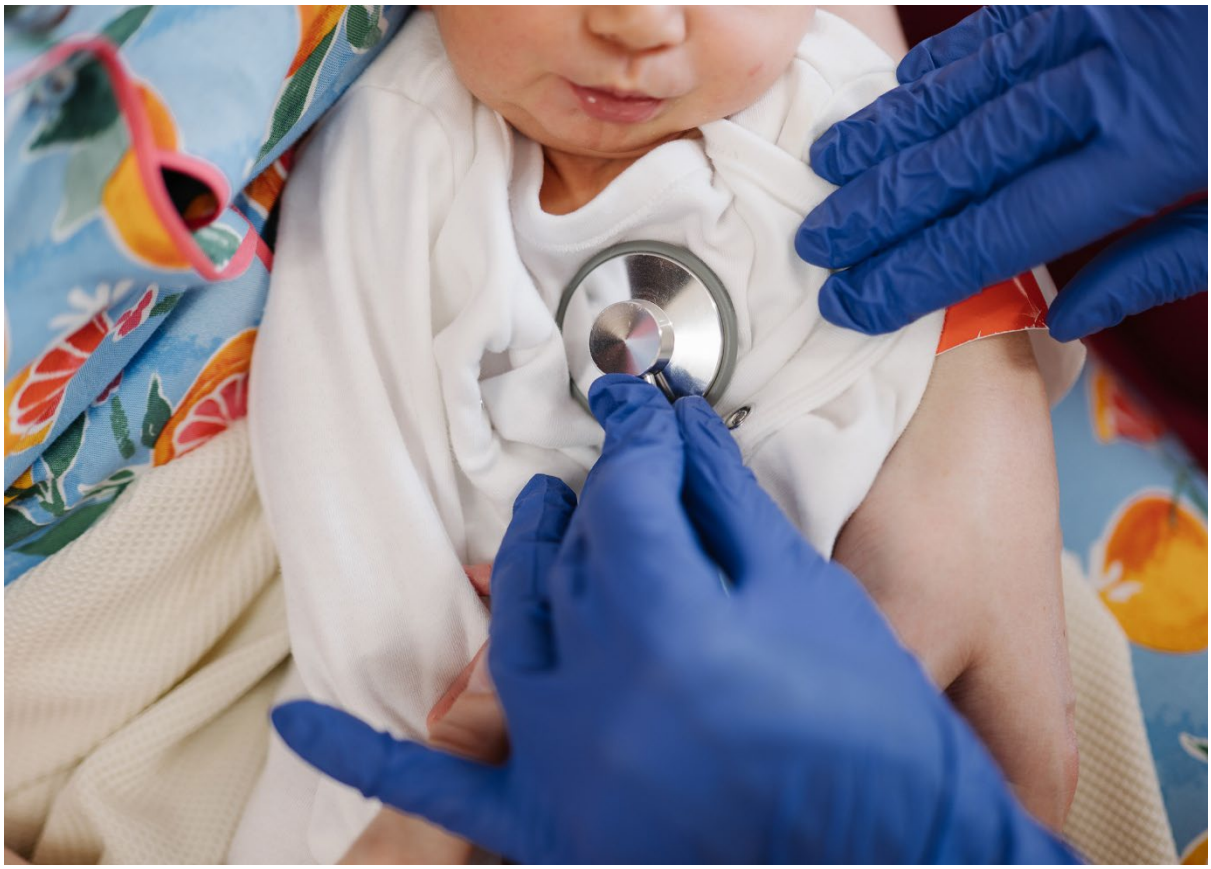
Inspected and rated
Good
Care Quality Commission

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Annual Report and Accounts 2025/26



We are
supportive
respectful
innovative
collaborative.
We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust
Annual Report and Accounts 2025/26

Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006

Contents

1. Group Chair's Introduction and Group Chief Executive's Statement

Group Chair's introduction
2025/26: a year to celebrate people, partnership and pride

Looking back on the year, I feel incredibly proud of the ways in which University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) colleagues have made a difference that matters to the lives of our patients and our population.

This year has been transformational for acute healthcare in Bristol, North Somerset and South Gloucestershire. The development of the Bristol NHS Group with North Bristol NHS Trust (NBT) has created the right conditions for us to act upon our vision of seamless, equitable and sustainable care for our population. It is true that the challenges facing the NHS are significant, but together we can play our part in creating an NHS that is fit for the future.

It's important to recognise that the team needed to achieve this ambition reached far beyond our hospital walls. I would like to extend a heartfelt thank you to our people, governors, volunteers, charities, NBT colleagues and other local partners all of whom have played an essential role in improving the health and wellbeing of the populations we serve this year.

As an anchor institution, reaching out into communities is as important as welcoming those who need care into our hospitals. A great example of this is the work of our Resuscitation Practitioners who this year teamed up with local sports clubs including Bristol City Walking Football Club and students from the Bristol Rovers Community Trust College to offer hands on CPR training. Our 'Alright My Liver?' scheme also reached new groups by leading its first drop-in clinic at the Big Issue offices in Bristol to help identify and support people who are at risk of conditions related to scarring on the liver.

Connecting our services and our communities strengthens the foundations on which we will build positive change together. And it can be fun too! Last Spring we invited local people to name our new Bristol Royal Hospital for Children paediatric neurosurgery robot for us. After thousands of votes from the public, our fantastic Young Ambassadors and colleagues from the Children's Epilepsy Surgery Service unveiled 'Captain Cortex'. It is joyful moments like this that embody the spirit of our Trust and celebrate the amazing communities we serve.

We still face serious challenges though, including how to address the health inequity that we know exists in our population. This is an absolute priority for me. Over the past 12 months, many colleagues and partners have joined me in this pursuit including Laura Lewinson, UHBW's first Diversity and Inclusion Midwife, who has worked tirelessly to address disparities in health and birth outcomes for Black, Asian, and marginalised women this year through education, inclusive policy reform, and working closely with community groups. I know that there are many others like Laura working tirelessly for health equity and I look forward to seeing what they will achieve in the year ahead.

Much has been achieved this year, but we cannot become complacent. There is so much more we must do to ensure that everyone who comes into contact with UHBW — whether as a person relying on our services, colleague, volunteer or partner — feels respected, heard and valued. But this year has shown the strength of our foundations on which I hope we will build with NBT as we look to come together as single organisation in the summer of 2026.

Thank you once again to everyone who has made 2025/26 such a significant and successful year filled with care, compassion and commitment. Without you, none of this is possible.

Best wishes,

Ingrid Barker
Group Chair

Group Chief Executive's statement

2025/26: a year of performance, partnership and transformational progress

This year, UHBW has continued to demonstrate why we are one of the highest performing NHS Foundation Trusts in the country. Ranking in the top tier of the NHS National Operational Framework, UHBW has consistently delivered high performance with a focus on getting things right for our 4Ps – our patients, our people, our population and the public purse.

The NHS is facing a once in a generation opportunity to transform how healthcare is provided. As a partner in the Bristol NHS Group, alongside colleagues at North Bristol NHS Trust (NBT), I'm proud to say that UHBW is leading the way to create an NHS that meets the needs of its communities both now and into the future. With a shared vision for seamless, equitable and sustainable care, our Group is one of the first of its kind to base its collaboration on a shared clinical strategy. Our mission aligns with the government's 10 Year Health Plan. Its three core shifts — from hospital to community, from analogue to digital, and from sickness to prevention — strongly reflect the direction we as a Group have already been taking through transformation and partnership.

Through our clinical strategy we are bringing together services where duplication exists, ensuring our patients receive excellent, equitable care in whichever hospital they attend. We are also proud to host many specialist services at UHBW, providing cutting edge, best in class treatments. For example, this year, Bristol Royal Hospital for Children was named as a new Tessa Jowell Centre of Excellence for Children, one of only four UK paediatric neuro-oncology centres to be awarded the designation. At Bristol Haematology and Oncology Centre, patients with melanoma, renal, lung and upper gastrointestinal cancers are now being offered pioneering Nivolumab immunotherapy which can half treatment waiting times and Weston General Hospital's endoscopy service has once again been awarded JAG (Joint Advisory Group on GI Endoscopy) accreditation.

We're also investing in the physical and digital infrastructure we need to be fit for the future. From expanding our Same Day Emergency Care Unit at Weston to introducing a new electronic prescribing system, this year alone, we have invested over £80m in capital in UHBW. As a Group, the opening of our shared facility - The Princess Royal Bristol Surgical Centre - in Southmead is a real highlight for me, increasing our capacity, modernising the environment in which care is delivered, and supporting better patient flow and experience.

All this is not to detract from the very real challenges and pressure we continue to face, but we continue to build, improve, innovate and seek out partnerships that will benefit the health and wellbeing of the population we exist to serve. As we continue on our exciting journey with NBT towards becoming a single organisation in 2026, I want to say thank you to each and every person who works at or alongside UHBW - our people, governors, volunteers, charities, NBT colleagues and other local partners. The commitment you show and the care you give is exceptional and I am proud to work alongside you all to serve the populations of Bristol, North Somerset and South Gloucestershire.

Best wishes,

Maria Kane
Group Chief Executive

2. Performance Report

2.1 Overview

In April 2025, UHBW and North Bristol NHS Trust confirmed the formation of the Bristol NHS Group, bringing together two major NHS providers with a shared ambition: to deliver seamless, high-quality, and equitable care for every person across Bristol, Weston, South Gloucestershire, and the wider South West. With a combined workforce of 28,000 and a budget of over £2.1 billion, we are coming together to tackle health inequalities, improve outcomes, and deliver better value for patients, staff, and the public. To this end, the Boards of UHBW and NBT met in common throughout 2025/26.

Through a Joint Clinical Strategy, Bristol NHS Group is transforming the way healthcare is delivered locally for our patients, our people, the population we serve, and the public purse. To fully realise these benefits, the two trusts have formally announced their intention to merge and create one acute trust for the Greater Bristol area, with the aim of completing this merger on 1 July 2026.

As UHBW remained a sovereign organisation during 2025/26, the information provided in this report does not include specific data in respect of NBT's performance.

In respect of Referral to Treatment (RTT), at the end of 2025/26 the Trust reported that only 0.6% of patients waited longer than 52 weeks for treatment, with 68.04% waited 18 weeks or less, both of which were within the planning guidance.

Emergency Department attendances during 2025/26 exceeded the levels seen in 2023/24 and 2024/25, and this, alongside high bed occupancy levels, impacted delivery of the four-hour standard of care. By the end of March, the Trust achieved 73.8% of patient attending ED being seen, treated if necessary, and either discharged or admitted within four hours, against a target of 78%. This compares to 75.2% in 2024/25.

Patients with cancer should start their first definitive treatment within 62 days of referral. The national standard is that 85% of patients should start their definitive treatment within this standard, and NHSE set an interim recovery target for providers of 75% by March 2026. The Trust has performed above this recovery standard through much out the year, achieving 72.7% at the end of March and setting a plan for 2026/27 to achieve the national ambition of 80% by March 2027.

In respect of diagnostic waiting times, The Faster Diagnosis Standard (FDS) was designed to measure the time from referral to a patient receiving a diagnosis, or having cancer ruled out, within 28 days. The Trust's performance met or exceeded the trajectory through most of the year, achieving 81.8% by end of March 2026 (against a plan of 80%).

The Trust delivered a net income and expenditure surplus of £4.976m (excluding technical items). 2025/26 was the 23rd year in a row that the Trust delivered a surplus or break-even income and expenditure position (excluding technical items).

The Trust Board of Directors and its Committees are monitoring the above performance metrics and proactively seek assurance that appropriate action is being taken to mitigate them and address any control issues identified. The Trust continues to prioritise these areas and work to minimise any potential negative impact they may have on patient care and safety. Overall, it has been a challenging year for the Trust and for the wider NHS, but the efforts of our staff to continue to provide the highest quality of care for patients has been exemplary. The Trust will continue to invest in our people to ensure they have the resources they need to deliver the care they aspire to give, and to work with our system partners to deliver the best possible care.

2.1.1 Principal activities of the Trust

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) is a public benefit corporation authorised by NHS England, the Independent Regulator of NHS Foundation Trusts on 1 June 2008.

We have more than 13,000 staff who deliver over 100 different clinical services across ten different sites, providing care to the people of Bristol, North Somerset and the South-West from the very beginning of life to its later stages. We are one of the country's largest acute NHS Trusts with an annual income of over £1,300m.

The Trust provides services in the three principal domains of clinical service provision: teaching and learning, and research and innovation. The most significant of these with respect to income and workforce is the clinical service portfolio consisting of general and specialised services.

For general provision, services are provided to the population of central and south Bristol and North Somerset, around 350,000 patients. A comprehensive range of services, including all typical diagnostic, medical and surgical specialties, are provided through outpatient, day care and inpatient models. These are largely delivered from the Trust's city centre campus and from Weston General Hospital in Weston-Super-Mare, with the exception of a small number of services delivered in community settings such as South Bristol Community Hospital.

Specialist services are delivered to a wider population throughout the South West and beyond, typically between one and five million people. The main components of this portfolio are children's services, cardiac services and cancer services as well as a number of smaller, but highly specialised services, some of which are nationally commissioned.

As a University Teaching Trust, we also place great importance on teaching and research. The Trust has strong links with both of the city's universities and teaches students from medicine, nursing and other professions allied to health. Research is a core aspect of our activity and has an increasingly important role in the Trust's business with a significant grant funding secured in 2025/26. The Trust is a full member of Bristol Health Partners, and of the West of England Academic Health Science Network and also hosts the Collaboration for Leadership in Applied Health Research for the West of England.

Whilst we do not believe that diversity in the Boardroom is adequately represented solely by a consideration of gender, we are required to provide a breakdown of the numbers of female and male directors in this report. At the end of 2025/26 the gender make-up of the eight Executive Directors (including non-voting Executive Directors) was three females and five males. Of the nine Non-executive Directors (including non-voting non-executive Directors) four were female and five were male.

2.1.2 Our mission, vision and values

Through 2025/26, our focus has been on embedding our Trust strategy, '*A difference that matters'.* Our vision, mission and strategic priorities our outlined below.

Our vision: ***To become the trust that pioneers new standards for patients, staff and communities.***

Our mission: ***To advance the health and wellbeing of our community***.

Our Trust values remain as:

2.1.3 Our Strategic Priorities

Delivery against the strategic priorities has remained our focus through 2025/26. Our Strategic Priorities are:

- **Experience of Care:** Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.
- **Patient Safety:** Together, we will consistently deliver the highest quality, safe and effective care to all our patients.
- **Our People:** Together, we will make UHBW the best place to work.
- **Timely Care:** Together, we will provide timely access to care for all patients, meeting their individual needs.
- **Innovate and Improve:** Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.
- **Our Resources:** Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.

2.1.4 Continuous Improvement

The following is a summary of the progress in 2025/26 of our improvement projects - which enable us to deliver our strategic priorities - and the vision metrics, which are the key measures to know we are making a difference to our patients, public and people.

A. Experience of Care: Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.

Vision metrics:

- Overall experience of care (as rated by patients): 92.6% of patients rated their experience of care as good or above in monthly maternity and inpatient surveys, against a trajectory of 95.4%. (2025/26).
- Happy with standard of care (as rated by staff):1.68 percentage point improvement (74.3% to 75.98%) in staff survey responses that they would be happy with standard of care for friend or relative

Key achievements:

Our Experience of Care Strategy: “My Hospitals Know and Understand Me.” has five goals:

- Asking “what matters to you?”
- Listening and responding well.
- Learning, embedding and spreading
- Designing and delivering together.
- Continually improving across the life course and patient journey.

Colleagues across the Trust have been working on delivering the year two priorities of the strategy, with the following successes in 2025/26:

- Fulfilment of booking requests for **spoken language interpreters** has demonstrated a sustained improvement, achieving 96% (target) or above every month since November 2024.This means more patients who have interpreting needs are having these met in a timely way, helping to tackle health inequalities for this group in our population. We also mobilised a new contract for non-spoken language (i.e. BSL) interpreting with provider Sign Solutions.
- **Growth of Experience** of Care Champions from 27 at March 2025 to 61 by March 2026 across the organisation. The role is undertaken by staff of any grade or profession in patient-facing roles who are passionate about improving the experience for patients and carers in their area. Support materials and training for champions have been developed.
- 750+ colleagues now have access to the **Patient Feedback Hub** (IQVIA) giving real-time access to patient feedback to colleagues across Divisions (an increase from 296 as at March 2023).
- 100% of wards visited as part of Clinical Accreditation displayed the **You Said, We Did** poster, demonstrating learning and action from patient feedback.
- Divisional **Experience of Care Groups** are now established in Medicine, Children’s, Weston and Specialised Services.
- Undertaken **community outreach** to faith communities in order to develop a more inclusive offer of Spiritual and Pastoral Care for patients, carers, families and staff.
- **What Matters to You** conversations are being used on 73.6% of adult wards, work continues to embed the approach and sustain initial improvements. 82.7%of patients felt involved in decisions about their care.
- Launch of a **Community Participation Group** (CPG) to bring public voice to the delivery of our Joint Clinical Strategy. The CPG is a collaborative space for the people and communities we serve to influence, challenge and shape the delivery of Bristol Hospital Group's Joint Clinical Strategy, ensuring the voice of all our patients and carers is embedded in all that we do.
- Delivery of Health Foundation funded Action Learning Set for **Coproduction in Health Services** with Peer Partnership to increase the skills and confidence of clinicians to design services together with communities. In 2026/27 work to increase involvement and co-production in improvement projects across the organisation will be a focus.
- Support for people living with dementia strengthened this year, with **Dementia Champions** launched in Weston General Hospital, activity co-ordinators in both the Bristol Royal Infirmary and Weston, and activity boxes available on wards.
- Launched the **End of Life Care volunteer service,** funded by Bristol and Weston Hospitals Charity, providing compassionate companionship and support to patients and their loved ones and end of life.
- Secured funding for permanent **Enhanced Midwifery support workers** to support EDI work in community teams including supporting Global Majority women to access maternity services early, reducing smoking in pregnancy, increasing uptake of breastfeeding.
- From April 2026 our **Midwife led unit** (MLU) will have a designated team allocated each shift, enabling more women to access this birthing environment. Work to promote the option has been undertaken, with women who met the criteria being asked to opt out rather than in.

- Our Midwifery service has established a **Birth Options Clinic**, where conversations are undertaken with women identified as being high risk for pregnancy/birth, enabling women to be supported to have a birth in a safe environment whilst still feeling empowered.

- With support from Bristol & Weston Hospitals Charity, four new **Reminiscence Interactive Therapy Activities (RITA) therapy devices,** which are pre- loaded with puzzles, films, games creative activities have been introduced across clinical areas within the medicine division to support patients with enhanced care needs. Their impact on patient experience has been extremely positive by helping to reduce boredom and distress and helping lower the risks associated with hospital acquired deconditioning.

- At the Bristol Royal Infirmary, the Medicine Division hosts a monthly **Inter-Generational Tea Party,** bringing patients together with children and families from the local community. The initiative has received outstanding feedback, with patients reporting both physical and emotional benefits, improving their experience of care and helping to reduce hospital-acquired deconditioning. In addition, the programme benefits parents, carers and children, reflecting our belief that we are 'healthier together'. Delivered in partnership with Alive and Bristol & Weston Hospitals Charity, the project supports NICE guidance for Older People: Independence and mental wellbeing.

- New **Sensory Bags,** containing a sensory bracelet, eye mask, ear defenders, stress ball, fidget toy, colouring book and crayons were introduced for Children and Young People with learning disabilities and autism who experience sensory overload in hospital, funded by Bristol & Weston Hospitals Charity.

Work completed by Divisions to improve our **Communication Score within inpatient services** has included:

- Detailed work in Bristol Heart Institute to bring a whole team focus on patient experience, using patient survey data from the Patient Feedback Hub (IQVIA) to target improvement actions
- A makaton workshop to enable staff to support patients with additional communication needs
- Communication improvements being sustained on Hutton Ward, Weston General Hospital with scores rising from 67.98 to 85.67, including improved handovers.

The Mental Health across UHBW programme has focused on the **Enhanced Therapeutic Observation Care (ETOC) project.** Key successes in 2025/26 included:

- Standardisation of Enhanced Therapeutic Observation Care (ETOC) assessment & observation processes rolled out across 15 wards.
- 62% reduction in agency spend for enhanced observation compared with the previous year.
- 114 healthcare support workers trained in ETOC with improved staff confidence in caring for patients with distressed behaviours.
- Audit of 187 patients found 25% had a reduced prescribing need and 25% a reduced ETOC level.

These improvements have reduced restrictive interventions, strengthened the consistency and safety of patient care, and enhanced staff knowledge and support—while maintaining stable rates of falls, violence and aggression. Alignment across the hospital group has progressed, with enhanced-care education and training due for completion in Q1 of 2026/27. A new enhanced-care policy has been shared with stakeholders and is now progressing through formal approval.

B. Patient Safety: Together, we will consistently deliver the highest quality, safe and effective care to all our patients.

Vision metrics:

Improvements have been seen in staff survey responses to the following patient safety culture related questions:

- 0.7 percentage point decline (63.8% to 63.1%) for 'not seen any errors/near misses/incidents that could have hurt staff/patients/service users'.
- 1.2 percentage point improvement (66.2% to 67.4%) for 'staff involved in error/near miss/incident treated fairly'.
- 0.4 percentage point decline (70.9% to 71.3%) for 'organisation ensure errors/near misses/incidents do not repeat'.
- 1.5 percentage point improvement (63.9% to 65.4%) for 'feedback given on changes made following errors/near misses/incidents.

Key achievements in 2025/26 include:

Sepsis Management has been a key focus, with the aim of improving awareness, knowledge and evidence of timely recognition and treatment. Informed by detailed diagnostic work, a number of improvements have been delivered:

- Application of human factors principles in the redesign of sepsis pathway documentation, to better reflect clinical workflows and support timely management of suspected sepsis.
- A programme of in-situ micro teaching sessions, training 1,011 staff on sepsis awareness, specifically including recognition, screening, treatment, and escalation.
- A bite-size sepsis training video (focusing on adult, non-maternity care processes) was introduced on the training platform to support ongoing staff learning.
- A Power BI dashboard has been developed to report compliance with sepsis screening for adult inpatients, significantly increasing the data available to monitor performance and inform improvement, compared with previous reliance on manual audit.
- Targeted work commenced to make improvements to delivery and documentation of required sepsis six pathway elements, this work will continue in 2026/27.
- Adoption of AoMRC (Academy of Medical Royal Colleges) guidance alongside the National Paediatric Early Warning Score (PEWS) to strengthen paediatric sepsis screening, with NICE (2016) guidance informing treatment has commenced. Plan–Do–Study–Act (PDSA) methodology is being used to test a new paper-based Paediatric Sepsis Screening Tool and Pathway, which will inform future design of a digital solution.
- A new Paediatric Deteriorating Patient (DP) eLearning package, including sepsis, has been introduced on the training platform to support ongoing staff learning.

Alongside the sepsis improvement work, the **Adult Deteriorating Patient** (DP) Programme has focused on:

- developing and testing a standardised SBARD (Situation, Background, Assessment, Recommendation, Decision) communication tool to support effective escalation, aligned with Advanced Life Support (ALS) principles. Its wider rollout will remain a key focus in 2026/27.
- an initial scoping to inform the design of revised escalation trigger processes, applying human factors approach through applied cognitive task analysis; development will continue in 2026/27.

The national patient safety initiative **Martha's Rule** been implemented across all adult inpatient settings, following the earlier deployment within the Bristol Royal Hospital for Children. Martha's Rule

provides a structured opportunity for daily feedback from the patient and their family on changes in the patient's condition. An urgent review can be requested if they feel the patient's condition is deteriorating and their concerns are not being adequately addressed. Our successful implementation has included:

- Easy to access Martha's rule documentation – leaflets, communication materials, standard operating procedures.
- Visible patient/carer information on how to use Martha's rule.
- Compliance with patient wellness questionnaires (PWQ) across UHBW, with adults' inpatient areas compliance monitored via a dashboard. PWQ is included in Clinical Accreditation reviews across all sites.
- Digital functions embedded for automated alerts, monitoring and compliance with the Martha's Rule standards. For example, email alerts to Matrons and Sisters to enable a timely follow up with patients, family and staff after a Martha's Rule call.
- Development of Critical Care Outreach Team processes to enable a response to Martha's rule calls.
- Total of 101 review requests, 22 related to acute signs of deterioration and led to an intervention being made.

By September 2025, **Careflow Medicine Management** (CMM) — the Trust's electronic prescribing and medicines administration (ePMA) system — had been fully deployed across all adult emergency and inpatient settings. Delivery at this scale required digital training for more than 9,000 staff, with around 900 receiving additional face-to-face training as super users. Across the phased go-lives, over 10,500 person-hours of floorwalking support were provided by the Digital Services Team, alongside temporary staff from Ideal Health and System C.

CMM provides a safer and more controlled prescribing and administration process. It's also given significantly improved visibility of the scale of medicines activity across our adult settings, since implementation there have been 37,171 Discharge prescriptions (TTAs) completed, 287,627 TTA items prescribed, 760,948 inpatient items prescribed, and more than 4.2 million administrations recorded.

Adult clinical teams consistently report benefits they would not want to be without, including reliable access to drug charts, remote prescribing and review, improved legibility, standardised protocols, clinical safety alerts, the TTA copy across function, and the removal of the need to rewrite full drug charts. The focus has shifted into evidencing these benefits and embedding CMM into business-as-usual processes and continuing to optimise the system.

A **Medical Equipment Procurement and Management** project commenced to strengthen the safety, usability and lifecycle management of medical equipment across the organisation. An innovative, system approach has been used, drawing on improvement and human factors methodology to understand critical themes across incidents, complaints, risks and staff experience, alongside regulatory and legislative requirements and NHS best practice for value-based procurement. With an estimated 43,000 medical devices in use, this will remain a key focus in 2026/27, with pilots of new processes informing changes across the end-to-end equipment lifecycle.

Supported by Bristol and Weston Charity, a new educational and safety-focused video to support staff in **managing complex airway cases** was created by the Difficult Airways Response Team. The video is used for induction and training of staff.

As part of the Fire Safety programme all Divisions have been focussing on strengthening **fire evacuation readiness and compliance**. Around 960 staff have completed fire warden training, and in quarter four a new process was introduced to enable clinical areas to plan for and evidence a fire warden on duty using the rostering system. The intention is to expand the use of this process to all areas, alongside evacuation simulations in 2026/27.

C. Our People: Together, we will make UHBW the best place to work.

Vision Metric:

- There has been no movement (68.6 % to 68.6%) in staff survey responses for staff recommending UHBW as a place to work.

Key achievements in 25/26:

Pro-Equity is inclusion in everything we do and embracing full-hearted care to eliminate disparities in staff experience. A detailed update on our Pro-equity promise is included in section 5.4.4, accompanied by an integrated delivery plan for divisions to deliver through their equality, diversity and inclusion forums.

Significant progress has been made in our **Medical Workforce programme**, focused on developing a strategic approach to the recruitment, deployment and configuration of medical staff, enabling delivery of the Clinical Strategy**:**

- By November 2025 78% of job plans had completed the review and signed off process.
- Clear job planning policy, and escalation process to resolve challenges are in place.
- Transition to prospective job planning for 2026/27 commenced in December 2025, for the very first time, with 93% reviewed and signed off by March 2026.
- Consistency panels were held to strengthen governance, improve alignment between activity, capacity and workforce, supporting more transparent deployment of consultant time.
- £2 million savings through compliance with Southwest region agency cap rates, with the exception of a small number of hard to recruit posts.
- A detailed rota review has commenced to ensure rotas are configured to meet service demand sustainably, support resident doctor training, and optimise safety, productivity and financial efficiency. This will continue to be a key focus in 2026/27.
- Introduction of a Locally Employed Doctors Rotation from August 2025, offering an alternative training experience with placements across medical specialities in Bristol and Weston spanning three Divisions. The rotation supports the development and supply of doctors into specialities that are traditionally harder to recruit into: including General Internal, Acute and Geriatric medicine.

Funding from NHS Charities Together is supporting an innovative programme to test a systematic approach for **managing fatigue** in our Bristol NHS Group, in association with Bristol and Weston Hospitals Charity and Southmead Hospitals Charity**.**

Unlike in other safety-critical industries, in health and social care there is no national framework for recognising and mitigating the risk of fatigue in the workforce.

In 2026/27 the Bristol FRAMEwork (fatigue risk assessment, management and education) will:

- Co-design and apply protocols that combine fatigue education, safety promotion, dynamic risk management, data tools and governance across six clinical and non-clinical pilot sites.
- Evaluate effects on staff wellbeing, safety and organisational performance.

The pilot reflects approaches from other safety-critical industries and explores how this could be applied within healthcare. The Bristol FRAMEwork is the first of its kind to amplify the profile of fatigue at an organisation level in a healthcare setting, and carries exciting promise for learning and ambassadorship of the approach beyond our Bristol NHS Group.

In April 2026, our Bristol Group will launch the NHS England **Safe Learning Environment Charter**. Strong engagement in the self-assessment process has already highlighted excellent practice in how we support learners, while also giving us a clear baseline of strengths and areas for development. This baseline will guide a phased roll-out across professions and specialties from April 2026 to May 2027, helping us embed a consistently high-quality learning environment across the organisation.

Learning and workforce development colleagues have aligned the core clinical skills curriculum as part of priority workstreams linked to the corporate services transformation. Building on the success of the blended clinical skills curriculum at North Bristol Trust, a single, **group-wide blended approach** is now in place, supporting consistent training delivery and enabling colleagues to apply their clinical skills effectively in patient care across the Group.

D. Timely Care: Together, we will provide timely access to care for all patients, meeting their individual needs.

Vision Metric:

10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospital:

- There has been a 5.1 percentage point improvement (32% to 37.1%) of ambulance handovers within 15 minutes in 2025/26 compared to 2024/25.
- There has been a 10.7 percentage point improvement (65.6% to 76.3%) of ambulance handovers within 30 minutes in 2025/26 compared to 2024//25.

Key achievements:

Our ***Proactive Hospital:*** **Urgent and Emergency Care** programme focusses on improving flow through our hospitals, and reducing the time that patients wait in our Emergency Departments. The programme has three key workstreams:

- Arrival into Emergency Departments/ Urgent Care settings.
- Flow through Emergency Departments.
- Flow through Inpatient wards.

Successes in the past year include:

- Collaborative development of **inter- professional standards**, incorporating GIRFT (Getting it Right First Time) Acute Care standards, with clinical leaders across the organisation including agreement on speciality referral and acceptance criteria. The launch is planned in March 2026, and effectiveness will be monitored using a newly established dashboard.
- A3 thinking structured problem-solving methodology has been used to:
  - identify top contributors to **ambulance handover** waits longer than 15 minutes at Weston General Hospital.
  - identify actions for reducing delays for patients in **BRI ED waiting for CT scans** and pathology results by streamlining processes and enabling improved communication.
  - identify actions for reducing delays for patients waiting in **BRI ED for over 12 hours for a medical bed** by strengthening governance processes, reducing bed turn-over time and creating a standard for escalating patients nearing12 hours in ED.
- Establishment of a **Frailty SDEC** (Same Day Emergency Care) pathway at Bristol Royal Infirmary and Weston General Hospital improving the provision of care for frail older patients and reducing unnecessary admissions.
- **Criteria Led Discharge** has been safely embedded into ward processes and doctor training, increasing its use from 3.3% to 5.6%, with particularly strong improvement in our Surgery Division (9.6% to 16.7%).
- **Discharge lounges** have supported more timely discharge, with 26.8% of eligible patients (5,930) discharged via the Bristol Royal Infirmary lounge and 40% (2,589) safely discharged home from the Weston lounge.

- 84% of adult inpatient wards now run a morning **proactive board round,** with 96% meeting core standards.
- **Proactive ward rounds** are being trialled at Weston General Hospital to support earlier discharge and improve overall patient experience.

Our Home First integrated discharge hub enables our acute Trust teams to work alongside community and social care partners. Key improvements include:

- **Discharge training**, including Criteria led discharge added to resident dr induction training.
- **Early supported discharges** were successfully embedded to safely reduce unnecessary inpatient stays for medically optimised patients awaiting the start of their community package of care. In 2025, this approach enabled 3935 bed days saved across 1241 patients, improving patient flow and ensuring timely access for patients with acute needs.
- **Rapid Patient Reviews** continue to demonstrate measurable impact on discharge progression. The reviews have strengthened proactive planning, facilitated earlier clinical decision-making, and improved discharge readiness across the community pathways. We are consistently seeing increases in same -day discharges, next-day discharges and weekend discharge activity, contributing to reduced delays and safer, more coordinated transitions of care.
- Since November 2025, **Pathway 0 improvements** have supported 2,525 patients across our Weston and Bristol sites, with 1,985 patients discharged on the day they are medically fit for discharge. This reflects a significant uplift in efficient, home-first discharge processes.
- **Continuing Health Care (CHC) Fast Track** – Bristol achieved a 3.8-day reduction in the average time from order to completion (February 2026) compared with the 2024 baseline of 7.2 days, demonstrating both improved responsiveness and strengthened end-of-life discharge processes.

- **Mental Capacity Assessment** (MCA) & **Best Interests Decision** (BID) improvements have shown an average reduction of 0.9 days in January 2026, alongside 83% of assessments completed within 48 hours in February 2026. These improvements are enhancing decision-making timeliness and reducing associated discharge delays.

UHBW provides surgical services in theatre suites across seven hospital sites, 9 theatre suites and 9 pre assessment areas. It covers a wide range of routine, emergency, robotic and specialist surgery. Our **Perioperative Improvement programme** has had the following successes:

- Latest model hospital performance shows our trust in the **highest quartile nationally** with utilisation of 83% for Feb 2026.
- Maintained a month-on-month increase in theatre utilisation compared to 2024 with an average capped touch-time utilisation (measured from a patient commencing their anaesthetic to leaving theatre) of over 80%, for 24 consecutive months, which is the highest recorded for the organisation.
- A Trust-wide pre-assessment dashboard was implemented, enabling real-time visibility of preassessment patient status and availability to book to theatre lists. This supports specialities to book appropriate case mix, adhere to best practice booking and scheduling and support Referral to Treatment (RTT) and cancer performance delivery.
- Four of the five elements of the NHS England pre-assessment mandatory requirements have been achieved. The final element will launch in April 2026, introducing screening and pre-assessment triage and enabling patients to be directed to the most appropriate intervention, such as telephone or face-to-face appointments and stop-smoking support.
- Pre-operative testing was piloted closer to home, via satellite thoracic clinics to complete testing locally alongside remote pre assessment (where clinically appropriate), enabling patients to only attend UHBW for surgery. Following successful delivery in Thoracic services, this model is now planned for roll-out across other cancer specialties.

- Targeted productivity improvements in specific theatre suites and specialities by working closely with surgeons, theatre staff and admin teams to improve booking, reduce downtime (late starts & early finishes) and improve patient flow through theatres.

2026/27 will be an important year as we carefully plan and phase major rebuild and refurbishment work in our largest adult theatre suite, minimising disruption to services while improving future reliability, productivity and patient experience.

UHBW provides outpatient clinics for 156 specialties across our 10 hospital sites. In 2025/26 we have continued our **Improving Outpatients productivity and efficiency programme** with a focus on reducing Did Not Attend (DNA) rates and improving appointment booking processes. Key success include:

- **Digital appointment letters** and assessments are available via the NHS App circa 85.000 digital letters are shared with patients each month. Over 1million digital letters have been shared 25/26. Circa 2,500 Assessments are being shared with patients through the NHS App each month.
- Successful pilot of **Bristol Eye Hospital (BEH) Clinic letters** shared with the NHS App and DrDoctor with a view to this being rolled out Trust wide.
- Patients are increasingly able to inform us of the need to cancel or rearrange appointments digitally, using our **DrDoctor patient portal,** with 65% of specialties using the basic rescheduling functionality. 100% Division of Medicine clinics are now live with basic rescheduling.
- Sustained **Did Not Attend (DNA) rate** reductions have occurred in all clinical Divisions, resulting in the lowest recorded monthly Trust DNA rate of 5.4% in February 2026.
- Work was undertaken to rebuild 12 partial booking waiting lists, predominantly within the Bristol Eye Hospital, **strengthening the foundations** of our outpatient systems to enable enhanced digital appointment booking and management, which will be progress in 2026/27.
- Improvement work to understand **local challenges with clinic flow** is underway, the common themes identified will be used to inform future improvement priorities within outpatients.

Our Adult Therapies teams, working with NBT and Sirona, delivered successful **community Musculo- Skeletal appointment days**, providing faster assessments for patients.

Working with NBT, the **Elective Care Centre** opened in September 2025, enabling safe transfer of ambulatory trauma, lower limb and GI surgical lists, increasing capacity and efficiency.

In October 2025 a new **expanded Same Day Emergency Care** (SDEC) facility opened at our Weston site, offering an improved environment for patients and staff. The expanded SDEC has enabled more patients to be seen for same day emergency treatment and care. In addition, it has enabled the team to develop a **frailty same day emergency care pathway**, which started in December 2025, meaning fewer admissions to hospital for our frail and elderly patients.

E. Innovate and Improve: Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.

Vision metric:

- There has been a 0.6 percentage point decline (75.1% to 74.5%) in staff survey responses reporting they are able to make suggestions to improve the work of their team/department.
- There has been a 0.5 percentage point improvement (59.0% to 59.5%) in staff survey responses reporting they are able to make improvements in their areas of work.

Key achievements:

Deployment of **Patient First**, our long-term approach to transforming hospital services for the benefit of patients and staff continued with the following successes:

- 115 staff have attended the revised **Fundamentals of Improvement training**, aligned with Patient First.
- Medicine Division, deployed **Driver meetings** though their three portfolios: Urgent and Emergency Care, Specialty Medicine and Elective Care, with up to 14 specialty meetings held each month to focus on agreed improvement priorities.
- 21 teams are sustaining their weekly **improvement huddles**, enabling staff to make improvements in their area of work. This is 72% of all teams who have started improvement huddles.
- Increased accessibility to **improvement guidance, tools and templates** via the organisation MyStaff app, enabling staff to develop their knowledge and continue use of the approaches in day-to-day work.
- Development of a **UHBW project dashboard** to widely share all the projects underway across the organisation, and monitor the volume of projects that support co-production, environmental sustainability, address health inequalities or have financial improvements.

  Embedding the use of this dashboard will continue in 2026/27, to enable the tracking of impact of improvements being delivered.

Working with North Bristol Trust, **a Sustainable Healthcare collaboration** has been established to prioritise, coordinate and accelerate clinically led sustainability projects across both Trusts. See Chapter 3 for more information on our sustainability performance.

A detailed update on **Innovation** is included within section 5.2.2 of this report**.** From April 2025 we started an Innovation Support group with multidisciplinary representation to help innovators both internal and external with developing their ideas with us. This group expanded in 2026 to include North Bristol Trust colleagues. We have secured 2 patents in the last 12 months, had 30 innovation enquiries leading to 18 active innovation projects by the end of the year.

We have been engaging with internal stakeholders and external partners on developing an innovation strategy and there is considerable support for our ambitions. We are now at the stage of seeking support to establish an Innovation function as part of Bristol NHS Group.

Our Clinical Divisions have delivered a range of exciting innovations to improve patient care:

- UHBW became the first UK centre to use **Harmony valves** to deliver percutaneous pulmonary valve replacements for high-risk patients.
- **Gamma Knife Service** expansion:
  - First neurovascular patient treated with Gamma Knife, making us only the **third centre in the UK** offering this capability.
  - Service expansion enabled treatment of **400 patients in 2025**, a **45% increase compared with 2024**, alongside broadened eligibility including AVM patients.
  - First adult Arteriovenous Malformation (AVM) patient treated using a fully integrated UHBW–NBT MRI and angiography pathway, described by patients as seamless.
  - Our expanded Specialist Stereotactic Radiosurgery (SRS) service is now fully operational, treating its first trigeminal neuralgia patient and expanding specialist care closer to home.
- Bristol Royal Hospital for Children treated our first paediatric patient using the Magnetic Resonance-guided Laser Interstitial Thermal Therapy (MRgLITT) technique. Commissioned by NHSE, this minimally invasive epilepsy treatment was supported by The Grand Appeal charitable funding of specialist equipment.
- The **Bristol Clamshell Emergency Thoracotomy Course**, created in response to rising knife-crime injuries, has a faculty of over 20 clinicians and has trained nearly 100 frontline colleagues, winning a Bristol Life Award for its contribution to community safety and clinical education.

- Our emergency departments in Bristol and Weston have now screened more than **94,000 patients** for HIV, hepatitis B and hepatitis C through the Bristol NHS Group **opt-out blood-borne virus (BBV) testing** programme. Key programme successes include:
    - Identified **over 220 people** living with previously undiagnosed BBVs and linked them swiftly into specialist care.
    - Expanded in December 2025 to include Weston's Same Day Emergency Care Unit, the initiative now operates across BRI, Southmead Hospital and Weston General Hospital.
    - High consent levels across sites – **80% at Southmead**, **72% at the BRI**, and **68% at Weston ED/SDEC** – demonstrate strong public confidence in routine BBV testing.
    - Funded by NHS England and delivered jointly by UHBW and NBT, the programme is reducing stigma, removing barriers to testing and improving long-term health outcomes through earlier diagnosis and treatment.

During the past year, significant progress has been made in developing a **unified Hospital Group Digital Strategy** that will act as an enabling strategy underpinning delivery of the Group Clinical Strategy.

This work has focused on extensive engagement with colleagues, patients and partners to understand current challenges, identify opportunities for improvement and shape shared priorities. Engagement activity is ongoing and includes collaboration with primary care, mental health services, adult and children's services, local authorities, patients and wider acute healthcare partners across the region, reflecting a strong theme of partnership working.

The Group Digital Strategy is being co-designed with these stakeholders and will set out how digital investment, capability and ways of working will support clinical transformation across the Group. The strategy is not yet published and will continue to be refined through further engagement ahead of formal approval later in 2026/27.

F. Our Resources: Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.

Vision metrics:

- The full financial position is included in section 2.3 Finance Review.
- We will treat more patients with elective care needs, exceeding 2019/20 activity levels.

Key achievements:

As part of the Trust's Operational Planning submission for 2025/26, demand and capacity modelling was used to determine the activity volumes required to meet the ambition that no patients would be waiting 52 weeks or longer for treatment by 31st March 2026. The modelling also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions. The outputs of the modelling were shared with clinical divisions who subsequently developed plans describing a series of schemes which supported delivery of the activity required to meet these ambitions, primarily focussing on productivity and efficiency.

Despite the challenging No Criteria to Reside position throughout the year, there has been a notable increase in elective activity volumes during 2025/26, with elective inpatient and day case activity increasing by c4.6% when compared with 2024/25 and by c10.1% when compared to 2019/20. The Trust has seen a similar level of non-elective demand at the during 2025/26 compared with the previous year and a c3.4% growth in ED attendances, which, when considered along with the continued No Criteria to Reside challenge, has had an impact on the volumes of patients with elective care needs that the Trust has been able to see and treat.

Productivity and efficiency improvements have largely counteracted these challenges during the year, and this is evident when reviewing the average length of stay for patients admitted to the BRI and Weston sites during 2024/25, which has remained broadly stable.

Through the **Driving Financial and Productivity Improvement programme**, the Trust delivered significant progress during the year in strengthening its financial position, underpinned by a refreshed approach to productivity and efficiency and a strong culture of financial accountability and value-driven decision making.

Delivery of a challenging **£53 million cost improvement programme,** whilst protecting patient safety has been delivered through:

- Targeted improvements to **reduce temporary staffing costs**, including the Medical Workforce programme and Enhanced Therapeutic Observation Care (ETOC) project, and a focus on rostering, vacancy management and workforce planning, delivered £3.6m agency and £5.6m bank savings, whilst supporting safer, more stable staffing models.
- A Trust-wide **headcount reduction programme** has been implemented to redesign services and workforce models, ensuring the organisation can continue to deliver exceptional care within a reduced resource envelope. This has included service reviews, role redesign and improved vacancy management, with a strong emphasis on protecting frontline care and maintaining quality standards.
- Continued delivery of our established **medicines value programme**, which delivers savings through both cost and volume reductions. A major focus has been the optimisation of high-cost ophthalmology drugs, including a significant programme centred on Aflibercept. Improved prescribing practice strengthened clinical engagement and enhanced contract management have collectively reduced unwarranted variation and ensured more efficient use of resources.
- Use of **national and regional benchmarking** including NHSE Productivity Packs, Model Health System, NCCI, Service Line Reporting (SLR) and Getting It Right First Time (GIRFT), supported by a strengthened specialty deep-dive approach and regional collaboration, to systematically identify, review and act on improvement opportunities.
- A step change in the Trust's approach to **non-pay expenditure**, with strengthened commercial, procurement and financial controls is delivering measurable improvements. Key achievements include:

    - £4.1m of UHBW CIP delivered through procurement initiatives, product switches, tendered savings, early energy purchasing and contract optimisation.
    - A major uplift in governance, transparency and assurance across non-pay spend including Divisional dashboards, new product/supplier oversight, improved reporting, and targeted reduction of non-catalogue and tail spend.
    - Stronger clinical engagement to ensure procurement decisions balance quality, safety and value.
    - Value-Based Procurement (VBP): Methodology development, national pilot participation, and an emerging pipeline focused on clinical outcomes as well as financial impact.
    - Improved contract management, supplier performance monitoring and category-level planning
    - An expansion of commercial income through a range of initiatives, including growth in commercial clinical trials and industry partnerships, increased research and development (R&D) activity, optimised use of the Trust's estate, including leasing and commercial opportunities and strengthened arrangements for charging private providers for services delivered.

We continued to invest in our estate through a major **five-year capital programme**, focused on safety, resilience and modern care environments. During the year, national funding was secured for major schemes, including **£41 million for Hey Groves Theatres**, **£12 million for Children and Young People's theatres**, and **£2.5 million for Weston Emergency Department Phase 1**. Several projects reached key design and construction milestones, and fire safety improvements progressed across inpatient and neonatal areas

Using A3 thinking methodology a **Capital Delivery improvement** project has been delivered, improving the spend of capital funds more evenly throughout the year. Key improvements include:

- More accurate forecasting and financial control: Monthly forecasting became significantly more reliable, with the largest variance £0.9m in 2025/26 compared to £3.2m variance in 2024/25, supporting more consistent spend through the year.

- Stronger governance and portfolio management: A portfolio management structure with 9 capital programmes was established, alongside multi-year (5-year) planning/master programme development, strengthening governance, reporting and accountability and making capital plans more realistic and deliverable.

Successful service developments include:

- UHBW was awarded the South-West contract to become the sole regional provider of **adult melanoma tumour-infiltrating lymphocyte (TIL) therapy**. This cutting-edge cancer treatment is progressing through MHRA licensing and NICE appraisal, with expected NHS availability later this year. Our Pharmacy and Specialised Services teams played a key role in the successful bid.
- Bristol Heart Institute have been selected as one of only **five UK cardiac surgery centres** to use Thoracoflo devices, supporting safer aortic procedures and improved patient outcomes.
- A new city wide **Adult Inherited Metabolic Disease (IMD) Service** is on track to go live **April 2026**, improving access to specialist care.

2.1.4 Group Clinical Strategy

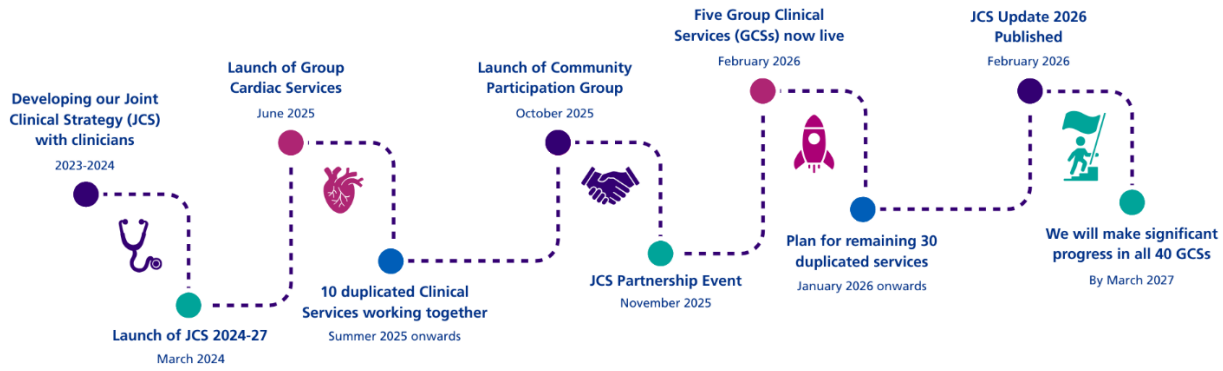
Our vision to deliver seamless, high-quality, equitable and sustainable care for the populations we serve was first set out in our Joint Clinical Strategy (JCS) in 2024. Developed by clinicians across United Bristol and Weston NHS Foundation Trust and North Bristol Trust, it has been the driving force behind forming the Bristol NHS Group and exploring a merger.

The strategy sets out how we will combine our collective strengths to address our shared challenges and make a bigger difference for our Four Ps: our patients, our people, the population we serve, and the public purse.

Our Group Clinical Strategy Update 2026 was published this year, and builds on our progress to date. It refreshes our ambitions to align with the key shifts outlined in the NHS 10 Year Health Plan, moving care closer to our communities, focussing on prevention and embracing digital.

Patients should never experience delays, duplication, or confusion because of where they live or which hospital they attend. Through our strategy, we will break down those barriers – ensuring care is consistent, connected, accessible and of the highest possible standard, wherever it's delivered – as well as ensuring our services support population heath.

Our journey to date is summarised below:



There are three phases of clinical transformation to deliver our vision. Phase one is already underway, with phase two starting in 2026 and running alongside it. Phase three will begin after the first two phases have made sufficient progress.

Feedback from clinical teams who have gone through the journey to bring their services together has shown that operating as two separate legal entities makes delivering change harder and slower. We are exploring a merger in response to that challenge and to remove barriers to delivering our strategy.

Irrespective of our Trusts exploring a merger, we will progress through these phases to bring clinical teams together and transform services to ensure we are able to meet the needs of our population and deliver the best possible care, now and for the future.

The Group Clinical Strategy is the cornerstone of the Group's integration, focusing on reducing duplication and variation across 40 clinical services. By 2027, all duplicated services will have made significant progress towards becoming Group Clinical Services (GCS).

GCS's offer a new way to deliver care across our Group and allow us to build on the best of each clinical and operational team. They will:

- Remove unnecessary duplication.
- Make best use of our people, expertise and infrastructure.
- Offer more consistent pathways and experiences for patients.
- Deliver more training and development opportunities for staff.
- Enable faster innovation and improvement at scale.
- Help us embrace opportunities to deliver care closer to home and support prevention.

Each of our 40 specialties will work towards one of the following milestones by March 2027, recognising that they each vary in terms of size, complexity and readiness for change.

Table 1: Joint Clinical Strategy Milestones

Milestone One	A **Leadership Forum** is in place to oversee delivery with a scoped benefits realisation plan.
Milestone Two	A **single leadership team** has been appointed, underpinned by strong site-based leadership.
Milestone Three	Group Clinical Service **minimum standards** have been achieved.

Table 2: Specialities in scope of the CGS programme

Duplicated Services		
Acute Medicine	Gynaecology	Palliative Medicine
Acute Oncology	Haematology	Pathology
Anaesthesia	Hepatology	Pharmacy
Cardiology	Imaging	Physiotherapy
Care of the Elderly	Liaison Psychiatry	Respiratory Medicine
Clinical Psychology	Maternity	Rheumatology
Colorectal Surgery	Medical Photography	Safeguarding

Duplicated Services		
Critical Care	MEMO/Clinical Engineering	Speech & Language Therapy
Dermatology	Neonatology	Sterile Services
Diabetes & Endocrinology	Neurophysiology	Theatre
Emergency Medicine	Nutrition & Dietetics	Trauma & Orthopaedics
Endoscopy	Occupational Therapy	Upper Gastro-Intestinal Surgery
Gastroenterology	Orthotics	
General Surgery	Pain Service	

As of March 2026, there are 15 specialties active in the Group Clinical Services (GCS) programme, with five GCS's now at milestone two and being led by a Single Leadership Team who are supported by strong site-based leaders. (Safeguarding, Cardiology, Pain, Trauma & Orthopaedics and Liaison Psychiatry). A roll-out plan towards March 2027 has been developed for the remaining specialties.

An implementation guide has been developed which outlines the key and enabling workstreams for GCSs. The approach to implementing a Group Clinical Service Programme is divided into **four phases**:

Phase 1: Getting Started	**Phase 2:** Planning and Design	**Phase 3:** Implementation	**Phase 4:** Handover to 'new BAU'

There are various workstreams within the programme, which include those which are **key** to the programme delivery, and **enabling** workstreams

- The key workstreams are: Programme Governance, Improvement Projects and Benefits, Clinical Model and Pathway Alignment, Health Equity and the 'Left Shift', and Single Leadership Team*
- The enabling workstreams are: Accountability Framework and Corporate Enablers, Communications, Organisational Development (OD), Patient and Public Involvement (PPI) and Business Intelligence (BI)

Early group integration has already delivered measurable improvements in consistency, reduced variation, streamlined pathways, and more effective use of collective expertise. The proposed merger will further expand research and innovation capacity, strengthen workforce development, and deliver more equitable care for patients across all sites. Some examples of improvements being delivered by our existing GCS's include the following.

Improving Access:

- In Group Cardiac Service, urgent Percutaneous Coronary Intervention (PCI) patients have been accessing the next available slot across hospitals through a 'treat and return' pathway, helping to equalise and reduce wait times. Building on this progress, a single PCI service is now being implemented for our Group.
- Single-use cardiac monitor patches used at NBT have been adopted across our Group, helping to reduce UHBW's 12-month waitlist and creating a fairer, community-based care pathway. The patches let patients self-fit at home, reducing hospital visits and easing pressure on clinical teams.

- Our Group Trauma & Orthopaedics (T&O) service are working with system partners to create a single patient pathway for Foot & Ankle and Hand & Wrist referrals. This will help equalise and reduce waiting times for patients by balancing demand and capacity.

Improving Experience:

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

Improving Outcomes:

- Performance of the Rapid Access Chest Pain Clinic within the Group Cardiac is now monitored by the same leadership team. When one site experienced a lot of staff absence in the summer, the Bristol Heart Institute was able to take 40 referrals to improve the number of patients seen within the NICE recommended 2-week period.
- In T&O, our Southmead and Weston sites are performing above the national average for getting patients to theatres quickly. A working group has now been established to look at theatre schedules and escalation processes at the Bristol Royal Infirmary to share learning from other sites.

Workforce Resilience:

- Our Group Liaison Psychiatry Service has created a collaborative bank for Registered Mental Health nurses and Mental Health Support staff for training and supervision Workers. This collaboration created is working towards creating a larger flexible workforce available to both Trusts, helping to manage staffing demands across different sites. It has also brought new opportunities to bank and is improving patient care through better workforce continuity.
- There have been four joint Consultant appointments within the Group Cardiac Service, with these team members working at both Southmead and Bristol Heart Institute. This means the leadership team have been able to organise interesting portfolios and job-plans for these staff to enhance recruitment and succession planning.

Financial Sustainability:

- Our Group Pain Service is planning for NBT patients, who currently go to the Independent Sector due to limited theatre space, to have their procedures at South Bristol Community Hospital. This change will improve access for patients and deliver significant cost savings, strengthening the service's long-term sustainability.
- The strategy aligns closely with the NHS 10-Year Plan's shifts; Hospital to Community, Sickness to Prevention, and Analogue to Digital. Ongoing engagement with system partners and communities ensures the strategy is responsive to evolving needs and priorities.
- Research and development, as well as innovation, are at the heart of the Group's clinical model. A merged organisation will position the new Trust as one of the largest providers of clinical trials and healthcare research in England, further enhancing patient outcomes, staff recruitment, and financial sustainability.

Keeping patients at the heart

- Our Community Participation Group (CPG) was formed in October 2025 to help shape hospital services and make sure we focus on what matters most to the people and communities we serve.

- The group is made up of people with lived experience, carers and representatives from voluntary, community and social enterprise organisations.

- Group members will meet every two months to offer honest and helpful feedback and to co-design how we involve patients and the public in designing our Group Clinical Services.

- Alongside shaping our hospital services with our CPG, we will actively seek input from wider community networks. We want to ensure that voices from diverse backgrounds and often unheard groups are represented in our decision-making, whilst also prioritising equity and addressing population health needs to reduce disparities and improve outcomes for all.

Working together as a system

- We recognise that we cannot achieve our goals in isolation – it's vital that we work with our healthcare system partners, Voluntary, Community and Social Enterprise organisations (VCSE) as well as academic and research partners. Our series of Partnership and Clinical Strategy Events (November 2025 and March 2026) are just one of the ways we're working with our local system to deliver a shared vision for more joined-up, patient centred and equitable healthcare services.

- As we redesign patient pathways through our Group Clinical Services, we want to explore opportunities to deliver care differently with our partners. In doing so, we hope to remove access barriers, address health inequalities together, shift more care into our communities and support prevention initiatives.

- Clinical teams are being empowered and supported to reimagine how they deliver their services through the resources of our Group and by working together with our system colleagues.

Addressing Health Inequalities

- A key focus of our Group Clinical Strategy is ensuring we deliver equitable services for everyone we serve and helping to reduce health inequalities that exist in our communities.

- As we establish our Group Clinical Services, teams will be supported to develop a Health Equity Improvement Plan to address inequalities in their area. This plan will help colleagues

- Agree how their service will act on Trust-wide inequality priorities

- Identify where further collaboration can reduce inequalities

- Consider areas where there is a need to understand more or improve

- This approach will be informed by data and engagement with patients and the public to understand issues and develop solutions.

2.1.5 Key risks to delivering our objectives.

During 2025/26, the Group has continued to strengthen a structured, Board-led approach to risk management through the Group Board Assurance Framework (BAF), ensuring that the most significant risks to the delivery of our strategic objectives are clearly articulated, owned and actively overseen. The BAF provides a consolidated view of the principal risks that threaten delivery of the Group's priorities and how these risks are being controlled, assured and mitigated.

The 2025/26 BAF identifies a set of principal risks that reflect both the operational realities facing the Trusts and the wider system context in which they operate. These include: Quality, Equipment, Workforce, Performance, Capacity, Digital, Finance, Estate and Compliance, alongside Fire Safety and Change Management as stand-alone principal risks. Together, these risks capture the cumulative impact of sustained demand, constrained capacity, capital and workforce pressures, digital dependency, and the scale and pace of transformation required across the NHS.

Key risks to delivering the Group's objectives in 2025/26 are dominated by persistent pressure on quality and performance arising from system-wide flow constraints, high numbers of patients with no criteria to reside, emergency department overcrowding, and reliance on escalation capacity. These pressures are now structural rather than episodic and directly affect patient safety, experience, staff wellbeing and the Trusts' ability to meet national standards. Workforce risks remain significant, driven by national shortages in key roles, sickness absence, reliance on temporary staffing, and the need to deliver major workforce and education reforms alongside business-as-usual services.

The BAF also highlights material risks associated with ageing estates and equipment, compounded by constrained capital availability. Limited CDEL continues to restrict the pace at which known estates, fire safety and equipment risks can be permanently resolved, increasing reliance on interim mitigations and elevating the risk of service disruption and regulatory non-compliance. Digital risk remains high, reflecting reliance on legacy systems, fragmented interoperability and the need for sustained investment to reduce technical debt and improve resilience, despite progress in closing specific cyber and infrastructure gaps.

Financial sustainability continues to present a strategic risk, with structural deficits, inflationary pressures and recovery requirements constraining investment and flexibility. These financial pressures interact directly with estates, workforce and digital risks, reinforcing the need for explicit Board-level prioritisation and trade-off decisions.

The introduction of Change Management as a principal risk recognises that the Trusts are operating in a continuous state of large-scale transformation, driven by Group development, national policy reform, digital change and financial recovery expectations. The cumulative burden of change, delivered alongside sustained operational pressure, presents a material risk to organisational capacity, delivery confidence and the maintenance of safe business-as-usual performance.

The principal risks set out in the 2025/26 BAF provide a clear articulation of the key threats to delivering the Group's objectives. They reinforce the need for sustained Board oversight, system working, risk-based prioritisation of limited resources, and a continued focus on assurance and delivery against the most material risks facing the organisation.

2.1.6 Going concern disclosure

The directors have a reasonable expectation that the services provided by the NHS foundation trust will continue in operational existence for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The monthly cash balances of the Trust's 2026/27 financial plan inform the going concern assessment. The cashflow forecast predicts positive cash balances throughout the period with a projected minimum cash balance of £35.408m as of December 2026. In addition, downside forecasting has been undertaken, which considers a number of factors, for example, failure to deliver the Trust's savings requirement in full and additional unforeseen cost pressures, to stress test the cashflow forecast. The downside forecast continues to predict positive cash balances throughout the period. The projected minimum cash balance is £19.183m as of 31st March 2027.

After consideration of the cashflow forecasts, the directors have adopted the going concern basis.

The going concern assessment has been prepared on the basis of University Hospitals Bristol and Weston NHS Foundation Trust as a standalone entity. The Trust is proposing to merge with North Bristol NHS Trust (NBT) by way of a technical acquisition in summer 2026. Management has considered NBT's going concern disclosure as at 31 March 2026, together with its cash flow forecast for 2026–27. Based on this review, it is not anticipated that the proposed transaction will have a material adverse impact on the going concern status.

2.1.7 Overview of financial performance

Similar to previous years, funding envelopes for 2025/26 were set at an Integrated Care System (ICS) level. Emphasis remained on Bristol, North Somerset and South Gloucestershire Integrated Care System (BNSSG ICS) achieving a break-even income and expenditure plan in aggregate and at organisational level.

As per 2024/25, in 2025/26 the majority of the Trust's NHS income was earned from NHS commissioners under the NHS Payment Scheme (NHSPS) with Aligned Payment and Incentive (API) contracts as the main payment mechanism. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity based on actual activity.

Elective recovery funding (ERF) continued to be available in 2025/26 to provide further non-recurrent, financial incentive to increase elective activity, reducing waiting times for patients.

The Trust's 2025/26 financial plan, was a breakeven revenue income and revenue plan, constructed in accordance with the national planning guidance issued by NHS England (NHSE) and was aligned with the BNSSG ICS system financial envelope including the South West regional specialised commissioners.

The Trust delivered a net income and expenditure surplus of £4.976m (excluding technical items). This is a significant achievement in the context of increasing financial constraints, and the continuing operational challenge of responding to increased urgent care demands, alongside actively reducing waiting lists for elective care. 2025/26 was the 23rd year in a row that the Trust delivered a surplus or break-even income and expenditure position (excluding technical items).

During the financial year, the Trust continued the implementation of a significant revenue and capital investment programme. Key investments included £18.9m replacing old medical equipment, £17.9m for estate improvements, £16.7m on major improvement projects to enhance access to high-quality patient care, and £16.6m on upgrades to digital systems and infrastructure.

The Trust delivered savings of £53.1m against a planned £53.0m, with 58% of these savings being non-recurrent. While the Trust continued to improve its overall level of savings delivered, the ability to secure recurrent savings in 2025/26 remained challenging. This reflected the actions required to reduce elective waiting times and respond to increased demand across urgent and emergency care services. The Productivity and Financial Improvement Group, established in 2023/24 and chaired by the Hospital Managing Director, continued to play a key role in driving the savings programme, supporting delivery of planned efficiencies, and enabling improvements in productivity.

The Trust's cash position remained positive with a year-end cash and cash equivalents balance of £73.1m.

Despite the continuing operational challenges of accessing the hospital estate, minimising operational disruption and securing regulatory approvals, the Trust invested £85.7m on capital projects, including reconfiguration and improvements to the Trust's estate, medical equipment purchases, and further investment in information technology.

In accordance with NHSE requirements, the Trust submitted its 2026/27 break-even financial plan on 18th March 2026. The plan was concluded in conjunction with system partners.

2.2 Performance Summary

2025/26 Priorities and Operational Planning Guidance

On 30th January 2025, NHS England released the 2025/26 priorities and operational planning guidance. The guidance outlined the priorities for the NHS in 2025/26 including improvements in elective and urgent and emergency care (UEC) performance. A range of performance objectives were defined in the document, and the core metrics are summarised in the table below.

Table 3: Performance Standards against priority areas

Priority areas	Performance standards
Urgent and Emergency Care (UEC)	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
Elective Care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement* Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement* Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
Cancer	Improve performance against the headline 62-day cancer standard to 75% by March 2026 Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

*Against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60% and performance on wait for first appointment to a minimum of 67%

Development of BNSSG Operating Plan for 2025/26

Following the publication of the 2025/26 Priorities and Operational Planning Guidance, the Trust, with other partner organisations, contributed to the development of the 2025/26 BNSSG Integrated Care System operating plan.

The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on the national ambition of <1% of patients waiting more than 52 weeks by 31st March 2026, whilst it also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions.

Demand modelling was shared with divisions who subsequently developed a series of delivery plans describing schemes that will be introduced, or continued, that would support the levels of activity required to meet the ambitions referenced above. Divisional delivery plans were primarily focused on productivity benefits and were reviewed and stress-tested by corporate colleagues, ensuring that the plans were well defined, feasible and affordable.

The modelled requirements met the associated performance standards and also satisfied the value of activity required to meet the Elective Recovery Fund (ERF) threshold.

The Trust's performance trajectories included in the operating plan submission are summarised in the following table.

Table 4: Performance trajectories in the Trust's operating plan submission

	Waiting time standard	Operational Planning Requirement (by March 2026)	UHBW Plan Submission (by March 2026)
Urgent and Emergency Care (UEC)[1]	Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	78%	78%[1]
Elective Care	Percentage of patients waiting no longer than 18 weeks for treatment	67.8% (i.e. a 5% improvement on baseline)	67.8%
	Percentage of patients waiting no longer than 18 weeks for a first appointment	71.7% (i.e. a 5% improvement on baseline)	71.7%
	Proportion of people waiting over 52 weeks for treatment	<1%	<1%
Cancer	62-day urgent referral to first treatment	75%	75%
	28-day Faster Diagnosis Standard	80%	80%

Notes:
[1] The performance standard is set as a system ambition of 78%, with a percentage uplift applied to UHBW based on the performance of Sirona Type-3 Emergency Departments (MIU and UTC).

Performance during 2025/26

The following sections summarise performance against performance standards in 2025/26.

2.2.1 Referral to Treatment (RTT)

18 week waits
The operational planning guidance required Trusts to improve the percentage of patients waiting no longer than 18 weeks for treatment to 67.8% by March 2026.

At the end of March 2026, the Trust reported that 68.04% of patients were waiting 18 weeks or less, achieving the year-end target.

Wait to first appointment
The Trust submitted a plan that achieved the national standard of 71.7% of patients waiting no longer than 18 weeks for a first appointment by March 2026.

The Trust fell slightly short of this target, reporting 71.3% on 31st March 2026.

52 week waits
The third RTT measure included in the Operational Planning Guidance related to patients waiting no longer than 52 weeks for treatment, with a target of less than 1% of total RTT waiting list by March 2026.

At the end of March, the Trust met the target, reducing the number of patients waiting 52 weeks or longer to 311, which equated to 0.6% of the total RTT waiting list.

2.2.2 Accident & Emergency four-hour maximum wait and 12-hour waits

Overall, ED attendances during 2025/26 have exceeded previous year's levels; activity volumes are shown below.

Table 5: Total attendances at Emergency Departments

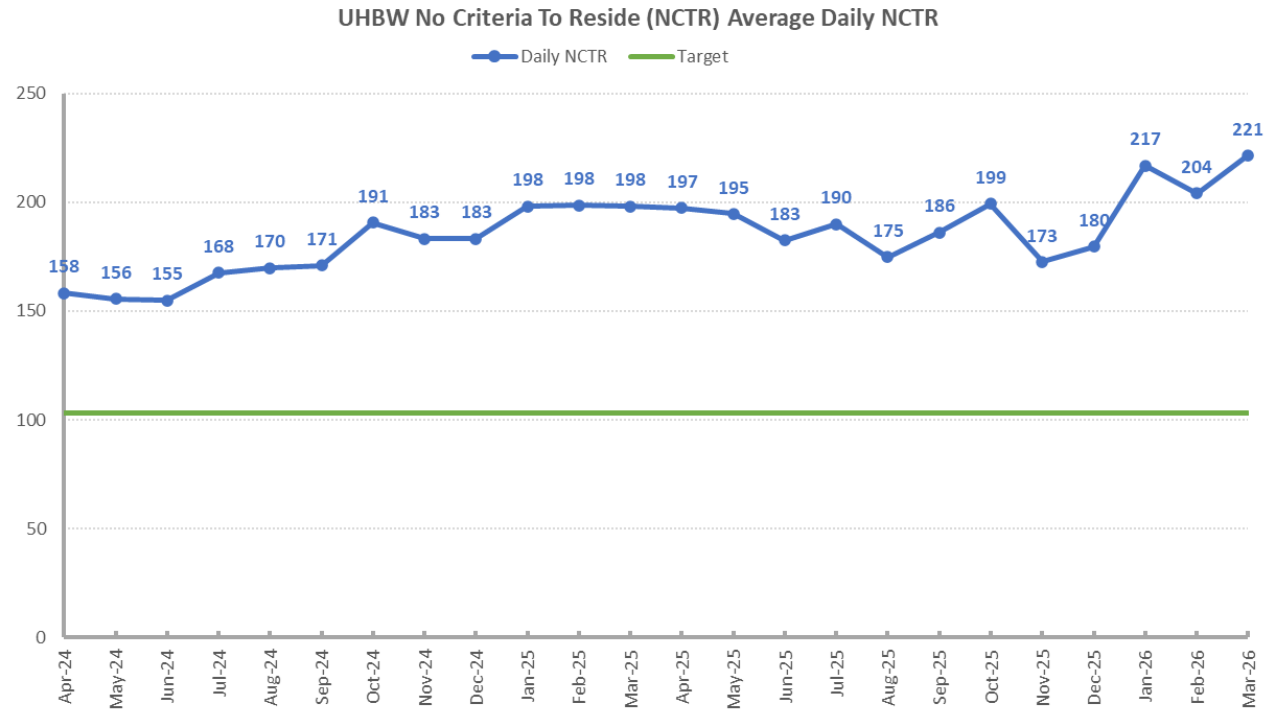
	Total Attendances			
Hospital Site	**2019/20**	**2023/24**	**2024/25**	**2025/26**
Bristol Royal Hospital for Children	44,499	47,879	48,918	48,722
Bristol Eye Hospital	24,941	26,771	27,666	29,286
Bristol Royal Infirmary	73,499	78,473	80,173	83,171
Weston General Hospital	50,315	51,435	54,407	56,914
TRUST TOTAL	**193,254**	**204,558**	**211,164**	**218,093**

Table 6: Average daily number of attendances at Emergency Departments

	Average Daily Attendances			
Hospital Site	**2019/20**	**2023/24**	**2024/25**	**2025/26**
Bristol Royal Hospital for Children	122	131	134	133
Bristol Eye Hospital	68	73	76	80
Bristol Royal Infirmary	201	214	220	228
Weston General Hospital	137	141	149	156
TRUST TOTAL	**528**	**559**	**579**	**598**

The operational planning guidance set out the requirement that a minimum of 78% of patients attending an emergency department be seen, treated if necessary, and either discharged or admitted within four hours, by the end of March 2026.

During 2025/26 the Trust saw increased demand in both attendances to its Adult Emergency Departments, which alongside high bed occupancy levels, impacted delivery of the four-hour standard of care. Alongside increased demand for our UEC services, there has been a continued challenge with the high number of patients in hospital with No Criteria to Reside.



There has been a significant effort to increase patient flow through a range of initiatives, and the Trust have also focused on ensuring timely ambulance turnaround times to reduce delays for patients coming to hospital, working closely with system partners through the Transfer of Care Hubs, to also ensure prompt discharge when patients are ready to leave hospital.

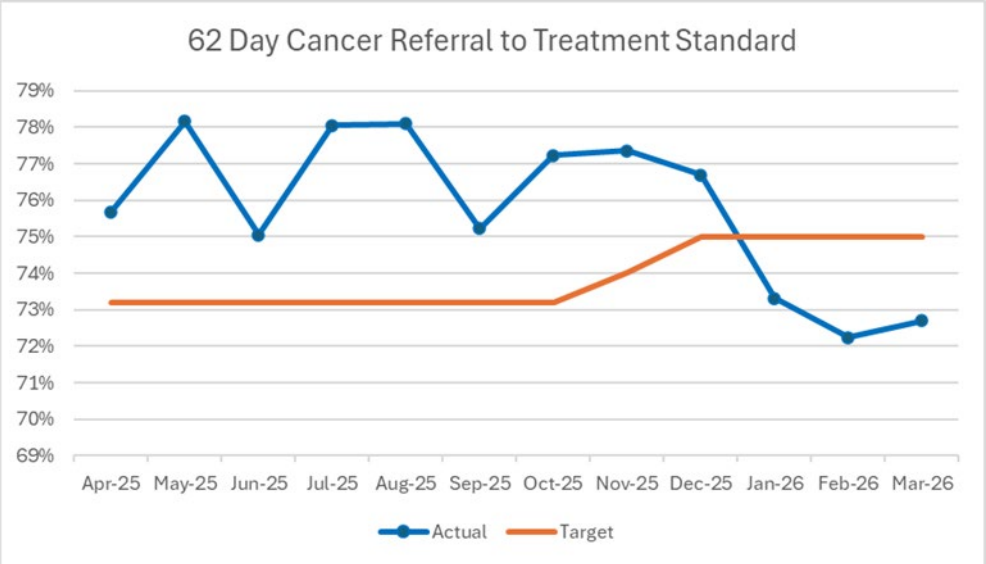
In February 2026, delivery against the four-hour standard of care, was 74.5%. From March 2026, NHS England requested that Trusts refocus their efforts to achieve the delivery of the March end position of 78%. In addition to the Winter Operational Plan 2025/26, the Trust mobilised a further hospital wide response, achieving 73.8% against this target. Of note, this performance includes Type 1, 2 and 3 attendances.

Across the course of 2025/26, 4.6% of patients attending ED spent more than 12 hours in the department, compared to 4.8% in 2024/25, achieving the stated ambition of an improvement on the previous year.

2.2.3 Cancer

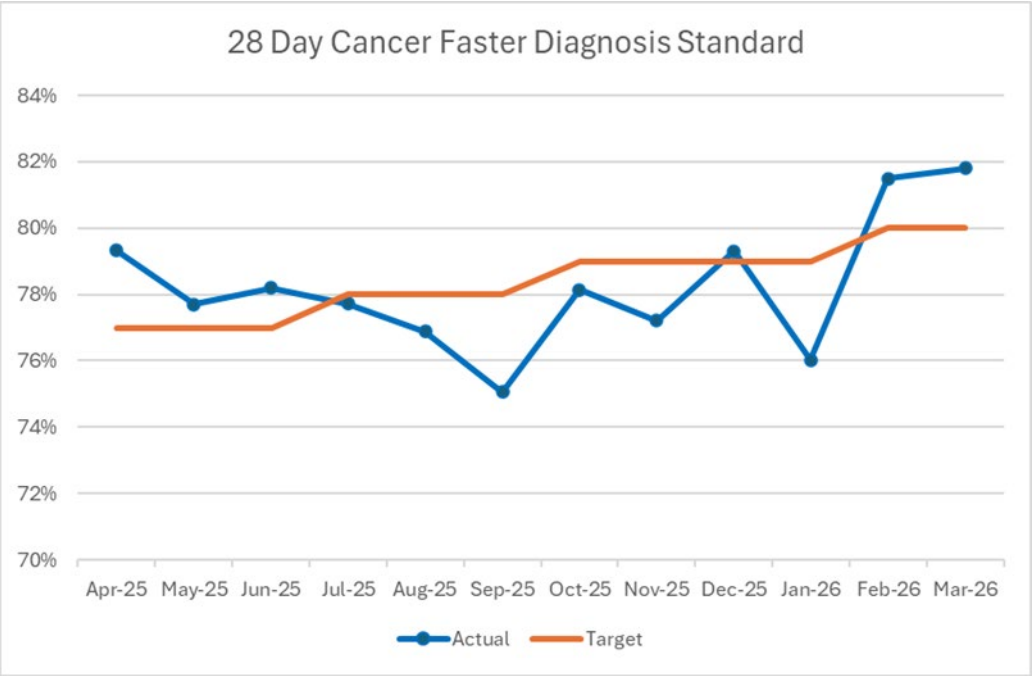
Patients with cancer should start first definitive treatment within 62 days of referral from a GP, screening programme or upgrade by a consultant. The national standard is that 85% of patients should start their definitive treatment within this standard and NHSE set an interim recovery target for providers of 75% by March 2026.

The Trust has performed above NHSE's recovery standard of 75% through much out the year, achieving 72.7% at the end of March and setting a plan for 2026/27 to achieve the national ambition of 80% by March 2027.



The Faster Diagnosis Standard (FDS) is designed to measure the time from referral to a patient receiving a diagnosis, or having cancer ruled out, within 28 days.

Performance met or exceeded the trajectory through most of the year, achieving 81.8% by end of March 2026 (against plan of 80%). Performance is anticipated to be maintained in line with the Medium Term Plan ambition of achieving 80% throughout the year.



2.2.4 NHS Oversight Framework (NHS OF)

NHS England published the revised NHS Oversight Framework 2025/26 on 26 June 2025, describing an approach to assessing NHS organisations, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

A score is calculated for each organisation, based upon performance against a range of metrics associated with:

- Access to services
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and productivity

This score is then used to determine a segment, which identifies the level of support that each organisation requires (segments described in table below):

Table 7: NHS Oversight Framework segments

Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

Segmentation allocation is republished each quarter and UHBW have been placed in segment 1 (the top performing segment) since publication of the revised NHS OF, placing the Trust in the top seven, non-specialist acute NHS Trusts in the country.

2.3 Financial Review

2.3.1 Financial analysis

The Trust delivered a net surplus of £4.976m, excluding technical accounting adjustments as set out in note 2 of the annual accounts. There are a number of items classified as technical which are excluded by NHSE when considering the Trust's financial performance. As in previous years, technical items include depreciation on donated assets, donated income in respect of assets, impairments, and reversal of impairments. The £4.976m surplus compares favourably with the breakeven plan.

Including technical items and as per the annual accounts, the Trust reported a net income and expenditure deficit of £10.595m.

The operating plan for 2025/26 was approved by the Trust's Finance and Estates Committee on behalf of the Trust Board under agreed delegated authority on 25th March 2025 ahead of the submission of the financial plan to NHSE on 27th March 2025. Significant variances in both income and expenditure items include, the impact of enhanced pay costs, the costs of escalation capacity relating to patients with 'No Criteria to Reside', the impact of a technical adjustment relating to the valuation of the Trusts building's and in-year changes to contracting arrangements.

The Trust's income and expenditure performance for the year is shown in the table below:

Table 8: 2025/26 Financial performance against plan:

	Plan £m	Actual £m	Variance Favourable/ (Adverse) £m
Income from Patient Care Activities	1,222.638	1,300.206	77.568
Other Operating Income	132.903	139.749	6.846
Total Operating Income	**1,355.541**	**1,439.955**	**84.414**
Employee Expenses	(852.829)	(880.823)	(27.994)
Other Operating Expenses	(443.740)	(514.173)	(70.433)
Depreciation (owned & leased)	(47.056)	(44.817)	2.239
Total Operating Expenditure	**(1,343.625)**	**(1,439.813)**	**(96.188)**
PDC	(13.774)	(11.661)	2.113
Interest Payable	(2.499)	(2.638)	(0.139)
Interest Receivable	3.446	3.765	0.319
Other Gains/(Losses)	-	(0.203)	(0.203)
Net Surplus/(Deficit) per Annual Accounts	**(0.911)**	**(10.595)**	**(9.684)**
Remove Impairments, Capital Donations, Grants, and Donated Asset Depreciation	0.911	15.571	14.660
Adjusted Financial Performance Surplus/(Deficit) Reported to NHSE	-	**4.976**	**4.976**

2.3.2 Savings

The Trust delivered savings of £53.1m against a plan of £53.0m. Of the savings achieved in the year, 55% were recurrent, with £29.1m identified as having a full year effect. Pay savings were primarily driven by strengthened vacancy management and vacancy control processes to support substantive workforce efficiencies. These measures also contributed to reductions in temporary staffing costs, alongside the implementation of agency cap rates, increased use of direct engagement for medical

and other clinical staff, and the rollout of the Enhanced Therapeutic Observation Care (ETOC) programme. Non pay savings were achieved through securing best value in procurement, tighter control of non-pay expenditure (including medicines), and the review of high-cost drugs to identify opportunities for generic substitution. The Trust continues to develop additional workstreams to deliver further savings in 2026/27 and future years.

Table 9: Savings achieved during 2025/26:

Workstream	Plan £m	Actual £m	Variance - Favourable / (Adverse) £m
Pay Efficiencies			
Agency - improve price caps compliance	0.586	0.493	(0.093)
Agency - reduce the reliance on agency	2.185	3.135	0.950
increase bank activity and address costs	1.212	4.642	3.430
Establishment reviews	10.629	10.108	(0.521)
E-Rostering / E-Job Planning	7.799	1.622	(6.177)
Corporate services transformation	1.823	1.807	(0.016)
Digital transformation	0.531	-	(0.531)
Unidentified	3.996	-	(3.996)
Total Pay Efficiencies	**28.761**	**21.807**	**(6.954)**
Non-Pay Efficiencies			
Medicines efficiencies	1.812	6.481	4.669
Procurement (excl drugs) - non-clinical directly achieved	2.395	3.378	0.983
Procurement (excl drugs) - MDCC directly achieved	7.441	8.610	1.169
Estates and Premises transformation	1.420	0.527	(0.893)
Pathology & imaging networks	0.120	0.120	-
Corporate services transformation	0.606	1.163	0.557
Digital transformation	0.474	0.048	(0.426)
Other	2.004	1.521	(0.483)
Unidentified	4.491	-	(4.491)
Total Non-Pay Efficiencies	**20.763**	**21.848**	**1.085**
Income Efficiencies			
Private Patient	0.150	0.130	(0.020)
Non-Patient Care	3.170	8.203	5.033
Other	0.156	1.145	0.989
Total Income Efficiencies	**3.476**	**9.478**	**6.002**
Grand Total	**53.000**	**53.133**	**0.133**

2.3.3 Statement of financial position

The Trust's cash and cash equivalents balance at 31st March 2026 was £73.093m, a movement of £0.798m from last year. How the Trust used its cash during the year is shown in the table below:

Table 10: Use of cash 2025/26

	£m	***£m***
Opening Cash Balance		***72.295***
Use of cash:		
Net cash flow from operating activities	***65.378***	
Capital investment	***(74.973)***	
Other net cash flows from investing activities	***4.583***	
Public Dividend Capital received	***32.731***	
Capital loan repayments to the DHSC	***(5.834)***	
Interest (on capital loan) payments to DHSC and other interest	***(1.162)***	
Public Dividend Capital dividend payment	***(10.837)***	
Finance lease payments	***(9.088)***	
Increase in cash balance 2025/26		***0.798***
Closing Cash Balance		***73.093***

The Trust's statement of financial position (balance sheet) reported total assets employed as at 31st March 2026 of £476.197m as summarised in the table below:

Table 11: Statement of Financial Position 2025/26

Statement of Financial Position	£m
Total Non-Current Assets	623.018
Total Current Assets	146.510
Total Current Liabilities	(165.768)
Net Current Assets	**(19.258)**
Total Assets Less Current Liabilities	**603.760**
Total Non-Current Liabilities	(127.563)
Total Assets Employed	**476.197**
Equity:	
Public Dividend Capital	370.289
Revaluation Reserve	51.420
Other Reserves	0.085
Income & Expenditure Reserve	54.403
Total Equity	**476.197**

2.3.4 Capital

The Trust Board approved the 2025/26 capital investment programme of £102.734m in March 2025. The approach to capital funding in 2025/26 remained the same with capital envelopes allocated to each Integrated Care System (ICS). This envelope set a limit on the capital expenditure within a system and required the partners to work together to prioritise capital expenditure. The Trust was allocated a 46.2% share of the £100m BNSSG ICS capital envelope. During the year, additional capital allocations were approved, including increases by the Department of Health and Social Care (DHSC) in respect of schemes to support estates backlog maintenance, diagnostics, gender service and digitalisation. The Trust and DHSC agreed that funding allocations for specific estates schemes could be carried forward to future years where delivery was not achievable within the financial year. The Trust's total capital funding for 2025/26 was £85.674m.

Table 12: 2025/26 capital funding by source

Capital Funding Source	£m
UHBW Funded - System Envelope	52.125
DHSC Approved Funding	32.731
Grants/Donations/Other	0.818
Total	**85.674**

The limit on capital expenditure meant that not all the Trust's prioritised capital schemes could be approved for delivery during the year. Schemes which were not approved for implementation have been carried forward for consideration in the prioritisation process for the 2026/27 plan.

The Trust's capital programme is managed through the Trust's Capital Programme Board with capital funding allocated to individual schemes in five areas. In 2025/26 the Trust invested £77.307m on capital projects, which included the following significant investments:

- Medical Equipment (*e.g. anaesthetic machines, theatre and patient monitoring equipment*) - £18.897m
- Estates and Building Improvement *(e.g. backlog maintenance and critical risk infrastructure)* - £17.819m
- Major Projects *(incl. Weston Same Day Emergency Care, linear accelerator and beside pendants)* - £16.745m
- Digital *(e.g. new devices, network, infrastructure, systems and server upgrades)* - £16.589m

In addition, the Trust also invested £8.367m on leased equipment and properties, with capital expenditure totalling £85.674m for the year. Total expenditure against the NHSE plan is shown in the

table below. The variance between the plan and the expenditure is due to the agreement with DHSC to reallocate national funding into future years.

Table 13: Funding and expenditure on capital schemes:

	2025/26 NHSE Plan £m	2025/26 Actual £m	2025/26 Variance £m
Source of Funding:			
PDC	55.171	32.731	(22.440)
Donations - Cash	1.500	0.818	(0.682)
Depreciation	47.055	44.817	(2.238)
Disposals	-	0.490	0.490
Cash Balances	(0.992)	6.818	7.810
Total Funding	**102.734**	**85.674**	**(17.060)**
Expenditure:			
Major Capital Schemes	44.727	16.745	(27.982)
Medical Equipment	5.994	18.897	12.903
Fire Improvement	3.500	7.257	3.757
Estates Schemes	39.670	17.819	(21.851)
Digital Services	3.343	16.589	13.246
Expenditure before leases and remeasurements	**97.234**	**77.307**	**(19.927)**
Other (New Leases and Remeasurements)	5.500	8.367	2.867
Total Expenditure	**102.734**	**85.674**	**(17.060)**

2.3.5 Countering Fraud, Bribery and Corruption

The Board takes the prevention and detection of fraud very seriously and has policies and procedures in place to minimise the risk of fraud, bribery and corruption. The Trust actively promotes procedures for the reporting of suspected wrongdoing.

The Trust works closely with its Local Counter Fraud Specialists (LCFS) to implement the NHS Counter Fraud Authority (NHSCFA) national strategy on countering fraud and to ensure the Trust is fully complying with Government, NHSCFA and Commissioner guidelines and regulatory requirements. The Trust participates in the National Fraud Initiative (NFI).

Work is carried out across all key areas of Counter Fraud activity, ensuring compliance against the 13 components required by the Government Functional Standard GovS 013: Counter Fraud (NHS Requirements). This work is evidenced in the annual completion of the Counter Fraud Functional Standard Return (CFFSR) and the annual Counter Fraud report presented to the Audit Committee.

The Local Counter Fraud, Bribery and Corruption policy and legislative background is also available on the Trust's intranet together with contact details of the LCFS and the NHSCFA.

2.3.6 NHS CFA Fraud and Corruption Reporting Line (FCRL)

Fraud prevention notices and alerts are regularly raised via the Trust's communication systems, including the dissemination of Counter Fraud newsletters and regular fraud awareness articles in the Trust's staff communications, on the intranet and via internal digital communication platforms. All materials contain the LCFS Team and FCRL (NHS CFA Fraud & Corruption Reporting Line) contact details.

2.3.7 Anti-Bribery Statement

The Bribery Act 2010 came into force on 1 July 2011. The aim of the Act is to tackle bribery and corruption in both the private and public sector.

The Act defines the following key offences with regards to bribery:

- Active bribery (offering, promising or giving a bribe)
- Passive bribery (requesting, agreeing to receive or accepting a bribe)
- Bribery of a foreign public official.
- A corporate offence of failing to prevent bribery

The Trust does not tolerate any form of bribery whether by staff, contractors, suppliers or patients. Bribery will have a detrimental effect on the Trust and can undermine the public's perception of the Trust and the integrity of its staff.

The Board is committed to applying and enforcing effective anti-bribery measures to prevent, examine and eradicate Fraud, Bribery and Corruption. The Board will seek to apply the strongest penalties to anyone involved in bribery activities, including staff, suppliers and public alike.

To reduce both the Trust's and its staff's exposure to bribery there are clear policies in place:

- Staff Conduct Policy.
- Local Counter Fraud, Bribery and Corruption Policy.
- Freedom to Speak Up Policy.
- Register of Interests, Gifts and Hospitality Policy.

A register of interest for all decision-making staff is held to demonstrate the open and transparent way we conduct our work within the Trust.

Any suspicions of Fraud, Bribery or Corruption may be reported by contacting the Local Counter Fraud Specialists or the NHSCFA FCRL.

2.3.8 Overseas Visitors (patients who are not ordinarily resident in the UK)

The Trust is committed to fulfilling its obligations under the Overseas Visitors NHS Hospital Charging Regulations 2015 and continues to work closely with NHS England, the Department of Health and Social Care and other organisations.

The Overseas Visitors Team provides a seven day a week eligibility checking service across the Trust. The team, which checks every patient that presents at the Trust, is responsible for establishing an individual's right to free NHS hospital treatment, the raising of invoices to directly chargeable visitors, the processing of reciprocal healthcare claims and for advising clinicians and other staff on their obligations under the regulations.

The Non-NHS Patient income Manager is co-chair of the NHS Overseas Visitors Eligibility Partnership.

2.3.9 Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. However, UHBW does calculate and publish these data to help track our progress against the Green Plan sustainability commitments. This data can be found below and in section 3 of this document. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the Annual Report and Accounts and in other external publications.

<u>Governance</u>
The Board provides strategic oversight of climate-related issues, approving all corporate commitments, including the refreshed ICS Green Plan published this year.

Day-to-day delivery is led by the sustainability team. They report to twice yearly to the Board, covering statutory reporting, annual Green Plan performance and the Carbon Reduction Plan. These focus on performance, highlighting progress and the financial and compliance transition risks associated with

this performance. For example, modelling of the financial exposure to transition climate risks from future legislation, policy and taxation.

The Green Plan covers a broad range of environmental priorities relevant to the Trust, including greenhouse gas emissions, waste, air quality, resource use, biodiversity and climate adaptation. The Carbon Reduction Plan focuses specifically on greenhouse gas emissions and associated mitigation measures.

Executive responsibility sits with the Group Chief Finance and Estates Officer with sustainability embedded within the Estates and Facilities Division. It manages the energy and waste budgets and monitors associated projects and costs. Climate-related risks and opportunities are escalated through the Finance, Digital and Estates Board Committee which is chaired by the Group Chief Finance and Estates Officer.

Clinical sustainability projects are driven by the Sustainable Healthcare Collaboration, which brings together representatives from clinical specialties from across the Bristol NHS Group. Our Green and Sustainable Healthcare lead acts as the link between the Collaboration and clinical divisions. Progress is shared through monthly divisional highlight reports. Financial saving opportunities from this work are shared directly with the finance team and the Group Chief Finance and Estates Officer with savings re-invested in Collaboration projects.

At a system level, the ICS Green Plan is governed through the monthly Green Plan Implementation Group chaired by the Head of Sustainability for the ICS. Quarterly Executive level oversight is achieved via the Green Plan Steering Group, which brings together Executive Directors from across the ICS. The Steering Group escalates risks to the System Executive Group. This provides a mechanism for climate-related risks to be fed back to our system partners.

The sustainability team prepares all disclosures, following reporting protocols and consistent methodologies. Drafts are reviewed by the Head of Sustainability and the ICS Head of Sustainability before Board submission. External auditors provide assurance through the Annual Report and Accounts process.

Strategy

Physical and transition climate-related risks and opportunities need to be considered over the short, medium and long-term. It is proposed to achieve this by integration into the yearly Trust operational planning process (short-term), Medium term 5-year integrated delivery plan and the NHS long term 10-year strategic plan timescales. The system annual operational planning includes assessment of contribution to the Green Plan, The ICS 5-year strategic commissioning plan is informed by the long-term ICS Healthier Together 2040 strategy. Across these timeframes, the degree of certainty and control over climate-related risks and opportunities decreases as the planning horizon extends.

Short term impacts (12-18 months) predominantly influence operational sustainability projects, compliance requirements and budget management. Regulatory changes may require investment to ensure compliance and changes to our operating instructions and processes. Lack of data accuracy and sensitivity impairs our ability to prioritise action and measure progress. Opportunities arise from resource-efficiency projects that reduce operating costs such as those delivered by the Sustainable Healthcare Collaboration. Access to funding and research also provides opportunities to better understand localised climate impacts. Key support areas affected include operations, supply chain, estates, procurement, fleet management and clinical services.

Medium term (18 months to 2035) impacts focus on strategic investment decisions, including decarbonising our energy use and planning for replacement of the CHP. Rising energy prices and potential carbon taxes create financial pressures that further incentivise investment in energy efficient and net zero technologies. Reputational risks may arise if the Trust does not meet its interim targets. Opportunities lie in embedding climate-related risk and opportunities into our decisions making processes. Medium term impacts affect estates, finance, clinical services, strategy and governance.

Long term risks (to 2045 and net zero) increased frequency of extreme weather disruption including coastal flooding in Weston, infrastructure damage and escalating resilience costs. Failure to meet our net zero target may result in substantial financial liabilities linked to carbon offsets or carbon taxes. Long-term opportunities relate to the adoption of climate-resilient technologies and low carbon clinical pathways. These impacts affect estates, emergency planning, finance, supply chain, strategy, operations, clinical services, workforce and adaptation.

The Trust has not yet undertaken formal climate scenario analysis for a 2-degree warming pathway over short, medium and long-term horizons as this is a large piece of work that will take some time to complete. However, preparatory work is underway. There are three impacts that we have prioritised:

- The impact of heatwaves on demand for hospital services.
- The impact of heatwaves on productivity.
- Disruptions to our supply chain.

As part of the Bristol NHS Group, UHBW are part of a research study looking into the impact of heatwaves on Emergency Department admissions. Also in development is a study looking at the impact of heatwaves on Pathology. Both studies will look to quantify the current impact and apply it to scenario models under a 2-degree warming pathway. This work is in the early stages but forms the basis of the Trust looking at the medium to long term impact of climate change on its strategy, operations and finances.

Integration of climate-related risks into strategic and financial planning is developing. Whilst it is not yet systematically embedded, the merger with NBT provides an opportunity to embed their Sustainable Impact Assessment process into business case development and decision making. The Assessment helps to quantify climate impacts. It focuses on mitigation actions but could be developed to include adaptation. Carbon budgeting for each division is also being considered but data availability remains a limitation to the introduction of this.

Risk Management

Climate-related risks follow the Trust's risk management policy, using the same processes for identification, scoring, monitoring and escalation. Scoring is determined by an assessment of likelihood and impact. Oversight is provided by the Finance, Digital and Estates Board Committee. Risks are identified using:

- Current and emerging regulatory requirements,
- Green Plan commitments,
- National NHS climate priorities,
- Previous evidence from operational impacts (e.g., increased cooling requirements during heatwaves),
- Local health priorities and
- Financial modelling of future energy and carbon related costs.

Long term risks carry greater uncertainty due to extended time horizons.

The sustainability team are responsible for identifying and ensuring compliance with all sustainability related laws and regulation, existing and new. They work closely with operational teams, professional bodies and suppliers to ensure early awareness and implementation. The Bristol NHS Group has a shared legal register of compliance obligations and requirements. We recognise that early identification, involvement and implementation are key to reduce the likelihood and impact of non-compliance.

Transition and physical climate related risks are listed on the Trust's risk management register. The climate-related risks listed below are on the Trust's risk management register.

Table 14: Climate Related Risks

Risk Type	Description	Mitigation Actions
Transition	• Financial investment required to decarbonise the Trust's operations. • Financial risk of not decarbonising through offsetting, increased energy costs, and carbon taxation.	• Green Plan targets and commitments. • Delivery plans to decarbonise Trust estate, waste management and travel and transport. • Applications for funding for decarbonisation projects.
Physical	• Acute – increased extreme weather events focusing on heatwaves and the increased need for cooling. • Chronic – climate change scenario analysis shows Weston General will be impacted by flooding from sea level rise using worst case climate change scenario analysis for 2100.	• Strategic planning through investing current impact of heat on our operations with a focus on ED and Pathology.

No mitigation measures are currently in place to address the increased risk of extreme weather events including the impact of coastal flooding at Weston General Hospital. The long-term time horizon that these risks cover do not complement current risk scoring mechanisms which leaves its priority in the face of more immediate pressures, low in comparison. Its inclusion reflects the Trust's commitment and recognition of the role of adaption.

Project level risks are managed through the Green Plan governance process and currently sit outside of the Trust's risk register. The Green Plan Implementation Group will be reviewing these risks in April 2026 and then on a quarterly basis.

A Board seminar is being scheduled to develop understanding of climate risks and address gaps in managing those risks. No climate-related risks are categorised as principal risks for the Trust.

Metrics and Targets

The ICS Green Plan contains a comprehensive set of environmental metrics to monitor performance, inform decision making and support compliance with NHS England reporting requirements. It outlines the interim and long-term targets for 5 years to 2030. All targets are absolute reduction targets. They are not science based but align with the wider NHS ambition for achieving net zero and reflect our local priorities and impacts. The Trust does not use an internal carbon price. The Green Plan can be found here; 6.2 - ICS Green Plan Refresh - ICB Board July 2025

The Trust's three main commitments are to:

- Improve the environment: reduce air pollution and restore biodiversity.
- Achieve net zero carbon:
  - Net zero for directly controlled emissions by 2030
  - 50% reduction in influenced emissions by 2030
  - Net Zero for influenced emissions by 2045
- Drive a wider sustainability movement: inspire change across local communities and partners.

The baseline year for our carbon target is 2019/2020, representing a pre-pandemic operating position for comparison.

In 2025, the Trust revised its net zero target for influenced emissions. The target date moved from 2030 to 2045. This decision aligns our target with the wider NHS net zero target. It also reflects the scale and complexity of scope 3 emissions.

Please refer to the ICS Green Plan for the specific measurable targets we are aiming to achieve under each Green Plan strategic commitment. The metrics are collected for regulatory compliance and NHS England reporting requirements. They also support the Trust in assessing and managing material climate-related risks. Metrics and performance have been reviewed by the Board and are publicly published in this document.

This data helps the Trust manage its climate-related risks in the following ways:

Table 15: Management of Climate Related Risks

Risk Area	Metrics	Purpose
Local health risks	Air quality monitoring Travel and Transport	• Inform operational and financial decisions relating to fleet purchases and supply chain deliveries. • Health and safety risk for staff exposed to high levels of air pollution. • Health benefits of active travel.
Financial risks	Greenhouse gas emissions Waste Management	• Inform offset cost modelling for future financial exposure associated with residual emissions. • Inform fossil fuel financial exposure in supply chain • Assess the energy-cost risks and investments requirements for decarbonisation projects. • Budget planning for waste management and potential savings resulting from waste reduction and improved segregation activities.
Compliance and Reputation	All metrics and data	• NHS England reporting and compliance. • Demonstrate transparency and progress against our ICS Green Plan commitments.

The Trust aligns its reporting boundaries and accounting methodologies with those of NHS England and the GHG Protocol Corporate Standard. Conversion factors are checked and updated each year where relevant. Scope 2 emissions use location-based factors.

Consumption based data is used for energy, waste, water, owned fleet and anaesthetic gas calculations.

Spend-based metrics are used for supply chain emissions including pharmaceuticals and business travel where consumption data is not currently available.
Travel and transport emissions are calculated via mileage claims, expenses claims or NHS England proxy formulas.

Air quality monitoring includes both Trust operated and Bristol City Council monitors placed in and around our hospital sites.

During 2025, the Trust introduced several changes to improve data accuracy:

- Inclusion of previously missing heating data from the Central Health Clinic to scope 2 emissions from the district heat network.
- Inflation adjustments applied to supply-chain scope 3 emissions
- Introduction of product-level carbon data for patient catering
- Separate calculation of emissions from inhalers.

Inflation adjustments have been made to all previous year's data including the baseline year to ensure their methodologies are comparable. Except for this, no other amendments have been made to the baseline year.

The data in the table below shows our performance data for 2025/26. It also shows performance for the previous two financial years and the baseline year to allow for comparison.

Table 16: Performance data for 2025/26

Emissions Source	**Unit**	**2019/20**	**2023/24**	**2024/25**	**2025/26**
Scope 1	tCO2e	12,772	19,477	18,600	19,010
Scope 2	tCO2e	6,684	1,228	1,335	873
Scope 3	tCO2e	130,253	147,548	152,180	166,403
Total	**tCO2e**	**149,709**	**168,253**	**172,115**	**186,286**
Energy					
Gas consumption	kWh	56,625,012	98,557,570	91,571,991	95,051,061
Oil Consumption	Litres	1,143,486	27,351	27,351	4,598,116
Electricity Consumption	kWh	26,149,963	5,930,672	6,449,920	30,008
Anaesthetic Gases					
Anaesthetic Gases	tCO2e	1,672	1,141	1,511	1,355
Supply Chain					
Purchased goods and services (including upstream transport and distribution)	tCO2e	110,990	129,000	132,895	147,061
Travel and Transport					
Trust owned Fleet	tCO2e	41	212	101	133
Business Travel (grey fleet)	tCO2e	437	328	402	333
Employee Commuting	tCO2e	2,471	3,131	3,385	3,390
Patient and Visitor Travel	tCO2e	11,823	9,938	10,638	10,765
Waste					
Waste - Total	Tonnes	2,371	3,536	3,787	3,858
	tCO2e	1,181	1,364	1,252	965
Incineration Waste	Tonnes	895	2,472	2,551	2,671
Landfill Waste	Tonnes	1,111	184	131	112
Recycling Waste	Tonnes	365	769	976	935
Anaerobic Digestion	Tonnes	0	110	129	141
Water					
Water volume	m3	226,918	276,797	260,616	256,950
Water volume and waste water	tCO2e	221	99	83	89

Current performance shows no significant reduction in total emissions, reflecting the dominance of Scope 3 emissions and limitations of spend based methodologies. We expect emission reductions to

occur as structural decarbonisation measures are implemented and as data becomes more sensitive to the mitigation activities introduced. Additional details performance is provided in Chapter 3.

Maria Kane
Group Chief Executive

3. Sustainability Report

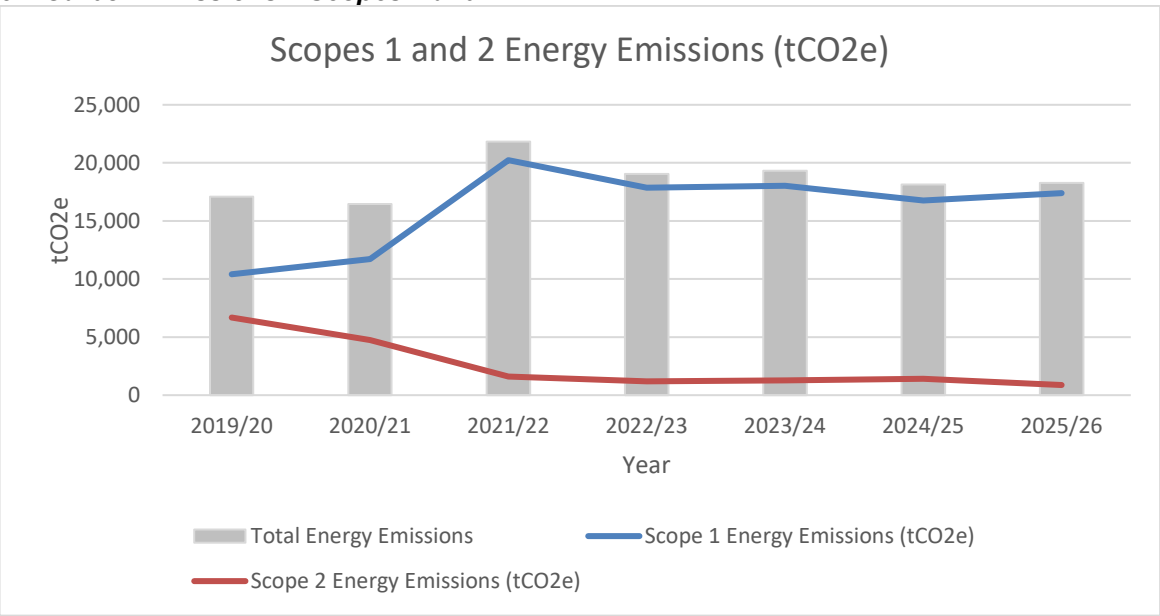
3.1 Overview

UHBW has focused on clinical sustainability projects this year through its Sustainable Healthcare Collaboration and department green teams. These projects have acted as trials to implement clinical sustainability improvements that can be rolled out and embedded across the Trust. Examples of the sustainability projects implemented include:

- The Bristol Royal Hospital for Children conducted a Green Operating Day, utilising the actions set out in the Intercollegiate Green Surgical Checklist and rationalising surgical trays to achieve a 50% reduction in carbon emissions from the chosen trial procedures.
- The Children's Emergency Department have implemented two quality improvement projects to reduce unnecessary chest x-rays and repeat blood tests. A reduction in chest x-rays of 20% was achieved over a 4-month period.
- Pathology have been working as part of the South-West Greener Pathology Network to develop a sustainability e-learning package for all pathology staff. They have significantly improved their waste segregation, correctly allocating waste for recycling that used to be offensive waste and are looking at circular economy programs for plastics. They have been working with clinical teams to reduce unnecessary and duplicate testing and have been involved in the planning and development of green spaces at the Trust with a focus on our allotment.

The rest of this section outlines progress made against our key sustainability commitments which can be found in our Green Plan and outlined above in our TCFD statement. It highlights some of the projects implemented to help us achieve them.

3.2 Carbon Emissions – Scopes 1 and 2



Overall, there has been no reduction in our total carbon emissions. While the graph above shows a decrease in Scope 2 energy emissions compared with the previous year, this has been offset by a corresponding increase in Scope 1 energy emissions. This change reflects an update in the electricity conversion factor and the improved operational performance of our combined heat and power (CHP) system, which achieved an average availability of 98% during the year, compared with 89% in the previous year. Full decarbonisation of our estate will take considerable financial investment to replace our CHP engine with a zero-carbon alternative. Our heat decarbonisation plan involves connecting to a Bristol City district heat network which has a route to net zero. This would involve retiring the CHP

asset and increasing our reliance on grid electricity. The increase electricity cost would result in a significant annual revenue impact and represents a risk to the delivery of the plan. To enable a district heat network connection, we need to lower our hospital heat network temperatures and this year we have undertaken feasibility studies and physically stress tested our heating systems to see how they perform at lower temperatures. The findings will establish if we can operate directly from the district heat network or if we will need additional air source heat pumps to uplift temperatures on-site.

Next year we will switch our back-up oil generated power to hydrotreated vegetable oil (HVO). HVO does not degrade as quickly and will therefore need replacing less frequently, it significantly reduces carbon emissions and improves air quality on site.

3.3 Carbon Emissions – Scope 3

We have continued to implement the steps set out in the NHS Net Zero Supplier Roadmap, embedding carbon reduction and social value into our competitive tendering processes.

Bristol and Weston Purchasing Consortium have been delivering clinical sustainability projects that help reduce scope 3 emissions by switching out single-use products. In a project led by Jake Saville, Bristol Eye Hospital and the Bristol Royal Hospital for Children have swapped from single-use to re-usable surgical gowns. The switch has saved an estimated 18 tonnes of carbon, £11,000 and 4 tonnes of offensive waste. Plans are in progress to roll out their use to all areas of the Trust to achieve greater benefits.

Working with our patient catering supplier, we have also reduced the carbon impact of our food offering by reducing processed and red meat options. Red meat has been reduced by 30% with 50% meat – 50% bean/lentil options introduced to help achieve this. Our new menus present our vegetarian and vegan options as our lead meal on 50% of days. New mini meals have been introduced with a high protein content but reduced starch. Our supplier has provided us with the carbon footprint of our main meal options, helping us to improve the accuracy of our carbon data and the carbon and monetary savings of moving to more sustainable food with a lower carbon footprint.

3.4 Air Pollution

Our Bristol hospitals sit within the Bristol Clean Air Zone. Since its introduction, nitrogen dioxide levels on Upper Maudlin Street outside our Emergency Department have reduced by approximately 26.9%. This benefits our patients, visitors, staff and wider population. However, air quality remains an issue at specific locations at our Bristol site with limits exceeding World Health Organisation limits.

Our fleet now consists of 75% electric vehicles and has benefited from the installation of 4 new electric vehicle charging points from the NHS England Decarbonisation fund.

We provide an extensive range of incentives and discounts to staff to support them in low carbon and active travel. Zero emission vehicles, bicycles and accessories are available as part of a salary sacrifice scheme. Discounts on bus, train travel and e-scooters are also available. Dr Bike attend our sites at least once a month to carry to carry out free bike maintenance checks and regular roadshows are also held, led by Bristol City Council to promote their incentives and programs to aid more sustainable travel. We have a strong partnership with Bristol City Council and the West of England Combined Authority on all aspects of travel and transport and a free bus service that links all our sites to the bus and coach station and train stations in both Bristol and Weston.

3.5 Waste

The Bristol NHS Group is working on a new sustainable waste management policy and the corresponding Standard Operating Procedures to embed the new policy into day-to-day delivery.

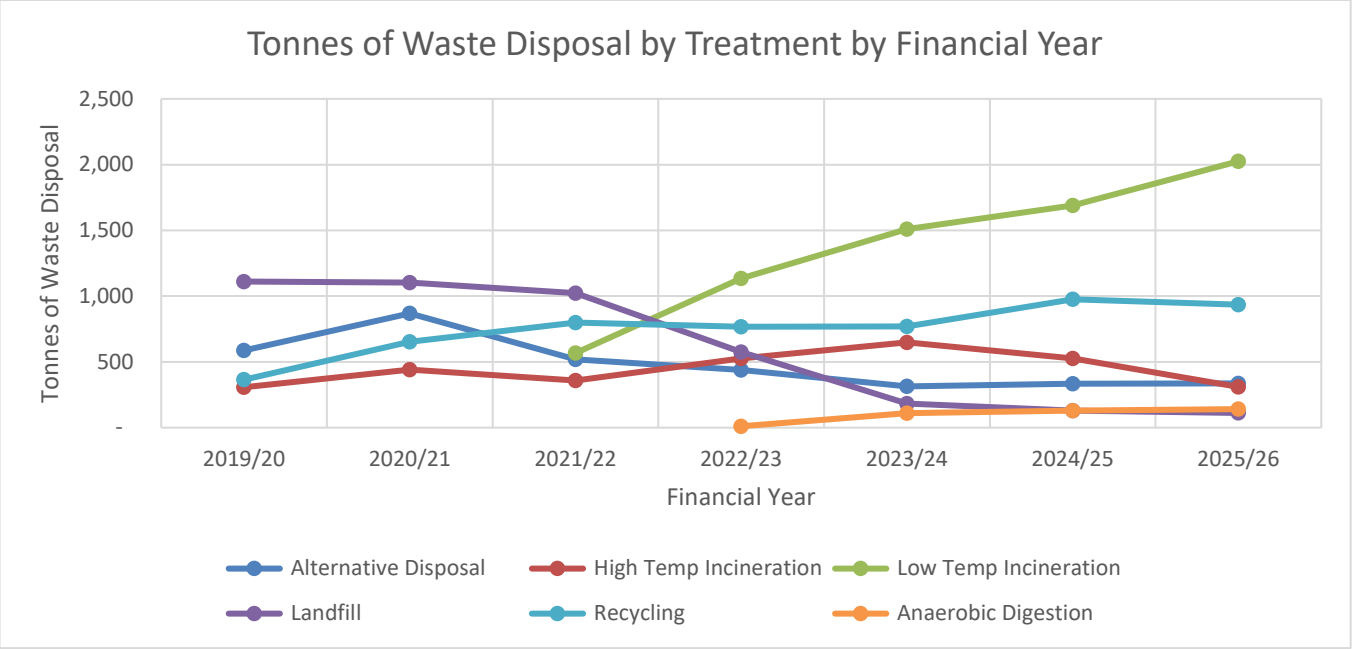
The Trusts waste management approach was externally audited this year and achieved an assurance score of ‘significant’, the highest available, reflecting the effectiveness and consistency of controls in place to deliver sustainable and compliant healthcare waste management services.

The Trust's Sustainable Waste Management team have undertaken waste composition audits in selected clinical areas. The audit analyses the types, quantities and sources of waste generated over a 24-hour period to improve waste segregation compliance and achieve the associated cost and carbon savings. It gives a specific picture of the issues, supporting the development of tailored training, signage and bin locations, informing conversations to drive behaviour change and strengthen partnership working between clinical teams and the waste team. Results from one audit over a 24-hour period demonstrated a potential carbon saving of 10 tonnes of carbon if all waste was correctly recycled. More audits are planned for next financial year.

Working with Facilities, the Sustainable Waste Management team have stared on the last piece of work to align to Simpler Recycling Legislation by trialling a process for the management of food waste in staff rest areas.

New recycling stations have been purchased and distributed across the Trust, this is to simplify waste disposal by the public and staff.

Our waste performance shows that our total waste produced has increased by 71 tonnes but our carbon emissions have decreased by approximately 23% when compared with last year. This reflects the work taken to ensure correct segregation.



Performance against our clinical waste segregation target is set out in the table below. We are closely aligned with the NHS target, maintaining a similar performance to last year.

Table 17: Performance against our clinical waste segregation target

Clinical Waste Segregation	Hight Temperature Incineration %	Infectious Waste %	Offensive Waste %
2025/26 UHBW	23	24	53
NHS Target	20	20	60

The UHBW Catering team have been reducing patient food waste at the Trust. All patient food waste is now collected, measured and sent to ne made into bio-fuel. Left over bread from the 600 sandwiches made each day for patients is used to create bread pudding to sell in our on-site outlets. Brown bananas are also used to make banana muffins. The Trust took part in a 'blue plate' trial. During the trial, standard white crockery was replaced with cornflower blue crockery. The trial took

place on one of our wards over an 8-week period. The use of the cornflower blue plates resulted in the number of empty plates increasing by 21% and the amount of food waste decrease by 68kgs. We also return all plastic food trays to our supplier as part of their closed loop recycling system called the Boomerang project. We also re-use our mayonnaise buckets for used battery containers.

4. Health Inequalities Report

This year, the Trust has continued to deliver the Group Clinical Strategy, with equity as a core pillar. Reducing healthcare inequalities and strengthening prevention of inequalities remain strategic priorities and are reflected in the Clinical Strategy Update. Our approach to health equity is rooted in understanding the needs of our population, working in partnership, and co-producing solutions with communities and system partners. As an anchor organisation, we recognise that inequalities affect our patients, our staff and the communities we serve.

Across 2025/26, Bristol NHS Group teams worked closely to align and strengthen our approach to health equity across NBT and UHBW. We collaborated with the NHS Race and Health Observatory to deliver a Board development session on health inequalities in June 2025, helping to identify priorities for action. In September 2025, our work was recognised nationally through a Health Systems Journal Patient Safety Award nomination for our project on improving access to outpatient services for people from the global majority and more deprived communities in Bristol, North Somerset and South Gloucestershire.

We recognise there is more to do, and working with system and community partners, we developed a Joint Health Equity Plan for 2026/27. This is informed by data, population insight and prevention priorities, and grounded in what we have heard from our communities. We remain committed to co-producing our longer-term plans for health equity with partners and local communities.

4.1 During 2025/26 we have focussed on:

4.1.1 Understanding and improving our data on population needs

We continue to work with public health teams and system partners, using Joint Strategic Needs Assessments, Health and Wellbeing Strategies and wider sources of data and evidence to guide our work. Internally, we are strengthening how inequalities data is used in service planning and delivery.

Ethnicity status in Trust datasets for elective pathways is an area of focus for improvement as high-quality data improves our ability to identify and address inequalities, including barriers to care. The Trust's target is for 80% of patients to have their ethnicity recorded. In March 2026, 75% of patients on the Referral To Treatment waiting list had their ethnicity recorded. This compares to 76.8% in March 2025 (data source: WLMDS, w.e 2.3.2025 and 1.3.2026). Our data quality improves once patients have accessed care, and for patients who have attended an outpatient appointment 85% from January 2026 had a known ethnicity, increased from 82% in March 2025.

During 2025/26, we delivered new staff training to support confidence and accuracy in recording ethnicity. We are also using national guidance and community insight to improve recording systems, co-develop resources for communities and patients on ethnicity recording and our equity work, and explore opportunities for data sharing. This work will continue into 2026/27.

4.1.2 Community involvement and partnerships

During 2025/26, the Trust strengthened its approach to patient and community involvement, with a greater emphasis on partnership and co-production. We worked closely with voluntary, community and social enterprise (VCSE) partners to support engagement in trusted community settings, including community centres, faith venues and local hubs. This approach recognises that people experiencing the greatest inequalities are often least likely to engage through traditional NHS routes. Community partners acted as trusted intermediaries, enabling culturally appropriate engagement and supporting more meaningful conversations about barriers to care. Insight gathered through this work has informed improvements to patient communication, information and service pathways, drawing on learning from Brigstowe and the Common Ambition Bristol co-production model.

Partnership working with the VCSE sector has also improved engagement with communities facing significant marginalisation, including Gypsy, Roma, and Traveller communities, where trusted relationships are essential to reducing barriers to access and participation.

4.1.3 Participation and the Health Equity Delivery Group (HEDG)

The Health Equity Delivery Group (HEDG) provides oversight of the Trust's approach to health equity and participation. We now have one HEDG for both Trusts. HEDG membership includes community partners Caafi Health, For All Healthy Living Centre, African Voices Forum, WECIL and The Diversity Trust, ensuring that lived experience and cultural insight inform service design and improvement. We remain grateful to our partners for their support, expertise, healthy challenge and commitment to collaboration.

This year, the Trust strengthened coordination between governance structures and established a Community Participation Group to work in partnership with Trust leadership and support delivery of the Group Clinical Strategy. To reduce duplication and maximise impact, we are developing a more consistent, team-based approach to capturing and using community insight, alongside a system-wide overview of engagement activity.

We are also strengthening the role of the VCSE sector in decision-making and commissioning, building on NHS England guidance. Work is underway on a VCSE Participation Policy informed by local learning, alongside practical steps to widen participation. These include guidance on involving patients and public partners in recruitment, available via the MyStaff app, and pilots for training and recruitment panel involvement.

Access to participation has been further supported by the development of a reimbursement policy for community partners, now progressing through governance, ensuring individuals and organisations are not financially disadvantaged by their involvement.

Alongside this, the Trust is investing in staff capability through action learning sets and a Community of Practice for Better Involvement, supporting co-production as a core way of working. Early impact includes increased participation from underserved groups, stronger community relationships, and service improvements shaped directly by lived experience.

To further strengthen participation and involvement, in 2026/27, the Trust will:

- Implement a new policy recognising the role of people and community partners
- Develop an accessible online involvement portal
- Extend the reach of the participation community, particularly among diverse communities and young people
- Launch a collaborative system-wide outreach model focused on tackling health inequalities, including senior leader community engagement
- Develop an evaluation tool to better evidence the impact of patient and community voice on service improvement.

4.1.4 Improving access to our services

The Trust recognises persistent disparities in access to care, as reflected in our data. We are taking a data-driven approach to identify and address inequalities across care pathways.

Trust-wide dashboards monitor elective waiting times and non-attendance rates by deprivation and ethnicity, alongside ethnicity recording completeness. This enables targeted action where inequalities are identified. Practical measures to improve access include strengthened interpreting services, implementation of the Accessible Information Standard, and reasonable adjustments for patients with additional needs.

Digital developments are also supporting more equitable access, with greater use of the NHS App for appointment letters and reminders, contributing to improved attendance rates. Virtual outpatient appointments are expanding, with DNA rates for first attendances now trending downwards. Targeted interventions are being developed for groups at higher risk of exclusion, informed by learning from cardiology and system-wide work on supporting timely access and engagement with elective care.

Patient-initiated follow-up, including virtual models, continues to expand, alongside active review to ensure equitable re-access to care. Access to My Medical Records is supporting clearer information sharing and improved follow-up, particularly for cancer services. These actions inform our future Clinical Strategy, aligned with the NHS 10-Year Plan and a shift towards more community-based, integrated and digital models of care.

4.1.5 Accessible Information Standard

The Trust continues to make steady progress embedding the NHS Accessible Information Standard (AIS), supported by partnership working with community organisations including the West of England Sight Loss Council, the Centre for the Deaf & Hard of Hearing Communities, Bristol City Council's Sensory Impairment Team and the Bristol Disability Equality Forum.

Staff have access to e-learning on Deaf Awareness and AIS, with increasing uptake among patient-facing roles. Following the refresh of the national standard in July 2025, further work is required to support implementation of the Digital Reasonable Adjustment Flag, alongside additional digital capacity to meet national requirements for SNOMED CT and reasonable adjustment compliance.

Recent progress includes co-designing and approving the provision of interpreter information to BSL users ahead of appointments to reduce anxiety, with implementation starting in June 2026. In April 2024, UHBW developed an internal improvement plan, aimed at ensuring improvements for all patients who need to access interpreting support, when required, using Patient First quality improvement methodologies and staff co-design to develop solutions based on frontline experience. The project aimed to look at three distinct improvement areas, including policy and training, external partnerships and digital systems and processes for recording communication patient requirements. In October 2025, this project was overall winner for the UHBW Continuous Improvement Award across the trust.

4.1.6 Neighbourhood Health

The Trust remains an active partner in the development of Neighbourhood Health across BNSSG and will continue to support locally delivered, community-based models of care throughout 2026/27. This work reflects a shift from engagement as an activity to patient and community involvement as a core function of delivering equitable, high-quality healthcare.

4.2 Our 2025/26 Spotlight Areas for Priority Groups and Services:

4.2.1 Homeless Health

Homelessness is rising nationally and locally, and people who experience homelessness often have multiple unmet health needs. Over the past 2.5 years, a Homeless Health Pathway has been established through the Integrated Discharge Service (IDS), with significant development of homelessness processes and workflows. IDS now provides Trust-wide coverage through a team of registered case managers working across emergency, acute, inpatient, and pre-operative settings to identify and support patients at risk of homelessness, with the aim of avoiding street homelessness at discharge wherever possible. A standardised IDS workflow supports consistent identification, screening within 24 hours of ward transfer, attendance at board rounds, and early escalation for advice and guidance when homelessness is identified.

When homelessness risk is identified, a Duty to Refer is completed to the relevant local authority, and IDS works closely with housing, voluntary-sector partners, and wider support services. Holistic care and integration between health and housing has been strengthened through named housing advisors, embedded St Mungo's support within the transfer of care hub, access to social services across all BNSSG local authorities, and standardised MDT and escalation processes. Training and development for IDS staff has focused on legal duties, barriers to engagement, and trauma-informed communication. As a result, referral volumes have increased alongside case complexity, but outcomes have improved, with many more patients discharged into accommodation and with appropriate support. Over the winter period we worked with our local authorities to implement the

Severe Weather Emergency Protocol during periods of extreme cold, and supported people at risk of rough sleeping to access emergency provision.

For 2026/27, priorities include improving awareness of homelessness with our clinical teams, further strengthening integration with housing and community services, strengthening successful joint working arrangements with our local authorities, and developing more robust data collection on homelessness referrals and discharge outcomes to support ongoing improvement and oversight.

4.2.2 Cancer Services

In the UK cancer commonly drives inequalities, including a higher risk of preventable cancers and later stage cancer diagnoses for some of our population groups. In 2025/26 we have supported implementation of the Early Diagnosis Plan in partnership with screening and community care providers, including delivery of Lung Cancer Screening led by NBT and initially targeted at the most deprived communities. Funding has been secured through SWAG for an Equity of Access Coordinator role to use inequalities data to proactively reach people who do not attend appointments, or are at risk of poorer outcomes, and to strengthen existing pathways to improve equity of access. The Cancer Improvement Collaborative 'Reasonable Adjustments in Cancer care' project was delivered to improve reasonable adjustments in cancer care and included the launch of a dedicated training module for specialist cancer staff across BNSSG, co-designed through focus groups with 45 people with lived experience and published in the *Journal of Cancer Policy*. Impact data for this training is currently being gathered.

Further progress has focused on improving patient experience, engagement, and health literacy. We have introduced a new question within the Patient Experience of Cancer survey to monitor progress on reasonable adjustments, and learning from this work is being shared beyond the region. Targeted engagement with global majority communities has included co-led focus groups exploring the experiences of Black women with cancer, with 28 participants contributing to the *Power in Our Voices* project supported by Black Women Rising, and a report of recommendations in development.
In collaboration with the ICB and using SWAG funding, locally adapted cancer information z-cards are being produced to support personalised care, particularly for people with limited digital access, and will be translated into the four most commonly spoken local languages. This work builds on wider outreach to improve cancer health literacy, screening uptake, and early presentation, in the Communities Against Cancer programme. The Group cancer teams work close with Macmillan and Caafi Health colleagues, delivering cancer awareness and screening support across BNSSG, having so far recruited over 50 community-based cancer champion volunteers, bringing cancer conversations into diverse communities by trusted individuals.

4.2.3 Learning Disabilities and Autism

People with a learning disability and who are autistic are at risk of health inequalities and may experience barriers to accessing health care. Learning disability and autism (LD/A) considerations are embedded within the Trust's inequalities dashboards for identifying and acting on inequalities. Within clinical systems flags are used to support proactive care planning. LD/A Liaison Teams work with clinical specialties on referral to coordinate care, support clinical decision-making, and advise on reasonable adjustments and advocacy. Long waits are monitored and addressed at specialty level, with current data showing higher DNA rates for patients with learning disabilities (8.2%) and autism (8.8%) compared with the Trust average (6.1%) and longer waits for first outpatient appointments (17 weeks for LD/A patients compared with 14 weeks for non-LD/A patients). A clear improvement focus is in place to reduce DNAs and improve RTT performance, with a new workflow pathway developed, user acceptance testing underway, and planned go-live in April/May.

The Trust remains actively engaged in system and quality improvement activity. This includes participation in the system-wide Co-improvement Group and the LeDeR Governance Group, reviewing deaths to ensure equity of care and sharing learning with Trust and system partners. There is a current system focus on training staff in autism, informed by data showing high suicide rates among autistic patients, alongside mandatory Oliver McGowan training. Annual bowel and constipation awareness activity ("Poo Matters") is delivered for acute staff, and targeted audits are undertaken in hotspot areas, including a recent audit of aspiration pneumonia in acute LD/A patients

completed in February 2026. System partners are also addressing evidence that patients with LD/A from Black and Minority Ethnic communities die younger than the wider LD/A population, with the Trust contributing to, and supporting this work through engagement with local communities.

This work will continue into 2026/27 under a single Learning Disability and Steering Group for the Bristol NHS Group. Paediatric care and transitions will be a focus, with recent recruitment of our specialist paediatric clinical nurse specialist and our transition nurse, and a feedback survey sent out to patients aged 14-21 to help shape the future service. Patient engagement will be a continued focus, with a patient engagement group running monthly across the Trusts by the LD/A liaison team.

4.2.4 Maternity Services

Our experiences during pregnancy and early childhood have a large influence on our future health. Our maternity service is committed to creating a culturally safe, inclusive, and equitable experience for every family we care for. Over the past year, we have continued to strengthen our approach to reducing the gap in health inequalities and ensuring an equitable experience for all through targeted initiatives that improve access, experience, and outcomes across all protected characteristics. At UHBW we continue to hold Consultant outreach clinics in Easton, Hartcliffe, Knowle West, Nailsea and Weston allowing easier access for families. We also continue to have midwifery continuity teams in place in Bedminster, Hartcliffe, Withywood, Knowle and Easton, working alongside or within the Family Hub estate and working collaboratively with Children's services. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience. The continuity teams also have enhanced maternity support workers who are able to give added support to women and help them navigate the maternity service. They have transformed engagement with maternity services in Bristol's global majority communities. Their outreach work has reduced late bookings and engagement in maternity services. They also support sanctuary seekers and are contributing to UHBW's application for city of sanctuary accreditation.

A comprehensive interpreting service is now well embedded allowing face to face, phone and video interpreting. Co-production with our Maternity and Neonatal Voices Partnership (MNVP) takes place on a regular basis to ensure our services reflect the voices of the communities we serve. Our work on cultural competency, anti-racism, education informed by local learning (in line with the Core Competency Framework), and specialist pathways and services support families from a wide range of ethnic, cultural, social backgrounds support families from a wide range of ethnic, cultural, social backgrounds. We have a very pro-active equity and inclusion midwife who is part of the maternity training team, and racial inequalities and anti-discrimination are included within the multi professional maternity statutory and mandatory training for staff.

Equity focused quality improvement is well embedded within the division and has been further driven by three cohorts of staff, including the Director of Midwifery and Nursing, undertaking the Black Maternity Matters Training across a period of three years, leaders within the Trust Executive team including have also taken part on the specific Senior Leaders Black Maternity Matters training. Equity training and development runs throughout the division, for managers and all staff.

Tools such as Martha's Rule and NEWTT-2 reinforce our commitment to listening to families and learning from their experiences. We are committed to looking at incident outcomes through the lens of inequalities and have adapted the Health Equity Warning Score (HEWS) to help us recognise and analyse health and social inequalities in our review of incidents. The Local Maternity and Neonatal Systems (LMNS) is part of the Race and Health Observatory learning action Network focusing on improving outcomes for premature babies born to the global majority women, and both UHBW and NBT are actively engaged in this work.

4.3 Prevention in action

4.3.1 Treating tobacco dependency (TTD)

Tobacco use remains a leading cause of health inequalities, premature mortality and preventable illness for our population. In pregnancy, smoking tobacco is the leading modifiable cause of poor outcomes including stillbirth and sudden infant death. Continued collaboration with integrated care system partners through the BNSSG Smokefree Alliance has been key to driving progress on tobacco dependency this year.

Our Trust-based Treating Tobacco Dependency (TTD) services works to treat and support patients in hospital and in maternity, working closely with community-based tobacco dependency services. This year, 360 maternity patients, and 967 inpatients were referred to the TTD services. For those who engage in a quit attempt, 233 patients successfully stopped smoking. As referrals increase, the inpatient service has used innovative approaches to reach more patients, including a digital support offer. The maternity team have launched the National Smokefree Pregnancy Incentive Scheme – offering financial incentives to help people to stay engaged with TTD support throughout pregnancy and to remain smokefree in the months immediately following delivery when relapse rates are high.

TTD services and the partnership approach have delivered significant health impacts. Smoking at the time of delivery (SATOD) rates for UHBW are now at a historic low of 5.3%, below the national target of 6%. This improves maternal health and substantially reduces the risk of infant mortality. Our understanding of smoking status is very good in maternity services; 100% patients have their smoking status recorded and of those, 100% of people who have smoked within 14 days of their booking appointment are offered a TTD referral and 85% engage with the service. We estimate that in the second half of 25-26, almost 20% of inpatients who smoke are identified and referred into the TTD service.

Smoking has wider impacts. Young people who grow up in a household with an adult who smokes are three times as likely to smoke themselves, and NHS staff who smoke are more likely to have time off work due to physical illness. We have prioritised using a whole household approach. In collaboration with our local authority partners, we have:

- embedded stop smoking support into our staff health checks
- connected patients' friends and family with local stop smoking services
- launched a pilot tobacco dependency service in Trauma and Orthopaedics for preoperative assessment and optimisation
- developed system-wide communications for the Swap To Stop scheme.

Our data shows that our TTD services are reaching groups where smoking rates are higher. Looking forward we will continue to grow the reach of our services and share best practice across the hospital Group.

"Friendly, non-judgemental support worker. Gave sound, professional and informative advice. Pleased to say I have not had a cigarette since our talk."
NHS service user; TTD inpatients

4.3.2 Prevention in action: Alcohol and Drugs

Alcohol and drug-related harm continue to be a major driver of health inequalities across Bristol and North Somerset, contributing significantly to emergency demand, prolonged inpatient stays and poorer outcomes for people in our most deprived communities. Over the past year, UHBW has strengthened its approach to addressing these inequalities through the development of a new Substance Use Service model, with confirmed funding to implement a phased, equitable service across both the Bristol Royal Infirmary and Weston General Hospital. Evidence shows that specialist Alcohol Care Teams can reduce hospital bed days by nearly 40% and unplanned admissions by over 40%, and the new model will help deliver earlier, safer and more consistent care for patients

presenting with alcohol or drug-related needs. A key enhancement will be the introduction of a new 7-day specialist service at the BRI, ensuring timely assessment and support every day of the week and reducing the risk of self-discharge or unmanaged withdrawal at the hospital front door. The service will improve continuity into community treatment pathways and support trauma-informed, person-centred care for patients with complex needs, including those facing homelessness or co-occurring mental health issues. This investment will play a vital role in reducing preventable harm, improving clinical outcomes, and narrowing the health inequality gap experienced by our most vulnerable populations.

4.3.3 Prevention in action: Cardiac Rehabilitation

Cardiovascular disease is a significant driver of early deaths and health inequalities, with some population groups more likely to experience a heart attack or stroke. For many people with a heart condition, cardiac rehabilitation programmes safely increase physical activity levels and support lifestyle change, to reduce the risk of dying and being re-admitted to hospital.

The two Trusts have been actively collaborating to improve the cardiac rehabilitation offer and better meet the needs of different patient groups. NBT and UHBW have worked with the psychology service to jointly develop a Woodland Wellbeing programme to better support the psychosocial needs of cardiac patients. This has received positive feedback and is continuing to run this year. NBT and UHBW have been working together to align services and provide equity of rehab across Bristol and Weston. Acceptance criteria have been matched and the modes of rehab are now very similar as work continues towards a joint service. UHBW provides rehabilitation for all key patient groups and across 3 venues with a high-quality phase 1 inpatient programme and improvements at NBT have developed parity of service quality. Both services have now achieved full certification status, meeting all 7 Key Performance Indicators set by the National Audit of Cardiac Rehabilitation.

For 2026/27, a significant patient and public involvement project is currently underway, seeking experiences from a large number of patients enrolled in both home and face-to-face rehab across NBT and UHBW. This will inform how to better meet the needs of our patients.

4.3.4 Prevention in action: Blood borne virus (BBV) screening

HIV and hepatitis B and C disproportionately affect deprived communities and socially marginalised groups, causing health inequalities. Earlier diagnosis allows access to support, treatment and knowing your status helps reduce transmission. Since 2021, NHS England has funded HIV opt-out testing in Emergency Departments (ED) in areas with higher diagnosed HIV prevalence, as part of the national HIV Action Plan. Partnering with the NHS England Hepatitis C Elimination Programme enabled the scope to expand to include testing for hepatitis B and C. In participating EDs all adults who are having blood tests are tested for BBVs unless they opt-out. With NIHR funding from 2023, Bristol sites were some of the earliest Phase 2 sites to commence opt-out BBV screening, launching in October 2024.

UHBW has worked closely as part of a Bristol-wide steering group with NBT, co-developing pathways and resources. This project is a successful example of cross-trust collaboration to deliver regional health improvement outcomes. In December 2025 we shone a spotlight on the programme for World Aids Day, and national evaluation showed our uptake is above national average. Partnership with community services is an important strategy to support people with a new or reidentified diagnosis to engage with our specialist services.

In 2025/26, UHBW performed over 33,000 BBV tests for patients attending the ED, giving an overall uptake of 66% of eligible patients. 85 new BBV diagnoses have been identified through this testing, with an engagement success rate of 73%. 27 patients who had been previously known to either the HIV or viral hepatitis services in Bristol but had subsequently been lost to follow-up have also been reidentified.

4.3.5 Prevention in action: Why Weight Pledge

The Bristol NHS Group is committed to the Why Weight Pledge for Creating Healthier Places Together, the system approach to prevention of obesity and the impacts of excess weight. Obesity is a significant driver of preventable illness and mortality for our population and causes health inequalities through the higher rates seen in some population groups and deprived areas. This year we have developed our organisational action plans, and will be seeking to improve access to healthy, sustainable and affordable food on our hospital sites. We will work with local providers and partners, bringing wider benefits for our area. We continue to make use of our green spaces on our hospital sites for the benefit of patients, staff and visitors. We have launched our “Why Weight” training for staff, run a training webinar with a patient, and will continue to work with system partners to learn more about patient and public experience of living with excess weight and receiving care.

4.3.6 Prevention in action: Staff Health Checks 2025/6

From September 2024 to May 2025 a partnership was formed between Bristol City Council, UHBW and NBT to deliver a national workplace cardiovascular health checks pilot organised by Department of Health and Social Care.

A total of 5,119 workplace health checks were delivered between UHBW and NBT which exceeded expectations at the outset of the pilot. They were delivered to colleagues at our two Trusts, alongside 14 other public and private sector organisations. People receiving a workplace health check were broadly representative of our workforce in terms of gender, and the Bristol population in terms of ethnic groups. Approximately half of recipients of workplace health checks were aged 40-59, followed by 39% who were less than 40 years of age and 10% were 60 years or more. And approximately 85% of recipients of an alternative health check were aged 40 or less, which demonstrates a demand for health checks in a younger cohort than the normal NHS health checks offer (aged 40-74). The aim was to reach the following occupation groups: porters, catering and cleaning, health care assistants and ancillary workforce with around a third of all participants were recorded in one of these groups.

We have referred substantial numbers of staff onwards to GPs for management of clinical risk factors. There is a wide variation in clinical risks across different occupational groups. We also monitor uptake and clinical risk by age group and ethnic group. We are now able to use the rich data from these health checks to inform future health checks delivery models that reduce inequalities and support gender and occupational differences in uptake.

4.4 Working with the Bristol & Weston Hospitals Charity

Over the past year, Bristol & Weston Hospitals Charity has made 28 grants totalling £418,000 which will support reducing health inequalities through our ‘Healthcare for All’ funding programme. We’re proud to have supported a wide range of different projects including: Cognitive Behavioural Therapy for cancer survivors going through menopause, Equality Access Improvement Project for patients with Learning Disabilities and Autism Spectrum Conditions, a toenail cutting service for older patients to help with mobility, sensory bags for young patients with additional needs, Enabling British Sign Language training for UBHW staff, Ready, Steady, Go, Hello, a project for young patients transitioning to adult services, and many more.

5. Accountability Report

5.1. Directors' Report

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board sets the strategic direction within the context of NHS priorities, allocates resources, monitors performance against organisational objectives, ensures that clinical services are safe, of a high quality, patient focused and effective, ensures high standards of clinical and corporate governance and, along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long-term vision, mission and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's annual plan, deliver safe, high-quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation. The Board delegates some of its powers to a committee of Directors or to an Executive Director and these matters are set out in the Trust's scheme of delegation. Decision making for the operational running of the Trust is delegated to the executive management team.

There are specific responsibilities reserved by the entire Board, which include approval of the Trust's long term objectives and financial strategy; annual operating and capital budgets; changes to the Trust's senior management structure; the Board's overall 'risk appetite'; the Trust's financial results and any significant changes to accounting practices or policies; changes to the Trust's capital and estate structure; and conducting an annual review of the effectiveness of internal control arrangements.

The Board of Directors has formally assessed the independence of the Non-executive Directors and considers all of its current Non-executive Directors to be independent in that notwithstanding their known relationships with other organisations, there are no circumstances that are likely to affect their judgement that cannot be addressed through the provisions of the Code of Governance for NHS Provider Trusts as evidenced through their declarations of interest, annual individual appraisal process and the ongoing scrutiny and monitoring by the Group Director of Corporate Governance.

Details of the arrangements in place to ensure that the Trust's services are well led (in accordance with the Care Quality Commission and NHS England well-led framework) can be found in paragraphs 5.7.3 to 5.7.6 of the Annual Governance Statement.

5.1.1 Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. The directors declare any interests before each Board and committee meeting which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust is satisfied with the independence of the Board for the entire year.

The Director of Corporate Governance maintains a register of interests, which is available to members of the public on the Trust's website: University Hospitals Bristol and Weston NHS Foundation Trust

Alternatively, members of the public by can contact the Director of Corporate Governance, University Hospitals Bristol and Weston NHS Foundation Trust, Trust Headquarters, Marlborough Street, Bristol BS1 3NU. Email: Trust.Secretariat@uhbw.nhs.uk.

5.1.2 Political donations

The Trust has made no political donations.

5.1.3 Internal audit

The Audit Committee had ensured that there was an effective internal audit function established by management that met Public Sector Internal Audit Standards and provided appropriate independent assurance. The Trust receives its internal audit service from ASW Assurance.

Table 18: Board of Directors – Terms of Office

Board Member
Ingrid Barker, Group Chair Appointment 1 June 2024
Arabel Bailey, Non-executive Director. Appointment as Associate Non-executive Director 1 July 2022 End of term as Associate Non-executive Director 30 June 2023 Appointment as Non-executive Director 1 July 2023 End of term as Non-executive Director 31 August 2025
Sue Balcombe, Non-executive Director and Senior Independent Director Appointment as Non-executive Director (Designate) 1 June 2019 Appointment as Non-executive Director 1 April 2020 End of first term 31 March 2023 Start of second Term 1 April 2023
Rosie Benneyworth, Non-executive Director Appointment 1 July 2023 End of Term as Non-executive Director 31 August 2025
Richard Gaunt, Group Non-executive Director Appointment as Group Non-executive Director 1 September 2025
Marc Griffiths, Group Non-executive Director (non-voting) Appointment as Non-executive Director 1 July 2022 Appointment as Group Non-executive Director (non-voting) 1 September 2025
Susan Hamilton, Associate Non-executive Director Appointment 1 July 2023 End of Term as Associate Non-Executive Director 30 June 2025
Linda Kennedy, Group Non-executive Director Appointment as Non-executive Director 1 June 2024 Appointment as Group Non-executive Director 1 September 2025
Poku Osei – Group Non-executive Director (non-voting) Appointment as Group Non-executive Director (non-voting) 1 December 2025
Sarah Purdy – Group Non-executive Director Appointment as Group Non-executive Director 1 September 2025
Roy Shubhabrata – Group Non-executive Director Appointment as Non-Executive Director 1 July 2022 Appointment as Group Non-executive Director 1 September 2025

Martin Sykes, Group Non-executive Director and Vice-Chair Appointment 4 September 2017 End of first term 31 August 2020 End of second term 31 August 2023 Start of third term 1 September 2023 End of Term as Non-executive Director of UHBW 31 August 2025 Appointment as Group Non-executive Director 1 September 2025
Anne Tutt, Non-executive Director Appointed 1 June 2024 End of Term as Non-executive Director 31 August 2025
Maria Kane, Group Chief Executive Appointed 29 July 2024
Paula Clarke, Executive Managing Director of Weston General Hospital / Group Formation Officer Appointed 4 April 2016 Appointed Group Formation Officer 1 June 2025
Neil Darvill, Group Chief Digital Information Officer Appointed 1 June 2023
Jane Farrell, Chief Operating Officer Appointed as Interim Chief Operating Officer 31 October 2022 Appointed as Chief Operating Officer 1 April 2023 Stood down as a member of the Board 31 May 2025
Deirdre Fowler, Chief Nurse and Midwife Appointed as Interim Chief Nurse 18 January 2021 Appointed as Chief Nurse and Midwife 29 April 2021 Stood down as a member of the Board 31 May 2025
Steve Hams, Group Chief Nursing and Improvement Officer Appointed Group Chief Nursing and Improvement Officer 1 June 2025
Neil Kemsley, Chief Financial Officer (UHBW) / Group Chief Finance and Estates Officer Appointed as Chief Financial Officer 1 July 2019 Appointed Group Chief Finance and Estates Officer 1 June 2025
Jenny Lewis, Group Chief People and Culture Officer Appointed Group Chief People and Culture Officer 29 September 2025
Rebecca Maxwell, Interim Chief Medical Officer Appointed 1 January 2024 Role ended 31 May 2025.
Stuart Walker, Hospital Managing Director UHBW Appointed as Chief Medical Officer 21 February 2022 Appointed as Interim Chief Executive 1 January 2024 Appointed as Hospital Managing Director 2 September 2024

Tim Whittlestone, Group Chief Medical and Innovation Officer Appointed Group Chief Medical and Innovation Officer 1 June 2025
Emma Wood, Chief People Officer and Deputy Hospital Managing Director Appointed 4 January 2022 Stood down as a member of the Board 31 May 2025

Biographies of the members of the Board are provided at Appendix A.

5.1.4 Statement on compliance with cost allocation and charging guidance

The Trust ensures that it sets any charges to recover full costs in line with the guidance issued by HM Treasury.

5.1.5 Income disclosures

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust provides a variety of goods and services to patients, visitors, staff, and external organisations. Such goods and services include catering, car parking, pharmacy products, IT Services, and medical equipment maintenance. The income generated covers the full cost of the services and where appropriate contributes towards funding patient care.

5.1.6 Better Payment Practice Code

The Better Payment Practice Code Trust requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Financial management controls ensure all invoices are appropriately checked and authorised before being paid. The complexity of services provided to the Trust requires detailed checking by divisional clinical and operational management staff, both in terms of activity and services provided.

The Trust's performance against this standard is shown in the table below:

Table 19: Performance against Better Payment Practice Code

	Year ended 31 March 2026			Year ended 31 March 2025		
	NHS	Non NHS	Total	NHS	Non NHS	Total
No. invoices paid within 30 days	2,267	148,134	150,401	2,917	161,279	164,196
No. invoices paid	3,609	172,074	175,683	3,733	179,347	183,080
Percentage paid within 30 days	62.8%	86.1%	85.6%	78.1%	89.9%	89.7%
	NHS £m	Non NHS £m	Total £m	NHS £m	Non NHS £m	Total £m
Value of invoices paid within 30 days	£44.709	£359.838	£404.547	£74.219	£345.737	£419.956
Value of invoices paid	£61.850	£407.754	£469.604	£87.484	£380.832	£468.316
Percentage paid within 30 days	72.3%	88.2%	86.1%	84.8%	90.8%	89.7%

Despite wider economic pressures affecting all NHS organisations and ongoing operational challenges, in-year performance remained broadly consistent with 2024/25. Obtaining timely budget holder authorisation for invoice payment continues to present difficulties; however, regular stakeholder engagement meetings have been constructive. Engagement during 2025/26, along with strengthened relationships with key suppliers, has continued to improve and has resulted in a reduction in supplier escalation and action. Ongoing review and streamlining of systems and processes have enhanced the Trust's ability to respond to increasing demand and are expected to further improve capacity and drive continued improvement in both the volume and value of invoices paid within the 30-day target.

In 2025/26, £0.001m (2024/25, £0.001m) in interest was payable for three claimants made under the Late Payment of Commercial Debts (interest) Act 1998. No other compensation was paid to cover debt recovery cost under this legislation.

5.1.7 Council of Governors

NHS Foundation Trusts are 'public benefit corporations' and are required by the National Health Service Act 2006 to have a Council of Governors, the general duties of which are to:

- Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the members of the corporation as a whole and the interests of the public.

The Council of Governors is responsible for regularly feeding back information about the Trust's vision, strategy and performance to the members who elected them and the stakeholder organisations that appointed them. It discharges a further set of statutory duties which include appointing, re-appointing and removing the Chair and Non-Executive Directors, approving the appointment and removal of the Trust's External Auditor, and approving any application by the Trust to enter into a merger, acquisition, separation or dissolution.

The roles and responsibilities of the Council of Governors are set out in a separate document. Governors and the Board of Directors communicate through the Group Chair who is the formal conduit, and through their meeting schedule, which allows many opportunities for Board-Governor interaction.

Communications and consultations between the Council and the Board include the Trust's annual Quality Report; strategic proposals; significant transactions, clinical and service priorities; proposals for new capital developments; engagement of the Trust's membership; performance monitoring; and reviews of the quality of the Trust's services. The Board of Directors present the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors at the Annual Members' Meeting.

The Council has developed a good working relationship with the Group Chair and Directors, and through the forums of Governor Focus Groups (dealing with matters of membership engagement, strategy and planning; and quality, people and performance monitoring), as well as development seminars and informal Governor-NED Engagement Sessions, governors are provided with information and resources to enable them to engage in a challenging and constructive dialogue with the Non-Executive Directors.

5.1.8 Council of Governors Meetings

The formal meetings of the Council of Governors are scheduled four times a year. There has been good attendance by governors at these meetings, which has meant governors are kept up to date on current matters of importance and can follow up on queries in more detail at separate meetings. The Council of Governors meetings have provided an opportunity for Governors to hear in depth from the Chairs and members of the Board Sub-Committees on matters of importance through a different committee theme at each meeting, and all governor and membership activities were formally reported at Council of Governors meetings. Updates from the Group Chair and Group Chief Executive or Hospital Managing Director are standing agenda items and provide an opportunity to brief Governors on the significant issues facing the Trust, provide updates on developments, and report on performance. Governors use these meetings to publicly seek assurance on matters of public and staff interest. They are also the formal decision-making meetings for governors, with decisions in 2025/26 including the Group Non-Executive Director appointments and re-appointments, Trust Constitution changes, the new External Auditor Contract, changes to the Nominations and Appointments Committee Membership, election of the Lead and Deputy Lead Governor, the Terms of reference and business cycle for the Nominations and Appointments Committee and the postponement of the Governor Elections in 2026.

There were four formal Public Council of Governors meetings in the year, one formal private Council of Governors meeting and two additional Extraordinary Council of Governors held in private.

Governors are required to disclose details of any material interests which may conflict with their role as governors at each Council meeting. A register of interests is available to members of the public by contacting the Group Director of Corporate Governance at the address given in Appendix B of this report.

Table 20: Membership and Attendance at Council of Governors meetings 2025/26

Council of Governors	Attended	Out of a possible	Attendance rate
Group Chair: Ingrid Barker	5	6	83%
Ben Argo	6	6	100%
Grace Burn	0	6	0%
John Chablo	6	6	100%
David Chandler	1	2	50%
Mary Conn	0	2	0%
Paul Cousins	4	4	100%
Megan Crofts	3	4	75%
Carolyne Crowe	3	4	75%
Carol Dacombe	0	2	0%
Robert Edwards	6	6	100%
Tom Frewin	1	2	50%
Lisa Gardiner	6	6	100%
Sarah George	2	6	33%
Reni George	2	4	50%
Suzanne Harford	6	6	100%
Rachel Harkness	1	4	25%
Aalia Herbert	0	4	0%
Robert Knowles-Leak	4	4	100%
James Lee	4	4	100%
Jay-Jay Martin	3	4	75%
Esther Obafemi	0	4	0%
Jude Opogah	4	6	67%
Mark Patteson	3	6	50%
Annabel Plaister	6	6	100%
Janis Purdy	6	6	100%
Stuart Robinson	2	6	33%
John Rose	6	6	100%
Martin Rose	5	6	83%
John Sibley	5	4	125%
Phil Smith	4	4	100%
Chloe Somers	4	4	100%
Libby Thompson	1	2	50%
Phoebe Turner	2	2	100%
Paul Wheeler	4	4	100%
David Wilcox	6	6	100%

Note:

- Sickness absence and other reasons for non-attendance are not recorded in the Annual Report.
- Governors who did not reach their statutory requirement have been reminded of their duty to attend these meetings.
- Some Governors finished or started their term during the year but are included in this list and therefore all attendances have been calculated by a percentage.

5.1.9 Governors' Nominations and Appointments Committee

The Governors' Nominations and Appointments Committee is a formal Committee of the Council established in accordance with the NHS Act 2006, the UHBW Trust Constitution, and the Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chair and Non-

executive Directors. The Committee is chaired by the Joint Chair and normally has 12 governor members; however as of 31 March 2026 there are 11 members, with a vacancy for a Staff Governor.

The Committee met via videoconference for three extraordinary meetings (one in July and two in October) and two meetings of standard business (in May and November) and in between meetings it conducted business via email. Committee members were involved in reviewing activity records and annual performance appraisal reports for each of the Non-Executive Directors and making recommendation on re-appointments. In the year, the Committee electronically recommended the approval of the external NED recruitment process to be sent for full Council approval.

5.1.10 Performance and development of the Council of Governors

Governors have been able to carry out their necessary formal statutory duties in the year through hybrid meetings. Governors provided constructive challenge, questions and feedback across a wide range of areas, including the Joint Clinical Strategy; development of the Group Hospital model and the proposed merger with North Bristol NHS Trust (NBT); the Trust's Strategic Priorities; oversight of the Membership Strategy; Staff Survey results; communications plans; system partnership updates; Digital Strategy developments; and Arts and Culture plans. Much of this work was carried out through meetings of the two governor groups: the Quality Focus Group and the Governors' Strategy Group.

In terms of formal development, four Governor Development Seminar days were held during the year (April, June, October and February). These seminars provided training on statutory duties, including mergers and acquisitions. The programme also covered updates from the Integrated Care Board and Bristol and Weston Hospital Charity; sessions on the development of the proposed merger with North Bristol NHS Trust (NBT); the development of the Governors' meeting schedule; and several visits to areas across the Trust estate. In addition to this, Governors were joined by divisional triumvirates for their annual 'Divisional Update Day', where each Division provided a presentation on its 'Success and Challenges'.

5.1.11 Governor elections

Governor elections at UHBW are held every two out of three years, and 2026 is an election year. Considering the proposed merger with NBT, the Group Board of Directors and Council of Governors collectively agreed to defer the 2026 Governor elections to autumn 2026 and to extend the terms of office of the relevant Governors. The Corporate Governance Team works with the Trust's Youth Involvement Group to support the appointment each year of two young governors for a 12-month term of office. Grace Burn continued with a third term of office, and Phoebe Turner was appointed into her first term of office in October 2025.

The Lead Governor for April 2025 – March 2026 was Ben Argo, Public Governor. Phil Smith was elected as the Deputy Lead Governor in December 2025, taking over from Martin Rose after an internal election.

Table 21: Governors by constituency – 1 April 2025 to 31 March 2026

There are 29 governor seats in total. As of 31 March 2025, there were 29 governors in post (17 public, 6 staff and 6 appointed) with no vacancies. This is a list of all Governors who have held office during this financial year.

Constituency	Name	Tenure	Elected or Appointed?
Public Governors			
Public Bristol	Mary Conn	June 2023 to May 2025	Elected
Public Bristol	John Chablo	June 2025 to May 2026 June 2022 to May 2025 June 2019 to May 2022 June 2017 to May 2019	Elected
Public Bristol	Carole Dacombe	June 2022 to May 2025 June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Robert Edwards	June 2025 to May 2028 June 2022 to May 2025	Elected
Public Bristol	Tom Frewin	June 2022 to May 2025 June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Phil Smith	June 2025 to May 2028	Elected
Public Bristol	Chloë Somers	June 2025 to May 2028	Elected
Public Bristol	Janis Purdy	June 2023 to May 2026	Elected
Public Bristol	Martin Rose	June 2025 to May 2028 June 2022 to May 2025 June 2019 to May 2022	Elected
Public Bristol	Paul Wheeler	June 2025 to May 2028	Elected
Public North Somerset	Suzanne Harford	June 2023 to May 2026	Elected
Public North Somerset	Annabel Plaister	June 2023 to May 2026 June 2021 to May 2023	Elected
Public North Somerset	John Rose	June 2023 to May 2026 June 2021 to May 2023 June 2017 to May 2020 (extended to May 2021)	Elected
Public South Gloucestershire	Ben Argo	June 2025 to May 2028 June 2022 to May 2025	Elected
Public South Gloucestershire	John Sibley	October 2025 to October 2026 June 2022 to May 2025 June 2019 to May 2022 June 2017 to May 2019	Elected
Public South Gloucestershire	David Chandler	June 2025 to May 2028	Elected
Public South Gloucestershire	Paul Cousins	June 2025 to May 2028	Elected
Public Rest of England and Wales	Mark Patteson	June 2025 to May 2028 June 2022 to May 2025	Elected
Public Rest of England and Wales	Carolyne Crowe	June 2025 to May 2028	Elected
Staff Governors			
Non-clinical Staff	Lisa Gardiner	September 2023 to May 2026	Elected
Other Clinical Healthcare	Esther Obafemi	June 2025 to May 2028	Elected
Nursing and Midwifery	Rachel Harkness	June 2025 to May 2028	Elected
Nursing and Midwifery	Reni George	June 2025 to May 2028	Elected

Medical and Dental	Megan Crofts	June 2025 to May 2028	
Non-clinical Staff	Jude Opogah	June 2023 to May 2026	Elected
Appointed Governors			
Bristol City Council	David Wilcox	October 2024 to May 2027	Appointed
Joint Union Committee	Stuart Robinson	December 2023 to May 2026	Appointed
University of Bristol	Sarah George	March 2023 to April 2026 April 2022 to March 2023	Appointed
University of the West of England	Libby Thompson	November 2022 to May 2025	Appointed
University of the West of England	James Lee	June 2025 to May 2028	Appointed
Youth Involvement Group	Grace Burn	October 2024 to October 2025 October 2023 to October 2024	Appointed
Youth Involvement Group	Aalia Herbert	October 2024 to October 2025	Appointed
Youth Involvement Group	Maisy McCollum	October 2023 to October 2024	Appointed

5.1.12 Foundation Trust Membership

The Trust maintains a broadly representative membership of people from eligible constituencies in keeping with the NHS Foundation Trust governance model of local accountability (see table 23 below). The Trust has two membership constituencies as follows:

- A public constituency with four constituency classes: Bristol; North Somerset; South Gloucestershire; and Rest of England and Wales
- A staff constituency with four constituency classes: medical and dental; nursing and midwifery; other clinical healthcare professionals; and non-clinical staff.

Staff are automatically registered as members on appointment of a permanent or fixed term role, or once they reach their 12-month anniversary on the bank but may opt out if they wish. Information on opting out of the scheme is on the intranet.

Public membership is open to members of staff who are not eligible to become a member of the Trust's staff constituency and any public who are seven years of age and above that live in England or Wales. Membership is free to join, and people can become members by completing a short application form, which is available on the Trust website or by contacting the Corporate Governance team.

Public members receive news from our hospitals, invitations to come to events or to have their say on our services and can stand for election as governors and vote for governors to represent them.

Members of the Trust can contact the elected governors who represent them by emailing FoundationTrust@uhbw.nhs.uk. This information is available on the Membership page of the Trust website: https://www.uhbw.nhs.uk/p/working-with-us/become-a-member-of-our-trust and is publicised in all communications to members.

Information about the composition of Trust membership is below.

Table 22: Members of the Foundation Trust

Public constituency	
At year start (1 April 2025)	3,642
New members	82
Members leaving	247
At year end (31 March 2026)	3,472

Staff constituency	
At year start (1 April 2025)	15,667
At year end (31 March 2026)	16,536

5.1.13 Membership Strategy

The Trust launched a new Membership Strategy for 2024-2027 in 2024. The Strategy is easy to read and includes four objectives:

1. Collaborate with system and local partners to raise awareness of the membership of the Trust with the aim to be reflective and representative of the local population.

2. To improve the quality of communication with members, finding more creative and innovative ways to reach and communicate with members so that they can better engage with the work of Governors.

3. Harness the experience, skills and knowledge of members who wish to be more active to support and influence the development of the Trust to achieve its objectives and improve services.

4. To develop the role of the Governor to meet and exceed the statutory duties and to be reflective and representative of our diverse communities.

Members were invited in the year to attend the Annual Members Meeting which was held face-to-face in a joint meeting with North Bristol NHS Trust.

Work is now turning to reaching the objectives as set out above and providing Governors with a second year look at what has been achieved against them. The Strategy will be monitored through the Governor's Strategy Group and Council of Governors meetings periodically.

Table 23: Analysis of current membership (residents in Bristol, North Somerset and South Gloucestershire only)

Public constituency	Number of members (Public members in Bristol, North Somerset and South Gloucestershire)	Eligible membership (Population of Bristol, North Somerset and South Gloucestershire)	Are we Over or Under Represented?
Total			
Age NHSI	3,425	1,020,697	
0-16	18	184,898	Under
17-21	118	72,748	Under
22+	3,289	763,051	Over
Ethnicity:	**3,194**	**979,235**	
White	2,810	855,088	Under
Mixed	68	32,047	Under
Asian or Asian British	188	45,659	Over
Black or Black British	123	33,531	Over
Other/ Not Stated	5	12,910	Under
Socio-economic groupings:	3,462	**414,070**	
AB	1,014	101,555	Over
C1	1,030	131,836	Under
C2	682	83,178	Under
DE	736	97,501	Under

Gender analysis	**3,316**	**1,020,695**	
Male	1,423	504,975	Under
Female	1,893	515,720	Over

Note 1 *- This analysis excludes public members living outside Bristol, North Somerset and South Gloucestershire, and (as appropriate) public members with no date of birth, no stated ethnicity or no stated gender.*

**The data for this age category is not comparable as the minimum age for membership is seven years old according to the Trust's constitution. We currently have no members under the age of 10, but one at 11 and one at 13.*

In relation to ethnicity, it should be noted that there is a high number of members who have not stated their ethnicity and so the figures cannot be interpreted as statistically significant. Actions agreed to address under-representation include:

- The production of a social media pack promoting membership and governor roles for circulation to Governors.
- Deliver a schools/colleges outreach schedule with Governor participation and involvement of the Youth Involvement Group for insight.
- Ensure there is a visible Governors' stand at the 2026 Annual Members Meeting and embed Governor engagement slots at Health Matters events.
- Explore CPD accreditation for relevant Health Matters events.

5.2 An Overview of Quality

The Trust's objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust. The Trust's strategic priorities for quality, expressed through our Patient First framework, remain focused on ensuring that patients receive timely and safe care, and that they are treated as individuals and involved in decisions about their care. Our Clinical Strategy and our Joint Clinical Strategy with North Bristol NHS Trust are focussed on achieving the best clinical outcomes possible for the people we care for. Together, Patient First and our Clinical Strategy place our patients at the heart of everything we want to achieve as a provider of healthcare services. The Trust has continued to make progress in the last 12 months to improve the quality of care that we provide to patients and address any known quality concerns. We have much to be proud of; a summary of our progress will be published in our Quality Account for 2025/26. Healthcare does not stand still. We need to continuously find new and better ways of enhancing value, whilst enabling a better patient experience and improved outcomes. Never has there been a greater need to ensure we get the best value from all that we do, and this can be further enhanced through the Bristol NHS Group development which is well underway.

5.2.1 Stakeholder Relations

The Trust continues to strengthen its approach to stakeholder engagement and community partnership as a core component of delivering high-quality, equitable care. This aligns with Goal 4 of the Experience of Care Strategy, which focuses on ensuring that people and communities are actively involved in the design and delivery of services.

We maintain a strong and longstanding relationship with Healthwatch, who provide independent scrutiny through their involvement in the Experience of Care Group and through quarterly anonymised feedback reports reflecting the experiences of people using our services.

During 2025/26, the Trust has expanded its partnerships with voluntary, community and social enterprise (VCSE) organisations, charities and wider community partners to support improvements in health equity. Key partners, including the Diversity Trust, For All Healthy Living Centre, African Voices Forum, Caafi Health and the West of England Centre for Inclusive Living, work alongside organisations such as Bristol Sight Loss Council, Bristol Disability Equality Commission and the Centre for Deaf and Hard of Hearing People. These partnerships bring lived experience, cultural insight and specialist expertise into Trust programmes, including the Health Equity Delivery Group and Accessible Information Standard Delivery Group.

Recognising that communities experiencing the greatest inequalities are less likely to engage through traditional NHS routes, the Trust has prioritised engagement within trusted community settings, including community centres, faith venues and local hubs. VCSE partners act as trusted intermediaries, supporting culturally appropriate engagement, improving reach into underserved communities and enabling more inclusive participation. This approach supports compliance with statutory duties to reduce health inequalities and improve access to services.

Through these partnerships, the Trust is contributing to system-wide priorities aligned to NHS England's Core20PLUS5 framework, including improvements in areas such as asthma and oral health for children and young people, as well as strengthening accessible communication and equality-focused staff training.

Governance and oversight of this work is provided through the Health Equity Delivery Group, with representation from VCSE partners ensuring that community voice informs decision-making. The Community Participation Group further strengthens this by providing a formal mechanism for lived experience to influence Trust leadership and the Joint Clinical Strategy.

The Trust has also supported engagement with wider system partners, including the Group Clinical Services work to develop more joined up equitable services across UHBW and North Bristol NHS Trust, and the Neighbourhood Health focus to improve integration of services in Weston-super-Mare. In North Somerset, the Trust has worked with partners to support the development of an All-Age Autism Strategy and is an active member of the North Somerset Carers Partnership Board.

To support inclusive participation, a reimbursement policy for people and community partners is progressing through governance, ensuring individuals are not financially disadvantaged by their involvement. In addition, the Trust has developed guidance to support patient and public involvement in recruitment and is progressing plans for an online engagement portal to improve access to involvement opportunities.

The Trust continues to invest in building capability for co-production, including an Action Learning Set programme delivered in partnership with Peer Partnership (Brigstowe), funded by the Health Foundation. This supports staff to work more effectively in partnership with communities and embed co-production approaches within service design and improvement.

Early evidence of impact includes increased participation from underserved communities, strengthened VCSE partnerships and examples of community insight informing improvements to communication, patient information and service pathways. Work is ongoing to strengthen evaluation and assurance mechanisms to better evidence the impact of involvement on quality, access and outcomes.

5.2.2 Research and Development

During 2025–26, the Group Hospital Model continued to bring the two Bristol acute hospitals closer together, and this has been reflected in the way our R&D teams now operate, with work to align the ways we work well under way. This approach builds on the complementary strengths of each organisation and the different academic and system partnerships we hold—particularly with the Universities of Bristol and the West of England, as well as our colleagues in primary care and the wider health and care system. Bringing these perspectives together is helping us to make better use of our shared clinical expertise and research infrastructure.

Research remains a cornerstone of high-quality care. Organisations that actively support research consistently achieve better outcomes for their populations, bringing treatment options that otherwise might not be available, and financial benefits. For UHBW, research is therefore not an optional extra but a central part of the care we deliver every day, improving treatments and outcomes both locally and nationally.

In 2025–26, 3,924 patients, staff, and volunteers took part in research delivered at UHBW. This is a reduction over the previous year and reflects a shift in our portfolio towards studies that are more specialised, more complex, and often focused on smaller patient groups aligned to our specialist services.

Colleagues across the Trust contribute to research in many different ways. Some clinicians, nurses, midwives, and allied health professionals lead their own studies as Chief Investigators, developing research ideas and securing external funding. Many others act as Principal Investigators for multi-centre studies sponsored by national or international organisations. These studies frequently involve advanced interventions or focus on rare conditions—reflecting our role as a regional tertiary centre—and often require collaboration across multiple departments. Delivering such research depends on a highly trained and coordinated workforce, including research nurses, clinical research practitioners, trial coordinators, data managers, technical specialists, and the broad expertise of the R&D support teams. Regardless of role, every member of staff across UHBW contributes to an environment where research can thrive, recognising it as a fundamental part of delivering safe, effective, and innovative care.

R&D builds capacity and capability through training and development and we were delighted that amongst our successes in 2025/26 was our fourth successful NIHR Senior Nursing and Midwifery Research Leader (SRL). More broadly, our Clinical Research Education Facilitator (CREF) has continued to support the learning of our research teams with standardised research inductions, new competency workshops and sharing of best practice across specialties. We are committed to raising the profile and visibility of research with clinical staff to encourage more staff to consider research as a career pathway. With research awareness e-learning now part of essential-to-role training for clinical staff alongside research being an integral part of the preceptorship programme, clinical staff now have greater access to research opportunities. Embedded research champions can be a great way to change culture and attitudes towards research and our Research Links programme, launched two years ago, now has 88 members across a range of clinical areas. These Research Links work within our clinical services and bridge the gap between clinical and research services. We have been working closely with them to ensure our patients have the best opportunity to find out about research, and the initiative has gained national interest from many organisations looking to replicate our programme. As a result, we have developed an implementation pack and templates which 12 different organisations across England are now using to start their own programmes. Our Research Link programme has also been featured recently in the NHS England publication Research Matters: A guide for executive chief nurses, and as a blog in Journal of Research in Nursing.

In May 2025 we were successfully awarded to host and run the NIHR Health and Care Professional Internship Programme for the Southwest Central region for the period 2025 – 2028. This programme provides health and care professionals with the opportunity to undertake tailored internship programmes to develop their research skills, knowledge and confidence. The first cohort of 22 interns from a range of professions and settings across the region started their programme in September 2025 with applications for the second cohort opening in March 2026.

In November 2025 we held our annual Research Showcase, which hosted over 100 attendees from a wide range of clinical and non-clinical professions, from within UHBW and across our partner organisations in Bristol. Our audience was welcomed by Tim Whittlestone, Bristol NHS Group's Chief Medical and Innovation Officer. We heard about the wide range of research studies being led by UHBW, including those awarded grants from our local charity and NIHR and ranging across areas such as delivering of Challenge studies and cell therapy studies, to completed large clinical trials. We are hosts for a range of National Institute for Health and Care Research (NIHR) infrastructure. The Bristol NIHR Clinical Research Facility (CRF) and NIHR Bristol Biomedical Research Centre (BRC) and the Applied Research Collaborative West (ARC West) form part of the NIHR@Bristol. UHBW is host to the NIHR Regional Research Delivery Network (RRDN) and to Bristol Health Partners Academic Health Science Centre (BHP AHSC). The South West Central RRDN is the local arm of the national NIHR Research Delivery Network (RDN), which invests millions in our local health research infrastructure to develop capacity and capability to attract, optimise and deliver research across the health and care system.

As a specialist centre, part of our strategy is to develop our early phase research capacity and capability and this has been facilitated through the award of the NIHR Bristol Clinical Research Facility (CRF), now in its fourth year of funding. The CRF provides dedicated clinic space to deliver early translational and experimental medicine (ET/EM) research. Alongside this, our funding supports a number of early phase research nurses in our core therapeutic areas of Vaccine development and Oncology & Immunotherapy, where we set up and support delivery of complex research in small numbers of participants. The NIHR CRF also funds training capacity and a Patient and Public Involvement and Engagement facilitator, who works across the NIHR BRC and the NIHR CRF. Alongside the NIHR funding, income generated by working with our academic and industry partners are a key part of this strategy and we have growing commercial and academic portfolios. As we look towards shaping our second CRF bid over the next two years, we have successfully recruited a Director Designate who will develop the bid and if we are successful, will take over as CRF director in April 2029. This year we secured capital funding from NIHR to refurbish two clinical rooms in the CRF into a small research ward area with capacity for overnight stays, which will substantially increase our marketability to ET/EM researchers in the region. We have also secured NIHR strategic funding to develop a Peripheral Blood Mononuclear Cell (PBMC) isolation service using our small laboratory. Our new specialist senior study coordinator has been working with research teams across Bristol NHS Group, including at Bristol Eye Hospital, Bristol Heart Institute (Cardiac Surgery team) and North Bristol Trust (Renal) to set up highly complex studies. Our vaccine clinical research delivery staff have been working flexibly with research teams who need additional support when the vaccine pipeline of work is less busy.

This year, the CRF has been in receipt of additional funding from NIHR BioResource which we have used to set up and run the Improving Black Health Outcomes (IBHO) study. This important project sets out to engage with and recruit people from Black African and Black Caribbean communities in order build a resource to benefit future generations. It requires a great deal of intensive outreach to successfully recruit to time and target from this underserved population.

Our NIHR Biomedical Research Centre (BRC) continues to make strong progress against its objectives, with all short-term objectives across all five research themes complete. Scientific highlights from the past year include research on inclusive school PE kit design that informed updated UK government guidance on school uniform policy, licensing of the Surgical Core Information Set to a digital consent software provider for use across 38 UK organisations and developing a new phone-based AI tool that uses voice analysis to detect deterioration in chronic lung conditions. Our Transition Fellowships, including four UHBW allied health professionals, have been funded for 12 months with ringfenced time to support the development of fellowship applications. The BRC's Translational Research Collaboration in Surgical and Peri-Operative Care is fully operational, leading collaboration across 14 partner BRCs nationally and having completed its first pump-priming call. The South West Secure Data Environment is now operational with the Data Access Committee in place, and our genomic platform is attracting significant commercial interest. The Bristol Research and Innovation Data Engineering (BRIDE) Hub has been initiated to develop NHS Group data engineering infrastructure. Planning for the next BRC application is well underway, led by Professor Richard Martin as Director Designate. NIHR has announced the plan to launch a new BRC funding competition with a deadline of mid-September 2026 for Stage 1 applications.

Our NIHR ARC has had a strong focus on building capacity and capability with system partners, and additional funding was awarded in 2024/25 to support research capacity in the social care sector, to build knowledge mobilisation capacity and capability to get effective treatments and models of care into practice, and to extend and expand the work in the Mental health Research Initiative.

In 25/26 we submitted a total of fifteen NIHR project/programme grants; three were awarded, totaling £3.85 million, the outcome is awaited for a further four. Our three newly awarded grants were: an NIHR-HTA trial in paediatric anaesthesia: “CATERPILLAR: Continuous wound infusion catheters for postoperative analgesia after paediatric laparotomy - a RCT” led by Caroline Wilson and Jane Blazeby; an NIHR-RfPB: “AIM2Change: Feasibility of ACT/DNA-V for Young People in NHS Complications of Excess Weight Clinics” led by Michelle Griffiths and Julian Hamilton Shield; and an NIHR-PDG “Improving perioperative care for children undergoing surgery for congenital heart disease

(CHD)" led by Maria Pufulete and Serban Stoica. In addition, Ema Swingwood (consultant physiotherapist) was awarded an NIHR Senior Clinical and Practitioner Research Award; Ema's has made a huge contribution to supporting other Allied Health Professionals (AHP) in research, including supporting four NIHR pre-doctoral fellowship applications this year.

Three of our large trials have completed and presented preliminary findings, two after protracted extensions due to effects of the pandemic on recruitment. Our Post-award Grant Manager is contributing to streamlined and improved management of contracting and finance post-award, which supports robust oversight and invoicing of our grant income. This, along with the increase in NIHR grant submissions over the last three years, will increase our grant income, and should drive an increase in research capability funding in the coming two years. The increase in capacity within the grants team has allowed the Grants Manager to reprioritise development of small grants and mentor and support new researchers in applying for local funding and conversion of small studies into the larger NIHR grants. We have funded specialist methodological support to support our small grant applicants, and on average receive approximately 23 applications per year; we continue to work closely with our AHP research lead to develop and encourage nurses, midwives, allied health professionals and clinical scientists to apply to our rolling local funding call to release time to develop a small grant application, or early-stage fellowships. We value the close collaboration we have with the University of the West of England (UWE), whose staff support and mentor our current and aspiring clinical researchers in the nursing, midwifery, allied health professions and clinical scientist professions that have traditionally received less funding and focus than medical and dental staff.

We significantly increased our levels of commercial research during 2025-26, opening around 25% more commercial studies and generating around £5m through invoices raised from contract commercial studies. This represents a 33% increase on the previous year and funds the research staff carrying out these studies, contributes to divisional and corporate income and provides flexibility to invest in strategically important areas, build capacity, and promote more growth.

Our relationships with industry partners are well established and we work with principal investigators and commercial partners to identify studies that may bring benefit to patients through the use of novel treatment options as part of the care UHBW offers, as well as supporting the health and wealth of the nation. We remain a 'Super Partner' site with IQVIA, one of the biggest global contract research organisations (CROs) and continue to enjoy a fruitful relationship. We engage directly with pharmaceutical and MedTech companies running research in the UK, explore more collaborative ways of working, and review upcoming pipelines which positions us well to express interest in trials of new compounds. This work has helped to increase the number of UK Chief Investigators (CI) for commercial trials we have at UHBW. In 2025-26 we opened 8 commercial trials where the CI has been a UHBW investigator and UHBW is the lead NHS site, with a further 5 studies currently in set-up.

We continue to build on our expertise in delivering involving Advanced Therapy Investigational Medicinal Products (ATIMPs). This year UHBW opened the EMERALD trial, a commercial trial involving Autologous Macrophages in participants with Liver Cirrhosis, which is our first cellular therapy trial being run outside Haematology/Oncology. Our first patient has been treated and dosed. We are also building on opportunities presented through the Hospital Group to increase collaboration with NBT. In early 2026, leaning on expertise within the Bristol NIHR CRF, we opened a phase I gene therapy trial in IgA Nephropathy at NBT, which will be run with the support of specialist staff at UHBW in the CRF and Pharmacy. Similarly, in BHOC we have opened our first CAR-T trial in a non-haematologic disease. The Auto1-SL2 trial is a Phase II commercial trial for patients with Lupus Nephritis. These patients are managed clinically at NBT and will be referred to Bristol Haematology and Oncology Centre Clinical Trials Unit (BHOC CTU) for the trial. The Principal Investigator is a Renal Physician from NBT who will work under a Licence to Attend to run the trial at UHBW alongside BHOC CTU.

At the core of everything we do is a strong framework of quality and governance. Our Research Operations Manager leads and maintains the quality systems that enable us to sponsor research to

the highest standards, and to host a diverse range of non-commercial studies alongside commercial, early-phase and experimental research.

We manage a broad and complex research portfolio designed to benefit both our local communities and the wider populations we serve. This reflects the extensive services provided by UHBW in an increasingly challenging environment, while generating the evidence needed to shape and enhance the care we offer.

5.3 Remuneration Report

This is the Report of the Remuneration, Nominations and Appointments Committee of the Board of Directors, for the financial year of 1 April 2025 to 31 March 2026.

5.3.1 Annual Statement on Remuneration

The purpose of the Remuneration, Nominations and Appointment Committee is to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and to review the suitability of structures of remuneration for senior management. The Committee was chaired by the Trust Chair and all Non-executive Directors were members of the Committee. The Committee was attended by the Chief Executive and the Chief People Officer / Group Chief People and Culture Officer in an advisory capacity when appropriate and supported by the Director of Corporate Governance to ensure it undertook its duties in accordance with applicable regulation, policy and guidance.

The Committee met on six occasions in the reporting period, all of which were held in common with the equivalent committee at North Bristol NHS Trust.

5.3.2 Major decisions and substantial changes

The Committee considered the annual review of Executive Directors' performance and remuneration levels. In addition, the Committee approved the new Group Executive structure and the process for appointments to the new Group Executive roles.

The Committee also approved a pay approach Very Senior Manager (VSM) leadership roles under the national Very Senior Manager (VSM) framework, and a framework for pay principles and role assignment for VSM and Agenda for Change Band 9 roles across the Group.

5.3.3 Senior Manager's Remuneration Policy

The Trust's approach to remuneration for Very Senior Managers (VSMs) continues to follow the national VSM Framework**,** which is designed to ensure:

- Alignment across the NHS - a consistent and equitable approach to senior pay across all ICBs and NHS provider trusts.
- Attractive and proportionate reward - enabling competitive total reward packages that remain appropriate and justifiable.
- Recruitment of experienced leaders - supporting the NHS to attract and retain highly skilled and experienced VSMs, particularly in the most challenged organisations.
- Stronger link to performance - ensuring remuneration is connected to operational delivery and service improvement.
- Integration with national performance frameworks - including alignment with the Board Member Appraisal Framework.
- Support for government priorities - ensuring senior pay arrangements reinforce wider system objectives.

The Remuneration Committee has agreed the following principles to govern all VSM posts:

- Fairness and equal pay - ensuring equal pay for work of equal value.
- Transparency - maintaining clear rationale and fully documented decision-making.
- Governance - ensuring auditable processes and appropriate oversight by the Remuneration Committee.
- Affordability - balancing competitiveness with responsible management of the pay bill and total reward costs.
- Equality proofing - undertaking Equality Impact Assessments, monitoring gender, ethnicity and disability pay gaps and taking corrective action where required.

Under the national VSM Framework, all pay cases exceeding £170,000 were submitted to NHS England for approval, and the organisation confirms compliance with all associated VSM guidance.

In setting VSM salaries, the Remuneration Committee has considered prevailing market conditions across the public sector and within the NHS. The Committee is satisfied that remuneration for these senior roles is reasonable, proportionate, and comparable with similar posts across the wider public sector. The Committee also recognises its responsibilities in addressing the gender pay gap and ensures regular monitoring of pay arrangements to ensure parity of remuneration between male and female Executive Directors**.**

Accounting policies for pensions and other retirement benefits (which apply to all employees) are contained in Note 1 of the Annual Accounts.

The following tables show the remuneration for the senior managers of the Trust for 2025/26 and 2024/25. There were two exit packages paid to directors in 2025/26 (none in 2024/25). This information has been subject to audit.

Table 24: Remuneration for the senior managers of the Trust 2025/26 (Audited)

	a	*b*	*c*	*d*		*e (a-d)*
Directors' remuneration for 2025/26 (£'000)	**Salary (bands of £5,000)**	**Taxable benefits (to nearest £100)**	**Annual performance related bonus (bands of £5,000)**	**Pension Related Benefits (bands of £2,500)**	**Exit Package (bands of £5,000)**	**Total (bands of £5,000)**
Chair:						
Ingrid Barker * *(Note 1)*	45-50	1,700	-	N/A	-	45-50
Non-Executive Directors						
Martin Sykes - UHBW to 31/08/2025 and Group Non-Executive Director & UHBW Vice Chair from 01/09/2025* *(Note 1)*	20-25	1,100	-	N/A	-	20-25
Linda Kennedy - UHBW to 31/08/2025 and Group Non-Executive Director from 01/09/2025*	15-20	300	-	N/A	-	15-20
Thomas (Marc) Griffiths - UHBW to 31/08/2025 and Group Non-Executive Director from 01/09/2025* *(Note 1)*	10-15	-	-	N/A	-	10-15
Roy Shubhabrata - UHBW to 31/08/2025 and Group Non-Executive Director from 01/09/2025 *	10-15	-	-	N/A	-	10-15
Sarah Purdy - Group Non-Executive Director & NBT Vice Chair *(from 01/09/2025)* *	5-10	-	-	N/A	-	5-10
Richard Gaunt - Group Non-Executive Director *(from 01/09/2025*) *	5-10	-	-	N/A	-	5-10
Poku Pipim Osei - Group Non-Executive Director *(from 01/12/2025)* *	0-5	-	-	N/A	-	0-5
Sue Balcombe	25-30	-	-	N/A	-	25-30
Arabel Bailey *(to 31/08/2025)*	5-10	-	-	N/A	-	5-10
Rosemarie Benneyworth *(to 31/08/2025)*	5-10	-	-	N/A	-	5-10
Susan Hamilton *(to 30/06/2025)*	0-5	-	-	N/A	-	0-5
Anne Tutt *(to 31/08/2025)*	10-15	-	-	N/A	-	10-15
Executive Directors						
Maria Kane, Group Chief Executive *	150-155	-	10-15	60-62.5	-	225-230
Stuart Walker, UHBW Hospital Managing Director	335-340	-	-	35-37.5	-	335-340
Neil Kemsley, Group Chief Finance and Estates Officer - UHBW only to 31/05/2025 and Group role from 01/06/2025 *	120-125	-	-	72.5-75	-	195-200
Paula Clarke, Group Formation Officer - (UHBW only to 31/05/2025 and Group role from 01/06/2025 *	105-110	-	-	27.5-30	-	135-140
Steve Hams, Group Chief Nursing and Improvement Officer *(from 01/06/2025)* *	80-85	-	-	42.5-45	-	125-130
Tim Whittlestone, Group Chief Medical and Innovation Officer *(from 01/06/2025)* *	120-125	-	-	52.5-55	-	170-175

Neil Darvill, Group Chief Digital Information Officer *	95-100	-	-	-	-	95-100
Jenny Lewis, Group Chief People and Culture Officer *(from 01/10/2025)* *	45-50	-	-	-	-	45-50
Jane Farrell, Chief Operating Officer *(to 10/12/2025)* ***(Note 2)***	170-175	-	-	-	30-35	170-175
Deirdre Fowler, Chief Nurse and Midwife *(to 31/08/2025)* ***(Note 2)***	85-90	-	-	7.5-10	20-25	95-100
Rebecca Maxwell, Interim Chief Medical Officer *(to 31/05/2025)*	35-40	-	-	5-7.5	-	40-45
Emma Wood, Chief People Officer & Deputy Hospital Managing Director *(to 30/09/2025*)	105-110	-	-	72.5-75	-	175-180

* *These are Bristol NHS Group roles where remuneration has been apportioned based on split working arrangements with North Bristol Trust (see Table 24A for term dates and total remuneration in a group role)*

Note 1 *Taxable benefits relate to reimbursement of travel cost for home to base mileage*

Note 2 *Payment for loss of office relates to payments in respect of statutory redundancy only*

Table 24A: Total Remuneration for Group Directors included under cost share with North Bristol Trust (Audited)

Directors' remuneration under cost share arrangement only *(note 1)* Total remuneration for the full financial year 2025/26 (£'000)		**Total (bands of £5,000)**
Chair:	**Notes**	
Ingrid Barker (*Note 1)*	Group role for the full financial year	90-95
Non-Executive Directors		
Martin Sykes - Group Non-Executive Director & UHBW Vice Chair *(Note 1)*	UHBW NED to August 2025 and Group NED from September 2025	30-35
Linda Kennedy - Group Non-Executive Director	UHBW NED to August 2025 and Group NED from September 2025	20-25
Thomas (Marc) Griffiths - Group Non-Executive Director *(Note 1)*	UHBW NED to August 2025 and Group NED from September 2025	15-20
Roy Shubhabrata - Group Non-Executive Director	UHBW NED to August 2025 and Group NED from September 2025	15-20
Sarah Purdy - Group Non-Executive Director & NBT Vice Chair	Group NED from September 2025	25-30
Richard Gaunt - Group Non-Executive Director	Group NED from September 2025	15-20
Poku Pipim Osei - Group Non-Executive Director	Group NED from December 2025	5-10
Executive Directors		
Maria Kane, Group Chief Executive	Group role for the full financial year	455-460
Neil Kemsley, Group Chief Finance and Estates Officer	UHBW Executive Director to May 2025 and Group Executive Director from June 2025	210-215
Paula Clarke, Group Formation Officer	UHBW Executive Director to May 2025 and Group Executive Director from June 2025	185-190
Steve Hams, Group Chief Nursing and Improvement Officer	Group Executive Director from June 2025	295-300
Tim Whittlestone, Group Chief Medical and Innovation Officer	Group Executive Director from June 2025	415-420
Neil Darvill, Group Chief Digital Information Officer	Group role for the full financial year	190-195
Jenny Lewis, Group Chief People and Culture Officer *(from 01/10/2025)*	Group Executive Director from October 2025	95-100

Note 1 - The Hospital Managing Directors are not included in this table as their salaries are disclosed in full in the respective trusts

Table 25: Remuneration for the directors of the Trust 2024/25 (Audited)

Director's remuneration: salaries and allowances for the 12 months to 31 March 2025	Salary (bands of £5,000)	Taxable benefits (to nearest £100)	Annual performance related bonus	All pension-related benefits (band of £2,500)	Total (bands of £5,000)
Chair					
Jayne Mee from 01 April 2024 to 31 May 2024	5-10	-	-	N/A	5-10
Ingrid Barker; Joint Chair from 01 June 2024 *(Notes 1 & 3)*	35-40	600	-	N/A	35-40
Executive Directors					
Maria Kane, Joint Chief Executive from 29 June 2024 *(Notes 1 & 3)*	120-125	200	5-10	-	130-135
Stuart Walker, Chief Executive from 01 April 24 to 28 June 24; Hospital Managing Director from 02 Sept 2024 *(Note 2)*	325-330	-	-	N/A	325-330
Jane Farrell, Chief Operating Officer *(Note 2)*	205-210	-	-	N/A	205-210
Paula Clarke, Executive Managing Director for Weston *(Note 4)*	185-190	-	-	40-42.5	225-230
Neil Kemsley, Chief Financial Officer	195-200	-	-	-	195-200
Deirdre Fowler, Chief Nurse and Midwife *(Note 2)*	200-205	-	-	N/A	200-205
Emma Wood, Chief People Officer & Deputy Chief Executive	200-205	-	-	55-57.5	255-260
Neil Darvill, Joint Chief Digital Information Officer *(Note 3)*	95-100	-	-	20-22.5	115-120
Rebecca Maxwell, Interim Medical Director	210-215	-	-	65-67.5	275-280
Non-Executive Directors					
Arabel Bailey	15-20	-	-	N/A	15-20
Sue Balcombe	15-20	-	-	N/A	15-20
Rosemarie Benneyworth	15-20	-	-	N/A	15-20
Bernard Galton	0-5	-	-	N/A	0-5
Emma Glynn	0-5	-	-	N/A	0-5
Thomas Griffiths	15-20	-	-	N/A	15-20
Susan Hamilton	5-10	-	-	N/A	5-10
Linda Kennedy	10-15	-		N/A	10-15
Jane Norman	0-5	-	-	N/A	0-5
Roy Shubhabrata	15-20	-	-	N/A	15-20

Note 1 *– Taxable benefits relate to reimbursement of travel cost for home to base mileage*
Note 2 *- No NHS Pension benefits have been disclosed as they are no longer a contributing member of the scheme*
Note 3 *- Remuneration has been apportioned based on split working arrangements with North Bristol Trust*
Note 4 *– Salary and total bands updated from 2024/25 published report to reflect salary amendment as reported to HMRC as 2024/25 taxable pay.*

The value of pension benefits accrued in the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

There were two payments made for loss of office totalling £0.056m in 2025/26 (nil in 2024/25) following the Group Executive appointments to the Bristol NHS Group.

There were no payments to past senior managers in either 2025/25 or 2024/25.

Real increases and employer's contributions are shown for the time in post where this has been less than the full year.

The following tables show the pension benefits for the senior managers of the Trust for 2025/26 and 2024/25. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.

This information has been subject to audit.

Table 26: Pension benefits for the year ended 31 March 2026 (Audited)

	a	*b*	*c*	*d*	*e*	*f*	*g*	*h*
Name	**Real increase in pension at pension age**	**Real increase in pension lump sum at pension age**	**Total accrued pension at pension age at 31 March 2026**	**Lump sum at age 60 related to accrued pension at 31 March 2026**	**Cash Equivalent Transfer Value at 31 March 2026**	**Cash Equivalent Transfer Value at 31 March 2025**	**Real Increase in Cash Equivalent Transfer Value**	**Employer's Contribution to Stakeholder Pension**
	(bands of £2,500)	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**£000**	**£000**	**£000**	**£000**
Maria Kane *	5-7.5	2.5-5	65-70	175-180	110	1,518	-	N/A
Stuart Walker *(Note 1)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neil Kemsley *	5-7.5	-	5-10	-	159	36	99	N/A
Paula Clarke *	2.5-5	-	10-15	-	227	162	40	N/A
Steve Hams * *(Note 2)*	2.5-5	5-7.5	50-55	130-135	1,107	963	88	N/A
Tim Whittlstone * *(Note 2)*	5-7.5	7.5-10	85-90	240-245	2,132	1,933	122	N/A
Neil Darvill *	-	-	75-80	190-195	233	172	38	N/A
Jenny Lewis *	-	-	10-15	-	244	535	-	N/A
Jane Farrell *(Note 1)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deidre Fowler *(Note 1)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emma Wood	2.5-5	-	40-45	-	632	551	58	N/A
Rebecca Maxwell *(Note 2)*	0-2.5	0-2.5	35-40	85-90	707	643	8	N/A

** These are Bristol NHS Group roles where remuneration has been apportioned based on cost sharing arrangements with North Bristol Trust*
F(
N
***Note 1** – Not covered by the pension arrangements during the reporting year*
***Note 2** – The real increase is apportioned to reflect the period in term*

This table includes details for the directors who held office at any time in 2025/26.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Table 27: Pension benefits for the year ended 31 March 25 (Audited)

Name	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at age 60 related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2024	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Maria Kane	-	-	55-60	165-170	1,518	1,436	-	N/A
Stuart Walker (Note 1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jane Farrell (Note 1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paula Clarke	2.5-5	-	5-10	0-5	162	103	32	N/A
Neil Kemsley	-	-	0-5	0-5	36	58	-	N/A
Deidre Fowler (Note 1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emma Wood	2.5-5	-	35-40	0-5	551	454	38	N/A
Neil Darvill	2.5-5	-	80-85	210-215	172	103	39	N/A
Rebecca Maxwell	2.5-5	2.5-5	30-35	80-85	643	540	51	N/A

Note 1 – Not covered by the pension arrangements during the reporting year

This table includes details for the directors who held office at any time in 2025/26.

Table 28: Future Policy Table

Element of pay (component)	How component supports short- and long-term objective/goal of the Trust	Operation of the component	Description of the framework to assess pay and performance
Basic Salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership.	Individual pay is set for each Executive Director on appointment; this is by reviewing salaries of equivalent posts within the NHS. (Please note that this does not include additional payments over and above the role such as clinical duties and Clinical Excellence award. Total remuneration can be found in the remuneration tables in the Annual Report on Remuneration).	Pay is reviewed annually by the Remuneration and Nomination Committee in respect of national NHS benchmarking. In addition, any Agenda for Change cost of living pay award, when agreed nationally, is considered for payment to the Executive Directors. Performance is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of the financial year.
Pension	Provides a solid basis for recruitment and retention of top leaders in the sector.	Contributions within the relevant NHS pension scheme.	Contribution rates are set by the NHS pension scheme.

***Note 1** - Where an individual Executive Director is paid more than £170,000, the Trust has taken steps to assure that remuneration is set at a competitive rate in relation to other similar NHS Trusts and that this rate enables the Trust to attract, motivate and retain executive directors with the necessary abilities to manage and develop the Trust's activities fully for the benefits of patients. All such appointments are subject to approval by the NHS South West Regional Team.*
***Note 2** - The components above apply generally to all Executive Directors in the table and there are no particular arrangements that are specific to an individual director.*
***Note 3** - The Remuneration, Nominations and Appointments Committee adopts the principle of the Agenda for Change framework when considering Executive Directors pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale*

5.3.4 Fair pay multiple (Audited)

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation against the 25th percentile, median, and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median, and 75th percentile is further broken down to disclose the salary component.

The remuneration report shows that the highest paid director's remuneration fell into the £335,000 to £340,000 band (2024/25 £325,000 to £330,000). The relationship to the remuneration of the organisation's workforce is disclosed in the tables below.

Table 29: Highest Paid Director (Audited)

Year	2025/26 £000's	2024/25 £000's	% change
Salary and allowances	340	330	3.0%
Performance pay and bonuses	-	-	-

Table 30: Average Employee (Audited)

Year	2025/26 £	2024/25 £	% change
Salary and allowances	52,457	49,123	6.8%
Performance pay and bonuses	-	-	-

Table 31: Pay Ratio Disclosure and Information (Audited)

2025/26	25th percentile	Median	75th percentile
Total remuneration - £	31,796	43,274	55,697
Salary component of total remuneration - £	31,796	43,274	55,697
Pay ratio information	10.7	7.9	6.1

2024/25	25th percentile	Median	75th percentile
Total remuneration - £	29,983	40,667	52,819
Salary component of total remuneration - £	29,983	40,667	52,819
Pay ratio information	11.0	8.1	6.2

Remuneration of the highest paid director was 7.9 times (2024/25, 8.1 times) the median remuneration of the workforce, which was £43,274 (2024/25, £40,667). Remuneration ranged from £24,465 to £331,432 (2024/25, £23,615 to £327,979).

In 2025/26, no (2024/25, nil) employees received total remuneration more than the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The information in the tables above does not include remuneration of temporary staff because the organisation believes it artificially inflates the 25th percentile, median, and 75th percentile remuneration and therefore reduces the ratio with the remuneration of the highest paid director. Including temporary staff would cause year on year changes in the ratios to be driven by the volume of agency workers used, rather than a change in the underlying salaries paid to employees.

To ensure compliance with mandatory reporting requirements, and to provide all available information, remuneration including temporary staff is disclosed in the tables below.

Table 32: Average Employee (including temporary staff) (Audited)

Year	2025/26 £	2024/25 £	% change
Salary and allowances	64,853	59,478	9%
Performance pay and bonuses	-	-	-

Table 33: Pay Ratio Disclosure and Information (including temporary staff) (Audited)

2025/26	25th percentile	Median	75th percentile
Total remuneration - £	33,841	45,839	64,095
Salary component of total remuneration - £	33,841	45,839	64,095
Pay ratio information	9.8	7.2	5.1

2024/25	25th percentile	Median	75th percentile
Total remuneration - £	31,728	43,400	58,952
Salary component of total remuneration - £	31,728	43,400	58,952
Pay ratio information	10.4	7.6	5.6

5.3.5 Remuneration of Non-executive Directors

The remuneration of the Chair and Non-executive Directors is determined by the Governors' Nominations and Appointments Committee. The Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, the Trust Constitution, and the Code of Governance for NHS Provider Trusts, and has responsibility to review the appointment, re-appointment, removal, remuneration and other terms of service of the Chair and Non-executive Directors.

Members of the Committee are appointed by the Council of Governors. The membership includes eight elected public governors, two elected staff governors and two appointed governors.

The Committee is chaired by the Chair of the Trust in line with the Code of governance for NHS provider trusts, and in her absence, or when the Committee is to consider matters in relation to the appraisal, appointment, reappointment, suspension or removal of the Chair, by the Senior Independent Director.

The purpose of the Committee with regard to remuneration is to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair and Non-executive Directors, and, on a regular basis, monitor the performance of the Chair and Non-executive Directors.

5.3.6 Assessment of performance

All Executive and Non-executive Directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12-month period running from 1 April to 31 March each year. During the year, regular reviews take place to discuss progress, and there is an end-of-year review to assess achievements and performance.

Executive Directors are assessed by the Chief Executive. The Chair undertakes the performance review of the Chief Executive and Non-executive Directors. The Chair is appraised by the Senior

Independent Director and rigorous review of this process is undertaken by the Governors' Nominations and Appointments Committee chaired for this purpose by the Senior Independent Director and advised by the Director of Corporate Governance.

5.3.7 Expenses

Members of the Council of Governors and the Board of Directors are entitled to expenses at rates determined by the Trust. Further details relating to the expenses for members of the Council of Governors and the Board of Directors may be obtained on request to the Director of Corporate Governance.

Table 34: Expenses paid to governors and directors (Audited).
Expenses are reimbursement of travel and subsistence costs incurred on Trust business

	Directors			Governors		
Year	Number in office	Number reimbursed	Amount (£)	Number in office	Number reimbursed	Amount (£)
2025/26	25	13	9,286	35	9	2,110
2024/25	23	12	14,880	29	8	2,011

Note 1 - The Bristol NHS Group Structure was implemented in June 2025 for the Executive Directors and September 2025 for the Non-Executive Directors. Group Director expenses are jointly funded between the 2 Trusts

5.3.8 Duration of contracts

All Executive Directors have standard substantive contracts of employment with a six-month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director.

5.3.9 Early termination liability

Depending on the circumstances of the early termination, the Trust would, if the termination were due to redundancy, apply the terms under Section 16 of the Agenda for Change Terms and Conditions of Service; there are no established special provisions. All other Trust employees (other than Non-executive Directors) are subject to national terms and conditions of employment and pay.

Maria Kane
Group Chief Executive

5.4 Staff Report

We recognise our workforce is our most valuable asset and have developed a clear People Strategy. Our aim is to be an employer of choice: attracting, supporting and developing a workforce that is skilled, dedicated, compassionate, and engaged, so that it can continue to deliver exceptional care, teaching and research every day.

5.4.1 Analysis of staff costs

The following table analyses the Trust's staff costs, following the format required by the Trust Accounting Consolidated Schedules (TACs) and distinguishes between staff with a permanent employment contract with the Trust (which excludes non-executive directors) and other staff such as bank staff, agency staff and inward secondments from other organisations where the Trust is paying the whole or the majority of their costs, but the individual does not have a permanent contract of employment. This information has been subject to audit.

Table 35: Analysis of staff costs (Audited)

	2025/26			2024/25		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	664,712	616,383	48,329	626,675	576,421	50,254
Social security costs	86,124	80,093	6,031	67,462	61,958	5,504
Pension costs*	127,828	123,404	4,424	121,672	116,291	5,381
Apprenticeship levy	3,241	3,241	-	3,122	3,122	-
Termination benefits	1,036	1,036	-	586	586	-
Agency/contract staff	7,505	-	7,505	12,694	-	12,694
Total Gross Staff Costs	**890,446**	**824,157**	**66,289**	**832,211**	**758,378**	**73,833**
Income in respect of salary recharges netted off expenditure	(4,077)	(4,077)	-	(3,806)	(3,806)	-
Employee expenses capitalised	(5,546)	(5,122)	(424)	(2,294)	(1,857)	(437)
Net employee expenses	**880,823**	**814,958**	**65,865**	**826,111**	**752,715**	**73,396**

5.4.2 Analysis of average whole time equivalent staff numbers

An analysis of the average whole time equivalent staff numbers employed by the Trust for 2025/26 and 2024/25 is shown in the table below. The information uses the categories required by the Trust Accounting Consolidated Schedules (TACs) and distinguishes between staff with a permanent employment contract with the Trust and other staff such as bank staff, agency staff and inward secondments from other organisations where the Trust is paying the whole or the majority of their costs. This information has been subject to audit.

Table 36: Average staff numbers (whole time equivalents) (Audited)

	2025/26			2024/25		
Staff category	**Total**	**Permanent**	**Other**	**Total**	**Permanent**	**Other**
Medical and dental	1,943	1,858	85	1,888	1,792	96
Administration and estates	2,532	2,475	57	2,564	2,497	67
Healthcare assistant and other support	1,106	930	176	1,115	961	154
Nursing, midwifery & health visitors	5,434	4,913	521	5,475	4,889	586
Scientific, therapeutic and technical	1,740	1,697	43	1,707	1,660	47
Healthcare science staff	272	272	-	262	262	-
Total staff	**13,027**	**12,145**	**882**	**13,011**	**12,061**	**950**

5.4.3 Education, Learning and Development

During the year, the department underwent a major reorganisation aligned to the national long-term workforce plan and the Safe Learning Environment Charter. It was renamed Learning and Workforce Development (LWDB) and now reports through the Learning and Workforce Development Board. The Trust continues to offer a wide range of learning and development opportunities through internal and external providers and maintains strong partnerships with regional colleges and universities delivering all levels of education and training. Collaboration across BNSSG ICS has strengthened, with progress in passporting training records and widening-engagement activity.

The Leadership, Management and Coaching offer has now been running for three years, reaching leaders and managers through workshops and programmes of learning. The mandated leadership programme continues to embed core skills and has achieved a 77% compliance rate. Around 300 colleagues have completed progressive leadership programmes. The Bridges Programme, supporting global majority colleagues, is delivering its seventh cohort with strong feedback. Work is underway to create a single leadership offer aligned with the new national code and framework launching in March 2026.

The Trust currently supports 441 apprentices (2.6% of the workforce), with a further 30 in the pipeline. The offer covers 62 standards across 37 providers, with growth in digital and administrative roles. Forthcoming enrolments include Operating Department Practitioners, Pharmacy, Science Manufacturing Technicians and Enhanced Clinical Practitioners. Demand remains high for Coaching Professional, Data Technician, Data Analyst, and Improvement Leader programmes. Work is ongoing to explore a Degree Apprenticeship in Design and Construction Management and progress Chartered Surveyor recruitment. The restructure has strengthened capacity to expand the apprenticeship pipeline and support internal career development pathways.

The NHS England Safe Learning Environment Charter will launch across the Bristol Group in April 2026. Strong engagement with the self-assessment process has highlighted excellent practice and provided a baseline for future improvement. A phased roll-out from April 2026 to May 2027 will support consistent, high-quality learning environments across professions and specialties.

Curriculum alignment continues as part of corporate services transformation work. Building on the blended clinical skills curriculum at North Bristol Trust, the Group now has a unified blended approach supporting consistent delivery and flexible access. The Trust also maintains a strong widening-participation programme with over 35 schools, colleges, and community partners, providing assemblies, careers events, work-experience placements, Project Search, Youth Guarantee schemes and taster opportunities.

In 2024/25, the Trust supported over 300 newly registered professionals across Nursing, Midwifery and AHPs. Profession-specific frameworks have been unified while retaining distinct requirements. Engagement has been strong across divisions, corporate services, and external partners. The Trust retains the Interim Nursing Gold Quality Mark and is working towards the Multidisciplinary National Quality Mark. The programme emphasises peer learning, reflective practice, wellbeing and psychological safety, supporting confidence and belonging. Over 400 staff have completed the programme. Placement capacity for UWE and University of Gloucestershire nursing programmes continues to expand with positive student feedback. The Trust also delivered an accelerated Registered Nursing Degree Apprenticeship cohort, with future cohorts due to qualify by October 2026.

Between January and December 2025, approximately 5,000 multi-professional placements were supported across the Group. Expanding placement capacity remains a key workforce enabler, with collaboration across health, care, and the VCSE sector. Since the Nurse Investment Pipeline launch, 189 nursing and nursing associate apprentices have been supported, with 105 currently active. Partnerships continue to grow with the Open University, BPP and the South West Institute of Technology.

Undergraduate medical education continues to expand across South Bristol and North Somerset Academies. Monitoring visits from the University of Bristol highlighted excellent administration, accommodation, teaching, and staff support. The Innovative Learning to Teach programme is now fully rolled out, with positive feedback. Preparations for the new Year 4 curriculum are underway. Additional innovations, such as wellbeing boxes and revitalised peer teaching, have further enhanced experience. Improvements at Weston General Hospital have led to removal from GMC enhanced monitoring. Resident doctors benefit from streamlined study-leave processes and a revised induction model enabling quicker transition to clinical duties.

The Library & Learning Hub continues to provide high-quality Library and Knowledge services and coordinated corporate training. Demand for evidence-based support remains strong. Key developments include the Knowvember campaign with NBT and progress toward an integrated Group library offer. The Learning Hub has strengthened eLearning and Kallidus systems, improved governance, and supported the rollout of a new corporate induction model. Mandatory training remains governed by MLOG to ensure alignment with organisational and national priorities including the NHS England Mandatory Learning Policy Framework.

The Simulation Champion Programme has expanded simulation-based learning capacity and developed a distributed leadership model across clinical services. Collaboration with the South West Simulation Network and ICS partners has supported regional education and improvement initiatives. Innovative technologies including immersive simulation and VR-supported learning have been introduced, enhancing capability and resilience across the organisation.

5.4.4 Diversity Equity and Inclusion

The Trust recognises its legal duties under the Human Rights Act 1998 and the Equality Act 2010 and is committed to undertaking action under the public sector equality duty as defined within the Act.

In summer 2024 UHBW launched its ‘Pro-equity’ trauma informed approach as a mission critical people project. Pro-Equity is inclusion in everything we do, even when people aren’t looking. It is embracing full hearted care by making UHBW a better place to work, building a place where everyone feels truly safe to be themselves. Where our differences are our strengths, and everyone feels like they belong here, because they do.

In 2024 we started this work from within, listening to our colleagues’ experiences, views and ideas about how we can make UHBW a fair, equitable place to work where everyone feels truly safe to be themselves. We undertook sexual-safety, anti-racism and anti-ableism listening workshops to understand the experiences and priorities of colleagues. This feedback resulted in over 1600 individual lines of feedback being thematically analysed, with key themes being used to create the Trust’s Pro-equity action plan which will be launched in April 2025. The Pro-equity assurance group reports into monthly SLT.

In October 2024 we published our anti-racism commitment. The words in this statement come directly from UHBW colleagues, setting out the changes we know we must make for our Black, Asian, Multiple Heritage, and other ethnically minoritised, global majority colleagues, patients and communities.

In April 2025 we launched the Trust’s pro-equity action plan to help us start tackling the systemic causes of discrimination in our organisation and to support our colleagues who experience any form of discriminatory behaviour whilst at work. It has been created from the experiences, ideas and feedback of colleagues across our organisation.

The pro-equity action plan consists of eleven priorities:

To achieve this, the Trust has established robust pro-equity governance and reporting pathways. The pro-equity assurance group is the Trust's key group delivering against the strategic objectives. The Associate Director OD and Wellbeing chairs the steering group and progress against the strategic objectives is monitored through the Trust's Senior Leadership Team (SLT) meetings as an important corporate project. Underneath the assurance group sit five subgroups, ensuring ownership across the Trust: trauma-informed culture and communication, inclusive recruitment, Learning and Development / Leadership and Management, HR workstream and inclusive and accessible estate. Divisional progress against the pro-equity plan is monitored quarterly at SLT evidenced and published in the OD Bi-annual Report.

High level outcomes from pro-equity for 2025/26

- Developed and launched Domestic Abuse and Sexual Violence policy.
- Launched comms plan focusing on Trauma informed and driving social movement for first two quarters of 2025/26.
- Each Division has recruited a Pro-Equity advocate lead, with over 135 advocates active across the trust.
- First UHBW Global Majority Hall of Fame launched and displayed online and across our sites.
- Created reporting systems for UHBW colleagues to encompass Pro-Equity, building on sexual safety work.
- Launched training and resources to support colleagues through the application and recruitment process
- Developed the inclusive approach of the recruitment team.

- Launched ‘Introduction to pro-equity’, ‘An introduction to trauma-informed practice’ and ‘racial literacy’ e-learning as part of the pro-equity framework.
- Neurodiversity e-learning launched.
- Datix to include screening questions to ensure that we are effectively capturing incidents that include Learners - this includes experiencing violence and aggression, including racism and ableism.
- Embed the Inclusive practice slides into the UHBW In-house Supporting Student Supervision and Assessment (SSSA) Practice assessor training to raise awareness of ethnicity awarding gaps, racism/discrimination in practice settings and the actions to take to support leaners.
- Creation of Inclusive Recruitment bite-size training materials have been made available on the Intranet for managers to use. These materials have also been shared across organisations in the BNSSG
- Applicant advice videos have been created to provide support in the application and interview sections of recruitment. These are available on our Careers website and links are sent to applicants through Trac.
- launched 'NHS Career Boost: Application and Interview Essentials' training sessions with bespoke training plans are now being offered to departments so staff can develop in this area.

The Group Chief People and Culture Officer is the nominated executive lead for People equality, diversity and inclusion on the Trust Board with delegated responsibility for the delivery of the programme of work sitting with the Associate Director OD and Wellbeing. The Group Chief Medical and Innovation Officer and Group Chief Nursing and Improvement Officer are the executive leads for Health inequalities, with the Health Equity & Inclusion Manager driving forward this agenda.

A range of equality, diversity and inclusion data is published by the Trust on its external website, including demographic information in relation to its workforce and patients and measures to improve equality, diversity and inclusion across all protected characteristics. The published information includes annual progress reports and action plans on Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES and Gender Pay Gap.

5.4.5 The Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is designed to ensure employees from Black, Asian, and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Through nine evidence-based measures, the WRES highlights any differences between the experience and treatment of white staff and Black, Asian and Minority Ethnic staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time. The WRES action plan is integrated into the Trust’s pro-equity action plan and progress against plan is reported bi-annually. This is the third year we have conducted a deep dive on both the WRES and WDES data, creating the Trust’s ‘DEI Data Report’ with year-to-year tracking and rating on performance. This has informed our Pro-equity Plan for 2026-27 and is being used at a division level to inform Culture and People plans for 2026-27.

As part of our Pro-equity mission critical project, we ran 14 anti-racism workshops from September to October 2024 to hear the experiences of our colleagues on what anti-racism means to them and what we need to do to tackle racism within the trust. The feedback from the workshops was used to create our anti-racism community commitment and, along with the sexual safety and anti-ableism feedback, was used to create our Pro-equity action plan.

This year has seen the seventh cohort of the Trust’s nationally recognised talent management programme ‘Bridges’ for Global Majority colleagues in Bands 1-5. Bridges is featured within the National EDI Repository as an example of best practice for High Impact Action 2: Overhaul recruitment processes and embed talent management processes.

5.4.6 The Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for disabled people working or seeking employment in the NHS. The WDES is a series of evidence-based metrics that provides NHS organisations with comparative data between disabled and non-disabled staff, giving a snapshot of the experiences of their disabled staff in key areas. This information is used to understand where key differences lie and provide the basis for the development of action plans, enabling organisations to track progress on a year-by-year basis. The WDES action plan is integrated into the Trust's pro-equity action plan and progress against plan is reported bi-annually. This is the third year we have conducted a deep dive on both the WRES and WDES data, creating the Trust's 'DEI Data Report' with year-to-year tracking and rating on performance. This has informed our Pro-equity Plan for 2026-27 and is being used at a division level to inform Culture and People plans for 2026-27.

As part of our Pro-equity mission critical project, we ran 12 anti-ableism workshops from October to November 2024 to hear the experiences of our colleagues on what anti-ableism means to them and what we need to do to tackle ableism within the trust. The feedback from the workshops, along with the sexual safety and anti-racism feedback, was used to create our Pro-equity action plan.

5.4.7 The NHS Equality Delivery System (EDS2022)

From 2026 UHBW will not be completing the NHS equality Delivery System report, as UHBW has existing and strong plans and frameworks which achieve the aims and outcomes as set out in the EDS 22 Domains. This was approved at People Oversight Group on 15th January.

There is no legal requirement to complete the EDS. However, all NHS provider organisations are expected to use the EDS to help improve their equality performance for patients, communities and staff, and to support compliance with the Public Sector Equality Duty (PSED) under the Equality Act 2010.

5.4.8 Gender Pay Gap Reporting

Public sector organisations are required to publish and report specific figures about their gender pay gap to show the pay gap between their male and female employees each year. The gender pay gap is a measure of the difference between the average earnings of men and women in an organisation, including the average difference in bonus payments. The Trust's yearly gender pay gap report is available as part of the annual DEI Data Report and has been reported on the Government's gender pay gap reporting portal as required. Comparison data can be found at: https://gender-pay-gap.service.gov.uk/ The gender pay gap report action plan is integrated into the Trust's pro-equity action plan with progress being reported on bi-annually.

5.4.9 Training and the Equality Act

The Trust's equality, diversity and human rights training has been developed in accordance with the UK Core Skill Framework. It is one of our essential training requirements undertaken as part of corporate induction and refreshed every three years for all staff at all levels. It is available online and face-to-face (on request). Compliance is monitored through monthly divisional performance reviews as part of the overall governance for essential training across the organisation. Trust- wide compliance with the training remains consistently good.

Over the last two years, the Trust has been a key stakeholder in the NHS England and UWE Bristol Inclusive Teaching Within Practice (ITP) Project. This year the Trust launched training resources from the project including Implicit Bias, Intercultural communication and racial literacy training modules. These are being embedded a spart of the Pro-equity Training Framework. The trust also engaged with the ITP Anti-racism train the trainer programme led by Dr Toyin Agbetu, with the Trusts' Diversity Equity and Inclusion manager and Practice Development Education Facilitator completing the training, upskilling them to lead the development of in-house anti-racism e-learning, co-creating with a lived experience group. This training aims to launch at the end of summer 2026.

In addition, we have recruited over 130 pro-equity advocates who are trained to provide Diversity Equity and Inclusion micro-teach sessions to their teams and to support active allyship. Each division has recruited a pro-equity advocate lead to connect teams to divisional leadership and local action.

5.4.10 Diversity and Inclusion in the Workplace

The Trust is committed to equality of opportunity for our staff across all protected groups through inclusive leadership and cultural transformation, positive action and practical support, accountability and assurance, monitoring progressive and benchmarking. Integral to this work are the four Trust staff networks:

- Able+ is the Trust's Staff Network for staff with both hidden and physical disabilities and health conditions.
- Race Equality and Inclusion network is open to all colleagues from Global Majority identities (Black, Asian, Multiple Heritage and other ethnically minoritised, global majority colleagues).
- LGBTQIA+ (Lesbian, Gay, Bi-sexual and Transgender) Staff Network is open to all LGBTQIA+ colleagues.
- Women's Network brings women together to create positive connections.

We also launched two new staff networks at the end of the 2025/26 financial year:

- Men's Network
- All Faiths and None.

Our staff networks give colleagues a space to come together to share their experiences, and to discuss their career and personal development. Staff networks are made up of colleagues coming together with a shared purpose to improve staff experience within their organisation and across the NHS. They share heritage, lived experience, and characteristics which are usually linked to the protected characteristics of the Equality Act 2010.Our networks rely on staff volunteers to run them and are supported by the Diversity, Equity and Inclusion (DEI) team. UHBW staff networks align with the NHS England Staff Network Toolkit and each network creates an annual development plan.

The Trust's HR Policies further underpin our commitment to equality, diversity and inclusion including:

- Equality, diversity and human rights: This sets out the Trust's commitments to equality, diversity, inclusion and human rights and its obligations under the Equality Act 2010 and the Human Rights Act 1998. It also describes the roles and responsibilities of individuals and groups in ensuring the Trust fulfils its commitments and obligations to develop and enhance a diverse and inclusive culture.
- Recruitment: This reflects the requirement to advance equality of opportunity and includes a commitment to interview all applicants with a disability who meet the minimum criteria for a job vacancy.
- Respecting Everyone: Respecting Everyone aims to resolve issues regarding bullying and harassment, grievances, conduct and capability, as quickly, and as fairly, as possible. Our 'Respecting Everyone' Framework is designed with this principle in mind and builds upon our organisational Values.
- Health and Wellness policy: This includes guidance on the Trust's duty to provide reasonable workplace adjustments to support the continuing employment of staff who have become disabled.

The Trust is also an accredited Disability Confident Employer and is a Mindful Employer signatory – an initiative which provides employers with access to information, support and training relating to staff mental health and wellbeing.

5.4.11 Analysis of staff diversity profile

The Trust's annual statutory monitoring of workforce and patient data reflects information as of 31 March 2026. Some of the key workforce data is given in the tables below. This data applies to staff with a permanent employment contract with the Trust.

Table 37: Staff with permanent contract

Sex – All staff with a substantive employment contract	Total	%
Female	10655	75.9%
Male	3374	24.1%
Grand Total	14029	

Table 38: Directors by Sex

Gender– Directors (Executive and non-Executive including CEO & Chair)	Total	%
Female	7	36.8%
Male	12	63.2%
Grand Total	19	

Table 39: Other Senior Managers by Sex

Gender – Other Senior Managers	Total	%
Female	44	69.8%
Male	19	30.2%
Grand Total	63	

Note - For the purposes of the staff section of the report, Senior Managers are defined as all staff at Band 8d & 9, Clinical Chairs of the Trust's Divisions.

Table 40: Ethnicity Grouping

Ethnicity Grouping	Total	%
Asian or Asian British (A)	2392	17.1%
Black or Black British (B)	1081	7.7%
Multiple Ethnicity/Dual Heritage (M)	334	2.4%
Other Ethnicity (O)	192	1.4%
White (W)	9376	66.8%
Unknown	654	4.7%
Grand Total	14029	

Note - These groupings are in line with Bristol's Race Equality H.R. Data Product.

Table 41: Ethnic Origin (ESR Categories)

Ethnic Origin	Total	%
Asian or Asian British - Indian	1600	11.40%
Asian or Asian British - Pakistani	128	0.91%
Asian or Asian British - Bangladeshi	52	0.37%
Asian or Asian British - Any other Asian background	325	2.32%
Asian Mixed	≤5	N/A
Asian Punjabi	≤5	N/A
Asian Kashmiri	≤5	N/A
Asian Sri Lankan	6	0.04%
Asian Tamil	≤5	N/A
Asian British	11	0.08%
Asian Unspecified	12	0.09%

Chinese	127	0.91%
Vietnamese	≤5	N/A
Japanese	≤5	N/A
Filipino	114	0.81%
Malaysian	≤5	N/A
Black or Black British - Caribbean	195	1.39%
Black or Black British - African	781	5.57%
Black or Black British - Any other Black background	46	0.33%
Black Somali	11	0.08%
Black Nigerian	38	0.27%
Black British	6	0.04%
Black Unspecified	≤5	N/A
Mixed - White & Black Caribbean	84	0.60%
Mixed - White & Black African	55	0.39%
Mixed - White & Asian	86	0.61%
Mixed - Any other mixed background	94	0.67%
Mixed - Black & Asian	≤5	N/A
Mixed - Chinese & White	≤5	N/A
Mixed - Asian & Chinese	≤5	N/A
Mixed - Other/Unspecified	8	0.06%
White - British	8218	58.58%
White - Irish	126	0.90%
White - Any other White background	897	6.39%
White Northern Irish	≤5	N/A
White English	19	0.14%
White Scottish	≤5	N/A
White Welsh	6	0.04%
White Cornish	≤5	N/A
White Greek	≤5	N/A
White Greek Cypriot	≤5	N/A
White Turkish	≤5	N/A
White Italian	6	0.04%
White Gypsy/Romany	≤5	N/A
White Polish	24	0.17%
White ex-USSR	≤5	N/A
White Mixed	9	0.06%
White Other European	51	0.36%
Any Other Ethnic Group	173	1.23%
Other Specified	19	0.14%
Not Stated	303	2.16%
Blank	351	2.50%
Grand Total	**14029**	100.00%

Table 42: Disability

Disability	Total	%
Yes	800	5.7%
No	12430	88.6%
Not declared, prefer not to answer or unknown	799	5.7%
Grand Total	14029	

Table 43: Age profile

Age profile	Total	%
<=20 Years	116	0.8%
21-25	979	7.0%
26-30	2012	14.3%
31-35	2283	16.3%
36-40	2180	15.5%
41-45	1652	11.8%
46-50	1422	10.1%
51-55	1289	9.2%
56-60	1079	7.7%
61-65	769	5.5%
66-70	190	1.4%
>=71 Years	58	0.4%
Grand Total	14029	

Table 44: Religious belief

	Total	%
Atheism	2998	21.4%
Buddhism	138	1.0%
Christianity	5598	39.9%
Hinduism	417	3.0%
Religious belief	578	4.1%
Judaism	13	0.1%
Sikhism	29	0.2%
Other	1028	7.3%
Not declared	3230	23.0%
Grand Total	14029	

Table 45: Sexual orientation

Sexual orientation	Total	%
Bisexual	375	2.7%
Gay or Lesbian	297	2.1%
Heterosexual or Straight	10946	78.0%
Other sexual orientation not listed	63	0.4%
Undecided	41	0.3%
Not declared	2307	16.4%
Grand Total	14029	

5.4.12 Occupational Health and Safety and Wellbeing

Wellbeing

We remain committed to fostering an environment that fully supports the physical, mental and emotional health and wellbeing of all our colleagues. This encompasses a comprehensive range of resources, services and interventions, progressively embracing a strategic approach to prevention through psychosocial risk identification and management. Our Workplace Wellbeing Strategic Action Plan 2025/2026 is rooted in data including NHS annual and quarterly staff surveys, which offer insights into colleague wellbeing at work, identifies high-level outcomes that are significant for our Trust and addresses gaps in this experience. These gaps, along with opportunities to align with local and national health and wellbeing strategy and research-informed best practice have been recognised as corporate objectives and actions, developed, lead and reviewed by subject matter experts from our internal Special Interest Group.

We are pleased to have received two major awards this year, which recognise our forward-thinking workplace wellbeing programme which is inclusive to all colleagues. In September, the Hospital Group obtained a workforce wellbeing transformation grant of £237,000 from NHS Charities Together to launch a Fatigue Risk Management pilot that adopts a 'Human Factors' approach across six hospital sites. This pilot aims to decrease any stigma around reporting and mitigating occupational fatigue to change culture at a systemic level. Funding provides a unique opportunity to pilot a six-part programme designed to proactively understand and influence organisational policies, shift design, break culture and other interventions to promote colleague wellbeing and subsequently patient safety. This initiative is unprecedented within health and care, with the goal of establishing a nationally recognised model for fatigue risk management in 2027 that can be implemented in other NHS Trusts in the future.

In November, we received the North Somerset Healthy Workplaces 'Gold' Award, which highlights the remarkable efforts of our teams in fostering an environment where individuals feel supported, valued, and empowered to succeed. The North Somerset Healthy Workplaces Gold Award is managed by the Public Health team to recognise organisations that excel in advancing workforce health and wellbeing. Earning this award signifies the pinnacle of achievement, with the Trust distinguished as one of only two member organisations to attain gold status for its wellbeing programme.

As we progress as a Hospital Group, our focus remains centred on creating a workplace where wellbeing is not just a priority, but a culture ingrained in every aspect of our evolving organisation. We acknowledge that wellbeing is dynamic, and our strategic approach will need to evolve to meet the changing needs of our people and ecosystem.

By embracing innovation, actively listening and responding to our people and fostering a compassionate workplace culture, we aim to cultivate organisational resilience and individual wellbeing that sustains us through the challenges and opportunities ahead and in full alignment to the NHS 10 Year Plan.

Occupational Health

The partnership between UHBW, NBT and Sirona continues to deliver an integrated occupational health service to all partners. In addition to meeting the needs of NHS organisations, the service generates income through external contracts, reducing the financial contribution required from NHS partners.

Over the past year, the service has worked closely with partners to deliver strategic improvements that support staff health and wellbeing. A significant focus has been placed on improving the completeness of staff immunity for key occupational communicable diseases and increasing uptake of occupational vaccinations for staff working in high-risk areas. Managers now receive immunity status reports for all new starters in patient facing roles, enabling meaningful conversations about the importance of vaccination in healthcare settings. This work will ultimately improve our capability to track and target staff during outbreaks of infectious disease, and to reduce the number of staff exclusions.

Visibility of the service has improved through enhanced engagement with staff and managers. This has included educational sessions for managers on occupational health topics, outreach activities, guidance documents and the development of a new website that will soon provide accessible advice and guidance for both staff and managers. Work has also progressed to take a more proactive approach to staff health, including targeted educational support for staff groups with high levels of musculoskeletal issues and exploration of a digital platform to support early intervention. The counselling team has piloted a suitability assessment for colleagues requesting counselling, demonstrating benefits in ensuring individuals are directed promptly to the most appropriate sources of support.

The service continues to deliver high-quality, evidence-based occupational health provision, as confirmed by the annual renewal of SEQOHS (Safe Effective Quality Occupational Health Service) accreditation. In addition, a reconfiguration of the data system is improving data quality and enabling better optimisation of service delivery, while providing robust business intelligence to support performance management, business planning and service improvement.

The work completed this year to improve service quality, visibility and proactive health, puts the service in a strong position to deliver efficient and high value occupational health moving into the future.

5.4.13 A Safe and Healthy Working Environment

The Trust's approach to maintaining a safe and healthy working environment continued to be underpinned by the Health and Safety Executive's *HSG65: Managing for Health and Safety* framework and the NHS Staff Council's *Workplace Health and Safety Standards*. These models provide an established basis for the systematic management of health, safety, welfare and wellbeing, and remained embedded across the organisation. The Trust recognises its legal duties under health and safety legislation and maintained clear governance arrangements to ensure that responsibilities were discharged effectively, risks were managed proactively, and performance was monitored and reviewed through appropriate reporting mechanisms.

During the reporting year, the Health and Safety service continued to provide specialist advice and technical support to staff and managers across all divisions. The service supported the effective identification and management of workplace risks, contributed to incident reviews, and offered responsive input into clinical and non-clinical concerns requiring health and safety expertise. Regular reporting into the Trust Health and Safety Committee ensured visibility of emerging trends, compliance performance and key operational issues, with escalations made to the to the Board where

appropriate. Health and safety risks continued to be incorporated within divisional risk registers ensuring alignment with the Trust's wider governance approach.

Internal departmental health and safety audits were undertaken during the year, and action plans are being developed by managers to address findings. Progress continues to be monitored through the Health and Safety Committee, enabling a consistent oversight structure across divisions. Key themes from the audits were shared across divisions to support learning and ongoing improvement.

Total Health and Safety incidents for the period were 4,049, an increase of 13.6% from 2024/25. Violence and aggression and clinical sharps injuries remained the highest-volume categories for staff harm. Violence and aggression incidents rose to 1,977 from 1,441 in 2024/25, a 37.2% increase year-on-year. Clinical sharps injuries fell to 282 from 318, a reduction of 11.3%. RIDDOR-reportable incidents totalled 74, compared with 64 in the previous year. The Trust maintained targeted risk-reduction activity across both areas throughout the year, including enhanced local controls, violence reduction officers, strengthened staff training, and collaborative divisional interventions informed by ongoing incident trend analysis.

Risk assessments and safe systems of work remained a cornerstone of local risk management, with all departments responsible for maintaining up-to-date and suitable documentation. The coverage of trained risk assessors across divisions continued to support the identification and management of local risks. The Health and Safety service continued to support managers in reviewing assessments, providing specialist input for complex risks, and assuring that actions were implemented.

The annual Training Delivery Plan continued to guide the Trust's health and safety-related training activity. Alongside core mandatory training, programmes included Managers training sessions and training for departmental risk assessors. Manual Handling Link Practitioner programmes were delivered across services, and advisory support for complex patient handling, workplace visits and health-promotion initiatives continued to be provided. Following the transition of statutory moving and handling training to the Education Department in 2025, governance oversight remained within the Health and Safety structure to ensure consistency and quality of provision.

The Trust-wide Respirator Fit Test service maintained a strong focus on high-risk clinical areas and continued to provide both routine and urgent support for departments. Monthly compliance reporting to the Operational Infection Control Group supported oversight and informed targeted interventions where uptake remained low. The service lead retained British Safety Industry Federation (BSIF) Fit2Fit accreditation for both qualitative and quantitative testing, enabling accredited in-house training for fit testers and reducing reliance on external providers.

Overall, the Trust continued to strengthen its arrangements for maintaining a safe and healthy working environment through robust governance, assurance processes, specialist advisory support and targeted improvement activity. The Trust remains committed to embedding strong safety culture, proactive risk management and continuous improvement across all services to support the safety of staff, patients and visitors.

5.4.14 Sickness Absence

The Trust's rolling 12-month cumulative sickness position for 2025/26 was 4.7%.

5.4.15 Staff Turnover

Turnover for all staff groups was 10.3% in April 2025 and reduced to 9.3 % March 2026. This was against a turnover target of less than 11.1%. The turnover metric at UHBW is based on permanent leavers only. Turnover reduced consistently all year, although in August 2025 it increased slightly to 9.7% before reducing for the remainder of the financial year. Turnover is monitored through the Trust Integrated Quality and Performance Report that is shared with Trust Board and People Committee.

5.4.16 Expenditure on consultancy

Consultancy is defined as the provision to management, of objective advice and assistance relating to strategy, structure, management, or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the business-as-usual environment. For 2025/26 the Trust's expenditure on consultancy was £1.776m (2024/25: £0.560m).

5.4.17 Off-payroll engagements

Individuals can only be paid via invoice provided the Trust's 'engaging workers off payroll' procedure has been followed. All engagements falling within the scope of IR35 require invoices to be paid via the payroll system and are therefore subject to PAYE. The procedure ensures that the appropriate employment checks have been made, an agreement detailing the terms of engagement has been issued and all HMRC and other statutory regulations have been met.

The Trust makes use of highly paid 'off payroll' arrangements only in exceptional circumstances. For instance, where there is a requirement for short term specialist project management experience which cannot be filled within the existing workforce because of capacity or in-house knowledge and experience. Where an executive director post becomes vacant, the Trust Board looks to put in place an "acting up" arrangement but may select an interim manager to provide cover pending recruitment.

The following tables provide information regarding off-payroll engagements entered into at a cost of more than £245 per day, and any off-payroll engagements of board members and/or senior officers with significant financial responsibility. The Trust defines officers with significant financial responsibility as executive directors, divisional directors and clinical chairs.

Table 46: Highly paid off-payroll worker engagements as at 31 March 2026, earning £245 per day or greater (Audited)

No. of existing engagements as of 31 March 2026	4
Of which…	
No. that have existed for less than one year at time of reporting	3
No. that have existed for between one and two years at time of reporting	
No. that have existed for between two and three years at time of reporting	-
No. that have existed for between three and four years at time of reporting	-
No. that have existed for four or more years at time of reporting.	1

Table 47: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater (Audited)

Number of off-payroll workers engaged during the year ended 31 March 2026	7
Of which:	
Not subject to off-payroll legislation	7
Subject to off-payroll legislation and determined as in-scope of IR35	-
Subject to off-payroll legislation and determined as out-of-scope of IR35	
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: number of engagements that saw a change to IR35 status following review	-

Table 48: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1st April 2025 and 31 March 2026 (Audited)

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility" during the financial year. The figure includes both off-payroll and on-payroll engagements.	41

5.4.18 Exit packages

The table below shows the number and cost of staff exit packages in 2025/26 with 2024/25 provided for comparison. Termination benefits are payable to an employee when the Trust terminates their employment before their normal retirement date, or when an employee accepts voluntary redundancy in exchange for these benefits. This information has been subject to audit.

Table 49: Exit packages (Audited)

	2025/26			2024/25		
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	5	41	46	-	10	10
£10,000 - £25,000	1	18	19	1	2	3
£25,001 - £50,000	5	4	9	2	2	4
£50,001 - £100,000	5	-	5	3	-	3
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	2	-	2	-	-	-
>£200,000	-	-	-	1	-	1
Total number of exit packages by type	**18**	**63**	**81**	**7**	**14**	**21**
Total cost (£'000)	**935**	**607**	**1,542**	**586**	**140**	**726**

An analysis of the non-compulsory departures agreed, which has been subject to audit, is as follows:

Table 50: Analysis of non-compulsory departures (Audited)

	2025/26		2024/25	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignation contractual costs (MARS)	43	515	-	-
Contractual payments in lieu of notice	20	92	13	124
Non-contractual payments requiring HMT approval	-	-	1	16
Total	**63**	**607**	**14**	**140**
Of which: Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

5.4.19 Engaging with staff.

The Trust Values provide the foundation for how we are expected to behave towards patients, relatives, carers, visitors and each other. The Trust values and leadership behaviours are integral to the culture of the organisation and set the expectation and accountability across the hospital community.

Our Trust values remain as:

Staff Values and leadership behaviours reflect the team here at University Hospital Bristol and Weston they were developed with our people, by our people in November 2021. The Trust values the role and contribution both Trade Unions and Professional Associations make in supporting and representing the Trust's workforce; and their active participation in partnership working across the Trust. Regular consultation with staff takes place through both informal and formal groups, including the Staff Partnership Forum, and the Local Negotiating Committee (for Medical and Dental staff). Staff and management representatives consult on change programmes, terms and conditions of employment, policy development, pay assurance and strategic issues, thereby ensuring that workforce issues are proactively addressed.

The Trust also has a cohort of staff governors who work closely with the Board of Directors on behalf of their staff constituents to ensure that the Board remains focused on staff issues on the frontline.

5.4.20 NHS staff survey

The Trust continues to be committed to the annual National Staff Survey for all colleagues, the results are utilised in developing organisational and local action plans to improve staff experience at work.

The 2025 National Staff Survey response rate was 61% with over 8300 colleagues taking time to provide feedback on their experience at work. This was significant 7% increase on previous year and above the national acute average.

Staff engagement is a key measure of how colleagues experience at work in the organisation, which is determined through nine questions in the national staff survey which measure three engagement themes: Motivation, Involvement, and Advocacy. The Trust engagement remained in a stable position score at 7.1 out of 10, which is above the benchmark group the national acute average.

Colleague feedback in the 2025 staff survey demonstrates that there is a pride in working at the Trust and the care they provide for patients knowing that patients are a top priority for the organisation.

This is further supported and demonstrated by positive improvements in the following questions:

- Colleagues not experiencing discrimination on basis of sex

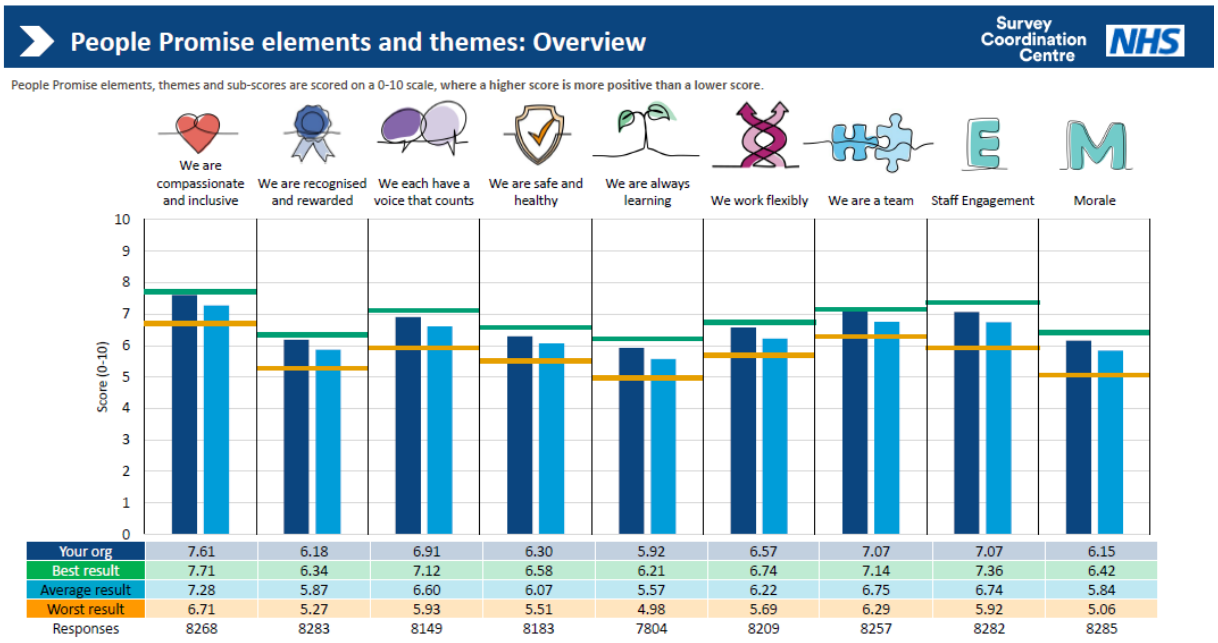
- In the last twelve months colleagues feel they have received an appraisal conversation.
- Teams in the organisation feel they work well together to achieve their objectives
- Colleagues fee they do not work any additional unpaid hours.

5.4.21 Staff Survey Reporting

The National Staff Survey results are aligned to the NHS People Promise and are benchmarked against NHS Acute and Acute Community Trust. The reporting themes are a combination of the seven elements of the people promise with the addition of Staff Engagement and Morale, making nine themes altogether.

The following table demonstrates the Trust's performance in the line with the benchmarking group and in line with the nine themes. In 2025, the Trust performed above the national average in all the of the nine NHS People Promise Themes.

Table 51: NHS Staff survey Results 2025



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.61	6.18	6.91	6.30	5.92	6.57	7.07	7.07	6.15
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	8268	8283	8149	8183	7804	8209	8257	8282	8285

5.4.22 Key areas for improvement

The Staff Survey data provides the largest feedback from UHBW colleagues on their experience at work, utilising this data to develop local and organisational plans and priorities is the key to engaging, motivating and delivering a workplace where colleagues are proud to work and recommend.

The response to the feedback is shared across the organisation as part of the cascade of the results, as well as in the development of organisational and local Divisional culture and people plans. The priorities are aligned to the People priorities, the Croup Clinical Strategy and People Patient First measures and intentions.

The Trust recognises that it needs to continuously engage and listen to its workforce and seeks to respond to all suggested areas for improvement. Working in partnership with the business to develop robust plans and priorities in response to the staff survey feedback, in line with the People Strategy miles stones and the Divisional culture and people plans will shape improved staff experience and create a workplace where colleagues continue to take pride, feel valued and recommend to others to work and have treatment.

5.4.23 Staff consultations

The Trust is committed to innovation and continuous improvement in order to deliver responsive and accessible services which deliver excellent patient care. Following the launch of our Joint Clinical

Strategy, we have continued to undertake change projects to ensure our teams are aligned across the hospital group enabling effective and efficient care for all. Some of the bigger examples of change management consultations are as follows:

- Commencement of the Corporate Services Transformation Program, enabling our Corporate Services to align and work more efficiently across the group.
- TUPE of Clinical Genetics Service to Royal Devon NHS.
- Completed consultations for Group Single Managed Services in several areas and commenced consultations in other areas in support of the delivery of the Joint Clinical Strategy.

5.4.24 Staff policies and actions applied during the financial year.

The alignment HR policies across the group alongside routine policy reviews and Employment Law changes has meant that significant work has taken place in this area, examples of this are as follows:

- Newly aligned Group policies were developed and launched for Incorrect Payments of Salary Policy, Transition to Alternative Roles (Redeployment) Policy and Local Counter fraud Policy.
- A full review of the Respecting Everyone and Health & Wellness at Work Policies has commenced to ensure alignment across the group.
- New policies were negotiated and implemented including Job Planning Policy for Consultants & SAS Doctors and the Rostering Policy.
- Work has commenced to review HR policies ahead of the upcoming Employment Rights Act changes.

5.4.25 Tackling Harassment and Bullying

Building on the launch of our Respecting Everyone early resolution policy; this year we realised a reduction in formal cases with some 25% more cases being resolved informally.

To continue to support the increase of informal and early resolution opportunities, Bitesize videos highlighting the benefits of early and informal resolution and key resources such as posters, advice clinics and drop-in sessions to learn how to resolve concerns have been developed.

As alignment of policies continues, the focus on early resolution approach, consistently across the group remains a key priority and focus for alignment work.

Last year's report highlighted our launch of Sexual Safety in the workplace guidance. Building on this launch, we have trained HR professionals to offer specialist advice, guidance and disclosure opportunities to staff, this has enabled increased reporting of sexual harassment cases meaning that as an organisation we are able to deal with situations more effectively. Alongside this new, enhanced support offer, a prevention campaign has been launched which includes posters for staff areas linking to an online reporting tool and posters for patient areas setting out expectations for behaviours, when and how to seek help and raising awareness of our approach to sexual safety in the workplace.

Finally, work throughout 2025/2026 to ensure that a trauma informed approach for all those involved in cases of bullying and harassment and sexual harassment in the workplace continues into 2025/2026 in the form of the Pro Equity Action Plan, HR policy alignment and through our People Services Team.

5.4.26 Freedom to Speak Up (FTSU)

At UHBW we are committed to an open and honest culture in which everyone who works in the organisation feels safe and empowered to speak up, and confident that their concerns will be heard and addressed. Supporting staff to raise concerns is essential to learning, improving, and ultimately enhancing the care we provide to our patients.

The Freedom to Speak Up (FTSU) Guardian works with a network of approximately 90 volunteer FTSU champions from a wide range of roles and locations across the organisation. FTSU champions play a vital role in raising awareness by being visible and accessible, role-modelling positive

speaking-up behaviours, and signposting and supporting individuals who raise concerns. In 2025-26, the quarterly FTSU champion network meetings were held jointly with North Bristol NHS Trust.

The National Guardian's Office / Health Education England 'Speak Up' core training is mandatory for all UHBW staff, with current compliance at 92.7% (March 2026). The accompanying 'Listen Up' module is also accessible to all staff.

The current FTSU strategy (approved in January 2025) focuses on three key priorities: raising awareness of FTSU, inspiring confidence to speak up, and removing barriers. It also includes a clear commitment from the Board to demonstrate leadership, accountability, and learning from concerns that are raised.

FTSU is one of several mechanisms available to staff for raising concerns at UHBW. During 2025/26, the FTSU Guardian recorded 100 concerns, compared with 110 in the previous financial year. The most frequently reported themes related to worker safety and wellbeing, followed by concerns about inappropriate attitudes and behaviours. A total of four concerns were raised anonymously, and two cases of detriment arising from speaking up were reported.

More details about the FTSU programme can be found in the FTSU annual report, which is available on the UHBW website.

Table 52: Number and themes of concerns raised via the FTSU Guardian in 2025/26 as reported to the National Guardian's Office

	Q1	Q2	Q3	Q4	Total
Number of cases raised with the FTSU Guardian	**26**	**22**	**33**	**19**	**100**
Cases relating to quality/patient safety	1	0	3	0	
Cases relating to bullying or harassment	6	2	1	0	
Cases relating to worker safety or wellbeing	9	6	13	9	
Cases relating to inappropriate attitudes or behaviours	3	6	4	8	

5.5 Code of governance for NHS provider trusts

University Hospitals Bristol and Weston NHS Foundation Trust has applied the principles of the NHS Code of governance for NHS provider trusts, which was issued on 1 April 2023, on a comply or explain basis. The Board considers that it was fully compliant with the provisions of the Code in 2025/26. Compliance with the Mandatory Disclosures is available from the Director of Corporate Governance.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this Code through the arrangements that it puts in place for our governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust.
- Standing orders.
- Standing financial instructions.
- Schemes of delegation and decisions reserved to the Board.
- Terms of reference for the board of directors, the Council of Governors and their committees.
- Role descriptions.
- Codes of conduct for staff, directors and governors.
- Annual declarations of interest.
- Annual Governance Statement.

All of the Non-executive Directors are considered to be independent in character and in judgement. The Executive Directors undertake an annual appraisal process to ensure that the board remains focused on the patient and delivering safe, high quality, patient centred care. Additional assurance of independence and commitment for those Non-executive Directors serving longer than six years is achieved via a rigorous annual appraisal and review process in line with the recommendations outlined in the Code. A report of the Governors' Nomination and Appointments Committee is detailed further in this report. The composition of the Board over the year is set out in Table 18 above.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long-term vision, mission and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's annual plan, deliver safe, high-quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation. The Board delegates some of its powers to a committee of Directors or to an Executive Director and these matters are set out in the Trust's scheme of delegation. Decision making for the operational running of the Trust is delegated to the executive management team.

There are specific responsibilities reserved by the entire Board, which includes approval of the Trust's long term objectives and financial strategy; annual operating and capital budgets; changes to the Trust's senior management structure; the Board's overall 'risk appetite'; the Trust's financial results and any significant changes to accounting practices or policies; changes to the Trust's capital and estate structure; and conducting an annual review of the effectiveness of internal control arrangements.

5.5.1 Board Performance

Boards of NHS Foundation Trusts have faced significant challenges, financial and operational, in 2025/26. Good governance is essential if we are to continue providing safe, sustainable and high-quality care for patients.

The Board monitors performance of the organisation against Leadership Priorities set as part of the annual Operating Plan via the Integrated Quality and Performance Report, which is presented to the Board each month, to ensure that these priorities are being delivered. This assessment is considered alongside the strategic and operational risks to the Trust, to ensure a comprehensive overview is considered by the Board, in addition the Board considers performance against the NHS England Single Oversight Framework with the focus on four key areas of performance: A&E four hours, 62-day GP cancer, Referral to Treatment times and six-week diagnostic waits. The Board does this, plus

review of quality and workforce information, via review of the Integrated Quality and Performance Report.

The Trust has a policy for Fit and Proper Persons and as part of this policy, checks have been completed for all Directors. Appropriate checks are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. It can be confirmed that as at the date of this report, none of the above-mentioned Directors appeared on the Disqualified Directors' Register.

During the year, the Board has undertaken a range of development activities. This has been supported by a Board Development Partner and with individuals with specific expertise to assist the Board in changing how it operates and to help shape the strategy and culture of the Trust.

5.5.2 Performance of the Board and Board Committees

The Board of Directors undertakes regular assessments of its performance to establish whether it has adequately and effectively discharged its role, functions and duties during the preceding period.

Throughout the year, the Board adhered to a comprehensive cycle of reporting, to ensure that it focused on the key strategic issues and to ensure that it met good practice principles. In addition, the Board met outside of the formal meetings in seminar format to undertake development activities including helping to shape decisions prior to formal decision making, understanding changes in local, regional and national context and to undertake joint learning around new or complex topics.

The findings of Internal Audit combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement support the Board's conclusions as to the efficacy of their performance.

In addition, the Board expects each of its committees to undertake a review of their performance and report this to the Board alongside any proposed changes to the Terms of Reference.

5.5.3 Qualification, Appointment and Removal of Non-executive Directors

Non-executive Directors and the Chair of the Trust are appointed by the Governors at a general meeting of the Council of Governors. The recruitment, selection and interviewing of candidates is overseen by the Governors' Nominations and Appointments Committee which also makes recommendation to the Council of Governors for the appointment of successful candidates. The Foundation Trust Constitution requires that Non-executive Directors are members of the public constituency. Removal of the Chair or any other Non-executive Director is subject to the approval of three-quarters of the members of the Council of Governors.

5.5.4 Committees of the Board of Directors

The Board has established the two statutory committees required by the NHS Act 2006 and the Foundation Trust Constitution. The Directors Remuneration, Nominations and Appointments Committee and the Audit Committee each discharge the duties set out in the Foundation Trust Constitution and their Terms of Reference as set out below.

The Board has chosen to constitute five additional designated committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and outcomes, financial management, people, digital services and the prospective merger with NBT. These are the Quality and Outcomes Committee, the Finance and Estates Committee, the People Committee, the Digital Committee and the Merger Committee. The role, functions and summary activities of the Board's committees are described below.

The Board of Directors discharged its duties during 2025/26 in nine private and seven public meetings, all but one of which were held in common with the NBT Board. The table below shows the membership and attendance of Directors at meetings of the Board of Directors and Board committees.

Table 53: Board and Sub-Committee Attendance 2025/26

	Board of Directors	Remuneration & Nomination & Appointments Cttee	Audit Cttee	Quality & Outcomes Cttee	People Cttee	Finance & Estates Cttee	Digital Cttee	Merger Cttee
No. of meetings	16	6	5	10	5	9	6	2
Group Chair								
Ingrid Barker	16	6(C)	0	2	1	0	0	0
Group Chief Executive								
Maria Kane	16	4	0	1	0	0	0	0
Non-executive Directors								
Arabel Bailey ‡	7	2*	0	0	1*	2	1*	0
Sue Balcombe	15	5*	3*	10*	0	0	3*	2(C)
Rosie Benneyworth ‡	7	2*	0	4*	0	0	0	0
Richard Gaunt †	15	6*	3(C)	0	0	1	4*	0
Marc Griffiths	13	2*	0	9*	5*	0	0	0
Susan Hamilton ‡	4	2*	0	3*	0	0	0	0
Linda Kennedy	13	4*	5*	0	5(C)	0	0	0
Sarah Purdy †	15	5*	0	5(C)	0	6	0	0
Poku Osei †	4	1*	0	0	0*	0	0	0
Martin Sykes	16	4*	5*	0	1*	9(C)	0	2*
Roy Shubhabrata	14	2*	0	0	1*	8	6(C)	0
Anne Tutt ‡	1	2*	3*	1	0	2	0	0
Executive Directors								
Paula Clarke	14	0	0	2	3*	1	2*	2
Neil Darvill	16	0	0	0	4*	3	5*	0
Jane Farrell ‡	4	0	0	1*	0	0	0	0
Deirdre Fowler ‡	2	0	0	1*	0	0	0	0
Steve Hams †	15	0	0	8*	4*	0	0	0
Neil Kemsley	16	0	5	0	0	9	5*	0
Jenny Lewis †	7	2	0	0	3*	0	0	0
Rebecca Maxwell ‡	4	0	0	5*	1*	0	0	0
Stuart Walker	14	1	5	6*	2	7	0	2*
Tim Whittlestone †	15	0	0	7*	2*	1	3*	0
Emma Wood ‡	4	0	0	0	0*	0	0	0

Key:
(C) Current Chair of Committee
* Member of Committee
† Joined the Board during 2025/26 - see table 18 for further details
‡ Left the Board during 2025/26 - see table 18 for further details

5.5.5 Remuneration and Nomination and Appointments Committees

The purpose of the Directors' Remuneration, Nominations and Appointments Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-executive Directors subject to approval by the Council of Governors). The Committee also gives consideration to succession planning for Executive Directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise that will be needed on the Board of Directors in the future.

The Committee is chaired by the Trust Chair and is attended by all Non-executive Directors. The Committee is attended by the Chief Executive and Group Chief People and Culture Officer in an advisory capacity when appropriate and is supported by the Group Director of Corporate Governance to ensure it undertakes its duties in accordance with applicable regulation, policy and guidance.

During 2025/26 the committee met six times, all of which were held in common with the equivalent NBT committee.

Further details of the activities of the Committee are included in the Remuneration Report.

5.5.6 Audit Committee Chair's Opinion and Report

In support of the Chief Executive's responsibilities as Accountable Officer, the Audit Committee is responsible for evaluating the Trust's systems of Governance, Assurance and Risk Management, especially with respect to the adequacy and effectiveness of our Financial Control mechanisms, independent Internal and External Audit programme, Strategic and Operational Risk Identification and Mitigation and activities to counter Fraud.

The Committee has met on a regular basis throughout the year, and from July 2025 met in common with NBT's Audit Committee. Both the Internal Audit Team and External Auditors have unrestricted access to the Chair of the Audit Committee and have met on a regular basis or as necessary.

The Audit Committee regularly undertakes an evaluation of the Trust's Board Assurance Framework, paying particular attention to the stated objectives detailed in our Strategic and Operational Plans. In addition, as part of our standing Agenda, the Committee reviews the results of Internal and External Audit findings and Counter Fraud activity. The committee also reviewed the Head of Internal Audit's Opinion and the External Auditor's year-end report for 2025/26.

From the information supplied, the Committee has formed the opinion that there is a mature and robust framework of control in place to provide effective assurance of The Trust's Systems of Governance and of the management of risk.

During the course of this year the Committee has sought to further improve its effectiveness and so the assurance it can offer to the Trust Board by:

- Reviewing the Trust's Information Governance arrangements, including the Data Security and Protection Toolkit.
- Reviewing the Board Assurance Framework and risk management arrangements on a regular basis.
- Rigorously following up outstanding recommendations arising from internal audit reports and holding detailed discussions on internal audit reports which had a limited assurance rating.

In summary, the Audit Committee has encouraged the Trust to further develop its approach to Governance, Assurance and Improvement, from what is already a mature and largely effective position. The Committee is likewise committed to seeking further opportunities to increase the Committee's effectiveness and value to the Trust and especially to its Accountable Officer.

5.5.7 Audit Committee

The primary purpose of the Audit Committee is to provide oversight and scrutiny of the Trust's governance, risk management, internal financial control and all other control processes, including those related to quality and performance. These controls underpin the Trust's Assurance Framework so as to ensure its overall adequacy, robustness and effectiveness. This addresses risks and controls that affect all aspects of the Trust's Day to day activity and reporting.

Additional oversight and scrutiny, in particular relating to quality and patient care performance is provided through the Quality and Outcomes Committee, Finance and Estates Committee, People Committee and Digital Committee, and information is triangulated from all four forums to ensure appropriate oversight and assurance can be provided to the Board in line with the Committee's delegated authority. The day-to-day performance management of the Trust's activity, risks and controls is however the responsibility of the Trust's Executive.

The Audit Committee is comprised of not less than three Non-executive Directors and includes in its membership a Non-executive Director who is considered to have recent and relevant financial experience. The committee met on five occasions during the year with the Chief Executive, Chief Finance and Estates Officer, other Trust Officers and the Internal Auditors in attendance. The External Auditors attended two of the five meetings during the year. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

The Committee is responsible for providing the Board with assurance on the adequacy of the Trust's Audit plans and performance against these, and the committee's review of accounting policies and the annual accounts.

During 2025/26, the Audit Committee reviewed the Annual Report and Accounts for the previous year, including the Annual Governance Statement together with the Head of Internal Audit statement and External Audit opinion.

The Trust's External Auditors are KPMG LLP (KPMG). In order to ensure that the independence and objectivity of the External Auditor is not compromised, the Trust has in place a policy that requires the Committee to approve the arrangements for all proposals to engage the External Auditors on non-audit work. The External Auditors did not undertake any non-audit work during the period. KPMG has also provided a statement of the perceived threats to independence and a description of the safeguards in place.

Both at the date of presenting the audit plan and at the conclusion of their audit, KPMG confirmed that in its professional judgement, they are independent accountants with respect to the Trust; within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team is not impaired. Together with the safeguards provided by KPMG, the Audit Committee accepts these as reasonable assurances of continued independence and objectivity in the audit services provided by KPMG within the meaning of the UK regulatory and professional requirements.

The Trust's Internal Audit and Counter Fraud function is provided by ASW Assurance through a consortia arrangement. The Audit Committee agreed the Strategic Audit Plan, including the Annual Audit Plan, and received regular reports throughout the year to assist in evaluating and continually improving the effectiveness of risk management and internal control processes in the Trust.

The committee sought reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. Notably, the committee received assurance with regard to risk management, counter fraud arrangements, information governance arrangements and the management of procedural documents within the Trust.

5.5.8 Quality and Outcomes Committee

The Quality and Outcomes Committee was established by the Board of Directors to support the Board in discharging its responsibilities for monitoring the quality and performance of the Trust's clinical services and patient experience. This includes the fundamental standards of care (as determined by Care Quality Commission), national targets and indicators and patient reported experience and serious incidents.

The Committee's membership includes four Non-executive Directors (one of whom is the Chair), the Hospital Managing Director (UHBW), the Hospital Managing Director (NBT), the Group Chief Medical and Innovation Officer and the Group Chief Nurse and Improvement Officer. The Committee is also supported by the Director of Corporate Governance or Head of Corporate Governance in an advisory role.

The Committee reviews the outcomes associated with clinical services and patient experience and the suitability and implementation of performance improvement and risk mitigation plans with particular regard to their potential impact on patient outcomes. The Committee is also required, as directed by the Board from time to time, to consider issues relating to performance where the Board requires this additional level of scrutiny.

During the course of the year, the Committee met on 10 occasions, and from September 2025 the committee met in common with the NBT Audit Committee as part of the Bristol NHS Group arrangements. The Committee considered a set of standard reports as follows:

- The integrated quality and performance report.
- The strategic and corporate risk registers.
- The clinical quality group meeting report (including clinical audit).
- Complaints and patient experience reports.
- Maternity update reports, including the Maternity Perinatal Quality Surveillance Matrix.
- Serious Incident Reports and Never Events.

Ad hoc reports and deep dives were also requested and received on particular areas of concern to the Committee.

5.5.9 Finance & Estates Committee

The Finance & Estates Committee has delegated authority from the Board of Directors, subject to any limitations imposed by the Schedule of Matters Reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- Control and management of the finances of the Trust.
- Target level of cash releasing efficiency savings and actions to ensure these are achieved.
- Budget setting principles.
- Year-end forecasting.
- Commissioning.
- Capital planning.
- Oversight and delivery of the Trust's Estates Strategy.

From July 2025 the committee met in common with the NBT Finance & Estates Committee as part of the Bristol NHS Group arrangements.

The Committee's membership includes four Non-executive Directors, and the Chief Finance and Estates Officer, the Hospital Manging Directors and the Group Chief people and Culture Officer. The Committee is also supported by the Group Director of Corporate Governance or Head of Corporate Governance in an advisory role.

The Finance and Estates Committee met on nine occasions during this reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

5.5.10 People Committee

The People Committee was established by the Board of Directors to support the Board in discharging its responsibilities in respect of people and workforce issues affecting the organisation. From July 2025 the committee met in common with the NBT People Committee as part of the Bristol NHS Group arrangements.

The key responsibilities of the Committee include:

- Ensuring that the strategic workforce needs of the Trust are understood, and plans are in place to deliver these.

- Provide oversight of workforce performance
- Understand the risks to the workforce and seek assurance that mitigating actions are in place.
- Support the development of enabling strategies including the Education Strategy.

The Committee's membership includes five Non-executive Directors, and the Group Chief People and Culture Officer, Group Chief Medical and Innovation Officer, Group Chef Nurse and Improvement Officer, Group Formation Officer and Group Chief Digital Information Officer.

The People Committee met on five occasions during the reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

5.5.11 Digital Committee

The Digital Committee was established by the Board of Directors in July 2025 to provide assurance to the Board on matters concerning digital strategy, the operational delivery of digital services and delivery of the digital transformation programmes across both Trusts. The scope of the Committee covers Digital strategy and transformation, digital systems, policy and operational performance, cyber security, and digital risks.

Since its inception the committee has met in common with the NBT Digital Committee as part of the Bristol NHS Group arrangements.

The Committee's membership includes four Non-executive Directors, the Group Chief Digital Information Officer, Group Chief Finance & Estates Officer, Group Chief Medical and Innovation Officer and Group Formation Officer.

The Digital met on six occasions during the reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

5.5.12 Merger Committee

The Merger Committee was established by the Board of Directors in October 2025 to independently assure the UHBW Board and Council of Governors on matters concerning all aspects of the merger of NBT and UHBW, and to ensure the final decision to merge and the merger timeline is in the interests of UHBW and the patients and people it serves. The scope of the Committee includes:

- Independent Review of the Full Business Case and Post Transaction Implementation Plan.
- Receiving and providing assurance on the robustness and appropriateness of the processes supporting the formal merger transaction.
- Review of evidence that the case for merging has identified and addressed the risks and benefits of the transaction for UHBW.

The Committee's membership includes two Non-executive Directors and the Hospital Managing Director (UHBW).

The Merger Committee met on two occasions during the reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring escalation to the Board.

Maria Kane
Group Chief Executive
Date: 23 June 2026

5.6 Statement of the Chief Executive's Responsibilities as the Accounting Officer of University Hospitals Bristol and Weston NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Bristol and Weston NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol and Weston NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts, and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed and disclose and explain any material departures in the financial statements.
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Maria Kane
Group Chief Executive
Date: 23 June 2026

5.7 Annual Governance Statement

5.7.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

5.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals Bristol and Weston NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals Bristol and Weston NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

5.7.3 Capacity to handle risk

The Group has appropriate leadership, capability and governance capacity to identify, manage and respond to risk at all levels of the organisation. Accountability for risk management ultimately sits with the Chief Executive as Accountable Officer, supported by Executive Directors through their portfolio responsibilities and collective oversight via the Executive Team.

Executive leadership capacity is supported by clear delegation and structured governance arrangements, ensuring that risks are actively managed before reaching the Board. The Executive Team provides coordination, challenge and prioritisation across risk domains, enabling competing operational, financial and strategic pressures to be balanced in a controlled and transparent way.

Operational capacity to manage risk is embedded across clinical and corporate services. Managers and senior clinicians are responsible for proactively identifying and managing risks within their areas, ensuring that risk assessments are undertaken, controls are implemented, and mitigation plans are progressed. Where risks cannot be adequately controlled locally, there are established routes for escalation to Executive Directors, operational monitoring groups and Board Committees.

Risk management is recognised as a core organisational capability rather than a specialist or centralised function. All staff have a role in identifying and escalating risk, supported by a culture that encourages openness, early reporting and learning. This supports early intervention and reduces the likelihood that risks emerge through harm or service failure. Staff capability is reinforced through mandatory risk awareness training, targeted development for risk owners and governance leads, and tailored development sessions for senior leaders and Board members. Training arrangements are reviewed and refreshed to ensure they remain aligned with the Group's evolving risk profile and governance maturity.

The Group is supported by a dedicated corporate risk management function, providing professional expertise, coordination and assurance. This function supports divisions and corporate teams in maintaining high-quality risk records, applying consistent standards, strengthening assurance, and supporting effective escalation and reporting. Capacity within the function is focused on enabling risk ownership across the organisation, rather than displacing accountability from operational leaders.

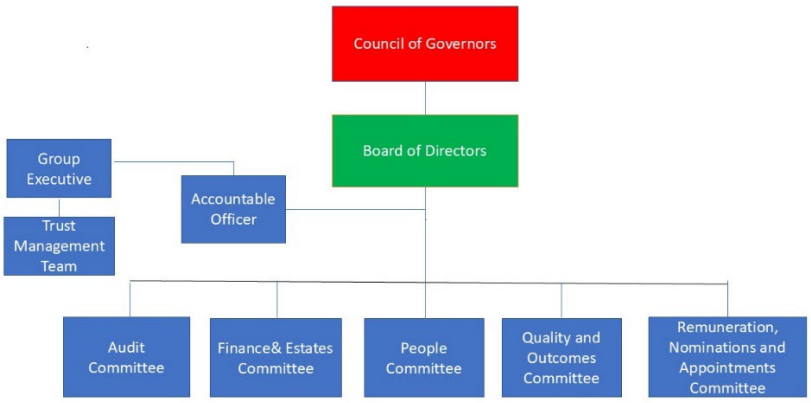
Board Committees provide additional capacity through focused scrutiny within their respective remits. Committees review risks, assurance and performance information relevant to their areas, providing challenge on control effectiveness, assurance gaps and delivery confidence. This layered approach

ensures that risks are examined in sufficient depth before being escalated to the Board, and that the Board's time is focused on the most material threats to strategic delivery.

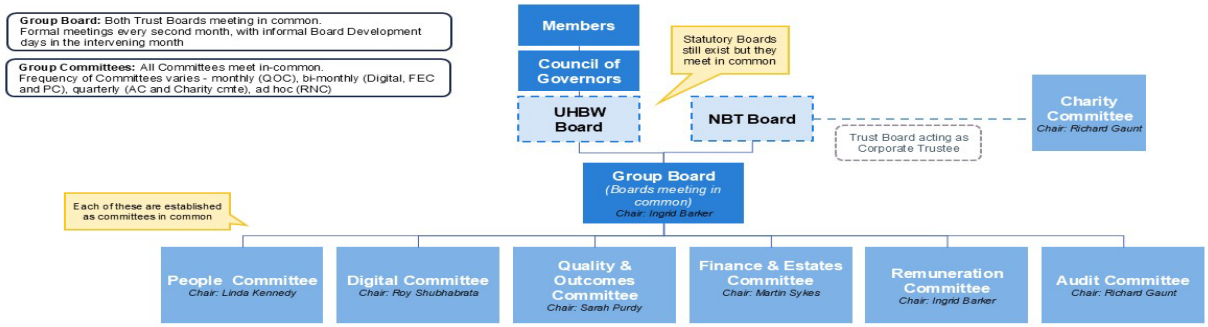
In December 2023 UHBW and NBT announced their decision to move to a Joint Chair and Joint Chief Executive and the strategic intention to form an NHS Group, with the aim of unlocking significant benefits for our patients, our population, our people and the public purse. The Bristol NHS Group was subsequently launched in April 2025 at which point the two Trusts announced their intention to formally merge, thereby creating one single acute trust for the Greater Bristol area. Subject to NHSE approval, it is anticipated that the merger will take place in July 2026.

As part of the formation of the Bristol NHS Group with UHBW, the Trust Board met in common with the NBT Board from April 2025 and subsequently aligned its committee structure with that of UHBW to allow the committees of both Trusts to meet in common.

The formal Board Committee structure as at April 2025 is set out below:



As of September 2025, all committees were meeting in common with UHBW and the revised group committee structure is set out below:



In addition to the above, the Board also established a time limited Merger Committee to provide it with assurance on the merger process as it proceeded.

Board members receive training in risk management which includes an overview of the risk systems. The Board is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective.

In 2023/24 DCO Partners undertook an external review against the Well-Led Framework, which included a comprehensive document review, observation of several Board and Committee meetings, interviews with Board members and senior managers, and engagement with key clinical and non-clinical staff within the Trust. The review was generally positive but did make a number of recommendations on where improvements could be made. The Board, in considering the report, agreed to focus on a small number of priority areas which were incorporated into an action plan, which was completed during 2024/25.

The CQC, in its last inspection report in 2022 into University Hospitals Bristol & Weston NHS Foundation Trust, gave it a rating of Good for the Well-led domain which recognised this domain was performing well and meeting the CQC's expectations.

Emphasis continues to be put into ensuring intelligence from incident investigation, patient safety projects, clinical audits and patient feedback is encompassed into the risk management framework. Through ensuring consistent and evidence-based risk assessments are managed at the appropriate level risk register, divisions are able to prioritise resources using risk-based information.
The Trust uses the national Electronic Staff Record (ESR) system which is managed by IBM. IBM are responsible for the design, implementation and operation of controls with regard to ESR, producing an annual ISAE 3000 report to provide reasonable assurance that the control objectives are achieved. This is subject to independent audit.

These arrangements provide the organisation with the capacity to handle risk in a proportionate, coordinated and sustainable way. They support timely identification of emerging risks, effective mitigation of known exposures, and clear assurance to the Board that risks are being actively managed in line with agreed appetite and tolerance.

5.7.4 The risk and control framework

The Group's risk and control framework is founded on a single, integrated approach to risk management, underpinned by the developing combined Group Risk Management Policy for University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust. The policy provides a consistent, ward-to-Board framework for identifying, assessing, managing, escalating and assuring risk, aligned to national best practice and the Group's governance arrangements.

The framework defines clear roles, responsibilities and accountabilities at every level of the organisation, ensuring that risks are managed as close as possible to the point of origin, while enabling proportionate escalation where risks exceed local control or tolerance. It establishes a standardised risk management cycle, supported by consistent terminology, scoring methodology, escalation thresholds and assurance expectations across the Group.

Risk oversight is structured through a tiered system of risk registers, spanning specialty and departmental risk registers, divisional risk registers, the Group Risk Register and the Board Assurance Framework (BAF). This structure ensures a clear line of sight from operational risks to strategic oversight and enables the aggregation of related risks to provide meaningful Board-level visibility of systemic and cross-cutting issues.

The BAF is the primary mechanism through which the Board gains assurance over the effectiveness of the risk and control environment The Board Assurance Framework (BAF) defines and assesses the principal strategic risks to the Trust's objectives and sets out the key controls and sources of assurance in place to manage these risks.

During 2025/26, the development of the Group model, including the establishment of a common Board, has enabled a more consistent and aligned approach to risk reporting at Board level across both organisations. Principal risks have been reviewed and aligned to support a coherent view of the most significant risks facing the Group, with increasing consistency in how Trust Level Risks (TLRs) and Corporate Risk Registers (CRRs) are articulated and escalated for Board oversight.

Each principal risk is assessed in terms of its impact on the delivery of the Trust's strategic objectives. Where gaps in control or assurance are identified, these are clearly articulated and translated into targeted actions to strengthen mitigation and improve the overall control environment.

The BAF is subject to regular review by the Board and its Committees, with a focus on material changes in risk profile, emerging risks, and progress against mitigating actions. This approach supports a clear line of sight from operational risks through to principal strategic risks.

The BAF also informs the Internal Audit programme, ensuring audit activity is aligned to the Trust's key risk areas. Audit findings contribute to the Board's overall assurance by confirming the effectiveness of controls or identifying areas requiring further improvement. In addition, principal risks are used to shape Committee work programmes, ensuring that scrutiny and assurance activity remains focused on the most significant risks to delivery of the Trust's strategy.

Risk appetite and risk tolerance are integral components of the framework. The Group's risk appetite statements are reviewed annually and approved by the Board, providing strategic direction on the level of risk the organisation is willing to accept in pursuit of its objectives. Risk tolerance thresholds translate this appetite into operational boundaries, supporting consistent decision-making on whether risks may be accepted, require further mitigation, or need escalation for senior or Board-level oversight.

The framework adopts an enterprise-wide approach to risk management, encompassing clinical, operational, financial, digital, estates, compliance and strategic risks. Risk identification is informed by multiple sources, including operational intelligence, incident reporting, complaints, audit activity, regulatory feedback and performance data. This ensures that the risk profile reflects both current exposure and emerging threats.

Assurance over the effectiveness of controls is provided through the Three Lines of Defence model. Operational management provides first-line assurance through day-to-day control activity; corporate oversight functions provide second-line assurance through policy, monitoring and thematic review; and independent assurance is provided through internal audit, external audit and regulatory inspection. The Audit Committee provides independent scrutiny of this assurance framework, ensuring that controls are effective and that gaps in control or assurance are identified and addressed.

The risk and control framework is integrated with wider governance and performance arrangements, including the Integrated Quality and Performance Report and strategic delivery processes, supporting a coherent and joined-up approach to assurance. These arrangements are subject to ongoing independent scrutiny through audit and regulatory review, providing confidence to the Board and the public that risks are being managed effectively. Through continued development of the combined Group Risk Management Policy and consistent application of the framework, the Group aims to promote a strong risk-aware culture, support informed decision-making, and provide robust assurance over the delivery of safe, effective and sustainable services.

5.7.5 Major Organisational Risks

The Trust's principal risks reflect a complex, high-demand operating environment and are aligned to the delivery of strategic objectives across quality, performance, workforce, resources and system working. During 2025/26, the risk profile has continued to be characterised by sustained operational pressure, increasing demand, and system-wide constraints, with a number of risks showing an increasing trend.

The most significant risks relate to:

- **Quality of care** – the ability to consistently deliver safe, high-quality care is challenged by workforce pressures, increasing demand, and infrastructure limitations, with risks around clinical safety, patient outcomes and experience.
- **Operational performance and patient flow** – persistent system constraints, particularly high numbers of patients with no criteria to reside (NCtR), are impacting patient flow, contributing to overcrowding, delays in treatment and increased risk to patient safety.
- **Workforce capacity and capability** – ongoing challenges in recruitment, retention and workforce supply, alongside increasing service demand, continue to impact the Trust's ability to align workforce capacity to future service models.
- **Financial sustainability** – the Trust faces a structural financial challenge driven by cost pressures, productivity requirements and limitations in capital funding, which constrain investment in services, estate and equipment.
- **Estates and equipment infrastructure** – ageing estate and clinical equipment, combined with capital constraints, present risks to service continuity, regulatory compliance and patient safety, and an increased fire risk.
- **Digital maturity and resilience** – limitations in digital infrastructure, interoperability and cyber resilience create risks to operational effectiveness, data quality and business continuity.
- **Compliance and regulatory requirements** – the complexity of operating within a Group model increases the challenge of maintaining consistent compliance with statutory and regulatory requirements across organisations.
- **Change management and transformation** – the scale and pace of organisational change, combined with the national changes arising from the NHS 10 Year Plan, creates risks relating to capacity to deliver transformation alongside business-as-usual is constrained.

These risks are interdependent and collectively impact the Trust's ability to deliver its strategic priorities. The BAF provides a structured approach to identifying, assessing and managing these risks, with oversight provided through Board committees and supported by internal and external sources of assurance.

While robust controls and mitigation plans are in place, a number of risks remain outside of the Trust's risk appetite, reflecting both internal pressures and wider system dependencies, particularly in relation to patient flow, workforce supply and financial sustainability.

5.7.6 Quality governance arrangements

The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and delivers the highest quality standards. The Board and Senior Leadership Team of the Trust have a critical role in leading a culture which promotes excellence. This requires both vision and action to ensure all efforts are focused on creating an environment for positive change. We have much to be proud of. Our continuous improvement programmes continue to show us what is possible when we have a relentless focus on quality improvement.

Throughout 2025/26 we have continued to work towards achieving the quality priorities set out in our annual Quality Account and brought to life through Patient First.

Our vision for quality expressed through Patient First is:

- To deliver person-centred, compassionate and inclusive care every time, for everyone.
- To consistently deliver the highest quality, safe and effective care to all our patients
- To provide timely access to care for all patients, meeting their individual needs.

A summary of progress against our strategic priorities for quality is included in section 2.1.4 of this report. For more information about the Trust's quality objectives, please refer to our annual Quality Account.

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The Trust's Quality and Equality Impact Assessment process

involves a structured risk assessment using a standardised framework. The Group Chief Nursing and Improvement Officer and Group Chief Medical and innovation Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality. The Trust's overall processes for monitoring quality and triangulating information provide a framework within which to monitor the impact of schemes. The Trust's comprehensive programme of clinical audit effectively also supports improving clinical quality in alignment with the Trust's quality priorities.

The Trust has a robust quality governance reporting structure in place through its Clinical Quality Group and the Group Quality and Outcomes Committee, both of whom monitor performance against a range of quality standards. Our urgent and emergency services in the Bristol Royal Infirmary were inspected by the Care Quality Commission in August 2025 and were rated "requires improvement" with all other services rated "good" or "outstanding". Our overall rating is "requires improvement". Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives.

The Board receives a regular report on Nursing and Midwifery staffing, providing assurance that the Trust has a clear validated process in place for monitoring and ensuring safe, sustainable and effective staffing in line with current national recommendations and is fully compliant with the 'Developing Workforce Safeguards' recommendations and the requirements of the National Quality Board (NQB) (2016). These have now been fully reviewed and passed by the NHSE Regional team.

The Clinical Quality Group and People, Learning and Development Group also receive monthly updates on safe nurse and midwifery staffing each month with a comprehensive Divisional review submitted every six-months detailing the Divisional staffing challenges and planned mitigating actions.

The Divisional Directors of Nursing and the Director of Midwifery each make a detailed annual presentation to the Trust Director of Nursing outlining how they have fully reviewed all areas against the National Quality Board (2016) triangulation approach. These six-monthly reports set out the results of the Safer Nursing Care Tool (SNCT) (Shelford 2023) and the Midwife to Birth ratios as recommended and found within the Birthrate Plus ® tool. The SNCT (2023) audits are used in both Adult and Childrens In-Patient wards and Emergency Departments, these results are then triangulated with patient quality outcomes and the findings from patient and staff survey results using the professional judgement process to draw their assurance conclusions and where required making specific staffing proposals based on this evidence to the Trust Director of Nursing, and the Chief Nursing and Improvement Officer, who then makes recommendations to the Board.

The Trust is fully compliant with the expectation of a monthly return on staffing levels is submitted to the NHSE and publishes these results on the Trust internet site. The reports used to provide clear assurance to the Trust are also published on the Trust internet site for further transparency.

The Trust's process for managing safe staffing on a daily basis is set out in a Safe Staffing Standard Operating Procedure that is reviewed every six months to keep it current to ensure consistency in the process of managing safe staffing, providing a clear process for the escalation of shifts both within normal hours and during the out of hours period. This articulates the triangulated approach to safe staffing that NQB requires and ensures robust decision making for all staff around the safe care of our patients.

Twice-daily safe staffing meetings are held in each site, overseen by a Divisional Director of Nursing (or deputy) for the day, where real time data of actual staffing levels and patient acuity are reviewed, additional temporary staff booked as necessary and staff redeployed as required to balance patient safety. In addition, key operational staff attend the afternoon meetings to provide a clear steer on the potential requirements to staff escalation areas to ensure these fully considered and safely staffed within the wider nursing demand across the different sites.

Our Governors engage with the quality agenda via their Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's Risk Register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement.

5.7.7 Review of economy, efficiency and effectiveness of the use of resources

The Trust has a range of processes to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of relevant monthly finance and performance reports to the Finance, & Estates, People, and Quality and Outcomes Committees, the Executive Team, the Senior Leadership Team, and to the Board. More information about this is in the financial review section of this report.

Our external auditors are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

5.7.8 Information governance

The Trust's Information governance processes serve as the framework for safeguarding information with utmost security and confidentiality. Encompassing the collection, storage, and sharing of data, it ensures that personal and sensitive information is handled legally, securely, and efficiently, ultimately aiming to deliver optimal care and service.

At the forefront of our information governance efforts is the Information Risk Management Group (IRMG), led by the Trust's Chief Data & Analytics Officer, under the delegated authority of the Chief Digital Information Officer, who acts as the Senior Information Risk Owner.

Our control and assurance mechanisms for information governance encompass several key elements:

- Designated Information Asset Owners and Information Asset Administrators responsible for maintaining systems containing patient and staff personal data.
- A trained Caldicott Guardian, Senior Information Risk Owner, and Data Protection Officer to uphold stringent standards of data protection.
- Implementation of a robust risk management and incident reporting process to swiftly address any breaches or incidents.
- Continuous staff training programs to ensure awareness and adherence to information governance protocols.
- Maintenance of an information governance risk register to systematically monitor and mitigate risks.
- Regular reviews to assess compliance with the Data Security and Protection Toolkit criteria.
- Internal audit reviews to validate the evidence provided for compliance with toolkit requirements.
    - UHBW's Internal Audit confirmed that:
        - UHBW's Overall Risk Rating: **Very Low**
        - Confidence in Self-Assessment: **High**
        - All minimum achievement levels have been met.
        - There was alignment between self-assessment and audit judgement across all outcomes reviewed.
        - No medium or high-risk findings were identified.

During the reporting period, financial year 2025/26, all information governance incidents were managed locally in line with established procedures. No incidents met the threshold for reportability to the Information Commissioner's Office.

5.7.9 Data Quality and Governance

As part of the contractual reporting requirements all Trusts must agree and undertake Data Quality Improvement Plans (DQIP's) for both NHS England and the regional Clinical Commissioning Group. The table describes the volume of queries identified and resolved over the past year:

Table 54: Data Quality Tasks

2025/26		
Data Quality Tasks Identified/Completed by Company Year	**Tasks Identified**	**Tasks Completed**
Both Commissioners	**16**	**9**
BNSSG	**5**	**4**
NHSE	**11**	**5**

In total, sixteen tasks have been identified in 2025/26. Of the sixteen tasks raised in 2025/26, seven are progressing to resolution through established plans and will be delivered in early 2026/27.

Processes for raising ad hoc data quality queries will remain in place and will be used on an ongoing basis to support the existing governance structures around quality and performance.

NHSE has confirmed that mandated Data Quality Improvement Plans will be implemented nationally in 2026/27. The Trust is currently reviewing the requirements and expects to be well-placed to respond.

Both Commissioners and key Trust stakeholders will be advised of data quality performance via established governance structures, and additional DQIPs may be instigated or amended in future should the need arise and with the agreement of all parties.

The performance against our Data Quality plans has been a recurring item of assurance for key governance forums.

Table 55: Secondary User's Service (SUS) Statistics

UHBW Provider vs National SUS Statistics	M10 2025 / 26			FY 2024 / 25		
Data Item	UHBW	**National**	**Variance to National**	**UHBW**	**National**	**Variance to National**
Attendance Indicator	**99.5%**	**99.5%**	0%	**99.8%**	**99.5%**	+0.3%
Attendance Outcome	**100.0%**	**93.1%**	+6.9%	**100.0%**	**94.2%**	+5.8%
Commissioner	**99.8%**	**99.4%**	+0.4%	**100.0%**	**99.3%**	+0.7%
Ethnic Category	**91.5%**	**91.8%**	-0.3%	**92.3%**	**92.4%**	-0.1%
First Attendance	**100.0%**	**99.8%**	+0.2%	**100.0%**	**99.8%**	+0.2%
Main Specialty	**99.8%**	**98.9%**	+0.9%	**100.0%**	**99.4%**	+0.6%
NHS Number	**99.9%**	**99.8%**	+0.1%	**99.9%**	**99.7%**	+0.2%
Org of Residence	**99.0%**	**96.6%**	+2.4%	**99.1%**	**96.9%**	+2.2%
Patient Pathway *	**0.3%**	**0.3%**	0%	**0.0%**	**0.2%**	-0.2%
Post Code	**100.0%**	**99.9%**	+0.1%	**100.0%**	**99.8%**	+0.2%

Primary Diagnosis	**97.0%**	**93.9%**	+3.1%	**99.5%**	**97.8%**	+1.7%
Primary Procedure	**99.6%**	**99.7%**	-0.1%	**99.7%**	**99.6%**	+0.1%
Priority Type	**100.0%**	**91.7%**	+8.3%	**100.0%**	**92.2%**	+7.8%
Referral Received Date	**100.0%**	**91.5%**	+8.5%	**100.0%**	**93.2%**	+6.8%
Referral Source	**98.8%**	**96.1%**	+2.7%	**98.7%**	**96.6%**	+2.1%
Registered GP Practice	**100.0%**	**99.6%**	+0.4%	**100.0%**	**99.4%**	+0.6%
Site Code of Treatment	**100.0%**	**95.8%**	+4.2%	**100.0%**	**96.1%**	+3.9%
Treatment of Function	**100.0%**	**99.3%**	+0.7%	**100.0%**	**99.4%**	+0.6%

*There is a National error within the Dashboard for this identifier which currently does not accurately represent the Trust's position, or the National compliance for Patient Pathway identifier for 2024/25, or 2025/26.

The Trust routinely submits a wealth of information and monitoring data centrally to our commissioners and the Department of Health. The accuracy of this data is of vital importance to the Trust and the NHS to ensure high-quality clinical care and accurate financial reimbursement.

Our data quality reporting, controls and feedback mechanisms are routinely audited and help us monitor and maintain high-quality data. We submit to the Secondary Users' Service (SUS) for inclusion in the Hospital Episode Statistics (HES). The table shows that the Trust continues to outperform the National average in most areas of measurement. This performance continues the pattern of excellent data quality established in recent years.

5.7.10 Significant Internal Control Issues

No significant internal control issues have been identified during the year.

5.7.11 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance & Estates Committee, People Committee and the Quality and Outcomes Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework (BAF) and on the controls reviewed as part of the internal audit work. My review of the effectiveness of the system of internal control is informed by executives and managers within the organisation, who have responsibility for the development and maintenance of the system of internal control and the assurance framework. The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its objectives have been reviewed.

The assurance framework has been reviewed by the Trust's internal auditors. They have confirmed that a BAF has been established which is designed and operating to meet the requirements of the 2025/26 Annual Governance Statement. Their opinion supported that overall, there is an satisfactory system of internal control to manage the principal risks identified by the organisation.

The Board reviews risks to the delivery of the Trust's performance objectives through bi-monthly monitoring and discussion of the performance in the key areas of finance, activity, national standards,

patient safety and quality and workforce. This enables the Board of Directors to focus on key issues as they arise and address them.

The Audit Committee oversees the effectiveness of the Trust's overall risk management and internal control arrangement. On behalf of the Board, it independently reviews the effectiveness of risk management systems in ensuring all significant risks identified, assessed, recorded and escalated as appropriate. The Audit Committee regularly receives reports on internal control and risk management matters from the internal and external auditors. None of the internal or external auditors' reports considered by the audit committee during 2025/26 raised significant internal control issues. There is a full programme of clinical audit in place.

The responsibility for compliance with the CQC essential standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The Trust is addressing all areas of underperformance and non- compliance identified either through external inspections, patient and staff surveys, raised by stakeholders, including patients, staff, governors and others or identified by internal peer review.

5.7.12 Conclusion

The Board is committed to continuous improvement of its governance arrangements to ensure that systems are in place which ensure risks are correctly identified and managed and that serious incidents and incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action, so that the patients, service users, staff and stakeholders of University Hospitals Bristol and Weston NHS Foundation Trust can be confident in the quality of the service we deliver and the effective, economic and efficient use of resources.

My review confirms that University Hospitals Bristol and Weston NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts.

Maria Kane
Group Chief Executive

Appendix A – Biographies of Members of the Board of Directors

Maria Kane – Group Chief Executive

Maria Kane OBE was appointed as Group Chief Executive of North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust in July 2024. Prior to this she was Chief Executive of NBT from April 2021.

Maria previously worked as Chief Executive of North Middlesex University Hospital NHS Trust from 2017 until 2021, as Chief Executive of Barnet, Enfield and Haringey Mental Health NHS Trust between 2007 and 2017, and as Executive Director at North West London Strategic Health Authority between 2002 and 2006. Maria has held a variety of senior roles in corporate and strategic development for the Royal College of Midwives, Medical Protection Society and the National Council of Voluntary Organisations.

In 2019, Maria was made an OBE for services to health care leadership over two decades, particularly in North London.

Maria is Chair of Bristol Health Partners, a member of the Bristol, North Somerset and South Gloucestershire Integrated Care Board, and sits on the board of Health Innovation West of England. She is also the South West representative for the NHS Genomics Board, and is the representative for the South West on the NHS Impact National Improvement Board.

Maria has previously been a trustee of Open Door, Umbrella Mental Health, and Young Minds, as well as an adviser to the Lullaby Trust and a special adviser to the Care Quality Commission. She was also chair of governors of a primary school for ten years.

Paula Clarke – Executive Managing Director, Weston General Hospital / Group Formation Officer

Paula is an experienced Executive who has held senior manager and Executive roles in commissioning, provider and primary care organisations over the last 30 years. She worked for 23 years in the integrated health and social care system in Northern Ireland bringing this experience of multidisciplinary and collaborative delivery into UHBW and the ICS. Paula has 14 years Board level experience, including serving as the interim chief executive of Southern Health and Social Care Trust in 2015/16. Over the pandemic, Paula was national lead for establishing large-scale mass vaccination centres and also led on delivery of the Bristol Nightingale Hospital. Paula has extensive experience in integrated care operational delivery, strategic planning, continuous improvement, partnership working and service transformation programmes.

Paula joined the Trust on 1 April 2016 and was appointed as Group Formation Officer on 1 June 2025.

Neil Darvill – Group Chief Digital Information Officer (non-voting position)

Neil has Board level responsibility for Digital Information at both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust. Neil has over 30 years of experience working in healthcare environments. Neil is responsible for setting and driving forward the IM&T Strategy at both Trusts and developing key partnerships with suppliers and customers alike to ensure targets and expectations are met, year on year. Neil joined the Trust on 1 June 2023.

Professor Steve Hams - Group Chief Nursing and Improvement Officer

With over 30 years' experience in nursing, Steve began his career in coronary care before taking on senior leadership roles across the NHS, voluntary sector, and higher education. Most recently, Steve was Chief Nursing Officer at NBT where he has led professional nursing, midwifery and allied health leadership since March 2022.

Committed to safety and compassion and a champion of inclusion, quality improvement, and the power of professional and patient voice in shaping excellent care, Steve was admitted to The Most Venerable Order of the Hospital of St John of Jerusalem in 2011 for his service to St John Ambulance, and he was awarded an MBE for services to nursing in the 2022 New Year Honours. His particular areas of interest include compassionate leadership, community engagement, mental health, and equality. Steve is a Visiting Professor at the University of the West of England.

Steve was appointed as Group Chief Nursing and Improvement Officer on 1 June 2025.

Neil Kemsley – Chief Financial Officer / Group Chief Finance and Estates Officer
Neil trained and qualified at The Trust before leaving in 1998 to progress his career through the finance ranks at University College London hospitals, Kings and then Portsmouth.
Neil has over 15 years' experience as a Board director working across the provider, commissioning and regulatory sectors of the NHS. He spent three-and-a-half years at University Hospitals Plymouth NHS Trust before returning to Bristol in 2019 as Chief Financial Officer.

Neil was appointed as Group Chief Finance and Estates Officer on 1 June 2025.

Jenny Lewis - Group Chief People & Culture Officer (non-voting position)
Jenny Lewis is an experienced HR and organisational development leader with a career spanning the NHS, local government, and the private sector. She brings a strong commitment to people, culture, and public service.

Before joining Bristol NHS Group, Jenny was Director HR & OD at Leeds Teaching Hospitals NHS Trust and Head of HR for Hampshire Public Services, where she led people services for a workforce of 55,000 across Hampshire County Council, Hampshire Constabulary, the Office of the Police and Crime Commissioner, Hampshire Fire and Rescue Service, and 500 schools. Her experience also includes working in Organisational Development for several global private sector organisations over two decades.

Jenny is passionate about creating inclusive, thriving workplaces. She believes that when colleagues feel supported, valued, and empowered, they deliver exceptional care and outcomes. Her focus includes advancing health equity, building partnerships across sectors, recruiting from local communities, and fostering cultures where wellbeing, development, and meaningful careers are at the heart of how teams work—where everyone feels they belong.

Jenny was appointed Group Chief People & Culture Officer on 29 September 2025.

Professor Stuart Walker – Hospital Managing Director
Professor Stuart Walker is an experienced NHS Executive Medical Director and previous Deputy Chief Executive Officer. He has a background in a broad range of senior leadership positions and, as a prior Cardiologist of 18 years standing, significant senior clinical experience. Before coming to UHBW in Feb 2022 he worked at Cardiff and Vale University Health Board as MD, Deputy CEO and then Interim CEO. He has also held prior Executive, and senior leadership, roles in the English NHS for example as MD at Taunton and Somerset NHS FT, and Chief Medical Officer at TSFT and Somerset Partnership FT. He was awarded the title of Honorary Professor by Cardiff University in 2021.

Professor Walker joined the Trust as Chief Medical Officer in February 2022 before being appointed as Interim Chief Executive on 1 January 2024 following the departure of the previous Chief Executive. He was appointed as Hospital Managing Director on 2 September 2024.

Professor Tim Whittlestone - Group Chief Medical and Innovation Officer
Tim is a Urological Cancer surgeon who trained in Cambridge, Oxford and Bristol. He was appointed a Consultant in the BRI in 2001 and has held a number of senior clinical leadership roles prior to

becoming Chief Medical Officer at NBT in 2021. He was Chief Medical Officer for the South West Nightingale hospital and BNSSGs vaccination services.

Tim is passionate about patient-led service transformation and was listed as one of the top 50 global healthcare innovators in 2022. In 2023 he led the clinically inspired strategy refresh, and more recently co-authored the Bristol Group Joint Clinical Strategy. He is the visiting Professor of Healthcare Technology at the University of the West of England.

Tim was appointed as Group Chief Medical and Innovation Officer on 1 June 2025.

Ingrid Barker – Group Chair
A qualified social worker, Ingrid has over 25 years of NHS board level experience. This has included roles as Chair at Gloucestershire Health and Care NHS Foundation Trust, Joint Chair of Gloucestershire Care Services NHS Trust and ²gether NHS Foundation Trust and as a Non-Executive Director of NHS Gloucestershire Primary Care Trust. She is also an active Governor at the University of Gloucestershire.

Ingrid's drive and commitment to the provision of high-quality services, accessible to all, is evidenced in her national policy and service redevelopment roles, notably leading on the transformation of mental health services community provision. She was also a Trustee and Board member of NHS Providers between 2013 and 2021, elected to represent Community Trusts across England.

Ingrid was appointed as Group Chair of University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust on 1 June 2024.

Sue Balcombe – Non-executive Director
Sue is a registered nurse with more than 35 years' experience within the NHS and significant NHS board experience at an executive level. In 2005 she was Director of Nursing at Taunton Deane Primary Care Trust followed by Chief Nurse at Somerset Community Health. Following a merger and acquisition in 2015 she became Chief Nurse at Somerset Partnership NHS Foundation Trust bringing together community and mental health services within an integrated Trust. Sue has extensive and varied clinical experience principally in urgent and emergency care and community care, assuming leadership roles in each. She brings significant experience in service integration and system redesign having played a clinical leadership role within Somerset STP prior to her retirement in 2018. Prior to joining the Board Sue was a Non-executive Director at Weston Area Health NHS Trust and a non- executive director (designate) at University Hospitals Bristol and Weston NHS Foundation Trust.

Sue is the Trust's Senior Independent Director and was previously the chair of the Quality and Outcomes Committee.

Richard Gaunt – Group Non-executive Director
Richard is an experienced Board member and Audit & Risk Committee Chair (most recently with Alliance Homes). Previous appointments as a Non-Executive Director or governor include a Further Education College, Multi-Academy Trust and a Charity. He brings a broad range of skills including significant strength in finance, strategy and treasury. Prior to his retirement in 2009, Richard was an Audit Partner at KPMG, and he remains a Fellow of the Society of Chartered Accountants England and Wales.

Richard was appointed as a Group Non-executive Director on 1 September 2025 and is the chair of the Audit Committee.

Professor Marc Griffiths – Group Non-executive Director (non-voting)
Marc is the Pro-Vice Chancellor (PVC) for Regional Partnerships, Engagement and Innovation at the University of the West of England, Bristol. He is responsible for leading and developing the regional

partnerships across all sectors, focusing on skills, education, innovation, enterprise and applied research opportunities. As part of Marc's PVC role, he leads the Integrated Care Academy at the University of the West of England, Bristol. Prior to joining the Bristol NHS Group Board, Marc was a Non-executive Director at UHBW.

Marc is a Principal Fellow within Advance HE, a Fellow of the Leadership Foundation in Higher Education, a Fellow of the College of Radiographers and also the co-founder of the Let's Talk Health and Care podcast series.

In terms of wider civic facing roles, Marc is the Vice-Chair of the Board of Governors at the City of Bristol College, an appointed Trustee at the Council of Deans of Health, a member of the Futures West Advisory Board and work closely with a number of partner organisations such as NHS England, Avon and Somerset Police and Bristol City Council.

Marc was appointed as a Non-executive Director of the Trust on 1 July 2022 and as a Group Non-executive Director (non-voting) on 1 September 2025.

Linda Kennedy – Group Non-executive Director
Linda has over 40 years of HR experience, working internationally across various geographies and covering many sectors, such as oil and gas, mining, support services, advertising, distribution, telecommunications and manufacturing. During her executive career, she has operated in both public PLC and PE backed organisations, having successfully led business change programmes delivering growth and improving performance. Roles of note include VP People and Chief Change Officer for EE during the merger of Orange and T Mobile, delivering transformation when Group HR Director of SIG plc, a FTSE 250 business for 5 years and laterally driving value as Chief HR Officer of kp films, a large PE backed manufacturing business. She is also a qualified coach and a Fellow of the CIPD.

From a non-executive perspective, Linda was a Member of Sheffield Hallam University Business School Advisory Board from 2015 to 2020 and is currently a Non-executive Director/Trustee of NEBOSH (the National Examination Board in Occupational Safety and Health).

Linda was appointed as a Non-executive Director of the Trust on 1 June 2024 and as a Group Non-executive Director on 1 September 2025. She is the chair of the People Committee.

Poku Osei - Group Non-executive Director (non-voting)
Poku has a strong business background and is a recognised leader in social impact, innovation, and system change. His previous board experience includes local government and higher education as well as the healthcare sector. Poku has a Master's degree in Business Management and is a Fellow of the Royal Society of Arts.

Poku moved to Bristol in 2009 and founded the social enterprise company Babbasa in 2010. In 2020, they were awarded the Queen's Award for Enterprise for Promoting Opportunity for their work supporting young people in Bristol from disadvantaged backgrounds gaining training and employment. Poku remains the Director of Babbasa and is the founder and Principal Consultant for Merop Consulting.

Poku was appointed as a Group Non-executive Director (non-voting) on 1 December 2025.

Professor Sarah Purdy – Group Non-executive Director
Sarah is Vice-Chair of North Bristol Trust and is a GP and clinical academic by background. Until 2022 Sarah was Pro Vice-Chancellor Student Experience at the University of Bristol and previously she led Bristol Medical School. Sarah has held leadership positions including as a Non-Executive Director and trustee in a number of organisations across the wider NHS, charities, and a multi-

academy trust. She is a Trustee of the Barts Charity. Sarah practiced as a GP from 1991 to 2022 and was awarded an OBE for services to general practice in the 2022 Queen's Birthday Honours.

Sarah was appointed as a Group Non-executive Director on 1 September 2025 and is the chair of the Quality and Outcomes Committee.

Roy Shubhabrata – Group Non-executive Director
Roy has spent the last two decades focused on digital transformation in healthcare across Europe, North America, Asia and Australia. His interest lies is in the collaboration of government, academia, charities and providers in the adoption of innovative technologies in health and care settings.
Roy is the Chief Executive of Healthinnova, an international health technology solutions company based in Bath. He is a Trustee of Age UK, the country's leading charity focused on older people, as well as HelpAge International UK, which focuses on ageing issues in low and middle-income countries.

Roy was appointed as a Non-executive Director of the Trust on 1 July 2022, and as a Group Non-executive Director on 1 September 2025. Roy is chair of the Digital Committee.

Martin Sykes – Non-executive Director
Martin studied chemistry at the University of Newcastle upon Tyne, where he obtained a PhD and spent a number of years working in post-doctoral research. He later qualified as an accountant and joined the NHS in 1995. Martin worked most recently at Frimley Health NHS Foundation Trust as finance director and deputy chief executive. Within the NHS Martin has also held executive responsibility for procurement; information management and technology; information governance; contracting; and strategy.

Martin is chair of the Finance and Estates Committee and Vice-Chair of UHBW. He was appointed as a Non-executive Director in 20217, and as a Group Non-executive Director on 1 September 2025.

Directors who left the Board during 2025/26

Jane Farrell – Chief Operating Officer
Jane has experience of working in and across large complex organisations and systems, including 19 years as an executive director. Her previous roles have included Executive Managing Director, Deputy Chief Executive, Director of Transformation and Chief Operating Officer across NHS organisations including Kings College Hospitals, Mid & South Essex FT, and Western Sussex Hospitals. Jane is a dual registered nurse, specialising in paediatric critical care. Jane joined UHBW on 31 October 2022 as Interim Chief Operating Officer and was appointed on a permanent basis from 1st April 2023. Jane left the Trust in December 2025.

Professor Deirdre Fowler – Chief Nurse and Midwife
Deirdre is an experienced executive nurse and midwife whose career in healthcare now spans over 30 years. Deirdre has worked in community, acute and academic sectors. She has held positions in senior midwifery leadership and commenced her first executive nurse post in 2013. Deirdre has worked at senior level in a range of organisations, more recently at South Tees Hospitals NHS Foundation Trust in the North-East. Deirdre also has a role as visiting professor at the University of the West England. Deirdre left the Trust in August 2025.

Dr Rebecca Maxwell – Interim Chief Medical Officer
Dr Rebecca (Becky) Maxwell was appointed to the role of Interim Chief Medical Officer from 1 January 2024. Dr Maxwell has significant clinical experience working as an Emergency Department Consultant, Clinical Chair and as Deputy Medical Director in the Chief Medical Officer team. Rebeccas stood down from her role as Interim Chief Medical Director on 31 May 2025 and ceased to be a member of the Board on that date.

Emma Wood – Chief People Officer & Deputy Hospital Managing Director
Emma is an experienced executive whose specialisms include employee relations and engagement, inclusion, organisational design and development, resourcing and talent development. With a strong track record across both private and public sector, Emma previously worked at South Western Ambulance Service NHS Foundation Trust as well as Avon and Somerset Constabulary. Emma holds a BA in Psychology and Education and an MSC in Integrated Professional Practice from UWE. She is a Chartered Fellow of the Chartered Institute of Personnel and Development and an Executive Coach. Emma started in the Trust on 4 January 2022. Emma left the Trust in September 2025.

Anne Tutt – Non-executive Director
Anne is a qualified Chartered Accountant (FCA) with more than 30 years' experience at Board level. In her early career she held commercial finance director roles. Anne's non-executive experience includes board roles for the Social Investment Business Foundation Group, DEFRA's Animal and Plant Health Agency and Her Majesty's Passport Office where she was also Chair of Audit Committee and DFID. Between 2009 and November 2023, Anne was Non-executive Director of Oxford University Hospitals NHS Foundation Trust, where she was also over time Vice Chair, Senior Independent Director, Chair of Audit and Risk Committee and Chair of Investment Committee.

Anne is currently a Trustee and Chair of the Finance Committee of Pancreatic Cancer UK, Trustee and Chair of Audit and Risk Committee at Action Aid UK, and Treasurer and Chair of the Finance and Strategy Committee of Swansea University, a Trustee and Chair of the Finance & Risk Committee at Katharine House Hospice Trust, a Trustee and Chair of the Audit Committee at Oxford Hospitals Charity and a Trustee of the Education Development Trust.

Anne was appointed as a Non-executive Director of the Trust on 1 June 2024 and was the chair of the Audit Committee. Anne stood down as a Non-Executive Director on 30 August 2025.

Susan Hamilton - Associate Non-executive Director
Susan has spent over 20 years in public health in the NHS, local government and charity sector and is currently Chief Executive of St Peter's Hospice. Prior to this she was Director of Public Health for North Northamptonshire Council. She is also a Board member and Vice Chair of the social housing and support provider Taff Housing. Susan spent her earlier career in public health and management research roles at the University of Bristol and the University of Birmingham. She then completed NHS speciality training and has held Consultant in Public Health roles in several organisations including NHS North Somerset and South Gloucestershire Council. Susan has also worked in the charity sector in the role of Executive Director for Strategic Development at the Royal Osteoporosis Society. Susan holds a BSc (Hons) in Medical Microbiology, a Master of Public Health and an MBA. She is a Fellow of the Faculty of Public Health and has served on the National Institute for Health Research Public Health Research Prioritisation Committee.
Susan was appointed as an Associate Non-executive Director of the Trust on 1 July 2023. Her term of office ended on 30 June 2025.

Dr Rosie Benneyworth – Non-executive Director
Rosie is the Interim Chief Executive Officer of the Health Services Safety Investigations Body (HSSIB). Rosie was a GP and clinical commissioner in Somerset for many years, and prior to her role with HSSIB, she was Chief Inspector for Primary and Integrated Care and the CQC. Rosie also spent two years as Managing Director of Southwest Academic Health Science Network during which time she led the national patient safety collaboratives. She was a Non-Executive Director and Vice Chair of the National Institute of Health and Care Excellence and is also a Trustee of the National Children's Orchestras of Great Britain.

Rosie was appointed as a Non-executive Director on 1 July 2023. She stood down as a Non-Executive Director on 30 August 2026.

Arabel Bailey – Non-executive Director
Arabel brings 30 years' experience of technology-driven transformation in the private sector, across a wide range of industries. She is an experienced business leader and has held numerous senior executive positions in the areas of Technology, Digital Transformation and Innovation. She is also a Non-executive Director at the Department for Work and Pensions working as part of their Transformation Advisory Committee. She provides expertise and insight around modernising and transforming the Department's citizen services. Arabel has long been a champion for Diversity and Inclusion, and for the need to bring a better gender balance to the Technology industry. She is recognised as a role model in this area and has received industry recognition for her leadership roles.

Arabel was appointed as an Associate Non-executive Director of the Trust on 1 July 2022 and was appointed as a Non-executive Director on 1 July 2023. Arabel stood down as a Non-Executive Director on 30 August 2025.

Appendix B – Contact Details

The **Trust Secretariat** can be contacted at the following address:

Joint Chief Corporate Governance Officer
University Hospitals Bristol and Weston NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

Email: Trust.Secretariat@uhbw.nhs.uk

The **Membership Office** can be contact at the following address:

Membership Office
University Hospitals Bristol and Weston NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

Email: FoundationTrust@uhbw.nhs.uk

Appendix C – Annual Accounts 2025/26

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Accounts for the year ended 31 March 2026

Neil Kemsley
Group Chief Finance and Estates Officer

Finance Department
Trust Headquarters
Marlborough Street
PO Box 3214
BRISTOL BS1 9JR

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2026

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2026 have been prepared by the University Hospitals Bristol and Weston NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Maria Kane
Group Chief Executive Officer

Date 23 June 2026

Statement of Comprehensive Income for the year ended 31 March 2026

	Note	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Operating income from patient care activities	3.1	1,300,206	1,214,380
Other operating income	4.1	139,749	132,409
Operating expenses	5.1	(1,439,813)	(1,385,891)
OPERATING SURPLUS / (DEFICIT)		**142**	**(39,102)**
Finance income	8.1	3,765	5,587
Finance expenses	8.2	(2,638)	(2,694)
Public dividend capital dividend expense		(11,661)	(12,137)
NET FINANCE COSTS		**(10,534)**	**(9,244)**
Other losses	7	(203)	(148)
DEFICIT FOR THE YEAR		**(10,595)**	**(48,494)**
OTHER COMPREHENSIVE EXPENDITURE			
Will not be reclassified to income and expenditure			
Impairments	8.3	(9,225)	(31,763)
TOTAL COMPREHENSIVE EXPENDITURE FOR THE YEAR		**(19,820)**	**(80,257)**

All revenue and income is derived from continuing operations.

The notes on pages 6-40 form part of these accounts.

Statement of Financial Position for the year ended 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
NON-CURRENT ASSETS			
Intangible assets	9	15,450	16,322
Property, plant and equipment	10	498,986	480,444
Right of use assets	10.1	107,112	107,520
Receivables	12.1	1,470	1,503
TOTAL NON-CURRENT ASSETS		**623,018**	**605,789**
CURRENT ASSETS			
Inventories	11	18,452	18,712
Receivables	12.2	54,861	53,803
Other financial assets	13	104	104
Cash and cash equivalents	14	73,093	72,295
TOTAL CURRENT ASSETS		**146,510**	**144,914**
CURRENT LIABILITIES			
Trade and other payables	15	(142,356)	(130,780)
Borrowings	17.1	(13,624)	(13,368)
Provisions	18.1	(838)	(364)
Other liabilities	16	(8,950)	(10,232)
TOTAL CURRENT LIABILITIES		**(165,768)**	**(154,744)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**603,760**	**595,959**
NON-CURRENT LIABILITIES			
Borrowings	17.1	(124,966)	(130,588)
Provisions	18.1	(2,597)	(2,085)
TOTAL NON-CURRENT LIABILITIES		**(127,563)**	**(132,673)**
TOTAL ASSETS EMPLOYED		**476,197**	**463,286**
EQUITY			
Public dividend capital		370,289	337,558
Revaluation reserve		51,420	60,645
Other reserves		85	85
Income and expenditure reserve		54,403	64,998
TOTAL EQUITY		**476,197**	**463,286**

The notes on pages 6-40 form part of these accounts
The accounts on pages 2 to 40 were approved by the Board on 23 June 2026 and signed on its behalf by:

Maria Kane, Group Chief Executive Date: 23 June 2026

Statement of Changes in Equity for the year ended 31 March 2026

Changes in Equity in the current year	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income & Expenditure Reserve	Total Equity
	£000	£000	£000	£000	£000
Equity at 1 April 2025	**337,558**	**60,645**	**85**	**64,998**	**463,286**
Surplus/(deficit) for the year	-	-	-	(10,595)	(10,595)
Revaluation		1,403			1,403
Impairments	-	(10,628)	-	-	(10,628)
PDC Received	32,731	-	-	-	32,731
Equity at 31 March 2026	**370,289**	**51,420**	**85**	**54,403**	**476,197**

Changes in Equity in the prior year	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income & Expenditure Reserve	Total Equity
	£000	£000	£000	£000	£000
Equity at 1 April 2024	333,465	92,408	85	113,492	539,450
Surplus/(deficit) for the year	-	-	-	(48,494)	(48,494)
Revaluation		11,623			11,623
Impairments	-	(43,386)	-	-	(43,386)
PDC Received	4,093	-	-	-	4,093
Equity at 31 March 2025	**337,558**	**60,645**	**85**	**64,998**	**463,286**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

Relates to historical balances and will not move.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Changes in Cashflow for the year ended 31 March 2026

	Note	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit) from continuing operations		142	(39,102)
OPERATING SURPLUS/(DEFICIT)		**142**	**(39,102)**
NON-CASH INCOME AND EXPENDITURE			
Amortisation	9	3,454	3,306
Depreciation	10 & 10.1	41,363	40,500
Net impairments	8.3	13,879	47,665
Income recognised in respect of capital donations		(818)	(1,967)
(Increase)/decrease in trade and other receivables	12.1 & 12.2	(1,849)	11,578
(Increase)/decrease in inventories	11	260	(1,990)
Increase/(decrease) in trade and other payables	15	9,243	(21,289)
Increase/(decrease) in other liabilities	16	(1,282)	505
Increase/(decrease) in provisions	18	986	(1,374)
NET CASH GENERATED FROM OPERATIONS		**65,378**	**37,832**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		3,765	5,587
Purchase of property, plant and equipment		(74,742)	(44,611)
Purchase of intangible assets		(231)	(845)
Receipt of cash donations to purchase capital assets		818	1,967
NET CASH USED IN INVESTING ACTIVITIES		**(70,390)**	**(37,902)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		32,731	4,093
Loans repaid to DHSC	17.4	(5,834)	(5,834)
Capital element of lease liability repayments	17.4	(7,559)	(7,181)
Interest paid	17.4	(1,162)	(1,369)
Interest element of lease liability repayments	17.4	(1,529)	(1,388)
PDC dividend paid		(10,837)	(12,679)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**5,810**	**(24,358)**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**798**	**(24,428)**
CASH AND CASH EQUIVALENTS AT START OF YEAR	14	**72,295**	**96,723**
CASH AND CASH EQUIVALENTS AT END OF YEAR	14	**73,093**	**72,295**

The accompanying notes form part of these financial statements.

1. Accounting policies

1.1 Basis of preparation

NHS England, in exercising its statutory functions, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual (FReM), defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Income

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulation which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The timing of satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms).

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under–Best Practice Tariff (BPT) schemes. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as a variable consideration under IFRS 15.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that when treatment has been given, it receives notification that the Department for Work and Pension's Compensation Recovery Unit has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though it were a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and are measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be provided to the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs, and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets that are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or corporate functions) are measured at their current value in existing use. Assets that are surplus with no plan to bring them back into use are measured at fair value, where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from

those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income.'

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of: (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Asset Type	Min Life Years	Max Life Years
Buildings excl. dwellings	7	48
Dwellings	13	22
Plant and machinery (incl. medical equipment)	1	31
Transport equipment	1	5
Information technology	1	11
Furniture and fittings	1	10

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software, which is integral to the operation of hardware, for example, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the operation of hardware, for example, application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying values of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Asset Type	Minimum Life Years	Maximum Life Years
Software (purchased)	1	9

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

There are no material differences between amortised costs and net book values of financial assets and liabilities. As a result, all financial assets and liabilities are held at net book value.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities measured at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method, less any impairment (for financial assets). The effective interest rate is the rate that discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of the financial asset or amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective

interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for

current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

Expected cash outflows	Years	HMT nominal rate	
		2025/26	2024/25
Short-term	Up to 5	3.64%	4.03%
Medium-term	> 5 to 10	4.22%	4.07%
Long-term	> 10 to 40	5.32%	4.81%
Very long-term	>40	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

Year	HMT inflation rate	
	2025/26	2024/25
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.95% in real terms (prior year: 2.40%.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution and in return all clinical negligence claims are settled. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims

arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets but would be disclosed in note 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but disclosed in note 20.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to and require repayments of PDC from the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation tax

The Trust has assessed that it has no liabilities (£nil prior year) for corporation tax under the activities for which tax may be payable as described below:

- if activity is not related to the provision of core healthcare as defined under the Health and Social Care Act. (Private healthcare falls under this legislation and is therefore not taxable).
- If activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax;

1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Trust has no assets or liabilities denominated in a foreign currency at the Statement of Financial Position date, nor any exchange gains or losses on monetary items.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 23 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are managed. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note 24 is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Transfers of functions to/from other NHS bodies

For functions that have been transferred to the Trust from another NHS government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

The net gain / (loss) corresponding to the net assets/ (liabilities) transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been subject to early adoption in 2025/26.

1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

Standards and Interpretations	Explanation
IFRS 18 Presentation and Disclosure in Financial Statements -	The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed
IFRS 19 Subsidiaries without Public Accountability: Disclosures	The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £357,922k as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £355,014m at 31 March 2026. This is expected to have a material impact on the value of property assets but is not possible to quantify the impact at this time.

1.26 Critical accounting estimates and judgements

Estimates and judgments are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

a) Depreciation

Depreciation is based on automatic calculations within the Trust's Fixed Asset Register and is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc.). Buildings can be assigned a useful economic life of up to 50 years by the Trust's approved Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required, for example following an external valuation by the Trust's approved Valuer This estimate will consider past experience. Typically, more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

The value of depreciation in the accounts is identified in note 10.

b) Revaluation

The Trust's assets are subject to a 5-year cycle of revaluations by the Trust's approved Valuer. In the interim years, the Trust's assets are revalued using desktop revaluations undertaken by the Valuation Office. The Valuation Office is an expert therefore there is a high degree of reliance on the Valuer's expertise.

Specialised assets and attached land are valued on a depreciated replacement cost basis using hypothetical modern equivalent assets (MEA). An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

In arriving at the valuation, the Valuer has used the RICS Building Costs Information Service 'All in' Tender Price Index (TPI), together with a Location Factor. The indices for March 2025 and March 2026 are shown below.

Index	March 2025	March 2026	% Movement
TPI	399.00	410.00	2.8%
Location Factor	1.00	0.97	-3.0%
Combined Index	**399.00**	**397.70**	**-0.3%**

A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality of the estimation uncertainty implicit in the valuation.

A high-level sensitivity analysis of the assumptions applied to the March 2026 valuation of £357,922k demonstrates that a further 2.5% movement in the TPI or location factor would not result in a material impact to the valuation.

Index	March 2026	+2.5% sensitivity	Impact on valuation
TPI	410.00	420.00	
Location Factor	0.97	0.99	
Combined Index	**397.70**	**415.80**	**+£15,088k**

Index	March 2026	-2.5% sensitivity	Impact on valuation
TPI	410.00	400.00	
Location Factor	0.97	0.95	
Combined Index	**397.70**	**380.00**	**-£14.754k**

The value of revaluations in the accounts is identified in note 10.

c) Impairment

Impairments are based on the Trust's approved Valuer's revaluation or on revaluation of individual assets e.g. when brought into operational use or identified for disposal. Estimates and judgments are used where the valuations and the assumptions used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

The value of impairments in the accounts is identified in note 8.3.

2 Segmental analysis

The Trust's healthcare segment delivers a range of healthcare services, predominantly to Integrated Care Boards and NHS England. The Trust is operationally managed through five clinical divisions, two support divisions and one business unit, all of which operate in the healthcare segment. Internally the finance, activity and performance of these areas are reported to the Trust Board. They are consolidated, as permitted by IFRS 8 paragraph 12, into Trust-wide figures for these accounts.

Expenditure and non-contract income is reported against the operational areas for management information purposes. The outturn position reported for 2025/26 is shown below with comparator figures for 2024/25.

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Corporate income	1,277,287	1,192,773
Corporate expenditure*	(30,750)	(18,456)
Divisions/functions net expenditure**		
Division of Diagnostic and Therapies	(119,045)	(109,931)
Division of Medicine	(170,500)	(161,970)
Division of Specialised Services	(211,653)	(194,312)
Division of Surgery	(230,687)	(214,494)
Division of Women's and Children's	(248,116)	(245,276)
Weston General Hospital	(62,420)	(58,795)
Facilities and Estates	(58,170)	(59,698)
Trust Services	(88,128)	(79,588)
Total division/function net expenditure	(1,188,719)	(1,124,064)
Earnings before Interest, Tax, Depreciation & Amortisation	**57,818**	**50,253**
Financing costs	(52,842)	(50,210)
Net surplus before technical adjustments reported to NHSE	**4,976**	**43**
Technical accounting adjustments		
Donations & Grants (PPE/Intangible Assets)	818	1,967
Depreciation & Amortisation - Donated	(2,510)	(2,839)
Gains /(Losses) on asset disposals - peppercorn leased	-	-
Net impact on DHSC donated consumables	-	-
Impairments	(13,879)	(47,665)
Total technical accounting adjustments	(15,571)	(48,537)
Surplus/(Deficit) for the year	**(10,595)**	**(48,494)**

* Expenditure is not attributed to a specific division or function.

**There has been an increase in expenditure in all divisions due to the nationally determined pay awards, additional costs related to industrial action and other inflationary pressures.

3. Operating income from patient care activities

All income from patient care activities related to contract income recognised in line with accounting policy 1.3.

3.1 Income by nature

	Year ended 31 March 2026 £000	*(note 4 Restated)* Year ended 31 March 2025 £000
Aligned payment & incentive (API) income - Fixed *(note 1 & 4)*	714,169	691,788
Aligned payment & incentive (API) income - Variable	277,663	224,261
Other high-cost drug and device income from commissioners	206,298	202,611
Other NHS clinical income (See significant items below) *(4)*	22,922	16,308
Private patients	1,177	1,454
Pay award central funding *(note 3)*	-	2,893
Additional pension contribution central funding *(note 2)*	50,605	48,127
Other clinical income (see significant items below)	27,372	26,938
Total	**1,300,206**	**1,214,380**

Note 1 *Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.*
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/
Note 2 *Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.*
Note 3 *Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.*
Note 4 *There is no change in total income. The comparatives for 2024/25 have been restated to reflect the correct classification of Stereotactic Radiotherapy activity of £3.730m as Other NHS income and not API – Fixed.*

Other NHS Clinical Income - Significant items include:

Low Volume Activity Block payments	8,819	6,670
Stereotactic radiotherapy	4,667	3,731
Bone Marrow Transplants and CAR- T Therapy	3,357	4,488
Cross provider charges under maternity pathways	1,165	1,132
Abortion Care Service	3,499	-

Other Clinical Income - Significant items include:

Genito-urinary medicine (Local Authorities)	4,574	8,447
Injury cost recovery	1,425	1,444
Devolved Administration clinical income	21,009	16,550

3.2 Income from patient care activities (by source)

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
NHS England *	275,930	570,500
Integrated Care Boards *	993,890	614,068
NHS Foundation Trusts	448	37
NHS Trusts	1,389	1,383
Local Authorities	4,575	8,447
Non-NHS private patients	1,177	1,454
Non-NHS overseas patients	319	438
NHS Injury Scheme	1,425	1,444
Non-NHS: other	21,053	16,609
Total	**1,300,206**	**1,214,380**

All income is from continuing operations

** From 01 April 2025 South West Specialised Commissioning was delegated from NHS England to NHS Somerset ICB.*

3.3 Income from patient care activities arising from Commissioner Requested Services

Under the terms of the provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested services and non-commissioner requested services. Commissioner requested are defined in the provider license and are services that commissioners believe would need to be protected in the event of failure. This information is provided in the table below:

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Income from services designated as commissioner requested	1,228,758	1,143,472
Income from services not designated as commissioner requested	71,448	70,908
Total	**1,300,206**	**1,214,380**

3.4 Income from overseas visitors

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Income recognised this year	319	438
For invoices raised in this and previous years:		
Cash payments received	172	166
Amounts added to provision for impairment of receivables	256	485
Amounts written off	9	73

4 Other operating income

4.1 Income by type

	Year ended 31 March 2026			Year ended 31 March 2025		
	Contract Income	Non-Contract Income	Total	Contract Income	Non-Contract Income	Total
	£000	£000	£000	£000	£000	£000
Research and development	35,561	10,166	45,727	29,548	8,452	38,000
Education and training	41,573	1,880	43,453	39,749	2,282	42,031
Non-patient care services to other bodies	18,940	-	18,940	18,811	-	18,811
Salary recharges	9,574	-	9,574	7,980	-	7,980
Receipt of capital grants and donations	-	818	818	-	1,967	1,967
Charitable and other contributions to operating expenditure	-	661	661	-	950	950
Rental income from operating leases	-	2,398	2,398	-	2,476	2,476
Other*	18,178	-	18,178	20,194	-	20,194
Total recognised operating income	**123,826**	**15,923**	**139,749**	**116,282**	**16,127**	**132,409**

All income is from continuing operations

Significant items include:

	Year ended 31 March 2026	Year ended 31 March 2025
	£000	£000
Clinical excellence awards	2,029	2,257
Trading services - MEMO	799	573
Trading services – Pharmacy	1,868	1,743
Catering	2,652	2,426
Staff accommodation rentals	480	743
Car park income	1,620	1,521
Energy income	511	1,544
Use of healthcare facilities	2,296	1,664

4.2 Additional Information on contract revenue recognised in the period

	NHS Providers	Other DHSC Group Bodies	Non-DHSC Group Bodies	Total
Year ended 31 March 2026	**£000**	**£000**	**£000**	**£000**
Revenue recognised in reported period that was included within contract liabilities at the previous period end	33	4,044	4,873	8,950
Year ended 31 March 2025				
Revenue recognised in reported period that was included within contract liabilities at the previous period end	44	4,752	5,436	10,232

4.3 Obligations

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Revenue from contracts entered into but expected to be recognised:		
- within one year	8,950	10,232
- after one year but not later than five years	-	-
- after five years	-	-

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

4.4 Lease income

This note discloses income generated in lease arrangements where the University Hospitals Bristol and Weston NHS FT is the lessor.

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Rental income – minimum lease receipts	2,398	2,476

Future minimum lease receipts due to the Trust

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
- no later than one year	2,003	1,859
- between one and two years	1,778	1,398
- between two and three years	1,569	1,155
- between three and four years	1,521	966
- between four and five years	1,268	919
- later than five years	4,895	2,467
Total	**13,034**	**8,764**

5. Operating expenses

5.1 Operating expenses by type

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Services from other bodies:		
- NHS & DHSC bodies	9,145	8,983
- non-NHS & non DHSC bodies	2,868	3,039
Purchase of healthcare from non-NHS bodies	13,056	11,987
Employee expenses excluding Board members	878,653	823,928
Employee expenses – Board members	2,170	2,183
Trust chair and non-executive directors	275	244
Supplies and services: clinical	134,245	126,299
Supplies and services: general	13,766	15,764
Drug costs	196,845	187,968
Establishment costs	21,575	20,050
Premises costs – business rates	4,357	4,256
Premises costs - other	20,429	22,783
Transport – business travel	1,046	1,474
Transport – other (including patient travel)	12,943	10,120
Depreciation on property, plant and equipment and right of use assets	41,363	40,500
Amortisation on intangible assets	3,454	3,306
Net impairments	13,879	47,665
Movement in contract credit loss allowance	3,874	(2,589)
Change in provisions discount rate	(6)	(2)
Auditor's remuneration - statutory audit	186	180
Internal audit	334	326
Clinical negligence	27,973	26,640
Legal fees	106	954
Research and development – other	9,167	7,462
Research and development – hosting payments	16,929	13,170
Education and Training	3,151	2,738
Other*	8,030	6,463
Total	**1,439,813**	**1,385,891**

Significant items include:

	£000	£000
Parking and security	921	762
Insurance	1,013	963
Apprenticeships	1,880	2,282
Childcare Vouchers	163	213
Immigration Surcharge	3	346

5.2 Other auditor remuneration and limitation of auditor's liability

There is no other non-audit service remuneration in note 5.1 for 2025/26. No other non-audit work at all was undertaken in 2025/26.

There is a limitation of liability of £138,000 in respect of external audit services unless unable to be limited by law, related to death or personal injury caused by negligence, bribery or fraud, or breach of obligation as to title implied by section 12 of the Sale of Goods Act 1979 or section 2 of the Supply of Goods and Services Act 1982.

5.3 Lease expenses

This note discloses costs and commitments incurred in lease arrangements where the University Hospitals Bristol and Weston NHS FT is the lessee.

	Year Ended 31 March 2026	Year Ended 31 March 2025
Minimum lease payments	**£000**	**£000**
Land	33	33
Buildings	8,362	7,808
Plant and machinery	693	728
Total	**9,088**	**8,569**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	8,770	8,508
Between one and five years	32,561	32,317
After five years	76,676	77,258
Total	**118,007**	**118,083**

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital. A 20-year lease was signed in March 2022, which contributes to the significant value reflected in the minimum lease payments due after five years.

6. Employee benefits

Further detail on senior manager remuneration, fair pay multiple, employee data and benefits and exit packages can be found in the Remuneration and Staff Report sections of the Annual Report.

6.1 Employee expenses

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Salaries and wages	664,387	626,675
Social security costs	86,124	67,462
Apprenticeship levy	3,241	3,122
Pension costs – employer contributions	77,223	73,545
Pension costs – employer contribution funded by NHSE	50,605	48,127
Termination benefits	935	586
Temporary staff - agency/contract staff	7,931	12,694
Gross employee expenses	**890,446**	**832,211**
Income in respect of salary recharges	(4,077)	(3,806)
Employee expenses capitalised	(5,546)	(2,294)
Net employee expenses	**880,823**	**826,111**

6.2 Retirement benefits

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years." An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 01 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

6.3 Retirements due to ill health

During the year ended 31 March 2026 there were 13 (2024/25: 7) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill health retirements are £2.301m (2024/25: £0.226m). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

7. Other Gains/Losses

The net loss on the disposal of property, plant and equipment of £0.203m (2024/25: net loss of £0.148m) related exclusively to non-protected assets. No assets used in the provision of Commissioner Requested Services have been disposed of during the year.

8. Financing

8.1 Finance income

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Interest on bank accounts	3,765	5,587
Total	**3,765**	**5,587**

8.2 Finance expenses

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Loan interest on DHSC loans	1,109	1,306
Interest on lease obligations	1,529	1,388
Total	**2,638**	**2,694**

In 2025/26, £nil (2024/25, £nil) interest was payable arising from claims made under the Late Payment of Commercial Debts (interest) Act 1998 and no other compensation was paid to cover debt recovery cost under this legislation.

8.3 Impairments

Net impairment charged to operating surplus resulting from:

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Impairment following valuation of assets brought into use	-	1,852
Changes in valuation	14,150	48,840
Reversal of impairments from change in valuation	(271)	(3,027)
Total net impairment charged to operating surplus	**13,879**	**47,665**
Net impairments charged to the revaluation reserve	9,225	31,763
Total net impairments	**23,104**	**79,428**

Property impairments occur when the carrying amounts are reviewed by the Valuation Office through formal valuation. Plant and equipment impairments are identified following an assessment of whether there is any indication that an asset may be impaired e.g. obsolescence or physical damage.

Property reviews are undertaken to ensure assets are reflected at fair value in the accounts, when they are brought into use or when they are identified as assets held for sale. At the first valuation after the asset is brought into use any write down of cost is treated as an impairment and charged into the Statement of Comprehensive Income.

The impairment losses charged to the Statement of Comprehensive Income relate to the following:

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Impairment following valuation of assets brought into use:		
Infrastructure scheme	-	1,852
Change in valuation		
Valuation Office's revaluation of land & buildings	13,879	45,813
Total	**13,879**	**47,665**

Where a revaluation increases an asset's value and reverses a revaluation loss previously recognised in operating expenses it is credited to operating expenses as a reversal of impairment and netted against any impairment charge.

9. Intangible assets

	Software Licences £000	Assets Under Construction £000	Total £000
Cost at 1 April 2025	45,439	112	45,551
Additions – purchased	231	-	231
Reclassifications with PPE	2,463	(112)	2,351
Disposals	(5,381)	-	(5,381)
Cost at 31 March 2026	**42,752**	**-**	**42,752**
Accumulated amortisation at 1 April 2025	29,229	-	29,229
Charged during the year – purchased	3,454	-	3,454
Charged during the year – donated	-	-	-
Disposals	(5,381)	-	(5,381)
Accumulated amortisation at 31 March 2026	**27,302**	**-**	**27,302**
Net book value at 31 March 2026			
Purchased	15,436	-	15,436
Donated	14	-	14
Total net book value at 31 March 2026	**15,450**	**-**	**15,450**

	Software Licences £000	Assets Under Construction £000	Total £000
Cost at 1 April 2024	43,817	110	43,927
Additions – purchased	843	2	845
Reclassifications with PPE	786	-	786
Disposals	(7)	-	(7)
Cost at 31 March 2025	**45,439**	**112**	**45,551**
Accumulated amortisation at 1 April 2024	25,930	-	25,930
Charged during the year – purchased	3,299	-	3,299
Charged during the year – donated	7	-	7
Disposals	(7)	-	(7)
Accumulated amortisation at 31 March 2025	**29,229**	**-**	**29,229**
Net book value at 31 March 2025			
Purchased	16,191	112	16,303
Donated	19	-	19
Total net book value at 31 March 2025	**16,210**	**112**	**16,322**

From 01 April 2025, the option to apply the revaluation model in IAS38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

10. Property, plant and equipment

The Valuation Office undertook a desktop valuation at the 31 March 2026 which valued the Trust's land and buildings on a depreciated replacement cost, Modern Equivalent Asset (MEA) valuation, adopting the optimised alternative asset approach. The valuation resulted in a net decrease at 31 March 2026 of £23.104m compared with the book values, with £13.879m charged to the Statement of Comprehensive Income as a net impairment and £9.225m movement to the revaluation reserve in the Statement of Financial Position.

The valuation has been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant Department of Health and Social Care Group Accounting Manual (DHSC GAM). They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation – Global Standards and RICS UK National Supplement, commonly known together as the Red Book, in so far as these are consistent with IFRS and the above-mentioned guidance; RICS VPGA1 and UKVPGA 5 refer.

The following are the agreed departures from the RICS Professional Standards and special assumptions:
It should be noted that the use of the terms 'Existing Use Value', 'Fair Value' and 'Market Value' in regard to the valuation of the NHS estate may be regarded as not inconsistent with those set out in the RICS Professional Standards, subject to the additional special assumptions that:

- no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously and in the respect of the Fair Value of 'held for sale' assets only;
- the NHS is assumed not to be in the market for the property interest; and
- regard has been had to appropriate lotting to achieve the best price.

	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction & Payments on Account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2025	8,808	357,528	2,918	38,084	138,143	1,292	40,405	1,025	588,203
Additions – purchased	-	10,857	104	56,773	7,585	74	864	-	76,257
Additions – donated	-	146	-	207	465	-	-	-	818
Impairments net	200	(23,266)	(38)	-	-	-	-	-	(23,104)
Reclassifications with intangibles	-	-	-	(2,351)	-	-		-	(2,351)
Reclassifications within PPE	-	16,931	86	(45,058)	13,935	247	13,706	153	-
Revaluations	-	(16,190)	(162)	-	-	-	-	-	(16,352)
Disposals	-	-	-	-	(14,456)	(15)	(15,342)	(641)	(30,454)
Cost or valuation at 31 March 2026	**9,008**	**346,006**	**2,908**	**47,655**	**145,672**	**1,598**	**39,633**	**537**	**593,017**
Accumulated depreciation at 1 April 2025	-	-	-	-	80,644	817	25,438	860	107,759
Charged during the year – purchased	-	16,190	162	-	11,874	149	4,422	78	32,875
Charged during the year – donated	-	-	-	-	-	-	-	-	-
Revaluations	-	(16,190)	(162)	-	-	-	-	-	(16,352)
Disposals	-	-	-	-	(14,253)	(15)	(15,342)	(641)	(30,251)
Total at 31 March 2026	-	-	-	-	**78,265**	**951**	**14,518**	**297**	**94,031**
Net book value at 31 March 2026									
Purchased	9,008	312,547	2,908	47,655	63,003	647	25,106	240	461,114
Donated	-	33,459	-	-	4,404	-	9	-	37,872
Total at 31 March 2026	**9,008**	**346,006**	**2,908**	**47,655**	**67,407**	**647**	**25,115**	**240**	**498,986**

	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction & Payments on Account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	17,765	417,791	2,715	35,135	134,100	1,385	35,380	1,019	645,290
Additions – purchased	-	4,377	14	34,453	5,028	-	114	-	43,986
Additions – donated	-	4	-	1,491	472	-	-	-	1,967
Impairments	(9,025)	(70,403)	-	-	-	-	-	-	(79,428)
Reclassifications with intangibles	-	-	-	(786)	-	-	-	-	(786)
Reclassifications within PPE	-	22,606	38	(32,209)	4,556	-	5,003	6	-
Revaluations	68	(16,847)	151	-	-	-	-	-	(16,628)
Disposals	-	-	-	-	(6,013)	(93)	(92)	-	(6,198)
Cost or valuation at 31 March 2025	**8,808**	**357,528**	**2,918**	**38,084**	**138,143**	**1,292**	**40,405**	**1,025**	**588,203**
Accumulated depreciation at 1 April 2024	-	-	-	-	75,253	772	21,249	801	98,075
Charged during the year – purchased	-	15,092	125	-	10,007	134	4,267	58	29,683
Charged during the year – donated	-	1,411	-	-	1,253	-	14	1	2,679
Revaluations	-	(16,503)	(125)	-	-	-	-	-	(16,628)
Disposals	-	-	-	-	(5,869)	(89)	(92)	-	(6,050)
Total at 31 March 2025	**-**	**-**	**-**	**-**	**80,644**	**817**	**25,438**	**860**	**107,759**
Net book value at 31 March 2025									
Purchased	8,808	325,430	2,918	36,584	53,150	475	14,951	163	442,479
Donated	-	32,098	-	1,500	4,349	0	16	2	37,965
Total at 31 March 2025	**8,808**	**357,528**	**2,918**	**38,084**	**57,499**	**475**	**14,967**	**165**	**480,444**

All land, buildings and dwellings are freehold assets

10.1 Right of use assets

The net book value of assets held under leases:

	Property (Land and Buildings)	Plant & Machinery	Total	Of which: Leased from Provider Org.	Of which: Leased from Other DHSC Group Bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	122,625	7,123	**129,748**	2,581	109,360
Additions	650	117	**767**	-	76
Remeasurements of the lease liability	7,645	(45)	**7,600**	-	2,896
Disposals/derecognition - lease termination	(645)	(69)	**(714)**	-	-
Valuation/gross cost at 31 March 2026	**130,275**	**7,126**	**137,401**	**2,581**	**112,332**
Accumulated depreciation at 1 April 2025 - brought forward	20,587	1,641	**22,228**	941	15,469
Provided during the year	7,932	556	**8,488**	314	5,833
Disposals/derecognition - lease termination	(358)	(69)	**(427)**	-	-
Accumulated depreciation at 31 March 2026	**28,161**	**2,128**	**30,289**	**1,255**	**21,302**
Net book value at 31 March 2026	**102,114**	**4,998**	**107,112**	**1,326**	**91,030**
Net book value at 01 April 2025	**102,038**	**5,482**	**107,520**	**1,640**	**93,891**

	Property (Land and Buildings)	Plant & Machinery	Total	Of which: Leased from Provider Org.	Of which: Leased from Other DHSC Group Bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	119,022	7,173	**126,195**	2,581	104,003
Additions	1,865	-	**1,865**	-	1,527
Remeasurements of the lease liability	4,321	-	**4,321**	-	4,271
Disposals/derecognition - lease termination	(2,583)	(50)	**(2,633)**	-	(441)
Valuation/gross cost at 31 March 2025	**122,625**	**7,123**	**129,748**	**2,581**	**109,360**
Accumulated depreciation at 1 April 2024 - brought forward	14,028	1,099	**15,127**	627	10,247
Provided during the year	7,546	592	**8,138**	314	5,663
Disposals/derecognition - lease termination	(987)	(50)	**(1,037)**	-	(441)
Accumulated depreciation at 31 March 2025	**20,587**	**1,641**	**22,228**	**941**	**15,469**
Net book value at 31 March 2025	**102,038**	**5,482**	**107,520**	**1,640**	**93,891**
Net book value at 01 April 2024	**104,994**	**6,074**	**111,068**	**1,954**	**93,756**

11. Inventories

Year ended 31 March 2026	Drugs	Consumables	Energy	High-cost devices	Totals
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	7,290	8,585	58	2,779	18,712
Additions	103,411	75,902	53	22,780	202,146
Consumed – recognised in expenses	(103,580)	(74,912)	-	(23,914)	(202,406)
Carrying value at 31 March 2026	**7,121**	**9,575**	**111**	**1,645**	**18,452**

Year ended 31 March 2025	Drugs	Consumables	Energy	High-cost devices	Totals
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	6,909	7,632	297	1,884	16,722
Additions	94,666	72,092	-	23,125	189,883
Consumed – recognised in expenses	(94,285)	(71,139)	(239)	(22,230)	(187,893)
Carrying value at 31 March 2025	**7,290**	**8,585**	**58**	**2,779**	**18,712**

The year-end stock balance for high-cost devices held is agreed with the Specialist Commissioners with a corresponding income balance included within deferred income.

Pharmacy inventory losses of £436k are disclosed in note 24.

12. Receivables

12.1 Non-Current Receivables

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Clinical pension tax provision reimbursement from NHS England	1,470	1,503
Total	**1,470**	**1,503**

12.2 Current Receivables

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Contract receivables	44,487	39,764
Contract receivable not yet invoiced	7,083	8,646
VAT receivable	2,266	924
Allowance for credit losses	(7,810)	(3,947)
Prepayments	8,249	7,015
Clinical pension tax provision reimbursement from NHS England	47	38
PDC dividend receivable	539	1,363
Total current receivables	**54,861**	**53,803**
Of which receivable from NHSE and group bodies	31,577	28,924

12.3 Allowance for credit losses

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Allowance as at 1 April	**3,947**	**6,536**
New allowances arising	6,701	1,421
Utilisation of allowance	(11)	-
Reversals of allowances	(2,827)	(4,010)
Balance at 31 March	**7,810**	**3,947**

13. Other financial assets

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Other receivables	104	104
Total	**104**	**104**

This relates to a section 106 deposit paid to Bristol City Council.

14. Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Balance at 1 April	72,295	96,723
Net change in year	798	(24,428)
Balance at 31 March	**73,093**	**72,295**
Broken down into:		
Cash with the government banking service	72,579	71,973
Commercial bank and cash in hand	514	322
Total cash and cash equivalents	**73,093**	**72,295**

15. Trade and other payables

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Current amounts:		
Trade payables	43,749	36,129
Accruals	53,993	54,963
Tax and social security	18,496	16,442
Pension contribution payable	10,478	9,987
Annual leave accrual	2,835	2,787
Subtotal	**129,551**	**120,308**
Capital payables	12,805	10,472
Total	**142,356**	**130,780**
Of which receivable from NHSE and group bodies	10,968	14,230

There are no non-current trade and other payables in either year.

Outstanding pension contributions of £10.470m (2024/25: £9.979m) to the NHS Pension scheme and £0.008m (2024/25: £0.008m) for National Employment Savings Trust (NEST) local pensions. PAYE of £9.283m (2024/25: £8.796m) and £9.213m National Insurance (2024/25: £7.646m) are included in tax and social security.

16. Other liabilities

	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Current liabilities:		
Deferred income – contract liabilities	8,950	10,232
Total	**8,950**	**10,232**

17 Borrowings

17.1 Borrowings split

Current borrowings:	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Capital loans from Department of Health and Social Care	6,121	6,174
Lease liabilities	7,503	7,194
Total	**13,624**	**13,368**
Non-current borrowings:		
Capital loans from Department of Health and Social Care	23,751	29,585
Lease liabilities	101,215	101,003
Total	**124,966**	**130,588**

17.2 Borrowing rates and repayments

The Trust has three loans with the Department of Health and Social Care for the capital investment purposes.

Amount borrowed	Interest Rate	Final repayment date
£20m	2.65%	June 2029
£70m	3.71%	June 2031
£5m	1.73%	March 2032

Payable:	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000
Before one year	5,834	5,834
Between one and five years	21,360	22,692
After five years	2,391	6,894
Net obligation	**29,585**	**35,420**

17.3 IFRS16 Lease obligations

Future lease obligations due under lease agreements where the Trust is the lessee.

Payable:	Year ended 31 March 2026 £000	Of which leased from NHS bodies Year ended 31 March 2026 £000
Before one year	8,770	6,672
Between one and five years	32,561	26,499
After five years	76,676	68,083
Sub-total	**118,007**	**101,254**
Less finance charges allocated to future years	(9,289)	(7,283)
Net lease liabilities	**108,718**	**93,971**
Of which:		
Leased from other NHS providers		1,351
Leased from other DHSC group bodies		92,620

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital. A 20-year lease, signed in March 2022, contributes to the significant value reflected in the minimum lease payments due after five years.

	Year ended 31 March 2025	Of which leased from NHS bodies Year ended 31 March 2025
Payable:	**£000**	**£000**
Before one year	8,508	6,541
Between one and five years	32,317	25,800
After five years	77,258	72,489
Sub-total	**118,083**	**104,830**
Less finance charges allocated to future years	(9,886)	(8,058)
Net lease liabilities	**108,197**	**96,772**
Of which:		
Leased from other NHS providers		1,663
Leased from other DHSC group bodies		95,109

17.4 Reconciliation of liabilities arising from financing activities

	DHSC Loans	Lease liability	Total
Year ended 31 March 2026	**£000**	**£000**	**£000**
Carrying Value at 01 April 2025	35,759	108,197	143,956
Cash Movements			
Principal	(5,834)	(7,559)	(13,393)
Interest	(1,162)	(1,529)	(2,691)
Non-Cash Movements			
Additions	-	767	767
Lease liability remeasurements	-	7,600	7,600
Interest Charge arising in year	1,109	1,529	2,638
Early termination	-	(287)	(287)
Carrying Value at 31 March 2026	**29,872**	**108,718**	**138,590**

	DHSC Loans	Lease liability	Total
Year ended 31 March 2025	**£000**	**£000**	**£000**
Carrying Value at 01 April 2024	41,656	110,788	152,444
Cash Movements			
Principal	(5,834)	(7,181)	(13,015)
Interest	(1,369)	(1,388)	(2,757)
Non-Cash Movements			
Additions	-	1,865	1,865
Lease Liability remeasurements	-	4,321	4,321
Interest Charge arising in year	1,306	1,388	2,694
Early termination	-	(1,596)	(1,596)
Carrying Value at 31 March 2025	**35,759**	**108,197**	**143,956**

18. Provisions

18.1 Provision for liabilities:

Year ended 31 March 2026	Clinical Pension Tax Reimbursement £000	Pension Injury Benefits £000	Pensions Early Departure £000	Legal Claims £000	Redundancy £000	Total £000
At 1 April 2025	1,541	441	221	246	-	2,449
Change in discount rate	(116)	(6)	-	-	-	(122)
Arising during the year	42	826	16	112	423	1,419
Utilised during the year	(47)	(33)	(26)	(50)	-	(156)
Reversed unused	-	(109)	(59)	(84)	-	(252)
Unwinding of discount rate	97	-	-	-	-	97
At 31 March 2026	**1,517**	**1,119**	**152**	**224**	**423**	**3,435**

Timing of economic outflow	Clinical Pension Tax Reimbursement £000	Pension Injury Benefits £000	Pensions Early Departure £000	Legal Claims £000	Redundancy £000	Total £000
Not later than one year	47	121	23	224	423	838
Between one and five years	230	465	91	-	-	786
After five years	1,240	533	38	-	-	1,811
Total	**1,517**	**1,119**	**152**	**224**	**423**	**3,435**

There are no other provisions.

Year ended 31 March 2025	Clinicians Pension Tax Reimbursement £000	Pension Injury Benefits £000	Pensions Early Departure £000	Legal Claims £000	Total £000
At 1 April 2024	1,509	1,863	236	215	3,823
Change in discount rate	(14)	(2)	-	-	(16)
Arising during the year	29	69	17	105	220
Utilised during the year	(58)	(50)	(32)	(45)	(185)
Reversed unused	-	(1,439)	-	(29)	(1,468)
Unwinding of discount rate	75	-	-	-	75
At 31 March 2025	**1,541**	**441**	**221**	**246**	**2,449**

The clinical pension tax reimbursement represent the arrangements NHS England has established where certain clinicians who incur annual allowance tax charges as a result of their continued membership of any NHS pension scheme at 31 March 2020 will be able to look to the NHS Pension Scheme to pay those tax charges under the Scheme Pays arrangements and will receive additional payments in the future to compensate for any reduction in such payments.

Pension injury benefits are in respect of staff injury allowances payable to the NHS Business Services Authority (Pensions Division). Legal claims represent liabilities to third parties for the excess payable by the Trust, under the NHS Resolution Liabilities to Third Parties Scheme.

18.2 Clinical negligence

NHS Resolution has included a £348.2m provision in its accounts (2024/25: £329.9m) in respect of clinical negligence liabilities of the Trust.

19. Capital commitments

	Year Ended 31 March 2026 £000	Year Ended 31 March 2025 £000
Property, plant and equipment	25,744	3,945
Total	**25,744**	**3,945**

There are seven capital schemes with contractual commitments of more than £1m; Enterprise Network Replacement Programme *(£19.926m),* CT Scanner *(£1.429m),* Lift Replacement *(£1.172m)* and Acute Obstetric Triage *(£1.135m).*

19.1 Leases: exposure to future cash outflows not included in lease liabilities

	Leases from Other NHS Providers £000	All Other Leases £000	Total £000
Commitments for leases not yet commenced to which the Trust is contractually committed	**-**	200	**200**

20. Contingencies

The Trust has no contingent assets at 31 March 2026 (2024/25: £nil).

The Trust has no material contingent liabilities at 31 March 2026. The Trust has contingent liabilities in relation to new claims that may arise from past events under the NHS Resolution "Liability to Third Parties" and "Property Expenses" schemes however the contingent liability will be limited to the Trust's excess for each new claim.

21. Related party transactions

The University Hospitals Bristol and Weston NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006.

During the year, none of the Board members or members of the key management staff of the Trust, or parties related to them has undertaken any material transactions with the Trust. Board members have declared interests in a number of bodies. Transactions between the Trust and these bodies are shown below.

	31 March 2026 (£m)		31 March 2025 (£m)		2025/26 (£m)		2024/25 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust	0.26	0.23	0.26	0.12	1.49	0.98	1.32	0.99
Bristol City Council	0.89	0.36	0.84	0.02	5.21	0.09	8.85	1.83
CHKS Ltd	-	-	-	0.07	-	0.11	-	-
NHS Confederation	-	-	-	-	-	-	-	0.02
North Bristol NHS Trust	3.21	2.44	2.22	3.59	13.20	22.08	10.21	21.80
Royal College of Physicians	-	-			-	0.03	-	-
St Peter's Hospice	0.03	-	0.08	-	0.2	0.01	0.19	0.01
Swansea University	-	-	-	-	-	0.01	-	0.01
Torbay and South Devon NHS FT	0.31	0.08	0.29	0.06	0.54	0.39	0.48	0.44
University of Bristol	0.75	0.38	0.35	1.33	3.29	12.42	3.30	9.14
University of Gloucestershire	-	-	-	-	-	-	-	0.01
University of Nottingham	-	-	-	-	-	-	-	0.01
University of the West of England	0.11	0.06	0.04	0.04	0.70	0.62	0.72	1.13
Associated Charities	See notes below							

All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and Social Care and its associated departments. Such bodies where an income or expenditure, or outstanding balances as at 31 March, exceeds £5m are listed below.

	31 March 2026 (£m)		31 March 2025 (£m)		2025/26 (£m)		2024/25 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol City Council	0.89	0.36	0.84	0.20	5.21	0.09	8.85	1.83
Community Health Partnerships	-	0.61	0.37	0.74	-	7.09	-	6.98
Department for Work and Pensions	-	-	-	9.98	-	-	-	0.15
Department of Health and Social Care	0.02	-	1.12	0.40	37.45	-	30.98	0.28
HM Revenue & Customs	-	18.50	0.92	16.44	-	89.37	-	70.60
Macmillan Cancer Support	0.03	-	0.03	-	0.18	-	0.41	-
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	0.94	0.08	0.46	0.05	21.40	-	20.93	-
NHS Blood and Transplant	0.06	1.57	-	1.34	0.20	8.49	0.23	9.04
NHS Bristol, North Somerset and South Gloucestershire ICB	8.9	0.15	6.11	0.69	607.98	0.94	547.70	0.46
NHS England - Core (now including expenditure and payables for all regions)	2.9	3.83	0.65	7.94	41.46	0.27	42.43	0.03
NHS England - Central Specialised Commissioning Hub	5.61	-	5.22	-	44.81	-	62.21	-
NHSE South West Regional Office (including commissioning hub 14F)	0.42	-	5.98	-	181.72	-	458.38	-
NHS Gloucestershire ICB	0.01	-	0.56	0.03	6.95	0.03	5.89	-
NHS Pension Scheme	-	10.48	-	-	-	127.78	-	121.63
NHS Resolution	-	-	-	-	-	27.97	-	26.64
NHS Somerset ICB	0.57	-	0.05	0.56	340.25	-	31.24	-
North Bristol NHS Trust	3.21	2.44	2.22	3.59	13.20	22.08	10.21	21.80
UK Health Security Agency	-	-			-	5.33	-	5.44
Welsh Assembly Government	-	-	-	-			13.90	-

In addition, the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees; £137.0m in 2025/26 (£128.4m in 2024/25). The Trust pays the NHS Pension Scheme for employees' contributions which totalled £51.4m in 2025/26 (£48.4m in 2024/25).

The Trust also has transactions with charitable bodies including Bristol & Weston Hospitals Charity which is the official charity for all hospitals within the Trust and, the Grand Appeal which is the Bristol Children's Hospital Charity. The Grand Appeal charities is independently managed by a board of trustees and is not consolidated within the Trust's accounts. The transactions are as follows:

	31 March 2026 (£m)		31 March 2025 (£m)		2025/26 (£m)		2024/25 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol & Weston Hospitals Charity (formally Above and Beyond)	0.41	0.34	0.23	0.01	0.76	0.08	0.53	0.01
Grand Appeal	0.21	-	0.21	-	0.16	-	0.52	-

22. Financial Instruments

22.1 Financial risk management

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), credit risk and liquidity risk. Risk management is conducted by the Trust's Treasury Management Department under policies approved by Trust Board.

a) Market Risk and Foreign Exchange Risk

As the Trust does not deal in currencies, invest in cash over the long term, borrow at variable rate or hold any equity investment in companies its exposure to market risk (either interest rate, currency, or price) is limited.

Market risk is managed by limiting investments to fixed rate and fixed term with credit worthy institutions, based upon market knowledge as to the likely movements in interest rates.

All financial assets and liabilities are recorded in sterling. Therefore, the Trust has no exposure to foreign exchange risk.

b) Credit Risk

Credit risk arises from cash and cash equivalents and deposits with financial institutions, as well as outstanding receivables and committed transactions. The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. This means that there is little risk that one party will fail to discharge its obligation with the other. However, disputes can arise, around how amounts are calculated. For financial institutions, only independently rated parties with a minimum rating (Moody) of P-1 and A1 for short-term and long-term respectively are accepted.

c) Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with local Integrated Care Boards, which are financed from resources voted annually by Parliament. Therefore, the Trust has little exposure to liquidity risk.

22.2 Carrying Value of Financial assets by category

	31 March 2026	31 March 2025
	£000	£000
Receivables with DHSC group bodies	32,293	29,053
Receivables with other bodies	12,937	16,951
Other financial assets	104	104
Cash and cash equivalents	73,093	72,295
Total	**118,427**	**118,403**

There are no material differences between amortised costs and net book value of the above financial assets. As a result, all financial assets are held at net book value.

22.3 Carrying Value of Financial liabilities by category

	31 March 2026	31 March 2025
	£000	£000
DHSC Loans	29,872	35,759
Obligation under leases	108,718	108,197
Trade and other payables with DHSC group bodies	9,403	12,895
Trade and other payables with other bodies	101,144	88,669
Total	**249,137**	**245,520**

There are no material differences between amortised costs and net book value of the above financial liabilities. As a result, all financial liabilities are held at net book value.

Maturity of financial liabilities based on undiscounted flows

	31 March 2026	31 March 2025
	£000	£000
Less than one year	126,119	117,069
In more than one year but not more than five years	55,848	57,699
In more than five years	79,114	84,402
Total	**261,081**	**259,170**

22.4 Fair values

The carrying value of the financial liabilities is considered to be approximate to fair value as the arrangement is of a fixed interest and equal instalment repayment nature and the interest rate is not materially different to the discount rate. The carrying value of short-term financial assets and financial liabilities are considered to be approximate to fair value.

23. Third party assets

At 31 March 2026, the Trust held £nil (31 March 2025: £nil) cash and cash equivalents relating to third parties.

24. Losses and special payments

Losses and special payments were made during the year as follows:

	2025/26		2024/25	
	No.	£000	No.	£000
Cash losses	1	1	52	9
Bad debts and claims abandoned	198	68	257	100
Damage to buildings, property etc.	4	436	5	655
Ex gratia payments	52	24	74	38
Total	**255**	**529**	**388**	**802**

The amounts reported are prepared on an accruals basis and exclude provisions for future losses.

25. Post Statement of Financial Position events

In June 2026, the Boards of University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust approved the acquisition of North Bristol NHS Trust by University Hospitals Bristol and Weston NHS Foundation Trust.

Regulatory approvals were subsequently obtained, with NHS England approval granted on 4 June 2026, followed by approval from the Secretary of State on 5 June 2026. A Grant of Application was issued on 17 June 2026.

Completion of the transaction is scheduled for 1 July 2026, at which point the services, staff, assets and liabilities of North Bristol NHS Trust will transfer to University Hospitals Bristol and Weston NHS Foundation Trust. Following completion, the enlarged organisation will be renamed Bristol NHS Foundation Trust, and North Bristol NHS Trust will cease to exist as a separate legal entity.

The Trust has assessed this event as a non-adjusting post balance sheet event. Accordingly, there is no impact on the amounts recognised in these financial statements.

Appendix D – Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of University Hospitals Bristol and Weston NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population.
- For a selection of cash payments and expenditure transactions in the period pre 31 March 2026, verifying that the expenditure had been recognised in the correct accounting period to which the expenditure related.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We did not identify any laws and regulations that are likely to have a material impact on the financial statements recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with laws and regulations to enquiry of the Accounting Officer and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 108, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 115, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

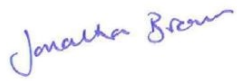
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March

2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of University Hospitals Bristol and Weston NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Jonathan Brown

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

25 June 2026