information	Group Chair	10:35 (5 mins)
Strategic				
7.	Group Chair's Report	Information	Group Chair	10:40 (10 mins)
8.	Group Chief Executive's Report	Information	Group Chief Executive	10:50 (15 mins)
9.	Group Benefits Realisation Quarter 4 2025/26	Information	Group Formation Officer	11:05 (10 mins)
10.	Merger Update	Information	Group Formation Officer	11:15 (15 mins)
11.	Green Plan Annual Report and Sustainability Initiatives	Approve	Group Finance and Estates Officer	11:30 (10 mins)
12.	Research and Development Annual Report	Information	Group Chief Medical and Innovation Officer	11:40 (10 mins)
BREAK – 11:50 - 12:00hrs				
Quality and Performance				
13.	Group Integrated Quality and Performance Report	Information	Hospital Managing Directors and Executive Leads	12:00 (20 mins)
14.	Corridor Care at UHBW and NBT	Approval	Hospital Managing Directors	12:20 (5 mins)
People				
15.	Freedom to Speak Up Annual Report	Information	Group Chief of Staff	12:25 (10 mins)
Governance				

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
16.	Accountability Framework	Approval	Group Director of Governance	12:35 (10 mins)
17.	Integrated Governance Report including Committee Chairs' Reports and Register of Seals	Information	Committee Chairs	12:45 (10 mins)
Concluding Business				
18.	Any Other Urgent Business – *Verbal Update*	Information	Group Chair	12:55 (5 mins)
19.	Date of Next Meeting **Tuesday, 14 July 2026**	Information	Group Chair	

DRAFT Minutes of the Public Group Board Meeting of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

Held on Tuesday, 10 March 2026 at 10am to 12.45pm
In the David Baker room at the Vassall Centre, Fishponds, Bristol

Present

Joint Members of both Boards:	
Ingrid Barker	Group Chair and Non-Executive Director
Paula Clarke	Group Formation Officer
Neil Darvill	Group Chief Digital Information Officer
Richard Gaunt	Group Non-Executive Director
Steve Hams	Group Chief Nursing and Improvement Officer
Glyn Howells	Hospital Managing Director, NBT
Maria Kane	Group Chief Executive
Neil Kemsley	Group Chief Finance and Estates Officer
Linda Kennedy	Group Non-Executive Director
Jenny Lewis	Group Chief People and Culture Officer
Pipim Poku Osei	Group Non-Executive Director
Sarah Purdy	Group Non-Executive Director and NBT Vice-Chair
Roy Shubhabrata	Group Non-Executive Director
Martin Sykes	Group Non-Executive Director and UHBW Vice-Chair
Tim Whittlestone	Group Chief Medical and Innovation Officer
NBT Board member:	
Shawn Smith	Non-Executive Director, NBT
UHBW Board member:	
Sue Balcombe	Non-Executive Director, UHBW

Also In Attendance:

Xavier Bell	Joint Chief of Staff
Richard Gwinnell	Deputy Trust Secretary, NBT *(author of minutes)*
Emily Judd	Corporate Governance Manager, UHBW
Philip Kiely	Chief Operating Officer, UHBW (substituting for Stuart Walker, Hospital Managing Director, UHBW) *(from minute number 10/03/26)*
Elliot Nichols	Group Director of Communications and Engagement
Lavinia Rowsell	Group Director of Corporate Governance
Emily Ayling	Head of Patient Experience, NBT (*for the patient story*)
John Kirby	General Manager, Urology Services (*for the patient story*)
Amy Hadley	Team Lead Uro-Oncology Clinical Nurse Specialist (*for the patient story*)
Observers, partner representatives and members of the public:	
Peter Bryant	NHS England System Assurance and Regulation
Anne-Marie Hellier	NHS England System Assurance and Regulation
Beth Woolfson	NHS England System Assurance and Regulation

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Elly Holmes	NHS Professionals
Kate Turnbull	NHS Professionals
Ben Argo	Lead Governor, UHBW
Jackie Haskins	Bristol Protect our NHS (campaign group)
Norma Wilson	Bristol Protect our NHS (campaign group)
Peggy Woodward	Bristol Protect our NHS (campaign group)
Pete	Patient, and Community Partnership Group member (*for the patient story*)
Russell Edwards	The Surgical Consortium
Dr Nick Smith	10-Point Plan Resident Peer Rep
Dr Joanna Fawcett	Locum Consultant Neurologist in Neurorehabilitation, NBT
Raj Kakar-Clayton	Associate Non-Executive Director, Gloucestershire Hospitals NHS Foundation Trust

Minute Ref.	***Item***	***Actions***
01/03/26	**Welcomes and Apologies for Absence**	
	Ingrid Barker, Group Chair, welcomed everyone to the meeting. Apologies for absence were received from Marc Griffiths, Group Non-Executive Director and from Stuart Walker, Hospital Managing Director, UHBW.	
02/03/26	**Declarations of Interest**	
	No interests were declared.	
03/03/26	**Patient Story**	
	The Board welcomed and heard from Pete, a prostate cancer patient (and a member of the Community Partnership Group). Pete described and explained the timeline and processes, from his initial symptoms to having tests, being diagnosed, being told his diagnosis and then being treated, and what had occurred since, as well as during the whole period since his visit to his GP in October 2024. Pete reflected on his experiences, highlighting: • the exceptional care he felt he had received at NBT in the 511 days of his care (so far): he described this as “world leading surgery and care; beyond good; excellent” • the significant improvements made by the Urology Service and the outstanding skills, compassion, care, kindness, efficiency and competency shown by staff • the extreme stress felt by patients about their condition, diagnosis, treatment and prospects, and the compassion with which the clinical nurse specialist had explained his diagnosis and the available procedures and options, listened to him and spent an hour with him, as well as accompanying him after his treatment and discharge to the lift, rather than leaving him alone to find his way • his My Medical Records experience, which enabled him to contact the oncology team when he was on holiday on a boat near Croatia, and subsequently to get an answer within an hour on what medication he needed (which he obtained when in Croatia) • that cancer was not a death sentence; he now felt cancer free and his regular testing regime was reducing in frequency	

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	• the worst bit of the whole experience was the 6-week wait between being tested and waiting for the news of his results; it would be good if this waiting time could be minimised to zero days • the unfortunate use (over the phone) of the word "unfortunately" at the very start of the conversation (with him by the clinical team) about his MRI test results; hearing "unfortunately" first negatively coloured the rest of the conversation and made the detail difficult to absorb • the helpful responses (to his letters) from the Chief Executive and the Director of Quality Governance, which demonstrated listening at all levels of the organisation, from the ward to the Board, and the importance of this to the overall quality of care delivered • that he had waited 154 days to receive a "bag full of paper" about his condition; this information would have been better provided much earlier and provided electronically • he would prefer to have attended in person to discuss his test results, rather than receiving a phone call (especially as a later appointment in person seemed to him a waste of time). John Kirby and Amy Hadley answered questions about the improvements being made in Urology, including faster diagnosis, better communication of results, My Medical Records, artificial intelligence (to speed up the time from MRI tests to results) and other processes and digital solutions, including linking up data and patient records between different systems and care providers. Board members thanked Pete and the Urology team, commenting on: • the importance of good communication with patients at all times • the importance of learning from patient stories and experiences • the challenge of trying to reduce unnecessary hospital attendances, while recognising that the hour spent by the clinical nurse specialist face to face with Pete was one of the most important hours with him • the importance of spending the right amount of time with patients at the right intervention times (and improving efficiency and effectiveness by reducing time wasted with patients at the wrong times) • the need to "slow down in order to speed up" i.e. increase time listening to patients early on in the process, to save wasted time later • the need during and after the Covid-19 pandemic to have conversations over the phone with patients about their test results and diagnoses, and the difficulties this had involved • the importance of triangulating (as the Trusts did) timeliness, safety and patient experience considerations • the importance of clinical teams seeing Pete's story and understanding experiences from the patient's perspective • the dangers of "hitting the target but missing the point" if staff did not have empathy with patients • the importance of remembering how psychological health impacted on physical health • Pete's continued work and connection with the Trusts through the Community Partnership Group. **RESOLVED: the patient story was noted and welcomed.** *Pete, Emily Ayling, Amy Hadley, John Kirby and Emily Judd left the meeting.*	

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04/03/26	**Minutes of the last meeting: 13 January 2026**	
	RESOLVED: the minutes of the Public meeting of the Board held on 13 January 2026 were approved as a correct record of that meeting.	
05/03/26	**Action Log and matters arising**	
	RESOLVED: the action log (with one closed item and no actions outstanding) was noted. No discussion arose.	
06/03/26	**Questions from the public**	
	The Board received the following questions from the public and answers to those questions, prepared by relevant officers of the Trusts. The questions which had been submitted in advance were read aloud by Lavinia Rowsell, Group Director of Corporate Governance. The replies (shown below in full) were summarised verbally by Paula Clarke, Group Formation Officer (who replied to questions 1 to 4) and by Neil Darvill, Group Chief Digital Information Officer (who replied to questions 5 to 7). The full written replies had also been sent to the questioners prior to the meeting: **Question 1**: What impact do you envisage the merger will have on patients? **Answer:** The benefits of merging are based on our assessment that this will give us the strongest possible platform to deliver for our patients, people, population and the public purse. By coming fully together, we will accelerate progress, deepen collaboration, and build the kind of modern, innovative and resilient organisation that our communities deserve. We believe a merger has the potential to deliver real and lasting benefits for patients across Bristol, North Somerset and South Gloucestershire. By bringing our two organisations together as a single entity, we can go further and faster in delivering our Joint Clinical Strategy (2024-2027) and creating more consistent, high-quality care with less variation across sites. Through our Group Clinical Services, which already bring clinical teams together across both Trusts, we have begun to see early evidence of what is possible. In areas such as cardiology, trauma and orthopaedics, and pain services, integrated teams are reducing waiting time variation, improving care coordination and strengthening service resilience. A merger would enable us to extend this model across all our services more rapidly. More specifically, patients can expect: • more consistent clinical pathways and reduced variation in outcomes, • better access to specialist services across more sites, • improved patient experience through unified digital systems for feedback and appointment management, • and a stronger platform for research and clinical trials, meaning more patients across our region can benefit from the latest treatments and innovations. We want to be clear that all current services will be maintained. The merger is about improving and integrating what we already do, not reducing it.	

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	Question 2: Which services do you plan to amalgamate, and will amalgamation reduce the services available to patients? **Answer:** No clinical services will be reduced or removed as a result of the merger. Our intention is to protect and strengthen services across all sites. The merger is one of equals. Parity across all hospitals, sites, and services is a founding principle of our approach. What the merger does enable is deeper clinical integration across services that are already working together through our Group Clinical Services model. We have identified 40 services where both Trusts currently provide similar provision and where closer working can reduce unnecessary duplication, standardise pathways and improve outcomes. This is not about closing or reducing services; rather, it is about clinical teams working more closely together to deliver more consistent, high-quality care wherever patients are seen. Should any future changes to service delivery be proposed, whether related to the merger or not, these will be subject to appropriate clinical review, patient and public engagement, and the relevant regulatory and governance processes. There are no current plans to change the configuration of services at any of our sites because of the merger. **Question 3**: What impact will the merger have on staff, and will there be an increase in staff numbers and/or redundancies? **Answer:** The case for merger is not being pursued as a redundancy programme or a cost-cutting exercise; it is focused on enabling better co-ordination, reducing duplication in processes and governance, and directing capacity and effort where it matters most: improving patient care and outcomes. The merger is being explored to support delivery of our Joint Clinical Strategy by removing organisational and administrative barriers that can slow down improvement and strengthen the resilience of the Group. For staff, the intended impact is greater opportunity and sustainability over time: a larger organisation will provide broader career pathways, enhanced training and development opportunities and a more resilient workforce model that is better able to respond to changing demand. The merger will mean that employees of North Bristol NHS Trust will transfer their employment to University Hospitals Bristol and Weston NHS Foundation Trust with all their contractual terms protected, ensuring a smooth transition to deliver the merger. If any future organisational changes were proposed that affected staff, they would be developed transparently and would follow appropriate engagement and consultation, in line with national requirements and employment law. There are no specific plans to increase staff numbers because of merger. However, the scale of the new organisation offers future opportunities for greater partnerships. **Question 4**: Will the merger detract from the work to reduce waiting lists? **Answer:** No. The merger exploration is intended to support, not detract from, the work to reduce waiting lists by strengthening our ability to plan and deliver improvements across clinical services at scale. The Joint Clinical	

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	Strategy and related transformation work are already underway and will continue regardless of the outcome of the merger exploration. The merger is not a prerequisite for elective recovery activity. However, it will enhance and make it easier by removing barriers, supporting innovation and maximising utilisation of available capacity across all sites, including approaches such as single points of referral access and joint management of waiting lists to keep waits to a minimum. In practical terms, the direction of travel is about improving access and flow by using collective capacity more effectively and reducing the friction that can be created when patients' journeys, workforce, data, or operational processes span organisational boundaries. This is consistent with the approach already being taken through joint planning and delivery, including the development of additional elective capacity via the Princess Royal Bristol Surgical Centre to support both Trusts in catching up on planned care activity, and the expansion of Community Diagnostic Centres to speed up diagnosis and treatment and help reduce waits by improving access closer to home. **Question 5**: Have you given consideration to the possibility of reputational damage, loss of public trust and moral injury to your staff, associated with the use of a company with Palantir's operational history? **Question 6**: Have you taken informed specialist advice on the ability to ensure that data stored by Palantir would not be available for them to sell or use for purposes other than that for which they have been contracted? **Question 7**: If the UBHW/NBT/Joint NHS Hospital Trusts have already agreed to the use of Palantir FDP, when is the contract due for review? **Answer:** In January, Bristol NHS Group published a statement on our Trust websites regarding the Federated Data Platform (FDP – Palantir). The statement explains what the FDP programme is, our current local position (early stages of adoption), and the governance arrangements and safeguards we are applying. The statement also confirms that we will not respond individually to concerns raised. Instead, we will keep a single Bristol NHS Group statement under review and updated, and we will direct people to the FDP information published by NHS England, including details of how to contact NHS England directly for further information. Martin Sykes, Group Non-Executive Director and Vice-Chair of UHBW suggested that the websites of the Trusts be reviewed to ensure information including FAQs about the merger was easily accessible to the public. Elliot Nichols, Group Director of Communications and Engagement, confirmed that this work was in hand.	
07/03/26	**Group Chair's report**	
	The Board considered a report of the Group Chair, informing them of activities undertaken by the Group Chair and Vice-Chairs in the period leading up to the Board meeting, including key developments at the Trusts and further afield, as	

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	well as meetings held and attended internally and externally with partners, including national and regional engagement activities. Ingrid Barker, Group Chair, outlined her report briefly, commenting on the significant focus on and progress with Group Clinical Services, Group development and merger work, as well as the extensive partnership work she was involved in, including meetings with Council leaders, Mayors, Chairs of other bodies including the Health and Wellbeing Board, West of England Combined Authority, voluntary and community sector organisations, the Police and Crime Commissioner, Healthwatch, One City Partners, Integrated Health and Social Care System partners and others. Sarah Purdy, NBT Vice-Chair commented on the privilege she had of attending the recent celebration of the 10,000th Robotics procedure. The event was attended by local school children as well as a number of staff, including porters and other staff who would not normally see the “big picture” but could pass on their newly gained knowledge and reassurance to the patients they came into contact with in future, having seen the demonstration. **RESOLVED: the Board noted the Group Chair’s report.**	
08/03/26	**Group Chief Executive’s report**	
	The Board considered a report of the Group Chief Executive, informing them of key items of interest to the Board, including engagement with system partners and regulators, events and key staff appointments, as well as national topics of interest and updates on the Integrated Care System, strategy and culture issues, operational delivery, and engagement and service visits. Maria Kane, Group Chief Executive, outlined her report briefly, highlighting: • the need for increased Board oversight in future in relation to supporting clinical research delivery; this would be incorporated in future plans • the two-year anniversary of Bristol Royal Hospital for Children’s “Coral Reef” clinical research facility and the excellent work it was doing to improve outcomes for children with complex and rare conditions, through clinical research and trials • the groundbreaking Gene Therapy study for kidney disease work taking place in the Bristol NHS Group • the appointment of new chief officers and non-executive directors in the Gloucestershire and Bristol, North Somerset and South Gloucestershire (BNSSG) Cluster • continuing operational delivery and performance challenges, including the need to go further to minimise and eliminate “temporary escalation spaces” (also known as “corridor care”) • the recent launch of the TUPE consultation process for staff of NBT who would be transferring to the employment of UHBW upon merger and the significant efforts being made to engage staff and reduce anxiety about the process and outcomes • the significant progress being made with Group Clinical Services and the extensive partner and public engagement taking place • both Trusts’ compliance with the Maternity Incentive Scheme standards	

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	• the significant amount of positive media coverage recently about the Trusts, the importance of public confidence in the care delivered by the Trusts, and her thanks to everyone involved for their hard work • the work taking place with the Integrated Care Boards (ICBs) (BNSSG and Gloucestershire) and the expectation of more information from NHS England on the functions of ICBs; allowing comparison, greater consistency and more joined-up working in future. Board members commented on: • positive media coverage of the Children's Hospital • the positive language and tone of the Group Clinical Strategy (GCS) • the opportunities to use South Bristol Community Hospital and its easy accessibility by public transport for patients • the need for Board members to see corridor care data in detail and understand what and where the challenges and barriers were • that this level of detail would be included in the Integrated Quality and Performance Report (IQPR) from May • all Trusts differed in their definition of escalation spaces; the issue was also about having the right staff in the right place at the right time • the need for more data on benefits in the GCS; e.g. how many more patients could be seen and whether they could be seen more quickly as a result of GCS • the Board had already debated the need for more key performance indicators (KPIs) and would see more in future • the GCS was aimed at multiple audiences and was principally designed to set out the ambition, not the granular detail of anticipated outcomes; this detail was nevertheless available and would be reported to the Board in due course • the links between the need for corridor care and no criteria to reside; too many people in hospitals (who didn't need to be in hospitals) meant less room for everyone • the need for clarity on the effect of GCS in terms of what estates would be needed and what IT would be needed in future • the work going on with ICB partners and internally to tackle no criteria to reside; the Trusts were doing everything in their power • the Board event planned for April, to discuss no criteria to reside issues, including barriers and solutions (internal and external) • the many interdependencies and complexities of the extensive work underway and the need to ensure integration of effort. **RESOLVED: the Board noted the Group Chief Executive's report.**	
09/03/26	**Merger Update**	
	The Board considered a report of the Group Formation Officer, providing an update on the programme of work underway to support the Board's intention to pursue a merger of NBT and UHBW. Paula Clarke, Group Formation Officer introduced the report, highlighting: • the importance of merger to delivering the benefits previously discussed in detail by the Board	

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	• the extensive detail of the merger plans and significant work taking place in various workstreams to ensure day 1 readiness and post-merger integration plans, as well as maintaining business as usual • that reports had been submitted to all Board committees on the detail relevant to them, as well as to UHBW Governors • the assurance given of robust day 1 plans and post-merger operationally safe organisational readiness through the full business case (FBC) and post-transaction integration plan (PTIP) previously considered by the Board and committees • that the FBC and PTIP had been submitted to NHS England for review; representatives of NHSE were testing the plans and were attending this meeting • the extensive consultation and engagement undertaken and continuing • the ongoing TUPE staff transfer process • challenges raised by the Audit Committee and work continuing to progress and prioritise the detailed merger plans. Board members commented on: • the open and honest communications taking place with staff (e.g. through the recent Town Hall event hosted by the Group Director of People and Culture) • the importance of engaging with and answering questions from staff, including the need for managers to be briefed, so they could answer questions from staff on a local level. Jenny Lewis, Group Director of People and Culture explained the extensive work ongoing to inform and engage with staff and to brief managers, including videos, FAQs, regular all-staff emails, intranet messaging and managers' packs. Trade union colleagues were also working hard to engage with staff who were traditionally less engaged. Maria Kane reported that there was anxiety but also excitement among staff about the prospects, that merging was the best way to sustain and improve NHS services in Bristol for the future. **RESOLVED: that the Board:** **(1) notes progress and the next steps for the merger programme, with focus on external assurance, readiness planning and robust, dynamic communication and engagement with staff and external stakeholders and** **(2) notes the current assurance position, including the Audit Committee and Quality and Outcomes Committee reviews.** The Board adjourned at this point for a brief comfort break.	
10/03/26	**Group Integrated Quality and Performance report (IQPR)**	
	Philip Kiely, Deputy Chief Operating Officer, UHBW, joined the meeting. The Board considered the IQPR, which provided the latest overview of NBT's and UHBW's performance across urgent and planned care, quality, workforce and finance domains.	

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	Glyn Howells, Hospital Managing Director, NBT outlined the NBT position on referral to treatment (RTT) targets, where NBT was slightly behind plan but had robust recovery and "sprint" plans in place, which had been agreed with NHSE. Confidence was high that gaps in performance would be closed by year-end. On diagnostics, performance would be on target (no more than 1% waiting more than 6 weeks) by year-end, with recent challenges overcome. On cancer, performance against the 62-day standard remained below target, again with recovery plans in place and agreed with NHSE, with an expectation of compliance by year-end (and compliance already achieved in most specialisms) except in relation to urology and breast, which accounted for more than half of cancer patients between them. There were particular challenges around the national shortage of radiologists (with a new recruit not arriving for six months) and the high number of patients being transferred to NBT from other hospitals (with treatment time targets already in breach for 96 out of 97 people). On urgent and emergency care (UEC), 4-hour performance was improving but not yet on target, due mainly to no criteria to reside numbers, with "sprint" work ongoing to improve achievement. The South-West Ambulance service had improved category 2 response times, with faster handovers at hospital front doors, but the number of conveyances of patients to hospital were significantly increased, leading to overcrowding in UEC due largely to no criteria to reside numbers and flow challenges. Philip Kiely outlined the UHBW position on RTT, where the Trust was on track to deliver against the 52-week target and had stretch targets in progress. On cancer, all three main standards had been achieved in December, with a dip in January due to patient choice decisions and chemotherapy capacity challenges, but recovery in February due to additional recruitment and planned building works. Diagnostics performance was below target due to the loss of two modular wards at the BRI and workforce challenges, but improvement actions were underway, working with partners. On UEC, performance was below target, due largely to the numbers of people with no criteria to reside and the loss of 50 beds (due to the loss of two modular wards). "Sprint" work was underway to improve performance against the targets, including launching new clinical operational standards, expanding Medical, Frailty, Surgical and BHOC same day emergency care (SDEC) capacity and learning from NBT's Acute Medical Triage system. Despite the challenges, including an exceptionally high number of conveyances to hospital, the improvement in ambulance handover times was being sustained. Maria Kane referred to discussions taking place at regional level and with the SWAG Cancer Alliance about the number of late-stage referrals to NBT from other hospitals, with progress expected soon on potential solutions. Reference was made to the apparent positive news in the IQPR, of improving targets and performance generally, including in relation to ambulance handover times. Comments were made about the huge pressures on staff and space, impacting on patients, including the need for "corridor care" to manage the continuing high levels of demand. Questions were also asked about Stroke performance being off target. Tim Whittlestone, Chief Medical and Innovation Officer reminded the Board that NBT had the largest Stroke Unit in the UK, with the greatest number of referrals to it, and that the service was under significant pressure, due mainly to the lack of sufficient Stroke rehabilitation beds outside hospital. The service	

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	had been designed in effect for too many patients, as a greater number of rehabilitation beds outside hospital had been assumed from the beginning. Too many people were staying in hospital for longer than needed, with no criteria to reside. Discussions were ongoing with ICB partners, in particular about improving stroke rehabilitation services for people in their own homes. NBT Stroke services were very successful in terms of improving outcomes for patients and demand far outweighed capacity. Sarah Purdy, Chair of the Quality and Outcomes Committee (QOC) confirmed that the QOC continued to focus on Stroke services. Ingrid Barker and Maria Kane reminded the Board of discussions planned for April about no criteria to reside and flow issues. Steve Hams, Group Chief Nursing and Improvement Officer, provided an update on the quality section of the IQPR, commenting on high levels of MRSA and C.Diff infections at UHBW, which were being closely monitored and had been reviewed by QOC; an increase in the number of falls at Weston General Hospital in January, the reasons for which were under review; complaint response times, which were volatile and where work was underway to look at solutions including AI; and the perinatal quality surveillance matrix data, which had been reviewed in detail by QOC. Tim Whittlestone commented on the learning from deaths data, including the recent structured judgement review, close working with the Medical Examiner service and opportunities for learning and improvement. The Summary Hospital Mortality Indicator (SHMI) rates for both NBT and UHBW were 'as expected'. Jenny Lewis commented on the People section of the IQPR, highlighting an increase in vacancies, with significant work ongoing in relation to some clinical vacancies, and deliberate holding of corporate services vacancies to achieve required efficiencies; and on Oliver McGowan training, where tier 1 training attendances were high and more work was required on tier 2 training. Neil Kemsley commented on the finance section of the IQPR, updating the Board with February data, including an improved position on the Trusts' deficit from £7.1m to £2.6m, high confidence of achieving breakeven by year-end, improvement in the cash position, high Cost Improvement Programme (CIP) achievement (£80m), ongoing discussions about aligning the NBT and UHBW CIP approaches, and on-track capital expenditure (c£110m in 2025-26). **RESOLVED: the Board noted the updates.**	
11/03/26	**Biannual Safe Staffing reports NBT and UHBW: Nursing and Midwifery Workforce**	
	The Board considered a report of the Group Chief Nursing and Improvement Officer, providing the Board with assurance, in line with National Quality Board guidance, that nursing and midwifery levels, patient acuity and workforce risks were systematically monitored and managed across the Group. Steve Hams outlined the report, highlighting: • his thanks to nursing and midwifery colleagues for their exceptional work, of which everyone should be proud	

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	• the use of the Safer Nursing Care Tool (SNCT) and BirthRate Plus (BR+) data collection exercises to inform this report • that the Trusts had a healthy pipeline of nurses and midwives, with some challenges recruiting and retaining healthcare support workers • challenges around the high number of patients and the need for additional temporary staff to meet the demand, alongside the increase in patient acuity, especially in women's and children's services • the differences in headroom between NBT and UHBW • the need for approximately 35 additional midwives, across the Group, to meet BR+ requirements, and the work taking place to plan ahead • recruitment challenges in neonatal intensive care (NICU) • that NBT had been awarded Best UK Employer of Nursing Staff in 2025. Questions were asked by NEDs and other Board members about the level of confidence in securing funding for the BR+ requirements and maternity triage at UHBW, about differences in staffing numbers between UHBW and NBT, about the "red flag" system for staff to raise concerns about staffing numbers, and about how the "stop the line" (Patient First) process sat alongside the red flag system. Neil Kemsley and Steve Hams responded, in summary, that: • there was provision in the 2026/27 budget plans for maternity triage and SNCT funding • the red flag system was a key part of good governance and would be retained, alongside the "stop the line" system, which empowered employees to "stop the line" if they had concerns • safer staffing review processes were being aligned between NBT and UHBW; this would lead to greater consistency and aligned reporting • staffing numbers were different as the Trusts were different; for example, in terms of ward layouts, single-patient or multiple-patient room arrangements, patient visibility and specialisms • professional judgement was very important in determining whether staffing was appropriate; but with patient acuity increasing, the need for nurses and midwives was increasing • interesting work was taking place in the USA around AI nursing • NBT and UHBW had very low mortality rates, which was an additional indicator of staffing sufficiency. **RESOLVED: that the Board notes:** **(1) the completion and outcomes of the SNCT and BR+ staffing reviews at NBT and UHBW** **(2) increasing patient acuity and associated resource implications across both Trusts** **(3) the continued need for investment in midwifery and in escalation areas (at both Trusts) highlighted through professional judgement and** **(4) the transition to a single Hospital Group safe staffing report for the next reporting cycle (summer 2026).**	
12/03/26	**Scheme of Delegation**	

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	The Board considered a report of the Head of Corporate Governance, UHBW and the Group Chief Finance and Estates Officer, seeking approval to amendments to the “approval of business cases” section of the Group scheme of delegation, to correct drafting errors in the version approved by the Board in September 2025. Neil Kemsley briefly outlined the changes. **RESOLVED: that the Board ratifies the amendments to the scheme of delegation as set out in the report and in appendix 1 to the report.**	
13/03/26	**Board Assurance Framework (BAF)**	
	The Board considered a report of the Head of Risk Management, UHBW and the Group Director of Corporate Governance, updating the Board on the Trusts’ principal strategic risk profile through the Quarter 4 BAF and setting out material developments in risk exposure and assurance since Quarter 3. Lavinia Rowsell, Group Director of Corporate Governance briefly outlined the report, reminding Board members that risk reports were submitted to all Board committees and of the changes in principal risks highlighted in the report. **RESOLVED: that the Board notes the Quarter 4 BAF and the changes to principal risks, assurance levels and identified gaps since Quarter 3.**	
14/03/26	**Risk Appetite Statement**	
	The Board considered a report of the Head of Risk Management, UHBW and the Group Director of Corporate Governance, presenting Group Risk Appetite Statements for approval and adoption. Lavinia Rowsell outlined the report briefly, reminding the Board of the Risk Appetite Seminar held in 2025 and that the risk appetite statement formed part of the risk policy, defining levels of tolerance, to inform escalation of risks where appropriate. Board members discussed the need to keep the Risk Appetite Statement in mind when making decisions to allocate and prioritise resources, especially when there were so many different needs. The challenge was to remember what risks were tolerated, and to what extent, when deciding to spend limited resources to mitigate relative risks, and to ensure greater focus on and investment in bigger, or less tolerated, risks. The opportunity costs of investing in one thing, compared to another, were emphasised. **RESOLVED: that the Board approves:** **(1) the risk appetite statements attached to the report and** **(2) that the statements will be adopted as the formal Group position and embedded within risk management processes going forward.**	
15/03/26	**Emergency Preparedness, Resilience and Response (EPRR) Annual reports 2025 for NBT and UHBW**	
	The Board considered reports of the EPRR Managers and the Chief Operating Officers for NBT and UHBW, informing the Board of the outcomes of the EPRR annual assurance processes (against the NHS England core standards for EPRR) at both Trusts. Glyn Howells outlined the report relating to NBT,	

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Minute Ref.	Item	Actions
	reporting that NBT was substantially compliant with the core standards (with an exception around training completion rates) and would be fully compliant by the end of March 2026. Philip Kiely outlined the report relating to UHBW, which was fully compliant. **RESOLVED: that the Board notes:** **(1) that NBT is substantially compliant with the NHS core standards for EPPR in 2025** **(2) the areas of improvement required for NBT to achieve full compliance in 2026 and the actions being taken to address these** **(3) that UHBW is fully compliant with the NHS core standards for EPPR in 2025.**	
16/03/26	**Integrated Governance report, including Committee Chairs' reports and register of seals**	
	The Board considered a report of the Group Director of Corporate Governance, informing them of the register of seals for NBT and UHBW and incorporating the upward reports of all Group Board Committees. Richard Gaunt, NED, highlighted relevant aspects of the Group Audit Committee report. In particular, Richard commented on a number of limited assurance audit reports considered by the Committee, which had been referred to other relevant committees to scrutinise and seek more detailed assurance. Roy Shubhabrata, NED, highlighted relevant aspects of the Group Digital Committee report. In particular, Roy commented on the Committee's focus on an operational update, merger day 1 readiness, the 2026 and Beyond Roadmap and an Electronic Patient Record (EPR) procurement strategic outline case. Martin Sykes, NED, highlighted relevant aspects of the Group Finance and Estates Committee report. In particular, Martin commented on the need for changes in the reporting of Group estate and health and safety risks. The Group Chair pointed out that this could be considered at a later time. Linda Kennedy, NED, highlighted relevant aspects of the Group People Committee report. In particular, Linda commented on the Committee's focus on communications and engagement around the merger, the focus on Oliver McGowan training, People Plan priorities and National Staff Survey results (which would be available widely from 12 March). Sarah Purdy, NED, highlighted relevant aspects of the Group Quality and Outcomes Committee report. In particular, Sarah commented on the Committee's escalation to the Board (in January) of no criteria to reside issues and the Committee's focus (in February) on the NHS England call to action around anti-microbial resistance, which would require increased Board focus in future; the Home Birth Clinical Safety Assessment, on which the Committee received assurance from both Trusts; and the Perinatal Mortality Review Tool (PMRT) data for both Trusts, which was recommended reading for all Board members and was available in the Convene Document Library.	

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Minute Ref.	Item	Actions
	Glyn Howells also highlighted the urology service deep-dive update, which showed positive improvements but continuing challenges, especially relating to the high volume of demand. **RESOLVED: that the register of seals update and the reports of the Group Board Committees be noted.**	
17/03/26	**Any Other Business**	
	There were no further items of business.	
18/03/26	**Date of Next Meeting - Tuesday, 12 May 2026**	

The meeting ended at 12.45pm

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Meeting of Group Board of Directors in Public on Tuesday, 12 May 2026

Action Log

There are no outstanding actions.

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Group Chair’s Report</td></tr>
<tr><td>Report Author:</td><td colspan="3">Bejide Kafele, EA to Group Chair of Bristol NHS Group</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Ingrid Barker, Group Chair of Bristol NHS Group</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td>✓</td></tr>
<tr><td colspan="3">The report sets out information on key items of interest to the Trust Board including activities undertaken by the Group Chair, and Vice Chairs.</td></tr>
<tr><td colspan="4">Key Points to Note (Including any previous decisions taken)</td></tr>
<tr><td colspan="4">The Group Chair reports to every public Board meeting with updates relevant to the period in question. This report covers the period Tuesday 11 March to Monday 10 May 2026.</td></tr>
<tr><td colspan="4">Strategic and Group Model Alignment</td></tr>
<tr><td colspan="4">The Group Chair’s report identifies activities throughout the preceding months and those of the Vice Chairs, providing an opportunity for Board discussion and triangulation. Where relevant, the report also covers key developments at the Trust and further afield, including those of a strategic nature.</td></tr>
<tr><td colspan="4">Risks and Opportunities</td></tr>
<tr><td colspan="4">Not applicable.</td></tr>
<tr><td colspan="4">Recommendation</td></tr>
<tr><td colspan="4">This report is for discussion and information. The Board is asked to note the activities and key developments detailed by the Group Chair.</td></tr>
<tr><td colspan="4">History of the paper (details of where paper has <u>previously</u> been received)</td></tr>
<tr><td colspan="4">n/a</td></tr>
<tr><td>Appendices:</td><td colspan="3">n/a</td></tr>
</table>

1. Purpose

1.1 The report sets out information on key items of interest to the Trust Board, including the Group Chair's attendance at events and visits as well as details of the Group Chair's engagement with Trust colleagues, system partners, national partners, and others during the reporting period.

2. Background

2.1 The Trust Board receives a report from the Group Chair to each meeting of the Board, detailing relevant engagements she and the Vice-Chairs have undertaken.

3. Activities across both Trusts (UHBW and NBT)

3.1 The Group Chair has undertaken several meetings and activities since the last report to the Group Board on 10 March:

- Attended check-in meetings with the Lead Governor.
- Attended a Strategy and Partnerships meeting to gain insight into how the Trust is continuing to deliver our partnership agenda.
- Chaired a Council of Governors meeting which included a merger update, Trust constitution amendments, and an update from the Finance and Estates committee on year end and the financial costs and benefits of merger.
- Attended a Governor development seminar to further consider assurances on merger and the proposed name of the merged Trust.
- Attended several governor and Board committee meetings including an Extraordinary Nominations and Remuneration and Nominations committee.
- Attended a Board development session, with a focus on national priorities and leadership.
- Led monthly Vice Chair touchpoints and NED check-in meetings.
- Participated in a panel discussion at an International Women's Day event organised by our Women's Network.
- Attended a UHBW Fire safety briefing for NEDs led by UHBW's Director of Facilities and Estates.
- Held the annual appraisal review for our CEO, where we undertook a review of the previous year's performance, and agreed objectives and priority areas for 2026/27.
- Visited two recently formed Single Managed Services under the Joint Clinical Strategy at UHBW - Trauma and Orthopaedics, and Pain - to learn about the opportunities and successes of the newly joint services. A visit to the NBT part of these services is scheduled for May.
- Attended a service of thanksgiving for our midwives and nurses, to recognise and give thanks for the outstanding contribution of nurses and midwives across Bristol and the wider region.
- The Chair also completed her Q1 Board Insight Visit (BIV) at South Bristol Community hospital. At least one BIV must be completed each quarter to encourage NED's to engage with colleagues to better understand what is happening on the ground, provide visible leadership, and provide additional triangulation opportunities.

4. Connecting with our Partners

4.1 The Group Chair has undertaken several visits and meetings with our partners:

- Alongside Maria Kane, met with the Chair and CEO of Avon AWP where we provided an update on the future of the Bristol NHS Group and the proposed merger, and discussed ongoing partnership opportunities between our two Trusts.
- Met with the Chair of Sirona to give an update on the future of the Bristol NHS Group.
- Attended a Roundtable meeting with Locality Partnership Chairs across BNSSG alongside Sarah Purdy (Vice Chair), and Paula Clarke (Group Formation Officer) where we provided an update on the future of the Bristol NHS Group, and our joint clinical strategy.
- Visited the Southville centre, with South Bristol Locality Partnership Co-Chairs Simon Hankins and Lisa Galvani (Divisional director UHBW) where we discussed potential areas for further partnership and collaboration and the Locality Partnership's own priorities for its population.
- Alongside CEO Maria Kane, I met with Helen Godwin, and Stephen Peacock, the Chair and CEO of the West of England Combined Authority where we briefed them on the future of the Group and potential merger and potential areas for closer working in the future.
- Hosted the Community Participation Group (CPG) with a focus on the Liaison Psychiatry service.
- Met with the North Somerset Council leader, Mike Bell, at Weston General Hospital, to brief him on Bristol Group developments and the progress towards merger.
- Alongside Maria Kane, met with Kerry McCarthy MP to brief her on Bristol Group developments and the progress towards merger.
- Alongside CEO Maria Kane, Prof Tim Whittlestone and Glyn Howells, met with Darren Jones MP following his visit to the Princess Royal elective Centre to discuss the Group's progress and potential future developments
- Hosted Sadik Al-Hassan, MP for North Somerset, to brief him on Bristol Group developments and the progress towards merger. Sadik, a former pharmacist, also met with Jon Standing and Matt Kaye, Directors of Pharmacy for UHBW and NBT respectively, where he undertook a visit of the UHBW Pharmacy and met with colleagues across the division. Sadik has since requested to visit our Pharmacy colleagues at NBT.

4.2 National and Regional Engagement

The Chair attended several meetings including:

- A National Chairs' Reference Group meeting chaired by the Chair of NHS England to review the role of NHS Chairs in the context of the Ten Year Plan.
- The NHS Providers Chairs and Chief Exec network.
- An NHS England South West Leaders Regional event, the first of a series of national road shows to consider regional successes and challenges alongside national priorities as presented by NHS Engand CEO and Chair.
- Quarterly meeting with the South West Regional Director for NHS England.
- Bi-monthly meeting with the Chair of the Integrated Care Board for Bristol, North Somerset and South Gloucestershire.

5. Vice-Chairs Report

This report details activities undertaken by the Vice-Chairs, in their capacity as Vice Chairs for the individual Trusts.

5.1 Vice Chair (UHBW):

The Vice Chair for UHBW undertook a variety of activities including:

- Conducted a Q1 BIV to UHBW's Finance department.
- Visited the Arts and Culture team at NBT to gain a better understanding of their priorities, challenges, and successes.
- Attended a Governors and NED engagement session.
- Attended the Council of Governors meeting.
- Attended a Board development session.
- Chaired the Finance and Estates committee.
- Attended a number of committee meetings including the People, and Audit committee.
- Touchpoint meetings with the Group Chair and the Vice Chair for UHBW.
- Attended a Merger quality governance review meeting with NHSE.
- Attended a UHBW Fire safety briefing.

5.2 Vice Chair (NBT):

The Vice Chair for NBT undertook a variety of activities including:

- Attended a Roundtable meeting with Locality Partnership Chairs across BNSSG alongside Ingrid Barker, and Lisa Galvani (Divisional Director, UHBW and Co-Chair of the South Bristol Locality Partnership).
- Interviewed for the University of Bath research study on the impact of public inquiries on NHS Boards.
- Met with the Faculty of Health and Life Sciences, University of Bristol.
- Attended an informal meeting with Jacky Hayden, Sirona NED.
- Shadowed A Consultant on an Emergency department shift.
- Attend a perinatal townhall.
- Attended a Merger quality governance review meeting with NHSE.

5.1 The NBT Vice Chair also attended the following meetings during this period:

- Council of Governors.
- Maternity and neonatal safety champions meeting.
- Perinatal safety champions meeting.
- Committee meetings including Finance and Estates committee, Renumeration, and Charity committee.
- UHBW Fire safety briefing.
- Planning meeting to agree the process for the Chairs annual appraisal.
- Chaired the Quality and Outcomes committee.
- Touchpoint meetings with the Group Chair, and the Vice Chair for UHBW.

- Board development session.
- BNSSG Primary care committee meeting.
- BNSSG Integrated Care Partnership Board.
- BNSSG Outcomes, Quality and Performance.
- Governors and NED engagement session.

6 Summary and Recommendations

The Trust Board is asked to note the content of this report.

Report To:	Public Group Board Meeting		
Date of Meeting:	12 May 2026		
Report Title:	Group Chief Executive Report		
Report Author:	Xavier Bell, Group Chief of Staff		
Report Sponsor:	Maria Kane, Group Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The report sets out information on key items of interest to Trust Boards, including engagement with system partners and regulators, events, and key staff appointments.		

Key Points to Note *(Including any previous decisions taken)*

The report seeks to highlight key issues not covered in other reports in the Board pack and which the Boards should be aware of. These are structured into five sections:

- National Topics of Interest
- Integrated Care System Update
- Strategy and Culture
- Operational Delivery
- Engagement & Service Visits

Strategic Alignment

This report highlights work that aligns with the Trusts' strategic priorities.

Risks and Opportunities

N/A

Recommendation

This report is for **Information**. The Boards are asked to note the contents of this report.

History of the paper (details of where paper has previously been received)

N/A	

Appendices:	N/A

Group Chief Executive's Report

Background

This report sets out briefing information from the Group Chief Executive for Board members on national and local topics of interest.

1. National and Regional Topics of Interest

1.1. Next steps on Neighbourhood Health

NHS England has published further guidance setting out the next steps on neighbourhood health and new population-based delivery models, reinforcing neighbourhood health as a core pillar of the NHS 10-Year Health Plan. The guidance expects Integrated Care Boards and local government partners to use 2026/27 as a developmental year, agreeing neighbourhood footprints, establishing integrated neighbourhood teams for priority populations, and putting in place the data, governance and funding arrangements required to support delivery.

From 2027/28, systems will be required to publish formal neighbourhood health plans aligned to national objectives and local population needs. This guidance was the subject of a recent ICB Seminar Session, and will shape future commissioning and contracting approaches, with increasing emphasis on integrated, outcome-based models and prevention-focused care delivered closer to home.

1.2. National and Regional NHS Leadership Changes

NHS England has confirmed a number of senior leadership appointments nationally and within the South West. Elizabeth O'Mahony has now been appointed permanently as Director General for Finance on the joint Department of Health and Social Care and NHS England Executive Team, following a year in an interim role. Sue Doheny will continue as Interim South West Regional Director during the forthcoming consultation on new regional structures. In addition, Dame Gill Morgan has been appointed as the new South West Regional Chair following an open and competitive process. These appointments provide continuity of leadership and support ongoing engagement between national, regional and local NHS organisations.

2. Operational Delivery

2.1. National Oversight Framework Segmentation

NHS England has confirmed the Quarter 3 (2025/26) NHS Oversight Framework (NOF) segmentation positions for both Trusts. UHBW remains in Segment 1, with a national league table ranking of 17th out of 134, reflecting a one-place improvement from Quarter 2, while NBT remains in Segment 2, ranked 25th nationally, a slight movement from the previous quarter. Both Trusts have been assessed as Green for provider capability. Overall, the positions reflect continued strong organisational performance across the Group, with stable oversight and positive regulatory assurance.

2.2. GIRFT UEC Further Faster Programme

Southmead Hospital has completed participation in the national GIRFT UEC Further Faster programme, which ran from October 2025 to March 2026. The programme recognised strong clinical and operational engagement and highlighted a number of

positive impacts, including improved four-hour performance and patient flow achieved through targeted test-of-change activity across the urgent and emergency care pathway.

GIRFT has set out a small number of recommended next steps to embed and sustain improvement, including elimination of corridor care, full implementation of new UEC clinical operational standards, and continued focus on front-door and ambulatory flow. These actions will be taken forward through the NBT UEC GIRFT Board, ensuring clear ownership, oversight and alignment with our wider improvement programmes.

2.3. Urgent Community Care Clinical Decision-making Framework

NHS England has published a new Urgent Community Care Clinical Decision-Making Framework, which supports clinicians and systems to safely manage more people with urgent care needs outside of hospital where appropriate. The framework sets out eight key actions to help balance patient, clinical and system risk, and identifies patient cohorts and presentations that may be suitable for community-based care. It is intended to support more consistent decision-making, reduce avoidable hospital admissions, and strengthen urgent community care as a core part of local urgent and emergency care pathways. Implementation will be taken forward through Integrated Care Systems as part of wider work to deliver care closer to home and improve patient flow.

2.4. Industrial Action

In April period the Trust was impacted by further industrial action by resident doctors, with the British Medical Association announcing six days of strike action in England from 7 to 13 April following the breakdown of national pay negotiations.

As with previous rounds, we worked closely with clinical leaders to prioritise patient safety and maintain essential services, and I would like to thank all colleagues who supported safe service delivery during this period. Against this backdrop, I recently met with our Resident Doctor leads to discuss our shared commitment to improving resident doctors' experience locally, including exception reporting and rota planning, and to reinforce how highly valued resident doctors are across both organisations.

While national discussions continue, the BMA has been clear that further industrial action remains a possibility should progress not be made and are holding a ballot for further Industrial Action in May. We will continue to engage constructively, plan responsibly, and keep patient safety at the forefront.

2.5. 2025 Staff Survey Results

The 2025 NHS Staff Survey results demonstrate a strong and consistent staff experience across both NBT and UHBW. With over 14,000 colleagues responding, both Trusts ranked as the top two highest-performing organisations in the South West among comparators on key advocacy measures, at a time when national results are at a five-year low.

Staff remain proud to work for their organisations, are confident in the care provided to patients and families and continue to report that patient care is their top priority. Notably, scores across the two Trusts are closely aligned, reinforcing the strength of a shared Group culture. While the results highlight many areas of real strength, they also point to opportunities for improvement, particularly in the quality of appraisal conversations. Work is now underway at Group, divisional and departmental level to translate these insights into action, ensuring we build on what is working well while addressing areas that matter most to colleagues.

3. <u>Strategy and Culture</u>

3.1. Bristol NHS Group Anniversary

April marked one year since the launch of **Bristol NHS Group**, bringing North Bristol Trust and University Hospitals Bristol and Weston together behind a shared vision and Joint Clinical Strategy. Over the past 12 months, the Group has made significant progress, including the establishment of a single Executive and Group Board, the launch of Group Clinical Services, increased community participation, major capital investment and new collaborative workforce models.

Subject to final regulatory approvals, this shared journey will take a further step forward from 1 July 2026 with the planned merger of the two Trusts to form **Bristol NHS Foundation Trust**. This milestone reflects our continued commitment to improving care for patients, creating opportunity for our people, supporting population health and making the best use of public resources. While we move towards a new organisational identity, our values, standards and focus on high-quality, equitable care remain unchanged. I would like to thank colleagues and partners across the Group for their commitment, collaboration and contribution over the past year as we build momentum towards the next phase of our shared future.

3.2. All-colleague Town Hall

On 28 April 2026 I held an all-colleague Town Hall, attended by staff from across the Bristol NHS Group. The session marked the first anniversary of the Group and provided a high-level update on progress towards merger, including the submitted business case, TUPE consultation and proposed new Trust name. Colleagues also received updates on Corporate Services Transformation and the Group Clinical Strategy, highlighting progress in bringing services together and shifting care closer to home. The Town Hall concluded with an open Q&A with staff.

3.3. March Group Clinical Strategy Event

In March, colleagues from across the Group came together with system partners and members of the Community Participation Group for a Group Clinical Strategy workshop focused on reframing clinical pathways. The event explored how services can be reshaped to strengthen prevention and deliver more care closer to home, working in partnership with primary and community care. Pathway discussions on COPD, frailty and diabetes transitional care demonstrated strong collaboration, shared learning and a clear collective commitment to improving outcomes for local people. The session also supported emerging Group Clinical Services to begin planning next steps together. I would like to thank all colleagues, partners and community representatives who participated for their openness, energy and practical contributions, which will directly inform the next phase of our Clinical Strategy.

3.4. 25 Years of the Bristol Royal Hospital for Children

In April, the Bristol Royal Hospital for Children marked its 25th anniversary, celebrating a quarter-century as a nationally leading centre for specialist paediatric care.

Since opening in 2001 as the UK's first purpose-built children's hospital, it has become a centre of excellence for children and young people across the South West and beyond,

including serving as the region's Children's Major Trauma Centre and home to the only dedicated Children's Emergency Department in the South West.

The anniversary provides an opportunity to recognise the outstanding clinical innovation, partnership with charitable supporters, and—above all—the commitment, skill and compassion of generations of staff who have cared for children and families over many decades of children's hospital services in Bristol. I would like to thank all colleagues, volunteers, fundraisers and partners who have contributed to this remarkable legacy and to the hospital's continued impact on the health and wellbeing of young people.

3.5. Two years of our Community Diagnostic Centres

We recently celebrated the two-year anniversary of our North Bristol and Weston Community Diagnostic Centres (CDC). Since opening, the two centres have welcomed more than 110,000 patients for tests and scans – an incredible achievement and a real credit to everyone involved in making the service possible.

In line with the ambition of the Government's 10 Year Health Plan to move more care into the community and supporting earlier diagnosis and prevention, these CDCs provide diagnostics in local locations, that are easier for people to attend. More convenient access to diagnostic tests is helping people get the care they need sooner and also freeing up hospital capacity so we can focus on patients with more complex needs.

3.6. Health Tech Roadshow

On Wednesday 13 May, colleagues from across BNSSG are invited to the Local Health Tech Roadshow – a chance to connect with peers from health and care, universities, and our tech partners, and explore how technology can genuinely transform health and social care.

The event will feature a Market Hall with hands-on demos from health tech companies, alongside inspiring keynotes from the NHS Digital Academy, our suppliers, and Group leaders. I'm especially pleased to announce that Health Innovation Network (HIN) will be joining us. As a trusted partner to both our Trusts, HIN will showcase practical solutions that can help us deliver on our Group Clinical Strategy by joining up care, rethinking how it's delivered, and reshaping the future of services.

4. Engagement and Visits

4.1. Team and Consultant Engagement

Since my last report to Board, I have met with a number of colleagues and teams across both Trusts. Of particular note in April and May, I have met with consultant colleagues from:

- Neurology at Southmead Hospital
- Paediatrics at the Bristol Royal Hospital for Children
- Trauma and Orthopaedics at the Bristol Royal Infirmary
- General Surgery at Southmead Hospital, and
- Cellular Pathology at Southmead Hospital.

4.2. Partnership and External Engagement

In addition to internal engagement, I have also met with colleagues from a number of partner organisation across BNSSG, the region and nationally, focusing on shared priorities and opportunities for collaboration. Since my last report to Board this has included meetings with:

- The Chair and Chief Executive of Avon and Wiltshire Mental Health Partnership NHS Trust, together with the Group Chair
- Chief Executive colleagues from both NHS Trusts in Gloucestershire
- The Chief Executive of Sirona Care and Health CIC
- BNSSG ICS' VCSE Lead
- The Chief Executive of Health Services Safety Investigation Body (HSSIB)
- The Chief Executive of UK Health Security Agency (UKHSA)

Recommendation

The Boards are asked to note the report.

Maria Kane
Group Chief Executive

Report To:	Public Group Board Meeting		
Date of Meeting:	12 May 2026		
Report Title:	Group Benefits Realisation Quarter 4 2025/26		
Report Author:	Cathy Caple, Group and Merger Benefits Lead		
Report Sponsor:	Paula Clarke, Group Formation Officer		
Purpose of the report:	Approval	Discussion	Information
			x
	To provide an update on progress with the Group benefits realisation plans as at Q4 2025/26.		

Key Points to Note *(Including any previous decisions taken)*

In April 2025 the Group Benefits Plan was approved by the Board. It detailed the benefits resulting from the formation of the Bristol NHS Group, reflecting the Group focus on delivery of improvements across our 4 Ps – our patients, our people, the populations we serve, and the public purse.

The Board has received two quarterly Group benefits delivery reports (September 2025 and January 2026) setting out the approach to benefits realisation, and the developing maturity of the benefits across the workstreams. The Board supported the intent to develop an overarching dashboard that provides assurance on progress alongside detailed review of benefit delivery against trajectories being undertaken in relevant Board Committees. This Q4 report includes the benefits dashboard for the first time. An update on delivery of benefits has been shared with the responsible Committees in March and April.

As part of the on-going process of assurance for all benefits, since January further reviews have been held by the Group PMO with each non-financial benefit owner. This review has tested the continuing validity of the benefits in light of organisational changes within the Group, the system and nationally; ensured all metrics have baselines and trajectories for delivery; and assessed the risk to delivery of the benefit.

The resulting benefit status and risk is summarised in the Group benefits dashboard at Appendix 1 and in section 3. Changes made to the quantum of benefit or timeline is referenced in section 4. The approach to financial benefits realisation is included for information in section 5. Board agreed in January 2026 that financial benefit delivery would be embedded into wider financial and CIP reporting for Finance and Estates Committee.

In summary:

- 63 individual benefits are currently confirmed for tracking of which 42 are live in delivery
- Of the 42, 6 benefits have completed in quarter 4 2025/26 (14%), 35 are on track (83%), and 1 benefit is experiencing a minor delay that will be recovered in quarter 1 2026/27
- An additional 10 benefits are still in development

- 21 benefits have not yet started. This reflects the maturity of some of the change programmes and the fact that several benefits will deliver over the longer-term.

Of the 63 Group confirmed for tracking, 24 have a high risk of non-delivery score as identified by the benefits owner. The key risk themes relate to dependency on funding being secured via internal business cases or external income, and/or delivery is dependent on organisational business change. Mitigation plans are in place and work is being undertaken to reduce this risk level through the Group workstreams.

This report is currently for Group benefits only. Merger benefits realisation will be stepped up after the merger approvals are confirmed. From July 2026, the Group and merger benefits will be integrated into a single benefits realisation programme. The inaugural report covering both areas will be produced for quarter 2, reflecting benefits delivery as at the end of September 2026.

This benefits report excludes the independent evaluation of Group impact by Health Innovation Network West of England (HIN), commissioned by the Group Board. Two of the four pathways have commenced in this evaluation with the remaining two to commence in 2026/27. Updates are provided into the Clinical Strategy Steering Group which reports into the Group Executive Meeting and onwards into Board Quality and Outcomes Committee.

Strategic and Group Model Alignment

The Group Benefits Delivery Plan supports the delivery of the Group Benefits Case and strategic priorities for the Group.

Risks and Opportunities

- Risk relates to the complexity and timing of demonstrating outcome versus process improvements and managing stakeholder expectations.
- There is a risk that while tangible benefits will be realised at pathway/service level for the clinical services workstream, it will take time to demonstrate an organisational level impact as this is reliant on the roll-out of Group Clinical Services, having single leadership teams in place to drive delivery and the time to evidence impact on patient outcomes.
- There is an opportunity to build on the Group Benefits Delivery Plan with additional merger benefits.
- There is an opportunity for Bristol NHS group to take a strategic approach to assessing the impact of the Group model across the 4 P's, incorporating process and outcome measures over time and contributing to the national gap in evidence on Group models.

Recommendation

The Board is asked to:

- Note the progress made on the Group benefits realisation plan;
- Confirm the new benefits dashboard approach meets the Board's assurance requirements.

History of the paper (details of where paper has previously been received)

Finance and Estates Committee	29 April 2026

Appendices:	Appendix 1: Group Benefits Realisation Dashboard Appendix 2: Extract of Group Benefits tracker Q4 20205/26 provided to QOC April 2026

	Appendix 3: Summary of outcomes for completed benefits Appendix 4: Highlights for benefits making significant progress

1. Purpose

1.1 This paper is presented to the Board to:

- provide an update on progress against delivery of the benefits approved by Board in the Group Benefits Case (April 2025);
- highlight the changes to some benefits based on delivery experience and the changing context for the Trust;
- provide assurance that there is a robust process in place to track financial and non-financial benefits delivery;
- highlight the next steps for realisation of benefits.

2. Background

2.1 In September 2025, the first quarterly Group benefits delivery report was considered by the Board, outlining developing plans across each of the workstreams and proposing the approach to benefits realisation. A further update report was presented in January 2026 demonstrating the developing maturity of the benefits across the workstreams, confirming key metrics, establishing baseline positions, agreeing ambitions and setting trajectories for delivery, which were in place for the majority of benefits.

2.2 The Board acknowledged that the breadth of benefits identified includes a level of detail that is best assured through Executive-led workstreams with specific oversight achieved through Board Committees. The Board requested that an over-arching benefits dashboard be developed for Board scrutiny. The first dashboard is included in this report (Appendix 1). The Board also confirmed that Group financial benefits will be tracked as part of wider financial reporting into Finance and Estates Committee and Board-in-common as this is integral with CIP delivery plans.

2.3 The process of maturing and assuring benefits realisation plans has continued since January 2026. Further internal reviews have been held by the Group and Merger Benefits Lead in the PMO with each benefit owner, testing the continuing validity of the benefits in light of organisational changes both within the Group, the system and nationally, and reviewing the standardisation and robustness of the benefits delivery processes. This has included ensuring all metrics have baselines and trajectories for delivery, that the risk to delivery of the benefit has been assessed and that, where possible, benchmarking standards are being applied.

3. Summary of benefits realisation

3.1 The status of the Group non-financial benefits at 31st March 2026 is given in the dashboard at Appendix 1. This is generated from a detailed benefits tracker which is held by the Programme Management Office, with each benefit owner providing updates quarterly. All 73 benefits are mapped against impact on our 4 Ps to demonstrate at a high level the delivery of improvements as a result of our Group working. An annual financial value delivered is included on the dashboard for information, however the detailed monitoring of the financial benefits is through each Trust's financial improvement groups.

3.2 A summary of the status of benefits delivery is given in the table below. 35 (83%) of the benefits that have started delivery are on track, with 1 (2%) benefit experiencing a minor delay that will be recovered in quarter 1 2026/27.

Delivery status of benefit	Number	Percentage
Complete	6	14%
On track	35	83%
Minor Delay	1	2%
Major Delay	0	0%
Sub total	**42**	**100%**
Defined - Not started	19	
Defined - Project Initiation Stage	2	
Sub total	**21**	
Benefit in development/not defined	10	
Total	**73**	

3.3 The 21 benefits where measurable targets have been defined but delivery has not yet commenced will see benefits begin to deliver between Q3 2026/27 and Q4 2030/31, with the majority being delivered by Q4 2027/28.

3.4 The ten benefits in development will derive from the Estates Group Strategy that is underway, the recently approved Clinical Strategy Update 2026, and a new People Offering Programme for 2026/27 which is being scoped.

3.5 The detailed plans on benefits delivery by workstream have been shared with the responsible Committees in March and April 2026:

Board Committee	Workstream
Quality & Outcomes	Group Clinical Strategy Innovation Strategy
People	Corporate Services Transformation Our People Offering
Digital (or DHPB)	Digital
Finance & Estates	Planning Alignment Commercial & Income Capture

3.6 The Committees have received a summary of the benefits delivery status and risk profile, and an extract of the Group benefits tracker detailing the specific measures. Appendix 2 gives the tracker extract provided to QOC as an example. The Committees supported the approach to benefits realisation and acknowledged that they would receive quarterly reports.

3.7 Each benefit owner has assessed the risk to delivery of their respective benefits. Any dependencies affecting delivery have also been noted. There is no risk assessment for the 6 completed benefits and the 10 benefits that are yet to be developed. This has enabled the development of a risk profile for the delivery of Group benefits:

Risk category of benefits	Number	Percentage
Low risk (1-3)	14	25%
Medium risk (4-6)	19	33%
High risk (8-12)	24	42%
Very high risk (15-25)	0	0%
Total	**57**	**100%**

24 have a high risk of non-delivery score of which 18 have been scored 8 or 9, and 6 have a score between 10 and 15. In general the *likelihood* of non-delivery is scored lower and the *consequence* of non-delivery of the benefit is scored higher. The key themes for these risks are:

- delivery of the benefit is dependent on funding via internal business cases or external income, mitigated through robust business cases that will include clear cost-benefit analysis and benefits plans;
- delivery is dependent on organisational business change, which will be mitigated through a project management approach to local delivery of the benefit.

3.8 Benefit owners are progressing the work to deliver each of the benefits. It should be noted that these benefits will deliver over different timelines with some having longer-term trajectories for full realisation.

3.9 Six benefits have completed in 2025/26, a summary of the outcome is given in Appendix 3. Four benefits have been completed for people services including enabling staff to safely work across our sites with minimal bureaucracy and completion of the programme to recruitment of staff from local socially deprived areas, enhancing the Group's anchor role.

3.10 Two benefits have made significant progress in 2025/26, and some highlights are included in Appendix 4. Five Group Clinical Services have made progress in moving towards more equitable waiting times across hospital sites resulting in faster access to services, and there have been opportunities to improve access to staffing across hospital sites. For research and development, the Group was able to open a new phase I gene therapy trial in IgA Nephropathy by bringing together UHBW's Bristol NIHR Clinical Research Facility and clinical expertise from NBT.

4. Proposed changes to benefits

4.1 The review of benefits in the last three months has highlighted some changes to the description, quantum or timeline, which are summarised below:

Group workstream	Proposed change to benefits
Group Clinical Services	The SRO for Group Clinical Services has identified five overarching metrics to measure Group benefits delivery as requested by the Board in January 2026. Benefits within each individual clinical service area will continue to be tracked by the Clinical Strategy delivery team (see QOC tracker extract at appendix 2).
Our People Offering	Review of project charters for the eight People sub workstreams identified a number of changes to the benefits in light of Group and system changes. For example, the

Group workstream	Proposed change to benefits
	Connect to Work (formerly Recruitment Pipeline) workstream profile of delivery has changed due to the investment of WECA funding and now focuses solely on connecting people from local lower socioeconomic groups.
Digital	Change to the timeline for delivery of transitioning the GP IT service from SCW CSU to Bristol Group due the BNSSG commissioning timeline – will now deliver 18 months later in January 2028.
Financial benefits across a number of workstreams	The Board supported the proposal in the January 2026 Board report for the financial benefit metrics to be reviewed by the Finance and Estates Committee on a quarterly basis and therefore will be reported separately from this non-financial benefits tracker to avoid duplication. The Head of Financial Sustainability at UHBW has confirmed that all benefits with a financial metric are already included on the Group financial benefits tracker and map to a financial benefit opportunity category.

4.2 The proposed changes have been shared with and supported by the relevant responsible Committee and approved by the Group Executive (GEM).

4.3 The Board is asked to note the proposed changes.

5. Approach to financial benefits

5.1 In 2025/26 the Group has delivered £2.6m of confirmed financial benefits, driven predominantly by corporate services efficiencies and procurement savings achieved through joint working across UHBW and NBT.

5.2 For 2026/27, Group benefits tracking will be fully integrated into the Group wide Cost Improvement Programme (CIP) reporting framework, with oversight through the Finance and Estates Committee. Cost reduction benefits will support delivery of the Trusts' divisional 5% savings requirements, with the Corporate Services Transformation Programme continuing to provide the most material contribution. Additional income generation and merger related benefits will also be captured and monitored, aligned to the newly defined corporate site location model, which establishes a third corporate site alongside UHBW and NBT.

5.3 The reporting approach for CIP and Group benefits will transition to the new unified format at the point of merger, with the first consolidated report scheduled for the Quarter 2 reporting cycle.

6. Future benefits realisation approach

6.1 This report is for Group benefits only. Merger benefits realisation will be stepped up after the merger approvals are confirmed. The Group and merger benefits will be brought together into one benefits realisation programme from July 2026, with the first report to

Board for quarter 2, i.e. benefits delivery as at end-September 2026. The Integration Programme Board will have oversight of merger benefits realisation.

6.2 Opportunities for alignment of Group and merger benefits into Group strategic and improvement priorities are continuing over 2026/27.

6.3 The PMO continues to support benefit owners in the realisation of the benefits. A benefits masterclass was held with our strategic partner Teneo on 13th April 2026 for workstream leads and leads from the PMOs across the Group to further develop capability in benefits planning and realisation which can be taken into future transformation programmes. This builds a legacy of skills and expertise to support the future strategic ambitions of the Group as a merged Tust and provides teams with personal development opportunities.

6.4 This benefits report excludes the independent evaluation of Group impact by Health Innovation Network West of England (HIN), commissioned by the Group Board and which commenced on 1st September 2025. The evaluation covers four priority pathways; cardiac rehabilitation and rapid access chest pain clinic have commenced, with workforce resilience and PCI to commence in 2026/27. This work is being overseen by a Hospital Group Evaluation Steering Group that includes a NED member. A full protocol has been approved by the Steering Group, outlining the scope, approach, methods, and initial understanding of each pathway.

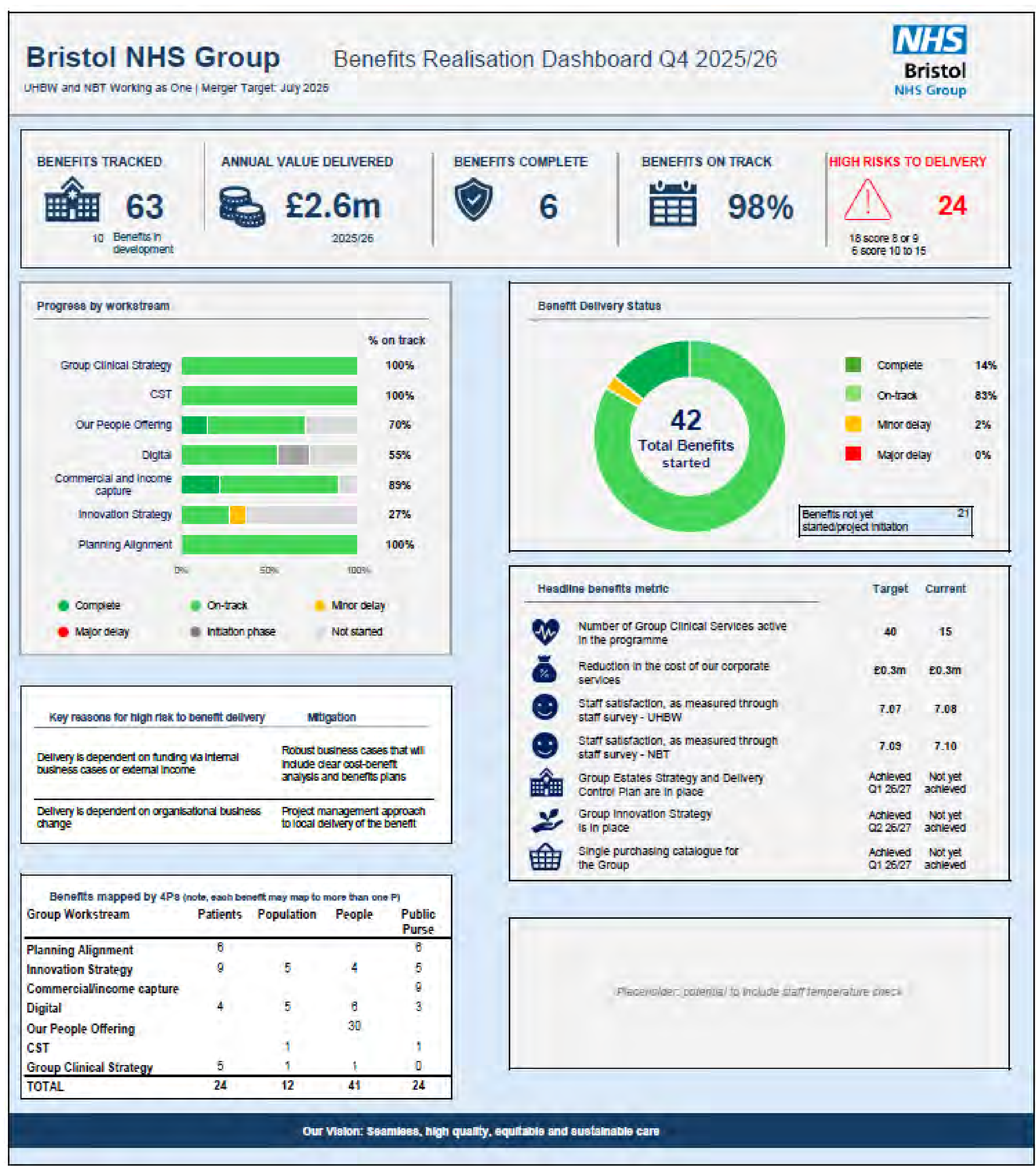
7. Recommendations

7.1 The Board is asked to:

i. Note the progress made on the Group benefits realisation plan.

ii. Confirm the new benefits dashboard approach meets the Board's assurance requirements.

Appendix 1: Group Benefits Realisation Dashboard



Key reasons for high risk to benefit delivery	Mitigation
Delivery is dependent on funding via internal business cases or external income	Robust business cases that will include clear cost-benefit analysis and benefits plans
Delivery is dependent on organisational business change	Project management approach to local delivery of the benefit

Headline benefits metric	Target	Current
Number of Group Clinical Services active in the programme	40	15
Reduction in the cost of our corporate services	£0.3m	£0.3m
Staff satisfaction, as measured through staff survey - UHBW	7.07	7.08
Staff satisfaction, as measured through staff survey - NBT	7.09	7.10
Group Estates Strategy and Delivery Control Plan are in place	Achieved Q1 26/27	Not yet achieved
Group Innovation Strategy is in place	Achieved Q2 26/27	Not yet achieved
Single purchasing catalogue for the Group	Achieved Q1 26/27	Not yet achieved

Benefits mapped by 4Ps (note, each benefit may map to more than one P)

Group Workstream	Patients	Population	People	Public Purse
Planning Alignment	6			6
Innovation Strategy	9	5	4	5
Commercial/income capture				9
Digital	4	5	6	3
Our People Offering			30	
CST		1		1
Group Clinical Strategy	5	1	1	0
TOTAL	24	12	41	24

Appendix 2: Extract of Group Benefits tracker Q4 20205/26 provided to QOC

Appendix 1: Bristol NHS Group Benefits Realisation tracker

Version: Update field for reporting by benefit owners | Target in development | Move to finance benefits tracker

Date:

Benefit description >>				4 Ps				Assurance Committee	Data capture >>		
ID	Workstream	Benefit strand	Description of objective to deliver benefit	Pa	Po	Pe	PP		Measure	Measure type	Change frequency
B201	Group Clinical Strategy	Delivering outstanding care for everyone who needs it	Improve clinical service access, experience and outcome for patients through the Group Clinical Services	Y				QOC	Number of Group Clinical Services active in the programme (milestone 1)	Input KPI	Quarterly
B202	Group Clinical Strategy	Delivering outstanding care for everyone who needs it	Improve clinical service access, experience and outcome for patients through the Group Clinical Services	Y				QOC	Number of Group Clinical Services at milestone 2 or beyond	Input KPI	Quarterly
B203	Group Clinical Strategy	Supporting our people to thrive and excel	Improve workforce resilience in Group Clinical Services	Y		Y		QOC	Increase in the number of joint appointments made in the Group Cardiac Service	Output KPI	Quarterly
B204	Group Clinical Strategy	Delivering outstanding care for everyone who needs it	Improve health outcome measures and prevention	Y	Y			QOC	*Measures to be developed from Group Clinical Strategy Update 2026*		
B205	Group Clinical Strategy	Getting the most out of our resources for the communities	Evidence of more remote monitoring/virtual work	Y			Y	QOC	*Measures to be developed from Group Clinical Strategy Update 2026*		
B601	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Finalise and launching our the Group Innovation Strategy	Milestone	Binary
B602	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Create the Group Innovation Hub	Milestone	Binary
B603	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Increase the number of ideas that can be patented	Output KPI	Annual
B604	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Increase the number of commercial partnerships	Output KPI	Annual
B605	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Increase the external grant funding secured for innovation (gross)	Output KPI	Quarterly
B606	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Increase the number of real world evaluations of innovations	Output KPI	Annual
B607	Innovation strategy	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy	Y				QOC	Improve the percentage of staff feeling able to make improvements	Output KPI	Annual
B608	Innovation strategy	Excelling in groundbreaking innovation and R&D	Increase income from international health initiatives				Y	QOC	Increase in net income from international health initiatives	Output KPI	Quarterly
B609	Innovation strategy	Supporting our people to thrive and excel	Have a consistent process for formally recognising and including R&D within job planning processes for all professions		Y	Y		QOC	Establishment of a Recognise and Reward Research T&F Group to develop policy and procedures for all professions, to facilitate R&D being embedded within job planning processes for all professions across the group	Input KPI	Binary
B610	Innovation strategy	Getting the most out of our resources for the communities we serve	Development of a Group-Wide View to planning R&D to limit instances where clinical capacity and/or access to support services are a restricting factor	Y	Y			QOC	Number of new trials taking place as a result of shared resources across the Group	Input KPI	Quarterly
B611	Innovation strategy	Excelling in groundbreaking innovation and R&D	Development of a joint R&D Strategy for Group	Y	Y	Y	Y	QOC	Development of the Group R&D Strategy	Input KPI	Binary

	Data capture >> (cont.)				Status >>						Expected benefit profile >>	Results >>
ID	Baseline (Apr 25)	Target	Achievement date (Q)	Benefit Owner	Delivery status	Likelihood benefit will not be delivered	Impact if benefit not delivered	Risk score	Risk to delivery	Dependency to benefit delivery	Q4 2025/26	Q4 2025/26
B201	0	40	Q4 2026/27	Valerie Clarke	On track	2	4	8	High	-	15	15
B202	0	32	Q2 2027/28	Valerie Clarke	On track	3	4	12	High	-	5	5
B203	0	4	Q4 2025/26	Valerie Clarke	On track	1	3	3	Low	-	3	3
B204				Valerie Clarke	Benefit under development							
B205				Valerie Clarke	Benefit under development							
B601	No Group Innovation Strategy	Group Innovation Strategy approved	Q1 2026/27	Tim Keen	On track	3	3	9	High	Business case approved	Not achieved	Not achieved
B602	No Group Innovation Hub	Group Innovation Hub commenced	Q1 2026/27	Tim Keen	Minor Delay	3	3	9	High	Business case approved	Not achieved	Not achieved
B603	0	1 per annum	Q4 2029/30	Tim Keen	Not started	2	3	6	Medium	Business case approved	1	1
B604	0	3 per annum	Q4 2028/29	Tim Keen	Not started	2	3	6	Medium	Business case approved	1	1
B605	£0	£50,000	Q4 2028/29	Tim Keen	Not started	3	3	9	High	Grant funding available nationally and internationally	--	--
B606	0	2 per annum	Q4 2026/27	Tim Keen	Not started	1	3	3	Low	Business case approved	0	0
B607	58.6%	61.9%	Q4 2029/30	Tim Keen	On track	3	3	9	High	Links to embedding Patient First	59.3%	59.3%
B608	£0	£600,000	Q4 2028/29	Tim Keen	Not started	2	4	8	High	Business case approved, enabled by merged organisation brand development and reputation	--	--
B609	No consistency in how research time is included/agreed in job plans for doctors and NMAHP staff across the two trusts.	Policy and procedures in place	Q4 2025/26	Diana Benton & Helen Lewis-White	Not started	4	3	12	High	Subject to business case approval and Group R&D strategy. Ability to release clinical staff for research.	Not achieved	Not achieved
B610	0	One new trial a year, subject to R&D 3-5 year business case, approval planned 30.6.26.	Q4 2027/28	Diana Benton & Helen Lewis-White	On track	1	1	1	Low		1	1
B611	No strategy	Group R&D Strategy approved	Q4 2026/27	Diana Benton & Helen Lewis-White	Not started	2	1	2	Low	May be delayed following merger due to other actions taking priority e.g. staff consultation	Not achieved	Not achieved

Appendix 3: Summary of outcomes for completed benefits

Benefit ID	Workstream	Objective	Measure	Outcome
B406	Our People offering	Increased cross-Trust recognition of learning	Passporting of 11 core skills and Oliver McGowan across the Group model: All training courses in scope successfully passported	Removes duplication of mandatory training, reducing time and cost while enabling staff to move more easily across the Group. Improves compliance consistency and accelerates workforce deployment by ensuring recognised, transferable competencies
B411	Our People offering	Flexibility and freedom of movement in people working across sites	Colleagues in group roles are able to deploy their skills across both organisations in a professional and legal way	Creates a more agile workforce that can be deployed where demand is greatest, improving service resilience and reducing reliance on temporary staffing. Enhances staff experience through broader career opportunities and more flexible working arrangements
B417	Our People offering	Increased recruitment numbers through socially deprived areas of the Group's geography	Achieved 20 Connect to Work participants by April 2026 as part of year one delivery, in line with WECA expectations and reduced initial scale.	Strengthens the local workforce pipeline while supporting social value and reducing health inequalities. Improves retention by recruiting from local communities and enhances the Group's role as an anchor institution within its geography
B427	Our People offering	Digitisation all paper-based new starter forms	100% of all paper based new starter forms digitised	Streamlines onboarding processes, reducing administrative burden and errors while improving data quality and compliance. Enables faster time-to-start for new employees and enhances overall candidate and staff experience
B805	Commercial and income capture	Increased education for budget holders on procurement best practice	Procurement best practice guidance issued to all users/budget holders	The first edition of educational materials for budget management and use of SAP Ariba has been shared with 4,000 SAP users. Further education materials will be issued over the coming year and drop in sessions are being held for user. Success of the materials will be evidenced through the spend using a purchase order, and fewer requests for additional products.

Benefit ID	Workstream	Objective	Measure	Outcome
B806	Commercial and income capture	Income capture & consistency in clinical activity coding to ensure we are paid fairly for the activity we deliver	Alignment of coding classification processes across the two Trusts	Coding classification processes have been aligned across the two Trusts produced by NBT and adopted by UHBW. This will drive consistency in clinical coding. Next steps are to drive improvements to coding through education for divisional staff, and corporate data interrogation across the two Trusts compared to national benchmarking, focusing initially on outpatient procedures.

Appendix 4: Highlights for benefits making significant progress

Benefit ID	Workstream	Objective	Measure	Highlights
B201	Group Clinical Strategy	Improve clinical service access, experience and outcome for patients through the Group Clinical Services	Number of Group Clinical Services active in the programme	The Group Clinical Services progressed during 2025/26, with a detailed update being provided to QOC. Highlights for benefits delivery include: Cardiology: Single PCI service for the Group, more equitable waiting times and joint PCI sub-specialty consultant lead appointed Trauma & Orthopaedics: improvement in referral to treatment times for patients through equalising waits in foot & ankle and hand & wrist services, focusing on reducing length of stay for elective hip and knee patients Pain: reprovision of pain procedures from the independent sector to South Bristol Community Hospital, improving access for patients and delivering cost savings Liaison psychiatry: collaborative bank for registered mental health nurses and mental health support staff to manage staff demands across different hospital sites Maternity and gynaecology: launch of a self-referral service for early pregnancy clinics across three hospital sites, providing faster access for approx. 100 patients per week
B610	Innovation strategy	Development of a Group-Wide approach to planning R&D to limit instances where clinical capacity and/or access to support services are a restricting factor	Number of new trials taking place as a result of shared resources across the Group (target one per year)	In December 2025, leaning on research expertise within UHBW's Bristol NIHR CRF and clinical expertise from NBT, we opened a new phase I gene therapy trial in IgA Nephropathy. The NBT principal investigator and research team have worked hand in glove with the UHBW CRF and pharmacy teams and will be recruiting NBT participants to this highly complex commercial trial at the Southmead site.

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Merger Update</td></tr>
<tr><td>Report Author:</td><td colspan="3">Robert Gittins, Group PMO and Merger Programme Director</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Paula Clarke, Group Formation Officer</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td>X</td></tr>
<tr><td colspan="3">To provide the Board with an update on progress toward the proposed merger of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), including what has changed since March 2026, the current focus of the programme, and the assurance position as the organisation approaches the final stages of the statutory approval process.

This report is for information.</td></tr>
<tr><td colspan="4">Key Points to Note (Including any previous decisions taken)</td></tr>
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- Since the March 2026 public Board report, the programme has moved from planning into **active external assurance and final readiness testing**, alongside intensified internal preparation for a safe and stable Day 1.
- **NHS England (NHSE) statutory assurance activity is well advanced**, with reviews covering quality, finance, governance and deliverability. As at the end of April, no issues have been identified that would prevent the merger proceeding, subject to completion of remaining statutory steps.
- **Internal assurance has been strengthened**, including completion of Gateway 3, supported by Internal Audit, confirming readiness to proceed to final Day 1 testing and clearer differentiation between Day 1 critical risks and longer-term integration risks.
- **Day 1 planning is deliberately focused on continuity and stability**, with no changes to patient safety arrangements, clinical governance processes or workforce terms and conditions, and only limited essential corporate and digital changes on Day 1**TUPE consultation** with NBT staff closed on 24th April and

feedback has been reviewed and will inform workforce planning, programme risks and Day 1 readiness actions.

- Engagement with **Governors** has continued, with monthly assurance updates provided to the Council of Governors alongside the on-going opportunity for questions to be answered and the regular meetings between governors and NEDs.
- **Board Committees continue to scrutinise** merger plans and risk management and Audit Committee, has concluded that assurance arrangements are robust and proportionate.
- The **merger risk profile remains well understood and actively managed**, with no unmitigated clinical quality or patient safety risks identified in relation to Day 1.
- Subject to statutory approvals later in June, the two trusts will come together as the **Bristol NHS Foundation Trust** from summer 2026, with **stabilisation and Year 1 integration activity** progressing thereafter under established Board and Committee oversight.

Strategic and Group Model Alignment

This paper supports the strategic intent of Bristol NHS Group to pursue a merger and become a single organisation. The merger is aligned with the Group's ambition to strengthen leadership, simplify the operating model and support consistent delivery of benefits for patients, people, populations and the public purse.

Risks and Opportunities

Progressing toward merger presents opportunities go further, faster towards delivering benefits across our 4 P's, embed consistent Group-wide governance and quality oversight from Day 1, reduce duplication and strengthen organisational resilience.

The principal risks associated with the proposed merger relate to the scale and complexity of transition activity as the programme approaches Day 1. These risks are predominantly transitional, and delivery-focused, reflecting capacity, sequencing and coordination rather than concerns about clinical quality or patient safety. No unmitigated risks relating to patient safety, quality of care or statutory compliance have been identified in relation to Day 1.

Risks are actively managed through the merger governance framework, including executive oversight, internal gateway assurance and ongoing engagement with NHS England. Established Board Assurance Framework arrangements will continue to

<table>
<tr><td colspan="2">operate before and after Day 1, ensuring that risks are monitored, mitigated and transitioned into business-as-usual governance where appropriate</td></tr>
<tr><td colspan="2">Recommendation</td></tr>
<tr><td colspan="2">This report is for information.
The Board is asked to:
Note progress since the March 2026 Public Board update;
Note the current assurance position, including active NHSE review and strengthened internal readiness arrangements; and
Note the programme’s continued focus on delivering a safe, stable Day 1 alongside statutory approvals</td></tr>
<tr><td colspan="2">History of the paper (details of where paper has <u>previously</u> been received)</td></tr>
<tr><td colspan="2">N/A</td></tr>
<tr><td>Appendices:</td><td>N/A</td></tr>
</table>

Merger Update – May 2026

1. Purpose of this report

This report provides the Public Board with an update on progress toward the proposed merger of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). It highlights what has changed since the last Group board report in March, the current focus of the programme, and the assurance position as the organisation approaches the final stages of the statutory transaction process.

The update reflects two parallel and reinforcing strands of work:

- Intensive internal preparation to ensure a safe, stable and well led Day 1 should the merger proceed; and
- Active external engagement and assurance with NHS England (NHSE) and other statutory bodies as part of the Section 56A Transaction approval process.

This report is for **information**.

2. What has changed since the March 2026 Public Board update

Since the March report, the merger programme has moved significantly from developing and approving plans into active external assurance and final readiness testing. Key developments include:

2.1 Progression through NHSE assurance

- NHSE is now nearing completion of its formal statutory review of the proposed transaction, covering quality, finance, governance and deliverability.
- A structured programme of interviews, Board and Committee observations and document reviews has been underway throughout April.
- As at the end of April, no issues have been identified through NHSE review activity that would prevent the merger proceeding, subject to completion of the remaining statutory steps.

2.2 Strengthened internal assurance

- A structured internal gateway assurance process is in place to provide confidence that the organisation is ready to proceed safely to legal merger and Day 1 operation. We have completed Gateway 3 of this internal assurance framework, supported by Internal Audit (Audit South-West) review. This gateway focused on transaction readiness and targeted digital Day 1 risks and confirmed that the programme is on track to proceed to final readiness testing.
- Risk maturity has continued to improve, with clearer ownership, mitigation and a stronger distinction between Day 1 critical risks and post merger integration risks.

2.3 Intensified Day 1 readiness activity

- With the proposed Day 1 date approaching, workstreams have sharpened their focus on what must be in place for safe continuity on Day 1, rather than full integration.
- Day 1 critical activities now form the core of programme reporting, supported by a consolidated tracker and executive review through the Merger Programme Board.

2.4 Ongoing engagement with Governors and Committees

- The UHBW Council of Governors has received a detailed assurance update in April and continues to be engaged ahead of its statutory decision-making role in June.
- The Audit Committee received a comprehensive pre-decision assurance report at the end of April.

3. Current position – assurance and readiness

3.1 External assurance with NHS England (NHSE)

The merger is being progressed under Section 56A of the NHS Act 2006. NHSE assurance activity is now well advanced and includes:

- Quality and financial governance reviews;
- Observation of Board and Committee meetings; and
- Structured engagement with executive and clinical leaders.

A formal NHSE Challenge Meeting is scheduled for 20th May, following which NHSE will meet regionally and then issue a transaction risk rating. A Green or Amber rating is required to proceed. Final approval is subject to statutory confirmation from the Trust Boards, the UHBW Council of Governors, and the Secretary of State.

3.2 Internal readiness and gateway assurance

Alongside NHSE assurance, the internal gateway process strengthens assurance that the merger can proceed safely:

- Checkpoints and early gateways have confirmed that governance, resources and plans are in place;
- Gateway 4 (mid-May May 2026) will provide the latest assessment of Day 1 and early Year 1 readiness; and
- A final Gateway 5 will confirm readiness immediately prior to legal completion, should NHSE approval be granted.

This layered approach ensures that decisions are informed by both external regulation and internal evidence based assurance.

3.3 Day 1 focus – safe and stable continuity

Day 1 planning is intentionally designed around continuity and stability, not wholesale change. Key principles include:

- No change to core clinical governance, escalation routes or patient safety processes;
- Continuity of workforce arrangements, including pay, terms and conditions and TUPE protections;
- Only a small number of essential corporate and digital system changes on Day 1, with controlled interim arrangements where needed; and
- Clear communications to staff and partners about what will and will not change on Day 1.

Full organisational integration will continue progressively through **Year 1**, supported by the Post Transaction Integration Plan (PTIP).

4. Communications, people and engagement

Communications and engagement activity has continued at pace since the March Public Board update and remains a core element of the organisation's approach to risk management and assurance.

4.1 Staff consultation

- Formal TUPE consultation with NBT staff has concluded, delivered in line with statutory requirements and supported by constructive engagement with staff side colleagues.
- Feedback from consultation has been reviewed and will inform workforce planning, programme risks and Day 1 readiness actions.

4.2 Ongoing engagement and culture

In parallel with formal consultation, wide-ranging engagement has continued across both organisations, including staff briefings, town halls, targeted sessions with managers and clinical leaders, walkarounds, intranet updates and frequently asked questions (FAQs).

Engagement is deliberately iterative, allowing emerging themes to be reflected quickly in leadership messaging, programme actions and risk mitigation.

A Cultural Diagnostic has been completed and is informing the next phase of the Culture and Organisational Development (OD) plan, supporting transition to a single statutory organisation. Culture and engagement remain part of ongoing discussion with NHS England and CQC as part of wider assurance.

Overall, the programme continues to place strong emphasis on listening, openness and visible leadership, ensuring staff are well informed, concerns are addressed early, and engagement activity supports safe delivery of Day 1 and beyond.

Subject to final statutory approvals, from 1 July 2026 the two trusts will come together as a single organisation called Bristol NHS Foundation Trust. This reflects the next step in a shared journey that began with the Joint Clinical Strategy and has progressed through closer clinical and corporate collaboration, shared leadership roles and a decision in principle to merge under a new, shared identity.

While adopting a new organisational name, what will not change are our standards and unwavering commitment to delivering seamless, high-quality and equitable care for our patients and communities. The proposed name is intended to resonate locally, while also reflecting Bristol's growing opportunities and reputation for innovation nationally and internationally, working together with system partners, universities, local authorities, charities and, above all, our combined workforce.

5. Risk position

The merger risk profile is well understood and actively managed.

- Current risks are predominantly transitional, and delivery-focused, reflecting capacity, sequencing and complexity rather than concerns about care quality or safety.
- No unmitigated clinical quality or patient safety risks have been identified in relation to Day 1.
- Higher exposure inherited risks (such as estates and fire safety) pre-date the merger and will continue to be managed through established Board Assurance Framework arrangements after merger.

Risk management arrangements for merger and integration will continue beyond Day 1, with appropriate transition into business-as-usual governance where required.

6. Forward look

Over the next period, the programme will continue to focus on:

- Completion of NHSE assurance and the statutory approvals process;
- Delivery of Gateway 4 and final Day 1 readiness assessments;
- Continued clear, proportionate communications and engagement to support staff, patients and partners through transition.; and
- Preparation for orderly and transparent decision making by the Trust Boards and the Council of Governors in early June.

Stabilisation and Year 1 integration activity will become the focus thereafter, with ongoing oversight through established Board and Committee arrangements.

7. Recommendation

This report is for information.

The Board is asked to:

- **Note** progress since the March 2026 Public Board update;
- **Note** the current assurance position, including active NHSE review and strengthened internal readiness arrangements; and
- **Note** the programme's continued focus on delivering a safe, stable Day 1 alongside statutory approvals.

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Green Plan Annual Report, Delivery Plan and Carbon Reduction Plan</td></tr>
<tr><td>Report Author:</td><td colspan="3">Sam Willitts, Head of Sustainability ICS BNSSG</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Neil Kemsley, Group Chief Finance & Estates Officer</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td>X</td><td></td><td></td></tr>
<tr><td colspan="3">To approve the Green Plan annual report, Delivery Plan and Carbon Reduction Plan</td></tr>
</table>

Key Points to Note *(Including any previous decisions taken)*

Refreshed Green Plan

We have updated our Green Plan in line with NHS England statutory guidance. This refresh moves from being an aspirational strategy to what we are going to deliver.

The annual report shows the progress made, across energy, achieving zero waste to landfill and increasing EVs. Our case studies highlight the new focus on clinical sustainability projects supporting cost improvement and reductions in the largest area of our emissions - procurement.

Delivery Plan

NHS England Green Plan guidance requires us to have an action plan approved by the Trust Board; the Delivery Plan sets out these actions establishing responsibilities, costings and timelines for delivery. Separate papers will be developed where further approval is required.

Carbon Reduction Plan

To act as a supplier for NHS and public sector contracts we are required to have Trust Board approved Carbon Reduction Plan.

Strategic and Group Model Alignment

This report addresses the UHBW strategic priorities of Experience of Care and Our Resources and NBT's improvement priorities of 'making the best use of limited resources' and 'in and for our community'.

It supports the Bristol NHS Group through the collaborative joint working being undertaken across Trusts on sustainability, the joint development and funding of solutions to decarbonising our estates and clinical sustainability projects.

Risks and Opportunities

Related to risks NBT 1777 (net zero carbon) and 1776 (climate change) and the Business Assurance Framework net zero carbon risk. UHBW *Principal risk 4 – Estates Infrastructure* 3472 - Risk that the Trust fails to deliver the ICS Green Plan. Other risks are set out in Green Plan.

Recommendation

This report is for **Approval**

It is recommended to:

- Approve the Green Plan annual report update on progress

- Approve the Delivery Plan, assigned leads, and actions to address challenges
- Approve the Carbon Reduction Plan for publication

History of the paper (details of where paper has previously been received)	
This paper follows on from the Green Plan refresh	July 2025
NBT TMT	7th January 2026
BNSSG SEG	15th January 2026
UHBW TMT	28th January 2026
Group Finance and Estates Committee	29th April 2026

Appendices:	
	Appendix 1 Green Plan Annual Report
	Appendix 2 Delivery Plan
	Appendix 3 Carbon Reduction Plan

1. Purpose

1.1 To gain approval of the Green Plan annual report update on progress.

1.2 To gain approval of the Delivery Plan, lead responsibilities, support actions to address challenges.

1.3 To gain approval of the Carbon Reduction Plan.

2. Background

2.1 The ICS Green Plan has been refreshed in accordance with national guidance and was approved by ICS boards and published 31st July 2025.

2.1 The statutory summary of progress on our Green Plan is published in the Trusts' annual report.

2.2 The Green Plan Annual Report provides further detail on areas we have been working on this year along with case studies and carbon footprint data.

2.3 NHSE Green Plan guidance requires us to set out the actions we are going to undertake. The Delivery Plan provides this and establishes responsibilities, costings and timelines for delivery of our actions.

2.4 Carbon Reduction Plans (CRPs) are mandatory in all procurements for suppliers bidding for NHS and other public sector contracts. NHS Trusts acting as suppliers are required to publish a CRP.

3. Green Plan Annual Report (Appendix 1)

3.1 This report is to update the Board on progress made against the ICS Green Plan.

3.2 Key outcomes and achievements:

3.3 Net Zero Carbon

- Direct emissions (Scopes 1 & 2) Target net zero 2030: Investment in energy efficiency. Finance solutions being explored for district heating.
- Scope 3 emissions: Target revised to 50% reduction by 2030, 80% by 2036, full decarbonisation by 2045. Established Sustainable Healthcare Collaboration.
- Carbon footprint: Total emissions reduced from 316,227 tCO_2e (2023/24) to 311,985 tCO_2e (2024/25).

3.4 Improve the Environment

- Waste: We have already achieved 100% landfill diversion incineration ratio improving.
- Reusable sharps bins: Reduced single-use bins from 124k to 31k; £66k savings and improved safety.
- Air Quality: Fleet transitioning to low emissions; partnerships with local authorities for sustainable travel infrastructure.
- Biodiversity: Appointed greenspace coordinator; delivered nature-based health and wellbeing programmes.

3.5 Culture Change

- Shifted engagement to ward-based Sustainability Audits (21 departments); delivering Gloves Off campaign, Sustainable Healthcare Showcase and Allotment Gala.

3.6 The case studies highlight the increasing scope of sustainability action moving beyond estates focus to being embedded in all the Group's activities and across all staff groups.

4. Delivery Plan (Appendix 2)

4.1 To satisfy the NHS England Green Plan guidance action plan requirement we have produced the Delivery Plan building on the Green Plan outcomes with detailed actions and KPIs. An overview of these is available in Appendix 2, whilst the full detail is available in the reading room of Convene.

4.2 The responsibilities, costs, benefits and timescales for delivery are set out in the plan. Further target dates and key milestones will be added in the next iteration

4.3 The Delivery Plan covers the following areas (specific challenges are shown in **Bold)**:

- Supply Chain and Procurement: Embed ethical, low-carbon procurement processes, supplier Carbon Reduction Plans and delivering social value. Reusable products to be the default.
    - **Establish a set of social value priorities that we want suppliers to deliver to include in our tender processes.**
    - **Pilot tenders including social value support for our healthier with nature hospitals' green social prescribing programme as a shift to prevention.**
    - **Setting a date when we will no longer procure single-use medical instruments where clinically appropriate to provide a clear signal to the market of our intention to move to reusables.**
- Medicines: Reduce overuse of medicines and medicines waste. Support lower impact alternatives to drugs including green social prescribing.
- Estates and Facilities: Decarbonising our buildings, increased biodiversity, zero waste by 2040.
    - **Sustainability Impact Assessment for all refurbishment and new building projects to implement the ICS Estates Standard Specification.**
    - **Managing our greenspaces for nature, wellbeing and safety - including participating in No Mow May annually.**
- Travel and Transport: Electrification of all fleet vehicles by 2027 and promotion of active travel to reduce emissions and improve health. Partnerships for transport improvements to reduce air pollution.
- Digital Transformation: Use digital services to cut emissions, circular IT equipment lifecycle practices, rationalise data centre footprints.
- Clinical Transformation: Embed sustainable practices into healthcare delivery, focusing on prevention and shifting from hospital to community care.
    - **Using Royal Colleges and societies sustainability toolkits and frameworks to support Green Plan delivery.**
- Food and Nutrition: Implement the "Why Weight?" pledge. Promote healthy, low-carbon food choices, reduce food waste, and improve health outcomes.

- Adaptation and Resilience: Embed climate resilience measures into estate strategy and service delivery, protecting vulnerable communities from heatwaves and climate risks.
    - **Undertake climate adaptation risk assessments as part of Divisions' business continuity and emergency preparedness planning.**
- Workforce and Leadership: Equip all staff with sustainability knowledge and responsibilities through training, and recognition and support of staff-led initiatives.
    - **Develop Board climate literacy and prioritisation of Delivery Plan and responsibility.**
    - **Embed sustainability into the appraisal process by requiring a sustainability objective to be set.**

4.4 Governance: The Green Plan is supported by a governance structure with executive oversight, a cross-system Green Plan Steering Group, and alignment with strategic transformation e.g. **Healthier Together 2040**.

4.5 Financial implications: Decarbonisation requires significant funding to meet our net zero carbon goal by 2030. Funding is actively sought from the System, which makes available £3m per year for decarbonisation, and from decarbonisation grants.

- **We are required to comply with the latest NHS contract to deliver allocated capital investment in decarbonisation projects and develop business cases for future investment where appropriate.**

4.6 Risks: NBT 1777 (net zero carbon) and 1776 (climate change) and the Business Assurance Framework net zero carbon risk. UHBW *Principal risk 4 – Estates Infrastructure* 3472 - Risk that the Trust fails to deliver the ICS Green Plan. Other risks are set out in Green Plan.

5. Carbon Reduction Plan (Appendix 3)

5.1 To act as a supplier for public sector and NHS contracts we must provide a Carbon Reduction Plan (CRP) to meet the procurement requirements. The Plan in Appendix 3 follows the government's Technical standard for completion of CRPs and the nationally mandated central government PPN 006 CRP template, for organisations to use.

5.2 National guidance sets out the requirements to cover UK Scope 1 and 2 emissions and a subset of Scope 3 emissions (aligned with PPN 006). We have provided all our scope 3 emissions aligning with our Green Plan.

5.3 The CRP must be approved and signed off by the board and published on the Trust's website.

6. Summary and Recommendations

6.1 Our Green Plan Annual Report outlines changes to our carbon target and progress made against the Green Plan including the new focus on scope 3 emissions and clinical sustainability projects to address supply chain emissions.

6.2 Progress is illustrated through case studies. There is still a long way to go in achieving our Green Plan outcomes.

6.3 Moving forward we are aligning our environmental and social sustainability work with the financial sustainability of the Group - prioritising clinical sustainability projects that deliver cost savings.

6.4 Our Delivery Plan sets out the actions to deliver the Green Plan outcomes with the responsibilities, costs and benefits where these have been identified. Further papers will be brought to TMT and Board where specific approvals are required.

6.5 Actions to address challenges:

Action	Owner	Target
Arrange Board seminar to: • Develop climate literacy and understanding of climate risks • Delivery Plan prioritisation • Establish a set of social value priorities that we want suppliers to deliver	Group Chief Finance and Estates Officer	2026/27 Q1
Identify pilot tenders to include social value support for our healthier with nature hospitals' green social prescribing programme as a shift to prevention.	Director of Procurement	2026/27 Q1
Gain agreement to a date when we will no longer procure single-use medical instruments where clinically appropriate to provide a clear signal to the market of our intention to move to reusables.	Director of Procurement	2026/27 Q1
Use Royal Colleges and Societies sustainability toolkits to support Green Plan delivery.	Divisional leads	2026/27 Q2
Undertake climate adaptation risk assessments as part of Divisions' business continuity and emergency preparedness planning.	Divisional leads	2026/27 Q3
Sustainability Impact Assessment on all refurbishment and new building projects as a tool to implement the ICS Estates standard specification	Head of Sustainability	2026/27 Q2
Embed sustainability into the appraisal process by requiring a sustainability objective to be set.	Head of Sustainability	2026/27 Q1
Ensure compliance with the latest NHS contract to deliver allocated capital investment in decarbonisation projects and develop business cases for future investment where appropriate.	Group Chief Finance and Estates Officer	2026/27 Q3

6.6 This report is for **Approval.**

It is recommended to:

- Approve the Green Plan annual report update on progress.
- Approve the Delivery Plan, assigned leads, actions to address challenges.
- Approve the Carbon Reduction Plan for publication.
- **Appendix 1 Green Plan Annual Report**

Bristol NHS Group
2024/25 Annual Report on Progress Towards Our Green Plan

Introduction

The Bristol NHS Group was formed in April 2025 and consists of two organisations - University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT). NHS Trusts in England are required to publish a Green Plan which outlines targets towards environmental and social sustainability. The Bristol NHS Group fulfils this by coming together with other regional partners to produce our Joint Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) Green Plan. A key piece of work this year was updating our Green Plan to be in line with new NHS England guidance. All Trust boards within our ICS approved the updates and we are currently in the process of formally publishing the update for public availability.

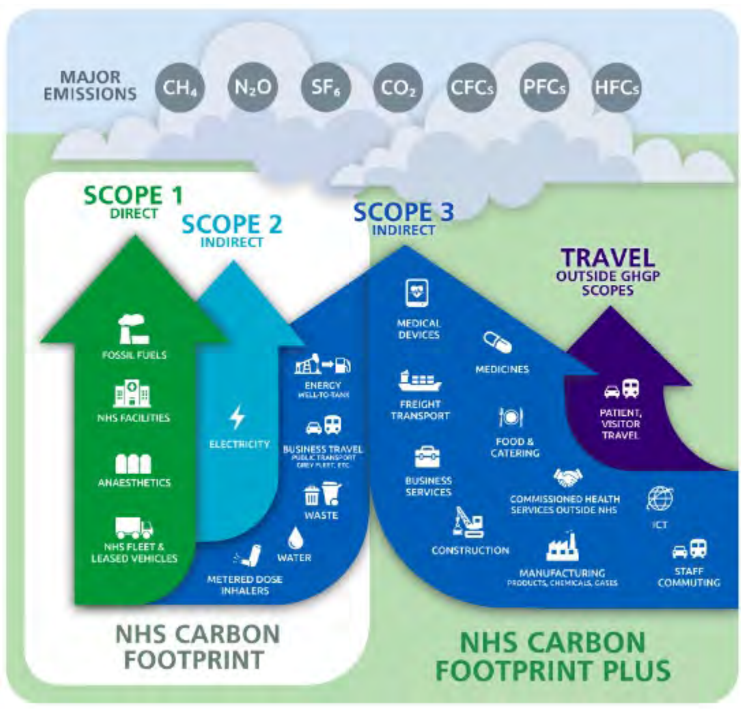
The refreshed Green Plan sets out three clear outcomes we are working towards:

- Net zero carbon: We will reduce the impact of our services on the environment by achieving net zero carbon for emissions under our direct control by 2030.
- Improve the environment: We will improve the overall environmental impact and sustainability of our services, creating a cleaner, safer, more ecologically resilient environment locally and globally, by reducing waste, improving air quality and restoring biodiversity.
- Contribute to a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment.

This report outlines progress made towards these outcomes in the 2024/25 financial year.

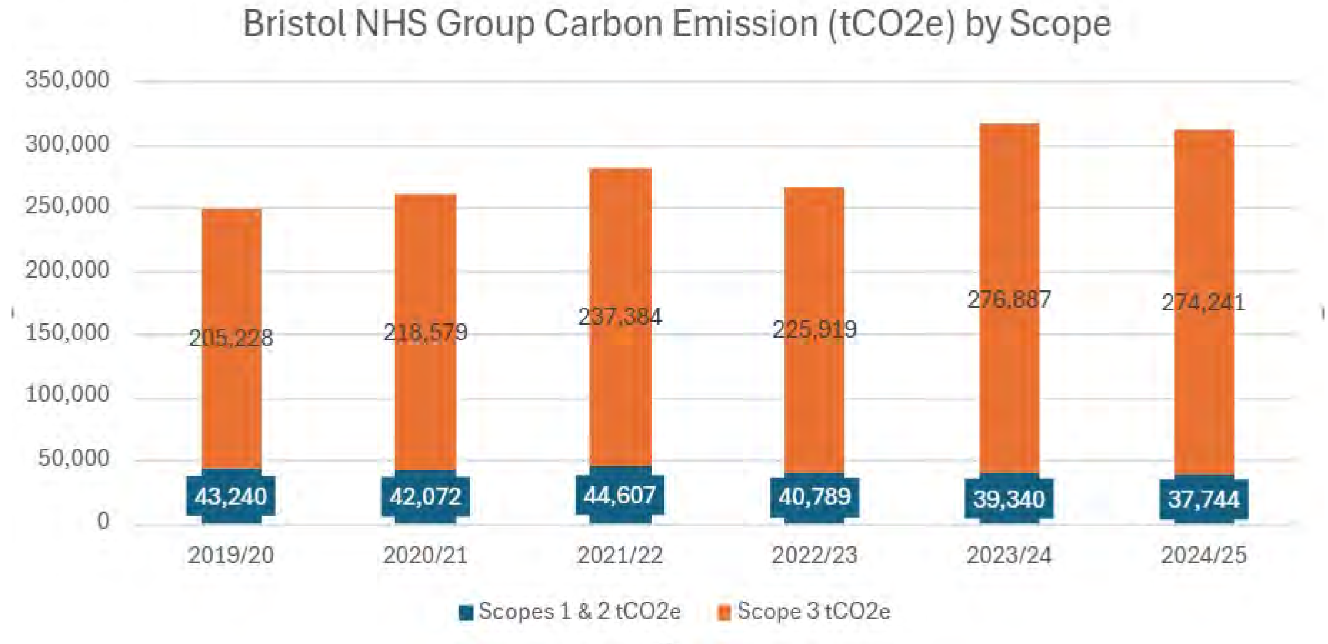
Green Plan Outcome 1 - Net Zero Carbon

The headline target in our Green Plan is achieving net zero greenhouse gas emissions by 2030. This total ‘carbon footprint’ can be broken up into direct emissions we control (scopes 1 + 2) and indirect emissions from our supply chain (scope 3) which is explained in the below graphic.



NHS Carbon Footprint and Carbon Footprint Plus

The below graph shows the limited (1% reduction in last year) progress towards our net zero goal.



We continued investing in energy-efficiency projects, achieving a 4% reduction in direct emissions (scopes 1 and 2). However, most emissions still come from natural gas use, which remains our

biggest barrier to decarbonisation until a major capital programme enables us to move away from gas-fired assets. This year, UHBW progressed plans for this transition and signed a Letter of Intent with Vattenfall, who are developing low-carbon district heating in Bristol.

We have a credible plan to decarbonise the emissions we directly control by 2030. For those we can only influence (NHS Carbon Footprint Plus), we achieved a 1% reduction but rely heavily on supply chains and wider society to decarbonise. As it became clear net zero by 2030 was unrealistic for scope 3, we updated our targets to a 50% reduction by 2030, 80% by 2036, and full decarbonisation by 2045, aligning with Bristol's One City programme and national NHS goals.

Recognising scope 3 as our largest and slowest-moving emissions area, we have prioritised accelerating progress. This has been supported by appointing a Joint Clinical Director for Green and Sustainable Healthcare and launching the Sustainable Healthcare Collaboration, our main programme for clinically led sustainability work.

Sustainable Healthcare Collaboration

In 2024, Sanjoy Shah was appointed as the Clinical Director for Green and Sustainable Healthcare across the Bristol NHS Group to drive forward and coordinate sustainability improvements. His roles both as a clinician and as a leader across the Group have been pivotal to accelerating change. Sanjoy created the Sustainable Healthcare Collaboration with the aim of centrally coordinating clinical sustainability projects to provide clear governance and encourage collaboration across the group.

The collaboration brings together high impact clinical specialities and key decision makers such as finance, procurement, quality improvement, and infection control to identify and unblock opportunities to transforming the way patient care is delivered so it does not harm the environment or deplete our limited resources. So far 140 opportunities have been identified and shared with divisions to review.

Below are two case studies which demonstrate how the collaboration has amplified the work of our determined staff, encouraged knowledge sharing and scaled up initiatives across the group.

Case Study

Green Emergency Departments

NBT and Children's Emergency Departments (ED) are making strong progress toward Green ED accreditation. This year, NBT's ED became one of only three nationally to earn the silver Green ED award, driven by several initiatives including a successful 'Gloves Off' campaign that cut average non-sterile glove use per patient from 12 to 9. The project has now expanded across the Bristol NHS Group.

Children's ED completed two Sustainability Quality Improvement projects. The first showed that half of chest x-rays for children with acute respiratory illness were unnecessary, leading to avoidable radiation, treatment delays, wasted resources, and higher emissions. After interventions such as posters, teaching, and a new standard operating procedure (SOP),

unnecessary x-rays fell by 20% between April and August 2025, with further reductions planned through training and SOP use.

The second project reduced inappropriate coagulation screen requests from 1 in 2 to 1 in 4 over 12 weeks. Halving monthly screens could save £1,310 and 85kgCO_2e while reducing patient discomfort from repeated blood tests.

Case Study
Children's Green Operating Day

In 2023, NBT's Neurosurgery team delivered a world-first Green Operating Day to cut carbon emissions. This year, Children's Hospital staff applied the same approach to Vagal Nerve Stimulator (VNS) insertions and battery replacements, common procedures for paediatric epilepsy. By analysing these high-volume surgeries, the team established their carbon baseline and identified sustainability improvements. Streamlining surgical trays reduced instruments needing sterilisation by nearly 70% and single-use consumables by 47.5%.

Baseline surgical tray set

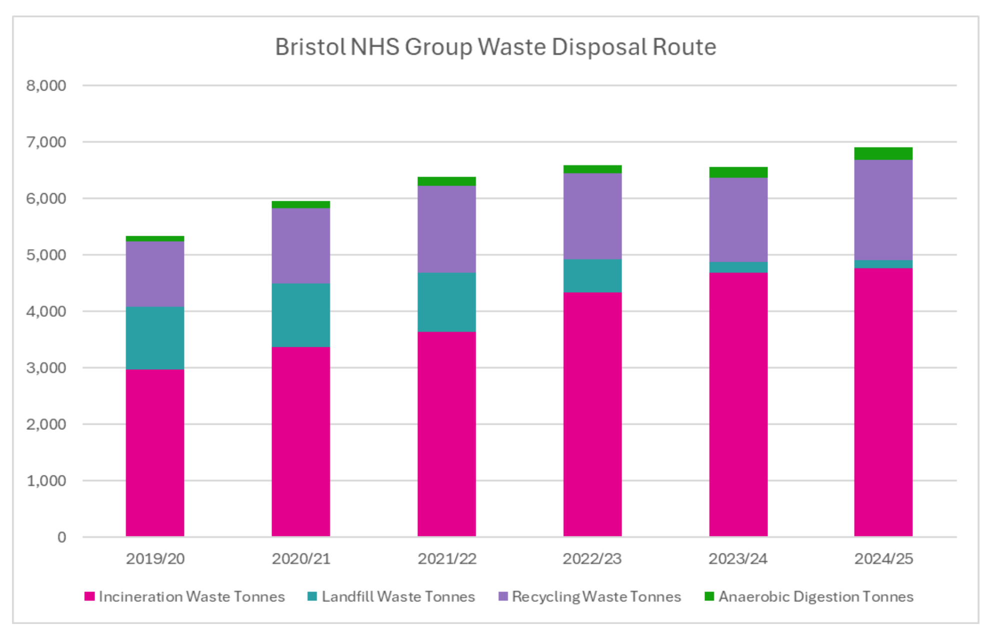
After the surgical tray set was rationalised

Alongside actions from the Intercollegiate Green Surgical Checklist, including improved recycling, this achieved a 50% carbon reduction for both procedures. If sustained for a year, these greener practices would save an estimated 1,176 kgCO_2e—the equivalent of a 4,440-mile journey in a petrol car.

Green Plan Outcome 2 - Improve the Environment

Waste

Another key target in our Green Plan is diverting 100% of our waste from landfill by 2025. We're very pleased to report this target was achieved on schedule. You can see from the graph below we still sent 96.3 tonnes to landfill in the start of the reporting year but had reduced to zero by the end of 2024.



Whilst this is a major milestone, we recognise there is still a long way to go in reducing our impact from waste. The above graph shows most of our total waste is currently being incinerated, and whilst we can capture energy from this process, it still has a high impact. There are three ways in which our waste is incinerated which are outlined in the table below. NHS England has a 20:20:60 clinical waste ratio target for these different incineration methods to move waste tonnages into lower impact categories.

Clinical Waste Segregation	High Temperature Incineration	Alternative Treatment	Offensive Waste
NHS England Target % Split	20	20	60
Bristol Group 2024/25 % Split	32	26	42

The table shows our progress against this target for the year and it shows that whilst we are close, we still have a way to go. Progress has improved over the year with data from March 2025 showing us being much closer to the target. We have implemented projects to increase segregation to stop waste from being over-treated and have also carried out bin composition audits for specific wards. The following case study describes our main project in this area implementing reusable sharps bins.

Case Study
Reusable Sharps Bins

The NHS generates sharps waste, traditionally disposed of in single-use plastic bins that are incinerated. In October 2024 we introduced reusable sharps bins, which are cleaned and returned for repeated use. This cut annual single-use bin consumption from around 124,000 to 31,000.

The switch has lowered our carbon footprint by reducing manufacturing and disposal impacts and supporting a circular economy. Although reusable bins require upfront investment, they are cheaper over their lifespan, delivering a £66k annual saving across the Bristol Group.

Safety has also improved: the sturdier reusable bins have led to fewer punctures and leaks and are designed for repeated sterilisation and full regulatory compliance.

Single use sharp bins and a reusable sharps bin

Air Quality

Air quality is a city-wide issue with major implications for the health of the population. Our Green Plan sets out the main ways we can positively impact air quality by:

- Improving the composition of our fleet to reach net zero emissions.
- Influencing staff, patients and visitors to travel to our sites using healthier, lower carbon modes of transport.
- Having strong partnerships with local transport authorities.

UHBW's fleet continues to shift rapidly to electric vehicles, with 75% now zero-emission. NBT has introduced its first EV, though further progress depends on expanding Southmead's electrical capacity or securing off-site charging. Remaining petrol and diesel vehicles across both Trusts are over 90% Euro 6 compliant. Emissions and costs could be reduced further by optimising fleet use, supported by telematics now installed in all UHBW vehicles and half of NBT's.

Measuring travel emissions from staff, patients and visitors remains difficult, but annual staff travel surveys and audits of active travel facilities help build understanding. A new Staff Transport Project has reintroduced staff parking charges at Southmead and is exploring improvements to active travel options and behaviour-change initiatives to reduce car use.

Both Trusts work closely with local authorities through the One City Transport Board and regular engagement with Bristol City Council and the West of England Combined Authority, contributing to upcoming transport infrastructure changes such as early planning for a Workplace Parking

Levy. Collaboration on Bristol's Clean Air Zone has already delivered major benefits, including a 26.9% drop in nitrogen dioxide levels outside the Bristol Royal Infirmary's Emergency Department.

Case Study
Sustainable Logistics

Emptying bins and collecting fallen leaves are essential tasks to keep our hospital site safe, tidy and pleasant for patients, visitors and staff. Around the Brunel building on our Southmead campus, those tasks fall to Bill Maries.

"I've been doing this job since the Brunel building opened over a decade ago. Until this year I did it all on foot, which took all day. There's a lot of bins!" Bill says.

To help Bill with his job, our facilities team were considering purchasing a diesel van for driving around site. The NBT sustainability team successfully applied to participate in the West of England Combined Authority's (WECA) urban mobility trial, giving us the use of an EAV 2Cubed electric cargo quadricycle free for a year to try out a cleaner way to get about the site, without increasing our carbon footprint by using a van.

Bill now covers around six kilometres a day in the EAV, filling it with bin bags for sorting and disposal. "It helps me move around the site efficiently and has plenty of space to carry bags. I'm using it for more things across the hospital too, like clearing fallen leaves and refilling grit bins ready for winter".

Trialling the EAV gives us a real-world understanding of the potential to use alternatives to full-size vans for some of our logistics requirements. With a purchase cost of around £14,000 compared to £29,000 for a small electric van there are significant potential savings.

Bill and the EAV during their daily rounds of the hospital

Restoring Biodiversity

Our Green Plan has a target of 30% of greenspace on our sites being improved and managed for wildlife and human wellbeing. To achieve this goal, we have integrated biodiversity questions into our sustainability impact assessments for business cases to understand the impacts our developments have on nature.

We've also appointed a grant funded Greenspace Coordinator who has been instrumental in improving the use of greenspace on our estate and delivering nature-based interventions for staff and patients' health and wellbeing. An example of this work is our tree planting programme at Weston General Hospital pictured below.

Staff came together to plant the first ten trees, donated by NHS Forest, in the Weston General Hospital orchard.

Green Plan Outcome 3 - Creating Culture Change

This year we have shifted our staff engagement approach to focus on outcomes. Our approach to creating culture change across our services has also evolved from passive methods such as holding stalls in the NBT Atrium to visiting wards and labs through our Sustainability Audit Programme. Through this programme we have audited 21 departments across the Bristol NHS Group, gaining valuable insights to clinical pathways and curating department-specific action plans to improve. Our waste managers have enriched this programme by delivering compositional waste audits that occur over several days and provide detailed insights on product packaging as well as compliance with waste policies.

Events such as the Sustainable Healthcare Showcase and Allotment Gala aimed to celebrate, educate and empower our staff. Through these events we engaged with over 120 people from our Group, the wider NHS and local community.

Staff and visitors at the 2025 Southmead Hospital Allotment Gala

Case Study
Catering for Health

Our role in supporting cultural change extends beyond our workforce and encompasses patients as well. UHBW's catering team is dedicated to providing patients with healthy, sustainable meals while actively reducing food waste. This year they became one of 22 organisations to take part in the "blue plate trial" launched by NHS England. Standard white crockery, used for patient meals, is replaced with cornflower blue crockery. The trial was a big success. From the data recorded over a period of 8 weeks, results show empty plates increased by 21.75% and plate waste decreased by 68.5kg. Reducing food waste supports our net zero goal and generates financial savings. The results also suggest that patients increase their food intake, which can promote faster recovery.

Every day, 600 sandwiches are made for patients, resulting in many end pieces of bread destined for the bin. Instead, the bread is used to make 360 pieces of bread pudding a week, to sell in on site outlets, as well as banana muffins made from browned bananas. Work is ongoing with Apetito, our patient catering supplier, to minimise the carbon footprint of meals. So far this has included removing red meat, increasing chicken and fish and menus leading with the vegetarian option. Through this work we hope to encourage more sustainable eating habits and shift ideas around food waste.

Case Study
Gloves Off

Reducing non-sterile glove use is one of six priorities in the Sustainable Healthcare Collaboration. Working with Infection Prevention and Control (IPC), we launched a Group-wide Gloves Off campaign after a survey showed staff were often unsure when gloves were needed, with COVID-19 influencing ongoing habits. The campaign focuses on educating staff to risk-assess their practice, use gloves only when appropriate, and prioritise hand hygiene.

Through governance meetings, education sessions and roaming teaching, 33 teams and 509 staff received Gloves Off training. IPC also produced 55 FAQs and a generic PPE task list to support consistent practice. Since training, teams have created their own PPE task lists, posters and further teaching. Early glove-purchasing data shows reductions at UHBW, with NBT expected to follow.

Over 500 stickers were distributed across NBT sites

Conclusion

We are really pleased with the progress made this year and are proud to present the case studies in this report, but we recognise there is a long way to go to achieving the outcomes in our Green Plan. We know our organisation, sustainability included, needs to deliver on the four Ps of our patients, our people, the populations we serve, and the public purse. Looking ahead we are therefore aligning our environmental and social sustainability work with the financial sustainability of the wider organisation. This will involve embedding clinical sustainability projects in our divisional Cost Improvement Plans and developing viable financial delivery models for our estates sustainability works. Our approach to our work going forward is set out in our delivery plan which outlines responsibilities, costings and timelines for delivery of our actions.

Appendix A – Data

Source	Units	2023/24			2024/25		
		UHBW	NBT	Total	UHBW	NBT	Total
Scope 1	tCO2e	19,477	10,878	30,355	18,600	9,359	27,959
Scope 2	tCO2e	1,228	7,757	8,985	1,335	8,450	9,785
Scope 3	tCO2e	147,548	129,339	276,887	152,180	122,061	274,241
Total	tCO2e	168,253	147,974	316,227	172,115	139,870	311,985
Energy							
Gas use	kWh	98,557,570	38,847,710	137,405,280	91,571,991	34,074,385	125,646,376
Oil use	Litres	27,351	560,244	587,595	27,351	226,960	254,311
Electricity use	kWh	5,930,672	37,459,751	43,390,423	6,449,920	40,812,725	47,262,645
Anaesthetic Gases							
Anaesthetic Gases	tCO2e	1,141	2,028	3,169	1,511	2,254	3,765
Supply Chain							
Purchased goods and services	tCO2e	129,000	105,864	234,864	132,895	98,158	231,053
Travel and Transport							
Trust owned Fleet	tCO2e	212	199	411	101	246	347
Business Travel (grey fleet)	tCO2e	328	235	563	402	97	499
Employee Commuting	tCO2e	3,131	4,705	7,836	3,385	4,893	8,278
Patient and Visitor Travel	tCO2e	9,938	13,300	23,238	10,638	14,040	24,678
Waste							
Waste - Total	Tonnes	3,536	3,032	6,568	3,787	3,119	6,906
	tCO2e	1,364	865	2,229	1,252	829	2,081
Incineration Waste	Tonnes	2,472	2,214	4,686	2,551	2,223	4,774
Landfill Waste	Tonnes	184	3	187	131	0	131
Recycling Waste	Tonnes	769	721	1,490	976	800	1,776
Anaerobic Digestion	Tonnes	110	94	204	129	96	225
Water							
Water Supply	m3	276,797	341,992	618,789	260,616	371,326	631,942
	tCO2e	99	126	225	83	121	204

Appendix 2 – Delivery Plan

Area	Outcome	Organisation	Executive lead	Director lead
Supply Chain & Procurement	**Outcome 1: Carbon reduction in our supply chains aligned to NHS net zero supplier roadmap**	BWPC	Neil Kemsley	Philip Lewis
		Bristol NHS Group	Neil Kemsley	Sam Willitts
	Outcome 2: Suppliers go beyond minimum requirements for carbon reduction and social value.	Bristol NHS Group	Neil Kemsley	Sam Willitts
		BWPC	Neil Kemsley	Philip Lewis
	Outcome 3: Our procurement activity delivers meaningful social value that supports health priorities in the local area.	Bristol NHS Group	Neil Kemsley	Sam Willitts
		BWPC	Neil Kemsley	Philip Lewis
	Outcome 4: Only reusable products are purchased (where clinically appropriate)	BWPC	Neil Kemsley	Philip Lewis
		Bristol NHS Group	Neil Kemsley	Sam Willitts
	Outcome 5: We will be proactive early adopters of new innovations and technologies.	BWPC	Neil Kemsley	Philip Lewis
Medicines	**Outcome 1: Switch highest carbon impact medicines to lower carbon alternatives where clinically appropriate A) Decarbonise metered dose inhalers**	NBT	Tim Whittlestone	Matt Kaye
		UHBW	Tim Whittlestone	Jon Standing
	Outcome 1: Switch highest carbon impact medicines to lower carbon alternatives where clinically appropriate B) Decarbonise anaesthetic gases	UHBW	Tim Whittlestone	Jon Standing
		NBT	Tim Whittlestone	Matt Kaye
	Reduced carbon impact of medicines by influencing the procurement and supply chain ensuring compliance with net zero commitment requirements	UHBW	Tim Whittlestone	Jon Standing
		NBT	Tim Whittlestone	Matt Kaye

	Outcome 4: Reduced anti-depressant prescriptions where appropriate by increasing our Green Social Prescribing offer	UHBW	Tim Whittlestone	Jon Standing
		NBT	Tim Whittlestone	Matt Kaye
Estates & Facilities	**E&F1 Net zero carbon emissions from our buildings. Developing and delivering capital programme upgrading our buildings and improving energy efficiency**	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
	E&F2 30% of greenspace on our sites improved and managed for wildlife and staff and communities wellbeing	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
	E&F3 zero waste - By 2040 we will produce no waste. We will manage resources within the circular economy, with items surplus to requirements becoming a resource in another part of the system. No waste will be sent to landfill or incineration without energy recovery	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
Travel & Transport	**Outcome 1: Fleet emissions are net zero**	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
	Outcome 2: Staff and patients travel is healthier and lower carbon	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
	Outcome 3: We will have strong partnerships with local authorities and local transport authorities to maximise funding and infrastructure opportunities on behalf of the ICS member organisations representing patients and staff	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
Digital Transformation	**Outcome 1: Maximise digital transformation opportunities to reduce emissions and improve patient care.**	Bristol NHS Group	Neil Darvill	Phill Wade
	Outcome 2: Adopt a circular framework for IT equipment, maximising reuse, remanufacturing and recycling.	Bristol NHS Group	Neil Darvill	Phill Wade
	Outcome 3: Low carbon and climate resilient digital infrastructure and systems.	Bristol NHS Group	Neil Darvill	Phill Wade
Clinical Transformation	**CT1 Healthcare system supports communities in keeping healthy and well reducing system demands and carbon emissions**	UHBW	Neil Kemsley	Sam Willitts
		NBT	Neil Kemsley	Sam Willitts
		UHBW	Neil Kemsley	Sanjoy Shah

	CT2 Clinical sustainability projects are delivered and scaled across the system, delivering carbon and cost savings	NBT	Neil Kemsley	Sanjoy Shah
	CT3 Sustainable healthcare net zero principles are considered in all service change, reconfiguration programmes and pathway redesign	UHBW	Neil Kemsley	Sanjoy Shah
		NBT	Neil Kemsley	Sanjoy Shah
Workforce & Leadership	**WL1 Staff have the knowledge and skills to deliver sustainable change in their everyday role**	UHBW	Neil Kemsley	Sam Willitts
		NBT	Neil Kemsley	Sam Willitts
	WL2 Staff have the tools and resources to deliver sustainable healthcare	UHBW	Neil Kemsley	Sam Willitts
		NBT	Neil Kemsley	Sam Willitts
	WL3 Staff are motivated to take action	UHBW	Neil Kemsley	Sanjoy Shah
		NBT	Neil Kemsley	Sanjoy Shah
	WL4 Sustainability is embedded into healthcare roles	Bristol NHS Group	Neil Kemsley	Sanjoy Shah
	WL5 Delivering sustainable healthcare is the responsibility of all staff	UHBW	Neil Kemsley	Sam Willitts
		NBT	Neil Kemsley	Sam Willitts
Food & Nutrition	**FN1 ICS organisations deliver the Why Weight? Pledge to improve access to healthy, low carbon food on healthcare sites**	NBT	Neil Kemsley	Tim Keen
		UHBW	Neil Kemsley	Andy Jeanes
	FN2 Food provided to staff and patients is healthy, affordable, culturally appropriate and low carbon	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
	FN3 Food waste is minimised	UHBW	Neil Kemsley	Andy Jeanes
		NBT	Neil Kemsley	Tony Hudgell
Adaptation	**Outcome 1: Healthcare sites and services are climate resilient and prepared for severe weather events**	Bristol NHS Group	Neil Kemsley	Sam Willitts
	Outcome 2: Impacts of climate change are embedded in infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions	Bristol NHS Group	Neil Kemsley	Sam Willitts

	Outcome 3: Our communities have increased their resilience to climate impacts	Bristol NHS Group	Neil Kemsley	Sam Willitts

Appendix 3- Carbon Reduction Plan

Bristol NHS Group - Carbon Reduction Plan

Publication date: December 2025

Commitment to achieving Net Zero

The Bristol NHS Group are committed to achieving Net Zero emissions for its scope 1, 2 and 3 emissions by 2045.

We have set both near-term (2030) targets and long-term targets to help achieve this.

Baseline Emissions Footprint

Baseline emissions are a record of the greenhouse gases that have been produced in the past and were produced prior to the introduction of any strategies to reduce emissions. Baseline emissions are therefore a reference point against which emissions reduction can be measured.

Baseline Year: 2019/20
Additional Details relating to baseline emissions calculations
The Bristol NHS Group was formed in April 2025. The group brings together two NHS Trusts - University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust – together in partnership under one Board with a shared ambition and vision. In April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form University Hospitals Bristol and Weston NHS Foundation Trust. The baseline year is 2019/20. The Bristol NHS Group aligns its reporting boundaries and accounting methodologies with those of NHS England. Scope 1 emissions include those from the use of anaesthetic gases which is calculated using volume. The purchased goods and services category reported as part of scope 3 emissions, is a cradle to gate calculation based on spend data with our supply chain. We are unable to separate the specific upstream transport and distribution emissions from this cradle to gate calculation, but they are captured within it. A complete supply chain calculation on all spend was not completed until the financial year 2021/22. The baseline year (2019/20) data shown in the table is calculated on partial data from 2019/20 and the remaining data from 2021/22. The downstream transport and distribution emission category is not relevant to the Bristol NHS Group and is therefore not included. Business travel emissions are reported using different calculation methodologies; > Grey fleet carbon emissions are calculated based on miles travelled from expenses claims. > All other modes of business travel are calculated based partially on mileage data where the data is available. Where it is not available the data is calculated based on cost. We recognise that this is not best practice but at present have no other means to calculate these emissions. Parts of the business mileage data were not calculated until the financial year 2022/23. The baseline year data is therefore a hybrid of data from the baseline year and 2022/23.

Emissions	Total (tCO2e)
Scope 1	26,112
Scope 2	17,128
Scope 3 - Mandatory requirement including purchased goods and services, waste, business travel, employee commuting.	169,675
Scope 3 – all other categories	35,553
Scope 3 Total	205,228
Total Emissions	248,468

Current Emissions Reporting

Please see notes in the baseline year for data coverage.	
Reporting Year: 2024/25	
Emissions	**Total (tCO2e)**
Scope 1	27,959
Scope 2	9,785
Scope 3 - Mandatory requirement including purchased goods and services, waste, business travel, employee commuting.	242,249
Scope 3 – all other categories	31,992
Scope 3 Total	274,241
Total Emissions	311,985

Emissions Reduction Targets

To continue our progress towards achieving Net Zero, we have adopted the following carbon reduction targets by 2030;

- Fully decarbonise the emissions we control. Powering our activities without the use fossil fuels.
- 50% reduction for the emissions we can influence.

We have also set long term targets to achieve;

- 80% reduction in the emissions we can influence by 2036
- Fully decarbonise by 2045.

This target is published as part of our Green Plan which can be accessed from the following link.

6.2 - ICS Green Plan Refresh - ICB Board July 2025

The Green Plan outlines the initiatives, projects and activities we will deliver to reach our net zero target and wider sustainability goals.

We project that carbon emissions will decrease over the next 5 years to 124,899 tCO2e by 2030. This is a reduction of 55%.

Carbon Reduction Projects

Completed Carbon Reduction Initiatives

The following environmental management measures and carbon reduction projects have been implemented since our baseline year. As our emissions have increased overall, it is not possible to calculate the reductions

achieved by the implementation of these measures. These measures will be in effect when performing the contract.

- Decommissioned desflurane anaesthesia and removed isoflurane vaporisers from anaesthetic scavenging machines.
- Collect medical devices for remanufacturing and use remanufactured devices in surgery.
- Increased the amount of low carbon inhalers prescribed to patients.
- Increased the number of virtual appointments delivered to patients.
- Installed more solar PV on site.
- Begun to convert to low-temperature hot water systems and replace steam boilers.
- Every tender has a minimum of 10% of the award criteria for social value.
- Use re-usable sharps bins.
- Send zero waste to landfill.
- Carried out waste audits and training to ensure that the correct bins are in place to aid segregation, reducing the amount of waste that is over treated.
- Introduced a cycle to work scheme open for applications all year round and for an increased value of £4k.
- Bespoke, personal travel plans for staff on their lower carbon and active travel options are available.
- Run a loan bike scheme for staff to trial cycling to work for one month.
- Improvements made to our free to use staff, patient and visitor shuttle bus service.

<u>In the future we hope to implement further measures such as</u>**;**

- Replace all domestic sized boilers with heat pumps.
- Fully remove all nitrous oxide manifolds from our estate.
- Install volatile gas capture technology on 100% of our anaesthetic machines.
- Adopt reusable tourniquets to reduce the incineration of single use plastics.
- Replace more single use medical devices with remanufactured options and increase their use by surgeons.
- Adopt Rub Don't Scrub as routine procedure in theatres to reduce water and energy use.
- Reduce the use of PPE such as gloves and couch roll.
- Rationalise surgical tray sets for appropriate procedures to reduce water and energy use.
- Switch from intravenous to oral medications where appropriate to reduce emissions associated with single use plastics and pharmaceuticals.
- Embed sustainable and active travel options in the recruitment process for new staff.

- Fully transition our entire owned fleet to electric vehicles.

Declaration and Sign Off

This Carbon Reduction Plan has been completed in accordance with PPN06/21 and associated guidance and reporting standard for Carbon Reduction Plans.

Emissions have been reported and recorded in accordance with the published reporting standard for Carbon Reduction Plans and GHG Reporting Protocol corporate standard[1] and uses
the appropriate Government emission conversion factors for greenhouse gas company reporting[2].

Scope 1 and scope 2 emissions have been reported in accordance with SECR requirements. Scope 3 emissions have been reported in accordance with the published reporting standard for Carbon Reduction Plans and the Corporate value Chain scope 3 standard[3].

This Carbon Reduction Plan has been reviewed and signed off by the Board of Directors.

Signed on behalf of Bristol NHS Group;

Date:

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Research and Development Annual Report</td></tr>
<tr><td>Report Author:</td><td colspan="3">Professor Fergus Caskey, Group Director of Research</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Professor Tim Whittlestone, Group Chief Medical and Innovation Officer</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td>X</td></tr>
<tr><td colspan="3">This report has two purposes:
1. It fulfils the Department of Health and Social Care requirement that performance against the government’s 150-day clinical trial set-up target, particularly for commercial interventional trials, is a standing priority at Board level.
2. It provides an overview of research activity and performance across the Bristol NHS Group, highlighting key achievements, performance trends, areas of focus, and alignment with strategic priorities.</td></tr>
</table>

Key Points to Note *(Including any previous decisions taken)*

This is the first R&D report to the NBT & UHBW Group Board. Key positives are:

- Combined 2025/2026 NIHR research capability funding, based on competitive grant income, that would put the Group in #1 position, nationally.
- In 2025/2026, NBT and UHBW recruited the first patients to 3x national, 1x European and 2x global commercial trials.
- In 2025/ 2026, collaborative working has enabled advanced therapy trials – cell therapies and gene therapies – to be co-delivered, for the first time, across UHBW and NBT.

However, both Trusts are falling below the government’s targets for clinical trial set-up, the Government metric. A set-up project is underway at UHBW to optimise workflows and systems. A Group R&D business case is being developed to enable more rapid clinical trial set-up. And work is underway as part of the merger to find the optimal merged R&D systems and processes, including vacancy review, that will enable improvement against this metric. A new National Institute for Health and Care Research ‘Delivery’ funding model has also led to a 7% reduction in funding for UHBW, which is requiring teams to adjust the way they allocate their activity.

Strategic and Group Model Alignment

R&D is a key enabler of the Bristol NHS Hospital Group’s strategic objectives, supporting high-quality patient care, innovation, workforce development, and financial sustainability. It’s activity supports:

- Patients and Populations by underpinning the Group’s commitment to quality, assurance, and performance improvement, and providing early access to emerging therapies.

- People through the development and retention of a skilled research workforce, while contributing to a culture of continuous improvement and innovation.
- The Public Purse through effective research delivery that maximises external income (commercial and non-commercial) and saves the NHS money on novel therapies that are funded by industry.

The upcoming merger provides opportunities to further align research strategy, governance arrangements, and delivery approaches across NBT and UHBW. Increased consistency and collaboration support more efficient use of resources, reduced duplication, and a stronger, more coherent research offer to funders, sponsors, and system partners.

Risks and Opportunities

Key Risks

- Delivery capacity and workforce sustainability: Delays in recruitment approvals for externally funded posts, ongoing workforce pressures, and reliance on time-limited funding are creating barriers to timely study progression, impacting income, performance and reputation.
- Financial and performance volatility: Research performance and income remain sensitive to study set-up, recruitment delivery, and data quality across multiple systems.
- Reputational risk: Failure to meet national expectations for research delivery, data quality, or compliance could impact funder and sponsor confidence and return business.

Key Opportunities

- Group working and system alignment: Group working has enabled closer working between the two R&Ds, but the merger will enable the formation of a single R&D function with opportunities to align strategy, governance, and delivery, reducing duplication and strengthening system impact.
- Commercial research growth: Streamlined processes and stronger sponsor engagement will support income generation and patient access to innovation. A business case to increase R&D capacity and grow commercial activity and income is in development.
- Patient and population benefit: A strong research portfolio supports improved outcomes, reduced inequalities, and alignment with system priorities. The merging of the two R&Ds will mean that patients receiving care in any of our Bristol hospitals will have the same access to research opportunities.

Recommendation

This report is for information.

History of the paper (details of where paper has previously been received)

N/A

Appendices:	N.A

1. Purpose

This report provides an overview of research activity and performance across the Bristol NHS Hospital Group. It highlights key areas of strength, identifies opportunities for improvement, and outlines the risks associated with current research activity. The report is intended to provide assurance to the Board on research delivery, performance, and alignment with strategic priorities across the Group.

2. Background

The R&D offer across Bristol NHS Group is well aligned with, and complementary to, the clinical strengths and specialist services of the two Trusts. Both organisations have established, successful R&D functions, currently delivered through slightly different operating models.

R&D is an externally funded service that generates income for the Trusts. Two key sources of funding are National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) funding and commercial research income. This funding supports the employment of research staff, enables patient access to research opportunities, contributes to innovation, delivers cost savings, and provides wider financial benefit to the Trusts.

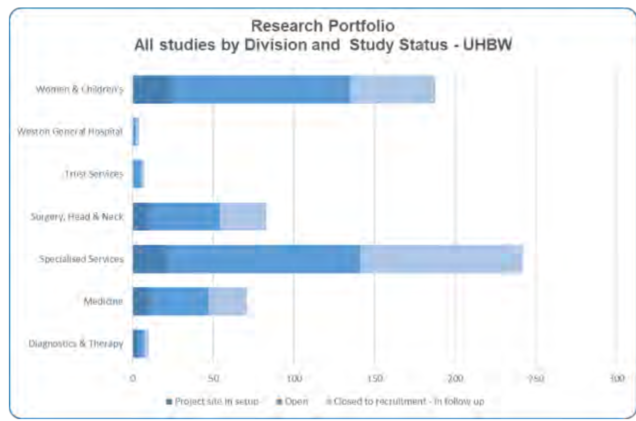
Trust performance is a key driver of RDN funding. In the previous year, a new set of key performance measures was introduced which directly influence funding allocations. This report presents performance against these measures.

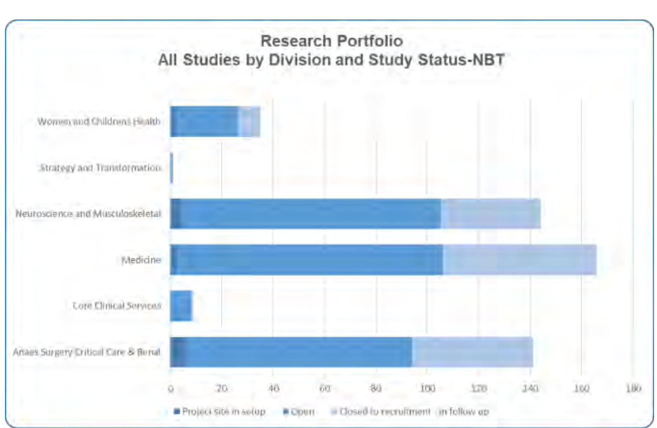
The report also highlights recent national and international research successes, alongside investment made through Research Capability Funding (RCF) to support staff development and grant income generation.

3. Research Activity and Performance- Group Overview

3.1 Research Portfolio - Breadth and Diversity

Bristol NHS Group has a substantial and diverse research portfolio, demonstrating breadth across clinical specialties and study types. At the point of reporting, the portfolio comprised 611 studies at UHBW and 523 studies at NBT, spanning interventional, observational, large observational, large interventional and commercial research. Activity is distributed across all stages of delivery, with a pipeline of studies in set-up, a large number open to recruitment, and a significant cohort closed to recruitment but in follow-up, evidencing both current delivery and future workload.

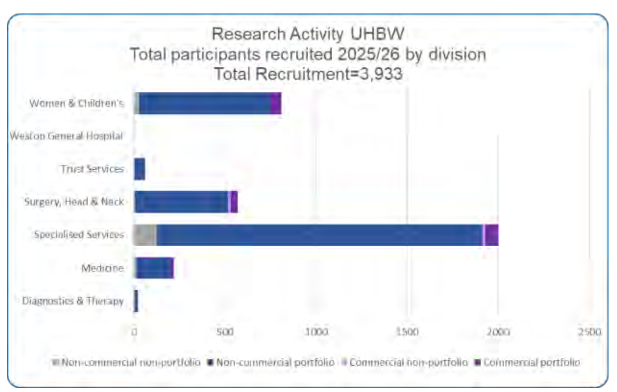


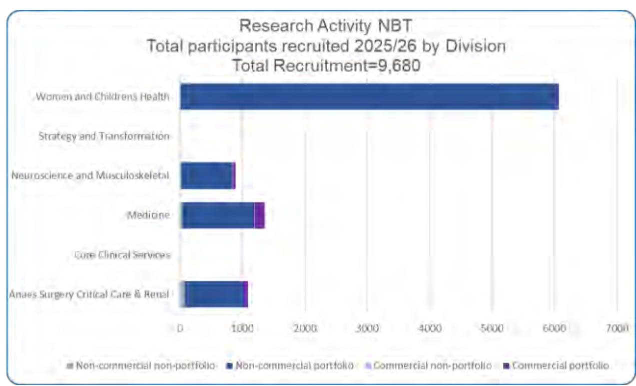


Number of studies in set-up, open to recruitment, and in follow-up, April 2026, by Trust.

3.2 Research Activity- Participant Recruitment and Engagement

Recruitment data shows strong participant engagement across Bristol NHS Group, with 3,933 participants recruited at UHBW and 9,680 at NBT during 2025/26. Activity spans commercial and non-commercial research, with the highest volumes in non-commercial portfolio studies.

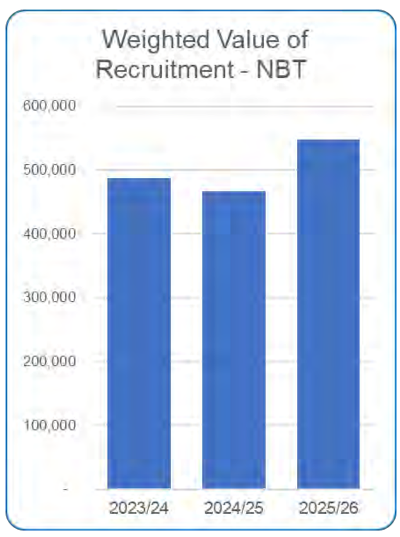


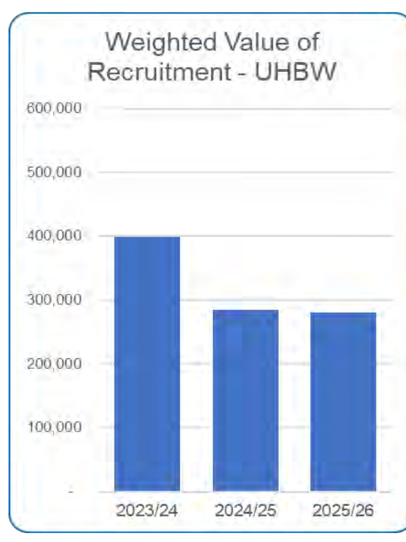


Recruitment activity (total number of participants recruited) in 2025/2026, by Trust.

From 1st April 2026, NIHR introduced a new activity-based funding model for allocating delivery funding to organisations. This recognised the different work involved in recruiting to different types of research.

Retrospective application of this formula led to a 1% increase and a 7% reduction in NBT and UHBW's NIHR Delivery funding, respectively. Both Trusts are working with delivery teams to make appropriate adjustments to their recruitment activity to optimise NIHR Delivery funding in future financial years.





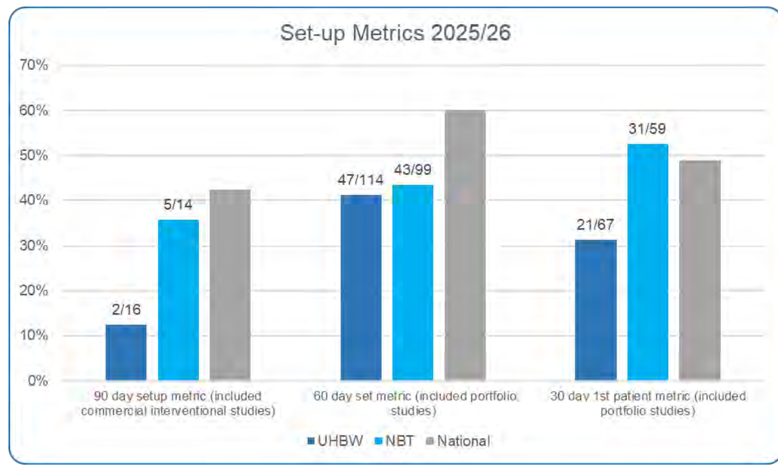
NIHR Delivery Funding weights per research participant recruited:

- Large observational = 1
- Large interventional = 29
- Observational = 86
- Interventional = 175

NIHR weighted value of recruitment activity, by financial year, by Trust.

3.3 Our Research Performance against Government and NIHR Metrics

Research performance against national timeliness metrics demonstrates variable delivery across the Hospital Group. Reported UKCRD (UK Clinical Research Delivery) data indicate that NBT performs more strongly than UHBW across the 90-day set-up, 60-day site opening, and 30-day recruitment to first participant measures, with the largest relative difference observed in the 30-day metric. Current performance shows that a minority of studies meet the 90-day target, with improved performance at 60 and 30 days, reflecting the complexity of study set-up and early recruitment.

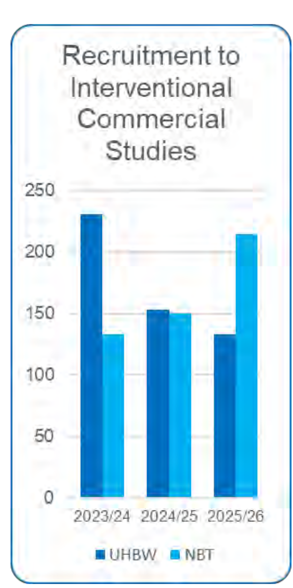


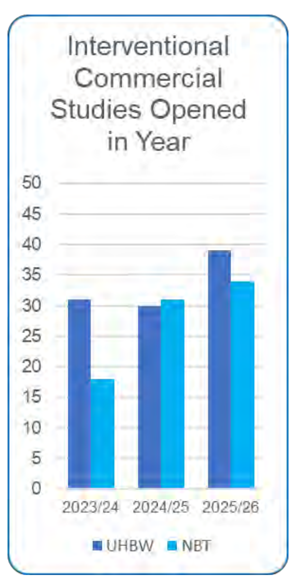
Both Trusts are committed to improving site-level performance across both metrics, supported by a jointly implemented programme between the two R&D departments to drive outcomes towards national levels. Variations in research portfolios across the Trusts are expected to contribute to some local differences in metrics, particularly in specialist settings such as Bristol Haematology and Oncology Centre and Bristol Royal Hospital for Children, where complex interventional trials are delivered

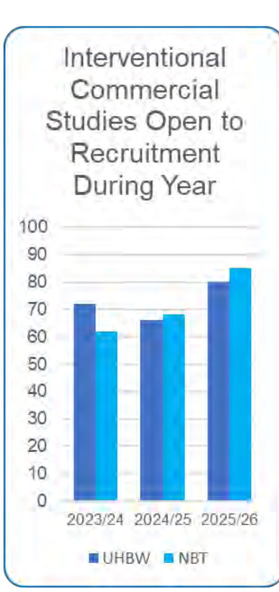
It should be noted that both the UKCRD and NIHR NHS Study Set-up App data are known to contain inaccuracies, and local operational data are being used to support internal oversight while these data quality issues are addressed. Performance against these national metrics remains a priority due to its direct impact on funding, reputation, and delivery assurance.

3.4 Commercial Research Growth and Delivery

Commercial research activity remains strong across Bristol NHS Group, with growth in the number of commercial studies opened in 2025/26 at both Trusts (UHBW 47; NBT 37). Growth in recruitment to commercial studies has been particularly strong at NBT in recent years.







Importantly, the portfolio of research at the two Trusts is complementary, with more emphasis on early-phase, rare disease studies at UHBW and more emphasis on later-phase studies at NBT.

Overall, the data demonstrate a continued and significant contribution of commercial research to the Group's portfolio, income generation, and patient access to innovative studies.

3.5 National and Global Competitiveness

During 2025/26, the Bristol NHS Group delivered multiple national and international patient firsts in highly complex commercial trials, including early-phase, gene therapy, advanced therapies and paediatric studies.

- **Apr 2025** – European first: Gene therapy in Parkinson's disease (NBT)
- **Jul 2025** – Global first: Paediatric vaccine study (UHBW)
- **Oct 2025** – Two UK firsts: Autoimmune disease and haematology trials (NBT and UHBW)

- **Feb 2026** – UK first: Paediatric nephrology trial (UHBW)
- **Mar 2026** – Global first: Gene therapy for IgA nephropathy (NBT)

3.6 Strategic Enablers of R&D

In 2025/26, both Trusts demonstrated strong performance in securing research funding. NBT received £1.56m in Research Capability Funding (RCF), ranking 3rd nationally for the third consecutive year, while UHBW secured £836k with significant growth forecast. Combined, this would put the Group in the top position for RCF income for NHS research organisations.

RCF continues to be spent internally to sustain core R&D infrastructure and support schemes that strengthen the pipeline from early-stage research to major NIHR programmes.

Both Trusts also secured Department of Health and Social Care pharmacy capacity funding to improve study set-up timelines and responsiveness, although workforce challenges persist. UHBW additionally secured £1.3m in NIHR capital funding to expand research facilities, enhancing capacity, efficiency, and patient experience, and supporting increased access to research opportunities.

3.7 Quality, Outcomes and Impact

A Case Study: Our People

In 2024/25, the Bristol NIHR Clinical Research Facility established a specialist role to support the delivery of complex early-phase and advanced therapy studies. Eve Watson, who was appointed to the role, has enabled expansion of these studies into new specialties – ophthalmology, hepatology, cardiac surgery and nephrology – across both Trusts. This includes the Group’s first CAR-T trials in non-haematological patients. This collaborative approach strengthens capability, broadens the research portfolio, and increases patient access to innovative therapies.

4 Summary and Recommendations

R&D activity across the Bristol NHS Group remains strong, with a large and diverse portfolio, high levels of participant recruitment, sustained growth in commercial research, and delivery of multiple national and global patient firsts in complex and innovative studies. Strategic investment in workforce, pharmacy capacity and infrastructure continues to support delivery and future growth. Efforts are currently focused on addressing underperformance against commercial trial set-up times, enabling growth in commercial trial income, and adjusting research delivery activity to sustain our NIHR Delivery funding. The developing Hospital Group model greatly assists this by providing an opportunity to further align research strategy and delivery, ensuring equitable access to research opportunities for patients across all Bristol hospitals.

Recommendation

This report is presented for information.

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Integrated Quality and Performance Report (IQPR)</td></tr>
<tr><td>Report Author:</td><td colspan="2">David Markwick, Director of Performance
Julie Crawford, Head of Patient Safety
Emma Harley, Head of Strategic Workforce Planning, Laura Brown, Head of HR Information Services (HRIS)
Kate Herrick, Head of Finance</td><td>Lisa Whitlow, Director of Performance
Paul Cresswell, Director of Quality Governance
Benjamin Pope, Associate Director for Workforce Planning, People Systems and Data
Simon Davies, Assistant Director of Finance</td></tr>
<tr><td>Report Sponsor:</td><td colspan="2">Responsiveness – Philip Kiely, Trust Chief Operating Officer
Quality – Sarah Dodds, Trust Director of Nursing, Becky Maxwell Trust Medical Director
Our People – Alex Nestor, Trust Director of People
Finance – Jeremy Spearing, Trust Director of Finance</td><td>Responsiveness – Nicholas Smith, Trust Chief Operating Officer
Quality – Su Monk, Trust Director of Nursing, Samir Patel, Trust Medical Director
Our People – Sarah Margetts, Interim Director of People
Finance – Elizabeth Poskitt, Trust Director of Finance</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td></td><td>x</td></tr>
<tr><td colspan="3">To provide an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.</td></tr>
<tr><td colspan="4">Key Points to Note (Including any previous decisions taken)</td></tr>
<tr><td colspan="4">This report provides an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.</td></tr>
<tr><td colspan="4">Strategic and Group Model Alignment</td></tr>
<tr><td colspan="4">This report aligns to the objectives in the CQC domains of Safe, Effective, Caring, Responsive and Well Led.</td></tr>
<tr><td colspan="4">Risks and Opportunities</td></tr>
<tr><td colspan="4">Risks are listed in the report against each performance area.</td></tr>
<tr><td colspan="4">Recommendation</td></tr>
<tr><td colspan="4">This report is for Information</td></tr>
<tr><td colspan="4">History of the paper (details of where paper has <u>previously</u> been received)</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td>Appendices:</td><td colspan="3">NBT PQSM
UHBW PQSM</td></tr>
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Integrated Quality and Performance Report.

Month of publication: May 2026
Data up to March 2026

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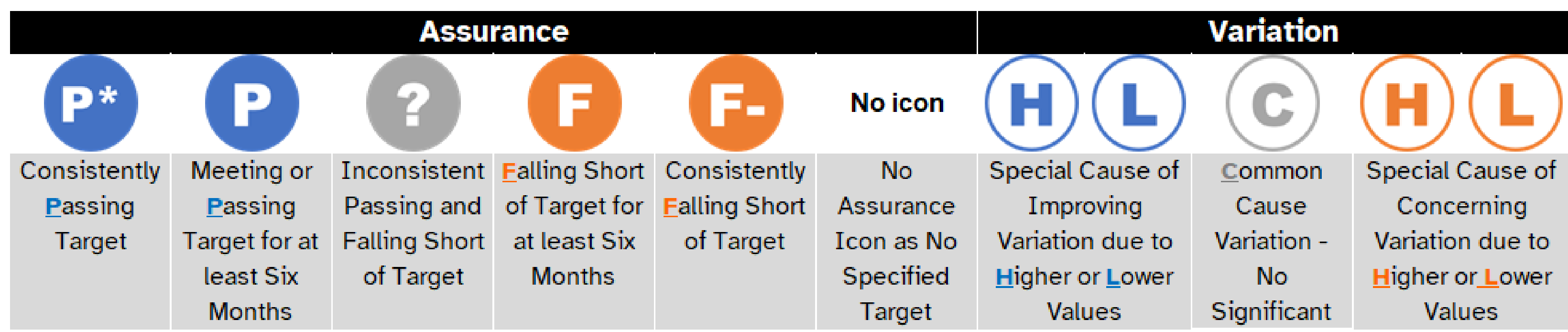
Key to KPI Variation and Assurance Icons



Assurance						Variation			
P*	P	?	F	F-	No icon	H L		C	H L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values		Common Cause Variation - No Significant	Special Cause of Concerning Variation due to Higher or Lower Values

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Escalation Rules: SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see page at the end for a detailed description.

Further Reading / Other Resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes a number of videos explaining the approach and a series of case studies – these can be accessed via the following link:

NHS England » Making data count

Scorecards Explained

Type of Metric; either Breakthrough Objective, Corporate Project or Constitutional Standard/Key Metric.

Name of Metric/KPI.

The most recent data period – this will be the last complete month for the majority, but some metrics are reported one or more

The target, where applicable, for the most recent month. This may be the national target or internal target / planned trajectory.

This icon indicates the assurance for this metric (see above key for summary or see Appendix for full detail).

Response taken based on the Metric Type and the Assurance and Variation Icon for the latest month (see Appendix for full detail). Action is either Note Performance, Escalation Summary, Counter Measure Summary or Highlight

Metric Type	CQC Domain	Experience of Care Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Constitutional Standards and Key Metrics	Caring	Monthly Inpatient Survey - Standard of Care	Sep 24	93.2%	94.1%	90.1%	F	C	Escalation Summary

The CQC Domain the indicator is covered by. See CQC Website for more information: The five key questions we ask - Care Quality

The actual performance for the most recent month.

The actual performance for the previous month.

This icon indicates the variance for this metric (see above key or see Appendix for full detail).

Business Rules and Actions

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values	Common Cause Variation - No Significant	Special Cause of Concerning Variation due to Higher or Lower Values

SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see the page at the end for a detailed description.

Metrics that fall into the blue categories above will be labelled as **Note Performance**. The SPC charts and accompanying narrative will not be included in this iteration.

Metrics that fall into the orange categories above will be labelled as **Escalation Summary** and an SPC chart and accompanying narrative will be provided.

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Executive Summary – Group Update

Responsiveness

Urgent Care

During March, UHBW ED 4-hour performance dropped slightly to 73.8% (74.5% in February) against a March 2026 target of 78% for all attendance types, including type-3 footprint uplift. A combination of demand, high bed occupancy and continued high levels of NCTR, continues to create a challenging clinical, operational and performance environment, thus impacting on 12-hour total time in the Emergency Department and ambulance handover metrics. For NBT, ED 4-hour performance was 64.5% for March 2026 (71.8% with footprint uplift). NBT have incorporated the GIRFT recommendations into the UEC programme and this will form the basis of 2026/27 improvement.

The System ambition to reduce the NC2R percentage to 15% remains unachieved. Delivery of the NC2R reduction was a core component of the Trusts ability to deliver the 78% ED 4-hour performance requirement for March 2026, this ambition has not been realised. However, the refreshed ICS discharge programme is underway, alongside a detailed redesign of the 15% NCTR Ambition Plan being developed in partnership with all system partners. An overview of challenges relating to flow was discussed in the Board seminar in April with agreement to look at risk thresholds and appetite to support more directly system partners.

Elective Care

At the end of March, UHBW reported that no patients were waiting 65 weeks or longer, anticipating that this will remain the case throughout 2026/27. NBT had one complex Plastic Surgery DIEP patient waiting longer than 65 weeks at the end of March 2026 due to ongoing absence in the consultant body. Both Trusts have exceeded the March 2026 ambition that less than 1% of the total waiting list will be waiting over 52 weeks.

Diagnostics

NBT improved further on the previous month from 0.7% in February to 0.5% for March. NBT remains in the top quartile nationally and for February ranked first amongst national peers for performance against the <1% constitutional standard. UHBW position in March has marginally deteriorated to 9.75% (9.4% in February) and recovery actions are in place to support the more challenged, specialist modalities, with performance expected to continue to recover into 2026/27.

Cancer Wait Time Standards

During February, UHBW performance was compliant against both the 28-day Faster Diagnosis Standard (FDS) and the 31-day standard, although fell short of the 62-day standard (reporting 72.2% against the 75% target). Whilst January and February have proven to be more challenging months, UHBW continue to work towards compliance with each of the three core cancer standards by the end of Q4, noting particular challenges relating to chemotherapy capacity. At NBT, 28-Day FDS, 31-Day and the 62-Day Combined position were off plan for the month of February. The work previously undertaken has been around improving systems and processes, and maximising performance in the high-volume tumour sites. The current position is due to challenges in the Urology and Breast pathway; there are improvement plans in place to reduce the time to diagnosis and provide sufficient capacity to deliver treatments. NBT forecast delivery of FDS by year-end and continue to deliver recovery plans into 2026/27 for the 62-Day and 31-Day standards.

Executive Summary – Group Update

Quality

NHS
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NHS Foundation Trust

Patient Safety

At UHBW there has been one MRSA case reported for March 2026. The end of year figure shows the trust as having seen a total of seven cases, this is reflective of the number of cases in year 2024/5. The QI approach has been refreshed with MRSA as a core element of this cross Divisional collaborative work. Directors of Nursing have been asked to review their Divisional case rates of infections with the Infection Prevention Control (IPC) team to scrutinise cases and apply specific Divisional actions for improvement. At NBT there have been no new cases in March 2026, three cases in total have been reported this year, all cases have had a full review with associated learning.

At UHBW there were eight cases of Escherichia Coli (E.coli) bacteraemia reported in March, resulting in an end of year total of 93 lower than the NHSE trajectory (limit) of 109 cases. There is detailed work being undertaken to review the last two years of E. Coli cases by the Medical Microbiology team, to understand areas of improvement that can be targeted. At NBT there were four new cases in March, total cases this year were below the NHSE trajectory (limit) of 84 ending the year on 60 cases.

At UHBW seven cases of Clostridium Difficile were reported in March, five Hospital Onset Hospital Acquired (HOHA) and two Community onset Community Acquired (COHA). This takes the end of year 2025/6 figures to 137 (100 HOHA and 37 COHA), this is an increase of eight cases of the previous year of 2024-25 being 129 respectively (87 HOHA and 42 COHA) which exceeds the NHSE trajectory limit of 109 cases. A renewed focus on Trustwide standards of cleanliness by the clinical Divisions and the facilities teams is being actioned. At NBT in March saw four additional cases of Clostridium Difficile, the end of year position for NBT is 104 cases exceeding the NHSE agreed trajectory of 79 , this although marks a reduction of total cases from year 2024/5.

At UHBW, the number of falls in March 2026 (165) increased from February 2026 (148), equating to 4.7 falls per 100 bed days, which remains below the Trust target of 4.8. There were three falls resulting in moderate harm, higher than the previous month (1). The divisions reporting higher fall incidence (Medicine and Weston) have undertaken thematic reviews of falls and falls with harm to identify themes and learning. Action plans will be developed, implemented, and shared across the divisions and the Trust. Quality improvement projects for the next 12 months have commenced, including consistent use of the Abbey Pain Scale, improving nutrition and hydration for people with dementia, and developing a falls management plan for non-inpatient areas.

During March 2026, UHBW recorded 279 medication-related incidents, none of which resulted in moderate or above harm. Work is ongoing to strengthen the dissemination and uptake of MHRA Drug Safety Updates, ensuring learning is embedded into clinical practice. During March 2026, NBT recorded 150 medication incidents involving patients of these, four were graded as moderate or above harm. The next round of Safe and Secure Handling of Medicines audits are being undertaken by the Medicines Governance Team in April. These serve as an opportunity to review practice and speak to ward staff about medicines management challenges. Combined our 2 Trusts are reporting lower than national averages for medication-related incidents, the majority of which are minor administration errors.

Patient & Carer Experience

At UHBW in February the Trust received 77 complaints with Surgery, Medicine and Women & Children's remain the highest-volume areas, 15 complaints responded to in January were reopened, these were mostly in Women's and Children's, 98% of all complaints actioned within 45 days with 255 cases closed in January 2026. The compliance rate decreased from 77% in January 2026 to 66% in February 2026. The decrease is attributed to a Division having a complaints co-ordinator vacancy, two Divisions saw an increase in the number of complex complaints requiring extensive work and a temporary reduction in availability for Executive sign off in the month.

At NBT the complaints compliance rate increased from 64% in February to 75% in March .This increase was due to an improvement in ASCR (56%) and strong performances in other divisions. Of the 89 complaints due for response in March, 67 were closed within the agreed timescale, 15 were outside the agreed timescale, and seven were still open at the time of reporting. ASCR continues to embed their recovery plan to bring them in line with the compliance scores of the other clinical divisions.

NBT Maternity Friends and Family Test (FFT) positive score (% 'Very good' or 'Good') fell from 88.2% in February to 84.4% in March. Since November, positive ratings have trended down (with a brief recovery in February) and March is now outside expected variation. The Women's & Children's Directorate Patient Experience Team is triangulating FFT with other feedback, and the Directorate is progressing improvement work including postnatal experience, translation access cards, and equity in pain management.

Executive Summary – Group Update

Our People

Please note the following variance in metric definitions:
Turnover – NBT report turnover for Permanent and Fixed Term staff (excluding resident Drs) whereas UHBW calculate turnover based on Permanent leavers only
Staff in Post – NBT source this data from ESR and UHBW source this data from the ledger. Vacancy is calculated by deducting staff in post from the funded establishment.
Work is in progress to move towards aligned metrics and where appropriate targets in common.

Turnover
- **NBT** turnover is 9.4% in March and below target
- **UHBW** turnover is 9.3% in March and below target.

Vacancy Rate
- **NBT** reduced from 7.3% to 7.0% but remains above target, triggering an escalation summary
- **UHBW** reduced from 5.0% to 4.8% but remains above target, triggering an escalation summary.

Sickness
- **NBT** rate is 4.8%, above the target of 4.4%. This is above target, triggering an escalation summary.
- **UHBW** rate is 4.7% in month, compared with 4.6% in February. This is above target, triggering an escalation summary.

Essential Training
- **NBT** – Core skills compliance for permanent staff now sits at 92.8%, above the group target rate of 90%. However, IPC and Information Governance remain below individual target rates.
- **UHBW** – Core skills compliance sits at 89.8% against a target of 90%. key hotspots are IPC, Moving and Handling, OMMT, Resuscitation and Information Governance

Learning and Development are conducting on-going discussions with subject matter expert to progress recovery actions, including delivery models and notifications, whilst also recognising the national review of statutory/mandatory topics. A particular focus remains upon Oliver McGowan tier 2 provision – the Face to Face and virtual training sessions. Further to the paper shared with GEM, individualised staff enrolment targets are being developed for each division against tiers 1 and 2 training sessions.

Executive Summary

In Month 12 (March), NBT delivered a £5.8m surplus position, against a surplus plan of £0.9m. At the end of 2025/26, NBT has delivered a surplus of £4.9m, against a breakeven plan.

UHBW delivered a £6.6m surplus in Month 12, against a surplus plan of £1.7m. At the end of 2025/26 UHBW has delivered a surplus of £5.0m, against a breakeven plan.

Pay expenditure within NBT, when pass through items are removed, is £4.8m adverse to plan in month. This is driven by overspends in nursing and healthcare assistants due to escalation and enhanced care and under-delivery against in-year savings. There are overspends on pay in month driven by increase in the annual leave accrual as well as other one-off costs.

Pay expenditure in UHBW is £4.3m adverse to plan in month. This is driven mainly by higher than planned substantive and bank expenditure particularly across nursing due to escalation and under-delivery against the pay savings plan.

The NBT cash balance as at the 31 March 2026 is £70.0m, £51.6m higher than planned, a £7.4m reduction from 31 March 2025.

The UHBW cash balance as at the 31 March 2026 is £73.1m, £12.3m higher than planned, a £0.8m increase from 31 March 2025.

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	ED % Spending Under 4 Hours in Department	NBT	Mar-26	64.5%	72.3%	64.3%	F-	C	Escalation Summary
		UHBW	Mar-26	66.2%	72.3%	67.4%	F	C	Escalation Summary
Responsive	ED % Spending Over 12 Hours in Department	NBT	Mar-26	9.3%	2.0%	9.6%	F-	C	Escalation Summary
		UHBW	Mar-26	6.8%	2.0%	6.9%	F	C	Escalation Summary
Responsive	Bristol Children's Hospital ED - Percentage Within 4 Hours								
		UHBW	Mar-26	78.3%	No Target	81.5%	N/A	C	Note Performance*
Responsive	ED 12 Hour Trolley Waits (from DTA)	NBT	Mar-26	576	0	430	F-	C	Escalation Summary
		UHBW	Mar-26	529	0	440	F	C	Escalation Summary
Responsive	Ambulance Handover Delays (under 15 minutes)	NBT	Mar-26	22.5%	65.0%	26.8%	F-	C	Escalation Summary
		UHBW	Mar-26	42.1%	65.0%	40.0%	F-	C	Escalation Summary
Responsive	Average Ambulance Handover Time	NBT	Mar-26	28.6	30.8	31.3	P	L	Note Performance
		UHBW	Mar-26	20.3	45.0	20.2	P*	L	Note Performance
Responsive	% Ambulance Handovers over 45 minutes	NBT	Mar-26	18.7%	0.0%	22.0%	F-	C	Escalation Summary
		UHBW	Mar-26	5.4%	0.0%	4.2%	F-	L	Escalation Summary
Responsive	No Criteria to Reside	NBT	Mar-26	22.2%	15.0%	23.2%	F-	L	Escalation Summary
		UHBW	Mar-26	24.5%	15.0%	23.5%	F-	H	Escalation Summary
Responsive	RTT Percentage Over 52 Weeks	NBT	Mar-26	0.1%	0.9%	0.2%	P	L	Note Performance
		UHBW	Mar-26	0.6%	0.9%	0.8%	F-	L	Escalation Summary
Responsive	RTT Ongoing Pathways Under 18 Weeks	NBT	Mar-26	70.7%	71.9%	67.9%	F-	H	Escalation Summary
		UHBW	Mar-26	68.0%	67.8%	67.5%	F-	H	Escalation Summary

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	RTT First Attendance Under 18 Weeks	NBT	Mar-26	75.6%	77.9%	73.3%	F-	H	Escalation Summary
		UHBW	Mar-26	71.3%	71.7%	71.1%	F-	H	Escalation Summary
Responsive	Diagnostics % Over 6 Weeks	NBT	Mar-26	0.5%	1.0%	0.7%	?	C	Escalation Summary
		UHBW	Mar-26	9.8%	5.0%	9.4%	F-	L	Escalation Summary
Responsive	Cancer 28 Day Faster Diagnosis	NBT	Feb-26	76.4%	78.5%	61.2%	F	L	Escalation Summary
		UHBW	Feb-26	81.5%	80.0%	76.0%	?	C	Escalation Summary
Responsive	Cancer 31 Day Decision-To-Treat to Start of Treatment	NBT	Feb-26	86.2%	90.6%	79.8%	?	C	Escalation Summary
		UHBW	Feb-26	96.3%	96.0%	94.2%	?	C	Escalation Summary
Responsive	Cancer 62 Day Referral to Treatment	NBT	Feb-26	65.2%	70.0%	65.2%	F	C	Escalation Summary
		UHBW	Feb-26	72.2%	75.0%	73.3%	?	C	Escalation Summary
Responsive	Last Minute Cancelled Operations	NBT	Mar-26	0.5%	0.8%	0.4%	P	C	Note Performance
		UHBW	Mar-26	3.1%	1.5%	1.9%	F	C	Escalation Summary
Responsive	% to Stroke Unit within 4 Hours	NBT	Feb-26	57.7%	90.0%	56.9%	F-	H	Escalation Summary
Responsive	Stroke Thrombolysis within 1 hour	NBT	Feb-26	68.2%	60.0%	21.4%	?	C	Escalation Summary
Responsive	90% Time in Stroke Unit Performance validated	NBT	Feb-26	72.2%	90.0%	63.1%	F-	C	Escalation Summary
Responsive	% Seen within 14 Hours by a Stroke Consultant - Validated	NBT	Feb-26	83.1%	90.0%	80.9%	F	C	Escalation Summary

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

North Bristol
NHS Trust

Responsiveness

UEC – Emergency Department Metrics

University Hospitals
Bristol and Weston
NHS Foundation Trust

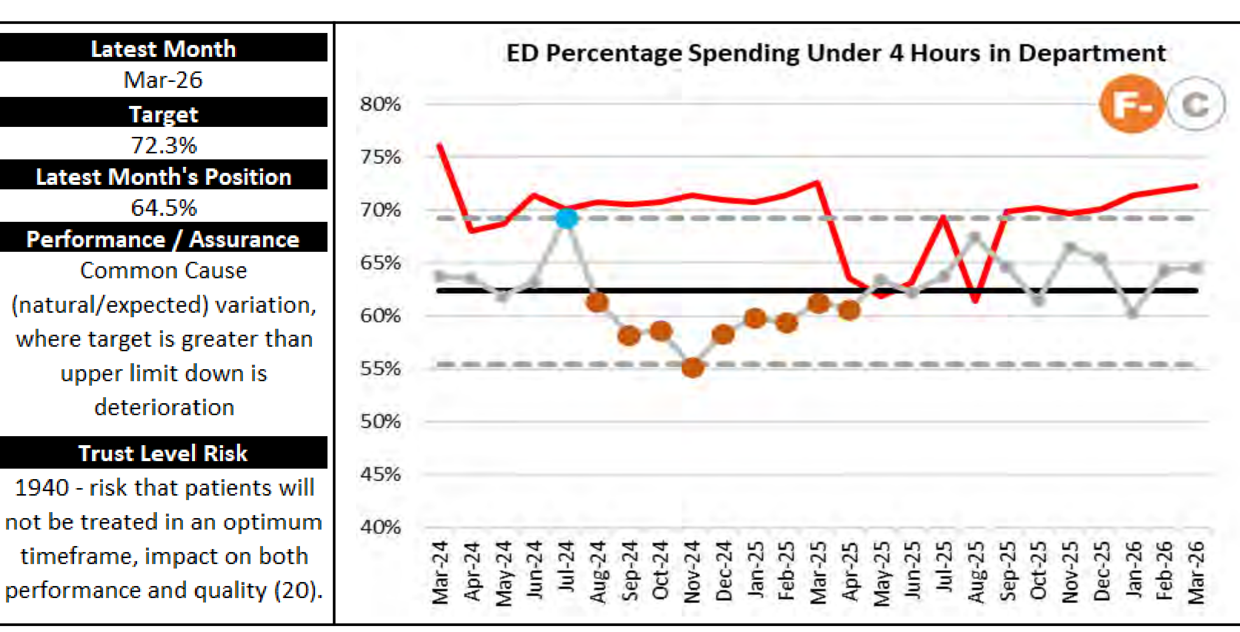
Latest Month
Mar-26

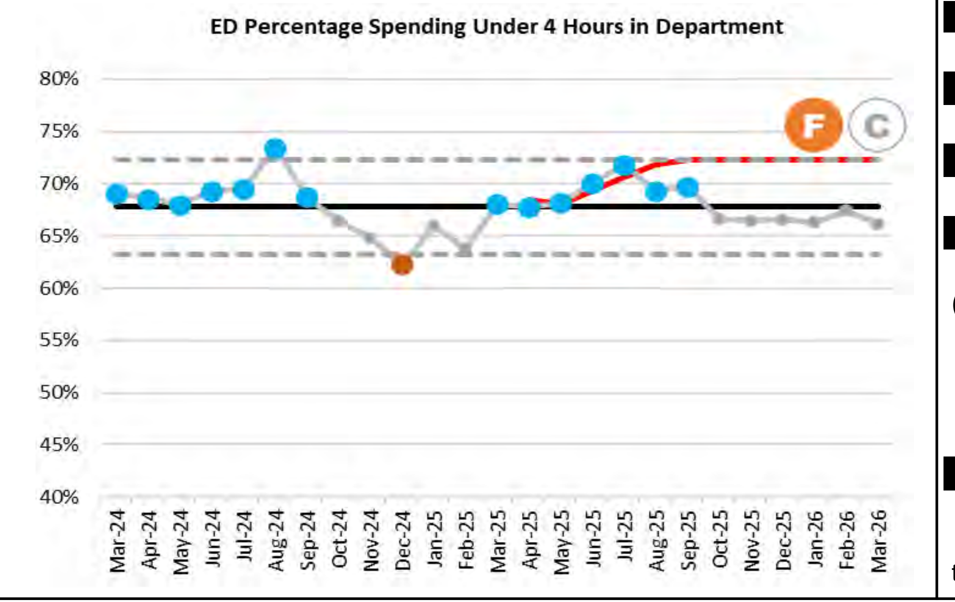
Target
72.3%

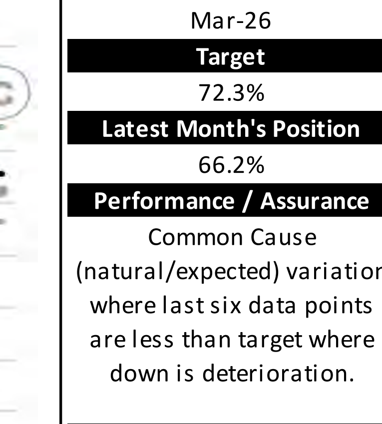
Latest Month's Position
64.5%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).







Latest Month
Mar-26

Target
72.3%

Latest Month's Position
66.2%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.

Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?
The percentage of patients spending under 4 hours in ED for March increased to 64.5%, c4% higher than the previous March. Attendances were above the mean.

Actions being taken to improve

- Capital funding secured to facilitate **moving ED minors** (Target date: November 2026) to an alternative onsite location. The current minors' area will be used to provide services in line with the new NHSE Model ED and extended emergency medicine ambulatory care (EEMAC) guidance. Service modelling, including performance benefits, and a detailed operational plan are currently being worked up.
- **Clinical Operational Standards** (COS) Oversight Group – Priority areas of focus are Standardised Referral Pathways, Diagnostic pathways, Frailty / Care Homes, which will reduce patient LOS across UEC pathways.
- **BNSSG Mental Health ED** – being developed as a partnership between liaison psychiatry and AWP and will reduce ED attendances for people in crisis.
- **Test of Change Weeks** (ToCW) – planning underway for the next cycle in May. Schemes identified so far will focus on releasing time to care by testing online referrals into community nursing, matching Frailty@Home with Pathway 1 to increase the levels of dependency possible in virtual wards (step up and step down) and reducing delays into Pathway 2 rehab beds.

Impact on forecast
April is tracking to deliver further improvement at c67% four-hour performance based on month-to-date data.

What does the data tell us?
The ED 4-hour standard across the trust deteriorated slightly during March at 66.2% compared to February (67.4%). All ED sites saw an increase in attendances throughout March, most notably at the BRI and BRHC.

Actions being taken to improve
Ongoing mobilisation of ED improvement plans across both BRI and Weston, including workforce reconfiguration to augment and better align senior decision makers to peak times IN & OOH, in addition to optimising SDEC utilisation and front door redirection models. AMT (Acute Medical Triage) service planned within front door footprint anticipated to reduce ED crowding and ED waits.
Whole hospital review of ED 'quality standards' is progressing, with a specific focus on embedding the Inter-Professional Standards, reducing delays in specialty reviews in ED and improving outward flow from ED. The department is also working closely with SWAST, community and primary care partners to maximise admissions avoidance schemes e.g. Frailty – Assessment & Coordination of Urgent & Emergency Care (F-ACE). NB UHBW currently leading the parallel development with Paediatrics (P-ACE), and increased utilisation of the Community Emergency Medicine service (CEMS)

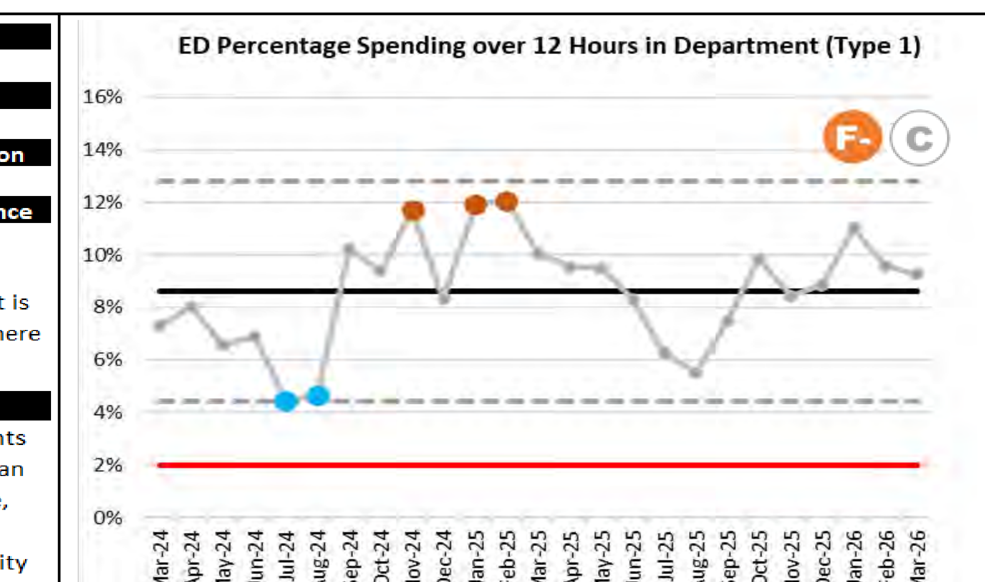
Impact on forecast
Forecasting that improvement plans will improve the Trust position; forecast for April is c70%

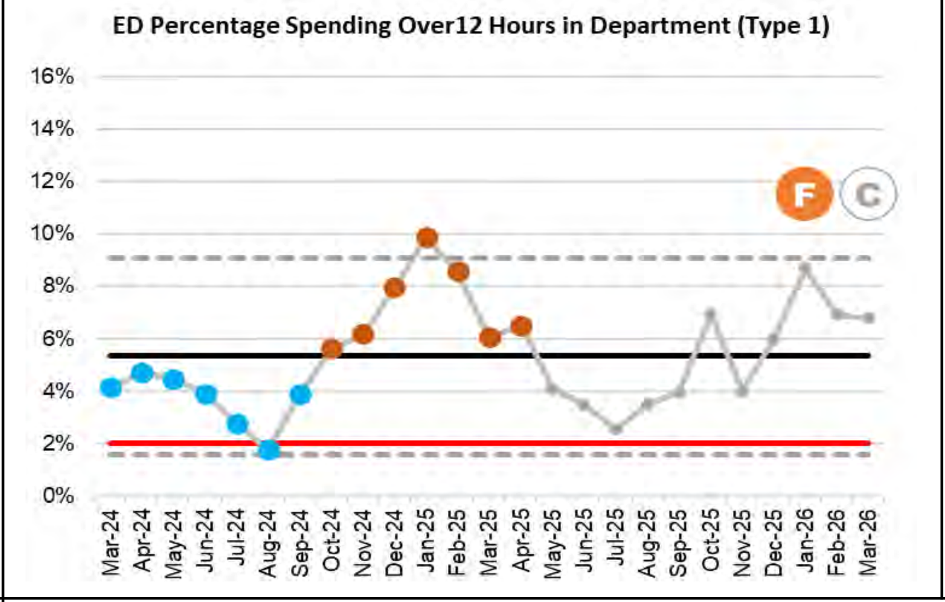
The End of Year (March 26) Target for this measure was 72.3% (78% inclusive of Sirona type-3 uplift)

Responsiveness

UEC – Emergency Department Metrics

Latest Month
Mar-26
Target
2.0%
Latest Month's Position
9.3%
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).





Latest Month
Mar-26
Target
2.0%
Latest Month's Position
6.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?
The percentage of patients spending over 12 hours in ED decreased to 9.3% in March, c 1% lower than the previous March.

Actions being taken to improve
1) As part of the UEC Programme 2026/27 NBT's **SDEC capability** will be reviewed with the aim of achieving as great a 0-day LOS benefit as possible across Surgical, and Medical SDECs. Surgical SDEC capital work is underway to create a seated observation area and an ultrasound room which will support pull from ED as well as reducing bed requirements on SAU. Frailty SDEC benefits will be analysed and a business case written.
2) The NEL LOS Group will commence work in Q1 on a Trustwide **review of weekend working** with the aim of formulating options to improve timeliness of essential process, including diagnostics and discharge decision making. Learning from the recent rounds of industrial action will be factored into this review.
3) **Every Minute Matters** approach – working to improve internal flow. Current projects include improving discharge summary processes, digital enablement (flow boards and discharge checklist) and nurse led discharge in urology.
4) **High Intensity User Group** – recently established and will be focussing on reducing impacts for people who frequently attend ED. Further work will support reductions in impact from NBT's most frequently using care homes and GP practices.

Impact on forecast
April continues to show improvement in this area, with month to date performance tracking at 6.3%.

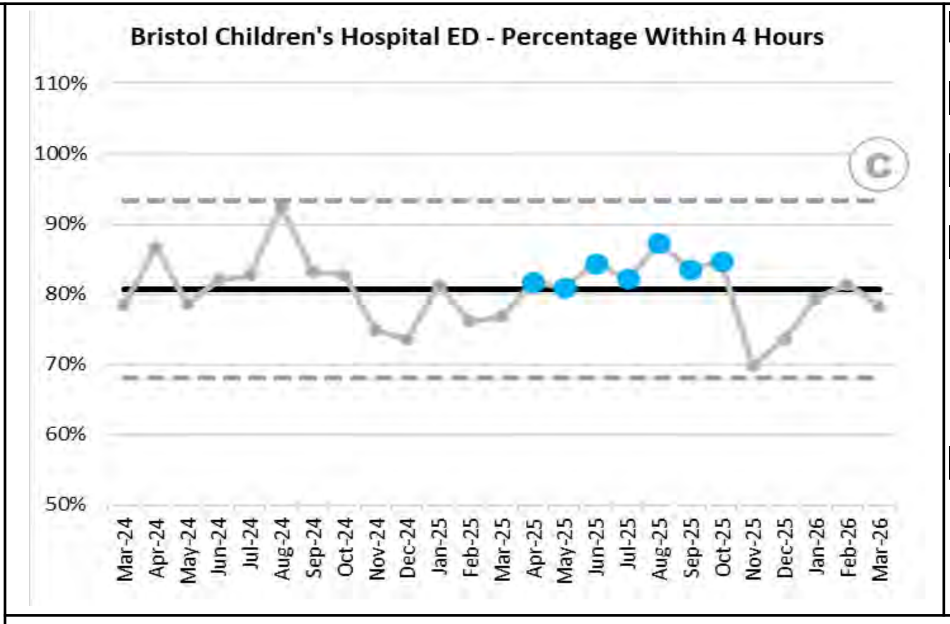
What does the data tell us?
The percentage of patients spending over 12 hours in ED for the month of March (6.8%) reduced slightly compared to February (6.9%) and still below the national threshold of 10%. BRI improved from 10% in February to 9.4% in March, despite an increase in No Criteria to Reside (NCtR) patients and growth in attendances and admissions during the month.

Actions being taken to improve
Embedding the principles within the newly implemented inter-professional standards (IPS) through monitoring of IPS performance in support of cross-divisional review of time to specialty assessments in ED.
Renewed focus on the medicine admitted pathway with actions identified to support the turn around time of inpatient beds and strengthen the process for escalation of 12 hr breaches in ED.
BRI consultant recruitment underway with two posts filled and further interviews in the next two months – will enable improved support into ED in Out of Hours periods.
Renewed focus on Every Minute Matters programme addressing efficiencies in flow and discharge processes tailored to each division.

Impact on forecast
Ward closures at the BRI and demand for IPC cubicles across both sites remain a challenge. Actions have been put in place to mitigate the ward closures, but the position may remain challenging throughout April. Forecast for April is c5%.

Responsive

UEC – Emergency Department Metrics



Latest Month
Mar-26
Target
No Target
Latest Month's Position
78.3%
Performance / Assurance
Common Cause (natural/expected) variation where up is improvement.
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?

4-hour performance in March was 78.3% which is a slight drop when compared to 81.7% in February 2026

There was an increase in attendances in March (158 per working day) when compared to February (141 per working day) which is likely to have contributed to the overall 4-hour position

Actions being taken to improve

Streaming has gone live on 16/3/26. The impact on 4-hour position will be reviewed and assessed in due course and a review/feedback meeting is scheduled in April.

A3 project to be launched with Diagnostics and Therapies division for laboratory turnaround times

Surgical teams to accept speciality referrals via CareFlow. This has been on hold due to absence within the consultant team, but discussions scheduled for March/April now staff have returned to work.

Time in motion study process map session took place on 2/4/26 - to review patient pathway from CED to medical ward to identify opportunity for improvements. Collating feedback to identify next steps

Impact on forecast

Forecast for April is c87%.

NHS
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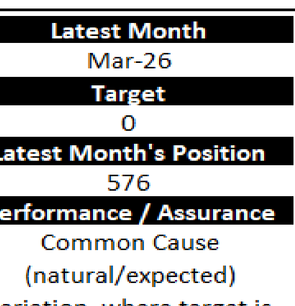
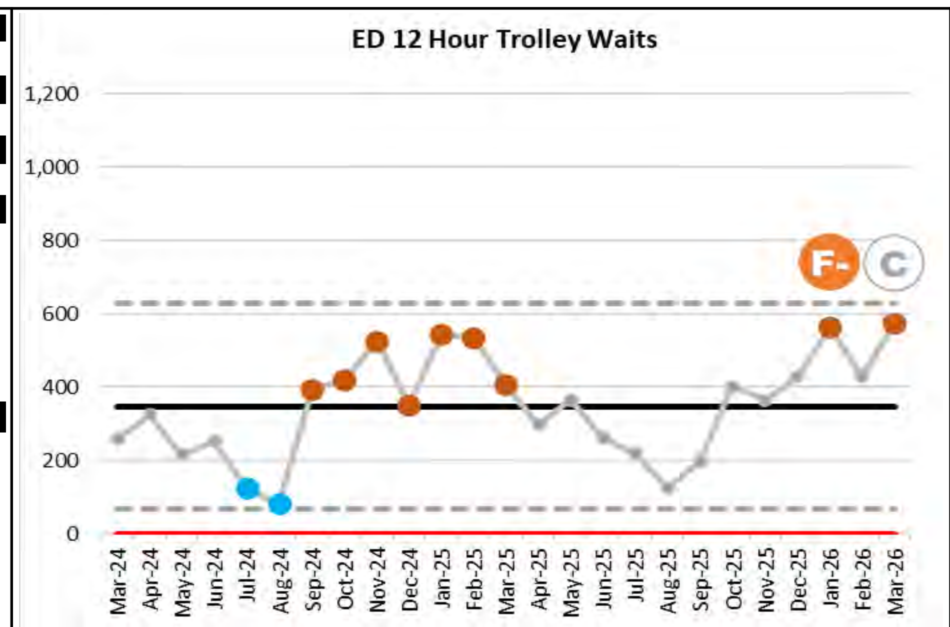
NHS Foundation Trust

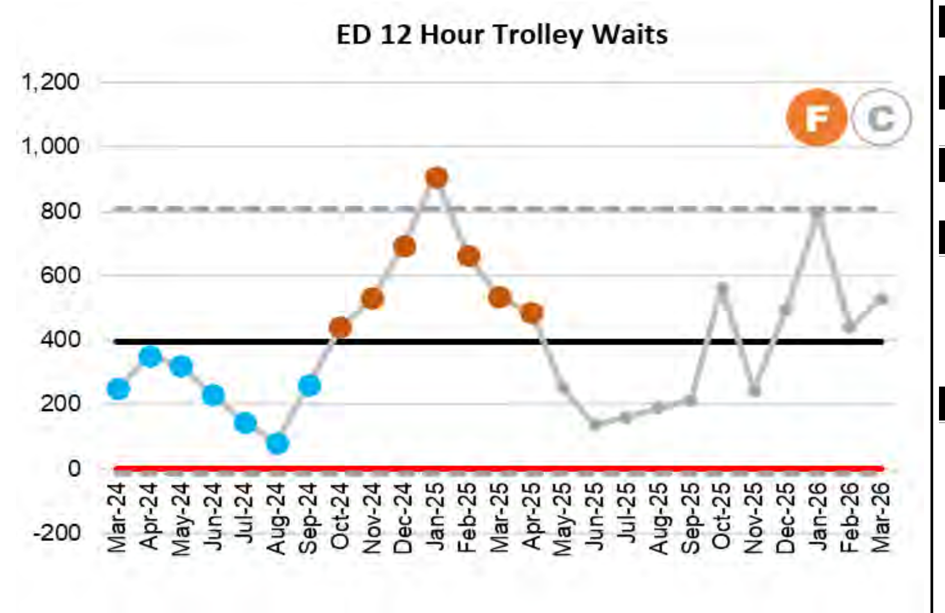
Responsiveness

UEC – Emergency Department Metrics



Latest Month
Mar-26
Target
0
Latest Month's Position
576
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).





Latest Month
Mar-26
Target
0
Latest Month's Position
529
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20). Risk 2614 - Sustained reliance on extra, temporary and corridor bed capacity (15)

What does the data tell us?
The number of 12-hour trolley waits increased compared to the previous month to 576.

Actions being taken to improve
See previous slides – all actions are relevant to 12-hour DTA reduction.

Impact on forecast
See previous slide.

What does the data tell us?
The number of 12 Hour trolley waits increased throughout March (17 per working day) compared to February (16 per working day).

Actions being taken to improve
Note actions from previous two slides

Impact on forecast
Along with improvement work noted against the 4-hour and 12-hour standard, it is anticipated that the number of 12-hour trolley waits should improve during April

Responsiveness

UEC – Ambulance Handover Delays

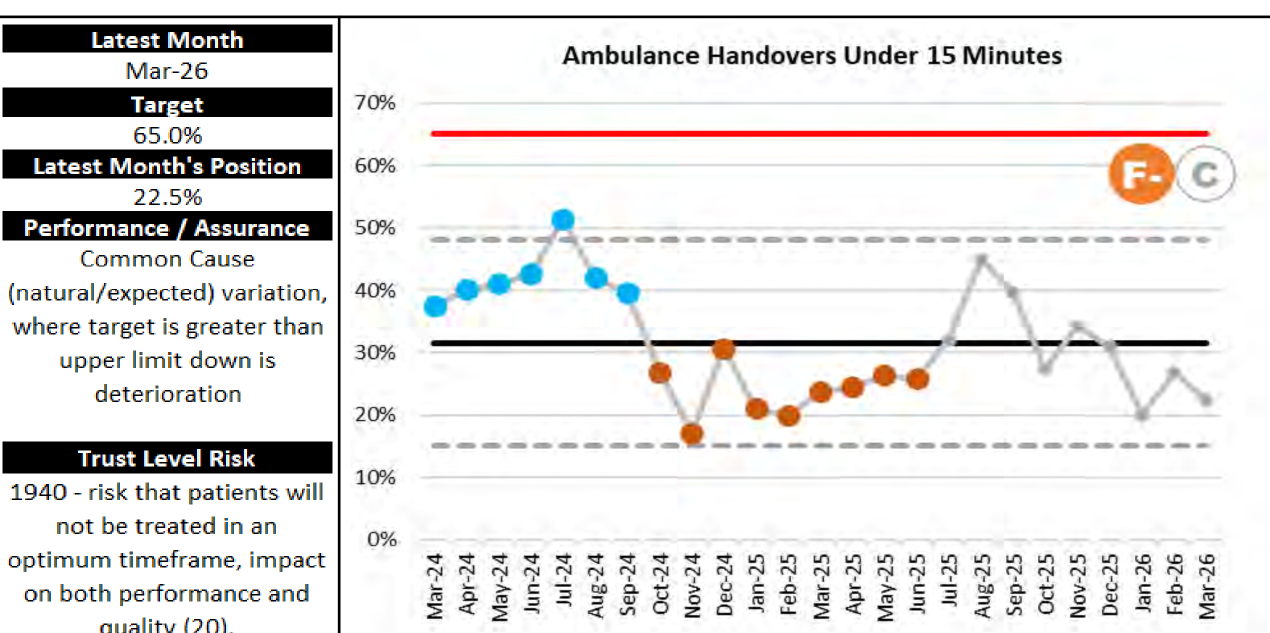
Latest Month
Mar-26

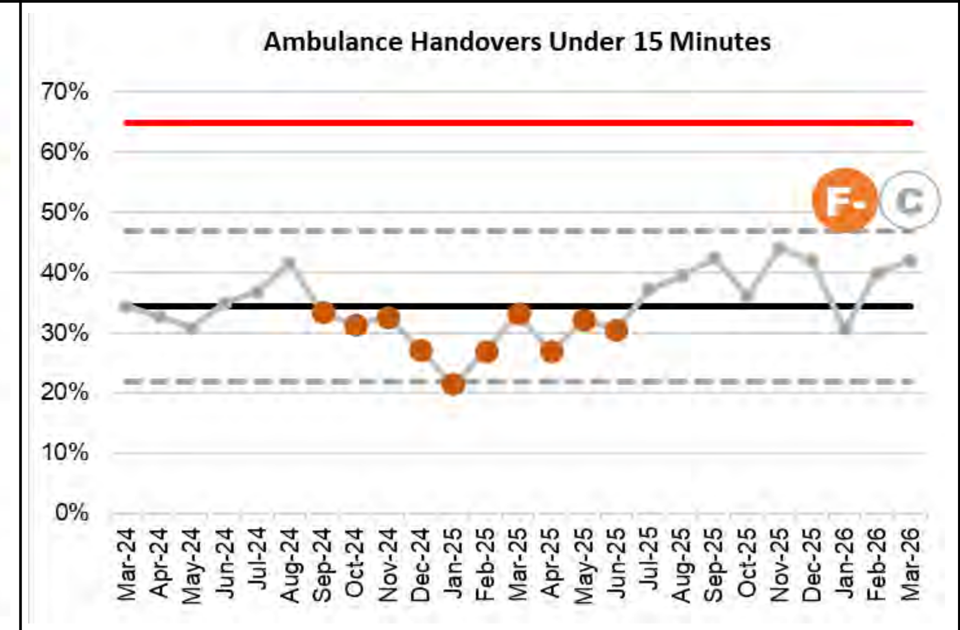
Target
65.0%

Latest Month's Position
22.5%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).





Latest Month
Mar-26

Target
65.0%

Latest Month's Position
42.1%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?
The proportion of handovers completed within 15 minutes decreased to 22.5% in March. Conveyances were up by around 300 from February and overall lost hours decreased.

Actions being taken to improve
1) Work with ICB, SWASFT and BrisDoc Severnside on validation of Category 3 and Category 4 ambulance dispositions – a new group to review process and impacts and assess benefits of working towards validation of Category 2 dispositions also.
2) System business case to expand the Community Emergency Medicine Service from three to seven substantive days of funding has been approved. The service will start to ramp up in line with recruitment from August onwards.
3) BNSSG level work on system care co-ordination will include a call-before-convey approach for paramedics. Early work has been presented at the UEC Operational Delivery Group with the next step being agreement of how to progress the recommendations.

Impact on forecast
An operational review with SWAST is scheduled for April and will include immediate actions to improve handover performance.

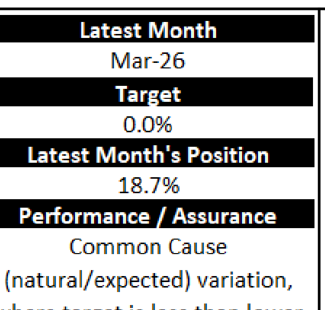
What does the data tell us?
Ambulance handovers within 15 mins show an improvement in March at 42.1% compared to February at 40% and a marked improvement compared to last year. Notable increase observed at the BRI from 37% in February to 41% in March. Conveyances across all three sites were up by approximately 500 from February.

Actions being taken to improve
Implementation of the updated SWAST Timely Handover Policy in response to the new NHSE KPI: zero tolerance to handovers over 45 mins - has resulted in a collective response within UHBW to embed additional actions and strengthen existing processes in support of timely ambulance handovers. An updated trust-wide escalation policy is due to be cascaded in April with clearly defined steps for the use of and de-escalation out of all 'corridor' spaces. Expansion to the CEMS service planned by the ICB should result in an improvement in ambulance conveyances throughout the year as this is implemented.

Impact on forecast
It is anticipated that the ongoing improvement work will continue to contribute to an improved position in the forthcoming months, though flow out of ED into the BRI bed base will remain challenging due to the closure of two inpatient wards. Current April forecast c46%

Responsiveness

UEC – Ambulance Handover Delays



Latest Month

Mar-26

Target

0.0%

Latest Month's Position

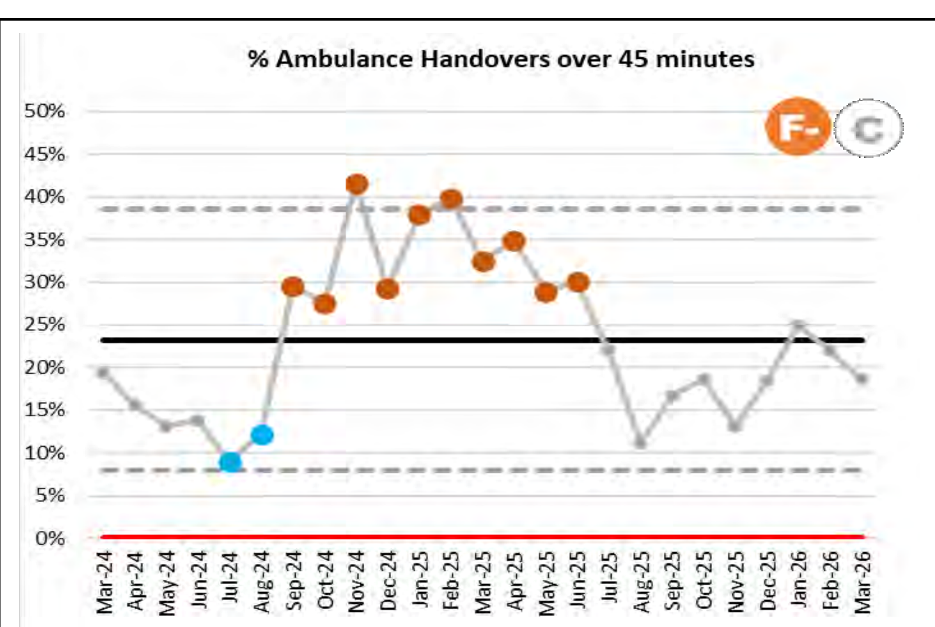
18.7%

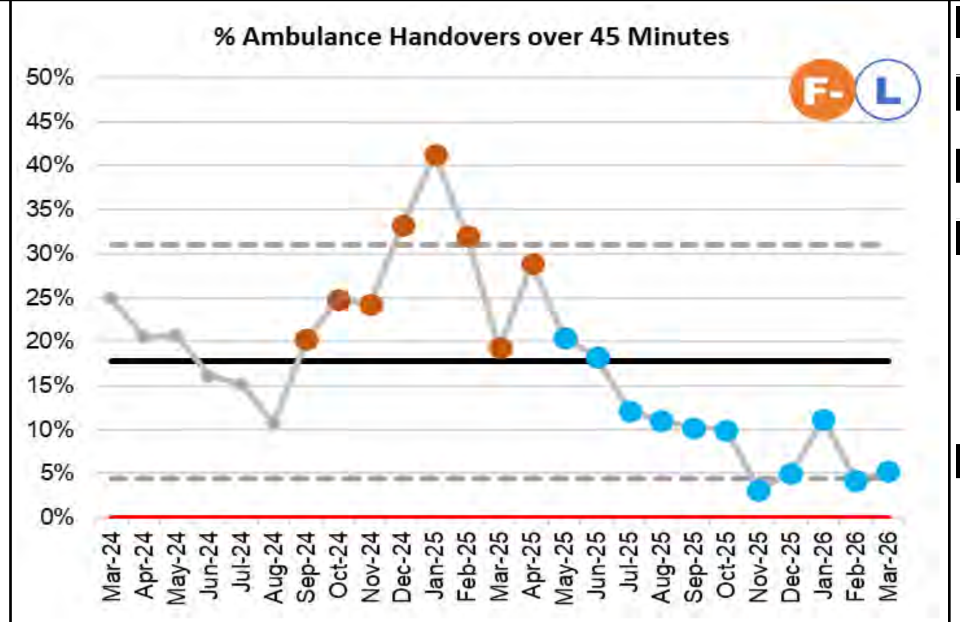
Performance / Assurance

Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration or greater than upper limit down is deterioration

Trust Level Risk

1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).





Latest Month

Mar-26

Target

0%

Latest Month's Position

5.4%

Performance / Assurance

Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.

Corporate Risk

Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?

The proportion of handovers over 45 minutes improved again in March to 18.7%.

Actions being taken to improve

Learning and recommendations from the BNSSG Rapid Emergency Assessment Framework (REAF) group review of the SWASFT Timely Handover Plan were presented at the BNSSG UEC Operational Delivery Group (ODG) in March. A follow-up session is being arranged to focus on a whole system approach to reducing long ambulance waits.

Impact on forecast

The REAF action plan needs further work to map the suggested actions to timeframes.

What does the data tell us?

Ambulance handover times within 45 minutes have deteriorated slightly throughout March at 5.4% compared to February at 4.2%.

Actions being taken to improve

As per previous slides actions are focussed on enabling improved flow through and out of ED, including embedding the Inter Professional Standards, Acute Medical Triage service, enhanced redirection processes and strengthening the processes in place regarding the use of escalation spaces and corridor care.

Expansion to the CEMS service planned by the ICB should result in an improvement in ambulance conveyances throughout the year as this is implemented.

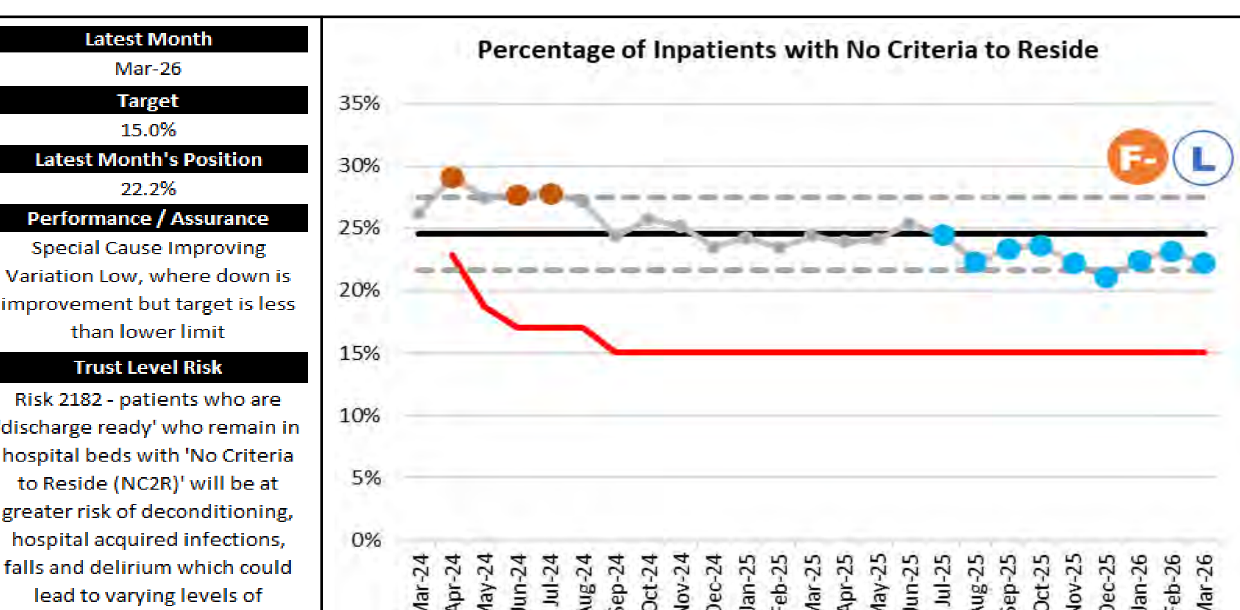
Impact on forecast

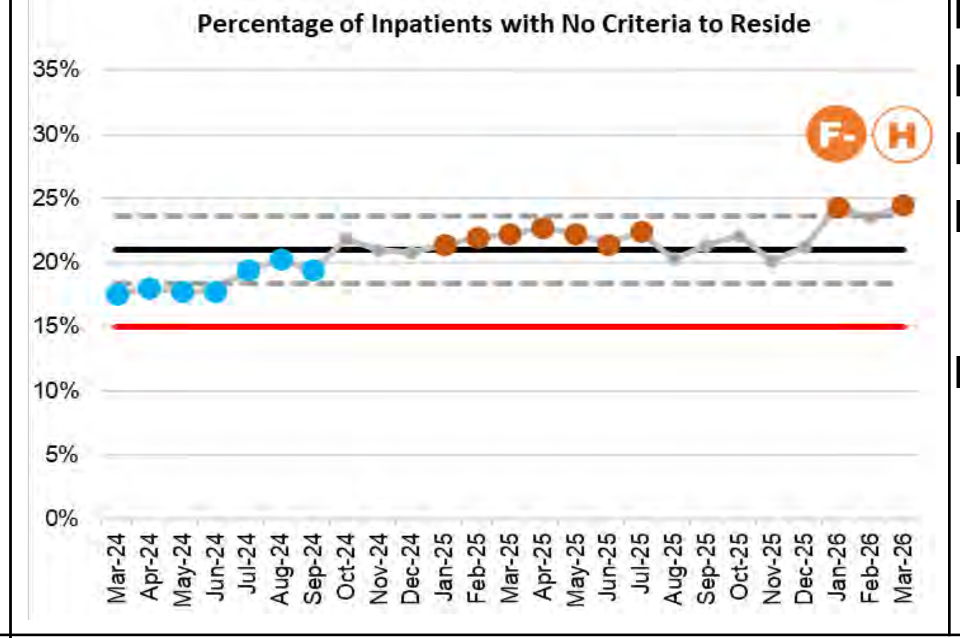
It is anticipated that the ongoing improvement work will continue to contribute to an improved position in the forthcoming months, though flow out of ED into the BRI bed base will remain challenging due to the closure of two inpatient wards. Current April forecast c3.5%

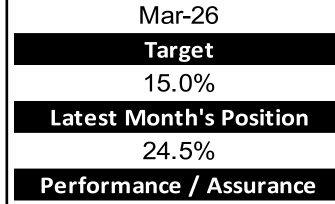
Responsiveness

UEC – No Criteria To Reside

Latest Month
Mar-26
Target
15.0%
Latest Month's Position
22.2%
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit
Trust Level Risk
Risk 2182 - patients who are 'discharge ready' who remain in hospital beds with 'No Criteria to Reside (NC2R)' will be at greater risk of deconditioning, hospital acquired infections, falls and delirium which could lead to varying levels of harm/patient outcomes (12).







Latest Month
Mar-26
Target
15.0%
Latest Month's Position
24.5%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.
Corporate Risk
Corporate Risk 423 - Risk that demand for inpatient admission exceeds available bed capacity (25). Corporate Risk 8252 - Patients with no criteria to reside continue to remain in hospital beds (20)

What does the data tell us?

No Criteria to Reside (NCTR) decreased to 22.2% in March, this was an average of 186 patients, 14 less than the previous March.

Actions being taken to improve

- Optimisation of the Elgar model of care continues with ongoing engagement with partners to reduce the overall system pressure for people with complex discharge requirements.
- Bristol NHS Group is hosting a system Transformation Programme related to home and inpatient based intermediate care. The aim is to support attainment of the 15% NCTR target. A workshop takes place on 16 April to set the initial workplan for the team.

Impact on forecast

% NCTR for April may be higher because of the number of escalation beds closed which impacts the denominator, though note that April to date shows further actual improvement with an average of 170 patients with NCTR.

What does the data tell us?

No Criteria to Reside (NCTR) performance deteriorated in March to 24.5% (212 daily average number of patients) vs 23.5% in February (204 daily average).
Particular capacity issues evident in North Somerset across all pathways

Actions being taken to improve

System focus on development of improvement plans to deliver the 15% NCTR reduction continues:
• >21d NCTR escalation meetings being established to provide a system partnership response to reduce the acute >21d NCTR position with BCC and Nsom, building on the escalation policies partners have agreed
•BNSSG case for purchasing an additional 30 community beds has been approved, with beds available in the coming weeks.
•System Transformation Programme related to home and inpatient based intermediate care being hosted by Bristol NHS Group.
•Trial at Weston to provide more robust action focussed discharge planning giving greater visibility of definite and potential discharges including P0 patients. Anticipated to rollout to BRI site and potential to extend to NBT site
•Continuing Health Care Fast Track - **a reduction of average 3.3 days** since April 25 and MCA and BID- **reduction of 1 day** since Aug 25
•Early Supported Discharges enable patients to leave hospital before their package of care start date with family support. 114 patients left hospital early saving 415 bed days in March.

Impact on forecast: System NCTR target: 15% (103) UHBW remains unmet (BRI 53; WGH 50).

Responsiveness

Planned Care – Referral to Treatment (RTT)

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

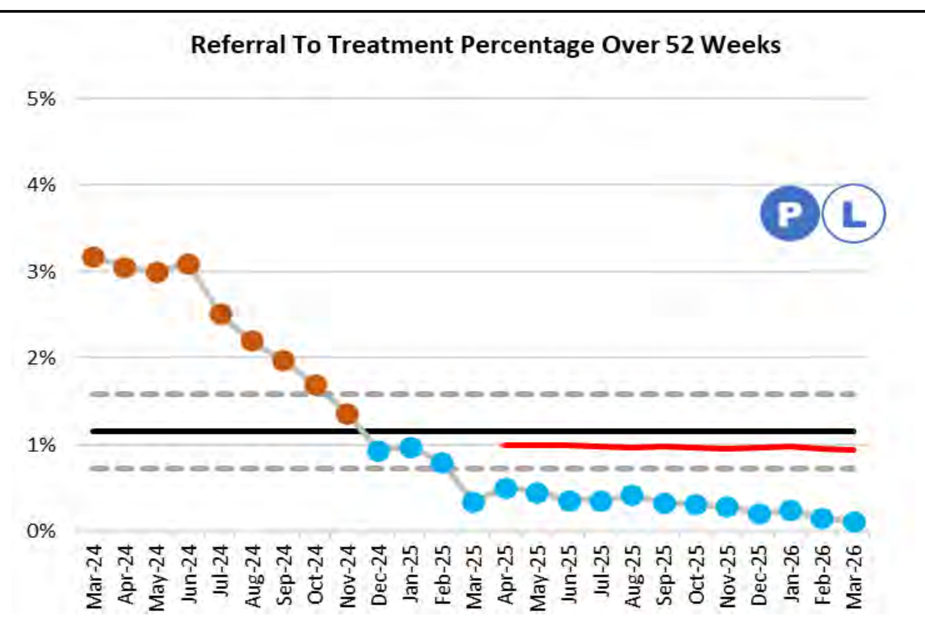
Latest Month
Mar-26

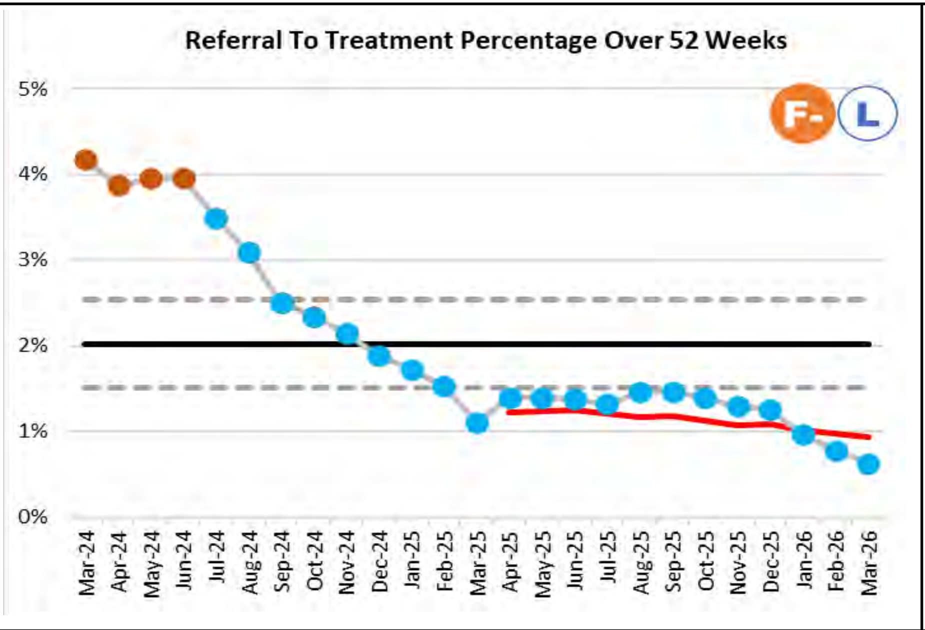
Target
0.9%

Latest Month's Position
0.1%

Performance / Assurance
Special Cause Improving Variation Low, where down is improvement and last six data points are less than target

Corporate Risk
No Trust Level Risk





Latest Month
Mar-26

Target
0.9%

Latest Month's Position
0.6%

Performance / Assurance
Special Cause Improving Variation where Down is Improvement, but target is less than lower limit

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

No narrative required as per business rules.

What does the data tell us?
At the end of March, there were no patients waiting beyond 65 weeks for their treatment . There were 311 patients waiting 52 weeks or more (389 in February). Against the total waiting list size of 49,624, this equates to 0.6% against the 0.9% trajectory set for March as part of the trust Operational Planning submission.

The national target was <1% by March 2026, which the Trust have achieved.

The overall waiting list size reduced by 239 to 49,624 during March and shows an annual reduction of 9.1% on the total waiting list.

Actions being taken to improve
Actions include a combination of augmentation to better align resources to the scale of the demand challenge, underpinned ultimately with support from productivity improvements, additional WLIs and Super Saturdays and use of insourcing and waiting list initiatives with on-boarding of consultants and specialist doctors to fill some of the recruitment gaps.

Recovery plans being enacted in specialties with more challenged waiting times.

The End of Year Target for this measure was 0.94%

Responsiveness

Planned Care – Referral to Treatment (RTT)

University Hospitals Bristol and Weston NHS Foundation Trust

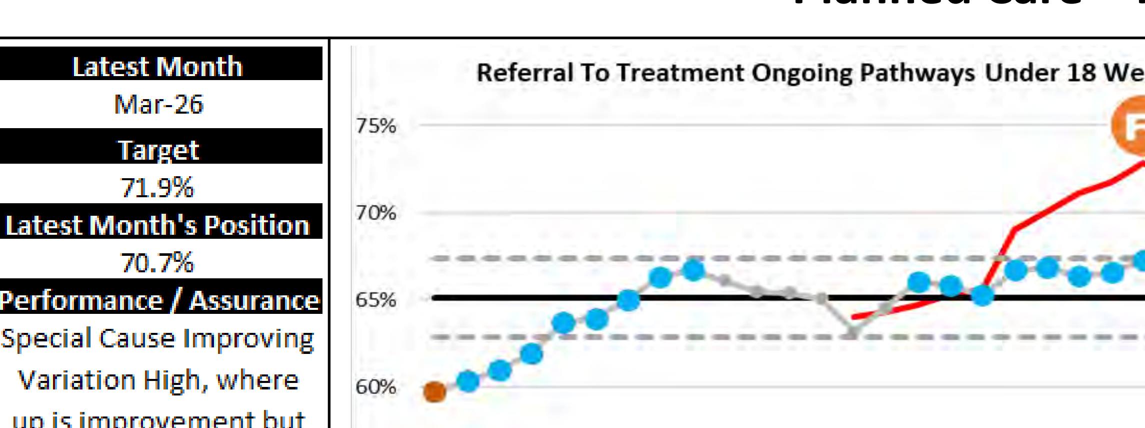
Latest Month
Mar-26

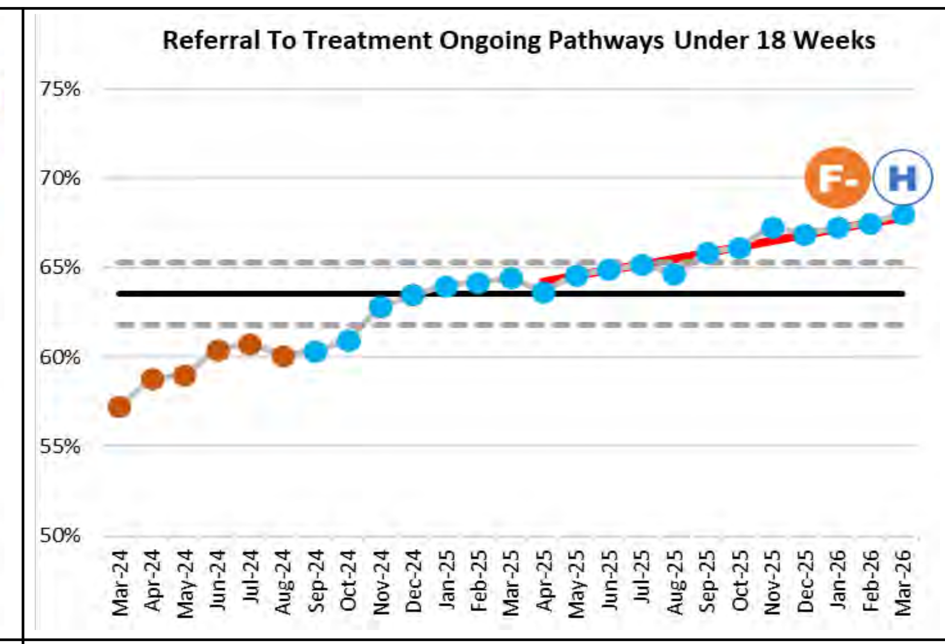
Target
71.9%

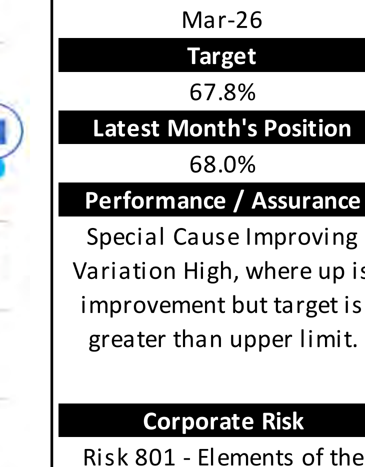
Latest Month's Position
70.7%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit

Trust Level Risk
No Trust Level Risk







Latest Month
Mar-26

Target
67.8%

Latest Month's Position
68.0%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

What does the data tell us?
At the end of March, the percentage of patients waiting less than 18 weeks was 70.7%, performing under the Trust trajectory set as part of the Trust operational planning submission (target of 71.9% by March 2026). This underperformance was partly due to the phased activity plan related to the BSC not meeting trajectory.

Actions being taken to improve
The 2026/27 delivery plans developed with clinical divisions, incorporate additional resource for some of the services (e.g. Cardiology, Gastroenterology, General Surgery, Gynaecology) requiring greater support to recover their position. The Princess Royal Bristol Surgical Centre (PRBSC) opened In September 2025 with a focus on optimising orthopaedic activity.
Additional patient contacts are being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions).
Operational re-focus to overall percentage performance established with successful delivery of NHSE Q4 outpatient and validation sprints.

Impact on forecast
We continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition into 2026/27.

What does the data tell us?
The Trust set an end of year (March 2026) target of 67.8% as part of the Operational Plan and a stretch target was more recently agreed with NHSE to 68.0% as part of the national RTT Sprint. At the end of March, the number of patients waiting less than 18-weeks was 35,762 (68.04%), achieving both the original and the subsequent stretch target.

Actions being taken to improve
The 2026/27 delivery plans developed with clinical divisions, incorporate additional resource for some of the services (e.g. dental and paediatric specialties) requiring greater support to recover their position.
The Trust continue to take part in the NHS England validation sprint, where an additional validation exercise focusses on patients across a broad range of specialties.
Additional patient contacts are also being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions)

Impact on forecast
We continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition into 2026/27

University Hospitals Bristol and Weston NHS Foundation Trust

Responsiveness

Planned Care – Referral to Treatment (RTT)

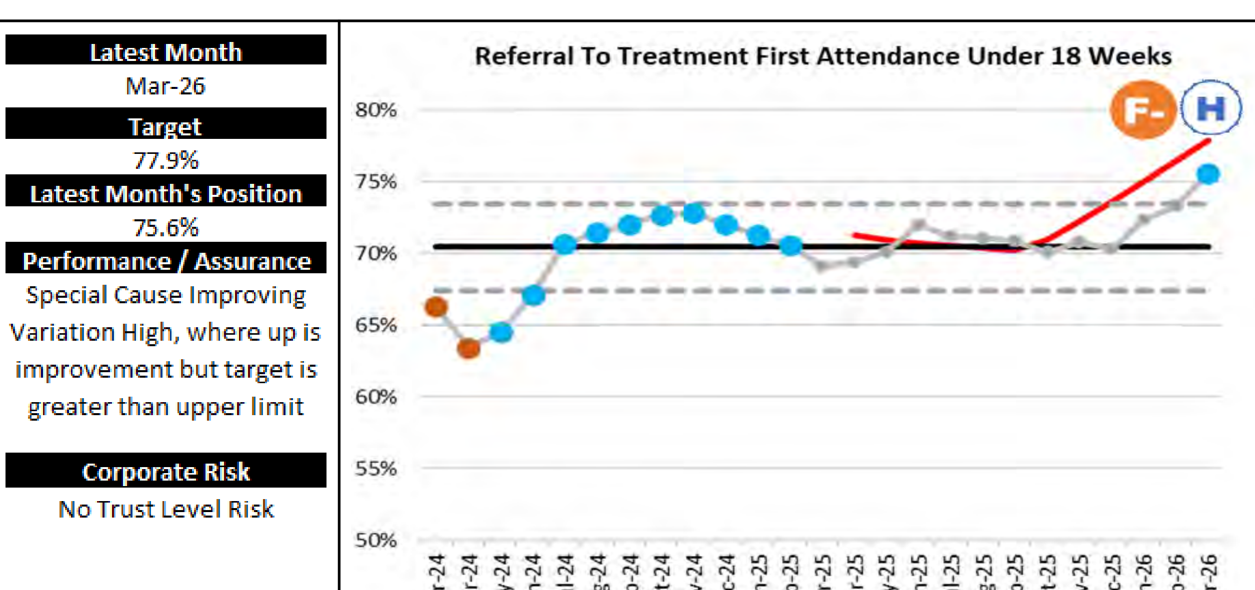
Latest Month
Mar-26

Target
77.9%

Latest Month's Position
75.6%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit

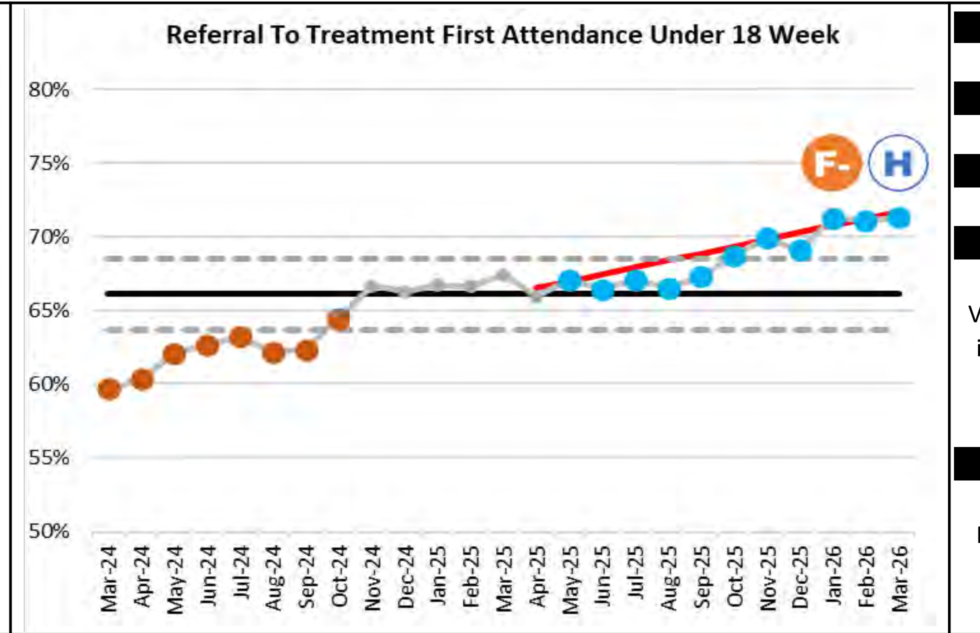
Corporate Risk
No Trust Level Risk

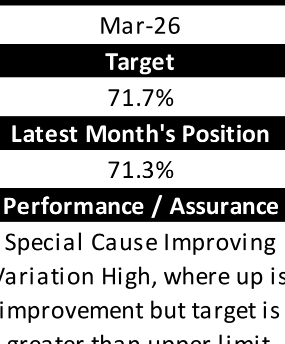


What does the data tell us?
At the end of March, the percentage of patients waiting less than 18 weeks for their first appointment was 75.6%. Performance was under the Trust trajectory of 77.9% set as part of the Trust operational planning submission, but this has been the highest performance to date.

Actions being taken to improve
The 2026/27 delivery plans developed with clinical divisions, incorporate additional resource for some of the services (e.g. Cardiology, Gastroenterology, General Surgery, Gynaecology) requiring greater support to recover their position. Additional patient contacts are being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions).
Operational re-focus to overall percentage performance established with successful delivery of NHSE Q4 outpatient and validation sprints.

Impact on forecast
The Trust continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition into 2026/27





Latest Month
Mar-26

Target
71.7%

Latest Month's Position
71.3%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

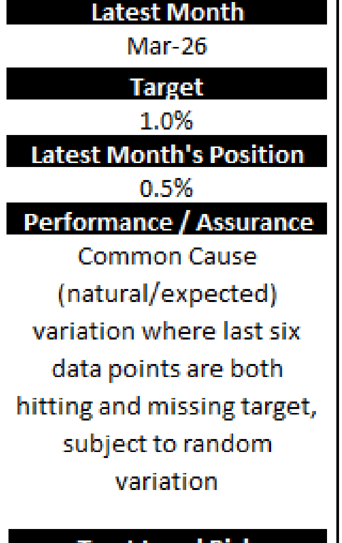
What does the data tell us?
At the end of March, the percentage of patients waiting less than 18 weeks for their first appointment is 71.3% against the target of 71.7% set for March 2026 as part of the Trust Operational Planning submission.

Actions being taken to improve
Actions align with previous slide, noting the focus on divisions booking patients earlier to ensure the first attendance is undertaken as soon as possible.
Actions to improve include the use of 'booking in order' reporting tools, utilisation of available clinic slots to see a greater number of new patients, running additional clinics via waiting list initiatives and increased use of insourcing arrangements. Oversight meetings are in play with the most challenged specialities to ensure that all plans for additional activity is exploited.

Impact on forecast
The Trust continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition into 2026/27

Responsiveness

Planned Care – Diagnostics



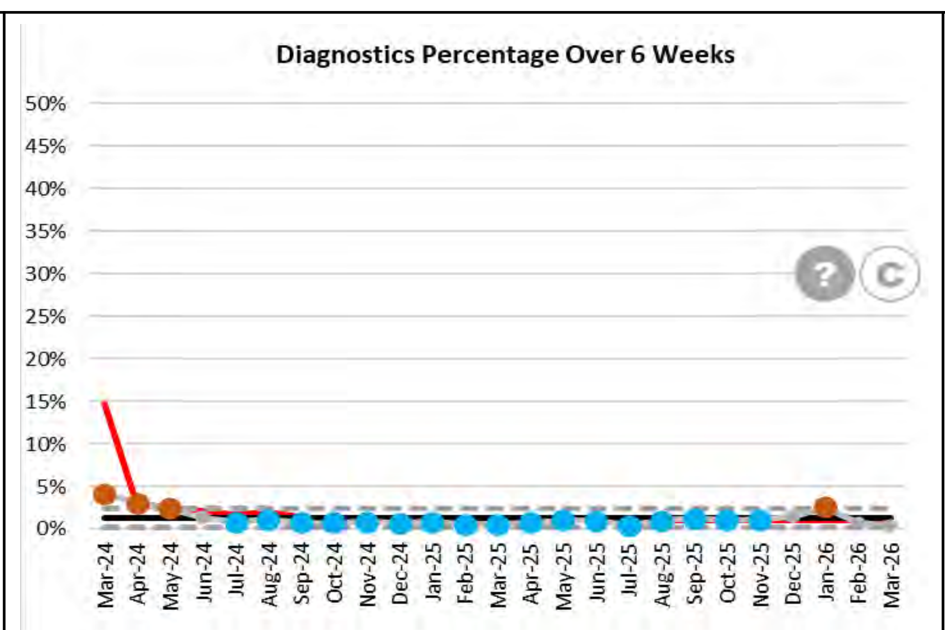
Latest Month
Mar-26

Target
1.0%

Latest Month's Position
0.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

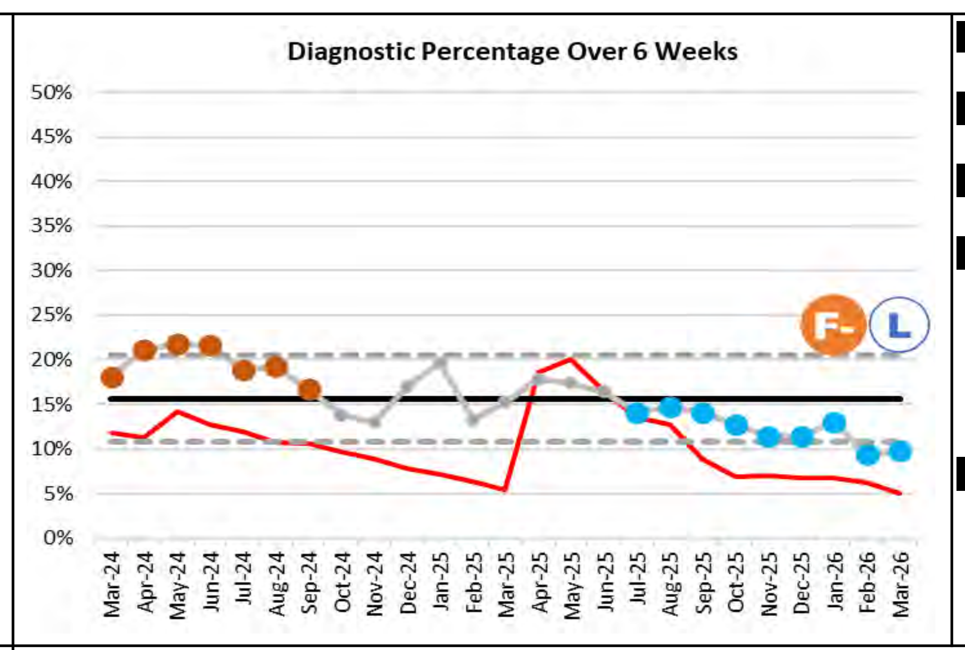
Trust Level Risk
No Trust Level Risk



What does the data tell us?
In March, the proportion of patients waiting over six weeks against the DM01 standard improved to 0.5%, (0.7% in February). There is a demonstrated improvement from previous month which means NBT ranked first amongst national peers.

Actions being taken to improve
DEXA and Echocardiography were the main contributors where performance deteriorated slightly between September to January this year. As forecast, the improvement actions in these modalities have supported recovery of the Trust position back to constitutional standard since February 2026.

Impact on forecast
Anticipate ongoing compliance to the constitutional standard with performance <1%.



Latest Month
Mar-26

Target
5.0%

Latest Month's Position
9.8%

Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

What does the data tell us?
The Trust plan for March 2026 was to reduce the percentage of patients waiting 6 weeks or more for their diagnostic test to 5%.

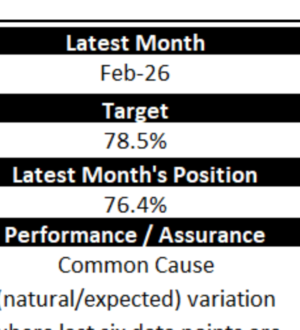
During March, the proportion of patients waiting over six-weeks against the DM01 standard dropped slightly to 9.75% (9.4% in February). Although a deterioration of 0.35% from the previous month. March data represents the strongest sustained position (<10%) since the pandemic.

Actions being taken to improve
Recovery plans are in place for Sleep services to return to the 1% constitutional standard.
Outsourcing arrangements within Non-Obstetric Ultrasound are funded to continue into new financial year
Bank lists remain in place to mitigate increased CT, MR and NOUS demand experienced during Q4.
Vanguard unit being set up to address the lost Endoscopy capacity in Weston due to the fire.

Impact on forecast
It is anticipated that these actions will support an improvement in DM01 performance during April.

Responsiveness

Planned Care – Cancer Metrics



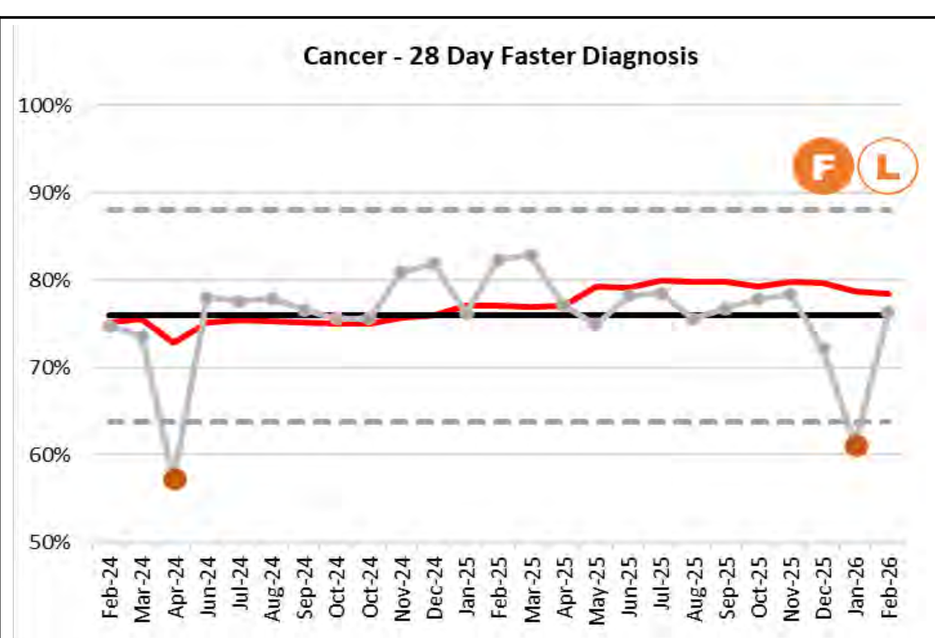
Latest Month
Feb-26

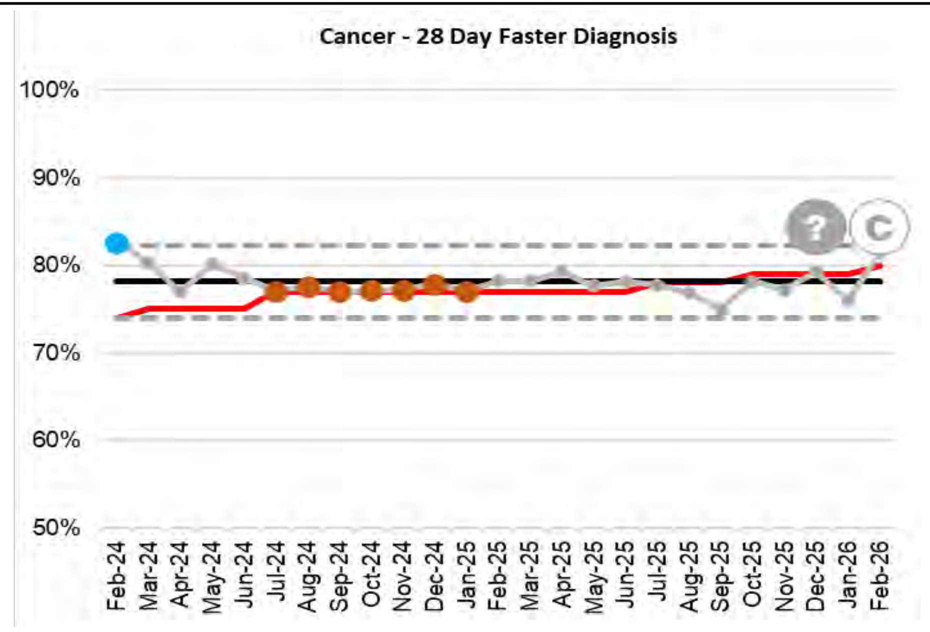
Target
78.5%

Latest Month's Position
76.4%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration

Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).





Latest Month
Feb-26

Target
80.0%

Latest Month's Position
81.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random

Corporate Risk
Risk 6782 - Risk that the 28-day faster diagnosis cancer standard is not met (12)

What does the data tell us?
As anticipated and forecast in the previous IQPR, 28-Day performance did not meet the trajectory for February. The primary driver for the position was due to under-provision of Breast one stop clinics related to specific workforce challenges.

Actions being taken to improve
Key areas of focus are 1st OPA within Breast and diagnostic capacity and turnaround times in Urology. SWAG and NHSE funding has been approved.

Additional high-cost insourcing to clear the backlog of patients waiting over 28 days for a diagnosis and review of core capacity delivered by NBT staff.

Impact on forecast
Forecasting a return to plan by year-end.

What does the data tell us?
The standard achieved compliance with the national 80% threshold, in line with expectations

Actions being taken to improve
To sustain compliance a priority is mitigating the impact of the Weston fire on endoscopy by resuming services on the Weston site as soon as possible. Whilst patients are being offered alternative locations, many prefer to wait and have the test locally. Ensuring sufficient dermatology capacity as the usual summer demand starts to impact is also important.

Impact on forecast
Sustained compliance is forecast

Responsiveness

Planned Care – Cancer Metrics

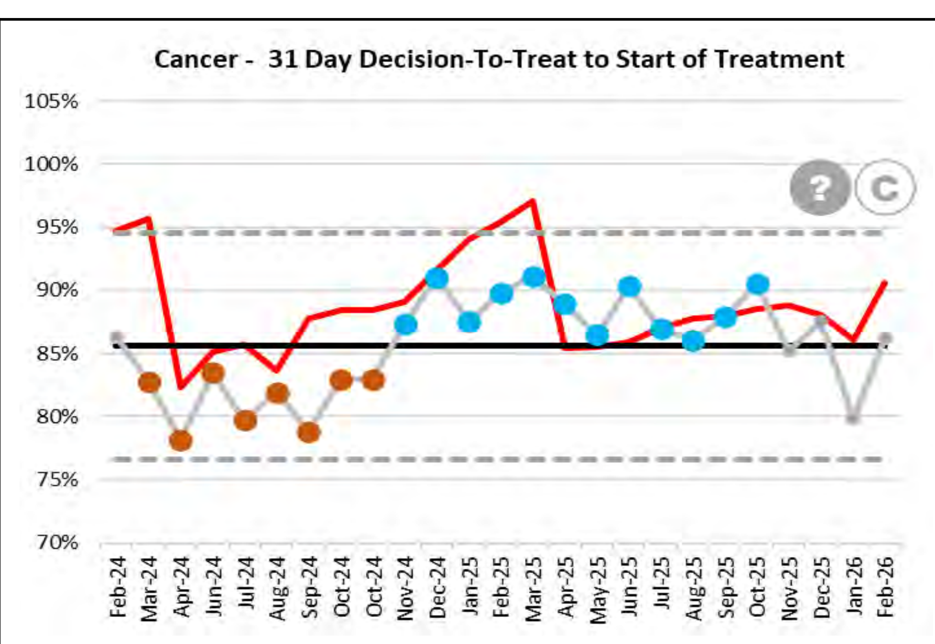
Latest Month
Feb-26

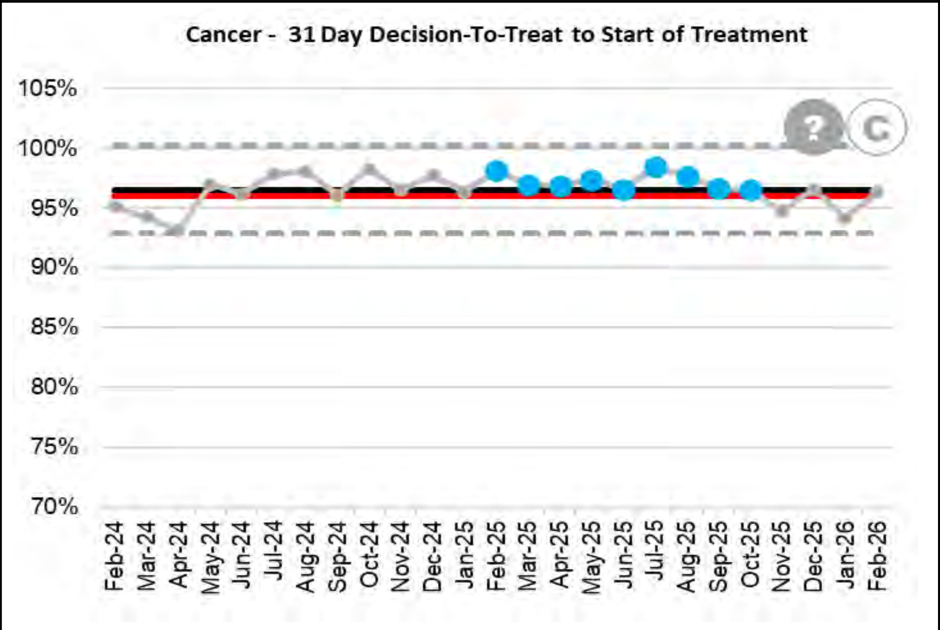
Target
90.6%

Latest Month's Position
86.2%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).





Latest Month
Feb-26

Target
96.0%

Latest Month's Position
96.3%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random

Corporate Risk
Risk 5532 - Non-compliance with the 31 day cancer standard (12)

What does the data tell us?
31-Day performance did not meet the trajectory for February. NBT treated more cancer patients in the month than planned, however many of these patients had already waited more than 31 days for their treatment.

Actions being taken to improve
Stretching recovery plans are in place to deliver additional treatments.

Recovery plans are being monitored on a weekly basis through a COO-led governance process.

Impact on forecast
Continue to deliver recovery plans into 2026/27.

What does the data tell us?
The standard achieved compliance with the national 96% threshold. Whilst the Trust have committed to maintain this performance into 2026/27 (as part of the Operational Plan), it is worth noting that NHSE has set a lower interim compliance threshold of 94% for 2026/27.

Actions being taken to improve
In order to sustain compliance against this standard, an additional chemotherapy facility is being built at South Bristol Community Hospital and additional chemotherapy capacity being put on at weekends.

Within the Dermatology service additional outsourcing has been arranged, and a locum is starting in May 2026.

These address the main risks to compliance in the coming months.

Impact on forecast
The standard remains at risk from the ongoing challenges with chemotherapy delivery. Performance is likely to fluctuate between compliant and narrowly non-compliant performance, at least until autumn when the new chemotherapy facilities at South Bristol Community Hospital are due to open.

Responsiveness

Planned Care – Cancer Metrics

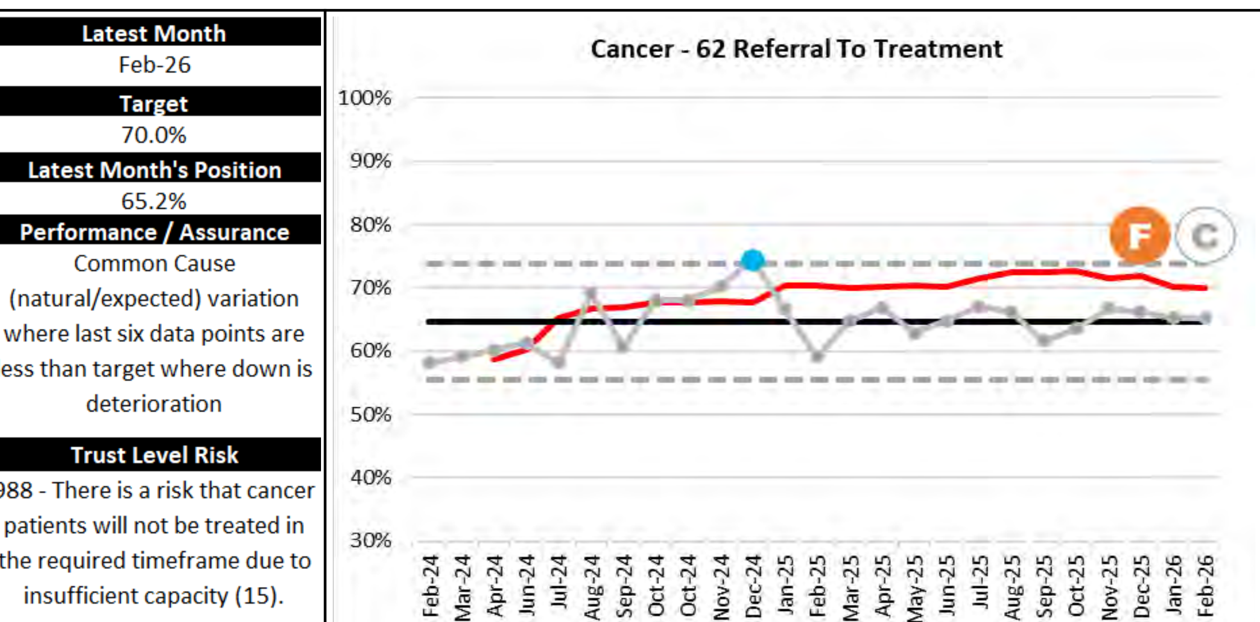
Latest Month
Feb-26

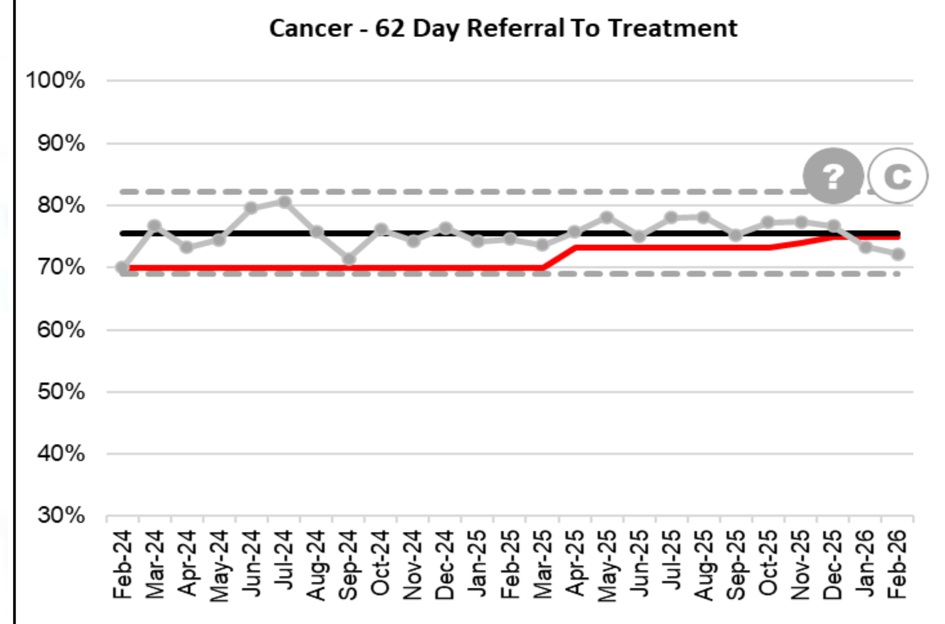
Target
70.0%

Latest Month's Position
65.2%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration

Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).





Latest Month
Feb-26

Target
75.0%

Latest Month's Position
72.2%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random

Corporate Risk
Risk 5531 - Non-compliance with the 62 day cancer standard (12)

What does the data tell us?
62-Day performance did not meet the trajectory for February. The overall treatment volume was above plan and there were more reported breaches. Breast and Urology make up 64% of the total breaches.

Actions being taken to improve
Detailed recovery plan provided to NHS England through the Tier 2 support; delivery of the plan is being monitored through COO-level oversight.

Key areas of focus are Urology which is demonstrating improvement and is on track against the specialty improvement plan. The other area of focus is Breast services, which are challenged in both screening and symptomatic pathways; this is primarily driven by workforce challenges relating to hard-to-recruit radiologists. There is increased director-level scrutiny through recovery sustainability meetings in both specialities.
There is an increasing trend of referrals from outside BNSSG, specifically in Urology, impacting on performance.

Impact on forecast
Continue to deliver recovery plans into 2026/27.

What do the data tell us?
Performance was not compliant against the 75% NHSE interim target due to the ongoing impact of chemotherapy delivery challenges, compounded by the shorter month and higher than usual numbers of complex/medically deferred patients being treated, which is a result of natural variation.

Actions being taken to improve
Additional chemotherapy capacity and dermatology capacity is being arranged, as outlined in the previous slide.

Impact on forecast
Performance may fluctuate between compliance and non-compliance with the improvement trajectory in 2026/27 (trajectory in place to reflect the interim compliance threshold rising to 80% by the end of March 27), at least until the new chemotherapy facility at South Bristol Community Hospital is in place.

Responsiveness

Last Minute Cancelled Operations

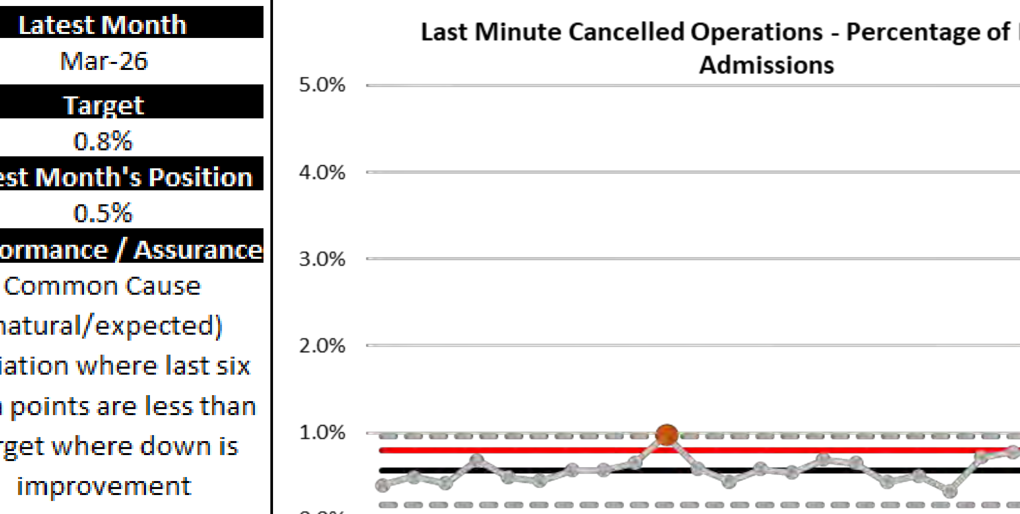
Latest Month
Mar-26

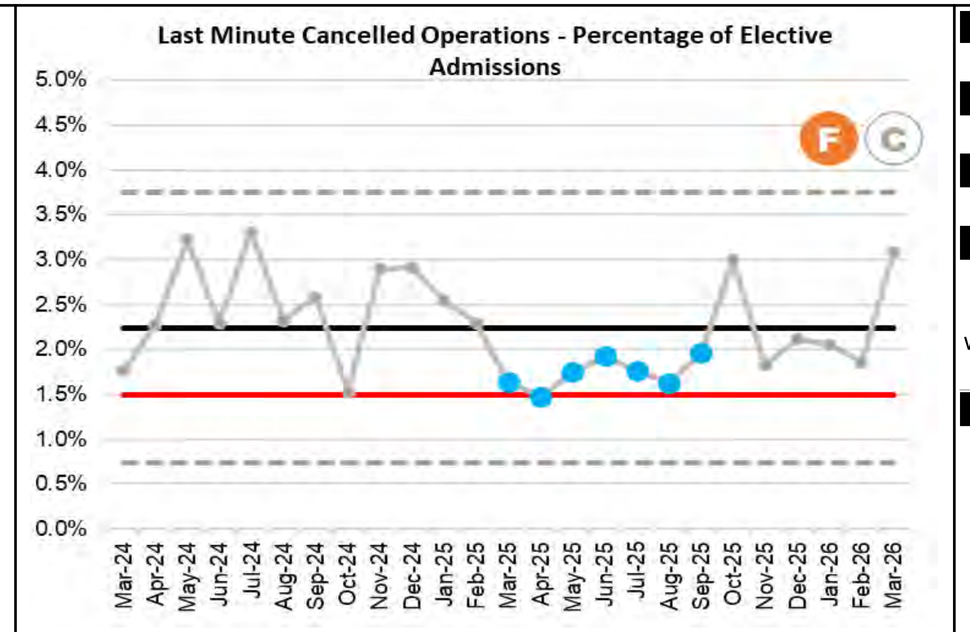
Target
0.8%

Latest Month's Position
0.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is improvement

Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26

Target
1.5%

Latest Month's Position
3.1%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to

Corporate Risk
Corporate Risk 1035 - Risk that BNSSG and tertiary catchment populations do not have access to sufficient critical care beds (16)

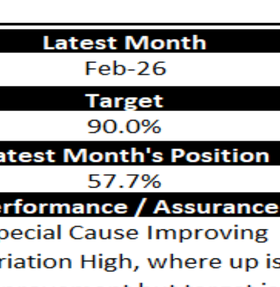
No narrative required as per business rules.

What does the data tell us?
During March, there was an increase in last minute cancellations, reflecting the operational challenges associated with the availability of Weston endoscopy rooms as well as notable bed pressures on the main sites.

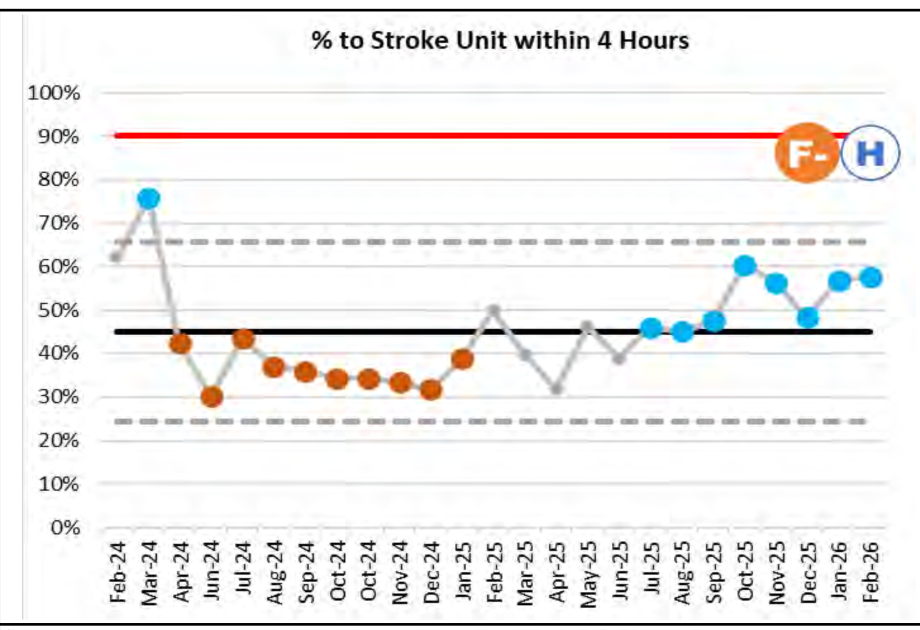
Actions being taken to improve
All divisions are working to mitigate the impact of current bed pressures and the theatre cancellation workstream remains a focus for the trust improvement work. Continued work relating to theatre booking, theatre scheduling and the pre-assessment workstream is anticipated to sustainably support a reduction in last minute cancellations in coming months.

Impact on forecast
Improvement is expected during into 2026/27 through focussed workstreams referenced above and robust management by the Perioperative Improvement Programme

Responsiveness
Stroke Performance - NBT



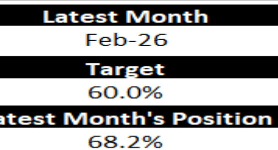
Latest Month
Feb-26
Target
90.0%
Latest Month's Position
57.7%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



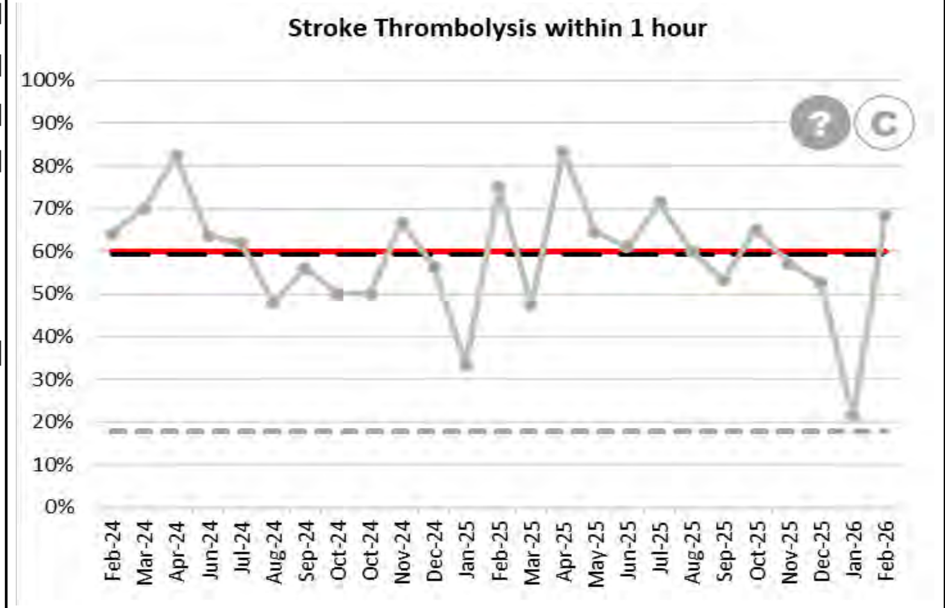
What does the data tell us?
We have recently updated how we categorise the Stroke Unit to include the Stroke Seated Assessment area (from Oct-25) – this is due to the Seated Assessment area matching the description on SSNAP (Sentinel Stroke National Audit Programme) of a Stroke Unit.
The performance has remained stable since the implementation.

Actions being taken to improve
The Hot Bed SOP has gone through Stroke and NMSK clinical governance - including consulting with NBT and BRI site teams. We are still waiting for it to go through the Operational Management Board.
This metric is directly related to occupancy, with system-level work, including work with Weston and South Bristol SSARUs continuing to support this.

Impact on Forecast
Reduced bed occupancy, due to improvements in flow in Mar and early Apr, will see an improvement in this metric.



Latest Month
Feb-26
Target
60.0%
Latest Month's Position
68.2%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



What does the data tell us?
Thrombolysis figures are based on a small patient cohort, which contributes to variability. We continue to provide an increasing amount of extended window thrombolysis on a case-by-case basis, often requiring additional investigations to support safe and well-informed decision-making; this affects 1-hour performance.

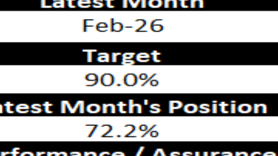
Despite the reduced figure in January, it sits amongst an improved picture and the small number of patients thrombolysed mean that there will be volatility in the data, as shown in February's subsequent improvement.

Actions being taken to improve
A bi-weekly reperfusion meeting is now well established. Our strengthened governance and review processes allow us to spot any early decline in performance and understand the cause, while routine monitoring of balancing measures ensures changes do not create unintended harm.
Timelier access to MRI is required to support decision-making for extended thrombolysis. Risk added to the risk register (MRI access) including mitigating actions. Business case for additional wake-up MRI slot approved at NMSK BCRG to support more extended thrombolysis.

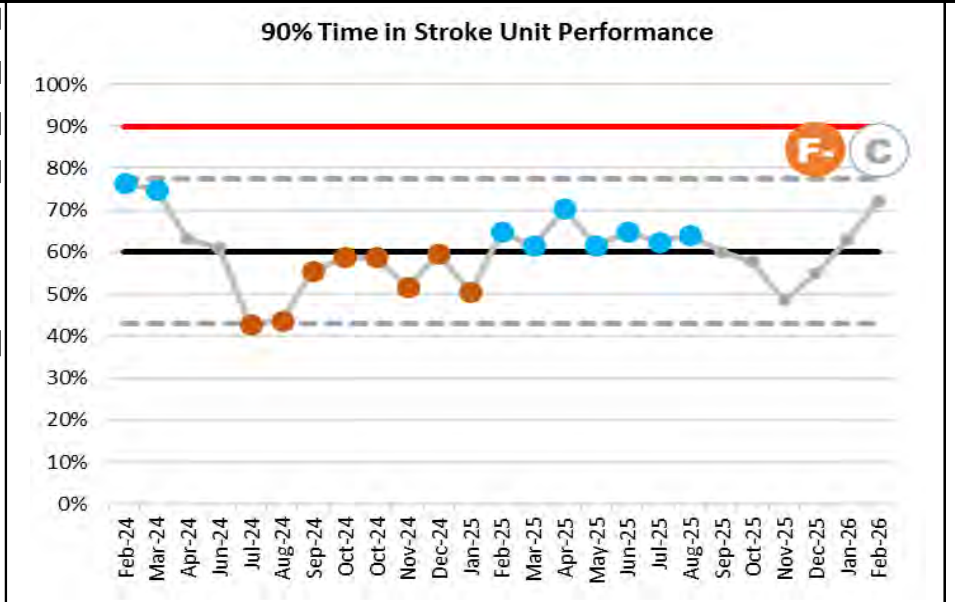
Impact on Forecast
We continue to see strong performance, although slightly impacted by performing more extended thrombolysis.

Responsiveness

Stroke Performance - NBT



Latest Month
Feb-26
Target
90.0%
Latest Month's Position
72.2%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



What does the data tell us?
February's performance is our best since March 2024. Lower occupancy has meant that fewer patients are outlined.

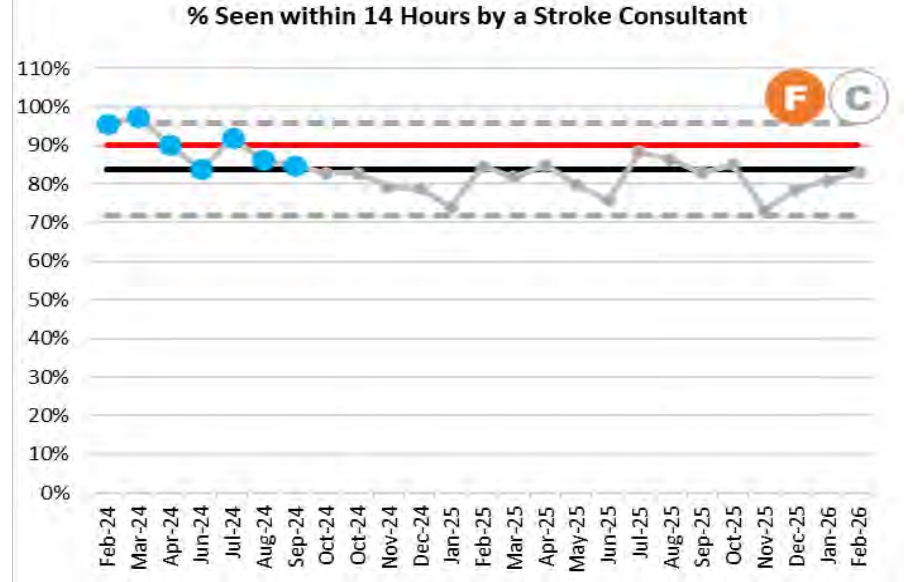
Actions being taken to improve
System-level work, including a recent UEC Board presentation, contributes to reducing occupancy levels. This involves engagement from ICB with a view to enhancing community provision and releasing acute capacity.

The challenge is still with community provision, and this has been escalated through the Operational Delivery Group and System forums via a review of service against the original business case. This is an ongoing process and requires input at system level to drive change.

Impact on Forecast
Occupancy levels for Mar and early Apr predict continued improved performance.

Latest Month
Feb-26
Target
90.0%
Latest Month's Position
83.1%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration

Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



What does the data tell us?
Small, consistent improvements for 3 months in a row.

Actions being taken to improve
Recent performance continues to be supported by a more sustainable and consistent consultant rota. Completeness of data is the next focus. The Careflow narrative form went live on 13/04/26.

This will further enhance the accuracy and completeness of data for this metric. This is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

Impact on Forecast
Expect to see improvements over the coming months as data completeness improves.

Quality
Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Safe	Pressure Injuries Per 1,000 Beddays	NBT	Mar-26	0.6	No Target	0.7	N/A	C	Note Performance
		UHBW	Mar-26	0.2	0.4	0.1	P*	C	Note Performance
Safe	MRSA Hospital Onset Cases	NBT	Mar-26	0	0	1	F	C	Escalation Summary
		UHBW	Mar-26	1	0	0	F	C	Escalation Summary
Safe	CDiff Healthcare Associated Cases	NBT	Mar-26	5	5	6	?	C	Escalation Summary
		UHBW	Mar-26	7	9.08	7	?	C	Escalation Summary
Safe	EColi Hospital Onset Cases	NBT	Mar-26	4	4.00	9	?	C	Escalation Summary
		UHBW	Mar-26	8	9.08	8	?	C	Escalation Summary
Safe	Falls Per 1,000 Beddays	NBT	Mar-26	5.3	No Target	5.4	N/A	C	Note Performance
		UHBW	Mar-26	4.7	4.8	4.7	?	C	Escalation Summary
Safe	Total Number of Patient Falls Resulting in Harm	NBT	Mar-26	6	No Target	2	N/A	C	Note Performance
		UHBW	Mar-26	3	2	1	?	C	Escalation Summary
Safe	Medication Incidents per 1,000 Bed Days	NBT	Mar-26	4.4	No Target	4.3	N/A	L	Note Performance
		UHBW	Mar-26	8.0	No Target	8.6	N/A	C	Note Performance
Safe	Medication Incidents Causing Moderate or Above Harm	NBT	Mar-26	4	0	2	F	C	Escalation Summary
		UHBW	Mar-26	0	0	3	F	C	Escalation Summary
Safe	Adult Inpatients who Received a VTE Risk Assessment	NBT	Mar-26	96.6%	95.0%	97.2%	F-	H	Escalation Summary
		UHBW	Mar-26	82.1%	95.0%	83.4%	F-	H	Escalation Summary
Safe	Staffing Fill Rate	NBT	Mar-26	102.1%	No Target	102.2%	N/A	C	Note Performance
		UHBW	Mar-26	101.9%	100.0%	99.7%	P*	C	Note Performance

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

Quality
Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	NBT	Nov-25	92.1	100.0	94.1	P*	L	Note Performance
		UHBW	Nov-25	87.9	100.0	87.9	P*	L	Note Performance
Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	NBT	Feb-26	55.8%	No Target	43.8%	N/A	C	Note Performance
		UHBW	Mar-26	52.8%	90.0%	56.3%	F-	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	NBT	Feb-26	90.7%	No Target	87.5%	N/A	C	Note Performance
		UHBW	Mar-26	92.5%	90.0%	84.4%	?	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	NBT	Feb-26	48.8%	No Target	41.7%	N/A	C	Note Performance
		UHBW	Mar-26	50.9%	No Target	53.1%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Inpatient	NBT	Mar-26	91.3%	No Target	91.3%	N/A	L	Escalation Summary
		UHBW	Mar-26	95.0%	No Target	95.3%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Outpatient	NBT	Mar-26	94.0%	No Target	94.4%	N/A	C	Note Performance
		UHBW	Mar-26	94.2%	No Target	94.6%	N/A	C	Note Performance
Caring	Friends and Family Test Score - ED	NBT	Mar-26	79.2%	No Target	78.0%	N/A	C	Note Performance
		UHBW	Mar-26	84.9%	No Target	84.9%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Maternity	NBT	Mar-26	84.4%	No Target	88.3%	N/A	L	Escalation Summary
		UHBW	Mar-26	97.4%	No Target	96.6%	N/A	C	Note Performance
Caring	Patient Complaints - Formal	NBT	Mar-26	89	No Target	82	N/A	H	Escalation Summary
		UHBW	Feb-26	77	No Target	76	N/A	H	Escalation Summary
Caring	Formal Complaints Responded To Within Trust Timeframe	NBT	Mar-26	75.3%	90.0%	63.6%	F	C	Escalation Summary
		UHBW	Feb-26	65.7%	90.0%	77.4%	F	C	Escalation Summary

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

Quality
Infection Prevention & Control

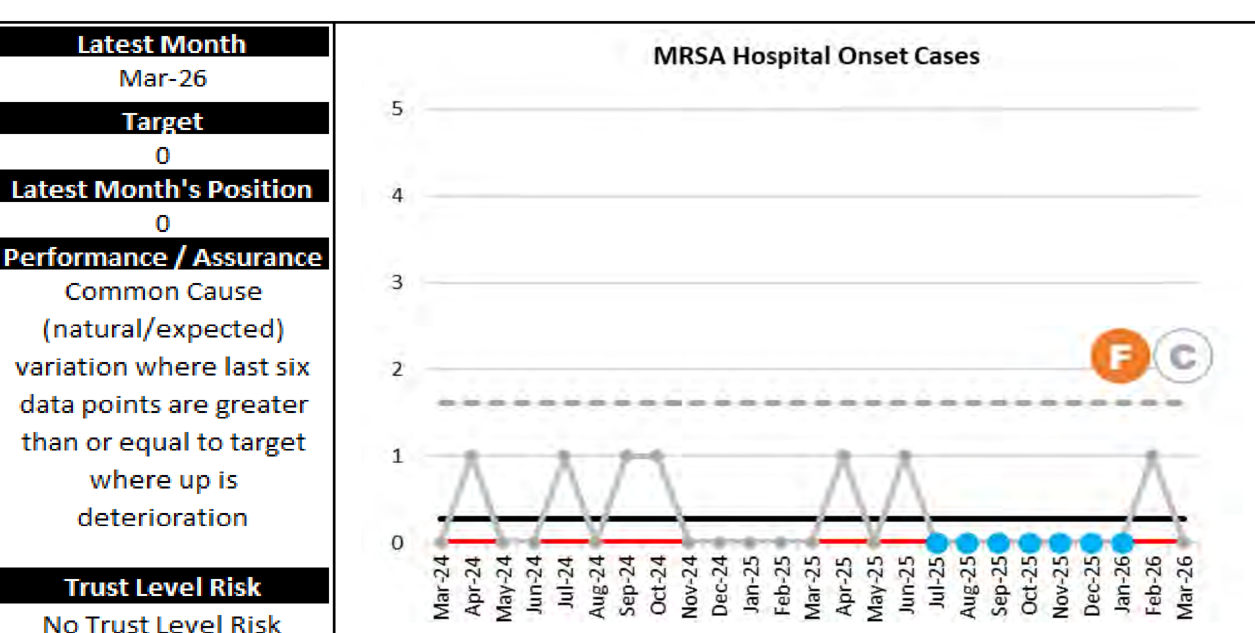
Latest Month
Mar-26

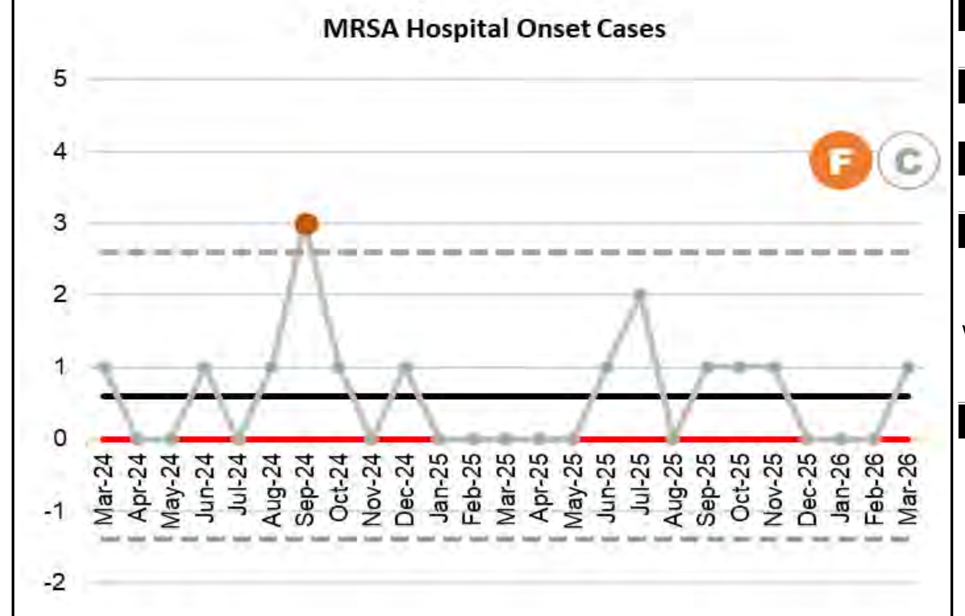
Target
0

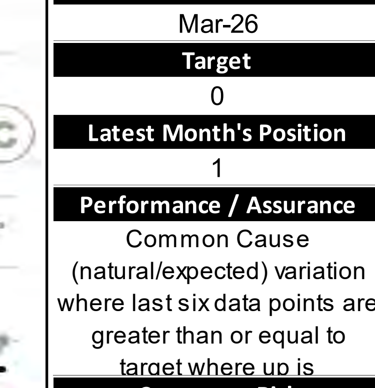
Latest Month's Position
0

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration

Trust Level Risk
No Trust Level Risk







Corporate Risk
Risk 6013 - Risk that the Trust exceeds its NHSE/I limit for Methicillin Resistant Staphylococcus aureus bacteraemia's (12)

What does the data tell us?
Three cases have been reported this year. All cases have had a full review with associated learning.

Actions taken to improve

Actions in place from reviews, this marks a reduction from the end of year position last year.

NBT is taking part in some regional ICB improvement work focusing on MSSA and MRSA reduction, learning from all MRSA cases, sharing learning, and looking at causation

Impact on forecast
The intention is to improve the position with the plans outlined above as well as learn from other trusts and ICBs.

What does the data tell us?
There has been one MRSA case reported for March. The end of year figure shows the trust as having seven cases. The data shows the same number of cases as 2024-25.

Actions being taken to improve
Improvement actions arising from this review are being monitored by the Infection Prevention and Control operational group. The QI approach has been refreshed with MRSA as a core element of this cross Divisional collaborative work.

Directors of Nursing have been asked to review their Divisional case rates of infections with the IPC to scrutinise cases and apply specific Divisional actions for improvement when required for this organism.

Supporting this system work is underway to understand community case rates of MRSA and preventative actions that are required as a wider healthcare system.

Impact on forecast
The actions outlined above are expected to strengthen prevention and control arrangements, support learning across the system, and contribute to an improved and more sustainable position over time.

Quality

Infection Prevention & Control

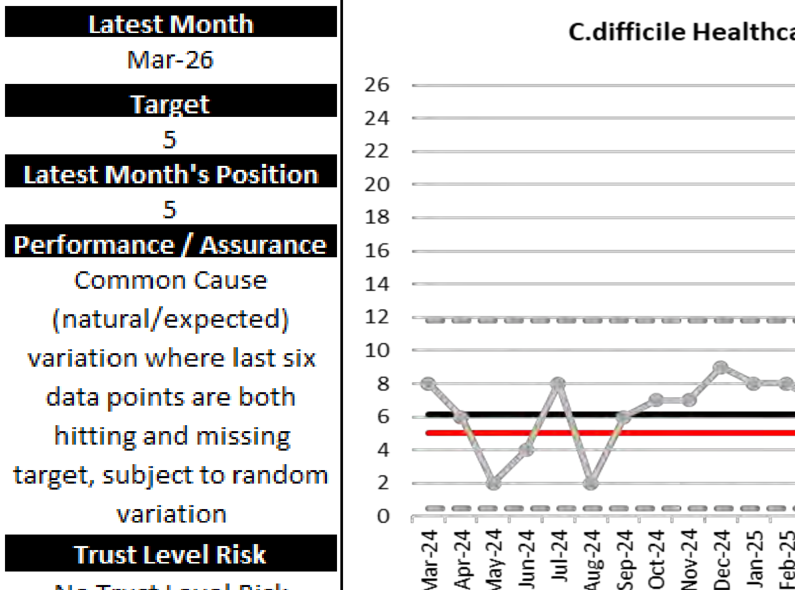
Latest Month
Mar-26

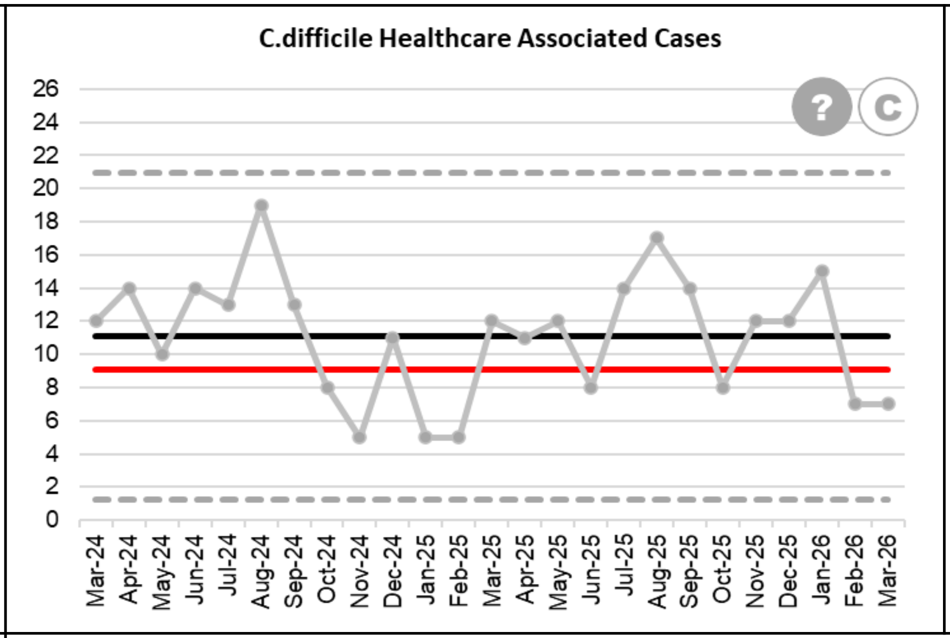
Target
5

Latest Month's Position
5

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26

Target
9.08

Latest Month's Position
7

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
Risk 3216 - Breach of the NHSE Limits for HA C-Diff (12)

What does the data tell us?
The end of year position of 104 cases being over the trajectory of 79, this marks a reduction in total cases from last year.

Actions being taken to improve
C.difficile ward rounds have seen improvements in the management of positive cases. A review of this process has taken place with very favourable outcomes, and the plan will be to continue this.

Following work to RED clean multi-occupancy bays, a plan is in place for a schedule of RED cleaning in these areas aligned with HOIST servicing and sitting in an operational bay closure maintenance plan.

Work also taking place through AMS pharmacist looking at appropriate prescribing of antibiotics, as these are the key themes
Following detection of a concerning Ribotyping strain at UHBW all cases are being typed for 6 months from 27th Jan 26 – noting that no 027 has been seen at NBT.

What does the data tell us?
Seven cases were reported in March, the breakdown for this is five Hospital Onset Hospital Acquired (HOHA) and two Community onset Community Acquired (COHA). This takes the end of year figures to 137 (100 HOHA and 37 COHA cases). The overall position for 2025/26 was eight cases eight higher than the previous year for 2024/25.

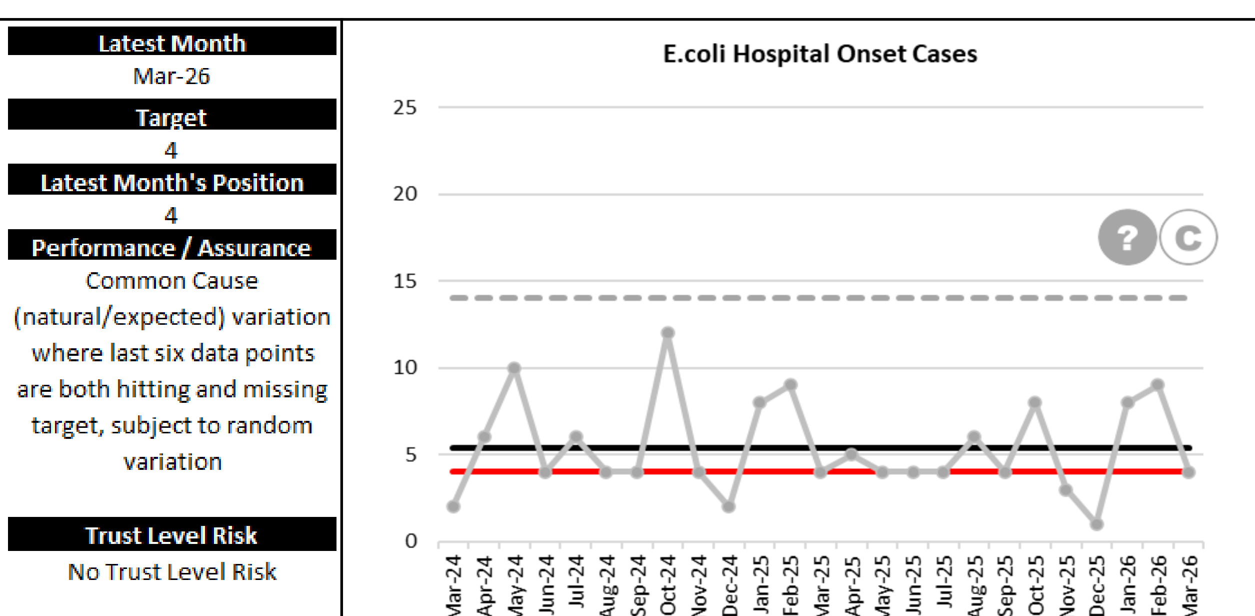
Actions being taken to improve
Each HOHA case is reviewed by medical microbiology, Infection Prevention and Control with the responsible clinical team. Ongoing Trust wide scrutiny of the standards of cleanliness continues with clinical Divisions and facilities teams.
Additional interventions have begun with ward based clinical and facilities team huddles focused on cleaning to galvanise interventions for improvements and enhance communication. The QI approach has been refreshed with C. difficile as a core element of this cross Divisional collaborative work. Directors of Nursing have been asked to review their Divisional case rates of infections with the IPC to scrutinise cases and apply specific Divisional actions for improvement when required for this organism.

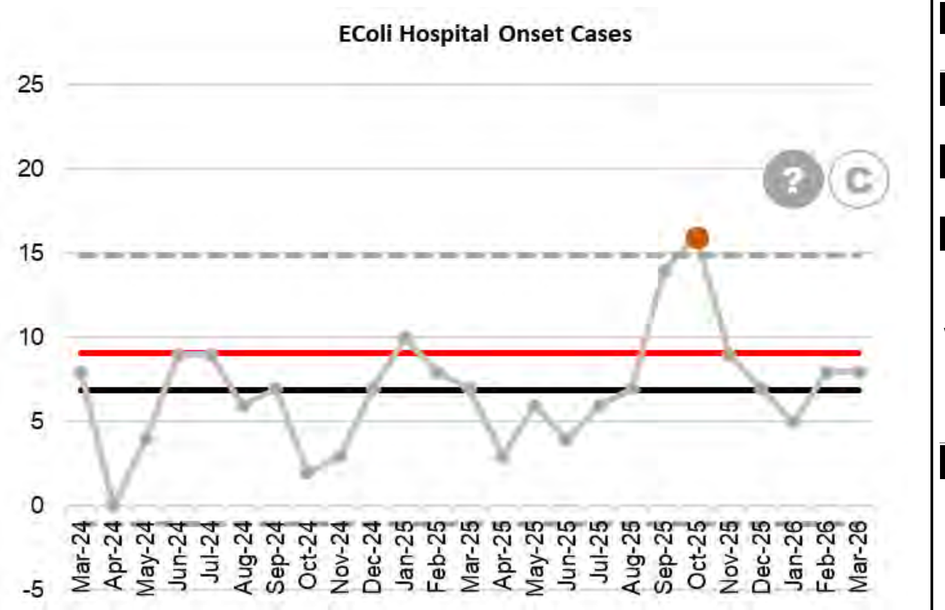
Impact on forecast
The NHSE trajectory (limit) for 2025/6, is 109 and has been exceeded with a total of 137 cases. BNSSG is noted for the elevated incidence in the southwest.

Quality

Infection Prevention & Control

Latest Month
Mar-26
Target
4
Latest Month's Position
4
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26
Target
9.08
Latest Month's Position
8
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
No Corporate Risk

What does the data tell us?
Total cases this year were below the trajectory of 84, ending the year on 60 cases.

Actions being taken to improve:
Working alongside BD Medical, looking at catheter care and reduction of CAUTI as a quality improvement project.

Impact on forecast:
Cases remain below the threshold, so the target will be achieved.

What does the data tell us?
Eight cases of Escherichia coli were reported in March. The end of year total is 93 was lower than lower than the predicted threshold of 109. The increased incidence in cases seen in September to October 2025-26 was unusual and affected the monthly rates.

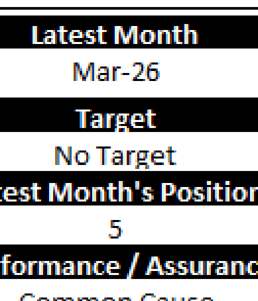
Actions being taken to improve
Ongoing oversight of all cases continues. Quality improvement activity remains focused on urinary catheter care, including monthly assurance audits undertaken by wards and monitored through the AMaT system.

There is detailed work being undertaken to review the last 2 years of E. Coli cases by the Medical Microbiology team, to understand areas of improvement that can be targeted.

Impact on forecast
The NHSE trajectory of 109 cases year 2025/6 has not been exceeded , the end of year total is 93.

Quality

Falls



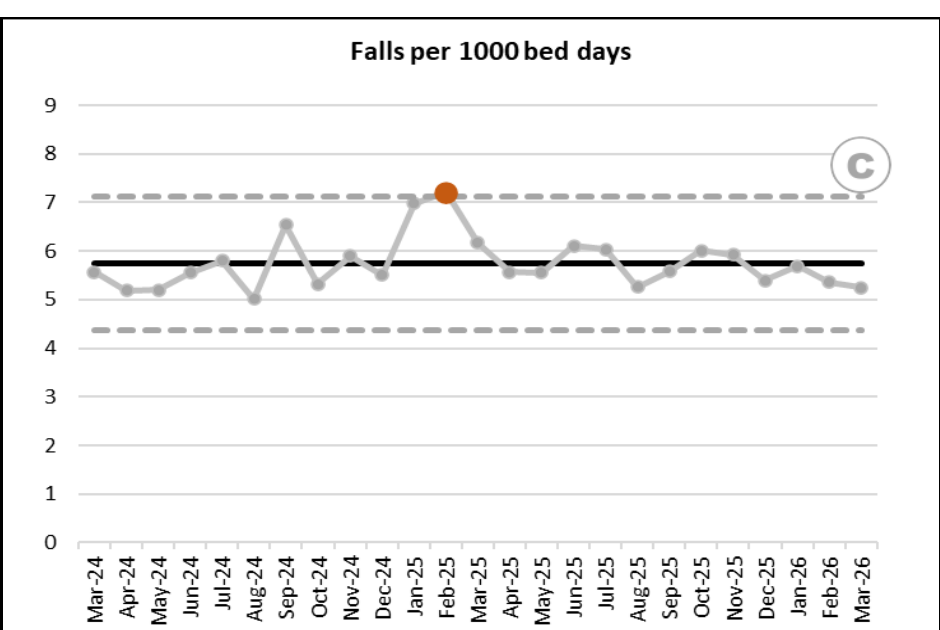
Latest Month
Mar-26

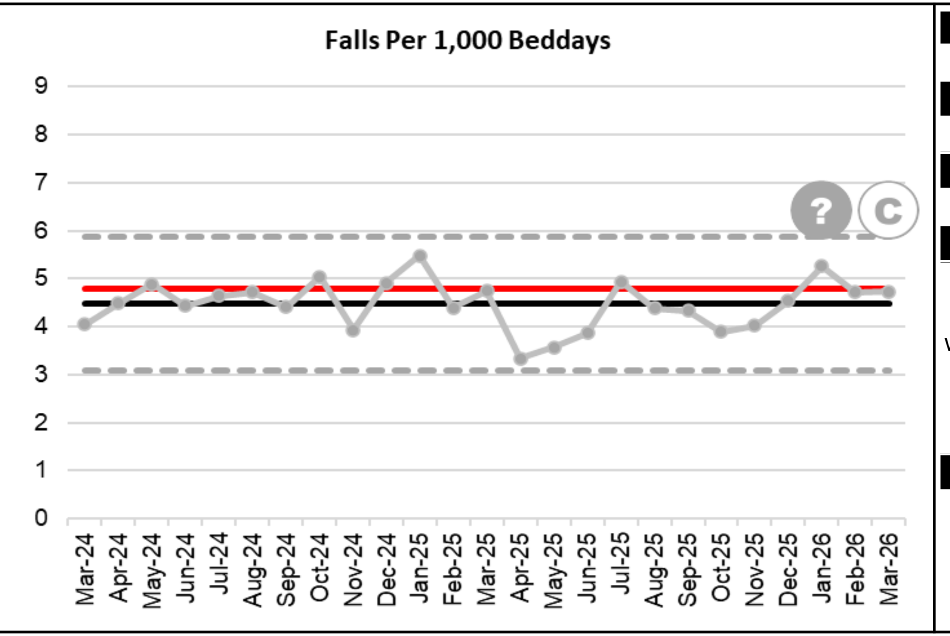
Target
No Target

Latest Month's Position
5

Performance / Assurance
Common Cause (natural/expected) variation with no target

Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26

Target
4.8

Latest Month's Position
4.7

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
Risk 1598 - Patients suffer harm or injury from preventable falls (12)

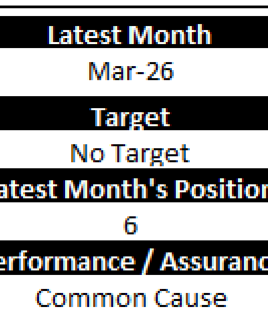
No narrative required as per business rules.

What does the data tell us:
The number of falls in March 2026 (165) is more than February 2026 (148). There were three falls with moderate harm, this is higher than the previous month (1).
Risk of falls continues to remain on the divisions' risk registers as well as the Trust risk register. Actions to reduce falls, all of which have potential to cause harm, is provided below.

Continued on next slide…

Quality

Falls



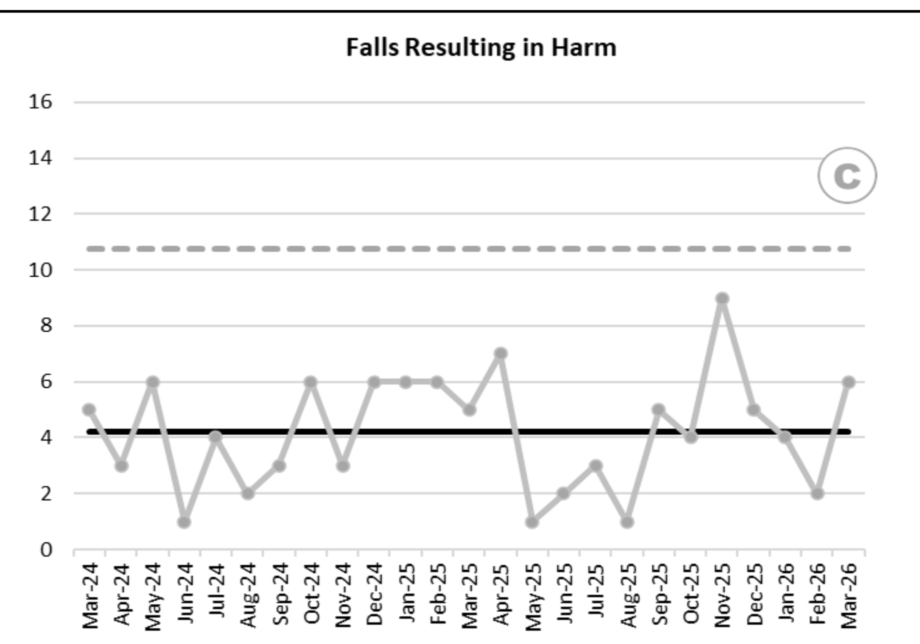
Latest Month
Mar-26

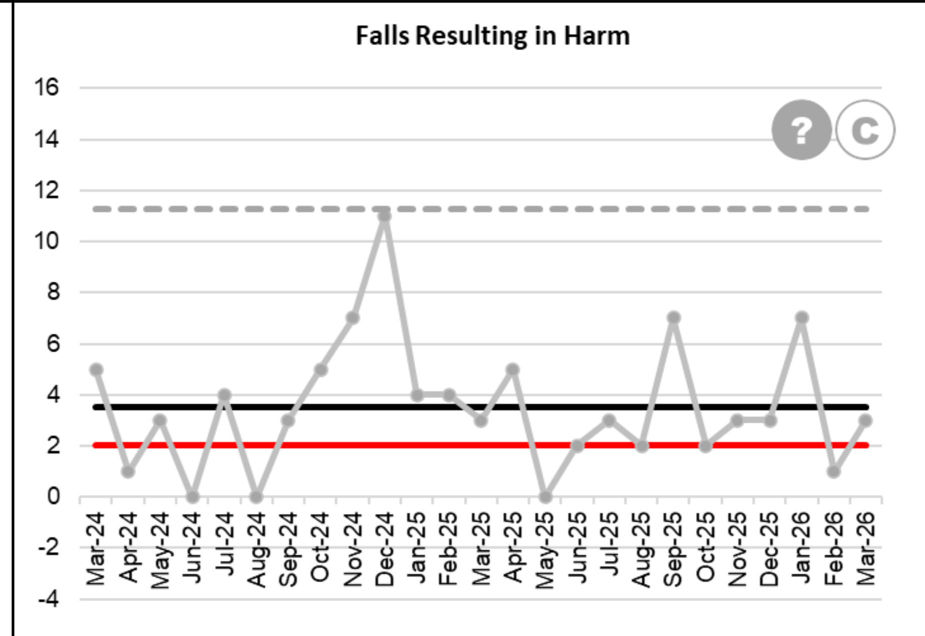
Target
No Target

Latest Month's Position
6

Performance / Assurance
Common Cause (natural/expected) variation with no target

Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26

Target
2

Latest Month's Position
3

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
Risk 1598 - Patients suffer harm or injury from preventable falls (12)

No narrative required as per business rules.

Actions being taken to improve

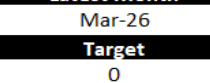
- Divisions (Medicine and Weston) which have reported higher falls incidences are currently undertaking thematic reviews of falls and falls with harm to identify themes and learning. Action plans will be developed, implemented and shared throughout the division and the Trust.
- We continue to work on personalisation, prediction, participation and prevention as a framework for reducing falls and falls with harm across the Trust.
- Quality improvement projects for the next 12 months have commenced, these include consistent use of Abbey pain scale, improving nutrition and hydration for persons with dementia and working on a falls management plan for non-inpatient areas.
- Audit: We continue to participate in the National Audit of Inpatient Falls and National Audit of Dementia.
- We are reviewing and updating the Trust Falls policy and associated documents over the next couple of months and will reflect the updated NICE (NG249) guidance in the revised version.
- Training -The DDF Steering Group provides an education component, bitesize education sessions are delivered to the group on relevant topics. The DDF team continue to deliver education sessions and simulation-based training.

Impact on forecast

We continue to monitor total falls, falls per 1000 bed days and falls with harm and continue to work on preventing and managing falls.

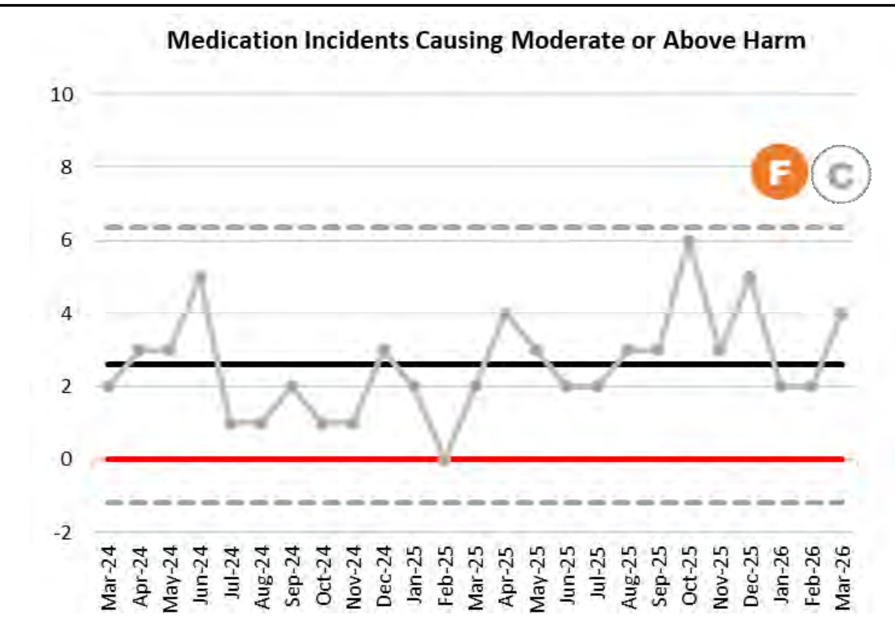
Quality

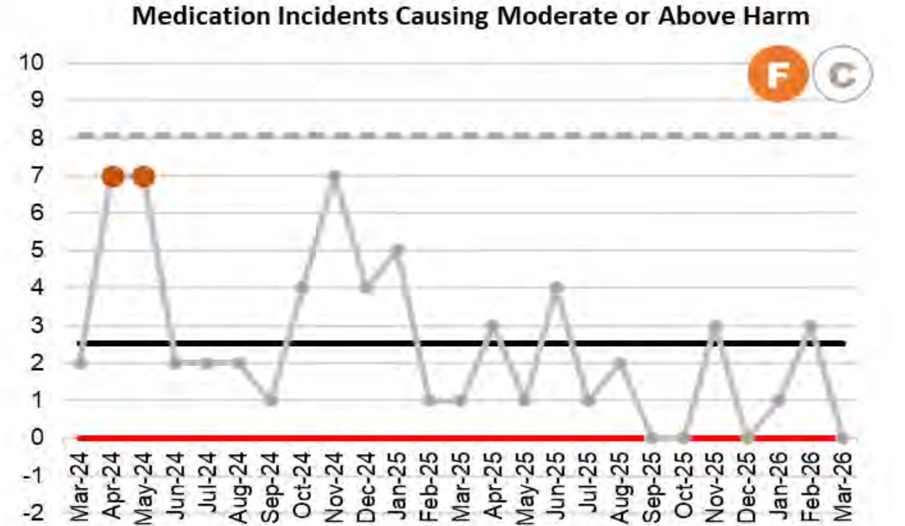
Medication Incidents



Latest Month
Mar-26
Target
0
Latest Month's Position
4
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration

Trust Level Risk
Risk 1800 – Allergy status may not be identified resulting in medication being incorrectly prescribed or administered (20).
Risk 2134 - risk to patient safety and service provision due to insufficient staffing within the Pharmacy Medicines Governance & Safety Team (16).





Graph depicting incidents taking place in month until Sep-25, when changed to incidents reported.

Latest Month
Mar-26
Target
0
Latest Month's Position
0
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Corporate Risk
Risk 7633 - Reliance on paper-based medication prescribing and administration (16)
Risk 8386 - Risk that patients come to harm from a known medication allergy (20)

What does the data tell us?
During March 2026, NBT recorded 150 medication incidents involving patients; of these, four were graded as causing moderate or above harm to a patient. (all moderate).

Actions being taken to improve
The next round of Safe and Secure Handling of Medicines audits are being undertaken by the Medicines Governance Team in April. These served as an opportunity to review practice and speak to ward staff about medicines management challenges.

The Medicines Governance team are also working closely with the CMM team to identify any emerging themes or trends in terms of incidents which may be related to changes in process following the CMM go live.
A resource proposal detailing the Pharmacy staffing required to support medicines safety improvement work going forward is being written for sharing with colleagues.

What does the data tell us?
During March 2026, UHBW recorded 279 medication-related incidents, none of which resulted in moderate or above harm. The dataset pre-April 2024 is based on previous harm descriptors in place in the Trust. The data indicates a good reporting culture with few harm incidents compared to number of incidents.

Actions being taken to improve
Patient Safety learning responses have been initiated following incidents associated with the prescribing and administration of subcutaneous syringe drivers on the CareFlow Medicines Management (CMM) system. Further system-level actions will be reviewed through the Patient Safety Group and monitored via a Trust level risk. Work is ongoing to strengthen the dissemination and uptake of MHRA Drug Safety Updates, ensuring learning is embedded into clinical practice.

Learning from medication incidents is routinely shared via Medicines Governance Group and with BNSSG system partners through system medicines quality and safety meetings. This report has been developed collaboratively by the UHBW and NBT medicines safety teams, supporting a consistent, group-wide approach to medicines safety.
A resource proposal is being developed to define the pharmacy workforce capacity required to support sustained medicines safety improvement across the Hospital Group.

Quality

VTE Risk Assessment

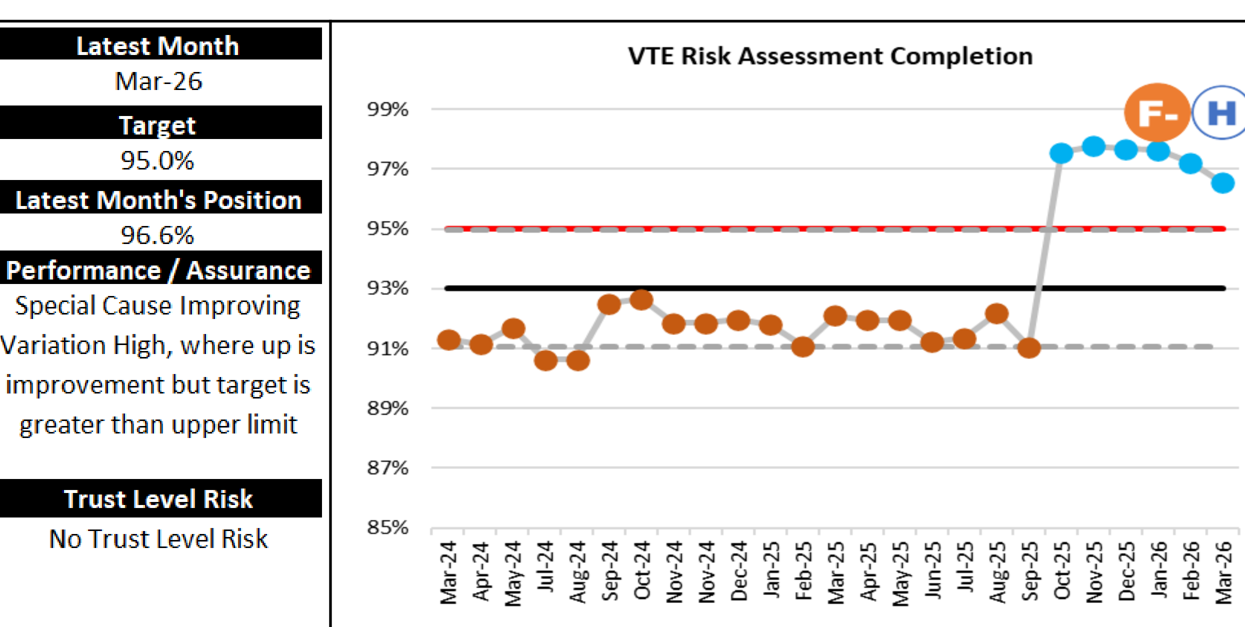
Latest Month
Mar-26

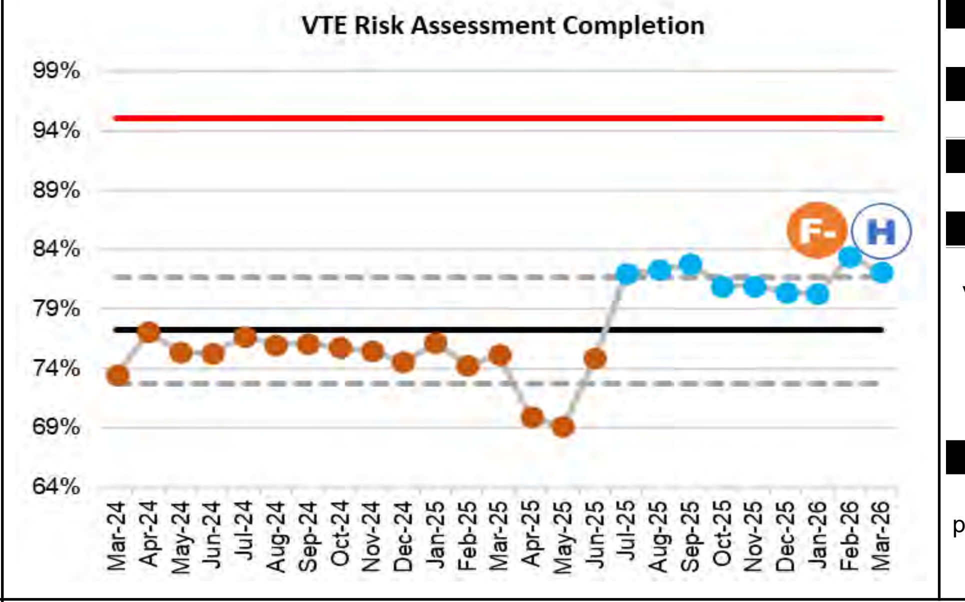
Target
95.0%

Latest Month's Position
96.6%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit

Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26

Target
95.0%

Latest Month's Position
82.1%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.

Corporate Risk
Risk 8448 - Risk that VTE prophylaxis is not prescribed when indicated (16)

What the data is telling us

Reported VTE risk assessment (VTE RA) compliance increased to around 97% from October 2025 following introduction of mandatory VTE RA within CMM. This metric reflects completion at any point during admission and does not yet align with the NHS Digital standard of completion within 14 hours of admission.

Reported performance is also influenced by cohorting, whereby defined patient groups are treated as VTE RA compliant. At NBT, VTE RA is mandated across a wide range of areas and is supported by long-standing organisational focus and established processes for VTE prevention.

Actions being taken to improve

Reporting is being aligned to the NHS Digital 14-hour standard. In parallel, cohort definitions are being reviewed and refined to ensure they meet national requirements and are applied consistently across the merged organisation. Improving transparency of performance across clinical areas will strengthen operational and divisional oversight.

Impact on forecast

Reported compliance is expected to reduce as timeliness standards are applied and cohort definitions refined, removing artificial inflation. Sustained performance will depend on timely VTE RA completion across all admission pathways.

What the data is telling us

VTE RA compliance has remained below the 95% target despite improvement following CMM mandation from July 2025. UHBW reporting already applies the NHS Digital standard of VTE RA completion within 14 hours of admission. Reported compliance is significantly influenced by cohorting, together with a higher proportion of patients admitted via the Emergency Department, where VTE RA is not mandated at the point of assessment.

Actions being taken to improve

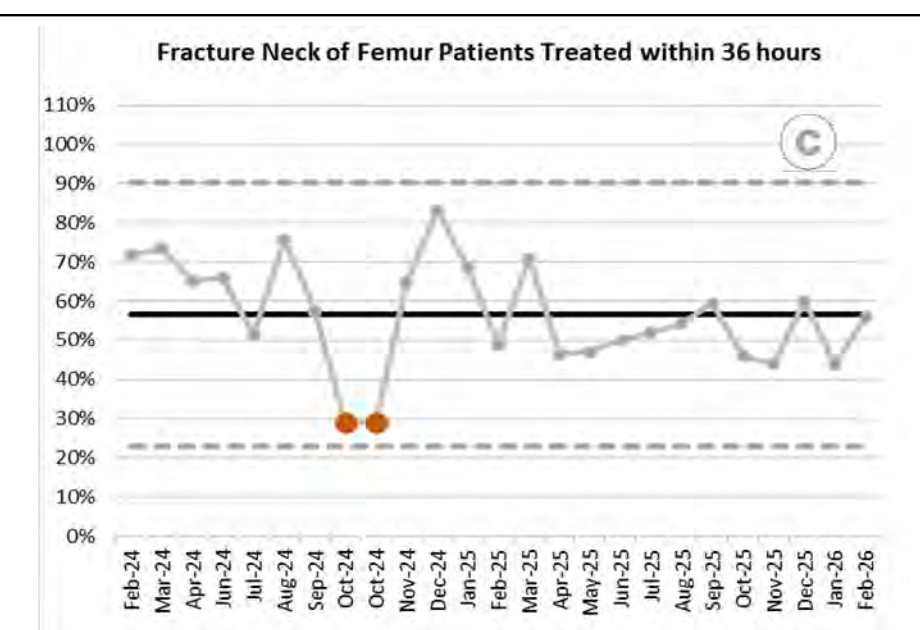
Cohort definitions are being reviewed and refined to ensure they meet national requirements and are applied consistently across the merged organisation. Improving transparency of performance through clearer cohorting and more consistent organisation and presentation of data across clinical areas will strengthen operational and divisional oversight and support improvement in VTE RA completion.

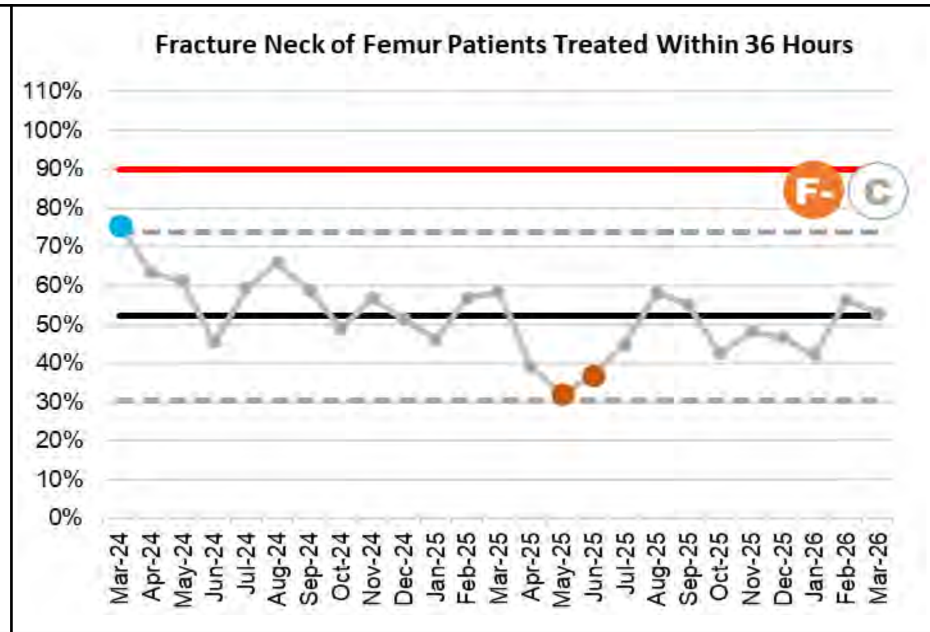
Impact on forecast

Reported compliance is expected to reduce further as cohort definitions are standardised, removing artificial inflation of the current position. Sustained improvement will depend on timely completion of VTE RA across all admission routes, supported by improved data visibility and oversight.

Quality
Neck of Femur

Latest Month
Feb-26
Target
No Target
Latest Month's
4.7%
Performance /
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26
Target
90.0%
Latest Month's Position
52.8%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.
Corporate Risk
Risk 924 - Delay in hip fracture patients accessing surgery within 36 hours (15)

No narrative required as per business rules.

What does the data tell us?

At UHBW in March 53 patients were eligible for the best practice tariff (BPT), 28/53 patients (53%) were operated on within 36 hours of admission, 49/53 (92%) received ortho-geriatric assessment within 72 hours, resulting in 27/53 patients (51%) met all BPT criteria.

Main reasons for missed targets:

At Weston: 14 patients missed the time to surgery target. This was due to lack of theatre space (7), specific surgeon required(2), Medical optimisation needed before surgery (1), patient not starved (1) and anticoagulation required stopping prior to surgery (3) . Four patients were not seen by the single part-time geriatrician. This was due to lack of support for the geriatrician during annual leave/study leave.
At the BRI: 11 patients missed the 36hrs target for surgery. This was primarily due to lack of theatre capacity.

Actions being taken

Extra theatre space is created where possible to reduce theatre delays. Elective theatre lists or CEPOD are often used at short notice to create extra support for trauma.

Impact on forecast Half day trauma lists (Tues+Thurs) and specialist trauma being planned on other lists impacts on daily admissions for surgery.

Quality

Neck of Femur

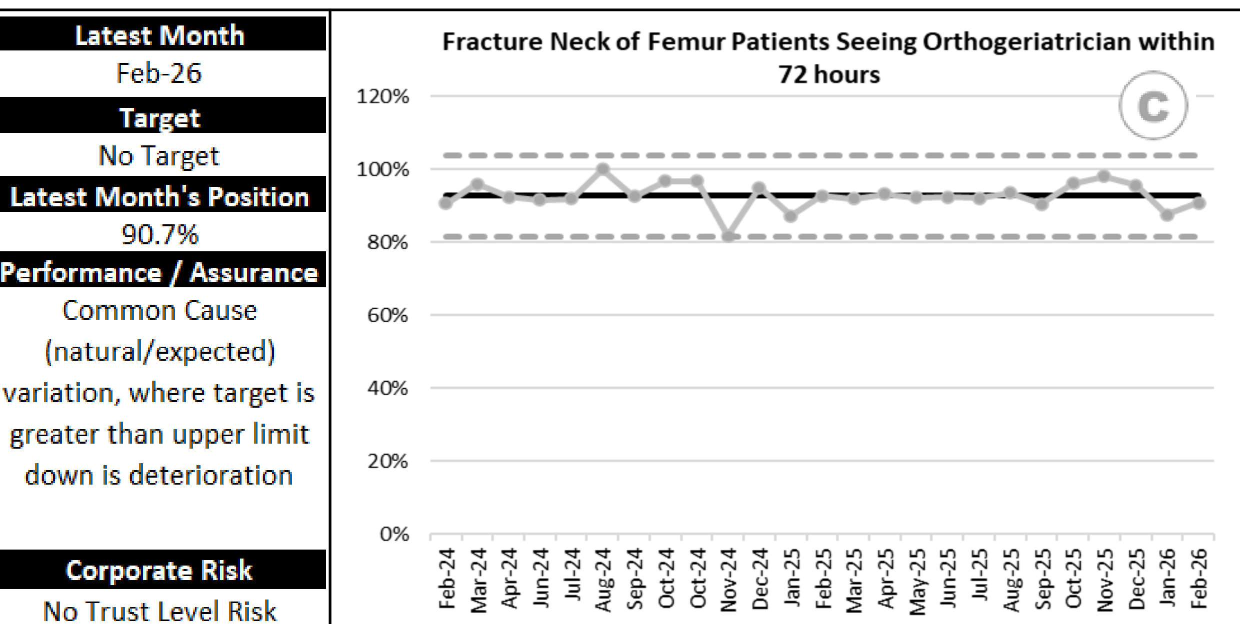
Latest Month
Feb-26

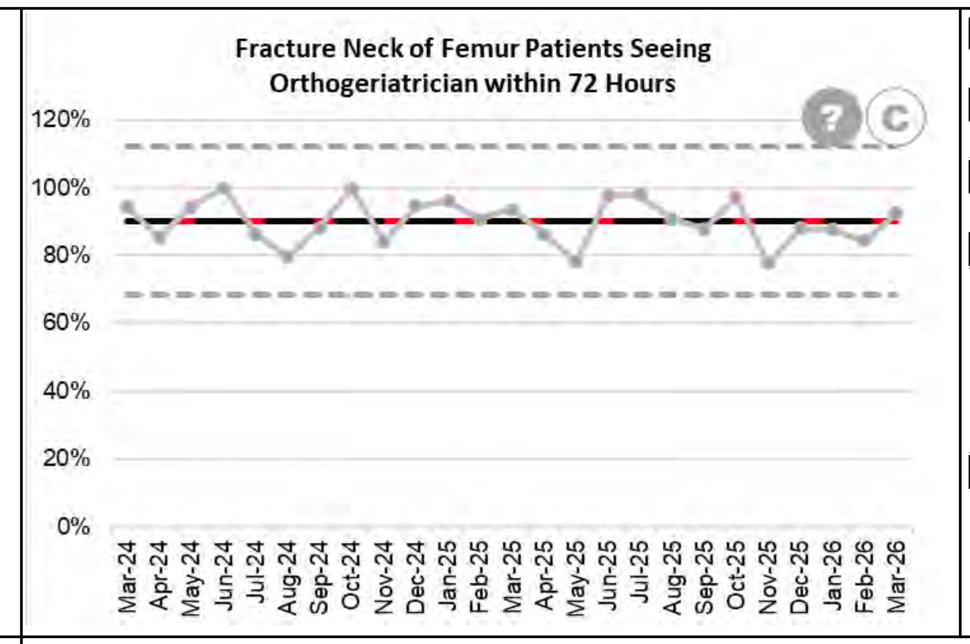
Target
No Target

Latest Month's Position
90.7%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

Corporate Risk
No Trust Level Risk





Latest Month
Mar-26

Target
90%

Latest Month's Position
92.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
No Corporate Risk

No narrative required as per business rules.

What does the data tell us?
49/53 (92%) Patients received an ortho-geriatric assessment within 72 hours.

Main reason for missed targets
At Weston four patients were not seen by the single part-time geriatrician. This was due to the lack of resilience when the geriatrician was on annual leave/study leave.

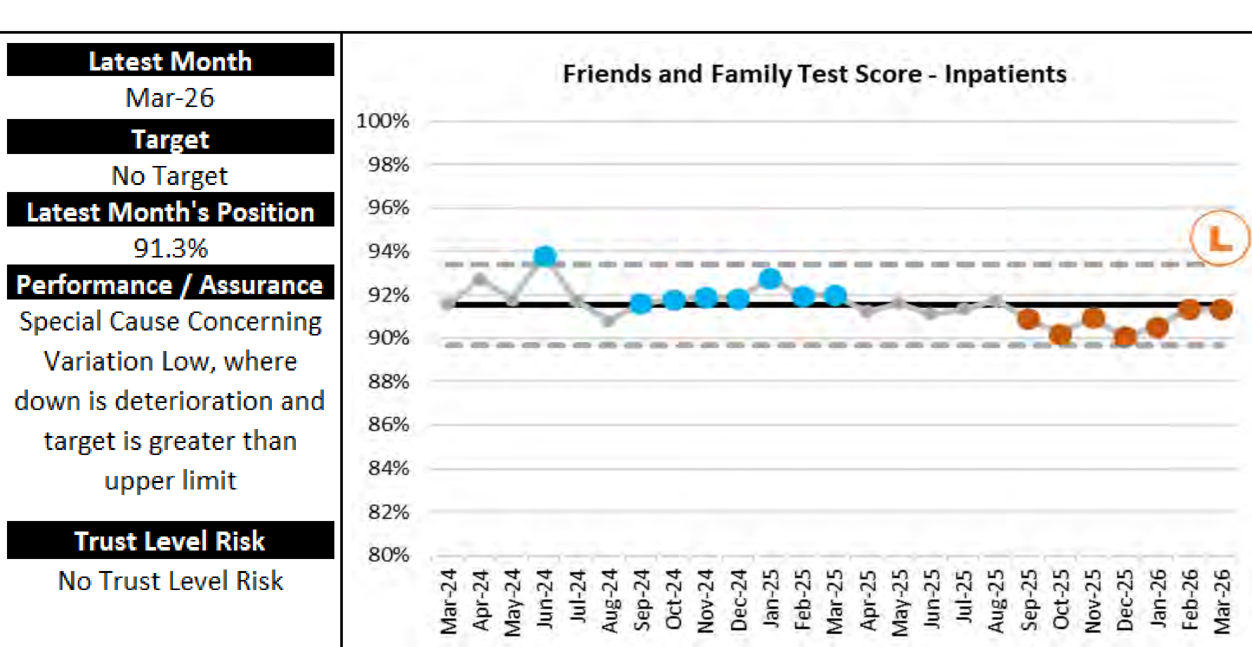
Impact on forecast
The presence of only one part-time geriatrician at Weston remains a persistent constraint especially during periods of high demand. This also impacts on medical delays for patients needing surgery.

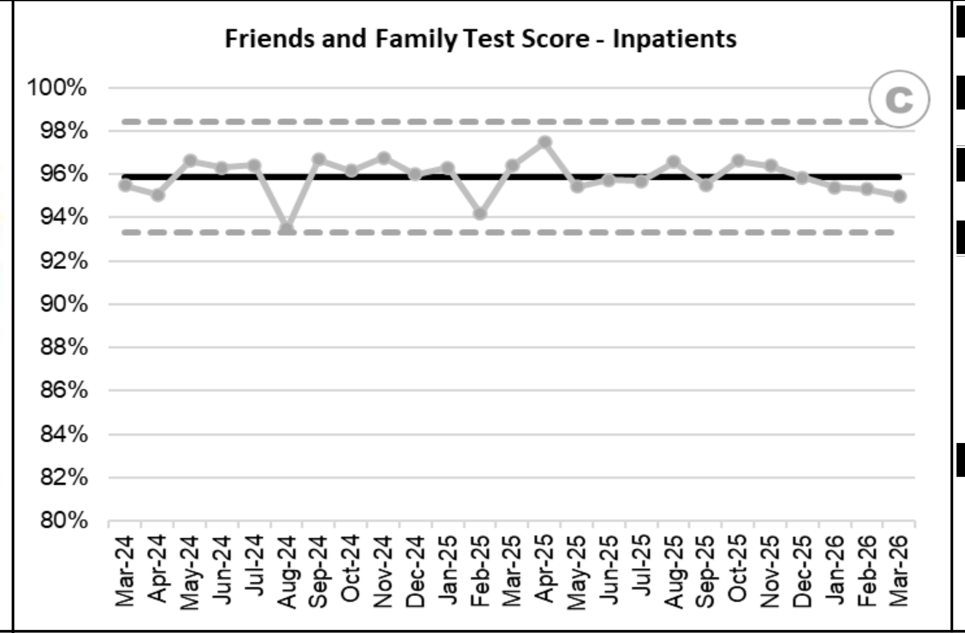
Quality

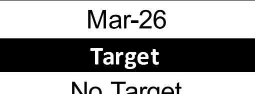
Friends and Family Test (FFT)

Latest Month
Mar-26
Target
No Target
Latest Month's Position
91.3%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit

Trust Level Risk
No Trust Level Risk







Latest Month
Mar-26
Target
No Target
Latest Month's Position
95.0%
Performance / Assurance
Common Cause (natural/expected) variation where up is improvement.

Corporate Risk
No Corporate Risk

What does the data tell us?

- The Inpatient FFT score (total % of patients rating their experience as 'Very good' or 'Good') has decreased slightly from 91.4% in February to 91.3% in March, and remains just below the mean, but within control limits.
- The top negative theme rising from comments is around 'Staff', followed by 'Communication'.

Actions being taken to improve

- The Divisional Patient Experience Teams continue to review their FFT data in conjunction with other feedback. This information and any actions are then presented at the Patient & Carer Experience Group.
- Improving Patient Experience – Customer Care training continues to be promoted.

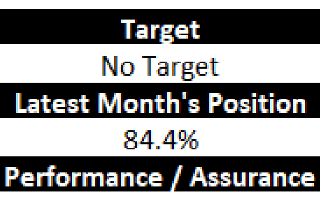
Impact on forecast

- The Trust transitioned to a new FFT provider on 1 April 2026 and, as part of this change, introduced a revised methodology for collecting inpatient FFT, aligning with UHBW. Patients are now invited to provide feedback at the point of discharge using FFT postcards. The change in methodology is likely to show different results starting next month, and will be helpful in aligning reporting with UHBW.

No narrative required as per business rules.

Quality

Friends and Family Test



Latest Month

Mar-26

Target

No Target

Latest Month's Position

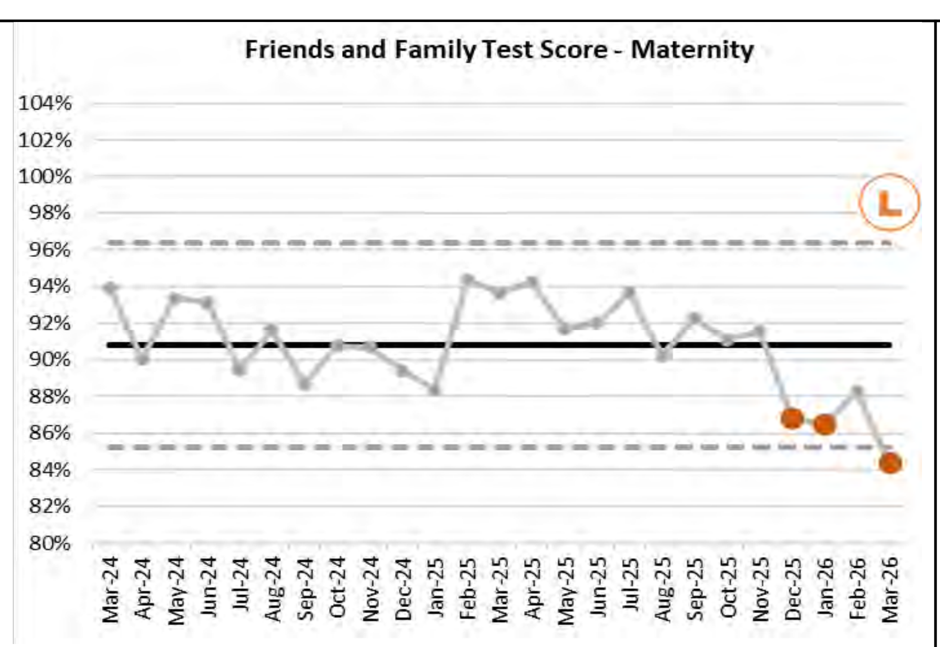
84.4%

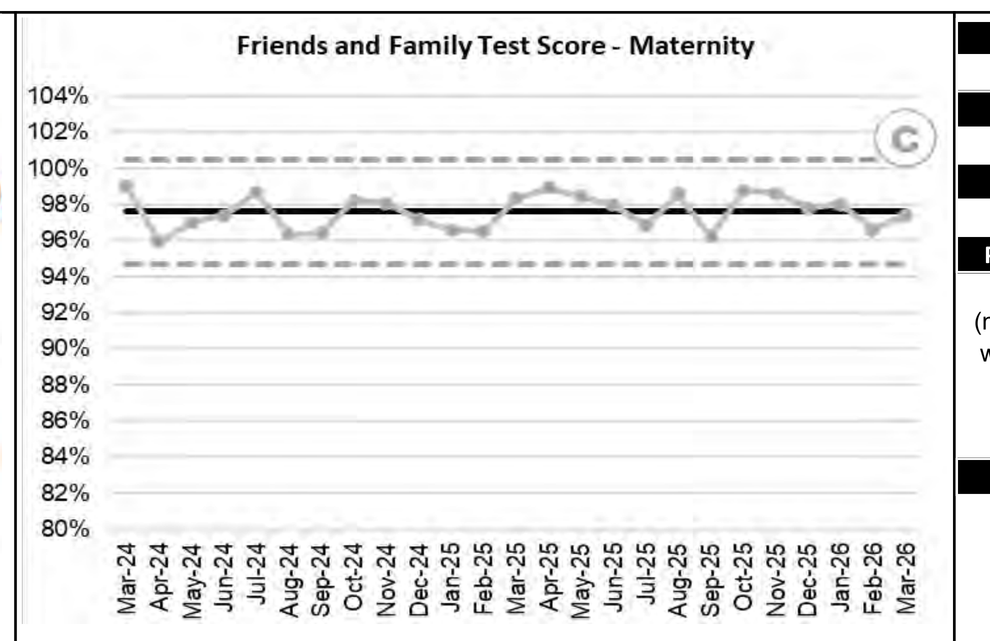
Performance / Assurance

Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit

Trust Level Risk

No Trust Level Risk





Latest Month

Mar-26

Target

No Target

Latest Month's Position

97.4%

Performance / Assurance

Common Cause (natural/expected) variation where up is improvement.

Corporate Risk

No Corporate Risk

What does the data tell us?

The Maternity FFT score (total % of patients rating their experience as 'Very good' or 'Good') has decreased from 88.2% in February to 84.4% in March. The top negative themes arising from comments are around 'Communication' followed by 'Staff'. Since November, positive FFT ratings have declined, initially within expected variation, with a recovery in February. However, the score has fallen further in March and is now outside the expected range of variation.

Actions being taken to improve

The WaCH Patient Experience Team continues to review their FFT data in conjunction with other feedback. This information and any actions are then presented at the Patient & Carer Experience Group. WaCH are currently working on several projects, including improvement work in postnatal, translation access cards for patients and equity in pain management.

Impact on forecast

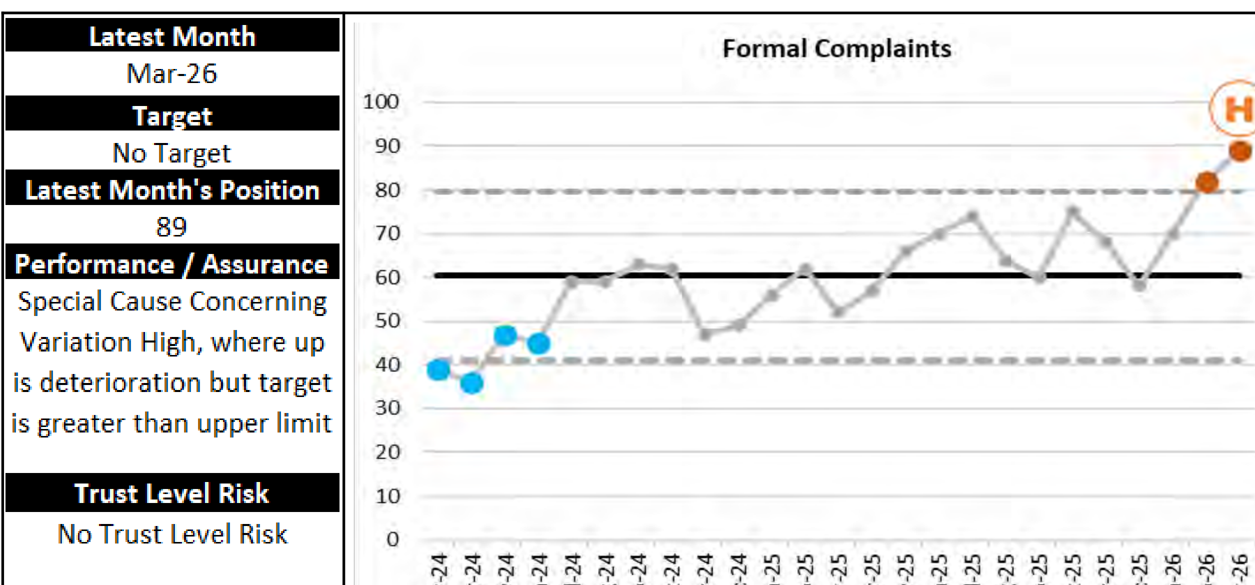
The Trust transitioned to a new FFT provider on 1 April 2026, aligning with UHBW. Maternity feedback now comprises of feedback from Antenatal, Birth, Postnatal Ward and Postnatal Community services. Antenatal feedback was not previously captured and is now included. As this introduces a new data source for Maternity, moving forward, overall results are difficult to predict, and it is likely there will be notable variation in future reporting.

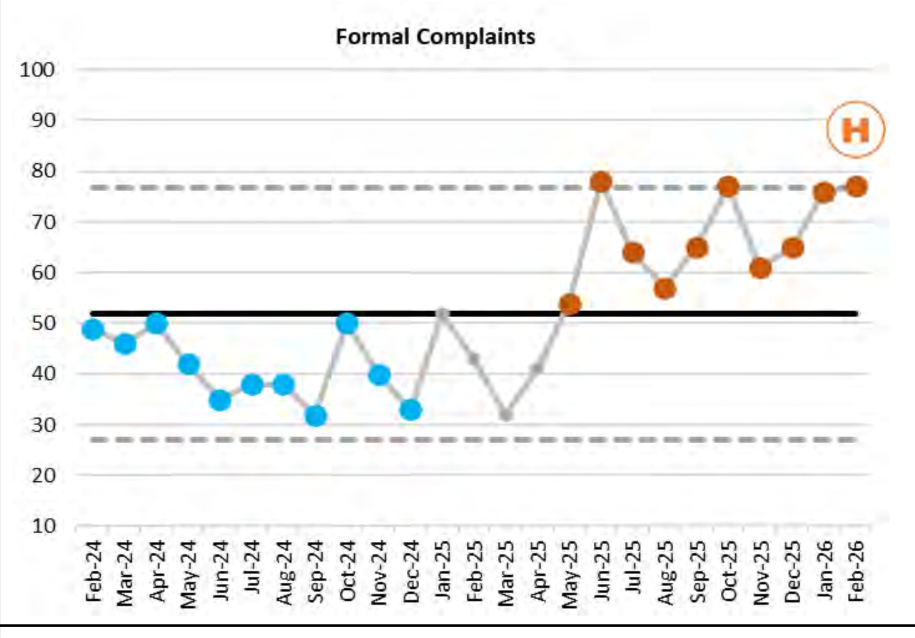
No narrative required as per business rules.

Quality

Complaints

Latest Month
Mar-26
Target
No Target
Latest Month's Position
89
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration but target is greater than upper limit
Trust Level Risk
No Trust Level Risk





Latest Month
Feb-26
Target
No Target
Latest Month's Position
77
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration.
Corporate Risk
No Corporate Risk

What does the data tell us?

- In March, the Trust received 89 complaints, which was seven more than the previous month, and 37 more compared to the previous year.
- Since April, we have received an average of 69 complaints per month.
- ASCR (23) received the most complaints, followed by MED (21) and WaCH (15).
- Clinical Care and Treatment was the most common lead theme of the complaints received, with 68% of the total.
- There is no change to the lead specialities receiving complaints, which are Emergency Medicine (10) and General Surgery and Gynaecology (8).

Actions being taken to improve

We continue to monitor and discuss any trends with the divisional patient experience teams.

Impact on forecast

It is difficult to predict the number of complaints received each month. This fluctuates largely based on patients' experience of the care and treatment they receive and often reflects the operational pressures faced by the Trust and changes in activity level. This is a trend that is being seen in Trusts across the region.

The number of PALS concerns received in March was also high (203), which is 39 more than the previous year.

What does the data tell us?

- In February the Trust received 77 complaints with Surgery, Medicine and Women & Children's remaining the highest-volume areas
- 15 complaints responded to in January were reopened, these were mostly in Women's and Children's
- 98% of all complaints actioned within 45 days with 255 cases closed in January

Actions being taken to improve

Continue to work with divisions to proactively extend complex complaints

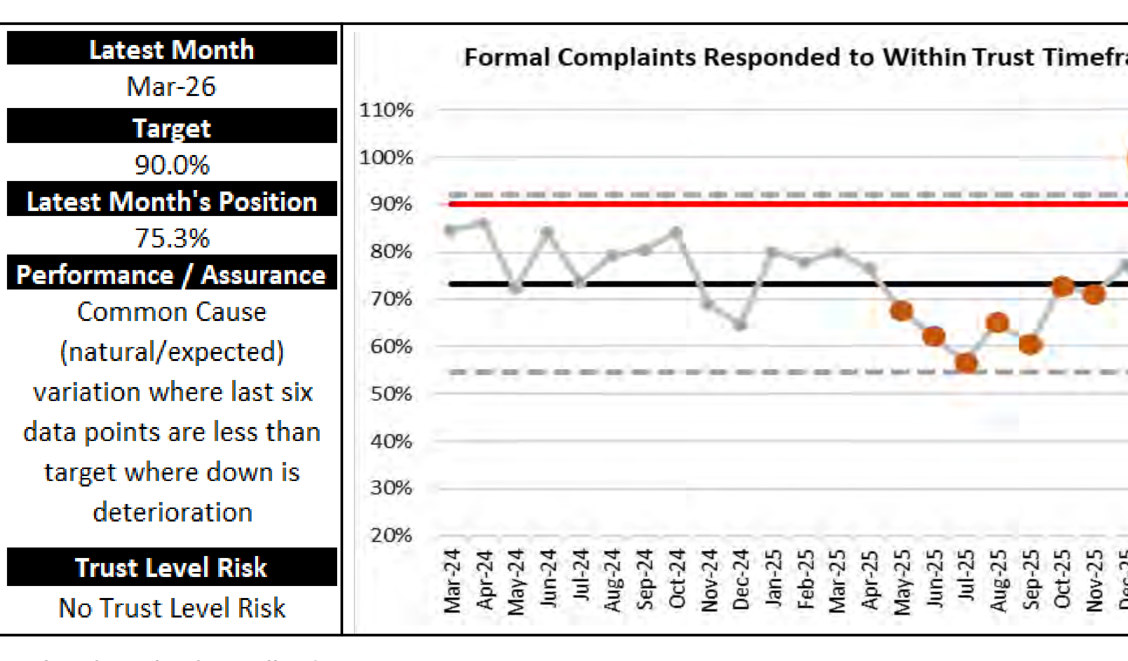
Prompt sending of complaints to divisions within 72 hours of complaint received, ensuring concerns are reviewed promptly by division

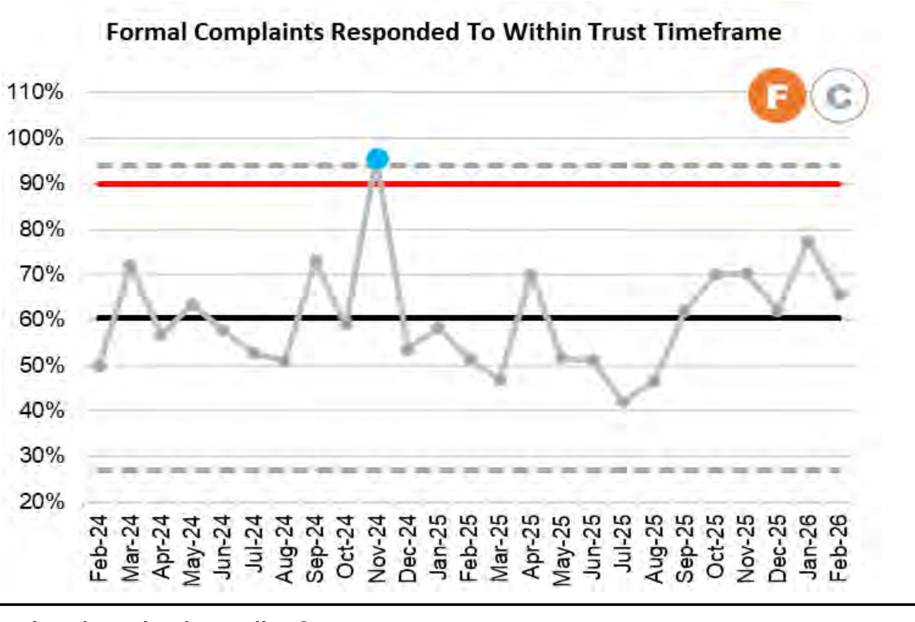
Impact on forecast

The large volume of complaints from the backlog are now under investigation or complete and therefore we will see the number of cases closed increase in the next couple months.

Quality
Complaints

Latest Month
Mar-26
Target
90.0%
Latest Month's Position
75.3%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration
Trust Level Risk
No Trust Level Risk





Latest Month
Feb-26
Target
90.0%
Latest Month's Position
65.7%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.
Corporate Risk
No Corporate Risk

What does the data tell us?

- The complaint compliance rate increased from 64% in February to 75% in March.
- This increase was due to an improvement in ASCR (56%) and strong performances in other divisions.
- Of the 89 complaints due for response in March, 67 were closed within the agreed timescale, 15 were outside the agreed timescale, and 7 were still open at the time of reporting.

Actions being taken to improve

- ASCR continues to embed their recovery plan to bring them in line with the compliance scores of the other clinical divisions.
- The Complaints & PALS Manager continues to hold weekly meetings with divisional patient experience teams to review upcoming/overdue cases, addressing complexities and agreeing appropriate resolutions, including proportionate extensions. A weekly tracker is shared with senior divisional leaders to escalate overdue complaints and support timely resolution.

Impact on forecast

The Trust score is still largely affected by ASCR performance due to the volume they receive. Further improvement from ASCR will likely result in a higher overall score for the Trust, providing the other divisions continue to sustain their performances.

What does the data tell us?

The compliance rate decreased from 77% in January 2026 to 66% in February 2026
The decrease is due to one Division having a gap in co-ordinator cover. In addition, two other Divisions had an increase in the number of complex complaints requiring extensive work. There was also a reduction in availability for Exec sign off

Actions being taken to improve

- Co-ordinator now in place; Exec sign off resources now in place
- Developing monthly Divisional SPC charts and a RAG rating of open complaints to align with NBT processes
- Review of complaint extensions complete, and monitoring process in place.
- Escalation policy for both PALS and Complaints team and divisional patient experience teams is being reviewed to enable improved responses.

Impact on forecast

A review of individual divisional compliance will allow focus on divisions to review case compliance to ensure that the divisions improves month to month.

Our People

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Well-Led	Workforce Turnover (Rolling 12-month)	NBT	Mar-26	9.4%	11.3%	9.4%	N/A*	N/A*	**No Commentary**
		UHBW	Mar-26	9.3%	11.1%	9.2%	N/A*	N/A*	**No Commentary**
Well-Led	Vacancy (Vacancy FTE as Percent of Funded FTE)	NBT	Mar-26	7.0%	5.1%	7.3%	F-	C	**Escalation Summary**
		UHBW	Mar-26	4.8%	4.0%	5.0%	F	C	**Escalation Summary**
Well-Led	Sickness (Rolling 12-month)	NBT	Mar-26	4.8%	4.4%	4.8%	N/A*	N/A*	**Commentary**
		UHBW	Mar-26	4.7%	4.5%	4.6%	N/A*	N/A*	**Commentary**
Well-Led	Essential Training Compliance	NBT	Mar-26	88.1%	90.0%	88.5%	F	L	**Escalation Summary**
		UHBW	Mar-26	89.8%	90.0%	89.7%	?	C	**Escalation Summary**

*Cannot generate Assurance and Variation icons as SPC not appproptiate for rolling data.

Our People

Retention

Latest Month
Mar-26
Target (Rolling 12-month)
11.3%
Turnover Rate
9.4%
Trust Level Risk
Risk 1979 - There is a risk to our clinical teams and services due to the inability to recruit into vacant specialist medical roles (16)

Workforce Turnover (Rolling 12-month)

Performance, Target; Mar-24 to Mar-26; 8% to 16%

Workforce Turnover (Rolling 12-Month)

Performance, Target; Mar-24 to Mar-26; 8% to 16%

Latest Month
Mar-26
Target (Rolling 12-month)
11.1%
Turnover Rate (Rolling 12-month)
9.3%
Corporate Risk
Risk 8383 - Risk that inability to recruit and retain specialist staff continues (16)

Metric meeting target.

Metric meeting target.

Our People

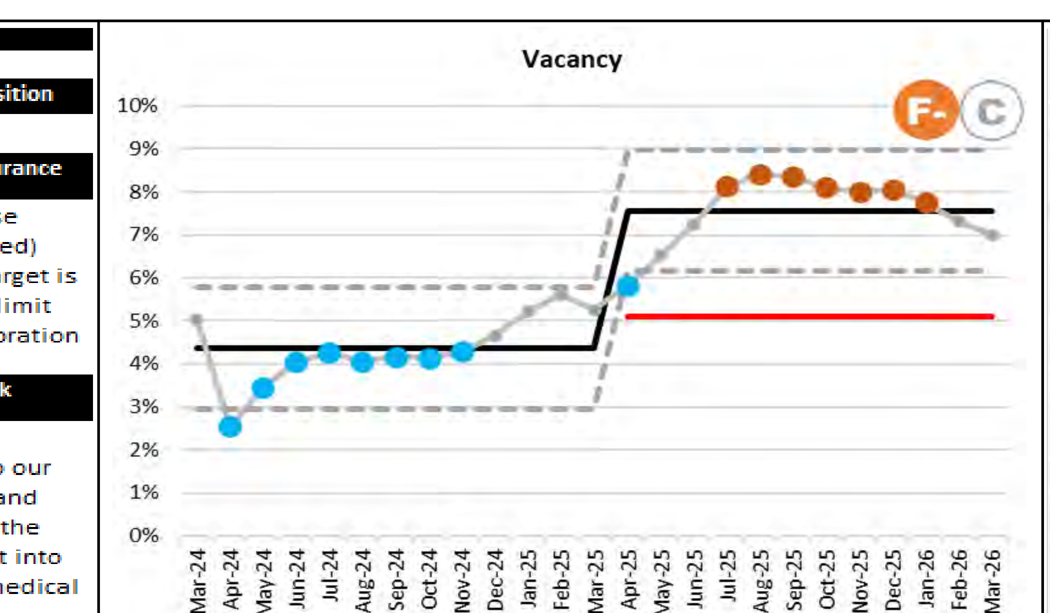
Vacancies

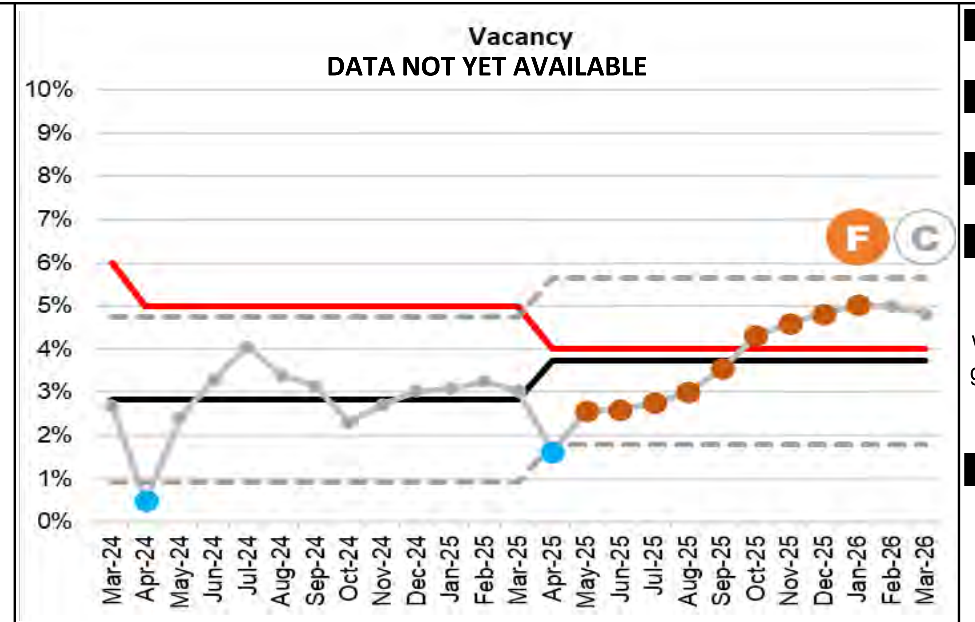
Latest Month
Mar-26

Latest Month's Position
7.0%

Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration

Trust Level Risk
Risk 1979 - There is a risk to our clinical teams and services due to the inability to recruit into vacant specialist medical roles (16)





Latest Month
Mar-26

Year End Target
4.0%

Latest Month's Position
4.8%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Corporate Risk
Risk 8383 - Risk that inability to recruit and retain specialist staff continues (16)

What does the data tell us?

Vacancies decreased by 33.1 fte in Mar-26. Overall staff in post increased by 33.3 fte; the largest staff group increase was seen in Medical and Dental and Nursing and Midwifery Registered at 8.9 fte and 8.7 fte respectively. Funded establishment saw no overall increase in Mar-26 compared to Feb-26.

Actions being taken to improve

- **HCSW Supply:** Trust wide and tailored Health Care Support Worker (HCSW) assessment centres continue on a monthly basis. **Mar-26 assessment centres** saw 19 candidates attend and 21 offers made
- **Youth Outreach:** Recruitment continue to work with the Kings Trust to supply candidates for entry level roles. Attendance at Careers fair planned for **Apr-26**
- **Consistent Recruitment :** Rolling recruitment planned through spring to address vacancy numbers. 29 offers for HCSW roles were made in **Mar-26**
- **Newly Qualifying nurses:** Adverts for NQ qualifying nurses to apply for roles in Sept-26 are live until **Apr 26**– Universities have been given links to Preceptorship roles. A programme of support sessions for application writing and Interview tips continue for students. Interviews planned for **May/June-26**

Impact on forecast

- Impact of enhanced assessment centres for Band 2/3 HCSW – 33.08 fte predicted to start in Clinical Divisions in **Apr/May-26 and 29.45** fte Band 5s in Nursing and Midwifery

What does the data tell us?

Vacancies reduced by 20.8 FTE in March. Overall staff in post increased by 31.2 FTE; the largest staff group increase was seen in Medical and Dental staff (22.4 FTE increase). Funded establishment increased by 10.4 FTE.

Actions being taken to improve

• Monitoring of the vacancy position through Divisional and SDR processes to avoid increased temporary staffing has identified a list of 15 posts as exempt from the Trust Management Team vacancy control process, so that once approved by Divisions they can progress to external recruitment immediately. These posts are either front line clinical or band 2 and 3 roles associated with cleaning, catering, Health Care or administration.

- **HCSW Supply:** Ad hoc adverts are live externally with eight offers being made in **Mar-26**
- **Youth outreach:** Recruitment work with the Kings Trust for entry level roles. Attendance at Careers fair **Apr-26**
- **Newly Qualifying nurses:** Adverts for NQ qualifying nurses for roles in Sept-26 are live until Apr 26– Universities have links to Preceptorship roles. Programme of application writing and interview tips continue for students. Interviews planned for May/June-26
- **Band 2 Admin and Clerical –** A Commitment to the Community Initiative, providing a waiting list of available candidates available to start an unpaid trial period immediately
- **Weston Nursing –** as part of the on-going control process for nurse vacancies a pilot rapid action review has been held with Weston nursing leads.

Impact on forecast

6 HCSW started in **Mar-26** with an additional 60 offers in the pipeline. 13 of which have start dates booked **Apr/May-26**

Our People

Sickness Absence

Latest Month
Mar-26
Latest Month's Position Rate (In-Month)
4.5%
Latest Month's Position Rate (Rolling 12-Month)
4.8%
Target
4.4%
Trust Level Risk
No Trust Level Risk

Sickness (In-Month)

Sickness (Rolling 12-month)

Performance — Target

Sickness (In-Month)

Sickness (Rolling 12-Month)

DATA NOT YET AVAILABLE

Performance — Target

Latest Month
Mar-26
Latest Month's Position Rate (In-Month)
4.8%
Latest Month's Position Rate (Rolling 12-Month)
4.7%
Target (Rolling 12-month)
4.5%
Corporate Risk
No Corporate Risk

What does the data tell us?

- Mar-26 absence rates in month were lower than Feb-26 (-0.3%) driven entirely by a seasonal reduction in short term absence. Mar-26 absence rates were also in line with Mar-25
- Long- term absence rates in month in Mar-26 remained at the same level as Feb-26 and are in line with the rate seen in Mar-25. Rolling 12-month absence rates for long-term sickness are higher in Mar-26 than in Mar-25 indicating the last 12 months has seen higher levels of long-term absence than the 12 months before

Actions being taken to improve

People Advice Team and Business Partnering

- Action plan in development to reduce reliance on 'other' category use for absence recording. Multiple drivers of current use and impact of different process improvements being assessed – **Apr 26**
- Review of CaseworkER recommended case benchmarks to enhance data quality undertaken and to be incorporated into new system standards following recent external audit outcome – **Apr 26**
- Proposed changes to return to work process to allow early identification and triangulation of absence causes and effective approaches for management to be included in new sickness absence policy to be introduced pre-merger – **May 26**
- Formation of a sickness absence management project, which will pull together the various workstreams focused on this **- Jul 26**

Impact on Forecast

- Expected reduction in proportion of absence recorded as 'Other' – enables more effective management of sickness by the identification of types of absence and hotspot areas through improved data quality.
- Improved and amended CaseworkER benchmarks will mean more effective oversight and management of cases, resulting in improved levels of sickness absence. The impact of having shortened long-term episodes may be noted due to fewer episodes being seen.

What does the data tell us?

- Top three contributors for March were unchanged Anxiety/Stress/Depression/Other Psychiatric Illness, Other Musculoskeletal and Cold, Cough, Flu. They accounted for 28.6%, 10.9% and 7.4% of total FTE days lost respectively.
- Sickness rates continue to be highest in Facilities and Estates, but rate have reduced slightly compared with February (reduced to 8.7% from 8.8%). The only divisional increase was seen in Weston General Hospital, increasing by 0.1 percentage points to 6.2%.
- Estates and Ancillary remains as the staff group with the highest sickness rate, however the largest increase compared with February was seen in Healthcare Scientists, where sickness increased from 3.6% to 3.9%.

Actions being taken to improve

- Sickness Project, includes Manager clinics to support 'hotspot' sickness areas and review return to work process and streamlined form. This has been piloted in E&F and is now being rolled out trust wide.
- Collaboration with Health Roster team to allow increased absence reporting from People Services team to ensure all sickness cases captured on Assure and that managers are supported effectively
- Working group reviewing support around reasonable adjustments, (FAQs and Bitesize videos) – **Mar 26**
- **Joint absence management policy being developed for Jul 2026** Formation of a sickness absence management project, which will pull together the various workstreams currently focused on this **- Jul 26**

Impact on Forecast

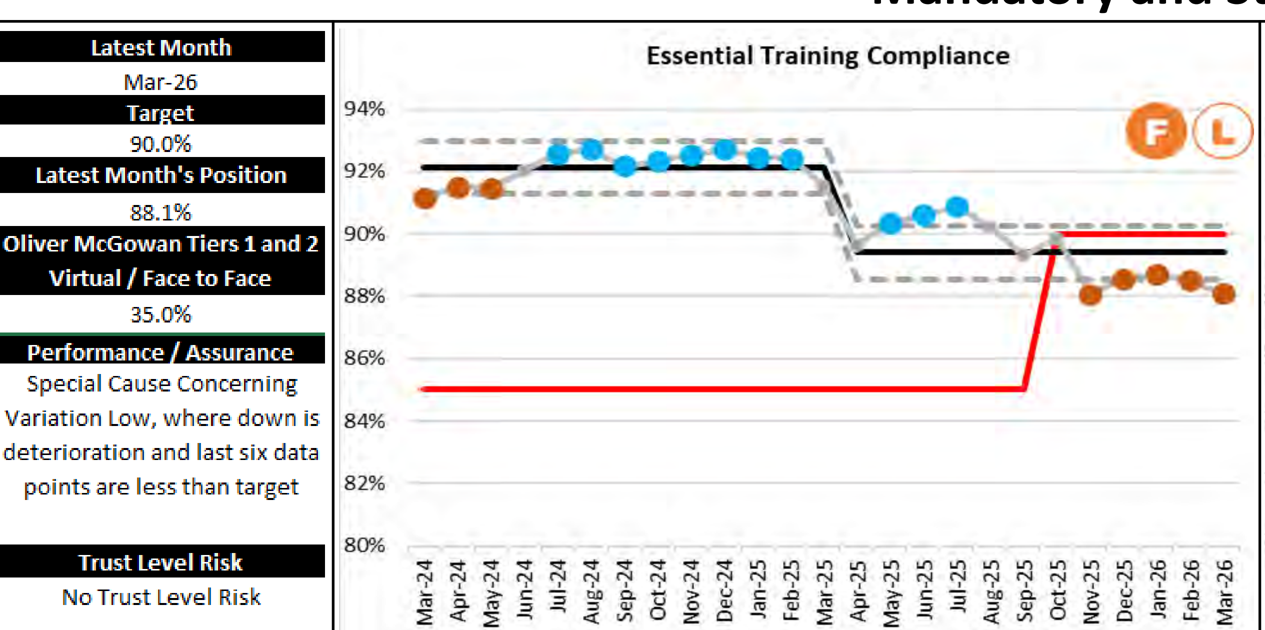
- Additional training for managers to allow for early supportive interventions to prevent work related long term absences to ensure adjustments put in place to allow return to works at earlier stages.

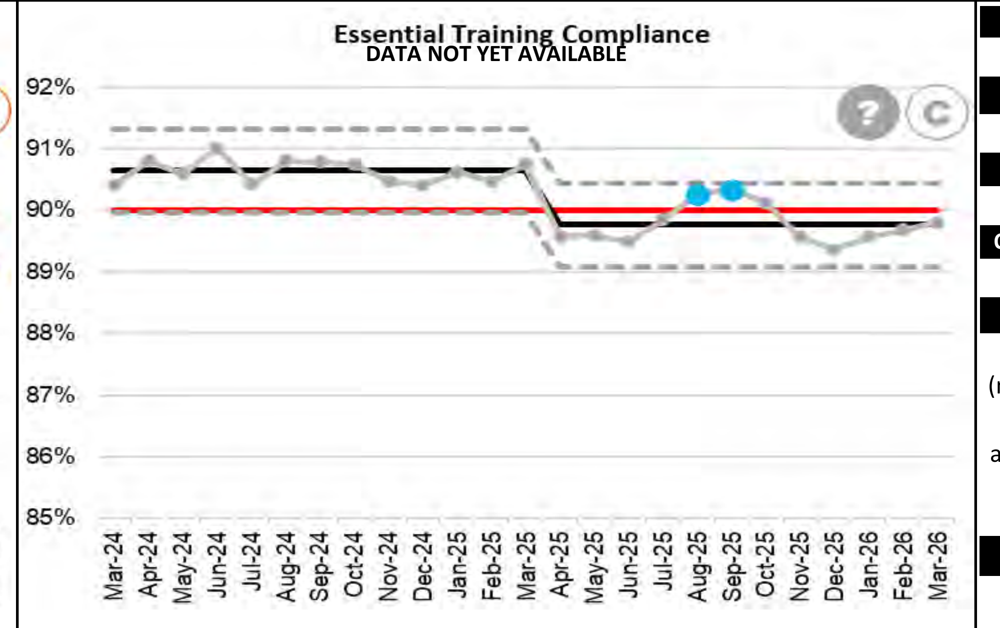
North Bristol
NHS Trust

Our People

NHS
University Hospitals
Bristol and Weston
NHS Foundation Trust

Latest Month
Mar-26
Target
90.0%
Latest Month's Position
88.1%
Oliver McGowan Tiers 1 and 2 Virtual / Face to Face
35.0%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and last six data points are less than target
Trust Level Risk
No Trust Level Risk





Latest Month
Mar-26
Target
90.0%
Latest Month's Position
89.8%
Oliver McGowan Tiers 1 and 2
47.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
No Corporate Risk

What does the data tell us? Compliance is below target, however IPC (87.4%) and Information Governance (82.7%) and Oliver McGowan (OMMT) Level 1 elearning (89.5%) remain below individual target rates.

Actions Being Taken to Improve

- **IPC:** national changes to the target audience are being updated. IPC has since improved and is now above target.
- **IG:** the SME actively monitors divisional data to identify targeted opportunities for improvement, working with divisions to improve compliance.
- **OMMT:** As per UHBW notes, compliance for tier 1 improved 1.1% to 39.5% and tier 2 compliance increased by 1.7% to 37.7%, however remaining significantly below target. 'Out-of-core' hours Tier 1 webinar sessions for estates and facilities staff have delivered notable improvements to compliance and further sessions may be planned across the new financial year. Since implement tier 1 out-of-hours sessions in December 2025, 299 staff have attended 15 sessions by March 2026. Representing a 32% improvement in compliance over the time period. Building upon the paper shared with GEM, compliance trajectories are being drafted and divisional targets developed for tiers 1 and 2 training.

Impact on forecast

- **IPC:** continued impact upon compliance is reviewed within the Infection Control Assurance Group to maintain the improvement**.**
- **IG:** maintaining on-going SME engagement remains a key focus to drive compliance**.**
- **OMMT:** Notable positive impact upon tier 1 compliance from the out-of-hours sessions and improved scrutiny of compliance through the trajectory data. In conjunction with the ICB continue to monitor and report upon DNA rates for Tier 2 provision.

What does the data tell us? Compliance is marginally below the target overall, being driven by specific areas, most notably for: Infection Prevention and Control (IPC) at 89.8%, Information Governance (IG) at 88.0%, Moving & Handling at 81.1%, Resuscitation at 75.9% and Oliver McGowan (OMMT) level 1 (eLearning) rate at 86.0%.

Actions Being Taken to Improve

- **IPC:** new resource designed to input into corporate induction to reinforce core requirements and therefore compliance. Training content and audiences being updated in line with new national guidance.
- **IG:** The roll-out of the eLearning module continues to be promoted to all staff to improve compliance.
- **OMMT:** Reporting as per NBT. The introduction of a new 'out of core' hours webinar has driven improvements amongst Estates and Facilities colleagues, with tier 1 compliance rising 7.9% to 44.4%; further sessions may be delivered across the new financial year. Tier 2 compliance rose by 0.2% to 49.4% with strong compliance within Weston at 69.0%.
- **Moving & Handling:** Improvements to the new delivery model continue to positively impact upon compliance which maintained an in-month improvement of 0.9% to 81.1%.
- **Resuscitation:** Continued in-month improvement in compliance of 0.6% to 75.9% which is positively impacted by the implementation of the self-service recording of compliance.

Impact on forecast

- **Moving & Handling:** Level 2 and thus overall compliance anticipated to continue to increase over coming months.
- **IG, IPC and Resuscitation:** Ongoing curriculum developments continues to positively impact compliance.
- **OMMT:** Notable positive impact upon tier 1 compliance from the out-of-hours sessions and improved scrutiny of divisional compliance through the trajectory data

Income & Expenditure

Actual Vs Plan (YTD)

Latest Month

Mar-26

Year to Date Plan

Break-even

Year to Date Actual

£4.9m surplus

YTD Plan vs Actuals

YTD Surplus/(Deficit) £m

Financial Year 2025-26

Plan

YTD actuals

YTD Plan vs Actuals

YTD Surplus/Deficit (£m)

Plan

YTD actuals

Latest Month

Mar-26

Year to Date Plan

Break-even

Year to Date Actual

£5.0m surplus

Summary

Summary:

- The financial plan for 2025/26 in Month 12 was a surplus of £0.9m. The Trust has delivered a £5.8m surplus and on plan. The 2025/26 year end position is a £4.9m surplus, which is £4.9m favourable to plan.
- In Month 12, the Trust received income from NHS England - £15m for recognised in-year pressure funding and £4.9m of deficit support funding due to forecasting a breakeven position which contributed to a favourable position. Offsetting this was additional one-off costs of £11.6m due to the year end review of provisions as well as a movement in bad debt and the annual leave accrual.
- The Trust continues to have higher than planned levels of No Criteria To Reside (NCTR) and high acuity driving pressures on escalation and enhanced care costs. This has led to overspends on nursing of £0.7m in month. This is offset by vacancies of £0.3m on Consultants and AfC staff.
- Elective Recovery Performance in month is driving a favourable position of £5.7m as funding was not clawed back from commissioners as expected in previous months as well as overperformance against associates. This is offset by overspends on medical and surgical consumables in NMSK and ASCR of £1.2m driven by activity.
- Other variances in month are driving an adverse variance including £0.6m MARS costs, £2.7m non pay costs (predominantly driven by CCS) and other smaller variances of £1.4m.
- In month, the Trust under-delivered against the recurrent Month 12 savings target by £3.6m driving a £2.8m adverse variance in month.
- The full year recurrent savings delivery is £20.3m and non-recurrent of £2.9m against a plan of £40.6m.

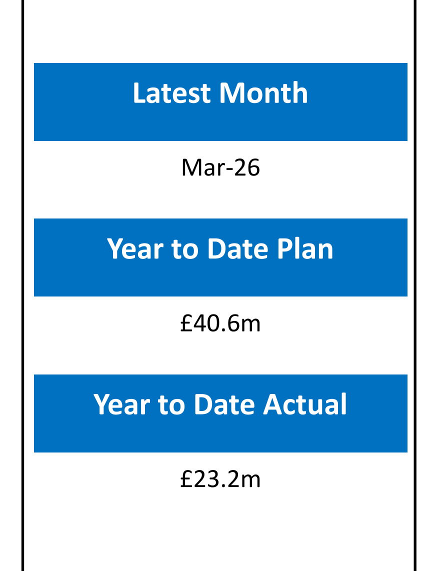
Summary

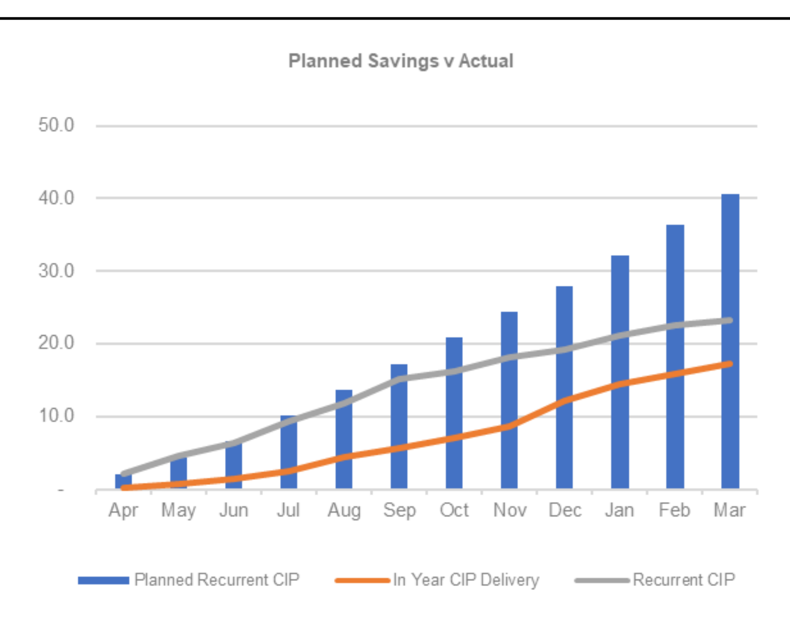
Summary:

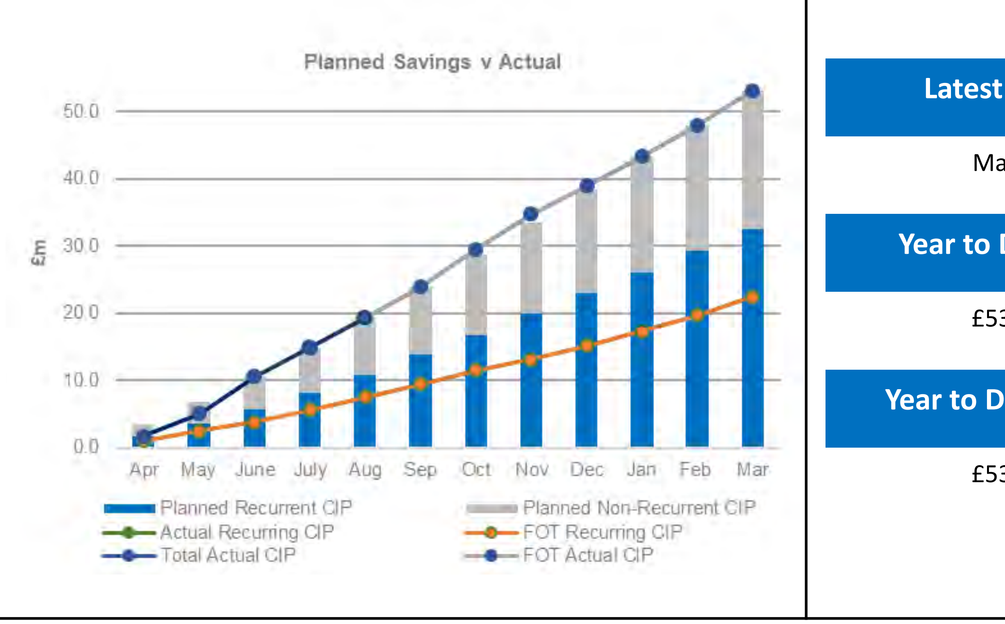
- The position at the end of March is a net surplus of £5.0m against a plan of breakeven. The Trust therefore ended the year £5.0m better than planned.
- Significant variances against plan are higher than planned pay expenditure (£28.0m) and increased non-pay costs (£68.2m, including a £13.9m net impairment). Excluding the impairment, the pay and non-pay operating expenditure variances are offset by higher than planned operating income (£84.4m).
- Total staff in post (substantive, bank and agency) has reduced since March 2025. Staffing levels in month exceeded funded establishment, following the trend seen for the majority of the year, with nursing and medical budgets driving the adverse pay position due to the additional use of registered mental health nurses, staffing of bed escalation areas linked to NCTR and increasing numbers of less than full time Resident Doctors.
- Agency and bank expenditure was higher in month compared with February and overall ends the year £5.4m higher than planned. Agency expenditure for the year is 13% lower than plan with expenditure in month of £0.6m, in line with February. Bank expenditure for the year is 13% higher than plan mainly due to the cost of industrial action and escalation linked to NCTR, with expenditure in month of £5.2m, £0.3m higher than February.
- The average number of NCTR patients in March is 212, significantly above the system trajectory of 103. This equates to 25% of the Trust's bed base being occupied by NCTR patients.

CIP

Actual Vs Plan (YTD)







Latest Month

Mar-26

Year to Date Plan

£53.1m

Year to Date Actual

£53.1m

Summary

Summary

- The CIP plan for 2025/26 is for savings of £40.6m with £23.2m delivered at year end, of which £2.9m is non-recurrent. This is £17.4m less than the savings required.
- The CIP delivery is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2025/26 impact and the recurrent full year impact. This can be seen on the orange line on the graph above.

Summary

Summary

- The Trust's 2025/26 recurrent savings plan is £53.0m.
- The Divisional plans represent 70% or £37.1m of the Trust plans. 30% or £15.9m sits centrally with the corporate finance team.
- As at the end of March 2026, the Trust is reporting total savings delivery of £53.1m, achieving the 2025/26 plan in full. The outturn is marginally higher than the forecast position of £52.8m.
- On a recurrent basis, the full year effect outturn is £29.1m. This leaves a recurrent shortfall of £23.9m that is carried forward and included in the 6% requirement for delivery in 2026/27.

Workforce

Pay Costs Vs Plan Run Rate

Latest Month

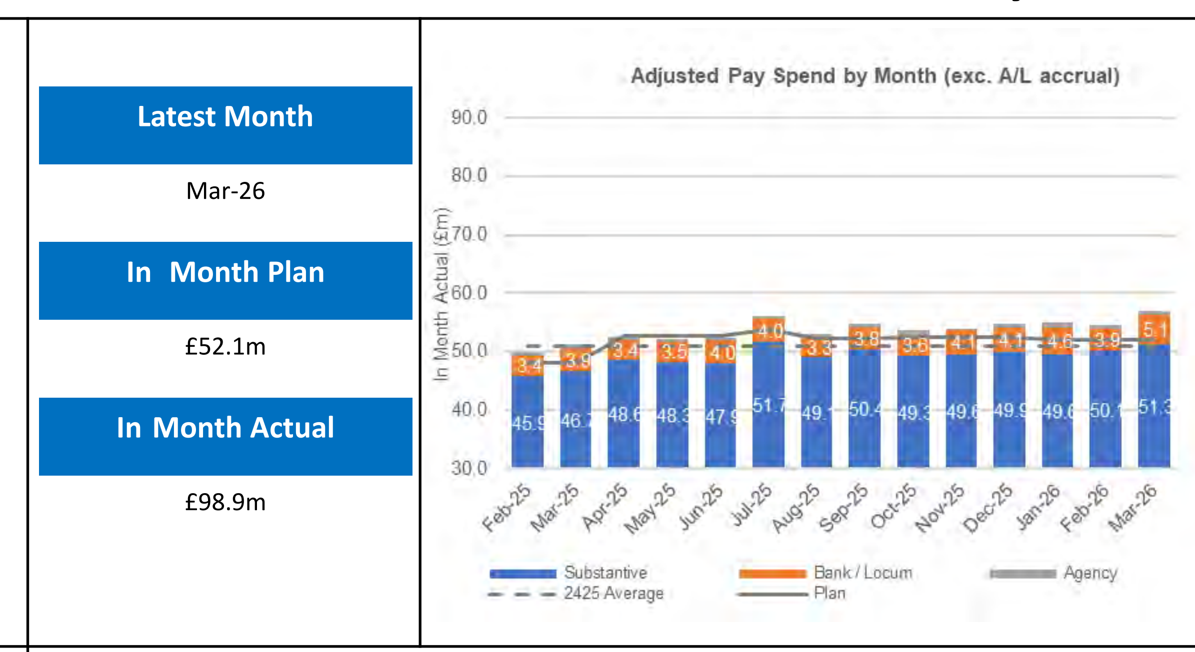
Mar-26

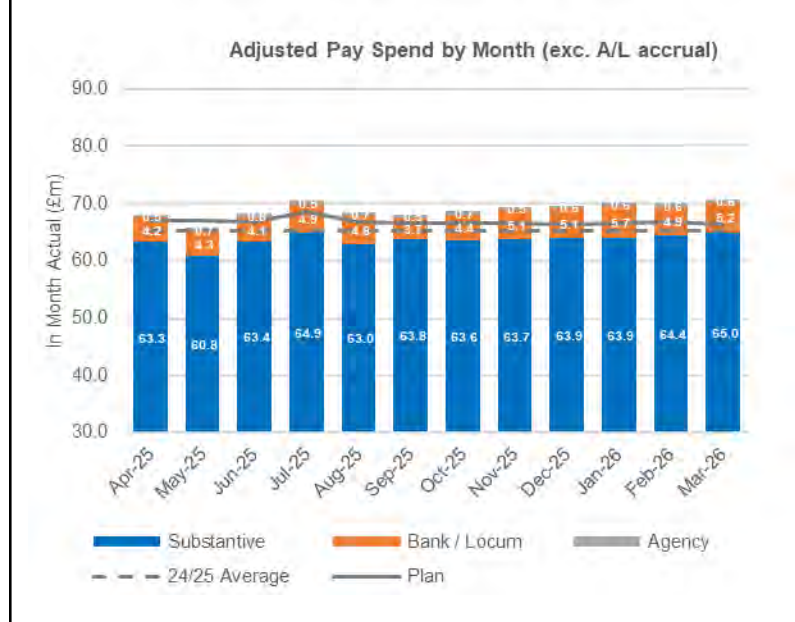
In Month Plan

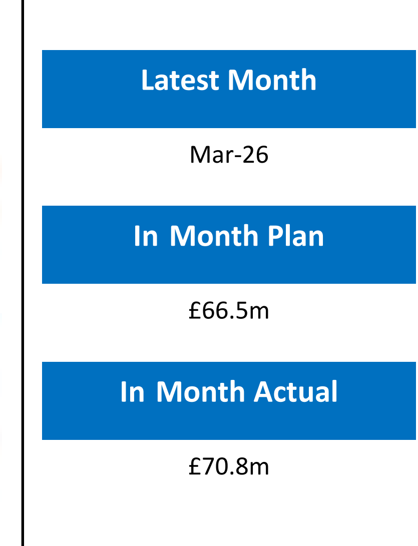
£52.1m

In Month Actual

£98.9m







Summary

Summary

- Pay spend is £46.7m adverse in month, when adjusted for pass through items, the revised position is £4.8m adverse to plan. The main drivers are:
  - In year CIP - £1.3m adverse, in month impact of recurrent CIP delivery.
  - Escalation and enhanced care - £0.7m adverse in nursing driven by hospital pressures.
  - Vacancies - £0.3m favourable due to consultant vacancies in Anaesthetics and Imaging and other clinical/admin vacancies across all divisions.
  - Annual leave accrual - £1.6m adverse
  - MARS costs - £0.6m adverse
  - Agency VAT on healthcare scientists- £0.5m adverse
  - There are other variances of £0.4m relating to smaller overspends in the divisions.

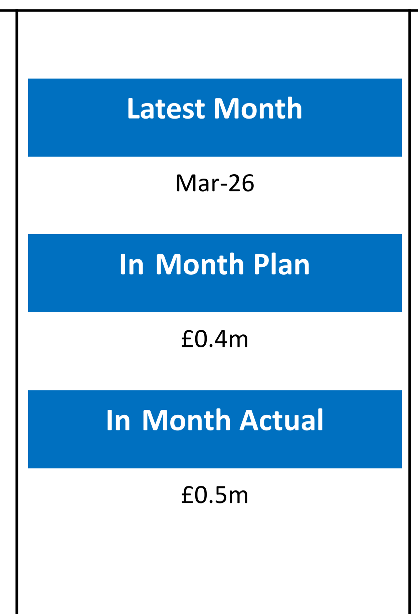
Summary

Summary

- Total pay expenditure in March is £70.8m, £4.3m higher than plan due to higher than planned substantive and bank costs.
- Pay costs for the year were higher than planned driven by the cost of nursing and medical staffing levels exceeding planned values. Overall levels of substantive and temporary staffing combined exceed the Trust's funded establishment by an average of 115WTE since April.
- Total nursing staffing levels exceed the funded establishment by 187WTE in March. Contributing factors to the ongoing over-establishment are the use of escalation capacity, high levels of acuity requiring additional mental health input and staff absence.

Temporary Staffing

Agency Costs Vs Plan Run Rate



Latest Month

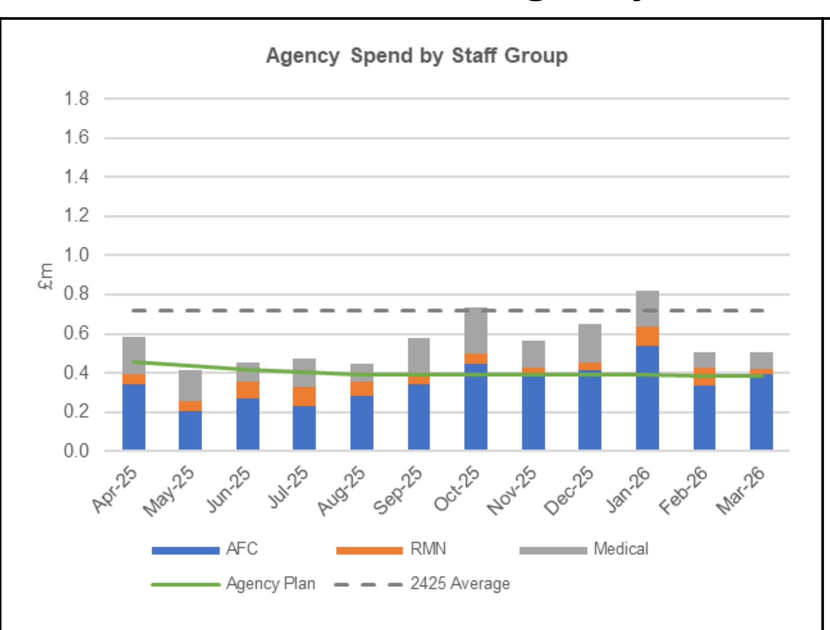
Mar-26

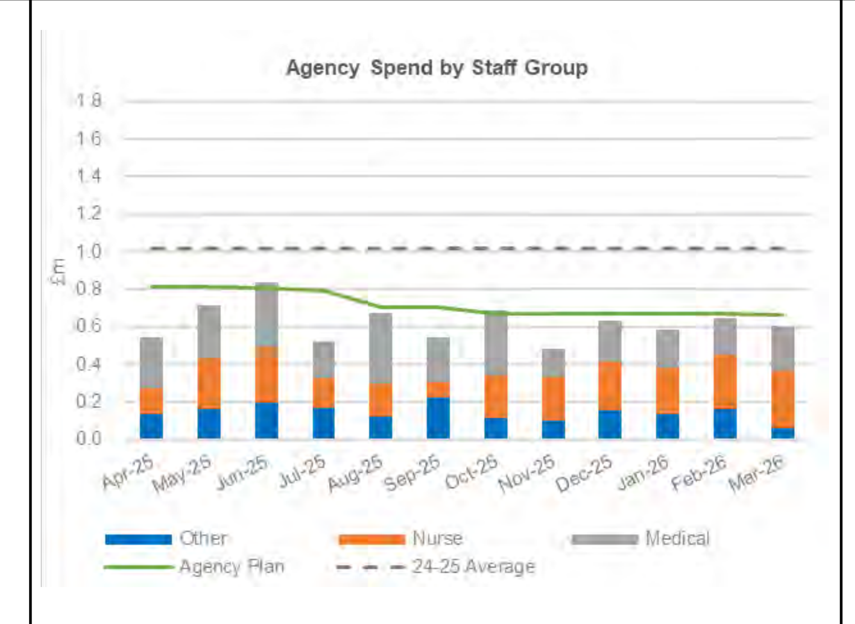
In Month Plan

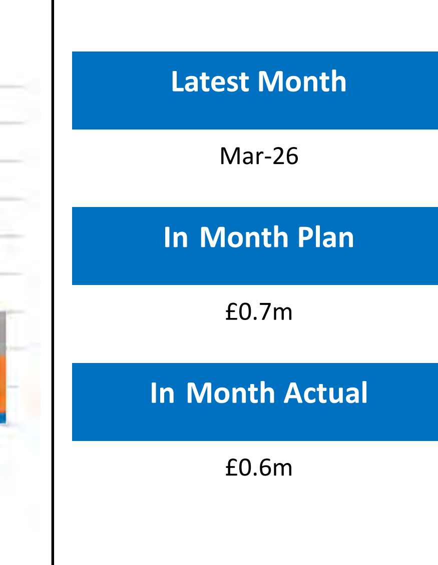
£0.4m

In Month Actual

£0.5m







Latest Month

Mar-26

In Month Plan

£0.7m

In Month Actual

£0.6m

Summary

Summary

Monthly Trend

- Agency spend in March has remained consistent compared to February.
- Overall spend in month is driven by consultant agency usage in Medicine and ASCR covering vacancies, nursing agency usage in ICU, ED and Gastroenterology wards driven by escalation (ED) and acuity (ICU and Gastro).

In Month vs Prior Year

- Trustwide agency spend in March is below 2024/25 average spend. This is due to increased controls being implemented across divisions from November last year, and their continued impact.

Summary

Summary

Monthly Trend

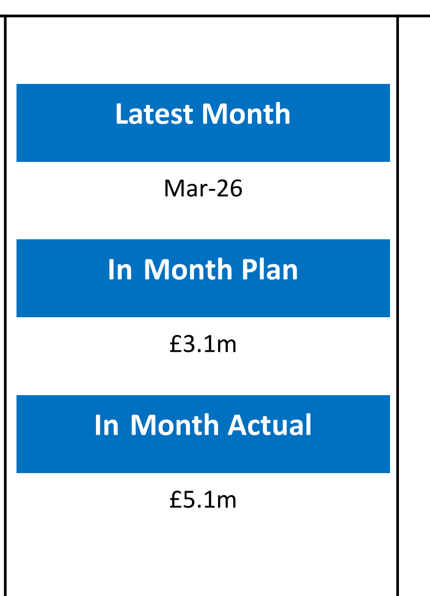
- Agency expenditure in March is £0.6m, £0.1m below plan and consistent with February's agency expenditure. Agency expenditure finished the year 13% below plan.
- Agency usage continues to be largely driven by additional escalation bed capacity across nursing and medical staffing due to a deterioration in the NCTR. The use of registered mental health nurses is also a key driver.
- Nurse agency shifts increased by 130 or 16% in March compared with February.
- Medical agency expenditure is marginally higher than the previous month. The number of shifts covered has decreased from 188 in February to 180 in March.

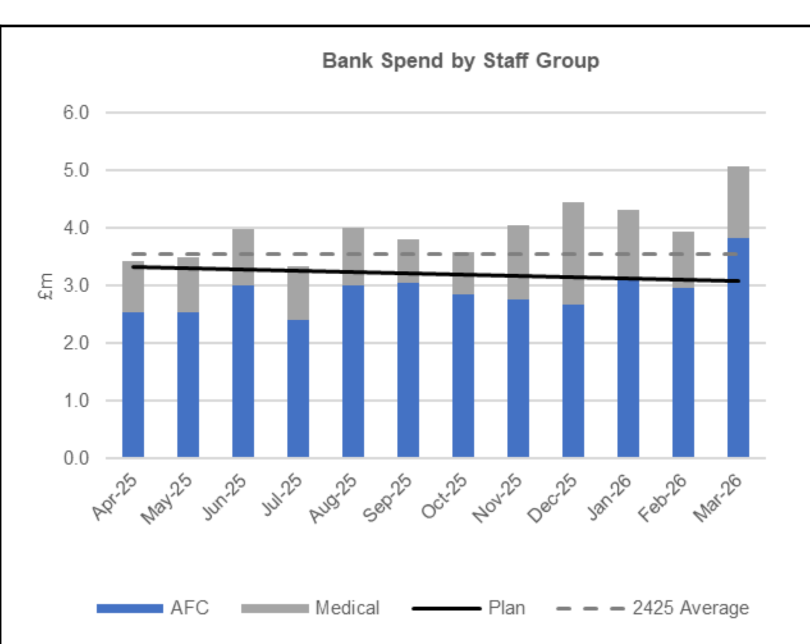
In Month vs Prior Year

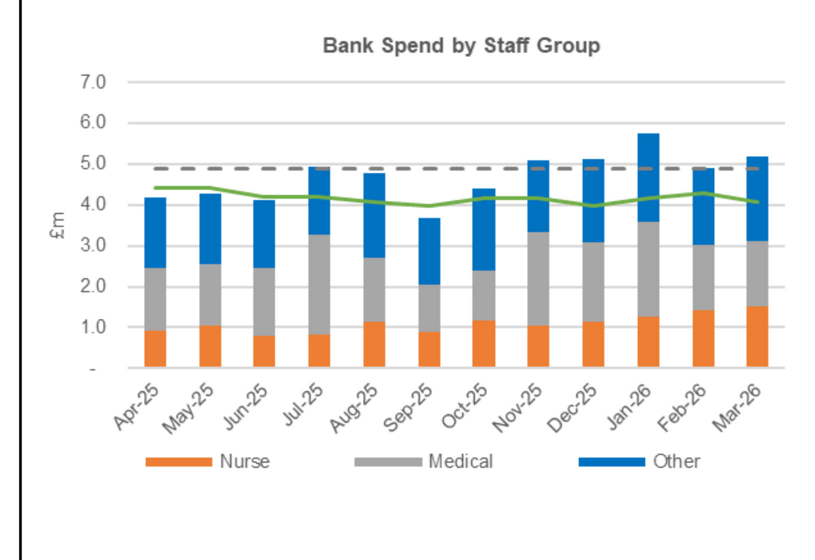
- Trustwide agency spend in March is £0.3m or c33% lower than March 2025. This is due to increased controls and scrutiny implemented across Divisions with the support Trust's Nurse and Medical leadership.

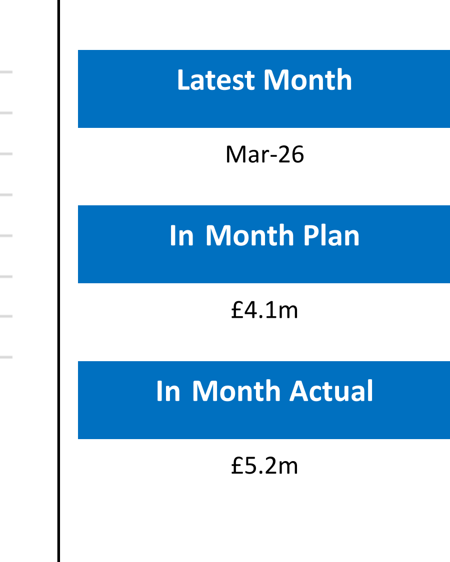
Temporary Staffing

Bank Costs Vs Plan Run Rate









Summary

Summary

Monthly Trend

- In March, there has been an increase in bank spend compared to February. The increase is due to increased annual leave taken in March due to the end of the annual leave year.

In Month vs Prior Year

- Bank spend in month is above the average 2024/25 spend, however 2024/25 spend reduced significantly in the second half of the year due to additional controls put in place. Compared to last year, the costs will have increased on run rate due to the National Insurance increases brought in from April.

Summary

Summary

Monthly Trend

- Bank costs in March are £5.2m, £0.3m higher than February. Full year costs are £6.5m higher than plan, due mainly to costs associated with operating escalation capacity due to NCTR and Industrial Action. Of the £5.2m spent in March, £1.6m relates to medical bank and £1.5m to registered nurse bank.
- Nurse bank expenditure increased by £0.1m in March from £1.4m in February, whilst shifts increased by 130 or 16%.
- Medical bank was consistent with February at £1.6m.

In Month vs Prior year

- Bank expenditure in March is £0.1m lower than the same period last year.

Capital

Actual Vs Plan

Latest Month

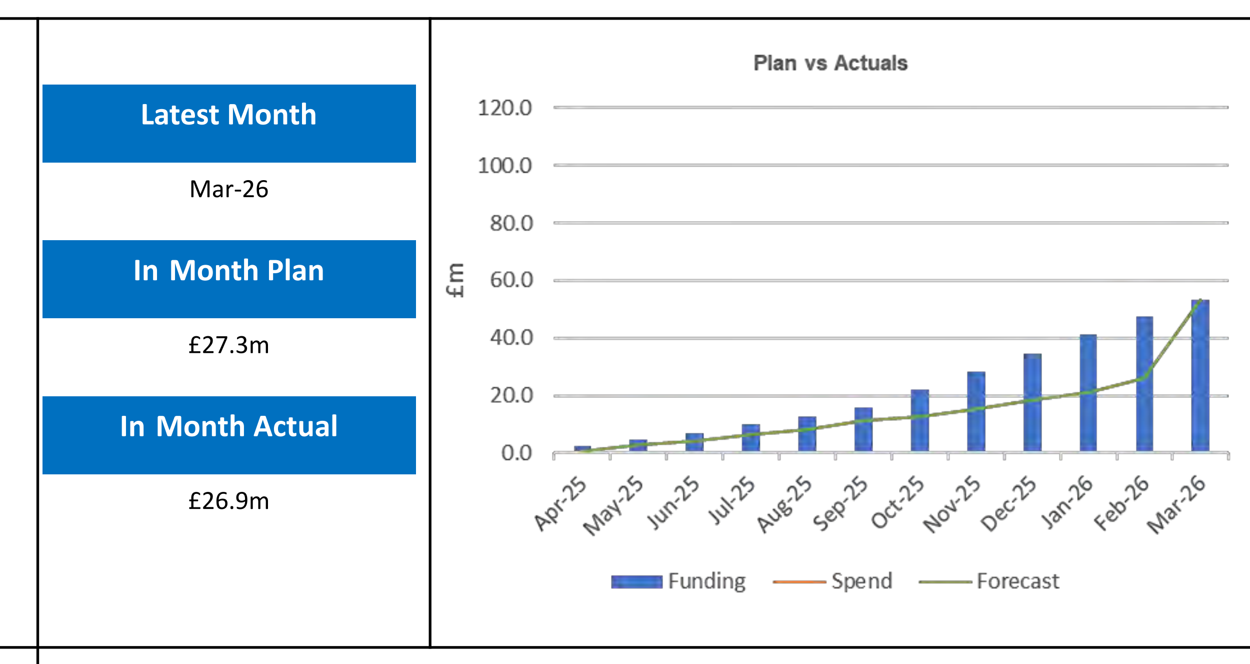
Mar-26

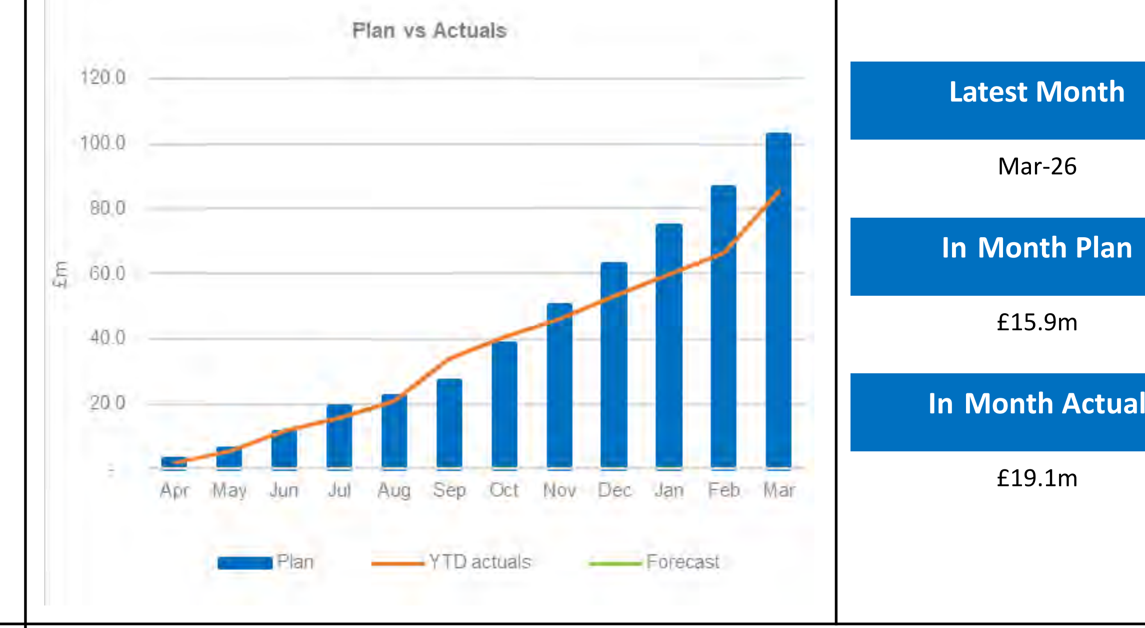
In Month Plan

£27.3m

In Month Actual

£26.9m





Latest Month

Mar-26

In Month Plan

£15.9m

In Month Actual

£19.1m

Summary

Summary

- Overall spend in 2025/26 was £53.4m. £7.8m is against the Bristol Surgical Centre.
- A further £19.3m of projects have been taken forwards as a result of national funding.
- Overall spend on the Bristol Surgical Centre to date is £49.9m, of which £38.3m relates to the main construction contract.
- The Trust has received approval for a £3.8m Salix grant to be spent on decarbonisation work. This funding will be received throughout the year to match spend
- As forecast, the Trust delivered the capital programme in line with the notified CDEL.

Summary

Summary

- Following NHSE confirmation of capital funding allocations of £55.2m, the Trust submitted a revised 2025/26 capital plan to NHSE on 30th April 2025 totalling £102.7m. The sources of funding include:
  - -£40.5m CDEL allocations from the BNSSG ICS capital envelope;
  - -£55.2m PDC matched with CDEL from NHSE including centrally allocated schemes;
  - -£5.5m Right of use assets (leases); and
  - -£1.5m for donated asset purchases.
- Expenditure at the end of March is £85.7m, £17.1m behind the full year plan of £102.7m. The variance is as a result of agreement with NHSE to re-profile national funding into future years.
- Significant variances to plan include slippage on Major Capital Schemes (£29.4m) and Estates Schemes (£22.1m), offset by over-delivery against medical equipment (£14.3m), digital services (£13.2m), fire improvement (£3.8m) and right of use assets (IFRS16).
- As forecast, the Trust delivered the capital programme in line with the notified CDEL.

Cash

Actual Vs Plan

Latest Month

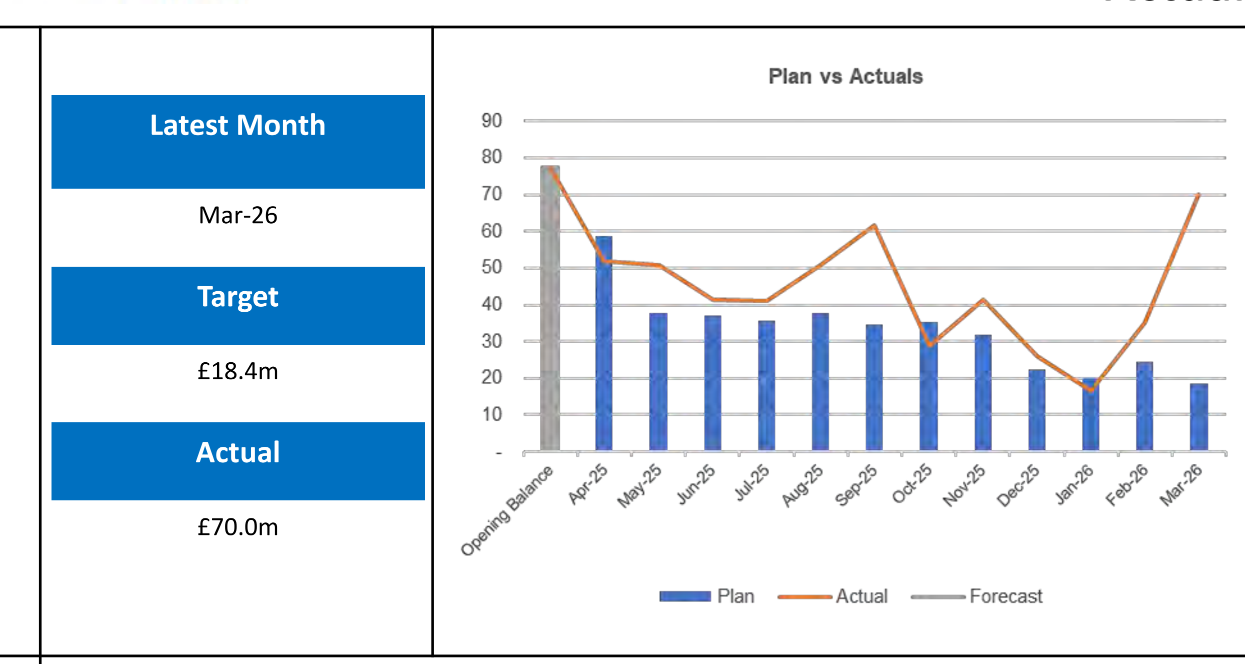
Mar-26

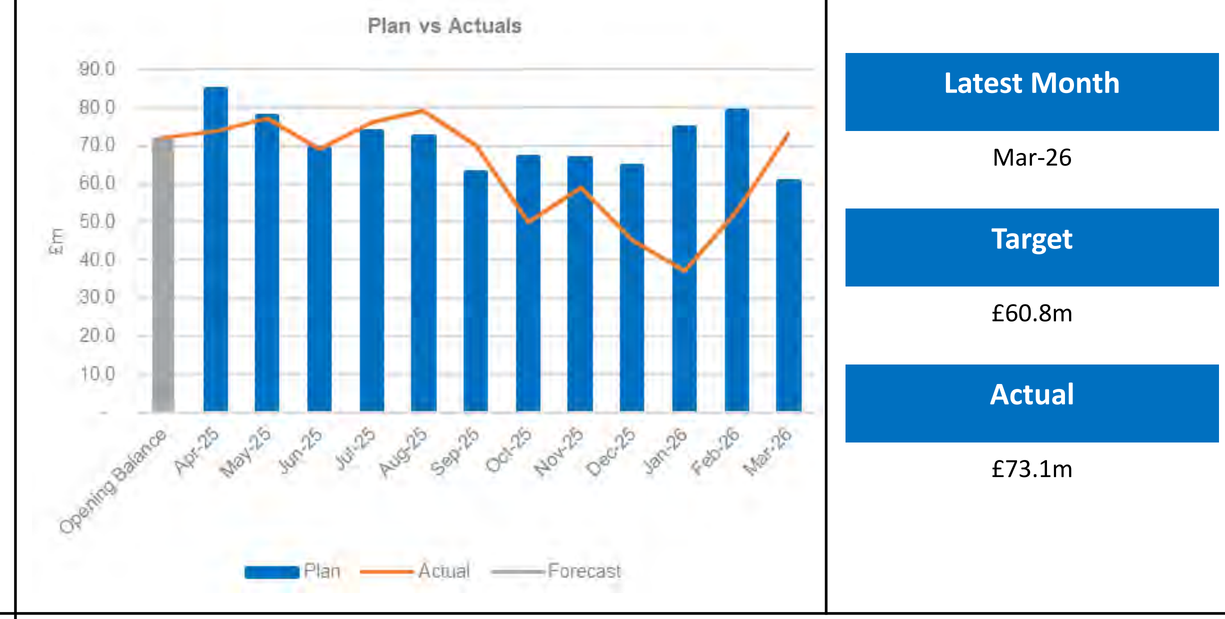
Target

£18.4m

Actual

£70.0m





Latest Month

Mar-26

Target

£60.8m

Actual

£73.1m

Summary

Summary

- In month cash is £70.0m, which is a £34.9m increase from February driven by movements in payables due to large maintenance contracts awaiting payment, additional contract income and additional PDC income received in month relating to capital projects where, due to invoice timings, cash will not be utilised until Q1 2026/27.
- The cash balance has decreased by £7.4m year to date, driven by capital expenditure, payment of invoices relating to 2024/25 and the underlying differences between PFI cash payments.

Summary

Summary

- The closing cash balance of £73.1m is an increase of £20.0m from February and is £12.3m above the plan for 2025/26.
- The £0.8m increase from 31st March 2025 is due to a net cash inflow from operations of £65.4m, offset by cash outflow of £70.4m relating to investing activities (i.e. capital), and net cash inflow of £5.8m on financing activities (i.e. loans, leases & PDC).
- The Trust's total cash receipts in March were £152.4m to cover payroll payments of £68.2m, supplier payments of £58.8m, PDC dividend of £5.3m and loan repayment of £0.1m.

Assurance and Variation Icons – Detailed Description

VARIATION ICON	ASSURANCE ICON	P*	P	?	F	F-	No icon
		Consistently Passing target (target outside control limits)	Passing target	Passing and Falling short of target subject to random variation	Falling short of target	Consistently Falling short of target (target outside control limits)	No Target
H	Special Cause Improving Variation High, where up is improvement	Special Cause Improving Variation High, where up is improvement and target is less than lower limit.	Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.	Special Cause Improving Variation High (where up is improvement) and last six data points are hitting and missing target, subject to random variation.	Special Cause Improving Variation High, where up is improvement but last six data points are less than target.	Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.	Special Cause Improving Variation High, where up is improvement and there is no target.
L	Special Cause Improving Variation Low, where down is improvement	Special Cause Improving Variation Low , where down is improvement and target is greater than upper limit.	Special Cause Improving Variation Low, where down is improvement and last six data points are less than target.	Special Cause Improving Variation Low (where down is improvement) and last six data points are both hitting and missing target, subject to random variation.	Special Cause Improving Variation Low, where down is improvement but last six data points are greater than or equal to target.	Special Cause Improving Variation Low , where down is improvement but target is less than lower limit.	Special Cause Improving Variation Low, where down is improvement and there is no target.
C	Common Cause (natural/expected) variation	Common Cause (natural/expected) variation, where target is less than lower limit where up is improvement, or greater than upper limit where down is improvement.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is improvement, or less than target where down is improvement.	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration, or less than target where down is deterioration.	Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration or greater than upper limit down is deterioration.	Common Cause (natural/expected) variation with no target.
H	Special Cause Concerning Variation High, where up is deterioration	Special Cause Concerning Variation High, where up is deterioration but target is greater than upper limit.	Special Cause Concerning Variation High, where up is deterioration, but last six data points are less than target.	Special Cause Concerning Variation High, where up is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation High, where up is deterioration and last six data points are greater than or equal to target.	Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.	Special Cause Concerning Variation High, where up is deterioration and there is no target.
L	Special Cause Concerning Variation Low, where down is deterioration	Special Cause Concerning Variation Low, where down is deterioration but target is less than lower limit.	Special Cause Concerning Variation Low, where down is deterioration but last six data points are greater than or equal to target.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are less than target.	Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit.	Special Cause Concerning Variation Low, where down is deterioration and there is no target.

KEY
Note Performance
Constitutional Standards and Key Metrics = Escalation Summary

North Bristol NHS Trust

Perinatal Quality Surveillance Matrix (PQSM) Dashboard data

Month of Publication April 2026
Data up to March 2026

Activity	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of women who gave birth (>=24 weeks or <24 weeks live)		429	435	456	453	467	439	460	477	466	473	454	397	434
Number of women who gave birth (>=22 weeks)		429	436	456	455	467	439	460	480	480	483	454	397	436
Number of babies born (>=24 weeks or <24 weeks live)		433	442	464	463	473	444	466	483	461	473	459	403	439
Number of livebirths 22+0 to 26+6 weeks		6	4	3	4	1	9	1	2	2	3	3	4	3
Number of livebirths 24+0 to 36+6 weeks		35	36	40	32	33	43	27	32	30	41	36	41	27
Number of livebirths <24 weeks		3	0	0	1	0	3	2	0	1	0	2	1	0
Induction of labour rate %		30.8%	31.7%	31.6%	32.7%	29.1%	33.3%	30.0%	28.1%	31.7%	29.2%	29.3%	26.2%	31.8%
Unassisted birth rate %		45.2%	42.3%	42.1%	41.5%	45.4%	44.2%	46.7%	44.2%	47.3%	44.4%	40.3%	42.8%	44.5%
Assisted birth rate %		12.1%	9.9%	14.0%	9.3%	8.8%	9.8%	8.0%	8.4%	10.2%	7.2%	10.8%	9.6%	12.0%
Caesarean section rate (overall) %		42.7%	47.6%	43.2%	49.0%	45.6%	46.0%	45.0%	47.0%	42.5%	48.4%	48.0%	46.9%	43.5%
Elective caesarean section rate %		17.9%	22.1%	20.4%	22.3%	22.7%	22.1%	22.4%	21.8%	18.7%	25.8%	29.9%	24.4%	21.7%
Emergency caesarean section rate %		24.7%	25.5%	22.8%	26.7%	22.9%	23.9%	22.6%	25.2%	23.9%	22.6%	27.1%	22.4%	21.9%

Safe - Maternity Workforce	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
One to one care in labour (as a percentage)* excludes BBAs	MIS 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with supernumerary status for labour ward coordinator	MIS 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of times maternity unit attempted to divert or on divert	Local	1	0	0	1	1	0	1	1	1	2	1	1	1
Number of obstetric consultant non-attendance to 'must attend' clinical situations	Local	0	0	0	0	0	0	0	0	0	0.0	0	0	0
Consultant Led MDT ward rounds on CDS day	SBLV3 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Led MDT ward rounds on CDS evening/night	SBLV3 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of 'staff meets acuity' - CDS	Birthrate+ 100%	53%	64%	65%	52%	65%	72%	45%	49%	54%	55	55%	51%	59%
Percentage of 'up to 3 MWs short' - CDS		36%	31%	45%	44%	33%	25%	50%	39%	43%	39	41%	38%	34%
Percentage of '3 or more MW's short' - CDS		11%	5%	8%	5%	2%	3%	6%	12%	4%	6	4%	11%	7%
Confidence factor in Birthrate+ (data recording on CDS)	Birthrate+ 60%	77.4%	82.8%	82.3%	73.9%	87.1%	84.4%	86.6%	83.9%	75.3%	79%	75.0%	83.0%	80.0%

Safe - Maternity Workforce	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	0%	-1.53%	-1.56%	-0.87%	0.77%	2.22%	4.53%	4.60%	4.36%	0.92%	1.84%	0.89%	0.08%	1.60%
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.50%	1.50%	2.0%	5.00%	5.00%	5.00%
Obstetric Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	2%	2%	2%	2%	2%	0%	0%	1%	1%	0.0%	0%	0%	0%
Midwifery Shift Fill Rate (%) - inpatient services day	100%	95.7%	96.7%	100.1%	94.5%	94.0%	95.5%	93.6%	93.2%	92.3%	90.1%	92.2%	91.7%	90.2%
Midwifery Shift Fill Rate (%) - inpatient services night	100%	98.9%	99.5%	100.1%	103.6%	99.8%	97.7%	95.5%	99.7%	97.3%	92.1%	94.7%	93.9%	91.3%
Obstetric Shift Fill Rate - acute services* day	100%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	98.0%	100.0%	99.0%	99.0%	100.0%	100.0%	100.0%
Obstetric Shift Fill Rate - acute services* night	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%

Safe - Neonatal Workforce	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of NICU consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs	0%	8.70%	10.99%	12.23%	10.79%	13.72%	14.71%	16.94%	14.22%	12.45%	13.57%	12.15%	7.32%	13.87%
Neonatal Nurse Qualified in Speciality establishment rate	BAPM 70%	52%	52%	52%	54%	63%	63%	63%	60%	60%	60%	65%	59%	59%
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	0%	0%	0%	5%	5%	5%	5%	5%	5%	5%	5%
Neonatal Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	0%	8%	8%	8%	8%	8%	8%	8%	0.00%	0.00%	0%
Neonatal Nursing Fill Rate (%) - acute services* using BAPM acuity tool	100%	100.0%	98.3%	91.8%	96.6%	100.0%	88.5%	86.0%	100.0%	100.0%	96.6%	71.4%	87.3%	85.2%
Neonatal Nursing QIS Fill Rate (%) - acute services using BAPM acuity tool	70%	75.0%	74.6%	49.2%	55.2%	50.0%	37.7%	28.3%	82.8%	92.3%	76.6%	39.5%	45.5%	52.0%
Neonatal (Medical) Shift Fill Rate (%) - acute services* day using BAPM acuity tool	100%	100.0%	100.0%	100.0%	100.0%	98.0%	97.8%	97.8%	96.0%	95.0%	95.0%	100.0%	100.0%	100.0%
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night using BAPM acuity tool	100%	100.0%	100.0%	95.7%	95.0%	94.6%	94.0%	93.3%	95.0%	95.0%	95.0%	100.0%	100.0%	100.0%

Training	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Training compliance fetal wellbeing day - Obstetric Consultants	MIS Y6 90%	89%	94%	90%	80%	80%	80%	56%	90%	100%	95%	95%	95%	90%
Training compliance fetal wellbeing day - Other Obstetric Doctors	MIS Y6 90%	82%	82%	85%	81%	78%	80%	84%	94%	87% (93%)	63%	68%	70%	76%
Training compliance fetal wellbeing day - Midwives (ALL)	MIS Y6 90%	84%	80%	85%	81%	81%	82%	80%	90%	97%	92%	90%	88%	90%
Training compliance in maternity emergencies and multi-professional training - Obstetric Consultants	MIS Y6 90%	90%	94%	85%	90%	90%	90%	100%	94%	100%	95%	100%	95%	89%
Training compliance in maternity emergencies and multi-professional training - Other Obstetric Doctors	MIS Y6 90%	91%	94%	100%	96%	97%	69%	81%	90%	94%	65%	68%	77%	86%
Training compliance in maternity emergencies and multi-professional training - Midwives (ALL)	MIS Y6 90%	86%	89%	92%	91%	92%	93%	82%	93%	97%	92%	91%	88%	87%
Training compliance in maternity emergencies and multi-professional training - Anaesthetic Consultants	MIS Y6 70%	91%	66%	69%	62%	63%	63%	70%	100%	96%	92%	84%	88%	87%

Training	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Training compliance in maternity emergencies and multi-professional training - Other Anaesthetic Doctors	MIS Y6 70%	61%	66%	77%	75%	86%	87%	88%	90%	100%	92%	85%	52%	60%
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	MIS Y6 90%	89%	87%	84%	87%	91%	90%	77%	88%	95%	91%	94%	90%	86%
Training compliance annual local NBLS - Midwives (ALL)										99%	90%	89%	86%	87%
Training compliance annual local NBLS - NICU Consultants	MIS Y6 90%	92%	92%	100%	92%	91%	91%	91%	91%	100%	94%	71%	93%	100%
Training compliance annual local NBLS - NICU Resident doctors (who attend any births)	MIS Y6 90%	100%	100%	100%	100%	100%	94%	100%	100%	100%	94%	100%	100%	83%
Training compliance annual local NBLS NICU ANNPs (ALL)	MIS Y6 90%	90%	90%	70%	70%	60%	80%	100%	100%	100%	100%	81%	100%	100%
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	MIS Y6 90%	93%	86%	91%	93%	91%	94%	98%	96%	96%	98%	87%	96%	91%
Training compliance annual local NBLS APs, HCAs and nursery nurses (dependant on their roles within the service - for local policy to determine)	MIS Y6 90%	87%	92%	89%	89%	90%	95%	97%	97%	97%	93%	82%	98%	95%

Safe - Delivery Metrics	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of shoulder dystocias recorded (vaginal births)		9	7	11	6	10	5	4	8	10	5	6	6	9
% of women with a high degree (3rd and 4th) tear recorded		3.7%	5.7%	5.0%	3.5%	5.5%	5.9%	2.8%	5.9%	4.9%	3.7%	3.0%	5.7%	6.5%
Number of women with a retained placenta following birth requiring MROP		11	8	9	9	8	9	9	17	6	17	11	7	10
Number of babies with an Apgar Score <7 at 5 mins (all gestations)		14	13	13	12	4	10	8	8	5	8	8	12	6

Infant Feeding & Skin to Skin	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
% of babies where breastfeeding initiated within 48 hours	80%	76.5%	88.2%	81.0%	80.2%	84.7%	82.7%	83.2%	83.1%	87.1%	80.2%	79.3%	80.6%	81.9%
% of babies breastfeeding on Day 10	80%	77.4%	76.3%	70.9%	75.5%	76.3%	78.5%	70.5%	77.6%	78.0%	76.0%	76.6%	74.3%	76.8%
% of babies breastfeeding at transfer to community	80%	68.4%	71.8%	67.1%	70.3%	72.9%	75.7%	72.2%	73.9%	73.7%	72.0%	72.1%	73.0%	71.1%
% of babies where skin to skin recorded within 1st hour of birth	80%	80.4%	82.7%	83.1%	82.6%	84.9%	83.5%	83.4%	84.1%	84.7%	81.3%	80.6%	81.3%	81.7%

Perinatal Morbidity and Mortality inborn	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total number of perinatal deaths (excluding late fetal losses)		9	2	2	4	3	4	1	2	0	4	4	2	2
Number of late fetal losses 16+0 to 23+6 weeks excl TOP		0	0	3	5	4	0	5	4	4	0	2	1	2
Number of stillbirths (>=24 weeks excl TOP)		4	2	2	3	3	0	0	1	0	2	2	1	2
Monthly Stillbirths per 1000 live births	2.6	9.32	4.52	4.31	6.48	6.34	0.00	0.00	2.07	0.00	0.42	0.60	2.48	4.56
Rolling Still Births per 1000 live births													3.05	2.65
Number of neonatal deaths : 0-6 Days		5	0	0	0	0	2	1	0	0	1	0	0	0

Perinatal Morbidity and Mortality inborn	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of neonatal deaths : 7-28 Days		0	0	0	1	0	2	0	1	0	1	0	1	0
Neonatal Deaths before 28 days per 1000 live births (ALL)	1.5	11.66	0.00	0.0	2.2	0.0	4.5	2.1	2.1	0.0	4.2	0.0	2.5	0.0
* NND before 28 days per 1000 live births (Inborn babies only)	1.5	8.93	0.00	0.0	2.2	0.0	4.5	4.6	6.4	0.0	11.1	0.0	8.6	0.0
PMRT grading C or D themes in report	0	0	0	2	2	1	0	0	1	1	0	1	0	1
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (MNSI referral)	0	1	0	0	1	0	0	0	0	0	0	1	0	2

Maternal Morbidity and Mortality	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of maternal deaths (MBRRACE)		0	0	0	0	1	0	0	1	0	1	0	0	0
Direct causes		0	0	0	0	0	0	0	0	0	0	0	0	0
Indirect causes		0	0	0	0	1	0	0	1	0	1	0	0	0
Number of women who received enhanced care on CDS (HDU)		36	32	33	39	39	23	30	38	31	38	32	25	19
Number of women who received level 3 care (ICU)		1	1	1	1	1	0	0	0	0	0	3	3	1

Insight	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of incident reported		166	99	106	124	56	113	100	106	122	135	117	110	108
Number of incidents graded as moderate or above (total) (Physical Harm)		0	3	0	1	0	6	4	1	0	1	1	2	6
incident moderate harm or above (not PSII, excludes MNSI)		0	3	0	1	4	6	4	1	0	0	0	0	1
incident PSII (excludes MNSI)		0	0	1	0	0	0	0	0	0	0	0	0	0
New MNSI referrals accepted		2	0	0	1	0	0	0	0	0	0	1	0	0
Outlier reports (eg. MNSI/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust	0	1	0	0	0	0	1	0	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trust Level Risks		3	3	3	4	5	5	5	5	7	5	6	4	3

NICU Data	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Neonatal Admission to NICU		59	41	46	52	48	52	37	48	43	63	57	63	43
of which Inborn Babies booked with NBT		44	31	33	33	29	38	26	28	31	40	41	46	28
of which Inborn Babies -booked elsewhere		2	0	3	4	5	4	1	1	3	4	3	4	3
of which readmission		3	3	5	6	3	2	4	9	2	9	5	3	5
of which ex-utero admission		7	4	4	9	8	5	3	6	4	7	5	7	3
of which source of admission cannot be derived		2	2	1	0	1	1	3	2	3	1	0	1	1
Neonatal Admission to Transitional Care		27	39	36	35	36	40	40	26	30	32	23	24	14

NICU Data	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Admission rate at term		7.2%	4.0%	4.8%	3.9%	5.8%	5.9%	3.9%	4.9%	6.0%	5.0%	6.2%	8.6%	4.6%
Admission Rate at Term that meet ATAIN Criteria	ATAIN <5%								3.1%	5.3%	3.6%	3.5%	4.2%	2.5%
NICU babies transferred to another unit for higher/specialist care		3	4	4	5	2	1	4	4	6	8	5	6	4
NICU babies transferred to another unit due to a lack of available resources	0	2	0	2	3	0	0	4	2	9	12	9	0	3
NICU babies transferred to another unit due to insufficient staffing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attempted baby abduction	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Involvement	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	90%	100%	100%	100%	100%	100%	100%	100%	86%	91%	100%	100%	100%	100%
Friends and family Test score (response rate % who rated 'very good' or 'good') Maternity	90%	94%	94%	91%	92%	94%	93%	92%	90%	91%	87%	89%	94%	83%
Service User feedback: Number of Compliments (formal)		37	59	78	61	79	69	63	60	46	47	48	60	64
Service User feedback: Number of Complaints (formal)		2	2	9	2	6	16	3	3	4	4	6	6	7
Staff feedback from frontline champions and walk-abouts (number of themes)		7	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting notes.docx	Safety Champions minutes February 2026v0.1.docx	

Maternity Triage	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Attendance to triage	90%	925	939	943	888	996	880	963	1167	1077	1026	1101	1039	1110
BSOTS KPI Initial assessment within 15 minutes	90%	56%	58%	63%	66%	65%	64%	56%	48%	47%	49%	48%	45%	54%
NICE Safer Staffing Red Flag Initial assessment within 30 minutes	90%	85%	85%	91%	91%	93%	90%	86%	81%	75%	78%	80%	75%	83%
Calls answered by triage (Day 0730-2000)		961	947	979	977	1150	997	1118	1262	1071	1120			
Calls answered by triage (Night 2000-0700)		280	272	291	352	368	323	354	414	381	399			
Patient Self -Discharges in Maternity Triage							19	25	30	43	25	20	14	18
Total Calls answered by Maternity Triage												1587	2383	2500
Total Calls abandoned by Maternity Triage >60 secs													156	
Phone calls abandoned on triage (Day 0730-2000)		168	182	204	154	149	152	242	230	237	216			
Phone calls abandoned on triage (Night 2000-0700)		39	29	26	37	36	25	24	32	47	31			
Calls answered by other clinical areas (CDS and Mendip - Day + Night)		734	606	522	522	536	484	493	615	542	505			
Phone calls abandoned in other clinical areas (CDS and Mendip - Day + Night)		21	12	22	28	30	28	14	34	29	18			

Perinatal Quality Surveillance (PQSM)

March 2026

UHBW Maternity

Inspected and rated
Good
Care Quality Commission

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Workforce & Acuity

Compliance with supernumerary status for labour ward coordinator (%)

October	November 2025	December	January	February 2026	March
100	100	100	100	100	100

6 monthly average

Trend

One to one care in labour * excludes BBAs (%)

October	November 2025	December	January	February 2026	March
100	100	100	100	100	100

6 monthly average

Trend

Number of times maternity unit attempted to divert or on divert

October, November 2025, December, January, February 2026, March

Trend

Consultant Led MDT Ward Rounds on CDS (%)

Day Shift Night Shift

	October	November 2025	December	January	February 2026	March
Night Shift	100	100	100	100	100	100
Day Shift	100	100	100	100	100	100

6 monthly average - Day Shift

Trend - Day Shift

6 monthly average - Night Shift

Trend - Night Shift

Number of obstetric consultant non-attendance to 'must attend' clinical situations (rolling 6 months)

0

Is the standard of care being delivered?

- No episodes where the supernumerary status of the CDS coordinator was not maintained
- One to One care in Labour is consistently achieved
- Consultant Led MDT ward rounds are conducted consistently for both day and night shifts on CDS

What are the top contributing factors to over/under achievement?

- **Oct 3 - Attempted closure of CDS.** Acuity on CDS, redistribution of staffing to ensure 1 to 1 care provided . **No admissions impacted.**
- **Feb 20 - Attempted closure of CDS** Acuity on CDS, redistribution of staffing to ensure 1 to 1 care provided . **No admissions impacted.**
- **Feb 21 - Closure of CDS** Ongoing acuity issues on CDS, redistribution of staffing to ensure 1 to 1 care provided . **No admissions impacted.**
- **Mar 13 - Closure of CDS**
- Acuity on CDS, option sought to redirect low-risk women. No admissions impacted.

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Workforce & Acuity

Obstetric and Midwifery Vacancy Rates

Day Shift Fill Rate - Acute services - Actual

Month	Midwifery Shift Fill Rate	Obstetric Shift Fill Rate	Anaesthetic (Obstetric) Shift Fill Rate
October 2025	90	100	100
November 2025	93	100	100
December 2025	91	100	100
January 2026	92	100	100
February 2026	93	100	100
March 2026		100	100

Night Shift Fill Rate - Acute services - Actual

Month	Midwifery Shift Fill Rate	Obstetric Shift Fill Rate	Anaesthetic (Obstetric) Shift Fill Rate
October 2025	109	100	100
November 2025	106	100	100
December 2025	100	100	100
January 2026	99	100	100
February 2026	101	100	100
March 2026		100	100

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Workforce & Acuity

Central Delivery Suite (CDS)

Confidence factor in Birthrate + (Central Delivery Suite)

January	February 2026	March
92	86	90

Trend

Birthrate Plus®

Capture of intrapartum (CDS) data is required 6 times during a 24-hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.

Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

Data entered outside of the time window may still be recorded by will not contribute to the overall compliance calculation.

CDS Acuity Summary - January

% of 'staff meets acuity' | Up to 2 MW's short | 2 or more MW's sho...

83 (83%) | 12 (12%) | 5 (5%)

CDS Acuity Summary - February

% of 'staff meets acuity' | Up to 2 MW's short | 2 or more MW's short

74 (74.75%) | 19 (19.19%) | 6 (6.06%)

CDS Acuity Summary - March

% of 'staff meets acuity' | Up to 2 MW's short | 2 or more MW's sho...

80 (80%) | 16 (16%) | 4 (4%)

Transitional Care (TC)

Confidence factor in Birthrate + (Transitional Care)

January	February 2026	March
78	80	89

Trend

TC Acuity Summary - January

% of 'staff does not meet acuity' | % of 'staff meets acuity'

66 (66%) | 34 (34%)

TC Acuity Summary - February

% of 'staff does not meet acuity' | % of 'staff meets acuity'

90 (90%) | 10 (10%)

TC Acuity Summary - March

% of 'staff does not meet acuity' | % of 'staff meets acuity'

67 (67%) | 33 (33%)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Workforce & Acuity

Ante / Post Natal Ward (Oak)

Confidence factor in Birthrate + (Oak Ward)

January	February 2026	March
64	75	69

Trend

Birthrate Plus®

Capture of intrapartum (CDS) data is required 6 times during a 24-hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.
Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.
Data entered outside of the time window may still be recorded by will not contribute to the overall compliance calculation.

Oak Acuity Summary - January

% of 'staff meets acuity' | % of 'staff does not meet acuity'

80 (80%)
20 (20%)

Oak Acuity Summary - February

% of 'staff meets acuity' | % of 'staff does not meet acuity'

88 (88%)
12 (12%)

Oak Acuity Summary - March

% of 'staff meets acuity' | % of 'staff does not meet acuity'

98 (98%)
2 (2%)

Ante / Post Natal Ward (Willow)

Confidence factor in Birthrate + (Willow Ward)

January	February 2026	March
56	69	65

Trend

Willow Acuity Summary - January

% of 'staff meets acuity' | % of 'staff does not meet acuity'

64 (64%)
36 (36%)

Willow Acuity Summary - February

% of 'staff meets acuity' | % of 'staff does not meet acuity'

68 (68%)
32 (32%)

Willow Acuity Summary -March

% of 'staff meets acuity' | % of 'staff does not meet acuity'

83 (83%)
17 (17%)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Neonatal Medical and Nursing Vacancy Rates

Vacancy Rate by WTE (axis: 0, 10)

Band 5/6/7 Nursing Vacancy Rate
Neonatal Consultant Vacancy Rate
Neonatal Registrar Vacancy Rate
Neonatal SHO Vacancy Rate

October, November 2025, December, January, February 2026, March

% of Neonatal Nurses with Qualified in Speciality (QIS) Certification (Local Target 94%)

Percentage with Qualification

	October	November 2025	December	January	February 2026	March
% QIS	61	61	61	60	58	59

Day Shift Fill Rate - Acute services - Actual

%	October	November 2025	December	January	February 2026	March
Neonatal Nursing Fill Rate (%) - acute services* day using BAPM acuity tool	108	112	100	116	92	126
Neonatal Nursing QIS Fill Rate (%) - acute services* day using BAPM acuity tool	65	69	66	74	59	89
Neonatal (Medical) Shift Fill Rate (%)	100	100	100	100	100	100

Night Shift Fill Rate - Acute services - Actual

%	October	November 2025	December	January	February 2026	March
Neonatal Nursing Fill Rate (%) - acute services* night using BAPM acuity tool	92	98	89	106	95	123
Neonatal Nursing QIS Fill Rate (%) - acute services* night using BAPM acuity tool	51	60	54	72	57	76
Neonatal (Medical) Shift Fill Rate (%)	100	100	100	100	100	100

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Metrics

Number of Women booked for maternity care

417

Number of Women booked before 10 weeks

230

Month	Number of Women Booked	Booked prior to 10 weeks
January	425	224
February 2026	419	207
March	417	230

Maternity Bookings: Traditional 'v' Continuity Teams

Month	Traditional Maternity Teams
January	64.94%
February 2026	66.59%
March	65.47%

Legend: Traditional Maternity Teams, Olive Team (COC), Juniper Team (COC), Grandy Oak Team (COC), Birch Team (COC)

Number of Inductions: Breakdown by Primary Reason

Month	Total
January	133
February 2026	124
March	136

Legend: Induction for a Fetal reason, Induction for a Maternal reason, Reason for IOL not recorded

Location of Birth

- Obstetric Theatre: 143 (45.98%)
- Delivery Suite: 136 (43.73%)
- Midwife Led Unit: 24 (7.72%)

Legend: Obstetric Theatre, Delivery Suite, Midwife Led Unit, Home, Other Locations (inc BBAs)

370

Number of Registerable Births (Women)

Jan 2026	Feb 2026	Mar 2026
342	311	370

375

Number of Registerable Births (Babies)

Jan 2026	Feb 2026	Mar 2026
345	315	375

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Metrics

Gestation at Birth

Extreme Pre-term - <27 weeks gestation · Early Pre-term - between 27 & 33 completed weeks · Pre-term - between 34 & 36 completed weeks · Term - between 37 & 41 completed weeks · Post-term - born >42 weeks

400
200
0

January 345 · February 315 · March 375

2026

Mode of Birth

January 342 · February 318 · March 369

2026

Month

Spontaneous Cephalic
Breech
Ventouse
Forceps
Grade 1 Emergency CS
Grade 2 Emergency CS
Grade 3 Emergency CS
Grade 4 Elective CS
CS Grade Unknown

Vaginal Birth after Caesarean

Women with a previous CS · Successful VBAC

50
0

Janu... Febr... March April May July August Sept... Octo... Nove... Dece... Janu... Febr... March

2025 2026

Postpartum Haemorrhage (PPH)

No PPH (Blood Loss <500mls) · PPH 500-999mls · PPH 1000-1499mls · PPH 1500-1999mls · PPH 2000mls+

400
200
0

Jan 2025 Mar 2025 May 2025 Jul 2025 Sep 2025 Nov 2025 Jan 2026 Mar 2026

5

Number of Grade 1 CS delivered outside of 30 minutes

11

Number of Grade 2 CS delivered outside of 75 minutes

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Metrics

Postpartum Haemorrhage (PPH)

Clinical Quality Improvement Metrics (CQIMs) comparisons

NHS

Homepage | Overview | Org Profile | CQIM | CQIM+ | CQIM SPC | Comparison | MCoC | NMI | NMI+ | Guidance

This page contains metrics sourced from the MSDS and published monthly, for the purpose of identifying areas requiring clinical quality improvement. Further details about these metrics can be found in the Metadata file. Please be aware the dashboard includes historic CQIM data not yet added in to the Maternity Services Monthly Statistics publication.

Select organisation
University Hospitals Bristol and Weston NHS Foundation Trust (RA7)

Select start month
January 2023

Select end month
January 2026

Not all CQIMs use the same time period. Details are provided on the CQIM Footnotes tab of the Metadata file

Select indicator
Women who had a PPH of 1,500ml or more (Rate per 1,000)

Robson Group definitions | Smoking CQIMs & SATOD

Women who had a PPH of 1,500ml or more values comparison over time for University Hospitals Bristol and Weston NHS Foundation Trust (Rate per 1,000)

Provisional data — Trust — MBRRACE — National
Trust Rolling Average (6 months) Upper/Lower Bounds

Select which values to view: All

60
40
20
0
Jan 2023 Jul 2023 Jan 2024 Jul 2024 Jan 2025 Jul 2025 Jan 2026

Trust | Region | LMNS | MBRRACE

Trust level CQIM values comparison with peers (Rate per 1,000)

Other trusts | Selected trust: University Hospitals Bristol and Weston NHS Foundation Trust

60
40
20
0
0 1000 2000 3000 4000
Deliveries (Past 3 months)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Neonatal Metrics

NNU activity BAPM 2011

BAPM 2011 Monthly Activity

Care Days

Month

Apr 2025 May 2025 Jun 2025 Jul 2025 Aug 2025 Sep 2025 Oct 2025 Nov 2025 Dec 2025 Jan 2026 Feb 2026 Mar 2026

IC HD SC NC Unknown

Neonatal Cot Summary

IC HD SC TC on NNU

March

Neonatal Commissioned Cot Summary

Intensive Care (IC) Cots =15
High Dependency (HD) Cots = 8
Special Care (SC) Cots = 8
Transitional Care (TC) Cots = 16

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Avoidable Term Admission Rate in NICU (ATAIN)

UHBW Avoidable term admissions to NICU % · UHBW Upper Limit · UHBW Rolling 12 Month Average · Current National Ambition

0 · 5

2021 · 2022 · 2023 · 2024 · 2025 · 2026

March 2026
UHBW Avoidable term Admission Rate 3.60%

As of End March 2026
UHBW Rolling 12 Month Average 2.50%

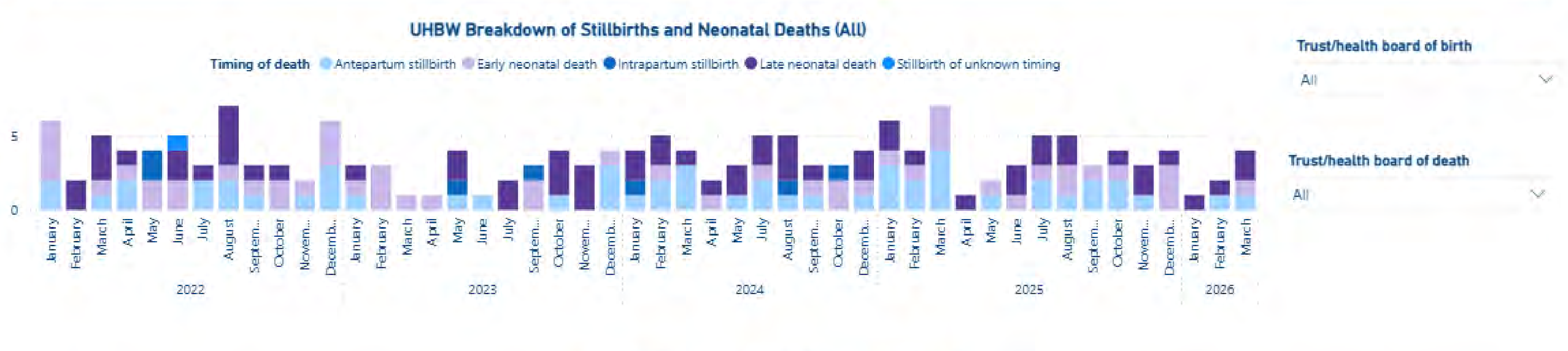
Primary Reason for Term Admission to NICU

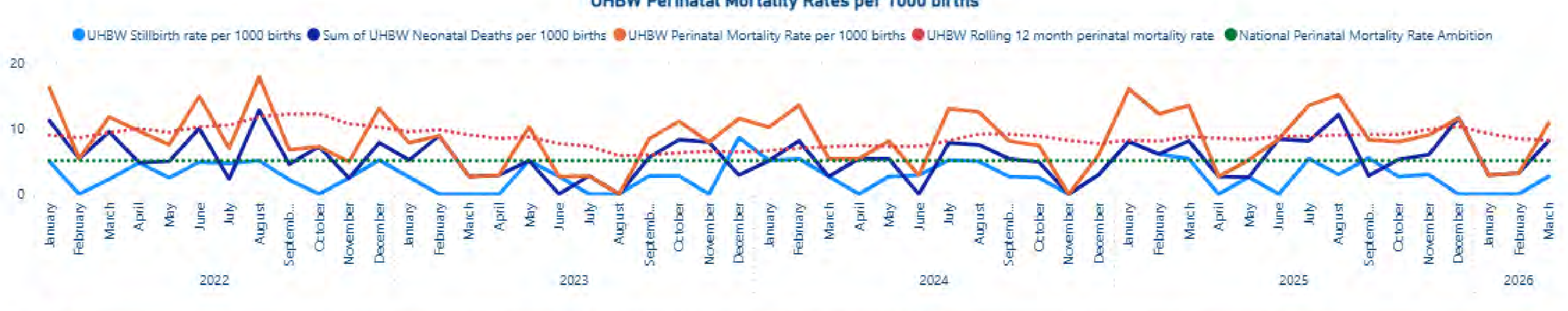
Primary Reason for Admission: Birth Trauma · Cardiovasc... · Congenital... · Early Onse... · Failed Oxi... · Feeding Is... · GIT Disease · HIE · Hypoglyca... · Infection · Investigati... · Jaundice · Maternal A... · Monitorin... · Neurological

	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
Year	2025												2026		
Total	17	21	20	14	16	18	16	15	12	13	13	23	14	19	25

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Perinatal Mortality Overview (up to end March 2026)





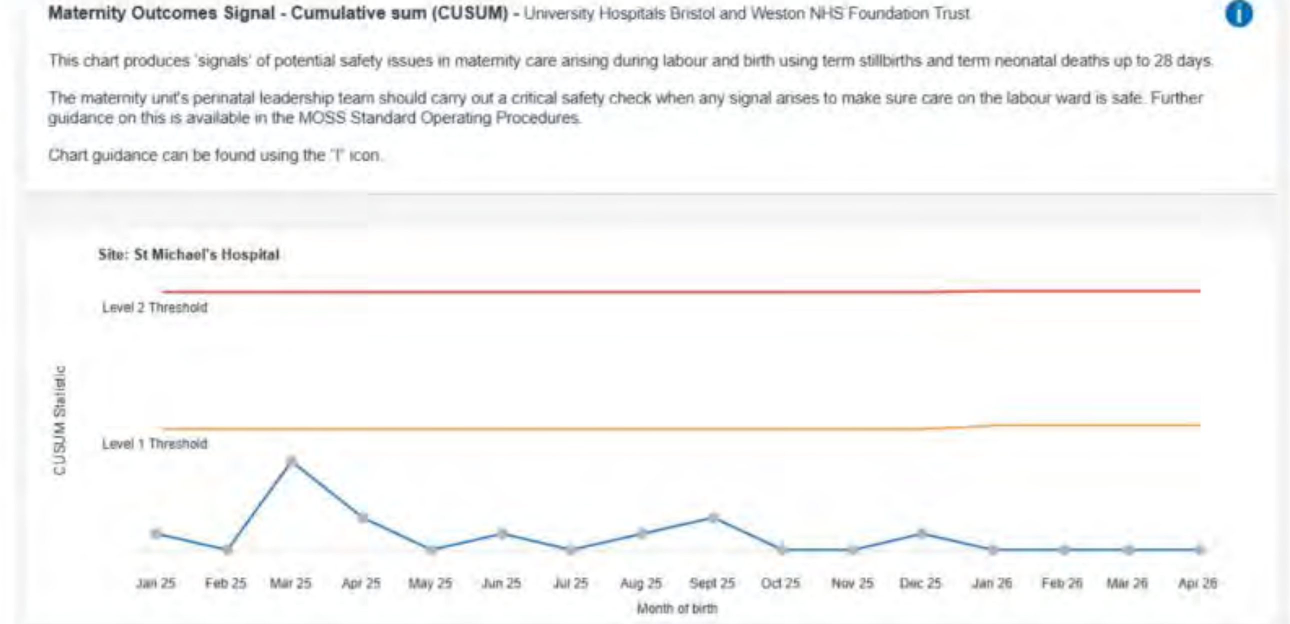
UHBW Rolling 12 Month Perinatal Mortality Rate at end March 2026 (per 1000 births) = 8.40
(Stillbirth Rate for March 2026 = 2.70 per 1000 births, Neonatal Death Rate for March 2026 =8.10 per 1000 births)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Maternity Outcomes Signal System (MOSS)

MOSS is a safety management system and not a performance management tool. MOSS signals flag potential safety issues, prompting a locally led critical safety check (see Standard Operating Procedures) to determine if there are real safety issues. Safety issues are governed under the Perinatal Quality Oversight Model.

Sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death. Potentially adjusting this data will be reviewed in 2026. Until then, perinatal leadership teams in these sites should remain curious and still proceed with the MOSS critical safety check as part of good practice.



Latest Event: **04 Dec 25**
Refreshed: **14 Apr 26**

Date of term birth	Events (term only)
04 Dec 25	1 Term Neonatal Death(s)
09 Sept 25	1 Term Neonatal Death(s)
08 Aug 25	1 Term Neonatal Death(s)
27 Jun 25	1 Term Neonatal Death(s)
19 Mar 25	1 Term Neonatal Death(s)
12 Mar 25	1 Term Stillbirth(s)
24 Jan 25	1 Term Stillbirth(s)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Perinatal Mortality & Morbidity - MNSI

Breakdown of HSIB/MNSI Referrals, by Year, Referral Criteria and Investigation Status

HSIB/MNSI Referral Criteria: Early Neonatal Death, HIE / Therapeutic Cooling, Intrapartum Stillbirth, Maternal Death

Accepted for Investigation

Case Rejected following Triage: Does Not Meet HSIB/MNSI...

Case Rejected following Triage: Normal MRI, no family or t...

Meets HSIB/MNSI Criteria - Unable to Proceed Investigatio...

Number of Incident Referrals

0 5 10

2018 2020 2022 2024

Year

MNSI Maternity & Newborn Safety Investigations

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England.

All NHS trusts are required to inform MNSI about certain patient safety incidents that happen in maternity care where an independent investigation may be beneficial.

Where identified MNSI may make safety recommendations which aim to improve services at local level and across the whole maternity healthcare system in England.

Date of Incident

17/08/2018 24/12/2025

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Perinatal Mortality & Morbidity - MNSI

HSIB/MNSI Case Status

HSIB/MNSI Referral Criteria ● Early Neonatal Death ● HIE / Therapeutic Cooling ● Intrapartum Stillbirth ● Maternal Death

Closed: Final Report Received

Closed: Investigation Not Undertaken

Draft Report Received - Factual Accuracy Process

In Progress

10
5
0
2018 2020 2022 2024
Year

MNSI Maternity & Newborn Safety Investigations

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England.

All NHS trusts are required to inform MNSI about certain patient safety incidents that happen in maternity care where an independent investigation may be beneficial.

Where identified MNSI may make safety recommendations which aim to improve services at local level and across the whole maternity healthcare system in England.

Date of Incident

17/08/2018 24/12/2025

Perinatal Quality Surveillance Matrix (PQSM) March 2026

PMRT Reviews

What is PMRT?

The **Perinatal Mortality Review Tool (PMRT)** is a systematic framework developed to conduct reviews of perinatal deaths, which include stillbirths and neonatal deaths. Launched in early 2018, the PMRT aims to provide bereaved parents with answers regarding the care their baby received and to identify areas for improvement in healthcare practices.

Grading of Care

The PMRT includes a grading system to evaluate the quality of care provided to mothers and babies. The grading typically follows these categories:

Grade A: No issues with care identified.
Grade B: Care issues identified that would not have affected the outcome.
Grade C: Care issues identified that may have affected the outcome.
Grade D: Care issues identified that likely made a difference to the outcome.

PMRT ID	Month reviewed	Date of Incident	Incident	Grading of care		Outcome/ Learning/ Actions (if grading C or D)
9xxxx	Mar-26		Stillbirth	Grading of care of the mother and baby up to the point of birth of the baby.	A	
				Grading of care of the baby from birth up to the death of the baby.	N/A	
				Grading of care of the mother following the death of her baby.	C	Missed TTA for antibiotics (the mother remained well). Over 6 month wait for post-mortem and postnatal counselling appointment causing distress to the family.
1xxxxx	Mar-26		Early Neonatal Death	Grading of care of the mother and baby up to the point of birth of the baby.	C	Missed opportunity to identify the mother was in established labour when she returned to the induction suite. This would have meant that she would have been cared for on CDS sooner and therefore monitoring would have commenced earlier. Missed opportunity to class CTG as pathological. This should have triggered a holistic review that encompassed the woman and baby's risk factors which may have led to a discussion about earlier delivery. This period of CTG was followed by a period of normal trace.
				Grading of care of the baby from birth up to the death of the baby.	A	
				Grading of care of the mother following the death of her baby.	A	

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Incident Oversight: March 2026

Executive summary

A total of 200 **incidents** were reported during March 2026. The incident profile continues to reflect sustained operational pressures, with activity concentrated across clinical assessment, medicines management, and service provision. Themes are consistent with a system operating under capacity constraints, with flow challenges and workforce pressures impacting timeliness and reliability of care.

Overall, the dataset suggests systemic vulnerabilities in routine care processes and escalation pathways, rather than isolated failures, with risks emerging from delays, process reliability, and interdependencies between teams and services.

Key themes and trends

Clinical monitoring and escalation (largest category)

Delays or omissions in observations, failure to escalate deterioration, and delays in senior review were the most requently reported incidents. These patterns indicate ongoing challenges in recognition and response to clinical deterioration. particularly in high acuity and busy environments.

Medication safety pressures

Medication-related incidents remain a significant theme,including incorrect dose or strength. delayed or omitted medications. and prescribing or administration errors. Issues span prescribing, transcription and administration processes.

Service pressure and staffing constraints

Staffing shortfalls, increased acuity, and workload imbalance are frequently cited. These pressures contibute to delays in care, monitoring gaps, and increased risk withing maternity services.

Delays in treatment or procedures

Incidents relating to delays in treatment, escalation, or procedures continue to feature, reflecting flow and prioritisation challenges across services and the impact of capacity constraints.

Equipment and device issues

Equipment failures, device malfunctions, and availability issues were reported. While not the most frequent theme. these incidents carry potential for high-risk impact in acute care settings.

Admission, discharge and patient flow

Unexpected admissions, transfer delays, and discharge-related incidents highlight ongoing flow inefficiencies and interface risks across teams and services.

Harm profile

Most incidents were recorded as no harm or low harm, with no indication of clustering of moderate or severe harm events. This reflects effective detection and reporting of risk, alongside opportunities for proactive system improvement.

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Patient Experience

Friends & Family Test Survey

Neonatal Services

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar 2026
Total	9	0	3	2	3	13	8	10	6	11	4	0

Positive / Neutral / Negative

Maternity Services

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar 2026
Total	142	180	213	178	113	170	136	109	146	136	69	61

Positive / Neutral / Negative

Maternity and Neonatal Complaints by Month First Received

Investigation Type: Complaint, Formal Investigation

October, November 2025, December, January, February 2026, March

March 2026 Complaints by Sub-Category

- Communication With Pat... 3 (42.86%)
- Transfer Arrangements 2 (28.57%)
- Clinical Care (Nursing/Midwif) 2 (28.57%)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Compliance with National Directives: Maternity Incentive Scheme - Year 8

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, The Royal College of Obstetricians and Gynaecologists (RCOG, the Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), the Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity Newborn Safety Investigation Programme (MNSI).

MIS Year 8: 6 New Updated Standards

A. Workforce and capacity (summary)

- Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action.
- Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use
- Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags
- Adds operational capacity monitoring, including elective Caesarean activity via SitRep
- Continues funded midwifery establishment (BirthRate+) and introduces funded neonatal establishment requirements.
- Confirms need for trained anaesthetic assistants and progress towards peri-operative team models.

B. Training (summary)

- Year 8 strengthens training and assurance with two compliance checkpoints (30 Nov plus one local).
- Training continues to cover fetal monitoring, maternity emergencies and neonatal resuscitation
- In-situ simulation now required in both hospital and community settings.
- Anaesthetic training requirement reduced to a half-day to support attendance.
- Impacted Fetal Head (IFH) scenarios must be included by year end to align with Avoiding Brain Injury in Childbirth (ABC) preparation

C. Learning from reviews and investigations (summary)

- Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement.
- The Perinatal Mortality Review Tool (PMRT), MNSI and Early Notification (EN) learning now aligned, with Submit a Perinatal Event Notification (SPEN) as the single national notification route.
- PMRT external review threshold increased to 60%.
- Quarterly Board-level thematic reports required.
- Greater focus on learning → action → impact.
- Statutory Duty of Candour reporting removed from MIS (already a legal requirement).

D. Service-user voice and equity (summary)

- Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments.
- Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care.
- Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps.
- Maternal and Neonatal Voices Partnership (MNVP) guidance issued by NHS England still applies. However, recognising capacity is sometimes limited, it is no longer a requirement for MIS. Where capacity is limited, trusts must ensure diverse and representative service user voices inform priorities, improvement work and governance.

E. Care bundles (summary)

- Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle (SBLCB) alongside preparation for the new Maternity Care Bundle (MCB).
- Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence.
- ICB assurance step removed as ICBs no longer hold a formal oversight role.
- Trusts must develop an MCB implementation plan with quarterly Board oversight.

F. Board oversight, governance, culture and leadership (summary)

- Clearer expectations for Board-level assurance and use of safety intelligence.
- Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs.
- Bimonthly Board Safety Champion meetings with MNVP involvement.
- Live Perinatal Culture Improvement Plan required, with quarterly Board review.

MIS Year 8 Guidance published 31 Mar 2026

Compliance Submission Deadline: 2 March 2027

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Compliance with National Directives: Saving Babies Lives (Version 3.2)

LMNS Assurance Review Dates:

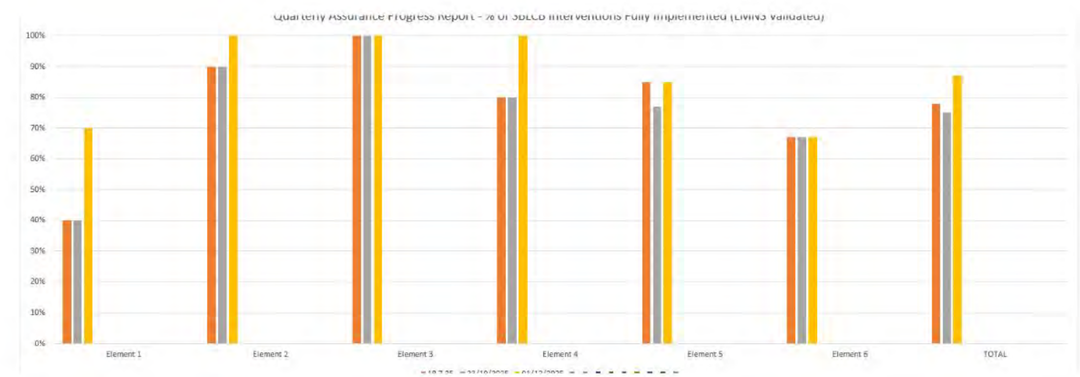
MIS Year 7:

Q1 18th July 2025 = 78%

Q2 23rd October 2025 = 75%

Q3 1st December 2025 = 87%

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	70%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	86%	Partially implemented	87%



Saving Babies' Lives Care Bundle (SBLCB) Version 3.2 is an NHS England national maternity safety initiative designed to reduce stillbirths, neonatal deaths, brain injuries, and preterm births. Version 3.2 builds on earlier iterations by strengthening evidence-based clinical practice and aligning with updated national guidance.

The bundle focuses on six core elements:

1. Reducing smoking in pregnancy through systematic identification, referral, and support.
2. Risk assessment and surveillance for fetal growth restriction, using standardised pathways and appropriate ultrasound monitoring.
3. Raising awareness of reduced fetal movements among pregnant women and ensuring timely, consistent clinical responses.
4. Effective fetal monitoring during labour, including improved CTG interpretation, training, and escalation.
5. Reducing preterm birth by identifying risk factors early and offering targeted interventions.
6. Management of pre-existing diabetes in pregnancy (Type 1 or Type 2), with a focus on multidisciplinary pathways and strengthened glucose management/technology to reduce adverse outcomes.

Version 3.2 emphasises equity, personalised care, multidisciplinary teamwork, and continuous quality improvement, supporting maternity services to deliver safer, more consistent care across England.

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Compliance with National Directives: Mandatory Training (MIS Year 8)

Fetal Wellbeing Study Day (90% Compliance Required)

Maternity Emergencies Multi-Professional Study Day (90% Compliance Required)

Newborn Basic Life Support (NBLS) (90% Compliance Required)

Perinatal Quality Surveillance Matrix (PQSM) March 2026

Compliance with National Directives: Three Year Delivery Plan

Maternity and Neonatal Three Year Delivery Plan Oversight Tool - Outlier summary

Contents page

NHS England

This sheet shows, for each ICB and Trust, how many measure results are demonstrating better outcomes / progress or needing further support / improvement, and which measures these relate to

MBRRACE-UK metrics: Better outcomes — Poorer outcomes

All other metrics: More positive — Improvement / support needed

Select organisation (table): University Hospitals Bristol and Weston NHS Foundation Trust

Select ICB or Trust level map: ICB

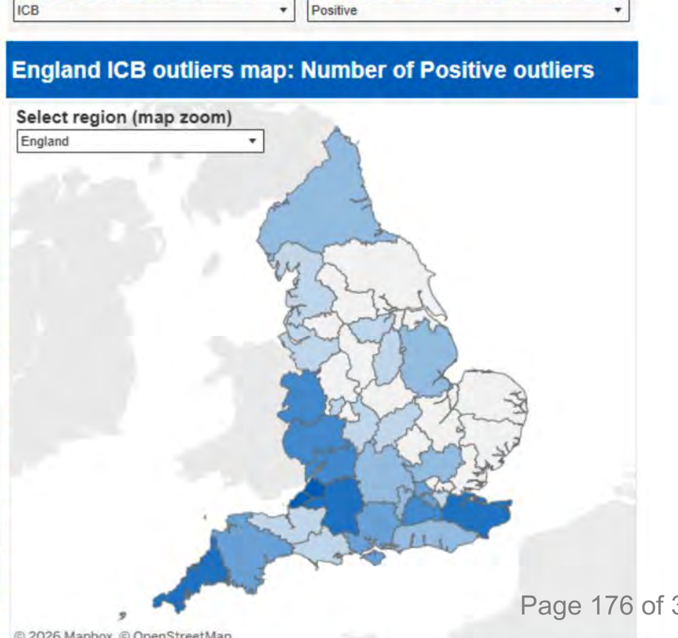
Select positive/negative outlier map: Positive

University Hospitals Bristol and Weston NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	41	2	9
Listening to and working with women and families with compassion	12	1	3
Growing, retaining and supporting our workforce	13	1	3
Developing and sustaining a culture of safety, learning and support	13		2
Standards and structures that underpin safer, more personalised, and more equitable care	3		1

Measure	Result
T1b:Involvement in antenatal care decisions	88.9%
T1e:Involvement in decisions during labour and birth	84.5%
T1ni:Baby Friendly Accreditation - Maternity	0.0%
T1nii:Baby Friendly Accreditation - Neonatal	100.0%
T2ai:Midwives' satisfaction with recognition for good work	53.2%
T2bi:Midwives' satisfaction with work being valued by your organisation	46.8%
T2ci:Opportunities to discuss and agree learning needs at the sta of training - Trainee Midwives	45.5%
T2hi:Midwife Turnover Rate	4.6%
T3bi:Midwives' confidence in organisations response to concerns about unsafe clinical practice	70.6%
T3ci:Midwives' recommendation of the service	88.9%
T4biii:Neonatal Mortality Rate (Stabilised) (MBRRACE)	2.4

England ICB outliers map: Number of Positive outliers



Perinatal Quality Surveillance Matrix (PQSM) March 2026

Compliance with National Directives: Three Year Delivery Plan

University Hospitals Bristol and Weston NHS Foundation Trust: Developing and sustaining a culture of safety, learning and support

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Comfortable raising concerns - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	75.1%	**100.0%**	100.0%		0.0% →
Comfortable raising concerns - Trainee Midwives	Percentage	2024	69.3%	**72.7%**	18.8%		54.0% ▲
Midwives' confidence in organisations response to concerns about unsafe clini…	Percentage	2024	55.0%	**70.6%**	57.7%		12.9% ▲
Midwives' experience of learning culture	Percentage	2024	73.4%	**80.7%**	81.2%		-0.5% ▼
Midwives' recommendation of the service	Percentage	2024	71.1%	**88.9%**	85.6%		3.3% ▲
Obs & Gynae confidence in organisations response to concerns about unsafe …	Percentage	2024	54.0%	**61.5%**	46.7%		14.9% ▲
Obs & Gynae experience of learning culture	Percentage	2024	69.3%	**61.5%**	64.3%		-2.7% ▼
Obs & Gynae recommendation of the service	Percentage	2024	75.0%	**84.6%**	86.7%		-2.1% ▼
Quality of clinical supervision out of hours for doctors	Percentage	2025	79.9%	**87.5%**	100.0%		-12.5% ▼
Quality of shift handovers for trainee doctors	Percentage	2025	89.3%	**100.0%**	92.9%		7.1% ▲
Recommendation of the training post - Obstetrics and Gynaecology Specialist …	Percentage	2024	64.8%	**62.5%**	100.0%		-37.5% ▼
Recommendation of the training post - Trainee Midwives	Percentage	2024	75.8%	**63.6%**	46.7%		17.0% ▲
Supportive working environment for trainee doctors	Percentage	2025	72.2%	**70.6%**	81.3%		-10.7% ▼

University Hospitals Bristol and Weston NHS Foundation Trust: Growing, retaining and supporting our workforce

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Midwife Sickness Absence Rate	Percentage	November 2025	6.4%	**8.2%**	3.6%		4.7% ▲
Midwife Turnover Rate	Percentage	Year to December 2025	6.6%	**4.8%**	12.1%		-7.3% ▼
Midwives' satisfaction with recognition for good work	Percentage	2024	41.7%	**53.2%**	49.0%		4.1% ▲
Midwives' satisfaction with work being valued by your organisation	Percentage	2024	33.8%	**46.8%**	37.5%		9.3% ▲
Obs & Gynae satisfaction with recognition for good work	Percentage	2024	52.7%	**53.8%**	60.0%		-6.2% ▼
Obs & Gynae satisfaction with work being valued by your organisation	Percentage	2024	44.0%	**38.5%**	33.3%		5.1% ▲
Obstetric Sickness Rate	Percentage	November 2025	2.2%	**2.7%**	0.5%		2.2% ▲
Opportunities to discuss and agree learning needs at the start of training - Obst…	Percentage	2024	95.4%	**100.0%**	100.0%		0.0% →
Opportunities to discuss and agree learning needs at the start of training - Trai…	Percentage	2024	83.4%	**45.5%**	62.5%		-17.0% ▼
Overall educational experience - Obstetrics and Gynaecology Specialist Traine…	Percentage	2024	61.6%	**62.5%**	92.3%		-29.8% ▼
Overall educational experience - Trainee Midwives	Percentage	2024	79.1%	**72.7%**	35.7%		37.0% ▲
Permitted to attend learning opportunities - Obstetrics and Gynaecology Speci…	Percentage	2024	59.2%	**62.5%**	61.5%		1.0% ▲
Permitted to attend learning opportunities - Trainee Midwives	Percentage	2024	75.3%	**63.6%**	42.9%		20.8% ▲

Key

Past Trend
- ● Baseline (Period closest to the publication of the three year delivery plan in March 2023)

Change from baseline (colour)
- Significant deterioration from baseline
- No significant change from baseline
- Significant improvement from baseline
- Not appropriate for significance testing

Change from baseline (symbol)
- ▼ Decrease
- ▲ Increase
- → No change

University Hospitals Bristol and Weston NHS Foundation Trust: Listening to and working with women and families with compassion

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Adequacy of information or explanations during postnatal hospital care	Percentage	2025	60.9%	**54.3%**	58.7%		-4.4% ▼
Adequacy of time spent discussing physical and mental health at the 6-8 week…	Percentage	2025	36.9%	**32.6%**	30.1%		2.5% ▲
Awareness of medical history during antenatal check-ups	Percentage	2025	53.4%	**47.6%**	55.0%		-7.4% ▼
Baby Friendly Accreditation - Maternity	Percentage	December 2025	32.1%	**0.0%**	0.0%		0.0% →
Baby Friendly Accreditation - Neonatal	Percentage	December 2025	13.8%	**100.0%**	100.0%		0.0% →
Being listened to during antenatal check-ups	Percentage	2025	84.1%	**85.5%**	88.9%		-3.3% ▼
Being listened to during postnatal care	Percentage	2025	77.2%	**82.8%**	83.1%		-0.3% ▼
Consideration of personal circumstances during postnatal care at home	Percentage	2025	74.5%	**75.8%**	78.1%		-2.3% ▼
Involvement in antenatal care decisions	Percentage	2025	81.9%	**88.9%**	82.4%		6.5% ▲
Involvement in decisions during labour and birth	Percentage	2025	76.9%	**84.5%**	78.2%		6.3% ▲
Kind and compassionate treatment during labour and birth	Percentage	2025	83.1%	**87.5%**	87.6%		-0.1% ▼
Response to concerns during labour and birth	Percentage	2025	81.6%	**83.8%**	87.5%		-3.7% ▼

University Hospitals Bristol and Weston NHS Foundation Trust: Standards and structures that underpin safer, more personalised, and more equitable care

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Neonatal Mortality Rate (MBRRACE)	Rate per 1,000	2023	N/A	**1.9**	4.3		-2.5 ▼
Neonatal Mortality Rate (Stabilised) (MBRRACE)	Rate per 1,000	2023	N/A	**2.4**	N/A		N/A ✕
Preterm Birth Rate (MSDS)	Percentage	November 2025	6.6%	**6.1%**	6.7%		-0.6% ▼
Stillbirth Rate (MBRRACE)	Rate per 1,000	2023	N/A	**2.1**	3.5		-1.4 ▼
Stillbirth Rate (Stabilised) (MBRRACE)	Rate per 1,000	2023	N/A	**3.3**	N/A		N/A ✕

Perinatal Quality Surveillance Matrix (PQSM)
March 2026

Compliance with National Directives: Ockenden

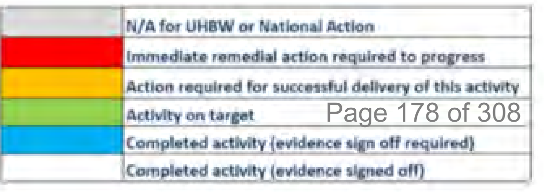
The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England and MNSI.

Description	Number of Assurance Questions	N/A for UHBW or National Actions	Red	Amber	Green	Blue	Completed and Evidenced	% of Compliance
Workforce Planning and Sustainability	11	1	0	0	0	0	10	100.00
Supporting Families	3	0	0	0	0	0	3	100.00
Safe Staffing	10	2	0	0	0	0	8	100.00
Pre-term Birth	4	1	0	0	0	0	3	100.00
Postnatal Care	4	0	0	0	0	0	4	100.00
Obstetric Anaesthesia	5	2	0	0	0	0	3	100.00
Neonatal Care	8	3	0	1	0	0	4	87.50
Multidisciplinary Training	9	0	0	0	0	0	9	100.00
Learning from Maternal Deaths	3	2	0	0	0	0	1	100.00
Labour and Birth	6	0	0	0	0	0	6	100.00
Incident Investigations and Complaints	7	0	0	0	0	0	7	100.00
Escalation and Accountability	5	0	0	0	0	0	5	100.00
Complex Antenatal Care	5	0	0	0	0	0	5	100.00
Clinical Governance and Leadership	7	1	0	0	0	0	6	100.00
Bereavement Care	4	0	0	0	1	0	3	75.00
	91	12	0	1	1	0	77	97.80

Next Steps for Progression:

•IEA13 – Expansion of new ' Bereavement Champion' role to support 7 day bereavement support

•IEA14 – Neonatal Staffing



Colour	Key
Grey	N/A for UHBW or National Action
Red	Immediate remedial action required to progress
Amber	Action required for successful delivery of this activity
Green	Activity on target
Blue	Completed activity (evidence sign off required)
White	Completed activity (evidence signed off)

Report To:	Public Group Board Meeting		
Date of Meeting:	12 May 2026		
Report Title:	Corridor Care		
Report Author:	Philip Kiely, Chief Operating Officer		
Report Sponsor:	Stuart Walker, Hospital Managing Director		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		

Key Points to Note *(Including any previous decisions taken)*
Corridor care is associated with poor patient experience, generates low morale for our staff, and undermines the public's confidence in the ability of the NHS to provide safe care when they need it to most. NHSE has set expectations regarding actions to virtually eliminate corridor care. These include increasing visibility and transparency of the use of corridor care through updated national definitions and reporting requirements. Actions are also being taken at a national level including the publication of a GIRFT improvement guide to support the virtual elimination of corridor care. This paper considers further trust-level actions to ensure that local leadership teams are doing everything within their control to eradicate corridor care and improve quality, safety and dignity of care.
Strategic and Group Model Alignment
The respective TMTs are overseeing the development of action plans and completion of gap analyses against the GIRFT improvement guide. Where opportunities arise, these actions will be brought together at Group level including the sharing of learning with wider leadership teams.
Risks and Opportunities
Risks There are several risks relating to inpatient bed demand versus capacity, and the related impact on timeliness of admission and reliance on corridor care. The risk score for 423 was increased to 25 in January on the basis that harm is occurring daily, with patients experiencing prolonged waits in ED and cohort areas. Rates of NCTR are acknowledged as a contributor to the pressures on inpatient bed capacity. 423 – Risk that inpatient demand exceeds bed capacity (25) 7769 – Risk that patients in ED do not receive timely care (20) 2614 – Risk that sustained reliance on extra, temporary and corridor bed capacity compromises patient care, safety, privacy and dignity (15)

8252 - Risk that patients with no criteria to reside remain in hospital (16)
8250 - Risk that the proportion of NCTR patients in WGH reduces the available beds for emergency and elective care (12)

Recommendation
The Group Board is asked to note the assessment of escalation spaces against corridor care criteria and the draft gap analysis against the GIRFT Corridor Care Improvement Guide Checklist. The Group Board is asked to approve the UHBW Action Plan for Corridor Care.

History of the paper (details of where paper has previously been received)	
Clinical Quality Group	Pending
Trust Management Team	8 April 2026
Group Executive Meeting	15 April 2026

Appendices:	Appendix A – Assessment Against Corridor Care Criteria Appendix B - Action Plan for Corridor Care Appendix C – GIRFT Corridor Care Improvement Guide Checklist (DRAFT)

Situation
On 4 March, a letter from Sarah-Jane Marsh, National Director of Urgent and Emergency Care and Operations, was sent to Trust CEOs and Chairs regarding additional actions to virtually eliminate corridor care. This letter outlined new standards, reporting requirements, and actions to support delivery at a national level and at trust-level. The GIRFT subsequently published a Corridor care improvement guide. This guide is intended to support services to reduce corridor care. The following paper outlines the trust response, gap analysis against the improvement guide and associated action plan.

Background

Standards

The national publications define the following red lines as standards that systems should be aiming for as a minimum:

1) Ambulance handovers no greater than 45 minutes
2) Zero tolerance for ED waits over 24 hours
   a) Any breach must trigger an immediate review of the patient's full journey, with direct oversight from the executive tri (CMO, CNO and COO)
3) Corridor care limits and escalation
   a) Each Trust must strengthen its full capacity protocol to include clear and explicit limits on the use of corridor care.
   b) Any breach must trigger a formal root cause analysis reported to the CEO, ensuring that learning is captured and underlying issues are addressed

Definition

A new definition of 'Corridor Care' has been published by NHSE. This definition replaces the existing 'Temporary Escalation Spaces' definition.

The term 'corridor care' is inclusive of any non-designated clinical space. It refers to care given in an unplanned or inappropriate clinical setting.

A space is designated as corridor care if it cannot meet one or more of the following criteria:

- Is it a clinically safe and appropriate setting?
- Can privacy be maintained?
- Can dignity be maintained e.g. access to food, water and toilets?
- Can lights be turned off to facilitate sleep?
- Have the IPC team approved as appropriate?

Where a patient is waiting in a comfortable place for a short period of time i.e. less than 45 minutes, with a plan to move to another place to progress their care, this should not be considered corridor care.

Reporting Requirements

The reporting requirements distinguish between corridor care in the Emergency Department and inpatient wards or other clinical areas.

Emergency Department:

- Count the number of patients who receive corridor care for more than 45 minutes in the previous 24-hour reporting period (midnight to midnight), in the same way that attendances are reported. This includes patients awaiting assessment, admission or transfer, or receiving treatment, and applies ED only.
- Ambulance handover delays should not be included in the count of number of patients who received corridor care and should continue to be reported separately.

Inpatient Wards or Other Clinical Areas:

- Count the number of patients receiving care on a ward outside a bed space for more than 45 minutes. This is limited to general and acute (G&A) beds and excludes ED. The figures provided should relate to the latest position on the day of reporting. This snapshot should be taken at 8am, showing the total number of adult G&A corridor care beds occupied on the day of reporting.

The newly defined corridor care measures will need to be submitted in the UEC Daily Sitrep collection. New fields to collect these data will be available for completion from 6 March. At the same time, the current fields used to collect Temporary Escalation Spaces will be stood down.

Based on this definition, data will be collected on corridor care and NHSE plan to publish it, subject to data quality, each month from May 2026.

Assessment

An assessment was undertaken of spaces being utilised as part of the Trust's ambulance handover SOP and escalation plan / fully capacity protocol.

A summary of this assessment against corridor care criteria is included in Appendix A. It indicates that 85 spaces fall within these criteria. These spaces fall broadly into three categories:

- ED queuing – 23 spaces
- Boarding – 35 spaces
- Pre-emptive boarding – 15 spaces
- Discharge lounges overnight only – 12 spaces

A similar exercise which considered the prior definition of Temporary Escalation Spaces identified 55 spaces. Therefore, the definition of corridor care has increased the number of spaces within scope by 30 spaces.

Note that corridor care is not synonymous with the use of non-inpatient facilities for escalation. The use of the Queen's Day Unit and Cath Labs at the BRI, and the Medical and Surgical Day Units in Weston, were assessed as not meeting the criteria for corridor care.

An initial assessment has also been undertaken against the GIRFT Corridor Care Improvement Guide checklist. This will be used to inform UEC improvement plans and support the elimination of corridor care.

Recommendation

The Group Board is asked to note:

- the assessment of escalation spaces against corridor care criteria (Appendix A)
- that the use of escalation spaces in day units (QDU, Cath Labs and Weston Day Units) fall outside of these criteria.
- the draft gap analysis against the GIRFT Corridor Care Improvement Guide Checklist. This will be further developed through the internal Urgent Care Operational Group (UCOG).

The Group Board is asked to approve:

- the UHBW Action Plan for Corridor Care (Appendix B). The action plan will be held by the internal Urgent Care Operational Group (UCOG) with regular updates to the Planning and Delivery Group.

Appendix A – Assessment Against Corridor Care Criteria

Area	Site	Location	Number of Spaces (based on maximum if all in use)
ED Corridor care	BRI	Queue E (A300)	4
		Queue D (A300)	4
		Majors A (Boarding)	2
		ED Obs (Boarding)	2
	WGH	Corridor A & B	8
		Corridor C	4
		Corridor D	3
General and acute corridor care	BRI	A400 Premptive boarding	1
		A515 Premptive boarding	3
		A801 pre-emptive boarding	2
		A400/A528/A524/A801/C808/A900/C705/C708/C805/A800/A700/A701 (boarding)	31
		Discharge lounge	6
	WGH	OPAU/Harptree/Berrow/Sandford/Uphill/Hutton/Cheddar/Kewstoke/Steepholm (pre-emptive boarding)	9
		Discharge lounge	6
Total			85

Escalation spaces used but not meeting corridor care criteria:

<table>
<tr><th>Area</th><th>Site</th><th>Location</th><th>Number of Spaces (based on maximum if all in use)</th></tr>
<tr><td rowspan="6">ED Corridor Care</td><td rowspan="6">BRI</td><td>Queue A (A300)</td><td>6</td></tr>
<tr><td>Queue B (A301)</td><td>3</td></tr>
<tr><td>Queue C (A307)</td><td>10</td></tr>
<tr><td>ED bay 15 (CDU)</td><td>2</td></tr>
<tr><td>ED majors/resus (overnight only)</td><td>12</td></tr>
<tr><td>ED minors (overnight only, See & Treat/Bay 13-15)</td><td>9</td></tr>
<tr><td rowspan="9">General and Acute Corridor Care</td><td rowspan="5">BRI</td><td>Procedure room A900</td><td>1</td></tr>
<tr><td>Procedure room C808</td><td>1</td></tr>
<tr><td>A518 boarding</td><td>2</td></tr>
<tr><td>Cath labs</td><td>11</td></tr>
<tr><td>QDU</td><td>13</td></tr>
<tr><td rowspan="4">WGH</td><td>Draycott ward boarding</td><td>2</td></tr>
<tr><td>Harptree ward boarding</td><td>1</td></tr>
<tr><td>Medical day case (MDCU)</td><td>4</td></tr>
<tr><td>Surgical day case (SDCU)</td><td>12</td></tr>
<tr><td colspan="3">Total</td><td>89</td></tr>
</table>

Appendix B - Action Plan for Corridor Care

Workstream	Action	Description	Target
1. National Definition and Policy Alignment	Update relevant trust policies and SOPs to reflect the change in definition of corridor care.	Changes are required to be made to the SOPs already in place to reflect change in terminology	30 April 2026
	Communicate to trust staff the new definition, the standards that have been set, and policy direction to work towards and elimination of use of corridor care	Cascade of documents and communication through Divisional teams. Working group in place for Nursing oversight of Corridor care	30 April 2026
2. Reporting and Data Quality	Report the number of patients who receive corridor care for more than 45 minutes in the Emergency Departments on daily UEC SITREP	This data is already reported against the current TES definitions. These numbers will be reported for the new corridor care submission.	1 Apr 2026
	Report the number of patients who receive corridor care for more than 45 minutes on wards or other clinical areas	Capturing the number of patients in corridor care at the census will be manageable for boarding beds (assuming that stay will be >45 mins). However, there may be data quality issues with data concerning pre-emptive boarding beds. This element of the return may have to rely on data collected by the site team.	1 Apr 2026
3. Governance, Oversight and Risk Management	Increase visibility of Trust Management Team in areas where corridor care is in regular use to provide opportunity to observe and speak to patients and staff about experiences.	Documentation of visits made by TMT to all clinical areas where corridor care is in place across all sites.	30 April 2026
	Review of trust escalation policy to reflect requirements concerning corridor care.	The Trust has already established a task and finish group to update the escalation policy. This	30 Apr 2026

Workstream	Action	Description	Target
		group will consider the requirements associated with corridor care including the definition of limits for maximum time that a patient can be placed in a pre-emptive boarding space. A clear protocol to be developed for de-escalation of patients in corridor care spaces to reduce likelihood that they will be in these spaces for greater than 45 minutes. Escalation policy to be approved at TMT level.	
	Identify data that will be reportable in the IQPR to Board in relation to corridor care.	As a minimum, the number of patients who received corridor care in ED and wards or other clinical areas will be reportable. Consideration should also be given to reporting the number of spells greater than 24 hours in emergency departments, and the use of escalation beds that fall outside of the definition of corridor care.	30 Apr 2026
4. Incident Reporting and Learning	Consider how corridor care should be managed within our incident reporting processes to ensure it both influences positive change and is practicable.	Reviewed and agreed at GEM that each individual incident will not be reported, but any incident of harm or concern must continue to be reported.	Closed
5. Patient Safety, Experience and Dignity	Review the current use of boarding beds and whether it is desirable to normalise the use of these spaces (i.e. changing the spacing between beds in bays and installing bed head services including call bells where possible).	To be considered with the support of Estates and IPC colleagues	30 Apr 2026
	Review use of pre-emptive boarding and boarding and the impact on patient outcomes.	Consider the relative data on quality of care, outcomes and length of stay associated with the use of these spaces.	30 Apr 2026

Workstream	Action	Description	Target
	Review of management of patients in escalation areas outside of the definition of corridor care (QDU and Cath Labs in BRI/BHI and Medical / Surgical Day Units in Weston).	Noting the 2026/27 bed modelling and likely continued reliance on escalation capacity to consider the supervisory nursing model in QDU, Cath Labs and Medical and Surgical Day Units in Weston.	31 May 2026
		To improve the facilities offered to patients in these areas by installing showering facilities in the QDU and Cath Labs.	30 Jun 2026
	Review the assurance process established within corridor spaces to ensure preservation of patient dignity and comfort: provide privacy screens, call bell/visibility to staff, explanations and apology, family communication, toileting privately, hydration/nutrition, warmth, and pain relief. Divisions to provide assurance of care provision and escalate risks and actions.	Assurance process in place across UHBW. Robustness of process requires reviewing. Areas who have patients requiring corridor care as a minimum should undertake an assurance assessment on a weekly basis. Monthly feedback on assurance templates to be established and reviewed by nursing corridor care oversight group.	31 May 2026
	Strengthen review process of feedback received from patients and families, identifying learning and sharing across divisions.	Feedback obtained from FFT, monthly inpatient survey and bespoke 6 monthly volunteers survey	31 May 2026
6. Operational Flow Improvements	Delivery of UEC capital schemes to more effectively manage demand at the front door	To establish an Acute Medical Triage model and to optimise use and availability of Medical SDEC and Frailty SDEC within the BRI.	Dec 2026
	Deliver UEC improvements against three priority workstreams: Arrival into ED – SDEC utilisation Flow through the ED – Inter-professional standards and NHS at Home utilisation Flow through wards – P0 improvement	Inter-professional standards and associated performance dashboard will be launched at the end of March 2026.	Complete

Workstream	Action	Description	Target
	Further develop Every Minute Matters programme to improve ward processes to support timely discharge	To be monitored through the Monthly Every Minute Matters programme and report to SLT	30 March 2027
	Benchmark practice against new Model Emergency Department and Model Acute Pathway and FRAIL strategy publications	Divisional leadership teams are considering these publications. EEMAC models likely to be adopted in both adult and paediatric services in preparation for winter.	30 Jun 2026

Appendix C – GIRFT Corridor Care Improvement Guide Checklist (DRAFT)

Domain	Standard	Assessment	RAG
Step 1 – Ambulance			
Single Point of Access (SPoA)	SPoA operates collaboratively across systems at ICB level to ensure that health and social care providers can rapidly access alternatives to hospital admission for patients with urgent healthcare needs.	ICB to complete	N/A
	Systems develop and appropriately scale community unscheduled care services, including same-day response, integrated CAS and rapid access to primary or planned community care pathways.	ICB to complete	N/A
	The service is available at least 12 hours per day, seven days a week via a single telephone number which any clinician can call for advice and guidance.	ICB to complete	N/A
	SPoA has real time visibility of all relevant patient case loads and lists, including ambulance portals, and is staffed by a MDT of senior clinical decision-makers (AHP, nursing, medical and non-medical staff).	ICB to complete	N/A
	SPoA has access to shared care records and direct booking into services, including specialty receiving areas, SDECs, UCR and virtual wards.	ICB to complete	N/A
Receiving Areas	Rapid assessment by a senior nurse and/or clinical senior decision maker within 15 minutes of arrival, resulting in appropriate diagnostic requests and initiation of time critical treatments.	Arrival to triage time - all patients: 42.3% UHBW, 37.9% WGH, 45% BRI. Target: 95%	2 – somewhat confident
	Default patients to Fit to Sit unless there is a documented clinical reason for trolley or bed care. Ensure that there is correct sized seating to meet demand.	Both BRI & WGH utilise a 'fit to sit' model, currently not formalised or monitored. Seating correctly sized	3 – established confident
	Enable rapid streaming to any appropriate service within the hospital.	Patients are streamed to other services within the Trust when identified/appropriate. Unclear if monitored	3 – established confident

Domain	Standard	Assessment	RAG
	Service triumvirate leads review the efficacy of the service, its data, and consistency of service once a month. This is reported and reviewed by an executive SRO.	WGH/BRI: ED tri meets weekly to review performance data with DHD with bimonthly specialty reviews with the SMT Not reviewed by an exec SRO: monthly high level UEC performance review at UCOG	4 – mature confident
	Full capacity protocols are used to ensure that every ambulance receiving area has a proactive trigger, mitigation and escalation document, which means the area always functions and does not default to ED.	Ambulance handover SOP under review alongside Escalation policy	2 – somewhat confident
	Receiving areas should exist in ED, SDEC, Frailty, SAU, GAU and AMU as a minimum.	All SDEC's & assessment units have a 'direct admit' protocol, capacity to support is variable	3 – established confident
Fit to Sit	Implement a trust-wide Fit to Sit SOP, co-designed with all stakeholders (including patients), which articulates the importance of patients sitting out of bed where clinically appropriate and the standards which will ensure patients are cared for in seated waiting areas.	No trust wide SOP though a fit to sit model is in place across both BRI & WGH	2 – somewhat confident
	Provide adequate seated areas to meet demand within ED, SDEC/EEMAC and acute receiving areas (e.g. AMU, Acute Frailty Unit, Surgical and Gynaecology Assessment Units) and ensure they have appropriate clinical oversight.		3 – established confident
	Record a daily decision for bedded patients, clearly documenting the clinical reason where a patient is not appropriate to sit out of bed.		TBC
	Move suitable patients awaiting discharge to the discharge lounge before 10am, unless a documented clinical reason prevents this.	Discharge lounge is used by ED and the main users of the lounge in the morning. Unclear how proactively this is encouraged or documented	2 – somewhat confident

Domain	Standard	Assessment	RAG
Step 2 – Emergency Department			
Streaming; Initial Assessment; Time to Treatment	A streaming policy is in place to allow clinical staff (including nurses and ACPs) to easily stream patients to the right service for their need, with appropriate escalation processes where this does not occur.	Not fully assessed - no SOP available on Mystaff. Guidance document is available for BRI redirection	1 – not confident
	Processes are in place to ensure patients presenting to UTC/ED have an initial assessment within 15 minutes, and are then seen, treated and either admitted or discharged within four hours. Performance against these standards should be monitored and regularly reviewed to ensure that services are aligned and resourced to deliver them.	Standard is regularly monitored through divisional performance structure and UCOG. Confidence level is based on monitoring of performance/awareness of 4hr standard	4 – mature confident
	Patients are streamed to a UTC (ideally co-located) where they have a non-life/limb-threatening minor injury or illness. The UTC should have consistent opening times throughout the week and be staffed to meet the expected demand and case mix.	BNSSG UTC's do not have consistent opening times: they close regularly when at capacity. UHBW patients are referred to any one of the 3 UTC's when appropriate and capacity allows. WGH: UTC located some distance from the acute site presenting barriers to streaming. Unable to stream to non-BNSSG UTCs from ED (i.e. Somerset)	2 – somewhat confident
	Clinical teams should undertake regular criteria-to-admit audits to identify and address opportunities to manage patients without hospital admission.		TBC
UTC or Equivalent	The service is co-located with the ED. The UTC must have a named senior clinical leader supported by an appropriate multidisciplinary workforce. It should be open 7 days a week, 12 hours a day as a minimum, typically increasing to 24 hours a day when co-located.	ICB to complete	N/A

Domain	Standard	Assessment	RAG
	All patients, regardless of arrival method, are assumed suitable for UTC until assessed otherwise.	ICB to complete	N/A
	UTCs must have access to bedside diagnostics and plain X-ray facilities throughout the UTC opening hours. UTCs must have access to investigations including timely blood testing (near patient testing when appropriate) and electrocardiograms (ECG) must be available, and in some UTCs D-dimer, troponin and CRP testing should also be considered.'	ICB to complete	N/A
	UTCs should have referral pathways into EDs and specialist services as required and operate as part of a networked model of urgent care to flow patients to the most appropriate service according to their need	ICB to complete	N/A
	Any patient presenting with a condition that could normally be managed in a general practice should be seen by an appropriate clinician in the most appropriate service.	ICB to complete	N/A
Step 3 – Alternatives to Admission			
Urgent Community Response	UCR is easily accessible and available in line with demand. It is an integral part of 'Call before Convey' processes via SPoA.	ICB to complete	N/A
	Access criteria are open and available to any healthcare practitioner within the community and acute setting and UCR is directly linked to the SPoA.	ICB to complete	N/A
	Commissioners and providers monitor patients supported by the service but also review the referrals of patients who were rejected to look for missed opportunities to increase the support offered.	ICB to complete	N/A
	UCR services have access to patient records from the acute, community, primary care, ambulance service providers and other relevant areas.	ICB to complete	N/A
	UCR services can proactively pull patients from the ambulance stack and can directly access any community or acute service. This should	ICB to complete	N/A

Domain	Standard	Assessment	RAG
	also include being able to access advice lines within those services 24 hours a day.		
SDEC	Operate an SDEC service for at least 12 hours a day, seven days a week, able to receive patients from ED, primary care, ambulance services and the community.	Variable service over the weekends. Confidence level reflects the number of established SDEC services across UHBW but also lack of weekend provision	3 – established confident
	Access criteria are not restrictive and avoid the use of clinical pathways as inclusion criteria and use an appropriate list of exclusion criteria to ensure that opportunities for SDEC are maximised.	WGH & BRI: SDEC SOP details exclusion criteria rather than pathway based	4 – mature confident
	Community Directories of Service have an accurate description of the service and opening hours. Activity should be monitored to ensure direct access is maximised.	DoS does not reflect all SDEC services currently	2 – somewhat confident
	Protect the SDEC areas, ensuring they are not used to accommodate patients requiring inpatient beds.	BRI medical SDEC part of escalation options for overnight use only (QC)	2 – somewhat confident
	Provide timely access to diagnostics, equivalent to ED and acute receiving areas.	Same access as per ED but not monitored currently	3 – established confident
	A Full Capacity Protocol is in place which clearly articulates how SDEC function will be maintained at times of heightened escalation without patients defaulting to ED.	FCP: UHBW use an 'escalation policy' incorporating FCP principles. It describes impact of use of QC (SDEC) at the BRI and de-escalation process	2 – somewhat confident
Frailty	Patients aged over 65 presenting to hospital as an emergency should be assessed by a competent clinical decision-maker within 30 minutes of arrival using the Clinical Frailty Scale (CFS) and the 4AT tool for delirium.	26% over 65's attending ED receive documented CFS (24% BRI/27% WGH) 4AT completed but cannot monitor compliance electronically.	2 – somewhat confident

Domain	Standard	Assessment	RAG
		Both BRI & WGH have Front door frailty team and Frailty SDEC, currently cannot monitor assessment within 30 mins by competent decision maker electronically	
	Implement a frailty advisory service and make it available for any community-based health care practitioner requiring it.	F-ACE is a community frailty service with specialist input across BNSSG - not acute hospital based	2 – somewhat confident
	Acute frailty services working within ED or in an ambulatory Acute Frailty Unit co-located with ED operate for at least 70 hours each week, pulling patients without the need for a full ED assessment.	Mon-Fri service with some cover across the weekend. WGH have a frailty 'take' and BRI have Frailty consultants on the medical 'take' (not every weekend). Some therapy/nursing provision at the weekends	2 – somewhat confident
	A trust pathway for managing frailty and delirium is available and used by all wards managing older people living with frailty.		TBC
	Organisations within a system work with care providers to develop pathways for falls, long lies, management of head injuries and effective advance care planning, initially focusing on the care homes with the highest rate of conveyance.		TBC
	An executive SRO leads on a clinically-led frailty strategy to reduce conveyance in close collaboration with the ICB and community partners	BRI and WGH have consultant clinical leads for frailty - no exec SRO for frailty specifically	2 – somewhat confident
Virtual Wards	Virtual wards are resourced to meet demand, and hospital and community teams work together to maintain occupancy as close to 100% as possible.	This is variable for each specialty. NHS@Home works closely with hospital and community teams to maintain occupancy and report through UCOG. Confidence score	3 – established confident

Domain	Standard	Assessment	RAG
		reflects established service, but also variability in capacity	
	The access criteria for virtual wards is open, and they are accessible by any healthcare practitioner within the community and acute trust		3 – established confident
	Ensure accurate listing on the Directory of Services, which is routinely monitored to ensure all opportunities are realised to 'step up' patients from the community. Virtual ward staff should also have access to near patient testing to reduce unnecessary conveyance to hospital.		TBC
	Virtual wards have access to hospital level diagnostics such as endoscopy, radiology, or cardiology and may include bedside tests such as point of care blood tests.		TBC
	Proactively identify and pull patients from acute receiving areas, ED, SDEC and specialty in-patient areas.	Variable dependant on staffing levels.	2 – somewhat confident
	Virtual wards have access to a designated expert clinical decisionmaker for at least 12 hours a day, seven days a week	Variable depending on specialty	3 – established confident
Hot Clinics / Urgent Specialty Opinion	Hot clinics are available for patients in all clinical specialties	BRI: cardiac, ENT, respiratory, acute medicine, nutrition & D&E (acute med at WGH)	3 – established confident
	Speciality service leads should carry out retrospective reviews based on inpatient referrals where it has been deemed that the patient could have been managed in an outpatient setting.	Not routinely undertaken	1 – not confident
	Each directorate conducts a demand and capacity review to ensure that no patient remains as an inpatient when a hot clinic appointment could have facilitated early discharge	Not routinely and not specifically focussed on inpatient v's hot clinic demand/capacity. SDEC 'bring	2 – somewhat confident

Domain	Standard	Assessment	RAG
		back' clinics regularly see patients being discharged 'early' with SDEC clinic appointment	
Step 4 – Inpatient Care			
Acute Receiving Areas	Acute receiving areas have a 48 - 72-hour length of stay model which is protected by the organisation.	All acute receiving areas have a service model SOP and aim to operate with an average LOS of 48-72 hrs, however there will be occasional circumstances where this difficult to achieve (i.e. IPC/ECO requirements/wait for transfer to downstream bed)	2 – somewhat confident
	Where a patient requires urgent specialty opinion for acuity, clinical decision-making or discharge planning, the specialty senior clinical decision-maker should respond within a maximum of two hours of the request. All patients accepted by a speciality should be moved to the specialty ward area within 12 hours of referral.	Some variability across specialties. Timely access to downstream specialty beds is challenging due to bed deficit and high NCTR numbers, also impacted by seasonal demand and deficit of cubicles side rooms, particularly at the WGH site.	2 – somewhat confident
	Patients in acute receiving areas have equitable access to diagnostics comparable to ED and other acute areas, including cross-sectional imaging, particularly if this is indicated due to clinical urgency or will facilitate early discharge.	Not yet monitored, will be through IPS dashboard	4 – mature confident
	Consultant-led MDT ward rounds are undertaken in all acute receiving areas, 365-days a year, supported by afternoon board rounds and face to face reviews where patients are either unwell, in a higher dependency area, or where review will facilitate discharge	Variable across the 2 AMU's, 2 OPAU's and 1 STAU. Weekend/bank holiday provision of MDT board rounds not in place routinely and afternoon board rounds not formalised on all wards	3 – established confident

Domain	Standard	Assessment	RAG
	All urgent primary care and SPOA referrals to present either to SDEC or acute receiving areas and not to ED unless the patient requires immediate resuscitation.	Impacted by capacity on the day. All have direct referrals in place	2 – somewhat confident
Reducing Length of Stay (including for NCTR patients); Enabling Discharge	Each ward holds a daily boar d/ward round led by an expert decision-maker and including a senior nurse and members of the wider MDT, focusing on patients who require face to face review to advance their care.	WGH & BRI: In place Monday-Friday. No ward based daily board round at weekends/bank holidays. Most wards except for Surgery have daily proactive MDT board rounds, variable over the weekends	4 – mature confident
	A post board/ward round huddle should occur to ensure that actions for the day have been allocated and are recorded.	Currently an EMM priority	1 – not confident
	Implement criteria-led discharge pathways. This should include to virtual wards and hot clinics.	Variable use of CLD: Surgery/SS high users, medicine/WGH less so - more challenging to set criteria in medical patients	2 – somewhat confident
	Patients identified for discharge the previous day should be transferred to the discharge lounge before 10am, unless a clinical reason is documented in the patient record.	Use of the discharge lounge pre 10 am is low unless patients have been on the unit overnight or are from ED. EMM priority to facilitate improved access to list of patients suitable for discharge the day before discharge	1 – not confident
	Twice-weekly multi-professional length of stay reviews are undertaken for all patients in hospital for more than seven days.	This is detailed within the Outlier SOP, unclear if multiprofessional	3 – established confident
	Patients are supported to sit out of bed routinely, unless a documented clinical reason prevents this, with particular focus on patients living with frailty.	This is part of the Active Hospitals initiative.	3 – established confident

Domain	Standard	Assessment	RAG
	Specialty leads understand and monitor the daily demand for their service, ensuring the required capacity is available to meet demand	This is part of specialty reviews held within medicine/WGH. Surgery and Specialised Services TBC.	3 – established confident
Step 5 – Culture and Leadership			
Clinical Operational Standards	Review trust COS/IPS against GIRFT COS and the Model Acute Pathway to ensure that trust standards match national recommendations.	IPS due to be implemented by end March in line with GIRFT COS/Model acute pathway	3 – established confident
	Trust COS are agreed by executives, senior medical leaders and all specialties, including clear escalation pathways to be used where standards are not met.	As above	2 – somewhat confident
	Trusts aim for all patients to be assessed by a competent clinical decisionmaker within one hour of referral from the ED or arrival on an acute receiving area. All admitted patients should be assessed by an expert clinical decisionmaker, normally a consultant, within a maximum of six hours during the day and 14 hours overnight.	As above and will be monitored through the IPS dashboard at UCOG	2 – somewhat confident
	Patients are moved to a specialty assessment area where clinically appropriate at the earliest possible opportunity.	Use of Tap to Transfer to highlight when a bed is ready is variable and currently under review. Aim is to move patients in a timely manner but multiple limiting factors. Some addressed through EMM programme and some through other workstreams	2 – somewhat confident
	Ensure all key 'Front Door'/UEC services have equitable access to diagnostics (e.g. cross-sectional imaging) and support services (e.g. therapies, pharmacy).	Weekend access to therapies/pharmacy variable at WGH	3 – established confident
	Ensure daily ward and board rounds are undertaken seven days per week, with full and effective utilisation of discharge lounges, virtual wards and hot clinics.	On going work within EMM to improve effectiveness of proactive board rounds/ward rounds. Variable offer over the weekends	3 – established confident

Domain	Standard	Assessment	RAG
Engagement and Support	Staff members across multiple services are able to name the executive team and recognise and describe the values of the organisation.	To be reconfirmed in context of Group development	3 – established confident
	The whole executive team are able to describe which factors impacting on care are not tolerated, e.g., corridor care, handover delays etc. and why.		TBC
	Trusts have in-person, monthly staff engagement events with the executive team.	Monthly 'town hall' sessions undertaken with Group Executive. Monthly TMT staff forum established	3 – established confident
	Each member of the executive team has a formal 360 appraisal from a cross-section of staff.		TBC
	Each executive spends regular, dedicated sessions working alongside clinical teams, reporting on their experience and learning at executive board meetings.		TBC
	The executive team ensures that junior staff feel empowered to develop and deliver improvements.		TBC
Operations / Site Management	An experienced, competent and empowered clinical site manager (Band 7 and above) should be on site running operations 24/7.	Site management in place at our hospital sites	4 – mature confident
	The site has permanent access to all flow dashboards across the system and hospital (including the ambulance service).	Leadership teams can access care traffic control dashboards providing key metrics across partner organisations SITREPs available on intranet	4 – mature confident
	Action-focused flow meetings occur at least three times per day and should have strict terms of reference which align with OPEL.	Flow calls scheduled daily at 8:30, 12:30 and 16:00. Daily system call scheduled at 11:00.	4 – mature confident

Domain	Standard	Assessment	RAG
	Senior clinicians and executives are present at all flow meetings when the trust or site is functioning at OPEL 3 and above, with a responsibility for de-escalating risk and supporting decision-making.	Senior divisional leadership present on flow meetings. There isn't routine executive presence on these calls	2 – somewhat confident
	The executive team always have access to the sitrep, are aware of the OPEL status and can articulate mitigation occurring when at OPEL 4.	OPEL status is presented on the intranet following each flow call. The OPEL status of each partner organisation and the system is presented on the care traffic control report	4 – mature confident
	All members of the operational site management team routinely recognise and manage risks associated with initial assessment, ambulance delays, category 2 delays, TTT delays and corridor care.		3 – established confident

Report To:	Public Group Board Meeting		
Date of Meeting:	12 May 2026		
Report Title:	Corridor Care		
Report Author:	Nicholas Smith, Chief Operating Officer Michael Puckey, Interim Hospital Director of Nursing		
Report Sponsor:	Glyn Howells, Hospital Managing Director		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		

Key Points to Note *(Including any previous decisions taken)*

Corridor care is associated with poor patient experience, generates low morale for our staff, and undermines the public's confidence in the ability of the NHS to provide safe care when they need it to most.

NHSE has set expectations regarding actions to virtually eliminate corridor care. These include increasing visibility and transparency of the use of corridor care through updated national definitions and reporting requirements.

Actions are also being taken at a national level including the publication of a GIRFT improvement guide to support the virtual elimination of corridor care. This paper considers further trust-level actions to ensure that local leadership teams are doing everything within their control to eradicate corridor care and improve quality, safety and dignity of care.

Strategic and Group Model Alignment

The respective TMTs are overseeing the development of action plans and completion of gap analyses against the GIRFT improvement guide.

Where opportunities arise, these actions will be brought together at Group level including the sharing of learning with wider leadership teams.

Risks and Opportunities

NBT Summary: Operational Pressure & Flow Risks

Several Trust Level Risks (TLRs) directly relate to operational pressure, patient flow constraints, overcrowding, and their downstream effects on safety, quality, and experience. The core themes are demand exceeding capacity, inability to move patients efficiently and congestion in emergency and inpatient pathways.

1. Overcrowding & Flow Constraints (TLRs 1940, 2233, 2157)

2. Delays in Discharge & No Criteria to Reside (TLR 2182)

3. Use of Escalation Areas & Boarding (TLRs 1881, 1970, 1972)

4. Mental Health Flow & Assessment Delays (TLRs 1697, 1699)

Overall Themes Across All Flow Related Risks

Theme	Description
Sustained demand > capacity	Chronic overcrowding in ED and inpatient beds.
System level discharge delays	Lack of community capacity driving high NC2R numbers.
Space used beyond design	Corridors, double rooms, boarding increase safety risk.
Workforce pressure	Staff fatigue, skill mix issues, reliance on temporary staff.
Compounded safety risks	Increased falls, delayed care, reduced oversight in cramped areas.
Fire/safety infrastructure limitations	Over-occupancy reduces ability to evacuate safely (TLR 2234).

Recommendation

The Group Board is asked to note the assessment of escalation spaces against corridor care criteria and the draft gap analysis against the GIRFT Corridor Care Improvement Guide Checklist.

The Group Board is asked to approve the NBT Action Plan for Corridor Care.

History of the paper (details of where paper has previously been received)	
NBT Clinical Quality Group NBT Trust Management Team	10.4.26

Appendices:	Appendix A – Assessment Against Corridor Care Criteria Appendix B - Action Plan for Corridor Care Appendix C – GIRFT Corridor Care Improvement Guide Checklist (DRAFT)

Situation
On 4 March, a letter from Sarah-Jane Marsh, National Director of Urgent and Emergency Care and Operations, was sent to Trust CEOs and Chairs regarding additional actions to virtually eliminate corridor care. This letter outlined new standards, reporting requirements, and actions to support delivery at a national level and at trust-level. The GIRFT subsequently published a Corridor care improvement guide. This guide is intended to support services to reduce corridor care. The following paper outlines the trust response, gap analysis against the improvement guide and associated action plan.

Background

Standards

The national publications define the following red lines as standards that systems should be aiming for as a minimum:

1) Ambulance handovers no greater than 45 minutes
2) Zero tolerance for ED waits over 24 hours
   a) Any breach must trigger an immediate review of the patient's full journey, with direct oversight from the executive tri (CMO, CNO and COO)
3) Corridor care limits and escalation
   a) Each Trust must strengthen its full capacity protocol to include clear and explicit limits on the use of corridor care.
   b) Any breach must trigger a formal root cause analysis reported to the CEO, ensuring that learning is captured and underlying issues are addressed

Definition

A new definition of 'Corridor Care' has been published by NHSE. This definition replaces the existing 'Temporary Escalation Spaces' definition.

The term 'corridor care' is inclusive of any non-designated clinical space. It refers to care given in an unplanned or inappropriate clinical setting.

A space is designated as corridor care if it cannot meet one or more of the following criteria:

- Is it a clinically safe and appropriate setting (Including bed head services, e.g. Oxygen and call bells?)
- Can privacy be maintained?
- Can dignity be maintained e.g. access to food, water and toilets?
- Can lights be turned off to facilitate sleep?
- Have the IPC team approved as appropriate?

Where a patient is waiting in a comfortable place for a short period of time i.e. less than 45 minutes, with a plan to move to another place to progress their care, this should not be considered corridor care.

Reporting Requirements

The reporting requirements distinguish between corridor care in the Emergency Department and inpatient wards or other clinical areas.

Emergency Department:

- Count the number of patients who receive corridor care for more than 45 minutes in the previous 24-hour reporting period (midnight to midnight), in the same way that attendances are reported. This includes patients awaiting assessment, admission or transfer, or receiving treatment, and applies to ED only.
- Ambulance handover delays should not be included in the count of number of patients who received corridor care and should continue to be reported separately.

Inpatient Wards or Other Clinical Areas:

- Count the number of patients receiving care on a ward outside a bed space for more than 45 minutes. This is limited to general and acute (G&A) beds and excludes ED. The figures provided should relate to the latest position on the day of reporting. This snapshot should be taken at 8am, showing the total number of adult G&A corridor care beds occupied on the day of reporting.

The newly defined corridor care measures will need to be submitted in the UEC Daily Sitrep collection. New fields to collect these data will be available for completion from 6 March. At the same time, the current fields used to collect Temporary Escalation Spaces will be stood down.

Based on this definition, data will be collected on corridor care and NHSE plan to publish it, subject to data quality, each month from May 2026.

Assessment

An assessment was undertaken of spaces being utilised as part of the Trust's ambulance handover SOP and escalation plan/full capacity protocol.

A summary of this assessment against corridor care criteria is included in Appendix A. It indicates that 108 (+) spaces fall within these criteria. These spaces fall broadly into two categories:

- ED Corridor Care – 22+ spaces (noting XROADS >6 - no confirmed max.)
- General and Acute Corridor Care – 86+ spaces (noting Double Occupancy fluctuates)

A similar exercise which considered the prior definition of Temporary Escalation Spaces identified 47 spaces. Therefore, the definition of corridor care has increased the number of spaces within scope by 61 spaces. To note, this increase incorporates the maximum use of

double occupancy that has ever been enacted at NBT (20 – more routinely this will be 8-10) and the same for >6 in XROADS (14 – more routinely 4-8).

Note that corridor care is not synonymous with the use of non-inpatient facilities for escalation. The use of Interventional Radiology, Medi-rooms, Elgar Enablement Unit and ED X-Ray and ED Paeds were assessed as not meeting the criteria for corridor care.

An initial assessment has also been undertaken against the GIRFT Corridor Care Improvement Guide checklist. This will be used to inform UEC improvement plans and support the elimination of corridor care.

Improvement plans aligned to the GIRFT guide will be managed as operational groups (e.g. via Every Minute Matters and the various Clinical Operations Standards workstreams) reporting to the GIRFT board. Scoping of the anticipated rate of benefits seen by this program of work is being assessed and will be shared at the May GIRFT board.

Recommendation

The Group Board is asked to note:

- the assessment of escalation spaces against corridor care criteria (Appendix A)
- that the use of escalation spaces in day units (Interventional Radiology, Medirooms, Elgar Enablement Unit, ED X-Ray and ED Paeds) fall outside of these criteria.
- the draft gap analysis against the GIRFT Corridor Care Improvement Guide Checklist. This will be further developed through the internal Urgent Care Operational Group (UCOG).

The Group Board is asked to approve:

- the UHBW Action Plan for Corridor Care (Appendix B). The action plan will be held by the GIRFT Board with regular updates to the Trust Management Team.

Appendix A – Assessment Against Corridor Care Criteria NBT

Area	Location	Number of Spaces (based on maximum if all in use)
ED Corridor Care	ARC (XROADS) >6 pts	14 (max to date)
	Long Corridor	3
	Vending	3
	Majors 15/16	2
	TOTAL	**22+**
General and Acute Corridor Care	1 Up in Bay	32
	Boarding Beds	22
	Double Occupancy	20 (max. To date)
	AMU Corridor	6
	AFU Corridor	3
	SAU Corridor	3
	TOTAL	**86**

Appendix B - Action Plan for Corridor Care

Workstream	Action	Description	Target
1. National Definition and Policy Alignment	Update relevant trust policies and SOPs to reflect the change in definition of corridor care.	Changes are required to be made to the SOPs already in place to reflect change in terminology	30 April 2026
	Communicate to trust staff the new definition, the standards that have been set, and policy direction to work towards and elimination of use of corridor care	Cascade of documents and communication through Divisional teams. Actions to virtually eliminate corridor care, Hospital Group Summit event – provisional date in late May / early June.	30 June 2026
2. Reporting and Data Quality	Report the number of patients who receive corridor care for more than 45 minutes in the Emergency Departments on daily UEC SITREP	Data is already reported against the current TES definitions. Reporting validated against new definitions and updated. These numbers will be reported for the new corridor care submission.	Complete
	Report the number of patients who receive corridor care for more than 45 minutes on wards or other clinical areas	Power BI report that captures 'ED Defined Corridor Care' and 'General and Acute Defined Corridor Care'.	10 Apr 2026
3. Governance, Oversight and Risk Management	Increase visibility of Trust Management Team in areas where corridor care is in regular use to provide opportunity to observe and speak to patients and staff about experiences.	Documentation of visits made by TMT to all clinical areas where corridor care is in place across all sites.	10 April 2026
	Review of trust ambulance handover SOP, escalation policy and full capacity protocol	Phase 2 action to update SOP's in line with elimination of corridor care (enablers in phase 1) A clear protocol to be developed for de-escalation of patients in pre-emptive boarding spaces to	1 July 2026

Workstream	Action	Description	Target
		reduce likelihood that they will be in these spaces for greater than 45 minutes. Escalation policy to be approved at TMT level.	
	Identify data that will be reportable in the IQPR to Board in relation to corridor care.	As a minimum, the number of patients who received corridor care in ED and wards or other clinical areas will be reportable. Consideration should also be given to reporting the number of spells greater than 24 hours in emergency departments, and the use of escalation beds that fall outside of the definition of corridor care.	30 Apr 2026
4. Incident Reporting and Learning	Consider how corridor care should be managed within our incident reporting processes to ensure it both influences positive change and is practicable.	Single Radar will be submitted by CSM to record total numbers meeting definitions in 24h period. Patient level data then available via data warehouse report to cross reference with any harm events.	Closed
5. Patient Safety, Experience and Dignity	Review the current use of boarding beds and whether it is desirable to normalise the use of these spaces (i.e. changing the spacing between beds in bays and installing bed head services including call bells where possible).	To be considered with the support of Estates and IPC colleagues	30 Apr 2026
	Review use of pre-emptive boarding and boarding and the impact on patient outcomes.	Consider the relative data on quality of care, outcomes and length of stay associated with the use of these spaces.	30 Apr 2026
	Review of management of patients in escalation areas outside of the definition of corridor care (IR/ Xray).	Noting bed modelling demonstrating overall bed deficit and likely continued reliance on escalation capacity, to review SOP's to make best use of appropriate escalation areas and maximise patient experience and outcomes	31 May 2026

Workstream	Action	Description	Target
		To consider feasibility improvements to the facilities offered to patients in these areas.	30 Jun 2026
	Review the assurance process established within corridor spaces to ensure preservation of patient dignity and comfort: provide privacy screens, call bell/visibility to staff, explanations and apology, family communication, toileting privately, hydration/nutrition, warmth, and pain relief. Divisions to provide assurance of care provision and escalate risks and actions.	Assurance process in place across NBT via checklist. Robustness of process requires reviewing, including move to digital recording for compliance and quality monitoring. Areas who have patients requiring corridor care should undertake an assurance assessment on a daily basis. Divisions to review compliance / feedback through Divisional Review process.	31 May 2026
	Strengthen review process of feedback received from patients and families, identifying learning and sharing across divisions.	Feedback obtained from FFT, monthly inpatient survey and bespoke 6 monthly volunteers survey. Review through Corridor Care standing agenda item at Clinical Quality Group.	31 May 2026
6. Operational Flow Improvements	Delivery of UEC capital schemes to more effectively manage demand at the front door	To establish an Acute Medical Triage model and to optimise use and availability of Medical SDEC and Frailty SDEC within the BRI.	Dec 2026
	Deliver UEC improvements against three priority workstreams: Arrival into ED – SDEC utilisation Flow through the ED – Inter-professional standards and NHS at Home utilisation Flow through wards – P0 improvement	Inter-professional standards and associated performance dashboard will be launched at the end of March 2026.	Complete
	Further develop Every Minute Matters programme to improve ward processes to support timely discharge	To be monitored through the Monthly Every Minute Matters programme and report to SLT	30 March 2027

Workstream	Action	Description	Target
	Benchmark practice against new Model Emergency Department and Model Acute Pathway and FRAIL strategy publications	To be embedded as part of the Minors relocation workstream.	30 Jun 2026

Appendix C – GIRFT Corridor Care Improvement Guide Checklist (DRAFT)

Domain	Standard	Assessment	RAG
Step 1 – Ambulance			
Single Point of Access (SPoA) **SRO: ICB and Chief Operating Officer (acute)**	SPoA operates collaboratively across systems at ICB level to ensure that health and social care providers can rapidly access alternatives to hospital admission for patients with urgent healthcare needs.	Care co-ordination is a BNSSG UEC strategic priority which is currently in the discovery phase of work being overseen by UEC ODG. Initial findings reported and now being refined into delivery priorities. Significant admission avoidance opportunities have been identified through the work.	2 – somewhat confident NB RAG rated amber due to the work only having recently started.
	Systems develop and appropriately scale community unscheduled care services, including same-day response, integrated CAS and rapid access to primary or planned community care pathways.	This has been picked up as part of the UEC strategy work on care co-ordination. Capacity in services such as UCR flagged as requiring review.	2 – somewhat confident
	The service is available at least 12 hours per day, seven days a week via a single telephone number which any clinician can call for advice and guidance.	Sirona SPoA is available in this way, but note there are several system SPoA, including also system CAS, F-ACE CEMS and SWAST. Integration of these functions will be picked up through the care co-ordination work.	2 – somewhat confident
	SPoA has real time visibility of all relevant patient case loads and lists, including ambulance portals, and is staffed by a MDT of senior clinical decision-makers (AHP, nursing, medical and non-medical staff).	Services such as F-ACE and system CAS have this type of MDT format, with the idea of integration of a single system SPoA / Care-Co picked up through the UEC strategy work.	2 – somewhat confident
	SPoA has access to shared care records and direct booking into services, including specialty receiving areas, SDECs, UCR and virtual wards.	This functionality exists for the current SPoA services, though visibility of referral pathways has been identified as an opportunity in the system care-co work eg GPs	2 – somewhat confident

Domain	Standard	Assessment	RAG
		currently unaware that they can refer directly into reablement.	
Receiving Areas **SRO: Chief Nursing Officer**	Rapid assessment by a senior nurse and/or clinical senior decision maker within 15 minutes of arrival, resulting in appropriate diagnostic requests and initiation of time critical treatments.	Arrival to triage time – all patients 68.0% NBT for 25/26 (Target 95%)	2 – somewhat confident
	Default patients to Fit to Sit unless there is a documented clinical reason for trolley or bed care. Ensure that there is correct sized seating to meet demand.	NBT utilises a 'fit to sit' model via EDAU, currently not formalised or monitored. Seating correctly sized although capacity risk.	3 – established confident
	Enable rapid streaming to any appropriate service within the hospital.	Patients are streamed to other services within the Trust when identified/appropriate. Streaming and redirection is monitored, with c15-20% of daily ED attendances redirected into alternative services – NB this is one of the highest rates of redirection nationally.	4 – mature confident
	Service triumvirate leads review the efficacy of the service, its data, and consistency of service once a month. This is reported and reviewed by an executive SRO.	Medicine DoD leads a weekly review meeting, including ED triumvirate. Output forms the reporting into Divisional Performance Reviews which is attended by Hospital Management Team.	4 – mature confident
	Full capacity protocols are used to ensure that every ambulance receiving area has a proactive trigger, mitigation and escalation document, which means the area always functions and does not default to ED.	Ambulance handover SOP under review alongside Escalation policy. The traditional full capacity protocol actions are challenging because NBT runs at >100% bed occupancy all year round, with boarding built into the continuous flow model.	4 – mature confident – processes are mature, impact is less so because of the very high occupancy level

Domain	Standard	Assessment	RAG
	Receiving areas should exist in ED, SDEC, Frailty, SAU, GAU and AMU as a minimum.	All SDEC's & assessment units have a 'direct admit' protocol. No medically expected patients come in via ED. New processes in place for specialty expected patients, with escalation process due to launch shortly.	3 – established confident
Fit to Sit **SRO: Chief Nursing Officer**	Implement a trust-wide Fit to Sit SOP, co-designed with all stakeholders (including patients), which articulates the importance of patients sitting out of bed where clinically appropriate and the standards which will ensure patients are cared for in seated waiting areas.	"Active hospitals" approach is being taken forwards through the Every Minute Matters approach and is one of the lines of enquiry in the "NCTR Optimisation" workstream.	2 – somewhat confident
	Provide adequate seated areas to meet demand within ED, SDEC/EEMAC and acute receiving areas (e.g. AMU, Acute Frailty Unit, Surgical and Gynaecology Assessment Units) and ensure they have appropriate clinical oversight.	Seating areas are provided across the emergency front doors, though capacity is variable due to high occupancy and the backlog of DTA's in ED / patients waiting to move from ax areas to inpatient beds.	3 – established confident
	Record a daily decision for bedded patients, clearly documenting the clinical reason where a patient is not appropriate to sit out of bed.	This is not in place but could be considered as part of the active hospitals approach.	1 – not confident
	Move suitable patients awaiting discharge to the discharge lounge before 10am, unless a documented clinical reason prevents this.	Discharges before 10am have increased across the Trust as part of the Every Minute Matters work, this includes numbers into the discharge lounge before 10am. ED are a significant user of the discharge lounge.	3 – established confident
Step 2 – Emergency Department			
Streaming; Initial Assessment; Time to Treatment	A streaming policy is in place to allow clinical staff (including nurses and ACPs) to easily stream patients to the right service for their need, with appropriate escalation processes where this does not occur.	ED robustly streams and redirects c35 patients / 15-20% of daily attendances into alternative services.	4 – mature confident

Domain	Standard	Assessment	RAG
SRO: Chief Medical Officer & Chief Nursing Officer			
	Processes are in place to ensure patients presenting to UTC/ED have an initial assessment within 15 minutes, and are then seen, treated and either admitted or discharged within four hours. Performance against these standards should be monitored and regularly reviewed to ensure that services are aligned and resourced to deliver them.	Standard is regularly monitored through divisional performance structure, DR and UEC governance, including new UEC delivery group and GIRFT Board. Confidence level is based on monitoring of performance/awareness of 4hr standard	4 – mature confident
	Patients are streamed to a UTC (ideally co-located) where they have a non-life/limb-threatening minor injury or illness. The UTC should have consistent opening times throughout the week and be staffed to meet the expected demand and case mix.	There is no UTC local to NBT to stream to (Yate is an MIU only). Opening hours are consistent, but close too early (8pm) when demand is still peaking. The MIUs and UTC in BNSSG frequently restrict access due to insufficient capacity.	2 – somewhat confident
	Clinical teams should undertake regular criteria-to-admit audits to identify and address opportunities to manage patients without hospital admission.	CTA audits take place regularly with partners from BrisDoc, primary care, ICB and Sirona.	3 – established confident
Co-located UTC or Equivalent **SRO: Chief Operating Officer**	The service is co-located with the ED. The UTC must have a named senior clinical leader supported by an appropriate multidisciplinary workforce. It should be open 7 days a week, 12 hours a day as a minimum, typically increasing to 24 hours a day when co-located.	There is no UTC local to NBT, but the Trust has funding to develop a business case during 2026/27 for a co-located UTC.	1 – not confident – NB low confidence rating due to current arrangements i.e. no UTC
	All patients, regardless of arrival method, are assumed suitable for UTC until assessed otherwise.	This will form part of the service model for the co-located UTC business case.	1 – not confident – NB low confidence

Domain	Standard	Assessment	RAG
			rating due to current arrangements ie no UTC
	UTCs must have access to bedside diagnostics and plain X-ray facilities throughout the UTC opening hours. UTCs must have access to investigations including timely blood testing (near patient testing when appropriate) and electrocardiograms (ECG) must be available, and in some UTCs D-dimer, troponin and CRP testing should also be considered.'	This will form part of the service model for the co-located UTC business case.	1 – not confident – NB low confidence rating due to current arrangements ie no UTC
	UTCs should have referral pathways into EDs and specialist services as required and operate as part of a networked model of urgent care to flow patients to the most appropriate service according to their need	This will form part of the service model for the co-located UTC business case.	1 – not confident – NB low confidence rating due to current arrangements ie no UTC
	Any patient presenting with a condition that could normally be managed in a general practice should be seen by an appropriate clinician in the most appropriate service.	Streaming and redirection will form part of the co-located UTC delivery model.	1 – not confident – NB low confidence rating due to current arrangements ie no UTC
Step 3 – Alternatives to Admission			
Urgent Community Response **SRO: ICB and Chief Operating Officer**	UCR is easily accessible and available in line with demand. It is an integral part of 'Call before Convey' processes via SPoA.	Access is easy, but discovery work as part of the system care co-ordination project has shown that referrers have been put off due to capacity shortfalls and lack of responsiveness. Demand and capacity review will form part of the	2 – somewhat confident

Domain	Standard	Assessment	RAG
		next steps of the UEC strategy work.	
	Access criteria are open and available to any healthcare practitioner within the community and acute setting and UCR is directly linked to the SPoA.	Yes, but note that capacity shortfalls have put off referrers (mainly GPs) who now often see admission to hospital as the only option.	2 – somewhat confident
	Commissioners and providers monitor patients supported by the service but also review the referrals of patients who were rejected to look for missed opportunities to increase the support offered.	The system care-co work has identified missed opportunity audit work as one of the potential next steps.	2 – somewhat confident
	UCR services have access to patient records from the acute, community, primary care, ambulance service providers and other relevant areas.	Some records available via connecting care. Sirona and primary care on different versions of EMIS.	2 – somewhat confident
	UCR services can proactively pull patients from the ambulance stack and can directly access any community or acute service. This should also include being able to access advice lines within those services 24 hours a day.	UCR does not operate a pull model. Advice lines are not available 24/7	1 – not confident
SDEC **SRO: Chief Meical Officer & Chief Operating Officer**	Operate an SDEC service for at least 12 hours a day, seven days a week, able to receive patients from ED, primary care, ambulance services and the community.	Medical, Surgical and Gynae SDEC operate 12 hours per day, though last admissions are a few hours prior to closing and service provision at the weekends in medical SDEC is limited. There is no frailty SDEC service.	2 – somewhat confident
	Access criteria are not restrictive and avoid the use of clinical pathways as inclusion criteria and use an appropriate list of exclusion criteria to ensure that opportunities for SDEC are maximised.	SDEC SOPs detail exclusion criteria rather than pathway based	4 – mature confident
	Community Directories of Service have an accurate description of the service and opening hours. Activity should be monitored to ensure direct access is maximised.	Yes, in place	4 – mature confident

Domain	Standard	Assessment	RAG
	Protect the SDEC areas, ensuring they are not used to accommodate patients requiring inpatient beds.	SDEC areas are never bedded.	4 – mature confident
	Provide timely access to diagnostics, equivalent to ED and acute receiving areas.	Same access as per ED and monitored as part of SLA	4 – mature confident
	A Full Capacity Protocol is in place which clearly articulates how SDEC function will be maintained at times of heightened escalation without patients defaulting to ED.	This is not in place but could be developed.	1 – not confident
Frailty **SRO: Chief Medical Officer & Chief Nursing Officer**	Patients aged over 65 presenting to hospital as an emergency should be assessed by a competent clinical decision-maker within 30 minutes of arrival using the Clinical Frailty Scale (CFS) and the 4AT tool for delirium.	Front door frailty team in place with assessment capacity on the Acute Frailty Triage area (in AFU). Having frailty SDEC provision would improve the front door offer and ability to turn patients around.	2 – somewhat confident
	Implement a frailty advisory service and make it available for any community-based health care practitioner requiring it.	F-ACE is a community frailty service with specialist input across BNSSG - not acute hospital based	3 – established confident
	Acute frailty services working within ED or in an ambulatory Acute Frailty Unit co-located with ED operate for at least 70 hours each week, pulling patients without the need for a full ED assessment.	Over occupancy across the inpatient areas means that the Acute Frailty Triage area is not able to take patients from ED in a timely enough way to avoid the need for full ED assessment. Frailty in-reach into ED does help with this, though is limited without frailty SDEC being in place.	2 – somewhat confident
	A trust pathway for managing frailty and delirium is available and used by all wards managing older people living with frailty.	No Trust delirium pathway.	1 – not confident
	Organisations within a system work with care providers to develop pathways for falls, long lies, management of head injuries and effective advance care planning, initially focusing on the care homes with the highest rate of conveyance.	The system care-co work has identified frailty as being an area where there are significant opportunities to improve the	1 – not confident

Domain	Standard	Assessment	RAG
		response to falls, long lies and head injuries. NBT is shortly to go live with a High Intensity User Group, thorugh which one workstream will focus on high conveyance care homes.	
	An executive SRO leads on a clinically-led frailty strategy to reduce conveyance in close collaboration with the ICB and community partners	There is no NBT or system frailty strategy, though this could be developed as part of the system care co-ordination work.	1 – not confident
Virtual Wards **SRO: Chief Medical Officer & Chief Nursing Officer**	Virtual wards are resourced to meet demand, and hospital and community teams work together to maintain occupancy as close to 100% as possible.	NHS@Home is funded to provide 165 virtual ward slots, though occupancy is around 60%. There are significant "step up" opportunities.	2 – somewhat confident
	The access criteria for virtual wards is open, and they are accessible by any healthcare practitioner within the community and acute trust	Yes, though clinicians often comment that referral routes are time consuming. Work is expected during the summer to move to a careflow referral which would streamline this.	3 – established confident
	Ensure accurate listing on the Directory of Services, which is routinely monitored to ensure all opportunities are realised to 'step up' patients from the community. Virtual ward staff should also have access to near patient testing to reduce unnecessary conveyance to hospital.	There are significant step-up opportunities for which a development plan is in place.	2 – somewhat confident
	Virtual wards have access to hospital level diagnostics such as endoscopy, radiology, or cardiology and may include bedside tests such as point of care blood tests.	Yes this is in place	3 – established confident
	Proactively identify and pull patients from acute receiving areas, ED, SDEC and specialty in-patient areas.	NHS@Home staff attend board rounds across clinicial areas	3 – established confident

Domain	Standard	Assessment	RAG
	Virtual wards have access to a designated expert clinical decisionmaker for at least 12 hours a day, seven days a week	Yes this is in place.	3 – established confident
Hot Clinics / Urgent Specialty Opinion **SRO: Chief Medical Officer & Chief Operating Officer**	Hot clinics are available for patients in all clinical specialties	Hot clinics are in place, through the Clinical Operational Standards workstream (NBT UEC Programme) work will be done to assess how timely access to hot clinics is.	3 – established confident
	Speciality service leads should carry out retrospective reviews based on inpatient referrals where it has been deemed that the patient could have been managed in an outpatient setting.	Not routinely undertaken	1 – not confident
	Each directorate conducts a demand and capacity review to ensure that no patient remains as an inpatient when a hot clinic appointment could have facilitated early discharge	Not routinely and not specifically focussed on inpatient v's hot clinic demand/capacity. SDEC 'bring back' clinics regularly see patients being discharged 'early' with SDEC clinic appointment	2 – somewhat confident
Step 4 – Inpatient Care			
Acute Receiving Areas **SRO: Chief Medical Officer & Chief Operating Officer**	Acute receiving areas have a 48 - 72-hour length of stay model which is protected by the organisation.	All acute receiving areas have a service model SOP and aim to operate with an average LOS of 48-72 hrs. LOS is limited by poor onward flow to specialty beds. LOS dashboards have been built and this will shortly be monitored by the Ops team with escalation where delays occur.	2 – somewhat confident
	Where a patient requires urgent specialty opinion for acuity, clinical decision-making or discharge planning, the specialty senior clinical decision-maker should respond within a maximum of two hours of the	Both aspects have been picked up in the COS workstream.	2 – somewhat confident

Domain	Standard	Assessment	RAG
	request. All patients accepted by a speciality should be moved to the specialty ward area within 12 hours of referral.		
	Patients in acute receiving areas have equitable access to diagnostics comparable to ED and other acute areas, including cross-sectional imaging, particularly if this is indicated due to clinical urgency or will facilitate early discharge.	In place and monitored via SLA, though performance / demand v capacity is difficult to ascertain.	2 – somewhat confident
	Consultant-led MDT ward rounds are undertaken in all acute receiving areas, 365-days a year, supported by afternoon board rounds and face to face reviews where patients are either unwell, in a higher dependency area, or where review will facilitate discharge	This is in place across acute receiving areas.	4 – mature confident
	All urgent primary care and SPOA referrals to present either to SDEC or acute receiving areas and not to ED unless the patient requires immediate resuscitation.	Alternative locations for specialty expected patients are in place for all NBT specialties and bedding in. A new escalation process is shortly to go live for any patient who inadvertently does attend via ED.	2 – somewhat confident
Reducing Length of Stay (including for NCTR patients); Enabling Discharge **SRO: Chief Medical Officer, Chief Operating Officer & Chief Nursing Officer**	Each ward holds a daily board/ward round led by an expert decision-maker and including a senior nurse and members of the wider MDT, focusing on patients who require face to face review to advance their care.	In place Monday-Friday. No ward based daily board round at weekends/bank holidays, though some specialties do have consultants on site reviewing the sickest patients.	3 – established confident
	A post board/ward round huddle should occur to ensure that actions for the day have been allocated and are recorded.	Post board round huddles do take place but work is needed to assure that all actions have been completed to escalated for senior support.	2 – somewhat confident
	Implement criteria-led discharge pathways. This should include to virtual wards and hot clinics.	CLD pathways are in place across the Trust including to NHS@Home and SDEC bring back clinics.	3 – established confident

Domain	Standard	Assessment	RAG
	Patients identified for discharge the previous day should be transferred to the discharge lounge before 10am, unless a clinical reason is documented in the patient record.	Trust wide discharges before 10am have increased. There is a project currently focussed on earlier moves to the discharge lounge.	2 – somewhat confident
	Twice-weekly multi-professional length of stay reviews are undertaken for all patients in hospital for more than seven days.	Division of Medicine has a weekly "stranded" review meeting for all patients >7 day LOS. IDS hosts a cross Divisional weekly review meeting for the top 20 LOS patients from each Division.	2 – somewhat confident
	Patients are supported to sit out of bed routinely, unless a documented clinical reason prevents this, with particular focus on patients living with frailty.	This is part of the Active Hospitals initiative under Every Minute Matters.	2 – somewhat confident
	Specialty leads understand and monitor the daily demand for their service, ensuring the required capacity is available to meet demand	The LOS Group (NBT UEC Programme) will be reviewing and holding specialty level demand and capacity data. A new report is being developed to support daily demand management for specialties as part of the continual flow approach.	2 – somewhat confident
Step 5 – Culture and Leadership			
Clinical Operational Standards **SRO: Chief Medical Officer**	Review trust COS/IPS against GIRFT COS and the Model Acute Pathway to ensure that trust standards match national recommendations.	Complete – due to launch with full comms and training plan in April.	3 – established confident
	Trust COS are agreed by executives, senior medical leaders and all specialties, including clear escalation pathways to be used where standards are not met.	As above	3 – established confident
	Trusts aim for all patients to be assessed by a competent clinical decisionmaker within one hour of referral from the ED or arrival on an acute receiving area. All admitted patients should be assessed by an expert clinical decisionmaker, normally a consultant, within a maximum of six hours during the day and 14 hours overnight.	As above and will be monitored through the COS dashboard at the COS oversight Group.	3 – established confident

Domain	Standard	Assessment	RAG
	Patients are moved to a specialty assessment area where clinically appropriate at the earliest possible opportunity.	Aim is to move patients in a timely manner but multiple limiting factors, particularly high bed occupancy. Some addressed through EMM programme and some through other workstreams	2 – somewhat confident
	Ensure all key 'Front Door'/UEC services have equitable access to diagnostics (e.g. cross-sectional imaging) and support services (e.g. therapies, pharmacy).	Equitable access to diagnostics are in place, though there is no therapy provision on AMU	3 – established confident
	Ensure daily ward and board rounds are undertaken seven days per week, with full and effective utilisation of discharge lounges, virtual wards and hot clinics.	On going work within EMM to improve effectiveness of board rounds/ward rounds. Variable offer over the weekends	3 – established confident
Engagement and Support **SRO: Chief Executive Officer**	Staff members across multiple services are able to name the executive team and recognise and describe the values of the organisation.	To be reconfirmed in context of Group development	3 – established confident
	The whole executive team are able to describe which factors impacting on care are not tolerated, e.g., corridor care, handover delays etc. and why.		3 – established confident
	Trusts have in-person, monthly staff engagement events with the executive team.	Monthly 'town hall' sessions undertaken with Group Executive. Monthly TMT staff forum established	3 – established confident
	Each member of the executive team has a formal 360 appraisal from a cross-section of staff.		TBC
	Each executive spends regular, dedicated sessions working alongside clinical teams, reporting on their experience and learning at executive board meetings.		TBC

Domain	Standard	Assessment	RAG
	The executive team ensures that junior staff feel empowered to develop and deliver improvements.		TBC
Operations / Site Management **SRO: Chief Operating Officer**	An experienced, competent and empowered clinical site manager (Band 7 and above) should be on site running operations 24/7.	This is in place, though note there is a single band 7 CSM overnight (eg compared to three at the BRI)	3 – established confident
	The site has permanent access to all flow dashboards across the system and hospital (including the ambulance service).	Leadership teams can access care traffic control dashboards providing key metrics across partner organisations SITREPs available on intranet	4 – mature confident
	Action-focused flow meetings occur at least three times per day and should have strict terms of reference which align with OPEL.	Flow calls scheduled daily at 8:30, 12:30 and 16:00. Daily system call scheduled at 11:00. A review of bed meetings is shortly to commence with support from the Patient First Team.	4 – mature confident
	Senior clinicians and executives are present at all flow meetings when the trust or site is functioning at OPEL 3 and above, with a responsibility for de-escalating risk and supporting decision-making.	Senior Divisional leads attend at OPEL 4. Membership and roles will be reviewed as part of the bed meeting review work.	2 – somewhat confident
	The executive team always have access to the sitrep, are aware of the OPEL status and can articulate mitigation occurring when at OPEL 4.	OPEL status is presented on the intranet following each flow call. The OPEL status of each partner organisation and the system is presented on the care traffic control report	4 – mature confident
	All members of the operational site management team routinely recognise and manage risks associated with initial assessment, ambulance delays, category 2 delays, TTT delays and corridor care.	Yes, this is in place	4 – mature confident

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Freedom to Speak Up (FTSU) Guardian Annual Reports 2025/2026</td></tr>
<tr><td>Report Author:</td><td colspan="3">Hilary Sawyer, Freedom to Speak Up Guardian, NBT
Kate Hanlon, Freedom to Speak Up Guardian, UHBW</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Xavier Bell, Group Chief of Staff</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td></td><td>x</td><td></td></tr>
<tr><td colspan="3">To provide an update on the following for both UHBW and NBT:
• Assessment of 2025/2026 FTSU data, themes and activity
• Triangulation of themes and 2025 staff survey results
• Action taken by the respective FTSU functions to support the speaking up, listening up and following up environment.
To highlight the following documents:
• NHSE England's document 'The future of Freedom to Speak Up' setting out revised responsibilities for FTSU across the NHS as a result of the closure of the National Guardian's Office in June 2026.
National Guardian Office reports published in 2025/2026:
• Speaking up annual data report 2024/2025 (Culture is a patient safety issue) (August 2025)
• FTSU Guardian Survey Thematic Review September 2025
• NGO Annual Report 2024/2025 (November 2025)
• Speak Up Review: Temporary Workers, Permanent Voices (March 2026)</td></tr>
<tr><td colspan="4">Key Points to Note (Including any previous decisions taken)</td></tr>
<tr><td colspan="4">The last report to Board was in July 2025.

Over the past 12 months, delivery of the Freedom to Speak Up service has been maintained during a period of leadership change and merger development. Guardians at both organisations have continued to operate their respective services, pending the outcomes of deliberations around the future structure and mechanisms, prioritising capacity on responding to concerns and enquiries and maintaining core visibility through proactive activities.

Work is underway to determine the future structure of the service within the merged organisation and how it will support progress against a wider Group People and Culture strategy. This will take into account the 2025 Dash review recommendations, noting that from 1 July 2026, NHS England will assume delivery of some activities following closure of the National Guardian's Office (NGO), with greater employer responsibility and accountability for effective FTSU arrangements in place with the right support to allow FTSU Guardians to deliver the role effectively, assessed by the CQC.</td></tr>
</table>

The FTSU 2025/2026 annual reports from NBT and UHBW are presented in an aligned format, allowing the Board to see organisational data side by side, encouraging cross organisational overview and discussion.

A Group Speaking Up Steering Group, chaired by the Group Chief Culture and People Officer, formed in March 2026 (meeting every two months) to ensure Executive oversight in supporting and strengthening a positive speaking up culture across Bristol NHS Group as part of shared values and safety mechanisms. This group will oversee the annual review of an organisational Speaking Up self-assessment, as required by NHSE, and will inform Speaking Up cultural improvement plans as part of the future People Strategy for the merged organisation, with intended resulting action plans for Speaking Up partners, e.g., FTSU, OD, Culture, Quality, Communications. Recommendations for improvements will also be made to Group Executive and Divisional leadership teams to ensure that speaking up is encouraged and recognised as an integral part of business as usual within all areas of the Group.

Reporting to Board will revert to a bi-annual report on FTSU in 2026/27, to ensure appropriate awareness and oversight of FTSU activity and an opportunity for discussion and identification of organisational learning.

Strategic and Group Model Alignment

A healthy speaking up culture supports both organisations' aims and Bristol NHS Group's vision to deliver seamless, high-quality, equitable and sustainable care, for the benefit of our patients, people, populations and the public purse. Consideration of future aligned service working will support the currently separate FTSU services, including review of best practice, the existing linking of the FTSU Champion networks and governance reporting structures and arrangements.

Risks and Opportunities

A healthy speaking up, listening up and following up environment is vital to a safe, effective and continuously improving organisation. It is a golden thread that runs through awareness and understanding issues of risk, safety, effectiveness, equity and inclusion, early on and/or preventing issues arising.

Triangulation of issues from speaking up (broadly) through various routes supports key items raised on the risk register.

In the current environment of organisational change, financial constraints, uncertainty and instability, a robust speaking up environment and FTSU Guardian service support patient safety, worker wellbeing, retention and reflection of themes for action and learning.

Recommendation

This report is for Discussion.

Board is asked to discuss:

- Alignment and divergence in FTSU data and themes across UHBW and NBT, how this intelligence triangulates with other assurance sources, and what it indicates about the current speaking up culture.

- Alignment of future approach to data triangulation, and how FTSU Guardians and Champions can help the Group understand, influence and strengthen speaking up culture toward best performing.

- Consider how the Board will actively support FTSU Guardians to continue their core work and expand proactive improvement activity, including leadership and support of FTSU Champion networks to help break down barriers to speaking up

- Reflect on how the Board and Executive Team can more visibly role-model speaking up, listening and following up, demonstrating how concerns lead to learning and change.
- Consider strengthening how learning from speaking up is captured, shared and communicated, ensuring workers see the value and positive impact of raising concerns or ideas translated into meaningful organisational improvement.

- The actions the Board can take to visibly role-model, encourage and support speaking up, listening up and following up.

Board is asked to note:

- Planned next steps for 2026/27, including consideration of the most effective FTSU structure and strategy for the merged organisation, refresh of organisational self-reviews and development of actions plans with key partners in related functions (Organisational Development, Leadership and Management Training, Patient Safety, EDI, Wellbeing, and Patient First improvement).

History of the paper (details of where paper has previously been received)	
N/A	

Appendices:	*Appendix 1 UHBW 2025/2026 Annual FTSU Report* *Appendix 2 NBT 2025/2026 Annual FTSU Report*

1. Purpose

The purpose of the report is to:

- Update the Board on Freedom to Speak Up (FTSU) data, themes, triangulation and activity at both organisations during 2025/2026
- Provide context for future requirements and arrangements for the FTSU service(s) across the Bristol NHS Group

2. Background

2.1 It has been 11 years since Sir Robert Francis' 'Freedom to Speak Up review' which led to the implementation of FTSU Guardians within the NHS.

2.2 There is a clear CQC well-led requirement to 'foster a positive culture where people feel that they can speak up and that their voice will be heard'. It is Board and Executive responsibility to ensure a strong, values-driven speaking up culture and to support the crucial work of the FTSU Guardians.

2.3 National arrangements for Freedom to Speak Up will change from 1 July 2026 as NHS England assumes responsibility for certain functions previously delivered by the NGO, in line with the 2025 DASH review recommendations. As a result, employers will be expected to take greater ownership and accountability for the effectiveness of their FTSU arrangements. This includes ensuring FTSU Guardians are appropriately supported to fulfil their role and that arrangements meet regulatory expectations, as assessed by the CQC. These changes heighten the need for continued Board oversight of FTSU effectiveness and resourcing.

2.4 The FTSU Guardians strongly support action to embed an inclusive speaking up environment (based on curiosity over judgement, safety over silence, learning over blame) through two key roles:

- **Proactive work:** a pivotal role as organisational improvement agents and subject matter experts in promoting an expectation (rather than exception) of speaking up in healthy organisations, supporting embedding a culture of trust, psychological safety, openness, transparency and accountability where worker voice is valued for safety, learning and improvement. This involves raising awareness and visibility, breaking down barriers (including through supporting networks of FTSU Champions under the leadership and supervision of the Guardians), training and engagement for workers, managers and leaders, supporting organisational learning, self-review and triangulation to improve the environment and response.
- **Responsive work:** a mandated safe, trusted, independent, confidential and impartial route to raise issues, concerns or suggestions for improvement where these are not heard through the usual route of escalation. Reducing fear of reprisal, providing support, focussing on response, resolution, and learning (restorative just, fair and learning culture), supporting the organisation to hear additional information, at times as early safety and cultural warning system, providing a mirror to the organisation on themes and dynamics and with independent constructive challenge

The FTSU Guardian role is not solely reactive as a 'concern handler and escalation point' but supports organisational safety, insight, learning and performance through identifying themes, hotspots, vulnerable groups, barriers, risk, culture challenges and testing whether workers feel safer to speak up over time.

This work is relational, challenging, complex, nuanced, and multi layered in a complex environment. When at its best the FTSU Guardian service can bring holistic and system-focussed approach to reflect patterns for action.

2.5 Current Resourcing

- UHBW: FTSU Guardian (0.8 WTE).
- NBT: Lead FTSU Guardian role (0.9 WTE) and Associate FTSU Guardian role (0.6 WTE –fixed term extended to late July 2026).

3. Update of data, themes and activity (in the separate UHBW and NBT reports)

3.1. Assessment of FTSU cases, data and themes

In 2025/26, UHBW reported 100 Freedom to Speak Up (FTSU) concerns – a level comparable to previous years (110 in 2024/25). The nature of concerns remained largely unchanged and continued to mirror national trends, with worker safety and wellbeing as the predominant theme. Concerns were most frequently raised by admin/clerical staff and registered nurses and midwives, and predominantly from staff in the Trust Services division. Common themes of concerns included:

- poor communication,
- challenging team dynamics,
- insufficient leadership and support, and
- unclear processes.

Of the 'teams in need' identified through the UHBW Data Triangulation Group, half had contacted FTSU. Although most concerns were resolved, 15 remained open at year-end, reflecting the persistent and complex nature of some cultural issues and investigation processes.

Feedback from those using the FTSU services indicated trust in the process itself; however, delays in actions beyond the Guardian's remit – including prolonged investigations – were identified as having a negative impact on psychological wellbeing and on staff confidence in learning and sustained organisational change.

In 2025/2026 a slightly higher number of concerns (137) were raised at NBT compared to the previous year. Board is asked to note that as some concerns are raised on behalf of a group of workers, more voices lie behind these concerns:

- The majority were again recorded in the inappropriate attitude and behaviours and worker wellbeing categories (similar to national trends).

- A higher level of anonymous concerns was raised during the year (including from Facilities and Bank workers).

Concerns raised brought valuable information to NBT for action. The themes from FTSU concerns triangulated with those reported through partner teams and together bring additional information for action. Some positive examples of responses to concerns being raised with local triangulation and action plans have been noted.

3.2. Actions taken to improve speaking up culture

- In 2025/26, the three core objectives of the UHBW Freedom to Speak Up (FTSU) Strategy continued to be largely met in relation to awareness, confidence, and accessibility.

- Awareness of FTSU was supported through high levels of training compliance (92.7%), alongside FTSU Guardian and champion engagement at staff inductions, walkarounds, and Trust-wide events.
- Confidence was further strengthened through the work of the UHBW data triangulation group, cross-site and regional champion collaboration, the sharing of peer support initiatives, and continued investment in champion development, including the appointment of the Trust's first bank FTSU champion.
- In 2025/2026 NBT FTSU service's key ongoing actions (pending the Group plans) remained supported by extension of the fixed term Associate Guardian secondment role, supporting proactive and responsive capacity and resilience including: visibility, awareness, training/engagement capacity to reach a wider range of workers, further evolution of the FTSU Champion network and their support (including networking CPD sessions with UHBW's network), input to related areas of NBT's cultural work (e.g., sexual safety, anti-racism).
- Since October 2024, the FTSU Champion and Guardian teams for the Group have come together as a network, meeting approximately quarterly (including CPD).

4. Summary and Recommendations

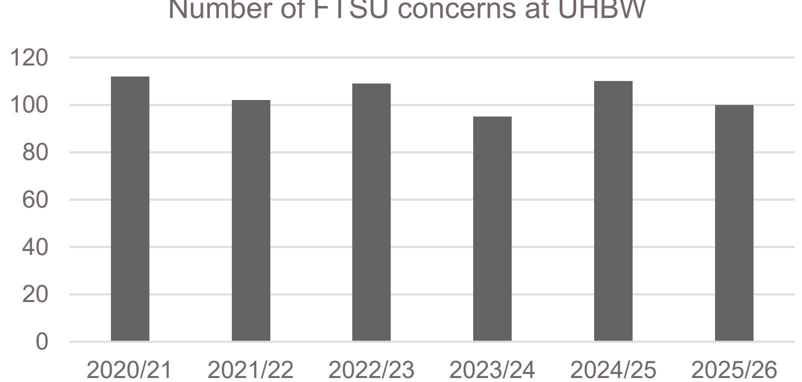
- The annual report provides some assurance to Board and indicates commonalities in data and themes across the organisations
- The evidence indicates that speaking up culture is variable and not yet consistently robust across all areas
- Current levels of FTSU activity largely reflect existing Guardian capacity and focus. To achieve further improvement, the organisation will need to agree strategic actions and focus, which is the planned remit of the new Speaking Up Steering Group.
- Intelligence from the UHBW Data Triangulation Group indicates that teams experiencing wider performance or cultural challenges are also likely to use the FTSU service, reinforcing its value as an early indicator of organisational health. Approaches to align data triangulation across the two organisations are in discussion.
- The National Guardian's Office, as it transfers responsibilities to NHS England, continues to emphasise the importance of visible Board and leadership support, sufficient Guardian capacity for proactive work, and accountability for openness and psychological safety.

The Board is asked to:

- Consider how it will actively support FTSU Guardians to continue their core work and expand proactive improvement activity, including leadership and support of FTSU Champion networks to help break down barriers to speaking up
- Reflect on how the Board and Executive Team can more visibly role-model speaking up, listening and following up, demonstrating how concerns lead to learning and change.
- Consider strengthening how learning from speaking up is communicated across the organisation, ensuring staff see the value and impact of raising concerns or ideas.
- Note planned work in 2026/2027 to review and determine the most effective FTSU structure and strategy, refresh organisational self-reviews; develop aligned action plans with key partners (Organisational Development, Leadership and Management Training, Patient Safety, EDI, Wellbeing, and Patient First improvement)

Appendix 1

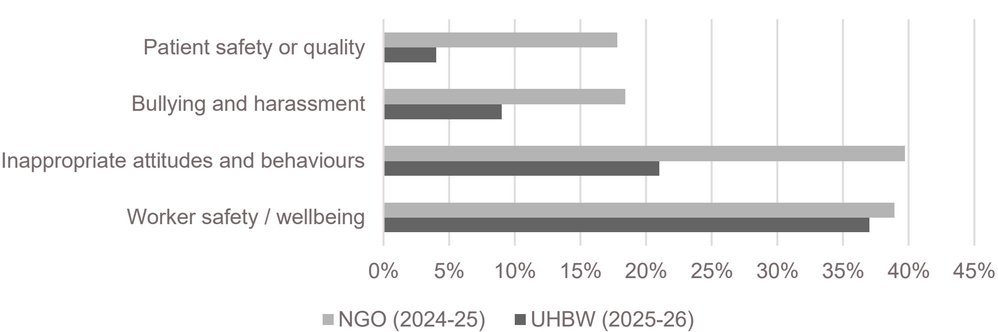
FTSU Annual Report 2025/2026: Part 1: Assessment of UHBW FTSU concerns



NB Where concerns are raised concurrently by multiple individuals, these are recorded as a single case. Where appropriate, individuals are signposted to local escalation routes if these have not already been explored. These contacts are *not* recorded as concerns.

Cases 2025/26	100
Raised anonymously	4

Concerns by quarter	Q1	Q2	Q3	Q4
Total	26	22	33	19



What insights can be drawn from the data?

- The number of FTSU concerns raised in 2025-26 is in line with previous years.
- The number of concerns specifically relating to patient safety or quality of care remains low, which is consistent with the presence of established alternative reporting routes for patient safety issues.
- However, as in previous years, the highest volume of concerns falls with the worker safety and wellbeing category. This is significant as staff safety and wellbeing are closely linked to workforce engagement, productivity and the ability to deliver high-quality patient care.
- A total of 20% of concerns were categorised as 'Policies and processes' (a category not monitored by the NGO). This number is slightly lower than last financial year (26%).

FTSU Annual Report 2025/2026: Part 1: Assessment of UHBW FTSU concerns

2025/2026 annual data by division

	Diagnostics and Therapies	Estates and Facilities	Medicine	Specialised Services	Surgery	Trust Services	Weston	Women's and Children's	Total
Apr 20-Mar 21	6	6	7	9	10	9	56	9	112
Apr 21-Mar 22	6	8	10	5	11	13	39	10	102
Apr 22-Mar 23	5	13	14	8	12	21	21	15	109
Apr 23-Mar 24	4	8	6	4	20	18	27	8	95
Apr 24-Mar 25	7	11	6	4	11	33	14	23	110*
Apr 25-Mar 26	**9**	**5**	**15**	**15**	**9**	**20**	**5**	**22**	**100**

*includes anonymous concerns where division is unknown

Division	**Actual staffing including bank and agency (March 2026)**	**Number of FTSU concerns**	**Concerns per 1,000 staff**
Diagnostics and Therapies	1,579.4	9	5.7
Facilities and Estates	1,076.1	5	4.6
Medicine	1,695.3	15	8.8
Specialised Services	1,431.2	15	10.5
Surgery	2,476.6	9	3.6
Trust Services	1,189.5	20	16.8
Weston	1,096.9	5	4.6
Women's and Children's	2,674.4	22	8.2
Total	**13,219.4**	**100**	**7.6**

What insights can be drawn from the data?

- Trust Services division is the outlier with the highest number of concerns by 1,000 staff. This is nearly double the Trust-wide typical rate and over four times the rate seen in Surgery.
- The division of Specialised Services has the second-highest rate of concerns. Although the absolute number of concerns matches Medicine, the smaller workforce means proportionately more staff are raising concerns. The FTSU Guardian is linking with the Wellbeing Lead Nurse, HR Business Partners and Director of Nursing to explore these concerns. There has been increased visibility through management visits to BHOC and BHI.
- The number of concerns reported in Women's and Children's remains high for second year in a row, with half of the concerns from one department. This department has divisional oversight.
- The division of Surgery has notably low numbers of concerns for its size in contrast to other clinical divisions.
- The number of concerns raised in the Weston division continues to fall in line with divisions of a similar size.

2025/2026 annual data by worker occupation

Staff group	Actual staffing including bank and agency (March 2026)	Number of FTSU concerns	Concerns per 1,000 staff
Allied Health Professionals	816.7	8	9.8
Medical and Dental	2,082.2	8	3.8
Registered Nurses and Midwives	4,080.4	28	6.9
Admin, Clerical	2,439.1	25	10.2
Additional professional scientific and technical	403.1	7	17.4
Additional clinical services (unregistered nursing and midwifery)	1,412.0	14	9.9
Estates and ancillary	1,145.4	3	2.6
Healthcare scientists	840.4	0	0.0
Students	N/A	1	-
Not known	-	5	-
Other	-	1	-
	13,219.3	**100**	

What insights can be drawn from the data?

- The number of FTSU concerns reported varies significantly by staff group, indicating that reporting behaviour is influenced by role context and culture, not solely workforce size.
- Registered Nurses and Midwives account for the highest number of concerns in absolute terms, reflecting workforce size, but their rate of concerns is moderate relative to other staff groups.
- Admin and Clerical staff report a disproportionately high number of concerns, with one of the highest rates per 1,000 staff.
- The highest reporting rate is seen in the Additional professional scientific and technical staff group. While numbers are small, this represents an outlier – though the number has fallen from 10 in 2024/25).
- Allied Health Professionals and unregistered clinical staff show relatively high concern rates (Four concerns raised in 2024/2025).
- Medical and Dental staff report low numbers of FTSU concerns, which may reflect use of alternative escalation routes or potential cultural barriers to raising concerns via FTSU. This is a national trend.
- Very low or zero concerns from Estates and Ancillary staff and Healthcare Scientists need cautious interpretation. Classification between Healthcare Scientists and Additional professional scientific and technical staff may not be accurate. It may also indicate reduced awareness of speaking up mechanisms or other barriers rather than absence of concerns.

FTSU Annual Report 2025/2026: Part 1: Assessment of UHBW FTSU concerns

UHBW FTSU Themes 2025/26

Patient safety / quality of care

- Skill mix
- Staff levels
- Lack of training and supervision
- Prioritisation of targets and cost savings over safety and quality
- Poor communication and behaviours

Inappropriate attitudes and behaviours

- Microaggressions
- Gaslighting
- Incivility
- Poor leadership behaviours
- Lack of feedback on concerns raised

Policies and processes

- Allocation of bank shifts and overtime
- Recruitment processes (substantive and bank roles)
- Use of contractors
- Management of probation and return from sickness
- Lack of role clarity

Worker safety / wellbeing

- Poor leadership and management
- Lack of balance in workload
- Lack of support/supervision
- Lack of psychological safety
- Lack of rest space
- Broken equipment
- Ventilation issues
- Poor response to incidents
- Impacts of low staffing and violence and aggression

FTSU timelines and processes

- Number of cases remaining open from the last financial year (as at end of Apri 2026) = 15 (10 from the last quarter).
- The longest open concern is from March 2025 – this is still under investigation as of April 2026. Four concerns raised between Oct and Dec 2025 remain open as no action has yet been taken to address the issues raised in these services (some of these services have flagged in data triangulation work).
- Most of the remaining open concerns relate to team culture/dynamic where no change has been seen. In some areas work is ongoing.
- Concerns are logged where the FTSU Guardian takes action, or where the individual/s raising a concern want the concern to be logged. Contacts with the FTSU Guardian relating to general guidance and support, particularly where local escalation has not been tried, are not logged as concerns.
- The FTSU Guardian keeps in touch with the individual/s raising concerns until feedback is given.

FTSU service user feedback

Once FTSU concerns are closed, colleagues are given the opportunity to complete a short, anonymous feedback survey. This is sent by the FTSU Guardian. 18 responses were collected this year, compared to 26 last financial year. Diversity monitoring information is captured at this point.

In response to the question: *"Did you feel that your concerns were taken seriously?"* 15 responded yes, three responded no. In answer to the question: *"Do you feel you have suffered in any way as a result of speaking up?"*, Three said yes, three didn't wish to say and 12 said no. In response to the question: *"Would you speak up again" 15* said yes, two said maybe, one said no.

The outcome wasn't satisfactory, the concerns kept on happening in the workplace, if not to me. It has happened to other colleagues and most of them has left the job due to stress surrounding the workplace.

FTSU was helpful but when it was fed back to the person/management that the concern was raised against, management made it a point that there was no need to involve FTSU and that they were disappointed to whoever raised concerns.

The freedom to speak up team especially Kate, have made me feel so heard and so supported and I genuinely believe I would have left a very long time ago if it wasn't for F2SU

Very professional, understanding and overall helpful. I actually felt Kate was keen to help which is often not something you feel in such a large organisation. She helped talk through options and listened. She also checked in months after the initial meetings, which was really helpful and thoughtful

I feel able to use the service again if needed

I was listened to and appropriate action was taken

Having the FTSU guardian call me within half-an-hour when I was very stressed was extremely helpful. Then her visiting my management team to make suggestions later in the week was also helpful.

Don't feel that the Freedom to Speak up have the correct level of power / sway with the Trust. Didn't feel that they could really take any action to make things better

Always know the service is there if I am unable to progress through other channels and feel happy that my concerns were taken seriously

Triangulation

The annual NHS staff survey contains questions on the NHS People Promise theme of 'we each have a voice that counts', and specifically four questions which reflect how staff feel about raising concerns in their organisation. The results for UHBW show a relatively stable picture with results largely in line with previous years. However, there remains work to be done to ensure we continue to improve these scores.

Staff Survey questions related to raising concerns (% agreeing / strongly agreeing with the following statements):	2020	2021	2022	2023	2024	**2025**
I would feel secure raising concerns about unsafe clinical practice	73.7%	75.9%	73.1%	72.3%	73.6%	**74.4%**
I am confident that the organisation would address my concern	63.7%	60.3%	57.9%	59.2%	60.0%	**60.8%**
I feel safe to speak up about anything that concerns me in this organisation	69.7%	66.8%	65.8%	68.4%	68.4%	**68.1%**
If I spoke up about something that concerned me I am confident my organisation would address my concern	Not asked in 2020	53.5%	51.0%	55.5%	55.1%	**54.5%**

The Trust **Data Triangulation Group** (established in 2024) brings together multidisciplinary specialists from across the organisation (including People Services, Medical HR, Assistant Chief Nurse, Divisional HR Business Partners, Psychological Services, Wellbeing, EDI, and FTSU) to identify and support 'teams in need' through a robust, intelligence-led approach. Co-led by the Organisational Development and the Leadership, Management and Coaching teams, the group ensures a holistic framework is in place, including a Trust-wide team development offer.

Teams in need are initially identified via staff survey data, supported by collective group insights. The group meets quarterly and is aligned to the annual national staff survey cycle.

During 2025/26, the UHBW Data Triangulation Group engaged with 29 teams across the organisation. By March 2026, Staff Survey outcomes were incorporated to assess progress for the identified teams. Results were positive: all teams with aligned survey data showed some level of improvement, with seven teams improving across all nine People Promise themes and 16 teams improving in four or more themes.

While overall performance improved - particularly in *We Are a Team*, *We Are Compassionate and Inclusive*, and *Safe and Healthy* - most teams continued to fall short in the themes *We Are Always Learning* and *Recognised and Rewarded*.

The March 2026 Data Triangulation meeting concluded the UHBW reporting period and confirmed alignment across the group for the next phase of development.

FTSU Annual Report 2025/2026: Part 2: Actions taken to improve speaking up culture

In line with the 2025 FTSU strategy, actions taken to improve speaking up culture are categorised under the following three objectives:

Raising awareness

- Divisional Speak Up training compliance: 92.7% overall (one-off mandatory training, introduced February 2021)

Speak Up training	Diagnostics & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Estates & Facilities	Weston	Women's & Children's
Mar-26	95.7%	92.3%	92.0%	90.3%	95.5%	98.0%	94.3%	89.5%

- Listen Up training for managers is not mandatory and compliance is low. This runs alongside the Compassionate and Inclusive Leader programme which is mandated for colleagues with line management / appraisal responsibility

Listen Up training	Diagnostics & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Estates & Facilities	Weston	Women's & Children's
Mar-26	17.5%	15.3%	15.2%	15.3%	18.4%	17.9%	34.3%	13.7%

- FTSU Guardian attends corporate induction (approx. twice monthly in Bristol and once a month in Weston – supported by FTSU champions)

- In Q1, awareness events included FTSU Guardian involvement in the Civility Saves Lives steering group (A600); Weston theatres walkround; Dermatology walkround with Medicine wellbeing nurse; A600 walkround with Ingrid Barker (Chair); Bristol Haematology and Oncology Centre walkround with Divisional Director of Nursing and Wellbeing Lead; T-level presentations. In Q2, a visit to South Bristol Community Hospital; attendance at a Digital Services all staff meeting; walkround of the Central Sterile Services Department; Bristol Heart Institute walkround with the Director of Nursing; Resident Doctor event; presentation to Bristol pharmacy technicians and students. In Q3, a Healthcare Support Worker introduction to FTSU; visit to Children's Theatres; Bristol Dental Hospital drop-in event; update on FTSU to Weston pharmacy staff; attendance at a Civility Saves Lives celebration at Bristol Eye Hospital. In Q4, attendance at the Primary Care Dental Service all staff meeting; staff meeting in Medical Records (BRI) and introductions to FTSU to Healthcare Support Workers.

- There are currently 90 FTSU champions across the Trust. Four 3.5-hour training sessions were held by the FTSU Guardian in the year supported by psychological services: April 2025; October 2025, December 2025 and March 2026.

Inspiring confidence

- Development of data triangulation work with the aim to support services/teams which are not thriving.

- Champion network development across group model – first joint champion meeting in October 2024. Joint champion meetings held approx. quarterly.

- FTSU Guardian working across divisions and services to improve links, visibility and share learning, e.g. Pro-equity; wellbeing; and staff networks. FTSU champion attendance at 'Learn and Share' events throughout the year hosted by psychological services.

Removing barriers

- Data is captured on protected characteristics from anonymous feedback but numbers remain low.

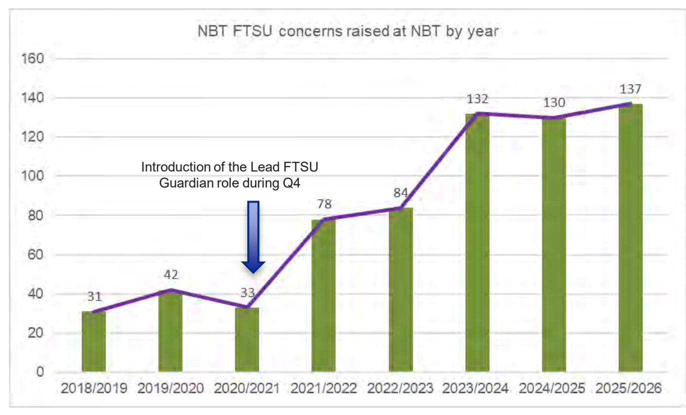
Assurance that FTSU arrangements are continually evaluated, and improvement identified

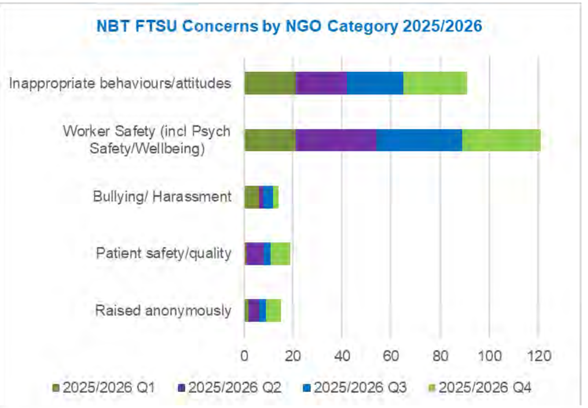
- Two cases of detriment was reported in the year – both are still under investigation. Includes the longest open FTSU case (March 2025). Non-executive lead to be briefed once investigations completed and learning to follow through Speaking Up Steering Group.
- FTSU Guardian reported quarterly data and themes of FTSU concerns via People Learning and Development Group until this group was stood down in March 2026. Future arrangements pending.
- Numbers and themes of concerns are also reported to the Managing Violence and Aggression Committee on a quarterly basis.

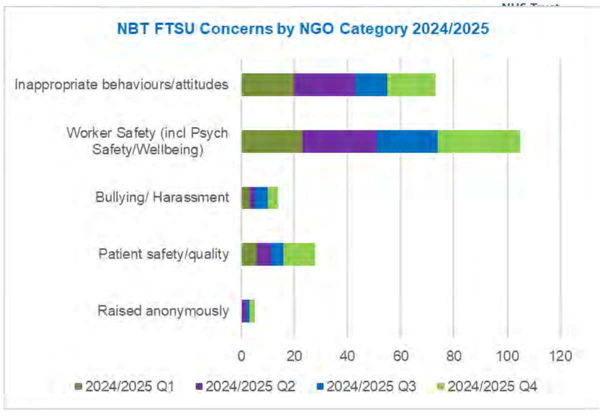
Ongoing as routine:

- FTSU information promoted through intranet and on UHBW website. Promotional cards and pens handed out at inductions.
- Diversity of FTSU champion network evaluated annually against Trust workforce (comparative workforce figures not available until summer).
- FTSU Guardian supervision (supported by psychological services).
- FTSU Guardian attends NGO events, South West Guardian network meetings and local meetings with NBT, AWP and Sirona Guardians for peer learning and support.
- FTSU Guardian attends clinical accreditation assessments to maintain links with patient care and quality.

Appendix 2: NBT 2025/2026 Annual FTSU Report: Part 1: Assessment of NBT FTSU 'cases'







	Q1	Q2	Q3	Q4	Total
2024/2025	28	34	31	37	130
2025/2026	26	36	37	38	137

A small number of simple signposting contacts are not included in these figures

One case can contain multiple elements across NGO reporting categories (as per national guidance) hence total concern level exceeded.
Categorisation reflects perceptions of the workers raising the issues
NGO annual data for 2025/2026 is not yet available
Accurate median benchmarking challenging due to differences in organisational factors however NBT results appear generally to track

What do the data tell us? – insights for 2025/2026 NBT FTSU data compared to 2024/2025:

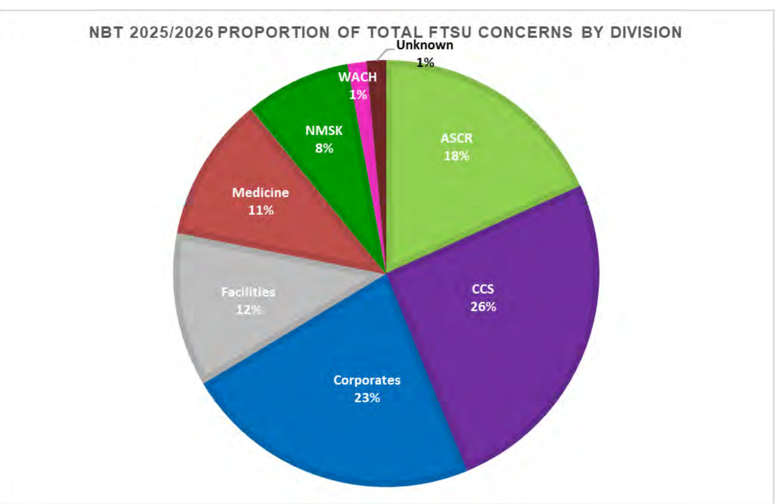
- Slightly higher total level of concerns raised (on average a similar number per quarter). N.B. some concerns cover issues for a wider group of workers.
- The total number of concerns raised anonymously was higher at 11% (15 compared to 5 in the previous year): notably from Facilities and Bank workers
- Fewer concerns were directly about patient safety or quality of care (there are established routine mechanisms for raising patient safety concerns)
- The highest number of concerns continue to fall into the 'inappropriate behaviours and attitudes' and impact on 'worker wellbeing/safety' categories
- The above appear to be broadly consistent with national reporting trends: National Guardian's Office Annual report 2024/2025
- **Senior leaders are reminded to note the strong correlation between patient safety and experience and worker experience, culture and environment**
- **Working environment/organisational culture ultimately affect quality of patient care and safety,** ways of working, communication, engagement, inclusion and staff thriving to provide high level care/retention (**two sides of the same coin:** safety, risk, patient experience and worker experience)

FTSU Champions support breaking down barriers to speaking up generally, through accessibility and signposting to various appropriate routes of support and reporting.
Contact data is collected but not included in current reporting: hence additional speaking up has been supported. A minority of signposting by Champions at NBT is to a FTSU Guardian.

Part 1: NBT Annual Data 2025/2026: Assessment of NBT FTSU concerns (continued)

By Division

2025/2026	ASCR	CCS	Corporates	Facilities	Medicine	NMSK	WACH	N/K
Total concerns	25	35	31	16	15	11	2	2
% of total NBT concerns by Division	18.00%	26.00%	23%	12.00%	11.00%	8.00%	1%	1.00%
Proportional substantive headcount by Division	22.00%	21.00%	10%	9.00%	18.00%	12.00%	8%	
Comparison % concerns to Substantive headcount	Slightly lower	Slightly Higher	Higher	Slightly higher	Lower	Lower	Lower	



What do the data tell us? – insights:

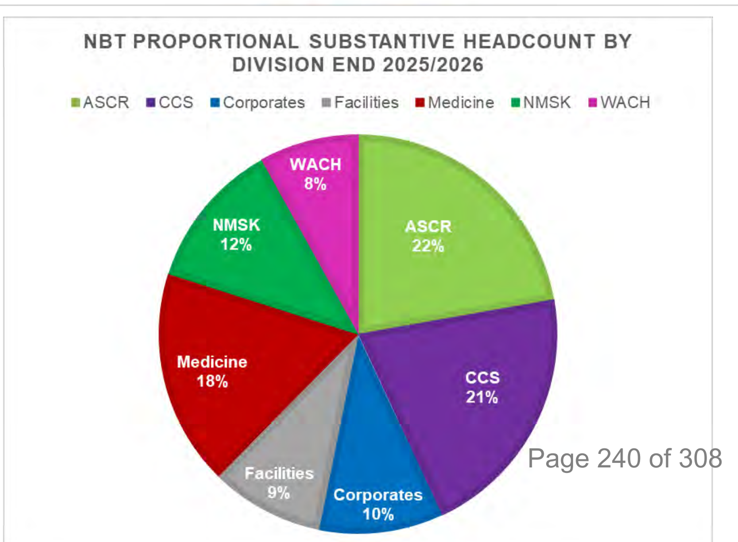
Concerns levels in 2025/2026 (proportional to headcount):

- **Higher in:** CCS (N.B. Q2 high number), Corporates, Facilities
- **Lower in:** Medicine, NMSK, WACH
- **Similar to headcount in**: ASCR

Concerns levels fluctuate across Divisions across the years, this may include hotspots
General trends proportional to headcount were similar to 2024/2025

Levels of concerns have remained low from WACH and are lower this year; visibility through walkarounds, discussion with HR BP, triangulation with NSS data, etc is ongoing

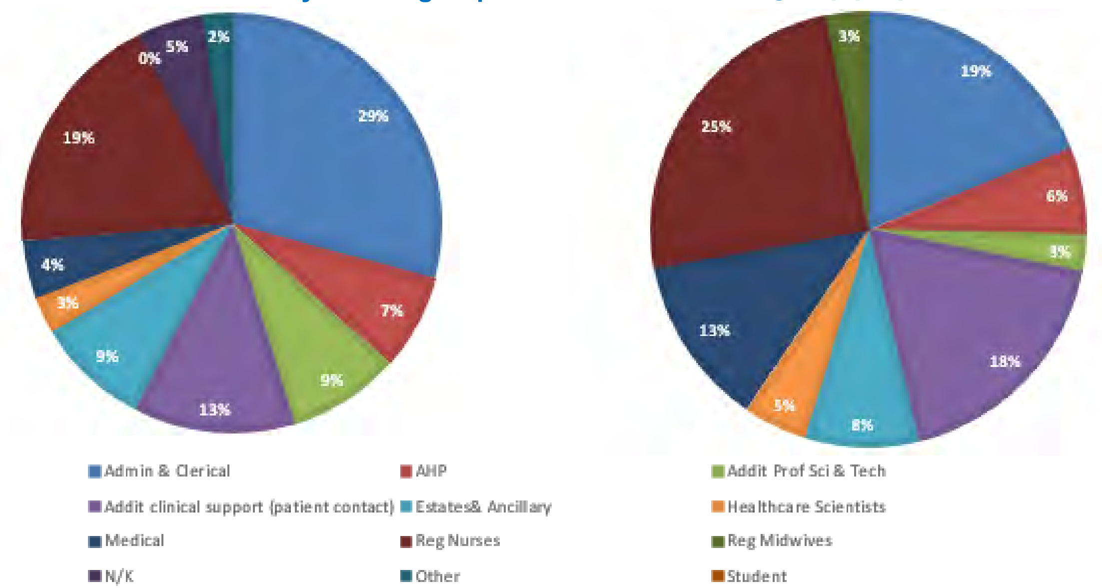
	ASCR	CCS	Corporates	Facilities	Medicine	NMSK	WACH	N/K	Total
2021/2022	13	13	16	9	13	3	9	2	78
2022/2023	16	11	19	13	14	8	3	0	84
2023/2024	25	16	38	7	21	14	6	5	132
2024/2025	15	25	25	20	21	15	5	4	130
2025/2026	25	35	31	16	15	11	2	2	137



Part 1: NBT Annual Data 2025/2026: Assessment of NBT FTSU concerns (continued)

By Worker Occupation

2025/2026	Admin & Clerical	AHP	Addit Prof Sci & Tech	Addit clinical support (patient contact)	Estates& Ancillary	Healthcare Scientists	Medical	Reg Nurses	Reg Midwives	N/K	Other	Student
Total number of concerns	40	10	12	17	12	4	6	26	0	7	3	0
As % of total concerns	29%	7.00%	9.00%	13.00%	9.00%	3.00%	4.00%	19.00%	0%	5.00%	2%	
Proportional substantive headcount	19%	6%	3%	18%	8%	5%	13%	25%	3%			



These results are being compared to 2025 NSS Occupational Raising Concerns results with the intention of discussion with Professional leads around any potential specific barriers to speaking up and any related actions (as capacity allows)

What do the 2025/2026 data tell us?

Higher numbers of concerns raised by:

Admin & Clerical, Registered nurses, additional clinical support staff

Proportionally:

High levels of concerns from:

- Admin & Clerical (national trend)
- Additional Prof Scientific and Technical

Levels of concerns are approx. proportional for:

- AHP
- Healthcare scientists
- Estates and ancillary

Levels of concerns are lower than proportional to headcount for:

- Additional clinical support
- Medical
- Midwives

Levels of concerns are slightly lower than proportional for:

- Registered Nurses. Nationally this group is one where the highest number of concerns are raised.

NBTCARES

*(**Rider:** These reflect the perceptions of staff raising the issues. Concerns can be challenging to theme/group together and discuss in sufficiently accurate/informative manner while dealing with these sensitively and confidentially, and not creating unintended 'false narrative')*

NBT FTSU Themes 2025/2026

Noted in blue font are broad themes common to the previous year

Patient safety/quality of care:

- Clinical practice
- Staffing levels impacting quality or efficiency of care
- Activity pressures and impact on patient care/quality
- Supervision or training challenges
- Patient care related to professionalism/staff attitudes and behaviours
- Communication and/or poor relations in teams/meetings

Inappropriate attitudes and behaviours:

- Incivility/culture and communication/dynamics/morale between colleagues or between professions or within teams
- Demeanour/attitudes and behaviours in interactions of managers and staff (e.g., compassion, empathy, tone, dismissiveness)
- Unprofessional behaviours/communication
- Lack of respect in interactions or feeling undermined
- Bullying, harassment
- Discriminatory attitude/behaviours/differential treatment
- Racist remarks/allegations of racist attitudes
- Confidentiality around worker situations or health
- Attitudes around support on training/progression/registration
- Fraud

Process issues:

- Situations not changing in response to issues raised in services
- Handling of People processes
- Fairness and Recruitment processes
- Processes related to VISA and fulfilling requirements for Certificate of Sponsorship

Worker safety/wellbeing

- Psychological safety related to speaking up
- Fatigue and burnout related to staffing resource and operational pressures/focus
- Sexual safety at work
- Safety at work (various)
- Disempowerment in role/lack of support to make improvement changes
- Assurance of action in response to behaviours of colleagues
- Aspects of support for neurodivergent staff
- Process and adjustment handling for disabilities/those with long term conditions
- Roster issues and work life balance
- Support for completion of training or effective mentoring

Additional anecdotal dialogue related to:

1) Organisational change: communication, uncertainty, fairness, and ability to speak up without disadvantage. 2) Impact of normalisation of corridor care.

FTSU process timeframes:

- FTSU cases raised are acknowledged within two working days
- Case closure timeframe is within range: two days to 5 months
- Number of cases prior to 2026/2027 financial year remaining open as of 27/04/26: 19 (these are either the more complex issues requiring careful and robust consideration, action and assurance by or to senior management or Executive oversight, those pending response from worker to discuss manager feedback, cases where those involved are on sick leave or communication breakdown involved, or more recently opened cases)
- Factors in protracted length to closure: complexity of issue(s), fear of worker and discussion of handling, sick leave of worker, leave of worker or manager, responsiveness of manager, FTSU workload balancing multiple cases, nuance, reflection and appropriate escalation/action/follow-up/closing the loop.
- Typical actions taken by FTSU Guardians: Depending on the situation (following active listening), action can range from: supporting the staff member to speak up to an alternative manager themselves, or escalation on behalf of the staff member(s) to a manager/senior manager/senior leader, through to reflection of themes and patterns for organisational action.
- Learning examples from concerns has included: transparency and communication with the team on process or progress, importance of face-to-face engagement early on and 'go and see' the issues being raised, having clear protocols in place, need for implicit bias training, reviewing impact of pressures, team-work, intentional building ability to feel safe to speak up, feedback into People processes
- **Additional assurance:** The Guardian(s) check in subsequently with those speaking up to request feedback and ensure that workers feel that they have not suffered any disadvantageous treatment; this also serves as opportunity to discuss whether they feel improvement has occurred, from worker perspective, as a result.

FTSU Service User feedback: a selection of responses

At closure, feedback is requested in line with NGO guidance (including satisfaction and any disadvantageous treatment from speaking up)

- I wanted to thank the FTSU Guardian for their time in really listening to me in a way that helped me feel truly heard and their attention and efforts to further the issues raised
- I wanted to express my sincere thanks for the support, guidance and time provided in a safe, compassionate and impartial space, willingness to listen, support and provide reassurance when I was feeling vulnerable – feeing heard and supported to navigate a challenging situation was invaluable.
- Raising these issues through FTSU reinforced the importance of speaking up, even when this is uncomfortable.
- Being able to raise issues through FTSU meant that, although still challenging, I was prevented from going off work sick long-term.
- The FTSU team were lovely and very approachable. It is good to have a safe space to share concerns, though resolution actions are in progress so long-term improvement will be awaited.
- Thanks for the support from FTSU. I am now in a better situation and hoping and some improvements generally have been seen.
- Thanks to FTSU for all the help, support and guidance with the situation that needed challenging
- I am very satisfied with the process and felt at ease and heard. I was listened to and shown empathy.
- I am satisfied with the FTSU Guardian service though feel that without clear improvement action yet I, and others, may be reluctant to speak up
- The FTSU Guardian is excellent though I feel could benefit from greater time resources. The FTSU Guardian remained true to their word while impartially challenging the organisation to respond in way that demonstrated that the issues were being listened to.
- Thank you for being prompt, kind and listening to my concerns, and signposting additional support during a challenging time. Also, for subsequently discussing general challenges around openness, psychological safety and culture and actions the organisation is moving towards for improvement.
- I felt like someone paid attention for the first time since I raised issues and actions were taken to address the issues raised. It was a very positive experience. I am aware/know that others are scared to speak up, however.
- Thank you for your support. I felt that my view was not welcomed before when raising issues with managers and that constructive dialogue without negative judgement would have prevented needing to raise this through FTSU. I feel that better listening and respect for diverse opinions are needed in NBT
- I found the FTSU service very different from other internal services accessed ahead, which were hard to navigate, especially when resilience is low – FTSU was very helpful rather than overwhelming or unsupportive.
- I truly appreciate the thought, effort, and commitment to ensure that voices, spoken and unspoken, are heard and reflected in a trauma-informed way and to support challenging conversations that are needed for organisational improvement.

At the time of reporting no cases of disadvantageous treatment/detriment requiring investigation were reported in 2025/2026

Trust-Wide Triangulation (2025/2026)

(NHSE guidance: *How matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve. What has been learnt and what improvements have been made as a result of workers speaking up.)*

The quarterly People and Quality Triangulation Group *(FTSU, People/Workforce/Culture, Staff Psychology, Patient Safety, Patient Experience, Chief Nursing Office, Health and Safety, Risk)* met in May (for Q4), August (for Q1), November 2025 (for Q2) and April 2026.

N.B. The meetings in November 2025 and April 2026 focussed on discussion of future arrangements and alignment of process with UHBW rather than fuller triangulation.

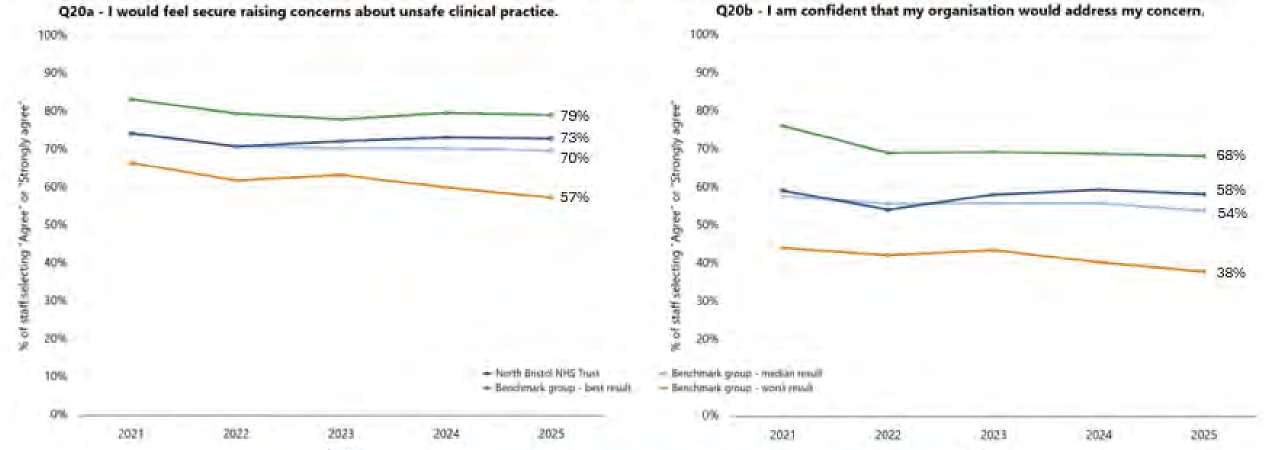
Over-arching themes across partners:

- Relationships, interpersonal behaviours, communication, attitudes, poor communication between colleagues, team dynamics and conflicts
- Bullying/harassment
- Violence and aggression, racism
- Fairness in treatment and application of processes (and related impact)
- Representation of global majority staff in formal HR cases
- Pressures, stress, fatigue, anxiety, burnout, morale
- Team culture and need for compassionate leadership
- Patient experience data reflecting need for compassion and human connection in care
- Psychological support required around grievances/people processes
- Neurodivergence: reasonable adjustments and awareness/understanding of managers
- Visa implications and need for clarity and support
- Middle management pressures and support and development needs
- Challenges of cultural communication and dynamics (with patients and colleagues), and need for culturally attuned approaches

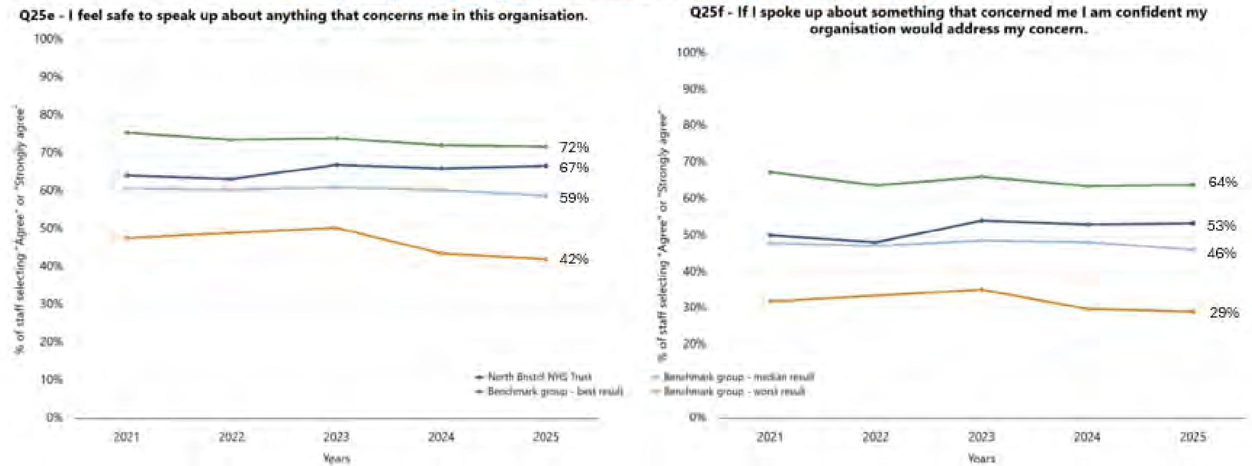
These themes are with the relevant partner to progress in existing workstreams.
Board may consider assurance through upward Committee reporting on the above themes and triangulation through National Staff Survey results.

See following slide for the NBT substantive workforce results on Raising Concerns overall

NBT FTSU Board report May 2026: Part 2: Triangulation: 2025 Substantive Staff Survey Raising Concerns



Q25e/f: raising of anything of concern and confidence that being addressed



Insights:

Clinical concern raising (security and confidence in response)**:**

- NBT results similar to previous year
- Opportunity to improve further

Any concern raising

- Slight increase in security
- Static confidence in response

Divisional leadership will be provided with RAG and variance scores for these questions for triangulation/actions:

1) Division overall
2) Service level

N.B. The NGO suggests other associated questions are also relevant around speaking up:
Support from managers (listening to concerns), reporting culture, feedback, improvement ideas, wellbeing/worker safety

Although some scores (not presented) for these questions are higher for staff from non-white ethnic groups a small downturn in score in three of these questions is noted.

Results for these questions for Bank only workers have improved to scoring close to substantive worker scores and above median (though much reduced response level is noted)

Board report May 2026: Part 2: Actions taken to improve wider speaking up culture:

Promotion of all speaking-up channels and engagement, training and support:

- Coverage of the national speaking up, listening up, following up ethos, speaking up routes and FTSU service at fortnightly corporate induction sessions
- Promotion of completion of the three **national e-learning modules** 'soft mandatory' (not Stat Man) at NBT (assigned in LEARN according to role).
  Compliance records: Slight improvement in scores from 2024/2025

NBT wide (Module)	Completed	Incomplete	Total comenced	Not started
Speak Up	67%	9%	76%	23%
Listen Up	37%	30%	67%	34%
Follow Up	42%	15%	57%	43%

Completed	ASCR	CCS	Corporates	Facilities	Medicine	NMSK	WACH
Speak Up	64%	74%	69%	81%	65%	63%	61%
Listen Up	44%	49%	39%	77%	42%	43%	30%
Follow Up	31%	39%	42%	50%	47%	41%	75%

- Speak Up Week October 2025 (national theme: 'Follow Up in action, Turn listening into lasting change') Divisional leaders were asked to use this week as an opportunity for their messaging. Activity included an Executive video, NBT FTSU network Q&A with Executive and Senior Leads, session availability for managers, walkarounds, drop-in provision and team engagement.
- Working with Divisional HR BPs to consider Divisional Speak Up actions: a series of huddle dialogue sessions Spring to Autumn 2025 to inform Divisional action plans (e.g., Divisional Speak Up posters, enrolling of FTSU Champions, manager training, e-learning completion)
- Through supporting related cultural work programmes; communicating the violence and aggression SOP and scripts with teams, as part of NBT's sexual safety at work group and round-table, antiracism work, supporting staff after violence and aggression discussions
- Regular tailored training sessions for: new Student nurses and midwives, Student Nurse Associates, Preceptors, GMC in-person sessions for International Medical Graduates, Apprentices, Accelerate programme.
- Engagement or visibility/walkarounds included: Awareness stalls in Brunel, IMT super-huddle, WACH (various), ED, AMU, Pathology, NBT Urology, Endoscopy, Elgar, Medirooms, Discharge lounge, Breast Care Centre, IDS, Palliative Care, Cossham, Weston Urology, Neurology Admin offices, various wards, further work supporting Pharmacy speak up culture with local leadership and FTSU Champion
- Ward Quality Clinical Accreditation theme document delivered on Speaking Up/Raising Concerns/FTSU in conjunction with the Matron Lead
- Inclusion of material on speaking up/FTSU through the Postgraduate Medical Education and support team (for undergraduate and Resident doctors)
- Further evolution of the network has included onboarding and attracting additional FTSU Champions (equalities data similar to last year) however with organisational change priorities this work has become protracted and would be a likely area of joint focus again post likely-merger. FTSU Champions have supported walkarounds/visibility. Several NBT FTSU Champions attended the SW FTSU Champion conference day (October) held in Keynsham

<table>
<tr><td>Report To:</td><td colspan="3">Public Group Board Meeting</td></tr>
<tr><td>Date of Meeting:</td><td colspan="3">12 May 2026</td></tr>
<tr><td>Report Title:</td><td colspan="3">Accountability Framework</td></tr>
<tr><td>Report Author:</td><td colspan="3">Lavinia Rowsell, Group Director of Corporate Governance</td></tr>
<tr><td>Report Sponsor:</td><td colspan="3">Lavinia Rowsell, Group Director of Corporate Governance</td></tr>
<tr><td rowspan="3">Purpose of the report:</td><td>Approval</td><td>Discussion</td><td>Information</td></tr>
<tr><td>X</td><td>X</td><td></td></tr>
<tr><td colspan="3">To present the Accountability Framework for approval by the Board.</td></tr>
<tr><td colspan="4">Key Points to Note (Including any previous decisions taken)</td></tr>
<tr><td colspan="4">To provide the Board with the Group Accountability Framework, including its purpose, scope and current stage of development, and to explain how it will support effective oversight and assurance through the Board and its sub-committees.</td></tr>
<tr><td colspan="4">Strategic Alignment</td></tr>
<tr><td colspan="4">The Accountability Framework sets out the planned governance arrangements for the newly merged organisation, in line with strategic organisational plans.
It aligns with the merger programme objectives by ensuring that robust governance and decision-making arrangements are in place from Day1, while also providing a framework that can be refined and embedded as the organisation matures post-merger.
The framework supports Group working across the four Ps – Patients, Population, People and Public Purse by enabling consistent standards, reducing duplication, improving clarity of accountability and supporting effective use of resources across the Group. It also aligns with system expectations for strong leadership, governance and assurance in a merged foundation trust.</td></tr>
<tr><td colspan="4">Risks and Opportunities</td></tr>
<tr><td colspan="4">Risk: If Group level accountability and escalation arrangements are not sufficiently clear or consistently applied, there is a risk of duplication, delay or confusion in decision making, particularly during the early post-merger period. Variations in the maturity of arrangements across framework areas could create uneven assurance if not actively managed through Executive and Board oversight.
Opportunity: A clear Accountability Framework strengthens Day1 readiness, regulatory assurance and longer-term effectiveness of the merged organisation.</td></tr>
<tr><td colspan="4">Recommendation</td></tr>
<tr><td colspan="4">The Board is asked to:
a) Note the purpose and current status of the Group Accountability Framework
b) Note the proposed phase 1 implementation plan
c) Approve the framework for submission to NHSE</td></tr>
<tr><td colspan="4">History of the paper (details of where paper has <u>previously</u> been received)</td></tr>
</table>

• Merger Programme Board in December 2025 and April 2026 • Group Executive Team in January and March 2026 • Each Board Committee has considered those aspects relevant to their terms of reference, including Audit Committee in April 2026 • Trust TMT discussions to be scheduled for their next meetings.	
Appendices:	Appendix 1: Accountability Framework Appendix 2: Implementation Plan Summary

1. Purpose

1.1 The Accountability Framework (Appendix A) is a key component of the Group's assurance arrangements, setting out the structures and processes that the merged organisation will have in place to support the delivery of safe, high quality, patient-focussed care in line with our vision, values and objectives. It describes the key roles and responsibilities, delegated authorities and accountabilities, structures and oversight arrangements for each major component of the organisation, including clinical and corporate services.

1.2 The structures within the Accountability Framework reflect the planned arrangements that will be in place once the implementation plan (summary attached as Appendix B) is complete, as far as current information allows. The framework does not detail the current position, except where final arrangements are already in place, or any interim arrangements that will be put into place over the coming months overseen by Board sub-Committees.

1.3 The Accountability Framework will continue to be reviewed and updated as the operating model develops in response to changes in the external environment and feedback received. Details will be updated to reflect changes in naming conventions (e.g. the framework uses the term Hospital Operating Unit to describe the current site-based arrangements, but this will be amended if the term changes).

2. Background

2.1 The Accountability Framework was initially developed to clarify the arrangements for the Bristol NHS Group. Following the decision to explore merger, the Framework was amended to address the new requirements, using examples from other recently merged NHS organisations.

2.2 The Framework is built on a set of guiding principles (as described on Slide Number 5), including the need to balance the flexibly that local delivery of services allows, with the benefits that centralisation of services gives in terms of standardisation, equity and efficiency.

2.3 The draft Accountability Framework has been reviewed by the Executive Team and shared with NHSE as part of the supporting documentation for the Full Business Case and Post Transaction Integration Plan.

2.4 In addition to the functional areas, flexibility has been built into the Hospital Operating Unit structure charts to reflect Executive discussions, retaining a focus on consistency for ease of reporting, but allowing for localisation where required based on the principle of "form follows function". Structural details for sub-groups and related processes, including Divisional Reviews, remain subject to further discussion, as detailed in the implementation plan.

3. **Board and Committee Assurance**

3.1 The Framework is a critical component of the overall assurance architecture. It underpins the system of internal control by clearly articulating where accountability sits for decision-making, delivery and oversight at each level of the organisation. By defining delegated authorities, reporting lines and escalation routes, the Framework provides the necessary clarity to support effective control and prevent gaps or overlaps in responsibility.

3.2 Relevant sections have been reviewed by each of the Board sub-committees to test whether the proposed arrangements provide assurance to the Board. Feedback received has been positive, and actions identified are reflected in the implementation plan.

4. **Next Steps**

4.1 Implementation of the Accountability Framework has already begun at Board and Executive level, with the remaining structures and processes to be implemented during the first-year post-merger.

4.2 Implementation of the framework for specific functional elements (e.g. Quality, People, Finance, Digital, etc.) will be led by the relevant Executive Director, overseen by the relevant Board Sub-Committee in line with agreed assurance reporting schedules, with central co-ordination and support to ensure that processes across all areas are aligned with corporate structures and reflect best practice.

4.3 Overall implementation of the Accountability Framework will be overseen by the GEM; this will include ensuring that it continues to reflect future Board plans.

4.4 A summary of the plan for implementation the Accountability Framework is attached as Appendix B.

5. **Conclusion**

5.1 The Board is asked to approve the Assurance Framework, noting that it will continue to be developed to address changes to the internal and external environments.

6. **Recommendations**

The Board is asked to:

- **Note** the purpose and current status of the Group Accountability Framework
- **Note** the proposed phase 1 implementation plan
- **Approve** the framework for submission to NHSE

7. **Attachments:**

- Appendix A: Accountability Framework v0.9 (May 2026)
- Appendix B: Implementation Plan Summary

Governance and Accountability Framework

V0.10 May 2026

Terminology

For the purposes of this document, we have used the following terms to describe the organisation:

- **GROUP**
  The new Trust continues to be referred to as a 'Group', as this clearly describes how we are able to leverage the benefits of scale whilst ensuring effective management and oversight at a local level.

- **HOSPITAL OPERATING UNIT**
  The term 'Hospital Operating Unit' is used to describe the campuses of legacy hospital trusts (NBT and UHBW) and their management and governance structures.

- **DIVISION**
- The term 'Division' is used to describe the management groups within the Hospital Operating Units, based on the legacy trust arrangements.

- **CLINICAL SERVICE**
  The term 'Clinical Service' is used to describe a specialty or cluster of specialties that share management and oversight arrangements.

- **CORPORATE SERVICE**
  A 'Corporate Service' is a non-clinical support service, under one of the Group Directors, which provide services to the Clinical Services and Operating Units.

Purpose of the Accountability Framework

Bristol | Weston

What is an accountability framework?	An accountability framework sets out the structures and processes we will have in place to support the delivery of safe, high quality, patient-focussed care in line with our vision, values and objectives.
Why do we need one?	An accountability framework allows clear expectations to be set for clinical and corporate services across the organisation. It ensures that there is appropriate oversight, along with arrangements for provision of support where required.
How does it work?	The accountability framework describes the key roles and responsibilities, delegated authorities and accountabilities, structures and oversight arrangements for each major component of the organisation, including clinical and corporate services.
What is included?	The accountability framework includes arrangements for Group and Hospital Operating Unit level management and oversight of risk management, clinical quality, workforce, performance management and finance.
Ongoing development and review	The accountability framework will be reviewed and updated as the operating model develops.

Guiding Principles

Clear Expectations

Clear objectives and measures of success will be developed for all parts of the organisation to support delivery of the vision

Consistent Standards

Consistent standards will be agreed for our patients and colleagues, regardless of where services are delivered

Centralised v Localised

Balancing between freedom to deliver flexibly to meet local needs and realising the benefits of standardisation and equity

Clear Accountabilities

Expectations, oversight arrangements and available support will be clear wherever accountability is devolved

Thresholds & Triggers

Clear thresholds and triggers for intervention, proportionate to the level of risk will be available for all devolved accountability

Oversight & Support

Oversight arrangements will be in place for early identification of potential areas of concern that need additional support

Open & Honest

Processes will be designed to promote openness and honesty over issues and risks, and the support needed

Inclusive

There will be a compassionate and inclusive leadership culture across all parts of the organisation and at every level

Inter-dependencies

Processes will take account of inter-dependencies within the organisation and across the wider system

People Strategy

An interim People Strategy is in place for the Group, with a more detailed unified strategy under development for the next 3-5 years, providing a clear view of 'where we want to be' and our strategic objectives, as well as an implementation plan to realise this strategy.

The ambition is to be in the top decile of the five People Promise themes in the NHS staff survey for 2027/28.

There will be a comprehensive stakeholder co-creation / engagement process, with input from colleagues across both Hospital Operating Units, senior leadership, staff side / unions, staff networks / representatives, People teams and key external stakeholders.

A framework will also be established for ongoing monitoring, reporting and evaluation of the People Strategy progress post-delivery phase via delivery groups and as part of the Accountability Framework.

Digital Strategy

The Digital Strategy being developed will be a unified strategy for the next 3-5 years, providing a clear view of how we plan to create a digitally mature environment across the new organisation, most effectively use our existing digital and IT systems and invest in order to have the biggest impact.

The strategy will include a unified digital infrastructure and interoperability, use of patient-centred digital tools, integrated data and analytics, cybersecurity and governance, digital innovation, alignment with wider system / regional priorities, etc.

The ambition is to improvements organisational digital maturity and infrastructure assessments for both Hospital Operating Units – e.g., via Healthcare Information & Management Systems Society (HIMMS) frameworks.

A framework will also be established for ongoing monitoring, reporting and evaluation of the Digital Strategy progress post-delivery phase.

Research & Development Strategy

The Research & Development (R&D) Strategy being developed will be a unified strategy for the next 3-5 years, providing a clear view of how we plan to grow and evolve R&D activity, improve levels of collaboration, increase efficiency and scale efforts more effectively.

The strategy, which will be created with wide consultation and stakeholder involvement, will include clear priorities and approach to funding streams, expanding patient access and opportunities for our people, celebrating success and best practice sharing, facilitating adoption, skill development and local adoption of national programmes.

The ambition is to increase income associated with R&D by £10–15m over 5 years, with a shift towards R&D being seen as part of clinical care evidenced by improvements in patient survey responses relating to research, and an increase in the number and diversity of staff involved in research activity.

A framework will also be established for ongoing monitoring, reporting and evaluation of the R&D Strategy progress post-delivery phase.

Innovation Strategy

The Innovation Strategy is a unified strategy for the next 3-5 years, providing a clear view of how we plan to support full opportunities for innovation.

The strategy includes the establishment of an Innovation Hub, with a clear pipeline of innovation opportunities and a defined framework for support.

The ambition is to increase the number of innovation projects successfully transitioning from pilot to business-as-usual implementation. This will include clearer and increased impact of innovation projects in terms of efficiency, patient outcomes, cost savings and quality improvement, along with increased external funding and increased opportunities available to staff.

A targeted marketing and engagement plan will support implementation of the strategy.

Estates Strategy

The Estates Strategy being developed will be a unified strategy for the next 3-5 years, providing a clear view of how we plan to most effectively use our combined estates and invest in order to have the biggest impact. This will include an estates development and investment roadmap.

The ambition is to reduce clinical infrastructure risk over the next 3-5 years, whilst achieving cost savings through rationalisation of assets and improving space utilisation.

The strategy will also cover sustainability and the environment, with a commitment to do everything in within direct control to achieve the net zero target by 2030.

A framework will also be established for ongoing monitoring, reporting and evaluation of the Estates Strategy progress post-delivery phase.

Foundation Trust Governance

Members	Council of Governors		Trust Leadership
Public Members (c. 4,000) Open to anyone 7+ living in England or Wales → Elect	**Public Governors** (17) Representing specific public constituencies	**Role** • Appoint Non-Executive Directors (NEDs), including Chair • Hold NEDs to account • Receive the annual report and accounts • Represent the views of members • Ensure the views of members, the public and key stakeholders are put forward • Consider and make suggestions on the Trust's strategy • Approve significant transactions (e.g. mergers)	**Group Chair** → **Group Board**
Staff Members (c. 17,000) All staff invited to become members → Elect	**Staff Governors** (6) Representing specific staff groups		
	Appointed Governors (6) Representing key local stakeholders		

Well-Led Framework

The Group model, with devolved accountability to Hospital Operating Units, supports Bristol NHS Group to be a ‘Well-Led’ organisation as defined by the CQC quality statement:

Shared direction and culture	Capable, compassionate and inclusive leaders	Freedom to speak up	Workforce equality, diversity and inclusion
Group leadership sets a vision and values, developing strategies to implement them. **Hospital Operating Units** deliver the vision and values by overseeing operational implementation.	**Group and Hospital Operating Unit leadership** ensure consistent arrangements are in place for the development and support of capable and compassionate leaders.	**Group and Hospital Operating Unit leadership** create a culture where people feel free to speak up and their voice will be heard.	**Group and Hospital Operating Unit leadership** create a compassionate and just culture where people feel valued and belong.

Governance, management and sustainability	Partnerships and communities	Learning, improvement and innovation	Environmental sustainability
Group leadership leads a governance framework holding the organisation to account. **Hospital Operating Units** oversee sustained operational delivery of the vision and values.	**Group** leadership, collaborating with the wider system, creates a consistent approach, which **Hospital Operating Units** deliver to maintain a high level of public participation.	**Group and Hospital Operating Unit leadership** continue to support and embed the Patient First approach to improvement and innovation.	**Group and Hospital Operating Unit leadership** continue to develop and implement green plans to positively contribute to environmental sustainability.

High Level Management Structure

- **GROUP BOARD / GROUP EXECUTIVE**
  The Group Board sets the vision and values and has overall responsibility for strategy, performance and governance. In addition, the Group Executive are responsible for delivery in their specific functional areas.

- **HOSPITAL OPERATING UNIT MANAGEMENT TEAMS**
  The Hospital Operating Unit Management Teams oversee operational delivery of clinical and associated services in line with Group strategies. The services and locations covered in each campus are aligned with the legacy trusts to maintain consistent delivery.

- **DIVISIONS**
  As with the Hospital Operating Units, the Divisions are consistent with the arrangements in the legacy trusts and will remain so for the foreseeable future, but this will be kept under review as clinical services integrate in line with the Joint Clinical Strategy

- **CLINICAL SERVICES**
  Clinical Services will report via the appropriate Divisions within the Hospital Operating Units, dependent on the specific arrangements developed as part of the Group Clinical Strategy.

- **CORPORATE SERVICES**
  Corporate Services are centralised under an Executive Director, providing services to the Hospital Operating Units and, where appropriate, partner and other organisations.

High Level Management Structure

- Group Board
  - Group Executive
    - Hospital Operating Unit Management Team (Weston and Bristol City Campuses)
      - Diagnostic & Therapies
      - Medicine
      - Specialised Services
      - Surgery
      - Weston
      - Women's & Children's
      - Estates & Facilities
    - Corporate Services
      - Comms & Engagement
      - Communities & Inclusion
      - Corporate Governance
      - Digital
      - Finance
      - Group PMO
      - Improvement
      - People
      - Quality
      - R & D and Innovation
      - Strategic Estates
    - Hospital Operating Unit Management Team (Southmead Campus)
      - ASCR
      - Core Clinical
      - Medicine
      - NMSK
      - Women & Children's
      - Estates & Facilities

Corporate Services is linked to each Hospital Operating Unit Management Team by a two-way dashed arrow (↔).

BHOC, BHI, BRHC, BRI, Dental Hospital, Eye Hospital, South Bristol Community Hospital, SMH, Weston CDC, WGH

BCE, Cossham Hospital, Frenchay BIRC, North Bristol CDC, Southmead, Thornbury Outpatient Clinic

Group Governance Structure

NHS Bristol NHS Group
Bristol | Weston

- **COUNCIL OF GOVERNORS**
  Hold Non-Executive Directors individually and collectively to account for the performance of the Board.

- **GROUP BOARD & COMMITTEES**
  The Group Board has established a range of NED chaired sub-Committees, including Statutory Committees, to provide assurance to the Board in key areas.

- **GROUP EXECUTIVE MEETING (GEM) & SUB-GROUPS**
  The Group Executive Meeting has established a range of Executive chaired sub-groups, aligned with Board sub-Committees, to oversee the provision of assurance to the Board in key areas. These sub-groups provide assurance via GEM or directly to the Board and its sub-Committees as appropriate.

  Specific sub-groups have been established to oversee key Executive accountabilities related to planning, improvement and specific programmes of work. Additional groups reporting to the GEM sub-groups may be established with the agreement of the appropriate subject matter expert and Executive Director, but such groups may be established at Hospital Operating Unit level.

- **HOSPITAL OPERATING UNIT MANAGEMENT TEAMS**
  The Hospital Operating Unit Management Teams and their sub-groups provide assurance via GEM or directly to GEM Sub-groups as appropriate.

Group Governance Structure

Council of Governors

Group Board

Audit Committee

People Committee

Finance & Estates Committee

Quality & Outcomes Committee

Digital Committee

Rem & Nom Committee

Reporting / assurance into Board and Committees

Group Executive Meeting

Hospital Operating Unit Management Team (Weston and Bristol City Campuses)

Hospital Operating Unit Management Structure (detailed in Hospital Operating Unit chart)

People Strategy Oversight Group

Executive Quality Group

Strategic Estates and Sustainability Group

Integration Programme Group

Health & Safety Committee

Finance Strategy Oversight Group

GEM Digital Groups

GEM Clinical Strategy Group

GEM Risk Management Group

NOTE – Provisional Sub-Group structure pending further discussion

Hospital Operating Unit Management Team (Southmead Campus)

Hospital Operating Unit Management Structure (detailed in Hospital Operating Unit chart)

Devolvement of Responsibility & Accountability

Responsibilities and accountabilities within the organisation are devolved to the most appropriate level in line with the following principles:

- Consideration of the benefits of scale and standardisation for centralised accountability versus the flexibility of local ownership

- Where responsibility and accountability is devolved, responsibilities and requirements are transparent, with clear escalation and intervention thresholds in place to ensure rapid support is available if required

- Governance models for devolvement are clear, and are consistent with the Joint Clinical Strategy and Corporate services Transformation Programme

Leadership Roles & Accountability Relationships

Role	Accountability
Group Leadership	
• Setting the Group long-term vision and strategy • Developing and agreeing the annual plan for Hospital Operating Units • Defining transformational priorities • Allocating resources • Holding Hospital Operating Units to account	• Accountable to Group Board • Accountable for the Hospital Operating Units discharging their statutory duties • Accountable for the delivery of corporate functions • Accountable for Group performance (quality, performance and financial) • Accountable for delivery of strategy and Group benefits
Hospital Operating Unit Management Teams	
• Delivering high quality, safe and effective clinical services within agreed budget • Managing, leading and engaging those who work in the Hospital Operating Unit • Delivery against Hospital Operating Unit Plan • Delivery of strategy and transformational priorities • Holding Divisions to account	• Accountable to the Chief Executive and Group Board • Accountable for Hospital Operating Unit performance (quality, financial and access) • Accountable for delivery of the Hospital Operating Unit Plan
Corporate Services Leaders	
• Developing and delivering high quality and effective support services within the agreed budget • Managing, leading and engaging those who work in shared Corporate Services • Delivery against agreed plans • Delivery of strategy and transformational priorities	• Directly accountable to Group Executive • Accountable to the Group Board and Operational Unit Management Teams for delivery of service • Accountable for the performance of support functions

Group & Devolved Accountabilities

Area	Group Leadership	Hospital Operating Unit Leadership
Strategy	• Develops the organisation's vision and values • Sets Group strategy and supporting strategies • Sets planning framework and approves Hospital Operating Unit Plans	• Develops Hospital Operating Unit Plans within Group framework • Develops deployment plans that align with Group strategy • Contributes local intelligence to inform Group planning • Delivers agreed local strategic initiatives
Risk Management	• Defines process for risk measurement and escalation • Sets the risk appetite for the organisation • Reviews high priority risks via the Board Assurance Framework	• Responsible for the accurate capture, measurement and management of risk • Reviews risks via the corporate risk registers • Escalates risks to GEM and Group Board over agreed threshold
Quality	• Promotes standardisation to reduce unwarranted variations in care • Maintains the Group's Patient First Improvement Methodology • Sets quality priorities and metrics across the Group	• Delivers high quality, safe and equitable care that meets regulatory requirements • Ensures spread of Patient First Methodology within the Hospital Operating Unit • Monitors and improves local patient experience
Digital	• Develops and agrees digital strategy and roadmap • Leads delivery of Group-wide technology roll-outs • Manages data architecture and interoperability between Hospital Operating Units	• Ensures effective engagement of Hospital Operating Unit in digital strategy and tech roll-outs • Drives adoption of technology • Delivers local change management linked to technology adoption

Group & Devolved Accountabilities

(Continued)

NHS Bristol NHS Group
Bristol | Weston

Area	Group Leadership	Hospital Operating Unit Leadership
Workforce	• Develops overarching workforce strategy and employee proposition • Defines Group-wide recruitment, retention and talent initiatives • Oversees senior leader talent identification and succession planning	• Develops and delivers local workforce plans • Recruits and retains a workforce that delivers high quality, safe and equitable care • Manages, leads and engages the workforce
Performance	• Develops and maintains a Group Integrated Performance Report (IPR) • Identifies opportunity to support achievement of performance standards • Monitors and provide support to areas of underperformance	• Delivers against agreed performance outcomes and trajectories • Readily supports other parts of the Group where required through mutual aid, moving patients across waiting lists, etc. • Manages local performance improvement initiatives
Finance	• Agrees overall resource allocation • Creates pooled budgets (where appropriate) • Oversees delivery of long and medium term financial plans • Sets Group-wide financial controls and reporting standards	• Works with Group to set a stretching but achievable financial plan • Accountable for delivery of the financial plan, including CIP • Identifies local efficiency and savings opportunities • Manages local financial risks within Group policy
Clinical Services	• Oversees development and ongoing review of the clinical strategy • Defines overarching service configuration • Provides support for delivery of appropriate governance frameworks	• Manages delivery of single services delivered by the Hospital Operating Unit and integrated services led by the Hospital Operating Unit • Works with other parts of the Group to ensure clinical standards are aligned across all services

Hospital Operating Unit Governance Structure

- The Hospital Operating Unit Management Teams have established sub-groups to oversee operational delivery in key areas. The majority of these are aligned with those at Board and GEM level. These are replicated in each Hospital Operating Unit.

- Other sub-groups have been established to oversee delivery of key workstreams; these are aligned where appropriate, but these may vary on a "form follows function" basis, depending on specific local need.

- Oversight of Divisional delivery is via monthly Divisional Reviews covering all areas of operational delivery, quality, finance and people.

- An Operational Risk Group has been established at each Hospital Operating Unit to oversee co-ordination of risk management across the Unit. This structure will be kept under review as part of the assessment of the organisation's risk maturity.

- Additional groups reporting to the sub-groups for each Hospital Operating Unit are detailed in the specific functional areas (quality, digital, people, performance and finance & estates). These are replicated in each Hospital Operating Unit, but arrangements may vary with the agreement of the appropriate subject matter expert and Executive Director.

Hospital Operating Unit Governance Structure

Where appropriate, structures within the Hospital Operating Units are duplicated for consistency of onward reporting.

However, some sub-groups may differ to meet specific local needs, based on the principle of "form follows function".

Group Executive Meeting

Reporting / assurance into GEM and Sub Groups

Hospital Operating Unit Management Team

Divisional Reviews

proposal to have additional 'estates and capital' subgroup

Operational Clinical Quality Group

Operational Digital Group

Operational People Group

Operational Finance Group

Operational Planning Group

Operational Risk Group

Operational Programme Groups

Hospital Operating Unit Management Team sub-structure (detailed in specific functional sections)

Additional Hospital Operating Unit Based Sub-Groups

Based on local need relevant to specific services provided (e.g. Oversight of Children's Hospital specific to Bristol City campus)

NOTE – Provisional Sub-Group structure pending further discussion

Risk Management

- A Group-wide risk management policy is currently under development, for implementation on 1 July 2026.

- The risk management policy will clearly describe the arrangements for risk management at all levels of the organisation, with responsibility and accountability for risk management devolved to the appropriate level of the organisation based on the Board's risk appetite.

- Risk management is central to the effective running of the organisation, and it is part of the overall management approach and organisational culture.

- The Group Board ensures that strategic and operational decisions made on behalf of the organisation are taken with consideration to the effective management of risk. Decisions are taken in the context of risk-assessed strategies, business cases, and projects to allow for due regard to the quality, safety and sustainability of services to patients and other service users.

- Clear escalation thresholds and processes are in place to ensure visibility of risks and provision of support as appropriate.

Risk Management – Board Assurance Framework

- The Board Assurance Framework (BAF) is used by the Group Board to oversee the risk to delivery of the strategic priorities, with a detailed review every six months along with escalation arrangements.
- The BAF considers principal risks and considers their impact on the delivery of six strategic priorities (Quality, Timely Care, People, Innovation, Resources and Commitment to Community).
- Each of the principal risks is linked to risks identified within Hospital Operating Units, along with the controls, assurances and related action plans.

BOARD ASSURANCE FRAMEWORK			Impact on Delivery of Strategic Priority						Linked Corporate Risks	
Principal Risk	Executive Lead	Trend	Quality	Timely Care	People	Innovation	Resources	Commitment to Community	UHBW	NBT
QUALITY	Chief Nursing and Improvement Officer & Chief Medical and Clinical Innovation Officer	↔	HIGH	HIGH	HIGH	HIGH	MODERATE	MODERATE	15	10
PERFORMANCE	Hospital Managing Directors	↔	HIGH	HIGH	MODERATE	HIGH	HIGH	MODERATE	11	3
NO CRITERIA to RESIDE	Hospital Managing Directors	↔	HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE	2	0
WORKFORCE	Chief People Officer	↑	MODERATE	HIGH	HIGH	HIGH	HIGH	LOW	5	2
ESTATE	Group Chief Finance and Estates Officer	↔	HIGH	HIGH	HIGH	HIGH	HIGH	MODERATE	7	3
FINANCE	Group Chief Finance and Estates Officer	↔	HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE	4	3
DIGITAL	Chief Digital Information Officer	↔	MODERATE	HIGH	MODERATE	MODERATE	MODERATE	HIGH	8	4
COMPLIANCE	Chief Corporate Governance Officer	↔	MODERATE	HIGH	HIGH	MODERATE	MODERATE	MODERATE	11	1

UHBW - Corporate Risks linked to Principal Risk – Number of linked risks over time

NBT - Trust Level Risks linked to Principal Risk – Number of linked risks over time

Quality Oversight

A Group-wide approach to quality governance and oversight is under development, focussed on the four key elements of a Quality Management System, with a plan to implement over the next 12 months:

- Quality Planning, to establish Group-wide quality aims and priorities
- Quality Improvement, using Patient First methodology to support all levels of the organisation to deliver the aims and priorities
- Quality Control, with standardised and accessible governance systems and structures in place from ward to Board
- Quality Assurance, with oversight arrangements in place to monitor progress and ensure targeted support

The Executive Quality Group will be responsible for overseeing implementation of the Quality Management System, with Operational Clinical Quality Groups responsible for overseeing delivery of quality requirements.

Quality Governance Oversight Structure

Group Board

Responsible for providing the Board with independent assurance on arrangements for governance and risk

Audit Committee

Group Executive Meeting

Quality & Outcomes Committee

Responsible for Board level oversight of all quality governance processes and outcomes

Hospital Operating Unit Management Team (Weston & Bristol Campuses)

Hospital Operating Unit Management Team (Southmead Campus)

Divisional Reviews

Executive Quality Group

Responsible for Executive oversight of quality governance processes, with direct oversight of Group based areas of quality including review of statutory annual reports

Key:

- Direct Reporting
- Assurance Route
- Information / KPIs

Operational Clinical Quality Group (Weston & Bristol)

Responsible for operational delivery of quality, with a focus on Divisional delivery of key quality requirements

Operational Clinical Quality Group (Southmead)

Hospital Operating Unit Based Sub-Groups

(Replicated in each HOU unless agreed as exception by Executive Quality Group)

Includes:
Clinical Effectiveness, Medicines (including Drugs & Therapeutics), Patient Safety (including Blood Transfusion, Deteriorating Patient, Falls, Resuscitation)

Group-wide Sub-Groups

(Operating in line with Group Quality Management System)

Includes:
CQC Steering Group, Infection Prevention & Control, Mortality Surveillance, Patient & Carer Experience, Research & Development, Safeguarding

Performance & Improvement and Oversight

Performance Management and Improvement systems and processes:

- Centrally compiled monthly performance reports, integrated across key areas of finance, people, operational performance and quality, broken down where appropriate to specialty / service level
- Improvement focussed reports, using Patient First principles and processes
- Clearly defined performance indicators, with governance arrangements for ratification and change, linked to Trust objectives
- Flexibility of scorecard format to enable emerging issues to be highlighted
- Exception reporting and escalation based on SPC exceptions
- Standardised scorecards at Divisional level, with specialty / service level reviews within Divisions, including review of Group Clinical Services where relevant, feeding into Divisional Review Meetings
- Improvement focussed Divisional Review Meetings, led by Hospital Managing Directors / Chief Operating Officers, feeding into Hospital Operating Unit Management Team Meetings to give a Unit-wide view of performance
- Relevant information shared with key Groups & Committees (relating to Quality, Finance, People and Operational Performance) to provide an overview of performance in the relevant area
- Hospital Operating Unit Management Teams feeding into GEM to give a Trust-wide view
- Board reporting based on agreed set of KPIs

Performance, Improvement and Oversight Structure

Key:
Direct Reporting
Assurance Route
Information / KPIs

Group Board

Group Executive Meeting

Board Sub Committees (QOC, People, Finance & Estates)

Hospital Operating Unit Management Team (Weston & Bristol Campuses)

Hospital Operating Unit Management Team (Southmead Campus)

GEM Sub Groups (Quality, People, Finance & Planning)

HOUMT Sub-Groups (Quality, People, Finance, Performance)

Divisional Review "balanced" scorecards centrally compiled

Divisions complete slide deck and self-assessment

HOUMT review and identify Key Lines of Enquiry

Divisional Review Meetings

Specialty / Service Level Review Meetings

Digital Oversight

Digital oversight structures:

- Key oversight of the digital agenda is via two GEM sub-groups, with the *Group Digital Hospital Programme Board* focussing on strategy delivery, and the *Group Divisional Operational Management Board* overseeing operational delivery of the digital agenda
- The *Group Divisional Operational Management Board* will act as the GEM Digital Group
- The groups will report directly to GEM for Executive oversight moving forward, but will also provide regular reports to the two Hospital Operating Unit Management Team meetings to enable local oversight
- Individual programmes and projects will have their own accountability for delivery, with clinically and/or operationally chaired meetings reporting to the *Group Digital Hospital Programme Board*
- Digital safety is overseen via two Hospital Operating Unit based Digital Safety Meetings, reporting to the Operational Clinical Quality Groups and escalating issues to the Executive Quality Group if required

Digital Oversight Structure

Key:
Direct Reporting
Assurance Route

Group Board

Responsible for Board level oversight of digital agenda

Digital Committee

Responsible for Executive oversight of digital strategy and delivery

Group Executive Meeting

Responsible for Executive oversight of clinical quality

Executive Quality Group

Hospital Operating Unit Management Teams

Operational Clinical Quality Groups

Digital Safety Meetings

Oversight of operational digital delivery

Group Divisional Operational Management Board (GEM Digital Group)

Group Information Risk Management Group

Oversight of digital strategy delivery

Group Digital Hospital Programme Board

Programme & Project Groups

Clinically / operationally chaired groups accountable for managing delivery of specific digital projects

People Oversight

Workforce oversight structures:

- The People Strategy Oversight Group (PSOG) provides strategic oversight of the People Strategy, providing assurance to GEM and the People committee that the People Strategy, sub-strategies and programmes are being delivered effectively, compliantly and in line with the vision, values and strategic objectives
- PSOG Meetings take place every 8 weeks with a blended diversity of corporate and clinical membership across the merged organisation, providing strategic direction, decision-making and escalation routes for people-related priorities and risks
- Planning for PSOG is aligned to the forward plan for the People Committee and GEM, ensuring appropriate scrutiny of business cases and reports prior to submission
- In addition to the formal subgroups of PSOG, professional groups with a significant workforce dimension are required to update PSOG for assurance, support, or information
- Key workforce, people, and education data (including EDI, resourcing, retention, and workforce planning metrics) are reviewed at PSOG to ensure improvement actions are in place and delivered

People Oversight Structure

NOTE – Sub-Group structure and names are indicative only, pending further discussion

Finance Oversight

Finance oversight structures:

- Divisional and corporate performance arrangements are as per the performance slide
- The Finance Strategy Oversight Group (FSOG) provides strategic oversight of Financial delivery and medium and long term planning and strategy. It provides assurance to GEM and the Finance & Estates Committee that financial performance and delivery, including capital, is being delivered effectively, compliantly and in line with the aims and ambitions of the organisation, through subgroups and site delivery.
- FSOG Meetings take place every month with a membership to represent the merged organisation, oversight and assurance on financial delivery and stewardship in the short and long term. FSOG also has a key role in ensuring finance strategy reflects elements of external horizon scanning.
- Delivery at a site level will be held via each HOUMT to provide oversight of in year savings, capital, financial performance, and the impact of performance and workforce on financial delivery.
- Key financial information and insight (including in year delivery, savings, capital, non-pay spend) are reviewed at FSOG to provide assurance and escalation.
- In addition, the data is included in the “balanced scorecards” provided to Divisional Review Meetings, feeding into the process for improvement-based discussions where performance issues are identified

Finance Performance Oversight Structure

Bristol | Weston

Key:
- Direct Reporting
- Assurance Route
- Information / KPIs

Group Board

Finance and Estates Committee

Group Executive Meeting

Hospital Operating Unit Management Teams
Finance Oversight Group

Finance Strategy Oversight Group

Pay oversight

People Strategic Oversight Group

Corporate Divisional Reviews

Divisional Reviews, including Estates and Ops

Non-Pay Spend Management

Capital Planning / Delivery Group

Transformational Delivery

Site Savings Group

Site Resourcing & Temporary Staffing Group

Site Business Case Review Group

Site Non-Pay Spend Management Group

Site Capital Planning/ Delivery Group

Site Elective Care Planning / Delivery Group

Consumables Group

Contracts Group

Drugs Group

Digital Capital Group

Estates Capital Group

Medical Equipment Group

Commercial Group

Receives updates on Merger Financial Benefits delivery including, Group Clinical Services, Corporate Services Transformation, income and non-pay merger benefits

Strategic Estates and Sustainability

Strategic Estates and Sustainability oversight structures :

- Formalise and ensure continuity of previous robust arrangements.
- Provide strategic oversight, assurance that we maximise the value and leadership for the Trust's existing and future estate and the delivery of the Green Plan.
- Oversee the development and delivery of an estates strategy and delivery plan that supports the Joint Clinical Strategy, the NHS 10-year plan three strategic shifts, whilst ensuring safe delivery of core acute hospital services across the whole of the Group's estate.
- Oversee the delivery of the Green Plan throughout the organisation.
- Oversee the development of a Group Estates Strategy and delivery plan that addresses the critical estates risks, including fire safety, in a way that is aligned to the Joint Clinical Strategy.
- Oversee alignment of reporting on estates risks across all Campuses.
- Will receive upward reporting from the Strategic Estates and Sustainability Steering Groups.
- The Strategic Estates Steering Group will work closely with the Capital Planning Group.
- The Sustainability Steering Group will work closely with other organisation wide groups including Health Inequalities.

Strategic Estates & Sustainability Oversight Structure

Key:
- Direct Reporting
- Assurance Route
- Information / KPIs

Group Board

Responsible for Board level oversight of estates and sustainability agenda

Finance and Estates Committee

Group Executive Meeting

Strategic Estates and Sustainability Group

Responsible for Executive Oversight of estates and sustainability agenda

Finance Strategy Oversight Group

Health inequalities

Green Plan Steering Group

Strategic Estates Steering Group

Capital Planning / Delivery Group

Sustainable Healthcare Collaboration

Green Plan Steering Group

Programme & Project Groups

Clinically / operationally chaired groups accountable for managing delivery of specific projects

Substructure Detailed in Finance Performance chart

Health and Safety Oversight

Health and Safety oversight structures:

- Key oversight of Health & Safety across the organisation, including fire, to be through a single Executive-led Health & Safety Committee.
- The GEM Health & Safety Committee will provide assurance to the Finance & Estates Committee (for oversight of regulatory health and safety and fire risks) and the People Committee (oversight of health & wellbeing and violence & aggression elements).
- The complex boundaries of accountability for health and safety assurance across Board sub-Committees will continue to evolve, learning from experience and from external peers.
- Obligations for Health & Safety in accordance with regulations and legislation, as well as policies and procedures of the Trust, will be monitored.
- Upward reporting will be received from subgroups, including fire, with a focus on risk and assurance of actions to ensure compliance.
- There will be transition arrangements in place to move from the predominantly site-based structures currently in place to a theme-based reporting structure covering the whole Group.

Health & Safety Oversight Structure

Appendix B –Assurance Framework Implementation Plan Summary

Board & Sub Committees	
Establish Board and Sub-Committees established, with standardised Terms of Reference	Complete
Develop standardised reporting templates for Board Sub-Committees, based on the "Alert" (Alert to matters that require the board's attention or action), "Advise" (Advise of areas of ongoing monitoring or development or where there is negative assurance), "Assure" (Inform the board where positive assurance has been achieved) model	Jun 2026
Review Terms of Reference of Sub-Committees to ensure they reflect the new structures and process of the merged organisation	Sep 2026
GEM and Sub Groups	
Establish Group Executive Meeting (GEM), with standardised Terms of Reference in line with Board Sub-Committees	Complete
Finalise terminology for meetings below Board level, to include use of terms such as 'Board', 'Committee' and 'Group'	Jun 2026
Establish GEM Sub-Groups, with standardised Terms of Reference	Sep 2026
Develop template for single monthly report from all GEM Sub-Groups to GEM, based on the "Alert", Advise", "Assure" model	Sep 2026
Review GEM Terms of Reference to ensure they reflect the new structures and process of the merged organisation	Dec 2026
Hospital Operating Units (HOUs)	
Share Accountability Framework with HOU Management Teams to explore options for management and committee structures	May 2026
Review arrangements for HOU Management Team Meetings to ensure Terms of Reference are standardised in line with GEM Sub-Groups	Jun 2026
Audit existing groups within each HOU to identify effectiveness	Sep 2026
Work with Hospital Managing Directors to agree structures within HOUs, including agreement on level of standardisation v localisation	Sep 2026
Standardise process for Divisional Reviews and how they fit into performance, improvement and planning oversight at HOU level	Sep 2026

Appendix B –Assurance Framework Implementation Plan Summary

Develop standardised Terms of Reference for groups reporting to the HOU Management Team Meetings, in line with other corporate meetings	Dec 2026
Review HOU Management Team Meeting Terms of Reference to ensure they reflect the new structures and process of the merged organisation	Mar 2027
Functional Structures	
Sign off development plans for each functional area at the relevant Board sub-Committee	Jun 2026
Ensure arrangements are in place for ongoing reporting of progress against development plans	Jun 2026
Implement transitional and final arrangements for each functional area, in line with agreed plans	Up to Jun 2027
Audit effectiveness of new arrangements for each functional area, in line with agreed plans	Up to Sep 2027
Finalisation and Review	
Corporate Governance Team to check to ensure transition to new arrangements is complete	Jun 2027
Review Accountability Framework to address findings any issues arising from audits and reviews of effectiveness	Sep 2027

Report To:	Public Group Board Meeting		
Date of Meeting:	12 May 2026		
Report Title:	Integrated Governance Report		
Report Author:	Jill Jaratina, Interim Head of Corporate Governance		
Report Sponsor:	Lavinia Rowsell, Group Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			x
	To present the integrated governance report, which brings together the Committee Chairs' upwards reports and the registers of seals for UHBW and NBT.		

Key Points to Note *(Including any previous decisions taken)*

Attached are the following items for the Board's information:

Committee Chairs' Reports from the March and April 2026 meetings:
Group Audit Committee (Appendix A) – 30 April 2026
Group Digital Committee (Appendix B) – 19 March 2026
Group Finance & Estates Committee (Appendix C) – 31 March and 28 April 2026
Group People Committee (Appendix D) – 26 March 2026
Group Quality and Outcomes Committee (Appendix E) – 31 March and 30 April 2026

Register of Seals – March to April 2026 (Appendix F)
Underlease and Licence to Underlet of Hampton House Health Centre

Strategic and Group Model Alignment

These documents directly support the Board's ambition to form a Group, and these documents support the new governance model being implemented.

Risks and Opportunities

None.

Recommendation

This report is for **Information.**
The Boards are asked to note the appendices to this report.

History of the paper (details of where paper has previously been received)

N/A	

Appendices:	Appendix A: Group Audit Committee Appendix B: Group Digital Committee Appendix C: Group Finance & Estates Committee Appendix D: Group People Committee Appendix E: Group Quality and Outcomes Committee Appendix F: Register of Seals (see below)

Appendix F: Register of Seals: March to April 2026

i) North Bristol NHS Trust (NBT)

There was no use of NBT's seal between March to April 2026.

ii) University Hospital Bristol and Weston NHS FT (UHBW)

Reference Number	Document	Date Signed
934	Underlease and Licence to Underlet of Hampton House Health Centre, St Michaels Hill, Cotham, Bristol	27/04/2026

Meeting of Group Board of Directors of NBT and UHBW held in Public
12 May 2026

Reporting Committee	Audit Committee in Common – April 2026 meeting
Chaired By	Richard Gaunt, Group Non-Executive Director
Executive Lead	Neil Kemsley, Group Chief Finance & Estates Officer

For Information

- The Committee received the following internal audit final review reports and discussed the assurance ratings.
  - Risk Management & Board Assurance Framework
    A joint NBT/UHBW review received an overall Satisfactory rating. Members noted strong engagement and noted the detailed recommendations which it was acknowledged would be very helpful when reframing the BAF.
  - Sickness Absence Reporting
    The Committee noted a Satisfactory assurance rating.
  - Patient Safety Incident Response Framework (PSIRF) – Maturity Assessment
    The Committee noted an advisory assurance rating and heard that UHBW achieved a notably high-scoring assessment, due to The Trust making strong progress in transitioning to the new PSIRF arrangements, and for having good foundations in incident reporting and learning in place.
- The Committee welcomed that UHBW had cleared all overdue recommendations and NBT, whilst still having 6 overdue recommendations, had none that were high-risk.
  - Data Security and Protection Toolkit (DSPT)
    The Committee noted that both trusts achieved “Standards Met” with no medium or high-risk recommendations identified. The Committee welcomed the strengthened governance and maturity of digital controls.
  - Human Tissue Authority
    The Committee received an update on the limited assurance report, and it was noted that good progress was being made with all actions on target to close by June 2026, which Internal Audit would follow up in line with standard procedures.
- The Committee received progress reports from NBT’s trusts’ external auditors and noted that Value for Money work was progressing as planned for UHBW.

- The Counter Fraud Progress Reports for each Trust were received where an increase in staff-related fraud referrals had been reported.

- The Committee reviewed the Single Tender Actions and Losses and Special Payments reports for both Trusts for the quarter.

- The Committee received the Accounting Policies and Critical Judgements for UHBW and noted no material changes in methodology, and approved the updates, subject to the final audit.

- The Committee reviewed both Trust's Draft Annual Governance Statements and noted no significant internal control issues identified by Trust Management Teams and requested minor narrative additions which would be reflected in the final Annual Reports.

- The Committee received assurance on merger arrangements, including governance, risk management, readiness assessments and gateway reviews supporting the forthcoming merger approval. It was noted that Gateway 4 (pre-merger readiness) was planned to assess: Day one readiness; Key digital dependencies and risks; Post-merger day-100 and year-one plans. Internal Audit involvement was being used to strengthen objectivity and robustness of this assurance.

- The Committee received an update on the Group Benefits Realisation framework, setting out the overall approach to identifying, tracking and reporting non-financial group benefits; and the current status of benefits delivery agreed as part of earlier Board decisions. It was noted that relevant Committees have reviewed and endorsed benefit changes and a consolidated benefits dashboard will be presented to the Board, supported by Committee-level scrutiny. Beyond this point, the Committee asked for clarity on the added value and future role of Audit Committee oversight of Group Benefits Realisation.

- The Committee received a single, integrated Risk Management Policy for the organisations to map risk ownership and escalation, and aligned to the Board-approved risk appetite, which was planned to go-live in July 2026. The Committee commended the report and agreed that the proposed approach provides a strong foundation for a unified Board Assurance Framework post-merger.

- The Committee received the results of the annual Committee Self-Assessment questionnaire for information.

- The Group Audit Committee Business Cycle for 2026/27 was received.

For Board Awareness, Action or Response

The Committee heard that UHBW achieved a notably strong and high-scoring assessment, which was described as one of the most positive PSIRF reviews undertaken across ASW's client base to date with strong leadership, commitment and organisational engagement with PSIRF principles, and good foundations in incident reporting and learning.
Key Decisions and Actions
The Committee approved the Internal Audit Plan for 2026/27, subject to clarification on the aim and coverage of the external review being carried out on No Criteria To Reside.
Additional Chair Comments
There were 6 limited internal assurance reports which will be the subject of a further internal audit follow-up report on outstanding actions included in the 2026/27 internal audit plan. The committee stressed the need for robust review of completed actions to ensure no further limited assurance report was received on follow up review.
Update from ICB Committee
N/A

Date of next meeting:	**Tuesday 16 June 2026 (Annual Report and Accounts)**

Public Group Board Meeting on 12 May 2026

Reporting Committee	Group Digital Committee – 19 March 2026
Chaired By	Roy Shubhabrata, Group Non-Executive Director
Executive Lead	Neil Darvill, Group Chief Digital Information Officer

For Information

The Committee met on 19 March 2026 and received the following reports:

1. **Operational Update:** The Committee received updates on Operational Performance across both Trusts. Key highlights included:
    - The electronic patient record (EPR) upgrade at UHBW had been deferred to July due to priority one patient safety issues.
    - The proposed paediatric CareFlow Medicines Management (CMM) (e-Prescribing) pilot was suspended due to concerns regarding safety, readiness and clinical alignment, with alternative options under consideration. The Committee agreed that assurance on clinical risk mitigation should be overseen through the Quality and Outcomes Committee.
    - The regional image-sharing programme continued to face affordability and funding challenges. A paper was scheduled for the Group Executive Meeting in April to support decision-making.

    The Committee discussed progress on the Business Intelligence (BI) work supporting the merger, the suspension of the paediatric CMM pilot, including the risks with existing paper-based and electronic prescribing arrangements, concerns about the lack of clear divisional and clinical ownership to sustain and scale the work of the specialist nurses and therapists in supporting ward teams to use digital tools, and medical records at Weston

2. **Cyber Security Bi-annual Report:** The Committee received the biannual Cyber Security Report. Key highlights included the development of a unified Group Cyber Security Operations Centre (CSOC) and a business case to develop an ICS-wide CSOC. The Committee heard about two major cyber-attacks that had affected NHS supply chains but was assured the incidents had very limited impact locally. The Committee discussed the ongoing work on password standards and the processes around proactively addressing issues highlighted by internal audit reports.
3. **Digital Strategy Update:** The Committee heard that delivery of the Digital Strategy was increasingly at risk due to financial pressures and a mismatch between digital demand and resource. The Committee discussed the need to strengthen business cases to unlock further investment and noted that delivery of the draft Digital Strategy would require difficult prioritisation decisions. The Committee agreed to receiving performance and benchmarking information at the next meeting to support clearer oversight and informed decision-making.
4. **Merger update:** The draft Full Business Case (FBC) and Post Transaction and Integration Plan (PTIP) had been approved by the Group Board and submitted into the national assurance process. The Committee heard that no significant changes had been made since those discussions.
5. **Accountability Framework:** The Committee received an early update on the development of the Accountability Framework for the near-merged Trust, which was a core requirement for evidencing the PTIP. The Committee discussed the digital

oversight and assurance arrangements, set out in the framework. The Committee noted that, while Digital Services already operated several Group-level structures, further work was required to formalise assurance mechanisms.

6. **Outpatient for the Future Update:** The Committee received an update on the Outpatients for the Future Update, to digitally enable outpatient services. The Committee discussed engagement with system partners and service users.
7. **Electronic Patient Record (EPR) Progress Update:** The Committee received an update on the development of the EPR programme, with opportunities being explored with Gloucestershire to pursue a shared procurement approach. A paper would be brought to the next Digital Committee in May 2026.
8. **Limited Assurance Internal Audit Report:** The Committee received limited assurance reports on SAP Ariba, Business Continuity (3rd Party IT Contracts), and Cyber Security. The Committee heard about the actions that had been taken to address the position, with most audit recommendations having been closed at UHBW and all audit recommendations having been closed at NBT. The Committee discussed the escalation of Group-level risks, the learnings from large-scale digital implementations, and the shared responsibility with clinical teams for delivery.
9. The Committee also considered:
   - The results of the recent committee self-evaluation
   - The 2026/27 Digital Committee work plan
   - The Digital Hospital Programme Board and Group Digital Management Board Minutes.

For Board Awareness, Action or Response (including risks)	
The Committee took assurance from all the above items, on behalf of the Board.	
Key Decisions and Actions	
N/A	
Additional Chair Comments	
N/A	
Date of next meeting:	Thursday 28 May 2026

Meeting of Group Board of Directors of NBT and UHBW held in Public
12 May 2026

Reporting Committee	Group Finance and Estates Committee – 31 March 2026
Chaired By	Martin Sykes, Group Non-Executive Director
Executive Lead	Neil Kemsley, Group Chief Finance & Estates Officer

For Information
1.Trust Joint Finance Report The Committee received detailed financial performance updates from the Finance Directors of both Trusts covering the period from 1 April 2025 to 28 February 2026, including an overview of overall financial performance and key financial risks. **2. Group Budget and 2026–27 Financial Plans** The Committee received a presentation on the Group budget for 2026–27, which covered savings requirements, capital allocation, cash-flow projections, and merger-related impacts. **3. Cost Improvement Programme (CIP) Progress** Updates were provided on the cost improvement programme (CIP) plans across both trusts, highlighting divisional progress, maturity ratings, workforce implications, and reporting challenges. **4. Merger Assurance and Corporate Services Transformation** The Committee received an update on the preparation for merger. It was agreed that the May meeting would review the risks associated with merged consultant episodes and pay alignment. The parts of the Accountability Framework relevant to the Committee are expected to be presented to the Committee at its next meeting. The Accountability Framework directly supports the Trust's strategic ambition to operate as a coherent Hospital Group **5. Health and Safety and Fire Incident Update** • Oversight of health and safety has moved from People Services to Estates & Facilities. Work continues to strengthen governance structures, reporting routes, and divisional assurance. Internal Audit findings indicate potential resource gaps, suggesting that current resourcing levels may not be fully aligned with operational and governance requirements. **Western Endoscopy Fire** • The fire was effectively contained due to previous investment and a strong operational response. • Insurance claim and root cause analysis are ongoing. • Temporary endoscopy units are being procured, with full recovery of capacity expected by late May.

6. Committee Self-Assessment Three responses were received to the annual survey. A more comprehensive review will be undertaken post-merger and may include face-to-face discussions as part of a broader assessment.	
For Board Awareness, Action or Response	
The North Bristol Trust Private Finance Initiative (NBT PFI) Refinancing Business Case will be presented to the Finance and Estates Committee in April for recommendation ahead of Board consideration in May and submission to the Department of Health and Social Care (DHSC) before the merger.	
N/A	
Additional Chair Comments	
There were no other matters that the Committee wished to bring to the attention of the Board.	
Update from ICB Committee	
N/A	
Date of next meeting:	**28 April 2026**

Meeting of Group Board of Directors of NBT and UHBW held in Public
12 May 2026

Reporting Committee	Group Finance and Estates Committee – 28 April 2026
Chaired By	Martin Sykes, Group Non-Executive Director
Executive Lead	Neil Kemsley, Group Chief Finance & Estates Officer

For Information
1.Trust Joint Finance Report The Committee received the year-end financial performance updates from the Finance Directors of both Trusts including an overview of cash positions and capital spend. **2. National Cost Collection Submission and Internal Benchmarking** The Committee received an update on the process and compliance status for the National Cost Collection (NCC) exercise. Planned work is underway to address compliance gaps, none of which are material, alongside the enhanced use of cost data to support internal benchmarking and the analysis of clinical variation in duplicate services. The Finance and Estates Committee approved the 2025/26 plan for the 2025/26 National Cost Collection submission for both UHBW and NBT. **3. PFI Refinancing Business Case and Approval Process** There was a detailed discussion on the proposed PFI refinancing for Southmead Hospital ahead of submission to the Board at its meeting in private for final approval. **4. Green Plan Annual Report and Sustainability Initiatives** The Committee received the Green Plan Annual Report, the delivery plan, and carbon reduction plan for the Trust's green agenda. There was discussion around the integration of sustainability into strategy, community engagement, climate adaptation, waste management, and embedding sustainability in staff objectives. The Finance and Estates Committee approved the Green Plan Annual Report, the delivery plan, and carbon reduction plan for the Trust's green agenda for submission to the Board for final approval **5. Accountability Framework for Finance, Estates, and Health and Safety** The Committee received the proposed Accountability Framework for the merged group, detailing governance structures for finance, estates, and health and safety. The Committee discussed local versus group oversight, community engagement, and the integration of fire safety and staff wellbeing. **6. Group Benefits Realisation and Non-Financial Benefits Tracking** The Committee received an update on the delivery of group benefits, highlighting progress, risks, and the removal of duplicate financial metrics from the non-financial tracker. The

Committee supported the recommendations and noted the future integration of merger benefits. 7. **Senior Structure Recruitment and Corporate Services Transformation** The Committee noted the progress in appointing senior finance roles, the ongoing corporate services transformation and the impact on staff roles, current savings and monitoring processes.
For Board Awareness, Action or Response
The following items are scheduled to be presented to the Board on 12 May 2026: 1. National Cost Collection Submission and Internal Benchmarking 2. PFI Refinancing Business Case and Approval Process 3. Green Plan Annual Report and Sustainability Initiatives 4. Group Benefits Realisation and Non-Financial Benefits Tracking
N/A
Additional Chair Comments
There were no other matters that the Committee wished to bring to the attention of the Board.
Update from ICB Committee
N/A
Date of next meeting: **26 May 2026**

Meeting of Group Board of Directors of NBT and UHBW held in Public on Tuesday, 12 May 2026, 10.00 to 13.00 at The Park Centre, Daventry Road, Knowle West, Bristol BS4 1DQ

Reporting Committee	People Committee – 26 March 2026
Chaired By	Linda Kennedy, Non-Executive Director
Executive Lead	Jenny Lewis, Group Chief People & Culture Officer

For Information

The Committee received and discussed assurance reports covering workforce performance (IQPR), People Strategy Oversight arrangements, the Employment Rights Bill, Sexual Safety Charter delivery, Speaking Up culture, and staff survey results. The Committee also considered merger-related updates including Day 1 readiness, TUPE progress, communications and engagement, group benefits tracking, workforce digital readiness, and the proposed people governance and accountability framework.

The Committee confirmed that merger preparations remain on track, with mitigations in place for identified workforce and people risks.

Ongoing areas of focus included:

- Preparations for the changes to the Employment Act and ensuring an internal audit to understand both Trusts readiness,
- pay and bank rate alignment,
- Oliver McGowan mandatory training compliance, and
- workforce digital dependencies.

Discussions were also held on merger assurance and readiness for day 1.

For Board Awareness, Action or Response

The Board is asked to note that People Committee was not quorate, and therefore items requiring formal approval will be confirmed in May.

Work is now underway to ensure alignment of Boards and Committees and ensure quoracy is not an issue wherever possible moving forward.

Key Decisions and Actions

The Committee agreed the Merger OD and Culture Plan, recognising the need for continued leadership engagement post-merger.

Actions from other areas of the meeting included:

- strengthen alignment with ICB activity on violence and aggression;

- undertake further analysis of staff survey responses relating to physical harm between colleagues; and
- consider inclusion of bank and agency compliance within the audit programme.

Additional Chair Comments	
The Chair highlighted the scale and pace of concurrent change across the system and emphasised the importance of consistent communication, visible leadership and assurance mechanisms to support staff through the merger period. Assurance was drawn from strong staff survey participation, active executive engagement, and the strengthening governance arrangements emerging across the Group.	
Update from ICB Committee	
The Chair advised that ICB People Committee arrangements are currently paused as part of wider system changes. The Committee discussed the importance of avoiding duplication of effort between Trust and system-level initiatives, particularly in relation to violence and aggression standards and people priorities.	
Date of next meeting:	**Tuesday 26 May 2026**

Public Group Board Meeting on 12 May 2026

Reporting Committee	Group Quality and Outcomes Committee (QOC) - 31 March 2026
Chaired By	Sarah Purdy, Non-Executive Director and NBT Vice-Chair
Executive Lead	Professor Steve Hams, Group Chief Nursing and Improvement Officer (CNIO) Tim Whittlestone, Group Chief Medical and Innovation Officer (CMIO)

For Information

The Committee met on 31 March 2026 and considered the following reports:

1. **Merger Assurance Update:** the Committee received an update on the proposed merger between NBT and UHBW, focussing on the Quality remit, summarising the current assurance position following approval of the Full Business Case and Post-Transaction Integration Plan, outlining key risks and mitigations, and describing day 1 readiness and governance arrangements to support a safe transition. The Committee noted and welcomed progress and the current assurance position, as well as the ongoing testing of the merger plans by NHSE and the involvement of internal audit. The committee was assured for day 1 merger readiness. It was also recognised that for quality related activities, significant actions within the PTIP are 'post day 1' and this carries greater risk, particularly due to the convergence with the Corporate Services Transformation Programme (CSTP) consultations that are running over that period, impacting leaders and teams who are pivotal to delivery.

2. **Group Accountability Framework (Quality Oversight and Assurance):** the Committee considered an update on progress with developing the Group Accountability Framework (GAF) including its purpose and scope, and whether the proposed arrangements would provide clear, robust and proportionate assurance to the Board. The Committee noted the purpose and status of the GAF, considered the proposed quality oversight and assurance arrangements set out in the GAF and provided feedback, particularly about the importance of integrating and aligning quality governance and Patient First, ensuring transparent lines of accountability and delivery, effective Executive oversight of quality issues, and a robust quality management system. They noted that work on the GAF was ongoing, with further reports to the Board planned for the next cycle.

3. **Integrated Quality and Performance Report (IQPR) (UHBW and NBT):** the Committee heard about the latest performance by both Trusts against key national quality and responsiveness metrics, including in relation to diagnostics, cancer, urgent and emergency care (UEC), and referral to treatment (RTT), as well as in relation to infection prevention and control, maternity and neonatal services, and patient and carer experience. Improvements in ambulance handover times, and against UEC 4-hour targets, RTT and diagnostic targets were reported, as were continuing challenges associated with recent bed losses, no criteria to reside levels and corridor care. Cancer targets were slower to improve, with ongoing specialist recruitment challenges and high numbers of referrals of patients (who were already in breach of treatment target times) to Bristol from other areas. The Committee discussed system-level discharge issues and ongoing partnership work, GP referrals, VTE

risk assessments at UHBW, pressure injury data and diagnostic and cancer targets in particular, as well as increasing use of AI by complainants. The Committee noted the update and was reminded of the upcoming Board event planned for April, to discuss no criteria to reside and flow issues.

4. **Upward report of the Clinical Quality Groups (CQG) (NBT and UHBW):** This was an upward report from meetings of the NBT CQG held on 6 March 2026 and the UHBW CQG held on 3 March 2026. The Committee noted the reports, with discussion taking place about the need for better co-ordination across the Group of Oliver McGowan training.

5. **Deep Dive into Service Provision for Children with Learning Disabilities and Autism at Bristol Royal Hospital for Children (BRHC):** this report provided an update (as requested by the UHBW QOC in 2024) on service provision for children with learning disabilities and Autism at BRHC. The Committee heard about the appointment of a paediatric learning disability and Autism clinical nurse specialist (LD&A CNS), the development of a standard operating procedure and outreach work with schools and community partners. The Committee noted progress since the appointment of the LD&A CNS and discussed the need for ongoing evaluation through complaints data, feedback, and potential future audits. They also discussed the need for strategic alignment of learning disability and Autism services across the Group, with plans to integrate these roles into the community inclusion portfolio.

6. **BNSSG Stroke Pre-alert Pathway - HSSIB pilot investigation action plan:** this report provided an updated action plan for improvement in response to a recent HSSIB report, following on from the report to the Committee's meeting held in January 2026. The HSSIB report identified seven areas for improvement, with updates provided against each. The Committee discussed the need for clear system leadership of the Stroke pathway, as well as the need for clear triage processes, and digital challenges. They noted the report and that discussions were ongoing system-wide and in the context of the Joint Clinical Strategy.

7. **Bristol Group Organ Utilisation (OU) Strategy:** this report provided an update and assurance on the first Bristol NHS Group OU Strategy, including compliance with the national OU Group recommendations, transplant activity trends, governance structures, risks and improvement opportunities. The Committee heard about the aims to maximise organ donation and transplantation, and about national and local trends, including growing waiting lists and reducing donations and organ availability, as well as about risks such as reliance on the Proton app, which was on the relevant Risk Register and reflected in the Group Digital Strategy. The Committee discussed the need for increasing alignment across the Group and asked for an annual report back, when relevant data updates were available.

8. **Fragile Services Update:** this report outlined the Group's "fragile services" and the approach to managing these, highlighting new national NHS England tools to support identification and escalation processes. The Committee heard about many fragilities being due to workforce challenges (e.g. shortages of specialist consultants) and the insufficiency of resources generally, and the need for judgement about the proportionality of service provision choices, in light of demand and supply. The Committee noted the update, noted the recent publication of new NHSE guidance and noted that fragile services data would continue to inform service prioritisation in the context of the Joint Clinical Strategy.

9. **Quarterly Experience of Care report (Q3) (UHBW and NBT):** this report provided an overview of experience of care information across both Trusts for quarter 3 of 2025/26, including complaints, Patient Advice and Liaison Service (PALS) activity, Friends and Family Test (FFT) feedback and other patient engagement work. The Committee heard about key themes from patient feedback, the increasing number and complexity of complaints, and about continued efforts to improve systems alignment between the Trusts. The Committee discussed the increasing use of AI by complainants and by the Trusts in complaints management and responses. They welcomed and were assured by the report.

10. **Maternity and Neonatal Safety Champion verbal report:** the Executive and NED Champions reported on the first cross-city Maternity and Neonatal Safety Champion meeting, which had been held recently. They discussed shared challenges, the potential use of ambient voice technology in maternity services and the increasing alignment of policies and guidelines across the Trusts.

11. **Committee self-assessment results 2025/26:** the Committee noted the results of the annual survey of Committee members; in particular, the consensus that the Committee's agenda was particularly challenging, as a result of the high volume of detailed and complex business, with two Trusts reporting into the Committee on a wide range of issues.

12. **Committee terms of reference interim review:** the Committee agreed changes to their terms of reference (set out in Appendix A to this report for the Board's approval).

13. **Committee workplan:** the Committee noted its current workplan, and that it would evolve further as new governance arrangements came onstream or developed (e.g. the proposed Group Executive Quality Group and the Clinical Quality Groups at NBT and UHBW). They asked that the Health Equity Plan be submitted to QOC (as well as the Board) in future.

For Board Awareness, Action or Response (including risks and escalations)

The Board's attention is particularly drawn to:

(a) minor changes to the Committee's terms of reference, attached for the Board's approval
(b) the Committee was significantly assured about the robustness of the merger plans
(c) the Group Organ Utilisation Strategy (a paper on which is available in the Convene Document Library)
(d) the Committee was assured about the Stroke Hyperacute pathway action plan, in response to the HSSIB report
(e) the positive work taking place at BRCH in terms of children's learning disability and Autism services.

Key Decisions and Actions

The Board is recommended to note this report and the activities undertaken by the Quality and Outcomes Committee on behalf of the Board, for assurance purposes.

Additional Chair's Comments

The Committee was also assured on the identification and management of patients presenting with possible meningitis, and that any suspected cases must be reported to the UK Health Security Agency.

Date of next Committee:	Tuesday 30 April 2026
Appendices:	Appendix 1 – QOC terms of reference including tracked changes (compared to the version approved by the Board in September 2025)

Meeting of Group Board of Directors of NBT and UHBW held in Public
12 May 2026

Reporting Committee	**Group Quality and Outcomes Committee – April 2026 meeting**
Chaired By	**Sarah Purdy, Group Non-Executive Director**
Executive Lead	**Professor Steve Hams, Group Chief Nursing and Improvement Officer**

For Information
The Committee received updates on the Group Clinical Strategy, including progress with Group Clinical Services and phase two engagement, and the development of improved benefits realisation metrics. The Committee also received detailed updates on integrated quality and performance, clinical quality escalations, corridor care, maternity and neonatal quality and safety, and patient experience.
For Board Awareness, Action or Response
The Board is asked to note the escalation of a corporate risk relating to the management of acutely unwell children at Weston ED, mitigations in place and the requirement for future investment. The Board is also asked to note increasing complaint volumes and complexity across both organisations, and the forthcoming alignment of group and merger benefits reporting. Concerns were raised over the national delays in receiving a postmortem examination on stillbirth babies due to a lack of specialist paediatric clinicians.
Key Decisions and Actions
The Committee approved the draft Quality Accounts for external consultation. Approval of Group Clinical Service metrics was granted. However, the committee requested that they be kept updated on further development of benefits realisation reporting. Actions were agreed to strengthen governance of action logs by applying clear completion dates.
Additional Chair Comments
The Chair highlighted the scale and complexity of information flowing to the Committee and welcomed ongoing work to better align and streamline quality reporting across both organisations. Strong assurance was received on the commitment and professionalism of clinical and quality teams during a period of sustained operational pressure.
Update from ICB Committee
N/A

Date of next meeting:	**Thursday 28 May 2026**