Meeting of Group Board of Directors of NBT and UHBW held in Public
on Tuesday, 13 January 2026, 10.00 to 13.00
Clifton and Hotwells Rooms, 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 (30 mins)
2.	Declarations of Interest	Information	Group Chair	
3.	Patient Story	Information	NBT Head of Patient Experience	
4.	Minutes of the Last Meeting held on 11 November 2025	Approval	Group Chair	10:30 (5 mins)
5.	Matters Arising and Action Log	Approval	Group Chair	
6.	Questions from the Public	Information	Group Chair	10:35 (5 mins)
Strategic				
7.	Group Chair's Report	Information	Group Chair	10:40 (10 mins)
8.	Group Chief Executive's Report	Information	Group Chief Executive	10:50 (15 mins)
9.	Group Benefits Realisation Report	Information	Group Formation Officer	11.05 (15 mins)
BREAK – 11:20 to 11:30				
Quality and Performance				
10.	Group Integrated Quality and Performance Report	Information	Hospital Managing Directors and Executive Leads	11:30 (20 mins)
11.	Health Equity Plan	Discussion	Group Chief Nursing and Improvement Officer / Group Chief Medical and Innovation Officer	11.50 (25 mins)
12.	Quarterly Learning from Deaths Report	Information	Group Chief Nursing and Improvement Officer	12.15 (10 mins)
Finance				
13.	Treasury Management Policy	Approval	Group Finance and Estates Officer	12.25 (5 mins)
Governance				
14.	Integrated Governance Report including Committee Chairs' Reports	Information	Committee Chairs	12:30 (20 mins)

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
Concluding Business				
15.	Any Other Urgent Business – *Verbal Update*	Information	Group Chair	12:50 (5 mins)
16.	Date of Next Meeting **Tuesday, 10 March 2026**	Information	Group Chair	

Report To:	Meeting of Group Board of Directors of NBT and UHBW Held in Public		
Date of Meeting:	Tuesday 13th January 2026		
Report Title:	Patient Story - lived experience with sickle cell disease.		
Report Author:	Moestak Hussein – Community Involvement and Partnership Lead (UHBW)		
Report Sponsor:	Steve Hams – Group Chief Nurse & Improvement Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			x
	Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality. The purpose of presenting a patient story to Board members is: • To set a patient-focussed context for the meeting. • For Board members to understand the impact of the lived experience for patients and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.		

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

Idara is a single mother raising two daughters, Joanne and Sharon. Joanne was born with sickle cell disease and has been under UHBW care since infancy. Her journey began with a pain crisis at just six months old, and some of her first words were “it hurts.” For most of her life, Joanne has been on hydroxycarbamide and has faced repeated crises.

When she was seven, she experienced a severe episode where both lungs collapsed, requiring surgery and an exchange transfusion. During this procedure, clinicians discovered a hole in her heart, leading to cardiology referrals. This was a turning point for Idara, who noticed a stark difference in wraparound support between Cardiology and Ocean Ward in Bristol Royal Hospital for Children. While Ocean Ward provided emotional support, practical assistance, and reassurance, the structured, coordinated, and wraparound support available in Cardiology was notably absent. Recognising this gap, Idara advocated for change, which ultimately led to the creation of a dedicated Benign Support Worker role in Ocean Unit during COVID pandemic, a development that transformed the family’s experience. This role provides in-reach across all clinical areas where a child or young person with a benign haematology condition is cared for, ensuring continuity of support as the role follows the child throughout their care journey.

Despite these improvements, Idara faced significant challenges in the community. She tried to create parent support groups but encountered cultural stigma, which made it difficult to connect families. She worked tirelessly, even printing leaflets and sharing her contact details, but found one-to-one support more effective, though time-consuming. Education was another major hurdle. Schools lacked understanding of sickle cell, making transitions stressful and isolating for

Joanne. Hayley's role helped with school letters and emotional support, but Idara had to navigate much of this alone for years.

Emergency care remains the most traumatic part of their journey. Joanne experiences anxiety whenever she needs A&E services, saying, "Mummy, I don't like going in there." Idara described a lack of empathy and knowledge among ambulance and A&E staff, delays in pain relief, and repeated questions despite treatment plans being available. These experiences erode trust and create fear, especially when compared to the safe, familiar environment of Ocean Ward. Sadly, Joanne feels unsafe to travel alone by ambulance. Idara reported several contributing factors:

- **Lack of empathy and knowledge** among ambulance and A&E staff
- **Delays in pain relief**, despite treatment plans being available
- **Repeated questioning**, which adds stress and undermines confidence in care

These experiences erode trust and create fear, particularly when contrasted with the safe, familiar environment of Ocean Ward. As a result, Joanne feels unsafe travelling alone with an ambulance crew. Idara emphasised the need for cultural competence and sickle cell-specific training for emergency staff to address these systemic gaps.

Joanne's treatment journey has included frequent transfusions, later replaced by exchanges to manage iron overload. Idara raised concerns about the lack of development in sickle cell treatments and the need for equitable access to emerging options like gene therapy. She reflected on systemic inequalities, racial bias in emergency care, and the emotional toll of navigating these challenges as a single parent. Despite everything, Joanne remains resilient and dreams of becoming a psychologist specialising in pain management. The family has engaged with charities like Make-A-Wish, which provided moments of joy amid hardship.

This story illustrates the importance of wraparound support, cultural competence, and patient voice in service design. It calls for replicating holistic care models across departments, expanding support worker roles, embedding co-production, and ensuring equitable access to advanced treatments. Idara's advocacy and lived experience offer invaluable insights into improving care for families affected by sickle cell disease.

This story is shared by Idara, a single mother, and her daughter Joanne, who lives with sickle cell disease and has been under care at UHBW Ocean Ward since infancy. It highlights:

- Positive care experiences and wraparound support from Ocean Ward and Cardiology teams.
- Challenges and systemic gaps, including emergency care experiences, cultural stigma, and education barriers.
- Opportunities for improvement, such as embedding psychosocial support, cultural competence training, and equitable access to emerging treatments.

The story aligns with:

- Joint Clinical Strategy vision for seamless, high-quality, and equitable care.
- Health Equity Plan launch in the New Year.

Strategic Alignment

This work aligns to the Experience of Care / Patient & Carer Experience priority at NBT and UHBW.

Risks and Opportunities	
Recommendation	
This report is for **INFORMATION.** The Board is asked to **NOTE** the report**.**	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	
Appendices:	*Sickle cell comparative review to inform policy report (2021) – NHS Race & Health Observatory SICKLE-CELL-COMPARATIVE-REPORT-.pdf*

Minutes of the Public Group Board Meeting of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)
Held on Tuesday, 11 November 2025, 10:00 to 12:45
in Room 1, BAWA Leisure, 589 Southmead Rd, Bristol BS34 7RG

Present

Joint Members of both Boards:	
Ingrid Barker	Group Chair
Maria Kane	Group Chief Executive Officer
Jenny Lewis	Group Chief People and Culture Officer
Neil Darvill	Group Chief Digital Information Officer
Neil Kemsley	Group Chief Finance and Estates Officer
Steve Hams	Group Chief Medical and Innovation Officer
Tim Whittlestone	Group Chief Medical and Innovation Officer
Linda Kennedy	Group Non-Executive Director
Marc Griffiths	Group Non-Executive Director
Martin Sykes	Group Non-Executive Director and UHBW Vice-Chair
Richard Gaunt	Group Non-Executive Director
Roy Shubhabrata	Group Non-Executive Director
Sarah Purdy	Group Non-Executive Director and NBT Vice-Chair
NBT Board members:	
Glyn Howells	Hospital Managing Director, NBT
Shawn Smith	Non-Executive Director (NBT)
UHBW Board members:	
Stuart Walker	Hospital Managing Director, UHBW
Sue Balcombe	Non-Executive Director (UHBW)

Also In Attendance:

Xavier Bell	Group Chief of Staff
Aimee Jordan-Nash	Senior Corporate Governance Officer & Policy Manager *(minutes)*
Emily Judd	Corporate Governance Manager
Sarah	Patient Representative
Emily Ayling	Head of Patient Experience (NBT)
Gifty Markey	Associate Chief Nursing Officer for Mental Health, Learning Disabilities & Neurodiversity (NBT)
Rob Gittins	Group PMO & Merger Programme Manager
Tim Keen	Associate Director of Strategy (NBT)
Cathy Caple	Deputy Director of Improvement and Innovation (UHBW)
Rosie Gregory	Improvement Partner (UHBW)

The Chair opened the meeting at 10.00am

Minute Ref.	*Item*	*Actions*
01/11/25	**Welcomes and Apologies for Absence**	
	Ingrid Barker, Group Chair, welcomed members of the Board to the meeting. Apologies for absence had been received from Paula Clarke, Group Formation Officer.	
02/11/25	**Declarations of Interest**	
	No interests were declared.	

Minute Ref.	*Item*	*Actions*
03/10/25	**Patient Story**	
	Steve Hams, Group Chief Nursing and Improvement Officer, introduced the patient story, and welcomed Emily Ayling, Head of Patient Experience (NBT), Gifty Markey, Associate Chief Nursing Officer for Mental Health, Learning Disabilities & Neurodiversity (NBT) and Sarah, Patient Representative, to share her experience. Sarah described three key messages from her journey: 1. The mental and emotional impact of illness can be as severe, or worse, than physical symptoms. 2. Healthcare often overlooks the person behind the illness, focusing narrowly on physical treatment. 3. Emotional intelligence in care is essential and should be embedded into practice. Sarah shared her background, including her work in expressive movement therapy and research linking physical and mental health. She illustrated how psychological pain can exceed physical pain, using an example of a patient defined by illness rather than identity. Reflecting on her own experience, Sarah explained that following her breast cancer diagnosis and treatment, she suffered significant psychological distress and medical trauma. She noted that staff lacked training to address emotional impacts, and her suffering was compounded by feeling unseen as a person. A personal note to hospital staff before surgery, asking them to acknowledge her emotional connection to her body, transformed her care experience and aided her healing. Sarah urged the Trust to lead a cultural shift towards an "Emotionally Intelligent Era of Healthcare," integrating emotional intelligence with clinical skills. She proposed piloting this approach in one department, using tools such as "About Me" notes, measuring patient wellbeing outcomes, and embedding emotional intelligence training across staff interactions. She emphasised that putting the person before their symptoms costs nothing but changes everything. During the ensuing discussion, the following points were noted: • Board members commended the story as powerful and inspiring, recognising the need for culture change alongside the organisational merger. • Suggestions included co-producing initiatives based on lived experience, embedding trauma-informed care, and exploring pilot programmes. • Emphasis was placed on incorporating emotional intelligence into staff training and medical education, ensuring holistic care remains central. • Existing programmes such as shared decision-making were noted as aligned with these principles and could be expanded. • The Board acknowledged the importance of maintaining humanity in care, particularly as technology advances. **RESOLVED that the Group Board noted the patient story and agreed to consider how the learning and approaches could be implemented across the Bristol NHS Group to enhance patient experience and psychological wellbeing.** *Sarah, Emily Ayling and Gifty Markey left the meeting.*	

Minute Ref.	*Item*	*Actions*
04/11/25	**Minutes of the Previous Meeting**	
	RESOLVED that the minutes of the meeting of the Public Group Board on 9 September 2025 be approved as a true and accurate record of that meeting subject to the following amendment: • **Correction on page 1 Steve Ham's job title to be changed from Group Chief Medical and Innovation Officer to Group Chief Nursing and Improvement Officer**	
05/11/25	**Matters Arising and Action Log**	
	The Group Board considered the items on the action log as follows: 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.* It was reported that the updated Group BAF would be circulated following discussion at the private Group Board meeting. The Group Board agreed that the action could be closed. **Action closed.** 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 report on the revised terms of reference and membership was agreed at September's meeting. **Action closed.** **RESOLVED that the Group Board noted and approved the action log and no matters arising were discussed.**	
06/11/25	**Questions from the Public**	
	Xavier Bell, Group Chief of Staff, read aloud a question submitted by a member of the public, together with the response provided: *Question: How does the Trust assess whether it lives by its values when considering the impact of decisions on their near neighbours in Kingsdown? How is such an assessment regularly made and how is it reported back to the Council?* *Answer: Thank you for your question. We fully recognise the importance of being a good neighbour and greatly value being part of such a thriving and close-knit community here in the heart of Bristol. We're always keen to strengthen our relationship with local residents and to ensure that the way we operate reflects our values and takes into account the impact on those who live nearby.* *Our Chief Communications and Engagement Officer, Elliot Nichols, would be very happy to meet to discuss how we can engage with you and your neighbours more regularly, and to explore how we can continue to improve our approach to local engagement.* The Board discussed improving local engagement and agreed that an action would be taken to bring a proposal/update back to a future Public Board meeting. The importance of ongoing dialogue and the need to consider what matters most to stakeholders was recognised and it was suggested that the	

Minute Ref.	*Item*	*Actions*
	format of engagement forums might need to be rethought to ensure effectiveness. Elliot Nichols confirmed that this work would form part of the wider engagement approach. Sarah Purdy, Group Non-Executive Director and NBT Vice-Chair, highlighted the value of learning from external models, such as those used by the University of Bristol, and agreed to share relevant contacts outside the meeting. Ben Argo, Lead Governor, sought assurance on the final position of the winter plan, noting that this issue had been raised frequently by local constituents. Maria Kane, Group Chief Executive, provided assurance that an ongoing review process was in place. The Trust had worked closely with system partners to agree additional capacity in preparation for winter pressures and potential industrial action. It was confirmed that the organisation was in an improved position regarding escalation and that assurance would continue to be reviewed weekly. Any significant changes would be reported to the Board. **RESOLVED that the Group Board acknowledged the public question submitted and noted the response provided and agreed to bring a proposal/update back to a future Public Board meeting.**	**XB/EN**
07/11/25	**Group Chair's Report**	
	Ingrid Barker presented her report to the Group Board, summarising key activities and engagements undertaken since the previous meeting. The following points were highlighted: • Continued visibility through visits, including the Same Day Emergency Care facility at Weston, the 3D Medical Centre in Frenchay, and Dermatology services. • Engagement with clinical leaders, including discussions on palliative care and neighbourhood working pilots. • Attendance at the NBT Staff Awards, which was noted as a successful and celebratory event. • Ongoing meetings with system partners and participation in the Community Partnership Group's second meeting, which was progressing well in co-creating ways of working. • Visit to BHealth community health clinic, with learning identified around accessibility and trust-building. • Continued partnership with Jessie May Children's Hospice and attendance at the Bristol & Weston Hospitals Charity strategy launch. • National engagement included contributing evidence to the Senior Salaries Review Body on Very Senior Manager pay and participation in NHS Providers and NHS Confed Chairs' networks. In addition, the Vice Chairs reported on activities including attendance at the UHBW Research Showcase and other strategic and operational meetings. **RESOLVED that the Group Chair's report was noted.**	
08/11/25	**Group Chief Executive's Report**	
	Maria Kane presented her report to the Group Board and highlighted the following key points: • The current national context including the Government announcement of an urgent review of antisemitism and racism in the NHS and the Medium-Term Planning Framework. • Bristol, North Somerset and South Gloucestershire (BNSSG) ICB was progressing plans to cluster with Gloucestershire ICB. Maria provided	

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	an update on the recent recruitment of the BNSSG ICB Cluster Chair and Cluster Chief Executive. • The upcoming industrial action by resident doctors scheduled for 14-19 November, and the mitigating plans in place. • The recent Bristol NHS Group Partnership Event which focused on delivering the Joint Clinical Strategy and population health priorities. Maria thanked attendees and noted the event provided a powerful summary of future focus areas. • The recent joint Senior Leadership Meeting which featured insights from the Royal Free Group on merger lessons and also focused on anti-racism and trauma-informed care. • Maria congratulated teams for their achievements, including national re-accreditation for Liaison Psychiatry services, the NBT Finance Team winning Finance Team of the Year at the HFMA South West Awards, and the NBT Stroke Team receiving national recognition for improvements in thrombolysis rates. • Maria also reported on her visit to Cossham Hospital with local MP Damien Egan to discuss maternity services and showcase facilities. Marc Griffiths, Group Non-Executive Director, acknowledged the operational pressures on staff and sought assurance on how they were coping. Maria recognised the challenges of using escalation spaces and the resulting impact on staff and commended leadership for their resilience and support. Maria encouraged Board members to undertake visits for greater insight and noted the significant operational impact of the Timely Handover Plan. Roy Shubhabrata, Group Non-Executive Director, commended the finance team for their award and welcomed feedback from the senior leadership meeting. The open discussion on clinical divisions, oversight, and the long-standing framework conversation was noted. Jenny Lewis, Group Chief People and Culture Officer, highlighted the value of the external speaker for shared learning and networking. Maria emphasised the importance of the joint clinical strategy and learning from different approaches. The Board welcomed the insights from external leadership engagement and noted the benefits of shared learning for future strategy. **RESOLVED that the Group Chief Executive's Report was noted for information.** *Rob Gittins joined the meeting.*	
09/11/25	**Merger Update**	
	Rob Gittins, Group PMO and Merger Programme Director, provided an update on progress towards the proposed merger of NBT and UHBW. Rob confirmed that the merger aimed to deliver improved patient care, enhanced opportunities for staff, better services for local communities, and best value for the public purse, building on the work of the Bristol NHS Group and the Joint Clinical Strategy. The statutory process would proceed under Section 56A of the NHS Act 2006, ensuring robust governance and public accountability. Due diligence was underway across clinical, financial, legal, and operational domains, supported by governance arrangements including a Merger Programme Board and statutory Merger Committees for each Trust. A Communications and Engagement Plan, structured around the Four Ps (Patients, People, Population, Public Purse), was in place and embedded within an Organisational Development (OD) and Culture Plan. Engagement	

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	activities included CEO newsletters, leadership cascades, town halls, and stakeholder updates. The first evaluation meeting with the university had taken place to ensure learning and innovation were captured and tracked over 1, 2, and 10 years. Development of the Full Business Case (FBC) and Post-Transaction Implementation Plan (PTIP) was underway, with a target decision on merger by summer 2026, subject to NHS England approval. The OD and Culture Plan would focus on shared values, leadership capability, team cohesion, wellbeing, and inclusion. During the ensuring discussion, the following key points were made: • Board members welcomed the structured approach and emphasis on engagement and culture. • Martin Sykes, Group Non-Executive Director and UHBW Vice-Chair, supported the timeline but noted resource constraints and the importance of planning for full integration post-transaction. Linda agreed and emphasised the importance of clear and consistent messaging to aid in articulating the purpose and benefits of the merger. • Richard Gaunt, Group Non-Executive Director, emphasised the importance of ensuring that risks arising from the transaction plan were captured on the corporate risk register and appropriately reflected within the Board Assurance Framework. Xavier Bell confirmed this would take place and noted that due diligent risks were due to be discussed at the next Merger Programme Board. • Lessons learned from previous mergers were discussed, with emphasis on robust implementation planning to realise benefits. **RESOLVED that the Group Board noted the updates on the progress with the merger programme.** *Rob Gittins left the meeting.* *Cathy Caple, Rosie Gregory and Tim Keen joined the meeting.*	
10/11/25	**Innovation Strategy**	
	Tim Whittlestone, Group Chief Medical and Innovation Officer, introduced the Innovation Strategy and welcomed Cathy Caple, Deputy Director of Improvement and Innovation UHBW, Rosie Gregory, Improvement Partner UHBW and Tim Keen, Associate Director of Strategy NBT, to the meeting. Tim Whittlestone outlined the proposed approach to developing the Group Innovation Strategy, which aimed to embed innovation as a core principle across the Group, foster a culture of curiosity and collaboration, and position the Group as a leader in health and care innovation. He highlighted the development of an Innovation Framework and a prioritisation platform to provide clear processes for idea submission, ethical and clinical review, and commercial viability checks. It was noted that the Group was working towards the formal launch of the Innovation Strategy in April 2026, supported by the establishment of a Group Innovation Hub as a single front door for innovators. Cathy Caple emphasised the importance of addressing barriers to innovation and building capability across both Trusts, supported by the Innovation Support Group. Rosie Gregory shared a practical example of innovation through the "Rate My Shift" initiative, which promoted reflective practice, achieved compliance with information governance, and recently won a Nursing Times Award. Tim Keen highlighted commercial opportunities and the need for	

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	investment to progress promising ideas, supported by structural enablers such as the Innovation Hub. Board members expressed strong support for the strategic direction and discussed the following points: • Marc Griffiths praised the focus on social innovation (emphasising its importance) and the potential to extend benefits to communities, highlighting links with the Health Innovation Network, universities, and commercial partners. Marc stressed the importance of embedding enterprise within the approach. • Roy Shubhabrata endorsed the strategy and queried the current capacity to dedicate resources to accelerate delivery, noting the need for risk appetite and investment. Tim Whittlestone recognised the challenges and confirmed that a business case was in development to support team expansion. • Maria Kane welcomed the progress and emphasised the need for pace in adopting innovation, leveraging both commercial and non-commercial income streams. She acknowledged the complexity of the external landscape and the importance of clear navigation and internal frameworks to avoid duplication. • Neil Kemsley, Group Chief Finance and Estates Officer, highlighted the need for alignment with the wider Group strategy and sustainability objectives. • Linda Kennedy, Group Non-Executive Director, and Ingrid Barker reinforced the cultural and reputational benefits of innovation and endorsed the approach. **RESOLVED that the Group Board:** • **Approved the milestones and timeline to develop the Group strategy for approval by the Group Board of Directors in March 2026.** • **Discussed and endorsed the strategic direction and principles outlined in the document.** *Cathy Caple, Rosie Gregory and Tim Keen left the meeting.*	
11/11/25	**Group Approach to Anti-racism**	
	Jenny Lewis, Group Chief People and Culture Officer, presented the proposed Group approach to anti-racism. Jenny outlined that achieving sustained improvement required a structured, transformational approach, underpinned by the R.A.C.E Model (Recognise, Analyse, Commit, Empower) and informed by Trauma-Informed Practice principles to ensure safety, trust, collaboration, and avoid re-traumatisation. Jenny noted that both Trusts had strong foundations, including listening events, staff networks, pledges, and training, with joint work underway on violence and aggression SOPs, allyship, and recruitment practices. Jenny highlighted the six-month priorities, which included: • Strengthening anti-racism and trauma-informed training for staff and leaders. • Embedding inclusive recruitment and career progression practices. • Developing consistent reporting processes and expand racial trauma peer support. • Integrating anti-racism principles into merger-related OD and culture plans.	

Minute Ref.	*Item*	*Actions*
	During the ensuring discussion, the following key points were noted: • Martin Sykes emphasised the need for frequent data monitoring to ensure visible progress. Jenny confirmed that measurements would include WRES/WDES indicators, staff surveys, and awareness tracking aligned to the RACE model. • Roy Shubhabrata sought assurance on tangible impact and evidence of change. Jenny confirmed initial actions would target areas with existing momentum, such as violence and aggression programmes, while embedding trauma-informed principles. • Marc Griffiths and Maria Kane stressed the importance of clear language and consistent messaging. It was suggested that external statements should clearly set out behaviours that would not be tolerated to make the messaging more powerful. • Marc highlighted the need to link anti-racism work to leadership development and mentorship programmes. Jenny committed to providing education and support to leaders to ensure they felt fully equipped, confident and able to model inclusive behaviours. • Sarah Purdy raised the issue of discrimination from patients and the need for clear external messaging to demonstrate zero tolerance for racism. • Ingrid Barker recognised the importance of maintaining focus on health inequalities and noted that anti-racism should be embedded in governance and merger plans. • Sue Balcombe, Non-Executive Director, UHBW, added that messaging must be handled carefully to avoid devaluing existing departmental work. The Board reaffirmed its commitment to the proposed approach, endorsed the six-month plan, and restated the overarching aim: "To eradicate racism within our organisations." **RESOLVED that the Group Board:** • **Discussed and support our proposed approach to anti-racism as a Hospital Group** • **Discussed the use of the R.A.C.E Model, underpinned by the golden thread of Trauma Informed practice.** • **Supported the plan of work for next six months** • **Discussed our over-arching anti-racism aim: *To eradicate racism within our organisations*** **Group Integrated Quality and Performance Report**	
12/11/25		
	The Group Board considered the Joint Integrated Quality and Performance Report which provided an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains for September 2025. <u>Performance</u> Stuart Walker, Hospital Managing Director, UHBW, and Glyn Howells, Hospital Managing Director, NBT, presented the performance update for UHBW and NBT and highlighted the following key areas: • **Urgent and Emergency Care (UEC):** Both Trusts continued to face significant operational pressures. UHBW reported persistent challenges because of No Criteria to Reside challenges and advised of the recent internal critical incident occurrence. Ambulance handover delays improved slightly, with 45-minute breaches reducing from 10% to 4%, but escalation areas remained in use. In addition, Children's ED saw	

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	increased demand but maintained strong performance. NBT reported record Emergency Department (ED) attendances (374 per day) and ongoing use of cohorting areas, raising concerns about patient privacy and dignity. In addition, surges in ambulance arrivals and the implementation of the Timely Handover Plan continued to impact performance. • **Elective Care:** Performance remained broadly on track for both Trusts, with good recovery in ENT and Cardiology. Paediatric dentistry remained challenged. • **Cancer:** UHBW maintained compliance with 31- and 62-day standards but fell short on 78% trajectory for the Faster Diagnosis Standard due to staffing shortages, but recovery was expected in November. NBT reported delays in Urology and Breast pathways, with improvement plans in place. • **Diagnostics:** UHBW performance has improved but remained above target at 14.1%. NBT was reporting at 1.3% as a result of service delivery challenges in DEXA and Neurophysiology. *Maria Kane left the meeting.* Roy Shubhabrata acknowledged corridor care compromised patient dignity and stressed that safety remained the red line. Board members expressed concern about the sustainability of escalation areas and urged visits to understand the reality on the ground. Marc Griffiths raised concerns about radiologist shortages in breast services and suggested exploring advanced support options to maintain service delivery. <u>Quality, Safety and Effectiveness</u> Steve Hams presented the quality, safety and effectiveness update for UHBW and NBT and highlighted the following key areas: • UHBW strengthened its approach to MRSA prevention following recent cases, focusing on IV line care. • NBT reported on the anticipated improvement in pressure ulcer rates after a spike earlier in the year. • VTE risk assessment compliance remained below ambition, but targeted interventions were underway. Steve provided assurance that the Quality and Outcomes Committee reviewed these issues in detail at the recent meeting. Board noted the Perinatal Quality Surveillance Matrix (PQSM) Dashboard data. Sue Balcombe questioned the plateau in VTE risk assessment figures. Tim Whittlestone confirmed the ambition for exemplar status and noted the targeted improvement actions. <u>People</u> Jenny Lewis presented the People update for UHBW and NBT and highlighted the following key areas: • Recruitment remained challenging in specific areas, notably Healthcare Support Workers (HCSW) at NBT. A comprehensive HCSW recruitment campaign was being implemented to drive improvement. • Work was ongoing to reduce sickness absence, particularly among unregistered clinical staff and estates and ancillary staff. • Mandatory training compliance was improving across both Trusts, but national requirements continued to present risks.	

Minute Ref.	*Item*	*Actions*
	Finance Neil Kemsley presented the Finance update for UHBW and NBT and provided an update on the month seven figures. NBT reported a £3.5m deficit position against a £2.8m deficit plan; UHBW reported an £8.3m deficit against £7.7m deficit plan. Neil also explained the capital plan delivery for both Trusts and the financial costs of the recent industrial action and the escalation costs. **RESOLVED that the Group Board noted the Group Integrated Quality and Performance Report.**	
13/11/25	**Integrated Governance Report**	
	The Group Board received the Integrated Governance Report and noted the following committee upward reports: • Digital Committee in Common on 18 September 2025. No issues were highlighted for escalation. • People Committee in Common on 25 September 2025. Linda Kennedy noted strong collaboration between the two Trusts and commended progress on joint initiatives. • Quality and Outcomes Committee in Common on 30 September 2025. Sue Balcombe reported on the September meeting, highlighting that the Maternity Safety Champion role would be jointly undertaken by herself and Sarah Purdy. • Finance and Estates Committee in Common on 30 September and 28 October 2025. Martin Sykes reported that the fire safety matters would be presented to the Board separately. • Audit Committee in Common on 28 October 2025. Richard Gaunt emphasised the need for dedicated Board time to review the Board Assurance Framework (BAF) and raised the importance of tracking potential opportunities identified in the bereavement report to ensure they were not lost. • Quality and Outcomes Committee in Common on 30 October 2025. Sarah Purdy presented the report and provided assurance to the Group Board on: o HTA compliance and Fuller Inquiry compliance reports and the Committee's call for detailed action plans in the near future o The Organ Donation and Safeguarding reports o The maternity and neonatal reports for NBT and for UHBW and the decisions made by the Committee on behalf of the Board. The Group Board noted the committee upward reports and the activities undertaken by the committees on behalf of the board. **RESOVLED that the Group Board noted the Integrated Governance Report including the committee upward reports.**	
14/11/25	**Any Other Business**	
	There were no further items of business.	
15/11/25	**Date of Next Meeting – Tuesday 13 January 2026.**	

The meeting concluded at 12.55pm.

Meeting of Group Board of Directors of NBT and UHBW held in Public on Tuesday, 13 January 2026

Action Log

Outstanding actions from the meeting held on 9 September 2025					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	*06/11/25*	Questions from the Public Proposal / update on improving local engagement to be brought back to a future Public Board meeting.	Group Chief of Staff / Group Chief Communications and Engagement Officer	January 2026	Verbal update to be provided at the meeting.
Actions closed at meeting held on 11 November 2025					
2.	*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.	Joint Chief Corporate Governance Officer	November 2025	November 2025 update This item was discussed at the November meeting. **Action closed.** September 2025 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.

Report To:	Meeting of the Group Board of Directors for NBT and UHBW held in Public		
Date of Meeting:	13 January 2026		
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 Tuesday 11 November 2025 to Monday 12 January 2026.			
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 Chair's attendance at events and visits as well as details of the Group Chair's engagement with Trust colleagues, system partners, national partners, and others during the reporting period.

2. Background

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

3. Activities across both Trusts (UHBW and NBT)

3.1 The Group Chair has undertaken several meetings and activities since the last report to the Group Board on 11 November 2025:

- Visited the Macmillan centre to learn about the innovative ways that the team support our service users and their families.
- Attended monthly check-in meetings with the Lead Governor.
- Chaired a Council of Governors meeting where the Governors discussed ongoing issues including the potential merger and an update from the Group Quality and Outcomes Committee
- Chaired the Governor's Nominations and Appointments committee meeting to present NED activity reports and the outcome of NED appraisals.
- Visited Fresh Arts Team at NBT, who wellbeing support to patients through art and dance. Ingrid spent time with the team and even had a dance in the atrium with the Dance for Parkinsons class, an initiative that gives people with Parkinsons disease the opportunity to exercise whilst socialising and showing off their dance moves.
- Attended a Board development session with Executive and Non-Executive Directors, with a focus on team building.
- Hosted Paul Miller, Chair of the Avon and Wiltshire Mental Health Partnership at the Bristol Royal Hospital for Children and the Bristol Royal Infirmary. Paul visited various services including Children's Emergency Department and Apollo Ward as well as the Home First and High Impact User teams, and the Liaison Psychiatry Service.
- Guest speaker at the Group Women's Network meeting.
- Chaired a Governor/NED engagement session.
- Led a number of monthly Vice Chair touchpoint meetings and NED check in meetings.

4. Connecting with our Partners

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

- Attended the fortnightly City Partners meeting, delivering a presentation on the Group's merger aspirations.
- Chaired the Bristol NHS Group Community Partnership Group meeting.
- Chaired the NHS Race Health Observatory regional conference, 'Fair Futures – Ethnicity Pay and Progression in Healthcare'. The conference shared data on the current position and its impact on the 30% of our NHS workfrce from ethnic minority

backgrounds, as well as examples of good practice. A national report bringing together the learning from the regional roadshows will be published in due course.

- Attended the Christmas Star festive concert organised by Bristol & Weston Hospitals Charity. Ingrid delivered one of the opening speeches before enjoying an incredible performance which helped raise essential funds for the Charity.
- Met with the Chair and CEO of the Grand Appeal, the Bristol Children Hospitals charity.
- Visited the CEO of the Care Forum and his deputy to discuss the Care Forum's progress in learning from the experience of marginalised groups of people in order to build more responsive services. The Care Forum also hosts and manages Healthwatch for BNNSG.
- Hosted a visit by the West of England Combined Authority Mayor at Southmead Hospital, highlighting technological developments including the Genomics lab, robotic surgery and a visit to the new Princess Royal Bristol Surgical Centre.

4.2 National and Regional Engagement

The Chair attended several meetings including:

- BNSSG Integrated Care Partnership Board
- BNSSG Chairs Reference Group
- NHS Providers' Chairs and Chief Executives Network
- NHS Confederation and NHS Providers' Quarterly Shared Chairs' Leadership Forum

5. Vice-Chairs Report

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

5.1 Vice Chair (UHBW):

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

- Visted NBT's Emergency Department.
- Visited the Severn Pathology team.
- Chaired the Finance and Estates Committee meeting.
- Visited the Princess Royal Bristol Surgical centre
- Attended the governor's strategy group.
- Visited BRI's Emergency Department.
- Attended a Board development session with Group Execs and non-Exec Directors across both Trusts.
- Touchpoint meetings with the Group Chair, and Vice Chair for NBT.
- Attended the Governors and NED engagement session.

5.2 Vice Chair (NBT):

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

- Visit to the UHBW's Pharmacy team.
- Meeting with Obstetric consultants at NBT.

- Visited the Maternity suite in her capacity as Perinatal Safety Champion.
- Reviewed the Maternity Incentive Scheme return and associated evidence for NBT and UHBW.
- Visited to Southmead's Emergency Department.
- Attended the NHS Race and Health Observatory roadshow.
- Visited NBT's Haematology and Oncology Departments.
- Attended a Board development session with Group Executives and non-Executive Directors across both Trusts.
- Attended a meeting with senior members of Faculty of Health and Life Sciences at the University of Bristol.
- Visited St Peter's Hospice.

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

- Council of Governors
- Trust Level Risks and Corporate Quality Risks meeting
- Maternity and perinatal safety champions meeting
- Quality and Outcomes committee.
- Finance and Estates committee.
- Touchpoint meetings with the Group Chair, and Vice Chair for UHBW.
- BNSSG Outcomes, Quality and Performance Committee meeting.
- Governors and NED engagement session.
- Renumeration and nominations committee.
- Quality focus group.

6 Summary and Recommendations

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

Report To:	Meeting of the Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	13 January 2026		
Report Title:	Group Chief Executive Report		
Report Author:	Xavier Bell, Group Chief of Staff		
Report Sponsor:	Maria Kane, Group Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The report sets out information on key items of interest to Trust Boards, including engagement with system partners and regulators, events, and key staff appointments.		

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

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

In early November, following the publication of the Medium-Term Planning Framework, NHS England published the Strategic Commissioning Framework, where they have set out a clearer articulation of the expectations on Integrated Care Boards as strategic commissioners.

The framework describes strategic commissioning as a continuous, evidence-driven process to plan, purchase, monitor and evaluate services over the longer term, with a strengthened emphasis on improving population health, reducing inequalities and securing best value from the NHS budget. It introduces an updated, four-stage commissioning cycle and highlights the need for deeper collaboration with providers, local government and communities, supported by seven key enablers such as strong system leadership, enhanced data and intelligence, and meaningful patient and public involvement.

ICBs are expected to adopt this approach from 2026/27, and NHS England will launch a Strategic Commissioning Development Programme in 2026 to build the capabilities required for successful implementation.

2. Integrated Care System Update

2.1. BNSSG ICB

The latest update from our ICB (as of 3 December 2025) confirms the continued progress in developing the Gloucestershire and BNSSG ICB cluster, aligned with national aims to reduce duplication, streamline functions and strengthen the future strategic commissioning role of ICBs. The publication of the Strategic Commissioning Framework (see above) provides a blueprint for translating population health needs into commissioning plans, and local work is now focused on building a leading commissioning organisation through strong data, evidence and partnership working. A Joint Transition Committee is overseeing key workstreams (governance, workforce, communications, finance and clinical delivery) to ensure a well-managed transition.

ICB Executive Director consultation on future leadership structures is underway, alongside preparations for a national voluntary redundancy scheme, with wider organisational consultation expected in the spring of 2026. Throughout this process, continuity of care and commitment to place-based working remains a central focus.

3. Operational Delivery

3.1. Quarter Two - National Oversight Framework (NOF) Segmentation

I am very pleased to confirm that both NBT and UHBW have retained their Segmentation status for Quarter two of 2025/26, with NBT remaining in NOF segment two and UHBW in segment 1. This means that both organisations remain in the top 25 out of 134 across

England, as measured by the NOF domains of elective and urgent care performance, quality of care, financial sustainability, workforce and leadership, patient experience and safety and outcomes.

3.2. NHSE South West region's approach to NHS provider oversight assurance in 2026

NHS England has confirmed the new South West provider oversight arrangements, which will take effect from January 2026 as responsibility for provider performance oversight and management formally transfers from ICBs to the NHSE regional team.

Oversight will be conducted in line with the NHS Oversight Framework, with meeting frequency determined by each organisation's NOF segment: UHBW is currently in segment 1, meaning annual oversight, while NBT is in segment 2, with six-monthly oversight.

The new approach aims to maintain strong regional relationships, ensure a smooth handover from ICBs, and apply proportionate, risk-based oversight across the five NOF domains, supported by a cluster-based model aligned to emerging ICB structures. Further updates will be brought to the Board as the arrangements embed.

3.3. Operational Pressures in Urgent and Emergency Care

Both organisations have continued to see sustained pressure on services throughout November and December, with a small period of respite over the Christmas bank holidays. Both Trusts have declared Critical Incidents during December, which supported the use of escalation actions to manage significant pressures. While there are issues across the system that mean both Trusts have high levels of patients with no criteria to reside (NCTR), both organisations are actively working to improve the flow of patients, and I am extremely grateful to colleagues for their continued efforts to support our patients during these particularly busy times. The Board will have the opportunity to discuss performance and related safety and outcomes metrics when considering the Integrated Quality and Performance Report.

3.4. Industrial Action

I am pleased to report that during the resident doctor industrial action in November the NHS was able to meet the ambitious goal of maintaining 95% of planned care, while still maintaining critical services. A further period of industrial action took place over 17-22 December, and I want to thank colleagues for their hard work to maintain operational preparedness across our Group sites to prioritise patient safety. While Industrial Action is a national dispute between the Government and Trade Unions, I maintain the commitment to work with Resident Doctors to address their concerns locally and ensure Bristol NHS Group is a place where all staff groups are heard, and I attended a joint NBT and UHBW Resident Doctors Forum in December and intend to join regularly moving forward.

3.5. Avon Breast Screening Service

I am pleased to inform the Board that the Avon Breast Screening Service has successfully completed its recent Screening Quality Assurance review, which took place in November. The review confirmed a high cancer detection rate, strong breast care nurse support, and clear improvements against key performance indicators. I would like to extend my sincere thanks to all colleagues across radiology, pathology, administration, and clinical teams for their professionalism, commitment, and the high quality care they provide to patients.

4. Strategy and Culture

4.1. Black History Month

In October 2025, we celebrated Black History Month under the theme “Standing Firm in Pride and Power”, honouring Black heritage, amplifying voices, and embracing the strength and creativity within our community. Highlights included art exhibitions, themed food, a Schwartz Round, and a moving performance by the Bread of Life Choir.

Our speaker sessions featured Katie Donovan Adekanmbi, Aiyisha Thomas, and Tyrell BX, each bringing powerful insights. We closed the month with an inspiring event led by Ingrid Barker, Bristol NHS Group Chair, and Dorcas Gwata, award-winning Mental Health Nurse and Ubuntu Coach, whose reflections on justice, health, and leadership left a lasting impact. I would like to thank everyone who took part.

4.2. Disability History Month

From 20 November - 20 December 2025 our NHS Group marked Disability History Month (DHM), a national campaign celebrating the contributions of disabled and neurodivergent people while raising awareness of the barriers they face. This year’s theme, “Disability, Life and Death”, explored how disabled people’s lives have been valued throughout history in healthcare and society.

4.3. NHS Sexual Misconduct Prevention Actions

In early December 2025, NHS England issued an update on national actions to prevent sexual misconduct, following recent media reports and ongoing police investigations. The letter highlights progress made across the NHS, with all trusts and ICBs now having sexual misconduct policies in place or in the process of being adopted, and 76% having implemented anonymous reporting routes. New expectations include:

- national investigation training for people professionals,
- expansion of specialist investigator capacity,
- strengthened chaperoning and incident-review arrangements, and
- a requirement for all providers, including primary care, to complete a revised sexual misconduct audit by 2 February 2026.

Reassuringly, these actions align closely with work already underway across both of our Trusts to enhance safety, strengthen reporting pathways, and promote a culture in which concerns are raised confidently and addressed robustly. Further detailed updates on implementation and progress will be reported through the Boards’ People Committee in the coming months.

4.4. NHS Genomics Healthcare Summitt 2025

I was pleased to attend the NHS Genomics Healthcare Summit 2025, held at the Queen Elizabeth II Centre in London, a key national event bringing together leaders from across healthcare, research, academia and industry to explore the latest advances in genomic medicine.

The Summit provided valuable insight into emerging clinical applications of genomics and opportunities for system-wide collaboration. I chaired one of the sessions, which brought together experts including Professor Dame Sue Hill, Chief Scientific Officer for England and Senior Responsible Officer for Genomics, at NHS England, Paul Maubach Director for

Neighbourhood Health, Department of Health and Social Care, and a number of other preeminent academics, clinicians as well as patient perspectives, to discuss the role of genomics in improving patient outcomes and accelerating the adoption of innovative approaches across the NHS.

It was a positive opportunity to showcase the strength of our regional contributions and to ensure our Trusts remain closely engaged with developments shaping the future of personalised and preventative care.

4.5. Bristol Health Partners Chair

As the Board may be aware, I recently stood down as Chair of Bristol Health Partners following a three-year term. I am pleased to note that our Chief Medical and Innovation Officer, Professor Tim Whittlestone, has now been appointed as the new Chair. As you will all appreciate Tim brings significant clinical and system leadership experience to this role, alongside his extensive contribution to regional innovation and research. His appointment has been warmly welcomed by Bristol Health Partners, who highlighted his commitment to advancing evidence-based improvement and strengthening collaboration across Bristol, North Somerset and South Gloucestershire. I echo these sentiments and look forward to seeing the partnership continue to thrive under his leadership.

4.6. Group Director of Corporate Governance

I'm pleased to share that following a competitive process, Lavinia Rowsell has been appointed as Director of Corporate Governance for the Bristol NHS Group. Lavinia has over a decade of experience overseeing governance processes at a senior level across the healthcare and non-profit sector, most recently as Director of Corporate Governance at Gloucestershire Health and Care NHS FT. This appointment is another important step in building our leadership team as we continue to work towards our vision of sustainable, high-quality care that best serves our Patients, our People, our Population, and the Public Purse.

4.7. UHBW Professor Jonathan Benger appointed CEO of NICE

I am delighted to advise that Professor Jonathan Benger CBE, Senior Consultant in Adult Emergency Medicine at UHBW, has been appointed Chief Executive Officer of the National Institute for Health and Care Excellence (NICE). Professor Benger has made an exceptional contribution both nationally (most recently as NICE's Chief Medical Officer, Interim Director of the Centre for Guidelines and Deputy Chief Executive) and locally through more than 23 years of clinical service at the BRI. His continued clinical practice ensures that the guidance NICE produces remain grounded in real-world NHS experience.

This is an outstanding achievement, and I ask the Board to join me in congratulating Professor Benger on his well-deserved appointment. We are extremely fortunate to continue benefiting from his expertise as he takes on this influential national leadership role.

4.8. New Years Honours

A number of former colleagues were honoured in the King's New Year's Honours List:

- Former NBT Consultant Anaesthetist, Dr Fiona Donald, was awarded an OBE for her services to anaesthesia, intensive care and pain management. Dr Donald retired last year, having worked at Southmead since 1997.

- Also receiving an OBE in the King's New Year Honours was former NBT Midwife and Director of Midwifery, Ann Remmers, who now works as Maternity and Neonatal Clinical Lead at Health Innovation West of England. Ann, who began her midwifery career at Southmead Hospital, was honoured for services to maternal and neonatal care.
- Former Head of Learning and Development at NBT, Jane Hadfield, was made a Member of the Order of the British Empire (MBE) in the New Year Honours for services to education. Jane, who started her career as a nurse at UHBW where she started her work in training and development before moving to NBT, is now the national NHS lead for Talent for Care, which is developing accessible employment, education and training.

I'm sure the Board will all join me in sending congratulations to these very worthy recipients.

4.9. Pathology and Occupational Therapy Week

In early November we celebrated both National Pathology Week and Occupational Therapy Week. We should take a moment to recognise the incredible work that our teams do in these vital areas, supporting patient care through diagnostics, testing, rehabilitation and recovery. Without these colleagues and the expertise, dedication and compassion they bring, our hospitals would not be able to function as effectively as they do.

4.10. UHBW Workplace Wellbeing Team

The UHBW Workplace Wellbeing Team has achieved a North Somerset Health Workplaces Gold Award, recognising the organisation's comprehensive and inclusive wellbeing programme, designed to support all colleagues across the organisation. It reflects the incredible work happening across our teams to create a culture where people feel supported, valued and empowered to thrive.

4.11. Innovation Spotlight – Dermoscopea Recognition

The internationally recognised Dermoscopea project, which was founded and led from NBT Dermatology and now active in more than 60 countries, was recently celebrated at the OpenUK Awards in the House of Lords. The team were finalists for the Open Hardware Award for developing the world's first open-source, self-assembly 3D-printable dermatoscope, and were awarded the runner-up prize.

This achievement reflects the creativity, commitment and altruism of the predominantly resident doctors, medical students, and engineering students who contributed to the project, and exemplifies the impact that a supportive environment for innovation can have. It is a powerful reminder of the importance of continuing to nurture and champion innovation across both our Trusts.

4.12. Tessa Jowell Centre of Excellence for Children

UHBW has been named as a Tessa Jowell Centre of Excellence for Children, highlighting the strength of its services for children with a brain tumour. We were one of four UK paediatric neuro-oncology centres to be awarded the designation in December by the Tessa Jowell Brain Cancer Mission (TJBCM).

UHBW was designated as a Tessa Jowell Centre of Excellence after working for the past 18 months to implement innovative new solutions. The centre's neuro-oncology team showed an exceptional commitment to service development, bringing together a wide number of specialties to deliver impactful changes. The designation follows a rigorous review process which examined multiple areas of the patient pathway in detail, together with patient feedback collected by The Brain Tumour Charity. Thank you to all colleagues involved in securing this prestigious designation.

4.13. Our Community Partnership with Bristol Rovers

The Boards will recognise that working with community partners is an essential part of our role as an anchor organisation. We have recently joined forces with Bristol Rovers Football Club to build a healthier, more connected community and have now launched this partnership. Through working together, members of Bristol Rovers Community Trust and the football club will receive free health checks from the Health Checks team at NBT to provide valuable wellbeing insights.

Initiatives like these recognise that improving healthcare for our population doesn't always have to happen inside the four walls of a hospital and can be much more accessible within familiar community settings like local sports environments. Together, we are committed to creating a healthier, more connected community for Bristol and beyond.

5. Engagement and Visits

5.1. Service Visits

Since our last Group Board meeting, I have visited a number of areas, and met with senior clinical staff across the Trusts including:

- Emergency Departments at Southmead, the BRI, and Weston General Hospital
- Colleagues from the UHBW Hepatology Specialty
- Colleagues from the Bristol and Weston Hospital Charity
- Colleagues from UHBW Paediatric Critical Care

Recommendation

The Boards are asked to note the report.

Maria Kane
Group Chief Executive

Report To:	Group Board		
Date of Meeting:	13th January 2026		
Report Title:	Group Benefits Realisation Report and Joint Clinical Strategy Update		
Report Author:	Rob Gittins, Group PMO and Merger Programme Director Catherine Rowe, Head of Programmes, Group and Merger Valerie Clarke, Programme Director, Clinical Services Transformation		
Report Sponsor:	Paula Clarke, Group Formation Officer Tim Whittlestone, Chief Medical and Innovation Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The purpose of this report is to provide an update to the Board on the progress made on the financial and non-financial benefits realisation plan for each of the Group delivery workstreams, with a focus on Joint Clinical Strategy benefits delivery and status update.		

Key Points to Note

- The ambitions set out at the creation of the Bristol NHS Group are exciting and stretching, with a relentless focus on delivery of benefits across our 4 P's - our patients, our people, the populations we serve and the public purse. Holding ourselves to account for delivery of these benefits is essential.
- In September 2025, the first quarterly Group benefits delivery report was considered by the Board, outlining developing plans across each of the workstreams and proposing the approach to benefits realisation. It was noted that there was variation in the degree of maturity across the workstreams in confirming key metrics, establishing baseline positions, agreeing ambitions and setting trajectories for delivery.
- Each workstream has now developed their Benefits profiles, 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 4 Ps.
- Key metrics, ambitions, baseline positions and trajectories for delivery have now been set for the majority of benefits.
- A number of benefits are dependent upon the delivery of key business changes, some of which are related to business case decisions.
- A benefits realisation plan is now in place, with planned quarterly cycle of benefits review by Board committees to provide assurance alongside the full report into the Group Board. This is based upon the approach already adopted by the IQPR and Patient First reports.
- The PMO provides targeted benefits realisation deep dive meetings with benefit owners based on a risk stratification approach. Tracking of financial costs and benefits delivery is financially led and the projected 2025/26 outturn delivery position included in this report.

- To bring reporting in line with quarterly and annual data cycle, it is proposed that the next Group benefits report to Board will be in May 2026, reporting on year-end data. This will integrate the proposed merger benefits, together with an aggregated dashboard of Group benefits.
- It is also proposed that from April 2026, Group financial benefits realisation will be reported through the full financial report into Finance and Estates Committee and Board-in-common as this is integral with CIP delivery plans.
- Delivery of the Joint Clinical Strategy (JCS) remains at the heart of our Group transformation plans. An update on progress in the last quarter is included in the report;
    - Four Group Clinical Services are live (Cardiology, Safeguarding, Trauma & Orthopaedics and Pain Services) with a fifth (Liaison Psychiatry) due to go live in January 2026.
    - Each GCS has a dedicated Benefits Realisation Plan as the single leadership team model goes live.
    - Independent evaluation of the Group Clinical Services pathfinder, Cardiology by Health Innovation Network, West of England (HiN, WoE) is underway since September 2025.
    - A successful second partnership event took place on 4th November 2025, with almost 200 attendees from across our health and care system. This is informing development of a JCS supplement strengthening how our clinical teams can respond to our system priorities and the direction set out in the NHS 10 Year Plan.
    - A follow up event with partners and the GCS speciality triumvirates will be scheduled for early March to strengthen delivery plans.
    - A roll-out plan for the remaining 30 duplicated services, all of which will have made significant progress towards becoming Group Clinical Services by March 2027.
    - The Community Participation Group has held its third meeting and will focus on co-designing the Patient, Public Involvement framework to be used by each GCS.

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 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 Public Board is asked to: **Note:** • Progress to date with establishing the Group benefit plan, including the early wins and forecast outturn for financial benefits delivery. • The intention to develop an aggregated dashboard for benefits delivery reporting • Progress on clinical and corporate services transformation implementation and next steps	
History of the paper	
Group Executive Meeting	7/1/26
Appendices:	Appendix 1: Group Benefits Tracker

Group Benefits Realisation Report December 2025

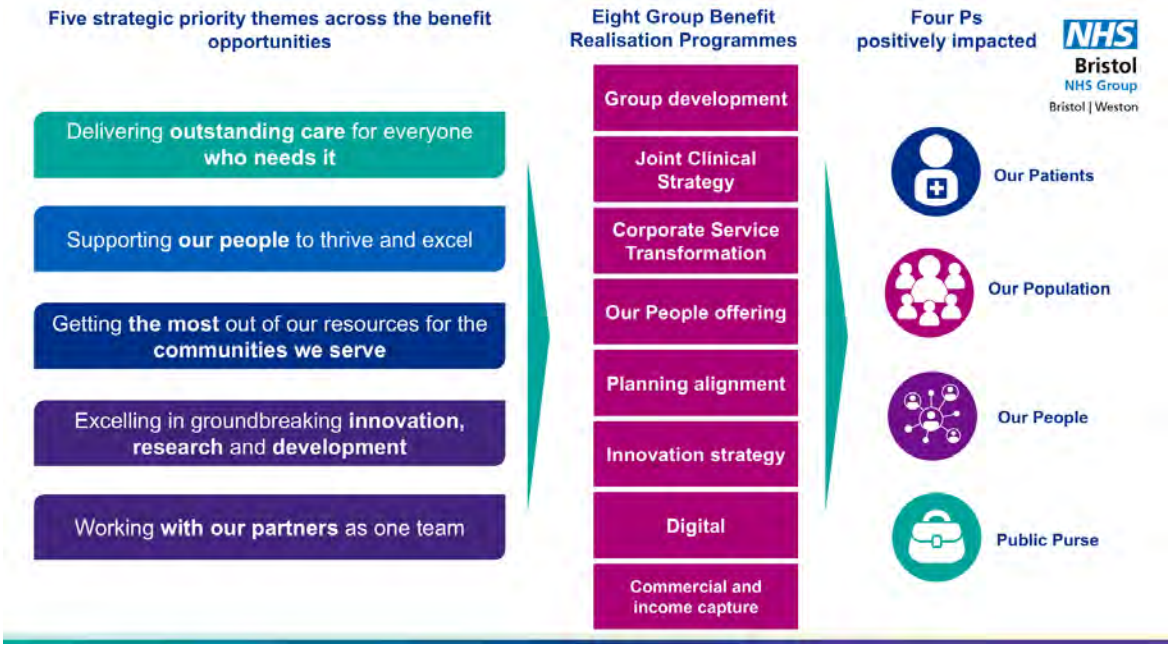
1. Purpose

1.1 The purpose of this report is to provide an update to the Board on the progress made on the benefits realisation plan for each of the Group workstreams, and to provide a detailed update on the delivery of benefits for the Joint Clinical Strategy.

2 Background

2.1 The Group Benefits Case, approved by the Group Board on 8th April 2025, captures the benefits across five benefit 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: Group Benefits Mapping



Each of the eight workstreams are led by an Executive SRO with delivery co-ordinated and overseen by the Group PMO, led by the Group Formation Officer.

2.2 In September 2025, the first quarterly Group benefits delivery report was considered by the Board, outlining developing plans across each of the workstreams proposing the approach to benefits realisation. It was noted that there was variation in the degree of maturity across the workstreams in confirming key metrics, establishing baseline positions, agreeing ambitions and setting trajectories for delivery.

3 Approach to Benefits Delivery

3.1 A benefits plan has been developed by the PMO team that provides the common framework to benefits management.

3.2 Each workstream has developed their benefit profiles based on the agreed Group Delivery Plans. All workstreams have identified non-financial quantitative and qualitative benefits as well as financial and productivity benefits against the five benefit strands. Since September, focus has been on confirming the key metrics, baselines, ambitions, trajectories and target dates for delivery.

3.3 To date, there have been no formal changes to agreed benefits. Where changes are proposed, a change control process will be followed. This is currently being used to test proposals from R&D, People and Estates to adjust either the target or the profile.

3.4 To ensure that benefits realisation monitoring is robust, the PMO team are working closely with our strategic partner to upskill workstream leads, for example through delivery of benefits masterclasses.

3.5 It is intended that the May 2026 Board report will begin to aggregate the benefits dashboard, with more detailed oversight being undertaken through Board Committees. The proposed aggregated dashboard will be developed to align with the Patient First approach across the Group and the IQPR. The alignment of the eight benefits realisation programmes with Committees is shown in table one.

Table 1: Board Committee – workstream oversight

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

3.6 As an example of this approach, the People Committee received a report on the Our People Offering workstream in November 2025, covering each of the 8 sub workstreams and progress against the project charters as well as an update on the Corporate Services Transformation programme.

3.7 Whilst this report is focussing on delivery of Group benefits, the PMO team will be using the same approach for merger benefits monitoring and delivery, as they either extend or are additional to the agreed Group benefits. Merger benefits will form part of the full business case for merger.

3.8 Reporting Schedule - Table 2 outlines the key dates and proposed frequency of the reporting cycle.

Table 2: Reporting Cycle

Activity	Frequency
Group workstream huddle – benefit spotlight sessions	Fortnightly
Benefit owner support deep dive sessions	Monthly
GEM review of benefit plans	Quarterly
Committee review of benefit plans	Quarterly
Group Board Benefits realisation report	Quarterly

4 Non-Financial benefits

4.1 Performance against the benefits plan will come to the May 2026 Group Board. Table 3 outlines the non-financial benefit measures.

Table 3: Non financial Group Benefit Measures

Workstream	Benefit Strand	Key Benefit type	Performance Measures
Our People Programme	Supporting our People to thrive and excel	• Improved OD and colleague experience • Recruitment function expansion improving recruitment and retention • Improvements in Learning & Workforce • People deployment framework in place • Improved medical workforce planning & productivity	Surveys (Pulse, GMC and national staff survey) Recruitment costs Training compliance rates
	Working with our Partners as one team	• Streamlining temporary services and improving experience • Use of automation	Audits and surveys Time taken for recruitment checks Level of digitisation Exception reporting for automation
Digital	Delivering outstanding care to everyone who needs it	• Increased system operability • Increased data access and visibility for clinical services cross site	Proportion of systems interoperable or joint Number of BI solutions available

Workstream	Benefit Strand	Key Benefit type	Performance Measures
	Supporting our people to thrive and excel	• Increased digital maturity • Improved workforce digital capabilities	Achievement of HIMSS EMRAM/INFRAM digital maturity standard framework Training rates
	Working with our partners as one team	• Increased income from digital services offers to partners	Value of net income Customer satisfaction measures
Innovation	Excelling in groundbreaking innovation & R&D	• Creation of innovation hub and strategy • Innovation embedded in clinical practice • Funding secured for innovation • Increased international health opportunities	Launch of hub and strategy No of Patented ideas and real-world evaluations Staff survey responses Increase in net income from international health initiatives
R&D	Supporting our People to thrive and excel	• Develop consistent processes for recognising and including R&D within job planning processes for all professions	Set up of task & finish group Development of policies
	Getting the most out of the populations we serve	• Planning R&D to ensure there is sufficient clinical capacity/support services to deliver	Number of clinical trials
Corporate Service Transformation	Supporting our People to thrive and excel	• Increased satisfaction for staff working in corporate functions • Function-specific impact metrics	Staff survey Productivity measures/use of digital tools

4.2 Early progress with the realisation of group benefits can be found in the early win's section 7 below.

4.3 Progress with realisation of Group Clinical Services and Group financial benefits are found in sections 5. and 6. of this paper.

4.4 Appendix 1 shows the fully populated Benefits Realisation Report.

5. Group Clinical Services Benefits Overview

5.1 Phase One of the Joint Clinical Strategy aims to address variation in access, experience and outcomes for all duplicated services by developing Group Clinical

Services (GCS). A roadmap exists that sets out how all 40 duplicated services will make significant progress to becoming a GCS by March 2027. Table 4 summarises the three key milestones and how benefits management will happen at each stage.

Table 4: Clinical Services – Key Milestones and associated benefits management

Milestones	Benefits Management
M1: A Leadership Forum is in place to oversee delivery with an agreed benefits realisation plan	Measures agreed and baseline positions are understood across all sites.
M2: A single leadership team has been appointed	Improvement trajectories set.
M3: GCS minimum standards have been achieved	Evidence of sustained improvements delivery.

5.2 Quantitative Benefits (Clinical)

5.2.1 Table 5 outlines the quantitative benefit measures for the GCSs that have a single leadership team in place (Cardiology, Trauma & Orthopaedics, Pain Services and Liaison Psychiatry). The measures have been agreed; baseline positions are understood and the related standard are described. Trajectories for improvement will be set, noting that there is no additional funding available. Any improvements across services will be realised by reprioritising existing resource allocation and/or aligning best practice.

5.2.2 In addition, as part of the further development of the Joint Clinical Strategy, the intention is that each GCS will have its Prevention and Health Equity Plan, demonstrating that healthcare outcomes are addressed for key population groups. Related metrics will be developed for the agreed prevention and health equity priorities.

5.3 Qualitative Benefits (Clinical)

5.3.1 Building collaborative relationships across organisational boundaries and ensuring effective communications and engagement is an integral part of the GCS programme. To support this, dedicated communications and organisational development resources are in place to supporting the individual GCS teams. Pulse Survey results will be used to monitor team cultural changes, especially the shifts from baseline, mid-change and post change. There will be a cultural dashboard (as part of merger planning) measuring KPIs such as turnover, absence level etc. that will include access for individual GCSs. In addition, stories of integration, lessons learned, thematic analysis, engagement surveys, leadership reflections and case studies of observed behaviour shifts will be captured.

5.3.2 Evidence of continuous engagement and involvement of communities and patients is also key. Dedicated Patient and Public Involvement (PPI) support is in place, and the Community Participation Group will co-produce the PPI framework that will underpin all GCS design. This will include impact measures.

Table 5: Clinical Services – Performance Measures and Standards

Performance Measures	Standard
Improving Access	
Cardiology: Rapid Access Chest Pain Clinic	100% of patients seen within 2 weeks
Cardiology: Elective PCI	100% treated within 3 months
Cardiology: Echocardiography (DM01)	< 1% patients waiting over 6 weeks
T&O: Hand and Wrist pathway: New OP Seen	% within 6 Weeks
T&O: Foot and Ankle pathway: New OP Seen	% within 6 Weeks
T&O: Access to Fracture Clinic	British Orthopaedic Standards: 100% of patients seen within 72hrs of presentation with injury includes referrals from ED, minor injury units, and general practice
Pain Service (consultant led) RTT	92% seen and treated within 18 weeks
Improving Experience	
Cardiology: 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
Pain Management Programme: % of patients on PMP with direct access (i.e. no consultant appt first)	There is no national standard
T&O: Reduced LOS (Total Hip and Knee Replacements-Electives)	GIRFT guidelines 0-1 day
Improving Outcomes	
Cardiac Rehab - Increase in the number of face2face locations offered to patients	100% of patients offered at least 3 locations
Cath Lab access: Number of PCI patients to lab within 72hours	100% of non-STEMI patients requiring a PCI, are treated within 72-hours
T&O: Time to theatre for NAFF (Non Ambulatory Fragility Fracture)	100% of patients get to theatre by the day following presentation with fracture (GIRFT)
Workforce Resilience	
Number of Joint Appointments	tbc

Performance Measures	Standard
Number of staff working cross-site	tbc
Liaison Psychiatry: Number of RMN/HCA shifts taking place through the Collaborative Bank	tbc
More financially sustainable	
NBT Cardiac Physiology Team - eliminate reliance on agency workforce by employing substantive staff	0wte/£0 spend on agency
NBT Pain Service - Repatriation of Southmead activity from IS (reprovided at SBCH)	0 patients/£0
T&O: Number of joints per list	4 per list
Liaison Psychiatry: Reduction in RMN Agency spend	tbc

5.4. Independent Evaluation (Clinical)

5.4.1. Alongside the internal Benefits Realisation Plans, the Group Boards initiated an independent evaluation of our JCS pathfinder project within the Group Cardiac Service. This evaluation is being conducted by the Health Innovation Network (HiN) West of England (WoE) and began on 1st September 2025.The evaluation has been intentionally designed to focus on a single specialty-cardiac services-to allow for detailed data analysis and precise conclusions. This targeted methodology is intended for future application across other Group Clinical Services (GCSs), promoting consistency and transferability of evaluation methods throughout the organisation. The primary aim of the evaluation is to assess the impact on both patients and staff, addressing two of the Four P's underpinning our strategic goals. By concentrating on these areas within cardiac services, the findings and methodologies will be adapted for use in other specialties, supporting broader benefits realisation throughout the Group.

5.4.2. Four priority pathways have been agreed for evaluation of impact 1) Cardiac Rehabilitation, 2) Cross-site working/Joint Appointment/Workforce Resilience, 3) Rapid Access Chest Pain Clinic and 4) Elective PCI/ Non-elective PCI pathway. The evaluation of the first two have been mobilised with an update planned to the second Evaluation Board meeting in February 2026.

6. Financial Benefits Update

6.1 Introduction and Context

6.1.1 The development of Bristol NHS Group remains 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. In addition, the proposed merger of the Trusts will bring additional incremental financial benefits that will be detailed in the Merger Business Case.

6.1.2 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.

6.1.3 In September 2025, the Benefits realisation report to the Board-in-common set out a revised position on financial benefits profiling based on matching transitional investment of £3.6m in 2025/26 to associated benefits release. This was driven by the scale of the challenge within the overall financial and operational plans of the two organisations, the scale of CIP committed to in the overall business plans at 5% and the need to ensure that there is zero double count between the benefits attributed to the Group and those set out in divisional and departmental plans.

6.1.4 This section of the January 2026 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 as part of composite financial reporting across CIP, Group and merger benefits opportunities and delivery (merger benefits remain subject to Business Case and wider approvals).

6.2 **2025/26 Expenditure and Benefits**

6.2.1 Expenditure/Investments

The forecast investment in 2025/26 into transitional funding to lever the transformational benefit release of the Group, remains on track. The forecast outturn is projected at £3.5m of which it is estimated that £1.9m is pay and £1.6m non-pay. Over £2.1m of this investment is into the essential clinical and corporate service transformative foundations necessary for future return on investment to be achieved

6.2.2 *2025/26 Benefits*

As previously described, as 2025/26 has progressed the intent has been to match the forecast transitional costs above, with financial benefit realisation, thereby avoiding any net cost impact on the Group in-year.

Table 6, below, sets out the 2025/26 benefits plan to deliver £3.6m (as reported to the Board in September) alongside the latest forecast of expected delivery against that plan. While this currently indicates a shortfall of £1.2m, good progress has been made to create the right conditions to recover planned savings in 2026/27. A brief summary of the progress being made and constraints in-year are included below.

Table 6 - 2025/26 Revised Planned Benefits

Planned 2025/26 Benefits / Cost Saving Opportunities	2025/26 Revised Plan £'000	Group / Merger FoT £'000
Recurrent funding commitment from the two Trusts	700	807
Procurement savings across the organisations	800	550
Corporate Savings	300	354
Variable income capture	1,500	-
Private Patient income	300	-
Other		
Corporate group roles not backfilled		676
Total benefits / cost savings	**3,600**	**2,387**

- Recurrent funding commitment: £807k has been recurringly allocated from reserves. This is slightly higher than the original financial plan for 2025/26, that included an allocation of £700k.
- Procurement savings: The target for Group procurement savings was originally set at £1.8m. This is in addition to the £4.0m x 2 = £8.0m 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, given the risks of achieving that level of savings in year, the target for the group element was scaled back to £800k back in September.

  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. 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. These coordinated procurement activities are central to achieving group-wide savings and embedding a more strategic, value-focused approach to non-pay expenditure. The current forecast procurement delivery for the year is £7.2m, which is £1.6m behind the combined Trust and Group target of

£8.8m. Within this figure, stand-alone Group related activities have delivered c£0.6m of the savings.

- Corporate savings: the target of £300k relates to the net benefit of creating the Joint Trust Board and implementing site leadership teams. Our current assessment of the in-year benefit for this is £0.35m with a recurring benefit in excess of £1.0m.
- Variable Income Capture and clinical activity coding: Well-established income capture processes are in place across both Trusts. Joint meetings between UHBW and NBT teams have been established to provide a forum to share best practice and mutual learning and work on alignment of processes for classification of clinical activity has begun with the intention to move to a single group wide forum over coming months. 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. Given the scale and focus on delivery of 5% CIP plans in-year, no additional benefits are yet attributable solely to the Group in this financial year.
- Private Patients: This workstream is now formally recognised under the Group Commercial Board. Significant work is underway in this area and a private patient 12-month programme has been drafted. This includes stretch income targets up to £10m over the next 5 years, proposed governance structures across finance, operations, governance and marketing, as well as identifying immediate priorities around insurance accreditation, pricing, resourcing, market research. However, due to challenges regarding commercial competition regulations, no additional benefits attributable to the Group have been realised from this work in this financial year.
- Commercial Income: – Other: Several other workstreams have been identified and are in development, reporting into the Group Commercial Board. These include Group International Health Programme, Marketing, Data Sharing, Training and Development. Subject to Trust approvals, the International Programme is close to securing the first major business case approval. The total benefits of which are c£450k but with the benefits to be realised in 2026/27.
- Corporate roles not backfilled: A number of appointments have been made to new Group roles on a transitional basis, with the resulting vacancies in Trust positions held and not backfilled. In these cases, the funding associated with the vacant posts has been redirected to support the Group's TIR rather than being applied to Trust-level CIP delivery. This represents a predominantly non-recurrent source of funding.

  Going forward, the Corporate Services Transformation programme will determine the recurrent savings to be achieved through functional changes

and restructuring, targeting savings at 5% in 2026/27, increasing to 12% in 2027/28.

6.3 Looking Forward to 2026/27

6.3.1 As described above, in 2025/26 it has been necessary to manage the net revenue impact of the group costs and benefits, given the overall challenge in delivering financial balance. As set out in the Group Benefits Case, 2026/27 is the first year when a net financial benefit is expected, assessed at £ 8.1m. Furthermore, by including the benefits of merger (over and above what we can achieve through grouping), the Full Business Case will include additional schemes that will support a material level of over-achievement, when compared with the original Group Case.

6.3.2 The expectation of a minimum 5% CIP delivery in 2026/27 plus the opportunities for accelerated and additional financial gains to be achieved through a merger, are currently being assessed as part of the NHSE requirement for a 5 year Medium Term Plan. The latter will be reviewed by the Finance and Estates Committee in January 2026 and discussed at Board on 10th February 2026, prior to national submission by 12th February 2026.

7 Early wins

7.1 Since the Bristol NHS Group was launched in April 2025, a number of positive benefits are evident beyond clinical services across Digital, Innovation, and People. An overview of some of these is provided below.

7.1.1 **Digital** - An important early milestone in the digital integration has been delivered by connecting both organisations' Teams and Email environments. This unlocks shared calendars, document collaboration, and improved directory visibility which should deliver productivity gains now whilst we progress toward moving everyone to a single solution on the national platform, including a single nhs.net address across the Group.

Also delivered are some 'behind the scenes work' driven by Digital forming a single group service such as:

- Standardisation of endpoint protection by moving UHBW from Trend to the national Microsoft Defender for Endpoint platform, in alignment with NBT. This delivered immediate cost savings, simplifies management and strengthens our overall security posture across both organisations.
- Strengthening the shared security posture by deploying Qualys vulnerability scanning into UHBW, bringing it in line with NBT. This provides us with consistent visibility of risks across both estates and will enable digital to deliver a unified approach to remediation in the future.

- Convergence of the Microsoft licence purchasing for UHBW and NBT into a single provision, avoiding significant cost increases while retaining the functionality required for operational needs and preparing us for movement to the national platform.

7.1.2 Innovation - International opportunities - Progress is in an advanced stage to establish an International Clinical Fellowship Programme with a one- or two-year placements. This supports income generation and enhancing our international reputation. These placements are additional to our funded establishment (with no cost to the Trusts'), ensuring we can continue to offer as many roles as possible for local doctors and secure additional capacity to enhance patient services.

7.1.3 People - Joint Resourcing Function - The creation of a joint resourcing function has led to significant improvements in recruitment efficiency and candidate experience across the Group:

- Recruitment processes and documents aligned and automated leading to a 40% reduction in candidate queries.
- Auto-online interviews with Trac integration and live updates for hiring managers and candidates resulting in an improved candidate experience and time saved for hiring managers
- 90% of ID checks now completed online – time taken for ID checks reduced from an average of 10 days to 4 days.
- Contracts are now automatically populates digitally reducing the time taken from 17 days to 13 days on average.
- Aligned offer processes with medical recruitment integrated into the joint function had reduced time for medical offers from 48 days to 24 days.

8. Corporate services transformation programme

8.1 Plans to integrate corporate services through our Corporate Services Transformation programme are a core part of Group benefits delivery. The Group Benefits Case confirmed that getting the most out of our resources for the communities we serve would be one of our five strategic priorities, and transforming and modernising the delivery of corporate functions across the Group is a mainstay of achieving this objective. This will ensure consistency of experience and support for all teams working across our three campuses – Bristol City, Southmead, Weston. Integrated corporate services also allow for increased efficiency, shared expertise and exciting career pathways, enable greater innovation and digitisation and create scale that supports provision of efficient corporate services to partner bodies.

8.2 The corporate programme is making strong progress in designing new Group structures that will enable the delivery of the Group financial benefits plan [12% financial savings by March 2028].

8.3 Currently, the programme is out to staff consultation on wave one service designs and preparing for waves two and three. All plans are on track.

9. Joint Clinical Strategy Update

9.1. Existing Group Clinical Services (GCS) Programme

- Ten of the forty duplicated services are active in the programme, and four single leadership teams will be in place by the end of December 2025 (Cardiology, Safeguarding, Trauma & Orthopaedics and Pain Services) with Liaison Psychiatry now planned for January 2026, as the HR consultation has been extended to allow for further consideration due to significant feedback.
- The adult therapies workstream, represents four duplicated services (Physiotherapy, Occupational Therapy, Speech &Language Therapy, and Nutrition & Dietetics). The programme is on track to have completed the detailed diagnostic in Q4, understanding the therapy models delivered by Diagnostics &Therapies division, Core Clinical Services division and non-Core Clinical Service divisions with a proposed future Group model designed by end of Q4.
- The remaining active GCS is Haematology. This work has impacted by the teams' involvement in leading the Clinical Genetics transformative work for the South-West region, including a current consultation process.
- Discussions have commenced with Dermatology and Clinical Psychology and the workstreams will start in Quarter 4.

9.2. Group Clinical Services Roadmap

- The Joint Clinical Strategy Board has approved the roadmap and roll-out timescales for implementing GCSs across the remaining 30 duplicated services. An expectation has been set that all GCSs need to make 'significant progress' by the end of March 2027. This will depend on the starting position, in terms of current collaborations underway and the scale and level of complexity of each individual service.

- The three milestones that constitute ‘significant progress’ are:
    - Milestone 1: A Leadership Forum is in place to oversee delivery with an agreed benefits realisation plan.
    - Milestone 2: A single leadership team has been appointed.
    - Milestone 3: Group Clinical Service minimum standards have been achieved (Maturity Framework).

9.3. Joint Clinical Strategy Update 2026

- A Joint Clinical Strategy Update 2026 will be published in the coming weeks, providing a bridge between the JCS (2024-27) and the future single Clinical Strategy that will be developed in the coming year. It aims to set out how we will ***refresh*** our JCS, ***reframe*** the ambitions given what we have learnt so far and ***reimagine*** healthcare for Bristol and Weston based on NHS 10 Year Plan. It will support clinical teams, working alongside partners and the community, to further develop their services aligned to the three radical shifts in the NHS 10 Year Plan, focussing on population health outcomes.
- This document was developed in consideration of the feedback received at our JCS Strategic Partnership Event on 4th November. Further engagement activities with our Community Participation Group and other partners will be undertaken during January prior to publication of the final document.

9.4. Clinical Capacity and Productivity Diagnostic

- As part of the Group Delivery Plan, it was agreed that a detailed diagnostic of current clinical capacity and productivity across both Trusts would be undertaken to develop a clear view of how our combined resources could be used to deliver care more effectively as a Group. This will include a 5-year demand forecast for our clinical services that reflect demographic and non-demographic growth assumptions and is a build of the clinical feasibility study work undertaken in 2023-24 to inform the Joint Clinical Strategy development.
- Several workshops have been held to ensure optimal use of existing internal data and insights data alongside exploration of how the application of data science and AI could support this work. This work is being led through subgroup to the JCS Board.

9.5. Community Participation Group

- The Community Participation Group has held three meetings and has started to lay some strong foundations in building trusted relationships, co-designing a group agreement, and clarifying its assurance and advisory role to the Joint Clinical Strategy.
- The next phase focuses on the role of the CPG members, new shared leadership via a community co-Chair and coproduction, beginning with a Patient and Public

Involvement (PPI) tiering framework for the Group Clinical Services (GCS) Programme.

9.6. Follow-up Partnership Event

- Building on the successful Strategic Partnership Event in November, a follow-up event is planned for Quarter 1 that will develop the delivery plans to support the GCS roll-out and the ambitions set out in the JCS Supplement.

10. Recommendations

Group Board is asked to:

Note:

- Progress to date with establishing the Group benefit plan, including the early wins and forecast outturn for financial benefits delivery.
- The intention to develop an aggregated dashboard for benefits delivery reporting
- Progress on clinical and corporate services transformation implementation and next steps

Appendix 1: Group Benefits Tracker

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
Digital	Patient, People	Delivering outstanding care to everyone who needs it	Increased clinical system interoperability and / or harmonisation	Proportion of core clinical systems which are interoperable or joint	2% of core clinical systems interoperable or harmonised across the Group	80%+ of core clinical systems interoperable or harmonised across the Group
Digital	Patient, people	Delivering outstanding care to everyone who needs it	Increased corporate system interoperability and / or harmonisation	Proportion of core corporate systems which are interoperable or joint. *Core corporate systems defined as Finance, HR, ESR interfaces, Payroll, Procurement, Rostering, PAS admin modules, Identity & Access management, and core reporting platforms.*	25-30% of core corporate systems interoperable or harmonised (reflecting partial alignment of ESR, finance reporting extracts ad identity services, but separate core platforms remain)	75%+ of core corporate systems interoperable or harmonised
Digital	People, Population	Delivering outstanding care to everyone who needs it	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-specialty Business Intelligence solutions developed Achieve HIMSS AMAM maturity standard framework	c.30 Executive/Operational service managers (SMs) with access to a single BI application across Trusts 0 cross specialty BI solutions using large data sets No baseline HIMSS AMAM (NBT or UHBW)	100% of Service managers have access to a single BI interface across Trusts Delivery of Inpatient, Outpatient and Urgent care data sets, and related Operational reporting, accessible via single BI interface HIMMS AMAM Stage 5/6/7 [to be profiled]
Digital	Patient, Population	Supporting our people to thrive and excel	Increased digital maturity	Achieve HIMSS EMRAM/INFRAM digital maturity standard framework	INFRAM Stage 5 (NBT) and stage 4 (UHBW) across both organisations	Achieve IMRAM stage 6/7 for the single organisation Achieve HIMSS EMRAM stage 6/7 for the single organisation

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
Digital	People	Supporting our people to thrive and excel	Improved workforce digital capabilities	Completion rate of Group-mandated digital, EPR/EPMA, data and cyber capability training	55-60% completion rate across workforce groups *(variation by staff group and Trust; higher in mandatory IG/cyber, lower in role-based digital capability and EPR optimisation)*	90%+ completion rate for digital capability training across workforce groups
Digital	Public Purse	Working with our partners as one team	Increased income from Digital services offer to partners	Value of (net) income from digital services Customer satisfaction measures - which includes post-incident/post-request satisfaction surveys, First Contact Resolution (FCR) rate, average response and resolution times against SLA, volume of repeat incidents for the same issue	80K per annum in net income from digital services (NBT) TBC£ per annum in net income from digital services (UHBW) CSAT ,80% across the Group, with variable performance between Trusts	Achieve £1.8m per annum in net income from digital services ≥90% IT Service Desk customer satisfaction with consistent SLA performance across the Group
People - OD & Colleague Experience	People	Supporting our people to thrive and excel	Improvement in staff satisfaction & experience	NHS Staff Survey/People Promise Results	NBT - 59.4 / 100 & UHBW 59.07/100	No decline in staff survey engagement scores by Mar 26
People - Group People Strategy	People	Supporting our people to thrive and excel	Improvement in staff survey response	NHS Staff Survey/People Promise Results	NBT - 59.4 / 100 & UHBW 59.07/100	To be in the top decile of the five People Promise themes in 2027/28 (results to be published in 2028)
People - Learning & Workforce Development	People	Supporting our people to thrive and excel	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	Consistent improvement on feedback responses received by Jul 26
People - Learning & Workforce Development	People	Supporting our people to thrive and excel	Increased training completion levels	Mandatory and leadership training compliance rates	Pending national review of leadership and management framework	100% compliance on a rolling basis by Dec 26
People - Learning & Workforce Development	People, population, patients	Supporting our people to thrive and excel	Increased cross-Trust recognition of learning	Proportion of training courses 'passported' between Trusts	Passporting of 11 core skills and Oliver McGowan across the Group model	All training courses in scope successfully passported by Feb 26
People - Recruitment	People, Population	Supporting our people to thrive and excel	Improvement to Recruiting Manager Experience	Pulse Surveys bi-monthly rating experience 1-10	average 7 score	8 scoring or above by Dec 26

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
function expansion						
People - Recruitment function expansion	People, Population	Supporting our people to thrive and excel	Improvement to candidate experience	Pulse Surveys bi-monthly rating experience 1-10	average 7 score	8 scoring or above by Dec 26
People - Recruitment function expansion	People, Population	Supporting our people to thrive and excel	Improvement to Colleague experience in Recruitment Team	NHS Staff Survey/People Promise Results - specifically focused on staff engagement	NBT - 7.10 / 100 & UHBW 7.08 /100	To have increased staff engagement scores in line with national staff survey staff engagement to 8 by March 27
People - Recruitment function expansion	Public Purse	Supporting our people to thrive and excel	Increase of cost saving through internal head hunting	Total cost of annual recruitment agency spend which is expected to reduce as direct sourcing volumes increase	Estimated spend March 24 - March 25 totalling £350,000	To have achieved a £50,000 saving in recruitment agency costs by March 2027
People - People Deployment Framework	People, Patients	Supporting our people to thrive and excel	Flexibility and freedom of movement in people working across sites	All colleagues in group roles experience no barriers to receiving and completing all deployment documentation that exist within the framework	All colleagues hired into group roles unable to deploy skills professionally and legally due to absence of framework	Colleagues in group roles are able to deploy their skills across both organisations in a professional and legal way by Jun 26
People - People Deployment Framework	People	Supporting our people to thrive and excel	Improved culture and staff experience, engagement and positive employee relations	Reduction in disputes and HR cases in relation to change from roll out (September 25) to proposed merger	Nil employee relations cases or disputes in relation to Group Clinical Services and a proportion of People Services.	To maintain zero employee relations cases or disputes in relation to Group Clinical Services and a proportion of people Services teams by Jun 26
People - Strategic Medical Workforce Plan	People, Public purse	Supporting our people to thrive and excel	Reduction in long term high-cost agency and bank locum	Agency and bank locum costs	*Programme not planned to commence until 26/27, baseline to be scoped at that point*	*Programme not planned to commence until 26/27, ambition to be scoped at that point*
People - Strategic Medical Workforce Plan	People, patients	Supporting our people to thrive and excel	Improved quality feedback from our LED and resident doctors	GMC Survey results	*Programme not planned to commence until 26/27, baseline to be scoped at that point*	*Programme not planned to commence until 26/27, ambition to be scoped at that point*
People - Strategic Medical	People, patients	Supporting our people to thrive and excel	Reduction in Trust-wide medical workforce risk scores within each Trust	Reduction in the TLR scores	*Programme not planned to commence until 26/27, baseline to be scoped at that point*	*Programme not planned to commence until 26/27, ambition to be scoped at that point*

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
Workforce Plan						
People - Connect to work	Population	Getting the most out of our resources for the communities we serve	Increased recruitment numbers through socially deprived areas of the Group's geography	Improvement in disparity ratio	Disparity ration of 1.71	Reforecasting info to reflect the recent investment of WECA funding. To be completed by Jan 2026
People - People Services offerings to Partners	People, Public Purse	Working with our partners as one team	Resource release from high volume/high effort human activity to be replaced with a high functioning reliable automated process	Reduction in errors on exception reporting produced every 24 hours (each transaction cycle)	Error rate in pre-employment checks (PECs) 10%–25%	To consistently reach accuracy of 2% in all process completion carried out by automation by Dec 26
People - People Services offerings to Partners	People	Working with our partners as one team	Streamlined temporary services processes and function to be operationally ready for the potential supply and service to systems partners/3rd parties and generate revenue	Temporary services function is streamlined and commercially ready, evidenced by high scoring results on operational audit Call volumes reduced via increased utilisation of digital platforms to deliver staffing supply. Bank staff survey response rate increased.	Call stats 400 per day. Bank staff survey response rate 21.8%. No SLA or KPIs embedded / adhered to.	To deliver a consistently high-quality temporary staffing service, meeting all operational / service standards to the Group by Dec 26. 40% reduction in call volumes, Bank staff response rate increased to 30%. KPIs and SLA effectively embedded and consistently monitored
People - People Services offerings to Partners	People, patients, Public Purse	Working with our partners as one team	Medical & Dental appointed into roles more swiftly	Time to complete employment checks. Conditional Offer to employment checks complete	50 days using the same period	Time to complete employment checks reduced by 50% (50 days to 25 days) by May 25
People - People Services offerings to Partners	People, patients	Working with our partners as one team	100% digitise all paper-based new starter forms	All forms digitised and accessed via a portal Average time to complete ID Checks	Non digitised new starter paperwork, 10 day average to complete ID checks	Significantly improved candidate experience. Consistently meeting 4 days for ID checks to complete by May 25
People - People Services offerings to Partners	People	Working with our partners as one team	100% of ID checks carried out online as opposed to in-person	Pulse Surveys bi-monthly rating experience 1-10	Average 7 score	Significantly improved hiring manager/customer experience. 8 scoring in pulse surveys or above by December 26

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
Corporate Services Transformation	Population, Public purse	Getting the most out of our resources for the communities we serve	Realise the economies of scale in corporate services	Cost and WTEs in corporate functions	Contracts automatically filled from Trac files by Aug 24	12% financial savings/productivity target (5% 26/27 and 7% 27/28)
Innovation	Patient	Excelling in groundbreaking innovation and R&D	Creation of Innovation Hub and strategy 1. Innovation embedded in clinical practice 2. Funding secured for innovation	Finalising and launching our Innovation strategy Creation of Innovation hub Number of ideas that can be patented Number of real-world evaluations completed Staff survey 3f - staff able to make improvements	No innovation Strategy No innovation hub 0 new patents in 24/25 0 real-world evaluation completed 58.6% of staff reporting they are able to make improvements happen at agree/strongly agree level	Approve innovation strategy - aim for March 26 Establish Innovation hub by Q1 26/27 Patents portfolio to 5-10 per year by 29/30 2 real world evaluations per year by 29/30 Within 1 percentage point of the best acute Trust by 29/30
Innovation	Public purse	Excelling in groundbreaking innovation and R&D	Increased income from international health	Increase in net income from international health initiatives (education & training)	£0	£0.6-0.8m in 28/29
Planning Alignment	Public purse, population	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 2. To reduce critical infrastructure risk 3. Cost savings through rationalisation of the estate 4. Reduced environmental impact	1.Group Estates Strategy and Delivery Plan 2. Measure of space utilisation 3. Number of infrastructure related risks 4. Savings delivered through exiting of commercial real estate 4. Carbon emissions target	No Joint Estates Strategy Space Utilisation (UHBW and NBT tbc) X (NBT) and 12 UHBW) Infrastructure Risks on BAF X£ (NBT) and Y£ (UHBW) on commercial leases Carbon emission perf. (NBT and UHBW tbc)	To develop a joint Estates and Facilities Strategy Ambitions for space utilisation and infrastructure related risks and commercial expenditure to be agreed Carbon emission targets - insert
R&D	People, Population	Supporting our people to excel and thrive	Have a consistent process for formally recognising and including R&D within job planning processes for all professions	Set up of a Recognise and Reward research T&F Group to develop policy and procedures for all professions	No Group currently in existence to look at recognition of R&D within job planning processes No consistency across Trusts	Policy in place to ensure R&D is embedded within job planning processes for all professions across the group
R&D	Patient, Population	Getting the most out of our resources for the communities we serve	Development of a Group-Wide View to planning R&D to limit instances where clinical capacity and/or access to support services are a restricting factor	Number of patients recruited to trials /ability to do trials	No clinical trials suitable at the Clinical Research facility at NBT	Clinical trials to be done at the Clinical Research facility at NBT

Workstream	4 Ps	Benefit Strand	Description of benefit	Performance Measure	Baseline - March 25	What is the ambition?
R&D	AI 4 Ps	Excelling in groundbreaking innovation and R&D	Development of a joint R&D Strategy for Group	Existence of strategy	No strategy in place	To have a strategy in place March 27

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public	
Date of Meeting:	13/01/2026	
Report Title:	Integrated Quality and Performance Report (IQPR)	
Report Author:	David Markwick, Director of Performance 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

	UHBW PQSM

NHS
North Bristol
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Bristol and Weston
NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication January 2026
Data up to November 2025

NHS North Bristol NHS Trust

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NHS University Hospitals Bristol and Weston NHS Foundation Trust

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Key to KPI Variation and Assurance Icons

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

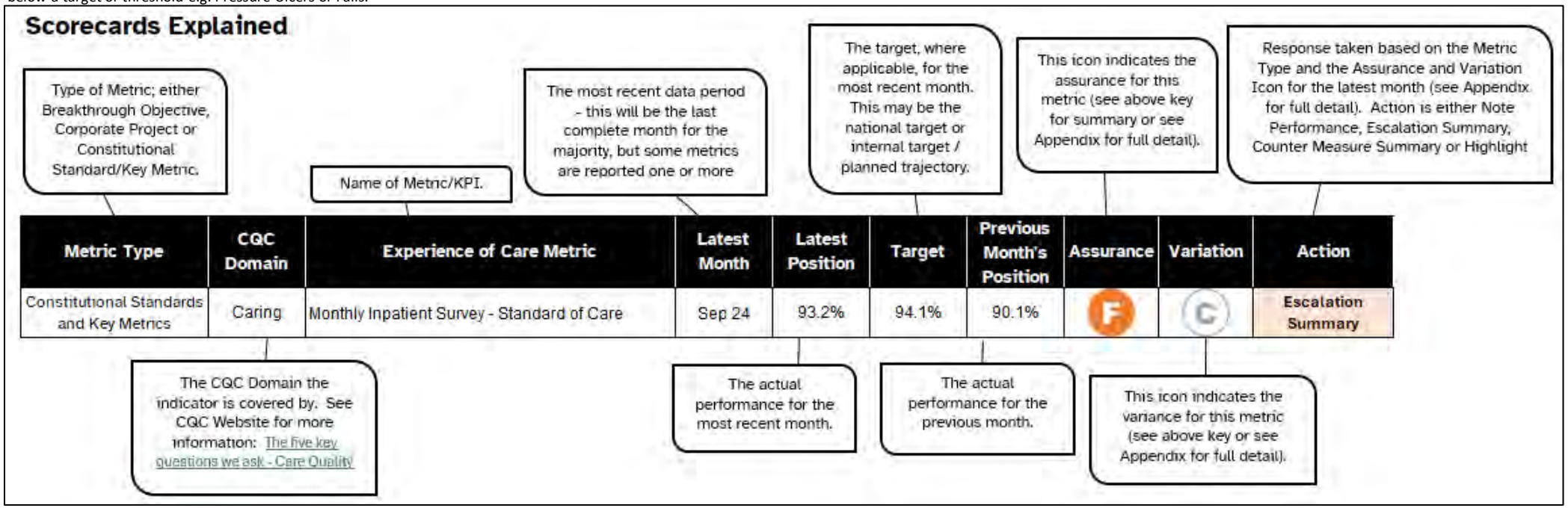
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

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

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



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

Responsiveness

Urgent Care

UHBW ED 4-hour performance dropped slightly to 73.4% in November (73.6% in October) against a March 2026 target of 78% for all attendance types, including type-3 footprint uplift. A combination of demand, high bed occupancy and continued high levels of NCTR, create a challenging clinical, operational and performance environment, thus, impacting on 12-hour total time in the Emergency Department and ambulance handover metrics. For NBT, ED 4-hour performance improved to 66.5% for November 2025 (72.8% 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. Delivery of the NC2R reduction is a core component of the Trusts ability to deliver the 78% ED 4-hour performance requirement for March 2025, as of 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 anticipate no further 65 week waits during 2025/26, noting that there were three patients waiting beyond 65 weeks at the end of November 2025; two Paediatric Dentistry patients were delayed due to sickness absence within the service and one trauma and orthopaedic patient was waiting in excess of 65 weeks, picked up through the trust validation process. All three patients have been rebooked to be treated in December 2025. Both Trusts have set the ambition that less than 1% of the total waiting list will be >52 weeks by the end of March 2026, with NBT already achieving this ambition. However, NBT had two complex Plastic Surgery DIEP patients waiting longer than 65 weeks at the end of November 2025 due to exceptional, unplanned, extended absence in the consultant body.

Diagnostics

For November, NBT's diagnostic performance was just outside of the national constitutional standard, reporting at 1.2%, remaining in the top quartile in the country. UHBW position in November has improved again to 11.5% but fell short of the November target of 7.0%. Performance at UHBW continues to improve across many diagnostic modalities and plans are in place for the small number of modalities which require additional support to achieve the recovery trajectory, with improvement in performance expected in year.

Cancer Wait Time Standards

During October, UHBW remains compliant with the 31-Day and 62-Day standards but fell short of the 79% trajectory set for the Faster Diagnosis Standard (FDS), reporting 78.1%. The expectation is that the FDS position will recover during Q3, and the March 2026 target of 80% achieved.

At NBT, 28-Day FDS and the 62-Day Combined position were off plan for the month of October but reported to plan for the 31-Day Standard. 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 pathway; 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

UHBW had one MRSA bacteraemia case for November; this now brings the year-to-date figure to six. We are currently at the same position for year to date in 2024/25. A continued focus remains around intravenous line care which has been cited as sub-optimal in some of the cases. A detailed external review of the six cases is being held in December 2025, work across the group to replicate the NBT successes is additionally being undertaken.
NBT has seen two cases for the year to date, with none in November.

In November, Trust apportioned Esherichia Coli bacteraemia commenced reporting in the IQPR. At UHBW the threshold limit for 2025/26 is 109 cases per year, there were nine cases of *E. coli* bacteraemia in November bringing our year-to-date figure to 65. This is an increase on our position in November of 2024/25 which was at 46 cases. A three month look back exercise is being undertaken to determine whether there are any themes associated with the increase in cases; initial reviews indicate that the main sources remain hepatobiliary and urinary in source.

At UHBW there were twelve Clostridioides difficile cases for November; the breakdown is eight Hospital Onset Healthcare Associated (HOHA) cases and four Community Onset Hospital Associated (COHA) cases. Total cases year-to -date is 96 (66 HOHA, 30 COHA). The NHSE threshold for UHBW is 109 cases. Investigations are currently underway after a cluster of cases were identified on a gastroenterology/hepatology ward, rigorous additional cleaning and staff training has been undertaken in this area and further ribotyping results are awaited to determine further actions. For NBT there were 3 cases in November (seven HOHA and three COCHA), marginally above year-to-date trajectory.

UHBW recorded 132 falls in November (4.091 per 1,000 bed days), below the Trust target of 4.8. Of these, 87 occurred at the Bristol site and 45 at Weston, with three resulting in moderate harm. The Trust Falls policy is under review and will be updated to reflect the latest NICE (NG249) guidance.

At UHBW November has seen a significant increase in hospital acquired pressure ulcers across all divisions not seen previously in the year to date. There were three unstageable pressure ulcers (reportable as category 3 in Weston, Specialised Services and Medicine. There were two device related category 3 pressure ulcers in Children's. There were seven category 2 pressure ulcers, two in Medicine , three in surgery, one in Weston and one in Children's. For NBT There has been no change in incidence of grade 2 pressure ulcers in November, but performance remains above historic trends. Improvement actions are set out in the main report, including admission zone work with the TVN team supporting clinicians with appropriate equipment choice and daily check/response to operational pressures.

Since the implementation of Careflow Medicines Management (CMM) at UHBW in June 2025, VTE risk assessment rates have improved by around 10% to approximately 80%. However, the link between VTE risk assessment and prescribing VTE prophylaxis has been disrupted; improvement work is ongoing. From November, VTE risk assessments became mandatory on AMU, and efforts are underway to make VTE RA and VTEP prescribing visible on ward boards. Teaching sessions for resident doctors are planned for December. For NBT compliance has improved following CMM implementation to 97.4%, above the national target of 95% for the first time.

In November 2025, UHBW recorded 296 medication-related incidents, with two causing moderate or greater harm (one further incident is under review). A resource proposal for Pharmacy staffing to support medicines safety improvement is being developed. NBT recorded 122 medication incidents, the overall trend continuing to illustrate a positive variation from the historic mean position.

Patient & Carer Experience

At UHBW the compliance rate for complaints responses has improved from 60% in September to 70% in October, of the 90 complaints responded to in October, 63 were closed within the agreed timescale and 27 were outside of the agreed timescale. Consistent improvement over the last 4 months is a result of the removal of any complaint backlog and the focus within the Divisions to respond in a timely manner.

Within NBT the monthly complaints figures continue to trend above the historical mean, with 68 received in November and a static position for PALS concerns. Timely response was relatively unchanged at 71%, reflecting the sustained positive impact of ASCR Division's recovery plan.

Executive Summary – Group Update

Our People

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

Turnover

- **NBT** turnover is 9.9% in November, below the NBT target of 11.3% for 2025/26
- **UHBW**, turnover is 9.5% in November and below target.

Vacancy Rate

- **NBT** is 8.0%, small reduction in vacancies driven by healthcare support worker recruitment. A deep dive into our 25/26 planning assumptions and our current position is in progress focussing on quantifying the risk of non-delivery. The outcome will be taken through Group People Oversight Group for review and agreement on mitigating actions.
- **UHBW** is 4.6%, an increase from 4.3% in October and above target, triggering an escalation summary.

Sickness

- **NBT** rate is 4.8%, above the target of 4.4%. NBT is carrying out detailed work on long term absence as the predominant driver of the position.
- **UHBW** rate is 4.5% in month, remaining the same as the October rate. This does not trigger an escalation summary against the cumulative annual target.

Essential Training

- **NBT** – 88.1% against a target of 90% - key hotspots are Infection Prevention Control and Information Governance
- **UHBW** - 89.6% against a target of 90%. key hotspots are Moving and Handling, Resuscitation and Information Governance

Both Trusts continue to carry out focussed work with subject matter expert in progress to identify recovery actions including improvements to delivery models, communication and promotion and ongoing governance and determine the level of confidence that actions will have required impact to recover our position.

Oliver McGowan - Level 2 Face to Face and Level 1 Virtual compliance will be presented with a trajectory to achieve compliance with the ICB target of 63.3% by Mar-26. Focus will be on what would be required to achieve target in terms of training attendance, available capacity and current future bookings to provide a confidence level for delivery – recognising the current challenge seasonal pressures provides in releasing staff for training.

Executive Summary

Finance

In Month 8 (November), NBT delivered a £1.1m deficit position which is £1.2m adverse to plan. Year to date NBT has delivered a £4.6m deficit position against a £2.7m deficit plan.

UHBW delivered a £2.7m deficit in month 8, against a deficit plan of £1.7m. UHBW's year to date deficit is £11.0m, £1.6m adverse to plan.

Pay expenditure within NBT is £1.3m adverse to plan in month. This is driven by 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 staff groups.

Pay expenditure in UHBW is £2.7m adverse to plan in month. This is driven mainly by higher than planned bank expenditure particularly across nursing due to escalation and enhanced care plus additional medical costs associated with industrial action.

The NBT cash balance as at the 30 November 2025 is £41.5m, £9.8m higher than planned, a £35.9m reduction from 31 March 2025.

The UHBW cash balance as at the 30 November 2025 is £58.9m, £7.9m lower than planned, a £13.4m reduction from 31 March 2025.

NHS North Bristol NHS Trust

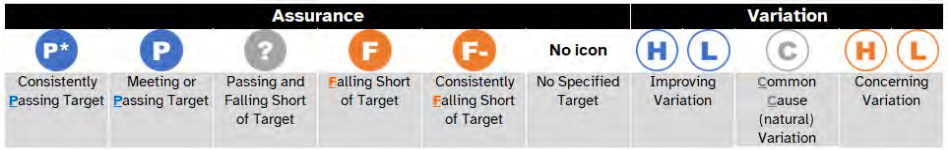
Responsiveness

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	ED % Spending Under 4 Hours in Department	NBT	Nov-25	66.5%	69.7%	61.5%	F-	C	Escalation Summary
		UHBW	Nov-25	66.5%	72.3%	66.6%	?	C	Escalation Summary
Responsive	ED % Spending Over 12 Hours in Department	NBT	Nov-25	8.4%	2.0%	9.9%	F-	C	Escalation Summary
		UHBW	Nov-25	4.0%	2.0%	6.9%	F	C	Escalation Summary
Responsive	Bristol Children's Hospital ED - Percentage Within 4 Hours								
		UHBW	Nov-25	69.7%	No Target	84.7%	n/a	C	Note Performance*
Responsive	ED 12 Hour Trolley Waits (from DTA)	NBT	Nov-25	366	0	401	F-	C	Escalation Summary
		UHBW	Nov-25	243	0	562	F-	C	Escalation Summary
Responsive	Ambulance Handover Delays (under 15 minutes)	NBT	Nov-25	34.3%	65.0%	27.4%	F-	C	Escalation Summary
		UHBW	Nov-25	44.2%	65.0%	36.2%	F-	H	Escalation Summary
Responsive	Average Ambulance Handover Time	NBT	Nov-25	25	44	29	P	C	Note Performance
		UHBW	Nov-25	19.0	45.0	23.6	P	L	Note Performance
Responsive	% Ambulance Handovers over 45 minutes	NBT	Nov-25	13.1%	0.0%	18.6%	F-	C	Escalation Summary
		UHBW	Nov-25	3.2%	0.0%	10.0%	F-	L	Escalation Summary
Responsive	No Criteria to Reside	NBT	Nov-25	22.2%	15.0%	23.7%	F-	L	Escalation Summary
		UHBW	Nov-25	20.1%	13.0%	22.1%	F-	C	Escalation Summary
Responsive	RTT Percentage Over 52 Weeks	NBT	Nov-25	0.3%	1.0%	0.3%	P	L	Note Performance
		UHBW	Nov-25	1.3%	1.1%	1.4%	F-	L	Escalation Summary
Responsive	RTT Ongoing Pathways Under 18 Weeks	NBT	Nov-25	66.4%	71.1%	66.9%	F-	H	Escalation Summary
		UHBW	Nov-25	67.3%	66.5%	66.2%	F-	H	Escalation Summary

* with commentary



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 First Attendance Under 18 Weeks	NBT	Nov-25	70.8%	72.3%	70.1%	?	H	Note Performance
		UHBW	Nov-25	69.9%	69.8%	68.7%	F-	H	Escalation Summary
Responsive	Diagnostics % Over 6 Weeks	NBT	Nov-25	1.2%	1.0%	1.1%	?	L	Note Performance
		UHBW	Nov-25	11.5%	7.0%	12.7%	F-	L	Escalation Summary
Responsive	Cancer 28 Day Faster Diagnosis	NBT	Oct-25	77.9%	79.2%	76.8%	F	C	Escalation Summary
		UHBW	Oct-25	78.1%	79.0%	75.1%	?	C	Escalation Summary
Responsive	Cancer 31 Day Decision-To-Treat to Start of Treatment	NBT	Oct-25	90.5%	88.5%	87.9%	?	H	Note Performance
		UHBW	Oct-25	96.6%	96.0%	96.6%	P	H	Note Performance
Responsive	Cancer 62 Day Referral to Treatment	NBT	Oct-25	63.5%	72.7%	61.6%	F	C	Escalation Summary
		UHBW	Oct-25	77.2%	73.2%	75.2%	P	H	Note Performance
Responsive	Last Minute Cancelled Operations	NBT	Nov-25	0.8%	0.8%	0.7%	P	C	Note Performance
		UHBW	Nov-25	1.8%	1.5%	3.0%	F	C	Escalation Summary
Responsive	% to Stroke Unit within 4 Hours	NBT	Oct-25	50.0%	90.0%	47.5%	F-	C	Escalation Summary
Responsive	Stroke Thrombolysis within 1 hour	NBT	Oct-25	57.1%	60.0%	53.3%	?	C	Escalation Summary
Responsive	90% Time in Stroke Unit Performance validated	NBT	Oct-25	36.7%	90.0%	60.0%	F-	L	Escalation Summary
Responsive	% Seen within 14 Hours by a Stroke Consultant - Validated	NBT	Oct-25	74.6%	90.0%	82.9%	F	C	Escalation Summary

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

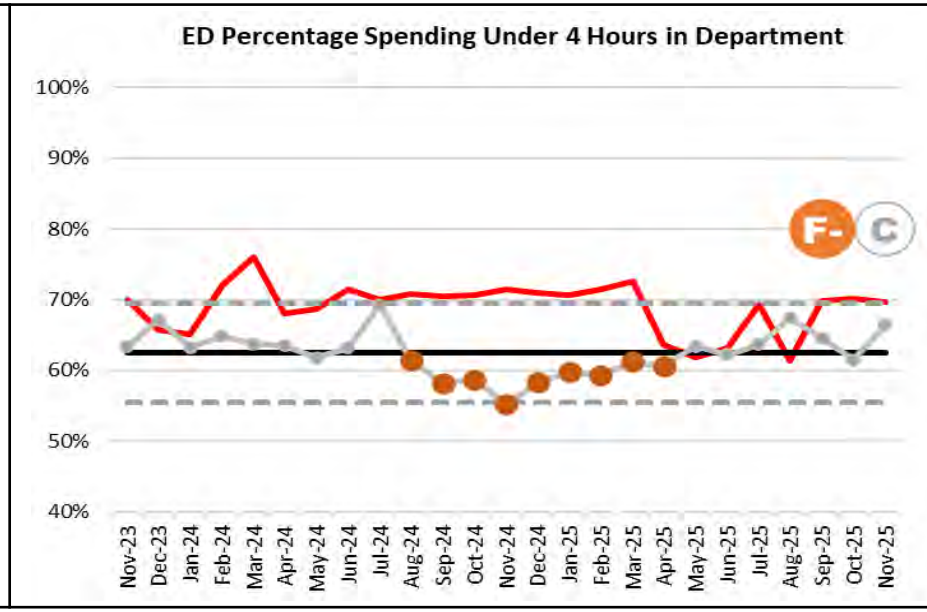
Responsiveness

UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Nov-25
Target
69.7%
Latest Month's Position
66.5%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).

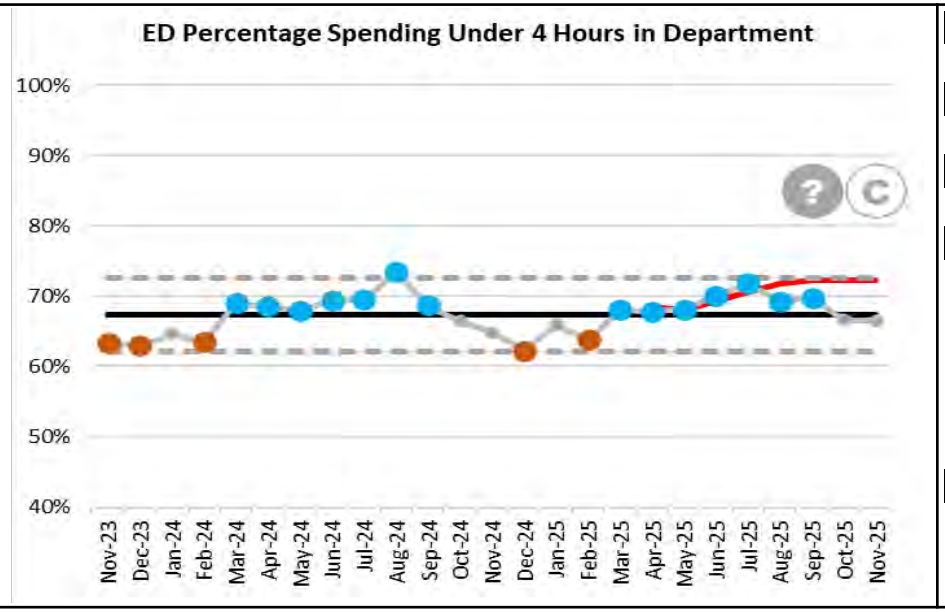


What does the data tell us?
The percentage of patients spending under 4 hours in ED for November increased to 66.5% (c11% higher than November 2024), and back above the mean. There were improvements across all streams (minors, non-admitted majors and admitted to inpatients). Attendances were down by c7% in November compared to October, but up by c3% compared to YTD.

Actions being taken to improve
The following actions are in train for December:

1) Following the test of Change week at the end of November the teams are working to embed the improvements (eg EDAU staffing model, alternative locations for expected patients and working with ICB and Community Emergency Medicine Service on reducing ambulance conveyances).
2) As part of the UEC improvement programme we will also be substantiating test of change weeks as part of our ongoing approach – we are currently working up a set of schemes to test in February and intend the run the process on a quarterly basis alongside our more major transformation projects.
3) Analysis has been produced looking into performance benefits seen during periods of resident doctor industrial action. We are reviewing this to determine what improvements we can replicate in non-strike periods.

Impact on forecast
December performance to date is predicted to be maintained at c 66-67% against the four-hour standard.



Latest Month
Nov-25
Target
72.3%
Latest Month's Position
66.5%
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?
The ED 4-hour standard across the trust remains static for November at 66.5% compared to 66.6% during October, though a notable improvement at the BRI (47% in October; 55% in November). November saw a decrease in attendances to all ED's across the trust except for the BRCH.

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 establishing the Inter-Professional Standards, reducing delays in specialty reviews in ED and improving outward flow from ED. The department is also working closely with SWAST, community and primary care partners to maximise admissions avoidance schemes e.g. Frailty – Assessment & Coordination of Urgent & Emergency Care (F-ACE). NB UHBW currently leading the parallel development with Paediatrics (P-ACE), and increased utilisation of the Community Emergency Medicine service (CEMS)

Impact on forecast
Forecasting improvement plans will continue to iterate and maintain the Trust position; c66% in December
The End of Year Target for this measure is 72.3% (78% inclusive of Sirona type-3 uplift)

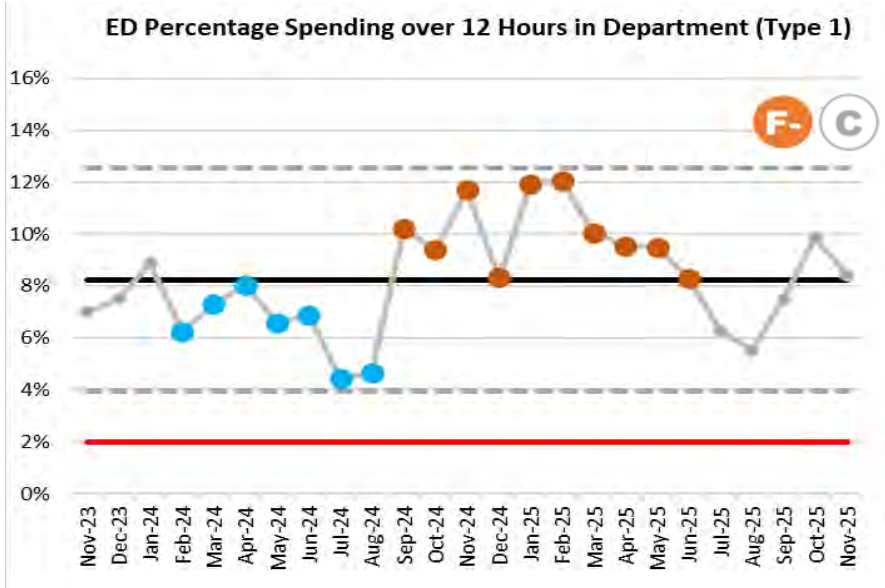
Responsiveness

UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Nov-25
Target
2.0%
Latest Month's Position
8.4%
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).



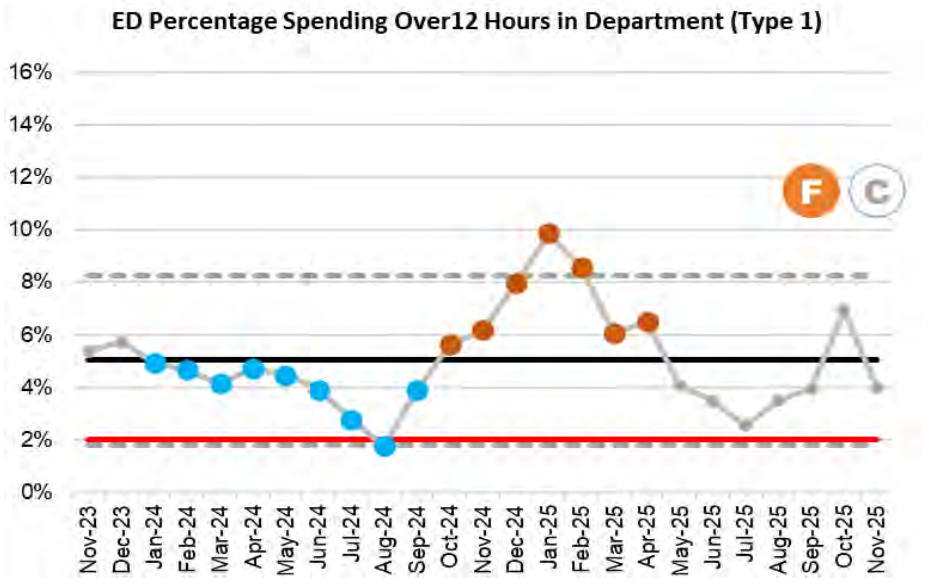
What does the data tell us?
The percentage of patients spending over 12 hours in ED decreased to 8.4% in November (which is 3.5% lower than November 2024). In November compared to October admissions were down by 4.6%, but remain at an overall 12% increase YTD.

Actions being taken to improve
We continue to focus on this important quality metric during November, with the following key projects underway:

1) During the GIRFT Test of Change Week improvements were made, including DTA flow out of ED at 8am, Medicine weekend discharge approach, care ready / bed turnaround times on inpatient wards and in the escalation approach for challenged continuous flow moves. We are working to embed these changes during December as well as working up the next test of change cycle for February.

2) NBT's GIRFT Lead chaired a Criteria to Admit Audit in the emergency department during November. We have a criteria to admit audit of the GP referred medical take planned for early January and intend to use this as a platform to work with system partners on increasing prevention of admission work.

Impact on forecast: December performance has been extremely challenged due to infection and we are currently tracking a deteriorated position. Work across the month will focus on pulling this back to a c8-9% position.



Latest Month
Nov-25
Target
2.0%
Latest Month's Position
4.0%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

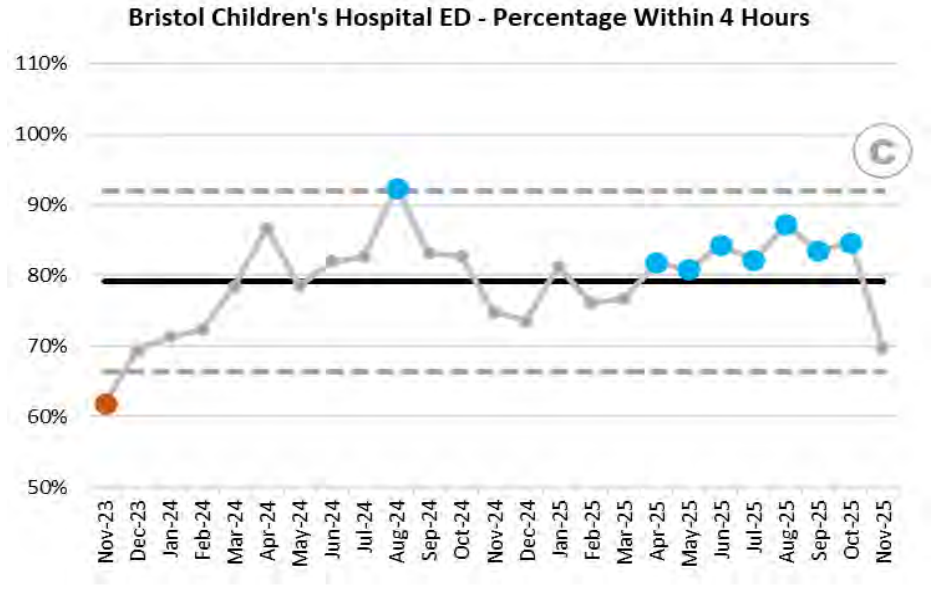
What does the data tell us?
The percentage of patients spending over 12 hours in ED for the month of November (4%) improved compared to October (6.9%) and well below the national threshold of 10%. Notable improvement was seen at the BRI with a decrease in 12 hr waits from 10% in October to 4% in November (BRI admitted patients waiting over 12 hrs dropped from 27% in October to 11% in November). November also saw a decrease in overall ED attendances and admissions across adult services and a slight drop in bed occupancy rates.

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 position through the remaining months of the year (c6% December).

Responsive

UEC – Emergency Department Metrics



Latest Month
Nov-25

Target
No Target

Latest Month's Position
69.7%

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 significant increase in ED attendances during November (158 per day in November; 141 per day in October) and an associated deterioration in ED 4-hour performance (November 69.7%; October 85%) which is a drop when compared with the previous November 2024 (75.67%).

There have been days where the Children's Hospital has seen over 200 patients and flow has been challenging due to high seasonal respiratory attendances. High acuity overnight with delays in patients waiting to be seen in ED plus delays with lab results preventing onward transfer to an inpatient bed.

Actions being taken to improve

- 4-hour breach working group has been established to review breaches and identify learning
- ENP to support streaming to support timely assessment and discharge
- Escalation policy at final stage of sign off and will be shared with the hospital
- Implementation of P-ACE to prevent admissions
- Patient Flow Coordinator has started on 13/12 which will further support validation of 4hr breaches
- Additional 'short late' consultant approved for 10 days in December to support bottleneck of patients in the department late into the evening waiting to be seen

Impact on forecast

4hr position continues to be a challenge ahead of the winter months (December provisional position c73%)

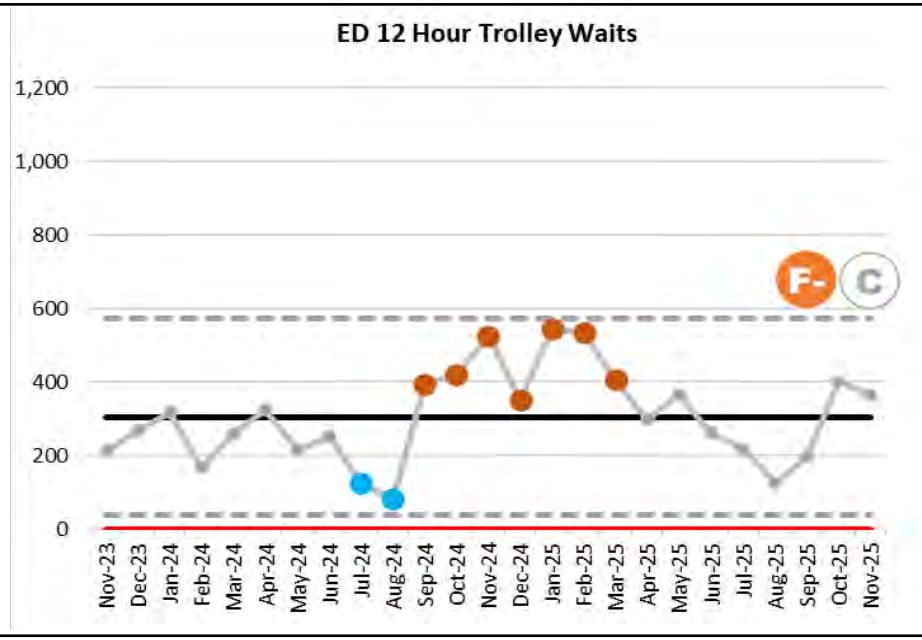
North Bristol NHS Trust

Responsiveness

UEC – Emergency Department Metrics

University Hospitals Bristol and Weston NHS Foundation Trust

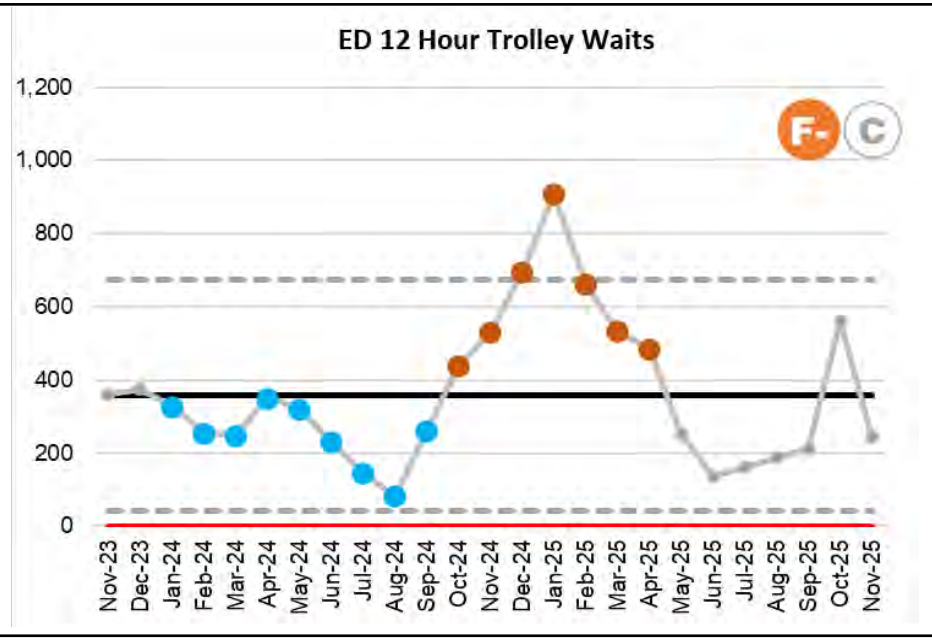
Latest Month
Nov-25
Target
0
Latest Month's Position
366
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
The number of 12 hour trolley waits decreased compared to the previous month to 366.

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
Nov-25
Target
0
Latest Month's Position
243
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 (15)

What does the data tell us?
The number of 12 Hour trolley waits decreased throughout November to 243 compared to 562 in October

Actions being taken to improve
Note actions from previous two slides

Impact on forecast
Along with improvement work noted against the 4-hour and 12-hour standard, it is anticipated that the number of 12-hour trolley waits will be maintained during December.

Responsiveness

UEC – Ambulance Handover Delays

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

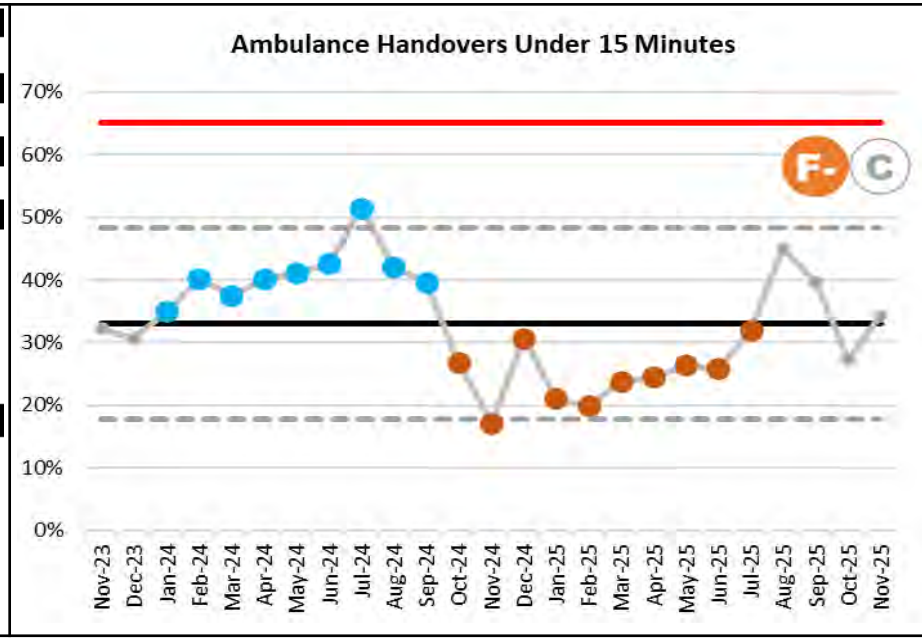
Latest Month
Nov-25

Target
65.0%

Latest Month's Position
34.3%

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

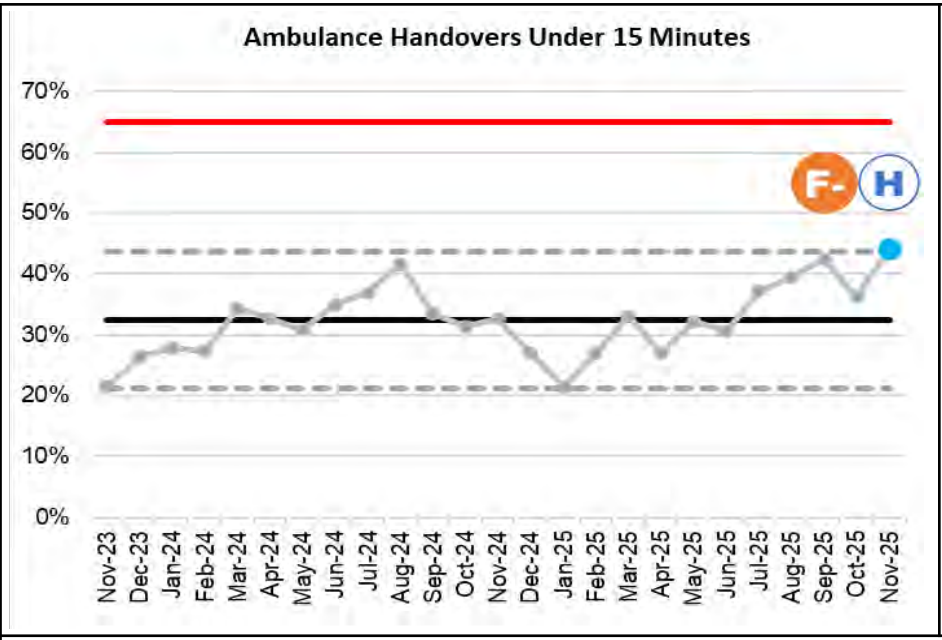
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
The proportion of handovers completed within 15 minutes has increased to 34.3%, back above the mean and an improved position compared to November of the two previous years. Total hours lost during the month was the lowest YTD. Total conveyances were up by an average of ten per day compared to November 2024.

Actions being taken to improve
The November test of change scheme linked to SWAST crews calling the Community Emergency Medicine Service prior to conveying to NBT ED was successful both in terms of avoiding conveyances and increasing engagement with SWAST on alternatives to ED. Results have been shared with the ICB and there is a system commitment to substantiating the CEMS services across seven days as part of the operational plan for next year. This would also benefit the BRI ED.

Impact on forecast
Learning from the call before convey test of change will be key in BNSSG to unlocking congestion in ambulance bays and promoting alternative pathways with SWAST.



Latest Month
Nov-25

Target
65.0%

Latest Month's Position
44.2%

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

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

What does the data tell us?
Ambulance handovers within 15 mins continue to show a trend of improvement into November at 44.2% compared to 36.2% in October. Notable increase observed at BRI from 28.5% in October to 42.7% in November. This is despite an increase in conveyances across all sites throughout November.

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

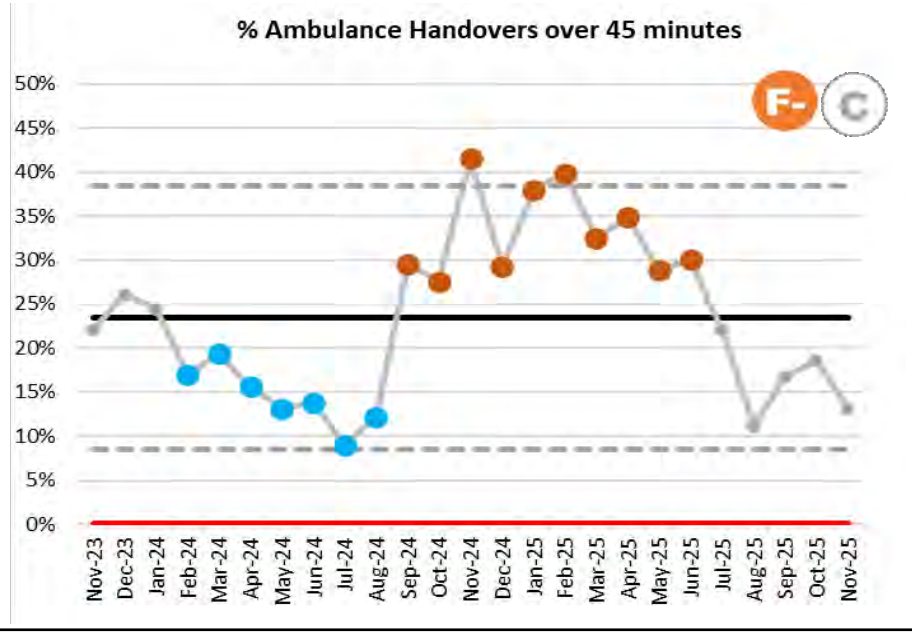
UEC – Ambulance Handover Delays

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Nov-25
Target
0.0%
Latest Month's Position
13.1%
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).

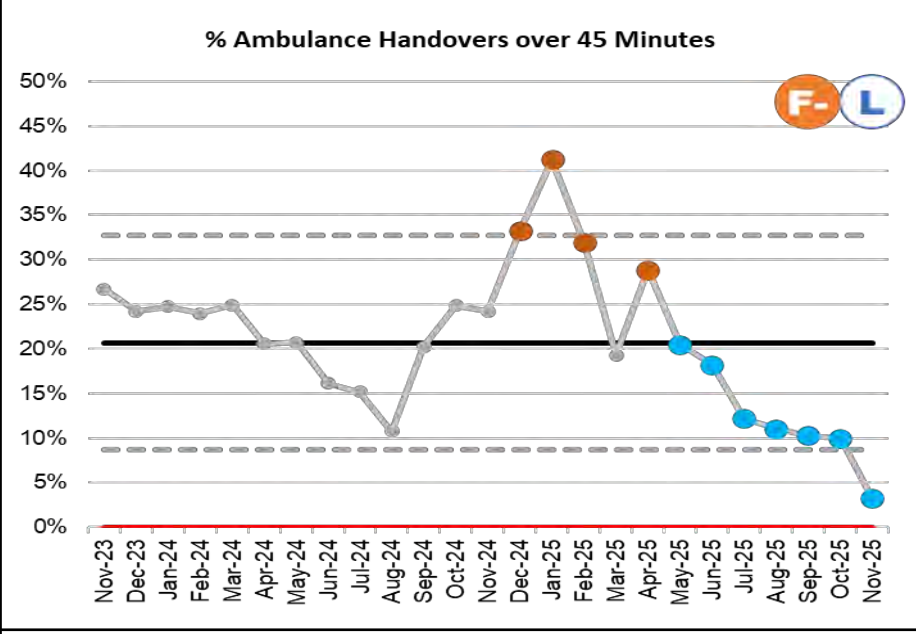


What does the data tell us?
The proportion of handovers over 45 minutes decreased in November 2025 to 13.1% , significantly lower than the previous two Novembers' performance. This has been positively impacted by application of the Timely Handover Plan, however, this has added pressure to the density of patients in the Emergency Department.

Actions being taken to improve
The Trust Medical Director led a Patient Safety and Experience Review during November into the impacts of SWAST's Timely Handover Plan, and handovers exceeding 45 minutes. Whilst we continue to work on internal actions to improve 45-minute handover performance, the work has also been referred into the system Rapid Emergency Assessment Framework (REAF) process for review by system senior clinicians.

A further test of change with the Community Emergency Medicine Service is being worked up for w/c 23 February with a view to testing enhanced weekend provision – usually one of NBT's most challenging times.

Impact on forecast
The above ongoing work is expected to further stabilise the position and promote an improving position again during December.



Latest Month
Nov-25
Target
0%
Latest Month's Position
3.2%
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.

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

What does the data tell us?
Ambulance handover times within 45 minutes have markedly improved throughout November at 3.2% compared to 10% in October, despite an increase in conveyances across all ED's. Improved inpatient flow and bed occupancy throughout November will have contributed towards the improvement in ambulance handovers within 45 mins.

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; December provisional position c5%

Responsiveness

UEC – No Criteria To Reside

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

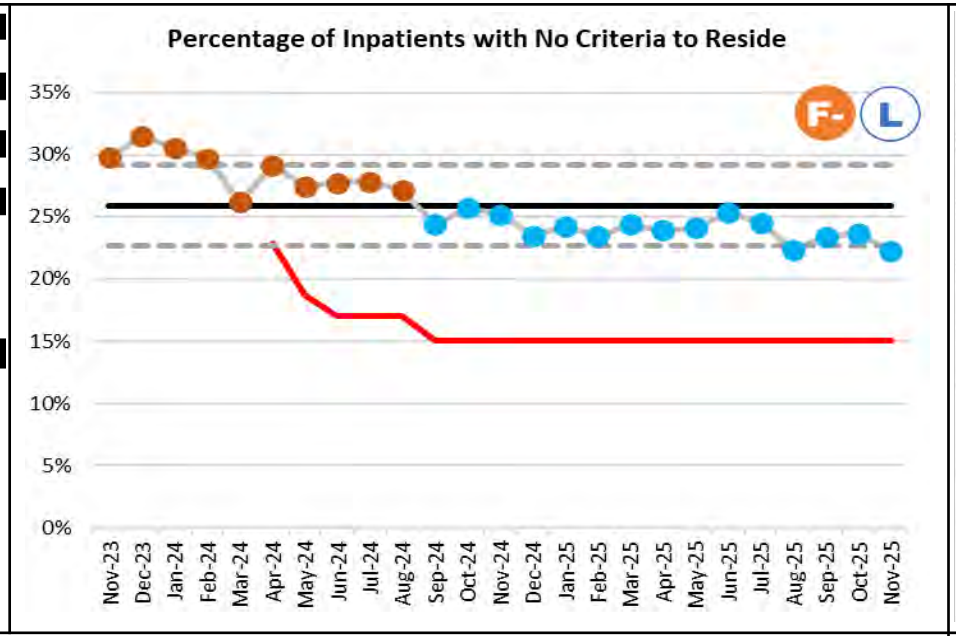
Latest Month
Nov-25

Target
15.0%

Latest Month's Position
22.2%

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

Trust Level Risk
Risk 2182 - patients who are 'discharge ready' who remain in hospital beds with 'No Criteria to Reside (NC2R)' will be at greater risk of deconditioning, hospital acquired infections, falls and delirium which could lead to varying levels of harm/patient outcomes (12).

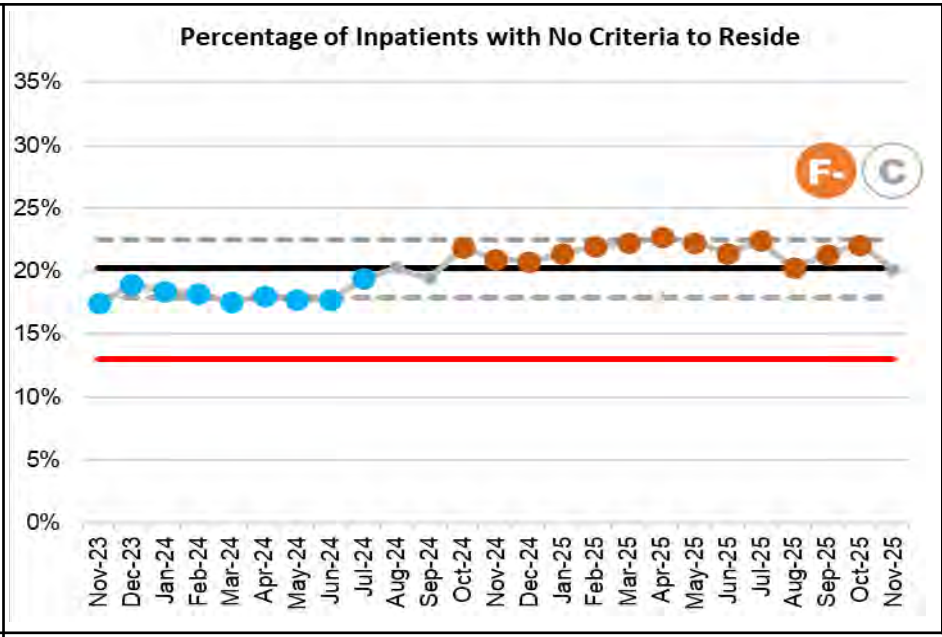


What does the data tell us?
No Criteria to Reside (NCTR) decreased to 22.2% but remains above the BNSSG system target of 15%.

Actions being taken to improve
There are some key areas of focus currently for NCTR reduction:

1) SSARU delays – BNSSG UEC Operational Delivery Group endorsed NBT's proposals to support SSARU delays, and additional capacity has been provided in SSARU and supported discharge.
2) System work on the Home Based Intermediate Care offer continues, with demand and capacity modelling part of the next phase of the work to ensure right provision in the right place at the right time.
3) A proposal for a system change team to lead the work to right size the community intermediate care inpatient capacity across BNSSG. This will be a strategic piece of work starting this financial year and running across part of next year. Providers have been asked to consider what staffing capacity they can offer to the programme.

Impact on forecast
System NCTR target: 15% NBT remains unmet.



Latest Month
Nov-25

Target
13.0%

Latest Month's Position
20.1%

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

Corporate Risk
Corporate Risk 423 - 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?
No Criteria to Reside (NCTR) position improved in November: 20.1% vs October, 22.1% (BRI: 17.3%, October 20.1% ; Weston 27.6%, October 30.3%), noting fewer discharges overall vs October. The proportion of complex patients requiring specialist care remains high with inadequate beds capable/available to support.

Actions being taken to improve
System focus on improvement plans to deliver the 15% NCTR reduction continues:
•Admission avoidance through various initiatives e.g. CEMs 5 days a week + telephone shifts
•Transformation work underway (national support by iMpower) to develop a Home Based Intermediate Care model,(HBIC): Demand and capacity modelling underway to ensure appropriate provision.
•Development of an IP Intermediate Care model: Capacity and Demand Modelling with Action Plan to reduce community LoS to be developed.
•Home First Team improvement projects: Continuing Health Care Fast Track - **a reduction of average 4 days since August**
Early Supported Discharges enables patients to leave hospital before their package of care start date with family support: 92 patients left hospital early saving 267 bed days in November.

Impact on forecast
System NCTR target: 15% UHBW remains unmet (BRI 11%; WGH 19%).

Responsiveness

Planned Care – Referral to Treatment (RTT)

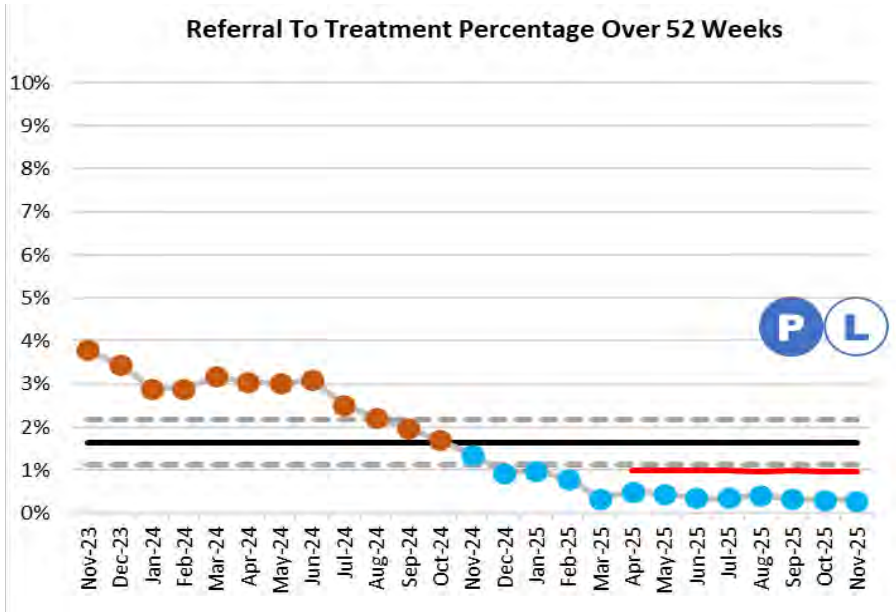
Latest Month
Nov-25

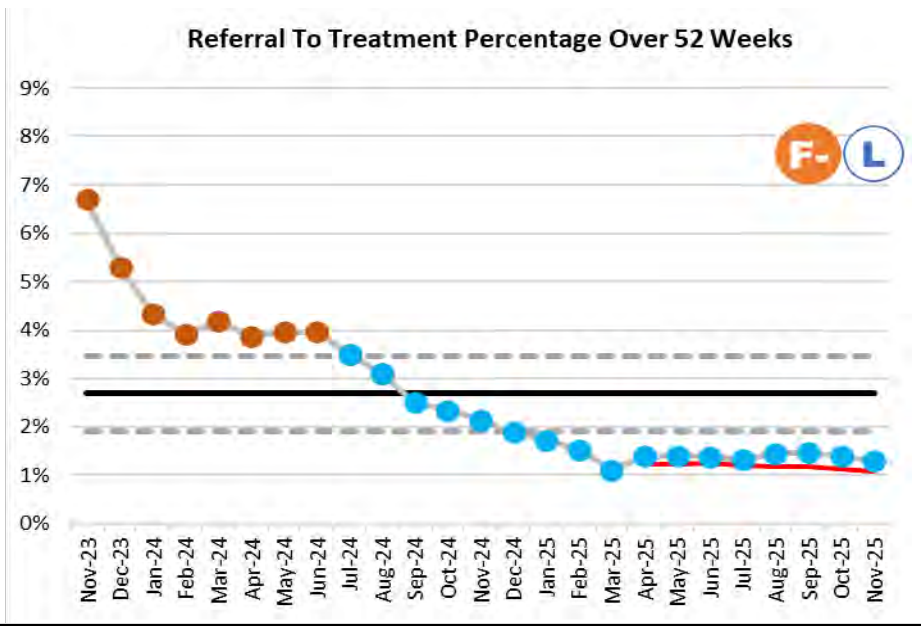
Target
1.0%

Latest Month's Position
0.3%

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
Nov-25

Target
1.1%

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 November there were three patients waiting greater than 65 weeks;

- Two Paediatric Dentistry patients due to unforeseen consultant sickness absence, further exacerbated by staffing in the anaesthesia team in the Children's Hospital.
- One T&O patient was identified through trust validation processes.

All three patients have dates for treatment in December.

673 patients were waiting 52 weeks or more at the end of November (730 in October), against the total waiting list size of 52,104 which equates to 1.3% against the 1.1% trajectory set for November 2025. The overall waiting list size reduced by 392 to 52,104 during October, against the Trust trajectory for October of 50,334

Actions being taken to improve

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

Recovery plans continue to be monitored in specialties with more challenged waiting times.

Impact on forecast

The End of Year Target for this measure is 0.9%

Responsiveness

Planned Care – Referral to Treatment (RTT)

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

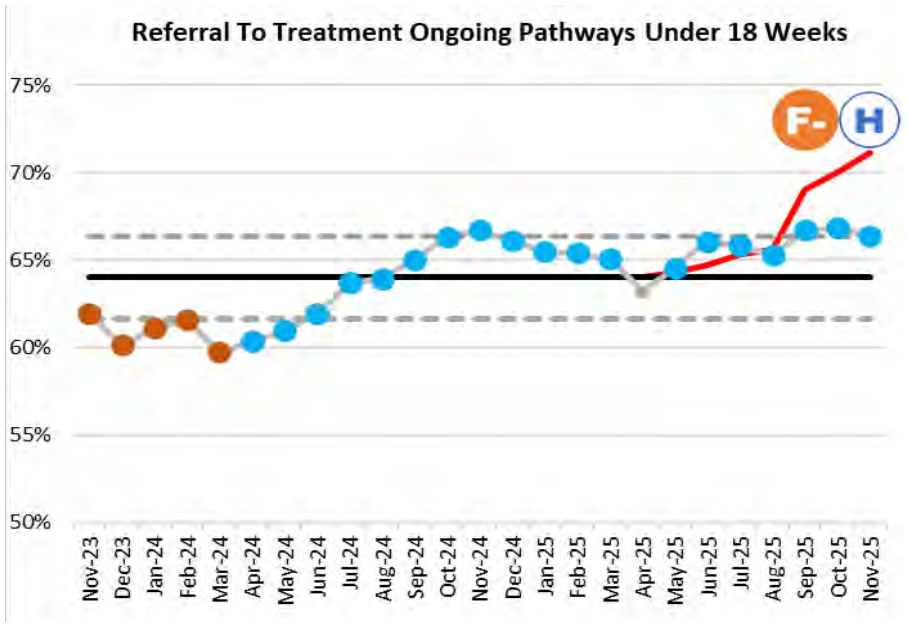
Latest Month
Nov-25

Target
71.1%

Latest Month's Position
66.4%

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

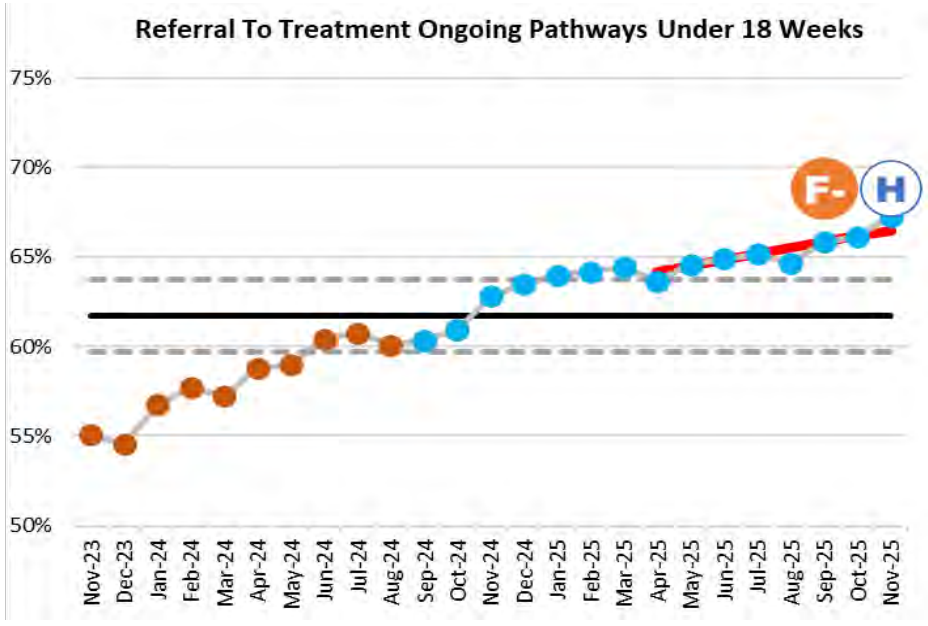
Trust Level Risk
No Trust Level Risk



What does the data tell us?
At the end of November, the percentage of patients waiting less than 18 weeks was 66.4%, performing under the Trust trajectory of 71.1% set as part of the Trust operational planning submission (target of 72% by March 2026). This deterioration was partly due to the phased activity plan related to the BSC not meeting trajectory and the relocation of gynaecology theatres affecting productivity.

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 Princess Royal Bristol Surgical Centre (PRBSC) opened earlier in the year with a focus on optimising orthopaedic activity in December.
Additional patient contacts are being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions).
Operational re-focus to overall percentage performance established going into Q4 which is being led by the COO.

Impact on forecast
Anticipated to deliver end of year target.



Latest Month
Nov-25

Target
66.5%

Latest Month's Position
67.3%

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

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

What does the data tell us?
At the end of November, the number of patients waiting less than 18-weeks is 35,069 (67.3%) exceeding the target for the end of November of 66.5%

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 continue to take part in the NHS England validation sprint, where validation focuses 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

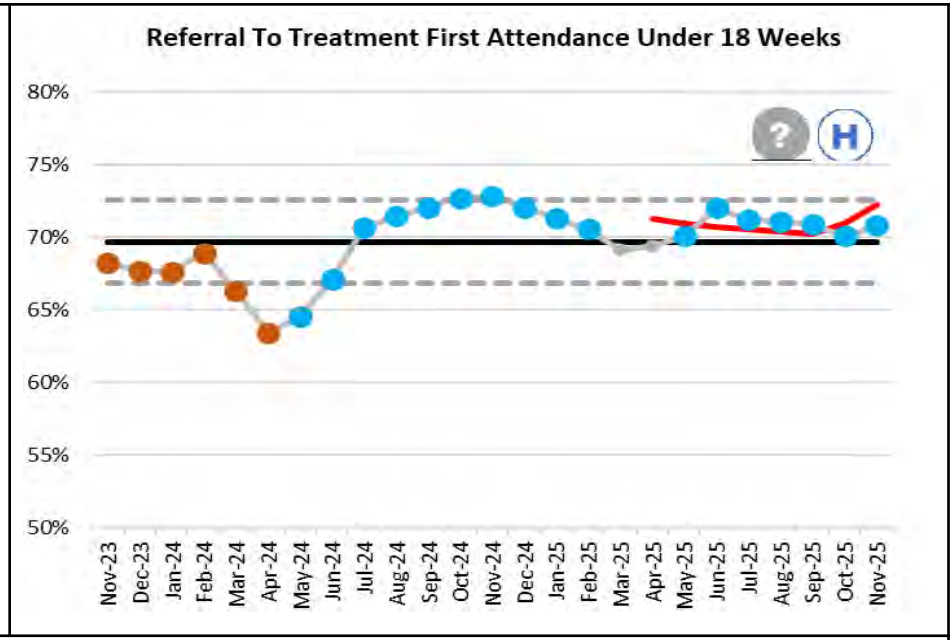
The End of Year Target for this measure is 67.8%

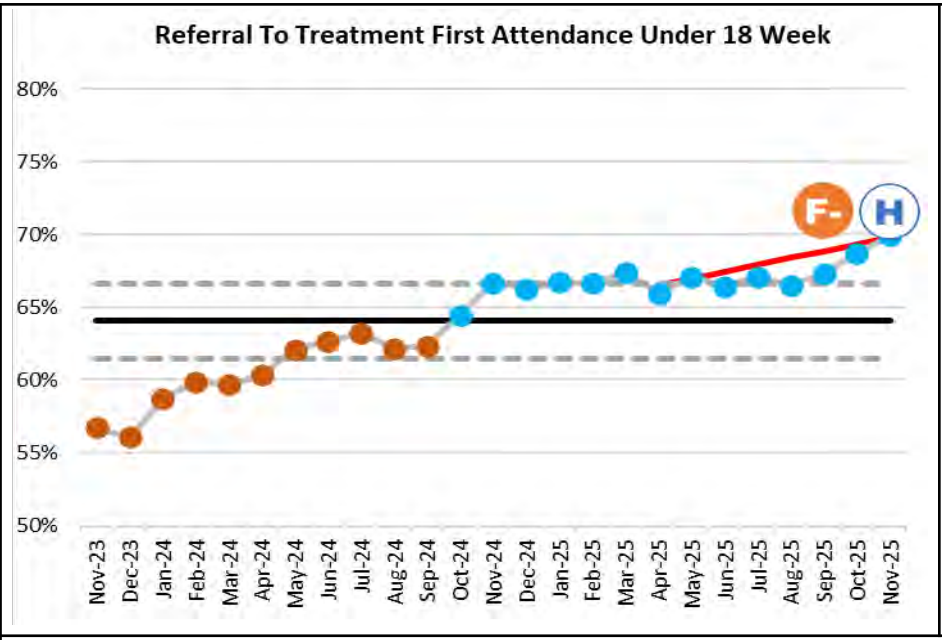
Responsiveness

Planned Care – Referral to Treatment (RTT)

Latest Month
Nov-25
Target
72.3%
Latest Month's Position
70.8%
Performance / Assurance
Special Cause Improving Variation High (where up is improvement) and last six data points are hitting and missing target, subject to random variation

Corporate Risk
No Trust Level Risk





Latest Month
Nov-25
Target
69.8%
Latest Month's Position
69.9%
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)

No narrative required as per business rules.

What does the data tell us?
At the end of November, the percentage of patients waiting less than 18 weeks for their first appointment improved to 69.9% (68.7% October) against the target of 69.8% set for November 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. Oversight meetings are in play with the most challenged specialities to ensure that all plans for additional activity is exploited.

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

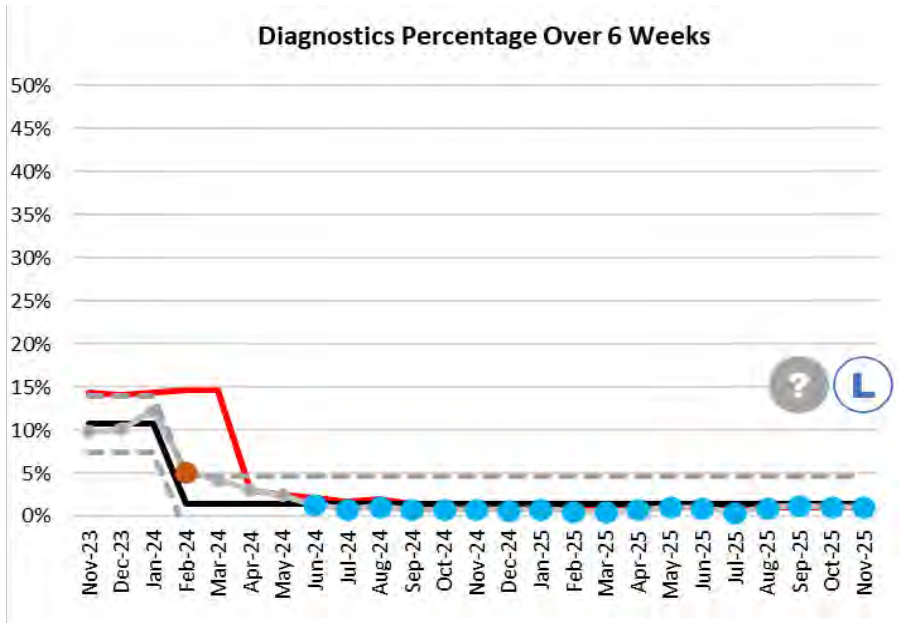
Latest Month
Nov-25

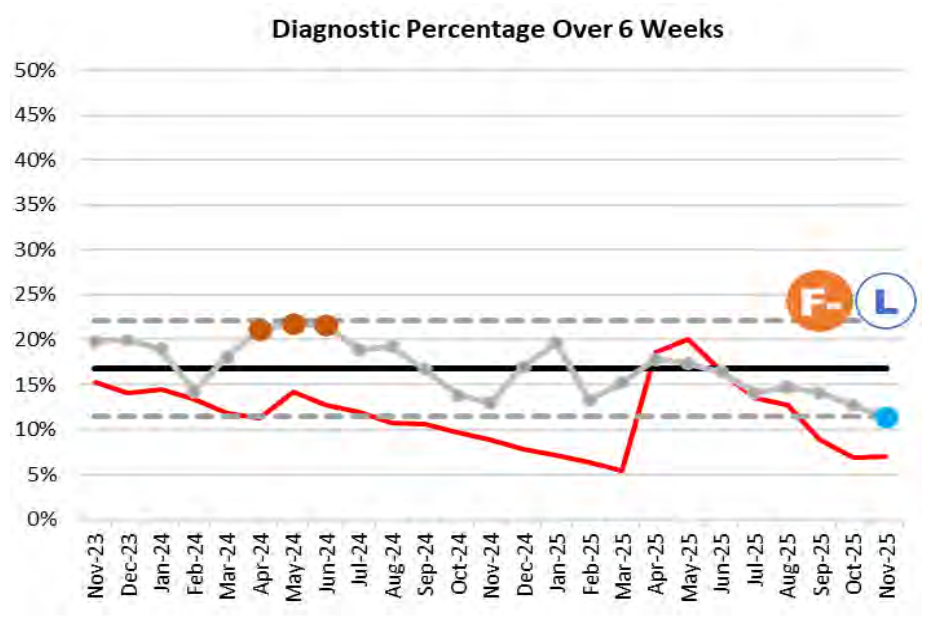
Target
1.0%

Latest Month's Position
1.2%

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
Nov-25

Target
7.0%

Latest Month's Position
11.5%

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

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

No narrative required as per business rules.

What does the data tell us?
In November, the proportion of patients waiting over six weeks against the DM01 standard improved to 11.5%, (12.7% in October). While this represents an improvement, performance remains above the planned level of 7%.

Actions being taken to improve
- Continue to utilise MRI Play Rocket for paediatric patients to reduce reliance on GA capacity. Any GA capacity lost due to staffing is being converted into Non-GA capacity to reduce paediatric MRI backlogs
- NOUS outsourcing planned in January 2026 to target Adult backlogs
- Several mitigations are ongoing for the loss of Adult Endoscopy capacity following the temporary move of Surgical Treatment Assessment Unit (STAU) into the Endoscopy Recovery Area including the utilisation of existing paediatric / community estate and continued outsourcing.
- Community Diagnostic Centre bookings to be sub-contracted back to the Trust with the aim of increasing conversion rates and throughput.

Impact on forecast
While performance is anticipated to improve in December, it is anticipated that performance will not meet the planned trajectory for December. January schemes are planned to close the gap between actual and planned performance.

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

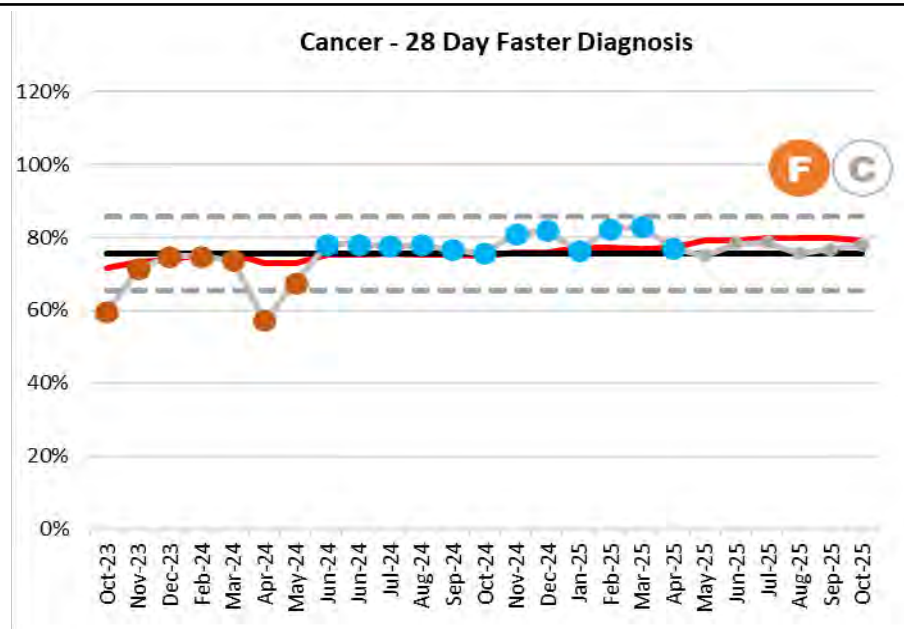
Latest Month
Oct-25

Target
79.2%

Latest Month's Position
77.9%

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

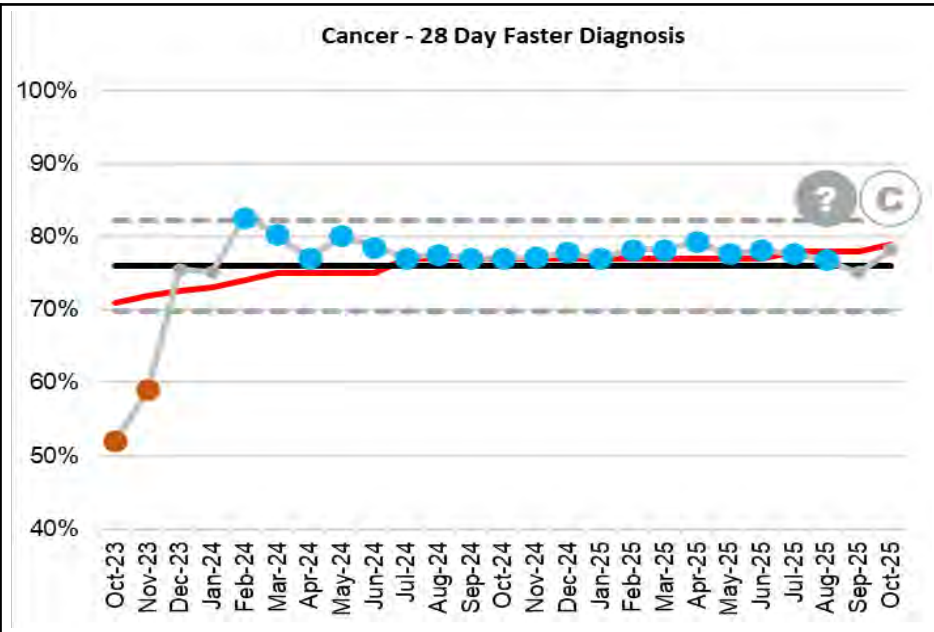
Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).



What does the data tell us?
28-Day performance did not meet the trajectory for October. The overall informed volume was below plan and there were more reported breaches. The position was driven by Breast and Urology.

Actions being taken to improve
Detailed recovery plan provided to NHS England through the Tier 2 support; the recovery plan details a return to plan by year-end.
Key areas of focus are 1st OPA within Breast and diagnostic capacity and turnaround times in Urology.
SWAG and NHSE funding has been approved.

Impact on forecast
To return to plan by year-end.



Latest Month
Oct-25

Target
79.0%

Latest Month's Position
78.1%

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 2680 - Complainants experience a delay in receiving a call back (12)

What does the data tell us?
Performance has recovered to its previous levels after a dip in August and September due to reduced activity and impact of staffing shortages in high volume areas. The performance remains just below the 79% improvement trajectory for the month.

Actions being taken to improve
With the high volume speciality of ENT having staff in all posts from November, performance is improving rapidly as expected. Performance is reported in retrospect therefore there is a lag time between actions completing and full impact on the percentage compliance figure. It is also possible for performance improvement following resolution of capacity problems to be preceded by a short-term deterioration, as backlogs are cleared.

Impact on forecast
The Trust expects to reach 80% by the end of the financial year as required, driven by the expected improvement in head and neck performance.

Responsiveness

Planned Care – Cancer Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

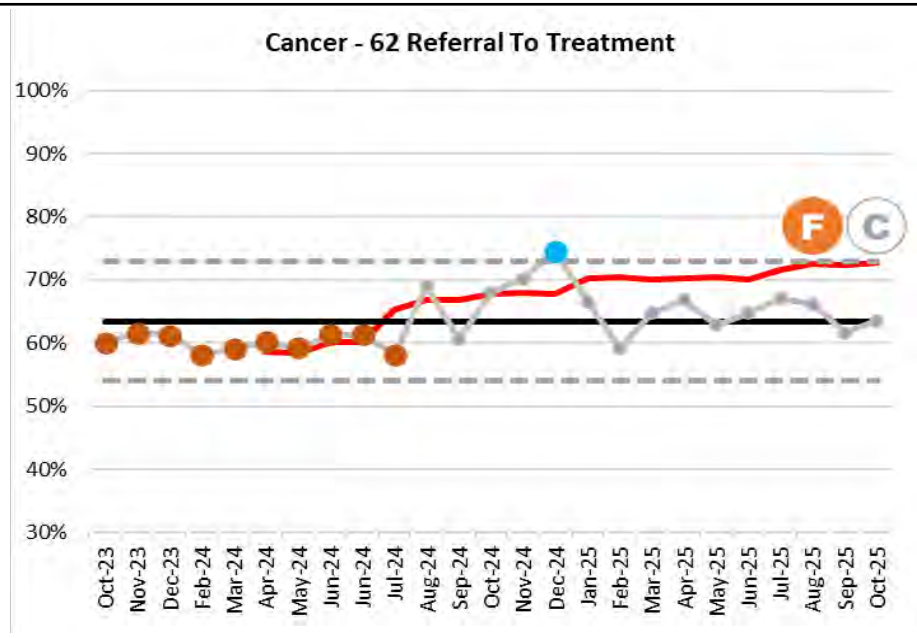
Latest Month
Oct-25

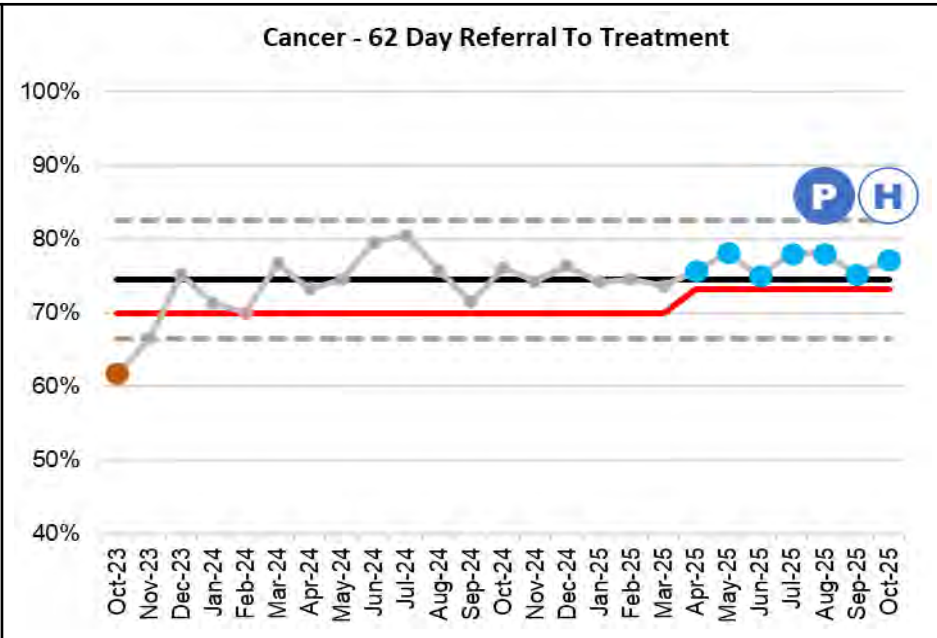
Target
72.7%

Latest Month's Position
63.5%

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
Oct-25

Target
73.2%

Latest Month's Position
77.2%

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 October, however did meet the recovery forecast. The overall treatment volume was above plan and there were more reported breaches. This was driven by Breast and Urology making up 70% of the total breaches.

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

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

Impact on forecast
Return to plan by year-end.

No narrative required as per business rules.

Responsiveness

Last Minute Cancelled Operations

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

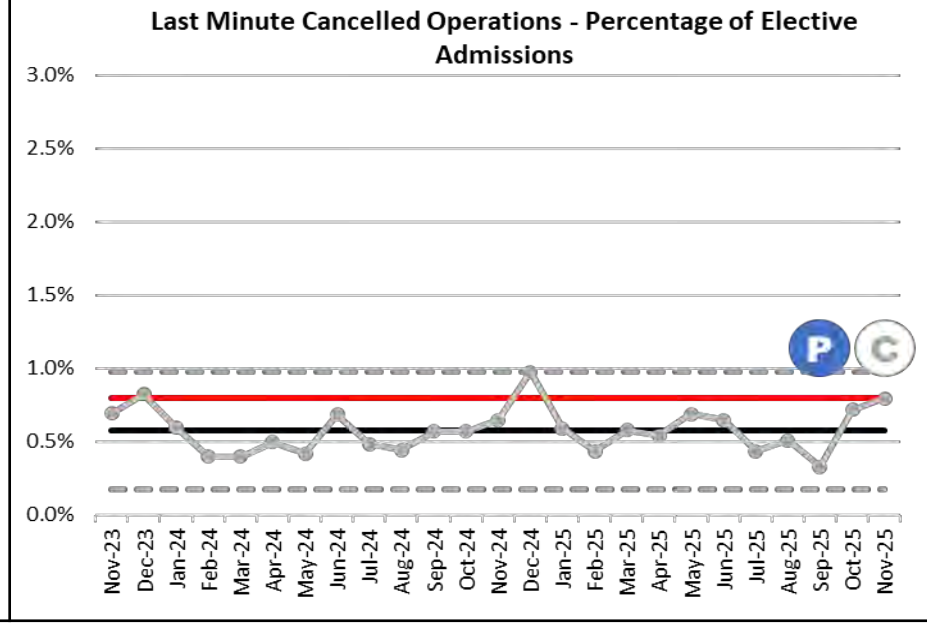
Latest Month
Nov-25

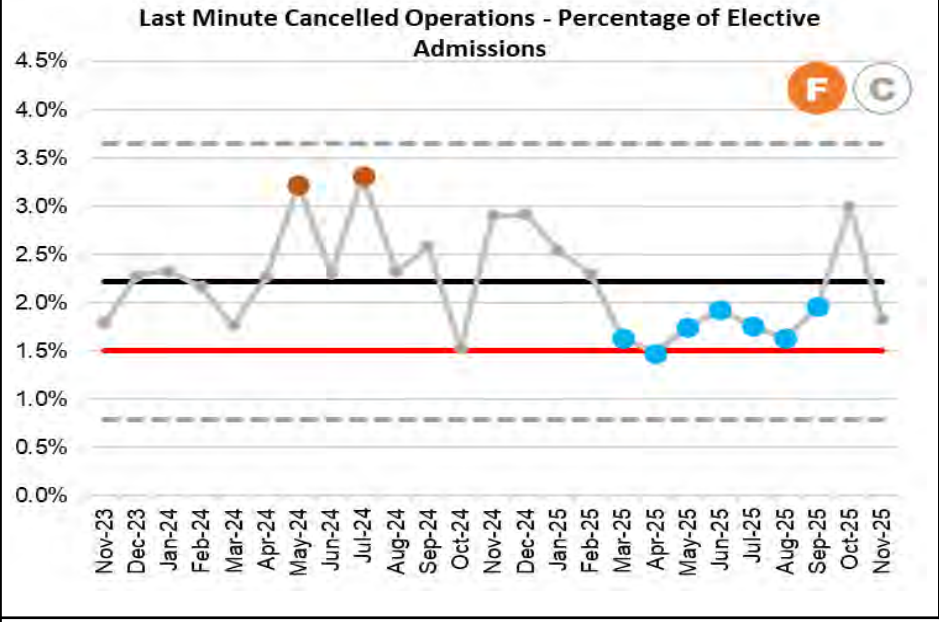
Target
0.8%

Latest Month's Position
0.8%

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
Nov-25

Target
1.5%

Latest Month's Position
1.8%

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

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

No narrative required as per business rules.

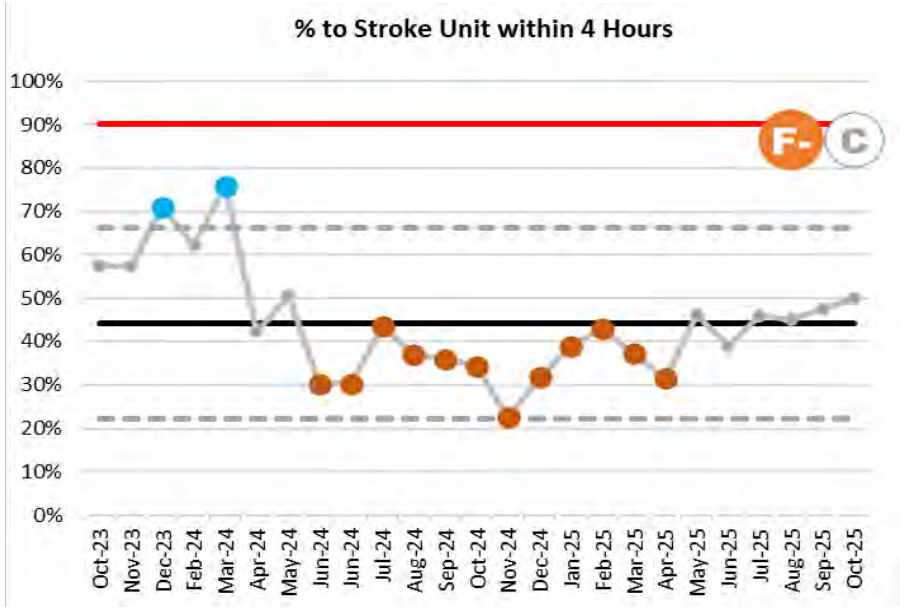
What does the data tell us?
During November 2025, a reduction in Last Minute Cancellations (LMCs) is noted, with 143 cancelled operations (262 October) out of 7,847 total admissions. This equates to 1.8% in November (3.0% October) against a target of 1.5%; 43 related to non-surgical specialties (primarily due to no ward beds) and 100 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 Perioperative Improvement Programme. As part of this Programme, the Trust is 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. A significant factor relating to surgical LMC's is short notice booking and this is part of a workstream trust wide to increase the time prior to pre op and TCI.

Impact on forecast
Continued improvement expected during Q3 and Q4 2025/26 through focussed management as referenced above.

Responsiveness
Stroke Performance - NBT

Latest Month
Oct-25
Target
90.0%
Latest Month's Position
50.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



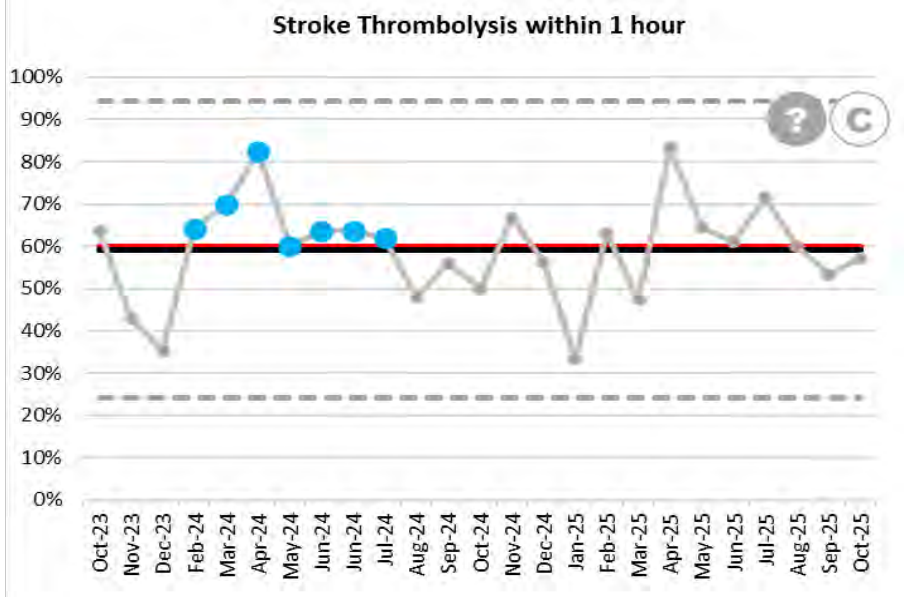
What does the data tell us?
There has been sustained improvement in the proportion of stroke patients admitted to the stroke unit within four hours of arrival for 4 months. Oct 25' the best performing month since May 24'.

Actions being taken to improve
The implementation of the revised flow processes to support timely transfers from the Emergency Department to the stroke unit continues to support patient flow.

The Hot Bed SOP has gone through Stroke and NMSK clinical governance - including consulting with NBT and BRI site teams. Divisional Governance has requested this now go through the OMB due to operational considerations. This will further support the creation of beds on a consistent basis, ensuring availability for new patients.

Impact on Forecast
The improvement plan continues to be rolled out, supported by the Hot Bed SOP. However, performance remains challenged by high bed occupancy (including NCTR patients) and sustained pressure within the Emergency Department.

Latest Month
Oct-25
Target
60.0%
Latest Month's Position
57.1%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub-optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



What does the data tell us?
Performance in October has recovered slightly from the September dip. However, this data is based on a small patient cohort which can influence variability. Data also has not been fully validated for October. There was one DTN over 60 min in October which was due to a valid clinical reason. There is also a continued trend toward considering extended thrombolysis on a case-by-case basis, which often requires additional investigations to support safe and informed decision-making.

Actions being taken to improve
Now that NBT's involvement with TASC has concluded, the aim is to ensure sustained performance. A bi-weekly reperfusion meeting has been stood up to support ongoing actions and further improvement opportunities.

Impact on Forecast
Continued improved performance, achieving the national and site-specific target, as monitored through SSNAP.

Responsiveness

Stroke Performance - NBT

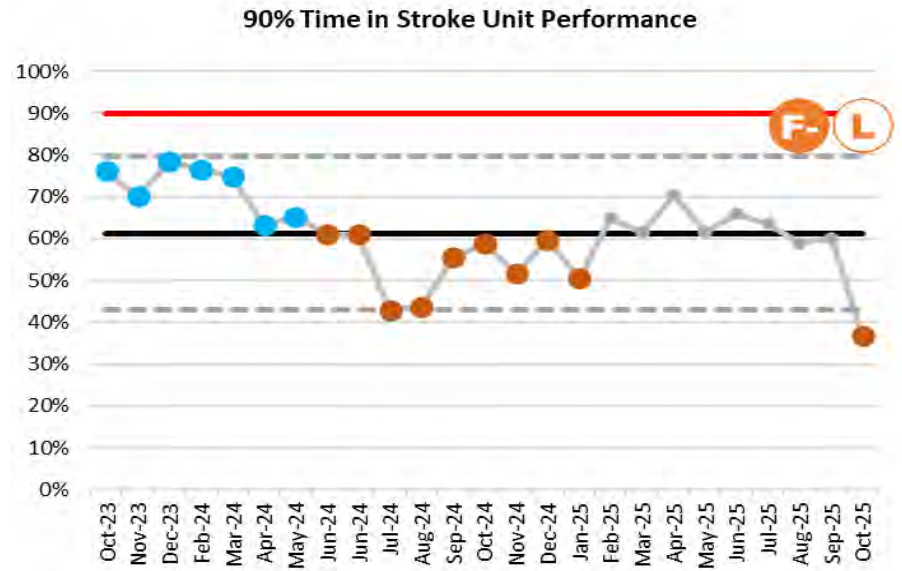
Latest Month
Oct-25

Target
90.0%

Latest Month's Position
36.7%

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

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



What does the data tell us?
Performance has declined heavily in October, however only 50% of October records are locked so we expect this to improve slightly.
However, October represents a large number of patients outlied beyond the stroke ward. This is due to sustained high patient numbers affecting NCTR. Overall stroke occupancy correlates with 90% in stroke unit. The challenge is with community provision, and this has been escalated through the ODG and HCIG through a review of service against the original business case.

Actions being taken to improve
Actions already described in Stroke unit within 4 hours metric – including the Hot bed SOP. System level work began to aid in reducing occupancy levels, this involves engagement from ICB with view to enhancing community provision and releasing acute capacity. Increase in bed numbers at SBCH and more ICSS staff – to support winter pressures and starting in January have been actioned.

Impact on Forecast
Current occupancy levels remain high and we expect the performance to continue to be challenged.

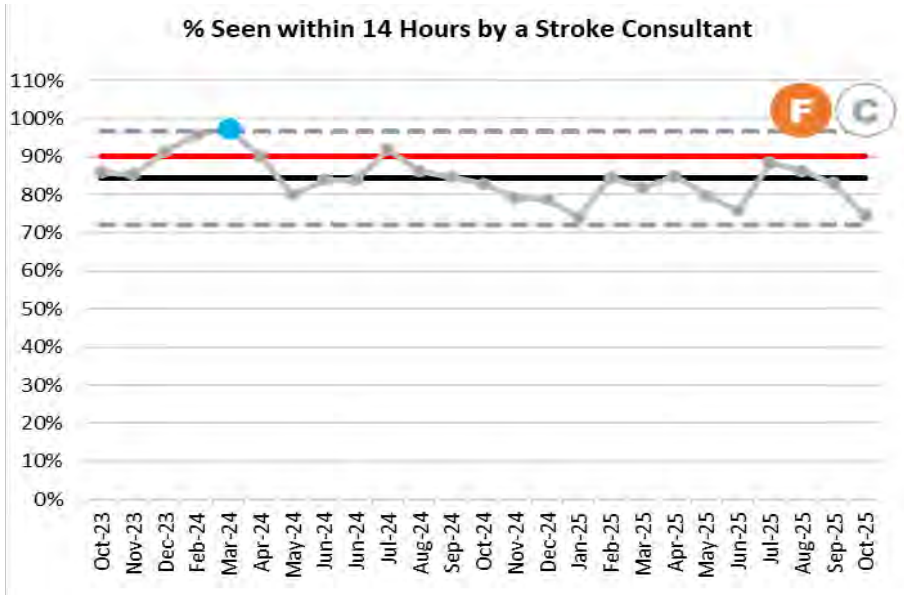
Latest Month
Oct-25

Target
90.0%

Latest Month's Position
74.6%

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

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



What does the data tell us?
There has been a small drop in performance in October for the percentage of patients reviewed by a stroke consultant within 14 hours of admission. Once October data is fully validated we expect this to increase slightly.

Actions being taken to improve
Recent performance has been supported by a more sustainable and consistent consultant rota. The paper admission proforma has been updated and is now in use. A specific consultant review section has been added to allow for clearer data capture when a patient is first reviewed by a consultant. There has been continued delay with the development and subsequent implementation of the new Careflow narrative form. This continues to be escalated and would further improve the accuracy and completeness of data capture for this metric.

Impact on Forecast
We expect slight improvement with the updated paper proforma and further improvement once the Careflow narrative form is in use.

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	Nov-25	0.8	No Target	0.8	N/A	H	Escalation Summary
		UHBW	Nov-25	0.4	0.4	0.1	P*	H	Escalation Summary
Safe	MRSA Hospital Onset Cases	NBT	Nov-25	0	0	0	F	C	Escalation Summary
		UHBW	Nov-25	1	0	1	F	C	Escalation Summary
Safe	CDiff Healthcare Associated Cases	NBT	Nov-25	3	5	7	?	C	Escalation Summary
		UHBW	Nov-25	12	9.08	8	?	C	Escalation Summary
Safe	EColi Hospital Onset Cases	NBT	Nov-25	3	4.00	8	?	C	Escalation Summary
		UHBW	Nov-25	9	9.08	16	?	C	Escalation Summary
Safe	Falls Per 1,000 Beddays	NBT	Nov-25	5.6	No Target	6.0	N/A	C	Note Performance
		UHBW	Nov-25	4.0	4.8	3.9	?	C	Escalation Summary
Safe	Total Number of Patient Falls Resulting in Harm	NBT	Nov-25	9	No Target	4	N/A	C	Note Performance
		UHBW	Nov-25	3	2	2	F	C	Escalation Summary
Safe	Medication Incidents per 1,000 Bed Days	NBT	Nov-25	3.8	No Target	4.5	N/A	L	Note Performance
		UHBW	Nov-25	9.0	No Target	10.0	N/A	C	Note Performance
Safe	Medication Incidents Causing Moderate or Above Harm	NBT	Nov-25	3	0	6	F	C	Escalation Summary
		UHBW	Nov-25	2	0	0	F	C	Escalation Summary
Safe	Adult Inpatients who Received a VTE Risk Assessment	NBT	Nov-25	97.6%	95.0%	97.5%	F-	H	Escalation Summary
		UHBW	Nov-25	80.8%	95.0%	80.9%	F-	C	Escalation Summary
Safe	Staffing Fill Rate	NBT	Nov-25	100.1%	No Target	98.9%	N/A	C	Note Performance
		UHBW	Nov-25	102.6%	100.0%	104.4%	P*	C	Note Performance

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

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
Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	NBT	Jul-25	94.8	100.0	95.1	P*	C	Note Performance
		UHBW	Jul-25	86.7	100.0	85.8	P*	L	Note Performance
Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	NBT	Oct-25	35.7%	No Target	63.6%	N/A	C	Note Performance
		UHBW	Nov-25	48.1%	90.0%	42.5%	F-	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	NBT	Oct-25	96.4%	No Target	100.0%	N/A	C	Note Performance
		UHBW	Nov-25	77.8%	90.0%	97.3%	?	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	NBT	Oct-25	39.3%	No Target	63.6%	N/A	C	Note Performance
		UHBW	Nov-25	37.0%	No Target	42.5%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Inpatient	NBT	Nov-25	90.2%	No Target	90.2%	N/A	C	Note Performance
		UHBW	Nov-25	96.4%	No Target	96.6%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Outpatient	NBT	Nov-25	94.6%	No Target	94.2%	N/A	L	Escalation Summary
		UHBW	Nov-25	93.6%	No Target	94.5%	N/A	C	Note Performance
Caring	Friends and Family Test Score - ED	NBT	Nov-25	77.8%	No Target	69.7%	N/A	C	Note Performance
		UHBW	Nov-25	85.4%	No Target	84.4%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Maternity	NBT	Nov-25	91.5%	No Target	91.1%	N/A	C	Note Performance
		UHBW	Nov-25	98.6%	No Target	98.8%	N/A	C	Note Performance
Caring	Patient Complaints - Formal	NBT	Nov-25	68	No Target	75	N/A	H	Escalation Summary
		UHBW	Oct-25	77	No Target	65	N/A	C	Note Performance
Caring	Formal Complaints Responded To Within Trust Timeframe	NBT	Nov-25	71.2%	90.0%	72.7%	F	L	Escalation Summary
		UHBW	Oct-25	70.0%	90.0%	62.0%	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

Pressure Injuries

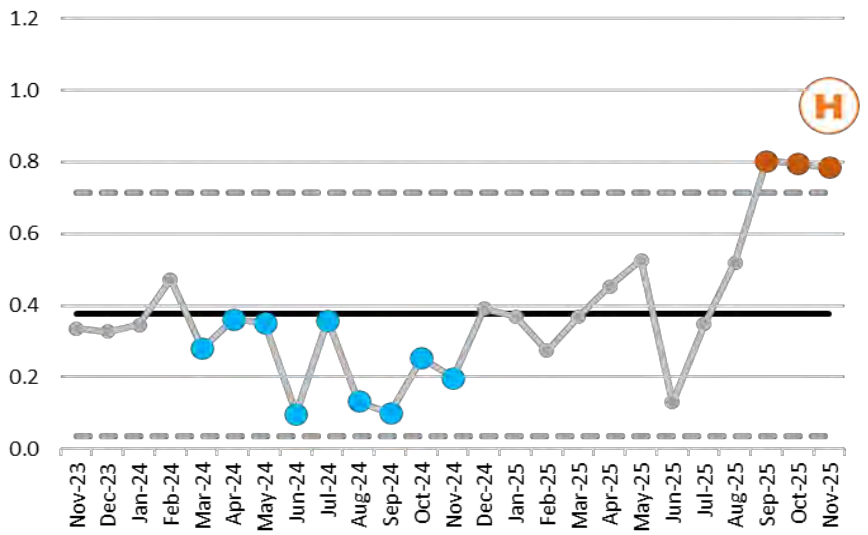
Latest Month
Nov-25

Target
No Target

Latest Month's Position
0.79

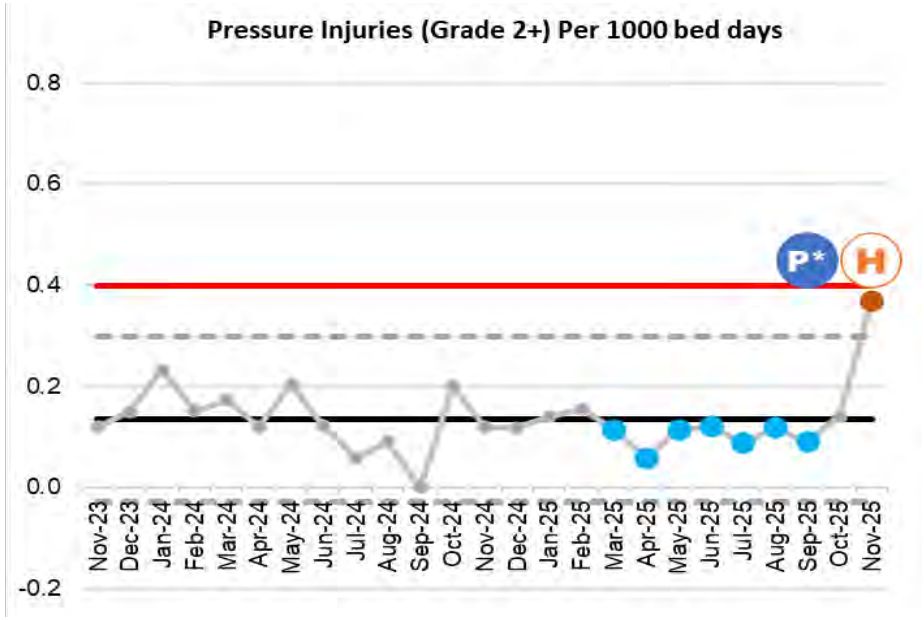
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration but target is greater than upper limit

Trust Level Risk
No Trust Level Risk



What does the data tell us?
• There has been no change in incidence of grade 2 PU within November being the same as October, this performance remains a variation to the norm with ongoing work as detailed below.

Actions taken to improve
• As previously described a sub working group met to explore the increase in PU prevalence, findings from this the following themes have been identified: increase patient acuity with complex co-morbidities and frailty. It has been noted delay in population of risk assessment tool (Purpose-T) not completed with national guidance timeframe. Additionally, gaps identified with documentation within the daily of record of care aSSKINg.
• Analysis of the sub working group has formed work within the divisions to address the above with divisional quality meetings focussing on improvement strategies. Alongside upward reporting to the Trust Tissue Viability Steering Group (TVSG).
• Admission zone work continues around the TVN team supporting clinicians at the front door to support appropriate choice of equipment and daily check and response to operational pressures.
•Divisional representatives will be expected to contribute and present upward reports to the TVSG, outlining identified PU themes and proposed mitigation strategies
• A Bed and Mattress meeting continues with operational themes that require addressing with facilities and divisions.
•**Impact on forecast –** The above actions are currently not resulting in a rapid reduction in PU prevalence, but it is expected following following work within the division and increased targeted education and training.



Latest Month
Nov-25

Target
0.4

Latest Month's Position
0.37

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

Corporate Risk
No Corporate Risk

What does the data tell us? Across the UHBW in November there were three unstageable pressure ulcers (reportable as category 3) one in Weston (posterior knee) one in Specialised Services (buttock) and one in Medicine (coccyx) There were two (device related) category 3 pressure ulcers both in Children's (heel & spine). There were seven category 2 pressure ulcers, two in Medicine (both heels), three in surgery (two heels, one sacrum), one in Weston (elbow), one in Children's (coccyx). November has seen a significant increase in hospital acquired pressure ulcers across all divisions. Whilst there has been a spread of anatomical locations, heel injuries and device related injuries (in paeds) has been a notable theme.

Actions being taken to improve: "Why Wait" heel offloading campaign relaunch – reminding staff of importance using heel offloading as a preventative measure in high-risk groups. Multi-disciplinary After-Action Review scheduled in Children's to cover themes and extract learning from all recent device related pressure injuries. Work underway with all divisions to offer tailored support on themes identified. TVN initiated Pressure Ulcer Care Plan monthly audit continues in Surgery, Weston and Medicine. Results submitted to Divisions at end of each month. Ongoing engagement with TV champions on wards to support good pressure prevention practice, including support, feedback, and wellbeing incentives. TVN Led bi-monthly TV study days rolled out in Bristol with three monthly study days in Weston. Ongoing engagement with TV champions on wards to support good pressure prevention practice, including support, feedback, and wellbeing incentives. Monthly Tissue Viability newsletters focusing on key themes each month and delivering key messages to staff. Individualised Christmas Newsletter for ED staff to support with "hints & tips" for pressure area care in ED during winter months. Bite size teaching to follow in Feb as part of rolling ED "Topic of the Month".

Impact on Forecast: The actions above aim to reduce the number of hospital acquired pressure ulcers through ongoing and targeted training and education and auditing of ward-based pressure ulcer care planning to monitor and support divisional compliance.

Quality

Infection Prevention & Control

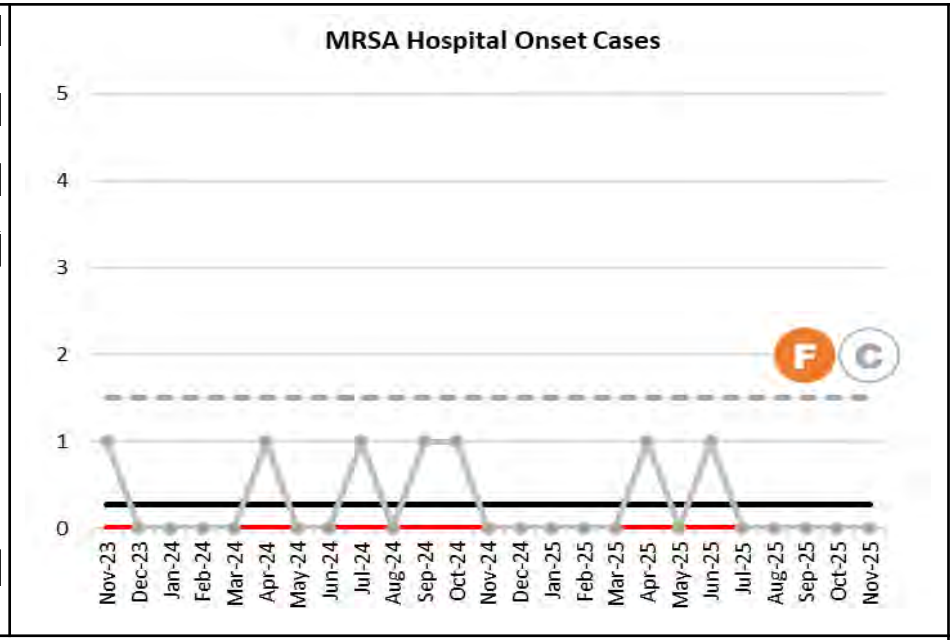
Latest Month
Nov-25

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

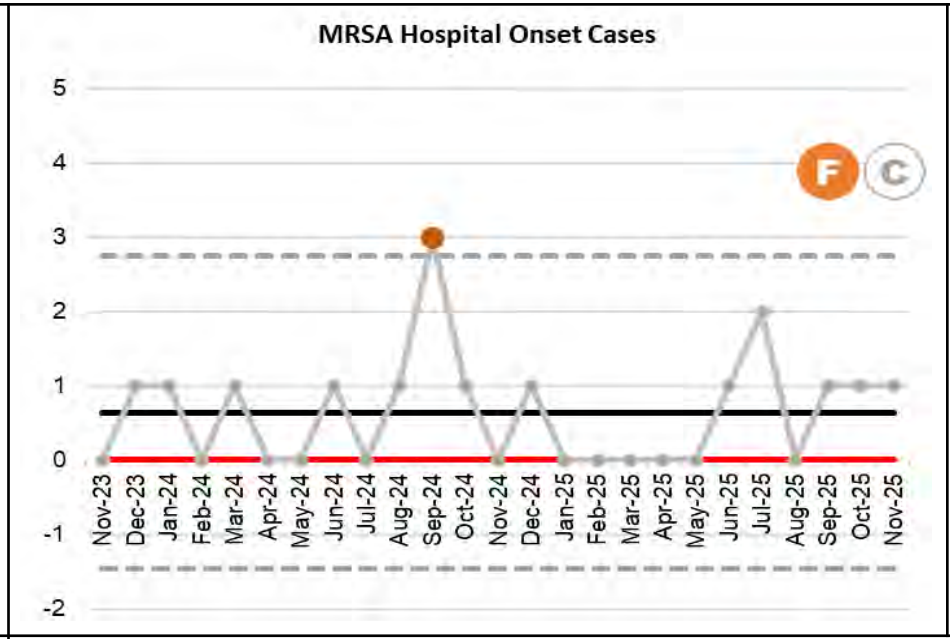


What does the data tell us?
With no new cases reported in November this totals two this year to date.

Actions taken to improve
The HCAI improvement and reporting group continues to have oversight and monitor potential risk factors. Work is continuing on influencing factors surrounding screening and decolonisation, This has resulted in a sustained improvement with no further MRSA cases .

NBT are 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 as well as learn from other trusts and ICBs.



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

What does the data tell us?
UHBW reported one MRSA bacteraemia in November bringing total cases for 2025/26 to six. We are currently at the same position for year to date in 2024/25.

Actions being taken to improve
A meeting to externally scrutinise all of these cases is being held in December 2025. A continued focus remains around intravenous line care which has been cited as sub-optimal in some of the cases. There is an intravenous care quality improvement group looking at standardised line care and actions for improvement.

Impact on forecast
UHBW has already breached the zero-threshold limit . We aim to work with our colleagues in NBT to learn from their successes.

Quality

Infection Prevention & Control

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

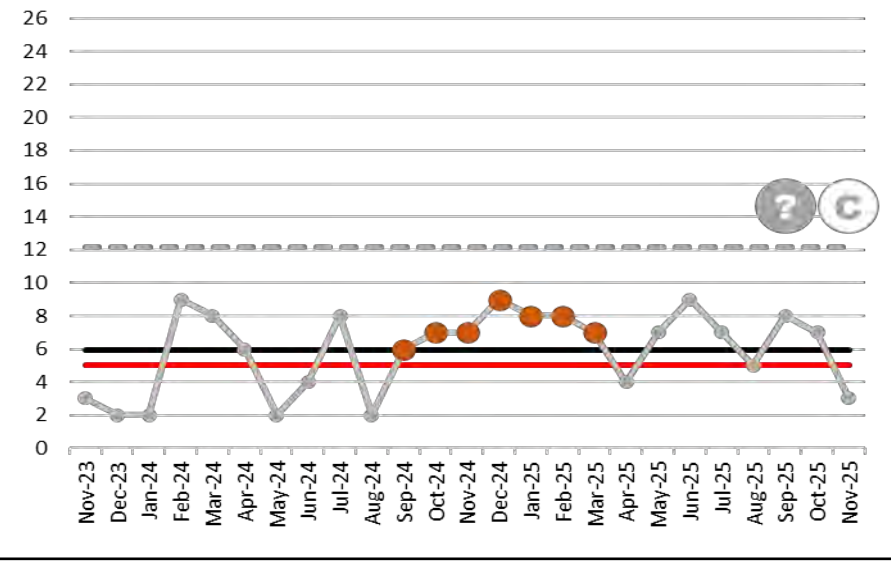
Latest Month
Nov-25

Target
5

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

Trust Level Risk
No Trust Level Risk



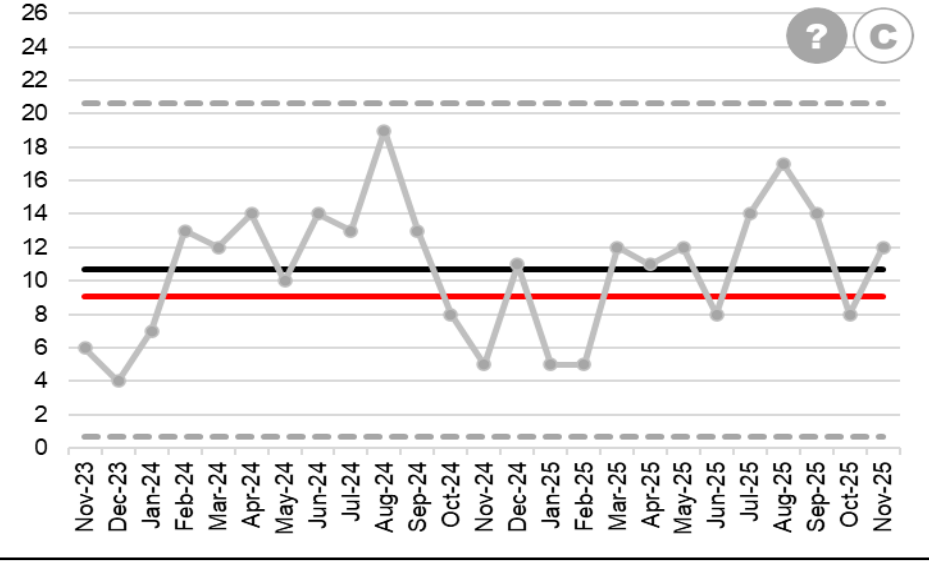
What does the data tell us?
Cases in November - 4 HOHA and 5 COHA - cases need to trend at 6 or lower monthly to match a trajectory position. The current position is trending slightly below the trajectory.
Total position so far this year 75 cases of a trajectory of 79

Actions being taken to improve
C.difficile ward rounds have seen improvements in the management of positive cases.

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

Education on sampling has been a strong focus that has been picked up through the divisional work to ensure timely sampling and correct use of sample stickers.

Work also taking place through AMS pharmacist looking at appropriate prescribing of antibiotics as these are the kept themes



Latest Month
Nov-25

Target
9.08

Latest Month's Position
12

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

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

What does the data tell us?
The trust reported12 *C. difficile* cases in November; the breakdown is 8 HOHA and 4 COHA cases.
Current position is 96 cases (66 HOHA 30 COHA) against a threshold limit of 109.

Actions being taken to improve
Improvement work continues to be focussed on timely, accurate stool chart completion and prompt stool sampling to identify cases and therefore reduce the possibility of cross infection and patient harm in the clinical environment.

Investigations are currently underway after a cluster of cases were identified on a gastroenterology/hepatology ward where potential cross-transmission has occurred. Rigorous additional cleaning and staff training has been undertaken in this area and further ribotyping results are awaited to determine further actions.

Quality

Infection Prevention & Control

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

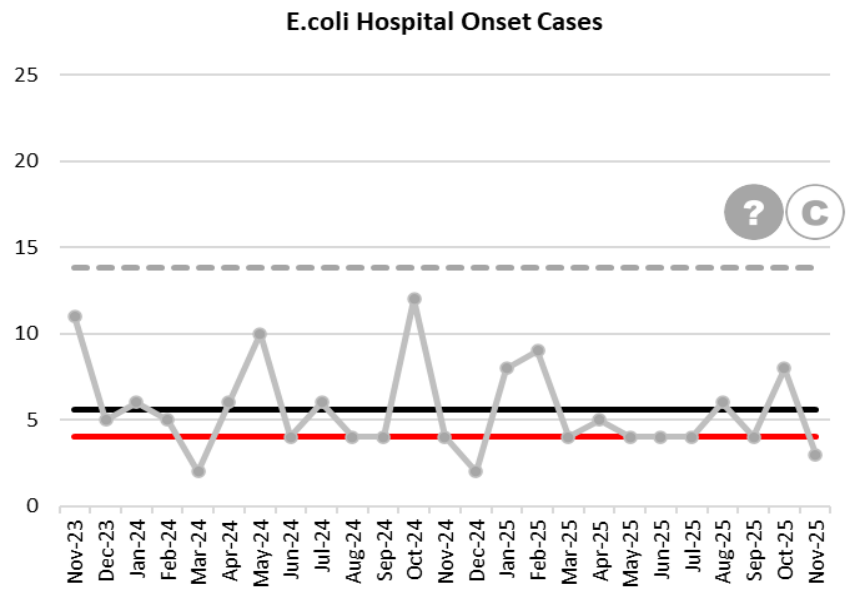
Latest Month
Nov-25

Target
4

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

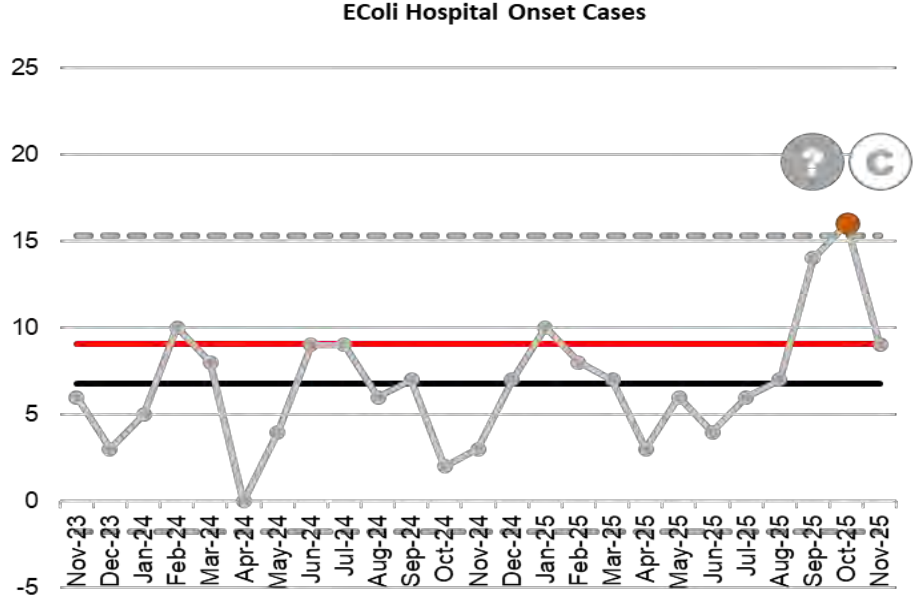
Trust Level Risk
No Trust Level Risk



What does the data tell us?
Cases have historically been below trajectory with this year seeing a rise, analysis is taking place with this likely to be attributed to the increase of urinary catheter related infection.

Actions being taken to improve
Work in place to look at analysis of themes with case reviews. This will then establish a work plan; this has also been aided by a catheter audit**.**

Impact on forecast
Threshold has increased but unlikely to exceed trajectory , but scope for improvement noted.



Latest Month
Nov-25

Target
9.08

Latest Month's Position
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
No Corporate Risk

What does the data tell us?
The trust reported nine cases of *E. coli* bacteraemia in November bringing our year-to-date figure to 65. This is an increase on our position in November of 2024/25 which was at 46 cases.

Actions being taken to improve
We are currently undertaking a 3-month look back to determine whether there are any themes associated with the increase in cases. Initial reviews indicate that the main sources remain hepatobiliary and urinary in source. The urinary source is not predominantly associated with catheter use.

Impact on forecast
Likely to exceed annual threshold.

Quality

Falls

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

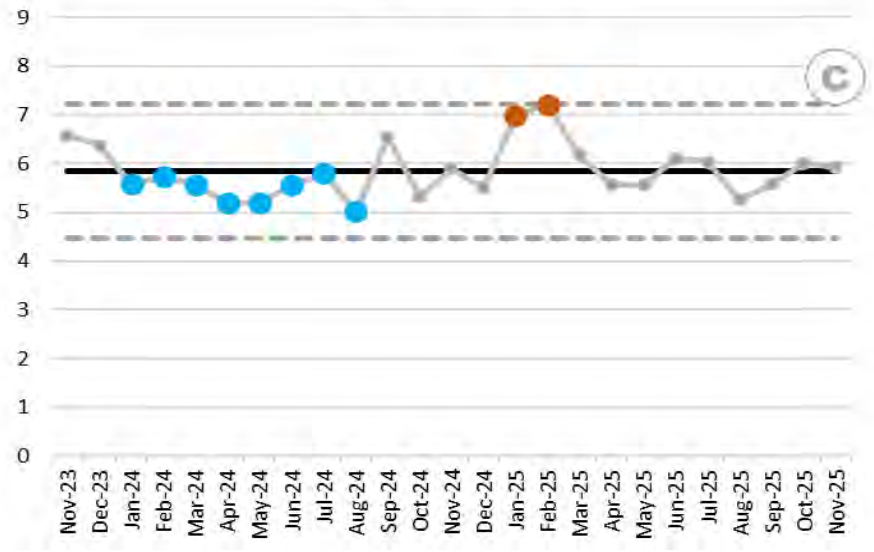
Latest Month
Nov-25

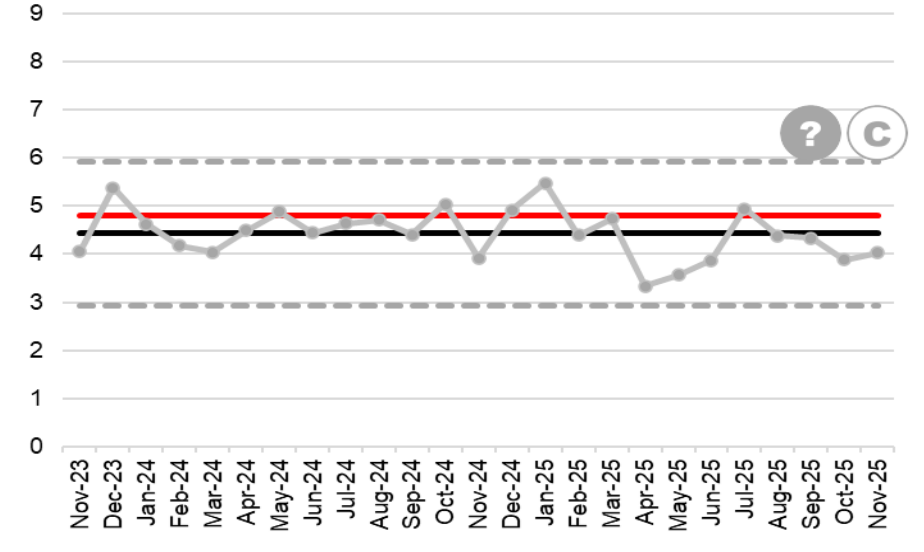
Target
No Target

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
Nov-25

Target
4.8

Latest Month's Position
4.0

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

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

No narrative required as per business rules.

What does the data tell us

During November 2025 at UHBW there have been 132 falls, which per 1000 bed days equates to 4.091, this is lower than the Trust target of 4.8 per 1000 bed days. There were 87 falls at the Bristol site and 45 falls at the Weston site. There were three falls with moderate physical and/or psychological harm.

The number of falls in November 2025 (132) is less than October 2025 (137). There were three falls with moderate harm, 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...

Quality
Falls

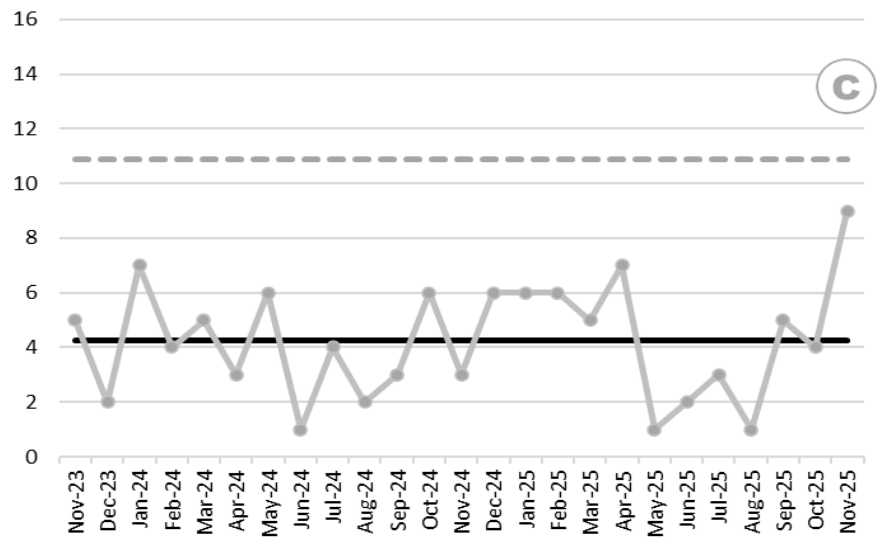
Latest Month
Nov-25

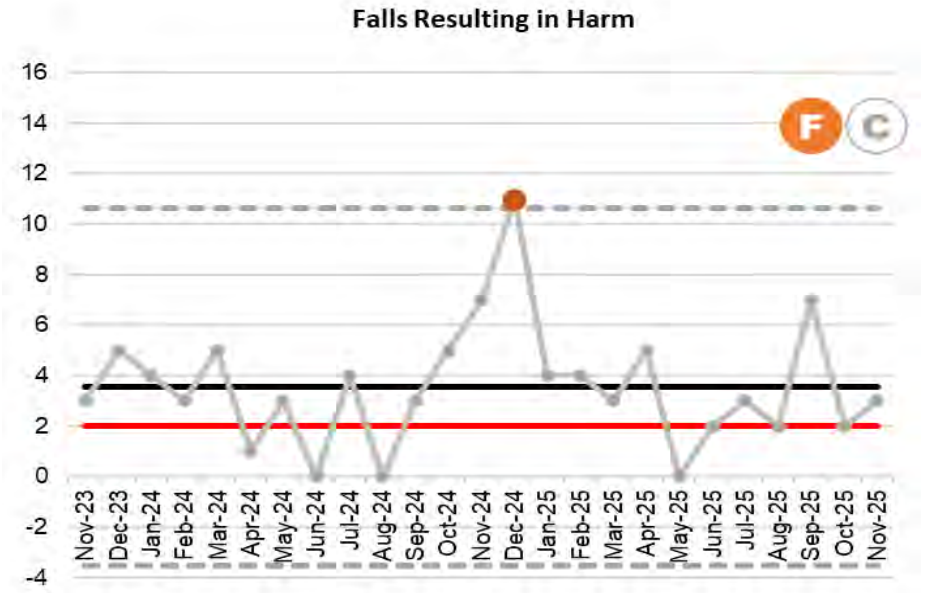
Target
No Target

Latest Month's Position
9

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
Nov-25

Target
2

Latest Month's Position
3

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 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

- Quality improvement projects for the next 12 months have commenced, these include consistent use of Abbey pain scale, improving nutrition and hydration for persons with dementia and working on a falls management plan for non-inpatient areas.
- Audit: We continue to participate in the National Audit of Inpatient Falls and National Audit of Dementia.
- We are reviewing and updating the Trust Falls policy and associated documents over the next couple of months and will reflect the updated NICE (NG249) guidance in the revised version.
- Training -The DDF Steering Group provides an education component, bitesize education sessions are delivered to the group on relevant topics. The DDF team continue to deliver education sessions and simulation-based training.

Impact on forecast

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

Quality

Medication Incidents

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

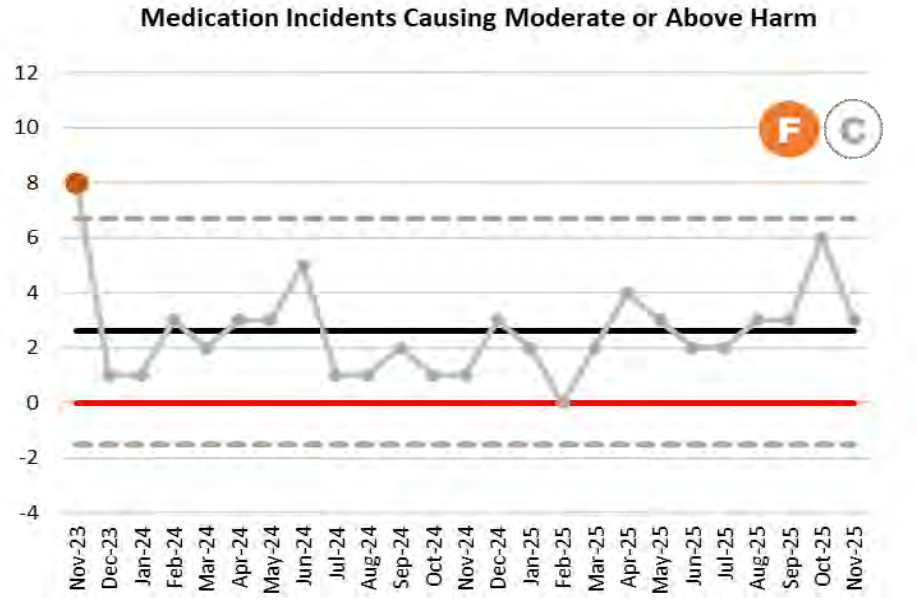
Latest Month
Nov-25

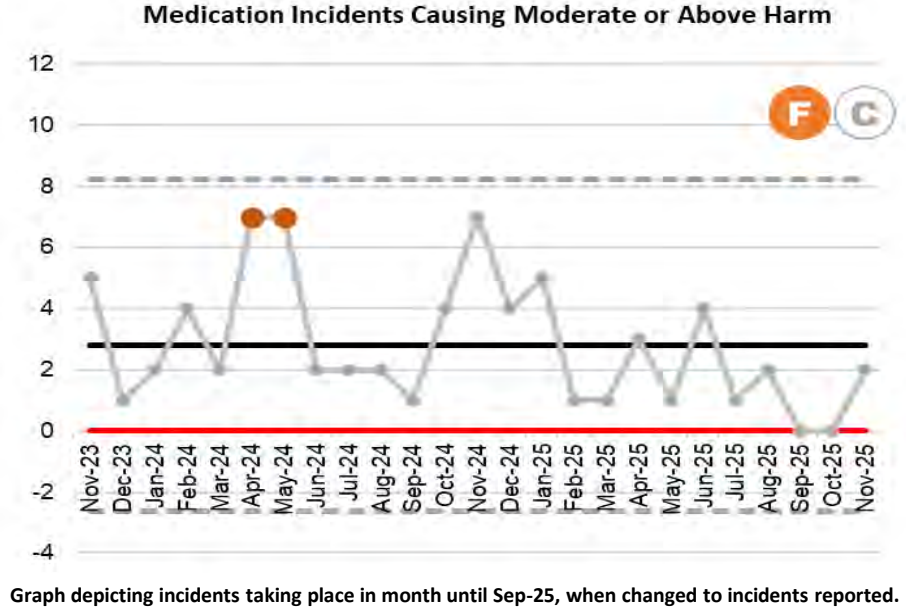
Target
0

Latest Month's Position
3

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

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





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

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

What does the data tell us?
During November 2025, NBT recorded 122 medication incidents involving patients of these, three medication incidents were reported as causing moderate harm to a patient.

This figure is significantly lower than last month but on processing this data a potential issue with the Radar reporting was noted (incidents not being tagged as involving a patient in the report when they were in the incident narrative). Radar team are currently working on this and if necessary figures for this month will be retrospectively altered and resubmitted in January.

Actions being taken to improve
Safe and secure handling of medicines audits undertaken in November by the Medicines Governance Team. These also served as an opportunity to speak to ward staff about medicines management challenges.

The Medicines Governance team are also working closely with the CMM team to identify any emerging themes or trends in terms of incidents which may be related to changes in process following the CMM go live.

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

What does the data tell us?
During November 2025, UHBW recorded 296 medication-related incidents. Two medication incidents were reported as causing moderate or above harm. One further incident is currently undergoing additional harm validation. If harm has occurred this will be reported in next month's report. The dataset pre-April 2024 is based on previous harm descriptors in place in the Trust. The data indicates a good reporting culture with few harm incidents compared to number of incidents.

Actions being taken to improve
Incidents related to the prescribing and administration of subcutaneous syringe drivers on CMM have led to a multiprofessional safety review recommending CMM changes be completed and a Trust wide safety alert to raise awareness of the new risks identified. 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.

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

Quality

VTE Risk Assessment

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

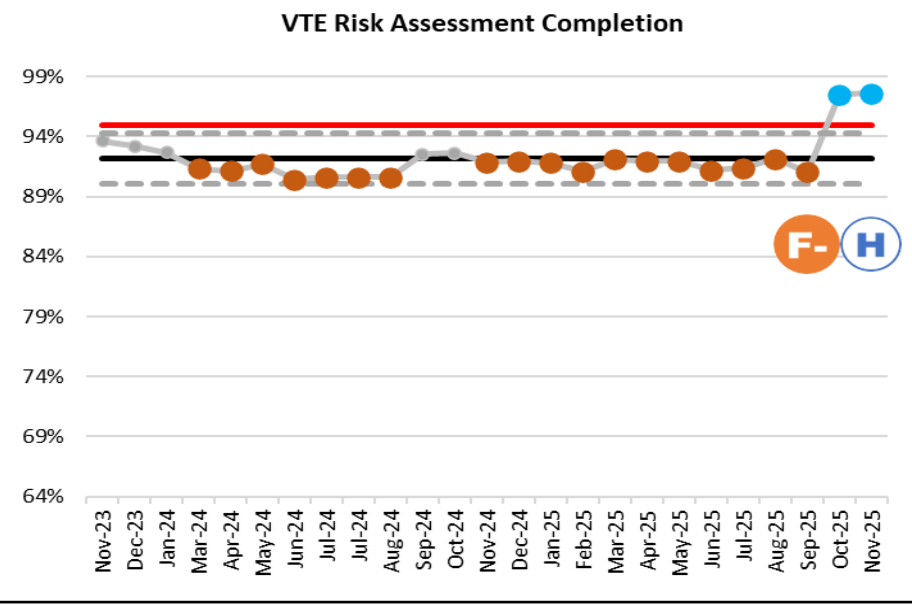
Latest Month
Nov-25

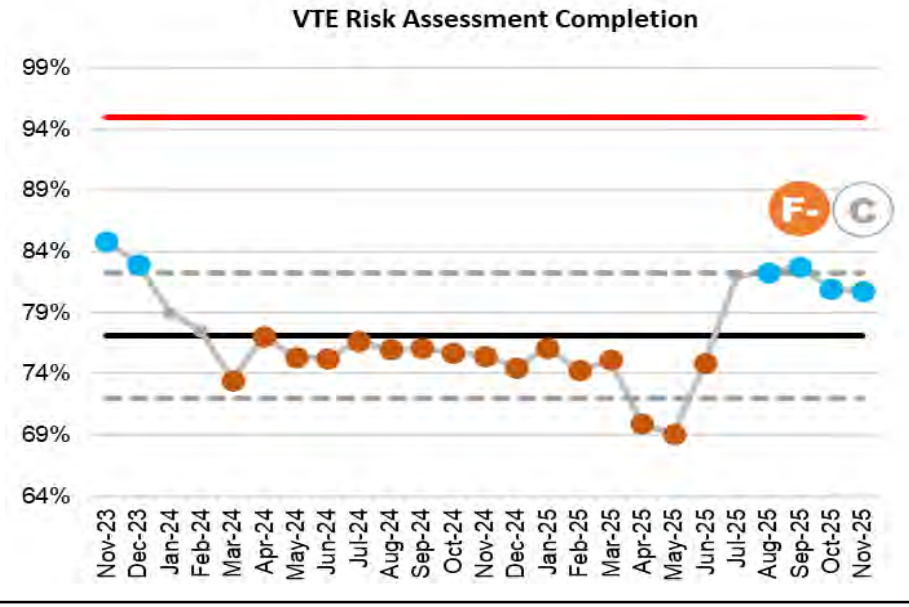
Target
95.0%

Latest Month's Position
97.6%

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

Trust Level Risk
No Trust Level Risk





Latest Month
Nov-25

Target
95%

Latest Month's Position
80.8%

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

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

What does the data tell us?

In October 2025, electronic prescribing, CMM, was introduced to the Trust

- A 'forcing' measure was introduced –prescribing unavailable until VTE RA was completed
- This forcing measure only applies to inpatient wards

Moving to a digital interface for administration, does not make it 'clear' which drugs have been prescribed – they are not grouped by type or colour coded, as with a paper drug sheet, and we have noted omissions in prescribing of VTE prophylaxis, resulting in VTE events

- As per UHBW we are also looking at ways that it can be seen that' VTE thromboprophylaxis has been prescribed'

Actions that are being taken to improve both VTE RA and prescribing of thromboprophylaxis:

- Ward-Level interventions, included:
  - Direct engagement with staff on wards;
  - Reminders about the importance of thromboprophylaxis
  - Encouragement to question omissions in prescribing.

Impact on forecast:

This graph is only showing those patients who have a VTE RA done – but not within the first 14 hours (as per NICE) . As we are now able to capture this data.

We expect the change in data collection will influence the figures in a negative way, while we work with the clinical teams to encourage timely VTE RA completion

What does the data tell us?

At UHBW since CMM implementation in June 2025, VTE risk assessment (RA) rates have improved by around 10% to around 80%. We have noted that there is a missing link between VTE RA and actually prescribing VTEP which is a concern that we are working to improve.

Actions being taken to improve

- As of 10th Nov 25, VTE RAs have become mandatory on AMU (initially not mandatory to allow for emergency prescribing on CMM)
- Working with IT to have VTE RA and VTEP prescribing visible on ward boards again following CMM – chasing up regularly
- Teaching session for F1 and F2 Dr's on VTE on Dec 10th
- Plan to arrange teaching sessions for nurses and HCAs to question if VTEP is not prescribed

Impact on forecast

We anticipate completion rates to increase further as admission through AMU is often the first step of a patient's journey in hospital, and by allowing PAs to complete VTE RAs as well and then prompt prescribers to prescribe VTEP. The ward boards will allow for targeted interventions. The teaching session will be a good starting point to remind Jr Dr's about the importance of VTE RAs and prescribing.

NHS North Bristol NHS Trust

Quality

Neck of Femur

NHS University Hospitals Bristol and Weston NHS Foundation Trust

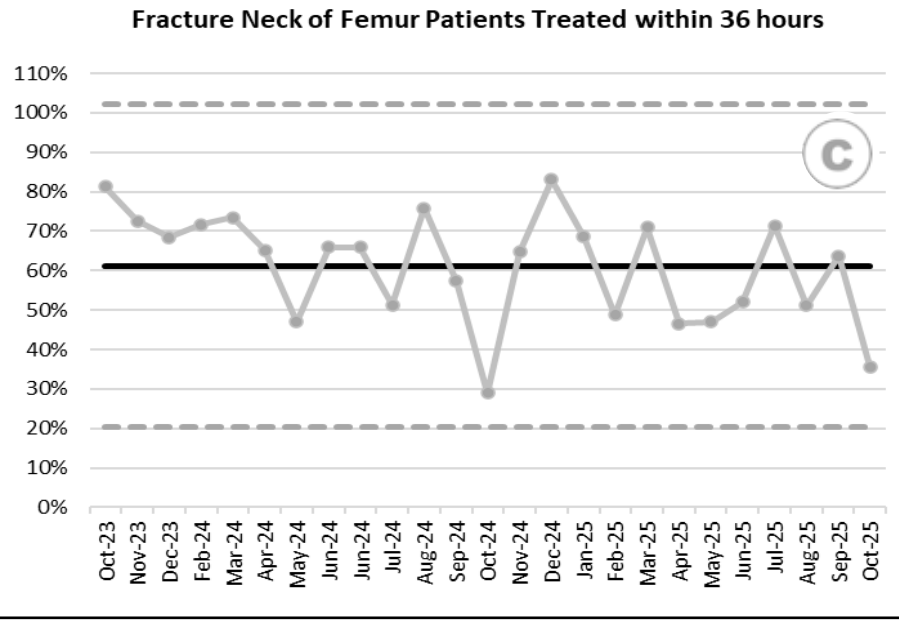
Latest Month
Oct-25

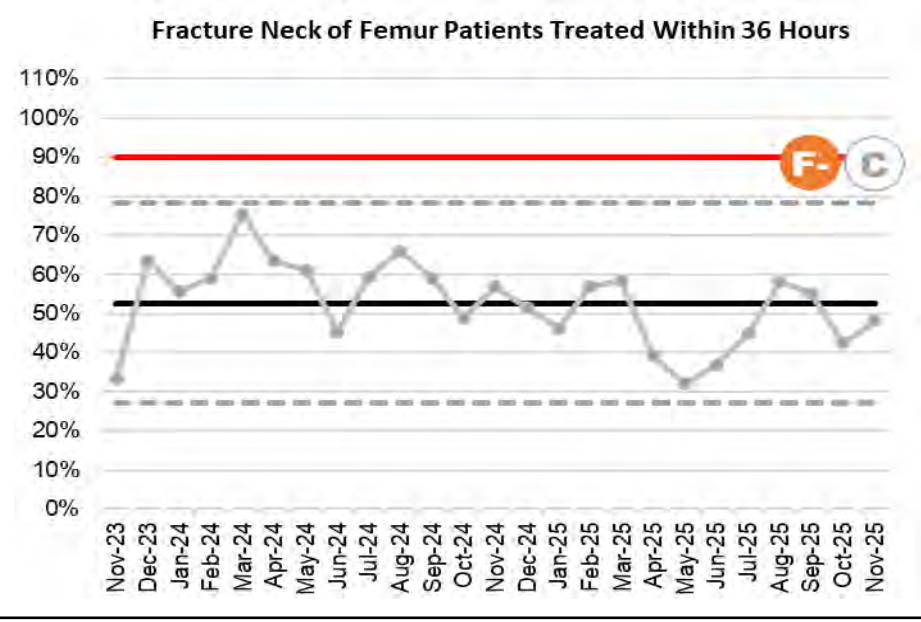
Target
No Target

Latest Month's Position
35.7%

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

Trust Level Risk
No Trust Level Risk





Latest Month
Nov-25

Target
90.0%

Latest Month's Position
48.1%

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?

In November, 54 patients were eligible for the best practice tariff (BPT), 26/54 patients (48%) were operated on within 36 hours of admission, 42/54 patients (77%) received ortho-geriatric assessment within 72 hours, resulting in 20/54 patients (37%) met all BPT criteria.

Actions being taken

- Extra theatre space is created where possible to reduce theatre delays

Impact on forecast

- When it is possible to create extra theatre capacity risk of delayed surgery for patients with fractured neck of femur can be reduced.

NHS North Bristol NHS Trust

Quality

Neck of Femur

NHS University Hospitals Bristol and Weston NHS Foundation Trust

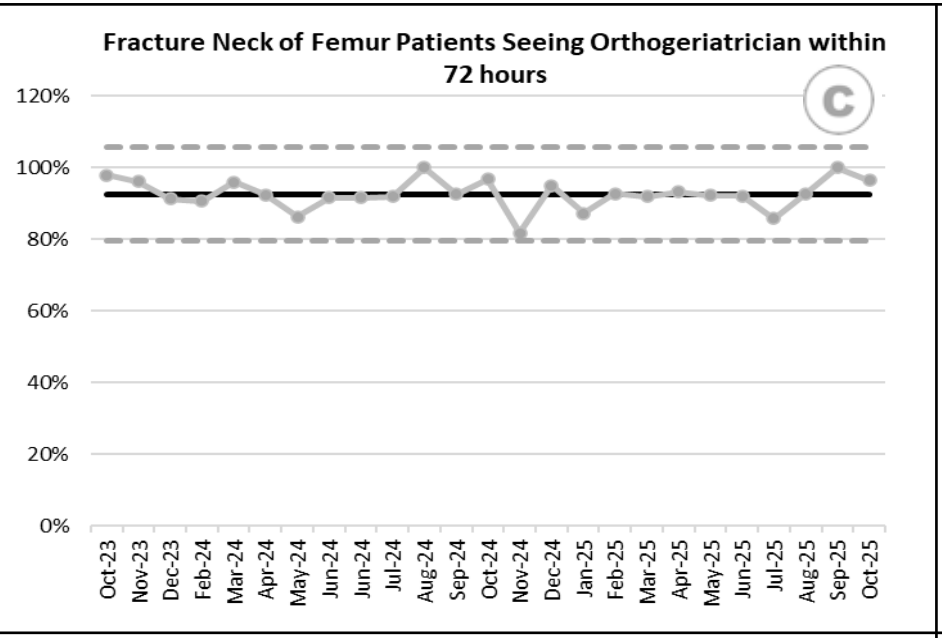
Latest Month
Oct-25

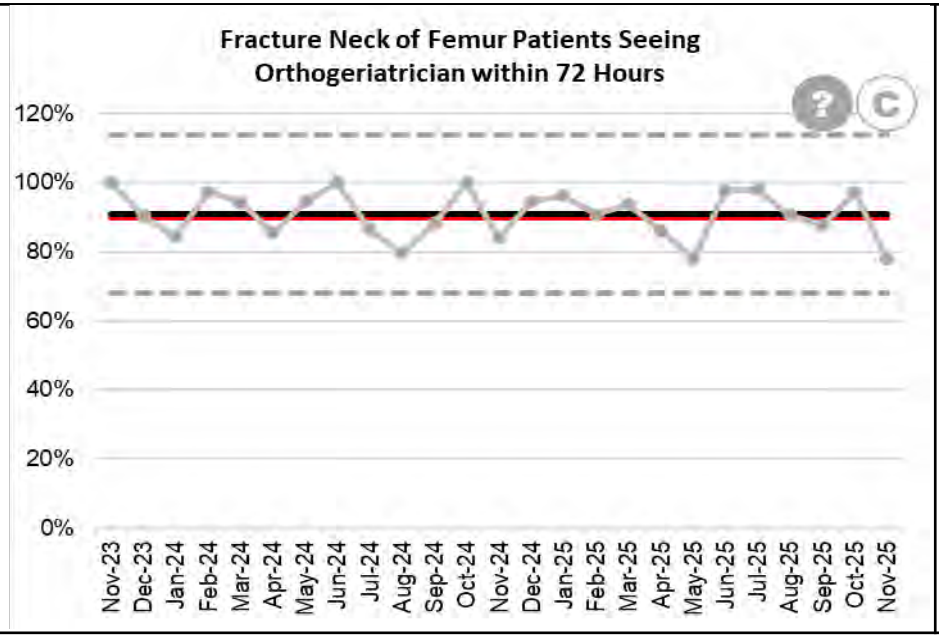
Target
No Target

Latest Month's Position
96.4%

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
Nov-25

Target
90%

Latest Month's Position
77.8%

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?
42/ 54 (77%) of patients received ortho-geriatric (OG) assessment within 72 hours. At the Bristol site one patient missed the 72 hr target as they were in theatre having surgery during OG morning rounds (weekend admission & Surgery Monday morning). At the Weston site the remaining 13 patients did not receive an ortho-geriaction review within the 72 hour target.

Action being taken
No new actions identified.

Impact on forecast
The presence of only one part-time geriatrician at Weston remains a persistent constraint especially during periods of high demand Additional high weekend admissions and OG staffing constraints at the BRI contributed to the second 72-hour OG compliance loss this month. This staffing limitation is likely to continue impacting BPT performance unless additional geriatric support is secured

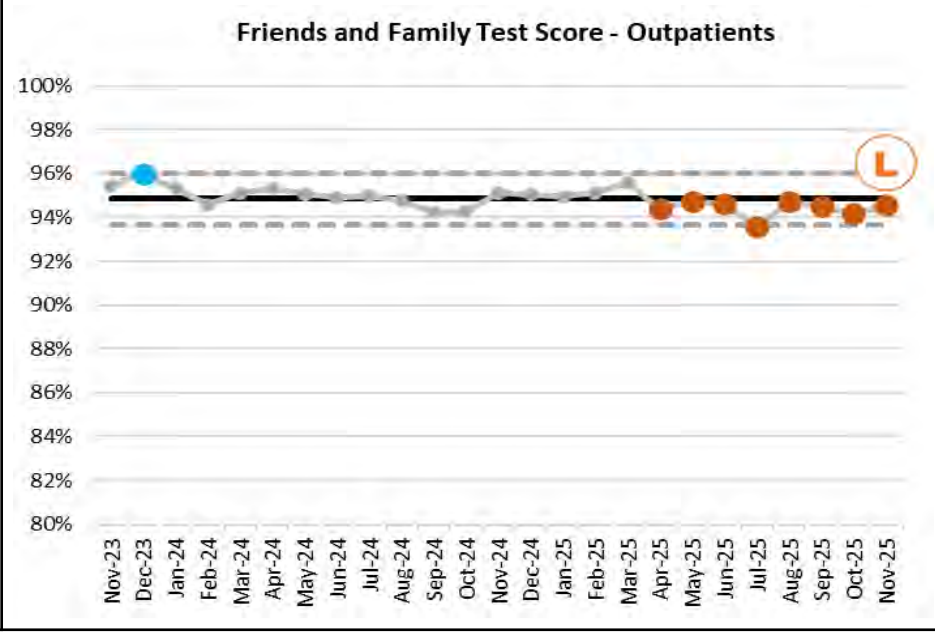
Latest Month
Nov-25

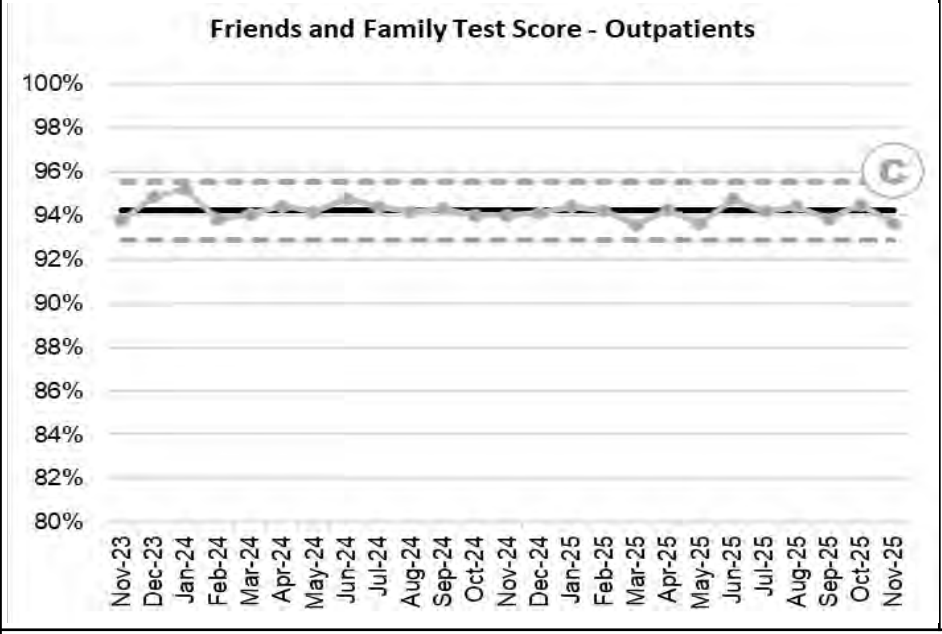
Target
No Target

Latest Month's Position
94.6%

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

Trust Level Risk
No Trust Level Risk





Latest Month
Nov-25

Target
No Target

Latest Month's Position
93.6%

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

Corporate Risk
No Corporate Risk

What does the data tell us?

- The Outpatient FFT score (total % of patients rating their experience as 'Very good' or 'Good') has remained lower than expected, though has improved from last month to 94.6% in November.
- The top negative theme identified in comments is 'Waiting time', followed by 'Communication'.
- Though the positive response ratings have decreased, they do remain very high. The negative response ratings remain consistent and below the Nationally reported average.

Actions taken to improve

- We are continuing to monitor results to identify any areas where improvements can be targeted.
- Improving Patient Experience – Customer Care training to become essential to role / targeted intervention for hotspot areas with negative feedback regarding communication and/or staff behaviour.

Impact on forecast

- It is difficult to predict, given the current pressures the Trust faces and that 'Waiting time' is a major factor in negatively reported experiences.

No narrative required as per business rules.

Quality

Complaints

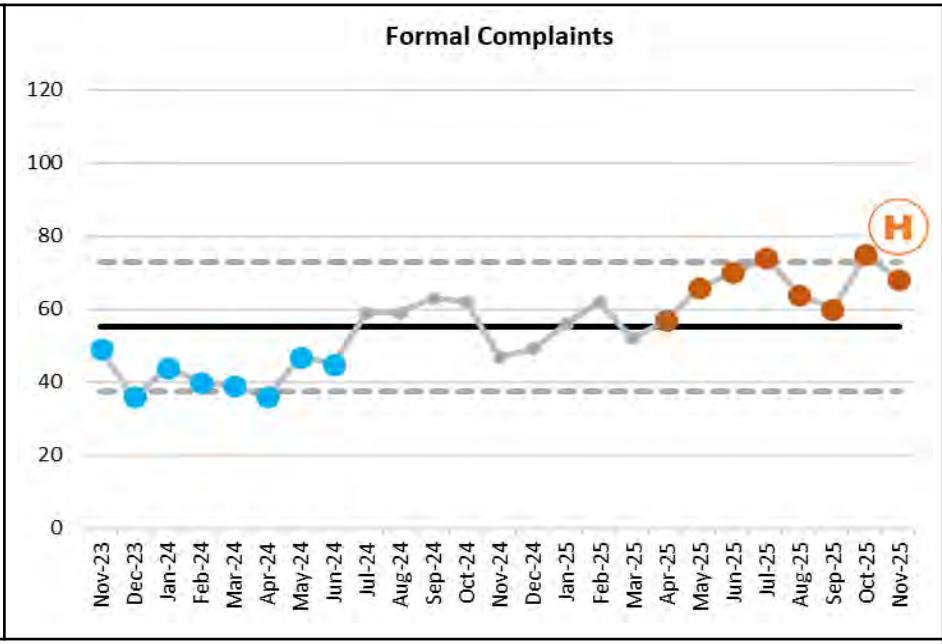
Latest Month
Nov-25

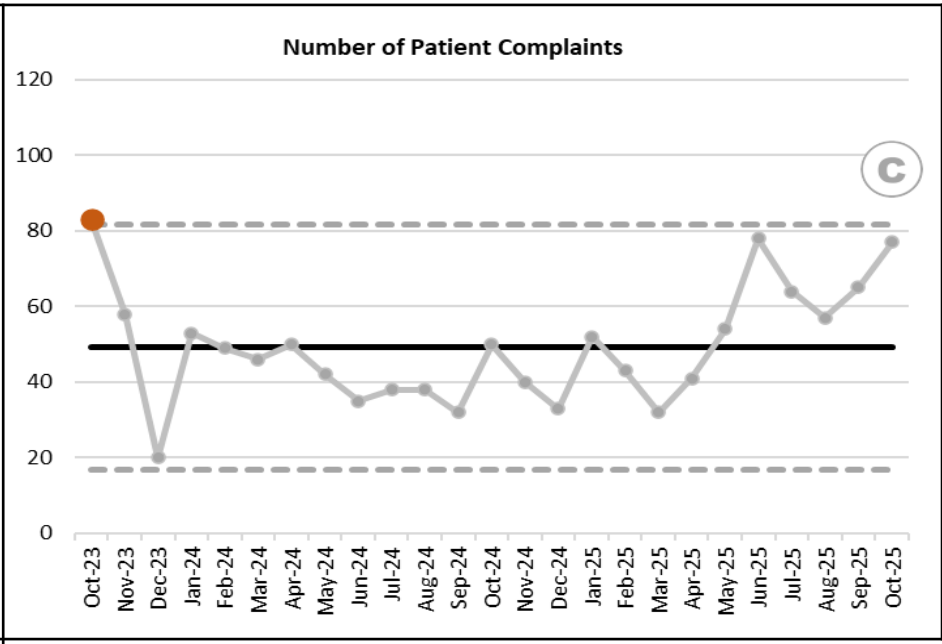
Target
No Target

Latest Month's Position
68

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

Trust Level Risk
No Trust Level Risk





Latest Month
Oct-25

Target
No Target

Latest Month's Position
77

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

Corporate Risk
No Corporate Risk

What does the data tell us?

- In November, the Trust received 68 complaints, which was 7 less than the previous month.
- Since April, the average number of complaints received per month has been 66.
- Urology (8) received the most complaints, followed by General Surgery (7), Emergency Medicine (6), Care of the Elderly (5), Gynaecology (5) and Maternity (5). The remainder of the complaints were spread across 20 other specialties.
- Clinical Care and Treatment was the most selected lead theme of the complaints received.
- We have not seen a decrease in the number of PALS concerns received that correlates with the increase in complaints. The number of PALS concerns received in November was 164, which is 3 more than the average since April.

Actions being taken to improve
We will continue to monitor, keeping a close eye on any spikes in particular services or areas.

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

No narrative required as per business rules.

NHS North Bristol NHS Trust

Quality

Complaints

NHS University Hospitals Bristol and Weston NHS Foundation Trust

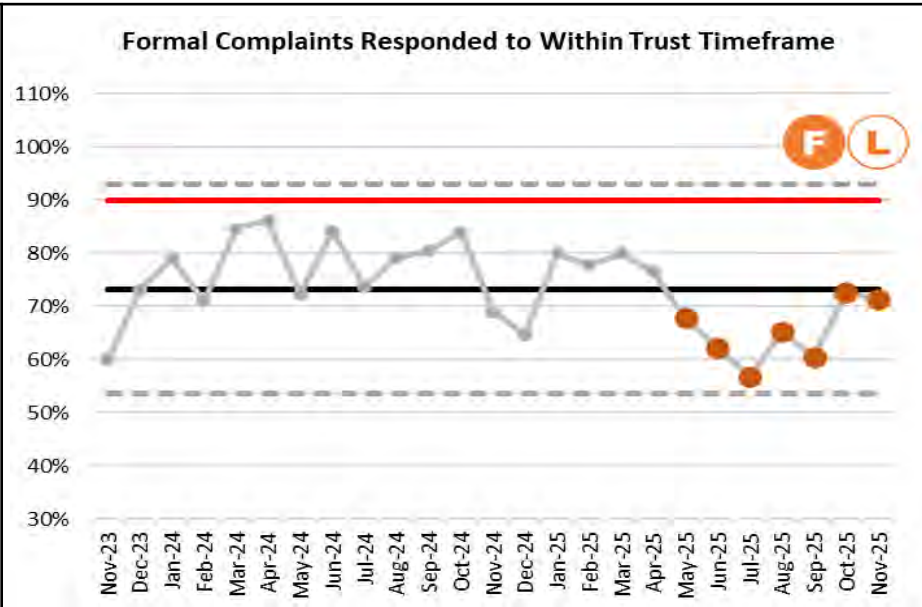
Latest Month
Nov-25

Target
90.0%

Latest Month's Position
71.2%

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?

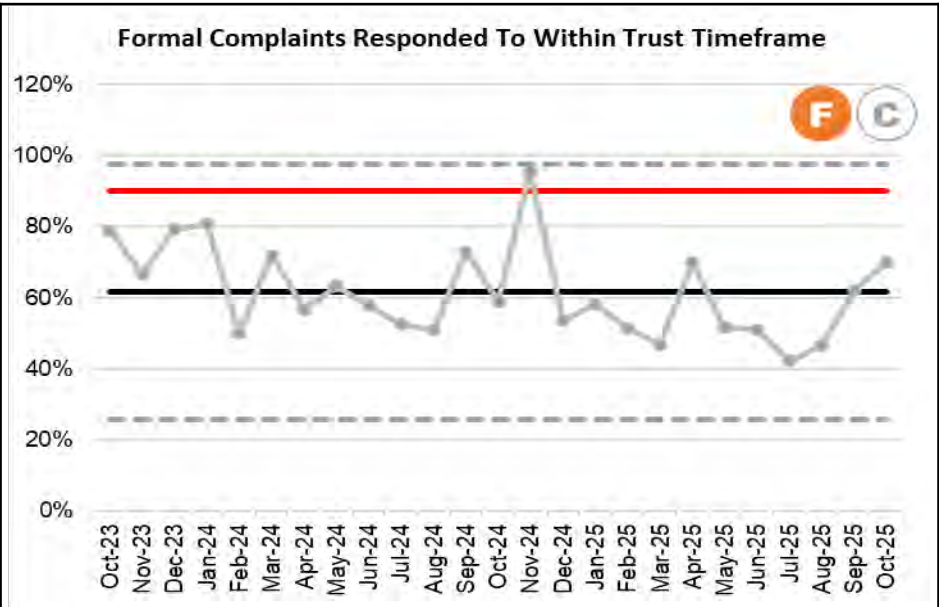
- The compliance rate decreased from 73% in October to 71% in November.
- Of the 73 complaints due for response in November, 52 were closed within the agreed timescale, 16 were outside the agreed timescale, and 5 were still open at the time of reporting.

Actions being taken to improve

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

Impact on forecast

The sustained improvement, for the second month running in the ASCR compliance score (71%), has contributed to the overall Trust compliance remaining above 70%. Compliance scores continue to be monitored across all divisions.



Latest Month
Oct-25

Target
90.0%

Latest Month's Position
70.0%

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

Corporate Risk
No Corporate Risk

What does the data tell us?

- Compliance rate improved from 60% in September to 70% in October.
- Of the 90 complaints responded to in October, 63 were closed within the agreed timescale and 27 were outside of the agreed timescale.
- Consistent improvement over the last 4 months is a result of the removal of any complaint backlog and the focus within the Divisions to respond in a timely manner.

Actions being taken to improve

- The PALS and Complaints team continue to process complaints in a timely manner, ensuring the Divisions have an appropriate timeframe to respond.
- Executive sign off members increased to ensure timely sign off and response to the complainant.

Impact on forecast

Performance is expected to continue to improve as the process is embedded and the Divisions respond to the backlog of complaints. The response rate will plateau once the large volume of complaints have been responded to and we maintain the timely efficient complaint response process now in place. This is expected by the end of Quarter 4.

NHS North Bristol NHS Trust

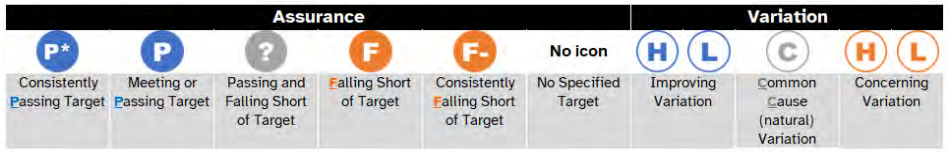
Our People

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
Well-Led	Workforce Turnover (Rolling 12-month)	NBT	Nov-25	9.9%	11.3%	9.8%	N/A*	N/A*	No Commentary
		UHBW	Nov-25	9.5%	11.1%	9.5%	N/A*	N/A*	No Commentary
Well-Led	Vacancy (Vacancy FTE as Percent of Funded FTE)	NBT	Nov-25	8.0%	5.1%	8.1%	F-	C	Escalation Summary
		UHBW	Nov-25	4.6%	4.0%	4.3%	?	H	Escalation Summary
Well-Led	Sickness (Rolling 12-month)	NBT	Nov-25	4.8%	4.4%	4.7%	N/A*	N/A*	Commentary
		UHBW	Nov-25	4.5%	4.5%	4.5%	N/A*	N/A*	No Commentary
Well-Led	Essential Training Compliance	NBT	Nov-25	88.1%	90.0%	89.9%	?	L	Escalation Summary
		UHBW	Nov-25	89.6%	90.0%	90.1%	?	C	Escalation Summary

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



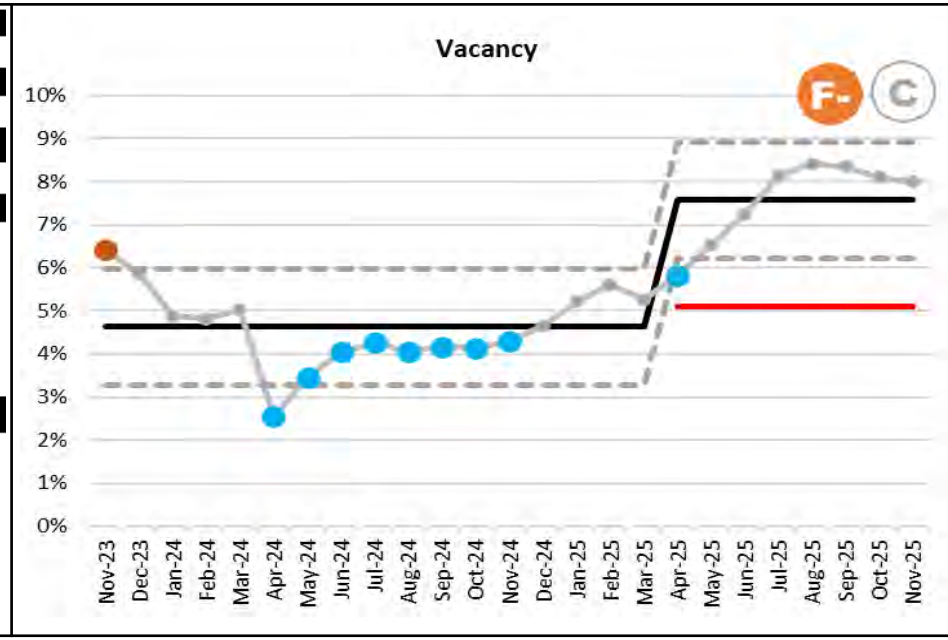
North Bristol NHS Trust

Our People

Vacancies

University Hospitals Bristol and Weston NHS Foundation Trust

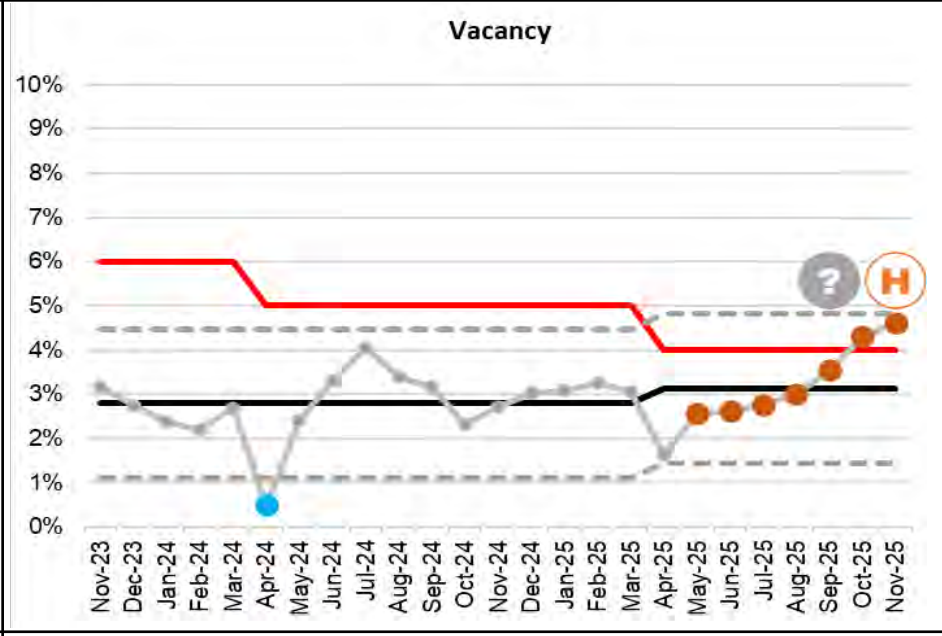
Latest Month
Nov-25
Year End Target
5.1%
Latest Month's Position
8.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk
Risk 1979 - There is a risk to our clinical teams and services due to the inability to recruit into vacant specialist medical roles (16)



What does the data tell us?
- Vacancies reduced in November (-15.9 fte). Reductions in Healthcare Support Worker vacancies has been greatest by volume with an increase of 11 wte staff in post.
- Review of our current position against year end target (set in previous years operational planning) is in progress

Actions being taken to improve
- **HCSW Supply** – Trust wide and tailored (hard to recruit) Health Care Support Worker (HCSW) assessment centres for scaled up candidate selection. Trust wide advert is **currently live** with Assessment Centre booked for early **Feb-26**.
- **Youth-focused outreach:** Launching a targeted campaign to promote the HCSW career pathway to young people, featuring a recruitment video to be shared with local education providers. Group wide campaign live - **Mar-26 outreach starting Apr-26**
- **Enhanced visibility and engagement:** Apprenticeship advert currently live on Gov.uk website for HCSW apprenticeship route. Planned social media promotion through **Jan-26**. Further social media campaign to showcase the role of the HCSW and the career pathway available aligned with Commitment to out Community priority – **live Feb-26**

Impact on forecast
- **45** HCSW starters in **Nov-25 and Dec 25**. 25 wte anticipated to start in December which will yield approximate net gain of 18 wte. Current Pipeline is **81** HCSWs undergoing checks - **41** have booked start dates for **Jan-26**



Latest Month
Nov-25
Year End Target
4.0%
Latest Month's Position
4.6%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
Risk 8383 - Risk that inability to recruit and retain specialist staff continues (16)

What does the data tell us?
- Vacancy rate increased to 4.6% in November, an increase of 38.7 FTE
- The 25/26 plan required a headcount reduction of 300 wte (with phased investments phased of 158 wte) Impact of vacancy freeze shows in the vacancy position, not yet reflected in adjusted funded establishments.
- Specialised Services vacancy increased to 5.2% from 2.8% (Oct 25), attributable to a budget increase of 18.7 FTE and a staff in post reduction of 14.9 FTE. Primarily driven by changes in BHOC Oncology/Haematology – linked to the BHOC growth case, and plan to operationalise the South Bristol element of the investment.

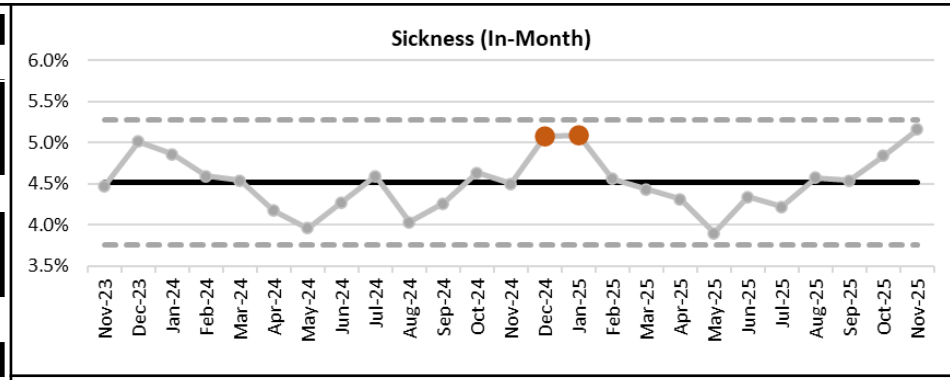
Actions being taken to improve
- **Monitoring of vacancy position through Divisional and SDR processes to avoid increased temporary staffing**
- **HCSW Supply** – Assessment centres, advert **live** with Assessment Centre early **Feb-26**.
- **Youth-focused outreach:** Targeted campaign to promote HCSW career pathway to young people, recruitment video to be shared with local education providers. Groupwide campaign live **Mar-26. outreach Apr-26**
- **Enhanced visibility and engagement:** Apprenticeship advert live on Gov.uk for HCSW apprenticeship route. Social media promotion through **Jan-26**. Social media campaign – **live Feb-26**

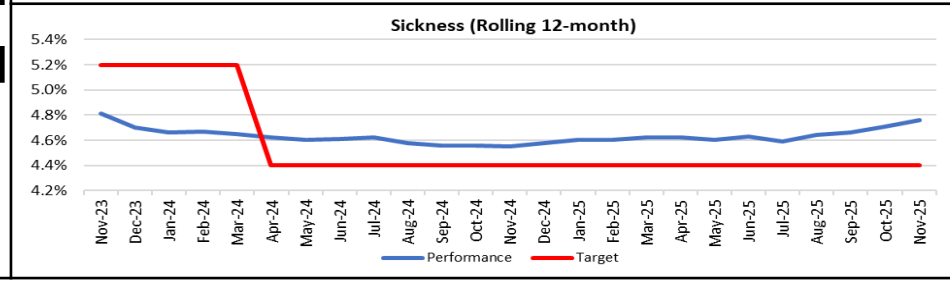
Impact on forecast
- SBCH posts are being recruited. Staff require chemo skills, can take upto 3 months of training, Recruits likely to be pulled from BHOC with little external interest. Delays in opening SBCH additional capacity due to Estates works means the unit should be fully operational Mar/ Apr 26., enabling the workforce supply.

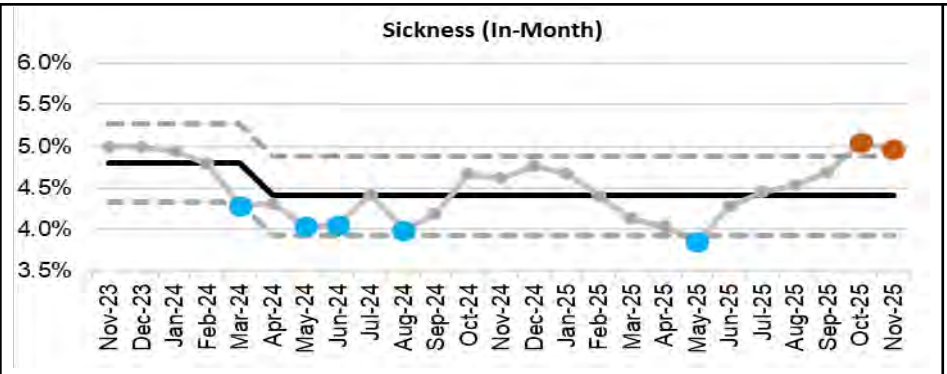
Our People

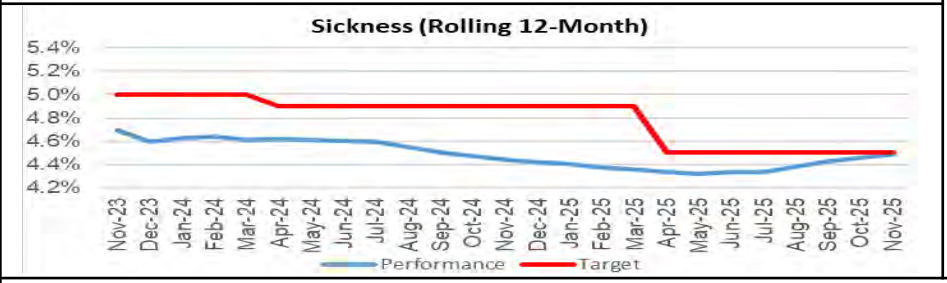
Sickness Absence

Latest Month
Nov-25
Latest Month's Position Rate (In-Month)
5.2%
Latest Month's Position Rate (Rolling 12-Month)
4.8%
Target
4.4%
Trust Level Risk
No Trust Level Risk









Latest Month
Nov-25
Latest Month's Position Rate (In-Month)
5.0%
Latest Month's Position Rate (Rolling 12-Month)
4.5%
Target (Rolling 12-month)
4.5%
Corporate Risk
No Corporate Risk

What does the data tell us?

- Current position continues to be driven by long term absence – in month absence rates having risen for the last three consecutive months with November's position at 2.83%, higher than last November (2.51%)
- Cough/Cold/Influenza remained saw a sharp rise in October and November, short term rates are in line with last year whilst long term rates are higher

Actions being taken to improve

People Systems and Data Team

- Diagnostic of use of 'Other Known Reasons' - **Action plan Q4 2025/26**

People Advice Team

- Analysis on long term absence reasons to understand what is contributing to longevity across the Trust **- Dec 25.**
- Review return to work process to allow early identification and triangulation of absence causes and effective approaches for management - **Feb 26**
- Robust review and management of sickness cases via divisions with oversight of these reported at DPR - **ongoing**

Staff Experience Team

- Fatigue Risk Management (FRM) Project with objective to reduce fatigue, improve staff health and wellbeing and improve patient safety – expected impact on Stress/Anxiety/Depression absence over 18 months – **launch Jan-26**
- Menopause train the trainer training delivered to refresh pool of trainers to deliver training to managers and leaders - **Dec-25**

Impact on Forecast

- Impact primarily on long term absence duration to bring down absence rates – analysis in progress to quantify – **Jan-26**

Metric meeting target.

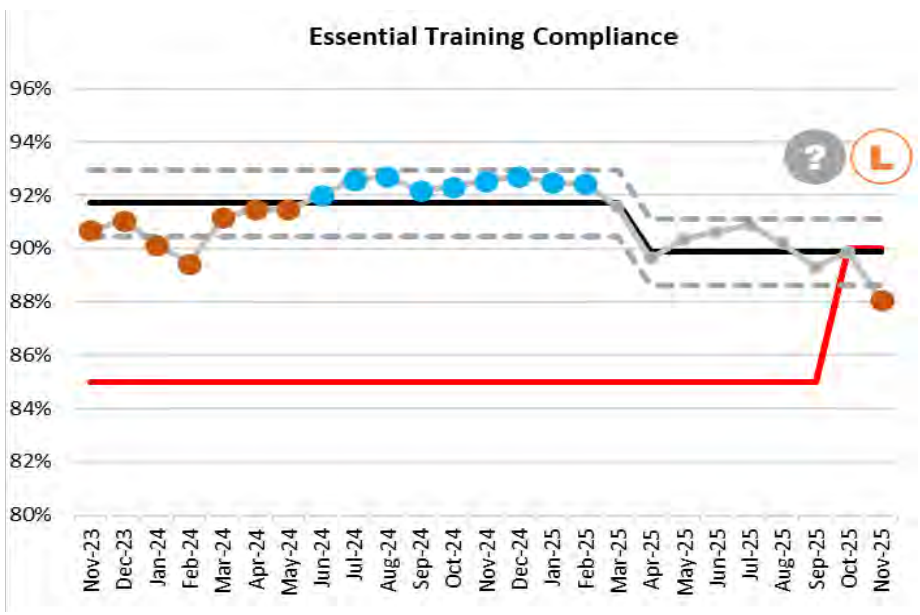
Our People

Mandatory and Statutory Training

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Month
Nov-25
Target
90.0%
Latest Month's Position
88.1%
Oliver McGowan Tiers 1 and 2 Virtual / Face to Face
26.7%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk



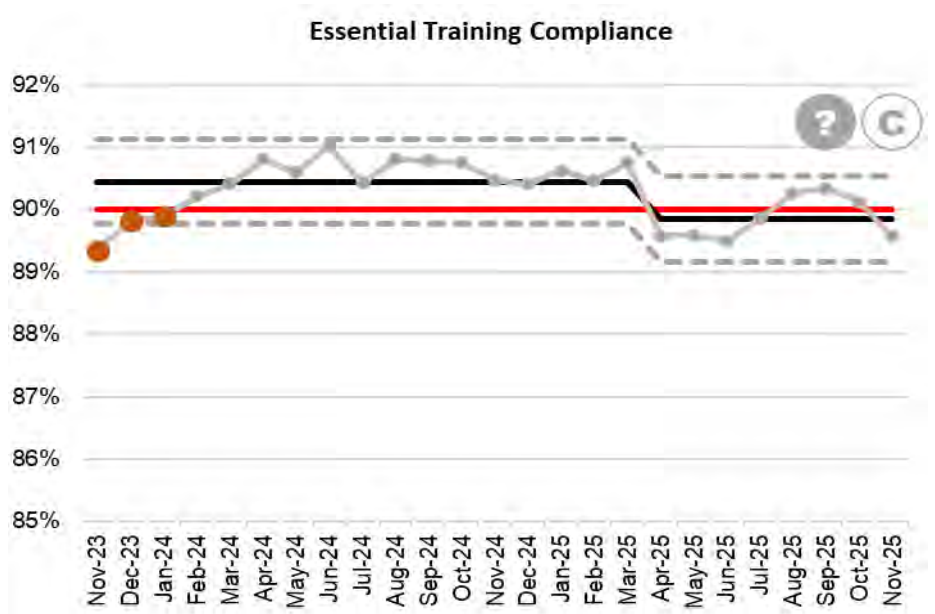
What does the data tell us?
Compliance is below the target overall, being driven by specific areas, most notably for: Infection Prevention and Control (IPC) at 82.88%, Information Governance (IG) at 84.65%, and Oliver McGowan (OMMT) level 1 (eLearning) combined rate at 85.84%. OMMT Level 2 face to face/Level 1 Virtual compliance 26.7% against Mar-26 ICB target rate of 63.3%

Actions Being Taken to Improve

- **IPC**: In Nov-25 NBT moved to national requirement of annual level 2 training for clinical staff, and non-clinical staff completing the level 1 IPC training. Compliance oversight is via quarterly Infection Control Assurance Group with all divisions – **Jan-26 (next meeting)**
- **IG:** Compliance rate meets national mandatory Data Security & Protection Toolkit (DSPT) 'appropriate understanding' standards. Compliance is promoted via Cyber Essential controls, regular Data Security & Awareness training within corporate induction, executive updates, and targeted campaigns, e.g., imminent communication highlighting recent cyber-attack at Barts Health NHS Trust to serve as critical reminder of importance of data security and training - **ongoing.**
- **OMMT** Additional on-site training sessions are available to improve compliance for clinical staff. A communications plan targeting low compliance groups **launched Dec 25**. Following discussions with the Group Estates and Facilities teams, additional capacity will be introduced in the new year to enhance access beyond core operating hours.

Impact on forecast

- **IPC**: Anticipate a short-term dip in compliance then recovery
- **IG**: Ongoing monitoring of compliance rates will take place to determine impact of actions
- **OMMT:** Expected positive impact of actions will be reflected in new trajectory against target in development



Latest Month
Nov-25
Target
90.0%
Latest Month's Position
89.6%
Oliver McGowan Tiers 1 and 2
40.0%
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

What does the data tell us?
Overall compliance is sitting just under the 90% target. Training compliance is lower than the target in specific areas, notably Information Governance (88.8%), Moving & Handling (76.9%), Oliver McGowan eLearning (84.1%) and Resuscitation (76.7%.)

Actions being taken to improve

- Level 2 Oliver McGowan training is at a combined rate of 40.0%, clinical face-to-face at 45.4% and the non-clinical webinar at 29.03% against an ICB target rate of 63.3% by March 2026. The BNSSG project team continue to review provision to support access to training across the region and improve the booking system. Following discussions with the Group Estates and Facilities teams, additional capacity will be introduced in the new year to enhance access beyond core operating hours.
- Action Information Governance: As noted within the NBT input, the compliance rate meets national expection for compliance. However, to meet the Trust compliance target the IG lead is working with Learning and Development to implement actions to improve compliance, such as accessibility of training sessions and review of delivery.
- Action Moving & Handling: an update curriculum will be launched mid-January, with changes supporting a more focussed and accessible delivery model based upon face-to-face training.
- Action Resuscitation: A robust training plan aimed at supporting a group newly-requiring PBLS was implemented, expectation to see improvement by May 2026. Improvements have been made to recording of higher-level resuscitation certification, moving to a self-service approach for those in the target audience.

Impact on forecast
Actions noted regarding changes to the delivery model for moving & handling are expected to positively impact accessibility and therefore compliance; and resuscitation in particular will serve to support improved targeting of training and therefore resulting compliance rates.

Income & Expenditure

Actual Vs Plan (YTD)

Latest Month

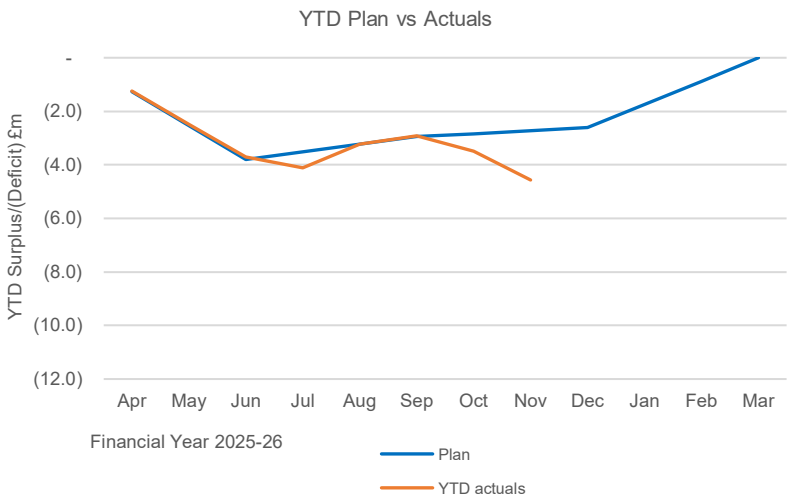
Nov-25

Year to Date Plan

£(2.7m) deficit

Year to Date Actual

£(4.6m) deficit



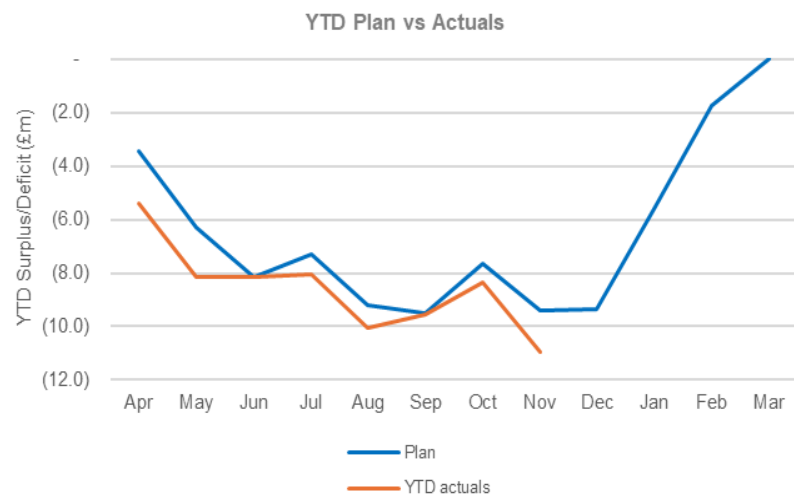
Summary

Summary:

- The financial plan for 2025/26 in Month 8 was a surplus of £0.1m. The Trust has delivered a £1.1m deficit and is £1.2m adverse to plan. Year to date the Trust has delivered a £4.6m deficit position which is £1.9m adverse to plan.
- In month, Resident Doctors took industrial action which resulted in a £0.6m reduction in income and £0.6m of additional shifts to cover gaps.
- 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 £0.4m in month. Due to increased activity, divisional non-pay is causing an adverse variance of £1.0m. This is offset by various non-recurrent benefits of £1.3m seen across income, pay and non-pay.
- Elective Recovery Performance in month is driving an adverse position of £0.1m (when the impact of industrial action is removed).
- In month, the Trust under-delivered against the recurrent Month 8 savings target by £1.7m contributing to a shortfall against in month delivery of £1.9m. This was offset in month by non-recurrent savings from consultant and AfC vacancies which contributed a £1.9m favourable variance.
- Year to date recurrent savings delivery is £16.3m and non-recurrent of £1.8m against a plan of £24.3m.

Key risks

- The Month 8 financial position is dependent on non-recurrent benefits which cannot be assumed to be available throughout the year, in year savings delivery, elective recovery activity 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

Nov-25

Year to Date Plan

£(9.4m) deficit

Year to Date Actual

£(11.0m) deficit

Summary

Summary:

- The position at the end of November is a net deficit of £11.0m against a planned deficit of £9.4m. The Trust is, therefore, £1.6m adverse to plan. This is due to the unplanned cost of industrial action.
- Significant variances against plan are higher than planned pay expenditure (£10.8m) and increased non-pay costs (£16.7m). This is offset by higher than planned operating income (£24.7m).
- Total staff in post (substantive, bank and agency) has reduced since March. Overall, staffing levels are within funded establishment in November. However, over-establishment in previous months, particularly across nursing budgets, is driving the adverse pay position due to additional use of registered mental health nurses and staffing of bed escalation areas linked to NCTR.
- Overall, agency and bank expenditure was higher in month compared with October, and YTD is £1.1m higher than planned. Agency expenditure is 16% lower than plan YTD with expenditure in month of £0.5m, compared with £0.7m in October. Bank expenditure is 6% higher than plan YTD mainly due to the cost of industrial action, with expenditure in month of £5.1m compared with £4.2m in October.
- The average number of NCTR patients in November is 173, significantly above the system plan of 136. This equates to 27% of the Trust's bed base being occupied by NCTR patients. The year end system plan is 103 NCTR patients

Key risks

- The delivery of elective activity necessary to secure the Trust's required level of income.
- 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 November central mitigations of £23m have been identified.

CIP

Actual Vs Plan (YTD)

Latest Month

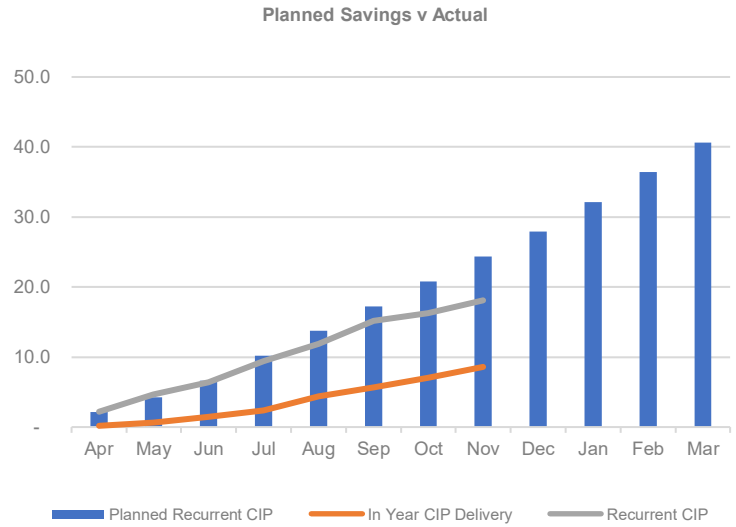
Nov-25

Year to Date Plan

£24.3m

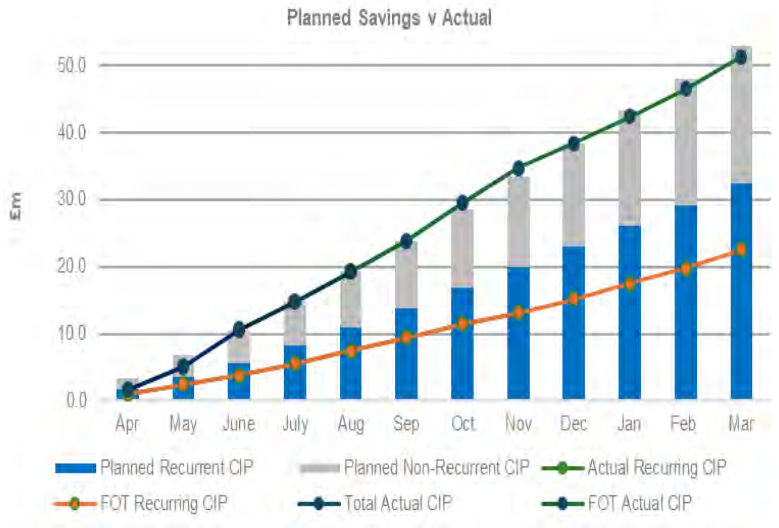
Year to Date Actual

£18.1m



Summary

- The CIP plan for 2025/26 is for savings of £40.6m with £24.3m planned delivery at Month 8.
- At Month 8 the Trust has £18.1m of completed schemes on the tracker, of which £1.8m is non-recurrent. There are a further £7.9m of schemes in implementation and planning, leaving a remaining £14.6m of schemes to be developed.
- The CIP delivery is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2025/26 impact and the recurrent full year impact. This can be seen on the orange line on the graph above.



Latest Month

Nov-25

Year to Date Plan

£33.4m

Year to Date Actual

£34.7m

Summary

- The Trust's 2025/26 recurrent savings plan is £53.0m.
- The Divisional plans represent 70% or £37.1m of the Trust plans. 30% or £15.9m sits centrally with the corporate finance team.
- As at 30th November 2025, the Trust is reporting total savings delivery of £34.7m against a plan of £33.4m.
- The Trust is forecasting savings of £51.3m, an improvement of £1.4m from last month. This improvement is due to an increase in non-recurring schemes linked to the Trust's FRP. Recurring savings represent 44% of the current forecast outturn.
- Against the annual savings plans of £53.0m, the current forecast savings delivery shortfall is £1.7m or 3%. The full year effect forecast outturn at month 8 is £30.9m, a forecast recurrent shortfall of £22.1m or 42%.

Workforce

Pay Costs Vs Plan Run Rate

Latest Month

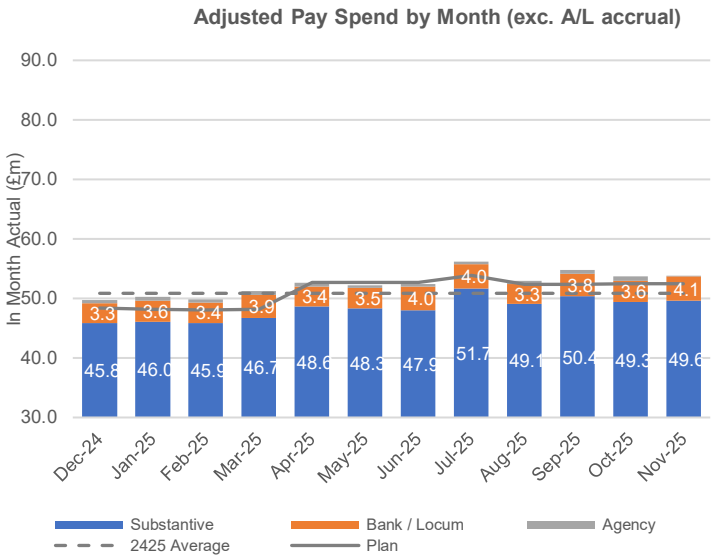
Nov-25

In- Month Plan

£52.5m

In-Month Actual

£53.8m

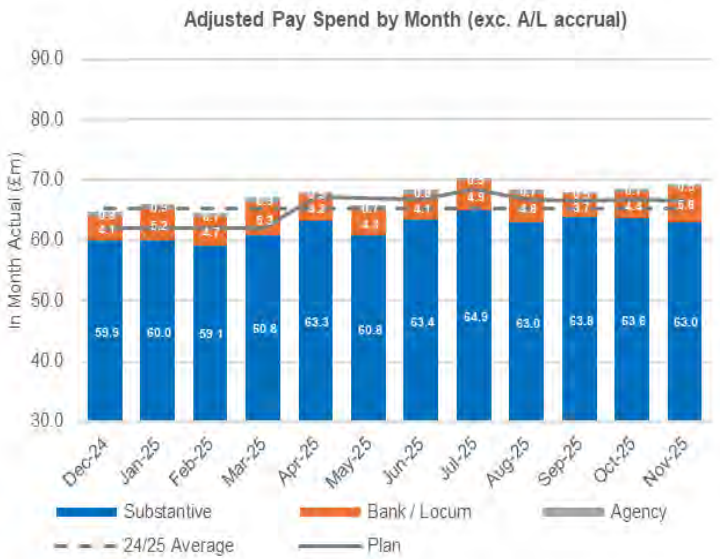


Summary

Summary

Pay spend is £1.3m adverse in month, when adjusted for pass through items, the revised position is £0.3m favourable to plan. The main drivers are:

- Industrial action – £0.6m adverse due to a Resident Doctor strike in month. This is the costs relating to additional shifts for cover.
- In year CIP - £1.0m adverse, in month impact of recurrent CIP delivery.
- Escalation and enhanced care - £0.4m adverse in nursing driven by hospital pressures.
- Vacancies - £1.9m favourable, £1.4m consultant vacancies in Anaesthetics and Imaging and other clinical/admin vacancies in Genetics and Facilities. There are also £0.5m of Nursing vacancies in specialist posts.
- In month £0.4m of non-recurrent benefits were recognised relating to prior year agency accruals.



Latest Month

Nov-25

In-Month Plan

£66.6m

In-Month Actual

£69.3m

Summary

Summary

- Total pay expenditure in November is £69.3m, £2.7m higher than plan due mainly to higher than planned bank costs.
- Pay costs remain higher than plan YTD driven by the cost of nursing staffing levels exceeding planned values with levels of substantive and temporary staffing combined beyond the Trust's funded establishment by an average of 256WTE since April.
- Nursing staffing levels exceed the funded establishment by 179WTE in November. Contributing factors to the ongoing over-establishment are the use of escalation capacity, high levels of acuity requiring additional mental health input and sickness absence.
- 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

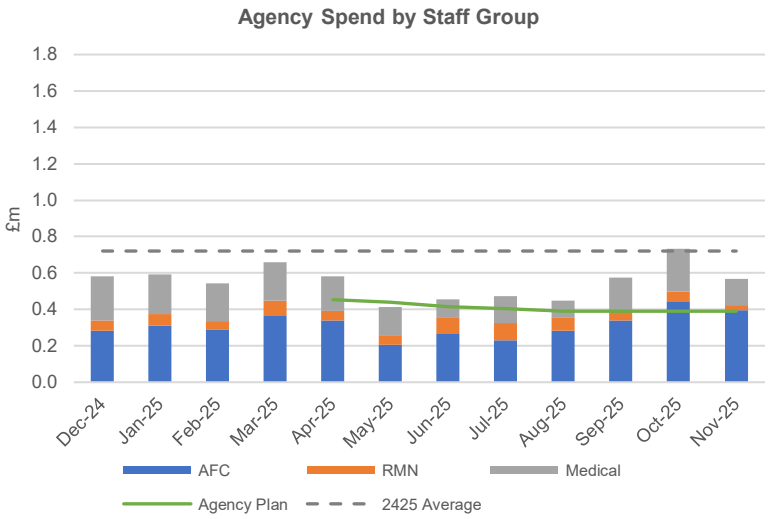
Nov-25

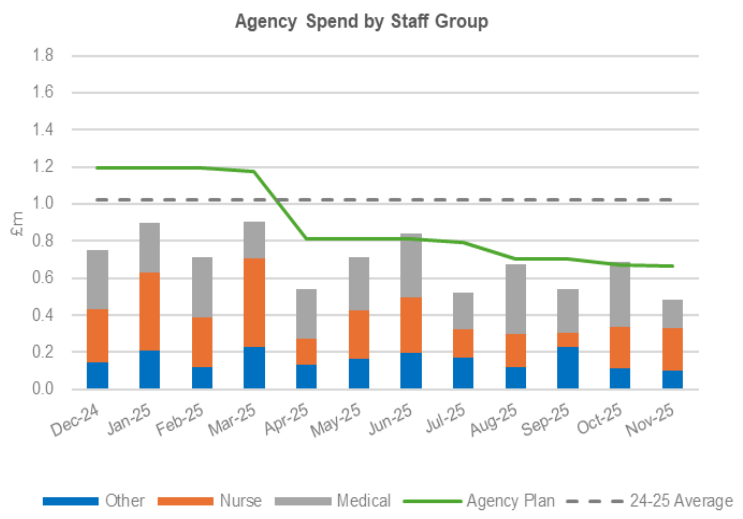
In-Month Plan

£0.4m

In-Month Actual

£0.6m





Latest Month

Nov-25

In-Month Plan

£0.7m

In-Month Actual

£0.5m

Summary

Summary

Monthly Trend

- Agency spend in November has decreased compared to October. This is largely driven by a drop in consultant agency in Cardiology which was used to cover sickness in October.
- 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 November is below 2024/25 spend. This is due to increased controls being implemented across divisions from November last year, and their continued impact.

Summary

Summary

Monthly Trend

- Agency expenditure in November is £0.5m, £0.2m below plan and lower than October's agency expenditure of £0.7m. YTD agency expenditure is 16% below plan.
- Agency expenditure is c1.0% of total pay costs.
- Agency usage continues to be largely driven additional escalation bed capacity across nursing and medical staffing due to a deterioration in the NCTR position against plan. The use of registered mental health nurses is also a key driver.
- Nurse agency shifts increased by 58 or 11% in November compared with October.
- Medical agency expenditure is lower by £0.2m from the previous month. The number of shifts covered has decreased from 284 in October to 183 in November.

In Month vs Prior Year

- Trustwide agency spend in November is £0.5m or c51% lower than November 2024. 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

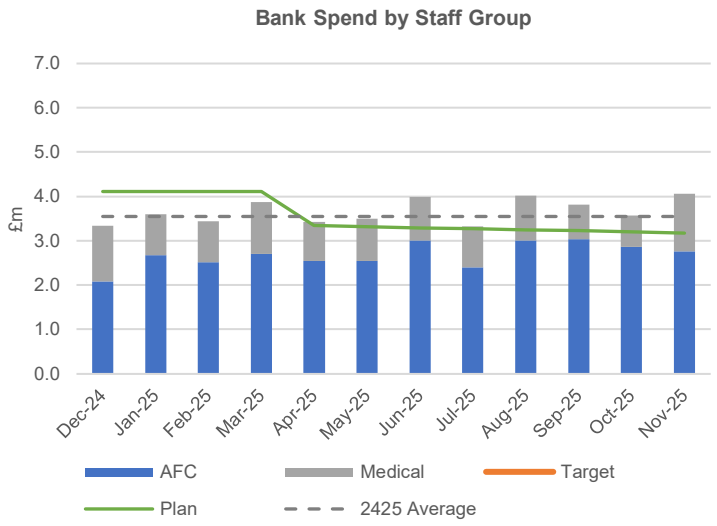
Nov-25

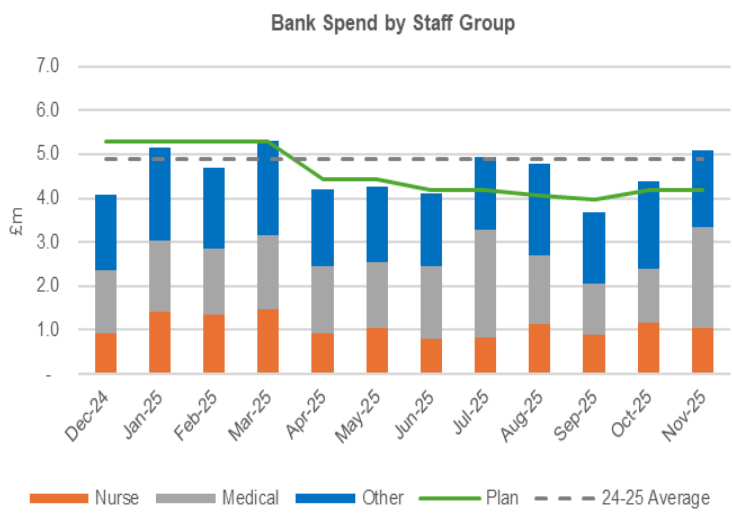
In-Month Plan

£3.2m

In-Month Actual

£4.1m





Latest Month

Nov-25

In-Month Plan

£4.2m

In-Month Actual

£5.1m

Summary

Summary

Monthly Trend

- In November, there has been an increase in bank spend compared to October. The increase has mainly been in Medical staff due to cover for the period industrial action

In Month vs Prior Year

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

Summary

Summary

Monthly Trend

- Bank costs in November are £5.1m, an increase of £0.7m from £4.4m in October. Costs are £0.9m higher than plan YTD, due mainly to costs associated with Industrial Action. Of the £5.1m spent in November, £2.3m relates to medical bank and £1.0m to registered nurse bank.
- Nurse bank expenditure decreased by £0.1m in November from £1.1m in October, whilst shifts decreased by 58 or 11%.
- Medical bank was higher than October at £2.3m. £0.8m relates to industrial action.

In Month vs Prior year

- Bank expenditure in November is £0.8m higher than the same period last year.

Capital

Actual Vs Plan

Latest Month

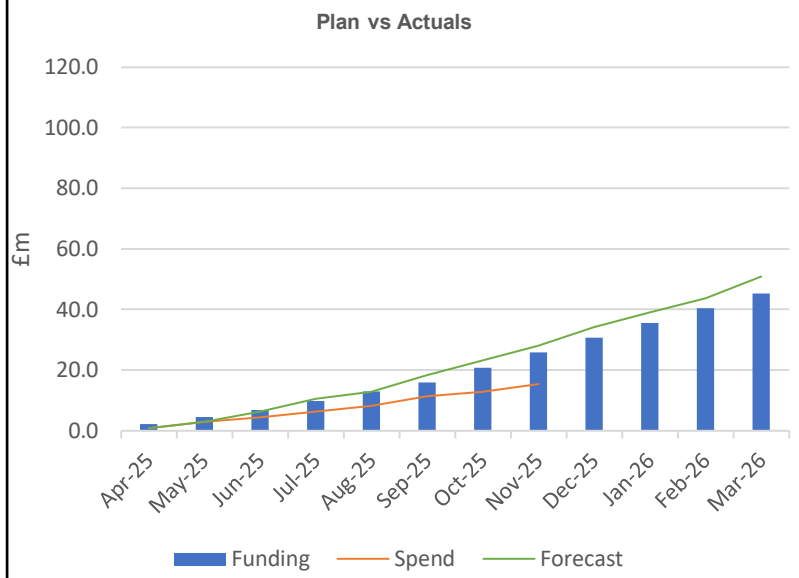
Nov-25

In-Month Plan

£4.9m

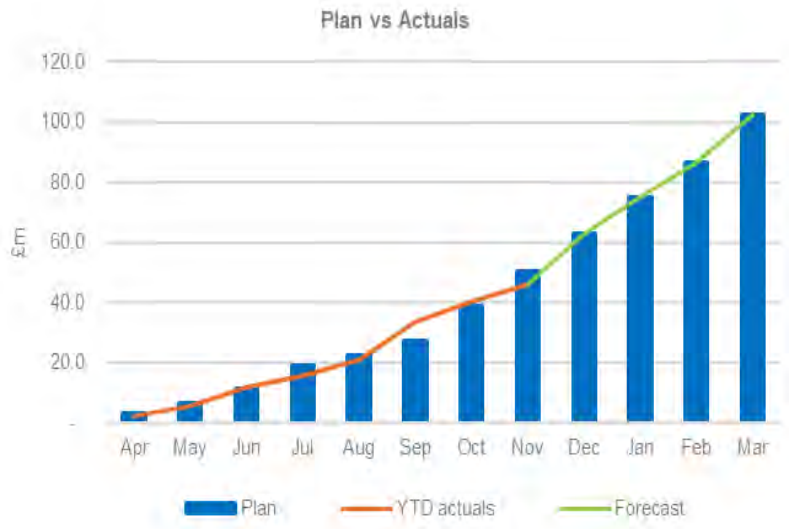
In-Month Actual

£2.5m



Summary

- The Trust currently has a system capital allocation of £22.7m for 2025/26. A further £11.0m of projects have been taken forwards for national funding.
- Overall spend in Month 8 was £1.5m. This takes the overall year to date spend to £15.4m, of which £7.3m is against the Bristol Surgical Centre.
- The year-to-date variance against the forecast is as result of slippage in several projects however the Trust is still forecasting to spend all allocated capital funding in year.
- Overall spend on the Bristol Surgical Centre to date is £49.4m, of which £38.3m 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

Nov-25

In-Month Plan

£11.7m

In-Month Actual

£5.7m

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 November is £46.1m, £4.3m behind the plan of £50.4m.
- Significant variances to plan include slippage on Major Capital Schemes (£13.5m) and Estates Schemes (£6.1m), offset by ahead of plan delivery against medical equipment, digital services and right of use assets (IFRS16).
- 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 Programme Board.
- The Trust continues to monitor the forecast outturn against the notified CDEL.

Cash

Actual Vs Plan

Latest Month

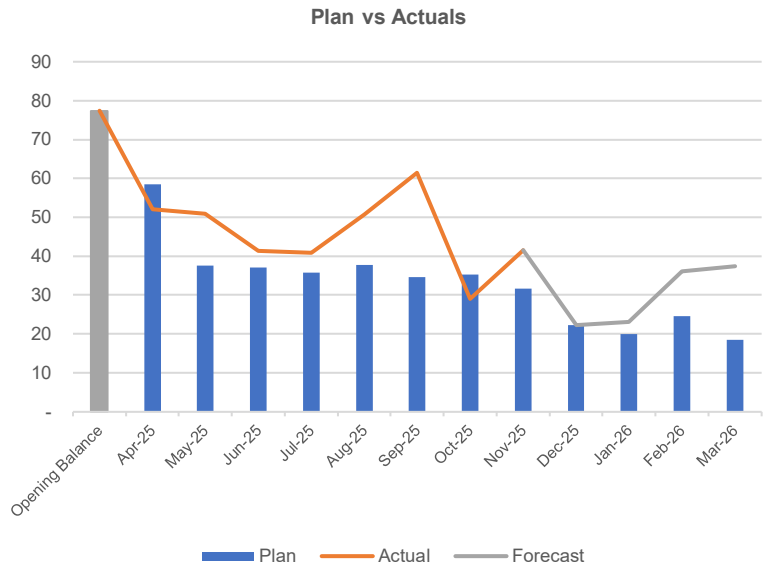
Nov-25

Target

£35.2m

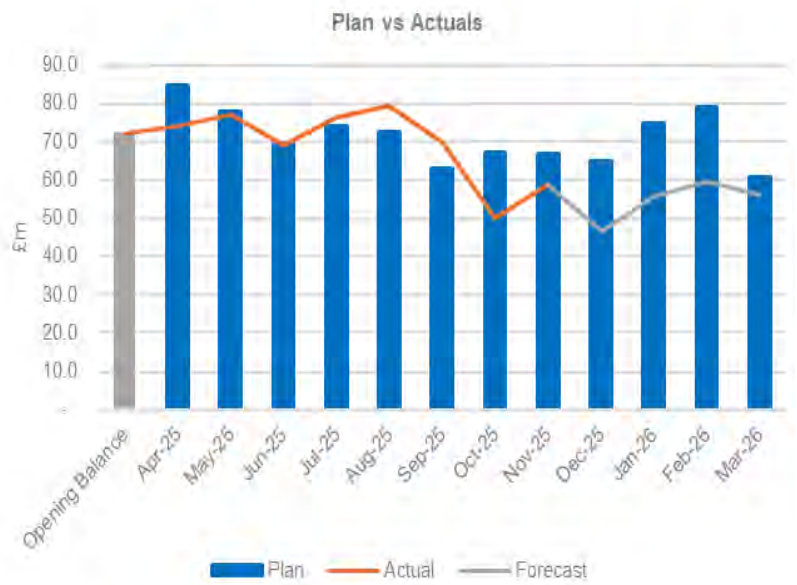
Actual

£28.9m



Summary

- In month cash is £41.5m, which is a £12.5m increase from October
- The movement in month is driven by a £14m pre-payment received from BNSSG, this is expected to unwind in December.
- The cash balance has decreased by £35.9m year to date, driven by the high level of capital cash spend linked to items purchased at the end of 2024/25.
- Year-to-date cash balances are £9.8m ahead of plan and the year end cash balance is forecast to be £19.0m above plan, primarily driven by lower than forecast capital cash spend.



Latest Month

Nov-25

Target

£66.8m

Actual

£58.9m

Summary

- The closing cash balance of £58.9m is a decrease of £8.9m from October.
- The £13.4m decrease from 31st March is due to a net cash inflow from operations of £29.0m, offset by cash outflow of £36.5m relating to investing activities (i.e. capital), and cash outflow of £5.9m on financing activities (i.e. loans, leases & PDC).
- The Trust's total cash receipts in October were £121.8m to cover payroll payments of £67.3m and supplier payments of £45.6m.
- YTD cash balances are £7.9m below plan and the forecast year end cash balance is below plan at £56.0m.

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 January 2026
Data up to November 2025

Activity	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number of women who gave birth (>=24 weeks or <24 weeks live)		397	454	448	394	429	435	456	453	467	439	460	477	466
Number of women who gave birth (>=22 weeks)		397	455	447	397	429	436	456	455	467	439	460	480	480
Number of babies born (>=24 weeks or <24 weeks live)		401	460	454	401	433	442	464	463	473	444	466	483	461
Number of livebirths 22+0 to 26+6 weeks		4	2	0	6	6	4	3	4	1	9	1	2	2
Number of livebirths 24+0 to 36+6 weeks		28	41	33	28	35	36	40	32	33	43	27	32	30
Number of livebirths <24 weeks		3	1	1	3	3	0	0	1	0	3	2	0	1
Induction of labour rate %		28.2%	30.4%	29.7%	27.9%	30.8%	31.7%	31.6%	32.7%	29.1%	33.3%	30.0%	28.1%	31.7%
Unassisted birth rate %		45.8%	43.8%	44.9%	40.1%	45.2%	42.3%	42.1%	41.5%	45.4%	44.2%	46.7%	44.2%	47.3%
Assisted birth rate %		8.3%	10.8%	9.6%	12.9%	12.1%	9.9%	14.0%	9.3%	8.8%	9.8%	8.0%	8.4%	10.2%
Caesarean section rate (overall) %		45.6%	44.9%	44.6%	46.4%	42.7%	47.6%	43.2%	49.0%	45.6%	46.0%	45.0%	47.0%	42.5%
Elective caesarean section rate %		21.4%	20.3%	21.4%	23.6%	17.9%	22.1%	20.4%	22.3%	22.7%	22.1%	22.4%	21.8%	18.7%
Emergency caesarean section rate %		24.2%	24.7%	23.0%	22.8%	24.7%	25.5%	22.8%	26.7%	22.9%	23.9%	22.6%	25.2%	23.9%

Safe - Maternity Workforce	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Apr-00	Sep-25	Oct-25	Nov-25
One to one care in labour (as a percentage)* excludes BBAs	MIS 100%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Compliance with supernumerary status for labour ward coordinator	MIS 100%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of times maternity unit attempted to divert or on divert	Local	1	1	1	0	1	0	0	1	1	0	1	1	1
Number of obstetric consultant non-attendance to 'must attend' clinical situations	Local	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultant Led MDT ward rounds on CDS day	SBLV3 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Led MDT ward rounds on CDS evening/night	SBLV3 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of 'staff meets acuity' - CDS	Birthrate+ 100%	67%	51%	55%	43%	53%	64%	65%	52%	65%	72%	45%	49%	54%
Percentage of 'up to 3 MWs short' - CDS		29%	45%	41%	45%	36%	31%	45%	44%	33%	25%	50%	39%	43%
Percentage of '3 or more MW's short' - CDS		4%	5%	3%	12%	11%	5%	8%	5%	2%	3%	6%	12%	4%
Confidence factor in Birthrate+ (data recording on CDS)	Birthrate+ 60%	81.1%	80.0%	87.1%	77.8%	77.4%	82.8%	82.3%	73.9%	87.1%	84.4%	86.6%	83.9%	75.3%

Safe - Maternity Workforce	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	0%	-1.45%	-1.12%	-2.14%	-1.64%	-1.53%	-1.56%	-0.87%	0.77%	2.22%	4.53%	4.60%	4.36%	1.23%
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	4.76%	4.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.50%	1.50%
Obstetric Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	2%	2%	2%	2%	2%	2%	2%	2%	0%	0%	1%	1%
Midwifery Shift Fill Rate (%) - inpatient services day	100%	95.9%	96.9%	98.8%	97.1%	95.7%	96.7%	100.1%	94.5%	94.0%	95.5%	93.6%	93.2%	92.3%
Midwifery Shift Fill Rate (%) - inpatient services night	100%	99.0%	100.7%	103.0%	99.6%	98.9%	99.5%	100.1%	103.6%	99.8%	97.7%	95.5%	99.7%	97.3%
Obstetric Shift Fill Rate - acute services* day	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	98.0%	100.0%	99.0%
Obstetric Shift Fill Rate - acute services* night	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%

Safe - Neonatal Workforce	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number of NICU consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs	0%	2.59%	7.70%	9.98%	9.47%	8.70%	10.99%	12.23%	10.79%	13.72%	14.71%	16.94%	14.22%	12.45%%
Neonatal Nurse Qualified in Speciality establishment rate	BAPM 70%	56%	55%	52%	52%	52%	52%	52%	54%	63%	63%	63%	60%	60%
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	5%	5%	5%
Neonatal Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	7.60%	7.60%	0%	0%	0%	8%	8%	8%	8%	8%	8%
Neonatal Nursing Fill Rate (%) - acute services* using BAPM acuity tool	100%	98.2%	100.0%	98.3%	100.0%	100.0%	98.3%	91.8%	96.6%	100.0%	88.5%	86.0%	100.0%	100.0%
Neonatal Nursing QIS Fill Rate (%) - acute services using BAPM acuity tool	70%	63.6%	78.0%	73.3%	96.43	75.0%	74.6%	49.2%	55.2%	50.0%	37.7%	28.3%	82.8%	92.3%
Neonatal (Medical) Shift Fill Rate (%) - acute services* day using BAPM acuity tool	100%	100%	100%%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	97.8%	97.8%	96.0%	95.0%
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night using BAPM acuity tool	100%	100%	100%%	100.0%	100.0%	100.0%	100.0%	95.7%	95.0%	94.6%	94.0%	93.3%	95.0%	95.0%

Training	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Training compliance fetal wellbeing day - Obstetric Consultants	MIS Y6 90%	90%	79%	90%	90%	89%	94%	90%	80%	80%	80%	56%	90%	100%
Training compliance fetal wellbeing day - Other Obstetric Doctors	MIS Y6 90%	86%	76%	76%	87%	82%	82%	85%	81%	78%	80%	84%	94%	87% (93%)
Training compliance fetal wellbeing day - Midwives (ALL)	MIS Y6 90%	95%	90%	87%	87%	84%	80%	85%	81%	81%	82%	80%	90%	97%
Training compliance in maternity emergencies and multi-professional training - Obstetric Consultants	MIS Y6 90%	100%	95%	90%	90%	90%	94%	85%	90%	90%	90%	100%	94%	100%
Training compliance in maternity emergencies and multi-professional training - Other Obstetric Doctors	MIS Y6 90%	88%	76%	68%	82%	91%	94%	100%	96%	97%	69%	81%	90%	94%
Training compliance in maternity emergencies and multi-professional training - Midwives (ALL)	MIS Y6 90%	94%	94%	89%	86%	86%	89%	92%	91%	92%	93%	82%	93%	97%
Training compliance in maternity emergencies and multi-professional training - Anaesthetic Consultants	MIS Y6 70%	93%	90%	90%	91%	91%	66%	69%	62%	63%	63%	70%	100%	96%
Training compliance in maternity emergencies and multi-professional training - Other Anaesthetic Doctors	MIS Y6 70%	100%	91%	95%	73%	61%	66%	77%	75%	86%	87%	88%	90%	100%
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	MIS Y6 90%	94%	93%	90%	87%	89%	87%	84%	87%	91%	90%	77%	88%	95%
Training compliance annual local NBLS - Midwives (ALL)														99%
Training compliance annual local NBLS - NICU Consultants	MIS Y6 90%	92%	94%	94%	94%	92%	92%	100%	92%	91%	91%	91%	91%	100%
Training compliance annual local NBLS - NICU Resident doctors (who attend any births)	MIS Y6 90%	100%	94%	94%	94%	100%	100%	100%	100%	100%	94%	100%	100%	100%
Training compliance annual local NBLS NICU ANNPs (ALL)	MIS Y6 90%	100%	82%	91%	91%	90%	90%	70%	70%	60%	80%	100%	100%	100%
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	MIS Y6 90%	96%	88%	98%	93%	93%	86%	91%	93%	91%	94%	98%	96%	96%
Training compliance annual local NBLS MSWs, HCAs and nursery nurses (dependant on their roles within the service - for local policy to determine)	MIS Y6 90%	91%	88%	90%	86%	87%	92%	89%	89%	90%	95%	97%	97%	97%

Safe - Delivery Metrics	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number of shoulder dystocias recorded (vaginal births)		9	9	10	6	9	7	11	6	10	5	4	8	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%	5.9%	2.8%	5.9%	4.9%
Number of women with a retained placenta following birth requiring MROP		3	9	9	7	11	8	9	9	8	9	9	17	6
Number of babies with an Apgar Score <7 at 5 mins (all gestations)		8	7	5	6	14	13	13	12	4	10	8	8	5

Infant Feeding & Skin to Skin	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
% of babies where breastfeeding initiated within 48 hours	80%	82.5%	79.1%	76.3%	82.3%	76.5%	88.2%	81.0%	80.2%	84.7%	82.7%	83.2%	83.1%	87.1%
% of babies breastfeeding on Day 10	80%	81.2%	73.5%	73.1%	78.2%	77.4%	76.3%	70.9%	75.5%	76.3%	78.5%	70.5%	77.6%	84.7%
% of babies breastfeeding at transfer to community	80%	71.2%	66.9%	66.9%	73.3%	68.4%	71.8%	67.1%	70.3%	72.9%	75.7%	72.2%	73.9%	73.7%
% of babies where skin to skin recorded within 1st hour of birth	80%	85.0%	81.2%	82.4%	81.0%	80.4%	82.7%	83.1%	82.6%	84.9%	83.5%	83.4%	84.1%	84.7%

Perinatal Morbidity and Mortality inborn	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Total number of perinatal deaths (excluding late fetal losses)		3	4	6	4	9	2	2	4	3	4	1	2	0
Number of late fetal losses 16+0 to 23+6 weeks excl TOP		4	1	2	1	2	0	3	5	4	0	5	4	4
Number of stillbirths (>=24 weeks excl TOP)		1	1	5	0	4	2	2	3	3	0	0	1	0
Stillbirths per 1000 live births	2.6	2.49	2.17	11.01	0.00	9.32	4.52	4.31	6.48	6.34	0.00	0.00	2.07	3.70
Number of neonatal deaths : 0-6 Days		1	1	0	3	5	0	0	0	0	2	1	0	0
Number of neonatal deaths : 7-28 Days		0	2	1	1	0	0	0	1	0	2	0	1	0
Neonatal Deaths before 28 days per 1000 live births (ALL)	1.5	2.49	6.5	2.2	10.15	11.66	0.00	0.0	2.2	0.0	4.5	2.1	2.1	0.0
* NND before 28 days per 1000 live births (Inborn babies only)	1.5	2.49	2.2	0.0	7.48	8.93	0.00	0.0	2.2	0.0	4.5	4.6	2.1	0.0
PMRT grading C or D themes in report	0	0	2	3	3	0	0	2	2	1	0	0	1	1
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (MNSI referral)	0	1	1	3	1	1	0	0	1	0	0	0	0	0

Maternal Morbidity and Mortality	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number of maternal deaths (MBRRACE)		0	0	0	0	0	0	0	0	1	0	0	1	0
Direct causes		0	0	0	0	0	0	0	0	0	0	0	0	0
Indirect causes		0	0	0	0	0	0	0	0	1	0	0	1	0
Number of women who received enhanced care on CDS (HDU)		40	37	32	33	36	32	33	39	39	23	30	38	31
Number of women who received level 3 care (ICU)		3	1	1	2	1	1	1	1	1	0	0	0	0

Insight	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Number of incident reported		79	95	99	108	166	99	106	124	56	113	100	106	122
Number of incidents graded as moderate or above (total) (Physical Harm)		0	1	0	0	0	3	0	1	0	6	4	1	0
incident moderate harm or above (not PSII, excludes MNSI)		0	0	0	0	0	3	0	1	4	6	4	1	0
incident PSII (excludes MNSI)		0	1	0	0	0	0	1	0	0	0	0	0	0
New MNSI referrals accepted		0	1	1	1	2	0	0	1	0	0	0	0	1
Outlier reports (eg. MNSI/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	1	0	0	0	0	1	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trust Level Risks		2	3	3	3	3	3	3	4	5	5	5	5	7

NICU Data	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Neonatal Admission to NICU		33	55	50	48	59	41	46	52	48	52	37	48	43
of which Inborn Babies booked with NBT		20	37	34	32	44	31	33	33	29	38	26	28	31
of which Inborn Babies -booked elsewhere		4	2	0	4	2	0	3	4	5	4	1	1	3
of which readmission		2	5	3	4	3	3	5	6	3	2	4	9	2
of which ex-utero admission		6	9	7	7	7	4	4	9	8	5	3	6	4
of which source of admission cannot be derived		1	2	3	1	2	2	1	0	1	1	3	2	3
Neonatal Admission to Transitional Care		26	28	40	29	27	39	36	35	36	40	40	26	30
Admission rate at term	ATAIN <5%	2.7%	4.1%	6.0%	5.7%	7.2%	4.0%	4.8%	3.9%	5.8%	5.9%	3.9%	4.9%	6.0%
NICU babies transferred to another unit for higher/specialist care		2	4	8	5	3	4	4	5	2	1	4	4	6
NICU babies transferred to another unit due to a lack of available resources	0	0	3	0	0	2	0	2	3	0	0	4	2	9
NICU babies transferred to another unit due to insufficient staffing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Attempted baby abduction	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Involvement	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	90%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	86%	91%
Friends and family Test score (response rate % who rated 'very good' or 'good') Maternity	90%	91%	90%	87%	95%	94%	94%	91%	92%	94%	93%	92%	90%	91%
Service User feedback: Number of Compliments (formal)		13	14	29	74	37	59	78	61	79	69	63	60	46
Service User feedback: Number of Complaints (formal)		4	0	11	2	2	2	9	2	6	16	3	3	4
Staff feedback from frontline champions and walk-abouts (number of themes)		0	0	0	8	7	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting

Telephone Triage	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Attendance to triage	90%	820	850	822	791	925	939	943	888	996	880	963	1167	1077
BSOTS KPI Initial assessment within 15 minutes	90%	70%	63%	69%	66%	56%	58%	63%	66%	65%	64%	56%	48%	47%
NICE Safer Staffing Red Flag Initial assessment within 30 minutes	90%	91%	88%	91%	91%	85%	85%	91%	91%	93%	90%	86%	81%	75%
Calls answered by triage (Day 0730-2000)		907	916	902	857	961	947	1711	1693	1525	1637	1857	1262	1884
Calls answered by triage (Night 2000-0700)		293	334	291	236	280	272	291	352	368	323	354	414	381
Phone calls abandoned on triage (Day 0730-2000)		134	176	146	159	168	182	301	154	149	207	347	230	237
Phone calls abandoned on triage (Night 2000-0700)		27	34	22	41	39	29	26	37	36	25	24	32	47
Calls answered by other clinical areas (CDS and Mendip - Day + Night)		688	729	726	669	734	606	522	522	536	484	493	615	542
Phone calls abandoned in other clinical areas (CDS and Mendip - Day + Night)		23	20	18	23	21	12	22	28	30	28	14	34	29

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Perinatal Quality Surveillance (PQSM)

November 2025

UHBW Maternity

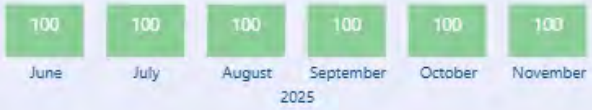
Inspected and rated Good
Care Quality Commission

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Workforce & Acuity

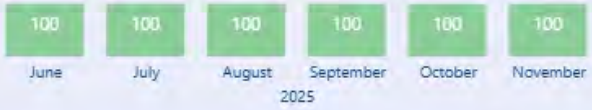
Compliance with supernumerary status for labour ward coordinator (%)



6 monthly average

Trend

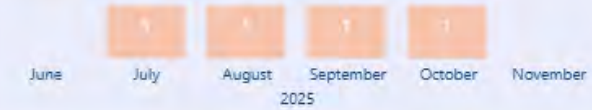
One to one care in labour * excludes BBAs (%)



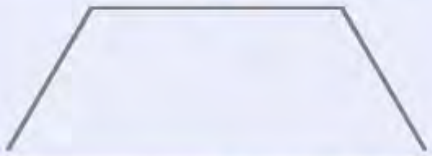
6 monthly average

Trend

Number of times maternity unit attempted to divert or on divert



Trend



Is the standard of care being delivered?

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

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

- **Jul 17** - Attempted closure of maternity unit
  High CDS acuity and cardiac in utero transfer en route from Torbay, reduced NICU staffing and no on-call midwifery staff - **No admissions impacted**
- **Aug 21** - Attempted closure of CDS.
  CDS at capacity with no ante/post natal beds availability - **No admissions impacted**
- **Sep 23** - Attempted closure of CDS.
  Acuity on CDS, redistribution of staffing to ensure 1 to 1 care provided . **No admissions impacted.**
- **Oct 3 - Attempted closure of CDS.**
  Acuity on CDS, redistribution of staffing to ensure 1 to 1 care provided . **No admissions impacted.**

Consultant Led MDT Ward Rounds on CDS (%)

6 monthly average - Day Shift

Trend - Day Shift

6 monthly average - Night Shift

Trend - Night Shift

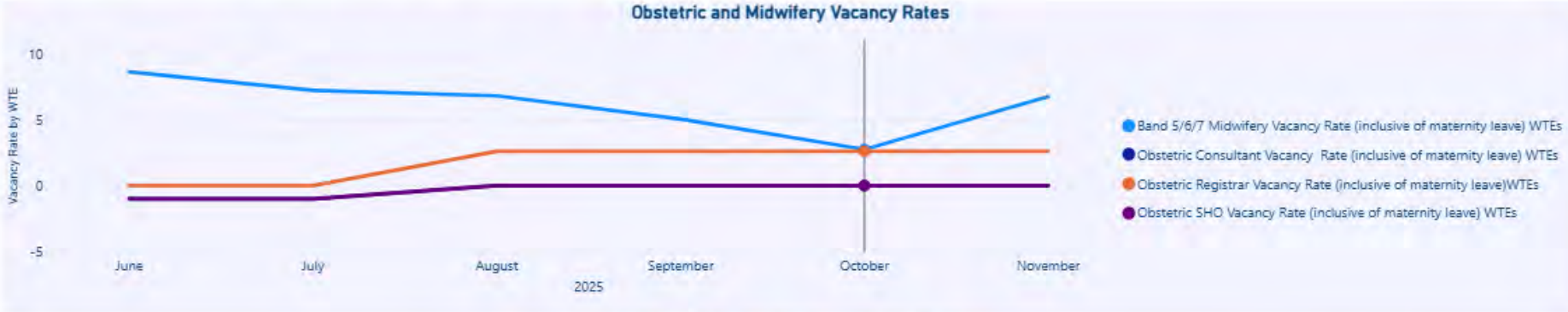
Number of obstetric consultant non-attendance to 'must attend' clinical situations (rolling 6 months)

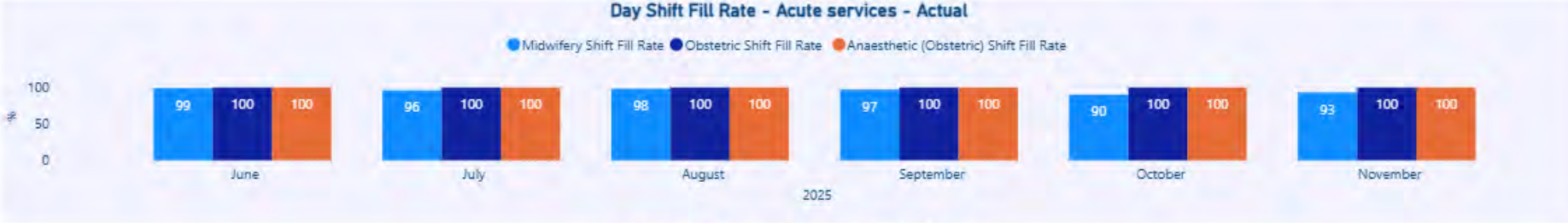
0

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Workforce & Acuity





Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Workforce & Acuity

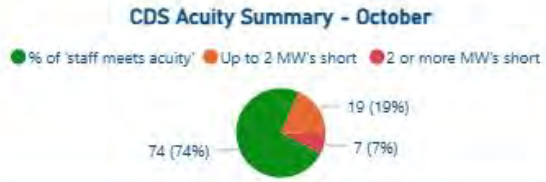
Central Delivery Suite (CDS)

Birthrate Plus®

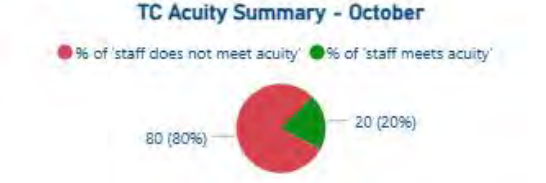
Capture of intrapartum (CDS) data is required 6 times during a 24-hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.

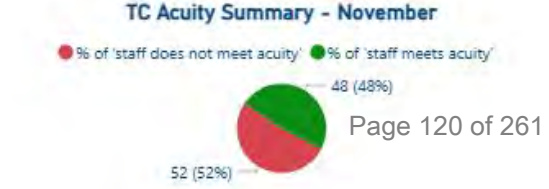
Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

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



Transitional Care (TC)





Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Workforce & Acuity

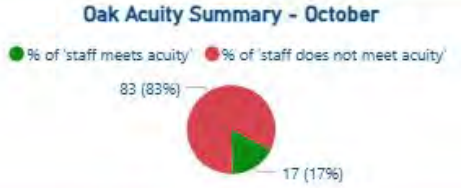
Ante / Post Natal Ward (Oak)

Birthrate Plus®

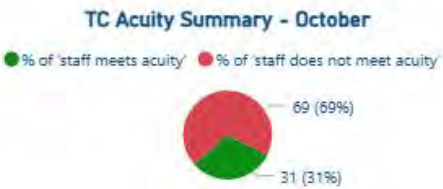
Capture of intrapartum (CDS) data is required 6 times during a 24-hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.

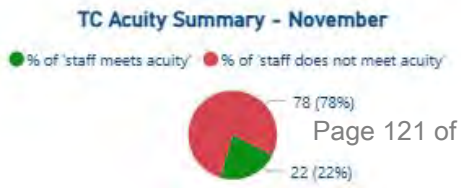
Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

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



Ante / Post Natal Ward (Willow)

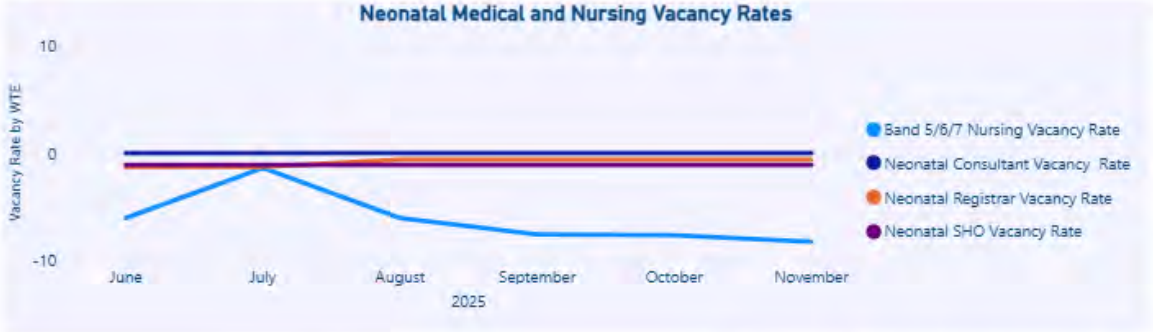


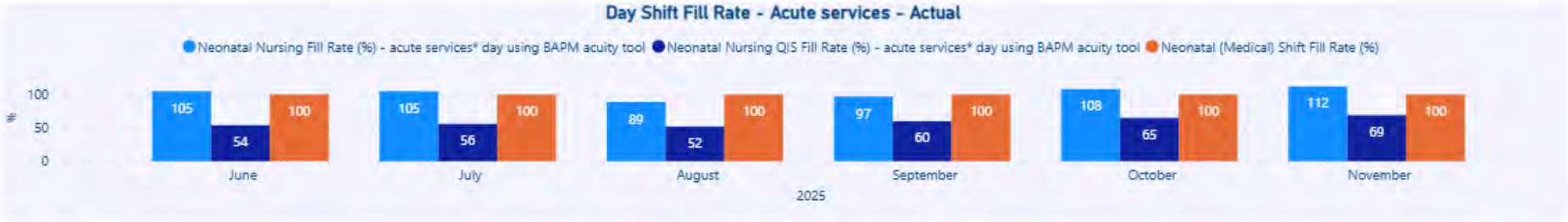


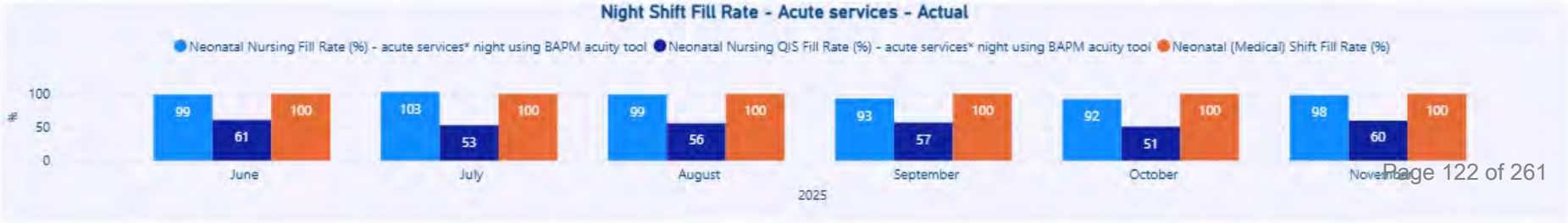
Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Neonatal Workforce & Acuity







Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

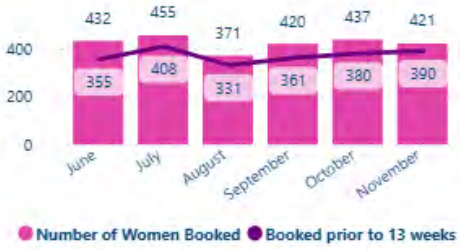
Maternity Metrics

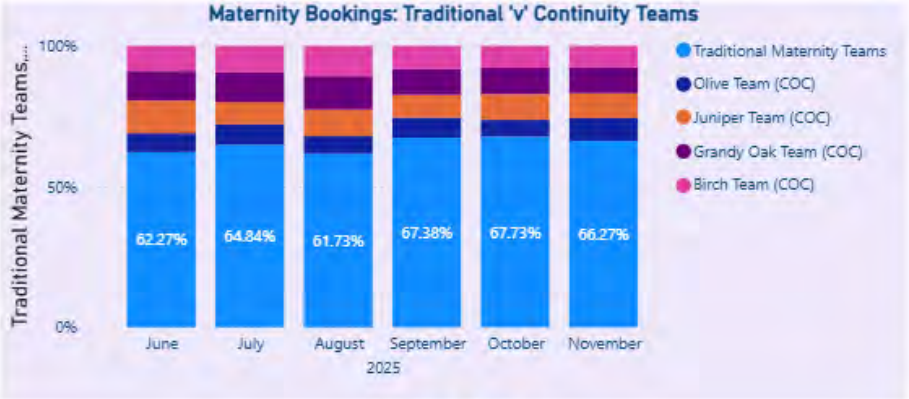
421

Number of Women booked for maternity care

390

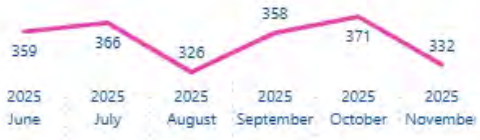
Number of Women booked before 13 weeks Gestation





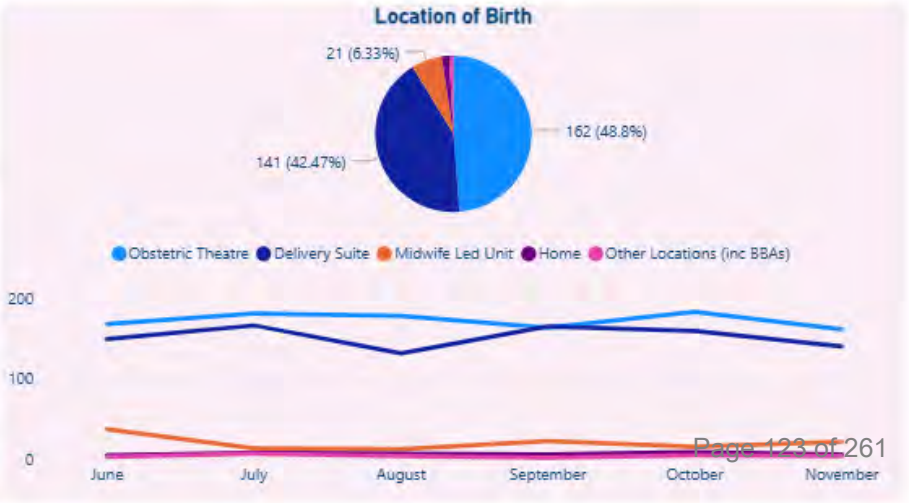
332

Number of Registerable Births (Women)



334

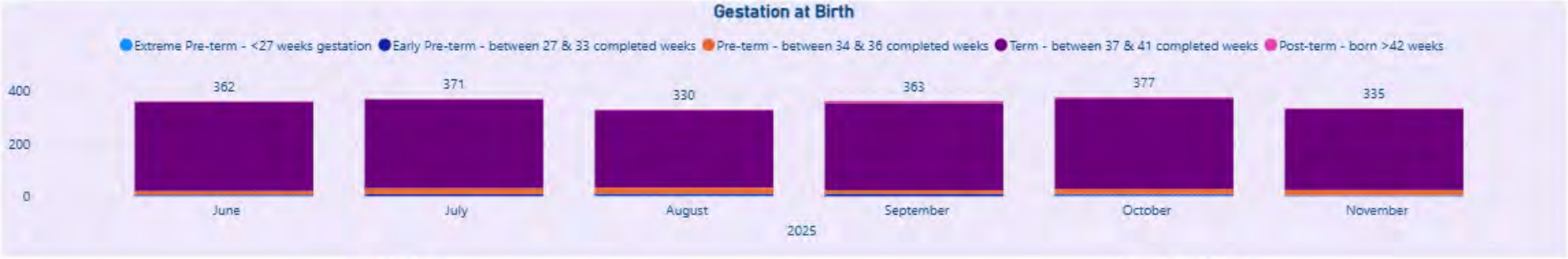
Number of Registerable Births (Babies)

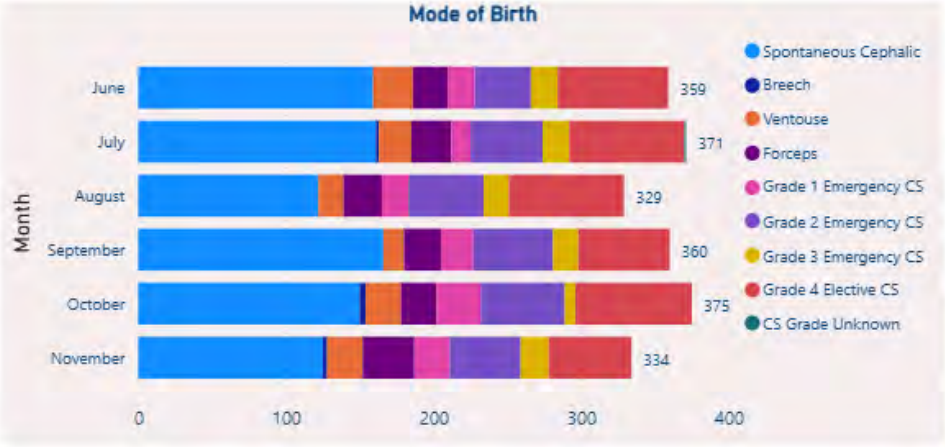


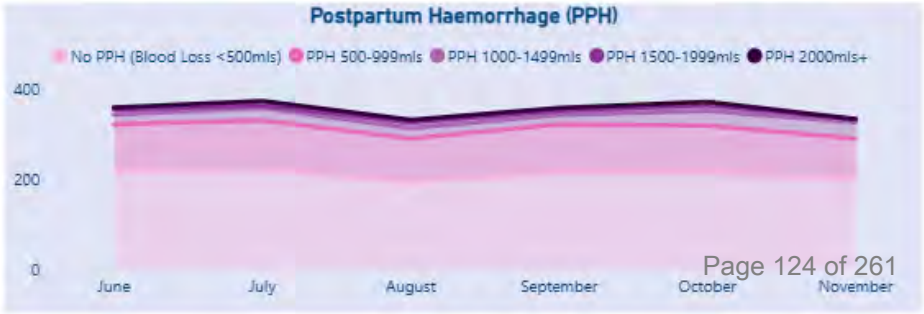
Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Metrics







10

Number of Grade 1 CS delivered outside of 30 minutes

11

Number of Grade 2 CS delivered outside of 75 minutes

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Metrics

Postpartum Haemorrhage (PPH)

Clinical Quality Improvement Metrics (CQIMs) comparisons

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

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

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

Select start month: September 2022

Select end month: September 2025

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

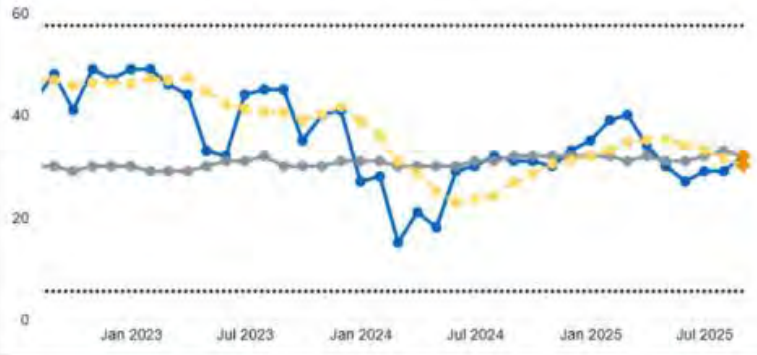
Select indicator: Women who had a PPH of 1,500ml or more (Rate per 1,000)

Robson Group definitions | Smoking CQIMs & SATOD

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

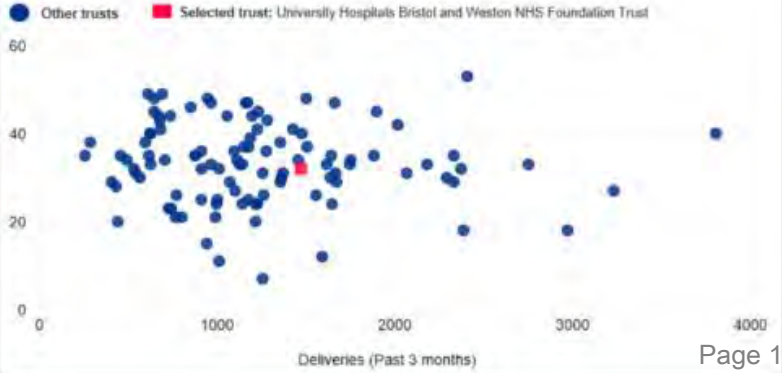
Provisional data — Trust — MBRRACE — National — Trust Rolling Average (6 months) ····· Upper/Lower Bounds

Select which values to view: Multiple selections



Trust | Region | LMNS | MBRRACE

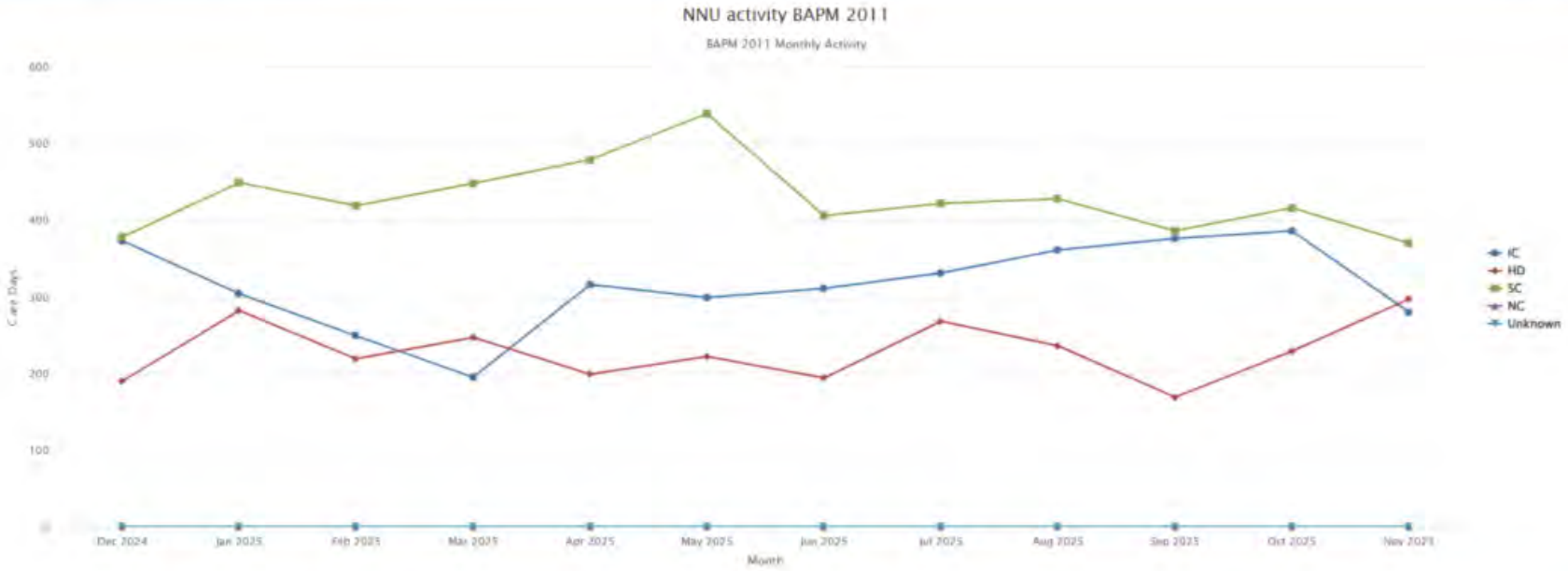
Trust level CQIM values comparison with peers (Rate per 1,000)

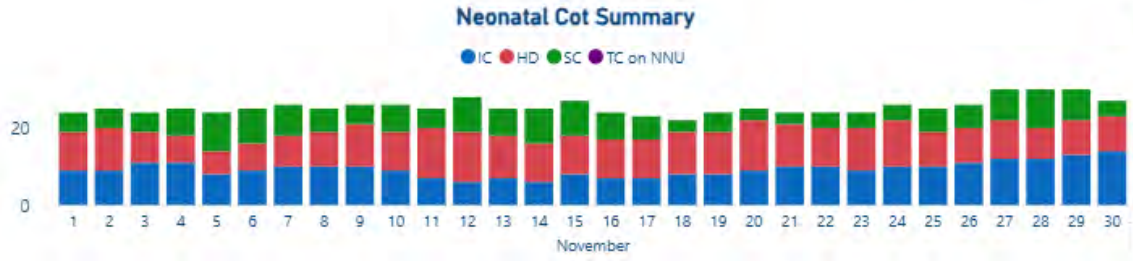


Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Neonatal Metrics





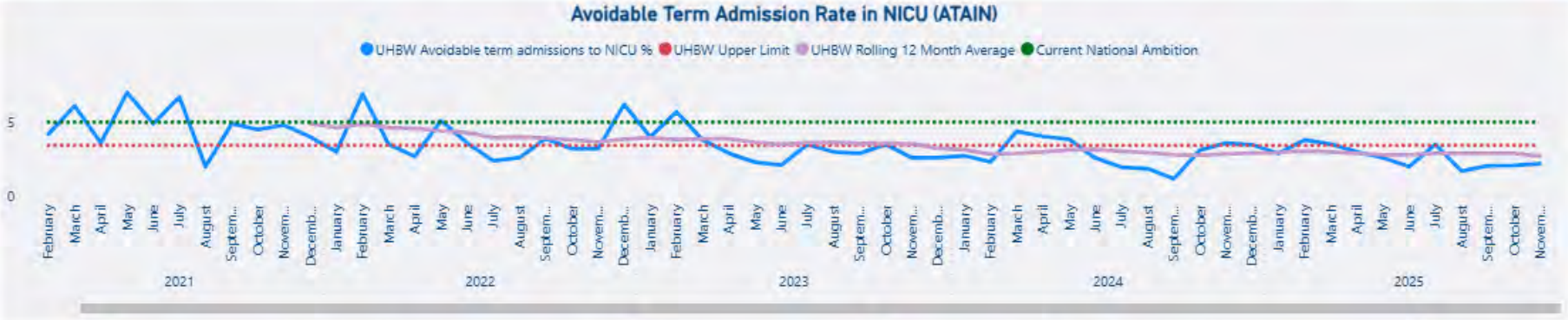
Neonatal Commissioned Cot Summary

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

Perinatal Quality Surveillance Matrix (PQSM) October 2025

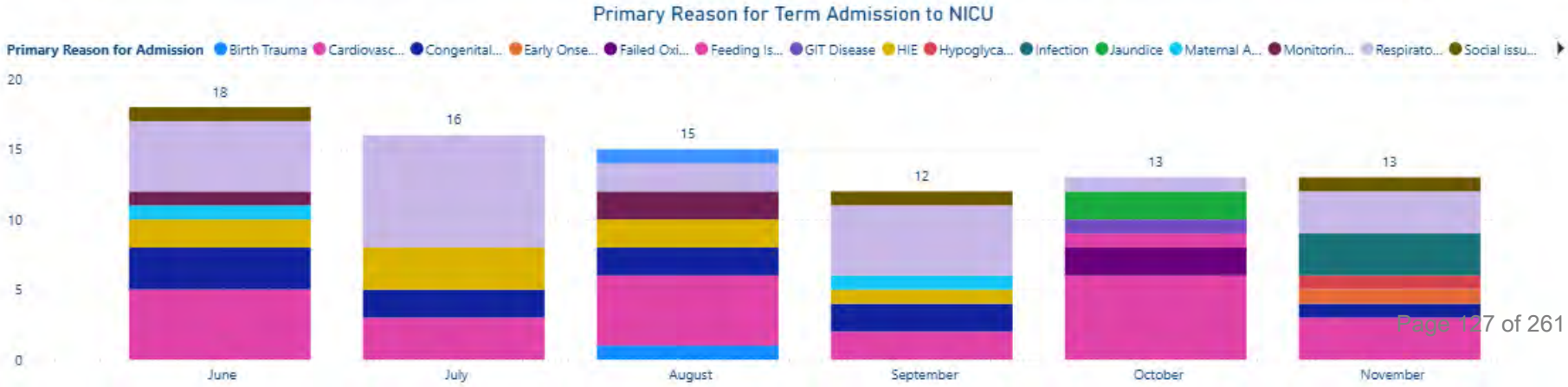
University Hospitals Bristol and Weston NHS Foundation Trust

Neonatal Metrics - Avoidable Term Admission Rate in NICU (ATAIN)



November 2025
UHBW Avoidable term Admission Rate 2.20%

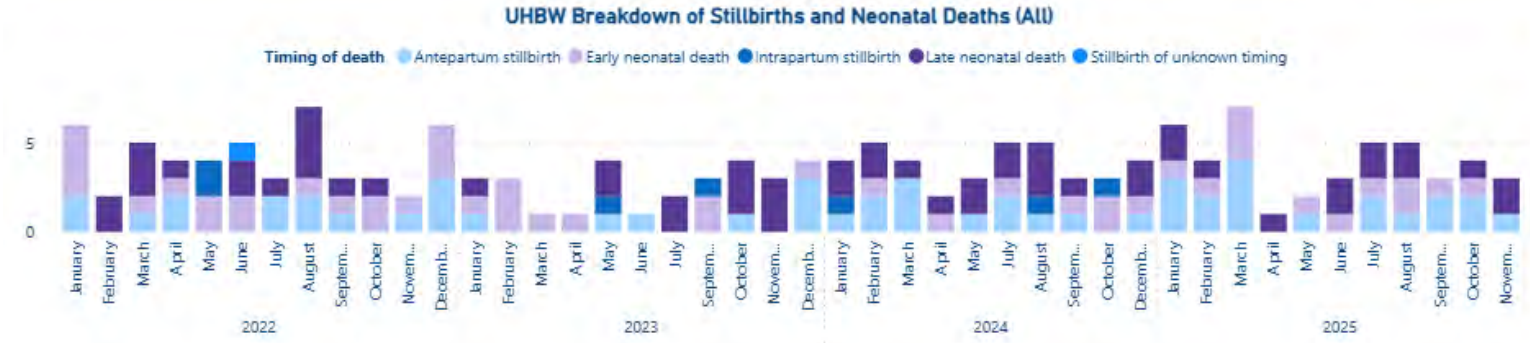
As of End November 2025
UHBW Rolling 12 Month Average 2.70%

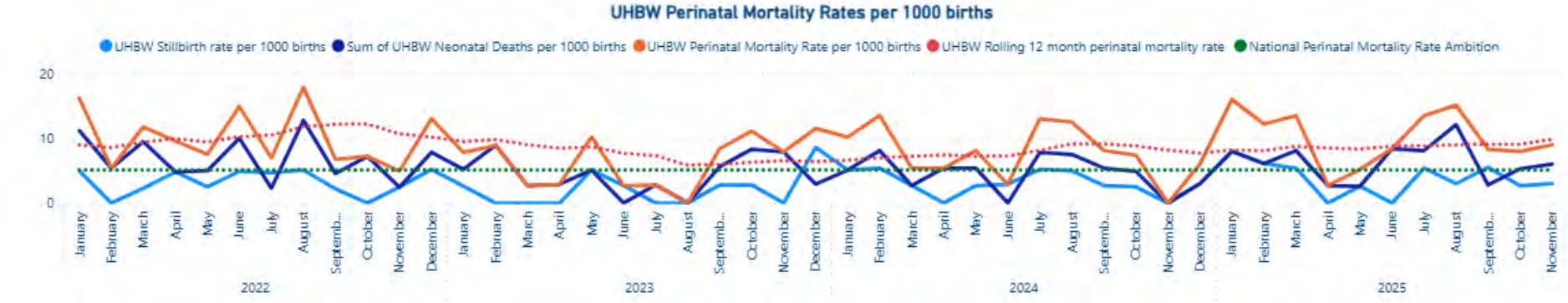


Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Perinatal Mortality Overview (up to end November 2025





UHBW Rolling 12 Month Perinatal Mortality Rate at end November 2025 (per 1000 births) = 9.80

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Maternity Outcomes Signal System (MOSS)

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

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

Maternity Outcomes Signal - Cumulative sum (CUSUM) - University Hospitals Bristol and Weston NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

Chart guidance can be found using the "i" icon.

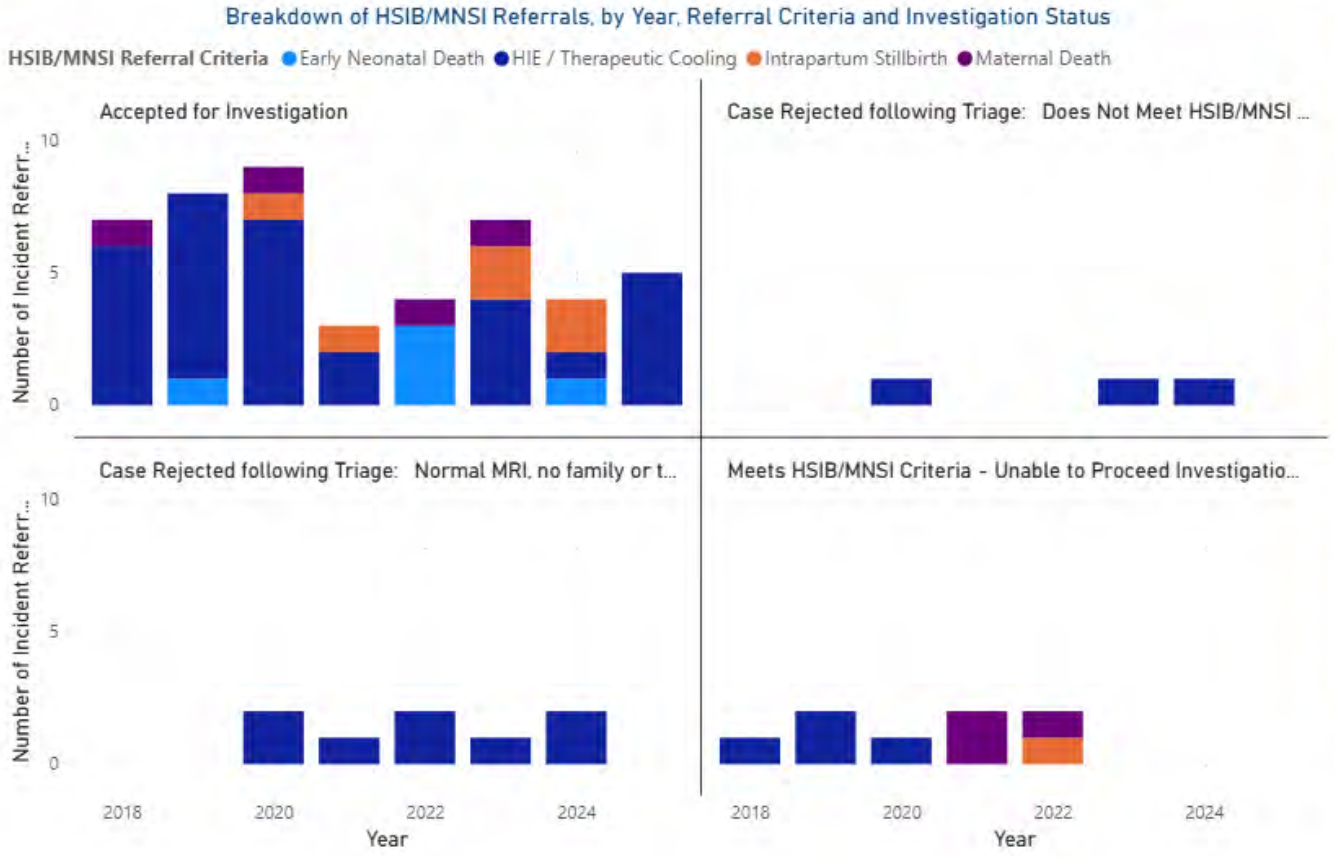
Latest Event: **09 Sept 25**
Refreshed: **10 Dec 25**

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

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Perinatal Mortality & Morbidity - MNSI



MNSI Maternity & Newborn Safety Investigations

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

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

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

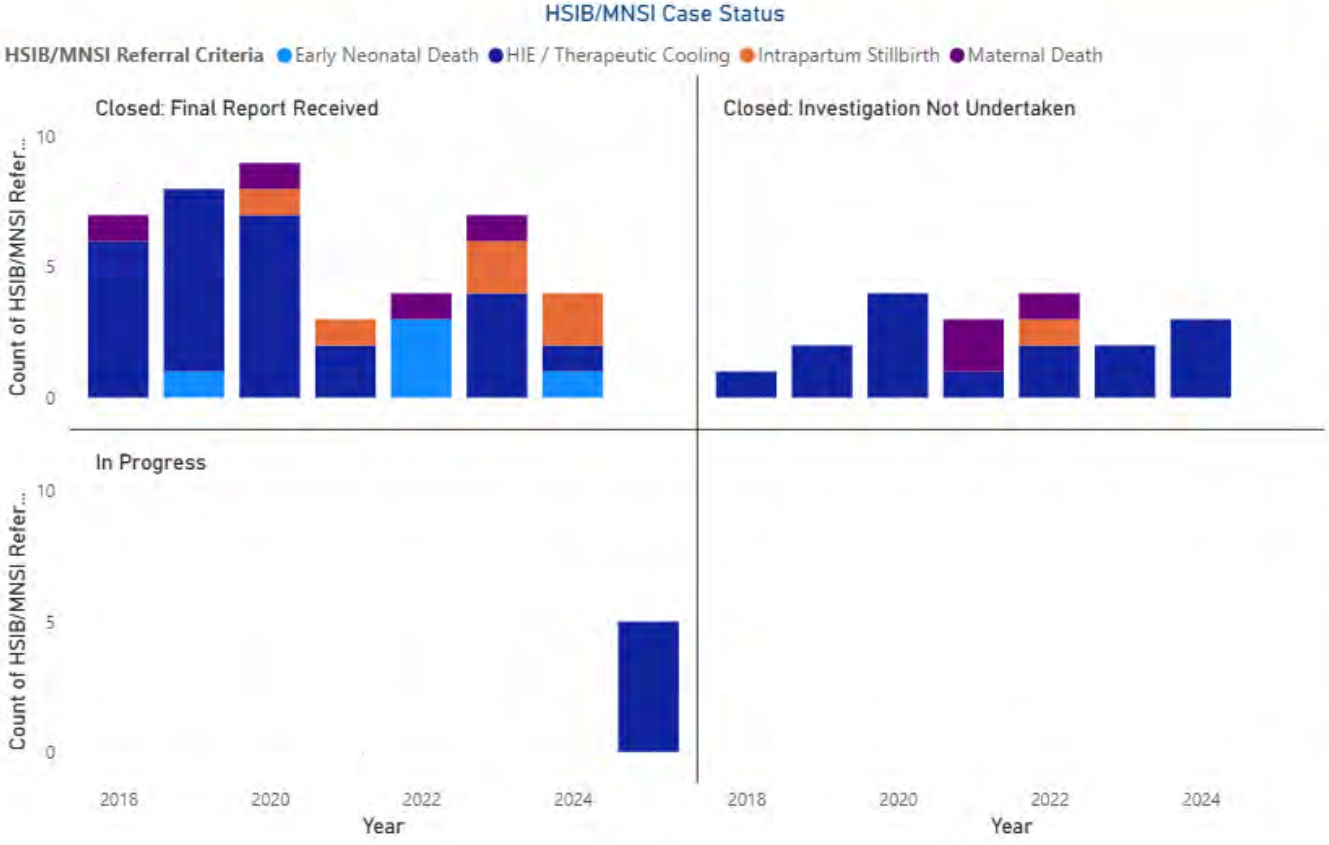
Date of Incident

17/08/2018 09/09/2025

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Perinatal Mortality & Morbidity - MNSI



MNSI Maternity & Newborn Safety Investigations

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

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

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

Date of Incident

17/08/2018 09/09/2025

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

PMRT Reviews

What is PMRT?

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

Grading of Care

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

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

PMRT ID	Month reviewed	Date of Incident	Incident	Grading of care		Outcome/ Learning/ Actions (if grading C or D)
99905	19/11/2025	19/08/2025	Stillbirth	Grading of care of the mother and baby up to the point of birth of the baby.	A	
				Grading of care of the mother following the death of her baby.	A	
100492	19/11/2025	29/09/2025	Stillbirth	Grading of care of the mother and baby up to the point of birth of the baby.	A	
				Grading of care of the mother following the death of her baby.	A	
94304	19/11/2025	13/07/2024	Neonatal Death	Grading of care of the mother and baby up to the point of birth of the baby.	Plymouth	
				Grading of care of the baby from birth up to the death of the baby.	B	
				Grading of care of the mother following the death of her baby.	Plymouth	

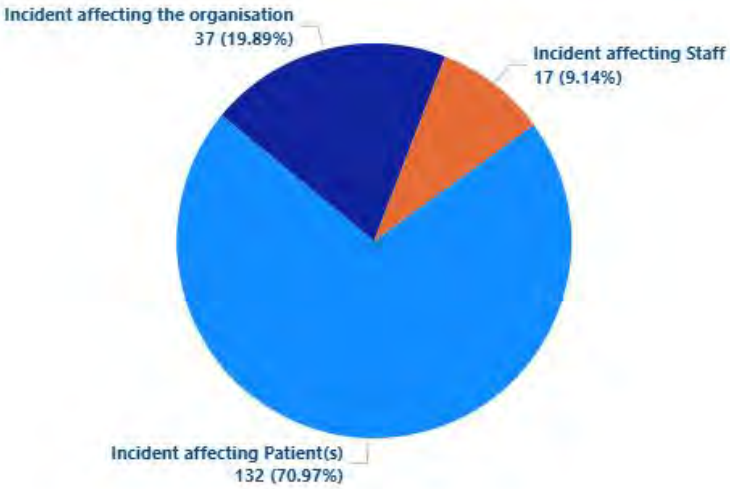
Perinatal Quality Surveillance Matrix (PQSM) October 2025

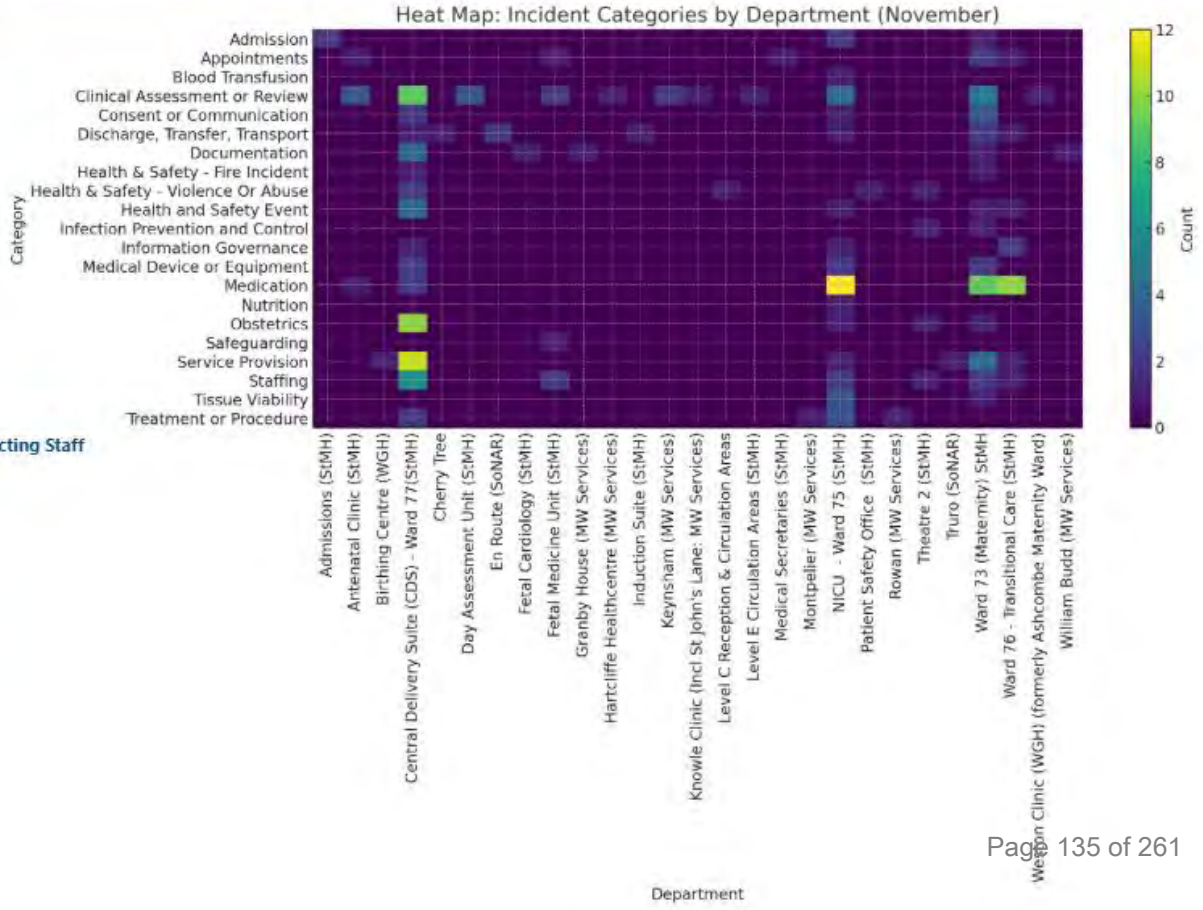
University Hospitals Bristol and Weston NHS Foundation Trust

Incident Reporting & Management

186

November 2025
Total Number of Incidents Reported





Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Incident Reporting & Management

Thematic Analysis: Top 4 Themes

Medication-Related Issues (Highest volume: 34 incidents)

Medication events represent the single largest thematic area. Common patterns include:

- **Prescribing errors** (omissions, incorrect doses, transcription mistakes).
- **Administration delays or deviations from protocol**, particularly during high-activity periods.
- **Incorrect medication supplied or unavailable**, often linked to stock issues.
- **Failure to follow double-checking procedures**, especially for high-risk drugs.

Overall, these incidents predominantly reflect **process reliability issues**, workload pressures, and inconsistent adherence to medication safety standards.

Clinical Assessment, Monitoring, or Review (32 incidents)

These incidents typically involve:

- **Delayed clinical assessment**, especially in triage and high-throughput areas.
- **Inadequate maternal or fetal monitoring**, including CTG interpretation delays.
- **Incomplete or incorrect clinical reviews** due to competing priorities or handover issues.

Themes point to **demand exceeding capacity**, resulting in reduced timeliness and robustness of clinical decision-making.

Service Provision Constraints and Environmental Factors (19 incidents)

Key drivers include:

- **Delays in care due to operational pressures** (e.g., bed availability, high activity).
- **Workflow disruptions** from environmental limitations (equipment availability, room readiness).
- **Systemic barriers** affecting patient flow across maternity and neonatal pathways.

These reflect broader **operational resilience challenges**.

Staffing-Related Pressures (14 incidents)

Incidents in this category frequently cite:

- **Under-staffing or unbalanced skill mix**, particularly during weekends and nights.
- **High workload intensity**, contributing to delays and increased error rates.
- **Inadequate staffing during surges**, impacting triage, CDS, and ward activity.

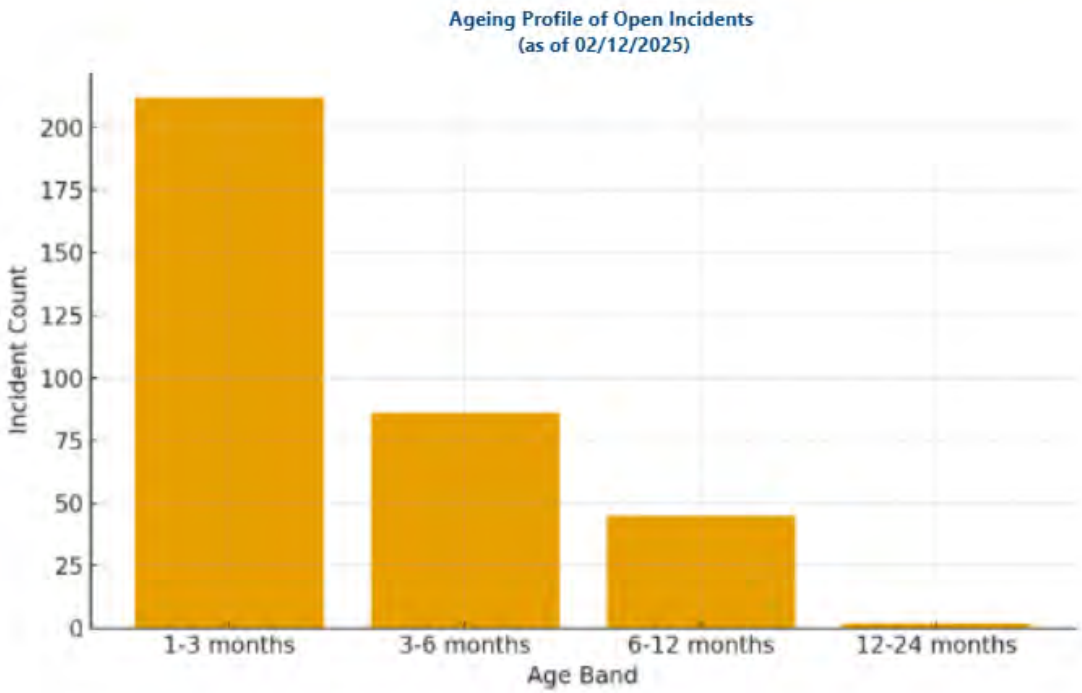
This theme intersects strongly with medication and assessment incidents, indicating **capacity mismatch** as an underlying contributor

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Incident Reporting & Management

Open and Overdue Incidents



345

Unclosed Incidents
(as of 02/12/2025)

The distribution of incidents is highly concentrated in a small number of clinical areas:

- **NICU – Ward 75 (103 incidents)**
- **Central Delivery Suite (CDS) – Ward 77 (96 incidents)**
- **Ward 73 Maternity (30 incidents)**

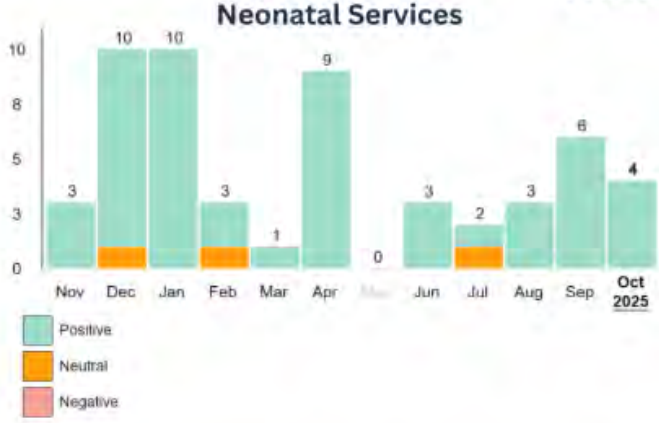
These three areas account for **over 65%** of all unclosed incidents. Remaining services each report significantly lower volumes, typically between 1 and 11 incidents.

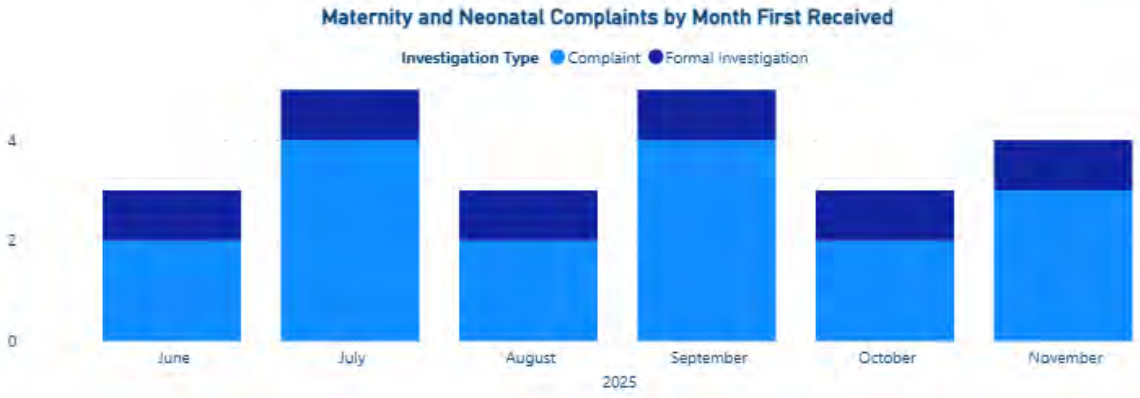
Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Patient Experience

Friends & Family Test Survey





Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Maternity Incentive Scheme - Year 7

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

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: 3 March 2026

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

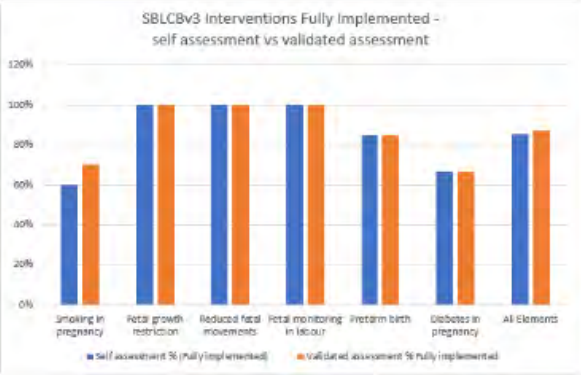
Compliance with National Directives: Saving Babies Lives (Version 3.2)

LMNS Assurance Review Dates:

MIS Year 7:

Q1 18th July 2025 = 78%

Q2 1st December 2025 = 87%



Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	70%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	86%	Partially implemented	87%

Saving Babies' Lives Care Bundle (SBLCB) Version 3.2 is an NHS England national maternity safety initiative designed to reduce stillbirths, neonatal deaths, brain injuries, and preterm births. Version 3.2 builds on earlier iterations by strengthening evidence-based clinical practice and aligning with updated national guidance.

The bundle focuses on six core elements:

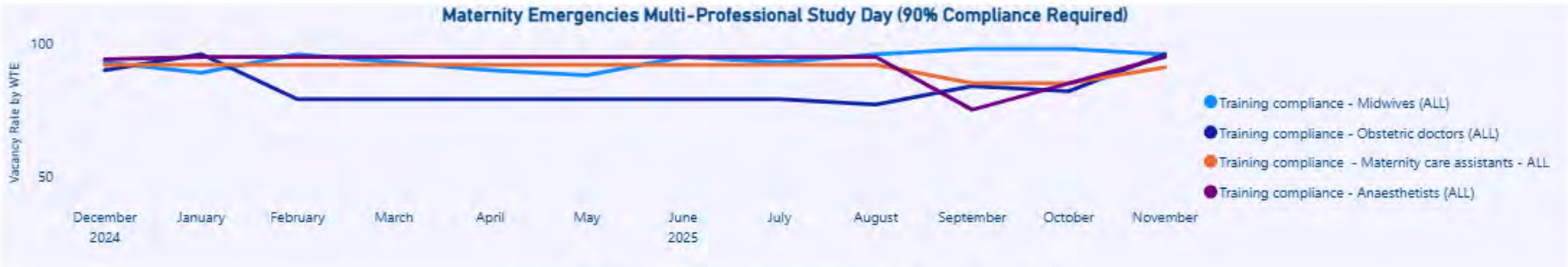
1. Reducing smoking in pregnancy through systematic identification, referral, and support.
2. Risk assessment and surveillance for fetal growth restriction, using standardised pathways and appropriate ultrasound monitoring.
3. Raising awareness of reduced fetal movements among pregnant women and ensuring timely, consistent clinical responses.
4. Effective fetal monitoring during labour, including improved CTG interpretation, training, and escalation.
5. Reducing preterm birth by identifying risk factors early and offering targeted interventions.
6. Management of pre-existing diabetes in pregnancy (Type 1 or Type 2), with a focus on multidisciplinary pathways and strengthened glucose management/technology to reduce adverse outcomes.

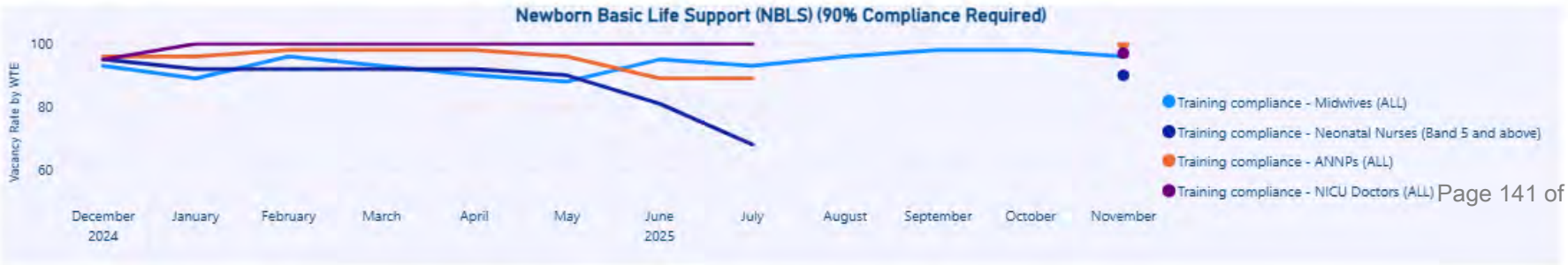
Version 3.2 emphasises equity, personalised care, multidisciplinary teamwork, and continuous quality improvement, supporting maternity services to deliver safer, more consistent care across England.

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Mandatory Training (MIS Year 7)





Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Three Year Delivery Plan

Maternity and Neonatal Three Year Delivery Plan Oversight Tool - Outlier summary

Contents page

NHS England

This sheet shows, for each ICB and Trust, how many measure results are demonstrating better outcomes / progress or needing further support / improvement, and which measures these relate to

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

MBRRACE-UK metrics: Better outcomes – Poorer outcomes

All other metrics: More positive – Improvement / support needed

Select ICB or Trust level map: Trust

Select positive/negative outlier map: Positive

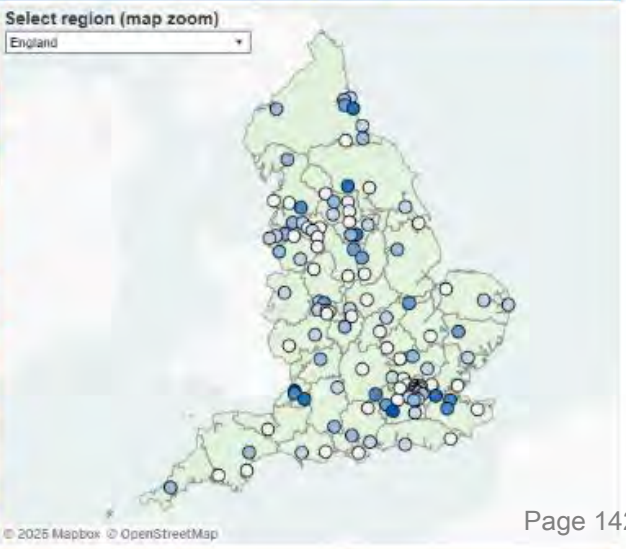
University Hospitals Bristol and Weston NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	41	2	10
Listening to and working with women and families with compassion	12	1	3
Growing, retaining and supporting our workforce	13	1	4
Developing and sustaining a culture of safety, learning and support	13		2
Standards and structures that underpin safer, more personalised, and more equitable care	3		1

T1b:Involvement in antenatal care decisions	90.7%
T1c:Being listened to during antenatal check-ups	88.6%
T1ni:Baby Friendly Accreditation - Maternity	0.0%
T1nii:Baby Friendly Accreditation - Neonatal	100.0%
T2ai:Midwives' satisfaction with recognition for good work	53.2%
T2bi:Midwives' satisfaction with work being valued by your organisation	46.8%
T2ci:Opportunities to discuss and agree learning needs at the sta of training - Trainee Midwives	45.5%
T2hi:Midwife Turnover Rate	5.1%
T2ii:Midwife Sickness Absence Rate	4.9%
T3bi:Midwives' confidence in organisations response to concerns about unsafe clinical practice	70.6%
T3ci:Midwives' recommendation of the service	88.9%
T4biii:Neonatal Mortality Rate (Stabilised) (MBRRACE)	2.4

England Trust outliers map: Number of Positive outliers

Select region (map zoom): England



Please contact england.matneo-oversighttool@nhs.net with any queries or feedback on this tool. This version of the tool is a Beta version and will be developed iteratively based on your input.

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Three Year Delivery Plan

University Hospitals Bristol and Weston NHS Foundation Trust: Developing and sustaining a culture of safety, learning and support

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Supportive working environment for trainee doctors	Percentage	2025	72.2%	70.6%	81.3%		-10.7% ▼
Recommendation of the training post - Trainee Midwives	Percentage	2024	72.3%	63.9%	46.7%		17.9% ▲
Recommendation of the training post - Obstetrics and Gynaecology Specialist...	Percentage	2024	84.2%	62.5%	100.0%		-37.5% ▼
Quality of shift handovers for trainee doctors	Percentage	2025	89.3%	100.0%	92.0%		7.1% ▲
Quality of clinical supervision out of hours for doctors	Percentage	2025	73.9%	87.5%	100.0%		-12.5% ▼
Obs & Gynae recommendation of this service	Percentage	2024	73.1%	34.6%	80.7%		-46.1% ▼
Obs & Gynae experience of learning culture	Percentage	2024	83.3%	61.5%	64.3%		-21.7% ▼
Obs & Gynae confidence in organisations response to concerns about wealth...	Percentage	2024	84.8%	91.5%	46.7%		14.9% ▲
Midwives' recommendation of this service	Percentage	2024	71.4%	84.3%	80.8%		3.3% ▲
Midwives' experience of learning culture	Percentage	2024	73.4%	69.7%	81.2%		-8.5% ▼
Midwives' confidence in organisations response to concerns about wealth (Int...	Percentage	2024	83.9%	76.4%	57.7%		18.8% ▲
Comfortable raising concerns - Trainee Midwives	Percentage	2024	83.3%	72.7%	18.8%		54.5% ▲
Comfortable raising concerns - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	75.1%	100.0%	100.0%		0.0% →

Key

Past Trend
- Baseline (Trend change in the publication of the three year delivery plan in March 2025)

Change from baseline (colour)
- Significant deterioration from baseline
- No significant change from baseline
- Significant improvement from baseline
- Not applicable for significance testing

Change from baseline (symbol)
- ▼ Decrease
- ▲ Increase
- → No change

University Hospitals Bristol and Weston NHS Foundation Trust: Growing, retaining and supporting our workforce

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Permitted to attend learning opportunities - Trainee Midwives	Percentage	2024	75.2%	63.6%	42.9%		20.8% ▲
Permitted to attend learning opportunities - Obstetrics and Gynaecology Speci...	Percentage	2024	69.2%	62.5%	61.5%		1.0% ▲
Overall educational experience - Trainee Midwives	Percentage	2024	75.1%	72.7%	72.7%		0.0% ▲
Overall educational experience - Obstetrics and Gynaecology Specialist Traine...	Percentage	2024	81.9%	62.5%	52.3%		-19.8% ▼
Opportunities to discuss and explore learning needs at the start of training - ...	Percentage	2024	81.1%	45.5%	61.1%		-17.0% ▼
Opportunities to discuss and explore learning needs at the start of training - ...	Percentage	2024	86.4%	100.0%	100.0%		0.0% →
Midwives' Sickness Rate	Percentage	June 2025	7.9%	8.2%	6.0%		2.2% ▲
Obs & Gynae satisfaction with work being valued by your organisation	Percentage	2024	83.3%	58.3%	53.3%		5.1% ▲
Obs & Gynae satisfaction with recognition for good work	Percentage	2024	52.7%	33.3%	60.0%		-8.2% ▼
Midwives' satisfaction with work being valued by your organisation	Percentage	2024	53.8%	46.8%	47.9%		0.3% ▲
Midwives' satisfaction with recognition for good work	Percentage	2024	41.7%	53.2%	49.0%		4.1% ▲
Midwife Turnover Rate	Percentage	Year to July 2025	7.7%	5.1%	12.1%		-7.0% ▼
Midwife Turnover Avoidance Rate	Percentage	June 2025	5.8%	4.8%	5.6%		-0.8% ▲

University Hospitals Bristol and Weston NHS Foundation Trust: Listening to and working with women and families with compassion

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Response to concerns during labour and birth	Percentage	2024	89.4%	88.2%	87.5%		0.8% ▼
Skin-to-skin contact given in the first hour after birth	Percentage	2024	81.6%	86.3%	87.5%		-1.4% ▼
Involvement in decisions during labour and birth	Percentage	2024	78.2%	80.0%	78.2%		1.7% ▲
Involvement in antenatal care decisions	Percentage	2024	79.6%	80.7%	82.4%		-1.7% ▲
Consideration of personal circumstances during postnatal care at home	Percentage	2024	71.7%	78.9%	79.1%		-0.2% ▼
Being listened to during antenatal care	Percentage	2024	74.9%	77.6%	83.1%		-5.5% ▼
Being listened to during postnatal check-ups	Percentage	2024	82.9%	82.6%	85.0%		-2.3% ▼
Baby Friendly Accreditation - Neonatal	Percentage	October 2025	14.3%	100.0%	100.0%		0.0% →
Baby Friendly Accreditation - Maternity	Percentage	October 2025	28.6%	0.0%	0.0%		0.0% →
Attendance at medical history during antenatal check-ups	Percentage	2024	52.9%	45.1%	55.0%		-10.0% ▼
Adequacy of time spent discussing exercise and mental health at the 6-8 week...	Percentage	2024	34.4%	28.0%	30.1%		-2.1% ▼
Attendance at maintenance of supervision during postnatal hospital care	Percentage	2024	58.2%	59.9%	58.7%		1.2% ▲

University Hospitals Bristol and Weston NHS Foundation Trust: Standards and structures that underpin safer, more personalised, and more equitable care

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Stillbirth Rate (Standard) (MBRRACE)	Rate per 1,000	2023	N/A	3.3	N/A		N/A ✕
Stillbirth Rate (MBRRACE)	Rate per 1,000	2023	N/A	2.8	3.2		-1.4 ▼
Preterm Birth Rate (MBRRACE)	Incidence	July 2025	8.3%	8.5%	8.3%		0.2% ▼
Neonatal Mortality Rate (Standard) (MBRRACE)	Rate per 1,000	2023	N/A	2.4	N/A		N/A ✕
Neonatal Mortality Rate (MBRRACE)	Rate per 1,000	2023	N/A	1.8	3.2		-1.4 ▼

Perinatal Quality Surveillance Matrix (PQSM) October 2025

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Ockenden

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England and MNSI.

Descprition	Number of Assurance Questions	N/A for UHBW or National Actions	Red	Amber	Green	Blue	Completed and Evidenced	% of Compliance
Workforce Planning and Sustainability	11	1	0	0	0	0	10	100.00
Supporting Families	3	0	0	0	0	0	3	100.00
Safe Staffing	10	2	0	0	0	0	8	100.00
Pre-term Birth	4	1	0	0	0	0	3	100.00
Postnatal Care	4	0	0	0	0	0	4	100.00
Obstetric Anaesthesia	5	2	0	0	0	0	3	100.00
Neonatal Care	8	3	0	1	0	0	4	87.50
Multidisciplinary Training	9	0	0	0	0	0	9	100.00
Learning from Maternal Deaths	3	2	0	0	0	0	1	100.00
Labour and Birth	6	0	0	0	0	0	6	100.00
Incident Investigations and Complaints	7	0	0	0	0	0	7	100.00
Escalation and Accountability	5	0	0	0	0	0	5	100.00
Complex Antenatal Care	5	0	0	0	0	0	5	100.00
Clinical Governance and Leadership	7	1	0	0	0	0	6	100.00
Bereavement Care	4	0	0	0	1	0	3	75.00
	91	12	0	1	1	0	77	97.80

	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 – Expansion of new ' Bereavement Champion' role to support 7 day bereavement support
- IEA14 – Neonatal Staffing

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	13th January 2025		
Report Title:	Bristol NHS Group Health Equity Plan 2026/2027		
Report Authors:	Kathryn Hamilton, Consultant in Public Health, Bristol NHS Group Tim Keen, Associate Director of Strategy, NBT Matthew Areskog, Head of Experience of Care & Inclusion UHBW, Abigail Jones, Programme Manager, Bristol NHS Group		
Report Sponsor:	Professor Steve Hams, Chief Nursing & Improvement Officer Professor Tim Whittlestone, Chief Medical & Innovation Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	
	This report sets out a framework for an integrated Bristol NHS Group approach to advancing Health Equity for patients and the local population, including a clear delivery plan for 2026/2027.		

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

The Health Equity Plan 2026/27 was approved by the Quality and Outcomes Committee in December 2025.

Health inequalities are unfair and avoidable differences in health between different population groups. Covid-19 shone a spotlight on the significant inequities that exist within our communities and highlighted a lack of systematic approach in the NHS in this area.

With growing national and regional attention, both NBT and UHBW have intensified our emphasis on this important work as Acute NHS Trusts working with our system partners. This plan represents a bringing together of the solid progress that both Trusts have made to date in this journey and meets one of the recommendations from the June 2025 Board Seminar on Health Equity.

As Bristol NHS Group develops with a potential merger, the Health Equity Plan describes objectives for 2026/2027, as well as potential areas of longer-term focus which we commit to co-designing with our people and communities. This document for 2026/2027 sets out the rationale, requirements and commitments for health equity and proposes four key goals:

1. Building equity into our services
2. Designing and delivering with communities for population health
3. Strengthening our capability to deliver on health equity
4. Developing our role as an Anchor organisation to tackle health inequalities

In preparation for bringing together a single Bristol NHS Group approach to Health Equity, the existing separate NBT and UHBW Health Equity Governance groups have met for the final time. A new, integrated Health Equity Delivery Group will meet for the first time in February 2026 and will be responsible for overseeing the delivery of the plan and reporting to Joint Clinical Strategy Board and Quality and Outcomes Committee on progress for assurance.

Strategic and Group Model Alignment

Advancing health equity is a pillar in the current Joint Clinical Strategy for the Bristol NHS Group. It is essential that we have a Health Equity Plan to drive forward that ambition. This plan, and the commitment to co-produce a longer-term population health delivery plan that integrates with the Joint Clinical Strategy is needed for progress on the 10-year plan shifts. Population health brings together a data-led approach to improving health including through prevention and effective action on health inequalities. Population health support the 4Ps and future strategic opportunities including Integrated Health Organisations.

The Health Equity Plan will support with a focus on the 4Ps, tackling health inequities for our patients and population. There is a significant body of research that suggests that a Health Equity mainstreamed approach also supports with better use of the public purse, i.e. that person-centred, accessible, and inclusive services are more efficient, for example by reducing missed appointment rates in marginalised communities.

We have consistently heard that we need to co-ordinate our equity approach to staff and our communities with our patients. This plan surfaces alignment to established plans and programmes of work for staff equity under our role as an Anchor Organisation.

This plan details the Acute response to the BNSSG Joint Forward Plan population health priorities and has been developed with input from our BNSSG Directors of Public Health and ICB colleagues.

Risks and Opportunities

The Health Equity Plan presents a unique opportunity to join our efforts, have a united focus, a single governance structure and pooled resource to best use the leverage Bristol NHS Group has in tackling health inequities in the local population.

We are in a significant period of organisational change which brings a high degree of complexity. There is a risk that prioritising a focus on Health Equity amongst many competing priorities may be challenging.

Recommendation

This report is for **Discussion.** Quality and Outcomes Committee has approved the plan, and the Board is asked to:

- Consider how the Board will continue to support delivery of the Health Equity Delivery Plan 2026/2027.
- Endorse the approach set out to co-design a longer-term plan for Population Health and Health Equity with patients, colleagues, and communities to support the effective delivery of the Joint Clinical Strategy and support our ambition to become an early Integrated Healthcare Organisation.

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

NBT Inequalities Steering Group	10th November 2025
UHBW Health Equity Delivery Group	20th November 2025
Quality and Outcomes Committee	25th November 2025
Group Executive Meeting	7th January 2025

Appendices:	Appendix 1: Bristol NHS Group Health Equity Delivery Plan

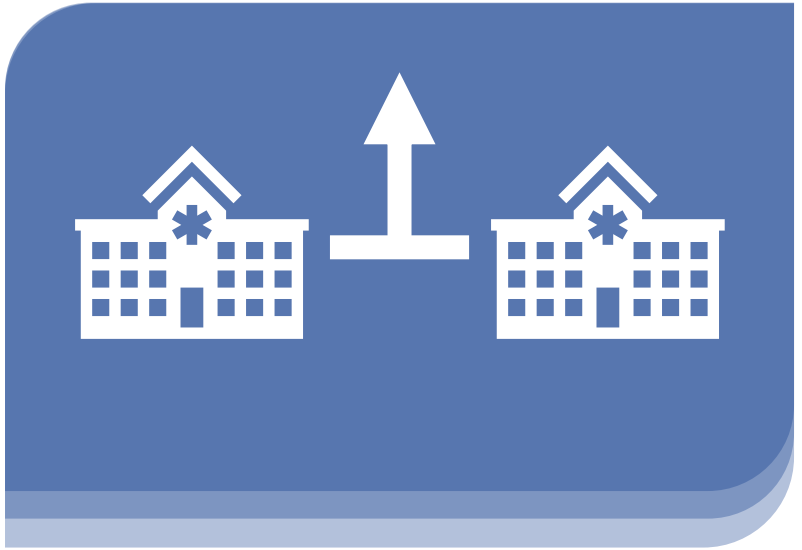
NHS
Bristol
NHS Group
Bristol | Weston

Bristol NHS Group Health Equity Plan 2026/27

Background and Summary

NHS Bristol NHS Group
Bristol | Weston

- Increasing health equity is a pillar in the Joint Clinical Strategy for the Bristol NHS Group. Our health equity plan will drive forward that ambition.
- As the Bristol NHS Group organisation is changing, this plan looks at goals for 2026/2027, as well as possible longer-term objectives which we commit to co-designing with our people and communities.
- The formation of the Bristol NHS Group brings opportunities to increase equity in our service design and delivery, for our population
- This document for 2026/2027 sets out the rationale, requirements and deliverables for health equity under four key goals:
  - Building equity into our services
  - Designing and delivering with communities for population health
  - Strengthening our capability to deliver on health equity
  - Developing our role as an Anchor organisation to tackle health inequalities
- This plan works in parallel with the plan for workforce Equality, Diversity and Inclusion.



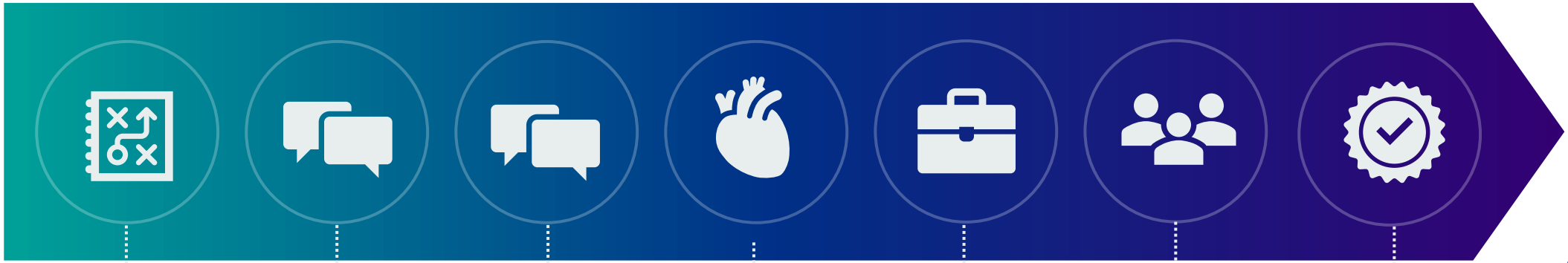
Equitable

Care is based on the needs of our patients and populations.

We strive to eliminate inequalities in access to services, options for treatment, opportunities to participate in research and outcomes.

Our journey with health equity

NHS Bristol NHS Group
Bristol | Weston



July 2022

UHBW Independent EDI baseline assessment

December 2022

NBT Inequalities Steering Group launches

March 2023

UHBW Health Equity Delivery Group launches with community participation

Summer 2023

Tobacco dependency service launches

September 2023

Inequalities dashboards launched in both Trusts

Jan 2024 – Apr 2025

Project to increase outpatient attendance funded by Health Foundation

November 2025

New translation service launches in both Trusts

26/27 Joint health equity plan for the Bristol NHS Group

Equitable

Care is based on the needs of our patients and populations.

We strive to eliminate inequalities in access to services, options for treatment, opportunities to participate in research and outcomes.

Understanding Population Health and Health Equity

Health inequalities are unfair and avoidable differences in health between different population groups.
Approximately 20% of a population's health is determined by access to healthcare – healthcare inequalities are avoidable differences in access, outcomes and experience in healthcare services.

We have a responsibility to provide high quality healthcare, and prevent inequalities in access, experience and outcomes.

Everyone should be able to access the right care at the right time in the right place. This will have a positive impact on the gaps in health outcomes that some groups in our population experience.

Health equity means we act to reduce health inequalities and build population health as healthcare providers and Anchor Organisations.

Our future health is mostly influenced by the environments in which we are born, grow, live, work and age. As Anchor Organisations, we work in partnership, to build positive opportunities for good health and embed prevention of ill health for our communities, patients and staff.

Our children are the future, and our childhood impacts on our health as adults. A lifecourse approach means prioritising health equity, prevention and early intervention from birth, through childhood and into adulthood and older age.

Health Equity and the 10-Year Plan

NHS Bristol NHS Group
Bristol | Weston

Health equity is fundamental to delivering England's 10-Year Health Plan. If equity isn't baked in, prevention programmes, community services and digital innovations could widen existing gaps. Improving population health requires targeted actions to reduce health inequalities at every step meaning improvements reach the people with the greatest need.

The longer term digital first approach must be co-developed with people at risk of digital exclusion, and include targeted support for people who need it.

Equity is not optional - it's the mechanism that turns the three shifts into fair, sustainable gains for the whole population.

Developing our health equity plan

NHS Bristol NHS Group Bristol | Weston

We have developed this plan through planning workshops, working with our Board (Appendix), and targeted engagement with our staff, community partners* and health system partners from the ICB and BNSSG public health teams. We have reviewed system priorities, our progress to date and listened to what is working well and where we can do better.

The plan responds to our national requirements (Appendix) and uses the CORE20PLUS5 frameworks and the NHSE Guide To Tackling Inequalities in healthcare access, experience, and outcomes principles:

- Committing to action to reduce inequalities in healthcare access, experience and outcomes
- Guided by and prioritised by local data and shared understanding
- Collaborating and building equitable partnerships, with our communities, and for our population
- Strengthening organisational and staff capability and confidence to understand and act
- Listening, learning and sharing our impact

Our staff are engaged and passionate about reducing health inequalities. The plan presents our key priorities for progress but does not describe all the health equity work across our organisations.

*UHBW Health Equity Delivery Group Community Partners: Caafi Health, The Diversity Trust, For All Healthy Living Centre, African Voices Forum, WECIL.

Bristol NHS Group Joint Clinical Strategy

Strategic Alignment

NHS Bristol NHS Group Bristol | Weston

The goals for health equity in this plan include patients, staff and our communities, and different functions within our organisations. This plan describes the essential connections with related Trust Strategies and Plans and their established programmes of work, including:

- UHBW Experience of Care Strategy and NBT Patient & Carer Experience Strategy
- UHBW and NBT People Strategies
- UHBW Volunteer Strategy, NBT Volunteer Services Strategic Plan
- UHBW and NBT Clinical Strategies
- UHBW and NBT Digital Strategies
- UHBW Outpatient Strategy
- NBT Commitment to Our community Plan

Alignment to BNSSG Population Health Priorities

NHS Bristol NHS Group
Bristol | Weston

This plan supports delivery of the three Health and Wellbeing Board Strategies and the BNSSG Population Health Priorities

Bristol Vision: For citizens to thrive in a city that supports their mental and physical health and wellbeing, with children growing up free of 'Adverse Childhood Experiences' and the gaps in health outcomes between the most economically deprived areas and the most affluent areas of Bristol significantly reduced.

North Somerset Vision: Working together to ensure equality of opportunity for everyone in North Somerset to start, live, work, age and die well and to enjoy good wellbeing and health.

South Gloucestershire Vision: Our vision is that South Gloucestershire is a healthy and inclusive place, where current and future generations feel safe, supported and empowered to lead healthy lives.

BNSSG Joint Forward Plan

We have a role in improving population health through delivering high quality accessible healthcare. We work in partnership to respond to shared population health priorities aligned to reduce inequalities in health outcomes, including:

- Whole system approaches to smoke free, healthy weight and drugs and alcohol
- Women's health
- Sexual and reproductive health, abortions and HIV
- Children and Young People
- Local maternity and neonatology
- Long Term Conditions
- Mental Health, Learning Disabilities and Autism
- Care Closer to Home

Equitable

Care is based on the needs of our patients and populations.

We strive to eliminate inequalities in access to services, options for treatment, opportunities to participate in research and outcomes.

What our local data tells us

Just over 1 million people live in BNSSG. On average, compared to 10 years ago, we are spending more years in ill health. The leading causes of avoidable mortality and health inequalities for our population are cardiovascular disease, cancer and respiratory disease. There is rising risk from chronic liver disease and disparities in outcomes are widening. BNSSG prevention priorities are tobacco dependency, alcohol and healthy weight.

In BNSSG we have big gaps in health outcomes for some population groups. This includes people living in areas of deprivation, some global majority groups, and people experiencing homelessness or other forms of social exclusion.

People at risk of worse health outcomes may face barriers in accessing opportunities for good health, including high quality healthcare. For people with the worst health outcomes we often see high levels of emergency health care usage, higher non-attendance rates and sometimes longer waits.

Within our organisations health inequality dashboards have real-time data on DNA rates, waiting times and recording of equity factors e.g. ethnicity

NBT Health Inequalities - Power BI

UHBW Health Inequalities - Power BI

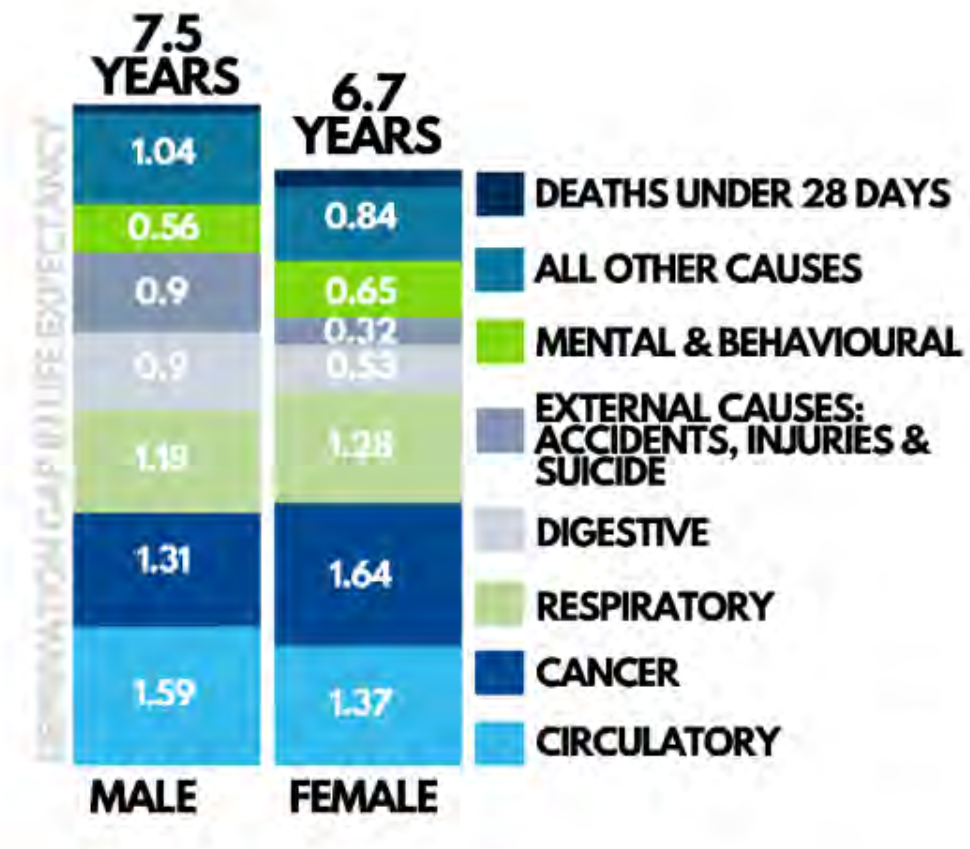


Fig 1. Causes of Gap in Life Expectancy for most deprived 20% of BNSSG population compared to least deprived 20%

Data sources: OurFutureHealth-Sept-2022.pdf, Our population | BETA - South Gloucestershire Council (includes BNSSG),

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **ASTHMA**
Address over reliance on reliever medications and decrease the number of asthma attacks

2. **DIABETES**
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

4. **ORAL HEALTH**
Address the backlog for tooth extractions in hospital for under 10s

5. **MENTAL HEALTH**
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Our Children and Young people are 20% of our population, 100% of our future

REDUCING HEALTHCARE INEQUALITIES

NHS

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

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ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

Our goals for health equity

NHS Bristol NHS Group Bristol | Weston

1. Building equity into our services

2. Designing and delivering with communities for population health

3. Strengthening our capability to deliver on health equity

4. Developing our role as an Anchor organisation to tackle health inequalities

Key year 1 measures of success

1. Building equity into our services	2. Designing and delivering with communities for population health
Reduction in DNA disparities for global majority and IMD-1 groups across all specialities Improved recording of ethnicity Trust-wide Improved recording of smoking status for emergency admissions	Review of substance misuse provision across hospital group At least 75% of health equity projects are coproduced with people with lived experience
3. Strengthening our capability to deliver on health equity	**4. Developing our role as an Anchor organisation to tackle health inequalities**
Training and information available on relaunched intranet Number and colleague reported effectiveness of training sessions completed Use of inequalities data and insights in senior forums and reviews Bristol NHS Group Health Equity Governance in place including reporting to QOC	Anchor metrics will be agreed, the below strategies and plans hold metrics within them •Clinical Strategy •Staff Health and Wellbeing Plan •People Strategy – Local workforce, inclusion •Quality Strategy – Co-design, improved outcomes •Experience of Care – Person-centred, equitable care •Digital Strategy – Data-driven innovation •Green Plan – Sustainability and procurement •One City – Local collaboration, VCSE frameworks

1. Building equity into our services

	Data and Intelligence	Technology	Accessible Communication	Quality inc Core20PLUS5
Vision	Quality intelligence on health inequalities is available to teams and is used to inform decisions at all levels of the organisation.	Emerging technology is fully exploited to reduce health inequalities, addressing digital poverty and digital literacy barriers.	Accessible communication empowers patients to understand, engage with, and make informed decisions about their care, leading to safer, more equitable, and person-centred outcomes.	High quality clinical care is available at the right time and place. National evidence and local data is used to drive action on clinical drivers of health inequalities, using a CORE20PLUS approach.
Year 1 Actions	• Improve data quality through better coding and system working for ethnicity and smoking • Develop staff knowledge and use of inequalities dashboards	• Implement alerts improvement project on Electronic Patient Record (EPR) including National Digital Reasonable Adjustments flag • Embed the use of video interpreting and on-demand translation across Bristol NHS Group	• Complete the NHS Accessible Information Standard self-assessment and begin to deliver improvements • Health Literacy update to Patient Information Policy • Deliver on improving access to Interpreting & Translation Services priorities	• Build systems to support improved access for Global Majority (GM) and 20% most deprived (IMD-1) patients, targeted to improving early cancer diagnoses • System working for paediatric respiratory pathways, homelessness, Black Maternity Matters and prisoner health
Longer Term	• Embed use of health inequalities metrics in operational decision making, service evaluation and Trust governance • Improve data for Inclusion health groups	• Digital systems that enable recording and sharing of data for health equity with partners	• Continue to deliver improvements to reach compliance with Accessible Information Standard, including through data sharing • Grow pool of local interpreters by working with community organisations • Comprehensive health literacy approach	• Inclusion health working group • Targeted work across pathways to evaluate and improve access. • Explore use of one stop pathways to reduce DNAs and demands on patients.
Key metrics/ governance	***% of patients with a known ethnicity and smoking status***	***Implementation of alerts on EPR***	***% interpreting bookings met by suppliers*** ***Reduction in incidents relating to accessible communication***	***DNA rate for GM and IMD-1 patients***

2. Designing and delivering with communities for population health

	Community Involvement and Coproduction	Prevention	Wider Determinants	Population health
Vision	Our communities form a key part of decision making at all levels. Service developments and initiatives are co-developed with communities.	Our organisations and services build opportunities for good health and use a Making Every Contact Count approach to reduce risk factors and health behaviours that drive health inequalities.	See the person and support patients with the non-clinical, wider determinants of health, reducing future demand on the healthcare system.	We work with system partners to take a population health approach to design and delivery of services that reduce health inequalities.
Year 1 Actions	• Codesign longer term objectives with patients, carers and communities • Improve representation within patient feedback including making PALS & Complaints service more accessible • Work with people with lived experience and community partners in Health Equity improvement projects	• Improve reach of Treating Tobacco Dependency, maternity incentive scheme • Why Weight Pledge implementation • Improvement plan for provision for drugs and alcohol • Develop our MECC approach as part of Shared Decision Making and Personalised Care	• Interpersonal violence reduction programme • Poverty Proofing Training Programme • Working with VCSE sector to improve access to services for wider determinants e.g. debt advice	• Active partners in system, place-based and neighbourhood forums • Strengthening use of population health data and intelligence • Weston High Intensity User service initiated with learning shared across sites
Longer Term	To be coproduced with patients, carers and communities	• Personalised prevention for health behaviours that drive preventable mortality embedded in clinical services • Innovations such as genetic risk models	• Pilot and evaluate initiatives to improve use of MECC within the Trust. • Embedded specialist service for victims of interpersonal violence	• Taking a population health approach to design and deliver our services based on population health needs, and reducing health inequalities
Key metrics/ governance	***Coproduced health equity interventions with community partners*** ***Continued improvement in representation within patient experience feedback***	***Why Weight pledge metrics*** ***Recording smoking status and % patients offered support*** ***Substance misuse business case UHBW***	***Poverty Proofing Training Programme***	***Active collaboration as system partners***

3. Strengthening our capability to deliver on health equity

	Leadership	Governance	Staff capability	Connect and collaborate
Vision	Senior leadership supports progress for health equity across the Trusts as a cornerstone of our Joint Clinical Strategy.	Clear accountability for health equity supports resourcing and delivery of Trustwide priorities.	Health equity and prevention are everyone's business. Our staff are engaged and empowered to act as part of their roles.	Bristol NHS Group collaborates with partners to understand and act on health equity and prevention.
Year 1 Actions	• Senior sponsorship model • Grow leadership within Divisions • Roll out Health Equity Toolkit with Group Clinical Services	• Develop Joint Health Equity Group membership and Terms of Reference • Community Partners to be recruited to Health Equity Group • Align Quality and Equality Impact Assessment (QEIA) process across hospital group	• Update online resources for health equity • Public Health For Clinical Practice webinars on prevention and equity themes • Community of Practice and Shared Resources for Coproduction • Building health equity into our patient safety and Patient First approaches	• Health equity leads across BNSSG providers and community partners identified and connections built • Develop external communications on our health equity programme
Longer Term	• Leadership across levels of our organisations for health equity	• Co-develop Health Equity Theory of Change	• Health equity embedded in Patient First, patient safety and core Trust programmes	• Shared goals and priorities across providers for health equity
Key metrics/ governance	***Senior Sponsor identified***	***Joint Health Equity Group formed with established governance – biannual reporting to QOC***	***E-learning available to support understanding and delivery across health equity and prevention***	***Active collaboration as system partners***

4. Developing our role as an Anchor organisation to tackle health inequalities

	Staff Physical and Mental Health	Experience and Opportunities at work	Purchasing and Procurement	Anchor Approach
Vision	An established approach to tackle health inequalities as specified in the Equality Delivery System 2022 domain: Workforce Health and Wellbeing.	An inclusive, equitable workplace where staff are supported to thrive from recruitment through employment, embedding health equity in every stage of experience and opportunity.	To use procurement as a lever for health equity and social value by embedding sustainability, and community benefit.	To embed as a leading NHS Anchor Organisation that maximises its economic, social, and environmental impact—improving health, prosperity, and wellbeing in Bristol and North Somerset.
Year 1 Actions	• An equitable workplace wellbeing offer inclusive to all socio-economic groups working across every location of the hospital group. Improve the collection, analysis and implementation of equity-related activity and impact data, to inform the evolving programme.	• Anti-racism pledge • Commitment to Our Community Plan	• Green Plan objectives to increase social value in tenders and how we evaluate and contract social value • Progressing inclusivity in our procurement of digital tools and products	• Agree Anchor Metrics • Engagement with local Anchors to grow Anchor networks • Strengthen approach to pilots, including sustainability and evaluation • Building Anchor work into Patient First approach
Longer Term	• Social prescribing in our occupational health services	• Embedding our trauma informed approach • Delivering a joint anti-racism framework across the Hospital group • Delivering on the Sexual safety charter • Embedding the social model of disability into practice	• Social value and sustainability are embedded in financial decision making, co-produced with our communities	• Mature Anchor Networks • Monetised Social Value framework • Anchor integrated across Trust • Supporting delivery of the One City plan missions
Key Metrics/ governance	***UHBW Workplace wellbeing SIG NBT Staff Health and Wellbeing Strategy Group***	***UHBW and NBT People Strategy and People Oversight Group, Workforce EDI Steering Group***	***Green Plan***	***Active Participation in Anchor networks***

Our Longer Term Plans

NHS Bristol NHS Group Bristol | Weston

- In the next year our Joint Clinical Strategy will be refreshed with a delivery plan for Group Clinical Services and our response to the 10 Year Health Plan for England.
- Population health and health equity are key to the Joint Clinical Strategy and Group Clinical Services.
- We recognise that a longer-term plan for population health and health equity is needed. We are committing to co-designing that plan with our communities, as part of the Joint Clinical Strategy.
- Our Community Participation Group and recruitment of community partners to our joint health equity delivery group will inform our approach to co-production. We will continue to work with our health system partners and align our population health and health equity work to system priorities and delivery of the forthcoming neighbourhood plans.

Useful data sources for population health

NHS Bristol NHS Group Bristol | Weston

- Trust inequality dashboards on service access for different population groups and recording of ethnicity:

NBT Health Inequalities - Power BI

UHBW Health Inequalities - Power BI

- Our Future Health BNSSG Report (2022).pdf: a summary of the BNSSG population, health inequalities and trends over time
- BNSSG Population Health Intelligence Resource Portal: a compilation of reports and data sources that is searchable for different population groups and topics
- BNSSG Understanding Healthcare Inequalities (2025): a report into healthcare access and use across different population groups and pathways
- Our population | hosted by South Gloucestershire Council: dashboards for the BNSSG population and different health and wellbeing areas across the lifecourse

Requirements of Acute Trusts

NHS Bristol NHS Group
Bristol | Weston

Integrated Care System primary legal purposes:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience, and access
3. Enhance productivity and value for money
4. Support broader social and economic development.

Identify, record, flag, share and meet people's communication and information needs (AIS)

NHS England » 2025/26 priorities and operational planning guidance

➔Work with ICBs to reduce inequalities and apply CORE20PLUS5 for adults and CYP

Exercise due regard for the Public Sector Equality Duty, including in designing services

NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

➔Restoring services equitably. Inpatient and Maternity Service TTD coverage. Children's dental health.

➔Apply CORE20PLUS5 in collaboration with ICS bodies.

➔Annual reporting.

Addressing health inequalities through engagement with people and communities - Care Quality Commission

➔Listening to, understanding, and responding to communities.

NHS England » Improvement framework: comm
language translation and interpreting services

Board Commitments

NHS Bristol NHS Group
Bristol | Weston

In June 2025, the Joint Board of the Bristol NHS Group agreed these actions to improve health equity:

- Align Health Equity Planning and Delivery across the Bristol NHS Group, in partnership across BNSSG
- Build visibility and accountable leadership at board level for health equity
- Routinely breakdown and review data for health equity for Trust-wide performance metrics – ethnicity and deprivation
- Build health equity capability across Trusts, including around data and community engagement
- Continue to engage, involve, co-produce and learn with our communities – consider who are we not hearing from
- Delivery of anti-racism commitments and equity for colleagues
- Strengthen a focus on prevention for health equity for colleagues and patients

Themes from Health Equity Joint Board Session June 2025

Abbreviation	Meaning	Significance
AIS	Accessible Information Standards	A legal requirement that services identify, record, flag and meet a person's information and communication needs
BNSSG	Bristol, North Somerset, South Gloucestershire	The area where most of our patients live which covers three local authorities
DNA	Did Not Attend	Missing a planned healthcare appointment
EDI	Equality Diversity and Inclusion	Interconnected concepts that aim to create fair and welcoming environments where people are treated equitably, differences valued and everyone has opportunities to participate
GM	Global Majority	A collective term for people who are racialized as non-white
HCIG	Health and Care Improvement Groups	BNSSG System Oversight Groups with responsibility for improving health and care provision
HWB	Health and Wellbeing Board	Statutory committees of local authorities that have responsibility for improving the health and wellbeing of populations. BNSSG has three Health and Wellbeing Boards.
ICB	Integrated Care Board	A statutory NHS organisation with responsibility for planning and funding local NHS services. Our local ICB is BNSSG, although footprints are changing and BNSSG will be clustering with Gloucestershire
ICS	Integrated Care System	Local partnerships that bring health and care organisations together to develop shared plans and joined up services. We are in the BNSSG ICS
IMD	Index of Multiple Deprivation	A tool used to measure deprivation in small areas in England. It combines 7 indexes including income, employment, education, health, crime and housing. IMD-1 means the 10% or 20% most deprived small areas in England.
LP	Locality Partnership	Collaborative groups of local health, care, voluntary sector and community organisations improving health at a local level. There are six locality partnerships in BNSSG.
LTC ODG	Long Term Conditions Operational Delivery Group	BNSSG System Collaboration Forum for improving healthcare for people with long term conditions
MECC	Making Every Contact Count	An evidence-based approach to improving health that makes the most of opportunities when people are in contact with services
RA	Reasonable Adjustments	Legally required changes to ensure service accessibility
QEIA	Quality and Equality Impact Assessment	A tool to understand the impact of policies and services on different groups of people and guide actions to promote equality
QOC	Quality and Outcomes Committee	A formal senior committee in the Bristol NHS Group that reports to the board, with responsibility for safe, effective and equitable care
SHIPPH	Strategic Health Inequalities, Prevention and Population Health Committee	BNSSG System Oversight Group with responsibility for improving health outcomes
Social Value	Social Value	The NHS is a large employer and has a large budget. Social value means the returns for our local communities
TTD	Treating Tobacco Dependency	Trust-based services for people who smoke, currently commissioned for inpatients and maternity patients

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	13 January 2026		
Report Title:	Learning from Deaths Report Q1 & Q2 reports 25-26 (North Bristol NHS Trust and University Hospitals Bristol & Weston NHS Foundation Trust)		
Report Author:	Dr. Joydeep Grover, Medical Director, Patient Safety & Quality, NBT Dr. Karin Bradley, Associate Medical Director, Patient Safety, UHBW Paul Cresswell, Director of Quality Governance, NBT		
Report Sponsor:	Prof. Tim Whittlestone, Group Chief Medical and Innovation Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	This report seeks approval of the Q1 and Q2 Learning from Deaths (LfD) reports and for a revised reporting proposal to improve the future focus of board reporting.		

Key Points to Note

Board reporting Approach

These are the first joint LfD reports for the Bristol NHS Group (covering each trust) for the first and second quarters of 2025/2026, meeting the requirements for quarterly reporting to Board in line with National Quality Board Guidance. They follow a similar aligned structure to the annual report for Learning from Deaths approved by the Group Board in September 2025.

As part of the Mortality Improvement Programme, we have reviewed the potential approach to future quarterly reporting, recognising that;

1. Longstanding mortality trends over time for NBT and UHBW are stable and within expected parameters.
2. SHMI trends are monitored monthly and considered for inclusion in the Group Board IQPR. This is triggered if SPC statistical rules require this to be reported.
3. Robust mortality governance exists within each trust and increasingly being aligned across the Group.
4. The NQB guidance (2017) pre-dates the implementation of the Medical Examiner Service and its statutory standing from 2023. This has significantly increased the visibility of mortality scrutiny (for all deaths) and the independence in this process.

Consequently, a revised approach is recommended to focus quarterly board review, as follows;

- **Quarterly reporting**: achieved via an expanded IQPR set (no more than 4 sections). This would meet the requirement but without taking up scarce board agenda time. The Mortality Improvement programme will make recommendations on content for this.
- **Annual Report** – fully aligned report as first received in September 2025, with continuous improvement of approach.

Future Timings

- Q3 – March
- Q4 - (Annual Report) – July
- Q1 – September
- Q2 - December

Assurance & Insights

There were 855 in hospital deaths for quarter 1 (the combined figures for UHBW and NBT for Q1 2024 were 1002). 43 SJRs were completed during this quarter with no death being assessed as definitely avoidable and in most cases overall care was rated as good or excellent.

For Quarter 2 there were 862 in hospital deaths (compared to 831 in Q2 2024). 20 SJRs were completed with no death being assessed as definitely avoidable and a similar majority of cases rated good or excellent.

SHMI data is released in arrears by 6 months. We have had no Variable Life Adjusted Display (VLAD) alerts during quarter one or quarter two of 2025/26 financial year. Quarterly Summary Hospital-level Mortality Indicator (SHMI) pre-release data is reviewed at each trust to consider potential pre-alerts and upon investigation in most cases this was linked to coding related queries.

100% of in hospital deaths have undergone ME scrutiny in each quarter, with 138 cases (Q1) and 124 (Q2) referred for further review or family support.

.

Key learning has been identified during quarter one focusing on communication and appropriate involvement of palliative care and for quarter two this included responding to deterioration, pain management, system access issues for the new clinical medication management system and initial assessments.

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.

Our systems, processes and data collection currently rely heavily on manual processes rather than automated digital systems. While our data is accurate, this requires significant administrative time and limits our ability to analyse trends efficiently. During 2026, we are investing in digital systems to address these limitations, track reviews more effectively, and reduce administrative burden on clinical staff.

Ongoing delivery of aligned processes and improving Learning from Deaths is dependent on the work of the Mortality Improvement Programme which is working across Bristol NHS Group.

Risks and Opportunities
There are no Trust Level Risks associated with this report. 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 2026, 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. .
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. The Board is also requested to consider and approve the revised reporting proposal for in year quarterly reporting outside of the annual report.

History of the paper (details of where paper has <u>previously</u> been received)	
UHBW report reviewed at UHBW Clinical Quality group. Alignment timings for board/governance changes have not enabled this at NBT. Trust level and Executive level approvals given.	November 2025
Appendices:	A – Q1 2025-26 – North Bristol NHS Trust & University Hospitals Bristol and Weston NHS foundation Trust. B - Q2 2025-26 – North Bristol NHS Trust & University Hospitals Bristol and Weston NHS foundation Trust.

Bristol NHS Group

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Learning from Deaths Quarterly Report

Q1 2025-26

For the period ended

30 June 2025

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Executive Summary

During Q1 2025-26 (April - June 2025), there were 855 in-hospital adult deaths across the Bristol NHS Group (398 at UHBW and 457 at NBT). This compares to 1002 [489 at UHBW and 513 at NBT Q1 24/25] in-hospital adult deaths in the same period last year.

4.13% of deaths received detailed case note reviews, with 43 Structured Judgement Reviews completed across both trusts. No deaths were assessed as definitely avoidable during the reporting period.

The Medical Examiner Service scrutinised 100% of eligible deaths and referred 138 cases for further review, feedback, or family support.

Key learning themes this quarter included communication with families, escalation processes and recognising when to involve palliative care.

Our mortality improvement programme continues to strengthen data systems and align processes across both trusts as part of Bristol NHS Group development.

This report meets all statutory requirements under NHS Quality Account Regulations and National Quality Board Guidance - see Appendix 1 for detailed compliance mapping.

Section 1: Deaths in our care

1.1 Quarterly overview of deaths in our care

During Q1 2025-26 (April - June 2025):

- UHBW: 398 adult in-hospital deaths
- NBT: 457 adult in-hospital deaths
- Bristol NHS Group combined: 855 deaths

This compares to Q1 2024-25:

- UHBW: 489 adult in-hospital deaths
- NBT: 513 adult in-hospital deaths

Across University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT) hospitals, most deaths occur in older people with multiple long-term health conditions, often following acute deterioration. 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.
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.

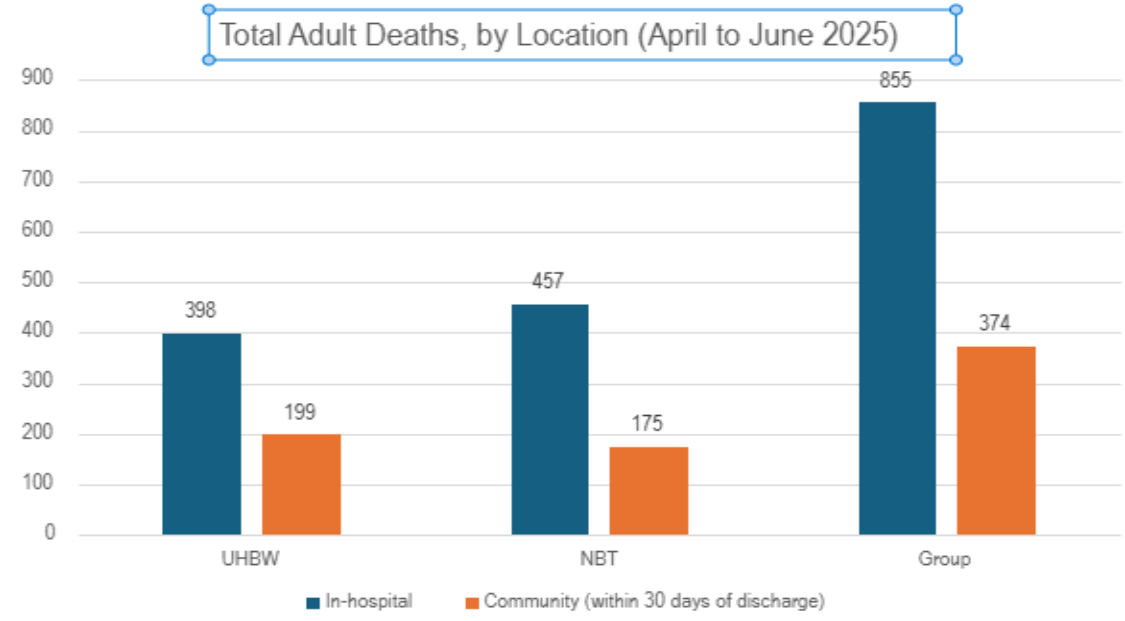

Figure 1 - Total Adult Deaths by location for April to June

Hospital deaths by site

Table 1 shows deaths by site. The variation reflects the diverse types of services provided at each hospital.

Organisation	Site	Deaths Q1 25/26 Adult	Deaths Q1 25/26 Child	Deaths Q1 Adult & Child 24/25
UHBW	Bristol Royal Infirmary	237	0	289
UHBW	Weston General Hospital	112	0	148
UHBW	Bristol Haematology and Oncology Centre	24	0	19
UHBW	Bristol Royal Children's Hospital	0	10	7
UHBW	St Michael's Hospital	0	4	5
UHBW	Died in ED	25	0	33
UHBW	30 Days of Discharge	199	3	Not known
UHBW Total	Total deaths	597	17	Not known
UHBW Total In Hospital	In-hospital deaths	398	14	501
NBT	Southmead Hospital	432	1	497
NBT	Died in ED	25	0	16
NBT	30 Days of Discharge	175	0	Not known
NBT Total	Total deaths	632	1	Not known
NBT Total In Hospital	In-hospital deaths	457	1	513
Group	In-Hospital Death	855	15	1014
Group	30 Days of Discharge	374	3	Not known
Bristol NHS Group Total	Total deaths	1229	18	

Table 1: Table showing the total deaths recorded by site for UHBW and NBT for Q1 April to June 2025

For detailed breakdowns by site and division see Appendix [2].

The Bristol NHS Group operates approximately 2009 inpatient beds across both trusts:

- UHBW: beds across five sites:
  - Bristol Children's Hospital (RBCH) 155
  - Bristol Eye Hospital (BEH) 11
  - Bristol Haematology and Oncology Centre (BHOC) 58
  - Bristol Royal Infirmary (BRI) 504
  - St Michael's Hospital (StM) 125
  - Weston General Hospital (WGH) 278
- NBT: beds at Southmead Hospital (SMD) 878

This provides context for the death distribution, which reflects both bed capacity and the types of services provided at each site.

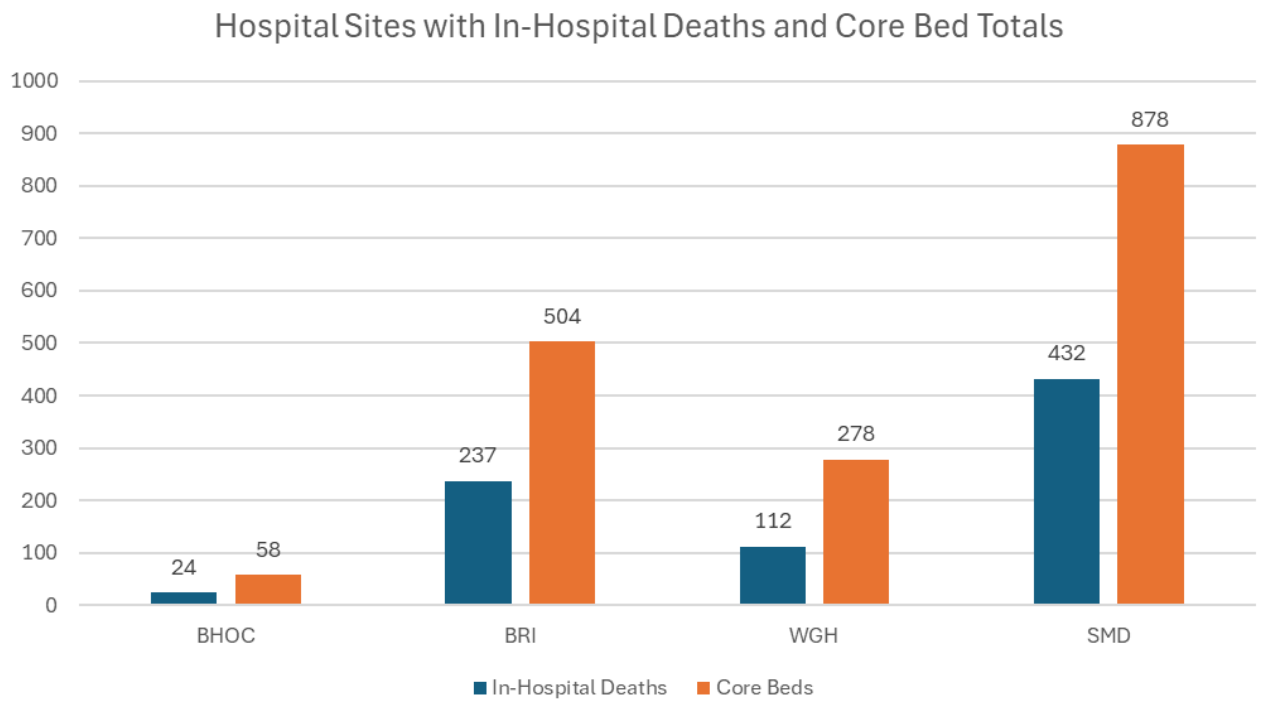

Figure 2 Hospital Sites by In-Hospital Deaths and Core Inpatient Beds

Bristol NHS Group

Both trusts reported stable quarterly mortality with combined mortality indicators remaining 'as expected'. Aligned processes are now in place for review selection, ME referral handling, and learning dissemination.

1.2 Independent scrutiny of every death

The Medical Examiner Service

When a patient dies at NBT or UHBW, their care record is updated and the care received by the patient is independently reviewed by the Medical Examiner (ME) Service.

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.

During the reporting period, the ME service scrutinised all adult deaths not referred to the coroner. The service also scrutinised 100% of 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.

Scrutiny Numbers Q1 2025-26

Trust	Adult Deaths Scrutinised	Scrutiny Rate
UHBW	398	100%
NBT	457	100%
Bristol NHS Group	855	100%

Table 2: Table showing the total number of adult deaths scrutinised by the ME service by Trust for Q1 April to June 2025

1.3 Understanding our mortality data

Summary Hospital-level Mortality Indicator (SHMI) and Variable Life Adjusted Display (VLAD) monitoring

NHSE releases SHMI and VLAD figures for all NHS Trusts to support monitoring of mortality across different diagnosis groups and other performance indicators.

Although released regularly, the data is in arrears by six months with figures for Q1 unavailable at time of reporting. SHMI is monitored and discussed regularly by both organisations, with a quarterly preview sign off established and aligned in both Trusts.

We further introduced aligned VLAD chart monitoring across both trusts in Q4 2024-25 and if alerts are issued upon release of the VLAD data these are discussed as part of the ongoing governance arrangements within the two organisations.

We continue to monitor coding accuracy and case-mix changes as part of our routine mortality surveillance. During this period there have been no alerts at NBT or UHBW which have required further investigation.

Section 2: How we review and learn from deaths

2.1 Our approach to reviewing deaths

Our responses to 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 to our governance teams:

At UHBW, the Associate Medical Director (Patient Safety & Mortality) reviews each Medical Examiner referral, along with patient safety and Trust Management Team colleagues, to ensure the right response and next steps are taken.

At NBT, referrals are triaged by Divisional Governance Teams who determine appropriate actions and escalate to the Medical Director (Safety & Quality) where needed.

The Medical Examiner (ME) and Medical Examiner Officers (MEO) provide families with the opportunity to feedback both positive and negative experiences as well as highlight care concerns. A higher referral rate to UHBW is anticipated, consistent with the previous financial year. While the difference will be reviewed in more detail next quarter, there is no immediate concern as the proportion of all types of referrals is greater at UHBW and does not reflect an increase specifically in care concerns but rather reflects an increase in reported positive feedback. Table 3 and figure 3 below illustrates the higher rate of positive feedback at UHBW.

The difference in ME referral rates reflects different processes in structure, reporting thresholds and case mix between the 2 trusts. A gap analysis of referrals January to March '25 detailed the differences in the process of dealing with response to referrals (with NBT using Radar and are reliant on divisional response whereas UHBW uses a multi-stage email/spreadsheet tracking system). This analysis concluded there was a need for each trust to be informed by the others processes and has formed the basis for further ongoing alignment work between the ME services. This alignment work aims to produce a clinically relevant thematic framework for ME referral categorisation across NBT and UHBW, enabling standardised analysis, enhanced cross-trust learning, and improved efficiency in mortality surveillance processes. This will include an integrated ME data system providing real time specifics to inform governance and quality outputs.

During Q1 2025-26, the Medical Examiner Service referred:

- UHBW: 83 cases
- NBT: 55 cases
- Bristol NHS Group: 138 cases

The breakdown of referral type is illustrated in Table 2 below.

Medical Examiner Referral Type	UHBW	NBT	Total
Concern only	47	48	95
Positive feedback and care concerns	5	0	5
Positive feedback only	20	3	23
Mandatory Referral	11	4	15
Total	**83**	**55**	**138**

Table 3: Medical Examiner referrals by type of referral and trust, Q1 2025-26

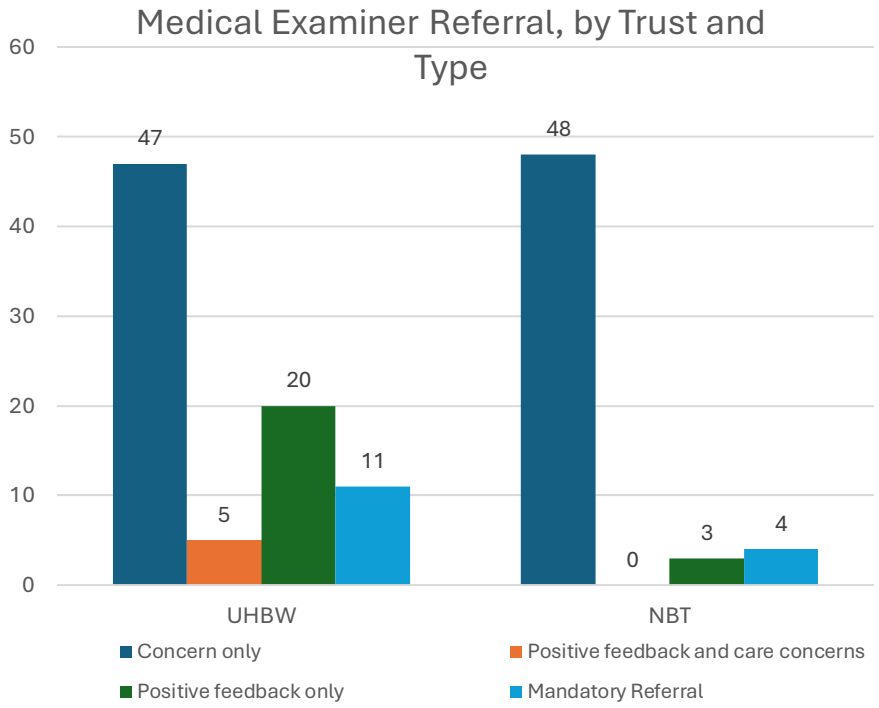

Figure 3 Bar chart showing the type of referral received by Trust for April to June 2025

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.

For cases referred following a concern, 12 UHBW cases and 0 NBT cases were identified as suitable for a detailed case note review, called a Structured Judgement Review (SJR). Figure 5 shows how we responded during Q1 2025-26.

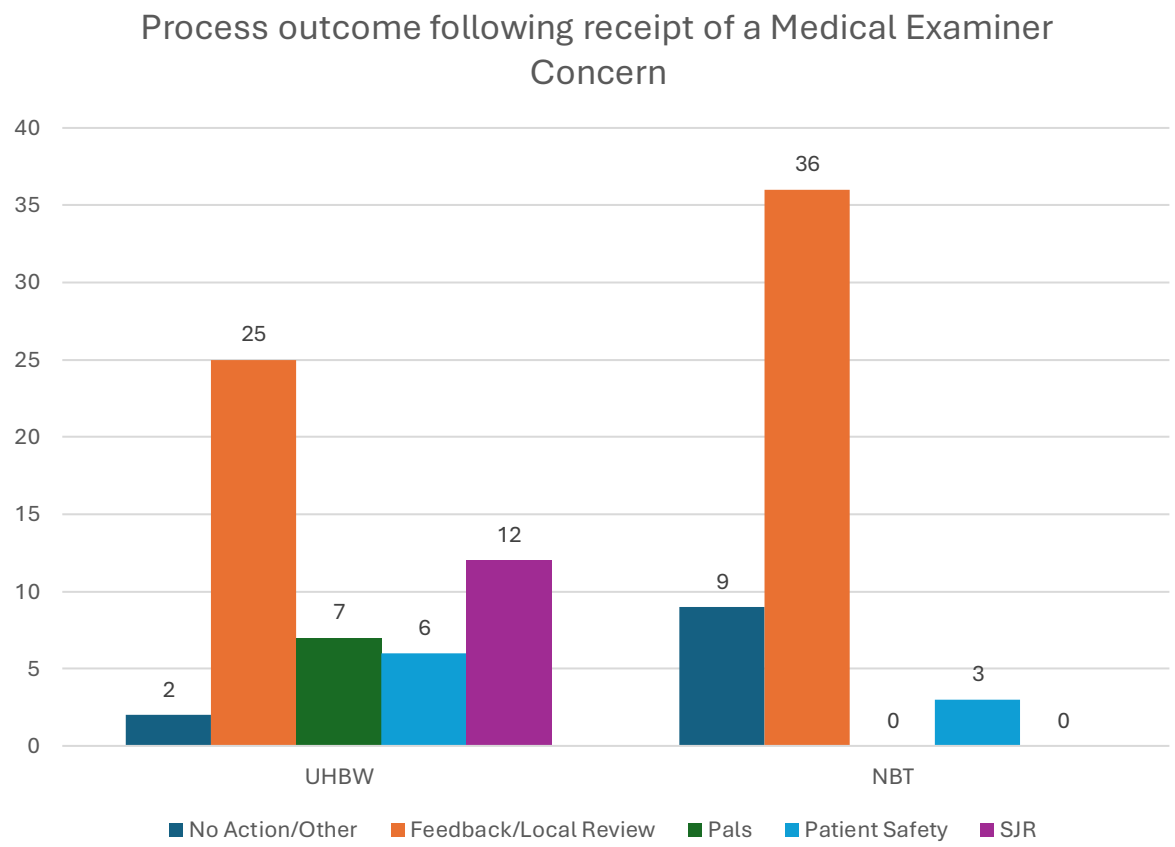

Figure 4 Process outcome following receipt of a Medical Examiner Concern by Trust for April to June 2025

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 our trust Patient Safety Incident Response Plans 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.

Common themes and our responses

The vast majority of in-patient deaths raise no concerns about care quality. A considerable amount of positive feedback on care is also received and personally shared with the staff involved. However, we take every concern raised seriously and use this feedback as an opportunity to learn and improve. During quarter 1 an aligned medical examiner referral concern list of themes was defined and agreed by both Trusts, to support the ongoing alignment of reviews. Each concern has been themed against the agreed definitions for the primary area of concern.

We categorise the referrals we receive to help us understand patterns in what families and the Medical Examiner Service are telling us. Figure 5 shows the most common themes across both trusts in Q1 2025-26.

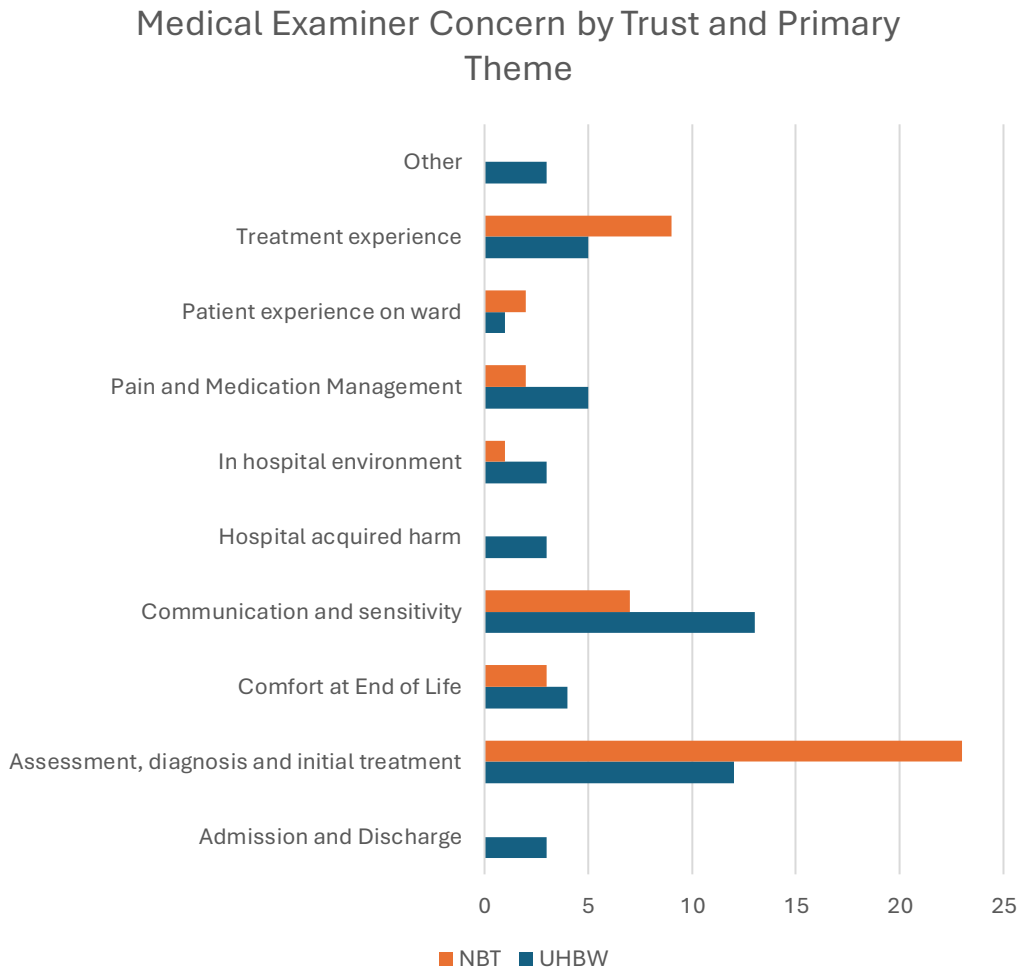

Figure 5 Bar chart depicting the primary theme for medical examiner referrals received for each Trust between April and June 2025

Learning from inquests

When a patient dies, the Medical Examiner determines whether the death should be referred to the coroner. This referral is a normal part of the death certification process and does not indicate concerns about care quality - many referrals are made for legal or administrative reasons, such as the death was violent or unnatural, the cause of death is unknown, or the deceased died while in state detention.

Further information about which deaths must be referred to the coroner is available on the Coroners - Courts and Tribunals Judiciary.

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

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 learning disabilities 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 wouldn't 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 the CQC, triggered SJRs.

Structured judgement review (SJR) distribution

During Q1 2025-26, we undertook:

- UHBW: 23 SJRs (4.37% of adult deaths)
- NBT: 20 SJRs (3.98% of adult deaths)

All SJRs were initiated in line with NQB guidance. There is no target for the number of SJRs that should be undertaken.

The total number of SJRs completed and the reasons for their initiation are detailed in Table 4.

Death Review Process	UHBW	NBT	Total
Adult In-hospital Patient Deaths Scrutinised by Medical Examiner	398	457	855
Patient deaths referred to Trust by the Medical Examiner (All concern referrals)	52	48	100
Structured Judgement Reviews			
Patient had a diagnosis of a learning disability or autism (ME or other notification)	4	6	10
Patient had a diagnosis of a Severe Mental Illness (ME or other notification)	5	3	8
Patient had an elective admission (ME or other notification)	3	3	6
Treatment or care concern (ME or Other)	11	4	15
Learning opportunity (no specific concern)	0	4	4
Total Structured Judgment Reviews Initiated	**23**	**20**	**43**
Structured Judgement Reviews initiated and completed	**9**	**16**	**25**

Table 4: Table showing breakdown of SJR reviews because of a medical examiner referral, Q1 2025

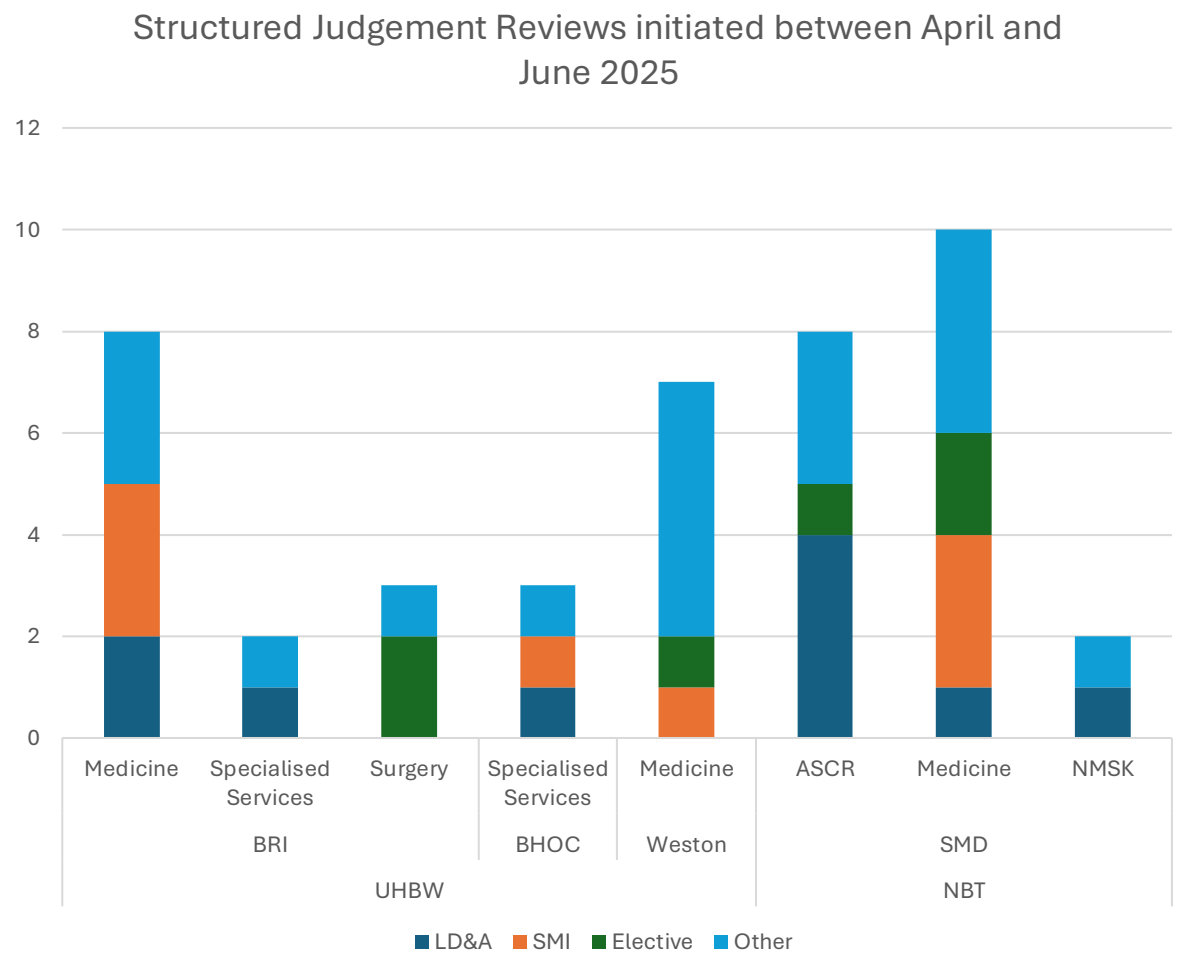

Figure 6 Bar Chart showing reason for an SJR being initiated by Trust, Site and Division for April to June 2025

This quarter, we initiated:

- 10 reviews for patients with a learning disability or autism diagnosis
- 8 reviews for patients with a severe mental illness diagnosis
- 6 reviews for patients with an elective admission
- 15 reviews following concerns raised by the Medical Examiner, families, or staff member

For ME referrals involving patients with learning disability, autism, or severe mental illness, as well as elective admissions and cases referred due to care concerns, we monitor the initial decision made following Medical Examiner scrutiny.

2.3 Mortality review completion times

UHBW

In Q1 2025-26, 23 SJRs were completed with the median time from death to divisional review completion being 53 days. Following divisional review, all SJRs are then formally approved at the trustwide Mortality Surveillance Group.

NBT

In Q1 2025-26, 34 SJRs were completed with the median time from death to divisional review completion being 56 days. Following divisional review, all SJRs for patients with a Learning Disability and/or Autism plus any SJRs scored as ‘poor’ or ‘very poor’ overall care scores are then scrutinised at the weekly Patient Safety Executive Meeting (PSEM).

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 different 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.

If a SJR identifies a potential problem in care that may have led to harm, NHS trusts are required to assess whether the death might have been avoided with different care or treatment. To do this, NHS trusts use a national scale from “definitely not avoidable” (1) to “definitely avoidable” (6). These ratings are the reviewer's professional and initial judgement only and are based on what they can see in the medical notes. An initial judgement of a potentially avoidable death is not an assignment of blame and will always trigger a further review to make sure the right process is followed.

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 Framework (PSIRF).

2.5 What we learned

Overall care scores

Of the 23 SJRs initiated at UHBW in Q1 2025-26, 9 have been completed and 14 remain in progress.

Of the 20 SJRs initiated at NBT in Q1 2025-26, 16 have been completed and 4 remain in progress.

The majority of completed SJRs scored overall care as good (4) or excellent (5). Table 5 shows the complete breakdown.

Overall Care Ratings (1-5 scale)

Overall Care Score	UHBW	NBT	Total
1 Very Poor	0	0	0
2 Poor	0	0	0
3 Adequate	0	3	3
4 Good	9	10	19
5 Excellent	0	3	3

Table 5: Breakdown of SJR review scores for UHBW and NBT for SJRs initiated and closed within April to June 2025

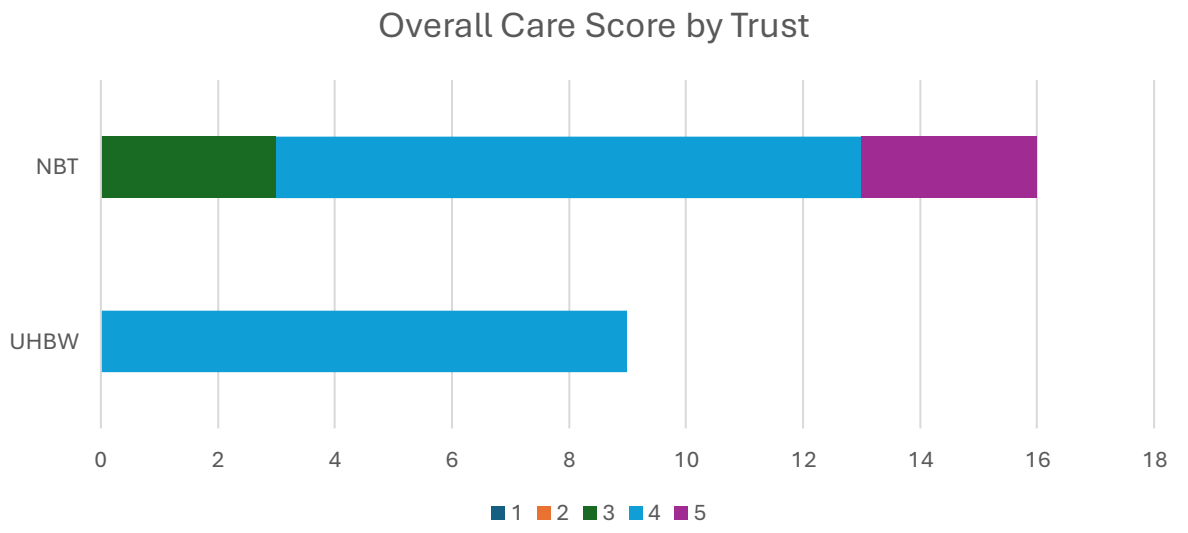

Figure 7 Bar chart showing the overall care breakdown by Trust

Avoidability Ratings (1-6 scale)

Both trusts assess whether deaths may have been avoidable due to problems in care, in line with National Quality Board (NQB) guidance, but through different pathways.

At UHBW, reviewers score avoidability for all SJRs at Mortality Surveillance Group. Of 9 reviews completed in the reporting period, none were identified as evidencing

that the death was more likely than not to have been due to problems in care (all scored 5-6, indicating very little or no evidence of avoidability).

At NBT, reviewers are only asked to rate avoidability where SJRs identify care concerns and cases are escalated to Patient Safety Executive Meeting (PSEM) for further review. No cases within the reporting period met this threshold.

At both trusts, Medical Examiner scrutiny identifies cases requiring investigation through other processes (such as by the coroner or though PSIRF) rather than SJR, avoiding duplication. Cases with immediate concerns about avoidability are captured through these pathways.

Recognised limitations

Avoidability scoring is subjective and open to individual reviewer interpretation, and a judgement is based on case notes alone. In practice, cases of genuine concern are recognised through ME review or initial screening and appropriately directed to the relevant investigation processes. The avoidability question in routine SJRs therefore adds limited additional value where effective filtering mechanisms are in place.

Alignment for Bristol NHS Group

Through the mortality improvement programme, Bristol NHS Group will agree a single approach that asks the avoidability question only in SJRs where it is appropriate – for example, where care quality scoring indicates potential concerns.

This approach is consistent with the principle of ensuring deaths are subject to the most appropriate review process, which is reflected in guidance from national leads and supported through the National Community of Practice for NHS Mortality and Learning from Deaths Leads.

Avoidability Score	NBT	UHBW
1 – Definitely avoidable – Strong evidence that the death could have been prevented	0	0
2 - Slight evidence of avoidability – More likely than not that the death was avoidable	0	0
3 - Possibly avoidable - more than 50:50 – Some evidence suggesting the death was avoidable	0	0
4 - Probably avoidable - less than 50:50 – limited evidence of avoidability	0	0
5 - Strong evidence of avoidability – Very little indication that the death could have been prevented	0	2
6 - Definitely not avoidable – No evidence that the death could have been prevented	0	7

Table 6: Table showing the breakdown of avoidability scores for UHBW for Q1 April to June 2025

Our mortality surveillance integrates with broader clinical governance through:

- Monthly mortality review group oversight through the Mortality Surveillance Group (MSG) and Patient Safety Group (PSG), with escalation to Clinical Quality Group (CQG) as required at UHBW
- Monthly mortality review group oversight through Clinical Effectiveness and Outcomes Group (CEOG) and divisional governance processes at NBT
- Board-level reporting and challenge
- Integration with PSIRF processes

This learning integrates with routine Morbidity and Mortality (M&M) meetings across all clinical specialties, ensuring frontline clinical teams can access and apply mortality insights directly.

Section 3: How we have improved

3.1 Learning and improvement from Structured Judgement Reviews

UHBW Examples

The Mortality Surveillance Group meets monthly and collates and minutes learning from SJRs and other mortality related data and information. During April and June, the group discussed:

- Progress of the alignment between NBT and UHBW for mortality review, including the recent approval of the joint Annual Report. Noted a standardising of definitions and consistent SJR triggers across the group, mapping governance structures, deepening understanding of mortality data and drive speciality-led engagement.
- Discussion of the Learning Disabilities and Autism Report – Noting strengths in communication, end-of-life care, and ReSPECT form completion. Improvement areas noted included pain management, mental capacity assessments, and consistent terminology use.
- Medical Examiner Annual Report – Referral rate disparity noted between UHBW and NBT, which was considered due to differing thresholds for referrals rather than a care issue. Improvement opportunities noted regarding the process of referring as currently manual.

Learning identified through SJRs

Site/Speciality	Learning Identified
BRI - Medicine	Issued raised around the documentation of fluid balance. Feedback to the local area taken forward by the Mortality lead.

Site/Speciality	Learning Identified
	Concerns raised around the ward escalation process. Learning from review to be forwarded to the ward QI project lead looking at the escalation process.
Weston - Medicine	Use of ReSPECT forms. Feed specific learning to the ongoing ReSPECT improvement programme of work. Action for MSG to raise awareness of digital system limitations. Discussion focused on CMM (Clinical Medication Management) system access issues. System transition issue during changeover period prevented prescription of antibiotic to be visible to clinicians.

Table 7: Learning identified through SJR reviews for UHBW by Site and Division

NBT Examples

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.

CEOG meets bimonthly, in May 2025 the group discussed:

- Q3 and Q4 2024/25 learning from deaths report noting that Key indicators for Q3–Q4 remain stable with high review completion rates and no major concerns. Concern referral rate dropped to 4.7% (from 10%) due to capacity, not care quality; divisions act on 93% of cases. Process improvements planned with governance leads.
- The trust was noted to be performing better than average overall on SHMI; higher hospital death rate and 22.5% deaths within 30 days of discharge noted. Areas flagged for monitoring include sepsis (elderly mortality), UTI cases, discharge delays, and coding accuracy.
- Learning Themes: SJR scores remain adequate to excellent; emerging ME concerns around delays in treatment, discharge management, and follow-up will be monitored.

Learning identified through SJRs

Division/Specialty	Learning Identified
Medicine – Care of the Elderly	Learning regarding communication identified – in particular around content of discussions with families regarding prognosis and recognition of a timely point to change focus of care, and when the prognosis is guarded.

Division/Specialty	Learning Identified
Medicine - Gastroenterology	Learning identified around recognising when to involve palliative care and stop active invasive investigations.

Table 8: Learning identified through SJRs for NBT by Division and Speciality

3.2 Measuring impact

In Q1 2025/26 scoping and discussions focused on the development of impact metrics across both trusts whilst recognising that some measures will be trust-specific due to different operational systems. For example:

- UHBW tracks via the Mortality Surveillance Group (MSG) action log and divisional reports
- NBT tracks via clinical effectiveness and outcomes group and divisional/speciality reports and action tracking

This work is being considered alongside the ongoing group work, where focus is placed on alignment of reporting and review processes. By Q4 2025-26, we aim to have harmonised impact reporting that shows both trust-level and Group-level improvements.

3.3 Looking forward

Current challenges and our plans to address them

In 2025-26, our Learning from Deaths policies are being updated in line with our Bristol NHS Group development. Rather than updating separately and aligning later, we are working together as part of our joint Mortality Improvement Programme to develop single policies from the outset. This ensures consistency whilst incorporating changes in national guidance, statutory Medical Examiner requirements, and PSIRF alignment. While our current policy requires updating, there are no high-risk concerns with our existing processes.

Our data collection relies heavily on manual processes rather than automated digital systems. While our data is accurate, this requires significant administrative time and limits our ability to analyse trends efficiently.

For 2025-26, we are investing in digital systems to address these limitations, track reviews more effectively, and reduce administrative burden on clinical staff.

Future Priorities and Commitments

During 2025-26, we will be:

- Updating the Medical Examiner referral system
- Implementing enhanced Structured Judgement Review (eSJR) processes
- Developing automated mortality surveillance dashboards

- Standardising review methods and data collection across both trusts
- Setting up shared learning forums and cross-trust specialty reviews

We are developing automated flags for cases with the highest learning potential, such as delays of 8+ hours from decision to admit, or patients who move from ward to ward then to intensive care. These help clinical teams identify cases for review and focus time on implementing learning.

Bristol NHS Group integration

Our mortality improvement work is directly aligned with our Bristol NHS Group development. Key deliverables include:

- Consistent SJR template and methodology across both trusts
- Aligned annual and quarterly Learning from Deaths reporting
- Joint mortality surveillance dashboards supporting Group Quality functions

System-wide collaboration

We continue to strengthen partnerships across Bristol, North Somerset and South Gloucestershire (BNSSG), working with Avon and Wiltshire Partnership on severe mental illness mortality reviews and with Sirona Care and Health on community learning opportunities.

Appendix 1

Regulatory Compliance Mapping

Requirement	Evidence Location in This Report
Total deaths (27.1)	_Section_1:_Deaths
Reviews conducted (27.2)	Section 2: How we review and learn from deaths
Avoidable deaths (27.3)	_Avoidability_Ratings_(1-6
Learning identified (27.4) Actions taken (27.5)	_3.1_Learning_and
Impact assessment (27.6)	_3.2_Measuring_impact

Table 9: Regulatory compliance mapping

Appendix 2

Hospital mortality – site and divisional context

Discharge Site	Discharge Division	In-Hospital	Community
Bristol Eye Hospital	Surgery	0	2
Bristol Haematology and Oncology Centre	Specialised Services	24	42
Bristol Royal Infirmary	Medicine	203	64
	Specialised Services	35	6
	Surgery	26	17
St Michael's Hospital	Women's and Children's	0	2
Weston General Hospital	Medicine	101	58
	Specialised Services		2
	Surgery	11	10
Southmead Hospital	Anaesthetics, Surgery, Critical Care and Renal	56	30
	Core Clinical Services	0	4
	Medicine	304	114
	Neurosciences and Musculoskeletal	97	26
	Women's and Children's	0	1

Table 10: Adult death recorded with discharge site and division, by Trust for Q1 April to June 2025

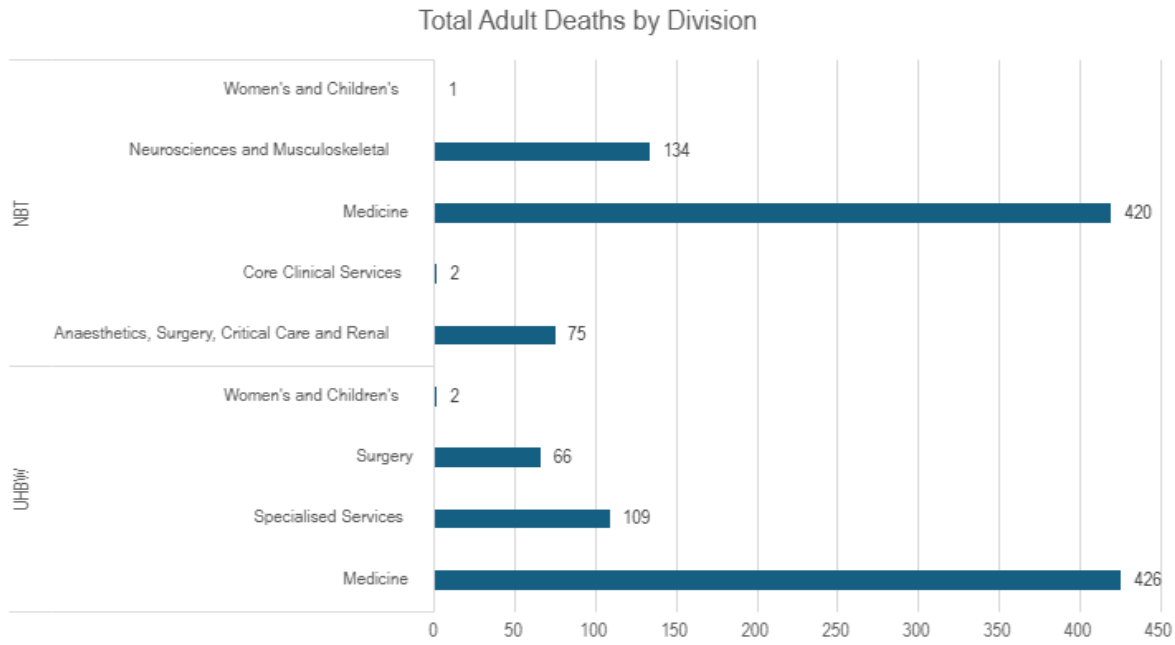

Figure 8 Bar chart showing the total adult deaths by discharge division

Bristol NHS Group

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Learning from Deaths Quarterly Report

Q2 2025-26

For the period ended

30 September 2025

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Executive Summary

During Q2 2025-26 (July - September 2025), there were 862 adult in-hospital deaths across the Bristol NHS Group (387 at UHBW and 475 at NBT). This compares to 831 Q2 24/25 deaths in the same period last year.

4.7% of deaths received detailed case note reviews, with 39 Structured Judgement Reviews completed across both trusts. No deaths were assessed as definitely avoidable during the reporting period.

The Medical Examiner Service scrutinised 100% of eligible deaths and referred 124 cases for further review or family support.

Key learning themes this quarter included responding to deterioration, system access issues for the new clinical medication management system and initial assessments.

Our mortality improvement programme continues to strengthen data systems and align processes across both trusts as part of Bristol NHS Group development.

This report meets all statutory requirements under NHS Quality Account Regulations and National Quality Board Guidance - see Appendix 1 for detailed compliance mapping.

Section 1: Deaths in our care

1.1 Quarterly overview of deaths in our care

During Q2 2025-26 (July - September 2025):

- UHBW: 387 adult in-hospital deaths
- NBT: 475 adult in-hospital deaths
- Bristol NHS Group combined: 862 deaths

This compares to Q2 2024-25:

- UHBW: 343 adult in-hospital deaths
- NBT: 488 adult in-hospital deaths

Across University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS (NBT) hospitals, most deaths occur 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.

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.

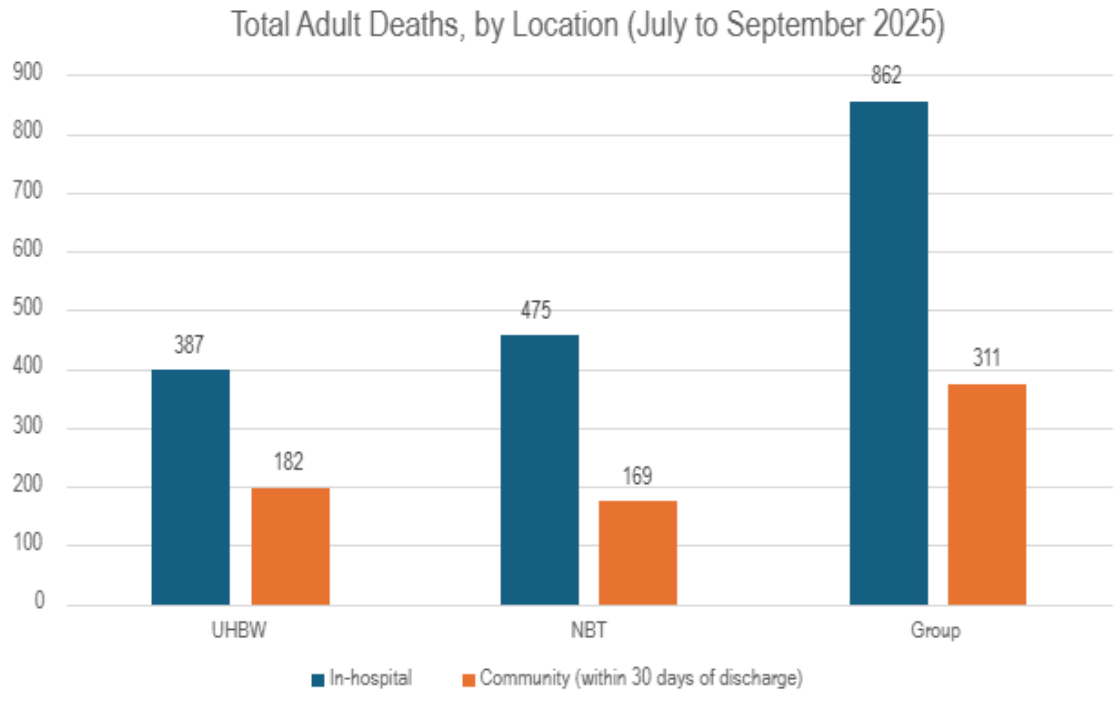

Figure 1 - Total Adult Deaths by location for July to September 2025

Hospital deaths by site

Table 1 shows deaths by site. The variation reflects the distinct types of services provided at each hospital.

Organisation	Site	Deaths Q2 25/26 Adult	Deaths Q2 25/26 Child	Deaths Q2 24/25 Adult& Child
UHBW	Bristol Royal Infirmary	221	0	204
UHBW	Weston General Hospital	127	0	101
UHBW	Bristol Haematology and Oncology Centre	24	0	28
UHBW	Bristol Royal Children's Hospital	0	8	12
UHBW	St Michael's Hospital	1	8	10
UHBW	Died in ED	14	1	1
UHBW	30 Days of Discharge	182	6	Not known
UHBW Total	Total deaths	569		Not known
UHBW Total In Hospital	In-hospital deaths	387	17	356
NBT	Southmead Hospital	459	3	469
NBT	Died in ED	16	1	19
NBT	30 Days of Discharge	169	1	176
NBT Total	Total deaths	644	5	664
NBT Total In Hospital	In-hospital deaths	475	4	488
Group	In-Hospital Death	862	21	844
Group	30 Days of Discharge	351	7	Not known
Bristol NHS Group Total	Total deaths	1213	28	

Table 1: Table showing recorded deaths by organisation and site for Q2 July to September 2025

For detailed breakdowns by site and division see Appendix [2].

The Bristol NHS Group operates approximately 2009 inpatient beds across both trusts:

- UHBW: beds across five sites:
  - Bristol Children's Hospital (RBCH) 155
  - Bristol Eye Hospital (BEH) 11
  - Bristol Haematology and Oncology Centre (BHOC) 58
  - Bristol Royal Infirmary (BRI) 504
  - St Michael's Hospital (StM) 125
  - Weston General Hospital (WGH) 278
- NBT: beds at Southmead Hospital (SMD) 878

This provides context for the death distribution, which reflects both bed capacity and the types of services provided at each site.

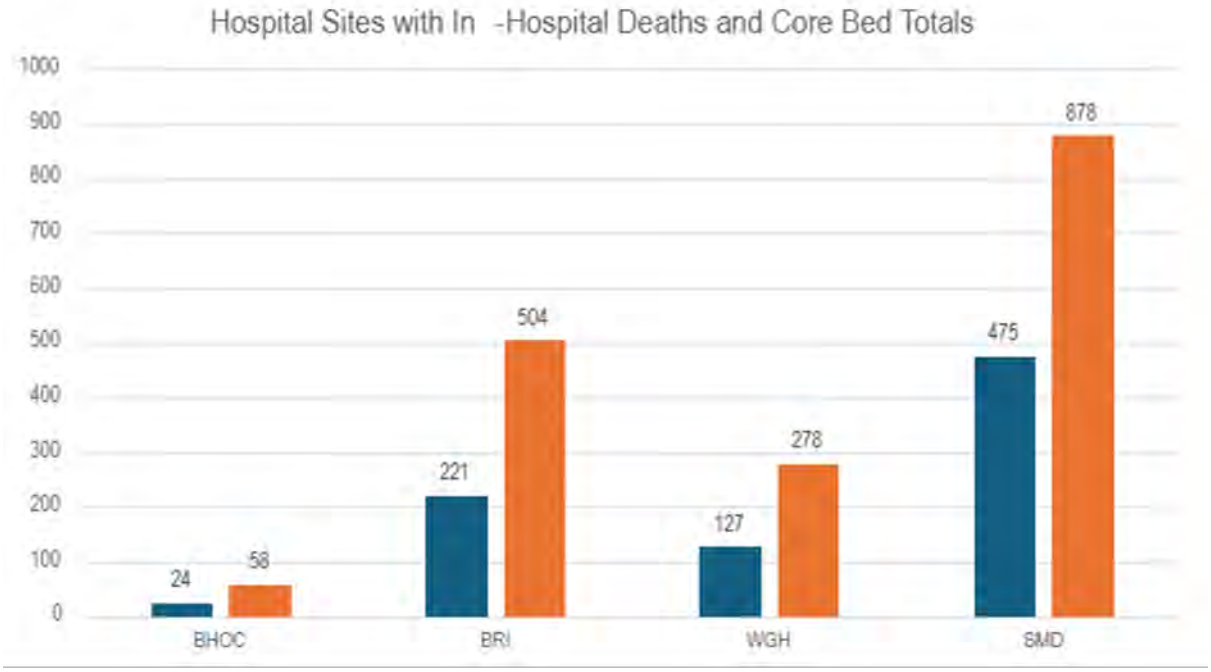

Figure 2 Hospital Sites by In-Hospital Deaths and Core Inpatient Beds

Bristol NHS Group

Both trusts reported stable quarterly mortality with combined mortality indicators remaining 'as expected'. Aligned processes are now in place for review selection, ME referral handling, and learning dissemination.

1.2 Independent scrutiny of every death

The Medical Examiner Service

When a patient dies at NBT or UHBW, their care record is updated and the care received by the patient is independently reviewed by the Medical Examiner (ME) Service.

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.

During the reporting period, the ME service scrutinised all adult deaths not referred to the coroner. The service also scrutinised 100% of 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.

Scrutiny Numbers Q2 2025-26

Trust	Adult Deaths Scrutinised	Scrutiny Rate
UHBW	387	100%
NBT	475	100%
Bristol NHS Group	862	100%

Table 2: Total adult deaths scrutinised by the medical examiner for Q2 Jult to September 2025

1.3 Understanding our mortality data

Summary Hospital-level Mortality Indicator (SHMI) and Variable Life Adjusted Display (VLAD) monitoring

NHSE releases SHMI and VLAD figures for all NHS Trusts to support monitoring of mortality across different diagnosis groups and other performance indicators.

Although released regularly, the data is in arrears by six months with figures for Q2 unavailable at time of reporting. SHMI is monitored and discussed regularly by both organisations, with a quarterly preview sign off established and aligned in both Trusts.

We further introduced aligned VLAD chart monitoring across both trusts in Q4 2024-25 and if alerts are issued upon release of the VLAD data these are discussed as part of the ongoing governance arrangements within the two organisations.

We continue to monitor coding accuracy and case-mix changes as part of our routine mortality surveillance. During this period there have been no alerts at NBT or UHBW which have required further investigation.

Section 2: How we review and learn from deaths

2.1 Our approach to reviewing deaths

Our responses to 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 to our governance teams:

At UHBW, the Associate Medical Director (Patient Safety & Mortality) reviews each Medical Examiner referral, along with patient safety and Trust Management Team colleagues, to ensure the right response and next steps are taken.

At NBT, referrals are triaged by Divisional Governance Teams who determine appropriate actions and escalate to the Medical Director (Safety & Quality) where needed.

The Medical Examiner (ME) and Medical Examiner Officers (MEO) provide families with the opportunity to feedback both positive and negative experiences as well as highlight care concerns.

The difference in ME referral rates reflects different processes in structure, reporting thresholds and case mix between the 2 trusts. A gap analysis of referrals January to March '25 detailed the differences in the process of dealing with response to referrals (with NBT using Radar and are reliant on divisional response whereas UHBW uses a multi-stage email/spreadsheet tracking system).

This analysis concluded there was a need for each trust to be informed by the others processes and has formed the basis for further ongoing alignment work between the ME services. This alignment work aims to produce a clinically relevant thematic framework for ME referral categorisation across NBT and UHBW, enabling standardised analysis, enhanced cross-trust learning, and improved efficiency in mortality surveillance processes. This will include an integrated ME data system providing real time specifics to inform governance and quality outputs.

During Q2 2025-26, the Medical Examiner Service referred:

- UHBW: 86 cases
- NBT: 38 cases
- Bristol NHS Group: 124 cases

The breakdown of referral type is illustrated in Table 2 below.

Medical Examiner Referral Type	UHBW	NBT	Total
Concern only	52	23	75
Positive feedback and care concerns	5	2	7
Positive feedback only	16	3	19
Mandatory Referral	**13**	**10**	**23**
Total	**86**	**38**	**124**

Table 3: Medical Examiner referrals by type of referral and trust, Q2 2025-26

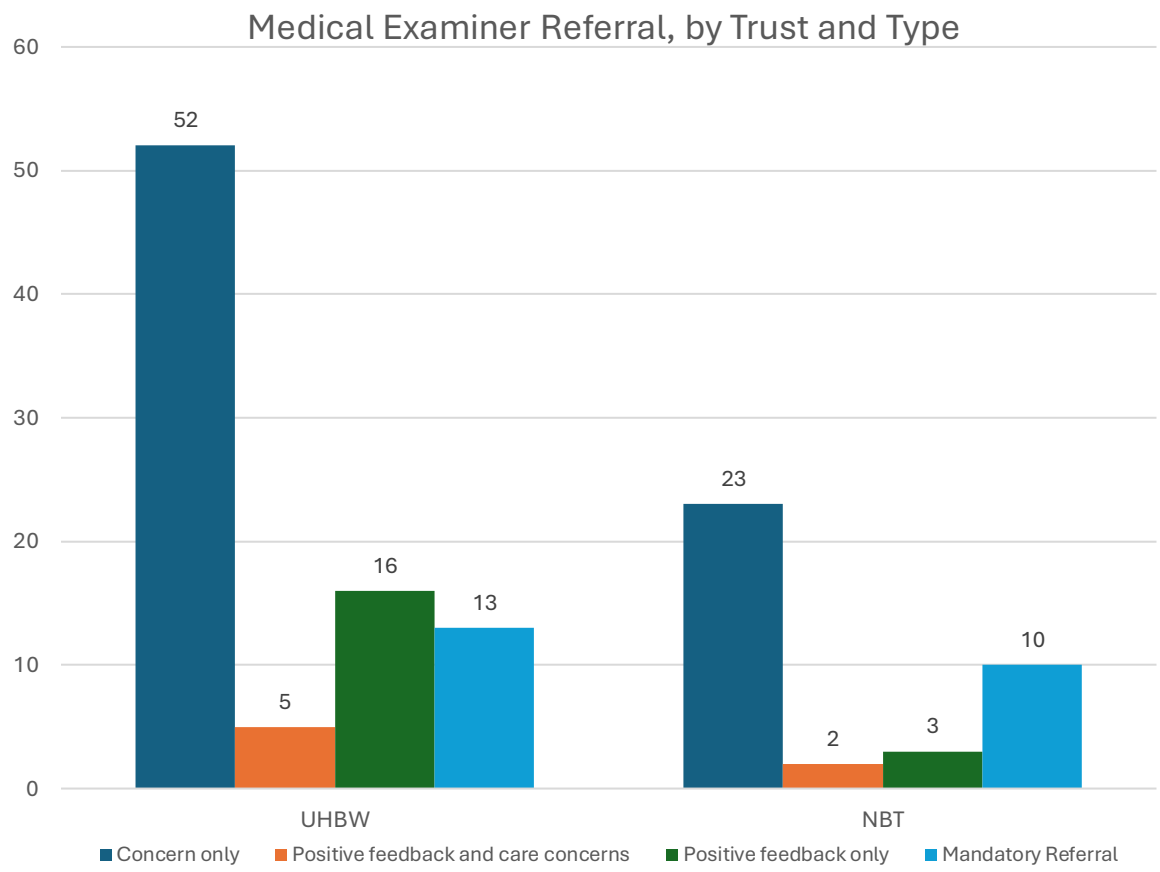

Figure 1 Bar chart showing the type of referral received by Trust for July to August 2025

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.

For cases referred following a concern, 12 UHBW cases and 1 NBT case were identified as suitable for a detailed case note review, called a Structured Judgement Review (SJR). Figure 5 shows how we responded during Q2 2025-26.

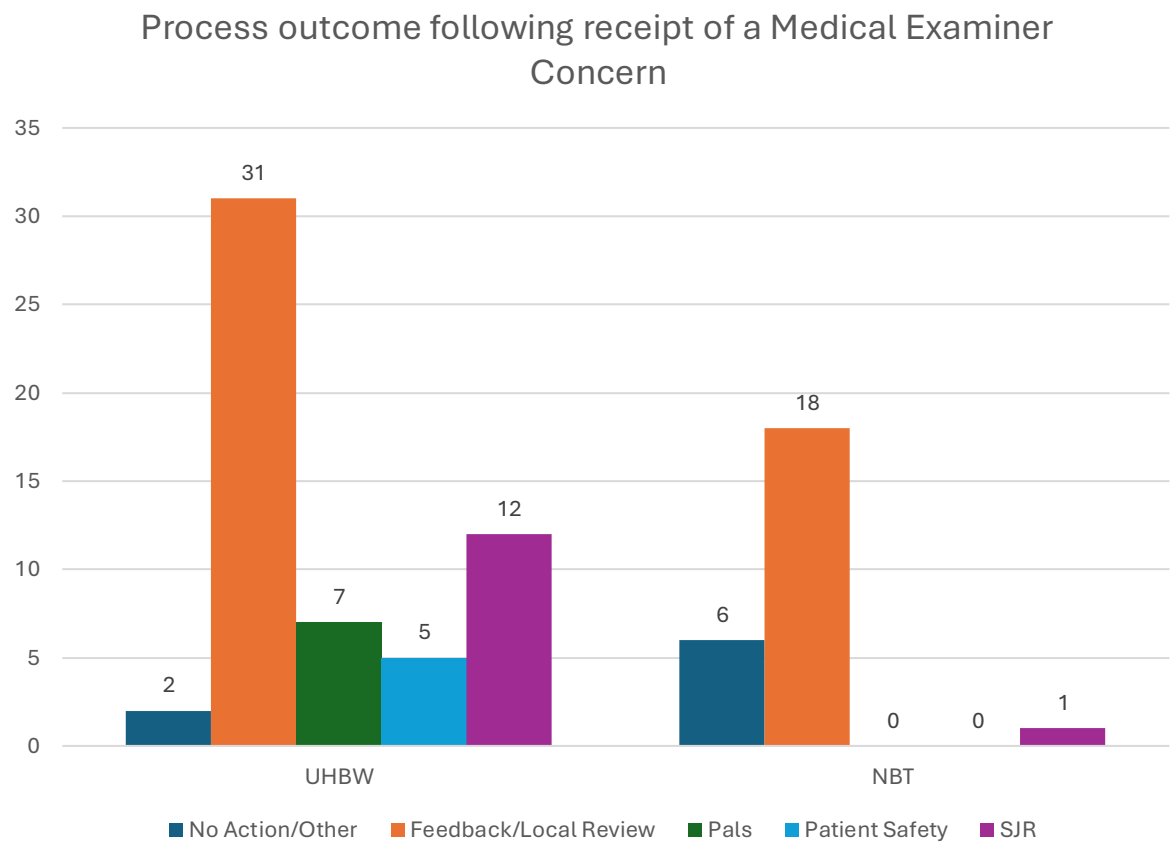

Figure 2 Process outcome following receipt of a Medical Examiner Concern by Trust for July to September 2025

This quarter, 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.

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. During quarter 2 an aligned medical examiner referral concern list of themes was defined and agreed by both Trusts, to support the ongoing alignment of reviews. Each concern has been themed against the agreed definitions for the primary area of concern. A review of the categorisation, following 6

months of referrals received, will be conducted in Q3 to ensure that the criteria continue to meet its intended objectives.

We categorise the referrals we receive to help us understand patterns in what families and the Medical Examiner Service are telling us. Figure 5 shows the most common themes across both trusts in Q2 2025-26.

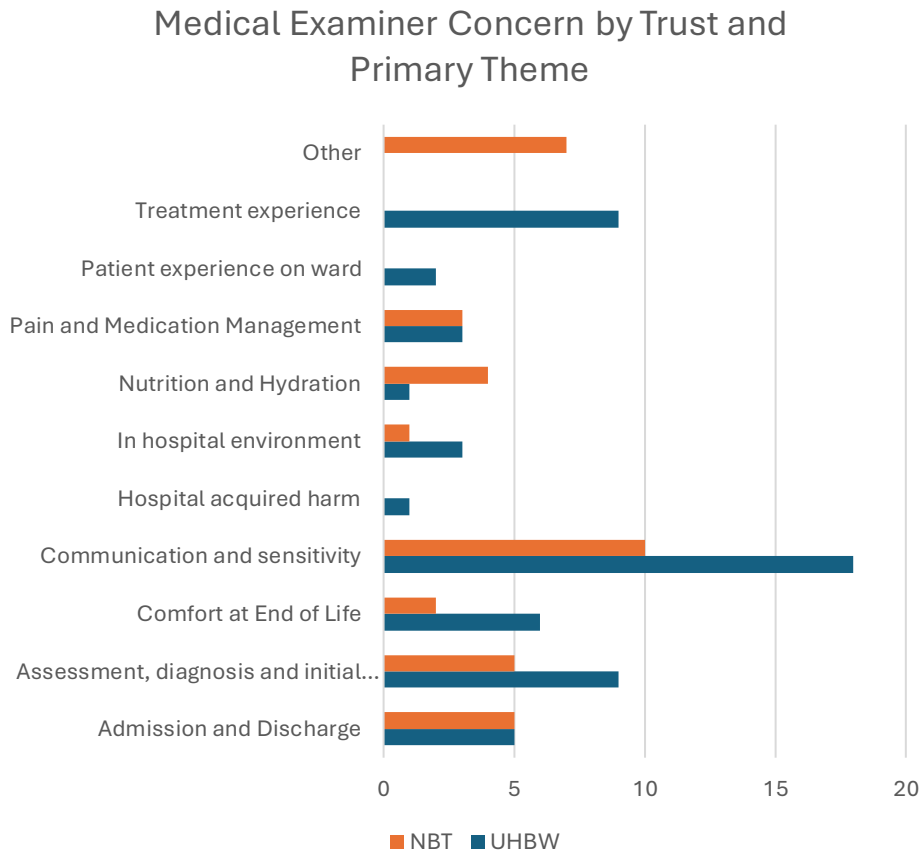

Figure 3 Bar chart depicting the primary theme for medical examiner referrals received for each Trust between July and August 2025

Learning from inquests

When a patient dies, the Medical Examiner determines whether the death should be referred to the coroner. This referral is a normal part of the death certification process and does not indicate concerns about care quality - many referrals are made for legal or administrative reasons, such as deaths within 24 hours of admission or deaths following accidents. Further information about which deaths must be referred to the coroner is available on the Coroners - Courts and Tribunals Judiciary.

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

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 learning disabilities 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 wouldn't 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 the CQC, triggered SJRs.

Structured judgement review (SJR) distribution

During Q2 2025-26, we undertook:

- UHBW: 25 SJRs (6.46% of adult deaths)
- NBT: 14 SJRs (2.95% of adult deaths)

All SJRs were initiated in line with NQB guidance. There is no target for the number of SJRs that should be undertaken.

The total number of SJRs completed and the reasons for their initiation are detailed in Table 4.

Death Review Process	UHBW	NBT	Total
Adult In-hospital Patient Deaths Scrutinised by Medical Examiner	387	475	862
Patient deaths referred to UHBW by the Medical Examiner (All concern referrals)	86	38	124

Death Review Process	UHBW	NBT	Total
Structured Judgement Reviews			
Patient had a diagnosis of a learning disability or autism (ME or other notification)	8	9	17
Patient had a diagnosis of a Severe Mental Illness (ME or other notification)	4	1	5
Patient had an elective admission (ME or other notification)	1	0	1
Treatment or care concern (ME or Other)	12	1	13
Learning opportunity (no specific concern)	0	3	3
Total Structured Judgment Reviews Initiated	**25**	**14**	**39**
Structured Judgement Reviews initiated and completed	**5**	**13**	**18**

Table 4: Table showing breakdown of SJR reviews because of a medical examiner referral, Q2 2025/26

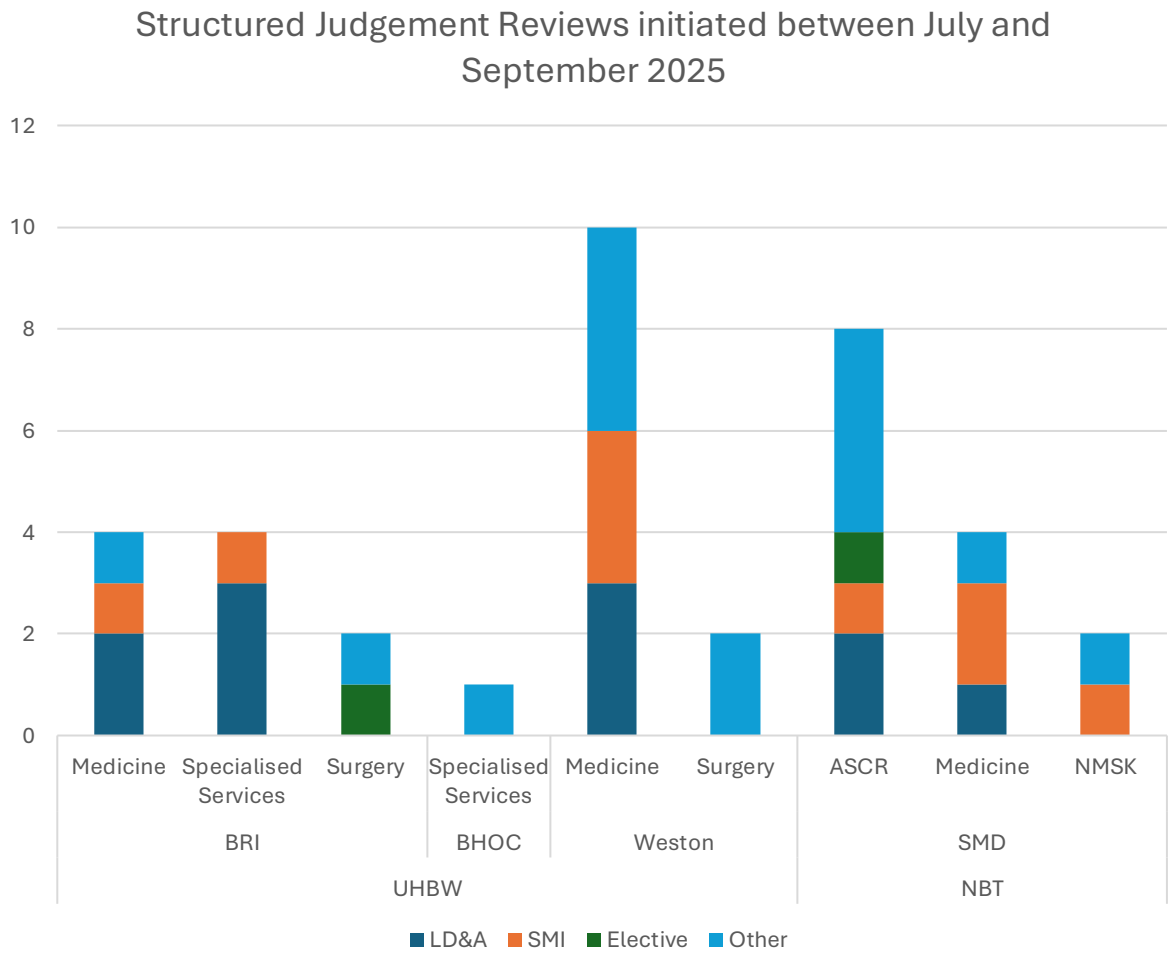

Figure 4 Bar Chart showing reason for an SJR being initiated by Trust, Site and Division for June to September 2025

This quarter, we initiated:

- 17 reviews for patients with a learning disability or autism diagnosis
- 5 reviews for patients with a severe mental illness diagnosis
- 1 review for patients with an elective admission
- Sixteen reviews following concerns raised by the Medical Examiner, families, or staff member

For ME referrals involving patients with learning disability, autism, or severe mental illness, as well as elective admissions and cases referred due to care concerns, we monitor the initial decision made following Medical Examiner scrutiny.

2.3 Mortality review completion times

UHBW

In Q2 2025-26, of the 25 reviews initiated, 13 SJRs were completed by the division, with the median time from death to divisional review completion being 45 days Following divisional review, all SJRs are then formally approved at the trustwide Mortality Surveillance Group.

NBT

In Q2 2025-26, of the 14 reviews initiated, 13 SJRs were completed with the median time from death to divisional review completion being 68 days. Following divisional review, all SJRs for patients with a Learning Disability and/or Autism plus any SJRs scored as ‘poor’ or ‘very poor’ overall care scores are then scrutinised at the weekly Patient Safety Executive Meeting (PSEM).

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.

If a SJR identifies a potential problem in care that may have led to harm, NHS trusts are required to assess whether the death might have been avoided with different care or treatment. To do this, NHS trusts use a national scale from “definitely not avoidable” (1) to “definitely avoidable” (6). These ratings are the reviewer's professional and initial judgement only and are based on what they can see in the medical notes. An initial

judgement of a potentially avoidable death is not an assignment of blame and will always trigger a further review to make sure the right process is followed.

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 Framework (PSIRF).

2.5 What we learned

Overall care scores

Of the 25 SJRs initiated at UHBW in Q2 2025-26, of those 7 have been completed and 18 remain in progress.15 SJRs in total have been signed off through MSG in Q2 (7 initiated in Q2, 8 prior to Q2)

Of the 14 SJRs initiated at NBT in Q2 2025-26, 13 have been completed and 1 remains in progress.

The majority of completed SJRs scored overall care as good (4) or excellent (5). Table 5 shows the complete breakdown.

Overall Care Ratings (1-5 scale)

Overall Care Score	UHBW	NBT	Total
1 Very Poor	0	0	0
2 Poor	1	0	1
3 Adequate	1	4	5
4 Good	10	8	18
5 Excellent	3	1	4

Table 5: Table showing breakdown of SJR review scores for both Trusts for SJRs initiated and closed within July to September 2025

1 case was rated 2 or poor for overall care for UHBW relating to pain management and palliative care during admission. As a result, shared learning was provided to the F1 teaching programme and awareness raised of nurse-led escalation of pain and palliative care services.

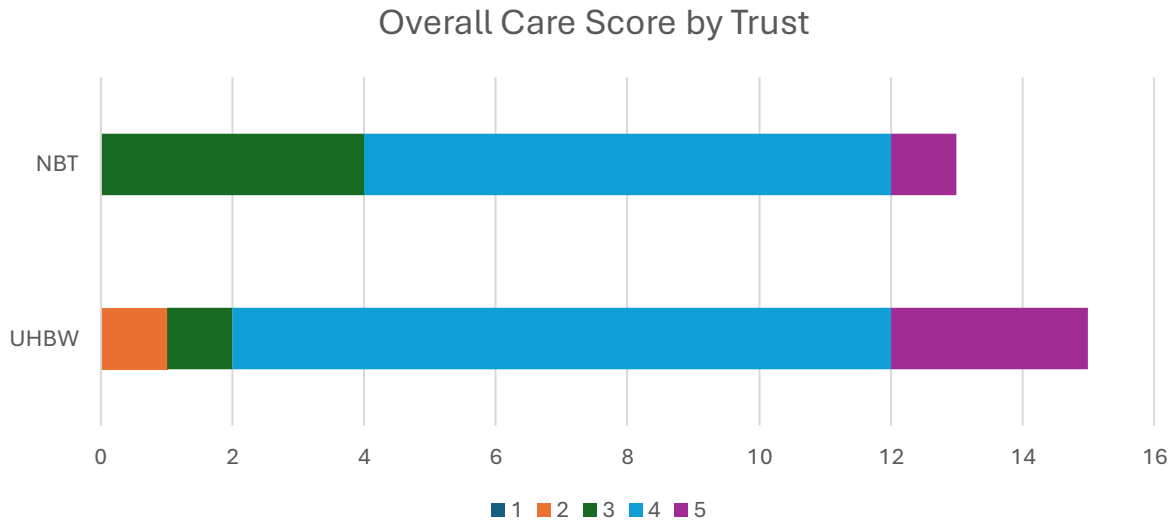

Figure 5 Bar chart showing the overall care breakdown by Trust

Avoidability Ratings (1-6 scale)

Both trusts assess whether deaths may have been avoidable due to problems in care, in line with National Quality Board (NQB) guidance, but through different pathways.

At UHBW, reviewers score avoidability for all SJRs at Mortality Surveillance Group. Of 9 reviews completed in the reporting period, none were identified as evidencing that the death was more likely than not to have been due to problems in care (all scored 5-6, indicating very little or no evidence of avoidability).

At NBT, reviewers are only asked to rate avoidability where SJRs identify care concerns and cases are escalated to Patient Safety Executive Meeting (PSEM) for further review. No cases within the reporting period met this threshold.

At both trusts, Medical Examiner scrutiny identifies cases requiring investigation through other processes (such as by the coroner or though PSIRF) rather than SJR, avoiding duplication. Cases with immediate concerns about avoidability are captured through these pathways.

Recognised limitations

Avoidability scoring is subjective and open to individual reviewer interpretation, and a judgement is based on case notes alone. In practice, cases of genuine concern are recognised through ME review or initial screening and appropriately directed to the

relevant investigation processes. The avoidability question in routine SJRs therefore adds limited additional value where effective filtering mechanisms are in place.

Alignment for Bristol NHS Group

Through the mortality improvement programme, Bristol NHS Group will agree a single approach that asks the avoidability question only in SJRs where it is appropriate – for example, where care quality scoring indicates potential concerns.

This approach is consistent with the principle of ensuring deaths are subject to the most appropriate review process, which is reflected in guidance from national leads and supported through the National Community of Practice for NHS Mortality and Learning from Deaths Leads.

Avoidability Score	UHBW
1 – Definitely avoidable – Strong evidence that the death could have been prevented	0
2 - Slight evidence of avoidability – More likely than not that the death was avoidable	0
3 - Possibly avoidable - more than 50:50 – Some evidence suggesting the death was avoidable	0
4 - Probably avoidable - less than 50:50 – limited evidence of avoidability	0
5 - Slight evidence of avoidability – Verly little indication that the death could have been prevented	2
6 - Definitely not avoidable – No evidence that the death could have been prevented	13

Table 6: Table showing avoidability scores for UHBW SJRs for Q2 July to September 2025

Our mortality surveillance integrates with broader clinical governance through:

- Monthly mortality review group oversight through the Mortality Surveillance Group (MSG) and Patient Safety Group (PSG), with escalation to Clinical Quality Group (CQG) as required at UHBW
- Monthly mortality review group oversight through Clinical Effectiveness and Outcomes Group (CEOG) and divisional governance processes at NBT
- Board-level reporting and challenge
- Integration with PSIRF processes

This learning integrates with routine Morbidity and Mortality (M&M) meetings across all clinical specialties, ensuring frontline clinical teams can access and apply mortality insights directly.

Section 3: How we have improved

3.1 Learning and improvement from Structured Judgement Reviews

UHBW Examples

The Mortality Surveillance Group meets monthly and collates and minutes learning from SJRs and other mortality related data and information. During July and September key topics the group discussed were:

- Inclusion of surgical consultants in Medical Examiner discussions especially in cases following an elective surgery. Support providing specialist input to ensure appropriate governance escalation.
- Discussion of the Learning from Deaths Annual Report, plan to share executive summary within divisions.
- Medical Examiner update on the risk of reduced coverage over winter period.

Learning identified through SJRs

Site/Division	Learning Identified
BRI/Medicine	Learning points identified around the escalation process undertaken. Escalation processes are under review, and case will be taken to deteriorating patient steering group.
	Learning points noted regarding management and treatment of sepsis. Feedback to ward teams for general learning.
	Concerns raised around pain management, no palliative care involvement and delayed escalation. Learning to be shared with F1 teaching programme. Reinforce nurse-led escalation to pain and palliative care services.

Site/Division	Learning Identified
BRI/Surgery	Documentation of key care elements was limited. Feedback to teams on documentation standards. Capture learning under the deteriorating patient steering group.
BHOC/Specialised Services	Learning noted around catheter blockages. Case and learning point to be flagged with the End-of-Life Steering Group
Weston/Medicine	Learning identified on system access issues for CMM (clinical medication management). Visibility is limited unless logged in directly via CMM. Awareness of digital system limitations. Noted that this could be linked to the system transition during changeover period.

Table 7: Learning identified for UHBW through SJR reviews

NBT Examples

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

CEOG meets bimonthly, in September 2025 the group discussed the 2024/25 Group Annual Learning from Deaths report, key discussions included:

- The first joint Learning from Deaths report by NBT and UHBW, aligning with national guidance; Medical Examiner Service now statutory (2024) and linked to CQC and Child Death Review.
- Key themes noted were communication (especially treatment escalation), end-of-life care coordination, impact of extended ED stays, and family feedback.
- The group noted that both trusts comply with guidance and show good care quality; ongoing work to standardise digital processes, review methods, and ME referral categorisation.
- The future focus on quarterly group-level reporting, policy alignment ahead of merger, and national leadership in defining care quality standards through the Community of Practice.

SJR Reviews	Learning Themes Identified
Positive aspects of care	• Overall good care delivered in most cases with appropriate and timely treatment • Thoughtful decision-making involving families and respecting patient wishes • Prompt escalation to senior decision-makers and specialist teams • Early recognition and treatment of sepsis in several cases

SJR Reviews	Learning Themes Identified
Areas for improvement	1. Initial Assessments a. Some initial clerking could have been more detailed b. Capacity assessments and documentation were sometimes unclear 2. Communication a. Family communication was inconsistent in some cases 3. Documentation a. Missing details on discussions about palliative care and symptom management in some cases b. ReSPECT forms not always completed promptly (though often would not have changed outcomes) 4. Systemic/Process Issues a. Transfers could be minimised for vulnerable patients.

Table 8: Learning identified through SJR reviews for NBT

3.2 Measuring impact

In Q2 2025/26 scoping and discussions continued regarding the development of impact metrics across both trusts whilst recognising that some measures will be trust-specific due to different operational systems. For example:

- UHBW tracks via the Mortality Surveillance Group (MSG) action log and divisional reports
- NBT tracks via clinical effectiveness and outcomes group and divisional/speciality reports and action tracking

This work is being considered alongside the ongoing group work, where focus is placed on alignment of reporting and review processes. By Q4 2025-26, we aim to have harmonised impact reporting that shows both trust-level and Group-level improvements.

3.3 Looking forward

Current challenges and our plans to address them

In 2025-26, our Learning from Deaths policies are being updated in line with our Bristol NHS Group development. Rather than updating separately and aligning later, we are working together as part of our joint Mortality Improvement Programme to develop single policies from the outset. This ensures consistency whilst incorporating changes in national guidance, statutory Medical Examiner requirements, and PSIRF alignment. While our current policy requires updating, there are no high-risk concerns with our existing processes.

Our data collection relies heavily on manual processes rather than automated digital systems. While our data is accurate, this requires significant administrative time and limits our ability to analyse trends efficiently.

For 2025-26, we are investing in digital systems to address these limitations, track reviews more effectively, and reduce administrative burden on clinical staff.

Future Priorities and Commitments

During 2025-26, we will be:

- Updating the Medical Examiner referral system
- Implementing enhanced Structured Judgement Review (eSJR) processes
- Developing automated mortality surveillance dashboards
- Standardising review methods and data collection across both trusts
- Setting up shared learning forums and cross-trust specialty reviews

We are developing automated flags for cases with the highest learning potential, such as delays of 8+ hours from decision to admit, or patients who move from ward to ward then to intensive care. These help clinical teams identify cases for review and focus time on implementing learning.

Bristol NHS Group integration

Our mortality improvement work is directly aligned with our Bristol NHS Group development. Key deliverables include:

- Consistent SJR template and methodology across both trusts
- Aligned annual and quarterly Learning from Deaths reporting
- Joint mortality surveillance dashboards supporting Group Quality functions

System-wide collaboration

We continue to strengthen partnerships across Bristol, North Somerset and South Gloucestershire (BNSSG), working with Avon and Wiltshire Partnership on severe mental illness mortality reviews and with Sirona Care and Health on community learning opportunities.

Appendix 1

Regulatory Compliance Mapping

Requirement	Evidence Location in This Report
Total deaths (27.1)	Section 1
Reviews conducted (27.2)	Section 2
Avoidable deaths (27.3)	Avoidabilty Ratings
Learning identified (27.4) Actions taken (27.5)	Section 3.1
Impact assessment (27.6)	Section 3.2

Table 9: Regulatory compliance mapping

Appendix 2

Hospital mortality – site and divisional context

Discharge Site	Discharge Division	In-Hospital	Community
Bristol Haematology and Oncology Centre	Specialised Services	24	37
Bristol Royal Infirmary	Diagnostic & Therapy	0	2
	Medicine	150	60
	Specialised Services	51	6
	Surgery	33	20
St Michael's Hospital	Women's and Children's	1	1
Weston General Hospital	Medicine	107	49
	Specialised Services	1	2
	Surgery	20	5
Southmead	Anaesthetics, Surgery, Critical Care and Renal	66	28
	Core Clinical Services	0	2
	Medicine	319	118
	Neurosciences and Musculoskeletal	90	21
	Women's and Children's	0	0

Table 10: UHBW and NBT in-hospital and community deaths by site and discharging division for Q2 (date of death July to September 2025).

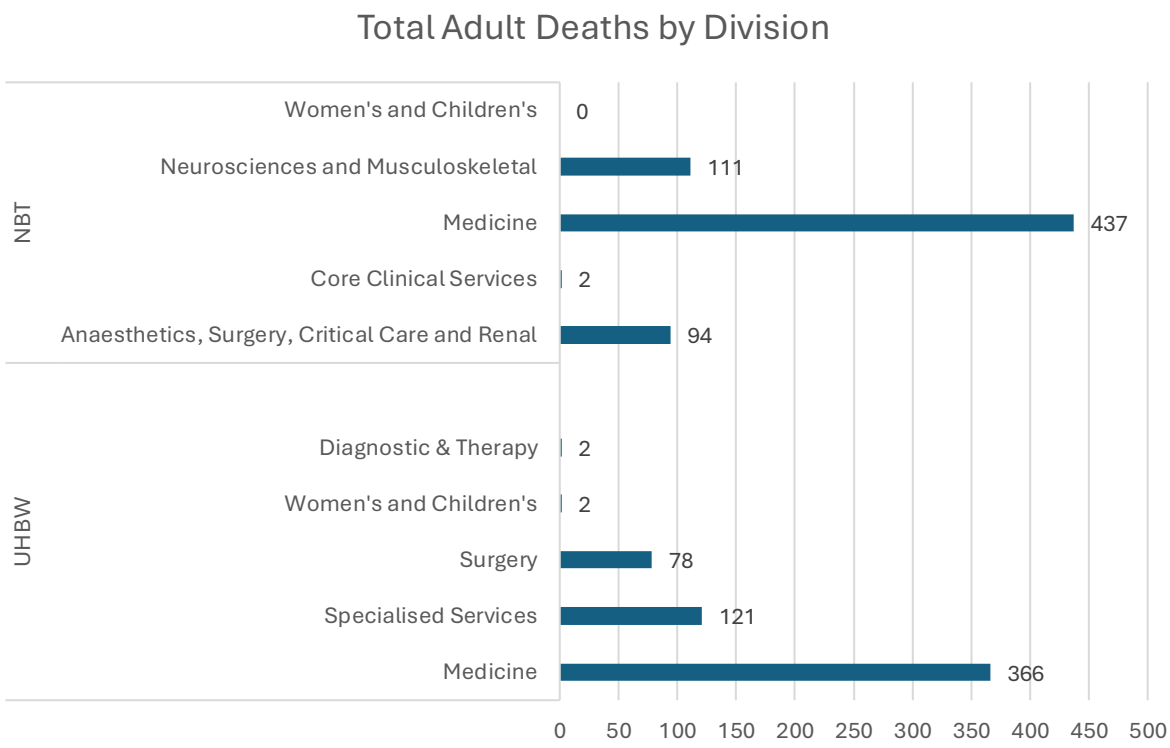

Figure 6 Bar chart showing the total adult deaths by discharge division

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	13 January 2026		
Report Title:	Treasury Management Policy		
Report Author:	Nick Wilson, Head of Controls and Assurance (UHBW)		
Report Sponsor:	Neil Kemsley, Group Chief Finance and Estates Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	✓		
	The Treasury Management policy sets out the Treasury Management activities and establishes a risk management environment in which objectives, polices and operating parameters are clearly defined.		

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

The policy is a Foundation Trust requirement and therefore specific to UHBW. The policy will be reviewed as part of the merger actions to ensure alignment with NBT practices.

The Treasury Management Policy, last reviewed in November 2024 requires only minor changes to reflect job titles, terminology, and operational process updates.

Strategic and Group Model Alignment

This policy is directly linked to the Patient First objective of 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore the Trust's strategic ambitions can continue to be supported, subject to securing CDEL cover.

Risks and Opportunities

None to note.

Recommendation

This report is for Approval

- The Board is asked to APPROVE the policy.

History of the paper (details of where paper has <u>previously</u> been received)	
Group Finance and Estates Committee	25 November 2025
Appendices:	N/A

Treasury Management Policy

Document Data			
Subject:	Procedural Document		
Document Type:	Policy		
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Executive Lead:	Group Chief Finance and Estates Officer		
Approval Authority:	Trust Board of Directors		
Review Cycle:	12		
Date Version Effective From:	**01/12/2025**	**Date Version Effective To:**	**01/11/2026**

What is in this policy?
The emphasis the Trust places on good corporate governance requires it to have a formally approved Treasury Management policy which sets out its current Treasury Management activities and establishes a treasury risk management environment in which objectives, polices and operating parameters are clearly defined.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
23/02/15	0.01	Deputy Director of Finance	None	No changes since last reviewed by Trust Board on 27 February 2014. (Original policy 2008)
18/02/16	0.03	Deputy Director of Finance	Minor	Minor changes to titles of posts, organisations and groups etc. Removal of consumer credit license
28/04/2017	0.04	Deputy Director of Finance	Minor	Changes to external references and internal cross references.
26/03/2018	0.05	Deputy Director of Finance	Major	Changes to job titles, changes to external references and internal cross references, and minor amendments to wording. Imported to new Trust policy layout.
14/06/2019	0.06	Deputy Director of Finance	Minor	Changes to job titles and role responsibilities
24/09/2020	0.07	Deputy Director of Finance – Governance and People	Minor	Changes to the Trust's name, current titles and responsibilities, and terminology. Update to the frequency of weekly payment runs and audit reviews. Reference to the arrangements in place for 2020/21 as part of the Covid response.
17/11/2023	0.08	Head of Finance – Financial Performance		Changes to job titles, responsibilities and terminology Remove references to Covid-19 arrangements. Update processes for borrowings, cash flow forecasting and credit notes.
14/11/2024	0.09	Head of Finance – Financial Service and Assurance	Minor	Changes to job titles

13/11/2025	0.10	Head of Controls and Assurance	Minor	Updates to job titles, steering group and committee names. Removal of reference to cheque payments Removal of reference to interest rate management Updated link to Standing Financial Instructions

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1. Introduction

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) has a wide discretion in the way they manage and invest cash. This policy sets out how these areas will be assessed, reported, and monitored. It closely follows best practice issued by NHS England 'Managing Operating Cash in NHS Trusts' and 'safe harbour' for investment of surplus operating cash. The guidance advises that Foundation Trusts should establish written policies covering their Treasury Management activities which should be formally approved by the Trust Board and regularly reviewed.

The Treasury Management function aims to support the Trust's activities by;

- Ensuring that cash is managed effectively.
- Ensuring the most competitive return on surplus cash balances, within an agreed risk profile.
- Ensuring that there is competitively priced funding available to meet borrowing requirements should it be needed.
- Ensuring that the Trust is aware of its cash position by regular, thorough reporting.
- Ensuring that all transactions and reviews are carried out within the appropriate timeframe and by the appropriate persons.
- Identifying and managing financial risks, including interest rate and foreign currency risks, arising from operating activities.
- Ensuring compliance with all banking covenants.

In order to meet these aims the treasury management function has the following key objectives:

(a) Surplus Cash: To obtain the most competitive deposit rates using National Loans Fund and a group of relationship banks, in line with the deposit guidelines approved by the Trust's ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

(b) Funding: Ensure the availability of flexible and competitively priced funding to meet the Trust's current and future requirements.

~~(c) Interest Rate Management: Maintain an interest rate structure which smoothes out the impact of rises or falls in interest rates on the Trust's Income and Expenditure position.~~

(d) Foreign Currency Management: Reduce the Trust's exchange rate movement risk by covering known foreign exchange exposures and mitigating material risks.

(e) Bank Relationships: Develop and maintain strong, long-term relationships with a core group of quality banks ("relationships banks") that can meet current and future funding requirements.

These objectives are targeted to ensure that the Trust is able to continue its operational activities without facing financial constraints and that financial support is available to fund future approved developments.

Treasury activities for purely speculative purposes are strictly prohibited.

2. Purpose

This policy has been set up as a practical way of reviewing and monitoring Treasury Management activities.

On a quarterly basis a Treasury Management Report will be presented to the Trust's ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee to provide an update on any new issues, movements and Key Performance Indicators, as set out in the detailed sections in the policy.

3. Scope

The policy applies to all Treasury Management functions across the Trust. All processes and controls must be delivered in accordance with the policy.

4. Definitions

4.1 Treasury Management

Treasury Management is the process of managing cash, availability of short term and long-term funds, foreign currency and interest rate risk, and relationships with banks and other financial institutions.

In order to facilitate effective corporate governance, it is necessary to formally set out the expected treasury activities and establish a treasury risk management environment in which all objectives and operating parameters are clearly defined.

In the main, the Treasury Management activities of the Trust will be conducted in accordance with the guidance given by NHS England for dealing with cash and working capital.

4.2 Bank Relationships

The Trust's approach is to develop long term relationships with a core group of high quality banks. This will be subject to a periodic tendering process by the Trust for banking services.

The Trust currently transacts with the Government Banking Service (GBS) and NatWest Bank. The Head of Finance – Financial Services & Assurance is able to meet with other high-quality banks to discuss the products and services they offer for information gathering purposes. If a new banking relationship proposal is suggested, this must be pre-approved by The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer before a proposal is made to the Trust's ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee. The proposal will detail the need and potential benefit of the new banking relationship, and the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will sanction or reject the proposal.

The quarterly Treasury Management Report update will include details of any significant meetings with banks, the outcome of any new banking proposals and any forthcoming new banking relationship proposals.

4.3 Investments

All cash balances should remain in a comparatively liquid form in order to reduce the Trust's exposure to risk. If there is surplus cash it should ideally be placed in investments that meet the "safe harbour" criteria. If "safe harbour" investments are not available or do not provide a competitive return, then investments that meet all of the criteria except the credit rating for long term investments (greater than 12 months) will be considered. Note that the Trust does not make long term investments. Appendix 1 details the criteria for "safe harbour" investments.

4.4 *Permitted Institutions*

The Trust will place investments with institutions that:

- Have been granted permission, or any European institution that has been granted a passport, by the Financial Conduct Authority to do business with UK institutions providing it has a short-term investment grade credit rating of P1/F1/A1 issued by a recognised rating agency; or
- Is an executive agency that is legally and constitutionally part of any department of the UK Government.

5. Duties, Roles and Responsibilities

Operational management of treasury related issues sits with Head of Finance – Financial Services & Assurance and the Head of Financial Accounts

5.1 *The Trust Board*

The Trust Board will be responsible for those Treasury Management issues specified by the Trust's Schedule of Matters Reserved for the Trust Board (Appendix 2), namely:

(a) Approval of external funding arrangements.

(b) Approval of overall Treasury Management policy.

The Trust Board delegates responsibility for approval of Treasury Management procedures, control and detailed policies to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

5.2 *The ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee*

The ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee shall make such arrangements as it considers necessary on matters relating to the control and management of the finances of the Trust. On matters relating to Treasury Management this will include:

(a) Approval of the overall Treasury Management policy and recommend for approval by the Trust Board.

(b) Approval of Treasury Management procedures, controls and detailed policies.

(c) Liquidity and cash planning and forecasting.

(d) Approval of the Trust's investment and borrowing strategy, ensuring compliance where appropriate with NHS England's best practice guidance.

~~(e) Approval of the Trust's interest rate risk management strategy.~~

(f) Approval of relevant benchmarks for measuring investment and general Treasury Management operational performance.

(g) Reviewing and monitoring investment and borrowing policies and performance against relevant benchmarks in respect of all the Trust's funds.

(h) Ensuring proper safeguards are in place for security of the Trust's funds by:

(i) Approving the Trust's commercial bankers, selected by competitive tender.

(ii) Approving a list of permitted relationship banks and investment institutions.

(iii) Setting investment limits for each permitted investment institution.

(iv) Approving permitted types of investments/instruments.

(v) Approving the establishment of new/changes to existing bank accounts.

(vi) Ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.

(i) Monitoring compliance with Treasury Management policies and procedures on investments, borrowing and interest rate management in respect of limits, approved institutions and types of investment/instruments.

(j) Approval of external funding arrangements, within delegated limits.

(k) Approval of long-term borrowing for capital and investment programmes.

The ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee delegates responsibility for Treasury Management operations to The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer

5.3 The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer

In line with Sections 6, 7, 11 and 17 of the Standing Financial Instructions the Group Chief Financial Officer is responsible for all treasury management operations, which include:

(a) Approve and maintain operational Treasury Management policies and procedures.

(b) Approve cash management systems.

(c) Open all bank accounts in the name of the Trust or any of its constituent parts.

(d) Authorise minor petty cash balances as may be decided and operated according to instructions by any officers specified by The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer.

(e) Approve the use of the Trust's credit card and ensure adequate controls are in place to prevent misuse.

(f) Approve dispute compromises with suppliers in excess of £1,000, up to £50,000. Proposed compromises in excess of £50,000 shall be considered by the Hospital Managing Director for approval.

(g) Hold meetings with the Head of Finance – Financial Services & Assurance and members of the Treasury Management team to discuss and consider any issues that should be brought to the attention of the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

5.4 ~~Capital Programme Steering Group~~ Capital Programme Board

The ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee delegates the following Treasury Management responsibilities to the ~~Capital Programme Steering Group~~ Capital Programme Board, which is directly accountable to the ~~Trust's Executive Committee~~ Trust Management Team.

(a) Formulating the Trust's medium term capital plan.

(b) Reviewing and setting the prioritisation criteria for capital projects, working in conjunction with system partners

(c) Ensuring capital projects support divisional operating plans, the local health economy strategy and the delivery of the Trust's annual operational plan and the national NHS plan.

(d) Reporting actions, decisions and progress on the Trust's capital programme to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

(e) Ensuring all capital projects have a robust business case, and for operational and major medical capital been appropriately scored using the designated prioritisation matrix and offer value for money.

(f) Considering and recommending changes to the Trust's capital programme to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

(g) Ensuring that the Trust's capital programme complies with the overall Financial Strategy of the Trust.

5.5 Head of Transactional Services

The Head of Transactional Services has the responsibility for the prompt collection of NHS (non-patient care income), non-NHS debts and collection of Non-Healthcare Provider to Provider debts. The Finance Manager (Patient Care Income) and Head of Transactional Services will review the credit notes raised in the month after each month end and report on any credit notes greater than £50k to the Head of Finance – Patient Care Income and Costing and Head of Finance – Financial Services & Assurance respectively. Responsibility for the payment of NHS and Non-NHS payables sit with the Head of Transactional Services.

Aged Receivables Review

Aged receivable reports will be reviewed monthly by the Head of Transactional Services and Finance Manager (Patient Care Income) for old unpaid items, to check that they have had the appropriate chasing letters issued. The Head of Finance – Financial Services & Assurance and Head of Finance – Patient Care Income and Costing will review the aged receivable reports at least quarterly and ensure that a recovery plan is in place for any significant outstanding receivable.

Bad Debt Write Off

The receivables ledgers will be reviewed at least quarterly for any receivable that potentially needs to be written off. The Head of Transactional Services and Finance Manager (Patient Care Income) will provide lists of invoices proposed for write off to the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy.

Non-NHS Payables

The Head of Transactional Services will process any invoices that are due for payment on the weekly BACS run. ~~Cheque payment runs are also produced to facilitate the payment of creditors who have not provided bank details.~~ The list of invoices ready for payment will be reviewed to ensure that

only due invoices are paid, or if invoices are being paid early it is because there is an advance payment discount available. The Head of Transactional Services will review the aged creditor report monthly to ensure that resolution of issues preventing the payment of outstanding invoices is being adequately progressed. Information regarding invoices awaiting authorisation will be used to escalate delays in processing to operational managers, Divisional Finance Managers and the Head of Finance – Financial Services & Assurance as appropriate.

NHS Payables

The Head of Transactional Services will process any invoices that are due for payment on a monthly payment run. The list of invoices ready for payment will be reviewed to ensure that only due invoices are paid.

The Head of Transactional Services will review the aged creditor report monthly to ensure that resolution of issues preventing the payment of outstanding invoices is being adequately progressed. Information regarding invoices awaiting authorisation will be used to escalate delays in processing to operational managers, Divisional Finance Managers and the Head of Finance – Financial Services & Assurance as appropriate.

Negotiations with Suppliers over Disputes

The Head of Transactional Services will liaise with suppliers where there are ongoing disputes. Where this involves compromise, the Head of Transactional Services must demonstrate to ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy that a compromise is necessary with the supplier.

5.6 Head of Financial Accounts

The Head of Financial Accounts is responsible for the Trust's banking processes, ensuring that sufficient cash balances are maintained, forecasting future cashflows for planning purposes and monitoring actual cash balances.

Short-Term Investments (Cash Deposits)

Short-term investments or deposits are defined as those of less than 12 months duration. Effective cash monitoring and forecasting on a weekly, monthly and longer-term basis by the Head of Financial Accounts will identify cash surpluses and an appropriate time to be able to invest them for. The Head of Financial Accounts will review and produce forecasts and calculations for investment. The Head of Financial Accounts will contact the National Loans Fund, and all 'relationship' banks and financial institutions and identify the product that generates the best return for the potential investment, ensuring all limits contained in this policy are met.

Investments of more than 3 months but less than 6 months require the prior written approval of The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer. Cash must not be placed on deposit for more than 6 months without the prior approval of the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

If longer term investment is required, this must be referred to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee detailing the reasons why there are such surplus funds, the duration of the proposed investment, and the product proposed. The ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee can refuse this investment because it may decide that it is more appropriate that the cash be spent on other alternatives.

5.7 Head of Finance – Patient Care Income and Costing

The Head of Finance – Patient Care income and Costing has overall responsibility for the prompt invoicing and collection of Healthcare Contract Income charges.

Bad Debt Write Off

The ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy and Head of Finance - Patient Care Income & Costing will review these lists;

- Against the payables ledger to check that there are no ongoing disputes on payments
- Against any other write offs that have happened in the past on this customer
- Against the GBS Unallocated Receipt suspense.
- Against the bad debt provision already held and
- To check that all the necessary steps to recover this money have been taken.

Debts that pass this checking process and require write off, must be authorised for write off in line with the delegated responsibilities contained within the Trust's Standing Financial Instructions. Write offs will be reported to the Trust's Audit Committee and will be summarised in the quarterly Treasury Management Report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

5.8 ~~Director of Operational Finance~~ Trust Director of Finance

Negotiations with Suppliers over Disputes

The ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy can agree compromise arrangements up to £10,000. Any values over this amount will need to be approved by The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer or Hospital Managing Director in accordance with delegated limits. Any compromise deal agreement will be reported in the quarterly Treasury Management Report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

Short-Term Investments (Cash Deposits)

The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer or ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy will review the investment proposals and approve if appropriate to do so. If any of these post holders refuse to authorise the deposit on principal, authorisation from the other post holders should not be sought unless the original authoriser has suggested onward discussion.

Approval of New Commercial Deposit Options

Where there is already an approved relationship with a Clearing Bank or other financial institution, the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy can identify new interest generating deposit account products that may benefit the Trust but will not increase, together or separately, the risk to the Trust's asset base.

Where a new product is required The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer or ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy will pre-approve the product. Because the product is changing the risk profile of the Trust, the decision must be reported to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee. If any of these post holders refuse to authorise the deposit on principal, authorisation from the other post holders should not be sought unless the original authoriser has suggested onward discussion.

Where a new product is available but not with an already approved relationship Clearing Bank or financial institution this must be referred to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee for approval.

5.9 Head of Finance – Financial Services & Assurance

Review of Old Invoices

Head of Finance – Financial Services & Assurance will review the Non-NHS and NHS aged creditor positions quarterly with the Heads of Controls and Assurance and Transaction Services to ensure that action plans are in place to resolve problems with old outstanding invoices. Any significant difficulties will be reported to the ~~Director of Operational Finance~~ Trust Director of Finance to ensure that appropriate action is taken.

Banking Covenants

Head of Finance – Financial Services & Assurance will keep a master list of all the covenants attached to bank, investment and funding arrangements and will report quarterly to the Trust's ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee on performance against these covenants.

6. Policy Statement and Provisions

6.1 Framework

Whilst the Trust has significant freedom to invest cash it has a number of responsibilities that it must discharge including;

(a) Under section 17 of the Health & Social Care Act (Community Health and Standards) Act 2003 ("the Act"), the Trust has discretion to invest money for the purposes of or in connection with its functions but must ensure this is managed carefully to avoid financial and/or reputational risks.

(b) Under Section 29 of the Act the Trust is required to exercise its function effectively, efficiently and economically.

(c) Under the Terms of the NHS Provider Licence, the Trust shall always remain a going concern.

It is essential that the Trust protects itself by ensuring that no imprudent or inappropriate treasury management or investment behaviour occurs. This policy will assist by providing a clearly defined risk management framework to be used by those responsible for treasury operations. The framework lays down responsibilities, protocols and procedures for the various aspects of treasury activities and sets out what should be reviewed and when.

6.2 Attitude to Risk in Key Treasury Activities

(a) Funding

The Trust will maintain a prudent approach to funding, recognising the on-going requirement to have funds available to cover existing business cash flows and reasonable headroom for seasonal debt fluctuations and capital programme expenditure. Additional finance required for longer term developments and investments will be built into cash flow workings as and when agreed and advised by the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

(b) Investments

Where investments are made with institutions that meet the conditions in section 4.3, but which subsequently drop in their short-term credit ratings, the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will be notified, but unless The ~~Chief Financial Officer~~ Group Chief

Finance and Estates Officer considers there to be excessive risk, the investment will continue to maturity.

The use of investments that do not satisfy the above conditions are prohibited unless explicitly approved by the Trust Board and should only be made to manage operational risk. This includes general equities, derivative products and speculative investments such as leveraged investments, hedge funds, derivatives, futures, options and swaps. If there is any doubt as to whether an investment meets the necessary conditions it should be referred to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

Investments for a period of three to six months will require the prior written approval of The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer or the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy. Proposed investments resulting for longer.

than six months must have the prior approval of the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee. No investment may be placed beyond 31 March.

Cash deposits should only be placed with the National Loans Fund and relationship banks in line with the deposit limits approved by the Trust's ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee. Cash should only be placed with organisations that hold appropriate credit ratings, based on the "safe harbour" criteria, with a recognised credit rating agency (Moody's, Fitch, or Standard and Poor's). The approved limits, at any one time, are as follows:

- Investments made with the National Loans Fund are unlimited.
- Individual Clearing Banks each have a limit of £15 million if backed by UK Government, £12m otherwise, (subject to the rate of return offered being at least 10 basis points higher than that offered by the higher of the National Loans Fund or Government Banking Service). Details of further limits applied to particular Clearing Banks can be found below.

(c) Permitted Institutions

The list of institutions being used for treasury deposits will be reviewed at least annually or earlier where market conditions or intelligence suggest the need to ensure:

- That each one meets the criteria set out in this policy; and
- That it is appropriate to add (or delete) any new institutions from the list of active deposit takers.

If an institution is downgraded or put on credit watch by a recognised rating agency, then the decision to invest with them should be reviewed.

The table below provides the investment limits for permitted financial institutions based on the credit ratings provided by recognised agencies.

Table: Investment limits

Institutions	Recognised Credit Rating Long-term/(Short-term)	Deposit Limit
Clearing Banks:		
Backed by UK Government	(P-1)	Lower of 50% cash available and £15m
Not Backed by UK Government	(P-1)	Lower of 25% cash available and £12m
Other permitted institutions:	Aaa/(P-1)	Lower of 10% and £7.5m
	Aa1, Aa2, Aa3/(P-1)	Lower of 10% and £5.0m
	A1, A2, A3/(P-1)	Lower of 10% and £2.5m
	Below the above	Nil

NB Appendix 1 provides definitions of risk ratings

Note that cash available is defined as the lowest projected cash balance over the period of the proposed investment.

(d) Interest Rate Management

If the Trust enters into long-term borrowings, it should negotiate terms that incorporate a fixed interest rate, swaps, or a cap, in order to mitigate risk.

If the Trust decides to borrow over a number of projects, this policy will be amended to include guidance on hedging interest rates exposure by use of interest rate swaps.

(e) Foreign Exchange Management

The Trust holds no foreign currency cash balances.

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of the transaction. Resulting exchange gains and losses are taken to the Income and Expenditure Account. The vast majority of foreign currency transactions are made in relatively stable currencies (the Euro or U.S. Dollar). In light of the above the Trust has a minimal risk exposure to foreign exchange rate fluctuation.

If foreign currency transactions with a value of over £50,000 (based on the current spot rate) are planned, then the Trust will consider mitigating risk by the use of a forward contract. Whether or not this is deemed appropriate will be dependent on the currency the transaction is denominated in and current market conditions.

6.3 Treasury Organisation and Responsibilities

(a) Receivables

Invoices for charges based on actual activity must be raised as soon as the activity data becomes available and no later than 4 weeks after the end of the month to which the charge relates. Invoices for fixed price service contracts must be raised monthly in advance and are due for payment in the month in which the service is provided.

Non-NHS Receivables

Non-NHS receivables can be split into the following categories.

- **Private patients** – before a private procedure is carried out the Private Patient Officers and/or the patient's Consultant will have agreed a price (as per the annual published private patient tariff) with the patient and the patient will have completed and signed a Private Patient Undertaking to Pay form.
- **Overseas patients** –in line with legislation all overseas visitors are charged in full for any care not deemed by a clinician to be 'immediately necessary' or 'urgent' and / or cease to provide such non-urgent care where payment is not received. The Non-NHS Patient Income Manager must ensure there are detailed written instructions on how to identify potential overseas patients, the treatment classification and the charging mechanisms.
- **Other non-NHS receivables** – various customers may be charged for services provided such as catering, rent and accommodation charges and occupational health services.

The following payment options are available to customers –, direct payment into the Trust's bank account, credit card/debit card payment, via the Trust's website and cheque sent to the Finance Department. All debts are due for payment within 30 days of the date of the invoice.

The process for recovering Non-NHS Receivables is primarily an automated dunning process comprising copy invoices, reminder letters and monthly statements of account. This process includes the use of a debt recovery agency as appropriate.

The quarterly Treasury Management report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will note the number, value and details of any debts passed to the Trust's debt administration and collection company.

(b) NHS Receivables

NHS Healthcare Contract Income Charges

Invoices will be raised for the following services:

- Agreed Contracts/Service Level Agreements (SLAs) with Integrated Care Boards, NHS England and other commissioners.
- Contract variations as agreed with Integrated Care Boards/ NHSE and other commissioners.

Block Invoices

Invoices for 1/12 of the expected annual value of block contracts will be raised on a monthly basis and are due in the month the service is provided. Settlement is due on the 1st and 15th of each month. Where a block invoice is not paid on time then processes approved by the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy, and the Head of Finance Patient Care Income and Costing will commence.

'Over/Under Performance' Invoices:

A reconciliation of the services provided will be sent to the commissioner after the end of the quarter. If the commissioner raises a valid query the Contract Income team will respond and resolve it in line with the timescales agreed in contract documents.

Activity information is sent to the Secondary User Service (SUS) on a monthly basis, in addition to

local data feeds in support of contract reporting and on a quarterly basis activity information is agreed between commissioners and the Trust, in line with the SUS reconciliation dates.

Non-contract activity

For non-contract activity, where services are provided outside of contracts, invoices will be sent within 30 days after the end of the month, with supporting activity information.

The under/over performance recovery process will be applied to debts of more than 30 days old.

NHS Non-Healthcare Inter-Organisation Charges

Invoices will be raised for the following services:

- Ad hoc service contracts agreed by Divisions and customer organisations.
- Other services such as medical staff recharges, catering, facilities provision etc.

Invoices for charges based upon actual activity must be raised as soon as the activity data becomes available and no later than 4 weeks after the end of the month to which the charge relates. Charges for fixed priced service contracts must be raised monthly in advance and are due for payment in the month in which the service is provided.

The process for the recovery of outstanding NHS inter-organisation debts comprises an automated process consisting of reminder letters and monthly statements of account, complimented by personal contact with debtor organisations, with escalation to the Group Chief Finance Officer or Trust Direct or Finance as appropriate.

The quarterly Treasury Management report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will note the number, value and details of any outstanding debts.

Credit Notes

Where a credit note is required, the information sent to the Credit Control Team must quote the invoice number to be credited and must be coded to the same code as the invoice. All credit notes must be reviewed by the Contract Income Team or the Accounts Receivable Team. Where a credit note is for items invoiced in previous financial years, the Division that earned the income must absorb the costs against the current year unless the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy has approved the use of the year end bad debt provision.

Where a credit note relates to a Contract Income invoice it must be signed off by the Finance Manager (Patient Care Income) with a supporting reconciliation to show why the credit note is required, before submission to the ~~Director of Operational Finance~~ Trust Director of Finance or nominated deputy for cancellation or write-off approval. Where the cancellation is offset by invoicing another commissioner, this can be approved by the Finance Manager (Patient Care Income).

The quarterly Treasury Management Report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will note the number and value of credit notes issued in the quarter.

Unapplied Cash

When a customer sends funds to the Trust without an explanation of what the funds are for, the funds will be initially credited to a suspense account and further investigations undertaken.

- For cash receipts and funds received direct to the Trust's main bank account the receipt will initially be credited to the Commercial Unidentified Receipt Suspense account. The Cashier will contact the customer for a remittance advice note. Assistance will also be sought from Divisional Financial Management teams to help identify the reason for the receipt and to reinforce to Service Managers that invoices must be raised for all income due to the Trust.

- For funds received into the Trust's Government Banking Service (GBS) account from commissioners (primarily contract income invoice payments) where no remittance is provided the receipt will be initially credited to the GBS Unidentified Receipt Suspense account. The Cashier will contact the customer for a remittance advice note. The Cashier may, in the absence of any alternative instructions from the Contract Income Team, use such receipts to clear the oldest Contract Income invoices relating to the payment period, i.e. a payment received in April will only be used to clear invoices raised for the period of April with any excess funds remaining in the GBS Unidentified Receipt Suspense account.

A reconciliation of the Commercial and GBS Unidentified Receipt suspense will be maintained identifying the balance remaining in each account, by period received and customer.

On a quarterly basis any cash still unallocated or under customer investigation that is older than 6 months will be taken to the Trust's central reserves, and it will be at The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer's discretion as to what the reserve is used for.

The value of unallocated cash taken to central reserves will be included in the quarterly Treasury Management Report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

(c) Payables

Cash Management

Cash is assessed on a daily basis to check that there are sufficient funds available to pay forthcoming liabilities.

Processing of Payments

The Trust's credit card will only be used for payment to suppliers where this is the only accepted method of payment or where to do so will allow the Trust to achieve savings. The use of the credit card is governed by a written procedure which is subject to review.

Standard terms of payment for both Non-NHS and NHS are 30 days from date of receipt of the invoice or the receipt of good/services (whichever is the later) unless they fall into a list of special categories (e.g. utilities, mobile phones, capital payment certificates). No invoices will be paid on any other terms unless expressly agreed by the Head of Finance – Financial Services & Assurance or if a vital clinical supply that will delay patient care will be delayed if payment is not made.

(d) Bank Reconciliations

Reconciliations of the Trust's bank accounts are undertaken monthly by the Financial Accounting Team. Accounts are also scrutinised daily, by the Cashier for any unauthorised transactions.

6.4 Reporting

The quarterly Treasury Management Report to ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will report on investments placed, returns earned and new investments set up.

(a) Long Term investments

Long term investments are defined as those over 12 months. The Trust does not undertake such investments.

(b) Borrowing

Monthly cash reporting will identify whether there are any cash flow shortages.

Short Term Shortages

Where short term cash flow shortages are identified due to working capital movements the following steps will be taken;

(i) The Head of Financial Accounts will notify the Head of Finance – Financial Services & Assurance and suggest a course of action.

(ii) Head of Finance – Financial Services & Assurance will refer to the ~~Director of Operational Finance~~ Trust Director of Finance depending on the seriousness of the issue.

(iii) Any cash held in investments with no or minimal penalty (other than lost interest) will be called back, short term first, followed by long term.

(iv) NHS Supplier payments will be delayed until funds become available.

(v) Non-NHS Supplier payments will be delayed until funds become available.

(vi) Additional pressure will be placed on debtors to make sure all debts are being paid on time or promptly chased.

(vii) Any cash held in investments where penalties will be incurred will be called back.

(viii) Non vital non-urgent stock orders may be delayed.

(ix) All non-vital capital may be delayed where possible.

(x) NHS England may be approached.

The quarterly Treasury Management Report to ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee will report on any overdraft usage.

Long Term Borrowings

Long term borrowings will only be used to fund longer term capital or investment programmes.

All strategic capital projects will be approved using the normal Trust Board and committee structure, and at ~~Capital Programme Steering Group~~ Capital Programme Board, ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee or Trust Board whichever is relevant to the particular project. All projects will have produced a detailed business case and have been approved in line with the Trust's Capital Investment Policy.

Progress on existing borrowings and any pending or approaching borrowings will be reported in the quarterly Treasury Management Report.

7. Standards and Key Performance Indicators

7.1 Applicable Standards

Internal Audit conducts a periodic review of the Finance Department that incorporates aspects of Treasury Management. This review will be used to assess how well this policy has been applied. In addition, on an annual basis The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer set an internal target for interest receivable. Achievement against this target will assess how effective the interest maximisation aspect of this policy has been.

7.2 Measurement and Key Performance Indicators

Daily Reporting

On a daily basis the Cashier:

(a) Downloads statements and transaction reports for the previous day's activities on the Trust's Government Banking Service account (via RBS Bankline) and NatWest commercial bank accounts (via NatWest Bankline).

(b) Advises the Head of Financial Accounts of any potential for cash surpluses and shortfalls.

Monthly Reporting

On a monthly basis the Head of Financial Accounts will update the monthly cashflow plan for the current financial year and forecast cashflow statement will be produced and reviewed by the Corporate Finance Team. The monthly cashflow will include:

(a) Updating the quarterly cashflow plan to reflect the actual receipts and payments (e.g. Payroll, Supplier Payments).

(b) Review and update, as appropriate, future planned receipts and payments in the quarterly cashflow plan in light of actual transactions.

Quarterly Reporting to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee

Appendix 3 details the items relating to Treasury Management that will be reported in a Treasury Management Report to the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee on a quarterly basis.

8. Associated Documentation

Standing Financial Instructions- SFIs

9. Appendix A – Safe Harbour Investments

Safe harbour investments are those that ensure adequate safety and liquidity for the Trust and ***must*** meet ***all*** of the following criteria.

- They meet the permitted short-term rating requirement issued by a recognised rating agency;
- They are held at a permitted institution;
- They have a defined maximum maturity date;
- They are denominated in sterling;
- They pay interest at a fixed, floating or discount rate; and
- They are within the preferred concentration limit.

The use of safe harbour investments negates the need for the Trust Board to undertake an individual investment review for these investments. In addition, NHS England will not require a report of these investments as part of its risk assessment process as they are deemed to have sufficiently low risk and high liquidity.

Safe harbour investments include (but are not limited to) money market deposits, money market funds, government and local authority bonds and debt obligations, certificates of deposit and sterling commercial paper provided that they meet the above criteria. The Treasury Management function is not permitted to undertake any of these investment options other than placing money on deposit at the National Loans Fund or pre-approved Clearing Bank without the prior approval of the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

Explanation of Terms

Each of the terms above and their limits for the trust are explained below. The appropriateness of the limits needs to be reviewed on an annual basis to confirm that they are still appropriate for the Trust.

Recognised rating agency - are agencies that grade companies and investments on their long-term standing and future viability based on information available in the market. Only Standard and Poor's, Moody's Investors Services and Fitch Ratings Ltd are recognised rating agencies.

Permitted rating requirement – the short-term rating should be A-1 (S&P), P-1 (Moody's') or F-1 (Fitch), which are the highest level of risk ratings and suggest a good quality investment.

Permitted institutions - include institutions that have been granted permission by the Financial Services Authority to do business with UK institutions, and the UK Government.

Maximum maturity date – for general investments, the maturity date must be before the date when the invested funds are needed and, in any event, should not exceed 6 months unless approved by the ~~Finance, Digital and Estates Committee~~ Finance and Estates Committee.

Preferred concentration limit - is to ensure that all the risk is not held in the one institution. The preferred concentration rate for the Trust is, with the exception of the National Loans Fund (where the concentration limit is unlimited) set out in the Treasury Management Policy.

10. Appendix B – Schedule of Matters Reserved to the Board issues requiring Trust Board approval

- Defining the overall strategic aims and objectives of UH Bristol and Weston.
- Approving the Membership Council's proposals for amendments to the Constitution (unless routed through the Joint meeting).
- Approving the scheme of delegation to officers and committees.
- Appointing, dismissing and receiving reports of Board Committees.
- Approving the draft Annual Report and accounts for submission.
- Approving the Annual Plan.
- Approving corporate organisational structures.
- Approving proposals for the acquisition, disposal or change of use of land and/or buildings.
- Approving HR policies incorporating the appointment, dismissal and remuneration of staff.
- Approving the health and safety policy.
- Approving revenue and capital budgets.
- Approving those matters reserved to it under the scheme of delegation:
    - Approval of variations to capital schemes of over £1,000,000;
    - All major investments (Strategic Outline Case, OBC and FBC) £~~15~~10m and over;
    - Individual write-offs and ex-gratia payments over £50,000;
    - Approving supplies or services contracts with a value over £1m.
- Approving and monitoring University Hospitals Bristol and Weston's policies and procedures for the management of risk and provision of assurance.
- Approving proposals for the acquisition, disposal or change of use of land and/or buildings. affecting the Trust's services.
- All monitoring returns required by the regulators shall be reported, at least in summary, to the Trust Board.
- Approving major regulatory submissions affecting the Trust as a whole.
- Approving the Standing Orders and Standing Financial Instructions of University Hospitals Bristol and Weston.

11. Appendix C – Contents of Quarterly Treasury Management Report to the Finance Committee

The following information will be reported quarterly to the Finance Committee in a Treasury Management Report:

- New banking relationships entered into in the current quarter, proposals presented to Finance Committee and outcome, any pending proposals, any good products seen at any meetings with institutions
- An update on compliance with covenant
- The number, value and details of any debts passed to the Trust's debt administration and collection company, Chief Financial Officer to Director of Finance meetings, arbitration cases issued, and court proceedings issued
- The number and value of NHS credit notes raised in the quarter
- Number and value of bad debt write offs in the quarter
- The value of unallocated credits over six months' old taken to central reserves.
- Compromise deal agreements following negotiations with suppliers over disputes
- Investments placed, returns earned and new investments set up
- Overdraft usage
- Potential requirements for working capital support identified in the next 12 months
- Borrowings taken out in the quarter, borrowings proposed, pending or approaching in the quarter
- Progress on any existing borrowing, including whether repayments are up to date
- Performance against Key Performance Indicators for any investments and proposed Key Performance Indicators for any new investments.

12. Appendix D- Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
The management and investment of cash will be assessed, reported, and monitored.	Reports to relevant committees	Audit	Monthly through The ~~Chief Financial Officer~~ Group Chief Finance and Estates Officer's Report with a Quarterly Treasury Management Policy report.	Chief Financial Officer's ~~Director of Operational Finance~~ Trust Director of Finance	Finance, Digital & Estates Committee

13. Appendix E – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Finance – Financial Services & Assurance
This document replaces existing documentation:	No
Existing documentation will be replaced by:	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	All finance staff and budget holders
Method of dissemination:	It will be available to download from FinWeb or upon request from the Head of Finance – Financial Services & Assurance
Training is required:	No
The Training Lead is:	[DITP - Training Lead Title]

Additional Comments
[DITP - Additional Comments]

14. Appendix F - Equality Impact Assessment (EIA) Screening Tool

Query	Response
What is the main purpose of the document?	This policy has been set up as a practical way of reviewing and monitoring Treasury Management activities.
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Staff group – Finance Staff and budget holders Add ☑ or ☒ Staff ☑ Patients ☒ Visitors ☒ Carers ☒ Others ☒

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		☑	
Disability (including physical and sensory impairments, learning disabilities, mental health)		☑	
Gender reassignment		☑	
Pregnancy and maternity		☑	
Race (includes ethnicity as well as gypsy travelers)		☑	
Religion and belief (include non-belief)		☑	
Sex (male and female)		☑	
Sexual Orientation (lesbian, gay, bisexual, other)		☑	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		☑	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		☑	

Will the document create any problems or barriers to any community or group? YES / **NO**

Will any group be excluded because of this document? YES / **NO**

Will the document result in discrimination against any group? YES / **NO**

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		☑	
Will it help to get rid of discrimination?		☑	
Will it help to get rid of harassment?		☑	
Will it promote good relations between people from all groups?		☑	
Will it promote and protect human rights?		☑	

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
Significant	Some	Very Little	**NONE**	Very Little	Some	Significant

Is a full equality impact assessment required? YES / **NO**

Date assessment completed: 14 November 2024.....

Person completing the assessment: Head of Controls and Assurance .....

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	13 January 2026		
Report Title:	Integrated Governance Report		
Report Author:	Mark Pender, Head of Corporate Governance Richard Gwinnell, Deputy Trust Secretary		
Report Sponsor:	Xavier Bell, Group Chief of Staff		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	To present the integrated governance report, which brings together the Committee Chairs' upwards reports, the registers of seals for UHBW and NBT, and other governance related items.		

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

Attached are the following items for the Board's information:

Committee Chairs' Reports from the November 2025 meetings:
Digital Committee in Common (Appendix A)
Finance & Estates Committee in Common (Appendix B)
People Committee in Common (Appendix C)
Quality and Outcomes Committee in Common (Appendix D)

UHBW & NBT Register of Seals – September to December 2025 (Appendix E)

Strategic and Group Model Alignment

These documents directly support the Board's ambition to form a Group, and these documents support the new governance model being implemented.

Risks and Opportunities

None.

Recommendation

This report is for **Information.**

The Boards are asked to note the documents attached to this report.

History of the paper (details of where paper has previously been received)	
N/A	
Appendices:	Digital Committee in Common (Appendix A) Finance & Estates Committee in Common (Appendix B) People Committee in Common (Appendix C) Quality and Outcomes Committee in Common (Appendix D) UHBW & NBT Register of Seals (Appendix E)

Meeting of Group Board of Directors of NBT and UHBW held in Public on 13 January 2026

Reporting Committee	**Digital Committee in Common**
Chaired By	**Roy Shubhabrata, Group Non-Executive Director**
Executive Lead	**Neil Darvill, Group Chief Digital Information Officer**

For Information

The Committee met on 20 November 2025 and received the following reports:

1. **Hospital Group Digital Systems, Policy and Operational Performance Update:** The Committee received updates on Group Digital Systems, Policy, and Operational Performance across both Trusts. Key progress included:
    - The Digital Services team was seeking organisational approval to undertake a new exercise to test full technical recovery following a cyber-attack.
    - The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) Cybersecurity Strategy had been approved and the BNSSG Information Sharing Charter had gone live, providing a legal basis for system-wide data sharing.
    - Draft audit reports on business continuity, cyber security follow-up, and SAP Ariba returned Limited Assurance, with follow-up reviews scheduled for 2026/27.
    - A revised Asset Management Policy was being finalised to address concerns about “shadow IT”, where teams manage IT assets without proper governance.
    - The Urology digital improvements project was progressing in phase two.
    - The Ambient Voice Technology proof of concept aimed to deliver a clear view of benefits by the start of 2026/27 with a business case planned for completion by March.

    The Committee discussed compliance targets for Information Governance training, the repeated limited assurance audit findings year-on-year, and the governance for the transfer of the Connecting Care Senior Responsible Owner (SRO) from the Integrated Care Board (ICB) to UHBW.
2. **Digital Strategy and Operational Business:** The Committee noted that both Trusts were currently below the national average of digital maturity across all categories. However, comparisons were noted as difficult due to differing question sets across settings. The committee discussed whether additional investment or alternative approaches could accelerate progress and agreed to reflect on this further.
3. **Single Digital Enterprise Team:** The Committee noted progress toward creating a single digital enterprise team, joining colleagues across the Group to improve resilience and efficiency. Leadership consultation began in December 2025, with wider staff consultation planned from April 2026. Full alignment was planned for Q2 of 2026-27.
4. **Hospital Group National Tenant:** The Committee received an update on the NHS Mail Unite Migration Programme, which will transition site-based email addresses to nhs.net. The four-stage project was underway, with completion and post-migration support expected from April 2026.
5. **IT work plan for Group Merger:** The Committee reviewed progress on defining digital requirements for the merger, noting interdependencies across workforce,

procurement, and finance systems, including the single ledger pathway. A list of must-have systems and a prioritised delivery plan for the next 24 months would be presented at the January meeting.

6. **Network Full Business Case (FBC):** The Committee reviewed the Enterprise Network Replacement Programme and noted that the FBC was not endorsed by the UHBW Trust Management Team (TMT) pending assurance on affordability, disruption management, and lessons learned. Work was underway to address these concerns, before resubmission to TMT and onward to the Finance and Estates Committee.
7. **Electronic Patient Record (EPR) Procurement Strategic Outline Case:** The Committee was advised that a Strategic Outline Case would be brought forward for consideration in January, outlining the planned next steps This was noted as a major programme expected to take at least two years, requiring enabling work such as network upgrades and supplier engagement. Opportunities for joint procurement with neighbouring organisations would be explored to reduce cost and support a patient-centric approach. A strategy session on resourcing and prioritisation was scheduled for January 2026.

For Board Awareness, Action or Response (including risks)	
The Committee took assurance from all the above items, on behalf of the Board.	
Key Decisions and Actions	
The committee requested a list of the “must-have” systems for Day One of the Merger and a prioritised list of programmes for delivery over the next 24 months including items that could be deferred, for the next meeting.	
Additional Chair Comments	
N/A	
Date of next meeting:	Thursday 22 January 2026

NHS Bristol NHS Group Bristol | Weston

Meeting of Group Board of Directors of NBT and UHBW held in Public
13 January 2026

Reporting Committee	**Group Finance and Estates Committee** • **25 November 2025 meeting**
Chaired By	**Martin Sykes, Group Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

1. The Committee received the Combined Finance Report for Month 7 (1 April 2025 to 31 October 2025). This was the first combined finance report for UHBW and NBT.

   - The costs of industrial action by resident doctors in July 2025 had contributed to an adverse variance to date for both trusts. Recent industrial action was predicted to have an impact on Month 8 finances. No NHSE funding was available to cover these costs.

   - NBT would be adversely affected by a recent Supreme Court ruling on VAT on hospital car parking charges.

   - Spending on no-criteria-to-reside costs and acuity measures had been mitigated by in-month benefits at NBT.

   - NBT had spent most of its capital allocation this year on the Bristol Surgical Centre. Although its year-to-date capital was below plan, projects were in place to deliver the full allocation. With regard to the Bristol Eye Hospital and the Children's Theatre projects, UHBW had agreed to hand back some capital allocation in 2025/26 in return for phased receipt over a longer period.

   - NBT's Month 7 savings shortfall had been offset by vacancies.

   - Both trusts' cash reserves had decreased. Cash was being actively managed via the ICB Cash Management Working Group and debtors were being chased for payment.

   - All UHBW clinical divisions except the Division of Surgery had hit their Month 7 trajectory. There had been a large increase in emergency activity whereas elective activity was below plan.

   - Delivery of UHBW's Cost Improvement Plan was ahead of plan.

2. The Committee received a verbal update on the Bristol, North Somerset and South Gloucestershire (BNSSG) Year-End Forecast. The System-level and Group's positions had improved marginally. Although delivering the financial

plan would continue to present a challenge, the System view was that there would be no need to alter the break-even position we had all committed to achieve.

3. The Committee received the UHBW Treasury Management Report for Quarter 2 2025-26 for information and approved minor changes to the UHBW Treasury Management Policy.

4. The Committee received an update on the Merger risks and mitigations relevant to the Committee. Work was underway to map out grade differentials between the Trusts and mitigation of the risk relating to harmonisation of pay and banding was included in the Merger business plan. The Committee noted that delivering the Merger financial benefits might also carry risk.

5. The Committee received a paper on Business Planning for 2026/27, noting internal and external pressures which were contributing to the Trusts' positions. Work was continuing apace to identify savings and productivity was a key focus.

6. The Committee received an upward report from the NBT Health and Safety Committee. Good progress was being made with mitigating Trust-level risks relating to Pathology and the Neonatal Intensive Care Unit and closing actions relating to a RIDDOR A&E audit. Late RIDDOR reports had reduced and reporting of sickness absence due to work injuries was improving. A thorough investigation of contractors' access to the NBT mortuary had highlighted the need to review access.

7. The Committee received an update on business cases presented to the NBT Business Case Review Group for information.

For Board Awareness, Action or Response

8. The Committee noted the very short timeframe between the Committee's January meeting and Private Board in February 2026 for the Committee to review certification aspects of the Merger business plan.

N/A

Additional Chair Comments

There were no other matters that the Committee wished to bring to the attention of the Board.

Update from ICB Committee

N/A

Date of next meeting:	**27 January 2026**

Meeting of Group Board of Directors of NBT and UHBW held in Public.
13 January 2026

Reporting Committee	**People Committee – November 2025 meeting**
Chaired By	**Linda Kennedy, Non-Executive Director**
Executive Lead	**Jenny Lewis, Group Chief People & Culture Officer**

For Information

November's People Committee was Jenny Lewis' first meeting as Group Chief People and Culture Officer. The meeting focussed on Corporate Services Transformation and Merger work.

Strategic Update

A joint strategic update for information covered shared challenges, opportunities, and activities in the Group. These included:

- Trade union capacity to support Merger arrangements.
- Participation in the NHS National Staff Survey, due to close on 28 November, and proposals to use Kaizen/Patient First methodology to robustly and quickly analyse and respond to responses.
- Planning for the People element of the merger, thinking beyond an annual planning cycle.
- Alignment of workforce metrics of both trusts and with national descriptors.
- Preparatory work to ensure the Group was ready for the introduction of the forthcoming Employment Rights Act.
- Challenges to workforce planning for employees affected by recent changes to visa thresholds.
- Ensuring participation in and quality of data from the National Education and Training Survey (NETS) was as good as possible.
- Multi-educational quality reviews, which had recently taken place for both Trusts, against the backdrop of NHS England's (NHSE's) increasing focus on how money given for education was made visible and could be tracked directly to spend.
- Visibility at Board of the Health and Wellbeing Guardians for Resident Doctors and the Guardians of Safe Working Hours.
- A Draft National People Target Operating Model, which envisaged People Services being delivered from a very large regional hub but aligned operational development and business partner functions, which would remain local.

Performance

An assurance report on key metrics for both Trusts was shared, noting the following exceptions:

- At 9.4%, UHBW turnover had reduced despite an increase in vacancies. Actions were in place to tackle pinch points at band 2. At NBT, turnover continued to reduce and was below the long-term target of 10%. Vacancies

had increased due to increase in establishment at the Bristol Surgical Centre and Ward 7b. Vacancy levels and bank and agency spend were areas of continuing focus.
- UHBW sickness absence had increased due to a large increase in flu, Covid and colds, but was still within target. NBT continued to address sickness absence, focussing particularly on long-term sickness. NBT was not an outlier.
- UHBW mandatory/statutory training compliance levels were above target. At NBT, mandatory training compliance was at exception levels in some areas, e.g. Oliver McGowan (OM) training. In both trusts, OM training levels were being monitored closely and reported separately. IT difficulties that some staff had experienced when trying to book OM training were being investigated.

There was discussion about the challenge of recruiting decontamination staff to the Bristol Surgical Centre. Addressing recruitment of these staff was a focus as posts were low-banded, traditionally hard to recruit to and had high turnover. Ways to facilitate recruitment included reaching out to local further education colleges.

Violence and Aggression Standards
The Committee received a joint assurance report on both trusts' progress against the National Violence and Aggression (V&A) Prevention Standards. V&A was particularly a concern at NBT, where there had been a spike in racist incidents against staff. The national position was also deteriorating. V&A was a multifactorial issue. Both trusts had well-developed V&A programmes of work and had achieved some quick wins. Prevention and proactive work were more difficult. A wide range of stakeholders had been engaged, and programmes of work were being developed. V&A incidents were unacceptable, whatever the staff area. Supporting staff was vital. An important message to convey was that V&A incidents did not always happen in ED with incidents in Care of the Elderly, Renal, and Women's and Children's wards being common and hard to tackle. Governance routes for reporting incidents and development of a joint database of service users on a behaviour contract/excluded were also discussed.

It was agreed that a joint delivery plan with dates and performance data would come back to the Committee at a future meeting.

Benefits Realisation
The Committee received an assurance update on progress with the Group benefits realisation workstreams, which were part of the Group benefits case. Workstreams included:

- Improvement in colleague experience
- A unified People Strategy for the next three to five years
- Amalgamation of Learning and Development, and Resourcing functions
- Development of a People Development Framework
- Development of a Strategic Medical Workforce Plan
- A reforecast Connect to Work programme
- Improvement in People Services' offerings to partners.

Draft Group People Strategic Priorities
The People Strategies in both Trusts had expired. The Committee received an update on the development of a draft Joint People Plan, which contained six priorities to ensure focus on these was not lost during the period of merger. The plan was to undertake full people strategy development post-merger. The Joint People Plan would be shared at January People Committee.

Merger
The Committee received assurance updates on Merger Progress, Corporate Services Transformation and the Merger Communications Plan.

- The Merger timeline was presented. TUPE pre-engagement was taking place with union colleagues. Alignment of payroll dates was a fundamental change, requiring ESR systems to be brought together. Proposals for alignment and dates for merging pay dates would be presented to Merger Board for approval in December. Adequate resource to manage the process was highlighted as medium to low risk. The importance of clear governance routes was stressed.

- A Level 2 Corporate Services Transformation consultation had been completed, and risks were being closely monitored.

- A communications and engagement plan had been signed off by GEM, and an assurance report detailing communications activity over the last period was presented, including details of the recent partnership event.

Group People Executive Upward Reports on Operational Delivery
Reports from UHBW's People Learning and Delivery Group and NBT's People Oversight Group were presented. There were no exceptional items to note.

Guardians of Safe Working Hours (GOSWH) Annual Reports
Annual reports from the UHBW sites were presented. The UHBW sites were fully compliant. Lack of global capacity to meet clinical demand was the most important theme. The GOSWH requested a deep dive to try to find money to meet capacity. A safety issue relating to resident doctors holding several bleeps on out-of-hours shifts was reported and the GOSWH recommended that all rotas had a float week to cover short-term sickness. There had been progress on improved data from Locum's Nest. The lack of a study budget for clinical fellows was highlighted, making the Trust an outlier in the region.

The UHBW Weston site was in a good position with relatively low levels of exception reporting and resident doctors generally happy with their rosters. The amount of locum and bank doctors, although decreasing, was highlighted as an opportunity to create more full-time resident doctor posts and place less reliance on bank and agency staff. Five full-time posts had been created in the last year.

For Board Awareness, Action or Response
NBT had won Best UK Employer of the Year at the Nursing Staff Times awards. Credit was given to the strong collaborative approach between nursing staff and other colleagues.
Key Decisions and Actions
It was agreed a deep dive on the immigration issues would be undertaken and reported to the new group People oversight Group, for assurance reporting to the People Committee.
Additional Chair Comments
- The Board was now required to see all reporting against the Resident Doctor Ten-Point Plan. - Clear governance routes and stakeholder mapping of Merger Workstreams were strongly encouraged.
Update from ICB Committee
N/A

Date of next meeting:	**29 January 2026**

Meeting of Group Board of Directors of NBT and UHBW held in Public
13 January 2026

Reporting Committee	**Quality and Outcomes Committee in Common (QOCIC)**
Chaired By	**Sarah Purdy, Non-Executive Director and NBT Vice-Chair**
Executive Lead	**Professor Steve Hams, Group Chief Nursing and Improvement Officer (CNIO)** **Tim Whittlestone, Group Chief Medical and Innovation Officer (CMIO)**

For Information

The Committee met on 25 November 2025 and received the following reports:

1. **Merger Update:** the Committee received a verbal update from the Group Chief of Staff, informing them of the membership and standing agenda items of the Merger Governance Task and Finish Group, which met every two weeks and discussed and progressed day one actions, due diligence risks, the accountability framework and other matters. The Committee heard about key actions in progress, including development of a transaction agreement and harmonisation of policies, as well as key actions completed, including Board Assurance Framework alignment, and about due diligence risks, none of which were rated red. The risks would continue to be managed through the Post Transaction Implementation Plan (PTIP). The Full Business Case and PTIP would be submitted to the Committee in January and the Governance and Accountability Framework would be submitted to the Board in January-February.

2. **Joint Clinical Strategy Update:** the Committee received a verbal update from the Group CMIO, informing them of the very successful partnership and community engagement event held in October, and of the plan to create a single Clinical Strategy for the new merged organisation, in time for the merger in 2026, to replace the existing Joint Clinical Strategy, which was due to expire in 2027. Key to the new Clinical Strategy would be neighbourhood and community-based provision of health services, with less dense provision in acute hospitals, alongside estates and digital considerations. The Committee welcomed the update and looked forward to receiving a draft of the new Clinical Strategy in due course, emphasising the importance of innovation and communication.

3. **Integrated Quality and Performance Report (IQPR) (UHBW and NBT):** the Committee heard from the Chief Operating Officers of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT) about the latest performance by both Trusts against a range of key national quality and responsiveness metrics. The Committee was informed of performance at UHBW and NBT in relation to diagnostics, cancer, urgent and emergency care (UEC), and referral to treatment (RTT), as well as in relation to infection prevention and control, maternity and neonatal services, and patient and carer experience. At UHBW, performance was compliant with targets in many areas, including cancer and Referral to Treatment (RTT) waiting times, with some slippage against the Faster Diagnosis Standard (FDS) but robust plans in place to recover.

The recent closure of 49 beds had presented challenges, which were ongoing, but all available capacity was being maximised. Ambulance handover times were an average of 23 minutes (against a target of no more than 45 minutes) and the number of patients with no criteria to reside (which had come down from approx. 210 to approx. 180) continued to present significant challenges. At NBT, October had been very challenging, with significant increases in patients attending and challenges with ambulance handover times. Improvements in UEC were being worked through, with the help of the Get it Right First Time (GIRFT) team (including a "test of change week") and these were helping achieve improvements in performance in many areas in November. No criteria to reside numbers continued to be a significant challenge, with work progressing with partners. On cancer, NBT was slightly below the FDS standard, with a recovery plan in place, accepted by NHS England and the position improving, with Further Faster and Days Matter work helping. RTT targets had been hit for the last six months, with a slight recent dip, similarly to diagnostics (1.2% against a target of no more than 1% waiting more than 6 weeks) and recovery plans in place. Discussion took place about theatre utilisation and the number of cancelled operations at UHBW, with the high number of no criteria to reside patients and the closure of 49 beds contributing but different pathways and solutions being worked through, to replace lost capacity. Also discussed was the rise in pressure injuries at NBT and the solutions being put in place, including pressure relieving mattresses, increased staffing and renewed guidance. The Committee was assured that mitigation plans were in place and every possible effort was being made to address the challenges.

4. **Upward report of the Clinical Quality Group (CQG) (UHBW and NBT):** This was an upward report from the UHBW CQG and a verbal report on progress with establishing a CQG at NBT (which would have its first meeting on 5 December 2025). The reduction in bed base, ongoing discussions about capacity mitigation and NICU capacity issues at UHBW were highlighted. The Committee noted both reports.

5. **Operational Planning Assumptions 2026/27: Performance (UHBW and NBT):** this report provided assurance and sought approval to the approach to developing the performance aspects of the operational plan. The Committee was informed that it would be very difficult to achieve higher targets and standards next year (e.g. 82% of patients seen within 4 hours in A&E, an increase from the current 78%) in view of the various challenges, for example that the bed base had been reduced at UHBW and no criteria to reside had not been reduced to 15% (which the current operational plan was predicated upon) and there was no realistic expectation of that happening. The Trusts were doing everything they could to mitigate gaps and meet the constitutional standards, but the plan for next year may not be compliant (as, for example, between the Trusts, 400 beds were taken up with patients who no longer needed to be in hospital but had nowhere more suitable to go). This was a system-wide issue, requiring system-wide solutions. Committee members expressed their concerns about the position and especially about the level of no criteria to reside, and its huge impact on patients, staff and performance across multiple areas of the Trusts. The Committee recognised the gaps, recognised the risks and the actions needed internally, supported those actions, and recognised that everything possible was being done to produce a compliant plan and meet the national standards. The Committee agreed to escalate its ongoing concerns about the high no criteria to reside numbers to the Board and approved the approach to the performance aspect of planning assumptions that would underpin the first submission of the operational plan, with those reservations and caveats.

6. **Urology Service Deep-dive (NBT):** this report provided an overview of the Urology service, along with quality and performance challenges, enabling the Committee to gain a deeper understanding of the service and the actions being taken to improve performance and respond to quality risks. The Committee was informed that Urology was one of NBT's biggest elective services (treating approximately 50,000 people per year with all types of cancer, unlike most other Trusts). The service treated patients not only of North Bristol but also from across the whole of the Bristol, North Somerset and South Gloucestershire (BNSSG) region, as well as further afield, with other Trusts referring their patients to NBT (sometimes after diagnostic or RTT targets had already been breached) because NBT provided such complex and specialist services, with a highly skilled, multidisciplinary team, for which it had a regional, national and international reputation. The <52-week waiting time target was being met, with <18-week targets challenged but improving. Prostate cancer was the most challenging area, with 43% of patients (often the most difficult cases) being referred to NBT from out of area, including from other countries. The additional capacity created with the opening of the Bristol Surgical Centre was helping, performance improvement plans were in place, digital initiatives were in progress (e.g. using AI for administrative processes and patient correspondence) and confidence was high of a return to planned position. The Committee was assured by the report and the good work taking place, asking about digital systems and how time-breached referrals could be reduced (with discussions taking place regionally about demand management and funding). The Committee recognised that the recent news of a national prostate cancer screening programme may result in even more referrals in future and asked for an update on performance data in three months.

7. **Patient Safety Quarter 2 report (UHBW and NBT):** this report provided assurance about how the National Patient Safety Strategy for England 2019 was embedded and how new insights, key learning themes and emerging risks were being converted into systemic improvement work and local risk reduction actions. The Committee discussed the high number of patient safety incidents recorded (approx. 2,600 at UHBW and 1,300 at NBT on average per month) as well as Duty of Candour data and the need for timely review of incidents and better understanding of the relevant thresholds and criteria. Differences between the Trusts in senior leader training were also noted, albeit alignment generally between the Trusts was progressing very well. One never event action plan remained outstanding long-term and the Committee asked for this to be prioritised. The Committee noted the report and the areas for development.

8. **Bristol NHS Group Health Equity Plan (HEP) 2026/27:** this report provided a framework for an integrated Bristol NHS Group approach to advancing health equity for patients and the local population, including a clear delivery plan for 2026/27. The Committee heard about the progress made and importance of tackling health inequalities and the need to do more. The Committee asked about the level of engagement with wider public health organisations and plans (e.g. the plans of Directors of Public Health and local authorities), as well as about the level of community engagement with the HEP and about when health equity work would be mainstreamed (e.g. into the IQPR). They were informed that data quality was a key issue, with little information available on the ethnicity or smoking status of patients referred to hospital for example. Without more reliable data, measurement was challenging, as was determining the right priorities. More work was therefore required and the HEP was a key part of the 2026/27 operational plan. The Committee supported the direction of travel including mainstreaming of health equity work into divisional business

planning, as well as further engagement with patients, colleagues and communities, but asked for a number of adjustments to the HEP itself. The Committee delegated authority to the Chair to approve the final version in due course, with those adjustments.

9. **Infection Prevention and Control Quarter 2 report (UHBW and NBT):** this report provided a summary of business discussed and decisions taken by the Infection Control Assurance Groups of both Trusts. Discussion ensued in relation to MRSA incident numbers at UHBW and the need for more work (which was ongoing) on human factors and improving front-line practices and IV-line care. The Committee heard about C.Diff, MSSA and other rates of infection and agreed to receive a further report and plan to tackle MRSA rates at a future meeting.

10. **National Inpatient Survey 2024 results (UHBW and NBT):** This report provided a joint analysis of the results of the 2024 National Inpatient Survey relating to UHBW and NBT. The Committee heard that patients scored UHBW 8.3 out of 10 and scored NBT 8.2 out of 10 for 'overall experience of care'. This placed UHBW 49th and NBT 60th out of 131 Trusts. The Committee heard about ongoing work and plans, including additional focus on discharge issues at UHBW and on cleanliness and environment issues at NBT. They also heard about the monthly local surveys, which supplemented and updated the national annual survey results, and about how no criteria to reside affected patient experience (with more beds used by people staying longer than they should and consequent impacts on those people, and other people who needed those beds). The Committee heard that the Experience of Care Groups and Clinical Quality Groups at both Trusts monitored detailed action plans. The Committee noted the report and welcomed the ongoing work.

11. **Maternity and Neonatal Quality and Safety report, UHBW, Quarter 2:** this report outlined locally and nationally agreed measures to monitor maternity and neonatal safety (perinatal quality surveillance matrix (PQSM) data), informing the Committee of any present or emerging safety concerns and actions in progress in line with the Ockenden report and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The Committee was informed that a more robust Neonatal Intensive Care Unit (NICU) Nursing Action Plan had been requested by the Neonatal Operational Delivery Network (ODN) and had recently been submitted to and approved by them. UHBW was on track to meet the required MIS standards, albeit training was 2% below target, with additional sessions for obstetricians being sought, to close this gap. The Committee noted the report.

12. **Maternity and Neonatal Quality and Safety report, NBT, Quarter 2:** This report outlined PQSM data as part of the pathway to ensuring safety intelligence was shared with all relevant stakeholders, locally and regionally. The Committee heard that NBT was on track to meet all required MIS standards, with additional training put in place. The NICU decant was progressing well and a new maternity triage service would be launched in January 2026, following significantly increased demand and the thematic review carried out. The Committee noted the report. The full Perinatal Mortality Review Tool (PMRT) report is in the Convene Document Library for all Board members' information.

13. **Maternity and Neonatal Safety Champion verbal report:** the Executive Champion and NED Champions for NBT and UHBW updated the Committee on recent activity and developments, including:

- increasing alignment between the UHBW and NBT maternity and neonatal services and teams, and increasing alignment of data
- the change from PQSM to PQOM (with the emphasis on Oversight), which would help Board colleagues understand the key messages behind the data
- ongoing work to raise the profile of the Neonatal and Maternity Safety Champions at both Trusts, with Safety Champions and staff meetings taking place regularly
- the significant amount of data and detail involved
- the significant national and local concern about women increasingly choosing to decline care and birth outside guidelines
- the risks to and impact on women, babies and maternity and neonatal staff such as midwives; guidelines and letters were currently being assessed nationally, with a view to strengthening perinatal advice to pregnant women.

For Board Awareness, Action or Response (including risks and escalations)

The Board's attention is particularly drawn to:

(a) the Committee's concerns about the operational planning assumptions for 2026/27 and beyond, and the Trusts' ability to deliver compliant plans, in light of the ongoing challenges including the level of no criteria to reside
(b) the Committee's consideration of the Health Equity Plan and the need to reflect the community engagement undertaken, as well as its alignment with other partner organisations' plans and
(c) the Committee's concerns generally about no criteria to reside (NCTR) numbers and the multiple impacts of NCTR, including on the ability of the Trusts to meet national targets and deliver the best services for all patients.

Key Decisions and Actions

The Board is recommended to note this report and the activities undertaken by the Quality and Outcomes Committee on behalf of the Board, for assurance purposes.

Additional Chair Comments

NEDs raised (also noted at the previous meeting) the extensive amount of information and data reported to the Committee, and how the Committee could effectively scrutinise and be assured on the vast array of services within its remit, in sufficient depth. It was suggested that Committee members submit questions in advance in future if possible, to enable the Committee to focus on the issues of most concern or interest to Committee members. The possibility of longer meetings was also mooted as a future development. Discussion also ensued about the possibility of holding "committee to committee" meetings between the Trusts/Group and the ICB/partners about ongoing no criteria to reside issues. The Committee concluded that Executive high-level discussions were already ongoing about no criteria to reside and that its concerns should again be escalated to the Board.

Date of next Committee meeting:	Thursday 27 January 2026

Appendices:	None

NBT Register of Seals

September to December 2025

Reference Number	Document	Date Signed
717	Lease for Unit 6b Derriford Business Park, Derriford, Plymouth, PL6 5QZ	08/12/2025
718	Lease relating to multi-use clinical suite, Concord Medical Centre, Braydon Avenue, Little Stoke, BS34 6BQ	08/12/2025
719	Deed of surrender relating to rooms 9,15,16 and part of room 97 – Concorde Medical Centre	08/12/2025

UHBW Register of Seals

September to December 2025

Reference Number	Document	Date Signed
931	Agreement for lease for Unit 3, Level 2 Queens Building (M&S in Welcome Centre)	05/11/2025
932	Agreement of lease for Unit 1, Level 2 Queens Building (W.H. Smiths in Welcome Centre)	05/11/2025