

**Meeting of Group Board of Directors of NBT and UHBW held in Public
on Tuesday, 10 March 2026, 10.00 to 12.45
In the David Baker Room at the Vassall Centre, Gill Avenue,
Fishponds, Bristol, BS16 2QQ**

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 13 January 2026	Approval	Group Chair	10:30 (5 mins)
5.	Matters Arising and Action Log	Approval	Group Chair	
6.	Questions from the Public	Information	Group Chair	10:35 (5 mins)
Strategic				
7.	Group Chair's Report	Information	Group Chair	10:40 (10 mins)
8.	Group Chief Executive's Report	Information	Group Chief Executive	10:50 (15 mins)
9.	Merger Update	Information	Group Formation Officer	11.05 (10 mins)
BREAK – 11:15 to 11:25				
Quality and Performance				
10.	Group Integrated Quality and Performance Report	Information	Hospital Managing Directors and Executive Leads	11:25 (20 mins)
11.	6 Monthly Nurse Safe Staffing Reports	Information	Group Chief Nursing and Improvement Officer	11.45 (10 mins)
Finance				
12.	Scheme of Delegation	Ratification	Chief Finance and Estates Officer	11.55 (5 mins)
Risk Management				
13.	Board Assurance Framework	Approval	Group Director of Corporate Governance	12.00 (10 mins)

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
14.	Risk Appetite Statement	Approval	Group Director of Corporate Governance	12.10 (5 mins)
Governance				
15.	Emergency Preparedness Resilience and Response (EPRR) Annual Reports 2025	Information	Hospital Managing Directors	12.15 (10 mins)
16.	Integrated Governance Report including Committee Chairs' Reports and Register of Seals	Information	Committee Chairs	12:25 (15 mins)
Concluding Business				
17.	Any Other Urgent Business – <i>Verbal Update</i>	Information	Group Chair	12.40
18.	Date of Next Meeting Tuesday, 12 May 2026	Information	Group Chair	

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Patient Story - Pete's Story (Urology)		
Report Author:	Emily Ayling, Head of Patient Experience (NBT)		
Report Sponsor:	Prof. Steve Hams, Group Chief Nursing and Improvement Officer		
Purpose of the report:	Approval	Discussion	Information
			X
	<p>Patient stories offer valuable insight into the quality of our services, highlighting opportunities for learning and revealing how effectively our systems and processes support, improve, and assure quality. Sharing a patient story with Board members serves two key purposes:</p> <ul style="list-style-type: none"> • To set a patient-centred context for the meeting. • To help Board members understand the impact of the lived experience of patients, and to reflect on what these experiences reveal about our staff, morale, organisational culture, quality of care, and the environment in which clinicians work. 		
Key Points to Note <i>(Including any previous decisions taken)</i>			
<p>Pete is a retired nurse who underwent treatment for prostate cancer at NBT in 2024. As you'll hear in his story, he wrote to the Chief Executive to share his experience and to thank staff for the exceptional care he received. He also wanted to highlight potential learning and opportunities for improvement for future patients.</p> <p>Pete first attended his GP in 2021, where his PSA (Prostate-Specific Antigen) level was recorded at 6.8 and later retested at 4.8. He was reassured and discharged.</p> <p>Three years later, at the age of 67, he returned to his GP for another PSA test and physical examination, after which he was referred to Urology at Southmead.</p> <p>Pete attended a 'one-stop clinic', subsequently underwent an MRI, and later had a biopsy. While he received excellent care from highly skilled staff, he reflects that this diagnostic stage of the pathway felt lengthy and contributed to his fear and anxiety.</p> <p>Following a consultation with a consultant, Pete underwent a robotic prostatectomy on 14 January 2025. He describes the care he received from staff as fantastic, and he has recovered well. Despite the high standard of care, he identified communication as an area for improvement, noting difficulties reaching the Urology Cancer Nurse Specialist helpline and the absence of an online or telephone check-in during the days immediately after his procedure.</p> <p>Since his prostatectomy, Pete continues to recover well and to receive excellent ongoing care and support.</p> <p>He has since joined the Community Participation Group (CPG) and the North Bristol NHS Trust Patient and Carer Participation Group (PCPG), using his lived experience to help shape improvements in care and support for others.</p>			

Pete's story is overwhelmingly positive and offers valuable opportunities for reflection and learning. It also highlights areas where we can consider improvement through different lenses. For example, performance against cancer targets and pathway timelines, as well as the emotional impact on patients, such as fear and anxiety. Pete suggests that these patient experience measures are just as important as traditional performance metrics.

Strategic Alignment

This aligns with our Joint Clinical Strategy and our commitment to delivering that strategy by working together and listening to Patients, Populations and Partners.

Risks and Opportunities

None identified.

Recommendation

This report is for **Information**.

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

N/A

N/A

Appendices:

N/A

**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, 13 January 2026, 10:00 to 12:45
Clifton and Hotwells Rooms, St James' Court, St James' Parade, Bristol, BS1 3LH**

Present

Joint Members of both Boards:	
Ingrid Barker	Group Chair
Maria Kane	Group Chief Executive Officer
Jenny Lewis	Group Chief People and Culture Officer
Paula Clarke	Group Formation Officer
Neil Darvill	Group Chief Digital Information Officer
Neil Kemsley	Group Chief Finance and Estates Officer
Steve Hams	Group Chief Nursing and Improvement 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
Poku Osei	Group Non-Executive Director
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
Lavinia Rowsell	Group Director of Corporate Governance
Mark Pender	Head of Corporate Governance (UHBW) (<i>minutes</i>)
Elliot Nichols	Group Chief Communications & Engagement Officer
Idara	Patient Representative (for item 3, Patient Story)
Rachel Hughes	Director of Nursing, Bristol Royal Hospital for Children
Moestak Hussein	Community Involvement and Partnership Lead, UHBW (for item 3, Patient Story)
Kathryn Hamilton	Consultant in Public Health (for item 11, Health Equity Plan)

The Chair opened the meeting at 10.00am

Minute Ref.	Item	Actions
01/01/26	Welcomes and Apologies for Absence	
	Ingrid Barker, Group Chair, noted that there were no apologies for absence. Ingrid welcomed members of the Board to the meeting, particularly Poku Osei (Non-Executive Director) and Lavinia Rowsell (Group Director of Corporate Governance) to their first meeting of the Board in their new roles.	
02/01/26	Declarations of Interest	

Minute Ref.	Item	Actions
	No interests were declared.	
03/01/26	Patient Story	
	<p>Moestak Hussein, Community Involvement and Partnership Lead (UHBW) introduced the patient story and welcomed Idara to present her story.</p> <p>Idara was a single mother of two daughters, one of whom (Joanne) lived with sickle cell disease. Joanne had been under the care at UHBW Ocean Ward since infancy. Pictures of Joanne were shown to the Board. During her story Idara highlighted the following relating to Joanne's care:</p> <ul style="list-style-type: none"> • 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. <p>Joanne had provided a statement on her experiences which Idara read out to the Board. Idara highlighted that emergency care remained the most traumatic part of Joanne's care journey, describing 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 eroded trust and created fear, especially when compared to the safe, familiar environment of Ocean Ward. Idara also reflected on systemic inequalities, racial bias in emergency care, and the emotional toll of navigating these challenges as a single parent. Despite everything, Joanne remained resilient and dreamt of becoming a psychologist specialising in pain management. The family has also engaged with charities like Make-A-Wish, which provided moments of joy amid hardship.</p> <p>During the ensuing discussion, the following points were noted:</p> <ul style="list-style-type: none"> • Maria Kane, Group CEO, commented that there was a lack of recognition amongst ED staff regarding the level of pain sickle cell sufferers experienced, and asked Steve Hams to comment on this. Steve replied that there was much to take from the story presented today, and more to be done in respect of recognising the levels of pain and tackling any unconscious racial bias there might be in the treatment of sickle cell. Rachel Hughes, Director of Nursing of the Bristol Royal Hospital for Children, agreed and stated that learning would be taken from this patient story, and that plans for improved Continuing Professional Development sessions on sickle cell were in place and a Children's ED Sickle Cell Champion was being considered to ensure the right information was available to staff and patients in this area. There was a need to ensure that training was done more consistently and ensure this took account of staff turnover. • Rachel also reported that previously 4 to 5 patients a year were diagnosed with sickle cell, but this had increased recently and 45 patients had been diagnosed with sickle cell disease in the Soth West over the past 3 years. • Steve Hams, Group Chief Nursing and Improvement Officer, suggested that there needed to be improvement in the learning on pain management at undergraduate level, and Marc Griffiths agreed to investigate this further at UWE. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • The difficulties in transitioning from Children’s to Adult care for both patients and parents was acknowledged, and it was noted that parents could still attend adult clinics. Again, better training was required in this area as this could be as traumatic for parents as it was for the patients. • Martin Sykes, Group Non-Executive Director, welcomed the focus on better training but also emphasised the need to keep the personal touch and maintain personalised care. Martin was also concerned how stories such as this could erode communities’ trust in the NHS, and the group needed to consider how best to respond to this. • Sue Balcome, Non-Executive Director, asked if patients such as Joanne were flagged on the system in ED if there was treatment management plan in place. It was confirmed that there were digitised treatment management plans in place in ED and alerts for these were on system. It was however noted that there was not universal access to these plans across all of the group’s services / locations. • Idara was asked if she received any support from primary or community care for ongoing management of Joanne’s condition. Idara responded that in her experience there had been a lack of understanding from primary care providers and she had multiple issues with obtaining prescriptions from her GP, and so she did not look for support from them. <p>Ingrid Barker, Group Chair, thanked Idara for sharing her story and commented that Joanne had shown herself to be an amazing young woman despite the challenges she faced with her condition.</p> <p>RESOLVED that the patient story be noted.</p> <p style="text-align: center;"><i>Moestak and Idara left the meeting.</i></p>	
04/01/26	Minutes of the Previous Meeting	
	<p>RESOLVED that the minutes of the meeting of the Public Group Board on 11 November 2025 be approved as a true and accurate record of that meeting subject to the following amendment:</p> <ul style="list-style-type: none"> • 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. 	
05/01/26	Matters Arising and Action Log	
	<p>The Group Board considered the items on the action log as follows:</p> <p>1. <u>Questions from the Public</u></p> <p><i>Proposal / update on improving local engagement to be brought back to a future Public Board meeting.</i></p> <p>Elliot Nichols reported that this worked needed to be moved to the group space with a single point of co-ordination to build on the good work that was emerging. Strong relationships were being built with local sports clubs such as Bristol Rovers FC and Gloucestershire Cricket Club, and a solid programme of public engagement was being developed. Further work was required but this was off to a strong start. Action closed.</p>	

Minute Ref.	Item	Actions
	RESOLVED that the Group Board noted and approved the action log and no matters arising were discussed.	
06/01/26	Questions from the Public	
	There were no public questions.	
07/01/26	Group Chair's Report	
	<p>Ingrid Barker presented her report to the Group Board and highlighted the following:</p> <ul style="list-style-type: none"> • Paul Miller, Chair of the Avon and Wiltshire Mental Health Partnership, recently visited the Bristol Royal Hospital for Children and the Bristol Royal Infirmary, including various services including the Children's Emergency Department and Apollo Ward as well as the Home First and High Impact User teams and the Liaison Psychiatry Service. Ingrid highlighted this visit as evidence of strengthening partnerships and joined up working across the system. • The Community Partnership Group was now meeting regularly and working on a framework with which to work with the group's Joint Clinical Strategy. • Ingrid regularly attended the fortnightly City Partners meeting and had recently delivered a presentation on the Group's merger aspirations to this meeting. • Ingrid had 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. <p>During the ensuing discussion Marc Griffiths, Non-Executive Director, commented on the launch of the One City Plan this month, which represented a real opportunity for the group, particularly in respect of health, wellbeing, and communities.</p> <p>RESOLVED that the Group Chair's Report be noted for information.</p>	
08/01/26	Group Chief Executive's Report	
	<p>Maria Kane presented her report to the Group Board and highlighted the following:</p> <ul style="list-style-type: none"> • NHS England had published the Strategic Commissioning Framework, which sets out a clearer articulation of the expectations on Integrated Care Boards as strategic commissioners. The framework described 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 also introduced an updated, four-stage commissioning cycle and highlighted 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 were expected to adopt this approach from 2026/27. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • Maria reported that patient flow had been very challenging recently, with both organisations seeing sustained pressure on services throughout November and December. Both Trusts had declared Critical Incidents during December, which supported the use of escalation actions to manage significant pressures. Despite this, UHBW and NBT had retained their respective status in the Q2 National Oversight Framework Segmentation. • Maria provided an update on the resident doctors' strike and reported that everything possible was being done at a local level. The goal of maintaining 95% of planned care during the industrial action had been achieved. • Maria reported on her attendance at the NHS Genomics Healthcare Summit, which brought together leaders from across healthcare, research, academia and industry to explore the latest advances in genomic medicine, and was a valuable opportunity to discuss the role of genomics in improving patient outcomes and accelerating the adoption of innovative approaches across the NHS. It was also a positive opportunity to showcase the strength of the Soth West region's contributions and ensure the trusts remain closely engaged with developments shaping the future of personalised and preventative care. • It was reported that Tim Whittlestone had recently become Chair of Bristol Health Partners. Maria also welcomed Lavinia Rowsell to her new role of Group Director of Corporate Governance. <p>At the conclusion of this item Ingrid added her thanks to staff for working under the current pressures, which had included both trusts declaring critical incidents in recent weeks.</p> <p>RESOLVED that the Group Chief Executive's Report be noted for information.</p>	
09/01/26	Group Benefits Realisation Report	
	<p>Paula Clarke, Group Formation Officer, presented a report which provided an update 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. Paula highlighted the following points:</p> <ul style="list-style-type: none"> • Each workstream had 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 reflected the group's commitments to its 4 Ps. • Key metrics, ambitions, baseline positions, and trajectories for delivery had now been set for the majority of benefits. • A number of benefits were dependent upon the delivery of key business changes, some of which were related to business case decisions. • A benefits realisation plan was now in place, with a planned quarterly cycle of benefits review by Board committees to provide assurance alongside the full report to the Group Board. This was based upon the approach already adopted by the IQPR and Patient First reports. <p>During the ensuing debate, the following points were raised:</p>	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • Marc Griffiths, Non-Executive Director, commented that following the Weston merger it took a long time for clinical integration to be achieved, and asked if this was currently on track from a group perspective. Paula responded that this would take some time and learning was being taken from those services who were more advanced in respect of integration. There was a clear trajectory that could be built into future reports. • Non-Executive Directors highlighted the need for alignment across the group and highlighted the importance of interdependencies in adding value to the work being undertaken. • Sarah Purdy, Group Non-Executive Director, asked how innovation and R&D fitted into this work, and Tim Whittlestone reported that research was moving very strongly as a joint service, and a report on this work would be presented to Board in April. Innovation was more difficult to define but a business case around this was currently being developed. • Poku Osei, Group Non-Executive Director, commented that the themes of population and community did not come through strongly from the report, which appeared to be quite transactional. This was accepted by Paula, and it was agreed that further thought would be given to how these themes could be woven into how the work was presented. <p>In terms of the financial benefits and costs, Neil Kemsley reported that the cost for 2025/26 were now projected as being £1.2m, which reflected additional expenditures associated with the merger. This had been built into the forecast outturn for the year. The financial benefit for 2026/27 was projected to be £8.1m with the ambition to overachieve on this figure.</p> <p>Tim Whittlestone then provided an update on the Joint Clinical Strategy and reported that work was continuing to transition more duplicated clinical services to single managed services, although it was recognised that the pace needed to increase, particularly in the light of the merger. An update to the Joint Clinical strategy was being developed following a Joint Clinical Strategy Strategic Partnership event in November.</p> <p>Roy Shubhabrata, Group Non-Executive Director, asked whether the benefits were being realised in Cardiology, which was one of the pathfinder single managed services, and Tim reported that this had been benchmarked very clearly and was on track to deliver by 2027. Benefits would be assessed by an external evaluation process. One observation was that there had been a lack of clarity on what success looked like, which would be taken on board for future work. Maria Kane added that a conversation about realistic expectations was required, with outcomes being realistic and achievable.</p> <p>Sue Balcome, Non-Executive Director (UHBW) asked whether Getting It Right First Time (GIRFT) methodology or other benchmarking was being used, and Tim confirmed that GIRFT had been the starting point for this work where a report was available.</p> <p>After further discussion it was RESOLVED that the following be noted:</p> <ul style="list-style-type: none"> • The progress to date with establishing the Group benefit plan, including the early wins and forecast outturn for financial benefits delivery. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • The intention to develop an aggregated dashboard for benefits delivery reporting. • The progress on clinical and corporate services transformation implementation and next steps. 	
10/01/26	Group Integrated Quality and Performance Report	
	<p>The Group Board considered the Joint Integrated Quality and Performance Report which provided an overview of NBT and UHBW's performance across the Urgent and Planned Care, Quality, Workforce and Finance domains for December 2025.</p> <p><u>Performance</u> Stuart Walker, Hospital Managing Director, UHBW, and Glyn Howells, Hospital Managing Director, NBT, presented the performance updates for UHBW and NBT. Both reflected on the pressure the system had been under over recent weeks, and Glyn reported that at NBT the critical incident had been stood down the previous day. UHBW remained in critical incident, with 220 No Criteria to Reside patients and 130 escalation beds open. This resulted in a very challenging environment, and the Trust was working closely with NBT, the ICB and other partners to manage the situation.</p> <p><u>Quality, Safety and Effectiveness</u> Steve Hams presented the quality, safety, and effectiveness update for UHBW and NBT. Sue Balcombe reflected that both trusts were not doing well in respect of fracture neck of femur treatment within 36 hours and asked if there had been any improvement. Tim Whittlestone reported that improvement had started in November 2025 and had continued in December. However, there was a danger this would be impacted by the critical incidents referred to above in January.</p> <p><u>People</u> Jenny Lewis presented the People update for UHBW and NBT and highlighted that sickness absence was worsening in both trusts – this was mainly around long-term sickness. Mandatory training was also an issue, with some areas not hitting targets and Oliver McGowen training some way off the end of year target – the pressures currently being experienced did not help in this regard.</p> <p><u>Finance</u> Neil Kemsley presented the Finance update for UHBW and NBT and reported that at the end of December both trusts were on plan, largely because of a £4m payment from NHSE to cover the cost of industrial action in November and December. UHBW was on track to deliver on its £53m savings target. There were however some risks associated with the ongoing pressure on services.</p> <p>RESOLVED that the Group Board noted the Group Integrated Quality and Performance Report.</p>	
11/01/26	Health Equity Plan	
	<p>Kathryn Hamilton, Consultant in Public Health, attended the meeting to present the Health Equity Plan 2026/27. It was noted that this had been approved by the Quality and Outcomes Committee at its meeting in December 2025 and had been brought to Board for awareness and discussion.</p> <p>Katheryn reported that health inequalities were unfair and avoidable differences in health between different population groups. Covid-19 had shone</p>	

Minute Ref.	Item	Actions
	<p>a spotlight on the significant inequities that existed within local communities and highlighted a lack of systematic approach in the NHS in this area. With growing national and regional attention, both NBT and UHBW had intensified emphasis on this important work, and the Health Equity Plan represented the bringing together of the solid progress that both Trusts had made to date.</p> <p>The Health Equity Plan described objectives for 2026/2027, as well as potential areas of longer-term focus for co-design with local people and communities. The document set out the rationale, requirements and commitments for health equity and proposes four key goals:</p> <ul style="list-style-type: none"> • Building equity into our services • Designing and delivering with communities for population health • Strengthening our capability to deliver on health equity • Developing the group’s role as an anchor organisation to tackle health inequalities <p>During the ensuing discussion, the following points were made:</p> <ul style="list-style-type: none"> • Martin Sykes, Group Non-Executive Director noted that aligning with local authority and ICB strategies was pivotal and asked how conversations were being aligned to ensure this happened. Kathryn responded that the Directors of Public Health and the ICB had been formally consulted on the Health Equity Plan and so it should reflect shared priorities. Making use of shared data and intelligence was the next step. Key areas included population health management (where the population health function at the ICB was key), cardiovascular disease and cancer. • Non-Executive Directors welcomes the work done to date and the approach set out in the plan and suggested that neighbourhood health was another that could be looked at in conjunction with local authority partners. It was requested that an update be provided to the Board on the year one deliverables of the plan in due course. <p>RESOLVED that:</p> <ul style="list-style-type: none"> • 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 the ambition to become an early Integrated Healthcare Organisation be endorsed. • The Board receive an update on year one deliverables of the plan in due course. 	
12/01/26	Quarterly Learning from Deaths Report	
	<p>Tim Whittlestone, Group Chief Medical and Innovation Officer, introduced the Learning from Deaths Report for quarters 1 and 2 of 2025/26. Tim reported that the group remained a very safe place to receive care, and that the opportunity was taken to learn from every death that occurred within the hospitals.</p> <p>It was reported that in future these reports would form part of the IQPR and the appropriate metrics were being developed to facilitate this. The Quality and Outcomes Committee would help refine these metrics.</p>	

Minute Ref.	Item	Actions
	RESOLVED that the assurance provided within the report be noted and the ongoing alignment work at a critical time of organisational change be endorsed.	
13/01/26	Treasury Management Policy	
	Neil Kemsley, Group Chief Finance and Estates Officer, presented the updated Treasury Management Policy to the Board for approval. This policy had been considered by the Finance and Estates Committee which had recommended it approval to the Board. RESOLVED that the UHBW Treasury Management Policy be approved.	
14/01/26	Integrated Governance Report	
	The Group Board received the Integrated Governance Report and noted the following committee upward reports: <ul style="list-style-type: none"> • Digital Committee in Common held on 20 November 2025: Roy Shubhabrata, Chair of the Committee, reported that this meeting had focussed on the actions required for the merger, and it was reported that most actions were on track. The Digital Enterprise Business Case would help to address concerns raised about business continuity and cyber security. • People Committee in Common held on 27 November 2025: Linda Kennedy reported that the workforce metrics had now been aligned with the national metrics and much of the meeting was spent looking at the alignments necessary for a successful merger. The meeting also looked at the work to address violence and aggression experienced by staff. • Finance and Estates Committee in Common held on 25 November 2025: There were no issues to escalate to the Board. • Quality and Outcomes Committee in Common held on 25 November 2025: Sarah Purdy highlighted the committee's ongoing concern regarding the No Criteria to Reside position. <p>The register of seals for UHBW and NBT were also considered by the Board for information.</p> <p>RESOLVED that the Integrated Governance Report, including the committee upward reports and register seals, be noted.</p>	
15/01/26	Any Other Business	
	There were no further items of business.	
16/01/26	Date of Next Meeting – Tuesday 10 March 2026	

The meeting concluded at 12.55pm.

Meeting of Group Board of Directors of NBT and UHBW held in Public on Tuesday, 10 March 2026

Action Log

Outstanding actions from the meeting held on 13 January 2026					
There are no outstanding actions from this meeting.					
Actions closed at meeting held on 13 January 2026					
No.	Minute reference	Detail of action required	Executive Lead	Due Date	Action Update
1.	06/11/25	<u>Questions from the Public</u> 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	Elliot Nichols reported that this worked needed to be moved to the group space with a single point of co-ordination to build on the good work that was emerging. Strong relationships were being built with local sports clubs such as Bristol Rovers FC and Gloucestershire Cricket Club, and a solid programme of public engagement was being developed. Further work was required but this was off to a strong start. Action closed.

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 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
			X
	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 <i>(Including any previous decisions taken)</i>			
The Group Chair reports to every public Board meeting with updates relevant to the period in question. This report covers the period Tuesday 14 January to Monday 9 March 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 10 January:

- Attended monthly check-in meetings with the Lead Governor.
- Chaired a Council of Governors meeting where the Governors received an update on planning for the merger including timelines. The holding to account theme for the meeting was the work of the Group People Committee. Governors received an update from the Chair of the Committee and Chief People Officer on the work the Committee does in assuring the Board on all matters relating to workforce supply, development and wellbeing. A presentation on the Bristol Fatigue Management initiative was well received.
- Attended several committee meetings including Quality and Outcomes, People, and Finance and Estates.
- Attended a Board development session, with a focus on developing highly performing teams and communication. The Board also discussed changes at a national level and the implications for the Trust.
- Led a number of monthly Vice Chair touchpoint and Non-Executive Director (NED) check-in meetings.
- Hosted Clare Moody, the Police and Crime commissioner at NBT, showcasing our work around interpersonal violence, community partnership working, and discussed the future of the Bristol NHS Group.

4. Connecting with our Partners

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

- Delivered a presentation alongside Maria Kane, our CEO, at the One City partner's breakfast where they provided an update on the future of the Bristol NHS Group, and our joint clinical strategies. This event is attended by key partners and stakeholders across Bristol including Avon fire and rescue service, the West of England Combined Authority, Avon and Somerset police, UWE, and the City of Bristol college.
- Visited Sirona where I was briefed on their adult and children's services. Slides from the presentations have been shared with Board colleagues.
- Alongside Linda Kennedy (Group Non-Executive Director) and Steve Hams (Group Chief Nursing and Improvement Officer), visited Pier Health primary care group in Weston where we discussed care at home, digital innovation and research, and explored opportunities for collaboration. We also attended a workshop of the Integrated Locality Partnership where we considered falls prevention, digital tools to ensure safe care at home and multidisciplinary community mental health initiatives.
- Visited the University of the West of England with Dr James Lee, Pro Vice Chancellor and Head of the College of Health, Science and Society, for a briefing and tour of the health and social care teaching and research provision at Glenside campus.
- Chaired the Community Participation Group (CPG) where they discussed a wide range of items including the CPG framework, our joint clinical strategy, and how the CPG can input into Group clinical services work.
- Met with Cllr. Stephen Williams, Chair of Bristol Health and Wellbeing board to brief him on Bristol Group developments and the progress towards merger.

- Met with the Chair of the South Western Ambulance Service Trust, Richard Crompton, to discuss matters of mutual interest between our Trusts.
- Met with Penny Gane, Chair of the West of England's Women's Commission where we discussed the future of the Bristol NHS group and potential further engagement in the West of England Combined Authority (WECA) Women's Commission activities.
- Met with Councillor Jenna Mo Harris, Chair of the North Somerset Health and Wellbeing board and current Chair of Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Partnership Board.
- Hosted a roundtable with colleagues from VCSE Alliance to discuss the future of the Bristol NHS Group and potential partnership opportunities.
- Hosted Councillors Maggie Tyrell and Ian Boulton, Co-Leaders of South Gloucestershire Council to brief them on Bristol Group developments.
- Alongside Paula Clarke, attended a meeting of Healthwatch to discuss Bristol Group developments.

4.2 National and Regional Engagement

The Chair attended several meetings including:

- Alongside Paula Clarke (Group Formation Officer) and Becky Maxwell (Hospital Medical Director, UHBW), presented at BNSSG Integrated Care Partnership Board on Bristol Group developments, the Joint Clinical Strategy and progress towards merger.
- Quarterly meeting with the South West Regional Director for NHS England.
- University Hospital Associations national steering group.
- Bi-monthly meeting with the Chair of the Integrated Care Board for Bristol, North Somerset and South Gloucestershire.
- Continued mentoring of potential Chairs through the national Chairs' Development Programme. Also undertook assessment of potential candidates for the next programme intake.
- Participation in the national learning set for Group Chairs where we discussed strategic commissioning, the potential impact of IHOs and neighbourhood working and the financial impact of the Ten Year plan.
- One-to-one meeting with Mayor of WECA.

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:

- Visited the Bristol Royal Infirmary physiotherapy and Children's outpatient's department.
- Attended Council of Governors.
- Supported the Selection panel for an external auditor.
- Attended a Board development session.
- Chaired the Finance and Estates committee.
- Attended the Audit committee.

- Met with UHBW'S Managing Director.

5.2 Vice Chair (NBT):

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

- Participated in the interview panel for a Consultant Geriatrician.
- Attended an NHS Providers webinar on the practical strategies for Governors during times of uncertainty.
- Supported the Women and Children's Structured Divisional Review.
- Attended an NHS Providers event on patient and public engagement.
- Attended a Safeguarding update.
- Chaired a Governor development session with attendance from members of the Integrated Care Board. The session was also attended by members of the Group Executive to present on the forthcoming merger. Governors received an overview of the case for merger, rationale, and day one planning.
- Attended an Innovation strategy meeting led by our Group Chief Medical and Innovation Officer.
- Attended the celebration of 10000th Robotics Procedure discussion event at NBT.
- Participated in the interview panel for a Histopathologist.

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

- Council of Governors.
- Maternity and neonatal safety champions meeting.
- Perinatal safety champions meeting.
- Quality and Outcomes committee.
- Finance and Estates committee.
- Touchpoint meetings with the Group Chair, and the Vice Chair for UHBW.
- NBT's Charity committee.
- NBT's merger committee, and a joint post committee meeting across both Trusts.
- Board development session.
- BNSSG Outcomes, Quality and Performance Committee meeting.
- Governors and NED engagement session.
- University of Bristol quarterly partnership meeting.
- Quality Focus Group.

6. Summary and Recommendations

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

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 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 <i>(Including any previous decisions taken)</i>			
<p>The report seeks to highlight key issues not covered in other reports in the Board pack and which the Boards should be aware of. These are structured into five sections:</p> <ul style="list-style-type: none"> • 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:	Appendix 1: Group Clinical Strategy Update 2026		

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. Letter from Minister – Supporting Clinical Research

In February NHS organisations received a letter from the Parliamentary Under-Secretary of State for Health Innovation and Safety outlining strengthened expectations for NHS organisations in supporting clinical research. The letter reinforces the need for robust Board-level oversight of research delivery - particularly performance against the 150-day commercial trial set-up target - and signals the forthcoming publication of the national Research Activity Framework in 2026, which we will integrate into future Board reporting.

It also highlights the requirement for Trusts to ensure adequate resourcing for research, and our focus on this area via both our Group Clinical Strategy and our strong performance in attracting national funding for research shows we are well positioned to take advantage of any further government policy focus in this area, for the benefit of our patients and wider population.

2. Integrated Care System Update

2.1. Chief Officer appointments for ICB Cluster NHS Gloucestershire and NHS Bristol North Somerset and South Gloucestershire (BNSSG)

NHS Gloucestershire and NHS BNSSG ICBs cluster have announced their new Executive team, following consultation and recruitment. Shane Devline, Chief Executive, is joined by:

- Chief Clinical Leadership and Delivery Officer (Nursing) – Rosi Shepherd
- Chief Clinical Leadership and Delivery Officer (Medical) – Dr Ananthakrishnan Raghuram MBE
- Chief Finance and Corporate Services Officer – Cath Leech
- Chief Population Health Improvement Officer – Dr Joanne Medhurst
- Chief Transformation, Organisational Development and People Officer – Jo Hicks
- Chief Strategic Commissioning Officer – David Jarrett

These are all excellent appointments, representing an important next step in the development of our new ICB as a strategic commissioner.

2.2. Joint Non-Executive Director appointment for ICB Cluster NHS Gloucestershire and NHS BNSSG

Following the appointment of the cluster Executive team (above), the Cluster has been working to put in place joint governance arrangements to guide how decisions are made and how the cluster delivers its responsibilities. This includes the appointment of five joint Non-Executive Directors (NEDs), selected from the current postholders in both ICBs following a robust process. From 1 April 2026, they will serve on both Boards and chair the committees that will guide the cluster's work and oversight.

The appointments are:

- Professor Dame Jane Cummings: Strategic Health Inequalities, Prevention, Population Health and Commissioning Committee.
- Ayesha Janjua: Transformation, People and OD Committee.
- Ellen Donovan: Finance, Performance and Quality Outcomes Committee.
- Alison Moon: Remuneration Committee.
- Professor Sir Steve West: Audit Committees for both ICBs, which will run in common to maintain independence.

3. Operational Delivery

3.1. Operational Performance

Board members will be aware that both Trusts faced periods of sustained operational pressures over January, with internal critical incidents called at various points, supporting an enhanced response to keep our patients safe and our services running during these challenging periods. I am grateful for the hard work and resilience of colleagues across both Trusts.

Pressures have eased over the past few weeks, but both Trusts continue to face challenges in Urgent and Emergency Care, with high number of patients with “No Criteria to Reside”. We continue to pursue internal opportunities for improvement, while working with system partners to develop longer-term interventions and initiatives which will support improved patient flow through our hospitals.

3.2. Maternity Incentive Scheme Year Seven Assurance Reports

I am pleased to report that in February the Board received reports that provided evidence and assurance that both NBT and UHBW perinatal services were compliant with each of the 10 safety actions set out in the NHS Resolution Maternity Incentive Scheme (MIS) Year 7 requirements. The Board was therefore able to approve the Declarations of Compliance for both Trusts for submission to NHS Resolution. The reports can be found on the respective Trust’s website.

3.3. TUPE Consultation Launch

On 27 February 2026 we launched the formal TUPE consultation for the transfer of NBT staff into a single organisation as part of our planned merger of the two Trusts. The consultation will run until 24 April 2026 and marks an important milestone in ensuring colleagues are fully informed, supported and engaged throughout the transition.

TUPE regulations protect employees’ rights during organisational transfers, meaning colleagues will retain their pay, leave, contractual terms and continuity of service. This process is supported by a comprehensive package including a full Consultation Document, FAQs, consultation events and communications, as well as guidance on how to submit feedback.

4. Strategy and Culture

4.1. Bristol NHS Group Clinical Strategy Update 2026

Following engagement with our partners, and discussion with Board members in January, we have issued our Group Clinical Strategy Update 2026 (**Appendix 1**), setting out the next steps in our journey to transform care for Bristol, north Somerset, South Gloucestershire (BNSSG) and beyond.

This update builds on two years of progress we've made since launching our [Joint Clinical Strategy](#) in 2024. During this time, several clinical services that are duplicated across our hospitals have begun working in a new, more joined up way, with shared leadership to drive improvements. Cardiac Services, Trauma & Orthopaedics, Pain, Liaison Psychiatry and Safeguarding are all now operating as Group Clinical Services, building on their combined strengths to improve access, provide more consistent experiences for patients, and work more efficiently.

At the heart of our strategy is a clear vision to deliver seamless, high quality, equitable and sustainable care for everyone. To help achieve this vision, our Group will focus on three major shifts in how care is delivered, aligned with the [NHS 10 Year Health Plan](#):

- Providing more care closer to home, expanding digital, remote, and community-based options.
- Focusing on prevention and early detection, helping people stay well for longer.
- Using digital tools to improve access and support modern ways of working.

Embracing these shifts as we continue bringing our clinical services together will deliver meaningful improvements for our Four Ps: better outcomes and experience for our patients, greater opportunities and clearer processes for our people, improved health for local populations, and better value for the public purse.

4.2. Groundbreaking Gene Therapy Study for Kidney Disease

Bristol NHS Group is involved in a world-leading research study investigating a pioneering gene therapy for kidney disease, demonstrating the value of coordinated expertise across our Group and our research partners. The study, delivered in collaboration with the life sciences sector, will assess the safety, tolerability and potential efficacy of a disease-modifying gene therapy for IgA nephropathy, the most common glomerular disease globally.

This work brings together NBT's Renal and Interventional Radiology services and UHBW's Pharmacy Production team with PureSpring Therapeutics, a UK biotechnology company originating from the University of Bristol and the first globally to develop a gene therapy specifically for kidney disease. Successful delivery of this study will further evidence the Group's capability to manage and deliver advanced gene therapy research and represents an important milestone for the region and for patients. Appreciation is extended to colleagues across both Trusts whose expertise continues to support the growth of advanced therapeutics and future kidney care.

4.3. Bristol NHS Group clinicians nominated for Bristol life Award

The Bristol Clamshell Emergency Thoracotomy Course, delivered by clinicians from NBT's Emergency Department, ICU and Anaesthetics, has been shortlisted for a Bristol Life Award in the Community and Civic category. This training programme was established in response to the rising incidence of knife-related assaults in the region and now operates with a rolling faculty of more than 20 clinicians from across the wider system, including strong representation from NBT. Since its introduction, nearly 100 frontline staff have been trained in the management of emergency thoracotomy, strengthening regional capability in time-critical trauma care. Communications will be issued across internal and external channels in the coming days to highlight this achievement.

5. Engagement and Visits

5.1. Health Minister visits Bristol Surgical Centre

In mid-January, Minister for Secondary Care, Karin Smyth MP, toured The Princess Royal Bristol Surgical Centre as part of an official visit to mark a year since the launch of the Government's Elective Reform Plan.

Since opening, 1,500 patients have had procedures in the new centre and the Minister was impressed by the facilities for patients and staff, calling it an example of what other hospitals could benefit from.

5.2. Casey Commission Visit

On 18 February 2026, Southmead Hospital hosted a visit from the [Casey Commission](#) as part of its national review of adult social care. The visit followed earlier correspondence from Bristol City Council outlining local integration challenges and the importance of shifting towards prevention and population health.

During the visit, the delegation met colleagues at the Southmead Transfer of Care Hub to understand our approach to supporting timely, safe discharge through multidisciplinary working across health, social care and the voluntary sector. The Commission had expressed particular interest in best-practice initiatives that strengthen adult social care and could be replicated at no additional cost, and the Hub provided an opportunity to demonstrate this collaborative model in practice. The visit will inform the Commission's ongoing work to shape national recommendations for the future of adult social care.

5.3. North Somerset Council CEO visit at Weston General Hospital

In January I hosted Mandy Bishop, the CEO of North Somerset Council for a visit to Weston General Hospital. We had the opportunity to discuss future aspirations for the Group, including transforming how healthcare is delivered locally, with a clear focus on making a difference for our Four P's: our patients, our people, the populations we serve, and the public purse. We also visited the Emergency Department, Same Day Emergency Care and the Older Persons Assessment Unit with members of the local management team.

5.4. Two-year anniversary of BRHC Coral Reef Clinical Research Facility

On 2 March I attended the second anniversary event for Bristol Royal Hospital for Children's pioneering 'Coral Reef' Clinical Research Facility (CRF). Since opening in 2024, the Coral Reef has supported approximately 100 interventional clinical trials, involving between 1,000 and 3,000 participants from across our region. In a very short space of time, the Coral Reef team has built a reputation as having some of the most clinically active research units in the UK, with a particular focus on paediatric and translational research aimed at improving outcomes for children with complex and rare conditions.

5.5. 10,000 Robotics Procedures

On 26 February we marked the 10,000th robotic assisted surgical procedure at NBT with a celebration event in the Brunel atrium at Southmead Hospital, with over 12,000 procedures now having taken place across Bristol NHS Group.

This milestone reflects more than a decade of commitment to innovation, clinical excellence and improved outcomes for our patients. It also highlights our long-standing partnership with Intuitive Surgical, whose technology and expertise have supported the continued growth of our robotic surgery programme.

5.6. Community Engagement

In February I spoke at a community engagement event at Gloucestershire County Cricket Club, attended by several hundred local people. This was an opportunity to talk about Bristol NHS Group and our proposed merger, the NHS 10 Year Plan, our Group Clinical Strategy and what this means for local people.

5.7. Team and Consultant Engagement

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

- Visited the team at the Weston General Hospital Endoscopy Unit
- Visited the team at the Frenchay Bristol 3D Medical Centre.

Recommendation

The Boards are asked to note the report.

Maria Kane
Group Chief Executive



NHS

Bristol
NHS Group

Bristol | Weston

Group Clinical Strategy Update 2026

Seamless, high quality, equitable and sustainable care

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

Executive Summary

Our updated Group Clinical Strategy for 2026 sets out a clearer, more ambitious direction for delivering joined-up, equitable care in Bristol and Weston. This strategy focuses on three core ambitions, each of which will be shaped by the views of our patients and delivered in collaboration with our healthcare system partners:

Delivering joined-up clinical services

We continue to develop our Group Clinical Services, bringing duplicated services together under a single leadership team, with shared planning and aligned patient pathways. Lessons learned from our first Group Clinical Services mean we can accelerate the programme and make significant progress across all 40 by March 2027. This will ensure more consistent access, improved experience, and better outcomes for our patients. Each service will also embed prevention and health equity as core parts of its development.

Reframing how services are delivered

We are committed to playing our part in shifting care towards prevention, early intervention, and more accessible models. This includes expanding remote and community-based care, reducing unnecessary face-to-face outpatient appointments, and ensuring every service plays a role in improving population health. Patient-reported outcomes and experiences will become central to assessing our impact.

Reimagining the future of care

As a Group, and potentially a single-merged organisation in the future, we will move from hospital-centred models to neighbourhood-focused, digitally enabled care. Infrastructure will be modernised, research activity strengthened, and future service design will be guided by a new ambitious clinical strategy for 2027-2032. The aim is a more innovative, flexible, and community-connected health system.

Together, these ambitions will enable Bristol NHS Group to deliver more preventative, equitable, and consistent care while preparing for the transformation required to make healthcare fit for the future in our region.

Introduction

A clinical strategy is not a one off. It is an evolution of ideas and ambitions that are shaped by real world experience, change and challenges.

Our Joint Clinical Strategy (JCS) 2024-2027 has been successful in beginning to address the structural barriers impacting our patients and uniting clinical teams to focus on reducing inequity in access and outcomes. It has strengthened collaboration and resilience across UHBW and NBT, showing the value of planning services together and placing patient need at the centre of our Group's design.

Our pathfinder specialty – Cardiology – and our early Group Clinical Services, have already adapted under this new strategic approach. Their progress has highlighted both the benefits of collaboration and the limitations of operating as two separate organisations. In response, we are now pursuing a merger to remove these barriers to change.

We have also listened closely to patients, partners and communities. The creation of our Community Participation Group and our series of Partnership Events have deepened our understanding of local needs and enabled constructive challenge of our strategic ambitions.

Working more closely with corporate teams has shown us that successful clinical transformation depends on strong Operations, Digital, Estates, Finance and People support.

Finally – but crucially – the NHS 10 Year Health Plan for England published in June 2025 gives us a clear mandate to adapt our strategic ambition. We need to:

- Move more care out of acute hospitals and closer to our communities.
- Keep our population healthier for longer by investing in public health, prevention and screening.
- Modernise services so that patients and partners can access care remotely through digital, at times that suit them.

The shifts can improve our population's health and in turn, reduce pressures on healthcare services. We need to use population health data, community co-production and embrace learning to deliver this agenda locally. We cannot achieve this alone, and we are committed to working in partnership with our communities and colleagues in the wider healthcare system.

As we move towards becoming a single organisation, we must refresh our clinical strategy to reflect what we've learned and reimagine how we deliver care across Bristol, North Somerset and South Gloucestershire.



Professor Tim Whittlestone
Chief Medical and Innovation Officer
North Bristol NHS Trust and University Hospitals
Bristol and Weston NHS Foundation Trust

Delivering benefits for our Four Ps

Our Patients



Our People



Our Population



The Public Purse



Our Goals

Delivering our refreshed Group Clinical Strategy

- All duplicated services will become a Group Clinical Service (GCS) with a single management team, benefits plan and Health Equity Plan. These services will have a focus on outcomes and experience for our patients as well as ensuring the workforce is sustainable.



Reframing how we deliver services

- We will align with the NHS 10 Year Health Plan to prioritise prevention, screening and easier access to care.
- We will aim to significantly reduce unnecessary routine face-to-face outpatient appointments and deliver follow up appointments remotely, incorporating patient reported outcome and experience measures (PROMS and PREMS).
- We will deliver patient education, screening and prevention tools for each GCS and introduce mandatory objectives for treating tobacco dependence, healthy weight and drug and alcohol addiction support, in line with our healthcare system's medium-term plan.
- We will move care for patients with chronic, long term illnesses closer to them, starting with Cardiovascular Disease (CVD), Diabetes and Chronic Obstructive Pulmonary Disease (COPD). We will work with partners to agree specific target measures for health outcome improvements, e.g. diabetic foot amputation rates, COPD admission rates and premature mortality from CVD.



Reimagining our plans for the future

- We will use technology, innovation and neighbourhood health ecosystems to move hospital-centric services into the community, asking our GCSs to work with partners to reconstruct care pathways that start and end in the patients home or community.
- We will modernise our infrastructure across our community based sites at Weston General, Cossham and South Bristol Community Hospital.
- We will embed research and innovation in every clinical service and encourage our staff and patients to contribute to new ways of working, therapeutics and pathways of care.
- We will work as a new and dynamic merged organisation that sets out a clear, holistic clinical strategy, supported by organisational change where needed. Together with our partners, we will develop delivery plans to shape an ambitious clinical strategy for 2027-2032.



Our Progress to Date

Since launching our Joint Clinical Strategy (JCS), we've seen meaningful improvements in patient care and experience. Our pathfinder specialties have led the way, delivering examples of faster access, better outcomes, and more joined-up care.

Group Cardiac Services became our first Group Clinical Service (GCS) in June 2025, driving innovation and collaboration across sites. Meanwhile Maternity, Neonatal and Gynaecology are collaborating on pathway improvements that will enhance safety, consistency, as well as long-term service alignment.

Building on this progress, 13 specialties have begun their journey toward integration, with five already operating as GCSs as of February 2026. These services are starting to deliver tangible benefits for our Four Ps.

Our launched services are:

- Cardiac Services
- Trauma and Orthopaedics
- Pain Services
- Liaison Psychiatry
- Safeguarding



Delivering Benefits

Improving outcomes



- Performance of the Rapid Access Chest Pain Clinic within Group Cardiac Services is now monitored by the same leadership team. When one site experienced a high staff absence in summer 2025, the Bristol Heart Institute was able to take 40 referrals to improve the number of patients seen within the NICE recommended two-week period.
- In Trauma and Orthopaedics (T&O), our Southmead and Weston sites are performing above the national average for getting patients to theatres quickly. A working group has now been established to look at theatre schedules and escalation processes at the Bristol Royal Infirmary to share learning from other sites.



Improving access



- In Group Cardiac Services, urgent Percutaneous Coronary Intervention (PCI) patients have been accessing the next available slot across hospitals through a 'treat and return' pathway, helping to equalise and reduce wait times. Building on this progress, a single PCI service is now being implemented for our Group.
- Our Group T&O service is working with system partners to create a single patient pathway for foot and ankle, and hand and wrist referrals. This will help equalise and reduce waiting times for patients by balancing demand and capacity.
- Single-use cardiac monitor patches used at NBT have been adopted across our Group, helping to reduce UHBW's 12-month waitlist and creating a fairer, community-based care pathway. The patches let patients self-fit at home, reducing hospital visits and easing pressure on clinical teams.

Improving experience



- In Maternity, Neonatal and Gynaecology we've launched a self-referral service for our Early Pregnancy Clinics, removing the need for some patients to contact a GP, emergency department or midwife before referral. This has significantly improved patient experience, as well as access to care with over 100 appointments delivered each week.
- In T&O, a working group is focused on reducing length of stay for elective hip and knee replacements, building on best practice at Weston General Hospital.



Workforce resilience



- Our Group Liaison Psychiatry Service has created a collaborative bank for Registered Mental Health Nurses and Mental Health Support Workers. Over 200 shifts have now taken place through the bank, supporting the service to create a larger flexible workforce available to both Trusts to help manage staffing demands across different sites. This has significantly improved the service's workforce resilience.
- The Liaison Psychiatry collaborative bank has also brought new opportunities to bank staff for training and supervision, and is improving patient care through better workforce continuity.
- There have been four Group Consultant appointments within Cardiac Services, with these team members working at both Southmead and Bristol Heart Institute. This means the leadership team have been able to organise interesting portfolios and job-plans for these staff to enhance recruitment and succession planning.

Financial sustainability



- Our Group Pain Service is planning for NBT patients, who currently go to the Independent Sector due to limited theatre space, to have their procedures at South Bristol Community Hospital. This change will improve access for patients and deliver significant cost savings, strengthening the service's long-term sustainability.



Listening to Patients, Populations and Partners

As we continue to deliver our strategy, we remain guided by a holistic approach that places patients and their families at the heart of everything we do.

The values of the NHS Constitution – working together for patients, respect and dignity, commitment to quality of care, compassion, and improving lives – underpin and shape how we collaborate with patients and the public, listening to their lived experiences and co-designing improvements.

In November 2025, our Joint Clinical Strategy Partnership Event brought these principles to life. The event was an invaluable opportunity to hear directly from patient and community representatives, as well as colleagues from across our healthcare system who share our vision. Their feedback reinforced the importance of co-production and collaboration as we reshape clinical services to meet the needs of our population within a more integrated health and social care system. This insight will inform every phase of implementation.

“
Let’s measure and value the wider determinants of health as much as we do waiting times.
”

“
Let the data drive the focus.
”

Feedback from our November 2025 Partnership Event

We heard

- Health inequalities and access to care are key concerns needing continued focus.
- Prevention is strongly supported as a priority, with interest in funding models that enable sustainable investment.
- A shared recognition that integration and collaboration remain important ambitions, though current structures can feel complex and siloed.
- Digital transformation is essential, but we need to address challenges with infrastructure, adoption and inclusivity.
- A desire for community engagement to be more collaborative and inclusive.
- Confidence in our readiness for the hospital-to-community shift is varied, but there is clear enthusiasm for working together to make progress.





Our Community Participation Group

Central to our ambition is the role of our Community Participation Group. This group acts as a vital connection between Bristol NHS Group and the communities we serve, ensuring that local voices are heard and reflected in decision-making. By working alongside patients, carers, and community representatives, the group helps us identify priorities, challenge assumptions, and co-design solutions that truly meet the needs of our communities. Their involvement strengthens our commitment to transparency, inclusion, and shared ownership of the changes we make.

As we move forward, we will continue to listen, learn, and act on feedback – scaling up our ambition to improve services through genuine partnership. Together, we will deliver care that is not only clinically excellent but also inclusive, respectful, and responsive to the voices of those we serve.

“
We need to move from designing for people in silos to designing with them using shared insight.
”

Feedback from our November 2025 Partnership Event

“
Start with what the patient needs.
”



Refresh Learning from Delivering our Strategy to Date

Since publishing our Joint Clinical Strategy (JCS), staff, patients and partners have fed back to us the successes, challenges and opportunities they have encountered in joining up services. These insights have reshaped how we continue to deliver our strategy.

Refining our model

Initially we asked the clinical services duplicated across UHBW and NBT to determine their own 'Single Managed Service' model. This could be a single management team delivering activities across all our hospitals, a single site service based in one location or a networked service model – where two distinct departments worked closely together but remained independent. The feedback from our teams was that this menu of options resulted in ambiguity and unnecessary complexity to make changes.

In response, we have concluded that all duplicated services will become Group Clinical Services (GCS).

This is a developed model in which services are led by a single leadership team, have a defined benefits plan, access to the entirety of the collective assets of our two Trusts and a clear mandate to improve access, experience and outcomes for patients. Clinical teams continue to have flexibility to shape their patient pathways and an operational model to suit the individual needs of their service, but with a clearer path to follow to make progress.

Enabling change through our corporate teams

Learning from our pathfinder specialty, Cardiology, we know that there are currently obstacles to realising the full potential of the GCS model because of the organisational barriers and differences between our Trusts. Separate corporate functions such as Digital, Finance, Operations, Estates and People, as well as regulatory systems that continue to treat us as independent organisations, have limited progress. Working around these differences is time consuming and prevents us from achieving patient benefits at pace. This key feedback informed our decision to pursue a merger.

We now know that the first priority for the single leadership teams within our GCSs is to set out a clear picture of the challenges they face – whether Digital, Workforce, Financial, or Estates related – alongside the key opportunities to deliver measurable improvements. This review should not only address current issues but also include a forward-looking perspective, grounded in an understanding of our population's needs.

Importantly, we now have both the mechanism and the commitment from our corporate services to work in partnership with these teams to find practical solutions. For example, in Cardiology, designing a way to combine waiting lists so that no patient is disadvantaged was critical to reducing inequity in access to care.

We recognise that not everything can be solved immediately. However, we have established a Corporate Services Transformation Programme to bring these teams together which can help accelerate the delivery of changes that matter most to our clinical services. In addition, enabling strategies – such as for Digital Services – are in development to provide the foundation for long-term, strategic progress.

Going further, faster

Listening to our staff we are often asked why the process of forming GCSs has been slower than anticipated. We have had to learn how to better enable and empower pathfinder teams to truly act as one service – but we know that it is now time for us to pick up the pace.

We have completed an evaluation of our pathfinder services, simplified the process to establish a GCS and ensured that resources are available to support the leadership teams. We are now committed to supporting all of our 40 duplicated clinical services to make significant progress towards forming a GCS by March 2027.

Looking beyond phase one of our JCS, we are inviting our single-site clinical services to look at the opportunities our Group and merger will bring. We want these services to critically evaluate whether they should provide care in a different way, provide care on multiple sites and cooperate differently with interdependent clinical teams.

Navigating organisational structures

Learning from our pathfinder specialty, Maternity, we have appreciated that differences in our divisional structures can make changing one service in isolation quite challenging.

Maternity, with its deep relationship to women's health, sexual health, Paediatrics and Neonatal and Fetal Medicine, found it hard to plan a single service for Bristol and Weston, working with interdependent services in different divisions.

We have delegated responsibility for managing the transition to GCSs to single divisional teams on behalf of Bristol NHS Group. This approach means that no single division is burdened with the full weight of change. As we look ahead to the benefits of becoming a single merged organisation, we can reassure our divisional teams that the work they are doing now will ensure our services are ready for merger.

In addition, within Bristol NHS Group, performance, finance, outcomes, and quality reporting are now reported in common which supports our approach.

Our divisional teams are focused on a shared understanding that we are working towards a common goal, serving a single population together.



Reframing How we Deliver Services

The NHS 10 Year Health Plan gives us a clear mandate to transform how healthcare is delivered.

Across providers and pathways, this means focusing on illness prevention, early detection through screening, and promoting wellbeing at every opportunity. Our own system shows persistent, avoidable differences in outcomes across Bristol, North Somerset and South Gloucestershire. Partners have told us they are ready to support more of the work that has shifted into acute hospitals over time, creating a significant opportunity to rethink our approach to Group Clinical Service (GCS) design.

Rethinking our outpatient model

What is the value of a face-to-face outpatient appointment? Patients have told us all too often about the effort and cost of travel, taking time off work or care duties, anxiety about attending a busy hospital – all of which carry a burden which may be unnecessary. Many face-to-face appointments add value – when a new diagnosis needs to be carefully explained, when a complex intervention requires a multi-disciplinary consultation, when a lesion needs to be examined. But many follow up, or routine appointments add little.

In forming GCSs, and when challenging single-site services to adapt, we want to see that routine and follow-up appointments are done differently. We are keen to share the work of some of our clinical teams in Cardiology, Rheumatology, Dermatology and Pain, who have provided ways for patients to interact with their service remotely, on demand or in group settings. We are asking leadership teams in clinical services to explore every opportunity to provide outpatient and diagnostic services remotely, using technology and out of hospital settings. We want every service to be focused on patient reported outcome and experience measures (PROMS and PREMS) with a roll out plan to support this.



Keeping our populations well

Most of our time, effort and resources are focused on acute care, treating patients when they face the extreme challenges of illness and injury. We know that we must start to reverse the current growth in our demand by keeping people well, if we are to manage our capacity with a growing and aging local population.

Our Group has fantastic examples of acute services who have stepped into disease education, prevention, screening and wellbeing – from our staff health screening programme, tobacco dependency team and liver disease screening service. We are asking all clinical services to critically evaluate what they can do to support our population's health, using a data-led approach and working partners in the community, primary care and patient advocate groups to share their expertise and insights. Our work must be measurable, and we will collaborate with system colleagues on shared organisational metrics for prevention and population health.

Care closer to home

Our three campuses – Southmead, Bristol City and Weston General – provide care at every stage of life, supporting frail and elderly patients, those with chronic conditions, and people who are terminally ill. We will always be there when patients need us. However, patients, carers, and community partners tell us that hospital is not always the best place for treatment and care.

Every GCS has a responsibility to make life easier for people with long-term conditions by helping them stay well and avoid unnecessary hospital admissions. Our frailty services have already developed excellent community-based support to help older people remain at home. We want to go further – working with our clinical teams and community care partners to design services that offer admission avoidance, diagnostics closer to home, reliable access to advice, and high-quality home care.

We will begin with Cardiovascular Disease (CVD), Diabetes and Chronic Obstructive Pulmonary Disease (COPD), residents of care and nursing homes, and people living with cancer, to create options that keep patients well, reduce hospital stays, and improve quality of life.



Reimagining Our Plans for the Future

We want to radically rethink how healthcare is delivered by shifting from hospital based treatment to prevention, early support, and provide continuity after recovery. Becoming a single merged organisation will give us the scale to do this.

National policy is clear and our partners, commissioners, and the voluntary sector are ready to play their part to support these shifts. Medicine is also rapidly changing driven by digital technology, genomics, molecular science, and robotics, offering major opportunities to treat many conditions differently.

As Group Clinical Services grow across multiple sites, our estate must evolve. Local hospitals like Weston General, Cossham, and South Bristol will broaden their services, and other facilities will modernise in line with the NHS 10 Year Health Plan. With population growth and ageing, services must become more resilient, adaptable, and future-ready.

Over 2026-27, we will develop a forward-thinking clinical strategy, using evidence and projections to design care working as one merged Trust. We will then publish this unified plan for our new organisation. Merging will remove barriers in Finance, Estates, Digital, and Operations, providing a platform for new operating models such as advanced Foundation Trusts and Integrated Healthcare Organisations.

This document outlines our ambition to work differently: extending care into communities, strengthening partnerships, and delivering care beyond hospital walls. Together with partners, we will now develop the delivery plans that will shape an ambitious clinical strategy for 2027-2032, reimagining healthcare for the people we serve for years to come.



Seamless



High Quality



Equitable



Sustainable





Bristol

NHS Group

Bristol | Weston

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Merger Update		
Report Author:	Robert Gittins, Group PMO and Merger Programme Director		
Report Sponsor:	Paula Clarke, Group Formation Officer		
Purpose of the report:	Approval	Discussion	Information
			X
	<p>This report provides an update on the programme of work underway to support the Boards' intent to pursue a merger of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). It builds on the intent and approach set out in the public Board report in November 2025 and reflects the progress and next stages for the formal assurance process.</p> <p>The report summarises:</p> <ul style="list-style-type: none"> - the key rationale for why merger is proposed as providing the optimal strategic platform towards a stronger, more resilient healthcare system that safeguards the best care for the people we serve now, and into the future; - how merger supports wider transformation already underway under the Group benefits delivery plan; and - progress, assurance and next steps as the organisation enters the NHS England external review period alongside intensified internal Day 1 readiness planning. <p>The Board is pursuing the option of organisational merger because it believes that, alongside the progress already being made as Bristol NHS Group, a single organisation has the potential to better support the scale and pace of change required to meet current and future challenges facing the NHS.</p>		
Key Points to Note (Including any previous decisions taken)			

- **The case for merging** – The merger aims to remove structural barriers created by operating as two separate statutory entities, simplify governance and accelerate delivery of our Joint Clinical Strategy vision for **seamless, high-quality, equitable and sustainable care**. This will deliver benefits across our **four Ps**:
 - creating a stronger, more integrated organisation that improves outcomes for **patients**,
 - supporting our **people** to thrive and have richer career opportunities,
 - strengthening our contribution to the health and wellbeing of our **populations**, and
 - delivering better value for the **public purse**.

- **Formal transaction phase underway** – Since the November 2025 public update, the merger programme has progressed from Strategic Case assurance into the formal transaction phase, with external assurance activity now in progress. As confirmed with the Board in November 2025, the legal framework for the merger will be via Section 56A of the NHS Act 2006 with UHBW as the Foundation Trust, acquiring NBT. This option is deemed to be the least complex way to create a single organisation that combines the considerable strengths of both current Trusts and maintains parity across all sites and services.

- **Full Business Case (FBC) approved** – In February 2026, the Group Board approved the draft FBC and Post-Transaction Integration Plan (PTIP) for submission as part of the statutory transaction process, to NHSE. The UHBW Council of Governors have also been stepped through the key aspects of the FBC and PTIP and remain supportive of the approach to merger assurance. This marks a significant milestone towards merger.

- **Governance, Quality and safety assurance confirmed** – In February 2026, the Audit Committee reviewed the key elements of the merger assurance framework relating to governance readiness, statutory compliance, risk management and Day 1 operational preparedness. The Committee confirmed the current status of assurance across these areas. In the February meeting of the Quality and Outcomes Committee, the planning approach to ensuring a safe and successful merger from Day 1 was reviewed with the Committee confirming that no unmitigated clinical quality or patient safety risks have been identified at this stage.

- **Formal TUPE consultation with NBT staff** has commenced for an eight-week period as part of widespread communication and engagement activities with all staff across the Group.

- **Focus for the next period** – The programme’s focus is now on completion of external assurance by NHSE alongside detailed internal Day 1 readiness planning and robust, dynamic communication and engagement with staff and external stakeholders.

Strategic and Group Model Alignment

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

Risks and Opportunities	
<p>Progressing toward merger presents opportunities go further, faster towards delivering benefits across our 4 P's, embed consistent Group-wide governance and quality oversight from Day 1, reduce duplication and strengthen organisational resilience. The benefits of merging, in addition to the benefits already identified from becoming Bristol NHS Group, are detailed in the draft FBC with a summary included in the paper below.</p> <p>The principal risks at this stage are transitional and system-level, reflecting the scale and pace of change rather than any deterioration in the quality or safety of care. In particular, there is a recognised risk of organisational capacity pressure during the external review period, which is actively managed through programme governance, prioritisation, and coordination.</p>	
Recommendation	
<p>This report is for Information.</p> <p>The Board is asked to:</p> <ul style="list-style-type: none"> • Note progress and next steps for the merger programme, with focus on external assurance, internal Day 1 readiness planning and robust, dynamic communication and engagement with staff and external stakeholders. • Note the current assurance position, including Audit Committee and Quality and Outcomes Committee reviews. 	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	N/A

Merger Update Report March 2026

1. Recap on Key Milestones Since the November 2025 Public Board Update

Since the last public update in November 2025, the merger programme has moved from Strategic Case assurance into formal transaction preparation. NHS England (NHSE) confirmation was received to proceed to Full Business Case (FBC) in September 2025, and the Group Board subsequently approved the draft FBC and Post-Transaction Integration Plan (PTIP) to proceed to NHSE Review in February 2026.

Since November 2025, assurance has been strengthened through Committee-level scrutiny and Executive dynamic review of governance, risk management, quality and Day 1 readiness. These key milestones are summarised as follows:

- **Formal transaction phase underway** - Since the November 2025 public update, the programme has progressed from Strategic Case assurance into the formal transaction phase, with external assurance activity now in progress. As confirmed with the Board in November 2025, the legal framework for the merger will be via Section 56A of the NHS

Act 2006 with UHBW as the Foundation Trust, acquiring NBT. This option is deemed to be the least complex way to create a single organisation that combines the considerable strengths of both current Trusts and maintains parity across all sites and services.

- **FBC approved** - In February 2026, the Group Board approved the draft FBC and PTIP for submission as part of the statutory transaction process, to NHSE. This approval followed detailed consideration of the merger case and plans by all the Board Committees (except for Audit Committee which occurred on 17th February 2026). The UHBW Council of Governors have also been stepped through the key aspects of the FBC and PTIP and remain supportive of the approach to merger assurance. This marks a significant milestone towards merger.
- **Governance, quality and safety assurance confirmed** - In February 2026, the Audit Committee reviewed the key elements of the merger assurance framework relating to governance readiness, statutory compliance, risk management and Day 1 operational preparedness. The Committee confirmed the current status of assurance across these areas. In the February meeting of the Quality and Outcomes Committee, the planning approach to ensuring a safe and successful merger from Day 1 was reviewed with the Committee confirming that no unmitigated clinical quality or patient safety risks have been identified at this stage.
- **Merger as an enabler of transformation** - The proposed merger is intended to better enable delivery of the Joint Clinical Strategy and Corporate Services Transformation plans developed as part of the Bristol NHS Group benefits case by removing remaining structural barriers and simplifying governance. These programmes continue towards delivery in parallel to merger planning. An update on progress was provided to the public Board meeting in February 2026 through the Group Benefits Delivery Report.
- **Formal TUPE consultation with NBT staff** has commenced for an eight-week period as part of widespread communication and engagement activities with all staff across the Group.
- **Focus for the next period** - The programme's focus is now on completing the external assurance process with NHSE, alongside sustaining detailed internal Day 1 readiness and post-transaction integration planning and continued dynamic and inclusive communication and engagement with staff and stakeholders. Further detail on these plans is included in section 7.

2. Why the Board is Pursuing a Merger

The Board is pursuing the option of organisational merger because it believes that, alongside the progress already being made as Bristol NHS Group, a single organisation has the potential to deliver **seamless, high-quality, equitable and sustainable care** faster and at scale. Benefits of merger include accelerating clinical integration, strengthening workforce resilience, enhancing research and innovation opportunities, and significantly improving financial sustainability. Building on the strong foundations of the Bristol NHS Group, the proposed merger would remove the remaining structural barriers that slow progress and ensure the organisation can respond effectively to rising demand, health inequalities, and the radical transformations expected in the NHS 10 Year Plan.

Significant progress has already been made through closer collaboration between North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust. This includes delivery of a Joint Clinical Strategy, the development of Group Clinical Services focussed on improving access, equity, patient experience and productivity, and the transformation of corporate services. Feedback from clinical and corporate teams involved in this work has consistently highlighted that continuing to operate as two separate legal organisations sustains some barriers to change, slows decision-making and limits the speed at which benefits can be delivered.

The Board therefore believes that a merger provides a stronger platform to go further and faster in delivering the changes already underway, by simplifying governance, reducing duplication and creating clearer accountability across the organisation.

Importantly, the Board's intent remains to create a merger of equals, establishing a single organisation with parity across all sites, hospitals and services. Both Trusts bring strengths: world-class research, national surgical leadership, specialist services, and community connections. Merger is about combining these strengths to deliver more across **our four Ps – our patients, our people, the populations we serve, and the public purse.**

Why this matters for our Four Ps

For our Patients

A single organisation has the potential to support more consistent, high-quality care with less variation across sites. By removing organisational boundaries, merger enables further alignment of clinical pathways, improved access to services and better patient experience, building on progress already made through Group Clinical Services.

For our People

Closer working as one organisation creates better career opportunities so our people can thrive, improved access to participate in research and innovation, and clearer leadership and decision-making. A merger supports a more unified organisational culture, while protecting staff terms and conditions and supporting colleagues through change.

For the Populations we serve

Operating as one single, cohesive organisation simplifies engagement for system partners, providing a clear route for co-design, shared governance and joint accountability – all essential for implementing successful integrated neighbourhood health models, expanding prevention and early intervention, and supporting the rebalancing of care from hospital to community. A merged organisation would strengthen the Trust's role as an anchor institution with a pivotal part to play in improving health, economic, and social outcomes for the region.

For the Public Purse

A merger has the potential to reduce duplication, standardise approaches, and make better

use of resources. By integrating leadership, governance and support functions, the organisation could improve resilience and create greater flexibility for strategic investment, delivering better long-term value for public money. The draft FBC demonstrates a robust and positive economic case for merger with efficiencies secured from removing duplication, consolidating procurement, integrating corporate services and digital systems, expanding commercial and research income, and accelerating clinical productivity improvements across our 40 duplicated services.

3. Wider Transformation Context

The proposed organisational merger sits alongside a wider programme of transformation already underway across Bristol NHS Group. In this context, merger is being explored as an enabler to support more consistent and timely delivery of change.

3.1 Delivering our Joint Clinical Strategy

The Joint Clinical Strategy (JCS) supports clinical teams to work together to deliver seamless, high-quality, equitable and sustainable care. Through the development of Group Clinical Services, teams are aligning pathways, reducing variation and building on shared strengths across sites. The Group Benefits delivery report to the Board in February 2026 provided an update on the progress with the JCS, with a summary overview in Figure 1.

Figure 1: Overview of Group Clinical Services delivery



3.2 Transforming our Corporate Services

Corporate Services Transformation is bringing together support functions such as People, Finance, Digital, Communications and Estates to create more joined-up, efficient and sustainable services that better support frontline care. This work is already well progressed with resourcing, temporary staffing, communications and engagement, and senior digital

teams already integrated, and a wide range of other functions having completed future model design and moving to consult with staff. This transformation programme makes better use of collective resources, achieves efficiency savings that can be reinvested to future-proof our corporate services and support clinical service improvements, and enhances career opportunities. While this work continues irrespective of whether merger proceeds, corporate staff have made it clear that streamlining systems and processes as a single Trust will accelerate benefit realisation plans.

4. Statutory Merger Process

The merger is being progressed under Section 56A of the NHS Act 2006, with external assurance applied to confirm that the transaction is safe, sustainable and in the best interests of patients and staff. The statutory process requires formal approvals from both Trust Boards and, for University Hospitals Bristol and Weston NHS Foundation Trust, the Council of Governors. Final approval and grant of acquisition is by the Secretary of State for Health.

The draft Full Business Case has now been submitted to NHSE, and the organisation has entered the formal external assurance period. No final decision has been taken, with approval subject to the statutory process including Council of Governors approval and Secretary of State sign-off.

5. Merger Programme – Current Focus

5.1 External assurance

The programme has entered the external assurance period, including quality, financial and Full Business Case reviews being undertaken by NHSE. This includes observation of key Board and Committee meetings and structured document review. The Board will continue to receive regular updates on progress, emerging themes and assurance during this period.

5.2 Internal Day 1 readiness and integration planning

In parallel, internal Day 1 readiness planning is being intensified in line with the PTIP. This includes ensuring continuity of clinical governance, workforce arrangements, digital access and corporate services from Day 1. Only a small number of critical corporate systems will change on Day 1, with plans in place to support staff and manage interim arrangements where required. All Committees will receive formal updates on merger-readiness in the March and May 2026 meetings (Audit Committee in April 2026).

5.3 People, OD, Culture and Workforce Transition (including TUPE)

People, organisational development, culture and workforce transition remain critical enablers of a safe and well-led merger. A structured approach is in place to support leadership alignment, staff engagement and continuity of employment arrangements.

A key milestone in this phase is the commencement of formal TUPE consultation for North Bristol Trust colleagues on 27 February 2026, undertaken in line with statutory requirements.

Staff terms and conditions are protected under TUPE, and a full review of employment contract terms and policies across both organisations is underway to ensure consistency and clarity for all colleagues.

Throughout March and April, a comprehensive programme of consultation activities will ensure staff have the opportunity to provide feedback, raise concerns and ask questions about the transition. This includes site-based roadshows and drop-in sessions across both Trusts, leadership walkarounds, a dedicated FAQ resource, bookable one-to-one sessions with managers and People/HR experts, and a confidential inbox for individual queries. All activity will be supported by regular communications updates.

Key aspects of this include:

- engagement and consultation with staff side representatives and recognised trade unions to ensure the staff voice is central throughout,
- roadshows and briefing sessions for staff and managers across both Trusts,
- a dedicated TUPE consultation pack with FAQs shared through multiple channels,
- accessible one-to-one sessions with People experts and managers, and drop-in sessions during the consultation period,
- a shared intranet space providing regular updates; and feedback reviews to capture staff input and refine our approach.
- a confidential inbox and bookable one-to-one sessions with People experts are available to ensure every colleague has access to individual support and guidance.

In addition, there will be proactive engagement with marginalised voices to ensure the consultation is inclusive and accessible for NBT staff.

Although only NBT staff are formally being consulted, a number of engagement activities and regular communications updates are also planned for UHBW staff to ensure they remain informed and supported throughout.

A Cultural and Organisational Development Plan has also been developed to support cultural integration, recognising that a strong shared culture is fundamental to a successful merger. In support of this and to demonstrate our commitment to staff voice, in line with NHS England best practice guidance, the GEM and Merger Board commissioned a cultural diagnostic in January and February 2026. A pragmatic approach was agreed, assessing key cultural indicators including leadership, communication, teamworking, workforce metrics and organisational values. The findings indicate a largely positive position, with strong cultural alignment across both organisations. Further work is underway to use the findings to inform Phase Two of the Culture and OD Plan.

6. Forward Look: Key Milestones and Timetable

This table sets out key transaction milestones ahead:

Milestone	Indicative Timing
External NHSE review activity underway	February–April 2026
Internal Day 1 readiness gateways	March–May 2026
Completion of external review period	May 2026
Final Board and Governor decision-making	June 2026
Proposed Secretary of State approval	June 2026 (TBC)
Target Day 1 for merged organisation (subject to approval)	Summer 2026

7. Communications and Engagement

Keeping staff, patients, partners and stakeholders informed and engaged remains a central feature of merger planning and wider transformation. Engagement activity continues through leadership cascades and walkabouts, staff roadshows, internal communications and public-facing updates, all essential in supporting transparency and confidence throughout this period of significant organisational change. We are committed to proactive, transparent communication throughout. We continue to look for innovative and targeted approaches to reach all colleagues and communities we serve, listen to the feedback from our internal and external stakeholders, and develop a diverse range ways to communicate and engage.

Ahead of the official TUPE consultation launch on 27 February 2026, engagement activity significantly intensified across both Trusts. 1185 colleagues attended a Group town hall event with CPCO Jenny Lewis on 12 February and a further 850+ joined Jenny again on 26 February for a launch event for the consultation. Staff roadshows and drop-in sessions have also been held across all major sites, with further sessions scheduled throughout the eight-week consultation period.

Leadership engagement has been a priority, with regular executive-led briefings, CEO newsletters, divisional communications and leadership cascade packs ensuring managers are equipped to support their teams. Our trust intranets have identical Group transformation pages providing real-time updates with an average of over 2000 views a month. Feedback from staff is actively reviewed and used to shape and refine our engagement approach. External stakeholder engagement continues in parallel, with MPs, local authority leaders and health and care partners kept regularly informed of progress.

8. Conclusion

The merger programme is progressing well and has reached a key point, with external assurance now underway and internal Day 1 readiness planning intensifying. This reflects the next stage of the assurance journey first set out to the Board in November 2025. Our focus equally remains on ensuring staff and stakeholders understand the drivers for the merger and are assured that this will bring added benefit across our four Ps and for the wider system and region.

The Board will continue to be updated on the external assurance process and the internal readiness required to ensure a safe, well-led transition, should the merger proceed, with detailed scrutiny of plans being undertaken via Board Committees.

9. Recommendations

This report is for **Information**.

The Board is asked to:

- **Note** progress and next steps for the merger programme, with focus on external assurance, internal Day 1 readiness planning and robust, dynamic communication and engagement with staff and external stakeholders.
- **Note** the current assurance position, including Audit and Quality and Outcomes Committees reviews.

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 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 Benjamin Pope, Associate Director for Workforce Planning, People Systems and Data Simon Davies, Assistant Director of Finance	
Report Sponsor:	Responsiveness – Philip Kiely, Trust Chief Operating Officer Quality – Sarah Dodds, Trust Director of Nursing, Becky Maxwell Trust Medical Director Our People – Alex Nestor, Trust Director of People Finance – Jeremy Spearing, Trust Director of Finance	Responsiveness – Nicholas Smith, Trust Chief Operating Officer Quality – Mike Puckey, Interim Trust Director of Nursing, Samir Patel, 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
			X
	To provide an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.		
Key Points to Note <i>(Including any previous decisions taken)</i>			
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:	Appendix 1: IQPR Appendix 2: NBT PQSM Appendix 3: UHBW PQSM Appendix 4: Mortality – Learning from Deaths		

Integrated Quality and Performance Report

Month of Publication March 2026

Data up to January 2026

Contents

Report Structure	Page
Key to KPI Variation and Assurance Icons	3
Business Rules and Actions	4

Summaries	Page
Executive Summary	5

Responsive	Scorecards	9
UEC – Emergency Department Metrics	Summary	11
UEC – Ambulance Handover Delays	Summary	15
UEC – No Criteria to Reside	Summary	17
Planned Care – Referral to Treatment	Summary	18
Planned Care – Diagnostics	Summary	21
Planned Care – Cancer Metrics	Summary	22
Planned Care – Last Minute Cancellations	Summary	25
Stroke Performance (NBT)	Summary	26

Quality	Scorecard	28
Infection Control	Summary	30
Falls	Summary	33
Medication Incidents	Summary	35
VTE Risk Assessment	Summary	36
Neck of Femur	Summary	37
FFT	Summary	39
Complaints	Summary	40

Our People	Scorecard	42
Vacancies	Summary	43
Sickness Absence	Summary	44
Essential Training	Summary	45

Finance	46
Assurance and Variation Icons Detailed Description	53

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	

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 a number of videos explaining the approach and a series of case studies – these can be accessed via the following link:

[NHS England » Making data count](#)

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.

Scorecards Explained

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

Name of Metric/KPI.

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

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

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

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

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

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

The actual performance for the most recent month.

The actual performance for the previous month.

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

Business Rules and Actions

Assurance					Variation					
					No icon					
Consistently P assing Target	Meeting or P assing Target for at least Six Months	Inconsistent P assing and F alling Short of Target	F alling Short of Target for at least Six Months	Consistently F alling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to H igher or L ower Values	C ommon Cause Variation - No Significant	Special Cause of Concerning Variation due to H igher or L ower 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 improved to 73.8% in January (73.5% in December) 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 “No Criteria to Reside” (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 was 60.3% for January 2026 (68.3% 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

Whilst UHBW anticipate no further 65 week waits during 2025/26, there was one Paediatric Dental patient waiting beyond 65 weeks at the end of January 2026, who has since been seen and treated at the beginning of February. NBT had two complex Plastic Surgery DIEP patients waiting longer than 65 weeks at the end of January 2026 due to further unexpected absence in the consultant body. At the end of January, both Trusts met the March 2026 ambition that less than 1% of the total waiting list will be >52 weeks.

Diagnostics

For January, NBT’s diagnostic performance reported at 2.6% which was impacted mainly by ongoing challenges in DEXA, as well as a deterioration in Echocardiography. NBT remains in the top quartile in the country and are forecasting improvement for February with a return to the constitutional standard at the end of March 2026. UHBW position in January has dropped to 13% (11.4% in December) primarily due to capacity constraints associated with non-obstetric ultrasound and endoscopy. Plans have been stood up to support recovery within the affected modalities, with improvement in performance expected in final two months of the year.

Cancer Wait Time Standards

During December, UHBW was compliant with all three, core cancer standards, reporting 96.6% (target of 96%) against the 31-day standard, 76.7% for 62-day metric (target of 73.2%) and 79.3% (target of 79%) against the 28-day Faster Diagnosis Standard. Whilst January may prove a more challenging month, UHBW expect to be compliant with each of the three core cancer standards by the end of Q4. At NBT, 28-Day FDS, 31-Day and the 62-Day Combined position were off plan for the month of December. 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. NBT anticipate returning to forecast by the end of February. Both trusts are part of the SWAG programme of improvement called ‘Days Matter’ which will focus on Urology pathways at NBT and Colorectal at UHBW.

Executive Summary – Group Update

Quality

Patient Safety

At UHBW, there have been no new MRSA cases for the trust in January and a total of six cases 2025/26 year to date compared with seven in the same period in 2024/25. A comprehensive review of the six MRSA bacteraemia's has been undertaken by NBT colleagues, Deputy DIPC and Lead IPC Doctor and will be presented to the Group Quality and Outcomes Committee in February. There have been no additional MRSA cases reported at NBT, the total for 2025/26 remains at two cases.

There were five UHBW Escherichia coli (E. coli) infections for January taking the figure to 77 year to date compared with 62 in the same period in 2024/25. Ongoing work continues to make improvements in urinary catheter care using an updated urinary catheter care plan. At NBT The number of cases reported has increased in January. Cases remain significantly below trajectory 58 cases to an end of year trajectory of 89.

There were 15 UHBW cases of Clostridium Difficile in January: 11 Hospital Onset Hospital Acquired (HOHA) and four Community Onset Hospital Acquired (COHA). We have exceeded our reduction target of 109 cases for 2025/26 with 123 cases year to date (89 HOHA 34 COHA) presently. The UHBW quality improvement initiative for C. difficile continues, led by a Divisional Director of Nursing. This has been reinvigorated and incorporated into the Operational Infection Control Group. For NBT, five HOHA and two COHA - cases need to trend at 6 or lower monthly to match a trajectory position. The current position is trending slightly above the trajectory. Total position so far this year 89 cases against a trajectory of 79.

In January there have been 183 falls at UHBW which is higher than the Trust target of 4.8 per 1000 bed days. There were seven falls with moderate physical and/or psychological harm. Divisions are undertaking reviews of falls and falls with harm to identify themes and learning. Action plans will be developed, implemented and shared throughout the division.

Following the appointment of new Group and Trust VTE leads, the Venous Thrombo-embolism (VTE) Risk Assessment indicator is being reviewed to analyse the contribution of data from various cohorts of patients that comprise the overall reported figure and identify where improvements could most effectively be targeted. NBT compliance continues to be sustained around 97%.

Patient & Carer Experience

In December 65 complaints were received. Surgery, Medicine and Women & Children's remain the highest-volume areas, 62% of complaints met the overall response target. All complaints actioned were completed within 45 days (100%) 223 cases were closed in December, showing good throughput. Work continues with divisions to reduce complaint response delays proactively extend complex complaints, prompt sending of complaints to divisions within 72 hours of complaint received. Performance is expected to continue to improve due to clearing of the backlog in the PALS and Complaints team.

Within NBT the monthly compliance rate decreased from 77% in December to 68% in January. Of the 65 complaints due for response in December, 44 were closed within the agreed timescale, seven were outside the agreed timescale, and 14 were still open at the time of reporting. The overall Trust compliance score has decreased due to a decline in ASCR from 63% in December to 37% in January. This is the first time since September that ASCR has been below 50%. An improvement from ASCR will likely result in a higher score for the Trust, provided the other divisions continue to sustain their performances. The average score for the other divisions for January was 86%.

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 9.5% in January, below the NBT target of 11.3% for 2025/26
- **UHBW** turnover is 9.1% in January and below target.

Vacancy Rate

- **NBT** is 7.8%, reduction in vacancies driven by enhanced and targeted nursing recruitment into Band 2, 3 and 5 roles
- **UHBW** is 5.0%, an increase from 4.8% in December 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 with a focus on impacting SAD and MSK absence
- **UHBW** rate is 4.6% in month, an increase from 4.5% in December. This is above target, so does now trigger an escalation summary.

Essential Training

- **NBT** – 88.7% against a target of 90% - key hotspots are Infection Prevention Control, OMMT and Information Governance
- **UHBW** - 89.6% against a target of 90%. key hotspots are Infection Prevention & Control, Moving and Handling, OMMT, Resuscitation and Information Governance

Both Trusts conducting on-going discussions with subject matter experts to progress sufficient recovery actions including delivery models, communication and promotion, ongoing governance and the level of confidence that actions will have required impact to recover our position with a particular on-going scrutiny of Oliver McGowan (Face to Face and virtual training sessions). Based on current compliance datasets and projected future booking trajectories, extrapolated compliance estimates for tiers 1 and 2 were generated for each organisation to meet the ICB 63.3% compliance. The output and an accompanying report to be disseminated to GEM and respective trust management teams.

Executive Summary

Finance

In Month 10 (January), NBT delivered a £0.9m surplus position, against a surplus plan of £0.9m. Year to date NBT has delivered a £1.7m deficit position which is on plan.

UHBW delivered a £3.9m surplus in Month 10, against a surplus plan of £3.8m. UHBW's year to date deficit is £5.4m, £0.2m favourable to plan.

Pay expenditure within NBT is £2.9m 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 £3.6m adverse to plan in month. This is driven mainly by higher than planned substantive and bank expenditure particularly across nursing due to escalation and enhanced care.

The NBT cash balance as at the 31 January 2026 is £16.6m, £3.3m lower than planned, a £60.8m reduction from 31 March 2025.

The UHBW cash balance as at the 31 January 2026 is £37.3m, £37.4m lower than planned, a £35.0m reduction from 31 March 2025. The variance from plan is largely driven by timing differences on the Capital Programme i.e. cash draw down for nationally funded schemes is later than initially planned.

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	ED % Spending Under 4 Hours in Department	NBT	Jan-26	60.3%	71.4%	65.4%	F-	C	Escalation Summary
		UHBW	Jan-26	66.3%	72.3%	66.6%	F	C	Escalation Summary
Responsive	ED % Spending Over 12 Hours in Department	NBT	Jan-26	11.0%	2.0%	8.9%	F-	C	Escalation Summary
		UHBW	Jan-26	8.7%	2.0%	6.0%	F	C	Escalation Summary
Responsive	Bristol Children's Hospital ED - Percentage Within 4 Hours								
		UHBW	Jan-26	79.3%	No Target	73.6%	N/A	C	Note Performance*
Responsive	ED 12 Hour Trolley Waits (from DTA)	NBT	Jan-26	564	0	430	F-	C	Escalation Summary
		UHBW	Jan-26	793	0	496	F-	H	Escalation Summary
Responsive	Ambulance Handover Delays (under 15 minutes)	NBT	Jan-26	20.0%	65.0%	31.0%	F-	C	Escalation Summary
		UHBW	Jan-26	30.5%	65.0%	42.0%	F-	C	Escalation Summary
Responsive	Average Ambulance Handover Time	NBT	Jan-26	36.2	45.0	28.3	P	L	Note Performance
		UHBW	Jan-26	25.2	45.0	20.3	P	L	Note Performance
Responsive	% Ambulance Handovers over 45 minutes	NBT	Jan-26	24.9%	0.0%	18.5%	F-	C	Escalation Summary
		UHBW	Jan-26	11.2%	0.0%	5.1%	F-	L	Escalation Summary
Responsive	No Criteria to Reside	NBT	Jan-26	22.4%	15.0%	21.1%	F-	L	Escalation Summary
		UHBW	Jan-26	24.4%	15.0%	21.2%	F-	H	Escalation Summary
Responsive	RTT Percentage Over 52 Weeks	NBT	Jan-26	0.2%	1.0%	0.2%	P	L	Note Performance
		UHBW	Jan-26	1.0%	1.0%	1.3%	F-	L	Escalation Summary
Responsive	RTT Ongoing Pathways Under 18 Weeks	NBT	Jan-26	67.3%	72.8%	66.6%	F-	H	Escalation Summary
		UHBW	Jan-26	67.3%	67.1%	66.9%	F-	H	Escalation Summary

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

* with commentary

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	RTT First Attendance Under 18 Weeks	NBT	Jan-26	72.3%	75.0%	70.3%	F-	H	Escalation Summary
		UHBW	Jan-26	71.3%	70.8%	69.1%	F-	H	Escalation Summary
Responsive	Diagnostics % Over 6 Weeks	NBT	Jan-26	2.6%	1.0%	1.5%	?	C	Escalation Summary
		UHBW	Jan-26	13.0%	6.8%	11.4%	F-	L	Escalation Summary
Responsive	Cancer 28 Day Faster Diagnosis	NBT	Dec-25	72.2%	79.7%	78.4%	F	C	Escalation Summary
		UHBW	Dec-25	79.3%	79.0%	77.2%	?	C	Escalation Summary
Responsive	Cancer 31 Day Decision-To-Treat to Start of Treatment	NBT	Dec-25	87.5%	88.1%	85.2%	?	C	Escalation Summary
		UHBW	Dec-25	96.6%	96.0%	94.7%	?	C	Escalation Summary
Responsive	Cancer 62 Day Referral to Treatment	NBT	Dec-25	66.2%	71.9%	66.8%	F	C	Escalation Summary
		UHBW	Dec-25	76.7%	73.2%	77.4%	P	C	Note Performance
Responsive	Last Minute Cancelled Operations	NBT	Jan-26	0.7%	0.8%	0.7%	P	C	Note Performance
		UHBW	Jan-26	2.1%	1.5%	2.1%	F	C	Escalation Summary
Responsive	% to Stroke Unit within 4 Hours	NBT	Dec-25	48.4%	90.0%	56.2%	F-	C	Escalation Summary
Responsive	Stroke Thrombolysis within 1 hour	NBT	Dec-25	52.6%	60.0%	57.1%	?	C	Escalation Summary
Responsive	90% Time in Stroke Unit Performance validated	NBT	Dec-25	55.0%	90.0%	48.5%	F-	C	Escalation Summary
Responsive	% Seen within 14 Hours by a Stroke Consultant - Validated	NBT	Dec-25	78.7%	90.0%	73.3%	F	C	Escalation Summary

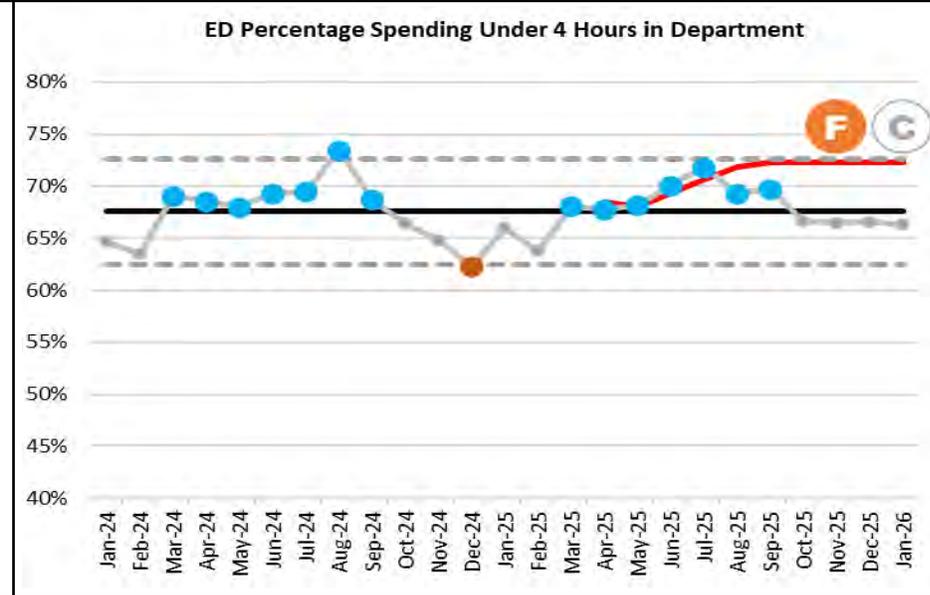
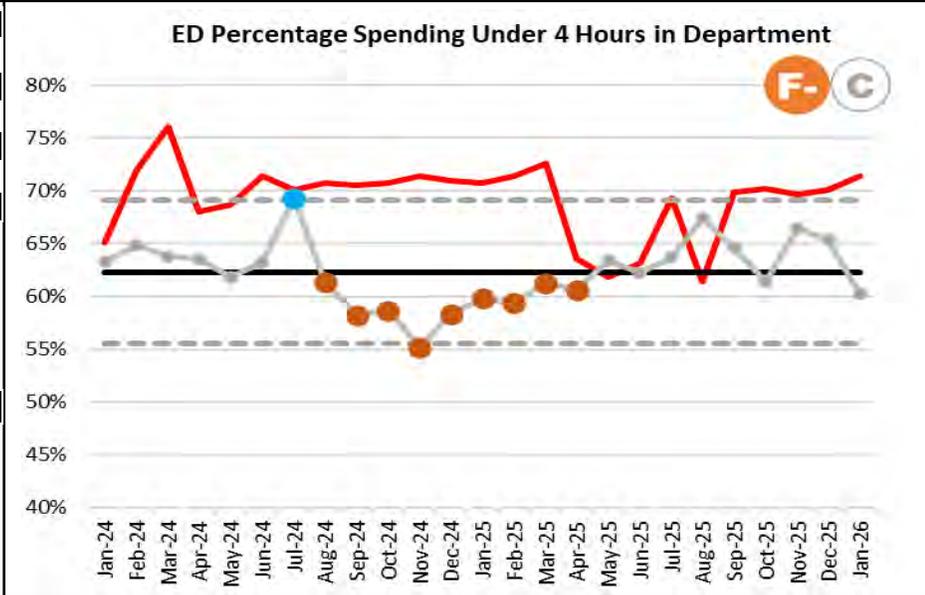
Please note - Stroke performance for December is provisional pending validation.

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

Latest Month
Jan-26
Target
71.4%
Latest Month's Position
60.3%
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).



Latest Month
Jan-26
Target
72.3%
Latest Month's Position
66.3%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.
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 under 4 hours in ED for January decreased to 60.3%. Attendances were static compared to December, but admissions increased, in particular those referred in via primary care (up by c12% month on month).

Actions being taken to improve

- Capital funding secured to facilitate **moving ED minors** (Target date: Summer 26) to an alternative onsite location. The current minors' area will be used to provide an expanded ED SDEC and ED majors area, reducing the requirement to use existing ED corridor areas.
- Clinical Operational Standards (COS) Oversight Group** (Medium term: 6 months) - GIRFT COS session held on 04/02/26. Priority areas of focus will be Standardised Referral Pathways, Diagnostic pathways, Frailty / Care Homes, all of which will reduce patient LOS across UEC pathways.
- Quarterly **Test of Change Weeks – November 2025 schemes** now embedded and include augmented ED staffing which has reduced ED LOS, pilot work with Community Emergency Medicine Service (which led to the system business case), alternative locations for each specialty to bring expected patients into (ie ED avoidance). **February 2026 ToCW** will test further changes to ED staffing, driving redirection further through new initial assessment model.

Impact on forecast
February is expected to land at c 65% four hour performance based on month to date data.

What does the data tell us?
The ED 4-hour standard across the trust remains relatively static for January at 66.3% when compared to December (66.6%), noting a deterioration in performance at Weston with a drop to 65% from 71% in December BRHC saw an improved performance at 79% compared to 74% in December, alongside a drop in overall attendances.

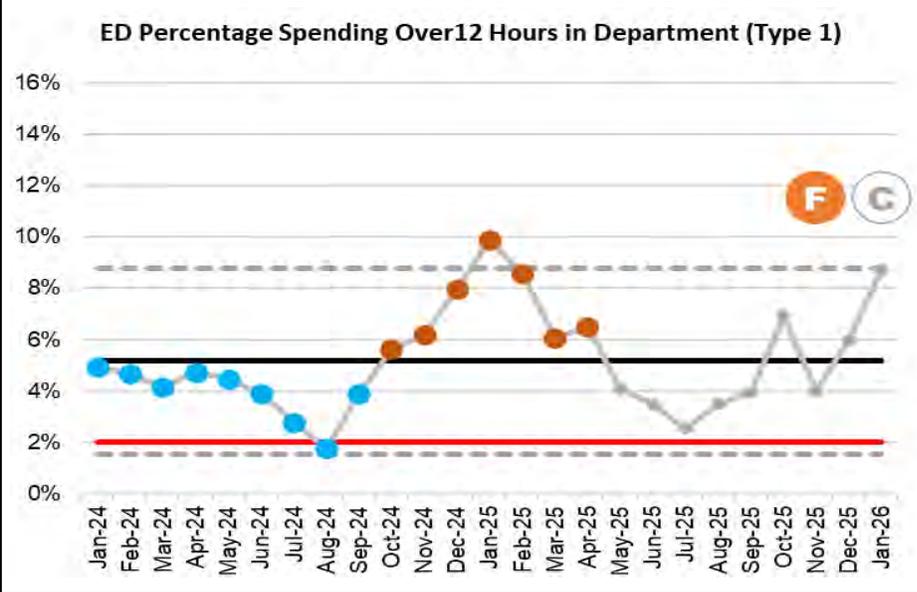
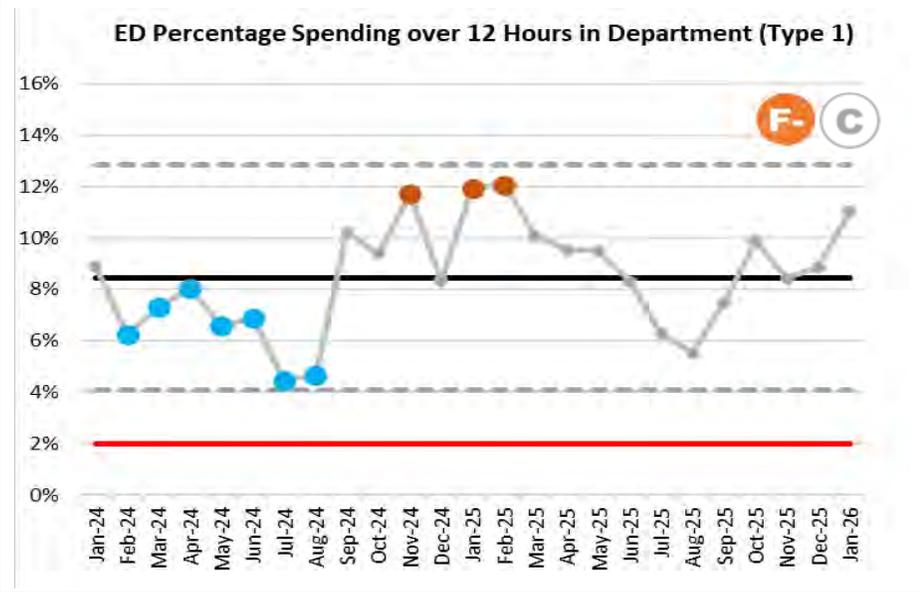
Actions being taken to improve
Ongoing mobilisation of ED improvement plans across both BRI and Weston, including workforce reconfiguration to augment and better align senior decision makers to peak times IN & OOH, in addition to optimising SDEC utilisation and front door redirection models. AMT (Acute Medical Triage) service planned within front door footprint anticipated to reduce ED crowding and ED waits.
Whole hospital review of ED 'quality standards' is progressing, with a specific focus on 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 aim to improve the Trust position; c68% in February
The End of Year Target for this measure is 72.3% (78% inclusive of Sirona type-3 uplift)

Responsiveness

UEC – Emergency Department Metrics

Latest Month
Jan-26
Target
2.0%
Latest Month's Position
11.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Latest Month
Jan-26
Target
2.0%
Latest Month's Position
8.7%
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 increased to 11% in January.

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

- 1) Improvements made during November test of change week have been sustained, including DTA flow out of ED at 8am and the Medicine weekend discharge approach.
- 2) For February's test of change week (w/c 23 February) schemes will focus on earlier discharge summary preparation in COTE, site wide use of the discharge lounge without TTAs, review of cleaning requests to reduce demand / increase flow.
- 3) Every Minute Matters approach – working to improve key internal flow and discharge metrics, including use of the discharge lounge, discharges before 10am and the proportion of weekend discharges.

Impact on forecast
Whilst February remains a challenging month, the teams are working to reduce 12 hour impacts, with month to date tracking at <10%.

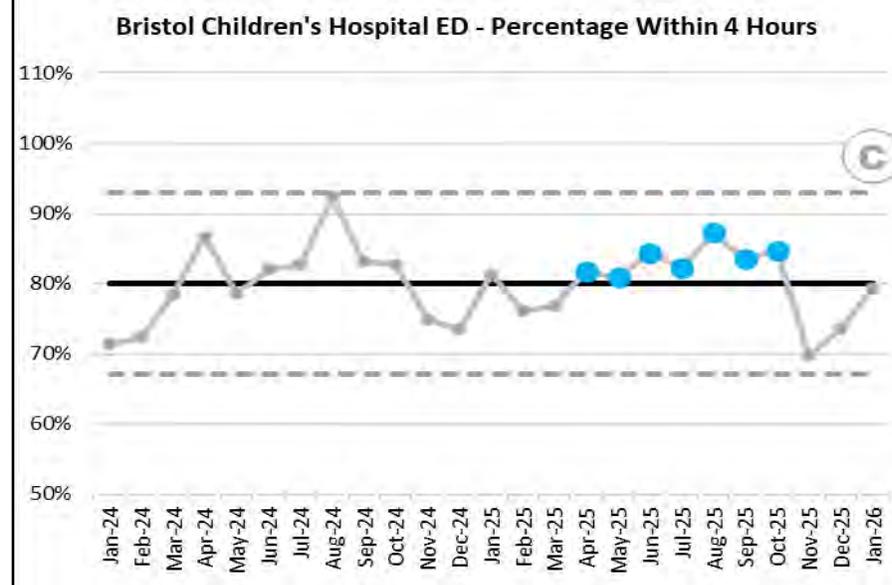
What does the data tell us?
The percentage of patients spending over 12 hours in ED for the month of January (8.7%) deteriorated compared to December (6%) but still below the national threshold of 10%. A notable increase occurred at the BRI (from 9.6% in December to 12.9% in January) with BRI admitted patients waiting over 12 hrs increasing from 24% in December to 33% in January. Weston also saw an increase from 5.6% to 9.8% with admitted 12 hr waits up from 13% to 22%. The number of patients with No Criteria to Reside increased across both sites impacting on overall flow and timely access to beds for patients in ED.

Actions being taken to improve
Note previous slide.
Implementation of inter-professional standards and accompanying dashboard due in March in support of cross-divisional review of time to specialty assessments in ED.
BRI consultant recruitment underway with 2 posts filled and further interviews in the next couple of months – will enable improved support into ED in Out of hours periods.

Impact on forecast
January performance has been particularly challenging with a critical incident declared at the beginning of the month alongside ongoing ward closures at the BRI and demand for IPC cubicles across both sites. Actions have been put in place to mitigate the ward closures, but the position may remain challenging throughout February. Forecast for February is c6%.

Responsive

UEC – Emergency Department Metrics



Latest Month
Jan-26
Target
No Target
Latest Month's Position
79.3%
Performance / Assurance
Common Cause (natural/expected) variation where up is improvement.
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?

4-hour performance improved in January (79%) when compared to December (73.6%)

The Trust saw a total of 4,195 attendances in January, which is significantly less than 4,765 in December but slightly higher when compared year on year to the 3,946 attendances in January 2025

There were 16x 12-hour breaches in January which is a reduction on the 45 reported in December

Actions being taken to improve

4-hour improvement plan continues to be worked through within the department, working towards delivery of 95% target for March 2027, with clear workstreams identified

Review of admitted patient pathway due to start, aiming to identify areas for improvement by reviewing whole patient pathway, from ED through to ward to discharge home

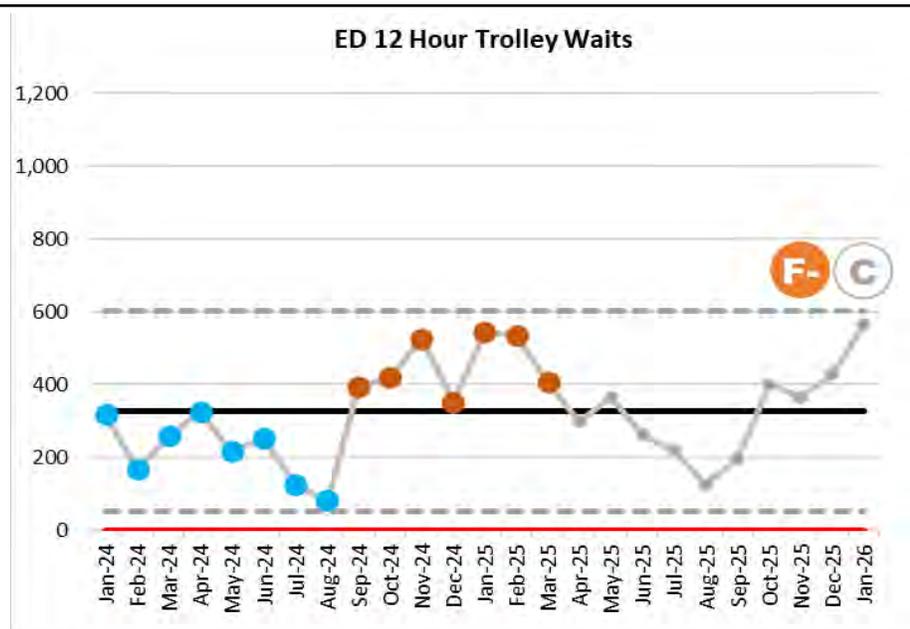
12-hour breach review meeting is ongoing

Posters shared with speciality teams regarding support needed to improve 4-hour position as a hospital

Responsiveness

UEC – Emergency Department Metrics

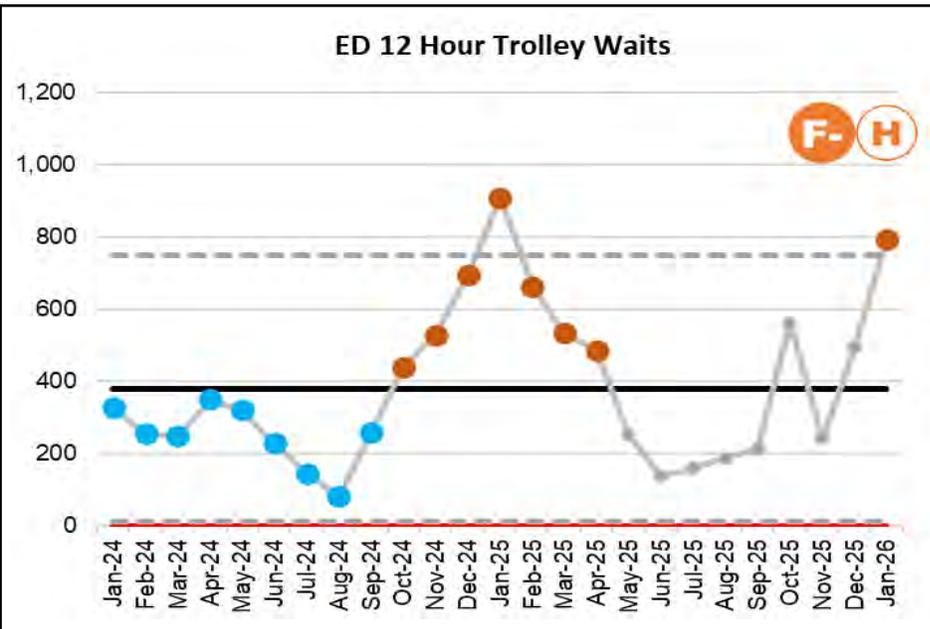
Latest Month	Jan-26
Target	0
Latest Month's Position	564
Performance / Assurance	Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration
Trust Level Risk	1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



What does the data tell us?
The number of 12 hour trolley waits increased compared to the previous month to 564.

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

Impact on forecast
See previous slide.



What does the data tell us?
The number of 12 Hour trolley waits increased throughout January (793) compared to December (496)

Actions being taken to improve
Note actions from previous two slides

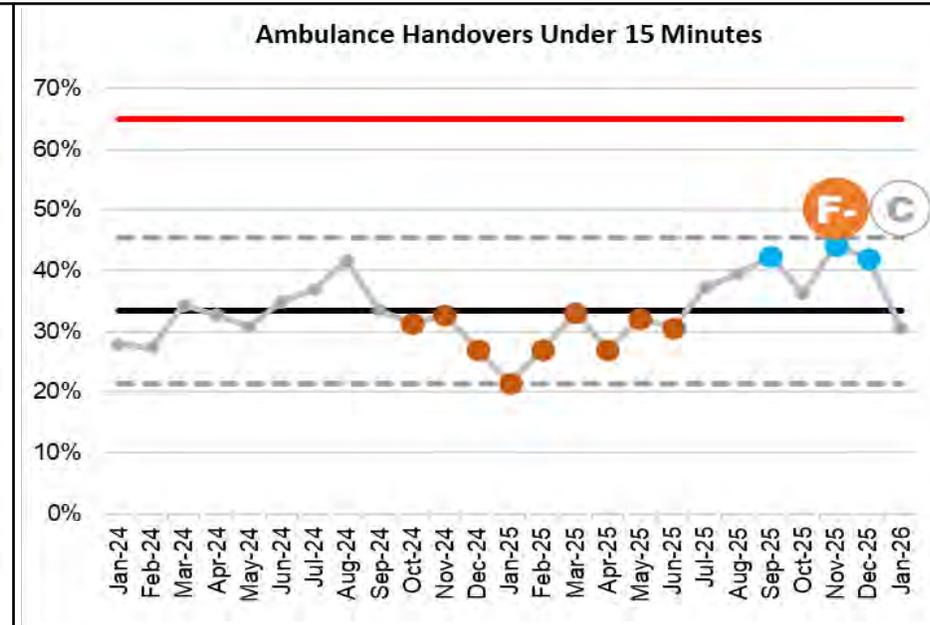
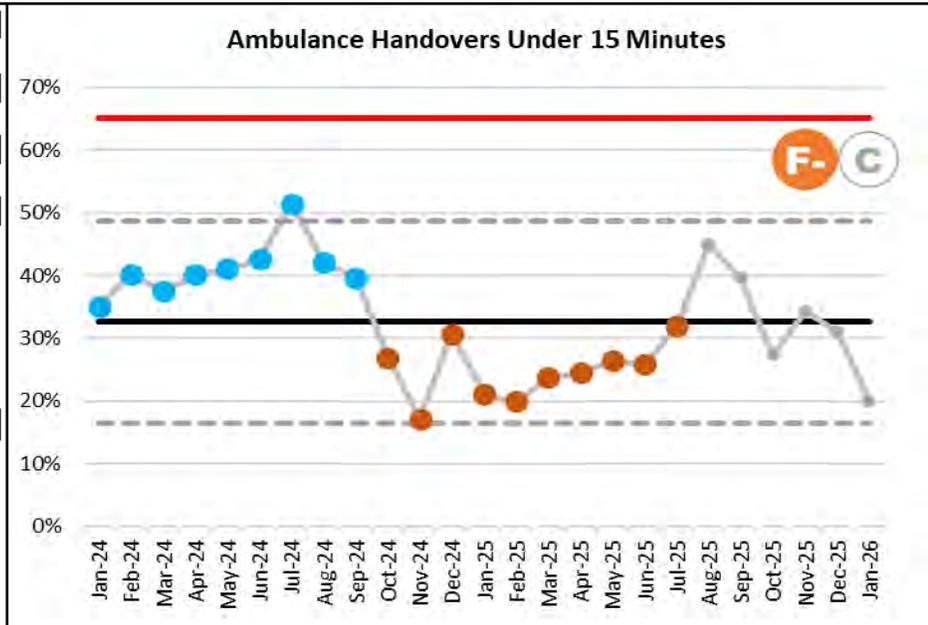
Impact on forecast
Along with improvement work noted against the 4-hour and 12-hour standard, it is anticipated that the number of 12-hour trolley waits should improve during February

Latest Month	Jan-26
Target	0
Latest Month's Position	793
Performance / Assurance	Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.
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)

Responsiveness

UEC – Ambulance Handover Delays

Latest Month
Jan-26
Target
65.0%
Latest Month's Position
20.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Latest Month
Jan-26
Target
65.0%
Latest Month's Position
30.5%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

What does the data tell us?

The proportion of handovers completed within 15 minutes has decreased to 20%.

Actions being taken to improve

- 1) Work with ICB, SWASFT and BrisDoc Severnside on validation of Category 3 and Category 4 ambulance dispositions – new group to review process and impacts and assess benefits of working towards validation of Category 2 dispositions also.
- 2) Support to ICB business case for seven-day Community Emergency Medicine Service provision which will reduce conveyances.

Impact on forecast

Based on month to date work in February a return to December level performance is expected for February 2026.

What does the data tell us?

Ambulance handovers within 15 mins show a deterioration in January at 30.5% compared to December at 42% but still a marked improvement compared to the last year. Notable decrease observed at BRI from 37.1% in December to 24.8% in January, despite a slight drop in conveyances with a very similar change observed at Weston. This correlates with reduced flow as described within 4hr and 12 performance updates.

Actions being taken to improve

Implementation of the updated SWAST Timely Handover Policy in response to the new NHSE KPI: zero tolerance to handovers over 45 mins - has resulted in a collective response within UHBW to embed additional actions and strengthen existing processes in support of timely ambulance handovers. An updated trust-wide escalation policy is due to be cascaded in March with clearly defined steps for the use of and de-escalation out of all 'corridor' spaces.

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

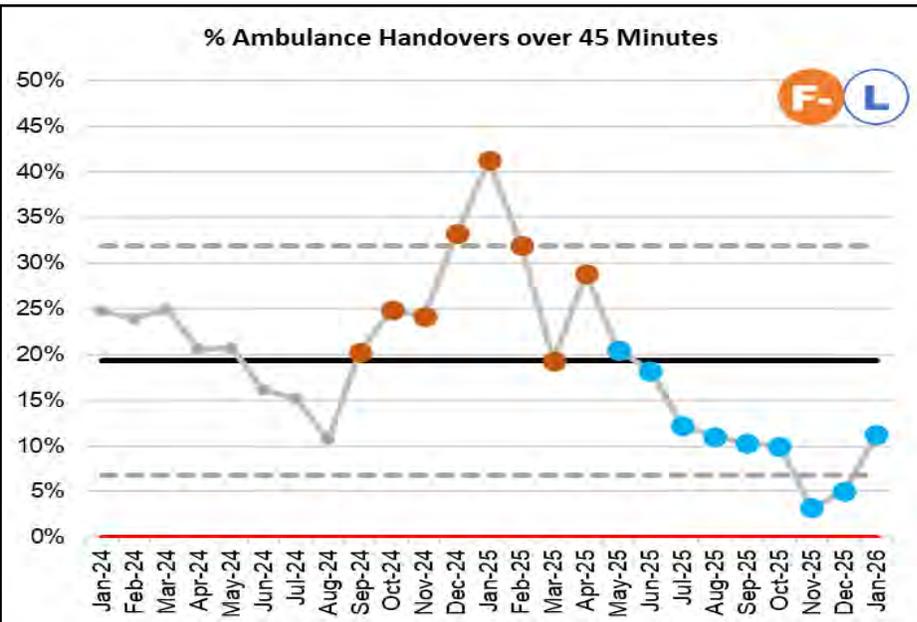
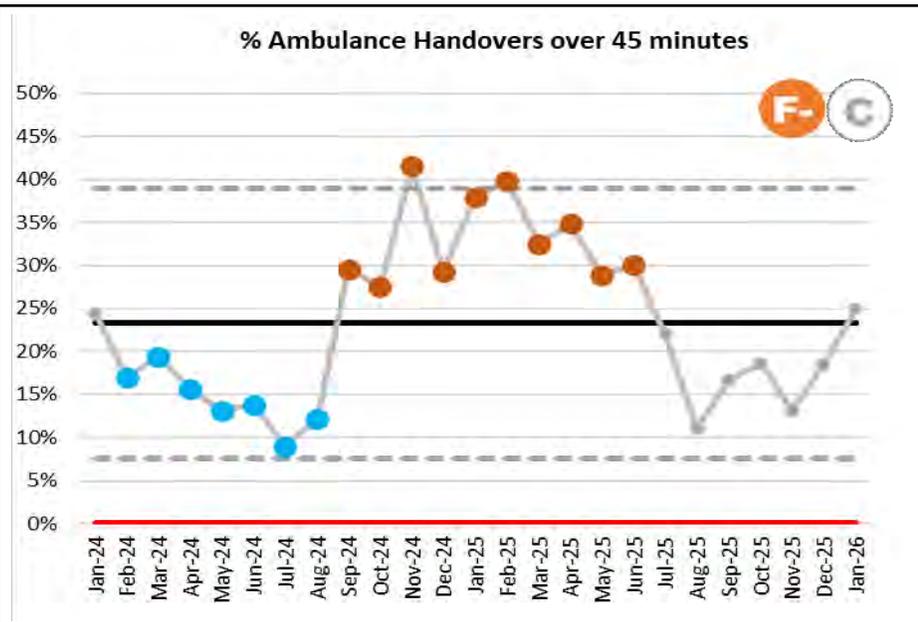
Impact on forecast

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

Responsiveness

UEC – Ambulance Handover Delays

Latest Month
Jan-26
Target
0.0%
Latest Month's Position
25.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration or greater than upper limit down is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Latest Month
Jan-26
Target
0%
Latest Month's Position
11.2%
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?
The proportion of handovers over 45 minutes increased in January 2026 to 25% .

Actions being taken to improve
The system Rapid Emergency Assessment Framework (REAF) group met and reviewed the impacts of the SWASFT Timely Handover Plan at a specially convened session in January. Learning and recommendations from that session are being compiled prior to a follow up review with acute clinical and operational staff. It is anticipated that an action plan will be developed and overseen via the BNSSG UEC Operational Delivery Group.

Impact on forecast
Additional demand management strategies are being deployed by partners to support a call before convey approach. Is successful these options should open up alternative pathways for SWASFT clinicians to use.

What does the data tell us?
Ambulance handover times within 45 minutes have deteriorated throughout January at 11.2% compared to 5.1% in December. Notable increase observed at BRI from 6.4% in December to 14.6% in January.

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

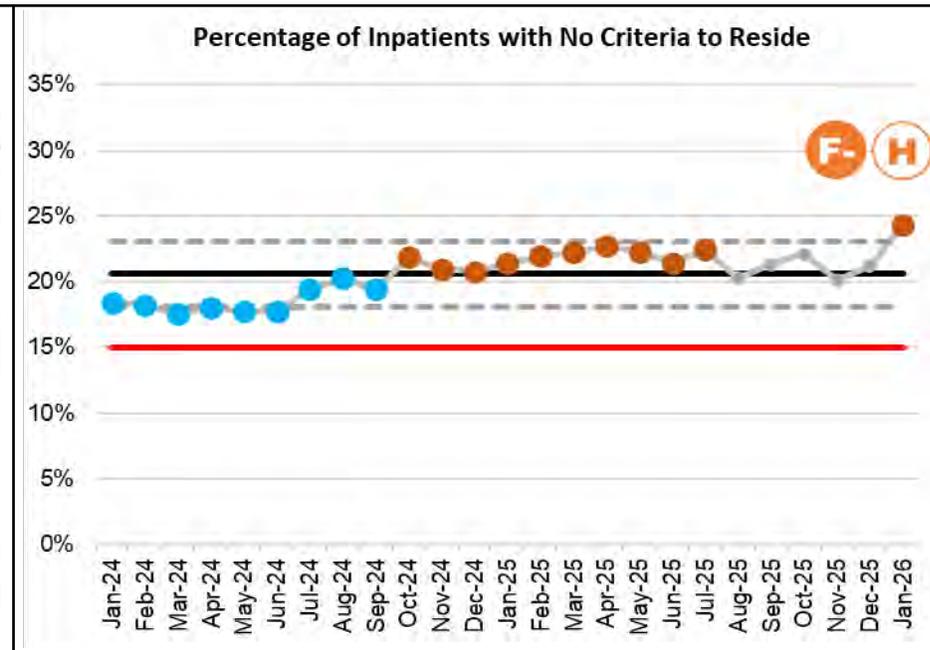
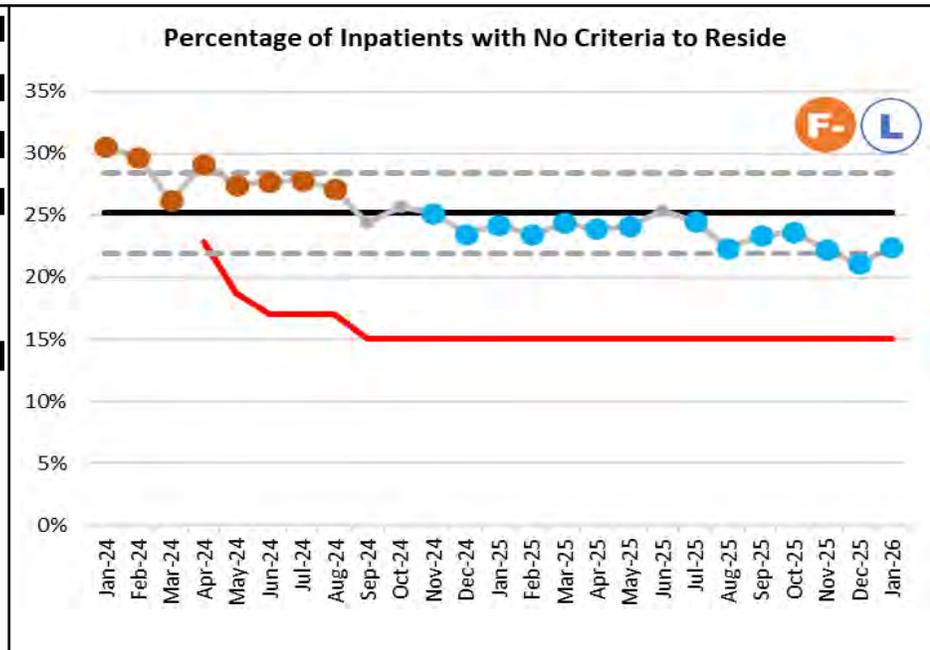
See previous slide for expansion of CEMs service.

Impact on forecast
It is anticipated that the ongoing improvement work will continue to contribute to an improved position in the forthcoming months, though flow out of ED into the BRI bed base will remain challenging due to the closure of 2 inpatient wards. Current February forecast c4%

Responsiveness

UEC – No Criteria To Reside

Latest Month	Jan-26
Target	15.0%
Latest Month's Position	22.4%
Performance / Assurance	Special Cause Improving Variation Low, where down is improvement but target is less than lower limit
Trust Level Risk	Risk 2182 - patients who are 'discharge ready' who remain in hospital beds with 'No Criteria to Reside (NC2R)' will be at greater risk of deconditioning, hospital acquired infections, falls and delirium which could lead to varying levels of harm/patient outcomes (12).



Latest Month	Jan-26
Target	15.0%
Latest Month's Position	24.4%
Performance / Assurance	Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.
Corporate Risk	Corporate Risk 423 - Risk that demand for inpatient admission exceeds available bed capacity (25). Corporate Risk 8252 - Patients with no criteria to reside continue to remain in hospital beds (16)

What does the data tell us?
No Criteria to Reside (NCTR) increased to 22.4% in January and remains above the BNSSG system target of 15%.

- Actions being taken to improve**
- Partnership work with ICB CNO team has resulted in a revised approach to Fast Track assessment and referral with a dedicated NBT team due to go live Apr-26. Estimated to reduce fast track LOS by c.5 days.
 - Home first approach taken in the Transfer of Care Hub (Ongoing) to reduce delays and support patient discharge to own home wherever possible.
 - NBT strategic review of Elgar Model (Medium term: 3-6 months), with first workshop in early Mar-26. This work will feed into the system review of inpatient intermediate care being led by Sirona CEO.
 - System redesign of home-based intermediate care (Medium term: 3-6 months), including detailed demand and capacity reviews at LA level to ensure right service first time on time for people leaving acute care.

Impact on forecast
System NCTR target: 15% NBT remains unmet, though the position is expected to improve marginally in February.

What does the data tell us?
UHBW No Criteria to Reside (NCTR) patient waiting list increased in January to 24.4% (217 patients) vs 21.2% (180 patients) in December.

BRI: Jan 21.5% (117pts) vs Dec 17.6% (96 pts) ; Weston: Jan 34% (100 pts) vs Dec 31% (84 pts).
Inadequate community capacity (beds & support services) available to meet high proportion of complex patients requiring specialist care, particular issues in North Som (all pathways) and P1 across all LA's.

- Actions being taken to improve**
System focus on development of improvement plans to deliver the 15% NCTR reduction continues:
- ICB Demand and capacity modelling undertaken across community beds.
 - P1: LAs and Sirona to reduce and improve the timeliness of handoffs in community P1. P1 Trial with Sirona giving dates up to 14 days in advance and exploiting opportunities for Early Supported Discharge
 - P2 Improvement work: GIRFT review by external assessor with internal clinical representatives.
 - P3: System review of patient choice in particular to be applied to Non D2A patients reducing overall LoS. UHBW linking in with Chelsea and Westminster Trust as per DAG meeting.
- Home First Team improvement projects:
•Continuing Health Care Fast Track - a reduction of average 4.9 days and MCA and BID- reduction of 1 day since Aug 25
•Early Supported Discharges enables patients to leave hospital before their package of care start date with family support: 188 patients left hospital early saving 465 bed days in January (highest number since 2022).
- Impact on forecast:** System NCTR target: 15% (103) UHBW remains unmet (BRI 53; WGH 50).

Responsiveness

Planned Care – Referral to Treatment (RTT)

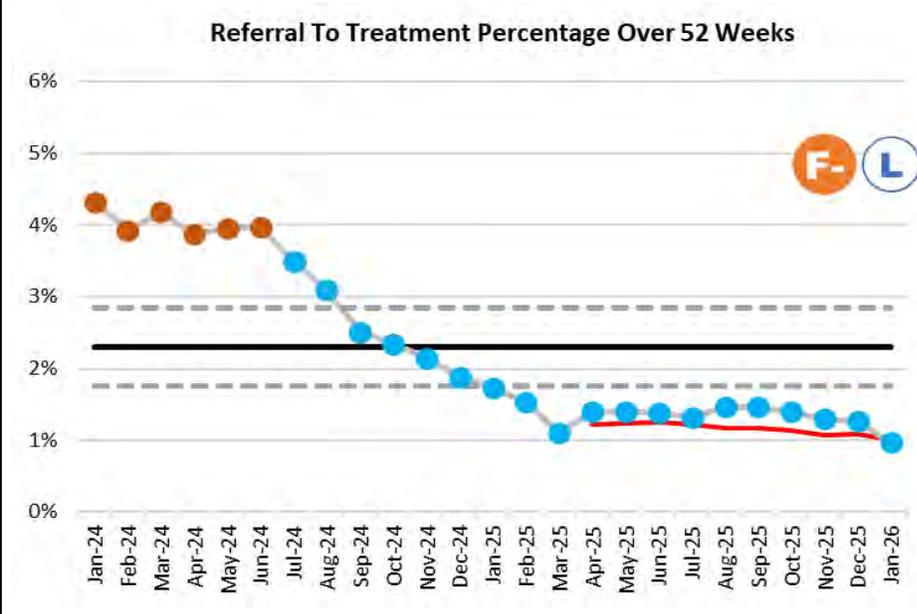
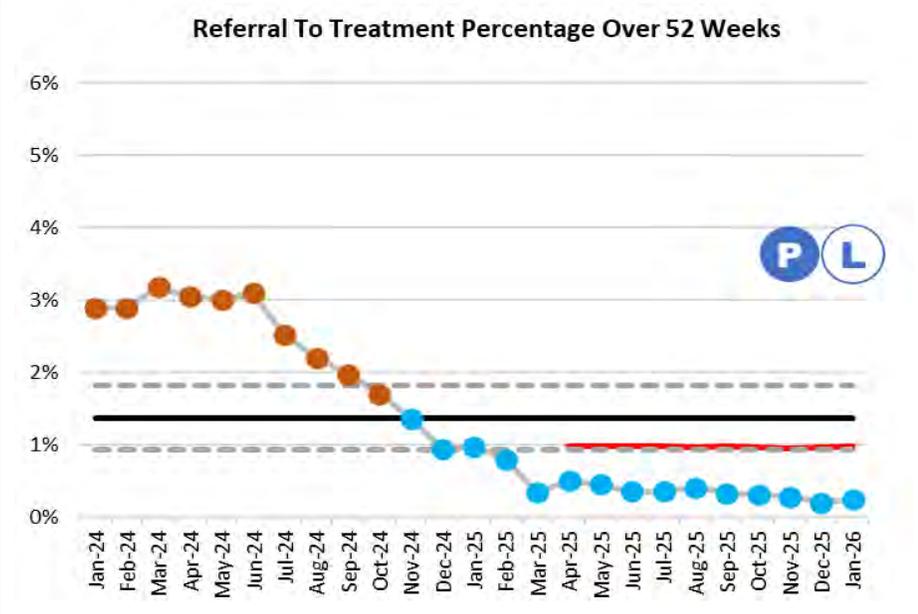
Latest Month
Jan-26

Target
1.0%

Latest Month's Position
0.2%

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
Jan-26

Target
1.0%

Latest Month's Position
1.0%

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?
486 patients were waiting for 52 weeks or more at the end of January (636 in December), against the total waiting list size of 50,188 which achieves the trajectory set for January 2026 of 1.1% and has met the NHSE March 2026 ambition of <1%. The overall waiting list size also reduced by 213 to 50,188 during January, against the Trust trajectory for January of 49,516

At the end of January there was one paediatric dentistry patient waiting greater than 65 weeks. This patient has since been seen and treatment commenced in early February.

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, 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.

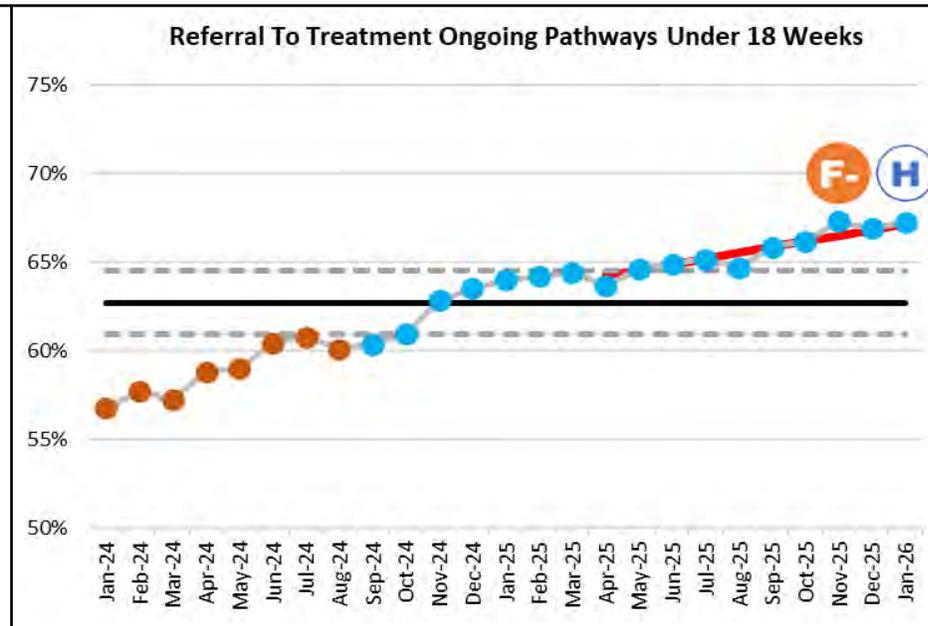
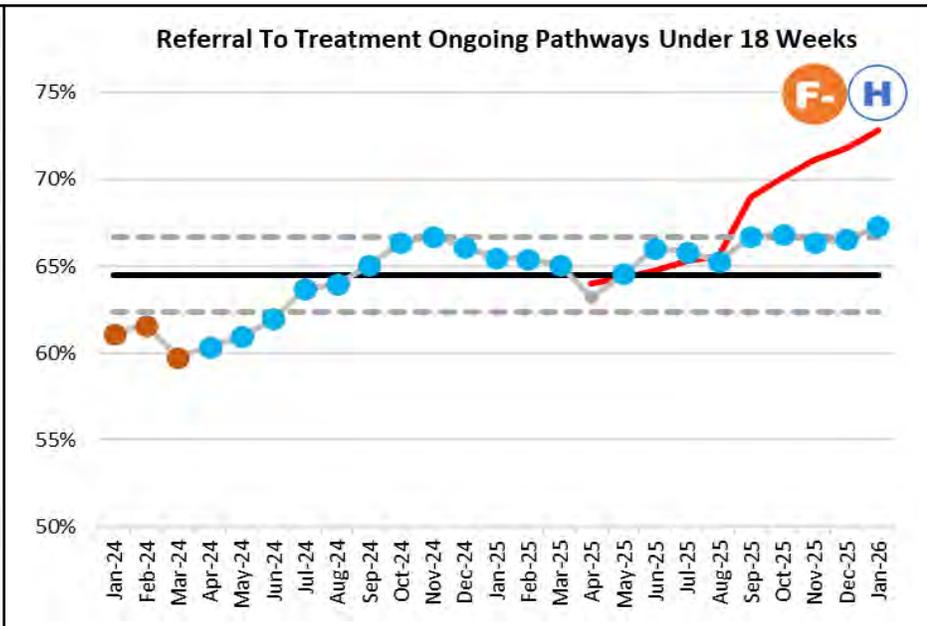
Recovery plans continue to be monitored in specialties with more challenged waiting times.

Impact on forecast
The End of Year Target for this measure is 0.94%

Responsiveness

Planned Care – Referral to Treatment (RTT)

Latest Month
Jan-26
Target
72.8%
Latest Month's Position
67.3%
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
Jan-26
Target
67.1%
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 January, the percentage of patients waiting less than 18 weeks was 67.3%, performing under the Trust trajectory of 72.8% set as part of the Trust operational planning submission (target of 71.8% by March 2026). This underperformance was partly due to the phased activity plan related to the BSC not meeting trajectory.

Actions being taken to improve
The 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. 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
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.

What does the data tell us?
At the end of January, the number of patient waiting less than 18-weeks is 33,756 (67.3%) , exceeding the Operational Planning trajectory target of 67.1%.

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 and RTT sprints, where an additional validation exercise focusses on patients across a broad range of specialties and additional outpatient and day case activity to reduce our waiting list size. Additional patient contacts are also being made via DrDoctor to identify whether patients no longer require to be seen (self-limiting conditions)

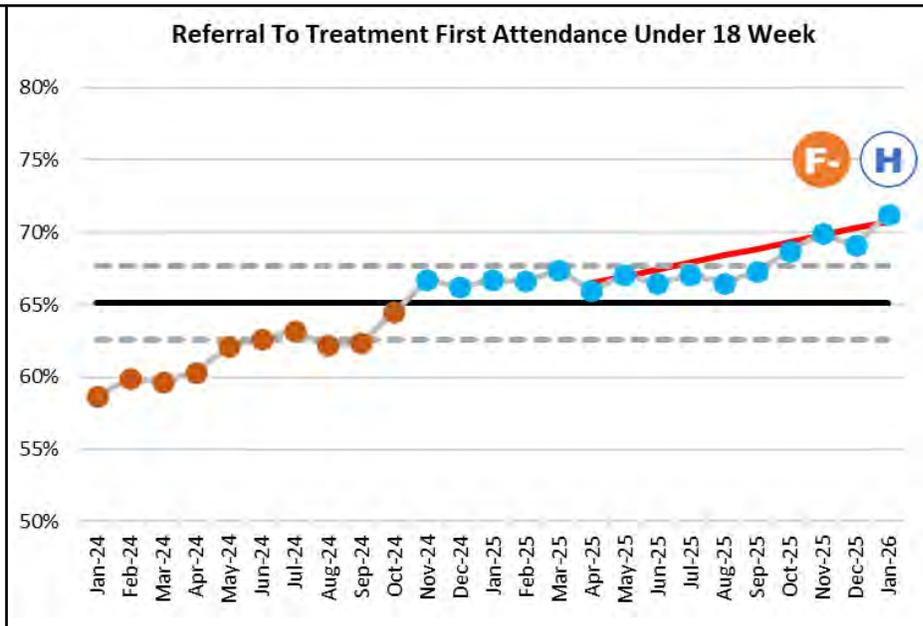
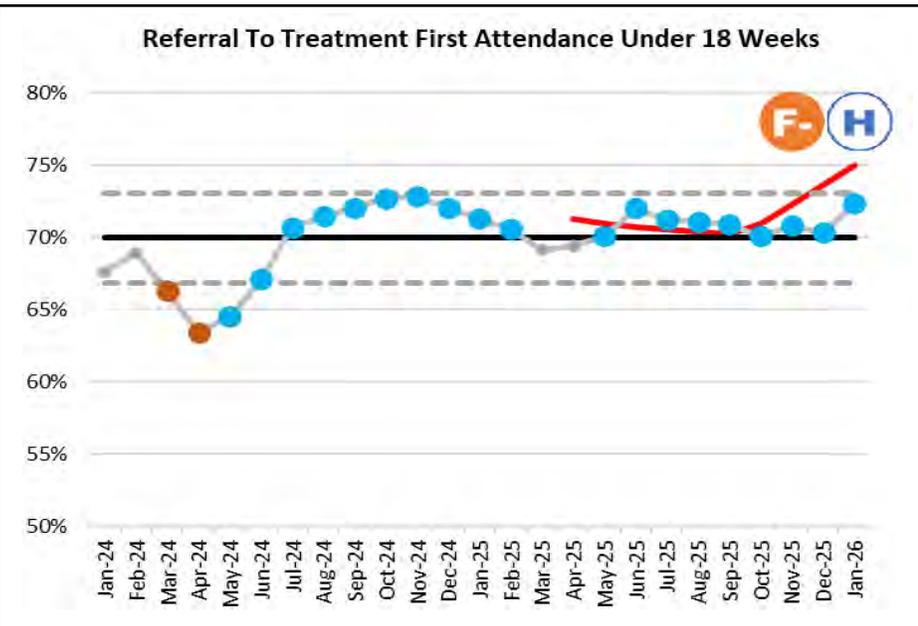
Impact on forecast
We continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition of the end of year target

The End of Year Target for this measure is 67.8%

Responsiveness

Planned Care – Referral to Treatment (RTT)

Latest Month
Jan-26
Target
75.0%
Latest Month's Position
72.3%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit
Corporate Risk
No Trust Level Risk



Latest Month
Jan-26
Target
70.8%
Latest Month's Position
71.3%
Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.
Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

What does the data tell us?
At the end of January, the percentage of patients waiting less than 18 weeks for their first appointment was 72.3%, performing under the Trust trajectory of 75% set as part of the Trust operational planning submission.

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. 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
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.

What does the data tell us?
At the end of January, the percentage of patients waiting less than 18 weeks for their first appointment is 71.3% against the target of 70.8% set for January 2026 as part of the Trust Operational Planning submission.

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

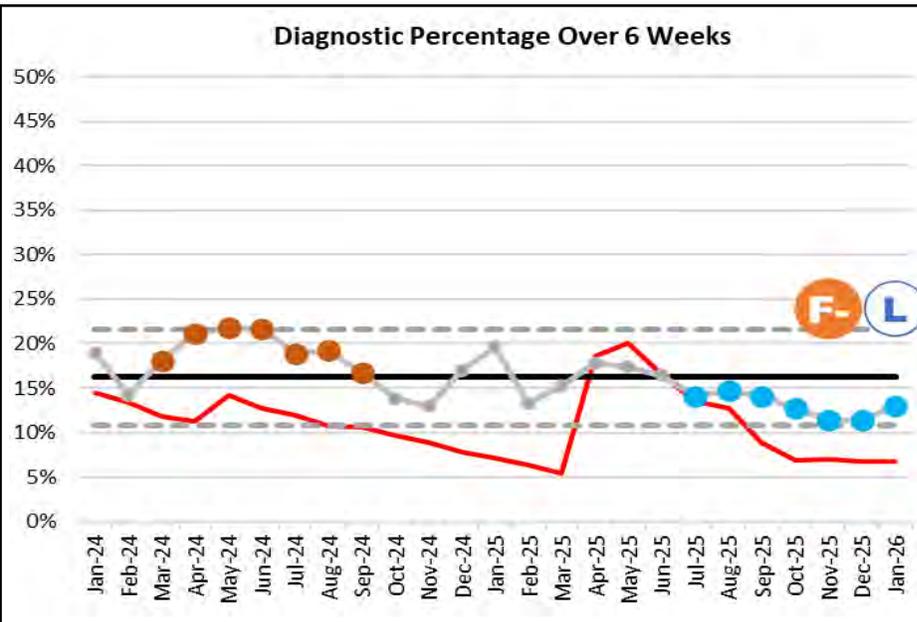
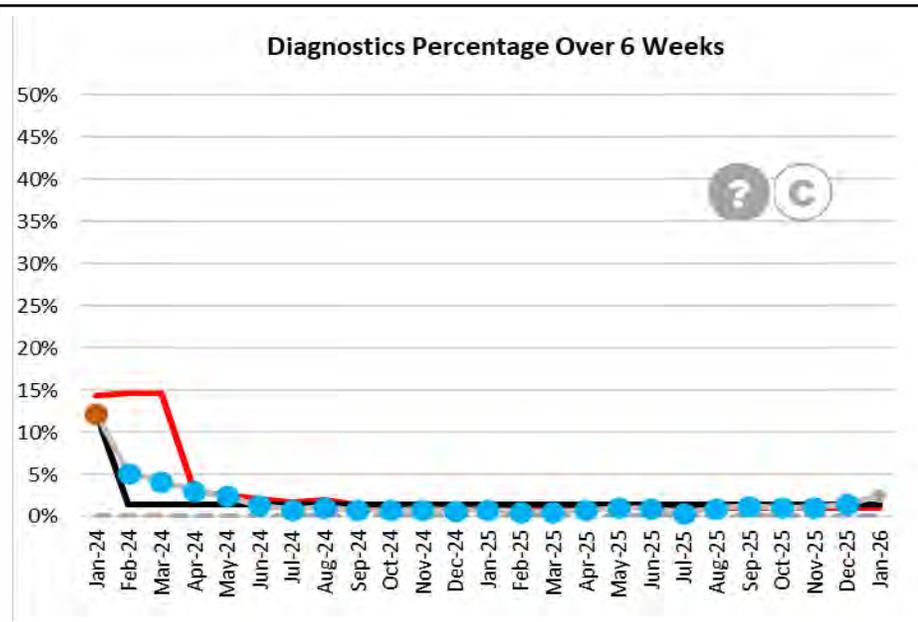
Impact on forecast
We continue to closely monitor the patients under 18-weeks and focused booking of first OPA earlier in the pathway to achieve the ambition of the end of year target

The End of Year Target for this measure is 71.7%

Responsiveness

Planned Care – Diagnostics

Latest Month
Jan-26
Target
1.0%
Latest Month's Position
2.6%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk



Latest Month
Jan-26
Target
6.8%
Latest Month's Position
13.0%
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.
Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

What does the data tell us?
In January, the proportion of patients waiting over six weeks against the DM01 standard deteriorated to 2.6%, (1.5% in December). DEXA has been the main contributor with ongoing challenges in the service, but Echocardiography also saw a deterioration in January.

Actions being taken to improve
DEXA - scheduling additional weekend clinics, consultant triage according to referral criteria to manage demand, and Medinet Insourcing.
Echocardiography – rota review to maximise core capacity, support from UHBW for additional staff capacity for clinics and additional agency support following a shortfall in agency across the festive period.

Impact on forecast
Expecting an improvement in February and a return to constitutional standard by the end of March 2026. Sustained performance expected in 2026/27.

What does the data tell us?
In January, the proportion of patients waiting over six weeks against the DM01 standard was 13.0%, signifying a 1.6% increase from December. Capacity constraints internally and within the Community Diagnostic Centre (CDC) were the biggest contributors to deteriorations in endoscopy and NOUS respectively.

Actions being taken to improve

- Restoration of Adult U/S capacity in the CDC which was significantly reduced in January due to workforce shortages. In addition to CDC capacity, Medicare outsourcing continues to create additional capacity to support Adult Ultrasound recovery.
- Endoscopy unit restored to full capacity following the unit's recovery beds being repurposed for Surgical Treatment Assessment Unit (STAU) due to unavoidable bed closures. Additional weekend lists are planned to support performance recovery by year end.
- Exploring insourcing options for complex Neurophysiology tests where workforce is specialised and constrained.

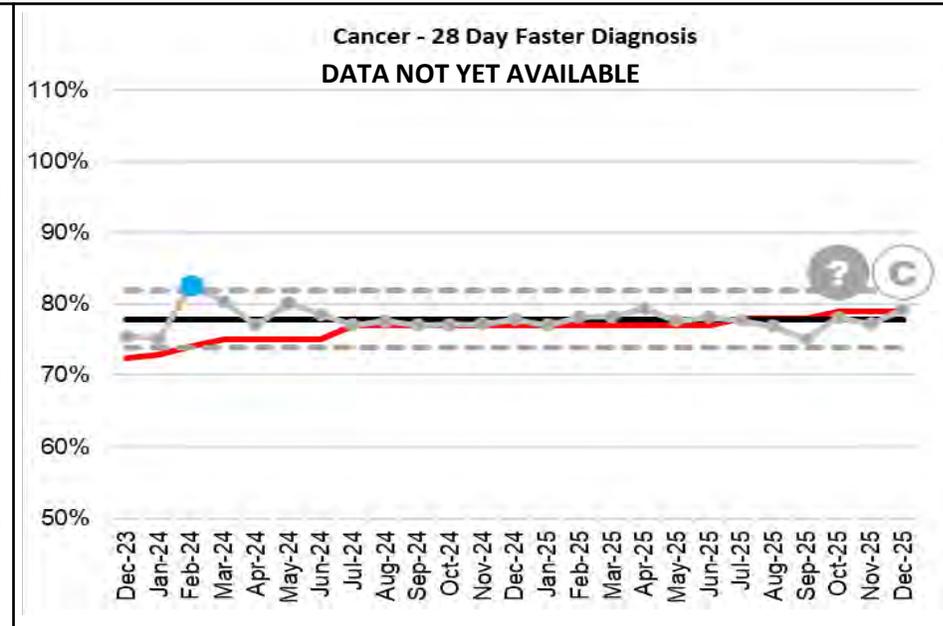
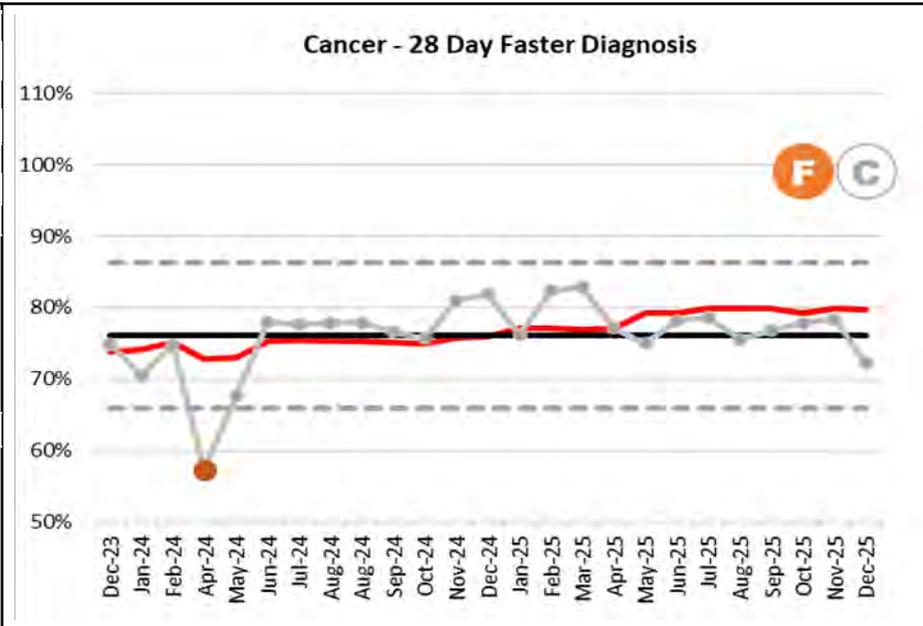
Impact on forecast
Performance recovery plans are anticipated to improve diagnostic performance, however, specialist sub-modalities where national workforce challenges preside present a constraint in fully recovering performance against trajectory in February.

The End of Year Target for this measure is 5.0%

Responsiveness

Planned Care – Cancer Metrics

Latest Month
Dec-25
Target
79.7%
Latest Month's Position
72.2%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration
Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).



Latest Month
Dec-25
Target
79.0%
Latest Month's Position
79.3%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
Risk 6782 - Risk that the 28-day faster diagnosis cancer standard is not met (20)

What does the data tell us?

28-Day performance did not meet the trajectory for December. 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

Forecasting a challenged January but returning to plan by year-end.

What do the data tell us?

Performance complied with the improvement trajectory for the month of 79%

Actions being taken to improve

Ongoing improvement being seen in head and neck following multiple vacancies being filled. Deterioration likely in January due to the impact of patient choice over the Christmas period

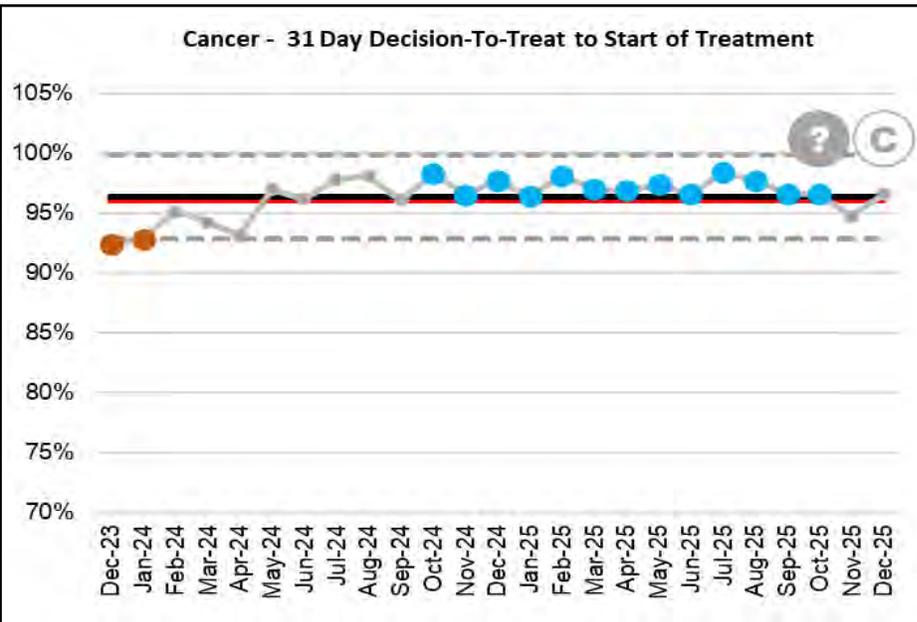
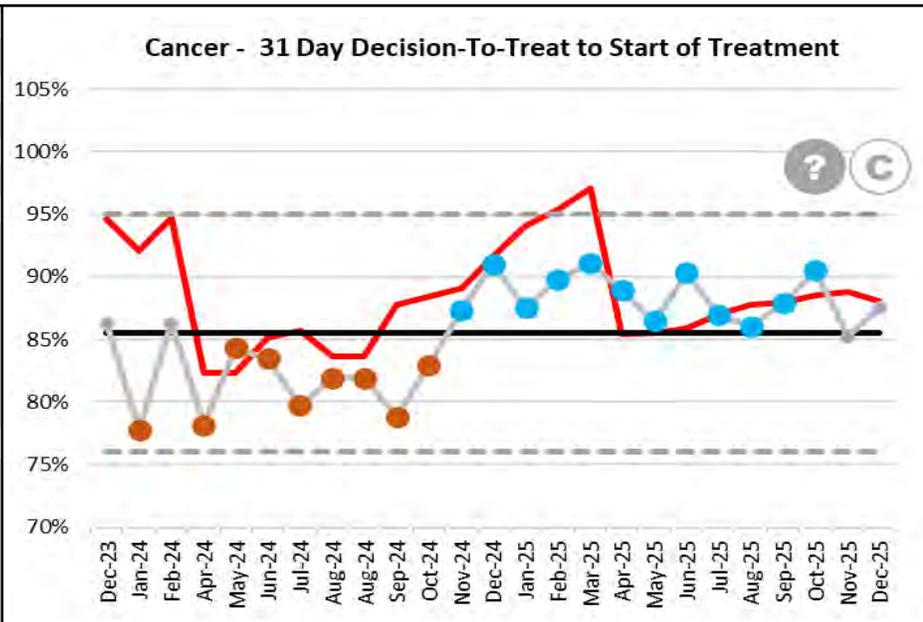
Impact on forecast

The Trust expect to reach compliance by end of March

Responsiveness

Planned Care – Cancer Metrics

Latest Month	Dec-25
Target	88.1%
Latest Month's Position	87.5%
Performance / Assurance	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk	988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).



Latest Month	Dec-25
Target	96.0%
Latest Month's Position	96.6%
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 5532 - Non-compliance with the 31 day cancer standard (12)

What does the data tell us?

31-Day performance did not meet the trajectory for December. The overall treatment volume was above plan and there were more reported breaches.

Actions being taken to improve

The delivery of recovery plans and backlog clearance across our high-volume treatment sites has contributed to delays from DTT to treatment. Key areas of focus are capacity in Skin and Urology for both first and subsequent treatments.

Impact on forecast

To return to plan by year-end.

What do the data tell us?

The Trust was compliant with the national threshold of 96%

Actions being taken to improve

Maintaining performance at the current level following drop in November, noting that January will be a challenged month

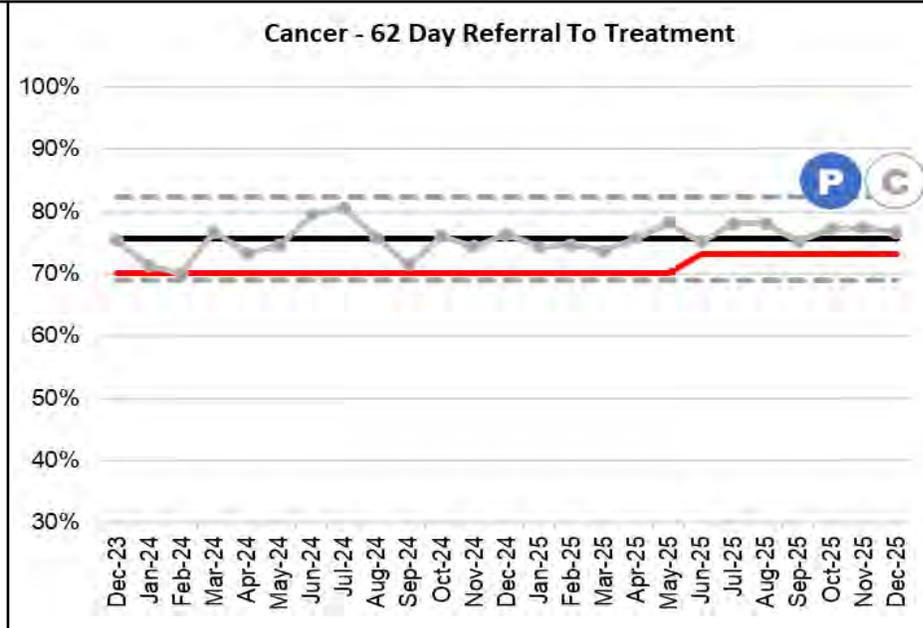
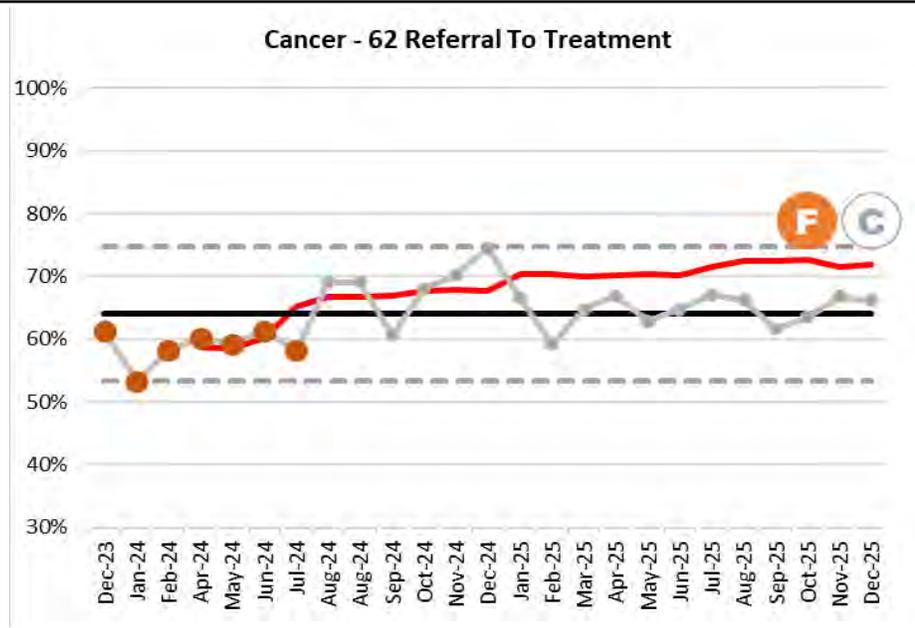
Impact on forecast

January is forecast to be non-compliant due to the impact of patient choice on the chemotherapy service following the festive period. Return to compliance expected by March 2026.

Responsiveness

Planned Care – Cancer Metrics

Latest Month
Dec-25
Target
71.9%
Latest Month's Position
66.2%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration
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
Dec-25
Target
73.2%
Latest Month's Position
76.7%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is improvement.
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 December. The overall treatment volume was above plan and there were more reported breaches. Breast and Urology makeup 74% 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.

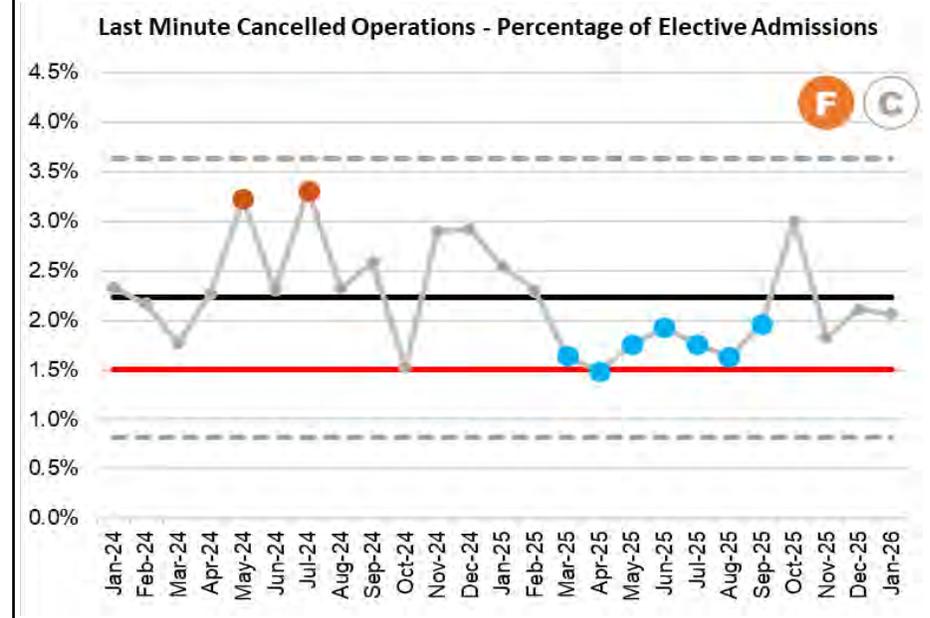
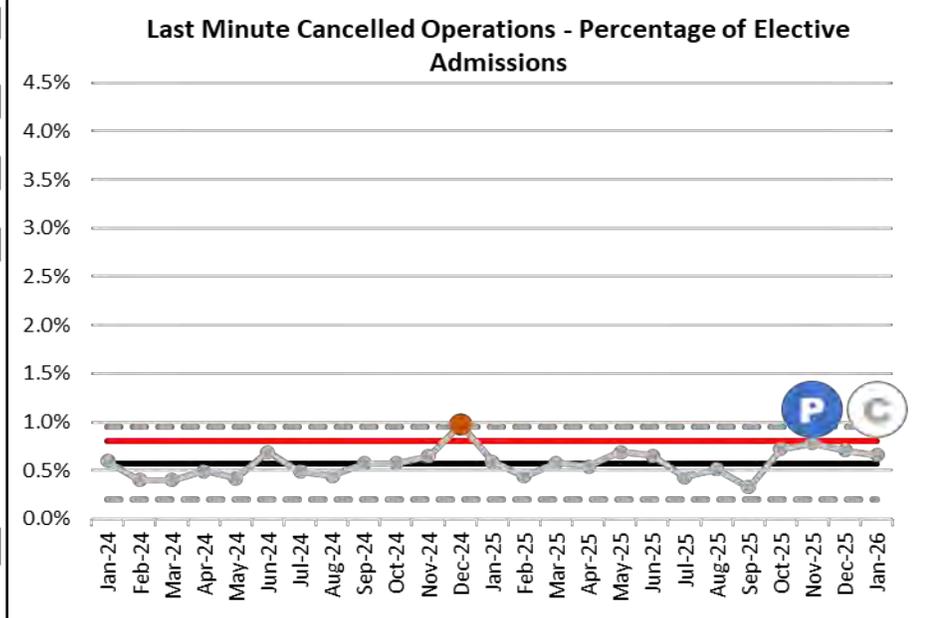
Impact on forecast
Recovery actions in place to mitigate further deterioration. Anticipating return to revised forecast as agreed with NHSE.

No narrative required as per business rules.

Responsiveness

Last Minute Cancelled Operations

Latest Month
Jan-26
Target
0.8%
Latest Month's Position
0.7%
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
Jan-26
Target
1.5%
Latest Month's Position
2.1%
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
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? The number of Last Minute Cancellations during January (175) was marginally higher than in December (168), with performance remaining at 2.1%. Cancellations within non-surgical specialities primarily related to lack of availability of ward beds and surgical cases cancelled were mostly due to available operating time and rescheduling of cases to prioritise clinically urgent patients.

Actions being taken to improve

A specific workstream is being set up by the Trust's Perioperative Improvement Programme to address both patient cancellations and session cancellations now that we have improved data and reporting. The trust dashboard is in use across divisions and monitored by the Planned Care Group with oversight and escalation via the Theatre Improvement Programme. Short notice booking remains an issue within most specialities and is a recognised risk to the improvement of last minute cancellations, however, improvements within pre assessment is expected to lead to a pool of patients for most specialities who are assessed as fit for surgery and available at short notice to fill gaps on lists

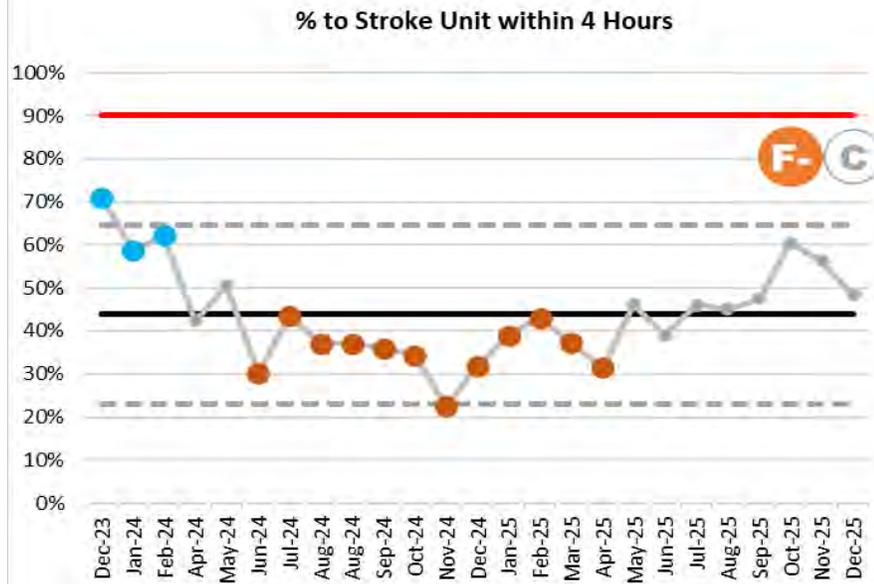
Impact on forecast

Improvement is expected during Q4 2025/26 and into 2026/27 through focussed workstreams and robust management by the Perioperative Improvement Programme

Responsiveness

Stroke Performance - NBT

Latest Month
Dec-25
Target
90.0%
Latest Month's Position
48.4%
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?

Performance on admitting patients to the stroke unit within four hours has generally improved over time, although there has been some natural month-to-month variation. Recent months showed encouraging progress, but the latest data point dips slightly. Data for December admissions are still being completed, so the final figure may change. This metric is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

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.

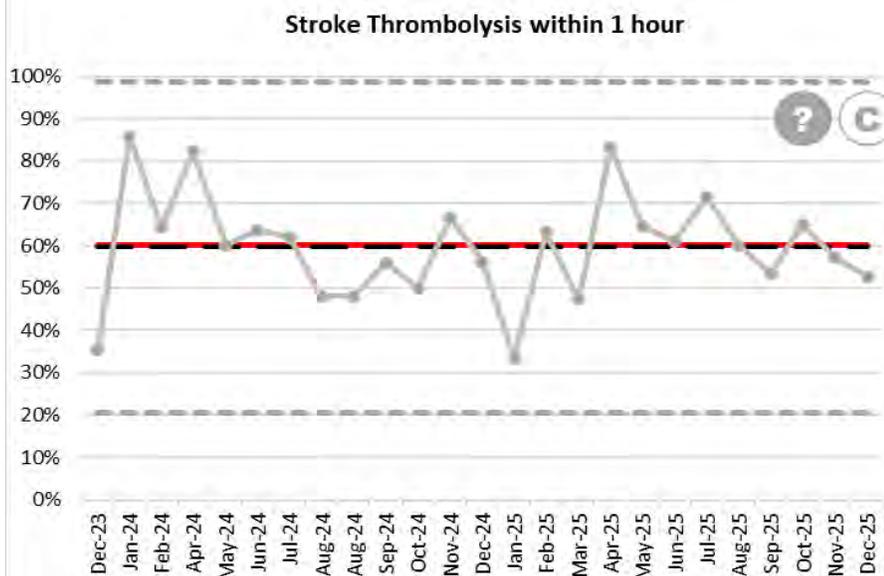
The Hot Bed SOP has gone through Stroke and NMSK clinical governance - including consulting with NBT and BRI site teams. It will now go through the OMB due to operational considerations.

Ongoing high NCTR highlights the need for input at a system level to support improvement.

Impact on Forecast

Despite some improvement, performance continues to be impacted by high bed occupancy (including NCTR patients needing SSARU) and ongoing pressure within the Emergency Department.

Latest Month
Dec-25
Target
60.0%
Latest Month's Position
52.6%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
Risk 1704 - There is a risk that patients receive sub- optimal stroke care and face potential worse clinical outcomes as a result of poor Trust performance against delivery of key national benchmarks (15).



What does the data tell us?

Thrombolysis figures are based on a small patient cohort, which can contribute to variability. We continue to provide extended window thrombolysis on a case-by-case basis, often requiring additional investigations to support safe and well-informed decision-making. Overall, our performance remains strong, with timely access to thrombolysis offering patients the potential for significantly improved outcomes. Data for December admissions are still being completed, so the final figure may change. This metric is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

Actions being taken to improve

A bi-weekly reperfusion meeting is now well established and continues to drive ongoing improvement. Our strengthened governance and review processes allow us to spot any early decline in performance and understand the cause, while routine monitoring of balancing measures ensures changes do not create unintended harm. Timelier access to MRI is required to support decision-making for extended thrombolysis. Risk to be added to risk register (MRI access) including mitigating actions.

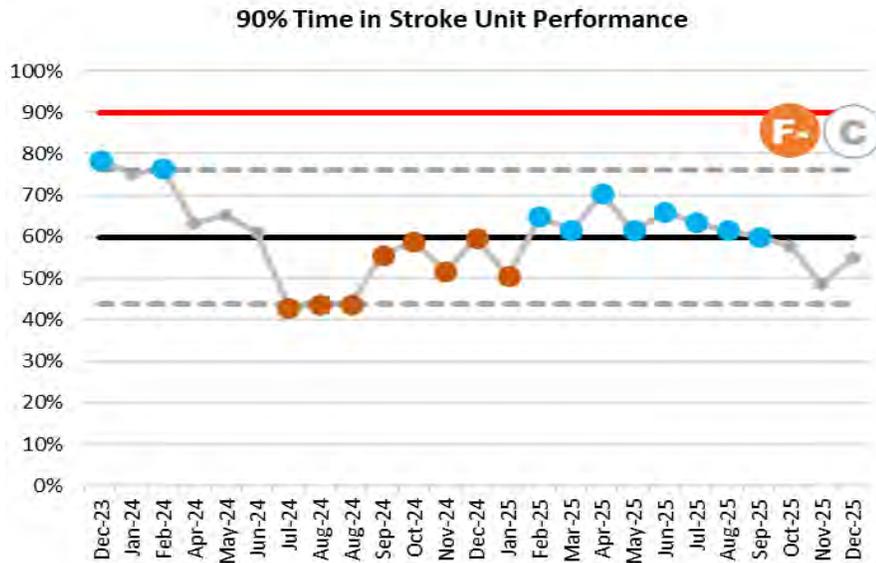
Impact on Forecast

We expect a return to achieving the national and site-specific target as monitored through SSNAP, while also progressing work toward safely implementing extended-window thrombolysis to further expand treatment for eligible patients.

Responsiveness

Stroke Performance - NBT

Latest Month
Dec-25
Target
90.0%
Latest Month's Position
55.0%
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?

Improvement from November's data but is still below the target of 90%. The ongoing high occupancy numbers have resulted in an increased number of outliers negatively affecting performance. Data for December admissions are still being completed, so the final figure may change. This metric is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

Actions being taken to improve

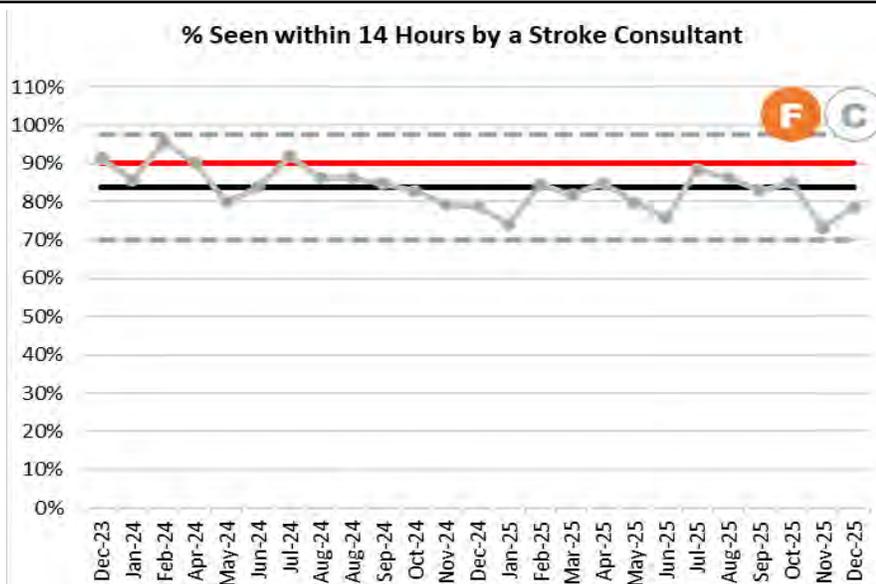
Actions already described in Stroke unit within 4 hours metric – including the Hot bed SOP. System level work ongoing to aid in reducing occupancy levels, this involves engagement from ICB with view to enhancing community provision and releasing acute capacity. Increased numbers of SBCH and BIRU beds as well more ICSS staff have been actioned.

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

Impact on Forecast

Current occupancy levels remain high, and we expect the performance to continue to be challenged, until occupancy levels reduce; there is a direct correlation to the NCTR position.

Latest Month
Dec-25
Target
90.0%
Latest Month's Position
78.7%
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?

Improvement from November's data noted. Data for December admissions are still being completed, so the final figure may change. This metric is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

Actions being taken to improve

Recent performance continues to be supported by a more sustainable and consistent consultant rota, strengthened further by the appointment of a new consultant who will be contributing to improved service stability. The Careflow narrative form is expected to be implemented soon, which will further enhance the accuracy and completeness of data for this metric. This metric is also monitored through SSNAP, providing an additional layer of oversight and external benchmarking.

Impact on Forecast

Expect to see sustained improvement over the coming months.

Quality Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Safe	Pressure Injuries Per 1,000 Beddays	NBT	Jan-26	0.0	No Target	5.0	N/A	C	Note Performance
		UHBW	Jan-26	0.2	0.4	0.2	P*	C	Note Performance
Safe	MRSA Hospital Onset Cases	NBT	Jan-26	0	0	0	F	L	Escalation Summary
		UHBW	Jan-26	0	0	0	F	C	Escalation Summary
Safe	CDiff Healthcare Associated Cases	NBT	Jan-26	5	5	5	?	C	Escalation Summary
		UHBW	Jan-26	15	9.08	12	?	C	Escalation Summary
Safe	EColi Hospital Onset Cases	NBT	Jan-26	8	4.00	1	?	C	Escalation Summary
		UHBW	Jan-26	5	9.08	7	?	C	Escalation Summary
Safe	Falls Per 1,000 Beddays	NBT	Jan-26	5.7	No Target	5.4	N/A	C	Note Performance
		UHBW	Jan-26	5.3	4.8	4.5	?	C	Escalation Summary
Safe	Total Number of Patient Falls Resulting in Harm	NBT	Jan-26	4	No Target	5	N/A	C	Note Performance
		UHBW	Jan-26	7	2	3	F	C	Escalation Summary
Safe	Medication Incidents per 1,000 Bed Days	NBT	Jan-26	4.2	No Target	4.3	N/A	L	Note Performance
		UHBW	Jan-26	7.5	No Target	8.4	N/A	C	Note Performance
Safe	Medication Incidents Causing Moderate or Above Harm	NBT	Jan-26	2	0	5	F	C	Escalation Summary
		UHBW	Jan-26	1	0	0	F	L	Escalation Summary
Safe	Adult Inpatients who Received a VTE Risk Assessment	NBT	Jan-26	97.5%	95.0%	97.6%	F-	H	Escalation Summary
		UHBW	Jan-26	80.1%	95.0%	80.4%	F-	H	Escalation Summary
Safe	Staffing Fill Rate	NBT	Jan-26	101.7%	No Target	99.3%	N/A	C	Note Performance
		UHBW	Jan-26	101.9%	100.0%	102.3%	P*	C	Note Performance

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

Quality Scorecard

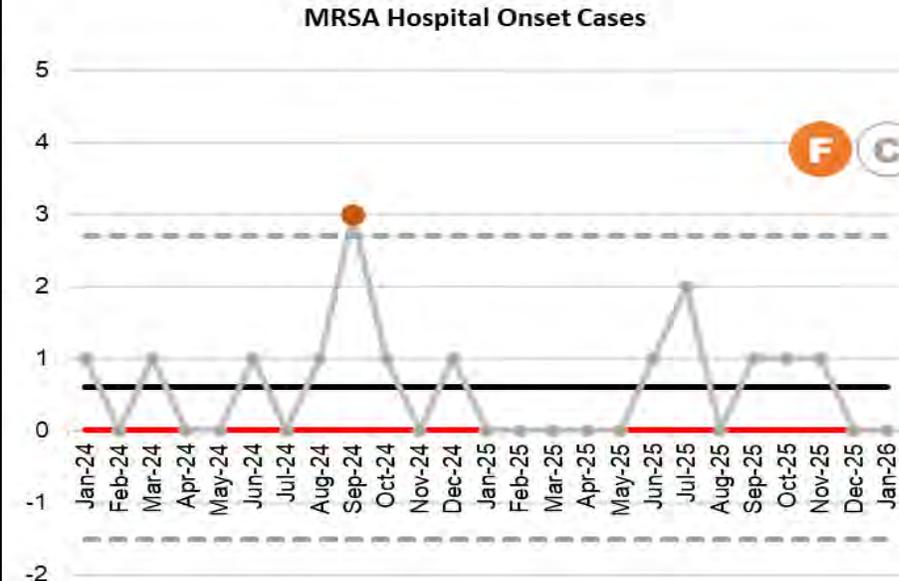
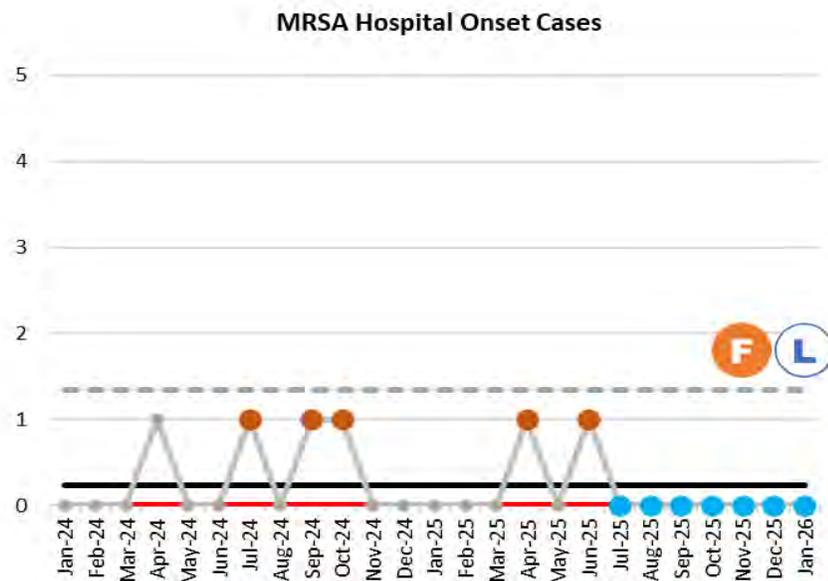
CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	NBT	Sep-25	94.1	100.0	94.2	P*	C	Note Performance
		UHBW	Sep-25	87.7	100.0	86.8	P*	L	Note Performance
Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	NBT	Dec-25	62.8%	No Target	44.0%	N/A	C	Note Performance
		UHBW	Jan-26	42.1%	90.0%	46.6%	F-	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	NBT	Dec-25	95.3%	No Target	98.0%	N/A	C	Note Performance
		UHBW	Jan-26	87.7%	90.0%	87.9%	?	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	NBT	Dec-25	55.8%	No Target	46.0%	N/A	C	Note Performance
		UHBW	Jan-26	33.3%	No Target	36.2%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Inpatient	NBT	Jan-26	90.2%	No Target	90.1%	N/A	C	Note Performance
		UHBW	Jan-26	95.4%	No Target	95.9%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Outpatient	NBT	Jan-26	93.9%	No Target	94.7%	N/A	L	Escalation Summary
		UHBW	Jan-26	94.7%	No Target	94.7%	N/A	C	Note Performance
Caring	Friends and Family Test Score - ED	NBT	Jan-26	76.9%	No Target	79.6%	N/A	C	Note Performance
		UHBW	Jan-26	85.9%	No Target	80.1%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Maternity	NBT	Jan-26	86.5%	No Target	86.8%	N/A	C	Note Performance
		UHBW	Jan-26	98.0%	No Target	97.8%	N/A	C	Note Performance
Caring	Patient Complaints - Formal	NBT	Jan-26	70	No Target	58	N/A	H	Escalation Summary
		UHBW	Dec-25	65	No Target	61	N/A	H	Escalation Summary
Caring	Formal Complaints Responded To Within Trust Timeframe	NBT	Jan-26	67.7%	90.0%	77.1%	F	C	Escalation Summary
		UHBW	Dec-25	62.1%	90.0%	70.1%	F	C	Escalation Summary

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

Quality

Infection Prevention & Control

Latest Month
Jan-26
Target
0
Latest Month's Position
0
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but last six data points are greater than or equal to target
Trust Level Risk
No Trust Level Risk



Latest Month
Jan-26
Target
0
Latest Month's Position
0
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.
Corporate Risk
Risk 6013 - Risk that the Trust exceeds its NHSE/I limit for Methicillin Resistant Staphylococcus aureus bacteraemia's (12)

What does the data tell us?

With no new cases reported in January Trust numbers remain at 2 cases .

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 ICB improvement work focusing on MSSA and MRSA reduction, learning from all MRSA cases are sharing learning as well as looking at causation

Impact on forecast

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

What does the data tell us?

There have been no new cases of MRSA for the trust in January. The cases for 2025/26 are now at six in total, this month in 2024/25 the trust was seven.

Actions being taken to improve

A comprehensive review of the six MRSA bacteraemia's, year to date, has been undertaken by NBT colleagues; Deputy DIPC and Lead IPC Doctor. The finding are due to be presented to QOCiC in February. Additional learning has been identified, and specifically clear Divisional accountability for the actions for improvement.

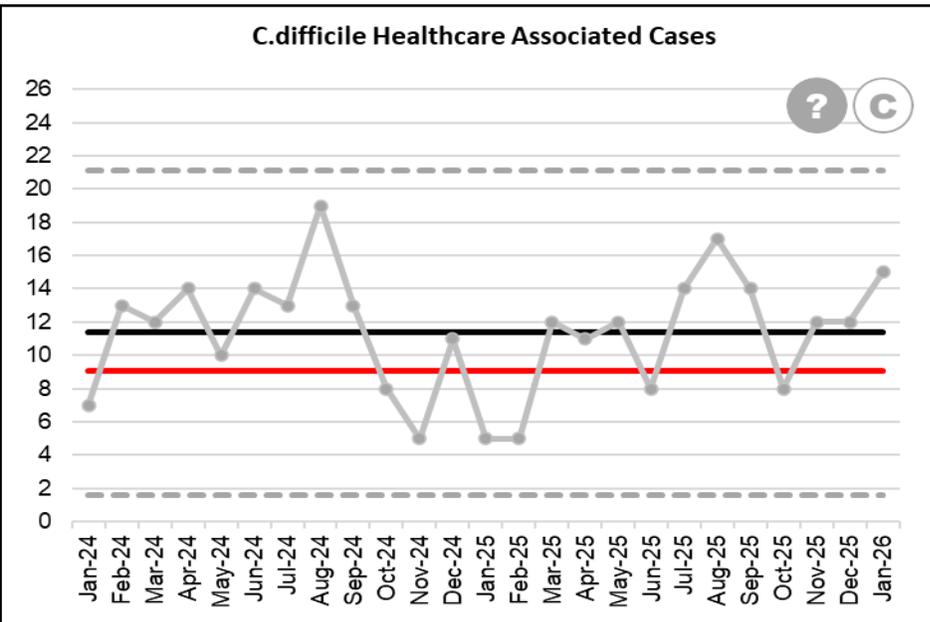
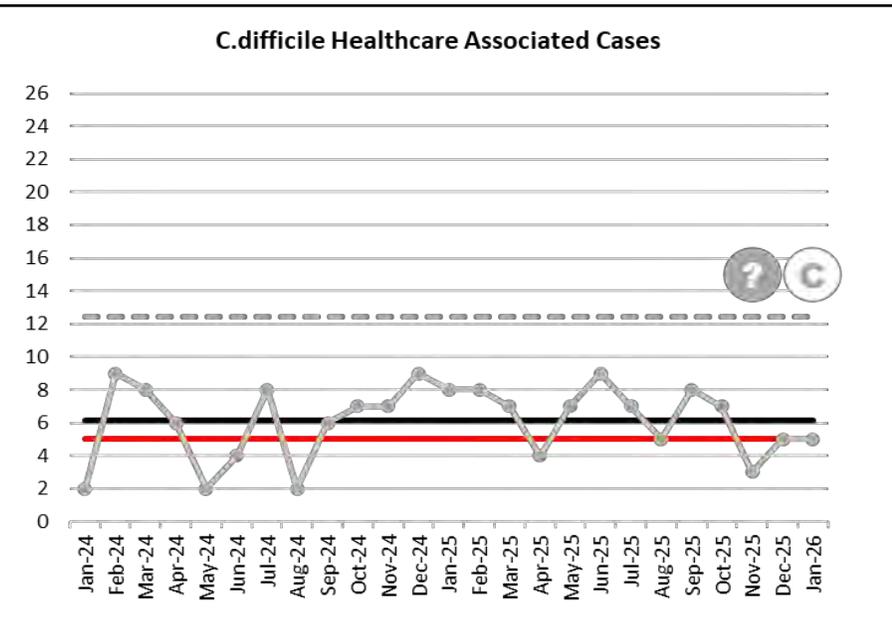
Impact on forecast

A system (BNSSG) MRSA task and finish group is now in place, as our system has the highest case rate of MRSA bacteraemia in the southwest. This work is chaired by UHBW, with two specific workstreams, focusing on health inequalities. The UHBW quality improvement initiative for MRSA bacteraemia continues, led by a Director of Nursing. This has been reinvigorated. This will pick up the actions for improvement from the MRSA review by NBT colleagues. The quality improvement work linked to IV access continues to build momentum with key stakeholders, led by a Director of Nursing.

Quality

Infection Prevention & Control

Latest Month	Jan-26
Target	5
Latest Month's Position	5
Performance / Assurance	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk	No Trust Level Risk



Latest Month	Jan-26
Target	9.08
Latest Month's Position	15
Performance / Assurance	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk	Risk 3216 - Breach of the NHSE Limits for HA C-Diff (12)

What does the data tell us?
Cases in January - 5 HOHA and 2 COHA - cases need to trend at 6 or lower monthly to match a trajectory position. The current position is trending slightly above the trajectory. Total position so far this year 89 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 an 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

Following detection of a concerning Ribotype strain at UHBW all cases are being types for 6 months from 27th Jan 26

What does the data tell us?
UHBW saw 15 cases of *C. difficile* for January the breakdown on this is 11 HOHA and 4 COHA. This now breaches our threshold of 109 to 123 cases (89 HOHA 34 COHA) presently.

Actions being taken to improve
The UHBW quality improvement initiative for *C. difficile* continues, led by a Director of Nursing. This has been reinvented and incorporated into the Operational Infection Control group.

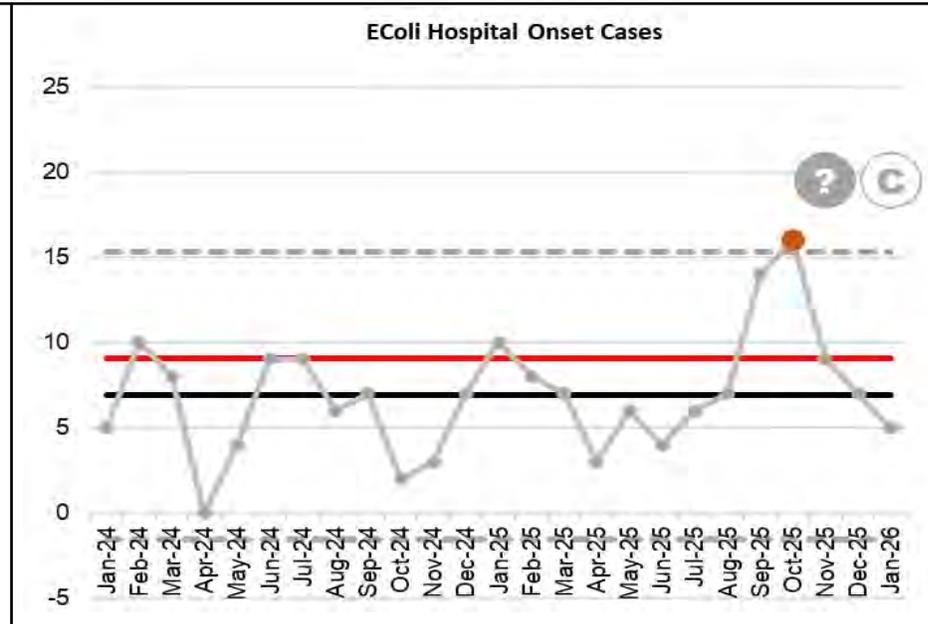
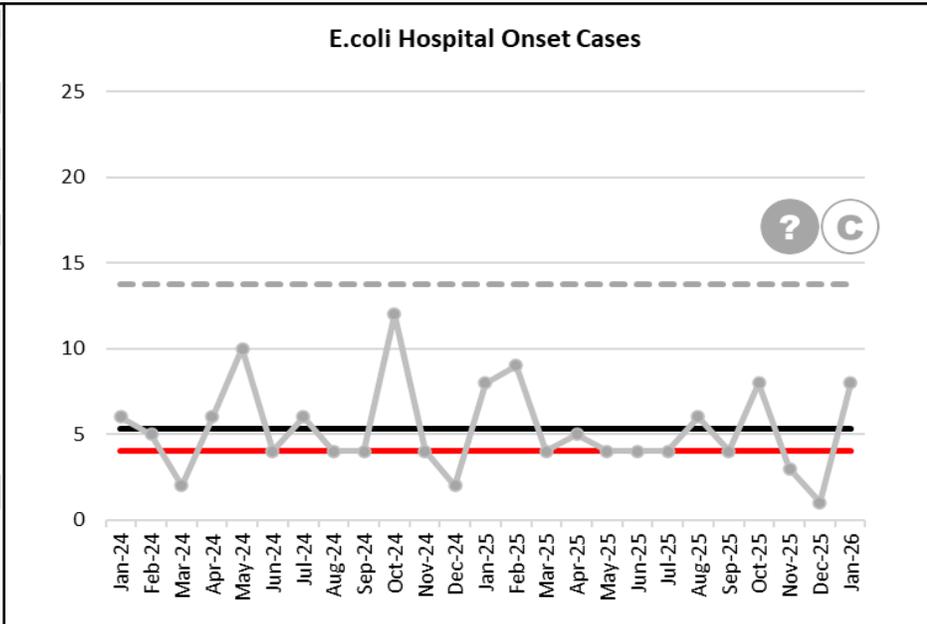
Following the outbreak of *C. difficile* reported in A900 in Quarter 3, continued vigilance has continued with delivery of robust and compliant cleaning standards, which is being picked up by the Directors of Nursing as further assurance is required.

Impact on forecast
UHBW has exceeded its *C. difficile* trajectory, (limit) which will likely continue until year end.

Quality

Infection Prevention & Control

Latest Month
Jan-26
Target
4
Latest Month's Position
8
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk



Latest Month
Jan-26
Target
9.08
Latest Month's Position
5
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
No Corporate Risk

What does the data tell us?

Cases remain significantly below trajectory 58 cases to an end of year trajectory of 89.

Actions being taken to improve
Working along side BD medical looking at Catheter care and reduction of CAUTI as a Quality improvement project.

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

What does the data tell us?

UHBW had an additional five cases of E. coli for January this takes the current figure to 77 for the year. The same period in 2024/25 showed that we had 62 cases.

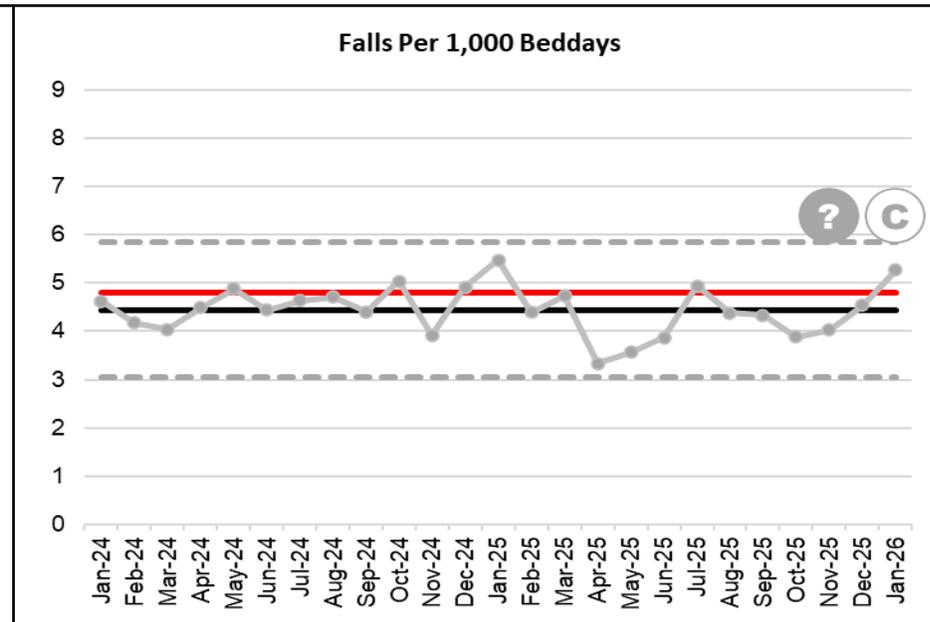
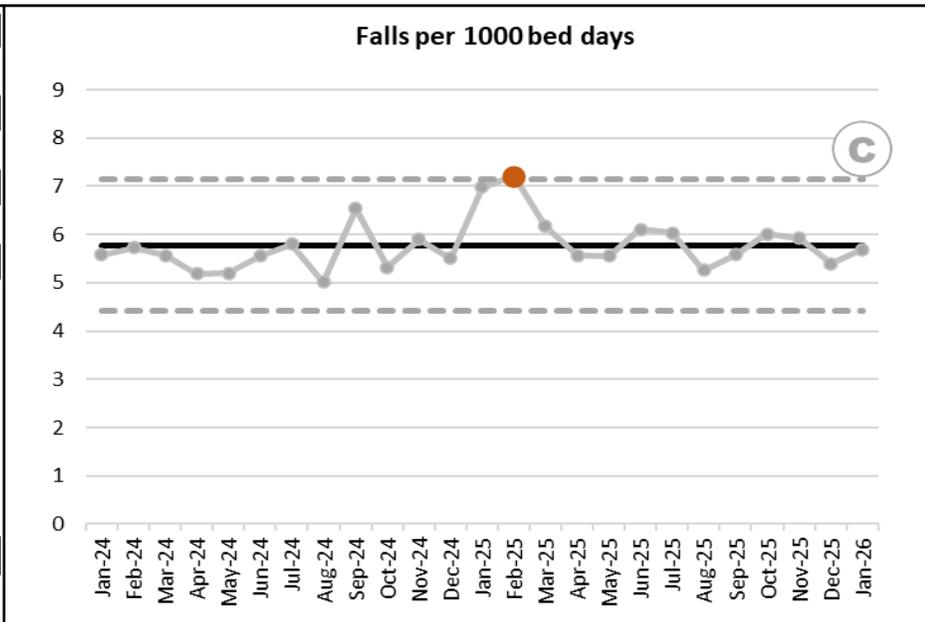
Actions being taken to improve
The case rates have been reviewed. Ongoing work continues about the improvements in urinary catheter care, with the updated urinary catheter care plan.

There is opportunity for wider collaborative work with Divisions, including hydration management.

Impact on forecast
Unlikely to exceed trajectory at year end.

Quality Falls

Latest Month
Jan-26
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
Jan-26
Target
4.8
Latest Month's Position
5.3
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
Risk 1598 - Patients suffer harm or injury from preventable falls (12)

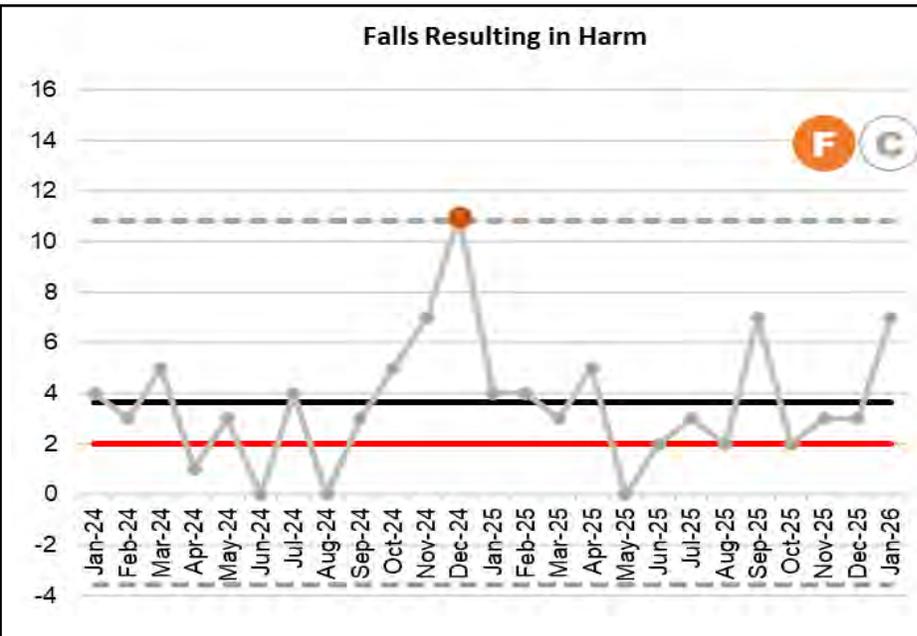
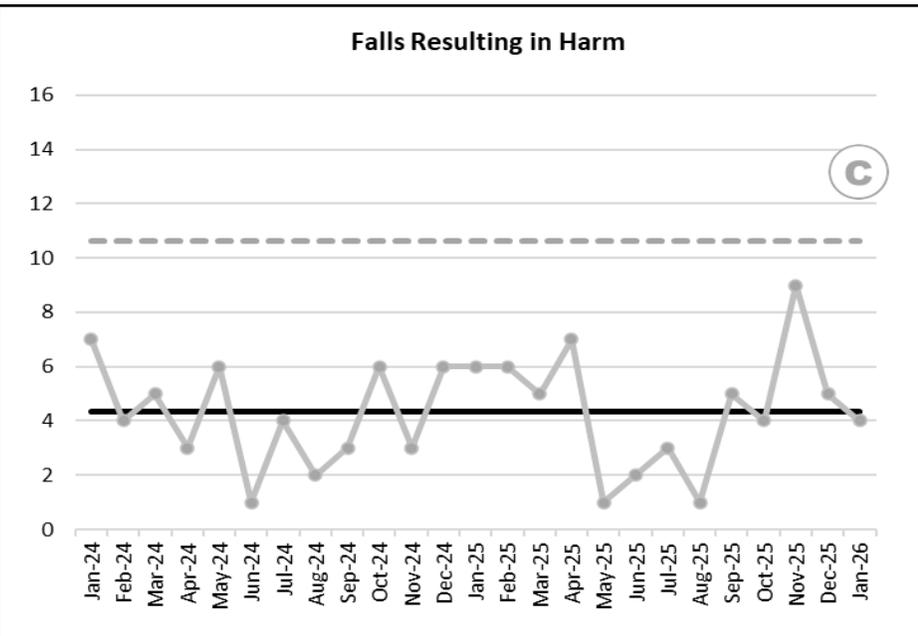
No narrative required as per business rules.

What does the data tell us:
 During January 2026: there have been 183 falls, which per 1000 bed days equates to 5.266, this is higher than the Trust target of 4.8 per 1000 bed days. There were 113 falls at the Bristol site and 70 falls at the Weston site. There were seven falls with moderate physical and/or psychological harm.
 The number of falls in January 2026 (183) is more than December 2025 (153). There were seven falls with moderate harm, this is higher than the previous month (3).
 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
Jan-26
Target
No Target
Latest Month's Position
4
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
Jan-26
Target
2
Latest Month's Position
7
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.

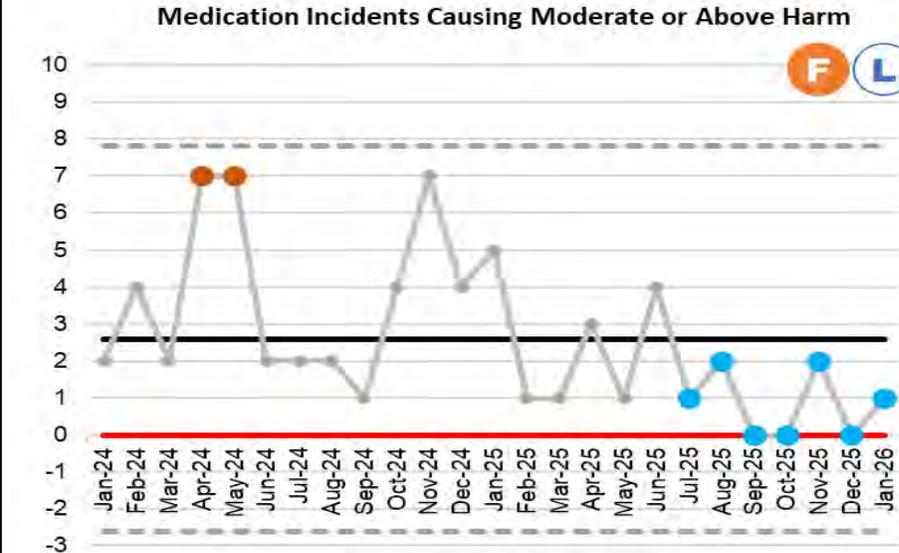
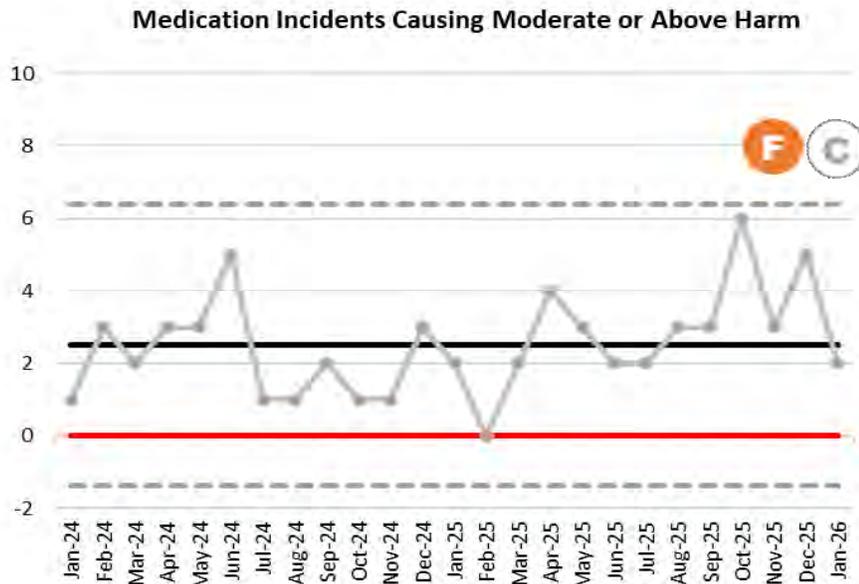
- Actions being taken to improve**
- Divisions which have reported higher falls incidences are undertaking reviews of falls and falls with harm to identify themes and learning. Action plans will be developed, implemented and shared throughout the division.
 - We continue to work on personalisation, prediction,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

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

Quality

Medication Incidents

Latest Month	Jan-26
Target	0
Latest Month's Position	2
Performance / Assurance	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration
Trust Level Risk	Risk 1800 – Allergy status may not be identified resulting in medication being incorrectly prescribed or administered (20). 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	Jan-26
Target	0
Latest Month's Position	1
Performance / Assurance	Special Cause Improving Variation Low, where down is improvement but last six data points are greater than or equal to target.
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 January 2026, NBT recorded 146 medication incidents involving patients of these, 2 were graded as causing moderate or above harm to a patient. (both moderate).

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 January 2026, UHBW recorded 262 medication-related incidents, one of which was reported as causing moderate or above harm. The dataset pre-April 2024 is based on previous harm descriptors in place in the Trust. The data indicates a good reporting culture with few harm incidents compared to number of incidents.

Actions being taken to improve

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. This will be discussed at Patient Safety Group.

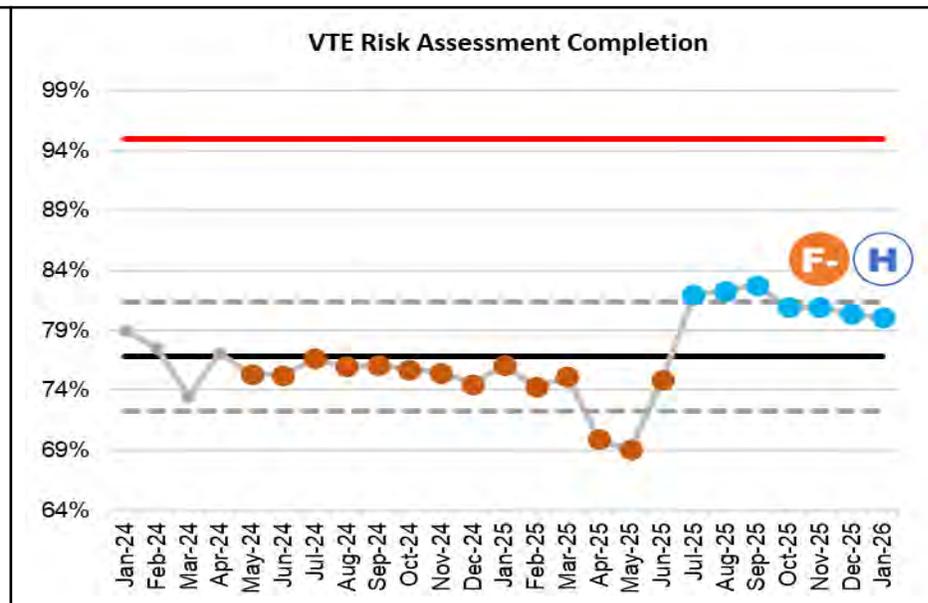
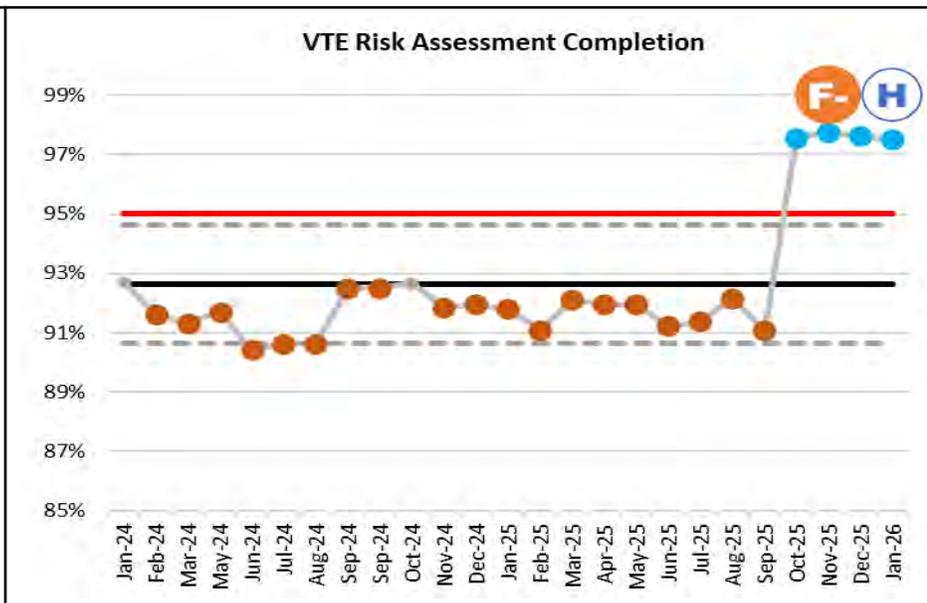
Specific learning is shared across the Trust via the Medicines Safety Bulletin and with BNSSG system colleagues via system medicines quality and safety meetings. This report has been developed collaboratively by the UHBW and NBT medicines safety teams.

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

Latest Month	Jan-26
Target	95.0%
Latest Month's Position	97.5%
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	Jan-26
Target	95.0%
Latest Month's Position	80.1%
Performance / Assurance	Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.
Corporate Risk	Risk 8448 - Risk that VTE prophylaxis is not prescribed when indicated (16)

What does the data tell us?
VTE RA compliance sat below the 95% target for over 2 years, demonstrating a persistent under-performance in part due to the CareFlow Narrative process of recording VTE RA. The sharp inflection in October 2025 was a result of CMM go live which forced VTE risk assessment on all admitted patients (unless they resided in the Emergency Department). As a result, figures are now sustained around 97%.

Actions being taken to improve
This new digital workflow has prompted assessments therefore reducing missed entries, and improved consistency.

Impact on Forecast
With performance now above target and stabilising, the Trust should be on track to maintain compliance in future reporting periods. Of note, reporting standards will be updated to NHSE specifications of VTE RA within 14 hours of admission. This will risk dropping compliance below 95%. Furthermore, patients stranded in ED due to poor flow will not receive the same forcing measure so can potentially drop compliance further.

What does the data tell us?
Since the move to CMM and mandatory VTE RA completion on all downstream wards, there has been a sustained improvement of around 10%. UHBW remains below the NICE 95% target at around 80% completion.

Actions being taken to improve

- Wardview boards have been delayed (planned by end of Jan '26) - these will increase visibility of VTE RA completion and VTEP prescribing so that ward staff can make targeted interventions.
- Venous Thrombo-embolism (VTE) Risk Assessment indicator is being reviewed to analyse the contribution of data from various cohorts of patients that comprise the overall reported figure and identify where improvements could most effectively be targeted.
- Reviewing pharmacy audit forms to gather general data on VTE RA completion and prescribing on wards (currently targeted audit to ensure VTEP prescribing has not been accidentally omitted)
- Focus on admission areas – observing workflow to identify areas for improvement and providing education

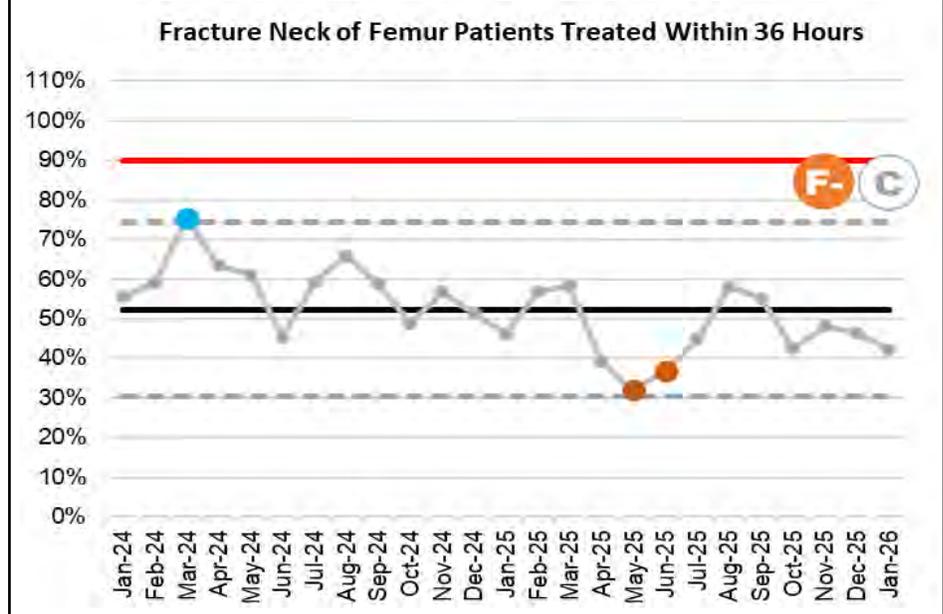
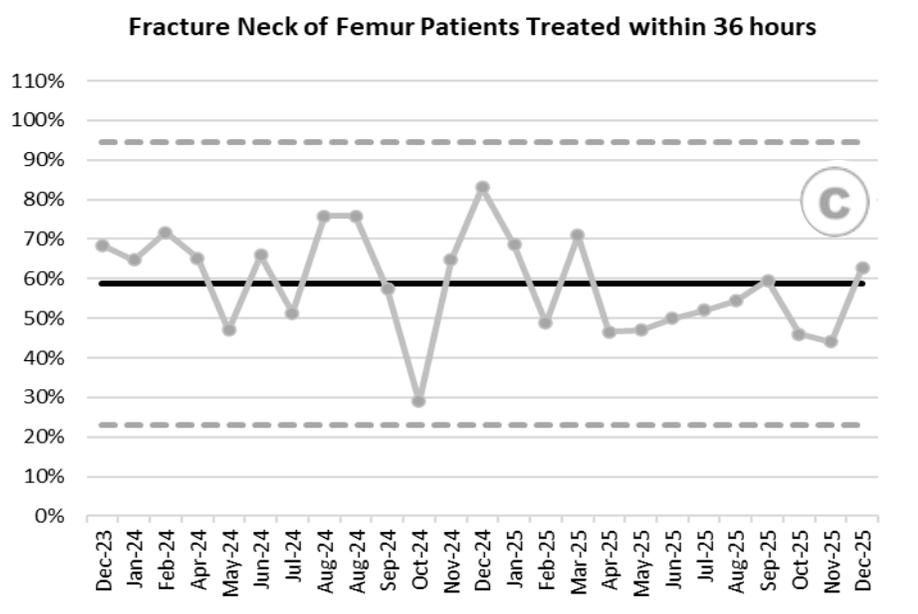
Impact on forecast

- The pharmacy audit will identify if cohorted areas are disproportionately reflecting the overall Trust position.
- Focusing on admissions wards should provide improvement in downstream areas

Quality

Neck of Femur

Latest Month
Dec-25
Target
No Target
Latest Month's Position
62.8%
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
Jan-26
Target
90.0%
Latest Month's Position
42.1%
Performance / Assurance
Common Cause
(natural/expected) variation,
where target is greater than
upper limit and down is
deterioration.
Corporate Risk
Risk 924 - Delay in hip
fracture patients accessing
surgery within 36 hours (15)

No narrative required as per business rules.

What does the data tell us?

At UHBW in January 57 patients were eligible for the best practice tariff (BPT), 24/57 patients (42%) were operated on within 36 hours of admission, 50/57 (88%) received ortho-geriatric assessment within 72 hours, resulting in 19/57 patients (33%) met all BPT criteria.

Main reasons for missed targets:

At Weston: seven patients missed the time to surgery target. This was due to lack of theatre space (4), THR surgeon required (1), Medical optimisation needed before surgery (1) and missed diagnosis (1). Six patients were not seen by the single part-time geriatrician. This was due to no support given when the geriatrician was on annual leave/study leave. Four additional patients did not meet other markers to meet BPT; 4 AT score (2) Physio assessment (2).

At the BRI: 26 patients missed the 36hrs target for surgery. This was primarily due to lack of theatre capacity. One Pt missed the 72-hr target for an Ortho-geriatrician (OG)review, admitted on Friday morning they missed the OG team review that day and hence did not get seen until Monday, time taken 78 hrs (missed by 6 hrs).

Actions being taken

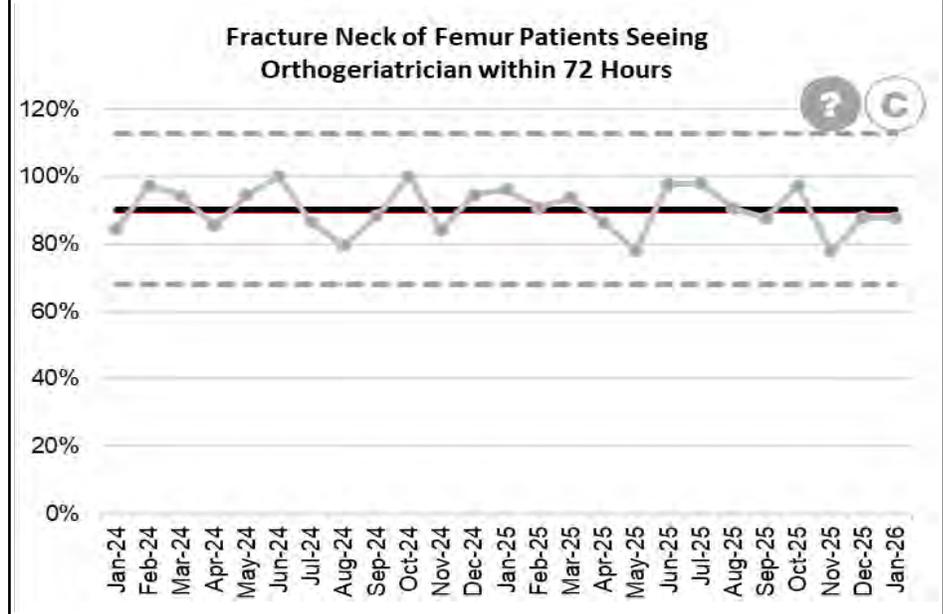
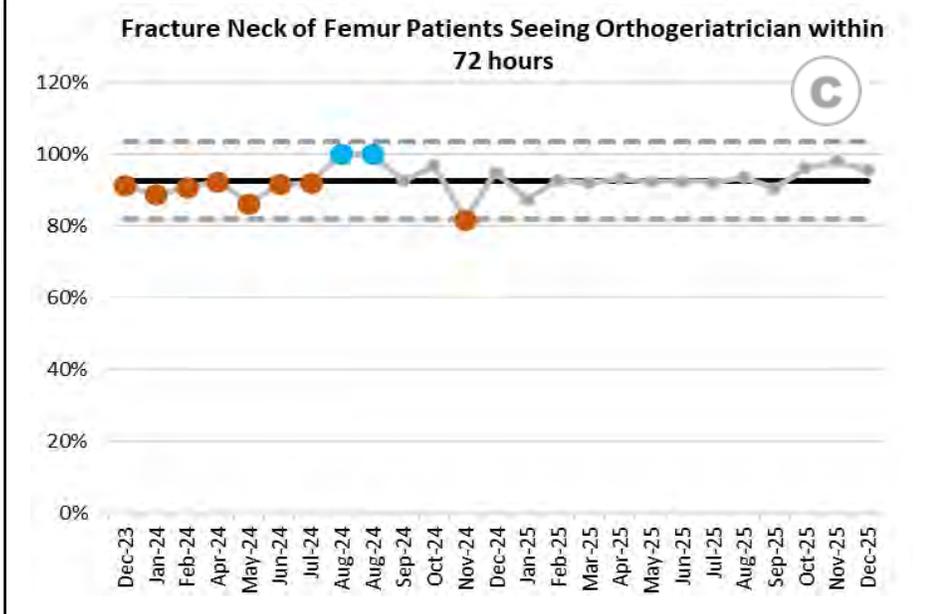
Extra theatre space is created where possible to reduce theatre delays. Elective theatre lists or CEPOD are often used at short notice to create extra support for trauma.

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

Quality

Neck of Femur

Latest Month	Dec-25
Target	No Target
Latest Month's Position	95.3%
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	Jan-26
Target	90%
Latest Month's Position	87.7%
Performance / Assurance	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk	No Corporate Risk

No narrative required as per business rules.

What does the data tell us?
50/57 (88%) Patients received an ortho-geriatric assessment within 72 hours.

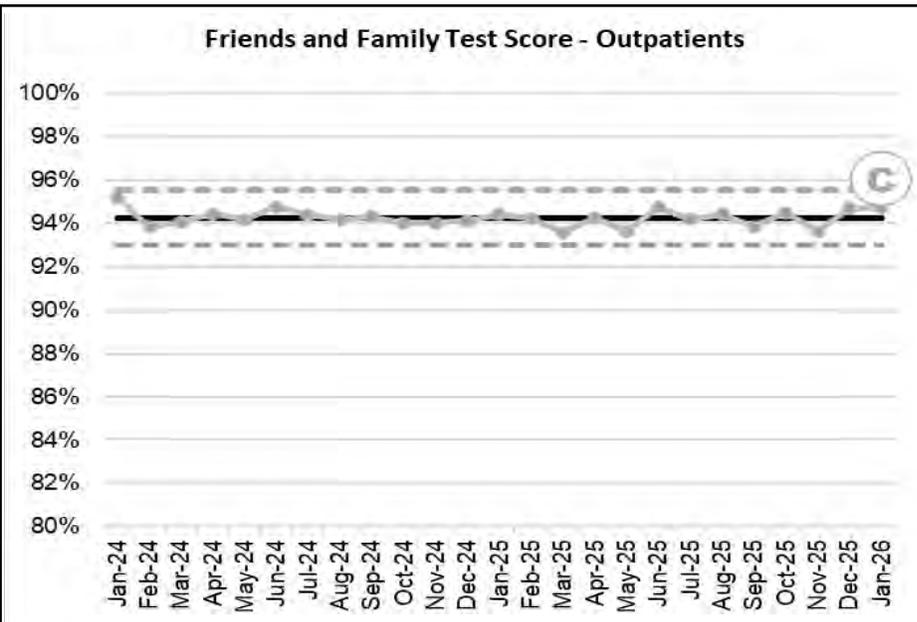
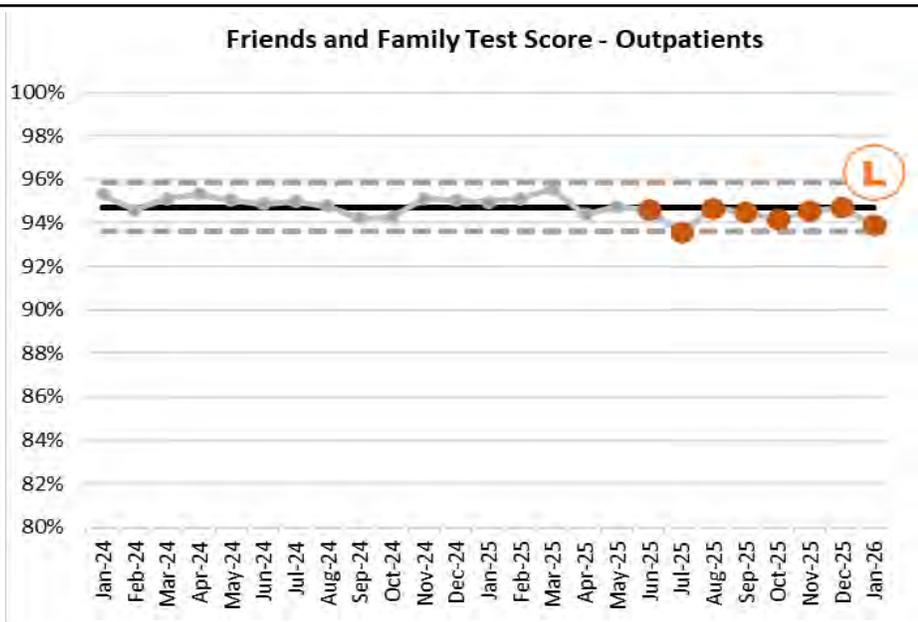
Main reason for missed targets
At Weston six patients were not seen by the single part-time geriatrician. This was due to the lack of resilience when the geriatrician was on annual leave/study leave.
At the BRI one patient missed the 72 hr target as admitted on Friday morning due to a lack of referral to Ortho-Geriatrician (OG) team on Friday, the patient was seen on Monday by OG team, time taken 78 hrs (target missed by 6 hrs).

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

Quality

Friends and Family Test

Latest Month
Jan-26
Target
No Target
Latest Month's Position
93.9%
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
Jan-26
Target
No Target
Latest Month's Position
94.7%
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 at 93.9% in January.
- 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, but the minor decrease this month is consistent with the drop seen for the same reporting period last year. 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.

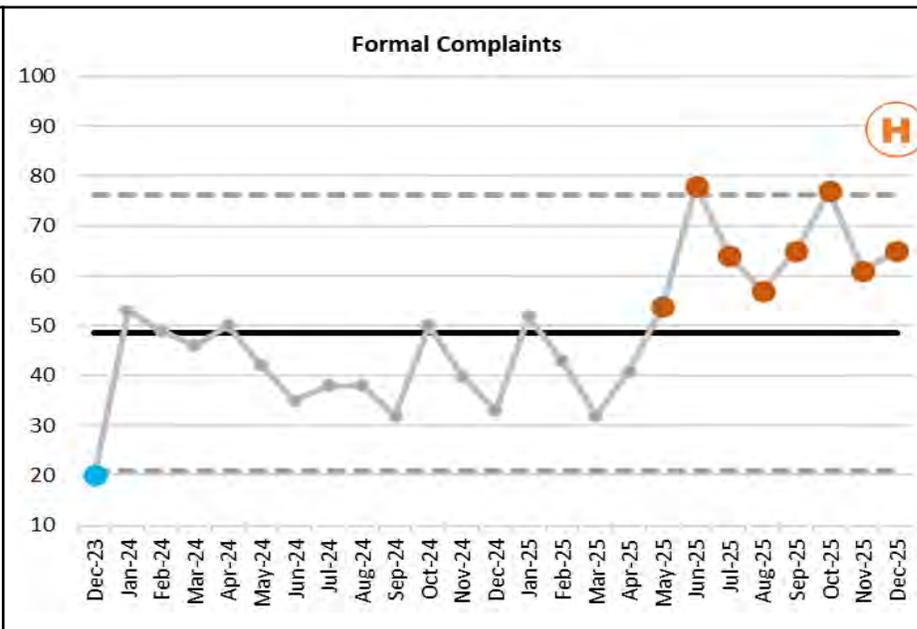
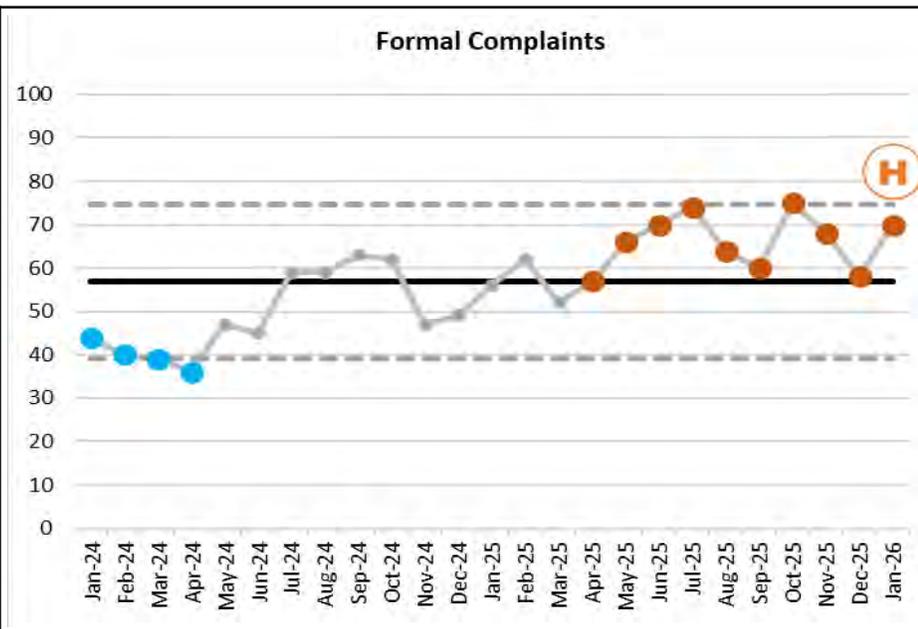
Impact on forecast

- 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
Jan-26
Target
No Target
Latest Month's Position
70
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
Dec-25
Target
No Target
Latest Month's Position
65
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration.
Corporate Risk
No Corporate Risk

What does the data tell us?

- In January, the Trust received 70 complaints, which was 12 more than the previous month, and 14 more compared to the previous year.
- Since April, we have received an average of 66 complaints per month.
- Gynaecology received the most complaints, followed by Urology, Emergency Medicine and Maternity. The remainder of the complaints were spread across 21 other specialties.
- Clinical Care and Treatment was the most selected lead theme of the complaints received.

Actions being taken to improve
We will continue to monitor and discuss any trends with the divisional patient experience teams.

Impact on forecast
It is difficult to predict the number of complaints received each month. This fluctuates largely based on 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. The number of PALS concerns received also remains high (165).

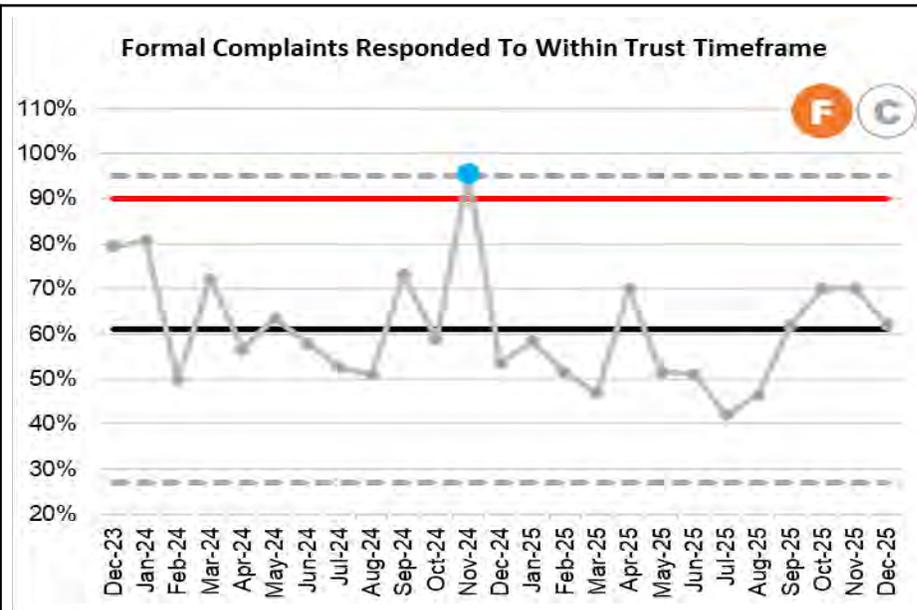
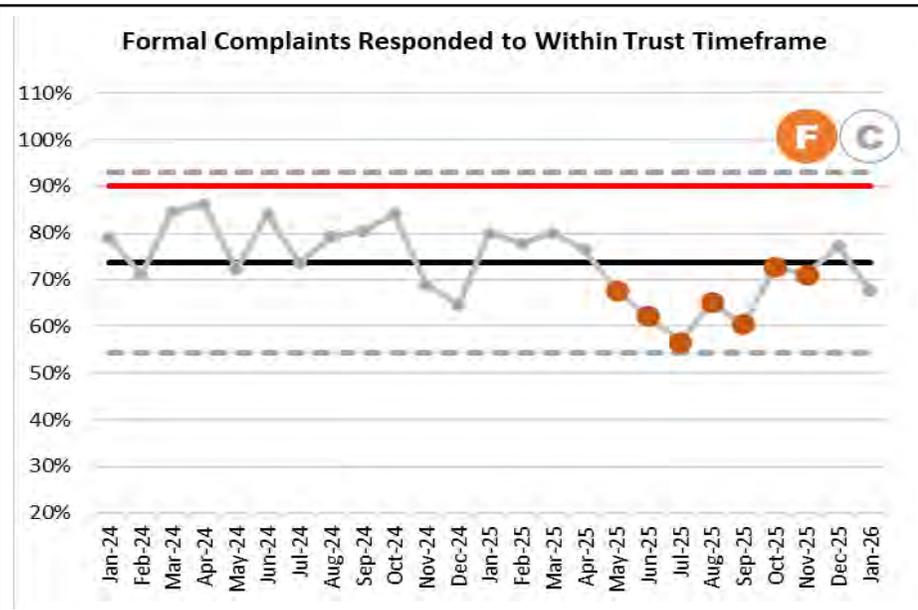
What does the data tell us?

- In December the Trust received 65 complaints with Surgery, Medicine and Women & Children's remaining the highest-volume areas
- 10 complaints were reopened, these were mostly in Surgery, Weston and Womens and Children's
- All complaints actioned were completed within 45 days (100%) with 223 cases closed in December.

Actions being taken to improve
Continue to work with divisions to proactively extend complex complaints
Prompt sending of complaints to divisions within 72 hours of complaint received, ensuring concerns are reviewed promptly by division.

Impact on forecast
Performance is expected to continue to improve due to clearing of the backlog in the PALS and Complaints team. The large volume of complaints from the backlog are now under investigation or complete and therefore we will see the number of cases closed increase in the next couple months.

Latest Month
Jan-26
Target
90.0%
Latest Month's Position
67.7%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration
Trust Level Risk
No Trust Level Risk



Latest Month
Dec-25
Target
90.0%
Latest Month's Position
62.1%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.
Corporate Risk
No Corporate Risk

What does the data tell us?

- The compliance rate decreased from 77% in December to 68% in January.
- This decrease was predominantly due to a decline in ASCR from 63% in December to 37% in January.
- Of the 65 complaints due for response in December, 44 were closed within the agreed timescale, 7 were outside the agreed timescale, and 14 were still open at the time of reporting.

Actions being taken to improve

- ASCR continues to embed their recovery plan to bring them in line with the compliance scores of the other clinical divisions.
- The Complaints & PALS Manager continues to hold weekly meetings with divisional patient experience teams to review upcoming/overdue cases, addressing complexities and 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 overall Trust compliance score has decreased due to a decline in ASCR. This is the first time since September that ASCR has been below 50%. An improvement from ASCR will likely result in a higher score for the Trust, provided the other divisions continue to sustain their performances. The average score for the other divisions for January was 86%.

What does the data tell us?

- The compliance rate decreased from 70% in November to 62.1% in December.
- There had been a steady increase in the compliance levels since July 2025 with the reduction in the back log. December is the first month where there has been a noticeable decrease in compliance.

Actions being taken to improve

- There is a review of complaint extensions and the number of extensions being requested by each division.
- The escalation policy for both PALS and Complaints team and divisional patient experience teams is being reviewed to enable improved responses.
- Recovery plans are being developed for divisions to improve quality and timeliness in complaint response.

Impact on forecast

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

Our People

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Well-Led	Workforce Turnover (Rolling 12-month)	NBT	Jan-26	9.5%	11.3%	9.5%	N/A*	N/A*	No Commentary
		UHBW	Jan-26	9.1%	11.1%	9.4%	N/A*	N/A*	No Commentary
Well-Led	Vacancy (Vacancy FTE as Percent of Funded FTE)	NBT	Jan-26	7.8%	5.1%	8.1%	F-	H	Escalation Summary
		UHBW	Jan-26	5.0%	4.0%	4.8%	?	H	Escalation Summary
Well-Led	Sickness (Rolling 12-month)	NBT	Jan-26	4.8%	4.4%	4.8%	N/A*	N/A*	Commentary
		UHBW	Jan-26	4.6%	4.5%	4.5%	N/A*	N/A*	Commentary
Well-Led	Essential Training Compliance	NBT	Jan-26	88.7%	90.0%	88.6%	?	C	Escalation Summary
		UHBW	Jan-26	89.6%	90.0%	89.4%	?	C	Escalation Summary

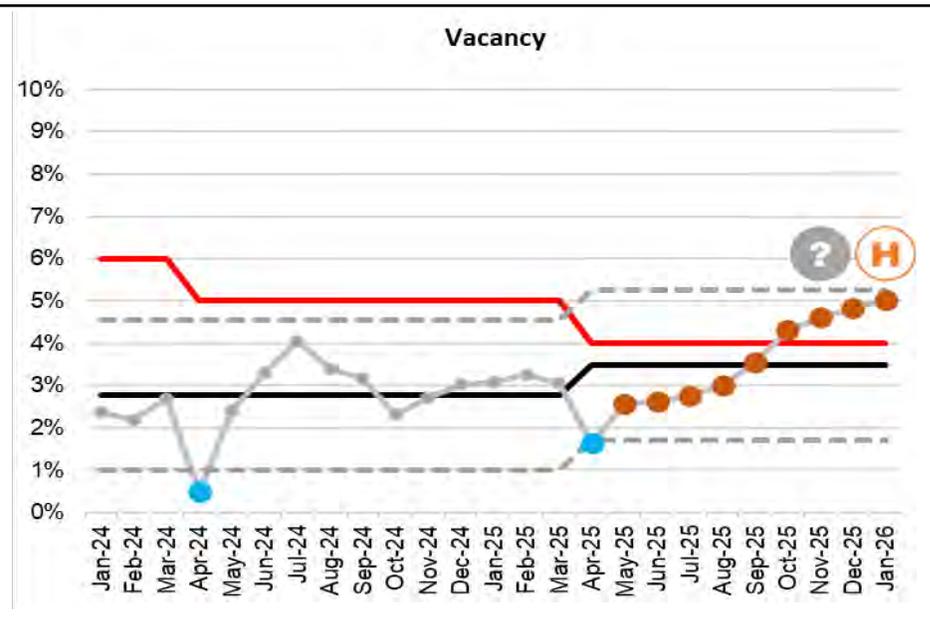
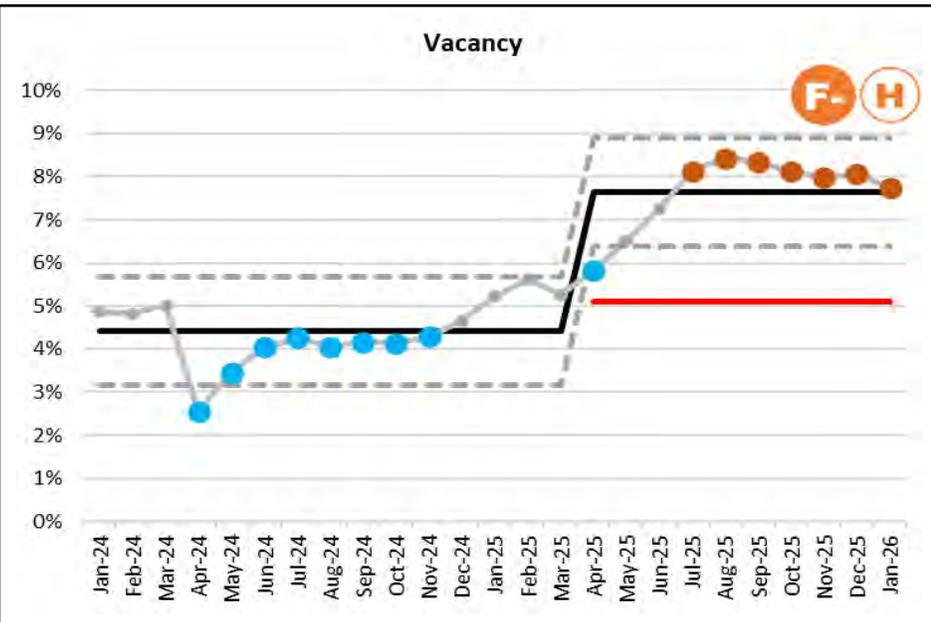
*Cannot generate Assurance and Variation icons as SPC not appropriate for rolling data.

Assurance					Variation					
					No icon					
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

Our People

Vacancies

Latest Month
Jan-26
Year End Target
5.1%
Latest Month's Position
7.8%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit
Trust Level Risk
Risk 1979 -
There is a risk to our clinical teams and services due to the inability to recruit into vacant specialist medical roles (16)



Latest Month
Jan-26
Year End Target
4.0%
Latest Month's Position
5.0%
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?

- Vacancies decreased by 33 fte in Jan-26 due to a high number of starters and an overall net gain of staff. Greatest reductions were in Band 5 and Band 2/3 Nursing and Midwifery staff, reflective of co-ordinated recruitment campaigns delivering 21 fte band 5 nurses and 36.5 fte band 2/3 HCSWs.

Actions being taken to improve

- HCSW Supply** – Trust wide and tailored Health Care Support Worker (HCSW) assessment centres for scaled up campaign. Assessment Centre in **Feb-26** saw 23 candidates attend and 9 offers made
- Youth Outreach:** Targeted campaign promoting HCSW career pathway 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 posted in **Jan-26** received over 40 applications. Our contacts with the Kings Trust is working with the applicants to make them interview ready before seeing at assessment centre – 7 Apprenticeship candidates were interviewed in **Jan-26**
- Strategy for NQ qualifying nurses to apply for roles in Sept-26 agreed across NBT and UHBW – Newly Qualifying nurses will be given links to apply in **Feb-26** with applications closing in **Apr-26**

Impact on forecast

- Impact of enhanced assessment centres for Band 2/3 HCSW – 35.2 fte predicted to start in Clinical Divisions in **Feb/Mar-26** and 44.2 fte Band 5s in Nursing and Midwifery for **Feb/Mar-26**

What does the data tell us?

Vacancies increased in January (26. fte). Budget increased by 10.5 fte (Surgery) to support the new standalone SDEC and overall staff in post reduced by 16.3 fte. Registered Nursing saw a budget increase of 7.7 fte and a staff in post reduction of 10.9 fte. Unregistered Nursing saw a staff in post reduction of 17.1 fte. Healthcare Scientists increased 7.2 fte staff in post.

Actions being taken to improve

- The 25/26 plan requires a net headcount reduction which is being managed in part via vacancy controls and the vacancy position reflects this. Monitoring of the vacancy position through Divisional and SDR processes is important to avoid increased temporary staffing
- HCSW Supply** – Assessment centres for Adult areas are currently on hold while staff in closed wards are re-distributed across the Trust. BRHC held an Assessment centre in Jan which recruited 2 PICU and 2 Mental Health support workers. Strategy for NQ qualifying nurses to apply for roles in Sept-26 agreed across NBT and UHBW – Newly Qualifying nurses will be given links to apply in **Feb-26** with applications closing in **Apr-26**
- Youth-focused outreach:** The Trust is working with the Kings Trust for a new candidate pipeline

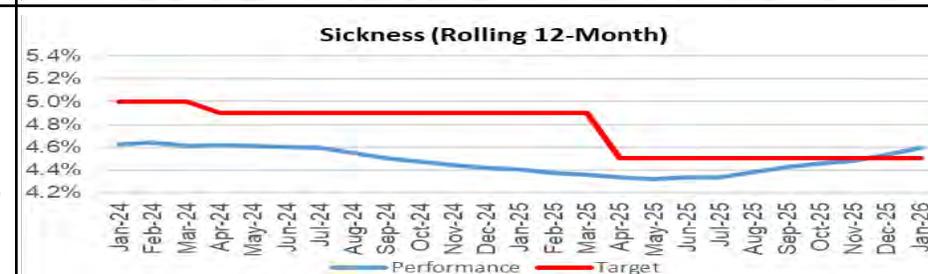
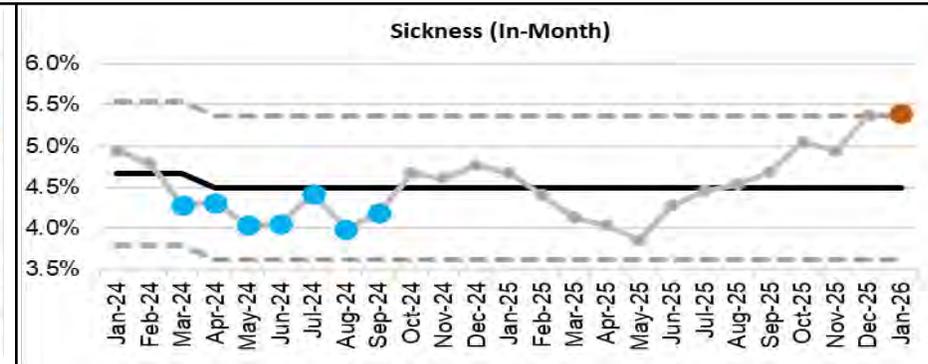
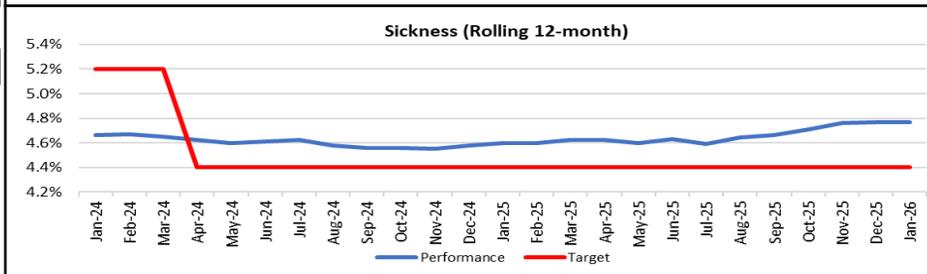
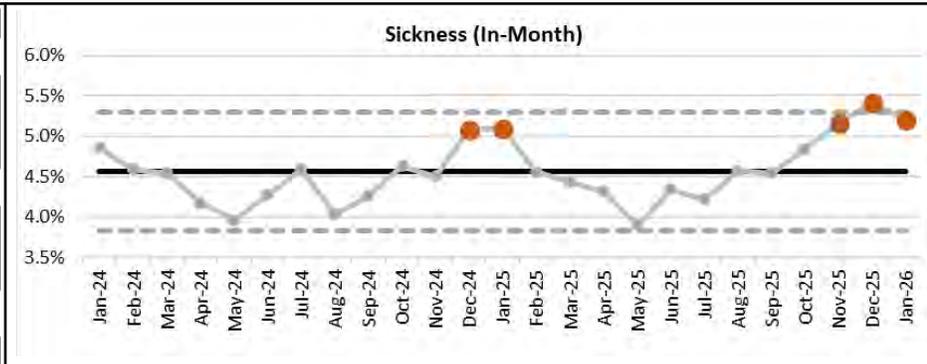
Impact on forecast

Recruitment for posts associated with Oncology growth require specialist chemo skills. Delays in opening SBCH additional capacity due to Estates works means the unit should be fully operational Mar/ Apr 26, enabling the workforce supply to be achieved.
3 HCSW started in **Jan-26** with an additional 62 offers in the pipeline. 20 of which have start dates booked **Feb – Mar26**

Our People

Sickness Absence

Latest Month
Jan-26
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
Jan-26
Latest Month's Position Rate (In-Month)
5.4%
Latest Month's Position Rate (Rolling 12-Month)
4.6%
Target (Rolling 12-month)
4.5%
Corporate Risk
No Corporate Risk

What does the data tell us?

- Jan-26 absence rate in month lower than Dec-26 (-0.4%) with reductions in season absence e.g., cough/cold/flu and gastrointestinal absence and lower than Jan-25 (-0.27%). SAD remain stable and continues to be main contributor to absence and MSK reasons has seen growth over winter, and Jan-26 rates are above this same point last year
- Both long- and short-term absence saw a reduction in Jan-26

Actions being taken to improve

People Advice Team and Business Partnering

- Action plan developed to reduce reliance on 'other' category use for absence recording – **Mar 26**
- Review of Caseworker recommended case benchmarks to enhance data quality undertaken and to be incorporated into new system standards following recent external audit outcome – **Apr 26**
- Proposed changes to return to work process to allow early identification and triangulation of absence causes and effective approaches for management to be included in new sickness absence policy to be introduced pre-Merger – **May 26**
- Executive DPR Focus - robust review and management of divisional sickness cases with new improvement tracking method to be implemented – **Mar 26**

Staff Experience Team

- Supporting staff experiencing psychological distress Training for Managers and Leaders (Staff Psychology team & MHLT) pilot delivered roll out spring 2026
- NBT Staff Physiotherapists trained in Mat Pilates – Delivery of 6-week Mat Pilates training to small groups of staff to improve mobility and musculoskeletal health.

Impact on Forecast

What does the data tell us?

- Top three contributors for January are Anxiety/Stress/Depression/Other Psychiatric Illness – 25.6% of all absence FTE days in Jan. Cold, Cough, Flu accounts for 11.3%, and Other Musculoskeletal Problems account for 7.8%. Anxiety/Stress/Depression/Other Psychiatric Illness account for 13,262.4 absent FTE days in January compared to 9,478.7 FTE in May. Cold, Cough, Flu accounts for 5,670.4 FTE absence days in January compared to 2014.0 FTE absence days in May. Sickness rates are highest in Facilities and Estates (8.5%, a reduction from 9.1% the previous month) and Weston General Hospital (6.5%, an increase from 5.5% the previous month).
- Unregistered Nursing and Midwifery staff absence rate of 7.7%, an increase from 6.7% the previous month.

Actions being taken to improve

- Sickness Project Launched Jan 26, includes Manager clinics to support 'hotspot' sickness areas and review return to work process and streamlined form to – Full roll out to be complete by **Mar 26**
- Collaboration with Health Roster to allow increased absence reporting from People Services team to ensure all sickness cases captured on Assure and that managers are supported effectively – **Feb 26**
- Bitesize video training and formal in person training on health and wellness being developed and launched – **Mar 26**
- Working group reviewing support around reasonable adjustments, (FAQs and Bitesize videos) – **Mar 26**

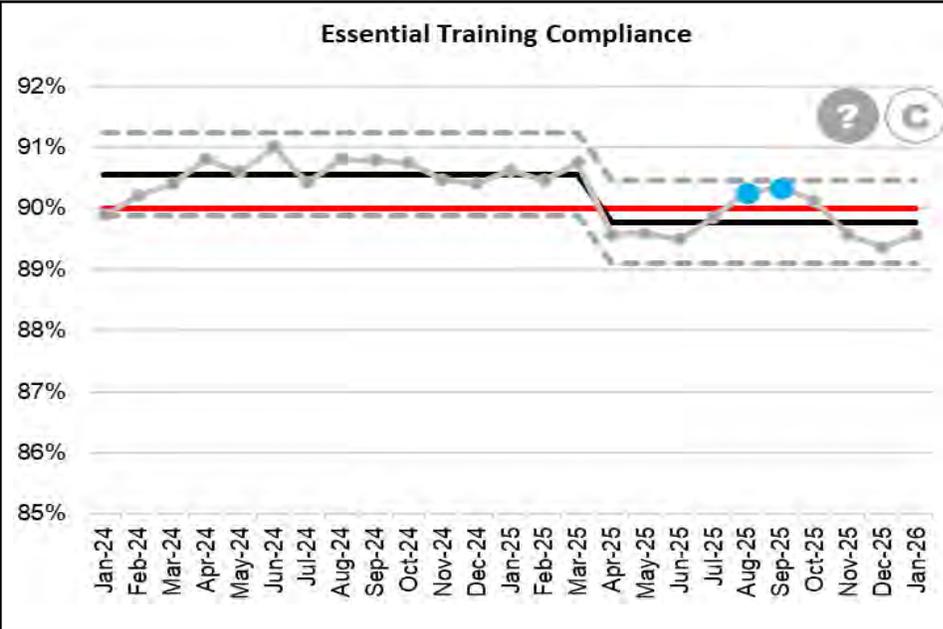
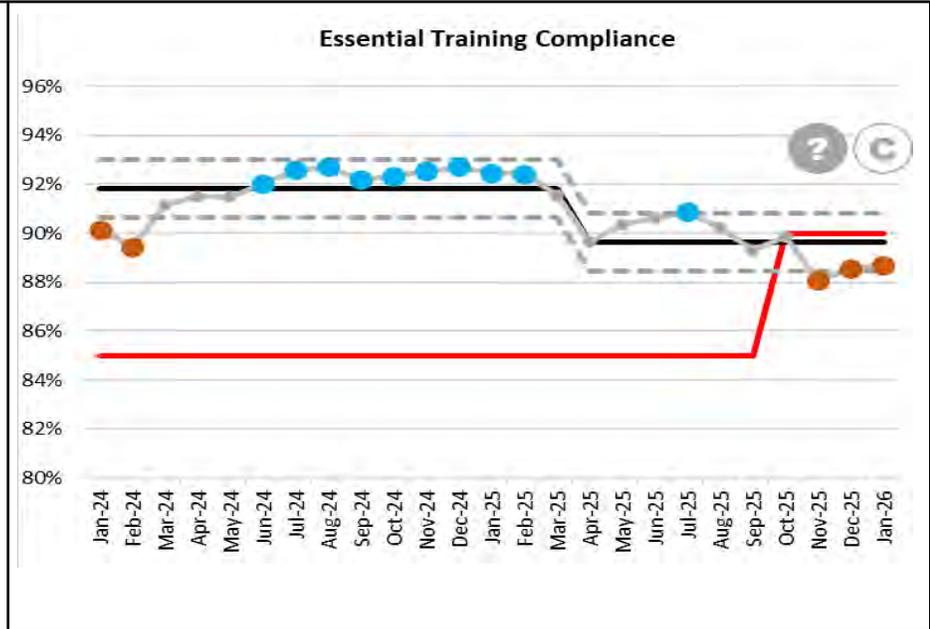
Impact on Forecast

- Sickness management project – aim to ensure absence cases are supportively and effectively managed at appropriate timescales to reduce length of absences where possible
- Additional training for managers to allow for early supportive interventions to prevent work related long term absences to ensure adjustments put in place to allow return to works at earlier stages.

Our People

Mandatory and Statutory Training

Latest Month
Jan-26
Target
90.0%
Latest Month's Position
88.7%
Oliver McGowan Tiers 1 and 2 Virtual / Face to Face
32.6%
Performance / Assurance
Common Cause
(natural/expected) variation where last six data points are both hitting and missing target, subject to random variation
Trust Level Risk
No Trust Level Risk



Latest Month
Jan-26
Target
90.0%
Latest Month's Position
89.6%
Oliver McGowan Tiers 1 and 2
42.8%
Performance / Assurance
Common Cause
(natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
No Corporate Risk

What does the data tell us? Compliance is below the target overall, driven by specific areas: Information Governance (IG) at 83.20%, Oliver McGowan (OMMT) level 1 (eLearning) rate at 85.72%, and Infection Prevention and Control (IPC) at 86.15%.

- Actions Being Taken to Improve**
- IPC:** We have started to see a recovery in this position, as clinical staff have realised that this needs to be annual. The divisions have escalated this message, and we have promoted this in IPC and on the IPC link page.
 - IG:** Compliance continues to meet national guidance recommendation but below group target. Appointment of the SME is awaiting outcome; however, steps are in place to validate divisional assurance and areas requiring greater local oversight.
 - OMMT:** At present, combined compliance for face-to-face and webinar training marginally increased to 32.6% (1.1% increase) and significantly below the ICB target which will not be met by the trust. Across the ICB, tier 2 attendance rates experienced a spike in Did Not Attend (DNA) rates impacted by critical incident. DNA rates for NBT bookings in January totalled 28%. Tier 1 webinar compliance currently stands at 32.2%. The introduction of an 'out-of-core' hours Tier 1 webinar sessions for estates and facilities staff has driven strong engagement, with 259 staff from NBT and UHBW attending the webinar sessions; positively impacting compliance rates by 0.25%. Based on current compliance datasets and projected future booking trajectories, extrapolated compliance estimates for tiers 1 and 2 have been generated for each organisation. These outputs will be reported to GEM and respective trust management teams.
- Impact on forecast**
- IPC:** The increase in compliance has been noted at the Infection Control Assurance Group, a quarterly meeting.
 - IG:** Continued SME engagement to maintain current performance and overall improvement.
 - OMMT:** Notable positive impact upon tier 1 compliance from the out-of-hours sessions. In conjunction with the ICB continue to monitor DNA rates for Tier 2 provision. Improved scrutiny of compliance through the trajectory data.

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 89.9%, Information Governance (IG) at 88.1%, Moving & Handling at 78.4%, Resuscitation at 76.3% and Oliver McGowan (OMMT) level 1 (eLearning) rate at 84.8%.

- Actions Being Taken to Improve**
- IPC:** team now contributing to corporate induction to reinforce core requirements. Training content and audiences being updated in line with new national guidance.
 - IG:** The eLearning module is actively promoted to all staff via the LMS.
 - OMMT:** Reporting as per NBT. Combined Level 2 compliance is 42.8% (↑1.8%) but below the ICB target which will not be met. Engagement supported via the LD & Autism Steering Group, focusing upon DNA's. However, DNA rate increased to 14% during critical incident. The introduction of a new out-of-core-hours webinar has driven improvements amongst Estates and Facilities colleagues, with tier 1 compliance rising by 3.8% from 259 staff attending across the group.
 - Moving & Handling:** An updated curriculum launched 2nd Jan; eLearning made available for those requiring a level 2 minimal patient-handling update. This will have resulted in a notable compliance improvement of 1.3%
 - Resuscitation:** A self-service approach to compliance recording introduced toward the end of 2025 for those undertaking higher-level training; improving efficiency and thus supporting greater compliance.
- Impact on forecast**
- Moving & Handling:** Level 2 and thus overall compliance anticipated to continue to increase over coming months.
 - IG, IPC and Resuscitation:** Ongoing monitoring of compliance rates will take place to determine impact of actions
 - OMMT:** Notable positive impact upon tier 1 compliance from the out-of-hours sessions and improved scrutiny of compliance through the trajectory data

Income & Expenditure

Actual Vs Plan (YTD)

Latest Month

Jan-26

Year to Date Plan

£(1.7m) deficit

Year to Date Actual

£(1.7m) deficit



Latest Month

Jan-26

Year to Date Plan

£(5.6m) deficit

Year to Date Actual

£(5.4m) deficit



Summary:

- The financial plan for 2025/26 in Month 10 was a surplus of £0.9m. The Trust has delivered a £0.9m surplus and on plan. Year to date the Trust has delivered a £1.7m deficit position which is on plan.
- The Trust continues to have higher than planned levels of No Criteria To Reside (NCTR) and high acuity driving pressures on escalation and enhanced care costs. This has led to overspends on nursing of £0.7m in month. In month, the Trust received £1.5m of NCTR funding towards costs seen in the year-to-date position.
- Elective Recovery Performance in month is driving an adverse position of £0.9m and divisional non-pay is causing an adverse variance of £0.4m due to increased activity in the hospital. This has been offset by PFI Funding received in month relating to prior year of £1.4m.
- There are other overspends driving a £0.5m adverse variance in month.
- In month, the Trust under-delivered against the recurrent Month 10 savings target by £2.3m driving a £1.8m adverse variance in month. This was offset in month by non-recurrent savings from consultant and AfC vacancies which contributed a £1.1m favourable variance.
- Year to date recurrent savings delivery is £18.2m and non-recurrent of £1.9m against a plan of £32.1m.

Key risks

- Delivery of planned elective activity and further in year savings delivery will be required to ensure the Trust delivers a breakeven position at year-end.

Summary:

- The position at the end of January is a net deficit of £5.4m against a planned deficit of £5.6m. The Trust is, therefore, marginally ahead of plan.
- Significant variances against plan are higher than planned pay expenditure (£17.6m) and increased non-pay costs (£25.1m). This is offset by higher than planned operating income (£41.6m).
- Total staff in post (substantive, bank and agency) has reduced since March. Although staffing levels are within budget in March, they have exceeded funded establishment for the majority of the YTD, with nursing budgets driving the adverse pay position due to additional use of registered mental health nurses and staffing of bed escalation areas linked to NCTR.
- Agency and bank expenditure was higher in month compared with December and overall is £3.7m higher than planned YTD. Agency expenditure is 14% lower than plan YTD with expenditure in month of £0.6m, comparable with December. Bank expenditure is 11% higher than plan YTD mainly due to the cost of industrial action, with expenditure in month of £5.7m, £0.6m higher than December.
- The average number of NCTR patients in January is 209, significantly above the system plan of 136. This equates to 26% 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 may result in failure to achieve the breakeven plan without a continuing change in delivery within Clinical Divisions and Corporate Services.
- Financial recovery plan actions necessary to support the Trust's FOT are not fully achieved.

Change step change

CIP

Actual Vs Plan (YTD)

<p>Latest Month</p> <p>Jan-26</p> <p>Year to Date Plan</p> <p>£32.1m</p> <p>Year to Date Actual</p> <p>£21.0m</p>	<p>Planned Savings v Actual</p> <p>£m</p> <p>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar</p> <p>Planned Recurrent CIP In Year CIP Delivery Recurrent CIP</p>	<p>Planned Savings v Actual</p> <p>£m</p> <p>Apr May June July Aug Sep Oct Nov Dec Jan Feb Mar</p> <p>Planned Recurrent CIP Planned Non-Recurrent CIP Actual Recurring CIP FOT Recurring CIP Total Actual CIP FOT Actual CIP</p>	<p>Latest Month</p> <p>Jan-26</p> <p>Year to Date Plan</p> <p>£43.3m</p> <p>Year to Date Actual</p> <p>£43.3m</p>
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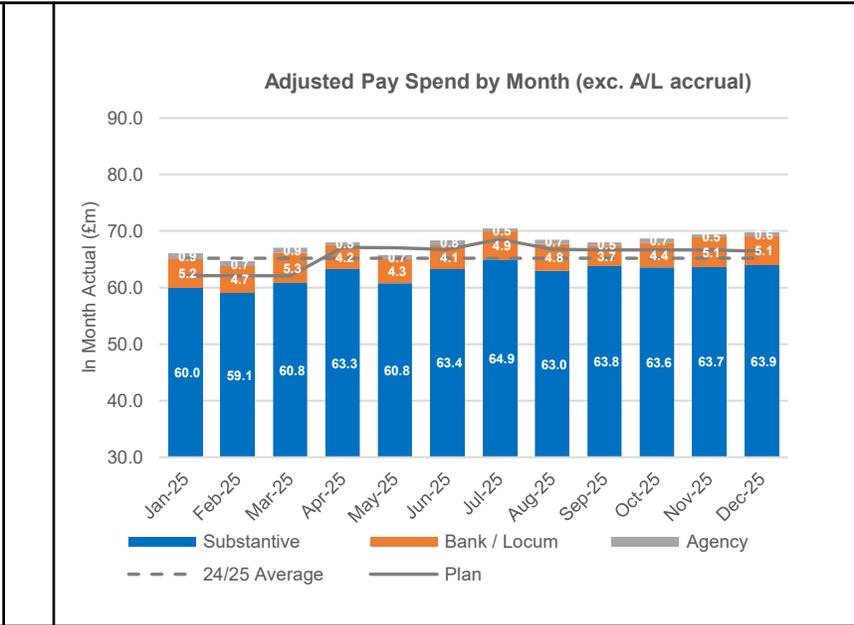
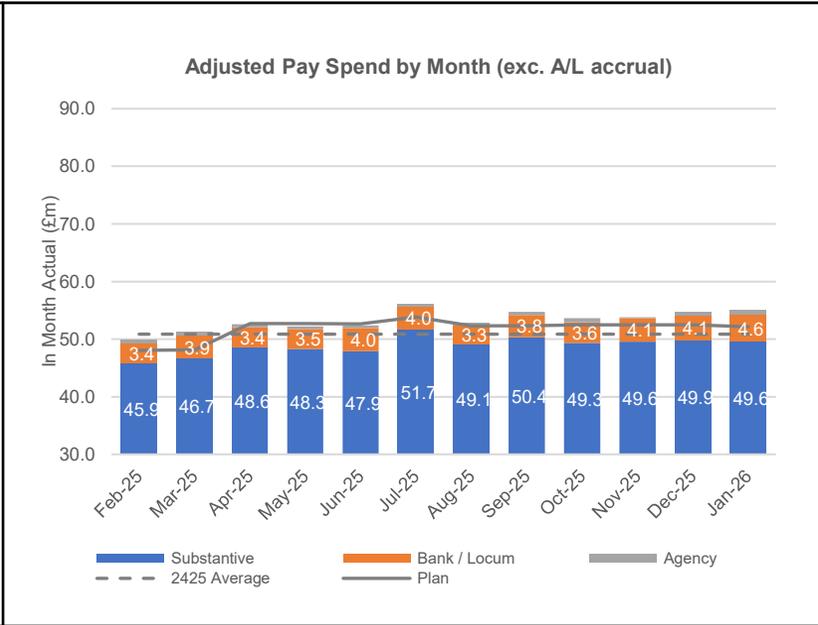
<p>Summary</p> <ul style="list-style-type: none"> The CIP plan for 2025/26 is for savings of £40.6m with £32.1m planned delivery at Month 10. At Month 10 the Trust has £21.1m of completed schemes on the tracker. There are a further £5.6m of schemes in implementation and planning, leaving a remaining £14.0m 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.
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<p>Summary</p> <ul style="list-style-type: none"> 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 31st January 2026, the Trust is reporting total savings delivery of £43.3m against a plan of £43.3m. The Trust is forecasting savings of £52.4m, an improvement of £0.2m from last month. This leaves a forecast in year savings delivery shortfall of £0.6m or 1%. On a recurrent basis, the full year effect forecast outturn at Month 10 is £29.6m. This leaves a resulting forecast recurrent shortfall of £23.4m or 44% of the 2025/26 target. A number of non-recurrent schemes have been utilised in year, which will not be repeatable in 2026/27. The largest component of this relates to central schemes which equates to £14.8m / 28% of the shortfall.
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Workforce

Pay Costs Vs Plan Run Rate

Latest Month
Jan-26
In Month Plan
£55.0m
In Month Actual
£52.1m



Latest Month
Jan-26
In Month Plan
£66.6m
In Month Actual
£70.2m

Summary
Pay spend is £2.9m adverse in month, when adjusted for pass through items, the revised position is £0.3m adverse to plan. The main drivers are:

- In year CIP - £0.4m adverse, in month impact of recurrent CIP delivery.
- Escalation and enhanced care - £0.7m adverse in nursing driven by hospital pressures.
- Vacancies - £1.1m favourable due to consultant vacancies in Anaesthetics and Imaging and other clinical/admin vacancies across all divisions.
- There are other variances of £0.3m relating to smaller overspends in the divisions.

Summary

- Total pay expenditure in January is £70.2m, £3.6m higher than plan due to higher than planned substantive and 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 129WTE since April.
- Nursing staffing levels exceed the funded establishment by 160WTE in January. 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

<p>Latest Month</p> <p>Jan-26</p> <p>In Month Plan</p> <p>£0.4m</p> <p>In Month Actual</p> <p>£0.8m</p>	<p>Agency Spend by Staff Group</p>	<p>Agency Spend by Staff Group</p>	<p>Latest Month</p> <p>Jan-26</p> <p>In Month Plan</p> <p>£0.7m</p> <p>In Month Actual</p> <p>£0.6m</p>
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<p>Summary</p> <p>Monthly Trend</p> <ul style="list-style-type: none"> Agency spend in January has increased compared to December. This is largely driven by an increase in Nursing spend due to increased hospital pressures and acuity. Overall spend in month is driven by consultant agency usage in Medicine and ASCR covering vacancies, nursing agency usage in ICU, ED and Gastroenterology wards driven by escalation (ED) and acuity (ICU and Gastro). <p>In Month vs Prior Year</p> <ul style="list-style-type: none"> Trustwide agency spend in January is below 2024/25 average spend. This is due to increased controls being implemented across divisions from November last year, and their continued impact. 	<p>Summary</p> <p>Monthly Trend</p> <ul style="list-style-type: none"> Agency expenditure in January is £0.6m, £0.1m below plan and consistent with December's agency expenditure. YTD agency expenditure is 14% 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 decreased by 57 or 7% in January compared with December. Medical agency expenditure is broadly similar to the previous month. The number of shifts covered has decreased from 207 in December to 142 in January. <p>In Month vs Prior Year</p> <ul style="list-style-type: none"> Trustwide agency spend in January is £0.3m or c35% lower than January 2025. This is due to increased controls and scrutiny implemented across Divisions with the support Trust's Nurse and Medical leadership.
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<p>Summary</p> <p>Monthly Trend</p> <ul style="list-style-type: none"> Agency expenditure in January is £0.6m, £0.1m below plan and consistent with December's agency expenditure. YTD agency expenditure is 14% 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 decreased by 57 or 7% in January compared with December. Medical agency expenditure is broadly similar to the previous month. The number of shifts covered has decreased from 207 in December to 142 in January. <p>In Month vs Prior Year</p> <ul style="list-style-type: none"> Trustwide agency spend in January is £0.3m or c35% lower than January 2025. This is due to increased controls and scrutiny implemented across Divisions with the support Trust's Nurse and Medical leadership. 	<p>Page 83 of 256</p>
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Temporary Staffing

Bank Costs Vs Plan Run Rate

<div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">Latest Month</div> <p style="text-align: center;">Jan-26</p> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">In Month Plan</div> <p style="text-align: center;">£3.2m</p> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">In Month Actual</div> <p style="text-align: center;">£4.3m</p>	<p style="text-align: center;">Bank Spend by Staff Group</p> <p style="text-align: center;">£m</p> <p style="text-align: center;"> ■ AFC ■ Medical — Plan — Target - - - 2425 Average </p>	<p style="text-align: center;">Bank Spend by Staff Group</p> <p style="text-align: center;">£m</p> <p style="text-align: center;"> ■ Nurse ■ Medical ■ Other — Plan - - - 24-25 Average </p>	<div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">Latest Month</div> <p style="text-align: center;">Jan-26</p> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">In Month Plan</div> <p style="text-align: center;">£4.2m</p> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center; font-weight: bold;">In Month Actual</div> <p style="text-align: center;">£5.7m</p>
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Summary

Summary
Monthly Trend

- In January (when spend is normalised), there has been a decrease in bank spend compared to December. The decrease is driven by medical staff staff due to industrial action costs in December. This is offset by an increase in AfC costs due to increased escalation and acuity.

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.

Summary

Summary
Monthly Trend

- Bank costs in January are £5.7m, £0.6m higher than December. Costs are £4.8m higher than plan YTD, due mainly to costs associated with operating escalation capacity due to NCTR and Industrial Action. Of the £5.7m spent in January, £2.3m relates to medical bank and £1.3m to registered nurse bank.
- Nurse bank expenditure increased by £0.1m in January from £1.2m in December, whilst shifts decreased by 370 or 5%.
- Medical bank was higher than December at £2.3m. c£0.3m of which relates to back-dated costs.

In Month vs Prior year

- Bank expenditure in January is £0.6m higher than the same period last year.

Capital Actual Vs Plan

Latest Month

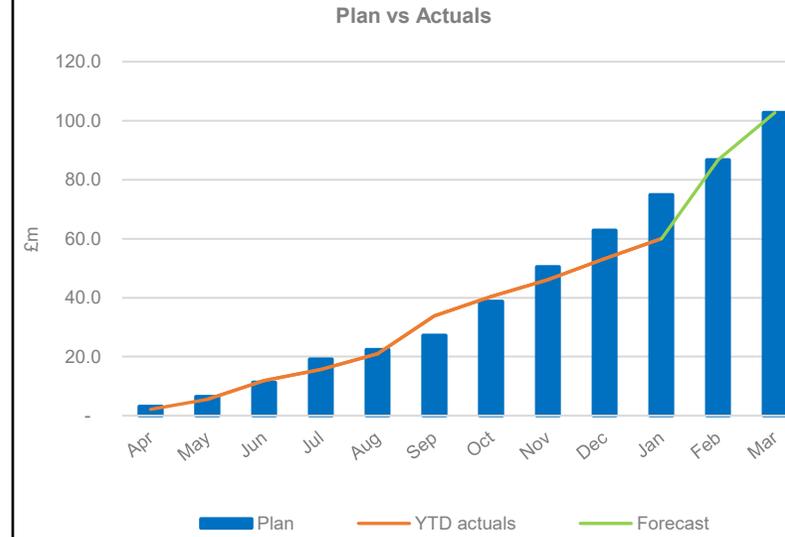
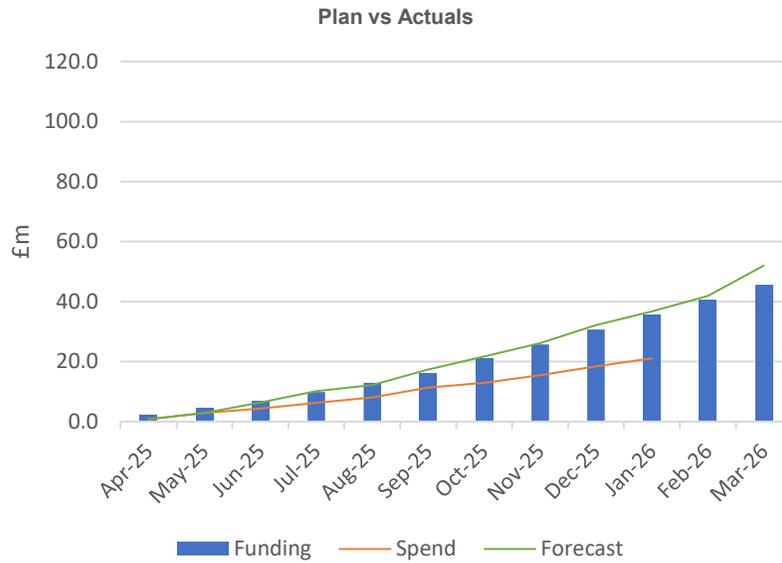
Jan-26

In Month Plan

£4.6m

In Month Actual

£2.6m



Latest Month

Jan-26

In Month Plan

£12.0m

In Month Actual

£6.8m

Summary

Summary

- The Trust currently has a system capital allocation of £22.7m for 2025/26. A further £14.7m of projects have been taken forwards as a result of national funding.
- Overall spend in Month 10 was £2.6m. This takes the overall year to date spend to £21.1m, of which £7.7m is against the Bristol Surgical Centre.
- The year-to-date variance against forecast is primarily due to delays across several projects. In most cases, spending is expected to accelerate in the coming months to align with the planned annual expenditure. Where slippage is anticipated into next year, mitigations have been implemented by bringing forward priority capital projects from 2026/27 to ensure full utilisation of available capital funding.
- Overall spend on the Bristol Surgical Centre to date is £49.8m, 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.

Summary

Summary

- Following NHSE confirmation of capital funding allocations of £55.2m, the Trust submitted a revised 2025/26 capital plan to NHSE on 30th April 2025 totalling £102.7m. The sources of funding include:
 - £40.5m CDEL allocations from the BNSSG ICS capital envelope;
 - £55.2m PDC matched with CDEL from NHSE including centrally allocated schemes;
 - £5.5m Right of use assets (leases); and
 - £1.5m for donated asset purchases.
- YTD expenditure at the end of January is £60.0m, £14.9m behind the plan of £74.9m. Due to the re-profiling of national funding into future years.
- Significant variances to plan include slippage on Major Capital Schemes (£21.2m) and Estates Schemes (£13.6m), offset in part by ahead of plan delivery against medical equipment, digital services, fire improvement and right of use assets (IFRS16).
- The Trust continues to monitor the forecast outturn via Capital Programme Board and expects to deliver in line with the notified CDEL.

Cash

Actual Vs Plan

Latest Month

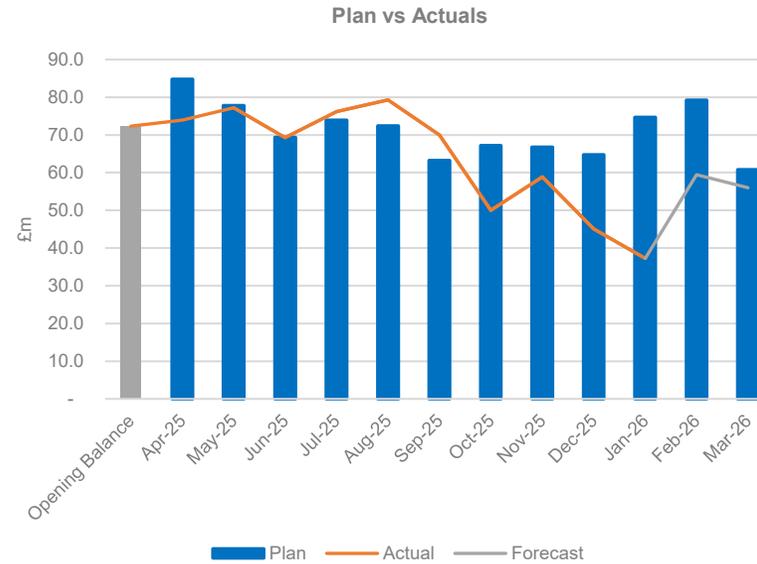
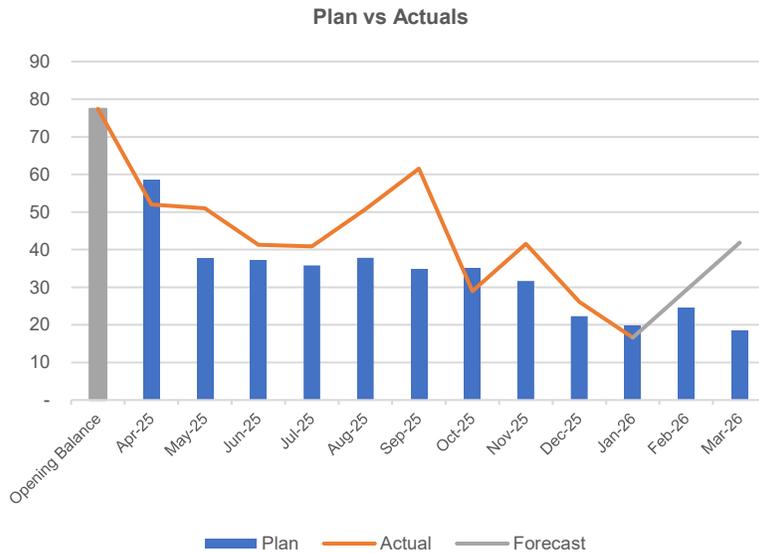
Jan-26

Target

£19.9m

Actual

£16.6m



Latest Month

Jan-26

Target

£74.7m

Actual

£37.3m

Summary

- In month cash is £16.6m, which is a £9.5m decrease from December driven by the unwinding of £7.5m pre-payment received from BNSSG received in December.
- The cash balance has decreased by £60.8m year to date, driven by capital expenditure, delays in receiving capital income, payment of invoices relating to 2024/25 and the underlying differences between PFI cash payments and the costs recorded in the revenue position .
- Year-to-date cash balances are £3.3m higher than plan and the year end cash balance is forecast to be £21.8m (£3.4m above plan), primarily driven by lower than forecast capital cash spend.

Summary

- The closing cash balance of £37.3m is a decrease of £7.8m from December.
- The £35.0m decrease from 31st March is due to a net cash inflow from operations of £21.1m, offset by cash outflow of £50.3m 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 January were £110.1m to cover payroll payments of £68.6m and supplier payments of £49.3m.
- YTD cash balances are £37.4m below plan due to timing difference on the Capital Programme (c£20m), in-month delays in receiving income (c£9m), underspend on depreciation (c£2m) and the difference directly related to the shortfall between the forecast year end cash position and the plan (c£6m).
- The forecast year end cash balance is £51.0m, £9.8m below plan.

Assurance and Variation Icons – Detailed Description

ASSURANCE ICON						No icon	
VARIATION ICON	Consistently Passing target (target outside control limits)		Passing target	Passing and Falling short of target subject to random variation	Falling short of target	Consistently Falling short of target (target outside control limits)	No Target
	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.
	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.
	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 where down is deterioration.	Common Cause (natural/expected) variation with no target.
	Special Cause Concerning Variation High, where up is deterioration	Special Cause Concerning Variation High, where up is deterioration and 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.
	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 February 2026
Data up to January 2026

<u>Activity</u>	<u>Dec-24</u>	<u>Jan-25</u>	<u>Feb-25</u>	<u>Mar-25</u>	<u>Apr-25</u>	<u>May-25</u>	<u>Jun-25</u>	<u>Jul-25</u>	<u>Aug-25</u>	<u>Sep-25</u>	<u>Oct-25</u>	<u>Nov-25</u>	<u>Dec-25</u>	<u>Jan-26</u>
<u>Number of women who gave birth (>=24 weeks or <24 weeks live)</u>	454	448	394	429	435	456	453	467	439	460	477	466	473	454
<u>Number of women who gave birth (>=22 weeks)</u>	455	447	397	429	436	456	455	467	439	460	480	480	483	454
<u>Number of babies born (>=24 weeks or <24 weeks live)</u>	460	454	401	433	442	464	463	473	444	466	483	461	473	459
<u>Number of livebirths 22+0 to 26+6 weeks</u>	2	0	6	6	4	3	4	1	9	1	2	2	3	3
<u>Number of livebirths 24+0 to 36+6 weeks</u>	41	33	28	35	36	40	32	33	43	27	32	30	41	36
<u>Number of livebirths <24 weeks</u>	1	1	3	3	0	0	1	0	3	2	0	1	0	2
<u>Induction of labour rate %</u>	30.4%	29.7%	27.9%	30.8%	31.7%	31.6%	32.7%	29.1%	33.3%	30.0%	28.1%	31.7%	29.2%	29.3%
<u>Unassisted birth rate %</u>	43.8%	44.9%	40.1%	45.2%	42.3%	42.1%	41.5%	45.4%	44.2%	46.7%	44.2%	47.3%	44.4%	40.3%
<u>Assisted birth rate %</u>	10.8%	9.6%	12.9%	12.1%	9.9%	14.0%	9.3%	8.8%	9.8%	8.0%	8.4%	10.2%	7.2%	10.8%
<u>Caesarean section rate (overall) %</u>	44.9%	44.6%	46.4%	42.7%	47.6%	43.2%	49.0%	45.6%	46.0%	45.0%	47.0%	42.5%	48.4%	48.0%
<u>Elective caesarean section rate %</u>	20.3%	21.4%	23.6%	17.9%	22.1%	20.4%	22.3%	22.7%	22.1%	22.4%	21.8%	18.7%	25.8%	29.9%
<u>Emergency caesarean section rate %</u>	24.7%	23.0%	22.8%	24.7%	25.5%	22.8%	26.7%	22.9%	23.9%	22.6%	25.2%	23.9%	22.6%	27.1%

Safe - Maternity Workforce	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Apr-00	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25
One to one care in labour (as a percentage)* excludes BBAs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with supernumerary status for labour ward coordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of times maternity unit attempted to divert or on divert	1	1	0	1	0	0	1	1	0	1	1	1	2	1
Number of obstetric consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0
Consultant Led MDT ward rounds on CDS day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Led MDT ward rounds on CDS evening/night	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of 'staff meets acuity' - CDS	51%	55%	43%	53%	64%	65%	52%	65%	72%	45%	49%	54%	55	55%
Percentage of 'up to 3 MWs short' - CDS	45%	41%	45%	36%	31%	45%	44%	33%	25%	50%	39%	43%	39	41%
Percentage of '3 or more MW's short' - CDS	5%	3%	12%	11%	5%	8%	5%	2%	3%	6%	12%	4%	6	4%
Confidence factor in Birthrate+ (data recording on CDS)	80.0%	87.1%	77.8%	77.4%	82.8%	82.3%	73.9%	87.1%	84.4%	86.6%	83.9%	75.3%	79%	75.0%

<u>Safe - Maternity Workforce</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	-1.12%	-2.14%	-1.64%	-1.53%	-1.56%	-0.87%	0.77%	2.22%	4.53%	4.60%	4.36%	0.92%	1.84%	1.27%
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs	4.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.50%	1.50%	2.0%	5.00%
Obstetric Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	2%	2%	2%	2%	2%	2%	2%	2%	0%	0%	1%	1%	0.0%	0%
Midwifery Shift Fill Rate (%) - inpatient services day	96.9%	98.8%	97.1%	95.7%	96.7%	100.1%	94.5%	94.0%	95.5%	93.6%	93.2%	92.3%	90.1%	92.2%
Midwifery Shift Fill Rate (%) - inpatient services night	100.7%	103.0%	99.6%	98.9%	99.5%	100.1%	103.6%	99.8%	97.7%	95.5%	99.7%	97.3%	92.1%	94.7%
Obstetric Shift Fill Rate - acute services* day	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	98.0%	100.0%	99.0%	99.0%	100.0%
Obstetric Shift Fill Rate - acute services* night	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	99.0%	100.0%

<u>Safe - Neonatal Workforce</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number of NICU consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs	7.70%	9.98%	9.47%	8.70%	10.99%	12.23%	10.79%	13.72%	14.71%	16.94%	14.22%	12.45%	13.57%	12.15%
Neonatal Nurse Qualified in Speciality establishment rate	55%	52%	52%	52%	52%	52%	54%	63%	63%	63%	60%	60%	60%	65%
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs	0%	0%	0%	0%	0%	0%	0%	0%	5%	5%	5%	5%	5%	5%
Neonatal Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs	0%	7.60%	7.60%	0%	0%	0%	8%	8%	8%	8%	8%	8%	8%	0.00%
Neonatal Nursing Fill Rate (%) - acute services* using BAPM acuity tool	100.0%	98.3%	100.0%	100.0%	98.3%	91.8%	96.6%	100.0%	88.5%	86.0%	100.0%	100.0%	96.6%	71.4%
Neonatal Nursing QIS Fill Rate (%) - acute services using BAPM acuity tool	78.0%	73.3%	96.43	75.0%	74.6%	49.2%	55.2%	50.0%	37.7%	28.3%	82.8%	92.3%	76.6%	39.5%
Neonatal (Medical) Shift Fill Rate (%) - acute services* day using BAPM acuity tool	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	97.8%	97.8%	96.0%	95.0%	95.0%	100.0%
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night using BAPM acuity tool	100%	100.0%	100.0%	100.0%	100.0%	95.7%	95.0%	94.6%	94.0%	93.3%	95.0%	95.0%	95.0%	100.0%

<u>Training</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Training compliance fetal wellbeing day - Obstetric Consultants	79%	90%	90%	89%	94%	90%	80%	80%	80%	56%	90%	100%	95%	95%
Training compliance fetal wellbeing day - Other Obstetric Doctors	76%	76%	87%	82%	82%	85%	81%	78%	80%	84%	94%	87% (93%)	63%	90%
Training compliance fetal wellbeing day - Midwives (ALL)	90%	87%	87%	84%	80%	85%	81%	81%	82%	80%	90%	97%	92%	90%
Training compliance in maternity emergencies and multi-professional training - Obstetric Consultants	95%	90%	90%	90%	94%	85%	90%	90%	90%	100%	94%	100%	95%	100%
Training compliance in maternity emergencies and multi-professional training - Other Obstetric Doctors	76%	68%	82%	91%	94%	100%	96%	97%	69%	81%	90%	94%	65%	68%
Training compliance in maternity emergencies and multi-professional training - Midwives (ALL)	94%	89%	86%	86%	89%	92%	91%	92%	93%	82%	93%	97%	92%	91%
Training compliance in maternity emergencies and multi-professional training - Anaesthetic Consultants	90%	90%	91%	91%	66%	69%	62%	63%	63%	70%	100%	96%	92%	84%
Training compliance in maternity emergencies and multi-professional training - Other Anaesthetic Doctors	91%	95%	73%	61%	66%	77%	75%	86%	87%	88%	90%	100%	92%	85%
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	93%	90%	87%	89%	87%	84%	87%	91%	90%	77%	88%	95%	91%	94%

Training	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Training compliance annual local NBLS - Midwives (ALL)												99%	90%	89%
Training compliance annual local NBLS - NICU Consultants	94%	94%	94%	92%	92%	100%	92%	91%	91%	91%	91%	100%	94%	71%
Training compliance annual local NBLS - NICU Resident doctors (who attend any births)	94%	94%	94%	100%	100%	100%	100%	100%	94%	100%	100%	100%	94%	100%
Training compliance annual local NBLS NICU ANNPs (ALL)	82%	91%	91%	90%	90%	70%	70%	60%	80%	100%	100%	100%	100%	81%
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	88%	98%	93%	93%	86%	91%	93%	91%	94%	98%	96%	96%	98%	87%
Training compliance annual local NBLS APs, HCAs and nursery nurses (dependant on their roles within the service - for local policy to determine)	88%	90%	86%	87%	92%	89%	89%	90%	95%	97%	97%	97%	93%	82%

<u>Safe - Delivery Metrics</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number of shoulder dystocias recorded (vaginal births)	9	10	6	9	7	11	6	10	5	4	8	10	5	6
% of women with a high degree (3rd and 4th) tear recorded	3.2%	5.6%	4.3%	3.7%	5.7%	5.0%	3.5%	5.5%	5.9%	2.8%	5.9%	4.9%	3.7%	3.0%
Number of women with a retained placenta following birth requiring MROP	9	9	7	11	8	9	9	8	9	9	17	6	17	11
Number of babies with an Apgar Score <7 at 5 mins (all gestations)	7	5	6	14	13	13	12	4	10	8	8	5	8	8

<u>Infant Feeding & Skin to Skin</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
% of babies where breastfeeding initiated within 48 hours	79.1%	76.3%	82.3%	76.5%	88.2%	81.0%	80.2%	84.7%	82.7%	83.2%	83.1%	87.1%	80.2%	79.3%
% of babies breastfeeding on Day 10	73.5%	73.1%	78.2%	77.4%	76.3%	70.9%	75.5%	76.3%	78.5%	70.5%	77.6%	78.0%	76.0%	76.6%
% of babies breastfeeding at transfer to community	66.9%	66.9%	73.3%	68.4%	71.8%	67.1%	70.3%	72.9%	75.7%	72.2%	73.9%	73.7%	72.0%	72.1%
% of babies where skin to skin recorded within 1st hour of birth	81.2%	82.4%	81.0%	80.4%	82.7%	83.1%	82.6%	84.9%	83.5%	83.4%	84.1%	84.7%	81.3%	80.6%

<u>Perinatal Morbidity and Mortality inborn</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Total number of perinatal deaths (excluding late fetal losses)	4	6	4	9	2	2	4	3	4	1	2	0	4	3
Number of late fetal losses 16+0 to 23+6 weeks excl TOP	1	2	1	0	0	3	5	4	0	5	4	4	0	1
Number of stillbirths (>=24 weeks excl TOP)	1	5	0	4	2	2	3	3	0	0	1	0	2	2
Stillbirths per 1000 live births	2.17	11.01	0.00	9.32	4.52	4.31	6.48	6.34	0.00	0.00	2.07	3.70	3.96	4.36
Number of neonatal deaths : 0-6 Days	1	0	3	5	0	0	0	0	2	1	0	0	1	0
Number of neonatal deaths : 7-28 Days	2	1	1	0	0	0	1	0	2	0	1	0	1	0
Neonatal Deaths before 28 days per 1000 live births (ALL)	6.5	2.2	10.15	11.66	0.00	0.0	2.2	0.0	4.5	2.1	2.1	0.0	2	0.0
* NND before 28 days per 1000 live births (Inborn babies only)	2.2	0.0	7.48	8.93	0.00	0.0	2.2	0.0	4.5	4.6	2.1	0.0	1	0.0
PMRT grading C or D themes in report	2	3	3	0	0	2	2	1	0	0	1	1	0	1
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (MNSI referral)	1	3	1	1	0	0	1	0	0	0	0	0	0	1

Maternal Morbidity and Mortality	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
<u>Number of maternal deaths (MBRRACE)</u>	0	0	0	0	0	0	0	1	0	0	1	0	1	0
<u>Direct causes</u>	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<u>Indirect causes</u>	0	0	0	0	0	0	0	1	0	0	1	0	1	0
<u>Number of women who received enhanced care on CDS (HDU)</u>	37	32	33	36	32	33	39	39	23	30	38	31	38	32
<u>Number of women who received level 3 care (ICU)</u>	1	1	2	1	1	1	1	1	0	0	0	0	0	1

<u>Insight</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
<u>Number of incident reported</u>	95	99	108	166	99	106	124	56	113	100	106	122	135	117
<u>Number of incidents graded as moderate or above (total) (Physical Harm)</u>	1	0	0	0	3	0	1	0	6	4	1	0	1	1
<u>incident moderate harm or above (not PSII, excludes MNSI)</u>	0	0	0	0	3	0	1	4	6	4	1	0	0	0
<u>incident PSII (excludes MNSI)</u>	1	0	0	0	0	1	0	0	0	0	0	0	0	0
<u>New MNSI referrals accepted</u>	1	1	1	2	0	0	1	0	0	0	0	0	0	0
<u>Outlier reports (eg. MNSI/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust</u>	0	0	0	1	0	0	0	0	1	0	0	0	0	0
<u>Coroner Reg 28 made directly to Trust</u>	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<u>Trust Level Risks</u>	3	3	3	3	3	3	4	5	5	5	5	7	5	6

<u>NICU Data</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
<u>Neonatal Admission to NICU</u>	55	50	48	59	41	46	52	48	52	37	48	43	63	57
<u>of which Inborn Babies booked with NBT</u>	37	34	32	44	31	33	33	29	38	26	28	31	40	41
<u>of which Inborn Babies -booked elsewhere</u>	2	0	4	2	0	3	4	5	4	1	1	3	4	3
<u>of which readmission</u>	5	3	4	3	3	5	6	3	2	4	9	2	9	5
<u>of which ex-utero admission</u>	9	7	7	7	4	4	9	8	5	3	6	4	7	5
<u>of which source of admission cannot be derived</u>	2	3	1	2	2	1	0	1	1	3	2	3	1	0
<u>Neonatal Admission to Transitional Care</u>	28	40	29	27	39	36	35	36	40	40	26	30	32	23
<u>Admission rate at term</u>	4.1%	6.0%	5.7%	7.2%	4.0%	4.8%	3.9%	5.8%	5.9%	3.9%	4.9%	6.0%	5.0%	6.2%
<u>NICU babies transferred to another unit for higher/specialist care</u>	4	8	5	3	4	4	5	2	1	4	4	6	8	5
<u>NICU babies transferred to another unit due to a lack of available resources</u>	3	0	0	2	0	2	3	0	0	4	2	9	12	9
<u>NICU babies transferred to another unit due to insufficient staffing</u>	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<u>Attempted baby abduction</u>	0	0	0	0	0	0	0	0	0	0	0	0	0	0

<u>Involvement</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	86%	91%	100%	100%
Friends and family Test score (response rate % who rated 'very good' or 'good') Maternity	90%	87%	95%	94%	94%	91%	92%	94%	93%	92%	90%	91%	87%	89%
<u>Service User feedback: Number of Compliments (formal)</u>	14	29	74	37	59	78	61	79	69	63	60	46	47	48
<u>Service User feedback: Number of Complaints (formal)</u>	0	11	2	2	2	9	2	6	16	3	3	4	4	6
<u>Staff feedback from frontline champions and walk-about (number of themes)</u>	0	0	8	7	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	Meeting	Walk-about minutes	

<u>Telephone Triage</u>	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
<u>Attendance to triage</u>	850	822	791	925	939	943	888	996	880	963	1167	1077	1026	1101
<u>BSOTS KPI Initial assessment within 15 minutes</u>	63%	69%	66%	56%	58%	63%	66%	65%	64%	56%	48%	47%	49%	48%
<u>NICE Safer Staffing Red Flag Initial assessment within 30 minutes</u>	88%	91%	91%	85%	85%	91%	91%	93%	90%	86%	81%	75%	78%	80%
<u>Calls answered by triage (Day 0730-2000)</u>	916	902	857	961	947	979	977	1150	997	1118	1262	1071	1120	
<u>Calls answered by triage (Night 2000-0700)</u>	334	291	236	280	272	291	352	368	323	354	414	381	399	
<u>Phone calls abandoned on triage (Day 0730-2000)</u>	176	146	159	168	182	204	154	149	152	242	230	237	216	
<u>Phone calls abandoned on triage (Night 2000-0700)</u>	34	22	41	39	29	26	37	36	25	24	32	47	31	
<u>Calls answered by other clinical areas (CDS and Mendip - Day + Night)</u>	729	726	669	734	606	522	522	536	484	493	615	542	505	
<u>Phone calls abandoned in other clinical areas (CDS and Mendip - Day + Night)</u>	20	18	23	21	12	22	28	30	28	14	34	29	18	

Perinatal Quality Surveillance (PQSM)

January 2026
UHBW Maternity



Inspected and rated

Good

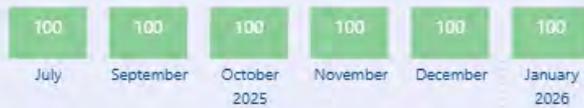


Perinatal Quality Surveillance Matrix (PQSM)

January 2026

Maternity Workforce & Acuity

Compliance with supernumerary status for labour ward coordinator (%)



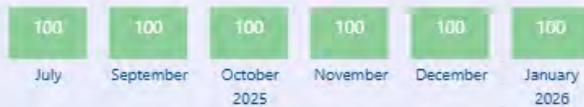
6 monthly average



Trend



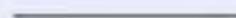
One to one care in labour * excludes BBAs (%)



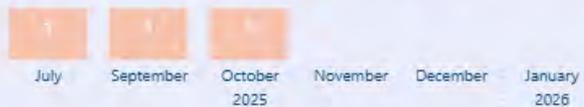
6 monthly average



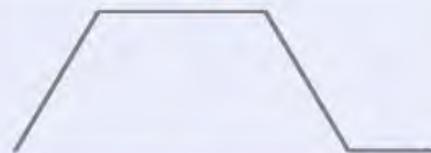
Trend



Number of times maternity unit attempted to divert or on divert

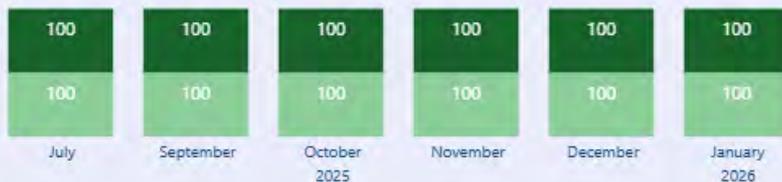


Trend



Consultant Led MDT Ward Rounds on CDS (%)

Day Shift Night Shift



6 monthly average - Day Shift



Trend - Day Shift



6 monthly average - Night Shift



Trend - Night Shift



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

0

Is the standard of care being delivered?

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

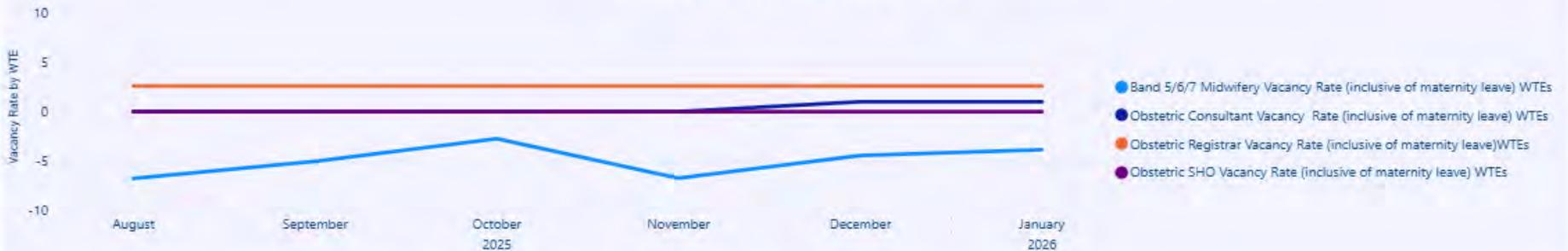
What are the top contributing factors to over/under achievement?

- 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.**

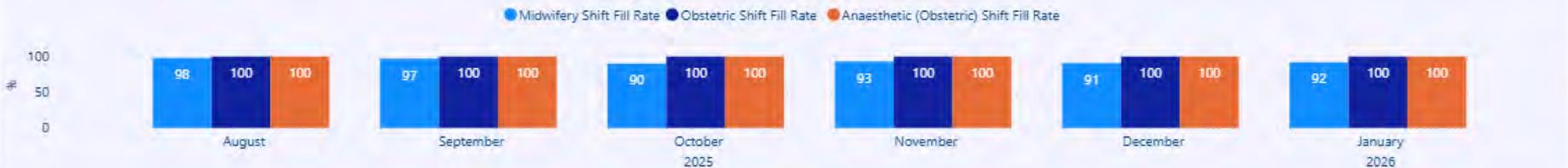
Perinatal Quality Surveillance Matrix (PQSM) January 2026

Maternity Workforce & Acuity

Obstetric and Midwifery Vacancy Rates



Day Shift Fill Rate - Acute services - Actual



Night Shift Fill Rate - Acute services - Actual

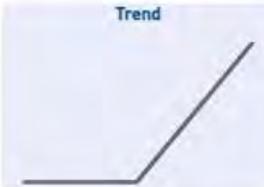
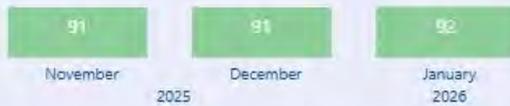


Perinatal Quality Surveillance Matrix (PQSM) January 2026

Maternity Workforce & Acuity

Central Delivery Suite (CDS)

Confidence factor in Birthrate + (Central Delivery Suite)



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 but will not contribute to the overall compliance calculation.

CDS Acuity Summary - November

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



CDS Acuity Summary - December

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



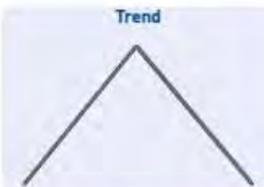
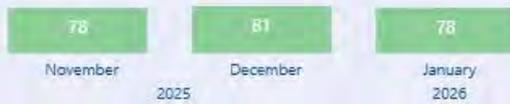
CDS Acuity Summary - January

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



Transitional Care (TC)

Confidence factor in Birthrate + (Transitional Care)



TC Acuity Summary - November

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



TC Acuity Summary - December

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



TC Acuity Summary - January

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



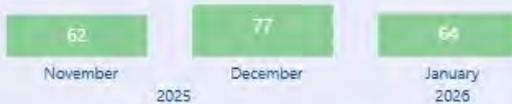
Perinatal Quality Surveillance Matrix (PQSM)

January 2026

Maternity Workforce & Acuity

Ante / Post Natal Ward (Oak)

Confidence factor in Birthrate + (Oak Ward)



Trend



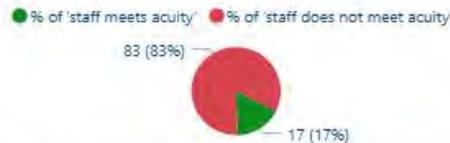
Birthrate Plus®

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

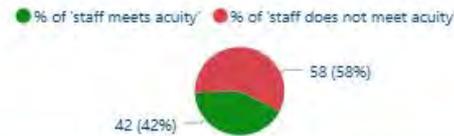
Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00), there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

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

Oak Acuity Summary - November



Oak Acuity Summary - December

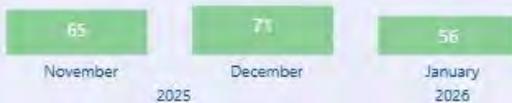


Oak Acuity Summary - January

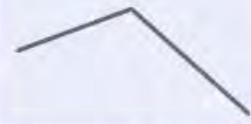


Ante / Post Natal Ward (Willow)

Confidence factor in Birthrate + (Transitional Care)



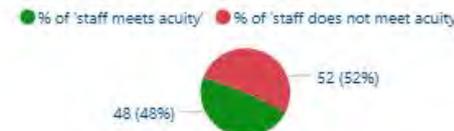
Trend



TC Acuity Summary - November



TC Acuity Summary - December



TC Acuity Summary - January



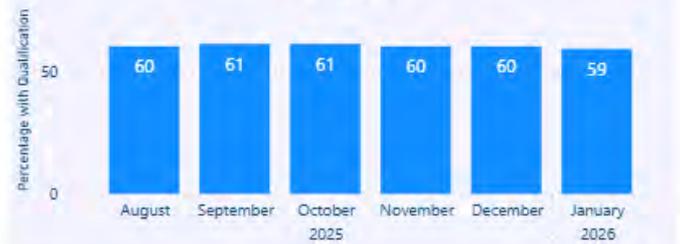
Perinatal Quality Surveillance Matrix (PQSM) January 2026

Neonatal Workforce & Acuity

Neonatal Medical and Nursing Vacancy Rates



% of Neonatal Nurses with Qualified in Speciality (QIS) Certification (Target 80%)



Day Shift Fill Rate - Acute services - Actual



Night Shift Fill Rate - Acute services - Actual



Perinatal Quality Surveillance Matrix (PQSM) January 2026

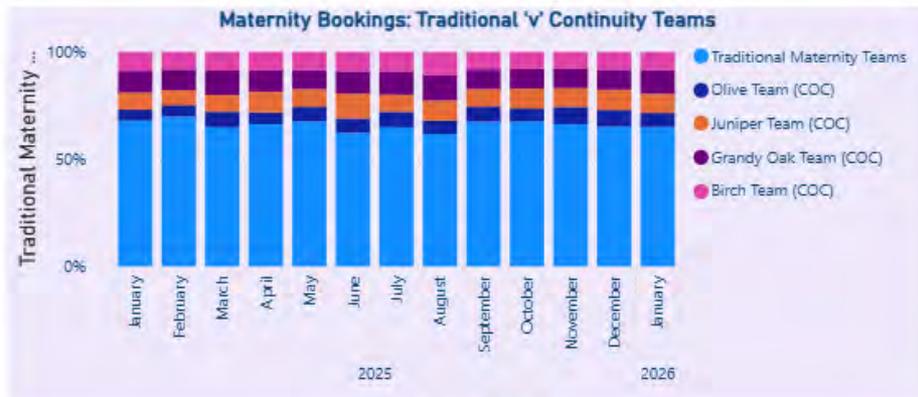
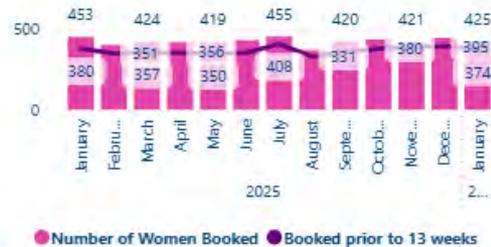
Maternity Metrics

425

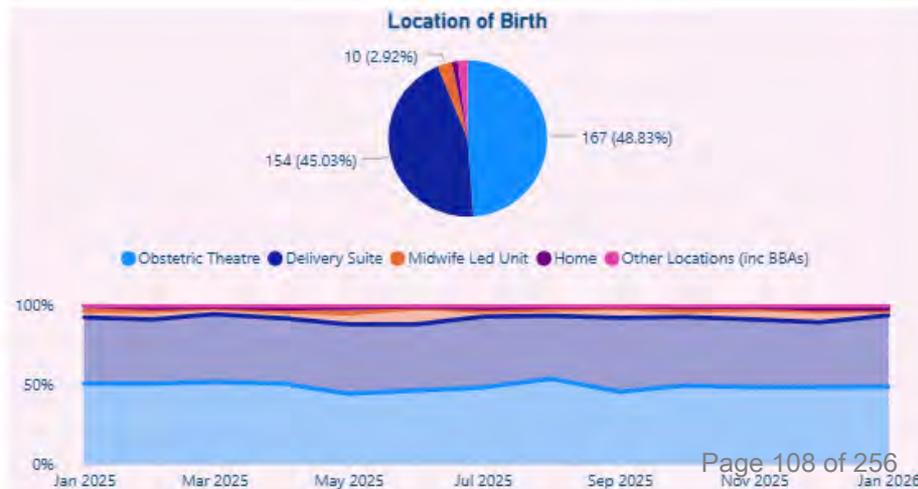
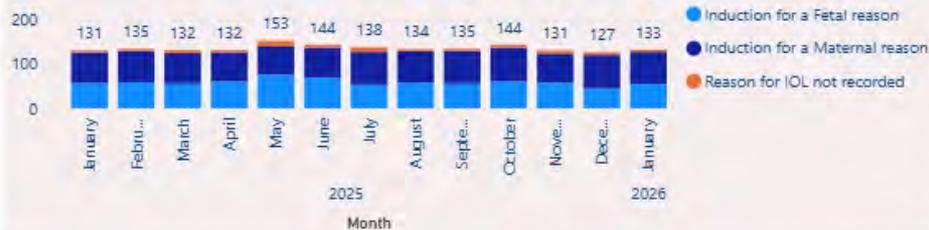
Number of Women booked for maternity care

374

Number of Women booked before 13 weeks Gestation



Number of Inductions: Breakdown by Primary Reason



342

Number of Registerable Births (Women)

345

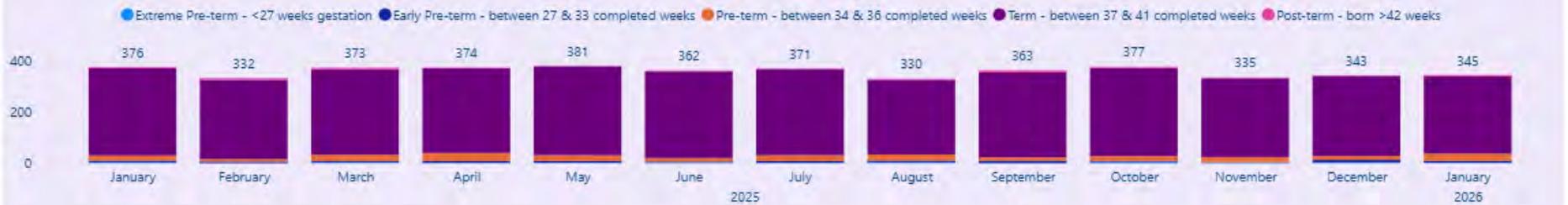
Number of Registerable Births (Babies)



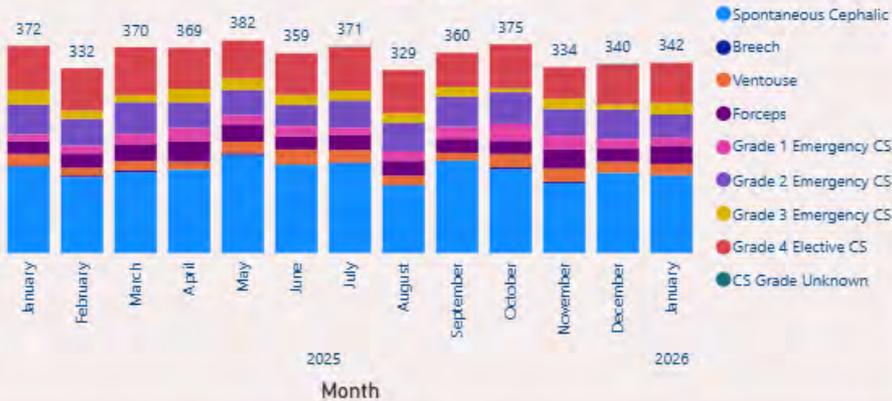
Perinatal Quality Surveillance Matrix (PQSM) January 2026

Maternity Metrics

Gestation at Birth



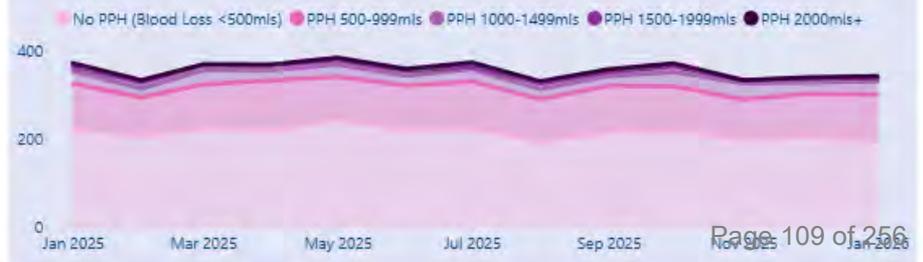
Mode of Birth



Location of Birth



Postpartum Haemorrhage (PPH)



3

Number of Grade 1 CS delivered outside of 30 minutes

15

Number of Grade 2 CS delivered outside of 75 minutes

Perinatal Quality Surveillance Matrix (PQSM) January 2026

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

November 2022

Select end month

November 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

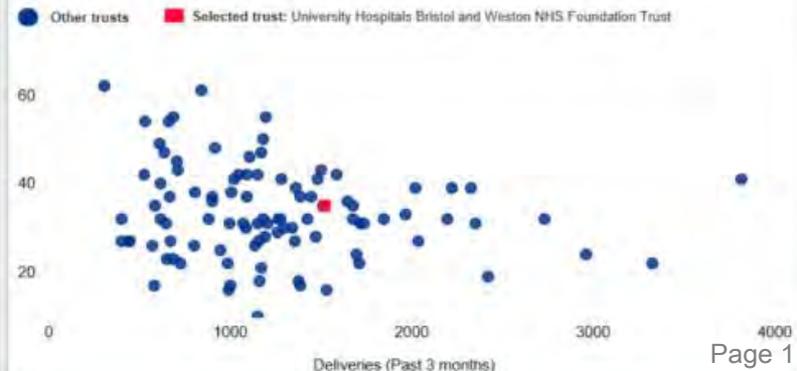
Smoking CQIMs & SATOD

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)



Trust Region LMNS MBRRACE

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

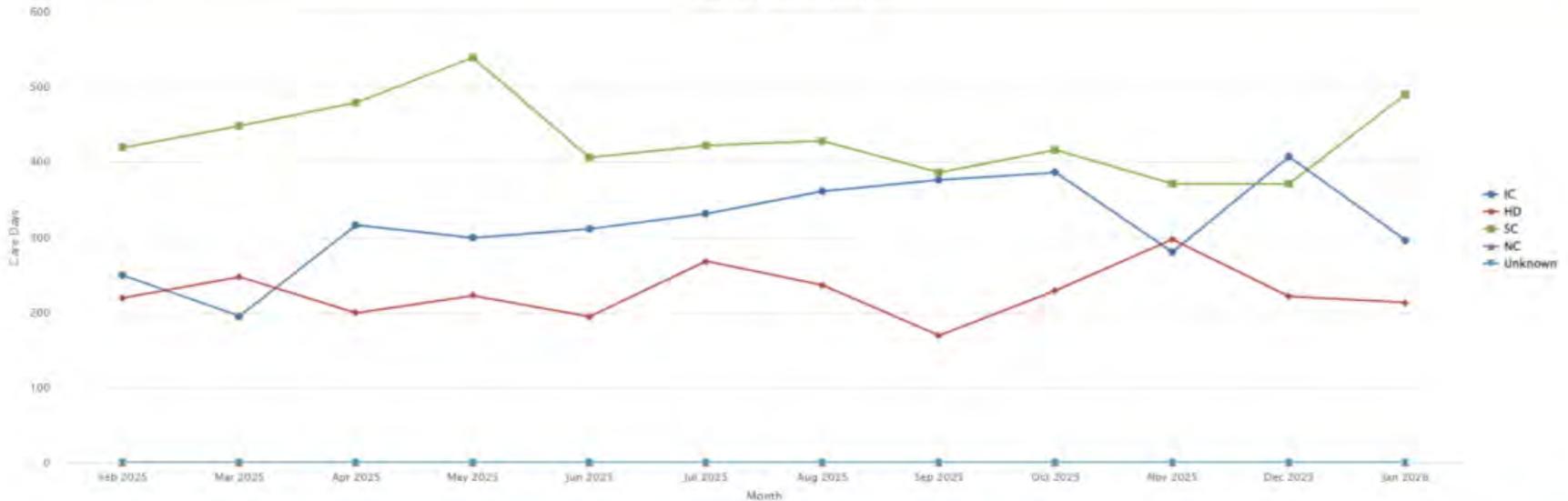


Perinatal Quality Surveillance Matrix (PQSM) January 2026

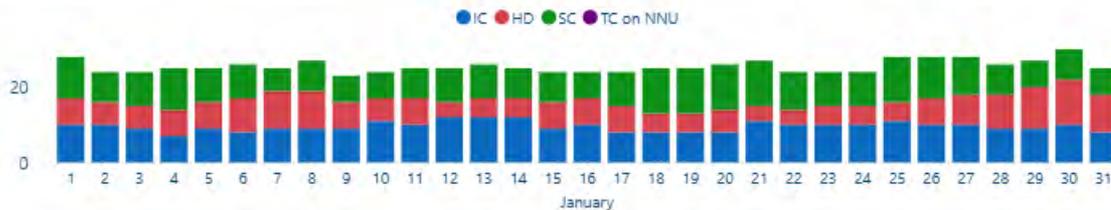
Neonatal Metrics

NNU activity BAPM 2011

BAPM 2011 Monthly Activity



Neonatal Cot Summary

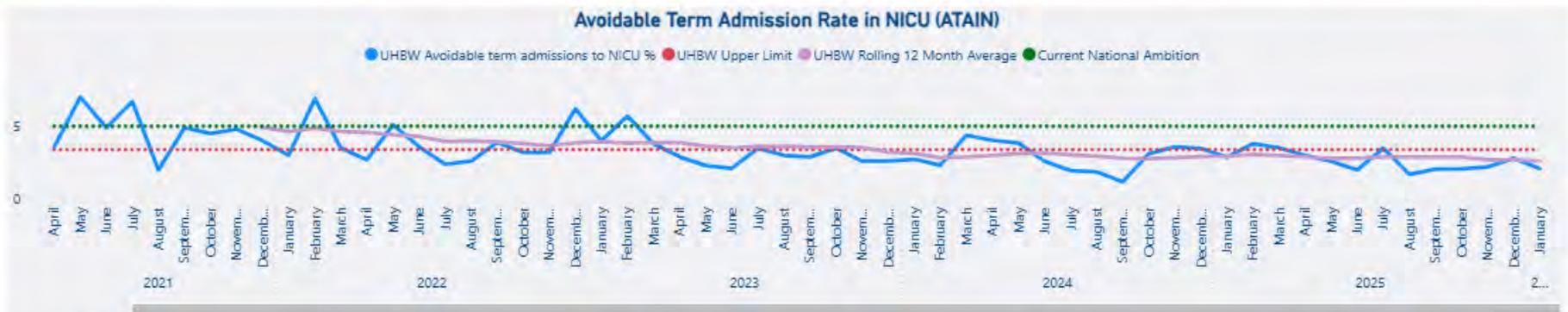


Neonatal Commissioned Cot Summary

Intensive Care (IC) Cots	= 15
High Dependency (HD) Cots	= 8
Special Care (SC) Cots	= 8
Transitional Care (TC) Cots	Page 111 of 256

Perinatal Quality Surveillance Matrix (PQSM) January 2026

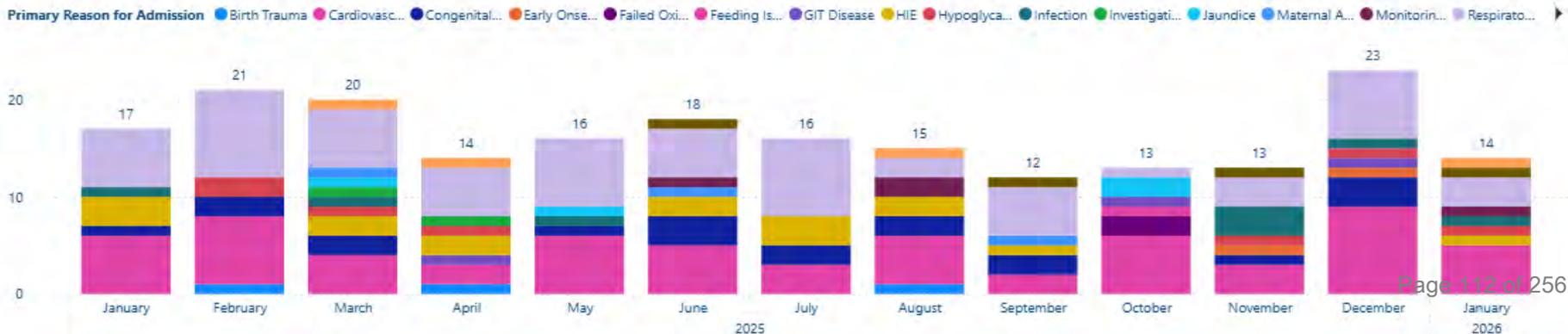
Neonatal Metrics - Avoidable Term Admission Rate in NICU (ATAIN)



January 2026
UHBW Avoidable term Admission Rate 2.10%

As of End January 2026
UHBW Rolling 12 Month Average 2.60%

Primary Reason for Term Admission to NICU



Perinatal Quality Surveillance Matrix (PQSM) January 2026

Perinatal Mortality Overview (up to end January 2026)

UHBW Breakdown of Stillbirths and Neonatal Deaths (All)

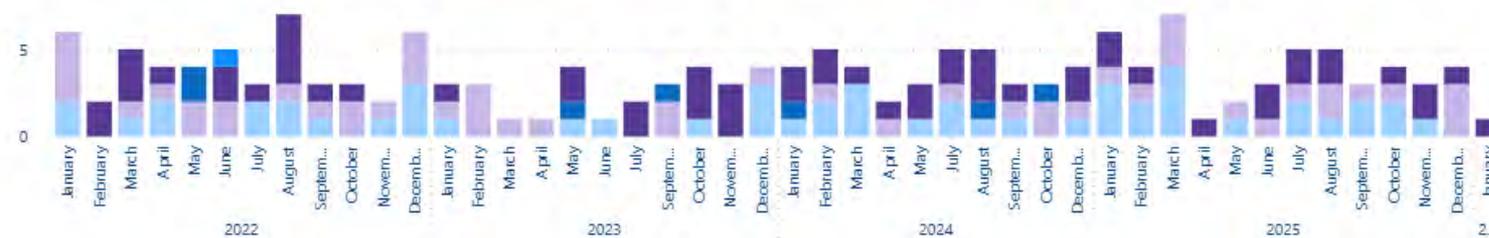
Timing of death: Antepartum stillbirth, Early neonatal death, Intrapartum stillbirth, Late neonatal death, Stillbirth of unknown timing

Trust/health board of birth

All

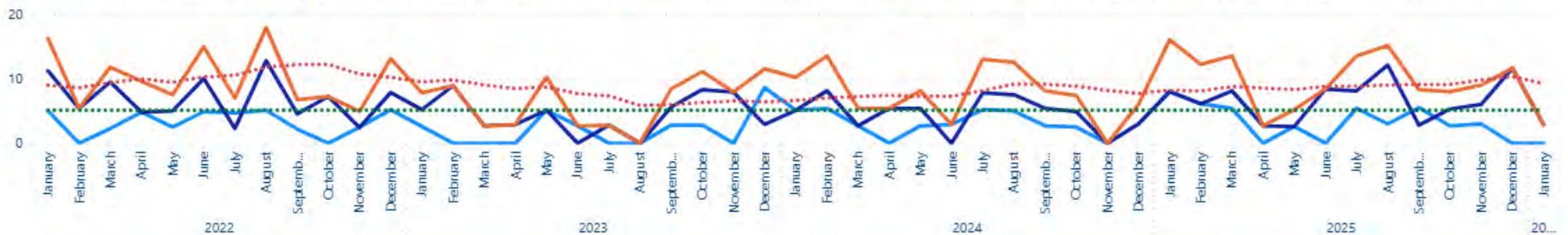
Trust/health board of death

All



UHBW Perinatal Mortality Rates per 1000 births

UHBW Stillbirth rate per 1000 births, Sum of UHBW Neonatal Deaths per 1000 births, UHBW Perinatal Mortality Rate per 1000 births, UHBW Rolling 12 month perinatal mortality rate, National Perinatal Mortality Rate Ambition



UHBW Rolling 12 Month Perinatal Mortality Rate at end January 2026 (per 1000 births) = 9.20

Perinatal Quality Surveillance Matrix (PQSM) January 2026

Maternity Outcomes Signal System (MOSS)

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

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

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: **04 Dec 25**
Refreshed: **17 Feb 26**



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

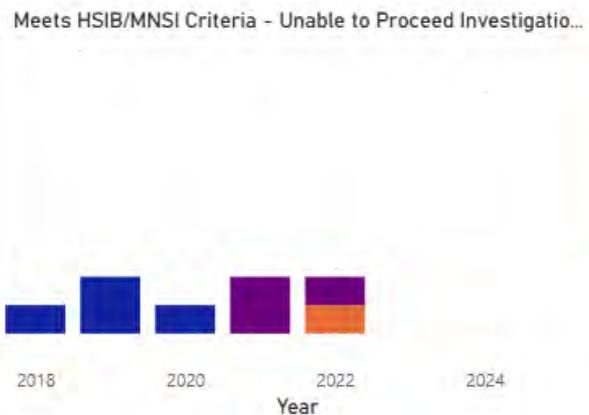
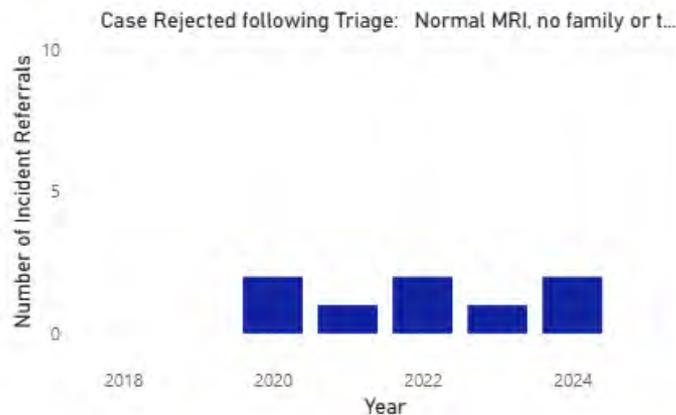
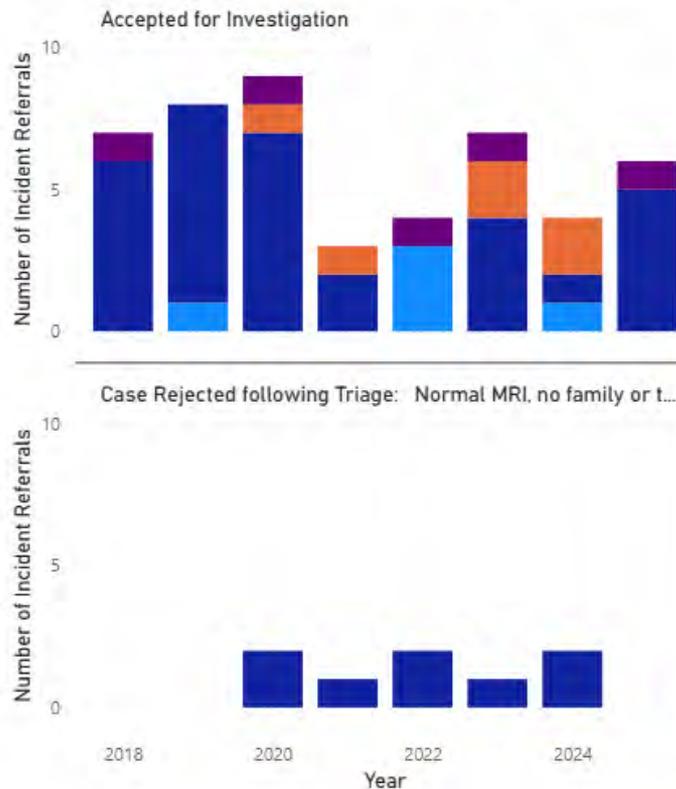
Perinatal Quality Surveillance Matrix (PQSM)

January 2026

Perinatal Mortality & Morbidity - MNSI

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

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



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

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

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

Date of Incident

17/08/2018 24/12/2025

Perinatal Quality Surveillance Matrix (PQSM) January 2026

Perinatal Mortality & Morbidity - MNSI

HSIB/MNSI Case Status

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



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Perinatal Quality Surveillance Matrix (PQSM)

January 2026

PMRT Reviews

What is PMRT?

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

Grading of Care

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

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

PMRT ID	Month reviewed	Date of incident	Incident	Grading of care	Outcome/ Learning/ Actions (if grading C or D)	Actions
10037	Jan-26	24/09/2025	Stillbirth	Grading of care of the mother and baby up to the point of birth of the baby.	A	
				Grading of care of the baby from birth up to the death of the baby.	N/A	
				Grading of care of the mother following the death of her baby.	C	<ul style="list-style-type: none"> - Confusion regarding use of the pool for Anna's labour - Delay in adequate analgesia in labour - Feedback regarding her obstetric care on CDS - The issues around the missing section of the umbilical cord - Poor mental health support and initially being told Anna would be discharged from AWP
96486	Jan-26	18/12/2024	Early neonatal death	Grading of care of the mother and baby up to the point of birth of the baby.	D	
				Grading of care of the baby from birth up to the death of the baby.	Pending	
				Grading of care of the mother following the death of her baby.	D	
10009	Jan-26	27/08/2025	Neonatal death	Grading of care of the mother and baby up to the point of birth of the baby.	D	
				Grading of care of the baby from birth up to the death of the baby.	Pending	
				Grading of care of the mother following the death of her baby.	C	<ul style="list-style-type: none"> - Oxycodone given which is contra-indicated for women with a history of serious psychological disorders.

Perinatal Quality Surveillance Matrix (PQSM)

January 2026

Incident Oversight: January 2026

Executive summary

A total of 243 incidents were reported during January 2026. The incident profile reflects ongoing winter operational pressures, with activity concentrated in medication processes, clinical assessment and review, and obstetric pathways.

Overall, the data suggests a reporting culture that captures operational and process risks early, particularly where delays, capacity constraints, and coordination challenges are present.

Key themes and trends

Medication safety (14%)

Medication incidents represent the largest category. Reports primarily relate to prescribing discrepancies, administration delays, and documentation issues. These patterns indicate ongoing vulnerability in medicines management processes, particularly during periods of high workload.

Clinical assessment and escalation (13%)

Incidents highlight delays in clinical review, escalation concerns, and challenges in timely decision-making. This suggests pressure on clinical capacity and reinforces the need to ensure robust escalation pathways.

Obstetric pathway pressures (13%)

Obstetric pathway pressures (13%)

Obstetric incidents remain a significant proportion, including emergency presentations, pathway delays (e.g., induction flow), and coordination challenges. Demand and flow on maternity services appear to be a continuing risk area.

Operational flow and service provision (9%)

Reports describe bed availability issues, clinic or theatre constraints, and system coordination challenges. These are consistent with seasonal demand pressures affecting patient flow.

Transfers and discharge processes (7%)

Transport delays and inter-departmental transfer issues continue to feature, highlighting interface risks across services.

Harm profile

Most incidents were recorded as no harm, or negligible. There were no clear signals of clusters of moderate or severe harm within the reporting period.

Perinatal Quality Surveillance Matrix (PQSM)

December 2025



University Hospitals
Bristol and Weston
NHS Foundation Trust

Incident Oversight: January 2026

Emerging risks

Sustained pressure on clinical capacity impacting timely review and escalation
Medicines management reliability during high workload periods
Maternity flow and responsiveness under demand
System coordination challenges affecting transfers and bed management
Incomplete harm documentation limiting assurance

Positive indicators

Continued incident reporting across a broad range of categories, indicating engagement with safety reporting processes
Predominance of low-harm and near-miss reporting, supporting proactive risk identification
Visibility of operational risks enabling targeted mitigation

Recommended areas of focus

Strengthen medicines safety assurance, including review of common error types and local learning.
Review escalation processes and clinical review capacity, particularly during peak demand periods.
Continue oversight of maternity flow and risk controls.
Improve completeness of harm coding and data quality.
Monitor transfer and discharge pathways for delays and coordination risks.

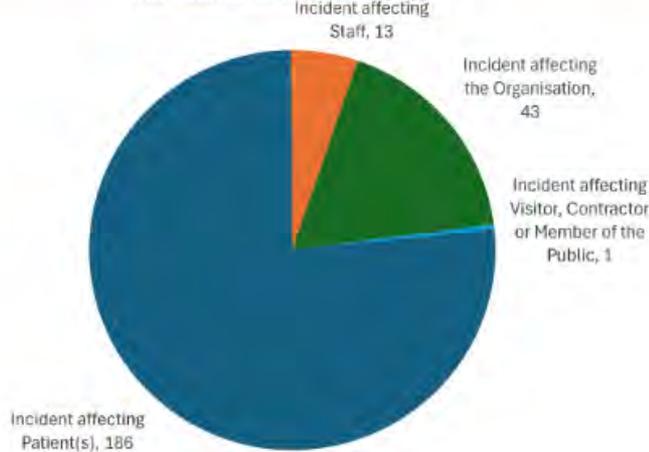
Conclusion

The January incident profile reflects system pressures rather than isolated failures, with risks concentrated around capacity, coordination, and process reliability. Continued focus on operational resilience, data quality, and targeted learning will support ongoing improvement in patient safety.

Perinatal Quality Surveillance Matrix (PQSM) January 2026

Incident Reporting & Management

Breakdown of Incident by Type



Heat Map: Incident Categories by Department (January 2026)

