BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 31 July 2025
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB074/25	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB075/25	**Bolton System of Care Accreditation (BoSCA) Platinum Application – Critical Care Unit** ***Purpose:*** *To **approve** the BoSCA application*	*Verbal*	CNO	
TB076/25	**Patient and Staff Story** ***Purpose:*** *To **receive** the patient and staff story*	*Presentation*	Chair	
TB077/25	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB078/25	**Minutes of the previous meeting held on 29 May 2025** ***Purpose:*** *To **approve** the minutes of the previous meetings*	*Report*	Chair	
TB079/25	**Matters Arising and Action Logs** ***Purpose:*** *To consider matters arising not included on the agenda, review outstanding and approve completed actions.*	*Report*	Chair	
WELL LED FRAMEWORK				
TB080/25	**Chair's Report** ***Purpose:*** *To **receive** the Chair's Report.*	*Verbal*	*Chair*	**13:20** (10 mins)
TB081/25	**Consent Agenda** ***a. Complaint, Concerns and Compliments Annual Report*** ***Purpose:*** *To **approve** the Complaints Annual Report*	*Report*		**13:30**
TB082/25	**Chief Executive's Report** ***Purpose:*** *To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)

TB083/25	**Board Assurance Framework** ***Purpose:*** *To* ***approve*** *the Board Assurance Framework.*	*Report*	*DCG*	**13:40** (10 mins)

IMPROVING CARE, TRANSFORMING LIVES

TB084/25	**Integrated Performance Report** ***Purpose:*** *To* ***receive*** *the Integrated Performance Report.*	*Report*	*Exec Directors*	**13:50** (20 mins)
TB085/25	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.*	*Verbal*	*QAC Chair*	**14:10** (05 mins)
TB086/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** ***Purpose:*** *To* ***receive*** *the CNST Maternity Incentive Scheme Report.*	*Report*	*CNO + Director of Midwifery*	**14:15** (05 mins)

A GREAT PLACE TO WORK

TB087/25	**People Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*PC Chair*	**14:20** (05 mins)
TB088/25	**Our Leaders Programme and Culture Update** ***Purpose:*** *To* ***receive*** *the Our Leaders Programme and Culture Update.*	*Report*	*CoP*	**14:25** (20 mins)
	COMFORT BREAK (10 mins)			**14:45**

A HIGH PERFORMING PRODUCTIVE ORGANISATION

TB89/25	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*F&I Chair*	**14:55** (05 mins)
TB90/25	**Audit and Risk Committee Chair's Report** **a) Audit and Risk Committee Annual Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee and approve the Audit and Risk Committee Annual Report*	*Report*	*ARC Chair*	**15:00** (05 mins)

TB091/25	**Charitable Funds Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*CFC Chair*	**15:05** (05 mins)

AN ORGANISATION THAT'S FIT FOR THE FUTURE

TB092/25	**Health and Safety Annual Report 2024/25** ***Purpose:*** *To* ***approve*** *the Health and Safety Annual Report 2024/25.*	*Report*	*CNO*	**15:10** (10 mins)
TB093/25	**Green Plan** ***Purpose:*** *To* ***approve*** *the Green Plan*	*Report*	*CFO*	**15:20** (10 mins)

A POSITIVE PARTNER

TB094/25	**Bolton 2040 Borough Plan** ***Purpose:*** *To receive the Bolton 2024 Borough Plan.*	*Presentation*	*CoSP*	**15:30** (15 mins)
TB095/25	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:45** (05 mins)
TB096/25	**Feedback from Board Walkabouts** ***Purpose:*** *To* ***receive*** *feedback following walkabouts.*	*Verbal*	*Members*	**15:50** (05 mins)

CONCLUDING BUSINESS

TB097/25	**Messages from the Board** ***Purpose****: To agree messages to be shared with all staff.*	*Verbal*	*Chair*	**15:55** (02 mins)
TB098/25	**Any Other Business** ***Purpose:*** *To* ***receive*** *any urgent business not included on the agenda*	*Report*	*Chair*	**15:57** (03 mins)
	Date and time of next meeting: • Thursday 25 September 2025			***16:00*** ***Close***

Chair: Martin North

Report Title:	Bolton System of Care Accreditation (BoSCA) Platinum Application – Critical Care Unit			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	The purpose of this Briefing Paper is to outline the Critical Care Unit's application for Platinum status under the Bolton System of Care Accreditation (BoSCA).

Previously considered by:	N/A

Executive Summary	The Bolton System of Care Accreditation awards services assessed White, Bronze, Silver or Gold status dependent of overall BoSCA score. Areas that have achieved two consecutive Gold status can apply for Platinum status. The Critical Care Unit is applying for Platinum status under the Bolton System of Care Accreditation (BoSCA), having achieved two consecutive Gold ratings in October 2023 and November 2024. This application follows a 12-month Quality Improvement Project aimed at reducing direct discharges home by 30% and achieving 100% safe discharges, aligning with Trust objectives on Safety, Effectiveness, and Patient experience. The Platinum application includes a declaration of sustained Gold BoSCA status and comprehensive portfolio of evidence outlining their 12-month Quality Improvement project. Showcase presentation to a multidisciplinary panel The panel assesses the unit's alignment with CQC domains - Safe, Effective, Caring, Well-led, and Responsive - through documentation review, service workarounds, and staff/patient engagement. The Critical Care Unit demonstrates a strong commitment to patient-centred care, staff development, and continuous improvement. Strong leadership and a culture of continuous improvement. High levels of staff and patient satisfaction. Providing Innovative discharge practices and holistic care with cohesive,

	motivated, and reflective team dynamics. Providing additional evidence supporting their BoSCA Gold quality improvement project.

Proposed Resolution	The Board of Directors is asked to ***approve*** the award of Platinum status, following positive feedback and endorsement from the BoSCA Platinum Showcase Panel.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Brenda Mason, (BoSCA) Quality Improvement Lead	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Report Title:	Bolton System of Care Accreditation (BoSCA) Platinum Application – Community Nursing Service (central north neighbourhood)			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	The purpose of this briefing paper is to outline the Community Nursing Service (Central North Neighbourhood) application for Platinum status under the Bolton System of Care Accreditation (BoSCA).

Previously considered by:	N/A

Executive Summary	The Bolton System of Care Accreditation (BoSCA) awards services White, Bronze, Silver, or Gold status based on overall scores. Areas achieving two consecutive Gold ratings are eligible to apply for Platinum. Community Nursing Services (Central North Neighbourhood) is applying for Platinum status, having achieved Gold in July 2022 and July 2023. This application follows a 12-month Quality Improvement (QI) project aimed at ensuring 100% of applicable patients receive consistent discharge information, reducing inappropriate referrals and improving patient experience. The submission includes a declaration of sustained Gold standards, a detailed QI portfolio, and a showcase presentation to a multidisciplinary panel. The panel assessed alignment with CQC domains—Safe, Effective, Caring, Well-led, and Responsive—via documentation, service walk rounds, and staff engagement. Key strengths include Mini BoSCA self-reviews, structured coaching for new starters, and a strong culture of continuous improvement. The team demonstrated data-driven decision-making, patient engagement, and consistent implementation of the BoSCA Gold QI project across all District

	Nursing neighbourhood teams. Their leadership in quality improvement and patient-centred care is commendable.

Proposed Resolution	The Board of Directors is asked to ***approve*** the award of Platinum status, following positive feedback and endorsement from the BoSCA Platinum Showcase Panel.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Brenda Mason, (BoSCA) Quality Improvement Lead	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Name:	Position:	Interest Declared	Type of Interest
Francis **Andrews**	Medical Director	Chair of Prescot Endowed School Eccleston (Endowment charity)	Non-Financial Personal Interest
Seth **Crofts**	Non-Executive Director	External Academic, Appointed Representative, The Open University, Academic Quality and Governance Committee	Non-Financial Professional interest
Rebecca **Ganz**	Non-Executive Director	Growth Catalyzers Ltd Director/Owner	Financial Interest
		Leodis Multi Academy Trust Trustee and NED	Financial Interest
		BlueSkeye AI Ltd - NED	Financial Interest
		Director BerDor Limited	Financial Interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Adviser, Private Public Limited	Financial Interest
		Director, Harriss Interim and Advisory	Financial Interest
		Family member works for Astra Zeneca	Non-Financial Personal Interest
		Non-Executive Director Borough Care	Financial Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	
James **Mawrey**	Chief People Officer / Deputy CEO	Nil Declaration	

Name:	Position:	Interest Declared	Type of Interest
Fiona **Noden**	Chief Executive	Trustee Bolton Community and Voluntary Services	Non-Financial Professional Interest
		Bolton Locality Place Based Lead	Non-Financial Professional Interest
		Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity & Neonatal System (LMNS).	Non-Financial Professional Interest
Martin **North**	Non-Executive Director	Spouse is a Director of Aspire POD Ltd	Indirect Interest
		Company Secretary Aspire POD Ltd	Financial Interest
		Director MIRL Group Ltd	Financial Interest
		Egerton Pre School Committee Chair	Non-Financial Personal Interest
Niruban **Ratnarajah**	Chair	GP Partner: Stonehill Medical Centre	Financial Interest
		Lead for GP Strategy and Placements at the University of Bolton	Financial Interest
		Director of Ratnarajah Holdings Limited	Financial Interest
		Director of Ratnarajah Medical Services Limited	Financial Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
Alan **Stuttard**	Non-Executive Director	Nothing to declare	
Fiona **Taylor**	Non-Executive Director	Chair of Governors St Georges CE Primary & Nursery School	Non-Financial Personal Interest
		Trustee St Ann's Hospice	Non-Financial Personal Interest

Name:	Position:	Interest Declared	Type of Interest
		Trustee Women for Well Women (Leigh)	Non-Financial Personal Interest
Annette **Walker**	Chief Finance Officer	Chief Finance Officer of both Bolton Foundation Trusts and GM ICP Bolton	Non-Financial Professional Interest
Rae **Wheatcroft**	Chief Operating Officer	Nothing to declare	
Sharon **White**	Chief of Strategy and Partnerships	Trustee George House Trust	Non-Financial Professional Interest
		Board Member of Bolton College	Non-Financial Professional Interest
		Partner employed by Trust	Non-Financial Personal Interest

GUIDANCE NOTES ON DECLARING INTERESTS

The Board believes that interests should be declared if they are material and relevant to the business of the Board and should, in any case, include:

- Directorship, including non-executive directorships held in private companies or private limited companies
- Ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for services with NHS services.

NB If there is any doubt as to the relevance of an interest, this should be discussed with the Trust Chair.

Types of Interests:

a) Financial Interest
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making;

b) **Non-Financial professional interest**
Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making;

c) **Non-financial personal interest**
Where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of the decisions they are involved in making; and

d) **Indirect Interests**
Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

Draft Minutes of the Board of Directors Meeting

Held in Boardroom

Thursday 29 May 2025

Subject to the approval of the Board of Directors Meeting on Thursday 31 July 2025

Present

Name		Initials	Title
Ratnarajah	Niruban	NR	Chair
Andrews	Francis	FA	Medical Director
Crofts	Seth	SC	Non-Executive Director
Ganz	Rebecca	RG	Non-Executive Director
Katema	Sharon	SK	Director of Corporate Governance
Mawrey	James	JM	Chief of People/Deputy Chief Executive
Noden	Fiona	FN	Chief Executive
North	Martin	MN	Non-Executive Director and Deputy Chair
Roberts	Tyrone	TR	Chief Nursing Officer
Stuttard	Alan	AS	Non-Executive Director
Taylor	Fiona	FLT	Non-Executive Director
Walker	Annette	AW	Chief Finance Officer
Wheatcroft	Rae	RW	Chief Operating Officer
White	Sharon	SW	Chief of Strategy and Partnerships

In Attendance

Carter	Rachel	RC	Associate Director of Communications and Engagement
Crompton	Victoria	VC	Corporate Governance Manager
Cotton	Janet	JC	Director of Midwifery (for item 59 and 60)
Garde	Tracy	TG	Freedom to Speak Up Guardian (for item 64)
Walmsley	Brett	BW	Director of Digital and Data Services (for item 68)
Wildman	Mel	MW	Assistant Divisional Nurse Director Family Care Division (for item 49)

Apologies

Harriss	Sean	SH	Non-Executive Director

There were eight observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
TB048/25	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting and apologies for absence were as noted above.	

TB49/25 **Patient and Staff Story**

The Chief Nurse introduced the patient story of Leanne, who had previously been a surrogate at another Trust and detailed her first experience at the Trust. The community midwives facilitated a connection between Leanne and Mel Wildman, Assistant Divisional Nurse Director, who met with her several times to develop a birth plan. The Legal Team was actively involved to ensure full legal compliance, particularly around the birth process and the baby's discharge to the intended parents in the event that Leanne had to remain in the hospital. As part of this process, The Surrogate Policy was also reviewed and updated accordingly.

A few challenges arose during the planning. One concern was that, in the event of a Caesarean section, only one person was typically allowed in the operating room. It was agreed the baby's mother would accompany Leanne, but this was not ideal, as the father would miss the birth of his child. Additionally, Leanne wanted her own husband present for support. After discussions, a plan was put in place, though it was dependent on available theatre space to accommodate the additional people.

Leanne had also expressed that she preferred to be called by her name, but was on occasion referred to as "mum". Despite the challenges, Leanne noted her experience at Bolton was more positive compared to other hospitals.

FA highlighted the broader learning opportunity regarding how Leanne was addressed and asked what steps could be taken to improve this. MW emphasised the importance of meeting with pregnant women as early as possible to begin those conversations and noted that such information should be documented.

NR queried whether it was standard practice for the senior team to engage with each surrogate mother. MW replied that whilst she was passionate about this issue, she did not want each surrogate mother to come to her directly. Instead, she aimed to empower the team and serve as a role model for them in handling such situations.

RESOLVED:
The Board of Directors ***received*** the Patient and Staff Story.

TB050/25 **Declaration of Interests Concerning Agenda Items**

The Board noted FN's ongoing declaration as Chair of Greater Manchester Maternity and Neonatal System Board GMEC Local Maternity and Neonatal System (LMNS) with regards to the CNST paper. The declaration was noted on the register.

RESOLVED:
The Board of Directors ***received*** the Declarations of Interest.

TB051/25 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 27 March 2025, and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 27 March 2025.

TB052/25 Matters Arising and Action Logs

The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions.

RESOLVED:
The Board of Directors ***approved*** the action log.

TB053/25 Chair's Update

The Chair took a moment to express gratitude from the Board to all colleagues' for their dedication and hard work, particularly in light of the ongoing challenges which were being faced by the organisation.

RESOLVED:
The Board of Directors ***received*** the Chair's Update.

TB054/25 Register of Interests, Gifts and Hospitality

The Director of Corporate Governance presented the Annual Register of Interests, Gifts and Hospitality Report which provided assurance of compliance with the n NHS England Managing Conflicts of Interests Guidance.

RESOLVED:
The Board of Directors ***received*** the Register of Interests.

TB055/25 Chief Executive's Report

The Chief Executive presented her report, which summarised activities, awards and achievements since the last Board meeting. The following key points were noted:

- The Endoscopy service was recognised for providing high quality consistent care to patients. The Joint Advisory Group (JAG) completed an annual assessment and awarded accreditation until April 2026.
- Artificial Intelligence (AI) technology was deployed to speed up the diagnosis of skin cancer and free up capacity within the Dermatology Service. The benefits of the technology included reduced caseloads for dermatologists and fast-tracking patients with suspected malignant or premalignant lesions.
- The Intravenous (IV) Therapy Team were finalists in the Green Initiative of the Year category for their work to provide care to some patients in their own home environment using elastomeric devices. The devices allowed nurses to only visit patients once a day, instead of three to four times per day.

AS commented that it was important to recognise the amount of excellent work which was being completed across the Trust.

RESOLVED:
The Board of Directors ***received*** the Chief Executive's Report.

TB056/25 Annual Governance Declaration

The Director of Corporate Governance presented the annual governance declarations including the following:

a) **Anti-Slavery and Human Trafficking Statement** for 2024/25 which provided assurance on the Trust's compliance with the Modern Slavery Act 2015.

RESOLVED:
The Board of Directors ***approved*** the Anti-Slavery Statement.

b) **The Fit and Proper Person Test (FPPT)** Report which provided an overview of the FPPT requirements and confirmed full compliance ahead of submission of the annual declaration to the regional team.

RESOLVED:
The Board of Directors ***received*** the Fit and Proper Person Test (FPPT Report)

c) **Compliance with the NHS Provider Licence** – the Trust was required to carry out self-certification as assurance that the organisation complied with the NHS Provider Licence Continuity of Services 7 (CoS 7) – availability of Resources. Where the Trust was not compliant, it was required to explain why and develop an action plan to achieve compliance. The report provided contextual

information and sources of assurance with regards to the Annual Trust Self-Certification against the NHS Provider Licence.

RESOLVED:
The Board of Directors ***approved*** the NHS Self Certification as assurance of compliance with the NHS Provider Licence CoS 7 – Availability of Resources.

d) **Compliance with the FT Code of Governance** – The Code comprised several provisions, some of which operated on a 'comply or explain' basis. In the latest review of compliance, the Trust met all mandatory provisions. However, one caveat remained: the requirement for an external review of Board effectiveness. Although originally scheduled for 2024, the review had been deferred to 2025. As a result, the area had been marked as Partially Compliant.

RESOLVED:
The Board of Directors ***received*** the Trust Compliance against the FT Code and ***approved*** the proposed declarations.

TB057/25 Integrated Performance Report

The Chief Operating Officer reported on the Trust's operational performance during the last financial year and in April 2025. She shared a presentation to outline the organisations improvement journey and the impact the continuous improvement methodology had on a number of areas.

- The Trust did not meet the Emergency Department (ED) performance target, however it was 10% better than last March.
- Whilst the Emergency Department (ED) target was 10% better than March 2024, the Trust did not meet the performance target of 72%.
- ED attendances remained within normal variation however the department saw almost 800 more patients in April 2025 compared to April 2024. Despite increased attendances the Trust had achieved 66.3% performance.
- The Trust was the second most improved ED in the country for this metric compared to March 2024, and as a result the national Urgent Emergency Care (UEC) team were visiting the Trust to hear about the great work the teams have done.
- The number of patients waiting more than 65 weeks remained consistent and none of those waiting were due to capacity reasons. The number of patients waiting more than a year for treatment was in special cause improvement and was in line with the operational planning submission.

- A new metric in the operating plan was to improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with each Trust expected to deliver a minimum 5% improvement. The metric would be added to the Integrated Performance Report (IPR).

Quality and Safety

The Chief Nurse and Medical Director provided a comprehensive update on quality and safety matters. The Chief Nurse advised that whilst the Trust's pressure ulcer improvement work aligned with the Pressure Ulcer Change Package, assurance remained inconsistent across Divisions and specific gaps had been identified. The findings were guiding targeted divisional improvements and the Pressure Ulcer Faculty continued to provide strategic oversight to ensure consistency and accountability.

Clostridioides Difficile (C. diff), changes had been implemented to automate isolation processes via the Electronic Patient Record (EPR) system. However, an issue had emerged which was causing isolation delays and this was now a focus.

On Maternity services, the "Booked by 12+6" metric had shown sustained improvement. The Trust was participating in the national ASAP campaign which encourages pregnant ladies to book an appointment with a midwife as early as possible in their pregnancy, and piloting the REACH pregnancy circles to enhance early antenatal care and education. This initiative also aimed to reduce stillbirth rates.

The Medical Director advised that the Martha's Rule escalation system was live across all adult inpatient areas and has been positively received. A system-wide Advance Care Planning event was held, aligning with national initiatives and focusing on neighbourhood models and virtual frailty wards. A clinically led action plan had been developed in response to the MIAA audit on deteriorating patients.

However, challenges remained. Data quality issues related to Venous Thromboembolism (VTE) risk assessment were under review, and clinical correspondence delays persist due to staffing shortages and a recruitment pause. Additionally, the Summary Hospital-level Mortality Indicator (SHMI) was being monitored, with concerns linked to coding practices rather than care quality.

Finance

The Chief Finance Officer, presented the Month 1 financial position. The Trust reported a year-to-date revenue deficit of £2.4 million, which was £0.9 million adverse to plan. Cost improvement delivery was behind by £1.4 million, and agency spending was at 2.2% of pay costs, exceeding the NHSE target of 1.5%. Capital spend was £0.5 million against a plan of £0.7 million.

Workforce

The Chief People Officer reported a reduction in sickness absence alongside a decrease in agency and bank staffing usage. The updated People Promise Plan and Our Voice Programme Phase 2 were addressing areas identified in the 2024 NHS staff survey. Turnover among unregistered clinical staff had decreased, and reductions in WTE, bank, and agency usage continued month on month.

AS raised concern regarding the 800 additional attendances in ED in April, whilst RG queried whether there had been any patient feedback following the installation of the porta-cabin for patient streaming. RW responded that the Trust has been experiencing higher volumes of patients through the Urgent Treatment Centre, which had been facilitated by the porta-cabin as it had enabled quicker patient streaming. Feedback from the Division indicated there had been no negative comments from patients. However, staff had expressed concerns regarding the porta-cabin, and the senior team were engaging with them to address any issues.

AS also addressed the matter of clinical correspondence within the Gynecology Department. FA explained the contributing factors were staff sickness, turnover, and workload. The ongoing administrative modernisation program aimed to provide support in addressing these challenges.

RG commented on the positive improvement on complaints responses and TR advised that the Chief Executive read and signed all complaint letters. However, the improvement was only common cause variation.

AS raised a query regarding the likelihood of obtaining cash support. AW confirmed that the guidance from the system was for trusts to work together collectively and that would be the initial step taken.

RESOLVED:
The Board of Directors ***received*** the Integrated Performance Report.

TB058/25 Quality Assurance Committee Chair's Report

Fiona Taylor presented the Chair's Reports from the Quality Assurance Committee meeting held on 26 March 2025; highlighting the following key points:

- Audiology Update – The Chief Operating Officer confirmed a new model, was being developed and the Director of Quality Governance advised that GM was in the early stages of reviewing Paediatric Audiology Providers. The Chair requested a detailed quality impact paper, especially for children.
- The Chief Nurse had highlighted the need for the Committee to select three Quality Account Improvement Priorities focusing on quality improvement and patient safety. The proposed and agreed priorities were:
    1. Recognition and response to deteriorating patients
    2. Releasing time to care (focus on documentation).
    3. Improving communication, especially patient involvement.
- NHS Resolution Claims Scorecard was reviewed and detailed the Trust's claims over the past decade during which the Trust received 565 claims. In 2023/24, there were 63 clinical claims.

RESOLVED:
The Board of Directors ***received*** the Quality Assurance Committee Chair's Report.

TB059/25 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report

The Director of Midwifery presented the report which provided an overview of the safety and quality programmes of work within the Maternity and Neonatal Services and ongoing work with regard to the NHS Resolution CNST year 7 Maternity Incentive Scheme (MIS). The key highlights were:

- Confirmation had been received from NHS Resolution that the CNST Year 6 submission had met the requirements of the external verification process. Details of the financial award were anticipated.
- The CNST year 7 scheme was published on 02 April 2025 and the relevant workstreams to deliver the scheme were being established.
- Ongoing monitoring of defined action plans included in the maternity incentive programme and detailed updates were provided within the report.

FLT commented that the report had been received at the Quality assurance Committee who were pleased to note the progress made.

RESOLVED:
The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

TB060/25 Nursing and Midwifery Staffing Reports

The Chief Nurse presented the bi-annual Nursing Staffing Report which provided an overview and assurance on safe nurse staffing levels. The report triangulated workforce information with patient safety measures to ensure that staffing was balanced in line with patient acuity.

The Director of Midwifery presented the Midwifery Staffing Report which highlighted the ongoing maternity workforce challenges, actions taken to mitigate risk to clinical safety, and ways to improve training compliance. Safe staffing levels were maintained during the period, in part mitigated by the ongoing closure of the Beehive and Ingleside birthing options and the reallocation of staff to alternative clinical areas to supplement staffing levels.

In response to a query from AS regarding any concerns with workforce numbers, TR confirmed that staffing, both in terms of numbers and quality were not a concern. The Trust consistently applied professional judgment to adjust staffing in accordance with official guidance.

RG raised concern regarding rostering and TR explained the current roster issues, particularly those highlighted in red, stemmed from hours either owed to staff or owed by staff to the Trust. Work was ongoing to improve the system so that the roster displayed over a longer timeframe, as it currently only shows data by month.

RESOLVED:
The Board of Directors ***received*** the Nursing and Midwifery Staffing Reports.

TB061/25 Learning from Deaths/Mortality Report

The Medical Director presented the report advising the Standard Hospital Mortality Index (SHMI) was in the 'higher than expected' range. The rise was primarily due to a national methodology change and an action plan had been developed.

It was noted that between November 2024 and January 2025, 313 deaths occurred, with 79 selected for primary review and 38 completed. Three secondary reviews were required; one had been completed with learning focused on advanced care planning. Nine secondary reviews remained outstanding from the previous quarter.

NR raised concern regarding the number of deaths, to which FA responded that Bolton typically had a higher death rate, as areas with higher deprivation tended to see more than double the number of deaths. All deaths were thoroughly reviewed by the Medical Examiners. The Medical Director was confident, based on multiple sources of information that the number of deaths was within acceptable levels.

RESOLVED:
The Board of Directors ***received*** the Learning from Deaths/Mortality Report.

TB062/25 People Committee Chair's Report

Alan Stuttard presented the Chair's Report from the People Committee meeting held on 20 May 2025; highlighting the following key points:

- NHS England Health & Wellbeing Presentation - Following an onsite visit from NHSE to showcase the Our Voice Programme, the Trust was asked to present at the North Network Event as a good practice example of how cultural improvement ultimately supported approaches to reduce absence and support wellbeing during challenging times.
- IFM Monthly People Report – the report provided oversight of the performance of workforce metrics and people projects in line with the iFM People Plan. The Committee asked that workforce plans were fully reflected in the overall Trust's plans with regard to the savings plans for 2024/25.

RESOLVED:
The Board of Directors ***received*** the People Committee Chair's Report.

TB063/25 Staff Survey Response and Our Voice Programme

The Chief People officer presented the Staff Survey Response and Our Voice Programme report which provided a summary of the results of the 2024 NHS National Staff Survey and the accompanying actions including next steps for the Our Voice Programme and the People Promise Plan.

FN commented that nine scores from the NHS Staff Survey were significantly better than the GM sector and congratulated everyone on the responses.

RESOLVED:
The Board of Directors ***received*** the Staff Survey Response and Our Voice Programme Report.

TB064/25 Freedom to Speak Up (FTSU) Annual Report

Tracey Garde, Freedom to Speak Up Guardian presented the FTSU Annual Report which provided an overview of FTSU activity in 2024/25. The report detailed themes mainly related to behaviour and leadership and work had begun on the new Our Leaders programme and relaunching the Trust Values and Behaviour Framework.

NR expressed gratitude on the work done by all involved, and queried what further work could be done with areas that did not regularly provide feedback. TG confirmed that the FTSU Guardians would be conducting walkabouts targeting areas that have not been reached previously. JM added the Trust had two excellent Freedom to Speak Up Guardians and 87 FTSU Champions, and extended his thanks to all Champions for their contributions.

FN expressed support for FTSU initiatives due to their positive impact on staff, which ultimately enabled staff to deliver the best possible patient care.

FA queried whether there were the correct number of FTSU Champions in each area. TG responded that whilst there were some gaps, efforts were underway to address this.

RESOLVED:
The Board of Directors ***received*** the Freedom to Speak Up Annual Report.

TB065/25 Guardian of Safe Working (GOSW) Hours Annual Report

The Medical Director presented the GOSW Annual Report which provided an overview of exception reporting activity from 01 April 2024 to 31 March 2025. The report contained details of the exception reports by department, grade and type with outcomes reached for the year together with activities and issues which arose during the reporting period.

RESOLVED:
The Board of Directors ***received*** the Guardian of Safe Working Hours Annual Report.

TB066/25 Finance and Investment Committee Chair's Report

Rebecca Ganz presented the Chair's report from the meeting held on 26 March and 23 April 2025, and provided a verbal update from the meeting held on 28 May 2025. The following key points were highlighted:

- The Trust had a deficit in Month one of £2.4m mainly due to Cost Improvement Programme (CIP) performance.
- Whilst there was an excess of cash in month one due to reconciling items, the underlying cash position remained challenging.
- The Trust had approached PWC for support and external scrutiny in evaluating the finance position and benchmarking against other providers.
- EPR update for Maternity, Outpatients and Community EPR Deployment - the status was much improved and training was underway In Outpatients and Community. Maternity were not in a position to agree a go live date.

RESOLVED:
The Board of Directors ***received*** the Finance and Investment Committee Chair's Report

TB067/25 Audit and Risk Committee Chair's Report

Alan Stuttard presented the Chair's Report from the meeting held on 07 May 2025. The following key points were highlighted:

- The Committee received the draft Audit and Risk Committee Annual Report and noted that the final version would be produced for the next meeting.
- The Committee received the draft Annual Accounts for 2024/25. The accounts showed the Trust had a year-end deficit of £8,9470k which after adjustments for impairments, capital donations and centrally procured inventories was an operational deficit of £5,900k. The Trust had a year-end cash balance of £10,6460k and capital expenditure of £16,7030k. The External Auditors were undertaking the audit of the accounts.
- The Committee received the draft Annual Report for 2024/25 and noted that the final Annual Report would be presented at the next meeting.

RESOLVED:
The Board of Directors ***received*** the Audit and Risk Committee Chair's Report

TB068/25 Digital Strategy Update

The Director of Digital and Data Services delivered a presentation which provided an annual update on the progress made and outlining future plans.

SW highlighted that there remained an outstanding CQC action concerning staff feedback, and efforts were underway to address this. She also noted a digital inclusion issue, emphasising that those who did not use digital tools or lacked access must be supported in using these systems. This consideration extended to staff as well.

AS queried the Trust's cyber resilience and BW advised that this encompassed both prevention and recovery, noting the Trust had completed testing on resilience and recovery procedures with weekly tests on backups and recovery processes.

FA asked if the systems were operating at the appropriate speed, considering the available bandwidth. BW confirmed that optimising performance was crucial as digital tools were increasingly used.

FN concluded by thanking the Digital Team for their involvement at Corporate Inductions, ensuring that new starters could log into their IT accounts on their first day.

RESOLVED:
The Board of Directors ***received*** the Digital Strategy Update Report.

TB069/25 Strategy 2024-29; performance against 2024-25 annual plan and new sustainability and delivery plan

The Chief of Strategy and Partnerships presented the report advising that as part of the Trust's commitment to tracking strategic progress, an evaluation of 2024-25 Annual Plan priorities showed that overall good progress had been made on the majority of priorities.

The development of the Sustainability & Delivery Plan Framework had previously been presented to the Executive team, with the key themes, priorities, and outcomes agreed. The Plan reflected a shift towards longer-term planning, stronger strategic alignment, and a whole-organisation view of transformation and delivery.

NR commented that the most valuable part was the appendix and what was presented back to Board should be Red, Green, Amber (RAG) rated and also include an infographic so the public could see organisational progress.

RESOLVED:
The board of Directors ***received*** the Strategy 2024-29; performance against 2024-25 annual plan and new sustainability and delivery plan

TB070/25 Questions to the Board

There were no questions received from members of the public to the Board of Directors.

TB071/25 Feedback from Board Walkabouts

FLT advised she had visited the Maternity triage area, which was generally positive, although space constraints in triage presented an issue. She spoke with patients who provided positive feedback. She also visited the Safeguarding Team, noting that they had a highly experienced group of professionals.

AS mentioned that he had visited Winifred Kettle and was warmly received by the staff there.

MN reported having visited Bolton One, where he spoke with the Sexual Health Team, who were in the process of relocating to the second floor.

RESOLVED:
The Board of Directors ***received*** the feedback from Board Walkabouts.

TB072/25 Messages from the Board

The messages from the Board were agreed.

TB073/25 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 16:30.

The next Board of Directors meeting would be held on 27 March 2025 at 1pm in the Boardroom.

Meeting Attendance 2025						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓	✓	✓			
Fiona Noden	✓	✓	✓			
Francis Andrews	✓	✓	✓			
James Mawrey	A	✓	✓			
Tyrone Roberts	✓	✓	✓			
Annette Walker	✓	✓	✓			
Rae Wheatcroft	✓	✓	✓			
Sharon White	✓	✓	✓			
Rebecca Ganz	✓	✓	✓			
Martin North	✓	✓	✓			
Alan Stuttard	✓	✓	✓			
Sean Harriss	✓	✓	A			
Fiona Taylor	✓	✓	✓			
Seth Crofts	✓	✓	✓			
Tosca Fairchild	✓	A				
Sharon Katema	✓	A	✓			
✓ = In attendance		A = Apologies				

May 2025 Actions

Code	Date	Context	Action	Who	Due	Comments
FT/25/03	27/03/2025	Feedback from walkabouts	FA would raise the issues with the disabled doors in Cardiology, as feedback received from patients had also highlighted this problem.	FA	Jul-25	FA escalated issue and resolved.

Key

complete	agenda item	due	overdue	not due

Report Title:	Annual Complaints, Concerns and Compliments Report 2024-2025			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	The Trust is required to publish an Annual Complaints Report in accordance with The Local Authority Social Services and NHS Complaints (England) Regulations 2009. This report sets out a detailed analysis of the nature and number of complaints, concerns and compliments received by Bolton NHS Foundation Trust from 01 April 2024 to 31 March 2025.

Previously considered by:	Clinical Governance and Quality Committee and Quality Assurance Committee.

Executive Summary	In 2024-25 there were 198 formal complaints registered. This is a slight increase on the previous year when we received 189. In 2024-25 the team facilitated 84 complaints with resolution meetings which is an increase of 31% on the previous year. The top themes include decisions about clinical treatment, delays in treatment and complications of treatment /surgery. Overall, the team managed 1859 cases through the Patient Advice and Liaison Service during 2024-25, which is a decrease when compared to the 1942 individual cases recorded the previous year. The top themes include decisions about clinical treatment, delays in receiving appointments and ineffective communication. Complaint response performance was 71% against a target of 95%. This is the same as last year's performance. No complaints exceeded the six month timeframe for resolution as set out in The Local Authority Social Services and NHS Complaints (England) Regulations 2009. In 2024/25 we were advised by the Parliamentary and Health Service Ombudsman (PHSO) that four complainants contacted them as they did not feel local resolution had been effective. Of these, the PHSO decided not to investigate any of the cases.

	The Trust received 329 compliments during the timeframe which is an increase on last year's figure of 187. A new process has been implemented in 2024-25 to centrally collate all compliments received across the divisions.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Annual Complaints, Concerns and Compliments Report 2024-2025.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Helen Lodmore Head of Quality Governance Patient Experience Team	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Vision | Openness | Integrity | Compassion | Excellence

NHS
Bolton
NHS Foundation Trust

Annual Complaints, Concerns and Compliments Report 2024-2025



Improving care,
transforming lives...for a better Bolton

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1. Executive Summary

This report provides a comprehensive overview of the complaints, concerns, and compliments received by Bolton NHS Foundation Trust between 1st April 2024 and 31st March 2025. It outlines key performance metrics, thematic trends, divisional activity, and the Trust's ongoing commitment to learning and service improvement.

Key Highlights

Overall Activity - The Patient Experience Team managed 2,057 individual cases in 2024–25, a slight decrease from 2,131 the previous year. This included 198 formal complaints, 1,859 informal concerns and an additional 703 enquiries signposted to other services.

Performance - 99% of complaints were acknowledged within 3 working days, 64% of responses were issued within the 35/60-day target. When a complaint response cannot be issued within the originally agreed timescale, complainants are kept informed of delays and a new robust escalation and tracking process was introduced to help improve timeliness of responses. A 41% reduction in complaints escalated from PALS indicates improved early resolution. None of our complaints received a response outside of the six-month timescale set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Themes and Trends - The most common complaint theme was in relation to decisions about clinical treatment which is consistent across all divisions. Communication issues, previously a top concern, showed improvement and no longer featured in the top five Trust-wide themes.

Divisional Insights:
Acute Adult Care Division (AACD): Increase in complaint numbers; key issues included clinical decisions and communication. Initiatives have included the introduction of bereavement meetings and noise reduction strategies.

Anaesthetics & Surgical Division (ASSD): Stable complaint numbers; learning focused on diabetes care, discharge planning, and communication clarity.

Diagnostics & Support Services (DSSD): Low complaint numbers however division supports and informs complaint responses in all other divisions; improvements included compassionate communication and confidentiality safeguards.

Family Care Division (FCD): Increased complaint numbers; actions taken in maternity and sexual health services to address clinical and communication concerns.

Integrated Community Services Division (ICSD): reduced complaint numbers; focus on carer involvement and medication safety.

Equality Monitoring - Ethnicity, gender, and age data were collected to ensure equitable access to the complaints process. A notable number of users chose not to disclose ethnicity, therefore collaboration with the EDI team to plan engagement events within the community to establish why some patient groups are not accessing the PALS and complaints service and what measures can be put in place to break down any barriers.

Looking Ahead: 2025–26 Priorities

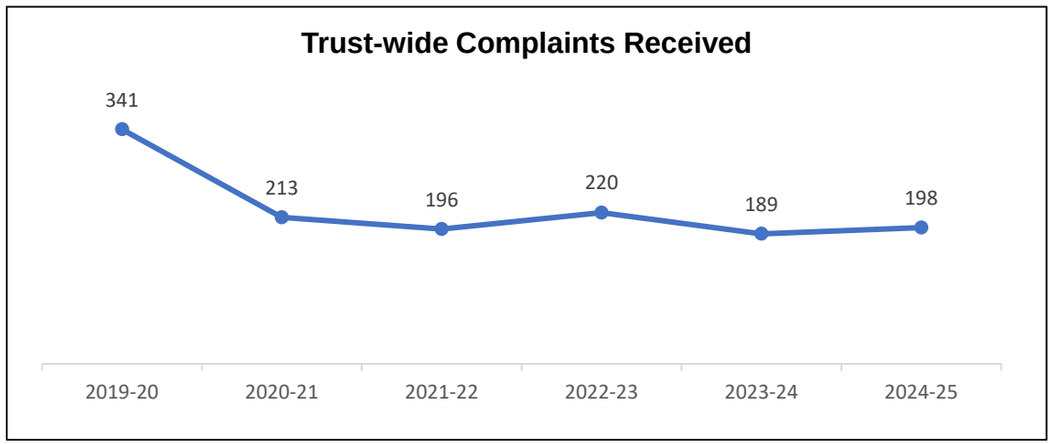
- Review and enhance the Patient Experience Team service and digital platforms to ensure that the team is more accessible, and responsive to patient needs.
- Promote FFT and Thanks@boltonft.nhs.uk through community engagement to build active participation among patients, their families and the public by raising awareness of feedback opportunities.
- Collaborate with EDI teams to understand and address barriers to service access to promote equity by identifying and removing obstacles that may prevent certain communities from accessing our services.
- Involve Patient Safety Partners in learning and feedback processes to embed patient perspectives into safety improvements, making care safer.
- Improve survey use and impact on patient experience to enhance meaningful actions from feedback by ensuring surveys are accessible, and effectively promote service development

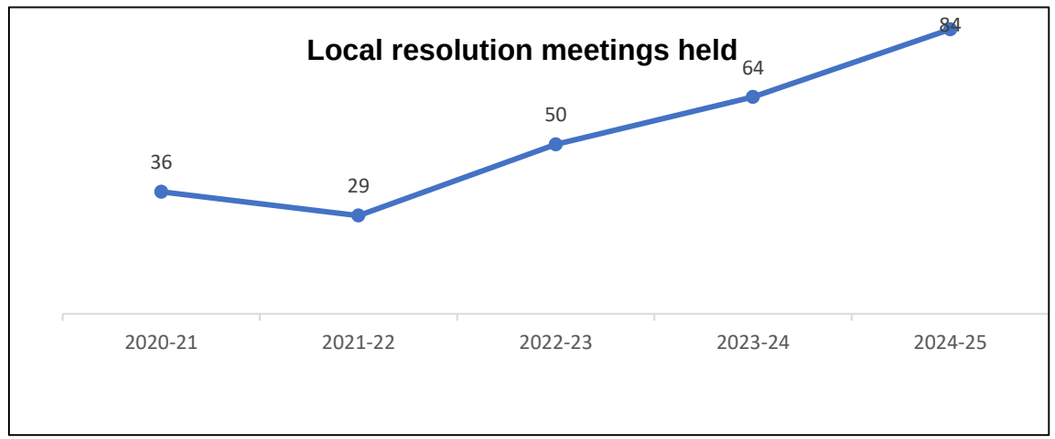
2. Progress in 2024-2025

Focus	Objective	Progress	RAG
To support the complaint/concern/compliment process	To provide a bespoke training package for Divisional complaint teams/leads to ensure high standards of complaint responses are maintained.	A training package is available for divisional governance teams to access and share with teams. In March 2025, thirty staff attended a Complaints Response training programme which also incorporated PSIRF principles. The objectives of this event were to • Enhance understanding • Develop skills • Promote empathy and respect and • Ensure accountability	
	To utilise different digital solutions such as recording complaint resolution meetings and issuing these together with a personalised cover letter from the CEO to complainants. This initiative is to promote early resolution of concerns and encourage the submission of positive feedback.	Work commenced with Communications Team to improve the Patient Experience website 'Your views matter to us' section on the Trust website. • PALS: New online Microsoft form 'Tell us about your experience' • Complaint: Updated contact information and clearer information to inform the complainant about the complaint process • Compliments: Feedback now can be received via a new email address thanks@boltonft.nhs.uk	
To provide complaints/PALS and compliment quarterly and monthly reports to strengthen oversight and monitoring.	To provide a Complaints monthly and quarterly written report to the Quality Patient Experience Forum (QPEF) and quarterly to the Clinical Governance and Quality Committee (CG&QC)	Reports are embedded within the Patient Experience Team work plan. Reports are presented and minuted at QPEF and CG&QC	
To promote and encourage face to face resolution meetings between complainant and divisional teams	To offer complainants an early resolution face to face meeting prior to progressing to a formal written response. The aim of a face-to-face meeting is to increase the quality of communication and promote positive relationships whilst adhering to the Trust values	This process is fully implemented within the complaints process	
To increase PET input to support divisions to meet target dates	To ensure the Patient Experience Team Complaint Coordinators provide support to Divisional teams.	Complaint Coordinators meet at least weekly to discuss cases and identify and resolve any issues at the earliest opportunity to ensure response rate targets are met as complaint responses Trust dates have not always been achieved. Reminder and escalation system in place as a safety net to track target dates. This process provides an auditable trail to support response rate compliance.	

Focus	Objective	Progress	RAG
		A new process is also presently being trialed within the ASSD to support response rate compliance and promote Divisional ownership. This has been positively received and aims to streamline the complaint process.	
To understand the reason why a complaint case might be reopened and ensure complainant receives resolution.	Complete a full review of any reopened cases to ensure all concerns raised have been addressed.	Cases are reopened when a complainant feels that their concerns have not been addressed. The Patient Experience team will review and reopen if this is the case. There has been an increase in the number of re-opened cases due to complainants having follow-up questions or seeking further clarification on the same concerns, and therefore requesting a face-to-face meeting to discuss them in more detail.	
To review themes and trends to identify learning in line with PSIRF principles	To review themes and trends of concerns and complaints received by completing thematic reviews and shared learning within the divisions	A thematic review of appointments the concerns raised received by PALS is being conducted This will be fed through the Patient Experience Group. Divisions also share their improvement plans for shared learning following a complaint. These are shared and monitored through QPEF	
To promote Friends and Family Test (FFT)	To ensure all patients receive access to be able to complete feedback through the FFT process	Ward/departments are set up with access to their own FFT template that incorporates a QR code as another option to complete. FFT will be available for those patients who speak one of the top 10 non-English languages spoken in Bolton. FFT available through other digital portals e.g. text messages. Training guides being shared with divisions on how to obtain response and satisfaction data.	
Patient Information leaflets	To ensure all Trust wide specialty patient information leaflets are in date and available on the trust intranet	Patient Experience team are in the process of setting up a system in share point to hold a library of all relevant patient information leaflets with a quarterly update provided to the divisions for oversight and monitoring.	

3. Trust Wide Activity: Complaints





Data reported in 2024-25 demonstrates a slight increase in complaints received in 2023-24.

There has been a reduction in the number of complaints which were upgraded due to unsuccessful PALS resolution from 22 in 2023-24 to 13 in 2024-25 reporting figures.

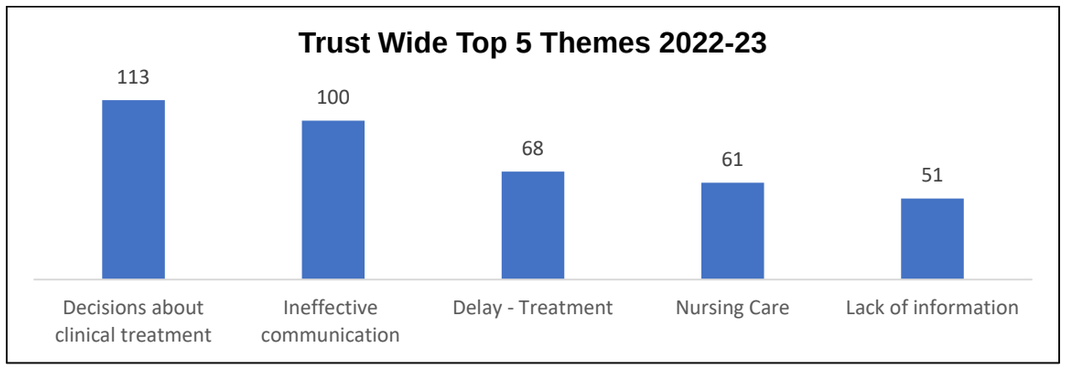
This represents a 41% decrease, indicating that PALS resolution has been increasingly effective for service users raising concerns.

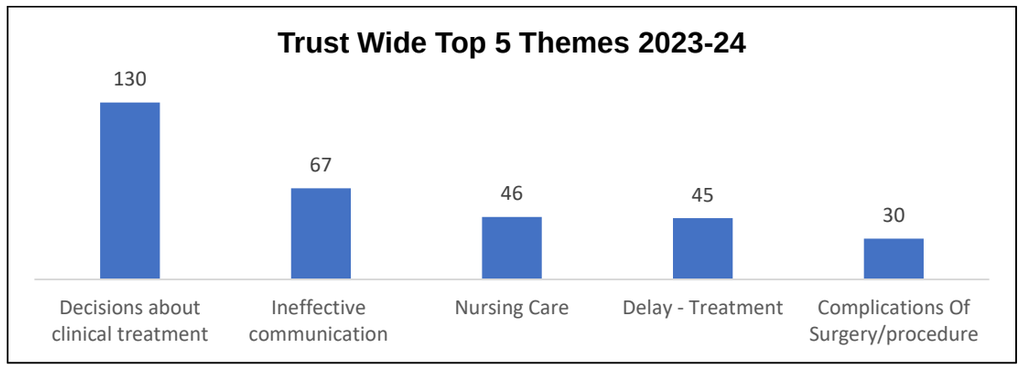
Local resolution meetings continued to be a focus in 2024-25 and recognising the impact that the patient voice has in Trust learning continues to be prioritised.

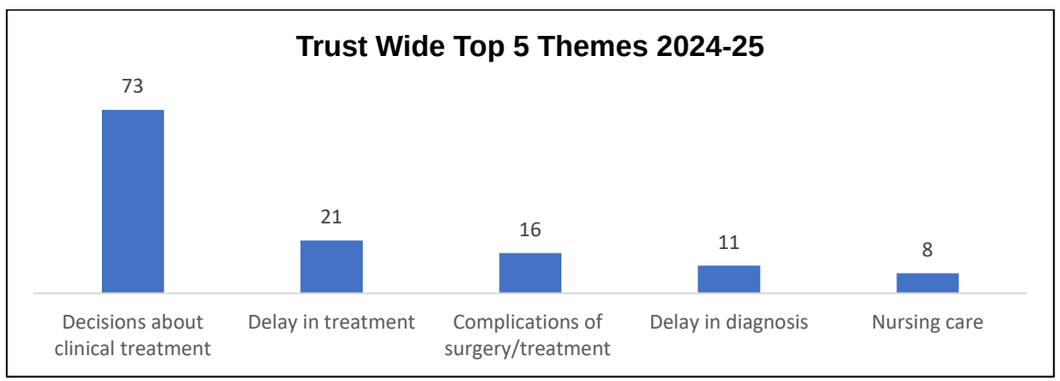
A 31% increase has been recorded in local resolution meetings since 2023-24 and the Trust will continue to utilise this format as a best practice outcome to formal complaints.

Decisions about clinical treatment remains the top theme and is consistent with data reported in 2023-24.

There has been an improvement in issues around communication which no longer features in the top 5 themes for 2024-25 and indicates a positive improvement in this area.



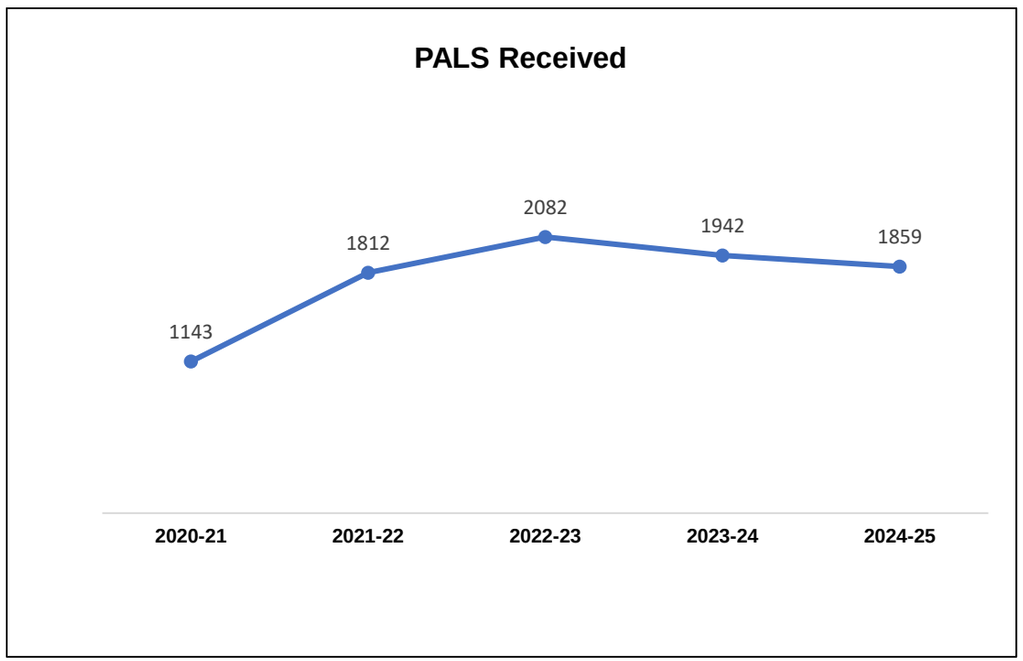




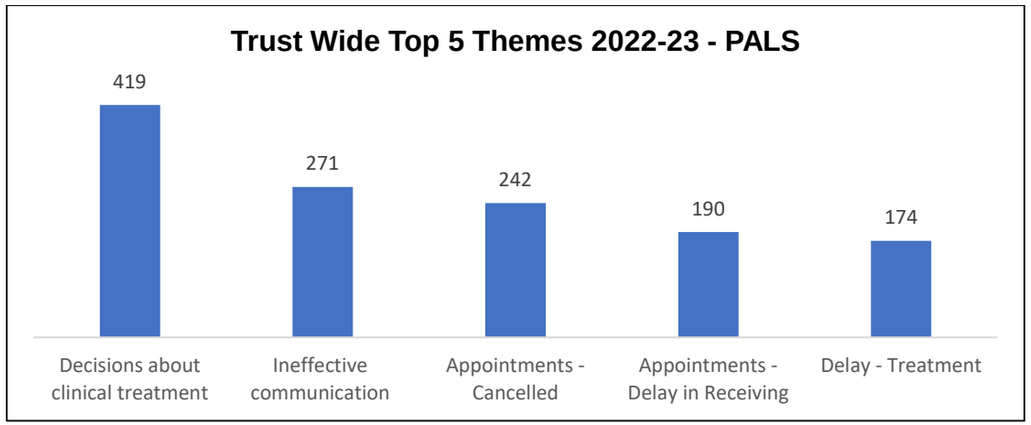
Across all three years, decision about clinical treatment consistently remained the most reported theme, with an increase each year. Ineffective communication fluctuated but had significant increase in 2024–2025, becoming the second-highest theme. Nursing care was consistent across all three years and showed a major increase in 2024 -2025.

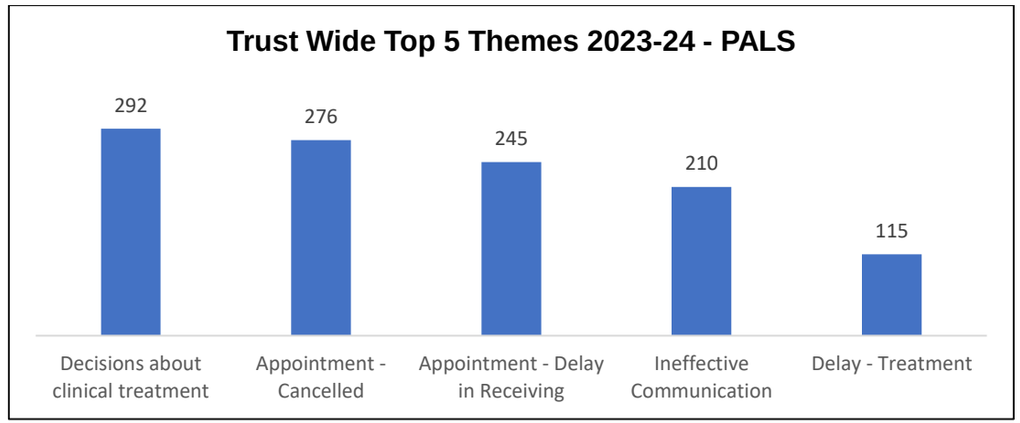
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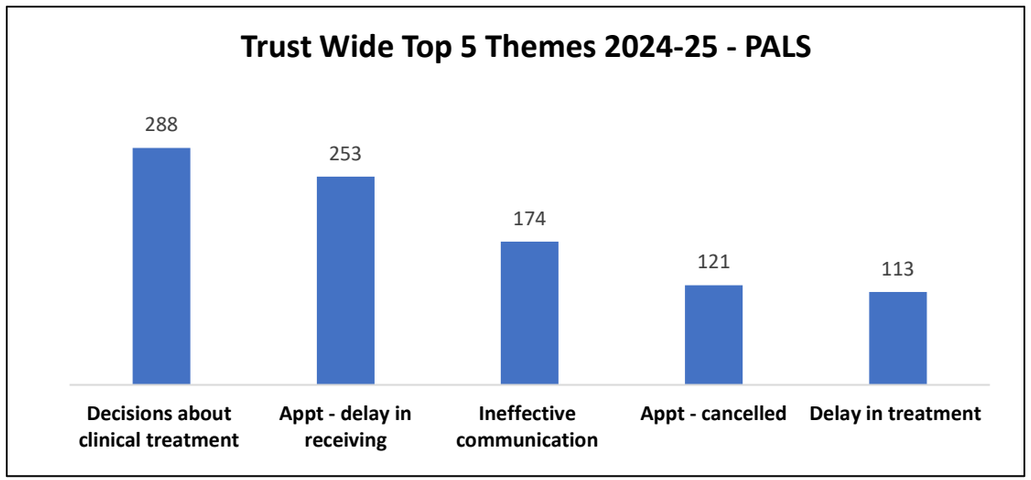
4. Trust Wide Activity: Patient Advice and Liaison Service (PALS)



- PALS activity in 2024-25 demonstrates a slight decline from the figures reported in 2023-24.
- There has been a reduction in the number of complaints which were upgraded due to unsuccessful PALS resolution from 22 in 2023-24 to 13 in 2024-25 reporting figures.
- The triage of PALS continues to be a focus to aid speedy and effective resolution for those raising concerns.



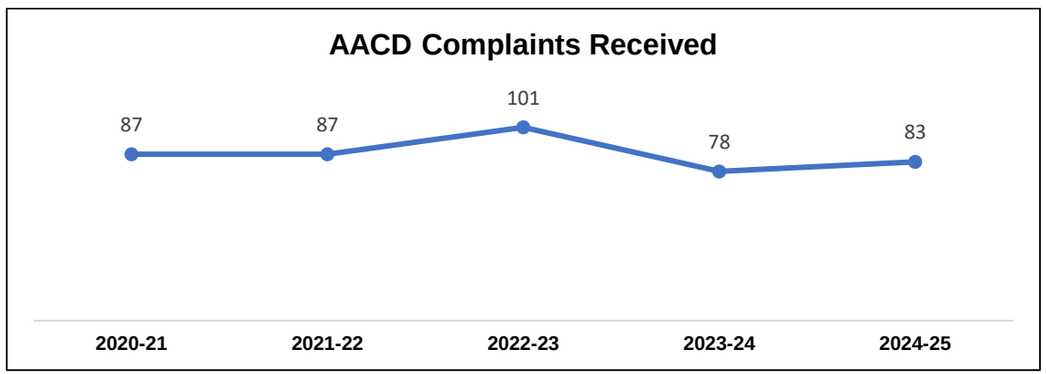


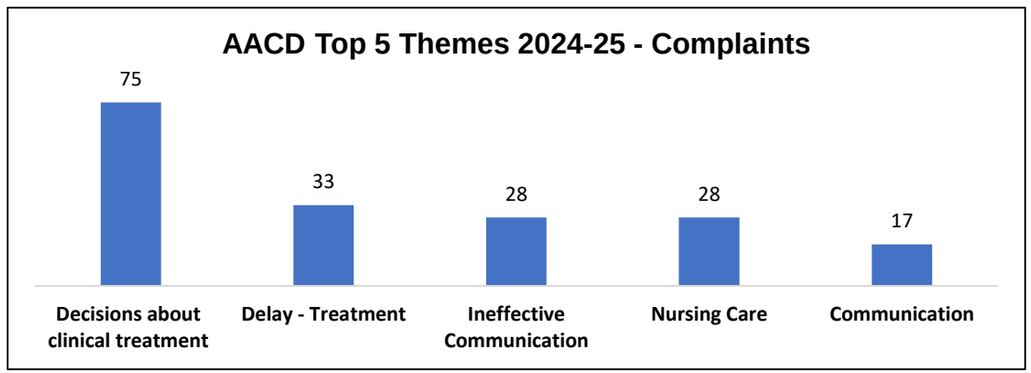


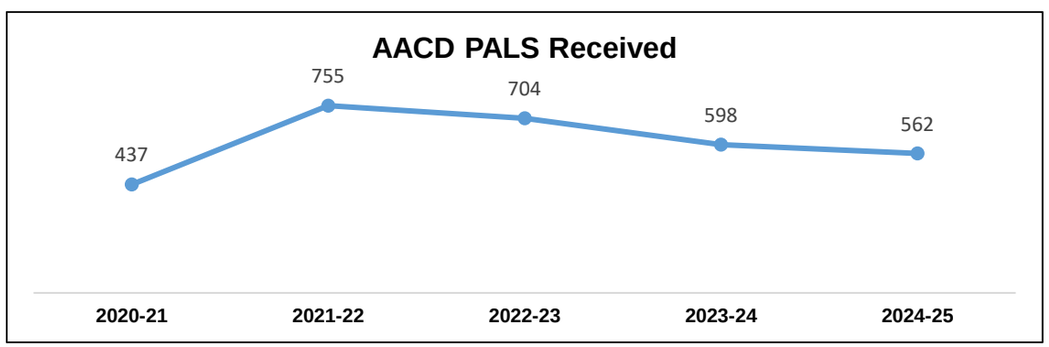
From 2022 to 2025, the most frequent theme across all three years remained decisions about clinical treatment, though there has been a gradual decline. Concerns regarding cancelled appointments increased in 2023–2024 but were notably reduced the following year. Similarly, concerns regarding treatment delays decreased over the three years period.

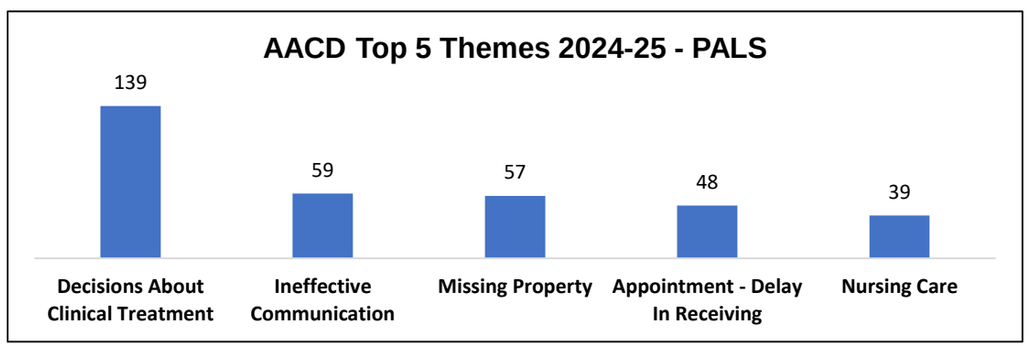
5. Acute Adult Care Division (AACD) Activity

The Acute Adult Care Division contains the busiest single site Emergency Department in Greater Manchester and has 17 adult inpatient wards, providing acute medicine and specialist medical services.









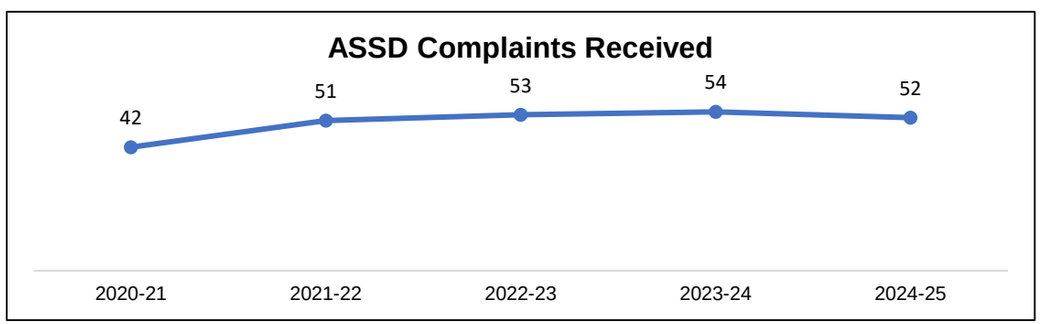
- AACD have seen an increase in the number of complaints received and a reduction in PALS received when compared with 2023-2024.
- The main theme from complaints is from complainants raising concerns in relation to decisions made about clinical treatment which are often linked to issues regarding ineffective communication.
- The main theme from PALS is also in relation to decisions about clinical treatment, ineffective communication and patient's property going missing.
- Ineffective communication features in both complaints and PALS

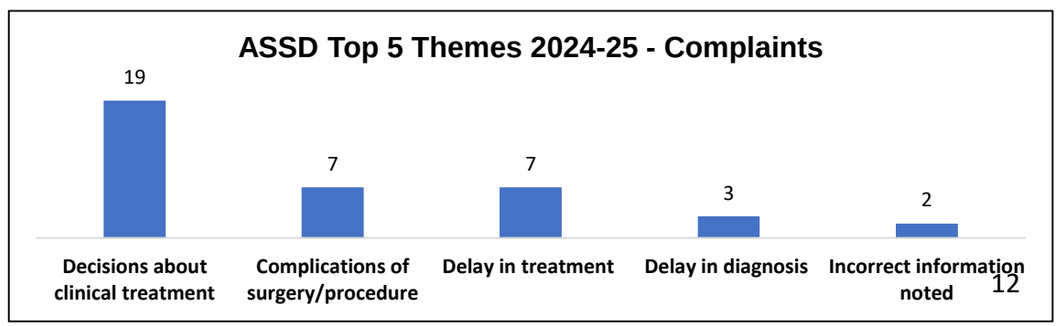
AACD Learning from Complaints

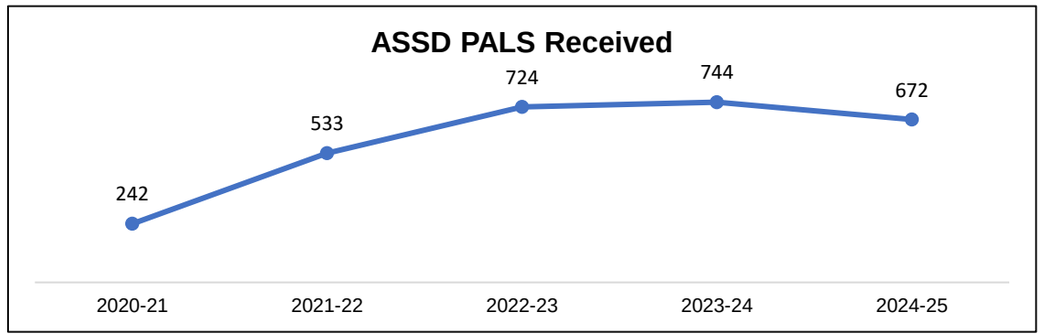
Concern	Action / Outcome
Concerns raised regarding noise on the ward at night when patients are trying to sleep.	A large visual ear has now been placed on the wards on a rotational basis. The ear changes from green, to amber, to red, dependent on noise levels. This is a large visual reminder for staff, which also produces data feedback of noise levels throughout the night, which is shared with staff.
Concerns raised regarding patients dietary requirements not being followed.	This has resulted in the introduction of a housekeeper handover sheet on all wards to prevent patients being given any foods they may have allergens to.
ED Patients being discharged without a discharge letter	ED are working on a project to provide every patient with a copy of their discharge letter, once the new WR/reception has been built. Target date is estimated November 2025.
A theme in complaints has been that patient's families using the complaint's process to get an opportunity to speak to staff about their loved one's death.	AACD are working with bereavement to instigate a pilot of "bereavement meetings" for families to meet with clinicians and nurses involved in their loved one's care. The bereavement meetings are already happening in AACD but the pilot is for this to happen Trust Wide and will be commencing in quarter two 2025/26.

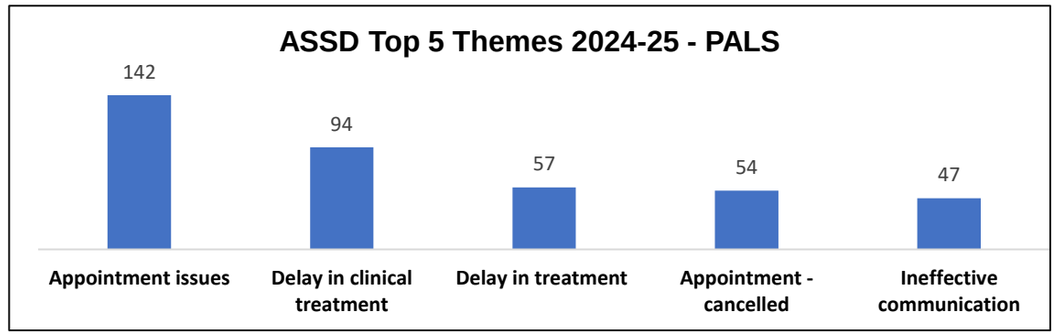
6. Anaesthetics & Surgical Division (ASSD) Activity

ASSD delivers elective and non-elective specialist care across a wide range of clinical specialties.









- ASSD have seen a consistent number of complaints received over the past 4 years and a decrease in the number of PALS received over the previous year.
- The main theme from complaints relates to decisions made about clinical treatment which includes assessment and investigations.
- The main theme from PALS is in relation to appointment issues which include cancellations and delays.
- In comparison to 2023-24, ineffective communication only features in top 5 PALS themes and not complaint themes.

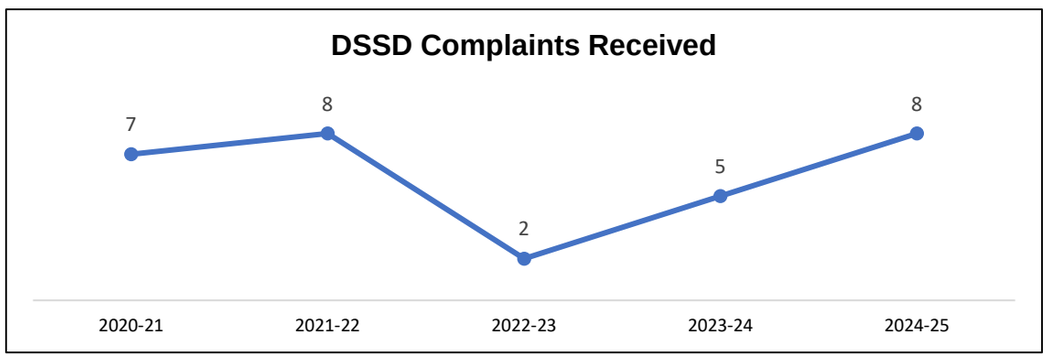
ASSD Learning from Complaints

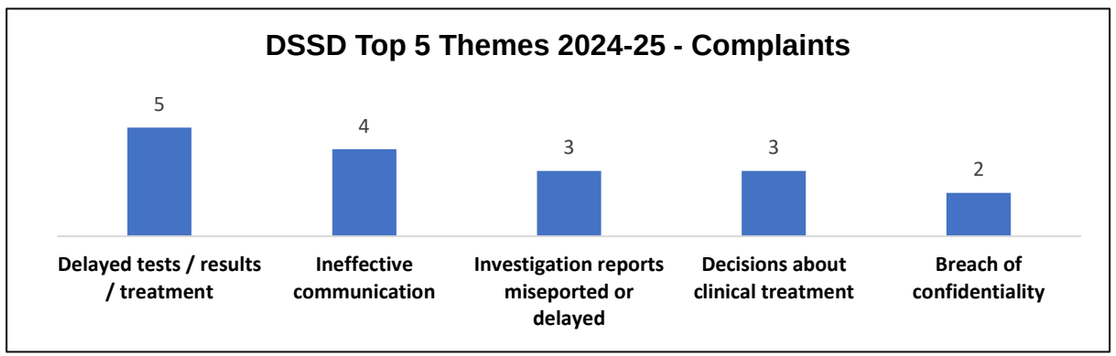
Concern	Action / Outcome
A young diabetic patient was admitted for non-elective surgery & didn't feel listened to about managing her diabetes to the point where she felt unsafe staying in hospital following her surgery as she believed she & her mum could monitor & manage her diabetes better at home.	As a result, the nursing staff all had refresher training for diabetes, the patient's story was told at various staff meetings & the patient was also provided with a patient passport for future attendances /admissions

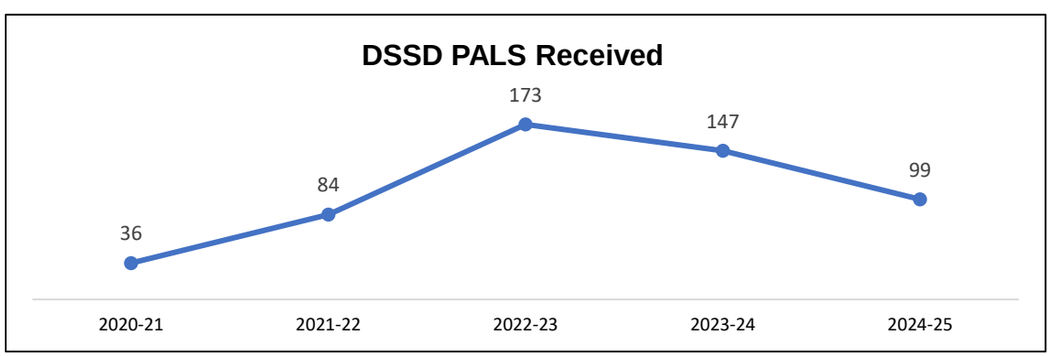
Concerns raised by the family of an elderly patient who was medically fit for discharge but awaiting an IMC bed for over a week. When he was eventually discharged he became very unwell within a short period of time & the family felt that his deterioration should have been noticed prior to discharge.	As a result, it was agreed that if a patient is awaiting IMC then weekly bloods will be carried out to check there is no deterioration that has not been picked up by general observations.
A patient received 2 letters from the consultant giving different information regarding the diagnosis. The consultant had dictated the first letter then realised he had made a mistake & dictated a further letter, the secretary didn't realise & subsequently typed & sent both.	Discussed within the clinical team & agreed that in future when a dictation is found to be incorrect the clinician completing the further (correct) dictation will clearly indicate via a verbal note at the start of the new dictation that the previous dictation must be discarded & if the letter has already been retyped it will be 'voided' from the system.
Doctor mentioned a 'new' procedure that could help with a patient's condition & that she was purchasing the device so she could offer this treatment to suitable patients. She did not explain clearly that this was something that was only available on a private basis.	All medical staff within the specialty have since been issued with an up to date copy of the GMC professional standards in identifying & managing conflicts of interest & setting up private medical practice; to ensure there is clarity on any such discussions with patients in the future.
Patient developed dry cracked lips & no evidence on EPR of staff providing mouth care/encouraging patient to brush her teeth etc. Audit subsequently carried out on oral hygiene/mouth care on the ward showed poor results.	Educational sessions regarding mouth care/oral hygiene were arranged & carried out, following this further audits showed significant improvement.

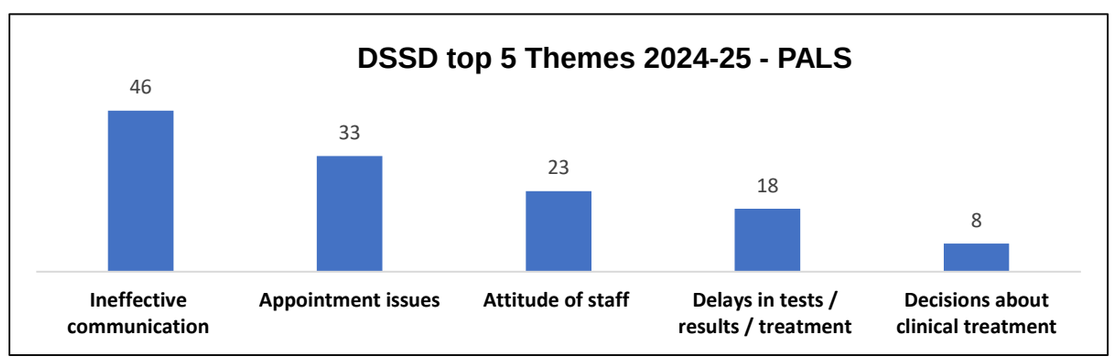
7. Diagnostics & Supports Services Division (DSSD) Activity

DSSD is a key support for Trust services and interacts with patients on many different inpatient and outpatient pathways. The division operates services including Pharmacy, Laboratory Medicine, Infection Prevention and Control and Radiology.









- DSSD have a low number of complaints compared to other divisions, although they contribute to investigations undertaken in all other Divisions where their services are involved.
- There has been a reduction in the number of concerns received by PALS in 2024-25 compared with the previous year.
- Decisions about clinical treatment and ineffective communication is a common theme within both complaints and PALS, however higher within the concerns raised to PALS

DSSD Learning from Complaints

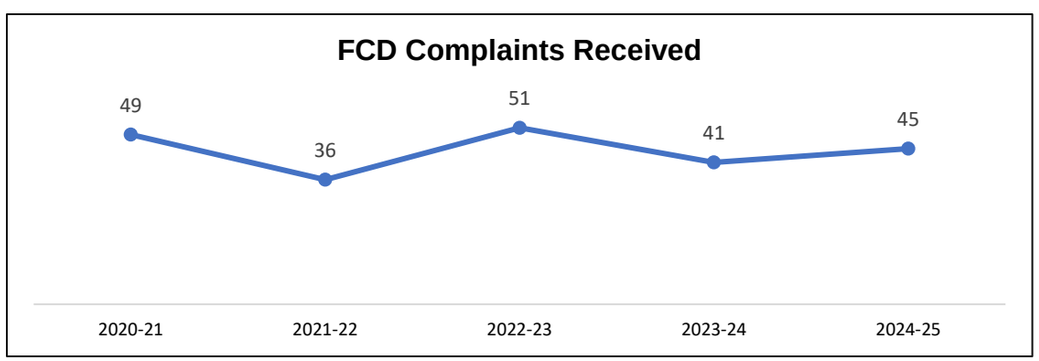
Concern	Action / Outcome
Concerns from patient at receiving a letter with a red cancellation stamp following a baby loss.	Review of process and production of a more compassionate letter where loss has been experienced. Development of an alert to trigger a more compassionate letter for future cancellations. The access booking and choice senior team are working with the Maternity department to develop a different pathway and then letters that are more considerate of the patients receiving them for women experiencing a miscarriage to reduce such unnecessary additional distress at what is already a very difficult time.
Experience of breast services - Magseed positioning and staff behaviours / professionalism.	Discussion with all consultants around standardising practice for patient with multiple area biopsies and the communication of the potential need for further biopsies. Produce a standard operating procedure (SOP) for biopsies. Ongoing discussion with ASSD about requesting requirements that comply with IRMER for mammographic procedures. Advanced practitioner are now on a rota to perform interventional procedures and Magseed will be booked on a planned list. Allowing time for planning and peer review discussions of each.
Self-check in machines situated adjacent to parking machines – potential confidentiality breach.	IFM requested Parking Eye to move the main unit to other side of the waiting area away from self-check ins. The Trust is in discussion with the manufacturers as to whether the default font sizes can be changed by the user allowing users to reduce the font size. If this becomes an available option the Trust will roll this out at all check-in booths.
Patient told x-ray was ok however a giant cell tumour was seen as an incidental finding but there was a delay in informing the patient	The radiographer informed the patient that there was no evidence of a fracture which is what she was referred for. Reflection for the Radiographer. She should have informed the patient that she had seen something incidental on the images but needed to have this reviewed by a Radiologist and that she would be contacted soon.

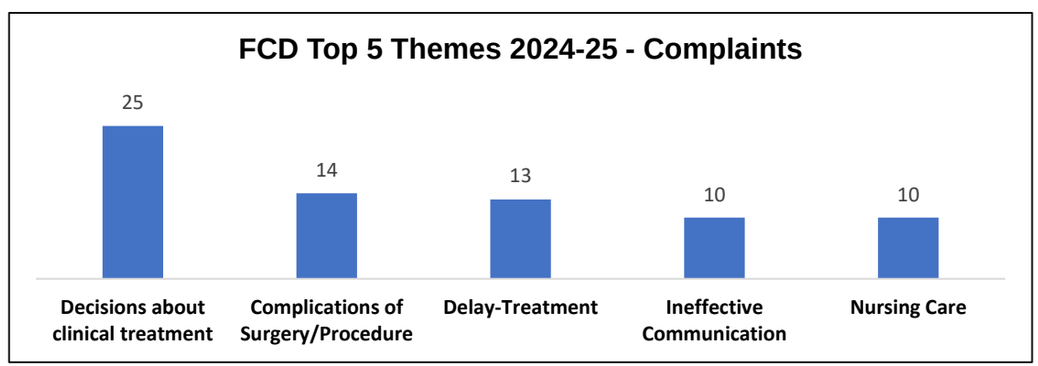
	The reporting radiographer has since changed the way she provides feedback to patients and now ensures that she gives clear instructions and timeframes to the patient about results and no always informs patients when a second opinion is required.
The patient felt there was a lack of fully explanation around the risks of CTPA and VQ scans on her unborn baby.	The department are developing a patient information document entitled '*Testing for Blood Clots during or after Pregnancy'*. This document will reflect current guidance and be developed in partnership with the team from the Radiology Department. This leaflet will include information on chest x-ray, CTPA and VQ scans and the associated risks for patients who are pregnant, postnatal or breastfeeding. The leaflet is to be finalised 5th August 2024. Following this, the leaflet will be disseminated to the Maternity and Radiology Teams for further finalisation and comments.

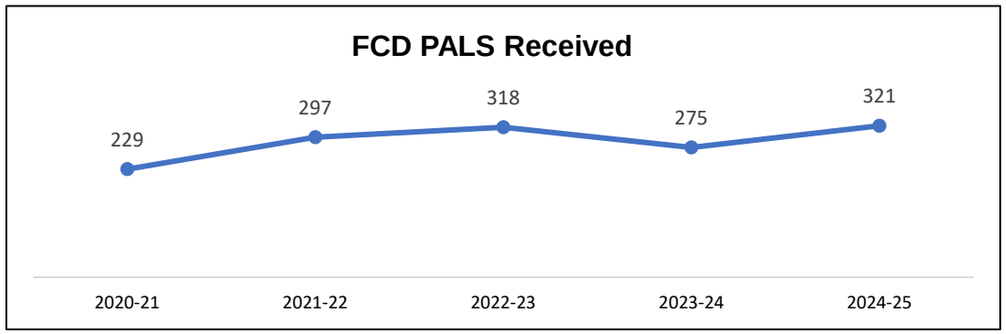
8. Family Care Division (FCD) Activity

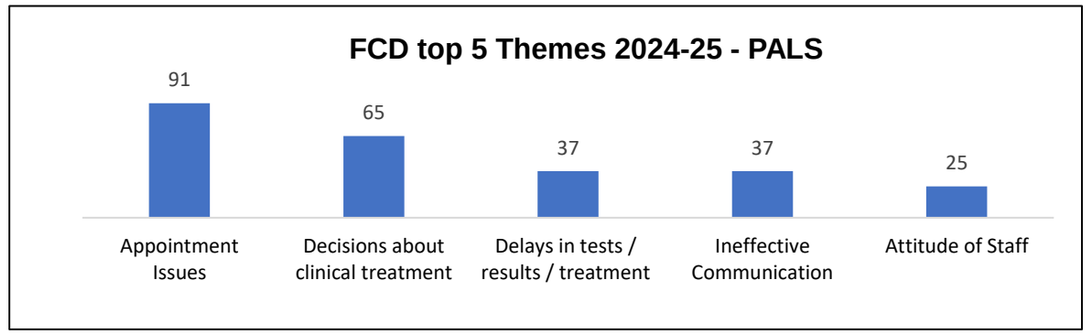
The FCD delivers maternity, neonatal, sexual health, gynaecology and a range of acute and community children's services including hospital and community based children's clinical services, 0-19 Public Health Nursing, Paediatric Allied Health Professionals and Paediatric Learning Disability.

More than 6,000 babies are delivered under our care and we carry out around 1,500 gynaecological procedures each year. We also have a tertiary level Neonatal Intensive Care Unit and a level 2 Paediatric High Dependency service working in collaboration with GM Acute paediatric services.









- FCD have seen an increased number of complaints received over the past three years
- There has been an increase in the number of concerns received by PALS compared with last year.
- Decisions about clinical treatment features as a main theme in both complaints and PALS.
- Communication and delays with treatment feature in both complaints and PALS

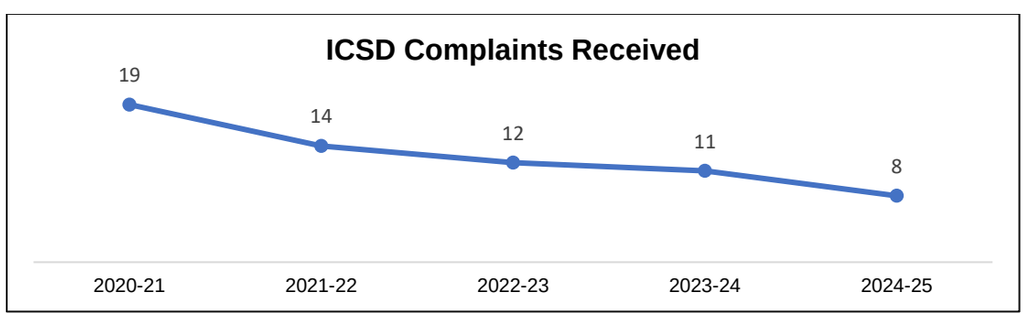
FCD Learning from Complaints

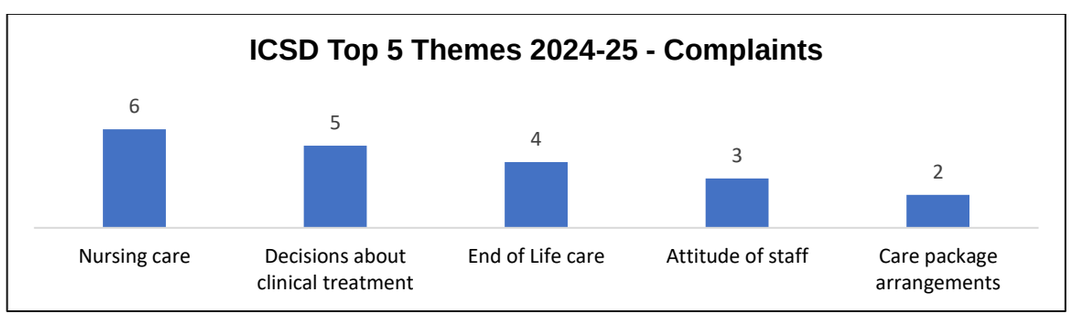
Concern	Action / Outcome
Maternity: Concerns relating to clinical decisions	As a result Maternity service implemented five actions including ensuring MEOWS chart on Patient Track electronic recording system aligned with MEOWS on paper, reminding staff importance of correctly completing MEOWS in line with trust policy and guidance and ensuring women are moved to a private room on CDS following suspected or confirmed bereavement on the ward. There is also Sepsis quality improvement work on-going within maternity service, new MEOWS rolled out from 2025 and Sepsis screening pathway tools to be included within antenatal admission packs. Plan of care and learning was also discussed at consultants meeting and disseminate to members of the medical team, also included within the midwifery team weekly safety huddles and discussed at the team meetings.
Sexual Health:	Actions implements included creation of NHS Foundation Shine Contraception poster regarding local anaesthetic availability for patients, by Bolton FT communications team and now sited in waiting room and each clinic room in SRH at Crompton HC.

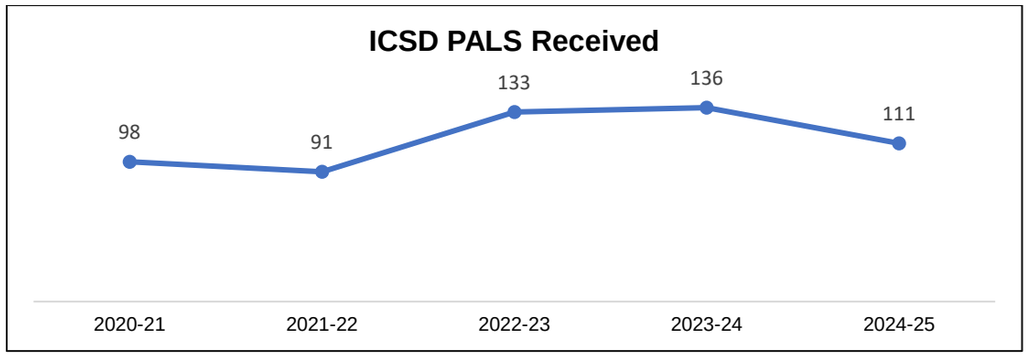
Concern	Action / Outcome
Concerns relating to complications post procedure	An additional box has been added to assessment on Lille Hub for staff to ensure they discuss the option of local anaesthetic with service user. Complex care clinic booking referral criteria has been updated and approved within service. All patients referred for 'coil' intervention are sent information leaflet via text message, at time of booking and documented within patient's notes
Maternity: Concerns relating to treatment on maternity:	New Induction of Labour proforma embedded within Induction of Labour GMEC Guideline and used in ANC, Maternity Triage and community midwifery settings where IOL's are booked. A new leaflet was created regarding analgesia prior to IOL. A flow coordinator midwife has been recruited. Ward managers have included within midwifery team safety huddle the importance of connecting and ensuring accurate recording on transfer and checking dates on NNBST cards. Neonatal medical team covering the postnatal ward reminded of importance of updating parents following clinical procedures (where parents are not at the bedside then to update the midwives to feed this information back)

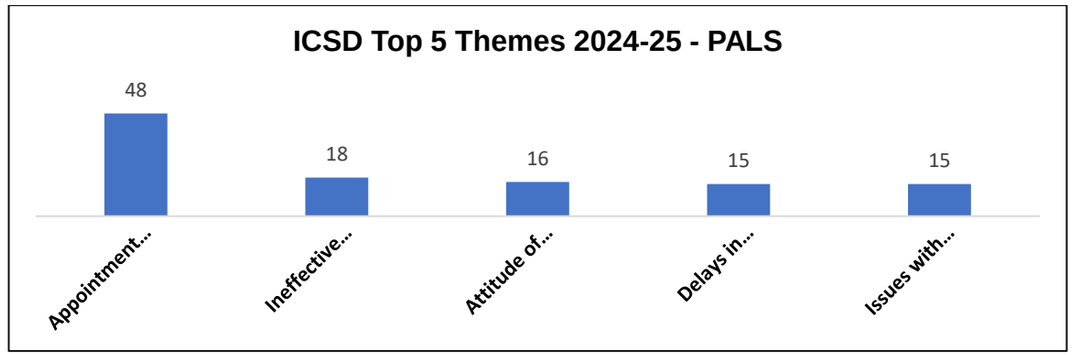
9. Integrated Community Services Division (ICSD) Activity

ICSD places an emphasis on avoiding hospital attendances and admissions by responding to health and social care issues in our community, which includes providing intensive therapy and re-ablement packages to support our patients' independence.









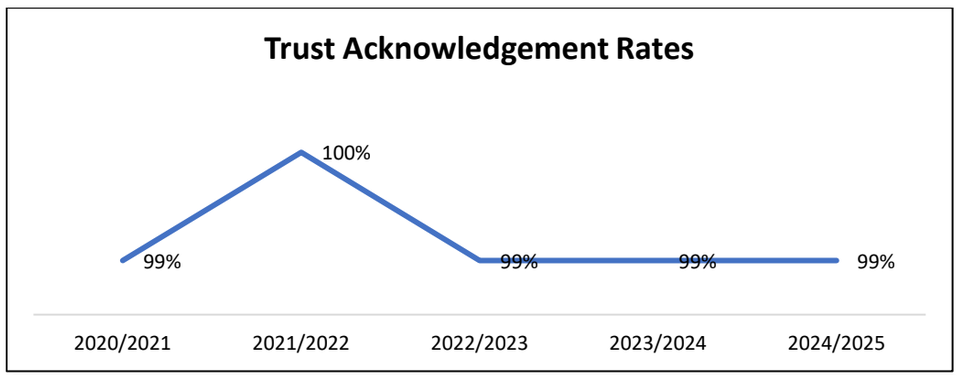
- The ICSD has seen a steady reduction of complaints over the past four years. PALS has seen a decreased from the previous year.
- Decisions about clinical treatment is the main theme for both complaints and PALS.
- Delays in receiving appointments also feature within both complaints and PALS.

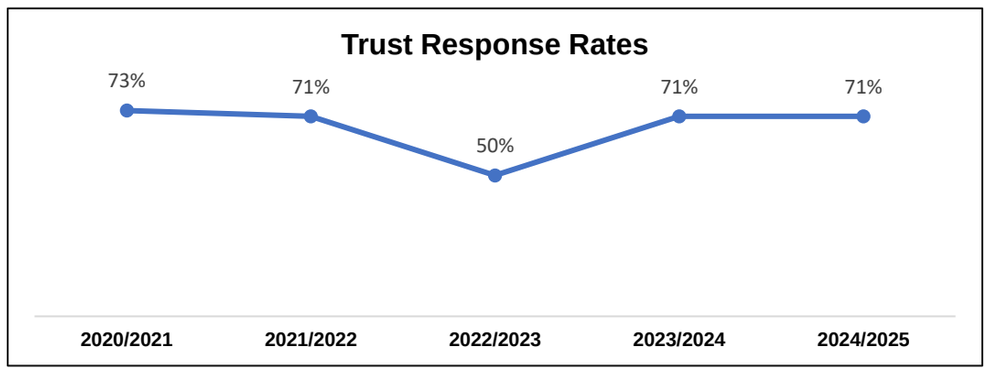
ICSD Learning from Complaints

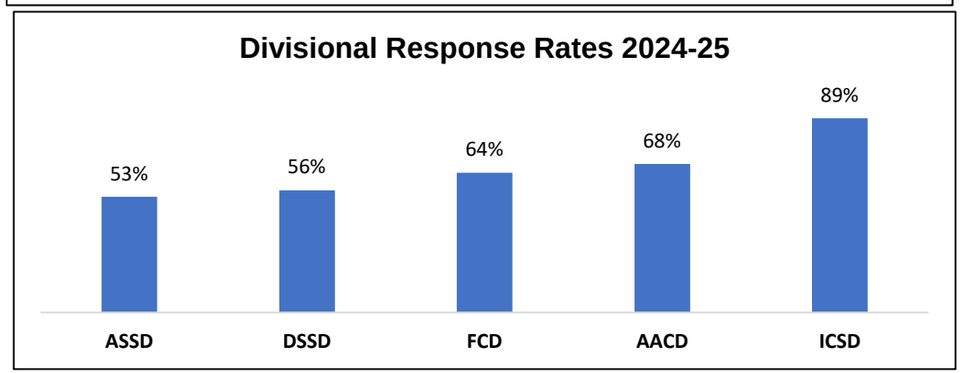
Concern	Action / Outcome
Patient's carer was not offered a carer's assessment, and documentation in the notes was incomplete	Staff have been reminded of the importance of thorough documentation and ensuring carers are fully involved in care discussions A divisional learning slide will be created to reinforce the need for clear communication and support for carers
Complaint highlighted missed district nurse visits and a lack of follow-up around medication disposal	A new SOP is being developed to prioritise visits. End-of-life care guidance is being updated, and a learning slide will be shared with teams to advise on how patients and families should safely dispose of medications. SWARMs are being introduced to support systems-based learning on medication safety
Complaint highlighted that there was a delay in patient receiving a visit, this was due to Patient visit not scheduled when required	Implementation of a new SOP for District Nurses was developed to ensure priority visits are scheduled at the start of each shift
Ensure staff aware of safe handling of controlled drugs	Share policy with all community teams. Update the induction part. Update induction programme to include end of life drugs
Ensure systems-based learning is derived from medication incidents	Complete SWARM templates for medication incidents and present them at the Safety Senate

10. Our Performance

- Performance is measured by monitoring our complaint acknowledgment rates within three working days from the day of receipt of a complaint.
- During 2024-25, 99% of complainants received an acknowledgement of their complaint within the three working days' target.
- The response target rate is for 95% of complainants to receive a response by 35 working days or 60 working days if the complaint is complex and/or crosses multiple providers. During 2024-25, 70.6% of our complainants received a response within this timeframe. In all cases where compliance with timescale was not achieved, the complainant was kept fully informed of progress and the cause of any delays throughout the complaints process. None of our complaints received a response outside of the six-month timescale set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.



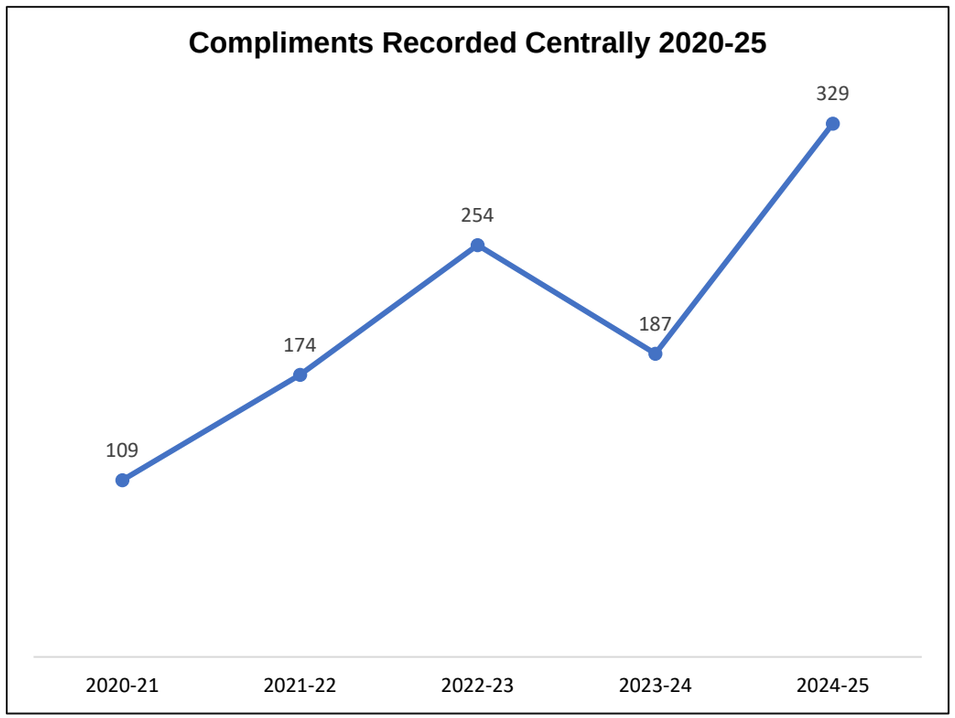


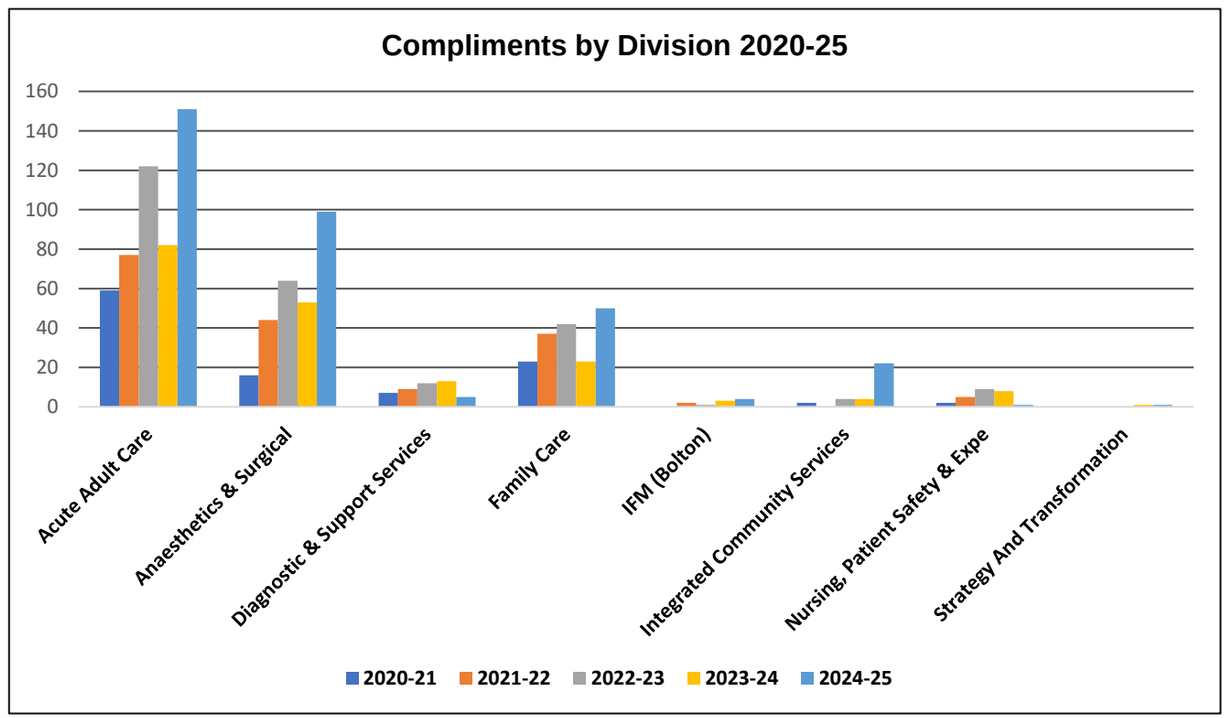


Response Rates within Target	
FCD	30 out of 47
AACD	69 out of 100
ICSD	8 out of 9
ASSD	32 out of 60
DSSD	5 out of 9

11. Compliments

- A new central repository has been implemented for the recording of compliments. A QR code has now been developed linking directly to Thanks@boltonft.nhs.uk where positive feedback can be shared.
- Divisions collate all expressions of gratitude including thank you cards and letters, gifts and donations and report these to the Patient Experience Team for recording centrally through Safeguard. A monthly compliments report is produced to share the data with Senior Management Teams.
- Anonymous reviews provided on patient feedback platforms such as Care Opinion and NHS Reviews are recorded in the same way, as are compliments received centrally via PALS. The charts below shows those recorded for the past 5 years in total and by Division.

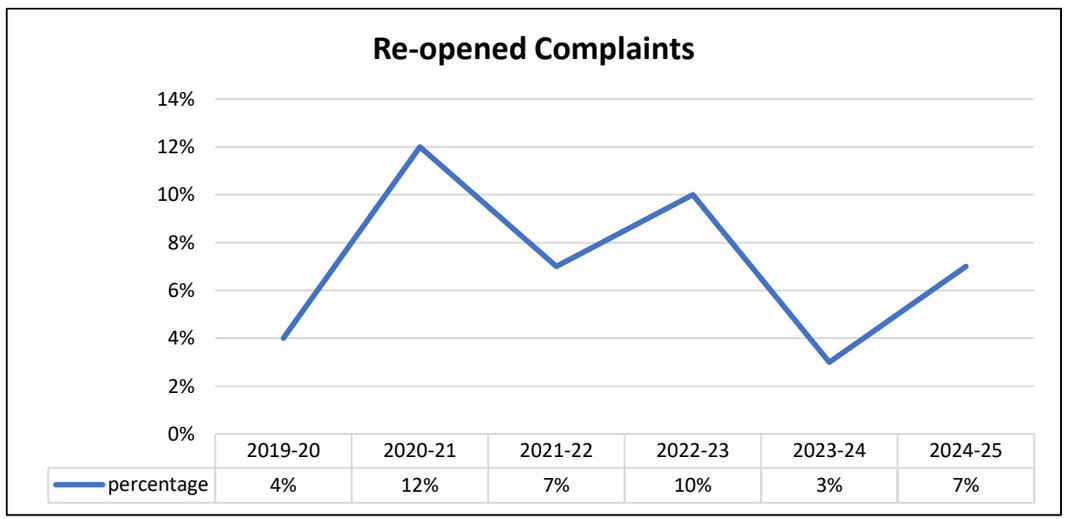


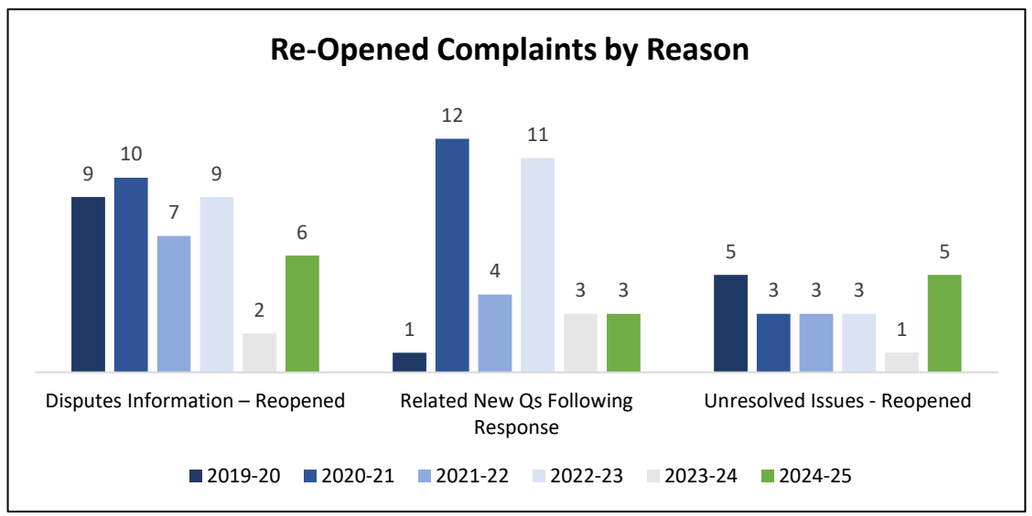


12. Quality Monitoring

We measure the quality of the responses provided to our complainants by monitoring re-opened cases, referrals to the Parliamentary and Health Services Ombudsman (PHSO) and offering local resolution meetings.

Re opened Complaints



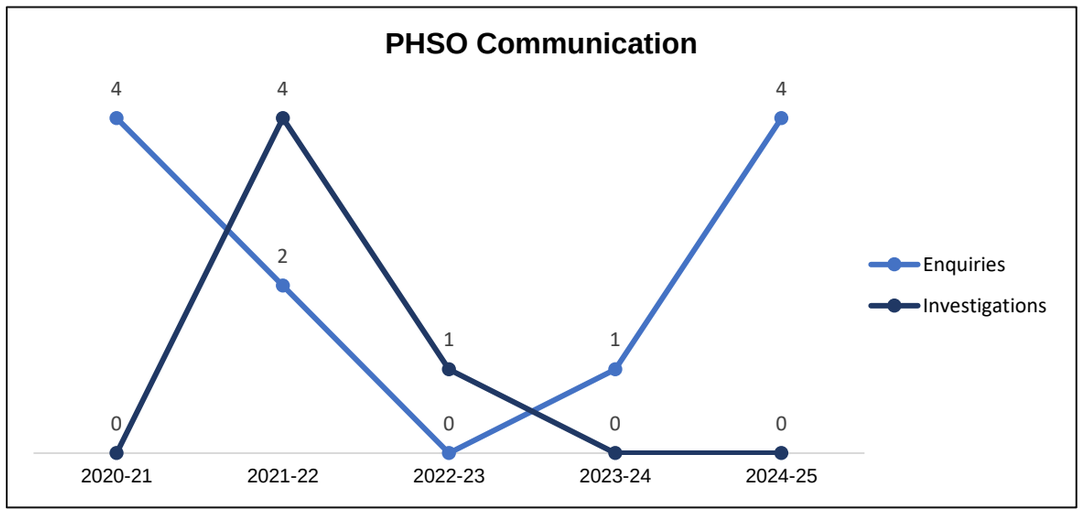


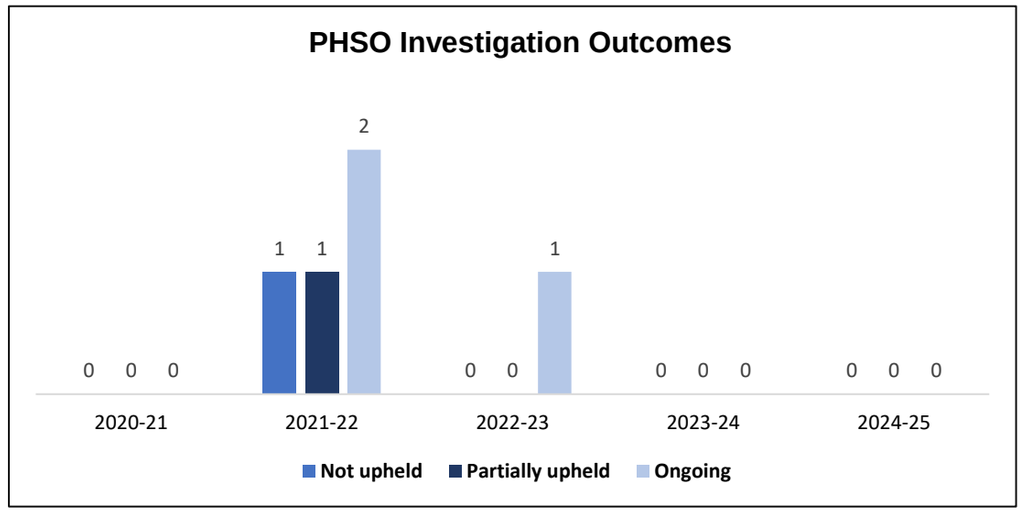
The above data demonstrates that there has been a slight increase in the number of reopened complaints in 2024-25.

The criteria below is the reason why a case might be re-opened:

- Where the complainant is seeking further information/clarification of issues addressed in the complaint response
- Where issues have arisen relating to the same episode
- Where a meeting has been requested to discuss the response in more detail
- Where a referral from the Parliamentary and Health Service Ombudsman (PHSO) has been received

13. Parliamentary and Health Service Ombudsman (PHSO)





A PHSO enquiry is the receipt of a complaint made to the PHSO regarding an outcome provided by an NHS Trust.

At this point a request might be made to request a copy of the complaint file for overview and to inform whether a PHSO investigation is indicated.

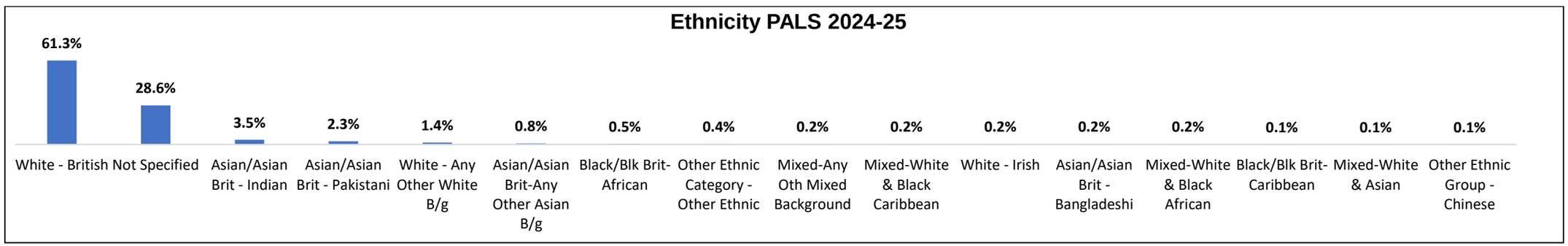
An investigation is decided if the PHSO conclude that the NHS Trust have not provided a satisfactory outcome or is in the wider public interest.

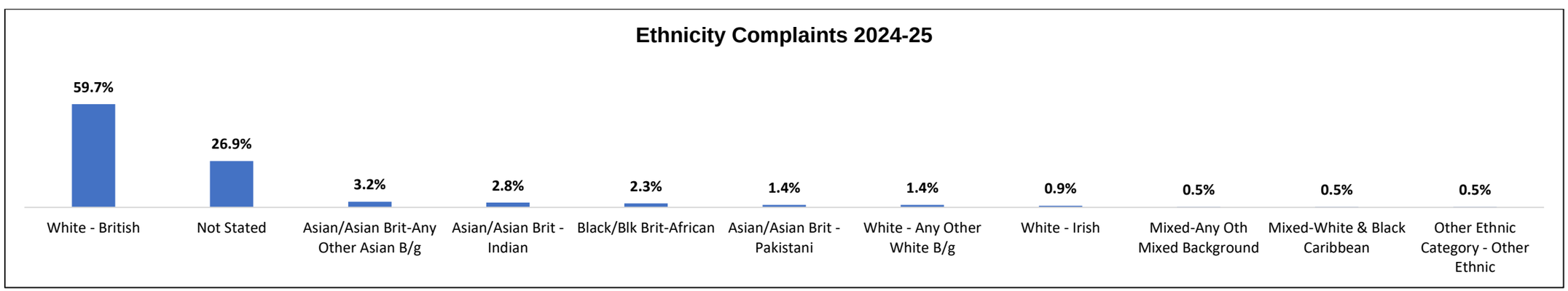
Data provided in the PHSO Investigation Outcomes chart for 2023-24 and 2024-25 reflects that no outcomes have been received as yet due to the wait times experienced by the PHSO.

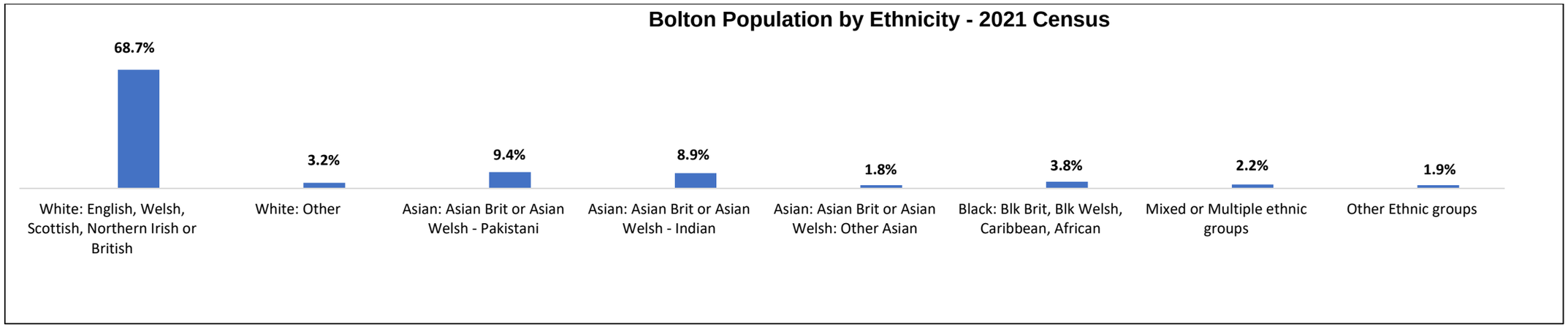
There were four new PHSO enquiries which resulted in no investigations.

14. Equality Monitoring 2024-2025 Ethnicity

The Trust takes seriously that all members of the public should feel comfortable in accessing the PALS and complaints service and as such captures information on the patient's age, gender and ethnicity to support this. A summary of this data is provided which has been measured against patient profile activity.







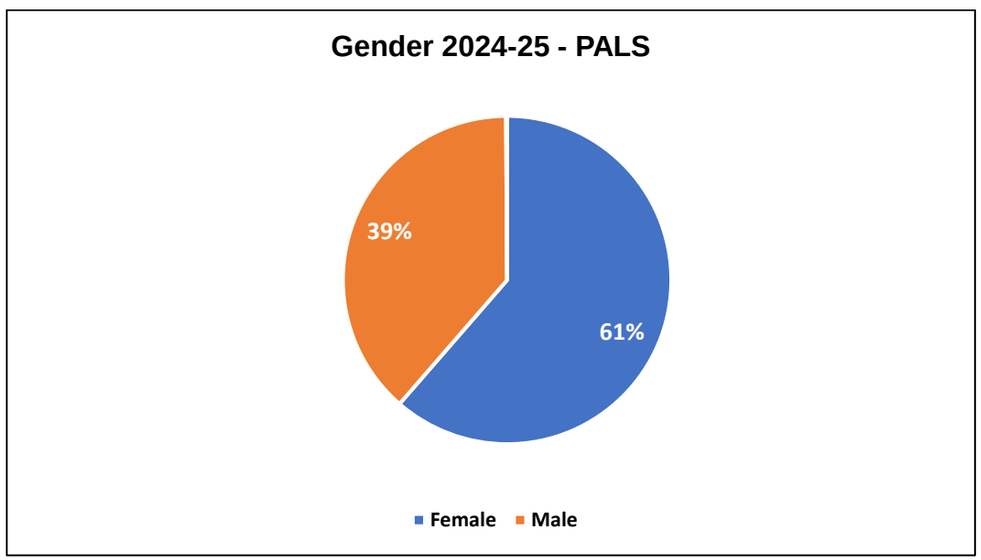
The table below compares Bolton's population by ethnicity, based on the 2021 Census, with the proportion of complaints received by Trust during the 2024 –2025 financial year

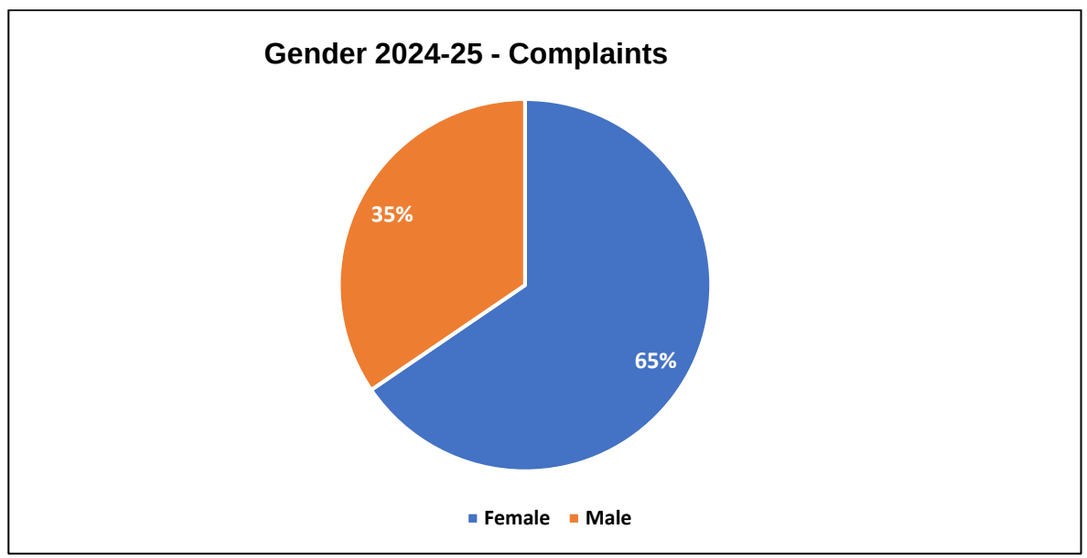
Ethnicity	Bolton Population by Ethnicity	Complaints Received by Ethnicity 2024-25	Observation
White – British	68.7%	59.7%	Slightly underrepresented
White – Other	3.2%	1.4%	Underrepresented
Asian – Indian	8.9%	2.8%	Significantly underrepresented
Asian – Pakistani	9.4%	1.4%	Significantly underrepresented
Asian – Other	1.8%	3.2%	Overrepresented
Black – African/Black British	3.8%	2.3%	Underrepresented
Mixed or Multiple Ethnic Groups	2.2%	0.5%	Underrepresented
Other Ethnic Group	1.9%	0.5%	Underrepresented

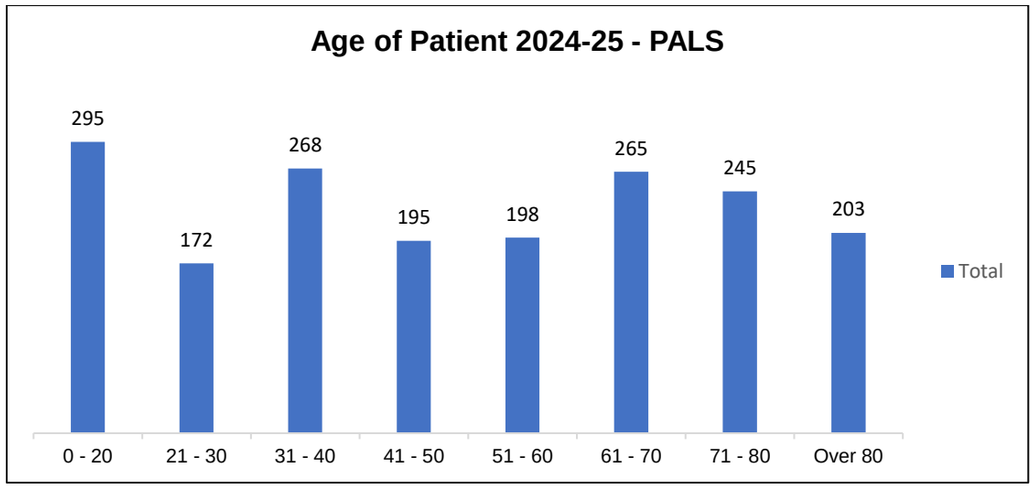
There is a notable increase in the number of service users not sharing or specifying ethnicity when being supported by the Patient Experience Team to resolve their complaint/concern.

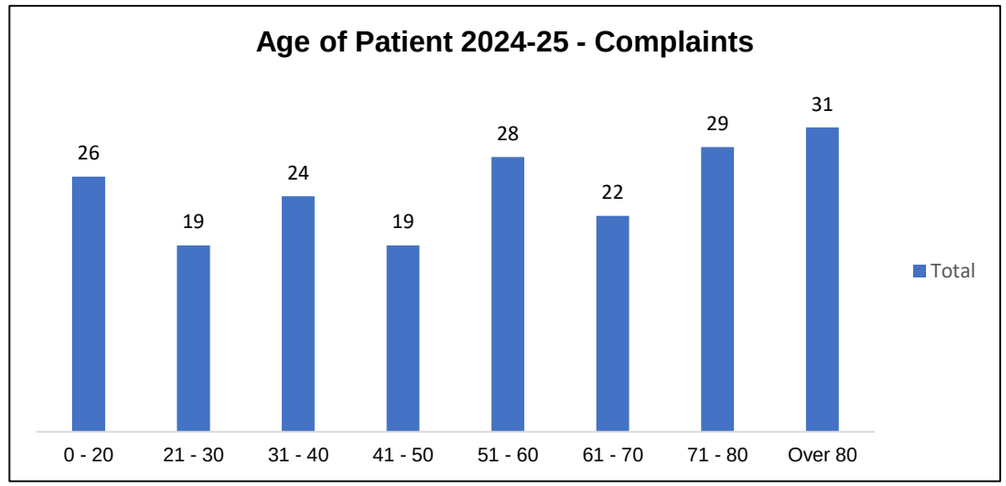
This field is now mandatory with an option of 'prefer not to say'. The vast majority of those who do state their ethnicity are white British. This does not reflect our local communities and as such we need to do more work in this area by collaborating with the EDI team to plan engagement events in the community to understand and break down any barriers to accessing the complaints process, providing feedback or understand why some people prefer not to tell us their ethnicity.

15. Equality Monitoring 2024-2025 Gender and Age







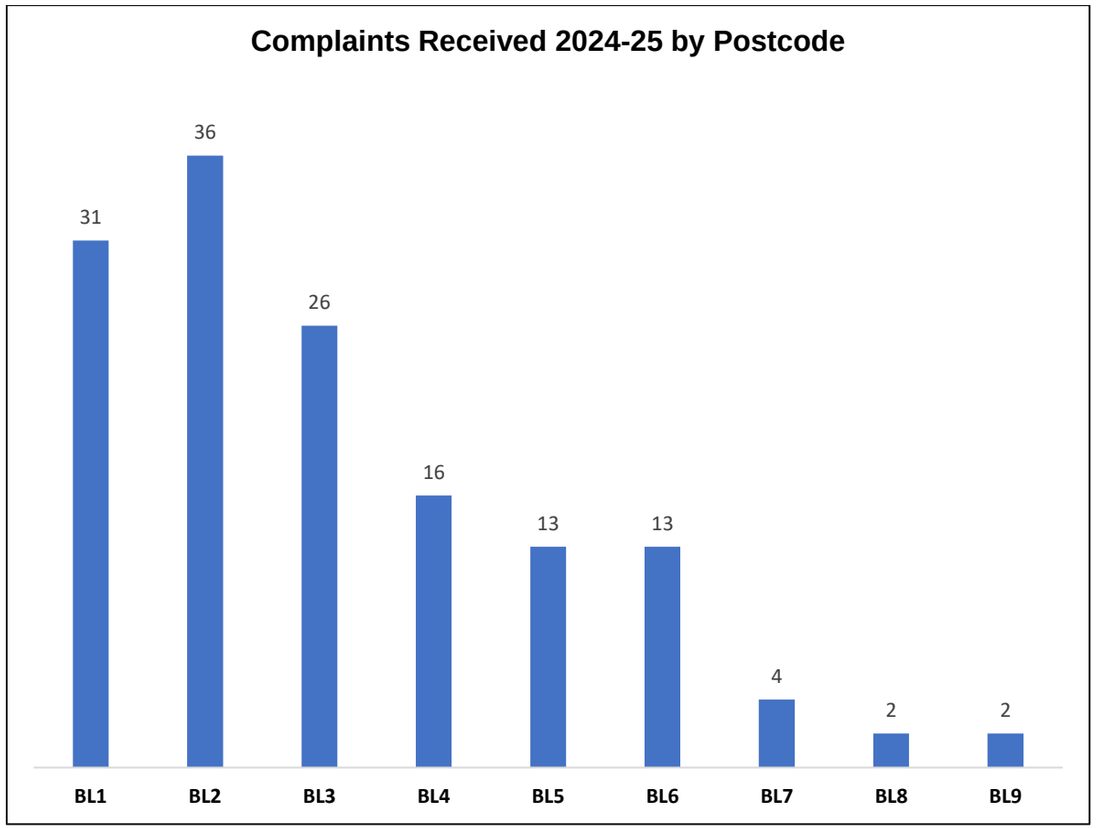


16. Our Neighbourhoods

The data provided by the office of national statistics 2025 states there is approximate Bolton population of 302,383.

The highest number of complaints in Bolton were related to patients living in the BL2 postcode area, with a majority of 25%.

The lowest number of complainants live in the BL7, BL8 and BL9 postcodes each of which sit on the outskirts of Bolton and on the border with Bury and therefore may not access our services. There are six neighbourhoods that sit within Bolton postcodes but within some postcodes the deprivation levels and ethnicity can vary widely. Therefore, it may be useful to breakdown the data into those neighbourhoods to truly understand what this data means.


Complaints Received 2024-25 by Postcode
31
36
26
16
13
13
4
2
2
BL1
BL2
BL3
BL4
BL5
BL6
BL7
BL8
BL9


Our six neighbourhoods
Bolton
HEALTH AND CARE PARTNERSHIP
• Populations of 30-55,000 served by integrated health and care teams
• Supporting integrated working in the place
• Providing proactive personalised care
• Helping people stay well for longer as part of a wide approach to prevention and health improvement
North
Central North
East
West
Central South
South

17. Our Focus for 2025-2026

Focus	Objective	Target Date
To review Patient Experience Team service	To review the Patient Experience Service to ensure in line with local and national standard requirements.	September 2025
To redesign the Patient Experience Trust website and incorporate easier access through different on line portals to submit a concern/complaint or feedback/compliments	To continue to review and improve the Patient Experience website to simplify the process for raising a concern/complaint/compliment	October 2025
	Build on newly established process to centrally record compliments received at point of care.	October 2025
	Undertake promotion Thanks@boltonft.nhs.uk email account and FFT by hosting a regular promotional stand in thoroughfare of main hospital and selected community settings	Quarterly
Engagement	Collaborate with EDI Team to plan engagement events within the community to establish why some patient groups are not accessing the PALS and complaints service and what measures can be put in place to break down any barriers.	November 2025
	To invite involvement of the PSIRF Patient Safety Partners when established in post	January 2026
Digital solutions	To continue to explore digital solutions to promote FFT and also enable enquiries to the Patient Experience team to be addressed in real time to ensure meet recommended compliance targets	February 2026
	Review Ulysses, online reporting system to ensure recording of complaints/concerns are categorized in line with national recommendations	January 2026
Involving complainants in the learning process	To triangulate divisional improvement plans and work closely with divisional teams to share findings of themes and trends for shared learning. In line with PSIRF principles involve Patient Safety Partners, patients/carers to contribute to learning feedback through patient stories of their experience	February 2026
Surveys	To understand the survey process, how these are shared with divisions and how the results influence patient experience.	March 2026

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Executive		Decision	

Purpose of the report	To update the Board of Directors on key internal and external activity that has taken place since the last public Board meeting, in line with the Trust's strategic ambitions.

Previously considered by:	Not Applicable.

Executive Summary	This Chief Executive's report provides an update on key activity that has taken place since the last public Board meeting including any internal developments and external relations.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Chief Executive's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

Prepared by:	**Fiona Noden, Chief Executive**	**Presented by:**	**Fiona Noden, Chief Executive**

Ambition 1: Improving care, transforming lives

We launched an opt-out scheme earlier in the year which routinely tests people aged 16 and over who are having a blood test in our Emergency Department. The initiative is helping to diagnose HIV, Hepatitis B (HBV) and Hepatitis C (HCV), making sure even more people are being informed about undiagnosed conditions and are being offered support and treatment, which can ultimately save lives.

During the first three months, our teams have conducted 7,604 HIV tests, 7,621 Hepatitis B tests and 7,591 Hepatitis C tests, significantly increasing the number of tests being carried out. As a result of those tests; 14 people were newly diagnosed with Hepatitis B, 8 with Hepatitis C and 3 with HIV. The approach aims to normalise testing, reduce stigma and ensure those who are unaware of their status are able to receive timely care.

Earlier this year, our Resuscitation Team and consultants carried out Basic Life Support training in Bolton's communities, working with local mosques, places of worship and community centres. This training has helped to save the life of a woman who experienced a heart attack and was in cardiac arrest. Following the training, a member of the community suffered a cardiac arrest and her relatives quickly jumped into action to start cardiopulmonary resuscitation (CPR) and called for an ambulance. The relatives say they were able to act thanks to the recent training they had received at a local mosque. Training sessions have been delivered at two mosques in Bolton so far, with plans for two more sessions in the coming months.

Our Endoscopy Service has been asking people to share their experiences of their admissions journey through the Endoscopy unit. The patient forum took place this month and enabled people to sit down with staff in a safe environment to provide feedback about what went well and what could be better. The aim of the session was to make sure staff are able to deliver the best care possible to patients and understand what improvements can be made for endoscopy patients.

Children visiting or staying at Royal Bolton Hospital are to be offered the chance to see behind the scenes and step into the world of the hospital's testing laboratories. Young patients will be invited to have a tour of the labs to help them and their families feel more at ease by meeting the hospital's biomedical science staff who analyse hundreds of daily tests to help diagnose illnesses.

The initiative is known as 'Harvey's Lab Tours', started by a biomedical scientist in blood transfusion, Malcom Robinson, who was asked to give a tour of his laboratory to Harvey Baldwin, a 7-year-old boy who was undergoing treatment for leukaemia at Worthing Hospital. Harvey's Lab Tours aim to help young patients to understand the importance of their blood tests and other samples, meet the biomedical scientists who work behind the scenes and feel more confident and in control of their healthcare journey.

The number of people catching measles is rising in Greater Manchester. One in five people with measles will go to hospital and in very rare cases people can die from the disease. People in certain at-risk groups including babies and young children, pregnant women, and people with weakened immunity, are at increased risk of complications from measles. Having the MMR (measles, mumps and rubella) vaccine is the best way to prevent it. Parents who are unsure if their child is up to date with all of their routine immunisations should check their child's Red Book (personal child health record), check the NHS app, or contact their GP practice. Adults who are unsure of their own vaccination status can speak to their GP

who will arrange for a catch up immunisation if necessary – this is also free of charge. Anyone who is unable to touch pork products can request a non-porcine version (Priorix) of the vaccination from their GP.

Ambition 2: A great place to work

In line with national requirements, we have now completed a number of nurse staffing reviews using the Safer Nursing Care Tool (SNCT). These reviews help us understand staffing needs across our wards and departments, and mean that some changes to staffing levels and shift patterns are needed to better meet patient needs. We are working with our ward leadership teams to agree updated staffing models, which will be reviewed and approved by senior leadership. Any changes will be supported by impact assessments. We have also introduced a new escalation process alongside this, for nurses to raise concerns about staffing in real time, and continue to monitor patient care quality and daily staffing pressures closely.

We are bringing together our assessment processes, to ensure that any change to a process or pathway does not compromise on the six aspects of quality, or disadvantage any particular group or community unfairly. Our quality impact assessment (QIA) and equality impact assessment (EIA) processes will merge, to help our teams ensure holistic oversight of any impact our decisions could have. This will ensure that the wider implications of a change of process are factored into our thinking.

Last week, resident doctors took part in industrial action, following a renewed mandate for strikes from the British Medical Association (BMA). Industrial action has a significant impact on our ability to deliver services, due to the volume of staff expected not to be in work, and the length of time it can continue. As ever, we applied our contingency plans so that were as prepared as possible, and put additional information in place to support the public, particularly around accessing urgent and emergency care.

This month we launched one of our new change teams, part of Our Voice change programme. The new team, ***Our Care***, will help us understand why some colleagues may or may not recommend the Trust as a place to receive care or treatment. The team will run alongside existing teams addressing challenges in digital, and working environments, and new team working our way, which will look at the behaviours and values expected of each other. The teams are an opportunity to learn from experiences, and work together to ensure that everyone has a positive experience of our care.

The Trust has been awarded a Silver accreditation in the Defence Employer Recognition Scheme (ERS), which is designed to encourage employers to support defence and inspire other organisations to do the same. The silver award recognises that we are an organisation that is forces-friendly and open to employing reservists and veterans including the wider armed forces community (cadet instructors and military spouses/partners). We actively ensure our workforce is aware of our positive policies towards defence people issues and that we support mobilisations and training of reservist colleagues.

Elections for people to join our Council of Governors' have now closed. This year, there are seven public seats available in Bolton North East (1), Bolton South East (5) and Rest of England (1). The elections were also open to staff members in the following groups - Nurses and Midwives (1) Doctors/Dentists (1) All other staff (2). Governors act as both a voice and a listening ear for members, ensuring their perspectives are heard and considered. They play a key role in influencing the Board's decisions on the

future delivery and development of services. The Notice of Poll will be published on 5th August, and the election will formally close on 1st September with result published shortly after.

We marked National Estates and Facilities Day 2025 on 18th June, celebrating the amazing efforts of the 567 people that work in facility services at Royal Bolton Hospital and across the community health centres of Bolton. iFM manage and employ the facilities staff covering a wide range of roles, including plumbers, joiners, electricians, decorators, grounds and gardens, domestics, catering, portering and many, many more. In the past year, iFM Bolton logged completed jobs through the Portering system, 13,855 estates requests were completed and an incredible 500,118 lunches and suppers were served to the hospital's inpatients.

Staff who have dedicated decades of their lives to providing care to Bolton's communities have been celebrated at our Long Service Awards 2025. The Long Service Awards honours Bolton NHS staff who have completed an incredible 25 and 40 years. Between those receiving their long service awards this year, staff have completed a remarkable 1,300 years between them and we are grateful to have them on the Bolton team.

Nominations for our annual FABB Awards have now closed. The People's Choice award and Charity Supporter of the Year award were open to the public and we received an incredible 669 nominations, with 44 of these coming from members of the public.

People have shared their heartfelt thanks to recognise the dedication, compassion and commitment of NHS staff and health and care workers, and for the first time will be celebrating those who have made a difference for Our Bolton NHS Charity. Thanks to the generous contributions from our sponsors, the awards ceremony will take place on 10th October at the Toughsheet Stadium in Horwich.

To mark Volunteers' Week (2-8 June), we took a moment to celebrate the contributions of volunteers and thank them for their invaluable efforts. The Trust has 394 volunteers who give up their time to take part in a huge range of roles that suit all types of interests and skills.

These roles include providing a warm welcome and offering helpful directors, being a dining companion or providing support on the hospital wards. Volunteers have contributed more than 13,000 hours to support staff and patients at Royal Bolton Hospital in the past year.

Ambition 3:
A high performing, productive organisation

On 30th June, we reconfigured the leadership of our clinical divisions, moving from five to four. Our clinical divisions are the structural units that organise and manage the various medical services that we provide. These clinical divisions group together related specialties and departments, allowing for focused management and delivery of patient care.

The new senior leadership teams for community services, families and diagnostics, medicine and surgery are now officially in place. The five former divisions had a great opportunity to present the amazing work that they have done by sharing their achievements and challenges of the last twelve months with the Board

of Directors at the recent service review day. We are looking forward to seeing what our teams achieve as four clinical divisions over the next twelve months and beyond.

We continue to work hard to reduce overall spend to deliver the financial control total needed as part of the Greater Manchester system. We have already identified £37m of cost improvement savings through a number of schemes, including introducing a stock management system to help avoid waste, digitalising some of our administration processes and reconfiguring parts of our estate. We have engaged the support of PWC to help us to understand if there are any missed opportunities within our current plans, and will be bringing their findings through future Board meetings.

A number of our teams continue to be recognised for the contributions they make to improve patient care and to transform our organisation. We were proud to have members of our staff recognised at the Greater Manchester Health and Care Champion Awards.

A massive well done to the IV Therapy Team, winning the *Green Initiative of the Year Award*, by introducing elastomeric devices to administer antibiotics at patients' homes - cutting single-use plastics and CO_2 emissions significantly.

Congratulations goes to Tyrone Roberts, Chief Nursing Officer, winner of the *Wellbeing Champion Award*. Tyrone has gone above and beyond to boost staff wellbeing. As a qualified fitness instructor and personal trainer, he launched and personally leads a free fitness and nutrition programme tailored for colleagues working all shift patterns. Sabana Bhikha, our Practice Educator and Neonatal Nurse was shortlisted for her passion for wellbeing, and ensuring everyone's mental health is prioritised.

The winner for the *Learner of the Year* went to student nurse, Nat Mulley. Through education at Salford University and training here at Bolton, Nat is improving the quality of nursing practise and patient care for those who are deaf or hard of hearing.

Oluchi Okoroafor, a Student Nurse on clinical placement at our hospital has been awarded the Health Support Worker of the Year Award at the Black Healthcare Awards 2025. Now in its second year, the awards shine a spotlight on individuals and teams who are making a real difference, through leadership, innovation, advocacy, and compassionate care.

Ambition 4:
An organisation that's fit for the future

The Government's 10 Year Health Plan for England has been launched, setting out a bold, ambitious and necessary new course for the NHS. The plan fundamentally reinvents our approach to healthcare so that we can guarantee the NHS will be there for all who need it for generations to come. It has been shaped by the experiences and expectations of members of the public, patients, our partners and the health and care workforce across the country, reflecting the changes that people wanted to see.

Through the 'three shifts' – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all. We are in the process of reviewing our current Trust strategy to understand the synergies with the 10 Year Health Plan, and any further work we need to do to work towards it.

We were delighted to welcome Sir Jim Mackay, NHS England's Chief Executive in June, to showcase some of the Trust's significant improvements to services and major estate developments. Sir Jim visited the Elective Care Centre, Urgent Care and stepped behind the scenes to see the work the hospital's Laboratories.

Whilst in the Elective Care Centre, which opened in January 2024, Sir Jim heard about the investment to create a new and modern theatre suite and the creation of on-site pre-assessment clinics, which aim to introduce patients to the environment and meet staff before they have their operation.

The tour included a brief visit through the multimillion pound redevelopment of maternity and women's health care, following the identification of reinforced autoclaved aerated concrete (RAAC) in 2023.

In Urgent Care, Sir Jim spoke to clinical and operational teams about a programme of transformation to improve performance and the timeliness and quality of care patients receive, which recently resulted in the Trust being named the third most improved in the country for 12-hour performance.

The visit concluded in Laboratories, with a focus on some the hospital's aging estate, where capacity is limited and further RAAC exists. Despite these challenges, Bolton has been named first in the country for the accuracy of tests in breast screening and its antenatal screening lab is the highest performing in England.

Sir Jim Mackey was able to spend time with staff throughout the tour, including Gareth Adedeji from the Trust's estates partner, iFM Bolton, who spoke about taking part in the weekend's Bolton IRONMAN 70.3 event.

Ambition 5: A positive partner

At the Bolton Vision Board the borough's 2040 plan was launched, which aligns seamlessly with our organisational strategy, the Greater Manchester plan, and the wider NHS 10 Year Health Plan. In recent years, cost-of-living pressures, growing health inequalities, and limited access to skills and employment have negatively impacted many of our residents, both in the short and long term. By 2040 we want Bolton to be a thriving borough, where people want to live, work, study, invest and visit.

NHS Greater Manchester has made significant strides, working more closely with NHS England to deliver a set of formalised agreed actions under one Single Improvement Plan (SIP) to enhance care for people across our region. In March this year, NHS GM reported compliance with 28 of the 36 undertakings, and we were making progress against the remaining eight.

This month NHS GM achieved compliance in two more undertakings – leadership and governance, and financial planning. Good progress has been noted on two undertakings related to 'quality' with an expectation that compliance will be approved this month (July). These relate to providers such as hospital

Trusts across GM meeting requirements set out in NHS GM's Quality Improvement Plan, and NHS GM demonstrating good quality governance assurance and oversight mechanisms.

NHS England has accepted GM Integrated Care Partnership's financial plan submission for 2025/26, which has achieved £335m of savings reducing the overspend to £200m - a much-improved position thanks to everybody's efforts. This demonstrates the efforts of our colleagues right across the GM health and care system.

A further review will be carried out regarding progress against the remaining undertakings in September. The focus across our region now will be on the remaining four undertakings:

- Delivering the 2025/26 NHS Greater Manchester financial plan
- Developing the medium-term financial plan with the aim of ensuring NHS GM enters 2026/27 in a "break-even" position
- Continuing to resolve outstanding historical commissioning arrangements
- Sustaining improvements in patient wait times (4 hours, 12 hours, and 14 days)

A member of our staff, Trish Lindley lifted the Dance Floor Heroes glitter ball trophy after taking part in the annual fundraising spectacular in Blackpool's Winter Gardens Empress Ballroom raising vital funds for Dance Floor Heroes and Tia's Crown mental health charity. Thousands of people from all over the country applied and auditioned to take part the Strictly-style experience, which sees people being partnered up with a professional dancer to learn a routine and perform in front of judges and an audience of 3,000 people.

Our Enhanced Care Team is running low on stationery supplies and an appeal has launched with the public to enable therapeutic activities that help distract and support vulnerable adult patients at risk of harm due to new confusion, cognitive decline, falls, or challenging behaviours. One of the easiest ways to make a difference is through Our Bolton NHS Charity's Amazon Wishlists, where we share a curated list of essential items needed by our teams to enhance patient care.

Brand new contactless donation devices have been installed at Royal Bolton Hospital to make it easier for people to support Our Bolton NHS Charity. Located at the hospital's Main Entrance and the Community Diagnostic Centre in J Block, the terminals allow people to tap and donate either £3, £5 or £10 using their contactless card or phone via Google Pay or Apple Pay. Funds raised will contribute towards projects that make a lasting and meaningful difference to the tens of thousands of people who use NHS services at Royal Bolton Hospital and in the community every year.

Parents and babies will now be able to stay closer together whilst staying in hospital following the introduction of new hot cots on Royal Bolton Hospital's post-natal ward. Funded by Our Bolton NHS Charity, the hot cots will support babies on the post-natal ward to maintain their body temperature and treat cases of hypothermia, with the aim of reducing admissions to the Neonatal Unit. Hot cots use a heated mattress to allow parents and care givers to have full contact with their baby by removing the physical barrier of an incubator.

Report Title:	Board Assurance Framework Q1 Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	

Purpose of the report	To provide assurance that the principal risks to achieving the Trust's Ambitions are identified, regularly reviewed, and systematically managed.

Previously considered by:	A review of the BAF was conducted with respective Executive Director Leads and at Committee prior to presentation.

Executive Summary	The Board Assurance Framework (BAF) provides a structured mechanism for evaluating whether the Trust has robust controls in place to manage strategic risks, and for assessing the effectiveness of the assurance provided through those controls. The BAF has been revised to align with the Trust's new Strategic Ambitions and now incorporates the updated Risk Appetite Statements agreed by the Board in December 2024. As part of this update: • A new strategic risk, **CO10a – Resilience against Cyber Threats**, has been added to reflect the increasing national escalation in cyber incidents and the Trust's evolving digital landscape. • It is proposed that **CO12** be expanded to reflect the Trust's ambition to become a **net zero healthcare provider**, in line with the NHS Net Zero Plan (*Delivering a 'Net Zero' National Health Service*), which commits the NHS to achieving net zero emissions by 2040. The BAF has been presented to all relevant Committee meetings ahead of Board consideration. Committees have been asked to review the robustness of the controls in place and evaluate the effectiveness of the assurance mechanisms supporting those controls. This process ensures the BAF continues to provide a reliable basis for strategic oversight and risk-informed decision-making. Due to the timing of the Quality Assurance Committee (QAC), a verbal update will be provided at the Board meeting.

Proposed Resolution	The Board of Directors are asked to **receive** the BAF.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Sharon Katema, Director of Corporate Governance	Presented by:	Sharon Katema, Director of Corporate Governance

Board Assurance Framework Explanatory Notes

Assurances	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. ○ 1st Line functions that own and manage the risks, ○ 2nd line functions that oversee or specialise in compliance or management of risk, ○ 3rd line function that provides independent assurance.
Controls	The measures in place to reduce either the Strategic Risk Likelihood or Impact and assist to secure delivery of the Ambition
Corporate Risk	Defined as risks rated 15 and above or those scoring Catastrophic (5) for Impact
Gaps in assurance	Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
Gaps in controls	Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
Linked risks	The key risks from the Corporate Risk Register that align with the Strategic Ambition and have the potential to impact on objectives.
Principal Risk	This is the overall risk to achieving our main Strategic Ambition
Risk Treatment	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners.
Strategic risk	These are the risks that populate the BAF; defined by the Board and managed through Lead Committees and Executive Directors.

1. INTRODUCTION

1.1. The Board Assurance Framework (BAF) provides a structure and process which enable the Board and its committees, to review its Strategic Ambitions, the extent to which the Trust has appropriate and robust controls in place to manage the strategic risks, and the level and effectiveness of assurance provided by and through those controls.

1.2. The BAF has a crucial role in promoting effective financial management, risk mitigation, and governance within the NHS ensuring financial stability, accountability, and transparency, which are essential for the efficient delivery of healthcare services.

2. Strategic Alignment

The BAF has been fully aligned with the Trust's Strategy for 2024–2029, ensuring that risk management is directly linked to the organisation's long-term vision and priorities. Each of the Trust's agreed Strategic Ambitions is now underpinned by a clearly defined set of Principal Risks, which represent the most significant threats to the achievement of those ambitions.

To enhance clarity, accountability, and assurance, each Principal Risk has been further broken down into individual Strategic Risks. These Strategic Risks are explicitly mapped to the Trust's Corporate Objectives, providing a structured and transparent framework for monitoring risk exposure and mitigation across all levels of the organisation.

Each Strategic Risk is supported by:

- Defined Controls: Measures in place to reduce the likelihood and/or impact of the risk.
- Sources of Assurance: Internal and external mechanisms that provide evidence of control effectiveness.
- Risk Appetite Statements: Reflecting the level of risk the Trust is willing to accept in pursuit of its objectives.

This alignment strengthens the Trust's ability to make informed decisions, allocate resources effectively, and provide robust assurance to the Board and stakeholders.

2.1. Executive Oversight

For each ambition, the responsible Executive Director holds responsibility for overseeing the associated risks and issues that may impact delivery. This includes:

- Regular Review of Strategic Risks, ensuring that emerging threats, operational challenges, and external influences are identified and assessed in a timely manner.
- Evaluation of the potential impact and likelihood of each risk materialising, ensuring that risk scores remain current and reflective of the operating environment.
- Controls in place to mitigate them
- Assurance mechanisms that demonstrate control effectiveness
- Where gaps in control or assurance are identified, SMART actions are developed with clear deadlines. These actions are monitored and updated regularly.

2.2. Governance and Review

The full BAF is reviewed:

- At least three times per year by the Board.
- Twice per year by the Audit Committee.

The Director of Corporate Governance has ownership of the overall BAF including population of the summary BAF.

3. RISK MANAGEMENT

3.1. The BAF provides a mechanism for identifying and managing financial risks effectively. It establishes a framework for assessing and monitoring risks related to financial management, including financial planning, budgeting, and financial controls. This enables the board to make informed decisions and take appropriate actions to mitigate risks.

3.2. To ensure consistency in approach, all risks have been assessed in line with our Risk Management Policy and have been graded using the system highlighted below to generate a risk score: **Severity (Consequence) x Likelihood = Risk Score**.

Severity		**Likelihood**		
1	Insignificant	2	Rare	Difficult to believe that this will happen / happen again
2	Minor	2	Unlikely	Do not expect it to happen / happen again but it may.
3	Moderate	3	Possible	It is possible that it may occur/ reoccur.
4	Major	4	Likely	It is likely to occur / recur but is not a persistent issue
5	**Catastrophic**	5	**Certain**	Will almost certainly occur / reoccur and could be a persistent issue

Risk Categorisation Matrix

Severity / **Likelihood**	1	2	3	4	5
1	1	2	3	4	5
2	2	4	8	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Key

15+	High
8 -12	Significant
4 - 6	Moderate
1-3	Low

3.3. **Principal Risks**

All Principal Risks within the BAF have now been disaggregated into individual Strategic Risks. Each of these Strategic Risks is explicitly aligned to a specific Corporate Objective, ensuring clearer accountability, improved oversight, and a more direct line of sight between risk exposure and organisational priorities.

This structured alignment enhances the Trust's ability to monitor, manage, and mitigate risks in a way that supports delivery of its strategic ambitions and strengthens assurance to the Board.

4. RISK APPETITE

4.1. **Risk Appetite Definition -** Risk appetite can be broadly defined as the amount of risk that an organisation is willing to take or the total amount of risk an organisation is willing to accept in order to meet its strategic objectives.

Risk exists in all environments, especially in Healthcare and the Trust recognises that it is impossible to achieve its aims and objectives without taking risks. Whilst the amount of risk that the Trust is willing to accept will vary, this will be captured in each of the strategic risks and may change as we move forward.

4.2. Risk Appetite Statements - Our Risk Management Policy defines the organisation's approach to risk through a series of Risk Appetite Statements, each tailored to reflect the level of risk the organisation is willing to accept in pursuit of its strategic objectives. These definitions provide a consistent framework for decision-making, assurance, and governance across all levels of the organisation.

Each Risk Appetite Statement is categorised as follows:

Appetite Statement 5 (Seek/ Mature)	In relation to this area of work, Bolton NHS FT is willing to accept risks that may occur and would then lead to some degree of damage to its reputation, possible financial loss, exposure, or short term disruption to no more than one service area
Appetite Statement 4 (Open)	In relation to this area of work, Bolton NHS FT is willing to accept risks that are likely to occur and would then lead to some degree of damage to its reputation, or possible financial loss, exposure or short term disruption to one or more service area
Appetite Statement 3 (Cautious)	In relation to this area of work, Bolton NHS FT is willing to accept risks might occur in certain circumstances that could lead to some degree of damage to its reputation, possible financial exposure, or minor disruption to one or more service areas
Appetite Statement 2 (Minimal)	In relation to this area of work, Bolton NHS FT is willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.
Appetite Statement 1 (Avoid)	In relation to this area of work, Bolton NHS FT is not willing to accept any risks that could lead to damage to its reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public.

5. Recommendation:

The Board of Directors are asked to **receive** the Board Assurance Framework, review the robustness of the controls in place and evaluate the effectiveness of the assurance mechanisms supporting those controls.

Board Assurance Framework Dashboard

Corporate Objective		Principal Risk	Risk Appetite	Risk Rating (S x L)	Exec Lead	
Ambition 1: Improving care, transforming lives						
CO1	Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care	If the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities and unsustainable services	Avoid	**12** 4 x 3	CNO	⟷
CO2	Create a culture where staff can innovate and collaborate to improve care	If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff	Cautious	**12** 4 x 3	MD	⟷
CO3	Play our part in improving health and preventing illness, so that people live healthier lives	If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequalities, unsustainable services and poor clinical outcomes	Cautious	**12** 4 x 3	CSP	⟷
Ambition 2: A great place to work						
CO4	Improve the experience of our staff and make our organisation a great place to work.	If the Trust does not achieve its Ambition (To be a great place to work) then it will be unable to recruit, retain and support staff to maximise their potential	Cautious	**16** 4 x 4	CPO	⟷
CO5	Help all staff to unlock their potential	If staff are not supported to unlock their full potential, then we risk reduced performance, lower morale, and missed opportunities for innovation and improvement	Cautious	**16** 4 x 4	CPO	⟷
CO6	Ensure that our workforce reflects the population we serve	If our workforce does not reflect the diversity of the population we serve, then we risk reduced public trust, diminished service effectiveness and potential reputational harm.	Cautious	**16** 4 x 4	CPO	⟷
Ambition 3: A high performing productive organisation						
CO7	Improving access to our services	If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.	Minimal	**16** 4 x 4	COO	↓
CO8	Being Efficient and Productive	If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services	Minimal	**12** 4 x 3	COO CFO	⟷
CO9	Delivering Financial Sustainability	If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability	Minimal	**16** 4 x 4	CFO	⟷
Ambition 4: An organisation that's fit for the future						
CO10	Being digitally enabled and inclusive Corporate Objective	If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities	Minimal	**12** 4x3	CSP	⟷
CO10a	Cyber Security	If the Trust experiences a cyber-attack and lacks effective defences and recovery plans, Then it may face serious disruption to patient care, data security, and regulatory compliance, with prolonged downtime and delayed recovery**.**	Avoid	**16** 4 x 4	CSP	⟷
CO11	Improving our estate	If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.	Avoid	**20** 4 x 5	CFO	⟷
CO12	Proactively planning for the future	If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy	Minimal	**16** 4 x 4	CFO	⟷
Ambition 5 : A positive partner						
CO13	Developing our neighbourhoods	If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed	Open	**12** 4 x 3	CSP	⟷
CO14	Working as one team	If the Trust does not promote a collaborative environment, it could result in fragmented efforts, misaligned objectives, and inefficiencies.	Open	**12** 4 x 3	CSP	⟷
CO15	Delivering financial sustainability	If the Trust does not establish partnerships that align with its ambitions then this could negatively affect the services on offer, infrastructure, and financial stability	Open	**12** 4 x 3	CSP	⟷

AMBITION 1: IMPROVING CARE, TRANSFORMING LIVES THROUGH FOCUSING ON SAFETY, EFFECTIVENESS AND EXPERIENCE
PRINCIPAL RISK: IF the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities, and unsustainable services.
Lead Committee: Quality Assurance Committee
Lead Directors: Medical Director, Chief Nurse, Chief of Strategy and Partnerships

Corporate Objectives	OUR IN-YEAR PRIORITIES FOR 2024-25	ENABLING PLANS
CO.1- Deliver high quality, safe care to everyone who uses our services and make sure that everyone has a positive experience of our care CO.2 - Create a culture where staff can innovate and collaborate to improve care. CO.3 - Play our part in improving health and preventing illness, so that people live healthier lives	Reducing the avoidable harms across all of our services by making our environment and processes safer, focusing on prevention, and learning from harm so that everyone is safe in our care	• Bolton Carers' Strategy • Bolton Locality Plan • Clinical Strategy • Quality Improvement Plan 2024-29 • Research Strategy (in development) • Nursing, Midwifery & Allied Health Professionals and Health-Care Scientist Priorities • Patient Safety Incident Response Plan • Quality account 2025/26

CO.1: Improving access to our services

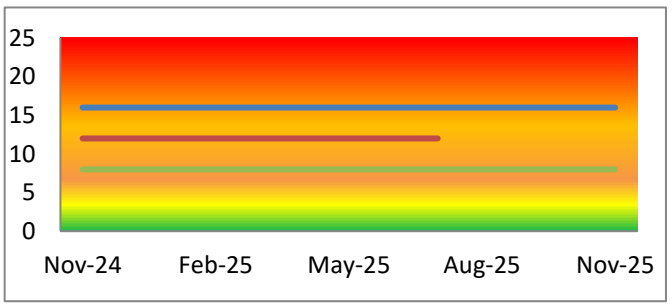
EXECUTIVE LEAD: CHIEF NURSING OFFICER

Risk Appetite: **AVOID**

We are not willing to accept any risks that could lead to damage to its reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public.

STRATEGIC RISK 1: If the Trust does not deliver high quality, safe and effective care to patients then everyone will not have a positive experience of our care resulting in an inability to learn from experience, poor clinical outcomes and unsustainable services.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

6193 (16) Reduced bed capacity DUE TO RAAC within the Maternity
5425 (16) Delivery of Urgent Care Performance Standards
1595 (15) Critical care delayed discharges & mixed sex accommodation breaches - QAC
6145(15) Maternity Theatres ventilation failures
6549 (16) Risk stratification and health optimisation in pre-op assessment
2937 (15) Orthopaedic Interface Service (OIS) waiting times

Issues impacting achievements of our objective

- ~~Future reductions in supply workforce as predicted based on reduced learner intake which may impact 27/28~~
- ~~Demand for services exceeding capacity~~
- Anticipated reductions in workforce supply and current service demand exceeding capacity threaten future sustainability.
- Limited capacity in Trust teams to support plans/projects and insufficient collaboration with adult social care hinder integrated planning and delivery
- Regulatory breaches and inconsistent application of quality improvement methodologies compromise standards and outcomes.
- Leadership inconsistency with application of required standards
- Financial health fragility impacting on service provision
- Inadequate access to patient experience and outcome data, along with missed opportunities to implement evidence-based interventions, restrict learning and innovation.

KPIs / Measures

- Year-on-year improvement in patients who report that they were treated with dignity and respect
- Year-on-year reduction in avoidable harm and mortality
- Compliant and achieving top quartile against National and local quality recommendations such as GIRFT
- Year-on-year improvement in the % of staff reporting they would recommend BFT as a place to receive care
- Year-on-year improvement/increase in the number of patients responding to national survey
- A minimum of 60% of our wards and departments score a silver or higher by 2029 as measured through our BOSCA accreditation programme
- Year-on-year improvement in patients who reported that they were involved in decision making

Controls

- Quality Account Priorities
- Quality Improvement Plan
- Patient Safety Incident Response Framework / Plan
- Being Open Policy (includes duty of candour)
- Enabling professional priorities established for Nursing, Midwifery, AHPs and Health-care scientists (NMAHP&HCS),
- ~~Enhanced~~ Accreditation (BoSCA) escalation framework
- Safeguarding Assurance Framework
- Quality Impact Assessments
- NHSE workforce safeguards
- ~~Scheduled programme of patient feedback (positive and opportunities for learning)~~ Learning from experience 6 monthly report
- ~~Deployment of a blend of QI Methodology (eg Lean and breakthrough series) Two QI collaborative to support~~ ~~embedding of QI methodology around priority areas~~
- ~~QI training offer~~
- Annual Leadership conference
- Talent management programmes in place for all NMAHP & Health Care Scientists (HCS)
- ~~Three year~~ Clinical Audit Work -Plan
- National patient safety alerts NICE guidance and other safety related guidance reviewed, audited and implemented where relevant and appropriate
- Policies/procedures to support safe care delivery, i.e. falls, pressure ulcers, safeguarding
- Fundamentals of care internal development programme for non-registered clinical staff

Assurances

1st line of Defence (Operational management)

- Risk registers reviewed at Risk Management Group
- Real-time patient experience with addition of key questions for all in-patients and community long term caseloads
- Monthly reports to Clinical Governance & Quality Governance Group
- NHS IMPACT self-assessment
- Nurse and Midwife sensitive clinical outcomes dashboard (heatmap)

2nd Line of Defence (Reports at Board and Committee Level)

Reports to Quality Assurance Committee and Board, namely:

- Integrated Performance Report with monthly heatmap
- Safe staffing report to Board in line with NQB recommendations within heatmap
- Quality Account Priorities
- Mandatory training compliance
- Bi-annual Nurse & Midwifery establishment reviews
- CNST & other Maternity related specific reports
- Risk Management Group chairs report to Audit and Risk Committee

3rd Line of Defence (Independent or external assurance)

- GMICB Bolton Locality Quality Spot Checks
- Internal audit reviews
- CQC inspection reports, visits, Insight reports, and engagement meetings
- Peer reviews and accreditation.
- Quality governance review via Good Governance institute 2023
- National patient surveys
- CQC Improvement Plan reporting/oversight to QAC. Well led recommendations reported through to appropriate committees of the Board

Actions

1. Scoping procurement of a digital solution to support with provision of aggregated data / thematic analysis**.** Expected (business case) presentation March 2025).
   July 25 Update: Revised Target Date Q3 2025
2. Roll out and embedding of community safer nursing acuity tool – **Target Completion Date 30.03.25**
   July 25 Update: Re
3. **Relaunched and revised target completion Q2 2025**
4. ~~4.~~ Development of Risk Management Framework with stakeholder engagement **Target Completion Date ~~30.12.2023~~.** Revised to September 25
5. Improvement plan to attain full compliance with NHSE workforce safeguards: **Target Completion Date 31.3.2026**
6. Completion of National research and development gap analysis tool (SORT); **Target Completion Date 31.3.26**
7. Provision of inclusive patient experience / service user feedback that represents all users; **Target Completion Date 31.3.26**
8. Agreement of initial NMAHP clinical outcomes for stratification by ethnicity and deprivation; **Target Completion Date 31.3.26**
9. Introduction of shared decision-making councils. TOR developed, further engagement planned in April with Divisional teams, first leadership council meeting in June **Target Completion Date** – revised date to **Q2 25/26**
10. Review of Divisional Quality Governance (Families and Diagnostics) **Target completion date Q2**
11. Review of Maternity specific outcomes against peer using available data (and new national datasets) **Target Completion Q3 2025**
12. Aqua facilitated Board Development on Continuous Improvement and Learning Organisation **Target Completion Q2 2025**

Gaps in Control

- Development of a Risk management framework/strategy
- Lack of robust non-medical research plan
- Lack of an ACP Workforce Strategy
- ~~Lack of consistency with training needs analysis~~

Gaps in Assurance

- NHSE workforce safeguards for Nursing partial compliance
- Lack of robust, co-ordinated & consistent intelligence on patient experience / service user feedback from those without / with limited, mental capacity and / or those for whom English is not first language
- Lack of robust process for inclusion of NMAHP&HCS outcome data stratified according to ethnicity and deprivation
- Real-time access to Quality KPIs and access to automated triangulation
- Ability to benchmark data in real time

Committee Feedback

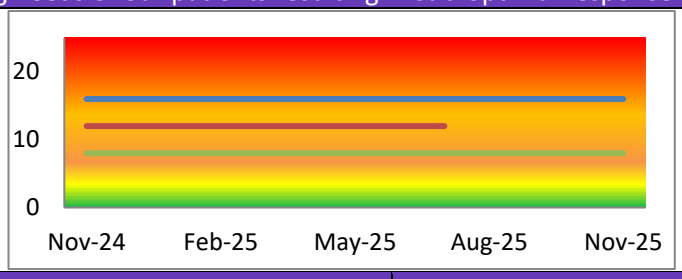
The QAC will receive the BAF at its 30 July 2025 meeting and will be be asked to approve the **AVOID** Risk Appetite Statement, as agreed by the Board in December 2024.

As Lead Committee, the Committee will review the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It will also review the Actions to adress the gaps.

CO.2 - Create a culture where staff can innovate and collaborate to improve care and reduce harm	EXECUTIVE LEAD: MEDICAL DIRECTOR
Risk Appetite: **CAUTIOUS**	We are willing to accept risks might occur in certain circumstances that could lead to some degree of damage to our reputation, possible financial exposure, or minor disruption to one or more service areas.

STRATEGIC RISK 2: If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)

Issues impacting achievements of our objective

- Missed Opportunities for Improvement or implementation of evidence-based interventions.
- Inadequate clinical data in EPR systems restricts innovation, learning, and evidence-based decision-making.
- Varied work practices, clinical commitments, and lack of shared values hinder effective collaboration across teams and with primary care.
- ~~Limited awareness and access to digital tools and licences (e.g. Microsoft) impede collaborative working.~~
- Absence of a structured innovation pathway and insufficient funding for pilot schemes to enable innovation.
- Lack of infrastructure undermines the development of a robust research programme.

KPIs / Measures

- Through developing our approach to quality improvement, embedding QI methodologies and nurturing a culture of improvement and innovation and will ensure that a minimum of 75% percentage of our staff have the skills and knowledge to do this
- Increased in the number of changes and innovations implemented annually aligned to the priorities in our clinical and organisational strategy
- Enhanced corporate and clinical decision-making accuracy and efficiency through the effective utilisation of technologies such as AI, predictive analytics and decision-support
- Expanded research collaboration and provision, providing service users with increased access to clinical trials and supporting our workforce to take part in research in line with the organisational research plan
- Improvement in NHS IMPACT self-assessment Maturity Matrix level
- Compliance with NICE guidelines and Clinical Audit Annual plan

Controls

- Quality Improvement collaboratives for deteriorating patients incorporating Martha's Rule (NHSE pilot)
- NHSE Improving Patient Care Together (IMPACT) self-assessment Maturity Matrix level
- ~~Attendance and membership of the Bolton University Joint Delivery Board.~~
- ~~System-wide programme for~~
- Advanced Care Planning (ACP) to support Admission Avoidance with monitoring at Mortality Steering Group (MSG)
- Increased attendance at the OUR LEADERS programme with the development of medic specific blended learning bundles and Action Learning Sets

Assurances

1st line of Defence (Operational management)

- Quarterly Quality Account updates to CG&QA committee ~~(on NEWS and antibiotic prescribing compliance)~~
- Clinical audits
- Alignment and monitoring of actions within the Research Plan

2nd Line of Defence (Reports at Board and Committee Level)

- Research Committee, Clinical Effectiveness Group, CG&QC, AI Steering Group
- Integrated Performance Reports to QAC and Board
- Reports on IPC, transfusion, Medicines Safety, Safeguarding
- Quarterly Mortality Steering Group and LfD reports to QAC
- Mortality reports to QAC and Board

3rd Line of Defence (Independent or external assurance)

- NIHR and GM research benchmarking
- National reporting and benchmarking
- AQuA audits of care
- GIRFT reviews into care provision
- External assessments and accreditation
- Report to Bolton University Joint Delivery Board

Actions

1. Implementing artificial intelligence (AI) and robotic process automation to enhance efficiency and aid in decision-making. **Target Completion Date: Q4 2025/26**
2. Expanding research trial access to benefit more people with innovative therapies. **Target Completion Date: Q4 2025/26**
3. Rolling out of Quality Improvement training to Medical staff. **Target Completion Date: Q4 2026**
4. Development of Research Plan. **Target Completion Date: Q3 2025**
5. System-wide quality improvement initiative for Advanced Care Planning (ACP) to support Admission Avoidance **Completion Date Q.4 2025**

Gaps in Control

- Development of a Research Plan
- Capacity in consultant job planning to support delivery of Ambitions.
- Lack of Quality Improvement education for medical staff.
- Central oversight of innovation
- Resident Doctor listening events
- Lack of consistent EPR solution
- Development of medic specific blended learning bundles and Action Learning Sets

Gaps in Assurance

Reporting and oversight of innovation and collaboration

Committee Feedback

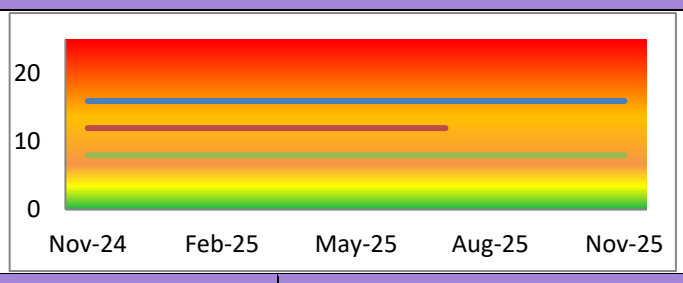
The QAC will receive the BAF at its 30 July 2025 meeting and will be be asked to approve the **CAUTIOUS** Risk Appetite Statement, as agreed by the Board in December 2024.

As Lead Committee, the Committee will review the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It will also review the Actions to adress the gaps

CO.3: Play our part in improving health and preventing illness, so that people live healthier lives	**EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS**
Risk Appetite: **CAUTIOUS**	We are willing to accept improbable risks that might occur, however, lead to some degree of damage to our reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 3: If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)

Issues impacting achievements of our objective

- Widening health inequalities if health disparities are not equitably implemented
- Reduced Life expectancy
- Increased chronic health diseases leading to long-term health implications and quality of life
- Higher healthcare costs resulting in diverting resources from other clinical areas

KPIs / Measures

- Contribute to Smoke Free targets for Bolton locality to support delivery of a reduction in the % of people who smoke
- Contribute to reduction in obesity targets for Bolton Locality to support delivery of a reduction in the % of people who are overweight or obese through implementation of Making Every Contact Count
- Continued optimisation of health outcomes for cancer and chronic conditions through earlier diagnosis and specific interventions; including playing our part in diagnosing 75% of cancers at Stage I/II by 2028
- Working towards decreased acute demand, as a result of proactive and preventive approaches i.e. reduced avoidable admissions, re-admissions and extended hospital stays

Controls

- Bolton Locality Plan
- NHS Greater Manchester Sustainability Plan
- Clinical Strategy
- Bolton Public Health Annual Report 2023
- Bolton Joint Strategic Needs Assessment (JSNA)
- Benchmarking through Model Hospital
- Bolton Carers' Strategy
- Health Inequalities Group
- Quality Improvement Plan
- Bolton Outcomes Framework
- Educational programme to improve communication with patients, families and carers
- Making Every Contact Count (MECC) Health Programme

Assurances

1st line of Defence (Operational management)

- Reports from Neighbourhood teams and weekly programme of community visits
- Neighbourhood maturity measured through the maturity matrix

2nd Line of Defence (Reports at Board and Committee Level)

- *Health Inequalities enabling group*
- *Neighbourhood Steering Group reporting to Locality board*

3rd Line of Defence (Independent or external assurance)

- Model Hospital metrics
- National reporting and benchmarking
- Reports to Bolton Locality Board
- GM Provider Collaboratives
- Outcomes framework reports to NHS GM Bolton Locality board

Actions

1. Enhancing links between primary, community, secondary, and social care to ensure people get the services and advice they need promptly. **July 25 Update:** Plan for provider collaborative developed (**Review March 2026)**
2. -Making Every Contact Count implemented and reviewed in Community Division **Target Completion Date: March 2026**
3. Identifying and involving carers in care planning, decision making and discharge so that we improve experience. **Target Completion Date: March** 2026
4. Board level discussion on our Socio Economic Duty and Action Plan. **Target Completion Date:** March 2026
5. Health Inequalities Action Plan reviewed and refreshed. **Target Completion Date**: March 2026
6. Ensuring continuity of care in our Maternity Services for those at most risk and from most deprived areas. **Target Completion Date: March 2026**
7. Ensure Health Inequalities Framework is embedded into the organisation – **Ongoing into 2026**

Gaps in Control

- Establishing new models of care in the community and through neighbourhoods
- Using technology to support people with long-term conditions to live well at home.
- Carer Plan Review

Gaps in Assurance

- PCN and Neighbourhood alignment
- Increasing focus on prevention and equitable access, experience and outcomes through community engagement and neighbourhood groups.
- Health inequality metrics to be added to the Integrated Performance Report presented to Committees and Board.

Committee Feedback

The QAC will receive the BAF at its 30 July 2025 meeting and will be be asked to approve the **MINIMAL** Risk Appetite Statement, as agreed by the Board in December 2024.

As Lead Committee, the Committee will review the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It will also review the Actions to adress the gap.

AMBITION 2: A GREAT PLACE TO WORK
PRINCIPAL RISK: Principal Risk: If the Trust does not achieve its Ambition (To be a great place to work) then it will be unable to recruit, retain and support staff to maximise their potential.
Lead Committee: People Committee
Lead Directors: Chief People Officer

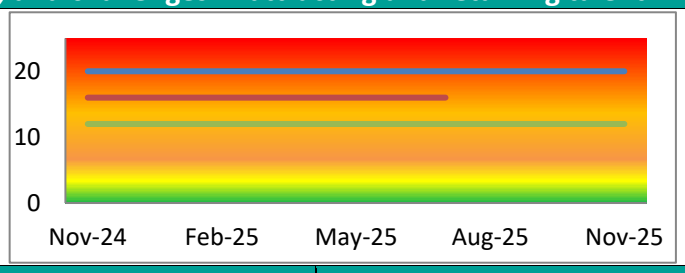
Our Objectives	OUR IN-YEAR PRIORITIES	ENABLING PLANS
CO.4 Improve the experience of our staff and make our organisation a great place to work. **CO.5 Help all staff to unlock their potential** **CO.6 Ensure that our workforce reflects the population we serve**	• Ensure no unplanned growth in headcount • Reduce agency spend to <3.2% • Deliver sickness absence rates of <4.8% • Reduce overall vacancy rate lower than 4% by 2025	• Equality, Diversity and Inclusion Plan 2022-26 • Medical Workforce Plan • Our People Plan

CO4: Improve the experience of our staff and make our organisation a great place to work. **EXECUTIVE LEAD: CHIEF PEOPLE OFFICER**

Risk Appetite: **CAUTIOUS** We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 4: If the Trust does not take action to improve staff experience and create a positive working environment, then we risk reduced morale, increased turnover, and challenges in attracting and retaining talent.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	5	4	2
Risk Score	20	16	8



Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15)Insufficient staffing within the pharmacy team is leading to reduced service provision
Risks added after People Committee meeting.

Issues impacting achievements of our objective

- Poor provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.
- Low staff engagement and satisfaction levels, resulting in low recruitment and retention of staff with the right skills and values.
- Failure to reduce reliance on agency staff

KPIs / Measures

- Year-on-year improvement in % staff reporting that they would recommend BFT as a place to work
- To remain in the top 20% of NHS organisations for staff engagement scores
- An achieved sickness rate of 4.8% or lower
- An achieved turnover rate of 10-12% in line with GM targets

Controls

Experience

- Staff Health and Wellbeing Plan
- Occupational Health Provision
- Our VOICE Change Programme
- Staff Health and Wellbeing programme
- Great Place to Work Plan
- Weekly / Monthly Safe Staffing meeting
- Consultants Job planning
- Staff Network groups
- Revalidation and annual Appraisals
- Mandatory and Statutory Training
- ESR Benefits realisation plan

Assurances

1st line of Defence (Operational management)

- Attendance KPI
- Friends and Family Tests
- Pulse Survey Staff Survey
- Divisional People Committees reports to People Committee
- IPM meetings with Divisions
- Reports to Vacancy Control Panel

2nd Line of Defence (Reports at Board and Committee Level)

- Integrated Performance Report to People Committee and Board.
- Staff Story included as a standing item in Board
- EDI Action Plan monitored at People Committee quarterly
- Our VOICE Change Programme reports to People Committee and Board

3rd Line of Defence (Independent or external assurance)

- NHS Staff Survey
- Local, Regional & national Benchmarking
- Internal Audit reviews
- Report and attendance at Bolton Locality Workforce Group

Actions

1. Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews.
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews.
3. ~~Our Voice Programme commenced with regular reports to People Committee and Executive Directors Group on a bi-monthly basis~~. July 25 Update: Completed
4. Regular meeting and expansion of Community voices group. **Target Completion Date: December 2025: July 25 Update**: Ongoing
5. EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date March 2025.**
   July 2025 Update: Revised Target Completion December 2025

Gaps in Control

Gaps in Assurance

EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee

Committee Feedback

The People Committee received the updated BAF at the July 2025 meeting and approved the **CAUTIOUS** Risk Appetite Statement, as agreed by the Board in December 2024.

As part of its role as Lead Committee, the Committee discussed and reviewed the Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

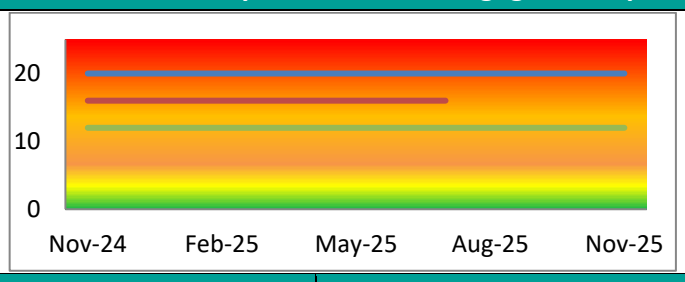
Following the Committee meeting, a further update of the BAF was undertaken and new risks have now been added to the Links to Risk Register A review of the current Risk Score of 16 will be undertaken to confirm its continued relevance and effectiveness.

CO.5: Help all staff to unlock their potential	**EXECUTIVE LEAD: CHIEF PEOPLE OFFICER**

Risk Appetite: **CAUTIOUS** We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 5: If the Trust does not support staff to reach their potential, then engagement, productivity, and innovation may decline.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	5	4	2
Risk Score	20	16	8



Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15)Insufficient staffing within the pharmacy team is leading to reduced service provision

Issues impacting achievements of our objective

- Poor provision of health and wellbeing support to staff, leading to an increase in sickness absence rates.
- Low staff engagement and satisfaction levels, resulting in low recruitment and retention of staff with the right skills and values

KPIs / Measures

- Continue to achieve and sustain an appraisal rate of 85% and deliver a year-on-year improvement in the % reporting that their appraisal helps them to perform their role
- Overall Trust vacancy rate lower than 4% by 2025
- To achieve compulsory training rates of 95% or greater

Controls

- Agile Working policy
- Workforce and OD Strategy
- Trust Health and Financial Wellbeing
- Our People Plan and Bolton interpretation of the NHS Workforce Plan
- Vacancy Control Panel

Assurances

1st line of Defence (Operational management)

- Resourcing and Talent reports to PC
- Divisional People Committees reports to People Committee
- IPM meetings with Divisions

2nd Line of Defence (Reports at Board and Committee Level)

- Integrated Performance Report to People Committee and Board.
- Staff Story included as a standing item in Board

3rd Line of Defence (Independent or external assurance)

- WRES, WDES,
- Gender Pay Gap report
- NHS Staff Survey
- Local, Regional & national Benchmarking
- Internal Audit reviews
- Equality Delivery System (EDS) 2022
- ICB EDI contract monitoring
- Report and attendance at Bolton Locality Workforce Group

Actions

1. Agile Working Action plan in place overseen by the agile working group including review of the Policy, roll out plan for equipment and risk assessments. **Target Completion Date: March 2026 -July 25 Update**: Ongoing with regular reviews
2. Review of Trust Well Being offer and financial well-being in light of cost of living pressures and national issues on pay. **Ongoing Target Completion Date: March 2026 July 25 Update**: Ongoing with regular review
3. Our Voice Programme commenced with regular reports to People Committee and Executive Directors Group on a bi-monthly basis. **Target Completion Date: March 2026 July 25 Update**: Ongoing with regular reviews
4. Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular review

Gaps in Control

Gaps in Assurance

EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee

Committee Feedback

The People Committee received the updated BAF at the July 2025 meeting and approved the **CAUTIOUS** Risk Appetite Statement, as agreed by the Board in December 2024.

As part of its role as Lead Committee, the Committee discussed and reviewed the Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

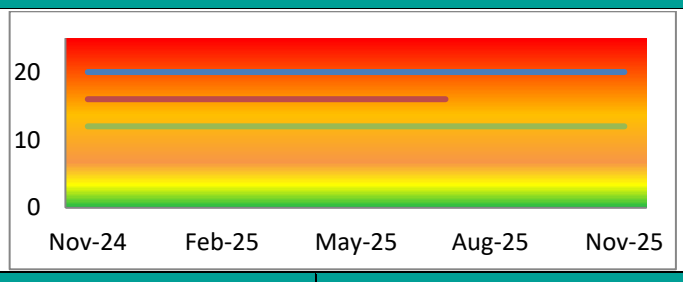
Following the Committee meeting, a further update of the BAF was undertaken and new risks have now been added to the Links to Risk Register A review of the current Risk Score of 16 will be undertaken to confirm its continued relevance and effectiveness

CO.6: Ensure that our workforce reflects the population we serve	EXECUTIVE LEAD: CHIEF PEOPLE OFFICER

Risk Appetite: **CAUTIOUS** — We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 6: If our workforce does not reflect the diversity of the population we serve, then we risk reduced cultural competence and inequitable service delivery.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	5	4	2
Risk Score	20	16	8



Link to Risks on Corporate Risk Register

6418 (16) Resident Doctor staffing levels
6422 (16) General Surgery CT on call rota
6438 (15)Insufficient staffing within the pharmacy team is leading to reduced service provision

Issues impacting achievements of our objective

- Failure to have an inclusive and diverse workforce representative of the population.
- Impact on improvement initiatives and attendance, and lost opportunities for increased efficiency and effectiveness
- Widening health inequalities impacting care provision, reputation, recruitment and retention

KPIs / Measures

- To have a workforce that represents the population we serve as measured by the WRES/ WDES

Controls

- NHSE EDI Improvement Plan
- Attendance and membership of Bolton wide People and culture group.
- Equality Diversity and Inclusion Strategy
- Equality Impact Assessments / Equality analysis
- Health Inequalities Enabling group
- Staff networks and forums representing diverse groups
-

Assurances

1st line of Defence (Operational management)

- Report and monitoring of EDS standards at Equality Diversity and Inclusion Steering Group
- Reports to Staff Experience Inclusion Steering Group
- Reports to Workforce and OD Group

2nd Line of Defence (Reports at Board and Committee Level)

- Integrated Performance Report to People Committee and Board.
- Review of WRES, WDES data at People Committee to identify and address
- EDI Action Plan monitored at People Committee quarterly

3rd Line of Defence (Independent or external assurance)

- WRES, WDES,
- Gender Pay Gap report
- NHS Staff Survey
- Local, Regional & national Benchmarking
- Internal Audit reviews
- Equality Delivery System (EDS) 2022
- ICB EDI contract monitoring
- Report and attendance at Bolton Locality Workforce Group

Actions

1. Regular meeting and expansion of Community voices group. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews
2. EDI Plan to be revised and complement the existing People Plan. **Revised Target Completion Date March 2026**
   July 25 Update: Ongoing with regular reviews

Gaps in Control

Gaps in Assurance

EDI Action plan updated with SMART objectives and with regular updates provided to Subgroups (EDI Steering group) and People Committee

Committee Feedback

The People Committee received the updated BAF at the July 2025 meeting and approved the **CAUTIOUS** Risk Appetite Statement, as agreed by the Board in December 2024.

As part of its role as Lead Committee, the Committee discussed and reviewed the Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

Following the Committee meeting, a further update of the BAF was undertaken and new risks have now been added to the Links to Risk Register A review of the current Risk Score of 16 will be undertaken to confirm its continued relevance and effectiveness.

AMBITION 3: A HIGH PERFORMING, PRODUCTIVE ORGANISATION

PRINCIPAL RISK: IF THE TRUST DOES NOT OPTIMISE PROCESSES OR ADHERE TO STANDARDS THEN THIS MAY HARM SERVICE PRODUCTIVITY AND EFFICIENCY, LEADING TO REGULATORY ACTION AND FINANCIAL INSTABILITY.

Lead Committee: Finance and Investment Committee

Lead Directors: Chief Finance Officer and Chief Operating Officer

Our Objectives	OUR IN-YEAR PRIORITIES FOR 2024-25	ENABLING PLANS
Corporate Objective 7- Improving access to our services Corporate Objective 8 – Being efficient and productive Corporate Objective 9- Delivering financial sustainability	• Reducing the time people spend waiting for urgent and elective care • Making the best use of our capacity to improve flow, reduce waiting times and improve utilisation of our services • Delivering recurrent cost improvement efficiencies and processes to make best use of public money.	• Clinical Strategy • Financial Outlook • Green Plan • Health Inequalities Plan • Operational Improvement Plan

CO7: Improving access to our services

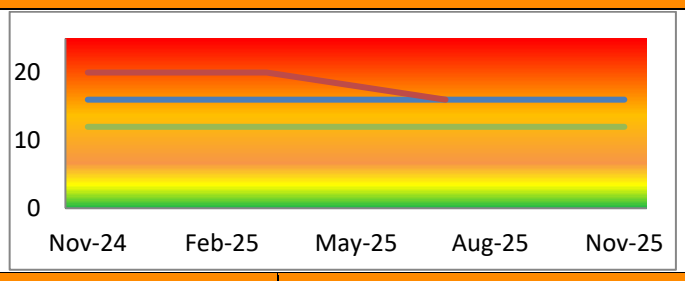
EXECUTIVE LEAD: CHIEF OPERATING OFFICER

Risk Appetite: **MINIMAL**

We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 7: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	5	4	3
Risk Score	**20**	**16 ~~20~~**	12



Link to Risks on Corporate Risk Register

Risk ID:
6072 – (16) *ED Cohorting in non-clinical areas*
5588 – (15) *ED Waiting Room*
5425(16) *Delivery of Urgent Care Performance Standards*
695 (5) *Emergency Planning Risks (Catastrophic for Impact)*

Issues impacting achievements of our objective

- Increased waiting list size and cancer backlog size since 19/20 baseline
- Insufficient diagnostic capacity within cancer pathways
- Insufficient capacity within the Emergency Department to deal with the demand
- ~~Lack of a sustainable Urgent Treatment Centre model~~
- Failure to ~~reliably meet the SAFER~~ timely discharge plan & apply SAFER ward standards
- Discharge capacity frequently does not meet demand
- Failure to deliver against nationally mandated performance ~~targets~~standards

KPIs / Measures

- Annual improvement in timeliness of care – including:
  - reduced wait times for appointments and treatment
  - response to requests
  - and length of stay
- Deliver annual operating plan ~~targets~~ standards

Controls

- Trust policies including (Escalation, Access, Discharge)
- Joint system working with NWAS, Council and ICS to admission avoidance, streaming from ED and discharge
- System Co-ordination Centre Meetings previously ~~(SORT)~~(SCC)
- Joint working with GM on cancer pathways to ensure equality of access across GM
- Regular validation of waiting lists
- Escalation Policy, Access Policy and Discharge Policy now refreshed and implemented
- Urgent care assurance meeting with GM
- Tier 2 meetings with the regional team about elective care delivery.
- Support from the Elective Care Improvement Team (ECIST)
- Support from the Emergency Care Intensive Support Team (ECIST)

Assurances

1st line of Defence (Operational management)

- Monthly Integrated Performance Management (IPM) meetings to review performance data
- Divisional Risk Registers at RMC
- Review of assurance programmes at Performance & Transformation Board
- Weekly Operational Update at Execs with regular ~~Urgent Care~~ Performance review across Urgent, Elective and Community services

2nd Line of Defence (Reports at Board and Committee Level)

- Bi-monthly IPR to QAC and Board
- Operational Update at Board
- Monitoring of performance at GM meetings

3rd Line of Defence (Independent or external assurance)

- Reports to GM Provider Oversight Meeting (POM)
- Reports to Locality Assurance Meetings
- NHSE Performance Assurance Framework NHS benchmarking data including Model Hospital Dashboard and North West performance data
- Getting it right first time (GIRFT) programme.
- Monitoring and scrutiny of performance targets by GM ICB & PFB teams, ECIST visits & peer reviews
- Internal Audit reviews
- Tier 1 & Tier 2 oversight meetings

Actions

1. Refreshed Capacity & Demand cycle **Revised target completion date December 2025)**
2. Development of a workplan following conclusion of the Internal Audit review of waiting list management. **(Target Completion Date December 2025)**
3. Full Implementation of actions following the ECIST review for both Emergency and Elective Care. **(Target Completion Date March 2026)**
4. Development of productivity tracker to monitor efficiencies. **(Target Completion Date March 2026)**

Gaps in Control

Lack of monitoring of the effectiveness of policies

Weak monitoring of the implementation of ward SAFER principles

Lack of a robust Capacity & Demand planning cycle

Gaps in Assurance

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting and

- Approved the **MINIMAL** Risk Appetite Statement, as agreed by the Board in December 2024.
- Approved the decrease in Likelihood to 4

As part of its role as Lead Committee, the Committee discussed and reviewed the Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

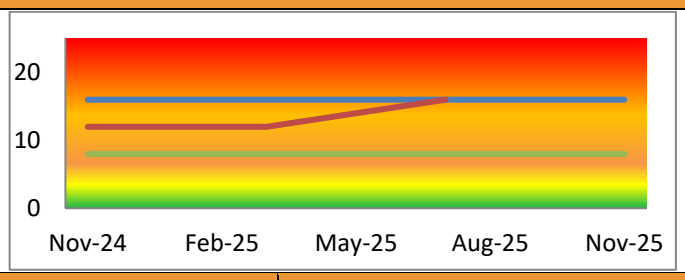
No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts.

CO.8 - Being efficient and productive	EXECUTIVE LEAD: CHIEF FINANCE OFFICER AND CHIEF OPERATING OFFICER

Risk Appetite: **CAUTIOUS** — We are willing to accept risks might occur in certain circumstances that could lead to some degree of damage to our reputation, possible financial exposure, or minor disruption to one or more service areas.

STRATEGIC RISK 8: If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	~~3~~ 4	2
Risk Score	16	~~12~~ 16	8



Link to Risks on Corporate Risk Register

6537 (20) 2025/26 Plan Delivery Risk
6539 (16) Cost Improvement Programme
6540 (16) Staffing/Headcount
6541(16) Variable Income
6542(16) Deficit Support
6543 (16) Annual Plan

Issues impacting achievements of our objective

- Improve performance in urgent & emergency care productivity due to the need to meet targets like reducing the number of patients waiting over 65 weeks.
- Financial challenges associated with meeting productivity targets. The need to reduce waiting times often leads to increased costs, impacting the overall budget.
- Time constraints make it difficult to implement long-term solutions, leading to short-term fixes that may not be sustainable.
- Waiting list initiatives to reduce the number of patients waiting which may not always be the most efficient way to achieve the desired outcomes.
- Financial shortfall arising from a combination of unfunded cost pressures and reduced income due to cessation of ERF Support.

KPIs / Measures

- Deliver year on year improvements in productivity and efficiency
- Achieve our annual plan targets
- Processes, workflows and pathways are streamlined resulting in minimised waste and optimised recourse allocation and reduced duplication
- Improved service performance to the highest benchmarking quartiles in Model Hospital and GIRFT, enhancing overall quality of care and productivity

Controls

- Increased productivity and partnerships through Clinical Diagnostics Centre
- Monthly cash flow forecast
- Monthly income monitoring and variance analysis through FIG
- Contractual safeguards to manage financial exposure through Finance Improvement Group (FIG)
- ~~Urgent Care Improvement Group~~
- Capacity and Flow Management: Controls are in place to:
  - Reduce waiting times for urgent and elective care.
  - Improve utilisation of services and patient flow
  - Leadership accountability and staff engagement programmes to foster a high-performing culture

Assurances

1st line of Defence (Operational management)

- Reports to FIG and Executive Directors:
  - Monthly cash flow forecast
  - Monthly income monitoring and variance analysis reports to FIG
  - AAA Chair's Report from Finance Improvement Group (FIG) and Urgent Care Improvement Group to Executive Directors Group
  - CIP Tracking and productivity reporting metrics at FIG
  - Weekly CIP Flash reporting to Executive Directors and DDOs
  - Income and Contract reports to Executive Directors

2nd Line of Defence (Reports at Board and Committee Level)

- Integrated Performance Reports to F&I and Board
- Operational Update to Board
- Monthly Finance Report to F&I
- Finance Report to Board from CFO

3rd Line of Defence (Independent or external assurance)

- Reports to GM Provider Oversight Meeting (POM)
- GM Provider Oversight Meetings
- Model Hospital benchmarking reporting to F&I Committee
- Membership and attendance at Trusts Provider Collaborative (TPC)
- PLICs reporting
- Independent assurance reports from Internal and external audit reviews

Actions

1. Use of patient-level costing and income reporting at Divisional level benchmarking. **Target Completion Date: Q2 2025/26**
2. Understand impact of contract reconciliation work and implications of the 10 year plan. **Target Completion Date: Q3 2025/26**
3. Improved activity and income reporting **Target Completion Date: Q3 2025/26**
4. A review of income and contract performance due to national funding pressures**. Target Completion Date: Q3 2025**

Gaps in Control

Productivity tracking reports to be presented to F&I Committee to ensure better control and oversight

Need for enhanced real-time data analytics to support decision-making

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee
- Visibility of activity and income reporting at Board level
- Activity Management Plans developed with the GM ICB

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting and approved the **CAUTIOUS** Risk Appetite Statement, as agreed by the Board in December 2024.

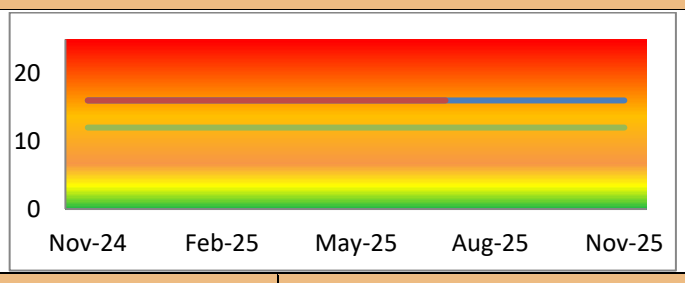
As part of its role as Lead Committee, the Committee discussed and reviewed the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts.

CO.9: Delivering Financial Sustainability	EXECUTIVE LEAD: CHIEF FINANCE OFFICER
Risk Appetite: MINIMAL	We are willing to accept improbable risks that might occur, however, lead to some degree of damage to our reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 9: If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	4	3
Risk Score	16	16	12



Link to Risks on Corporate Risk Register

6537 (20) 2025/26 Plan Delivery Risk
6539 (16) Cost Improvement Programme
6540 (16) Staffing/Headcount
6541(16) Variable Income
6542(16) Deficit Support
6543 (16) Annual Plan

Issues impacting achievements of our objective

- Bridging the financial gap, noting the scale of the challenge
- Delivering a sustainable, recurrent cost improvement to achieve a good financial position.
- Staffing ratios and digital advancements also contribute to increasing costs, making it challenging to provide modern healthcare services within budget
- Cost control and managing inflation effects.
- Shortage of revenue and capital funding.
- Meeting NHS England Productivity requirements.
- Working within GM ICB (jointly responsible and reliant on others results).

KPIs / Measures

- WTE Headcount reductions
- Deliver financial break-even
- Achieve financial sustainability
- A measurable increase in income/revenue growth (measured through recording gains, contract review, commercial opportunities)
- Annual achievement of our Cost Improvement Programme
- Annual bank / agency spend
- Ensuring return on investment through regular review and evaluation of business cases and investments as agreed through Investment Assurance Group and CRIG

Controls

- Executive / CRIG approval of business cases
- PMO coordination of CIP
- Monthly financial reporting to budget holders
- Divisional accountability through IPM
- Annual budget setting and planning processes
- Finance department annual business planning process
- Development of annual procurement savings plans
- Monthly accountability letters to DOF
- Standing Financial Instructions
- Scheme of Delegation
- Establishment of Pay / Vacancy Control Panel
- Representation at Place Based Finance and Assurance Committee
- ~~Weekly Financial Improvement Group~~
- Tracking of wte and headcount through Committees and Executive Groups
- Weekly review of CIP programme through Executive and Financial Improvement Group
- *Finance and Intelligence Group* reviews of productivity and actions to improve

Assurances

1st line of Defence (Operational management)

- Capital Revenue Investment Group (CRIG) and Executive reports
- Reports to Integrated Performance Management Meetings
- Monthly cash flow forecast
- Reports to Finance Improvement Group
- Review of Cost Improvement Programme at Finance Improvement Group

2nd Line of Defence (Reports at Board and Committee Level)

Reports to F&I including

- Monthly Finance Reports
- National Cost Collection
- (~~*PLICs reporting)*~~
- Cost improvement progress reports
- Quarterly benchmarking reports
- Procurement report
- Monthly Chair's Report from CRIG to F&I
- SFI breach report to Audit and Risk Committee

3rd Line of Defence (Independent or external assurance)

- Internal and External audit reports
- System Reports to Greater Manchester ICS and NHS England
- Costing returns
- National Agency Team reports
- GM Performance Oversight Meetings (POM)
- Model Hospital

~~Meetings with GM ICB Turnaround Director~~

Actions

1. Understand cost and income at budget level **Target Completion Q3 2025**
2. Clarity on GM Financial Strategy **Ongoing to be reviewed**
3. Expanded use of Model Hospital benchmarking reporting. **Target Completion Q.4 2025**
4. Implement the outcome of the Drivers of Deficit Financial improvement work and resulting Action Plan. **Target Completion Q3 2025**

Gaps in Control

- GM ICB overarching strategy ~~and financial strategy~~

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting and approved the **MINIMAL** Risk Appetite Statement, as agreed by the Board in December 2024.

As part of its role as Lead Committee, the Committee discussed and reviewed the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts.

AMBITION 4: AN ORGANISATION THAT IS FIT FOR THE FUTURE
PRINCIPAL RISK: IF THE TRUST DOES NOT OPTIMISE PROCESSES OR ADHERE TO STANDARDS THEN THIS MAY HARM SERVICE PRODUCTIVITY AND EFFICIENCY, LEADING TO REGULATORY ACTION AND FINANCIAL INSTABILITY.
Lead Committee: Finance and Investment Committee
Lead Directors: Chief of Strategy and Partnerships and Chief Finance Officer

Our Objectives	OUR IN-YEAR PRIORITIES FOR 2024-25	ENABLING PLANS
Corporate Objective 10a- Being digitally enabled and inclusive **Corporate Objective 10b – Being resilient against Cyber Threats** **Corporate Objective 11 – Improving our estate** **Corporate Objective 12 - Delivering financial sustainability**	• We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. • We will look for opportunities to reduce the impact we have on the environment	• Clinical Strategy • Financial Outlook • Green Plan • Health Inequalities Plan • Operational Improvement Plan

CO.10a - Being digitally enabled and inclusive

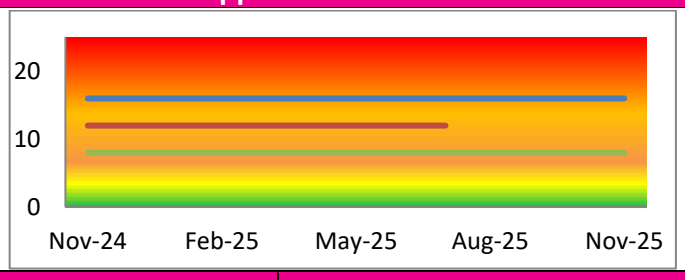
EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

Risk Appetite: **MINIMAL**

We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 10a: If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

6491 (15) Failure of ambulatory cardiac monitoring analysis software
6009 (15) Blick Stanley Paging System
6428 (15) ICE Upgrade / End of Life

Issues impacting achievements of our objective

- Availability of investment for Digital programmes against need and expectations
- Digital exclusion within Bolton which can lead to health inequalities
- Availability of digital staff to support growing demand
- Increased demand for data and information

KPIs / Measures

- Year on Year improvement in the Digital maturity matrix level
- Regular updated capacity and demand data
- Full EPR rollout 2026
- Increasing the number of specialties in which Patients will have digital access to Self Help Information & Information about procedures
- Sub-KPI: Publication of a clear plan for agile working 2025

Controls

- Board approved Digital Plan
- Lead Bolton Borough wider Partnership
- Digital Performance and Transformation Board
- Digital Maturity Matrix
- Data Protection Toolkit Annual assessment
- External and Internal Audit reports
- ~~*ISO assessments*~~
- ~~*Regular penetration testing and cyber security testing arranged with external expertise.*~~
- ~~*All High severity Cyber alerts are acknowledged within 48 hours to NHS Digital (NHSD) and actions and mitigations submitted.*~~
- Digital Teams manage delivery of programme based on good practice project methodology
- Divisions included in the Digital Performance and Transformation Board to ensure they have oversight of the Digital program

Assurances

1st line of Defence (Operational management)

- Monthly review performance data IPM meetings through Execs and DDO
- Reports to the Digital Performance and Transformation Board
- All IT projects requiring resourcing go through Capital Revenue Investment Group (CRIG)
- Significant IM&T Risks monitored by Risk management Committee
- Review of Data Security and Protection Toolkit (DSPT) and information governance reports at Information Governance Group

2nd Line of Defence (Reports at Board and Committee Level)

- Monthly review of Integrated performance report at F&I and Board
- Annual Digital Report at Board
- IA reports at Audit Committee

3rd Line of Defence (Independent or external assurance)

- NHS Digital Toolkit
- Internal Audit Reviews
- Use of resources benchmarking
- Cyber Security national assessments

Actions

1. Refresh Digital Strategy – **Target Completion Date: March 2026**
2. ~~Workforce plan digital team – **Target Completion Date: March 2025**~~ ~~**July 25 update: Removed as linked to 5**~~
3. System for staff feedback – **Target Completion Date: March 2025** **July 25 update: Complete 1/4ly survey in place. Action plan and you said we did to be put in place**
4. ~~*Ongoing training program linked to EPR and IG / Cyber – **ongoing into 2025***~~
5. Digital and Data capacity and demand assessment by internal audit - **Target Completion Date: March 2026**
6. Maternity EPR Rollout – **Target Completion Date: March 2026**
7. Community and OPD Rollout - **Completed: July 2025**
8. LIMs roll out – **August 2026**
9. Digital Strategy refresh**. Target Completion Date: March 2026**

Gaps in Control

- Require system to understand and respond to staff feedback on Digital support
- Digital Strategy to be refreshed 2026

Gaps in Assurance

- Requirement for key Digital roles and increase in substantive capacity in the digital programme - still working with agencies and Procurement for the remainder of the programmes to fill posts.
- Capacity within wider trust teams for digital system implementations.
- NHS Benchmarking for digital workforce is difficult to compare for Digital Teams so a different system of assurance is required

Committee Feedback

The F&I Committee received the BAF and

- Approved the **MINIMAL** Risk Appetite Statement as this reflected Board discussions in December 2024.
- Approved a split of the Digital Ambition so there was a separate Strategic Cyber risk as agreed at Board.

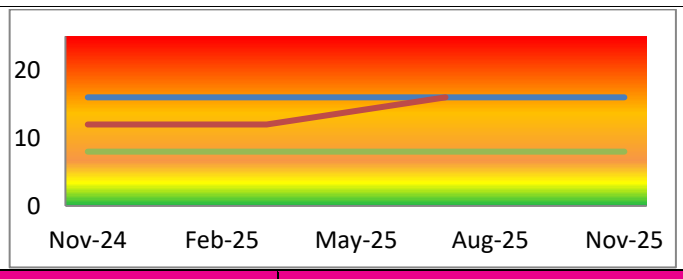
A review of the current Risk Score of 12 has been initiated to confirm its continued relevance and effectiveness. This will ensure the score accurately reflects the current risk environment, aligns with the organisation's risk appetite, and informs appropriate mitigation and decision-making.

There are no other proposed changes

CO.10b - Being resilient against Cyber Threats	EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS
Risk Appetite: AVOID	We are not willing to accept any risks that could lead to damage to our reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public

STRATEGIC RISK 10b: If the Trust experiences a cyber-attack and lacks effective defences and recovery plans, then it may face serious disruption to patient care, data security, and regulatory compliance, with prolonged downtime and delayed recovery

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

Under review

Issues impacting achievements of our objective

- Availability of skilled staff due to a shortage of cybersecurity professionals.
- Increased demand for data and information and the resilience on digital services.
- Increased demand for the use of AI technology
- Inadequate digital integration or cyber security measures from a medical device perspective.
- System wide integration of IT systems across the ICB
- Infrastructure capacity to cope with digital solutions.
- Evolving cyber threats landscape needs the latest technology
- Create a culture of cyber resilience
- User behaviour and human error
- Dependency on the supply chain, for example cloud providers, third-party vendors
- Legacy systems and equipment
- Complexity of compliancy requirements, could be resource-intensive
- Investment for the right technology to allow an effective recovery time

KPIs / Measures

- Meeting "Standards Met" of the Data Security and Protection Toolkit year on year
- Achieving Informatics certifications, such as:
  - ISO 27001 and
  - Secure Email Standards (DCB1596)
- Bi-monthly report to the Information Governance Group with cyber security KPIs, including:
  - Unsupported systems and hardware
  - Patching stats
  - Cyber security alerts from NHSE (old CareCerts), etc.
- Monthly reports to Digital Performance Transformation Board
- Incidents with lessons learnt reports
- Improvement log from ISO 27001

Controls

- IG Group and sub-groups, such as Cyber Security Group
- Trustwide IG/IT policies
- Data Security and Protection Toolkit
- Digital Maturity Matrix
- Digital plan
- Digital strategy
- Contract management of systems
- Software licences
- Accreditations such as: ISO 27001 and Secure Email Standards
- Yearly penetration tests
- Cyber security training material for all staff, which is our first line of defence against cyber threats.
- Cyber alerts notifications circulated across the Trust to be vigilant
- NHS Digital Alerts actioned as per NHS England instructions

Emergency planning

- Business continuity plans
- Tabletop exercises carried for cyber by external providers and our EPRR lead

Assurances

1st line of Defence (Operational management)

- Reports to the Digital performance and transformation Board which reports into sub-committees of the Board
- All project requires IG and IT approval through Data Protection Impact Assessments before finance approve business cases.
- A report on unsupported systems and data protection implications presented IG Committee
- Significant Informatics Risks monitored by Risk management Committee
- Information Governance Group
- All at risk systems have support in place, or the cyber risk is assessed and appropriately mitigated
- Capital Revenue Investment Group for the investment and upgrade of system
- Monthly digital updates to Finance & Investment Group

2nd Line of Defence (Reports at Board and Committee Level)

- Yearly submission of the DSPT to the board
- Board Assurance Framework
- Report to Audit and Risk Committee around the DSPT work. (6 months update plus final report)
- 6 monthly digital updates to board
- Cyber and IG risk to Risk Management Committee every 3 months
- DSPT external audit to Audit & Risk committee
- Monthly review of DPTB risks at F&I

3rd Line of Defence (Independent or external assurance)

- Reports to GM Provider Oversight Meeting (POM)
- GM Provider Oversight Meetings
- Model Hospital benchmarking reporting to F&I Committee
- Membership and attendance at Trusts Provider Collaborative (TPC)
- PLICs reporting

Actions

1. Review of digital team responsibilities to put a dedicated Cyber security role in place. **Target Completion Nov 2025**
2. Cyber Sub Group to be established with the needed representation from divisions **Target Completion Nov 2025**
3. Complete the recommendations from the Toolkit submission and MIAA report **Target Completion Nov 2025**
4. Review Cyber risks on the corporate risk register and BAF following the go live of Community and Outpatient EPR and national escalation in Cyber Incidents – **August 2025**

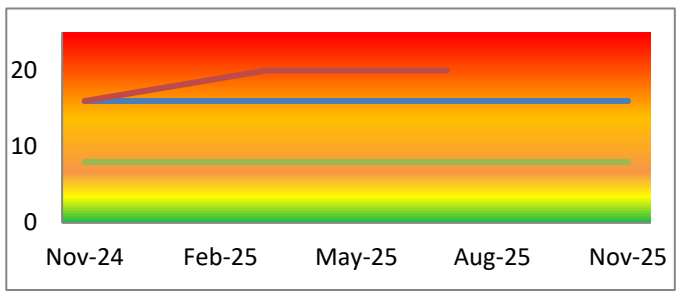
	• Independent assurance reports from Internal and external audit reviews	
Gaps in Control	**Gaps in Assurance**	**Committee Feedback**
Completion of the recommendations from the cyber security review Completion and implementation of the recommendations from the IT Disaster Recovery REview	• Performance Monitoring should be reviewed to included cyber KPIs measures to be consider for a holistic assessment. • The Trust should reinstate the Cyber Security Group across the Trust with the representation from essential functions, for example LabMed, Radiology, Pharmacy, EBME. This will report into IG Committee	The F&I Committee received the BAF and • Approved the **AVOID** Risk Appetite Statement as this reflected Board discussions in December 2024. • Approved this new Strategic Cyber Risk as a standalone from the 10.a Digital A review of the current Risk Score of 12 has been initiated to confirm its continued relevance and effectiveness. In light of the recent go-live of the Community and Outpatient EPR and the national escalation in cyber incidents, cyber risks on the Corporate Risk Register and Board Assurance Framework are being reassessed to ensure alignment with the organisation's risk appetite and adequacy of mitigation measure There are no other proposed changes

CO.11 – Improving our estate	EXECUTIVE LEAD: CHIEF FINANCE OFFICER
Risk Appetite: AVOID	We are not willing to accept any risks that could lead to damage to our reputation, financial loss or exposure, major breakdown in services, information systems or integrity, failings in significant aspects of regulatory and/or legislative compliance, potential risk of injury to staff, service users or public.

STRATEGIC RISK 11: If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.

Risk Statement: If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	5	2
Risk Score	16	20	8



Link to Risks on Corporate Risk Register

5958 (25) Estates Backlog
4060 (16) Electrical Distribution boards
1670 (16) Steam and condense services
5747 (15) Substation 10 Air circuit breaker replacements
6054 (15) Reinforced Autoclaved Aerated Concrete (RAAC
3194 (16) Outdated ventilation systems within ophthalmology
5926 (16) Site-wide building management system upgrade
6145 (15) Maternity Theatres ventilation failures
5929 (15) Site wide roofing repairs

Issues impacting achievements of our objective

- Shortage of capital and revenue funding
- Changes to capital regime
- High levels of backlog maintenance
- Planning, traffic constraints to the site
- Controllability of community estates not owned by BFT
- PDC bids/funding not linked to Strategy
- Shortage of cash

KPIs / Measures

- Achievement of our Green Plan targets with a focus on annual improvement towards net zero,
- Year on Year improvement in estates utilisation
- Improved safety and compliance through a year-on-year reduction in backlog maintenance

Controls

- Estates Strategy and supporting Business Cases to make the case for external capital to CRIG, F&I, Board
- Established links to GM and NHSE
- Capital processes to ensure correct prioritisation
- Links with local partners including LA, University
- Membership of Bolton Strategic Estates Group
- Premises Assurance Model
- Enterprise Asset Management CAFM
- ~~Backtrac system~~
- Agile Working Programme
- Our Green Plan
- Demolition and Disposal Strategy
- IFM asset management
- Digital Plan that maps back to the Trust strategy
- Clinical Strategy
- National RAAC team support
- Estates utilisation group

Assurances

1st line of Defence (Operational management)

- Monthly review of business cases at CRIG and Executive Directors.
- Estates Reports into Executive and Strategic Estates Group
- Critical estates priorities presented to F&I and Trust Board

2nd Line of Defence (Reports at Board and Committee Level)

- Integrated Performance Reports to F&I and Board
- Annual Estates Report at Board
- Green Plan Report to F&I and Board

3rd Line of Defence (Independent or external assurance)

- ERIC reports, Premises Assurance Model
- Model Hospital estates and facilities metrics
- Use of resources benchmarking
- Locality Board oversight
- Management Framework

Actions

1. Production of a shared vision for the site and neighbouring land. **Target Completion Date**: **December 2025**
2. Monitor and manage the aging estate and escalate urgent issues with the estates. **Target Completion Date: December 2025**
3. Review and formalisation of Strategic Estates Group to F&I. **Target Completion Date: Q3 2025**

Gaps in Control

- Achievement of our Green Plan targets with a focus on annual improvement towards net zero
- Estates Strategy

Gaps in Assurance

- Formalisation of Strategic Estates Group and reporting lines to F&I el Hospital benchmarking reporting to F&I Com

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting and approved the **AVOID** Risk Appetite Statement, as agreed by the Board in December 2024.

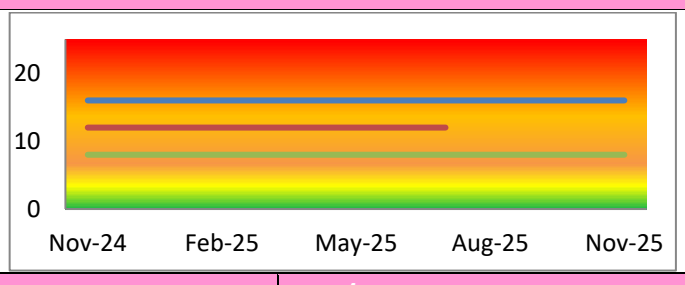
As part of its role as Lead Committee, the Committee discussed and reviewed the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation efforts

CO.12 – PROACTIVELY PLANNING FOR THE FUTURE	EXECUTIVE LEAD: CHIEF FINANCE OFFICER
Risk Appetite: MINIMAL	We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 12: If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy.

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

6245 (16) Elective Care microscope obsolescence issued

Issues impacting achievements of our objective

- The Greater Manchester (GM) financial position is a significant factor
- Shortage of revenue and capital funding.
- Meeting NHS England Productivity requirements.
- Working within GM ICB (jointly responsible and reliant on others results)
- Inability to deliver high levels of cost improvement

KPIs / Measures

- Improved accuracy and timeliness in forecasting service demand, leading to optimised resource allocation, strategic planning and enhanced decision making
- Comprehensive understanding of long term healthcare trends, their impact on our services and plans in place to address
- Estates and capital planning based on data and intelligence on demographic and demand changes
- % of clinical services that have access to demographic data and disease prevalence and use this to inform planning
- Sub-KPI: Approach to workforce planning and service design informed by population health changes
- Sub-KPI: Succession planning effectiveness measured by the percentage of key positions with identified successors

Controls

- PMO coordination of CIP
- Annual budget setting and planning processes
- Finance department annual business planning process
- Finance and Intelligence Group reviews of productivity and actions to improve
- Financial Improvement Group
- Executive pay panel
- Discretionary non pay panel

Assurances

1st line of Defence (Operational management)

- Annual Planning Process
- Reports to Finance Improvement Group (FIG)
- Review of Cost Improvement Programme at Finance Improvement Group

2nd Line of Defence (Reports at Board and Committee Level)

Reports to F&I Board

3rd Line of Defence (Independent or external assurance)

- Internal and External audit reports
- System Reports to Greater
- NHSE Operating Plan and Guidance
- GM Operating Plan
- Model Hospital benchmarking

Actions

1. Understand cost and income at Divisional and specialty level through at budget level **Target Completion Date Q3 2025/26**
2. *Closer / joint local working in Bolton System.* ***Ongoing***
3. Clarity on GM Financial Strategy which would inform local Strategic Planning. **Target Completion Date**
4. Ongoing revision of the three-year Financial Outlook. **Target Completion Date: Mar 26**
5. Enhanced workforce controls and reporting triangulated with activity and finance **Target Completion Date Q2 25/26**

Gaps in Control

Pay and non pay controls require further enhancement

Gaps in Assurance

- Model Hospital benchmarking reporting to F&I Committee
-

Committee Feedback

The F&I Committee received the updated BAF at the July 2025 meeting and

- approved the **MINIMAL** Risk Appetite Statement, as agreed by the Board in December 2024.
- Agreed with the proposal to expand CO12 to reflect the Trust's ambition to become a net zero healthcare provider, in line with the NHS Net Zero Plan (Delivering a 'Net Zero' National Health Service), which commits the NHS to achieving net zero emissions by 2040.

As part of its review, the Committee examined the Risk Score, Controls, Assurance, and the identified gaps in both Control and Assurance. It also considered the actions currently in place to address these gaps.

There are no other proposed changes

AMBITION 5: A POSITIVE PARTNER

PRINCIPAL RISK: IF THE TRUST DOES NOT MAINTAIN TRANSPARENT AND COLLABORATIVE COMMUNICATION WITH STAKEHOLDERS, THEN TRUST AND ENGAGEMENT MAY DECLINE, POTENTIALLY UNDERMINING THE EFFECTIVENESS OF PARTNERSHIP INITIATIVES.

Lead Committee: Executive Committee through Trust Management Committee

Lead Director: Chief of Strategy and Partnerships

Our Objectives	OUR IN-YEAR PRIORITIES	ENABLING PLANS
Corporate Objective 13- Developing our neighbourhoods	•	• Clinical Strategy • Financial Plan • Green Plan
Corporate Objective 14– Working as one team		
Corporate Objective 15- Partnership for local benefit		

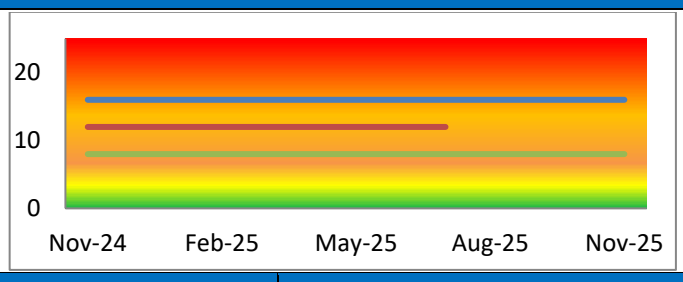
CO13: Developing our neighbourhoods

EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS

Risk Appetite: MINIMAL — We are willing to accept improbable risks that might occur, however, lead to some degree of damage to its reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 13: If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)

Issues impacting achievements of our objective

- If BFT and other system partners have a financial deficit, there is a risk this may fragment integration and slow development
- Lack of collaboration with system partners to understand and respond to the wider determinants of health
- Changes in the wider health economy may destabilise our organisation
- the people of Bolton will experience poorer outcomes, and demand for acute and community services will remain high in future potential fragment integration and slow development

KPIs / Measures

- Staff report that neighbourhood working is improving the care, experience and outcomes of the people we serve
- Patient, service user and carer feedback demonstrates that neighbourhood working has improved their care, experience and outcomes
- Increase in the number of services that are provided in the neighbourhood footprint
- Neighbourhood leaders report that they are able to use data and intelligence to inform the health and care priorities for their neighbourhood
- Percentage reduction in preventable hospital admissions as our neighbourhoods mature

Controls

- Community engagement plan developed for Bolton Locality
- Accountability for delivery of through the Place Based Lead
- Bolton Alliance Agreement to support the governance of the partnership
- Representation at Locality Board and System Finance Board on use of the of the Bolton £ .
- ICB Locality Delegation agreement with GM in place with Governance model for delivery in place.
- GM Sustainability Plan
- Bolton Locality Plan and Outcomes Framework)

Assurances

1st line of Defence (Operational management)

- Monthly report to Performance and Transformation Board on Community Transformation
- Report to Bolton Strategy Planning and Delivery Committee from 7 Transformation workstreams delivering against key priorities

2nd Line of Defence (Reports at Board and Committee Level)

- Oversight of Workforce Transformation Plan through People Committee
- Oversight of system finance and impact through F&I Committee
- Spotlight on service transformation of neighbourhoods
-

3rd Line of Defence (Independent or external assurance)

- Reports to Bolton Health Overview and Scrutiny Committee
- Reports to GM scrutiny and oversight
- Reports to Locality Board with engagement from key partners

Actions

1. Refresh and embed the Locality Plan and ensure delivery. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews
2. Implement regular stakeholder engagement forums. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews
3. Ensure timely and clear communication of decisions and developments. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews
4. Monitor stakeholder feedback and adjust communication strategies accordingly. **Target Completion Date: March 2026**
   July 25 Update: Ongoing with regular reviews

Gaps in Control

- System transformation plan to transform services and drive integration being developed
- System finance plan in development

Gaps in Assurance

Committee Feedback

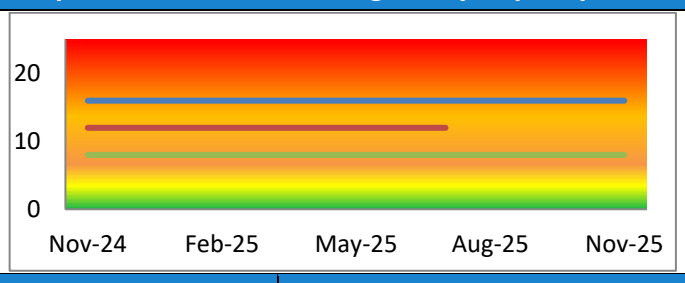
The risk appetite has been changed to **OPEN** from Seek to reflect discussion at Risk Appetite session in December 2024.

The Risk Score has been reviewed. There are no other proposed changes.

CO.14 - Working as one team	EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS
Risk Appetite: SEEK	We are willing to accept risks that may occur and would then lead to some degree of damage to its reputation, possible financial loss, exposure, or short term disruption to no more than one service area.

STRATEGIC RISK 14: If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)

Issues impacting achievements of our objective

- Inadequate workforce to deliver safe, effective care.
- Strategic partnership opportunities will be missed
- Impact to access, experience and outcomes for the people of Bolton

KPIs / Measures

- Working with partner organisations to agree integration priorities (i.e. shared systems) and delivering on these priorities
- Percentage increase in shared electronic health records linked to partner organisations
- Improvement in patient and service user satisfaction and feedback/decreased complaints
- Sub-KPI: Staff report an improvement in their ability to work across teams and with partner organisations to achieve organisational priorities

Controls

- Bolton Joint Strategic Needs Assessment (JSNA)
- Membership of Bolton Strategic Development and Partnership Meetings
- Bolton Locality Governance Structure
- Bolton Partner Communication Update
- Community engagement plan and meetings with partners at Locality
- Bolton Alliance Agreement to support the governance of the partnership
- Governors Monthly Update
- Membership Newsletter
- Quarterly update to Locality following BFT Board meetings
- Active Connected and Prosperous (ACP)
-

Assurances

1st line of Defence (Operational management)

Deputy Place Based Lead attendance monthly at Executive Directors

2nd Line of Defence (Reports at Board and Committee Level)

- Locality Updates in Chief Executive's Report to the Board
- Bi-monthly presentation of IPR at Committees and Board
- Oversight of system finance and impact through F&I Committee

3rd Line of Defence (Independent or external assurance)

- Reports to Bolton Strategic Development and Partnership Meetings
- GM Local Assurance Meeting (LAM)
- Reports to Locality Board and System Finance Board on use of the of the Bolton £

Actions

1. Continued participation in GM working group to shape and influence the developing programme **Target Completion Date: March 2026** **July 25 Update**: expected to be ongoing with regular reviews
2. Implementation of GM PACs and LIMS procurements. **Target Completion Date: March 2026** **July 25 Update**: Ongoing with regular reviews
3. Finalisation of GM network agreements **July 25 Update**: Ongoing with regular reviews
4. Development of Local pathology, radiology and pharmacy clinical service strategies. **Target Completion Date: March 2026** **July 25 Update**: Ongoing with regular reviews

Gaps in Control

- GM PACs and LIMS procurements.
- Finalisation of GM network agreements
- Development of Local pathology, radiology and pharmacy clinical service strategies.

Gaps in Assurance

Committee Feedback

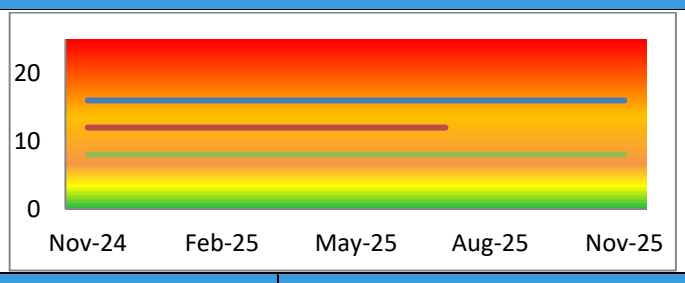
The risk appetite has been changed to **OPEN** from Seek to reflect discussion at Risk Appetite session in December 2024.

No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation effortsThe Risk Score has been reviewed.

CO.15: Partnering for local benefit	EXECUTIVE LEAD: CHIEF OF STRATEGY AND PARTNERSHIPS
Risk Appetite: MINIMAL	We are willing to accept improbable risks that might occur, however, lead to some degree of damage to our reputation, financial exposure, or minor disruption to a service area, should these risks materialise or fail to be mitigated.

STRATEGIC RISK 15: If the Trust does not establish partnerships that align with its ambitions then this could negatively affect the services on offer, infrastructure, and financial stability

Risk Assessment	Inherent	Current	Target
Severity	4	4	4
Likelihood	4	3	2
Risk Score	16	12	8



Link to Risks on Corporate Risk Register

There are no risks scoring 15 and above or Catastrophic for Impact (5 Severity on Risk Register)

Issues impacting achievements of our objective

- Resilience of GM clinical services
- Increasing demand for services
- Resilience of sector and GM Radiology, Pharmacy and Pathology to support reconfigured services
- Develop Provider Collaborative across GM
- Sustainable Workforce Pipeline
- Lack of relationships with neighbouring landowners and developers.
- Missed opportunity for strategic partnerships

KPIs / Measures

- Readiness to be lead partner for Bolton Medical School in 2024/25
- 100% tenders published by BFT include a social value section
- % of total spend on goods and services from local suppliers

Controls

- Strong Educational partnership through Bolton Health and Academic Partnership Board to support workforce development
- Strong Private sector partnerships through Health Innovation Bolton Partnership
- Attendance at Greater Manchester (GM) Trust Provider Collaborative (TPC)and its work streams
- Increased productivity and partnerships through Clinical Diagnostics Centre
- Engagement through GM Exec Director Forums/ TPC
- Reporting structure for Bolton Academic Partnership and Programme Management/Support
- GM Joint Forward Plan
- Regular meetings between Directors of Strategy for BFT and WWL
- Increased productivity and partnerships through Clinical Diagnostics Centre

Assurances

1st line of Defence (Operational management)

- Engagement with senior leaders on Strategy at Trust Provider Collaborative meetings (TPC)
- Health economics to understand future changes in demand which will influence our clinical Strategy
- Reports to Bolton Locality Board through Place Based Leadership Team

2nd Line of Defence (Reports at Board and Committee Level)

- Reports into People Committee
- Reports to Board and discussion at informal board meeting.
- Board Development Day sessions

3rd Line of Defence (Independent or external assurance)

- Internal and External audit reports
- Membership and attendance at GM Provider Collaborative Board and other Joint Leadership Group
- Attendance at GM Director Forums
- Report to the Bolton Health and Academic Partnership
- Reports to the Bolton Health Innovation Partnership

Actions

1. Development of a stronger partnerships with local academic providers to develop a workforce pipeline **– Target Completion Date: March 2026** **July 25 Update**: expected to be ongoing with regular review
2. Expansion of clinical courses and programmes mapped to workforce demand—**Target Completion Date: March 2026** **July 25 Update**: Ongoing with regular reviews
3. Development of new programmes to fulfil recruitment issues e.g. health informatics. **Target Completion Date: March 2026** **July 25 Update**: Ongoing with regular reviews
4. Production of a shared vision for the site and neighbouring land. **Target Completion Date: March 2026.** **July 25 Update**: Ongoing with regular reviews

Gaps in Control

Substantive membership and participation in service transformation programmes within GM.

Development of Local pathology, radiology and pharmacy clinical service strategies

Gaps in Assurance

- GM Sustainable Services work programme at an early stage though conversations ongoing through Directors of Strategy and Executive Medical Directors
- Finalisation of GM network agreements

Committee Feedback

The risk appetite has been changed to **MINIMAL** from Seek to reflect discussion at Risk Appetite session in December 2024.

No further changes were proposed at this stage, and the Committee was satisfied that the framework continues to reflect the organisation's current risk posture and mitigation effortsThe Risk Score has been reviewed.

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Deputy Chief Executive and Chief People Officer		Decision	

Purpose of the report	To present the Month 3 Integrated Performance Report.

Previously considered by:	The report was previously discussed at Integrated Performance Meetings (IPMS) and at July Committees.

Executive Summary	The Integrated Performance Report provides an overview of the Trust's performance against the reported metrics during June 2025. The narrative describes issues that are affecting performance and any mitigating actions to improve performance.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Integrated Performance Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**Yes**	**Trust performance included within report, for any areas of concern narrative is provided.**
Legal/ Regulatory	**Yes**	
Health Inequalities	**Yes**	
Equality, Diversity and Inclusion	**Yes**	

Prepared by:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey, Chief People Officer/Deputy Chief Executive

Bolton NHS Foundation Trust

Integrated Performance Report

June 2025

Guide to Statistical Process Control

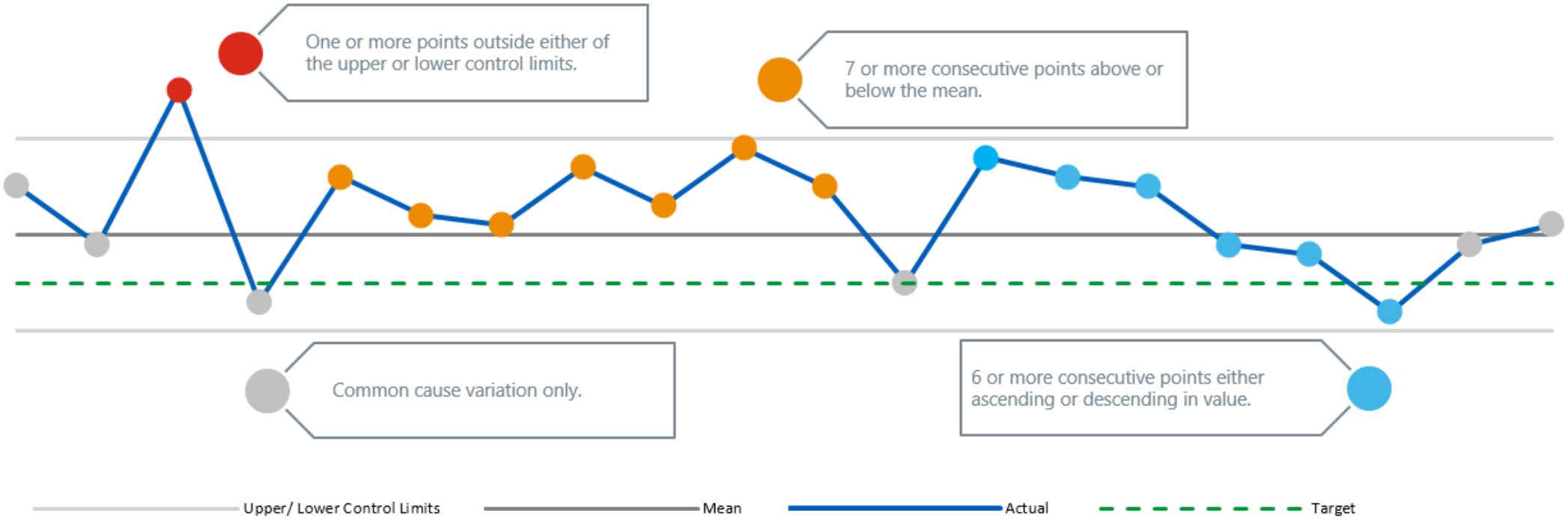
NHS Bolton NHS Foundation Trust

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC. There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. There are other resources on the NHS Improvement page that you may find useful **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line **(dark grey)** is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

Whilst the SPC charts in this report display data from the last four financial years, the SPC rules and control limits are calculated using data from as far back as 5 years where available. The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.

Prior to September 2022 the report highlighted runs of 6 or more points above or below the mean. This was changed to 7 points to match the methodology used in Model Hospital



Executive Summary

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
	Common cause variation.	Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.	Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.	We can be confident in consistantly meeting the required level of performance for this KPI.	Indicates that we should not expect to achieve the required level of performance for this KPI.	We cannot be confident in consistently achieving the required level of performance as the target is within the range of common cause variation.
Quality and Safety								
Harm Free Care	13	2	3	0	1	1	3	12
Infection Prevention and Control	10	0	0	0	0	0	0	7
Mortality	4	2	1	0	1	0	0	3
Patient Experience	12	3	0	0	1	2	0	14
Maternity	9	0	1	0	0	1	0	8
Operational Performance								
Urgent Care	9	0	1	0	1	2	5	4
Elective Care	6	0	5	1	3	2	6	4
Cancer	2	1	0	0	0	0	0	3
Community Care	5	3	0	0	0	0	2	6
Workforce								
Sickness, Vacancy and Turnover	2	0	2	0	0	0	2	1
Organisational Development	1	3	0	0	2	1	2	3
Agency	0	0	2	1	0	0	2	1
Finance								
Finance	2	0	0	0	1	1	0	2
Appendices								
Heat Maps								

Variation

Common cause variation.

Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.

Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.

Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.

Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.

Assurance

We can be confident in consistantly meeting the required level of performance for this KPI.

Indicates that we should not expect to achieve the required level of performance for this KPI.

We cannot be confident in consistently achieving the required level of performance as the target is within the range of common cause variation.

Performance

6/6 Indicates how many times we have achieved the required level of performance across the last 6 data points.

Quality and Safety - Harm Free Care

NHS Bolton NHS Foundation Trust

Pressure Ulcers

During the reporting period, Category 2 and 3 pressure ulcers across both inpatient and community settings remained within common cause variation. A reduction in hospital-acquired Category 2 and 3 ulcers was observed in the Medicine and Surgery Divisions, supported by strengthened documentation, increased RN oversight, and the introduction of photographic assessment at the point of identification to support accurate verification within Medicine. Integrated Community Services reported an increase in Category 3 ulcers; however, all cases were reviewed with no concerns identified in care delivery. All pressure ulcer incidents were reviewed by the Patient Safety Review Panel, and the Tissue Viability-led verification process introduced in June has contributed to the lowest number of Category 2 ulcers reported since December 2023.

To note: Pressure Ulcer data remains unvalidated for 60 days from date of reporting whilst patient safety incident response framework review underway

Falls

Falls with harm affected one patient in the reporting period in the Adult Acute Care Division. This was reviewed through the Patient safety Review process, and was deemed accidental. Progress on improvement measures is being actively monitored through the Patient Safety Committee which seeks assurance that learning from incidents and necessary actions have been embedded into clinical practice.

VTE

VTE data shown is based on previous guidance, not the updated guidance of patients receiving an assessment within 14 hours. This data is available and the Trust have submitted nationally based on the updated guidance. A paper will be discussed at the next Quality Assurance Committee in July regarding the changes and reporting going forward.

Patient Safety Incident Investigation turnaround performance by agreed deadline

In Month 3 there were no PSII reports due for approval. There are currently three PSII's in process, two are due for approval in Month 4 and one is due for approval in Month 5.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	96.0%	Jun-25		>= 95%	96.9%	May-25	>= 95%	96.2%	
9 - Never Events	= 0	0	Jun-25		= 0	0	May-25	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.05	Jun-25		<= 5.30	3.46	May-25	<= 5.30	4.03	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	1	Jun-25		<= 1.6	0	May-25	<= 4.8	5	

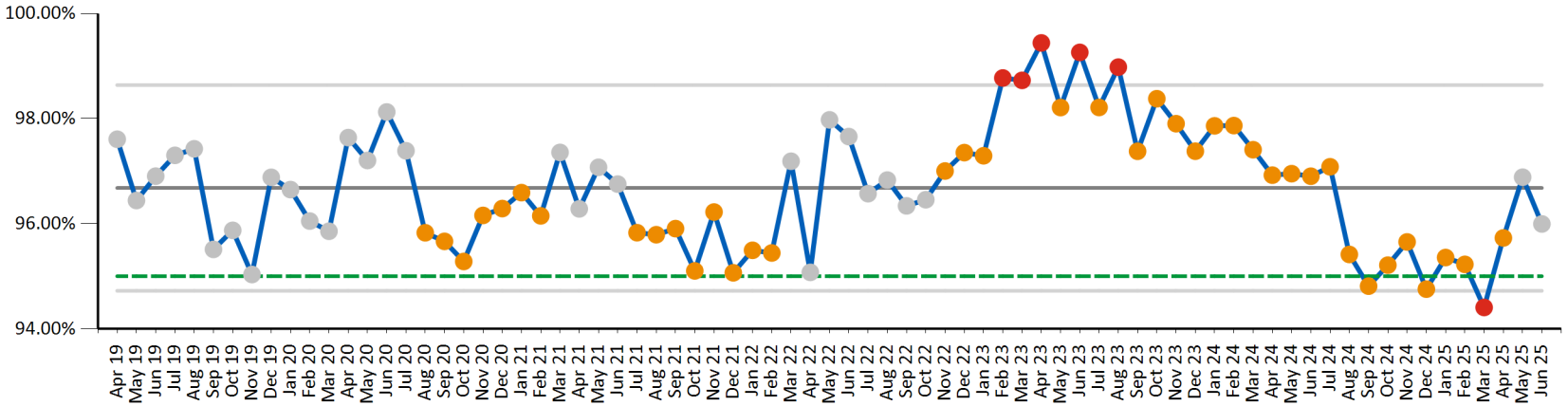
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	8.0	Jun-25		<= 6.0	15.0	May-25	<= 18.0	33.0	?
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	3	Jun-25		<= 1	4	May-25	<= 2	14	?
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Jun-25	L	= 0.0	0.0	May-25	= 0.0	0.0	?
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	12.0	Jun-25		<= 7.0	9.0	May-25	<= 21.0	34.0	?
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	15	Jun-25		<= 4	6	May-25	<= 12	24	?
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	1.0	Jun-25		<= 1.0	0.0	May-25	<= 3.0	4.0	?
535 - Community patients acquiring pressure damage - significant learning category 2		0	Jun-25	L		0	May-25		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Jun-25			0	May-25		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Jun-25			0	May-25		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	77.8%	Jun-25	H	>= 95%	77.9%	May-25	>= 95%	77.4%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	55.8%	Jun-25	L	>= 95.0%	63.7%	May-25	>= 95.0%	60.0%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Jun-25		= 100%	50.0%	May-25	= 100%	83.3%	?
88 - Nursing KPI Audits	>= 85%	96.7%	Jun-25	H	>= 85%	96.0%	May-25	>= 85%	96.2%	P
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	0.0%	Jun-25		= 100%	50.0%	May-25	= 100%		?
8 - Same sex accommodation breaches	= 0	6	Jun-25		= 0	14	May-25	= 0	29	F

6 - Compliance with preventative measure for VTE

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
>= 95%	96.0%	Jun-25

Previous

Plan	Actual	Period
>= 95%	96.9%	May-25

Year to Date

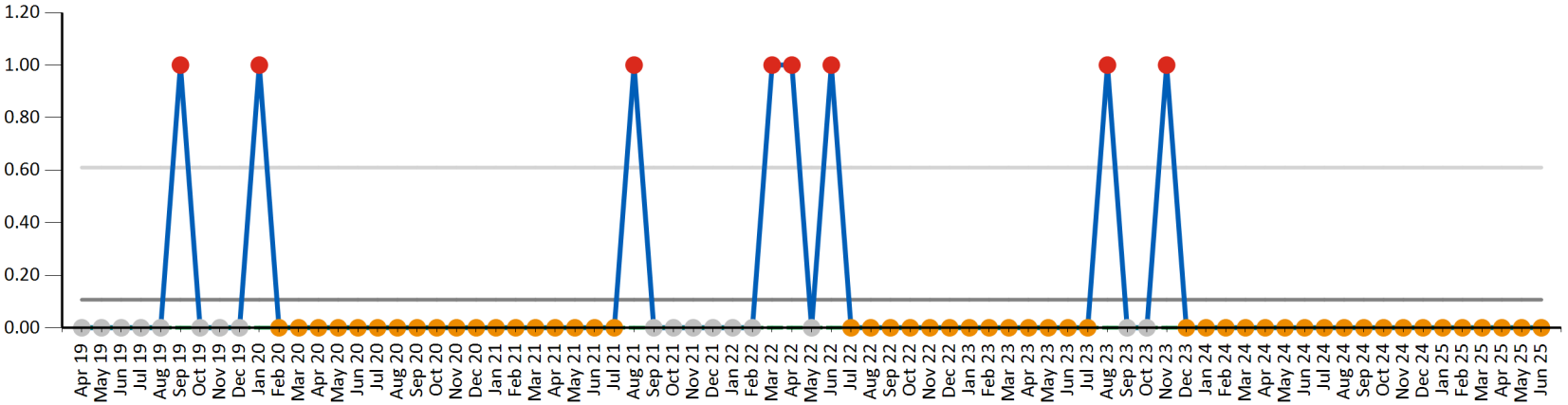
Plan	Actual
>= 95%	96.2%

9 - Never Events

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
= 0	0	Jun-25

Previous

Plan	Actual	Period
= 0	0	May-25

Year to Date

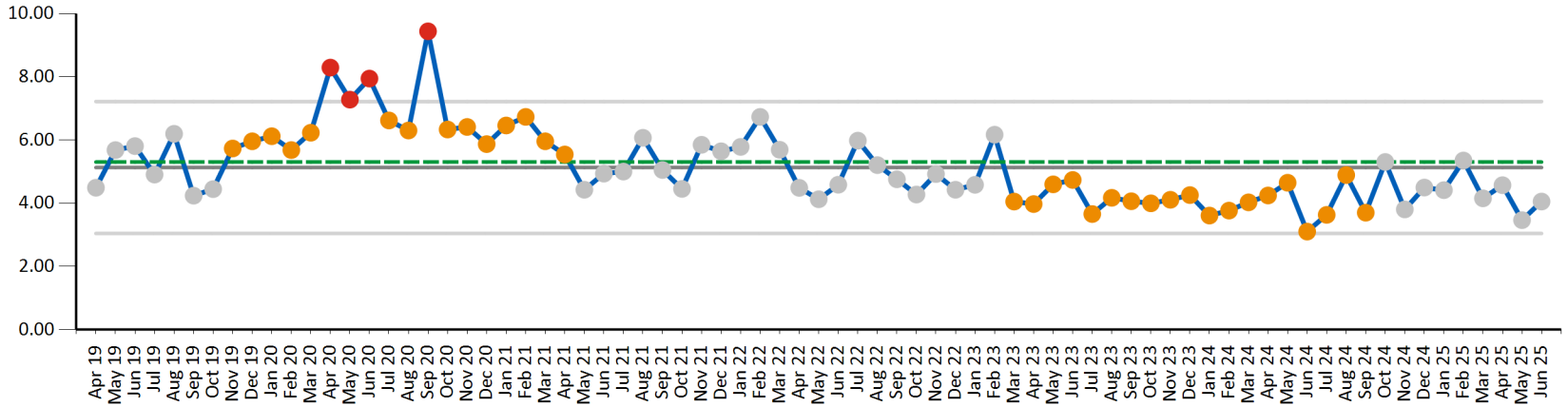
Plan	Actual
= 0	0

13 - All Inpatient Falls (Safeguard Per 1000 bed days)

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
<= 5.30	4.05	Jun-25

Previous

Plan	Actual	Period
<= 5.30	3.46	May-25

Year to Date

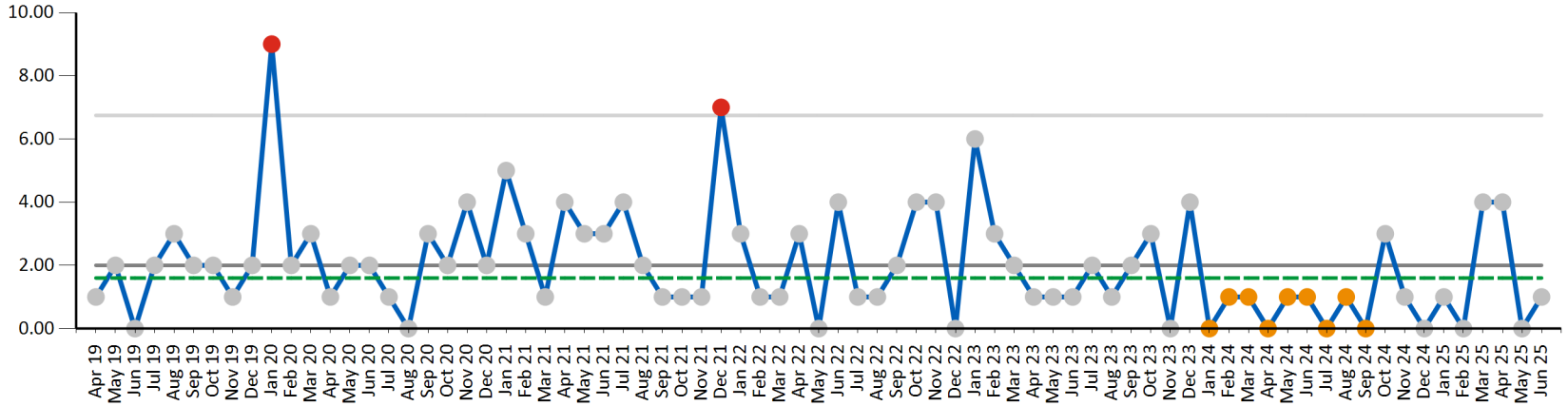
Plan	Actual
<= 5.30	4.03

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
<= 1.6	1	Jun-25

Previous

Plan	Actual	Period
<= 1.6	0	May-25

Year to Date

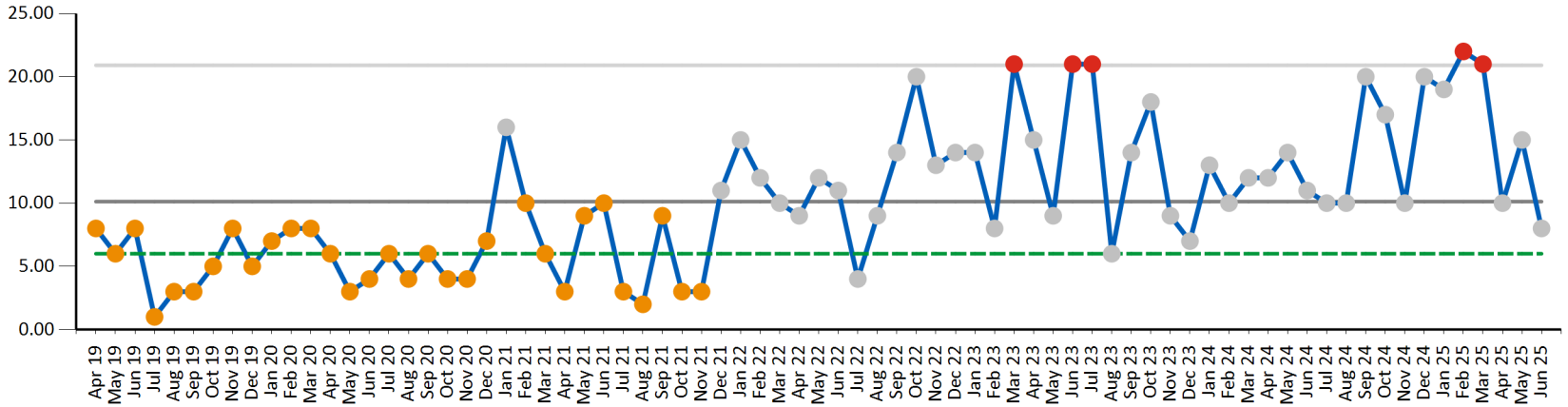
Plan	Actual
<= 4.8	5

15 - Number of Acute Inpatient incidences - pressure damage (category 2)

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
<= 6.0	8.0	Jun-25

Previous

Plan	Actual	Period
<= 6.0	15.0	May-25

Year to Date

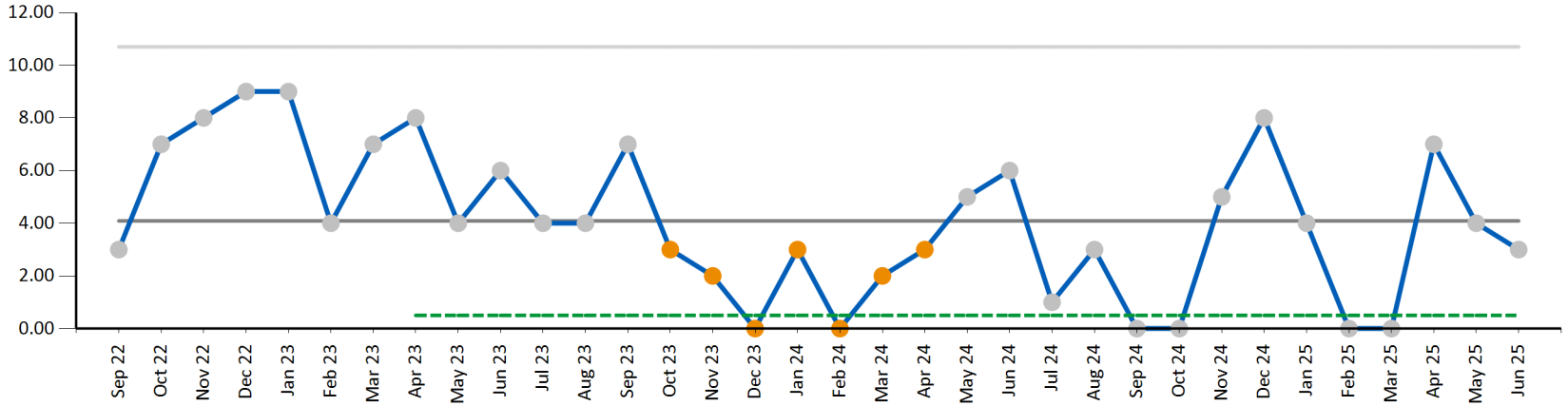
Plan	Actual
<= 18.0	33.0

620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)

Common cause variation.

We will not regularly meet the target due to normal variation.

2/6



Latest

Plan	Actual	Period
<= 1	3	Jun-25

Previous

Plan	Actual	Period
<= 1	4	May-25

Year to Date

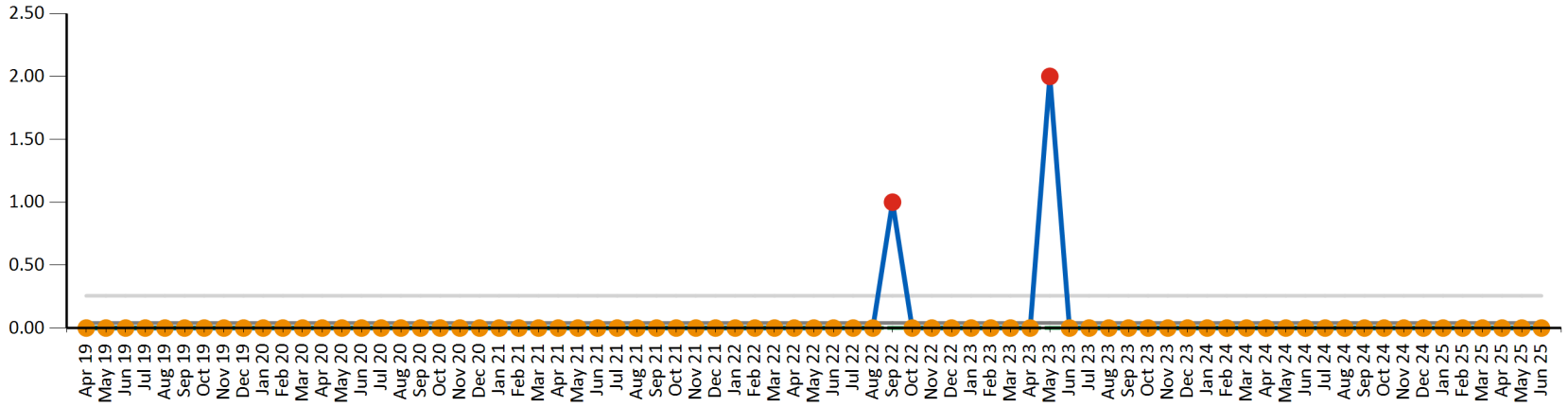
Plan	Actual
<= 2	14

17 - Number of Acute Inpatient incidences - pressure damage (category 4)

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
= 0.0	0.0	Jun-25

Previous

Plan	Actual	Period
= 0.0	0.0	May-25

Year to Date

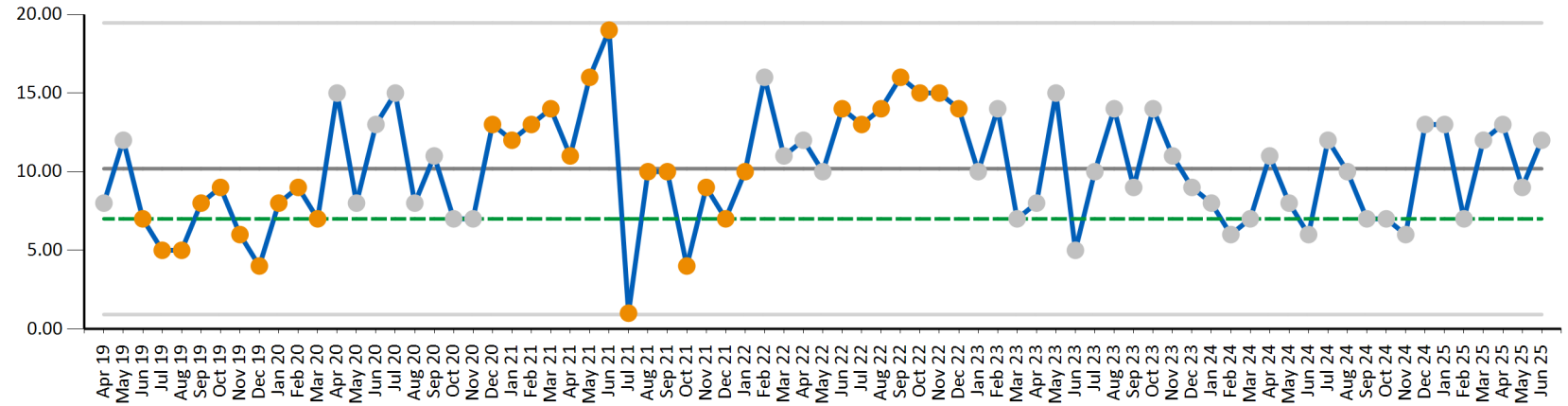
Plan	Actual
= 0.0	0.0

18 - Number of Community incidences - pressure damage (category 2)

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
<= 7.0	12.0	Jun-25

Previous

Plan	Actual	Period
<= 7.0	9.0	May-25

Year to Date

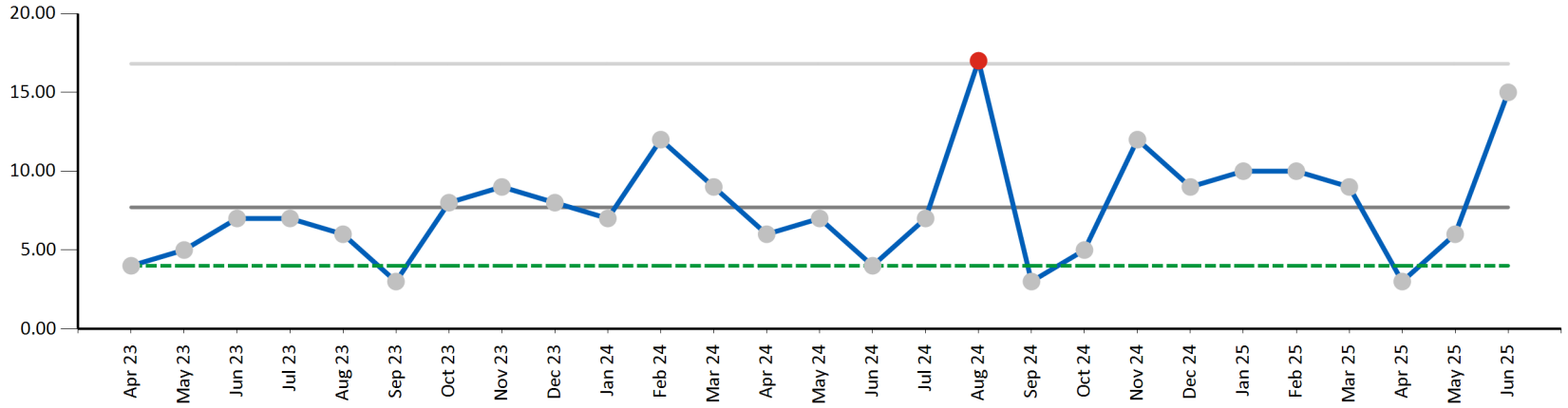
Plan	Actual
<= 21.0	34.0

621 - Number of Community incidences - pressure damage (category 3 plus unstageables)

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
<= 4	15	Jun-25

Previous

Plan	Actual	Period
<= 4	6	May-25

Year to Date

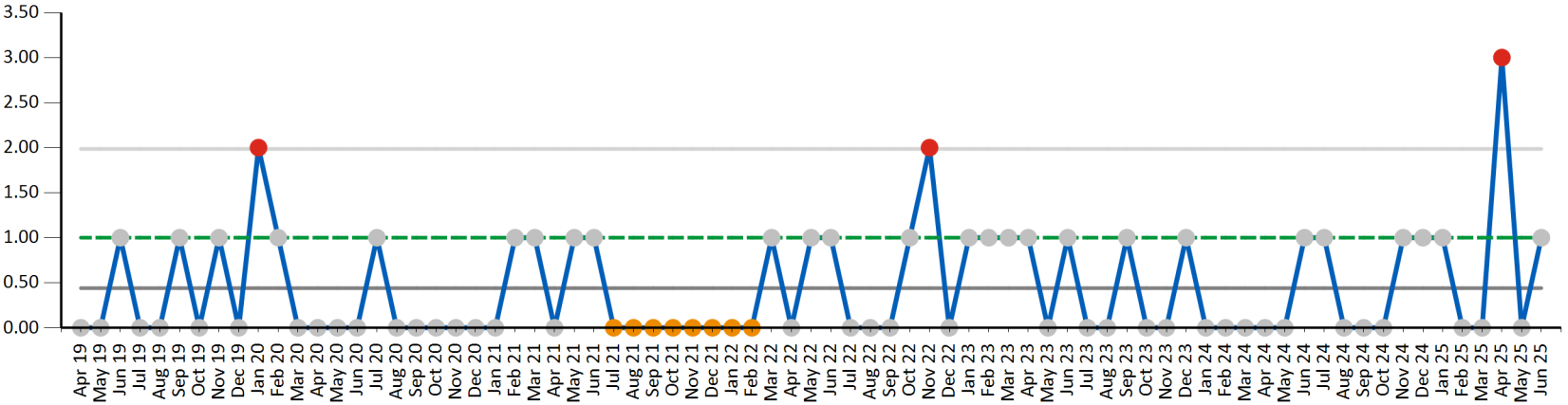
Plan	Actual
<= 12	24

20 - Number of Community incidences - pressure damage (category 4)

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Jun-25

Previous

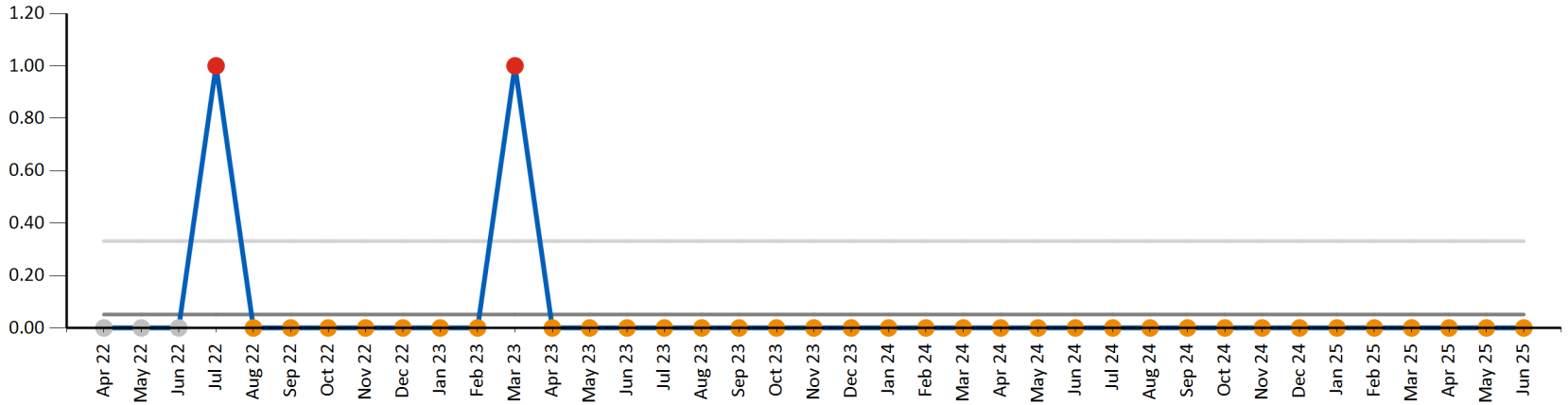
Plan	Actual	Period
<= 1.0	0.0	May-25

Year to Date

Plan	Actual
<= 3.0	4.0

535 - Community patients acquiring pressure damage - significant learning category 2

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Jun-25

Previous

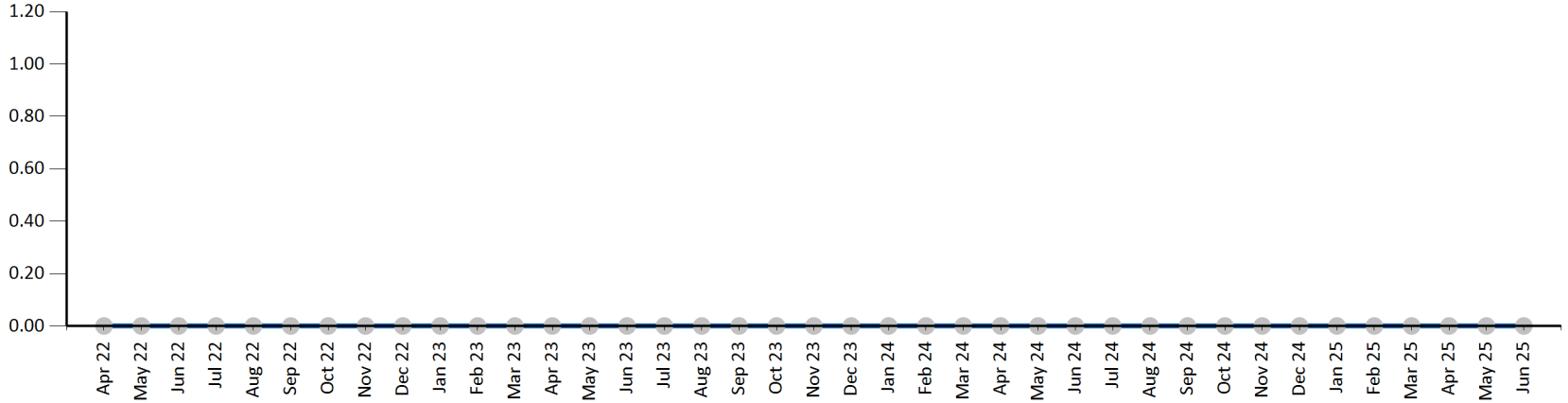
Plan	Actual	Period
	0	May-25

Year to Date

Plan	Actual
	0

536 - Community patients acquiring pressure damage - significant learning category 3

Common cause variation.



Latest

Plan	Actual	Period
	0	Jun-25

Previous

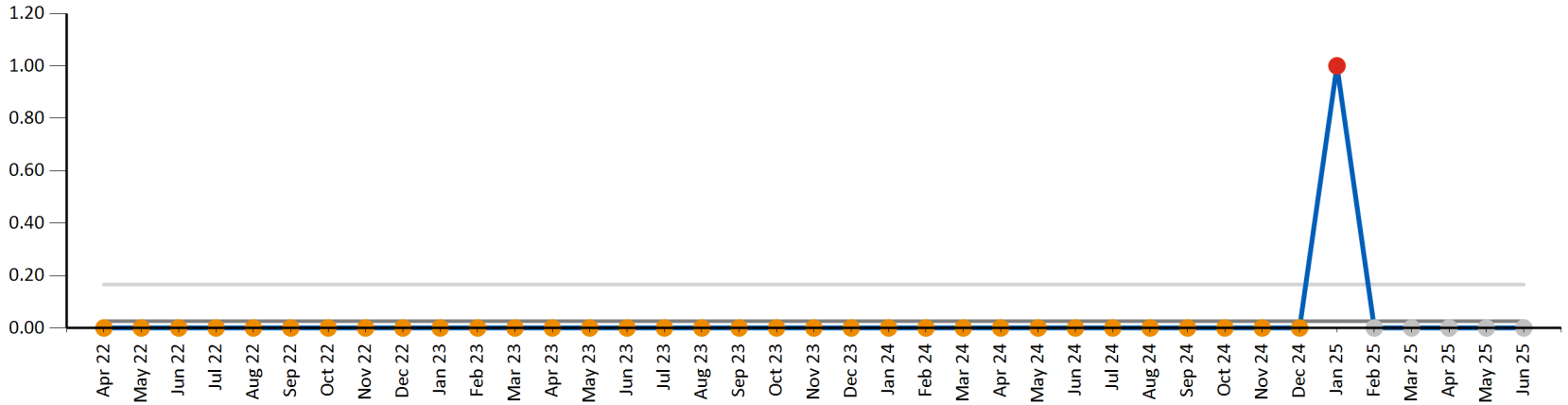
Plan	Actual	Period
	0	May-25

Year to Date

Plan	Actual
	0

537 - Community patients acquiring pressure damage - significant learning category 4

Common cause variation.



Latest

Plan	Actual	Period
	0	Jun-25

Previous

Plan	Actual	Period
	0	May-25

Year to Date

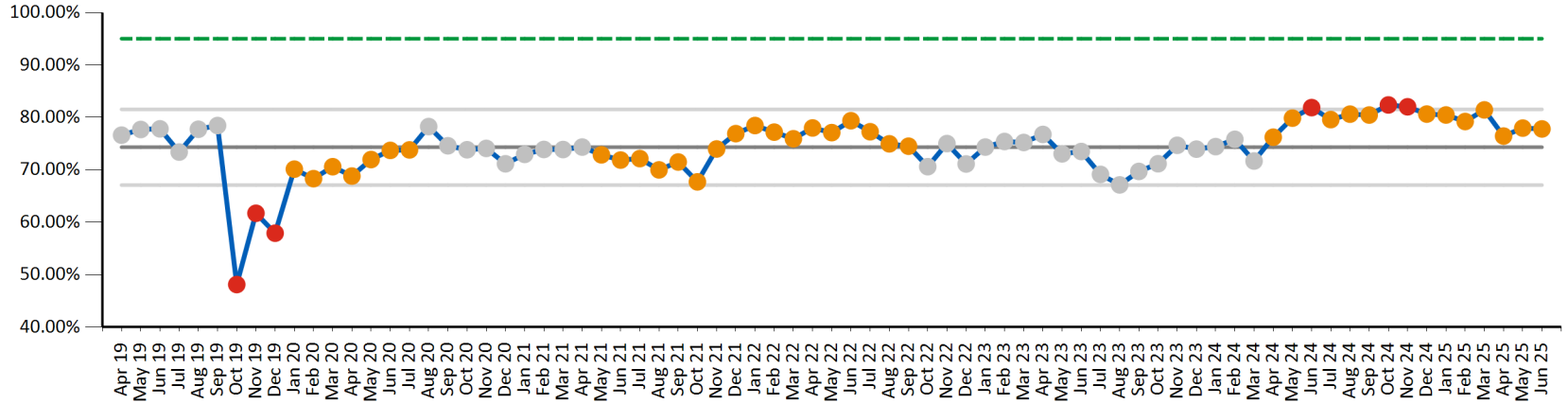
Plan	Actual
	0

30 - Clinical Correspondence - Inpatients %<1 working day

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	77.8%	Jun-25

Previous

Plan	Actual	Period
>= 95%	77.9%	May-25

Year to Date

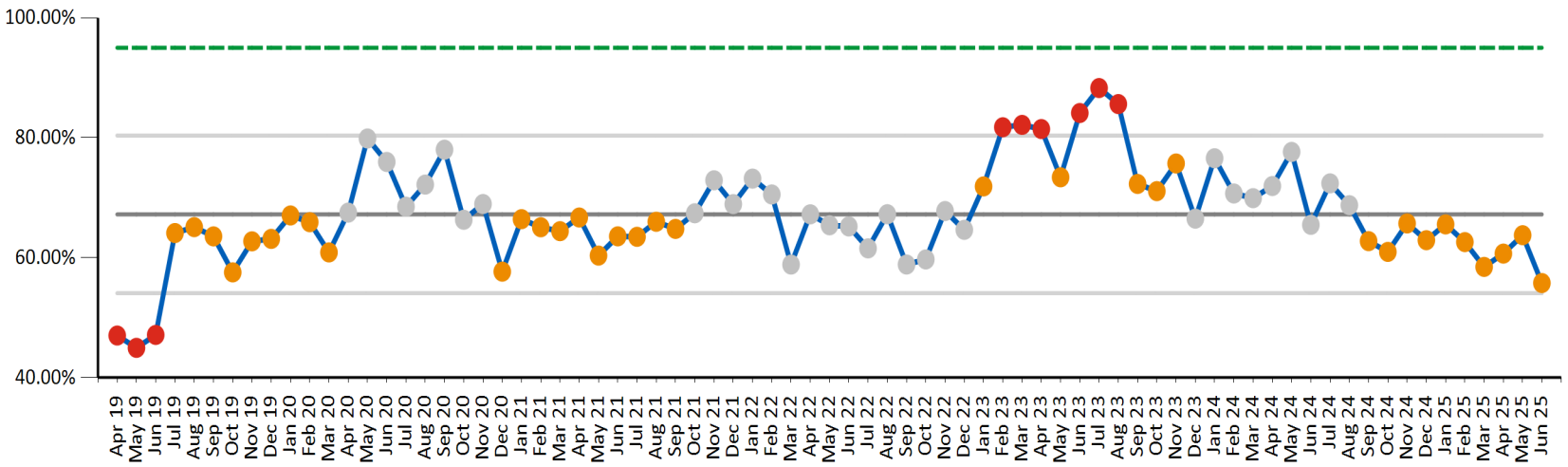
Plan	Actual
>= 95%	77.4%

31 - Clinical Correspondence - Outpatients %<5 working days

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	55.8%	Jun-25

Previous

Plan	Actual	Period
>= 95.0%	63.7%	May-25

Year to Date

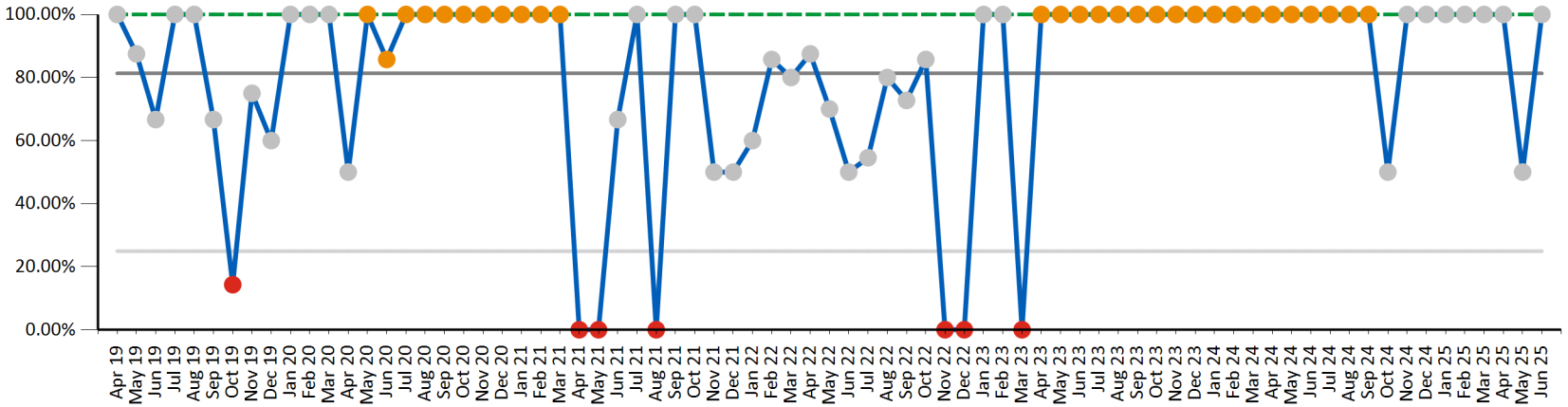
Plan	Actual
>= 95.0%	60.0%

86 - Patient Safety Alerts - Trust position

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Jun-25

Previous

Plan	Actual	Period
= 100%	50.0%	May-25

Year to Date

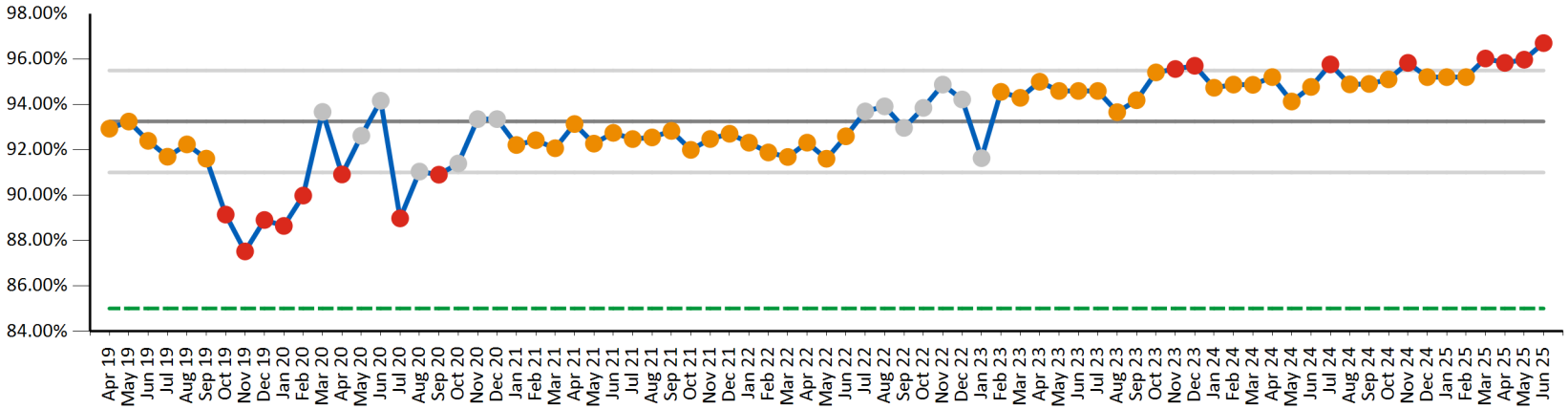
Plan	Actual
= 100%	83.3%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	96.7%	Jun-25

Previous

Plan	Actual	Period
>= 85%	96.0%	May-25

Year to Date

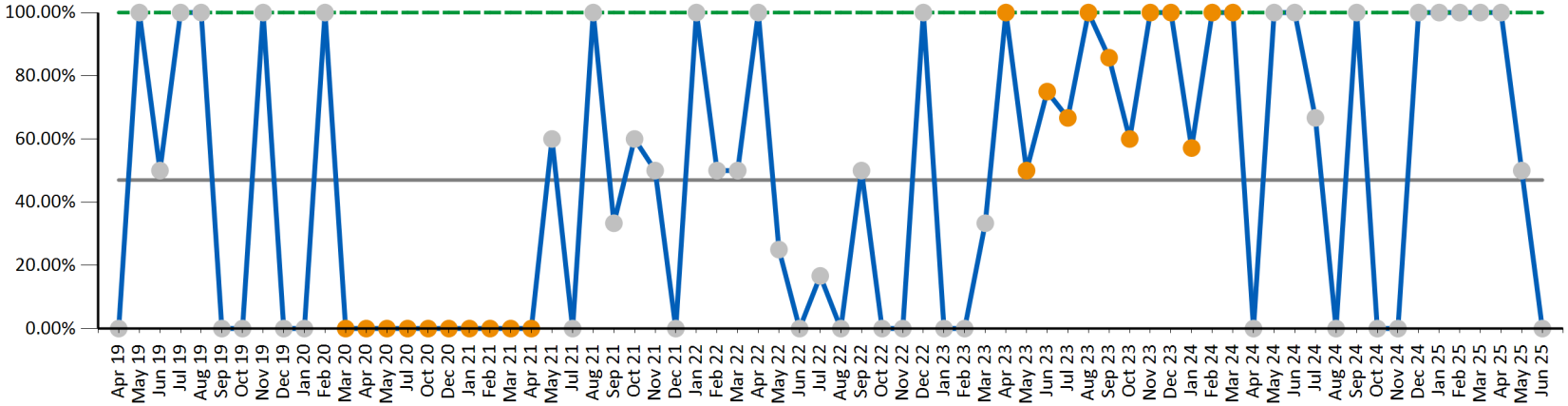
Plan	Actual
>= 85%	96.2%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
= 100%	0.0%	Jun-25

Previous

Plan	Actual	Period
= 100%	50.0%	May-25

Year to Date

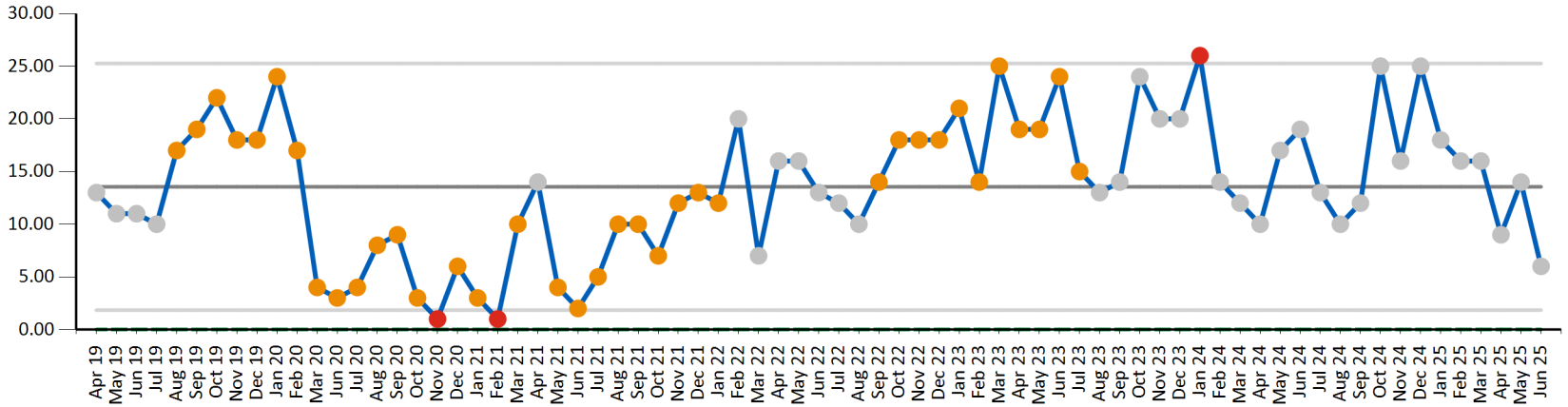
Plan	Actual
= 100%	

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	6	Jun-25

Previous

Plan	Actual	Period
= 0	14	May-25

Year to Date

Plan	Actual
= 0	29

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

CDT cases remain the IPC challenge with 12 healthcare associated cases in June. The case numbers remain in common cause variation and there is no clear reason for this increase in case numbers. Measures such as isolation of patients with loose stool continues to improve. There is still a net improvement with 24 fewer cases in Q1 of 25/26 when compared with Q1 in 24/25 and with incidence 9 cases better than the NHSE target.

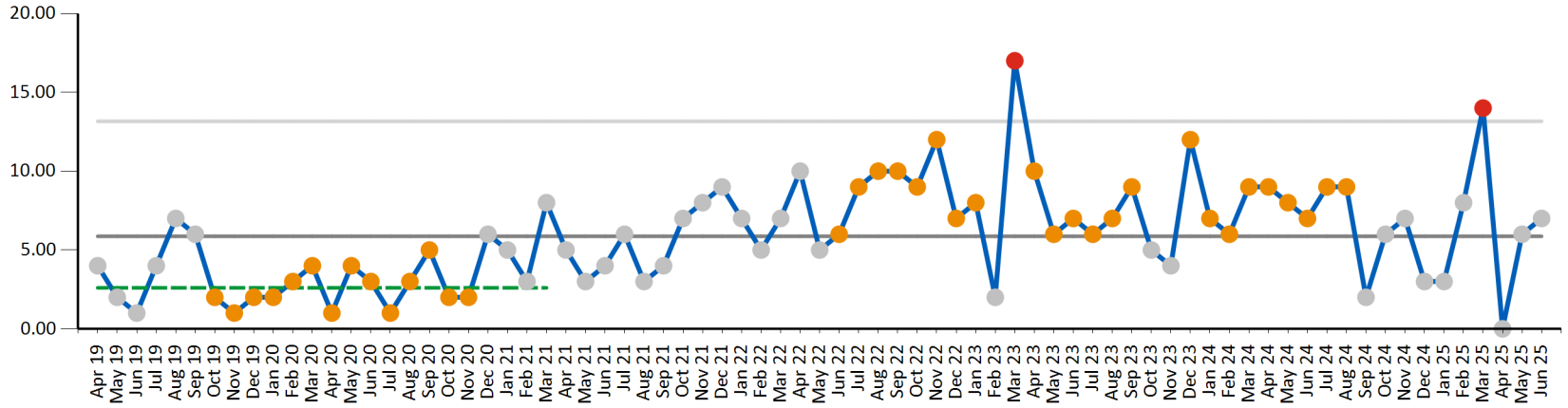
The QI change package has now been launched and there is an ambition for the five changes to be embedded by December 2025.

The remaining HCAI performance remains strong. The Trust is one of the three best performing trusts for the other measures and is the best performer for MRSA and E. coli bacteraemias in GM by rate. Bolton is the only provider in GM that hasn't had an MRSA bacteraemia in 25/26 and it has been 450 days since the last hospital onset case.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		7	Jun-25			6	May-25		13	
346 - Total Community Onset Hospital Associated C.diff infections		5	Jun-25			1	May-25		6	
347 - Total C.diff infections contributing to objective	<= 10	12	Jun-25		<= 10	7	May-25	<= 30	19	?
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Jun-25		= 0	0	May-25	= 0		?
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	5	Jun-25		<= 5	8	May-25	<= 16	16	?
219 - Blood Culture Contaminants (rate)	<= 3%	3.2%	Jun-25		<= 3%	3.2%	May-25	<= 3%		?
304 - Total Trust apportioned MSSA BSIs	<= 1.0	1.0	Jun-25		<= 1.0	3.0	May-25	<= 3.0	5.0	?
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	2	Jun-25		<= 1	2	May-25	<= 2	5	?
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Jun-25		= 0	1	May-25	= 0		?
491 - Nosocomial COVID-19 cases						8	May-25		19	

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	7	Jun-25

Previous

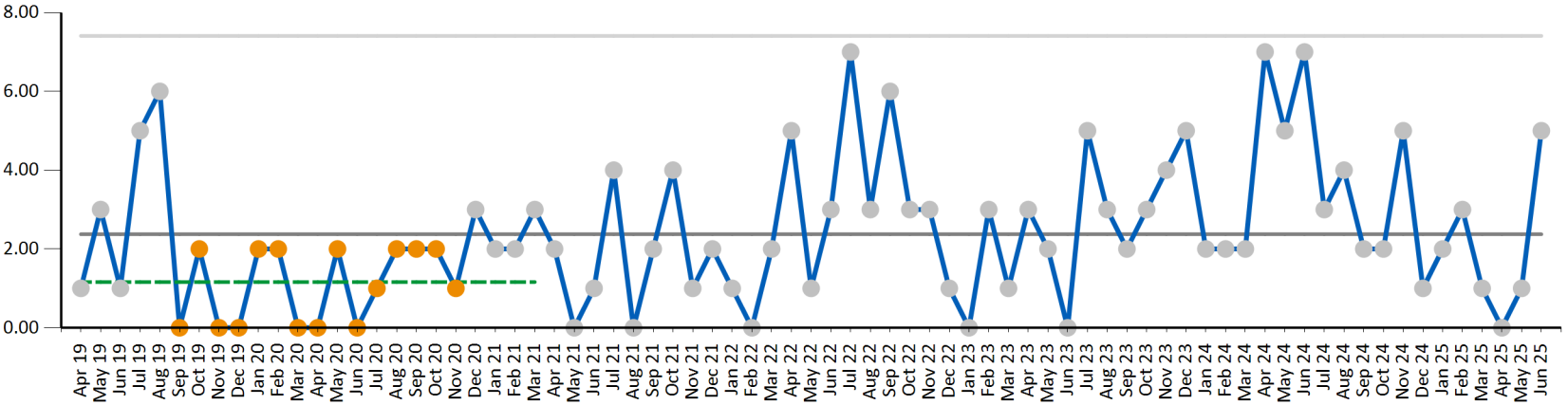
Plan	Actual	Period
	6	May-25

Year to Date

Plan	Actual
	13

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Jun-25

Previous

Plan	Actual	Period
	1	May-25

Year to Date

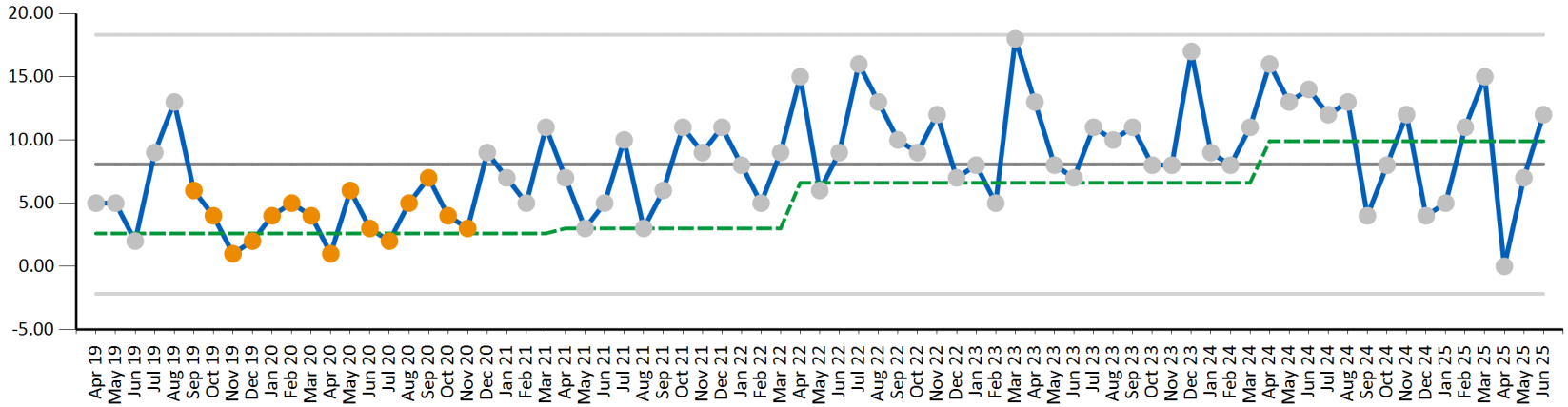
Plan	Actual
	6

347 - Total C.diff infections contributing to objective

Common cause variation.

We will not regularly meet the target due to normal variation.

3/6



Latest

Plan	Actual	Period
<= 10	12	Jun-25

Previous

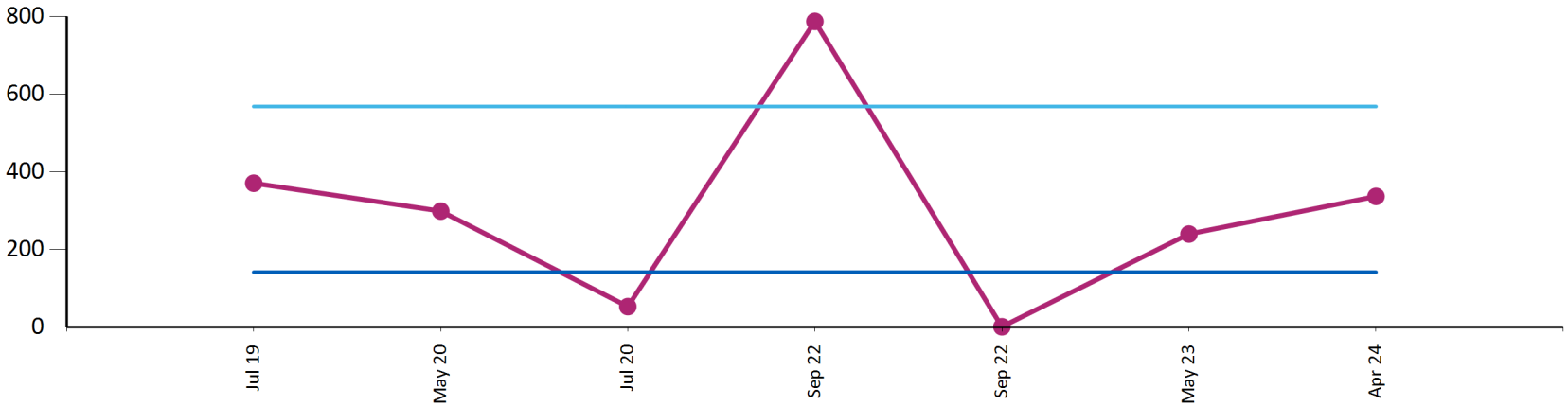
Plan	Actual	Period
<= 10	7	May-25

Year to Date

Plan	Actual
<= 30	19

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Jun-25

Previous

Plan	Actual	Period
	0	May-25

Year to Date

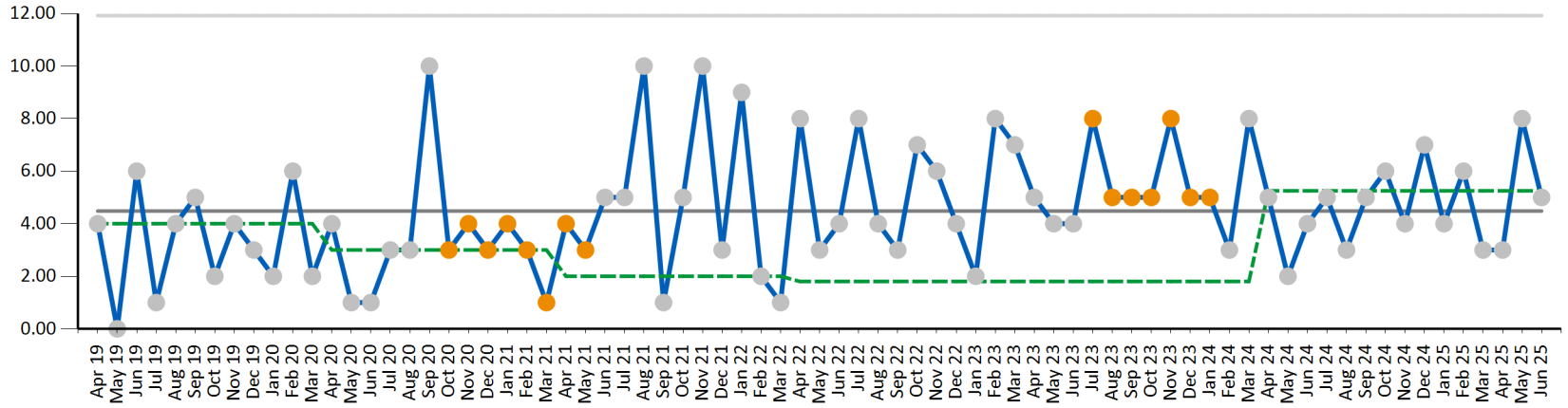
Plan	Actual

218 - Total Trust apportioned E. coli BSI (HOHA + COHA)

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
<= 5	5	Jun-25

Previous

Plan	Actual	Period
<= 5	8	May-25

Year to Date

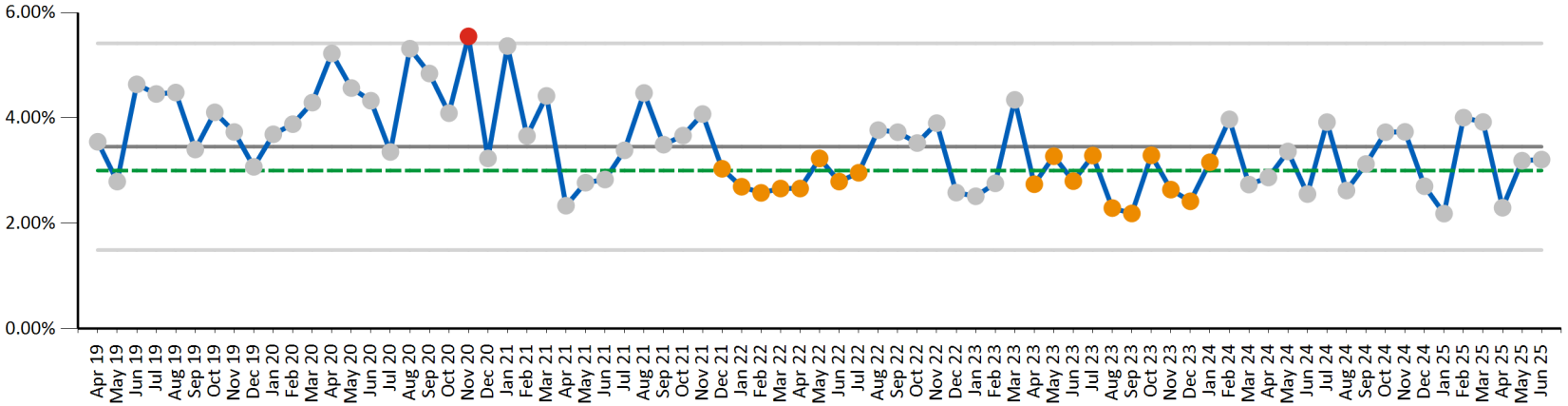
Plan	Actual
<= 16	16

219 - Blood Culture Contaminants (rate)

Common cause variation.

We will not regularly meet the target due to normal variation.

2/6



Latest

Plan	Actual	Period
<= 3%	3.2%	Jun-25

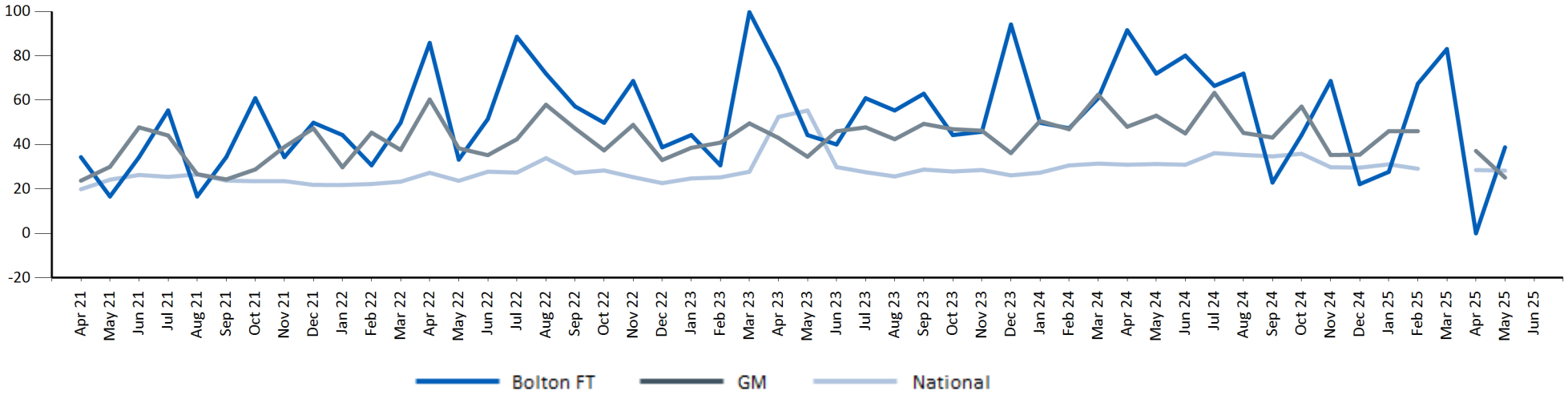
Previous

Plan	Actual	Period
<= 3%	3.2%	May-25

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

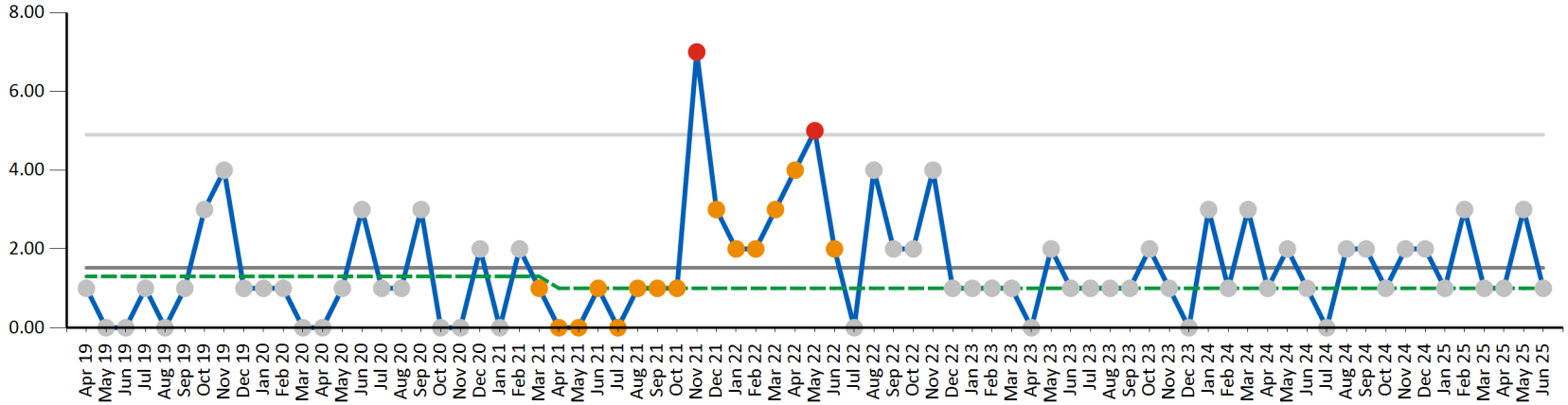


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
<= 1.0	1.0	Jun-25

Previous

Plan	Actual	Period
<= 1.0	3.0	May-25

Year to Date

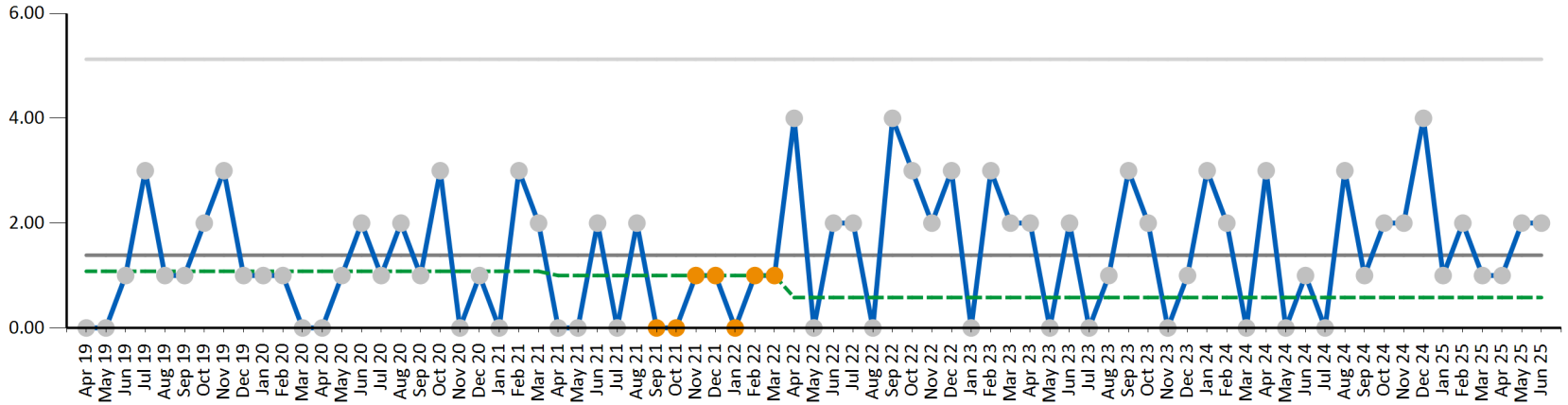
Plan	Actual
<= 3.0	5.0

305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
<= 1	2	Jun-25

Previous

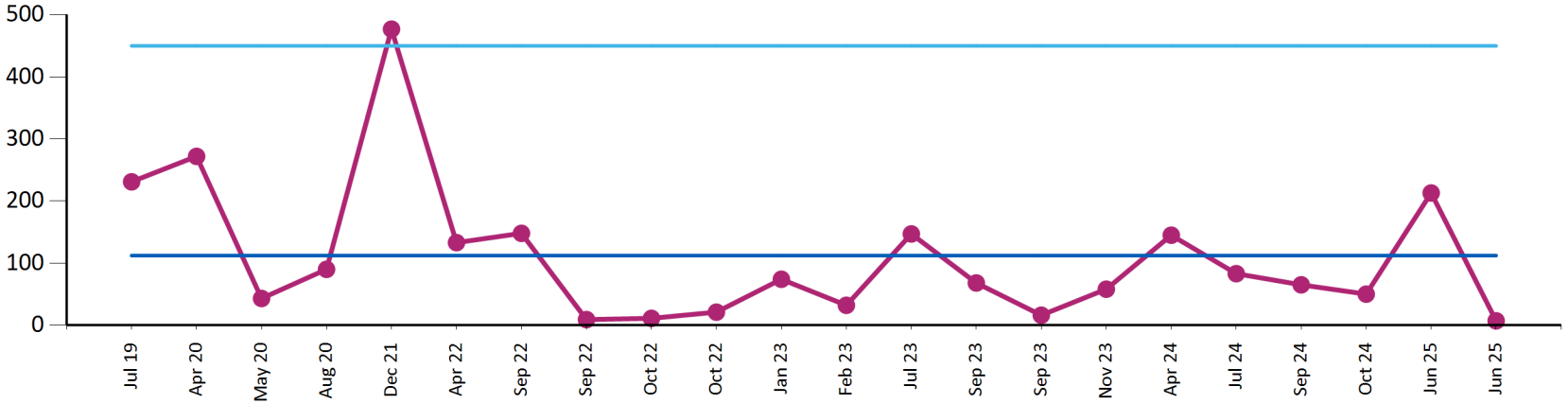
Plan	Actual	Period
<= 1	2	May-25

Year to Date

Plan	Actual
<= 2	5

306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)

0/6



Latest

Plan	Actual	Period
	0	Jun-25

Previous

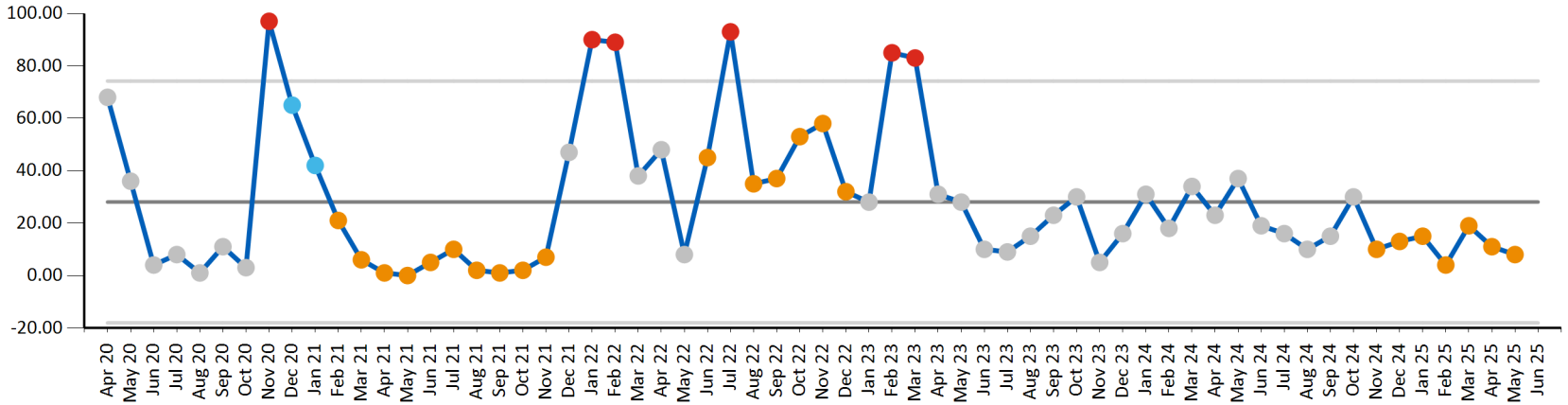
Plan	Actual	Period
	0	May-25

Year to Date

Plan	Actual

491 - Nosocomial COVID-19 cases

Common cause variation.



Latest

Plan	Actual	Period

Previous

Plan	Actual	Period
	8	

Year to Date

Plan	Actual
	19

Quality and Safety - Mortality

Bolton NHS Foundation Trust

Crude – in month rate is below Trust target and average for the timeframe and is showing as 16 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is above the average for the period and remains in control. The 12 month rolling average to March 2025 is 113.98 which is a 'Red' alert when compared to other Trusts.

SHMI – In month figure is below the average for the time period and remains in control. The published rolling average for the period March 2024 to February 2025 is 114.8 which is 'as expected'.

The proportion of Charlson comorbidities is above average for the time frame. The depth of recording remains in control but is lower than average. Both indictors are still lower when benchmarked against the England average of all Acute Trusts.

The proportion of coded records at the time of the snapshot remains above the average for the timeframe.

The early neonatal mortality remains in control and has been for more than 12 months.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	83.0%	Jun-25		>= 85%	100.0%	May-25	>= 85%	88.7%	
495 - HSMR		120.06	Mar-25			114.51	Feb-25			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	102.20	Jan-25		<= 100.00	118.76	Dec-24	<= 100.00		
12 - Crude Mortality %	<= 2.9%	1.4%	Jun-25	L	<= 2.9%	1.6%	May-25	<= 2.9%	1.6%	
519 - Average Charlson comorbidity Score (First episode of care)		4	Feb-25	H		4	Jan-25			
520 - Depth of recording (First episode of care)		6	Feb-25	L		6	Jan-25			
521 - Proportion of fully coded records (Inpatients)		96.6%	Feb-25	H		97.3%	Jan-25			

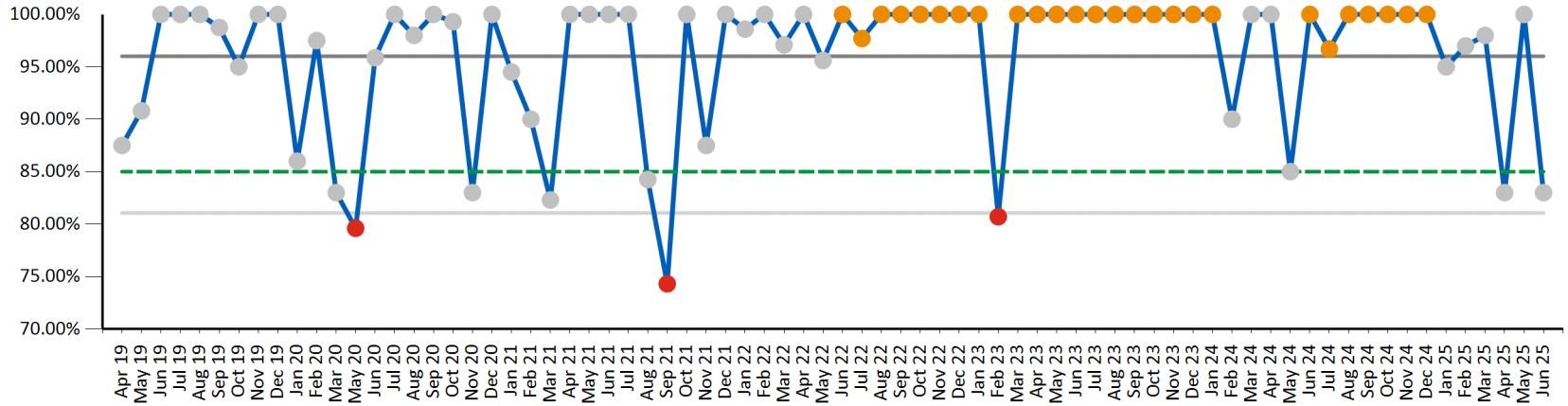
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		0.00	Jun-25			2.50	May-25			

3 - National Early Warning Scores to Gold standard

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 85%	83.0%	Jun-25

Previous

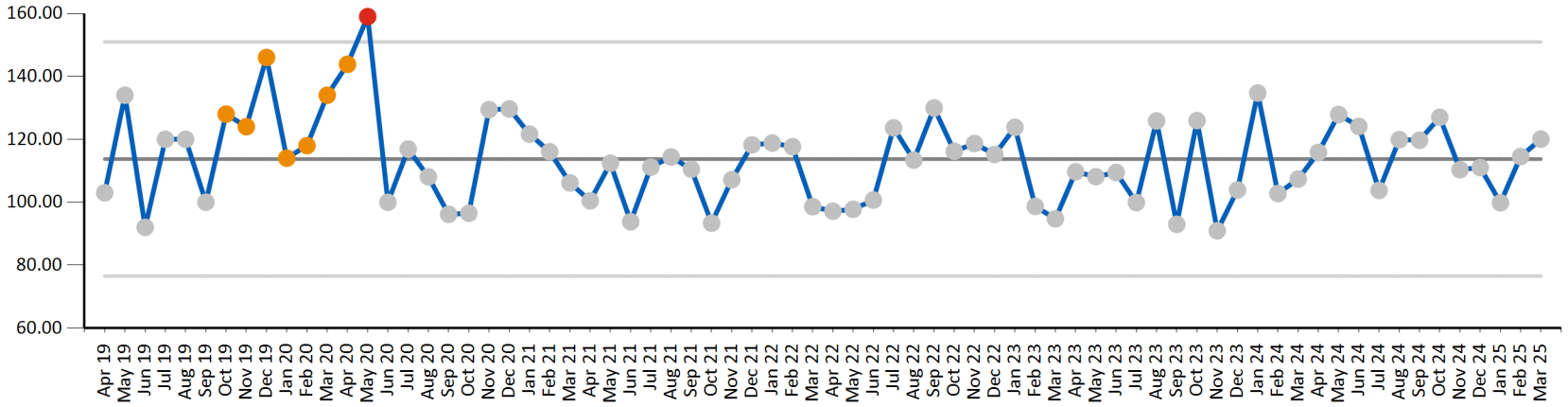
Plan	Actual	Period
>= 85%	100.0%	May-25

Year to Date

Plan	Actual
>= 85%	88.7%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	120.06	Mar-25

Previous

Plan	Actual	Period
	114.51	Feb-25

Year to Date

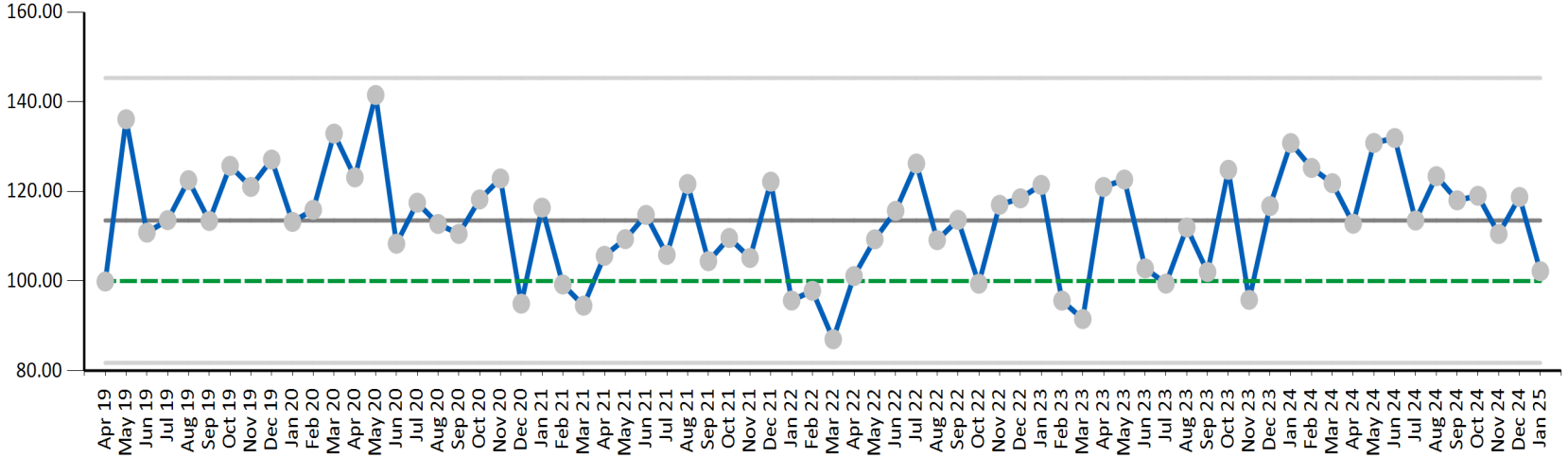
Plan	Actual
	120.06

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
< = 100.00	102.20	Jan-25

Previous

Plan	Actual	Period
< = 100.00	118.76	Dec-24

Year to Date

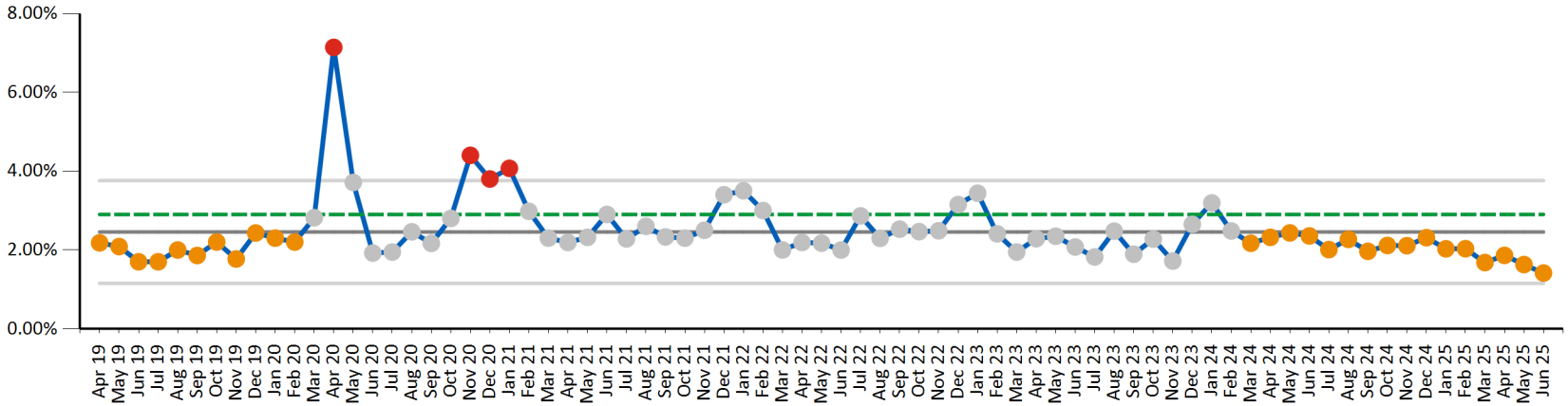
Plan	Actual
< = 100.00	102.20

12 - Crude Mortality %

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
<= 2.9%	1.4%	Jun-25

Previous

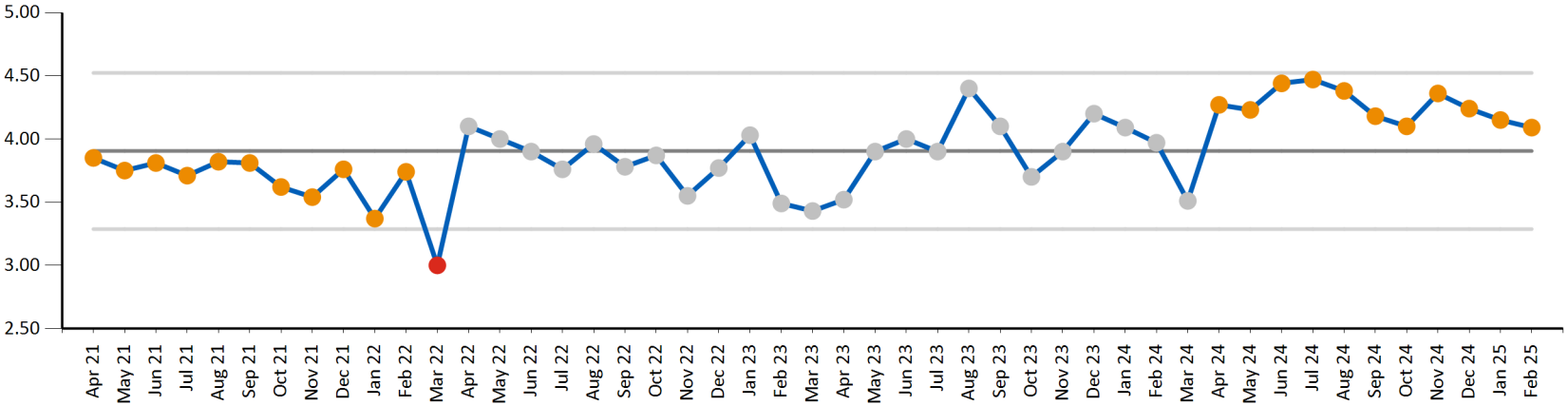
Plan	Actual	Period
<= 2.9%	1.6%	May-25

Year to Date

Plan	Actual
<= 2.9%	1.6%

519 - Average Charlson comorbidity Score (First episode of care)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	4	Feb-25

Previous

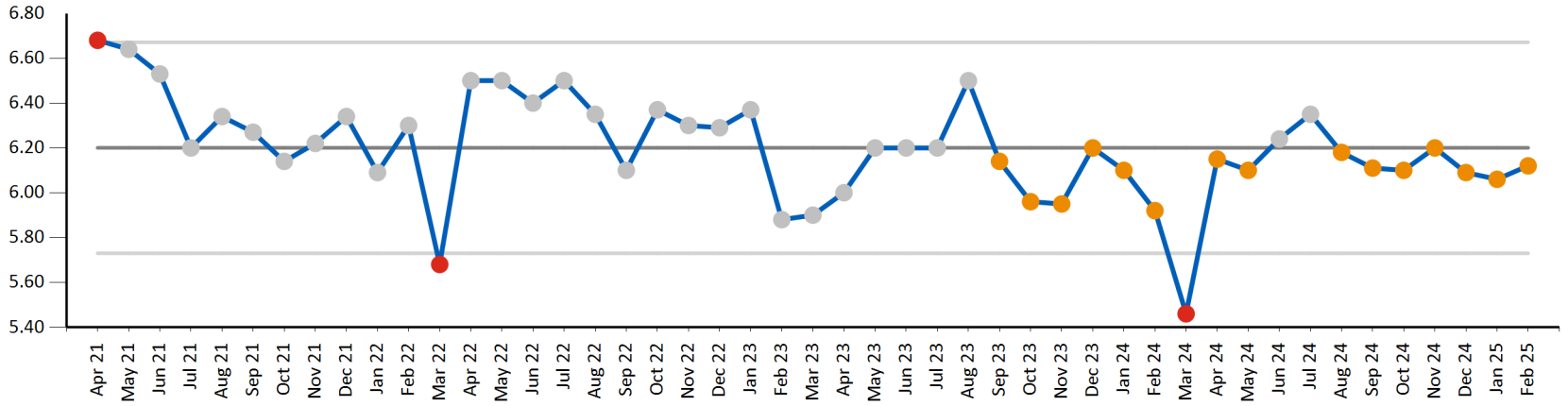
Plan	Actual	Period
	4	Jan-25

Year to Date

Plan	Actual
	47

520 - Depth of recording (First episode of care)

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	6	Feb-25

Previous

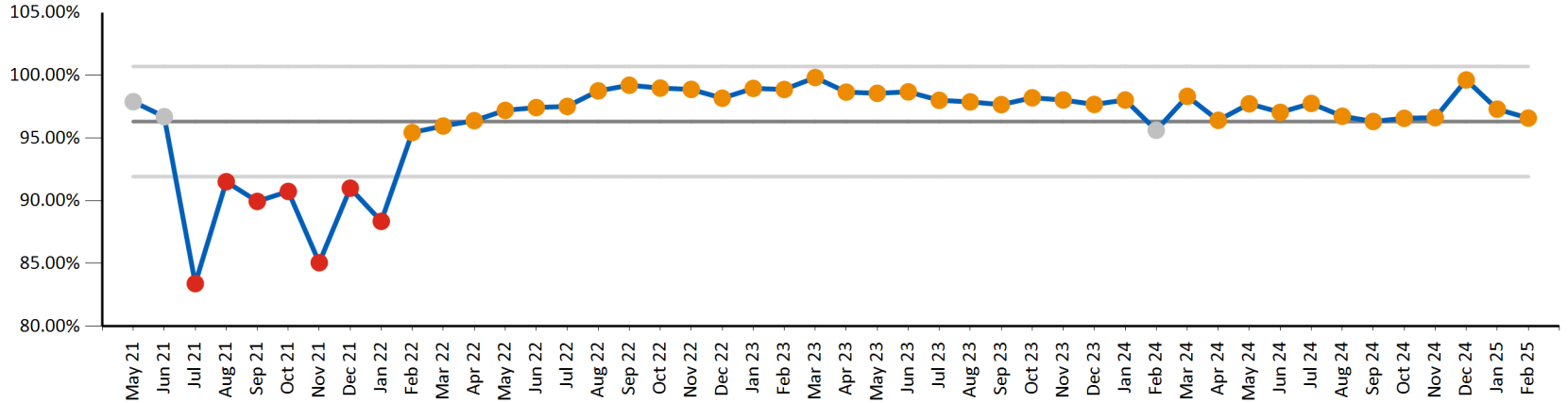
Plan	Actual	Period
	6	Jan-25

Year to Date

Plan	Actual
	68

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	96.6%	Feb-25

Previous

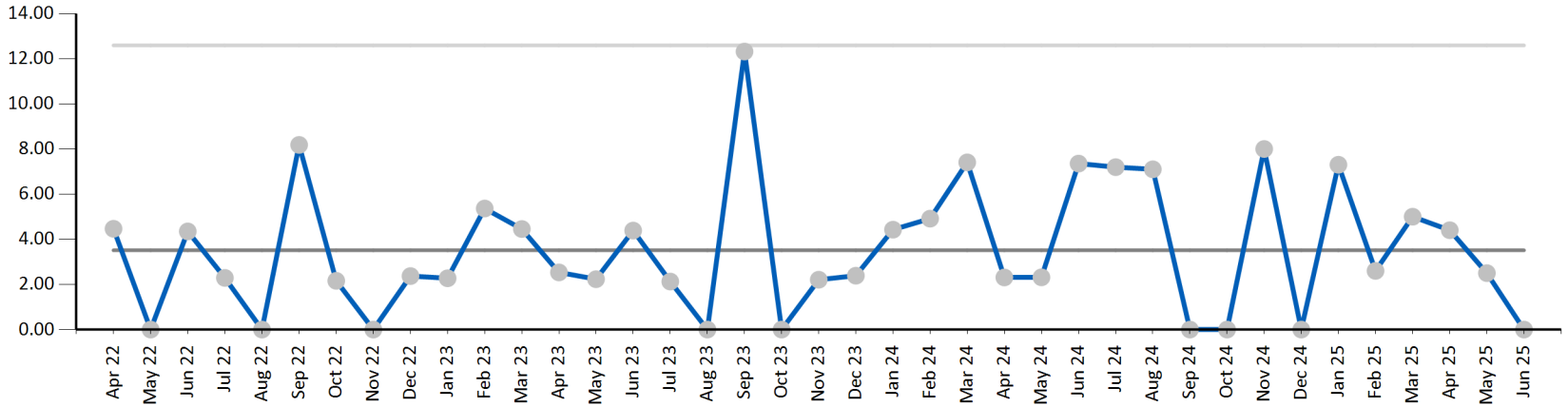
Plan	Actual	Period
	97.3%	Jan-25

Year to Date

Plan	Actual
	97.2%

604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)

Common cause variation.



Latest

Plan	Actual	Period
	0.00	Jun-25

Previous

Plan	Actual	Period
	2.50	May-25

Year to Date

Plan	Actual

Quality and Safety - Patient Experience

NHS Bolton NHS Foundation Trust

FFT Response and Satisfaction rates

Emergency Department response rates remain below the planned 20% target rate. ED satisfaction rates remain below the target of 90% but are within standard variation. The department continues to review patient experience feedback from a variety of sources and have a Patient Experience Improvement Plan with oversight at ED Governance. Paediatric ED responses use a colourful paper model which is distributed by all staff and the option of a QR code is available for older children. Completion of FFTs is supported by an onsite Play Worker, or HCAs in their absence, to encourage participation.

Inpatient response rates remain within common cause variation however are below target. Inpatient satisfaction rates are however above the target rate of 90%.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	14.4%	Jun-25	L	>= 20%	14.0%	May-25	>= 20%	14.2%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	84.0%	Jun-25		>= 90%	85.8%	May-25	>= 90%	85.4%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	28.7%	Jun-25		>= 30%	27.0%	May-25	>= 30%	27.3%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.2%	Jun-25		>= 90%	97.5%	May-25	>= 90%	97.0%	P
81 - Maternity Friends and Family Response Rate	>= 15%	31.5%	Jun-25		>= 15%	27.7%	May-25	>= 15%	28.1%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	96.4%	Jun-25	H	>= 90%	94.2%	May-25	>= 90%	94.0%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	33.4%	Jun-25	H	>= 15%	19.8%	May-25	>= 15%	22.5%	?
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	98.0%	Jun-25		>= 90%	95.6%	May-25	>= 90%	97.1%	?
83 - Birth - Friends and Family Response Rate	>= 15%	41.7%	Jun-25	H	>= 15%	43.1%	May-25	>= 15%	41.4%	P
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	94.4%	Jun-25		>= 90%	92.9%	May-25	>= 90%	92.0%	?
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	22.2%	Jun-25		>= 15%	22.6%	May-25	>= 15%	21.0%	?

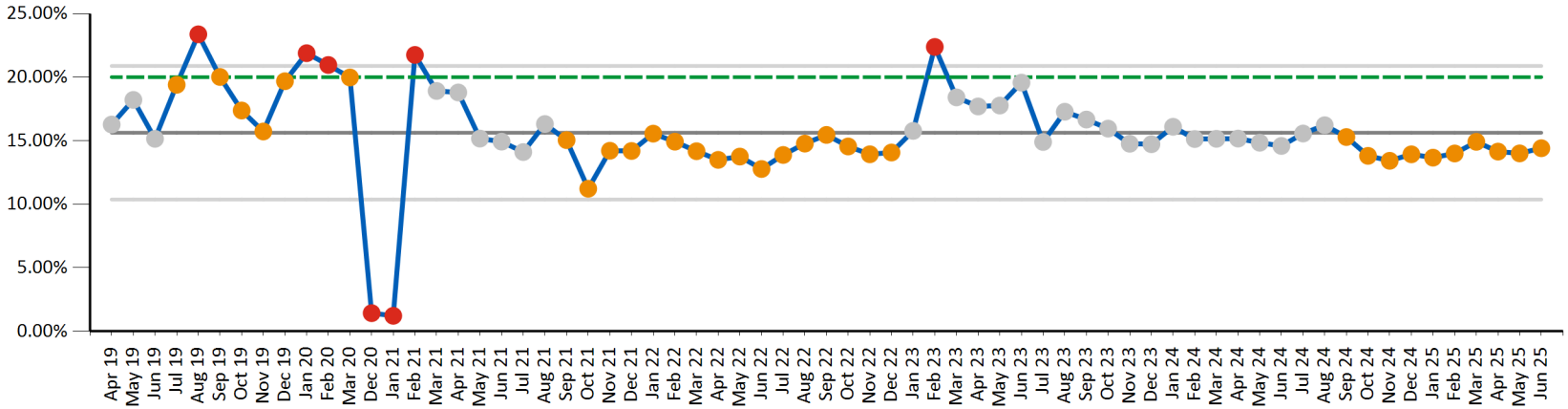
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.3%	Jun-25		>= 90%	95.2%	May-25	>= 90%	92.4%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	25.4%	Jun-25		>= 15%	25.2%	May-25	>= 15%	25.7%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.0%	Jun-25		>= 90%	94.5%	May-25	>= 90%	95.0%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Jun-25		= 100%	100.0%	May-25	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	100.0%	Jun-25		>= 95%	85.7%	May-25	>= 95%	89.7%	

200 - A&E Friends and Family Response Rate

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 20%	14.4%	Jun-25

Previous

Plan	Actual	Period
>= 20%	14.0%	May-25

Year to Date

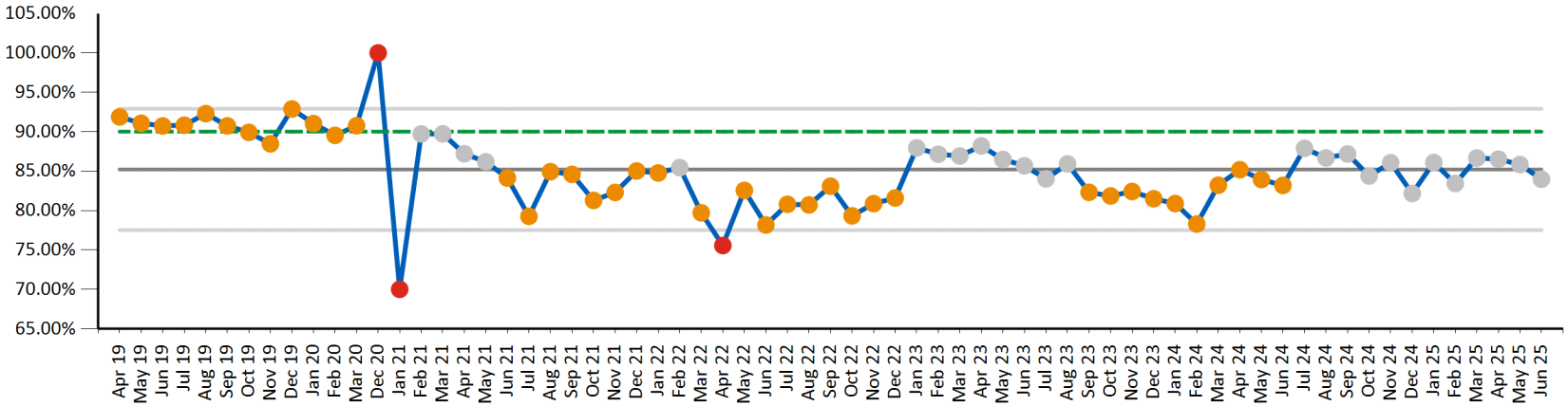
Plan	Actual
>= 20%	14.2%

294 - A&E Friends and Family Satisfaction Rates %

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 90%	84.0%	Jun-25

Previous

Plan	Actual	Period
>= 90%	85.8%	May-25

Year to Date

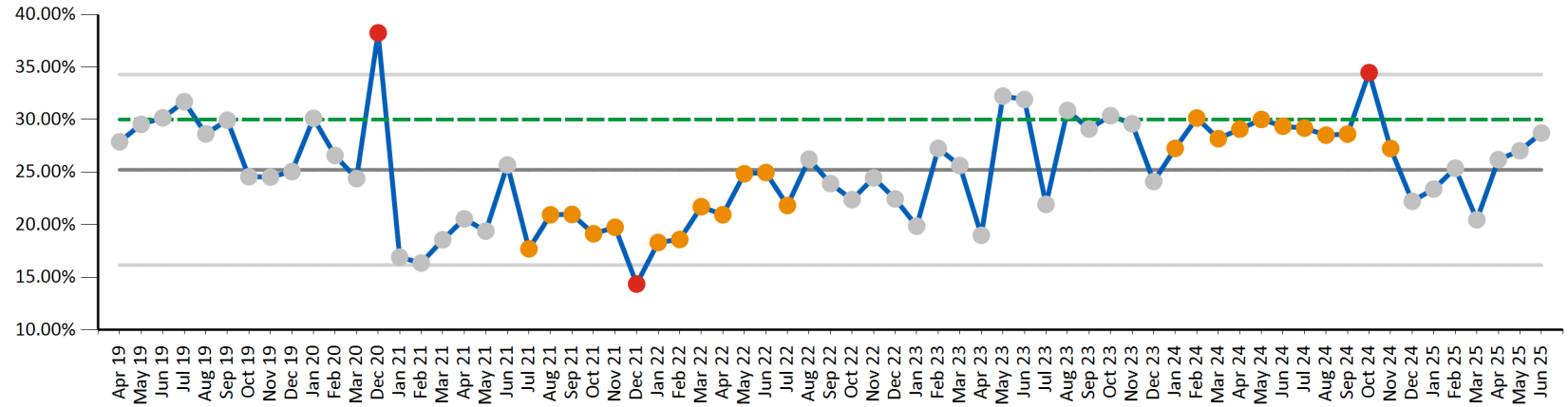
Plan	Actual
>= 90%	85.4%

80 - Inpatient Friends and Family Response Rate

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 30%	28.7%	Jun-25

Previous

Plan	Actual	Period
>= 30%	27.0%	May-25

Year to Date

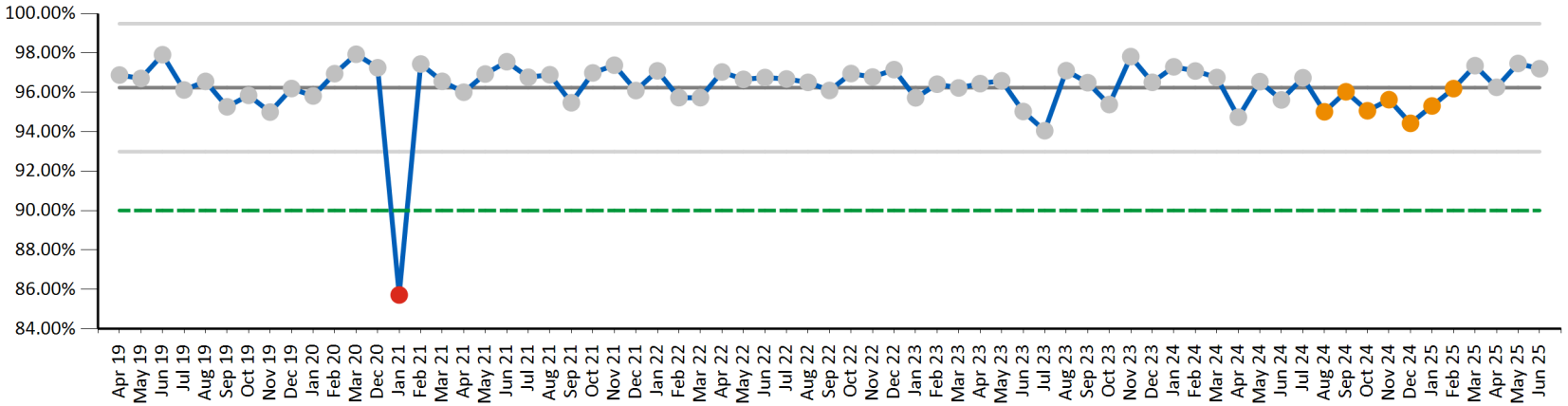
Plan	Actual
>= 30%	27.3%

240 - Friends and Family Test (Inpatients) - Satisfaction %

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	97.2%	Jun-25

Previous

Plan	Actual	Period
>= 90%	97.5%	May-25

Year to Date

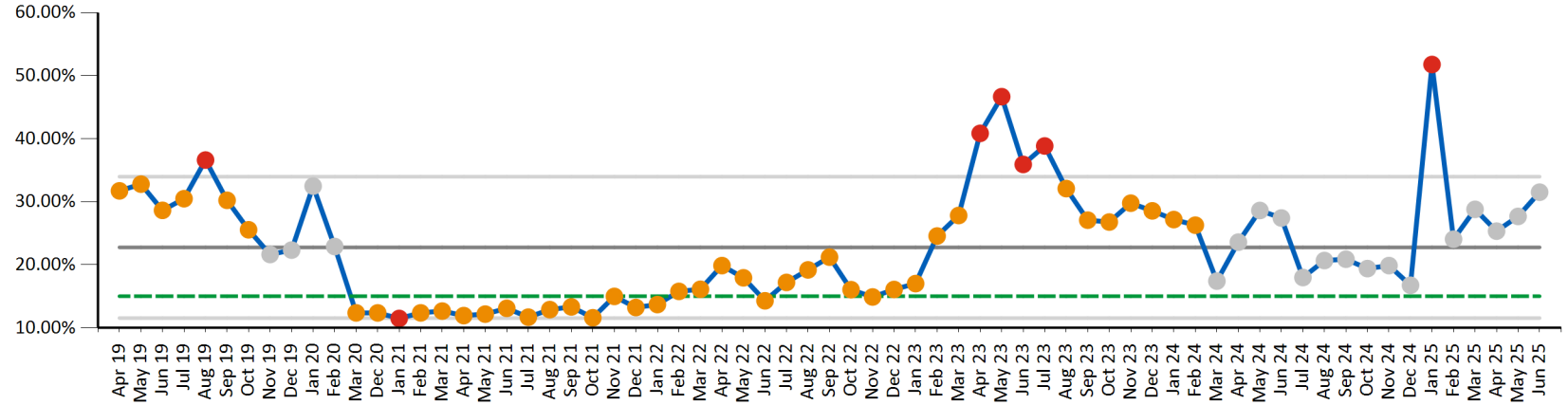
Plan	Actual
>= 90%	97.0%

81 - Maternity Friends and Family Response Rate

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 15%	31.5%	Jun-25

Previous

Plan	Actual	Period
>= 15%	27.7%	May-25

Year to Date

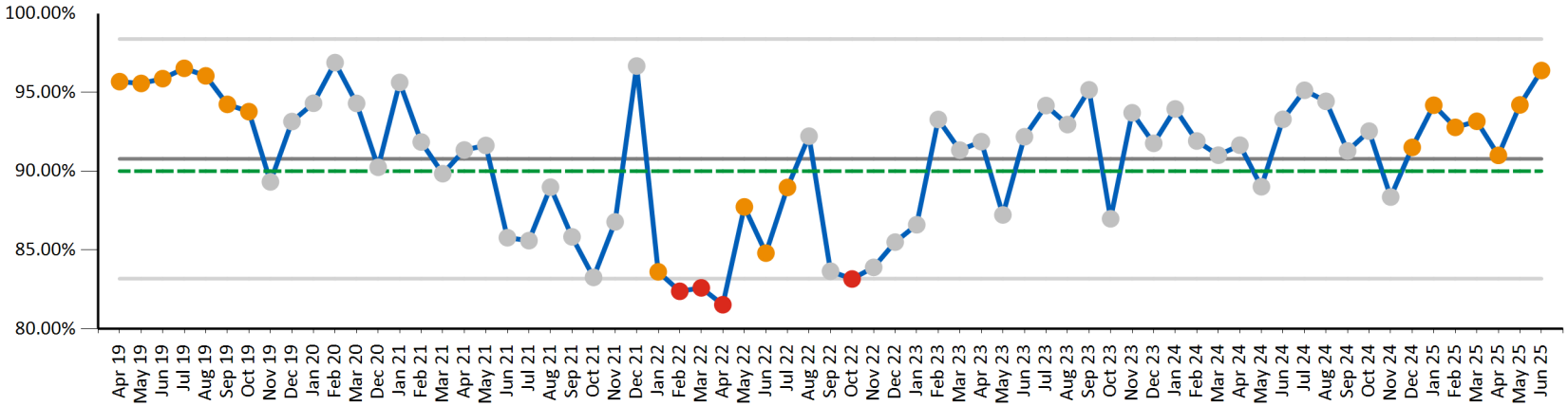
Plan	Actual
>= 15%	28.1%

241 - Maternity Friends and Family Test - Satisfaction %

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 90%	96.4%	Jun-25

Previous

Plan	Actual	Period
>= 90%	94.2%	May-25

Year to Date

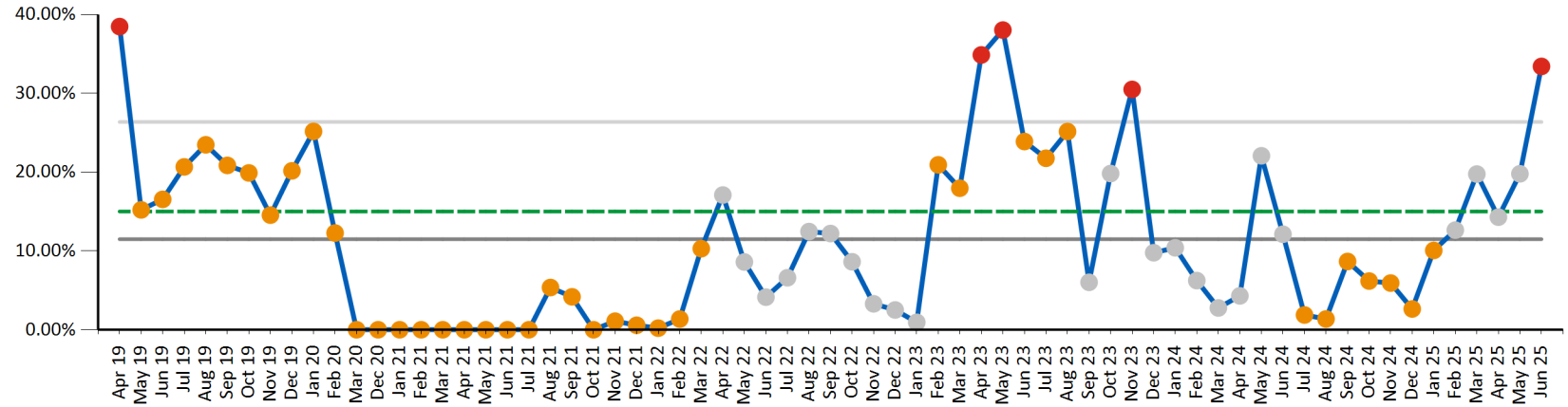
Plan	Actual
>= 90%	94.0%

82 - Antenatal - Friends and Family Response Rate

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

3/6



Latest

Plan	Actual	Period
>= 15%	33.4%	Jun-25

Previous

Plan	Actual	Period
>= 15%	19.8%	May-25

Year to Date

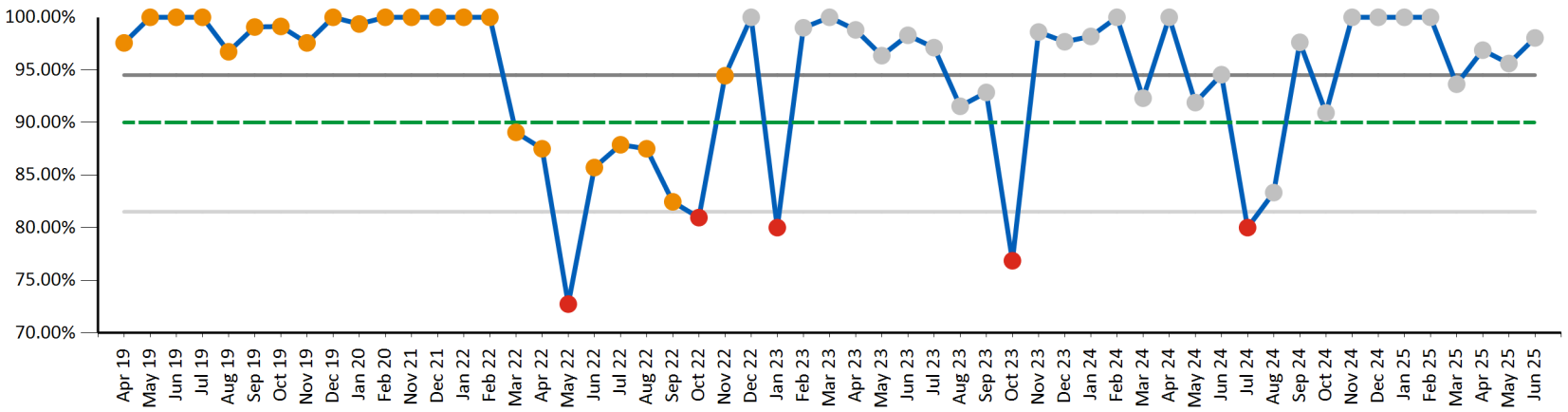
Plan	Actual
>= 15%	22.5%

242 - Antenatal Friends and Family Test - Satisfaction %

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 90%	98.0%	Jun-25

Previous

Plan	Actual	Period
>= 90%	95.6%	May-25

Year to Date

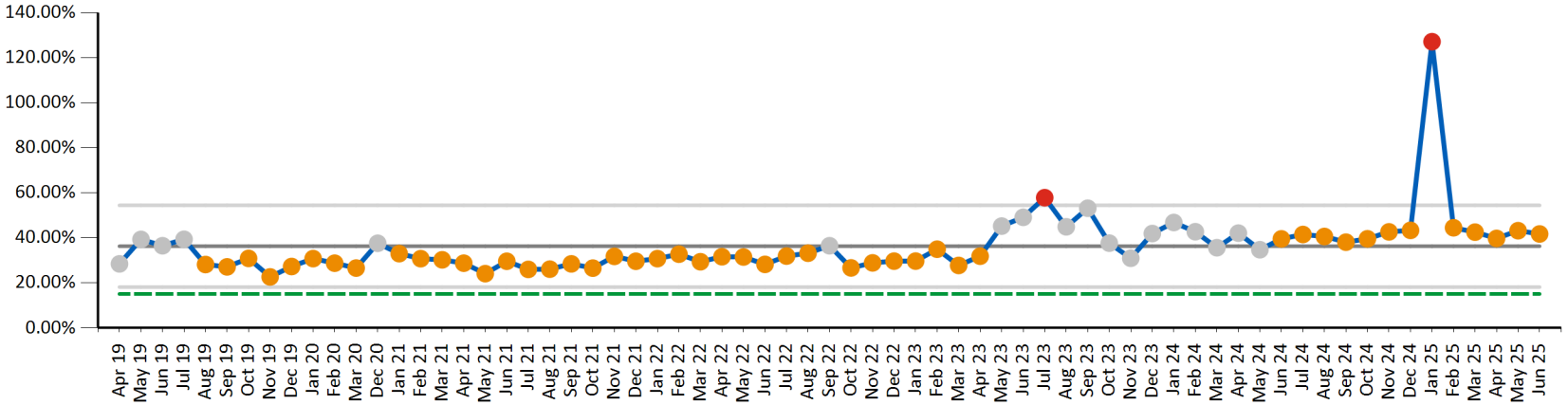
Plan	Actual
>= 90%	97.1%

83 - Birth - Friends and Family Response Rate

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	41.7%	Jun-25

Previous

Plan	Actual	Period
>= 15%	43.1%	May-25

Year to Date

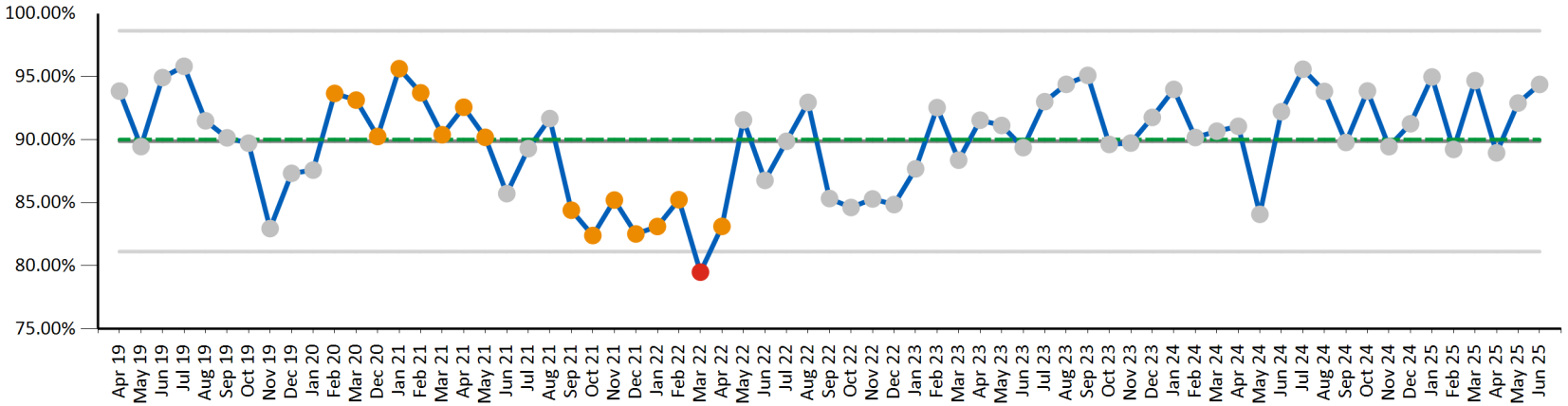
Plan	Actual
>= 15%	41.4%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 90%	94.4%	Jun-25

Previous

Plan	Actual	Period
>= 90%	92.9%	May-25

Year to Date

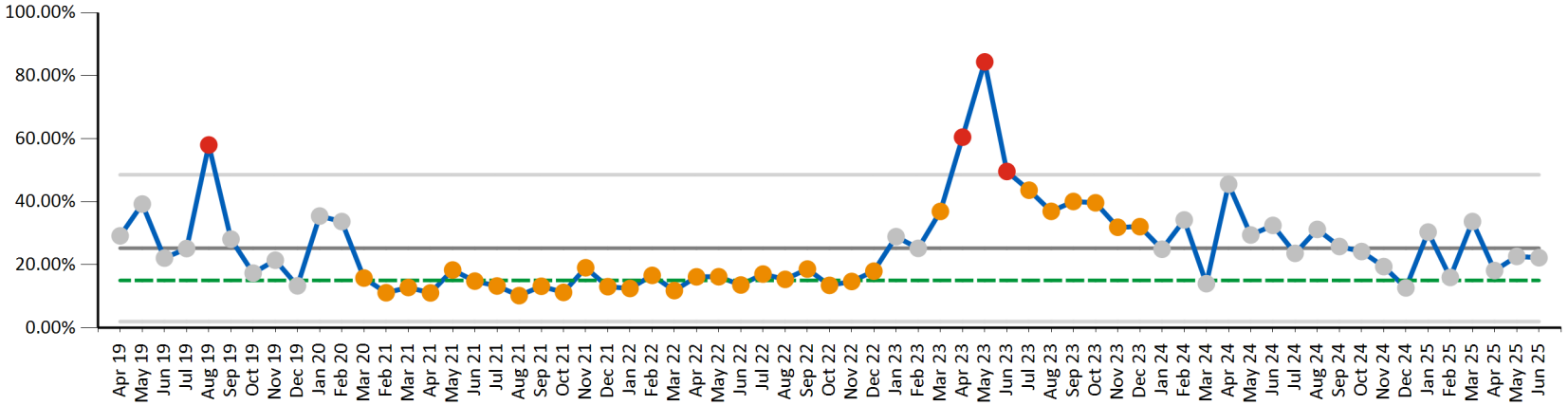
Plan	Actual
>= 90%	92.0%

84 - Hospital Postnatal - Friends and Family Response Rate

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 15%	22.2%	Jun-25

Previous

Plan	Actual	Period
>= 15%	22.6%	May-25

Year to Date

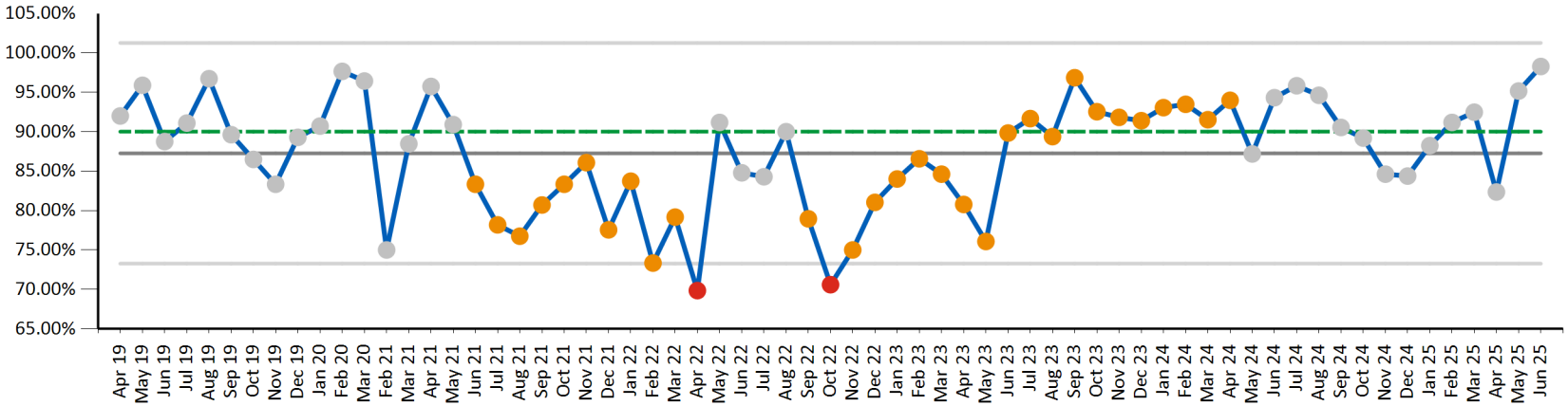
Plan	Actual
>= 15%	21.0%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 90%	98.3%	Jun-25

Previous

Plan	Actual	Period
>= 90%	95.2%	May-25

Year to Date

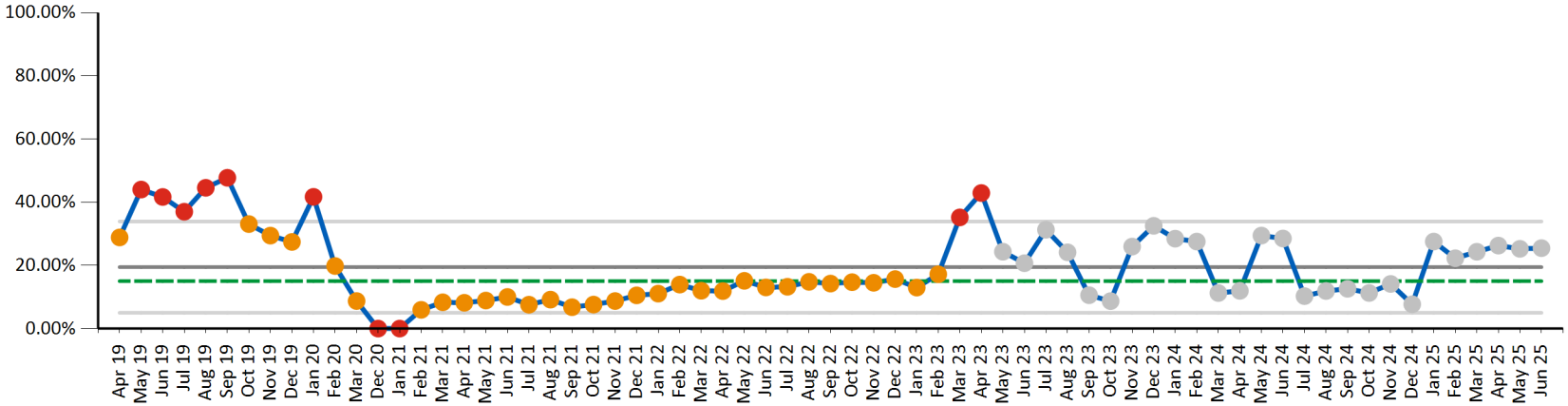
Plan	Actual
>= 90%	92.4%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 15%	25.4%	Jun-25

Previous

Plan	Actual	Period
>= 15%	25.2%	May-25

Year to Date

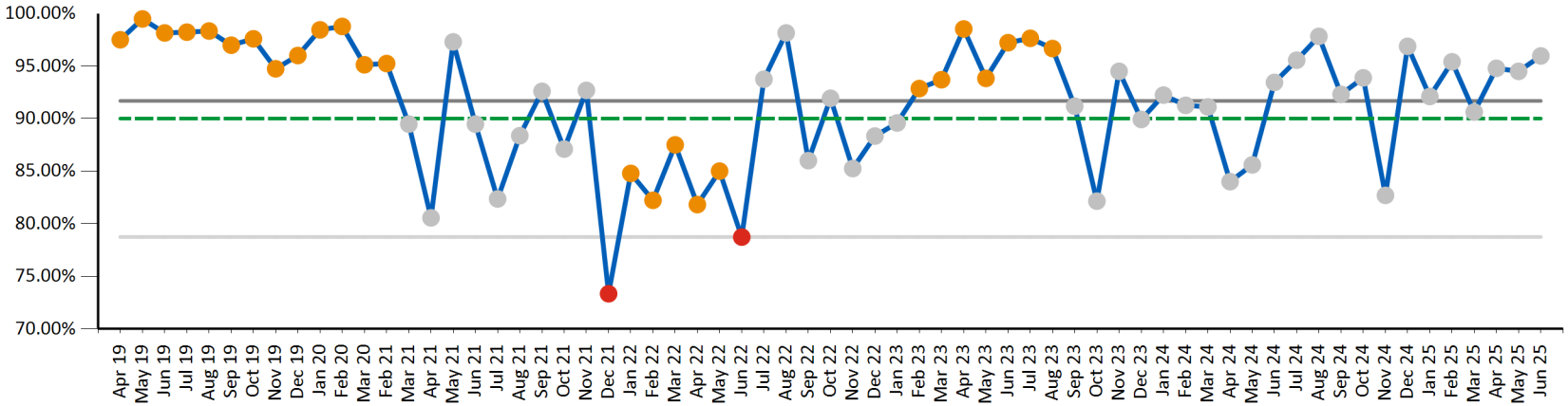
Plan	Actual
>= 15%	25.7%

245 - Community Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 90%	96.0%	Jun-25

Previous

Plan	Actual	Period
>= 90%	94.5%	May-25

Year to Date

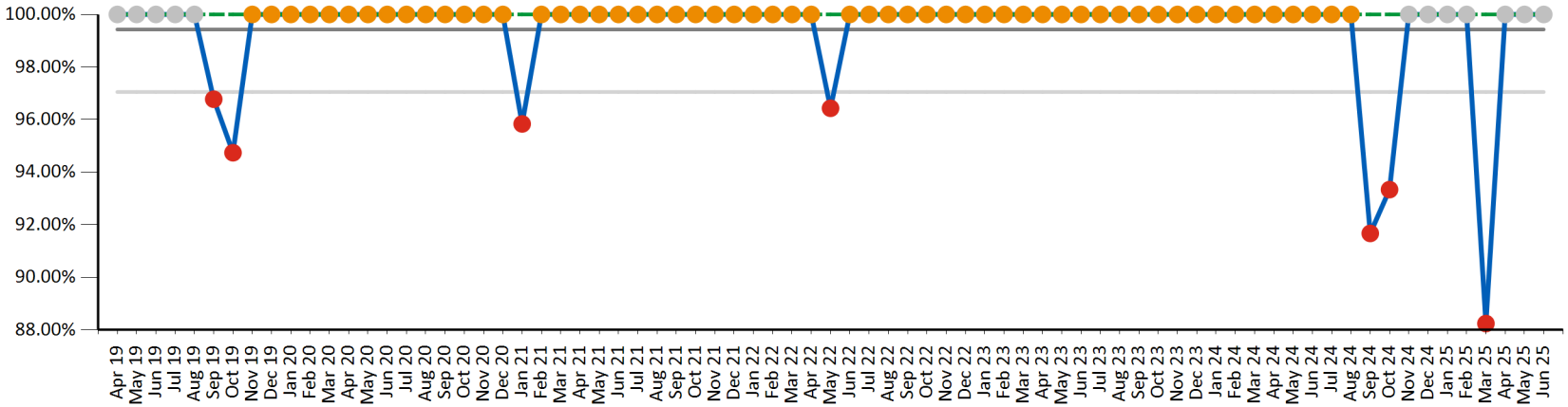
Plan	Actual
>= 90%	95.0%

89 - Formal complaints acknowledged within 3 working days

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
= 100%	100.0%	Jun-25

Previous

Plan	Actual	Period
= 100%	100.0%	May-25

Year to Date

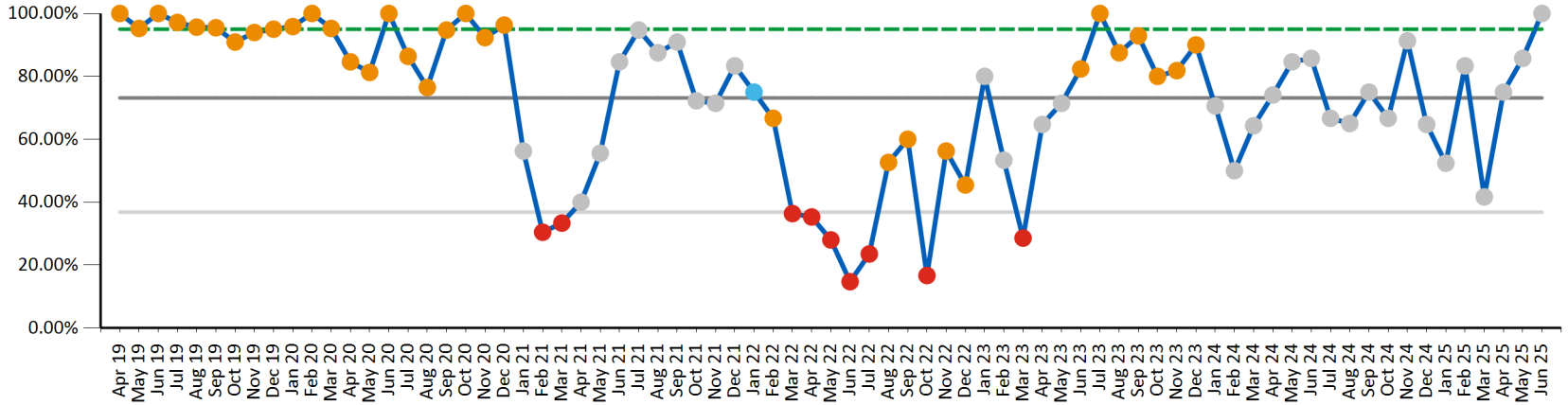
Plan	Actual
= 100%	100.0%

90 - Complaints responded to within the period

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
>= 95%	100.0%	Jun-25

Previous

Plan	Actual	Period
>= 95%	85.7%	May-25

Year to Date

Plan	Actual
>= 95%	89.7%

Quality and Safety - Maternity

Friends and Family Response Rate – Response rate had been slightly increased to 31.5% in month from 27.7% with common cause variation noted. Special cause improvement in overall maternity satisfaction rate in month to 96.4%.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – No cases reported in May or June 2025. The first REACH circle has been held in June 2025 (involves 8-10 pregnant women who live close together having their antenatal care and education in a community setting together) with a focus on the pregnant cohort between 24-27 weeks gestation. Further update will be presented to Quality Assurance Committee in September 2025.

¾ degree tears – There has been a sustained low rate of 2.1% in month. Recruitment to the perinatal pelvic health Midwifery post Band 7 0.6wte underway – all other posts within the team already in place.

1:1 care in labour – Compliance rate 99.1% in month. Action plan in place as per CNST requirements – staff recruitment positive – -9WTE Registered Midwife deficit anticipated by October 2025.

Booked by 12+6 is a clinical indicator relating to the timing of the initial antenatal booking visit that ensures women access care in a timely way and are still in a position to have a scan and antenatal screening blood tests taken. Sustained improvement in uptake again noted with 91% compliance reported in June 2025 and notable improvement from 84.3% reported in February 2025. This has improved following the introduction of an early bird antenatal session as a pilot at Ingleside.

Booked by 10 weeks (target reflects bookings by 10+0 gestation as per national standard which removes the impact of ultrasound booking scan date changes made and associated impact). Trust performance has been sustained at 68.1%. This has improved following the introduction of an early bird antenatal session as a pilot at Ingleside.

Inductions of labour delayed by >24 hours – 35.8% of induction of labour cases were delayed by 24 hours in June 2025 – this is noted to be a common cause variation in the statistical process chart evaluation. Work remains ongoing to scope additional bed capacity to relieve pressure in the service with a current focus on expansion of the maternity triage capacity.

Breastfeeding initiation – Slight increase in month to 67.97% - significant staffing changes to be noted within team. Baby Friendly stage 2 implementation delayed until spring 2026 in response.

Preterm birth (less than 37 weeks gestation) – Common cause variation in preterm incidence within reduction in month with 4.9% reported in June 2025. Review of preterm referral pathway being undertaken in response to recent incident.

The GMEC maternity analysis toolkit has highlighted the Trust has a higher rate of incidence for some metrics when compared to the GM average over the past twelve months. In response it has been flagged to GMEC LMNS that the performance of the tertiary level maternity service at Bolton needs to be compared with comparator tertiary peers to identify areas of outlier status and thus a revision is being made to the maternity analysis toolkit to address this concern. The service is currently compliant with all perinatal quality surveillance monitoring requirements, however is reviewing the process of the perinatal quality surveillance review within the service and liaising with other providers to ascertain best practice prior to enacting change to improve oversight and surveillance.

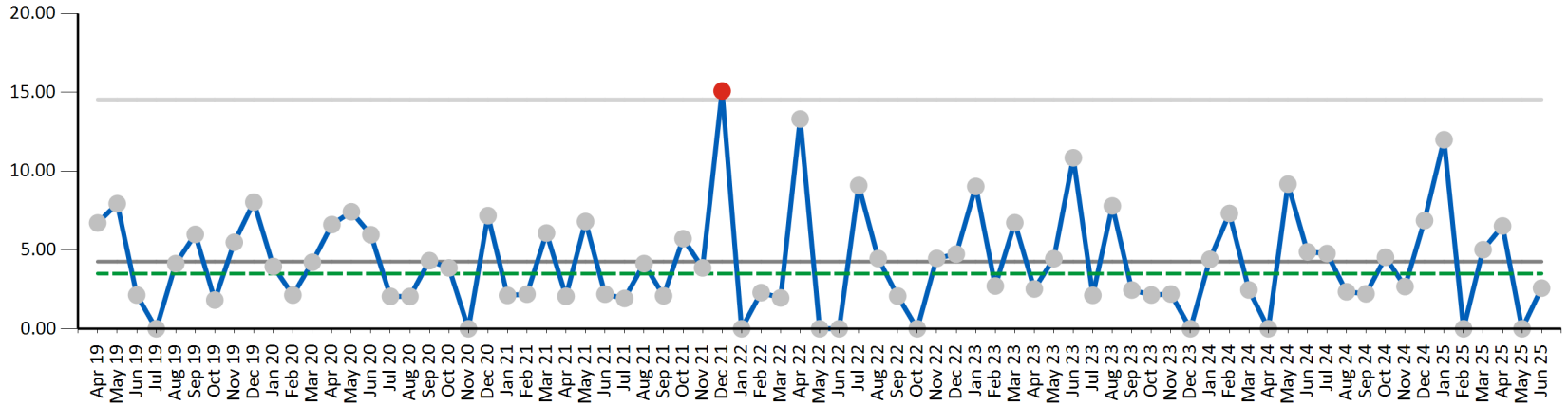
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	2.58	Jun-25		<= 3.50	0.00	May-25	<= 3.50	3.22	
23 - Maternity -3rd/4th degree tears	<= 3.5%	2.1%	Jun-25		<= 3.5%	3.3%	May-25	<= 3.5%	2.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	99.1%	Jun-25		>= 95.0%	99.4%	May-25	>= 95.0%	99.2%	
203 - Booked 12+6	>= 90.0%	91.0%	Jun-25		>= 90.0%	93.3%	May-25	>= 90.0%	91.5%	
586 - Booked 10+0		68.1%	Jun-25			69.3%	May-25		65.1%	
204 - Inductions of labour - delayed > 24 hours	<= 40%	35.8%	Jun-25		<= 40%	35.1%	May-25	<= 40%	34.9%	
210 - Initiation breast feeding	>= 65%	67.97%	Jun-25		>= 65%	70.39%	May-25	>= 65%	68.71%	
213 - Maternity complaints	<= 5	1	Jun-25		<= 5	0	May-25	<= 15	1	
319 - Maternal deaths (direct)	= 0	0	Jun-25		= 0	0	May-25	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	4.9%	Jun-25		<= 6%	9.3%	May-25	<= 6%	7.5%	

322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)

Common cause variation.

We will not regularly meet the target due to normal variation.

3/6



Latest

Plan	Actual	Period
<= 3.50	2.58	Jun-25

Previous

Plan	Actual	Period
<= 3.50	0.00	May-25

Year to Date

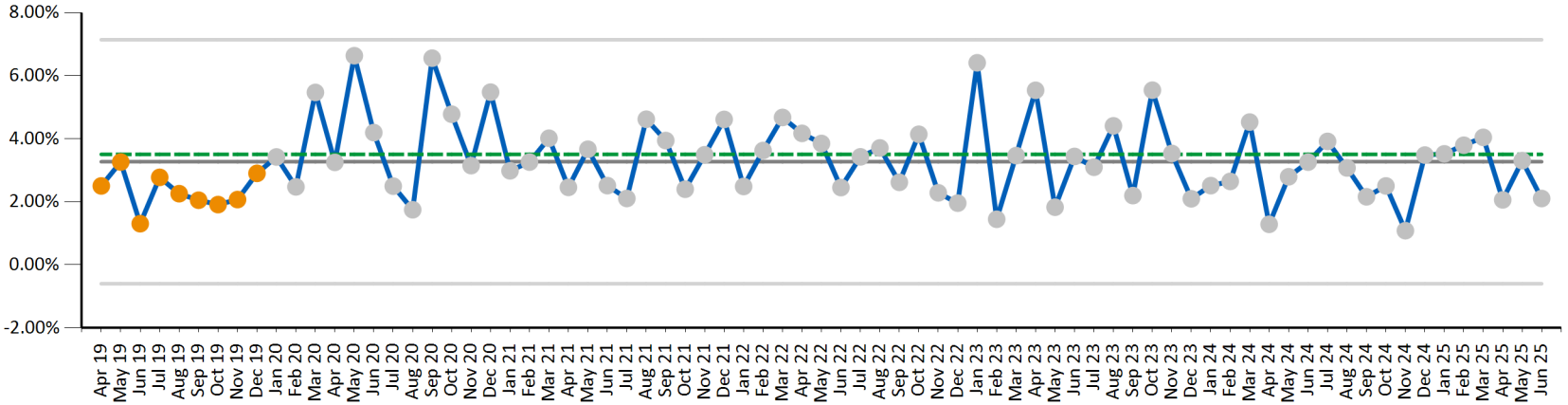
Plan	Actual
<= 3.50	3.22

23 - Maternity -3rd/4th degree tears

Common cause variation.

We will not regularly meet the target due to normal variation.

3/6



Latest

Plan	Actual	Period
<= 3.5%	2.1%	Jun-25

Previous

Plan	Actual	Period
<= 3.5%	3.3%	May-25

Year to Date

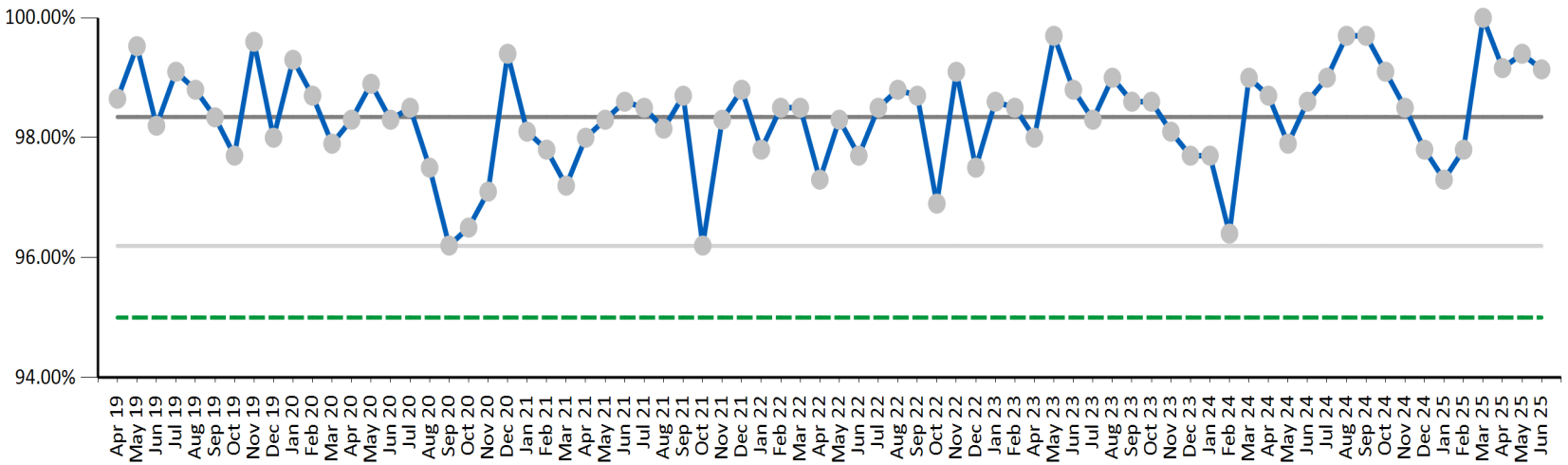
Plan	Actual
<= 3.5%	2.5%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 95.0%	99.1%	Jun-25

Previous

Plan	Actual	Period
>= 95.0%	99.4%	May-25

Year to Date

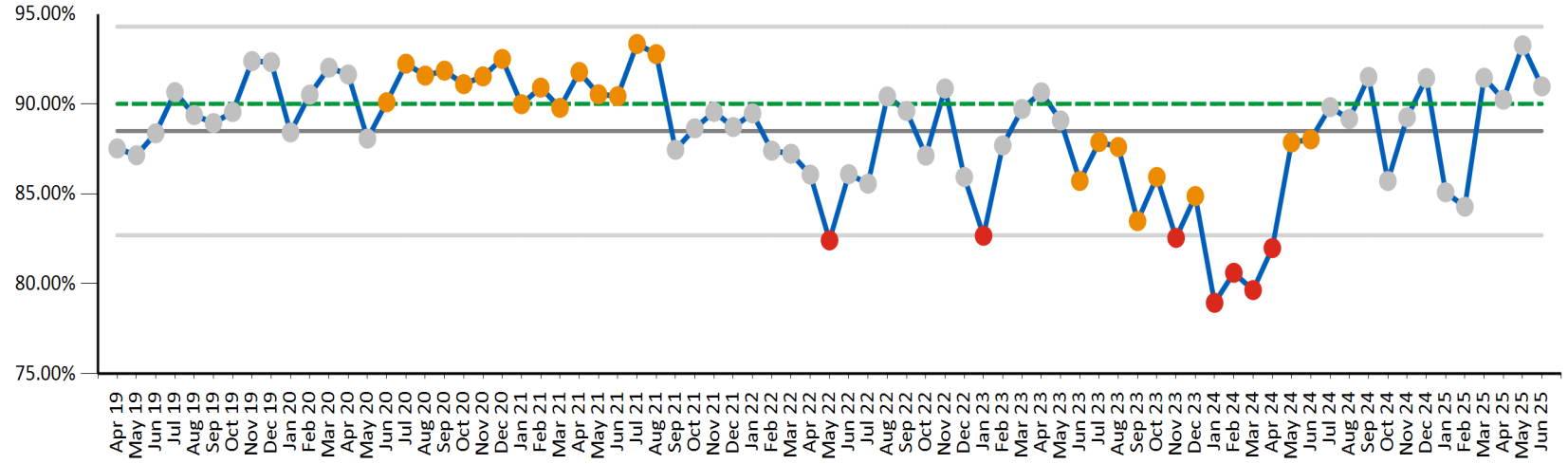
Plan	Actual
>= 95.0%	99.2%

203 - Booked 12+6

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 90.0%	91.0%	Jun-25

Previous

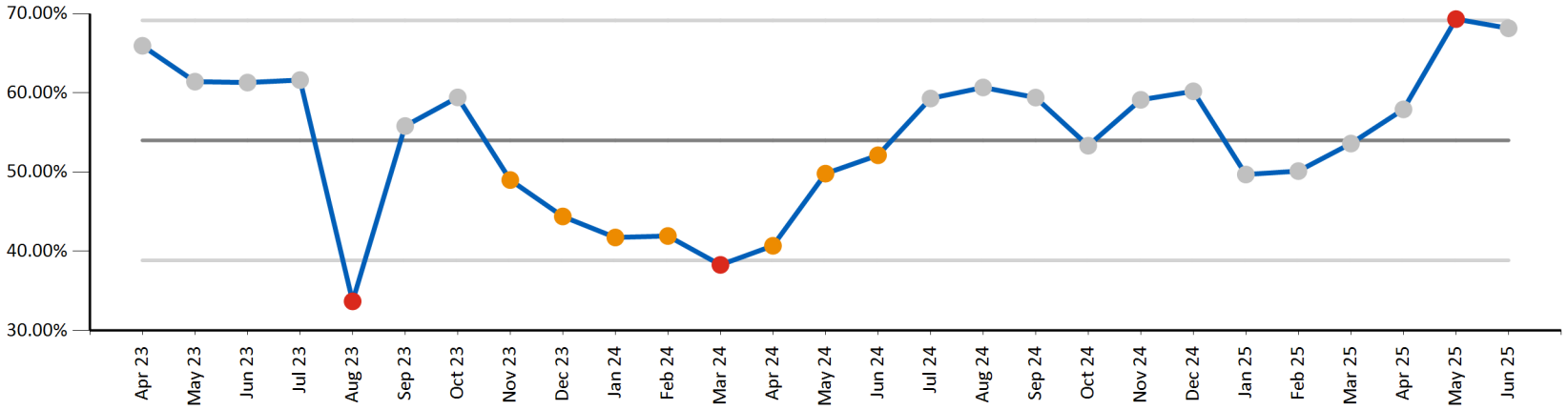
Plan	Actual	Period
>= 90.0%	93.3%	May-25

Year to Date

Plan	Actual
>= 90.0%	91.5%

586 - Booked 10+0

Common cause variation.



Latest

Plan	Actual	Period
	68.1%	Jun-25

Previous

Plan	Actual	Period
	69.3%	May-25

Year to Date

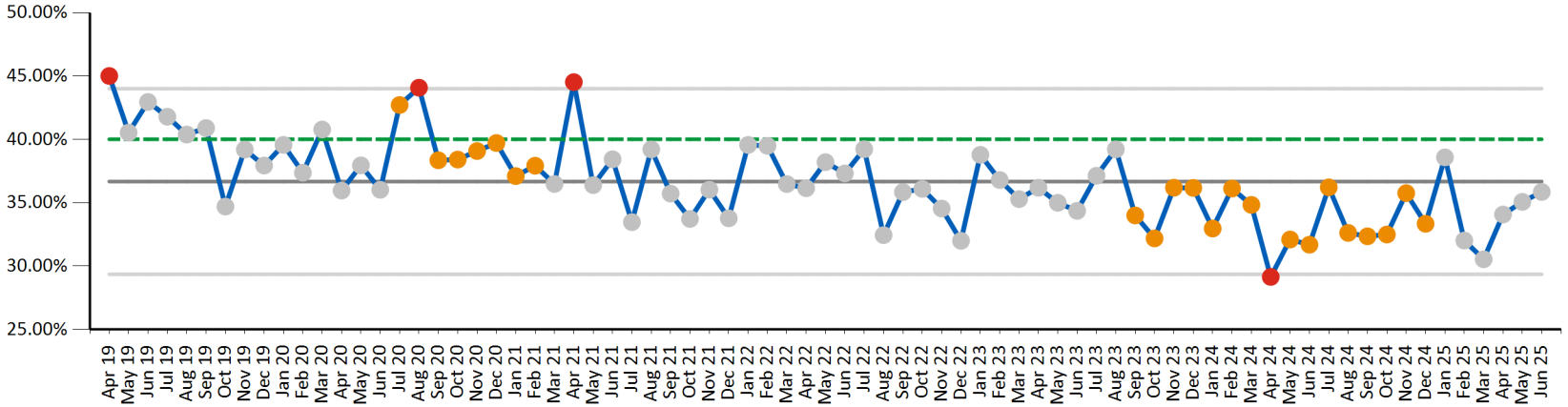
Plan	Actual
	65.1%

204 - Inductions of labour - delayed > 24 hours

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
<= 40%	35.8%	Jun-25

Previous

Plan	Actual	Period
<= 40%	35.1%	May-25

Year to Date

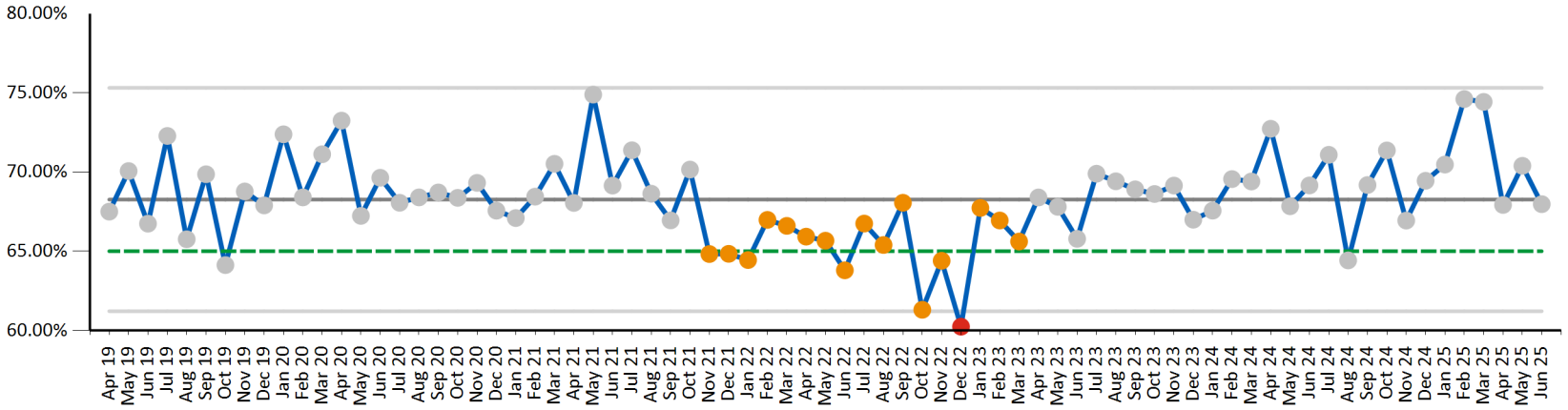
Plan	Actual
<= 40%	34.9%

210 - Initiation breast feeding

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 65%	67.97%	Jun-25

Previous

Plan	Actual	Period
>= 65%	70.39%	May-25

Year to Date

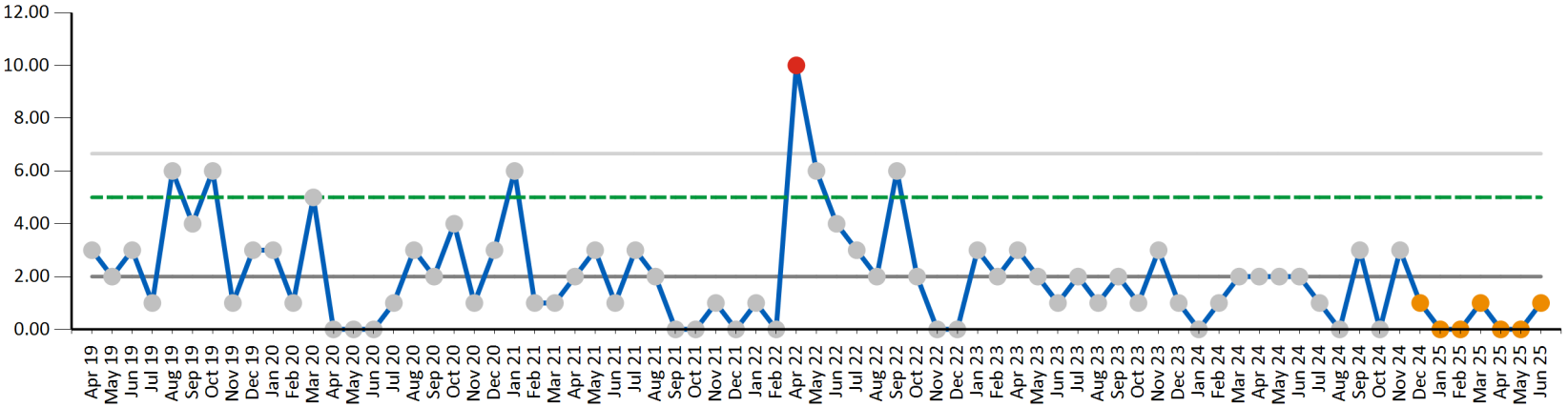
Plan	Actual
>= 65%	68.71%

213 - Maternity complaints

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
<= 5	1	Jun-25

Previous

Plan	Actual	Period
<= 5	0	May-25

Year to Date

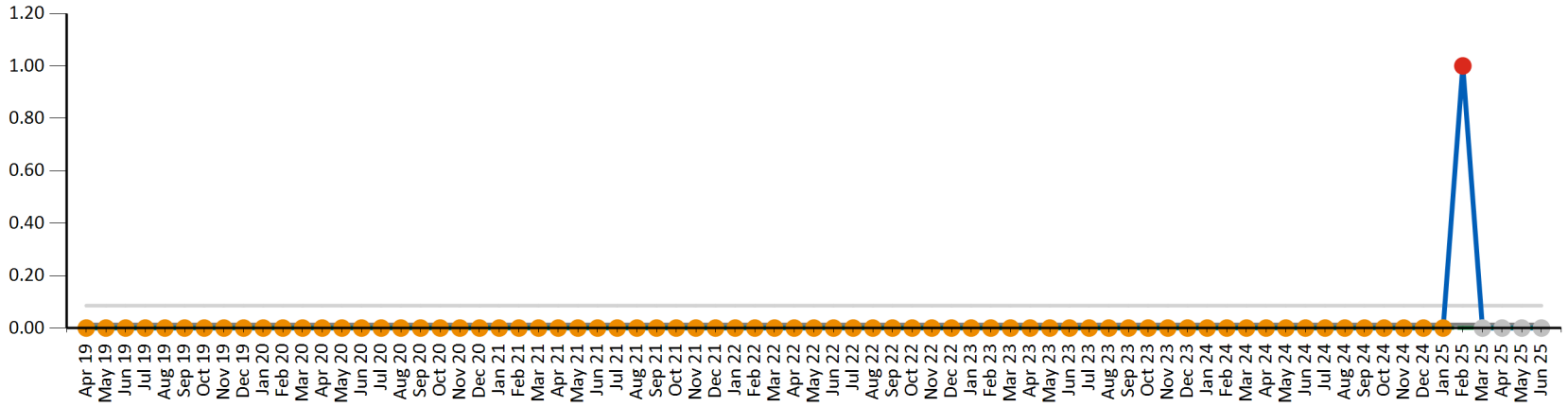
Plan	Actual
<= 15	1

319 - Maternal deaths (direct)

Common cause variation.

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
= 0	0	Jun-25

Previous

Plan	Actual	Period
= 0	0	May-25

Year to Date

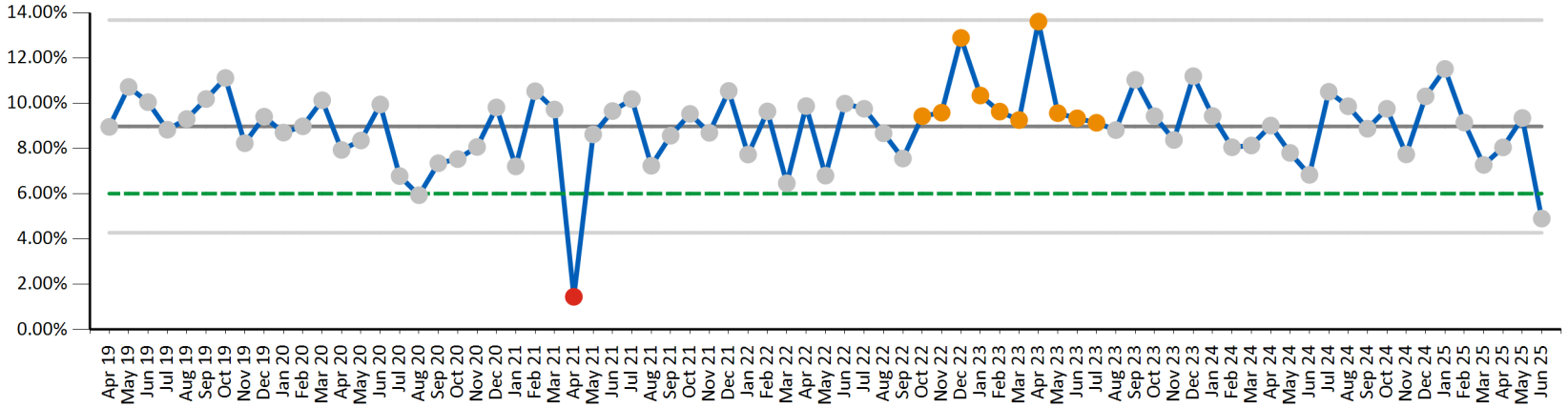
Plan	Actual
= 0	0

320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
<= 6%	4.9%	Jun-25

Previous

Plan	Actual	Period
<= 6%	9.3%	May-25

Year to Date

Plan	Actual
<= 6%	7.5%

Operational Performance - Urgent Care

Bolton NHS Foundation Trust

Urgent Care

In June 2025, performance against the all-types 4-hour standard was 64.9%, this is a decline of 5.4% from May 2025 (70.3%) and below the operational plan trajectory of 75%. Ambulance handover performance within 15 minutes declined to 58% in June 2025 from 63.5% in May 2025. This metric is demonstrating common cause variation however, performance has been above the mean for six consecutive months, and is one month from demonstrating special cause improvement. Ambulance handovers within 30 minutes declined to 88% in June 2025 from 91.6% in May 2025, and handovers within 60 minutes remained broadly static at 96.8% - both metrics are demonstrating common cause variation.

In June 2025 the total A&E 12-hour waits was 723 which is aa increase from 506 patients in May 2025. Performance in June represents the third lowest monthly ED 12-hour waits since April 2022, with March 25 and May 25 accounting for the first and second lowest months for ED 12-hour waits since April 2022; this evidences an improving trajectory.

In June 2025, non-elective length of stay improved by 0.31 days month-on-month and is now at 4.71 days, this represents the lowest non-elective length of stay since February 2021 with performance demonstrating special cause improvement. Stranded patients with a LoS over 21 days in June 2025 fell to 73 patients. This is the lowest volume since October 2021. G&A bed occupancy fell from 86.8% in May 2025 to 85.5% in June 2025; this is subsequent to the phased closure of A4 ward through June 25 following the closure of B4 ward in May 25.

In June 2025, re-admissions within 30-days of discharge has remained static month on month at 11.1%, this metric remains in common cause variation and is performing better than the plan of 13.5%

NOF

Our fractured neck of femur performance remained at an improved position following the implementation of additional theatre capacity.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 75%	64.9%	Jun-25		>= 72%	70.3%	May-25	>= 75%	67.2%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	58.0%	Jun-25		>= 65.0%	63.5%	May-25	>= 65.0%	57.0%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	88.0%	Jun-25		>= 95.0%	91.6%	May-25	>= 95.0%	86.0%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	96.80%	Jun-25		= 100%	97.21%	May-25	= 100%	95.10%	?
539 - A&E 12 hour waits	= 0	723	Jun-25		= 0	506	May-25	= 0	2,198	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	51.5%	Jun-25	L	>= 75%	54.1%	May-25	>= 75%	40.4%	?

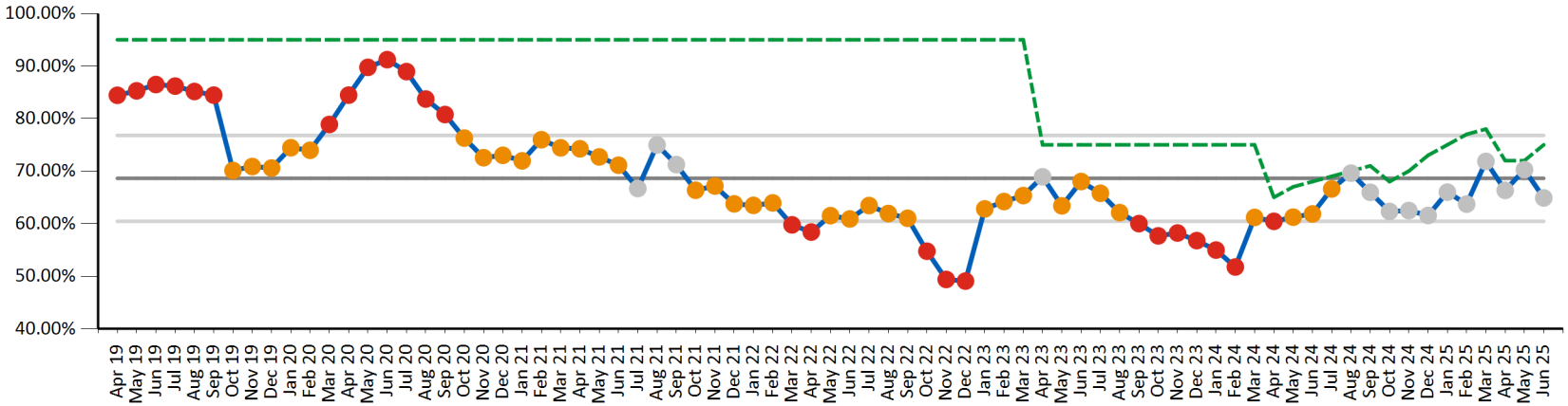
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
56 - Stranded patients - over 7 days	<= 200	236	Jun-25		<= 200	234	May-25	<= 200	236	F
307 - Stranded Patients - LOS 21 days and over	<= 69	73	Jun-25		<= 69	87	May-25	<= 69	73	?
541 - Adult G&A bed occupancy	<= 92.0%	85.5%	Jun-25		<= 92.0%	86.8%	May-25	<= 92.0%	87.0%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.71	Jun-25	L	<= 3.70	5.02	May-25	<= 3.70	5.01	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	11.1%	May-25		<= 13.5%	11.0%	Apr-25	<= 13.5%	11.1%	P

53 - A&E 4 hour target

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 75%	64.9%	Jun-25

Previous

Plan	Actual	Period
>= 72%	70.3%	May-25

Year to Date

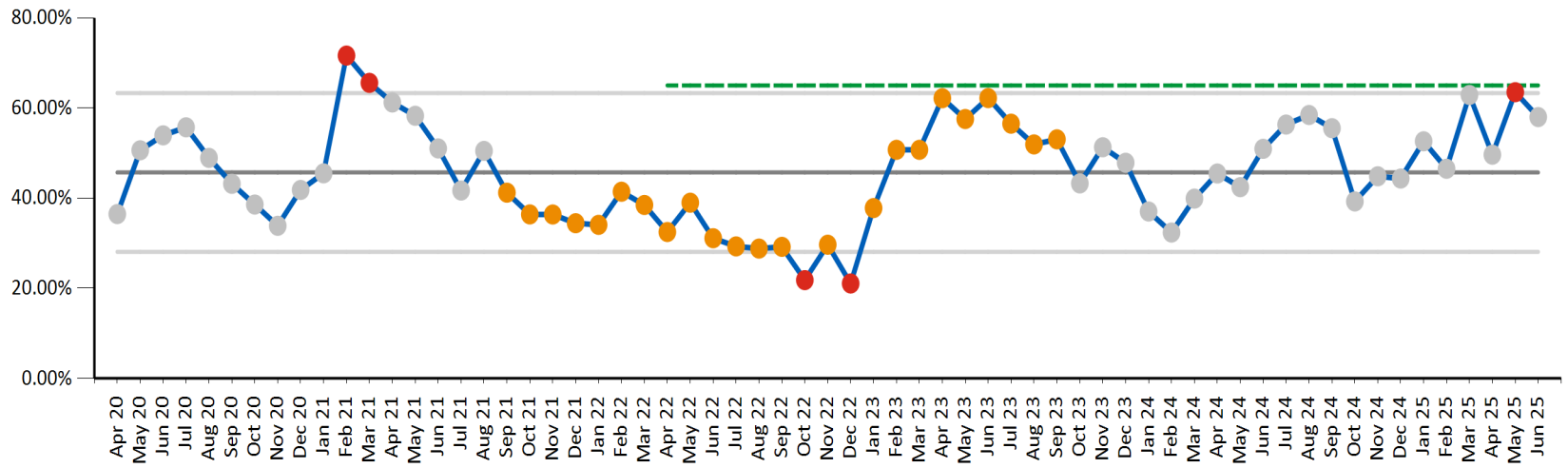
Plan	Actual
>= 75%	67.2%

538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 65.0%	58.0%	Jun-25

Previous

Plan	Actual	Period
>= 65.0%	63.5%	May-25

Year to Date

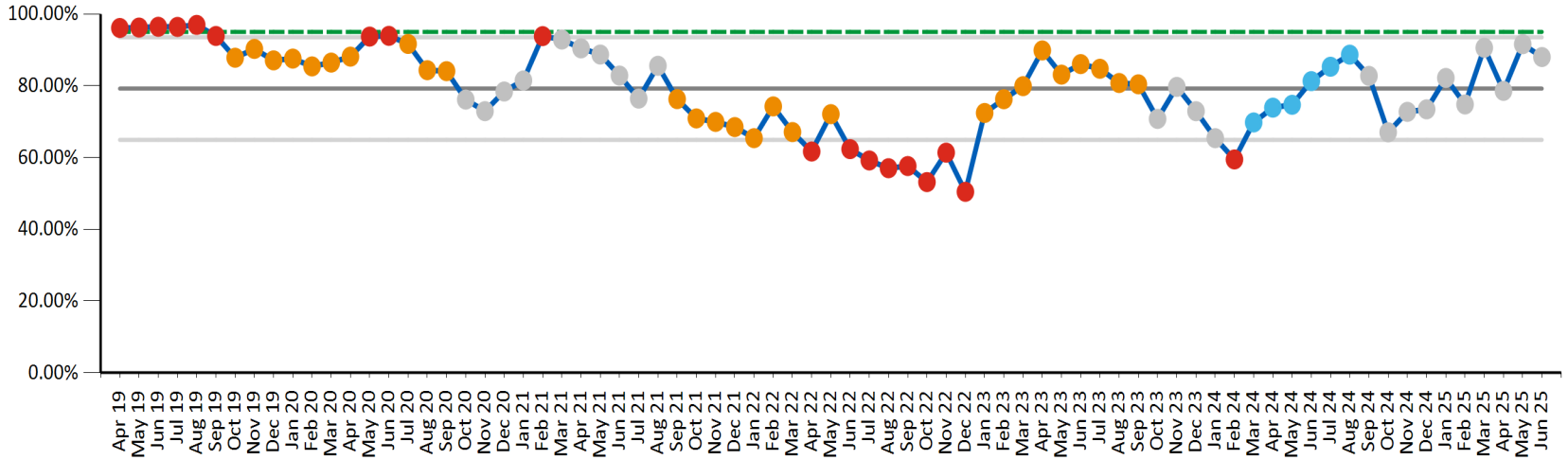
Plan	Actual
>= 65.0%	57.0%

70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95.0%	88.0%	Jun-25

Previous

Plan	Actual	Period
>= 95.0%	91.6%	May-25

Year to Date

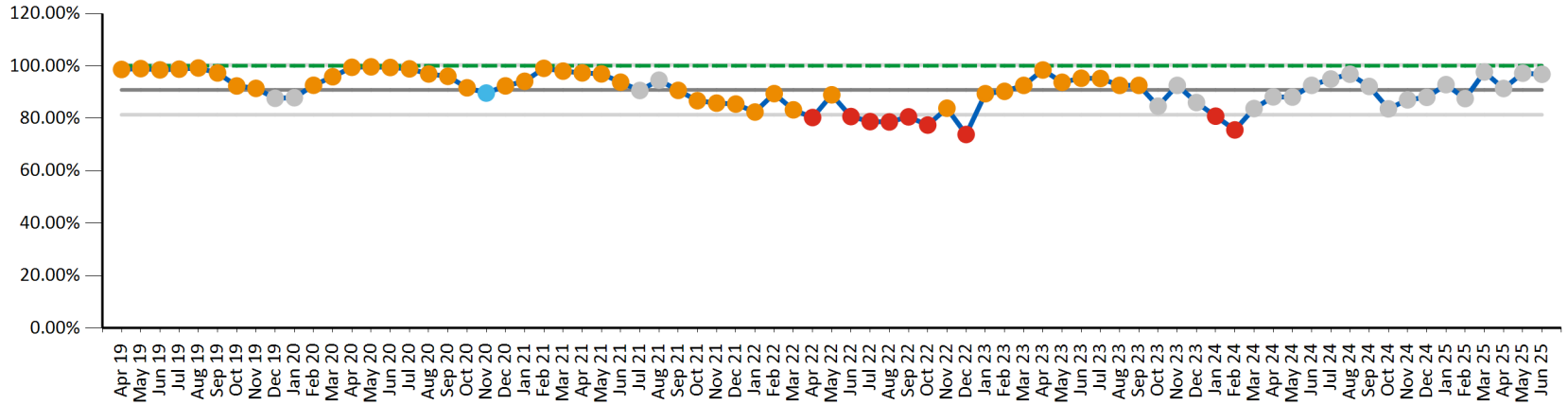
Plan	Actual
>= 95.0%	86.0%

71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
= 100%	96.80%	Jun-25

Previous

Plan	Actual	Period
= 100%	97.21%	May-25

Year to Date

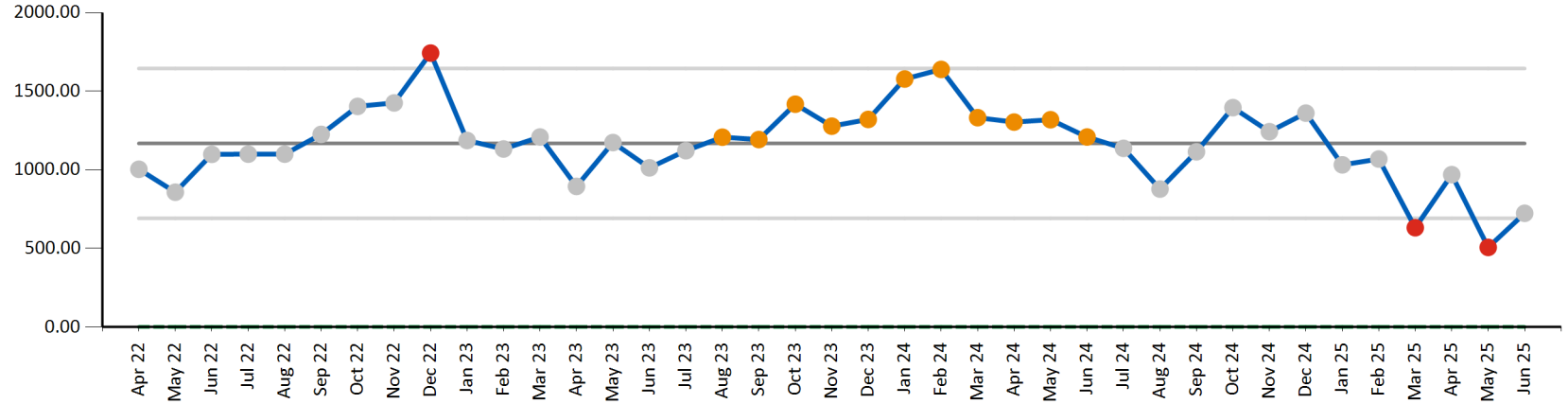
Plan	Actual
= 100%	95.10%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	723	Jun-25

Previous

Plan	Actual	Period
= 0	506	May-25

Year to Date

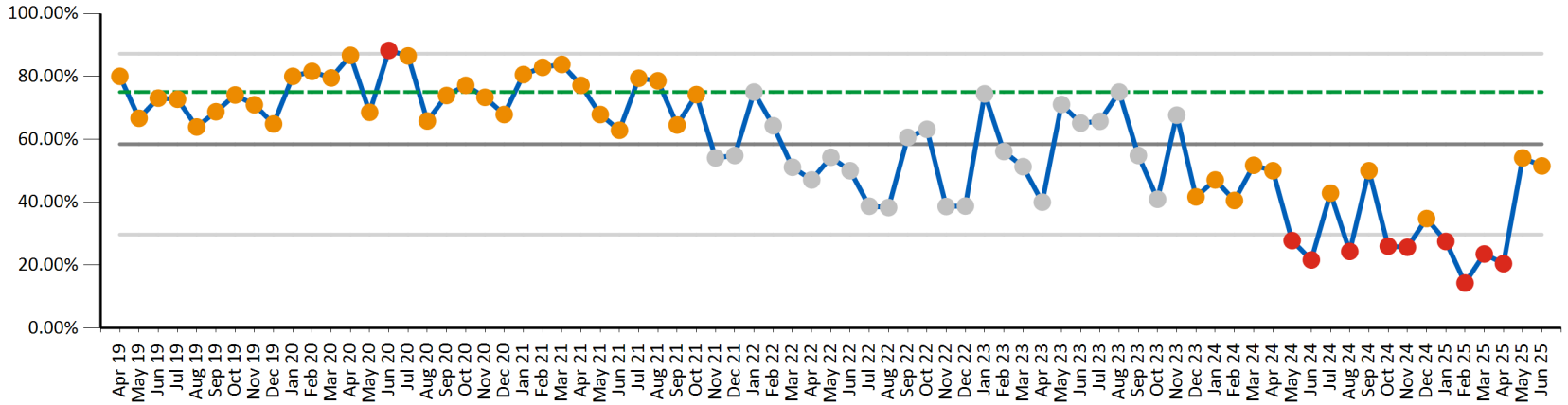
Plan	Actual
= 0	2,198

26 - Patients going to theatre within 36 hours of a fractured Neck of Femur

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 75%	51.5%	Jun-25

Previous

Plan	Actual	Period
>= 75%	54.1%	May-25

Year to Date

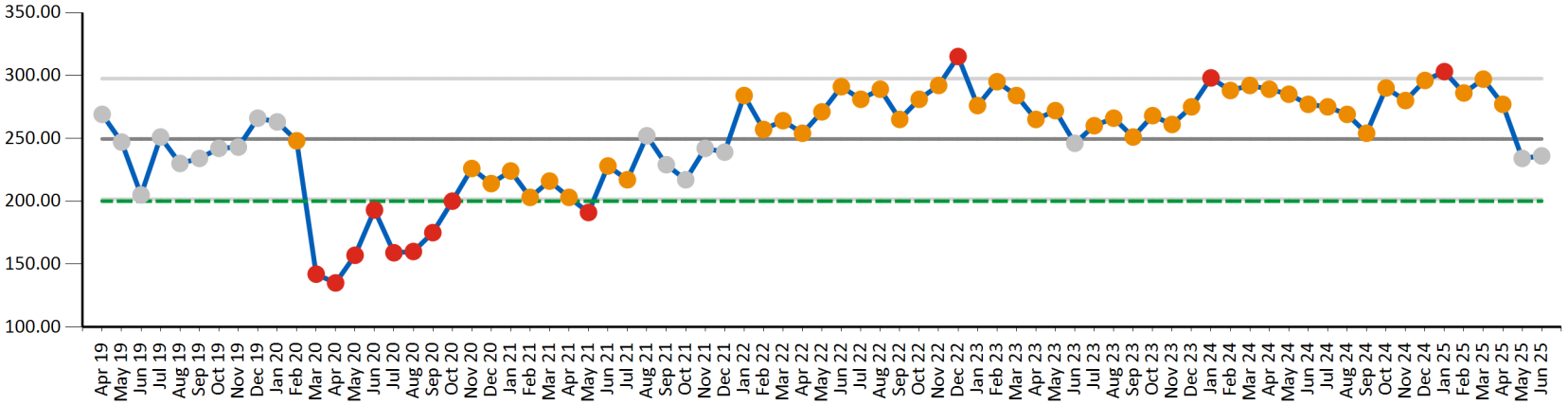
Plan	Actual
>= 75%	40.4%

56 - Stranded patients - over 7 days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	236	Jun-25

Previous

Plan	Actual	Period
<= 200	234	May-25

Year to Date

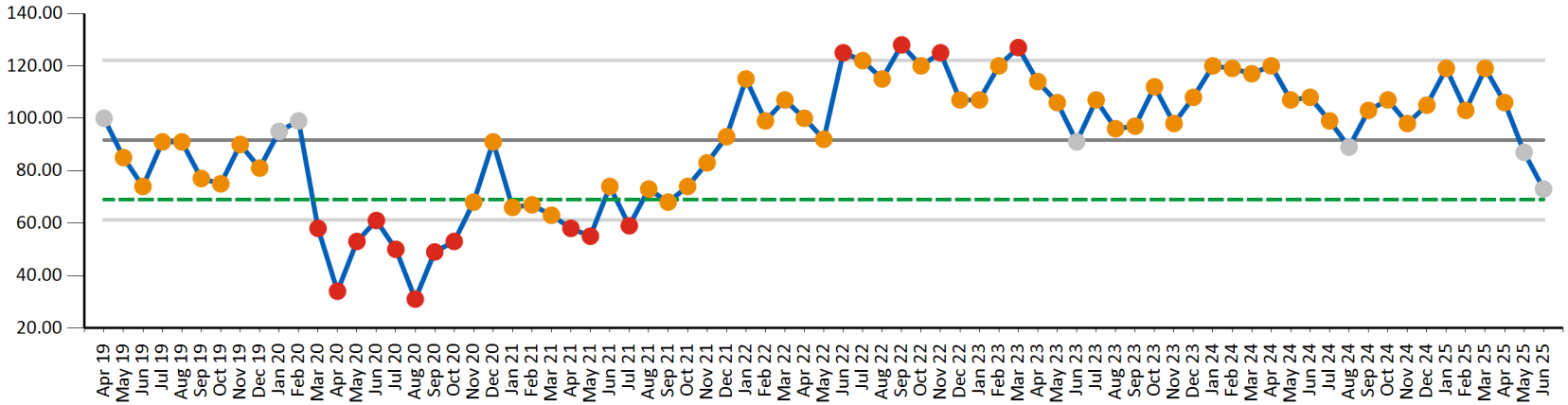
Plan	Actual
<= 200	236

307 - Stranded Patients - LOS 21 days and over

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
<= 69	73	Jun-25

Previous

Plan	Actual	Period
<= 69	87	May-25

Year to Date

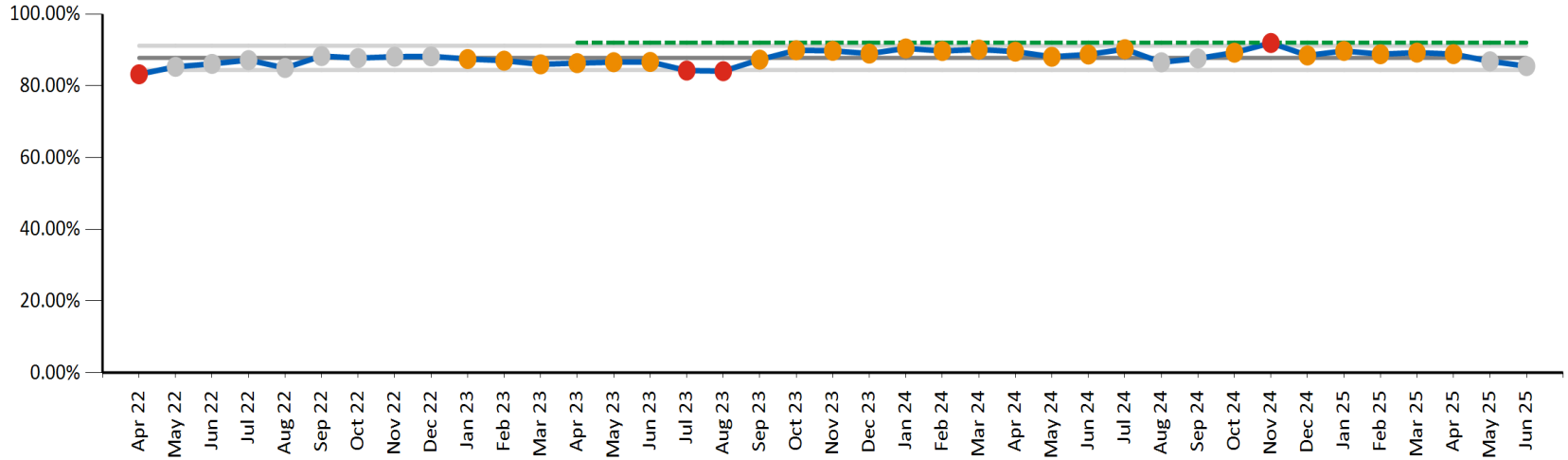
Plan	Actual
<= 69	73

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	85.5%	Jun-25

Previous

Plan	Actual	Period
<= 92.0%	86.8%	May-25

Year to Date

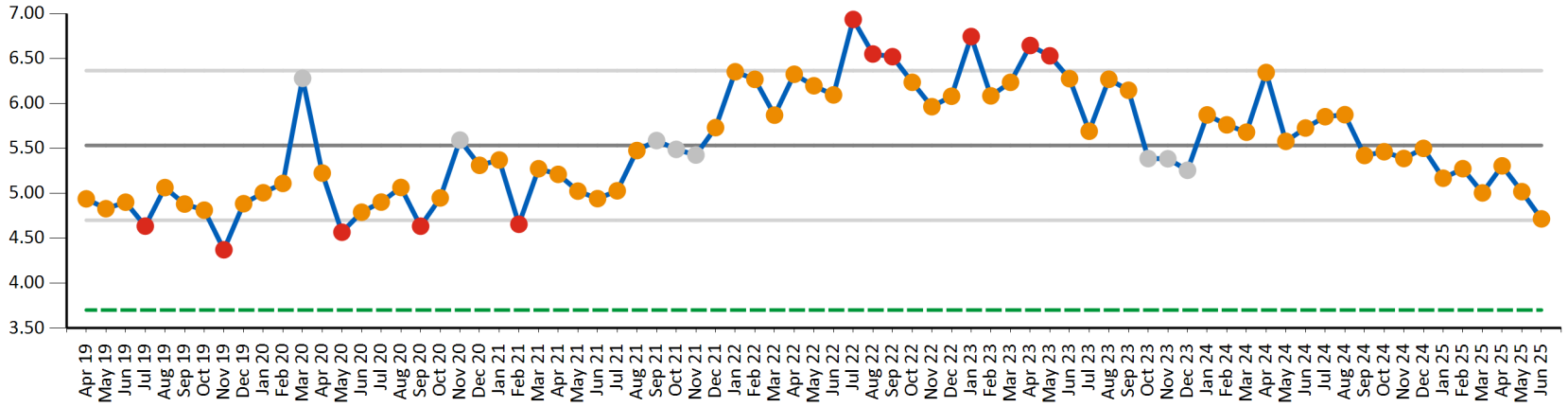
Plan	Actual
<= 92.0%	87.0%

66 - Non Elective Length of Stay (Discharges in month)

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 3.70	4.71	Jun-25

Previous

Plan	Actual	Period
<= 3.70	5.02	May-25

Year to Date

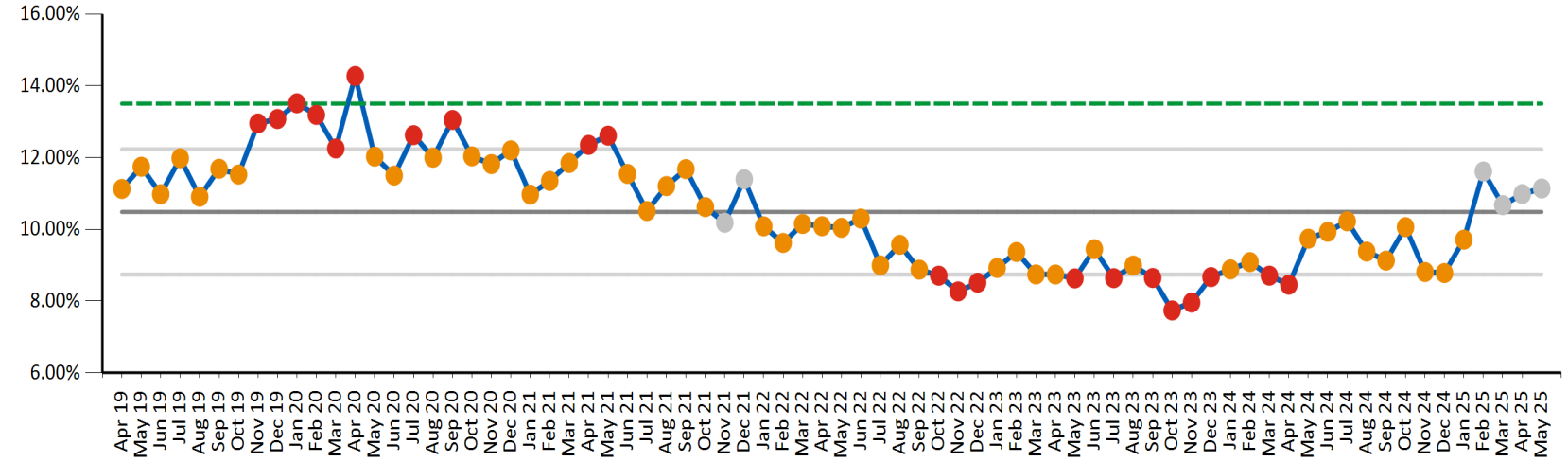
Plan	Actual
<= 3.70	5.01

59 - Re-admission within 30 days of discharge (1 mth in arrears)

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 13.5%	11.1%	May-25

Previous

Plan	Actual	Period
<= 13.5%	11.0%	Apr-25

Year to Date

Plan	Actual
<= 13.5%	11.1%

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

Our 18 week RTT performance continues to improve and our waiting list size is continuing to reduce.

We had one 78-week waiting patient in June which was a patient awaiting corneal graft material.

Our 65-week waiting position remains static, this is due to patients 9 were awaiting corneal graft material and 14 chose to delay their treatment or were not clinically suitable for treatment.

DM01

M03 position is validate at 14.8%. This is a 1.0% increase in month and is 9.8% above the national target.

Audiology continues to demonstrate a decline in performance (2.3% in month), this is due to pressure within the paediatric audiology services due to capacity issues (resource and room utilisation due to increase ABR referrals including sedated cases). A capital case will provide addition soundproof booths to deliver 4 sessions per week. The service has also been affected by sickness, but LLP activity is being undertaken to support adult services. A best case recovery trajectory forecasts that the service will be compliant by September 2025, with a significant increase in performance throughout August.

Cystoscopy demonstrated a 3.5% deterioration in month, with the current overall position recorded at 12.3%. Increase in cancer referrals has impacted on capacity to deliver activity for patients on a DM01 waiting list. Urodynamic has experienced a significant performance downturn in month of 17.2%, taking the in-month validated position to 32.4%. Complexity of procedures listed for day case and waiting list validation, to remove non-DM01 procedures are in progress. The service maintains a recovery date of September 2025.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	56.9%	Jun-25	L	>= 92%	55.8%	May-25	>= 92%	55.9%	F
314 - RTT 18 week waiting list	<= 38,813	37,252	Jun-25	H	<= 39,126	37,308	May-25	<= 38,813	37,252	P
42 - RTT 52 week waits (incomplete pathways)		1,154	Jun-25	L		1,294	May-25		3,702	
540 - RTT 65 week waits (incomplete pathways)	<= 922	23	Jun-25	L	<= 936	19	May-25	<= 2,807	56	P
526 - RTT 78 week waits (incomplete pathways)	= 0	1	Jun-25	L	= 0	1	May-25	= 0	4	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Jun-25	L	= 0	0	May-25	= 0	0	F
72 - Diagnostic Waits >6 weeks %	<= 5%	14.8%	Jun-25	L	<= 5%	13.6%	May-25	<= 5%	13.2%	F

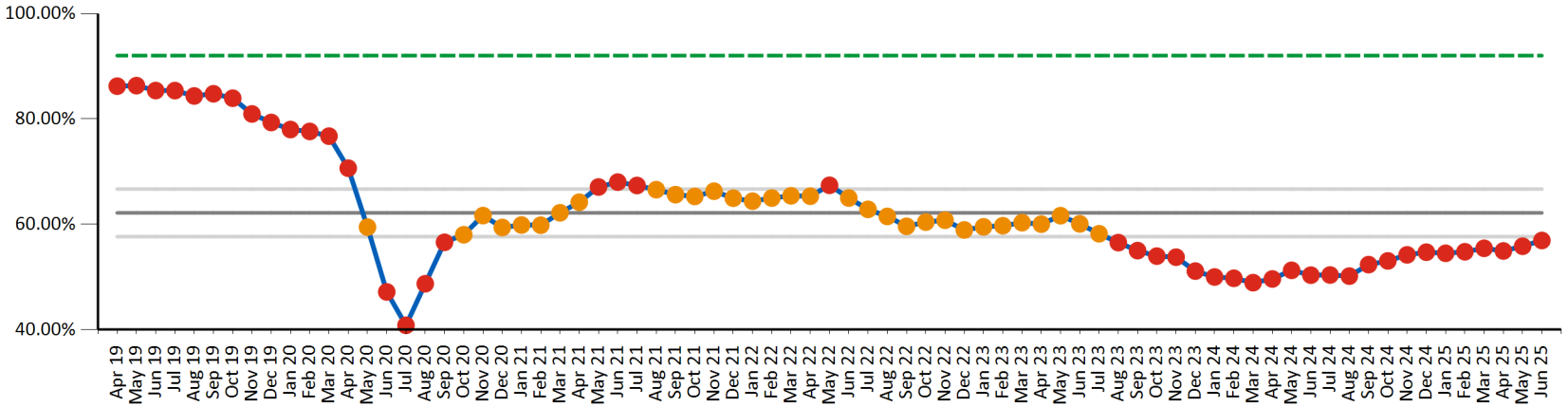
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
489 - Daycase Rates	>= 85%	80.4%	Jun-25	L	>= 85%	79.2%	May-25	>= 85%	80.1%	?
582 - Theatre Utilisation - Capped		76.7%	Jun-25			77.2%	May-25		76.1%	
583 - Theatre Utilisation - Uncapped		80.2%	Jun-25	L		80.3%	May-25		79.9%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.5%	Jun-25		<= 1%	2.4%	May-25	<= 1%	1.9%	?
62 - Cancelled operations re-booked within 28 days	= 100%	72.1%	May-25		= 100%	68.1%	Apr-25	= 100%	29.6%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.92	Jun-25		<= 2.00	3.19	May-25	<= 2.00	3.31	?
309 - DNA Rate - New	<= 6.3%	9.7%	Jun-25		<= 6.3%	9.3%	May-25	<= 6.3%	9.5%	F
310 - DNA Rate - Follow up	<= 5.0%	9.4%	Jun-25		<= 5.0%	9.1%	May-25	<= 5.0%	9.1%	F

41 - RTT Incomplete pathways within 18 weeks %

L Special cause variation with deteriorating performance

F We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	56.9%	Jun-25

Previous

Plan	Actual	Period
>= 92%	55.8%	May-25

Year to Date

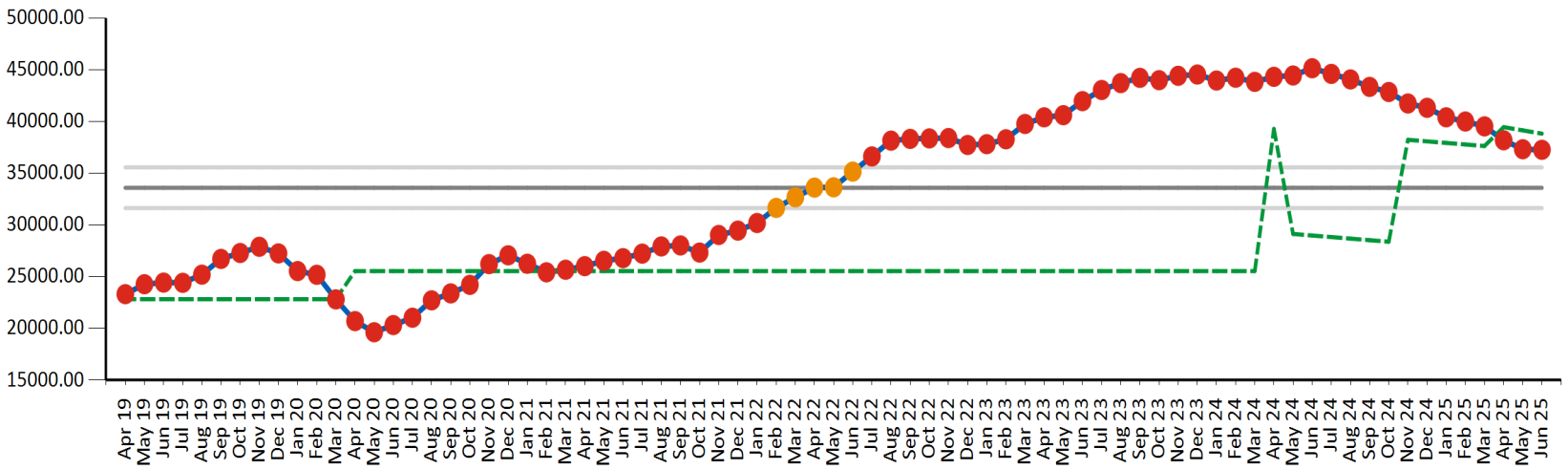
Plan	Actual
>= 92%	55.9%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

3/6



Latest

Plan	Actual	Period
<= 38,813	37,252	Jun-25

Previous

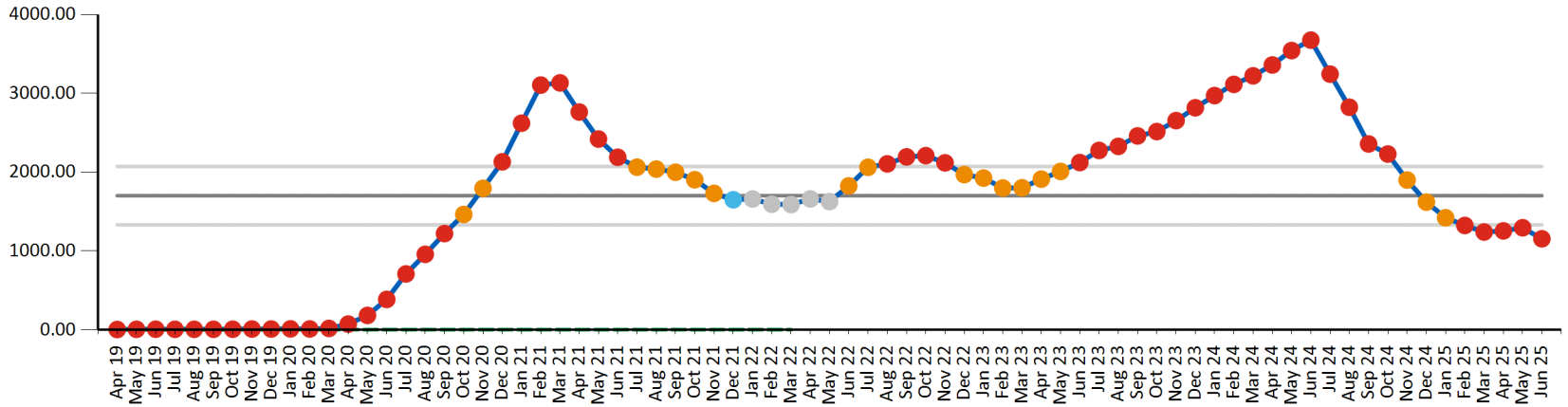
Plan	Actual	Period
<= 39,126	37,308	May-25

Year to Date

Plan	Actual
<= 38,813	37,252

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	1,154	Jun-25

Previous

Plan	Actual	Period
	1,294	May-25

Year to Date

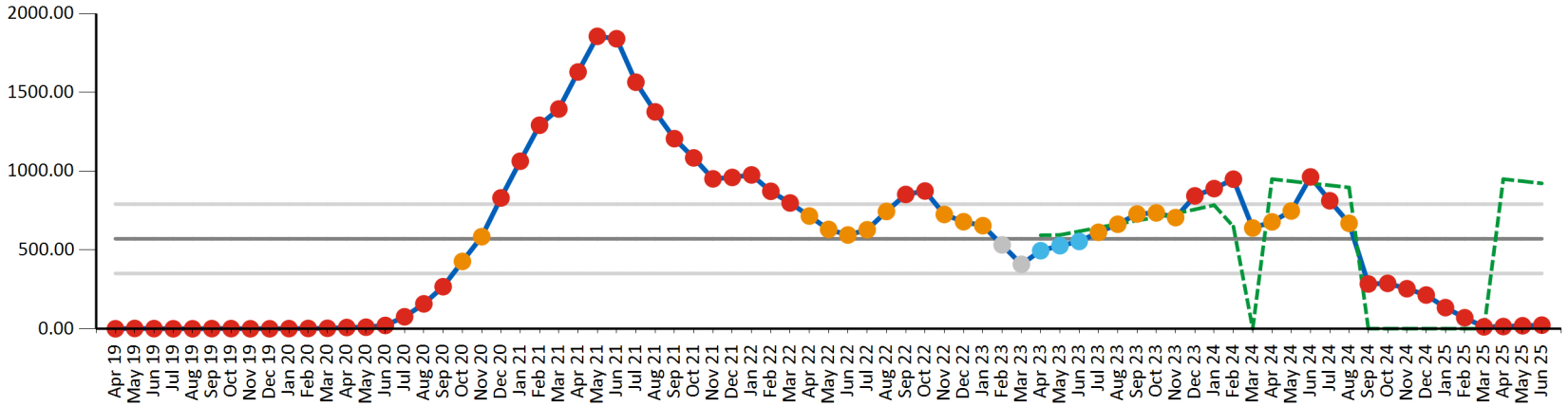
Plan	Actual
	3,702

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

Target will be regularly met.

3/6



Latest

Plan	Actual	Period
<= 922	23	Jun-25

Previous

Plan	Actual	Period
<= 936	19	May-25

Year to Date

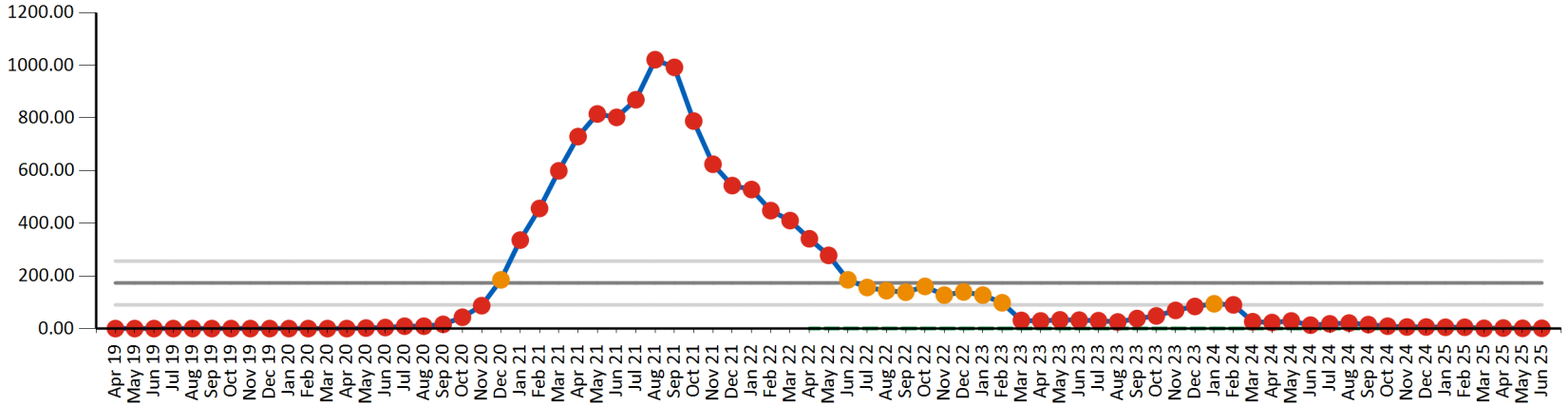
Plan	Actual
<= 2,807	56

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1	Jun-25

Previous

Plan	Actual	Period
= 0	1	May-25

Year to Date

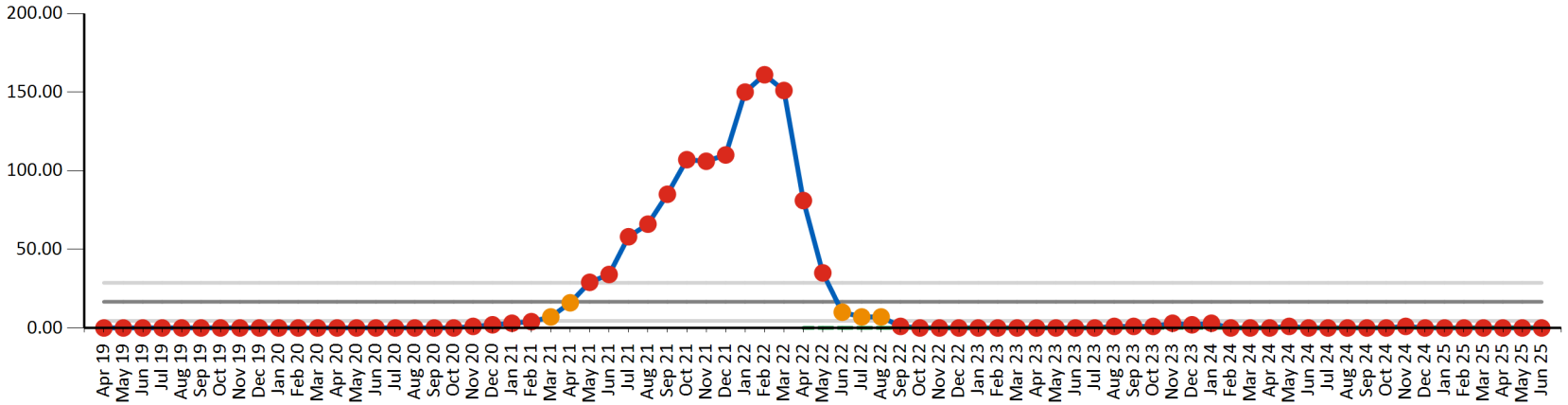
Plan	Actual
= 0	4

527 - RTT 104 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0	0	Jun-25

Previous

Plan	Actual	Period
= 0	0	May-25

Year to Date

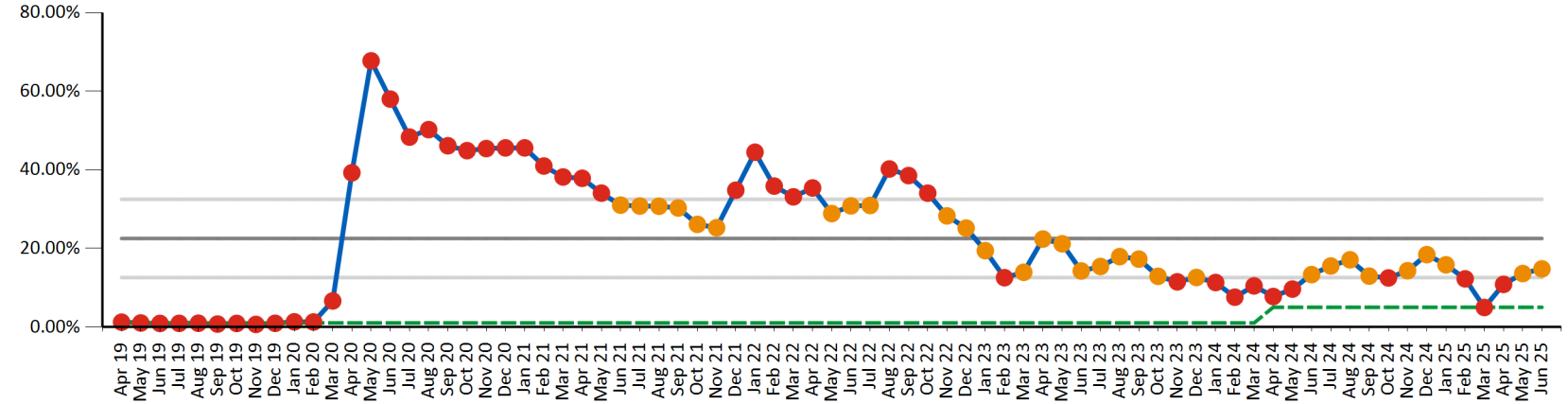
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
<= 5%	14.8%	Jun-25

Previous

Plan	Actual	Period
<= 5%	13.6%	May-25

Year to Date

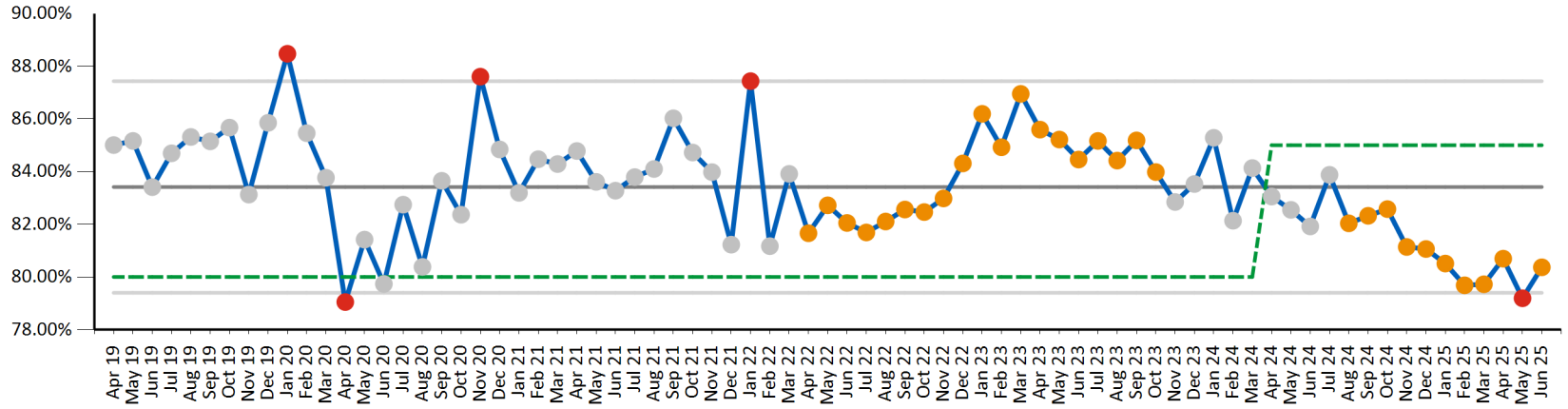
Plan	Actual
<= 5%	13.2%

489 - Daycase Rates

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 85%	80.4%	Jun-25

Previous

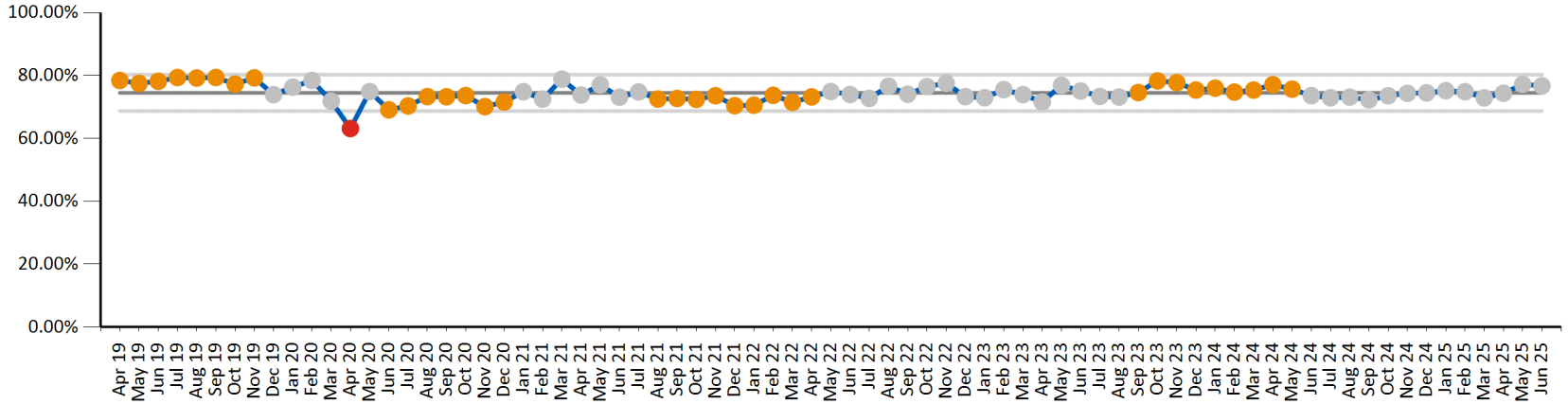
Plan	Actual	Period
>= 85%	79.2%	May-25

Year to Date

Plan	Actual
>= 85%	80.1%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	76.7%	Jun-25

Previous

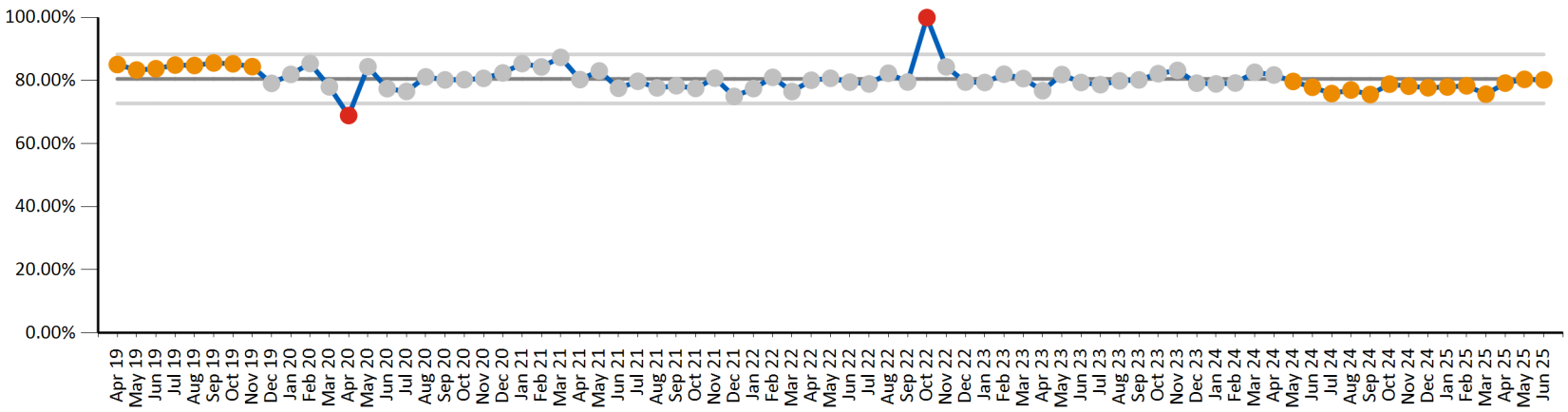
Plan	Actual	Period
	77.2%	May-25

Year to Date

Plan	Actual
	76.1%

583 - Theatre Utilisation - Uncapped

Special cause variation with deteriorating performance



Latest

Plan	Actual	Period
	80.2%	Jun-25

Previous

Plan	Actual	Period
	80.3%	May-25

Year to Date

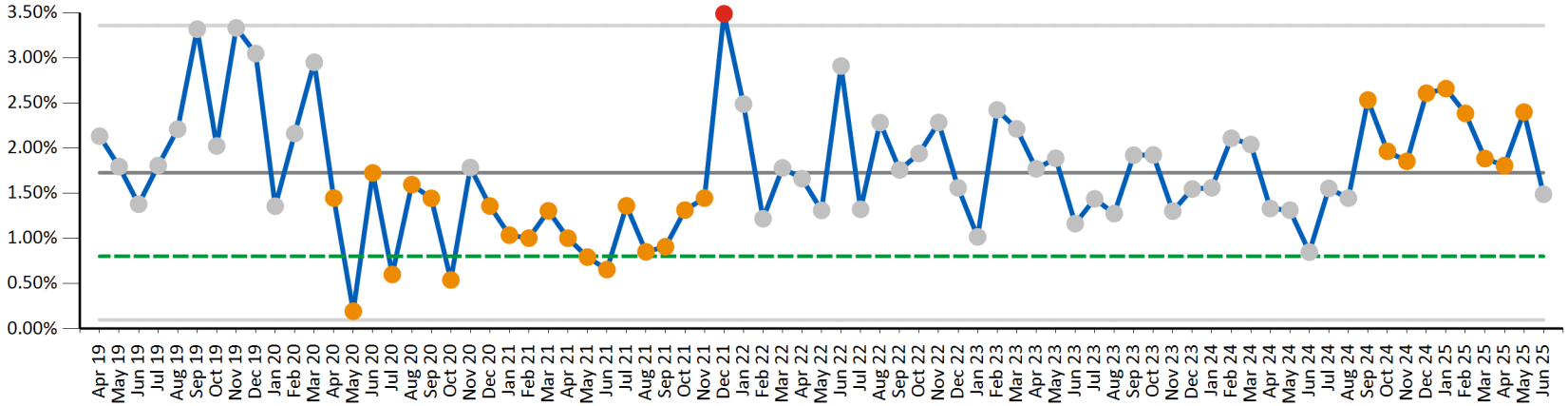
Plan	Actual
	79.9%

61 - Operations cancelled on the day for non-clinical reasons

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
<= 1%	1.5%	Jun-25

Previous

Plan	Actual	Period
<= 1%	2.4%	May-25

Year to Date

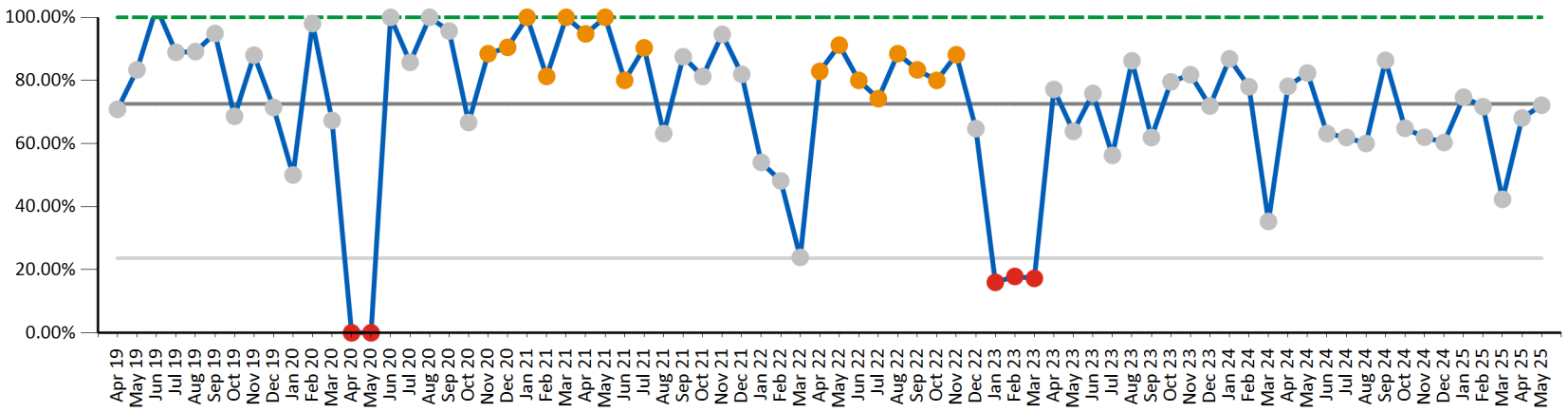
Plan	Actual
<= 1%	1.9%

62 - Cancelled operations re-booked within 28 days

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
= 100%	72.1%	May-25

Previous

Plan	Actual	Period
= 100%	68.1%	Apr-25

Year to Date

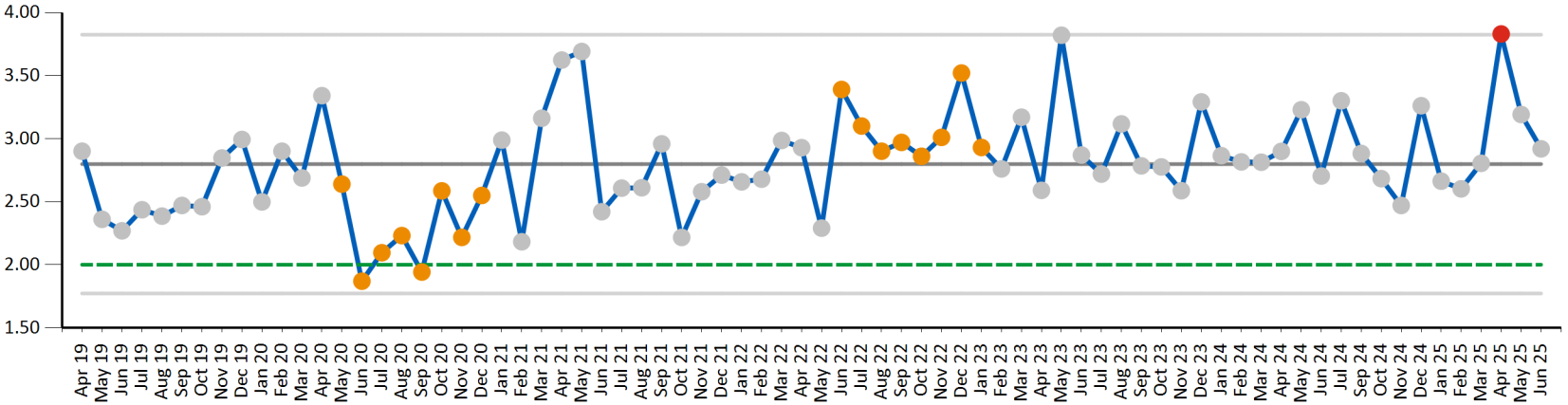
Plan	Actual
= 100%	29.6%

65 - Elective Length of Stay (Discharges in month)

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
<= 2.00	2.92	Jun-25

Previous

Plan	Actual	Period
<= 2.00	3.19	May-25

Year to Date

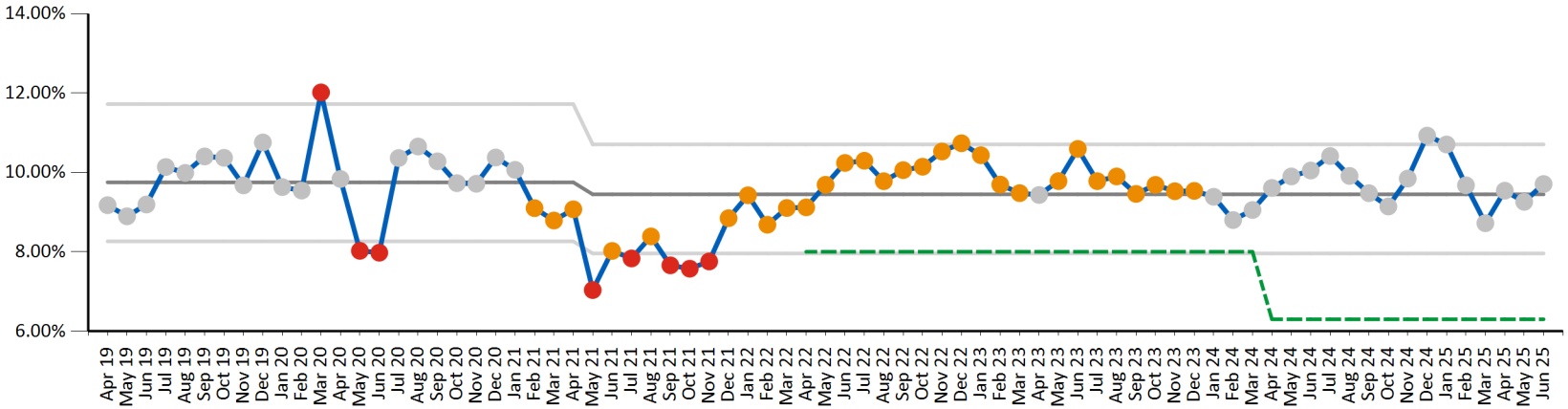
Plan	Actual
<= 2.00	3.31

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.7%	Jun-25

Previous

Plan	Actual	Period
<= 6.3%	9.3%	May-25

Year to Date

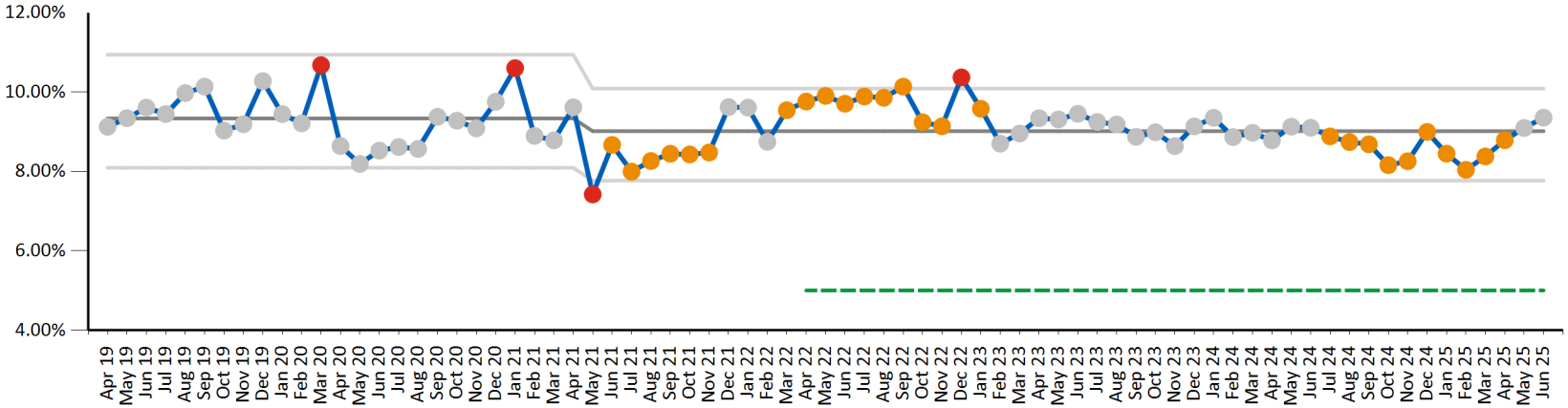
Plan	Actual
<= 6.3%	9.5%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.4%	Jun-25

Previous

Plan	Actual	Period
<= 5.0%	9.1%	May-25

Year to Date

Plan	Actual
<= 5.0%	9.1%

Operational Performance - Cancer

We achieved the 62 day standard for May as well as the Faster Diagnosis standard, we continue to perform well in this metric nationally.

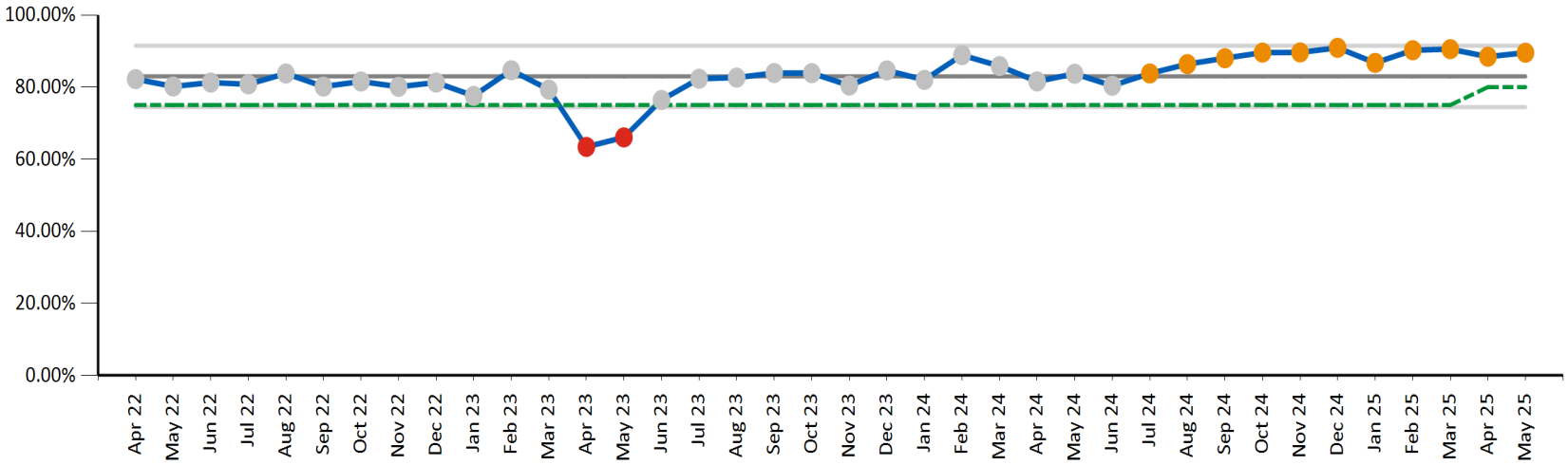
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 80.0%	89.5%	May-25	H	>= 80.0%	88.4%	Apr-25	>= 80.0%	89.0%	?
584 - 31 Day General Treatment Standard	>= 96%	96.7%	May-25		>= 96%	99.2%	Apr-25	>= 96%	97.9%	?
585 - 62 Day General Standard	>= 75%	87.8%	May-25		>= 75%	86.8%	Apr-25	>= 75%	87.3%	?

542 - Cancer: 28 day faster diagnosis

H — Special cause variation with improving performance

? — We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 80.0%	89.5%	May-25

Previous

Plan	Actual	Period
>= 80.0%	88.4%	Apr-25

Year to Date

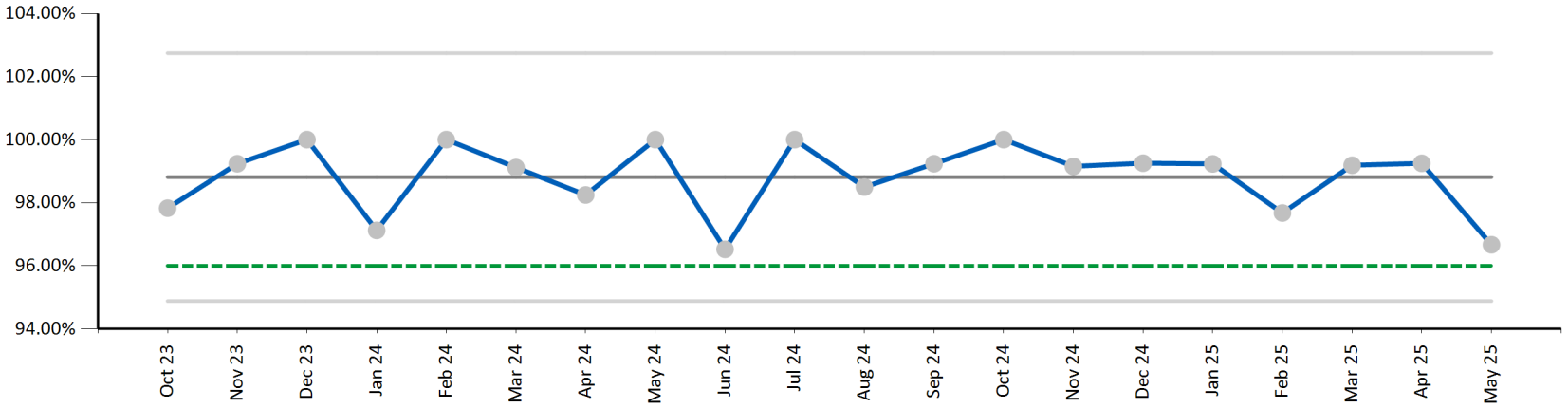
Plan	Actual
>= 80.0%	89.0%

584 - 31 Day General Treatment Standard

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 96%	96.7%	May-25

Previous

Plan	Actual	Period
>= 96%	99.2%	Apr-25

Year to Date

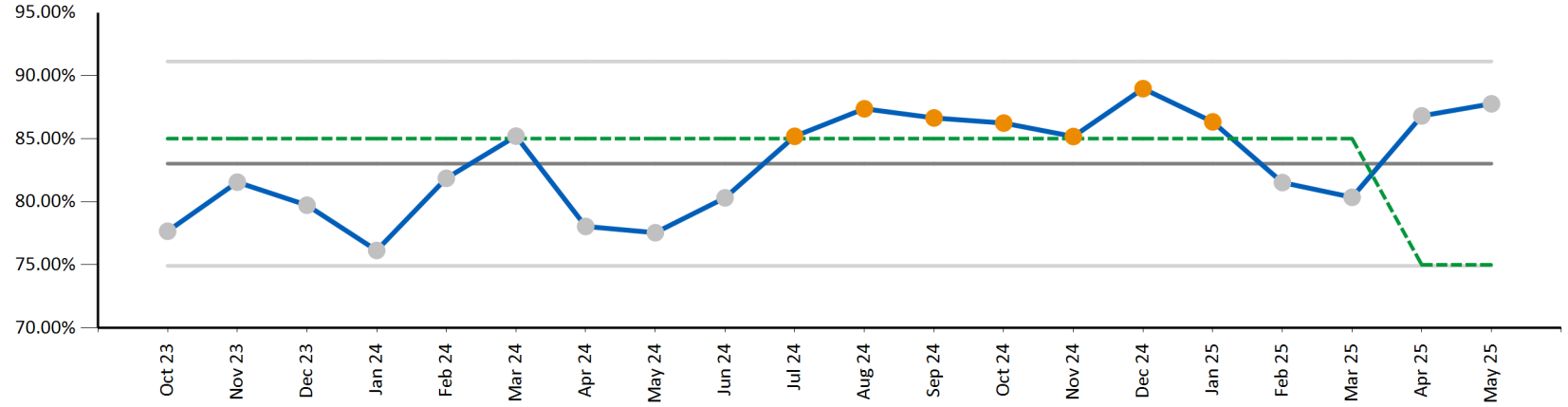
Plan	Actual
>= 96%	97.9%

585 - 62 Day General Standard

Common cause variation.

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 75%	87.8%	May-25

Previous

Plan	Actual	Period
>= 75%	86.8%	Apr-25

Year to Date

Plan	Actual
>= 75%	87.3%

Operational Performance - Community Care

Bolton NHS Foundation Trust

Emergency Department deflections

ED deflections for Month 3 have increased to 563 from 552 and remain above the plan of 400. The number of deflections has continued to remain above 500 and this demonstrates the impact of the continued work by the Admission Avoidance Team (AAT) and Home First. AAT continue to promote 2hr Urgent Care Response and pathways into the service from North West Ambulance Service, Primary Care and Care Homes.

Further improvements to ED deflections are expected incrementally over the remainder of the year, based upon the new nationally mandated target of 180 referrals per 100,000 population per month for 2 hr UCR for 2025/2026. The AAT leadership team have in place a robust improvement plan, aligned to the national standard, which includes implementation of new pathways, improved engagement and embedding of call before you convey as business-as-usual practice.

Work is now underway across the system to develop a UEC SPOA with the implementation of single telephony on 30th June 2025. This has stream lined access to UEC services delivered by AAT, Bardoc and AAU1 (SDEC) as NWAS will have just one number to access all services. Phase two planning is underway to utilise the full functionality of the telephony system and enable health and social care professionals to access the one number.

NCTR

In Month 3, the average number of patients with No Criteria to Reside (NCTR) has reduced to 83 from 90 to meet the operational target, with a reduction in lost bed days to 541 from 725. This improved position has been supported by the daily grip and control of the IDT leadership team and the now established out of area team within IDT.

The OOA team leader facilitates daily escalation calls/meetings with Wigan, Salford and Bury and the two new discharge facilitator roles are focusing on OOA patients with CTR and NCTR at a ward level to ensure the GM trusted assessment process is enacted as soon as possible. The discharge facilitators also have designated wards with a high volumes of NCTR activity and early LOS data has shown the role on B1 has contributed to a reduction in LOS to 8.5 from 10.3 days.

GM locality agreed target of 75 was achieved and maintained for M3, demonstrating effective flow through the system for Bolton residents residing in RBH and OOA GM hospitals. We were the only locality in GM to meet the target every week since 6th April 2025.

0-5 Years Mandated Contacts

The performance for 0-5 Years Mandated Contacts remains off the target of 95%, however is demonstrating special cause improvement, with a further improvement from 86% to 88% in June. This continues the recent trend of improved mandated contact performance despite the changes to the service and reduced financial envelope. Recruitment remains ongoing for health visitors, however, vacancies are still causing pressures and this is recorded on the divisional risk register (R6036). Work is ongoing to build a tableau dashboard that will enable real time monitoring of performance.

EHCP compliance

Compliance has been 100% in months versus the 95% target and continues to consistently perform between 90-95% (91% in April 2025). . Robust processes are in place to monitor and escalate delays.

Looked after Children

Initial Health Assessment performance was 93% in June, up from 90% in May. There were 3 breaches in month, 2 due to non-attendance and 1 due to a delay in consent.

100% of Review Health Assessments were completed within timescale in May 2025.

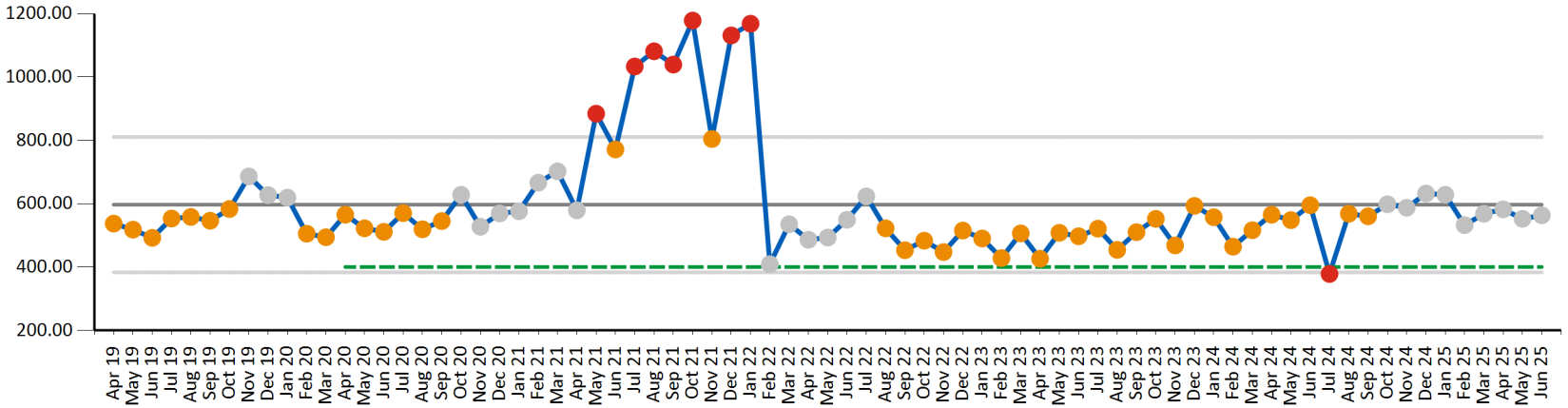
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	563	Jun-25		>= 400	552	May-25	>= 1,200	1,697	
493 - Average Number of Patients: with no Criteria to Reside	<= 91	83	Jun-25		<= 90	90	May-25	<= 91	83	
494 - Average Occupied Days - for no Criteria to Reside	<= 360	541	Jun-25		<= 360	725	May-25	<= 1,080	1,932	
267 - 0-5 Health Visitor mandated contacts	>= 95%	88%	Jun-25		>= 95%	86%	May-25	>= 95%	86%	
269 - Education, health and care plan (EHC) compliance	>= 95%	100%	Jun-25		>= 95%	93%	May-25	>= 95%	95%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	94.0%	Jun-25		>= 90.0%	93.0%	May-25	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	82.0%	Jun-25		>= 90.0%	90.0%	May-25	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Jun-25		>= 90.0%	100.0%	May-25	>= 90.0%		

334 - Total Deflections from ED

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
>= 400	563	Jun-25

Previous

Plan	Actual	Period
>= 400	552	May-25

Year to Date

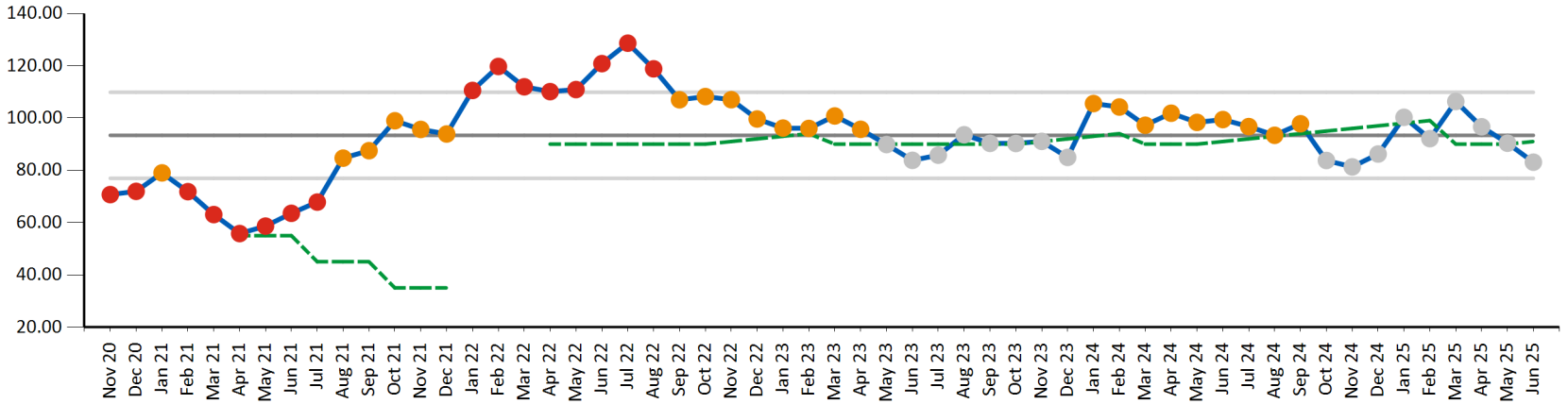
Plan	Actual
>= 1,200	1,697

493 - Average Number of Patients: with no Criteria to Reside

Common cause variation.

We will not regularly meet the target due to normal variation.

2/6



Latest

Plan	Actual	Period
<= 91	83	Jun-25

Previous

Plan	Actual	Period
<= 90	90	May-25

Year to Date

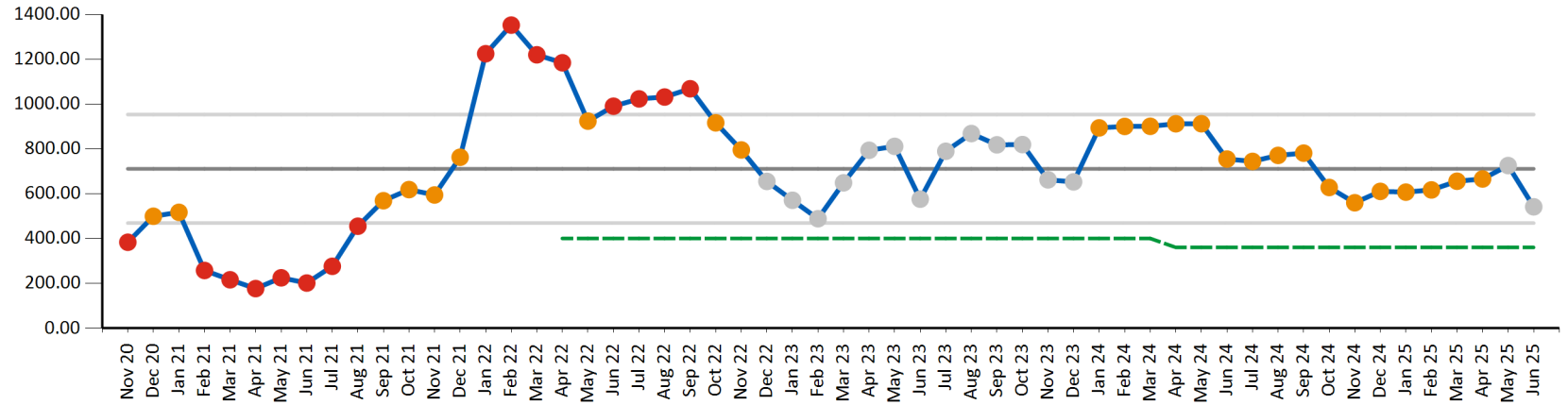
Plan	Actual
<= 91	83

494 - Average Occupied Days - for no Criteria to Reside

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 360	541	Jun-25

Previous

Plan	Actual	Period
<= 360	725	May-25

Year to Date

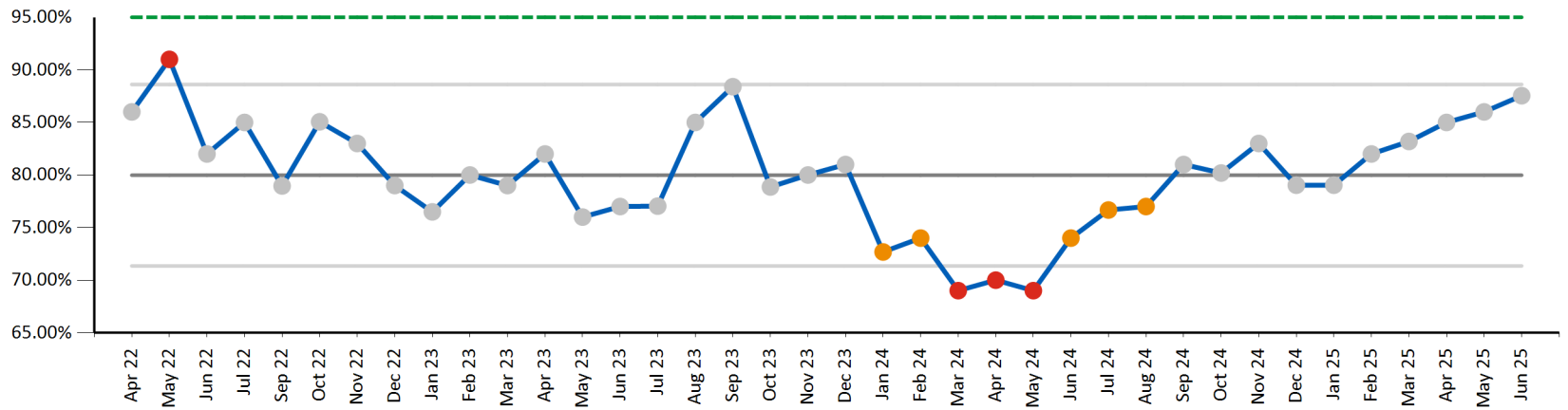
Plan	Actual
<= 1,080	1,932

267 - 0-5 Health Visitor mandated contacts

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	88%	Jun-25

Previous

Plan	Actual	Period
>= 95%	86%	May-25

Year to Date

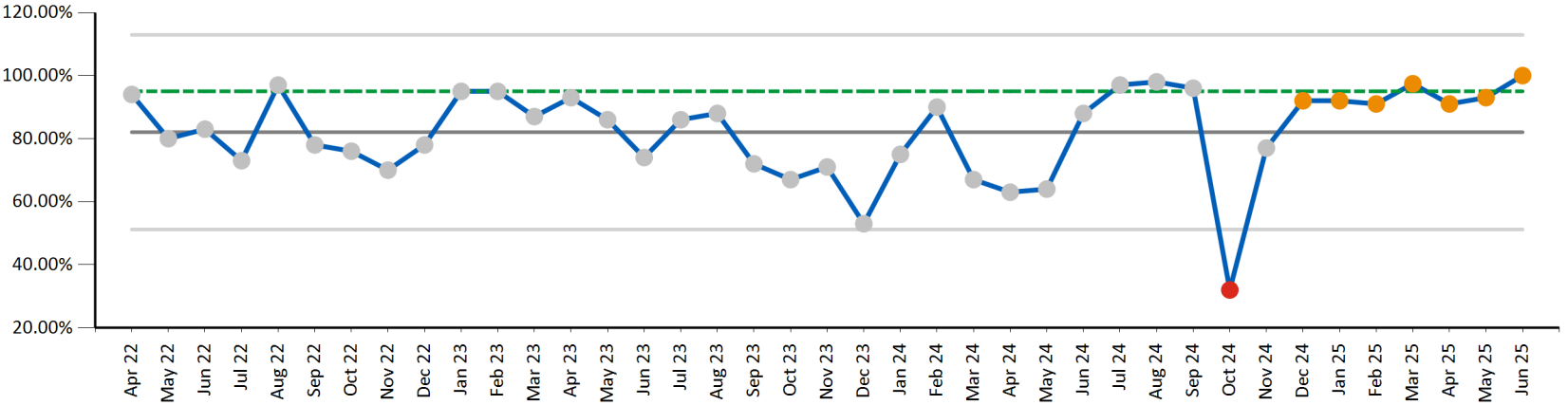
Plan	Actual
>= 95%	86%

269 - Education, health and care plan (EHC) compliance

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

2/6



Latest

Plan	Actual	Period
>= 95%	100%	Jun-25

Previous

Plan	Actual	Period
>= 95%	93%	May-25

Year to Date

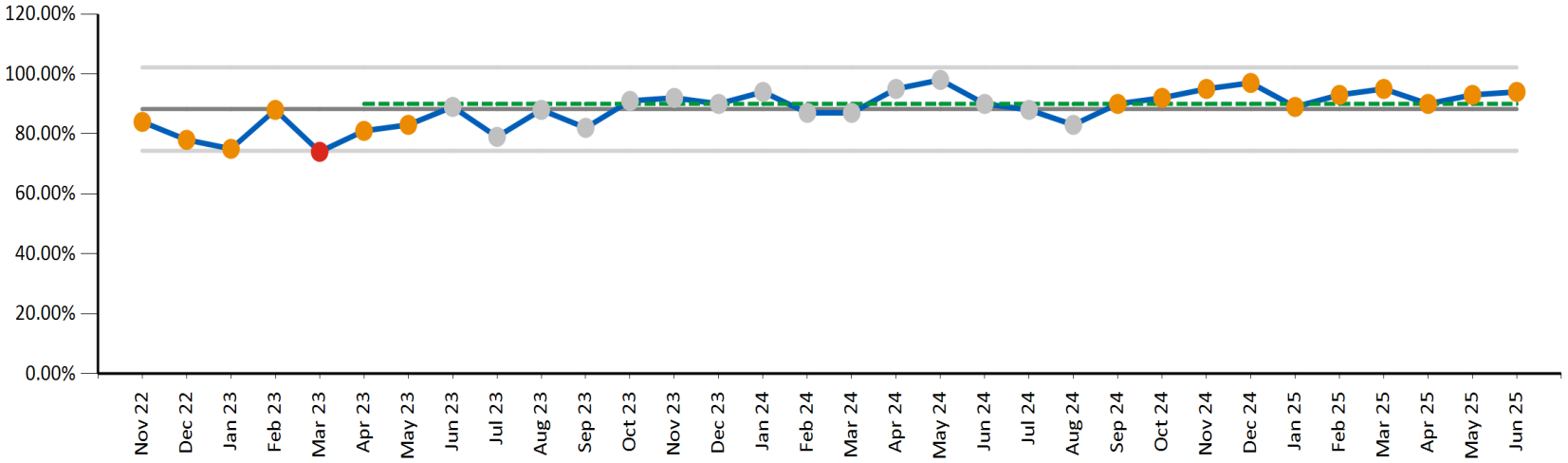
Plan	Actual
>= 95%	95%

550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
> = 90.0%	94.0%	Jun-25

Previous

Plan	Actual	Period
> = 90.0%	93.0%	May-25

Year to Date

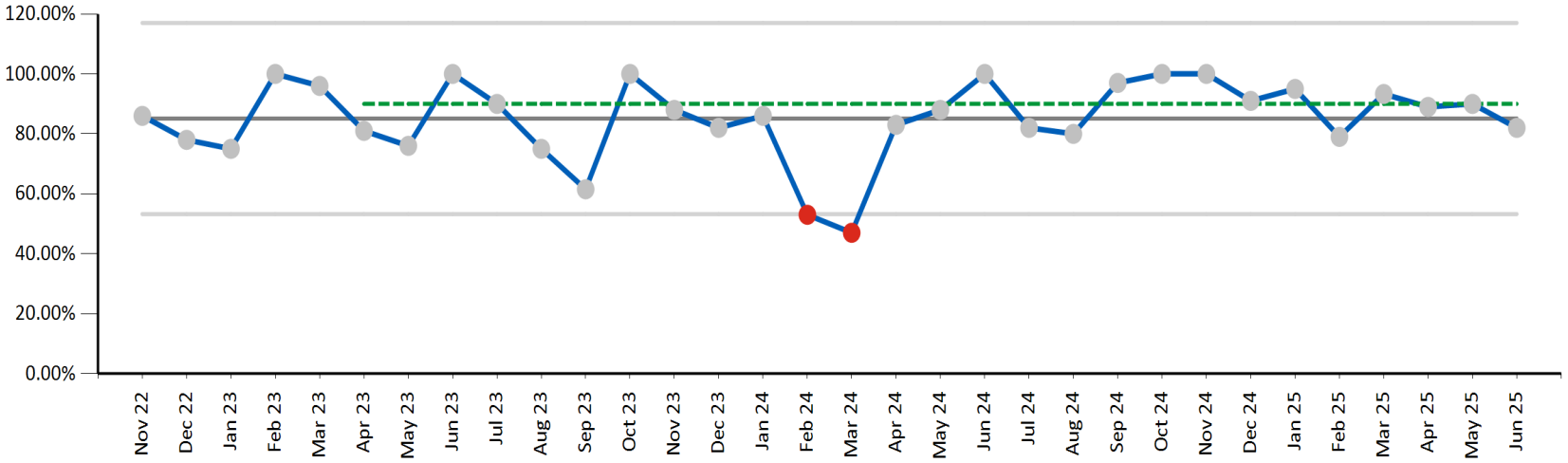
Plan	Actual
> = 90.0%	

551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales

Common cause variation.

We will not regularly meet the target due to normal variation.

3/6



Latest

Plan	Actual	Period
> = 90.0%	82.0%	Jun-25

Previous

Plan	Actual	Period
> = 90.0%	90.0%	May-25

Year to Date

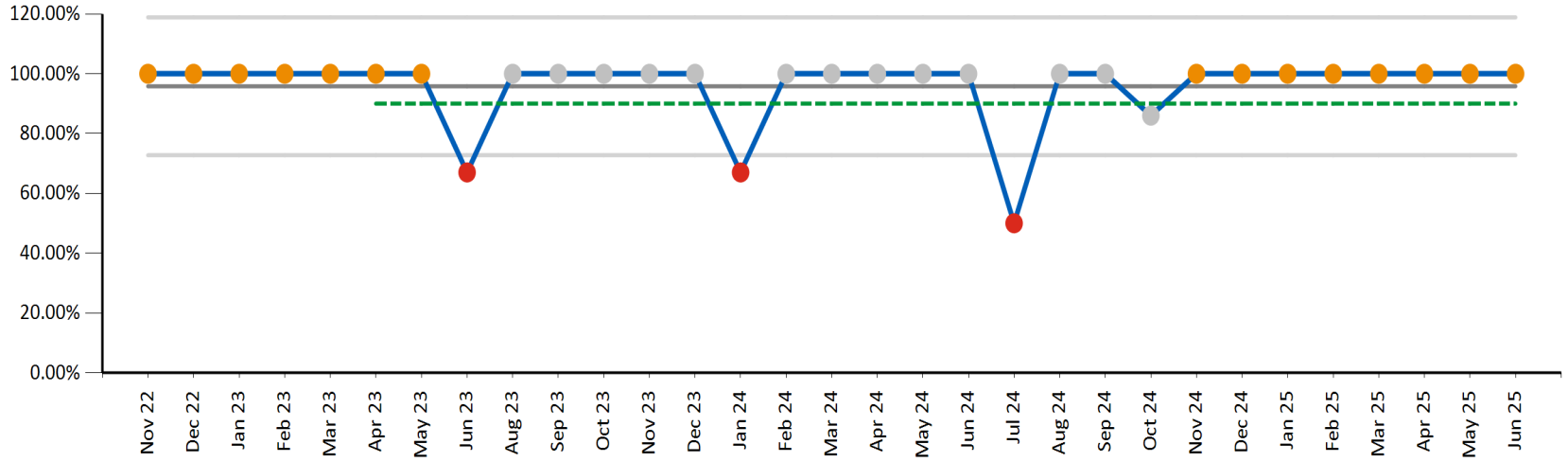
Plan	Actual
> = 90.0%	

552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Jun-25

Previous

Plan	Actual	Period
> = 90.0%	100.0%	May-25

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

NHS Bolton NHS Foundation Trust

Sickness:
Sickness has increased slightly in June 25 at 4.84% compared to 4.64% in May 2025. There has been an increase in sickness absence in across the majority of Divisions and teams with slight reductions in some of the corporate teams. Each Division and corporate function continues to undertake a review of sickness, with an increased focus on providing wellbeing support through Occupational Health and wider wellbeing initiatives. The Divisional and Workforce teams continue to work together to closely monitor sickness, and provide a range of health and well-being support to our staff.

Turnover:
Turnover remained relatively static in June 2025 (a slight reduction of 0.09%) which is a continuation of a pattern seen since the start of the calendar year. We expect to see some modest increases in July and August 2025 as a result of MARS exits from the Trust.

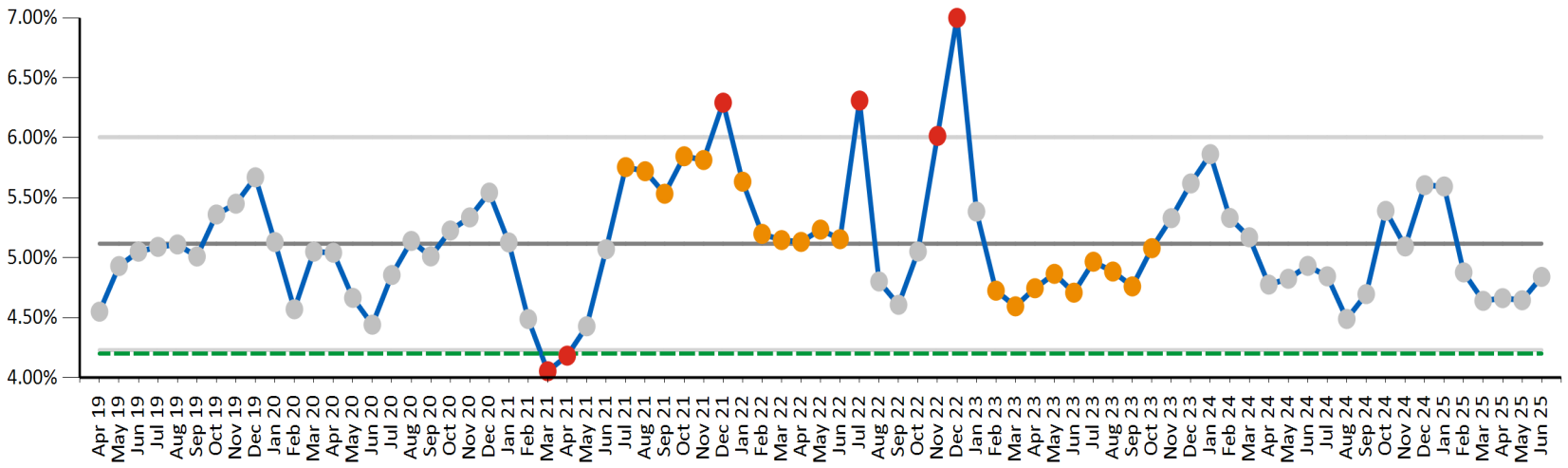
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	4.84%	Jun-25		<= 4.20%	4.64%	May-25	<= 4.20%	4.72%	F
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		?
121 - Turnover	<= 9.90%	10.97%	Jun-25	L	<= 9.90%	11.06%	May-25	<= 9.90%	11.03%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Jun-25	L		0	May-25		0	

117 - Sickness absence level - Trust

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	4.84%	Jun-25

Previous

Plan	Actual	Period
<= 4.20%	4.64%	May-25

Year to Date

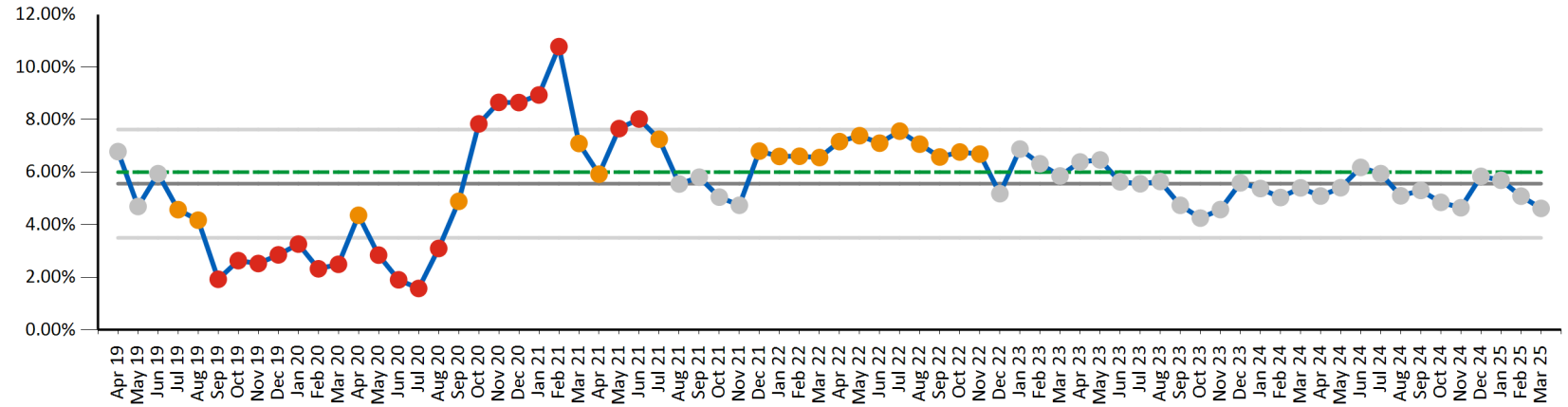
Plan	Actual
<= 4.20%	4.72%

120 - Vacancy level - Trust

Common cause variation.

We will not regularly meet the target due to normal variation.

6/6



Latest

Plan	Actual	Period
<= 6%	4.62%	Mar-25

Previous

Plan	Actual	Period
<= 6%	5.08%	Feb-25

Year to Date

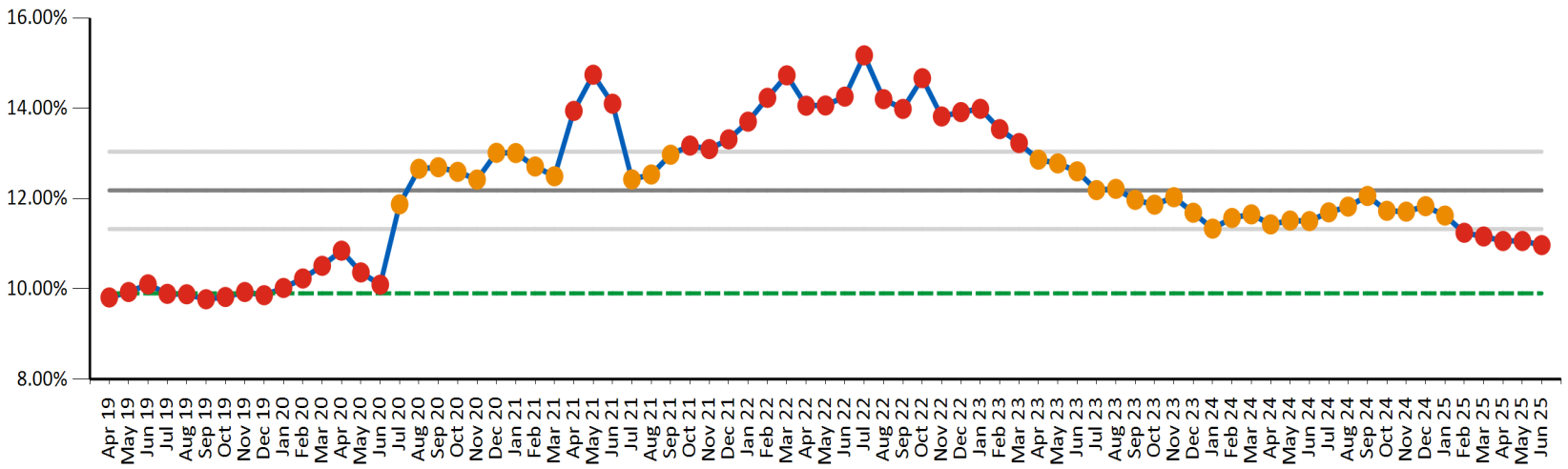
Plan	Actual
<= 6%	5.31%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	10.97%	Jun-25

Previous

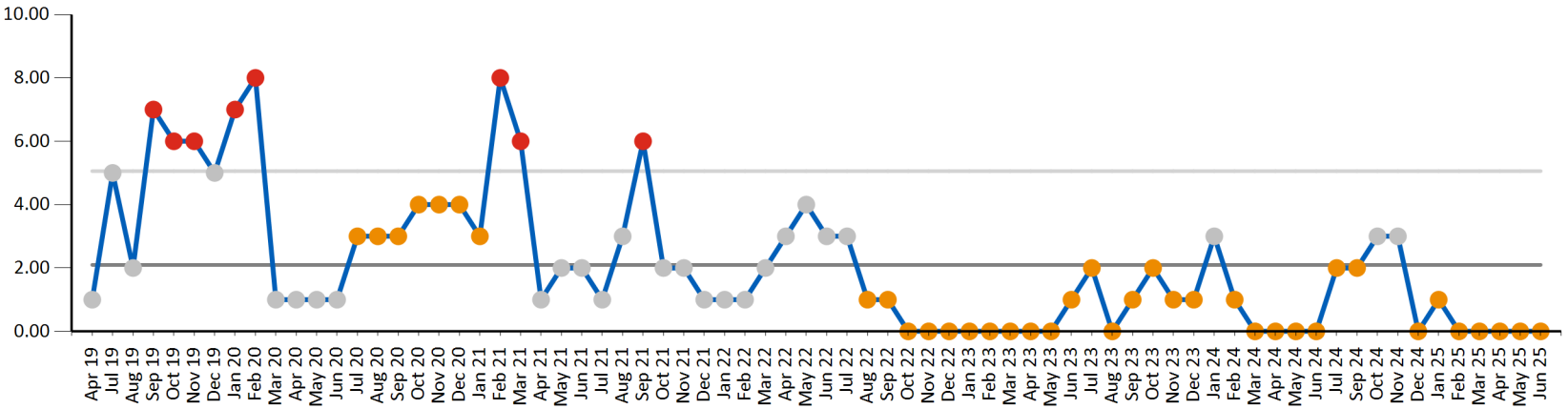
Plan	Actual	Period
<= 9.90%	11.06%	May-25

Year to Date

Plan	Actual
<= 9.90%	11.03%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Jun-25

Previous

Plan	Actual	Period
	0	May-25

Year to Date

Plan	Actual
	0

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training

Another positive month with improved performance at 94.35%, the highest % compliance recorded for the Trust since Sept 2021.The introduction of e-learning module for level 3 safeguarding (adults & children) has had a positive impact.

BLS (86.5%) and M&H (85.61%) remain challenged, a drop in for BLS at the beginning of July should support an improvement for the next report. The DNA QI project started on 30th June with the introduction of contacting all staff who DNA to identify the main blockers to attending which will inform actions to address.

The NHS England Mand/Stat programme has now confirmed the commitment to recognise all 'in date' Compulsory Training for staff movement across all Trusts in England, reducing the need for new starters to have to repeat training within 28 day of their start date.

Trust Mandated Training

The performance at 91.98% is the highest % compliance recorded for the Trust. Aseptic Non Touch Technique (ANTT) remains the only subject not to meet the 85% standard (84.5%). The divisional practice educators are being supported to understand the reduction in compliance for AACD/ DSD/ Families (as per divisions before 1st July 2025, prior to transition to new Divisions)

Appraisal

There has been a very slight deterioration in performance in month (85.08%). A focused approach is being undertaken to understand those areas that have deteriorated in month, as to what the barriers for completing timely appraisal are, balancing this with organisational messaging that appraisal conversations should also be carried out in a quality and meaningful way, as per rollout of the refreshed FABB guidance, training and support.

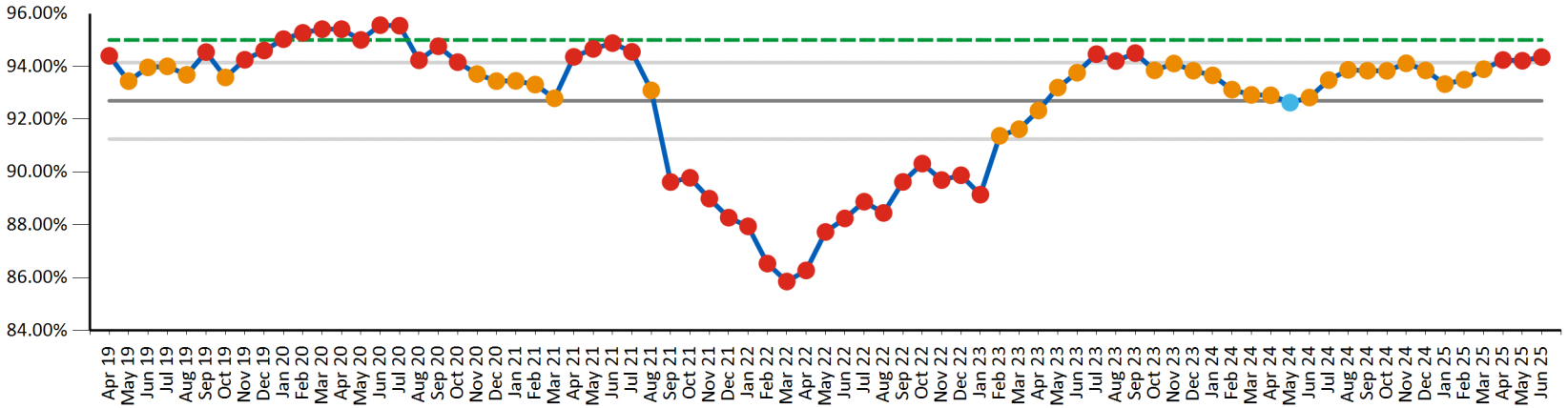
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	94.4%	Jun-25	H	>= 95%	94.2%	May-25	>= 95%	94.3%	F
38 - Staff completing Trust Mandated Training	>= 85%	92.0%	Jun-25	H	>= 85%	91.6%	May-25	>= 85%	91.8%	P
39 - Staff completing Safeguarding Training	>= 95%	94.56%	Jun-25		>= 95%	94.24%	May-25	>= 95%	94.38%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.1%	Jun-25	H	>= 85%	85.1%	May-25	>= 85%	85.0%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	45.5%	Q1 2025/26	L	>= 66%	51.8%	Q4 2024/25	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	51.4%	Q1 2025/26	L	>= 80%	54.9%	Q4 2024/25	>= 80%		F

37 - Staff completing Compulsory Training

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	94.4%	Jun-25

Previous

Plan	Actual	Period
>= 95%	94.2%	May-25

Year to Date

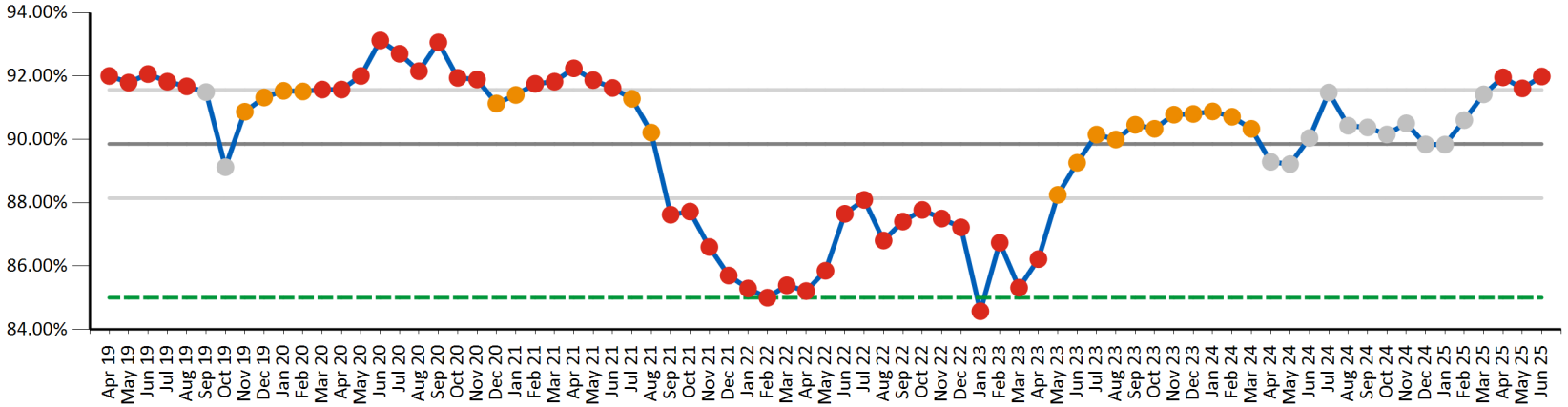
Plan	Actual
>= 95%	94.3%

38 - Staff completing Trust Mandated Training

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	92.0%	Jun-25

Previous

Plan	Actual	Period
>= 85%	91.6%	May-25

Year to Date

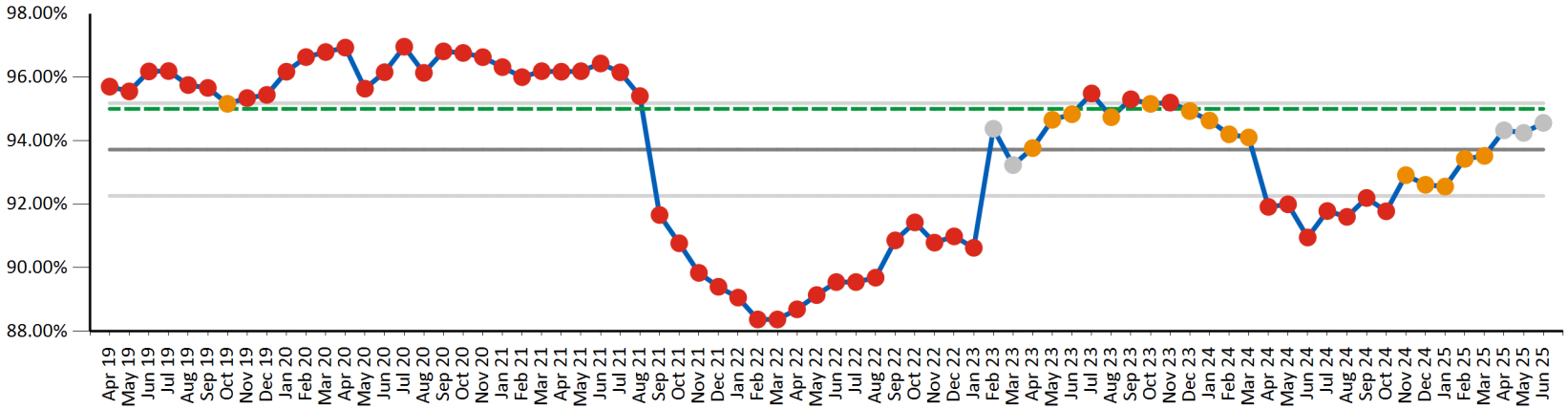
Plan	Actual
>= 85%	91.8%

39 - Staff completing Safeguarding Training

Common cause variation.

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 95%	94.56%	Jun-25

Previous

Plan	Actual	Period
>= 95%	94.24%	May-25

Year to Date

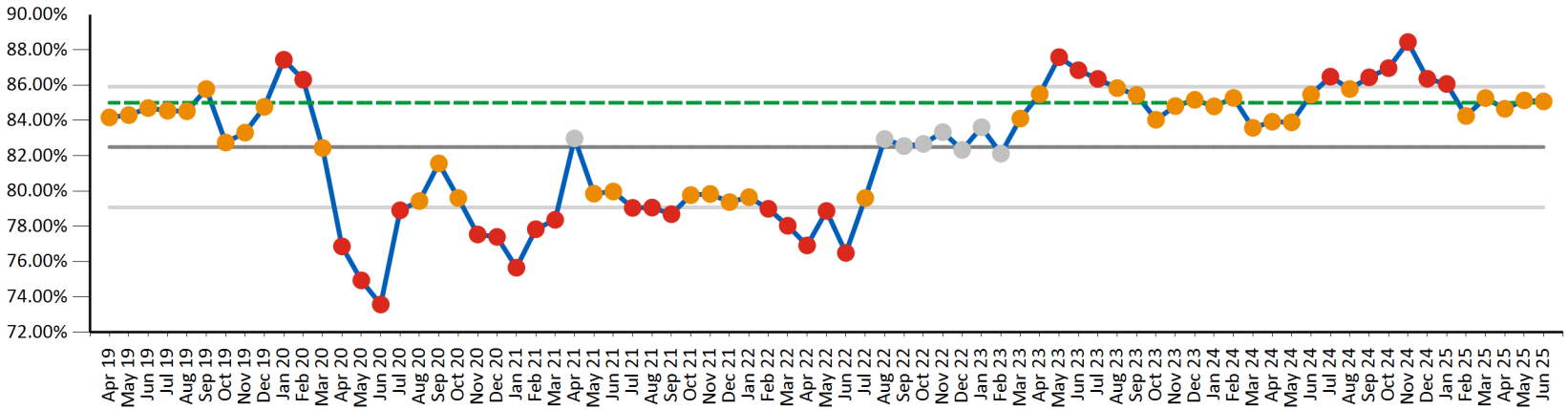
Plan	Actual
>= 95%	94.38%

101 - Increased numbers of staff undertaking an appraisal

Special cause variation with improving performance

We will not regularly meet the target due to normal variation.

4/6



Latest

Plan	Actual	Period
>= 85%	85.1%	Jun-25

Previous

Plan	Actual	Period
>= 85%	85.1%	May-25

Year to Date

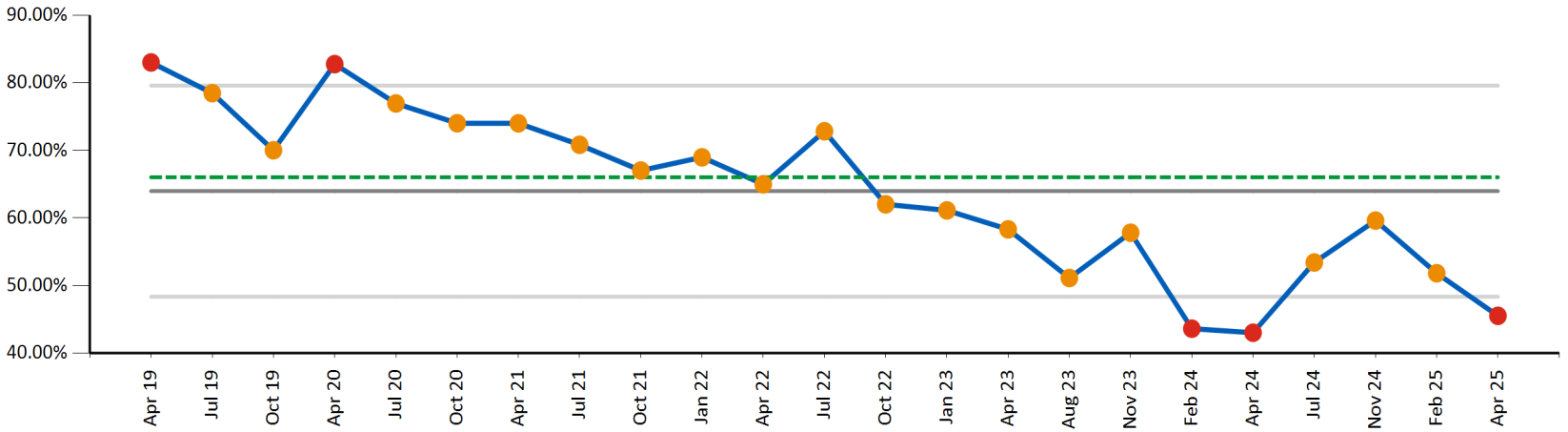
Plan	Actual
>= 85%	85.0%

78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation.

0/6



Latest

Plan	Actual	Period
>= 66%	45.5%	Q1 2025/26

Previous

Plan	Actual	Period
>= 66%	51.8%	Q4 2024/25

Year to Date

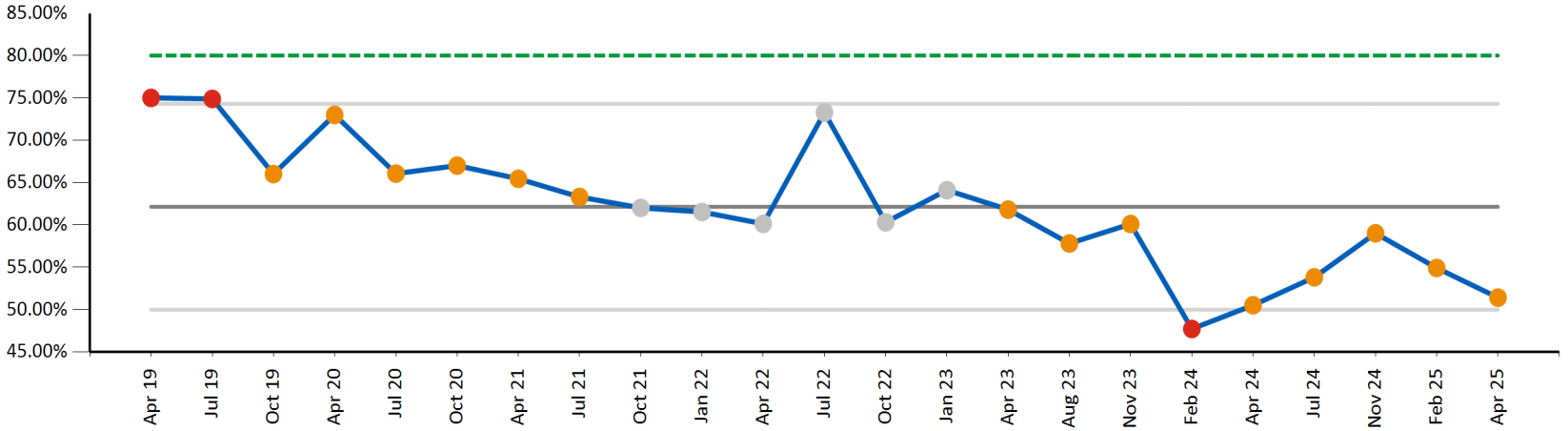
Plan	Actual
>= 66%	

79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 80%	51.4%	Q1 2025/26

Previous

Plan	Actual	Period
>= 80%	54.9%	Q4 2024/25

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Usage of agency across the Trust continues to fall – the majority of all agency usage relates to medical, and Allied Health Professionals, hard-to-recruit vacancies; the Trust is working hard to consider all option to mitigate this and, for most of those roles, we have exit strategies and expect usage to further fall as a result. It is important that we maintain a close focus on this to ensure we meet NHSE expectations for control on usage, and limits on agency spend as a percentage of total pay cost.

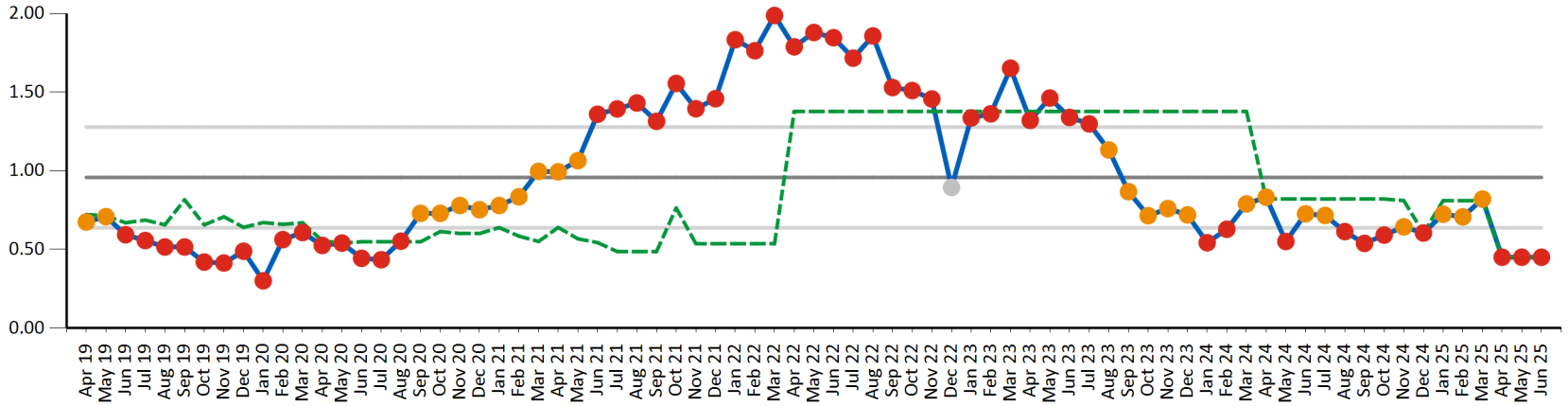
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 0.45	0.45	Jun-25	L	<= 0.45	0.45	May-25	<= 1.35	1.35	F
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.02	0.02	Jun-25	L	<= 0.02	0.02	May-25	<= 0.06	0.06	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.53	0.53	Jun-25	H	<= 0.48	0.48	May-25	<= 1.52	1.52	?

198 - Trust Annual ceiling for agency spend (£m)

L Special cause variation with improving performance

F We will regularly fail to meet the target.

3/6



Latest

Plan	Actual	Period
<= 0.45	0.45	Jun-25

Previous

Plan	Actual	Period
<= 0.45	0.45	May-25

Year to Date

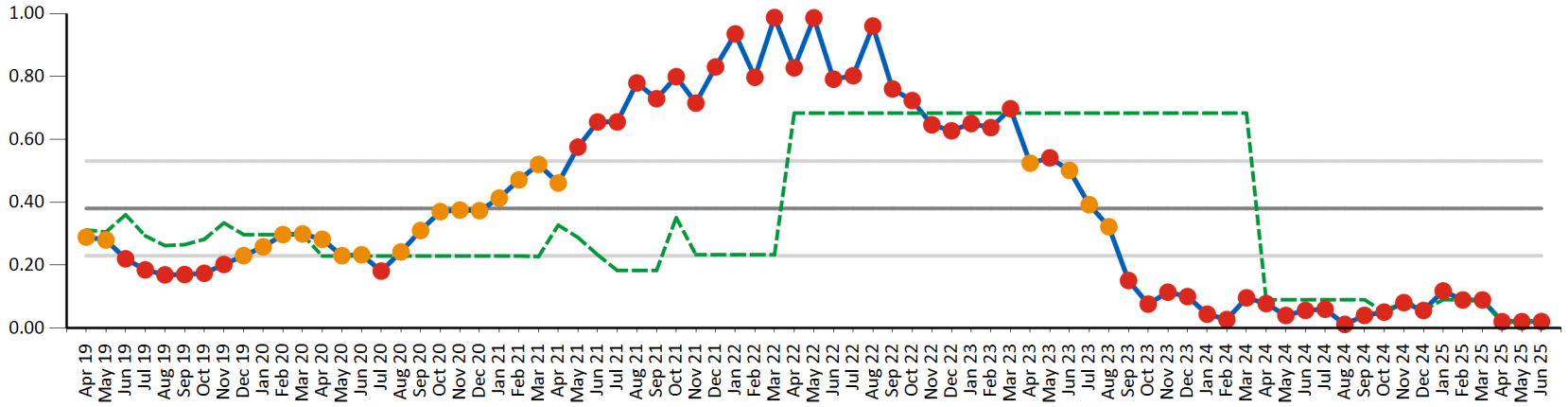
Plan	Actual
<= 1.35	1.35

111 - Annual ceiling for Nursing Staff agency spend (£m)

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6



Latest

Plan	Actual	Period
<= 0.02	0.02	Jun-25

Previous

Plan	Actual	Period
<= 0.02	0.02	May-25

Year to Date

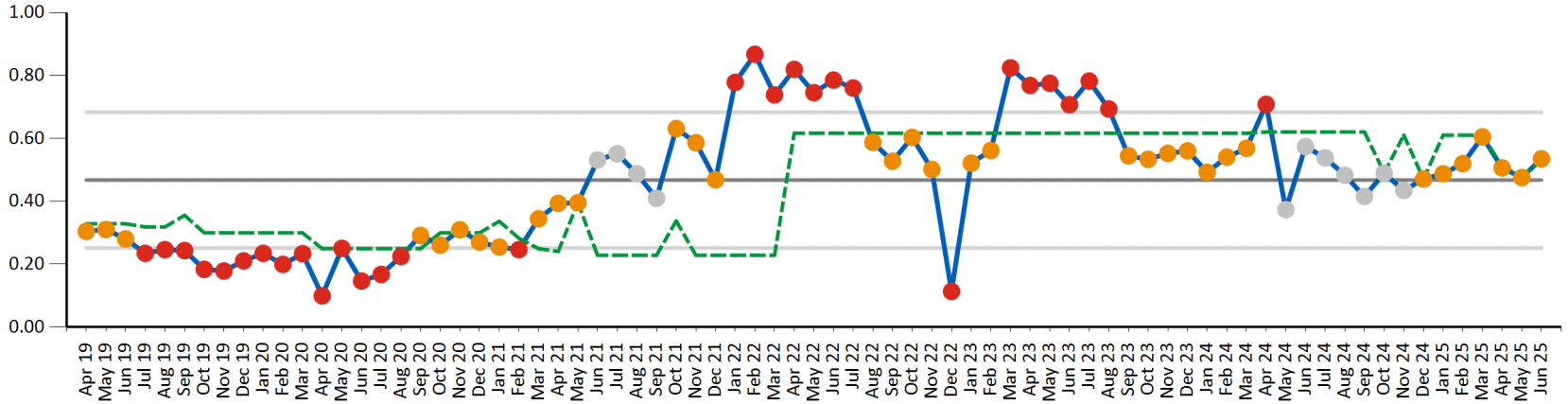
Plan	Actual
<= 0.06	0.06

112 - Annual ceiling for Medical Staff agency spend (£m)

Special cause variation with deteriorating performance

We will not regularly meet the target due to normal variation.

5/6



Latest

Plan	Actual	Period
<= 0.53	0.53	Jun-25

Previous

Plan	Actual	Period
<= 0.48	0.48	May-25

Year to Date

Plan	Actual
<= 1.52	1.52

Finance - Finance

Surplus / (Deficit)
The Trust is reporting a cumulative deficit of £6.1m largely due to CIP under-delivery partially offset by income inflation not yet being spent (incremental drift and non-pay inflation). The in-month position is on-plan.

Forecast
The external forecast has been reported as meeting plan, representing the best case scenario. There are some significant risks to achieving this, even if the CIP target is delivered in full, with mitigations needed for existing issues and a residual gap needing to be addressed. The most likely scenario is a deficit of £21.6m and the worst case scenario is a deficit of £34.9m, this range will narrow as the year progresses and risks/mitigations materialise.

Income
Commissioner income is based on contractual and budget values, including above-plan Planned Care Variable Income performance of £1.7m YTD. Pass through income for Devices is also above plan. Additional Injury Cost Recovery Scheme income of £1.2m has been recognised in-month. Q1-2 Deficit Support funding is now secured at £3.3m although Q3-4 could be at risk.

Pay
WTEs and underlying Pay Costs have reduced in month driven by leavers and increased Bank controls, there is an adverse variance against CIP delivery and Worked WTEs are still adverse to the Trust plan.

Non Pay
Non Pay costs have increased from M2, including an increase in the Bad Debt Provision of £0.3m driven by Overseas Visitors debt, although the main driver of the adverse variance is under-delivery of CIP

Non Operating
Interest received has been slightly higher than planned.

Cash
The Trust was above plan by £8.0m in Month 3. PDC funding cash has provided a temporary benefit of £2.0m and some other cash has been received in advance. The underlying cash position is an overdrawn position of £4.4m and it is anticipated that cash support will be required during 2025/26, likely early in Q2.

CIP Delivery
Increase in delivery from M2 to M3, although still under plan. There are minimal opportunities for central non-recurrent items to support delivery in 2025/26.

Capital
£48.8m of capital budget for the year, the majority is anticipated from Q2 onwards

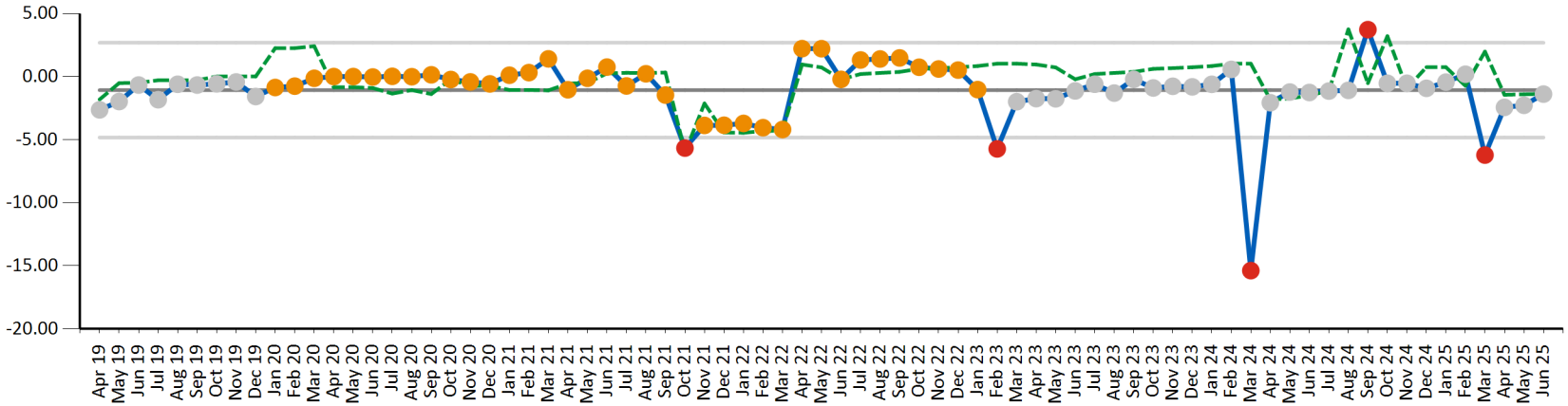
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
220 - Control Total (£ millions)	>= -1.4	-1.4	Jun-25		>= -1.4	-2.3	May-25	>= -4.2	-6.1	
222 - Capital (£ millions)	>= 0.9	0.5	Jun-25		>= 1.1	1.3	May-25	>= 2.6	2.2	
223 - Cash (£ millions)	>= 4.6	10.4	Jun-25		>= 2.1	14.5	May-25	>= 4.6	10.4	

220 - Control Total (£ millions)

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
>= -1.4	-1.4	Jun-25

Previous

Plan	Actual	Period
>= -1.4	-2.3	May-25

Year to Date

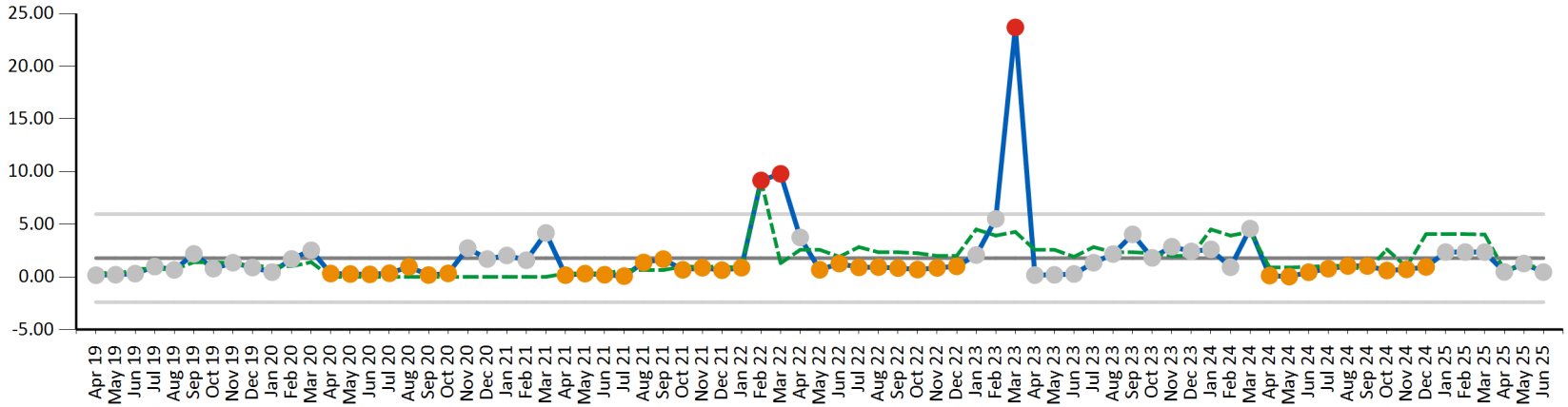
Plan	Actual
>= -4.2	-6.1

222 - Capital (£ millions)

Common cause variation.

We will not regularly meet the target due to normal variation.

1/6



Latest

Plan	Actual	Period
>= 0.9	0.5	Jun-25

Previous

Plan	Actual	Period
>= 1.1	1.3	May-25

Year to Date

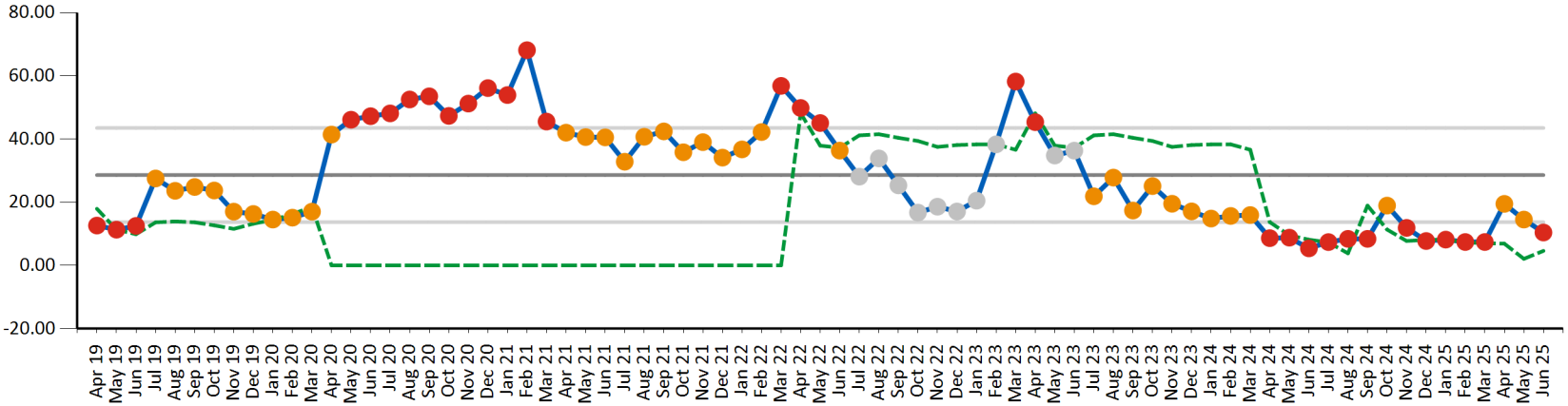
Plan	Actual
>= 2.6	2.2

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 4.6	10.4	Jun-25

Previous

Plan	Actual	Period
>= 2.1	14.5	May-25

Year to Date

Plan	Actual
>= 4.6	10.4

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Quality Assurance Committee Chair		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the Quality Assurance Committee.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Quality Assurance Committee meeting held in May 2025.

Executive Summary	This report provides a summary of key matters discussed at the QAC meeting held on 28 May 2025. It outlines the assurances received by the Committee in relation to the Trust's quality governance, patient safety, and clinical effectiveness. There are no Alerts that require the attention of the Board. Due to the scheduling of the July Board meeting, a verbal update on the Committee's discussions will be provided. A full written report, capturing the outcomes and recommendations from the July meeting, will be submitted to the subsequent Board meeting for formal consideration.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Quality Assurance Committee Chair's Reports.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of Key Elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Fiona Taylor, Quality Assurance Committee Chair	**Presented by:**	Fiona Taylor, Quality Assurance Committee Chair

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee:	Quality Assurance Committee	**Reports to:**	Board of Directors
Date of Meeting:	28 May 2025	**Date of next meeting:**	30 July 2025
Chair	Fiona Taylor	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING:

- Patient Story – Family Care Division
- Escalation of a Deteriorating Patient – MIAA Report
- Quality Account
- Integrated Performance Report
- VTE Update
- Safeguarding Update
- Mortality and Learning from Deaths Report
- Family Care Mortality Update
- Maternity Incentive Scheme Year 6 Progress Update
- NHS Resolution Claims Scorecard
- Clinical Governance and Quality Committee Chair's Report
- Performance and Transformation Board Chair's Report

ALERT

Agenda items	Action Required
No items of Alert.	

ADVISE

- **Patient Story** – Family Care Division - The Head and Deputy Head of Midwifery presented the story of Leanne who was in her third surrogate pregnancy and who expressed deep gratitude to the Community Midwifery Team, especially the Deputy Head of Midwifery who provided comprehensive support, including developing a birth plan, legal liaison, and emotional reassurance.
- **Escalation of a Deteriorating Patient** – MIAA Report - The Chair noted the Trust's response to the report had been reviewed at Audit and Risk Committee, following a request from the Medical Director to better understand incident review rationale. The Committee was asked to note completed actions and next steps.
- **Quality Account** - following review by the Quality Assurance Committee, the draft Quality Account for 2025/26 would proceed to Audit and Risk Committee for assurance, with final approval by the Board of Directors and publication by 30 June 2025.
- **Mortality and Learning from Deaths Report** – the Summary Hospital-level Mortality Indicator (SHMI) for reporting period November 2023 – October 2024 was 118.34 which was within the 'higher than expected' range and slightly increased from 117.65. The rise was largely due to a national methodology change. An action plan was in place to address the issues.
- **Family Care Mortality Update** - mortality data for the Division was reflected in both Hospital Standardised Mortality Ratio (HSMR) and SHMI; stillbirths were included in HSMR but excluded from SHMI. HSMR for Q3 has improved, moving out of the amber alert range, though data quality improvements are still needed. SHMI remained within expected range due to risk adjustments and exclusion of stillbirths. Specialty-level data and governance processes were included for context. Data is monitored and reported through the Mortality Group.

- **Maternity Incentive Scheme Year 6 Progress Update** - NHS Resolution confirmed the Clinical Negligence Scheme for Trusts (CNST) Year 6 submission met external verification requirements; financial award details were expected by end of June 2025. CNST Year 7 launched on 02 April 2025, with workstreams now being established. The report met quarterly perinatal quality surveillance requirements, including national data set reporting. All cases in the monitoring period were reviewed to standard and cross-checked with national data; thematic learning is detailed in the appendices.

ASSURE

- **Venous Thromboembolism (VTE) Update** – performance remained above the 95% target. March data indicated a special cause variation, though compliance was still achieved. A clinically led VTE action group had been established to address data quality and align with national guidelines. The Electronic Patient Record (EPR) system for Maternity, which would support improvements, has been delayed to Q4. The Chair asked the Chief Nurse to consider updating the risk register accordingly.
- **Safeguarding Update** - The report provided an update on the safeguarding team during Q4, 2024/25. The Chair noted it was great to meet the team recently and great to see improvements made.
- **NHS Resolution (NHSR) Claims Scorecard** - the Chief Nurse presented the 2025/26 NHSR Claims Scorecard. The Trust's total contribution was £24.5m, comprising £15.9M for maternity and £8.6M general. Contributions were based on 60% experience and 40% exposure. Bolton remained above average for maternity claims and slightly above average for general claims. Claims governance had been strengthened with the introduction of a Clinical Claims Panel, chaired by the Medical Director, to review all claims and identify learning. Updates would be reported to the Clinical Governance and Quality Committee.

New Risks identified at the meeting: No new risks.

Review of the Risk Register: N/A

Meeting Attendance 2025

Members	May	Jul	Sept	Nov	Jan	March
Fiona Taylor	✓					
Martin North	✓					
Seth Crofts	✓					
Francis Andrews	✓					
Tyrone Roberts	✓					
Rae Wheatcroft	✓					
Sharon Katema	✓					

✓ = In attendance A = Apologies

Report Title:	Clinical Negligence Scheme for Trusts Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Chief Nurse		Decision	✓

Purpose of the report	The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts year 7 (CNST) Maternity Incentive Scheme (MIS).

Previously considered by:	Clinical Governance and Quality Committee, Family Care Division Clinical Governance and Quality Committee and Quality Assurance Committee.

Executive Summary	Key highlights: • All ten safety actions work streams have been established and are progressing well. • Notification of the CNST year 6 financial award is due to be received by the Director of Finance at the end of June 2025. • The service was awarded a significant assurance rating and score of 99% following the submission of the Safety Action 6 evidence relating to the implementation of the Saving Babies Lives Care bundle in the service. • The service continues to make good progress with the attainment of the required training elements prior to the 30 November 2025 • Ongoing monitoring of defined action plans included in the maternity incentive programme and detailed updates are provided within this report.

Proposed Resolution	The Board of Directors is asked to **receive** the report, **approve** the action plans and **approve** the sharing of this report within the Local Maternity and Neonatal System and at the regional level quality surveillance meeting, with subsequent submissions to committees as required

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Potential impact upon maternity incentive scheme fund reimbursement.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse	**Presented by:**	Janet Cotton, Director of Midwifery Tyrone Roberts, Chief Nurse

Glossary – definitions for technical terms and acronyms used within this document

ATAIN	Avoiding Term Admissions into Neonatal Units
BAPM	British Association of Perinatal Medicine
CNST	Clinical Negligence Scheme for Trusts
GMEC	Greater Manchester and East Cheshire
ICB	Integrated Care Board
MIS	Maternity Incentive Scheme
NIPE	Newborn and Infant Physical Examination
NWNODN	North West Neonatal Operational Delivery Network
NHSR	NHS Resolution
PMRT	Perinatal Mortality Review Tool
PQSM	Perinatal Quality Surveillance Model
PROMPT	Practical Obstetric Multi-Professional Training
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and babies; reducing risk through audit and confidential enquiries
RCOG	Royal College of Obstetricians and Gynaecologists

1. Introduction

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services and ongoing work with regard to the NHS Resolution Clinical Negligence Scheme for Trusts year 7 (CNST) Maternity Incentive Scheme (MIS).

The incentive scheme continues to support safer maternity and perinatal care by driving compliance with ten safety actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

2. CNST year 7 progress tracker

Progress with regard to attainment of the CNST recommendations is detailed in Table 1. All work streams have now been established.

Table 1: - CNST year 7 progress tracker

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	2	0	0	0	2
3	3	2	1	0	6
4	17	2	0	0	19
5	0	12	0	0	12
6	1	7	1	0	9
7	1	3	0	0	4
8	0	21	0	0	21
9	1	7	1	0	9
10	8	1	0	0	9
Total	33	62	3	0	98

Key:

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

3. Mandatory updates

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?

a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.

b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.

c) **Review the death and complete the review**: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. **For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.**

d) Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 01 December 2024.

All cases within the monitoring period have been reviewed to the required standard as detailed in Appendix 1 and this has been cross checked with the national reporting database. The thematic learning and ongoing actions from all cases completed to date is detailed within Appendix 1a.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The July 2025 data submission to the maternity services dataset (MSDS) will be used for the assessment in the year 7 scheme and requires data fields relating to the birth weight and ethnic category of the mother to be submitted as the assessment criteria. The delay in the implementation of the maternity electronic patient record within the Trust will not impact upon delivery of this standard.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

The service has a detailed action plan in place to progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice (Appendix 2)**.** The action plan will continue to be shared periodically during the year 7 scheme to evidence ongoing progression of the actions as per scheme requirements.

The service can evidence preparation for the delivery of care to neonates from 34 weeks gestation has commenced.

Following receipt of the hot cots funded by the hospital charity implementation was initially delayed to allow time for staff to complete their training. The cots are now in use.

Modelling of staffing for the future model is currently being scoped and will be included in the upcoming Birth Rate Plus reassessment due in autumn 2025. Full implementation of the revised transitional care service will not be realised until the opening of the first floor renovation with increased cot capacity.

Work remains ongoing on the quality improvement project to reduce term admissions to the neonatal unit and improve thermoregulation of the babies following delivery. Preparations for the implementation of the national Newborn Early Warning Track and Trigger chart (NEWTT2) remain ongoing and the guideline is currently awaiting ratification at Trust level. A further update will be presented to safety champions in July 2025.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a**) Obstetric medical workforce**

The service continues to monitor compliance of consultant attendance for the clinical situations listed in the RCOG workforce document and this is detailed in the safety champion's dashboard (table 3). Trusts are required to ensure they are compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations.

The Q4 2024/2025 RCOG attendance audit report has been published with no reported breaches to the standard during the period of the audit.

c) Neonatal medical workforce

The reallocation of the PAs following the recent appointment of an additional SAS doctor remains ongoing to release Consultant cover for the Tier 3 rota and the business case is underway in response.

d) Neonatal nursing workforce

The Neonatal Unit endeavour to achieve and continue to strive for > 70% QIS trained at direct cot side care with ongoing recruitment and progression of staff to undertake further training. The recent NWNODN calculation confirmed that the current service QIS rate is 63.9% and the funded establishment meets the needs of the current activity levels. There are currently an additional 5 staff members in training and a further 4 due to commence training in September 2025.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The bi-annual maternity staffing paper that fulfils the requirements of the scheme was presented to the Board of Directors in May 2025.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle version three?

A quarterly assurance saving babies lives care bundle implementation update was held on the 17 June 2025 chaired by the LMNS acting on behalf of the ICB and Trust providers.

Evidence was submitted prior to the session by the lead specialist midwife for external scrutiny of the LMNS. In response the Trust received a significant assurance grading with an overall 99% compliance rating awarded with regard to completion of all required elements and per national and LMNS requirements. The Trust self-assessment grading submitted with the evidence aligned fully with the LMNS grading for all elements. The need to develop a one stop clinic for pregnant women with diabetes was highlighted as an area of future service development.

An update was also provided on the quality improvement work that has been undertaken over the past twelve months to reduce preterm births and to optimise care for babies born early. The update confirmed the maternity service participation in the Partner trail that aims to identify women at risk of preterm birth or placental problems early in pregnancy that may lead to stillbirth.

The maternity service has been allocated to the intervention arm in the PARTNER trail; a clinical trial that involves the use of a clinical decision support tool to identify women at risk of pregnancy complications and ensure appropriate referral to relevant pathways. Referral to the preterm birth clinic has been a theme identified in recent incidents and this will be negated by the use of the app and identification of appropriate persons for referral using the Tommy's app.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house, one day multi-professional training?

The service is progressing well with regard to attainment of the profession specific CNST training elements as detailed in table 2. A monthly meeting is held to oversee challenges and ensure each trajectory remains on track to meet the required 90% standard.

Table 2 – Training compliance as of 18 June 2025

Course	Total	Advanced Neonatal Practitioners	Consultant Obstetricians	Obstetric Medical Doctors	MSW	HCA	Midwives	Neonatal Consultants	Neonatal Doctors	Neonatal Nurses	Obstetric Anaesthetic Consultant	Obstetric Anaesthetist
PROMPT	96.32%	NA	100.00%	93.33%	93.55%	94.87%	96.48%	NA	NA	NA	100.00%	96.88%
Fetal Monitoring Core Competency Stds.	94.96%	NA	90.48%	90.91%	NA	NA	95.76%	NA	NA	NA	NA	NA
Fetal Monitoring GMEC Comp. Assessment	69.23%	NA	90.48%	90.91%	NA	NA	95.76%	NA	NA	NA	NA	NA
Neonatal Life Support	88.28%	100.00%	NA	NA	NA	NA	90.97%	100.00%	80.00%	81.97%	NA	NA

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

The board safety champions and perinatal leadership team last met on the 07 May 2025 and discussed the cultural action plan (Appendix 5). A bespoke survey has recently been completed to seek the wider views of medical staff with regard to improving the culture and working practices within the maternity service. Feedback sessions have been planned to address improving communication between the wider multidisciplinary team in response to the findings.

As part of the work of the safety champions walkabouts are held bi-monthly. Information gathered continues to be collated and shared in a 'You Said – We Did' simple format and displayed in clinical areas (Appendix 4).

The Board Safety Champion continues to work with the safety champions and utilise safety intelligence to improve safety within the service.

The current area of shared focus relates to the maternity triage department and the need to source additional capacity to ensure care can be delivered in accordance with the Birmingham symptom specific triage system (BSOTS). In response an options appraisal has been collated and approved by the Divisional leadership team to enable the expansion of the current offer to non-clinical space on the Delivery Suite corridor or to an alternative available venue in the wider Trust if this can be sourced.

4. Ongoing monitoring

The requirement for maternity services to ensure a consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and the 'Implementing a revised perinatal quality surveillance model (PQSM) guidance published in 2020.

In response Board level safety champions have presented a locally agreed dashboard to the Board quarterly since November 2022 as detailed in table 3. The dashboard fulfils part of the requirements of the perinatal surveillance reporting guidance. Additional required datasets from staff/service user feedback sessions are displayed in Appendix 4.

The dashboard is used in conjunction with monthly integrated performance management reports to evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. The dashboard will continue to be presented by a member of the perinatal leadership team to provide supporting context. In line with the PQSM, on a quarterly basis this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback (Appendix 4) and review of the culture survey or equivalent. The last analysis was included in the May 2025 Board report.

Ongoing monitoring of the metrics continues to be undertaken at bi-monthly safety champion meetings with the perinatal quadrumvirate leadership team where any additional support required of the Board is identified and escalated. The last bimonthly meeting was held on the 07 May 2025.

Table 3 – Safety Champions locally agreed dashboard

CQC rating	Overall	Safe	Effective	Caring	Well -Led	Responsive
Regional Support Programme	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Indicator	Goal	Red Flag	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 24
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		434	412	383	397	457	396
Maternal deaths direct	0	1	0	0	1	0	0	0
Still Births			3	5	0	2	3	0
Still Birth rate per thousand	3.5	≥4.3	6.9	12.0	0	5.0	6.5	0
HIE Grades 2&3 (Bolton Babies only)	0	1	0	0	0	0	1	1
Early Neonatal Deaths (Bolton Births only)	Information only		0	3	1	2	2	1
END rate in month <7days	Information only		0	7.3	2.6	5.0	4.4	2.5
Late Neonatal deaths	Information only		1	0	0	0	0	0
PSII Incidents (New only)	0	2	0	0	0	0	0	0
MNSI referrals (Steis reportable)			0	0	1	0	2	
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events			0	0	1	0	7	1
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	97.8%	97.3%	97.8%	100.0%	99.2%	99.4%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	0	0	0
BAPM compliance ratio/nurses acuity Indirect (neonatal unit)	>99%	<79%	95%	95%	90%	101%	100%	97%
Fetal monitoring training compliance (overall)	<90%	>80%	92%	91%	90%	90%	92%	95%
PROMPT training compliance (overall)	<90%	>80%	99.00%	96.00%	96.00%	97.16%	95.00%	96.00%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:20	1:20	1:19	1:19	1:19	1:19
RCOG benchmarking compliance	Information only		82%	100%	100%	100%		
Compensatory rest breaches			0					
Proportion of MWs who would recommend the Trust as a place to work or receive treatment	Annual							
Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours	Annual							

Hypoxic Ischaemic Encephalopathy (HIE) data analysis

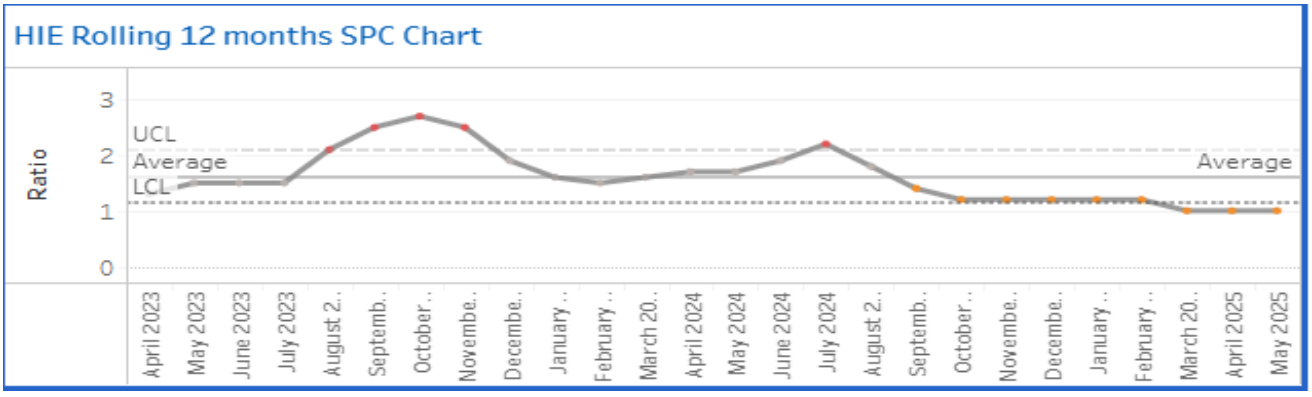
The service has been identified as an outlier in Greater Manchester and East Cheshire LMNS due to an increase in the incidence of Hypoxic Ischaemic Encephalopathy **(**HIE) within the service within the last quarter.

Using the GMEC maternity analysis toolkit an CHI statistical analysis has been undertaken to compare the data with Oldham the peer comparator – this analysis has identified the risk ratio between providers when comparing data over the past twelve months is not significant.

Assurance can be provided that all cases of moderate or severe (grade 3) HIE grade are referred for external review by the Maternity and Newborn Safety Investigation (MNSI) branch. However due to the acknowledged delay in the publication of the MNSI reports for assurance a local review of the themes from the HIE cases over the last quarter will be undertaken in order to identify any learning that can be used to inform practice.

The new tableau statistical process analysis charts (table 4) provided by Business Intelligence will enable such variations in incidence within the key performance indicators to be identified at an earlier stage.

Table 4 – HIE statistical process chart



Claims Scorecard

The Q4 scorecard review (Appendix 3) triangulates the Trust claims score card that includes claim data from 1 April 2013 – 31 March 2023 with contemporary incident and complaint data received within the maternity service during Q4 2024/2025.

Despite an obvious time lag between claims, incident and complaints data, triangulating the associated data can be used to ensure learning takes place from the themes identified.

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 4 2024 – 2025.

- Delay in clinical assessment.
- Communication

Ongoing quality improvement work is in progress to address the themes highlighted.

5. Summary

This report provides assurance of the ongoing monitoring of the relevant CNST action plans within the year 7 scheme and of defined key performance safety metrics relating to the perinatal quality surveillance model.

6. Recommendations

It is recommended that the Board of Directors:

I. Receive the contents of the report.
II. Approve the action plans detailed within this report.
III. Approve the sharing of this report within the local maternity and neonatal system and at the regional level quality surveillance meeting, with subsequent submissions to committees as required.

Appendix 1 – Perinatal mortality review tool cases as from 1 December 2024

Case ID no	SB/NND/ TOP/LATE FETAL LOSS	Notify within 7 working days	Gestation	DOB/ Death	PMRT Started 2 Months Deadline Date	Date parents informed/concerns questions	External Member present at review panel	Report published within 6 months
96354	SB	1	24+4	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96351	NND	1	29+1	04.12.2024	04.02.2025	04.12.2024	**External support 17.04.2025**	04.06.2025
96412	SB	1	33+1	09.12.2024	09.02.2025	10.12.2024	**External Support 15.05.2025**	09.06.2025
96482	LFL	3	22-23	13.12.2024	13.02.2025	16.01.2025	**External Support 15.05.2025**	13.06.2025
96621	LFL	1	22+3	26.12.2024	26.02.2025	26.12.2024	**External Support 29.05.2025**	26.06.2025
96707	SB	1	38+5	31.12.2024	31.02.2025	31.12.2024	**External Support 13.03.2025**	31.06.2025
96723	SB	0	24+3	03.01.2025	03.03.2025	03.01.2025	**External Support 22.05.2025**	03.07.2025
96783	SB	1	37+1	06.01.2025	06.03.2025	07.01.2025	External Was Arranged Did not attend	06.07.2025
96865	SB	0	31+4	11.01.2025	11.03.2025	13.01.2025	**External Support 22.05.2025**	11.07.2025
96927	NND	1	27+	15.01.2025 AN care at Preston	15.03.2025	16.01.2025	**External Support 29.05.2025**	15.07.2025
97050	SB	0	35+4	24.01.2025	24.05.2025	24.01.2025	**External Support 08.05.2025**	24.07.2025
97091	ENND	0	22+6	25.01.2025	25.05.2025	25.01.2025	**External Support 08.05.2025**	25.07.2025
97179	ENND	1	22+2	31.01.2025	31.05.2025	31.01.2025	**External Support 12.06.2025**	31.07.2025

97164	ENND	0	32+3	02.02.2025	02.06.2025	02.02.2025	Arranged For 10.07.2025	02.08.2025
97466	NND	0	35.2	24.02.2025	24.04.2025	24.02.2025	**External Support 10.06.2025**	24.08.2025
97729	SB	1	24+3	12.03.2025	12.05.2025	13.03.2025	TBC	12.09.2025
97757	SB	1	38+5	13.03.2025	13.05.2025	13.03.2025	Arranged For 10.07.2025	13.09.2025
97832	NND	1	28	18.03.2025	18.05.2025	19.03.2025	Arranged For 31.07.2025	18.09.2025
97882	NND	0	23	23.03.2025	23.05.2025	27.03.2025	Arranged For 31.07.2025	23.09.2025
98014	NND	1	23	01.04.2025	01.06.2025	02.04.2025	Arranged For 19.06.2025	01.10.2025
98019	NND	0	36+2	02.04.2025	02.06.2025	02.04.2025	TBC 14.08.2025	02.10.2025
98062	SB	1	40+4	04.04.2025	04.06.2025	04.04.2025	TBC 21.08.2025	04.10.2025
98164	SB	1	34+0	14.04.2025	15.06.2025	14.04.2025	TBC 04.09.2025	15.10.2025
98259	LFL	1	22+1	18.04.2025	18.06.2025	19.04.2025	TBC 11.09.2025	18.10.2025
98238	LFL	2	22+6	19.04.2025	19.06.2025	21.04.2025	TBC 11.09.2025	19.10.2025
98346	SB	3	39+6	25.04.2025	25.06.2025	28.04.2025	TBC 18.09.2025	25.10.2025
98847	NND	1	22+2	03.06.2025	03.08.2025	03.06.2025	TBC 06.11.2025	03.12.2025
98956	SB	0	24+6	11.06.2025	11.08.2025	11.06.2025	TBC Burnley	11.12.2025

Appendix 1a – Ongoing themes actions highlighted in completed reviews relevant to the deaths reviewed

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	Antenatal booking appointment to be completed within recommended timeframe	Trudy Delves	01/10/2024	08.10.24 Ongoing Improvement Plan for Maternity Bookings in place. Self-referral booking process progressing with digital support. Monitoring of compliance undertaken monthly via IPM pack of 10+0 and 12+6 pathways.	3
2.	Inclusion in the ASAP national programme to promote early booking	Trudy Delves	01/10/2024	17.12.24 Link made with lead from national ASAP programme and initial draft communications shared.	4
3.	CO monitoring to be undertaken at each appointment	Trudy Delves	01/10/2024	08.10.24 CO monitors in clinics and all areas. Maternity Tobacco Dependency Midwife allocated training time	4

				on new SBLV3 training day agenda. 22.11.24 Ongoing audit of compliance continued in accordance with CNST guidance	
4.	Domestic Abuse question to be asked at booking appointment	Trudy Delves / Jayne Maguire	01/12/2024	08.10.24 Undertake audit of compliance and identify actions to be undertaken in response. 20.02.24 Audit awaited 17.06.25 Audit completed by Named Midwife for safeguarding	**3**
5.	Triage BSOT assessment to be undertaken with evidence of audit	Emma Jones	01/10/2024	08.10.24 BSOTS action plan and review of triage in progress. 30.08.24 BSOTs audit ongoing as per clinical audit schedule to monitor delays in assessment and actions as appropriate.	**4**
6.	Syntometrine given to a patient with hypertension. Contraindicated in the management of blood pressure.	Kathryn Bolton	30.12.2025	To share in huddle that patients who are hypertensive, unless contraindicated with ongoing bleeding then oxytocin should have been the first point of active management. Information shared in huddle week commencing 30.12.2024. Huddle	**4**

				attached to the incident.	
7.	Sepsis 6 pathway to be followed	Lizzy Dean/Emma Jones	01/3/2025	08.10.24 National MEOWS in process of being implemented as a formal project. 1.11.24 E-learning implementation offered to all staff and added to ESR learning package 26.02.24 National MEWS launch in service 17.06.25 Audits of compliance ongoing.	**3**
8. 5	Targeted offer for multigravida families in highest risk areas to be considered using REACH pregnancy circles service.	Trudy Delves	01/03/2025	18.12.24 REACH pregnancy circle training commenced. 20.02.24 REACH circles to areas of high deprivation to be piloted. 24.04.25 First circle due to commence in June 2025	**3**
9.	No bereavement care since death of baby			03.01.25 Review of funding for counselling offer for bereaved families completed. Funding secured for an external service to provide this offer.	**4**
10.	Book ANDU appointment at point of discharge			All Ward Clerk staff on CDS advised and trained to offer appts at the point of discharge	**4**

				from Triage rather than advise woman to call to make subsequent apt.	
11.	Glucose Tolerance testing clinic to be delivered in accordance with national standards	Debra Smith	31.05.25	16.6.25 GTT clinic reinstated.	**3**
12.	Lack of clarity within the regional guideline as to the starting gestation of which SFH should commence from. For those on a low risk pathway	Lauren Goddard	31.03.2025	Trust SBL lead has already highlighted this issue at a Regional Meeting, this has been addressed in the updated version of this guideline which is due to be ratified by March. Ongoing audit of SFH compliance from 26 weeks is carried out quarterly with 100% compliance on the recent audit. SBL lead to feedback to individual's line manager who saw patient at 26 weeks gestation. 12/3/25 Confirmation received from GMEC LMNS at SBL Champions meeting on 11/03/25 that publication of latest version of the FGR guideline (with amended wording re when to commence SFH measurement from) is expected by 31st March. Draft version of this guideline and email from DOM added to attachments. Action of informing regional guideline author of	**4**

				confusion rewording in previous version completed via FGR regional forum meetings. On-going audit of SFH compliance monitored via SBL assurance process 100% compliance achieved and maintained. Q2 & 3 2024 audits added to attachments. Audits shared via audit meeting and also in FGR face to face training on Mandatory Training Day 4 (Saving Babies Lives) Ongoing audit of SFH compliance monitored via SBL assurance process. 100% compliance achieved and maintained. Q2 & 3 2024 audits added to attachments. Audits shared via audit meeting and also in FGR face to face training on Mandatory Training Day 4 (Saving Babies Lives) Email sent to team leader on 11/03/25 so that directed feedback can be provided to midwife involved. Added to attachments	
13.	This mother only had partial investigations for underlying metabolic and/or haematological abnormalities as	Seema Kala		The checklist for postnatal bloods are in every grab bag with a signature checklist. This was updated in December 2024.	**4**

	per the local guideline.			Continuing monitoring of postnatal blood tests are being reviewed through the PMRT review tool.	
14.	Postnatal Blood tests not performed	Kathryn Bolton and Seema Kala	01.12.2024	Update in CDS weekly staff huddle shared on the 11.11.2024. Checklist for postnatal bloods in every bereavement care pack. Continuing monitoring of postnatal blood tests are being reviewed through the PMRT review tool.	**4**
15.	Progress in labour not recorded on partogram	Seema Kala	31.07.2025	AMP to include in QI snapshot learning back to basics. Bereavement midwives to include this on study day.	**2**
16.	Delay in diagnosis of pre-eclampsia due to not obtaining PlGF	Sara Luke	31.08.2025	Learning visual slide to be created for pre-eclampsia, in particular, what tests to be taken and when. Visual learning slide created (see evidence attached) and confirmed with consultant JB that information correct (all information obtained from policies). Learning Slide, policies and PlGF appendix sent via email (see evidence attached) to all ward managers and matrons to disseminate with teams. Laminated copies put in all antenatal areas: G3, CDS, Triage and ANDU	**4**

17.	Incorrect risk assessment at booking due to unclear category of abdominal surgery.	30.09.2025	Elizabeth Dean	Antenatal guideline needs to be reviewed by policy owner and obstetric team. Policy states referral needs to be made for abdominal surgery, this needs clarification, amendment and ratification. Dissemination to the obstetric and midwifery team needs to be complete upon ratification.	**2**

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3-6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Appendix 2 – Transitional care – 34+4 action plan with updates.

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Transitional Care Lead	1.1 Appoint a Transitional Care Lead	Complex Care Matron	January 2024	**03.10.2023** Transitional care lead appointed – awaiting start date. **29.01.2024** TC lead commenced post.	
2	Workforce Funding	2.1 Seek additional funding for staffing to ensure 24/7 cover, with BAPM guidance of TC staffing ratio being at least 1:4	Director of Midwifery / Operational Business Manager	July 2025	**03.10.2023** Business case to be submitted to seek additional funding to expand the care provision to 24/7 for preterm infants. **21.06.2024** Business case to uplift to BR+ standards awaiting approval for	

					midwifery staffing. **03.10.2024** Birth rate plus staffing model approved for midwifery staffing uplift. **08.10.2024** Meeting arranged with HOM to discuss TC staffing model, staffing model will include x6, Band 6 neonatal nurses/midwives, to cover a 24/7 service in line with BAPM guidance of infant to TC nurse being a ratio of 1:4. The Model of care will provide TC service provision to any infant who meets the criteria for TC within any area of intrapartum care. **04.04.2025** Meeting with ADMD and Matron for complex care to discuss staffing model. Advised to prepare a TC staff job description and person specification. 17.06.25 Draft business case collated awaiting review.	

3	Provision of service	3.1 Confirm location of TC service to be provided	Director of Midwifery / Lead NNU Consultant	March 2025	**06.11.2024** HOM confirmed TC infants will receive service within the new remodel of intrapartum services, with 4 beds being allocated for the most vulnerable of TC infants and all other TC infants will be allocated alternative beds within intrapartum services. NNU Lead consultant discussed with HOM SCBU cots availability, for TC service provisions. **27.01.2025** Divisional Director of Operations shared an update of the redevelopment plans, TC cots allocated within the 1st floor plans and opposite the neonatal resus room.	
		3.2 Audit available equipment for TC service	TC Lead	August 2025	**24.04.2025** TC Lead will audit all equipment when completing the quarterly Aquatherm SOP audit.	

4	Training	4.1 Ensure maternity staff are appropriately trained to provide safe and effective care to neonates from 34-weeks gestation	TC Lead	July 2025	**03.10.2023** Training plan to be developed to include a training passport. **08.10.2024** Confirmed with complex care matron all maternity staff have completed the NHS England ATAIN e-learning module as a one-off training. **03.12.2024** Complex care matron met with NNU ANNP to discuss training package required. **15.01.2025** TC Lead met with NNU ANNP and training package for staff has been started, to share with NNU TC consultant and start training April 2025. **24.04.2025** Awaiting confirmation from NNU consultant, that the training materials cover	

					sufficient content. Meeting arranged with NNU ANNP 24.04.2025 to discuss if training can commence.	
		4.2 Design a TC pathway for infants who require naso-gastric feeds and all maternity staff to complete a training package	NNU Consultant, NNU ANNP, TC Lead	July 2025	**10.06.2024** Staff competencies for NG feeding designed. **03.10.2024** Guideline completed, however awaiting plans for model of care to be confirmed prior to dissemination and approval with consultant team. **08.10.2024** Met with NNU Consultant who is supporting TC service development to discuss infant criteria. TC Lead to design a guideline. ANNP supporting TC development to design training package for maternity staff. **03.12.2024** TC Lead completed NGT guideline and to be shared with NNU ANNP and	

					confirmation of which infants will be identified to meet the criteria for TC NGT pathway. **15.01.2025** TC Lead met with NNU ANNP, criteria for guideline agreed, and guideline final to be shared with NNU TC consultant. **24.04.2025** Awaiting date to discuss final draft with NNU Consultant, then a robust training plan will be created, to safely train the maternity staff.	
		4.3 Introduce the Aquatherm heated mattresses to be used within intrapartum areas to support thermoregulation and all maternity staff to sign an equipment competency after training	TC Lead	June 2025	**24.10.2024** Delivery to the trust of 8 Aquatherm heated mattresses**.** **07.11.2024** Aquatherm SOP sent to NNU Consultant and NNU ANNP for comments. **28.11.2024** Aquatherm SOP sent to Matron for	

					complex care and intrapartum care ward managers for comments. **23.01.2025** TC Lead presented SOP at Maternity PDOC meeting. **10.02.2025** TC Lead sent updated SOP to be added to the Maternity Speciality Governance meeting 26.02.2025 for ratification. **24.04.2025** SOP now added to BOB, staff training to safely use the equipment is ongoing and launch planned for May 2025.	
5	Clinical Governance	5.1 Ensure accessible and evidence-based guidance to underpin clinical practice and a robust audit cycle	TC Lead	Quarterly	**02.05.2024** Q4 2024 TC SOP audit designed and completed. **19.08.2024** Q1 2024 TC SOP sent to HOM, with 100% compliance reported. **07.11.2024** Q2 2024 TC SOP sent to HOM, with 100% compliance reported.	

					10.02.2025 Q3 2024 TC SOP sent to HOM, with 100% compliance reported.	
		5.2 Audit NNU local service activity of 34-weeks gestation infants in Q1 and Q2 2024 admitted to NNU, to benchmark the care requirements for this group of infants.	TC Lead	May 2025	**02.12.2024** Audit data collected with an audit population of babies born between 34+0 weeks and 34+6 weeks that was admitted to NNU and recorded on BadgerNet. **12.12.2024** Audit data analysed and to be formatted into a report to share with HOM, Complex care Matron and NNU consultants. **24.04.2025** TC Lead to meet with NNU ANNP to discuss data, in relation to staff teaching for 34 weeks gestation TC pathway.	
6	Service user experience	6.1 Link with Maternity & Neonatal Voice's Partnership (MNVP) for any service user feedback for 34-weeks gestation experiences, to	TC Lead	May 2025	**29.11.2024** TC Lead contacted Bolton MNVP to request feedback of families experience with babies born at 34 weeks' gestation.	

		refine the care model that can be provided within TC			**19.12.2024** Bolton MNVP provided feedback of three families that agreed to be contacted for an informal survey. **01.04.2025** TC Lead reached out to families for feedback and will be presented with audit report for creating the TC pathway.	
		6.2 Review resources available on BAPM, ODN network and design a parental leaflet for TC service	TC Lead, Matron for complex care	August 2025	**10.01.2025** Discussed with matron for complex care, the idea of adding TC service information to PADLET **21.01.2025** Requested sharing of other trust resources used for TC leaflet, at TC LMNS meeting. **24.04.2025** LMNS confirmed there are no generalised TC leaflets being used, TC Lead will gather feedback form service users and design a trust TC leaflet.	

Appendix 3 – Trust scorecard Q4 2024/2025

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NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q4 2024-2025

Claims Scorecard April 2013 – March 2023

Top 5 injuries by volume for obstetrics	Top 5 injuries by value for obstetrics
Injury 1 Unnecessary Pain 2 Stillborn 3 Fatality 4 Admit/Unnecessary Operation(s) 5 Cerebral Palsy	Injury 1 Cerebral Palsy 2 Brain Damage 3 Hypoxia 4 Wrongful Birth 5 Deafness
Top 5 causes by volume for Obstetrics	Top 5 causes by value for Obstetrics
Causes 1 Failure/Delay Diagnosis 2 Fail to Recog. complication of 3 Fail / Delay Treatment 4 Fail To Make Resp To Abnrm FHR 5 Inappropriate treatment	Causes 1 Fail To Make Resp To Abnrm FHR 2 Fail To Interpret Uss 3 Fail Antenatal Screening 4 Fail / Delay Treatment 5 Failure/Delay Diagnosis

Themes from complaints Q4

Complaints have been divided into informal and formal complaints and themes have been outlined below.

- Decisions about clinical treatment
- Ineffective communication

Incident themes: Cause Group 1

570 incidents were reported within the maternity speciality throughout Q4 2024,25, and of those, none had a final impact of a category 3, 4 or 5 level harm. All incidents have been mitigated prior to closure in keeping with Trust incident management policies.

Incident Cause group 1	Number of incidents
NNU - Unexpected Admission	89
Postnatal haemorrhage	32
Fetal growth restriction	31
Communication failure	26
Failure to follow procedure	21

Triangulation of learning Q4

The following themes were identified following triangulation of the maternity incidents and complaints for quarter 4 2024 – 2025.

- Delay in clinical assessment.
- Communication

Ref	Key actions	Lead Officer	Deadline	Progress Update	Status
Reduce unexpected admissions to Neonatal Unit for hypothermia and delayed feeding by 20%.	To focus on the term infant transitioning in the "Golden hour" after birth.	Sara Luke	September 2025	04.11.2024 QI project commenced.	
Increase staff ability to recognise deterioration of unwell women	Introduce National MEWS Tool.	Vicky Hamilton	March 2025	18.10.2024 Project commenced. Joint working with ED department to improve care for women attending there. Added to ESR for mandatory training.	

Appendix 4 – Staff and patient feedback from the safety walk rounds.

You Said	We did
May 2024 Lack of bed capacity remains an ongoing concern for staff.	Staff briefed on the submission of the RAAC business case to NHS England and the interim actions taken to reduce the ongoing pressure such as the provision of an extra doctor at weekends and a NIPE Midwife to support activity. Options appraisal in progress to consider short to medium term actions to be taken until all works completed.
Battery pack needed in baby resuscitation units to ensure heating can be provided during transfer to other areas.	Giraffe unit being procured
July 2024 Additional ward equipment required	Request made for additional equipment to be provided namely: - CTG machines on G3 - Additional computer G4 - Medicine trolley for G4 - Examination of the newborn equipment.
September 2024 Room for telephone Triage awaited	Estates request approved for sink removal in consultant room Work commenced – October 2024
Staff not aware of progress of RAAC works	Engagement sessions scheduled to promote staff and service user engagement.
Midwifery staffing	Professional judgement review of all clinical areas undertaken and staff will be realigned to the new allocations Staffing consultation process due to commence early in 2025.
November 2024 Trolley needed with rails to support the safe transfer of patients to CDS when required	Trolley provided

January 2025 Antenatal QR code used to collect patient feedback needs updating. Posters to be relocated in cubicle areas with ANDU	Communication team contacted to refresh QR survey offer Posters to be relocated by ward lead.
April 2025 Focus on walk around was on culture of staff	Informal feedback received on day of visit Staff survey feedback received in Division and shared in engagement sessions Speciality action plan being developed in response
May 2025 Hot cot implementation Maternity Triage	Training in use of hot cots continues – implementation delayed until June 2025 Lack of capacity remains an issue – options appraisal to be submitted re sourcing additional space

Appendix 5 - Cultural improvement plan developed to align with the Family Care Division Staff Survey Plan

Theme	Observation	Actions
Capacity and resource	**Burnout is seen as high post Covid.** Majority of staff resonate with high burnout climate, some saw it an issues for senior staff	• **Actively promote resources such as Vivup, Occupational Health, GM Resilience Hub.** • **Take time to check in with colleagues and focus on wellbeing and health** • **Ensure timely referrals and sign posting to support wellbeing** • **Encourage breaks and hydration** • **Encourage self-care and boundaries between work and personal time** • **Encourage staff to engage in activities that recharge them Continue to roll out team engagement days and activities to encourage positivity and teambuilding in the workplace**
	Lack of resources, staffing and duplication in process impacting on burnout. Most staff felt that there were insufficient resources and staffing with appropriate systems and process that required duplication of effort	• **Full staffing review of the service, now recruited to staffing deficit.** • **Further funds to be sought to actively recruit into maternity leave.** • **Staffing updates to be feedback to the team so they are aware of staffing plans and feel included.** • **To continue with ongoing recruitment to support turnover and improve skill mix. Staff to be encouraged to support the recruitment process to allow them exposure and involvement in making improvements and strengthening the team.** • **Management team to remain visible.** • **Ensure staff are utilising annual leave appropriately to support rest and recuperation.** • **Encourage staff to access unit psychology support (once in post)**
	Work life balance and burn out. Some staff feel this was compounded by issues outside work, e.g. cost of living	• **Ongoing reviews of processes to avoid duplication of workload** • **Timely occupational health referral's and reasonable adjustments put in place if necessary.**

		• **Ensure staff are utilising annual leave appropriately to support rest and recuperation.** • **Encourage staff to access unit psychology support (once in post)** • **Continue to ensure team members access FABB conversations and have an open-door policy.**
	Support to staffing in training / preceptorship and review skill mix.	• **Training gaps to be identified- to support staff** • **To continue to provide educational support and training to support staff to time manage and review resources which may avoid duplication, and labour intensive measures**
	Perception of a lack of space for rest breaks. A number of staff commented on the physical estate and the lack of space for rest breaks.	• **Support timely meal breaks in clinical areas.**

Theme	**Observation**	**Actions**
Collaboration within teams	**Positive team working in community.** Some staff commented positively on elements of team working in community.	• **Daily huddle format updated to incorporate staff daily health and wellbeing concerns.**
	Communication breakdown are often drive by trust system and process. Some staff report that breakdown in communication were exhibited by sub-optimal systems and process	• **Encourage staff to speak out and vocalise the need for support if they feel pressure which may compromise the care they provide and / or their wellbeing.** • **review workloads and allocation on a shift by shift basis**
Leadership & learning	**Visibility of the leadership team**. Some staff would welcome the opportunity for more visibility	• **Encourage staff to engage in Family care connect sessions to share any issues or any concerns.** • **Management team to remain visible and accessible to all.** • **Fortnightly walk rounds**

	Positive local line management. Staff felt the community line manager was positive and supportive	• **Continue to ensure team members access FABB conversations and have an open-door policy.** • **Daily check in with staff at safety huddles.** • **To continue to share FCD good news with all staff** • **To improve feedback mechanisms and encourage current measures** • **To encourage staff to attend IPM, CLIP and specialist locality meetings where possible and be involved.** • **Encourage open and honest feedback** • **Invest in development – sharing information about upcoming courses, study days etc.** • **Take the time to say Thank You**
	Opportunity for learning and feedback. Some staff felt this needed to be prioritised, as t had fallen off during the pandemic.	• **Continue to champion FTSU guardians as a point of contact for raising concerns.**

Report Title:	People Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief People Officer		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work delegated to the People Committee.

Previously considered by:	The matters included in the Chair's report were discussed and agreed at the People Committee meeting held on 15 July 2025.

Executive Summary	This report provides a summary of the key matters discussed and assurances received by the People Committee in relation to workforce strategy, operational delivery, and organisational development. The Committee considered a range of reports, including updates on job planning, workforce transformation, and the Integrated Facilities Management (IFM) monthly people report. Assurance was also received from the Divisional People Committees and Steering Groups with particular attention given to workforce resourcing trends, retention strategies, and equality, diversity, and inclusion initiatives. There are no Alerts that require the attention of the Board of Directors.

Proposed Resolution	The Board of Directors is asked to ***receive*** the People Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	An optimal workforce is key to the delivery of our financial plan.
Legal/ Regulatory	Yes	Adherence to employment legislation is a key responsibility for our organisation.
Health Inequalities	Yes	Ensuring our workforce is representative of the population we serve and free from discrimination is critical to equal patient care.
Equality, Diversity and Inclusion	Yes	Ensuring everyone in our organisation has equal opportunities, regardless of their abilities, their background or their lifestyle is critical to good patient care. As a diverse organisation we appreciate the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Prepared by:	Sean Harriss, Non-Executive Director	Presented by:	Sean Harriss, Non-Executive Director

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee	People Committee	**Reports to:**	Board of Directors
Date of Meeting:	15 July 2025	**Date of next meeting:**	16 September 2025
Chair	Sean Harriss	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- **Board Assurance Framework**
- **Resource and Retention Update**
- **OD, Leadership and EDI Update**
- **Job Planning Update**
- **Locality Workforce Transformation**
- **IFM Monthly People Report**
- **Steering Group Chair Reports**
- **Divisional People Committee Chairs reports**

ALERT

Agenda Items	Action Required

ADVISE

Board Assurance Framework

The Director of Corporate Governance presented the latest presentation of the BAF which had been reviewed by the Chief People Officer, and updated to reflect the new Trust Strategy and was based on ambition 2, to be a great place to work. The Committee received and discussed the content and in particular the controls and assurances in place to achieve the Ambition.

Resource and Retention Update

- The WTE had seen an increase in trend since November 2024. June 2025 did reduce but the Trust was still over plan.
- Bank reduced by 18 in May 2025 but remained over plan.. Agency was a more positive picture.
- Further discussions would take place at the Financial Improvement Group and Executive Directors on 18 July 2025 regarding potentially revising the workforce plan in order to meet the financial challenges facing the organisation.

ASSURE

OD, Leadership and EDI Update

This item would be discussed at the Board of Directors therefore a full narrative was not included. Of note the work taking place was fully debated and endorsed by the People Committee.

Job Planning Update

NHSE expected 95% of medical staff to have a job plan signed off in the preceding 12 months by October 2025. 66% of the medical workforce meet that standard. 23% of job plans were currently sitting in the sign off process and therefore could be rapidly progressed to being approved. Work was being undertaken within departments and divisions to progress all other plans to completion.

Locality Workforce Transformation

The Assistant Director of Organisational Development provided an update on the Locality workforce group, known as the People and Culture Group. Three key priorities identified; locality workforce data, leadership,

culture. It was noted that the work taking place was helpful and remained critical to achieving the Bolton locality focus.

- **IFM Monthly People Report**

The Committee received the iFM update which noted performance agasint many workforce metrics. Members noted that the sickness rate continued to reduce and was 5.38%. The iFM staff survey would run in parralled with the Trust Staff Survey in quarter 3.

Steering Group Chair's Reports

Medical Education Board Chairs report June - In relation to patient safety concerns highlighted via the GMC free test feedback, the Trust's Medical Director had reviewed them and changes had been made.

Divisional People Committee Chairs' reports

AACD Chairs report June - Further to a rise in sexual misconduct cases being highlighted in AACD, these had been addressed formally through HR. The Trust had signed up to the Sexual Charter and a new policy was ready to be signed off.

New Risks identified at the meeting: None identified**.**

Review of the Risk Register: None

Meeting Attendance 2025/26						
Members	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**March**
Sean Harriss (Chair)	✓	✓				
Alan Stuttard	✓	✓				
Annette Walker	✓	✓				
Fiona Taylor	✓	✓				
Francis Andrews	✓	✓				
James Mawrey	✓	✓				
Rebecca Ganz	✓	**A**				
Seth Crofts	✓	✓				
Sharon Katema	✓	✓				
Sharon White	✓	✓				
Tyrone Roberts	✓	**A**				
✓ = In attendance A = Apologies						

Report Title:	Leadership and Culture Update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Chief People Officer		Decision	

Purpose of the report	To report will provide an update to Board on Organisational Development and culture, with a particular focus on supporting the Trust through organisational change

Previously considered by:	People Committee.

Executive Summary	The report sets out themes, evaluation and next steps on the Our Leaders Development Programme, including a participant story. It proposes the following key messages: • We recognise the importance of supporting the people side of organisational change, alongside maintaining ongoing cultural improvement work and have set out our offer to the Trust • Equality Impact Assessments play a vital role in supporting change • The Our Leaders Development Programme is being received well and is gaining momentum • More attendance from B7+ leaders and managers is needed on Our Leaders Programme if we are to achieve our overall target by end 2026

Proposed Resolution	The Board of Directors are asked to ***receive*** the Our Leaders Programme and Culture Update and note the People Committee will oversee all relevant actions on behalf of the Board.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**YES**	The Workforce & OD offer to support organisational change well will be a key resource to support effective implementation of our Financial Improvement Plan
Legal/ Regulatory		
Health Inequalities	**YES**	The requirement to complete Equality Impact Assessments for change programmes will support the Trust to address health inequalities
Equality, Diversity and Inclusion	**YES**	EDI is intrinsic to our cultural improvement work and the Our Leaders Programme includes a 'We all Belong' section

Prepared by:	Sarah Richard, Head of People Development Lisa Rigby, Assistant Director Organisational Development	**Presented by:**	James Mawrey, Chief People Officer

1. Introduction

The People Committee received the Culture and Leadership Update. A full and detailed discussion took place around the internal offer to support the Trust through change and progress on the Our Leaders Programme.

Board members will be aware that supporting staff through change and supporting leaders, linked to wider culture improvement remains a critical priority for Bolton Foundation Trust and is a key ingredient of the Trust Strategy, People Plan and NHS People Promise.

2. People Committee discussions and actions

The Committee of the Board expressed their appreciation for the comprehensive presentation and noted the following points during their discussion:

- The introduction of a simple 360 development tool linked to Our Way was welcomed. The tool is currently in the pilot stage and is due to launch in September.
- Committee members provided positive feedback on the Our Leaders Programme
- The Committee acknowledged the action to encourage B7 and above colleagues to attend Our Leaders and discussed a number of options to improve this.
- The Committee suggested it would be helpful to include percentages of attendance by band for future updates.
- The RESET Programme proposal for divisional, corporate and IFM leadership teams was received positively, particularly the devolving of activity to all staff at all levels to embed Our Way.
- A consistent change model was suggested – OD to work with QI Team to develop a simple model and link to Our Voice Change Programme.

3. Recommendation to the Board of Directors

The Board of Directors is asked to note the details of this paper and note that the People Committee will continue to oversee all relevant actions.

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OD Update
Supporting Change

Improving care,
transforming lives...for a better Bolton

Current Context of Organisational Change

External Drivers for Change

- Financial sustainability, reducing running costs and meeting savings specified by GM ICB
- Delivery of national targets, maintaining quality for patients and achieving the GM ICP Strategy
- Responding to changes through NHS England
- Engaging with the new Model ICB Blueprint to reshape the strategic role of ICBs
- Realising the ambitions of the 10 Year Health Plan through three strategic shifts:
  - Treatment to prevention
  - Hospital to community
  - Analogue to digital

Our multiple, large-scale internal change programmes, examples below

Divisional Reconfiguration
Transition to four Divisions, resulting in changes to services, teams and individuals

MARS Scheme
Changing the experience, skills and talent mix across our internal workforce

Admin Modernisation Programme
Leading to different ways of working, through digital changes and standardisation

Trust Wide Service Improvements
Continually improving quality and equity for patients/service users and reducing costs

Culture we Aspire To

Agile and flexible, adaptable to challenges

Collaborative leadership and accountability for achieving results



Open, transparent and feedback through regular check-ins

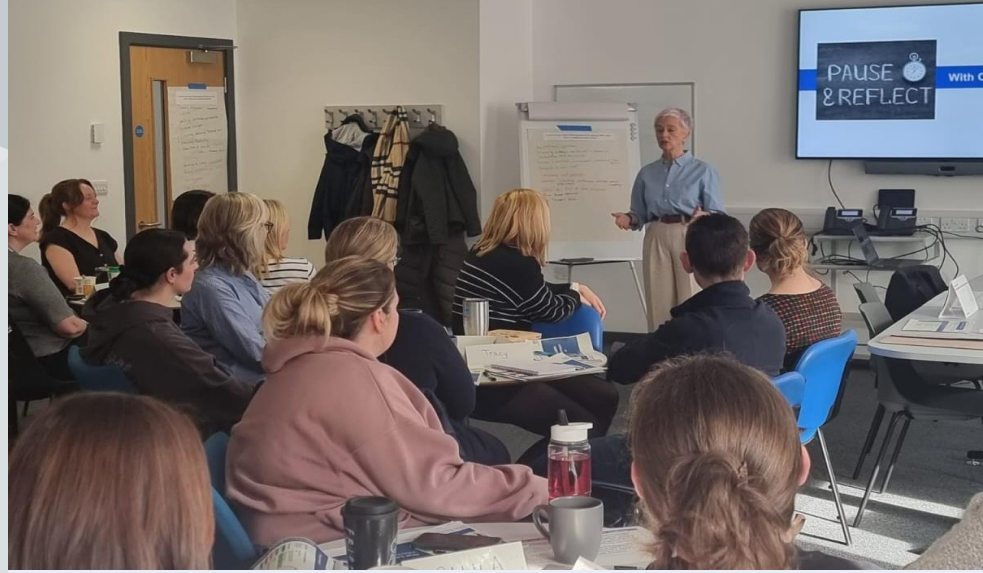
Involved and empowered to make changes

A pro-active and preventative approach

Person-centred and compassionate, with a focus on support and well-being

A psychologically safe and just learning environment

Collective responsibility for challenging behaviours



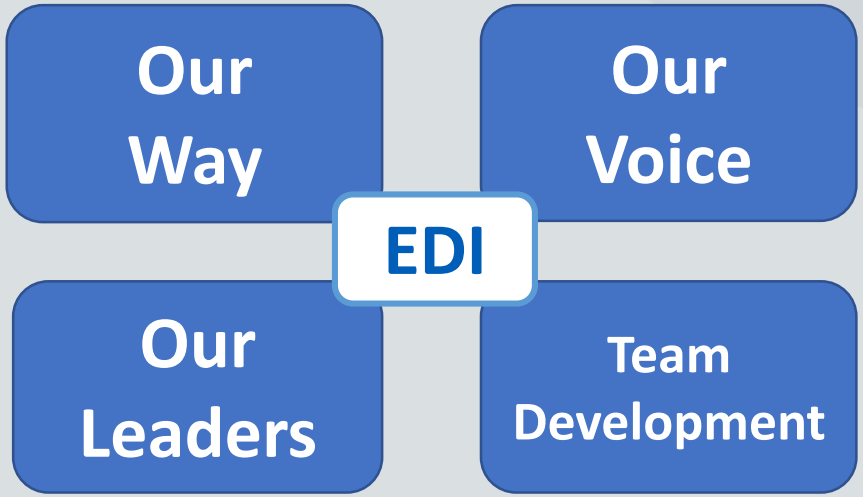
Most popular themes in the questions asked to our Executive Team on Our Leaders…

- Financial pressures, national context and resource constraints
- Organisational divisional change and communication
- Team morale with operational challenges
- Leadership visibility and leadership behaviours
- Personal leadership career journey
- Work life balance, resilience and relaxation
- Biggest challenges in your career
- Opportunities for staff development and career progression

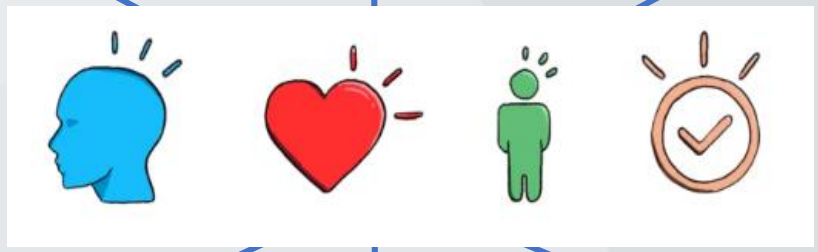
Leading Our People through Change

Being successful in leading large-scale organisational change depends on how we focus on our people and culture:

- Actively retaining staff and maintaining levels of satisfaction, ensuring well-being support for change
- Guiding and designing the people side of change through supporting leaders and managers at every level
- Focusing change on sustainability of both services (patients/service users) and culture (staff), using this as a chance to ‘reset’ to ensure readiness both now and in the future
- Paying attention to maintaining organisational trust, sustaining the momentum of ongoing culture improvement programmes



Workforce, HR & OD Supporting Change



Occupational Health & Wellbeing

OD

ESR Workforce

Employment Services

HR

Workforce Deployment

Our cohesive offer includes:

- ✓ RESET programme of events with associated tools and resources
- ✓ Supporting Trust wide comms to 'tell the full story' of organisational change
- ✓ Managing Change Well sessions and Blended Learning Bundle
- ✓ Supporting staff engagement
- ✓ Promotion of our well-being offer
- ✓ Updating staff data on systems to reflect changes to Divisions
- ✓ Processing contractual changes
- ✓ Regular reporting of workforce and culture data

RESET Programme

RESET EVENTS

7 x half-day events facilitated by OD & HRBPs:

- Exec & TMC (AUG)
- 4 x Divisions (SEP)
- Corporate (OCT)
- iFM (OCT)

Events will follow the same format and content, led by the first top-level event.

RESET CASCADE

OD will provide tools, resources and activities to support leaders to engage with staff in their teams at a local level, cascading the same principles from the RESET events.

Divisions will decide how to use the tools, resources and activities, and manage the cascade in the best way that works for each service/team.

CONTENT & FOCUS

- Consistency in the guiding principles in which we all work
- Direction of where we are heading and how our target operating models align with our strategic direction
- Shaping an inclusive culture through our programmes and activities
- Consistency in our approach to managing change well
- Operational considerations (communication, governance, KPIs, staffing, retention, skills and talent)

Why is RESET important?

- Is critical in supporting leaders across the Trust to embed and embrace change
- Provides structure to address the key elements for moving forward
- Involves staff in shaping the future, refocusing/reenergising as a united team

The RESET events will:

- ✓ Provide clarity and refocus on the key elements of working at Bolton FT that we have all committed to
- ✓ Engage with staff to decide how we will address continued challenges together
- ✓ Co-create purpose, brand and identity for each Division and services within
- ✓ Set the direction and priorities ahead
- ✓ Provide a safe space to explore emotional impact, rebuild team and collaboration
- ✓ Clarify expectations and mindsets
- ✓ Outcome of a set of collective commitments per Division/Service

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NHS Bolton NHS Foundation Trust

Leadership Development Update



Improving care, transforming lives...for a better Bolton

Our Leaders 2-Day Event

332
Attended

74% B5-7
22% B8a+
6% B8b+

Key points from the attendance data:

- Attendance is higher amongst our middle managers and lower amongst our senior managers
- More attendance of our Band 7+ target group is needed to achieve overall 1500 target by end 2026 (currently 171 have attended from the target group)
- Whilst we have a further 333 booked on, we are averaging a 20% DNA rate so we need to sustain momentum
- We are attracting our BAME leaders and managers to attend (50 attended, 15% of all attendees)
- The 2-day event has been extended to all iFM leaders and managers, and across our locality (25 places for ICB and VCSE)
- Quarterly attendance reports for Divisions and Directorates are in place for them to monitor and follow up attendance

Embedding Learning to Improve Culture

- ✓ 173 people have accessed ‘Blended Learning Bundles’ on culture and L&M topics, available for everyone
- ✓ 28 people have attended ‘Lunch and Learn’ sessions
- ✓ Refreshed guidance and training for FABB conversations/annual appraisals are live for everyone
- ✓ An Our Leaders 360 feedback tool is in development, based on the Our Leaders core leader responsibilities
- ✓ We are aligned with the emerging NHSE L&M standards



Where we are focusing our efforts next…

- Encouraging attendance amongst the target group of leaders/managers (B7+)
- Promotion of the blended learning bundles and ‘lunch and learn’ sessions
- Rolling out ‘Managing Change Well’ blended learning bundle and sessions to support with the reconfiguration of Divisions
- Promotion Our Leaders to medical leaders, within a broader medical leadership development package
- Operational rollout of the Our Leaders 360 feedback tool
- Encouraging more returns of the 3-month evaluation survey
- Expanding our range of case studies to celebrate the impact on individuals and teams

Leaders and Managers have told us what they value the most from the programme….

- The impact of modelling vulnerability and creating psychological safety, for a supportive and open team environment
- Increased awareness of privilege, cultural difference and the importance of inclusivity
- Tools and methods to implement positive changes, with QI praised for being practical and engaging
- Connecting and networking with peers from different teams, sharing and learning from different experiences
- The sense of a growing 'leader' community providing support and inspiration in carrying out my role
- Opportunity to have open and honest conversations with our Executive Team

"We all struggle as a leader at times and it's ok to show my vulnerability"

"I will ask my team how I can be better for them"

"I want to understand others more and be actively anti-racist"

"I am more open to ideas and listening"

"It has helped me to make connections across the Trust"

"I am already noticing improvements to staff morale and patient experience"

Reported increase in skills *and* confidence across…		**EMBED actions they have committed to…**
	We all LEAD by example	Be more visible Have regular catch ups for staff Arrange time as a team to focus on culture Identify team goals
	We all BELONG	Utilise EDI calendar and celebrate occasions Educate staff on privilege & unconscious bias Review processes to ensure inclusivity
	We are always IMPROVING	List and register my current QI projects Talk to other teams for ideas Help myth bust on incident reporting with my team

Key Messages

Supporting Change

- We recognise the importance of support the people side of organisational change, alongside maintaining ongoing cultural improvement work and have set out our offer to the Trust
- Equality Impact Assessments play a vital role

Leadership Development (Our Leaders)

- Positive feedback received and over 300 have attended so far
- Key leadership themes are emerging
- More attendance from B7+ leaders and managers is needed if we are to achieve our overall target by end 2026
- More attendance from our B8b+ senior managers is needed, to embed the overall culture and leadership messages

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Staff Story – culture & leadership

Rafeedah Karajada

Hani Samsudin

Labratories

Improving care, transforming lives...for a better Bolton

Report Title:	Finance and Investment Committee Chair's report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an update from the Finance & Investment Committee meetings held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Finance and Investment Committee meetings held on 28 May and 25 June.

Executive Summary	The attached Chairs' reports provide a comprehensive overview of the key matters discussed during the F&I Committeee meetings. These reports outline the strategic, financial and operational issues considered, the assurances received by the Committeee, and highlight specific areas of concern that warrant the attention of the Board of Directors. Each report details: • The scope of discussions and decisions taken at the respective meetings. • The level of assurance provided in relation to governance, risk management, financial oversight, and service delivery. • Emerging risks or unresolved issues that require escalation to the Board for further scrutiny or action. In light of the timing of the July committee meeting, a verbal update will be presented at the July Board meeting to ensure timely communication of any urgent matters. A written report capturing the full outcomes of the July meeting will be included in the September Board meeting pack.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Finance and Investment Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Rebecca Ganz, Finance and Investment Committee Chair	**Presented by:**	Rebecca Ganz, Finance and Investment Committee Chair

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee	Finance & Investment Committee Meeting	**Reports to:**	Board of Directors
Date of Meeting:	28 May 2025	**Date of next meeting:**	25 June 2025
Chair	Rebecca Ganz	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- CIP update
- Month 1 Finance Report
- EPR update for Maternity, Out-Patient and Community EPR Deployment
- Digital support for the Admin Modernisation Programme
- Digital Update May 24 - 25

ALERT

Agenda Items	Action Required
Month 1 Finance Report • The Trust had a deficit in Month 1 of £2.4m mainly due to Cost Improvement Programme (CIP) performance in month 1. • The Committee was asked to focus on the cumulative position to achieve the break-even target. • Whilst there was excess cash in month 1 due to reconciling items, the underlying cash position remains challenging. • PWC have been asked to provide external scrutiny and support in triangulating the finance position and benchmarking against other providers. **EPR update for Maternity, Out-Patient and Community EPR Deployment** • Status is much improved with some amber risks and the direct printing process in red which is expected to move to amber by tomorrow. • Training was underway In Outpatients and Community and the team were working with the Medical Director regarding engagement. • The main focus was Outpatients and Community with a go live date of 18 June 2025. Maternity were not in a position to agree a go live date, but it was likely to be the end of January/February 2026.	

ADVISE

Cost Improvement Update

- £33.4m CIP had been identified against a target of £36.9m,with £17.9m risk rated.
- There had seen an improvement of £1m with identified CIP increasing to £34.5m
- The aim was dto over deliver and the team had considered a 30% over delivery target.

- Weekly informal Finance Improvement Group meetings were in place with weekly flash reports submitted to Divisions and Executive Directors.
- Greater Manchester's CIP target was £655m, with £515m identified and £226m risk rated.

ASSURE

Digital Support for the Admin Modernisation Programme

The report provided assurance as the digital team were key to delivery. The first scheme was speech recognition and clinical correspondence supporting the concept and testing with around 30 users. The existing infrastructure had been upgraded. Meetings occurred weekly feeding into the clinical correspondence task and finish group with the aim to roll out in November/December. A business case on the Reception Transformation was to be presented at CRIG.

Digital Update May 24 - 25

The Chief of Strategy and Partnerships presented the digital update to the Committee and highlighted the achievements so far and plans for the year which would also be presented at the Board of Directors.

New Risks identified at the meeting: *None identified.*

Review of the Risk Register: NA

Meeting Attendance 2025/26							
Members	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Rebecca Ganz (Chair)	✓	✓					
Annette Walker	**A**	✓					
Rae Wheatcroft	✓	✓					
Sharon Katema	✓	✓					
James Mawrey	**A**	✓					
Sharon White	✓	✓					
Sean Harriss	✓	**A**					
Martin North	✓	✓					
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
✓ = In attendance A = Apologies							

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report			
Name of Committee	Finance & Investment Committee Meeting	**Reports to:**	Board of Directors
Date of Meeting:	25 June 2025	**Date of next meeting:**	23 July 2025
Chair	Rebecca Ganz	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Revised Terms of Reference and Workplan
- CIP update
- Month 2 Finance Report
- Productivity report
- Procurement Update
- National Cost collection
- Draft Green Plan
- EPR Update
- Digital Programme Update
- Artificial Intelligence Update
- Refurbishment of Chamber 2 and Non-Acute Boiler Plant Rooms
- Refurbishment of the Paediatric Emergency Department

ALERT

Agenda Items	Action Required
Month 2 Finance Report • The Trust had an accounts deficit in Month 2 of £2.3m. • Cumulatively the deficit was £4.7m, which was adverse to plan by £1.8m. • Under-delivery of Cost Improvement Programme (CIP) was driving a £0.5m adverse variance in-month, £1.8m cumulatively. Cash was better than expected for month 2. The Integrated Care Board (ICB) were aware of the position and the potential requirement for cash by the end of Quarter 1. **Digital Programme Update** The Director of Digital highlighted the challenges of resource constraints and the need to prioritise projects. The team is working on various digital initiatives to improve efficiency and productivity.	

ADVISE

CIP update

- The Trust had a CIP target of £36.9m.
- The latest position as of 20 June 2025 was £37.82m identified CIP with £27.56m risk rated.
- The team was working to protect the £6.5m target by the end of June.
- The Finance and Investment Group was now chaired by the Chief People Officer.

ASSURE

Revised Terms of Reference and Work plan

The revised terms of reference were discussed and adjustments agreed. The amended terms of reference and work plan would be circulated for final approval.

Productivity report

The productivity report was presented which highlighted the operational improvement programs in Elective, Urgent Care, and Neighbourhood Health. Examples of success were given along with opportunities for improvement, emphasising the need for increased productivity without additional spending. Further triangulation was requested between productivity and CIP delivery to provided greater visibility on cost advoidance and cash releasing programmes.

Procurement Update

The Trust had made ratified procurement savings of £1.63m and £0.8m in cash released savings. The team were focused on the rollout of inventory management which was live in Urology and Cardiology and due to go live in Theatres on 07 July 2025. The system should bring considerable savings.

Discussions with Greater Manchester (GM) continued in relation to collaboration and centralisation however due to the Trust's Procurement Department being part of iFM there may not be savings made in centralising and it could have an adverse effect due to the tax implications.

The system was anticipating delivering £2m of recurrent savings across the Trust.

National Cost collection

The Associate Director of Finance presented the National cost collection pre-submission report, highlighting improvements in engagement with divisions and more accurate allocations. The plan was to submit next week, with an opportunity to resubmit if required.

Draft Green Plan

A Green Plan for the Trust for 2025-2030 had been drafted after internal and external stakeholder engagement. The draft had been reviewed by the GM ICB, Our Green Group, and the iFM Executive Board, and updated accordingly. The Finance and Investment Committee approved the draft green plan subject to inclusion of historic performance against targets including further transparency on the current status of CO2 emissions.

Electronic Patient Record (EPR) Update

EPR was now live in Outpatients and Community. The go live date recommended by the Maternity EPR Board in June, was 24 February 2026. The committte thanked the Digital team for the amasing work which has been completed.

Artificial Intelligence (AI) Update

The Chief Data Officer presented the AI update focusing on communication, education, governance and collaboration. The team was working on an AI strategic vision and preparing for an AI symposium.

Refurbishment of Chamber 2 and Non-Acute Boiler Plant Rooms
The Committee approved the Refurbishment of Chamber 2 and Non-Acute Boiler Plant Rooms.

Refurbishment of the Paediatric Emergency Department
The Committee approved the Refurbishment of the Paediatric Emergency Department

New Risks identified at the meeting: *None identified.*

Review of the Risk Register: NA

Meeting Attendance 2025/26							
Members	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Rebecca Ganz	✓	✓	✓				
Annette Walker	**A**	✓	**A**				
Rae Wheatcroft	✓	✓	✓				
Sharon Katema	✓	✓	✓				
James Mawrey	**A**	✓	**A**				
Sharon White	✓	✓	A				
Sean Harriss	✓	**A**	✓				
Martin North	✓	✓	**A**				
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
✓ = In attendance A = Apologies							

Report Title:	Audit and Risk Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	

Purpose of the report	To provide an update from the Audit and Risk Committee meeting held since the last Board of Directors meeting.

Previously considered by:	The matters included in the Chair's reports were discussed and agreed at the Audit and Risk Committee held in June.

Executive Summary	The attached Chair's Report from the Audit and Risk Committee provides a detailed summary of the key matters discussed at the Committee meeting held on 25 June 2025. It outlines the Committee's oversight activities and deliberations across a range of financial, governance, assurance, and risk-related areas. The report highlights: • Key topics reviewed during the meeting, including internal and external audit updates, risk management developments, and compliance matters. • Sources of assurance received by the committee in relation to the Trust's systems of internal control, financial stewardship, and risk mitigation. This report forms part of the committee's formal assurance framework and supports the Board in discharging its responsibilities for effective governance and oversight.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Audit and Risk Committee Chair's Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance		
Legal/ Regulatory		
Health Inequalities		
Equality, Diversity and Inclusion		

Prepared by:	Alan Stuttard Non-Executive Director	**Presented by:**	Alan Stuttard Non-Executive Director

LERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Audit and Risk Committee	**Reports to:**	Board of Directors
Date of Meeting:	25 June 2025	**Date of next meeting:**	17 September 2025
Chair	Alan Stuttard	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Audit and Risk Committee Annual Report 2024/25
- Audited Annual Accounts 2024/25
- Annual Governance Statement 2024/25
- Annual Report 2024/25
- Forvis Mazars Audit Completion Report 2024/25
- Letter of Representation
- MIAA Internal Audit Reports
- Trust Banking Arrangements
- Salary Overpayment Report
- Compliance with the FT Code of Governance
- Risk Management Committee Chair's Reports

ALERT

Agenda Items	Action Required

ADVISE

Audited Annual Accounts 2024/25

The Chief Finance Officer introduced the Audited Annual Accounts, highlighting the year-end deficit of £8.9m on the face of the accounts, but an actual financial performance deficit of £0.6 million. The Chair thanked the Assistant Director of Finance and the team for their work on the accounts.

The Audit and Risk Committee approved the Audited Annual Accounts for 2024/25 and recommended approval by the Board of Directors.

Forvis Mazars Audit Completion Report 2024/25

The committee received the External Audit Completion Report, stating that the Trust's financial statements showed a true and fair view. The report identified no significant issues in the completion of the financial statements, and the auditors plan to issue an unqualified opinion on the financial statements. Under Section 8 of the Report, relating to Value for Money, Forvis Mazars had identified a significant weakness relating to Financial Sustainability in respect of the Cost Improvement Programme, the use of non-recurrent deficit support and the potential need for cash support in 2025/26. The Chair noted that these matters were fully consistent with the financial position reported to the Board by the Chief Finance Officer.

Letter of Representation

The Audit and Risk Committee approved the Letter of Representation.

Trust Banking Arrangements

The Associate Director of Finance presented the Trust Banking Arrangements report, which had previously been reviewed by the Finance & Investment Committee. The report confirmed that the Trust's Banking Arrangements were in order and the Committee approved.

Salary Overpayment Report

For the period 01 April 24 to 31 March 25, the Trust had incurred 78 salary overpayments. The largest group of these overpayments related to late notifications from managers. A further 597 adjustments (£400) had been made to employee records to adjust for overpayments to staff in post. It was highlighted that this was 0.75% of all payslips processed and overall a very good result. The Audit and Risk Committee approved the Salary Overpayment Report.

ASSURE

Audit and Risk Committee Annual Report 2024/25

The Director of Corporate Governance presented the Audit and Risk Committee Annual Report, summarising the Committee's activities and providing assurance that the terms of reference were achieved. The final report would be presented to the Board of Directors in July and the Council of Governors in August. The Chair thanked the DCoG for the work completed. The Audit and Risk Committee approved the Audit and Risk Committee Annual Report 2024/25.

MIAA Internal Audit Reports:

Final Head of Internal Audit Opinion and Annual Report 2024/25

The Head of Internal Audit Opinion for 2024-25 was one of Moderate Assurance. The Chief Finance Officer added the Trust would naturally follow up and improve. The Chair advised the Internal Audit Plan was based on a risk assessment and some areas had been identified knowing that there were likely to be some areas of weakness. The Internal Audit Reports should be seen in a positive light of looking to improve on the controls and systems.

Final Internal Audit Plan 2025/26

The Regional Assurance Director for MIAA advised that no changes had been made other than including narratives and additional columns.

Internal Audit Progress Report and Final Assignment Reports

Six Internal Audit reports had been finalised including the Assurance Framework Review, Key Financial Controls Review, Patient Safety Incident Response Framework (PSIRF) Review, Job Evaluation Process Review, Digital Asset Control Review, and Health and Well-being Review. Two reports were in draft awaiting management response. The Data Security and Protection Toolkit audit was now complete and the Procurement review had been deferred by one month.

Annual Governance Statement 2024/25

The Chief Executive presented the Annual Governance Statement, outlining the Trust's governance, risk management, and internal control processes. The statement highlighted key areas such as workforce and culture, quality and CQC compliance, information governance and data quality, sustainability and social responsibility, and principal risks.

The AGS confirmed the Trust had all controls in place and the CEO thanked the Director of Corporate Governance and the Associate Director of Finance for preparing the report. The Audit and Risk Committee approved the Annual Governance Statement and recommended approval by the Board of Directors.

Annual Report 2024/25

The Director of Corporate Governance presented the Annual Report for 2024-2025, detailing the Trust's performance, governance, financial position, and adherence to the NHS net zero plans. The DCoG added that an additional amend is to be made to the final version before being submitted to the Auditors.

The Chair and Chief Executive acknowledged the comprehensive nature of the report and thanked the DCoG and the team for their work. The Audit and Risk Committee approved the Annual Report 2024/25 and recommended approval by the Board of Directors Board of Directors.

Compliance with the FT Code of Governance

The Director of Corporate Governance presented the FT Code of Governance Compliance report, confirming that the Trust was compliant with all provisions except one mandatory provision related to an externally facilitated Board review.

The Chief Executive and the Chair agreed that the Trust was fully compliant, given the CQC review in 2023 and the planned review in 2025. The DCoG would draft a one page document to explain this as it is already in the public domain.

Risk Management Committee Chair's Reports

The Chief Finance Officer presented the Risk Management Committee Chair's Report, noting that there were 25 risks currently scored at 15 or above. A question was raised over why there were no risks scored at 20 and 25 relating to Finance and the Estate which was down to the closure of some risks for 2024/25 but they had not been reassessed for 2025/26. The Director of Corporate Governance advised that the corporate risk register would be presented to the Board of Directors in July.

New Risks identified at the meeting: None

Review of the Risk Register: Not required

Meeting Attendance 2025/26					
Members	**May**	**June**	**Sept**	**Dec**	**Feb**
Alan Stuttard	✓	✓			
Sean Harris	✓	✓			
Fiona Taylor	✓	✓			
In Attendance	**May**	**June**	**Sept**	**Dec**	Feb
Annette Walker	✓	✓			
Sharon Katema	✓	✓			
✓ = In attendance A = Apologies					

Report Title:	Audit and Risk Committee Annual Report 2024/25			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	This report provides a summary of the activities of the Audit Committee and sets out how the Committee met its terms of reference and key priorities in 2024/25.

Previously considered by:	Audit and Risk Committee.

Executive Summary	This Audit and Risk Annual Report provides an overview and summary of the following key points: • Membership, frequency and effectiveness of meetings • Governance arrangements to support the committee • The work and performance of the committee during the financial year including work supported by internal audit, external audit, and counter fraud. • The Committee's role with regards to internal systems of control and receiving assurance on information governance, risk management, financial management and corporate governance. • The role of the committee in reviewing and approving the Trust's Annual Report and Annual Accounts. In preparing the report, the Chair of the Audit and Risk Committee is of the view the committee has taken appropriate steps to perform its duties as delegated by the Board of Directors and it has no cause to raise any issues of significant concern with the Board arising from its work during 2024/25.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Audit and Risk Committee Annual Report

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Victoria Crompton, Corporate Governance Manager	**Presented by:**	Sharon Katema, Director of Corporate Governance

Audit and Risk Committee

Annual Report

2024 - 25

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1. Purpose

The production of an Audit and Risk Committee Annual Report represents good governance practice and ensures compliance with the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook. This Annual report covers the financial year 2024/25.

This Annual Report has been prepared for the attention of the Board of Directors and reviews the work and performance of the Audit and Risk Committee in satisfying its Terms of Reference.

Following presentation at Board, the Annual Report will be received and considered by the Council of Governors as a means of providing assurance on how the Non-Executive Directors supported by internal and external auditors, have effectively scrutinised internal control systems, promoting good governance and accountability. This report also provides the Council of Governors with an outline of the work carried out by the external auditors, Forvis Mazars, whom they appoint.

2. Introduction

The Audit and Risk Committee (Committee) is a formal Committee of the Board established under Board delegation with approved terms of reference aligned with the HFMA NHS Audit Committee Handbook.

The Committee provides an independent and objective review of the Trust's internal controls and seeks assurance on the effectiveness of the Trust's governance, risk management and systems of internal control. The Committee has responsibility for ensuring that independence is maintained for any non-audit work undertaken by the Trust's external auditors, Forvis Mazars.

There was no non-audit work carried out during the reporting period.

3. Committee Membership and attendance at meetings

The Chair and members are appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust. The membership of the Committee is made up of four Non-Executive Directors. To ensure that Committee members have the skills required to carry out their role, all members have the opportunity to attend training courses including those provided by MIAA which cover topics that are relevant specifically to members of NHS Audit Committees.

The Chair of the Trust is not a substantive member of the Committee but may be invited to attend one meeting during the financial year.

The Chief Executive, in her role as Accounting Officer of the Trust, is invited to attend at least one meeting a year to present the Annual Governance Statement.

The Committee met on five occasions in the period covered by this report to discharge its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

Attendance at the Committee is shown in the table below.

	Meeting Dates				
	08/05/24	26/06/24	18/09/24	04/12/24	12/02/25
Alan Stuttard (Chair)	✓	✓	✓	✓	Apologies
Martin North	✓	✓	✓	Apologies	
Fiona Taylor	✓	✓	✓	✓	✓
Tosca Fairchild	Apologies	✓	Apologies	Apologies	✓
Sean Harriss					Apologies

During the 2024-25 financial year, meetings of the Committee were attended on a regular basis by

- Chief Financial Officer
- Director for Corporate Governance
- Associate Director of Finance - Financial Services,
- Mersey Internal Audit Agency (MIAA)
- External audit representation was provided by Forvis Mazars
- Local Counter Fraud Specialist

Invitations were extended to members of the executive team who attended meetings to present and make assurances on Limited Assurance Opinion internal audit reviews.

The Committee is assured that its members and regular attendees, have sufficient knowledge of the organisation's business to identify key risks.

4. Terms of Reference and Committee Workplan

The Chair and members of the Audit and Risk Committee confirm that the Committee has fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference.

The Terms of Reference of the Audit and Risk Committee are reviewed annually and were last reviewed in December 2024 and are attached at Appendix 1 for information. The committee were advised of the change in name of the Audit Committee to the Audit and Risk Committee and that risk management and information governance are now included in the Terms of Reference, all of which were approved by the

Board of Directors in January 2024.

The Audit and Risk Committee members met in private with both the Internal and External Auditors during the reporting period.

The Audit and Risk Committee agenda is formulated from the Annual Workplan and is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate governance, financial management, risk management and information governance.

5. Reports to the Board Of Directors

The Chair of the Audit and Risk Committee provides a summary report of the Committee's activities to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee, and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

The Committee Chair has also made recommendations for items that needed to be considered the by the Quality Assurance Committee of the Board.

6. Work of the Committee during 2024-25

The Committee's work predominantly focusses on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives. The Committee had a pivotal role to play in reviewing the disclosure statements from the organisation's assurance processes; in particular, the Annual Governance Statement, which includes the Head of Internal Audit Opinion. The Committee also has a key role in reviewing the reports of the External and Internal Auditors and their findings for the Trust.

The Annual Governance Statement describes the system of internal control that supports the achievement of the Trust's policies, aims and key priorities. The Audit and Risk Committee reviewed the draft Annual Governance Statement for the period 01 April 2024 to 31 March 2025 at its meeting on 25 June 2025.

The Audit and Risk Committee considered all audit reports and findings in respect of IFM Ltd, the wholly owned subsidiary of the Trust and the Trust Charity.

The Audit and Risk Committee agendas in the reporting period covered the following:-

Board Assurance Framework

The Audit and Risk Committee received the Board Assurance Framework at meetings held in May 2024 and December 2024. The Committee was assured on both the content and the process on both occasions and did not recommend any amendments to the content.

Risk Management

The Committee received AAA Key Issues Reports from the Risk Management Committee which is chaired by the Chief Nursing Officer**.**

Registers and Declarations of Interest process:

The Committee reviewed the Declaration of Interest Register which includes Gifts and Hospitality Register and Sponsorship Register to ensure appropriateness and completeness of the content. The Committee approved a change to the Managing Conflict of Interests Policy to incorporate a change to the definition of decision makers from Agenda For Change (AFC) Band 8C to band 8D.

The Committee reviewed the Register of Interests for 2024/25 noting the 86.7% rate for declarations from identified decision makers. The compliance rate lower than the previously report rate of 88% in 2023.

Losses and Special Payments

The Audit and Risk Committee was provided with regular information regarding the levels and values of losses and special payments within the Trust and IFM Ltd. There were no areas of concern noted with these payments.

Tenders Waived

The Audit and Risk Committee received a summary of all tenders waived by both the Trust and IFM Ltd above a £50k value at each meeting. The Committee reviewed the explanations given for the waivers to ensure that there is effective control over the financial and procurement process with the overall aim of reducing the number of waivers.

Information Governance Annual Report

In line with the change to the Terms of Reference, the Committee received the Information Governance Annual Report which provided assurance on the information governance and security activity for the period 01 July 2023 to 30 June 2024. The report set out objectives for the forthcoming year and highlighted areas including the Data Security and Protection Toolkit, Freedom of Information requests, Subject Access requests, data protection incidents and ensuring data security. The Audit Committee received the Information Governance Annual Report.

7. Counter Fraud

Counter Fraud services are provided through a Service Level Agreement with Wrightington, Wigan and Leigh NHS Foundation Trust. A nominated Local Counter Fraud Specialist (LCFS) works with the Trust and regularly attends Audit and Risk Committee meetings.

The Audit and Risk Committee received Local Counter-Fraud Progress Reports and details of investigations carried out at each of its regularly scheduled meetings throughout the year. These updated the Committee on the major findings and any lessons learnt from individual cases on counter-fraud. Assurances were received about the processes in place to tackle fraud and bribery.

The Committee approved the 2024/2025 Counter Fraud Work Plan which is designed to help manage fraud, bribery and corruption risks across the Trust ensuring compliance with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.

The Chair and Chief Financial Officer signed off the annual return to the NHS Counter Fraud Authority during the financial year.

8. External Audit

The Audit and Risk Committee received and approved the External Audit Plan for 2025/26. The Plan identified significant inherent audit risks related to:

- Management override of controls
- Fraud in revenue recognition
- Fraud in expenditure recognition
- Valuation of land and buildings revalued in year

The Committee received the 2024/25 External Audit Report (including the ISA 260 Report) at its meeting held on 25 June 2025. The report confirmed that no significant audit issues had arisen in respect of the significant inherent audit risks and key audit judgements listed above. The report further confirmed that no audit adjustments or disclosure deficiencies had been identified. An Unqualified audit opinion was given on the Trust's accounts for 2023/24.

As part of their Audit work the External Auditors also undertook the Value for Money risk assessment for the year ended 31 March 2025 as required by the Code of Audit practice the auditors reported that "we have completed our work in respect of the Trust's arrangements for the year ended 31 March 2025 and have identified one significant weakness in arrangements and have made associated recommendations".

Following the Committee meetings in June 2025, the Committee made recommendations to the Board of Directors to approve the Audited Accounts, Annual Report and Annual Governance Statement for 2024/25.

In addition to reviewing the Accounts for the Trust the External Auditors also undertake the External Audit for IFM Ltd and conduct the Independent Review of the Charitable Fund Accounts, Forvis Mazars provided regular progress reports and technical updates to the Audit and Risk Committee.

9. Internal Audit

The Internal Auditors, MIAA were in attendance at all Committee meetings and presented findings of internal audit reviews and the associated management responses and monitored the implementation of recommendations through regular progress reports. The conclusions, as well as the findings and recommendations, of all Internal Audit reports finalised during the year were shared with the Audit and Risk Committee.

The Committee challenged Internal Audit on assurances provided and, where appropriate, requested additional information, clarification and follow-up work if considered necessary. Progress towards the implementation of agreed recommendations was also reported (including full details of all outstanding recommendations) to the Executive Management Team. The Audit and Risk Committee reviewed and was satisfied by the progress reports.

The Committee also referred some reports to the other Board Committees for consideration where concerns had been raised or to support the work of the other Committees in the provision of assurance to the Board of Directors.

The Head of Internal Audit Opinion for 2024/25 presented to the Audit and Risk Committee stated that Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

The following Internal Audit Reports were received by the Audit and Risk Committee during the reporting period:

Audit Title (Final Reports)	Report classification	Critical	High	Medium	Low	Total
		Number of findings				
Assurance Framework	N/A	N/A	N/A	N/A	N/A	**5**
Risk Management Core Controls	Substantial	N/A	N/A	1	N/A	**1**
Finance Systems Deep Dive – Fixed Assets	Substantial	N/A	N/A	3	1	**4**
Divisional Quality Governance	Substantial	N/A	N/A	3	2	**5**
Bank and Agency Staff Controls	Substantial	N/A	N/A	4	N/A	**4**
Job Evaluation Process	Moderate	N/A	1	6	N/A	**7**
Digital Asset Controls	Limited	N/A	2	2	1	**5**

Critical Application Review (LIMS)	Limited	N/A	3	1	N/A	**4**
Data Security and Protection Toolkit 23/24 Phase II	Substantial/ Moderate	N/A	N/A	2	16	**18**
Escalation of a Deteriorating Patient (2023/24) Review)	Moderate	N/A	1	2	1	**4**
Patient Safety Incident Response Framework (PSIRF)	Substantial	N/A	N/A	3	3	**6**
Key Financial Transactional Processing Controls	Moderate	N/A	1	1	4	**6**
Quality Spot Checks (Draft)	Limited	N/A	3	N/A	N/A	**3**
Theatre Productivity (Draft)	Substantial	N/A	N/A	3	0	**3**
Health and Wellbeing	Sustantial	N/A	N/A	2	1	**3**
TOTAL		**0**	**11**	**33**	**29**	**78**

Action tracking:

The Committee received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress of outstanding actions.

10. Financial Reporting

During and in respect of the financial year, the Committee reviewed the Annual Accounts for IFM Ltd for the year ended 31 March 2024 and the Charitable Fund Accounts for the year ended December 2024.

The Committee received, gained assurance and actioned the following:

- Approved the Annual Report & Quality Account 2025/26 timetables for production.
- Confirmed that the Accounts for 2024/25 be prepared on a going concern basis.
- Recommended approval of the 2024/25 Annual Report and Annual Accounts to the Board of Directors following completion of the External Audit in June 2025.
- Reviewed the Draft Annual Accounts for 2024/25 prior to submission to the External Auditors.
- To review the Annual Accounts following completion of the audit by the External Auditors and recommended the Accounts for approval by the Board of Directors.
- Reviewed the Letter of Representation 2024/25 for approval by the Board of Directors and

signing by the Accountable Officer.
- Reviewed the Annual Report and recommended the Report for approval by the Board of Directors.

11. Effectiveness of the Audit and Risk Committee

In November 2024, the Committee undertook a self-assessment of its effectiveness. This involved a range of questions covering different elements of the work of the Committee. This follows good governance practice in accordance with the NHS Audit Committee Handbook.

The results were generally positive with no Strongly Disagree responses. Compared to the 2023 Committee survey, seven out of 33 questions had shown an improvement. There had been a decrease in responses and some areas were identified for further development. The Committee will review how the overall effectiveness can be improved.

12. Conclusion

The Audit and Risk Committee has an important role in delivering good governance, providing challenge and oversight and in advising senior management on the effectiveness of risk management processes.

Committee members recognise that although progress has been made the Trust must not be complacent and must build on recent successes to embed strong and sustainable governance arrangements throughout the Trust.

The Audit and Risk Committee has an important role to play in ensuring appropriate governance and control arrangements are also in place for iFM Ltd.

As Chair of the Audit and Risk Committee I would like to take this opportunity to thank the members of the Committee for their support and input to the work of the Committee and also to thank all those who attend the Committee along with the Corporate Services team who provide us with all the administrative support.

Report Title:	Charitable Funds Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief of Strategy and Partnerships		Decision	

Purpose of the report	The purpose of this report is to provide an update and assurance to the Board of Directors on the work of the Charitable Funds Committee.

Previously considered by:	Charitable Funds Committee

Executive Summary	This attached report provides a summary of the key matters discussed during the Charitable Funds Committee meeting convened on 02 June 2025. The report outlines the principal areas of focus, the assurances received by the Committee in relation to its delegated responsibilities, and highlights specific issues that warrant escalation to the Board of Directors for further consideration.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Chair's report for the Charitable Funds Committee.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	Financial performance outlined in the Finance report and Centros update
Legal/ Regulatory	Yes	Legislative changes that will affect Our Bolton NHS Charity are outlined in the Outlook report
Health Inequalities	Yes	Our Bolton NHS Charity remains committed to playing an active role in tackling health and care inequalities as a positive partner and funder
Equality, Diversity and Inclusion	Yes	Our Bolton NHS Charity remains committed to playing an active role in supporting equality, diversity and inclusion as a positive partner and funder

Prepared by:	Sarah Skinner, Charity Manager	Presented by:	Martin North, Chair of the Charitable Funds Committee

Glossary – definitions for technical terms and acronyms used within this document

CDEL	Capital Departmental Expenditure Limits
ORA	Ocular Response Analyser
NCVO	National Council for Voluntary Organisations

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	Charitable Funds Committee	**Reports to:**	Board of Directors
Date of Meeting:	02 June 2025	**Date of next meeting:**	08 September 2025
Chair	Martin North	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Purchase of the surgical robot table
- Highlight report
- Finance report and Centros update
- Application for charitable funds: ORA technology for Ophthalmology
- Outlook report
- CFC workshop background and agenda
- Workforce wellbeing grant application

ALERT

Agenda items	Action Required

ADVISE

Matters arising – purchase of the surgical robot table

The Committee received an update on the purchase of the surgical robot table (£100k), which was previously discussed by the Committee and supported in principle. Due to end of year Capital Departmental Expenditure Limits (CDEL), the table was purchased by the Trust (together with the surgical robot) rather than the Charity. The Committee discussed whether a retrospective grant should be made to the Trust (given there was a record of support in principle) or whether charitable funds should be prioritised elsewhere.

Prioritisation of charitable funds

The Committee discussed prioritisation of available funds, and agreed a formal process was required to ensure funds were prioritised in line with Trust need (as well as the Charity's principles of expenditure), rather than on a first come, first served basis. The Charity team to work with Deputy Divisional Directors to support forward planning.

ASSURE

Highlight Report

The Committee received the highlight report for Q1, including activity updates and learning insights across different income streams and wider team functions.

Finance report and Centros update

The Committee received the finance report, which outlined the financial position up to 31 March 2025.

There was a net decrease in funds of £140k, compared with a £324k decrease last year. Expenditure fell to £288k from £595k the prior year, and income was £165k, (down from £271k), mainly from general donations. Legacy income was particularly low at £3k (previous years: £81k and £556k). Fund balances stand at £807k, with a call on funds of £137k (down from £167k), and £125k has been spent on charitable purposes.

Charity operations fully transitioned to Centros from 01 April 2025, improving automation from requisition to invoice payment. Ongoing work includes setting up requisitioners individually and developing budget statements and e-forms for better visibility and efficiency.

Application for charitable funds: Ocular Response Analyser (ORA) technology for Ophthalmology

The Committee received an application for charitable funds for £47,000 for the purchase of the new ocular pressure measurement ORA technology machines for Ophthalmology. Funding for this purchase comes from a £15k legacy to Ophthalmology and donations to the general purposes fund.

The Committee approved the application.

Outlook report

The Committee received the Outlook report, which provides:

- A state of the sector update, highlighting key issues, risks and opportunities, informed by the National Council for Voluntary Organisations (NCVO) 'The Road Ahead' 2025
- Forthcoming changes in legislation and governance/accounting practice that will impact the charity
- A horizon scan of known and potential funding opportunities

The Committee noted the report, acknowledging the new rules under the Data (Use and Access) Bill may present greater flexibility and opportunities for the charity in terms of donor acquisitions and stewardship.

CFC workshop background and agenda

The Committee received an update on the forthcoming CFC workshop and proposed agenda. The Committee discussed the need for the workshop content to reflect governance and strategic roles, not just operational involvement to ensure maximum strategic value.

The Committee supported the agenda points discussed and look forward to the workshop.

Workforce Wellbeing – Local Grants Fund for England

The Committee received a presentation outlining the detail of the Charity's bid for £250,000 as part of the Workforce Wellbeing - Local Grants Fund for England from NHS Charities Together in partnership with

NHS England. The deadline for applications is 06 June and applicants will be notified of the outcome in mid-August.
New Risks identified at the meeting: **N/A**
Review of the Risk Register: Risks have now been transferred to the Safeguard system and will be reviewed quarterly and presented to Risk Management Committee as part of the 'Communications and Strategy' risk portfolio.

Report Title:	Trust Annual Health and Safety Report 01 April 2024 – 31 March 2025			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	This report is to inform the Board of Directors of the Trust Annual Health and Safety report for the period 01 April 2024 – 31 March 2025

Previously considered by:	Group Health and Safety Committee, Clinical Governance and Quality Committee and Quality Assurance Committee.

Executive Summary	During the reporting period, the Trust remained fully compliant with all relevant Health and Safety legislation. A total of 18 LTPS claims were received, representing a reduction of 10 compared to 2023/24. While the Trust did not meet the 95% compliance target for Moving and Handling Level 2 training, a new initiative commencing April 2025 will see weekly sessions delivered at a community base to improve accessibility and compliance for community staff. Health, Safety and Welfare training compliance consistently exceeded the 85% target throughout the year. Notably, there was a reduction of 216 reported Health and Safety incidents via the Safeguard system, with the most significant decrease seen in the "Violent, Aggressive or Disruptive Behaviour" category (down by 155 incidents). Conflict Resolution online training achieved an average compliance of 93.31%, peaking at 100% in December 2024. Fire Safety training averaged 92.8% compliance, slightly below the 95% target, with a high of 93.79% in November 2024. All Divisions exceeded the 95% compliance target for Manual Handling Level 1 training by year-end, with Trust-wide improvement noted since May 2024.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Health and Safety Annual Report.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes/ No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Michael Hodds Health and Safey Manager	**Presented by:**	Tyrone Roberts, Chief Nursing Officer

Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

Health and Safety Annual Report

01 April 2024 – 31 March 2025

for a better Bolton

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Executive Summary:

During the period 01 April 24 to 31 March 2025 the Trust was compliant with all the relevant Health and Safety Legislation.

In the period 01 April 2024 to 31 March 2025 the Trust received eighteen (18) LTPS claims, a reduction of <10 received claims against the previous reporting period (23/24).

The Trust did not meet the compliance target to 95% with Moving and Handling Level 2 in 2024/25, however from April 2025, Manual Handling Level 2 will be taught weekly at a community base (Integrated Community Equipment Stores, Adelaide Street) to aim to improve community staff access and compliance.

Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2024/25.

This reporting period saw a decrease in reported Health and Safety Incidents of 216 against 2023/24 figure.

The 2024/25 reporting period saw a reduction of 216 Health and Safety reported incidents recorded through the Trust on-line Safeguard reporting system, with the largest decrease noted under Violent, Aggressive or Disruptive Behaviour cause group of <155 incidents (395 in 2023/24 to 240 in 2024/25).

Conflict Resolution on-line training compliance training achieved average figure of 93.31%, with a notable 100% achieved in December 2024.

The Fire Safety on-line training figures provides data that during the period April 2024 – March 2025 the Trust achieved an average compliance figure of 92.8% against the required 95% target, with the highest achieved being 93.79% in November 2024.

On conclusion of the reporting period (Mar 2025) all Divisions were compliant and exceeded the Manual Handling Level 1 Training compliance against its 95% target.

Compliance figures for Manual Handling Training Level 1 has increased across the Trust since May 2024.

Overview:

Although monitoring and reviewing Health and Safety performance is legally required, there is no legal or regulatory obligation to publish this information in annual reports. This is however considered best practice and for openness and transparency, the Health and Safety Team have produced this annual report to highlight the work undertaken across Bolton NHS Foundation Trust in relation to Health and Safety.

The Health and Safety at Work Act 1974, provides a legislative framework to promote, simulate and encourage excellent Health and Safety at work standards with delegated responsibility through the Chief Executive Office to nominated Directors to implement systems that ensure Trust staff work in a safe and compliant manner to protect both themselves and other service users from significant or avoidable harm.

The purpose of this report is to provide the Trust Board with assurances that there are Health and Safety policies, procedures and systems in place for managing Health and Safety within the Trust within the period 01 April 2024 – 31 March 2025.

The report summarises the prevailing legislative framework within which health & safety is managed, addressed and outlines the local governance arrangements that underpin Health and Safety management within the Trust.

Included within the report is statistical analysis and key information regarding Health and Safety activity, audit programme and progress, training compliance, reported incidents & RIDDOR data across the Trust.

The report also provides summative information for the following key areas:

- Alerts
- Asbestos
- Audits
- Claims
- Fire Safety
- Inspections
- Manual Training
- Occupational Health
- Overview of Legal Compliance
- Policies
- Safety - Summary of Accident data, RIDDOR and Performance
- Security
- Training Compliance
- Ventilation/Heating and Temperature control

- Water Safety

This is the fifth Health & Safety annual report. The report and purpose of it conforms to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.

*Note: *Data provided in this report ended 31 March 2025*

Overview of Legal Compliance:

At the conclusion of this reporting period the Trust was compliant with all its Health and Safety legal requirements.

The table below outlines the main Health and Safety legislation and identifies the reactive and proactive work that the Trust has carried out in order to ensure compliance.

Legislation	Description of Actions/Compliance	Status
Health and Safety at Work Act 1974	Trust Health and Safety Management Policy published Competent persons in place to provide compliance advice. GH&SC held monthly	
Management of Health & Safety at Work Regulations 1999	Annual Health and Safety Audit programme Annual Health and Safety Work plan	
Display Screen Equipment Regulations 1992	DSE self-assessment tool has been updated and includes an action plan for users. Competent staff to provide additional support including Health and Safety and OH Department	
Reporting of Injuries, Disease and Dangerous Occurrences Regulations 19995 (RIDDOR)	Investigations have been implemented for all RIDDOR incidents and the findings are shared with the GH&SC and divisions / iFM Bolton Management Teams	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 19996 Safety Representatives and Safety Committees Regulations 1977	Terms of reference are reviewed as part of GH&SC agenda cycle Trust Health and Safety Policy in place Health and Safety Trade Union Reps in place GH&SC is well attended by Managers, Trust Competent Persons and TU Safety Reps. GH&SC reports on audits, action plan progress, KPIs and risk register. GH&SC also acts as consultative committee for Health and Safety policies GH&SC reports to the Clinical Governance & Quality Committee and Quality Assurance Committee	

Legend:	
Compliant	
Non-compliant	

Safety – Summary of Accident data, RIDDOR and performance:

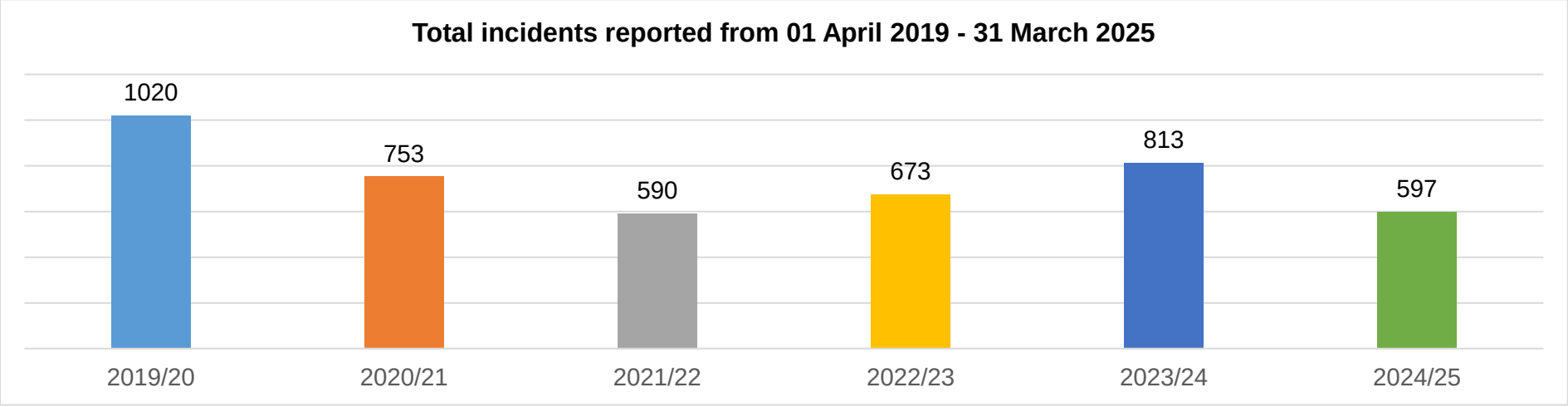
Health & Safety Incidents are reported through the Trust on-line Ulysses Safeguard (Safeguard) system. From 01 April 2024 to 31 March 2025 a total 597 incidents were reported in relation to Health and Safety.

Data in this report relates to incidents reported on Safeguard covering a staff, visitor or contractor accident/incident under the following cause groups:

- Accident/Incident
- Blood Exposure/Needle stick Injury
- Falls
- Moving & Handling
- Violent, Aggressive or Disruptive Behaviour
- Workplace Environment and Welfare

Incidents Reported by Financial Year

The total number of incidents reported between April 2024 and March 2025 has decreased against the previous year from 813 to 597.



Reasons for the decreased incident figures since 2024/25 are believed to be;

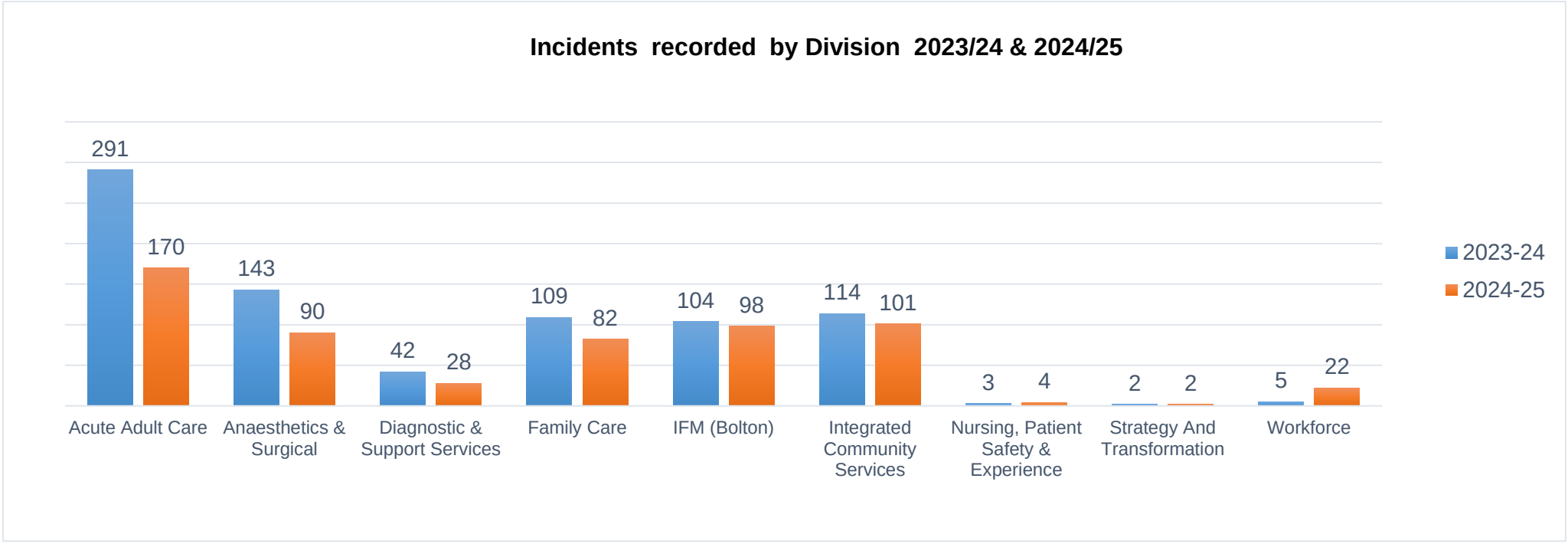
- Decrease of violent and aggression incidents to report
- Improvement in staff awareness of what constitutes a Health and Safety incident needing to be reported
- Bespoke incident data reports presented at GH&SC designed around Divisional ask
- Benefits of sharing of incidents data from Trust meetings to Divisions, providing feedback to staff including appropriate the sharing of Lessons Learnt
- Identifying and deescalating situations before it becomes a reportable incident (noting <155 drop in reported Violent, Aggressive or Disruptive Behaviour incidents)

Incidents recorded by Division

Acute Adult Care Division (AACD) remained the highest reporting division with 170 incidents, which equates to 28% of the total number.

By having available appropriate incident data, sharing lessons learnt, and improving Health and Safety awareness e.g. Health and Safety Workplace Folders across the division a positive impact is that during this reporting period there's been a decrease of 121 incidents reported by AACD.

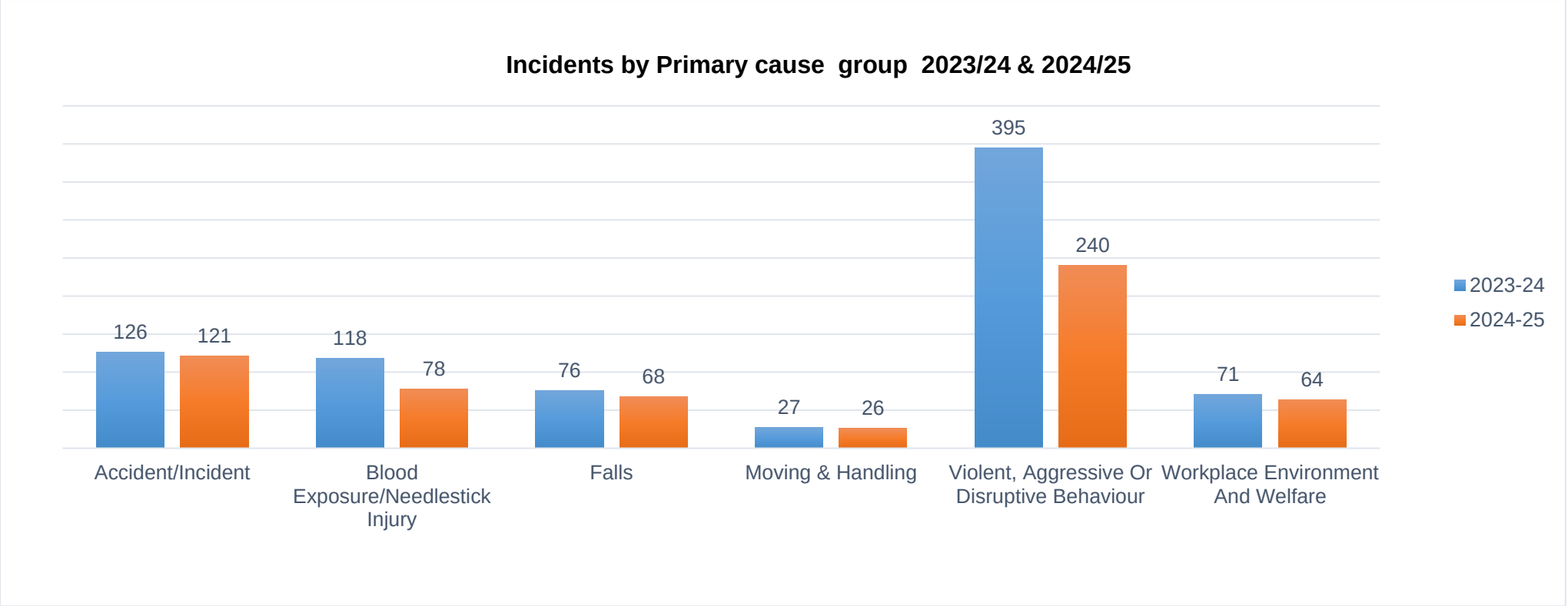
Visual representation in the graph below of incidents reported across the Trust covering the last 24 months:



Incident by Primary Cause Group

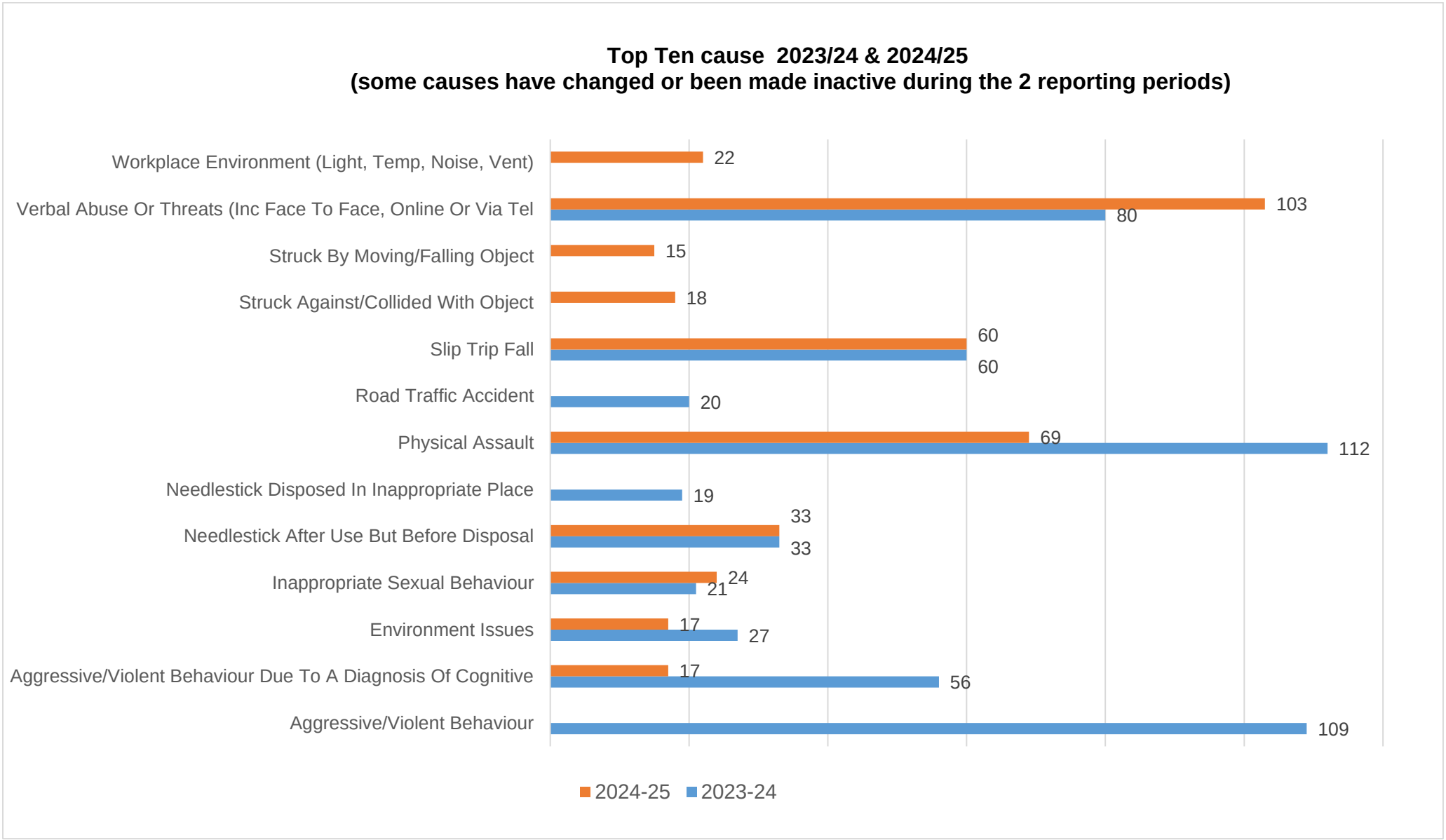
The cause group themes are consistent with the previous year with the highest cause group reported remaining Violent, Aggressive or Disruptive behaviour.

In this reporting period the Trust saw a reduction against reported incidents under the cause group Violent, Aggressive or Disruptive Behaviour from 395 (2023/24) to 240 (2024/25) incidents. This reduction may be a result on the increase of staff numbers undertaking Prevention and Management of Violence and Aggression (PMVA) training recorded since March 2024 as well as a continued progressive increase reported during 2024/25 period.



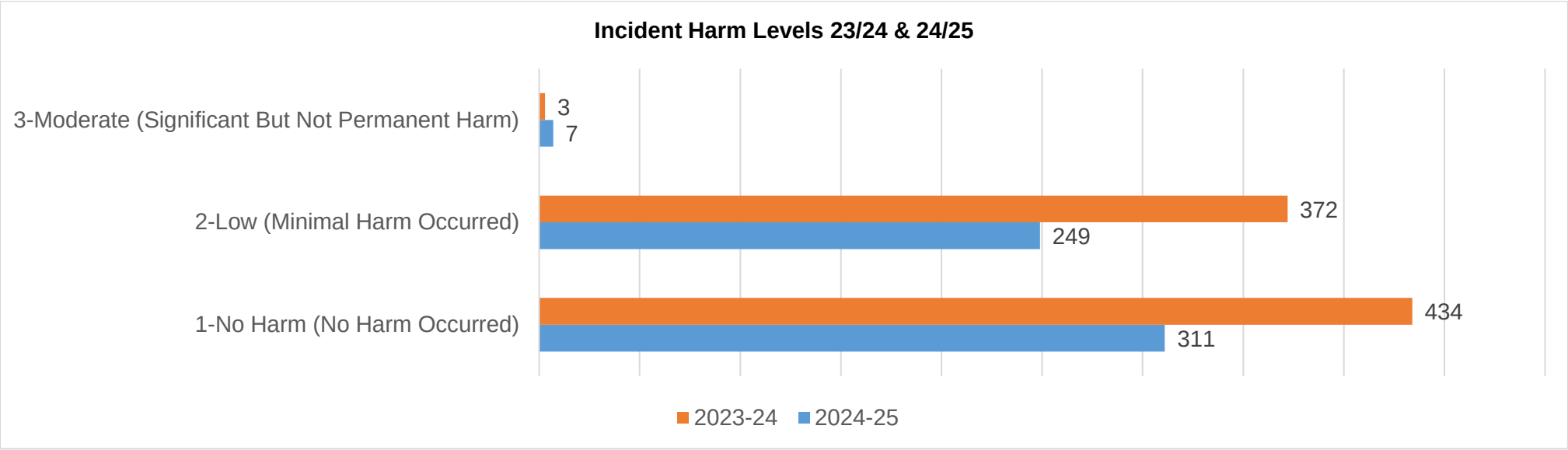
Violent, Aggressive or Disruptive Behaviour incidents account for **40%** of all Health & Safety incidents reported between April 2024 - March 2025 which is an **8.5%** decrease on the number reported in 2023/24 which totalled 48.5% of the total Health and Safety incidents reported during that period.

Top Ten Cause Groups



Incidents by Actual Impact

98.8% of the total Health and Safety incidents reported were of 'No or Low Harm', which is a decrease of <0.7% against the 2023/24 reporting period.



Moderate Harm Incidents

In 2024/25, **7** incidents recording moderate harm, none appeared to have themes, an overview of theses incident descriptions are as follows:

- Incident 246845 - Slip, Trip and Fall Incident

A staff member slipped whilst walking on a clinical floor surface. The staff member sustained a fractured shoulder. A review on the cause of the wet floor could not be ascertained as the water/liquid may have been splashed from a nearby sink that available for individuals to wash their hands or from the floor having been recently mopped. Lessons learnt included ensuring that floors must be dry after mopping, that any splashes on floors caused are dried up, and that fluids on floors are cleaned up.

- Incident 246670 - Struck by moving/falling object

A member of staff fell onto the floor when missing their chair when sitting back down. The member of staff experienced acute pain to their lower back. Medication taken included pain relief tablets and anti-inflammatory medications & physiotherapy support. Lessons learnt, that when sitting down individuals should ensure that it is safe to do so, which may include physically holding onto a chair when lowering themselves down especially those chairs with wheels fitted.

- **Incident 250371 - Slip, Trip and Fall Incident**

A member of staff tripped and fell after leaving a patients property, and sustained a fractured shoulder. The fall occurred when the individual walked on a path outside the patient's house. No lessons learnt, this was an unfortunate accident sustained during work.

- **Incident 250811 - Physical Assault**

A call from security guards positioned in A&E asked for assistance with a patient who was refusing to get out of a taxi. Patient was extremely aggressive, de-escalating techniques used didn't work so it was decided to call the police seeking their assistance. With police assistance the individual was moved from the taxi into the hospital through the main entrance. Whilst moving into the hospital entrance a struggle occurred which resulted in a member of our Security Staff sustaining a broken bone in their wrist. The aggressiveness of the patient when held was unforeseen and even with staff having the appropriate level of training unfortunately sustained injury occurred.

- **Incident 257715 - Aggressive/Violent Behaviour due to a diagnosis of cognitive**

A member of staff sustained an injury to their hand whilst removing a male patient from a ladies bay which happened when the doors closed trapping the members of staff hand. No lessons learnt, an unfortunate accident occurred with the staff member was focused on dealing with a challenging patient.

- **Incident 265889 - Moving & Handling (non-patient)**

A member of iFM Portering lost steering control of a large Tug which resulted the equipment striking the staff members own right foot. The incident was reviewed and recorded as Operator error, as the staff member wasn't positioned correctly when operating the Tug as previously instructed. Lessons learnt was that further/refresher advise to the member of staff was given on their correct positioning when operating/moving the tug with the aim to reduce the likelihood of a similar incident reoccurring.

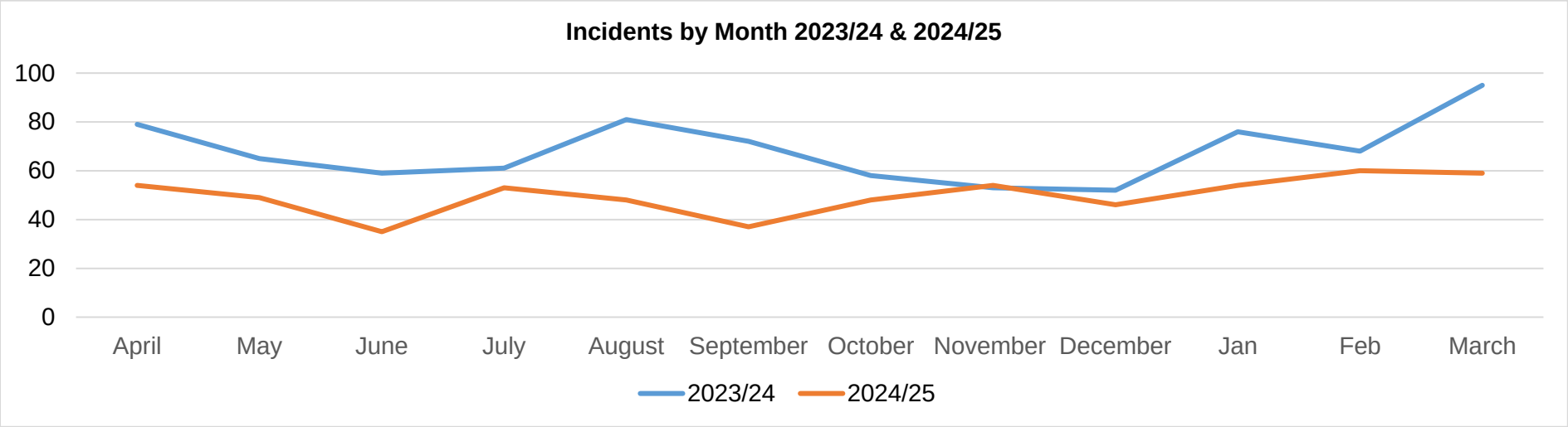
- **Incident 266633 - Aggressive/Violent Behaviour due to a diagnosis of cognitive**

Staff member sustained an injury above and below their eye which required stitching which happened as a result of being struck by an aggressive patient's walking stick. This attack was unforeseen and occurred after the patient cornered the member of staff in the staff room. IFM Security Guards assisted with de-escalating the situation. The patients' medication prescription was reviewed by a doctor.

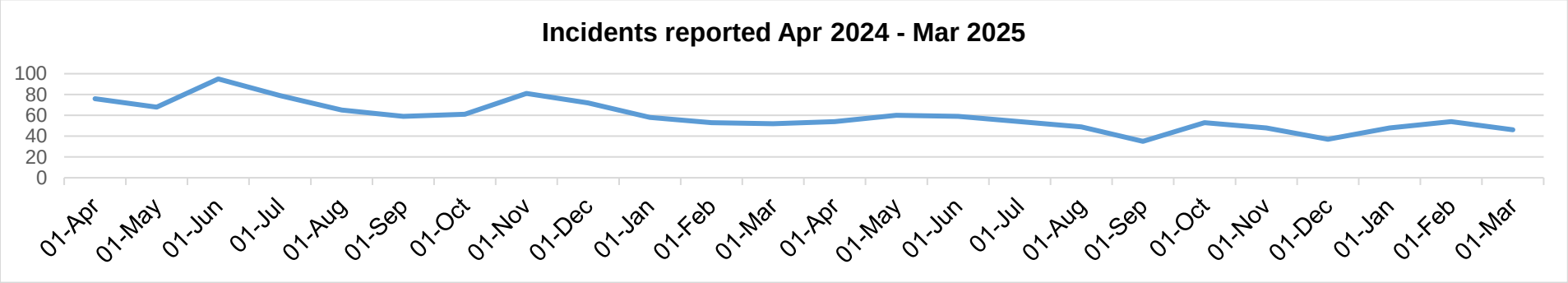
Incidents by Month

On viewing the number of Health and Safety incidents reported per month occurring both during in 2023/24 and in 2024/25 there are periods where there appears to be a correlation with the number of increases and decreases in incident numbers i.e. a decrease noted between April and June, and August to September and increases noted the periods December and March against both reporting periods.

Currently there is no themes as to when a particular Incident Cause Group occurs more often or has more of a physical impact (severity) to staff against a specific period within the year i.e. more falls occur in the winter months than against the summer period, or less Slip Trips incidents are reported in the summer periods (dry, brighter etc.) than during the winter period. The overall trend is that reported incident numbers is on the decrease.



The graph below shows this data as a continuous time-line from 01 April 2023 to 31 March 2025



Incidents by day and time

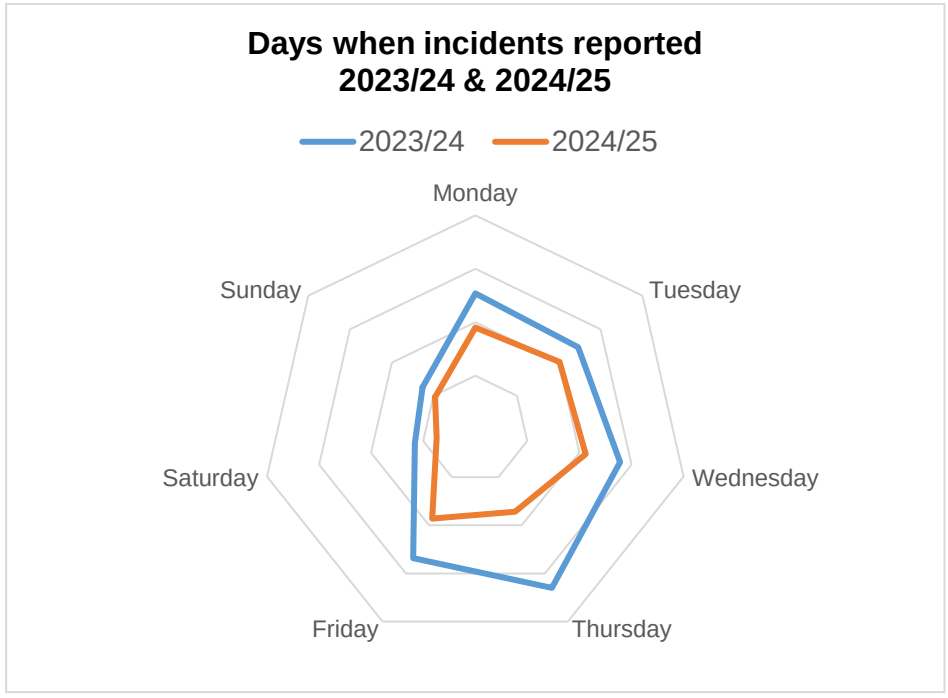
Dates and times are crucial for analysing incident data as they provide a timeline and context for events, enabling organizations to identify patterns, understand response times, and improve incident management processes. They help establish when an incident occurred, when it was discovered, and how long it took to respond and resolve.

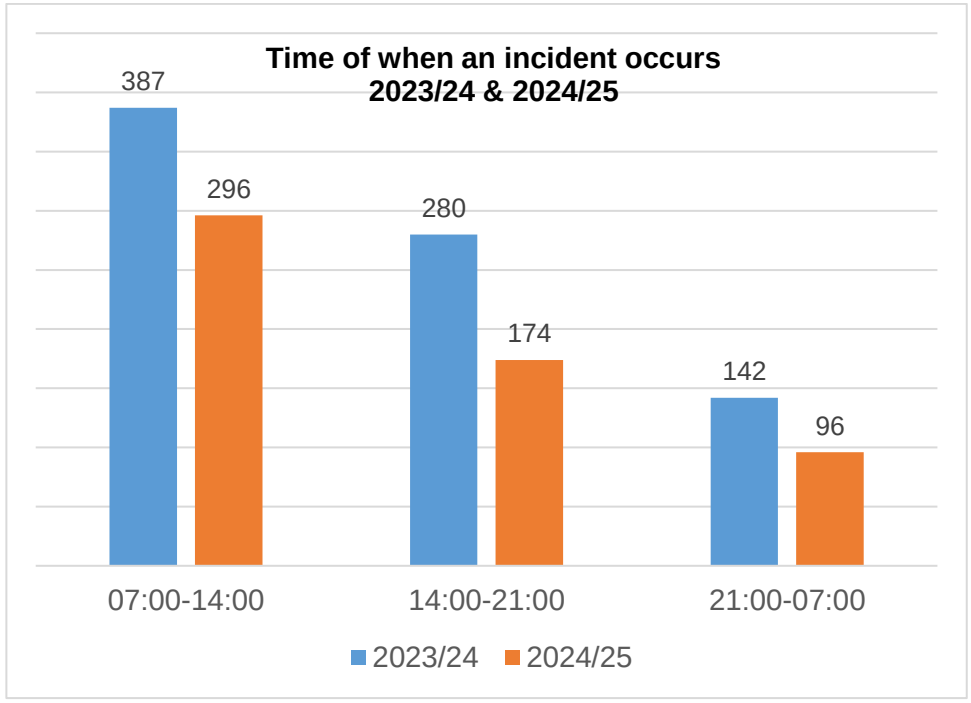
The two charts provided show when accidents happened within the week (Monday – Sunday) and when within a day an incident occurs.

With this data there appears to be no link against a popular day an incident occurs, as in 23/24 this was a Thursday, where in 24/25 Wednesday was the most reported day for incidents.

In regards the most frequent period of a day in which an incident occurs this remained consistent i.e. 0700 -14.00, 14.00-21.00 then 21.00-07-00.

A possible factor that may influence more Health and Safety incidents being reported during 07.00 -14.00 may include: staff may not be fully awake or alert leading to lapses especially in jobs that require high levels of attention such as healthcare, workplace pressures place on staff to get jobs/tasks completed quickly and a greater number of staff work within this time period



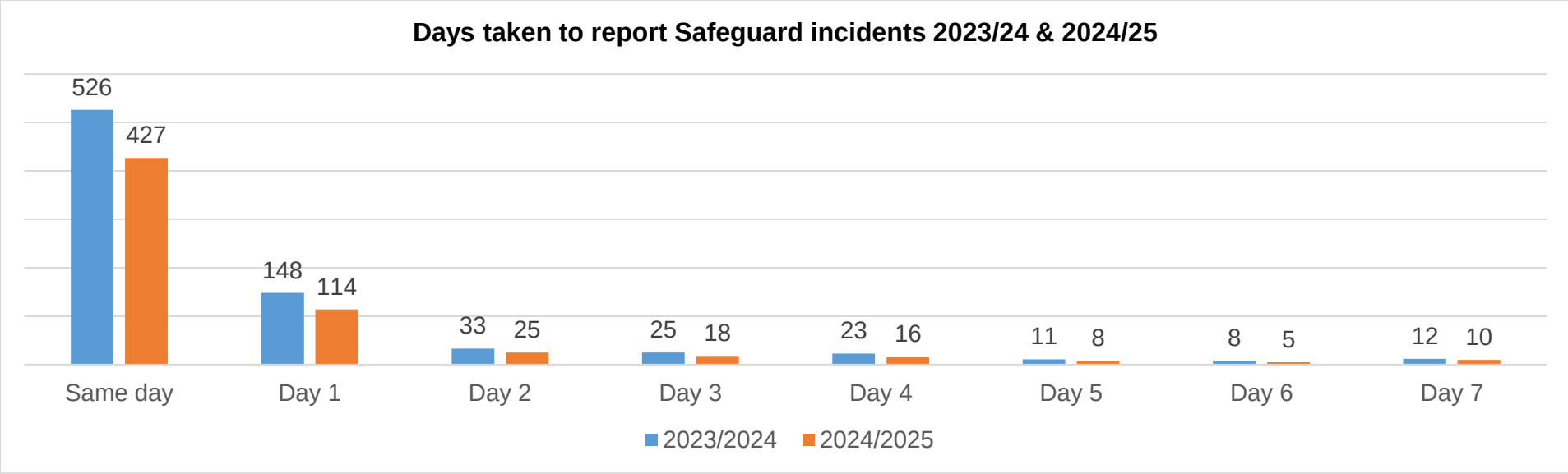


Days taken to report an incident

A strong culture of immediate incident reporting means employees feel safe and empowered to report any safety concerns, near misses, or incidents without fear of blame or reprisal. This fosters a proactive approach to safety, allowing organizations to identify hazards and prevent future incidents.

Most of the Health and Safety incidents were reported within one day of occurring (87% n=623) which indicates a good timely reporting culture.

This shows an increase of 4% against the previous reporting period (83% n=674).



Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The Trust as an employer and when it has control of premises it has a legal requirement to report specific workplace accidents, injures and dangerous occurrences to the Health and Safety Executive (HSE).

If someone has died or has been injured because of a work-related accident, this may have to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

Not all accidents need to be reported – a RIDDOR report is only required when:

- The accident is work related, and
- It results in a reportable injury

Types of reportable incidents

Below are the summaries on the types of reportable incidents RIDDOR reportable.

There are presently four types of reportable incidents is scope of RIDDOR that the Trust reported against:

The 7 Reportable RIDDOR types, are:

- Death of any person (with the exception of a suicide) if it resulted from a work related accident (Regulation 6)
- Specified injury to a worker (Regulation 4)
- Over-7-day incapacitation of a worker (Regulation 4)
- Non-fatal accidents to people other than workers (Regulation 5)
- Occupational diseases - diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work (Regulation 8) Regulation 9 requires employers to report any disease caused by an occupational exposure to a biological agent and cases of occupational cancer
- Dangerous occurrences - Dangerous occurrences are certain incidents with a high potential to cause death or serious injury. Those incidents which must be reported are listed Schedule 2 of RIDDOR
- Gas incidents - Distributors, fillers, importers and suppliers of flammable gas must report incidents in connection with that gas, where someone has: died, lost consciousness, or, been taken to hospital for treatment diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work

Trust Incidents that were reported to Health, Safety & Environment (HSE) under RIDDOR for the period 2024/25

For the period 2024/25 the Trust reported 16 RIDDOR incidents.

This is an increase of >10 against the previous figure reported during the 2023/24 period.

The largest increase of RIDDOR incidents was reported under the category: Over 7 Days Incapacitation seeing a rise from 2 to 5.

2 RIDDOR incidents were reported under Occupational Disease in 2024/25, where none were reported during the period 2023/24 (from 0 to 2).

Themes, trends & learning

On reviewing the RIDDORs, all those reported by the Trust came from areas across the Trust (Acute and Community), with the trend that the Trust reported its 16 RIDDORs under just three (4) different types:

- Over 7 Days Incapacitation
- Specified Injury; &
- Dangerous Occurrence

- Occupational Disease

This is against a total of seven (7) reportable HSE RIDDOR categories have available.

- Against the two reported Occupational Disease RIDDOR's, OH&W and Health and Safety have worked to raise the profile of occupational dermatitis and in conjunction with ongoing health surveillance is continuing to identify cases and support staff going forward. It should be noted that health care workers are acknowledged by the HSE as an at risk occupational group due to the prevalence of known risk factors for the disease e.g. high frequency of hand washing and glove use

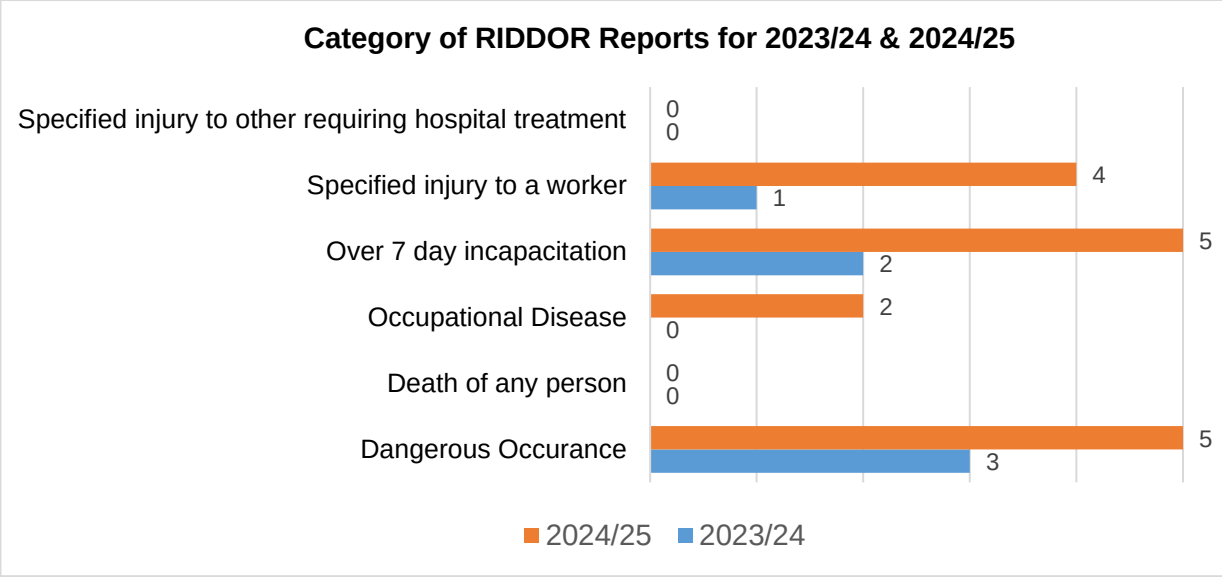
Within the Over 7 Days Incapacitation reported number of five (5) RIDDORs, 2 related to staff receiving injuries occurring whilst undertaking their tasks, and 2 where unwanted injuries received by a 3rd party i.e. a patient.

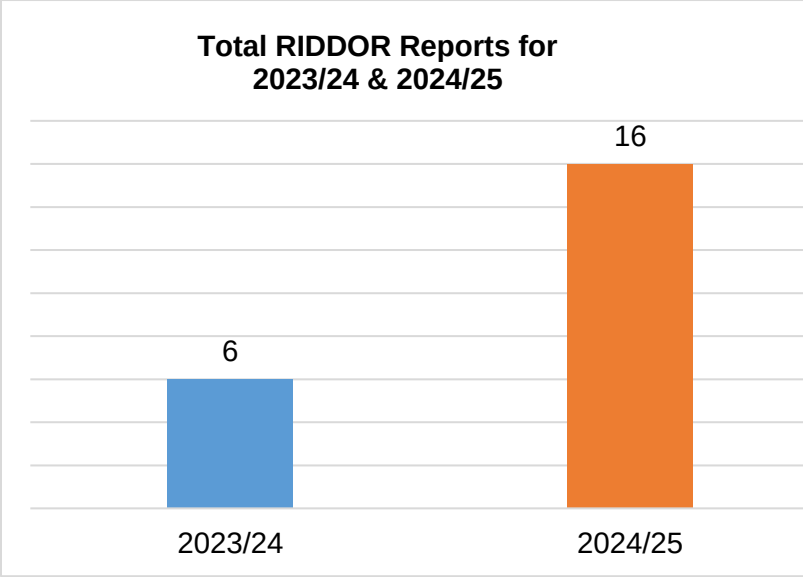
The other joint largest category of RIDDOR's were reported under:

- Dangerous Occurrence, which totalled five (5)

These five (5) incidents were related to needlestick incidents and similar to the Over 7 Day Incapacitation incidents were recorded across Trust services against different teams/departments/wards.

One theme that does appear is that the majority of the five (5) reported is that three (3) of these incidents occurred to staff after the use of a sharps and before its disposal. This is consistent with the overall figures for reported needlestick injuries over the same period which saw a total of 103 incidents with 49 of those being after use before disposal. Whether this is due to environmental factors, human factors, work practices or workload the ongoing work by the Trust to provide needle safe devices where possible and an emphasis on point of use disposal (POUD) will reduce where possible the window of opportunity for contaminated sharps to be involved in a staff injury.





Timeframes of reporting to HSE RIDDOR reportable incidents

For most types of incidents, the responsible person must notify the enforcing authority without delay, and in accordance with the reporting procedure a report must be received by HSE within 10 days of the incident.

For accidents resulting in the over 7 day incapacitation of a worker, the responsible person must notify the enforcing authority within 15 days of the incident, using the appropriate online form.

Cases of occupational disease, including those associated with exposure to carcinogens, mutagens or biological agents, must be reported as soon as the responsible person receives a notification of a diagnosis.

The Trust & iFM Bolton reported 7 incidents outside of the HSE timeframe for the period 2024/2, with the following rationale for delayed reporting:

- Incident 260448

Incident initially submitted & closed as outside of Bolton Foundation Trust, onward reported to HSE by Health and Safety Team within 10 days of being notified.

- Incident 255192

Delay in confirmation of diagnosis which then triggered escalation of incident as a RIDDOR.

- Incident 248500

Staff initially in work - Non compliant with the current Safe System Of Work (SSOW) procedure and MH training, no pre-user check carried out , continued to use despite fault, refused A&E, did not follow managers advice or modified their duties - therefore potentially cumulative damage could not be ruled out.

- Incident 246670

Staff member was initially in work - Manager failed to notify the Health and Safety Team of sickness until their RTW - delay in division supplying staff details.

- Incident 263892

Multiple delays in providing information - initially believed non specified injury with injured staff member remaining in work and possible medical collapse needing to be excluded.

- Incident 267297

Delay in providing required information.

- Incident 266633

Delay in initial notification and further delay providing required information, onward reported by Health and Safety Team within 10 days of notification.

Next Steps

The Health & Safety Team have been working to raise awareness of RIDDOR with information available on the Trust Intranet and making information available for managers/staff within each workplace departments Workplace Health & Safety File. Staff also have the option when reporting an incident of flagging it as being potentially RIDDOR reportable, prior to its initial submission when completing the incident reporting process on-line.

These incidents are automatically sent to the Health & Safety Team who undertake a review and/or investigate them accordingly. For the future the team are planning standalone training sessions on RIDDOR but also covering the topic RIDDOR during the Corporate Welcome package under the Teams Health & Safety Induction presentation. These together are envisaged to improve awareness and reduce reporting time scales.

Training compliance:

Core Skills Training Framework (CSTF) – NHS Trusts in England

The CSTF sets out the minimum learning outcomes, frequency of refresher training and links to relevant legislation or expert guidance.

The aim of the CSTF is 'to enable consistency in the core content of statutory and mandatory education and training' by creating a set of documents and processes that support organisations to align to the same standard and content. The CSTF is key enabler of portability for statutory and mandatory training across the NHS.

Included within the 11 Core Training Frameworks for Trust staff to comply with and be in date against, includes:

Conflict Resolution Fire Safety Moving and handling Health, Safety and Welfare

Conflict Resolution & Prevention and Management of Violence and Aggression (PMVA) Training

- The Trust did not meet its mandated target of at least 95% compliant for the reporting period 2024/25
- The Trust only exceeded the training compliance figure of 95% once throughout 2024/25, which was in December 2024 with 100% compliance

Note: Conflict Resolution is a standalone training package that all staff are required to complete, it also forms part of a suite of training packages available for identified staff to undertake. The additional training packages on top of Conflict Resolution come under Prevention and Management of Violence and Aggression Training (PMVA) packages. These additional levels of training are titled PMVA Level 2, 3, 4 or 5 and do contain the additional need to complete Conflict Resolution i.e. PMVA Level 3 (Conflict resolution, plus blocks and breakaway techniques). As a standalone training package the Trust records Conflict Resolution as PMVA Level 1.

Figure 1. Conflict Resolution & Prevention Training Compliance figures between 01 April 2024 & 31 March 2025

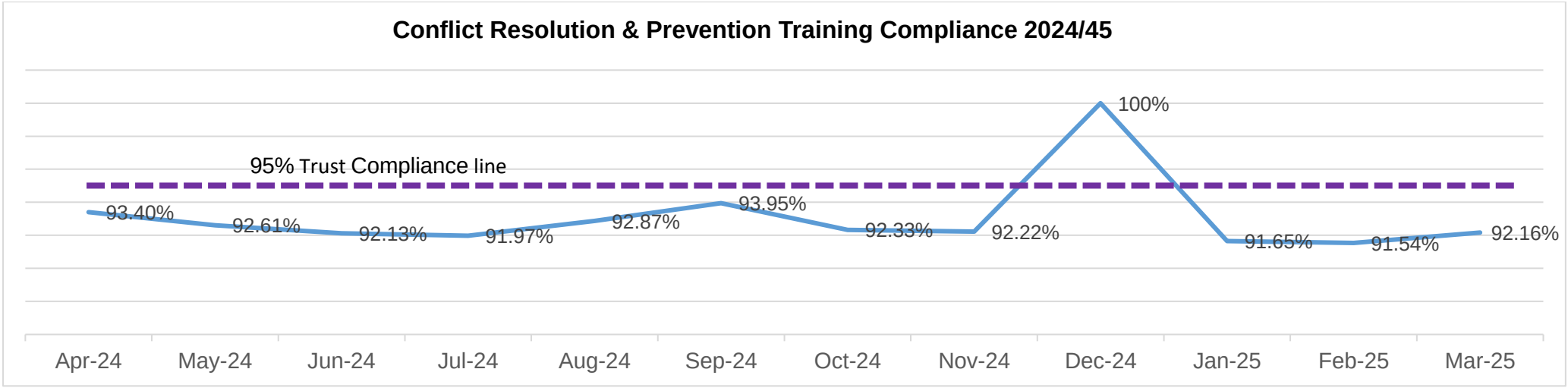
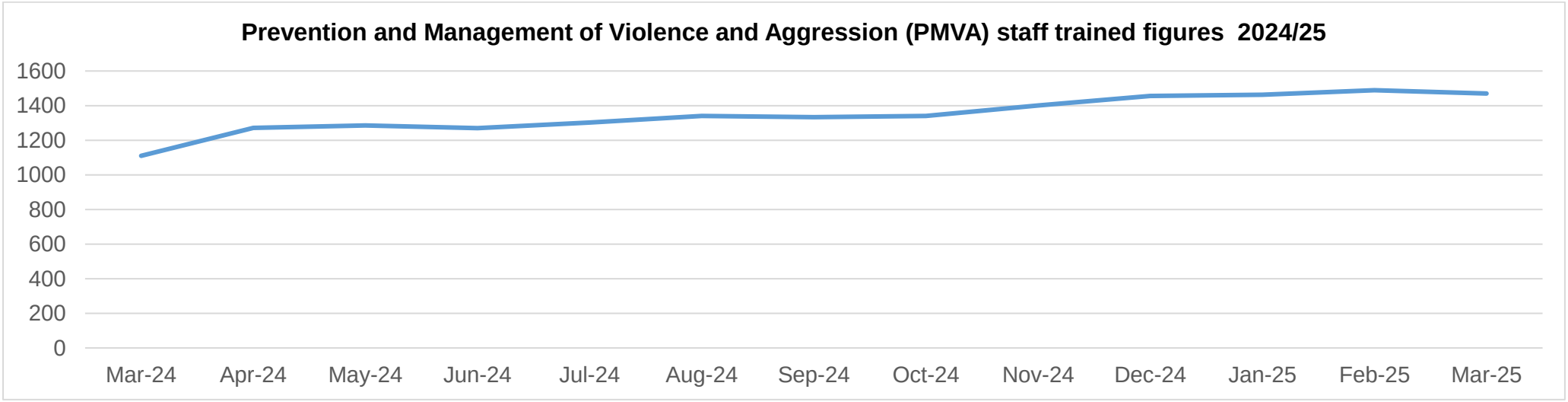
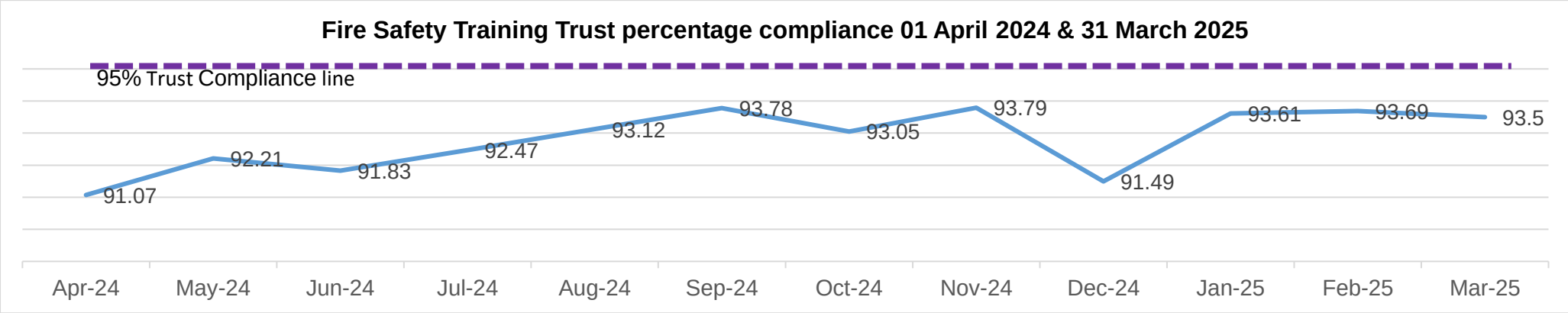


Figure 2. PMVA trained staff training figures between 01 April & 31 March 2025



Fire Safety Training

Fire safety training remained consistently under the Trust target of 95% during 2024/25 but remained above 91% throughout the year. Fire Warden training is non-mandatory with 67 staff members receiving training during this period. This training qualification is valid for 3 years.



Manual Handling Training

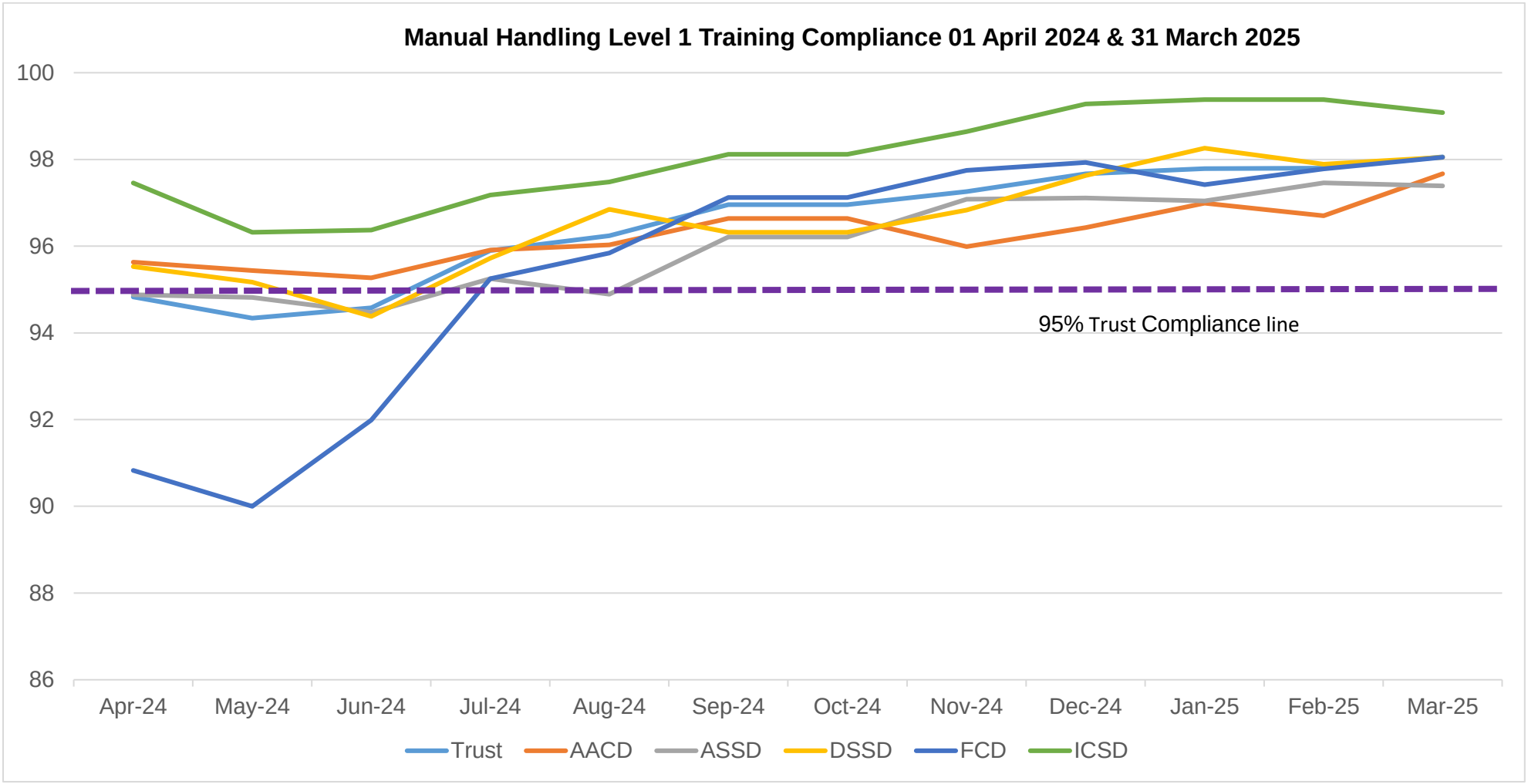
- Manual Handling Level 1, the Trust met its mandatory requirement target of 95% compliance for the period 2024/25 (see Figure 1 below)
- Manual Handling Level 2, the Trust did not meet the compliance target of 95% in 2024/25 (See Figure 2 below)

Not achieving training compliance in the workplace can have severe consequences, impacting everything from safety and morale to productivity and legal standing. Failure to complete training can lead to increased accidents, reduced efficiency, and even legal ramifications for both individuals and the Trust.

From a Health and Safety perspective not having trained staff can result in unsafe work environments, increasing the likelihood of accidents and injuries.

Divisions are to focus on improving their Moving and Handling Training figures and the promotion of why training is important, with oversight through the Group Health and Safety Committee.

Figure 1. Manual Handling Level 1 training compliance percentages between 01 April 2024 & 31 March 2025.



[Figure 1](#) **above,** Shows Manual Handling Level 1 training compliance percentages between 01 April 2024 & 31 March 2025 as per Trust overall compliance percentage and per Division compliance percentage.

Main themes:

- The overall Trust compliance target for mandatory training is **95%** which the Trust did not achieve in **Q1,** but did in **Q2, Q3 and Q4**
- Two divisions (**AACD and ICSD**) achieved and maintained compliance throughout the reporting annual period

- Two divisions (**DSSD and FCD**) did not achieve compliance in **Q1** however achieved and maintained compliance in **Q2, Q3 and Q4**
- **ASSD** did not achieve compliance in **Q1,** however achieved and maintained compliance in **Q2**, **Q3 and Q4**

Observations:

There has been a noted improvement for overall Trust compliance throughout the reporting annual period.

Within all divisions, there has been a noted improvement from the start of the reporting period to the end of the reporting period and acknowledge the on-going commitment to have maintained/improved on these figures.

There has been a noted improvement within the Trust as **FCD** had the lowest compliance figure achieved in 90% (May 2024), which by March 2025 the lowest had increased to **98.05%** a huge marked improvement.

Figure 2. Manual Handling Level 2 training compliance percentages between 01 April 2024 & 31 March 2025

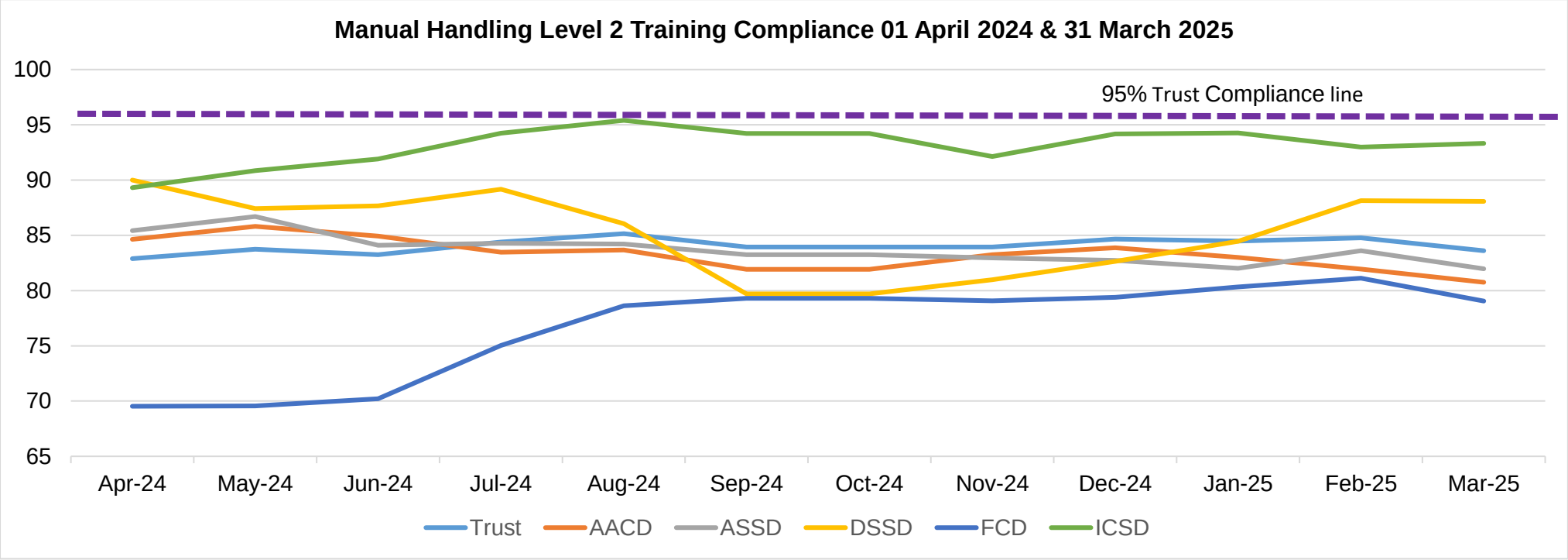


Figure 2 above, shows Manual Handling Level 2 training compliance percentages between 01 April 2024 & 31 March 2025 as per Trust overall compliance percentage and per Division compliance percentage.

Main themes:

- The overall Trust compliance target for mandatory training is **95%,** which the Trust did not achieve as a collective (**AACD, ASSD, DSSD, FCD, Trust and ICSD**) in any quarter of this reporting annual period

- **AACD** achieved their lowest compliance figure of **80.75%** in **March 2025** and their highest compliance of **85.81%** in **May 2024**

- **ASSD** achieved their lowest compliance figure of **81.97%** in **March 2025** and their highest compliance of **86.7%** in **May 2024**
- **DSSD** achieved their lowest compliance figure of **79.7%** in **September and October 2024** and their highest compliance of **90% in April 2024**

- **FCD** achieved their lowest compliance figure of **69.52%** in **April 2024** and their highest compliance of **81.12%** in **February 2025**

- **ICSD** achieved their lowest compliance figure of **89.31%** in **April 2024** and their highest compliance of **95.4%** in **August 2024**

Observations:

There has been a noted improvement for overall Trust compliance from the start of the reporting annual period to the end of this reporting period.

The overall picture during this period is the Trust started at **82.89% in April 2024** and increased to **83.61% by March 2025.**

There has been a noted improvement in **ICSD** as they achieved compliance of **95.4% in August 2024** as the only division to achieve compliance for one month throughout the **FCD, ICSD & the Trust** ended this reporting period (Mar 25) on a higher training compliance figure than they started back in April 2024.

Health and Safety Training

All staff that work in a health and social care setting are required to undertake Health, Safety and Welfare training which is included within the 11 core topics captured under the UK Core Skills Training Framework (CSTF).

For the Trust, Health Safety and Welfare training compliance remained consistently above the Trust target of 85% throughout 2024/25, in line with 2023/24 figures.

Figure 3. Health, Safety & Welfare training compliance percentages between 01 April 2024 & 31 March 2025.

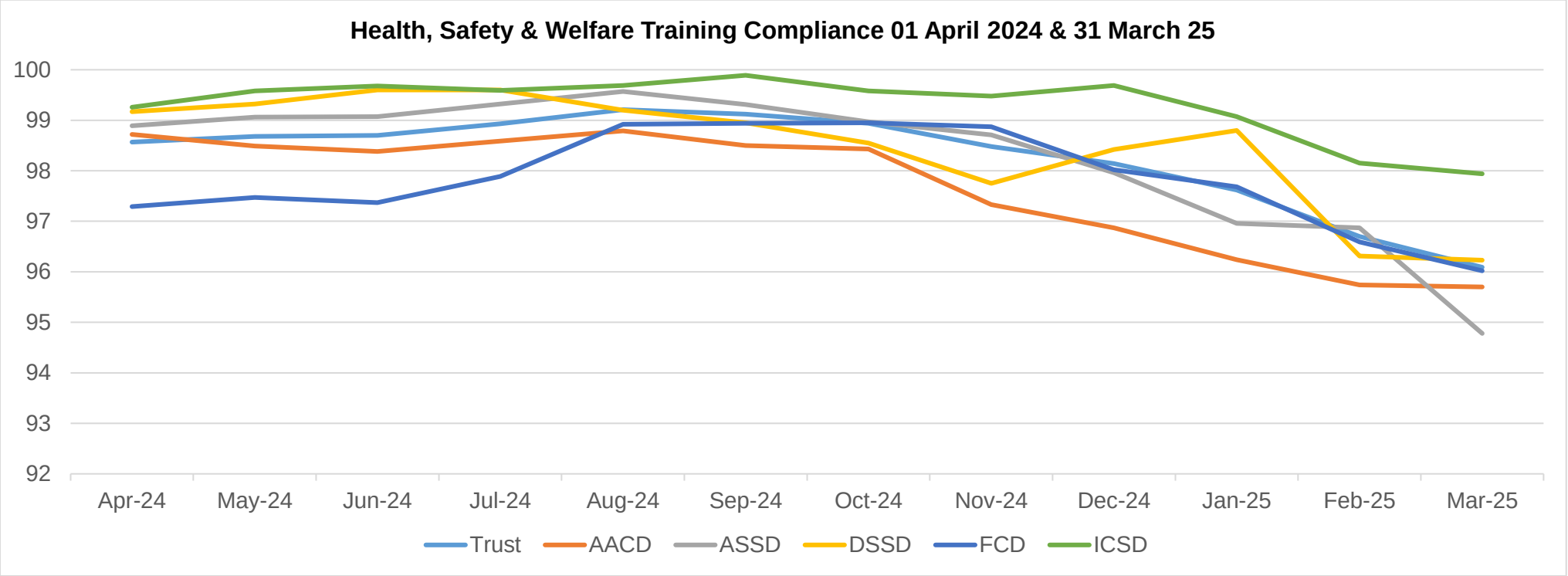


Figure 3 above, Shows Health, Safety & Welfare training compliance percentages between April 2024 & March 2025 as per Trust overall compliance percentage and per Division compliance percentage.

Main themes:

The overall Trust compliance target for mandatory training is **85%** which the Trust achieved in all quarters of this reporting annual period.

The lowest training compliance percentage was **94.78%** achieved across the reporting period

Observation:

The Trust achieved compliance throughout the reporting period, however all Divisions (**AACD, ASSD, DSSD, FCD, Trust and ICSD)** finished on a lower level of training compliance figure than at the start of the reporting period.

Manual Handling:

During the reporting annual period of **01 April 2024 & 31 March 25** the number of incidents per quarter were:

- **Q1** received **26** incidents reported
- **Q2** received **17** incidents reported
- **Q3** received **19** incidents reported: and,
- **Q4** received **31** incidents reported
- The lowest number of incidents were reported in **December 24** with **4** incidents; and,
- The highest number of incidents were reported in **January 25** with **14** incidents reported

Observation:

An increase of incidents reported compared to 2023/24.

Across all divisions the number of incidents reported remained in **single figures,** with no area identified as an outlier.

A total of **16** incidents were initially reported as '*Near Miss (Captured Before)'* when rated on its initial severity, a noted increase in 2024/25.

A total of **45** incidents resulted in '*No Harm'* being reported.

Incident investigations continue to promote a culture of learning and preventive measures.

Manual Handling incidents recorded as *'No Harm or Low Harm' were reported for the majority of quarters within 20*24/25.

There was only **1** incident (Q3) reported as *'Moderate Harm'*. (*See: **Incident 265889***).

During the reporting annual period of **24/25** there were **2 incidents** were reported **(Q1)** *RIDDOR (See: Trust Incidents that were reported to HSE under RIDDOR).*

Next steps

Actions for 2025/26:

- From April 2025, Manual Handling Level 2 will be taught weekly at a community base (Integrated Community Equipment Stores, Adelaide Street) to aim to improve community staff access and compliance

- In April 2025, Manual Handling Advisor and Key iFM Bolton representatives are meeting to aim to align Moving and Handling e-learning packages, induction presentations, assessment methods and review the need for Moving and Handling Level 2 aspects for Portering staff involved in patient handling to aim to teach Portering staff safe handling techniques when their assistance is required

- Update post falls process and equipment flowchart jointly with the Trust Enhanced Care Lead to ensure an effective post falls process is in place and staff are trained to utilise all equipment available in the event of a fall

- Review and remove self-competency assessment facility currently available for stand aids and hoists items of equipment with the aim to improve assurance of staff competence. Also, create a regular face to face training schedule for stand aid and hoist training for appropriate staff members improving staff level of competency

- Develop new training content for bespoke Manual Handling Level 2 training sessions to support Theatres, Maternity and Paediatric staff to meet their unique training needs and improve patient and staff safety

- Obtain a permanent and suitable training room with equipment, storage and resources available

- Implement new Bariatric Specialist Rental Contact with Five Mobility to improve Bariatric patient care and equipment requirements

- Implement new Slide Sheets Supplier with GBUK Banana to improve utilising the correct technique for patient and staff safety

- Key personnel to provide relevant support and guidance during period of Manual Handling Advisor maternity leave – Actions to be prioritised upon return to work

Claims:

The Liabilities to Third Parties Scheme (LTPS) handles all non-clinical negligence claims against member NHS bodies. The LTPS is run and administered by NHS Resolution (NHSR). The LTPS covers the Trust against Employers Liability claims (EL) and Public/Occupiers Liability claims (PL).

The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year. Individual member contribution levels are influenced by the number of staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions.

LTPS claims are reported to NHSR through the Ministry of Justice Personal Injury Portal. There are some types of claims that are not reported via the Portal and these are Data Protection claims and claims which involved assault on a member of staff by a patient. Claims that fall into this category are reported in accordance with the LTPS reporting guidelines.

Learning from claims and applying the learning plays an essential role in reducing the costs to the Trust associated with EL and PL claims. The excess payable by the Trust under the LTPS cover to the Trust's insurer is £10,000 (EL) and £3000 (PL) for each claim.

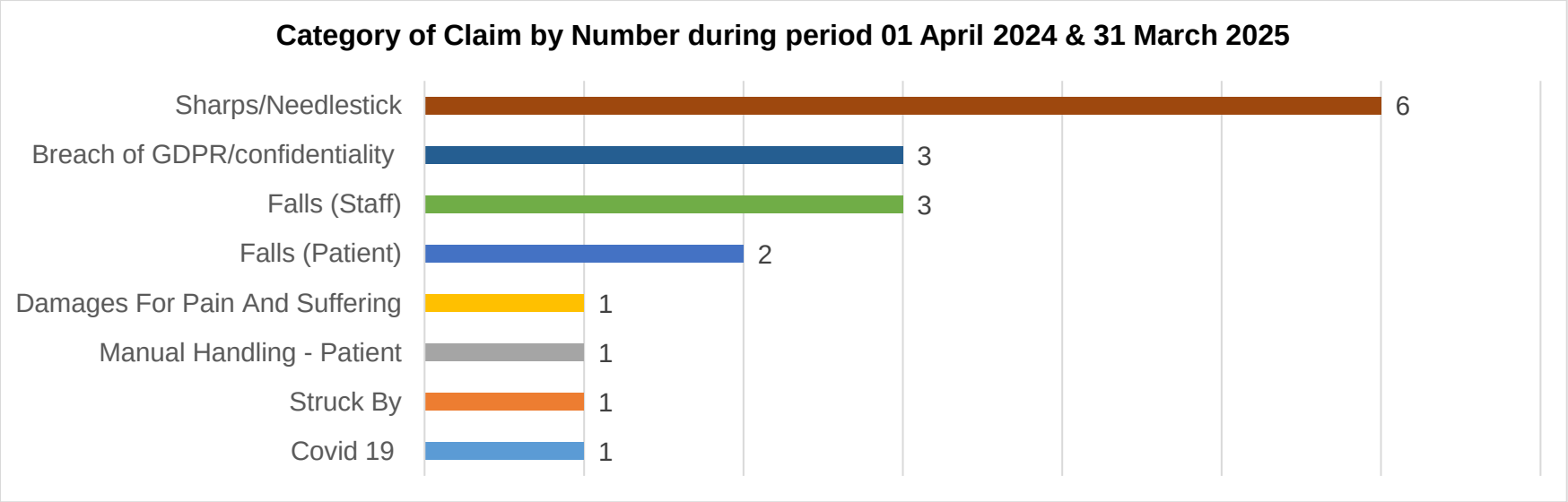
In addition to the cost of damages, there are additional costs related to the administration of legal actions, the costs related to sickness and absences, such as agency costs and the physical and psychological costs to staff involved. Other costs to consider are the impact on visitor wellbeing arising from injuries sustained.

The Trust's contribution to the RSPT for the year 2025/2026 is **£231,800,** an increase on last year's premium of **£27,968**.

In the period 01 April 2024 to 31 March 2025 the Trust received eighteen (18) LTPS claims, 8 of these were claims from employees of the Trust. The other 10 claims were either received from the public or iFM Bolton employees. This is a decrease against the same period previously (23/24) which was 28 received claims.

The category and number of each claim made during the period 01 April 24 & 31 March 2025 are shown in Figure 1 chart below:

Figure 1. Category type and number of claims



In the period 1 April 2024 – 31 March 2025;

- Seventeen claims were closed. It should be noted that the closed claims will relate to claims received in other financial years
- A total of 6 claims were settled with damages totalling **£63,000**, claimant costs of **£42,457** and defence costs of **£4,811.20**
- 2 of the settled claims were claims from employees, the maximum cost payable by the Trust is the excess of £10,000 for each claim. The remaining five were public liability claims from either visitors or iFM Bolton employees, the excess for these claims is £3000
- 10 of the closed claims had been defended, and 1 of the claims the Trust was not the correct Defendant and the claim was redirected to iFM Bolton

Learning from closed claims:

- All staff reminded of Trust Policy regarding the safe transportation of notes as per policy (SBAR circulated)
- IG Training to be updated to include Transportation of notes within community settings
- To ensure all departments have the zipped bags to store/transport notes
- Rollout of EPR within Integrated Community Services Division
- Matron and A4 Ward Manager discussed needle stick incident with A4 clinical and medical teams and the importance of safe disposal of sharps

- Utilisation/escalation of Sharps incidents including lessons learnt through the re-established Trust Sharps Safety Committee

Audits:

While Health and Safety audits are not legally mandatory, they are strongly recommended and can be crucial for a Trust to stay compliant and ensure a safe working environment. However, there might be situations where an audit is not immediately necessary, particularly if a Trust has a well-established and effectively maintained safety management system, minimal risk, and a good safety culture.

Listed are why during this period the Team have identified a safety audit an immediate priority, including:

Existing robust safety management system:

If a business has a strong system in place, including clear policies, procedures, training, and regular inspections, an audit might seem redundant.

The Trust has strong and accountable assurance committee which holds divisions to account in regards to Health and Safety requirements in place i.e. risk assessment.

The GH&SC is held accountable by the Quality Assurance Committee ensuring it submits its Assurance Report which identifies/escalates risks.

Staff Health and Safety Training figures are above compliance requirements.

Effective risk assessments and regular inspections:

If a business regularly conducts thorough risk assessments and performs regular inspections to identify and address potential hazards, the need for a formal audit might be less urgent.

The Trust has in place a Workplace Health and Safety Folder, which all Divisions through the GH&SC provide formal assurance that these are reviewed and in date, with actions plan implemented where gaps are identified.

Proactive risk management:

Even in situations where an audit might not be an immediate priority, proactive risk management, including regular inspections and risk assessments, is still essential for maintaining a safe workplace.

Workplace are audited through Bolton System Care Accreditation (BoSCA).

Health and Safety Team have previously audited Workplaces and provided feedback to limit/mitigate risk.

Manual Handling equipment is inspected, serviced, calibrated as part of PPM in place (managed through EMBE or Divisions).

Management of Medical Devices is through the Medical Devices Committee who meet monthly where assurances are provided through formal reporting, Assurance Reporting is then via the GH&SC.

The Health and Safety Team are planning a program of ward visits in 2025/26 period linked to the Workplace Health and Safety Folder, with its findings feedback directly to wards, Governance Managers and the Groups Health and Safety Committee.

Health and Safety Executive (HSE) inspections:

During 2024/25 the Health and Safety Executive (HSE) undertook no inspections to the Trust.

This is against two HSE visits that the Trust received the previous reporting period.

Alerts:

During 2024/25 there was one National Patient safety Alert related to Health and Safety, as detailed below:

Note: This was an update to a previously received NPSA alert (NatPSA/2023/015/UKHSA which the Trust confirmed compliant with from 2023.

Date	Reference No.	Alert Type	Title of the Alert	Date Closed	Outcome
02/04/2024	NATPSA/2023/015/UKHSA(1)	National Patient Safety Agency	UKHSA - Update to advice provided in National Patient Safety Alert NatPSA/2023/015/UKHSA (carbomer containing lubricating eye products)	07 May 2024	Compliant All Actions undertaken.

Policies: Status of Health and Safety policies

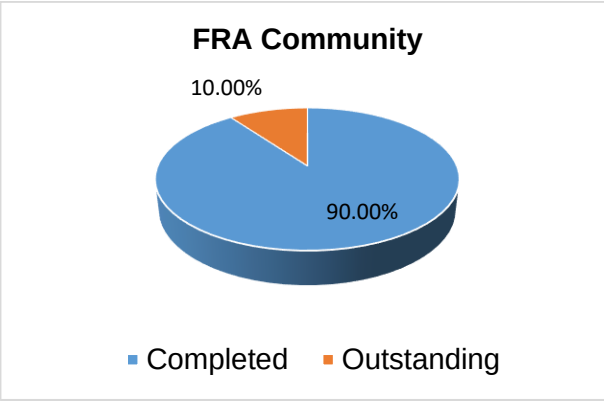
Name	Doc Type	Review Date	Status
Control of Contractors Policy.pdf	Policy	31/03/2028	
Management of Violence and Aggression Policy.pdf	Policy	21/11/2027	
Personal Protective Equipment Policy (PPE).pdf	Policy	01/04/2025	
Trust Fire Safety Policy.pdf	Policy	01/06/2025	
Medical Devices Training Policy.pdf	Policy	01/08/2025	
Control Of Substances Hazardous to Health (COSHH) Policy.pdf	Policy	01/12/2026	
Medical Devices Operational Policy v10.pdf	Policy	01/12/2026	
Electrical Safety Policy.pdf	Policy	01/04/2027	
Health and Safety Policy.pdf	Policy	01/04/2027	
Workplace Ergonomics and Display Screen Equipment	Policy	01/09/2025	
First Aid at Work Policy	Policy	01/05/2027	
Control of vibration at work policy.pdf	Policy	01/06/2027	
Safe Management of Sharps Policy	Policy	01/06/2027	
Latex Policy	Policy	01/06/2027	
Using Bedrails Safely Policy	Policy	01/06/2027	
Log Roll Technique and Training Policy .pdf	Policy	01/08/2027	
Manual Handling Policy .pdf	Policy	01/08/2027	

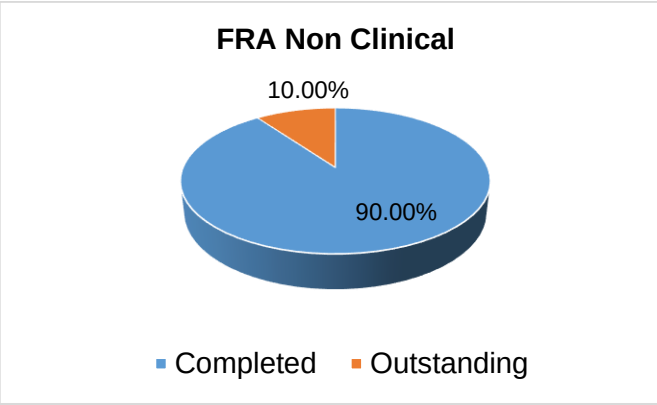
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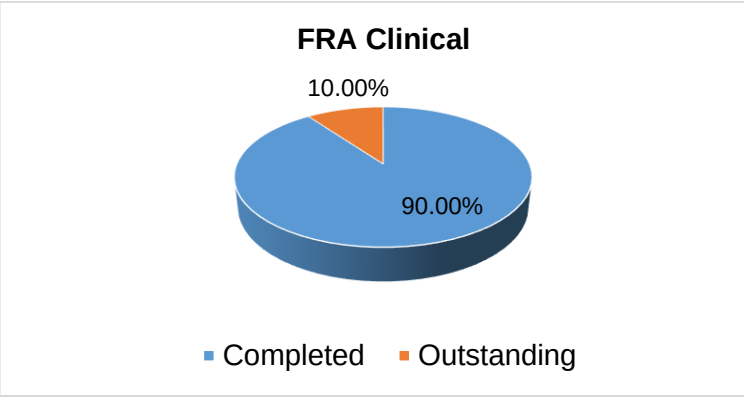
Fire Safety:

Fire Risk Assessments for all Royal Bolton Hospital buildings including Community buildings

iFM Bolton achieved a 90% compliance figure for completing/undertaking Fire Risk Assessments (FRA), with compliance progress tracked monthly at Fire Safety Committee for Assurance of over 191 Fire Risk Assessments.







Reporting period 2024/25

Background:

iFM Bolton have a KPI of 95% for compliance for Fire Risk Assessments (FRA) for all Royal Bolton Hospital buildings including Community buildings.

Snapshot on progress during this reporting period:

- In 2024/25 there was a 5% decrease in completion of FRA compared to the previous reporting period (23/24), which was due to a Team vacancy, which reduced the staffing level to 50%. A new Fire Safety Officer was successfully recruited in October 2024.

- In 2024/25 the number of completed/in-date FRA for the Trust was 90% compliant.
- Compliance on completed FRA continues to be monitored through the Joint Fire Safety committee.

- In 2024/25 iFM BOLTON provided support and guidance for fire safety where ever Trust staff work, this is across all premises including Community buildings.

Observations:

- By monitoring and reviewing the cause of incidents, it was established in 2023/24 against all reported False Alarms, 45% of these were associated with Greater Manchester Mental Health (GMMH K Block)
- The Fire Safety Team worked collaboratively with GMMH to find a solution against reported False Alarms which involved the splitting of shared alarm systems whilst ensuring both parties maintained a safe fire alarm
- Initially Unwanted Fire Signals were reduced by 60% (2023/24), which has since been reduce again by 28% in 2024/25

Fire Safety Governance

The Joint Fire Safety Committee continues to maintain oversight of Fire Safety for the Trust and reports through on a monthly basis to the Group Health and Safety Committee (GH&SC) via a Chairs report.

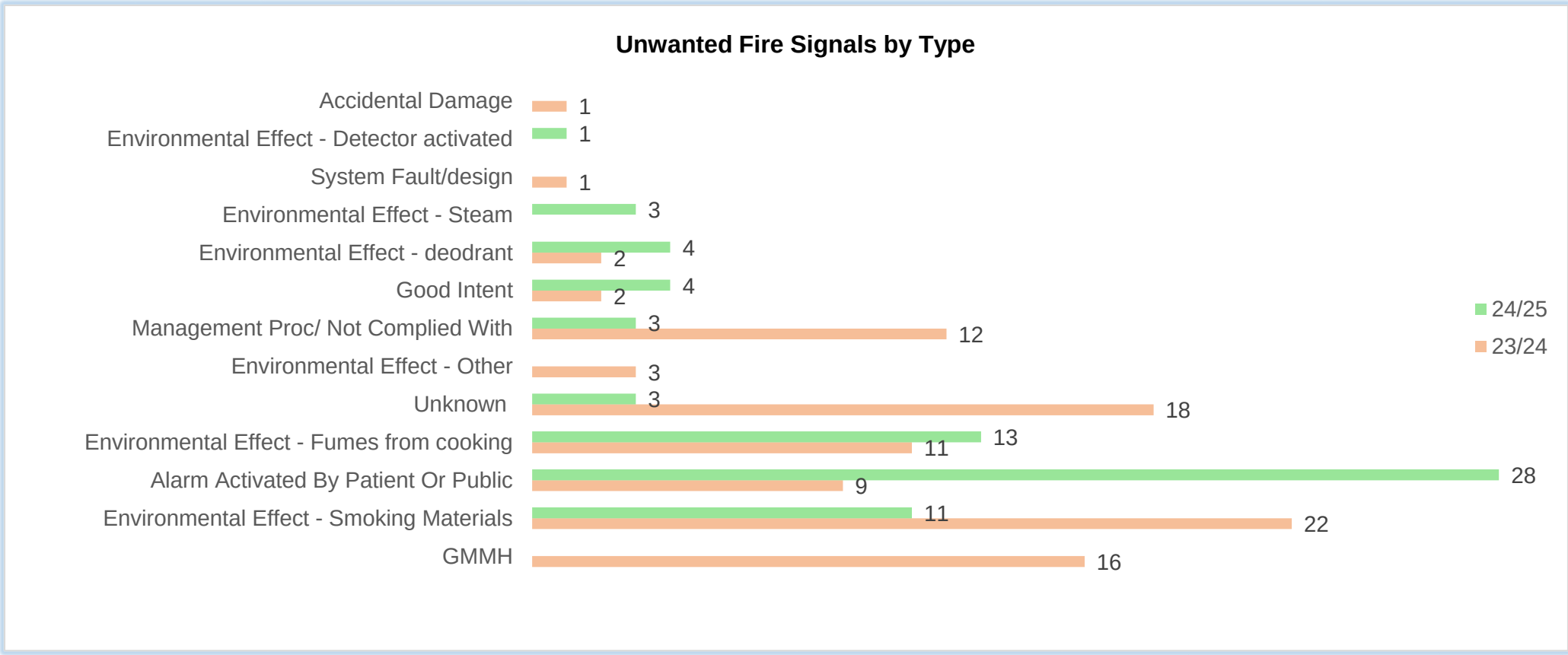
The Fire Safety Dashboard continues to be presented to the Fire Safety committee, to ensure assurance is provided with any areas of concern are then escalated through the applicable Governance Route.

The Fire Safety dashboard gives oversite against key areas of performance which are, listed below:

- False Alarms – Including types of Unwanted Fire Signals
- Fire Risk Assessment Compliance
- Fire Risk Assessments completed monthly
- Total actions open – By due date and status

Note: Unwanted Fire Signals by Type

An unwanted fire signal occurs when a fire alarm system activates due to something other than a genuine (real) fire. These are commonly referred to as a false alarm.



Present Risks

Compartmentation

Background Information:

Compartmentation is crucial for building safety as it restricts the spread of fire, smoke and heat, providing occupants (staff, patients & visitors) more time to evacuate and allowing firefighters to respond effectively.

Current Trust position

The compartmentation work required to ensure Trust buildings both in clinical, and none-clinical areas is sufficient and appropriate remains outstanding. Our program of works is progressing through CRIG to allocate capital expenditure for non-clinical areas and as part of the ward decant program clinical areas will be confirmed in Q1 (2024/25). It is anticipated to be completed within the next two financial years.

Whilst on-going compartmentation continues to mitigate associated risks the Trust has an evacuation strategy for all Trust occupied areas, Fire Safety Training is provided to individual staff as part of the NHS UK Core Skills Training Framework, early means of detection through the current existing fire alarm system. On top of this individual training the Emergency Response Teams (Fire Safety Officers, EPRR Manager, and Manual Handling Advisor as examples) can provide additional individual workplace training support. This training helps to ensure staff have the knowledge and skills to safely continue any evacuation if required, and supports the Trust compliance requirements against NHS EPRR Core Standards.

Incidents

The Trust has experienced two (2) real fire related incidents in 2024/2025, with both being risk scored as minor.

- The cause of the fire was a the charging port on the new computer on wheels, cause was loose connection to the charging port, identified by staff isolated removed power source, IT informed unit and the unit was subsequently removed from ward.
- Patient smoking in ED whilst on oxygen, small fire, extinguished immediately patient suffered minor injuries. A post incident was carried out. Whist a patient is in ED a full patient assessment isn't carried out, this only occurs if & when a patient leaves ED and continues into the hospital i.e. moves onto a ward, which is where staff complete a full assessment where a smoker is identified (cigarettes and/or e-cigarettes (including vapes)). At this point the dangers associated with smoking whilst on oxygen would be shared if relevant.

iFM Bolton continues to support the Trust with all fire safety related compliance, and fire safety issues.

Security:

Security Team – Staffing levels

In May 2024 the iFM Bolton Security Team consisted of 18 permanent, 1 Supervisor and 2 Bank officers with responsible for the Royal Bolton Hospital site. Individual officers are fully PMVA trained, fully SIA licensed and fully Conflict Management trained.

This section includes Security Risk Assessment assurances covering premises and departments for both the Community and Royal Bolton Hospital site

Group Security Committee is a subcommittee of Group Trust Health and Safety Committee and is authorised to set standards, for the management and control of security related issues across the Trust.

The purpose of the committee is to ensure arrangements are in place to manage security related risks to staff, patients and others in compliance with the Management of Health and Safety at Work Regulations 1999.

Assurance

Each of the clinical divisions provides an assurance report to the committee on a bi-monthly basis. This report provides assurance on compliance with completed Security Risk Assessments, Lone Worker risk assessments, new security related risks and controls, training compliance for Conflict Resolution and the Prevention and Management of Violence and Aggression and any learning from security related incident reporting.

Security Risk Assessments

In line with the current Trust Violence and Aggression Policy iFM Bolton Security Team assists departmental managers in the completion of their annual security risk assessments, which following this actions plans will be developed and recorded on the Trust Risk Register. Actions being prioritised based on the protection of life and avoidance of harm followed by the protection of assets and property.

Compliance figures against Security risk assessments for the period 2024/25: are

- May 2024 percentage rate of completed Risk Assessments in RBH were at: - 98%
- May 2024 percentage rate of completed Risk Assessments in Community sites: - 100%
- The percentage rate that stands now in April 2025
- April 2025 percentage rate of completed Risk Assessments in RBH were at: - 99%
- April 2025 percentage rate of completed Risk Assessments in Community sites: - 100%
- Including External Risk Assessments for all buildings not within directly physically connected to the main hospital spine e.g. J & K Blocks: - 100%

Additional support with Trust PMVA training compliance

In November 2024 a member of the iFM Security Team qualified as a Train the Trainer in PMVA, a qualification that will assist both the Trust and iFM BOLTON staff.

Security - Future plans

By the end of 2025 iFM Bolton expect to have installed a new CCTV system for the hospital, which will provide a better visual deterrent across the building assisting with any issues that arise helping both GMP and the Trust.

iFM Bolton Security related policies

All policies that are the responsibility of iFM Bolton Security have been reviewed and updated.

Asbestos:

Arrangements

This section of the report provides assurance against Asbestos regulations, which includes compliance requirements such as:

- Identifying 7 assessing asbestos-containing materials (ACM's)
- Management of risks and develop a plan
- Training and Safe Work Practices
- On-going monitoring and review

IFM Bolton seeks reasonable assurances from landlords of their premises or facility that are occupied by the Trust under a lease or tenancy agreement to provide a current Asbestos Management survey and/or policy.

Any person who undertakes work that exposes or is liable to expose any persons to asbestos must ensure that all control measures identified by an assessments are implemented.

iFM Bolton ensures its staff and contactors are aware of the results of any assessments, the risk to health of asbestos, precautions to be observed and any other information required to safeguard themselves or others.

All persons commissioning works ensure that any persons undertaking works on our/Trust premises are first informed of the location of any known asbestos containing materials which is near the proposed task. If an incident occurs or where there is an uncontrolled release of suspected asbestos iFM Bolton must be informed immediately.

Annual inspections

In 2024/25 iFM Bolton procured a new appointed Asbestos specialist contractor who continues to undertake inspections and provide recommendations on best practices and control.

Compliance in line with legislation is captured through monitoring carried out through regular inspections (also known as a survey), having in place in- date risk assessments, and the maintenance of an asbestos register.

The purpose of an Asbestos inspection aims to:

- Provide accurate information on the location, amount and condition of asbestos-containing materials (ACMs)
- Assess the level of any damage or deterioration of the ACMs and whether remedial action is required
- Provide information to produce an asbestos register and an asbestos management plan for the premises
- Identify hidden ACMs to be removed before refurbishment work or demolition

There are presently 48 locations on the Asbestos register that require an annual inspection with all locations being inspected in 2024/25 ensuring risks are appropriately managed.

Where existing Asbestos Containing Materials (ACM's) are in good condition and are not likely to be damaged, their condition will be managed to ensure the remain undisturbed (as reasonably practicable), through continued periodical monitoring (every 12 months) managed by iFM Bolton as per HSE guidance.

Regular inspections are carried out at least every 12 months, but could be more frequently if an ACM is in high risk area or is deteriorating.

As part of regular inspections where the condition of ACM is assessed by a visual inspection, validating the risk of harm and then ensuring the Asbestos Register is kept up to date.

Incidents, Shortfalls and Learning

Where asbestos reports highlight damaged ACM's or high-risk ACM's clarity is given to assure that the outcome of the actions taken is sufficient to control and avoid exposure to the mentioned materials.

There has been 1 incident related to asbestos during this reporting period. This incident occurred when a contractor who was carrying out work in a hospital site electrical substation, who came into close proximity to a gasket which contained Asbestos. A post incident review confirmed that the contractor was provided details of asbestos in the area through access of the Asbestos Register prior to starting, unfortunately when working in the substation it was noted that this particular pipe in which the gasket was located in was damaged visually exposing the gasket containing Asbestos. On report of the incident the

immediate area was subjected to atmospheric testing which confirmed no release of fibers in the area. The area was subsequently cleaned with gasket disposed of appropriately.

Training

The new specialist contractor has delivered annual refresher training to the iFM Estates team and the Health and Safety team members, designed to update and reinforce knowledge and skills related to working with asbestos, including awareness, non-licensed work and licensed work. Though there is no strict legal requirement to retake a full formal awareness course every year, some form of refresher training is generally recommended to ensure continued competence and awareness.

Summary

All Asbestos work has been completed in accordance with legislation and managed in line with both ACOP's L127 (The management of asbestos in non-domestic premises) and L143 (Work with material containing asbestos), which for some work requires notification to the HSE. Compliance involves a multi-faceted approach to manage the risks associated with asbestos-containing-materials (ACMS) which includes iFM Bolton on behalf of the Trust, assessing the recorded risk (Risk Register, implementing control measures such as visitors booking in onto site prior to undertaking work (Control of Contractors), ensuring proper training both for iFM and contractors, disposal procedures are followed i.e. using designated recycling center or a licensed landfill site, with an object properly wrap and a consignment note when appropriate.

Within iFM BOLTON Estates staff i.e. those who carry out maintenance work staff have received appropriate Asbestos training, which is provided annually. It should be noted though there's no strict legal requirement to retake a full formal awareness course every year, some form of refresher training is generally recommended to ensure continued competence and awareness.

As detailed when asbestos containing materials are identified and undisturbed, the fibers remain intact and therefore present no risk of harm.

Where existing asbestos containing materials are in good condition and are not likely to be damaged, their condition will be managed to ensure they are not disturbed, we continue to monitor periodically (every 12 months) as per HSE guidance.

Ventilation/Heating and Temperature Control:

There is a Ventilation Safety Group in line with the NHS England Premises Assurance Model with an agreed Terms of Reference (ToR). This is a collaborative group between the Trust and iFM Bolton.

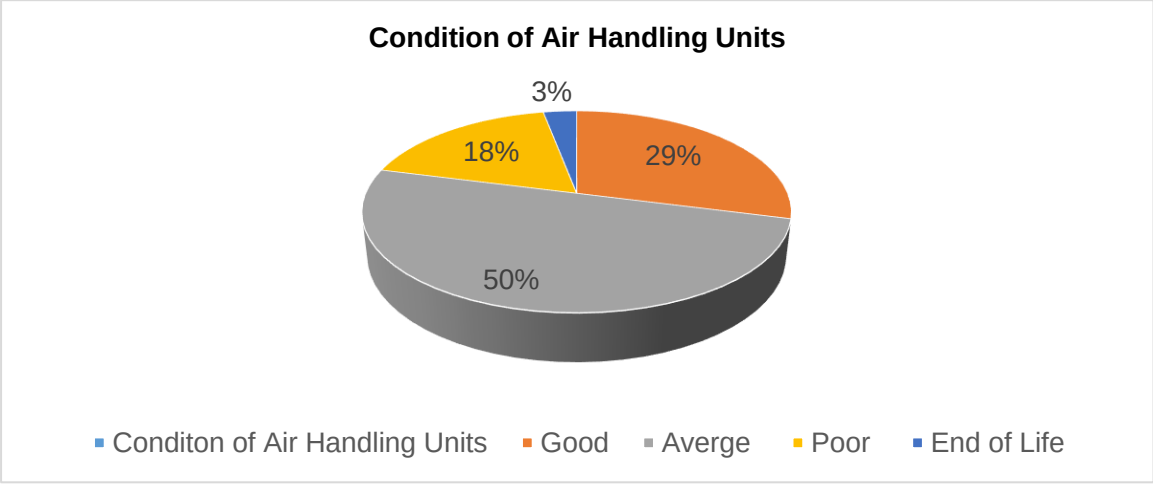
Within the NHS it has the NHS PAM framework, which is a tool to assess the safety, efficiency and effectiveness of an organisations estates and facilities management. By using such tool iFM Bolton helps it provide a comprehensive approach to assessing and assuring the safety and quality of the Trust premises.

The Trust Ventilation Safety Groups contributes within this toll to ensure that ventilation systems in the Trust premises are designed, installed ad maintained according to relevant standards and regulations. The group works with other stakeholders, including clinical leads, iFM Bolton managers and infection prevention and control teams (IPC) to ensure a holistic approach to ventilation safety.

It is chaired by a Trust representative (Deputy Director of Infection Prevention and Control) and has oversight around safety, risk, experience and assurance and meets bi-monthly reporting into both Group Health and Safety Committee and Infection Prevention and Control Committee.

Observation:

The group has identified and escalated that the condition of much of the critical ventilation currently in use within the hospital site is in poor condition. There are now 38 critical Air Handling Units (AHUs):



The risks associated with the condition of these 38 Air Handling Units have been added to the Trust Risk Register. Assurance this risk is being managed accordingly is through the Risk Management Committee.

Risk details:
Risk Number 3194 owned by IFM Bolton:
If the Ventilation plant fails in Ophthalmology and Maternity Theatres, then there will be no air supply to the Theatres. This will pose an infection risk to patients and will ultimately lead to cancelled lists.)

Controls to mitigate:
Building management system monitors temperatures and alarms during hot weather staff are deployed to ensure as much free cooling can be diverted onto the wards utilising external night time temperatures to cool the environment.
Annual audit of ventilation plant undertaken to inform maintenance management of general condition.
Fans have a backup motor available

ACTION

Business case to secure funding to upgrade/replace ventilation system and submitted to CRIG as soon as possible.
Within this reporting period there have been issues noted with the air handling systems in the new Elective Care Centre (ECC); these have been reviewed by the Authorised Engineer (Ventilation) and rectified but discrepancies were noted in the commissioning of the theatres. A review of the commissioning process has been undertaken which has identified learning to be built into future ventilation commissioning.

Water Safety:

The Trust has in place a Water Safety Group (WSG) in line with the NHS England Premises Assurance Model. The groups operates under its agreed Terms of Reference (ToR) which are reviewed at least annually.

This is a collaborative group between the Trust and iFM Bolton. It is chaired by a Trust representative (Deputy Director of Infection Prevention and Control) and has oversight around safety of water used by patients, staff, and visitors within Trust premises.

The group meets bi-monthly reporting into both Group Health and Safety and Infection Prevention and Control Committees.

There are no issues that the Water Safety Group felts necessary to escalate as an issue under Alert (AAA Chair's Key Issues Report) to the Group Health and Safety Committee.

The group has worked on several projects/work streams during this period, including:

It has developed some teaching resources for Water Safety. This will be disseminated to Matrons and Ward Managers in 2025/26 in line with a new Trust Water Safety Policy

Reviewing the assurance processes for logging and completing flush logs for low-use outlet facilities it is responsibility for.

Refreshed Water Safety Plan that has been developed in conjunction with the Authorised Engineer (Water) and approved by the Water Safety Group. The Water Safety Group has approved the Responsible Persons (RP), Authorised Persons (AP) and Competent Persons (CP) in line with HSE Approved Code of Practice (ACOP) L8 publications and Health Technical Memoranda (HTM) 04-01 Water Systems.

The site Business Continuity Plan for water has been reviewed with additional measures added to improve resilience.

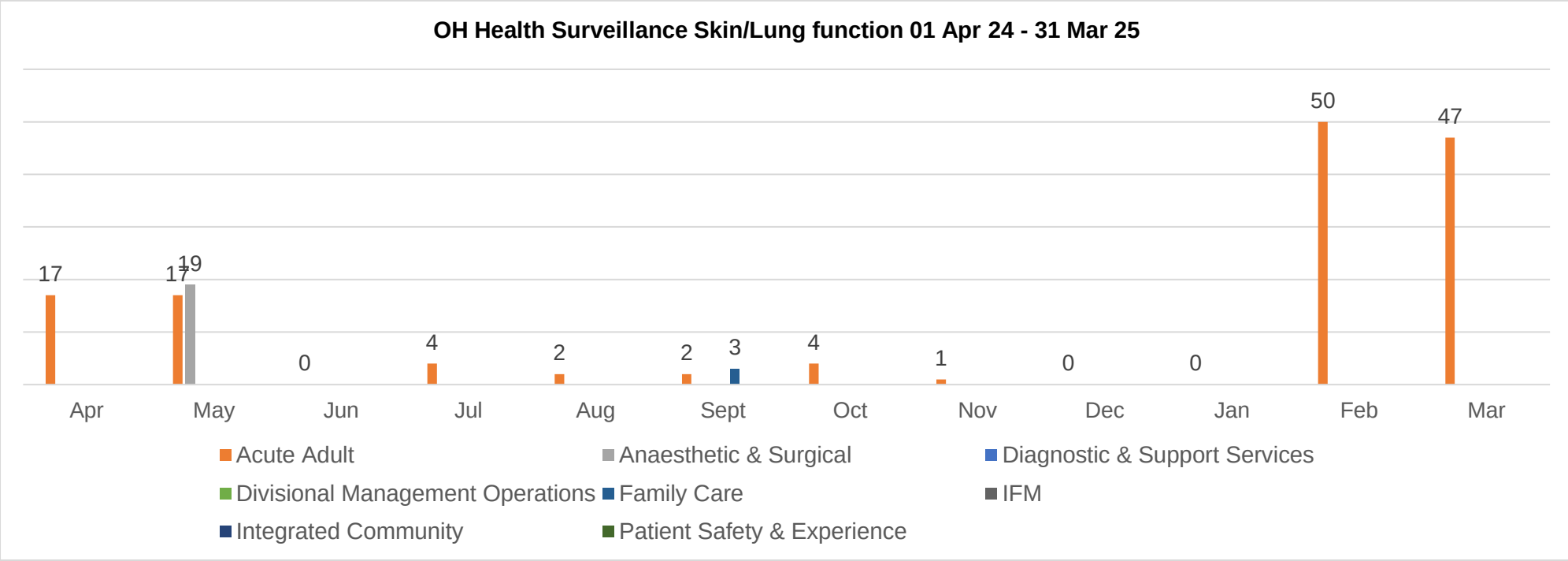
The Trust and iFM Bolton have commissioned regular water testing (thermal controls for Legionella Control and regular sampling for *Legionella spp.* and *Pseudomonas aeruginosa*) in compliance with HSE Approved Code of Practice (ACOP) L8 publications and Health Technical Memoranda (HTM) 04-01 Water Systems respectively from a new contractor. This new contract includes access to a data searchable repository, provides more assurance and active alerting than our previously contracted service provider.

Occupational Health:

The Occupational Health & Wellbeing (OH&W) Service continues to provide expert, Trusted, effective Occupational Health advice to the Trust and over the last twelve months has provided an effective response to a number of new and existing potential health hazards that may impact staff such as Occupational Disease (Dermatitis) flu and the management of infectious disease outbreaks. The Wellbeing service transitioned into the service in April 2024, and this has resulted in an evidence based wellbeing service being delivered and impacting staff positively.

OH&W continued during this reporting period, to roll out the extensive Health Surveillance programme linked to occupational dermatitis and skin health, which commenced in 2021. A total of 166 surveillance was completed in this reporting year, with one RIDDOR of Occupational Dermatitis (Acute adult). This is a marked decrease from the initial RIDDOR reporting period in 2022/23, and shows the robust health surveillance management programme and monitoring is reflective of this. . The robust clinical governance framework and programmes the OH&W department has in place and the data for 2024/25 shows the Trust is fully compliant with HSE requirements.

Total number of surveillances undertaken during this reporting period, per division



There has been more awareness of the Trust OH&W Team through their attendance and reports raised through numerous groups, including the Trust Group Health & Safety Committee and its continued work along-side the Health & Safety Team with formal meetings where support for staff has been identified through incident reviews and a receipt of an individuals' OH Report.

Annual Report 2023/24 Actions:

Action	By Whom	By when	Update
Recruitment to Manual Handling Advisor post	Health and Safety Manager	April 2024	Completed May 2024.
To develop a training schedule for Train the trainer courses and refresher courses for Manual Handling Training Assessors and Log Roll Training Assessors	Manual Handling Advisor	August 2024	Completed. Nov 2024. Training in place for both MH and Log Rolle Assessors
Review Manual Handling training on induction and refresher training updates	Manual Handling Advisor/Clinical Skills Lead	March 2025	Completed. Fist training session held 06 Jan 2025
To liaise with high risk areas including Theatres. Maternity and Community services to identify bespoke manual handling needs and solutions	Manual Handling Advisor	March 2025	Completed March 2025. Liaised with all departments. Community package is being run from April 25. Theatres don't require a spoke package. Maternity and Paediatrics are currently happy to attend the Community training package.
Amend Incident report to include prompt for potential RIDDOR incident	Health and Safety Manager/Risk and Assurance Team	May 2024	Completed, Implemented and is now visible as part of the Safeguard Incident reporting procedure
To develop actions ref compartmental options required under fire safety, to be available to progress the compartmentation work during 2024/2025	Trust/iFM Bolton Management	April 2025	A program of work was developed and agreed on how to complete the clinical areas as a priority,

			included within the ward-based closure program. Note: Due to high patient demands, the presence of RACC being discovered within the Trust site, this the implementation of the plans has been difficult to achieve, a business case is currently in progress with a plan to undertake remedial actions in line with the Decant Plan.
To receive divisional assurance risk assessment reports at Group Health and Safety Committee	Divisional Governance Leads	June 2024	Completed June 2024. Assurance Report is a standing Agenda Point with GH&SC meetings

Legend:	
Compliant	
Work in progress towards compliance	
Non-compliant	

Annual Report 2024/25 Actions:

Action	By Whom	By when	Update
Ventilation: Produce and submit a Business Case to secure funding to upgrade/replace ventilation system	iFM Bolton supported by Trust Water Safety Group	Sept 25	
Manual Handling Training: To produce and introduce a revised iFM Manual Handling course for its staff, aligned to the Trust Manual Handling training standards/expectation	Manual Handling Advisor	Aug 25	
Manual Handling: Post Falls Process and Equipment Flowchart Update jointly with Enhanced Care Lead to ensure effective post falls process is in place including staff training to enable them to utilise all equipment available in the event of a fall.	Manual Handling Advisor	Aug 25	
Fire Safety: Building Fire Risk Assurances (FRA), now with the iFM Fire Safety Team fully staff their aim is for iFM Bolton to achieve at least the compliance figure of 95% by June 2025	iFM Fire Safety Team	Jun 25	
Security: iFM Bolton to have installed by the end of 2025 new CCTV system for the hospital, which will provide a better visual	IFM Security	Dec 25	

deterrent across the building assisting with any issues that arise helping both GMP and the Trust.			
Health and Safety: To ensure that compliance reporting covering the requirement for staff to access to workplace risk assessments, becomes a mandatory Agenda items within the Group Health and Safety Committee meetings along with Divisions submitting a status of in date workplace risk assessments presented in sequence with the Annual Health and Safety Compliance Calendar	Health and Safety Team	Sept 25	

Report Title:	Green Plan			
Meeting:	Board of Directors	**Action Required**	Assurance	
Date:	31 July 2025		Discussion	
Executive Sponsor	Chief Finance Officer		Decision	✓

Purpose of the report	The purpose of this report is to provide the final draft of the 2025-30 Bolton Foundation Trust Green Plan for approval.

Previously considered by:	Greater Manchester Integrated Care Board, Our Green Group, iFM Executive Board, Finance and Investment Committee and Strategic Estates Group.

Executive Summary	A Green Plan for Bolton NHS Foundation Trust 2025-2030 was drafted after internal and external stakeholder engagement. The draft has been reviewed by the Greater Manchester Integrated Care Board, Our Green Group, and the iFM Executive Board, Finance and Investment Committee and Strategic Estates Group and updated accordingly. The Green Plan is supported by an internal action plan, which details the steps required to achieve the Green Plan actions. A relaunch plan is being drafted to ensure the Green Plan is communicated throughout the hospital, and community.

Proposed Resolution	The Board of Directors is asked to ***approve*** the Green Plan.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	**A great place to work**	**A high performing productive organisation**	**An organisation that's fit for the future**	**A Positive partner**
✓	✓	✓	✓	✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	Yes	To achieve our targets there are financial requirements for investment of our estate and service infrastructures to achieve our Net Zero Goals
Legal/ Regulatory	Yes	Non-compliance with sustainability regulations can lead to legal repercussions and fines, making it essential for businesses to stay informed about the latest regulations.
Health Inequalities	Yes	Have an opportunity to intentionally manage our land and buildings in a way that has a positive social, economic and environmental impact.
Equality, Diversity and Inclusion	Yes	We will deliver high quality, patient centered accessible services and as an employer provide a positive, inclusive and fair workplace culture free from discrimination.

Prepared by:	**Charlotte Houghton, Energy and Sustainability Manager**	**Presented by:**	**Annette Walker, Chief Finance Officer**

Introduction

The refreshed Green Plan is required to be published by 31 July 2025. The previous Green Plan actions were reviewed and consolidated into the new Areas of Focus and the new NHS England guidance actions were reviewed in context of Royal Bolton Hospital to ensure they were relevant and achievable. Stakeholders were engaged at this stage to support the action review.

A first draft of the 2025-30 Green Plan was produced with a supporting internal action plan, that was reviewed by Greater Manchester Integrated Care Board, Our Green Group, iFM executive board, F&I committee, and Strategic Estates Group. Appendix 1 shows the final version of the Green Plan, taking into account all updates. Appendix 2 is the internal action plan that sits alongside the Green Plan.

Stakeholder engagement

The following stakeholders were engaged for the areas of focus throughout the months of April and May. This engagement was to review the previous actions to decide whether they were still relevant and needed to be incorporated into the Green Plan or removed. It was also to decide which of the NHS England actions were relevant for Bolton Royal Hospital and are achievable sustainability goals.

- Bolton Council – Nicola Farrell
- Workforce and Leadership – Dawn Grundy and Vicky Welsby
- Digital Transformation – Brett Warmsley, Sarah McKiernan, Zoe Fitzsimmons and Dawn Devine
- Net Zero Clinical Transformation – Dr. Francis Andrews,
- Travel and transport – Dan Alcock
- Estates and Facilities – Mark Tootill
- Medicines – Simon Harrison
- Biodiversity and Green Space – John Leever
- Supply Chain and Procurement – Nicola Kenny, Darren Phips and Lee Bruton
- Food and Nutrition – Jason Waggett
- Climate Adaptation – Mark Prickard, Dayle Pickup

During this process, it was agreed that the new Green Plan would highlight priority actions with measurable goals but there would be an internal action plan sat behind it that is flexible, adaptable, and will allow closer tracking and reporting.

This internal action plan (Appendix 2) is still under construction and will be a live document once launched. It is expected that this action plan will change and adapt over the next 5 years as work progresses, and legislation and priorities change.

Governance

The agreed governance route with timings for the Green Plan review is below. After each meeting, any changes were implemented before it progressed further.

Committee	Date	Paper Deadline
Board of Directors	31 July 2025	18 July 2025

Finance and Investment Committee	25 June 2025	13 June 2025
Strategic Estates Group	27 June 2025	13 June 2025
IFM Board	10 June 2025	05 June 2025
Green Group	03 June 2025	23 May 2025

Green Plan launch

The Green Plan will have a relaunch planned for late August or September, and this will communicate the plan widely, while engaging with staff around sustainability and relaunching the Green Champions network. This relaunch is currently being planned.

Vision | Openness | Integrity | Compassion | Excellence

NHS
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NHS Foundation Trust

Our Green Plan

2025-2030



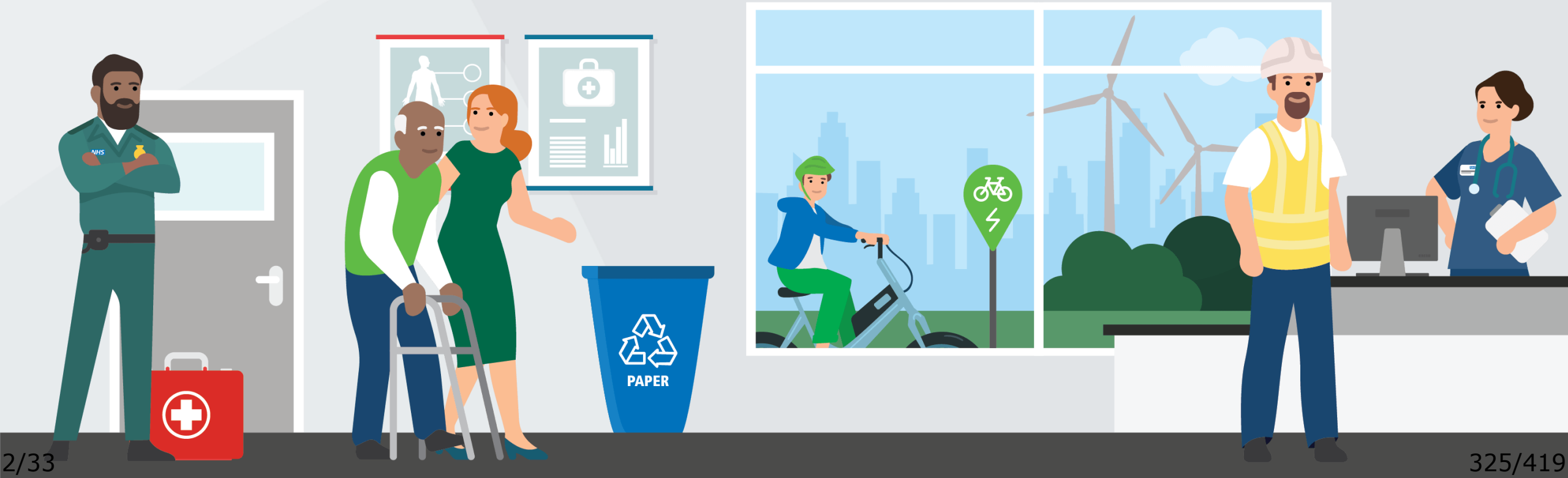
Improving care,
transforming lives...for a better Bolton

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NHS
Bolton
NHS Foundation Trust

Our Green Plan

2025-2030



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Foreword

At Bolton NHS Foundation Trust, we are committed to delivering continuously improving, sustainable healthcare. My senior leadership colleagues and I are fully behind our Green Plan and to the work involved in the NHS becoming carbon net zero.

We have already made great progress during the last Green Plan, and the Trust and our staff continue to make small everyday changes to become more sustainable, and through our new Green Plan we will continue to adapt to more environmentally sound practices.

As a large Trust that touches many areas across Bolton, we have a significant environmental impact, and it is important that we address this now rather than later.



Annette Walker

Chief Finance Officer
Net Zero Board Lead

About us

Bolton NHS Foundation Trust provides a range of health and wellbeing services to the people of Bolton, delivering care at Royal Bolton Hospital, in a range of community venues and in people's own homes.

Bolton NHS Foundation Trust is one of the North West's busiest acute NHS foundation trusts, serving people across Bolton and other parts of Greater Manchester and the surrounding area.

We aim to:



Bolton NHS Foundation Trust has over 6,000 substantive staff, working across 25 sites in Bolton and providing clinics for various specialities in neighbouring areas.

Executive summary

The UK has committed to reaching net zero carbon by 2050, and the NHS has a legal duty to act on the emissions from its activities.

Climate change is already impacting the health of the UK population, with the most vulnerable being the most affected. The NHS contributes approximately 4% of the UK emissions, and ambitious strategies are needed to reduce these emissions, and limit the effect of climate change.

This is the second Bolton NHS FT Green Plan, spanning 2025-30. A 5-year Green Plan aligns more closely with both the Bolton NHS FT Strategy and the Bolton Locality Plan. The 71 actions detailed in the Green Plan for 2022-25 have been reviewed with internal and external stakeholders, considering the new thematic areas and guidance provided by NHS England. The actions have either been completed, consolidated, or superseded. The priority actions for 2025-30 are outlined in Appendix 1, and there is a detailed internal programme plan to support these actions.

Significant financial investment will be required to complete all the actions detailed for 2025-30. There is currently no fully costed plan, but further work will be undertaken to understand the investment needed. All risks and challenges have been identified and will be monitored throughout the Green Plan. Progress against the plan will be reviewed yearly in the Trust annual report, along with a carbon emission analysis and narrative on environmental sustainability projects undertaken.

NHS Bolton NHS Foundation Trust

Our vision and ambitions

Our Vision

To deliver exceptional care to improve the health and wellbeing of our communities.

Our Values

Vision – Be Positive

Openness – Be Inclusive

Integrity – Be Honest

Compassion – Be Kind

Excellence – Be Bold

Our five core ambitions

A great place to work

We will invest in our staff and support them to develop their skills so they are able to provide the best care. Our workforce will feel a sense of belonging and be reflective of our communities.

What this means in practice:

- Improving staff experience
- Unlocking Our potential
- Reflecting our population

A high performing, productive organisation

We will make the best use of our resources and identify opportunities to innovate, develop research and continually evolve so that we can be the best we can possibly be, both now, and in the future.

What this means in practice:

- Improving access to our services
- Being efficient and productive
- Delivering financial sustainability

Improving care, transforming lives

We will deliver high quality care through a focus on safe and effective systems and processes, and make sure that everyone has a positive experience in our care. We will work to improve people's health, to transform the lives and outcomes of the people of Bolton.

What this means in practice:

- Improving safety, effectiveness & experience
- Innovating & collaborating for the future
- Playing our part in improving health

A positive partner

We will embrace and build on the partnerships we have with our communities and organisations in Bolton and across Greater Manchester, and to improve health and outcomes for our population.

What this means in practice:

- Developing our neighbourhoods
- Working as one team
- Partnering for local benefit

An organisation that's fit for the future

We will make sure that we have the right infrastructure and technology to allow our systems to work seamlessly, and our buildings will enable us to provide the best care. We will look for opportunities to reduce the impact we have on the environment.

What this means in practice:

- Being digitally enabled & inclusive
- Improving our estate
- Proactively planning for the future

Our partnerships

Greater Manchester Integrated Care Partnership

NHS Greater Manchester Integrated Care Board

The Bolton NHS Foundation Trust Green Plan supports the second Green Plan for Greater Manchester by aligning both with the thematic areas, but with the priority actions and annual work programme.

The partnership with the Integrated Care Board is vital to the success of the Green Plan, and collaboration with other Greater Manchester Trusts will allow us to achieve more over the time frames detailed.



Our partnerships

Bolton Council

"Bolton Council has a Climate Change strategy with the aim of getting to Net Zero as soon as possible as a Borough and which encourages all partners to work together to reduce carbon emissions. I therefore applaud and support the objectives of the Foundation Trust's Green Plan'."

"Bolton NHS Foundation Trust is one of the largest partners in the Bolton Family and this ambitious Green Plan makes a significant contribution to meeting our shared target.

"We have a good, established relationship with The Trust to work on delivering better health outcomes for our residents, and it is a demonstration of the strength of this relationship that our partnership working extends to improving our environment and working to prevent global heating."

Councillor Richard Silvester

Executive Cabinet Member for Climate Change and Environment

Councillor Sean Fielding

Executive Cabinet Member for Adult Social Care & Housing

Our partnerships

iFM Bolton
Clean, Safe and Sustainable
A wholly owned subsidiary of Bolton NHS Foundation Trust NHS

iFM Bolton Ltd

Integrated Facilities Management (iFM)

Integrated Facilities Management (iFM) Bolton Ltd is a wholly owned subsidiary of Bolton NHS Foundation Trust. iFM provide a range of services across the Trusts sites, including engineering and equipment maintenance, capital project management, procurement, transport and courier services, and catering among many others.

IFM work closely with the Trust, ensuring that patients are receiving high quality and safe services. It is through this close working relationship that the iFM Bolton team will strive to incorporate sustainability into the everyday running of Bolton NHS Foundation Trust.



Drivers for change

International

- 17 UN Sustainable Development Goals
- World Health Organisation
- Intergovernmental Panel on Climate Change
- 2015 Paris Agreement
- The United Nations Framework Convention on Climate Change

National

- Climate Change Act 2008
- Environment Act 2021
- Health and Care Act 2022
- UK Government Net Zero Strategy
- Powering Up Britain: The Net Zero Growth plan
- Delivering a ‘Net Zero’ National Health Service
- NHS Long Term Plan
- NHS Standard Contract Service Conditions
- NHS England national strategies
  - Clinical waste
  - Travel and transport
  - NHS Estates new zero carbon delivery plan
  - Net Zero Building standard

Local

- The Greater Manchester Strategy
- Bolton Council Strategy
- GM level strategies
  - GM Transport strategy 2040
  - Manchester climate change framework 2020-2025
  - The NHS ICB Green Plan



Trust carbon emissions

As a large and busy acute hospital with ageing buildings and infrastructure, Bolton NHS Foundation Trust consumes a significant quantity of energy through utilities and resources through the supply chain. 2019/20 is the baseline year as defined in the Delivering a Net Zero NHS report, and NHS England provided an estimated contribution of each trust towards the overall NHS carbon emissions for that year to be used a baseline. This is based on ERIC (Estates Return Information Collection) data and is annually reported.

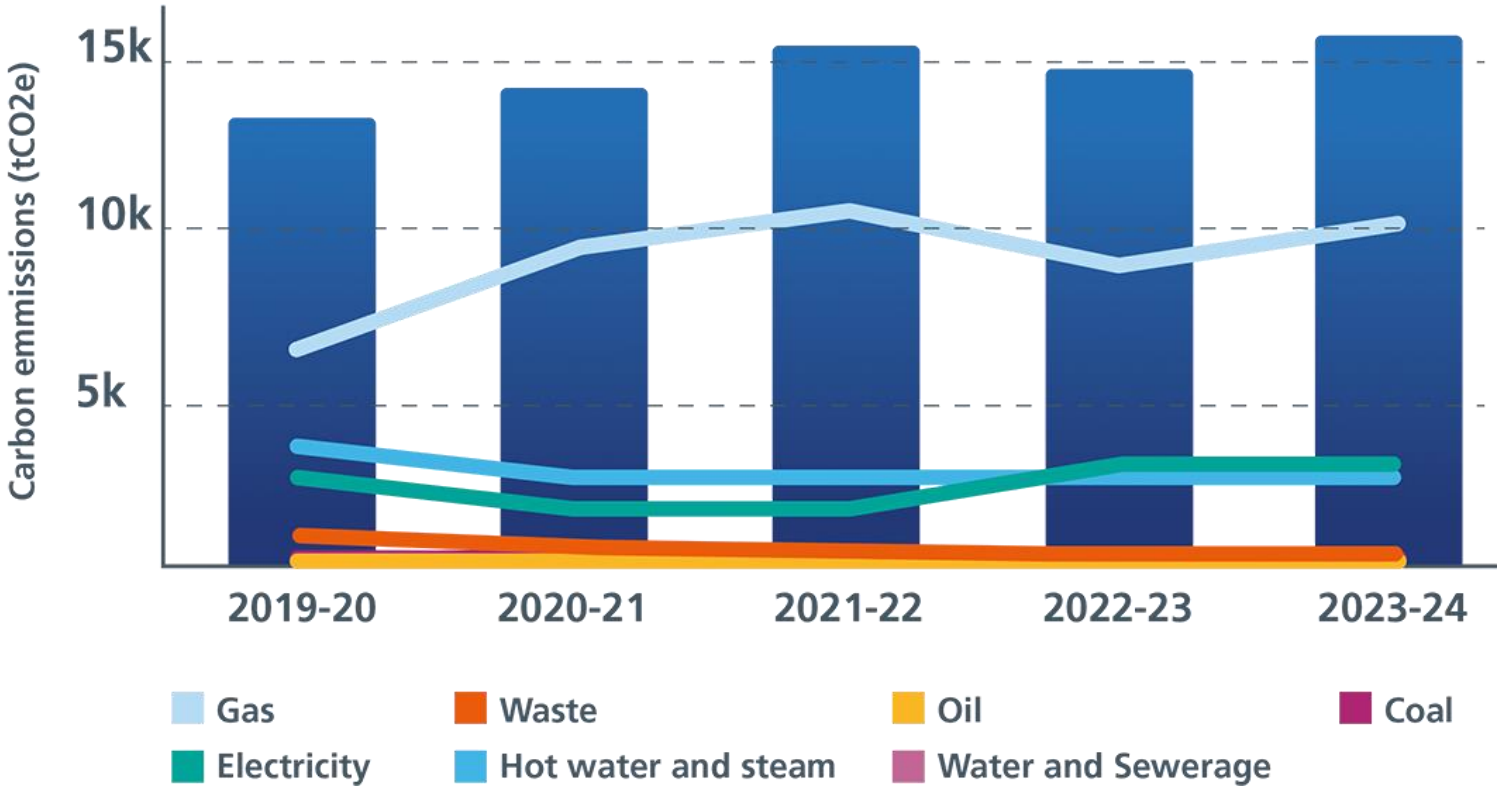


Figure 1 – Bolton NHS Foundation Trust emissions since the baseline as reported by ERIC.

Trust carbon emissions

Bolton NHS Foundation Trust recognises that to meet the NHS England set targets of net zero for the NHS carbon footprint by 2040 and Net Zero for the NHS carbon footprint plus by 2045 (Figure 2), we need to align our carbon emission reporting with the NHS Carbon Footprint Plus, and provide a yearly narrative on the emissions changes.

This Green Plan aims to address this by prioritising robust governance, and data and reporting standards going forward.



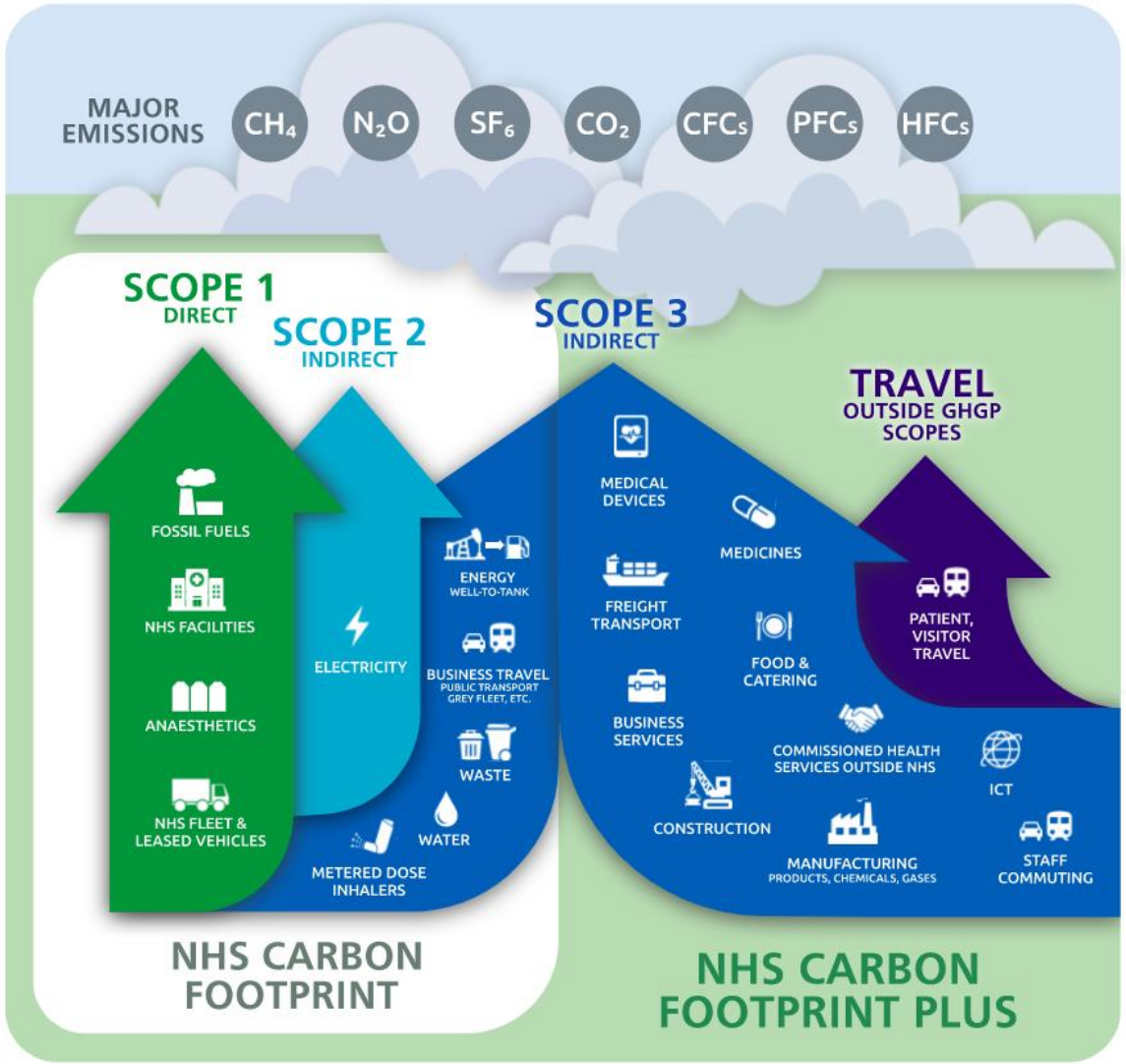


Figure 2 – NHS Carbon Footprint and NHS Carbon Footprint Plus

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Key achievements to date

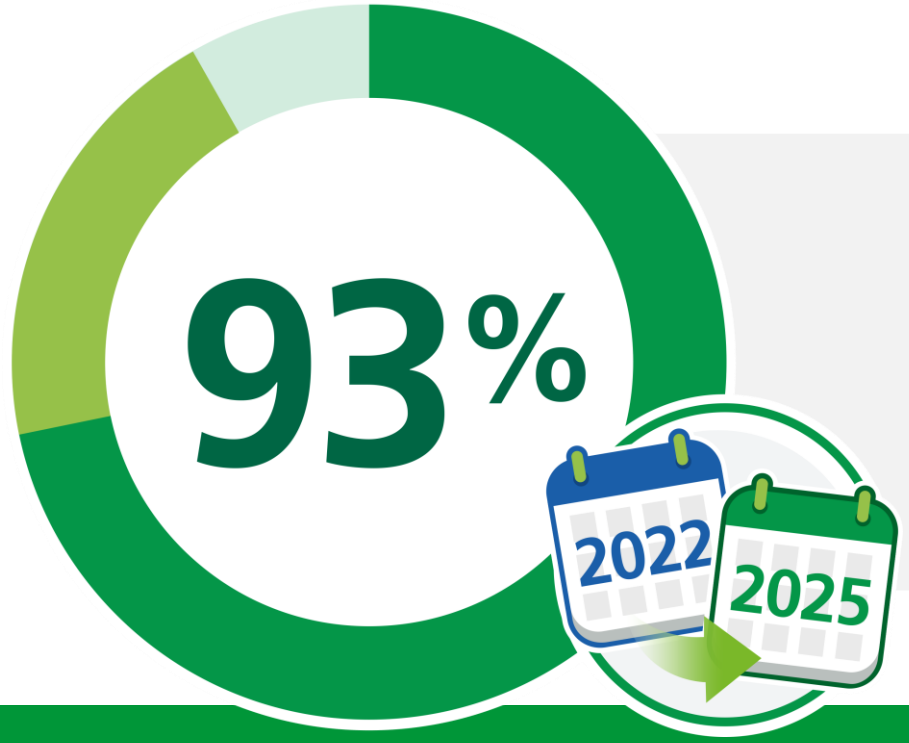


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Key achievements to date

The previous Green Plan included 71 actions across 10 different areas of focus. Out of those 71 actions, 93% (66 actions) had progress against them, with 23% (16 actions) being completed between 2022 and 2025.

All the actions that were progressing but not yet completed were either superseded by new actions or consolidated into the new areas of focus provided by NHS England. This decision was made on an action-by-action basis throughout the stakeholder engagement progress for refreshing the Green Plan.



93% (66 actions) had progress against them

70% (50 actions) were on track

23% (16 actions) fully completed

Key achievements to date

10%
weighted scoring embedded into tenders for sustainability and social value.



All food waste now sent for anaerobic digestion which produces biogas for electricity generation.



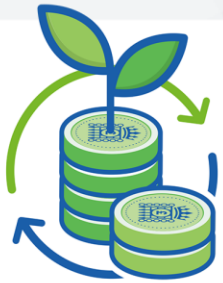
All single-use plastic crockery and cutlery removed.



Plant menu introduced to catering.



Investment in new anaesthetic machines which allow digital dosing.



Removed the volatile anaesthetic agent desflurane in line with national guidance.



x2
Two nitrous oxide manifolds fully decommissioned.



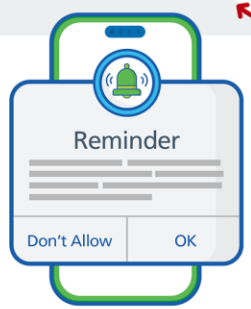
250
Planted over 250 trees across site.



Switched to 100% recycled content paper for all office-based functions.



Introduction of the text reminder service.



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Areas of focus



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Areas of focus

Workforce and leadership

Many actions towards a sustainable future rely on ensuring staff are engaged with the Green Plan and have the resources and capabilities to be a part of the solution. NHS staff show strong support for a greener future with 9 in 10 staff supporting the NHS net zero ambition (YouGov, 2023).

Priority actions:

1.1 Develop a communication and engagement scheme related to Sustainability.

1.2 Assess workforce capacity and skill requirements for delivering the green plan and investigate training possibilities for sustainability upskilling.

Net Zero clinical transformation

All the services at Bolton NHS Foundation Trust aim to deliver the best quality of care within the resources available. Transforming clinical care to ensure they are as low carbon as possible but remain a patient centred approach that prioritises health will propel the NHS towards its net zero goals.

Priority actions:

2.1 Identify a clinical lead with formal links into board-level leadership and governance.

2.2 Establish a multidisciplinary working group responsible for reducing emissions in clinical areas.

2.3 Complete quality improvement project(s) in the clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities.

Areas of focus

Digital transformation

The commitment to deliver a Net Zero NHS must recognise the value of digital transformation to improve the access and quality of care. The NHS England's 'what looks good' framework should be used to find the balance between the increase in digital services and a reduction in carbon emissions.

Priority actions:

3.1 Continue the move towards a paperless, technology focused hospital.

3.2 Complete the Digital Maturity Assessment to embed sustainability into all digital services.

Medicines

Medicines account for around 25% of NHS emissions, with a small number of medicines accounting for most of these emissions. For example anaesthetic gases (2%) and inhalers (3%). As well as focusing on reducing these specific emissions, wider actions to optimise prescription, use and disposal also require consideration.

Priority actions:

4.1 Reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the updated nitrous oxide waste mitigation toolkit.

4.2 Support patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, reducing the use of pressurised inhalers and moving towards powdered inhalers where clinically appropriate.

4.3 Complete the Greener pharmacy toolkit

Areas of focus

Travel and transport

The carbon emissions from the fleet and business travel form part of the NHS Carbon Footprint and are under the direct control of Bolton NHS Foundation Trust. A robust travel and transport strategy will provide a roadmap to decarbonise the Bolton NHS fleet and business travel, provide active travel options to staff and patients, while also providing cost-savings and health benefits.

Priority actions:

5.1 Prepare and publish a travel policy prepared in line with the other Greater Manchester Trust's by the end of 2026.

5.2 Investigate converting the NHS on site fleet to electric by end of 2027.

Estates and facilities

Bolton Royal Hospital and the associated community centres consume significant amounts of energy and resources every year, which presents a significant expenditure, and are a significant proportion of the yearly carbon emissions. By embedding sustainability into the existing and future estate, Bolton NHS Foundation Trust will improve resilience and patient care as well as improve operational efficiency while driving down costs.

Priority actions:

6.1 Develop a road map to net zero for the Royal Bolton Hospital site and Trust community centres.

6.2 Create policies and procedures for all new builds and refurbishments to comply with the NHS zero carbon standards for buildings.

Areas of focus

Supply chain and procurement

Supply chain and procurement make up a large part of the NHS Carbon Footprint Plus. The NHS will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 for these not direct but influenceable emissions. The NHS net zero supplier roadmap outlines steps suppliers must follow to align with the NHS net zero ambition between now and 2030.

Priority actions:

7.1 Explore reliance of single-use products in clinical and non-clinical settings with a view to reduce the purchased volume.

7.2 Align all relevant procurement activities to the NHS net zero supplier roadmap, Carbon Reduction Plan and Net Zero Commitment.

7.3 Ensure suppliers go beyond minimum requirements by engaging with the Evergreen Supplier Assessment.

7.4 Improve the operation of walking aid recycling schemes across the community.

Food and nutrition

It is estimated that food and catering services in the NHS account for approximately 6% of the NHS's Carbon Footprint Plus. Bolton Foundation Trust provide almost 700,000 patient meals per year. Healthier, locally sourced food can improve wellbeing while cutting emissions across the supply chain for the NHS.

Priority actions:

8.1 Trial innovative ways to reduce food waste across the site in line with the KPI's already in place.

8.2 Ensure the digital meal ordering system for patients is available across all wards.

8.3 Investigate increasing menu reviews from yearly to quarterly to add seasonal, lower carbon options.

Areas of focus

Biodiversity and greenspace

Having access to greenspace is has a positive impact on mental health, as well as illness prevention and illness recovery. Bolton Foundation Trust has a significant area of greenspace across the estate; this must be protected and enhanced for the benefit of staff, patients, and visitors.

Priority actions:

9.1 Prepare a biodiversity and greenspace strategy for the estate.

9.2 Enhance the green space across the site to encourage employee wellbeing alongside increasing the environmental benefits.

Adaptation

Climate change will adversely affect the world around us and impact on the NHS's ability to care for its patients and staff. Adapting Bolton Foundation Trust's services to be resilient in the context of a changing global climate requires resilience and adaptation to be built into business continuity and longer-term planning to avoid climate-related service disruptions.

Priority actions:

10.1 Develop and publish a long-term climate change adaptation plan, which has robust governance and reporting procedures.

10.2 Develop guidelines for Estates and Capital teams to factor in the effects of climate change when making infrastructure decisions and designing new facilities.

Green Plan Governance

For Bolton NHS Foundation Trust to successfully deliver this Green Plan, it is essential that all executives, directors, staff and stakeholders across the organisation are committed to delivering the Green Plan by aligning policies, procedures and processes to reflect the sustainability vision and associated targets.

The delivery of the Green Plan is facilitated through working groups and overseen by the Green Group, which is chaired by the Bolton NHS Foundation Trust net zero board lead, which then reports into other committees as detailed here.

Priority actions:

11.1 Document the Green Plan governance and embed into the Trust governance process, including an annual review to ensure updates are given regularly to all stakeholders.



Tracking and reporting progress

Bolton NHS Foundation Trust will report on the progress against the Green Plan in line with national reporting requirements, including an annual summary of progress that will be presented to the board and published in the annual report. This summary will include a narrative on progress, the key achievements and milestones reached, any risks to future delivery and any quantitative progress data against the defined targets. The Task Force on Climate-related Financial Disclosures (TCFD) guidelines will also be followed in the annual reports. Quantitative progress data will be provided via the Greener NHS dashboard quarterly.

Alongside the national reporting requirements, an internal performance report will be prepared and presented to the board. This will highlight achievements, risks and challenges monthly. This report alongside an AAA (Alert, Advise, and Assure) report and KPIs (Key performance indicators) for the Green Plan will ensure that all stakeholders are updated as it will be escalated as required.

Priority actions:

12.1 Adhere to the national reporting requirements, both quarterly and annually.

12.2 Prepare monthly performance reports and AAA reports, alongside updating the relevant KPI's.



Finance, risks and challenges

Bolton NHS Foundation Trust aims to achieve financial sustainability alongside providing world class health and social care across our communities. Achieving this Green Plan will require significant investment, and although the actions detailed in this Green Plan have not been fully costed further work will be undertaken to understand the financial investment required.

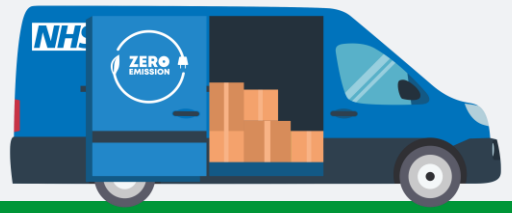
External funding opportunities will be identified for any large capital expenditure required. Low-cost projects that have a return on investment due to the efficiencies achieved will be prioritised to reduce energy and procurement costs.

Bolton NHS Foundation Trust will continue to improve its overall economy, efficiency and effectiveness of its current resources while striving towards the NHS England net zero targets through the priority actions detailed in this Green Plan.

Risks and challenges of achieving this plan, and the priority actions, have been identified and will be monitored through the 5-year cycle to ensure that progress is being made and risks are mitigated where possible. A full risk assessment of the plan is required and will be prepared alongside key stakeholders.

Priority actions:

13.1 Prepare a risk assessment for the Green Plan.





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Green plan priority actions



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Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Workforce and leadership	1.1	Develop a Trust level communication and engagement scheme related to Sustainability	Published communication and engagement scheme	**A great place to work**
Workforce and leadership	1.2	Assess workforce capacity and skill requirements for delivering the green plan and investigate training possibilities for sustainability upskilling	ESR training records	**A great place to work**
Net Zero clinical transformation	2.1	Identify a clinical lead with formal links into board-level leadership and governance.	Clinical lead in place	**Improving care, transforming lives**
Net Zero clinical transformation	2.2	Establish a multidisciplinary working group responsible for reducing emissions in clinical areas.	Working group created	**Improving care, transforming lives**
Net Zero clinical transformation	2.3	Complete quality improvement project(s) in the clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities.	Successful projects implemented	**Improving care, transforming lives**

Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Digital transformation	3.1	Continue the move towards a paperless, technology focused hospital	Reduction in paper usage	**An organisation that's fit for the future**
Digital transformation	3.2	Complete the Digital Maturity Assessment to embed sustainability into all digital services	Successful projects implemented	**An organisation that's fit for the future**
Medicines	4.1	Reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the updated nitrous oxide waste mitigation toolkit	Greener NHS dashboard	**An organisation that's fit for the future**
Medicines	4.2	Support patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, reducing the use of pressurised inhalers and moving towards powdered inhalers where clinically appropriate	Greener NHS dashboard (from Q1 25/26)	**Improving care, transforming lives**
Medicines	4.3	Complete the Greener pharmacy toolkit	Completed toolkit	**Improving care, transforming lives**

Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Travel and transport	5.1	Prepare and publish a travel policy prepared in line with the other Greater Manchester Trust's by the end of 2026	Published travel plan	A positive partner
Travel and transport	5.2	Investigate converting the NHS on site fleet to electric by end of 2027	Greener NHS dashboard	An organisation that's fit for the future
Estates and facilities	6.1	Develop a road map to net zero for the Royal Bolton Hospital site and Trust community centres	Published road map Estates Return Information Collection Greener NHS dashboard (from Q4 24/25)	An organisation that's fit for the future
Estates and facilities	6.2	Create policies and procedures for all new builds and refurbishments to comply with the NHS zero carbon standards for buildings	Published policies and procedures	An organisation that's fit for the future
Estates and facilities	6.3	Implement and deliver the NHS waste strategy targets	Estates Return Information Collection	A high performing, productive organisation

Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Supply chain and procurement	7.1	Explore reliance of single-use products in clinical and non-clinical settings with a view to reduce the purchased volume	Reduction in single use products purchased	**An organisation that's fit for the future**
Supply chain and procurement	7.2	Align all relevant procurement activities to the NHS net zero supplier roadmap, Carbon Reduction Plan and Net Zero Commitment	Greener NHS dashboard	**A positive partner**
Supply chain and procurement	7.3	Ensure suppliers go beyond minimum requirements by engaging with the Evergreen Supplier Assessment	Evergreen introduced to all supplier on boarding	**A positive partner**
Supply chain and procurement	7.4	Improve the operation of walking aid recycling schemes across the community	Greener NHS dashboard	**A positive partner**
Food and nutrition	8.1	Trial innovative ways to reduce food waste across the site in line with the KPI's already in place	Estates Return Information Collection	**An organisation that's fit for the future**
Food and nutrition	8.2	Ensure the digital meal ordering system for patients is available across all wards	Digital meal ordering in place	**A high performing, productive organisation**

Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Food and nutrition	8.3	Investigate increasing menu reviews from yearly to quarterly to add seasonal, lower carbon options	Quarterly reviews in place	**An organisation that's fit for the future**
Biodiversity and greenspace	9.1	Prepare a biodiversity and greenspace strategy for the estate	Published biodiversity strategy	**An organisation that's fit for the future**
Biodiversity and greenspace	9.2	Enhance the green space across the site to encourage employee wellbeing alongside increasing the environmental benefits.	Successful projects implemented	**A great place to work**
Climate adaptation	10.1	Develop and publish a long-term climate change adaptation plan, which has robust governance and reporting procedures.	Published climate change adaptation plan	**An organisation that's fit for the future**
Climate adaptation	10.2	Develop guidelines for Estates and Capital teams to factor in the effects of climate change when making infrastructure decisions and designing new facilities	Published guidelines to factor in climate change	**A high performing, productive organisation**

Appendix 1: Green plan priority actions

Area of focus	Reference	Action	Reporting Measures	Trust ambition alignment
Green Plan governance	11.1	Document the Green Plan governance and embed into the Trust governance process, including an annual review to ensure updates are given regularly to all stakeholders	Published Green Plan governance	**A high performing, productive organisation**
Tracking and reporting progress	12.1	Adhere to the national reporting requirements, both quarterly and annually	All national and quarterly reports completed	**A high performing, productive organisation**
Tracking and reporting progress	12.2	Prepare monthly performance reports and AAA reports, alongside updating the relevant KPI's	Monthly reports completed	**A high performing, productive organisation**
Finance, risks and challenges	13.1	Prepare a risk assessment for the Green Plan	Risk assessment prepared	**A high performing, productive organisation**

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Minerva Road, Farnworth
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Area of focus	Ref	Green Plan Priority Action	Internal Action Plan	Status	RAG	Comments	Update
Workforce and leadership	1.10	Develop a Trust level communication and engagement scheme related to Sustainability					
Workforce and leadership	1.11		Green Champions network relaunched through the Our Voice Change programme				
Workforce and leadership	1.12		3-4 sustainability engagement initiatives run per year through the Green Champions network				
Workforce and leadership	1.13		Sustainability based FABB award communicated and celebrated				
Workforce and leadership	1.14		Ensure sustainability is included in all staff inductions and appraisals				
Workforce and leadership	1.20	Assess workforce capacity and skill requirements for delivering the green plan and investigate training possibilities for sustainability upskilling				Considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways	
Workforce and leadership	1.21		Carry out a survey (pulse, listening activity), into interest for training				
Workforce and leadership	1.22		Investigate the potential for a sustainability training programme available to all staff			Greener NHS, Carbon literacy -uptake targets? specialist in house training for green plan delivery? Start in 2027.	
Net Zero clinical transformation	2.10	Identify a clinical lead with formal links into board-level leadership and governance.					
Net Zero clinical transformation	2.20	Establish a multidisciplinary working group responsible for reducing emissions in clinical areas.					
Net Zero clinical transformation	2.30	Complete quality improvement project(s) in the clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities.				Critical and perioperative care, mental health, urgent and emergency care, diagnostic tests and procedures, medical pathways. Share all learning and outcomes through the ICB and NHSE.	
Digital transformation	3.10	Continue the move towards a paperless, technology focused hospital					
Digital transformation	3.11		Reduce paper usage across the estate				
Digital transformation	3.12		Maximise the benefits of digital transformation to reduce emissions and improve patient care, for example, by reducing the use of paper and providing virtual pathways where clinically appropriate				
Digital transformation	3.20	Complete the Digital Maturity Assessment to embed sustainability into all digital services.				Using circular and low-carbon approaches to IT hardware management, which may include longer device lifetimes, leasing models, buying refurbished or remanufactured equipment and PC power down configuration	
Digital transformation	3.21		Considering low carbon hosting, promoting good data hygiene (such as, deduplication and archiving) and engaging digital suppliers			Need to include AI	
Medicines	4.10	Reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the updated nitrous oxide waste mitigation toolkit				Already progressing	
Medicines	4.20	Support patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, reducing the use of pressurised inhalers and moving towards powdered inhalers where clinically appropriate				Currently 95% pressurised and 5% powder	
Medicines	4.30	Complete the Greener pharmacy toolkit					
Travel and transport	5.10	Prepare and publish a travel policy prepared in line with the other Greater Manchester Trust's by the end of 2026					
Travel and transport	5.11		Annual survey of staff to fully understand staff commutes and barriers				
Travel and transport	5.12		Ensure that provisions are in place for staff and patients to chose low carbon travel to and from the hospital				
Travel and transport	5.13		Offer only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements)				
Travel and transport	5.14		Investigate park and ride, further bus provisions, cycle parking, lockers and showers, cycle training etc.				
Travel and transport	5.20	Investigate converting the NHS on site fleet to electric by end of 2027					
Travel and transport	5.21		Investigate the installation of EV chargers across site				
Travel and transport	5.22		Find out when the fleet are due to be replaced anyway and build the business case ready for this				
Travel and transport	5.23		Make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only from December 2027 onwards (excluding ambulances)				
Estates and facilities	6.10	Develop a road map to net zero for the Royal Bolton Hospital site and Trust community centres				phasing out of all existing fossil-fuel primary heating systems by 2032 and Considering Local Area Energy Plans and opportunities from heat networks and other low-carbon solutions	
Estates and facilities	6.11		Carry out a metering gap analysis for the site covering all utilities				
Estates and facilities	6.12		Heat map the site to find the highest carbon emitters				
Estates and facilities	6.13		Prepare a heat decarbonisation plan				
Estates and facilities	6.14		Create and maintain an opportunity log which covers all low carbon technology, interventions and initiatives that can support RBH				
Estates and facilities	6.15		Prepare and maintain a grant tracker with business case ready projects to enable sustainability projects get off the ground				
Estates and facilities	6.20	Create policies and procedures for all new builds and refurbishments to comply with the NHS zero carbon standards for buildings					
Estates and facilities	6.21		Investigate the inclusion of embodied carbon into the business cases for new builds and refurbs				

Estates and facilities	6.30	Implement and deliver the NHS waste strategy targets					
Supply chain and procurement	7.10	Explore reliance of single-use products in clinical and non-clinical settings with a view to reduce the purchased volume					
Supply chain and procurement	7.11		Audit single use items (plastic first as the priority) that is purchased and used				
Supply chain and procurement	7.12		Identify and progress opportunities to reduce single use items across the estate				
Supply chain and procurement	7.20	Align all relevant procurement activities to the NHS net zero supplier roadmap, Carbon Reduction Plan and Net Zero Commitment					
Supply chain and procurement	7.30	Ensure suppliers go beyond minimum requirements by engaging with the Evergreen Supplier Assessment					
Supply chain and procurement	7.40	Improve the operation of waling aid recycling schemes across the community					
Food and nutrition	8.10	Trial innovative ways to reduce food waste across the site in line with the KPIs already in place					Blue plate trial, cold sandwiches for last minute admissions
Food and nutrition	8.20	Ensure the digital meal ordering system for patients is available across all wards					4 wards are done but the wifi rollout is holding this up
Food and nutrition	8.30	Investigate increasing menu reviews from yearly to quarterly to add seasonal, lower carbon options					Currently annual reviews
Biodiversity and greenspace	9.10	Prepare a biodiversity and greenspace strategy for the estate					
Biodiversity and greenspace	9.11		Engage with a contractor to survey the green space and biodiversity on the site				
Biodiversity and greenspace	9.12		Ensure that the survey includes all baselines including air quality				
Biodiversity and greenspace	9.13		Ensure all actions to tackle biodiversity loss are added into the opportunity log				
Biodiversity and greenspace	9.20	Enhance the green space across the site to encourage employee wellbeing alongside increasing the environmental benefits.					
Climate adaptation	10.10	Develop and publish a long-term climate change adaptation plan, which has robust governance and reporting procedures					Seperate from your business continuity plan
Climate adaptation	10.11		Ensure the organisation has a nominated lead who is accountable for adaptation planning and management				
Climate adaptation	10.12		Set out actions to prepare for severe weather events and improve climate resilience of local site and services, including digital services				
Climate adaptation	10.13		Ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government's Adverse Weather and Health Plan				
Climate adaptation	10.20	Develop guidelines for Estates and Capital teams to factor in the effects of climate change when making infrastructure decisions and designing new facilities					including enhancements like improved green spaces, drainage systems and passive cooling solutions.
Green Plan governance	11.10	Document the Green Plan governance and embed into the Trust governance process, including an annual review to ensure updates are given regularly to all stakeholders					
Green Plan governance	11.11		Update TOR for the Green Group				
Green Plan governance	11.12		Build sustianability into all business cases and paper templates to ensure alignment with the Green Plan across the trust				
Green Plan governance	11.13		Ensure sustainability working groups are created for each area of focus				
Green Plan governance	11.14		Document the Green Plan governance and ensure annual review				
Tracking and reporting progress	12.10	Adhere to the national reporting requirements, both quarterly and annually					Greener NHS quarterly reporting and annual report requirements (iFM report and Trust TFCD)
Tracking and reporting progress	12.12		Ensure carbon emissions are calculated as per Carbon Footprint Plus				
Tracking and reporting progress	12.20	Prepare monthly performance reports and AAA reports, alongside updating the relevant KPI's					
Finance, risks and challenges	13.10	Prepare a risk assessment for the Green Plan					

Report Title:	Bolton 2040 Borough Plan			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	31 July 2025		Discussion	✓
Executive Sponsor	Chief of Strategy and Partnerships		Decision	

Purpose of the report	This report seeks to inform Board members of the strategic direction, ensure alignment with corporate priorities, and support implementation and impact.

Previously considered by:	The report was previously discussed at Bolton Vision Board

Executive Summary	The Bolton 2040 Borough Plan sets out a bold and inclusive vision for Bolton to become a thriving, inclusive Borough by 2040, where people want to live, work, study, invest and visit. It is structured around six missions and underpinned by the principles of prevention, investment, and sustainable growth. The Plan focuses on early intervention, community empowerment, and strategic investment in housing, education, health, and the economy to reduce inequalities and improve residents' quality of life. Aligned with this, the Bolton All Age Prevention and Inequalities Framework provides a practical, evidence-based model for embedding prevention across all services. It promotes a shared language and approach to addressing the root causes of poor outcomes, with emphasis on proportionate universalism, intersectionality, and system-wide collaboration. Together, these documents are fully aligned with Ambition 5 of Our Strategy as they reinforce shared priorities including reducing health inequalities, strengthening community voice, improving access to opportunity, and delivering integrated, place-based services.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Bolton 2040 Borough Plan.

Strategic Ambition(s) this report relates to				
Improving care, transforming lives	A great place to work	A high performing productive organisation	An organisation that's fit for the future	A Positive partner
✓	✓	✓		✓

Summary of key elements / Implications		
Implications	**Yes / No**	**If Yes, State Impact/Implications and Mitigation**
Finance	**No**	
Legal/ Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Sharon White, Chief of Strategy and Partnerships

Bolton 2040

BOROUGH PLAN





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Welcome
to our Bolton2040 Borough Plan

By 2040 we want Bolton to be a thriving borough, where people want to live, work, study, invest and visit.

Bolton is a town with a proud history and a bright future. With a population of over 300,000, Bolton stands as a beacon of cultural richness, historical significance, and vibrant community spirit. Our longstanding commitment to collaboration is crucial as we reflect on our current position and embrace opportunities and challenges in an ever-changing future.

By setting out a 15-year vision, we allow ourselves enough time to make significant strides towards the goals outlined in our Bolton2040 Plan. This plan encourages innovative efforts to enhance our borough for all residents. It serves as a guide for the aspirations and initiatives of our residents and partners throughout the borough, fostering a collective belief in Bolton's potential. At the outset, we need to take stock and understand what we are trying to change.

In recent years, cost-of-living pressures, growing health inequalities, and limited access to skills and employment have negatively impacted many of our residents, both in the short and long term. Many residents are increasingly having to access and rely on support services that they never needed before. These ongoing challenges highlight the scale and complexity of the issues faced by both our local people and our public services.

Therefore, we need to reconsider our approach and find better ways to work together, creating the conditions for a better quality of life. The overarching focus of this plan is clear: by adopting an approach that emphasises prevention, investment, and growth, we will positively impact inequality and poverty across the borough. By anticipating challenges, acting decisively, and working with our residents, we aim to improve the well-being of all.

From enhancing public health to bolstering our local economy, we are proactive in our strategies to ensure that no one is left behind.

We all have a part to play in achieving this plan.

Boltonians are the heartbeat of our town. Their resilience, compassion, and unwavering commitment to one another form the very fabric of our community.

We truly believe that together we can tell a better and shared story of our borough, and we have a real opportunity to turn Bolton into a place of possibilities.
In developing this plan, our Vision partners have worked together closely, ensuring the different perspectives of our communities, businesses, and organisations are heard.

This collaboration ensures that our borough's vision and ambitions represent everyone who has an interest in Bolton's future. We are committed to ensuring that our communities thrive, and through this plan, we aim to shape the future of our borough.



A new vision

for Bolton, our journey to 2040

In 2017, the Bolton Vision Partnership launched ‘Bolton2030,’ a long-term vision to create an Active, Connected, and Prosperous borough.

While substantial progress has been made, the past six years have brought significant global changes, requiring a reassessment of our goals and strategies for Bolton. The pandemic forced people to adapt to unprecedented ways of living, technology has advanced rapidly, and individuals have had to navigate numerous pressures simultaneously, including economic uncertainty, mental health challenges, and social isolation.

Despite these challenges, our strengths have also shone through. We’ve seen our communities come together in remarkable ways, demonstrating resilience, compassion, and an unwavering commitment to supporting one another. These times have urged us to rethink how we approach Bolton’s future—how we build a vision that is not just ambitious but adaptable, inclusive, and truly reflective of the needs of our people. As we transition to Bolton2040, we carry forward the lessons learned and the collective strength of our community. This new vision reaffirms our dedication to a borough that is shaped by and for its people.

. . .where people want to live, work, study, invest and visit.

This borough plan will serve as the framework under which current and future strategies and plans are aligned with our missions and priorities. By anchoring all efforts to this road map, we can ensure that resources are allocated thoughtfully, preventing disjointed initiatives and promoting targeted, effective action. This unified approach will aim to make it so that every plan contributes to a coherent, collective path towards a truly thriving borough, where people want to live, work, study, invest and visit.

We also recognise the opportunity to extend our influence across the region. The rise of devolution and the role of the Greater Manchester Combined Authority have brought significant changes to the region’s governance. Devolution has provided greater local control over key areas such as transport, housing, and health, enabling more tailored and effective solutions to local issues. As the new Greater Manchester Strategy takes shape, Bolton will harness opportunity to shape the city region and deliver our collective ambitions.

Our residents

Bolton's population



302,383



73,832
aged 0-17



176,783
aged 18-64



51,768
aged 65+



14,930 stay at home to look after family/home.



3,453 births in 2021



2,132 children with special educational needs



63.9% of pupils achieving a good level of development at EYFS (aged 0-5yrs)



0.14% children and young people were permanently excluded



322 of our **544** Looked After Children are in in-house foster placements



15% of Looked After Children adopted



190 Care leavers



4,331 of adults are accessing long-term support



1,469 residents have a different sex from the one registered at birth



2 year lower life expectancy than England average



26% live in an area that is among the 10% most deprived nationally



18% (16+) have a disability



25,980 unpaid carers



31.24% ethnic minority



7,345 Armed forces veterans



5,695 LGBT+ community



Within Bolton, life expectancy varies by 14.9 years (male) and 9.9 years (female)



Children and young people make up **19%** of all offenders in Bolton



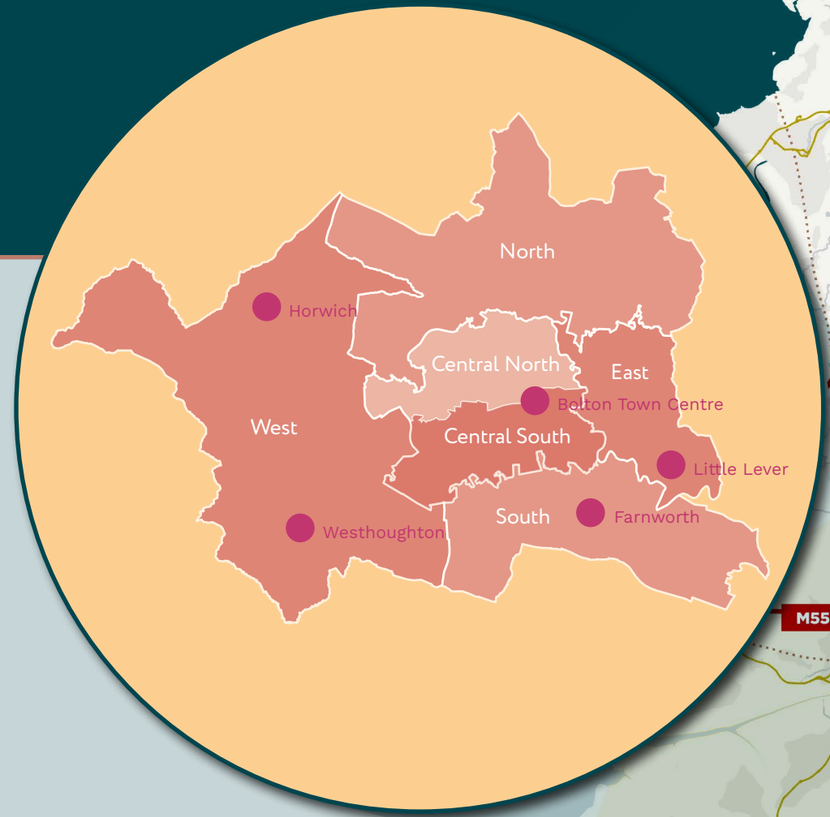
93% of babies visited by public health nurses within 14 days of birth



89.7% of adults with a learning disability live in their own home or with their family

Information accurate as of April 24

Our borough



£3.8m
refurbishment of Museum

£12m
refurbishment of Octagon Theatre

3.4m visitors to Bolton (2021)

Award winning food and drink festival

£1bn
regeneration programme

£13.3m
Future High Street funding awarded

1,100
businesses

£83m GVA

Awarded **£11m** to develop and deliver a heat network

12 miles
from Manchester City Centre

1 million
people live within 45 minutes of Bolton

60% of UK businesses are within a 2-hour drive

10,000 jobs

Direct access
to major transport links

Information accurate as of April 24

Our path forward:

Prevention, investment and growth

Bolton recognises its role in Greater Manchester, and we welcome the changes brought to increase the scope of local decision-making. We look forward to building on these changes as the UK government expands devolution and brings benefits directly to our communities.

As we shape our next Borough Plan, we have spotted a great opportunity to align our goals with the Greater Manchester Strategy, particularly around boosting growth and preventing future challenges.

In partnership with our regional colleagues, Bolton will ensure our local priorities—like improving well-being—work hand in hand with broader regional plans.



A focus on prevention

We believe that preventing problems before they escalate makes our community healthier and more resilient.

Bolton is committed to taking early action to reduce inequalities through our All-Age Prevention and Inequalities framework. This framework emphasises early intervention and the promotion of healthy lifestyles, aiming to create a healthier and more equitable community.

We recognise that to truly make a difference, we cannot rely solely on quick fixes but must cultivate better conditions for Bolton, in which people across our borough can grow, live, work, and age well.



Investing in our future

Improving the places where we live, learn, work, and play is key to our plan.

By attracting smart investments in skills, green spaces, health, and local infrastructure, we can create a dynamic and sustainable community for everyone. Investments in education and training will boost our workforce's future, while enhancements to parks and infrastructure will raise our quality of life and support a healthier environment.

Fundamentally, this plan is about investing in people—empowering every individual with the tools, opportunities, and support they need to flourish in Bolton.



Fostering sustainable growth

Sustainable, long-term growth will ensure that Bolton remains a vibrant and prosperous place.

By supporting local businesses and encouraging innovation, we aim to build an economy that benefits all residents—creating new opportunities and helping our community to prosper.

Together, these three pillars — prevention, investment, and growth — guide our six key missions, outlining the positive differences we want to see in Bolton by 2040.

The foundations
to building a stronger future together

1. Sharing our Bolton Story

Bolton's narrative is built on pride, ambition, and opportunity. Our new brand shows who we are and where we're heading, positioning Bolton as an ideal place to live, work, study, invest, and visit in the North of England. This effort brings together businesses, public services, community groups and residents to celebrate our borough, boost our economy, and attract investment. We believe that by changing our mindset and actions, Bolton can fully use its strengths—spreading influence, building confidence, nurturing strong leadership, and uniting business with community.

Our Bolton story goes beyond simple marketing; it's a signature of our identity. It brings us together under a shared vision and inspires confidence in our future. This narrative invites businesses, employers, and visitors to see Bolton as a place of real opportunity and growth. Through our ambassador programme and community efforts, we're sharing this story to improve our town centre, open up new opportunities and make Bolton a thriving borough. Sharing our story is about pride and shaping our future together.

2. Informed decision making

By effectively using our data and insight, we can identify challenges early, direct resources where they are needed most and track our progress accurately. In basing our decisions on evidence rather than assumptions, we can tackle issues like crime, public health challenges and poverty more effectively. Reliable information helps us understand what works, adjust quickly to emerging issues, and make informed choices that benefit all Bolton residents.

But data and insight are only useful when it drives real action. It must be used to inform what we do—from making policies and designing services to planning investments for the future. This means that we constantly refine our approach, learn from successful examples, and base our plans on clear, measurable results. Making evidence the foundation of our decisions allows Bolton to become more efficient, more effective, and well-prepared for the future.

3. Community Voice: Empowering residents to shape their future

In Bolton, we know that the best ideas come from the people who live here. That's why we're putting community voice at the centre of everything we do—not just by listening, but by empowering residents. We're committed to providing the tools, support, and resources needed to help people lead positive change in their neighbourhoods. This approach ensures that everyone feels valued, connected, and proud to call Bolton home, with a role to play in achieving our vision.

4. Building on Bolton's strengths

Bolton's power comes from its strong partnerships, its fantastic people, and its rich history. These elements form the bedrock of a bright future, and we want to harness the collective strength of our community to create meaningful change.

Our people are the heartbeat of Bolton. By investing in our borough, we make sure that everyone can help shape our town's future and share in its success. With a proud legacy of industry, innovation, and community spirit, Bolton is turning its history into new opportunities. Positioned in an important area of the UK, Bolton is ready to grow, attract investment, and become a leading hub for innovation. By building on our strengths, we set the stage for a future that benefits all who call Bolton home.

5. Working Together: Stronger partnerships, greater impact

Bolton's success depends on strong, collaborative partnerships. When local businesses, community organisations, schools, health services, and volunteer groups work together, we become stronger. By breaking down barriers and fostering true collaboration, we can address complex challenges such as poverty, crime, and climate change more effectively.

Our whole-system approach makes sure that no one is working in isolation. Whether it's offering early support to families, creating new job opportunities, or improving overall health outcomes, we are united by a shared commitment to making Bolton a better place for everyone.

Our missions

Our Bolton2040 Borough Plan is a visionary document, providing a roadmap for transforming our community into a place where everyone can thrive.

For our plan to succeed, we must concentrate on the initiatives we can genuinely tackle together.

This plan is built around six missions that will guide our collective efforts, with priorities that are comprehensive, concrete, and geared toward taking real action.



…transforming our community into a place where everyone can thrive.

MISSION ONE

Family-friendly, where every child matters

Every child in Bolton deserves the best possible start in life.

Our first mission is to create a borough where families feel supported, children grow up free from harm, and no child or family is held back by poverty. By taking a strength-based, early intervention approach, we will provide the right support at the right time, helping families to thrive.

Our mission is clear, to improve outcomes for all children and young people. For those who need extra support, we will ensure they remain at the centre of decisions, with services built around their needs and aspirations. When families thrive, children thrive – and thriving children are key to a flourishing Bolton.

1 Families benefit from an integrated Family Help approach

2 Less families are experiencing poverty

3 Every child is achieving their potential

Families benefit from an integrated family help approach

Ensuring children grow up in safe, stable environments is a shared responsibility. The support we offer needs to be well co-ordinated, focused on the whole family and delivered through partnerships with schools, health services, and community organisations. This will help families to access the right resources at the right time, and ensure challenges are addressed holistically through services working together effectively.

We recognise that all families may need support at different stages of their lives—whether during pregnancy, early childhood, education, or key life transitions. Evidence shows that timely family help is far more effective than reacting later, preventing families from reaching crisis points and reducing the incidence of trauma. This in turn reduces the need for the most intensive interventions.

Our approach is simple:
work with families as early as possible, supporting them to thrive independently in the long-term.

Through this plan, we are committed to improving families' access to tailored support, whether they are struggling with financial pressures, mental health, parenting challenges, or other life changes. This could mean guidance for new parents, access to childcare and education, mental health support for young people, or advice on employment and housing. By helping families to overcome difficulties and build long-term resilience for the future, Bolton will be home to confident, healthy, and thriving communities.

by 2030

Families across Bolton will have easy access to local, community-based support through a family network offer.

by 2035

Families at risk receive proactive, tailored support to prevent challenges from escalating.

by 2040

Bolton will be a regional leader in family help, with a system that ensures families thrive and childhood trauma is greatly reduced.

Less families are experiencing poverty

Poverty is a growing issue, in Bolton and across the country, and we must act now to better protect and support some of our society's most vulnerable members. Growing up in poverty affects children's well-being, limits opportunities, and has long-term consequences for their life chances.

Breaking this cycle is at the heart of our vision for Bolton.

Tackling poverty across our borough is not only a moral imperative but also represents an investment in our future. By addressing the root causes of poverty, improving access to education and employment, and ensuring no person is disadvantaged by their background, we will unlock potential and create a stronger, more prosperous borough.

Our lived experience helped shaped the Tackling Poverty Strategy and findings from this has made it clear that there needs to be greater focus on early intervention, including ensuring financial education is embedded in schools.

Beyond this, we want to maximise income for our families, improve educational attainment and enhance access to affordable, safe and secure housing, all of which are key priorities within this borough plan.

by 2030

Families across Bolton can easily identify and access all of the support according to their needs.

by 2035

Families will have access to stable, Living Wage employment and secure, permanent housing as the norm, not the exception.

by 2040

Bolton will be a place where child poverty is significantly reduced, and families are empowered to thrive through maximised income, good housing, and strong communities.

Every child is achieving their potential

Every child in Bolton deserves the opportunity to achieve their full potential, regardless of their background or circumstances. Our mission is to create a borough where children and young people are equipped with the education, support, and skills they need, not only to succeed in school but also to prosper throughout their lives.

A strong start is key to ensuring future success. School readiness plays a vital role in preparing children for their educational journey and we will work with families to provide children with the social, emotional, and cognitive skills needed to thrive.

Unlocking a child's potential is rooted in a robust education system. We are committed to making sure every child has access to a high-quality school place, with the right support in place to help them flourish. This includes addressing barriers to learning, such as special educational needs, mental health challenges, or financial hardship, so that no child is left behind.

As part of this approach, we must also plan ahead to ensure we are meeting the demand for school placements across the borough.

We want our children to have a positive school experience, where they are happy and safe in education, engaging with their learning and receiving the support they need to succeed. Children must be in education to realise its benefits, and work must continue across the borough to support our children to attend school where possible and feel safe and included when there.

Beyond the classroom, we want our children to feel prepared for adulthood.

We will work to equip young people with life skills, career guidance, and financial literacy. Whether transitioning from primary to secondary school, into post-16 education, or into employment, we will provide clear pathways and support to help young people navigate these key life stages.

by 2030

All children who require extra support, will benefit from robust school services, targeted intervention and early career advice.

by 2035

Young people will have access to a wider range of education and training opportunities, with strengthened transition support to help them move confidently into adulthood.

by 2040

Bolton will be a place where all children, regardless of background, achieve their potential and are equipped with the skills, confidence, and opportunities to succeed in adulthood.



MISSION TWO

Thriving,
investment-ready with a growing economy

Our second mission is to make Bolton a thriving, investment-ready borough with a growing economy. As one of the largest towns in Europe, we have the confidence to think big and offer big opportunities. A Bolton that is born to perform.

Attracting investment, fostering job creation, and upskilling our residents are central to this mission. This mission focuses on creating a business-friendly environment, supporting businesses to grow and reducing barriers between residents and skill opportunities.



1 An increase in inward investment

2 More businesses with a diverse range of jobs in Bolton

3 A skilled Bolton workforce

An increase in inward investment

The Bolton Blueprint: A Bolton Vision for 2040, signals our ambition for attracting investment into Bolton. Working closely with private sector partners, Bolton has already developed a £1bn investment pipeline to transform the town centre and drive growth.

Bolton is also investing in its district centres. The areas of Farnworth, Horwich, Westhoughton and Little Lever, each with their own unique heritage and identity, have received funding to meet the needs of residents and to address local priorities.

The Wigan-Bolton Growth Corridor (NorthFold) is one of the six growth locations in Greater Manchester, with a focus on innovation as a driver of growth, primarily in logistics, manufacturing, and healthcare. It is expected to deliver 9,000 new homes, 342,000 sqm of industrial space and £356.3m of GVA by 2035.

NorthFold will be a place for start-ups and SMEs to find their feet and grow, creating more employment opportunities in exciting new fields and creating more skilled workers across a range of sectors.

A quality bus corridor, motorway link road, and enhanced rail will also help to connect more Bolton residents to employment and skills opportunities within the borough and across Greater Manchester.

Despite already delivering a significant regeneration plan, we remain highly ambitious for the future and are eager to advance our growth plans even further. The introduction of a Mayoral Development Zone will turbo-charge our regeneration plans, further driving economic growth, create jobs, and build new homes through coordinated efforts between the public and private sector.

by 2030

There is an increase in inward investment, including key sectors like manufacturing, logistics and healthcare.

by 2035

Bolton becomes a hub for investment with a focus on sustainable and high-value industries.

by 2040

Bolton is a recognised investment hub in Greater Manchester.

More businesses with a diverse range of jobs in Bolton

Investment and job creation go hand in hand, and as we grow, so to will our businesses and job opportunities. Our Economic Growth and Resilience Plan (EGR) aims to foster a business-friendly environment in Bolton, encouraging more companies to establish and thrive here.

Though our EGR, we are focused on attracting a diverse range of businesses that will create many types of jobs for our community. We aim to encourage innovators, start-ups, and well-established companies from different sectors to invest in Bolton.

Our approach means that the jobs created won't be one-size-fits-all.

We are actively working with partners to develop training programmes that meet the demands of today's diverse industries. Whether it's technical roles in cutting-edge technology, creative jobs in emerging industries, or essential positions in the service sector, we want every Bolton resident to have the chance to find work that aligns with their skills and aspirations.

By investing in our infrastructure, we're setting the stage for long-term business growth that benefits everyone. This inclusive approach isn't just about economic growth; it's about building a resilient community where there are opportunities for personal and career advancement for all.

by 2030

There is a creation of new jobs (mix of entry-level and skilled roles) in sectors like advantaged manufacturing, logistics and healthcare.

by 2035

Bolton has a growing and more resilient business market with an increase in the total cumulative of jobs including higher skilled job roles.

by 2040

Bolton has a significant portion of new jobs in high-value industries and is an established economic player in the region with a thriving ecosystem.

A skilled Bolton workforce

Bolton's economic growth is not just about numbers; it's about people. As we grow, we must ensure that no one is left behind, and this means prioritising skills development.

By providing access to education and training opportunities, we can ensure that our workforce is equipped with the skills needed to thrive in a rapidly changing job market. This not only benefits individuals by enhancing their employability and earning potential but also strengthens our local economy by creating a more versatile and capable workforce.

Through this plan, we want to focus on supporting those facing barriers to the labour market, ensuring everyone achieves a minimum skills level, and providing the core and generic skills required across the business base.

Additionally, the borough needs higher-level skills to drive productivity growth and transition towards a higher-skilled, higher-wage economy. To do this, we need to have clear progression pathways in place and instate a culture that values learning and development and all stages of life.

by 2030

More targeted programmes in place, particularly in growth industries to begin addressing skills gaps in the borough.

by 2035

Boltons unemployment rate and economic inactivity has dropped closer to the national average driven by a skilled and adaptable workforce.

by 2040

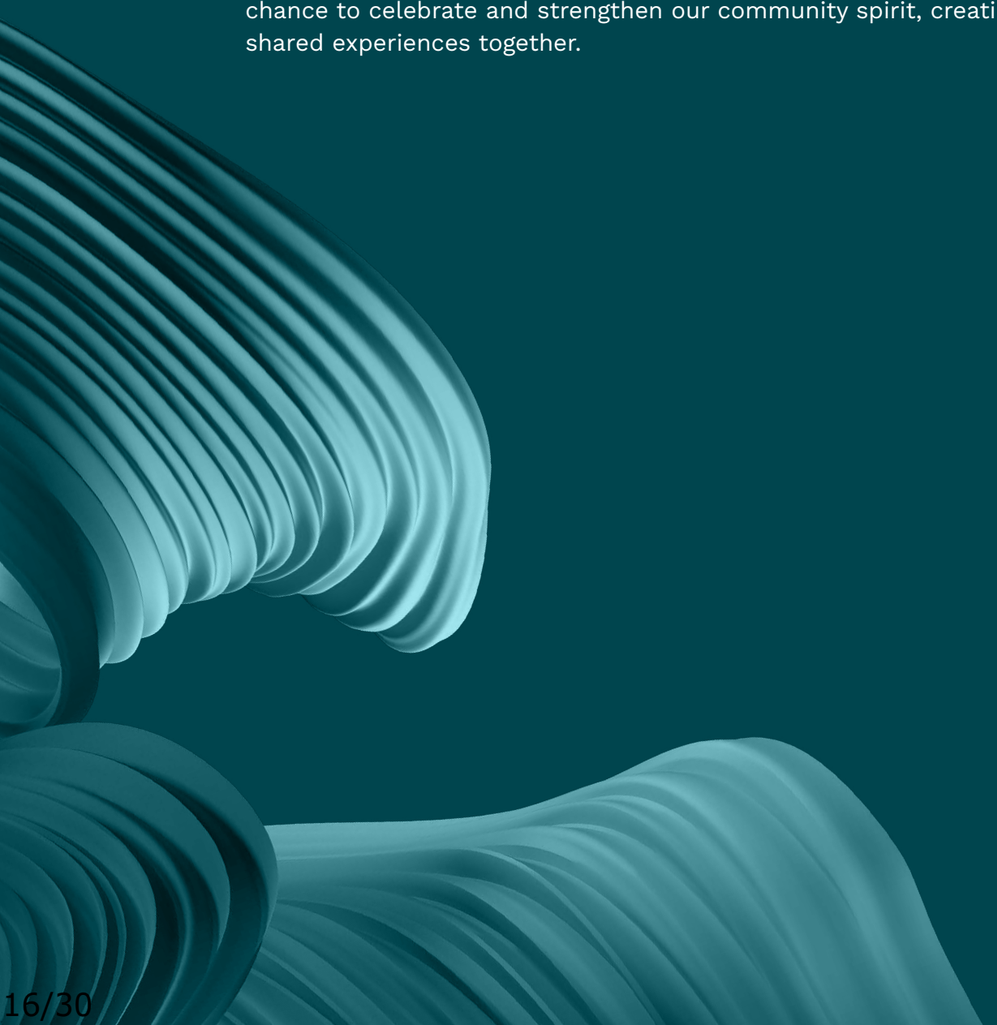
No resident is left behind due to a lack of skills, with comprehensive support in place for all demographics.



MISSION THREE

Inclusive, with access to culture, leisure and visitor opportunities

Inclusivity is at the heart of this mission. Our goal is to showcase Bolton's unique identity, rich diversity, and outstanding assets, ensuring that everyone has the chance to participate in the experiences our borough has to offer. A range of cultural, leisure and visitor opportunities will give us the chance to celebrate and strengthen our community spirit, creating more shared experiences together.



1 An accessible culture offer that celebrates Bolton

2 A wider range of sports and leisure opportunities

3 A bold Bolton Story to tell

An accessible culture offer that celebrates Bolton

Bolton's rich cultural heritage is deeply embedded in our theatres, museums, football club, and award-winning festivals. Institutions like the Octagon Theatre, Bolton Central Library and Museum, and the Albert Halls all play a vital role in shaping our town's identity, hosting world-class events such as the Bolton Food and Drink Festival, major music concerts, and the Bolton Film Festival.

These events not only attract visitors from across the country but also create a sense of pride and belonging for our residents.

We want culture to run through all that we do, shaping our identity, strengthening our sense of place, and bringing people together.

We are committed to ensuring that all Boltonians feel connected to and involved in the cultural life of the town, celebrating what makes our community unique and a culture offer which meets the needs of all our residents.

by 2030

More people are engaging in Bolton's vibrant cultural, food and drink offer, and cultural leadership is strong, connected, and diverse.

by 2035

Bolton is a recognised cultural hub with sustained growth in the offer and engagement, and a reputation for community-led cultural projects.

by 2040

Bolton is a national 'go to' destination for its unique culture, food and drink offer, where all residents have equitable opportunity for high quality cultural experiences.

A wider range of sports and leisure opportunities

Culture and leisure go hand in hand. Connecting people to sports and leisure opportunities is key to improving well-being and social cohesion. Bolton offers a wide range of attractions—from the UK's largest retail park to our stunning natural landscapes and green spaces, we want everyone to find an activity that suits them.

Bolton's extensive range of sports and recreational spaces encourages residents to stay active and connected, in whichever way suits them best. This could be taking part in team sports, going for a swim, or even taking a leisurely walk in one of our green spaces.

We want all residents to have the opportunity to lead active, healthy lives, with access to a variety of activities that suit their interests and needs.

We also recognise that barriers to this exist —whether it's busy schedules, digital distractions, or even the weather.

For some, including older adults, those with disabilities, or people managing long-term health conditions, these challenges can be even greater. That's why we're focused on creating an environment that makes it easier to enjoy what Bolton has to offer, in a way that fits different lifestyles and abilities.

by 2030

A growing number of residents engage in active lifestyles, leading to improved self-reported health and wellbeing outcomes.

by 2035

Health and wellbeing is embedded within Bolton's sports, leisure and physical activity programmes, promoting long-term participation.

by 2040

All residents have equal access to leisure facilities and green spaces, contributing to a significant improvement in mental and physical health.

A bold Bolton Story to tell

Bolton has all the ingredients to position itself as a top visitor destination.

However, we often don't shout about it enough. By leveraging our cultural and leisure assets, we can attract investment, increase visitor footfall and spending, and enhance the quality of life for our residents.

Bolton is born to perform and has produced a wealth of talent over the years, with well-known figures such as Peter Kay, Paddy McGuinness, Sara Cox, Vernon Kay, Jason Kenny, Amir Khan, Maxine Peake and Clive Myrie proudly championing their hometown. Their success highlights the depth of creativity, ambition, and community spirit that defines Bolton, qualities we all share and have a role in promoting.

As part of our new brand initiative, we've enlisted dedicated brand ambassadors to tell Bolton's story on a wider footprint, igniting pride and celebrating Bolton. The newly formed board and ambassador programme will promote the borough as a place for business, a place with a growing population, a place of connectivity, a place with a diverse leisure and cultural offer, and a place committed to growth.

Through bold storytelling and innovative thinking, Bolton can become a top visitor destination.



by 2030

A strong Bolton brand identity which showcases our cultural highlights, local heritage, and visitor attractions.

by 2035

Bolton will be recognised as one of the North Wests top visitor destinations, known for its vibrant culture, landscapes, and warm hospitality.

by 2040

Bolton will have an expanded reach and reputation as a visitor destination across the UK.

Bolton
IS BORN TO PERFORM

MISSION FOUR

Supportive, empowering and where people feel a sense of belonging

The fourth mission is about creating a supportive and empowering environment where residents feel a strong sense of belonging. We want Bolton to be a place where everyone feels supported, empowered, and connected—a borough where people have independence over their lives, access to quality housing, and the infrastructure to stay connected both digitally and physically.

1 People are living well independently

2 A quality housing offer

3 Better connected residents

People are living well independently

We envision a community where every Bolton resident thrives independently, supported by services and resources tailored to their circumstances. Central to this is the provision of high-quality, person-centred care—to ensure individuals maintain their independence.

We want to empower our residents to make decisions about their care and daily lives; with care and support personalised to focus on their strengths and the outcomes they want to achieve.

When additional care and support is needed, we are committed to delivering quality services that meet these needs effectively. For most people, this will mean receiving care in the comfort of their own homes. However, for those who require hospital or specialist care, we will work to ensure that their time away from home is as brief as possible, supporting their return home as soon as it is safe to do so.

Given that a significant number of older individuals in Bolton are homeowners who will continue residing in their current homes, it's imperative to support them in maintaining their quality of life. This includes assistance with home maintenance, necessary adaptations, and improvements in energy efficiency.

Such initiatives not only enhance living conditions but also promote sustainable and independent lifestyles.

by 2030

Bolton will expand community-based support services, including tailored care and support packages for older and vulnerable people.

by 2035

Residents with long-term health conditions have access to personalised care plans and assistive technology.

by 2040

Innovative care packages with provisions are in place to provide personalised care and community-led solutions

A quality housing offer

A sense of belonging starts with a place to call home. We are committed to making Bolton a place where people feel at home, with housing that meets diverse needs and strengthens communities ability to thrive.

To achieve this, we need to expand the supply of high-quality, affordable housing that meets the needs of all residents – whether that's young people buying their first home, families seeking stability, or older adults wanting to live independently. Through developing more inclusive and sustainable housing options, we aim to address housing challenges and create vibrant communities where people feel safe, secure, and supported.

At the same time, it is just as important to ensure that existing housing provides a strong foundation for people's lives. Through collaboration with landlords as part of The Good Landlord Charter, we will work to raise renting standards across GM, supporting landlords to meet enhanced standards, above the minimum legal requirements. The charter starts from the principle that a renting experience cannot be considered 'good' unless it is: Affordable, Inclusive, Private and secure, Responsive, Safe and decent, Supportive and Well Managed.

By having a strong housing offer, we can work to ensure that people can live safely, and independently within their own communities, whatever their circumstances.

by 2030

More residents benefit from stable and secure housing through a combination of improved housing standards and an expanded supply of affordable and social homes.

by 2035

Bolton has a diverse housing market, addressing any long-term housing shortages with good quality housing.

by 2040

Bolton has mixed-use neighbourhoods that combine residential, commercial, and recreational spaces, meeting the needs of residents.

Better connected residents

As part of this mission, creating a well-connected borough is key. Reliable transport infrastructure ensures that residents can access work, healthcare, education, and leisure opportunities seamlessly, no matter where they live.

Meanwhile, digital connectivity has become an integral part of modern life, enabling access to online services, remote healthcare, social connections, and opportunities to develop essential digital skills. By improving public transport networks, promoting active travel options, and reducing digital exclusion across our communities, we can remove barriers to participation and foster a more inclusive and accessible Bolton.

At the same time, better connectivity complements the broader goal of empowering individuals to take control of their own lives.

When people are less isolated and better equipped to make decisions about their education, careers, and daily lives, they are more likely to thrive, reach their full potential, and make meaningful contributions to their communities.

This self-sufficiency, fuelled by improved infrastructure and opportunities, nurtures confidence, resilience, and a greater sense of personal empowerment.

by 2030

All residents in Bolton can access affordable and reliable public transport and digital infrastructure, helping to reduce social exclusion.

by 2035

No one in Bolton experiences involuntary exclusion from transport or digital services, ensuring full connectivity for all.

by 2040

Public transport becomes the preferred mode of travel for most residents, while universal digital literacy empowers everyone to engage fully in modern life.



MISSION FIVE

Safe and protected, with confident, cohesive communities

Every resident deserves to feel safe, valued, and connected to their community. Our fifth mission focuses on making Bolton a place where people feel protected, crime and anti-social behaviour is tackled effectively, and communities have a strong voice in shaping their future.

By improving community safety, improving our environment, and strengthening local engagement, we will foster a borough where people take pride in their surroundings and work together to create a better future.



1 Safer communities

2 Stronger Community voice and cohesion

3 A cleaner, greener Bolton

Safer communities

Reducing crime and exploitation is a key priority. Crime has a significant negative impact not just on victims, but also on families, offenders, and the wider community - carrying a major social and financial cost. Reoffending alone costs society an estimated £18 billion per year. Here in Bolton, we are committed to breaking these cycles by investing in both enforcement and prevention.

As we work to reduce crime, we need to ensure a joined up, evidence-led approach which brings agencies together at a local level to consider the root causes of the problem. This means working with partners and communities to understand the factors that contribute to crime, such as trauma, poor mental health, school exclusion, unemployment, housing instability, substance misuse, and exploitation. Addressing these root causes of crime is essential to building safer, more resilient communities.

We also recognise the growing risks posed by criminal exploitation, gang involvement, and online harm. Many young people are drawn into unsafe situations due to a lack of positive opportunities, economic hardship, or coercion by others. Early intervention is key to preventing this cycle.

Through stronger partnerships between schools, youth services, and community organisations, we will equip children and young people with the knowledge, resilience, and support networks needed to stay safe.

Our borough plan emphasises early intervention and targeted support to prevent children, young people, and adults from entering the criminal justice system. Additionally, we must implement proactive measures to deter reoffending and ensure the safety of our residents.

by 2030

Effective multi-agency action is taken to reduce the risk of exploitation, cut crime rates, and break cycles of reoffending, creating safer communities.

by 2035

Sustained investment in prevention and early intervention programmes significantly reduces crime rates, ensuring long-term safety and resilience within communities.

by 2040

Bolton is a safe borough, where exploitation is actively prevented, and residents feel safe and empowered in their communities.

Stronger community voice and cohesion

Safer communities are built on trust, cooperation, and shared responsibility. As part of this mission, we will work with residents to ensure they have a greater say in decisions that affect them, enabling people to actively shape services and improvements in their communities.

Whether through stronger partnerships or by enabling grassroots initiatives, we want local people to feel heard, connected and involved in the future of their area.

As part of this plan, we want to create the conditions to enable residents to use their voice. By integrating learned and lived experiences, we can co-produce solutions that are more effective and responsive to the real needs of our community. This approach lays the foundation for creating a new relationship with communities, built on collaboration and trust.

Through informed decision making and better connections between communities and services, we will be able to amplify our respective strengths to improve service delivery. We want to move away from doing things to our residents; instead, we will work alongside Bolton's residents to support and empower them to help themselves.

by 2030

Bolton has robust ways of engaging the community, that empower residents to influence local decisions whilst strengthening social cohesion.

by 2035

Bolton will be a borough where community voice drives local priorities, reflecting the strength of more connected communities.

by 2040

Residents will play an active role in decision-making to meet the needs of all communities in Bolton.

A cleaner, greener Bolton

The delivery of green infrastructure, alongside social and physical infrastructure, is integral to Bolton's plan to ensure growth is sustainable whilst also reducing our carbon footprint and improving our environment.

The world around us is changing rapidly, with increasing temperatures, extreme weather, and threats to property, health, and the environment. Climate change affects everyone, but we all have the ability to make a difference. Studies show that a future powered by clean energy is possible, but to achieve this, we need to commit to our goals and start taking action immediately.

In 2019, a climate emergency was declared in Bolton, leading to the development of Bolton's Climate Change Strategy 2030. As we implement this strategy over the coming years, it is essential that we remain adaptable, embrace new technologies, and work collaboratively on both regional and national levels. We also recognise that our residents must play an active role, as we cannot achieve this for Bolton alone.

Through our plan, we will continue investing in public spaces, improving infrastructure, and addressing environmental issues, creating communities where people feel secure and proud to live.

In exchange, we want our residents to play their part, by looking after the environment, embracing renewable energy options and making active travel a part of daily life.

by 2030

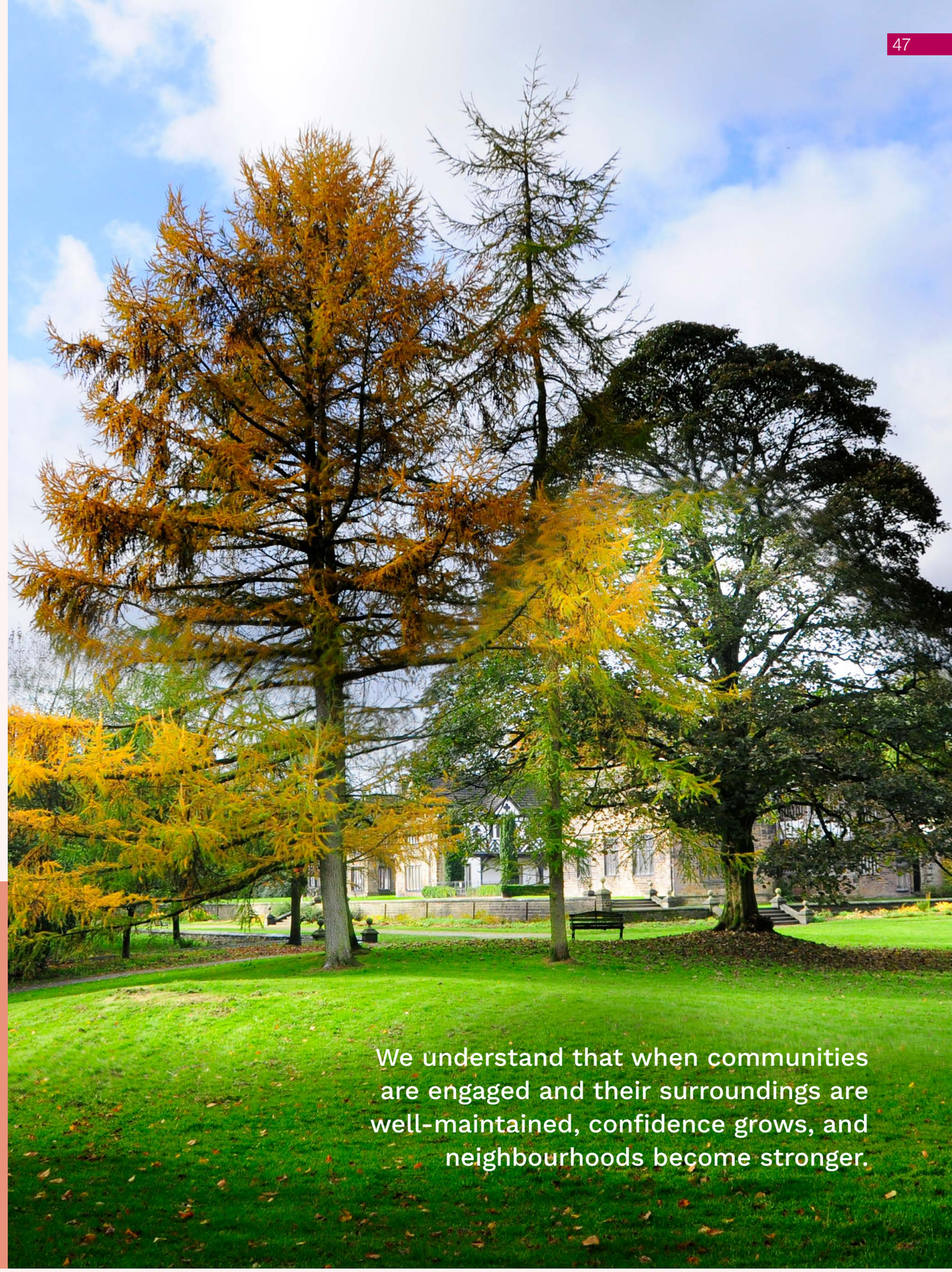
The carbon emissions of our borough are reduced, working towards net zero.

by 2035

Key community infrastructure is adapted to prepare for a changing climate and our local natural environment is protected.

by 2040

Bolton has a flourishing green economy with the Right Mix of sustainable transport options across the borough.

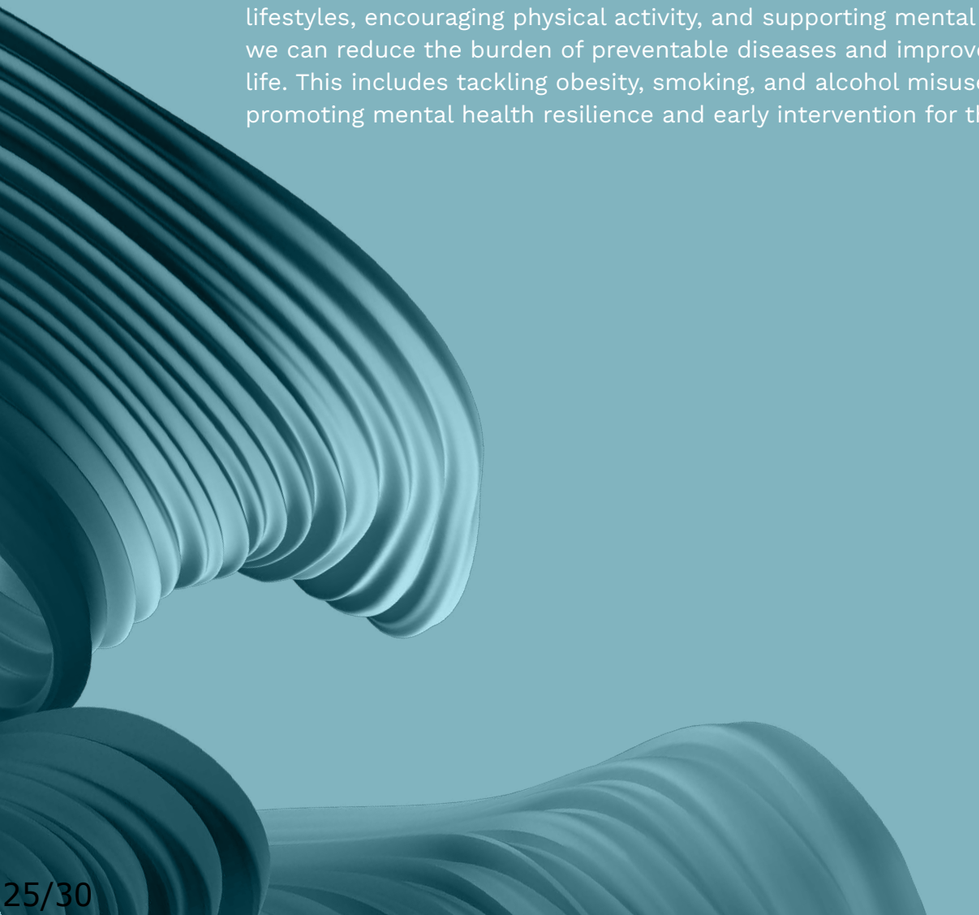


MISSION SIX

Healthy, where our population live well for longer

Our sixth mission is to ensure that Bolton becomes a borough where everyone can live a long, healthy, and fulfilling life. This mission is rooted in prevention, empowerment, and innovation, with a focus on creating a healthier, more resilient population. We aim to reduce health inequalities, promote well-being, and ensure that every resident has access to the resources and support they need to thrive.

Prevention is one of the key pillars of this plan. By promoting healthy lifestyles, encouraging physical activity, and supporting mental well-being, we can reduce the burden of preventable diseases and improve quality of life. This includes tackling obesity, smoking, and alcohol misuse, as well as promoting mental health resilience and early intervention for those at risk.



1 Bolton residents are living healthier lives

2 Strengthened neighbourhood health services

3 A reduction in unfair differences in health

Bolton residents are living healthier lives

We are committed to creating a borough where residents can lead healthier, more fulfilling lives through a combination of preventative and proactive measures. In doing so, we must achieve the right balance between preventative, proactive and reactive care to build a more efficient and effective health and social care system that prioritises prevention alongside timely treatment.

For those already facing health challenges, it's important to identify and address potential health issues before they become severe or symptomatic.

To do this, proactive care must be delivered effectively, focusing on early detection and interventions which prevent the progression and migration of health problems.

However, we recognise health is not just the absence of illness, it's about creating conditions where people can flourish physically, mentally, and socially. We will take a holistic approach by tackling the broader factors that influence health - such as housing, education, employment, and the environment—through our wider missions.

by 2030

A more embedded proactive care model to enhance health outcomes and improve quality of life.

by 2035

There are measurable improvements in the overall quality of life for residents, including mental health, physical fitness, and chronic disease management.

by 2040

Bolton residents enjoy longer, healthier lives, with increased healthy life expectancy and improved overall wellbeing.

Strengthened neighbourhood health services

Having accessible, neighbourhood health services is reducing barriers to care and helping our residents live healthy, fulfilling lives. By expanding these services to ensure care is available closer to home, we reduce the need for unnecessary hospital visits and provide faster, more proactive care when residents need it most.

This coordinated approach allows us to meet the full spectrum of physical, mental, and social health needs, making community-based health services the first point of contact for residents.

In Bolton, we have been actively redefining what community-based care can be, ensuring that residents have easy access to this full spectrum of services right at their doorstep. Local initiatives are working to create accessible neighbourhood health services where care is more than just a visit—it's a coordinated, proactive process aiming to reduce unnecessary hospital trips while delivering timely, targeted treatments.

By pooling resources, sharing information, and coordinating efforts across professional disciplines, we aim to provide services that are tailored specifically to the residents of its diverse neighbourhoods. This model tackles health issues at their roots, from prevention and early intervention to managing chronic conditions, thereby easing the demand on hospital-based services and ensuring care is as community-oriented as possible.

by 2030

There is an expansion of neighbourhood health services with integration of wider support services.

by 2035

Full integration of health and social care services which provide seamless support for individuals transitioning from hospital to home.

by 2040

Bolton has holistic care models which integrate physical, mental and social care, where neighbourhood health services are a first point of contact.

A reduction in unfair differences in health

A core focus of this mission is addressing health inequalities and reducing unfair differences in health outcomes across Bolton. We are committed to understanding and addressing the health challenges faced by the most vulnerable groups in our community, ensuring they have access to the services and support they need.

By targeting the borough's most deprived areas and focusing on our most at-risk populations, we will work towards closing the life expectancy gap and ensuring that all residents, regardless of background, can enjoy the benefits of good health and well-being.

Our vision is a Bolton where health and well-being are woven into the fabric of everyday life. Through collaboration with communities, healthcare providers, and partners, we will create an environment that supports healthy choices, fosters resilience, and empowers individuals to take control of their health.

Together, we will build a borough where everyone has the opportunity to live a longer, healthier, and more fulfilling life.

by 2030

A strengthened understanding and reduction in health inequalities for Bolton's 5 PLUS groups.

by 2035

Measurable progress in reducing health inequalities for the most deprived residents in Bolton.

by 2040

Life expectancy differences across Bolton's communities are significantly narrowed, creating a more equitable health landscape.



Making Bolton's Borough Plan happen

To bring this plan to life, we need strong leadership, teamwork, and accountability at every level. To stay on track, we've set up a clear structure to guide decision-making and ensure real progress.

The Vision Board oversees the big picture, making sure our goals stay on course. While it does not directly carry out the plan, it helps keep priorities focused on what Bolton needs most. Supporting this, three key groups—the Vision Executive Group, Locality Board, and Health and Wellbeing Board—work behind the scenes to tackle challenges, make sure efforts are coordinated, and use resources wisely. These groups work alongside Strategic Delivery Partnerships which, with help from the wider team, lead specific projects and drive progress towards our Vision.

Making this plan a reality isn't just down to governance boards and partners — **it relies on all of us.**

It's about all of us. Residents, businesses, and community groups can get involved in shaping Bolton's future. Whether it's taking part in local projects, giving feedback on services, or simply helping in the community, small actions—like volunteering or joining a local forum—can have a big impact. When we work together, we can turn our shared vision into a reality and create a better Bolton for everyone.

To stay on track, we will closely measure progress to make sure all our missions lead to real, positive change. By using clear indicators, we can see what's working and step in when we need to keep things moving in the right direction. This approach ensures that Bolton's future will be built on solid foundations.



By 2040 we want Bolton to be a thriving borough, where people want to live, work, study, invest and visit.


Together, we will build a
brighter future for Bolton...
www.boltonvision.org.uk
Bolton
2040

Bolton

ALL AGE PREVENTION AND INEQUALITIES FRAMEWORK



BPF
BOLTON PREVENTION FRAMEWORK



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INTRODUCTION

Bolton is committed to ensuring that prevention is at the heart of everything that we do. From our Anchor Institutions, Private Sector, Voluntary, Community and Social Enterprise (VCSE) Organisations, right through to our communities and residents, there are opportunities to create the conditions for good health and economic prosperity.

Seen through the lens of a place, opportunities for prevention are broad and not limited to a narrow set of services or sectors. Across local areas there are a whole range of services and approaches – often strengths or asset based, relational or community-focused – working to address the root causes of problems, harness the power of our assets, improve outcomes for people, and potentially reduce the need for further support from statutory and other services.

Of course, a shift to prevention brings with it challenges: directing funding further upstream whilst fighting the fires as they happen; integrated and cross system working to meet national and local priorities and outcomes frameworks and being realistic about the limitations and possibilities of local areas to address some of the place based and legislative challenges that require national drive and direction for population level impact. But the potential of a shared framework for prevention, applied consistently across a locality is considerable.

And to meet these challenges we require a shared understanding of the range and scope of prevention that can be used to shape strategy, policy, services and places by all those who serve, live and work in Bolton. We need a shared language that describes our prevention opportunities and gaps, and a simple framework within which we can apply other tools and guidance about interventions, place shaping and community development to reduce inequalities. The Bolton All Age Prevention and Inequalities Framework is intentionally simple and based in the basics of prevention evidence.

This framework draws upon the Public Health evidence base of what works for prevention and as a result, makes reference to health in a number of sections. However, it will add value to any prevention topic or challenge in order to improve the places, experiences and outcomes for Bolton people.



AIM AND OBJECTIVES

AIM

The Bolton All Age Prevention and Inequalities framework will provide a strategically agreed vision and ways of working to deliver prevention activities which reduce health inequalities across the Bolton Borough. This will be achieved through the following objectives:

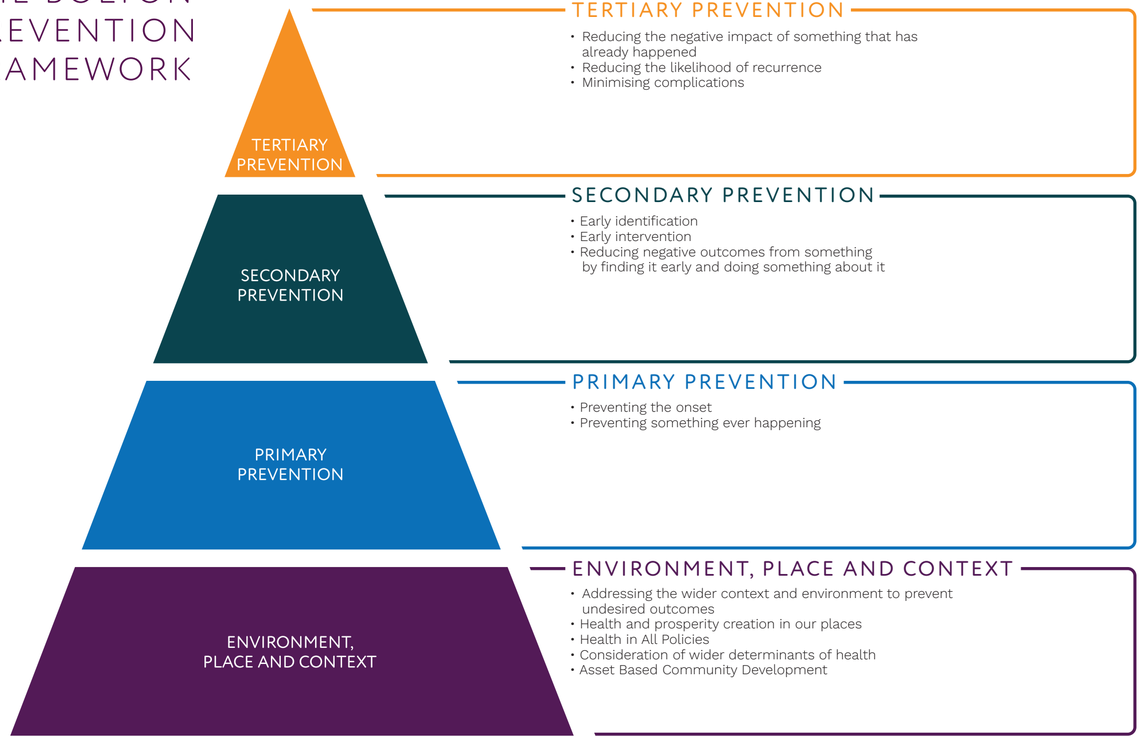
OBJECTIVES

1. To define a common understanding of the definitions and scope of prevention, health inequalities and healthcare inequalities

2. To define the prevention framework for Bolton and provide guidance for its use

3. To identify supplementary tools and evidence to underpin the application of the Bolton Prevention and Inequalities Framework

THE BOLTON PREVENTION FRAMEWORK



Further information about practical use of The Framework can be found in this document on pages 22-28.

SHARED UNDERSTANDING AND LANGUAGE

Prevention

Primary Prevention is when we take action to stop a health problem or any other undesired outcome from ever developing in the first place. An example might be banning the use of asbestos in construction to prevent certain types of lung cancer, giving an immunisation, or developing green spaces in communities.

Secondary Prevention is when we try to identify undesired outcomes early and intervene as soon as possible in order to limit the negative consequences. Screening programmes such as the bowel cancer screening programme (BCSP) and early help services are a good example of this.

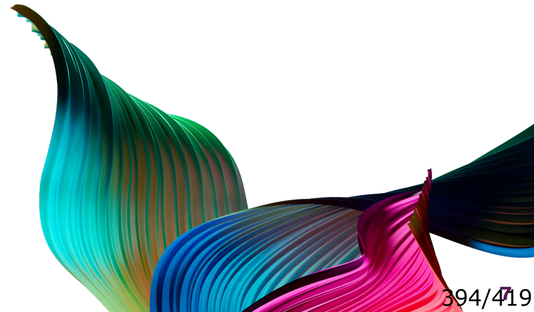
Tertiary Prevention is when we try to limit the negative impacts of an undesired outcome. This can be done by helping people to manage a health condition and live as full a life in their own home for as long as possible.

Wider/Social Determinants of Health are the conditions in which people are born, live, work, and age which contribute to their health, wellbeing and life outcomes. These are sometimes referred to as the 'causes of the causes' - the factors in a person's environment which may make it difficult or even impossible to make healthy 'choices' or to fulfil their full potential.

Inequalities

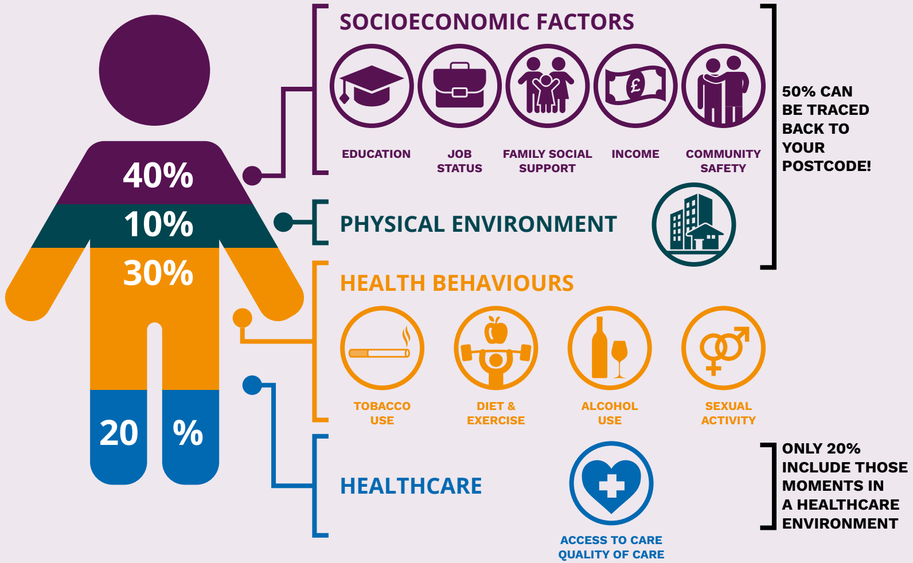
Health Inequalities are unfair, systematic, and avoidable differences in health between different groups of people. They are directly influenced by the social determinants of health.

Healthcare Inequalities are a specific type of health inequality which refer to the systemic inequalities within healthcare organisations such as hospitals or GP surgeries. They can be caused by various factors such as the way healthcare systems are organised (for example locations and times of appointments) and funded, or the unconscious biases of staff.



WHAT MAKES US HEALTHY?

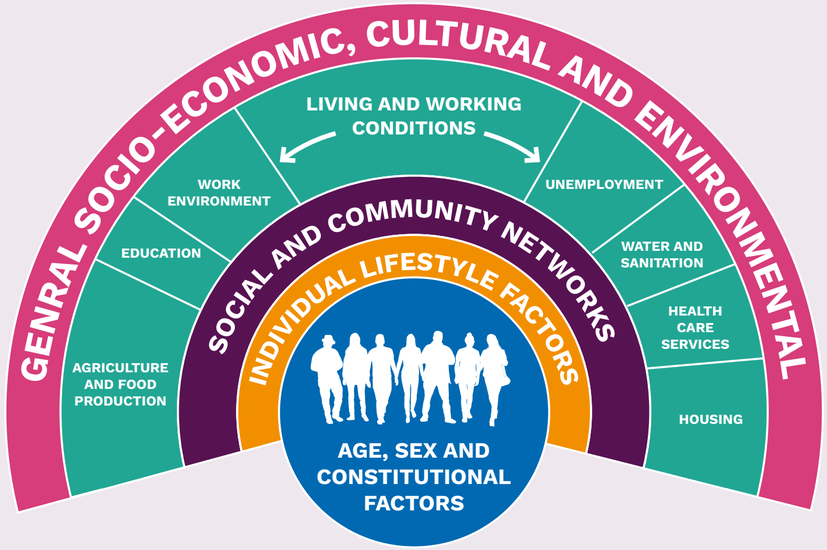
There are many different factors that make us healthy or unhealthy. It is really important to understand how these factors work alongside one another, and can be used in combination to prevent poor health and social care outcomes.



Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems (October 2016)

Different groups of people have different experiences of these, which affect their overall health and ability to take up and benefit from services for treatment and support.

Many less supportive factors (such as low income, low level of educational qualifications, high crime, poor air quality) are clustered together in our more deprived areas.



Social Determinants of Health (Dahlgren and Whitehead, 1991)



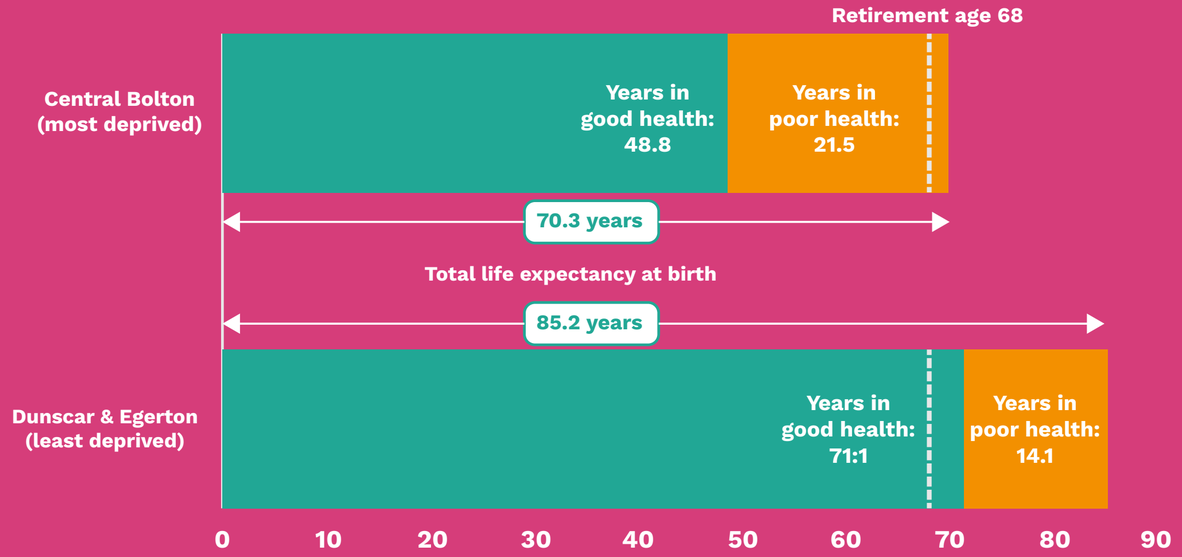
WHAT DO INEQUALITIES LOOK LIKE IN BOLTON?

Life Expectancy and Healthy Life Expectancy

Together life expectancy and healthy life expectancy are important indicators of overall population health, and inequalities in health. A longer life isn't a sufficient measure of health, instead alongside this measure we also consider healthy life expectancy (HLE) which describes the estimated number of years individuals can expect to live in "very good" or "good" health.

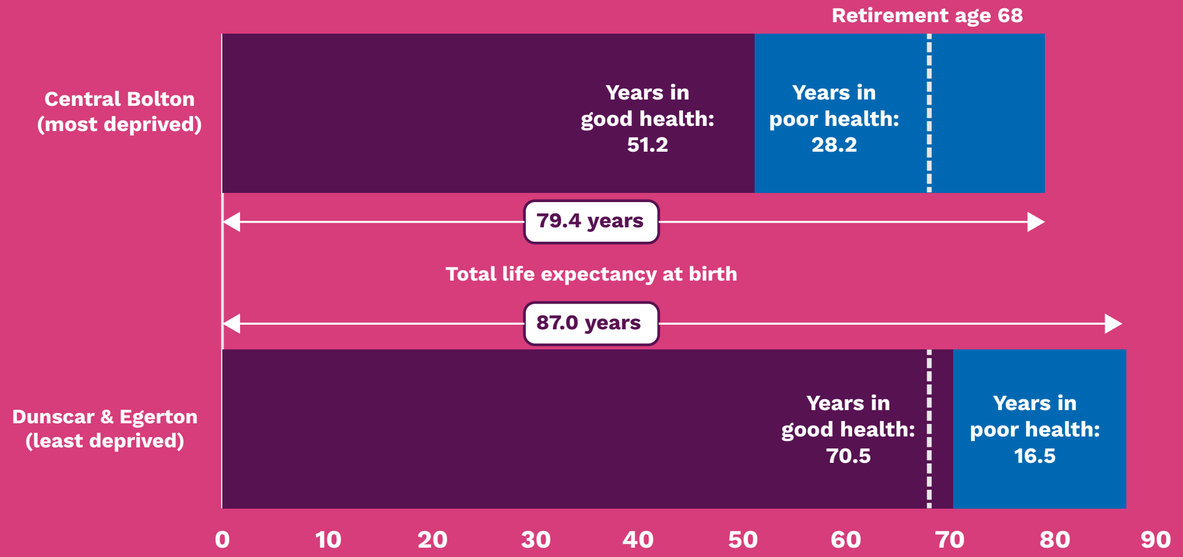
These charts on the following pages show us that, not only do residents in Bolton's least deprived areas live significantly longer than those in our most deprived areas, but they also live longer in good health. On average, both men and women in Bolton's most deprived areas experience poor health even before the age of retirement, an inequality that has much wider impacts on quality of life and economic prosperity.

Bolton years lived in good health and mortality - male



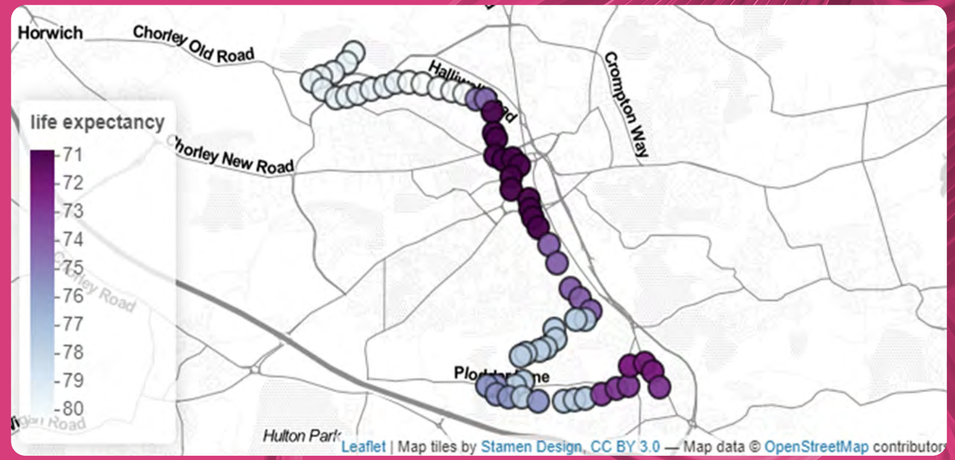
MSOA life expectancy at birth 2016-20 | MSOA healthy life expectancy at birth 2013-17

Bolton years lived in good health and mortality - female



MSOA life expectancy at birth 2016-20 | MSOA healthy life expectancy at birth 2013-17

DEPRIVATION



The map shows male life expectancy along the 501 bus route (2016-2020), for that the highest is 79 & lowest is 70 & difference 9 years

More Information

More data and intelligence about inequalities in Bolton can be found in our Joint Strategic Needs Assessment (JSNA): Home – Bolton JSNA

LIFE EXPECTANCY

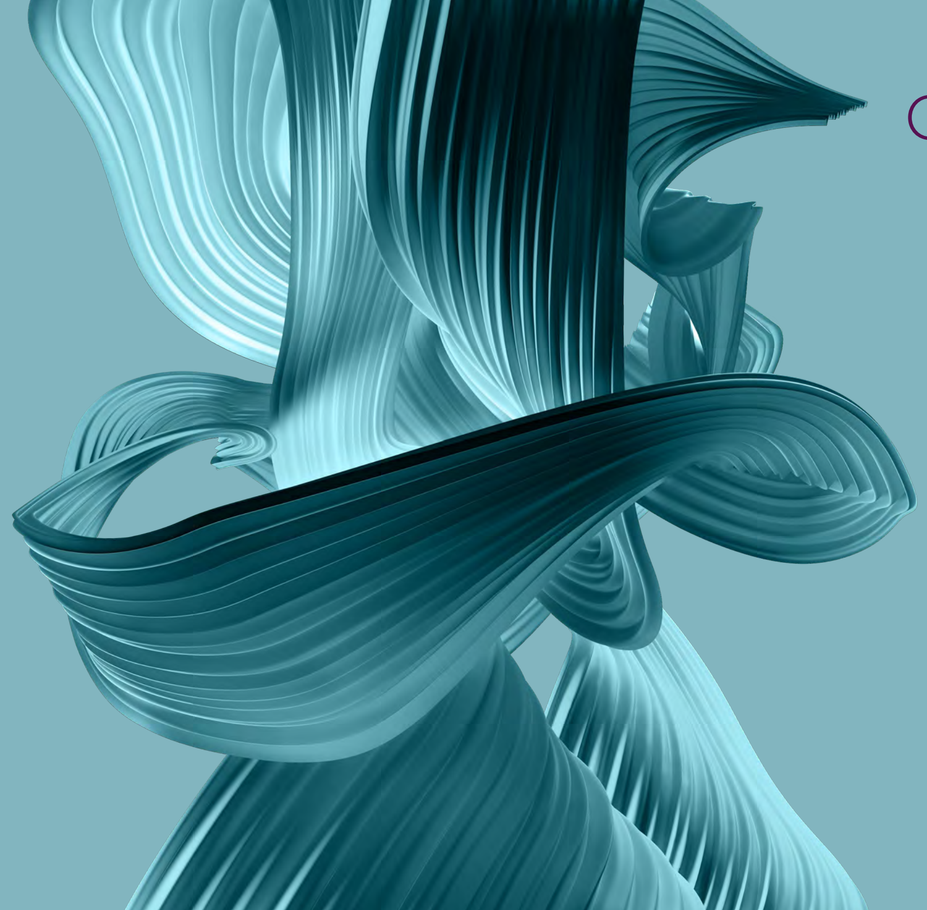
HIGHEST
79 years

LOWEST
70 years

DIFFERENCE
9 years



POLICY CONTEXT



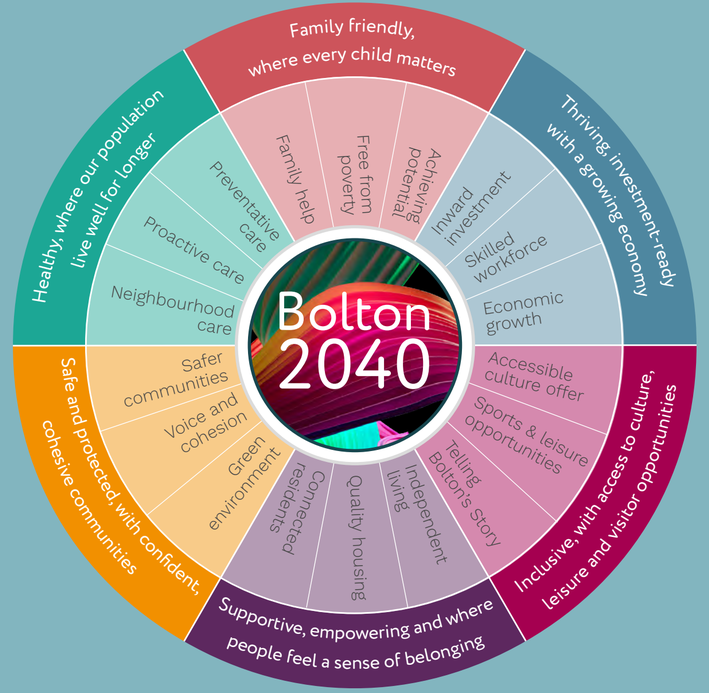
Vision 2040

Bolton 2040 is a vision for making Bolton a better place to live, work, and visit by the year 2040. It aims to create a stronger economy, healthier communities, and better opportunities for everyone. The plan focuses on good jobs, quality housing, safer neighbourhoods, and better education. Local people, businesses, and organisations are working together to make these changes happen. The goal is for Bolton to be a thriving, welcoming, and fair place for all. Everyone in the community has a role to play in shaping the future.

The next place plan for Bolton, Bolton 2040 is currently in development to continue to build on the aspirations set out in Bolton 2030.

OUR VISION

Bolton is a thriving borough, where people want to live, work, study, invest and visit.



BOLTON LOCALITY PLAN

Through listening to the voices of Bolton people, The Bolton Locality Plan sets out six strategic aims which provide policy direction which can be maximised through application of a prevention approach.

1. Reduce unfair differences in health

Reducing the unfair and preventable disparities in health which impact the quality of life, care options, health conditions and life expectancy Bolton people experience

- Sometimes, I feel that you can often be overlooked because of your gender and age.
- Unfair differences to health pops out. There are postcode lotteries - everyone should get the same access.
- Getting appointments is different throughout the borough, for example Horwich is different to Westhoughton.

2. Support connections in our communities

Improving the impact of our services by having Bolton people as our partners in the development of holistic community centric services

- There should be better links between the job centre and the doctors and other public services.
- We need to be more active to promote health and well being.
- Empower people and patients so they can help themselves and understand what's needed.
- Connections in the community is very important - how do I look after myself, local initiatives in the community to join (active groups). Signposting initiatives, community groups for the public to join and 'Let's keep Bolton moving'.

3. Help Bolton people to live healthy lives

Providing proactive, innovative, high-quality, and timely care throughout a person's life, which supports them to live independently for as long as possible

- My top priority is speedy access to frontline services.
- I would also like a simple one stop shop for folk to have X-rays and bone density scans instead of long waits in A and E.
- Being able to get a GP appointment is a challenge.

4. Give our children every chance to succeed

Giving our children the best possible start in life, so that they have every chance to succeed and be happy

- Early intervention is key. We need to stop kids falling into the water, rather than pulling them out.
- Being able to access GP appointments for kids on the day you request one.

5. Make the best use of our resources

Understanding the most significant drivers of both cost and demand in the system as well as introducing efficiencies, cost reductions and quality improvements

- We worry about charges for services in the future and that we won't be able to afford the care we need.
- Funding for NHS is vital. They do a wonderful job but they just don't have enough money.

6. Invest in our current staff and open doors for future

Improving the recruitment, retention, training and leadership pipeline for those working in/ aspiring to work in the health and care sectors

- Mental health services are not there when we need them - there is a lack of well trained and well paid staff.
- Nursing staff at Bolton hospital were top notch every time I've been in.
- Not only invest in our staff but invest in the community, put on digital sessions, how to access digital letters and text for example.



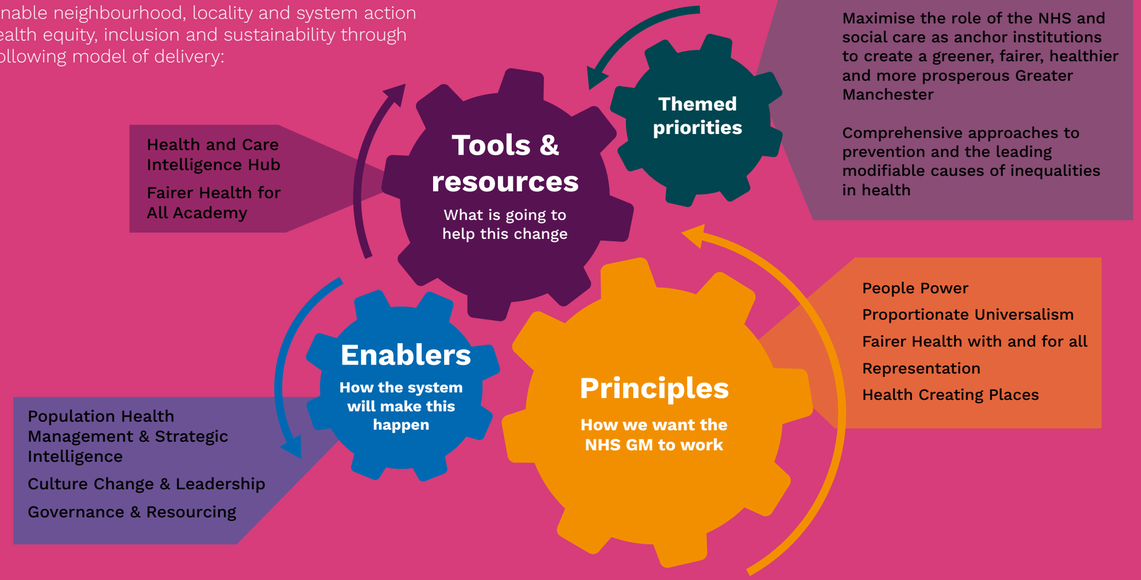
FAIRER HEALTH FOR ALL

Fairer Health for All is a plan to improve health and reduce inequalities in Greater Manchester. It focuses on making sure everyone, no matter where they live or their background, has a fair chance at good health. The plan tackles big issues like poverty, housing, jobs, and education, which all affect people's well-being. It also works to improve NHS services and social care, making them easier to access and fairer for everyone. Mental health support and preventing illness before it starts are key priorities. Communities and local groups are involved in shaping solutions that work for them. The goal is to help people live longer, healthier lives with better support when they need it. The plan is led by local health and care organisations, working together to create lasting change.



FAIRER HEALTH FOR ALL: IN SUMMARY

The Greater Manchester Fairer Health for All framework will enable neighbourhood, locality and system action on health equity, inclusion and sustainability through the following model of delivery:



PUTTING THE BOLTON PREVENTION FRAMEWORK INTO PRACTICE

Before starting to use the framework for your topic area, run through the following questions to develop the building blocks of your approach.

Stage 1 - **For the thing that you are trying to prevent, what do you know about:**

The root causes (primary prevention opportunities)?

Early signs and presentation and the best way to identify these (secondary prevention opportunities)?

Complexities and recurrence patterns (tertiary prevention)?

Assets or strengths that mitigate against the thing happening?

Stage 2 - **Confirm with evidence what works well for the population you are trying to reach.**

Intelligence to consider: -

Published literature, journals and research studies

Local engagement, consultation and codesign/co-production intelligence

Local population data held within the Joint Strategic Needs Assessment

Local, regional and national policy

Clinical guidelines

Prior experience and service evaluation

Stage 3 - **Gap Analysis**

What is already being done across the prevention triangle?

Who by?

With what outcomes?

What is missing across the prevention triangle and who is best to address this gap?

Stage 4 - **Scale and Scope**

Is the prevention gap you need to fill in your direct control?

Who do you need to work with to address the gap?

What prevention activities require whole system change or delivery?

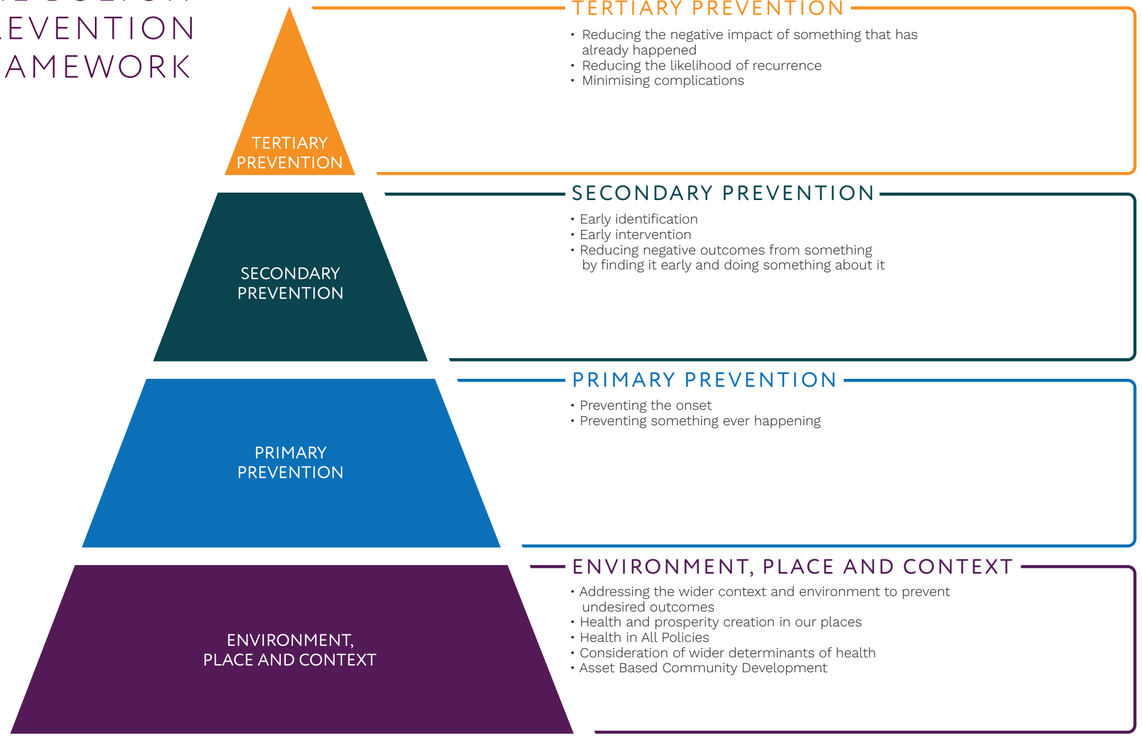
What resources and capacity are needed and is there a case for Return on Investment/Invest to Save?

Do you need to stop doing something to try a different approach?

Are there some elements that are outside of local control or influence?

Over what time period will you see the impact of any interventions, services, offers, programmes; does this meet the prevention need?

THE BOLTON PREVENTION FRAMEWORK



TERTIARY PREVENTION

- Reducing the negative impact of something that has already happened
- Reducing the likelihood of recurrence
- Minimising complications

SECONDARY PREVENTION

- Early identification
- Early intervention
- Reducing negative outcomes from something by finding it early and doing something about it

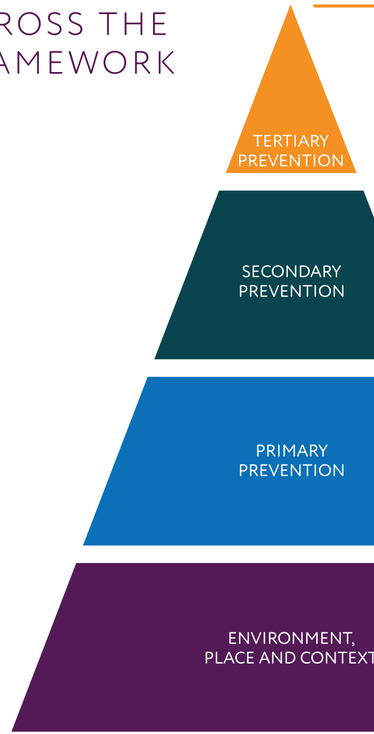
PRIMARY PREVENTION

- Preventing the onset
- Preventing something ever happening

ENVIRONMENT, PLACE AND CONTEXT

- Addressing the wider context and environment to prevent undesired outcomes
- Health and prosperity creation in our places
- Health in All Policies
- Consideration of wider determinants of health
- Asset Based Community Development

CONSIDERATIONS ACROSS THE FRAMEWORK



TERTIARY PREVENTION

- What do we know about the risk of the thing reoccurring, what do we know will reduce this risk?
- What are the potential negative consequences or complexities if the thing you are trying to prevent has already happened? What can we do to reduce this risk?
- Consideration of services, interventions, offers, community assets, health creating places

SECONDARY PREVENTION

- What are the early signs of the thing you are trying to prevent?
- Who might notice or identify these (think current and potential), how and when?
- What opportunities are there to reduce early identified risk, who might need to be involved?
- Consideration of services, interventions, offers, community assets, health creating places

PRIMARY PREVENTION

- Are there any services, offers, programmes or delivery that can stop the root causes of the thing you are trying to prevent?
- Don't forget to consider community assets, health creating places

ENVIRONMENT, PLACE AND CONTEXT

- Do you understand the root causes of the thing you are trying to prevent?
- What can you do to address the environment, context and place to address the root causes of the thing you are trying to prevent?

PUTTING THE BOLTON PREVENTION FRAMEWORK INTO PRACTICE

USING THE BOLTON PREVENTION FRAMEWORK:

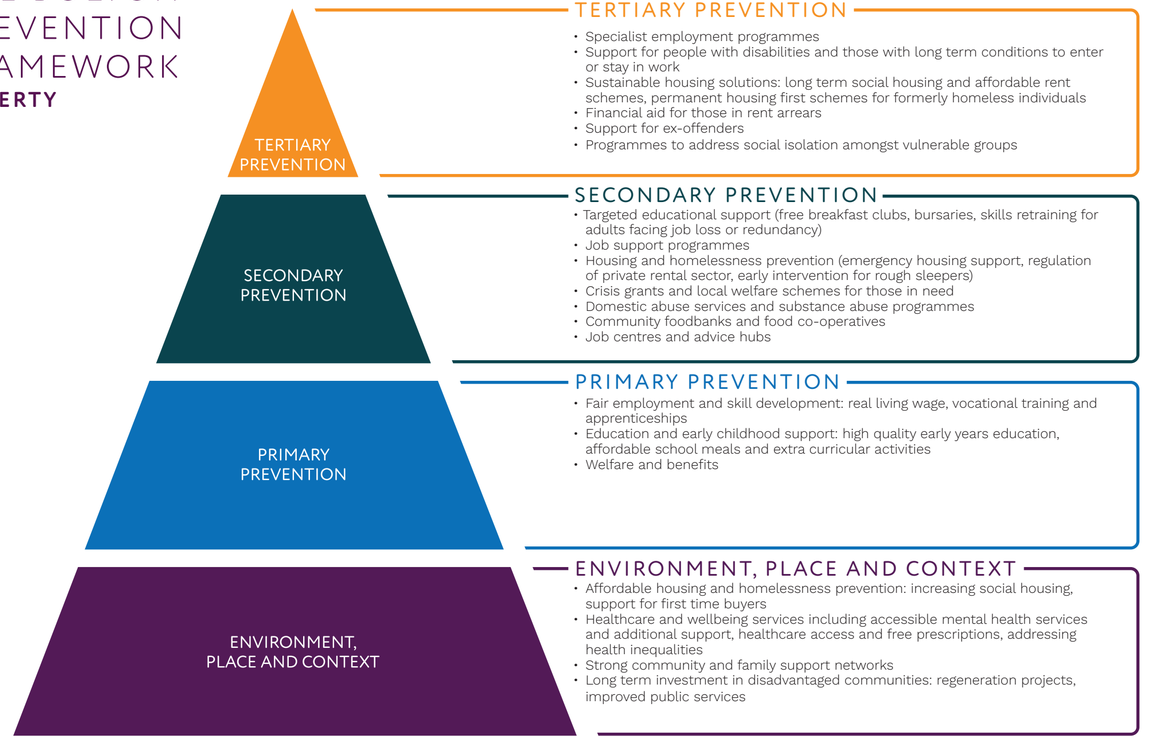
Some Examples

The following examples are intended to provide an illustration of how the prevention framework might be used to map opportunities and existing ways that a range of topics might be prevented. These examples are provided for illustrative purposes only and have not been subject to rigorous development.



THE BOLTON PREVENTION FRAMEWORK

POVERTY



TERTIARY PREVENTION

- Specialist employment programmes
- Support for people with disabilities and those with long term conditions to enter or stay in work
- Sustainable housing solutions: long term social housing and affordable rent schemes, permanent housing first schemes for formerly homeless individuals
- Financial aid for those in rent arrears
- Support for ex-offenders
- Programmes to address social isolation amongst vulnerable groups

SECONDARY PREVENTION

- Targeted educational support (free breakfast clubs, bursaries, skills retraining for adults facing job loss or redundancy)
- Job support programmes
- Housing and homelessness prevention (emergency housing support, regulation of private rental sector, early intervention for rough sleepers)
- Crisis grants and local welfare schemes for those in need
- Domestic abuse services and substance abuse programmes
- Community foodbanks and food co-operatives
- Job centres and advice hubs

PRIMARY PREVENTION

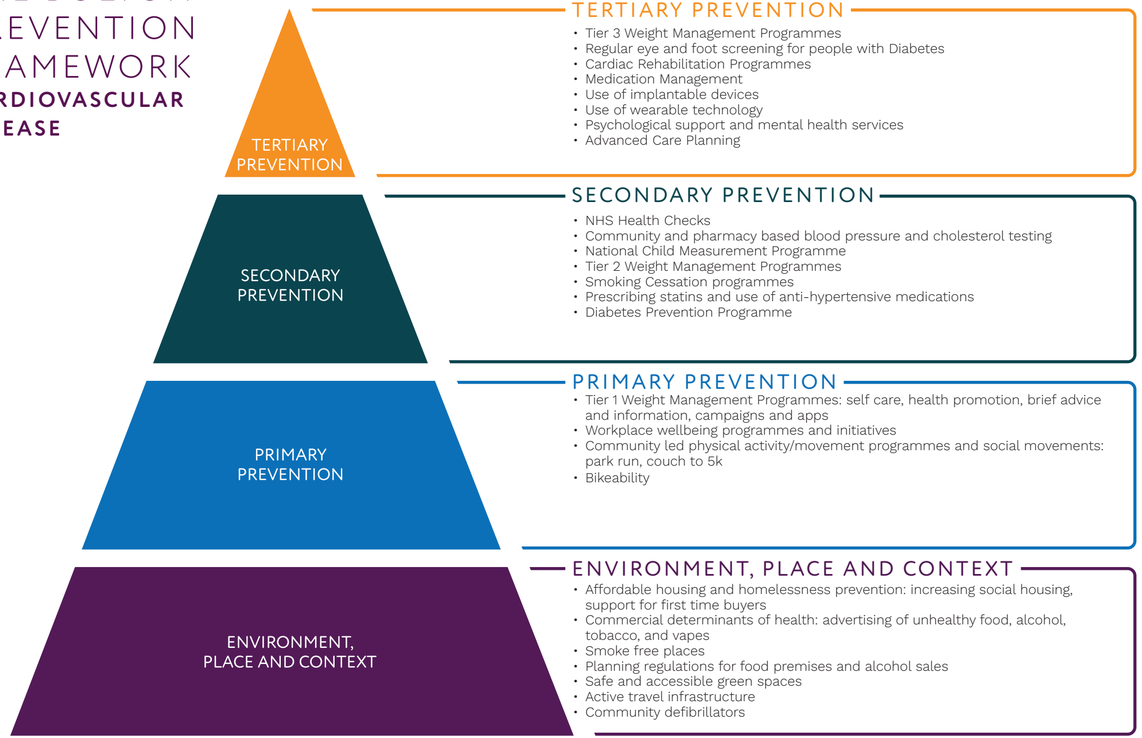
- Fair employment and skill development: real living wage, vocational training and apprenticeships
- Education and early childhood support: high quality early years education, affordable school meals and extra curricular activities
- Welfare and benefits

ENVIRONMENT, PLACE AND CONTEXT

- Affordable housing and homelessness prevention: increasing social housing, support for first time buyers
- Healthcare and wellbeing services including accessible mental health services and additional support, healthcare access and free prescriptions, addressing health inequalities
- Strong community and family support networks
- Long term investment in disadvantaged communities: regeneration projects, improved public services

THE BOLTON PREVENTION FRAMEWORK

CARDIOVASCULAR DISEASE



TERTIARY PREVENTION

- Tier 3 Weight Management Programmes
- Regular eye and foot screening for people with Diabetes
- Cardiac Rehabilitation Programmes
- Medication Management
- Use of implantable devices
- Use of wearable technology
- Psychological support and mental health services
- Advanced Care Planning

SECONDARY PREVENTION

- NHS Health Checks
- Community and pharmacy based blood pressure and cholesterol testing
- National Child Measurement Programme
- Tier 2 Weight Management Programmes
- Smoking Cessation programmes
- Prescribing statins and use of anti-hypertensive medications
- Diabetes Prevention Programme

PRIMARY PREVENTION

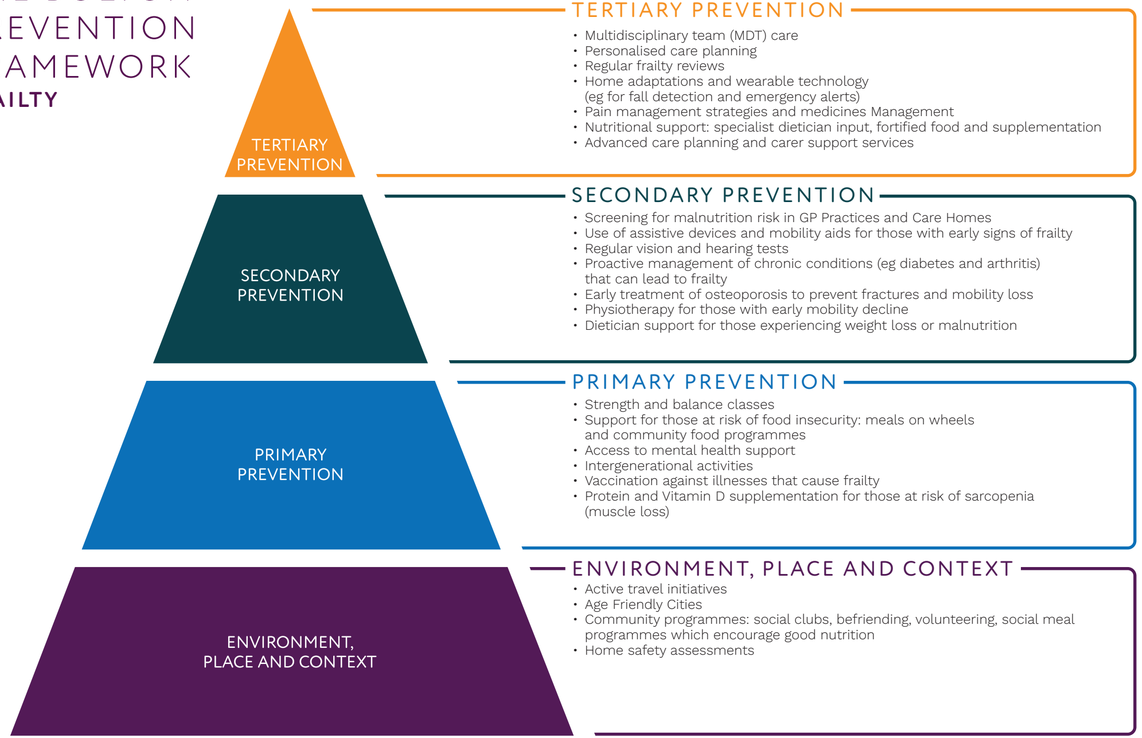
- Tier 1 Weight Management Programmes: self care, health promotion, brief advice and information, campaigns and apps
- Workplace wellbeing programmes and initiatives
- Community led physical activity/movement programmes and social movements: park run, couch to 5k
- Bikeability

ENVIRONMENT, PLACE AND CONTEXT

- Affordable housing and homelessness prevention: increasing social housing, support for first time buyers
- Commercial determinants of health: advertising of unhealthy food, alcohol, tobacco, and vapes
- Smoke free places
- Planning regulations for food premises and alcohol sales
- Safe and accessible green spaces
- Active travel infrastructure
- Community defibrillators

THE BOLTON PREVENTION FRAMEWORK

FRAILTY



TERTIARY PREVENTION

- Multidisciplinary team (MDT) care
- Personalised care planning
- Regular frailty reviews
- Home adaptations and wearable technology (eg for fall detection and emergency alerts)
- Pain management strategies and medicines Management
- Nutritional support: specialist dietician input, fortified food and supplementation
- Advanced care planning and carer support services

SECONDARY PREVENTION

- Screening for malnutrition risk in GP Practices and Care Homes
- Use of assistive devices and mobility aids for those with early signs of frailty
- Regular vision and hearing tests
- Proactive management of chronic conditions (eg diabetes and arthritis) that can lead to frailty
- Early treatment of osteoporosis to prevent fractures and mobility loss
- Physiotherapy for those with early mobility decline
- Dietician support for those experiencing weight loss or malnutrition

PRIMARY PREVENTION

- Strength and balance classes
- Support for those at risk of food insecurity: meals on wheels and community food programmes
- Access to mental health support
- Intergenerational activities
- Vaccination against illnesses that cause frailty
- Protein and Vitamin D supplementation for those at risk of sarcopenia (muscle loss)

ENVIRONMENT, PLACE AND CONTEXT

- Active travel initiatives
- Age Friendly Cities
- Community programmes: social clubs, befriending, volunteering, social meal programmes which encourage good nutrition
- Home safety assessments

BOLTON ALL AGE PREVENTION AND INEQUALITIES FRAMEWORK SUPPORTING TOOLS

The Prevention Opportunity
What are you trying to prevent?
Opportunities for prevention
Prevention timescales and opportunities

Inequalities
Progressive universalism
Intersectionality

System Drivers
Bolton Strategy Landscape
Determinants of Health
Carnell Farrar

Local Government
Social Determinants of Health

Framework for Local Government

NHS and Healthcare
Core 20 Plus 5

Neighbourhoods and Communities
Principles
Approaches
Assets

OVERVIEW OF TOOLS

The following supporting tools can be used in combination or alone, to help to identify the best opportunities to maximise prevention in a range of situations, settings and contexts. They offer further evidence-based guidance that can support prevention activities when applying the Prevention Framework (“The Triangle”).

The Prevention Opportunity

Tool 1 Define what it is that you are trying to prevent

Tool 2 Opportunities for prevention

Tool 3 Define the timescales required, challenge yourself to consider each of the short, medium and long term

Consideration of Inequalities

Tool 4 Have you considered Progressive Universalism in your approach?

Tool 5 How might intersectionality widen or reduce inequalities?

System Drivers

Tool 6 Consider other Bolton Partnership Strategies and partners that might support in delivery of prevention elements

Tool 7 How might addressing/working with partners to address wider determinants impact on the success/scale of your prevention activities?

Tool 8 Are there opportunities in your prevention work to include high impact areas as outlined in the Carnell Farrar work?

Local Government considerations

Tool 9 Have you considered the impact or influence of other Local Government departments on the thing you are trying to prevent?

NHS and Healthcare considerations

Tool 10 Does your work have the potential to impact positively or negatively on priority inequality areas for the NHS and Bolton Locality?

Considerations for Neighbourhoods and Communities

Tool 11 Bolton Principles for Community Engagement

Tool 1

THE PREVENTION OPPORTUNITY

Defining the Prevention Task

When applying the Bolton All Age Prevention framework, it is important to define what it is that you are intending to prevent. As described earlier, this simple framework (“The Triangle”) can be used to consider, explore and design services, policies and strategies applying a prevention lens to most topic areas.

This tool provides just a small number of examples where the Bolton Prevention Framework could help to shape prevention efforts.



Tool 2

Opportunities for Prevention

Sometimes the “Prevention Triangle” (which provides the structure for the Bolton Prevention Framework) is depicted as upstream and downstream prevention opportunities. Looking at this way can sometimes help to understand the opportunities for prevention.

The upstream-downstream model of prevention is a way of thinking about how to stop problems before they start, rather than just dealing with the effects.

Upstream prevention focuses on tackling the root causes of issues—like improving housing, education, and healthcare so that fewer people get sick or struggle later. We also know this as Primary Prevention.

Midstream prevention works on reducing risks as they appear, such as offering free health screenings or mental health support in schools to catch problems early. We also know this as Secondary Prevention.

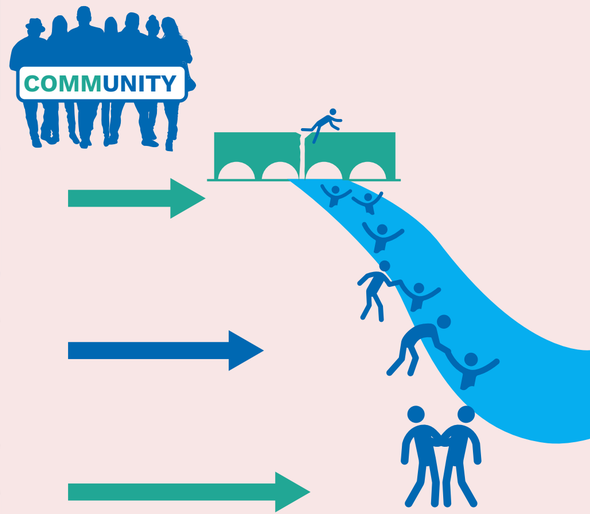
Downstream prevention deals with the consequences of issues that have already happened, like hospital treatments or crisis interventions for homelessness. We also know this as Tertiary Prevention.

Understanding the Community
Population structure, differences between communities, community assets

Understanding the Risks (Environment and Context; Primary Prevention)
"Fixing the bridge"
Preventing people falling in the river in the first place

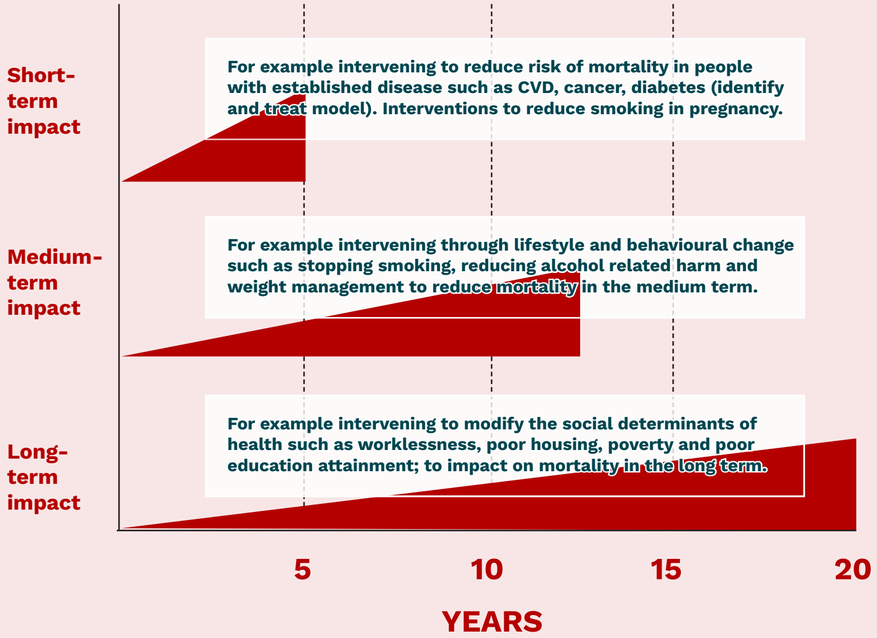
Early Identification and Intervention
(Secondary Prevention)
"Throwing a rope"
Shortening the period in the river and promoting early recovery

Downstream Intervention
(Tertiary Prevention)
"Pulling people out of the river"



Long, Medium and Short-Term Prevention

Source: Reducing health inequalities: system, scale and sustainability (2017)



The Chris Bentley Health Inequalities Unit graph typically outlines different strategies for addressing health inequalities in the short, medium, and long term, categorising them based on the immediate impact versus more systemic, structural changes.

Short-term Prevention:

• These interventions focus on addressing immediate health issues and providing direct support to individuals or communities.

• Examples include improving access to healthcare services, providing emergency medical care, targeted health education programs, or distributing resources like vaccines or health screenings.

• The impact is often quick but may not address the root causes of health inequalities.

Medium-term Prevention:

• These strategies aim to create healthier environments by implementing changes that will have a lasting impact over a few years.

• Policies might include promoting healthier lifestyles through community health programmes, improving access to nutritious food, enhancing physical activity programmes, and addressing socio-economic disparities.

• The focus is on improving infrastructure and providing targeted interventions that go beyond individual needs.

Long-term Prevention:

• These are structural and policy-level changes aimed at reducing health inequalities in the long run (often decades).

• Interventions include tackling social determinants of health such as poverty, education, employment, and housing. They also involve changes to systems that affect health, like social policies, economic development, and healthcare system reforms.

• The goal is to create systemic change that ensures equitable access to resources, reduces the gap in health outcomes, and prevents the rise of health inequalities over generations.

This tool is helpful because it provides a clear framework for understanding how different interventions work at various stages to address health inequalities. Here's why this is useful:

1. Guiding Resource Allocation:

• It helps policymakers and health professionals prioritise actions based on the urgency and long-term impact. Immediate resources can be directed toward short-term prevention, while more substantial investments can be made in long-term solutions that drive systemic change.

2. Identifying the Scope of Action:

• By distinguishing between short, medium, and long-term strategies, the graph helps stakeholders understand the range of actions needed to tackle health inequalities at different levels. It shows that health disparities cannot be solved with just quick fixes; structural change is necessary for lasting improvement.

3. Comprehensive Approach:

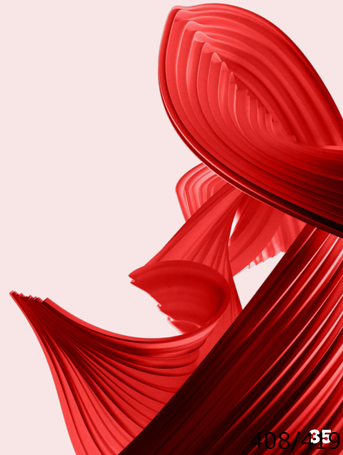
• The graph encourages a holistic view of health inequalities, reminding that solutions need to target both individual and systemic factors. Short-term solutions might help individuals, but only medium and long-term policies can address the root causes like poverty, education, and housing.

4. Improving Prevention Strategy:

• It allows prevention programmes to be designed in a way that incorporates both immediate needs and sustainable progress. For instance, a health initiative can provide immediate support to a vulnerable community while simultaneously laying the groundwork for policy changes that will prevent health inequalities from re-emerging.

5. Tracking Progress:

• It helps in evaluating the effectiveness of interventions over time. Short-term outcomes might show quick improvements, but long-term success is seen when health disparities start to shrink due to systemic changes.



Tool 4

CONSIDERATION OF INEQUALITIES

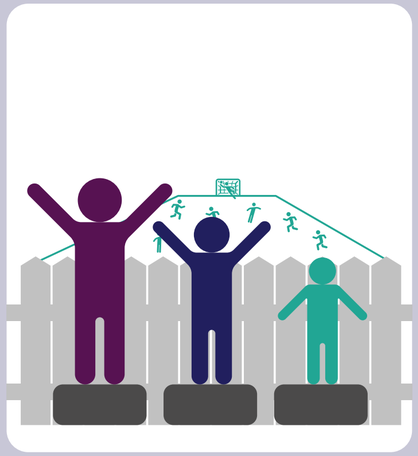
Proportionate Universalism



REALITY

One gets **more than** is needed, while the other gets **less than** is needed.

Thus, a huge disparity is created.



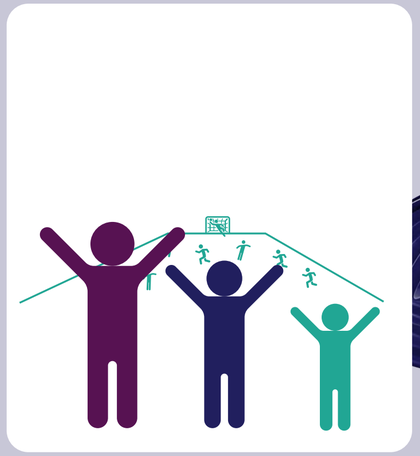
EQUALITY

The assumption is that **everyone benefits from the same supports.** This Is considered to be equal treatment.



EQUITY

Everyone gets the support they need, which produces equity.



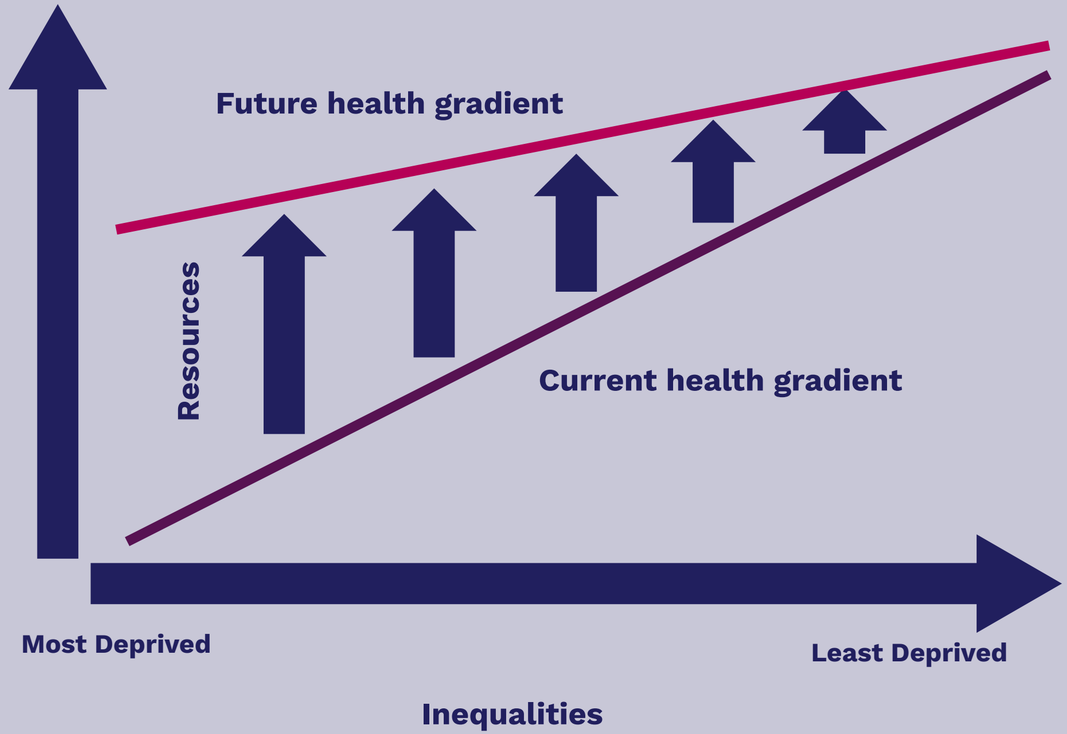
JUSTICE

Nobody needs supports or accommodations because **the cause(s) of the inequity was addressed.**

The systemic barrier has been removed.

Source: Original graphic from Interaction Institute for Social Change (2016)

Tool 4



Source: Ford, J. et al (2021). Transforming health systems to reduce health inequalities. Future Healthcare Journal. Vol. 8, no. 2.

Proportionate universalism is a policy approach that aims to provide services or support to everyone, but adjusts the level of support depending on how much someone needs. It's similar to progressive universalism, but with a slightly different focus on making the support proportional to people's circumstances, rather than just giving extra help to those most in need.

How it works:

- **Universal** means that the service or benefit is available to everyone, regardless of their background or income.

- **Proportionate** means that the amount of support someone gets is proportional to their need. So, everyone gets something, but those who are struggling the most get more, and those who need less get a bit less.

For example, in healthcare:

- Everyone gets access to healthcare services (universal), but if someone has a chronic illness, they might receive more focused care and attention (proportionate).

- Someone with no health problems might get basic check-ups, but they wouldn't need as much care as someone dealing with a serious condition.

Why it's important for reducing inequalities:

1. Tailored Support: Instead of treating everyone the same, proportionate universalism recognises that not everyone starts from the same place. Some people face bigger challenges (e.g., poverty, discrimination), so they need more help to achieve equal outcomes. By giving everyone support based on their needs, it helps to ensure fairness.

2. Prevents Worsening Inequalities: If we only focus on the most disadvantaged without providing universal support, it could create division or exclude people who may not be as disadvantaged but still need help. Proportionate universalism ensures that everyone is included, but those who need more support get what's right for them.

3. Inclusive Growth: By making sure everyone gets some level of support but adjusting for those who need more, proportionate universalism helps to improve overall wellbeing in society. It can raise the baseline level of health, education, and opportunity for everyone.

4. Prevention of Social Gaps: If support is only targeted at the most disadvantaged, it can sometimes create a divide or reinforce stigma. Proportionate universalism ensures that society doesn't divide people into "needy" and "not needy." Instead, it treats everyone as worthy of support but ensures it's given in a way that reduces existing inequalities.

Proportionate universalism is about providing universal support, but in a way that's adapted to the different needs of people. It's important for reducing inequalities because it ensures everyone gets help in a way that's fair and considers their unique circumstances, helping to create more equal opportunities for all.

Tool 5

Intersectionality

Intersectionality is a key concept for health and social care professionals and policymakers to ensure services are fair and accessible for all. **Kimberlé Crenshaw** introduced it in 1989 to explain how different aspects of a person's identity—such as race, gender, disability, and socioeconomic status—combine to create unique challenges. Traditional approaches often focus on single issues, but intersectionality highlights how overlapping factors can deepen inequalities.

For example, a Black disabled woman may face barriers in healthcare that differ from those of a white disabled man or an non-disabled Black woman. An LGBTQ+ asylum seeker may experience mental health challenges that require tailored support. Recognising these overlapping factors helps professionals design services that meet people's real needs rather than applying a one-size-fits-all approach.

To apply intersectionality in practice:

- **Collect and analyse data** on multiple identity factors to identify hidden inequalities.
- **Ensure services are culturally competent** by considering language, accessibility, and discrimination risks.
- **Engage diverse communities** in shaping policies and services to reflect real experiences.

• Train staff to recognise and respond to complex needs with sensitivity and awareness.

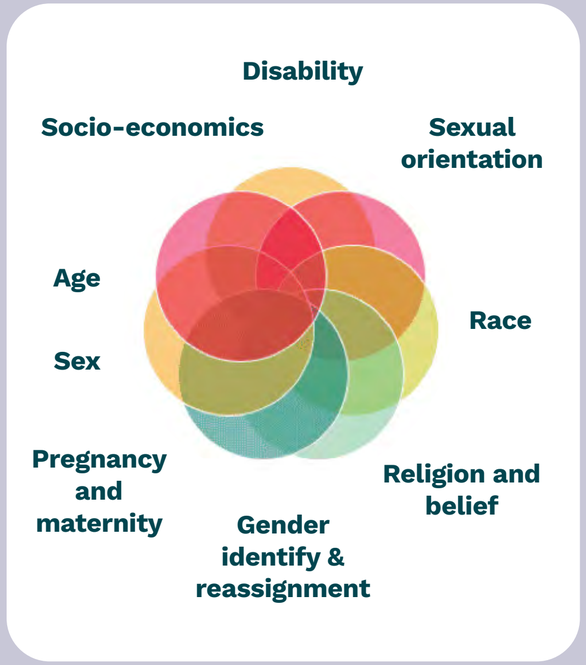


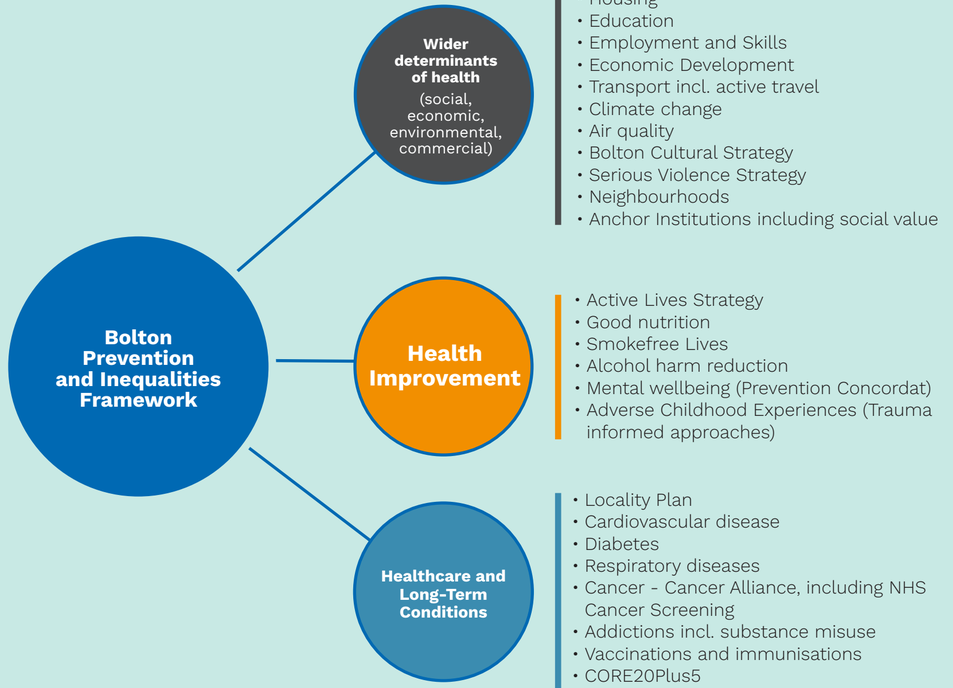
Image credit: Devon County Council Equality, Diversity and Inclusion by Design - Equality, Diversity and Inclusion

Tool 6

SYSTEM DRIVERS

The Better Bolton Strategy Landscape

This diagram aims to demonstrate a number of strategies in place across Bolton which can support the development of prevention focussed activities. There are, of course, new strategies in development and emerging all the time and therefore this diagram will not include all strategies available to provide guidance and support.



Wider and Social Determinants of Health

The **wider determinants of health**—also known as the **social determinants of health**—are the social, economic, and environmental factors that influence a person's health. These include factors like **income, education, employment, housing, access to healthy food, social support networks,** and **living conditions.** In the UK, addressing these determinants is crucial for improving health outcomes and for the effectiveness of prevention strategies in both health and other public sector services.

Why the Wider Determinants of Health Matter for Prevention:

1. Prevention of Poor Health at the Root Level

·**Wider determinants** play a key role in the development of **chronic diseases** (e.g., diabetes, heart disease, respiratory conditions) and mental health problems.

By addressing these factors before they lead to illness, public services can help prevent the development of health issues in the first place.

• For example, improving **housing conditions** can reduce respiratory problems caused by poor indoor air quality, while increasing access to **education** and **employment opportunities** can improve overall mental and physical health.

2. Health Inequalities

• Health inequalities are often driven by the **social determinants of health.** People from disadvantaged socio-economic backgrounds are more likely to experience poorer health outcomes because they face multiple barriers to accessing healthcare, healthy food, safe housing, and good education.

• By addressing these **wider factors**, public sector services can **reduce health inequalities** and ensure more equitable health outcomes across all communities. For example, improving **education** can lead to better job prospects and higher incomes, which in turn can lead to better health.

3. Tackling Root Causes for Long-Term Impact

• **Prevention** works best when it focuses on the **root causes** of health issues rather than just the symptoms. By targeting the wider determinants we can create long-lasting improvements in population health.

• For example, tackling **poverty** and **unemployment** can improve mental health and reduce the likelihood of people turning to unhealthy coping mechanisms, such as smoking, excessive drinking, or poor diet.

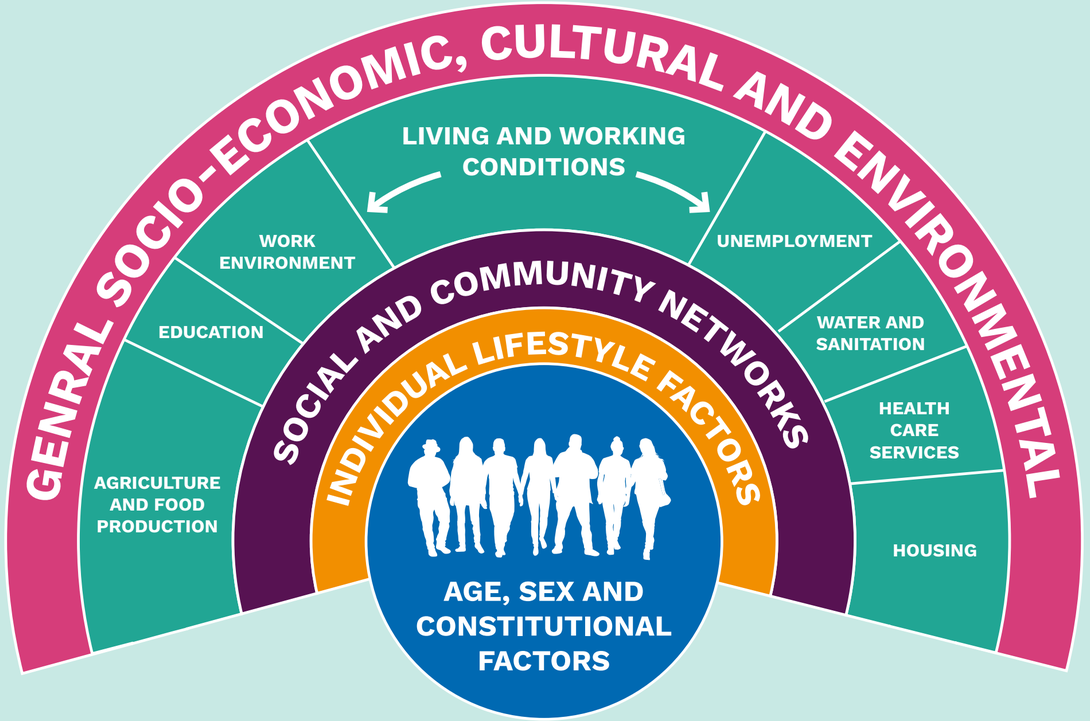
4. Better Resource Allocation and Cost Savings

• Addressing the **wider determinants** of health through early intervention can save costs in the long run. If we focus on improving people's living conditions, education, and employment prospects, fewer resources will need to be spent on treating avoidable conditions and diseases that arise from poor social conditions.

• For instance, investing in **early childhood education** can improve cognitive development, reducing the likelihood of future health problems and educational challenges. This can reduce healthcare costs and the need for more intensive services later in life.

5. Integrated and Holistic Approach

• The **wider determinants** require a **whole-system approach** that involves not just the healthcare sector, but also sectors like housing, education, employment, and transport. Tackling health inequalities effectively means working across these sectors to create supportive environments for health.



Social Determinants of Health (Dahlgren and Whitehead, 1991)

• For example, improving **access to green spaces** can encourage physical activity, which in turn prevents conditions like obesity, diabetes, and heart disease. Providing **affordable housing** can reduce stress and improve mental well-being, leading to better overall health.

6. Improving Public Health Resilience

• People who experience social disadvantage are often more vulnerable to health risks, especially in times of crisis (e.g., pandemics, economic downturns). By addressing the wider determinants, we can **build resilience** in these populations, helping them cope with and recover from difficult situations.

• For example, increasing access to **mental health support** and **social services** can help people cope with stress, while improving **job security** and **income equality** can reduce economic strain and its negative impact on health.

7. Creating Supportive Environments for Health

• Creating an environment that promotes wellbeing is key to prevention. The **physical environment** (e.g., clean air, access to parks) and the **social environment** (e.g., supportive communities, strong social networks) can significantly affect health outcomes.

• For instance, improving **public transport access** can encourage people to walk more, improving cardiovascular health. Ensuring **safe, walkable neighbourhoods** can reduce the likelihood of injuries and increase opportunities for social interaction, which supports mental health.

8. Addressing Health in All Policies

• The concept of **Health in All Policies** emphasises that health should be considered in every policy decision across sectors, not just in healthcare. Addressing the wider determinants of health through other public services (e.g., education, transport, housing, etc.) helps to improve the overall well-being of the population and prevents future health issues.

• For example, a **housing policy** that ensures homes are warm and safe can prevent respiratory conditions and reduce the burden on the NHS. A **school policy** that encourages healthy eating and physical activity can reduce the risk of obesity-related conditions.

Addressing the **wider determinants of health** is essential for preventing health problems and reducing health inequalities. By focusing on the **root causes**—such as poor housing, low income, lack of education, and limited access to social support—we can help create healthier, more resilient communities. This approach not only prevents illness but also promotes **equity** and **social justice**, ensuring that everyone, regardless of background, has the opportunity to live a long, healthy life.



Tool 8

Carnell Farrar High Impact Areas (www.carnallfarrar.com)

The **purpose and aim** of the **Carnall Farrar review** for Greater Manchester's NHS was to assess the local healthcare system and provide strategic recommendations to improve health outcomes, reduce health inequalities, and create a more sustainable, integrated, and efficient health and care system.

The **Carnall Farrar review** of Greater Manchester's NHS system identified several key opportunities to enhance population health:

1. Strengthening Prevention Efforts:

• The review emphasised the importance of shifting focus from treating illness to promoting health. This involves investing in preventive measures to reduce the incidence of diseases and improve overall community well-being.

2. Enhancing Data and Digital Capabilities:

• Improved data collection and digital infrastructure is crucial for informed decision-making. Access to high-quality, interoperable data enables proactive management of health issues and efficient resource allocation.

3. Fostering System Collaboration:

• Encouraging collaboration among health and care providers, local authorities, and community organisations can lead to more integrated and effective services. This approach ensures that interventions are comprehensive and tailored to the specific needs of the population.

4. Investing in Primary Care and Social Care:

• Unlocking the potential of primary care and social care services, along with their workforce, is vital. This includes providing adequate training, resources, and support to these sectors to enhance their capacity to address health needs at the community level.

5. Revising Financial Approaches:

• The review suggests resetting financial strategies to embed change, focusing on value-based healthcare. This involves allocating resources based on the effectiveness of interventions in improving health outcomes, rather than traditional volume-based metrics.

Implementing these recommendations aims to create a more proactive, collaborative, and efficient health system in Greater Manchester, ultimately leading to improved population health and reduced health inequalities.

This set of quantified opportunities map to primary, secondary, and social determinant focused interventions

For the purposes of initial investment quantification - opportunity one has been aligned with primary intervention, opportunity two with secondary interventions, and opportunity three with social determinants of health interventions

Opportunity 1: Reducing the growth in prevalence and progression of ill health	Opportunities to reduce prevalence and progression of ill health relative to baseline trend based on targeted prevention and early detection activities	Primary Prevention intervention across five key areas: • Smoking • Obesity • Diet • Exercise • Alcohol Dependency
Opportunity 2: Optimising models of care	Opportunities to change models of care to deliver more consistent proactive care to support effective population health management	Secondary intervention, targeting five specific patient cohorts: • Cardiovascular Disease • Diabetes • Respiratory Conditions • Frailty • Serious Mental Illness
Opportunity 3: Improving care for the most disadvantaged communities	Opportunities to improve health and address and reduce disparities in care for people in deprived socioeconomic groups	Interventions targeting four social determinants of health areas: • Housing • Food Insecurity • Transport • Substance Misuse

CF Bolton - population health opportunities

Tool 9

Prevention in Local Government. Social determinants of health and the role of local government.

The role of local government in health prevention focuses on addressing the social determinants of health. Local Authorities influence health through their roles as employers, service providers, regulators, and community leaders. By integrating public health into their policies, local government can improve health outcomes across communities by focusing on factors like housing, employment, education, and social support. Their approach enables the creation of healthier environments, supports prevention efforts, and reduces health inequalities.



Source: Local Government Association (2020). Social determinants of health and the role of local government.



Tool 10

Core20Plus5 (NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities)

Core 20 Plus 5 is an important framework developed by the NHS in England to reduce health inequalities, especially in relation to prevention and addressing disparities in healthcare. The initiative focuses on a targeted approach to improve health outcomes for the most disadvantaged groups, ensuring that everyone has an equal opportunity to access and benefit from healthcare services.

Core 20 Plus 5 is crucial for prevention and addressing inequalities by:

1. Targeting the Most Disadvantaged Groups (Core 20)

• **Core 20** refers to the most deprived 20% of the England population, who also experience the worst health outcomes and face significant barriers to accessing care.

• By focusing on this group, the NHS ensures that the resources and interventions are tailored to those who need them the most. Addressing their specific needs helps to prevent these groups from being left behind, which could further widen health inequalities.

2. Focusing on Key Areas of Health Inequalities (Plus)

Each Local Area will identify "Plus" groups who should receive further targeted support due to being likely to experience greater health inequalities. In Bolton these groups are:

- **People with drug and alcohol dependence**
- **Asylum seekers and refugees**
- **Carers**
- **Gypsy, Roma, Traveller communities**
- **Learning Disabilities/ Autism/Neurodiversity**

3. Focusing on specific conditions (5)

• **5** refers to **five clinical areas** where health inequalities are particularly pronounced. For adults these include:

- **Maternity care**
- **Severe mental illness**
- **Chronic respiratory disease**
- **Early cancer diagnosis**
- **Hypertension**

And for children:

- **Asthma**
- **Diabetes**
- **Epilepsy**
- **Oral Health**
- **Mental Health**

• These areas are critical because they have a significant impact on health outcomes and are often more common in disadvantaged communities. Focusing on these clinical areas ensures that health inequalities are tackled in the most prevalent and impactful health conditions.

4. Preventive Care

• **Core 20 Plus 5** emphasises a shift toward prevention and early intervention. For example, promoting better lifestyle choices (e.g., healthy eating, physical activity) in disadvantaged communities can help prevent conditions like diabetes, heart disease, and cancer. Early interventions, such as regular health screening or mental health support, are key to identifying problems before they become more serious.

• Targeting prevention in these high-risk groups reduces the future burden on healthcare services and improves long-term health outcomes.

5. Tailored, Holistic Approach

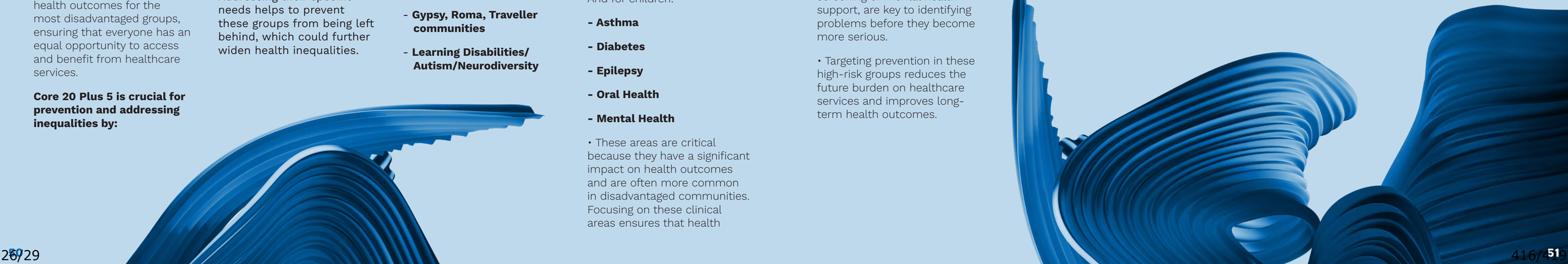
• The framework promotes a more **holistic, personalised approach** to care, recognising that people from disadvantaged backgrounds often face complex, overlapping issues. The initiative encourages healthcare providers to consider the social determinants of health and provide care that is culturally appropriate and accessible.

6. Improved Access and Equity

• Core 20 Plus 5 pushes for **better access** to healthcare for marginalised communities, ensuring that everyone, regardless of their background or social status, has the support and services they need to lead healthier lives. This helps to create a fairer, more equitable healthcare system.

7. Why It Matters:

Core 20 Plus 5 is about tackling the **root causes of health inequality** and making sure that people who need the most support are not overlooked. By focusing on prevention and early intervention in key clinical areas, the NHS can help to break the cycle of poor health in disadvantaged populations, leading to **better health outcomes** for all and ultimately reducing the overall burden on healthcare services.



REDUCING HEALTHCARE INEQUALITIES

NHS

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



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

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

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

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

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

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

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

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

SMOKING CESSATION
positively impacts all 5 key clinical areas

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

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



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PLUS
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Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

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

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

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

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

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

Bolton Principles for Community Engagement

Bolton Community Engagement Guiding Principles

These are intended as guided principles for everyone to use when thinking about how they engage with communities.

They are not a linear process and some will be more relevant than others at different times.

COLLABORATE OUT LOUD

Asset-based

Appreciating everything communities can do for themselves and creating the space and conditions for them to utilise and develop their asset and play to their strengths.



Inclusion focussed

Working with community champions who can communicate effectively with people in their local communities as they already have trusted relationships.



Collaboration and boundary spanning

Being able to establish bridges with other groups and organisations. Boundary spanning can be defined as "the efforts by an organisation to establish connections both within and outside the organisation"



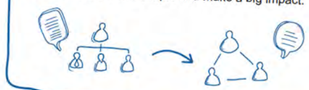
Gate opening (not gate keeping)

Bringing people and communities together who wouldn't ordinarily work together. Encouraging them to share opportunities and resources without creating channels that reply on particular groups or individuals.



Connecting

Understanding the needs, preferences and aspirations of our communities and connecting them to others who share them and/or who have gifts and resources which may help meet these needs. These connections are often surprising and simple and make a big impact.



Capacity building

Working alongside our communities. Not doing to people or for them. Capacity building so people and groups can do more for themselves and respond to emerging challenges and opportunities. Creating a sustainable approach which is supportive and realistic.



Diversity and difference

Appreciating and understanding the different communities and the power that these differences bring to what can be achieved collectively.



Visibility

Trust is built through a 'boots on the ground' approach where people are very visibly doing the work which in turn helps to build relationships and accountability.

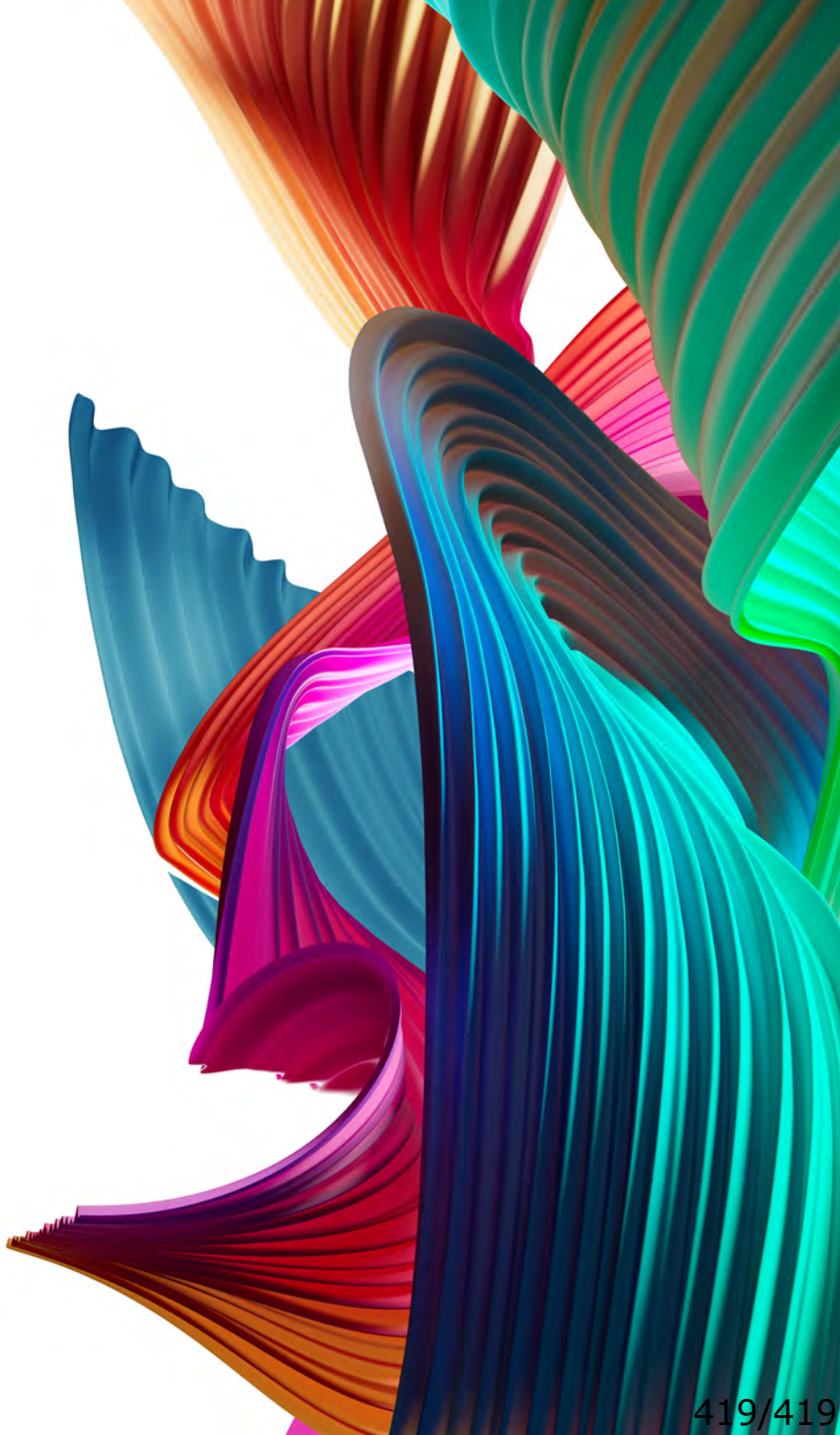


Embrace the Chaos

The informal and unstructured nature of working with communities is embraced and there is an understanding of the need to embrace this and work at the pace and with the energy of the community.



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BOLTON PREVENTION FRAMEWORK

Bolton Council