Meeting of Group Board of Directors of NBT and UHBW held in Public on Tuesday, 09 September 2025, 10.00 to 12.45

In the Training Room, St James' Court, St James' Parade, Bristol, BS1 3LH

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
Preliminary Business				
1.	Apologies for Absence	Information	Group Chair	10:00 (5 mins)
2.	Declarations of Interest	Information	Group Chair	
3.	Patient Story	Information	NBT Head of Patient Experience	10:05 (20 mins)
4.	Minutes of the last meeting held on 8 July 2025	Approval	Group Chair	10:25 (5 mins)
5.	Matters Arising and Action Log	Approval	Group Chair	
6.	Questions from the Public	Information	Group Chair	10:30 (5 mins)
Strategic				
7.	Group Chair's Report	Information	Group Chair	10:35 (10 mins)
8.	Group Chief Executive's Report	Information	Group Chief Executive	10:45 (10 mins)
9.	Group Benefits Realisation Report (including JCS update)	Information	Group Formation Officer	10.55 (20 mins)
BREAK – 11.15 to 11.25				
10.	Winter Plan Board Assurance Statement	Approval	Group Chief Executive	11.25 (10 mins)
Quality and Performance				
11.	Group Integrated Quality and Performance Report	Information	Hospital Managing Directors and Executive Leads	11:35 (15 mins)
12.	Learning from Deaths Annual Report	Approval	Group Chief Medical and Innovation Officer	11:50 (20 mins)
13.	UHBW & NBT Revalidation report	Approval	Group Chief Medical and Innovation Officer	12.10 (10 mins)
Governance				
14.	Integrated Governance Report including Committee Chairs' Reports / Register of Seals	Information	Committee Chairs	12:20 (10 mins)
15.	Group Scheme of Delegation and Standing Financial Instructions	Approval	Group Chief Finance and Estates Officer	12.30 (10 mins)

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
16.	Committee Terms of Reference and Membership	Approval	Group Chief of Staff	12:40 (5 mins)
Concluding Business				
17.	Any Other Urgent Business – *Verbal Update*	Information	Group Chair	12:45
18.	Time and Date of Next Meeting **Tuesday, 11 November 2025**	Information	Group Chair	-

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Patient Story – Craft sessions at the Macmillan Wellbeing Centre		
Report Author:	Kerry Than, Head of Patient Experience and Emma Bedggood, Assistant Chief Nursing Officer for Cancer		
Report Sponsor:	Prof Steve Hams, Group Chief Nursing and Improvement Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	
	This report shares a Patient Story from four individuals who describe the positive impact of volunteer-led craft sessions at the Macmillan Wellbeing Centre at North Bristol NHS Trust (NBT). These stories provide valuable insight into the emotional and wellbeing benefits of creative activities, helping us celebrate compassionate care and identify opportunities to enhance patient experience across the Hospital Group.		

Key Points to Note

- During Patient Experience Week in April, the Macmillan Wellbeing Centre received an Outstanding Patient Experience award for the support they provide patients and family members affected by cancer.
- A visit by Prof Steve Hams and Kerry Than highlighted the opportunity to share the centre's work more widely, particularly the monthly craft sessions and the positive impact they have on wellbeing.
- Volunteer Liz leads these sessions, preparing a variety of creative activities from card making and seasonal decorations to painting, textile crafts and paper flowers – all designed to be accessible and support wellbeing for patients at any stage of their cancer pathway.
- The four patients featured in the story describe how engaging in creative activities helps to reduce anxiety, improve mood, and foster a sense of purpose and connection - demonstrating the value of arts in healthcare and its impact on their overall wellbeing.
- Arthur Quinn, the Centre Manager, shares how the craft sessions have become a valued part of the centre's offering, with patients often expressing how the creative environment helps them feel more relaxed, supported, and connected during a challenging time.
- The story encourages reflection on how similar craft sessions and arts programmes could be adopted by other services, with consideration of how sessions at the Macmillan Wellbeing Centre can be made more accessible to underrepresented groups, ensuring inclusivity and equity in wellbeing support.

Strategic and Group Model Alignment

This Patient Story aligns with the NBT's strategic aim for Outstanding Patient Experience and supports the Patient and Carer Experience Strategy 2023-26. It contributes to the Trust's commitments to:

- Listening to what patients tell us
- Supporting and valuing individuals
- Promoting inclusion and responsiveness
- Enhancing visibility of patient and carer experience

This patient story will be shared with colleagues across the Hospital Group, with potential for collective learning and service alignment across cancer centres at NBT and University Hospitals of Bristol and Weston (UHBW), positively impacting the 4Ps: Patients, Population, People, and Public Purse.

Risks and Opportunities

Opportunities:

- To expand volunteer-led art and craft initiatives in other services, improving awareness and access to wellbeing approaches, and enhancing inclusivity (e.g., gender and other group imbalances in participation).
- Collective learning and service alignment across cancer information and support centres:
    - Macmillan Wellbeing Centre, Southmead Hospital
    - Cancer Information and Support Centre, Bristol Haematology and Oncology Centre
    - Macmillan Wellbeing Centre, Weston General Hospital

This collaboration could support continuity and equity of experience and streamline wellbeing initiatives, noting the variation of experience across the wider cancer pathway.

Recommendation

This report is for Discussion.

The Board is asked to discuss the patient story and consider how the learning and approaches shared could be applied to enhance accessibility to arts and crafts at the Macmillan Wellbeing Centre and more broadly across the group to enhance patient wellbeing and experience.

History of the paper (details of where paper has <u>previously</u> been received)

None	N/A
Appendices:	N/A

Patient Story – Trust Board Meeting in Common

NHS Bristol NHS Group Bristol | Weston

Prof Steve Hams, Group Chief Nursing and Improvement Officer

Craft Sessions at the Macmillan Wellbeing Centre

Craft Sessions at the Macmillan Wellbeing Centre

NHS Bristol NHS Group Bristol | Weston

Introduction:

- Emotional support is at the heart of **compassionate care**
- The **Macmillan Wellbeing Centre** offers a place for people affected by cancer, their family and friends to gain support and information, and to meet and spend time with others
- The centre **supports people across BNSSG** helping them to manage their own care needs, whilst liaising, signposting and referring to community partners, to enable good communication and seamless care

Liz, a volunteer, supports patients with **craft sessions** – these are simple, yet powerful creative activities.

The film features **four patients** sharing the impact of these sessions.

Take time to reflect on how **similar approaches** could enhance patient experience **across the Trust.**

Craft session patient story

NHS Bristol NHS Group Bristol | Weston

Please click this link to access the Patient Story video on YouTube:

Macmillan - Patient Experience Story - YouTube

Alternatively, the link below allows you to access via sharepoint:

Macmillan video FINAL.mp4

Learning

NHS Bristol NHS Group Bristol | Weston

Benefits of arts and crafts on wellbeing:

- Highlights the value of craft for patients - to help improve wellbeing
- Offers the opportunity to access general emotional support from the centre staff, volunteers and others
- The importance of wellbeing support provided alongside clinical care and treatment

Wellbeing provision and variation of access:

- Referrals by Clinical Nurse Specialists and Cancer Support Workers is key to ensure people affected by cancer know about the Macmillan Wellbeing centre
- The positive impact on patients when the centre and clinical teams work in partnership

Gender imbalance noted:

- Mostly women attend craft sessions; opportunity to improve diversity and inclusivity

Increase awareness and access:

- To a broader audience, considering groups that are less represented

Actions to take forward

- Continue to raise awareness of the centre and what is provides
- Explore how volunteer-led craft sessions can be introduced in other areas
- Identify, develop and promote support options to ensure inclusion of people from diverse communities
- Involve NBT Patient and Carer Partners in a ‘15-step challenge’ - identify opportunities to improve accessibility and approachability to the centre
- Share Patient Story at Southwest Community of Practice for Cancer Information Centres - share learning across the region and generate improvement ideas
- Improve signage to direct patients and family to the centre
- Explore shared learning and service alignment across the group cancer centres to enhance continuity of care across cancer pathways e.g. room space coordination, streamlining patient wellbeing events

DRAFT Minutes of the Public Meeting "In Common" of North Bristol NHS Trust (NBT) Board and University Hospitals Bristol and Weston NHS (UHBW) Foundation Trust Board. Held on 8 July 2025 at 10am to 12:45pm at the Healthy Living Centre, 68 Lonsdale Avenue, Weston-Super-Mare, North Somerset, BS23 3SJ.

Present (Board members):

NBT		UHBW	
Ingrid Barker	Bristol NHS Group Chair	Ingrid Barker	Bristol NHS Group Chair
Sarah Purdy	Non-Executive Director and NBT Vice-Chair	Martin Sykes	Non-Executive Director and UHBW Vice-Chair
Shawn Smith	Non-Executive Director	Arabel Bailey	Non-Executive Director
Kelly Macfarlane	Non-Executive Director	Linda Kennedy	Non-Executive Director
Kelvin Blake	Non-Executive Director	Sue Balcombe	Non-Executive Director
Richard Gaunt	Non-Executive Director	Roy Shubhabrata	Non-Executive Director
Maria Kane	Bristol NHS Group Chief Executive	Marc Griffiths	Non-Executive Director
		Rosie Benneyworth	Non-Executive Director
Glyn Howells	Hospital Managing Director, NBT	Maria Kane	Bristol NHS Group Chief Executive
Neil Darvill	Bristol NHS Group Chief Digital Information Officer	Stuart Walker	Hospital Managing Director, UHBW
Neil Kemsley	Bristol NHS Group Chief Finance and Estates Officer	Neil Darvill	Bristol NHS Group Chief Digital Information Officer
Tim Whittlestone	Bristol NHS Group Chief Medical and Innovation Officer	Neil Kemsley	Bristol NHS Group Chief Finance and Estates Officer
		Tim Whittlestone	Bristol NHS Group Chief Medical and Innovation Officer
Steve Hams	Bristol NHS Group Chief Nursing and Improvement Officer	Steve Hams	Bristol NHS Group Chief Nursing and Improvement Officer
Paula Clarke	Bristol NHS Group Formation Officer	Paula Clarke	Bristol NHS Group Formation Officer

Also in attendance:

Xavier Bell	Group Chief of Staff	Mark Pender	Head of Corporate Governance, UHBW
Aimee Jordan-Nash	Senior Corporate Governance Officer & Policy Manager, NBT *(Minutes)*	Kelly Jones	Corporate Governance Officer, NBT

Presenters:

Matthew Areskog	Head of Experience of Care & Inclusion *(present for minute item 03/07/25)*
Aimee Vafaie	Consultant in General Paediatrics and Safeguarding at UHBW *(present for minute item 03/07/25)*
Beth Shirt	Director of Nursing at UHBW for Children's services *(present for minute item 03/07/25)*
Gemma Lewis	Sister at the Seashore Unit, Weston Hospital *(present for minute item 03/07/25)*
Moestak Hussein	Community Involvement and Partnerships Lead *(present for minute item 03/07/25)*
Sam Willitts	Head of Sustainability *(present for minute item 09/07/25)*
Hilary Sawyer	Lead Freedom to Speak Up Guardian, NBT *(present for minute item 12/07/25)*
Kate Hanlon	Deputy Freedom to Speak Up Guardian, UHBW *(present for minute item 12/07/25)*
Onny Miller	Associate Freedom to Speak Up Guardian, NBT *(present for minute item 12/07/25)*

01/07/25 Welcomes and Apologies for Absence **Actions**

Ingrid Barker, Bristol NHS Group Chair, welcomed everyone to the meeting and acknowledged the significance of holding the session at the For All Healthy Living Centre, a community interest company providing integrated services to the local population. The Chair noted the alignment of the venue with the NHS 10-Year Plan's emphasis on neighbourhood health centres and praised the co-location of the Community Diagnostic Centre as a tangible example of partnership working.

Apologies for absence had been received from

- Anne Tutt, UHBW Non-Executive Director
- Jane Khawaja, NBT Non-Executive Director

Departing members Rosie Benneyworth, UHBW Non-Executive Director, and Kelvin Blake, NBT Non-Executive Director, were recognised for their longstanding contributions to both Trusts.

02/07/25 Declarations of Interest

Rosie Benneyworth advised that effective from 1 July 2025 she would be a Non-Executive Director for Somerset NHS Foundation Trust.

No other interests were declared.

Matthew Areskog, Aimee Vafaie, Beth Shirt, Gemma Lewis, Moestak Hussein and Melaine joined the meeting.

03/07/25 Patient Story

Matthew Areskog, Head of Experience of Care & Inclusion, introduced the patient story and welcomed to the meeting Melanie, mother of Arthur, a 10-year-old boy with complex neurological and respiratory needs.

Melanie shared deeply moving and insightful feedback of her family's journey through the healthcare system, highlighting:

- The importance of continuity of care and long-term relationships with clinicians.
- The critical role of the Seashore Centre in Weston in providing local, responsive care.
- The emotional and logistical challenges of long-term hospitalisation and end-of-life planning.
- The exceptional compassion, communication, and professionalism of staff at Bristol Royal Hospital for Children (BRHC) and at Weston General Hospital.

The Boards expressed their gratitude and admiration for Melanie's courage and advocacy and for sharing Arthur's story. The story was acknowledged as a powerful reminder of the human impact of integrated, compassionate care and the importance of listening to families.

The Boards shared the following reflections, which were formally noted:

- The Chair thanked Melanie for her openness and acknowledged the dedication of staff.
- Rosie Benneyworth highlighted the importance of listening to carers and the transformative impact of continuity of care.
- Paula Clarke, Bristol NHS Group Formation Officer, emphasised the value of linking local services with specialist expertise to deliver high-quality care close to home.

- Kelvin Blake reflected on the challenge of ensuring such positive experiences were consistently delivered across all services.

RESOLVED that the Boards noted the Patient Story and welcomed the feedback to embed learning into future service development.

Matthew Areskog, Aimee Vafaie, Beth Shirt, Gemma Lewis, Moestak Hussein and Melaine left the meeting.

04/07/25 Minutes of the Last Meeting

RESOLVED that the minutes of the public meeting of the Boards of North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust held in common on 13 May 2025 were approved as a true and accurate record.

05/07/25 Action Log and Matters Arising

Action 1: 13/04/25 - Group Board Assurance Framework (BAF)
A separate risk should be added to the BAF in relation to the level of no criteria to reside and its impact on the Trusts' ability to deliver against the operating plans of both NBT and UHBW.
It was noted that the updated BAF would be brought to September's Board meeting. **Action Ongoing.**

Action 2: 14/04/25 - Board Workplan and Committee Terms of Reference
Further reports on the Board Workplan and committee terms of reference, quorums, remits and memberships to be submitted to answer Board members' queries.
It was noted that the updated workplan and committee terms of reference would be brought to September's Board meeting. **Action Ongoing.**

RESOLVED that the Boards noted the action log and no matters arising were discussed.

06/07/25 Questions from the Public

No questions from the public were received for this meeting.

07/07/25 Group Chair's Report

The Chair summarised her report, commenting briefly on the visits she had undertaken as listed in the report, as well as her work with key partners and national initiatives she was involved with.

The Chair highlighted the following to the Boards:

- A six-month review with both Vice Chairs had been conducted to assess the effectiveness of the role and identify opportunities for further alignment and support across the Group.
- Attendance at the UHBW "Heart of Care" awards celebrating exceptional frontline staff. The event was noted as a morale-boosting occasion that highlighted the dedication and compassion of staff.
- Visits to the Bristol Eye Hospital and St Michael's Hospital. At St Michael's, the Chair personally thanked staff who responded to the recent rooftop fire, praising their professionalism and resilience.
- Engagements with system partners including Sirona, Brunelcare, and Bristol City Council.
- Participation in the inaugural NHS Group Chairs Forum and the Bristol, North Somerset and South Gloucestershire (BNSSG) Chairs Reference Group.

The report was noted, and the Chair's continued advocacy for integrated care and community engagement was commended.

Sarah Purdy, Non-Executive Director and NBT Vice-Chair, provided feedback on her visit to the Apprenticeship Centre to celebrate Learning at Work Week, noting its diversity across disciplines and the range of qualification levels offered. The visit highlighted the strategic value of apprenticeships in supporting career development and enhancing workforce capability.

RESOLVED that the Boards noted the Group Chair's report.

08/07/25 Group Chief Executive's Report

Maria Kane, Bristol NHS Group Chief Executive, presented her report and highlighted the following:

- The publication of the NHS Oversight Framework 2025–26 and its implications for provider segmentation and performance assessment.
- The Secretary of State's announcement of a national review into maternity and neonatal services, and the Trust's ongoing work to assess local care quality, culture, and inequalities in line with national expectations.
- The NHS 10-Year Plan's emphasis on local, digital-first care and the shift from hospital to community-based services.
- The recent fire at St Michael's Hospital and the exemplary response by staff and partners.
- Progress on global partnerships, research funding, and digital transformation initiatives.
- Recognition of Professor Parag Singhal who has been awarded the Order of the British Empire (OBE) in the King's Birthday Honours List 2025 for his outstanding services to health education and to black and minority ethnic doctors.

Following a query from Rosie Benneyworth regarding the application of the oversight framework across the Group, Maria confirmed that there would not be a single, consolidated score for the Group as a whole. Instead, each Trust within the Group would receive its own distinct oversight score.

RESOLVED that the Boards noted the Group Chief Executive's report.

Sam Willitts joined the meeting.

09/07/25 Green Plan Refresh

Sam Willitts, Head of Sustainability, presented the refreshed Green Plan for 2025–2030 which outlined the progress to date, key updates, and the strategic direction for sustainability across the system. The refresh reflected the changes since the original plan and set out a realistic, system-wide approach to achieving environmental goals.

The following key points were highlighted:

- A reaffirmed commitment to net zero carbon by 2030 for directly controlled emissions.
- Alignment with national NHS targets for supply chain and indirect emissions.
- The plan distinguished between areas under direct control and those where influence was required. Emphasis was placed on ensuring the plan was pragmatic, deliverable, and resilient to system-level changes.
- The refreshed plan had been approved by Integrated Care Boards (ICB) and served as a blueprint for provider-level implementation. It would be embedded within wider system strategies and delivery plans.

- Integration of sustainability into clinical transformation, estates, procurement, and workforce development.
- Establishment of a £3 million annual decarbonisation fund.
- Emphasis on community engagement, biodiversity, and health equity.
- A refreshed delivery plan was in development and would include updated actions, responsibilities, and named leads to drive implementation.
- The greatest sustainability impact was expected through prevention and service transformation with all staff playing a key a role in its delivery.

Queries and comments from the Board were as follows:

- Arabel Bailey, UHBW Non-Executive Director, praised the realism of the plan and its effective integration with the overarching 10-year strategy. However, she raised concerns regarding ownership and delivery, particularly in the context of ongoing system-level changes. She emphasised the importance of clarifying responsibilities and establishing clear delivery mechanisms. Sam confirmed that sustainability resources were already embedded within Trusts, ensuring resilience.
- Neil Darvill, Bristol NHS Group Chief Digital Information Officer, highlighted that patient transport accounted for 17% of NHS carbon emissions, underscoring its significant environmental impact. He advocated for service redesigns aimed at reducing travel, such as the expansion of virtual outpatient services. He also supported embedding transport considerations into broader clinical transformation efforts.
- Roy Shubhabrata, UHBW Non-Executive Director, inquired about how Gloucestershire was being integrated into the wider system plan. He expressed concerns about the alignment of metrics across regions, noting discrepancies such as differing zero-waste targets. Additionally, he flagged the carbon impact of digital technologies, particularly Artificial Intelligence (AI) and cloud computing.
- Marc Griffiths, UHBW Non-Executive Director, commended the inclusion of the Sustainable Healthcare Collaboration within the plan. He encouraged stronger links with universities and community-based education to support cultural change and innovation.

Maria Kane left the meeting.

- Rosie Benneyworth highlighted the need to link sustainability with quality, safety, and health inequalities, advocating for combined impact assessments and cultural change to embed sustainability in everyday practice.
- Martin Sykes, Non-Executive Director and UHBW Vice-Chair, stressed the urgency of decarbonising the UHBW estate and the need to reflect this priority within the medium-term financial plan. He called for practical steps to ensure the plan was deliverable by 2030, particularly in relation to capital investment requirements.

The Chair concluded by acknowledging the contributions of system partners and the importance of collective action. It was noted that feedback would be incorporated into the delivery plan.

RESOLVED that the Boards:

- **Discussed the changes made to the green plan in the refresh process and noted that these met the NHSE aims.**
- **Noted that the plan had been taken for approval at the ICB Board and that ICS organisations were taking the plan to individual boards for approval and the addition of any organisation specific appendices.**

- **Noted that the delivery plan would be updated to reflect the outcomes and actions in the refreshed plan and committed to organisational responsibilities for delivery.**
- **Noted that a public facing green plan document would be designed to be published on ICB, NHSE and organisations' websites.**
- **Noted that the delivery plan would be updated to reflect the refreshed Green Plan.**
- **Approved the refreshed Green Plan.**

Sam Willitts left the meeting.

10/07/25 Maternity and Neonatal Care – National Review

Steve Hams, Bristol NHS Group Chief Nursing and Improvement Officer, presented the Maternity and Neonatal Care – National Review. Steve provided assurance that the five immediate actions outlined by NHS England (NHSE) were being implemented across maternity and neonatal services within the Bristol NHS Group. Steve also outlined the current progress, the areas for further development, and reaffirmed the Group's commitment to delivering safe, compassionate, and equitable maternity care.

Steve noted that both Trusts were rated 'Good' by the Care Quality Commission (CQC) and have successfully achieved all ten safety actions under the Maternity Incentive Scheme. Steve emphasised the opportunity to come together as a Group to share learning and strengthen collective practice.

Queries and comments from the Board were as follows:

- Kelly Macfarlane, NBT Non-Executive Director, commented that the paper was comprehensive and provided valuable insight into the culture of both organisations. Kelly highlighted the data-driven approach and patient engagement as examples of best practice. However, she raised concerns about estates infrastructure, noting that it presented a significant risk to capacity, workforce morale, and the overall fitness for purpose of maternity environments.
- Rosie Benneyworth stressed the importance of culture, acknowledging the substantial work underway across both Trusts. She emphasised the need to maintain a laser focus on cultural improvement and learning, particularly as services transition to a Group model. Rosie also referenced Melanie's feedback on listening to patients, reinforcing the importance of patient voice in shaping services. Steve reiterated that there were many good examples of practice across both organisations and that the Group model presented a valuable opportunity to share learning and strengthen collaboration.

Maria Kane rejoined the meeting.

- Sue Balcombe, UHBW Non-Executive Director, welcomed the opportunity for joint working and noted that the Quality and Outcomes Committee (QOC) conducted regular reviews and deep dives. She suggested that while listening and learning were embedded, there was scope to do more, particularly in addressing inequalities and improving access. She observed that some services had only been superficially reviewed in this regard.
- Glyn Howells, NBT Hospital Managing Director, raised concerns about the limited number of Freedom to Speak Up (FTSU) cases within Women and Children's Division. He noted that efforts had been redoubled to encourage staff to raise concerns through multiple channels and that there were now signs of improvement in staff voice being heard.

- Sarah Purdy highlighted the need to consider the impact of new housing developments and demographic changes on maternity service demand. She noted that increasing complexity in secondary care would require further provision and planning.
- Martin Sykes emphasised the importance of recognising site-specific differences and tailoring learning appropriately, given the distinct populations served by each Trust.

The Chair concluded the discussion and noted the following key themes:

- Estates remained a significant challenge and required continued attention.
- There was a strong foundation of good work to build upon.
- Demographic changes should be considered in future planning.
- While the current position provided assurance, there was more to do to improve responsiveness and quality.

Rosie Benneyworth added that assurance should be maintained at each stage of maternity service updates and advised that the Board should continue to monitor progress closely.

RESOLVED that the Boards discussed the initial response to the five immediate actions to improve maternity and neonatal care (as outlined in the letter from Sir Jim Mackey and Duncan Burton), whilst considering areas of continued development, improvement, oversight and any additional assurance required.

11/07/25 Joint Integrated Quality and Performance Report

The Boards considered the Joint Integrated Quality and Performance Report for May 2025.

Performance

Stuart Walker, UHBW Hospital Managing Director, and Glyn Howells presented the performance update for UHBW and NBT.

- Glyn reported that NBT's diagnostic performance was in line with national targets. Cancer metrics would appear worse before improving due to planned activity levels. Referral To Treatment (RTT) performance was only 1% behind plan. He outlined a five-point plan for Urgent and Emergency Care, reviewed by the QOC, with tactical actions already underway. Ambulance handover times averaged 44 minutes.
- Stuart confirmed that UHBW was in a good and improving position despite significant pressures. Key challenges included demand, acuity, and system delivery of No Criteria to Reside (NC2R). Four-hour ED performance stood at 77%, with 12-hour waits improving. Ambulance handovers had reduced to 32 minutes, and UHBW had adopted a zero-tolerance approach for delays exceeding 45 minutes.

Marc Griffiths raised concerns about NC2R trends and winter planning. Stuart noted NC2R remained high at 23% in June, particularly at Weston, against a system aspiration of 15%. Multiple workstreams were in place, but it was recognised that winter planning needed to ensure that the system responded effectively to pressure.

Marc Griffiths also highlighted the impact of housing growth on service demand. Stuart agreed that demographic changes would increase complexity, and noted that while improvements were possible before winter, full system assurance was not yet in place. Glyn added that a more active role in performance ownership was required from the ICB, with discussions underway to transition leadership of NC2R oversight. The Chair acknowledged the impact of system changes on

service users, noting that governors have raised concerns about NC2R and advised that a meeting with governors was planned to explore their suggestions.

Sue Balcombe found the side-by-side IQPR comparison enlightening, identifying opportunities for alignment and shared learning. Differences in ambulance handover times were noted as a potential area for process review. Richard Gaunt, NBT Non-Executive Director, emphasised the need for consistent KPIs and a winter plan that addressed core flow issues, not just contingency measures. Stuart confirmed this year's winter planning was focused on resolving underlying system challenges.

The Chair concluded that while the overall picture was improving, significant challenges remained. She thanked operational and clinical teams for their continued efforts.

People

Stuart Walker advised of the recently announced resident doctor industrial action and recognised the impact of this. Glyn Howells reported on the vacancy rates and sickness and absence rates for NBT.

Kelvin Blake queried differences in sickness management across NBT and UHBW. Glyn and Stuart confirmed that work was ongoing to align processes across the People function. Linda Kennedy, UHBW Non-Executive Director, noted that this would be explored through the People Committee.

Kelvin Blake left the meeting.

Quality, Safety and Effectiveness

Steve Hams reported on:

- The Perinatal Quality Surveillance Model (PQSM) data and the ongoing harmonisation efforts,
- The challenges re the neonatal nurse training and the neonatal deaths. It was noted that NBT reported zero neonatal deaths for two consecutive months, addressing prior concerns.
- The Infection, Prevention and Control (IPC) challenges, particularly with Clostridium Difficile (C.Diff), with improvement efforts focused on antimicrobial stewardship and collaboration with community partners.
- The ongoing work re patient experience improvements and to improve complaint response times.

Tim Whittlestone, Bristol NHS Group Chief Medical and Innovation Officer, shared stroke performance insights, noting capacity issues (due to rising demand and limited rehabilitation access) and the impact of NC2R. Tim spoke about the prevention efforts and the importance of community collaboration to improve discharge and rehabilitation pathways. Tim also advised on the VTE performance and noted that VTE risk assessment and electronic prescribing were key areas of focus.

Following a query from Rosie Benneyworth re stroke pathway confidence, Tim confirmed that there was confidence and advised of staffing improvements and early identification efforts. Sarah Purdy sought reassurance on stroke care transitions. Ingrid confirmed the next joint chair visit would be focused on stroke services.

Sue Balcombe raised concerns about fractured NOF surgery access. Tim explained the theatre utilisation improvements and elective centre impact.

Finance

Neil Kemsley, Bristol NHS Group Chief Finance and Estates Officer, provided a comprehensive update on the financial position as of Month 3 (June 2025), building on the Month 2 data presented in the report and highlighted:

- NBT remained on plan with a year-to-date deficit of £3.8m, supported by vacancy underspends. Cash was at £41m, ahead of plan, and elective activity was performing well.
- UHBW had recovered its earlier adverse variance and was now on plan with a £8.2m deficit. Cost Improvement Plans (CIP) delivery was on track at £10.6m, though supported by non-recurrent measures. Cash was on plan at £69m.
- NC2R pressures continued to drive escalation costs, impacting workforce budgets.
- Both Trusts were reducing bank and agency costs in line with plan.
- Capital investment included a £7.5m decarbonisation grant for NBT and £103m for UHBW, up from £48m, supported by national infrastructure funding.
- The Group had committed to £40m more savings than last year. While Q1 was on track, further actions were needed to meet full-year targets.

Stuart Walker left the meeting.

In response to a query from Roy Shubhabrata, Neil Kemsley confirmed that UHBW was currently forecasting £48 million in savings against a £53 million target, leaving a £5 million gap. This shortfall was backloaded and would be addressed in the recovery plan due to be presented to the Board in September.

RESOLVED that the Boards noted the Joint Integrated Quality and Performance Report for March 2025.

*Hilary Sawyer, Kate Hanlon and Onny Miller joined the meeting***.**

The Boards adjourned at this point for a brief comfort break.

Kelvin Blake and Stuart Walker re-joined the meeting.

12/07/25 **Freedom to Speak Up Annual Report 2024/25**

Xavier Bell, Group Chief of Staff, introduced the Freedom to Speak Up (FTSU) annual report, noting the ongoing work to align processes across the Group and the changes from the National Guardian's Office.

Kate Hanlon, UHBW Deputy Freedom to Speak Up Guardian, and Hilary Sawyer, NBT Lead Freedom to Speak Up Guardian, presented the report and highlighted the data, themes and activity at both organisations during 2024/2025, the triangulation information and the context for future requirements and arrangements for the FTSU service(s) across the Bristol NHS Group.

Kate reflected on recurring concerns raised by staff, including behaviours, safety, wellbeing, and leadership clarity. She emphasised the link between staff wellbeing and patient safety, and the need for compassionate leadership, recognition, and follow-up to ensure staff feel heard and valued.
Hilary reinforced the consistency of themes across both Trusts, with triangulation work identifying team-level issues and a slight increase in concerns related to patient safety and quality. She highlighted the importance of aligning FTSU insights with staff survey results and ensuring actions were visible and effective.

The Boards were invited to consider how it could further support FTSU guardians and networks, including:

- Normalising a culture of speaking up.
- Strengthening communication flows.

- Supporting managers to listen and respond effectively under pressure.

The Chair suggested further exploration of FTSU themes through dedicated development sessions and future board forums. Sue Balcombe and Arabel Bailey stressed the importance of reducing pressure on staff and investing in compassionate leadership.

Kelly Macfarlane challenged executives to ensure FTSU processes were effective, with a focus on closing cases and improving appraisal rates, particularly at NBT.

The Chair concluded by affirming board support for the FTSU agenda and proposed incorporating triangulation and people-focused themes into the forward workplan for assurance and oversight.

RESOLVED that the Boards noted the annual FTSU report and:

- **Discussed the commonalities of the data and themes and the triangulation,**
- **Discussed how the Boards would actively support all aspects of the work of the FTSU Guardians in supporting a healthy, learning Speak Up culture,**
- **Discussed how the Boards will role-model, encourage and support speaking up broadly, with proactive listening and clear learning, closing the loop, and communicate the value to further improve buy-in and reduce feelings of futility or fear.**
- **Noted the planned next steps for discussion later in 2025/26, including consideration of the most effective FTSU structure for the Group, refreshing the organisational self-reviews, and strategy planning during 2025/2026.**

*Hilary Sawyer, Kate Hanlon and Onny Miller left the meeting***.**

13/07/25 Committee Upward Reports

Digital Committee (in common) – May 2025 meeting

Roy Shubhabrata, Co-Chair of the Digital Committee, presented the committee's report, expressing enthusiasm for its establishment and the opportunity to shape its role. Roy outlined key areas of discussion and noted:

- That the Clinical Medicines Management (CMM) system would be subject to a 12-month review to ensure benefit realisation.
- Both Trusts were commended for their strong performance in Information Governance.
- The committee supported the development of an AI policy.

Rosie Benneyworth raised concerns about the pace of delivery in relation to the 10-year plan. Roy acknowledged the challenge of balancing ambition with funding and implementation capacity. Neil Darvill added that aligning ambition with delivery capability would be key to success. The Chair welcomed the committee's formation and noted its strategic importance.

RESOLVED that the Boards noted the Digital Committee (in common) held in May 2025.

NBT Quality and Outcomes Committee – May and June 2025 meeting

Sarah Purdy, Chair of the NBT Quality and Outcomes Committee, summarised the contents of the NBT reports to the Board.

RESOLVED that the Boards noted the NBT Quality and Outcomes Committee held in May and June 2025.

UHBW Quality and Outcomes Committee – May and June 2025 meeting
Sue Balcombe, Chair of the UHBW Quality and Outcomes Committee, summarised the contents of her report to the Board. Sue highlighted the proposal for the Clinical Genetics Service and the improvements in the translating and interpreting service for the Trust.

RESOLVED that the Boards noted the UHBW Quality and Outcomes Committee held in May and June 2025.

14/07/25 Register of Seals

Mark Pender, UHBW Head of Corporate Governance, presented the Register of Seals report for information. It was reported that there had been four sealings since the previous report.

RESOLVED that the Boards received and noted the Register of Seals for information.

15/07/25 Amendments to the UHBW Constitution and NBT Standing Orders

Xavier Bell presented the amendments to the UHBW Constitution and NBT Standing Orders report and outlined the proposed amendments.

RESOLVED that:

- **The UHBW Board endorsed the proposed amendments to the UHBW Constitution and recommended them to the Council of Governors for approval.**
- **The NBT Board approved the amendments to its Standing Orders.**

16/07/25 Any Other Business

No other business was raised.

17/07/25 Date of Next Meeting

The next Board in common meeting in public was scheduled to take place on Tuesday 9 September 2025, at 10am. The Board papers would be published on the websites and interested members of the public would be invited to submit questions in line with the Group's normal processes.

The meeting ended at 12.45pm.

Meeting of Group Board of Directors of NBT and UHBW held in Public on Tuesday, 09 September 2025

Action Log

Outstanding actions from the meeting held in April 2025 (NB none outstanding since)					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	*13/04/25*	Group Board Assurance Framework (BAF) separate risk should be added to the BAF in relation to the level of no criteria to reside and its impact on the Trusts' ability to deliver against the operating plans of both NBT and UHBW.	Joint Chief Corporate Governance Officer	November 2025	**Action Ongoing.** September 2026 update This will now come to the November 2025 meeting. July 2025 update The updated BAF is due to be reported to the Boards in September, and this change will be reflected at that time. May 2025 update The Group Board Assurance Framework (BAF) will be updated with the additional risk and will be presented to the Boards in Common at their July meeting.
2.	*14/04/25*	Board Workplan and Committee Terms of Reference Further reports on the Board Workplan and committee terms of reference, quorums, remits and memberships to be submitted to answer Board members' queries.	Joint Chief Corporate Governance Officer	September 2025	September 2025 update A report on the revised terms of reference and membership, which covers quorums and committee remits, is on the agenda for today's meeting. **Suggest action is closed.** July 2025 update This has been deferred to the September meeting of the Boards to allow time for further consultation on these documents. May 2025 update

					Work is ongoing and will be reported back to the to the Boards in Common at their July meeting.

Report To:	Meeting of the Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Group Chair's Report		
Report Author:	Bejide Kafele, EA to Group Chair of Bristol NHS Group		
Report Sponsor:	Ingrid Barker, Group Chair of Bristol NHS Group		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	The report sets out information on key items of interest to the Trust Board including activities undertaken by the Group Chair, and Vice Chairs.		
Key Points to Note *(Including any previous decisions taken)*			
The Group Chair reports to every public Board meeting with updates relevant to the period in question. This report covers the period 1 July to 8 September 2025.			
Strategic and Group Model Alignment			
The Group Chair's report identifies her 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.			
Risks and Opportunities			
Not applicable.			
Recommendation			
This report is for discussion and information. The board is asked to note the activities and key developments detailed by the Group Chair.			
History of the paper (details of where paper has <u>previously</u> been received)			
n/a			
Appendices:	n/a		

1. Purpose

1.1 The report sets out information on key items of interest to the Trust Board, including the Group Chairs attendance at events and visits as well as details of the Group Chairs 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 8 July 2025:

- Several meetings with the Council of Governors, including a joint meeting with Maria Kane, CEO, to discuss No Criteria to Reside, a Group strategy meeting, and attendance at the quarterly Council of Governors meeting
- Guest Speaker at a Senior Medical staff engagement session
- Shadowing with the Volunteers team at UHBW
- Participation on the interview panel for the Group People and Culture Director
- Interviews for Group NED appointments
- Led an Orientation session for the Group NED Team
- 1-2-1s with newly appointed Group executive directors
- Supporting the Walkerbot appeal at NBT
- Chairing the first meeting of the Group's Community Participation Group.

4. Connecting with our Partners

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

- Participation on the interview panel for Sirona's CEO
- Joint meeting with Maria Kane, Stephen Peacock, West of England Combined Authority (WECA) CEO, and the newly appointed WECA Mayor, Helen Godwin
- A meeting with Chrissie Thirwell, Clinical Professor and Head of Bristol Medical School at the University of Bristol
- Joint visit with Glyn Howells, Hospital managing Director, and Carla Denyer MP to the Community Diagnostics Centre
- Visit to St Peters Hospice with Susan Hamilton, CEO
- Hosted a visit to UHBW from Barbara Brown, the Chair of Sirona

4.2 National and Regional Engagement

- NHSE Management and Leadership Framework – Non-Executive Director (NED) and Chair Implementation.
- NHS Confed all member chairs group
- Attendance at the University Hospital Association Executive Steering Group

5. Vice-Chairs Report

5.1 The Vice-Chairs' activity report is slightly limited for this period due to the NED recruitment process which took place w.c. 30 June 2025.

5.2 Both Martin Sykes and Sarah Purdy were successful applicants and will assume their positions as Group Vice Chairs representing both Trusts from the 1 September 2025.

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

5.3 Vice Chair (UHBW)

- Participation on the interview panel for the Group People and Culture Director
- Attended the BNSSG Chairs reference group on behalf of the Group Chair
- Co-hosted a visit from Councillor Stephen Williams to the NBT Library
- Attended the Finance committee
- Attended the Governors strategy session

5.4 Vice Chair (NBT):

- Attended a meeting with the Consultant Surgeon and lead for Senior Doctor wellbeing
- Participation on the interview panel for the Group People and Culture Director
- Attended a meeting with the Deputy Vice Chancellor of the University of Bristol
- Attended a meeting with the Dean of the Faculty of Life Sciences, University of Bristol
- Attended the BNSSG ICB Primary Care Committee meeting
- Attended the Quality and Outcomes Committee meeting
- Attended a Corporate Trustee meeting

6. Summary and Recommendations

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

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
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 four 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 <u>previously</u> 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 Topics of Interest

1.1. Provider Capability Assessment – NHS Oversight Framework (NOF)

NHS England has launched a new Provider Capability Assessment process as part of the NHS Oversight Framework. This initiative complements existing NOF segmentation by providing a more holistic view of provider performance, focusing on governance, oversight, and Board capability. Organisations are required to complete a self-assessment, aligned with themes from The Insightful Board guidance, by 22 October 2025. Both Trusts are currently progressing their assessment, which will need Trust Board sign-off in October prior to submission.

These assessments will be reviewed by regional oversight teams, triangulated with delivery track records and third-party intelligence, and used to inform segmentation, eligibility for Foundation Trust status, and entry into the National Provider Improvement Programme. The process is intended to support continuous improvement and strengthen internal assurance.

2. Integrated Care System Update

BNSSG ICB continues to progress plans to cluster with Gloucestershire ICB, as part of a nationally driven programme to reduce running costs and streamline strategic commissioning. While no formal merger has yet occurred, the two ICBs are working closely through a transition group, with a view to potential merger by April 2026 or 2027. This development is part of wider NHS reforms aimed at improving efficiency and aligning ICB functions across larger footprints.

As part of this process, Dr Jeff Farrar has been formally announced as the Chair of the NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) and the NHS Gloucestershire ICB cluster. His appointment was confirmed by NHS England on 2 September 2025, following a competitive interview process.

Jeff is well known to both Boards, as he has been Chair of BNSSG ICB since 2021 and was also previously Chair of UHBW. I am sure the Boards will join me in congratulating Jeff on his appointment.

3. Operational Delivery

3.1. Industrial Action

I would like to acknowledge the recent period of industrial action by resident doctors and recognise the right of colleagues to take such action. Throughout this time, staff across the two Trusts demonstrated professionalism and resilience, ensuring patient safety remained paramount. Careful planning and collaborative working helped mitigate disruption to services, and the Trusts maintained continuity of care for patients. The collective effort across departments reflects our shared commitment to delivering high-quality care, even in difficult circumstances.

The BMA has recently announced a new ballot for industrial action. This ballot is specifically focused on the specialty training places crisis and pay restoration and is open to employed first-year foundation doctors (FY1s). The ballot opens on 8 September 2025 and closes at noon on 6 October 2025.

Following a consultative vote in July, in which a significant majority of Royal College of Nursing (RCN) members in England and Wales rejected the Government's 2025/26 pay award, the RCN has also confirmed its intention to proceed to a formal ballot for industrial action. This development reflects ongoing concerns around pay and career progression within the nursing workforce. The Trusts continue to monitor the situation closely and remains committed to supporting staff wellbeing and maintaining safe, high-quality care for patients throughout any future periods of disruption.

3.2. Q2 Tiering Update – Cancer

Following a regional and national review of elective, cancer, and diagnostic performance, NHS England has confirmed that NBT will be placed in Tier 2 for Cancer for Q2 2025/26. This decision reflects a deterioration in both the Faster Diagnosis Standard and the 62-day treatment standard, with performance falling behind the Trust's submitted operational plans. Tier 2 status will involve regular engagement with regional colleagues through Performance Tuesday governance meetings to monitor progress and identify any required support. Tiering status will continue to be reviewed quarterly, with potential for in-quarter adjustments in exceptional circumstances.

These performance challenges at NBT are driven largely within Urology and Breast (the highest volume cancer specialties) and improvement work is focused in those areas.

UHBW remains in Tier 1 for Quarter 2.

3.3. The Princess Royal Bristol Surgical Centre

I am delighted to be able to report that the Trust took partial possession of the new Surgical Centre on 21 August with in-patients moving across on the 22 and surgery being commenced on 26 in two of the four theatres. The remaining two theatres came into use on 1 September with the remaining externals transferring on 12 September. It is a testament to the cross Trust team efforts that we have been able to build and then bring this facility into clinical use 23 months after receiving business case approval from NHS England. This facility will support the delivery of an additional 6,500 procedures per annum and now form a key part of the Group's surgical capacity.

The endoscopy service at North Bristol NHS Trust had their five-year accreditation visit recently and have had their re-accredited confirmed. This means the Bristol NHS Group now have two accredited endoscopy units, one at Weston General Hospital and one at Southmead Hospital. I hope the Boards will join me in congratulating the teams involved.

3.4. NHS Veteran Aware Accreditation

I am proud to inform you that North Bristol NHS Trust has been successfully reaccredited as 'Veteran Aware' by the National Steering Group for the NHS Veteran Covenant Healthcare Alliance. Congratulations and well done to all the colleagues who have been involved in this process.

NHS Veteran Aware accreditation aims to ensure that patients from the Armed Forces community are not disadvantaged when accessing healthcare. Accredited trusts do this by developing, sharing and driving the implementation of best practice, at the same time aiming to raise standards for everyone accessing NHS trusts in England. Accreditation is overseen by the Veterans Covenant Healthcare Alliance (VCHA).

Accreditation supports NHS trusts, and an increasing number of independent healthcare providers and hospices, to pay due regard to the Armed Forces Covenant. The Covenant, part of the Armed Forces Act (2021), is a promise by the nation to ensure that those who serve, or who have served, in the Armed Forces, and their families, are not disadvantaged when accessing healthcare.

3.5. Recognition in RCOG 2025 TEF Awards

Southmead Hospital has been recognised by the Royal College of Obstetricians and Gynaecologists (RCOG) in the 2025 Trainee Evaluation Form (TEF) Awards, receiving the accolade of Overall Winner for Gynaecology in the large hospitals category, and Highly Commended for both Obstetrics and Overall performance. These awards are based on national trainee feedback across a range of indicators including educational supervision, clinical governance, wellbeing, and professional development.

This recognition reflects the outstanding commitment of our NBT Women's and Children's Division to delivering high-quality training and education. The RCOG has invited the Trust to share insights and best practices to support improvement across the wider system. Certificates from the College will be shared with teams and trainees, and the results were published on the RCOG website in August.

3.6. NBT Staff Travel and Parking – Engagement on Proposed Changes

From October 2025, the NBT is proposing the reintroduction of staff parking charges for eligible permit holders, set at 0.75% of salary. This forms part of a broader strategy to develop a fairer and more sustainable travel system across the organisation. Existing permits will remain valid unless cancelled by the holder. A comprehensive staff engagement programme is now underway, including workshops, surveys, and feedback sessions, to ensure that staff views inform future travel and parking policy. Revenue generated from permit charges will be reinvested into improving alternative travel options for staff commuting to Southmead.

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

4.1. Action against potential perpetrators for sexual misconduct in the NHS

On 20 August all NHS Chief Executives received a letter from the Chief Nursing Officer for England, Duncan Burton, the NHS England National Medical Director, Dr Claire Fuller, and the NHS England National Medical Director, Professor Meghana Pandit, asking them to take further actions to identify and act against potential perpetrators of sexual misconduct in the NHS.

I am pleased to say that I have been able to respond confirming that NBT and UHBW have both completed the required actions outlined in the national CEO and CPO communication on sexual misconduct, including self-assessment against the revised assurance framework, staff training, policy updates, and improvements to case management systems. This will continue to be a focus at both Trusts as part of the NHS commitment to safeguard our patients and our staff against sexual misconduct.

5. Engagement and Visits

5.1. South West Ambulance Service Visit

As part of the collaborative South West Chief Executives Group, I joined Dr Penny Dash, NHSE Chair, and fellow NHS Chief Executives for a visit to the South Western Ambulance Service base in Exeter. We explored and discussed a number of key strategic issues facing the NHS including the three strategic shifts set out in the 10-year Plan and the NHS in-year delivery priorities; the future of regulation and regulators; and the emerging position around capital and PFI. The visit also provided valuable insight into how the SWAST service triages, assesses, diverts, and conveys patients, highlighting the complexity and responsiveness of frontline operations. It was a timely opportunity to strengthen system-wide understanding and support for urgent and emergency care pathways.

5.2. WECA

In July the Group Chair and I met with newly appointed West of England Combined Authority (WECA) Mayor, Helen Godwin, and the WECA Chief Executive Stephen Peacock. This was an opportunity to discuss neighbourhood and population health and how we might work together for the benefit of our shared populations.

5.3. Secretary of State for Science, Innovation and Technology

In July I was delighted to welcome the Rt Hon Peter Kyle MP, Secretary of State for Science, Innovation and Technology, to Southmead Hospital to see our surgical robots in action. The Secretary of State saw how we're using technology to transform patient care and innovate services across the Trust, including through using AI to improve our radiology services and using surgical robots across a range of specialties. He also met a patient who had recently undergone robotic surgery at Southmead, and Trust leadership team and consultants who are championing the use of robotics and AI across our hospitals.

5.4. Mental Health in the Acute Sector

I was proud to recently host an event on mental health in acute settings with clinical and operational colleagues from both Trusts and system partners. This important collaboration with colleagues from across our healthcare system and in the community is vital for a necessary shift from isolated improvements to a systemic transformation in how we manage mental and physical health together, particularly as our Psychiatric Liaison service develops into a Group Clinical Service in line with our Joint Clinical Strategy. We welcomed Claire Murdoch, NHS England's National Mental Health Director, to help us align with NHS England mental health priorities, and Huda Hajinur from Caafi Health to ensure the voice of our community was part of the conversation.

5.5. Service Visits

I have visited a number of areas, and met with senior clinical staff across the Trusts including:

- Visiting the Bristol Heart Institute where I heard about the great work around our new Group Cardiac Services
- Visiting the UHBW Cochlear Implant Team
- One-to-one meetings with Consultants from ENT and Children's ED Specialities

Recommendation

The Boards are asked to note the report.

Maria Kane
Group Chief Executive

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Group Benefits Realisation Report (including Joint Clinical Strategy update)		
Report Author:	Valerie Clarke, Programme Director, Clinical Services Transformation		
Report Sponsor:	Paula Clarke, Group Formation Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The purpose of the paper is to provide an update to the Board on the proposed approach to benefits realisation as part of the Group Delivery Programme and a progress update on the Joint Clinical Strategy implementation.		

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

- Formal confirmation in June 2025 of the Group Executive roles has enabled all eight workstreams that form the Group Delivery Programme to be established with confirmed Executive SROs, and delivery is overseen by a Group PMO which is led by the Group Formation Officer.
- Each workstream is developing their Benefits Realisation Plan, framed around the five benefits strands set out in the Group Benefits Case approved by the Boards-in-common on 8th April 2025. This reflects our commitments to our patients, our people, our population and the public purse.
- These plans are in development, with some variation in the degree of maturity across all eight workstreams in confirming key metrics, establishing baseline positions, agreeing ambitions and setting trajectories for delivery. Some examples of progress to date across the eight workstreams are included in this report (Appendix 1).
- It is proposed that once confirmed, specific key metrics are reviewed by the most relevant Board Committees based on the approach already adopted to the IQPR.
- Tracking of financial costs and benefits delivery is underway with the projected 2025/26 delivery position included in this report.
- For the next quarterly Board report in January 2026, we plan to present a fully populated Benefits Realisation report (financial and non-financial benefits).
- A Joint Clinical Strategy refresh is underway with three key areas of focus: accelerating Group Clinical Services, undertaking a clinical capacity and productivity diagnostic and exploring what and how we “left shift” out of hospital-based care into communities. A refresh event is scheduled for 4th November which will include system partners.
- A separate evaluation of the Group Cardiac Service by Health Innovation Network, West of England (HiN, WoE) commenced on 1st September 2025 with baselining work underway.
- The Community Participation Group is established and held its initial engagement meeting on 4th September, hosted by the Group Chair and Chief Nursing and Improvement Officer.
- Further work is required to consider the most effective way to monitor stakeholder satisfaction across the whole Group in terms of reputational impact.

Strategic and Group Model Alignment
• The Group Benefits Delivery Plan supports the delivery of the Group Benefits Case and the development of the Group Model.
Risks and Opportunities
• There is a risk to timescales for implementation of the Group Delivery Programme due to competing pressures with operational performance and planning for merger. • 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 and having single leadership teams in place to drive delivery. • There is an opportunity to build on the Group Benefits Delivery Plan to inform the merger case.
Recommendation
Group Board is asked to: **Note:** • the approach to developing financial and non-financial benefits realisation across all eight Group Delivery workstreams, including Board Joint Committees scrutiny. • progress to date and timescales to the first fully populated Benefits Realisation Plan. • progress on Joint Clinical Strategy implementation and next steps.

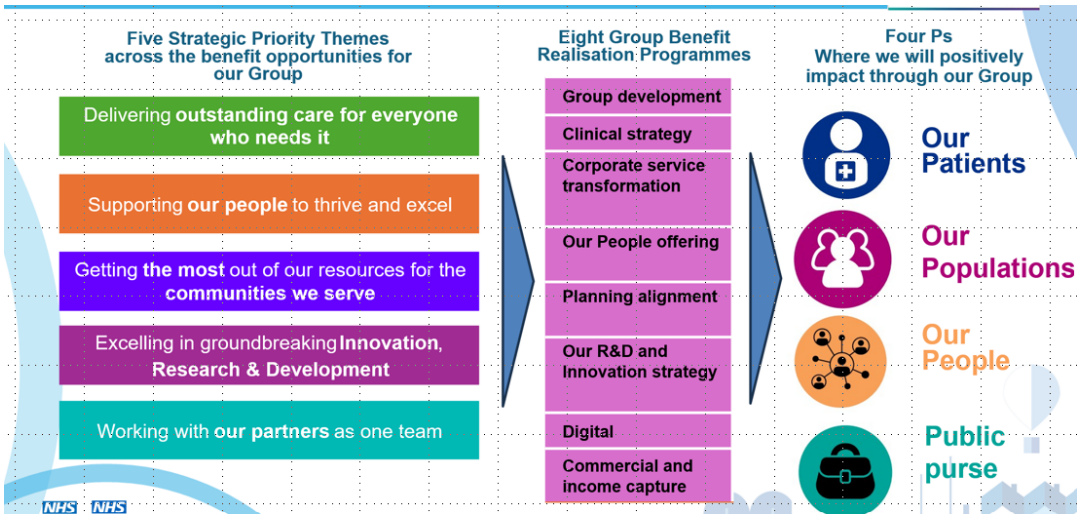
1. Purpose

1.1 The purpose of the paper is to provide an update to the Board on the proposed approach to benefits realisation as part of the Group Delivery Programme and a progress update on the Joint Clinical Strategy implementation.

2. Background

2.1 The Group Benefits Case, approved by the Boards-in-Common on 8th April 2025, captures the benefits across five benefits strands, realised through eight workstreams that are focussed on delivery against four key outcomes – the four P's - as illustrated in Figure 1 below.

Figure 1



2.2 Formal confirmation in June 2025 of the Group Executive roles has enabled the eight workstreams that form the Group Delivery Programme to be established with confirmed Executive SROs, and delivery is overseen by the Group PMO which is led by the Group Formation Officer.

3. Planned approach

3.1 Each workstream is developing their Benefits Realisation Plan framed around the five benefits strands with variation in the degree of maturity. The relevant Executive SRO is responsible for the development and delivery of their plan, which is overseen by the Group PMO. All workstreams have identified non-financial quantitative and qualitative benefits as well as financial and productivity benefits against the five benefit strands. Current focus is on confirming the key metrics, baselines, ambitions, trajectories and target dates for delivery. Further work is required to consider the most effective way to monitor stakeholder satisfaction across the whole Group in terms of reputational impact. This will be progressed with the Group Chief Communications Officer.

3.2 Appendix 1 summarises progress to date across the workstreams. Each workstream is currently at a different level of development, with some framed around organisational impact from the outset. Others, such as Clinical Services, have a more granular focus at

pathway/service level that over time will build to an organisational level impact as more Group Clinical Services are established with single leadership teams in place to drive delivery. The intention is to take a fully populated Benefits Realisation Report to the Board in January 2026, and quarterly thereafter. As this develops, the aim is to bring a more aggregated dashboard for benefits delivery to the Board.

3.3 While each workstream has its own programme governance to sign off and monitor benefits delivery, it is proposed that further assurance is given to the Board with key benefits being reviewed at Board Committee level as happens with the IQPR. The workstreams will report as summarised in Table 1 below.

Table 1

Board Committee	Workstream Overview
Board	1. Group Development
Quality and Outcomes	2. Clinical Services 3. R&D and Innovation Strategy
People	4. Corporate Services Transformation 5. Our People Offering
Digital	6. Digital
Finance and Estates	7. Planning Alignment 8. Commercial and Income capture

3.4 In addition, there will be robust central monitoring of all the financial benefits identified across all workstreams as described below.

4. Financial Benefits

4.1 Introduction

The development of Bristol NHS Group is a key component of achieving a financially balanced and sustainable position for acute services across BNSSG over the next 5 years and beyond. Achieving this is a key priority for both the Trusts and the broader system, and the Group is an essential part of accomplishing this; - reducing our combined cost base over time, as well as maximising alternative income streams.

The detailed Group Benefits Case approved by the Boards-in-common on 8th April 2025, identified a ROI over the 5 years from 2024/25 to 2028/29 as 200-220%, indicating a recurrent additional net return beyond annual expected CIP delivery by each Trust, of approx. £33m. This recognised that it would not be possible to achieve many of the financial benefits without initial investment – in particular, in digital infrastructure and programme resource to support realisation. Investment into transitional resources over the 5 years from 2024/25 was expected to be front-loaded with the scale of recurrent benefits significantly increasing from 2026/27 onwards.

A process has been established by the Chief Finance and Estates Officer to track the transitional costs and financial benefits against the Group Benefits Case. This section of the September 2025 Benefits Realisation report provides a summary position statement

for the costs and benefits incurred to date and forecast to 31st March 2026. It is proposed that the joint Finance and Estate Committee will review the detailed report available on a quarterly basis.

4.2 2025/26 Planned and Revised Expenditure and Benefits

4.2.1 Planned Benefits

The expected net cost of investment in transitional resources against the benefits to be delivered in 2025/26 in the Group Benefits case was £0.7m. This was based on projected transitional investment requirements (TiR) of £7.8m and a total of £7.1m benefit realisation and non-recurrent income. It is important to note that the TiR included over £2.0m of contingency and £1m associated with a potential General Practice IT proof of concept and pilot project which has subsequently been deferred.

4.2.2 Revised Benefits

Given the scale of the challenge within the overall financial and operational plans of the two organisations for 2025/26, a revised assessment was made to seek to ensure that the transitional investments committed in 2025/26 can be matched by the associated financial benefits and therefore ensure that the group formation work does not add an additional pressure to the Group's bottom-line.

The challenge has been compounded by the scale of CIP committed to in the overall 2025/26 financial plan and the need to ensure that there is zero double count between the benefits attributed to the Group and those already set out in departmental plans.

In this context it is important to recall that the Group Benefit Case was developed on the basis that the expenditure reductions and income generation opportunities afforded by group activity, would be over and above a trust level efficiency requirement of 1% recurring and 0.5% non-recurring, equivalent to 1.5% in total. Given the higher national efficiency requirement for 2025/26 and the need to reduce the Trusts' underlying deficits, the actual CIP target included in plans was c.5%.

A robust process has therefore been established, including a Group Vacancy Control Panel, to ensure that as transitional investment requirements are released, we stay in line with the forecast of in-year financial benefits. Whilst this financial discipline is important, we will continue to review cases for investment and ensure that the necessary controls do not thwart the preparation required to deliver the Group benefits in full in 2026/27.

Given the context described above, the planned expenditure as detailed in the Group Benefit Case has been scaled back, giving a revised commitment to remain in line with the latest estimate of cost savings and income generation opportunities, as set out in Table 2. The focus during 2025/26 remains on reprioritising capacity alongside transitional investment to secure the recurrent delivery of net benefits from 2026/27.

Table 2 2025/26 Revised Planned Benefits

Planned 2025/26 Benefits / Cost Savings Opportunities	£'000

Recurrent funding commitment from the two Trusts	700
Procurement Savings Across Organisations	800
Corporate Services Transformation Savings	300
Variable Income	1,500
Private Patient Income	300
Total benefits / cost savings	**3,600**

In support of the summary of the financial benefits set out in Table 1, the following points should be noted.

1. The £700k has been allocated from reserves, so this is not a financial benefit per se, but is a secure resource to fund the core team.

2. Procurement savings are in addition to the £4.0m in each Trust (i.e. £8.0m across the Group) target included as part of the Trusts' core CIP for 2025/26. Although the pipeline for procurement savings exceeds the total requirement of £9.8m, the risks of achieving that level of savings fully in year has been considered with a prudent scale back of the Group element to £800k.

   To support the delivery of non-pay savings across both sites in 2025/26, a Group Non-Pay Board has been established to oversee Trust-wide procurement efforts including Trust CIP and additional Group benefit savings. This includes:

   - Trust-Level CIP Delivery: Targeted procurement activity is being deployed at specialty level, informed by a comprehensive review of spend across both sites. This approach enables focused interventions where the greatest savings potential exists, with plans in place to deliver the £8.0 million Trust savings requirement.
   - Group-Level Savings Delivery: A Group Spend Management Project is underway to assess all purchasing routes across the Trusts. The project aims to introduce clearer guidance and tighter controls over purchasing decisions, including supplier selection and product standardisation.

   Strategic benefits expected from this work include:
   - Reduction of unwarranted variation in purchasing
   - Full visibility of spend to inform value-driven strategies
   - Improved efficiency in managing the supplier base
   - Standardisation through Spend Groups and product rationalisation
   - Increased education for budget holders on procurement best practice

   These coordinated procurement activities are central to achieving group-wide savings and embedding a more strategic, value-focused approach to non-pay expenditure.

3. The corporate savings target of £300k relates to the net impact of creating the joint board and implementing the site leadership teams. Our current assessment is that the net benefit on a recurring basis will exceed £1.0m. The current year impact is lower due to timing and other non-recurring issues.

4. The rest of the benefits are all income related. For R&D and private patient income there is a similar challenge to procurement, regarding the plans already baked into departmental CIP. Another challenge relates to the 'additional income assumptions' both trusts included in their respective financial plans for this year. That said, at £900k per organisation, this additional requirement should not be insurmountable.

   As assurance for Group benefits realisation, well-established **Income Capture processes** are in place across both Trusts. Joint meetings between UHBW and NBT teams are scheduled to commence in September, providing a forum to share best practice and mutual learning. Further work is planned to compare coding data across both sites, with the aim of identifying opportunities for improvement through alignment of coding practices and reduction of variation.

   The **Private & Overseas Patients** workstream is now formally recognised under the Group Commercial Opportunities Board and efforts are underway to enhance private patient revenue at one Trust, pending resolution of competition law considerations. A market analysis is currently being conducted across both Trusts to inform strategic focus and identify areas of opportunity, and a business case will be developed in the Autumn. A new Overseas Patients policy has been implemented at NBT, while UHBW continues to operate established processes and revenue streams. Options for alignment across the Group will be explored in September.
   Several other **Commercial Income** workstreams have been identified and are in development, reporting into the Group Commercial Opportunities Board. These include Group International Programme, Marketing, Data Sharing, Training and Development.

The delivery of the benefits set out above is being driven by a Task and Finish Group, chaired by the Group Chief Finance and Estates Officer, meeting on a fortnightly basis. In addition, financial benefits identified in the other workstreams will be monitored centrally.

4.3 <u>Looking Forward to 2026/27</u>

Whilst it has been necessary to manage the net revenue impact in 2025/26, we remain committed to achieving the full level of benefits set out in the Group Benefits Case, as we move into 2026/27. Furthermore, in our initial assessment of the additional benefits of merger (over and above the benefits of group); we are expecting to achieve a further net benefit of £10.0m.

As set out in the Group Benefits Case, in 2026/27, we are planning to achieve a net benefit of £8.3m.

Furthermore, in contradiction to the approach (driven by the timing in 2025/26), it is important to recognise that these Group savings can be applied as the first elements of the overall financial improvement programme we need to implement next year.

5. Joint Clinical Strategy Update

5.1 The Joint Clinical Strategy Refresh is underway with three areas of focus:

- acceleration of Group Clinical Services
- a clinical capacity & productivity diagnostic
- exploring what and how we "left-shift" out of hospital-based care into communities

5.2 Accelerating the Group Clinical Services means all 44 duplicated clinical services will have made significant progress against the following three milestones by Q4 2026-27.

- Milestone 1: Leadership forum in place with agreed benefits realisation plan
- Milestone 2: Single leadership team appointed
- Milestone 3: Group Clinical Service Maturity Assessment completed

5.3 Each Trust/Hospital unit will lead on approx.. 50% of the Group Clinical Services implementation. The next services to go live with single leadership teams are Liaison Psychiatry, Safeguarding, Trauma & Orthopaedics, Haematology and Pain Services.

5.4 The Group Cardiac Service's single leadership team has been in post since June and has set some clear ambitions and benefits including:

- One PCI clinical service & One RACPC service
    - One elective waiting list
    - Address waiting list variation across sites (9 months vs 6 weeks)
    - Flexible, agile working of staff across both sites
    - Standardised non elective urgent care pathway to lab – to achieve % urgent patients' procedures within 72hrs
- Improve cath lab & pacing room utilisation- 6/4/2 scheduling, CCW system at NBT, Pacing room capital scheme
- Increase use of TAVI & EP Non elective to elective pathway
- One Bristol Cardiac Annual Plan 2026/27
- Medical workforce plan across both sites

5.5 Capturing lessons learned is integral to our Continuous Improvement approach. Some of the learning our cardiac services team have shared into the next phase of Group Clinical Services includes:

- Establishing clear accountabilities and expectations early
- Focussing on the benefits for the patients of today and the future throughout the change processes
- Communicate early and often – even when nothing new to say
- Identify change champions/ambassadors
- Corporate services are essential to enable single service management and planning to work well (and merger will make this even easier)

5.6 A clinical capacity and productivity diagnostic scoping exercise is underway. The goal is to:

- establish our baseline - understanding our combined Group capacity and complete a detailed diagnostic of our current clinical productivity.
- gap analysis against the 10-year plan – assess if we achieve all the ambitions set out in the plan, what our system could look like in 10 years' time. This will provide a compelling narrative to deliver Phases 1 and 2 of the Joint Clinical Strategy and inform how we approach Phase 3 and wider Group Clinical Strategy development.

5.7 We are planning an Autumn JCS refresh event (confirmed as 4th November) which will include system partners**.**

5.8 In addition to the internal Benefits Realisation Plans, the Boards-in-Common commissioned independent evaluation of our Joint Clinical Strategy pathfinder work; Group Cardiac Service, from the HiN WoE that commenced on 1st September. This evaluation has been deliberately designed to be focussed on a single specialty, so that data can be examined and conclusions drawn at a granular level, with the intention that the same methodology could be used in other GCSs. The work will specifically target the impact for patients and our people (two of our four P's) in cardiac services, thereby identifying how the hospital group operating model enables any impact to be made. Recognising the shortcomings with other organisations' broader-scale attempts to evaluate the impact of Group working, this focussed approach was agreed at the Group Board in January 2025 who also supported the wider assessment of benefits through the PMO as set out in this report.

5.9 **Community Participation Group (CPG)**

The Community Participation Group is established and held its initial engagement meeting on 4th September, hosted by the Chair and Chief Nursing and Improvement Officer. The extensive promotion of the work with media campaign and drop-in sessions attracted 77 applications from individuals and VCSE organisations. Feedback from communities has been overwhelmingly positive, highlighting the CPG as a unique and meaningful opportunity to shape the future of the Bristol NHS Group through a deliberative democratic process.

6. Recommendations

Group Board is asked to:

Note:

- the approach to developing financial and non-financial benefits realisation across all eight Group Delivery workstreams, including Board Joint Committees scrutiny.
- progress to date and timescale to the first fully populated Benefits Realisation Plan.
- progress on Joint Clinical Strategy implementation and next steps.

Appendix 1: Examples of Group Benefit Measures

1. Clinical Services: Group Cardiac Services

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Delivering outstanding care to everyone who needs it	Improved and more equitable waiting times	**Rapid Access Chest Pain Clinic** - Increase the % of patients seen within 2 weeks	100% of patients seen within 2 weeks	tbc	BHI 71.0% NBT 36.1% Weston 2.9% Combined 49.3%
		Elective PCI - Increase the % of patients treated within 3 months	100% of patients treated within 3 months	tbc	BHI 89.0% NBT 32.3% Combined 73.5%
		Echocardiography - Decrease in % over 6 weeks	0% of patients waiting over 6 weeks	tbc	BHI 12.4% NBT 0.9% Combined 9.4%
		Devices - Increase the % patients treated within X months	tbc - cross site discussions underway to design model	tbc	BHI NBT Combined
	Improved and more equitable outcomes	**Cardiac Rehab** - Increase in the % of patients offered and taking up the offer for rehab	85% of eligible patients take up the offer of rehab	tbc	UHBW NBT Combined
	Improved and more equitable patient experience	**Cardiac Rehab** - Increase in the number of face2face locations offered to patients	100% of patients offered at least 3 locations	tbc	UHBW 100% NBT 0% Combined
		Use of Patch technology - Increase in the % patients accessing monitoring within 3 weeks	100% of eligible patients have access to patch technology within 3 weeks	tbc	UHBW 0% NBT 100%
	Evidence of continuous engagement of communities and patient	Count of activities undertaken	Embed engagement activities from the outset - success measures to be define	tbc	1 x survey (477 respondents) 3 x workshops 3 x pathway focus groups 12 x 1:1 interviews 2 x patient stories at Board
Supporting our people to excel and thrive	Workforce resilience	**Joint Appointments** - Increase in the no. of joint appointments made	tbc	tbc	2
		Cross-site working - Increase in the no. of staff working across multiple sites/providing shared services	tbc	tbc	4
	Positive sentiment toward 'Group' activities	Count of activities undertaken e.g all staff briefings, staff questionnaires, team building sessions etc.	Embed engagement activities from the outset - success measures to be define	tbc	3 x all staff briefings 2 x team building sessions 3 x informal meet and greets 5 x clinicla model development sessions
Getting the most out of our resources for the communities we serve	More financially sustainable	**NBT Cardiac Physiology Team** - eliminate reliance on agency workforce by employing substantive staff	0wte/£0 spend on agency	tbc	NBT: £719k spend on agency in 24/25
	Increased productivity	**NBT Pacing Room** - Increased % utilisation	80-90% utilisation rate	tbc	NBT: 15% sessions filled
		Total patients treated - overall increase in the total number of patients treated	Count of total - tbc	tbc	tbc
	Flexible use of clinical capacity	Evidence of activity re-purposed between Trusts to deliver the performance metrics above - (tbc -likely to be simple pacing)	tbc	tbc	tbc
	Evidence of more remote monitoring/virtual work	Increase in the number of patients receiving remote monitoring/virtual care - tbc	tbc	tbc	tbc
Excelling in groundbreaking innovation & R&D	tbc	tbc	tbc	tbc	tbc
Working with our partners as one team	Evidence of more activity happening in a community settting	Increase in the amount of activity happening in a community setting ? Heart failure - tbc	tbc	tbc	tbc

For the Clinical Services workstream, metrics will be developed to demonstrate benefits realisation at pathway/servcie level which will aggregate to an organisational impact over time, as more Group Clinical Services go live with Single Leadership Teams in place to drive delivery,

2. Corporate Services

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Getting the most out of our resources for the communities we serve	Economies of scale in corporate services	Number / proportion of corporate WTEs working in 'Group' function/ team Performance in NHSE corporate benchmarking Cost and WTEs in corporate functions	12% savings/productivity target	FY2027/28	In progress
Supporting our People to excel and thrive	Increased satisfaction for corporate services teams	Localised pulse surveys for staff working in corporate functions (to be defined)	Increase in satisfaction for staff working in corporate services - target TBC	Mar-27	TBC

3. Our People Programme

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Supporting our people to excel and thrive	**OD & Colleague Experience** 1. Improved staff satisfaction and experience	Maintenance of the five People Promise themes in 2025/26 and 2026/27: Staff Engagement, Morale, Safe and Healthy, We are always learning, We are compassionate and inclusive. Localised pulse surveys at the start and hand off of each Group Clinical Service (to be defined)	To be in the top decile of the five People Promise themes in 2027/28 (results to be published in 2028)	Jul-26	tbc
	Learning & Workforce Development (Group Function) 1. Improved culture of continuous learning	Safe Learning Environment Charter (SLEC) positive feedback	5% within first year and subsequent annual improvement at 5%, until 80% reached	Jul-26	scoping underway
	2. Increased training completion levels	Mandatory and leadership training compliance rates	Pending national review of leadership and management framework	Dec-26	scoping underway
	3. Increased cross-Trust recognition of training	Proportion of training courses 'passported' between trusts	Passporting of 11 core skills and Oliver McGowan across the Group Model	Feb-26	scoping underway
	Recruitment function expansion 1. Improved hiring manager experience and support	Hiring manager satisfaction survey scores	90% HM satisfaction	Mar-26	tbc
	2. Reduction in vacancy position over key hotspots	Monthly vacancy position	Medical and Dental – less than 2.0% Nursing and Midwifery Registered – less than 6.0% Nursing and Midwifery Unregistered – less than 5.0% (all) and 13% (Band 2 &3)	Mar-26	tbc
	3. Improved medical workforce experience	GMC survey red outlier scores for LED and resident doctors	Reduce by 60%	TBC - review as valid measure	
Getting the most out of our resources for the communities we serve	**Learning & Workforce Development (Group Function)** 1. Reduced Operating Costs	Pay budget reduction	4% savings to be realised in 25/26	Jul-26	CIP Plan
	Recruitment function expansion 1. Reduction in staff costs, blended teams, development of one culture	Successful completion of staff consultation	5.60%	Oct-25	Operating costs of £2.37m
Working with our partners as one team	**People Services Offering to partners** 1. Resource release from automation of high volume/effort processes	Reduced operating costs Improved error rate	90% accuracy rate/30wte	Jan-27	4 x B3WTE
	2. Streamlined temporary services processes to be operationally ready for migrationof new partners	Resource cost released TBC (£)	Operating costs TBC. To support robust revenue generating modles via 3rd parties	Jan-27	££TBC

4. Finance – Estates Planning alignment

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Getting the most out of our resources for the communities we serve	**Group Estates Strategy** 1. To make better use of our combined estate and assets	Measure of space utilisation	TBC	TBC	TBC
	2. To reduce critical infrastructure risk	Number of infrastructure related risks, assessed as High risk	TBC	TBC	TBC
	3. Cost savings through rationalisation of the estate	Savings delivered through exiting of commercial real estate	TBC	TBC	TBC
	4. Reduced environmental impact	Carbon emissions	TBC	TBC	TBC

5. Finance- Commercial & Income Capture

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Getting the most out of our resources for the communities we serve	**Income capture & clinical activity coding** 1. To ensure we are paid fairly for the activity we deliver	Coding accuracy rate from periodic audits	2025/26 £1.5m future years tbc	tbc	tbc
	Private and Overseas patients 1. To increase income from private and overseas patients	Income from private and overseas patients	2025/26 £300k future years tbc	tbc	tbc
	Procurement Savings 1. To realise non-pay savings	to be finalised Reduction of unwarranted variation in purchasing Full visibility of spend to inform value-driven strategies Improved efficiency in managing the supplier base Standardisation through Spend Groups and product rationalisation Increased education for budget holders on procurement best practice	2025/26 £800k future years tbc	tbc	tbc

6. R&D and Innovation

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Excelling in groundbreaking innovation & R&D	**Group R&D Strategy** 1. Increase in income from commercial trials 2. Growth (tbc) 3. Savings delivery 4. NIHR Board level metrics	R&D income	tbc	tbc	tbc
	Creation of Innovation Hub and Strategy 1. Innovation embedded in clinical practice 2. Funding secured for innovation	Number of innovation projects successfully transitioning from pilot to BAU Value of external funding secured for innovation	tbc	tbc	tbc
	International Health Opportunity 1. Increase in income from international health	Value of income from international health	tbc	tbc	tbc

7. Digital

Benefit Strands	Benefit	Performance measure	Ambition	Target achievement date	Baseline March 2025
Delivering outstanding care to everyone who needs it	1. Increased **clinical** system interoperability and / or harmonisation	Proportion of clinical systems which are interoperable or joint	To unify digital systems across clinical and corporate domains To enable seamless data flow and system interoperability across the Group To provide all colleagues with a single, intuitive BI interface To support cross-specialty collaboration through shared data insights	80%+ of clinical systems interoperable or harmonised across the Group 75%+ of corporate systems interoperable or harmonised All service managers (SMs) have access to a single BI interface across Trusts Delivery of at least 5 cross-specialty BI solutions using large data sets	Clinical and corporate systems are fragmented across sites and teams Limited interoperability between systems, leading to duplication and inefficiencies Business Intelligence (BI) tools are siloed, with inconsistent access and visibility across Trusts Data sharing between specialties and services is constrained
	2. Increased **corporate** system interoperability and / or harmonisation	Proportion of corporate systems which are interoperable or joint			
	3. Increased data access and visibility for clinical services across sites	Number/proportion of Group Clinical Services with a single Business Intelligence interface across Trusts Number of 'large data set' cross-speciality Business Intelligence solutions developed			
Supporting our people to excel and thrive	1. Increased digital maturity	HIMSS EMRAM / INFRAM framework	To become a digitally mature, data-driven organisation To ensure seamless integration and interoperability across systems To empower staff with the digital skills and confidence needed to innovate and improve care To align digital transformation with strategic priorities across both organisations	Achieve HIMSS EMRAM Stage 6 or higher across both organisations 90%+ completion rate for digital capability training across workforce groups Demonstrable improvements in clinical efficiency and patient outcomes through digital interventions Realise measurable return on digital investment within 3 years	Digital maturity varies across departments and sites Fragmented use of digital tools and systems Limited integration between existing platforms Workforce digital confidence and capability is inconsistent
	2. Improved workforce digital capabilities	Completion rate of digital-related training courses			
Working with our partners as one team	**Digital Service offering to partners** 1. Increased income from Digital services	Value of (net) income from Digital services	To establish a high-quality, scalable digital service portfolio for system partners To position the Group as a trusted provider of digital solutions across the region To ensure services are commercially viable, customer-focused, and aligned with partner needs To build a reputation for excellence in digital service delivery	Achieve £1.8m per annum in net income from digital services Implement robust customer satisfaction measures across all digital offerings Deliver consistent service quality across commercial digital products Expand partner engagement and service uptake year-on-year	Digital services for system partners are currently ad hoc and vary in quality and scope Limited commercial structure or pricing strategy for digital offerings Customer satisfaction and service quality metrics are not consistently tracked Income from digital services is modest and not fully optimised
	2. Commercial Digital service quality	Customer satisfaction measures			

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	09/09/2025		
Report Title:	Winter Plan Board Assurance 2025/26		
Report Author:	David Markwick, Director of Performance Emilie Perry, Trust Chief Operating Officer	Lisa Whitlow, Director of Performance Nicholas Smith, Trust Chief Operating Officer	
Report Sponsor:	Stuart Walker, Hospital Managing Director	Glyn Howells, Hospital Managing Director	
Purpose of the report:	**Approval**	**Discussion**	**Information**
	✓		
	To seek Board approval for the Assurance Checklist for the 2025/26 Winter Plan.		

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

- The Trust Winter Plan serves to provide strategic oversight of the delivery of care during the winter period.
- NHS England published the Urgent & Emergency Care Plan for 2025/26 in June 2025. This document has been reviewed to ensure that the required actions and focus areas are contained within the Winter Plan.
- In addition, the Winter Planning Board Assurance Statement was published in July 2025. This includes a winter plan checklist to provide Board with assurance that the Trust plans fulfil the requirements.
- Regional testing of plans will be undertaken on the 10 September 2025.
- The full winter plan will be received by Quality and Outcomes Committee in Common on 30 September 2025. This will include both Trust plans and append the ICS plan for completeness.
- Residual risks to delivery of full operational plans relate to ongoing high levels of No Criteria to Reside patients and any fluctuations in Infection rates. Predicted Influenza surge levels have not yet been shared nationally - plans will be tested and augmented further once confirmed.

Strategic and Group Model Alignment

Trusts and the ICB have worked together to develop robust Winter Plans for 2025/26.

Risks and Opportunities

Risks and mitigations are listed in the full winter plans with assurance via the Quality and Outcomes Committee in Common.

Recommendation

This report is for **Approval** and submission to NHS England by 30 September 2025

History of the paper (details of where paper has <u>previously</u> been received)

N/A	
Appendices:	NBT Board Assurance Statement UHBW Board Assurance Statement

Winter Plan Board Assurance 2025/26

NHS Bristol NHS Group
Bristol | Weston

September 2025

A partnership between: North Bristol NHS Trust, and University Hospitals Bristol and Weston NHS Foundation Trust

Overview

- NHSE require that Boards complete a Board Assurance Statement (BAS) to demonstrate that they have oversight of the Winter Plan for 2025/26 and that all key considerations have been met.
- The BAS must be signed off by the CEO and Chair.
- Submissions must be made to the national UEC team by 30 September 2025.
- Quality and Outcomes Committee will receive both Trust's full winter plans plus the ICS plan on 30 September 2025.

Urgent & Emergency Care Plan Preparing for Winter 2025/26

Areas of focus released by NHS England June 2025 detailed in the

1. System-Wide Winter Preparedness

- **Whole-system collaboration to improve urgent and emergency care** performance.
- Emphasis on **leadership accountability** and **integrated planning**.
- Utilise **national & regional tools and Support offers**

2.Reducing Demand and Improving Access

- Prevention through **vaccination** and **community-based care**.
- Expansion **of urgent care services outside hospitals.**
- **Performance improvement** in 4 hour waits and 12 hour waits in ED and in Category 2 ambulance response times

3.Improving Hospital Flow and Reducing Delays

- **Faster ambulance handovers and reduced corridor care.**
- **Streamlined discharge** processes and **reduced length of stay**.

4.Mental Health Crisis Response

- Investment in **crisis assessment centres / specialist alternatives to ED**.
- Reducing out-of-area placements and **long ED waits for mental health patients.**

5.Digital Transformation

- Use of **real-time data and predictive analytics**.
- **Data system expansion**: NHS Federated Data Platform and Connected Care Records.

Acute Surge Plan and Residual Risks

Trust / Site	Bed Shortfall	Amber Escalation	Bed Shortfall Inc Amber Escalation	Red Escalation	Bed Shortfall Inc Red Escalation	System Mitigation Required (15% NC2R)
NBT	**-147**	**54**	**-93**	**49**	**-44**	**<102 NC2R c60 pt reduction**
UHBW TOTAL	**-148**	**57**	**-91**	**31**	**-60**	**<105 NC2R c63 pt reduction**
BRI	-116	54	-62	20	-42	<55 NC2R c46 pt reduction
Weston	-32	3	-29	11	-18	<50 NC2R c17 pt reduction

- Based on Trust bed modelling methodology
- Current shortfalls do not account for any impact of flu/infection – national predictive modelling not yet published
- Use of red escalation assumes routine use of corridor care, >100% bed occupancy and potential impact on elective delivery
- Requirement for NC2R to deliver at system ambition of 15% is referenced, as key to ensuring Operational Plan delivery at both Trusts

Recommendation

- That the Trust Board in Common delegate authority to the Chair and Chief Executive to sign off the Winter Plan Board Assurance Statement checklist on 30 September 2025.
- That the Quality and Outcomes Committee in Common will complete a review of the ICS and Trust plans to provide assurance for Board and the individuals with delegated authority to submit the Board Assurance Statement checklist.

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	North Bristol NHS Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	As per completion of the Winter Plan checklist. Full winter plan, including ICS plan being received by QOC 30/09/25. Residual risks remain in relation to NC2R and IPC fluctuations.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Has been completed and appended to the QOC Winter Plan paper.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	As per system winter plan and regional testing event.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Due to timing, the Board has delegated authority of this to a Board sub-Committee to ensure deadlines are met.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Yes, Hospital Managing Director.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	As per responses to the Winter Plan checklist - recommendation is that the Board confirms they are assured.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	It is understood that there is a residual risk related to ongoing high levels of NC2R and the need for escalation capacity to manage this demand.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the	Yes	The Trust has been clear that delivery of the operational plan across all metrics is contingent on system delivery

Provider:	North Bristol NHS Trust

trajectories already signed off and returned to NHS England in April 2025.		of the reduction of NC2R to 15%.

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Plan to be presented to TMT and OMB with emphasis on increasing levels by 5% (last year we gave 5726 Flu vaccines to our staff. With a 5% increase = 6012), revised communication strategy and linked to a broader well-being offer to maintain wellness during winter. Investment in this offer is being reviewed. Trust-wide communications to be put in place, as per previous years.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Bed model completed using planned activity and LoS to establish likely demand (plan at 85th centile) with escalation plans. Scenario testing at Regional event on 10/09/25 to understand impact of e.g. flu.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Provision made for investment at peak times to increase medical, nursing and AHP workforce as demand dictates.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	System plans in place, however, ongoing risk re: NC2R and impact of infection prevention and control on ability to discharge patients into the community.

5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Established ring-fenced Elective beds within the Brunel building and the newly opened Surgical Centre ensure ongoing delivery of the Elective programme throughout the winter.
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Yes, in particular focussed on managing outbreaks. 7-day IPC processes and management support in place for winter. Near-patient testing in place for winter.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Fit testing is recorded on LEARN, so staff level recording and reporting is maintained. PPE stock is in place and have national stock supply available for periods of high demand.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Cohorting Policy in place year-round. Review of all escalation capacity undertaken by ICB Chief Nurse, Sirona and NBT Chief Nurse.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	As per year-round processes. All Divisions complete exercises, which test their processes and learning is taken from these for future training via debriefs. On call refresher training undertaken by all individuals on the rota every year. Executive and Director testing undertaken via EMERGO exercises.

10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Yes, newly developed Executive level dashboard established.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	N/A
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	N/A

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	University Hospitals Bristol and Weston NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	As per completion of the Winter Plan checklist. Full winter plan, including ICB system plan received by QOC in common 30/09/25. Residual risks remain in relation to NC2R, influenza surge profiles and other infectious disease. Winter plans will be further tested and augmented once this information is available
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Has been completed and appended to the QOC Winter Plan paper.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	As per system winter plan and regional testing event.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Due to timing, the Board has delegated authority of this to a Board sub-Committee to ensure deadlines are met.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Hospital Managing Director.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	As per responses to the Winter Plan checklist - recommendation is that the Board confirms they are assured.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	It is understood that there is a residual risk related to ongoing high levels of NC2R and the need for escalation

Provider:	University Hospitals Bristol and Weston NHS Foundation Trust

		capacity to manage this demand.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	The Trust has been clear that delivery of the operational plan across all metrics is contingent on system delivery of the reduction of NC2R to 15%.

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Plan to be presented to Trust Management Team and Clinical Quality Group. Trust-wide communications to be put in place, as per previous years. Plan explicitly refers to an increase of 5% on the 24/25 frontline healthcare worker vaccination uptake, bringing UHBW's target uptake for frontline staff to 50.5% or 6,815 vaccinations.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Bed model completed using planned elective and non-elective activity and LoS to establish likely demand with escalation plans assuming 93% bed occupancy. Scenario testing at regional event on 10/09/25 to stress test plans, including impacts of infectious disease surge, i.e. Influenza.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Winter schemes have been developed across all Divisions and sites, focussed on augmenting admission avoidance and discharge across the out of hours periods.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	System plans in place, including a pro-active increase in community bedded capacity, however, there remains an ongoing risk to high levels of NC2R

			and the potential impact of infection prevention and control practice on the ability to discharge patients into community capacity.
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	The bed modelling referenced above accounts for increased non-elective demand through the winter, ensuring ongoing delivery of elective, cancer and diagnostic performance across the year, as outlined in the 2025/25 Operating Plan submission.
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	The Trust have an IPC specific task and finish group within the winter planning structure, who continue to be involved in managing Influenza surge and / or other infectious disease. 7-day IPC processes and management in place for winter.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Fit testing in place for staff and training available via Kallidus, Training compliance rates monitored and shared by the Fit testing team with departments and divisions. There is no anticipated issue with PPE stock levels.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Full Capacity Protocol in place year-round. Review of all escalation capacity undertaken by ICB Chief Nurse, Sirona and NBT Chief Nurse.
Leadership			

9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	As per year-round processes. We comply with standard 20 and 21 of the NHSE Core standards for EPRR which covers trained on-call staff and resilient on-call mechanisms which are tested routinely. Each division also have on-call consultants for out of hours medical provision. Whilst we do not have an on-call nurse leader role the organisation have 24/7 senior nurse leadership from the site operational team.
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Yes, newly developed Executive level dashboard established.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	N/A
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	N/A

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public	
Date of Meeting:	09/09/2025	
Report Title:	Integrated Quality and Performance Report (IQPR)	
Report Author:	David Markwick, Director of Performance James Rabbitts, Head of Performance Reporting Anne Reader/Julie Crawford, Head/Deputy Head Quality (Patient Safety) Emma Harley, Head of Strategic Workforce Planning, Laura Brown, Head of HR Information Services (HRIS) Kate Herrick, Head of Finance	Lisa Whitlow, Director of Performance Paul Cresswell, Director of Quality Governance Juliette Hughes, Deputy Chief Nursing Officer Benjamin Pope, Associate Director for Workforce Planning, People Systems and Data Simon Davies, Assistant Director of Finance
Report Sponsor:	Responsiveness - Emilie Perry, 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	Responsiveness – Nicholas Smith, Trust Chief Operating Officer Quality - Mark Goninon, Trust Director of Nursing, Sanjoy Shah, Trust Medical Director Our People – Sarah Margetts, Interim Director of People Finance – Elizabeth Poskitt, Trust Director of Finance

Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	To provide an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.		

Key Points to Note *(Including any previous decisions taken)*
This report provides an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.
Strategic and Group Model Alignment
This report aligns to the objectives in the CQC domains of Safe, Effective, Caring, Responsive and Well Led.
Risks and Opportunities
Risks are listed in the report against each performance area.

Recommendation	
This report is for **Information**	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	
Appendices:	NBT PQSM data UHBW PQSM data

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication September 2025
Data up to July 2025

NHS North Bristol NHS Trust

Contents

NHS University Hospitals Bristol and Weston NHS Foundation Trust

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 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 are 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 page at end for 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 provided

Executive Summary – Group Update

Responsive

Urgent Care

UHBW ED 4-hour performance was ahead of plan improving to 78.7% during July (77% in June) for all attendance types, including type-3 footprint uplift. There continues to be a significant number of patients with no criteria to reside (NCtR) contributing to a high bed occupancy and subsequently impacting flow and performance, notably on the Weston site where NCtR has been as high as 34% during July. ED 12-hour performance also continues to improve at UHBW, reporting 2.5% (3.5% June). For NBT, ED 4-hour performance improved to 63.7% for July 2025 (71.6% with footprint uplift). NBT is actively working with the GIRFT team to align their findings with their UEC programme and a summary of this was presented at NBT's Quality Outcomes Committee.

The System ambition to reduce the NC2R percentage to 15% remains unachieved. This ambition was central to the Trusts being able to deliver the 78% ED 4-hour performance requirement for March 2025. As yet, there is no evidence this ambition will be realised. However, the refreshed ICS discharge programme is underway and alongside a detailed redesign of the 15% NCTR Ambition Plan being developed in partnership with all system partners. In the meantime, internal hospital flow plans continue to be developed and implemented across all sites.

Elective Care

UHBW successfully eliminated 65 week waits by the end of 2024/25 and compliance is forecast for Q2 with the exception of cornea graft due to previously reported national shortage of graft material which has resulted in four patients waiting beyond 65 weeks at the end of July, noting that NHSE formal dispensation for cornea graft still applies. Both Trusts have set the ambition that less than 1% of the total waiting list will be waiting 52 weeks by the end of March 2026, with NBT already achieving this ambition and UHBW at 1.3%.

Diagnostics

For July, NBT's diagnostic performance met the national constitutional standard, reporting at 0.47%. UHBW position in July improved to 14.1% (16.5% in June) falling slightly short of July target of 13.5%. Diagnostic recovery plans are in place to continue to meet the recovery trajectory, with further improvement in performance expected during Q2.

Cancer Wait Time Standards

During June, UHBW remains compliant with the FDS-28-Day standard and continues to deliver the 31-Day and 62-Day standards with the expectation that this will continue through 2025/26.

At NBT, both FDS and the 62-Day Combined position were off plan for the month of June. The work previously undertaken has been around improving systems and processes, and maximising performance in the high-volume tumor sites. The current position is due to challenges in the Urology and Breast pathways, there are improvement plans in place to reduce the time to diagnosis and provide sufficient capacity to deliver treatments.

Both trusts are part of the SWAG programme of improvement called 'Days Matter' which will focus on Urology pathways at NBT and Colorectal at UHBW.

Executive Summary – Group Update

Quality

Patient Safety

At UHBW in July there were two cases of MRSA (three year to date). The two July cases are in unrelated locations. None were seen at NBT (two year to date). There were 14 reported cases of Clostridium Difficile in July, 45 cases year to date. The data is showing some seasonal variation with higher case rates seen during the same period in 2024 (51 cases in April to July 2024). At NBT there were 7 hospital onset hospital acquired and 3 community onset. This brings the NBT total position to 3 cases above the year to date trajectory.

During July 2025, there were 168 falls at UHBW (4.94 per 1,000beddays) which is slightly above the Trust target of 4.8 per 1000 bed days. There were three falls with moderate physical and/or psychological harm. The increase in falls in Weston has been investigated with additional learning around catheter care and supporting patients who present with alcohol withdrawal identified and improvement work is being taken forward.

Since the launch of Careflow Medicines Management (CMM) at UHBW in summer 2025, the VTE risk assessment completion is slowly increasing with July reported at almost 80%. We expect this to continue to rise as staff become familiar with the new system and as more wards adopt a mandatory approach. However, despite the improvement in risk assessment completion, we have observed an unexpected reduction in VTE prophylaxis prescribing. This has emerged as CMM has been rolled out across the organisation. In response, we have raised a new risk (Risk 8448): Risk that VTE prophylaxis is not prescribed when indicated. A human factors analysis has identified key contributing factors, and targeted actions have been developed to address these issues and strengthen existing controls. At NBT VTE risk assessment completion is improving slightly. In October 2025, when the CMM is launched, completion of the VTE RA will become a ‘forcing’ measure. It is projected that this will improve the position, and the lessons learned from the UHBW CMM implementation are being taken into the NBT go live.

Patient & Carer Experience

51% (23/45) of complaints responses sent out by UHBW in June were within the agreed deadline. 77% (78/101) of responses to PALS concerns sent out by the Trust in June were within the agreed timescale. This category includes cases which until 31/3/25 were categorised by UHBW as informal complaints. Reasons why complaints are not responded to within agreed deadlines are multi-factorial and were explored as part of a ‘deep dive’ report to the Quality and Outcomes Committee in June. These include clinicians’ capacity, the increasing complexity of complaints received, and current gaps in key divisional complaints support roles. Benchmarking also shows that many trusts are working to longer timescale for more complex complaints, typically up to 60 working days. The trust is exploring how digital/AI technology might support complaints resolution in the future. Within NBT 57% complaint responses were achieved within deadline, a further deterioration from previous months. The number of formal complaints being received remains high, with 74 complaints were received in July, 15 more than the same period last year. This particularly applies within ASCR Clinical Division’s, where the compliance rate was the lowest and had a significant impact on the overall Trust score. This is the primary area of improvement action.

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
Sickness – NBT report rolling 12-month sickness whereas UHWB report the absence in month
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 at NBT is 10.4% in July, below the NBT target of 11.3% for 2025/26. At UHBW turnover is 9.6% in July and below target.
The vacancy rate at NBT has increased from 7.3% in June to 8.1% in July predominantly driven by increases in establishment associated with the Bristol Surgical Centre. At UHBW the vacancy rate for July is 2.8%, an increase from 2.6% in June but remaining below target.
For NBT, sickness remains at 4.6% which is above the target of 4.4%and for UHBW sickness is at 4.5% which has increased from 4.3% the previous month.

Essential Training
NBT: Overall compliance across staff groups currently stands at 83.4%, just below the Trust 85% target. Areas of particular note include Oliver McGowan training at 51.63%, Resuscitation at 82.22%, and Preventing Radicalisation at 83.98%. Overall compliance for the Oliver McGowan programmes includes eLearning (level 1) at 85%, with level 2 compliance at 25.05% for clinical and 7.2% for non-clinical staff. The ICB continues to increase the capacity and accessibility of the level 2 provision, with additional dedicated sessions running on-site within NBT. Within resuscitation, additional BLS sessions were provided but take-up remained low.
Note: We have 3 years to achieve full Oliver McGowan level 2 compliance so have agreed we will be producing this as separate data and a trajectory against this for both Trusts to ensure that we are on track to meet this.

UHBW: The inclusion of the Oliver McGowan training compliance aggregate rate has impacted overall compliance, resulting in a decrease of -5.3% for the overall core skills rate, now sat at 85.1%, below the target of 90%. Additional core skills titles, information governance, moving and handling, and resuscitation are below target rate, which is 90% for all titles except information governance which has an exception rate of 95%. Oliver McGowan compliance rates continue to rise on a monthly basis, as more staff can access the webinar or face to face training. Of the three Oliver McGowan titles, eLearning compliance sits at 81.1%, tier 1 attendance at 19.5% and tier 2 attendance at 36.8%. Training capacity within the ICB to deliver the Oliver McGowan continues to grow whilst training places are heavily in demand, however there remains a level of DNA's reported within the data (although this is declining). The BNSSG training provider working to increase capacity will support compliance improvements and the target of 30% system compliance for tier 1 and tier 2 compliance is set to hit 30% by the end of August 2025. Including tier 1 and tier 2 compliance in the data will serve to focus on and address areas of low compliance. The tracking and reporting of Oliver McGowan training compliance is now aligned across the Bristol Hospitals Group. This supports the national focus on the subject and on-going reporting of provider compliance. Therefore, the core skills table now includes an aggregate rate for the Oliver McGowan mandatory training titles – eLearning, tier 1 attendance and tier 2 attendance.

Executive Summary – Group Update

Finance

In Month 4 (July) NBT delivered a £0.4m deficit position which is £0.7m adverse to plan. Year to date NBT has delivered a £4.1m deficit position against a £3.5m deficit plan, which is £0.6m adverse to plan.

UHBW delivered a £0.1m surplus in month 4, against a surplus plan of £0.9m. UHBW's year to date deficit is £8.0m, £0.8m adverse to the deficit plan of £7.2m.

The adverse variance for both Trusts is driven by industrial action in month.

Pay expenditure within NBT is £1.7m adverse to plan in month. This is driven by industrial action, overspends in nursing and healthcare assistants due to escalation and enhanced care, under-delivery against in-year savings which is offset by vacancies in consultant and other agenda for change staff groups.

Pay expenditure in UHBW is £1.8m higher than the plan for July and £3.1m higher year to date. This is due to staffing exceeding budgeted establishments, particularly across nursing budgets and the inclusion of the additional medical costs to cover the resident doctor industrial action. The position is partly offset by higher than planned pay savings.

The NBT cash balance as at the 31 July 2025 is £40.9m, £5.1m higher than planned, a £36.5m reduction from 31 March 2025.

The UHBW cash balance as at the 31 July 2025 is £76.2m, £2.2m higher than planned and a £3.9m increase from 31 March 2025.

North Bristol NHS Trust

Responsiveness

Scorecard

University Hospitals Bristol and Weston NHS Foundation Trust

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	Jul-25	63.7%	69.3%	62.2%	?	C	Escalation Summary
		UHBW	Jul-25	71.8%	69.3%	70.1%	?	C	Escalation Summary
Responsive	ED % Spending Over 12 Hours in Department	NBT	Jul-25	6.3%	2.0%	8.3%	F-	C	Escalation Summary
		UHBW	Jul-25	2.5%	2.0%	3.5%	F	C	Escalation Summary
Responsive	ED 12 Hour Trolley Waits (from DTA)	NBT	Jul-25	220	0	263	F-	C	Escalation Summary
		UHBW	Jul-25	161	0	137	F-	C	Escalation Summary
Responsive	Ambulance Handover Delays (under 15 minutes)	NBT	Jul-25	32.6%	65.0%	26.6%	F-	C	Escalation Summary
		UHBW	Jul-25	37.2%	65.0%	30.6%	F-	C	Escalation Summary
Responsive	Average Ambulance Handover Time	NBT	Jul-25	33	45	42	?	C	Escalation Summary
		UHBW	Jul-25	26	45	32	?	C	Escalation Summary
Responsive	% Ambulance Handovers over 45 minutes	NBT	Jul-25	22.0%	0.0%	30.1%	F-	C	Escalation Summary
		UHBW	Jul-25	12.2%	0.0%	18.2%	F-	C	Escalation Summary
Responsive	No Criteria to Reside	NBT	Jul-25	21.3%	15.0%	22.3%	F-	L	Escalation Summary
		UHBW	Jul-25	22.4%	13.0%	21.5%	F-	H	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

NHS North Bristol NHS Trust

Responsiveness

Scorecard

NHS University Hospitals Bristol and Weston NHS Foundation Trust

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	RTT Percentage Over 52 Weeks	NBT	Jul-25	0.4%	1.0%	0.4%	P	L	Note Performance
		UHBW	Jul-25	1.3%	1.2%	1.4%	F-	L	Escalation Summary
Responsive	RTT Ongoing Pathways Under 18 Weeks	NBT	Jul-25	65.8%	65.3%	66.1%	F	H	Escalation Summary
		UHBW	Jul-25	65.2%	65.1%	64.9%	F-	H	Escalation Summary
Responsive	RTT First Attendance Under 18 Weeks	NBT	Jul-25	71.2%	70.6%	72.0%	F	H	Escalation Summary
		UHBW	Jul-25	67.1%	67.4%	66.5%	F-	H	Escalation Summary
Responsive	Diagnostics % Over 6 Weeks	NBT	Jul-25	0.5%	1.0%	1.0%	?	L	Note Performance
		UHBW	Jul-25	14.1%	13.5%	16.5%	?	C	Escalation Summary
Responsive	Cancer 28 Day Faster Diagnosis	NBT	Jun-25	78.2%	79.2%	75.0%	?	H	Note Performance
		UHBW	Jun-25	78.2%	77.0%	77.7%	P	C	Note Performance
Responsive	Cancer 31 Day Decision-To-Treat to Start of Treatment	NBT	Jun-25	90.3%	85.9%	86.5%	?	H	Note Performance
		UHBW	Jun-25	96.6%	96.0%	97.4%	P	H	Note Performance
Responsive	Cancer 62 Day Referral to Treatment	NBT	Jun-25	64.8%	70.1%	62.9%	F	C	Escalation Summary
		UHBW	Jun-25	75.0%	73.2%	78.2%	P	H	Note Performance
Responsive	Last Minute Cancelled Operations	NBT	Jul 25	0.4%	0.8%	0.7%	P	C	Note Performance
		UHBW	Jul-25	1.8%	1.5%	1.9%	?	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	

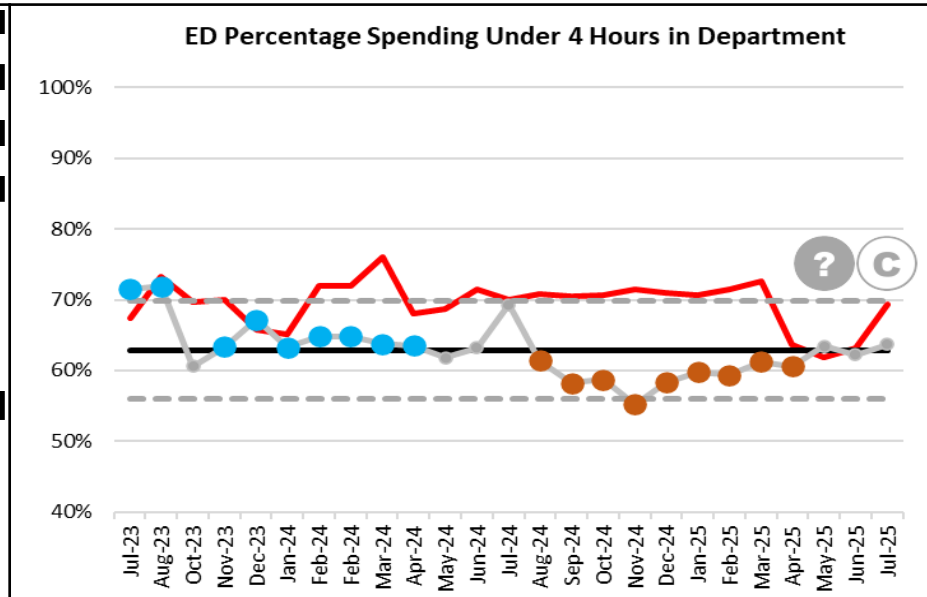
Responsiveness

UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
69.3%
Latest Month's Position
63.7%
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
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).

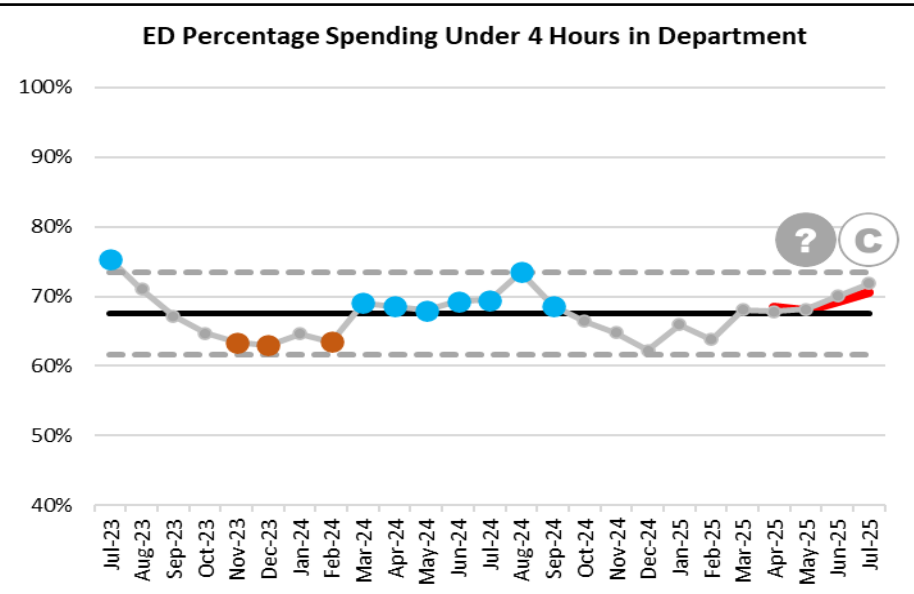


What does the data tell us?
The percentage of patients spending under 4 hours in ED for the month of July improved again to 63.7%

Actions being taken to improve
The ED team are running a "Focus on Four Hours" approach to improving departmental four hour processes, including internal escalation where there is delay. The GIRFT team are supporting this, with national leads shadowing in the ED on 21 August to support identification of opportunities.
The continuous flow model relaunched on 17 July and has supported a more predictable pattern of flow out of ED – as a result admitted performance improved to 40.8%, which is the best since July 2024.
The UEC transformation programme updates include:

1) Minors' relocation to Gate 24 with performance target of 95%. Backfill opportunity will unlock ED SDEC space which will improve non admitted performance which currently operates at c50-60%. There is some risk to the delivery date (was November) of this project associated with the significant decant required for current Gate 24 staff.
2) Medicine bed base review and move into new capacity on 7B – now taking place from early September = additional 16+ medical beds.

Impact on forecast
Month-to-date performance for August shows further improvement at c.66%.



Latest Month
Jul-25
Target
69.3%
Latest Month's Position
71.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

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

What does the data tell us?
An improved position across the trust against the ED 4-hour standard at 71.8 % in July compared to 70.1% in June and exceeding the target of 69.3%.

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.
Whole hospital review of ED 'quality standards' continues, with a specific focus on 'specialty reviews' and 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).

Impact on forecast
Forecasting improvement plans will continue to iterate and improve the Trust position; c70% in August 25/26.
The End of Year Target for this measure is 72.3% (78% inclusive of Sirona type-3 uplift)

Responsiveness

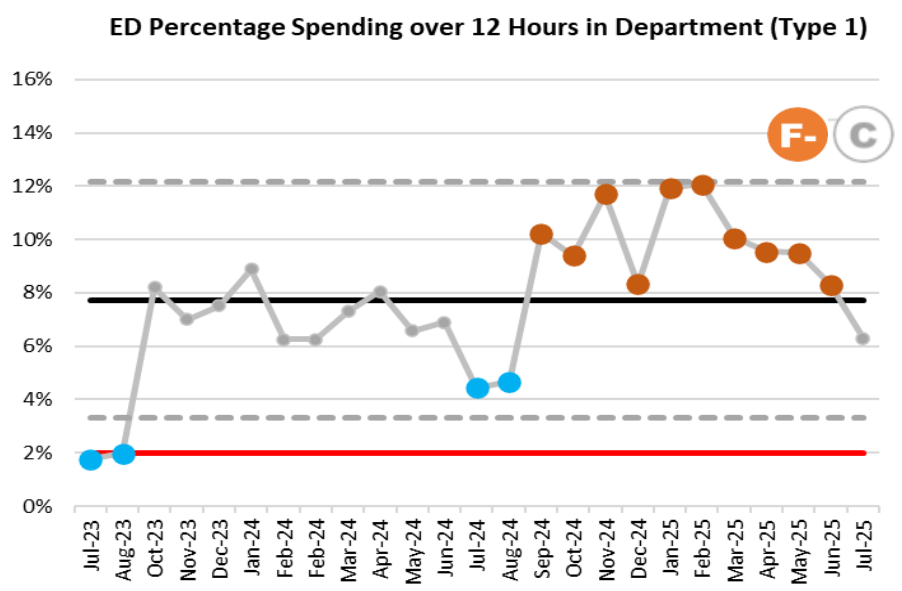
UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
2.0%
Latest Month's Position
6.3%
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).



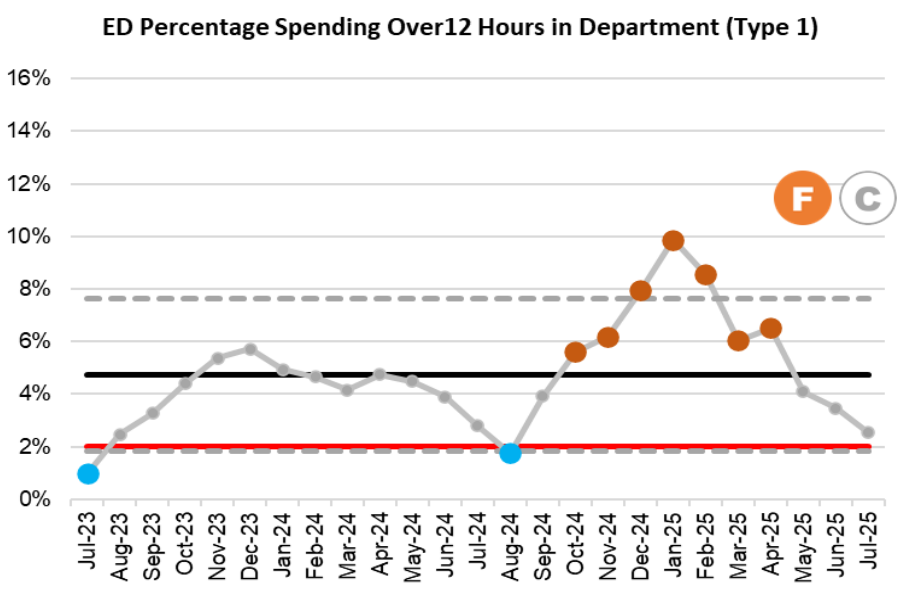
What does the data tell us?
The percentage of patients spending over 12 hours in ED reduced for the fifth month running to 6.3% in July, representing the best performance since August 2024 and now below the mean.

Actions being taken to improve
Continuous flow relaunched mid July and has improved admitted four and 12 hour performance.
The UEC transformation programme focusses through several projects on admitted flow and therefore reduction in 12-hour delays, including:

1) Every Minute Matters – our approach to ward-based flow and discharge processes. Currently focussing on use of the discharge lounge, including 10 by 10am, and new projects on improving discharge letter writing processes and reducing reliance on hospital transport, both of which should improve discharge timeliness.
2) Radiology review – through the work on this review we have mapped the impacts of ambulance cohorting in the x-ray area on scanning turnaround times, and as a result have changed the order in which we cohort to preserve x-ray as much as possible to support x-ray timeliness.

The GIRFT team spent a day with the cardiology team and next steps will be to map out the opportunities to reduce cardiology length of stay and improve pull from AMU into the cardiology ward.

Impact on forecast
Unvalidated data for the first half of August is showing further improvement against this metric.



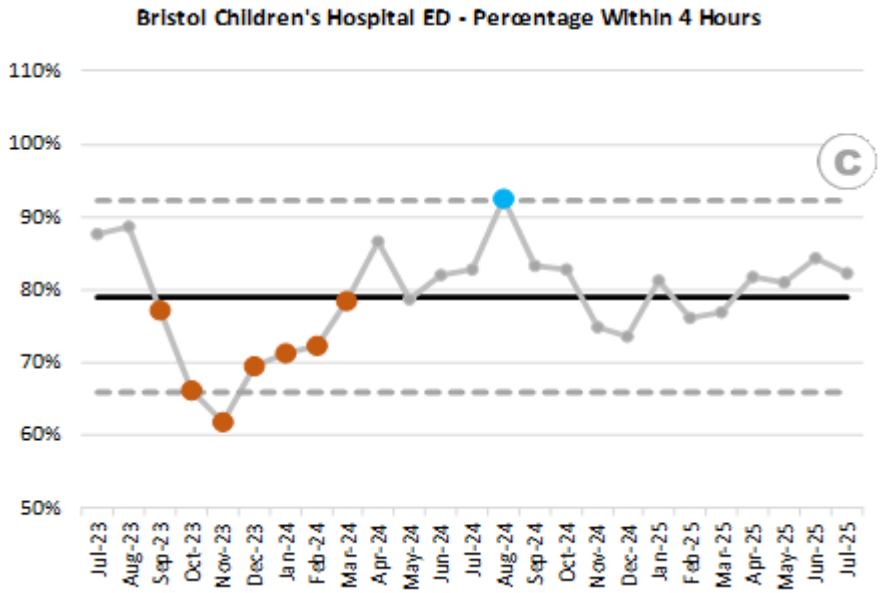
Latest Month
Jul-25
Target
2.0%
Latest Month's Position
2.5%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?

The percentage of patients spending over 12 hours in ED for the month of July (2.5%) improved again compared to June (3.5%) with consistent improvement observed over the last 3 months.

Actions being taken to improve
Note previous slide.
Additionally, ED 12-hour performance data is being reviewed by all divisions/specialties across BRI/Weston sites in support of a trust-wide approach to reducing 12-hour waits through improved responsiveness to requests for Specialty Reviews, in addition to improved support into ED in Out of hours periods.

Impact on forecast
The focused improvement efforts described above are anticipated to maintain the improved position at c2.5% during August 25/26



Latest Month
Jul-25

Target
No Target

Latest Month's Position
82.2%

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?

A very similar position in BRHC performance overall ED 4-hour at 82.2% in July compared to 82.7% in July 2024. A slight deterioration when compared to June 2025, which was 84.4%.

Actions being taken to improve

- Whole hospital review and updated document of escalation plans to improve 4-hour performance.
- The department is working with Brisdoc to fully open our pACE service where GP's and Community Partners can contact a Paediatric clinician to discuss clinical concerns, the aim of the service is to provide advice and guidance to avoid ED attendances.
- BRHC are working with SWAST and wider hospital to improve ambulance handover times and quicker transfer to an inpatient bed.
- BRHC are reviewing process to board and pre-emptive bed utilisation.
- Focused project on Patient Flow Coordinator roles in conjunction with nursing and medical teams to improve patient flow and timely treatment in the department

Responsiveness

UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

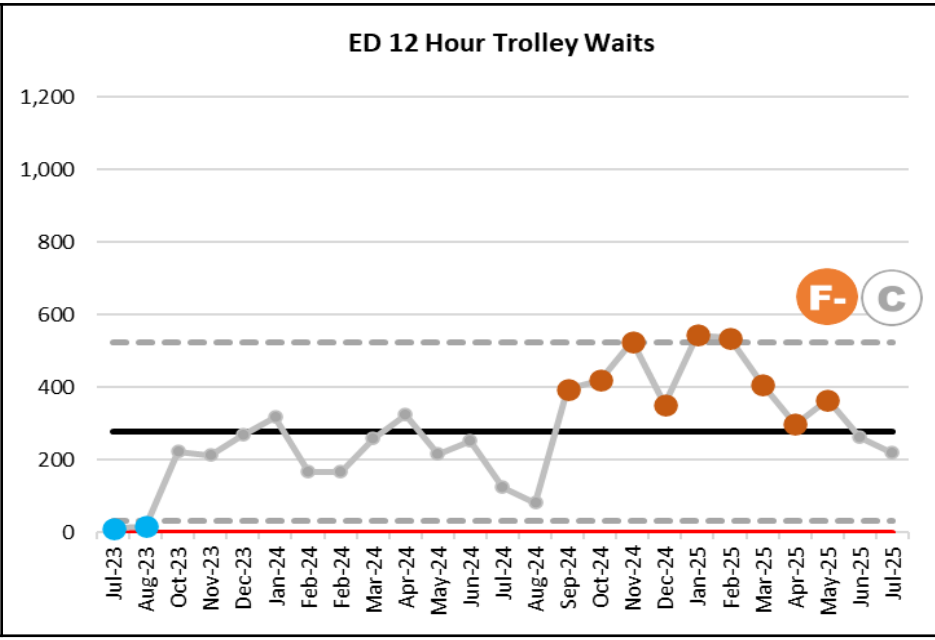
Latest Month
Jul-25

Target
0

Latest Month's Position
220

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

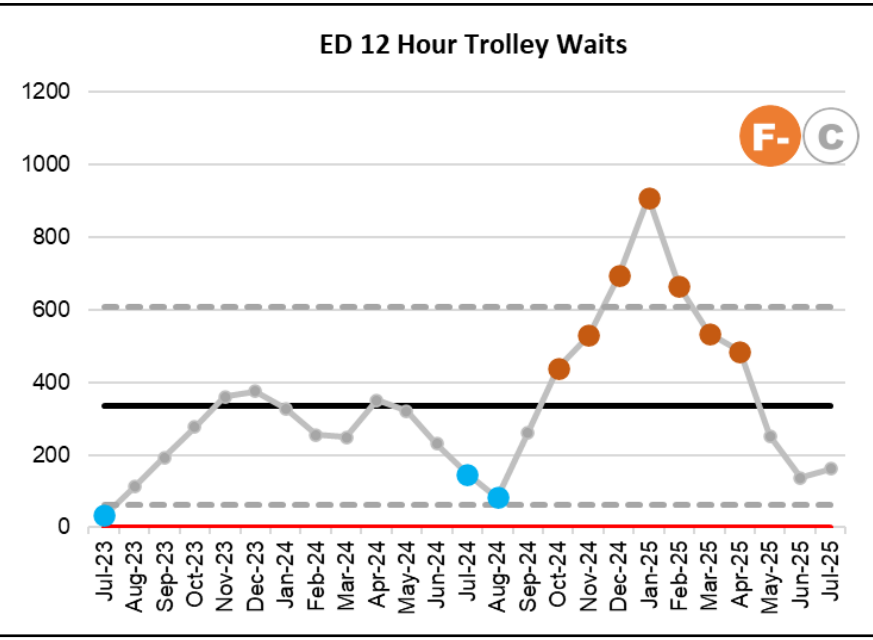
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
The number of 12 Hour trolley waits decreased compared to the previous month to 220.

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

Impact on forecast
See previous slide.



Latest Month
Jul-25

Target
0

Latest Month's Position
161

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

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)
Risk 2614 - Risk that patient care and experience is affected due to being cared for in extra capacity locations

What does the data tell us?
The number of 12 Hour trolley waits increased slightly throughout July to 161 compared to 137 in June.

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 12-hour trolley waits will reduce in August as a result of the enhanced focus and re-launch of the ED Quality Standards in relation to "Speciality Reviews" in particular.

Responsiveness

UEC – Ambulance Handover Delays

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

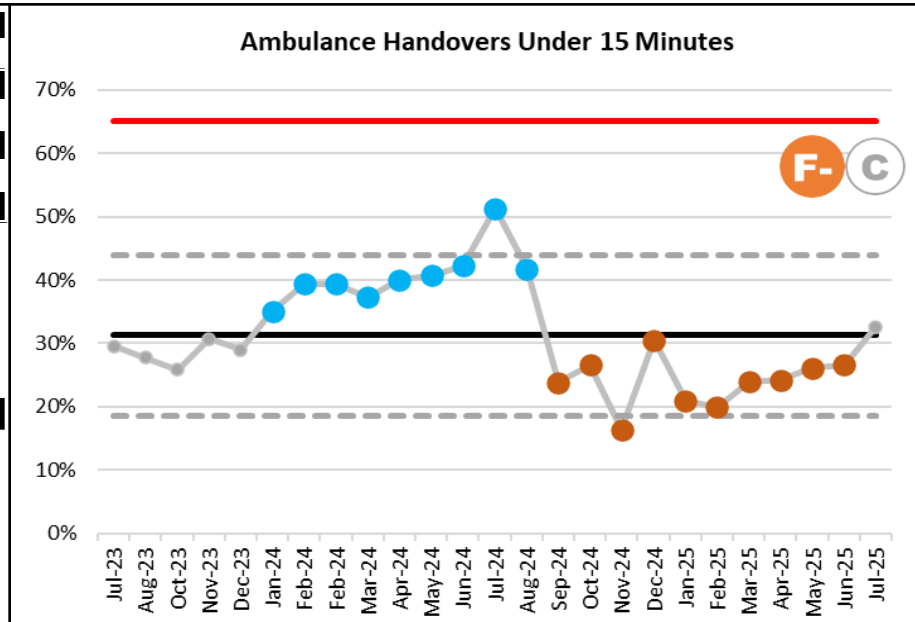
Latest Month
Jul-25

Target
65.0%

Latest Month's Position
32.6%

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

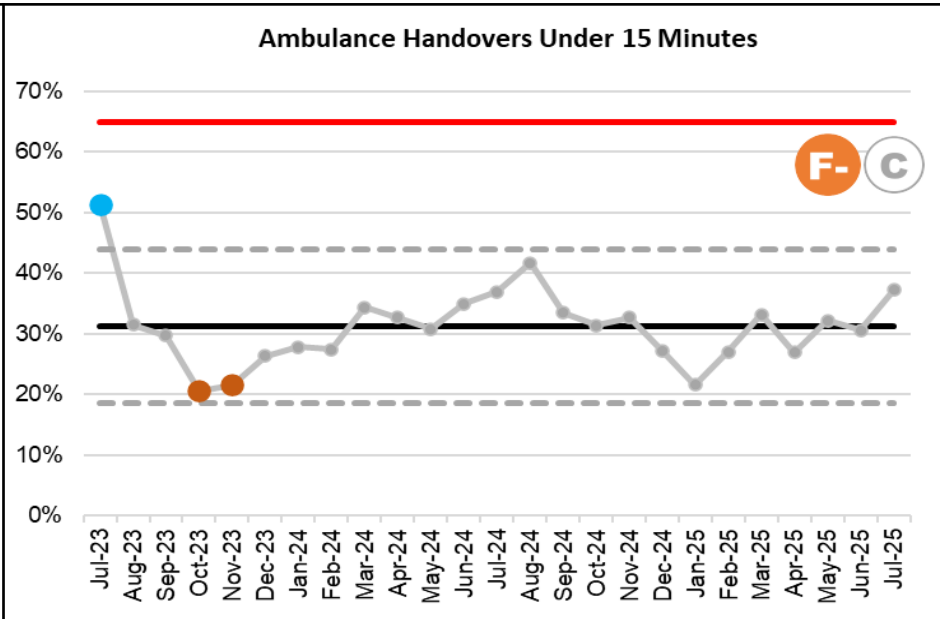
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
The proportion of handovers completed within 15 minutes has continued to improve over the last five reporting months, with performance now back above the mean.

Actions being taken to improve
A piece of rapid improvement work commenced from 15 July focussing on improving the proportion of handovers within 15 minutes. This work continues during August with a joint session with SWAST focussing on refinement of the handover process to shave off further minutes, and a focus on handovers direct to the stroke team.

Impact on forecast
The work undertaken so far in August has seen the proportion of handovers within 15 minutes increase to c60%.



Latest Month
Jul-25

Target
65.0%

Latest Month's Position
37.2%

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?
Ambulance handovers within 15 mins have increased across UHBW throughout July (37.2% compared to 30.6% in June).

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.

Impact on forecast
It is anticipated that the ongoing improvement work will continue to contribute to an improved position in the forthcoming months.

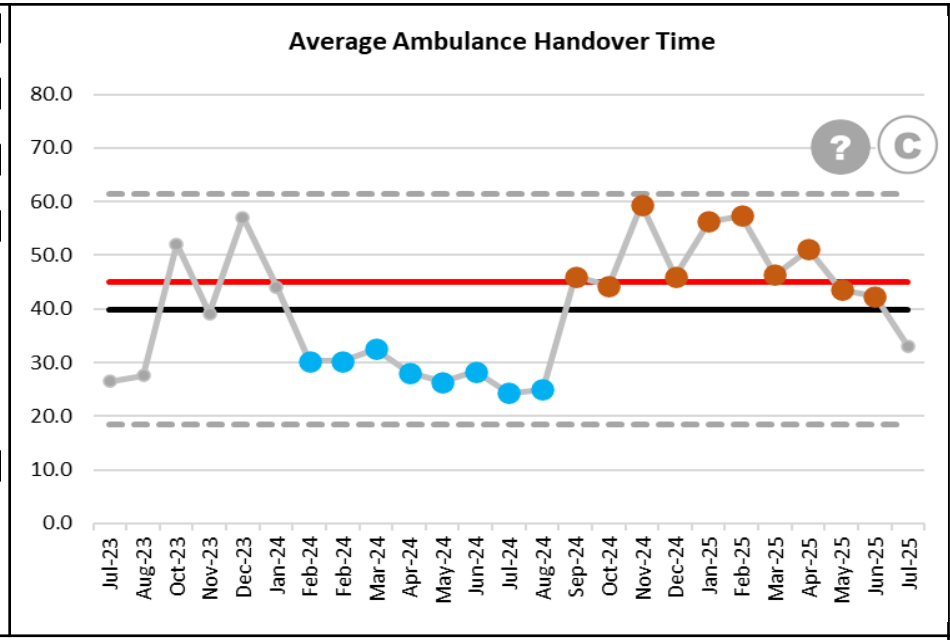
Responsiveness

UEC – Ambulance Handover Delays

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

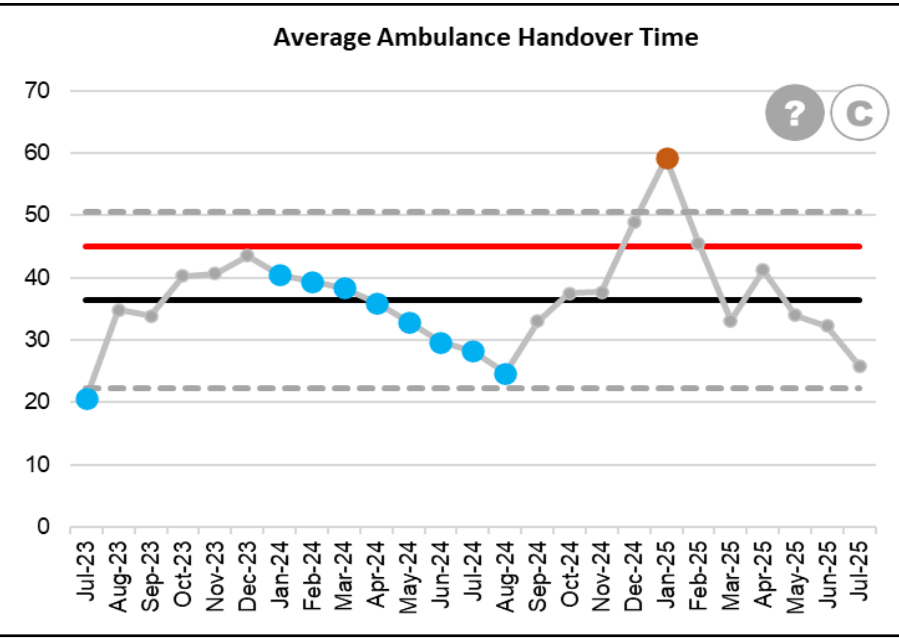
Latest Month
Jul-25
Target
45.0
Latest Month's Position
33.1
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
For July 2025, the average handover time for ambulance conveyances improved to 33.1 minutes, taking this metric back below the mean with best performance since August 2024.

Actions being taken to improve
The rapid improvement work described on the previous slide and the Timely Handover work described on the next slide are both relevant to improving average handover times. In addition to this, direct access for paramedics to medical SDEC goes live from 1 September, with direct access to gynae and surgical SDEC already in place.
The UEC programme work to relocate minors will unlock space within the current ED footprint which will support better handover time adherence. This is by creating an additional nine majors' spaces and two extra ambulance receiving centre spaces. The start date for the relocation is being recalculated due to decant requirements changing.

Impact on forecast
The actions taken together are expected to improve overall handover times, and therefore average handover.



Latest Month
Jul-25
Target
45
Latest Month's Position
25.8
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?
Average ambulance handover time across UHBW has improved throughout July at around 26 minutes compared to 34 minutes in June

Actions being taken to improve
A programme of work has been established focussing specifically on maintaining the zero tolerance to >45-minute ambulance handovers across UHBW. Actions have been identified across the BRI and WGH ED sites in particular - that focus on improving timelier flow of patients out of ED and ensuring more patients are directed to alternative services such as Same Day Emergency Care where appropriate. This in turn will enable continued improvements in ambulance handover times.

Impact on forecast
The improvement work outlined above is expected to contribute to the ongoing achievement of the <45- minute average ambulance handover time.

Responsiveness

UEC – Ambulance Handover Delays

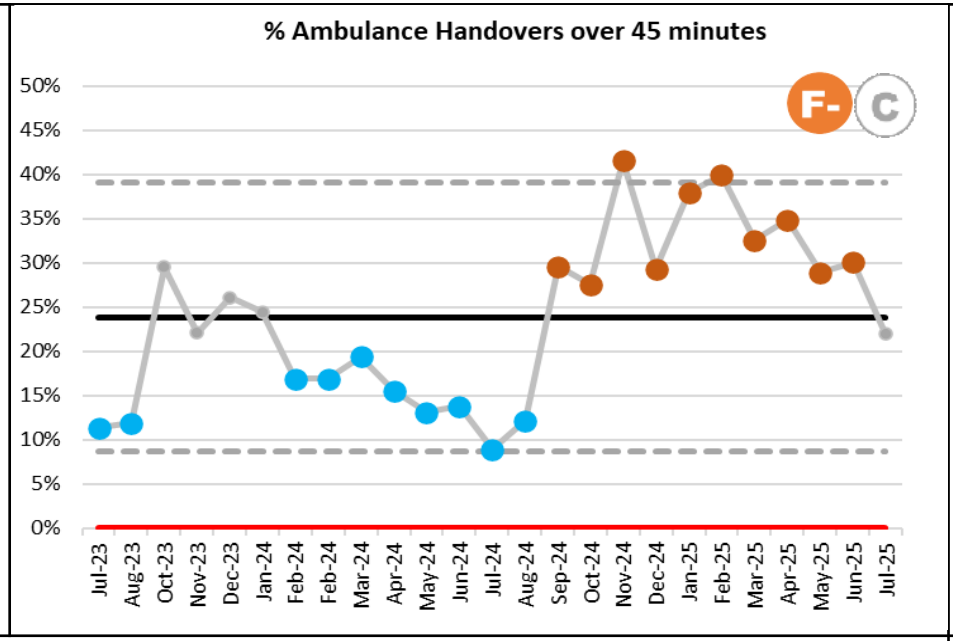
Latest Month
Jul-25

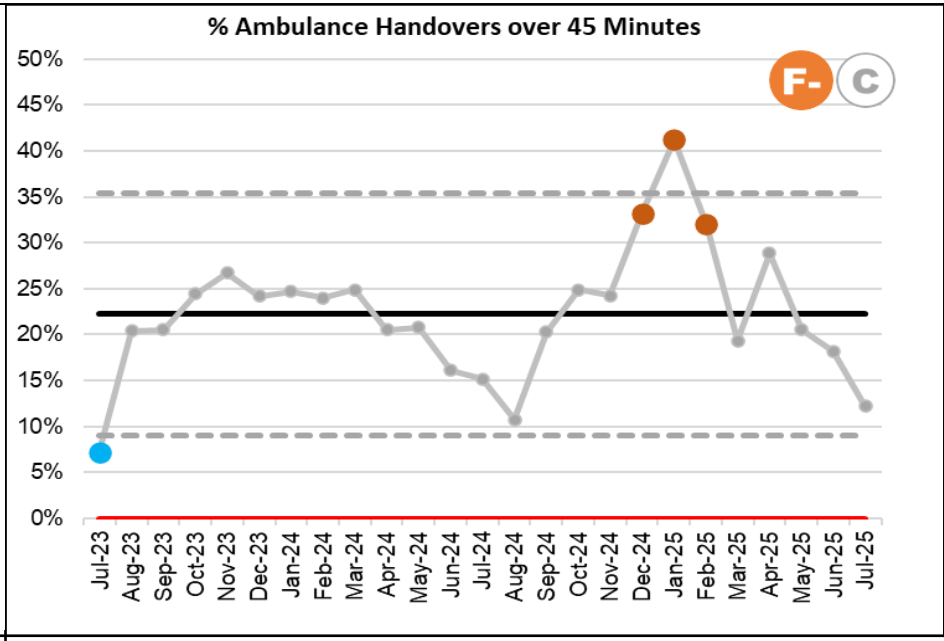
Target
0.0%

Latest Month's Position
22.0%

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
Jul-25

Target
0%

Latest Month's Position
12.2%

Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up 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 45 minutes improved significantly in July 2025 to 22.0%, taking this metric back below the mean with the best performance since August 2024.

Actions being taken to improve
In partnership with SWAST NBT implemented the Timely Handover Plan on 30 June 2025. This process sees us using a series of escalation huddles, including very senior Divisional and Operations staff, to unlock actions which create ED exit flow and therefore offloading space. During July we further refined this approach, including huddling earlier to maintain at least two offload spaces at any one time to better manage surges in arrival.

Impact on forecast
Data for August to date shows further significant improvement against this metric at <18%.

What does the data tell us?
Ambulance handover times within 45 minutes have continued to improve across the last three months.
See Previous Slide for Ambulance Handover Summary detail

North Bristol NHS Trust

Responsiveness

UEC – No Criteria To Reside

University Hospitals Bristol and Weston NHS Foundation Trust

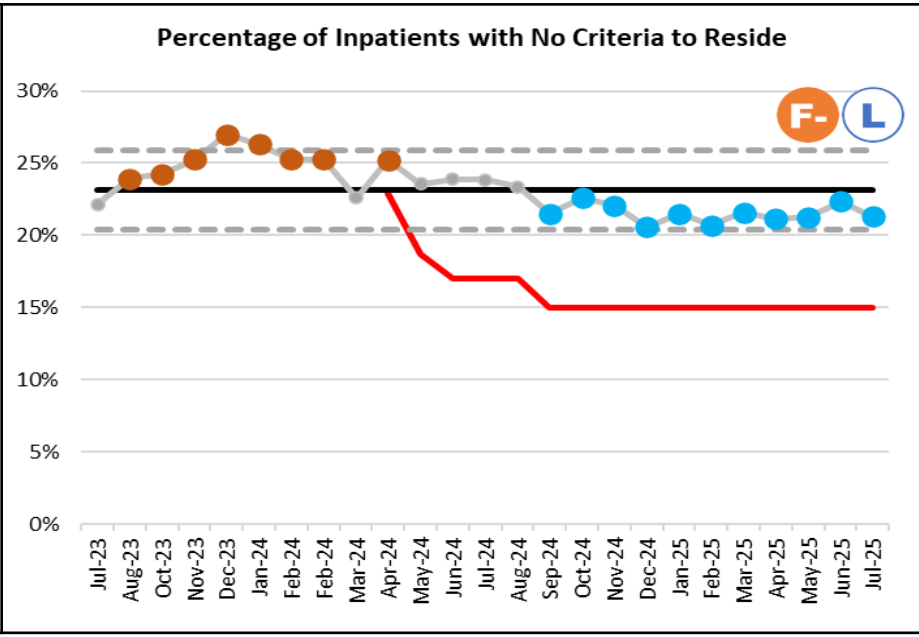
Latest Month
Jul-25

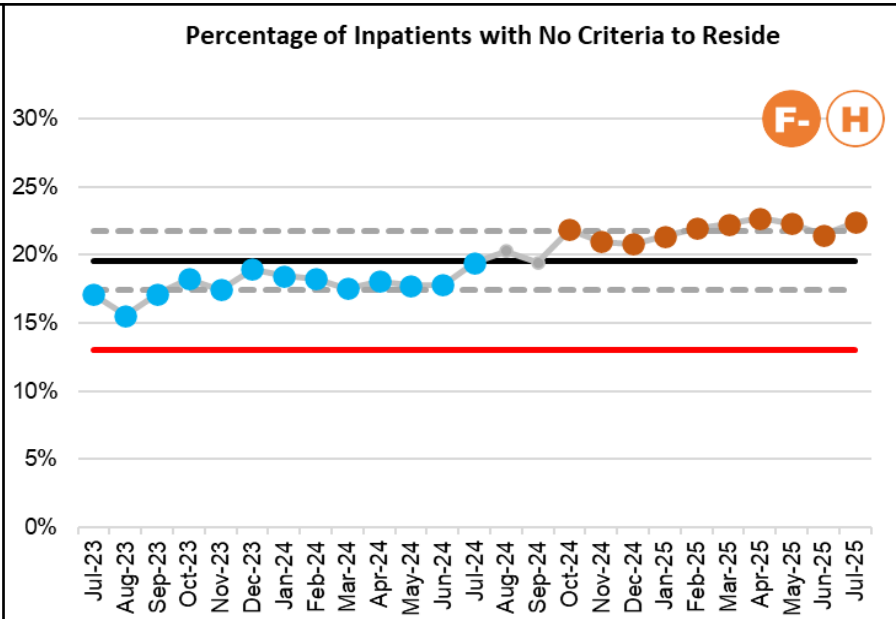
Target
15.0%

Latest Month's Position
21.3%

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

Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25

Target
13.0%

Latest Month's Position
22.4%

Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.

Corporate Risk
Corporate Risk423 - Risk that demand for inpatient admission exceeds available bed capacity (20).
Corporate Risk 8252 - Patients with no criteria to reside continue to remain in hospital beds (16)

What does the data tell us?
There has been an overall downward trend in NC2R since the same period last year, with July decreasing on the previous month at 21.3%.

Actions being taken to improve
Towards the end of July NBT started a piece of demand management work across Pathway 1 – this has led to a 66% reduction in Pathway 1 referral, and a reduction in acute NCTR of c 35 patients.
The system-wide ICS discharge plan also continues:

1) Pathway 1 transformation – includes likely national support via the LGA by iMpower.
2) Pathway 2 and 3 bed consolidation – ICS wide work to provide a community bedbase fit for the future, with fewer, larger units all able to take a greater complexity of need.
3) Area performance meetings for each LA hosted in the Transfer of Care Hubs went live in July with the aim of reducing the cycle times for each pathway.

Impact on forecast
The first half of August has seen significant improvement at c185%. The reduction is equivalent to a Brunel ward's worth of patients (c35).

What does the data tell us?
No Criteria to Reside (NCTR) position deteriorated in July 22.4% (vs June 21.5%): Weston 31% (27.7% June); BRI 20% (20.1% June). Poor discharge rates for P3 in WGH impacted performance, escalated at system level.

Actions being taken to improve

- Development of system-wide improvement plans to deliver the 15% NCTR position continues. Focused work on: Pathway 1:
- releasing capacity by reducing demand in Acutes. Quick Wins working party launched in June, exploring various opportunities. 27% reduction in demand in July.
- Pathway 2: increased 4 beds in Orchard Grove. Exploring opportunities to increase bed capacity at SBCH.
- Pathway 2 and 3: reducing overall LoS in Acute and community beds based on nationally benchmarked data. Area Performance Meetings launched to improve performance and drive efficiencies.
- Early Supported Discharges enables patients to leave hospital before their package of care start date, supported 117 patients to leave hospital early saving 338 bed days.

Impact on forecast
System ambition of reducing NCTR to 15% remains (BRI 11%; WHG 19%) remains unmet (however significant improvement in P0 at 15.14% and P1 19.19% against 22/23 baseline).

NHS North Bristol NHS Trust

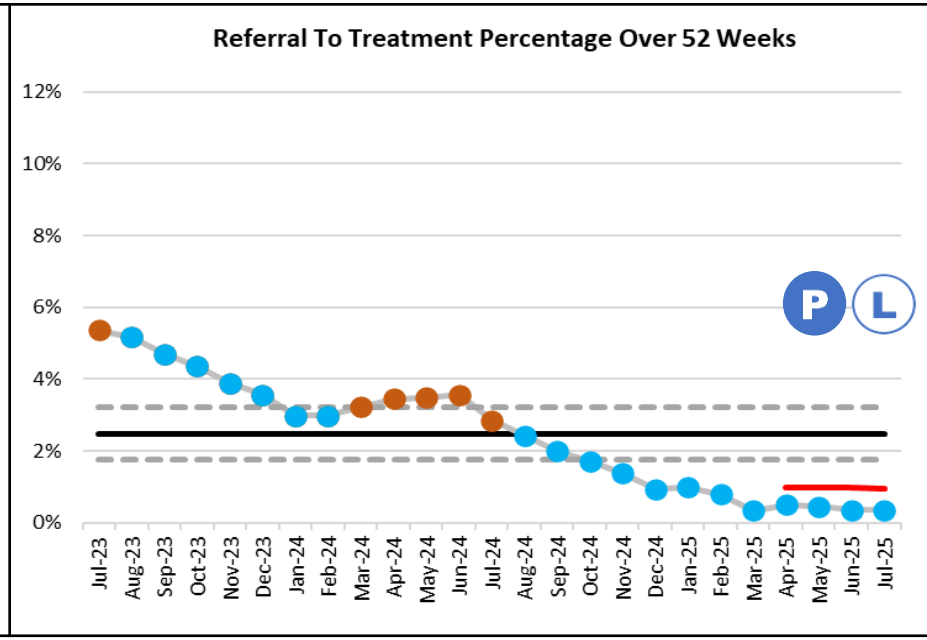
Responsiveness

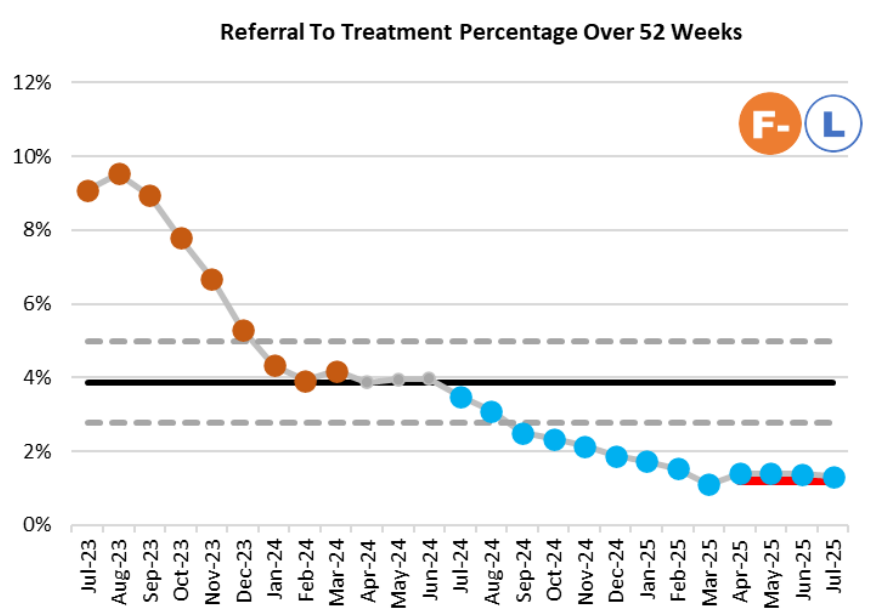
Planned Care – Referral to Treatment (RTT)

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
1.0%
Latest Month's Position
0.4%
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
Jul-25
Target
1.2%
Latest Month's Position
1.3%
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 July, 716 were waiting 52 weeks or more for treatment (759 in June), with long waits predominantly noted in dental and paediatric specialties. Against the total waiting list of 54,179 this equates to 1.3% against the 1.2% trajectory set for July 2023 as part of the trust operational planning submission (national target <1% by March 2026). There were four 65-week wait breaches, all of which relate to patients who require cornea graft material and, whilst there is sufficient internal capacity to date these patients, the national shortage of graft material prevented treatment in month.
The overall waiting list size reduced during by 944 when comparing July and June and although this is a reduction, the waiting list size is higher that our set trajectory for July when our waiting list size in the planning submission was set at 51,970.

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.

Impact on forecast
A revised trajectory was issued for Q2 with recovery anticipated at end of Q2.
The End of Year Target for this measure is 0.9%

Responsiveness

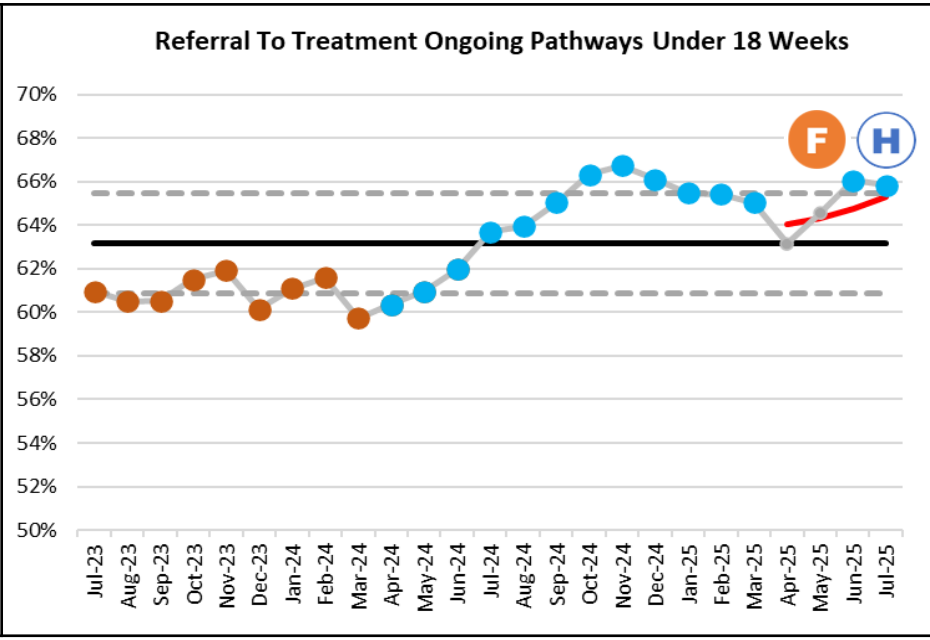
Planned Care – Referral to Treatment (RTT)

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
65.3%
Latest Month's Position
65.8%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement but last six data points are less than target

Trust Level Risk
No Trust Level Risk



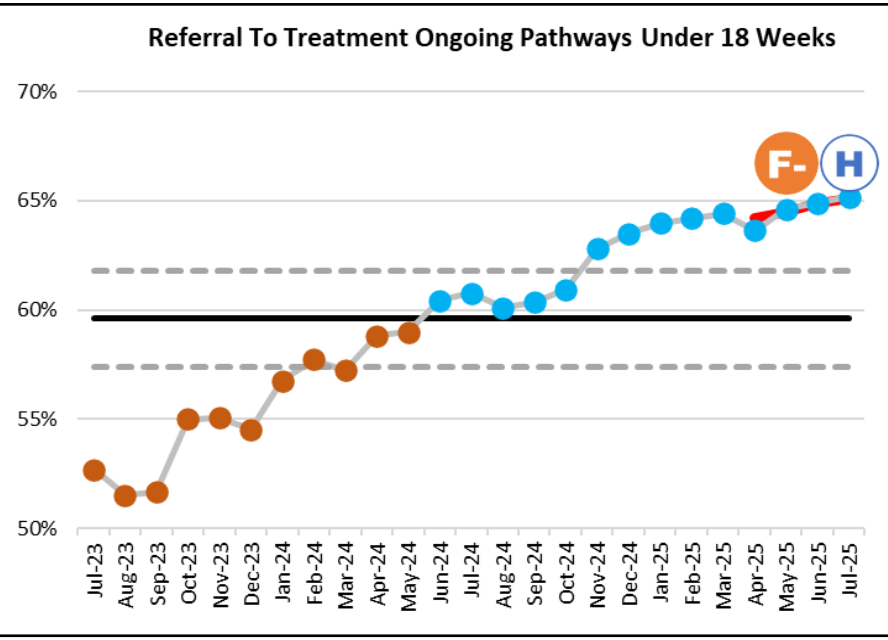
What does the data tell us?
At the end of July the percentage of patients waiting less than 18 weeks was 65.8%, performing better than the Trust trajectory of 65.3% set as part of the Trust operational planning submission (target of 72% by March 2026).

Actions being taken to improve
The 2025/26 delivery plans developed with clinical divisions, incorporate additional resource for some of the services (e.g. neurology and pain specialties) requiring greater support to recover their position.

The Trust are taking part in the NHS England validation sprint, where an additional validation exercise will focus on patients across a broad range of specialties, this has been supported by additional validation resource for select specialties.

Additional patient contacts are being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions).

Impact on forecast
Anticipated to deliver end of year target.



Latest Month
Jul-25
Target
65.1%
Latest Month's Position
65.2%
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 July, the number of patients waiting less than 18-weeks is 35,310 (65.2%) which meets the trust level trajectory on percentage performance for end of July.

Actions being taken to improve
The 2025/26 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 are taking part in the NHS England validation sprint, where an additional validation exercise will focus 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 of the end of year target
The End of Year Target for this measure is 67.8%

Responsiveness

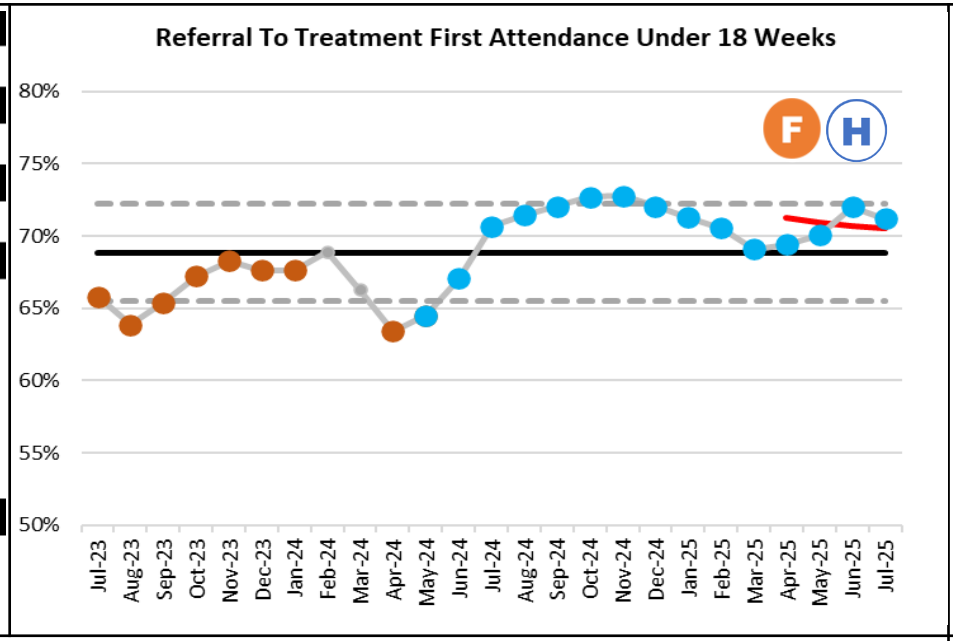
Planned Care – Referral to Treatment (RTT)

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
70.6%
Latest Month's Position
71.2%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement but last six data points are less than target

Corporate Risk
No Trust Level Risk

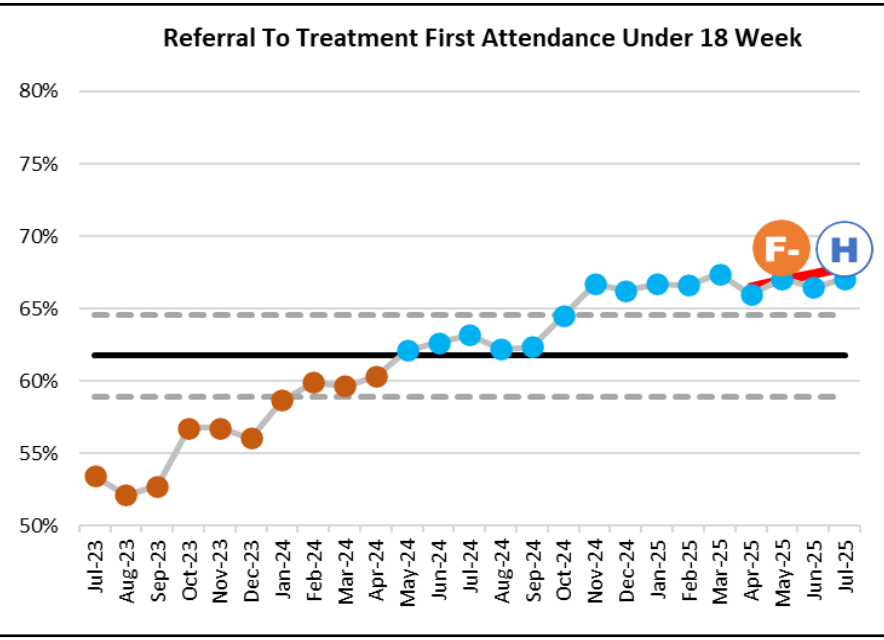


What does the data tell us?
At the end of July, the percentage of patients waiting less than 18 weeks for their first appointment is 71.2%, performing better than the trajectory of 70.6% set as part of the Trust operational planning submission (target of 78% by March 2026)

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.

This also includes 'booking in order' where clinically appropriate, utilisation of available clinic slots to see a greater number of new patients, running additional clinics via waiting list initiatives, increased use of insourcing arrangements and the use of digital solutions to reduce the number of patients who do not attend their appointments.

Impact on forecast
Ongoing work to undertake actions and recover to the trajectory for year-end target.



Latest Month
Jul-25
Target
67.4%
Latest Month's Position
67.1%
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 July, the percentage of patients waiting less than 18 weeks for their first appointment is 67.1% against the target of 67.4% set for July 2025 as part of the Trust operational planning submission (target of 71.7% by March 2026)

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.

Impact on forecast
Continue to monitor the position with the ambition of delivery of the end of year operational planning trajectory
The End of Year Target for this measure is 71.7%

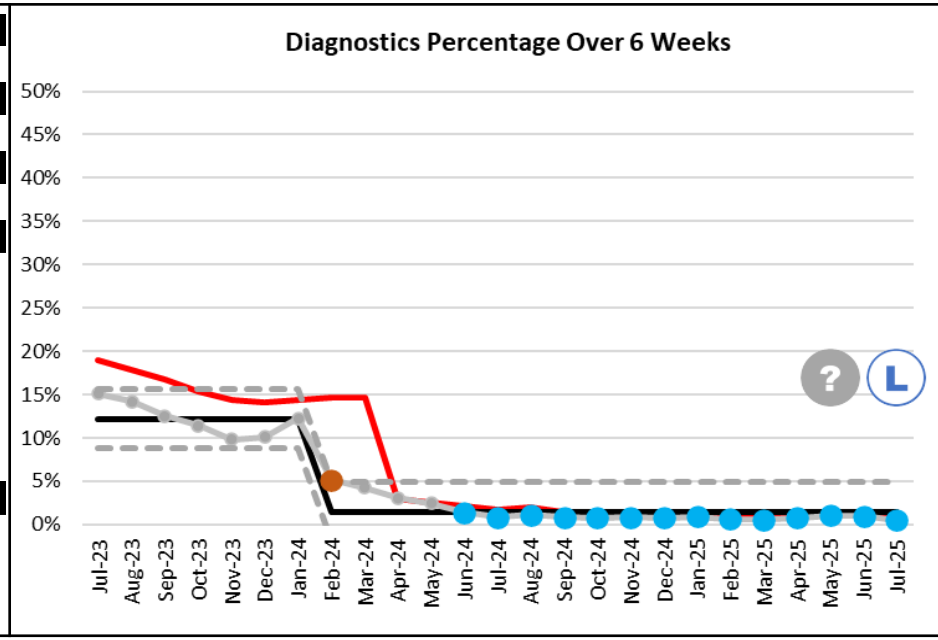
Responsiveness

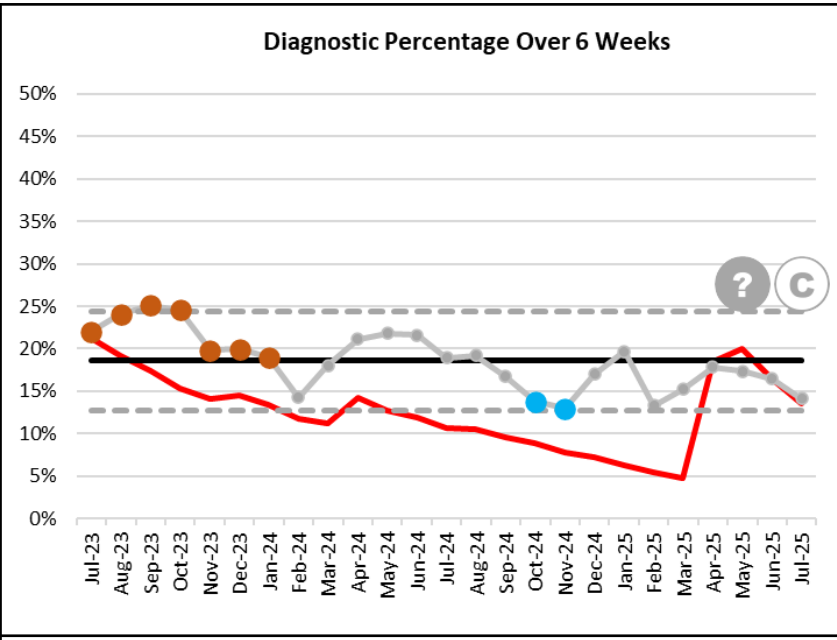
Planned Care – Diagnostics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
1.0%
Latest Month's Position
0.5%
Performance / Assurance
Special Cause Improving Variation Low (where down is improvement) and last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25
Target
13.5%
Latest Month's Position
14.1%
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 801 - Elements of the NHS Oversight Framework are not met (12)

No narrative required as per business rules.

What does the data tell us?
Overall Trust performance against the DM01 6ww standard improved from 16.5% in June to 14.1% in July. Despite a 2.4% improvement, July 6ww performance is 0.6% above July trajectory of 13.5%.

Actions being taken to improve
- Ongoing review of Non-Obstetric Ultrasound core capacity to quantify capacity shortfalls as part of backlog recovery plans which are sustainable
- Continued outsourcing of Cardiac MRI scans (60 scans per week), coupled with additional weekend sessions to target the longest and most complex longest waiting patients as part of efforts to reduce backlogs.
- Continue to utilise the Weston Community Diagnostic Centre to reap the benefits of faster waiting times. Focus on increasing the referral to activity conversion rate to increase the impact at the Weston Community Diagnostic Centre

Impact on forecast
Current CDC and outsourcing criteria mean longest waiters are often unsuitable, so both <6ww and >6ww patients are treated to maximise capacity utilisation. This drives total list reductions that are disproportionate to 6ww breaches, creating a risk to achieving forecast performance. In parallel to outsourcing arrangements, internal actions are now focused on the most complex, longest waiters to rebalance impact.
The End of Year Target for this measure is 5.0%

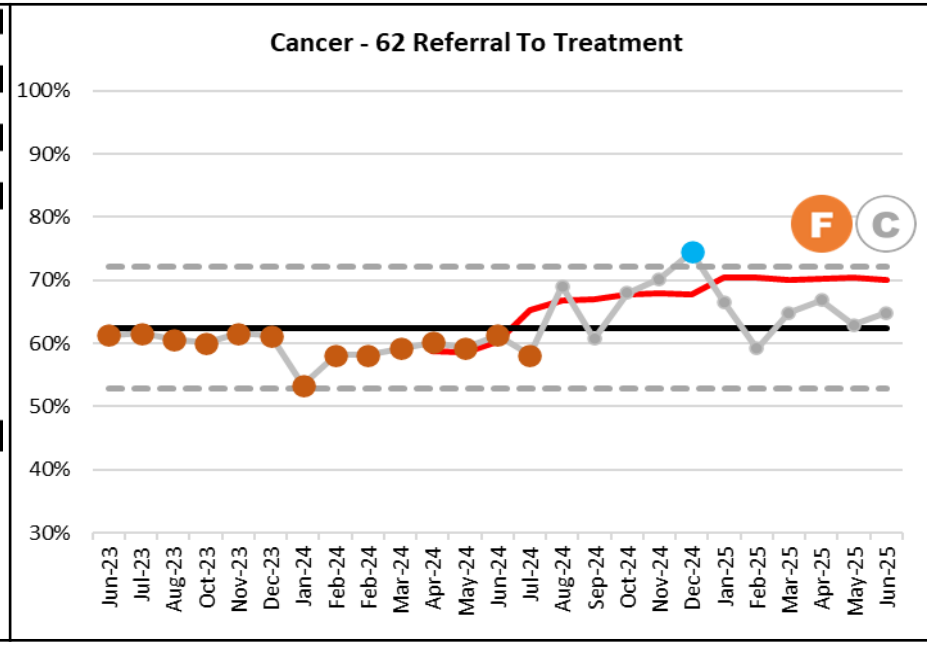
Responsiveness

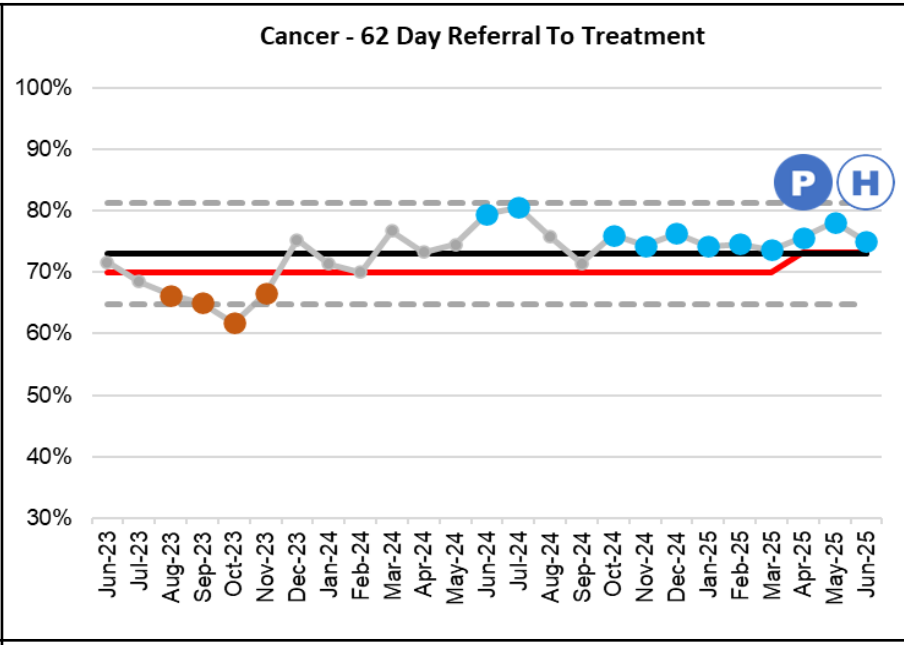
Planned Care – Cancer Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jun-25
Target
70.1%
Latest Month's Position
64.8%
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
Jun-25
Target
73.2%
Latest Month's Position
75.0%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.
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 June. The overall treatment volume was in line with plan however there were more reported breaches. This was driven by Breast and Urology.

Actions being taken to improve
Additionality in Urology Robotic Assisted Laparoscopic Prostatectomy is required to clear local and tertiary workload. Agreed investment into diagnostic capacity, specifically MpMRI.
Additional capacity in all tumour sites is planned to balance demand.

Impact on forecast
Breaches remain high for July; it is expected to improve but remain off trajectory.

No narrative required as per business rules.

Responsiveness

Last Minute Cancelled Operations

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

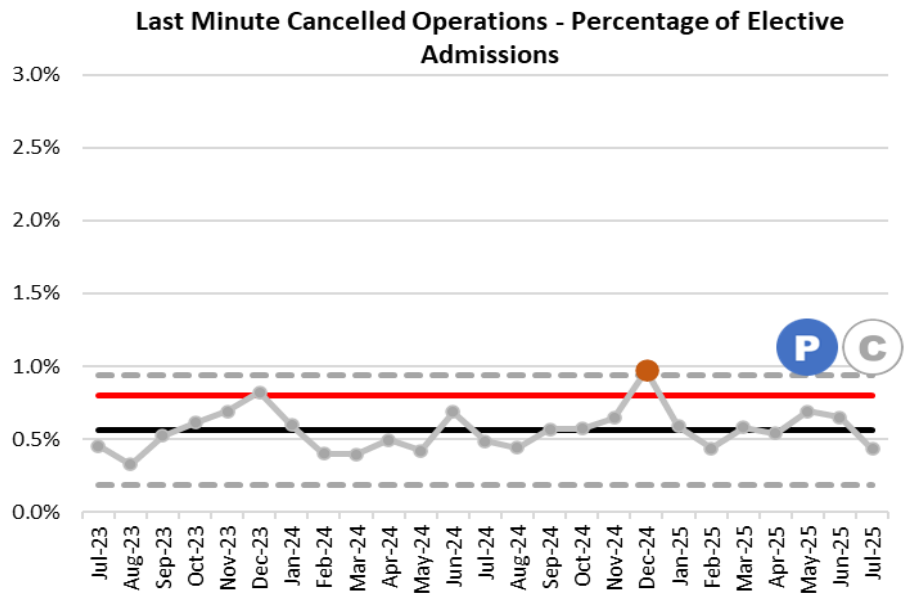
Latest Month
Jul-25

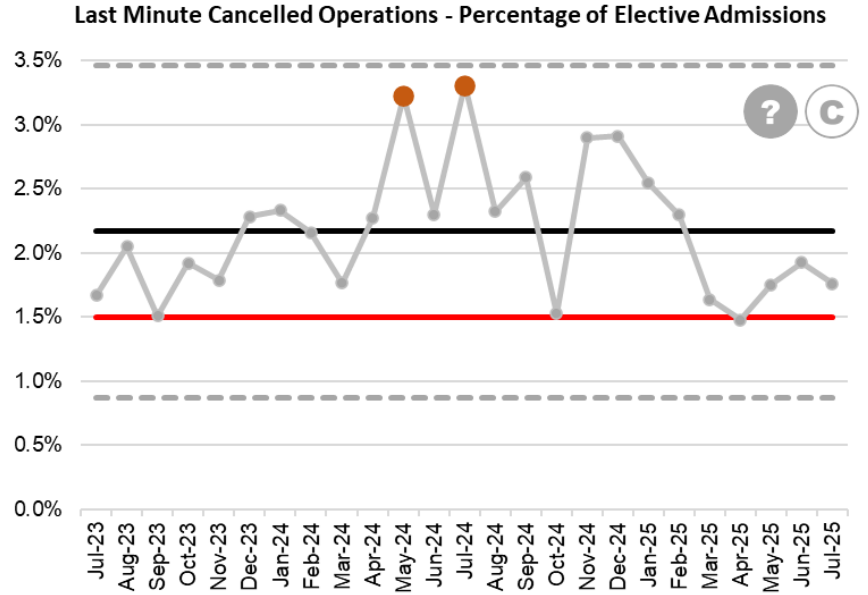
Target
0.8%

Latest Month's Position
0.4%

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
Jul-25

Target
1.5%

Latest Month's Position
1.8%

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

No narrative required as per business rules.

What does the data tell us?
Improvements in data quality and a concerted focus within divisions has contributed towards an improved performance since December 2024 with a slight deterioration across the last two months (1.5% April). During July 2025, there were 155 cancelled operations out of 8,802 total admissions (1.76%) against a target of 1.5%;
47 related to non-surgical specialties (primarily due to no ward beds) and 108 to surgical admissions, which were primarily due to available operating time and rescheduling of cases to prioritise clinically urgent patients.

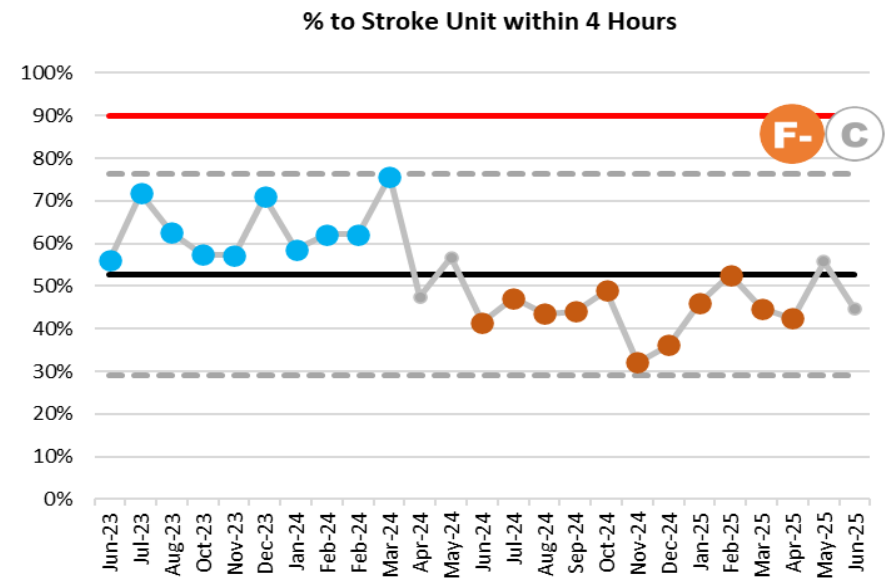
Actions being taken to improve
Actions for reducing last minute cancellations are being delivered by the Trust's Theatre Productivity Programme. As part of this Programme, the Theatre Improvement Delivery Group and Planned Care Group are continuing to work on the data quality associated with this metric. A dashboard is available, with data concerning the timeliness of validation at specialty level. The dashboard is in use across divisions and monitored via Planned Care Group

Impact on forecast
Improvement expected during Q2 2025/26 through focussed management as referenced above.

Responsiveness
Stroke Performance - NBT

Latest Month
Jun-25
Target
90.0%
Latest Month's Position
44.7%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

Trust Level Risk
No Trust Level Risk



What does the data tell us?
There has been a decline in the percentage of stroke patients being admitted to the stroke unit within four hours of arrival.

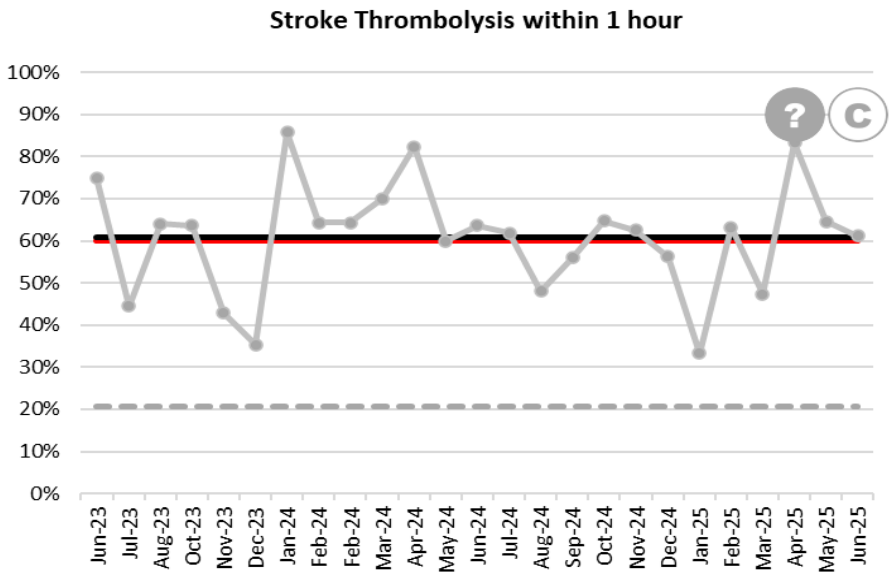
To note, the current national average from the Jan-Mar SSNAP report is 45%.

Actions being taken to improve
The implementation of the revised flow processes to support timely transfers from the Emergency Department to the stroke unit. Additionally in June 2025 there was targeted improvement work within the Stroke Seated Assessment Area to enhance patient flow and reduce delays.

Impact on Forecast
There is ongoing implementation of the improvement plan. High occupancy and ED pressures continue to affect performance.

Latest Month
Jun-25
Target
60.0%
Latest Month's Position
61.1%
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 April there was an improvement in the proportion of stroke patients receiving thrombolysis within one hour of arrival. It is important to note that this data is based on a relatively small number of patients (1-3 per month), and several of the recorded breaches are attributable to valid clinical reasons, such as complex presentations or required diagnostic clarification prior to treatment. June data is slightly reduced but still above the 60% target. Again, noting the low patient numbers.

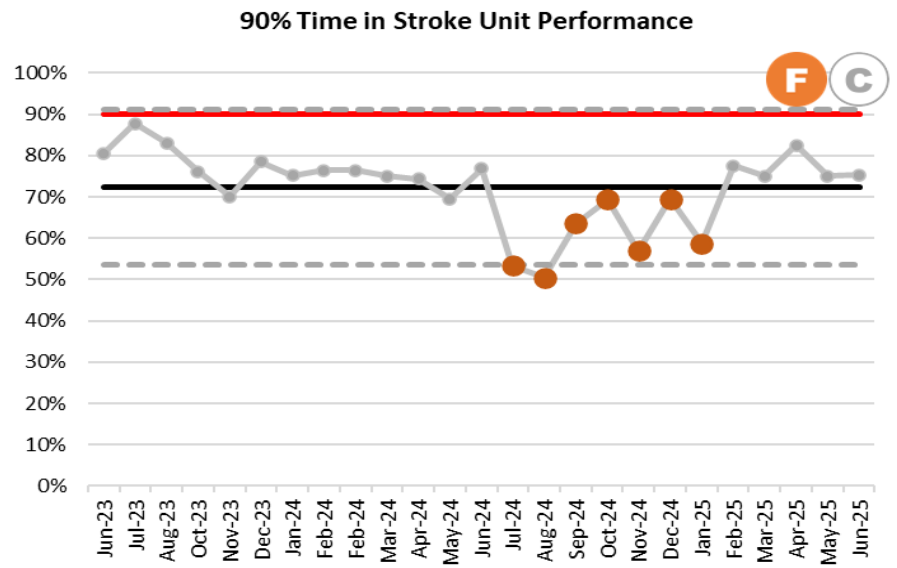
Actions being taken to improve
NBT is one of 12 trusts nationally taking part in the Thrombolysis in Acute Stroke Collaborate (TASC) prestigious programme, aimed at increasing thrombolysis rates and improving door-to-needle times. The programme provides targeted quality improvement support, peer learning, and access to national best practice to help embed sustainable changes within the stroke pathway.

Impact on Forecast
The projected 12-month outcome includes a potential doubling of thrombolysis treatment rates, alongside a significant improvement in average door-to-needle times.

Responsiveness

Stroke Performance - NBT

Latest Month
Jun-25
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

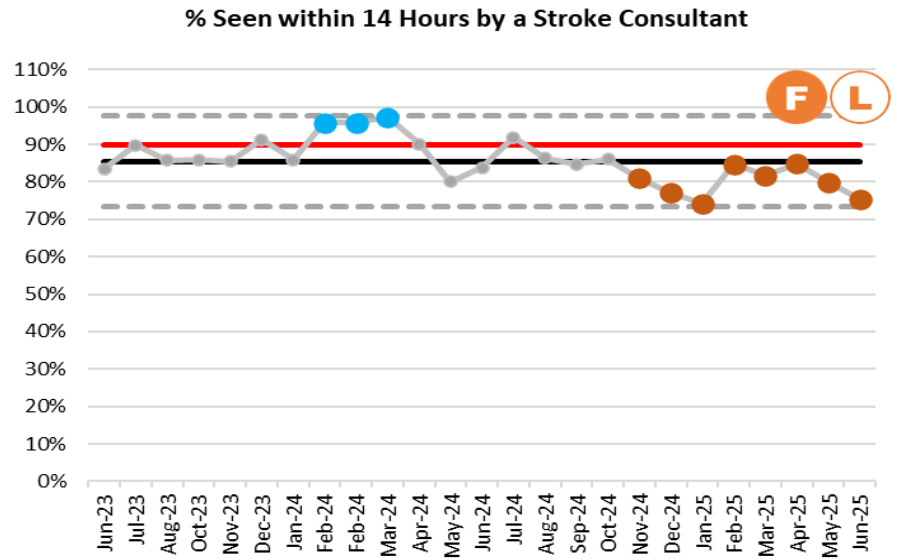


What does the data tell us?
The sustained improvement from February is directly linked to lower, albeit still high stroke occupancy levels, exceeding the modelled bed base of 42. As a result, the number of stroke outliers has decreased, lessening the negative impacts on pathway delivery and specialist care provision.

Actions being taken to improve
Since January 2025, improved flow and fewer NCTR patients have reduced stroke bed occupancy. A contingency plan to cohort outliers was agreed but has not been needed due to sustained improvement.

Impact on Forecast
Current occupancy levels remain at the numbers we have seen since Feb 25' and the sustained improved performance is expected to continue.

Latest Month
Jun-25
Target
90.0%
Latest Month's Position
75.5%
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



What does the data tell us?
There has been a decline in performance in May and June in the percentage of patients reviewed by a stroke consultant within 14 hours of admission.

Actions being taken to improve
Improvements in the sustainability and consistency of the consultant rota have contributed to recent performance gains. From 6/8/25 the HASU board round is moving to a slightly later time to allow earlier PTWR – improving time to consultant reviews for those admitted overnight. Notably, work has been progressed on Careflow proforma development which will better capture data for this metric.

Impact on Forecast
Given current stability in workforce arrangements, and improvements in data capture the strong performance in timely consultant reviews is expected to be maintained.

NHS North Bristol NHS Trust

Quality
Scorecard

NHS University Hospitals Bristol and Weston NHS Foundation Trust

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Safe	Pressure Injuries Per 1,000 Beddays	NBT	Jul-25	0.4	No Target	0.1	N/A	C	Note Performance
		UHBW	Jul-25	0.1	0.4	0.1	P*	C	Note Performance
Safe	MRSA Hospital Onset Cases	NBT	Jul-25	0	0	1	F	C	Escalation Summary
		UHBW	Jul-25	2	0	1	F	C	Escalation Summary
Safe	CDiff Healthcare Associated Cases	NBT	Jul-25	7	5	9	?	C	Escalation Summary
		UHBW	Jul-25	14	9	8	?	C	Escalation Summary
Safe	Falls Per 1,000 Beddays	NBT	Jul-25	6	No Target	6.1	N/A	C	Note Performance
		UHBW	Jul-25	4.9	4.8	3.9	?	C	Escalation Summary
Safe	Total Number of Patient Falls Resulting in Harm	NBT	Jul-25	3	No Target	2	N/A	C	Note Performance
		UHBW	Jul-25	3	2	2	?	C	Escalation Summary
Safe	Medication Incidents per 1,000 Bed Days	NBT	Jul-25	4.2	No Target	5.2	N/A	L	Note Performance
		UHBW	Jul-25	11.0	No Target	9.6	N/A	C	Note Performance
Safe	Medication Incidents Causing Moderate or Above Harm	NBT	Jul-25	2	0	2	F	C	Escalation Summary
		UHBW	Jul-25	1	0	4	F	C	Escalation Summary
Safe	Adult Inpatients who Received a VTE Risk Assessment	NBT	Jul-25	91.1%	95.0%	91.2%	F-	L	Escalation Summary
		UHBW	Jul-25	79.8%	95.0%	74.8%	F-	C	Escalation Summary
Safe	Staffing Fill Rate	NBT	Jul-25	98.6%	No Target	99.9%	N/A	C	Note Performance
		UHBW	Jul-25	105.6%	100.0%	107.1%	P	H	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

North Bristol NHS Trust

Quality
Scorecard

University Hospitals Bristol and Weston NHS Foundation Trust

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	Mar-25	96.6	100.0	97.1	P*	L	Note Performance
		UHBW	Mar-25	88.5	100.0	89.0	P*	L	Note Performance
Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	NBT	Jun-25	52.0%	No Target	47.7%	N/A	C	Note Performance
		UHBW	Jul-25	44.9%	90.0%	37.0%	F-	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	NBT	Jun-25	92.0%	No Target	93.2%	N/A	C	Note Performance
		UHBW	Jul-25	98.0%	90.0%	97.8%	?	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	NBT	Jun-25	46.0%	No Target	37.3%	N/A	C	Note Performance
		UHBW	Jul-25	38.8%	No Target	37.0%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Inpatient	NBT	Jul-25	91.3%	No Target	91.1%	N/A	C	Note Performance
		UHBW	Jul-25	95.7%	No Target	95.7%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Outpatient	NBT	Jul-25	93.6%	No Target	94.6%	N/A	C	Note Performance
		UHBW	Jul-25	94.2%	No Target	94.7%	N/A	C	Note Performance
Caring	Friends and Family Test Score - ED	NBT	Jul-25	70.5%	No Target	70.3%	N/A	C	Note Performance
		UHBW	Jul-25	88.0%	No Target	85.1%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Maternity	NBT	Jul-25	93.7%	No Target	94.4%	N/A	C	Note Performance
		UHBW	Jul-25	96.8%	No Target	98.0%	N/A	C	Note Performance
Caring	Patient Complaints - Formal	NBT	Jul-25	74	No Target	70	N/A	C	Note Performance
		UHBW	Jun-25	78	No Target	54	N/A	C	Note Performance
Caring	Formal Complaints Responded To Within Trust Timeframe	NBT	Jul-25	56.8%	90.0%	62.2%	F	C	Escalation Summary
		UHBW	Jun-25	51.1%	90.0%	51.6%	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 Control

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

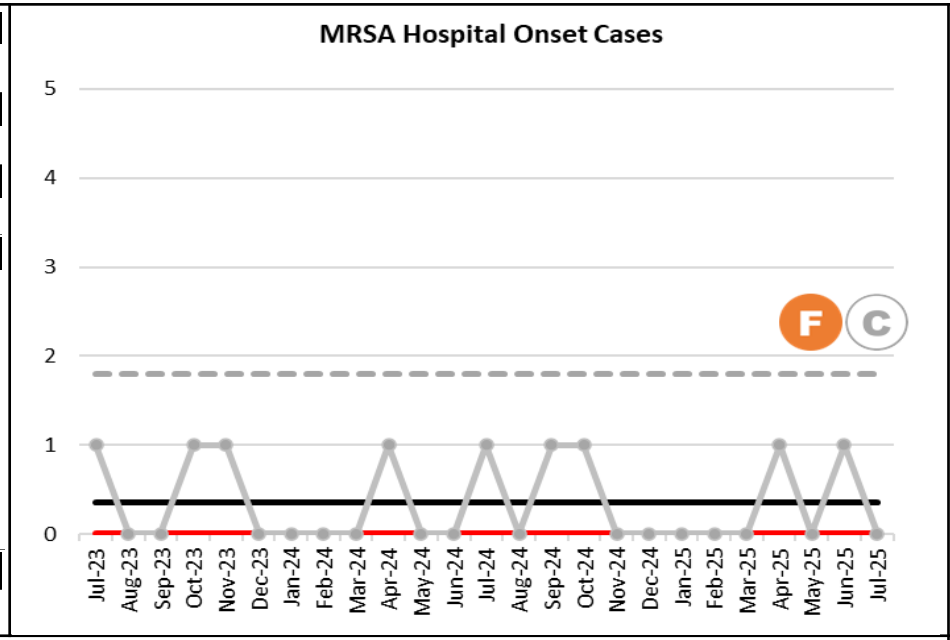
Latest Month
Jul-25

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

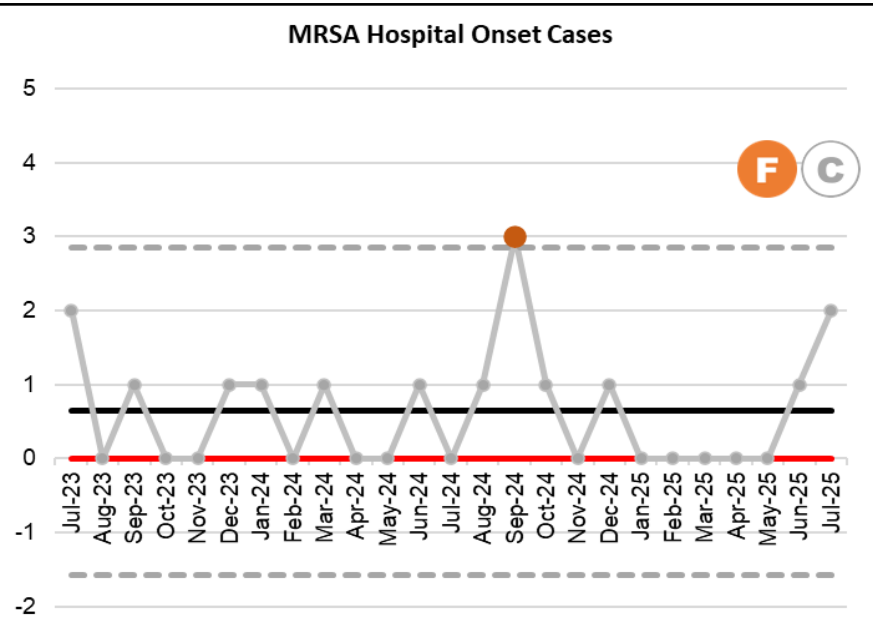


What does the data tell us?
With no new cases reported in July, this totals two this year to date.

Actions taken to improve
The HCAI improvement and reporting group continues to have oversight and monitor potential risk factors. Work continue on influencing factors surrounding screening and decolonisation as well improvements with vascular management, access and education.

NBT will be taking part in some regional improvement work focusing on MSSA and MRSA reduction , learning from all MRSA cases are shared with the ICB

Impact on forecast
The intention is to improve the position with the plans outlined above.



Latest Month
Jul-25

Target
0

Latest Month's Position
2

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

What does the data tell us?
In July there were two cases of MRSA (three year to date). The two July cases are in unrelated locations.

Actions being taken to improve
- Previously reported actions continue using audit data to drive improvements in MRSA compliance and targeted patient screening and decolonisation. Further actions for improvement will follow.
- A quality improvement group has been convened to take forward associated improvement work regarding intravenous (IV) line care.

Impact on forecast
The intention is to continue vigilance and risk reduction interventions to reach and sustain zero cases.

Quality

Infection Control

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

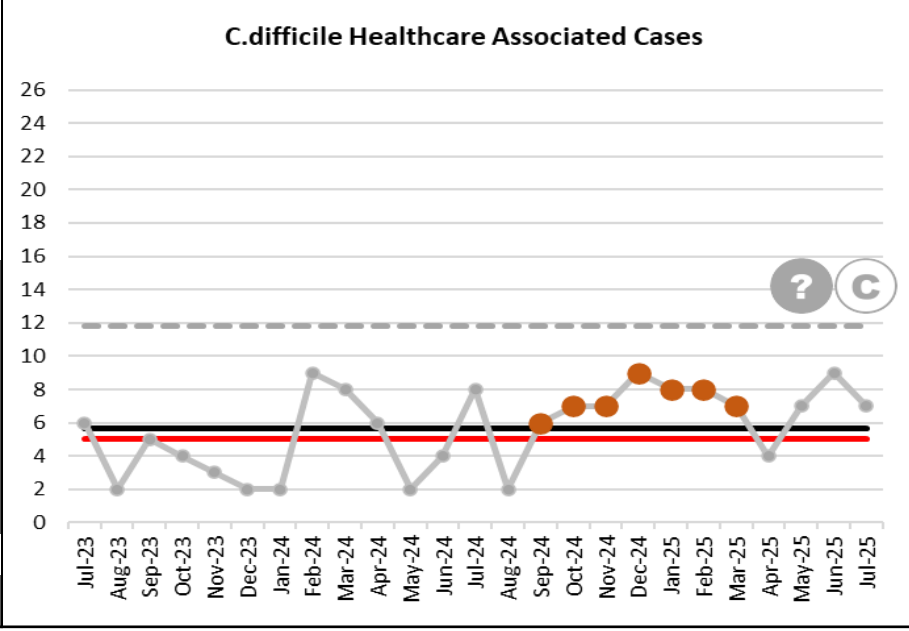
Latest Month
Jul-25

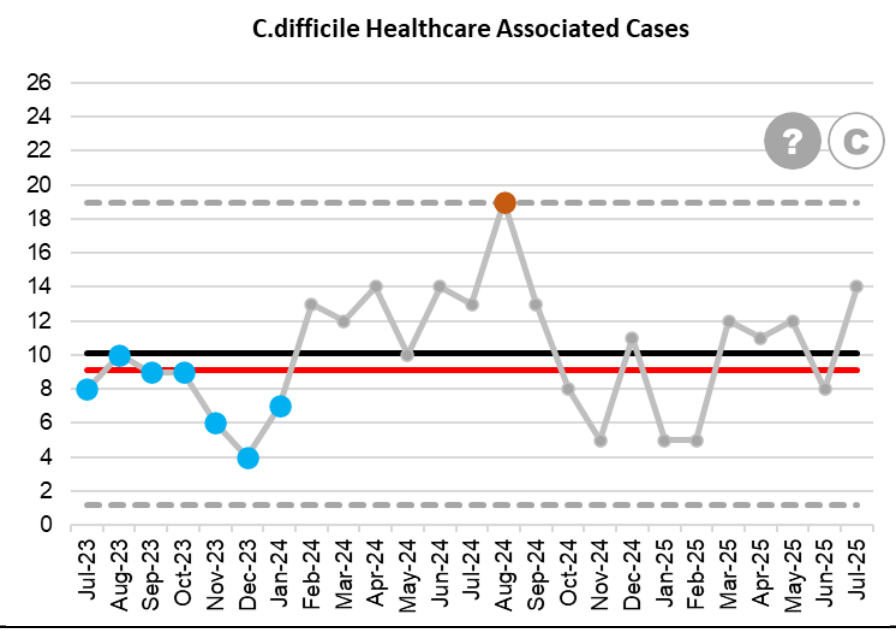
Target
5

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

Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25

Target
9.08

Latest Month's Position
14

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?
Cases in July – 7 HOHA and 3 COHA - cases need to trend at 6 or lower monthly to match a trajectory position. The current position is 3 cases above the trajectory .
Total position so far this year being 38 cases of a trajectory of 79.

Actions being taken to improve
C. difficile targeted plans include adopting weekly C. difficile ward rounds to review microbiologically treated cases, educate, advise and intervene including escalation to microbiology for escalated symptoms and antibiotic management.

Wards that have a cluster of cases have been subject to an enhanced efficacy audit looking at the rectifications and fixing that is required as well as a RED RAG clean, these areas have not seen cases reappear.

Education on sampling and documentation, some issues with digital noting being rectified so documentation is easier and not missed.

What does the data tell us?
There had been 14 reported cases of Clostridium Difficile in July. The breakdown for these is eight HOHA and six COHA giving us a total of 45 year to date. There is some seasonal variation, we had higher case rates during the same period in 2024 with 51 cases in April to July 2024.

Actions being taken to improve
The quality improvement group for C. Difficile continues with remaining actions previously reported to be delivered as 'work in progress'. Antimicrobial stewardship is a key element that should improve as electronic medicines prescribing is implemented from May 2025 facilitating greater scrutiny and collaboration between pharmacy and clinical teams.

Impact on forecast
The UKHSA declared incident relating to a national increases in C. Difficile cases remains, with ICB's having increased scrutiny of community onset cases after acute hospital discharge to improve feedback/learning to acute trusts and better inform actions for improvement. There continues to be an upward trend across the southwest.

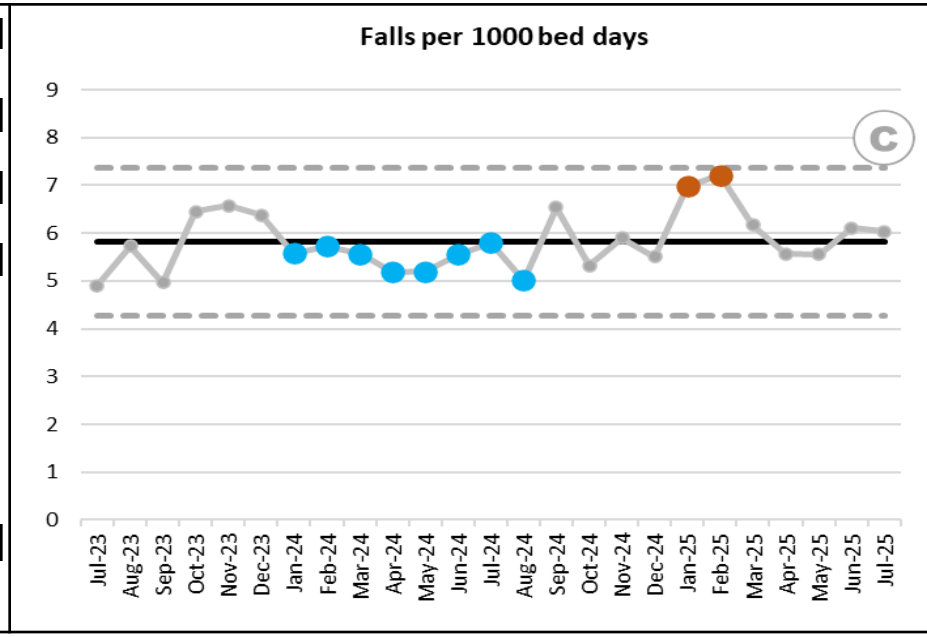
Latest Month
Jul-25

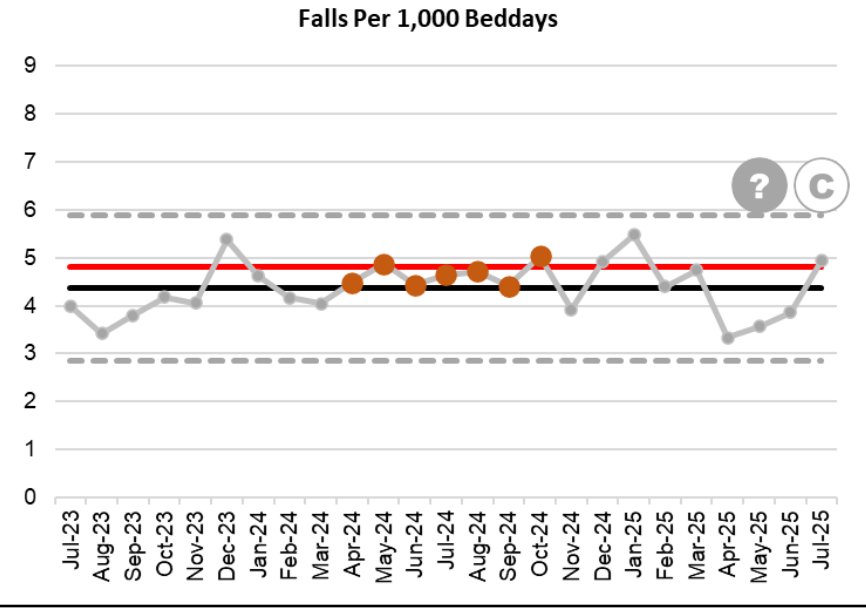
Target
No Target

Latest Month's Position
6

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

Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25

Target
4.8

Latest Month's Position
4.9

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.

Performance:
During July 2025: there have been 168 falls at UHBW (4.94 per 1,000beddays) which is slightly higher than the Trust target of 4.8 per 1000 bed days. There were 108 falls at the Bristol site and 60 falls at the Weston site. There were three falls with moderate physical and/or psychological harm.

What does the data tell us:

- The number of falls in July 2025 (168) is slightly more than June 2025 (127). There are three falls with harm in July 2025, this is higher than the previous month (2).
- 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...

NHS North Bristol NHS Trust

Quality
Falls

NHS University Hospitals Bristol and Weston NHS Foundation Trust

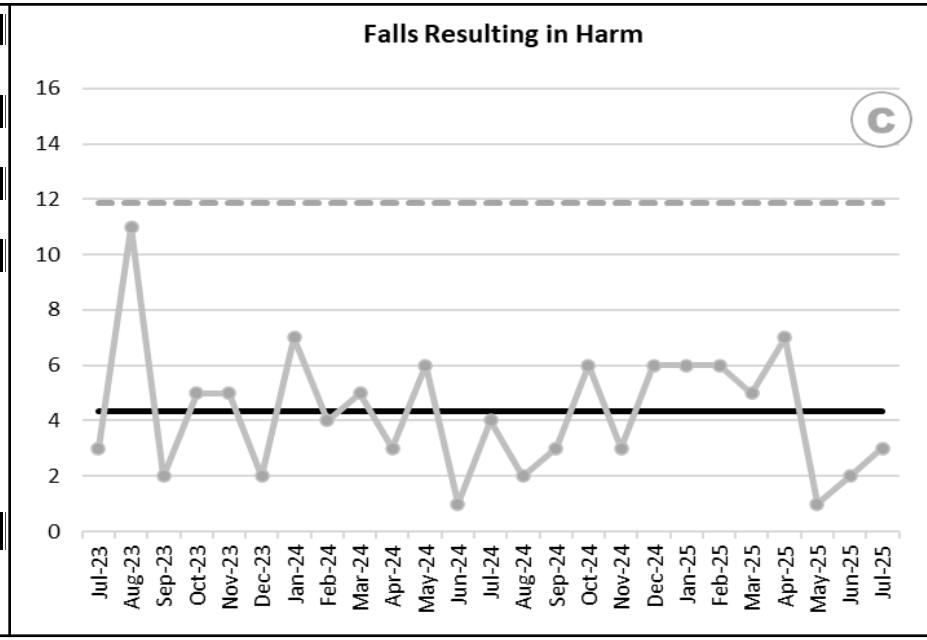
Latest Month
Jul-25

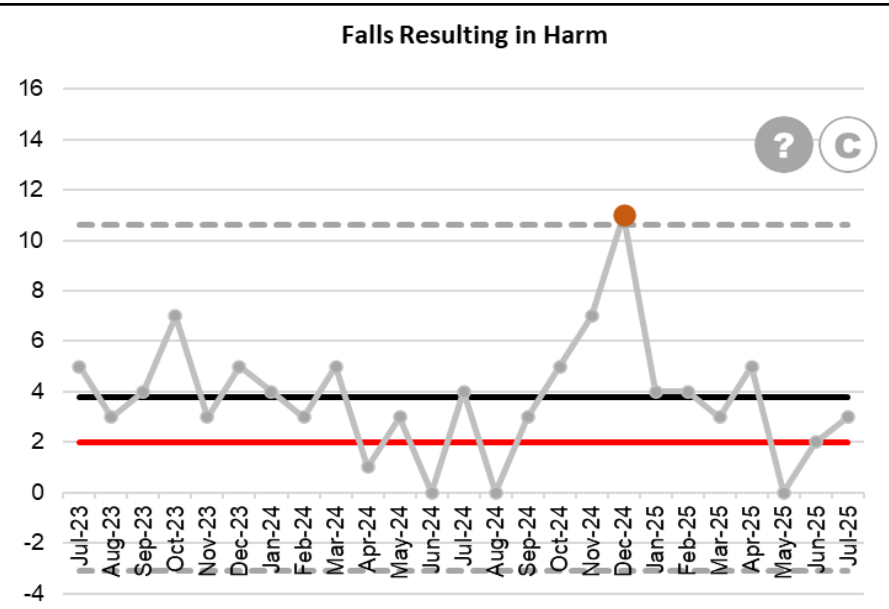
Target
No Target

Latest Month's Position
3

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

Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25

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.

…Continued from previous slide

Actions being taken to improve:

- An increase in falls in Weston has been investigated and additional learning around catheter care, continued completion of Multi-Factorial Risk Assessment and supporting patients who present with alcohol withdrawal has been identified.
- Audit: We are participating in the National Audit of Inpatient Falls, the audit is expanding to include hip fractures, head injury, spinal injury or any fracture from an inpatient fall. This may provide new national and local insights for improvement.
- NICE have published NG249 - Falls; assessment and prevention in older people and people 50 and over at higher risk. A compliance self-assessment report has been completed. Gap analysis was shared at the Trust Clinical Effectiveness Group and projects around identified gaps will be implemented over the next 12 months.
- 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

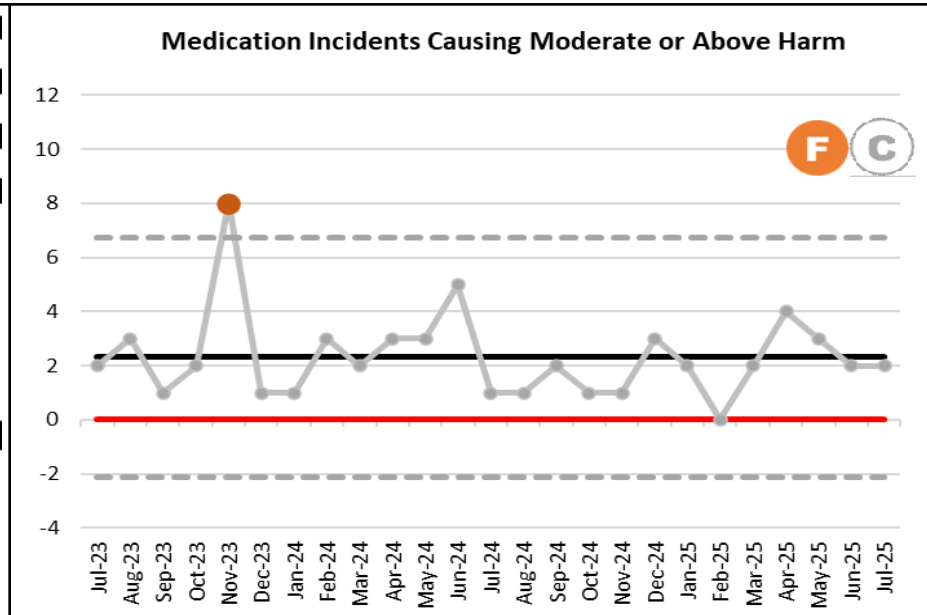
Medication Incidents

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
0
Latest Month's Position
2
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)

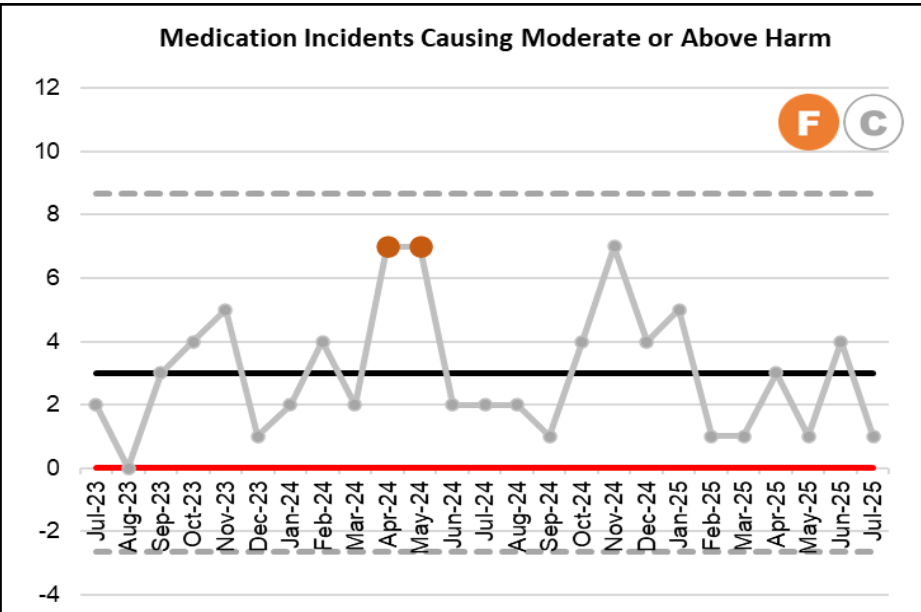


What does the data tell us?
During July 2025, NBT recorded 132 medication incidents. Two medication incidents were reported as causing moderate or above harm.

The move from Radar to Datix for incident reporting during July may have an impact on incident reporting and data analysis. This may limit ability to identify trends for July.

Actions being taken to improve
Over the past few months, the Medicines Governance Team and Patient Safety team have been taking stock of the success of, and challenges faced by the Medicines Safety Forum. At present the monthly meetings have been paused to reflect on the learning to date, gather feedback from group members and senior Trust staff and to agree a strategy moving forward which harnesses the enthusiasm of group members and allows us to focus on a streamlined set of agreed priorities. An initial meeting with senior stakeholders has taken place and actions from this are currently being undertaken.

A resource proposal detailing the Pharmacy staffing required to support medicines safety improvement work going forward is being written for sharing with colleagues.



Latest Month
Jul-25
Target
0
Latest Month's Position
1
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)

What does the data tell us?
During July 2025, UHBW recorded 375 medication related incidents. One medication incident was recorded as causing moderate, or above harm.
Following additional harm validation, the number of incidents causing moderate or above harm in June was increased from three to four. This is reflected in the graph above.
The dataset pre-April 2024 is based on previous harm descriptors in place in the Trust. The data indicates a good reporting culture with a low percentage of harm incidents (0.97%) compared to number of incidents.

Actions being taken to improve
- Medication incidents are reviewed by the UHBW medication safety team. Incidents are identified for enhanced learning response according to the Patient Safety Incident Response Plan. No specific themes have been identified from the low number of medication incidents associated with moderate and above harm following review at the multidisciplinary Medicines Governance Group. The implementation of Careflow Medicines Management will help reduce some risks associated with medicines use.
- Specific learning is shared across the Trust via the Medicines Safety Bulletin and with BNSSG system colleagues via system medicines quality and safety meetings. This report has been developed collaboratively by the UHBW and NBT medicines safety teams. This takes advantage of the new joint Hospital Group Medication Safety Officer role.

North Bristol NHS Trust

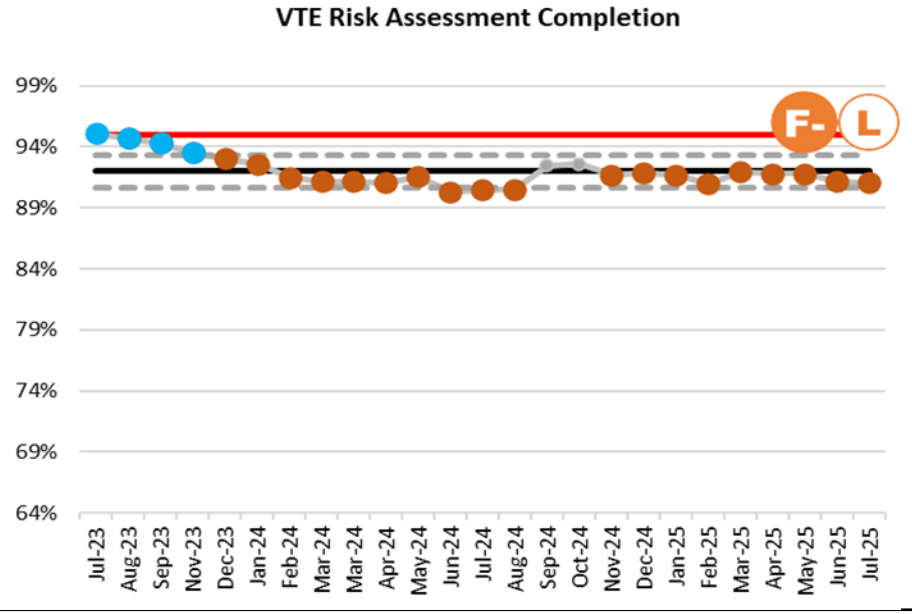
Quality

VTE Risk Assessment

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
95.0%
Latest Month's Position
91.1%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit

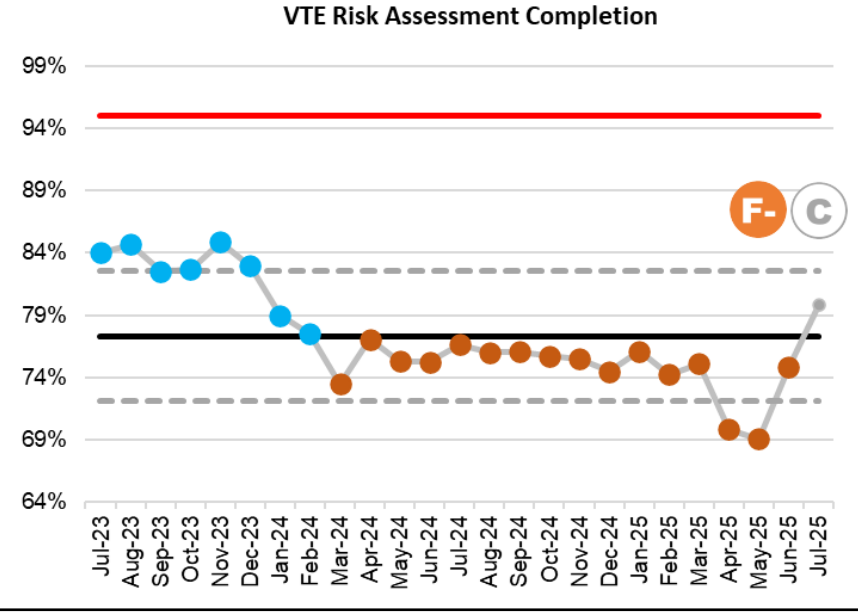
Trust Level Risk
No Trust Level Risk



What does the data tell us?
VTE risk assessment completion is improving slightly. In June 2022, there was a noticeable dip in VTE RA compliance. An audit of patient notes revealed that VTE forms were not consistently completed.

Actions that are being taken to improve
In February 2023, a pilot of a VTE digital assessment took place; this was successful and was thus rolled out across the Trust in July 2023. Reasons for the drop in compliance are linked to the hybrid clerking process, with 'main clerking' on paper and VTE RA digital, and we are working towards improving compliance with regular audit, teaching, and reminders typed into Careflow. Audit is undertaken, ad hoc, on the wards. VTE prophylaxis appears to be 100% prescribed; however, errors in the dose of Enoxaparin are not uncommon – this seems to be related to a lack of visible weight. Consequently, a decision was made at the Safe Care Group that all weights MUST be recorded digitally. Compliance against this has been included in the 2nd round of questions, as part of the Clinical Accreditation Programme

Impact on forecast
In October 2025, when the Careflow Medicine Management Programme (CMM, e-prescribing) is launched, completion of the VTE RA will become a 'forcing' measure. It is projected that this will improve compliance.
In the meantime, the VTE team constantly reviews the requirements for a VTE RA for individual patients, identifies cohorts of patients who do not require a VTE RA, and ensures that the data collection is accurate.



Latest Month
Jul-25
Target
95%
Latest Month's Position
79.8%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration.

Corporate Risk
No Corporate Risk

What does the data tell us?
Since the launch of Careflow Medicines Management (CMM) at UHBW in summer 2025, VTE risk assessment completion is slowly increasing with July reported at almost 80%. We expect this to continue to rise as staff become familiar with the new system and as more wards adopt a mandatory approach. However, despite the improvement in risk assessment completion, we have observed an unexpected reduction in VTE prophylaxis prescribing. This has emerged as CMM has been rolled out across the organisation. In response, we have raised a new risk (Risk 8448): *Risk that VTE prophylaxis is not prescribed when indicated*. A human factors analysis has identified key contributing factors and targeted actions have been developed to address these issues and strengthen existing controls.

Actions being taken to improve
Human factors analysis of the contributing factors to this new risk has identified key actions are to close the gaps in controls related to the new VTE prescribing risk have been identified. These have been worked through and presented to Patient Safety Group,
Additional work is being undertaken with the BI team in order to target interventions

Impact on forecast
We expect the overall VTE risk assessment completion to continue to improve over the coming months.

NHS North Bristol NHS Trust

Quality

Neck of Femur

NHS University Hospitals Bristol and Weston NHS Foundation Trust

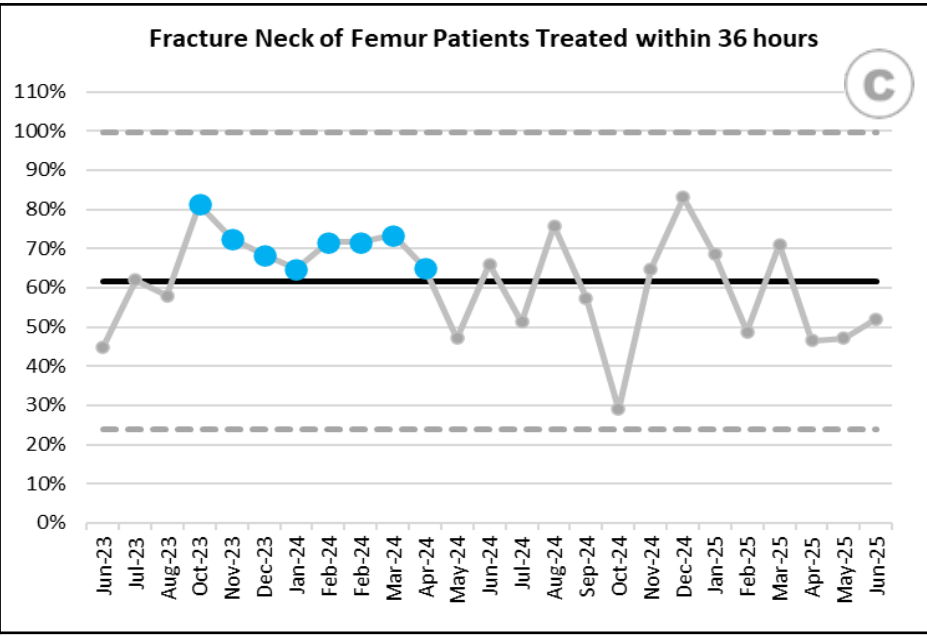
Latest Month
Jun-25

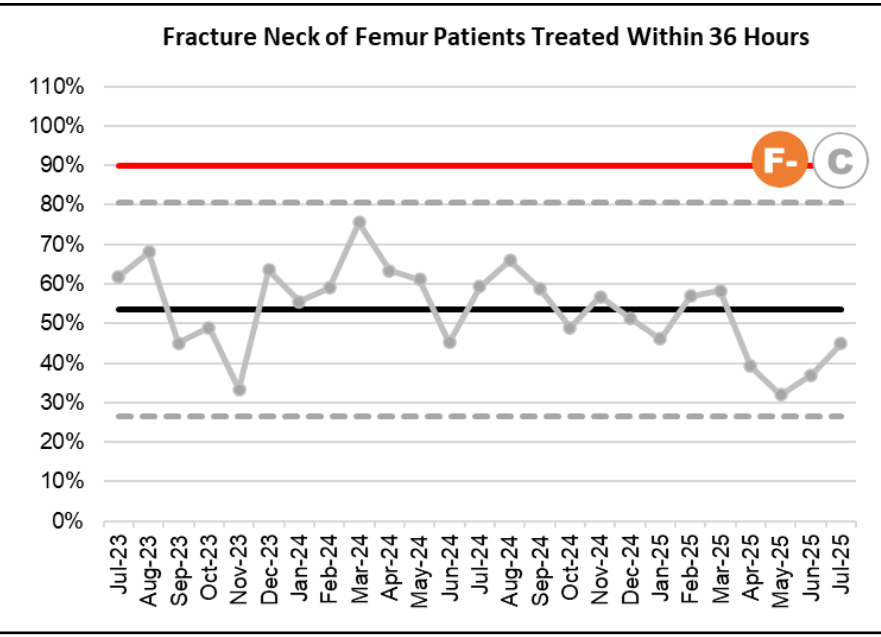
Target
No Target

Latest Month's Position
52.0%

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
Jul-25

Target
90.0%

Latest Month's Position
44.9%

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?

Weston / BRI July Best Practice Tarriff (BPT) Data (Fractured Femur): 49 patients eligible for Best Practice Tariff (BPT) of which 38% (19/49) met all BPT criteria, 45% (22/49) underwent surgery within 36 hours of admission, 98% (48/49) received ortho-geriatric assessment within 72 hours.

The reason for the missed target include: 24 patients missed the 36-hour surgery target due to a lack of theatre space and additionally due to clinical delays- medical optimisation(1) , diagnostic clarification (1), DOAC-related anaesthetic delay (1) and documentation gaps (3 missing pre-operative 4AT assessments).

Actions being taken to improved

- Clinical pathways reviewed in governance meetings to streamline pre-operative optimisation and imaging decisions.
- Anaesthetic protocols being updated to better manage patients on anticoagulants.
- Theatre scheduling - extra theatre space is created where possible to reduce delays.
- Staff education to ensure consistent completion of pre-operative 4AT assessments

Impact on forecast

Documentation improvements alone could immediately boost compliance by ~19% (3 patients).

Operational efficiencies may reduce delays, improving time-to-surgery rates and overall patient outcomes.

North Bristol NHS Trust

Quality

Neck of Femur

University Hospitals Bristol and Weston NHS Foundation Trust

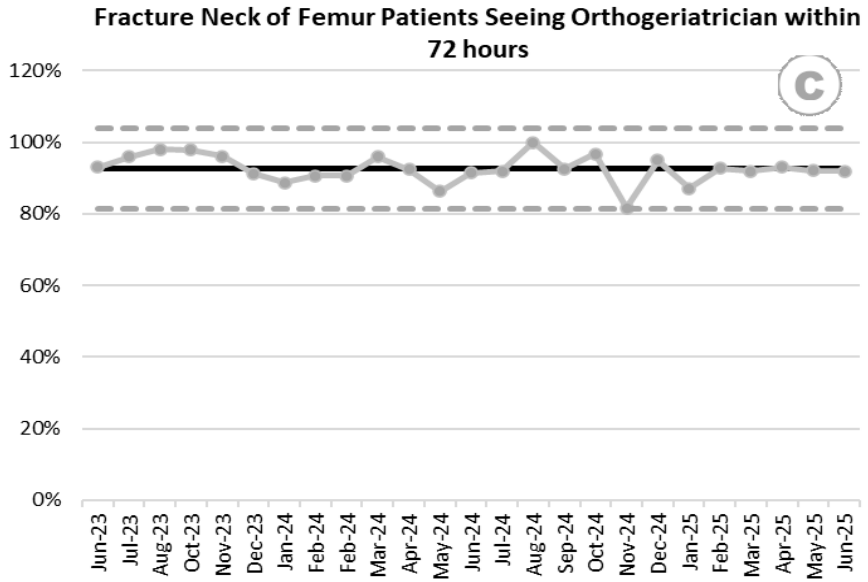
Latest Month
Jun-25

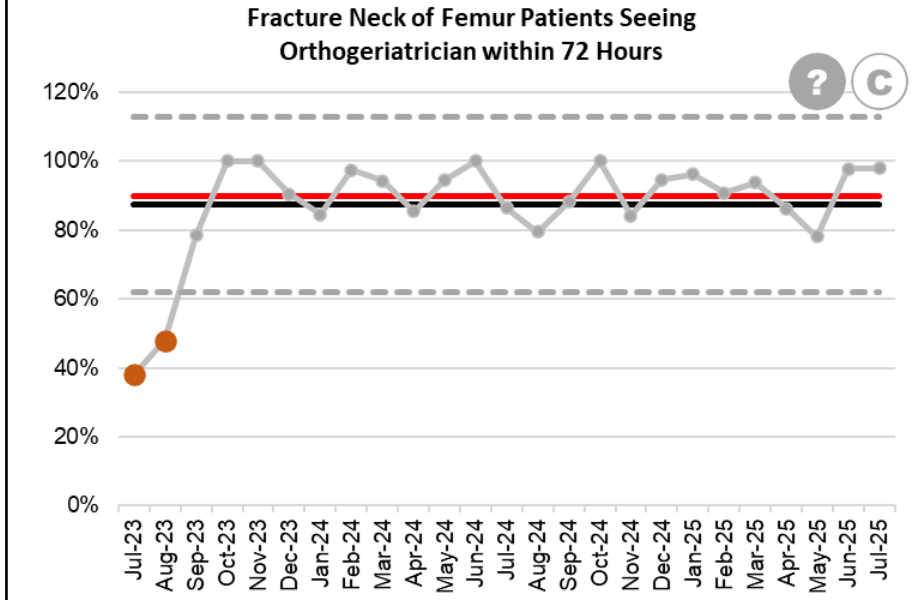
Target
No Target

Latest Month's Position
92.0%

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
Jul-25

Target
90%

Latest Month's Position
98.0%

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?

- There has been an increase in the percentage of patients reviewed by an ortho-geriatrician with 72 hours to 98% (48/49 patients) above the 96% standard in June.
- One patient at the BRI missed time to Ortho-geriatrician review due to the bank holiday weekend when they were first admitted in May.

NHS North Bristol NHS Trust

Quality

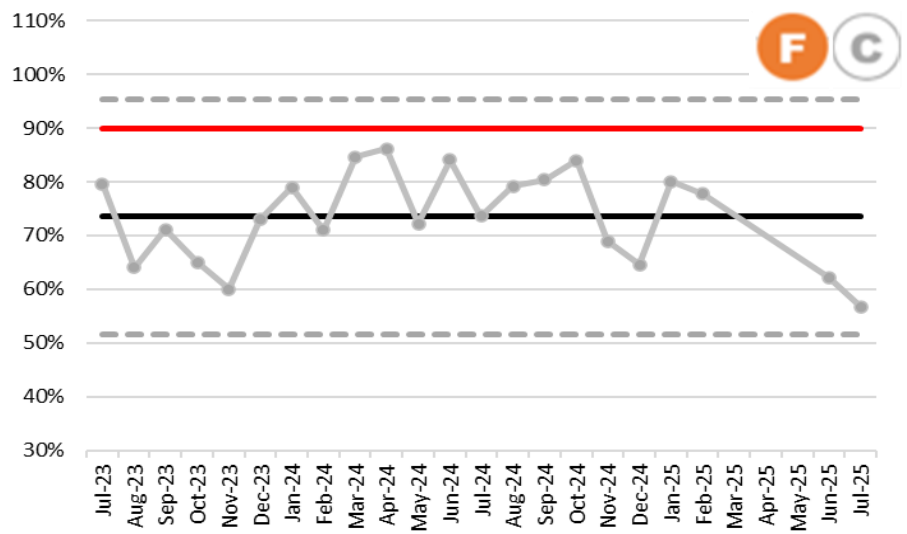
Complaints

NHS University Hospitals Bristol and Weston NHS Foundation Trust

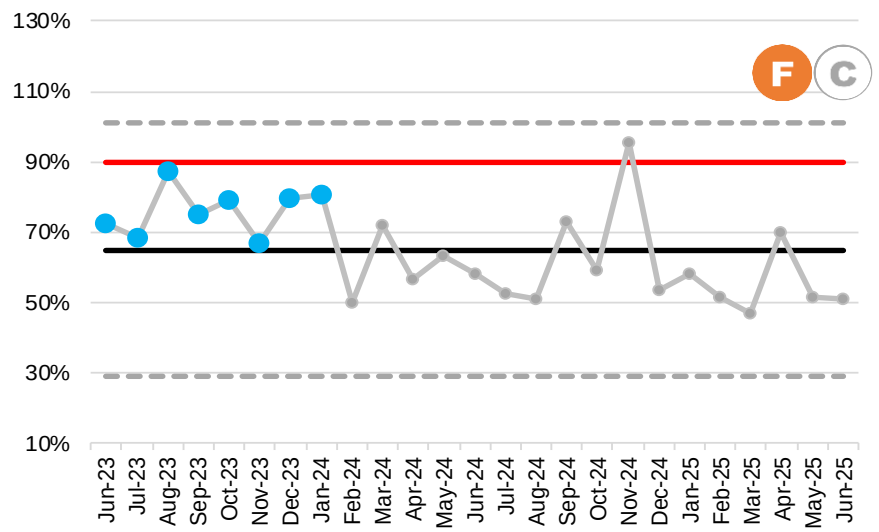
Latest Month
Jul-25
Target
90.0%
Latest Month's Position
56.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

Trust Level Risk
No Trust Level Risk

Formal Complaints Responded to Within Trust Timeframe



Formal Complaints Responded To Within Trust Timeframe



Latest Month
Jun-25
Target
90.0%
Latest Month's Position
51.1%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.
Corporate Risk
Risk 2680 - Complainants experience a delay in receiving a call back (12)

What does the data tell us?

- The compliance rate for formal complaints responded to within the agreed timeframe is below the 90% target, with a decrease from 62% in June to 57% in July.
- Of the 74 complaints due for response in July, 42 were closed within the agreed timescale, 18 were outside the agreed timescale and 14 were still open at the time of reporting.
- ASCR's compliance rate was notably the lowest across all divisions, which had a significant impact on the overall Trust score. If ASCR's performance had matched that of the next lowest division, the overall Trust score would have risen to around 77%.
- The number of formal complaints being received remains high. 74 complaints were received in July, which is 15 more than the same period last year.

Actions being taken to improve

- A meeting has been arranged with the ASCR senior team to discuss compliance and how this can be improved.
- The Complaints/PALS Manager continues to hold weekly meetings with divisional patient experience teams to review upcoming and overdue cases, addressing complexities and agreeing appropriate resolutions, including proportionate extensions where appropriate. A weekly complaints tracker is shared with senior divisional leaders to escalate overdue complaints and support timely resolution.

Impact on forecast

Divisions continue to prioritise timely complaint resolution, balancing this with the limits of available capacity. We will continue to closely monitor compliance scores across all divisions to understand any issues which may impact the compliance score returning to above the mean.

What does the data tell us?

51% (23/45) of complaints responses sent out by UHBW in June were within the agreed deadline.

Actions being taken to improve

77% (78/101) of responses to PALS concerns sent out by the Trust in June were within the agreed timescale. This category includes cases which until 31/3/25 were categorised by UHBW as informal complaints. UHBW actively encourages informal resolution, where appropriate, to provide enquirers with faster responses to their questions. Reasons why complaints are not responded to within agreed deadlines are multi-factorial and were explored as part of a 'deep dive' report to the Quality and Outcomes Committee in June. These include clinicians' capacity, the increasing complexity of complaints received, and current gaps in key divisional complaints support roles. Benchmarking also shows that many trusts are working to longer timescale for more complex complaints, typically up to 60 working days. The trust is exploring how digital/AI technology might support complaints resolution in the future.

Impact on forecast

Based on the current standard timescale of 35 working days, it is likely that in the short term the timeliness of complaints responses will remain below target due to the stated challenges.

North Bristol NHS Trust

Our People

Scorecard

University Hospitals Bristol and Weston NHS Foundation Trust

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Well-Led	Workforce Turnover Rate	NBT	Jul-25	10.4%	11.3%	10.5%	P	L	Note Performance
		UHBW	Jul-25	9.3%	11.1%	9.6%	P*	L	Note Performance
Well-Led	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	NBT	Jul-25	8.1%	5.1%	7.3%	F-	C	Escalation Summary
		UHBW	Jul-25	2.8%	4.0%	2.6%	P	C	Note Performance
Well-Led	Sickness Rate	NBT	Jul-25	4.6%	4.4%	4.6%	F-	L	Escalation Summary
		UHBW	Jul-25	4.5%	4.5%	4.3%	P	C	Note Performance
Well-Led	Essential Training Compliance	NBT	Jul-25	84.3%	85.0%	83.6%	?	C	Escalation Summary
		UHBW	Jul-25	85.1%	90.0%	85.1%	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

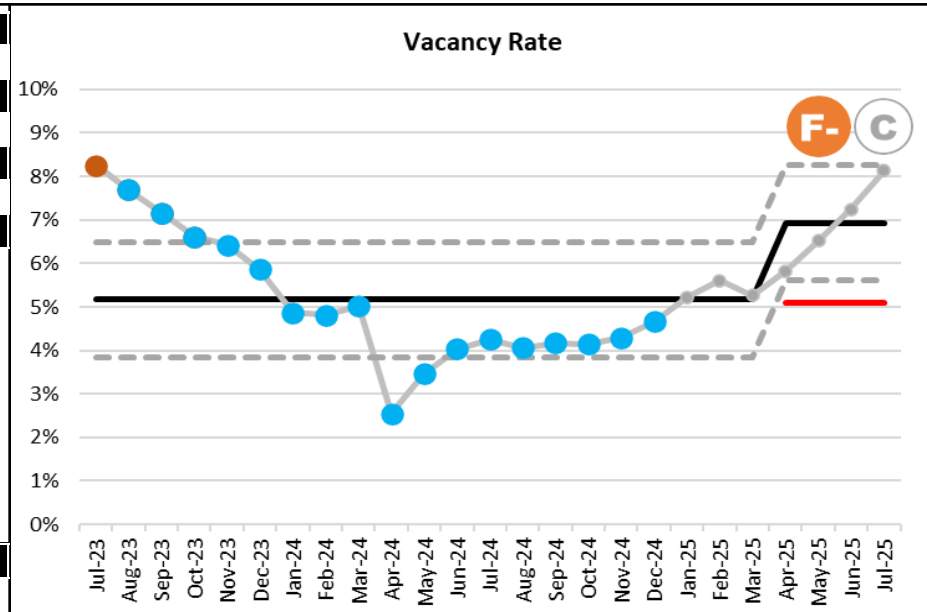
Our People

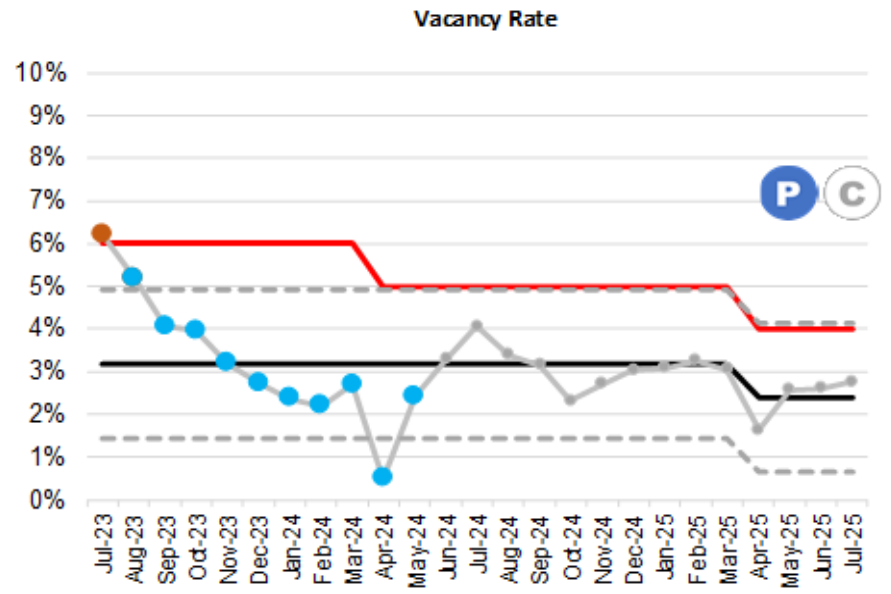
Vacancies

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Jul-25
Target
5.1%
Latest Month's Position
8.1%
Performance / Assurance
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
Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25
Target
4.0%
Latest Month's Position
2.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is improvement.
Corporate Risk
No Corporate Risk

What does the data tell us?
The vacancy factor is in exception based on the SPC business rules as the target position represents our Mar-26 year-end position which balances out Bristol Surgical Centre and Headcount Reduction changes which will impact throughout the year. Overall vacancies have increased in June by 94 wte predominantly in Nursing and Midwifery, Allied Health Professionals, Healthcare Scientists and Estates and Ancillary relating to funded establishment increased associated with Safe Staffing, Bristol Surgical Centre and Business Cases.

Actions being taken to improve
For registered nursing and midwifery work is in progress to receive our intake of undergraduate newly qualified nurses in September along with other work streams to strengthen our registered and unregistered pipelines. Bristol Surgical Centre working group and resourcing plans remain in place to deliver resource required .

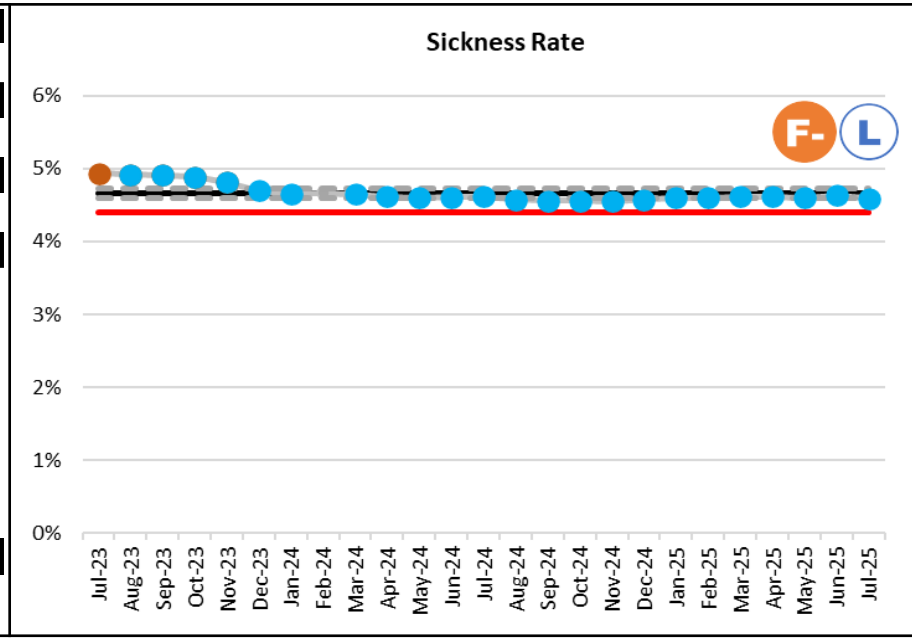
No narrative required as per business rules.

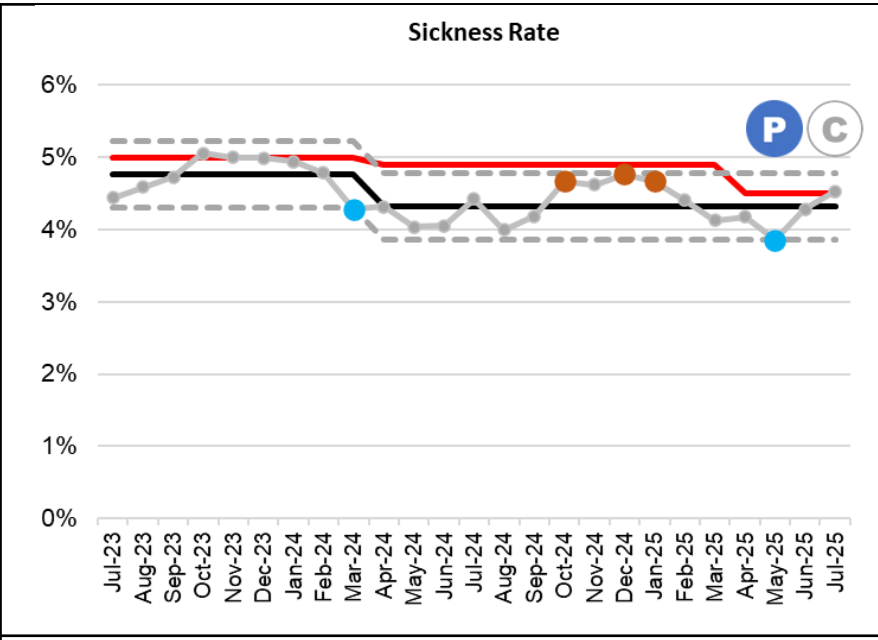
Our People

Sickness Absence

Latest Month
Jul-25
Target
4.4%
Latest Month's Position
4.6%
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit

Trust Level Risk
No Trust Level Risk





Latest Month
Jul-25
Target
4.5%
Latest Month's Position
4.5%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is improvement.
Corporate Risk
No Corporate Risk

What does the data tell us?
The Trust rolling 12-month sickness absence rate has shown statistically significant improvement but have plateaued at 4.6% against an ongoing target of 4.4%. Our in-month position for Jul-25 is 4.2%.

Actions being taken to improve
People Advice Team working with Divisional People Business Partners to embed a more risk-tolerant approach to case management to resolve complex and long-term sickness absence cases. Redeployment and Pay Protection policies to be aligned across the Group to provide further avenue for resolution of cases. New review process for longest (100 day+) long term cases to be stood up between People Advice Team and Divisional Management, to ensure all avenues explored.

NBT Staff Health and Wellbeing Plan launched 14th July with trust wide communications. Active Care Pilot in NMSK July – September – EAP Health Assured provides a support call for staff absent due to Stress and Anxiety in first two weeks of absence continuing.

- EAP contract conducted a full procurement process new KPI's introduced including increase in utilisation rates from 9% to 15% in the next 12 months.
- Two new quick reference guides presenting mental health support offer in 3 categories: Proactive Preventative Responsive supporting managers to identify appropriate support for colleagues.

The impact of these interventions will start to be analysed through our Operational Planning Process for 2026/27 which will begin in Autumn 2025.

No narrative required as per business rules.

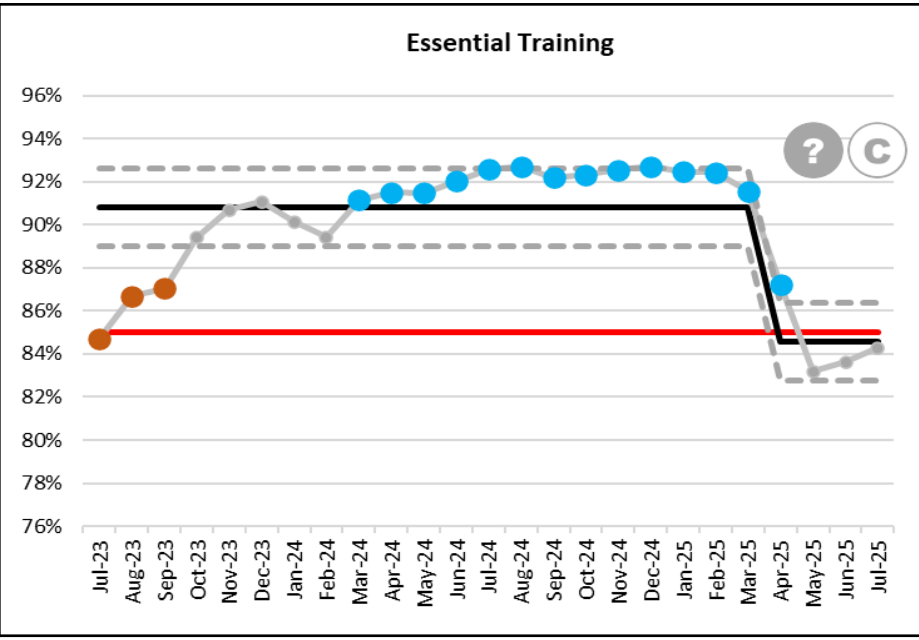
NHS North Bristol NHS Trust

Our People

Mandatory and Statutory Training

NHS University Hospitals Bristol and Weston NHS Foundation Trust

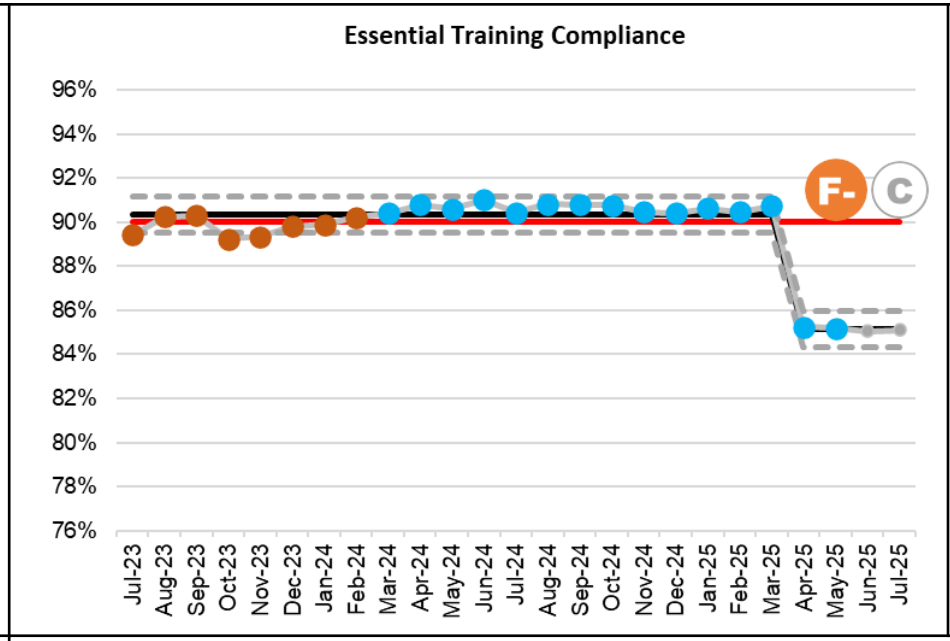
Latest Month
Jul-25
Target
85.0%
Latest Month's Position
84.3%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk



What does the data tell us?
Overall compliance is below the 85% target at 83.4% (87.01 permanent staff, 64.73% fixed-term temp, and 75.7% other staff). Subjects negatively impacting our compliance rates are: Oliver McGowan at 51.63%, Resuscitation at 82.22%, Preventing Radicalisation at 83.98%, and Information Governance at 84.15%. Staff absences, reduced training releases, and OPEL 4 escalations have impacted compliance. Despite offering three extra BLS sessions, only five staff attended. Resus team does not currently deliver Level 2 Paediatric BLS course.
Aggregate compliance for Oliver McGowan is 51.63%, below our target of 85%. Level 1 e-learning is 85.01%, level 2 is 25.05%, and the level 1 webinar is 7.2%. Resuscitation compliance is low at 82.22% (81.84% level 2 adult, 80.41% level 3 newborn, 57.14% level 1, 41.27% level 2 paediatric.

Actions being taken to improve
Compliance rates for Oliver McGowan Mandatory Training are steadily increasing, driven by access to Tier 1 webinars and Tier 2 face-to-face sessions. While BNSSG ICB works to expand capacity, but system capacity remains sufficient to meet NHSE KPIs by March 2026. From September, more sessions will be held locally, with Tier 1 webinars increasing to three per day. Efforts continue to address barriers and boost uptake, including collaboration with the BNSSG ICB training team for bespoke and face-to-face Tier 1 sessions and ringfenced on-site Tier 2 spaces at NBT. Commitment to expanding training access and increasing participation remains a priority in 2025/26.
Resuscitation - Request support from Directors of Nursing for frontline staff to attend under-capacity training. Offer courses to non-attendees from previous BLS courses, and who are now >6 months overdue. Ascertain training facilitators and barriers to Level 2 Paediatric BLS provision.

Recommendation
Align the Trust level compliance targets across the group – this will be presented in a wider paper on IQPR metrics to the September Group People Committee



Latest Month
Jul-25
Target
90.0%
Latest Month's Position
85.1%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration.
Corporate Risk
No Corporate Risk

What does the data tell us?
The inclusion of the Oliver McGowan training compliance aggregate rate has impacted overall compliance, resulting in a decrease of -5.3% for the overall core skills rate, now sat at 85.1%, below the target of 90%. Additional core skills titles, information governance, moving and handling, and resuscitation are below target rate, which is 90% for all titles except information governance which has an exception rate of 95%

Actions being taken to improve
Oliver McGowan compliance rates continue to rise on a monthly basis, as more staff can access the webinar or face to face training. Of the three Oliver McGowan titles, eLearning compliance sits at 81.1%, tier 1 attendance at 19.5% and tier 2 attendance at 36.8%. Training capacity within the ICB to deliver the Oliver McGowan continues to grow whilst training places are heavily in demand, however there remains a level of DNA's reported within the data (although this is declining).

Impact on forecast
The BNSSG training provider working to increase capacity will support compliance improvements and the target of 30% system compliance for tier 1 and tier 2 compliance is set to hit 30% by the end of August 2025. Including tier 1 and tier 2 compliance in the data will serve to focus on and address areas of low compliance.

Income & Expenditure

Actual Vs Plan (YTD)

Latest Month

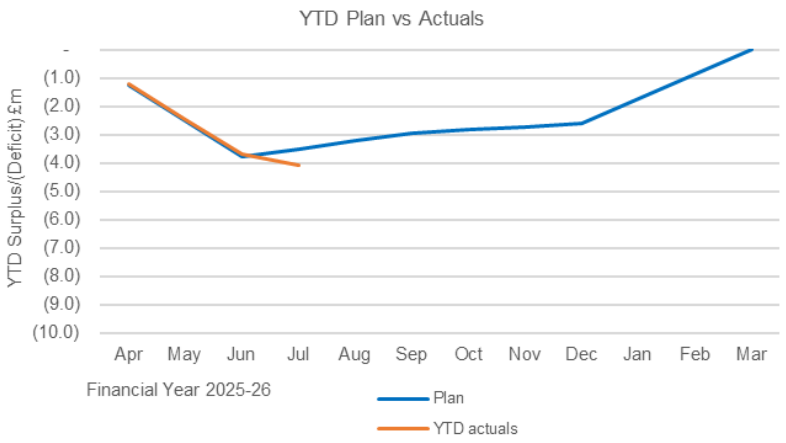
Jul-25

Year to Date Plan

£(3.5m) deficit

Year to Date Actual

£(4.1m) deficit



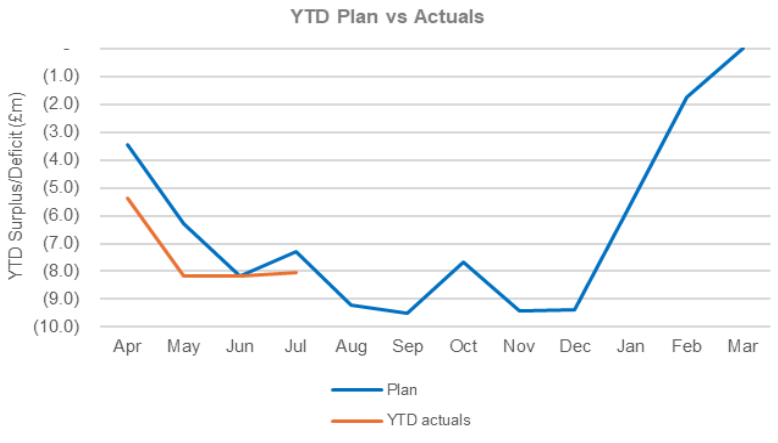
Summary

Summary:

- The financial plan for 2025/26 in Month 4 was a surplus of £0.3m. The Trust has delivered a £0.4m deficit and is £0.7m adverse to plan. Year to date the Trust has delivered a £0.6m adverse position to a £3.5m deficit plan.
- The Trust saw additional costs of £0.6m in Month 4 in relation to the Resident Doctor industrial action for five days. The Trust does not expect to receive further funding from NHSE to offset these costs, hence, this is driving an adverse variance to the position.
- In Month 4, 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 £0.6m in month.
- Performance in Elective Recovery activity in month is driving a favourable income variance of £2.2m, of which £0.6m relates to the catch up in coding from previous months.
- In month, the Trust marginally under-delivered against the recurrent Month 4 savings target by £0.5m. There was also a shortfall against in month delivery of £2.6m. This was partially offset in month by non-recurrent savings from consultant and AfC vacancies contributing a £1.4m favourable variance.
- Year to date recurrent savings delivery is £9.4m against a plan of £10.2m.

Key risks

- The Month 4 financial position is dependent on non-recurrent benefits which cannot be assumed to be available throughout the year, in year savings delivery and NCTR will therefore need to be addressed if the Trust is to break even at year end, whilst divisions need to deliver within budgets.



Latest Month

Jul-25

Year to Date Plan

£(8.0m) deficit

Year to Date Actual

£(7.2m) deficit

Summary

Summary

- The position at the end of July is a net deficit of £8.0m against a planned deficit of £7.2m. The Trust is, therefore, adverse to plan by £0.8m. This is due to the estimated pay costs of industrial action at £0.8m in July.
- Significant variances to plan are higher than planned pay expenditure (£3.1m) and increased non-pay costs (£5.4m) linked to pass-through costs and activity. This is largely offset by higher than planned operating income (£7.4m).
- Total staff in post (substantive, bank and agency) has reduced since March, but staffing levels continue to exceed the funded establishment primarily within nursing linked to increased use of registered mental health nurses and increased staffing of escalation capacity resulting from higher than planned NCTR. The estimated cost impact of industrial action of £0.8m also contributes to the adverse position.
- Overall, agency and bank expenditure increased by c£0.5m in July compared with June but YTD remains below plan. Agency expenditure is 19% lower than plan YTD with expenditure in month of £0.5m, compared with £0.8m in June. Bank expenditure is now 2% higher than plan YTD due to the costs of industrial action in July.
- The number of NCTR patients has increased from 161 to 175 in July. This equates to 22.4% of the Trust's bed base being occupied by NCTR patients.

Key risks

- A shortfall in savings delivery will result in failure to achieve the breakeven plan without a continued step change in delivery within Clinical Divisions and Corporate Services.
- Central mitigations of £25m necessary to support the breakeven plan are not fully identified. However, as at the end of July central mitigations of £20m have been identified.

CIP

Actual Vs Plan (YTD)

Latest Month

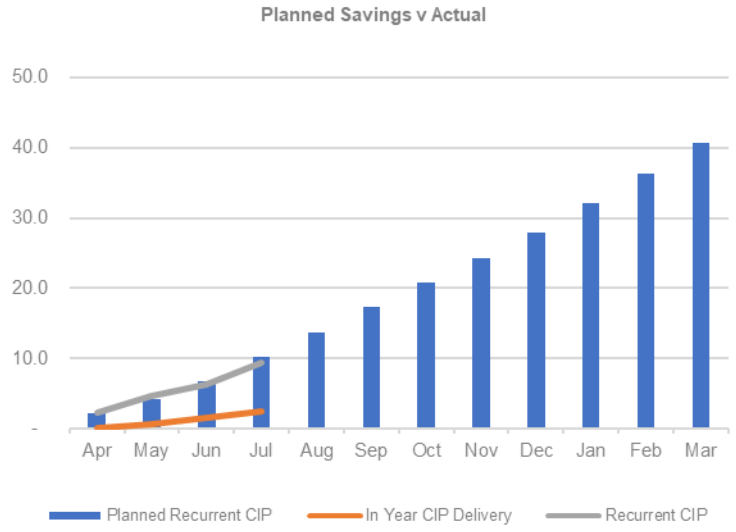
Jul-25

Year to Date Plan

£10.2m

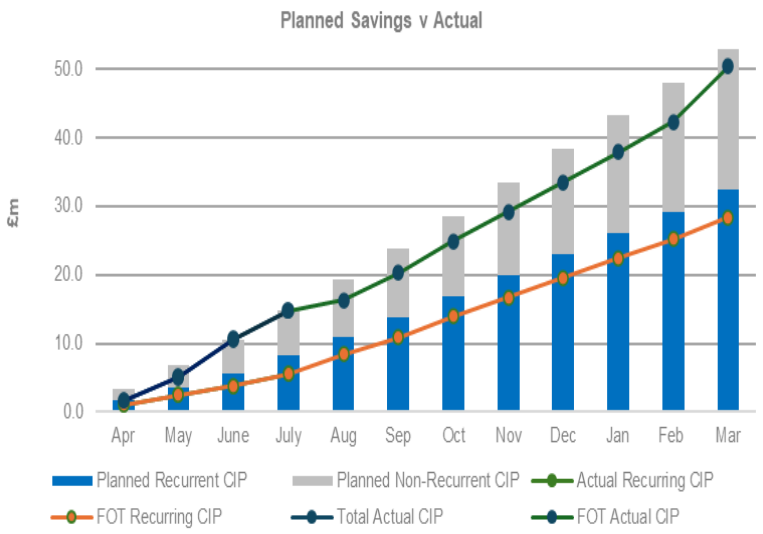
Year to Date Actual

£9.4m



Summary

- The CIP plan for 2025/26 is for savings of £40.6m with £10.2m planned delivery at Month 4.
- At Month 4 the Trust has £9.4m of completed schemes on the tracker. There are a further £11.7m of schemes in implementation and planning, leaving a remaining £19.5m of schemes to be developed.
- The total identified CIP schemes on the tracker, with pipeline included, would deliver £0.4m more than the target.
- The table above reflects the delivery to date of £9.4m of savings in 2025/26. This 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.



Latest Month

Jul-25

Year to Date Plan

£14.8m

Year to Date Actual

£14.8m

Summary

- The Trust's 2025/26 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 31st July 2025, the Trust is reporting total savings delivery of £14.8m against a plan of £14.8m, therefore UHBW is currently on plan. The Trust is forecasting savings of £50.4m, an improvement of £0.7m on last month. However, the improved forecast outturn entirely relates to additional non-recurrent savings. Against the annual savings plans of £53.0m, the current forecast savings delivery shortfall is £2.6m or 5%.
- The full year effect forecast outturn at month 4 is £35.2m, a forecast recurrent shortfall of £17.8m or 34%.

Workforce

Pay Costs Vs Plan Run Rate

Latest Month

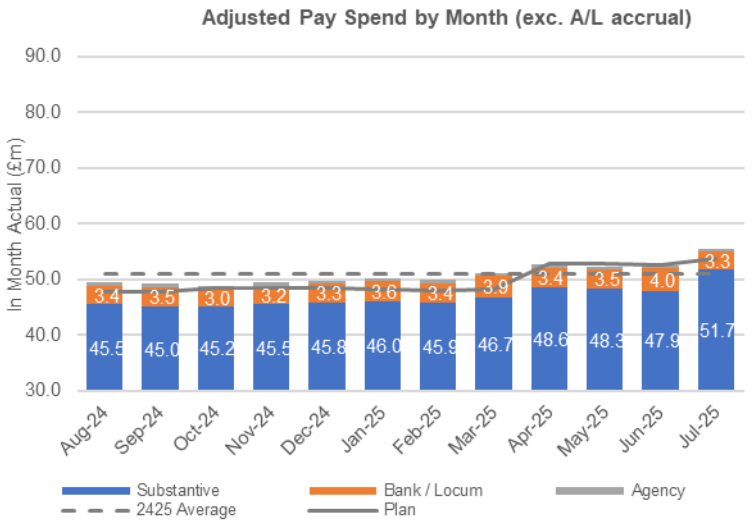
Jul-25

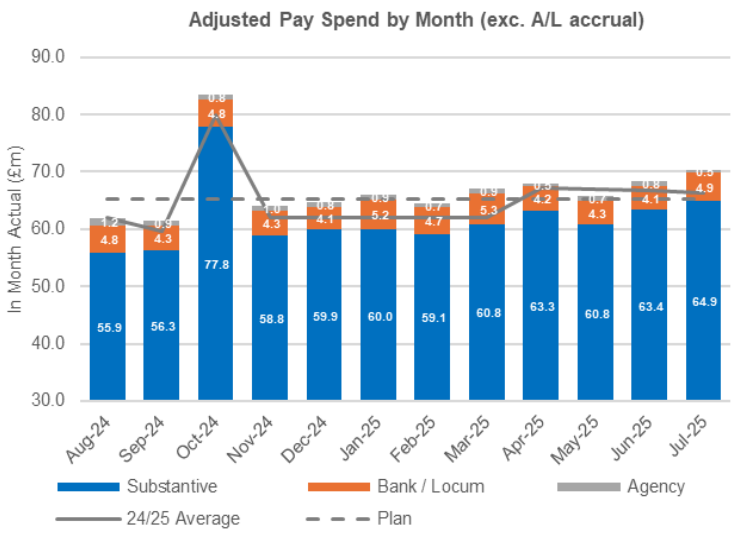
In Month Plan

£53.8m

In Month Actual

£55.5m





Latest Month

Jul-25

In Month Plan

£68.6m

In Month Actual

£70.4m

Summary

Summary

Pay spend is £1.7m adverse in month, when adjusted for pass through items, the revised position is £1.1m adverse to plan. The main drivers are:

- In year CIP - £1.3m adverse, in month impact of recurrent CIP delivery.
- Escalation and enhanced care - £0.6m adverse in nursing.
- Industrial action - £0.6m adverse due to costs for Consultants to cover Resident Doctor strikes.
- Vacancies - £1.4m favourable, consultant vacancies in Anaesthetics and Imaging and AfC vacancies in Genetics and Facilities. Facilities and ASCR vacancies relate to Bristol Surgical Centre posts not yet fully recruited.
- In month agency spend is £0.5m and bank/locum spend is £3.3m.

Summary

Summary

- Total pay expenditure in July is £70.4m, £1.8m higher than the plan for July primarily due staff in post exceeding funded establishment (primarily nursing) and industrial action costs.
- Pay costs are higher than plan YTD mainly due to the cost of nursing staffing levels exceeding planned values with levels of substantive and temporary staffing combined beyond the Trust's funded establishment by 248wte in July.
- Nursing staffing levels exceed the funded establishment by 276wte linked to higher registered mental health usage and staffing of escalation capacity linked to NCTR.
- Additional workforce controls have been put in place with effect from 1st August and the expected reduction in staff in post back to establishment remains the focus of the Clinical Divisions

Temporary Staffing

Agency Costs Vs Plan Run Rate

Latest Month

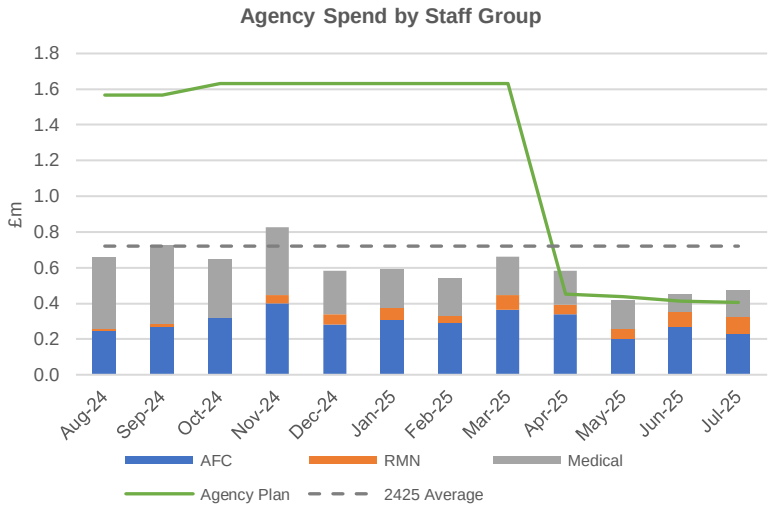
Jul-25

In Month Plan

£0.4m

In Month Actual

£0.5m



Summary

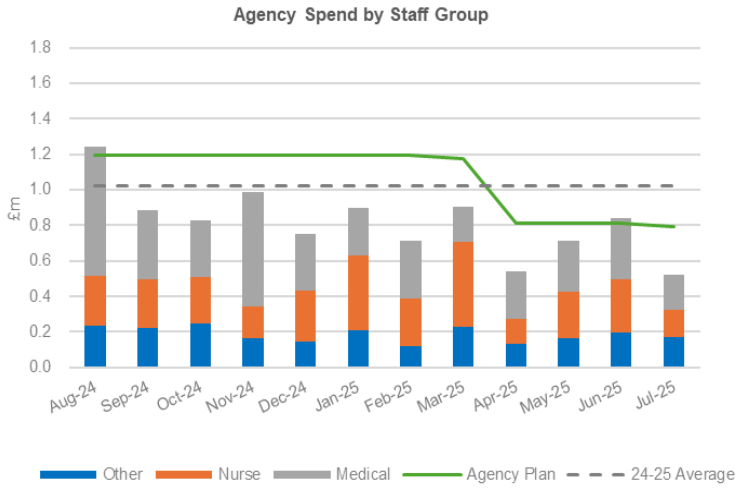
Summary

Monthly Trend

- Agency spend in July has increased compared to June but remains a reduction on run rate. The decrease in AFC is driven by a £45k VAT rebate relating to Nursing, and Consultants has returned to run rate having been lower in June due to one-off benefits.
- Overall spend in month is driven by consultant agency usage in Medicine and ASCR covering vacancies, Nursing agency usage in Critical Care and ED due to increased acuity, as well as Healthcare Scientists in Cardiology to deliver ECHO activity.

In Month vs Prior Year

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



Latest Month

Jul-25

In Month Plan

£0.8m

In Month Actual

£0.5m

Summary

Summary

Monthly Trend

- Agency expenditure in July is £0.5m, £0.3m lower than plan and lower than June's agency expenditure of £0.8m. YTD agency expenditure is 19% below plan.
- Agency expenditure is 0.7% of total pay costs.
- Agency usage continues to be largely driven by absence and additional escalation bed capacity across nursing and medical staffing due to no improvement in the NCTR position. Use of registered mental health nurses is also a key driver.
- Nurse agency shifts increased by 93 or 22% in July compared with June.
- Nurse agency spend is £0.1m lower than June due mainly to a decrease in the average cost per shift.
- Medical agency expenditure is lower by £0.1m from the previous month. The number of shifts covered has increased from 261 in June to 313 in July.

In Month vs Prior Year

- Trustwide agency spend in July of £0.5m is below July 2024 spend of £1.2m. This is due to increased controls and scrutiny implemented across Divisions with the support Trust's Nurse leadership.

Temporary Staffing

Bank Costs Vs Plan Run Rate

Latest Month

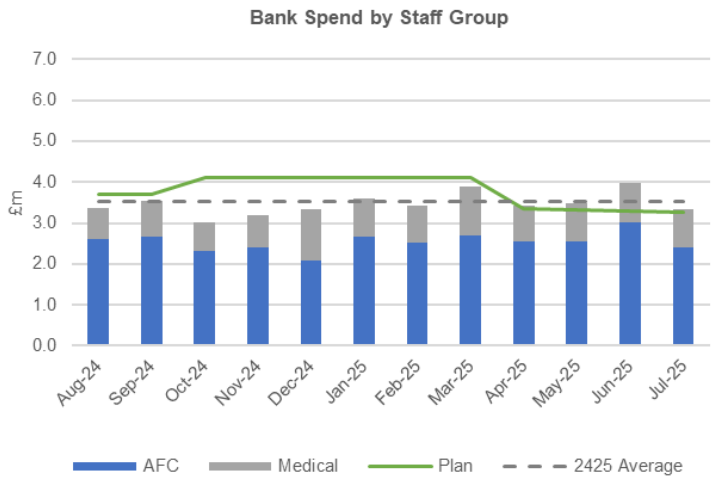
Jul-25

In Month Plan

£3.3m

In Month Actual

£3.3m



Summary

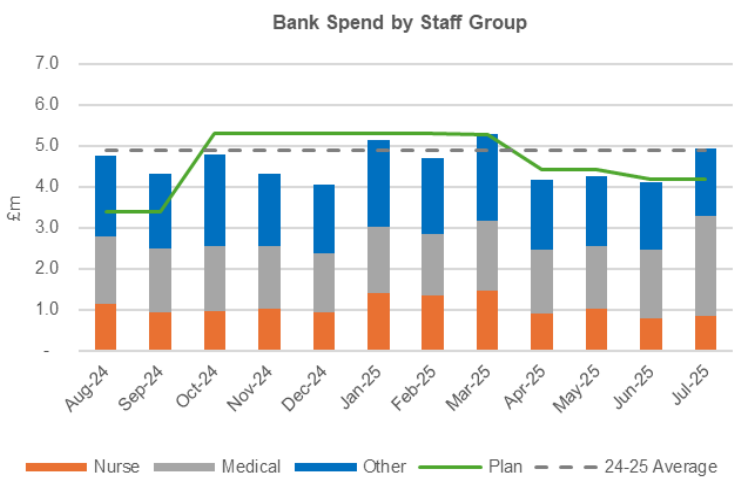
Summary

Monthly Trend

- In July, there has been a decrease in bank spend with this returning to being consistent with run rate. The decrease has largely been in nursing due to June being a 5 week month as well as containing enhanced payments from the May bank holidays.
- Included in Other is the impact of Locums Nest arrangements and the UHBW collaborative bank, where the Trust's doctors and nurses work shifts for other local providers. These costs are recharged and so do not represent additional cost to the Trust.

In Month vs Prior Year

- Bank spend in month is lower than 2024/25 spend, however 2024/25 spend reduced significantly in the second half of the year due to additional controls put in place. Against the post-control run rate July is broadly in line.



Latest Month

Jul-25

In Month Plan

£4.2m

In Month Actual

£4.9m

Summary

Summary

Monthly Trend

- Bank costs in July are £4.9m, an increase of £0.8m from £4.1m in June. Excluding industrial action costs (£0.8m), costs are similar to June and in line with plan. Of the £4.9m spent in July, £2.4m relates to medical bank and £0.8m to registered nurse bank.
- Nurse bank expenditure remained the same in July as June at £0.8m, whilst shifts decreased by c700 or 10% . The average cost per shift increased by 31% compared with the previous month.
- Medical bank increased in July by £0.8m to £2.4m as a result of industrial action.

In Month vs Prior year

- Bank expenditure in July (excluding industrial action) is £0.8m lower than the same period last year, due to increased nursing controls and scrutiny introduced during 204/25.

Capital

Actual Vs Plan

Latest Month

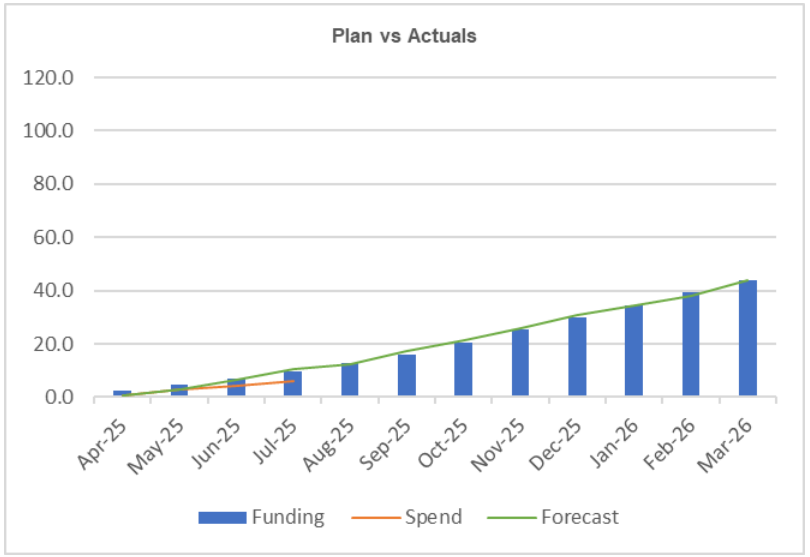
Jul-25

In Month Plan

£2.1m

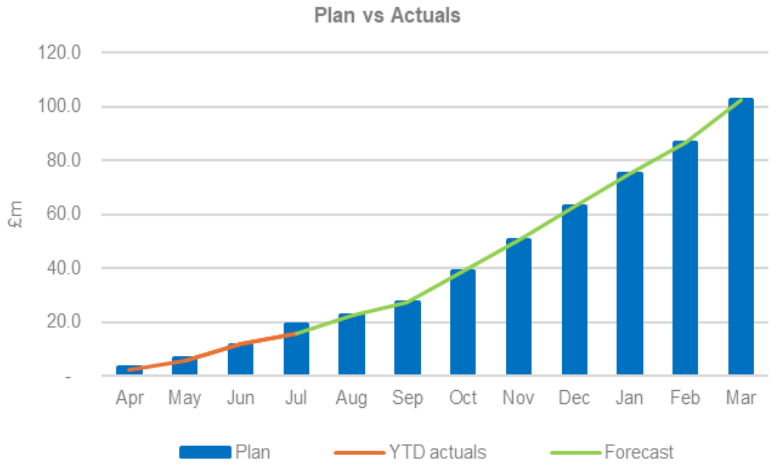
In Month Actual

£1.9m



Summary

- The Trust currently has a system capital allocation of £22.7m for 2025/26. A further £9.6m of projects have been taken forwards for national funding.
- Overall spend in Month 4 was £1.9m, of which £1.7m was against the Bristol Surgical Centre. This takes the overall year to date spend to £6.3m, of which £5.3m is against the Bristol Surgical Centre.
- The year to date variance against the forecast is related to spend on the Surgical Centre, but is not expected to impact either the full year spend or forecast completion date.
- Following a system prioritisation process, a further £3.3m of system funding has been secured to support previously identified and unfunded risks.
- Overall spend on the Bristol Surgical Centre to date is £47.4m, of which £38.0m relates to the main construction contract.
- The Trust has received approval for a £7.3m Salix grant to be spent on decarbonisation work. This funding will be received throughout the year to match spend.



Latest Month

Jul-25

In Month Plan

£7.9m

In Month Actual

£3.7m

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.
- YTD expenditure at the end of July is £15.7m, £3.5m behind the plan of £19.2m.
- Significant variances to plan include slippage on Major Capital (£8.0m), offset by ahead of plan delivery against Estates Schemes (£1.4m) and Right of Use assets (£2.1m).
- Management of the delivery of the capital plan has been revised to drive project delivery via the Trust's Capital Group, newly formed Estates Delivery Board and the Capital Program Steering Group.

Risks

- The Trust is unable to utilise its full CDEL without the support of brokerage via either system partners or NHSE South West.

Cash

Actual Vs Plan

Latest Month

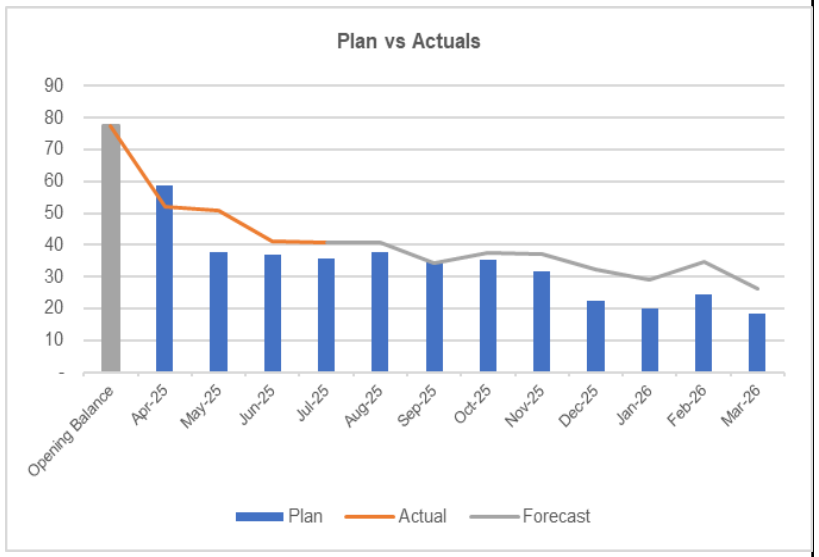
Jul-25

Target

£35.8m

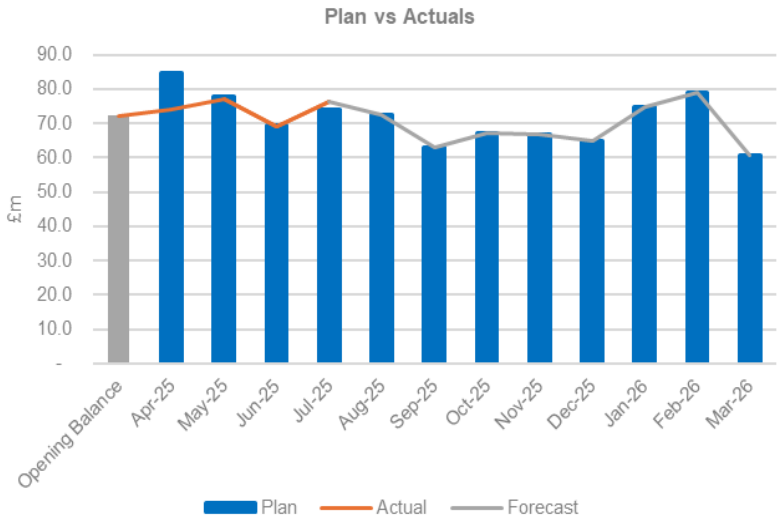
Actual

£40.9m



Summary

- In month cash is £40.9m, which is a £0.4m decrease from June.
- The payables movement in month is driven by £4.5m deferred income for Education and CPD & a £3.0m cost accrual for the 25/26 pay award, which is offset in receivables.
- The receivables movement in month is driven by £3.0m accrued income for the 25/26 pay award funding, which is offset in payables and a £3m increase in invoiced debtors.
- The cash balance has decreased by £36.5m year to date, driven by the movements in payables due to the high level of capital cash spend linked to items purchased at the end of 2024/25, and the payment of large maintenance contracts.
- YTD cash balances are £5.1m above plan and the year end cash balance is forecast to be £7.7m above plan, primarily driven by lower than forecast capital cash spend.



Latest Month

Jul-25

Target

£73.9m

Actual

£76.2m

Summary

- The closing cash balance of £76.2m is a £6.9m increase since June.
- The £3.9m increase from 31st March 2025 is due to a net cash inflow from operations of £25.9m, offset by cash outflow of £17.5m relating to investing activities (i.e. capital), and cash outflow of £4.5m on financing activities (i.e. loans, leases & PDC).
- Working capital movements YTD are:
  - for assets, an increase in receivables of £13,364k and an increase in inventories of £393k; and
  - for liabilities, an increase in trade and other payables of £12,916k and deferred income of £14,869k.
- The Trust's total cash receipts in July were £118.3m offset by payroll payments of £65.8m and supplier payments of £45.6m.
- YTD cash balances are £2.3m above plan and the forecast year end cash balance is on plan at £60.8m.

Assurance and Variation Icons – Detailed Description

VARIATION ICON	ASSURANCE ICON	P* Consistently Passing target (target outside control limits)	P Passing target	? Passing and Falling short of target subject to random variation	F Falling short of target	F- Consistently Falling short of target (target outside control limits)	No icon 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 September 2025
Data up to July 2025

Activity	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of women who gave birth (>=24 weeks or <24 weeks live)	397	454	448	394	429	435	456	453	467
Number of women who gave birth (>=22 weeks)	397	455	447	397	429	436	456	455	467
Number of babies born (>=24 weeks or <24 weeks live)	401	460	454	401	433	442	464	463	473
Number of livebirths 22+0 to 26+6 weeks	4	2	0	6	6	4	3	4	1
Number of livebirths 24+0 to 36+6 weeks	28	41	33	28	35	36	40	32	33
Number of livebirths <24 weeks	3	1	1	3	3	0	0	1	0
Induction of labour rate %	28.2%	30.4%	29.7%	27.9%	30.8%	31.7%	31.6%	32.7%	29.1%
Unassisted birth rate %	45.8%	43.8%	44.9%	40.1%	45.2%	42.3%	42.1%	41.5%	45.4%
Assisted birth rate %	8.3%	10.8%	9.6%	12.9%	12.1%	9.9%	14.0%	9.3%	8.8%
Caesarean section rate (overall) %	45.6%	44.9%	44.6%	46.4%	42.7%	47.6%	43.2%	49.0%	45.6%
Elective caesarean section rate %	21.4%	20.3%	21.4%	23.6%	17.9%	22.1%	20.4%	22.3%	22.7%
Emergency caesarean section rate %	24.2%	24.7%	23.0%	22.8%	24.7%	25.5%	22.8%	26.7%	22.9%

Safe - Maternity Workforce	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
One to one care in labour (as a percentage)* excludes BBAs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%
Compliance with supernumerary status for labour ward coordinator	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%
Number of times maternity unit attempted to divert or on divert	1	1	1	0	1	0	0	1	1
Number of obstetric consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0
Consultant Led MDT ward rounds on CDS day	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Led MDT ward rounds on CDS evening/night	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of 'staff meets acuity' - CDS	67%	51%	55%	43%	53%	64%	65%	52%	65%
Percentage of 'up to 3 MWs short' - CDS	29%	45%	41%	45%	36%	31%	45%	44%	33%
Percentage of '3 or more MW's short' - CDS	4%	5%	3%	12%	11%	5%	8%	5%	2%
Confidence factor in Birthrate+ (data recording on CDS)	81.1%	80.0%	87.1%	77.8%	77.4%	82.8%	82.3%	73.9%	87.1%

Safe - Maternity Workforce	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	-1.45%	-1.12%	-2.14%	-1.64%	-1.53%	-1.56%	-0.87%	0.71%	2.40%
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs	4.76%	4.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Obstetric Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	2%	2%	2%	2%	2%	2%	2%	2%
Midwifery Shift Fill Rate (%) - acute services* day	90.3%	92.6%	93.7%	92.7%	90.0%	88.8%	92.5%	88.8%	
Midwifery Shift Fill Rate (%) - acute services* night	99.0%	100.7%	103.0%	99.6%	98.9%	99.5%	100.1%	103.6%	
Obstetric Shift Fill Rate - acute services* day	100%	100.0%	100.0%	100.0%	100.0%	100.0%	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%

Safe - Neonatal Workforce	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of NICU consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs	2.59%	7.70%	9.98%	9.47%	8.70%	10.99%	12.23%	10.79%	
Neonatal Nurse Qualified in Speciality establishment rate	56%	55%	52%	52%	52%	52%	52%	54%	63%
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	0%	0%	0%	0%	0%	0%
Neonatal Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	7.60%	7.60%	0%	0%	0%	8%	8%
Neonatal Nursing Fill Rate (%) - acute services* using BAPM acuity tool	98.2%	100.0%	98.3%	100.0%	100.0%	98.3%	91.8%	96.6%	76.8%
Neonatal Nursing QIS Fill Rate (%) - acute services using BAPM acuity tool	63.6%	78.0%	73.3%	96.43	75.0%	74.6%	49.2%	55.2%	37.7%
Neonatal (Medical) Shift Fill Rate (%) - acute services* day using BAPM acuity tool	100%	100%%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night using BAPM acuity tool	100%	100%%	100.0%	100.0%	100.0%	100.0%	95.7%	95.0%	94.6%

Training	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Training compliance fetal wellbeing day - Obstetric Consultants	90%	79%	90%	90%	89%	94%	90%	80%	80%
Training compliance fetal wellbeing day - Other Obstetric Doctors	86%	76%	76%	87%	82%	82%	85%	81%	78%
Training compliance fetal wellbeing day - Midwives (ALL)	95%	90%	87%	87%	84%	80%	85%	81%	81%
Training compliance in maternity emergencies and multi-professional training - Obstetric Consultants	100%	95%	90%	90%	90%	94%	85%	90%	90%
Training compliance in maternity emergencies and multi-professional training - Other Obstetric Doctors	88%	76%	68%	82%	91%	94%	100%	96%	97%
Training compliance in maternity emergencies and multi-professional training (includes NBLS) - Midwives (ALL)	94%	94%	89%	86%	86%	89%	92%	91%	92%
Training compliance in maternity emergencies and multi-professional training - Anaesthetic Consultants	93%	90%	90%	91%	91%	66%	69%	62%	63%

Training	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Training compliance in maternity emergencies and multi-professional training - Other Anaesthetic Doctors	100%	91%	95%	73%	61%	66%	77%	75%	86%
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	94%	93%	90%	87%	89%	87%	84%	87%	91%
Training compliance annual local NBLS - NICU Consultants	92%	94%	94%	94%	92%	92%	100%	92%	91%
Training compliance annual local NBLS - NICU Resident doctors (who attend any births)	100%	94%	94%	94%	100%	100%	100%	100%	100%
Training compliance annual local NBLS NICU ANNPs (ALL)	100%	82%	91%	91%	90%	90%	70%	70%	60%
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	96%	88%	98%	93%	93%	86%	91%	93%	91%
Training compliance annual local NBLS MSWs, HCAs and nursery nurses (dependant on their roles within the service - for local policy to determine)	91%	88%	90%	86%	87%	92%	89%	89%	90%

Safe - Delivery Metrics	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of shoulder dystocias recorded (vaginal births)	9	9	10	6	9	7	11	6	10
% of women with a high degree (3rd and 4th) tear recorded	7.4%	3.2%	5.6%	4.3%	3.7%	5.7%	5.0%	3.5%	5.5%
Number of women with a retained placenta following birth requiring MROP	3	9	9	7	11	8	9	9	8
Number of babies with an Apgar Score <7 at 5 mins (all gestations)	8	7	5	6	14	13	13	12	4

Infant Feeding & Skin to Skin	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
% of babies where breastfeeding initiated within 48 hours	82.5%	79.1%	76.3%	82.3%	76.5%	88.2%	81.0%	80.2%	84.7%
% of babies breastfeeding on Day 10	81.2%	73.5%	73.1%	78.2%	77.4%	76.3%	70.9%	75.5%	76.3%
% of babies breastfeeding at transfer to community	71.2%	66.9%	66.9%	73.3%	68.4%	71.8%	67.1%	70.3%	72.9%
% of babies where skin to skin recorded within 1st hour of birth	85.0%	81.2%	82.4%	81.0%	80.4%	82.7%	83.1%	82.6%	84.9%

Perinatal Morbidity and Mortality inborn	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Total number of perinatal deaths (excluding late fetal losses)	3	4	6	4	9	2	2	4	3
Number of late fetal losses 16+0 to 23+6 weeks excl TOP	4	1	2	1	2	0	3	5	4
Number of stillbirths (>=24 weeks excl TOP)	1	1	5	0	4	2	2	3	3
Stillbirths per 1000 live births	2.49	2.17	11.01	0.00	9.32	4.52	4.31	6.48	6.34
Number of neonatal deaths : 0-6 Days	1	1	0	3	5	0	0	0	0
Number of neonatal deaths : 7-28 Days	0	2	1	1	0	0	0	1	0
Neonatal Deaths before 28 days per 1000 live births (ALL)	2.49	6.5	2.2	10.15	11.66	0.00	0.0	2.2	0.0
* NND before 28 days per 1000 live births (Inborn babies only)	2.49	2.2	0.0	7.48	8.93	0.00	0.0	2.2	0.0
PMRT grading C or D themes in report	0	2	3	3	0	0	2	2	1
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (MNSI referral)	1	1	3	1	1	0	0	1	0

Maternal Morbidity and Mortality	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of maternal deaths (MBRRACE)	0	0	0	0	0	0	0	0	1
Direct causes	0	0	0	0	0	0	0	0	0
Indirect causes	0	0	0	0	0	0	0	0	1
Number of women who received enhanced care on CDS (HDU)	40	37	32	33	36	32	33	39	39
Number of women who received level 3 care (ICU)	3	1	1	2	1	1	1	1	1

Insight	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of incident reported	79	95	99	108	166	99	106	124	56
Number of incidents graded as moderate or above (total) (Physical Harm)	0	1	0	0	0	3	0	1	4
incident moderate harm or above (not PSII, excludes MNSI)	0	0	0	0	0	3	0	1	4
incident PSII (excludes MNSI)	0	1	0	0	0	0	1	0	0
New MNSI referrals accepted	0	1	1	1	2	0	0	1	0
Outlier reports (eg. MNSI/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust	0	0	0	0	1	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0
Trust Level Risks	2	3	3	3	3	3	3	4	5

NICU Data	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Neonatal Admission to NICU	33	55	50	48	59	41	46	52	48
of which Inborn Babies booked with NBT	20	37	34	32	44	31	33	33	29
of which Inborn Babies -booked elsewhere	4	2	0	4	2	0	3	4	5
of which readmission	2	5	3	4	3	3	5	6	3
of which ex-utero admission	6	9	7	7	7	4	4	9	8
of which source of admission cannot be derived	1	2	3	1	2	2	1	0	1
Neonatal Admission to Transitional Care	26	28	40	29	27	39	36	35	36
Admission rate at term	2.7%	4.1%	6.0%	5.7%	7.2%	4.0%	4.8%	0.5%	0.0%
NICU babies transferred to another unit for higher/specialist care	2	4	8	5	3	4	4	5	2
NICU babies transferred to another unit due to a lack of available resources	0	3	0	0	2	0	2	3	0
NICU babies transferred to another unit due to insufficient staffing	0	0	0	0	0	0	0	0	0
Attempted baby abduction	0	0	0	0	0	0	0	0	0

Involvement	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	100%	100%	67%	100%	100%	100%	100%	100%	100%
Friends and family Test score (response rate % who rated 'very good' or 'good') Maternity	91%	90%	87%	95%	94%	94%	91%	92%	94%
Service User feedback: Number of Compliments (formal)	13	14	29	74	37	59	78	61	79
Service User feedback: Number of Complaints (formal)	4	0	11	2	2	2	9	2	6
Staff feedback from frontline champions and walk-abouts (number of themes)	0	0	0	8	7	Walk-about minutes	Meeting	Walk-about minutes	Meeting

Telephone Triage	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Attendance to triage	820	850	822	791	925	939	943	888	996
BSOTS KPI Initial assessment within 15 minutes	70%	63%	69%	66%	56%	58%	63%	66%	65%
NICE Safer Staffing Red Flag Initial assessment within 30 minutes	91%	88%	91%	91%	85%	85%	91%	91%	93%
Calls answered by triage (Day 0730-2000)	907	916	902	857	961	947	1711	1693	1525
Calls answered by triage (Night 2000-0700)	293	334	291	236	280	272	291	352	368
Phone calls abandoned on triage (Day 0730-2000)	134	176	146	159	168	182	301	154	149
Phone calls abandoned on triage (Night 2000-0700)	27	34	22	41	39	29	26	37	36
Calls answered by other clinical areas (CDS and Mendip - Day + Night)	688	729	726	669	734	606	522	522	536
Phone calls abandoned in other clinical areas (CDS and Mendip - Day + Night)	23	20	18	23	21	12	22	28	30

University Hospitals Bristol and Weston NHS Foundation Trust

Perinatal Quality Surveillance (PQSM)

July 2025

UHBW Maternity

Inspected and rated Good

Care Quality Commission

Maternity Workforce & Acuity

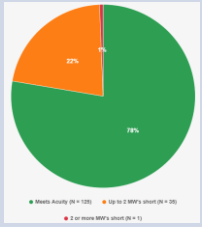
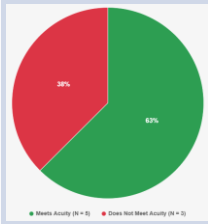
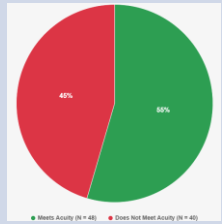
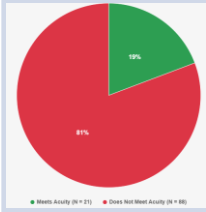
Safe – Maternity Workforce	Target	Local Threshold G	A	R	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Year to date average	Trend	SPC Variation	SPC Assurance	Comment
One to one care in labour (as a percentage)* excludes BBAs	SBLV3 100%	100%		≤99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Compliance with supernumerary status for labour ward coordinator	SBLV3 100%	100%		≤99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	99.9%				On the night shift of the 26th July, short period of time where both Band 7s had a patient. Coordinators patient did not require 1:1 care and was receiving 4 hourly observations.
Number of times maternity unit attempted to divert or on divert	Local	0		≥2	1	3	0	0	0	0	0	0	0	1	0	0	0.4				
Number of obstetric consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	0	0	0	0	0	0	0	0	0	0				
Consultant Led MDT ward rounds on CDS day	SBLV3 100%	100%		≤90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%				
Consultant Led MDT ward rounds on CDS evening/night	SBLV3 100%	100%		≤90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%				
Percentage of 'staff meets acuity' – CDS	Birthrate + 100%	≥90%		≤85%	77%	69%	73%	85%	87%	85%	82%	80%	80%	84%	83%	78%	80.3%				
Confidence factor in Birthrate+ (data recording on CDS)	Birthrate + 60%	≥55%		≤45%	55.4%	61.1%	79.0%	90.0%	88.2%	87.6%	88.1%	83.9%	91.1%	90.9%	90.6%	86.6%	82.7%				
Percentage of 'staff meets acuity' – Ward 73	Birthrate + 100%	≥90%		≤85%	23%	64%	29%	79%	86%	52%	77%	43%	45%	Data Unavailable	48%	59%	50.4%				Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC
Confidence factor in Birthrate+ (data recording on Ward 73)	Birthrate + 60%	≥55%		≤45%	10%	9.2%	13.7%	23.3%	17.7%	20.2%	23.2%	24.2%	27.5%	Data Unavailable	78%	69%	26.4%				Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC
Percentage of 'staff meets acuity' – Ward 76	Birthrate + 100%	≥90%		≤85%	0%	0%	36%	58%	56%	31%	30%	19%	19%	36%	38%	19%	28.5%				Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC
Confidence factor in Birthrate+ (data recording on Ward 76)	Birthrate + 60%	≥55%		≤45%	6.5%	4.2%	17.7%	31.7%	20.2%	25.8%	42.0%	33.9%	35.8%	42.7%	85.0%	87.0%	36.0%				Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC

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.

Central Delivery Suite (CDS)	Antenatal & Postnatal Inpatients (Ward 73) (Oak & Willow)	Transitional Care (Ward 76)
	 	

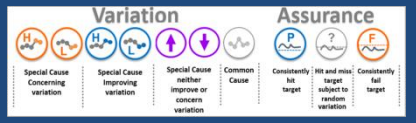
Is the standard of care being delivered?

- 1 episodes where the supernumerary status of the CDS coordinator was not maintained for short period of time where 4 hourly obs were performed

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

- Low compliance with completing Birthrate+ consistently on Ward 73 and Ward 75 continues to impact the reliability of this data

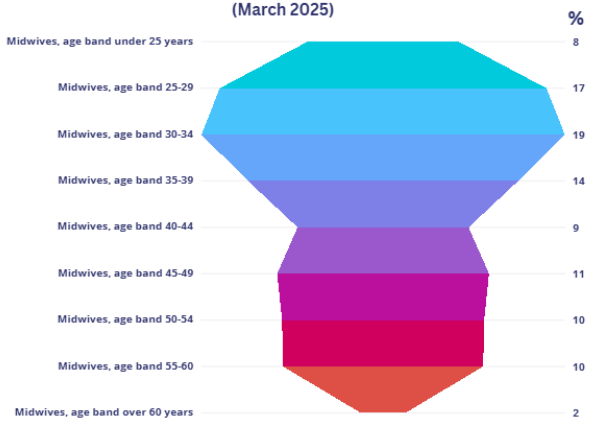
Maternity Workforce & Acuity



Safe – Maternity Workforce	Target	Local Threshold			Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Year to date average	Trend	SPC		Comment
		G	A	R															Variation	Assurance	
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	197.78 WTE 100%	≤5		≥10	7.79	6.48	2.95	3.16	1.16	0.16	0.16	-3.93	-9.01	-8.64	-8.60	-7.20	-1.3		L	?	
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0.9	0.9	0.9	0.9	0.9	0.9	1.0	0.0	0.0	0.0	1.0	1.0	0.7		L	?	2 x consultants not currently on the on-call rota due to illness/injury - gaps in on-call rota being covered through locum shifts
Obstetric Registrar Vacancy Rate (inclusive of maternity leave)WTEs		≤1		≥3	2.4	2.4	2.4	2.4	2.4	2.4	-1.0	-1.0	0.0	0.0	0.0	0.0	1.0		L	?	
Obstetric SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	0	0	1.0	1.0	1.0	1.0	-0.2		H	P	
Midwifery Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%	95.3%	95.1%	92.3%	102.1%	99.5%	101.1%	87.6%	85.7%	97.3%	98.3%	99.4%	96.1%	1.0			?	
Midwifery Shift Fill Rate (%) - acute services* night		≥97.5%		≤95%	88.0%	87.4%	88.7%	98.8%	92.5%	95.1%	95.0%	93.0%	91.9%	97.2%	96.9%	96.8%	0.9		H	?	
Obstetric Shift Fill Rate - acute services* day		≥97.5%		≤95%	100%	98.2%	99.1%	96.7%	99.6%	98.3%	98.1%	100.0%	98.2%	99.2%	100.0%	100.0%	1.0			?	
Obstetric Shift Fill Rate - acute services* night		≥97.5%		≤95%	100%	98.9%	98.9%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1.0		H	?	
Anaesthetic (Obstetric) Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1.0		H	P	
Anaesthetic (Obstetric) Shift Fill Rate (%) - acute services* night		≥97.5%		≤95%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1.0			P	

UHBW Midwives in post: demographics

Data Source: NHS Model Health System
(March 2025)



Midwifery Staff currently in the on boarding process:

Band 7 0.0 wte Band 6 0.0 wte Band 5 0.0 wte

UHBW Midwives in post: Ethnicity

Data Source: NHS Model Health System
(March 2025)

Demographic profile of staff in post: Ethnicity	Data period	Provider value	Peer average	National value	National value method	Chart
Midwives: Asian/Asian British	Mar 2025	2.0%	1.4%	2.6%	Provider median	
Midwives, Black/African/Caribbean/Black British	Mar 2025	4.8%	3.5%	5.7%	Provider median	
Midwives: Mixed/Multiple ethnic groups	Mar 2025	3.2%	1.9%	2.1%	Provider median	
Midwives: Not stated	Mar 2025	1.3%	1.6%	1.8%	Provider median	
Midwives: Other	Mar 2025	0.3%	0.6%	0.9%	Provider median	
Midwives: White	Mar 2025	88.4%	92.3%	89.3%	Provider median	

July 2025

Midwifery Maternity Rate:

13.04 wte

NICE Midwifery Red Flags

NICE Red Flags, as identified within: Safe midwifery staffing for maternity settings, NG14 published 27/02/2015

	Data Source	Reliability of Data	Rationalle for current reliability assessment	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Delayed or cancelled time-critical activity	Datix/ BadgerNet/ Birthrate +	Variable	Cat 1 and Cat 2 CS delays captured in BadgerNet. All other delayed or cancelled time-critical activities rely of Datix submission by clinical staff	23	18	26	13	24	15	11
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	3	0	0	1	1	1	0
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	2	6	3	6	4	6	3
Delay of more than 30 minutes in providing pain relief	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	1	0	0	0	0	1	4
Delay of 30 minutes or more between presentation and triage	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	9.66% (64 attendances)	9.57% (56 attendances)	12% (78 attendances)	12.5% (76 attendances)	6.7% (40 attendances)	4.3% (25 attendances)	6.9% (43 attendances)
Full clinical examination not carried out when presenting in labour	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	22.8% 85 assessments not completed / partially completed	19.8% 66 assessments not completed / partially completed	22.2% 82 assessments not completed / partially completed	20.5% 76 assessments not completed / partiallly completed	19.5% 75 assessments not completed / partially completed		
Delay of 2 hours or more between admission for induction and beginning of process	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	80.15% 105 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 352 minutes	68.6% 94 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 230 minutes	81.2% 108 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 518 minutes	78.0% 103 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 300 minutes	78% 117 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 316 minutes	70% 101 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 219 minutes	82% 116 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 216.5 minutes
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	Datix/ BadgerNet/ Birthrate +	Variable	SEPIS trigger data extracted directly from BadgerNet. Recognition of abnormal urine output relies of Datix submission by clinical staff	8	2	8	3	1	1	1
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	Datix/ BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	0	0	0	0	0	0	0

Neonatal Workforce & Acuity

Safe - Neonatal Workforce	Target	Local Threshold G	A	R	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Year to date average	Trend	SPC Variation	SPC Assurance	Comment
Number of NICU consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	0	0	0	0	0	0	0	0	0	0		L	?	
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs		≤5		≥10	6.76	-2.54	-7.54	11.61	2.91	0.3	2.91	4.83	3.54	3.80	3.80	3.80	3		L	?	
Neonatal Nurse Qualified in Speciality establishment rate	BAPM 70%	≥70%		≤60%	52.0%	62.0%	62.0%	66.0%	61.0%	60.0%	61.0%	61.0%	58.0%	58.0%	58.0%	58.0%	59.75%		H	F	
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0	0	0	0	0	0	0	0	0	0	0		0			?	1 x consultant on long term sickness - locum coverage
Neonatal Registrar Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	0.0	0.7	1.3	1.3	1.3		0		H	?	shortage being covered with locums
Neonatal SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0.9	0.9	0.9	0.9	0.9	0.9	0.0	0.0	0.3	0.3	1.1		1		L	?	
Neonatal Nursing Fill Rate (%) - acute services* day using BAPM acuity tool		≥97.5%		≤95%	99.7%	98.4%	116.3%	100.6%	97.2%	100.8%	113.4%	128.2%	105.3%	107.2%	104.9%	105.0%	106.42%			?	
Neonatal Nursing Fill Rate (%) - acute services* night using BAPM acuity tool		≥97.5%		≤95%	107.1%	104.6%	102.5%	106.3%	103.4%	105.0%	112.1%	128.1%	105.7%	104.9%	99.2%	103.0%	106.83%		H	?	
Neonatal Nursing QIS Fill Rate (%) - acute services* day using BAPM acuity tool		≥70%		≤60%	57.8%	62.4%	77.3%	65.0%	58.3%	61.5%	72.1%	83.0%	62.1%	68.2%	53.7%	55.7%	64.76%			?	
Neonatal Nursing QIS Fill Rate (%) - acute services* night using BAPM acuity tool		≥70%		≤60%	61.8%	62.4%	63.2%	66.6%	64.7%	60.1%	73.1%	82.6%	61.5%	70.2%	60.5%	52.6%	64.94%			?	
Neonatal (Medical) Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.78%		H	?	
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night		≥97.5%		≤95%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.68%		H	?	

SONAR Workforce

No delayed / postponed dispatches or other operational impact resulted from gaps in the Middle Tier Rota – related to the resilience we have in the system

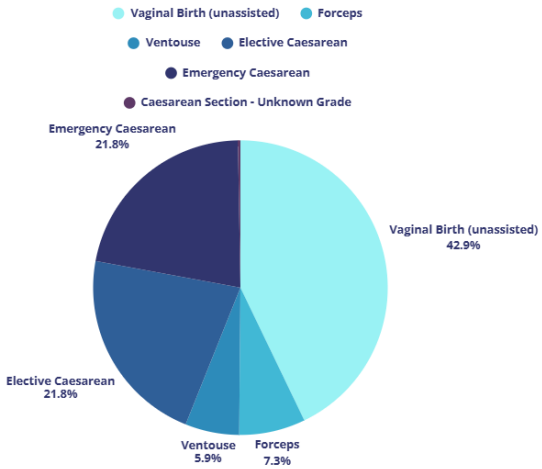
	Staffing Funded (North)	Staff in Post (North)	Vacancy Rate (North)	July Uncovered Shifts (North)	July Uncovered Shifts (South)
Nursing Tier	12.0	12.45	0%	0	0
Middle Tier	12.0	10.8	10%	5	4
Consultant	24 hr cover			0	0

Maternity Metrics: July 2025

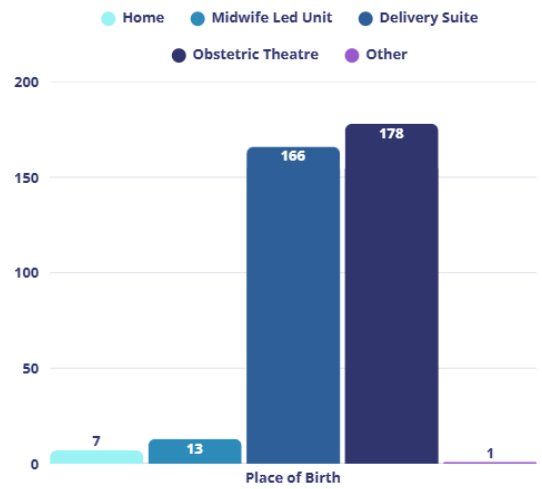
Percentage of Women booked with a Continuity Team (%)

Mode of Birth

371 Registerable Babies born during July 2025



Location of Birth



Induction of Labour Rate

37.7%

VBAC

17.3%

Shoulder Dystocia's (% of vaginal births)

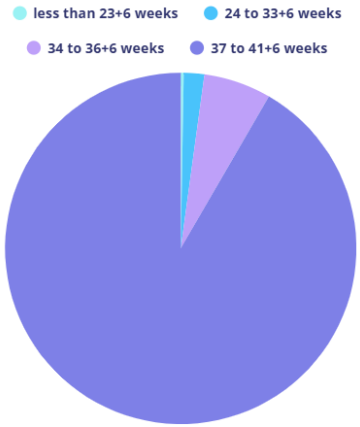
0.5%

% of women commencing vaginal birth sustaining a 3rd/4th degree tear

1.9%

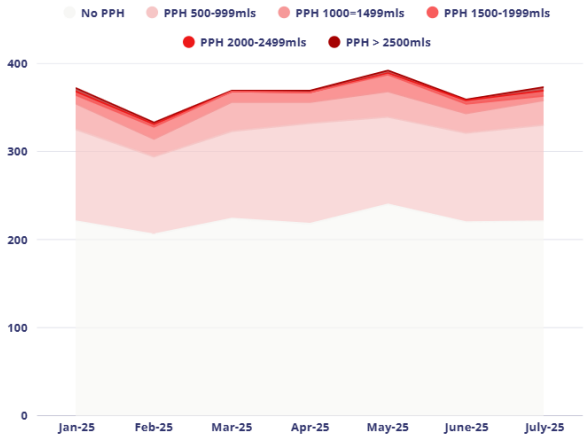
Gestation at Delivery

371 Registerable Babies born during July 2025

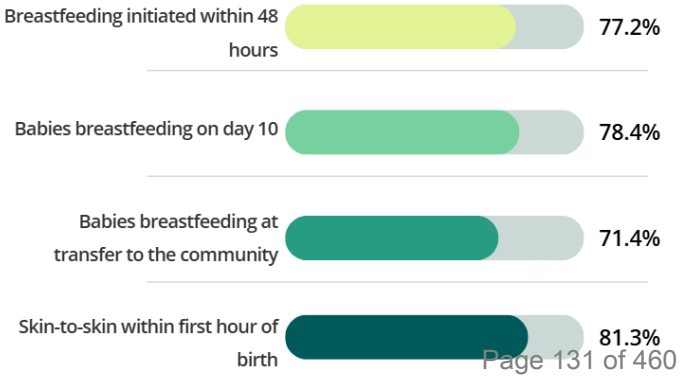


Postpartum Haemorrhage (PPH)

(Count of women)



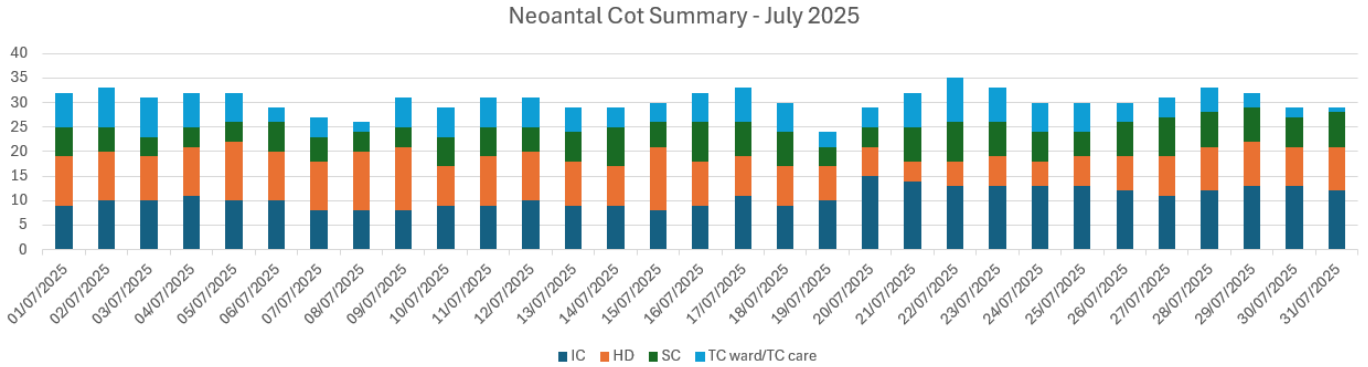
Infant Feeding & skin to skin (%)



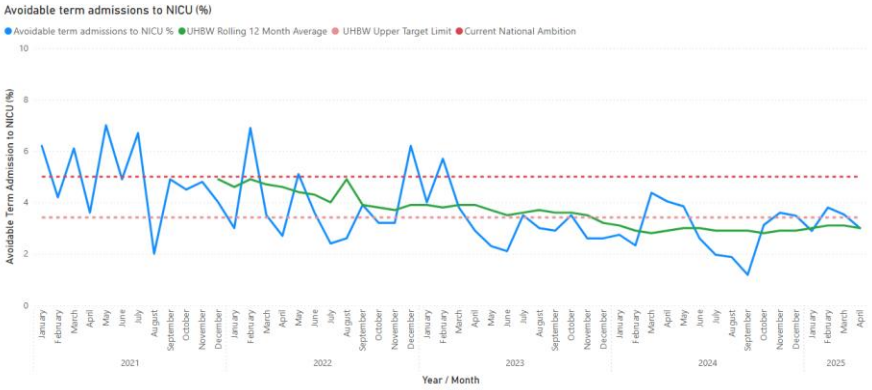
Neonatal Metrics: July 2024

Neonatal Commissioned Cot Summary

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

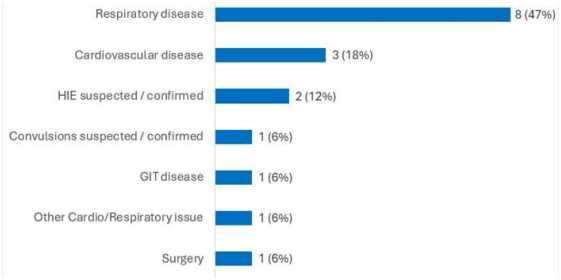


Avoidable Term Admission Rate in NICU (ATAIN)



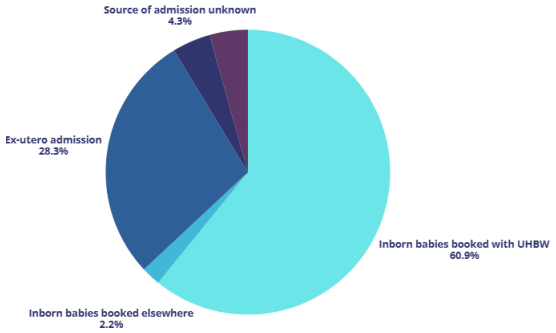
NNU* Principal reason for first admission for July 2025 Term babies

*NNU includes babies requiring neonatal care admitted to either NICU, Transitional Care or the Postnatal Ward

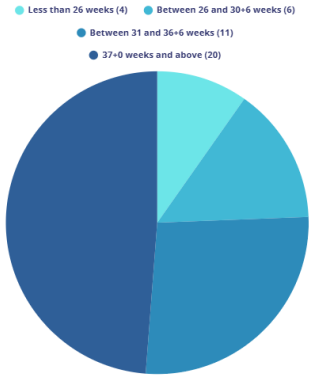


NICU Admission by Source

41 Babies Admitted to NICU in July 2025

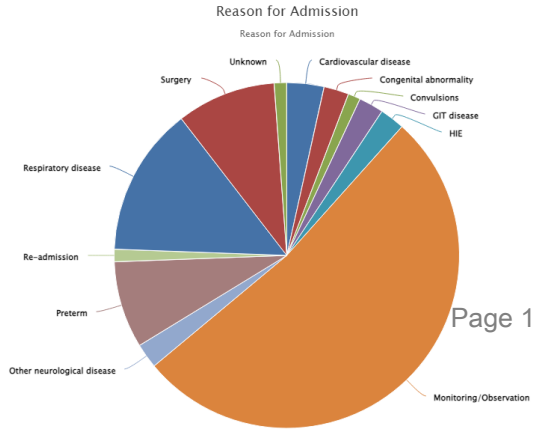


NICU Admission by Gestation



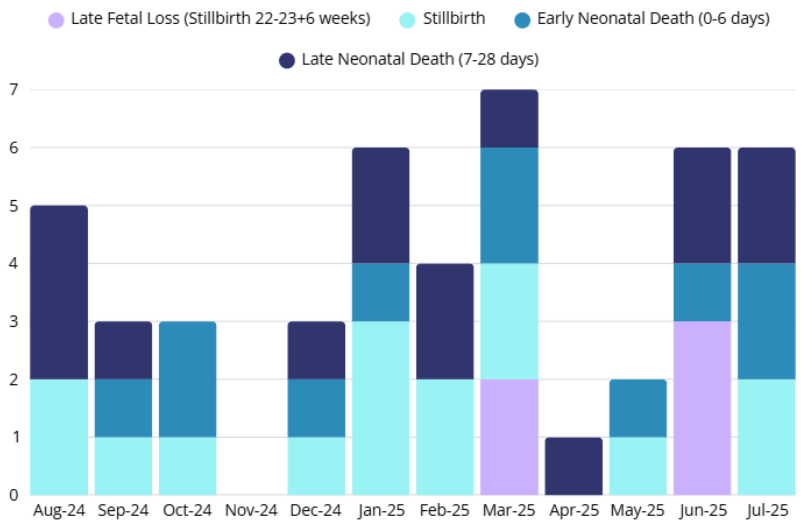
NNU* Principal reason for first admission July 2025 (all babies)

*NNU includes babies requiring neonatal care admitted to either NICU, Transitional Care or the Postnatal Ward



Perinatal Mortality & Morbidity

All Stillbirths, Neonatal Deaths (inborn and outborn) plus Late Fetal Losses



Maternity and Newborn Safety Investigations (MNSI)

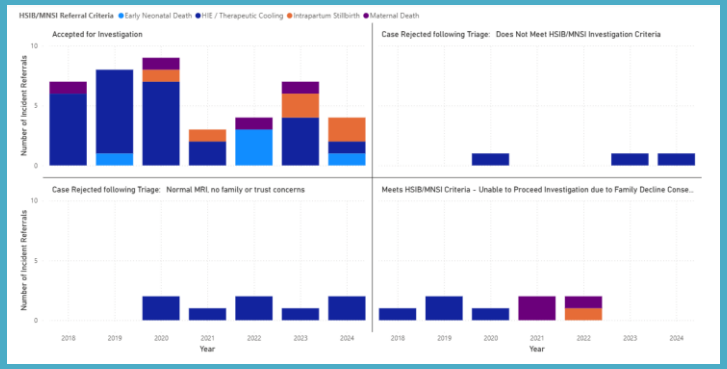
The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

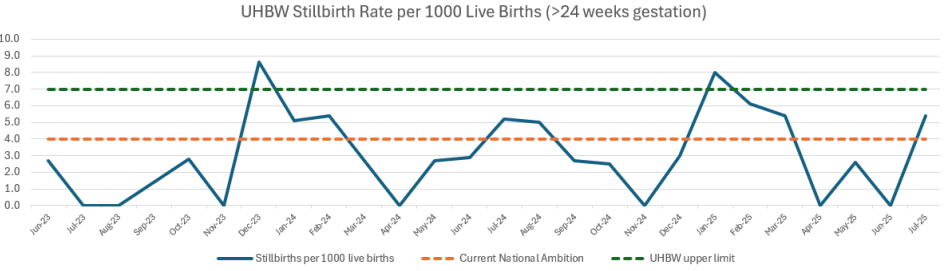
- Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England
- maternal deaths in England

MNSI Referrals & Investigations by Criteria

2 NEW MNSI Referrals in July 2025 (HIE)

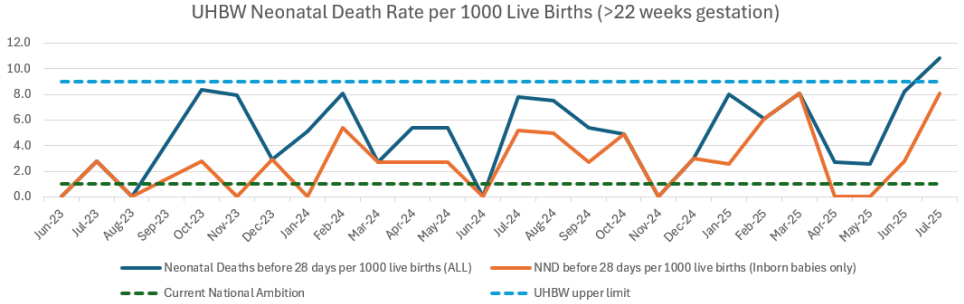
1. MRI since returned as NAD – Case closed
2. RUH referral however UHBW CMW's provided early labour





July 2025
Rolling 12 monthly stillbirth rate:

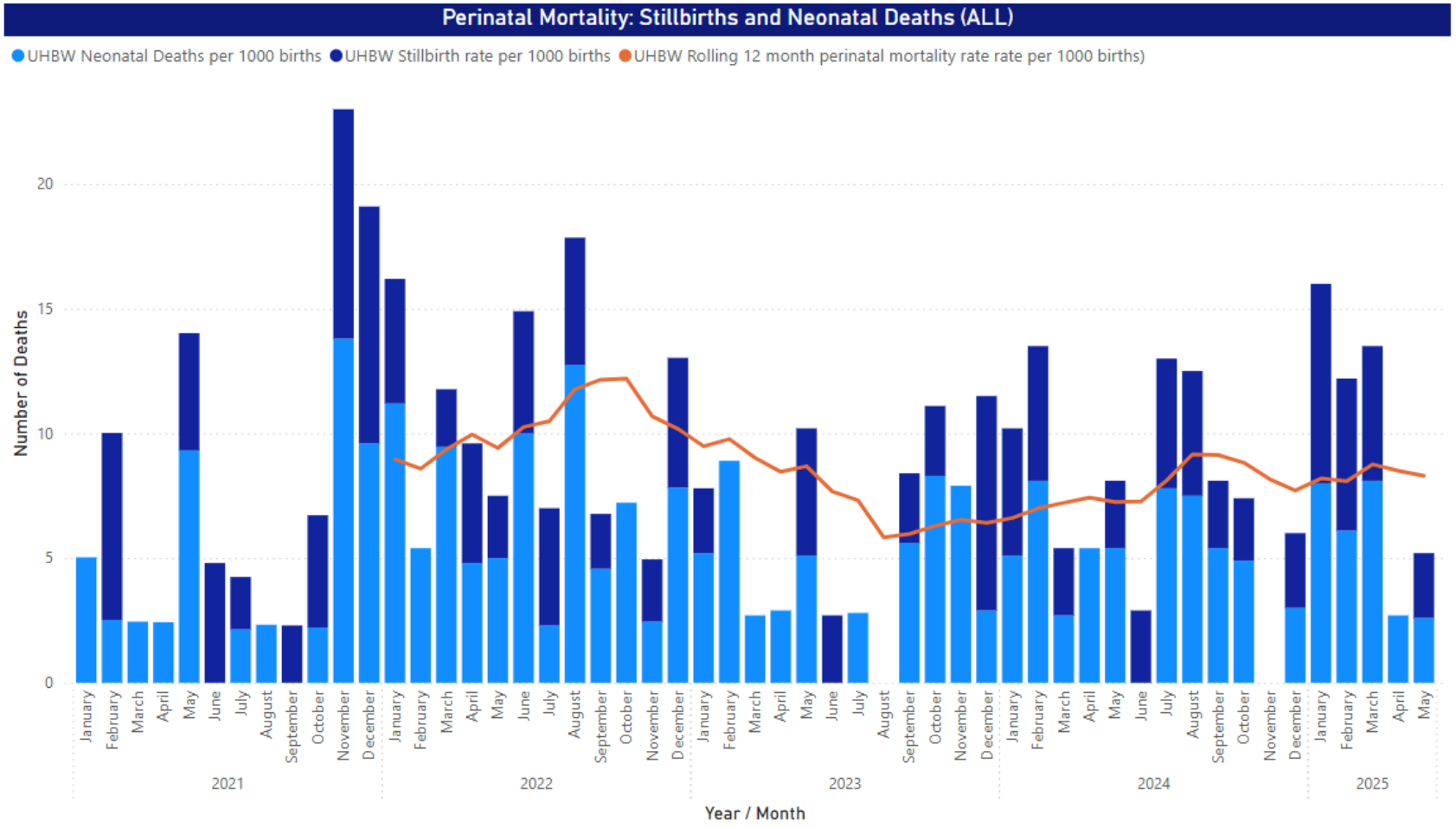
3.4 per 1000 births



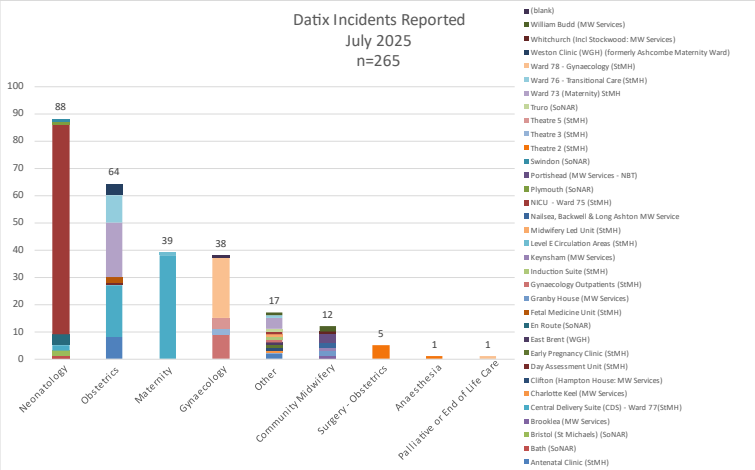
July 2025
Rolling 12 monthly neonatal death rate (ALL):

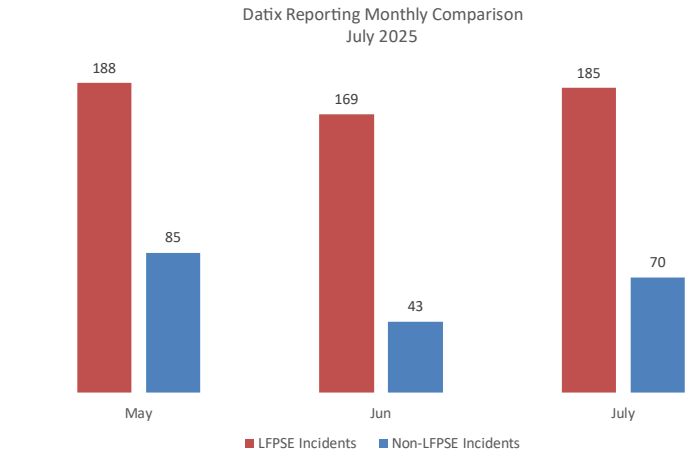
5.6 per 1000 births

Perinatal Mortality & Morbidity



Incident Reporting & Reviews





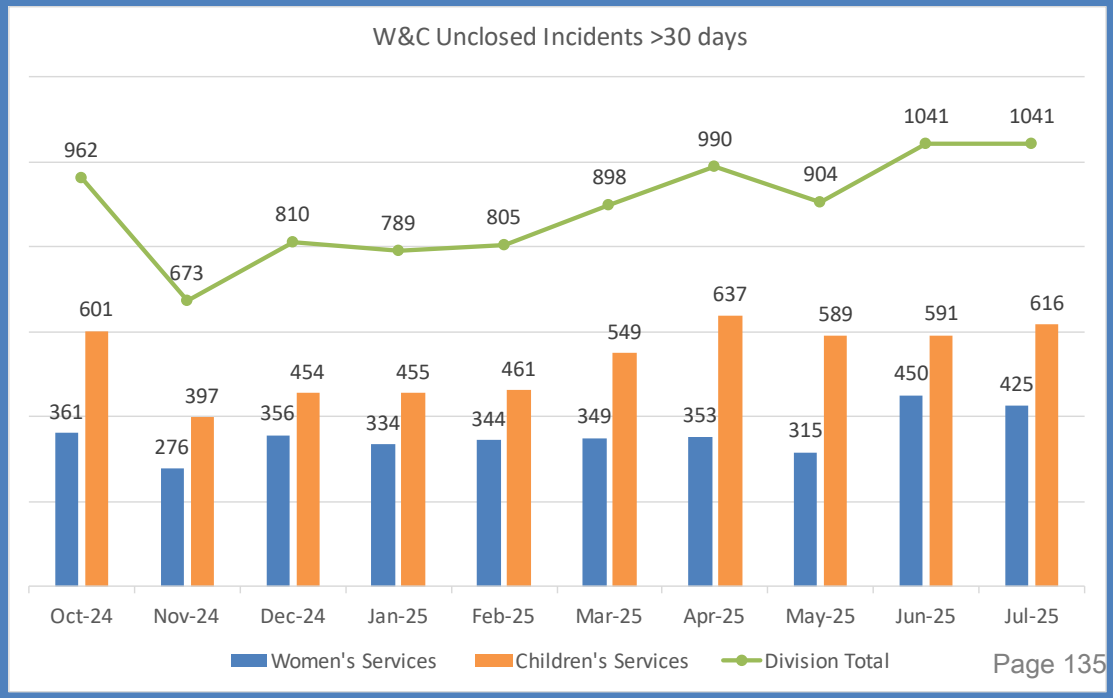
CQC Action Required:
The service must ensure incidents are reviewed in a timely manner. Regulation 17 (2) (b)

Steady progress, although slower than desirable being made.

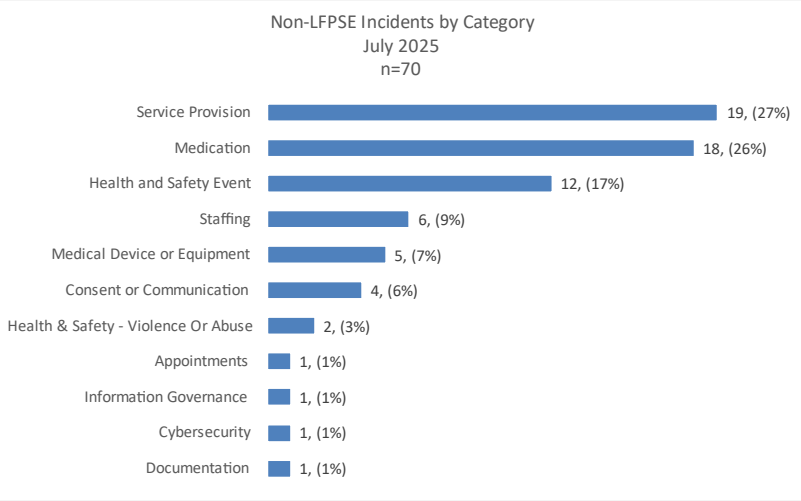
The QPS team continues to offer support to Datix / Incident handlers to ensure timely review and closing of incidents.

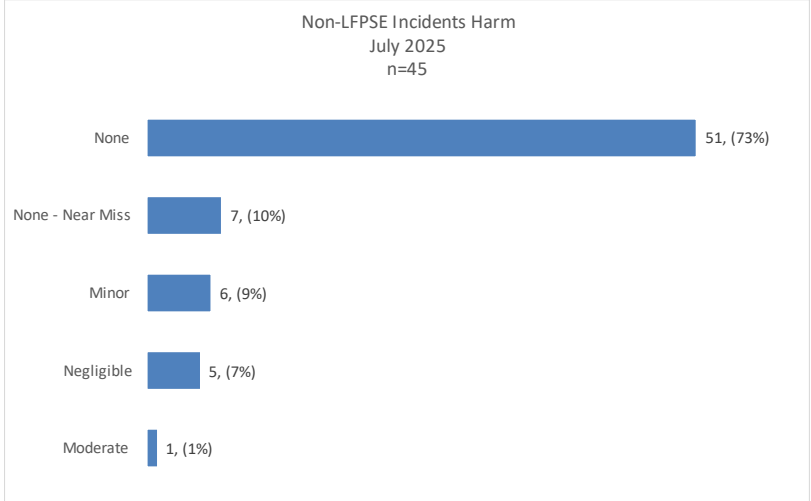
Current Hotspots:
- **NICU**
- **Central Delivery Suite**

Acuity within these area's continues to impact timely review and closure of Datix / incidents.

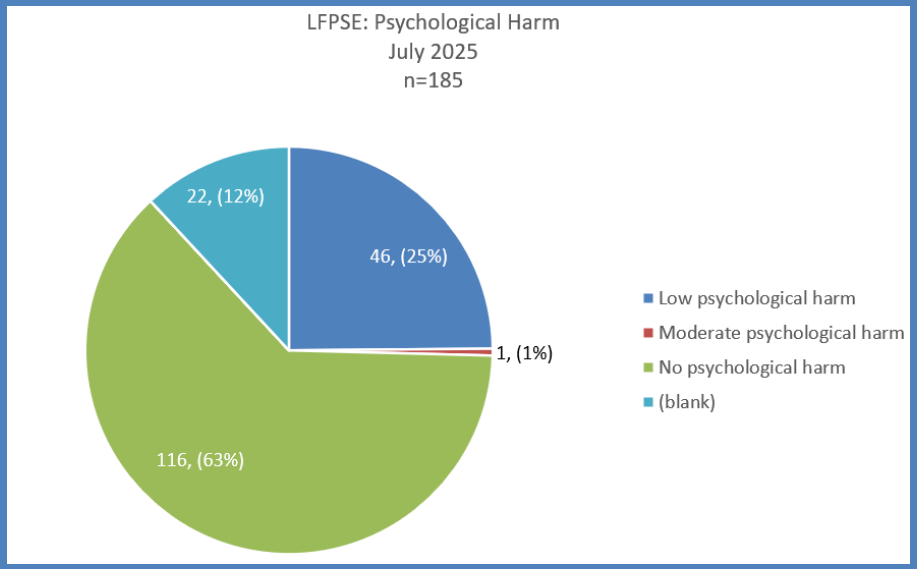


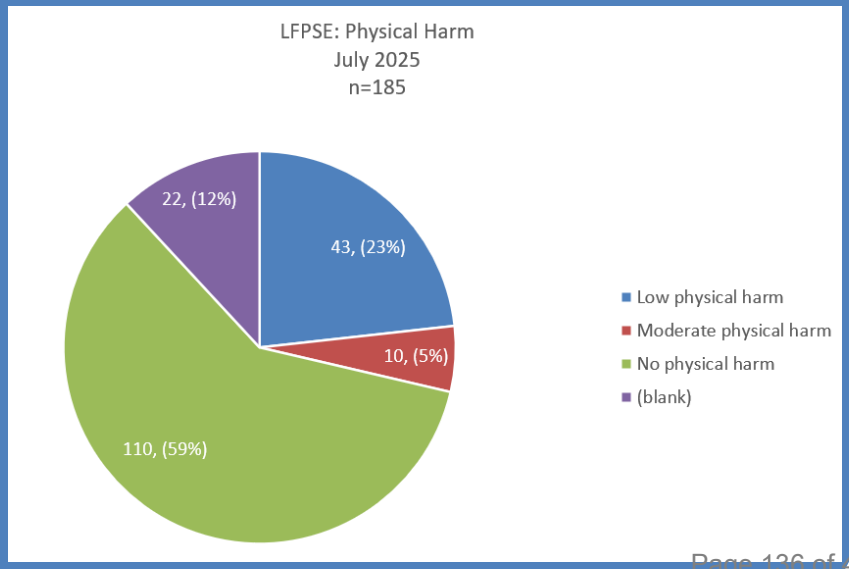
Incident Reporting & Reviews





Learning from Patient Safety Events (LFPSE)





New 'Harm' Cases Reported in July 2025

Datix	Date of Incident	Level of Harm	Incident	Outcome/ Learning Actions	MNSI Reference (If applicable)
296739	06/07/2025	Psychological Harm to mother	NND	PMRT and MNSI completion due Jan 2025	MI-043517
296762	07/07/2025	Psychological Harm to mother	NND	PMRT completion due Jan 2025	N/A
296013	01/07/2025	Psychological Harm	Antenatal Stillbirth	PMRT completion due Jan 2025	N/A
296137	02/07/2025	Psychological Harm	Antenatal Stillbirth	PMRT completion due Jan 2025	N/A
297424	12/07/2025	Psychological Harm to mother	NND (>28 days)	PMRT completion due Jan 2025	N/A
297763	02/07/2025	Fatal	(Indirect) Maternal Death	MBRRACE Referral complete – No care management issues identified	N/A
297447	12/07/2025	Moderate Physical	Extravastion injury	Will be reviewed as part of PMRT – Datix 297424	N/A
298973	26/07/2025	Moderate Physical	HIE - cooling	MRI normal – MNSI case rejected	N/A
299562	27/07/2025	Moderate Physical	Fractured femur (birth injury)	Awaiting initial review and RIR	N/A

Perinatal Mortality Review Meeting Outcomes: June 2025 (July 2025 meeting cancelled)

PMRT Ref No.	Intrauterine Death (IUD) or Neonatal Death (NND)	Datix No.	Date Discussed	PMRT Grading	Issues/ Actions?	Issue (generated by PMRT)	Issue Explanation	Categorisation of Issue	Sub-Category of Issue	Action Description	Categorisation of Action	Sub-Category of Action	Datix Action No.	Target Date	Datix Action Completion	Effectiveness Audit or additional action required? If yes, add as action to Datix and put Action number here	Audit / additional action Follow up
97813	IUD	285666	18/06/2025	1 = A 3 = B	Issue/ No Action	This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	The partogram does not show hourly maternal pulse or comment on contractions (oxytocin was given).	Omission	Clinical documentation								
					Issue/ No Action	Custom	Mother was invited in to continue the induction of labour process in the afternoon due to the acuity of the unit. Mother fedback that she felt she was waiting a while to be phoned to be invited in. She would have preferred if she could have been given a clearer plan of when she may have been called.	Quality assurance	Communication - Family								
					Issue/ Action	Custom	A student midwife attended the home postnatal visit with a community midwife. The mother would have preferred not to have a student present and would have declined if this had been discussed with her prior.	Quality assurance	Communication - Family	Reminder to community midwives that they should gain consent for a students prescence at a home visit, especially when there has been a perinatal loss.	Quality assurance	Communication - Family	106717	01/08/2025	Outstanding		
97332	IUD	282616	18/06/2025	1= A 3 = D	Issue/ Action	Custom	This mothers fundal height measurement had gone up by 2cm in 3 weeks. This would not prompt a growth ultrasound scan however the review of this case highlighted that our Trust SFH could be improved to be made clearer when a growth USS is required.	Guidance	Fetal growth surveillence	Please could Antenatal Governance review the SFH guideline and clarify what is tailing growth on SFH measurement and therefore when a referral for USS is required.	Guidance	Fetal growth surveillence	103376	01/08/2025	Outstanding		
					Issue/ Action	Custom	A community midwife phoned this mother on Day 5, having not read the maternity notes, to arrange a 'baby check'. Understandably, this was distressing to the mother and further postnatal community visits were declined. This likely contributed to why this mother did not received adequate postnatal advice e.g. around exercise. In view of this, the review group graded this mothers care post-loss as a 'D'.	Quality assurance	Communication - Family	Reminder to community midwives to ensure that a robust system is in place of checking notes/ key information prior to making contact with a family.	Quality assurance	Communication - Family	106719	01/08/2025	Outstanding		
97247	NND	282193	18/06/2025	1=A 2=A 3=A	Issue/ No Action	The thermal management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate	Due to Hajars' lack of movement, she did not have the ability to maintain her own temperature whilst under going central access despite trying to optimise her incubator temperatures. Transwarmers and increasing incubator temperatures as well as bubble wrap were used where possible.	Quality assurance	Neonatal care								
97788	NND	285647	19/06/2025	1=A 2=A 3=A	Issue/ Action	Custom	The review group highlighted that the size of the theatre and space available for twin deliveries, especially extreme pre-term twins where complex resuscitation and stabilisation is required, is not always adequate. Although this had no impact on the outcome for these twins, this is something that the trust should consider adding to the risk register.	Quality assurance	Birth enviroment	Discussion around limitation of space in Theatre 2 at CDS governance and preterm birth group and addition of risk to the Trust risk register.	Quality assurance	Birth enviroment	106716	01/08/2025	Outstanding		
97788	NND	285647	20/06/2025		Issue/ Action	During resuscitation the baby required intubation but this was not achieved	Multiple attempts to intubate made however due to extreme prematurity, unsuccessful. Difficult intubation escalated via 2222 to difficult airway ENT team however adult ENT team arrived instead of paediatric. This had no impact on the outcome.	Misinterpretation	Communication - Staff	Action to obtain recording from switchboard to identify where learning required i.e. the team making the request or the switchboard team.	Quality assurance	Communication - Staff	106722	01/08/2025	Outstanding		

Ongoing MNSI Investigations / PSIIs

Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
254196	25/04/2024	Severe physical harm Moderate psychological harm	Emergency Caesarean for fetal wellbeing Post-operative Illius with conservative manangement Subseqent bowel perforation / ICU admission	**Meets criteria for PSIRF Learing Response:** Verbal DOC completed, written DOC completed in conjuction with Surgical Services Joint RIR Meeting held with Surgical Services Accepted for **Trust PSII** (investigation commence July 2024) Referral for psychological services completed	N/A
265400	22/08/2024	No physical harm Moderate psychological harm	Intrapartum Stillbirth	**MNSI** Final report received and shared – Action plan pending	MI-038042
269518	03/10/2024	No physical harm Moderate psychological harm	Intrapartum Stillbirth	**MNSI** Final report received and shared – Action plan pending	MI-038599
279844	16/01/2025	Never Event	Retained Vaginal Swab following Instrumental Delivery	**Meets criteria for PSIRF Learing Response:** Verbal and written DOC completed Accepted for **Trust PSII**	NA
295869	27/6/25	Psychological Harm (to mother)/ Harm to baby	Unexpected term HIE	MNSI case accepted	MI-043517
298973	26/7/25	Harm downgraded	Term HIE	Case referred to MNSI and subsequently rejected by MNSI as MRI normal	MI-044717
299591	23/7/25	Awaiting metabolic test results to determine harm	Term HIE	Baby delivered at RUH however so e early labour are provided by UHBW CMW's. Referred to MNSI however awaiting test results for potential underlying metabolic cause.	MI-944721

Maternity Safety Support Programme:

N/A

Coroner's regulation 28:

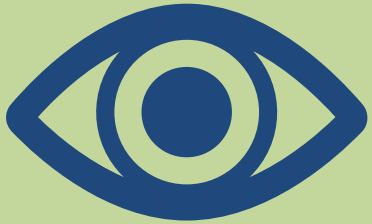
N/A

Service Insights: Patient & Staff Engagement

Patient Safety Walk Round

July 2025

Departments: CDS, NICU
Date: 30th July 2025
Areas: CDS, NICU



CDS - We discussed the strain that increased rates of maternal choice caesareans are having on CDS and the CDS Band 7 midwife highlighted that having a separate area for elective caesareans would be helpful.

CDS - The lack of IT support overnight was discussed. Now that CDS uses BadgerNet, CMM and has centralised CTG monitoring it was felt that overnight IT support would be very helpful.

CDS - It was highlighted that on CDS there is ongoing connectivity issues with the centralised CTG monitoring system. These incidents are being consistently submitted to datix and are being reviewed by the informatics midwife and IT to identify ways to rectify this issue.

NICU – we spoke to a Band 6 staff nurse whose positivity and attitude impressed the group immensely. We discussed the need for more QIS nurses on NICU and more staff in general. We spoke to a Band 7 nurse who was undertaking interviews for both these roles on that day. The group noted that the removal of one cot space in the temporary ITU 1 was really helping.

Compliance with National Directives: Maternity (and Perinatal) Incentive Scheme – Year 7

MIS Safety Actions	Compliance with MIS Actions Year 5	Compliance with MIS Actions Year 6	Compliance with MIS Actions Year 7
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?			
Can you demonstrate an effective system of clinical workforce planning to the required standard?			
Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?			
Listen to women, parents and families using maternity and neonatal services and coproduce services with users.			
Can you evidence the required elements of local training plans and 'in-house', one day multi professional training?			
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?			
Have you reported 100% of qualifying cases to MNSI and to NHS Resolutions Early Notification (EN) Scheme?			

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 7 Guidance published 2 April 2025

Compliance Submission Deadline: 3March 2026

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Compliance with National Directives: Maternity (and Perinatal) Incentive Scheme – Mandatory Training

Training	Target	Local Threshold			Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Year to date average	Trend	SPC		Comment
		G	A	R															Variation	Assurance	
Training compliance fetal wellbeing day - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	62%	68%	70%	93%	91%	91%	75%	63%	63%	63%	63%	63%	72%				
Training compliance fetal wellbeing day - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	90%	94%	95%	98%	91%	91%	88%	87%	84%	89%	88%	90%	90%				
Training compliance in maternity emergencies and multi-professional training - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	69%	72%	70%	93%	90%	96%	79%	79%	79%	79%	79%	79%	80%				
Training compliance in maternity emergencies and multi-professional training (includes NBLS) - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	92%	93%	89%	96%	93%	89%	96%	93%	90%	88%	95%	93%	92%				
Training compliance in maternity emergencies and multi-professional training - Anaesthetists (ALL)	MIS Y6 70%	≥70%		≤60%	53%	49%	47%	94%	94%	95%	95%	95%	95%	95%	95%	95%	84%				
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	MIS Y6 90%	≥90%		≤80%	86%	84%	89%	96%	92%	92%	92%	92%	92%	92%	92%	92%	91%				
Training compliance annual local NBLS - NICU Doctors (ALL)	MIS Y6 90%	≥90%		≤80%	91%	95%	95%	95%	95%	100%	100%	100%	100%	100%	Data Pending	Data Pending	81%				
Training compliance annual local NBLS NICU ANNPs (ALL)	MIS Y6 90%	≥90%		≤80%	95%	93%	96%	96%	96%	96%	98%	98%	98%	96%	89%	89%	95%				
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	MIS Y6 90%	≥90%		≤80%	74%	80%	88%	97%	95%	92%	92%	92%	92%	90%	81%	68%	87%				Added to NICU gov agenda to discuss reopening risk 7562 as complisnce has dropped below 70%

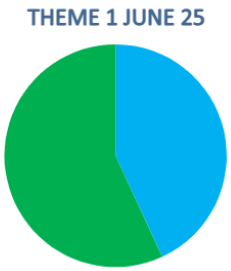
Compliance with National Directives: Three Year Delivery Plan

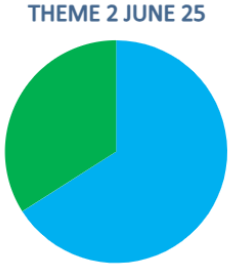
Theme 1

Milestones/targets	Work completed Q1	Work scheduled
Birth Choices	NBT established UHBW set up a pilot personalised clinic system	Review Sept 2025
Share LMNS Equity and Equality Plan Highlight report with Trusts	Shared with Trusts	Explore whether this can be made a live document and whether we can create a one page infographic
Commence NBT/UHBW Equity in Pain Management Q1 Project	First meeting held 29/4/25	Literature review in progress
Complete MNVP self assessment tool and develop action plan	Self assessment took place 19/5/25	This will be completed quarterly
Define and agree Personalised Care workstreams across LMNS, UHBW and NBT	LMNS Programme Manager appointed, draft action plan and ToR developed. Task group for patient communication/patient leaflet set up.	First meeting scheduled for Sept.
Commission Real Birth Company	Funding approved at LMNS Board 15/5/2025	Date to be agreed for training to commence and go live
Commission and implement community perinatal mental health service	Both Trusts have established services. VCSE offer is being re-commissioned	Award contract and ensure oversight from LMNS

Theme 2

Milestones/targets	Work completed Q1	Work scheduled
Retention issues and improvement plans	Review of retention by staff group completed and sharing of good practice via COP once established	LMNS to feedback to Trusts LMNS rep to attend COP once established
Agree staffing levels	LMNS have developed a workforce tool, shared regionally – positive feedback	Take to D&T in July for full discussion and sign off
Student placement capacity	Interviews concluded with MNVP rep. 2 places awarded per Trust for MSW to attend midwifery apprenticeships Sept 25	Support MSW on their courses.





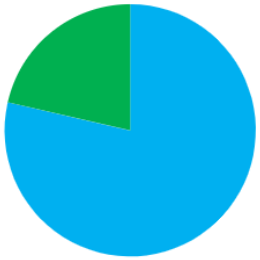
RAG Key	
Complete / BAU	33 (75%)
In progress on track	10 (23%)
Planned (for year 3)	1 (2%)
Not started/overdue	0
TOTAL	44

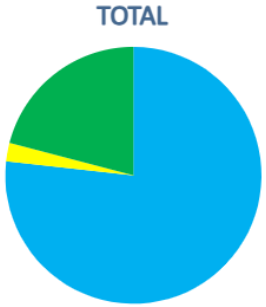
Compliance with National Directives: Three Year Delivery Plan

Theme 3

Theme 4

Milestones/targets	Work completed Q1	Work scheduled
System wide meeting to discuss the launch of SBLv3.2	Meeting held in May and reporting schedule planned	Complete reporting schedule
System wide meeting to discuss the launch of MIS Year 7	All system partners attended NHSE launch event	
Commission care with due regard to NICE	Programme Manager in post	Programme manager to review technical guidance. Escalate to regional team for guidance re evidence.





RAG Key	
Complete / BAU	33 (75%)
In progress on track	10 (23%)
Planned (for year 3)	1 (2%)
Not started/overdue	0
TOTAL	44

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, e (MNSI).

IEA	Number of Assurance Questions	N/A for UHBW or National Actions	Red	Amber	Green	Blue	Completed and evidenced	% of Compliance
1. Workforce Planning and Sustainability	11	1	0	0	0	0	10	100
2. Safe Staffing	10	2	0	0	0	1	7	88
3. Escalation and Accountability	5	0	0	0	0	0	5	100
4. Clinical Governance and Leadership	7	1	0	0	0	0	6	100
5. Incident Investigations and Complaints	7	0	0	0	0	2	5	71
6. Learning from Maternal Deaths	3	2	0	0	0	0	1	100
7. Multidisciplinary Training	9	0	0	0	0	0	9	100
8. Complex Antenatal Care	5	0	0	0	1	0	4	80
9. Pre-term Birth	4	1	0	0	0	0	3	100
10. Labour and Birth	6	0	0	0	0	0	6	83
11. Obstetric Anaesthesia	5	2	0	0	0	0	3	100
12. Postnatal Care	4	0	0	0	0	0	4	100
13. Bereavement Care	4	0	0	1	0	0	3	75
14. Neonatal Care	8	3	0	1	0	0	4	80
15. Supporting Families	3	0	0	1	0	0	2	67
TOTAL	91	12	0	3	1	3	71	90

	N/A for UHBW or National Action
	Immediate remedial action required to progress
	Action required for successful delivery of this activity
	Activity on target
	Completed activity (evidence sign off required)
	Completed activity (evidence signed off)

Next Steps for Progression:

- IEA13 – Creation of new ' Bereave ent Cha pion' role to support day bereave ent support
- IEA14 – Neonatal Staffing action plan review scheduled
- IEA15 – Improving accessibility to psychological services to ensure equitability for all patients/families

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Annual Learning from Deaths Report reports 24-25 (North Bristol NHS Trust and University Hospitals Bristol & Weston NHS Foundation Trust)		
Report Author:	Dr. Joydeep Grover, Medical Director, Patient Safety & Quality Dr. Karin Bradley, Associate Medical Director Paul Cresswell, Director of Quality Governance		
Report Sponsor:	Prof. Tim Whittlestone, Group Chief Medical and Innovation Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		

Key Points to Note

The 2024-25 annual Learning from Deaths (LFD) reports for each Trust within the Bristol NHS Group mark a significant milestone in our UHBW-NBT collaborative journey. For the first time, the framework of the annual reports is fully aligned, paving the way for a future combined report. This achievement has been delivered by the Joint Mortality Improvement programme – a collaboration that was formally established as a jointly resourced initiative in February 2025.

Each report (**Appendices A & B**) meets all statutory requirements under NHS Quality Account Regulations and National Quality Board Guidance and our collaboration to date is already contributing towards both preventing avoidable harm and promoting dignity in the last phase of life. Within **Appendix C**, we have compared the current systems and approaches at each trust.

The ongoing work for mortality improvement will drive considerable future benefits around the underlying mortality surveillance approaches – clinically, operationally and digitally. This will provide a key assurance source during the significant corporate and clinical changes that will continue under the Joint Clinical Strategy and as we progress towards and then beyond the planned organisational merger during 2026.

From an in-year reporting and assurance perspective.

- The total number of in-patient deaths in 2024-25 remains stable compared to 2023-24 for both trusts.
- Both trusts remain safe organisations with a Standardised Hospital Mortality Index (SHMI) falling safely within the NHSE ‘as expected’ category and we undertake detailed reviews of the quarterly SHMI data to identify potential outlier conditions.
- Beyond SHMI, the LfD processes provide more detail and insights into the quality of care that our patients receive and help identify areas where we can further learn and improve.
- 17.3% of UHBW deaths were highlighted for further review following independent scrutiny by the Medical Examiner (ME) service (which includes listening to concerns raised by the bereaved). This figure was relatively lower, at 8.3% for NBT. We have scoped a focused

review of Medical Examiner referral thresholds and themes to understand this variation, which is now in progress and will evaluate the cause and inform future alignment actions.

- All ME feedback is reviewed at an individual patient level to ensure that any learning opportunities are sought whilst also avoiding duplication of work. A variety of pathways may be triggered by ME feedback, including a patient safety or PALS process, feedback to specific clinical teams or a detailed review of the deceased's last hospital admission known as a Structured Judgement Review (SJR). During 2024- 25 SJRs were completed on 5.7% of adult deaths at UHBW and 8.5% at NBT (noting the separate well-established Child Death Review process).
- Importantly, neither an ME referral nor an SJR being triggered are valid outcome metrics of quality of care, they are merely triggers for additional reflection. The completed SJRs scored in-patient care at as adequate, good or excellent (majority good or excellent) in 96.7% of cases (UHBW) and 97.7% of cases (NBT). No deaths were thought to have been 'definitely avoidable' at either trust.
- We complete a priority review for all patients who have died at either NBT or UHBW with a learning disability or autism diagnosis. Because these groups are known to experience poorer health outcomes due to healthcare inequalities, every death is subject to an enhanced review process. Whilst most care scores were rated at least 'adequate' or better, several themes required attention including constipation management, mental capacity assessment, and documentation of decision-making processes. We identified challenges in involving Independent Mental Capacity Advocates (IMCAs) when required. We are addressing these issues through our Mental Health Strategy implementation at each trust and also through sharing across the wider healthcare system via the LEDER programme.
- Considerable positive family feedback has also been received for both trusts and shared directly with relevant staff.

Strategic and Group Model Alignment

The Learning from Deaths national guidance was published in March 2017, by the National Quality Board (NQB). NBT and UHBW have both consistently achieved the key requirements. A joint approach to the nationally mandated establishment of the Medical Examiner Service was undertaken in 2020 and a commitment to ensuring robust integration. This placed NBT and UHBW in a strong position during the pandemic and beyond.

More recently the establishment of a joint Mortality Improvement Programme is a fundamental link into our wider community (working with the Medical Examiner Service which now covers all deaths including outside of hospital) and to ensure alignment and improvement of our respective approaches at each trust, which is particularly key as we bring clinical services together under the Joint Clinical Strategy and align/merge corporate services.

Risks and Opportunities

The top learning themes identified from SJRs were around communication at staff handover, communication between staff and patients/relatives (especially at end of life), improving pain relief and reducing risks of extended days within the Emergency Department. Learning and actions are managed through Divisional mortality and patient safety leads and shared with Divisional senior triumvirates for oversight.

Case review, data collection and tracking for LFD relies heavily on disparate processes between each trust, which require alignment. In some cases, this currently requires significant administrative

time and limits the ability to analyse trends efficiently. In 2025-26, we plan to enhance digital systems for mortality and look to further integrate LfD with our Patient Safety Incident Response Framework (a recognised national challenge). We also aim to more closely integrate the LfD requirements with speciality Mortality and morbidity meetings to enhance efficiency and broaden learning opportunities.

There is continued opportunity to deliver future combined NBT-UHBW LfD reports and to further strengthen system-wide partnerships across the region and continue to lead national policy through chairing the National Community of Practice in this area.

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Recommendation
This report is for Approval. The Board is asked to consider the assurance provided within this ongoing key area of quality governance and to endorse the ongoing alignment work at a critical time of organisational change.

History of the paper (details of where paper has <u>previously</u> been received)	
UHBW report reviewed at UHBW Clinical Quality group.	September 2025
Alignment timings for board/governance changes have not enabled this at NBT. Trust level and Executive level approvals given.	September 2025

Appendices:	A – North Bristol NHS Trust Annual Learning from Deaths report 2024/25 B - University Hospitals Bristol & Weston NHS Foundation Trust Annual Learning from Deaths report 2024/25 C - Bristol NHS Group Learning from Deaths - Board Briefing Comparative Analysis 2024-25

North Bristol NHS Trust

Learning from Deaths Annual Report 2024-25

For the period ended

31 March 2025

CARING | AMBITIOUS | RESPECTFUL | SUPPORTIVE

NHS Bristol NHS Group Bristol | Weston

Contents

Foreword

In 2024-25 we have progressed further on our journey that started with Mortality Reviews, moved to Learning from Deaths, and is now contributing towards both preventing avoidable harm and promoting dignity in the last phase of life.

The data in the report illustrates that NBT remains a safe trust, serving not only patients with very complex needs at a supra-regional level, while also providing basic acute care to the local population. Our SHMI data remains stable and 'better than expected' of comparable trusts.

Our internal processes are robust with SJR completion rates of 99%, and zero ratings of 'definitely avoidable' deaths. The overall care provision scores which moved up in July 2023 have consistently now remained at high levels giving us a new, higher, baseline.

The report also illustrates how we have developed methods to review mortality signals, tally SHMI with clinical and other coding data, and identify areas of excellence as well those in which we need to focus further. It describes our governance process around mortality and various safety nets that exist to ensure that all deaths are reviewed and learning taken and shared.

There is obviously more to do, some areas of focus are described, and these include achieving consistency in SJRs across specialties, and in closing the loop with learning from the ME service feedback amongst others.

NBT launched its Mortality Improvement Program in December 2023, with an aim for it to be a system wide program. In January 2025 it was formally agreed as a group activity and is already well on its way to not only describing the issues around process and cultures but also clarifying how the governance across the group on this important aspect of safety will be aligned to a single process. This joint report highlights the immense dedication of our colleagues who have made this possible and to all of them I am very grateful.

Dr Joydeep Grover

Medical Director - Safety and Quality

Executive Summary

Our learning from deaths processes enables us to identify areas where we can improve care for future patients and recognise the excellent care that many families[1] specifically wanted us to acknowledge.

Key statistics for 2024-25

- **2,097 total deaths** – stable compared to 2023–24, with SHMI consistently classified as "as expected."
- **189 Medical Examiner referrals (152 concerns) (8.3% of deaths) following independent review**
- **179 detailed reviews (8.5% of adult deaths) following Medical Examiner Referral and/or allocation by clinical teams**
- **99 detailed case note reviews for mandatory priority groups** – including 25 for patients with a learning disability or autism and 30 for patients with a severe mental illness.

This report builds on the foundations set out in our 2023–24 report, where we identified priorities around coding accuracy, timely reviews, and improved system collaboration. Over 2024–25 we have delivered against many of those priorities.

Key Achievements

- **97.7% of reviews rated care as adequate, good, or excellent.**
- **No deaths assessed as "definitely avoidable."**
- **Enhanced processes for learning disability and autism deaths**, reducing review times.
- **Joint Mortality Improvement Programme expansion with UHBW,** piloting enhanced Structured Judgement Reviews (eSJR) and digital automation.
- **Improve clinical coding and documentation,** supporting a clearer reflection of clinical reality in national statistics, where case-mix and national methodologies allow.

Top learning themes

1. **Communication** – clearer, more consistent updates for families and improved documentation of treatment escalation plans.
2. **End-of-life care** – strengthened advance care planning and more coordinated palliative care support.
3. **Patient Flow and safety** – targeted work in the Emergency Department to identify and reduce risks linked to extended stays.

What families told us

Families praised staff for their kindness and professionalism, describing care as “compassionate,” “calm,” and “beyond expectations.” Feedback also highlighted opportunities to improve communication, which have informed targeted improvement actions.

Looking ahead to 2025-26

We will develop our use of digital systems for real-time data analysis, integrate our Learning from Deaths approaches with the Patient Safety Incident Response Framework, refine our Medical Examiner feedback thresholds, and strengthen our system-wide partnerships to share learning more effectively across our region.

Section 1: Deaths in our care

1.1 Annual overview of deaths in our care

The national guidance on learning from deaths recommends reporting annual information on the total of in-hospital deaths recorded by each Trust. During 2024-25 there have been a total of 2097 deaths at North Bristol Trust (NBT).

As is it to be expected, deaths are not evenly distributed across the Trust, and the Care of the Elderly specialty saw the most deaths in older people with multiple long-term health conditions, often following acute deterioration of their condition. While these deaths may not be unexpected given the person's underlying health, we systematically review selected cases to identify ways to improve care and share good practice.

Child deaths, stillbirths, and maternal deaths

Child deaths are excluded from this report as they follow separate specialist Child Death Review (CDR) processes with different timelines. CDR meetings are typically arranged within 3 months. However, post-mortem and investigation reports can take several months or years to complete, meaning data becomes available later than adult mortality data.

The CDR process at NBT follows statutory guidance and is integrated with our quality and patient safety processes, which report through our Women & Children's Divisional Mortality Oversight Committee and the Child Death Overview Panel.

Stillbirths, late foetal losses, neonatal deaths, and direct maternal deaths (deaths during pregnancy or within 42 days of delivery) are also excluded from this report as they follow separate national review processes.

Stillbirths, late foetal losses, and neonatal deaths are reviewed through the Perinatal Mortality Review Tool (PMRT), while maternal deaths are reviewed through the national Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) process. These reviews involve teams from across divisions and follow specialised national guidance.

Total hospital deaths

The figures in this report include all deaths in our hospitals, with 'deaths reviewed' referring to adult deaths only due to separate processes for neonatal, child, and maternal deaths. Figure 1 demonstrates stable year-on-year mortality with normal quarterly variation. Regional mortality context is provided in Appendix 1.

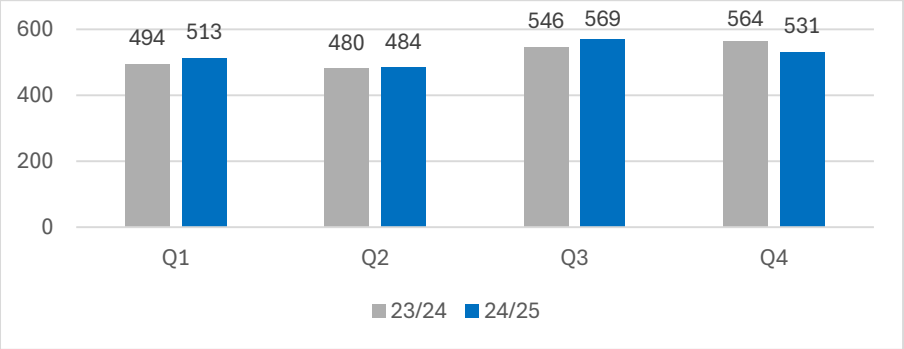

FIGURE 1: NBT TOTAL DEATHS BY QUARTER, 2023-24 AND 2024-25 COMPARISON

Division/ Specialty	Number of Deaths	Number of Completed SJRs	% of Deaths with a Completed SJR
NBT	**2097**	**179**	**8.5%**
ASCR	**484**	**40**	**8.3%**
Critical Care	282	29	10.3%
General Surgery	106	1	0.9%
Plastic, Burns & Dermatology	1	0	0.0%
Renal & Transplant	22	4	18.2%
Urology	34	2	5.9%
Vascular	39	4	10.3%
CCS	**1**	**0**	**0.0%**
Radiology	1	0	0.0%
Medicine	**1324**	**131**	**9.9%**
Acute Medical Unit	285	10	3.5%
Cardiology	34	0	0.0%
Care of the Elderly	614	22	3.6%
Clinical Haematology	14	0	0.0%
Diabetes & Endocrinology	12	0	0.0%
Emergency Medicine	96	88	91.7%
Gastroenterology	32	2	6.3%
Infectious Diseases	64	1	1.6%
Respiratory	173	8	4.6%
NMSK	**264**	**8**	**3.0%**
Neurology	28	0	0.0%
Neurosurgery	26	3	11.5%
Stroke	146	4	2.7%
Trauma	64	1	1.6%
WACH	**24**	**0**	**0.0%**
Maternity	10	0	0.0%
NICU	14	0	0.0%

FIG 2: NUMBER OF DEATHS AND SJRS - DIVISION AND SPECIALTY BREAKDOWN

The distribution of deaths across specialties is as expected with the majority of deaths occurring in Care of the Elderly under Medicine Division. We aim to have a fair and representative distribution of SJRs across the Trust which is currently not the case. While ITU, Neurosurgery, Vascular review approximately 10% of their mortality, on one end of the scale Surgery only reviewed 1 death (0.9%), and ED reviewed 88 (91.7%) While it is understandable that various specialties will not necessarily need to evaluate a set percentage, we aim to complete SJRs in line with criteria set by the National Quality Board (NQB) with more consistency across various specialties. As part of piloting new systems and processes with the Mortality Improvement Programme, the ED team is now evaluating this practice. A more targeted, criteria-based approach is being tested, ensuring all mandatory categories and a random sample continue to be reviewed. This aims to deliver a more proportionate review process, in line with both local and national Patient Safety Incident Response Framework (PSIRF) principles.

We will also be approaching specialties which are completing fewer SJRs to ensure there is a wide coverage of mortality at speciality level.

1.2 Summary Hospital-level Mortality Indicator (SHMI)

We monitor our Summary Hospital-level Mortality Indicator (SHMI) alongside our mortality review processes to understand the factors contributing to our banding. SHMI helps organisations identify areas where deeper exploration through Learning from Deaths processes might be needed. For further information on SHMI, see Appendix 3.

SHMI is the ratio between the actual number of patients who die following hospitalisation (up to 30 days post-discharge) at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. SHMI is NHS England's preferred national mortality indicator.

We review our SHMI data every month to check for any changes or patterns such as statistical variations. We report this to our Trust Board every quarter, alongside information about Medical Examiner referrals and detailed death reviews, giving us robust oversight and surveillance, and a complete picture of mortality across our Trust. For further information about how we use our data alongside our review processes for learning from deaths, see Appendix 3.

The most up-to-date available data for SHMI covers the period February 2024 – January 2025. NBT's value for that full period is 97.78 and our peer value is 100.22, indicating that we are performing better than our peer organisations. The SHMI for NBT has been consistently classified by NHS England as 'as expected' throughout 2024-25.

As illustrated in Figure 3, we have seen some normal variation in our in-month SHMI values. This has not been outside the process limits, indicating statistical stability with no individual months outside of the control limits prompting concern.

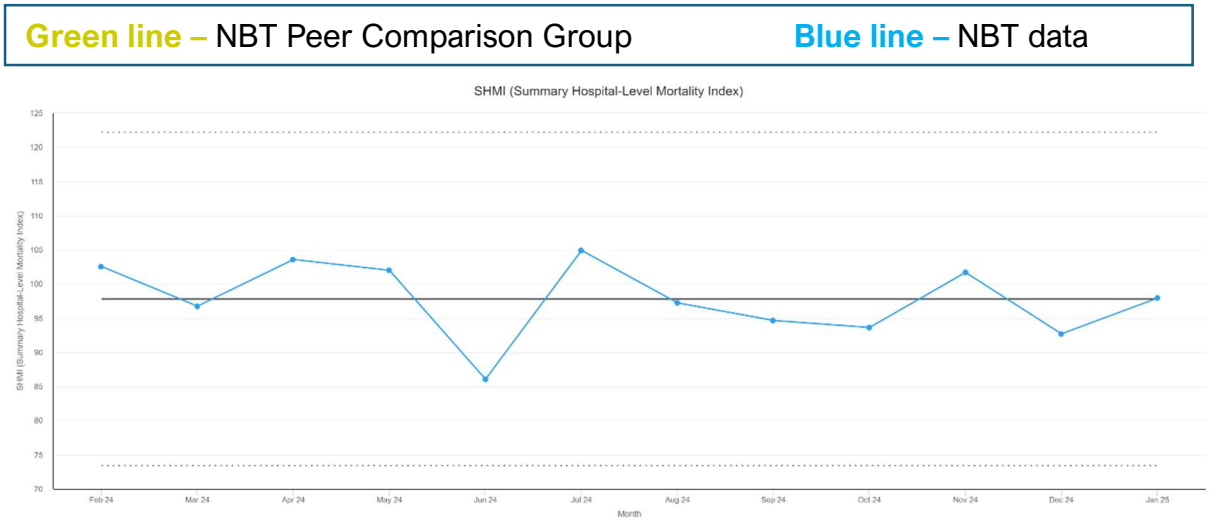

Figure 3: NBT SHMI Monthly values with statistical process control (SPC) limits, February 2024-January 2025 (data extracted from CHKS, latest available at time of publication)

Our trajectory for SHMI shows an upward trend over the reporting period whilst remaining below the peer average for the majority of months, as illustrated in Figure 4. The peer organisation figure is derived by averaging the SHMI totals of all acute NHS trusts and should show greater consistency each month as an averaging of a large sample. As SHMI is always a comparison, the trend is not necessarily indicative of any worsening of standards, it may simply suggest that comparator organisations are improving.

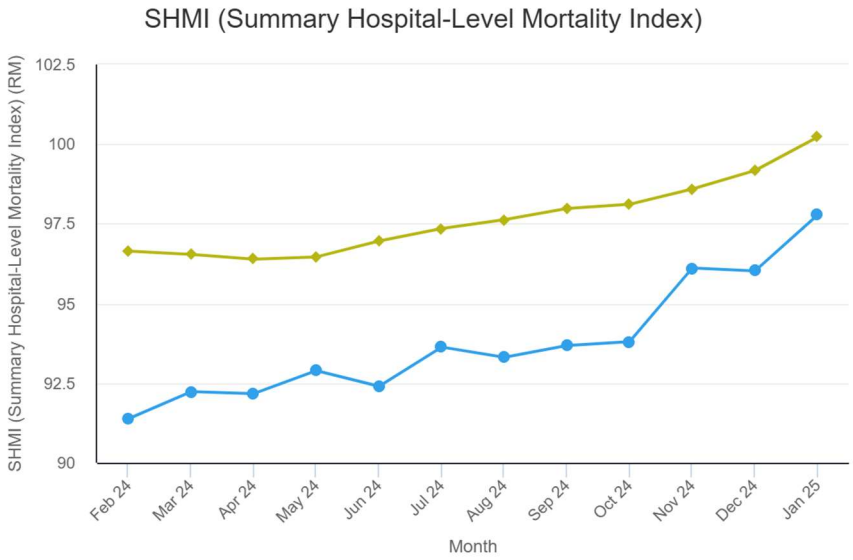

Figure 4: NBT SHMI time series chart (NBT in blue, peer group average in yellow), February 2024-January 2025 (data extracted from CHKS, latest available at time of publication)

Our peer distribution chart, see Figure 5 below, shows that NBT is positioned favourably within our peer group for the 12-month reporting period, which would be expected given that the majority of months NBT's SHMI was below the peer average.

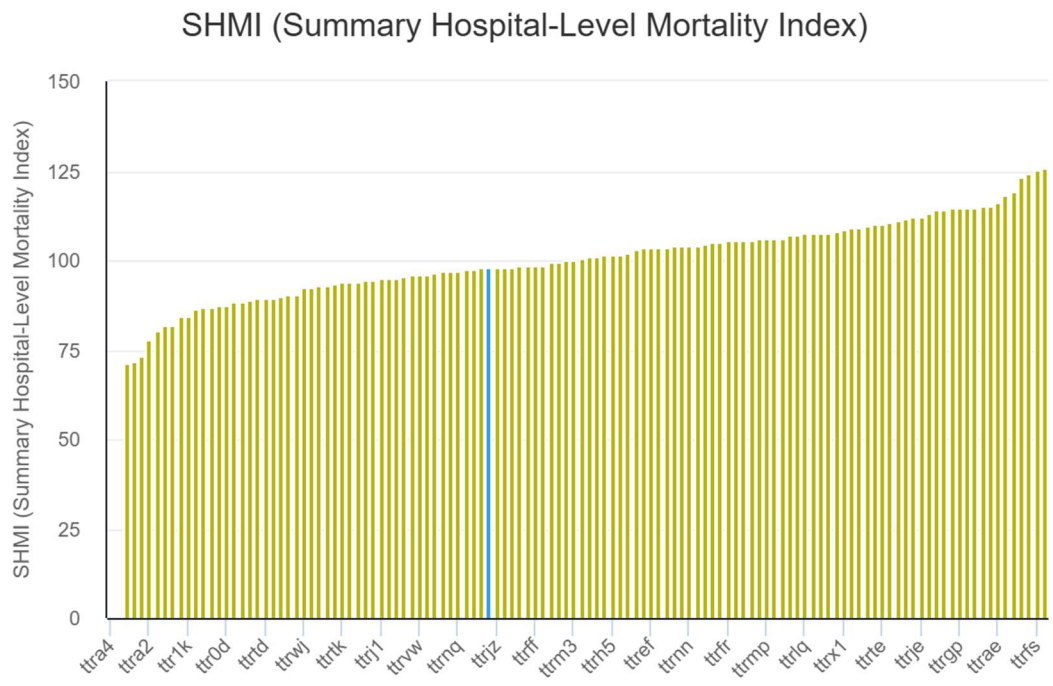

Figure 5: NBT SHMI positioning within our peer group for the 12-month reporting period time (NBT in blue, peer group average in yellow), February 2024-January 2025 (data extracted from CHKS, latest available at time of publication)

While SHMI tells us about patterns across all our patients, our Learning from Deaths processes tell us about the quality of care patients receive. Through detailed reviews of individual cases, Medical Examiner scrutiny, and systematic learning, we can identify specific issues and improvements that overall statistics cannot reveal. Together, they give us a complete picture of both our statistical performance and the real experiences of patients and families.

As part of our Mortality Improvement Programme, and in line with NHS England's "pyramid of investigation" for special cause variation, we have an aligned approach with UHBW on how we review SHMI preview data to identify where deeper clinical exploration or case reviews may be warranted. This structured approach ensures that statistical signals are first checked for coding accuracy and triangulated with audit findings and clinical insight before triggering detailed reviews.

High level insights from these reviews have also been shared with BNSSG public health teams, particularly around alcohol-related liver disease. Although NBT's mortality rates are not statistically higher than our peers, the region experiences higher numbers of liver-related deaths. We will continue to work with system partners to evaluate whether recent pathway changes are improving outcomes and to monitor how those changes are reflected in mortality data.

Over the reporting period, our approach to reviewing SHMI has delivered tangible improvements in how we understand and respond to mortality data. Diagnosis codes are now applied more accurately, meaning mortality is grouped more appropriately in national reporting, particularly for palliative care and allergy-related cases. This includes a targeted improvement in the use of "R-codes," which are applied for signs and symptoms rather than a confirmed diagnosis. While this coding is sometimes appropriate — for example, when a patient dies before a diagnosis is made — clearer documentation in some cases would have supported a more specific code. Alongside clinical teams, we have also improved our approach to documenting potential sepsis, ensuring it is only coded when clinically confirmed. These changes reduce statistical noise and help our SHMI data better reflect clinical reality.

However, it is important to note that SHMI is a high-level statistical tool rather than a direct indicator of care quality. Even with improved coding, interpretation requires triangulation with detailed case reviews, national and local clinical audits, and external benchmarking to ensure insights are meaningful and actionable.

1.3 Independent scrutiny of every death

The Medical Examiner Service

When a patient dies at NBT, their care record is updated, and the care received by the patient is independently reviewed by the Medical Examiner.

Since 9 September 2024, all deaths in England and Wales that are not investigated by a coroner must now be reviewed by NHS Medical Examiners, following the Department of Health and Social Care's Death Certification Reforms.

Bristol, North Somerset and South Gloucestershire (BNSSG) Medical Examiner Service

In 2020, we worked together with University Hospitals Bristol and Weston NHS Foundation Trust to establish the BNSSG Medical Examiner service ahead of the statutory requirement date, ensuring we had independent scrutiny of deaths and care quality four years before it became legally required.

During 2024-25, the service scrutinised all NBT adult and child deaths not referred to the coroner. This provided independent assurance for cause of death accuracy and gave every bereaved family the opportunity to raise concerns or receive answers about the care provided.

We also collaborate closely with the Senior Coroner, with the Medical Examiner Service providing clinical input on coroner referrals where appropriate, helping to maintain comprehensive oversight across deaths at our hospitals.

Section 2: How we review and learn from deaths

2.1 Our approach to reviewing deaths

We follow the National Learning from Deaths guidance for reviewing adult in-hospital deaths, and we meet all statutory reporting requirements under the NHS Quality Account Regulations. For detailed compliance data, see Appendix 2.

Deaths at NBT receive Medical Examiner scrutiny in line with statutory requirements. Where this scrutiny identifies concerns or where deaths meet specific criteria, we undertake the appropriate type of further review as detailed in our Learning from Deaths policy.

Some deaths require a full detailed review regardless of whether concerns are raised, as described in section 2.2.

Medical Examiner referrals

The Medical Examiner service enables families and carers to provide both positive and negative feedback. When the Medical Examiner identifies a concern or learning opportunity, this is referred into our Quality Governance team. These are disseminated to divisional governance leads who review each Medical Examiner referral to ensure the right response and next steps are taken. Further details on the different responses and processes used are available in the NBT Learning from Deaths Policy.

Between April 2024 and March 2025, the Medical Examiner Service referred 189 cases to NBT. The breakdown of referral type is shown in Table 1 and Figure 6 below.

Medical Examiner Referral Type	Number of Referrals
Concern only	146
Positive feedback and care concerns	6
Positive feedback only	37

TABLE 1: MEDICAL EXAMINER REFERRAL TYPES (CONCERNS AND POSITIVE FEEDBACK)

Referral rates vary between trusts, reflecting differences in case mix, reporting thresholds, and operational models. We continue to work with the Medical Examiner service to ensure consistent approaches across our Bristol NHS Group.

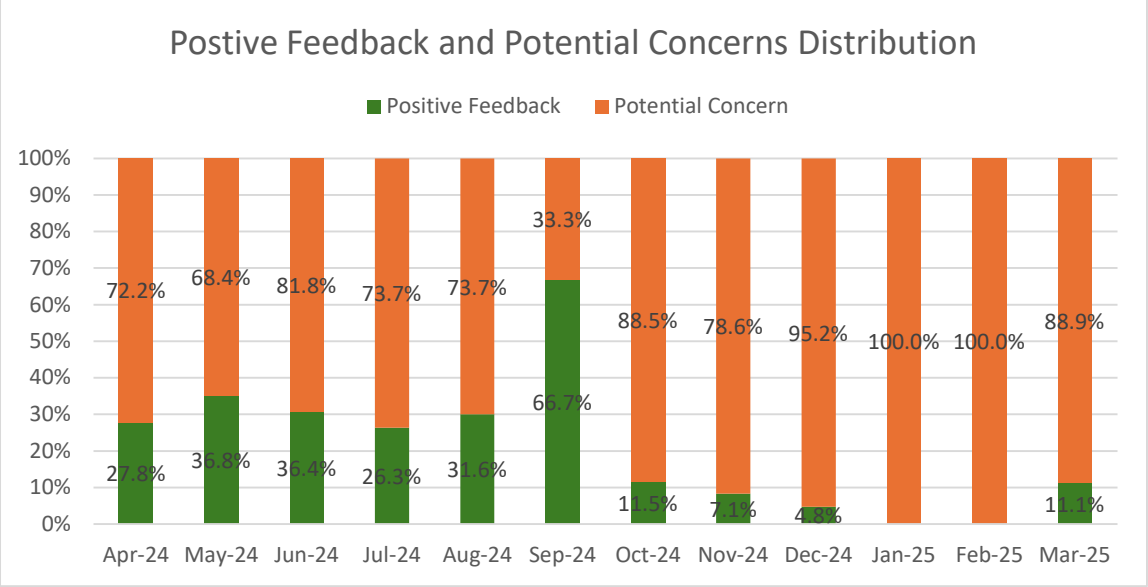

FIG 6: MEDICAL EXAMINER REFERRAL TYPE POSITIVE FEEDBACK VS. CONCERN DISTRIBUTION

Our responses included providing feedback to clinical teams about specific care improvements, connecting families with our Patient Advice and Liaison Service (PALS) for support, and initiating Patient Safety learning responses, ensuring any identified incidents are reported and any learning explored through established patient safety processes.

For cases referred following a concern, detailed case note reviews, called Structured Judgement Reviews (SJRs), were undertaken where appropriate. Table 2 shows how we responded during 2024-25.

This year, we responded to Medical Examiner referrals in a range of ways. We shared feedback with clinical teams, initiated SJRs, and referred cases to patient safety or PALS teams. Each response is carefully considered to support bereaved families and ensure learning while being mindful of staff wellbeing. For example, feedback may go to the ward matron or consultant rather than individual staff members, depending on the situation and what will be most constructive for learning and improvement. This reflects our continued work to embed the Patient Safety Incident Response Plan and to refine how we respond to concerns and feedback.

In relevant cases, we used more than one response. For example, completing an SJR while also referring families to PALS for additional support. Our shared goal is to ensure each referral leads to meaningful action and learning.

We monitor referral variations closely, noting changes across quarters and compared to previous years. While the Medical Examiner service operates independently, we maintain regular communication and have confirmed that recent variations are not concerning. The variation partly reflects the service becoming statutory in September 2024, and we expect to see further natural variation in referral patterns as the service continues to mature.

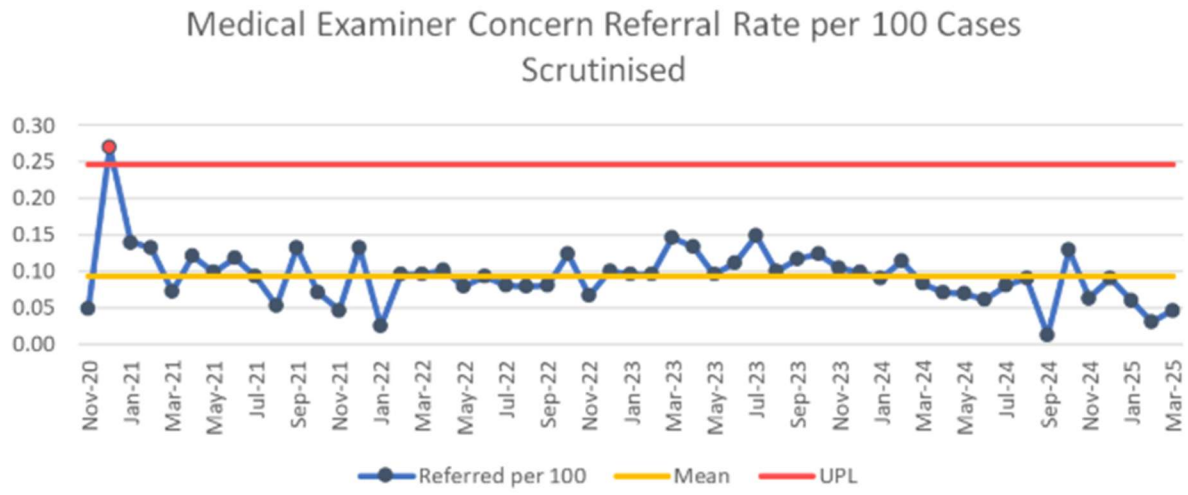

FIG 7: MEDICAL EXAMINER CONCERN REFERRAL RATE PER 100 CASES SCRUTINISED

We responded to Medical Examiner referrals in several ways during 2024-25. The remaining referrals were managed through detailed reviews, Patient Advice and Liaison Service (PALS) support, legal team involvement for coroner processes, and safeguarding referrals where required.

- undertook detailed Structured Judgement Reviews (SJRs),
- supported families through our Patient Advice and Liaison Service (PALS),
- engaged our legal team for coronial processes in 12 cases, and
- made safeguarding referrals in 8 cases.

Each response is carefully considered to support bereaved families and ensure learning, while being mindful of staff wellbeing. In some cases, more than one response is used — for example, completing an SJR while also referring families to PALS for additional support.

Response Type	2023-24	2024-25
SJR	39 (17.1%)	25 (17.4%)
Patient safety response	52 (22.8%)	46 (31.9%)
PALS	49 (21.5%)	39 (27.1%)
Thematic feedback	101 (44.3%)	46 (31.9%)
Legal	21 (8.3%)	12 (8.3%)
Safeguarding	1 (0.4%)	8 (5.6%)

TABLE 2: MEDICAL EXAMINER NHSE REPORTING CATEGORIES 2023/24 – 2024-25

We had fewer referrals overall in 2024-25 compared to 2023/24. In 2023/24, a larger proportion of referrals were directed to clinical teams as thematic feedback for learning. These were typically cases where families did not need support from PALS, and the concerns did not meet the threshold for a patient safety investigation or a detailed case review.

This year, thematic feedback referrals reduced from 101 to 46 cases, while referrals leading to Structured Judgement Reviews (SJRs), Patient Safety responses, and PALS support remained broadly comparable.

The reason for this reduction is not yet fully understood and is being explored further with the Medical Examiner service. Families continue to have clear routes to share feedback, and referral pathways remain unchanged. In the meantime, we are monitoring referral patterns closely to ensure opportunities for organisational learning are not being missed.

For cases referred following a concern, 25 cases were identified as suitable for a detailed case note review, called a Structured Judgement Review (SJR). Figure 9 shows how these were categorised. A full quarterly breakdown is in Appendix 2.

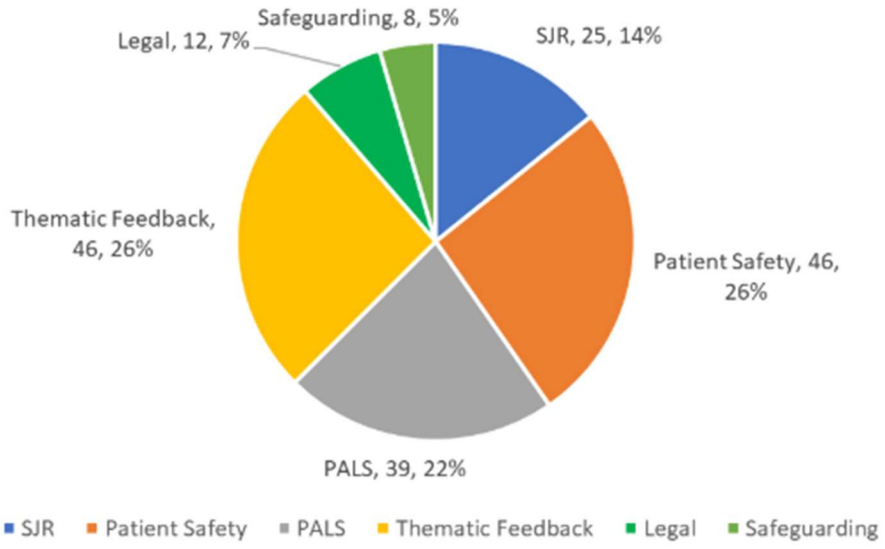

FIG 9: MEDICAL EXAMINER NHSE REPORTING CATEGORIES 2024/25

Learning from family feedback

The Medical Examiner Service contacts bereaved families to discuss the cause of death and ensure death certificates are accurate. As independent senior doctors, Medical Examiners can answer questions about the cause of death and provide an independent perspective on care.

During these conversations, families can raise concerns or share positive feedback about any aspect of care. This feedback is passed to our Trust Governance Team through referrals, and families are also given details of our Patient Advice and Liaison Service (PALS) and bereavement support services if they need additional help.

The Medical Examiner's office submits data to NHS England on a quarterly basis outlining the nature of referrals. Further information about the Medical Examiner process and coroner referrals is available on the BNSSG Healthier Together website https://bnssghealthiertogether.org.uk/the-medical-examiner-service/information-for-the-public/

Response to Medical Examiner Referrals

When the Medical Examiner refers concerns following scrutiny, the referral is sent to the divisional leads who decide on the most appropriate response and manage this through their divisional governance processes. However, we do not currently have a central system to track what actions the divisions have taken in response to referrals.

During 2025-26, we will launch a joint project with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) as part of our Mortality Improvement Programme to develop standardised outcome recording processes for Medical Examiner referrals. This will include establishing regular audit mechanisms to ensure referrals are being appropriately actioned and that learning from independent scrutiny and family feedback is captured systematically across Bristol NHS Group hospitals.

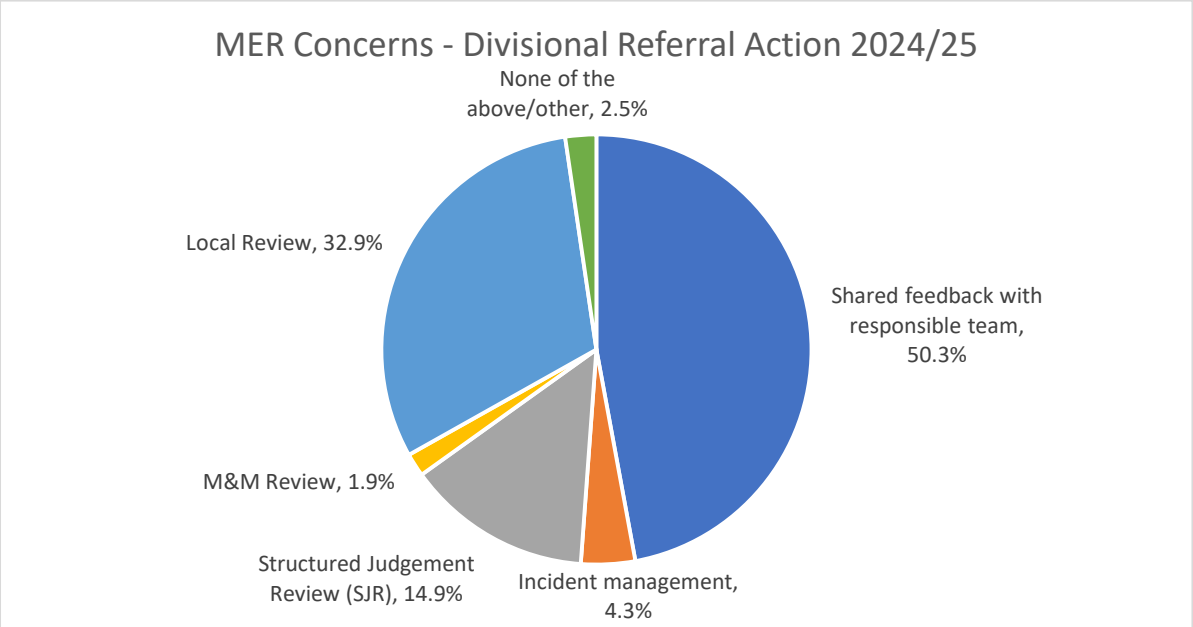

Figure 10: Divisional Actions on Medical Examiner Concerns

2.2 Which deaths we review in detail

Beyond the Medical Examiner's scrutiny of every death, we conduct detailed case note reviews, called Structured Judgement Reviews (SJRs) for specific cases. This is in line with National Quality Board Guidance.

We use SJRs to learn from deaths in several situations:

- When families, carers, or staff have raised concerns about the care provided.
- When a person had a learning disability or severe mental illness, as these groups are known to experience poorer health outcomes.
- When the Medical Examiner has identified potential learning opportunities.
- When there are patterns in data or alerts from regulators that suggest we need to look more closely at care in particular areas.
- When deaths happen in situations where they would not normally be expected. For example, during a planned procedure.
- When reviewing deaths will help us improve care on which we are already working. For example, if we have a quality improvement priority relating to a specific condition or treatment.

During the reporting period, no alerts, or alarms from external sources such as CQC triggered SJRs. We introduced an aligned approach to NHSE VLAD chart monitoring with UHBW in Q4 of the reporting period and when we identify alerts or variations outside control limits in our mortality data, we follow the NHS England's 'pyramid of investigation for special cause variation' approach – first checking coding accuracy, triangulating with national clinical audit data, and undertaking case note reviews only when clinically indicated. As part of our mortality improvement programme, we are further developing proportionate and aligned responses to statistical variations to ensure appropriate review and oversight across our Bristol NHS Group.

The combination of Medical Examiner scrutiny and SJRs helps us identify the most significant learning opportunities and ensures we promptly direct cases to the right review process.

During 2024-25, we undertook SJRs on approximately 8-9% of deaths, maintaining consistent review rates throughout the year as illustrated in Figure 11.

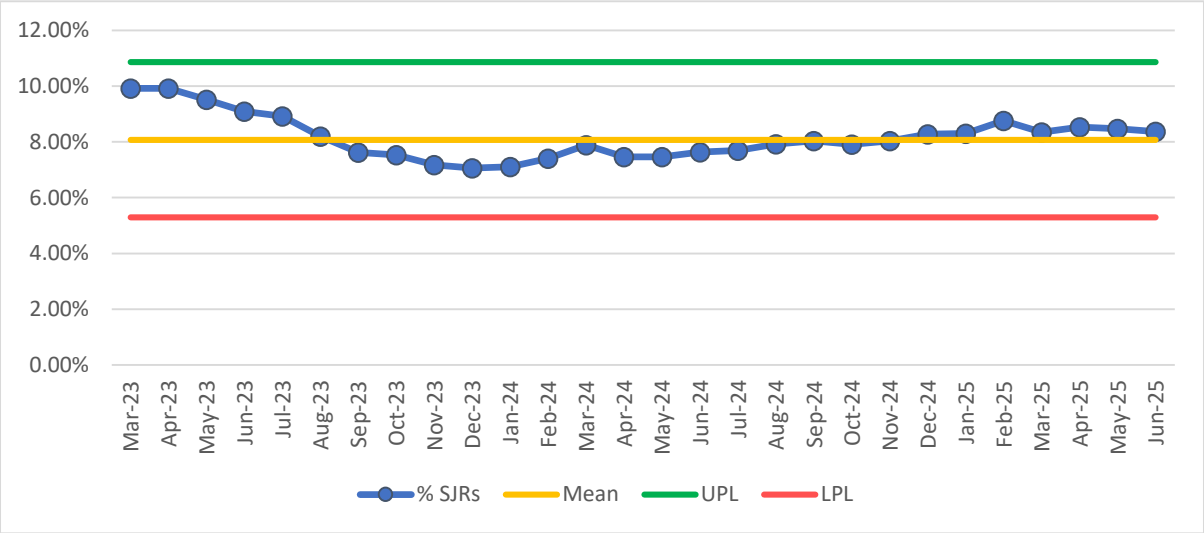

FIG 11: PERCENTAGE OF SJRS UNDERTAKEN OUT OF ALL DEATHS 2024-25

Mortality review completion and referral outcomes

All in-hospital deaths at NBT are scrutinised by the Medical Examiner unless referred to the coroner. This scrutiny supports accurate certification and provides an opportunity to identify and respond to any concerns raised during the process.

What happens when patient safety concerns are raised

Most patient safety concerns are identified and acted on immediately through staff logging an incident on our patient safety incident reporting system. This means we can respond quickly, before the death certification and mortality review process.

If a Medical Examiner referral identifies as a patient safety concern, a patient safety response is initiated rather than an SJR. This is because Patient Safety Incident Response Framework (PSIRF) responses are specifically designed for these events. Inquests or PSIRF responses may supersede the need for an SJR.

https://www.nbt.nhs.uk/about-us/our-standards/patient-safety

In the less likely event that an SJR itself identifies a significant care or safety concern; we immediately initiate a patient safety response. As part of this, we communicate with families and all relevant parties, in line with our duty of candour responsibilities. Our PSIRF plan outlines how we undertake investigations and other learning responses to

patient safety incidents. Further information on our PSIRF plan is available on the NBT website: https://www.nbt.nhs.uk/about-us/our-standards/patient-safety

This is in line with the National Patient Safety Strategy. Further information on the national strategy is available on the NHS England website https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

Structured judgement review (SJR) distribution

During 2024–25, we undertook SJRs on 8.5% of adult deaths, all of which were initiated in line with NQB guidance. There is no target for SJRs that should be undertaken.

The total number of SJRs completed at NBT and the reasons for their initiation are detailed in Table 3.

Death Review Process	Q1	Q2	Q3	Q4	All
Adult In-hospital Patient Deaths Scrutinised by Medical Examiner	515	488	530	564	2097
Patient deaths referred to NBT by the Medical Examiner	44	46	39	46	175
Patient had a diagnosis that put them at risk of poorer healthcare outcome – Learning disability or autism	*5*	*3*	*2*	*3*	*13*
Patient had a diagnosis that put them at risk of poorer healthcare outcome – Severe Mental Illness	*4*	*1*	*1*	*2*	*8*
Treatment or care concern	*10*	*8*	*9*	*9*	*36*
Total Structured Judgment Reviews Initiated	**47**	**45**	**40**	**47**	**179**

Table 3: Table showing breakdown of SJR reviews because of a medical examiner referral, 2024-25

Over 2024-25, the number of SJRs undertaken across NBT has not been evenly distributed. This is illustrated in Figure 12. This is because some divisions have more deaths due to the types of patients they treat. However, we recognise that we should make sure there are not areas in the Trust where no reviews are undertaken. Therefore, we will work to refine our SJR process in 2025–26 to ensure we have a representative sample of SJRs from across all bed-holding divisions where SJRs are the primary review method for adult deaths.

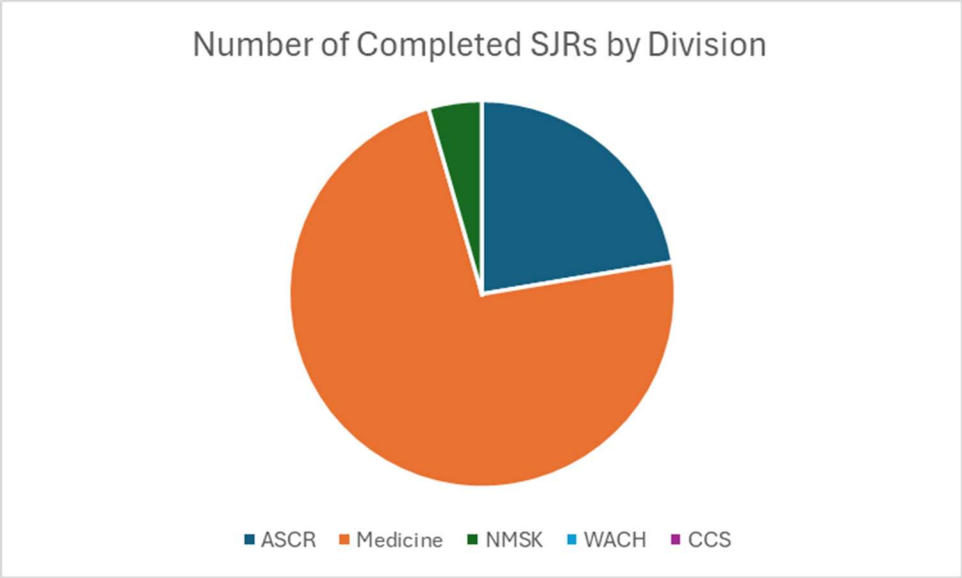

Figure 12: Distribution of SJRs by Division, April 2024-March2025

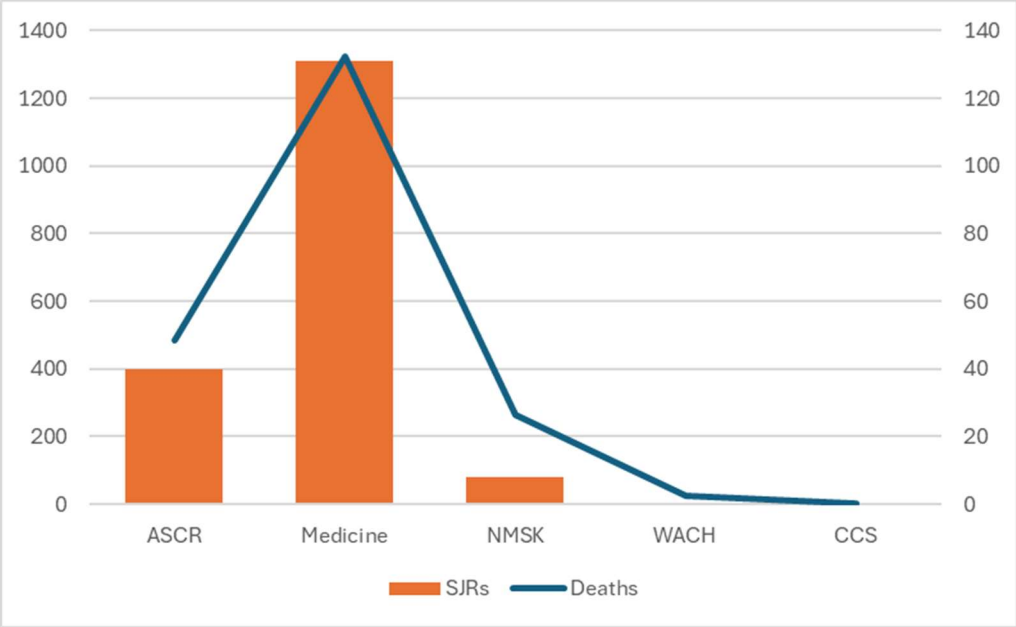

Figure 13: Total deaths by division with corresponding SJR numbers, 2024-25

Figure 13 illustrates the relationship between total deaths and SJR numbers by division, demonstrating that SJR distribution broadly reflects the volume of deaths in each area.

This year, we initiated 179 Structured Judgement Reviews, representing 8.5% of adult deaths. Of these, 43 reviews were triggered by mandatory criteria – such as patients with a diagnosis of learning disability, autism, or severe mental illness, or those who died following an elective admission – as identified through Careflow, which is our electronic patient record (EPR) system. The Medical Examiner service also flags cases

where a Structured Judgement Review may be valuable. These referrals are screened by the relevant division, and only progress to review where this is judged to add value. This explains why the number of cases suggested by the Medical Examiner is higher than the number undertaken.

For referrals involving patients with a learning disability, autism, or severe mental illness, as well as elective admissions and cases referred due to care concerns, we also monitor the initial decision made following Medical Examiner scrutiny. This includes whether the case proceeded to a Structured Judgement Review (SJR), a Patient Safety Incident Response Framework (PSIRF) investigation, or inquest proceedings. These figures, summarised in Table 4, reflect decisions at the point of referral and do not capture subsequent review completion or overlapping pathways.

Response	Inquest	No Inquest
SJR	0	24
Patient Safety Response	0	53
Other Response	0	88

Table 4: Table showing initial responses to Medical Examiner Referrals by inquest status, 2024-25

During the reporting period, 189 referrals were made by the Medical Examiner. Of these, 24 met the criteria for a Structured Judgement Review (SJR). The remaining cases resulted in a range of responses, including clinical team feedback (50.3% of cases), Patient Safety Incident Response Framework (PSIRF) investigations, PALS support, legal processes for coronial cases (12 cases), and safeguarding referrals (8 case). Some cases triggered more than one response (for example, an SJR and PALS support), but for reporting clarity only one response type is counted per row.

While each referral decision is recorded, the manual nature of our current systems makes it difficult to produce a consolidated view across all review pathways. We are working to improve this through our digital development programme, as outlined in Section 5.4.

2.3 Mortality review completion times

We aim to complete all mortality reviews as soon as practical to ensure that relevant parties receive feedback promptly and that learning can be implemented without delay.

The following charts indicate the mortality review completion rate per 100 deaths. A review completion includes a screening review with no concerns flagged, or Medical Examiner scrutiny, or a full mortality case note review (Structured Judgement Review). Monthly data is reported as the summation of the previous 12 months, 2 months in arrears – this is to allow a completion window for the cases.

NBT has maintained a consistently high completion rate during 2024-25 and previous years. This shows that review processes are well embedded into the Trust.

In 2024–25, the median time from death to completion of review was 41 days, a slight increase from 38 days in 2023–24. Most reviews were completed between 30 and 53 days after death, with only a small number extending beyond 100 days. These longer cases typically involved complex reviews requiring multiple specialties, or cases subject to enhanced scrutiny, such as learning disability deaths, which often require more detailed Structured Judgement Reviews (SJRs).

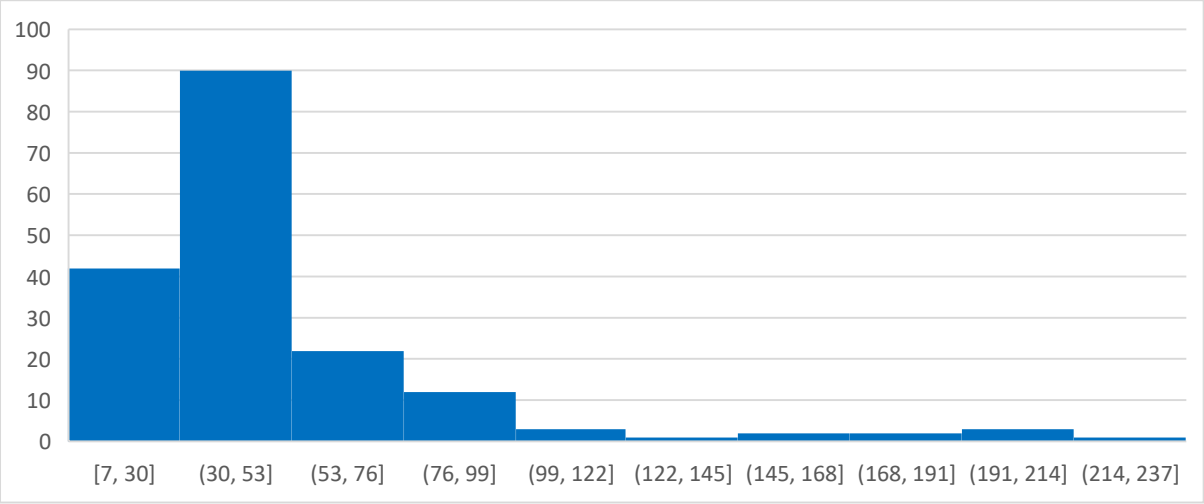

FIG 14: SJR TIME FROM DEATH TO REVIEW (DAYS) DISTRIBUTION 2024-25

NBT has maintained a 99% mortality review completion rate during 2024–25, comparable to 99.6% in 2023–24, demonstrating that review processes are well embedded across the Trust.

Figure 15 illustrates these trends over time.

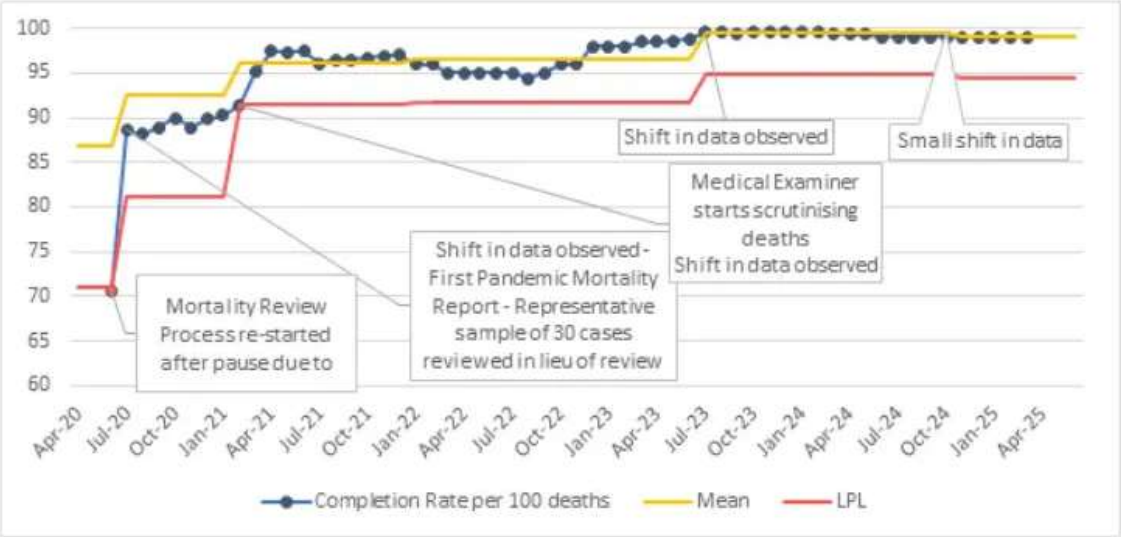

Figure 15 – Median and Range of Review Completion Times

During 2024–25, we continued to face challenges that affected the timeliness and efficiency of our mortality review processes. Much of our data collection and tracking remains manual, requiring significant administrative effort and limiting our ability to analyse information in real-time.

To address this, we have launched a digital improvement workstream within the mortality improvement programme that will:

- Introduce a new digital platform to support Medical Examiner scrutiny,
- Implement an enhanced Structured Judgement Review (eSJR) processes, and
- Enable faster, automated reporting to clinical teams and divisional governance groups.

We are working closely with divisional leads and clinical teams to tailor dashboards and automated outputs to local needs, ensuring that improvements in timeliness and usability deliver benefits where they are most needed. Phased implementation of these tools will continue through 2025–26.

High priority mortality reviews

Mortality reviews labelled as high priority are those that fall into the mandatory review categories of patients with a learning disability or autism, patients with a serious mental illness, elective admissions, cases that have been screened for review either by the Medical Examiner or the Trust due to a care concern. All high priority reviews

are usually undertaken using a Structured Judgement Review, however in exceptional cases where there is high complexity a round table review might be undertaken with outcomes recorded in an SJR format.

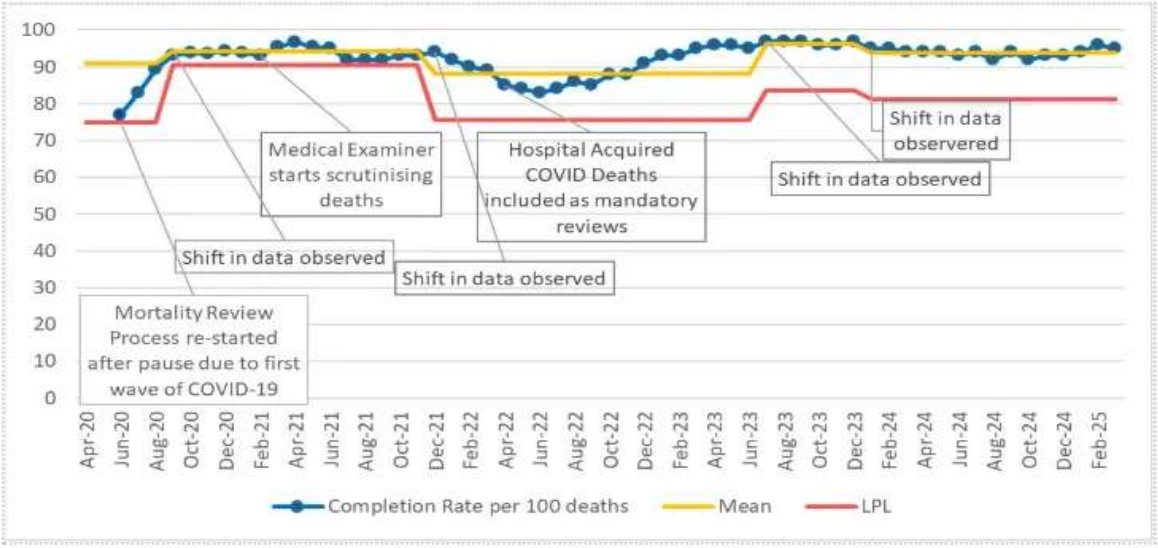

FIG 16: HIGH PRIORITY MORTALITY REVIEW COMPLETION OVER TIME APR 20 – MAR 25 (ROLLING 12 MONTH DATA 2 MONTHS IN ARREARS)

Our high priority mortality review rate remained stable during 2024-25 with 94% completion over the 12 months. Monthly data is reported as the summation of the previous 12 months, 2 months in arrears – this is to allow a completion window for the cases.

2.4 Assessing the quality of care we provided

In all SJRs, a number from “very poor” (1) to “excellent” (5) is used to indicate how good the care was during distinct phases of a patient's time in hospital. These scores are standard in NHS Trusts. They are the reviewer's professional and initial judgement based on what they can see in the medical notes at the time of the review. If there are concerns about the care, this will always trigger a further review to make sure the right process is followed.

When we identify areas for improvement in care, we collaborate with teams to understand what happened and prevent similar issues. Examples of improvements we have made are detailed in Section 3.4.

If a review identifies poor care, a problem in care, or where the death might have been avoidable, we take further action to investigate and ensure appropriate action is taken. This is always in line with our commitment to openness and transparency, and with our Patient Safety Incident Response Plan (PSIRP).

Mortality and Morbidity Meetings

Alongside clinical audits, monitoring of mortality data, SJRs, and other responses described in this report, all clinical specialties in NBT hold regular Mortality and Morbidity (M&M) meetings. These meetings are an essential element in clinical governance, and key practice in our drive towards continuous quality improvement.

M&M meetings examine both deaths and morbidity, including complications that cause patients to need further intervention or a prolonged stay in hospital. This includes specifically defined complications, incidents or misadventures causing morbidities, and any other unexpected morbidity based on clinical judgement.

The meetings are used to review cases, data, and to share learning within specialties and divisions. Cross divisional learning is shared through upward thematic reporting of the outcomes of mortality and morbidity reviews.

Our meetings are conducted in a spirit of learning and continuous improvement, and there is open and transparent review of individual cases. Teams use meetings to develop action plans and prevention strategies, without resorting to blaming others. The aim is to help colleagues deliver safer care.

The learning from these meetings feeds into the broader mortality surveillance processes described throughout this report, ensuring that insights from frontline clinical practice inform Trust-wide improvements.

2.5 What we learned

Overall care scores

In 2024–25, NBT completed 179 Structured Judgement Reviews (SJRs). The majority of completed SJRs scored overall care as good (4) or excellent (5).

The percentage of cases reviewed with an overall care score of adequate, good, or excellent was 97.7%, consistent with the previous year's 98.1%.

Table 5 shows the quarterly breakdown of SJR overall care scores for 2024–25. This allows us to track variation across the year and confirms that the distribution of care scores has remained stable.

Figure 18 illustrates the overall distribution of SJR care scores for 2024–25. The chart demonstrates that the majority of reviews assessed care as good or excellent,

reflecting consistent performance in care quality while still highlighting opportunities for learning in every care category.

8 reviews in 2024–25 recorded a score of poor care (2). Of those, 6 were considered at the Patient Safety Executive Meeting for potential Patient Safety Incident Investigations, with 3 cases being confirmed as poor care, and 3 cases upgraded to good care. Two cases were declared as a PSII, the third confirmed poor care case was reviewed through the patient safety process in a non-PSII format.

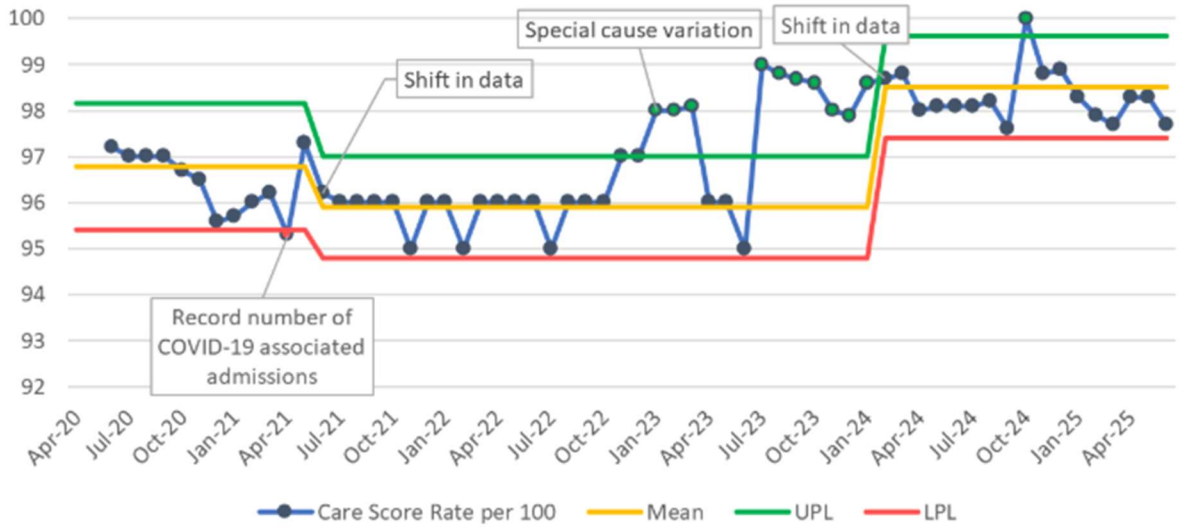

FIG 17: PERCENTAGE OF SJRS RATED 3-5 (ADEQUATE TO EXCELLENT) APR 20 – JUN 25 (12 MONTH ROLLING DATA 2 MONTHS IN ARREARS)

From the chart it is evident there was a positive shift in data around the start of July 2023. In February 2024 we recalibrated our care scores upwards, and this trend has been maintained, indicating a stable process with performance consistently above our lower process limit. At the time a review was undertaken of hospital operations data to try and understand why this shift might have occurred, however it just appears to be a 'new normal.'

Overall Care Score						
Quarter	Total SJR	Excellent	Good	Adequate	Poor	Very Poor
Q1	46	20	15	10	1	0
Q2	41	16	17	6	2	0
Q3	52	18	22	11	1	0
Q4	40	16	14	9	1	0

Table 5: Table showing SJR overall care score by quarter, 2024-25

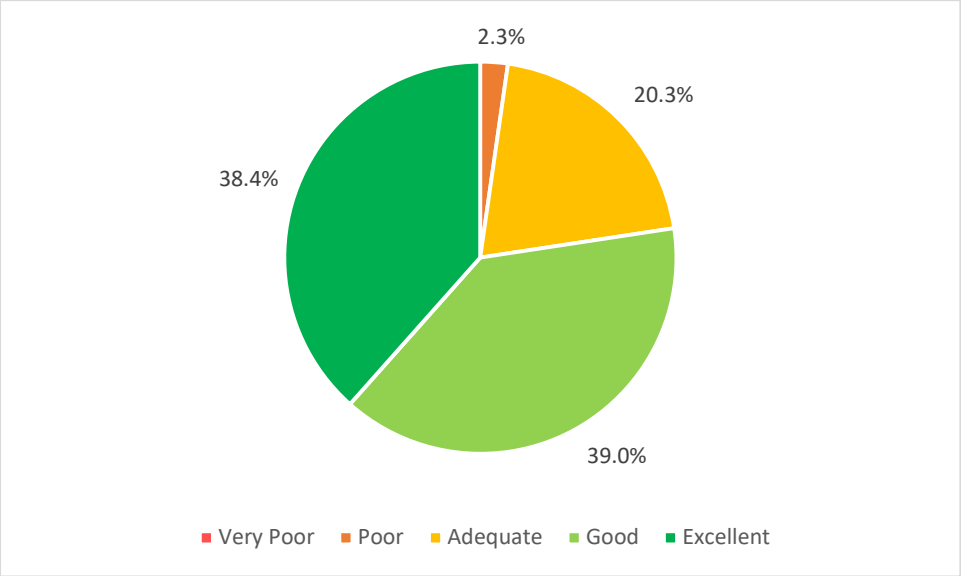

Figure 18: Pie chart showing overall SJR care score distribution for 2024-25

Avoidability Ratings (1-6 scale)

Across all quarters in 2024–25, no deaths were assessed as avoidable. Where a review identified poor care or raised significant concerns, the case was escalated to the Patient Safety Executive Meeting (PSEM) and, these cases are then assessed through the appropriate investigation processes under the Patient Safety Incident Response Framework (PSIRF).

This approach reflects our commitment to openness, transparency, and consistent application of the national framework, ensuring that all concerns are managed through the most appropriate governance pathway.

We are working with the Mortality Improvement Programme to align this approach across the NBT and UHBW, ensuring that avoidability data is recorded and reported consistently across the Bristol NHS Group.

Common themes and our responses

The vast majority of cases reviewed receive positive feedback or raise no concerns about care quality. However, we take every concern seriously and use this feedback as an opportunity to learn and improve.

We categorise the referrals we receive to help us understand patterns in what families and the Medical Examiner Service are telling us. Figure 19 shows the five most common themes in 2024–25 for potential concerns and positive feedback.

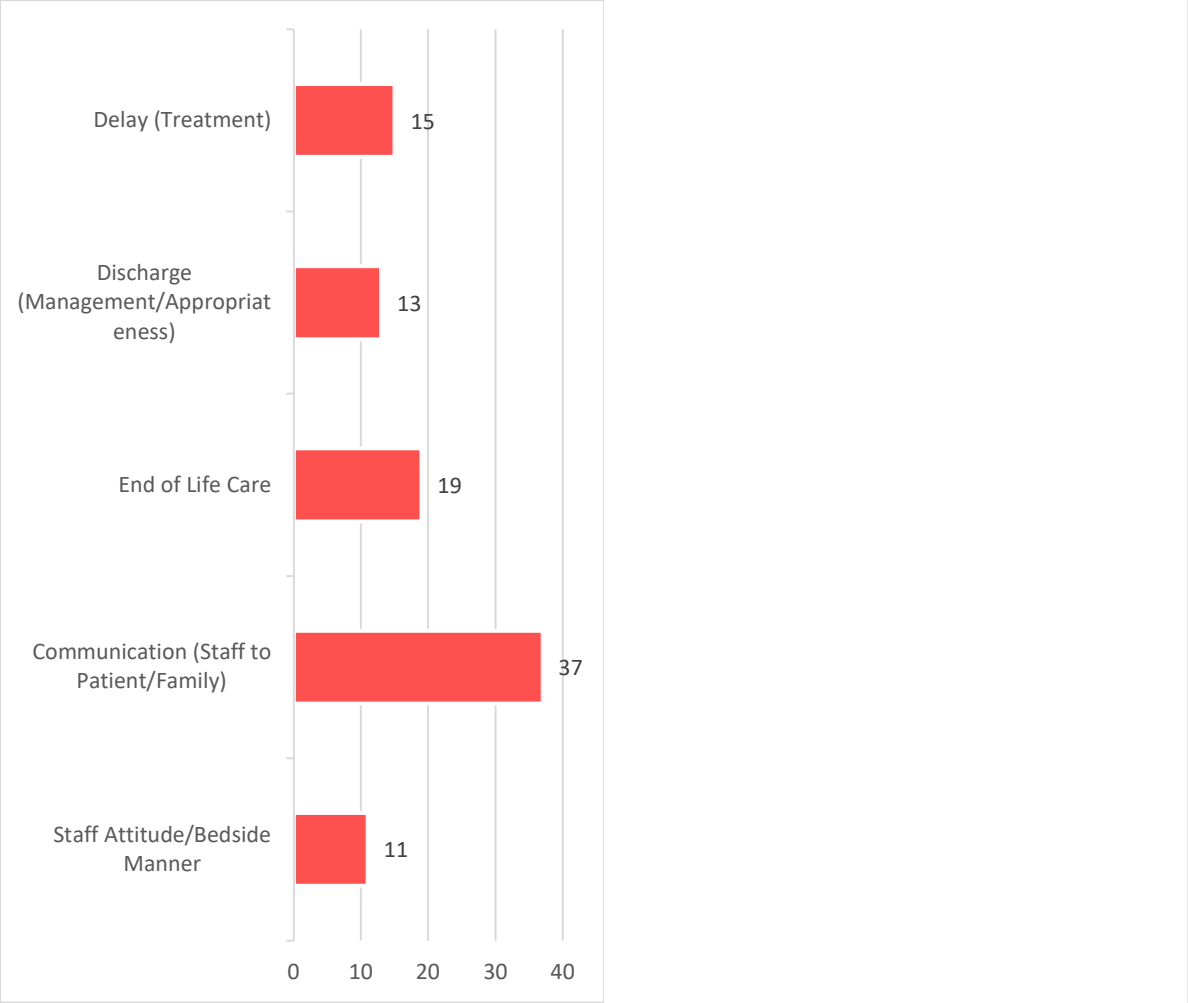

Figure 19: Top 5 Medical examiner referral themes by frequency, 2024-25 (Red = Potential Concerns, Green = positive feedback)

Communication issues

Referrals highlighted communication gaps, such as families not being kept informed about deterioration, changes in care plans, or test results. In other cases, inconsistent messages between teams created confusion or distress. This feedback has been shared with divisional leads, and structured handover and communication tools are being embedded to improve consistency and ensure families are included in care discussions.

End-of-life care concerns

Some families described delays in recognising end-of-life needs or challenges with coordination of care during the final days of life. These cases have informed ongoing work to improve the timeliness of palliative care referrals and to enhance ward

environments for patients nearing the end of life, building on the Trust's Purple Butterfly initiative.

Pain management and medication

Concerns were raised about delays or omissions in pain relief, particularly in complex end-of-life cases. These referrals have prompted reviews of escalation protocols and pharmacy processes to ensure urgent symptom management needs are addressed more quickly and reliably.

Discharge and follow-up

A small number of families highlighted concerns about the timing and planning of discharge, including a need to improve communication about ongoing support or follow-up investigations. These cases are being used to strengthen coordination with community teams and primary care, ensuring improved discharge.

Basic care needs

Some referrals raised issues around nutrition, hydration, and hygiene, such as patients not receiving assistance with meals or lapses in skin integrity monitoring. This feedback has been shared with ward managers for targeted local action and is monitored through divisional governance forums to ensure improvement.

Learning from coroner's inquests

Following any coroner's inquest or Regulation 28 report, we collaborate closely with our colleagues in legal services to identify learning and review our own processes to determine what improvements we should make.

Our monthly Patient Safety Group, with trustwide and divisional clinical leads includes an overview of all upcoming and completed inquests, together with key themes and lessons learned. This summarises our preparation for complex inquests, supporting staff in their responsibilities and ensuring that we our working well with families and carers, as appropriate. Our legal team also regularly meets with each Clinical Division as part of their Divisional Quality Governance meetings and holds a bi-monthly Healthcare legal case review panel with trustwide medical and nursing leads to ensure cases are being effectively managed from all perspectives. The output reports into the weekly Patient Safety Executive Meeting to join this work up with the wider patient safety agenda.

We maintain regular liaison with the coroner's office and continue to monitor developing cases to ensure appropriate learning is captured when inquests conclude.

Learning from excellent care

Positive feedback from the Medical Examiner and from families is a vital part of our learning. It helps us recognise excellent care and share examples across the Trust and the Bristol NHS Group so that good practice can be celebrated and spread.

The following themes were identified from talking to patient's families:

1. **Compassionate Care**
   Feedback consistently highlights the quality of care delivered across multiple wards and departments. Families described the care as: 'Outstanding,' 'Amazing,' and 'Second to none.' Referrals stated that care was delivered with empathy, dignity, and respect, especially during end-of-life care. This reflects a culture of patient-centred care, where staff go beyond clinical duties to provide emotional support and reassurance.
2. **Family Engagement and Support**
   Relatives felt included, informed, and supported throughout the patient's journey because of regular updates and clear communication, emotional support during critical moments, and recognition of family needs and preferences. This demonstrates a commitment to holistic care, acknowledging the importance of the family unit in patient wellbeing.
3. **Recognition of Individual Staff Members**
   Numerous comments specifically named a staff member who had made a significant impact, including doctors praised for compassionate communication and nurses recognised for going "above and beyond." Support staff such as catering and domestic teams also received commendation.
4. **High-Quality End-of-Life Care**
   Many families expressed gratitude for the dignified and peaceful end-of-life experiences provided. Key elements include: timely palliative care interventions, respectful treatment of patients in their final moments, and sensitivity to family presence and emotional needs. This reinforces the importance of maintaining and enhancing end-of-life care pathways, including the Purple Butterfly initiative.
5. **Positive Environment**
   Families appreciated the physical environment of the hospital. This highlights the value of environmental design to patient and family experience.

Several families shared praise for the care their loved ones received in 2024–25, describing staff as:

- "showing great empathy to the patient and making the family feel special and at ease"
- "going above and beyond, being extremely kind and considerate to everyone"
- "fighting for the patient up until the end, despite her being old and frail"
- "providing a calm, open and bright environment that made visiting easier and more comforting"

These reflections offer a powerful reminder of the compassion, professionalism, and excellence shown by staff during some of the most difficult moments for patients and their families.

Learning from this feedback is shared at mortality and morbidity meetings, divisional governance forums, and the Clinical Effectiveness and Outcomes Group (CEOG) to celebrate excellent practice and to help spread approaches that families value most highly.

Section 3: Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

The Learning from Lives and Deaths (LeDeR) programme was set up by NHS England in 2017. The aims of the programme are to:

- Improve care for people with a learning disability and autistic people
- Reduce health inequalities for people with a learning disability and autistic people
- Prevent people with a learning disability and autistic people from early deaths

"A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. Instead, it includes episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality review that may have taken place following a person's death." (NHS England, 2025)

When someone with a learning disability or an autistic person dies within NBT, we share information with the LeDeR team. This helps the team understand the full picture of that person's care and identify ways to improve services for other people.

The LeDeR team publish their findings in annual reports. There is a systemwide LeDeR report for our Bristol North Somerset and South Gloucestershire (BNSSG) ICB that shows our local data and areas of, good practice, learning and improvements for our system partners. This feeds into the national reports. Further information can be found on the NHS England website https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/

Supporting people with a learning disability and autistic people

We have specialist teams working seven days a week to support patients with a learning disability or autism during their admission. The Sirona Learning Disability and Autism Liaison Team provides expert advice on reasonable adjustments and capacity assessments, including helping patients communicate their needs. Our Associate Chief Nursing Officer for Mental Health, Learning Disability and Neurodiversity coordinates with the national LeDeR programme and our mortality governance processes.

3.1 Learning disability and autism reviews

We complete a priority review for all patients who have died at NBT with a learning disability or autism diagnosis. Because these groups are known to experience poorer health outcomes due to healthcare inequalities, every death is subject to an enhanced review process. This process includes specialist questions and input from the Learning Disability and Autism Liaison Team, alongside a Structured Judgement Review (SJR) completed by a senior doctor.

When a review is completed, the findings are shared with senior staff in the relevant department to support immediate local action. Learning is also reported to the Patient Safety Executive Meeting (PSEM), which oversees Trust-wide patient safety governance and ensures actions are tracked and delivered.

In addition, all deaths are reviewed by the Bristol, North Somerset and South Gloucestershire (BNSSG) multi-agency LeDeR panel. This panel brings together health and social care professionals to identify system-wide patterns and issues. This collaborative approach ensures that improvements benefit people with a learning disability or autistic people across the wider system and helps prevent problems from recurring elsewhere.

Annual overview

Mortality and admission rates for patients with a learning disability or autism have been tracked throughout 2024–25, as illustrated in Figures 20-22. While admissions have shown some variation during the year, the overall number of deaths has remained stable, consistent with patterns seen in previous years.

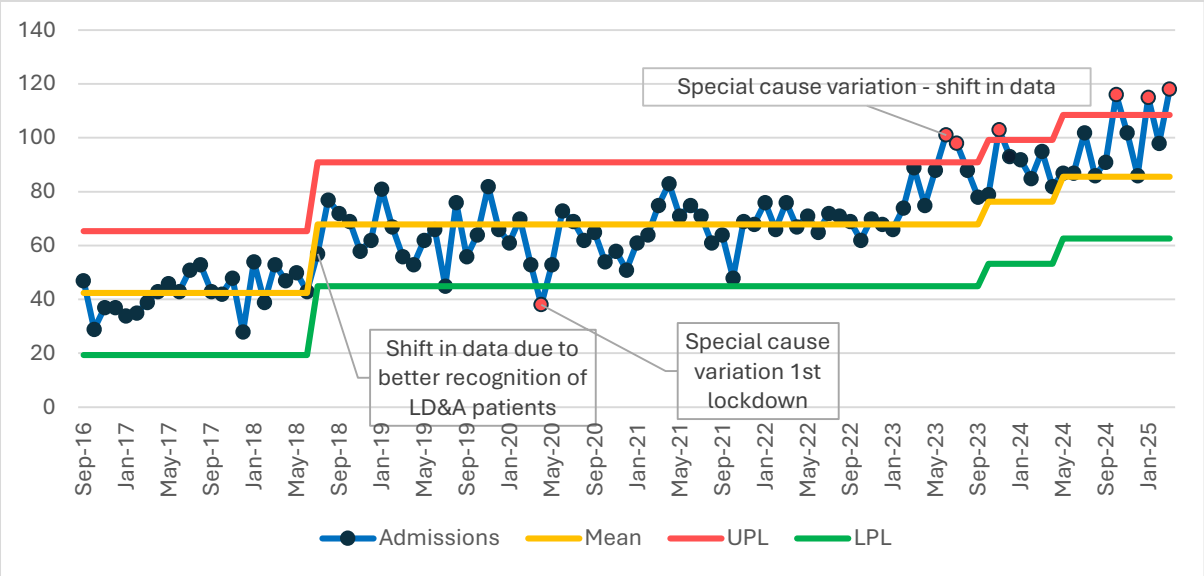

FIG 20: LEARNING DISABILITY AND AUTISM ADMISSION RATES BY DATE OF ADMISSION 2024-25

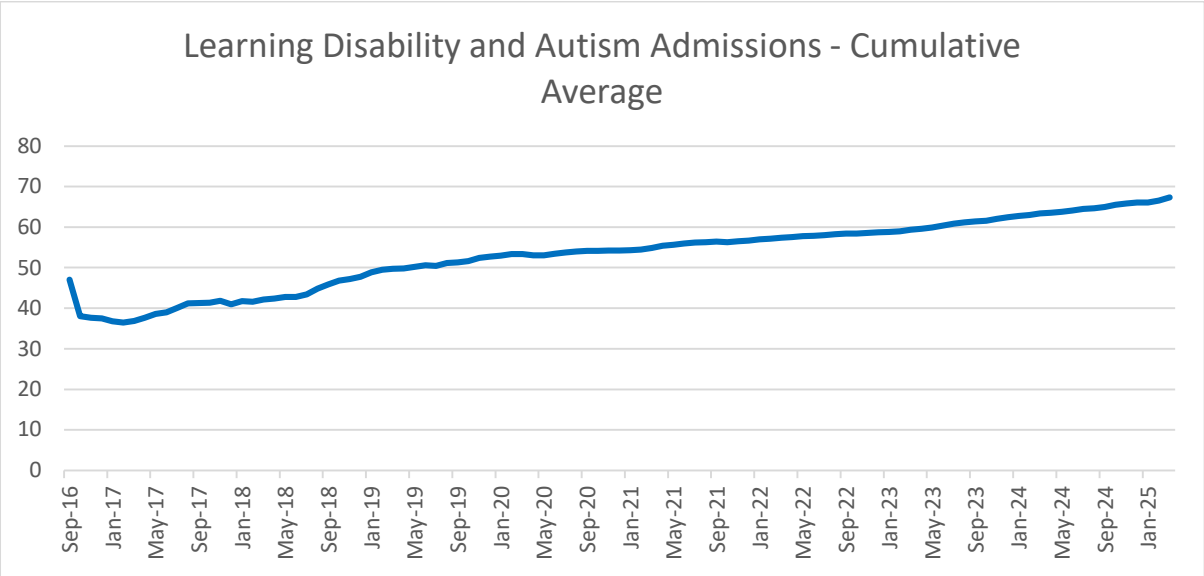

FIG 21: LEARNING DISABILITY AND AUTISM ADMISSIONS CUMULATIVE AVERAGE BY DATE OF ADMISSION 2024-25

The cumulative average in Figure 21 shows the running average number of admissions over time. This helps identify overall trends by smoothing short-term fluctuations.

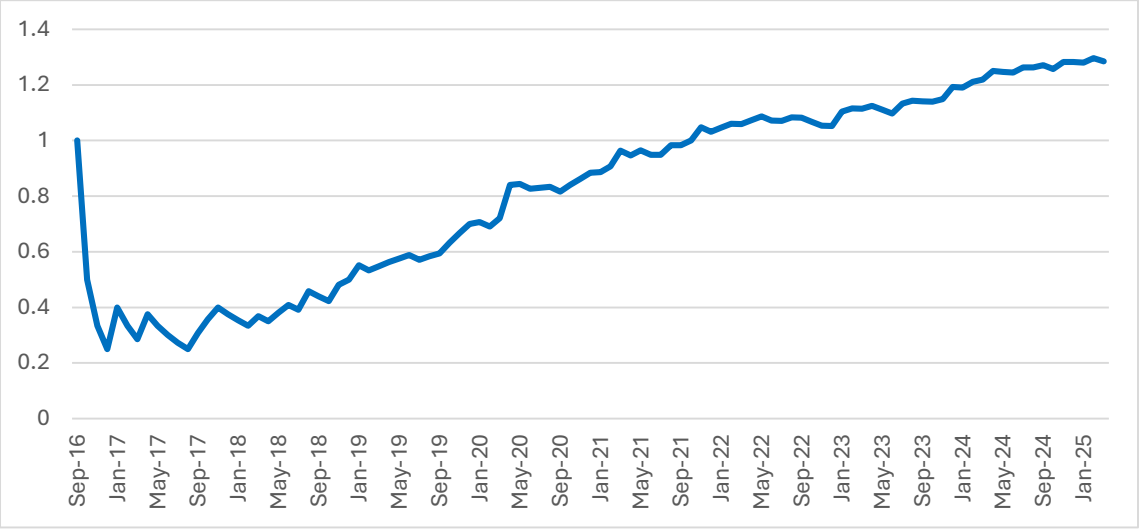

FIG 22: LEARNING DISABILITY AND AUTISM DEATHS CUMULATIVE AVERAGE BY DATE OF ADMISSION 2024-25

The monthly mortality data shows natural variation, with some months recording slightly higher numbers of deaths. All cases were reviewed through our enhanced processes, and no common themes were identified that would suggest systemic care issues.

The statistical process control (SPC) chart in Figure 20 shows a recent special cause variation in admissions for patients with a learning disability or autism. As part of the Mortality Improvement Programme, we will collaborate with colleagues across BNSSG to better understand the drivers of this change, including the role of clinical coding and admission processes. For example, whether the variations relate to how diagnoses are recorded in the clinical notes.

Earlier special cause variation in the chart reflects both the impact of improved recognition and coding of learning disability and autism patients in 2019 and the changes in admission patterns during the first COVID-19 lockdown.

Admissions are now consistently above the previous mean, while mortality rates have remained stable. This suggests that while more patients with a learning disability or autism are being accurately recorded and supported during admissions, the quality and safety of care have remained consistent.

We remain vigilant in ensuring timely and appropriate access to hospital care when required. Our enhanced SJR process ensures every death is reviewed to identify and address any barriers to care or concerns about the person's experience. Improved identification and clinical coding also continue to help us recognise and support people with a learning disability or autism more effectively during their hospital stay.

3.2 Learning disability and autism review completion times

At NBT, we complete a priority review for all patients who have died with a learning disability or autism diagnosis. Because these patients are known to experience poorer health outcomes, all learning disability and autism deaths are subject to an enhanced review process.

This process includes:

- A Structured Judgement Review completed by a consultant reviewer
- A second review by the Learning Disability and Autism Liaison Team
- Presentation at the Patient Safety Executive meeting for final sign-off

This provides additional safeguards compared to standard mortality reviews and ensures specialist expertise is applied to understanding the care provided. The specialist review process for people with a learning disability or autism may take longer than other SJR categories. The additional time reflects the detailed nature of the reviews, including the involvement of specialist teams and compliance with LeDeR requirements.

During 2024–25, the median time from death to completion of review was 61.5 days. This represents an improvement compared to 2023–24, when review completion times had increased due to higher case volumes and complexity. Sign-off at PSEM occurred after a median of 152 days, reflecting the additional governance steps built into the enhanced process.

As shown in Figure 23, the number of deaths has remained relatively stable over recent years. Earlier peaks in completion and sign-off times were linked to increased case volumes in 2023–24. Performance improved in 2024–25 as review capacity was strengthened and processes streamlined, reflecting our commitment to timely completion of these important reviews. This gives assurance that our enhanced processes are delivering timely, robust reviews while maintaining quality and governance oversight.

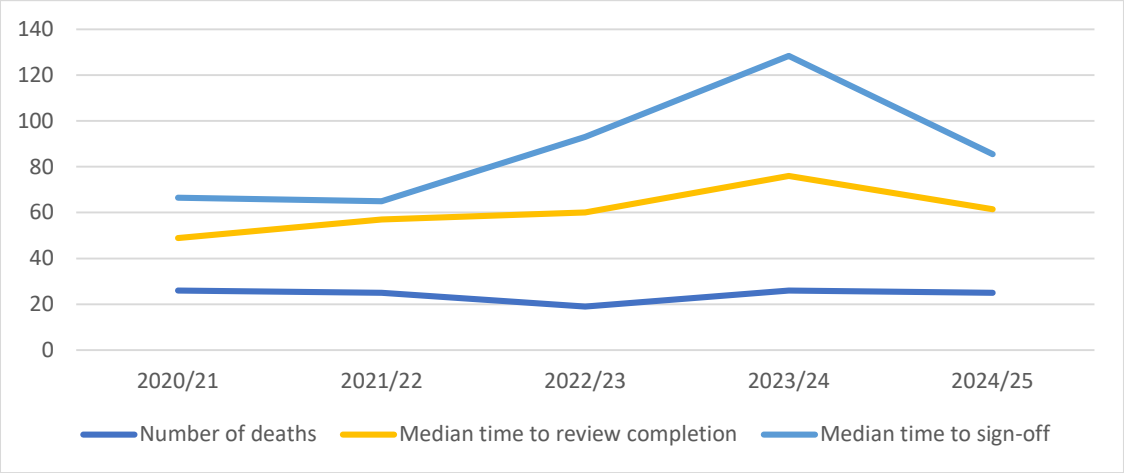

FIG 23: MEDIAN TIME TO REVIEW COMPLETION AND SIGN-OFF (DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR AUTISM)

3.3 What we learned

Our enhanced reviews have identified several areas for improvement alongside examples of excellent care.

Overall care scores

Over the reporting period, 25 reviews were completed and signed off for patients who died with a learning disability or autism. 4 reviews had an overall score of 5 or Excellent, 14 reviews scored 4 or Good, and 6 as adequate. There was 1 review where the overall care score was poor. The breakdown of overall care scores is illustrated in Figure 24.

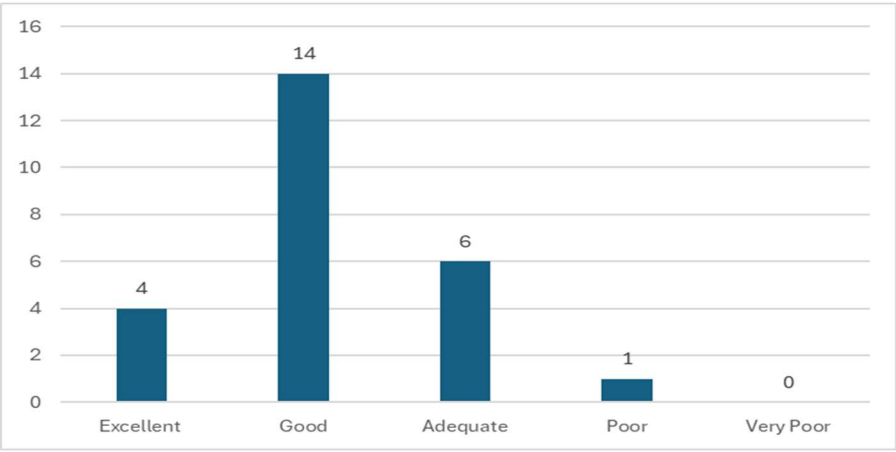

Figure 24: SJR overall care scores for patients with a learning disability or autism for 2024-25

Areas for improvement

Our reviews identified opportunities to improve pain management, which is particularly important as people with a learning disability or autism may find it difficult to communicate discomfort clearly. We also found some staff were still using outdated terminology that can affect access to appropriate services.

Several themes required attention including constipation management, mental capacity assessment, and documentation of decision-making processes. We identified challenges in involving Independent Mental Capacity Advocates (IMCAs) when required. These themes are shared regularly with the Learning Disability and Autism Steering Group and annual events are organised to raise awareness on these to improve these areas.

We are supporting ongoing insight into these issues through our Mental Health Strategy implementation, specifically through Priority 1 commitments to pilot new mental health focused mortality review approaches, and Priority 4 work to align specialty-level mortality review guidelines and develop mandatory mental health data points for richer case reviews. This work is being delivered through our Mortality Improvement Programme to strengthen mental health mortality tracking across Bristol NHS Group. Further information about our Mental Health Strategy is available on the NBT website: https://www.nbt.nhs.uk/sites/default/files/document/Mental%20Health%20Strategy%202024.pdf

Examples of excellent care

Reviews also highlighted many positive aspects of care, including the consistent use of reasonable adjustments, culturally sensitive and patient-centred approaches, and strong collaboration with families. The involvement of the Learning Disability and Autism Liaison Team in these cases ensured specialist input and comprehensive support alongside other clinical teams.

3.4 Improvements we have made

Once a review has been completed, it is discussed at the Patient Safety Executive Meeting (PSEM) to identify learning and determine actions. Our mortality governance arrangements, which include PSEM, the Clinical Effectiveness and Outcomes Group (CEOG), and the Trust Board, provide oversight and ensure that improvements are embedded. Full details are available in our Learning from Deaths Policy.

We then share this learning across NBT, and where appropriate with external partners across the Bristol NHS Group and the wider BNSSG system, to help improve care for future patients.

The key learning from 2024–25 includes:

Managing constipation

Constipation continues to be a recurrent theme in reviews of deaths, both locally and nationally, for patients with a learning disability or autism. We take this seriously and have strengthened our education and awareness work to ensure staff understand the importance of monitoring, recognising, and managing constipation effectively.

Our annual “Poo Matters” campaign and event raises awareness of the importance of preventing and managing constipation and its related complications. We have collaborated with the Poo Museum to deliver engaging education sessions for staff, and we are linking this work to wider awareness of gastrointestinal health, including bowel cancer prevention.

Staff training and awareness

We continue to deliver targeted training and awareness sessions for clinical and non-clinical staff, supported through Trust workstreams such as LDA in house training delivered by our LDA liaison teams LDA Champion Training and the Oliver McGowan training programme. This ongoing training ensures that learning from reviews translates into sustained improvements in care delivery.

Working as Bristol NHS Group

As part of our joint mortality improvement programme, we have been collaborating with colleagues at UHBW to develop a new shared approach to reviewing deaths of people with a learning disability or autism. This will reduce duplication and help our teams focus on what matters most, which is ensuring people get the reasonable adjustments they need.

Sharing good practice

Learning from enhanced reviews is shared across NBT and with partners across the Bristol NHS Group and BNSSG system. This collaborative approach ensures that good practice is recognised and embedded, and that lessons from individual reviews are translated into wider system improvements in care.

System wide collaboration

We have also worked across the BNSSG system, attending LeDeR Quality Assurance and Oversight Group Meetings which quality-check system-wide reviews, agreeing on themes and learning that are included the BNSSG LeDeR Annual Report.

This collaborative approach ensures that our learning contributes to improvements across the wider health and social care system, benefiting people with a learning disability and autistic people regardless of where they receive care.

Section 4: How we have improved

4.1 Learning and improvement from medical examiner referrals

The following examples of learning highlight how concerns raised through Medical Examiner referrals and family feedback have directly shaped improvements in the care we provide across all divisions.

Our processes for positive feedback

The volume of positive feedback varies for several reasons. Many families tell the Medical Examiner Service that they are grateful for the care their loved one received. However, because the statutory focus of the Medical Examiner role is on identifying and escalating concerns — and there is no national guidance on thresholds for sharing positive feedback — these comments have not always been consistently referred into governance processes.

Following the introduction of statutory Medical Examiner arrangements in September 2024, we noticed a reduction in the number of positive referrals being recorded. On review, we found that this reflected the Medical Examiner team's priority focus on concerns, rather than any reduction in the quality of care or appreciation expressed by families.

We have since worked with the Medical Examiner team to explain the importance of capturing and sharing positive feedback. This ensures we continue to recognise excellent care and embed good practice across our hospitals. A joint project is now underway, to be delivered during 2025–26, to develop a Bristol NHS Group and BNSSG-wide threshold for positive referrals. This will provide a consistent, proportionate approach that is meaningful for our hospitals and other BNSSG providers, without placing an excessive administrative burden on the Medical Examiner team.

Our processes for potential concerns

When the Medical Examiner refers concerns following scrutiny, the referral is sent to the divisional leads who decide on the most appropriate response and manage this through their divisional governance processes. We always attempt to respond to potential concerns through existing governance processes such as incident management or PALS (see section 2.1). Improvements because of Medical Examiner referrals are referenced within the following section alongside those achieved through other mechanisms.

4.2 Learning and improvements within our divisions

Our divisional leads and clinical teams oversee the review of deaths within their areas. The following summaries set out how learning from mortality reviews has informed governance, education, and quality improvement activity across our divisions during 2024-25.

Anaesthetics, Surgery, Critical Care and Renal Division

Intensive Care Unit (ICU)

Learning from mortality and morbidity reviews has prompted a project to evaluate whether admitting all ventilated meningitis patients from the region to the unit would improve outcomes. The rationale is that access to specialist neuro-critical care expertise may benefit this group. The project is in progress, with outcomes to be evaluated to inform future practice.

Alongside this, the ICU team has been working closely with the Mortality Improvement Programme to help shape the new digital mortality review system and processes. This includes piloting enhanced SJRs for patients who have had an ICU stay during their final admission. In this model, the discharging treatment function completes the primary review, and ICU then completes an additional question set. This approach brings multiple perspectives and supports a genuinely multidisciplinary review process, ensuring learning and improvement are embedded across teams. The pilot of this process is due to conclude in September 2025.

The ICU team has also been instrumental in developing an Application Programming Interface (API) – a secure digital link that automatically pulls key clinical information from multiple Trust systems into the mortality review platform. This integration reduces manual administration, makes data more accessible, and supports faster, more focused learning. They are also testing a prototype specialty-specific mortality report, providing a clear overview of deaths within a selected time period to support timely case selection for review.

Urology

Following mortality reviews, we are strengthening our ReSPECT documentation processes by incorporating these forms directly into admission booklets, ensuring treatment escalation decisions are captured systematically for all appropriate patients.

Medicine Division

Acute Medicine

Case reviews of patients with extended emergency department stays have highlighted opportunities to improve patient flow and reduce time to ward admission. Alongside this, several examples of excellent teamwork and communication have been identified and shared directly with the staff involved to support positive reinforcement and spread good practice.

Care of the Elderly

Our reviews have highlighted the importance of clear discharge planning and realistic discussions about access to hospice care. In response, the team has consulted with palliative care colleagues to improve understanding of hospice bed availability and to encourage “parallel planning.” This means making referrals early, even if beds are not immediately available. This learning has been shared through the April divisional newsletter to ensure consistent communication with patients and families, supporting informed decision-making and patient preference.

Emergency Department (ED)

Our learning from deaths has driven several quality improvement projects within ED. For example, we have improved communication in the major’s area through using whiteboards for tracking outstanding tasks and at regular safety huddles.

Working closely with the Acute Medicine team, we have also introduced a process for “hot handovers” — direct verbal handovers to the medical specialist registrar (SpR) for patients with significant clinical risk. This now happens alongside the standard digital referral sent through Careflow, our electronic patient record (EPR) system. This approach ensures that critical information is transferred promptly and safely, supporting faster clinical decision-making and reducing delays to treatment.

We have also improved our approach to recording allergies on drug charts to reduce the risk of errors. Allergy status is now documented solely by the initial prescribing clinician, following a full multi-point check, rather than by nursing staff after patient questioning. This change is supported by a new Trust-wide allergy prescribing policy, which has been shared and promoted across clinical teams to ensure consistent practice.

We have reviewed the impact of extended stays in the ED on patient outcomes. In collaboration with internal teams and partners across BNSSG, we have implemented improvement actions to reduce ED length of stay and minimise associated risks for patients.

Following this work, the ED team has also collaborated with the Mortality Improvement Programme to integrate ED research and quality improvement into the enhanced SJR pilot. Together, we are testing automated case identification for patients who spend more than eight hours between decision to admit and admission, ensuring these cases are consistently reviewed and learning is rapidly shared.

In addition, we also have recognised and shared multiple examples of good practice in end-of-life care in ED, particularly in how treatment escalation plans are communicated and documented. Treatment escalation plans set out an agreed approach to care in the event of deterioration, ensuring that patients, families, and clinical teams have a shared understanding of the options and preferences for treatment. This clarity supports timely, person-centred decision-making and reduces the risk of confusion or conflict during critical moments.

Gastroenterology

We continue to work with the Mortality Improvement Programme Team as early adopters in developing a new digital system for mortality reviews. This platform is designed to reduce the administrative burden for senior clinicians by automating case identification for Structured Judgement Reviews (SJRs) and Mortality and Morbidity (M&M) discussions, integrating these processes to create a more efficient “closed loop” for learning and improvement.

The Gastroenterology team has been instrumental in shaping this development, including work on the API for our new mortality review tool. This approach is helping to democratise data, reducing the manual collation required and making insights more readily accessible for clinical teams. The team is also testing a prototype specialty-specific mortality report, providing an at-a-glance overview of all deaths within a selected time period to support timely review and learning.

Alongside this, we are conducting a project on patients who do not attend the liver clinic, analysing their characteristics and outcomes to inform targeted interventions aimed at reducing non-attendance among disadvantaged patient groups. Early findings show a higher mortality rate in those who do not attend appointments. Documented learning from individual case discussions has been more limited, but this work is helping us to understand underlying drivers and develop responsive improvements.