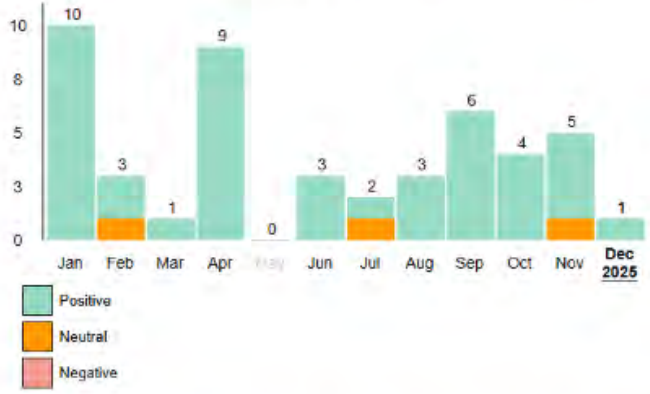
Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

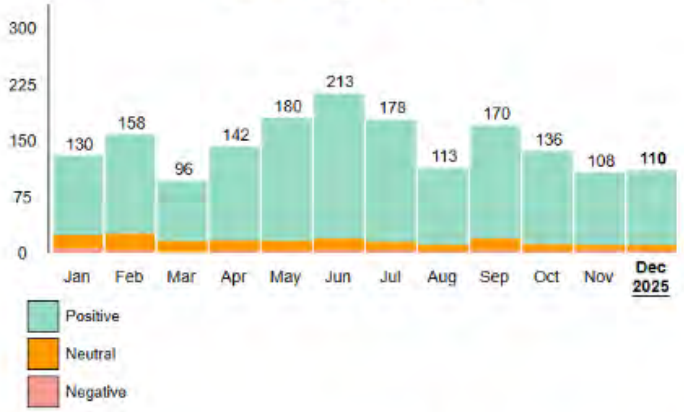
Patient Experience

Friends & Family Test Survey

Neonatal Services

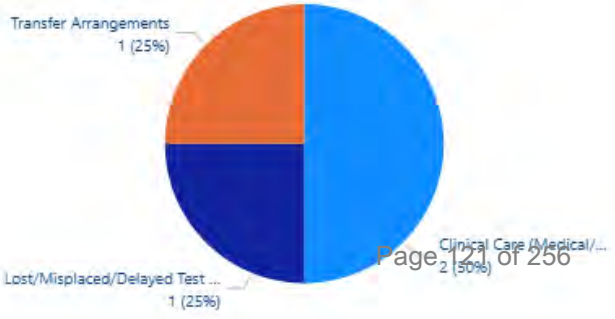


Maternity Services



Maternity and Neonatal Complaints by Month First Received

January 2026 Complaints by Sub-Category



Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Maternity Incentive Scheme - Year 7

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

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, The Royal College of Obstetricians and Gynaecologists (RCOG, the Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), the Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity Newborn Safety Investigation Programme (MNSI).

MIS Year 7 Guidance published 2 April 2025

Compliance Submission Deadline: 3 March 2026

Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

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

LMNS Assurance Review Dates:

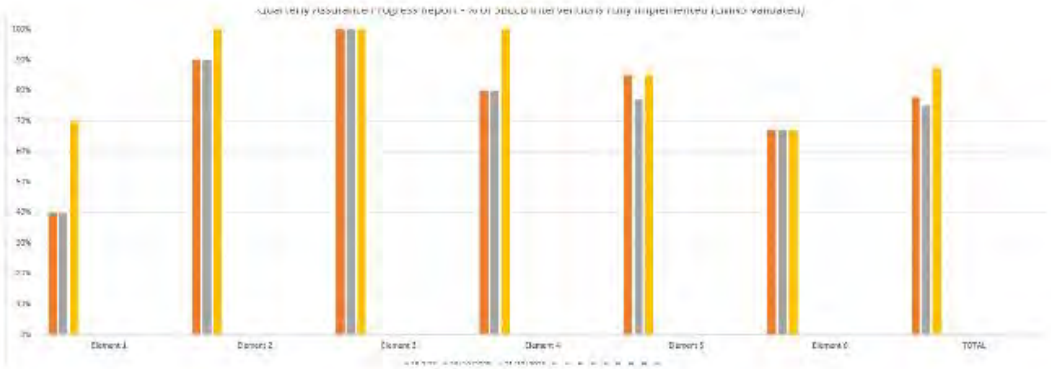
MIS Year 7:

Q1 18th July 2025 = 78%

Q2 23rd October 2025 = 75%

Q3 1st December 2025 = 87%

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	88%	Partially implemented	87%



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

The bundle focuses on six core elements:

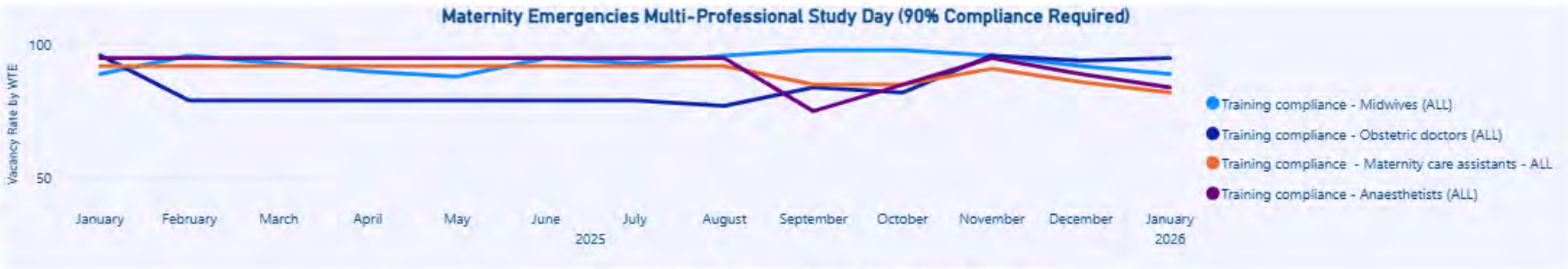
1. Reducing smoking in pregnancy through systematic identification, referral, and support.
2. Risk assessment and surveillance for fetal growth restriction, using standardised pathways and appropriate ultrasound monitoring.
3. Raising awareness of reduced fetal movements among pregnant women and ensuring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

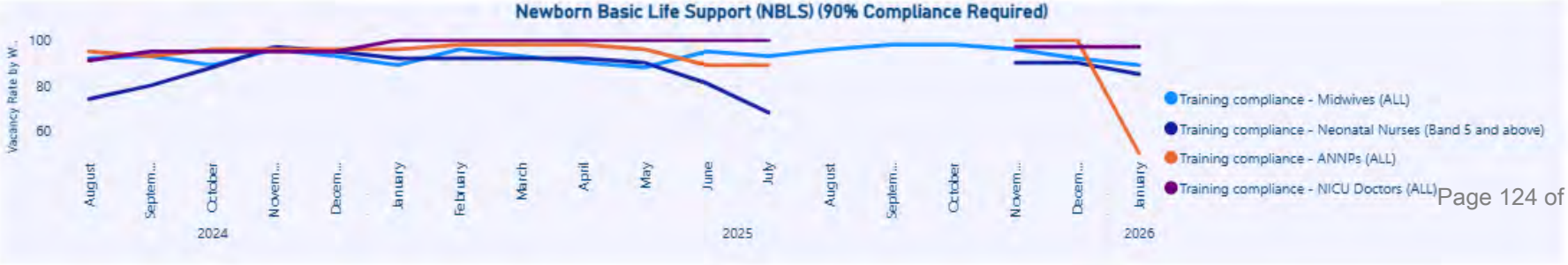
Version 3.2 emphasises equity, personalised care, multidisciplinary teamwork, and continuous quality improvement, supporting maternity services to deliver safer, more consistent care across England.

Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

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





Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Three Year Delivery Plan

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

Contents page

NHS England

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

MBRRACE-UK metrics: Better outcomes — Poorer outcomes

All other metrics: More positive — Improvement / support needed

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

Select ICB or Trust level map: ICB

Select positive/negative outlier map: Positive

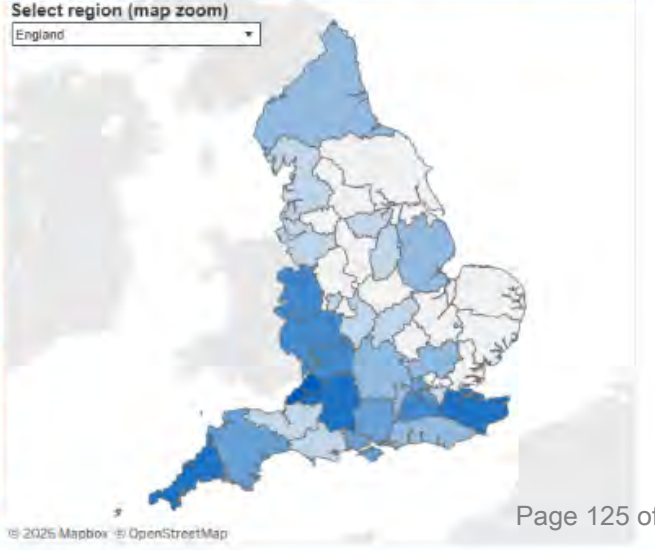
University Hospitals Bristol and Weston NHS Foundation Trust outlier summary: comparison to national result / benchmark

	Total measures	Negative outliers	Positive outliers
Total	41	2	9
Listening to and working with women and families with compassion	12	1	3
Growing, retaining and supporting our workforce	13	1	3
Developing and sustaining a culture of safety, learning and support	13		2
Standards and structures that underpin safer, more personalised, and more equitable care	3		1

T1b:Involvement in antenatal care decisions	88.9%
T1e:Involvement in decisions during labour and birth	84.5%
T1ni.Baby Friendly Accreditation - Maternity	0.0%
T1nii.Baby Friendly Accreditation - Neonatal	100.0%
T2ai.Midwives' satisfaction with recognition for good work	53.2%
T2bi:Midwives' satisfaction with work being valued by your organisation	46.8%
T2ci:Opportunities to discuss and agree learning needs at the sta of training - Trainee Midwives	45.5%
T2hi:Midwife Turnover Rate	4.6%
T3bi:Midwives' confidence in organisations response to concerns about unsafe clinical practice	70.6%
T3ci:Midwives' recommendation of the service	88.9%
T4biii.Neonatal Mortality Rate (Stabilised) (MBRRACE)	2.4

England ICB outliers map: Number of Positive outliers

Select region (map zoom): England



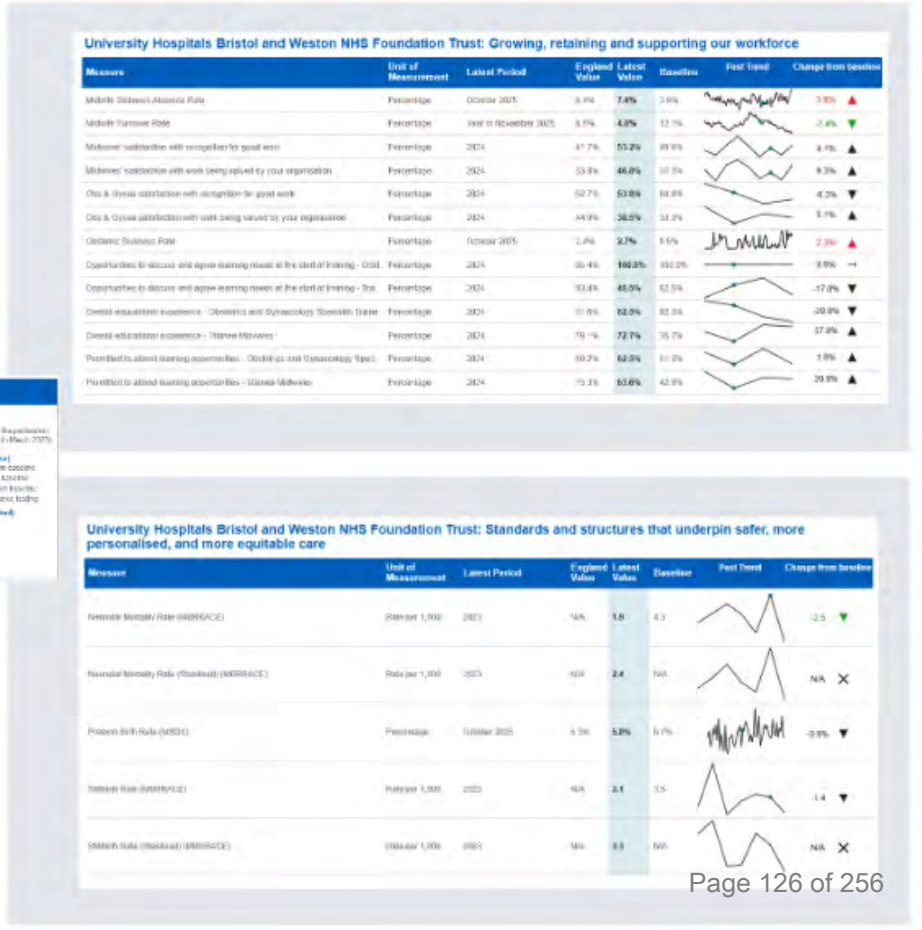
Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Three Year Delivery Plan

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

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Comfortable raising concerns - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	75.1%	100.0%	100.0%		0.0% →
Comfortable raising concerns - Trainee Midwives	Percentage	2024	60.3%	72.7%	18.8%		54.0% ▲
Midwives' confidence in organisations response to concerns about unsafe care	Percentage	2024	65.9%	78.0%	57.7%		12.9% ▲
Midwives' experience of learning culture	Percentage	2024	73.4%	88.7%	81.2%		48.9% ▼
Midwives' recommendation of the service	Percentage	2024	71.1%	88.5%	85.0%		3.3% ▲
Obs & Gynae confidence in organisations response to concerns about unsafe care	Percentage	2024	74.0%	91.5%	40.7%		14.5% ▲
Obs & Gynae experience of learning culture	Percentage	2024	60.0%	91.5%	84.2%		-7.1% ▼
Obs & Gynae recommendation of the service	Percentage	2024	75.0%	84.0%	85.7%		-7.1% ▼
Quality of clinical supervision out of hours for doctors	Percentage	2025	70.0%	87.5%	100.0%		-12.5% ▼
Quality of shift handovers for trainee doctors	Percentage	2025	83.5%	100.0%	92.0%		7.1% ▲
Recommendation of the training post - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	64.0%	62.5%	100.0%		-37.5% ▼
Recommendation of the training post - Trainee Midwives	Percentage	2024	55.8%	62.5%	46.7%		37.8% ▲
Supportive working environment for trainee doctors	Percentage	2025	72.2%	70.0%	61.3%		-10.7% ▼



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

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Midwife Sickness Absence Rate	Percentage	October 2025	6.4%	7.4%	3.6%		3.8% ▲
Midwife Turnover Rate	Percentage	Year to November 2025	8.5%	4.0%	12.1%		-2.4% ▼
Midwives' satisfaction with recognition for good work	Percentage	2024	47.7%	53.2%	49.9%		4.1% ▲
Midwives' satisfaction with work being valued by your organisation	Percentage	2024	53.9%	46.0%	37.3%		9.3% ▲
Obs & Gynae satisfaction with recognition for good work	Percentage	2024	52.7%	53.0%	58.8%		-4.2% ▼
Obs & Gynae satisfaction with work being valued by your organisation	Percentage	2024	44.8%	36.5%	32.3%		5.1% ▲
Obstetric Sickness Rate	Percentage	October 2025	2.4%	2.7%	0.5%		2.3% ▲
Opportunities to discuss and agree learning needs at the start of training - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	60.4%	100.0%	100.0%		0.0% →
Opportunities to discuss and agree learning needs at the start of training - Trainee Midwives	Percentage	2024	53.4%	46.0%	63.5%		-17.0% ▼
Overall educational experience - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	81.9%	62.0%	82.5%		-20.5% ▼
Overall educational experience - Trainee Midwives	Percentage	2024	79.1%	72.7%	55.7%		17.0% ▲
Permitted to attend learning opportunities - Obstetrics and Gynaecology Specialist Trainees	Percentage	2024	69.2%	62.5%	61.9%		1.0% ▲
Permitted to attend learning opportunities - Trainee Midwives	Percentage	2024	75.3%	63.6%	42.9%		20.8% ▲

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

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Adequacy of information or explanation during postnatal hospital care	Percentage	2025	90.9%	84.3%	88.7%		-4.4% ▼
Adequacy of time spent discussing physical and mental health of the baby	Percentage	2025	36.9%	32.0%	30.1%		2.0% ▲
Assessment of medical history during antenatal check-ups	Percentage	2025	53.4%	47.6%	55.0%		-7.4% ▼
Baby Friendly Accreditation - Maternity	Percentage	December 2025	32.1%	0.0%	0.0%		0.0% →
Baby Friendly Accreditation - Neonatal	Percentage	December 2025	13.8%	100.0%	100.0%		0.0% →
Being listened to during antenatal check-ups	Percentage	2025	84.7%	85.3%	90.9%		-5.3% ▼
Being listened to during postnatal care	Percentage	2025	77.2%	82.9%	83.1%		-0.3% ▼
Consideration of personal circumstances during postnatal care at home	Percentage	2025	74.6%	71.8%	74.1%		-2.3% ▼
Involvement in antenatal care decisions	Percentage	2025	91.9%	88.9%	82.4%		6.5% ▲
Involvement in decisions during labour and birth	Percentage	2025	78.9%	84.8%	78.2%		6.3% ▲
Kind and compassionate treatment during labour and birth	Percentage	2025	93.1%	87.8%	97.8%		-9.1% ▼
Reasons to consent during labour and birth	Percentage	2025	91.9%	83.8%	87.5%		-3.7% ▼

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

Measure	Unit of Measurement	Latest Period	England Value	Latest Value	Baseline	Past Trend	Change from baseline
Neonatal Mortality Rate (MBRRACE)	Rate per 1,000	2023	N/A	1.8	4.3		-2.5 ▼
Neonatal Mortality Rate (Workload) (MBRRACE)	Rate per 1,000	2023	N/A	2.4	N/A		N/A ✕
Preterm Birth Rate (MSDS)	Percentage	October 2025	6.3%	5.8%	6.7%		-0.9% ▼
Stillbirth Rate (MBRRACE)	Rate per 1,000	2023	N/A	2.1	3.5		-1.4 ▼
Stillbirth Rate (Workload) (MBRRACE)	Rate per 1,000	2023	N/A	3.3	N/A		N/A ✕

Perinatal Quality Surveillance Matrix (PQSM) January 2026

University Hospitals Bristol and Weston NHS Foundation Trust

Compliance with National Directives: Ockenden

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

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

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

Next Steps for Progression:

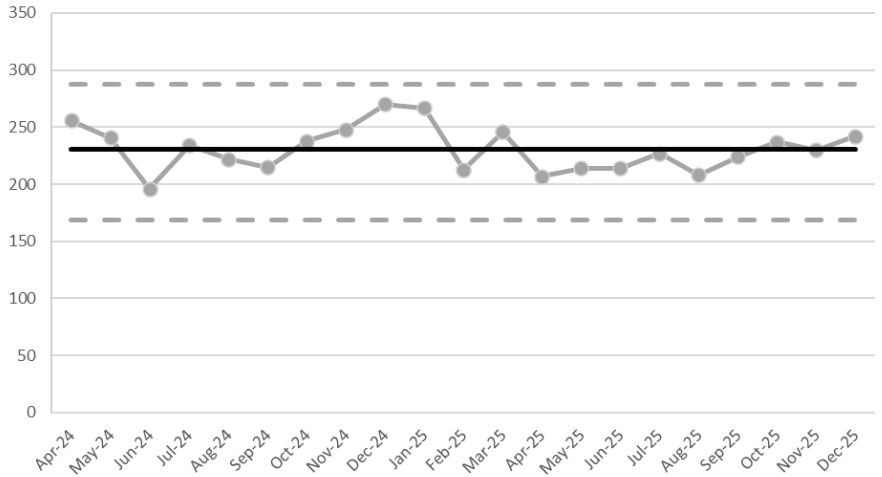
- IEA13 – Expansion of new ' Bereavement Champion' role to support 7 day bereavement support
- IEA14 – Neonatal Staffing

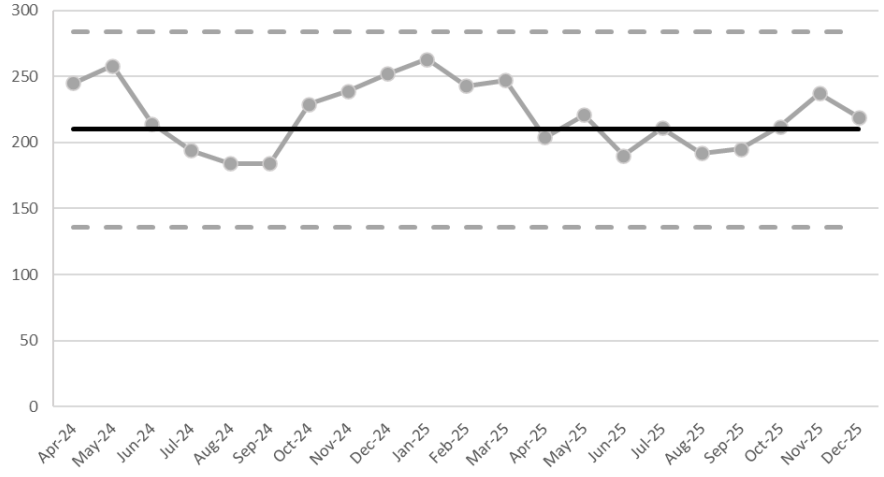
Learning from Deaths
Mortality Rates

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Quarter
Oct to Dec 2025
Target
No Target
Latest Quarter
709
Assurances
Decrease in reported deaths quarter to quarter in line with Southwest trend
Trust Level Risk
None





Latest Quarter
Oct to Dec 2025
Target
No Target
Latest Quarter
668
Assurances
Decrease in reported deaths quarter to quarter in line with Southwest trend
Corporate Risk
None

Benchmarking and southwest comparison for latest quarter
709 deaths were recorded in Oct-Dec 2025 compared with 756 deaths recorded in Oct-Dec 2024, 47 fewer deaths recorded quarter on quarter (-6.2% percentage decrease).
ONS figures for southwest show a percentage decrease of -1.2% quarter to quarter.
Latest SHMI position (August 24 to September 25) for NBT is recorded at 94.11 which is 'as expected'.
- Southmead hospital had a SHMI of 0.9411 (as expected).

Organisational level figures for latest quarter
Of the 709 patient deaths, there were 707 adult and 2 child deaths. This compares with 751 adult and 5 child deaths in Oct to Dec 2024.
Of the 709 patient deaths, 71.7% died as an inpatient (497 on an inpatient ward and19 within the emergency department) and 28.3% (193) within 30 days of discharge.

Mortality alerts
There are 4 active local SHMI alerts, no national outlier alerts.
- Active alerts for intracranial injury, other connective tissue disease, syncope and mycoses diagnosis group. Initial review indicates no cause for concern regarding clinical care. Ongoing investigation focusing on coding accuracy and risk adjustment.

Benchmarking and southwest comparison for latest quarter
668 deaths were recorded in Oct to Dec 2025 compared with 720 deaths recorded in Oct to Dec 2024, 52 fewer deaths recorded quarter on quarter. (-7.2% percentage decrease).
ONS figures for southwest show a percentage decrease of -1.2% quarter to quarter.
Latest SHMI position (Oct 24 to Sep 25) for UHBW is recorded at 87.73 which is 'as expected'.
- Bristol Royal infirmary had a SHMI of 0.9641 (as expected) and Weston General Hospital of 0.8184 (lower than expected)

Organisational level figures for latest quarter
Of the 668 patient deaths, there were 641 adult and 27 child deaths. This compares with 694 adult and 26 child deaths in Oct to Dec 2024.
Of the 668 patient deaths, 69.2% died as an inpatient (440 patients died on an inpatient ward and 22 within the emergency department) and 30.8% (206) within 30 days of discharge.

Mortality alerts
There are no active SHMI alerts for UHBW

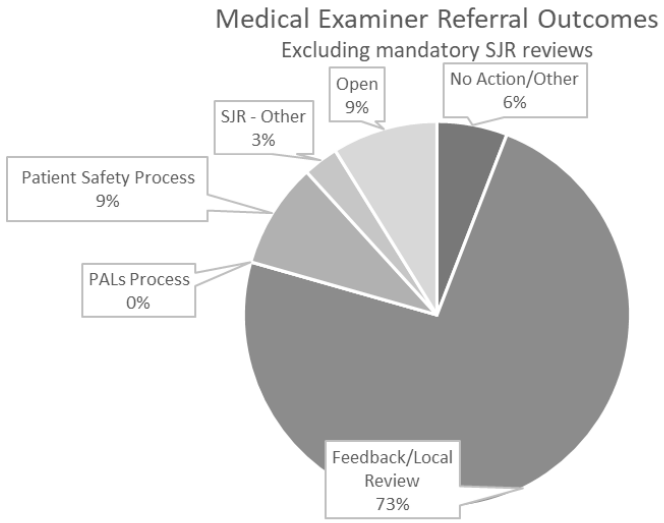
Learning from Deaths

Medical Examiner Referrals and Mandatory Reviews

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Latest Quarter
Oct to Dec 2025
Target
No Target
Latest Quarter
34
Assurances
Variation in referral rates typically reflects known differences in staffing, referral thresholds and work load. It should not be assumed to be a marker of concern, any changes in trend are discussed with the Medical Examiner Service
Trust Level Risk
None



Medical Examiner Scrutiny

The Medical Examiner Service scrutinised 100% of patient deaths in the latest quarter

The Medical Examiner Service forwarded 34 governance referrals to NBT, this compares with 45 for the Oct to Dec 2024. Of the 34 governance referrals 31 recorded concerns and 3 positive feedback.

The Medical Examiner Service have advised that the decrease in referrals is related to operational and staffing changes specific to the medical examiner service and site and does not indicate any change in care provided.

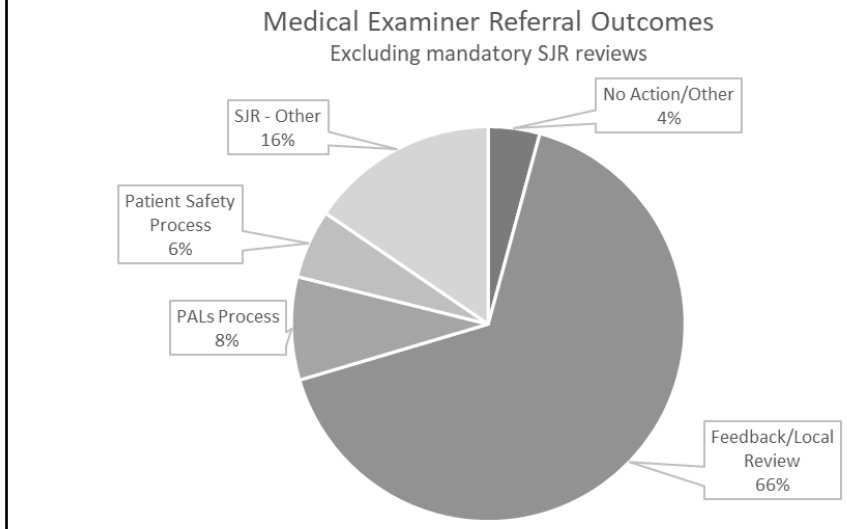
The top themes of the Medical Examiner referral concerns were:

- Assessment, diagnosis and initial treatment 5 (19.2%)
- Communication and sensitivity 5 (19.2%)
- Treatment experience 4 (15.4%)
- Admission and discharge 3 (11.5%)

Structured Judgement Reviews

27 SJRs were initiated for NBT between Oct to Dec 2025

- 8 for a patient with a diagnosis of a learning disability or autism
- 10 for a patient with a diagnosis meeting the definition of a severe mental illness
- 2 for a patient admitted for an elective procedure
- 5 screened in by the speciality or division as a result of a care concern



Latest Quarter
Oct to Dec 2025
Target
No Target
Latest Quarter
71
Assurances
Variation in referral rates typically reflects known differences in staffing, referral thresholds and work load. It should not be assumed to be a marker of concern, any changes in trend are discussed with the Medical Examiner Service
Corporate Risk
None

Medical Examiner Scrutiny

The Medical Examiner Service scrutinised 100% of patient deaths in the latest quarter

The Medical Examiner Service forwarded 71 governance referrals to UHBW, this compares with 54 for Oct to Dec 2024. Of the 71 governance referrals 48 recorded concerns, 7 recorded both concerns and positive feedback and 15 were positive feedback.

The Medical Examiner Service have advised that the increase in referrals is related to operational and staffing changes specific to the Medical Examiner service and site and does not indicate any change in care provided.

The top themes of the Medical Examiner referral concerns were:

- Communication and sensitivity 14 (23.7%)
- In-hospital environment 9 (15.3%)
- Assessment, diagnosis and initial treatment 7 (11.9%)
- Admission and discharge 6 (10.2%)
- Treatment experience 6 (10.2%)

Structured Judgement Reviews

24 SJRs were initiated for UHBW between Oct to Dec 2025

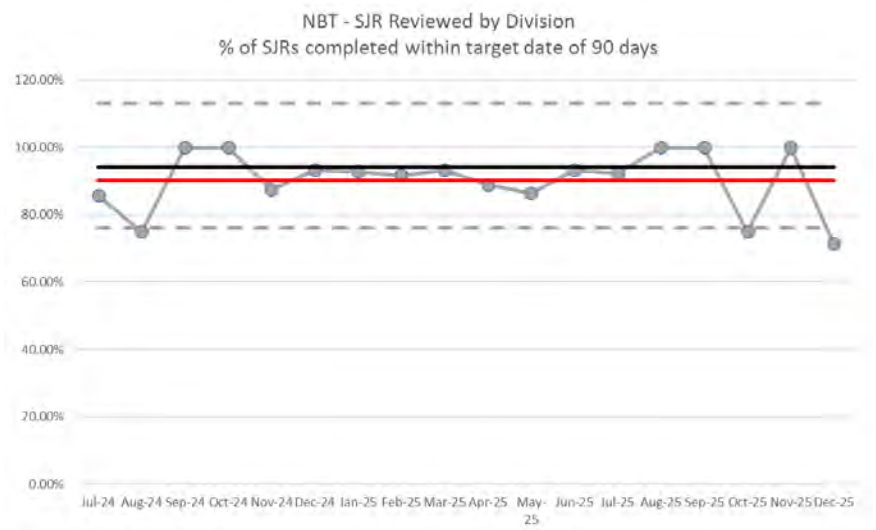
- 8 for a patient with a diagnosis of a learning disability or autism
- 4 for a patient with a diagnosis meeting the definition of a severe mental illness
- 1 for a patient admitted for an elective procedure
- 11 as agreed by the Trust Management Safety Meeting as a result of a care concern

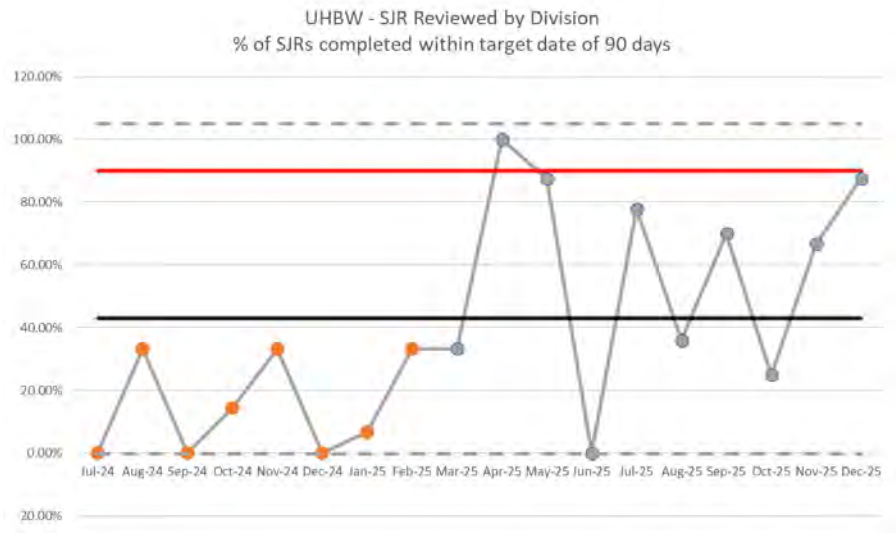
Learning from Deaths
Structured Judgement Reviews and Mortality Insights

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Latest Quarter
Oct to Dec 2025
Target
90%
Latest Quarter
82.14%
Assurances
Common cause (natural/expected) variation, where target is upper control limit and down is deterioration
Trust Level Risk
None





Latest Quarter
Oct to Dec 2025
Target
90%
Latest Quarter
59.72%
Assurances
Common cause (natural/expected) variation, where target is upper control limit and down is deterioration
Corporate Risk
None

Review timeliness

NBT specialities reviewed 11 of 14 (82.1%) SJRs with a target date between Oct to Dec 2025, slightly below target of 90%.

Closed reviews

Reviews are considered closed once they have been reviewed by the speciality. The exceptions to this are any review where poor or very poor overall care or the patient has a diagnosis of a learning disability of autism is noted is signed off by the Patient Safety Executive Meeting. There were 41 reviews closed by specialities between Oct to Dec 2025.

There was 1 poor care score which is currently under Review. 66% of SJRs resulted in an overall care score of good or excellent.

NBT	Very Poor	Poor	Adequate	Good	Excellent
Oct			3	7	1
Nov			8	9	2
Dec		1	2	5	3

Insights obtained

- Issues identified relating to treatment escalation planning, for example making decisions earlier to align with patient wishes.
- Some opportunities for improvement in early escalation, for example CT findings overnight and early recognition of sepsis and timely involvement of senior decision makers.
- Theme of documentation improvement noted, including frailty assessment, consent, palliative discussions and neuroprognostication processes

Review timeliness

UHBW specialities and divisions reviewed 13 of 22 (59.7%) SJRs with a target date between Oct to Dec 2025, below the target of 90% but an improved picture from the previous financial year.

Closed reviews

UHBW considers a review closed once it has been signed off at the Mortality Surveillance Group following speciality review. UHBW signed off 19 reviews through the Mortality Surveillance Group between Oct to Dec 2025.

There was 1 poor care score signed off at MSG. 53% of SJRs signed off by MSG resulted in an overall care score of good or excellent.

UHBW	Very Poor	Poor	Adequate	Good	Excellent
Oct			2	2	2
Nov			3	2	
Dec		1	3	3	1

Insights obtained

- Several cases highlighted poor symptom recognition and early end-of-life care with learning shared with the End of Life steering group.
- Themes noted around transfers and ward moves especially inappropriate moves for end-of-life patients.
- The poor care score identified concerns relating to clinical oversight, particularly with senior review responsibility and cross-team communication. Further learning to be identified by a patient safety incident response.

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Biannual Safe Staffing Report: Nursing and Midwifery Workforce – NBT and UHBW		
Report Author:	Michael Puckey, Acting Hospital Director of Nursing (NBT) Sarah Dodds, Hospital Director of Nursing (UHBW) Dominique Duma, Group Director of Professional Standards and Practice		
Report Sponsor:	Professor Steve Hams, Group Chief Nursing and Improvement Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			x
	In accordance with National Quality Board guidance, the Group Chief Nursing and Improvement Officer must present biannual safe staffing reviews to the Board, offering assurance that nursing and midwifery staffing levels, patient acuity and workforce risks are systematically monitored and managed across the Group.		

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

This biannual report provides the Board with assurance regarding compliance with national safe staffing requirements across Nursing and Midwifery services at North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). It summarises findings from the most recent data collections, triangulated with professional judgement and quality indicators, in preparation for full alignment under the developing Hospital Group.

NBT

- A full Safer Nursing Care Tool (SNCT) data collection was completed in October–November 2025, covering adult inpatient and assessment areas and Emergency Department (ED).
- There has been increasing patient acuity, a shift toward higher-dependency patients, and frequent care of additional (unfunded) patients, particularly within Medicine.
- Vacancy rates remain 6.6% for Registered Nurses (RN) and 17.4% for unregistered staff, mitigated by active recruitment programmes and apprenticeship pathways.
- The Birth Rate Plus (BR+) data collection was completed in October 2025, in accordance with the Maternity Incentive Scheme requirements.
- The BirthRate Plus® midwifery assessment (Dec 2025) identified a clinical establishment deficit of 19.94 Whole Time Equivalent (WTE) (with headroom uplifted to 24%), requiring staged investment.

UHBW

- UHBW completed the six-monthly Nursing and Midwifery staffing review (July 2024 – September 2025) using SNCT and BirthRate Plus methodology.
- Fill rates generally remain stable, with over establishment in RN staffing in several divisions, supporting escalation areas and ED queues.

- Continued improvement in recruitment and retention has reduced Band 5 RN vacancies to 1.12 WTE from previous surpluses.
- Key risks relate to Enhanced Therapeutic Observational Care (ETOC) demand, escalation capacity, and specialised areas such as oncology and NICU.
- The Birth Rate Plus data collection was completed in July 2025, in accordance with the Maternity Incentive Scheme requirements.
- BR+ (July 2025) identified 14.52 WTE Registered Midwife (RM) requirement for the new 24/7 obstetric triage service.

Strategic and Group Model Alignment

Safe staffing is a fundamental enabler of the Hospital Group strategic priorities for Patients, People, Population and Public Purse.

Both Trusts are now aligning methodology, data cycles and assurance frameworks to produce a single Groupwide staffing report from summer 2026. This work supports the Group ambition to standardise workforce modelling, strengthen resilience and provide equitable, high-quality care across the system.

Risks and Opportunities

Key Risks

- Unfunded additional patients at NBT continue to require significant temporary staffing, driving cost pressures.
- Patient acuity increases in both organisations require sustained uplift in staffing to maintain safety.
- Midwifery deficits (NBT BR+ findings; UHBW triage requirements) pose potential safety and quality risks if not fully funded.
- NBT: Gate 26b establishment misalignment, neonatal nursing shortages, Medicine escalation areas.
- UHBW: High ETOC demand, Neonatal Intensive Care Unit (NICU) qualified in speciality (QIS) staffing (58% vs 85% standard), oncology RN vacancies.

Opportunities

- Transition to a Group Model enables harmonised workforce planning and better deployment.
- Improved BR+ compliance and SNCT accuracy enhances triangulation and benchmarking capability.
- Recruitment pipelines (apprenticeships, scholarships, preceptorships) support long-term sustainability.

Recommendation

This report is for **Information**.

The Board is asked to note:

1. Completion and outcomes of the SNCT and BR+ staffing reviews at NBT and UHBW.
2. Increasing patient acuity and associated resource implications across both Trusts.
3. Continued need for investment in midwifery and in escalation areas (both Trusts) highlighted through professional judgement.
4. The transition to a single Hospital Group safe staffing report for the next cycle (summer 2026).

History of the paper (details of where paper has <u>previously</u> been received)	
NBT Trust Management Team UHBW Trust Management Team	4th March 2026 10th December 2025
Appendices:	**Appendix A: NBT Report, including:** • Appendix 1: Safer Nursing Care Tool – Level Descriptor • Appendix 2: Skill mix by department • Appendix 3: Temporary Staffing spend and performance • Appendix 4: SNCT Predictions vs Funded Establishment and Patient Mixes **Appendix B: UHBW Report, including:** • Appendix 1: Divisional staffing dashboards • Appendix 2: Divisional skill mix and patient mix summaries

North Bristol NHS Trust
Biannual Safe Staffing Review
Nursing and Midwifery

March 2026

Executive Summary

The document is the biannual Safe Staffing Review for Nursing and Midwifery at North Bristol NHS Trust (NBT), dated March 2026. It provides assurance to the Trust Board regarding safe and effective staffing, using the Safer Nursing Care Tool (SNCT) and Birth Rate Plus® (BR+) for midwifery, with data collected primarily in October and November 2025. This is the final NBT-specific report before transitioning to a unified Hospital Group reporting model with University Hospitals Bristol and Weston (UHBW).

Introduction and Background

The report aligns with National Quality Board (NQB) guidance and NHS England and Improvement standards, emphasising deployment of sufficient, qualified staff, systematic staffing approaches, and compliance with legislation and guidance. It references updated national frameworks including the 2025 Review of Patient Safety and the NHS Long Term Workforce Plan 2024.

Safer Nursing Care Tool (SNCT)

NBT uses the Shelford Group's SNCT, a nationally validated tool that calculates nursing requirements based on patient acuity and dependency. The October 2023 update to SNCT introduced multipliers for trusts with high single-room wards like NBT, and additional patient acuity levels (1c and 1d) reflecting greater patient complexity. NBT remains fully licensed and compliant with the tool's use.

Review Process and Data Collection

The review covers adult inpatient and assessment areas at Southmead Hospital, excluding, ED, ICU, theatres, outpatient services, NICU, and ambulatory renal dialysis. Data was collected over 30 days from 20 October to 23 November 2025, with one area requiring extension due to data loss. Data included acuity and dependency assessments, budgeted staffing, and hours worked (including bank and agency) to evaluate sufficiency of funded establishments.

Nursing Workforce Overview

NBT was awarded "Best UK Employer of the Year for Nursing Staff" at the 2025 Nursing Times Awards, reflecting its commitment to workforce quality. Vacancy rates

stand at 6.6% for registered and 17.4% for non-registered staff, with active recruitment pipelines aiming to close these gaps. Recruitment initiatives include assessment centres, community outreach, university partnerships, and executive commitment to filling vacancies despite national financial pressures. Temporary staffing use remains significant due to operational pressures and vacancies.

Sickness absence is at 5.7%, with main causes being stress, anxiety, depression, respiratory illnesses, and miscellaneous reasons. Retention has improved slightly for registered staff (turnover 8.9%) but remains higher for non-registered staff (12.57%), exceeding the Trust target of 10%.

NBT has developed training pipelines including Health Care Support Worker apprenticeships, Student Nursing Associate placements, Registered Degree Nursing apprenticeships, and upcoming nursing scholarships to address workforce supply.

Nursing Workforce Metrics

Care Hours per Patient Day (CHpPD) for adult inpatients is 8.8, placing NBT in the second quartile nationally, slightly above peer and national averages. The skill mix during data collection was 55% registered nurses (RN) and 45% non-registered staff, varying by division:

Division	Registered Worked %	Non-Registered Worked %
ASCR	59%	41%
Medicine	54%	46%
NMSK	54%	46%
Women and Children's	68%	32%

Temporary staffing usage remains high, driven by operational pressures, vacancies, and short-term sickness. NHS England targets for agency and bank spend reductions are unlikely to be met this year.

Patient Acuity and Additional Patients

Comparing November 2025 to February 2025, there was a decrease in Level 0 patients (those cared for in standard ward settings) by 5.8%, with increases in Levels 1a, 1b, and 1c patients who require additional nursing interventions and supervision. Level 2 patients decreased slightly, and Level 3 patients remained managed within ICU.

On average, 50.7 additional patients were cared for beyond funded establishments, requiring an estimated additional 91.03 whole time equivalent (WTE) nursing staff. These patients are often accommodated in non-standard areas such as bays, corridors, or clinical rooms, contributing substantially to temporary staffing costs.

Variance Analysis and Divisional Reviews

The variance between SNCT requirements and funded establishments has reduced over recent years, though the high proportion of single rooms and the presence of additional patients remain key drivers for staffing gaps. Headroom in the tool is nationally recommended at 22%, with NBT funded at 21%.

ASCR Division

The Adult, Specialist and Critical Care (ASCR) division reports a staffing variance of 64.5 WTE (39.3 RN and 25.5 HCSWs - Healthcare support workers), a reduction from prior reports. Increased acuity, especially Level 1a patients, and additional patients impact staffing needs. Investment of £212,820 increased establishment by 5.19 WTE HCSWs, helping reduce variance. Risks remain related to funded establishment gaps and operational pressures, including bed capacity issues at Gate 26b, which requires separate investment.

Medicine Division

The Medicine division shows a variance of 105.2 WTE (44.8 RN and 60.4 HCSWs), an increase of 32.2 WTE from previous data. This is driven by higher patient acuity, more additional patients, and extensive escalation areas. Seasonal respiratory illness contributed to increased staffing needs. Funding generally meets established needs, but non-recurrent funding is sought for escalation areas.

NMSK Division

Neurology, Musculoskeletal and Stroke (NMSK) division reports a variance of 23.8 WTE (9.2 RN and 14.6 HCSW), a significant reduction. Patient acuity changes include increases in Level 0 and 1c patients. Previous investments totalling £297,546 increased establishments by 5.20 WTE RN. Stroke services face pressures due to delayed discharges, requiring additional funded staffing during winter months.

Women's and Children's Division

This division has a variance of 18.9 WTE (9.3 RN and 9.6 HCSWs), mainly in Cotswold Ward and gynaecology. Patient acuity remained stable, but the temporary repurposing of Cotswold Ward during NICU refurbishment affected staffing and data. Risks include neonatal nursing workforce shortages and lack of 24/7 telephone triage in maternity, with recruitment and establishment increases underway.

Midwifery Safe Staffing – BirthRate Plus®

The December 2025 BirthRate Plus® report evaluates midwifery staffing at Southmead Hospital and community services, incorporating annual activity, case mix,

and professional judgement. Annual births declined slightly from 5556 (2021/22) to 5318 (2024/25), but acuity increased with more high-risk categories (IV and V), influenced by comorbidities, mental health, BMI, induction rates, and operative deliveries.

Maternity wards have significant antenatal and transitional care workloads, with community and outpatient activities included. The BR+ methodology aligns with NICE and Royal College guidance.

The funded midwifery establishment has an overall deficit of approximately 10.42 WTE clinically, increasing to 19.94 WTE when including a 24% uplift for training needs. Additional support staff are also required across delivery suite, wards, triage, and clinics. Funding to cover the 21% deficit is recommended in line with the Maternity Incentive Scheme, with the remaining 24% uplift to be invested over two years.

Summary and Recommendations

The November 2025 SNCT review shows increased nursing and midwifery vacancies, especially among non-registered staff, with active recruitment mitigating the gaps. Additional patients, particularly in the Medicine division, remain unfunded, driving temporary staffing costs. Patient acuity has shifted toward more dependent and acutely unwell patients requiring enhanced support. The variance gap between SNCT requirements and funded establishments continues to close but remains influenced by the high single-room estate and additional patient care needs.

No new investment requests are made in this report, but two points are highlighted for future funding consideration:

- Nursing requirements for additional patients and escalation areas will be addressed in the 2026/27 financial business planning via non-recurrent funding.
- Gate 26b's establishment reduction has not aligned with patient numbers, necessitating a separate investment request.

The BirthRate Plus® assessment's overall midwifery deficit requires funding consistent with national expectations, with staged investment over two years. Going forward, a unified six-monthly safe staffing report will cover both NBT and UHBW under the Group Model.

Key Recommendations:

- **Note** completion and review of the November 2025 SNCT data collection.
- **Recognise** the increased patient numbers beyond funded budgets contributing to temporary staffing costs.
- **Acknowledge** changes in patient acuity and dependency toward more complex needs.

- **Consider** the difference in national (22%) versus NBT funded (21%) headroom in staffing calculations.
- **Note** the BirthRate Plus® findings and required funding for midwifery staffing.
- **Prepare** for combined Group Model safe staffing reporting with UHBW.

This comprehensive review ensures that NBT continues to meet national safe staffing requirements while addressing ongoing operational challenges and workforce pressures.

1. Introduction

This paper aims to offer assurance to the Trust Board and facilitate the Board's fulfilment of its obligations regarding safe and effective nursing and midwifery staffing, in alignment with National Quality Board requirements. The methods applied for data collection, analysis, and interpretation are consistent and transparent.

The previous biannual safer staffing report provided an in-depth review of data captured in February and March 2025 and was presented in August 2025. Data for this review was collected over a 30-day period in October and November 2025 using the national Safer Nursing Care Tool (SNCT).

As with previous views the Tool's level descriptors are included in Appendix 1. The SNCT is licensed from the Shelford Group to North Bristol NHS Trust (NBT), and we remain fully compliant with all associated copyright.

During October 2025, the maternity service undertook a review of midwifery staffing using the mandated Birth Rate + Tool, this was completed in line with the Maternity Incentive Scheme expectations, which requires all NHS providers to complete an assessment every three years.

2. Proposed Amendments to Reporting

NBT now operates in a "Group Model" with University Hospitals Bristol and Weston (UHBW). To ensure alignment and provide consistent assurance across the Hospital Group, this will be the final NBT specific safe staffing review report.

At present, both organisations are reviewing their approaches to the biannual safe staffing board reporting, to developing a unified and standardised methodology and reporting framework that maintains the previous high level of assurance previously achieved in both organisations. This is expected to be delivered during the summer 2026.

Data collection for spring 2026 has commenced, with both organisations completing simultaneously.

3. Background

In line with previous Board reports, this paper aims to maintain compliance with National Quality Board (NQB) guidance (2016) and NHS England and Improvement (2018).

The NQB (2016) identifies three core requirements for providers:

- Providers must deploy sufficient numbers of suitably qualified, competent, and experienced staff to meet patients' care and treatment needs safely and effectively
- Providers should adopt a systematic approach to determining staffing numbers and skill mix must meet patient needs and maintain the safety at all times.
- Providers must use an approach that reflects current legislation and guidance, where available.

NHS England and Improvement (2018) further states that NHS providers must have processes in place to ensure safe nursing staffing across all services. While this guidance remains in place, it has been supplemented by more recent national publications, including the Review of Patient Safety Across the Health and Care Landscape (2025), NHS Long Term Workforce Plan (2024) and the NHS Health and Wellbeing Framework (2021).

4. Safer Nursing Care Tool (SNCT)

For the purpose of the biannual safer staffing review, NBT uses the Shelford Group's Safer Nursing Care Tool (SNCT), this is a nationally validated tool for predicting nursing establishment requirements.

The SNCT calculate clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, support chief nurses in making their decisions on setting optimal nurse staffing establishments recommendations to their Board. The tools:

- Provide organisational level metrics to monitor impact on the quality of patient care and outcomes
- Give a defined measure of patient acuity and dependency
- Can support benchmarking activity in organisations when used across trusts
- Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources
- Include staffing multipliers to support professional judgement
- Provide accurate data collection methodology

In October 2023, the Shelford Group published an updated version of the SNCT. This revision included specific multipliers for organisations where wards comprise 75% or more single rooms, which is applicable to NBT given the high proportion of single-patient accommodation. The update also introduced two additional patient classifications (Levels 1c and 1d) to reflect increasing patient complexity, particularly for patients requiring enhanced supervision or 1:1 care to maintain safety. These changes directly correlated with the increased nursing resources predictions across all divisions. This report represents the fourth review using the updated Tool.

NBT holds a license from the Shelford Group for use of the SNCT across adult assessment and inpatient areas, as well as the Emergency Department (ED). The Trust remains fully compliant with copyright requirements, and the Tool has not been adapted.

5. Safer Staffing Review Process

A well-established process is in place for the six-monthly Safer Nursing Care Tool (SNCT) reviews within the portfolio of the Group Chief Nursing and Improvement Officer, the review was led by the Deputy Chief Nursing Officer, with contributions from the corporate nursing team, the five Divisional Directors of Nursing (Midwifery), their clinical teams, and the Head of Strategic Workforce Planning.

The review encompasses all adult inpatient and assessment areas at Southmead Hospital. Excluded from the review are the Emergency Department (ED), Intensive Care Unit (ICU), theatres, outpatient services, Neonatal Intensive Care Unit (NICU), and ambulatory renal dialysis services.

Data collection commenced on 20 October 2025 and concluded on 23 November 2025, representing a 30-day data collection period. All results were validated by senior nursing staff and recorded electronically.

One clinical area has required a two-week extension due to data loss, which prevented achievement of the minimum required number of data collection days.

6. Data Reviewed

To ensure the total nursing resource requirement was captured the data collection included acuity and dependency assessments of additional patients. This relates to patients cared for within clinical areas above the funded establishment, including those accommodated in bays or corridors. This approach reflects NBT's continued support of additional patients in response to sustained operational and performance pressures across both the organisation and wider system.

To support accurate and comprehensive analysis, SNCT outputs were reviewed alongside budgeted Whole Time Equivalent (WTE) staffing and total hours worked during the review period, including bank and agency usage. This enabled assessment of whether the funded establishment was sufficient to meet patient need or whether additional staffing was required.

Given the short interval between completion of data collection and the Board reporting deadline, Divisional leaders were asked to triangulate the SNCT outputs with their professional judgement and provide conclusions on the predicted staffing requirements. To further strengthen the robustness of this process, conclusions were supported through triangulation with additional indicators, including clinical incidents, falls, pressure ulcers, sickness absence, staff turnover, complaints, and missed clinical observations.

7. Nursing Workforce at NBT

NBT's ability to deliver an outstanding patient experience and consistently high-quality care is underpinned by a reliable, credible, stable, and motivated nursing workforce.

In November 2025 NBT attended the annual Nursing Times Awards event in London, having been shortlisted for three national awards:

- Best UK Employer of the Year for Nursing Staff (Proud to belong)
- Best Social Responsibility Programme (Commitment to Community)
- Overseas Nurse of the Year

Following independent judging and fierce competition NBT was awarded the "Best UK Employer of the Year for Nursing Staff.

The Trust remains committed to ongoing compliance with National Quality Board (NQB) requirements and to supporting its nursing workforce to deliver the safest and most effective care possible.

8. Nursing Staff Cost per Weighted Activity Unit (WAU)

As part of the bi-annual safer staffing report, an update is normally provided on NBT's performance against the Weighted Activity Unit (WAU) productivity measure. This data is sourced from Model Hospital, a national platform that enables NHS organisations to submit data and narrative across a range of performance indicators and supports benchmarking across providers.

However, there has been no updated position on Model Hospital WAU since the previous report; therefore, this is not provided.

9. Recruitment and Retention

9.1 Current Vacancies

At the time completion, for inpatient areas considered within the SNCT census, NBT has a total of 188.31 Whole Time Equivalent (WTE) Nursing and Midwifery vacancies across the organisation. This is in the context of a denominator of 1667.3 WTE.

This position represents a modest reduction in vacancies since the previous board report. More specifically, vacancy rates have remained stable for registered staff, while showing a slight increase for non-registered staff groups since the previous report. Current vacancy rates are 6.6% for registered staff and 17.4% for non-registered staff. It is noted there is an active recruitment programme with starter pipeline that closes the registered gap and significantly improves the non-registered gap. It should be recognised however, that recruitment of non-registered workforce remains more challenging in the current workforce climate.

During the time between the previous paper and this there has been an increase in services, to include the opening of the Elective Care Centre alongside establishment increases from the previous safe staffing paper. These elements will have an ongoing effect on the current vacancy position. In the following sections assurance will be given on actions taken to address this increase.

9.2 Recruitment

NBT implemented a range of targeted workforce initiatives to address these gaps. These include Health Care Support Worker assessment centres, which allows a greater number of candidates to be assessed simultaneously, reducing the number of individual interviews this reviews candidates' interactions, ability to work as part of a team and understanding of the role (this has been seen as a success).

NBT's "Commitment to our Community" outreach programme has continued with local events at T-level institutions to promote entry level career positions into the NHS, University sessions with our university partners to promote NBT as an employer of choice for pre-registration students upon qualification have also continued.

There has been a continued commitment from executives to recruit to vacant clinical positions despite the current political and financial climate where other organisations may choose to hold vacancies, it is believed that this will also highlight the organisations commitment to support the nationally mandated requirement to reduce the volume of workers used through its temporary workforce or agency staff.

Where departments are noted to have an increasing number of vacancies or usage of temporary/agency workforce internal Resourcing and Temporary Staffing Operational Group (RaTSOG) are commenced. This brings together key individuals across the NBT together to facilitate a coordinated approach to support actions to address the current position. These have been successful across the Intensive Care Unit, Emergency Department, and the wider Medicine Division.

9.3 Attendance

The current sickness percentage at time of the report is 5.70% (5.20% registered nursing and midwifery and 6.91% non-registered) this has increased slightly since the last report which was 5.61%.

The top three main reasons for sickness and absences have remained the same for nurses, midwives and health care assistant which are:

- Stress, Anxiety, Depression
- Cough/ cold/ influenza
- Miscellaneous

9.4 Retention and Turnover

In previous papers there was a positive trend for retention amongst the nursing and midwifery workforce this has continued with an improvement from 9.14% in March 2025 to 8.90% for Registered staff. However, for non-registered staff, it was 12.40% in March 2025 and is currently 12.57% which correlates with the increased vacancy

picture. The Trust turnover target is set at 10% with associated workstreams to achieve this.

9.5 Training Pipelines – in year progress

In line with the 5-year Nursing and Midwifery supply business case that was approved in early 2025 the following routes to nursing were commissioned:

9.6 Health Care Support Worker Apprenticeships

The in house NBT HCSW apprenticeship programme which runs over 18-months has so far this year has accepted 25 individuals onto the course, there are a further 8 places have been ringfenced for the clinical divisions. On completion of this course, individuals can apply to undertake the Student Nursing Associate 2-year foundation degree as students will have the required maths and English requirements. This stream is seen as a pivotal entry point onto the academic pathway and will continue.

9.7 Student Nursing Associate

Currently NBT offers fully funded placements for non-registered staff who wish to undertake a 2-year foundation degree leading to registration with the Nursing and Midwifery Council (NMC) as a Registered Nursing Associate (RNA), 14 places have been offered.

9.8 Registered Degree Nursing Apprenticeship

The top up apprenticeship from RNA to Registered Nurse (RN). NBT continues to be supported, this is full apprenticeship route that can be taken from Health Care Support Worker (HCSW) to RN.

This year 19 funded places were commissioned, and all have been allocated, NBT has recently been given further funding via National Health Service England (NHSE) for four additional places.

9.9 Nursing Scholarships

Given the reduction in nursing student undergraduate applicants across the traditional pipeline, NBT have cocreated an innovative student pathway using nursing scholarships with university providers. This is currently at the procurement stage, but we look forward to launching this in 2026 for 20 funded full and partial scholarships places. This will enable to students at the end of the three-year scholarship to apply for registration as an RN.

10. Our Nursing Workforce: Meeting the Needs of Adult Inpatients

10.1 Care Hours per Patient Day (CHpPD)

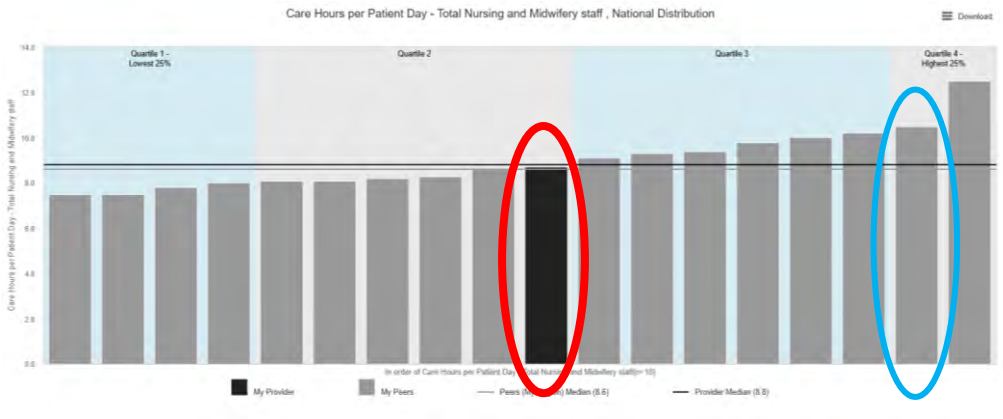
CHpPD is a measurement of workforce deployment and can be broken down by staff group, from organisational to individual departmental level.

For adult inpatient areas, organisations submit the amount of registered and non-registered hours worked over the 24-hour period and the number of patients who are in beds at midnight. This is then divided to give the number of CHpPD, it can be used as a benchmark to determine how effective staff deployment is, a low CHpPD rate

may indicate a potential patient safety risk, whereas high rates could suggest that departments are ineffective or have inefficient staffing rostering processes.

The most recent data, November 2025 shows that NBT is sitting at the top Quartile 2 with a mean of 8.8 compared to peer average of 8.6 and national average of 8.5.

NBT is highlighted in red for direct comparison for direct comparison University Hospitals Bristol and Weston are detailed in “Blue.”



10.2 Skill Mix

Skill mix on clinical departments has been reviewed as part of the professional judgement provided to clinical divisions. The worked skill mix % for inpatient wards/assessment areas at NBT during the data collection period overall is 55% for registered practitioners and 45% of non-registered. A high-level breakdown is provided below; departmental level breakdown can be found in Appendix 2.

Division	Registered Worked %	Non Registered worked %
ASCR	59%	41%
Medicine	54%	46%
NMSK	54%	46%
Women and Childrens	68%	32%

10.3 Temporary Staffing

There continues to be reliance on the use of temporary/ agency workers across NBT the reason for the usage is multifactorial however some frequent requirements are:

- Sustained operational pressure/ additional patients
- Vacant Nursing/Midwifery positions which are not mitigated by current staffing
- Unplanned short term sickness cover to ensure safe and effective patient care

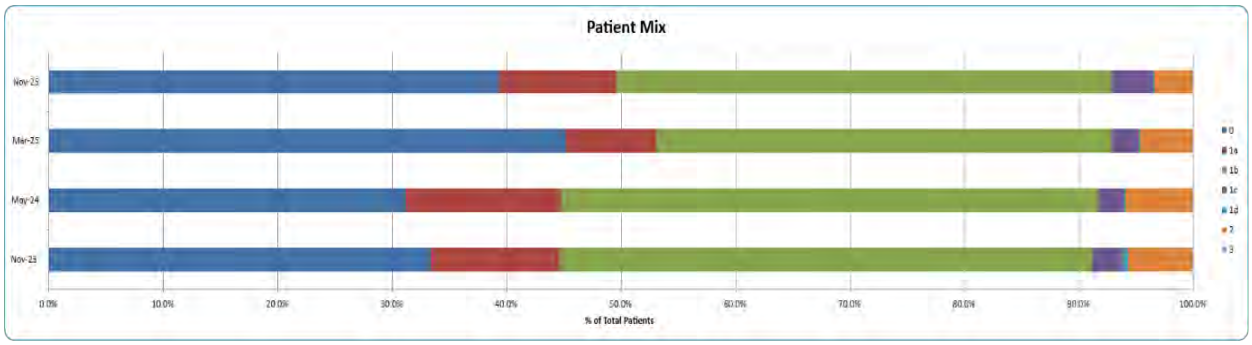
As detailed before NHS England has applied a targeted spend reduction in this financial year of 30% agency reduction and 10% for bank. Given the sustained operational pressure and the need to safely staff additional patient cohorts this reduction looks unlikely to be met.

ID Medical the “Master Vendor” came into operation in April 2025 NBT continues to work collaboratively with the wider Bristol Consortium to standardise performance and bank rates.

A breakdown of current bank and agency performance can be found in Appendix 3.

10.4 Acuity and dependency changes

Below are the patient dependency levels for the past four data collections. For ease of analysis comparisons will be drawn between November 25 and February 25.



- Level 0 – In November 2025 we saw a decrease of 5.8% across the organisation, meaning that these patients are cared for in normal ward environments.
- Level 1a – In November 2025 we saw an increase of 2.3% across the organisation, meaning those being cared for were not classified as “unstable with a greater potential to deteriorate”.
- Level 1b – In November 2025 we saw an increase of 3.5% across the organisations, these are stable patients but required additional interventions from nursing staff for needs such as washing and dressing, toileting etc.
- Level 1c - In November 2025 we saw an increase of 1.2% across the organisations, these are patients who are stable but require additional intervention to mitigate the risk and maintain their safety.
- Level 1d – On comparison these remained stable.
- Level 2 – In November 2025 we saw a decrease of 1.2% in this patient group, these are patients managed in specialist areas due to complex care requirements.
- Level 3 – There were no level 3 patients being cared for outside the specialist unit of Intensive Care during both data collections.

This means that during the most recent data collection we saw a reduction in patients who could be cared for under normal ward provision, with an increase in dependent patient and those who were either acutely unwell or had a greater potential to deteriorate. There was also an increase in the number of patients who are stable but require additional support to maintain their safety has also increased.

10.5 Additional patient nursing requirement

During the 30-day data collection, there was an average of 50.7 additional patients being cared for across the inpatient departments at NBT which is a slight reduction

however these patients are more dependent on nursing care and more likely to deteriorate. These patients who are cared for as additional patients in bays or in environments which would not have normally be used for inpatient care such as clinical rooms and corridors. To maintain operational flow and enhance patient safety, we know that these patients equate to an additional nursing requirement. Based on the numbers below during the collection period, when calculated using the SNCT equates to an additional 91.03 WTE workforce requirement.

This cohort of additional patients across the past four data collections, ensuring they are cared for appropriately and safely continues to drive a high degree of the additional spend within temporary staffing as these are not within the departments budgeted numbers.

A breakdown of the average additional patients and associated WTE resource can be found below.

Division	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Level 2	Level 3	Total
ASCR	1.8	1.3	0.8	0	0	0.5	0	**4.4**
NMSK	2.1	0.1	4.8	1.3	0	0	0	**8.3**
Medicine	21.7	2.7	12.3	0.5	0	0	0	**37.2**
W&C	0.8	0	0	0	0	0	0	**0.8**
	26.4	**4.1**	**17.9**	**1.8**	**0**	**0.5**	**0**	**50.7**

WTE Resource
8.41
17.72
63.7
1.2
91.03

10.6 Variation Analysis from Data Collection

Below is the SNCT requirement vs Funded Establishment:

	Based on SNCT Data			Based on Funded		
Division	Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Establishment Total
339 Anaesthesia, Surgery, Critical & Renal Division	238.4	157.4	395.8	199.1	132.2	331.3
339 Medicine Division	417.5	431.1	848.6	372.7	370.7	743.4
339 Neurosciences & Musculoskeletal Division	252.2	253.3	505.5	243	238.7	481.7
339 Women and Childrens Division	4.8	5	9.8	14.1	14.6	28.8
Grand Total	**912.9**	**846.7**	**1759.6**	**828.9**	**756.2**	**1585.2**

Below is the variance across the previous three data collections:

Collection Date	Variance Registered - WTE	Variance Non-Registered - WTE	Total	Additional patient requirement - WTE	Headroom Variance	Total
Nov-25	83.1	90.5	**173.6**	91.3	17.59	**64.71**
Feb-25	135	110.3	**245.3**	82	13	**150.3**
May-24	193	162.7`	**355.8**	40.3	13.5	**302**

SNCT requirement vs Funded Establishment vs Worked:

Division	Total Funded Establishment	Total SNCT Required	Total Worked WTE
339 Anaesthesia, Surgery, Critical & Renal Division	331.3	395.8	364.6
339 Medicine Division	743.4	848.6	819.1
339 Neurosciences & Musculoskeletal Division	481.7	505.5	496.9
339 Women and Childrens Division	28.8	9.8	25.8
Grand Total	**1585.2**	**1759.6**	**1706.4**

10.7 Variance from SNCT to funded establishment 2023/2025

In the most recent data, there is a clear reduction in the variance gap and there are several explanations for this:

- Number of patients with “no criteria to reside” (those awaiting onward transfer to social care providers).
- The additional resource required to care for the additional patients which is not budgeted for in the departmental establishments and is a clear driver for the use on temporary workforce. This is shown in the table above.
- As detailed in previous reviews, headroom in the tool is set at 22% (nationally recommended) which is 1% above the NBT funded for adult inpatient wards. This is laid out in the table above for viability and oversight.

Development over the past 3 years of the newer SNCT tool that accounts for estates with 75% single side rooms, demonstrates national recognition that while offering significant patient benefits, there is an associated staffing requirement. Accordingly, while the variance gap has been consistently closing across the previous three census periods, the primary driver of the gap is noted to be this.

11. November 2025 Results

Following calculation of the initial data, the results were presented to divisional nursing leaders to undertake the professional judgement. Clinical indicators such as harm events, missed clinical observations etc were also used as part of the wider triangulation. Each Division has fed back the outcomes from this in the sections below.

11.1 ASCR

The ASCR Division reports a variance of 39.3 WTE Registered Nurses (RN) and 25.5 WTE Healthcare Support Workers (HCSWs), resulting in a total variance of 64.5 WTE. This represents a reduction in variance compared with the previous board paper. During this reporting period, the Division has seen an increase in patient acuity, specifically Level 1a patients, of 1.6%, alongside a continued reduction in Level 2 patients.

In the previous board paper, ASCR received £212,820 of investment, increasing the establishment by 5.19 WTE HCSWs on Gate 33a. This investment has supported a reduction in the variance between funded establishment and SNCT-required staffing.

The Division continues to accommodate additional patients to meet organisational demand, including those requiring enhanced care support to maintain safety. Both factors have a direct impact on required staffing levels.

A breakdown of ASCR's SNCT predictions compared with funded establishment, alongside patient mix, is provided in Appendix 4.

ASCR Divisional Risks

Risk 1284 (ASCR Division) Risk of harm, suboptimal care due to funded establishment being below SNCT indicated numbers – risk reviewed and reduced to moderate score of 6 due to increased funding, remaining action to close the gap as follows - SNCT from Q3 2024/25 concluded, wards still have a total variance of 64.5 against acuity; generally areas feel safer than previously; anomaly remains with 26b - skill mix suits previous medical model and will require review within budget to manage and the outstanding action to address the removal of funding due to the plan to close beds Saturday evening to Monday am that has not been realised due to high acuity and bed pressures at the front door - should now be refunded to the ward.

Risk 1215 (ICU) Risk to patient safety, staff wellbeing, recruitment, and retention of ICU if staffing and acuity are not matched on a daily basis. – risk remains as recruitment is ongoing with fluctuating need for 50% etc, EBE request to extend to end Mar 26 impending.

Risk 1970 Patient Experience: There is a risk that caring for and treating patients in areas outside of the planned ASCR divisional bed base will present multifactorial risks for both patients and the trust (this is a trust level risk aggregated across divisions) – risk remains.

ASCR Recommendations

While no request for additional investment is being made through the safer staffing data, attention must be drawn to Gate 26b.

Gate 26b had its establishment reduced when the Elective Care Centre opened, as it was anticipated that when Gate 7b resumed operation as an acute medical ward, 26b's bed stock would decrease by 16 beds from Saturday night to Monday morning to accommodate elective requirements. This reduction in patient numbers has not materialised, and Gate 26b continues to operate at full capacity, resulting in an overspend on current staffing. The related investment request will be submitted separately from this board paper.

11.2 Medicine

Medicine division has illustrated a variance of 44.8 WTE for RN and 60.4 WTE for HCWS: totalling of 105.2 WTE which is a notable increase of 32.2 WTE. There has been a sustained increase in the number of additional patients being supported across medicines inpatient bed base, and a higher proportion of escalation areas are held within this divisions thus leading to increased additional staffing requirements.

The division has seen a change in patient acuity and dependency mix since the previous data collection in May 2024. The number of Level 0 patient has decreased by 12.3% with an increase across 1a, 1b and 1c patients who all require additional nursing support to maintain safety or meet their needs.

At the time of the data collection the seasonal variation in conditions such as respiratory illness was seen hence an increased requirement to support these patients

who require more intensive nursing interventions has continued which is supported by some seasonal funding.

There is an increased number of patients who require enhanced care to support and maintain their safety, where possible these patients are co-located to maximise the deployment of staff; however, this is not always achievable due to number or condition.

A breakdown of Medicine SNCT predictions verses the funded establishment, and patient mix can be found in Appendix 4.

Medicine Divisional Risks

Risk 2077 (AMU) Staffing Ratios

Risk 1455 (Medicine Division) Number of Nursing vacancies

Risk 1565 (Medicine Division) Risk to safe patient care due to skill gaps within workforce

Medicine Recommendations

The funded establishments are generally appropriate to meet the funded requirements of the Division when prior agreed increases are implemented. However, the large proportion of patients nursed in escalation areas has a direct correlation on hours worked as these areas need to be covered by appropriately skilled staff. The staffing of these additional areas is assessed daily to ensure appropriate staffing resource. While no request for additional funding is made through this paper it will be sort through the financial business planning 26/27 in relation to establishing the escalation areas through a non-recuring funding request titrated annually.

11.3 NMSK

The NMSK Division reports a staffing variance of 9.2 WTE Registered Nurses and 14.6 WTE Healthcare Support Workers, giving a total variance of 23.8 WTE. This represents a significant reduction compared with the previous board paper.

Since the previous data collection in March 2025, there has been a change in patient acuity and dependency mix. The proportion of Level 0 patients has increased by 5.3% and Level 1c patients by 3.4%, while Level 1a has remained static. Level 1b patients have decreased by 7.8%, alongside a small reduction in Level 2 patients.

In the previous board paper, NMSK received £297,546 of investment, increasing the establishment by 5.20 WTE RN across Gate 25b and Gate 34a. This investment has supported a reduction in the variance between funded establishment and SNCT-indicated staffing.

The Division has continued to support additional patients across its bed base. Given the nature of the patient cohort, there has also been ongoing expenditure on enhanced care to maintain patient safety and reduce the risk of harm.

This issue is compounded by sustained pressure in the Stroke services as patients continue to wait for longer periods for discharge to sub-acute rehabilitation beds. This has resulted in the number of inpatients consistently exceeding 60 patients compared

to the modelled inpatient bed base of 42. There is also a further pressure of registered staff within this service line being required to provide specialist care to patients who are retained in Medi-rooms post thrombectomy due to no availability of beds within the stroke wards. This increased activity is equivalent to 5.2 WTE but isn't captured within the SNCT data collection process, this is currently funded through seasonal funding during the winter period – however this does not cover the summer months.

A breakdown of NMSK's SNCT predictions verses the funded establishment, and patient mix can be found in Appendix 4.

NMSK Divisional Risks

The two previously held nursing staffing risks have been mitigated through the increased establishment agreed within the August 2025 bi-annual Safer Staffing paper. These risks have therefore now been closed.

NMSK Recommendations

The Division concludes that funded establishments are appropriate to meet current staffing requirements, considering the agreed investments.

Changes in patient acuity and case mix identified in the most recent data collection will continue to be monitored on an ongoing basis. Patients cared for in escalation areas and those requiring enhanced care have a direct impact on hours worked, as these areas must be staffed by appropriately skilled staff

11.4 Women's and Children's Services

The Women and Children's Division data identified a variance between required and funded staffing of 9.3 WTE for Registered Nurses (RN) and 9.6 WTE for Healthcare Workers (HCWs), giving a total variance of 18.9 WTE. This variance is attributable to Cotswold Ward and gynaecology services.

The division's patient acuity and dependency mix has remained static compared with the previous data collection in March 2025. It should be noted that a high proportion of the division's inpatient departments do not utilise the Safer Nursing Care Tool (SNCT), as it is not licensed for use within maternity or neonatal services.

At the time of the November 2025 data collection, the Neonatal Intensive Care Unit (NICU) was undergoing refurbishment. To maintain neonatal services, Cotswold Ward (the gynaecology ward) was extensively repurposed to act as a decant area for NICU activity. This significant change in ward function had a substantial impact on staffing deployment, activity levels, and data capture during the collection period. As a result, the findings for this period are widely influenced by the temporary repurposing of Cotswold Ward and should be interpreted with caution. During this time, gynaecology services were reduced, and staff were redeployed to other clinical areas.

A breakdown of Women and Children's SNCT predictions verses the funded establishment, and patient mix can be found in Appendix 4.

W&C Divisional Risks

Risk 1179 (W&C) Lack of robust and fully established nursing workforce within Neonatal nursing. The risk remains the same although the neonatal nursing recruitment has been successful. Once all staff are in post the risk will be reassessed.

Risk 1900 (W&C) A Risk to patient safety due to a lack of 24/7 telephone triage as a single point of access for all women accessing maternity services. This leads to delays in appropriate care and assessment and variation in advice offered. The division has now received an increase in establishment to implement a 24/7 and are currently recruiting once in post this risk will be reduced or fully mitigated.

12. Midwifery safe staffing - BirthRate Plus®

The BirthRate Plus® (BR+) report, dated December 2025, provides a comprehensive evaluation of midwifery staffing for Southmead Hospital and its surrounding community. Utilizing the BR+ methodology, the report incorporates annual activity data, detailed case mix (acuity) analysis, and professional judgement to accurately determine staffing requirements. These findings are then compared against the current funded establishment to identify any deficits or surpluses in staffing levels.

Birthrate Plus® methodology aligns with NICE guidance and is endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG)/

12.1 Key Findings

Intrapartum Services

Annual births have slightly decreased from 5556 in 2021/2022 to 5318 in 2024/2025.

The acuity has risen with a shift from lower-risk Categories I–III to higher-risk Categories IV–V, driven by factors such as diabetes, mental health, high BMI, increased induction, and operative deliveries. Additional intrapartum activity includes antenatal cases needing 1:1 care, inductions, postnatal readmissions, escorted transfers, and non-viable pregnancies.

Ward & Clinic Activity

The maternity wards have significant antenatal activity, including inductions of labour, and the impact on the workload from the higher acuity of mothers and babies. There is still high activity related to transitional care of babies and those requiring an extended stay. The midwives on the unit currently undertake the newborn examination of hospital and home births daily.

Outpatient clinics

Include obstetric, specialist midwife/obstetric and fetal medicine clinics held in Southmead, Patchway and the community.

Community Activity

Covers home births (currently provided by a dedicated homebirth team based within the hospital), women within the local population who birth in neighbouring units (imports), safeguarding cases and attrition due to pregnancy loss or relocation.

The case mix (complexity/acuity of women requiring care) has a major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V (20% for a Category III, 30% for a category IV and 40% for a category V) results in an increase from the one midwife to one woman ratio for Categories I and II.

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
Delivery Suite 2025	0.4	1.7	15.9	25.1	56.9
	18.0%			82.0%	
Delivery Suite 2021	0.7	4.2	16.1	29.9	49.1
	21.0%			79.0%	

The table above shows there has been an increase in the acuity of women, with 82% of women being in the 2 higher categories, an increase of 3% from the 2021 data. Whilst this is a small overall increase, the most significant factor is the move from IV to V of 7%.

Factors impacting the case mix include more comorbidities such as diabetes, mental health, high BMI, increased induction rates usually in line with national clinical guidance, an increase in operative deliveries and neonatal factors are some of the contributing reasons.

12.2 Summary of Workforce

Current Funded Clinical, Specialist, Management wte	Birthrate Plus wte	WTE Variance
292.66wte	303.08wte	-10.42wte

The total current and Birthrate Plus® establishments do include the RN in Delivery Suite recovery and Band 3 contribution and postnatal services.

The results in the table above indicate the funded baseline establishment has an overall deficit. 10.42wte in the clinical establishment when combining all roles.

NBT maternity services, requested the BR+ report to include calculations with uplifted headroom of 24% to cover the training needs of all midwives in line with increased training requirements, as shown in the table below:

%uplift	Current Total WTE	Birthrate Plus WTE	Variance WTE
21%	292.66wte	303.08wte	-10.42wte
24%	292.66wte	312.60wte	-19.94wte

12.3 Midwifery Safe Staffing Recommendations

The results of BR+ indicate the funded baseline midwifery establishment has an overall deficit of 19.94 WTE (calculated with a 24% headroom uplift) in the clinical

establishment when combining all roles. This includes the RN working on CDS (theatre recovery) and band 3 contribution in postnatal services (Percy Phillips, Transitional care, and community services). The overall deficit of WTE at 21% uplift will need to be funded in keeping with the Maternity Incentive Scheme expectations, with the remaining 24% uplift requirement invested over the next two years.

In addition to the midwifery staffing, there is a need to have additional support staff working on the delivery suite, maternity wards, triage, day unit and outpatient clinics as in the table below

Place of work	Current MSW wte	Required MSW wte	WTE Variance
Antenatal Clinics	5.49	9.36	3.87
Delivery Suite	12.75	14.00	1.25
Mendip Birth Centre	4.98	5.42	0.44
Quantock	13.55	16.26	2.71
Community	19.52	19.52	0

13. Summary

The outcome of the SNCT November 2025 data collection has been reviewed by the Divisional Directors of Nursing and triangulated with professional judgement and clinical indicators as referenced throughout the paper.

Since the last report NBT has seen an increase across its nursing and midwifery vacancies particularly within the non-registered workforce. The organisation has put actions into place to mitigate these increases and there is noted improvement in the pipeline of applicants who are at present going through pre-employment checks which will continue to support the reduction in vacancies. The number of additional patients has slightly reduced overall in this period, however there is a higher number hosted in the medicine division. This patient cohort is unfunded therefore providing this provision of care comes at an additional cost, noted as a driver for the bank and agency workforce spend.

The patient cohort has changed in the most recent collection we have seen a reduction in level 0 patients (those who's needs are met through normal ward provision) with an increase in dependent patient and those who are acutely unwell. The number of patients who are stable but require additional support to maintain their safety and their care has increased.

No request for investment is made via this bi-annual safer staffing paper however the board are asked to note the following two points

- Nursing requirements of the additional patients and escalation areas as investment will be sort through the financial business planning 2026/27 to establish the escalation areas through a non-recuring funding request titrated annually.
- Gate 26b had its establishment reduced when the Elective Care Centre opened, as it was anticipated that when Gate 7b resumed operation as an acute medical ward, 26b's bed stock would decrease by 16 beds from Saturday night to Monday morning to accommodate elective requirements. This reduction in patient numbers has not materialised, and Gate 26b continues to operate at full

capacity, resulting in an overspend on current staffing. The related investment request will be submitted separately from this board paper.

The outcome of the Birth Rate + assessment has been reviewed by the Director of Midwifery, Acting Hospital Director of Nursing and Group Chief Nursing and Improvement Officer and recommending the overall deficit of WTE at 21% uplift will need to be funded in keeping with the Maternity Incentive Scheme expectations 2026/27, with the remaining 24% uplift requirement invested over the next two years.

The conclusion is that professional judgement indicates that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities, whilst also supporting development for both the registered and non-registered Nursing and Midwifery workforce.

14. Recommendations

- Note the completion of the SNCT November 2025 data collection and the associated reviews that have taken place across NBT.
- Note the increase patient numbers who are cared for in our departments, but where there is no additional fixed budget for these patients which continues to contribute to a substantial amount of the temporary staffing spend.
- Note that the patient acuity and dependency have changed since the last data collection, specifically that our patients are more dependent and are more acutely unwell.
- As in previous reviews note the implication of the difference in headroom of the national standard (22%) to NBT's funded (21%).
- Note the completion of the Birth Rate + assessment, and deficit gap in funded versus required. The overall deficit of WTE at 21% uplift will need to be funded in keeping with the Maternity Incentive Scheme expectations, with the remaining 24% uplift requirement invested over the next two years.
- Note that going forwards under a “Group Model” that there will be one six monthly safe staffing paper across NBT and UHBW.

Appendix 1 – Safer Nursing Care Tool – Care levels:

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

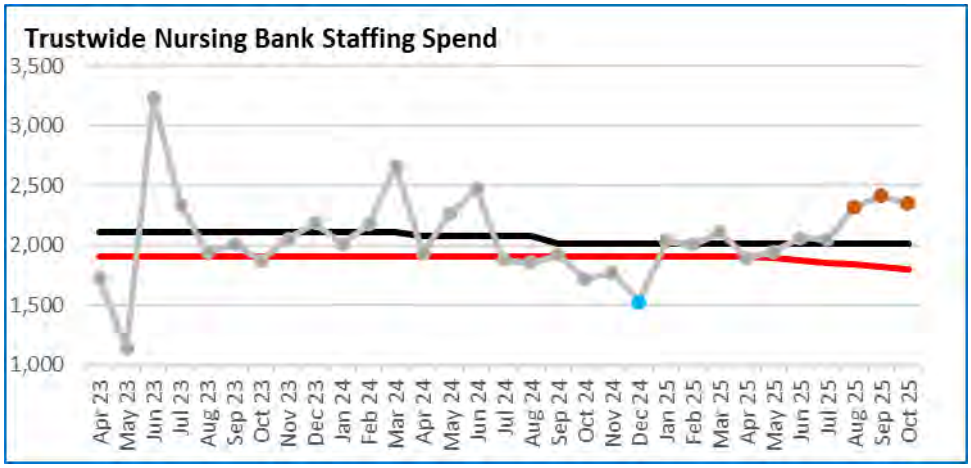
Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: - Greater than 50% oxygen continuously - Requiring close observation due to acute deterioration and needing advanced organ support - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium - CNS depression of airway and protective reflexes - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

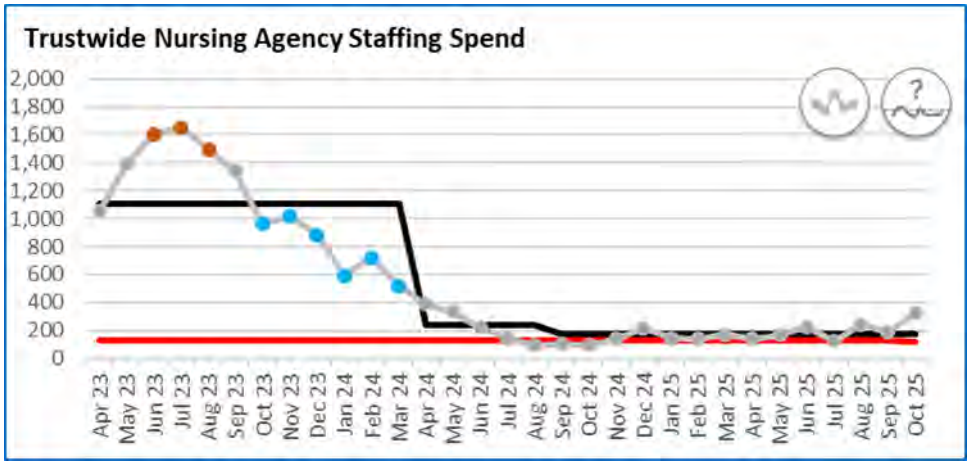
Published October 2023

Appendix 2 – Skill Mix by Division and inpatient areas:

Division	Cost Centre	Specialty	Registered Establishment	Unregistered Establishment	Registered Skill Mix	Unregistered Skill Mix	Required Registered	Required Unregistered
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14104 Ward 32B**	Surgical Admissions	42.2	30.9	58%	42%	36.2	26.5
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14221 Ward 33A Surgical**	Burns and Plastics	29.8	18.2	62%	38%	37.3	22.8
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14222 Ward 26A Surgery**	Vascular	30.1	19.3	61%	39%	41.3	26.5
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14324 Ward 33B Urology**	Urology	31.2	18.2	63%	37%	39.8	23.2
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14325 Ward 26B**	Elective Surg	23.7	25.2	48%	52%	30.8	32.7
339 Anaesthesia, Surgery, Critical & Renal Division	**339 14411 Ward 8B (Renal - 38 Bed)**	Renal	42.2	20.4	67%	33%	53.1	25.7
339 Anaesthesia, Surgery, Critical & Renal Division Total			**199.1**	**132.2**	**60%**	**40%**	**238.4**	**157.4**
339 Medicine Division	**339 14031 Acute Medical Unit Gate 31A&B**	Acute Medical Admissions	78.9	54.3	59%	41%	64.3	44.2
339 Medicine Division	**339 14103 Ward 32A**	Acute Frailty Admissions	28.6	36.4	44%	56%	30.5	38.8
339 Medicine Division	**339 14402 Ward 27A**	Cardiology	33.0	18.2	65%	35%	37.3	20.5
339 Medicine Division	**339 14403 Ward 28A Respiratory**	Respiratory (Inc Resp HDU)	33.8	26.5	56%	44%	31.3	24.6
339 Medicine Division	**339 14410 Ward 8A (Flex Capacity)**	Gastro / Endo	28.6	23.4	55%	45%	36.1	29.5
339 Medicine Division	**339 14501 Ward 9B Flex Capacity**	Complex Care	23.4	31.2	43%	57%	33.7	45.0
339 Medicine Division	**339 14502 Ward 28B (Complex)**	Respiratory / Gen Med	23.4	29.6	44%	56%	35.4	44.8
339 Medicine Division	**339 14503 Ward 9A**	Complex Care	23.4	31.2	43%	57%	32.4	43.2
339 Medicine Division	**339 14509 Ward 10A**	Short Stay Frailty	23.4	31.2	43%	57%	19.3	25.7
339 Medicine Division	**339 14520 Ward 27B**	Infectious Diseases / Haematology	33.8	26.5	56%	44%	42.1	33.1
339 Medicine Division	**339 17003 EEU**	Elgar	19.2	31.2	38%	62%	28.5	46.3
339 Medicine Division	**339 14525 Ward 7B (Medicine)**	Gen Med	23.4	31.2	43%	57%	26.6	35.4
339 Medicine Division Total			**372.7**	**370.7**	**50%**	**50%**	**417.5**	**431.1**
339 Neurosciences & Musculoskeletal Division	**339 14211 Ward 7A**	NEUROSURGERY	31.2	31.2	50%	50%	34.6	34.6
339 Neurosciences & Musculoskeletal Division	**339 14241 Ward 6B**	NEUROSURGERY	36.4	41.6	47%	53%	34.0	38.9
339 Neurosciences & Musculoskeletal Division	**339 14242 Ward 25B**	TRAUMA & ORTHOPAEDICS	26.0	37.9	41%	59%	37.3	54.4
339 Neurosciences & Musculoskeletal Division	**339 14302 Ward 34B**	Stroke	77.9	70.1	53%	47%	79.2	71.3
339 Neurosciences & Musculoskeletal Division	**339 14312 Ward 25A**	TRAUMA & ORTHOPAEDICS	31.5	26.0	55%	45%	37.1	30.5
339 Neurosciences & Musculoskeletal Division	**339 25000 Neuropsychiatry (non Medical)**	NEUROPSYCHIATRY	10.4	5.2	67%	33%	8.8	4.4
339 Neurosciences & Musculoskeletal Division	**339 14311 Rowan Ward**	TRAUMA & ORTHOPAEDICS	29.7	26.7	53%	47%	21.3	19.1
339 Neurosciences & Musculoskeletal Division Total			**243.0**	**238.7**	**50%**	**50%**	**252.2**	**253.3**
339 Women and Childrens Division	**339 01269 Cotswold Ward**	Gynae	14.1	14.6	49%	51%	4.8	5.0
339 Women and Childrens Division Total			**14.1**	**14.6**	**49%**	**51%**	**4.8**	**5.0**
Grand Total			**828.9**	**756.2**	**52%**	**48%**	**912.9**	**846.7**

Appendix 3 – Bank and Agency usage and shifts requested:



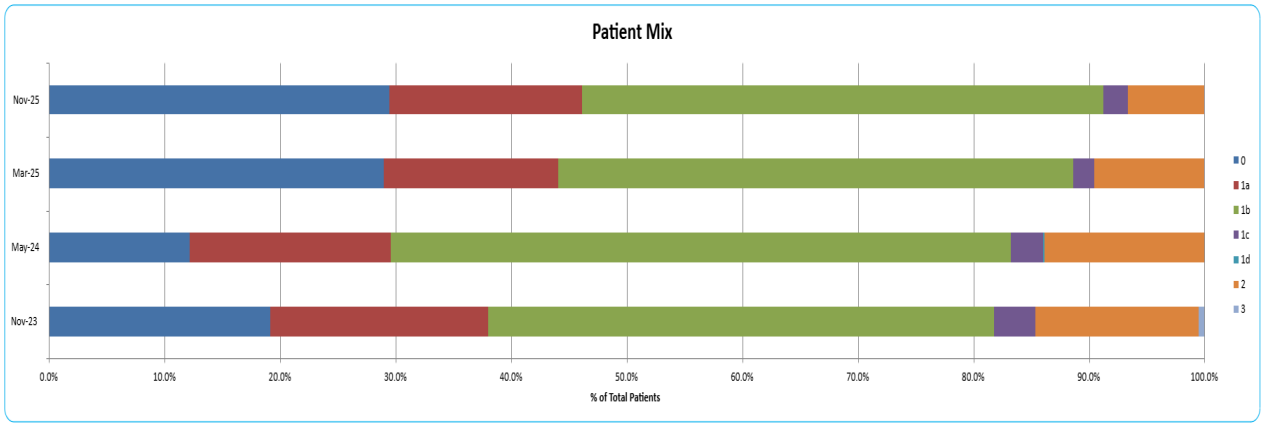


	Aug	Sept	Oct	Nov
Bank & Agency Registered				
Registered Shifts requested	708	667	723	529
Registered Filled Bank	369	288	275	279
Registered Filled Agency	165	240	324	149
%	75%	79%	82%	80%
Bank Non-Registered				
Non-Registered Requested	1596	1552	1507	1287
Non-Registered filled Bank	1228	1040	1003	903
% fill rate	77%	67%	66%	70%

Appendix 4 – Divisional SNCT Predictions vs Funded Establishments and Patient Mix

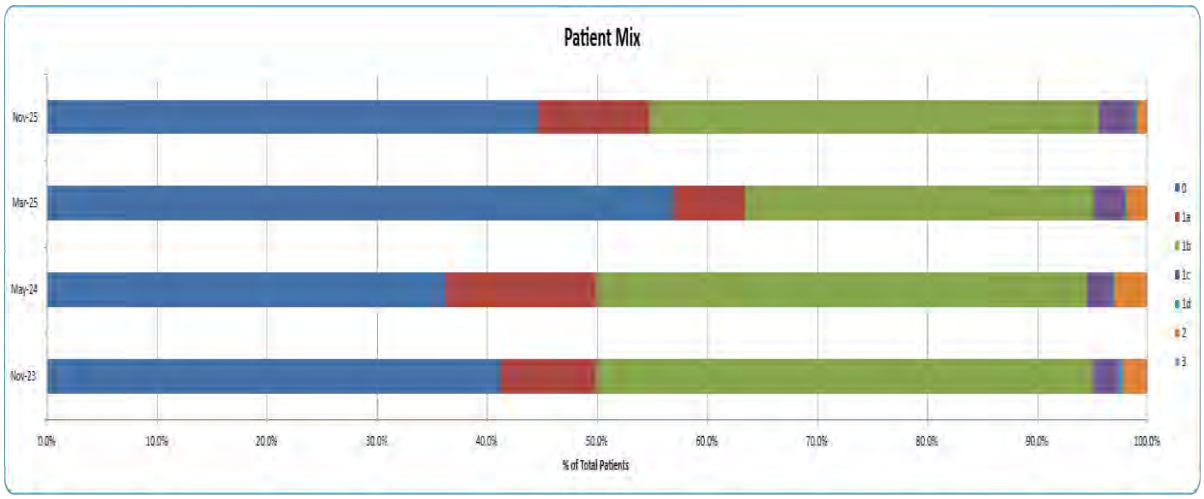
ASCR

		Based on SNCT Data			Based on Funded		
Cost Centre	Specialty	Required Registered	Required Unregistered	Required Total	Registered Establishment	Unregistered Establishment	Establishment Total
339 14104 Ward 32B	Surgical Admissions	36.2	26.5	62.8	42.2	30.9	73.1
339 14221 Ward 33A Surgical	Burns and Plastics	37.3	22.8	60.1	29.8	18.2	48.0
339 14222 Ward 26A Surgery	Vascular	41.3	26.5	67.8	30.1	19.3	49.3
339 14324 Ward 33B Urology	Gastro	39.8	23.2	62.9	31.2	18.2	49.4
339 14325 Ward 26B	Elective Surg	30.8	32.7	63.5	23.7	25.2	49.0
339 14411 Ward 8B (Renal - 38 Bed)	Renal	53.1	25.7	78.8	42.2	20.4	62.6
Grand Total		**238.4**	**157.4**	**395.8**	**199.1**	**132.2**	**331.3**



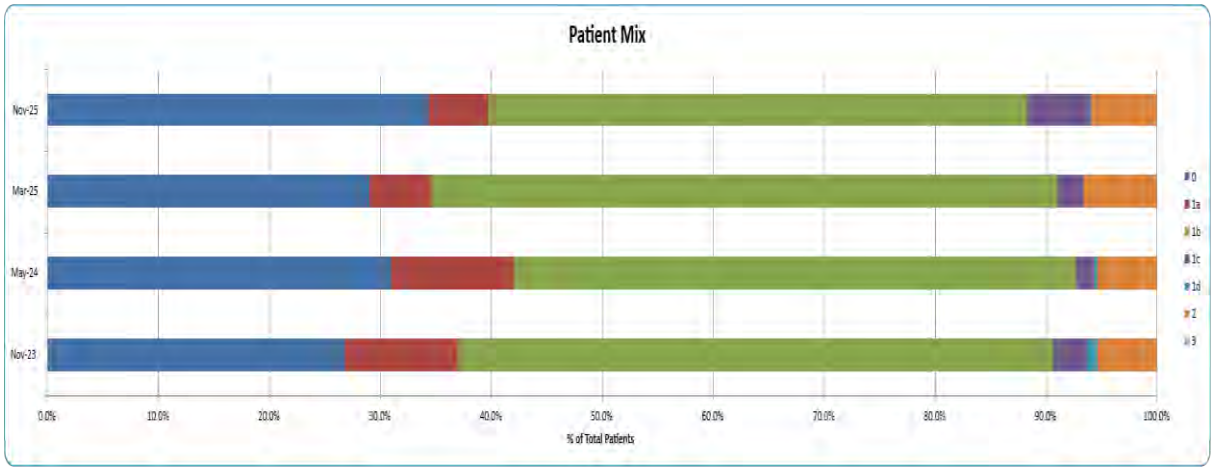
Medicine

		Based on SNCT Data			Based on Funded		
Cost Centre	Specialty	Required Registered	Required Unregistered	Required Total	Registered Establishment	Unregistered Establishment	Establishment Total
339 14031 Acute Medical Unit Gate 31A&B	Acute Medical Admissions	64.3	44.2	108.5	78.9	54.3	133.3
339 14103 Ward 32A	Acute Frailty Admissions	30.5	38.8	69.3	28.6	36.4	64.9
339 14402 Ward 27A	Cardiology	37.3	20.5	57.9	33.0	18.2	51.2
339 14403 Ward 28A Respiratory	Respiratory (Inc Resp HDU)	31.3	24.6	55.9	33.8	26.5	60.3
339 14410 Ward 8A (Flex Capacity)	Gastro / Endo	36.1	29.5	65.6	28.6	23.4	51.9
339 14501 Ward 9B Flex Capacity	Complex Care	33.7	45.0	78.7	23.4	31.2	54.6
339 14502 Ward 28B (Complex)	Respiratory / Gen Med	35.4	44.8	80.2	23.4	29.6	52.9
339 14503 Ward 9A	Complex Care	32.4	43.2	75.6	23.4	31.2	54.6
339 14509 Ward 10A	Short Stay Frailty	19.3	25.7	44.9	23.4	31.2	54.6
339 14520 Ward 27B	Infectious Diseases / Haematology	42.1	33.1	75.2	33.8	26.5	60.3
339 17003 EEU	Elgar	28.5	46.3	74.8	19.2	31.2	50.4
339 14525 Ward 7B (Medicine)	Gen Med	26.6	35.4	62.0	23.4	31.2	54.5
Grand Total		**417.5**	**431.1**	**848.6**	**372.7**	**370.7**	**743.4**



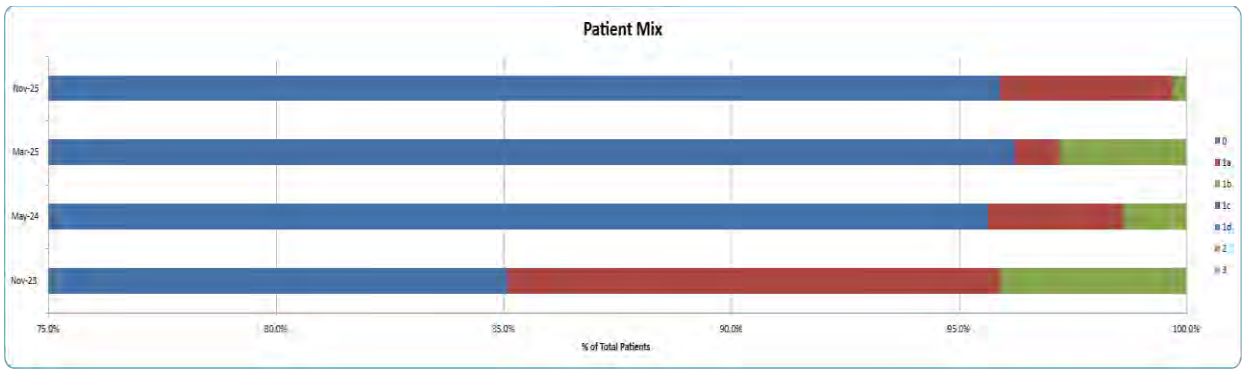
NMSK

Cost Centre	Specialty	Based on SNCT Data			Based on Funded		
		Required Registered	Required Unregistered	Required Total	Registered Establishment	Unregistered Establishment	Establishment Total
339 14211 Ward 7A	NEUROSURGERY	34.6	34.6	69.2	31.2	31.2	62.3
339 14241 Ward 6B	NEUROSURGERY	34.0	38.9	72.9	36.4	41.6	77.9
339 14242 Ward 25B	TRAUMA & ORTHOPAEDICS	37.3	54.4	91.7	26.0	37.9	63.9
339 14302 Ward 34B	Stroke	79.2	71.3	150.5	77.9	70.1	148.1
339 14312 Ward 25A	TRAUMA & ORTHOPAEDICS	37.1	30.5	67.6	31.5	26.0	57.5
339 25000 Neuropsychiatry (non Medical)	NEUROPSYCHIATRY	8.8	4.4	13.3	10.4	5.2	15.6
339 14311 Rowan Ward	TRAUMA & ORTHOPAEDICS	21.3	19.1	40.4	29.7	26.7	56.4
Grand Total		**252.2**	**253.3**	**505.5**	**243.0**	**238.7**	**481.7**



Women's and Childrens

Cost Centre	Specialty	Based on SNCT Data			Based on Funded		
		Required Registered	Required Unregistered	Required Total	Registered Establishment	Unregistered Establishment	Establishment Total
339 01269 Cotswold Ward	Gynae	4.8	5.0	9.8	14.1	14.6	28.8
Grand Total		**4.8**	**5.0**	**9.8**	**14.1**	**14.6**	**28.8**



University Hospitals Bristol and Weston NHS Foundation Trust

Report on Nurse (RN's) and Midwifery (RM's) Staffing Levels UHBW (April 2025 – September 2025).

Context

Following publication of the Francis Report 2013[1] and the subsequent "Hard Truths" (2014)[2] document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift on the Trust website.
- Provide a 6-month report on nurse (RN/ RCN), midwife (RM) staffing to the Group Board of Directors.

Contents

1. Nursing Report
2. Midwifery Report
3. Assurance Statement and Summary
4. Recommendations.

There are two specific strategic nursing and midwifery staffing risks graded as high risk held on the corporate risk register as below. The risks have remained unchanged due to the continued favourable vacancy and turnover positions sustained over the past six months.

For all staff groups:

Risk Number	Details	Risk Level	Current Score	Target score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff – all staff groups.	Strategic Risk Register	8	8
2694	Risk that the Trust is unable to retain members of the substantive workforce.	Strategic Risk Register	8	8
5477	Risk that nurse staffing levels will not be met.	Strategic Risk Register	6	6

For Midwives:

Risk 33 - This risk remains very high due to experienced staff turnover and availability of courses to train new staff. Work continues to reduce the impact of this as more Qualified In Specialty (QIS) staff are recruited.

Risk Number	Details	Risk Level	Current Score	Target score
33	Risk that inadequate nursing levels in line with BAPM standards 2011 will affect neonatal outcomes.	Departmental	15	6
988	Risk that neonates are transferred out to alternative NICU units due to lack of cot capacity (linked to Risk 33)	Departmental	9	3
3623	Risk that extreme pre-term babies will have a sub-optimal outcome due to inability to deliver in a tertiary centre	Departmental	8	4

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
[2] NHS England » Guidance issued on Hard Truths commitments regarding the publishing of staffing data

- The report highlights the work being undertaken to mitigate the above risks.

1. Nursing Report

Trust Metrics Overview

The previous six months Trust level staffing metrics are contained within Table 1; the Divisional summary tables can be found in the appendices.

Key points to note: -

- Over the past six months, the adult fill rates have seen a slight decline below the 95% level on occasions particularly during the daytime when wider clinical support is available. The night HCSW fill rate remains above 100%, this is to ensure vulnerable patients are kept safe with enhanced care observation overnight.

- All in-patient area fill rates are based on funded beds and do not include additional escalation beds. Additional escalation beds include boarding beds (additional beds in ward areas) and escalation areas (use of day case areas for inpatients, alongside additional queues in ED and Same Day Emergency Care areas). When utilised, additional RNs and HCSWs are required to meet patient care needs in these areas. (See appendix for Escalation usage).

- Overall, there are minimal band 5 vacancies for the trust through over recruitment, however this surplus has now become part of the established numbers. In September 2025 the trust has 1.12 WTE band 5 vacancies or 0.01% of the establishment overall compared to a surplus of – 106.98 WTE back in April 2025 or 5.7% of the establishment.

- The Registered Nurse Turnover rate has been between 7.7% and 8.6% for this period, this is down from between 10.1% and 11.7% for the previous period, due to successful recruitment and the impact of the Trust wide focus on retention initiatives.

- Care hours per patient day (CHPPD) is a measure of actual nursing resource deployment and the registered nurse (RN) CHPPD and total CHPPD are included in the metric tables. Trust wide RN CHPPD has remained within the range 6.6 – 6.8. UHBW benchmarks well against peers (CQC rated good) in the model hospital dashboard and is in the top national quartile for CHPPD.

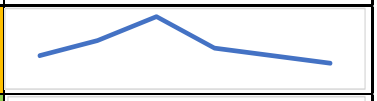
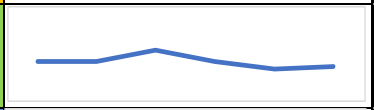
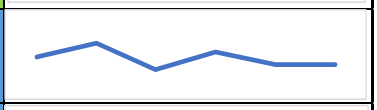
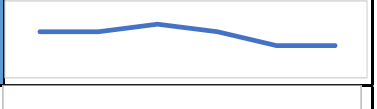
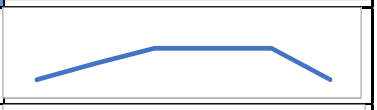
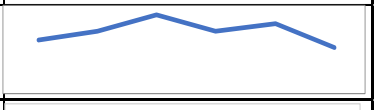
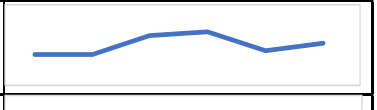
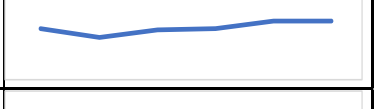
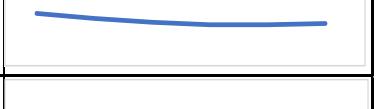
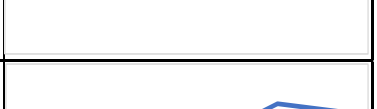
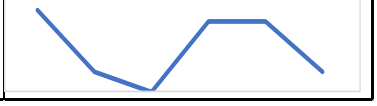
- The level of red flag reporting for in-patient wards has decreased over this 6-month period, those reported were mainly due to difficulty in covering Enhanced Therapeutic Care Observation (ETOC) shifts by Health Care Support Workers. Red flag shifts for Registered nurses remain low due to the low vacancy levels however those reported all revolved around having to move staff to cover escalation shortfalls or very late notice staffing gaps in other clinical areas.

- NICE Midwifery red flags are included in the midwifery section and are reported each month through the Safe Staffing Report. (please refer to the midwifery report).

- Both the level of agency and bank usage in all divisions continue to be low as where possible a higher proportion of shifts have been filled by substantive staff.

- Staffing the Trust's escalation areas has been a significant feature over the last six-month period. Overall, this equates to a constant, additional 10.5 WTE per week (RN and HCSW) on top of the current staffing demand.

Table 1 - Trust Metrics

Trust Overview Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	94%	96%	99%	95%	94%	93%	
Registered Nurse Fill Rate - Night	97%	97%	102%	97%	94%	95%	
Unregistered Nurse Fill Rate - Day	120%	123%	117%	121%	118%	118%	
Unregistered Nurse Fill Rate - Night	137%	134%	134%	137%	136%	137%	
All Staff Fill Rate - Overall	106%	106%	107%	106%	104%	104%	
Registered Care Hours per Patient Day	6.6	6.7	6.8	6.8	6.8	6.6	
Total Care Hours per Patient Day	10.6	10.7	10.9	10.7	10.8	10.5	
Supervisory Ward Sister %	78%	78%	83%	84%	79%	81%	
Sickness (Rostering KPI)	6.1%	5.0%	6.0%	6.2%	7.1%	7.0%	
Registered Nurse Band 5 Turnover Rate	8.4%	8.0%	7.7%	7.8%	8.6%	8.2%	
Unregistered Nurse Band 2/3 Turnover Rate	12.3%	11.5%	11.0%	10.6%	10.7%	10.8%	
Registered Nurse Band 5 Vacancy WTE	-107.0	-64.5	-63.0	-68.8	-58.2	1.1	
Unregistered Nurse Band 2/3 Vacancy WTE	29.7	79.6	75.6	64.3	70.4	94.9	
% Agency staff used to support substantive staff	1%	1%	1%	1%	1%	0%	
% Bank staff used to support substantive staff	13%	13%	14%	14%	16%	15%	
Lower than expected Staffing Incidents - In patient Wards	45	46	15	30	60	53	
Red Flag Reported incidents - In patient Wards	8	2	0	7	7	2	

Safer Nursing Care Tool (SNCT) 2023*

The Trust has now used the revised Safer Nursing Care Tool (2023) four times to underpin the review of the nursing establishments. The new version has been expanded to include the care for one-to-one Enhanced Therapeutic Observational Care (ETOC) assignments and for patients requiring a two-to-one or more staffing level to ensure both patients and staff are kept safe.

- The first SNCT audit using the new tool was undertaken in July 2024 with continued improved compliance and was repeated in November 2024, February 2025 and July 2025. This complete dataset provided detailed evidence-based information including seasonal variations from which the annual establishment reviews were undertaken in October 2025.

- The indicative staffing numbers derived from the tool form the start point for the safe staffing annual reviews. The subsequent quality outcomes, staff experience and professional judgment evaluation ensure that all aspects of ward work are included in the assessment to safeguard patient safety.

- All results have been shared with the divisions and reviewed by triangulating the acuity and dependency generated staffing levels, then applying professional judgement to ensure patient safety elements and all additional components of ward activity not captured by the tool are evaluated. This includes reviewing the patient outcome metrics for the period. This follows the recommended approach by the National Institute of Clinical Excellence (NICE).

- Emergency Department SNCT tool remains unchanged and continues to be undertaken in July and February each year as standard.

- The divisional overview is shown below and has been contrasted against the in-patient ward's funded establishment in hours (dark blue), total worked hours for the period (orange) and the SNCT indicative staffing level in hours (green).

- These figures have been adjusted for the different headroom allowances of 21% (UHBW) and 22% SNCT respectively.

- The worked level is equal to or slightly greater than the total SNCT indicated staffing level in most Divisions in Bristol confirming staffing matches acuity and dependency.

- The individual ward figures, the 3 audits and the overall average across the three audits are shown in Appendix 2. The correct scoring of patients has improved over the audit cycles as the patient types are more accurately coded and match the operational demands. This includes both acuity for patients and the ETOC/RMN 1:1 assignments.

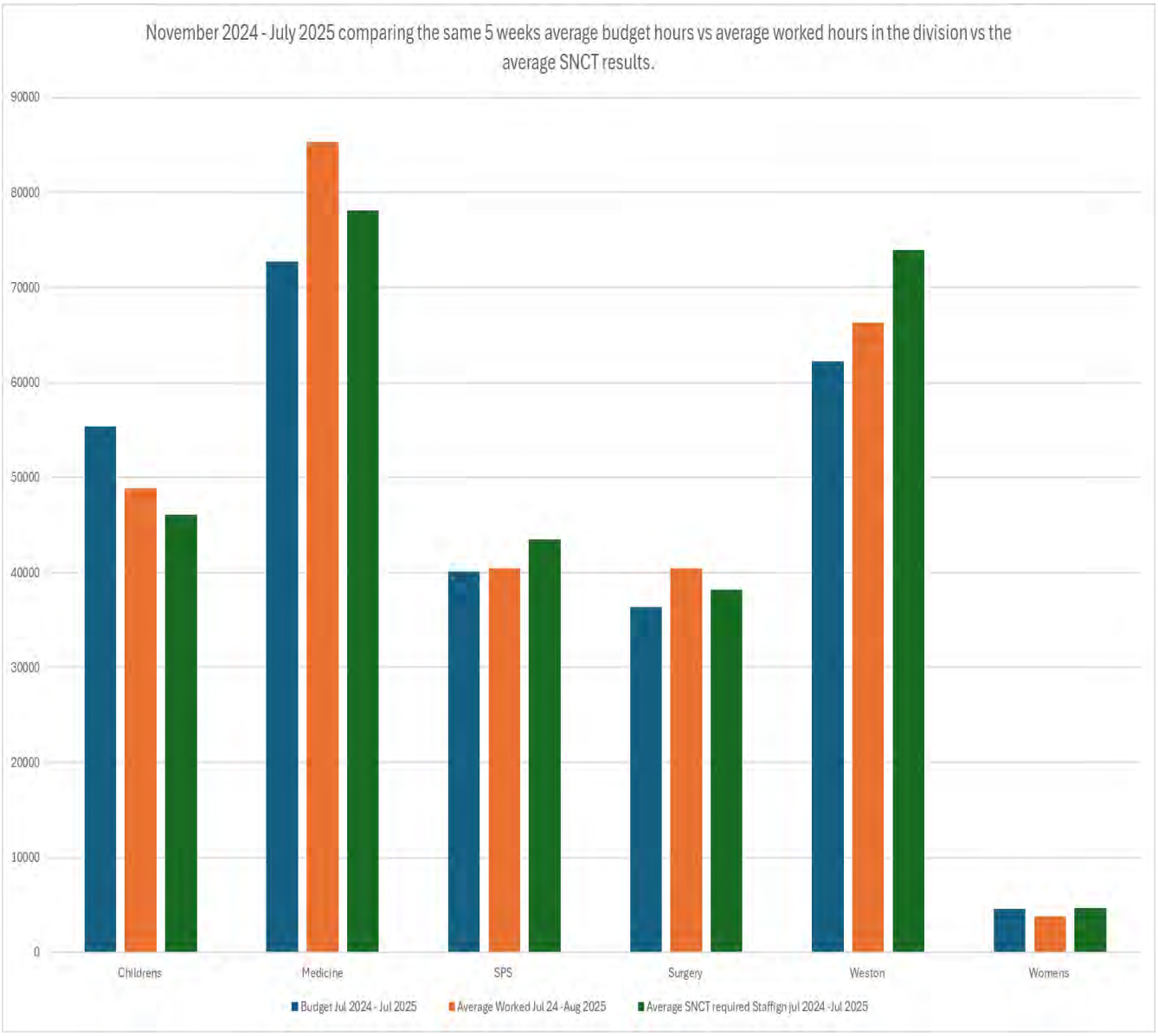
- Weston SNCT results indicate that acuity and dependency are higher across the hospital, and the worked elements indicate a higher establishment in some areas is required.

- The new children and young people's tool is due for release imminently, however the results shown here were undertaken using the old tool. Given the increased prevalence of mental health requirements in the Childrens, no changes are planned until the new tool can be used.

The graph (Fig 1) on the next page shows the comparison between the budgeted hours available during 5-week audits, the worked hours including all temporary staffing requirements extracted from the rostering system and the total hours indicated from the SNCT audit across the previous three audits. The individual ward results were reviewed in detail during the annual review process. Please note that escalation areas are not included here and are in addition to

these figures. In the four main adult Divisions the worked and SNCT results exceeded the Budgeted figures in the main due to covering the increased demand for ETOC patients.

Fig 1



*The Shelford Group, Safer nursing care tool implementation resource pack. The Shelford Group 2023

Key Divisional points to note from the SNCT audits.

Medicine

There is a significant mismatch between SNCT requirements and worked hours in several wards caused mainly due to the continued high ETCO/1:1 demand (1c patients) (see fig 1). The division does have the highest level of patients scored in the 1c and 1b (stable but requiring a high level of assistance) demonstrating the continued level of dependence by patients on the nursing resource. The ETOC demand has exceeded 100 WTE over the last 6 months but there is only 27 WTE funded in the ETOC team. The current staffing models have yet to fully account for the newly recruited activity coordinators or the impact of the new ETOC approach. This will be worked on over the next 6 months.

When considering the SNCT outputs, the professional judgement process must also draw on factors outside of the tool. Many wards in Medicine (e.g.A525, A528, A900 and A801) have structural/layout-driven inefficiencies (e.g., split wards) or are small in size that require staffing in excess of the SNCT suggested levels.

Although the SNCT audits reflect the level of additional patients added to the funded bed base (boarding beds) on the ward, they do not reflect any of the escalation areas/ ED queues that are required to be safely staffed.

Specialised Services

Specialised Services had the highest level of patients in the 1a category (acutely unwell indicating the high level of acuity the division has had to manage. Over the course of the three audits the SNCT results suggest most wards require more staff than they are funded for indicating a potential undersupply of RNs across all areas (see Fig 1).

Within Specialised Services there is an explicit recognition that SNCT tool may not fully capture the full complexity, particularly the smaller specialist units, nor does it cover the full impact of the psychological support required for life-limiting conditions. Despite this the compliance within the division has improved to 100% (SNCT completion throughout indicating good compliance with the process and improving the accuracy of the results).

The staffing of boarding beds has also increased the demand for additional staffing (See Fig 1) across the Division and has featured heavily in the increased level of lower-than-expected red flag staffing reports.

Surgery

Surgery has seen an overall improvement in compliance and accuracy of SNCT tool over the range of audits particularly the scoring of Level 2 (very high acuity and dependency) patients recorded on A800, this is the step-down unit for ITU patients and regularly see very unstable patients still in their acute recovery phase following the spell in ITU.

For wards A609 and A701, both show working hours greater than the SNCT audit with causes likely to be related to the additional requirement to cover fire evacuation and covering the patient chair activity in A609 that is not included in the SNCT audit process. During the February 2026 SNCT audit the focus will be on validation of these results as well as incorporating the chair activity in the professional judgment process.

Weston

The SNCT audits have highlighted HCSW-driven increase in demand over the three audit periods, particularly on Hutton ward which saw the biggest increase. This will be reviewed after the February 2026 audit following the implementation of the new ETOC programme.

On Sandford Ward (Medical Assessment Ward) the SNCT data (averaged across the last three audits) consistently shows an RN shortfall. This ward has a high volume of Level 2 and has a high throughput of patients and take the majority of patients direct from the Emergency Department.

For Berrow ward, the SNCT data shows a clear need to increase RN numbers, especially during winter, Berrow is the main respiratory ward on the Weston site and takes all patients requiring non-invasive ventilation. The rise is particularly seen during the winter months.

Women's

Within the Women's Division only Ward 78 uses the SNCT tool. Over the three most recent audit cycles the funded establishment, the worked hours used and the SNCT indicative staffing suggestions consistently align well. The situation has also improved following the review of the major take across the city that has streamlined the admission process.

All Midwifery areas use the BirthRate Plus tool that is reported in the midwifery section.

Children's

The SNCT Childrens and Young People Tool is used for all the paediatric areas, and this data is now showing a much better alignment between funded establishment and actual staffing demand (helped by significant investment over recent years). The improvement seen in the SNCT data compliance has also facilitated improved engagement from ward teams and matrons, as the tool embeds and provides more accurate results.

The Children's Division continues to care for a significantly higher proportion of mental health patients with very high acuity. This remains poorly captured by the current paediatric SNCT tools however a national update to a newly revised tool is expected in 2026 following sign off by the Shelford Steering Group.

The Emergency Department Safer Nursing Care Tool (SNCT)

BRHC ED SNCT audits show a much-improved picture and with ED expansion last year the area is now less crowded and the risk to children significantly reduced. Key staff in the department also attended and passed the national ED SNCT training session to refresh their knowledge and assessment of patients prior to undertaking the July 2025 audit.

BRI ED - The July 2025 ED SNCT audit identified further opportunities to closer align staffing to the attendance results. This builds on the previous changes made which have made a positive impact on staffing and improvement to patient flow through the department. Key staff in the department also attended and passed the national ED SNCT training session to refresh their knowledge and assessment of patients prior to undertaking the July 2025 audit.

Weston ED - The Rapid Triage and Treatment service and ED observation unit changes are now fully embedded and working very effectively. Following the last audit the configuration of staff and shift times have been reviewed to provide a more aligned staffing model as the attendance pattern has changed over the years. Significant work now is focused on ensuring the benchmark level of Registered Childrens Nurses in Weston ED is maintained across the full opening hours. Key staff in the department also attended and passed the national ED SNCT training session to refresh their knowledge and assessment of patients prior to undertaking the July 2025 audit.

6th Monthly Review

Below are the key points noted from the annual staffing review process using the guidance set out in the National Quality Board expectations for Trusts.

Medicine

The Medicine Division continues to have an RN over-establishment, however this has been used to help cover, where possible, the increased ECO demand, the pre-emptive boarding beds, some of the escalation areas or short-term sickness. Given the demand to staff escalation areas the RN surplus cannot cover all these areas. However, the Division has commenced detailed work to explore how to effectively and efficiently manage workforce requirements according to patient demand in escalation areas. In addition to this the Division also has several HCSW vacancies that continue to create daily operational pressure to support our most vulnerable patients. The rollout of the ETOC project is expected to support the reduction of this by providing a more streamlined pathway to effectively care for these patients.

Staff have reported that moving staff to escalation areas (especially the ED queues) remains a major stressor for the Division, therefore plans are in place that include:

- Planning for out-of-hours staffing no less than one week in advance so staff know when it is their turn to move.
- A review of the historical shift pattern inconsistencies across the division.

- The maintenance and expansion of proactive staff movement support, including orientation to ED Queue areas and increased use of flexible working patterns (school-run shifts, twilights, etc.), which has seen a positive uptake in some areas.

Key successes for the division include completing appraisals for 97.7% of staff to support retention, this level was the highest in the Trust. The Division also oversaw a significant reduction in agency RN usage with over £500k saved on RMN agency by improving the process for assessing, booking and de-escalating these assignments.

ED staffing has been reviewed following ED SNCT audits and flow changes in the Department. As a result, shift times have changed and are now tailored to patient demand, with a benefit realisation of patient movement though and out of ED.

Specialised Services

Overall, the division reports good progress on establishment/skill-mix reviews and rostering oversight but highlights several material staffing risks - notably: BHI outpatients, D603 oncology vacancies, SDEC transformation, SNCT indicating underfunding/undersupply, and dependency on fixed-term/charity funding in some services.

The Division highlighted that D603 oncology has had a rise in vacancies of up to eight RN WTE. It is expected this will be mitigated by planned external recruitment. However, even with recruitment, the service expects some variability whilst embedding new staff, given the specialist skill set required of chemotherapy competency, detailed oncology education, and understanding the end-of-life complexity.

In line with the 10-year plan, service provision has been reviewed to move to more chemotherapy satellite clinics, with funding agreed for 26/27. This approach will be reviewed in terms of patient care improvements prior to further funding consideration for 27/28.

BHI outpatients identified a significant operational and safety risk (risk score 16) due to the reliance on a very small RN workforce covering both complex outpatient and pre-op work. A full-service review is now being undertaken to deliver the service requirements in a more streamlined way. Whereas the BHOC specialist practice teams have seen positive developments: substantiating several fixed-term posts, recruiting a consultant practitioner role, and expanding palliative care with external recruitment.

A workforce skill mix review is also underway in the Cardiac Catheter Labs, approved to progress at the annual staffing, this review is designed to improve retention with no financial impact.

Surgery

The Surgical Division has moved from being over-established to now having vacancies with 15.59 RN vacancies (mix of Band 5/6, with Band 6 gaps in specialist areas including theatres, ITU, The Eye Hospital Emergency Department). This will increase by 3.35 Band 5 RN vacancies expected due to internal promotions to Band 6 posts supporting internal succession planning.

The HCSW vacancies projected to be 42.8 WTE by December mainly due to the changes required for services to start the move to single managed services, the reconfiguration and changes to theatre timetables across the sites and to support the continued use of assessment units. Band 2 recruitment is particularly challenged due to the recent visa changes and the reduced suitability of Band 2 roles in higher-acuity wards e.g. A701, A609 and A604 making Band 3s more appropriate. The competencies required to work in STAU are being reviewed to support streamlining the Band 3 pipeline into the unit.

Key staffing projects that the Division has undertaken include reviewing the theatre workforce establishment and aligning it with the new theatre timetable following a major revision and roster rebuild. Significant work has also been completed to improve St Michael’s Theatres operating out of hours, resulting in two full theatre teams available overnight, meeting the

emergency patient demand. This has significantly reduced the pressure on the staff and minimised next day cancellations due to staffing gaps.

The Division is also ensuring that all the CNS budgets have had an annual review to identify any gaps between activity and allocated budget highlighting the need for a more robust job planning process for CNS roles and accuracy of workload mapping.

There has been significant pressure on staff escalation areas, especially on the Queens Day Unit that has been used every night. The Division has also noted the adverse impact whereby the frequent movement of staff between wards is contributing to morale issues and reluctance to pick up bank shifts. The Division is working with other Divisions to provide more support and planning to reduce the impact of this.

Critical Care Outreach as a 'Trustwide service' has seen an increase in demand at the Bristol adult site, as acuity on the wards increase, critical care demand rises coupled with the implementation of Martha's rule has resulted in an increase in escalations to the team. Therefore, staffing requirements have been worked up (in line with the national benchmark) following the staffing review as part of the annual planning process. This equates to 5.88 WTE Band 7's to provide the required new additional tier (Bristol site). There is a requirement to review current Band 6s at both Weston and Bristol sites, to align to job requirements.

Children's

The Children's Division is currently over-established in many areas and has benefited from excellent recruitment and retention success. However, the focus has now shifted to aligning internal and external recruitment opportunities to support the NICU shortages.

The Children's ED staffing uplift now embedded following the previous SNCT audits has had a demonstrable improvement in safety in the department leading to fewer Datix incidents.

The Paediatric Critical Care Outreach review was completed with a recommendation to provide a full service across the Children's Hospital, resulting in additional requirement of 2.6 WTE. The expected outcome is the improvement of patient safety, smoother flow through the hospital and the reduction of patient admissions to Paediatric Intensive Care, positively impacting the quality-of-care provision.

The theatre workforce has undergone major stabilisation and has successfully dropped from 23 above-cap agency nurses down to nil, which is a major achievement. The Division will continue the theatre workforce model redesign to optimise the workforce. This will report back for the 2026/27 review and planning round. Another key success for the Division includes the increase in mental health practitioners that are now present daily significantly improving the CAMHS pathway to support the increasing number of mental health patients cared for by the Division.

Weston

A shift flow coordinator on Sandford (Acute admission unit) is required to support efficient and safe transfer of patients from ED into the ward and onto the other specialist wards in a timely way. This is supported by the SNCT data and professional judgement and would require an additional 5.3 WTE RN.

Berrow Ward cares for patients requiring non-invasive ventilation (NIV), demand throughout the year continues to be high and patients require a 2 to 1 nurse ratio. To meet this demand, the Division have reviewed and recommended an increase in staffing by one RN per shift, equating to 5.3 WTE, consistent with the SNCT results and is included in winter planning this year for Berrow.

The Weston team have been collaborating with the Children's Division to review increased Paediatric nurse availability in line with National guidance for the ED in Weston to ensure it is fit for purpose now, and in the future as population demographics may change. The additional staffing requirement will be 2.2 WTE Registered Children's Nurses.

The Division is exploring a variety of recruitment offers for staff, including offering Registered Nurse posts with flexibility to rotate between wards, to provide a broad base of experience.

Women's – see report for Midwifery Services

For gynaecology

Succession planning for the Early Pregnancy Clinic has proved difficult due to long-term sickness and providing the required support to train new recruits. However, there is now an active programme in place to mitigate these issues. During the annual review the Division highlighted that across the maternity, gynae, and NICU there are significant operational pressures, driven largely by continued workforce shortages (vacancies, sickness, skill mix), the rising complexity and acuity of both babies and mothers, persistent flow issues across the maternity service especially linked to NICU capacity and the rapid growth in specialist caseloads without any corresponding increase in the workforce. To mitigate this a number of actions, require trust-level decision making, particularly signing off the final triage staffing and business case, approving the specialist midwife funding (especially substance misuse), supporting the NICU establishment review and expansion including sustained improvement plans for postnatal care and triage responsiveness.

2. Midwifery Services Report

Introduction

This section of the report details the specific requirements and actions taken by Midwifery Services to ensure that all mothers and babies are given quality care in a safe and secure environment.

The Trust continues to review its services against the landmark publications of the Ockendon Reports in December 2020 and March 2022, to provide assurance that Midwifery Services are responding appropriately to the recommendations outlined in these two reports.

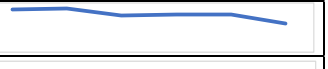
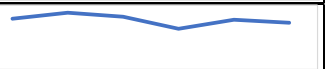
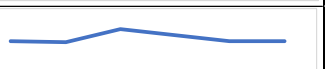
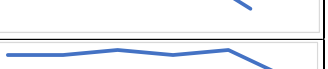
A full Birthrate Plus workforce assessment was undertaken in July 2025 and the final report was received. Generally, the report found staffing was in line with the guidance, however the additional midwifery requirements to support the recommendations expected from the report centred around the provision of a 24/7 fully supported triage service for women arriving in the Central Delivery Suite. This represents an additional 14.52 WTE Registered Midwives (Band 6) with 1 WTE Band 7 in support.

Staffing in the Neonatal Intensive Care Unit (NICU) has remained challenging due to the level of sickness (long and short term), maternity leave and increased acuity. The unit is commissioned to care for fifteen ITU patients but frequently cares for eighteen ITU patients. These patients require one-to-one nursing, so staffing is sometimes required to flex up at very short notice. The flexibility of the workforce and joint working between midwifery and the neonatal unit has maintained safe staffing, with maternity sometimes having the capacity to release the ward 76 neonatal nurse to NICU and NICU staff able to be flexible with shift change and at times to move training and management days. Overall, NICU's nursing vacancy rate has improved but the proportion of Qualified in Specialty (QIS) nurses remains a challenge which puts NICU in derogation of British Association of Paediatric Medicine (BAPM) staffing standards for QIS. The BAPM standards indicate that UHBW staffing standards are to have 85% of the nursing workforce QIS trained, current proportion is 58%.

In order to support staff on NICU with staffing pressures and increased acuity, there has been a focus on staff well-being, bank incentives and additional senior support.

The recruitment, retention and training of Qualified in Specialty (QIS) nurses to NICU continues to be a local, regional and national challenge. Work within the regional Network has supported access to additional education funding and course provision.

The fill rate for each maternity ward is illustrated on the next page.

	Division - Womens Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
CDS	Registered Midwife Fill Rate - Day	150%	167%	188%	212%	211%	211%	
	Registered Midwife Fill Rate - Night	149%	146%	167%	180%	175%	175%	
	Unregistered Maternity Support Worker (MSW) Fill Rate - Day	100%	100%	100%	100%	100%	100%	
	Unregistered MSW Fill Rate - Night	100%	100%	100%	100%	100%	100%	
	All Staff Fill Rate - Overall	133%	140%	158%	165%	160%	160%	
Ward 73	Registered Midwife Fill Rate - Day	95%	96%	89%	90%	90%	80%	
	Registered Midwife Fill Rate - Night	85%	85%	86%	85%	82%	84%	
	Unregistered Maternity Support Worker (MSW) Fill Rate - Day	100%	100%	100%	100%	100%	100%	
	Unregistered MSW Fill Rate - Night	100%	100%	100%	100%	100%	100%	
	All Staff Fill Rate - Overall	87%	93%	90%	90%	86%	83%	
Ward 76	Registered Midwife Fill Rate - Day	156%	178%	163%	125%	154%	144%	
	Registered Midwife Fill Rate - Night	102%	107%	107%	107%	97%	83%	
	Unregistered Maternity Support Worker (MSW) Fill Rate - Day	130%	113%	117%	110%	116%	114%	
	Unregistered MSW Fill Rate - Night	99%	93%	100%	102%	99%	101%	
	All Staff Fill Rate - Overall	126%	130%	90%	114%	109%	118%	
NICU	Registered Nurse Fill Rate - Day	84%	85%	86%	72%	85%	85%	
	Registered Nurse Fill Rate - Night	89%	86%	88%	74%	66%	91%	
	Unregistered Nurse Fill Rate - Day	94%	234%	100%	65%	71%	105%	
	Unregistered Nurse Fill Rate - Night	83%	155%	100%	70%	63%	78%	
	All Staff Fill Rate - Overall	87%	87%	91%	72%	74%	88%	
Ward 78	Registered Nurse Fill Rate - Day	100%	98%	95%	99%	93%	95%	
	Registered Nurse Fill Rate - Night	100%	99%	108%	104%	100%	100%	
	Unregistered Nurse Fill Rate - Day	89%	96%	93%	89%	97%	81%	
	Unregistered Nurse Fill Rate - Night	100%	101%	102%	100%	109%	100%	
	All Staff Fill Rate - Overall	98%	98%	99%	98%	99%	94%	

In Midwifery, the hospital on-call midwife and the on-call community midwives are used in periods of high acuity and/or activity to support staffing shortfall across the hospital. They appear on the CDS line elevating the fill rates. In addition, the midwifery on-call manager is also available for support. These incidents are now increasingly rare. There are twice-daily flow meetings held between maternity, gynaecology, and neonatology each weekday with the 'flow midwife monitoring activity and the movement of staff during the week. At weekends, a morning flow meeting is held via Teams to enable the on-call manager to remain sighted on

the staffing and acuity position. The data recorded in the Birthrate Plus tool informs the flow midwife of hotspots on the day.

The fill rates for the maternity and women's services are shown above, Ward 76 historically operated with one midwife each night with a registered nurse from NICU (they are included in the NICU numbers) also rostered on the ward. Clinical midwifery support was provided from Ward 73 or CDS when required.

Birth Rate Plus Acuity Tool

The Birth rate Plus acuity tool is used on the central delivery suite (CDS), the maternity ward (73) and transitional care (76) to help manage the midwifery staffing and trigger escalation when required.

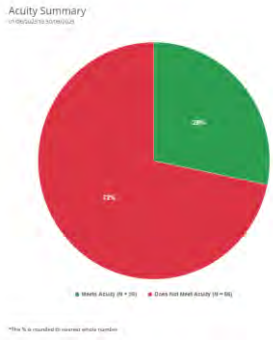
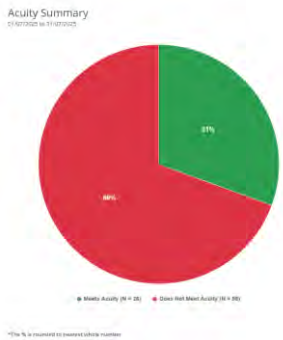
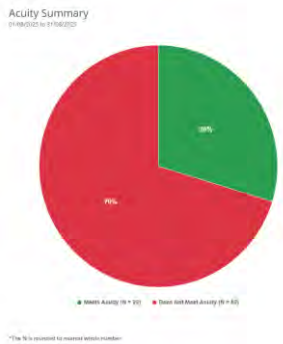
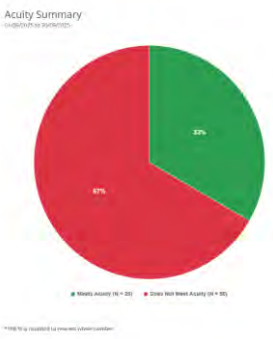
The Birth Rate Plus data capture must occur within a 1 ½ hour window and if inputted outside of the window the data is discounted.

The % is rounded to the nearest whole number. Green = staffing meets acuity, orange = up to 2 midwives short, red = staffing does not meet acuity.

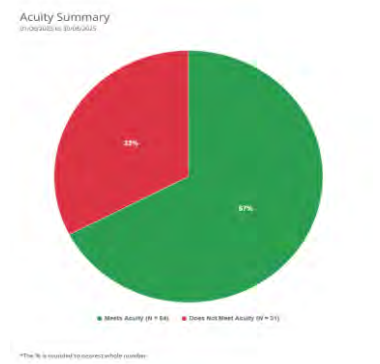
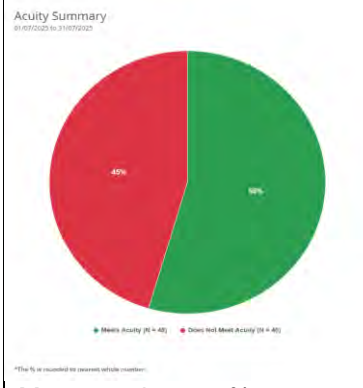
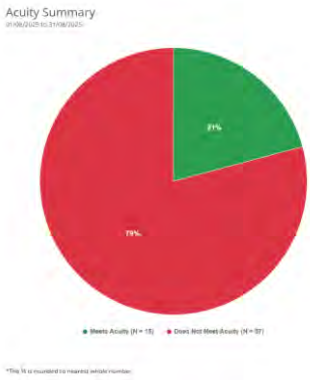
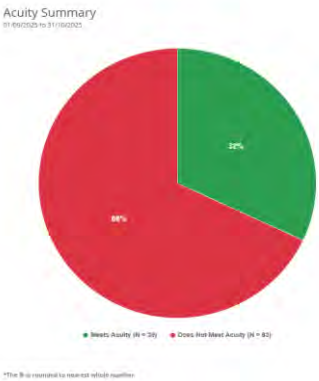
The completed schedule data entry level ranges from 45% to 60%. Further work to improve compliance is in progress with an action plan generated which is overseen by the Divisional governance process to monitor improvement.

Ward 73 (Oak) – Q1 & 2 – Acuity Summary

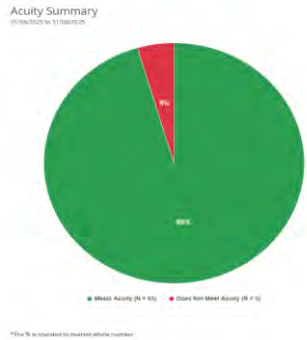
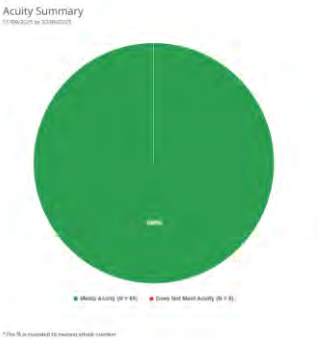
The % is rounded to the nearest whole number. Green = staffing meets acuity, red = staffing does not meet acuity.

April 2025	May 2025	June 2025
No data available for this period (all W73 areas merged prior to this date)	No data available for this period (all W73 areas merged prior to this date)	 Meets acuity = 28%
July 2025	**August 2025**	**September 2025**
 Meets acuity = 31%	 Meets acuity = 30%	 Meets acuity = 33%

Ward 73 (Willow) – Q1 & 2 – Acuity Summary

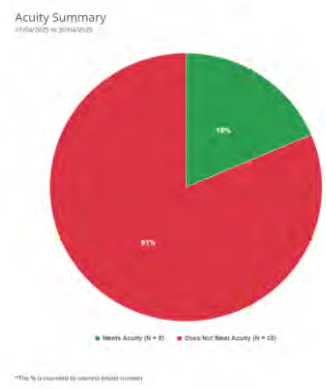
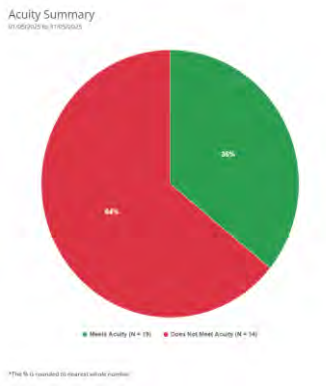
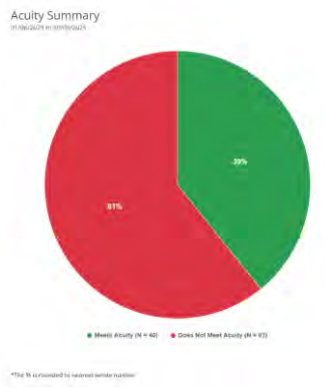
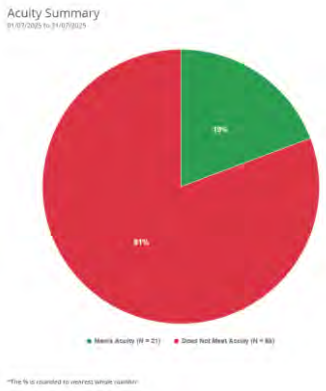
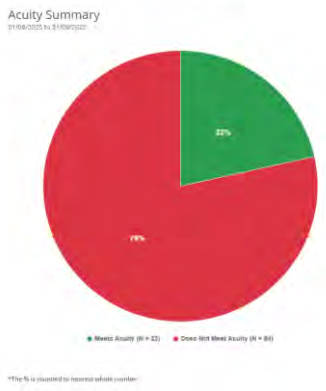
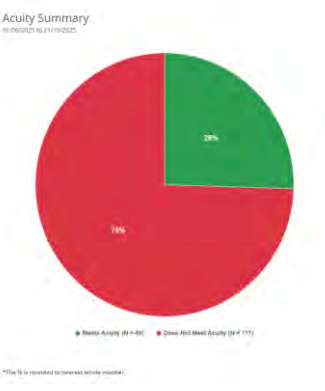
April 2025	May 2025	June 2025
No data available for this period (all W73 areas merged prior to this date)	No data available for this period (all W73 areas merged prior to this date)	 Meets acuity = 67%
July 2025	**August 2025**	**September 2025**
 Meets acuity = 55%	 Meets acuity = 21%	 Meets acuity = 32%

Ward 73 (Induction Suite) – Q1 & 2 – Acuity Summary

April 2025	May 2025	June 2025
No data available for this period (all W73 areas merged prior to this date)	No data available for this period (all W73 areas merged prior to this date)	No data available for this period
July 2025	**August 2025**	**September 2025**
No data available for this period	 Meets acuity = 95%	 Meets acuity = 100%

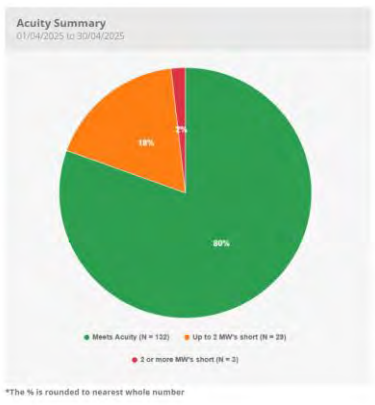
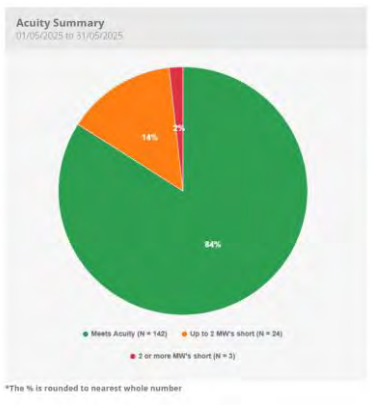
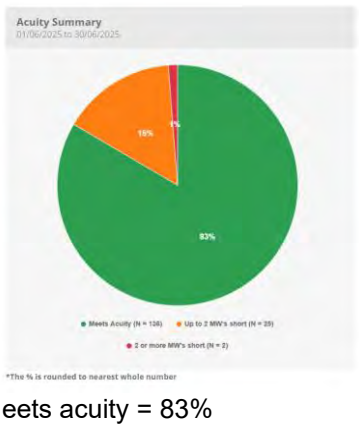
Ward 76 Q1 & 2 – Acuity Summary

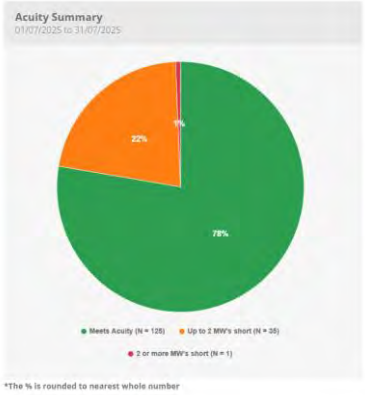
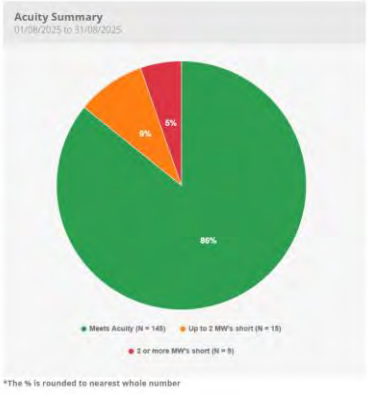
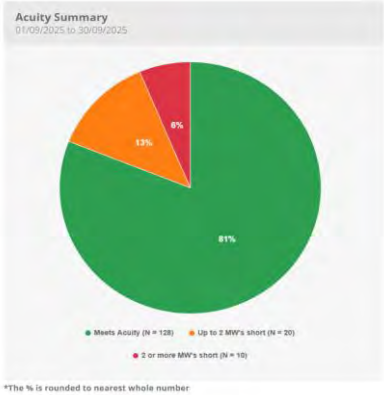
With improved compliance with Birth Rate Plus acuity reporting on ward 76, we were able to assess our staffing needs in relation to the BAPM standards on Ward 76 (see below for more detail). Maternity services have acted on the data and an increase in staffing has been made from one registered midwife (RM) per shift to two RMs (in addition to the NICU nurse and a maternity support worker).

April 2025	May 2025	June 2025
 Meets acuity = 19%	 Meets acuity = 36%	 Meets acuity = 39%
July 2025	**August 2025**	**September 2025**
 Meets acuity = 19%	 Meets acuity = 22%	 Meets acuity = 25%

Ward 77 (CDS) Q1 & 2 – Acuity Summary

CDS data compliance for April-September 2025 is provided below. Since November 2025 there has been a huge improvement in data inputting compliance, increasing from an average of 50-60% per month to the current 86.56% - 91.11% over the last year. There have been a few changes to enable this improvement, ranging from education, reminders and communication.

April 2025	May 2025	June 2025
 Meets acuity = 80%	 Meets acuity = 84%	 Meets acuity = 83%

July 2025	August 2025	September 2025
		
Meets acuity = 78%	Meets acuity = 86%	Meets acuity = 81%

Data Input Compliance

Improvements with data input compliance are needed on ward 73 (antenatal and postnatal care). With improved compliance on ward 76, we were able to assess our staffing needs in relation to the BAPM standards. As this is a transitional care ward, the BAPM standards could apply but the acuity is variable. Although it is unlikely ward 76 will always require BAPM level staffing, the acuity is generally more intense and improved compliance with BR+ has demonstrated this. Maternity services have acted on the data made available from improved compliance with reporting and an increase in staffing has been made from one registered midwife (RMW) per shift to two RMWs (in addition to the NICU nurse and a maternity support worker). This reflects the intensity of the work which often involves varying for a high proportion of families who are subject to child protection proceedings and experiencing other social complexities as well as higher needs around physical care for the infant.

Individual compliance data for Oak, Willow and the Induction of Labour Suite are not available prior to June 2025 as these areas were merged in one reporting area prior to this. As the single, merged area no longer exists on Birth rate Plus it is not possible to retrieve any of this data.

Ward		April	May	June	July	August	September
CDS		91.11%	90.86%	90.56%	86.56%	90.86%	87.78%
73	Oak	X	X	74.17%	68.55%	59.68%	61.67%
	Willow	X	X	79.17%	70.26%	57.26%	49.17%
IOL Suite		X	X	X	X	53.23%	54.17%
76		35.00%	42.74%	87.10%	80.83%	86.29%	74.17%

Data Input Compliance Action Plan Ward 73

The input completion rate for the Birth rate Plus (BR+) acuity tool on Ward 73 is poor, therefore, staffing compliance data cannot be considered to be accurate.

Understanding the problem

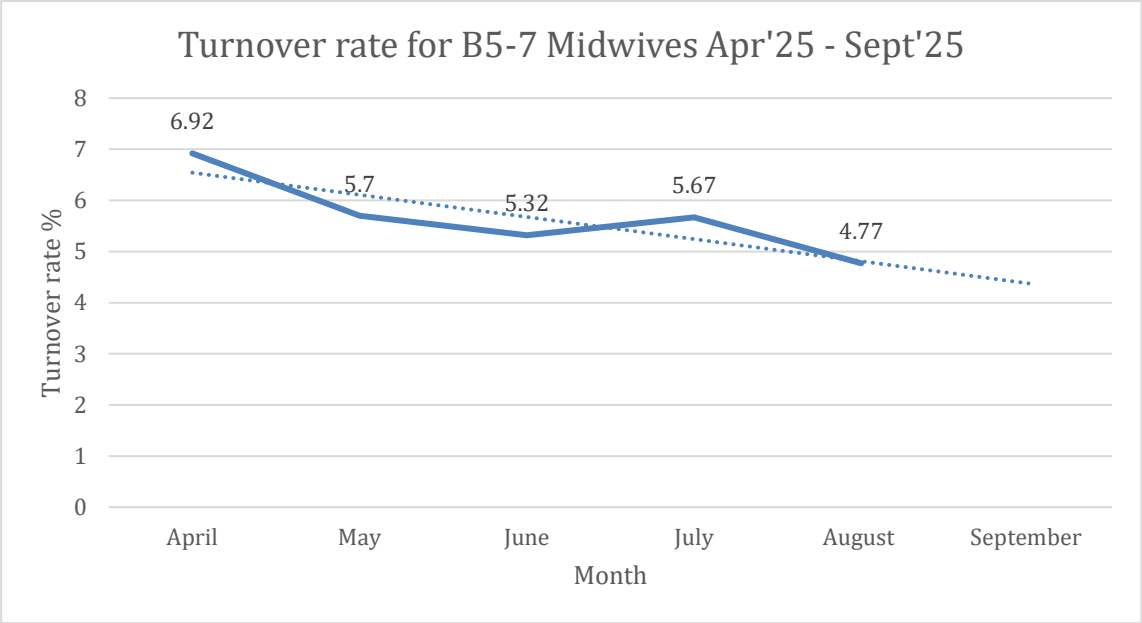
To improve the accuracy of care-needs reporting, changes have been made to enable the midwives caring for the patients to input the data, however, some data collection windows conflicted with a period of high clinical activity for the midwives delivering clinical care.

Several Improvements and mitigations have been devised in order to improve the accuracy of care needs reporting and ensure compliance 7 days a week.

Recruitment

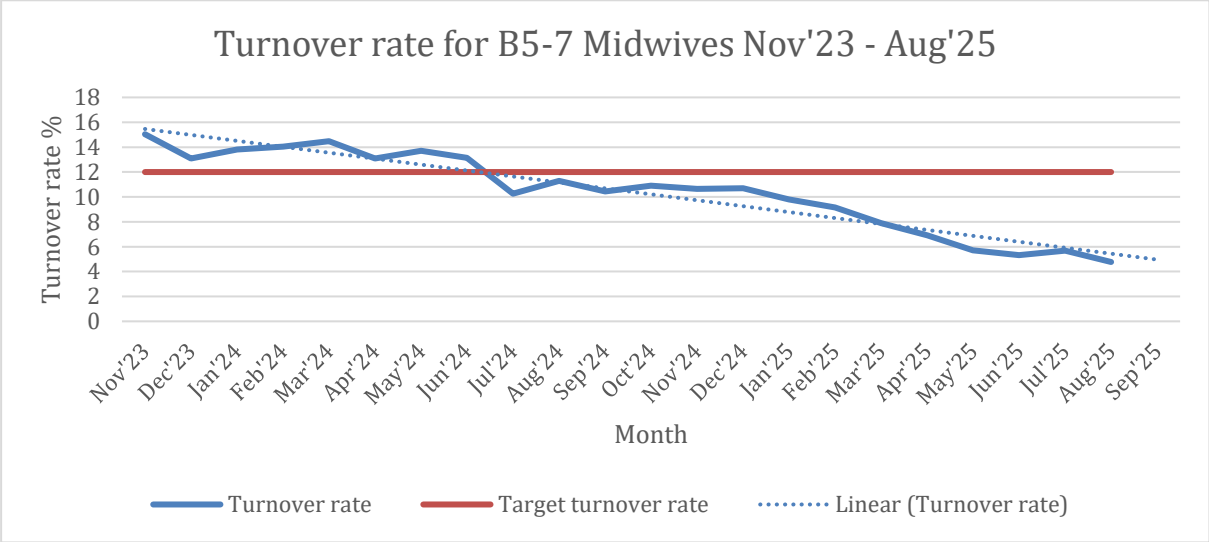
There has been a successful level of recruitment into Midwifery services over the past six months. There was an intake of Newly Qualified Midwives who started in April 2025 and another intake that is predicted to be in post by the end of November 2025.

Last 6 months



The department now has a substantive recruitment and retention midwife in post, who works alongside the Divisional recruitment and retention lead. This role actively ensures exit interviews are encouraged and leads on the wellbeing initiatives for staff.

The graph below demonstrates the impact of this role on the turnover rate for B5-7 Midwives since the retention and recruitment midwife came into post (November 2023 to August 2025).



In March 2025 we recruited band 7 and band 6 Nurses to our neonatal service. All but one were internal promotions into bands 6, 7 and 8a have commenced since the last reporting period, with 1.85 WTE vacancies at band 5.

Maternity leave (6.52 WTE), long-term sickness and short-term sickness across lines band 5 to band 7 remain uncovered and have required temporary staff to fill, as substantive recruitment has been unsuccessful.

The current percentage of nursing staff who are QiS trained is 58%, with the BAPM recommendation of 89.5%.

NICU can support ten nurses per year to undertake the QiS training. Three nurses commenced the QiS training course in September 2025 but one withdrew leaving two nurses on the autumn cohort. A further four are due to commence on 3rd December for the second cohort totalling six out of a possible ten places taken up, with further work underway to increase the uptake of the QiS training course.

In order to support NICU and enable staff development, consideration is currently being given to ways in which newly qualified midwives could be offered a NICU rotation as part of their preceptorship package.

Staffing and CQC.

The Maternity service was inspected in December 2023 by Care Quality Commission and was rated as 'Good' overall, with one requirement and one recommendation made for Safe Staffing.

CQC Requirement	Regulation	Findings	Action
That 'red flag' midwifery staffing incidents are monitored effectively, including delays to induction of labour, in line with national guidance.	Regulation 18 (1)	The service did not effectively monitor maternity 'red flag' staffing incidents in line with NICE guideline 4 'Safe midwifery staffing for maternity settings'... Managers did not monitor and compare maternity red flag incidents in the six nursing and midwifery staffing reports to trust board in line with national guidelines	1) Ensure all managers monitor and compare maternity red flags. 2) Report on Midwifery red flags in the Monthly safe staffing report highlighting any action.

Red flags including delayed inductions are monitored through the PQSM (Perinatal Quality and Safety Maternity Matrix) and daily flow meetings. Red flags as per NICE guidelines were added in July 2023 on the Datix system. Red flags and themes of staffing issues are monitored monthly through the individual area governance groups and at the hospital Women's Governance Group and escalated as necessary to the Divisional Quality Assurance Committee.

Staffing is monitored daily at flow meetings and staff are moved to manage any risks, including use of the on-call midwife. As a result of the CQC visit all staff were reminded to record any staffing-related safety incidents or where mitigations have been required when reporting unsafe staffing-related incidents on Datix including the use of NICE red flags.

Table 3 – Midwifery red flag reporting

Incident type 1 in the table below relates directly to staffing, however incidents 2 and 3 are included as these types of incidents *may* be related to staffing (although may also be attributable to acuity surges).

Only those incidents which are reported via Datix will be represented in the table below and it should be acknowledged that in periods of short staffing / high acuity, Datix reporting may not be prioritised (a human factor).

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
1	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to	0	0	0	0	0	0

	a woman during established labour						
2	Delay of 30 minutes or more between presentation and triage	12.5% 76 attendances	6.7% 40 attendances	4.3% 25 attendances	6.9% 43 attendances	6.2% 36 attendances	4.8% 29 attendances
3	Delayed or cancelled time-critical activity	13	24	15	11	19	24

Red Flag event 2 (table above): April continued the same trajectory as Q4 (March 2025: 12%) however as staffing establishment has settled this has seen an improvement.

		Apr 25	**May 25**	**Jun 25**	**Jul 25**	**Aug 25**	**Sep 25**
1	Births (babies born)	374	386	362	375	332	364
2	Midwives (WTE) (excludes specialist midwives/ maternity leave/ onboarding))	179.64	177.11	176.07	175.63	177.12	175.28
3	Midwife to birth ratio	25.00	26.2	24.7	25.6	22.5	24.9

The recommendation from the CQC for staffing was to ensure there are enough midwifery staff to provide a full range of maternity choices including use of the midwifery-led unit (MLU). The CQC noted that "Midwifery staffing levels impacted on the availability of the midwifery led unit'.

The midwifery led unit is staffed from the eleven midwives assigned to Central Delivery Suite (CDS). Any two midwives could be released to attend the midwifery led unit if a woman requested admission to the facility. Staffing gaps due to sickness and vacancy had impacted on the ability of CDS to support this within a specific shift. The inclusion of a fully operational triage service in CDS will further support this move,

The most recent data has however suggested that we now have a high rate of transfer from MLU back to CDS. The reasons appear multi-faceted but links with this current staffing model have been explored as it offers midwives limited exposure to normal physiological birth, resulting in an inconsistent experience in supporting physiological births, which may translate into a low threshold for transfer back to CDS. The allocation of named MLU Midwives on each CDS shift had made it easier to support the appropriate Midwife to open the MLU. However, a recent increase in transfers back to CDS from MLU triggered a review and resulted in a new staffing approach by utilising the expertise of the Continuity Team Midwives in facilitating physiological birth in low-risk settings.

Continuity of Carer teams

The service has maintained the four continuity-of-carer midwifery teams, mainly present in areas of high deprivation and ethnic diverse population. In addition, funding is now recurrent from the Local Maternity & Neonatal System (LMNS) for enhanced maternity support workers to reach out to vulnerable women and facilitate earlier engagement into the Maternity service.

The Triennial Summer 2025 Birthrate Plus Assessment

The Birth Rate Plus workforce assessment tool was completed in July 2025 and demonstrated that for clinical, specialist and management WTE there was a gap of 3.13 WTE mainly for specialist midwife roles.

The report did not consider the staffing for the new Acute Obstetric Triage Unit (AOTU) however triangulating data from the CDS BirthRate Plus daily audit tool, patient activity data and the published guidelines for this service 14.52 WTE Band 6 midwives were required. This fully adopts the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), a twenty-four-hour triage system developed to improve the safety and management of pregnant women, recommended by the Royal College and Obstetricians and Gynaecologists (RCOG)

and the Care Quality Commission (CQC).

the increase in specialist midwives would be used to expand the perinatal mental health and substance misuse specialist midwifery service, as highlighted after a detailed gap analysis.

3. Assurance statement and summary.

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards guidance (2018). The SNCT cycles completed over the past 12 months support the nursing establishment setting process using a recognised evidence-based approach. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short- and long-term staffing shortfalls.

The conclusion is that professional judgement indicates that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities, whilst also supporting development for both the registered and non-registered Nursing and Midwifery workforce.

The last six months have seen significant improvement with continued recruitment and retention of registered nurses providing an over establishment in many adult areas that are now reporting and recruited to turnover position.

Safe staffing in specific areas where vacancies remain has been supported with nurse bank incentives which have ensured safety and enabled a sustained reduction of off-framework agency use. The significant improvement in the vacancies and effects of the retention programmes has ensured that the Trust is well prepared for increases in staffing demand.

Pressure on the front door service has continued over this six-month period, requiring the regular opening of extra capacity areas and supporting the ED queues in both adult ED departments. With the over-establishment, these areas are now being staffed by a combination of substantive staff and temporary bank staff.

In October 2025, two wards were closed due to environmental issues and the adult bed base has been reconfigured using some escalation beds as an interim. The staffing resources released will enable escalation areas to be safely staffed and support some of the staffing recommendations set out below.

4. Recommendations for Trust Board

The Group Trust Board is able to gain Safe Staffing assurance from the detailed monthly monitoring and reporting to the Quality and Outcomes committee, which provides fill rates by wards, red flag reporting and detailed analysis and review of all the safe staffing incidents reported, along with triangulation of impact on patient quality outcomes and staff experience.

The Board is asked to note the following:

- The Trust has undertaken the six-monthly floor to board safe staffing review using the Safer Nursing Care Tool (SNCT) assessments to underpin nursing establishments on all adults and children's in-patient wards and ED's, acknowledging this is a process that will evolve over time after each assessment. The Birthrate Plus review has also been completed in October 2025. Recommended uplifts of staffing have been subject to scrutiny and support via the annual staffing review process prior to submission to the operational planning round.

- The fourth audit using the new adult SNCT tool was undertaken in July 2025 to provide the 'whole year' (July 2024, November 2024, February 2025 and July 2025) picture from which the optimised nursing numbers can be compared. The overall average of all

the audits has been shared with the divisions and triangulated using professional judgement and patient outcomes to provide a ‘Business as Usual’ comparator.

- This has been reviewed against the funded budgets available, worked hours during the audit period and the suggested SNCT staffing levels. Over the four audits there has been a shift to scoring patients that closer reflect the acuity of patients leading to improved engagement with the process. Areas of note will be reviewed again in the 2026 annual staffing reviews looking across the whole 12-month period.(see Fig 1)

The following are supported through the Annual Safe Staffing review, to progress to the Operational planning round. There will be a detailed review of the staffing resources released from the closure of the two wards, in order to support some of these recommended increases.

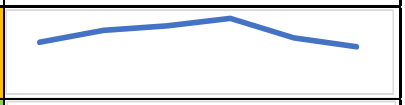
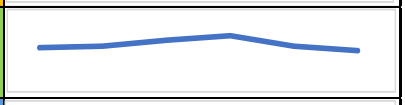
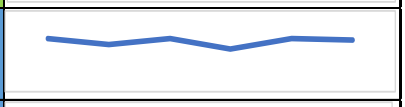
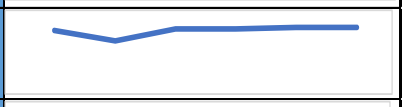
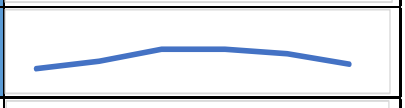
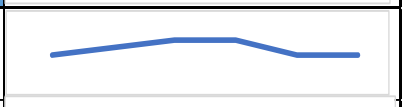
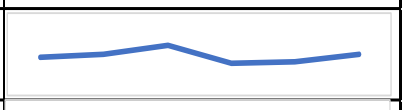
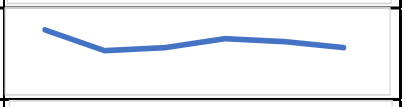
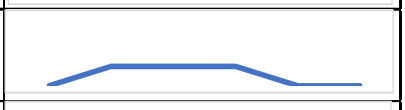
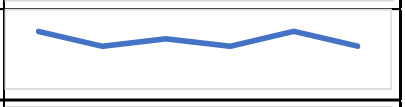
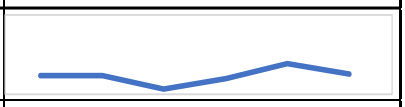
- **Sandford Ward by 1 RN per shift (5.3 WTE)** to provide a shift coordinator to ensure there is robust management to improve safety and optimise patient flow throughout the 24-hour period. This mirrors the approach used in Bristol that has supported improved patient flow. There has also been a continuous negative variance against the SNCT baseline.

- **Berrow Ward by 1 RN per shift (5.3 WTE)** to support the increase in acuity and demand for Non-Invasive Ventilation and a continued negative variance against the SNCT baseline.

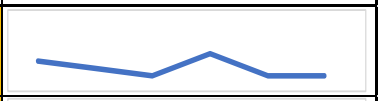
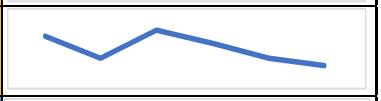
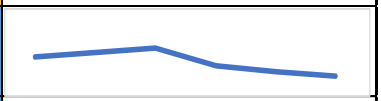
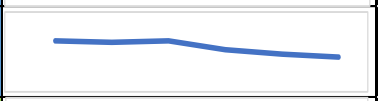
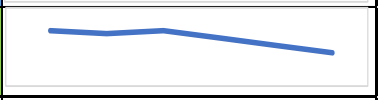
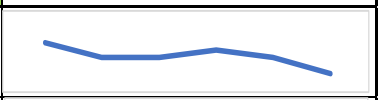
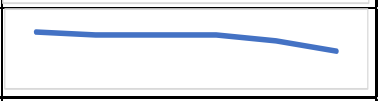
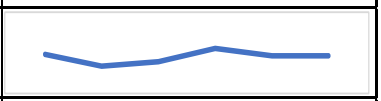
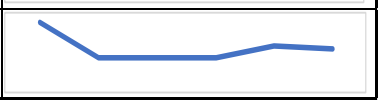
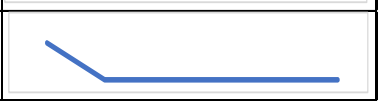
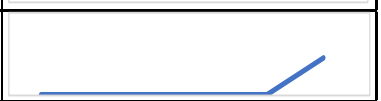
Support the increase in staffing in **specialist midwives**, as recommended by the BirthRate Plus review in July 2025, of an **uplift of 3.13 WTE Band 7 specialist midwives.**

The other investment assessments highlighted as part of the safe staffing reviews will be considered separately and incorporated as part of the Operational planning process.

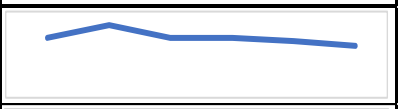
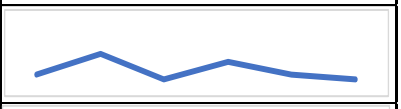
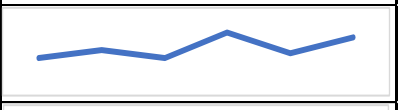
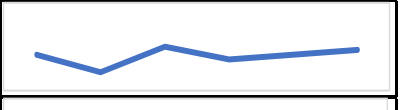
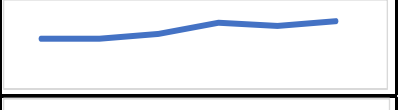
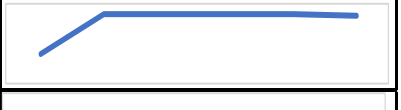
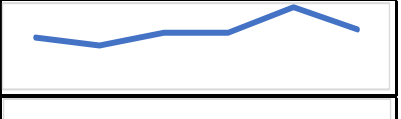
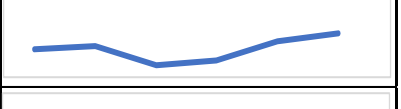
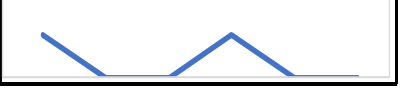
Appendix 1 – Divisional staffing dashboards
Medicine

Division - Medicine Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	92%	95%	96%	98%	93%	91%	
Registered Nurse Fill Rate - Night	100%	101%	104%	106%	101%	98%	
Unregistered Nurse Fill Rate - Day	136%	120%	139%	106%	138%	133%	
Unregistered Nurse Fill Rate - Night	149%	123%	154%	154%	159%	158%	
All Staff Fill Rate - Overall	115%	117%	120%	120%	119%	116%	
Registered Care Hours per Patient Day	5	5.1	5.2	5.2	5	5	
Total Care Hours per Patient Day	10.9	11.2	11.4	11.2	11.3	11.2	
Supervisory Ward Sister %	78%	80%	84%	75%	76%	80%	
Sickness	8.4%	5.7%	6.1%	7.2%	6.8%	6.0%	
Registered Nurse Band 5 % Turnover Rate	6.3%	7.7%	7.7%	7.7%	7.8%	7.6%	
Unregistered Nurse Band 2/3 Turnover Rate	15.2%	12.6%	12.6%	12.6%	12.7%	13.1%	
Registered Nurse Band 5 Vacancy WTE	-44.2	-32.59	-32.59	-32.6	-33.6	-34.6	
Unregistered Nurse Band 2/3 Vacancy WTE	23.8	25.9	25.9	25.9	25.9	25.8	
% Agency staff used to support substantive staff	0%	1%	1%	1%	0%	0%	
% Bank staff used to support substantive staff	22%	20%	21%	20%	22%	20%	
Lower than expected Staffing Incidents	12	12	3	10	20	13	
Red Flag Reported incidents	3	0	0	0	0	0	

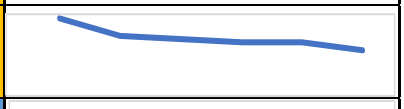
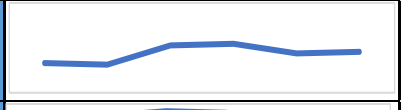
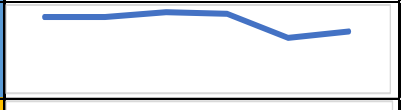
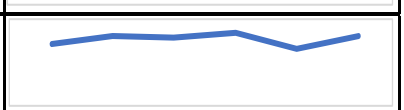
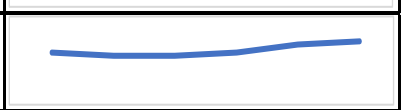
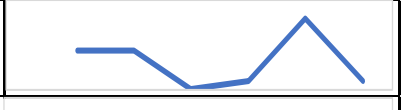
Specialised Services

Division - Specialised Services Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	94%	93%	92%	95%	92%	92%	
Registered Nurse Fill Rate - Night	97%	94%	98%	96%	94%	93%	
Unregistered Nurse Fill Rate - Day	123%	126%	129%	118%	114%	112%	
Unregistered Nurse Fill Rate - Night	158%	156%	158%	145%	138%	135%	
All Staff Fill Rate - Overall	105%	104%	105%	103%	101%	99%	
Registered Care Hours per Patient Day	7.6	7.4	7.4	7.5	7.4	7.2	
Total Care Hours per Patient Day	10.4	10.3	10.3	10.3	10.1	9.8	
Supervisory Ward Sister %	80%	74%	76%	83%	79%	79%	
Sickness	5.2%	5.1%	7.9%	7.3%	7.6%	7.1%	
Registered Nurse Band 5 Turnover Rate	10.3%	7.6%	7.6%	7.6%	7.7%	7.8%	
Unregistered Nurse Band 2/3 Turnover Rate	14.4%	12.0%	12.0%	12.0%	12.8%	12.6%	
Registered Nurse Band 5 Vacancy WTE	9.5	11.5	11.5	11.5	11.6	10.6	
Unregistered Nurse Band 2/3 Vacancy WTE	12.8	1.5	1.5	1.5	1.6	1.6	
% Agency staff used to support substantive staff	0%	0%	0%	0%	0%	1%	
% Bank staff used to support substantive staff	14%	14%	15%	14%	15%	15%	
Lower than expected Staffing Incidents	5	5	5	1	2	3	
Red Flag Reported incidents	2	2	0	0	0	0	

Surgery

Division - Surgery Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	94%	97%	94%	94%	93%	92%	
Registered Nurse Fill Rate - Night	95%	100%	94%	98%	95%	94%	
Unregistered Nurse Fill Rate - Day	109%	111%	109%	115%	110%	114%	
Unregistered Nurse Fill Rate - Night	134%	124%	133%	132%	133%	139%	
All Staff Fill Rate - Overall	102%	104%	101%	104%	102%	102%	
Registered Care Hours per Patient Day	7.8	7.8	7.8	8.6	8.5	7.8	
Total Care Hours per Patient Day	12	11.8	12.2	13.4	13	12.3	
Supervisory Ward Sister %	78%	74%	80%	77%	78%	79%	
Sickness	5.9%	6.0%	6.4%	7.8%	7.4%	7.9%	
Registered Nurse Band 5 Turnover Rate	10.2%	9.4%	9.4%	9.4%	9.1%	8.9%	
Unregistered Nurse Band 2/3 Turnover Rate	9.7%	7.6%	7.6%	7.6%	7.8%	7.6%	
Registered Nurse Band 5 Vacancy WTE	-5.52	-0.4	-0.4	-0.4	-0.7	0.9	
Unregistered Nurse Band 2/3 Vacancy WTE	3.9	8.9	8.9	8.9	8.9	8.8	
% Agency staff used to support substantive staff	0%	1%	0%	0%	0%	0%	
% Bank staff used to support substantive staff	12%	10%	13%	13%	19%	14%	
Lower than expected Staffing Incidents	7	8	3	4	9	11	
Red Flag Reported incidents	1	0	0	1	0	0	

Children's

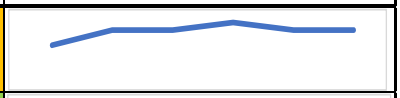
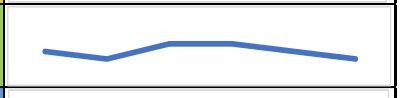
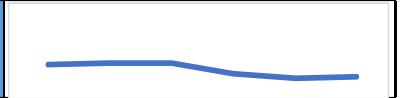
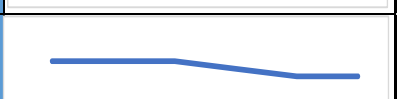
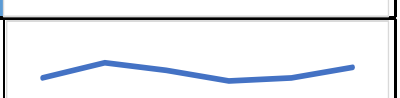
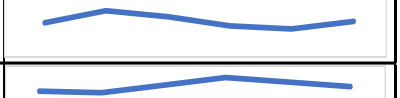
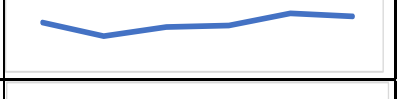
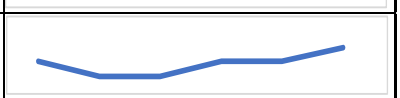
Division - Childrens Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	104%	95%	93%	94%	93%	90%	
Registered Nurse Fill Rate - Night	99%	94%	93%	92%	92%	90%	
Unregistered Nurse Fill Rate - Day	113%	112%	124%	125%	119%	120%	
Unregistered Nurse Fill Rate - Night	115%	115%	117%	116%	105%	108%	
All Staff Fill Rate - Overall	107%	99%	97%	97%	95%	93%	
Registered Care Hours per Patient Day	12.3	12.3	13.1	13.1	14.2	12.8	
Total Care Hours per Patient Day	15	15.1	16.1	15.9	17.5	15.6	
Supervisory Ward Sister %	76%	87%	84%	91%	70%	87%	
Sickness	6.3%	5.8%	5.8%	6.3%	7.3%	7.6%	
Registered Nurse Band 5 Turnover Rate *	8.4%	6.9%	6.9%	6.9%	7.0%	8.2%	
Unregistered Nurse Band 2/3 Turnover Rate *	16.2%	17.9%	17.9%	17.9%	17.6%	17.4%	
Registered Nurse Band 5 Vacancy WTE *	-22.3	-32.1	-32.1	-32.1	-33.1	-35.0	
Unregistered Nurse Band 2/3 Vacancy WTE *	-6.3	-14.5	-14.5	-14.5	-15.5	16.3	
% Agency staff used to support substantive staff	0%	0%	0%	0%	1%	2%	
% Bank staff used to support substantive staff	6%	6%	6%	7%	7%	9%	
Lower than expected Staffing Incidents	5	5	0	1	9	1	
Red Flag Reported incidents	0	0	0	0	0	0	

Women's Overall

Division - Womens in Patient Wards Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	101%	105%	105%	94%	105%	102%	
Registered Nurse Fill Rate - Night	98%	96%	110%	90%	82%	100%	
Unregistered Nurse Fill Rate - Day	99%	107%	100%	90%	87%	93%	
Unregistered Nurse Fill Rate - Night	99%	105%	122%	101%	99%	104%	
All Staff Fill Rate - Overall	100%	101%	104%	93%	92%	99%	
Registered Care Hours per Patient Day	9.9	10.2	10.7	9.9	10.2	9.6	
Total Care Hours per Patient Day	12.5	12.6	13.3	12.3	13	12.3	
Supervisory Ward Sister %	100%	100%	100%	100%	100%	100%	
Sickness	3.8%	3.6%	4.6%	4.2%	4.9%	4.6%	
Registered Midwife Band 6 Turnover Rate	9.0%	7.8%	6.9%	7.2%	6.7%	6.2%	
Registered Nurse Band 5 Turnover Rate	5.8%	4.5%	4.8%	5.6%	10.2%	10.3%	
Unregistered Midwife/Nurse Band 2/3 Turnover Rate	19.2%	19.1%	18.1%	16.9%	17.4%	17.7%	
Registered RM and RN Band 6 Vacancy WTE *	19.9	24.6	23.4	21.5	20.5	16.21	
Registered Nurse Band 5 Vacancy WTE	-20.7	-19.9	-16.9	-20.6	-16.1	-8.7	
Unregistered Midwife/Nurse Band 2/3 Vacancy WTE	1.3	-0.5	3.1	1.3	2.0	2.9	
% Agency staff used to support substantive staff	1%	1%	0%	0%	1%	1%	
% Bank staff used to support substantive staff	6%	6%	6%	7%	7%	8%	
Lower than expected nurse staffing incidents	2	2	2	5	3	8	
Nursing red flag reported incidents	0	1	0	2	2	1	
Lower than expected midwifery staffing incidents recorded on Datix	2	3	1	1	3	3	
Midwifery red flag reported incidents recorded on Datix	0	0	0	0	1	0	

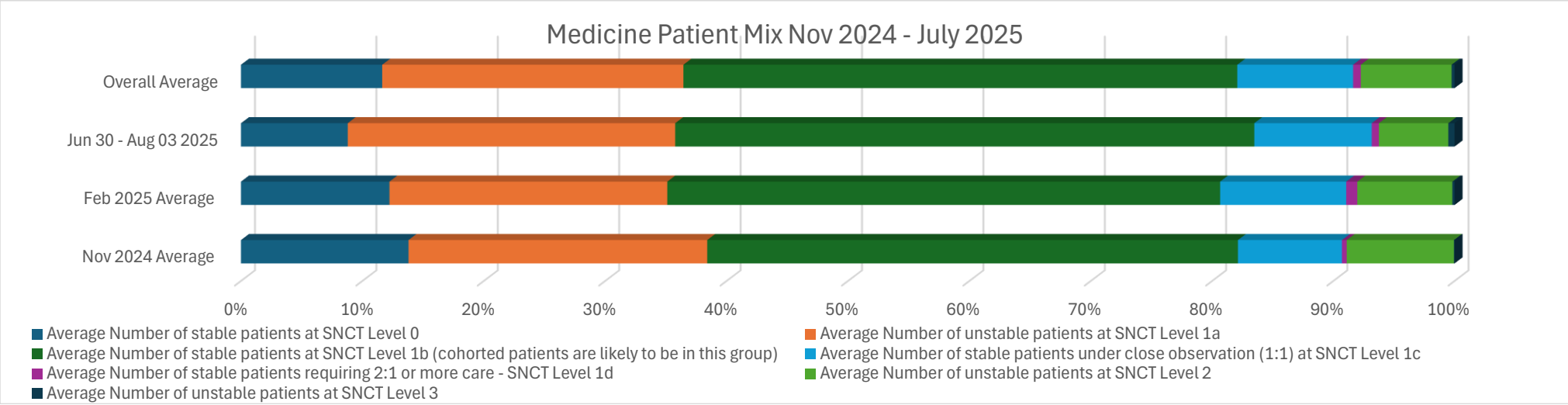
* Band 6 Vacancy Level includes all womens services

Weston

Division - Weston Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
Registered Nurse Fill Rate - Day	91%	93%	93%	94%	93%	93%	
Registered Nurse Fill Rate - Night	99%	98%	100%	100%	99%	98%	
Unregistered Nurse Fill Rate - Day	122%	123%	123%	116%	112%	113%	
Unregistered Nurse Fill Rate - Night	141%	135%	136%	134%	132%	129%	
All Staff Fill Rate - Overall	111%	111%	111%	109%	107%	107%	
Registered Care Hours per Patient Day	5.8	6.4	6.1	5.7	5.8	6.2	
Total Care Hours per Patient Day	9.9	10.7	10.3	9.7	9.6	10	
Supervisory Ward Sister %	73%	71%	80%	89%	83%	78%	
Sickness	6.2%	4.5%	5.6%	5.8%	7.6%	7.2%	
Registered Nurse Band 5 Turnover Rate	11.0%	7.1%	7.1%	7.1%	7.1%	7.5%	
Unregistered Nurse Band 2/3 Turnover Rate	10.7%	8.0%	8.0%	8.0%	8.0%	8.9%	
Registered Nurse Band 5 Vacancy WTE	1.7	7.6	7.6	7.6	7.6	7.6	
Unregistered Nurse Band 2/3 Vacancy WTE	-2.7	-4.5	-4.5	-4.5	-4.5	-4.7	
% Agency staff used to support substantive staff	1%	1%	1%	1%	1%	2%	
% Bank staff used to support substantive staff	17%	16%	16%	17%	17%	18%	
Lower than expected Staffing Incidents	14	14	3	9	25	17	
Red Flag Reported incidents	2	1	0	4	4	1	

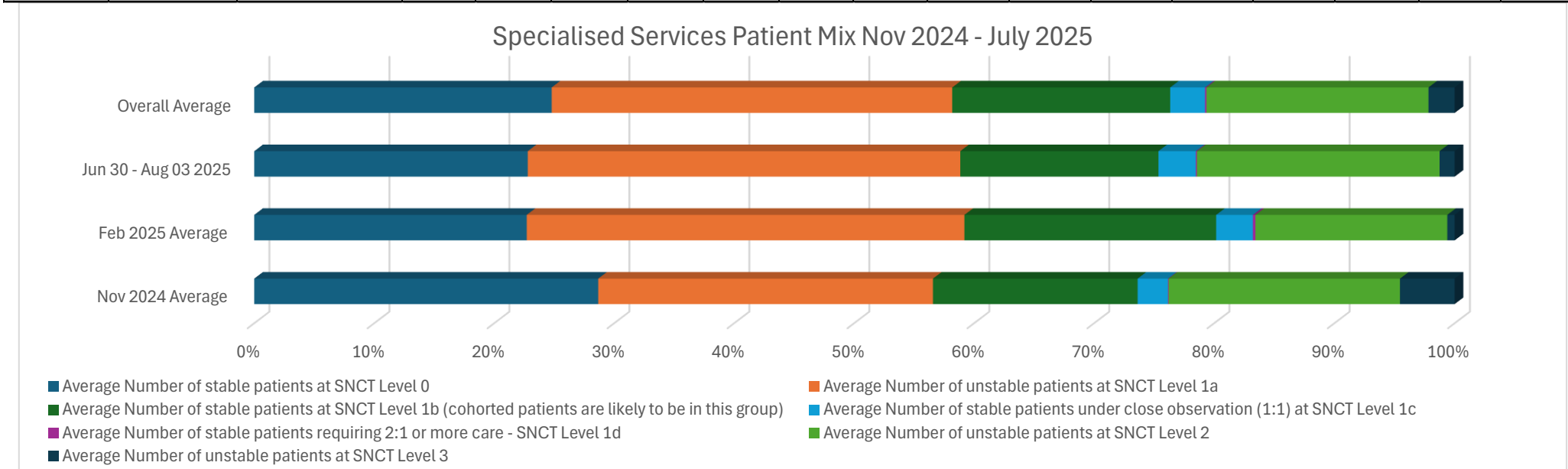
Appendix 2 Division Skill Mix and Patient Mix Summaries. Medicine

Division	Cost centre	SNCT Tool profile	Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night,	Average Nov 24 - Jul 25 SNCT without 1c and 1d staffing	Staffing required to cover 1:1 care or 2:1 + care (1c and 1d patients) Covered internally or by using bank	Average Nov 24 - Jul 25 SNCT minimum registered	Average Nov 24 - Jul 25 SNCT minimum un-registered.
Medicine	A400 AMU	Acute Assessment	66.34	40.63	25.71	61.2%	38.8%	32	9.5	8	4.0	8	4.0	56.5	12.5	34.6	21.9
	A515 OPAU	Acute Assessment	46.77	25.28	21.49	54.1%	45.9%	24	8.3	5	4.9	5	4.9	45.2	9.2	24.4	20.8
	A518 Medical Short Stay	Acute In Patient	23.37	12.13	11.24	51.9%	48.1%	15	6.6	2	7.4	2	7.4	24.3	8.1	12.6	11.7
	A522 Care of the Elderly NCTR	Acute In Patient	37.67	16.99	20.68	45.1%	54.9%	26	6.7	4	6.4	3	8.6	36.5	17.8	16.4	20.0
	A524 Care of the Elderly	Acute In Patient	35.72	15.23	20.49	42.6%	57.4%	22	7.3	3	7.3	3	7.3	36.8	11.2	15.7	21.1
	A525 Respiratory	Acute In Patient	38.68	22.01	16.67	56.9%	43.1%	23	7.6	5	4.6	4	5.8	28.6	11.1	16.3	12.3
	A528 Care of the Elderly	Acute In Patient	38.85	17.76	21.09	45.7%	54.3%	21	8.2	4	5.2	3	7.0	28.1	12.5	12.8	15.2
	A605- Care of the Elderly	Acute In Patient	31.91	15.24	16.67	47.8%	52.2%	18	7.7	3	6.0	3	6.0	23.9	11.0	11.4	12.5
	A801 General Respiratory and CF	Acute In Patient	31.30	15.23	16.07	48.7%	51.3%	18	8.0	3	6.0	3	6.0	27.2	6.6	13.2	13.9
	A900 Gastrology	Acute In Patient	48.82	27.73	21.09	56.8%	43.2%	25	8.6	6	4.2	5	5.1	42.1	8.0	23.9	18.2
	C808 Respiratory High Care	Acute In Patient	64.11	42.39	21.72	66.1%	33.9%	25	13.6	8	3.2	8	3.2	45.1	5.8	29.8	15.3



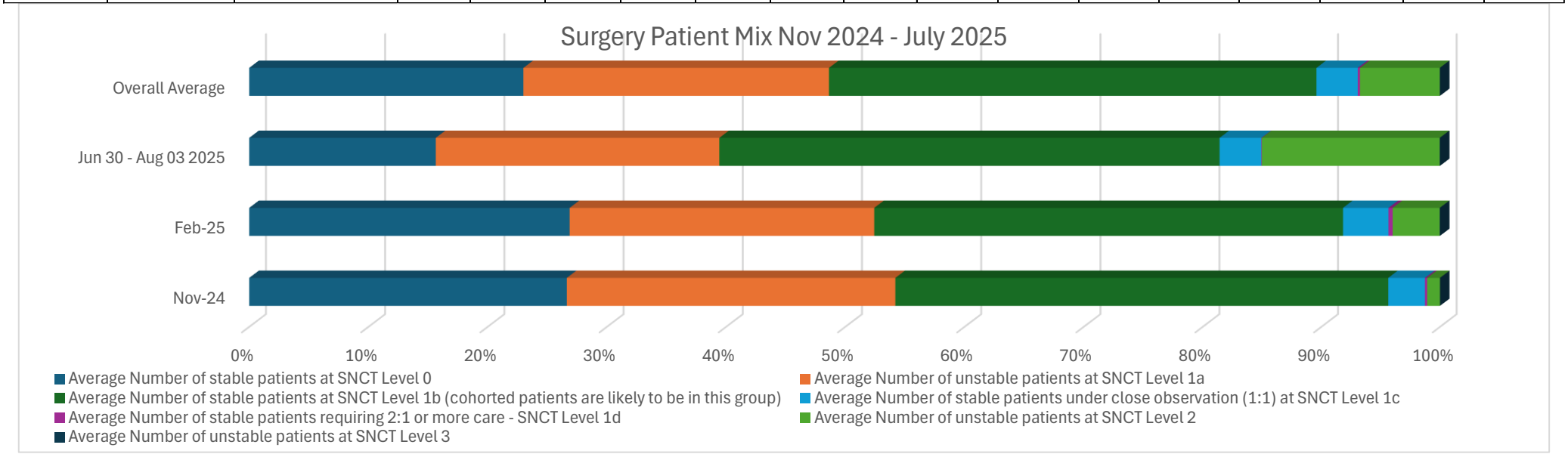
Specialised Services

Division	Cost centre	SNCT Tool profile	Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night	Average Nov 24 - Jul 25 SNCT without 1c and 1d staffing	Staffing required to cover 1:1 care or 2:1 + care (1c and 1d patients) Covered internally or by using bank	Average Nov 24 - Jul 25 SNCT minimium registered	Average Nov 24 - Jul 25 SNCT minimium un-registered
Specialised Services	CCU Coronary Care Unit	Acute Assessment	29.09	23.82	5.27	81.9%	18.1%	11.0	11.5	5.0	2.2	4.0	2.7	31.2	0.4	25.6	5.7
	C705 Cardiology	Acute In Patient	40.21	24.08	16.13	59.9%	40.1%	33.4	5.8	5.0	6.7	4.0	8.4	38.7	7.0	23.2	15.5
	C708 Cardiac Surgery	Acute In Patient	33.17	18.80	14.37	56.7%	43.3%	25.7	5.8	4.0	6.4	3.0	8.6	37.3	2.4	21.1	16.2
	C805 Cardiology	Acute In Patient	40.16	24.05	16.11	59.9%	40.1%	32.9	5.8	5.0	6.6	4.0	8.2	41.0	5.4	24.6	16.5
	D601 Teenage and Young people Cancer Care	Acute In Patient	15.08	9.77	5.31	64.8%	35.2%	6.0	11.5	2.0	3.0	2.0	3.0	10.0	0.1	6.5	3.5
	D603 Oncloogy	Acute Assessment (60%) Adult inpatient (40%)	47.83	34.50	13.33	72.1%	27.9%	23.3	7.0	6.0	3.9	5.0	4.7	49.5	5.3	35.7	13.8
	D703 Haematology	Acute In Patient	52.66	39.33	13.33	74.7%	25.3%	24.2	10.1	8.0	3.0	8.0	3.0	54.0	0.4	40.3	13.7



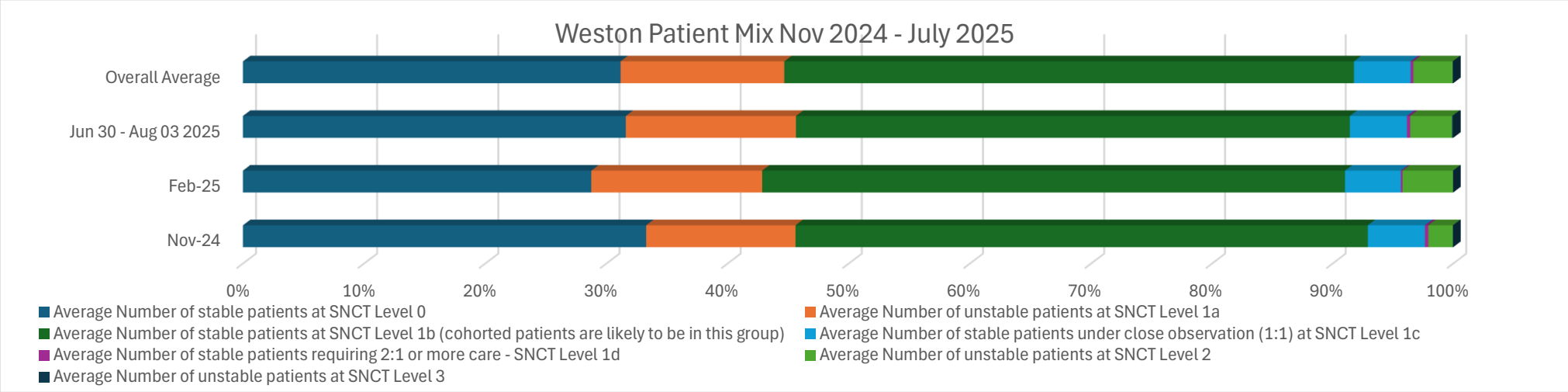
Surgery

Division	Cost centre	SNCT Tool profile	Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night,	Average Nov 24 - Jul 25 SNCT without 1c and 1d staffing	Staffing required to cover 1:1 care or 2:1 + care (1c and 1d patients) Covered internally or by using bank	Average Nov 24 - Jul 25 SNCT minimium registered	Average Nov 24 - Jul 25 SNCT minimium un-registered.
Surgery	A413 Escalation Ward	Acute In Patient	20.5	10.36	10.14	50.54%	49.46%	12.2	5.4	2.5	4.9	3.0	4.1	13.5	0.7	6.8	6.7
	A602 Trauma and Orthopaedic	Acute In Patient	26.24	14.53	11.71	55.37%	44.63%	17.3	6.0	3.0	5.8	2.0	8.7	30.5	4.8	16.9	13.6
	A604 Trauma and Orthopaedic	Acute In Patient	35.05	19.13	15.92	54.58%	45.42%	21.7	7.1	4.0	5.4	3.0	7.2	36.8	4.3	20.1	16.7
	A609 Surgery and Trauma Assessment Unit	Acute Assessment	39.16	23.57	15.59	60.19%	39.81%	22.6	6.6	4.0	5.7	4.0	5.7	37.8	2.2	22.7	15.0
	A700 Thoracic, Max Fax and ENT	Acute In Patient	39.77	22.98	16.79	57.78%	42.22%	25.8	6.7	5.0	5.2	4.0	6.5	40.4	2.8	23.3	17.0
	A701Thoracic, Max Fax and ENT	Acute In Patient	34.14	18.55	15.59	54.34%	45.66%	19.7	8.1	4.0	4.9	3.0	6.6	26.7	6.0	14.5	12.2
	A800 Colorectal Surgery	Acute In Patient	45.36	24.19	21.17	53.33%	46.67%	25.6	8.2	5.0	5.1	4.0	6.4	39.3	2.5	21.0	18.3
	H304 Opthamology	Acute In Patient	25.28	17.4	7.88	68.83%	31.17%	15.0	7.2	4.0	3.8	2.0	7.5	N/a	N/a	N/a	N/a



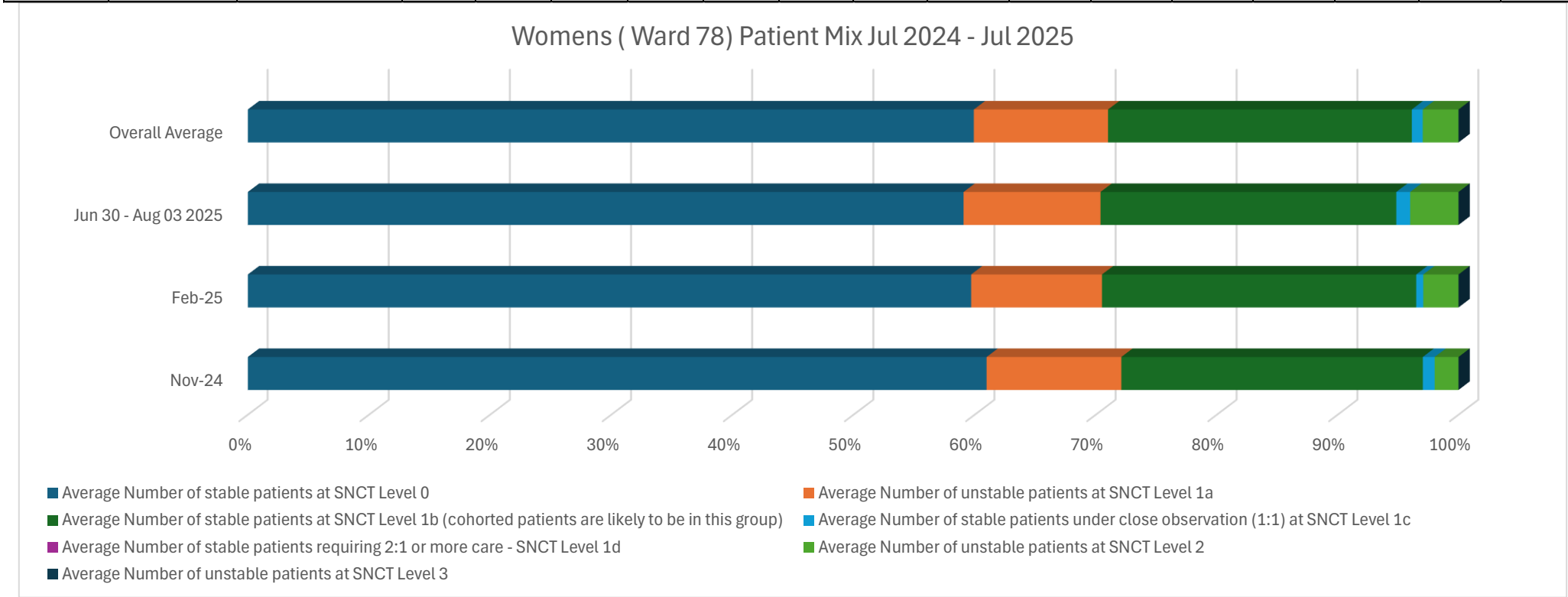
Weston

Division	Cost centre	SNCT Tool profile	Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night,	Average Nov 24 - Jul 25 SNCT without 1c and 1d staffing	Staffing required to cover 1:1 care or 2:1 + care (1c and 1d patients) Covered internally or by using bank	Average Nov 24 - Jul 25 SNCT minimium registered	Average Nov 24 - Jul 25 SNCT minimium un-registered.
Weston	Berrow Respiratory	Acute In Patient	37.13	19.55	17.58	52.7%	47.3%	27.1	7.4	5	5.4	4	6.8	36.1	7.0	19.0	17.1
	Cheddar General Medicine	Acute In Patient	37.33	18.95	18.38	50.8%	49.2%	24.9	6.2	4	6.2	3	8.3	36.6	4.2	18.6	18.0
	Draycott Medical Short Stay	Acute In Patient	35.33	17.75	17.58	50.2%	49.8%	26.2	6.7	4	6.6	3	8.7	36.9	4.2	18.5	18.4
	Harptree Cardiology	Acute In Patient	35.73	17.75	17.98	49.7%	50.3%	27.0	6.4	4	6.8	3	9.0	37.6	4.5	18.7	18.9
	Hutton Surgery	Acute In Patient	36.53	18.95	17.58	51.9%	48.1%	26.4	6.0	4	6.6	3	8.8	41.9	5.9	21.7	20.2
	Kewstoke Care of the Elderly	Acute In Patient	35.93	18.35	17.58	51.1%	48.9%	27.4	6.2	4	6.9	3	9.1	38.4	9.6	19.6	18.8
	Knightstone Orthopaedics	Single Side room	15.83	10.81	5.02	68.3%	31.7%	10.7	5.8	2	5.4	2	5.4	17.1	0.1	11.6	5.4
	OPAU	Acute Assessment	25.67	15.23	10.44	59.3%	40.7%	14.0	8.2	3	4.7	3	4.7	26.0	4.7	15.4	10.6
	Sandford AMU	Acute Assessment	44.07	26.49	17.58	60.1%	39.9%	28.1	9.0	6	4.7	5	5.6	48.9	9.8	29.4	19.5
	Steepholm Surgery	Acute In Patient	35.73	17.75	17.98	49.7%	50.3%	21.7	7.3	4	5.4	3	7.2	33.7	3.6	16.7	17.0
	Uphill ward Stroke Unit	Acute In Patient	35.93	18.35	17.58	51.1%	48.9%	23.6	7.3	4	5.9	3	7.9	40.4	3.9	20.6	19.8
	Waterside Surgery	Single Side room	20.36	10.14	10.22	49.8%	50.2%	13.1	3.7	2	6.5	2	6.5	26.1	3.9	13.0	13.1



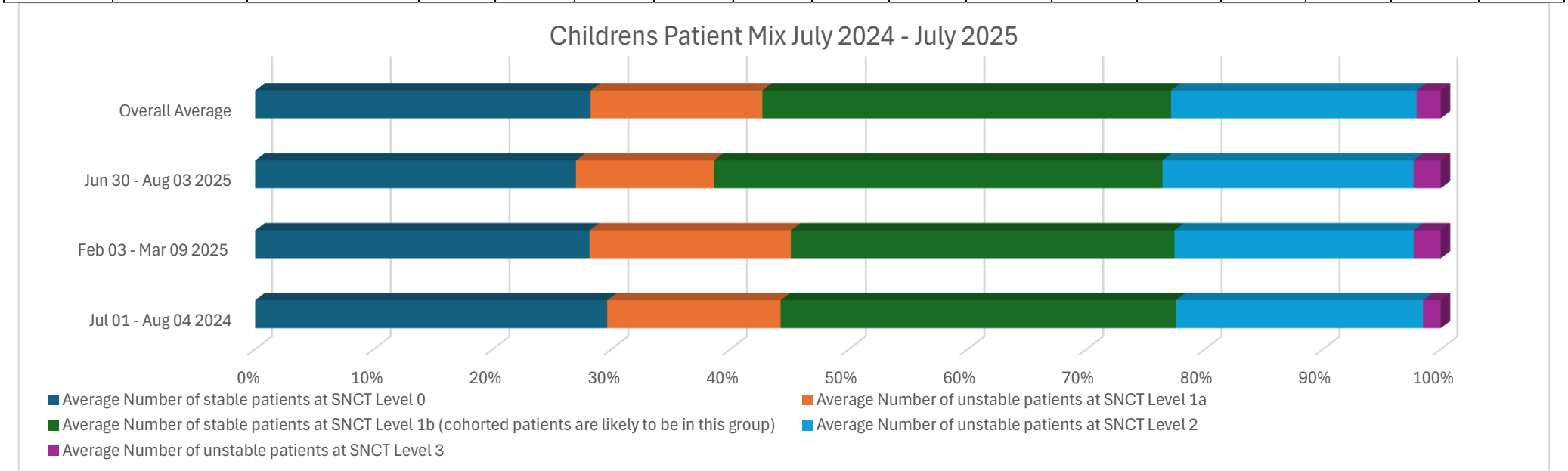
Women's

Division	Cost centre	SNCT Tool profile	Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night,	Average Nov 24 - Jul 25 SNCT without 1c and 1d staffing	Staffing required to cover 1:1 care or 2:1 + care (1c and 1d patients) Covered internally or by using bank	Average Nov 24 - Jul 25 SNCT minimium registered	Average Nov 24 - Jul 25 SNCT minimium un-registered.
Women	Ward 78 Gynaecology	Assement Ward 50% and In patient Ward 50%	28.73	17.69	11.04	61.6%	38.4%	18	5.5	3	5.9	2	8.9	29.7	0.8	18.3	11.4



Childrens – note the SNCT Childrens tool only has 5 levels at present compared to 7 levels in the adult tool.

Division	Ward		Total Funded (SV Sister not included)	Funded registered	Funded un-registered	Funded registered skill mix,	Funded un-registered skill mix	Averaged Actual Beds	Total Funded CHpPD,	Registered Demand Day	Registered to Patient Ratio - Day. 1:	Registered Demand Night	Registered to Patient Ratio - Night,	Average Nov 24 - Jul 25 SNCT Minimium Staffing	Average Nov 24 - Jul 25 SNCT minimium unregistered	Average Nov 24 - Jul 25 SNCT minimium unregistered.
Childrens	E406 Lighthouse Renal	Acute In Patient CYP	22.32	20.18	2.14	90.4%	9.6%	8	10.9	3	2.5	3	2.5	17.7	16.0	1.7
	E500 Bluebell/ Sunflower Neurosciences	Acute In Patient CYP	41.19	31.23	9.96	75.8%	24.2%	17	9.4	6	2.8	6	2.8	41.9	31.8	10.1
	E510 Caterpillar Medical Assessment and HDU	Acute In Patient CYP	80.12	73.39	6.73	91.6%	8.4%	26	9.3	12	2.2	12	2.2	68.8	63.0	5.8
	E512 Daisy Burns and Plastics and HDU	Acute In Patient CYP	29.73	26.87	2.86	90.4%	9.6%	9	13.8	5	1.8	5	1.8	25.2	22.8	2.4
	E600 Dolphin Cardiology and HDU	Acute In Patient CYP	33.2	27.07	6.13	81.5%	18.5%	15	10.8	7	2.1	6	2.5	35.9	29.3	6.6
	E602 Penguin Surgery	Acute In Patient CYP	36.93	31.14	5.79	84.3%	15.7%	17	7.3	7	2.5	5	3.5	41.6	35.1	6.5
	E700 Starlight Oncology	Acute In Patient CYP	41.99	36.86	5.13	87.8%	12.2%	15	11.3	8	1.9	6	2.5	36.9	32.4	4.5
	E702 Apollo Ward 35 Adolescent Ward	Acute In Patient CYP	30.7	25.56	5.14	83.3%	16.7%	13	12.3	5	2.6	4	3.3	31.6	26.3	5.3



Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Group Scheme of Delegation		
Report Author:	Mark Pender, Head of Corporate Governance		
Report Sponsor:	Neil Kemsley, Group Chief Finance and Estates Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	To ratify amendments to the Approval of Business Cases section of the Group Scheme of Delegation to correct drafting errors in the version approved by Board in September 2025.		

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

The Group Scheme of Delegation (SoD) was approved by the Board at its meeting on 9 September 2025. It subsequently came to light that there was a drafting error in the 'Approval of Business Cases' section of the SoD. This related to the approval of capital business cases with a value of £10m to <£25m and also capital digital business cases. The required amendments were as follows:

- Remove the requirement to gain Council of Governors support for business cases with a value of £10m to <£25m. The intention was that this should only be required for business cases above £25m which also require NHSE and His Majesty's Treasury (HMT) approval.
- Delete the paragraph relating to digital business cases with a value below £25m (or below £30m whole life cost). This would require ALL such business cases to get Board approval and Council of Governor support, irrespective of their value. Instead, the existing provisions of the SoD should apply to such business cases.
- Update the table in Appendix 3 of the SoD to reflect the above changes.

The relevant updated sections of the SoD are attached as Appendix 1.

These changes required urgent approval by the Board in February, and the Board was therefore consulted upon these via correspondence and subsequently approved by the Group Chair and Group Chief Executive under para 5.3 of the Standing Orders of the Board (annex 6 of the constitution). In line with this paragraph, these amendments are now presented to the Board in Public for ratification.

Strategic and Group Model Alignment

This report is directly linked to the Patient First objective 'making the most of our resources'. The financial governance framework provides clarity on responsibilities for supporting the delivery of a break-even position and a capital programme which enables us to continue to support the Trust's strategic ambitions.

Risks and Opportunities

Risks • If the SoD had not been updated in a timely manner additional costs would have been incurred.	
Recommendation	
This report is for **Ratification.** The Group Board is asked to ratify the amendments to the Scheme of Delegation, as set out in this report and attached as Appendix 1.	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	Appendix 1 – Updated sections of the Scheme of Delegation

Extract from Scheme of Delegation
Approval of Business Cases
Delegated matters

UHBW

Capital

- *<£2m*
  Authority delegated to **Annual Capital Prioritisation and Trust Board**.

- *£2m to <£5m*
  Authority delegated to **Business Development Group and Capital Programme Steering Group**.

- *£5m to <£10m*
  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team**.

- *£10m to <£25m*
  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board. ~~with Board of Governors support~~**.

- *£25m to <£50m*
  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors support and p~~P~~otential onward approval at NHSE and HMT**.

- *>£50m*
  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors and onward approval at NHSE and HMT**.

- ~~*Digital - <£25m or <£30m whole-life cost*~~
  ~~Authority delegated to **Business Development Group, relevant Executive Committee sub-group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors' support**.~~

- *Digital - >£25m or >£30m whole-life cost*
  Authority delegated to **Business Development Group and DH Programme Board Capital and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors and onward approval at NHSE and HMT**.

Appendix 3

UHBW

Business Case Approval Route – Capital

Value (capital)	Approval Route	Ultimate Approver
		Trust Board
£2m to <£5m	Business Development Group (BDG), Capital Programme Board	CPSG
£5m to <£10m	BDG, Capital Programme Board, Trust Management Team	
£10m to <£25m	BDG, Capital Programme Board, Trust Management Team, Group Finance and Estates Committee, Trust Board	Trust Board
	BDG, Capital Programme Board, Trust Management Team, Group Finance and Estates Committee, Trust Board, Council of Governors	Council of Governors
>£50m		HMT

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Board Assurance Framework		
Report Author:	Sarah Wright, Head of Risk Management, UHBW		
Report Sponsor:	Lavinia Rowsell, Group Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	To update the Board on the Trust's principal strategic risk profile through the Quarter 4 Board Assurance Framework and to set out material developments in risk exposure and assurance arrangements since Quarter 3.		

Key Points to Note

The Board Assurance Framework (BAF) sets out the principal risks which, if realised, would prevent the organisation from achieving its strategic objectives.

All principal risks and their associated detailed Corporate Risk Registers have been formally presented to the relevant Board sub-committees during the Quarter 4 governance cycle. Each committee has undertaken scrutiny within its delegated remit. Where appropriate, matters have been escalated through established governance routes and are reflected within this iteration of the BAF.

Detailed operational and trust-level risks continue to be reviewed routinely through established governance structures across both organisations, including divisional governance forums, specialty governance groups and programme boards. This layered approach ensures that operational risk management is maintained at source, with strategic oversight provided through committee assurance and formal escalation to the Board where required.

The Quarter 4 review reflects sustained operational and system pressures. Since Quarter 3, several principal risks have increased in exposure, most notably Quality, Workforce, Performance, No Criteria to Reside and Digital. In most cases, this does not reflect a breakdown in internal controls but rather clearer recognition of cumulative demand, capital constraint, workforce pipeline fragility and system dependency.

During Quarter 4, two additional principal risks have been added to the BAF: Change Management and Fire Safety.

- Change management has been added to reflect the scale, complexity and pace of transformation required across the organisation and the wider NHS.
- Fire safety has been added to reflect the ongoing level of risk exposure associated with inherited and emerging estate-related fire safety deficiencies, particularly within complex acute hospital environments.

A consistent theme across Quarter 4 is a shift in emphasis from whether controls are in place, to whether those controls are sufficient and sustainable in the medium to long term. Assurance gaps now more explicitly reference long-term resilience, reliance on external partners and system-wide constraints.

This report should be read in conjunction with the Integrated Quality and Performance Report (IQPR), which provides the detailed operational performance metrics, trajectory data and supporting narrative underpinning the strategic risk position set out within the BAF. While the BAF articulates the principal risks to delivery of the Trust's objectives, the IQPR provides the granular performance and quality intelligence through which those risks are monitored and managed. Together, these reports provide a coherent line of sight from operational delivery through to strategic risk oversight.

Strategic and Group Model Alignment

The BAF directly supports delivery of the Trust's strategic direction by identifying and managing the principal risks that could compromise delivery.

The most significant movements this quarter relate to risks impacting:

- High Quality Care – through sustained service demand, workforce pressure and capital constraints.
- Timely Care and Flow – particularly in relation to the numbers of patients with No Criteria to Reside and emergency department overcrowding.
- Our People – through workforce sustainability, immigration legislation and industrial action exposure.
- Sustainability and the Public Purse – through capital replacement pressures, discharge delays and system inefficiencies.

The BAF is aligned to Patient First priorities by ensuring that risk identification, mitigation and assurance are embedded within improvement programmes, recovery plans and transformation workstreams.

From a Group perspective, the Quarter 4 review strengthens alignment across both organisations. Principal risks and associated corporate risks are being managed through developing shared governance routes and comparable assurance structures. Collaboration across the emerging Hospital Group supports a consistent risk language, shared oversight and coordinated mitigation, particularly in relation to flow, workforce and digital infrastructure.

The BAF therefore both supports and is strengthened by Group formation, particularly where risks are structural and system-wide in nature.

Risks and Opportunities

- The Quarter 4 position reflects sustained exposure to structural pressures rather than absence of internal control. System flow constraints, capital limitations, workforce supply fragility and digital maturity gaps continue to create interconnected risks across quality, performance and financial sustainability.

- If not effectively prioritised and managed, these pressures could result in financial inefficiency, regulatory scrutiny, reputational impact and risk to delivery of strategic objectives. There is also a risk that the cumulative scale of reform and transformation may place strain on organisational capacity and business-as-usual delivery.

- The clearer articulation of these structural risks strengthens the Board's oversight of medium- and long-term resilience. The addition of the Change Management principal risk supports more coordinated governance of NHS reform, digital transformation and the shift from acute to community models of care. The development of the Hospital Group also presents opportunities for aligned planning, shared mitigation and more sustainable use of resources across the system.

Recommendation	
• This report is for **Approval**. • Board members are asked to **note** the Quarter 4 Board Assurance Framework and the changes to principal risks, assurance levels and identified gaps since Quarter 3.	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	
Appendices:	Appendix A: Board Assurance Framework

BOARD ASSURANCE FRAMEWORK		Impact on Delivery of Strategic Priority						Linked Corporate Risks	
Principal Risk	Executive	Quality	Timely Care	People	Innovation	Resources	Commitment to Community	No. of Risks	Trend
1. QUALITY	Group Chief Nursing and Improvement Officer & Group Chief Medical and Clinical Innovation Officer	HIGH	HIGH	HIGH	HIGH	MODERATE	MODERATE	29	↑6
2. EQUIPMENT	Group Chief Nursing and Improvement Officer & Group Chief Medical and Clinical Innovation Officer	HIGH	HIGH	MODERATE	LOW	MODERATE	MODERATE	11	↔
3. WORKFORCE	Group Chief People & Culture Officer	MODERATE	HIGH	HIGH	HIGH	HIGH	LOW	10	↑1
4. PERFORMANCE	Hospital Managing Directors	HIGH	HIGH	MODERATE	HIGH	HIGH	MODERATE	20	↑5
5. NO CRITERIA to RESIDE	Hospital Managing Directors	HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE	9	↑4
6. DIGITAL	Group Chief Digital Information Officer	MODERATE	HIGH	MODERATE	MODERATE	MODERATE	HIGH	13	↑1
7. FINANCE	Group Chief Finance and Estates Officer	HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE	8	↓1
8. ESTATE	Group Chief Finance and Estates Officer	HIGH	HIGH	HIGH	HIGH	HIGH	MODERATE	11	↓1
9. COMPLIANCE	Group Chief Medical and Clinical Innovation Officer	MODERATE	HIGH	HIGH	MODERATE	MODERATE	MODERATE	6	↑1
10. FIRE SAFETY	Group Chief Finance and Estates Officer	LOW	MODERATE	MODERATE	MODERATE	HIGH	LOW	2	↔
11. CHANGE MANAGEMENT	Group Formation Officer	HIGH	MODERATE	MODERATE	HIGH	MODERATE	MODERATE	2	↔

Impact Ratings Key

The tables above and below summarise how each principal risk may impact delivery of the Group's strategic priorities, based on judgement and known interdependencies. Ratings are assigned using the RAG rating below:

HIGH	A significant threat to delivery of the strategic priority, requiring active mitigation to avoid adverse consequences
MODERATE	A notable but manageable constraint, requiring localised or thematic action.
LOW	A minimal threat to delivery, requiring routine monitoring only.

Strategic Priority	Impact of Risks on Strategic Priorities	Sources of Assurance
Quality	Risks linked to workforce, estates, equipment, digital systems, and performance can compromise patient safety, delay care, and affect patient experience.	Clinical audits, patient safety reporting, safe staffing reports, patient surveys, CQC inspections, internal audit.
Timely Care	Risks relating to workforce availability, theatre and bed capacity, flow constraints, and industrial action affect the ability to provide treatment within required timeframes.	IQPR, operational performance reports, UEC Board/IDS hubs, NHSE oversight.
People	Risks such as staff shortages, industrial action, wellbeing, fatigue, and employment legislation changes impact recruitment, retention, and staff experience.	Staff survey, People Committee deep-dives, WRES/WDES, Guardian of Safe Working, CQC feedback, HEI visits.
Innovation	Risks linked to digital infrastructure, cyber security, estates limitations, and workforce capability may slow adoption of new technologies, research, and service models.	Digital Hospital Programme Board, DSPT, cyber testing, HIMSS maturity assessments, internal audit.
Resources	Risks relating to capital constraints, estates compliance, equipment replacement, and financial pressures affect financial sustainability and investment capacity.	Finance & Estates Committee, ICS DoF group, CIP monitoring, external audit, Model Hospital.
Commitment to Community	Risks associated with inequalities, service capacity, performance pressures, and regulatory compliance may affect population health outcomes and partnership working.	Health Inequalities Programme, ICS frameworks, community partnership reporting, IQPR (inequalities).

PRINCIPAL RISK 1. QUALITY		Trend
Executive Leads	Chief Nursing and Improvement Officer & Chief Medical & Clinical Innovation Officer	↑ Increased
Board Committee	Quality & Outcomes Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	HIGH	HIGH	HIGH	MODERATE	MODERATE

Principal Risk Description

There is a risk that the Trust's ability to consistently maintain high standards of care and clinical safety is compromised by increasing service demand, workforce shortages, financial constraints, and operational pressures, combined with the complexity of clinical pathways.

This is a long-term, structural risk and the ability to maintain high-quality care is also affected by limitations in funding, restricting the Trust's ability to replace essential clinical equipment and upgrade facilities, which may lead to increased downtime, suboptimal patient care, and further operational inefficiencies.

There is also a heightened risk of hospital-acquired infections, prolonged recovery times, and avoidable complications, if staffing levels and resources are stretched. Failure to uphold quality standards may result in health inequalities, diminished patient satisfaction, reputational damage, and difficulties in staff recruitment and retention. Regulatory scrutiny, legal liabilities, and financial consequences could arise if the Trust does not effectively mitigate these risks.

Existing Controls

Board-level controls

- Board Assurance Framework oversight and reporting (BOTH)
- Quality & Outcomes Committee oversight (BOTH)
- Policies and guidelines (BOTH)
- ICS-led patient flow initiatives, NHS funding access, and regional coordination for urgent and emergency care (BOTH)
- Communication, patient surveys, and structured engagement (BOTH)

Operational controls

- Clinical audits, patient safety initiatives, and incident reporting (BOTH)
- Staff recruitment, retention and training and education programs (BOTH)
- Infection prevention protocols (BOTH)
- Elective recovery plans (BOTH)

Sources of Assurance

Independent / external assurance

- CQC inspection outcomes (BOTH)
- External regulatory reviews (BOTH)

Board / committee assurance

- Quality & Outcomes Committee reports (BOTH)
- Board performance and quality reports (BOTH)

Operational assurance

- Patient Safety Reports (BOTH)
- Integrated Quality & Performance reporting (BOTH)
- Incident trend analysis and thematic reviews (BOTH)

Independent – 3rd Line of Defence

Causal & Contributory Factors

- Resource Constraints (BOTH)
- Lack of Standardisation (BOTH)
- Failure to address systemic issues (BOTH)
- Communication Breakdowns (BOTH)
- Ineffective feedback mechanisms (BOTH)
- Aging equipment (BOTH)
- Insufficient investment in infrastructure (BOTH)
- Lack of robust digital infrastructure and processes (UHBW)

Gaps in Controls or Assurance

- Insufficient training uptake due to staff availability (BOTH)
- Reliance on temporary staffing (BOTH)
- Limited capacity in community and primary care services (BOTH)
- Need for external funding to support major infrastructure improvements (BOTH)
- Lack of robust digital infrastructure and processes (UHBW)
- Lack of robust Business Intelligence function (UHBW)
- Limited assurance on the effectiveness and sustainability of quality controls at a system level, including the organisation's resilience to cumulative pressures and future safety risk (BOTH)

Planned Mitigation

- Joint Clinical Strategy, Healthy Weston phase 2 and the UHBW Elective Strategy (BOTH)
- Experience of Care Strategy (UHBW)
- Implementation of Careflow Medicines Management (UHBW)
- Deteriorating Patient Programme and Implementation of Martha's rule. (UHBW)
- Mental Health Across UHBW Corporate Project (UHBW)
- Implement the Community Diagnostics Centre expansion (NBT)
- Increase elective surgical capacity through the new Bristol Surgical Centre (NBT)
- Engage with ICS to secure additional community capacity for patient discharge (NBT)

UHBW Corporate Risks

8386	That medication allergies are not visible within Careflow	↔	20
8425	Pts with stroke symptoms will not receive timely specialist treatment	↑	16
8448	That VTE prophylaxis is not prescribed	↑	16
6677	Non-compliant behaviours for effective IPC practice amongst staff	↔	16
7566	Staff fatigue impacts performance and patient safety	↔	16
7919	That sepsis is not considered, recognised and responded to	↔	16
7633	Continued reliance on paper-based medication prescribing	↔	16
2264	Delays in commencing induction of labour	↔	16
588	Patient deterioration is not recognised and responded to	↔	15
856	Emotional & mental health needs of C&YP may not be met	↔	15
8157	Discharge summaries do not communicate effectively	↔	15
2614	Patient care and experience is affected due to being in extra capacity	↑	15
3115	Clinical decision-making made based on incomplete information	↔	12
418	Routine radiology reports are not signed off/ acknowledged timely	↔	12
1598	Patients suffering harm or injury from preventable falls	↔	12
1702	Communication needs of patients are not recognised	↔	12
3216	NHSE limits for Clostridioides difficile are breached	↔	12
6013	Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia's	↔	12
6691	Medicines not stored securely	↔	12

NBT Trust Level Risks

1760	Hybrid clinical noting leads to delayed or inaccurate decision making	↔	20
1800	Patient record systems do not robustly identify known allergies	↔	20
2157	Continued significant overcrowding within the Emergency Dept	↑	20
2105	Delay in delivery of blood product(s)	↔	16
2134	Service provision within the Pharmacy Medicines Governance & Safety	↔	16
2102	Non-compliance with AfPP staffing guidance	↑	16
701	Limited capacity of maternity theatres and theatre team	↔	15
1697	Transfer of medically fit patients requiring Mental Health services	↔	15
1704	Sub-optimal delivery of Stroke Care to patients	↔	15
1699	Absence of a Core 24 service in BNSSG delays Mental Health Act	↔	12
1831	Insufficient resourcing of the Vascular Access Service	↔	12
1900	Lack of 24/7 telephone triage as a single point of access for maternity	↔	12
1982	Lack of anaesthetic support Endoscopic Retrograde	↔	12
2002	Incorrect allocation of treating Consultant	↔	12
2182	Patients with NC2R remaining in hospital at greater risk of deconditioning	↔	12
2041	Aging nurse call system in Women and Children's sector	↔	12
2177	Pathway constraints impacting ability to investigate functioning of ITB pump	↑	12

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through the established governance structures in both organisations. It has been considered by the Clinical Quality Group (UHBW), as a formal subgroup of the Trust Management Team, and by the Risk Management Group (North Bristol NHS Trust). As part of that review, associated corporate and trust-level risks were scrutinised for trajectory, adequacy of controls and sufficiency of assurance.

During the quarter, several underlying corporate risks were escalated. At UHBW, three corporate risks increased in score, reflecting evidence of sustained likelihood and/or the need for strengthened senior oversight. At North Bristol, three trust-level risks also increased in score during the reporting period, either due to reassessment of impact and likelihood or the formal recognition of emerging pathway and capacity pressures. These movements were reviewed through operational governance forums prior to escalation and are reflected within the current risk profile.

Following operational and executive-level review, this principal risk has been reported through formal governance routes to the Quality & Outcomes Committee, which provides Board-level oversight of quality, safety and clinical performance across the Group. The Committee has received assurance regarding risk management arrangements and ongoing mitigation activity, and has confirmed continued monitoring at principal risk level.

Detailed operational risks underpinning this principal risk continue to be managed through divisional governance structures, specialty governance groups and programme boards, with escalation applied where exposure exceeds agreed thresholds.

PRINCIPAL RISK 2. EQUIPMENT		Trend
Executive Leads	Chief Nursing and Improvement Officer & Chief Medical and Clinical Innovation Officer	↑ Increased
Board Committee	Quality & Outcomes Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	HIGH	MODERATE	LOW	MODERATE	MODERATE

Principal Risk Description

There is a risk that medical equipment is not adequately procured, maintained, replaced, or disposed of in accordance with clinical, operational, regulatory, and environmental requirements.

This risk cannot be fully mitigated through operational action alone, as failures in procurement planning, lifecycle management, and disposal processes may result in unsafe, inefficient, or environmentally unsustainable equipment usage. This includes acquiring unsuitable or non-compliant equipment, failing to replace ageing assets in a timely manner, and disposing of medical devices without meeting legal or sustainability standards.

These issues can result in patient harm, service disruption, financial inefficiencies, regulatory breaches, and environmental impact.

Existing Controls

Board-level controls

- Capital investment prioritisation and oversight (BOTH)
- Medical Equipment Strategy (BOTH)
- Policies and regulatory compliance frameworks (BOTH)
- Group Medical Equipment Group (UHBW)
- Asset management and lifecycle planning processes (BOTH)

Operational controls

- Planned preventative maintenance programmes (BOTH)
- Equipment replacement programmes (BOTH)
- Local equipment inventories and escalation processes (BOTH)

Sources of Assurance

Independent / external assurance

- Regulatory compliance inspections (BOTH)
- External audit reviews (BOTH)

Board / committee assurance

- Capital programme reporting (BOTH)
- Medical Equipment Group assurance reports (BOTH)

Operational assurance

- Maintenance compliance reports (BOTH)
- Equipment failure and incident data (BOTH)

Compliance – 2nd Line of Defence

Causal & Contributory Factors

- Aging estate and clinical infrastructure (BOTH)
- Historic decisions to defer replacement cycles (BOTH)
- Inadequate capital allocation relative to the value of equipment (BOTH)
- Variation in oversight between capital and revenue funded (BOTH)
- Fragmented and inconsistent procurement processes (BOTH)

Gaps in Controls or Assurance

- No formal replacement programme for revenue-funded equipment (UHBW)
- Multiple uncontrolled entry points for equipment (BOTH)
- Lack of real-time, centralised inventory management (BOTH)
- Reliance on maintenance contracts for obsolete devices (BOTH)
- Weak unsustainable assurance around operational workarounds (BOTH)
- Limited triangulation of incident, audit, and inventory data (BOTH)
- Low visibility of maintenance contract performance (BOTH)
- Limited assurance on the long-term sustainability and criticality of the medical equipment base, including dependency on external capital funding and alignment with future service models (BOTH)

Planned Mitigation

- Patient First Corporate Project - Equipment Procurement & Management (UHBW)
- Clear programme of equipment which has been captured within the 10-year Capital plan (NBT)
- Local business continuity plans in place in the event of equipment failure (NBT)

UHBW Corporate Risks

6907	Siemens plain film room at SBCH could fail beyond repair	↔	20
7073	Failure of aging radiology equipment	↔	20
7477	Failure of Hybrid/Theatre 10 equipment	↔	20
7720	Failure of radiotherapy treatment machine Linac H	↔	20
7722	Failure of aging CT Sim equipment fails	↔	16
8067	Inadequate size of decant bunker in Radiology	↔	16
8566	Equipment is not adequately maintained or replaced	↑	15
7449	Equipment is not effectively procured	↔	12
8568	Equipment cannot be reliably tracked or located	↔	12

NBT Trust Level Risks

1681	Aging Imaging equipment reaching end of life may fail	↔	16
2041	Aging nurse call system in Women and Children's sector	↔	12

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through the established governance structures in both organisations. It has been considered by the Clinical Quality Group (UHBW), as a formal subgroup of the Trust Management Team, and by the Risk Management Group (North Bristol NHS Trust). As part of that review, associated corporate and trust-level risks were scrutinised for trajectory, adequacy of controls and sufficiency of assurance relating to procurement, lifecycle management and equipment resilience.

During the quarter, movements in underlying risks were identified and reviewed through operational governance prior to escalation. At UHBW, one corporate equipment risk increased in likelihood score to reflect the systemic and recurring nature of equipment-related failures and delayed replacement cycles. In addition, a concentration of high-scoring departmental equipment risks continues to be monitored through divisional governance, reflecting ageing and obsolescent assets and reliance on planned capital replacement programmes. At North Bristol, equipment-related trust-level risks remain under active review, with programme-based mitigation in place for ageing infrastructure and critical systems.

Following operational and executive-level review, this principal risk has been reported through formal governance routes to the Quality & Outcomes Committee, which provides Board-level oversight of quality, safety and clinical performance across the Group. The Committee has received assurance regarding risk management arrangements, capital prioritisation and mitigation planning, and has confirmed continued monitoring at principal risk level.

PRINCIPAL RISK 3. WORKFORCE		Trend
Executive Leads	Group Chief People & Culture Officer	↑ Increased
Board Committee	People Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
MODERATE	HIGH	HIGH	HIGH	HIGH	LOW

Principal Risk Description

There is a risk that the Group's ability to align workforce capacity, capability and culture to future service models is compromised. This is a long-term, structural risk.

Demand for workforce capacity is expected to rise for some discrete staff groups and specialities this will be driven by service expansion, population health changes and new models of care. There remains a small number of hard to fill posts that are difficult to recruit into.

The Group operates in a highly competitive labour market, with high living costs and limited transport infrastructure reducing the appeal of city centre hospital sites for some candidates. At the same time, national constraints on the training pipeline, growing expectations for flexible and values-led careers, and the need for inclusive, future-focused leadership present further challenges in aligning the workforce to future service needs. Ensuring visible progress on equality, diversity, and inclusion remains vital for building a culture where all colleagues feel valued, supported, and able to thrive, particularly in a diverse urban population. Shifts in government priorities or NHS-wide restructuring could intensify financial constraints potentially leading to greater restrictions on recruitment and the continuation of workforce controls across the Group. These pressures could result in greater instability, increased reliance on temporary staffing, and a diminished ability to deliver safe, high-quality care across the Group in the years to come.

Existing Controls

Board-level controls

- People Strategy and Workforce Strategy (BOTH)
- People Committee oversight (BOTH)
- Equality, Diversity and Inclusion Strategy (BOTH)
- HELM (leadership development programme) (BOTH)
- Group workforce planning arrangements (BOTH)
- Leadership development frameworks (BOTH)
- Recruitment and retention initiatives (BOTH)

Operational controls

- Vacancy management processes (BOTH)
- Agency and temporary staffing controls (BOTH)

Sources of Assurance

Independent / external assurance

- People themed Internal Audit Reports (BOTH)
- CQC reports contain feedback on workforce (BOTH)
- NHSE Quality visits to Education (BOTH)
- Annual site visits from HEI's of student experiences and placements (BOTH)
- British Safety Council Audit and Safer Learning Environmental Charter (UHBW)

Board / committee assurance

- People Committee deep-dives and performance reviews (NBT)
- Deliverables of People Strategy Reports (UHBW)

Operational assurance

- Staff Survey Results Reporting (BOTH)
- Compliance Reports with standards related to staffing levels and safety (BOTH)
- Integrated Quality & Performance Report contains people metrics (BOTH)
- Freedom to Speak up process and reports (BOTH)
- Guardian of safe working reports (BOTH)
- National Violence and Aggression Prevention Standards (BOTH)
- Gender pay-gap report and WRES/WDES data Reports (BOTH)

External – 3rd Line of Defence

Causal & Contributory Factors

- Increasing demand for services along with budget constraints (BOTH)
- Challenges associated with shortages of specialists nationally (BOTH)
- Fixed Agenda for Change reward structure (BOTH)
- Tempory staffing costs and market forces (BOTH)
- Insufficient training provision and uptake (BOTH)
- Workload and work related stress (BOTH)
- Dr rotation allocation (BOTH)
- Capacity of HEI's and FE's to develop workforce plan (BOTH)
- Inconsistent culture and experience across staff groups (BOTH)
- Pipeline, leadtimes and funding for developing the workforce (BOTH)
- Industrial action (BOTH)

Gaps in Controls or Assurance

- Competition between providers for the same staff (BOTH)
- Differentialsacross the region in grading between similar roles (BOTH)
- Pro-equity and Anti Racism statement is in development (UHBW)
- Understanding the productivity of our workforce (UHBW)
- Ability to forecast future threats to local supply of workforce (UHBW)
- Current workforce plan for medical roles needs to be refreshed to include hard to fill posts, (UHBW)
- Long term plan financial and student allocations are unknown (UHBW)
- Limited independent and forward-looking assurance on long-term workforce sustainability, leadership succession, and future capability aligned to service models (BOTH)

Planned Mitigation

- Development of the Group People Strategy (BOTH)
- The People Benefit Strand of the Hospital Group Benefits Case will focus on ensuring aligned and complementary workforce arrangements between the two Acute Trusts and across the wider system (BOTH)
- The People Strategy year 3 delivery plan (UHBW)
- Medical Workforce programme (UHBW)
- Delivering the pro-equity promise (UHBW)
- Talent acquisition team are providing targeted support to affected specialties (NBT)

UHBW Corporate Risks

7566	Staff suffering from fatigue*	↔	16
8383	Workforce shortages in specialist roles	↔	16
8467	Introduction of changes to the Immigration Law*	↔	16
422	Patients and staff experience violent or aggressive behaviour	↔	12
674	Use of agencies who are non-compliant with national pricing caps*	↔	12
6502	Industrial action impacts patient safety, elective recovery and finances*	↔	12
7875	Impact of Group Model development and implementation on BAU	↔	12
8360	Introduction of changes to the Employment Law*	↑	12
8652	Educator Workforce Capacity and delivery of Workforce Strategy	↑	12

*UHBW has these risks listed as Corporate Risks due to their current risk scoring and escalation status, whereas equivalent risks at NBT are either below the current escalation threshold or remain in draft/development and therefore do not appear on the TLR.

NBT Trust Level Risks

1979	Workforce shortages in specialist medical roles	↔	16
2102	Non-compliance with AfPP staffing guidance	↑	16
374	Patients and staff experience violent or aggressive behaviour	↔	15

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through established governance structures in both organisations. It was considered through executive-led workforce governance arrangements and formally reviewed by the People Learning & Development Group.

At UHBW, two workforce-related corporate risks increased in score, reflecting the growing impact of forthcoming employment law changes and the strategic importance of educator workforce capacity and training compliance. At North Bristol, one trust-level workforce risk increased following reassessment of staffing resilience within maternity services against national standards. These movements were reviewed through divisional and corporate governance forums prior to escalation and are reflected in the current risk profile.

The principal risk has subsequently been reported to the People Committee, which has received assurance regarding workforce controls, strategy delivery and mitigation planning, and has confirmed continued monitoring at principal risk level.

PRINCIPAL RISK 4. PERFORMANCE		Trend
Executive Leads	Hospital Managing Directors	↑ Increased
Board Committee	Quality Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	HIGH	MODERATE	HIGH	HIGH	MODERATE

Principal Risk Description

System-level constraints, including a high number of patients with no criteria to reside, constrained community and primary care capacity, and workforce pressures across the BNSSG system, are limiting patient flow across our hospitals

This contributes to delays in care, overcrowding, and increased stress on staff. Patients face prolonged wait times, which can worsen clinical outcomes, while overcrowding heightens the risk of infection spread. The inability to discharge patients in a timely manner directly impacts bed availability, leading to delays in Emergency Departments, including breaches of key targets such as timely treatment and ambulance handovers. Stretched resources also elevate the risk of errors, compromising patient safety.

As a consequence, despite local recovery plans being in place for most national standards, system flow constraints, particularly discharge and community capacity, are preventing the Trusts from reliably meeting operational targets. These conditions are now persistent rather than episodic, with patients experiencing prolonged waits, sustained crowding in care environments and ongoing delays to treatment on a daily basis

Existing Controls

Board-level controls

- System working (BOTH)
- Integrated discharge, planning and Transfer of Care Hub (BOTH)
- NHS@Home to prevent admission and facilitate discharge (BOTH)
- Telemedicine (BOTH)
- Repatriation Policy (NBT)

Operational controls

- Bed management and pre-emptive transfer planning (BOTH)
- Same Day Emergency Care Departments (SDEC) prevents admission (BOTH)
- Extra capacity locations identified (BOTH)
- RTT Recovery Plan (NBT)
- UEC Board and Improvement Plan (NBT)

Sources of Assurance

Independent / external assurance

- Internal Audit Reports on performance and Data Quality Framework (UHBW)
- CQC Inspection Reports (BOTH)

Board / Committee assurance

- Finance & Performance Committee deep-dives into operational performance (NBT)

Operational assurance

- Integrated Quality & Performance Reports (BOTH)
- True North Timely Care Quality Report (UHBW)

Independant – 3rd Line of Defence

Causal & Contributory Factors

- Sustained high numbers of patients with No Criteria to Reside blocking acute beds due to insufficient community, social care and step-down capacity (BOTH)
- Poor coordination between different parts of the healthcare system (BOTH)
- Access to primary care and capacity of social care to support discharge (BOTH)
- Growing and aging population increases the need for healthcare services (BOTH)
- Sudden surges in demand due to outbreaks of illness (BOTH)
- Limited bed capacity and space in emergency departments and wards (BOTH)

Gaps in Controls or Assurance

- System-wide inability to reduce NC2R to safe levels despite escalation, resulting in persistent bed blocking and ED crowding (BOTH)
- Ability to staff extra capacity locations (BOTH)
- Ability to discharge in a timely manner (BOTH)
- Inability to ring fence critical care beds for elctive procedures due to emergency admissions (BOTH)
- Ability to measure productivity (UHBW)
- Not yet seeing evidence that investment in “Discharge 2 Assess” initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (NBT)
- Limited assurance on the deliverability and sustainability of system-wide flow solutions that sit outside the Trust’s direct control (BOTH)

Planned Mitigation

- System working regards improvements to discharge and unscheduled care flow, including escalation via the ICS to secure additional community capacity (BOTH)
- System-wide discharge and flow programme via the ICS, including joint escalation through the System Chief Executive Group, D2A Board, Transfer of Care Hubs and community capacity bridging schemes to stabilise unscheduled care flow (BOTH)
- Whole-system escalation of UEC pressures to secure short-term community and step-down capacity when hospital flow becomes unsafe (BOTH)
- Proactive Hospital, Improving Outpatients and theatres productivity and efficiency Projects and Ready for discharge Breakthrough Objectives (UHBW)
- Community Diagnostics Centre and Bristol Surgical Centre (NBT)
- Additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (NBT)

UHBW Corporate Risks

423	That demand for inpatient admission exceeds available bed capacity	↑	25
7769	Patients in the Trusts ED’s may not receive timely and effective care	↔	20
6782	Non-compliance with the 28 day faster diagnosis cancer standard	↑	20
1035	Access to critical care beds for BNSSG and tertiary catchment areas	↔	16
6320	That there is inadequate Clinical Site Management resource overnight	↔	15
924	BRI Patients with #NOF access surgery within 36 hours of admission	↔	15
801	That elements of the NHS Oversight Framework are not met	↔	12
2244	Long waits for Outpatient follow-up appointments	↔	12
5520	Patients from deprived/marginalised communities face inequtable care	↔	12
5531	Non-compliance with the 62 day cancer standard	↔	12
5532	Non-compliance with the 31 day cancer standard	↔	12

NBT Trust Level Risks

2157	Continued significant overcrowding within the Emergency Dept	↑	20
1940	Delays in patient flow through the hospital impact timely treatment	↔	16
1765	Complaint/PALS responses not achieving statutory timframes (ASCR)	↔	16
1881	Caring for patients in non-clincal areas & outside planned bedbase (Medicine)	↔	15
1970	Caring for patients in non-clincal areas & outside planned bedbase (ASCR)	↔	15
1972	Caring for patients in non-clincal areas & outside planned bedbase (NMSK)	↔	15
2182	Patients with NC2R remaining in hospital at greater risk of	↔	12
523	Urology Service waiting list	↔	12

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through established governance structures in both organisations. Associated corporate and trust-level performance risks were scrutinised through executive-led operational governance and system flow forums prior to escalation.

During the quarter, two UHBW corporate performance risks increased in score, reflecting sustained inpatient demand exceeding bed capacity and continued deterioration against the 28-day faster diagnosis cancer standard. At North Bristol, one trust-level performance risk increased in score following reassessment of Emergency Department overcrowding and its impact. These movements were reviewed through divisional and corporate governance arrangements before escalation and are reflected in the current risk profile. This principal risk has subsequently been reported through formal governance routes to the Quality Committee, which provides Board-level oversight of operational performance and system flow. The Committee has received assurance regarding recovery planning, system escalation and mitigation actions, and has confirmed continued monitoring at principal risk level.

PRINCIPAL RISK 5. NO CRITERIA TO RESIDE		Trend
Executive Leads	Hospital Managing Directors	↑ Increased
Board Committee	Quality Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE

Principal Risk Description

Persistently high numbers of patients with no criteria to reside (NCtR) across UHBW and NBT reflect system-wide challenges in discharge planning, patient flow, and community capacity. This risk reflects a system-level constraint rather than a local failure.
This results in patients remaining in hospital longer than clinically required, delays for those needing timely care, sustained crowding in Emergency Departments and inpatient areas, and increasing pressure on staff and services across both Trusts., reduced operational efficiency, financial strain, reputational risk and directly correlates to patients waiting over 12 hours for an inpatient bed from Emergency Departments. The financial impact is significant. The need to staff unfunded escalation areas often requires high-cost temporary or agency staffing, placing additional pressure on budgets. Extended lengths of stay for patients with no criteria to reside result in occupied beds and staff resources that could otherwise support elective or emergency care, ultimately reducing patient throughput and associated income. This inefficiency increases the overall cost of care and may also expose the Trust to financial penalties or heightened scrutiny from regulators. This risk is a primary driver of the Trusts' performance, quality, workforce and financial risks, and directly underpins the critical position reported under the Performance principal risk.

Existing Controls

Board-level controls

- Close working with ICS partners and use of discharge funding streams (BOTH)
- Participation in Integrated Discharge Service (IDS) (NBT) and discharge hubs (BOTH)
- Home First team supporting ED and assessment units (BOTH)

Operational controls

- Daily discharge planning processes and escalation (UHBW)

Sources of Assurance

External / Independent assurance

- National reporting of >21 day NCtR patients (BOTH)

Operational assurance

- NCtR Numbers reported via IQPR (BOTH)

Compliance – 2nd Line of Defence

Causal & Contributory Factors

- Lack of community/social care capacity (BOTH)
- Delays to rehab/intermediate care, pathways are full or slow to accept (BOTH)
- Workforce shortages in partners, community and social care teams (BOTH)
- Community capacity isn't aligned with acute demand (BOTH)
- Frailty and comorbidities complicate discharge planning (BOTH)
- Delays from patient/family choice and time taken to agree placements (BOTH)
- Limited ability to discharge during the weekend (BOTH)
- Partner coordination of roles and responsibilities unclear or fragmented (BOTH)
- Seasonal pressures causing peaks in admissions outpace discharge (BOTH)
- Differing risk appetite to community providers (BOTH)
- Delays from LA funding panels on decisions for packages of care and long tern placements (BOTH)

Gaps in Controls or Assurance

- Limited domiciliary or reablement capacity in community and social care (BOTH)
- High demand outpacing available capacity for community placements (BOTH)
- Workforce shortages across the system, including social care (BOTH)
- Insufficient influence over wider system constraints at local Trust level (BOTH)
- Absence of independent or Board-level assurance on the adequacy and sustainability of community and social care capacity underpinning discharge (BOTH)
- The Trusts have limited ability to directly influence or secure the volume and pace of community and social care capacity required to reduce NCtR to safe and sustainable level (BOTH)

Planned Mitigation

- System-wide NCtR recovery programme through the ICS, including delivery of the 15% NCtR target, with specific focus on length of stay in Pathway 2 and 3 and expansion of intermediate care and community bedded capacity (BOTH)
- The refreshed ICS-led Discharge to Assess (D2A) Transformation Programme and NCtR trajectory are now in place, with a system programme of work to deliver agreed recovery targets (BOTH)
- Reviewing internal criteria assessment / referrals to improve efficiencies in the system (BOTH)
- Local Authority led Area Performance Meetings to review community performance and agree improvement actions (BOTH)

UHBW Corporate Risks

423	That demand for inpatient admission exceeds available bed capacity	↑	25
7769	Patients in the Trusts ED's may not receive timely and effective care	↔	20
8252	Patients with no criteria to reside continue to remain in hospital beds	↔	16
2614	Patient care and experience is affected due to being in extra capacity	↔	15

NBT Trust Level Risks

2157	Continued significant overcrowding within the Emergency Dept	↑	20
1940	Delays in patient flow through the hospital impact timely treatment	↔	16
1881	Caring for patients in non-clincal areas & outside planned bedbase	↔	15
1970	Caring for patients in non-clincal areas & outside planned bedbase	↔	15
1972	Caring for patients in non-clincal areas & outside planned bedbase	↔	15
2182	Patients with NC2R remaining in hospital at greater risk of deconditioning	↔	12

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through executive-led system flow and discharge governance forums across both organisations.

During the quarter, one UHBW corporate risk relating to inpatient bed capacity increased in score, reflecting sustained demand and discharge constraints. At North Bristol, one trust-level risk relating to Emergency Department overcrowding also increased following reassessment of impact severity. These movements were reviewed through operational governance prior to escalation and are reflected in the current risk profile.

The principal risk has subsequently been reported to the Quality Committee, which has received assurance regarding the ICS-led discharge programme and NCtR trajectory management, and has confirmed continued monitoring at principal risk level.

Operational discharge and flow risks continue to be managed through divisional and system governance structures, with escalation applied where thresholds are exceeded.

Principal Risk 6. Digital		Trend
Executive Lead	Chief Digital Information Officer	↑ Increased
Board Committee	Digital Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Moderate	High	Moderate	Moderate	Moderate	High

Principal Risk Description

A lack of digital maturity, oversight, and coordination across the group, combined with an aging infrastructure at UHBW requiring significant investment, increases the risk of an insecure and unstable digital environment.

This risk cannot be fully mitigated through operational action alone, as it requires sustained investment and coordinated transformation across the Group.

This could result in siloed and incomplete data, poor system interoperability, and an inconsistent user experience. Systems that are not fully accessible or joined up across sites may limit access to critical information, creating operational challenges, inefficiencies, and delays in decision-making. A significant cyber-attack or prolonged IT system failure could further compromise patient safety, disrupt business continuity, and impact the ability to deliver critical services. The consequences include data breaches, privacy violations, financial and regulatory repercussions, and reputational damage, ultimately eroding confidence in the Trust's digital resilience.

Existing Controls

Strategic controls

- Digital Hospital Programme Board and its supporting bodies (BOTH)
- New procurement process for introduction of Digital systems (BOTH)
- NHSE cyber security alerting and briefing programme 'CareCert' (BOTH)
- NHSE South West Regional Cyber Security Group (BOTH)
- Digital Security Policies, Procedures and audits (BOTH)
- Clinical Risk Management System for Digital Systems (BOTH)
- Disaster recovery backup in place and business continuity plans (BOTH)

Operational / delivery controls

- Regular scanning for vulnerabilities or attacks and antivirus software (BOTH)
- Timely server and software updates and patch application (BOTH)
- CareFlow Clinical Workspace (BOTH)

Sources of Assurance

External / Independent

- Internal Audit reports of the Trust's Information Security Policies, Cyber-Security Action Plan, and Business Continuity Plans in the Trust's digital supply chain (BOTH)
- Annual IT Health Check (BOTH)
- Digital Maturity Assessment (BOTH)
- HIMSS Electronic Medical Record Adoption Model (BOTH)

Internal / Operational

- HIMSS Infrastructure Adoption Model Assessment has scored our digital infrastructure capability at 4 out of 7 (UHBW)
- DSPT Self-Assessment and Audit Report (BOTH)

Independant– 3rd Line of Defence

Causal & Contributory Factors

- Limited and fragmented investment in digital infrastructure has led to a variety of systems, presenting challenges in maintenance, future-proofing, performance, and alignment with evolving cybersecurity standards (UHBW)
- Delays in investment and prioritisation of replacing end-of-life software have resulted in a reliance on unsupported systems(UHBW)
- Business Intelligence (BI) capabilities are affected by data silos, continued use of paper records, and inconsistent data quality(UHBW)
- The existence of shadow IT complicates the coordination of digital systems, making it harder to consolidate information and ensure security (BOTH)
- The capacity for digital transformation is spread thin due to competing priorities and the complexity of managing multiple initiatives (BOTH)

Gaps in Controls or Assurance

- The Information Asset Register is incomplete, making it difficult to confirm full compliance with Information Security Policies (UHBW)
- Contract management for digital systems is currently limited (UHBW)
- Business Intelligence (BI) reporting tools are not user-friendly or advanced enough to meet the needs of users (UHBW)
- The data quality function is limited (UHBW)
- A significant portion of shadow IT and some Digital Services systems do not yet comply with the clinical risk management system (BOTH)
- Servers are operating on unsupported systems (NBT)
- The current infrastructure and insufficient alignment of core IT systems is not equipped to support joint working across the Group (BOTH)
- Limited assurance on the long-term sustainability, interoperability and benefits realisation of the digital estate beyond cyber security compliance (BOTH)

Planned Mitigation

- Digital Strategy delivery plan (UHBW)
- Careflow Medicines Management Project (UHBW)
- Enterprise Network Replacement Programme – Business Case approval expected Jan 2026 (UHBW)
- Implementation of tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity (NBT)
- Improvement or replacement the existing back-up solution (NBT)
- Ongoing remediation work for areas highlighted by the vulnerability scanner (NBT)
- Remove or mitigate 146 Windows 2012 servers from the estate (NBT)
- Development of an assessment process with the Trust auditors to investigate cyber resilience of the supply chain with procurement (BOTH)
- The BNSSG Cyber Security Governance Group has been established to focus on governance reporting across the ICS and considering converging Cyber Security toolsets (BOTH)

UHBW Corporate Risks

8386	That medication allergies are not visible within Careflow	↑	20
7051	Risk that bespoke Homegrown Solutions limits future development	↔	16
7633	Reliance on paper-based medication prescribing	↔	16
291	Trust IT infrastructure does not meet the needs of a Digital hospital	↔	15
292	The Trust is impacted by a cyber incident	↔	15
418	Routine radiology reports are not signed off or acknowledged	↔	12
1374	Obsolete network components are not replaced	↔	12
3115	Clinical decision making may be based upon incomplete information	↔	12
6129	Inappropriate access to systems is undetected	↔	12

NBT Trust Level Risks

1760	Continued use of hybrid clinical noting (paper and electronic notes)	↔	20
1800	Trust systems do not record the allergy ststus of patients	↔	20
545	Building 180 data centre will overheat and IT Services will fail	↔	16
1893	Poor performance of the pathology middleware solution (Remisol)	↔	16

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through executive-led digital governance arrangements across both organisations.

During the quarter, one UHBW corporate digital risk increased in score following identification of material weaknesses in the recording and visibility of medication allergy information across clinical systems. This escalation was reviewed through operational and corporate governance routes prior to reporting and is reflected in the current risk profile. At North Bristol, no trust-level digital risks increased during the reporting period.

The principal risk has subsequently been reported to the Digital Committee, which has received assurance regarding digital resilience, infrastructure stability and cyber security controls, and has confirmed continued monitoring at principal risk level.

Operational digital risks continue to be managed through programme boards and technical governance forums, with escalation applied where thresholds are exceeded.

PRINCIPAL RISK 7. FINANCE		Trend
Executive Leads	Chief Strategic Finance and Estates Officer	↑ Increased
Board Committee	Finance & Estates Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE

Principal Risk Description

This is a long-term, structural risk. Failure to achieve financial sustainability due to an inability to meet cost improvement targets, productivity targets, elective activity targets, non-identification of non-recurrent income, and/or manage cost pressures that may lead to budget deficits.

The underlying deficit increases for both Trusts poses the risk of regulatory intervention, including heightened scrutiny, stricter reporting requirements, and potential limitations on decision-making authority. A deteriorating financial position across the Group could also result in service reductions, compromised patient access and care, further headcount controls, recruitment constraints, and reduced financial autonomy, with greater oversight from the System and Regulators. These factors collectively impact the ability to operate effectively, maintain stakeholder confidence, and invest in future service and organisational improvements.

Existing Controls

Board-level controls

- Investment Prioritisation (BOTH)
- Financial Forecasting and Scenario PlanningRe (BOTH)
- Financial escalation frameworks (BOTH)
- ICS Directors of Finance (DoF) Group and System Planning Processes (BOTH)
- Monthly Financial Returns and review with NHSE (NBT)
- Internal budget Planning and Oversight (BOTH)
- Procurement controls (BOTH)
- Business Case Review Group (NBT)
- Local counter fraud service (BOTH)

Operational / delivery controls

- Regular financial reporting at divisional and Trust level (BOTH)
- Divisional Performance Management (BOTH)
- Weekly CIP Monitoring Reports (NBT)

Sources of Assurance

External / Independent assurance

- Model Hospital Benchmarking Reports/Productivity Packs (BOTH)
- Internal Audit Reports (BOTH)
- External Audit Reports and Value for Money Review (BOTH)

Board / Committee assurance

- Monthly reporting to Finance Committee and onwards to the Board (BOTH)
- Monthly reporting of CIP/ERF at PFIG (with ICB/NHSE review) and finance sustainailty board (NBT)
- Capital plan monitoring at Capital Progam Steering Group (UHBW)
- ICB review through BNSSG Performance and Recovery Board and BNSSG Finance, Estates & Digital Committee (BOTH)

Operational assurance

- Monthly reporting to GEM and TMT (BOTH)
- Intenal and External Audit submissions to Audit Committee (BOTH)
- Report from Local counter fraud service (BOTH)

Independent – 3rd Line of Defence

Causal & Contributory Factors

- Insufficient revenue funding from the ICB and Specialised Commissioners (BOTH)
- Insufficient CDEL and/or cash for capital investment (BOTH)
- Underlying financial challenge (BOTH)
- Increasing demand, with fixed and/or limited growth funding (BOTH)
- Workforce supply challenges, with premium costs or contained capacity (BOTH)
- Operational inefficiencies and negative productivity (BOTH)
- Estate configuration, condition and infrastructure maintenance (BOTH)
- Political priorities (BOTH)
- Macro-economic conditions (BOTH)
- Technological advancements (BOTH)

Gaps in Controls or Assurance

- Failure to achieve CIP targets on a recurring basis (BOTH)
- Overspending on pay budgets due to over-establishment and premium workforce costs (UHBW)
- Negative productivity (as measured by NHSE) and linking elective recovery investment (of more inputs) with elective activity delivery (UHBW)
- Review of previous investments to ensure benefits realised (UHBW)
- Being at or close to funded establishment means timely delivery of CIP becomes more important and reallocating resources to meet operational needs becomes a priority to avoid incurring additional temporary staffing costs (NBT)
- Limited assurance that financial mitigations and recovery plans are sustainable beyond the current planning horizon and resilient to adverse scenarios (BOTH)

Planned Mitigation

UHBW

- Driving Productivity and Financial Improvement project (UHBW)
- Digital procurement, stores & materials management transformation project (UHBW)
- Medical Workforce Programme, reducing premium spend project (UHBW)

NBT

- Divisions and Trustwide teams need to develop plans to allow CIP schemes to be delivered (NBT)
- Additional controls to be applied to manage both substantive recruitment and committing additional temporary staffing costs (NBT)
- Improved non-pay governance actions underway (BOTH)

UHBW Corporate Risks

416	That the Trust fails to fund the Trust's Strategic Capital Programme	↔	20
7130	That the Trust is unable to fund the strategic estate programme	↔	16
7877	That there is Insufficient CDEL budget allocation	↑	16
291	Trust IT infrastructure does not meet the needs of a Digital hospital	↔	15
6494	That specialised commissioning structures (delegation) impacts income	↔	12
5375	That the Trust doesn't deliver the in-year financial plan	↔	12
674	That the use of agencies who are non-compliant with national pricing	↔	12
5645	That the Trust fails to achieve its stated Clean Air Hospital Framework	↔	12

NBT Trust Level Risks

1777	Negative financial impact from decarbonisation targets and carbon	↔	20
2087	Delivery of recurrent savings	↔	20

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through executive-led financial governance arrangements across both organisations.

During the quarter, one UHBW corporate finance risk relating to insufficient CDEL allocation increased in score and has been escalated to reflect its strategic impact on capital prioritisation and estates risk reduction. At North Bristol, one trust-level financial risk reduced below the escalation threshold following identification of additional non-recurrent income. These movements were reviewed through operational and corporate governance routes prior to reporting and are reflected in the current risk profile.

The principal risk has subsequently been reported to the Finance & Estates Committee, which has received assurance regarding financial recovery planning, capital constraints and sustainability measures, and has confirmed continued monitoring at principal risk level.
Operational financial risks continue to be managed through divisional and corporate financial governance structures, with escalation applied where thresholds are exceeded.

PRINCIPAL RISK 8. ESTATE		Trend
Executive Leads	Group Chief Finance and Estates Officer	↑ Increased
Board Committee	Finance & Estates Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
High	High	High	High	High	Moderate

Principal Risk Description

The hospital group faces a significant risk due to aging estate infrastructure, with UHBW's older buildings requiring modernisation and NBT's retained estate nearing the need for major refurbishment.

This risk cannot be fully mitigated through operational action alone, as limited decant space, competing priorities, and restrictions on capital expenditure, including CDEL limits, may delay essential upgrades and maintenance, increasing the likelihood of unplanned service failures, equipment malfunctions, and regulatory non-compliance.

If buildings become unsafe or unusable, clinical services may be disrupted or forced to close, impacting patient care and operational performance. This could compromise patient safety, disrupt clinical services, and negatively impact staff morale and patient experience.

Existing Controls

Board-level controls

- Capital Planning and Investment (BOTH)
- Collaboration and Strategic Partnerships (BOTH)
- Sustainability and Environmental Initiatives (BOTH)
- Risk Management and Contingency Planning Functions (BOTH)
- Health, Safety, and Compliance Functions (BOTH)
- Technology and Innovation (BOTH)

Operational controls

- Estate Management and Maintenance (BOTH)

Sources of Assurance

Independent / external assurance

- Internal Audit Reports (BOTH)
- Regulatory Inspections and Third-Party Assessments (BOTH)
- Quality Assurance Programs (BOTH)
- Certification Programs (BOTH)
- Submission of ERIC returns (BOTH)

Operational assurance

- Strategic Estates Plan (UHBW)
- Capital Planning Reports (BOTH)
- Premises Assurance Model (PAM) Reports (UHBW / being developed at NBT)
- Estates Returns Information Collection (ERIC) Benchmarking reports (BOTH)
- Health & Safety and Compliance Reports (BOTH)
- Performance Reviews (BOTH)
- Control of Infection Committee (NBT)

Independent – 3rd Line of Defence

Causal & Contributory Factors

- Aging Infrastructure (BOTH)
- Deferred Maintenance (BOTH)
- Technological Obsolescence (BOTH)
- Inadequate Funding (BOTH)
- Lack of Strategic Planning (BOTH)
- Regulatory Compliance Issues (BOTH)
- Environmental Factors (BOTH)
- Capital Expenditure Restriction (BOTH)
- Staffing Shortages (BOTH)
- Avalibility of decant facilities (BOTH)

Gaps in Controls or Assurance

- Technology integration (BOTH)
- Lack of full Condition Survey (BOTH)
- Lack of comprehensice Asset Registers (BOTH)
- Incomplete Planned Prevantative Maintance (PPM) Programme (UHBW)
- Data and information management (BOTH)
- Resource allocation (BOTH)
- Availability of decant space (BOTH)
- Workforce skills and training (BOTH)
- Workforce capacity (BOTH)
- Limited assurance on the feasibility and timing of capital delivery and decant solutions required to address estate risk within existing funding constraints (BOTH)

Planned Mitigation

UHBW

- Joint Estates Strategy to develop interim plan
- Heygroves Theatres refurbishment
- Neonatal Intensive Care Unit (NICU) Fire Safety
- Bristol Eye Hospital (BEH) Theatres

NBT

- Estates and W&C teams are assessing unresolved risks beyond available CDEL, identifying mitigation measures, and outlining business continuity plans for high-risk services
- The Bristol Surgical Centre *could* provide support in the event of catastrophic failure within other theatres

UHBW Corporate Risks

5325	BHOC services are compromised due to estate condition	↔	16
7130	The Trust is unable to fund the strategic estate programme	↔	16
7131	That the strategic estate programme is not delivered	↔	16
7877	That there is Insufficient CDEL budget allocation	↑	16
8237	Building Safety Act delays capital investment projects	↔	16
6112	Estates backlog maintenance may not be adequately funded	↔	15
3472	That the Trust fails to deliver the ICS Green Plan	↔	12
5540	The Trust infrastructure is inadequate for extreme weather	↔	12

NBT Trust Level Risks

1946	Condition of WACH Estate	↔	20
1587	Pathology Chiller Failure	↔	20
2059	Trip hazard due to exposed cables in patient bedrooms	↔	12

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through executive-led estates and capital governance arrangements across both organisations.

During the quarter, one UHBW corporate estates risk relating to insufficient CDEL allocation increased in score, reflecting the growing strategic constraint on capital delivery and risk remediation. One UHBW estates-related risk reduced following achievement of Clean Air Framework objectives. At North Bristol, specific estates risks have been reviewed following mitigation actions and decant works, with continued monitoring of condition-related exposures. These movements were considered through operational and corporate governance routes prior to reporting and are reflected in the current risk profile.

The principal risk has subsequently been reported to the Finance & Estates Committee, which has received assurance regarding capital prioritisation, backlog management and compliance planning, and has confirmed continued monitoring at principal risk level.

Operational estates risks continue to be managed through estates governance, capital programme boards and compliance forums, with escalation applied where thresholds are exceeded.

PRINCIPAL RISK 9. COMPLIANCE		Trend	Impact on Delivery of Strategic Priority					
Executive Leads	Chief Medical & Clinical Innovation Officer	↑ Increased	Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Audit Committee		MODERATE	HIGH	HIGH	MODERATE	MODERATE	MODERATE

Principal Risk Description	Existing Controls	Sources of Assurance	
This is a long-term, structural risk**.** Failure to comply with regulatory requirements, statutory duties, and NHS governance standards may lead to enforcement actions, financial penalties, reputational damage, and reduced public and stakeholder confidence. The complexity of operating as a Group introduces challenges in maintaining consistent compliance across both Trusts, particularly in areas such as data protection, health and safety, safeguarding, financial governance, and clinical regulations. Variability in local implementation of policies, differing regulatory interpretations, and resource constraints may contribute to non-compliance. Failure to meet Care Quality Commission (CQC), NHS England, and other regulatory requirements could result in enforcement actions, special measures, or increased scrutiny, impacting operational effectiveness and strategic priorities. Inadequate compliance mechanisms may also lead to legal liabilities, workforce implications, and compromised patient safety. Ensuring robust oversight, aligned governance frameworks, and clear accountability across the Group is critical to mitigating this risk.	Strategic / Board-level controls • Regular monitoring of compliance with accountability at Board level (BOTH) • Clear accountability for compliance across operational, clinical, and corporate functions (BOTH) • Specialist teams oversee key statutory areas and report compliance with related standards into operational groups (BOTH) • Policies and procedures covering regulated activities (BOTH) • Processes for reporting and escalating compliance breaches (BOTH) Operational / delivery controls • Regular staff training on key compliance areas, including GDPR, safeguarding, health and safety, and safeguarding and targeted training for high-risk roles (e.g., clinicians, data handlers) (BOTH) • Confidential freedom to speak up channels for staff to report compliance concerns without fear of retaliation (BOTH)	External / Independent • Internal audit reports (BOTH) • Reports from CQC, MHRA and other regulatory bodies (BOTH) Internal / Operational • Health & Safety Reports (BOTH) • CQC Action plans in response to inspections (BOTH) • Premesis Assurance Model reports (BOTH) • Safeguarding Reports (BOTH) • IQPR containg compliance with NHS England Oversight Framework Report (BOTH) • DSP Toolkit (BOTH) • Equality, Diversity & Inclusion Compliance (BOTH) • NICE Compliance (BOTH) • Environmental & Sustainability Compliance Report (BOTH)	Independant – 3rd Line of Defence

Causal & Contributory Factors	Gaps in Controls or Assurances	Planned Mitigation
• Frequent updates to NHS, CQC, and statutory requirements (BOTH) • Limited specialist compliance staff and training (BOTH) • Variability in applying policies across sites (BOTH) • Competing priorities deprioritising compliance activities (BOTH) • Third-party providers failing to meet regulatory standards (BOTH) • Delays in updating policies and unclear ownership (UHBW) • Differences in policies and governance create inconsistencies (UHBW) • Lack of integrated digital systems for compliance oversight (UHBW) • Lack of awareness and training on compliance requirements (UHBW)	• Complexity leads to no single, clear reference of obligations (BOTH) • Opportunities to improve training engagement (UHBW) • Inconsistent implementation and monitoring of policies (UHBW) • Limited independent assurance on the consistency of compliance maturity and regulatory readiness across all sites and services within the Group (BOTH)	UHBW • Fire Safety Programme (UHBW) • Objective to improve completion weekly fire evacuation checks (UHBW) • Neonatal Intensive Care Unit (NICU) Fire Safety project (UHBW) NBT • Business case approved for mortuary compliance works and funding allocated.

UHBW Corporate Risks				NBT Trust Level Risks			
8569	Mortuary and Body Stores do not meet the HTA/Fuller Requirements	↑	20	2152	IRR 17 compliance in diagnostic and interventional imaging	↔	16
2695	Risk that the Trust fails to establish and maintain robust governance	↔	12	2016	Mortuary Compliance with Human Tissue Act	↔	16

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through established compliance and corporate governance arrangements across both organisations.

During the quarter, one UHBW corporate compliance risk relating to mortuary and body store standards increased in score following inspection feedback and confirmation of gaps against HTA and Fuller requirements. At North Bristol, one trust-level compliance risk relating to AfPP staffing guidance escalated to reflect reassessment of regulatory exposure. These movements were reviewed through operational and corporate governance routes prior to reporting and are reflected in the current risk profile.

The principal risk has subsequently been reported to the Finance & Estates and Audit Committees, which has received assurance regarding regulatory compliance, action planning and oversight arrangements, and has confirmed continued monitoring at principal risk level.

Operational compliance risks continue to be managed through specialist governance forums and statutory oversight groups, with escalation applied where thresholds are exceeded.

PRINCIPAL RISK FIRE SAFETY		Trend	Impact on Delivery of Strategic Priority					
Executive Leads	Chief Strategic Finance and Estates Officer	↔ Unchanged	Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Finance & Estates Committee		LOW	MODERATE	MODERATE	MODERATE	HIGH	LOW

Principal Risk Description	Existing Controls	Sources of Assurance
The Trust continues to recognise fire safety as a principal strategic risk, reflecting the complexity and interdependency of the acute estate and the ongoing requirement to ensure robust whole-site compliance with statutory fire safety obligations. Due to the sensitive nature of information relating to estate configuration, fire compartmentation, evacuation strategy and mitigation measures, detailed risk narrative, controls, assurance position and mitigation trajectory are reported to the Board within private session. The Board and relevant subcommittees continue to receive regular assurance regarding fire safety compliance, progress against the Fire Improvement Action Plan, regulatory engagement and the adequacy of oversight arrangements. The decision to classify detailed fire safety information as confidential reflects the potential security sensitivities associated with publication of estate layout, compartmentation strategy and mitigation phasing.	<Redacted>	<Redacted>

Causal & Contributory Factors	Gaps in Controls or Assurance	Planned Mitigation
<Redacted>	<Redacted>	<Redacted>

UHBW Corporate Risks	NBT Trust Level Risks	Changes to Risks
<Redacted>	<Redacted>	<Redacted>

PRINCIPAL RISK CHANGE MANAGEMNT		Trend
Executive Leads	Group Formation Officer	↔ No change
Board Committee	Quality & Outcomes Committee	

Impact on Delivery of Strategic Priority					
Quality	Timely Care	People	Innovation	Resources	Commitment to Community
HIGH	MODERATE	MODERATE	HIGH	MODERATE	MODERATE

Principal Risk Description

The scale, pace and interdependency of change initiatives across the Group create a risk that the cumulative burden of transformation exceeds organisational capacity. This may place sustained pressure on staff and leaders, constrain the Trusts' ability to deliver strategic change alongside business-as-usual operations, and reduce the reliability and pace of transformation delivery.

If the overall change portfolio is not prioritised, sequenced and governed in a coherent and aligned way, there is a risk of strategic drift, workforce fatigue, cultural friction, financial inefficiency and operational disruption. Over time, this could undermine patient safety, service quality, delivery of the NHS 10-Year Plan and the Trusts' ability to realise the intended benefits of the Group model and wider system reform

Existing Controls

Strategic controls

- Group governance through the System Transformation Group, GEM and Programme Boards to set priorities and oversee delivery of the change portfolio.
- Group Development PMO providing portfolio coordination, dependency management and reporting.
- Patient First operating system and standardised change management framework supporting consistent design and delivery.
- Performance, benefits and risk reporting integrated into corporate and BAF oversight.

Operational controls

- Programme and project management disciplines, including stage-gates, milestones and delivery plans.
- Leadership, change and continuous improvement training to build delivery capability.
- Communications and stakeholder engagement to support staff understanding and adoption.

Sources of Assurance

Board-level assurance

- Regular reporting to the Board and Committees on priorities for improvement and change delivery.
- Integrated Quality and Performance Reports (IQPR) and balanced scorecard metrics providing oversight of delivery, capacity and impact.
- Internal Audit, external reviews and independent assurance over governance, programme delivery and controls.
- Corporate and BAF risk registers providing formal escalation and scrutiny.
- Benchmarking and peer comparison to test performance and maturity against national and system standards.

Operational assurance

- Programme and project reporting against milestones, benefits and delivery plans.
- Policies, procedures and standard operating frameworks supporting consistent change delivery.
- Staff feedback, engagement and incident reporting highlighting emerging pressures and impacts.
- Training and competency assessments confirming capability to deliver change safely and effectively.

Governance – 2nd Line of Defence

Causal & Contributory Factors

- Complexity and scale of the change agenda, with multiple interdependent initiatives whose purposes, sequencing and intended outcomes require continual clarification and communication.
- Inconsistent application of change management approaches, with variation in the use of tools, techniques and disciplines across programmes and divisions.
- Volume of concurrent projects and programmes, with insufficient prioritisation, sequencing and capacity planning across the total change portfolio.
- Complex and layered governance structures, which can slow decision-making, dilute accountability and create barriers to timely change.
- Limited capacity for staff involvement in co-design, driven by clinical and operational pressures that constrain time and engagement.
- Legacy of previous change programmes, which shapes staff confidence, expectations and appetite for new initiatives.
- Mismatch between perceived and available resources, including time, people, funding, space and enabling infrastructure required to deliver change.
- Competing stakeholder, system and regulatory demands, which pull the organisation in different directions and create conflicting priorities across the change portfolio.

Gaps in Controls or Assurance

- Limited capacity within the Improvement and Transformation functions to deliver training, coaching and support at the pace required by the scale of the change portfolio.
- Constraints on staff availability to attend training and participate in change activity, particularly for clinical leaders, reducing the organisation's ability to consistently apply Patient First, change and programme management methodologies.
- Difficulty in releasing clinical and operational leaders from business-as-usual responsibilities to lead and sponsor major change programmes, weakening ownership and delivery confidence.
- Variable awareness and understanding of strategic priorities, Patient First and the overall change agenda across the organisation, limiting alignment and engagement.
- The Group Development PMO is currently resourced for the Design phase only, with the scale, skills and capacity required to support full implementation, benefits realisation and dependency management still being defined.
- Limited assurance over total change capacity and affordability, meaning the organisation cannot yet reliably demonstrate that the full portfolio of change is deliverable alongside business-as-usual operations.

Planned Mitigation

Patient First Deployment directly mitigates this risk:

- Focus on smaller number of improvement projects at corporate, division, specialty and team levels to enable focus of improvement resource and accelerate pace of change
- Systems, processes and tools for change projects with focus on purpose and root cause understanding
- Dedicated Continuous Improvement team providing training, coaching and support to teams undertaking improvement
- Trustwide training programmes in leadership, management and coaching, and leadership for change aligned to the Patient First approach
- Communication plan underway for Trust strategy A Difference that Matters raising awareness of strategic priorities and local team contributions to achieving
- Group Development focus on delivery of Joint Clinical Strategy and corporate enablers included in strategic priorities.

UHBW Corporate Risks

7875	Business as usual is disrupted due to Group Model implementation	↔	12
2695	Risk that the Trust fails to establish and maintain robust governance	↔	12

NBT Trust Level Risks

Changes to Risks

This principal risk has been reviewed during the Quarter 4 cycle through executive-led transformation and portfolio governance arrangements across the Group, including GEM and to the Quality & Outcomes Committee.

During the quarter, associated corporate risks relating to business-as-usual disruption and governance maturity were reviewed through operational governance forums. No new trust-level risks were escalated during the reporting period; however, the cumulative impact of concurrent change initiatives continues to be monitored closely to ensure alignment, prioritisation and capacity management.

Report To:	Public Group Board Meeting		
Date of Meeting:	Tuesday 10 March 2026		
Report Title:	Risk Appetite Statement		
Report Author:	Sarah Wright, Head of Risk Management, UHBW		
Report Sponsor:	Lavinia Rowsell, Group Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	To present the Group Risk Appetite Statements to the Board for formal approval and adoption.		

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

The attached Risk Appetite Statements were developed following the Group Board Risk Appetite Seminar held in October 2025.

During that session, Board members discussed and agreed the Group's overarching approach to risk appetite, including:

- Adoption of the Good Governance Institute (GGI) definition of risk appetite
- Agreement of appetite levels across principal risk domains
- Confirmation of tolerance thresholds to inform corporate risk escalation
- Agreement of the overarching "risk appetite triangle" framing.

The document reflects the outcomes of that seminar and subsequent consolidation into a formal statement. Following the seminar, the statements were circulated to Board members for endorsement.

The purpose of this paper is not to revisit the substance of the appetite discussion, but to seek formal Board approval so that the statements can be:

- Incorporated into the Risk Management Strategy and Policy
- Used to inform Board Assurance Framework (BAF) calibration
- Applied consistently across risk registers and escalation thresholds
- Referenced in decision-making and business case development.

Strategic and Group Model Alignment

The Risk Appetite Statements support:

- Delivery of the Group's strategic objectives
- Effective oversight of principal risks
- Proportionate escalation of corporate risks
- Transparent and consistent decision-making.

Risks and Opportunities

- Decision-making may lack an agreed reference point when balancing risk and opportunity, particularly within the Group operating model.
- There is a risk of continued legacy variation between organisations in the absence of a single, endorsed position.

Recommendation		
The Board are asked to: • **Approve** the Risk Appetite Statements as set out in the attached document • **Agree** that the statements will be adopted as the formal Group position and embedded within risk management processes going forward.		
History of the paper (details of where paper has <u>previously</u> been received)		
Group Executive Team		November 2025
Appendices:	Appendix A – Risk Appetite statement	

Appendix A: Risk Appetite – Bristol NHS Group – March 2026

Bristol NHS Group adopts the Good Governance Institute (GGI) definition of risk appetite as 'the amount and type of risk that an organisation is prepared to pursue, retain or take' in achieving its objectives. Risk appetite provides the board with a framework to **balance opportunity with risk**, and to set clear expectations for decision-making. It is distinct from tolerance, which is the day-to-day variation management can operate within.

Risk appetite levels (**definitions**):

- **None** – avoidance of risk, absolute priority on compliance/safety
- **Minimal** – preference for only safe, proven options
- **Cautious** – willing to accept some limited risk in carefully managed circumstances
- **Open** – ready to consider balanced risk-taking where benefits justify it
- **Seek** – actively willing to take significant risks for substantial benefit

Risk types:

Risk Type:	Description
Patient Safety	Covers risks that could cause harm to patients through clinical error, system failure, delayed treatment, or unsafe care environments.
Patient Experience	Covers risks that affect the dignity, comfort, communication, and overall experience of patients and families.
Workforce	Covers risks affecting the Group's people, including ability to attract, recruitment, retention, wellbeing, morale, training, equality, diversity, inclusion, and culture.
Performance	Covers risks to delivery against national standards and constitutional targets and the ability to meet operational performance expectations and/or commitments in annual plan.
Finance	Covers risks to financial sustainability, value for money, efficiency, income, expenditure, and ability to demonstrate a strong control environment and deliver statutory financial duties including the annual plan.
Regulatory	Covers risks of non-compliance with laws, regulations, licence conditions, statutory and mandatory requirements, and external regulatory frameworks
Reputational	Covers risks to the reputation of the Group which might negatively impact the public, political, or regulatory perspective of the Group.

Risk Appetite Approach

The Group Board recognises that risk is taken within a broader strategic and operational context, and that this context is critical to understanding both the nature and value of risk. Risk appetite is not simply about avoiding harm – it is about actively balancing risk with opportunity and seeing both dimensions in every decision.

We acknowledge that viewing risk appetite solely through traditional categories – such as patient safety, workforce, finance, or reputation – can be limiting. Instead, we commit to considering risks holistically, recognising the interdependencies across domains and the need to make decisions that reflect both immediate pressures and longer-term ambitions.

Our approach is guided by a risk appetite triangle: balancing risk, opportunity, and the delivery of minimum standards. We are prepared to take risks and pursuing opportunities across all risk types, using data and evidence wherever available to inform our decisions. Where data is lacking, we will ensure our approach generates the insight needed to evaluate and refine our position over time.

The Board understands that some risks may be worth taking now to unlock future benefits, and we will remain thoughtful and transparent in how we assess and communicate these trade-offs.

Risk Type:	**Appetite level**	**Tolerance level***	**Statement**
Patient Safety	**Cautious**	**≥** 12	We will take measured and considered risks to improve and deliver safety outcomes where there is potential for significant benefit however, we will not knowingly compromise the safety of our patients.
Patient Experience	**Open**	**≥** 16	We are open to trying new and innovative approaches to improving patient experience and recognise that in limited circumstances we may have to risk poorer patient experience to reduce risk in other areas such as patient safety.
Workforce	**Open**	**≥** 16	We will explore innovative practices and opportunities that fit with our values and behaviours, despite higher inherent risk.
Performance	**Open**	**≥** 16	We are keen to trying new approaches, recognising the need to maintain minimum standards.
Finance	**Open**	**≥** 16	We are keen to trying new approaches, recognising the need to maintain delivery of a balanced plan and commitments to regulators.
Regulatory	**Minimal /Open**	**≥** 12	Our appetite for risk is minimal where failure can risk our services or patients, open where we have the relationships to mitigate and can justify our position.
Reputational	**Cautious**	**≥** 12	We recognise that a good reputation will open doors and provide opportunities for the benefit of our patients, our people, our populations, and the public purse.

*Tolerance level will inform what risks are classified as Corporate Risks / Trust Level Risks and reported to Group Executive / Committees / Board.

No risk exists in isolation from others, and risk management is about finding the right balance between risks and opportunities to act in the best interests of our patients, our people, our population and the public purse. When balancing risks, we will tolerate some risks more than

others. For example, we will seek to minimise avoidable risks to patient safety in the delivery of care but in the case of innovative approaches to service delivery, we are open to taking risks so long as appropriate controls are in place. Where we have identified a risk appetite of open or higher, this still means that appropriate action must be taken to understand and manage the risk, including:

- A clear and comprehensive risk assessment, ensuring that the risk is understood, and that trade-offs and unintended impacts have been considered.
- Clear controls and mitigations are in place, and that the risk has been reported and escalated in line with the Trust's policy.
- We can evidence that there are worthwhile and measurable potential benefits to taking the risk.
- Appropriate rapid cycle monitoring is in place to enable swift corrective action if necessary.

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Report 2025		
Report Author:	Paul Cousins, EPRR Manager		
Report Sponsor:	Nick Smith, Chief Operating Officer (NBT)		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The purpose of this report is to brief the Group Board on the outcome of the 2025 Emergency preparedness, resilience and response (EPRR) annual assurance process		

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

North Bristol NHS Trust (NBT) is a "Category 1 Responder" under the Civil Contingencies Act (CCA) 2004 and has a responsibility to ensure local arrangements are in place should an emergency occur.

The outcome of the Emergency Preparedness Resilience and Response (EPRR) Assurance process is that North Bristol Trust's compliance level for 2025 is Substantial (93%) with the assessment showing 58 of 62 compliance of standards.

Strategic and Group Model Alignment

This report aligns with the Trust's Patient First priorities of Innovate to Improve through effective debriefing after exercises and incidents. This helps to identify areas for improvement to our processes which benefit patient care and outcomes throughout the Trust during an incident.

This report also aligns with delivering High Quality Care through ensuring that our emergency planning arrangements and learning from incidents has patient experience as the core purpose whilst ensuring safe and effective response plans.

One of the underpinning principles for EPRR within the NHS is cooperation and integration. This requires organisations to adopt a positive relationship through mutual trust and information sharing. This will be a key 2026/27 priority for EPRR to continue to strengthen the existing collaboration with University Hospitals Bristol and Weston (UHBW) across training, emergency response plans, business continuity and shared learning as we move forward with the merger.

EPRR activity directly supports the 4Ps by protecting **Patients** through robust preparedness and response plans, safeguarding our **Population** through effective risk assessment and system wide coordination, supporting our **People** with clear roles, training and safe working practices and ensuring efficient use of resources in line with the **Public Purse**. This alignment reflects national EPRR expectations and strengthens collaborative working across the system.

Risks and Opportunities

The merger of the NBT and UHBW EPRR teams presents a strategic opportunity to enhance organisational resilience by creating a single, integrated function with consistent standards, streamlined governance and a unified Command and Control structures. A combined team would strengthen system-wide collaboration, improve workforce sustainability through shared capacity and mutual aid and support more efficient operational processes. It would also enable a coordinated training and exercising programme, reduce duplication, maximise specialist expertise and deliver better utilisation of resources. Collectively, these benefits would contribute to a more resilient, coherent and effective EPRR service across the organisation
Recommendation
This report is for Information. The Trust Board is asked to note that the Trust is 'substantial compliant' with the NHS Core Standards for EPRR and the areas of improvement required to achieve full compliance in 2026
History of the paper (details of where paper has <u>previously</u> been received)

Emergency Preparedness, Resilience and Response Group	27th January 2026
Appendices:	Appendix 1. Confirmation letter from NHSE: Emergency Preparedness, Resilience and Response (EPRR) annual assurance outcome for 2025

1. Purpose

To provide the Trust Board with the Trust's Emergency Preparedness Resilience and Response (EPRR) Annual Report for 2025 for assurance.

2. Background

2.1 North Bristol NHS Trust is a "Category 1 Responder" under the Civil Contingencies Act (CCA) 2004 and has a responsibility to ensure local arrangements are in place should an emergency occur.

2.2 The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

2.3 The applicability of each domain and core standard is dependent on the organisation's function and statutory requirements.

3. Annual NHS England Assurance Process

3.1 NHS Providers organisations are required to undertake annual self – assessment covering 62 core standards as set out in the NHS Core Standards for EPRR Guidelines and a series of deep dive questions which change on an annual basis.

3.2 In August 2025, SWAST completed an CBRN capability review which fed into the overall assurance process.

3.3 Core Standard Overview

Domain	Self assessment RAG
Governance	Fully compliant
Duty to risk assess	Fully compliant
Duty to maintain plans	Fully compliant
Command and control	Fully compliant
Training and exercising	Fully compliant
Response	Fully compliant
Warning and informing	Fully compliant
Cooperation	Fully compliant
Business Continuity	Fully compliant
Hazmat/CBRN	Partially compliant

4. 2025 Annual Report

4.1 The Trust has completed the annual self-assessment and has confirmed substantial compliance against 58 of 62 applicable core standards of an Acute NHS Organisation

4.2 NHSE has reviewed the Trusts self-assessment and has provided formal written confirmation of the substantial complaint status to BNSSG ICB following the confirm and challenge meeting held with BNSSG ICB on 29th September **(See Appendix 1)**

4.3 The overall compliance rating is a decrease in overall compliance from full to Substantial

4.4 The trust scored partially complaint for CBRN – Planning arrangements CBRN - Equipment and supplies, CBRN - Equipment - Preventative Programme of Maintenance, CBRN - Staff training - recognition and decontamination

4.5 The Trust expects to achieve full compliance with its planning arrangements (58) by 1st April 2026.The current CBRN policy is undergoing review with key stakeholders and is being updated to reflect the latest government guidance

4.6 The Trust expects to achieve full compliance with Equipment and Supplies (60) for the 2026 review. Since the review, the A&E Department has implemented a robust system that provides a complete inventory including asset numbers and expiry dates.

4.7 The Trust expects to achieve full compliance with Preventative Programme of Maintenance (61) for the 2026 review. Since the review, EPRR & A&E Department has set up a shared CBRN channel where a database of equipment audits and maintenance logs

4.8 The Trust expects to achieve full compliance with Staff Training, Recognition and Decontamination (64) by 1st April. Feedback from the review highlighted the need for updated training for the Security team. Arrangements are now being implemented to ensure all Security staff receive this training as part of business as usual processes.

5. Summary and Recommendations

5.1 The Trust Board is asked to **note** that the Trust is 'substantial compliant' with the NHS Core Standards for Emergency Preparedness Resilience and Response (EPRR) and the actions being taken to address the areas of improvement.

Our Reference: BNSSG/Nov25

To: David Jarrett, Chief Delivery Officer (Accountable Emergency Officer), NHS BNSSG ICB

Copy: Janette Midda, EPRR Manager, NHS BNSSG ICB
Ian Phillips, Dep. Director Resilience, NHS England

Keith Grimmett
NHS England South West
Head of EPRR

Tel: 07783 816496
Email: k.grimmett@nhs.net

06 November 2025

Sent by email

Dear David,

NHS BNSSG Integrated Care Board (ICB) and System Emergency Preparedness, Resilience and Response core standards assurance confirm and challenge outcome.

Thank you for preparing and submitting your self-assessment and supporting evidence. This letter summarises the outcome from the confirm and challenge meeting held on 9 October 2025, capturing any agreed actions and points from our discussions.

ICB Outcome Summary

Organisation	2024	2025
NHS BNSSG ICB	Full	Full

Your organisational compliance level for 2025 is Full, with the assessment showing full compliance against 100% of applicable standards (47 of 47). See annex 1 for descriptors.

ICB Good Practice and Innovation

1. Pro-active System leadership of new arrangements and capabilities, such as National Power Outage Planning in 2024 and Evacuation and Shelter in 2025.
2. Continued effective engagement with LHRP partners, particularly notable regarding the Local Authorities.
3. Maintaining emphasis on training and exercising, such as an updated Training Needs Analysis and Exercise Celestial Sphere in support of the North Bristol Trust HCID capability.

NHS England Observations

The leadership and wider organisational support of EPRR in the ICB continues to provide the foundations for a stable and consistent programme of work.

The structured approach to planning and horizon scanning, along with a willingness to tackle difficult issues, has facilitated progressive planning arrangements that have been utilised both within BNSSG and in neighbouring Systems.

This has been achieved in a relatively complex System given the number of organisational relationships within the LHRP and wider LRF.

System Outcome Summary

You provided a full and concise overview of the approach you have used to undertake the EPRR Core Standards confirm and challenge process with your commissioned providers for 2025.

Organisation	2024	2025
AWP	Full	Full
NBT	Full	Substantial
Severnside	Full	Substantial
Sirona	Substantial	Partial
UHBW	Substantial	Full
South West Ambulance Service NHS Foundation Trust	Full	Substantial

NHS England System Observations

There are two organisations achieving Full compliance which we congratulate and acknowledge the effort and hard work that contributes to the achievement.

Two organisations have decreased in overall compliance from ‘Full’ to ‘Substantial’ (excluding SWASFT). The context you have provided relating to staffing changes is acknowledged and your proposed actions to monitor compliance accepted.

One organisation has shown a deterioration from Substantial to Partial which has triggered the need for enhanced monitoring and support until a stable position is resumed. You described appropriate interventions to achieve this and NHSE is available to support as required.

The SWASFT assessment is provided by Dorset ICB and monitored through their assurance processes, to which you have contributed as required.

Next Steps

The outcome of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHSE South West Regional Executive Team before being submitted to the NHSE National Resilience Team.

We welcome any reflections you may have on this year's assurance process and invite your feedback via your EPRR practitioners.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,

Keith Grimmett, Head of EPRR

NHS England South West

Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025 UHBW		
Report Author:	Damien Macdonald, EPRR Manager UHBW		
Report Sponsor:	Philip Kiely, Chief Operating Officer UHBW		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The purpose of this report is to brief the Group Board on the outcome of the 2025 EPRR annual assurance process against the NHSE Core standards for EPRR.		

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

University Hospitals Bristol and Weston (UHBW) NHS Foundation Trust is a Category 1 responder under the Civil Contingencies Act 2004. The act requires us to adhere to a number of duties under the act in relation to emergency preparedness and business continuity.

We are measured against these using the NHSE EPRR core standards of which there are 62 standards across 10 domains that we are measured against.

In 2025 UHBW were recorded as fully compliant (100%) against all 62 standards.

Strategic and Group Model Alignment

This report provides assurance on UHBW's compliance with the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and supports the Trust's strategic direction by confirming the robustness of arrangements that protect patient safety, staff wellbeing and service continuity during major incidents and periods of disruption.

Effective EPRR arrangements underpin delivery of the Patient First programme by supporting safe, reliable and resilient care, particularly during times of exceptional pressure. Compliance with the Core Standards ensures the Trust can maintain critical services, manage surges in demand and support staff to respond effectively to emergencies.

The report primarily aligns to the True North Strategic Priority of Safety, providing assurance that risks arising from major incidents and emergencies are effectively managed. There is also a clear contribution to Quality, as resilient systems support consistent delivery of high-quality care under all circumstances.

EPRR is a system-wide responsibility, and this report reflects UHBW's role as a Category 1 responder within the Integrated Care System and Local Resilience Forum. The findings and recommendations support alignment with system strategy by promoting coordinated planning, shared standards and effective multi-agency response arrangements. Any improvement actions identified have system relevance and should be considered collaboratively to strengthen collective resilience.

EPRR supports the 4P's in the work we do to keep patients safe by:

- **Patients** – More consistent and coordinated responses during major incidents.

• **Population** – Improved system resilience in protecting population health. • **People** – Shared training, exercising and leadership capability. • **Public Purse** – Opportunities for efficiency through shared approaches and resources. Overall, the report demonstrates that EPRR compliance is a key enabler of the Trust's strategic objectives and provides a strong platform for future system and provider collaboration.
Risks and Opportunities
The merger of UHBW and NBT will allow opportunities to strengthen and enhance our resilience through a single Incident Response Plan allowing aligned responses to incidents, training and exercising opportunities. There are however inherent risks specifically at UHBW surrounding the estate challenges and a large amount of time has been spent in 'response' meaning there is a risk that other preparedness mitigations aren't as strong as they could be. These are outlined in Datix risks 8964 and 8963.
Recommendation
This report is for **Information**. The Board is asked to **note** that UHBW is 'fully compliant' with the NHS Core standards for EPRR in 2025.
History of the paper (details of where paper has <u>previously</u> been received)

UHBW Trust Management Team	3rd January 2026
Appendices:	Appendix 1: NHSE to BNSSG ICB Outcome letter Appendix 2: UHBW EPRR Core standards confirm and challenge notes

1. Purpose

1.1 To provide the Group Board with the UHBW Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2025 Assurance.

2. Background

2.1 UHBW is defined by the Civil Contingencies Act 2004 as a Category 1 responder which requires us to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency

These are measured through the NHSE Core standards for EPRR of which there are 62 standards for acute NHS Trusts across 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business Continuity
10. Hazmat / CBRN (Chemical, Biological, Radiological and Nuclear)

3. Summary and Recommendations

The Board is asked to **note** that UHBW is 'fully compliant' with the NHS Core standards for EPRR in 2025.

Our Reference: BNSSG/Nov25

To: David Jarrett, Chief Delivery Officer (Accountable Emergency Officer), NHS BNSSG ICB

Copy: Janette Midda, EPRR Manager, NHS BNSSG ICB
Ian Phillips, Dep. Director Resilience, NHS England

Keith Grimmett
NHS England South West
Head of EPRR

Tel: 07783 816496
Email: k.grimmett@nhs.net

06 November 2025

Sent by email

Dear David,

NHS BNSSG Integrated Care Board (ICB) and System Emergency Preparedness, Resilience and Response core standards assurance confirm and challenge outcome.

Thank you for preparing and submitting your self-assessment and supporting evidence. This letter summarises the outcome from the confirm and challenge meeting held on 9 October 2025, capturing any agreed actions and points from our discussions.

ICB Outcome Summary

Organisation	2024	2025
NHS BNSSG ICB	Full	Full

Your organisational compliance level for 2025 is Full, with the assessment showing full compliance against 100% of applicable standards (47 of 47). See annex 1 for descriptors.

ICB Good Practice and Innovation

1. Pro-active System leadership of new arrangements and capabilities, such as National Power Outage Planning in 2024 and Evacuation and Shelter in 2025.
2. Continued effective engagement with LHRP partners, particularly notable regarding the Local Authorities.
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NHS England Observations

The leadership and wider organisational support of EPRR in the ICB continues to provide the foundations for a stable and consistent programme of work.

The structured approach to planning and horizon scanning, along with a willingness to tackle difficult issues, has facilitated progressive planning arrangements that have been utilised both within BNSSG and in neighbouring Systems.

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There are two organisations achieving Full compliance which we congratulate and acknowledge the effort and hard work that contributes to the achievement.

Two organisations have decreased in overall compliance from ‘Full’ to ‘Substantial’ (excluding SWASFT). The context you have provided relating to staffing changes is acknowledged and your proposed actions to monitor compliance accepted.

One organisation has shown a deterioration from Substantial to Partial which has triggered the need for enhanced monitoring and support until a stable position is resumed. You described appropriate interventions to achieve this and NHSE is available to support as required.

The SWASFT assessment is provided by Dorset ICB and monitored through their assurance processes, to which you have contributed as required.

Next Steps

The outcome of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHSE South West Regional Executive Team before being submitted to the NHSE National Resilience Team.

We welcome any reflections you may have on this year's assurance process and invite your feedback via your EPRR practitioners.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,

Keith Grimmett, Head of EPRR

NHS England South West

Annex 1: Compliance Levels

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UHBW EPRR Core Standards – Confirm and Challenge Meeting

1. Minutes of the meeting held on 2nd October 2025 at 15:00pm-15.30pm, via MS Teams.

Minutes

Present		
David Jarrett (Chair)	BNSSG ICB	DJ
Janette Midda	BNSSG ICB	JM
Jack Robison	BNSSG ICB	JR
Emilie Perrie	UHBW	EP
Damien Macdonald	UHBW	DM
Sebastien Denault	UHBW	SD

	Item	**Action**
01	### Introduction David Jarrett welcomed attendees, introduced the session, and outlined the agenda: updates on progress/achievements, feedback on submissions, agreement on next steps, and preparation for the upcoming regional review	
02	### Detailed Review of Self-Assessment • Damien took over the EPRR lead role in January, succeeding John Wintle. • Outlined work completed with Sebastien Denault since January and plans for the rest of 2025 and into 2026. • Governance changes due to group formation with NBT (NHS Bristol) and interim structures; possible merger next year.	

	Item	Action
	• Emphasis on maintaining compliance and early preparation for changes. **Key Areas of Work:** • **Duty to Maintain Plans**: o High Consequence Infectious Diseases (HCID) plan refreshed via a task and finish group. o Collaboration with IPC colleagues and emergency departments. o PPE stockpiling and best practice sharing with NBT. • **Disaster Recovery**: o Working with IMT on disaster recovery processes for clinical and non-clinical systems. o Ensuring incident response and lockdown plans are up to date. • **Lockdown Plans**: o Refreshed plans following incidents, especially in Bristol. o Collaboration with Western for site-specific security arrangements. • **Command & Control**: o New On-Call Manager Forum for sharing experiences and micro-learns. Good attendance (30-40 participants). o Reviewing On-Call model for fitness and support. o Major incident cascade improvements with Switchboard and SWAST. • **Training & Exercising**: o Refreshed loggist training (Sebastien Denault led). o Plans for tactical level training for On-Call managers (aiming for 75% baseline, with ambition for 100%). o Upcoming winter exercise to test divisional winter plans and new full capacity plan.	

	Item	Action
	• **Incident Coordination Centre (ICC) Refresh**: o Modernising ICC facilities, learning from power outage incidents. • **Cooperation**: o Strong representation at LHRSCP and LRF Tactical Coordinating Group meetings. o Developing MOU with Sirona for mass casualty arrangements (use of South Bristol Community Hospital for P3 casualties). o IPTT radios procured for system-wide communication. o Participation in regional and system exercises (Pegasus, NPO, Emergo). • **Business Continuity (BC)**: o New business impact analysis tool rolled out. o Support for divisions in updating BC plans. o Collaboration with digital matrons on CMM rollout and exercise design. o Sebastien Denault pursuing CBCI qualification. o DSPT standards met this year. o Business Continuity Planning Group established. • **CBRN**: o Tents renewed at BRI and Western. o Improved control over Brown Genie servicing and compliance. o Planning a blended Emergo/live exercise for CBRN response. **Priorities for Next Year:** • Training (benchmark 75%, aim for 100%). • Fit-for-purpose exercise plan (proactive and embedded).	

	Item	Action
	• Incident Response Plan (IRP) and major incident plans to be split for clarity. • CBRN improvements ahead of next year's capability review.	
03	**Feedback and Discussion** • All submitted documents meet minimum standards; compliance confirmed. • EPMS in draft, work plan received. • No issues with risk documentation or plans. • Some reviews are biannual, so not all are documented for 2024, but work plan and EPMS will address this. • Evacuation shelter validated twice (recent outage and St. Michael's fire). • MOU with Sirona for mass casualty arrangements is progressing well. • Command and control, training, and exercise documentation are robust. • Communications plan and cascade arrangements in place for warning and informing. • Strong cooperation with local resilience partnerships and attendance at relevant meetings. • Business continuity documentation is strong, especially for sexual health and pharmacy. • CBRN documentation is adequate, but some documents have not been reviewed for 11 months; improvements planned for next year. • Overall, 100% compliance achieved, with recognition that further development is planned for the coming year.	
05	**Next Steps** • Regional meeting with NHS England scheduled for Thursday, October 9, 2025. • Annual letter of assurance to be issued following the regional meeting. • Maintain and build on compliance for next year.	
	Any Other Business None.	

Jack Robison
EPRR Officer

Report To:	Public Group Board Meeting		
Date of Meeting:	10 March 2026		
Report Title:	Integrated Governance Report		
Report Author:	Kelly Jones, Corporate Governance Officer		
Report Sponsor:	Lavinia Rowsell, Group Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	To present the integrated governance report, which brings together the Committee Chairs' upwards reports, the registers of seals for UHBW and NBT, and other governance related items.		

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

Attached are the following items for the Board's information:

Committee Chairs' Reports from the January, February and March 2026 meetings:
Group Audit Committee (Appendix A) – 17 February
Group Digital Committee (Appendix B) – 22 January
Group Finance & Estates Committee (Appendix C) – 27 January and 3 March
Group People Committee (Appendix D) – 29 January
Group Quality and Outcomes Committee (Appendix E) – 27 January and 24 February

Register of Seals – January to February 2026 (Appendix E)

Strategic and Group Model Alignment

These documents directly support the Board's ambition to form a Group, and these documents support the new governance model being implemented.

Risks and Opportunities

None.

Recommendation

This report is for **Information.**

The Boards are asked to note the appendices to this report.

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

N/A	

Appendices:	Appendix A: Group Audit Committee Appendix B: Group Digital Committee Appendix C: Group Finance & Estates Committee Appendix D: Group People Committee Appendix E: Group Quality and Outcomes Committee Appendix F: Register of Seals (see below)

Appendix F: Register of Seals

NBT Register of Seals

January to February 2026

There was no use of NBT's seal between January to February 2026.

UHBW Register of Seals

January to February 2026

Reference Number	Document	Date Signed
933	Lease and Licence Agreement for Unit 2B, Level 2, Queen's Building, BRI (The Stock Shop)	02/02/2026

NHS Bristol NHS Group Bristol | Weston

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Audit Committee - 17 February 2026**
Chaired By	**Richard Gaunt, Group Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

- The Committee received the Merger Oversight Framework and Post-Transaction Implementation Plan (PTIP) for information and consideration of risks. The only risk flagged by other committees was that associated with a single capital position. The merger process, including gateways and timelines, was discussed. The Committee noted the operational focus of the PTIP. The possibility of post-merger dips in performance was highlighted as a potential risk. The need for an increased focus on hearts and minds in the Communications plan was noted.

- The Committee received progress reports from both trusts' external auditors. There were no exceptional items to note. The Committee also approved the external auditor fees for 2025/26.

- The Committee reviewed the Board Assurance Framework (BAF) for Quarter 4 2025/26 (1 January 2026 to 31 March 2026) and noted the potential reintroduction of two principal risks. Work was continuing to align the NBT and UHBW risk management frameworks. The Committee discussed the Group's level of confidence in managing risks in the changing operational environment, including aligning risk reporting from Day 1 of the merger and reducing the number of risks overseen by the Committee following the revised Group appetite work carried out last year.

- The Committee received the following internal audit final review reports and discussed the assurance ratings.

    - UHBW16/26 – SAP Ariba Post implementation (*joint review with NBT*) – limited assurance. This complex audit involving several UHBW and NBT departments and BWPC identified several key issues, particularly in relation to the rapid implementation of the new system. The Committee highlighted the need for good implementation procedures, project management and planning in future large digital projects. The Digital and Finance and Estate Committees would monitor progress.

    - UHBW19/26 – Health and Safety – limited assurance. The Finance and Estates Committee would monitor progress.

    - UHBW09/26 – Limited Assurance Follow-up Business Continuity (3rd Party IT Contracts) – limited assurance. Several closed recommendations had not been fully implemented. The Digital Committee would monitor progress.

- UHBW13/26 – Limited Assurance Follow-up Cyber Security – limited assurance. All recommendations had been agreed by the Digital Team. The Digital Committee would monitor progress.

- NBT05/26 – HR Disciplinary Case Management – limited assurance. The audit found no discrimination with regard to the HR disciplinary case management process but several discrepancies and inconsistencies in the new HR system which the Committee was assured were being addressed. The People Committee would monitor progress.

- The Committee received the following UHBW and NBT Audit reports, all with satisfactory assurance ratings: UHBW29/26 – Patient Safety Alerts; UHBW25/26 – Use of Volunteers; UHBW21/26 – Job Planning; NBT03/26 – High Level Financial Controls.

- The Committee received the UHBW audit reports UHBW04/26 – High Level Financial Controls and UHBW15/26 – Waste Management, which were given significant assurance ratings.

- The Committee received the NBT audit report NBT07/26 – Waiting List Management (Clinical Prioritisation Process), which had not been given an assurance rating as work was still ongoing. This report would be brought back to the next Committee meeting with an assurance rating.

The number of overdue audit actions was the lowest for some time.

- The Committee received the 2026/27 Draft Internal Audit Programme for NBT and UHBW for discussion. Members requested a focus on the no-criteria-to-reside situation. Discussion was taking place with People leaders to identify topics for internal audit. Contingency would need to be built into the plan to respond to dynamic nature of change during the next financial year. A further version would be brought to the April Committee meeting.

- The Counter Fraud Progress Reports for each trust were received.

- The Committee reviewed the Losses and Special Payments reports for both trusts for Quarter 3 2025/26. UHBW Pharmacy losses were noted to be high due to specialty mix and high-value oncology medicines. Work to reduce losses of patient property was noted. Although their monetary value was relatively small, the importance to patients and families was acknowledged.

- A report on Single Tender Actions at both trusts was received.

- The Group Audit Committee Business Cycle for 2026/27 was received.

• The Committee discussed the annual Committee Self-Assessment questionnaire.
For Board Awareness, Action or Response
• The Committee discussed the role of committees in overseeing audits of areas falling within their remit and agreed that all audits with limited assurance ratings would be sent to the relevant committee for discussion and monitoring. • The response to a limited assurance report on a previous limited assurance report would need to be considered further and refined.
Key Decisions and Actions
N/A
Additional Chair Comments
N/A
Update from ICB Committee
N/A

Date of next meeting:	**3 March 2026 (extraordinary meeting)** **30 April 2026 (ordinary meeting)**

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Digital Committee – 22 January 2026**
Chaired By	**Roy Shubhabrata, Group Non-Executive Director**
Executive Lead	**Neil Darvill, Group Chief Digital Information Officer**

For Information

The Committee met on 22 January 2026 and received the following reports:

1. **Operational Update:** The Committee received updates on Operational Performance across both Trusts. Key highlights included:
    - The NHS mail migration had moved into the "readiness" phase.
    - Delivery of the Digital Patient Engagement Programme was underway across the Group. The programme was in its early stages, with a fuller programme update due in March.
    - Drug library mapping had been successfully completed in CareFlow Medicines Management (CMM), the e-prescribing system, with no reported issues, which was noted as a significant achievement.
    - Further work and discussions were ongoing in relation to Digital priorities, such as the West of England Regional Image Sharing Business Case and the UHBW Ambient Voice Technology Business Case.

    The Committee discussed the impact of the NHS mail migration on staff and its interdependencies with the Merger, cyber preparedness and the need for investment to support full technical recovery in the event of a cyber-attack, and concerns about the ongoing delays with electronic prescribing at the Children's Hospital.
2. **Merger Full Business Case (FBC) and Post Transaction Integration Plan (PTIP):** The Committee received the Merger FBC and PTIP. They heard that the documents set out a strong merger rationale and expected benefits. While the Committee sought confidence on the realism of Day 1 plans, the Digital Team confirmed they were collectively confident in delivery, with further detailed work continuing.
3. **2026 Roadmap and Beyond:** The Committee received the Group Digital Roadmap, which outlined the significant scale, complexity and interdependencies of the programme to 2029. It was noted that, while individual projects appeared manageable, the collective portfolio was substantial and exceeded current delivery capacity, requiring a formal prioritisation process and clearer articulation of risks. The Committee discussed the widening gap between ambition and resources, the impact on business-as-usual activity, and the Group's limited agility to respond to emerging clinical needs.
4. **Electronic Patient Record (EPR) Procurement Strategic Outline Case:** The Committee received an update on the development of the Strategic Outline Case (SOC) and Outline Business Case (OBC) for EPR procurement. The Strategic Case had been drafted and was undergoing assurance, with the full SOC expected for approval in March 2026.
5. **Quarterly Group Board Assurance Framework (BAF) (Q4):** The Committee received the Group BAF for Q4. The Committee discussed the risk of allergy information being recorded outside core systems and agreed to escalate the issue to the Quality and Outcomes Committee.

For Board Awareness, Action or Response (including risks)

The Committee took assurance from all the above items, on behalf of the Board.
Key Decisions and Actions
The Committee agreed to escalate the following issues to the Quality and Outcomes Committee: • Delays with electronic prescribing at the Children's Hospital, and • The risk of allergy information being recorded outside core systems.
Additional Chair Comments
N/A

Date of next meeting:	Thursday 19 March 2026

NHS Bristol NHS Group Bristol | Weston

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Finance and Estates Committee - 27 January 2026**
Chaired By	**Martin Sykes, Group Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

1. As the Merger Committees reported to the Board on 10 February 2026, the Group Finance and Estates Committee received the Merger Full Business Case (FBC) and Post-Transaction Implementation Plan (PTIP). Main areas for assurance were identification of risks, approaches to managing and mitigating risks and transition from Group to merged organisation. The important role of Digital systems in facilitating a smooth transition was highlighted; risk areas had been clearly identified and interim solutions with dedicated capacity employed. Pay date alignment was highlighted as an issue of concern; grade differentials between the trusts were being identified with a view to ensuring equity through redesignation of responsibilities or levelling across where required.

   The merger gave greater assurance to mitigating estates risks than UHBW could provide as a stand-alone organisation. Overall, the net financial benefit of merger was demonstrated as being greater than the benefit of working as a Group with two statutory organisations, with particular additionality from the corporate services redesign and merged clinical services. Risk adjustment had been applied to benefits and the merged organisation was projected to break even within its first two years and generate surplus thereafter. Ways to clarify presentation of the FBC were discussed and incorporated into the final version of the Finance Chapter subsequently presented to Trust Board.

2. The Committee received the Combined Finance Report for Month 9 (1 April 2025 to 31 December 2025).

3. The Committee received a paper on Business Planning for 2026/27 with a view to highlighting progress towards submission on 12 February 2026 including the key risks to delivery.

- All areas of the Plan were compliant apart from two aspects of performance, NBT workforce and UHBW capital. It was recommended that the Group work towards a compliant revenue plan for the February submission, which would include figures for whole-time-equivalent post reductions and projected targets for sickness absence levels.
- Risks to delivery would be presented to the Acute Health and Care Improvement Group.
- Assurance was received about several new assessments in the Board Assurance Framework (BAF).
- Members discussed whether to equalise both trusts' CIP targets.

- It was agreed that financial caveats should be included in discussion of the no-criteria-to-reside situation.

4. The Committee received an upward report from the NBT Health and Safety Committee for information. Despite a continuing focus on reducing incidents of patient-to-staff violence and aggression, there was clearly still more to do.

5. The Committee received an update on business cases presented to the NBT Business Case Review Group for information.

6. The Committee received the BAF for Quarter 4 2025/26 (1 January 2026 to 31 March 2026) for information. Principal risks were highlighted. The divergence between risk profiling in NBT and UHBW was highlighted as was the need to retain a manageable number of principal risks.

For Board Awareness, Action or Response

7. There was discussion about where health and safety issues should be reported, given their overlap between People and Estate issues.

8. It was agreed that the Committee would receive a summary report on estates and health and safety issues in future. Fire issues would be presented at Board.

9. The Committee recommended that the Board approve the UHBW Enterprise Network Full Business Case. The Committee agreed that upgrade was necessary and received assurance about the procurement process. Urgent approval was requested due to an impending increase in supplier costs.

10. A question on whether Committee meetings fostered an open and safe psychological culture where members felt safe to raise concerns would be added to the list of Committee self-assessment questions.

Key Decisions and Actions

N/A

Additional Chair Comments

There were no other matters that the Committee wished to bring to the attention of the Board.

Update from ICB Committee

N/A

Date of next meeting:	**31 March 2026**

NHS Bristol NHS Group Bristol | Weston

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Finance and Estates Committee – 3 March 2026**
Chaired By	**Martin Sykes, Group Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

1. The Committee received the Combined Finance Report for Month 10 (1 April 2025 to 31 January 2025).

2.The Committee received an update on the 2026/27 Business plan. Discussion with NHSE had focussed on non-compliance with some performance metrics and the robustness of plans supporting CIP and performance. Improvement in the no-criteria-to-reside situation would be an important factor in moving towards a compliant Business Plan. Several initiatives within both trusts were targeting this situation but external System assurance was also needed. Risks were also highlighted. There had been progress in identifying CIP items for 2026/27.

3. The Committee received a paper on the UHBW and NBT National Cost Collection Index for 2024/25. The indices for both trusts were above 100. The data were used effectively with divisions and outlier specialties to inform discussions about the cost of services, understand local cost drivers, and identify opportunities for cost reductions and CIP. Merger economies of scale were expected to improve the indices.

4. The Committee received the UHBW Quarterly Treasury Management Policy Report for Information.

5. The Committee discussed the draft Business Cycle for 2026/27. This presented the opportunity for deep dives, which would be identified during the year using a risk-based approach. The dual People/Estates nature of health and safety management was noted as was the importance of triangulating risks discussed in different committees and Board. Fire was identified as a multifactorial issue, with risks being overseen by Board and compliance issues by the Audit Committee. Discussions about the Business Cycle and reporting routes would continue.

4. The Committee received an upward report from the NBT Health and Safety Committee for information.

For Board Awareness, Action or Response

7. The Committee requested that the Board delegate authority to the Audit Committee to sign off the budget for 2026/27 at the end of March 2026.

Key Decisions and Actions

N/A

Additional Chair Comments

There were no other matters that the Committee wished to bring to the attention of the Board.
Update from ICB Committee
N/A

Date of next meeting:	**31 March 2026**

Public Group Board Meeting on 10 March 2026

Reporting Committee	**People Committee – 29 January 2026**
Chaired By	**Linda Kennedy, Non-Executive Director**
Executive Lead	**Jenny Lewis, Group Chief People & Culture Officer**

For Information

The Committee welcomed Poku Osei (Group Non-Executive Director) to his first People Committee meeting in January 2026.

Merger

The Committee received the Merger Business Case and Post-Transaction Implementation Plan for discussion, both of which set out strongly the case for change and the many substantial strategic opportunities the merger would bring. Risks had been identified, processes were in place to manage these, and the schedule and prioritisation of OD and culture actions were supported.

The Committee also received the Merger Communications and Engagement Assurance Report and was assured that via an increasingly well-established iterative programme and close collaboration with Digital Services that important messages were disseminated throughout both trusts. Leadership packs were being developed to support managers and joint campaigns on areas such as TUPE were working well. Patient-focussed messages were prioritised. The Committee recognised the importance of pulse surveys in assessing the impact of change associated with merger and requested further assurance on this area at their next meeting.

Upward Reports/Briefings

The Committee received upward reports on operational delivery from UHBW's People, Learning and Delivery Group (PLDG) and NBT's People Oversight Group (POG). After this meeting, the groups would be merged and present a single upward report to Committee. The Committee noted the following points:

- Following a local decision to avoid duplication data would no longer be reported to the Equality Delivery System (EDS)
- Work on understanding the implications of the Employment Rights Act 2025 was continuing
- The Sickness Management Project, which aimed to support compassionate management of sickness absence and support colleagues back to work, was continuing. NBT's long-term sickness absence level was higher than desirable but in line with national and regional levels. Nevertheless, the Trust was working hard to reduce this via a detailed programme of work.
- More detail was requested of five RIDDOR reports at Weston General Hospital.

National and Regional Issues

The Committee received an assurance report on improving the working lives of doctors in training, which was one arm of a response to national widespread

dissatisfaction among resident doctors arising from several current challenges including over-training, job security and cultural issues relating to the professional role. This had led to the creation of the national Ten-Point Plan, which NHSE had adopted. The Committee praised the work being done by the trusts to address issues and noted the following points:

- NBT and UHBW had conducted an award-winning joint onboarding programme for over a year.
- A hierarchy of needs among resident doctors had been identified: 1) Do I have a job? 2)Where is the job? 3) Will the allocated job support training requirements? and 4) Will the job match my lifestyle expectation?
- Key themes were being addressed, including ensuring pay was correct, a smooth transition between organisations, a review of rotas and implementation of a new e-roster system.
- NBT/UHBW had submitted a joint bid to become lead employer for all specialties in the southwest region. This was one of the most important things that could be done to improve the working lives of doctors in training.

Going forward it is worth noting that the Committee will receive a combined Guardians of Safe Working Hours report.

Workforce metrics
The Committee received the People elements of the Integrated Quality and Performance Report (IQPR) for information. The following points were highlighted:

- Although NBT/UHBW employees had attended over 14,000 episodes of Oliver McGowan training, the trusts were unlikely to meet the ICB target trajectory for 62.3% combined Tier 1&2 training. Issues regarding training capacity had been resolved, although it was recognised that the value of onsite training to aid ease of access was an issue. A trajectory and recovery plan were under development for agreement by the Group Executive.
- To tackle long-term sickness absence at NBT, targeted absence review groups had been stood up. Pilots to support staff with musculoskeletal issues, long-term conditions and terminal diagnoses had been introduced.
- Reducing bank and agency spend at NBT was a focus.

People Plan Priorities
The Committee received the People Priorities Plan and the People Committee Forward Plan for discussion. The People Priorities Plan was an interim solution, ahead of developing a people strategy fully aligned to the achievement of the NHS 10-year plan. The plan identified six People Priorities to ensure a sustained focus on these critical issues during a period of significant transformation. All People initiatives throughout the organisation would be aligned to the six priorities and the Plan would be used at the People Committee for assurance. Deep dives would be conducted throughout the Committee cycle on each of the six priorities.

The Committee also received the first draft of the Operational Workforce Plan for discussion. A compliant plan would be submitted in February; this was a key plan which, it was proposed, would be monitored in the Committee metrics during 2026/27.

The Committee then received the preliminary results of the 2025 NHS National Staff Survey (under embargo) for discussion. Both trust's responses were closely aligned and generally positive. A detailed programme of work was underway to respond quickly to the results with a workshop planned to bring senior divisional leads together across both Trusts in early March to plan actions together. A further update would be provided at the March People Committee.

The Committee received an update on development of the Training and Education Strategy. Key priorities for delivery over the next 12 to 18 months would be presented at the March Committee meeting and a three-to-five-year learning and development strategy involving fuller internal and stakeholder engagement would be developed post-merger. The Committee discussed the role of AI in the strategy, noting the importance of increasing confidence and knowledge of staff, particularly for high-volume, low-productivity tasks, thereby allowing time to be released for clinical duties. The ambition of the trusts to use AI to support the left shift were noted, as were the considerable cost implications. This was a continuing area of discussion between the organisation's Clinical, Digital and People leaders.

Governance
The Committee received the People elements of the Board Assurance Framework for discussion, noting the escalation of risks relating to change management, complexity of identifying the educator workforce, employment law and the capacity of NBT Maternity Services to deliver category 1 caesarean sections within Royal College of Obstetrics and Gynaecology timeframes. These risks were being closely monitored.

Draft Committee self-assessment questions were also discussed.

For Board Awareness, Action or Response

There was discussion about where People elements of the health and safety agenda should be reported, given their overlap between People and Estate issues; they were currently reported to the Finance and Estates Committee.

A question on whether Committee meetings fostered an open and safe psychological culture where members felt safe to raise concerns would be added to the list of Committee self-assessment questions.

Key Decisions and Actions

N/A

Additional Chair Comments

A recent visit by the Group Chair, Committee Chair and Chief Nursing and Improvement Officer to Pier Health in Weston-Super-Mare was discussed, as was lack of clarity about terms such as “Neighbourhood”. The importance of involving the Group’s Community Participation Group in establishing clear definitions of commonly used terms was recommended.	
Update from ICB Committee	
At the ICB’s penultimate meeting on 28 January 2026, the need for organisations to maintain close links against the backdrop of current change and uncertainty was highlighted. The lack of consensus about the definition of “Neighbourhood” was discussed”. The ICB Committee praised the inclusion of EDI as one of the six People Priorities of the Group’s People Priorities Plan.	
Date of next meeting:	**26 March 2026**

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Quality and Outcomes Committee (QOC) - 10 March 2026**
Chaired By	**Sarah Purdy, Non-Executive Director and NBT Vice-Chair**
Executive Lead	**Professor Steve Hams, Group Chief Nursing and Improvement Officer (CNIO)** **Tim Whittlestone, Group Chief Medical and Innovation Officer (CMIO)**

For Information

The Committee met on 27 January 2026 and considered the following reports:

1. **Merger FBC and PTIP:** the Committee received the latest version of the Merger Full Business Case (FBC) and the Post-Transaction Integration Plan (PTIP). The Committee discussed these documents and was assured about the level and robustness of clinical involvement in the merger plans, and the extensive engagement with regional and ICB colleagues. The Committee was assured that the FBC evidenced the case for change and that day 1 systems were being managed appropriately. They discussed various risks, including digital services capacity to deliver the transformation required and the potential distraction from delivering "business as usual" services. The Committee was assured that these risks were identified, being mapped out and mitigated as robustly as possible. The Committee did not highlight any material issues in or omissions from the FBC or PTIP and was content that it had sufficient assurance for the case to proceed through the merger approvals process.

2. **Joint Clinical Strategy Update:** the Committee received a verbal update from the Group CMIO, informing them of good progress being made on rolling out joint clinical services. The Committee welcomed the update and asked for further reports in future on relevant data, as well as milestones, challenges, benefits and impacts of joint clinical services, starting with details of trauma and orthopaedics.

3. **Integrated Quality and Performance Report (IQPR) (UHBW and NBT):** the Committee heard about the latest performance by both Trusts against key national quality and responsiveness metrics, including in relation to diagnostics, cancer, urgent and emergency care (UEC), and referral to treatment (RTT), as well as in relation to infection prevention and control, maternity and neonatal services, and patient and carer experience. The Committee sought and received assurance that Careflow Medicines Management was being rolled out across all areas of the Group, including in the Children's Hospital. The Committee noted the update, reiterating concerns expressed previously about the level of no criteria to reside and its significant impacts across the Trusts on performance, patient safety, quality and patient experience.

4. **Upward report of the Clinical Quality Groups (CQG) (UHBW and NBT):** This was an upward report from two meetings of the UHBW CQG and a verbal report on progress with establishing a CQG at NBT (which would have its first meeting in early February 2026). The Committee noted the reports.

5. **Operational Planning Assumptions: Performance 2026/27 (UHBW and NBT):** this report provided details of the approach to operational planning for the year ahead and the submission of the Operational Plan to NHS England on 12 February 2026. The Committee discussed the plans and the extensive work taking place internally to achieve compliance. They also discussed that the plan would not be compliant with the national standards (particularly in terms of UEC targets and the 62-day cancer target), because the plan (as with the previous plan) was contingent on no criteria to reside numbers being reduced to 15% and this was not within the power of the Trusts to achieve (it required further system investment). Alongside the external work required, internal work was also necessary and ongoing at both Trusts. The Committee supported the approach and direction of travel, in particular the measures being taken internally to achieve a compliant plan, but did not approve the plan, as it would not result in compliance with the national standards. The Committee noted the further discussions taking place at Board and ICB level around no criteria to reside issues.

6. **CQC Assurance Report (UHBW and NBT):** this report provided assurance on the Group's actions to be "CQC ready" in line with the CQC regulatory inspection regime and the single assessment framework, including alignment work across both Trusts. It was noted that the CQC had a key role and obvious interest in the merger programme, before and after the legal transaction, and that the most recent engagement meeting had been attended by the CQC's Deputy Director for the South-West, in addition to the engagement team, and that there had been useful dialogue. The Committee noted and was assured by the report.

7. **Healthcare Services Safety Investigation Body (HSSIB) review of BNSSG Hyperacute Stroke Pathway:** this report outlined the Group's initial actions in response to a recent HSSIB report, which had been commissioned by the Group, into where people were taken (by the ambulance service) or where they went, if they had symptoms of a possible stroke. In an ideal world, everyone should go to Southmead Hospital, which was the local specialist stoke site, but this would result in the Southmead ED being overwhelmed, as up to 100 additional patients would have to be admitted, if every suspected stroke patient went straight to Southmead. Many people suspected of having a stroke were not having a stroke and had other difficulties. The Committee was informed that the evidence was clear; patients were not coming to harm as a result of the current inconsistencies in the pathway, and that no patients sent elsewhere in the past would have benefited from being taken straight to the Southmead specialist stroke unit. The HSSIB report nevertheless contained a number of recommendations about improving and evolving the service which were useful and actions were underway. The Committee asked for a timeline and report back on progress with the first four areas for improvement identified in the HSSIB report within three to six months.

8. **Quarterly Experience of Care report (Q2) (UHBW and NBT):** this report provided an overview of the experience of care across both Trusts for quarter 2 of 2025/26, including complaints, Patient Advice and Liaison Service (PALS) activity, Friends and Family Test (FFT) feedback and other patient engagement work. The Committee heard about the significant amount of work underway, the increasing complexity of individual complaints, and some of the challenges and successes, as well as about efforts to improve alignment between the Trusts and to reach out to and hear the voices of traditionally less engaged communities (e.g. racial minority and global majority people and young carers). They

discussed the increasing and potential use of AI in dealing with complaints and welcomed and were assured by the report.

9. **Maternity and Neonatal Safety Champion verbal report:** the Executive Champion and NED Champions for NBT and UHBW updated the Committee on recent activity and developments, including:

    - a recent visit to the Maple Tree Midwifery Hub in Weston-Super-Mare
    - the need to do more to support midwives (in light of negative national headlines about maternity services) and promote the many options for women to give birth (including at Weston)
    - worrying trends (e.g. in Weston) with increasing drug and alcohol use and domestic abuse and their effects on pregnant women
    - very good safeguarding work taking place and the need to do increasingly more, with partner organisations, as an anchor in the community
    - a recent visit to the Pier Health Group
    - the return of NICU to its original building at Southmead Hospital and the good work done on its ventilation, flooring and décor, improving the environment and infection prevention and control
    - plans for a decant and improvement of the UHBW NICU
    - ongoing discussions about improving alignment and the NED Champion roles.

10. **Group Board Assurance Framework (UHBW and NBT):** this report provided an overview of the most significant risks facing the Group, how these risks were being managed and the controls and assurances in place. The Committee discussed equipment risks and how these were monitored and managed. The Committee noted and was assured by the update.

For Board Awareness, Action or Response (including risks and escalations)

The Board's attention is particularly drawn to:

(a) the Committee's concerns about the operational planning assumptions for 2026/27 and beyond, and the Trusts' ability to deliver compliant plans, in light of the ongoing challenges including the level of no criteria to reside
(b) the Committee's ongoing concerns specifically about no criteria to reside and its multiple impacts across the Group on performance, quality, patient safety and patient experience (among other things)
(c) the assurance given to the Committee in relation to the proposed merger
(d) the Committee's intention to receive further reports and assurance on progress against the Joint Clinical Strategy and with joint clinical services
(e) the very positive quarterly experience of care report
(f) the assurance given to the Committee in relation to the HSSIB report, the safety of the stroke pathway and the intention for a report back on actions.

Key Decisions and Actions

The Board is recommended to note this report and the activities undertaken by the Quality and Outcomes Committee on behalf of the Board, for assurance purposes.

Additional Chair's Comments	
The committee would welcome an update on NCTR, and the implications of this for operational planning and ongoing performance, at the March Board meeting.	
Date of next Committee:	Tuesday 24 February 2026
Appendices:	None

Public Group Board Meeting on 10 March 2026

Reporting Committee	**Group Quality and Outcomes Committee (QOC) - 24 February 2026**
Chaired By	**Professor Sarah Purdy, Group Non-Executive Director and NBT Vice-Chair**
Executive Lead	**Professor Steve Hams, Group Chief Nursing and Improvement Officer (CNIO)** **Professor Tim Whittlestone, Group Chief Medical and Innovation Officer (CMIO)**

For Information

The Committee met on 24 February 2026 and received the following reports:

1. **Merger Update:** The Committee received a comprehensive update on the merger programme, including assurance on regulatory progress, quality governance arrangements and preparedness for Day 1. Members discussed the balance between Day 1 readiness and post-merger risks, particularly in relation to digital systems, incident reporting and patient safety processes. The Committee was assured that robust governance arrangements were in place and that quality risks were being actively managed through existing programmes.

2. **Joint Clinical Strategy Update:** The Committee received an update on progress with Group Clinical Services and the Joint Clinical Strategy. Members were advised of the number of services now operating as group clinical services, those actively in transition, and the continued focus on health equity as a core requirement of service design. The Committee heard about the equity of access issues, and the ongoing work to address disparities, particularly in trauma and orthopaedics. The Committee agreed to review progress in four months, acknowledging the need for time to demonstrate improvements.

3. **Integrated Quality and Performance Report (IQPR) (UHBW and NBT):** The Committee considered the integrated Quality and Performance Report and received detailed updates from both Trusts, covering referral-to-treatment (RTT), cancer, diagnostics, emergency care, and improvement initiatives, with additional discussion on cross-organisational collaboration and specific challenges in cancer. At UHBW, the Committee noted RTT performance, with reductions in long waits, improvements in paediatric specialties, and ongoing work to address chemotherapy treatment constraints, while emergency care performance remained challenged due to capacity issues. At NBT, the Committee heard about the progress in clearing 52-week waits, challenges in 18-week waits and diagnostics, improvement plans in cancer services, and capital investment to improve emergency care (i.e. expanding the ED footprint by relocating Minor Injuries as agreed by the Board previously).

4. **Upward report of the Clinical Quality Group (CQG) (UHBW and NBT):** The Committee received upward reports from both Trust CQGs, which included the first formal report from NBT's CQG. The Committee discussed training compliance, the successful launch of the End-of-Life Care Volunteer Service at UHBW, and escalation and assurance processes. The Committee was assured that risks were being appropriately managed within CQGs, with clear escalation routes to the Committee where required.

5. **Urology Service Deep Dive (NBT):** The Committee received a detailed deep dive on urology services at NBT, following previous updates about the service's contribution to Trust-level performance and risks. Significant improvement in RTT performance was reported, including clearance of 52-week waits, alongside more sustainable delivery through core capacity. Ongoing challenges in cancer pathways were discussed, particularly relating to tertiary referrals. The Committee recognised the progress made and agreed to receive a further update in six months, unless risks reduced sooner.

6. **Patient Safety Quarter 3 Report (UHBW and NBT):** The Committee received an update on the ongoing work to align quality and patient safety reporting across both Trusts, including plans to implement Martha's Rule as business as usual at UHBW by the end of March. The Committee discussed Duty of Candour compliance and patient safety training alignment.

7. **Infection Prevention and Control (IPC) Quarter 3 Report (UHBW and NBT) and MRSA Bacteraemia External Review 2025/26 (UHBW):** The Committee reviewed the quarterly IPC reports and received an update on MRSA and C. difficile performance, including learning from recent case reviews. The Committee discussed environmental cleaning challenges and a rare O27 C. difficile strain outbreak at UHBW, with ribotyping now performed on all samples and system-wide collaboration planned to address higher-than-expected infection rates in the Southwest.

8. **Anti-microbial resistance (AMR): NHSE call to action:** Following the call-to-action letter received in November 2025 from NHS England and the UK Health Security Agency, the Committee received a report on antimicrobial resistance and the NHS call to action. Members discussed stewardship activity, workforce capacity challenges and the need for clearer Board-level oversight. The Committee reviewed current performance and compliance against national AMR targets, benchmarked against the latest English surveillance programme, and identified key concerns and immediate actions required. The Committee noted the importance of leadership, workforce capability, and resource allocation, and agreed to set priorities for improvement. Progress would be reviewed quarterly at QOC with annual assurance reporting to the Group Board.

9. **Group Safeguarding Quarterly Report, Quarters 1 and 2:** The Committee received the Group safeguarding report, noting increased activity in adult and child safeguarding, particularly in relation to domestic abuse, self-neglect, neglect, and serious youth violence. The Committee discussed Section 42 referrals, safeguarding midwifery support, and targeted engagement with local authority partners.

10. **Maternity and Neonatal Quality and Safety report, UHBW, Quarter 3:** The Committee received and discussed the Quarter 3 Maternity and Neonatal Quality and Safety Report for UHBW, presented by the Director of Midwifery. The report set out performance against the Perinatal Quality Surveillance Matrix (PQSM), learning from Perinatal Mortality Review Tool (PMRT) reviews, Avoiding Term Admissions into Neonatal Units (ATAIN), complaints, and progress against national requirements, including the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The Committee discussed the triangulation of claims, complaints and incidents, noting the value of this approach in identifying recurring themes and areas for improvement. Workforce challenges were highlighted, particularly in relation to neonatal nursing shortages, which was recognised as a national issue. The Committee was assured by the report. The full PMRT report is available to Board members via the Convene document library for information.

11. **Maternity and Neonatal Quality and Safety report (including PQSM, PMRT and ATAIN information), NBT, Quarter 3:** The Committee received and discussed the Quarter 3 Maternity and Neonatal Quality and Safety Report for NBT, presented by the Divisional Director of Midwifery and Nursing. The report set out performance against the PQSM, learning from PMRT reviews, ATAIN, complaints, and progress against national requirements, including the CNST MIS. The Committee noted PMRT gradings and the actions being taken to address learning, particularly in relation to listening and communication, and the exponential rise of telephone triage calls. The Committee was assured by the report. The full PMRT report is available to Board members via the Convene document library for information.

12. **Home Birth Clinical Safety Assessment (NBT and UHBW):** The Committee considered the Home Birth Clinical Safety Assessment completed by both Trusts in response to national guidance issued following a Prevention of Future Deaths report. The assessment reviewed governance arrangements, risk assessment processes, operational delivery and staff support for home birth services. The Committee discussed increasing complexity associated with women choosing to birth outside clinical

guidance and the importance of clear documentation, repeated offer of clinical advice and robust staff support. The Committee was assured that both Trusts had appropriate governance and escalation arrangements in place and that staff were supported in managing complex decision-making. The Committee agreed that the assessment should be shared with the Board for assurance.

13. **Maternity and Neonatal Safety Champion verbal report:** the Executive Champion and NED Champions for NBT and UHBW updated the Committee on recent activity and developments, including:
    - Continued progress in aligning maternity and neonatal services across the Group, including increasing consistency of data and reporting.
    - The Terms of Reference under development for cross-city maternity safety champions.
    - The new maternity care bundle recently published by NHSE which would need to be delivered by the Trusts.
    - The Birthrate+ paper due to go to the Board in March and the importance of delivering Birthrate+ (e.g. additional midwifery staff) to achieve MIS Year 8 and gain associated funding.

For Board Awareness, Action or Response (including risks and escalations)

The Board's attention is particularly drawn to:
- Anti-microbial resistance NHS call to action
- Home Birth Clinical Safety Assessment.

Key Decisions and Actions

The Board is recommended to note this report and the activities undertaken by the Quality and Outcomes Committee on behalf of the Board, for assurance purposes.

Additional Chair Comments

This was the first meeting with formal upward reports from CQGs at both UHBW and NBT. This is an important part of assurance for the Group QOC, and reporting will continue to evolve to ensure matters that require QOC's attention, as opposed to attention from Trust level committees, are clearly flagged.

Date of next Committee meeting:	Tuesday 31 March 2026
Appendices:	The following appendices are available in the Convene document library or on request from trust.secretary@nbt.nhs.uk: Appendix 1: NBT PMRT report Appendix 2: UHBW PMRT report Appendix 3: Home Birth Clinical Safety Assessment Appendix 4: AMR Report