NHS Bolton NHS Foundation Trust

BOARD OF DIRECTORS' AGENDA

MEETING HELD IN PUBLIC

To be held at 1pm on Thursday 29 January 2025
In the Boardroom, Royal Bolton Hospital, Minerva Road

Ref No.	Agenda Item	Process	Lead	Time
PRELIMINARY BUSINESS				
TB001/26	**Chair's welcome and note of apologies** ***Purpose:*** *To record apologies for absence and confirm the meeting is quorate.*	*Verbal*	Chair	
TB002/26	**Patient and Staff Story** ***Purpose:*** *To **receive** the patient and staff story*	*Presentation*	Chair	
TB003/26	**Declaration of Interests concerning agenda items** ***Purpose:*** *To record any interests relating to agenda items*	*Verbal*	Chair	**13:00** (20 mins)
TB004/26	**Minutes of the previous meeting held on 27 November 2025** ***Purpose:*** *To **approve** the minutes of the previous meetings.*	*Report*	Chair	
TB005/26	**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				
TB006/26	**Chair's Update** ***Purpose:*** *To **receive** the Chair's Update*	*Verbal*	*Chair*	**13:20** (10 mins)
TB007/26	**Chief Executive's Report** ***Purpose:*** *To **receive** the Chief Executive's Report.*	*Report*	*CEO*	**13:30** (10 mins)
TB008/26	**Board of Directors Effectiveness Survey** ***Purpose:*** *To **receive** the Board Effectiveness Report*	*Report*	*Chair*	**13:40** (10 mins)
TB009/26	**Corporate Governance Report** ***Purpose:*** *To **receive** the Corporate Governance Report*	*Report*	*Chair*	**13:50** (10 mins)

IMPROVING CARE, TRANSFORMING LIVES				
TB010/26	**Integrated Performance Report** ***Purpose:*** *To* ***receive*** *the Integrated Performance Report.*	*Report*	*Exec Directors*	**14:00** (30 mins)
TB011/26	**Quality Assurance Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on the work delegated to the Committee.*	*Report*	*QAC Chair*	**14:30** (10 mins)
TB012/26	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** ***Purpose:*** *To* ***receive*** *the CNST Maternity Incentive Scheme Report.*	*Report*	*CNO + Director of Midwifery*	**14:40** (10 mins)
TB013/26	**Learning from Deaths/Mortality Report** ***Purpose:*** *To* ***receive*** *the Learning from Deaths/Mortality Report.*	*Report*	*MD*	**14:50** (10 mins)
TB014/26	**Thematic Review: Total Laparoscopic Hysterectomy Injuries from August 2024 to November 2024** ***Purpose:*** *To* ***receive*** *the Thematic Review: Total Laparoscopic Hysterectomy Injuries from August 2024 to November 2024.*	*Report*	*MD*	**15:00** (10 mins)
	COMFORT BREAK (10 mins)			**15:10**
A GREAT PLACE TO WORK				
TB015/26	**People Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report*	*PC Chair*	**15:20** (10 mins)
A HIGH PERFORMING PRODUCTIVE ORGANISATION				
TB016/26	**Finance and Investment Committee Chair's Report** ***Purpose:*** *To* ***receive*** *assurance on work delegated to the committee.*	*Report &Verbal*	*F&I Chair*	**15:30** (10 mins)
A POSITIVE PARTNER				
TB017/26	**Questions to the Board** ***Purpose:*** *To discuss and respond to any questions received from the members of the public.*	*Verbal*	*Chair*	**15:40** (05 mins)

TB018/26	**Feedback from Board Walkabouts** ***Purpose:*** *To* ***receive*** *feedback following walkabouts.*	*Verbal*	*Members*	**15:45** (10 mins)

CONCLUDING BUSINESS

TB019/26	**Messages from the Board** ***Purpose****: To agree messages to be shared with all staff.*	*Verbal*	*Chair*	**15:55** (02 mins)
TB020/26	**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 26 March 2026			***16:00*** ***Close***

Chair: Dr Niruban Ratnarajah

Board of Directors Register of Interests – Updated January 2026

Name:	Position:	Interest Declared	Type of Interest
Tony **Allen**	Non-Executive Director	Locala Community Partnership	Financial Interest
		Inclusion Group	Financial Interest
		YMCA Together Liverpool	Non-Financial Professional Interest
		Kiklees ICB Finance Committee member	Financial Interest
Gita **Bhutani**	Associate Non-Executive Director		
Seth **Crofts**	Non-Executive Director	External Academic, Appointed Representative, The Open University, Academic Quality and Governance Committee	Non-Financial Professional interest
Sean **Harriss**	Non-Executive Director	Trustee at Age Exchange	Non-Financial Professional Interest
		Senior Advisor, 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
Janat **Hulston**	Non-Executive Director	Non-Executive Director Chorley Building Society	Financial Interest
		Vice Chair/Trustee Manchester Care and Repair Charity	Non-Financial Professional Interest
Sharon **Katema**	Director of Corporate Governance	Nil Declaration	

Board of Directors Register of Interests – Updated January 2026

Name:	Position:	Interest Declared	Type of Interest
James **Mawrey**	Chief People Officer / Deputy CEO	Partner employed at a neighbouring NHS Trust within Greater Manchester.	Non-Financial Personal Interest
Rauf **Munshi**	Medical Director	Nil declaration	
Tiri **Mutambasere**	Associate Non-Executive Director	Trustee GoChurch	Non-Financial Personal Interest
		Director SubmitFox Limited	Financial 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

Board of Directors Register of Interests – Updated January 2026

Name:	Position:	Interest Declared	Type of Interest
Tyrone **Roberts**	Chief Nurse	Personal Trainer	Non-Financial Personal Interest
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
		Trustee Women for Well Women (Leigh)	Non-Financial Personal Interest
		Chair of North West Non-Executive Director Network	Non-Financial Professional 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	Nil declaration	
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
Ian **Williamson**	Non-Executive Director	Vice Chair The Gaddum Charity	Non-Financial Professional Interest
		Trustee Connect Academy	Non-Financial Professional Interest
		Director Primary Care Commissioning	Non-Financial Professional Interest
		Spouse is Chair of Manchester Carers Forum	Indirect 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 the Boardroom

Thursday 27 November 2025

Subject to the approval of the Board of Directors Meeting on Thursday 29 January 2026

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
Harriss	Sean	SH	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 136 and 138)
Fletcher	David	DF	Divisional Director of Nursing, Medicine Division (for item 125)
Omalley	Lindsay	LOM	Staff Nurse, D3 Ward (for item 125)

Apologies

None

There were six observers in attendance

AGENDA ITEM	DESCRIPTION	Action Lead
TB124/25	**Chair's Welcome and Note of Apologies** The Chair welcomed everyone to the meeting. There were no apologies for absence.	

AGENDA ITEM	DESCRIPTION	Action Lead

TB125/25 Patient and Staff Story

The Board of Directors received a patient story from the Medicine Division relating to a patient who described initially experiencing breathlessness and swollen ankles and was subsequently diagnosed with a left bundle branch block. In June 2021, under the care of Dr Scott and Heart Failure Specialist Nurse Kate Leithwaite, he commenced an enhanced heart failure medication regime, which stabilised his condition until he later underwent a ten-hour cardiac procedure.

From September 2022, the patient participated in a cardiac rehabilitation programme, which included structured exercise and weekly education sessions delivered by nursing staff on lifestyle, diet and cardiac health. He described the programme as excellent and highly recommended it. The patient commended the continuity of care provided by the cardiac team, highlighting that staff were consistently aware of his history, even when his usual link nurse was unavailable.

The patient expressed gratitude to the Cardiology team at Bolton, crediting them with prolonging his life as he was now able to return to playing sports since recovery.

Staff Story

Lindsay, a staff nurse on D3 delivered the staff story advising that she qualified in September 2024 after completing her training at the Trust as a mature student. Her decision to enter nursing was influenced by her experience as a patient whilst undergoing treatment for breast cancer during pregnancy.

Lindsay reflected on her experience during her first year in post on Ward D3 advising that she felt well supported by colleagues and described strong team working in an open, supportive culture. Lindsay expressed pride in her development and the level of commitment to deliver excellent patient care. She cited an example of her initiative to improve ward organisation by introducing baskets for patient tables.

Lindsay advised that she had contributed to an article for Cancer Research and aspired to progress with her career development to the role of Sister. She also highlighted that the clinical skills training programme for newly qualified nurses would benefit from being delivered in a single week to support timely sign-off. She expressed gratitude to the Trust, noting

AGENDA ITEM	DESCRIPTION	Action Lead

SC asked about the challenges faced as a newly qualified nurse. Lindsay explained that she had initially experienced imposter syndrome but had benefited greatly from a supportive team and good communication on the ward. She noted that the most significant challenge had been securing timely supervision sign-off due to clinical pressures. Lindsay advised that based on her recent experience, she was now beginning to support students herself and was proud to be giving back.

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

TB126/25 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.

TB127/25 Minutes of the previous meetings

The Board received and approved the minutes of the meeting held on 25 September 2025, as a correct and accurate record of proceedings.

RESOLVED:
The Board of Directors ***approved*** the minutes from the meeting held on 25 September 2025.

TB128/25 Matters Arising and Action Logs

The Board 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.

TB129/25 Chair's Update

The Chair advised that this meeting marked the final meeting for Francis Andrews in his role as, Medical Director. The Chair expressed the Board's appreciation for

AGENDA ITEM	DESCRIPTION	Action Lead

his significant contribution to the organisation, acknowledging his leadership throughout the Covid-19 pandemic, the introduction of Martha's Rule, and his wider legacy of commitment and service to Bolton.

The Chair further advised that this meeting would also be the final Board meeting for Non-Executive Directors Alan Stuttard and Rebecca Ganz. The Chair extended thanks to Alan who had been with the Trust for seven years and had taken up the role of Audit and Risk Committee Chair in the last three years and Rebecca for the seven years with the Trust. The Board recorded its thanks for their dedicated service and the valuable contributions they had made during their tenure.

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

TB130/25 Consent Agenda

Infection Prevention and Control Annual Report
The Chief Nursing Officer presented the Infection Prevention and Control Annual report which outlined performance against key metrics and provided assurance that the Trust was a provider of clean safe care. It was noted that of the six Healthcare Acquired Infections (HCAI) that were included in the UKHSA mandatory reporting scheme, Bolton ranked second of the seven GM providers for four and third for a fifth. For the sixth measure, Clostridium difficile toxin cases Bolton was a significant outlier in GM; the report described both the work in 2024/25 and the ongoing work in 2025/26 to improve clinical outcomes for these infections.

RESOLVED:
The Board of Directors ***received*** the Infection Prevention and Control Annual Report.

Safeguarding Annual Report
The Chief Nursing Officer presented the Safeguarding Annual Report noting that the Trust consistently fulfilled its statutory safeguarding obligations, prioritising the protection and well-being of children, young people, and vulnerable adults. The safeguarding framework was grounded in national legislation and guidance, with strategic direction led by the Chief Nurse and operational management overseen by a multidisciplinary safeguarding team.

AGENDA ITEM	DESCRIPTION	Action Lead

Looking ahead to 2025/26, priorities included enhancing digital reporting, strengthening quality assurance processes, and embedding learning from audits and reviews. The Trust remained committed to working collaboratively with partners to ensure safeguarding was everyone's responsibility and to deliver safe, person-centred care for all.

RESOLVED:
The Board of Directors ***received*** the Safeguarding Annual Report.

Standing Orders
The Director of Corporate Governance presented the Board Standing Orders, which set out the rules governing Board operations, including meeting conduct, decision-making processes, and the roles and responsibilities of Board members and committees. The Standing Orders protect both the Trust's interests and staff by ensuring clear and proper procedures.

The Standing Orders were last reviewed in January 2024. A further review had since been completed, with only template updates reflecting the new Trust strategy and no substantive changes proposed. The document would be considered by the Audit and Risk Committee on 03 December 2025, and any amendments arising from that discussion would be brought back to the Board for approval.

RESOLVED:
The Board of Directors ***approved*** the Standing Orders.

Standing Financial Instructions and Scheme of Delegation
The Director of Corporate Governance presented the Standing Financial Instructions which were the financial rules and regulations by which the Trust was governed in order to ensure compliance with the law, probity, transparency and value for money. The Financial Scheme of Delegation sets out the powers and financial levels of authority of the Board, its Committees and the Executive.

The Standing Financial Instructions and Financial Scheme of Delegation combine to form part of the Standing Orders of the organisation and were reviewed periodically. It should be noted that minor changes may continue to be made following the publication of committee papers.

RESOLVED:

AGENDA ITEM	DESCRIPTION	Action Lead

The Board of Directors ***approved*** the Standing Financial Instructions and Scheme of Delegation.

TB131/25 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 Director of Midwifery, Janet Cotton, received the Chief Midwifery Officer's Silver Award in recognition of her outstanding contribution to improving maternity services in Bolton.
- Dr Rauf Munshi had been appointed Medical Director following a competitive process, succeeding Dr Francis Andrews, who would retire in February 2026.
- The Trust won Proud2bOps Trust Network of the Year for the second year running. Laboratory Medicine and Mortuary Services won the Innovation and Technology and Operational Delivery award, and Bethan Pope was shortlisted for Aspiring Operational Manager of the Year.
- Recent data showed the Trust was one of only three trusts in England to have met NHS cancer targets over the past 12 months. cancer care.
- Major transformation of the Maternity and Women's Health Unit was underway, with RAAC removal progressing using innovative technology.

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

TB132/25 Board Assurance Framework (BAF)

The Director of Corporate Governance presented the BAF, noting it had been reviewed by all relevant Committees ahead of Board consideration to confirm the robustness of controls and assurance processes.

No changes were proposed to the strategic risk scores since the last report. To reflect the updated Quality Assurance Committee Terms of Reference, Strategic Risk 7 (Improving Access to our Services) would now fall within the Committee's remit, ensuring oversight of both quality and operational performance. Updates since September were marked in track changes.

TR noted that changes to CO1 were highlighted and a review of risk management and risk appetite would be undertaken, so the appetite would likely return to "open".

AGENDA ITEM	DESCRIPTION	Action Lead

In January, there would also be a review of all Quality Impact Assessments (QIA) submitted to evidence the effectiveness of mitigations and ensure there were no unintended consequences.

RESOLVED:
The Board of Directors ***received*** the Board Assurance Framework

TB133/25 2026 Board Workplan

The Director of Corporate Governance presented the 2026 Board Workplan, noting its importance in ensuring timely reporting and alignment with the annual meeting cycle. The Workplan set out the items to be brought to the Board across the year and would also inform committee workplans.

The Workplan provided a structured approach to agenda planning, ensuring governance and strategic priorities were covered and allowing for adjustments in response to national and local issues. Draft agendas were routinely reviewed by the executive team before discussion with the Chair and Chief Executive.

RESOLVED:
The Board of Directors ***approved*** the 2026 Board Workplan.

TB134/25 Integrated Performance Report

The Chief Operating Officer presented an update on community and urgent care performance.

- Urgent Community Response (UCR) referrals remained below plan, though October saw the highest volume to date. Improvements reflected strengthened data capture and engagement with primary care and care homes. Work continued to promote the pathway, develop out-of-hours options, and implement the acute urinary retention pathway. The team continued to exceed the two-hour response standard.
- Deflections from ED were at their highest since the COVID period, supported by UCR and the Call Before You Convey initiative, which was diverting around five patients per day.
- ED attendances remained extremely high, with 599 more attendances than October 2024, and the highest level recorded. Locality work was underway to understand demand and promote alternative pathways.

AGENDA ITEM	DESCRIPTION	Action Lead

- Ambulance handover and four-hour performance remained a challenge due to demand, staffing and ED capital works. NHS England scrutiny continued, with an expectation of improvement following completion of the refurbishment in December.
- The Trust continued to benchmark in the lower range across Greater Manchester for four-hour performance. Improvement plans remained in place.

Quality and Safety

The Chief Nurse noted progress in Infection Prevention and Control following approval of a £680k business case, which had enabled deep cleaning and flooring improvements and resulted in fewer Clostridium Difficile Toxin (CDT) cases, reduced associated costs, and improved bed-day availability.

The Board received a Deep Dive Review of maternity performance metrics, including Local Maternity Neonatal System (LMNS) ambitions, Statistical Process Chart (SPC) analysis, and findings from an NHSR claims review. Themes had been identified and a safety improvement plan had been developed for ongoing monitoring and would be monitored through Divisional governance

Perinatal mortality analysis indicated stillbirth rates were broadly in line with national levels, with identified peaks linked to case mix and ongoing improvement actions were in place. Planned developments included expanding REACH, establishing a diabetes one-stop service, and introducing the Partner Trial risk-assessment tool.

The Board reviewed delays in induction of labour over 24 hours, noting national clarification on reporting and local factors such as staffing and capacity pressures. Despite a historical 34-bed reduction, SPC analysis showed no significant deterioration. A recent audit identified gaps in obstetric reviews, and actions were underway including strengthened staffing models, Multi-Disciplinary Team (MDT) huddles, prioritisation processes and leadership adjustments.

Triangulation with NHSR claims data (2015–2025) highlighted 40 open claims, with significant injury themes. Hypoxic Ischaemic Encephalopathy (HIE) rates remained above the Local Maternity Neonatal System (LMNS) target, and stillbirth continued to represent the highest-value category of harm, reinforcing the need for continued maternity safety improvements. A comprehensive improvement plan was in place and would be monitored through existing governance structures.

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The Medical Director advised that:

- There had been a slight improvement in inpatient clinical correspondence compliance. Divisional risks and mitigations had been reviewed, and the Quality Improvement Team (QI) had been engaged to develop a Trust-wide collaborative to support improvement in clinical correspondence.
- Outpatient clinical correspondence compliance had decreased with the impact of administrative capacity highlighted as an issue on performance. This had been escalated.
- Crude mortality remained below the Trust target and average. Hospital Standardised Mortality Ratio (HSMR) was at the period average and stable. Summary Hospital-level Mortality Indicator (SHMI) was just below the average and remained in control.
- Charlson comorbidities remained above average, whilst depth of coding was stable and slightly below average; both remained lower than the England acute Trust average. Coding completeness remained above average, and early neonatal mortality had remained in control for over 12 months.
- Venous Thromboembolism (VTE) variations remained between the data presented in the Integrated Performance Report and the validated audit data due to the timing of data extraction and subsequent validation. The validated divisional VTE Risk Assessment compliance figures confirmed the Trust continued to meet and exceed required standards.

Finance

The Chief Finance Officer, presented the Month 7 status finance report advising:

- A year-to-date deficit of £13.7m was noted, £6.2m adverse to plan, with workforce numbers 45 Whole Time Equivalent (WTE) above plan. The full-year forecast remained break-even, dependent on delivering £19.7m Cost Improvement Programme (CIP) and ongoing financial controls.
- CIP delivery was £7.3m year-to-date which was £6.7m behind plan.
- Agency spend was £4.1m which was above the £3.2m NHSE target. Bank spend was £10.5m against a £14.6m target.
- Capital spend was £7.0m against a plan of £16.6m.
- The cash position was £9.3m, ahead of plan due to timing, though the underlying position remained £15.8m overdrawn. £8.3m of cash support had been approved for November.

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Workforce

The Chief People Officer reported that sickness absence has increased, driven by seasonal illness. The Staff Survey response rate was 41% ahead of closure at the end of November. Appraisal compliance had fallen to 82.8%, due to time pressures. Flu vaccination uptake among frontline staff was over 40%, the highest in Greater Manchester and among the highest in the Northwest.

SH queried the increase in Emergency Department attendances, asking how much of the rise was attributable to population changes and how much to increased clinical acuity. FN noted that the geography was a contributing factor and noted that there had been population growth in the Salford area.

RESOLVED:

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

TB135/25 Quality Assurance Committee Chair's Report

Fiona Taylor presented the Chair's Reports from the Quality Assurance Committee meeting held on 24 September and 26 November 2025; the following key points were highlighted:

- The Committee noted that theatre utilisation remained below target and the contributing factors were highlighted. Recovery actions were reported to be in progress.
- The Committee received assurance that automation and strengthened governance had significantly reduced the risk of e-RS 'drop-off' incidents. Full mitigations remained dependent on reducing first appointment waiting times.
- The Committee received the Patient Safety Incident Response Framework (PSIRF), which set out five local patient safety priorities and the associated investigation and learning processes.

FLT also advised that responsibility for health inequalities would be moving under the remit of the Quality Assurance Committee.

RESOLVED:

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

AGENDA ITEM	DESCRIPTION	Action Lead
TB136/25	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report** The Director of Midwifery presented the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Report advising that: • Eight recommendations were yet to commence and were classified as red. It was anticipated all requirements would be fulfilled during the CNST year 7 programme subject to all staff attending the CNST training as planned prior to the 30 November 2025. • The Trust had declared non-compliance to the Local Maternity and Neonatal System (LMNS) with the element within Safety Action 7 relating to the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements as the service was unable to fulfil quorate attendance at the defined meetings with the current establishment funded by the Greater Manchester and Eastern Cheshire (GMEC) LMNS. **RESOLVED:** The Board of Directors ***received*** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme and ***approved*** the actions plans.	
TB137/25	**People Committee Chair's Report** Sean Harriss presented the Chair's Reports from the People Committee meeting held on 18 November 2025, highlighting the following key points: • Resourcing & Workforce Retention updated confirmed that WTE reduced by 265 with further reductions required; Substantive WTE remained above plan; Bank usage continued to fall; Agency reduced to 22 WTE but spend remained above NHSE target. • The staff survey response rates were lower than previous years due to workload pressures. The Committee noted ongoing staff support measures. • The Committee received an update on sickness-related wellbeing initiatives, occupational health activity and flu vaccination uptake. • The EDI Plan, 2025 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) reports and the Trust's response to NHSE's zero-tolerance call-to-action were reviewed. • GMC Survey Action Plan - GP O&G Training and Foundation Surgery Training placed under NHSE monitoring; improvement plans developed and to be overseen by the Medical Education Board	

AGENDA ITEM	DESCRIPTION	Action Lead

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

TB138/25 Nursing and Midwifery Staffing Report

The Chief Nursing Officer presented the Nursing and Midwifery Staffing Report, confirming compliance with national safe-staffing requirements and NHSI Workforce Safeguard standards. The February 2025 Safer Nursing Care Tool (SNCT) census showed an over-establishment of registered nurses and a slight under-establishment of healthcare assistants, with establishment changes implemented in August 2025. Mandatory training compliance was 94.35%, and substantive recruitment had reduced temporary staffing.

Some challenges remained, including inconsistent red flag reporting and difficulties interpreting Emergency Department (ED) census data due to service reconfiguration. Priority actions included improving red flag reporting, refining SafeCare categories, and completing analysis of ED and September 2025 census data.

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

Bi-annual Maternity Staffing Report
The Director of Midwifery presented the bi-annual maternity staffing review. The external Birthrate Plus review last took place in 2022, with a new review underway from September 2025. The funded establishment of 282.90 WTE aligned with the 2023 recommendations, and recruitment was ongoing.

There were no breaches of the supernumerary co-ordinator standard. One-to-one care in labour remained below 100% due to vacancies, with an action plan in place. The 2024 maternity survey showed improved patient experience.

Overall, despite ongoing workforce challenges, safe staffing was maintained, supported by temporary service closures and staff redeployment.

RESOLVED:
The Board of Directors ***received*** the Maternity Bi-Annual Staffing Update.

AGENDA ITEM	DESCRIPTION	Action Lead
TB139/25	**Inclusion Update**	

Staff Health and Wellbeing Report

The Chief People Officer presented the Staff Health and Wellbeing Report, emphasising that supporting staff wellbeing was essential to maintaining a resilient workforce and delivering safe, high-quality patient care. The report outlined the actions being implemented across the organisation to strengthen physical, mental and emotional support for staff.

RESOLVED:

The Board of Directors ***received*** the Staff Health and Wellbeing Report.

Staff Engagement Update

The Chief People Officer presented the Staff Engagement Update, noting that NHS Staff Survey response rates were lower than in previous years and outlined key recommendations to improve engagement. The update also provided an overview of phase 2 of the Our Voice Change Programme, summarising progress to date, current staff engagement themes, and actions to strengthen and sustain staff experience.

RESOLVED:

The Board of Directors ***received*** the Staff Engagement Update.

Workforce Race Equality Standard, Workforce Disability Equality Standard Reports and Annual Equality Information Monitoring Report

The Chief People Officer presented the Workforce Race Equality Standard, Workforce Disability Equality Standard and Annual Equality Information Monitoring Report, noting they had been considered by the People Committee and the Board in line with statutory requirements. The reports showed progress in representation, recruitment equity and staff experience, with actions aligned to the EDI Plan.

The Annual Equality Information Monitoring Report provided insight into patient and workforce demographics, access, experience and outcomes, highlighting areas for improvement and informing the patient and workforce priorities within the EDI Plan. It also outlined progress made in EDI over the past year.

NR asked for the key highlights and challenges arising from the WRES and WDES reports. JM advised that the WRES position was generally positive, with the Trust's workforce broadly reflecting the local population. However, he noted that the

AGENDA ITEM	DESCRIPTION	Action Lead

experience of staff from the global majority continued to fluctuate and remained an area requiring sustained focus.

With regard to the WDES, he highlighted that the principal challenge related to low levels of disability declaration within the workforce, with only around 4% of staff identifying as disabled, whereas it was estimated that the true figure was likely to be closer to 20%. Improving the accuracy of this data remained a priority.

The Board noted that the Trust had two highly active staff networks, including the EDI Network chaired by FA, which continued to play an influential role within the organisation.

RG queried the ease with which staff were able to declare their disabilities. JM confirmed that improvements were required to the interface feeding into ESR, and that this work was currently underway.

RESOLVED:
The Board of Directors ***received*** the Workforce Race Equality Standard and Workforce Disability Equality Standard Reports.

EDI Plan and Annual Report

The Chief People Officer presented the EDI Plan and Annual Report, confirming the launch of the 2025–2027 Plan, which set out eight patient and workforce priorities supported by measurable KPIs and informed by national EDI data sources.

RESOLVED:
The Board of Directors ***received*** the EDI Plan and Annual Report.

TB140/25 **Finance and Investment Committee Chair's Report**

Rebecca Ganz presented the Chair's Report from the meetings held on 23 July 2025, and provided a verbal update from the meeting held on 24 September 2025; highlighting the following key points:

- Significant risks remained to delivering the year-end plan, including the requirement to reduce 263 WTE from Month 7. Grip and control measures continued but delivery risk was high.

AGENDA ITEM	DESCRIPTION	Action Lead

- Month 7 deficit was £1.7m (adverse £1.9m). CIP under-delivery was the main driver. Cash remained temporarily improved due to one-off benefits but underlying position was overdrawn. Capital spend was below plan.
- EPR implementation neared completion across major services by year-end. Ongoing challenges included governance of project prioritisation and constrained resources across Digital teams.
- Effectiveness Survey: October 2025 results remained positive and benchmarked well against previous years.
- The committee reviewed the BAF and confirmed adequacy of controls and actions to address gaps.

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

TB141/25 **Charitable Funds Committee Chair's Report**

Martin North presented the Chair's Report from the meeting held on 23 October 2025; highlighting the following key points;

- The Committee received an overview of lessons learned from Winter 2024 and plans for 2025. Key activities included the Christmas Light Switch-On, Festive Friday, and Amazon wish lists. The Winter markets would not be repeated due to low return.
- The Committee received a briefing on the new Failure to Prevent Fraud Legislation. As the Charity was not a separate legal entity and did not meet criteria for criminal liability, no specific action was required.
- Finance update: £71k income, £140k expenditure (incl. £99k management fee), net decrease £69k, fund balance £832k. The Committee requested a management fee review and sector benchmarking update.
- An update was received on divisional capital pipeline prioritisation and application of expenditure principles. Quarterly meetings between divisions and the charity team will support alignment with Trust priorities and improve fund visibility.
- The Committee approved the annual report and accounts.

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

Charitable Funds Committee Annual Report

AGENDA ITEM	DESCRIPTION	Action Lead

The Chief of Strategy and Partnerships presented the Charitable Funds Committee Annual Report and Accounts. The report described the structure, governance and management of the Charity; provided a breakdown of income and expenditure; outlined the key priorities for 2025/26 and set out the financial position for the year ending 31 March 2025.

The Charitable Funds Committee Annual Report and Accounts had been received by the Committee and would be submitted to the Charity Commission by the deadline of 31 January 2026.

RESOLVED:
The Board of Directors ***received*** the Charitable Funds Committee Annual Report and Accounts

TB142/25 EPRR Core Standards Report

The Chief Operating Officer presented the EPRR Core Standards Report advising that NHS England required all health organisations participating in the 2025 NHS Core Standards self-assessment process to ensure their Boards or governing bodies are sighted on the level of compliance achieved and the action plan for the forth-coming period.

From the self-assessment return for Bolton Royal NHS FT submitted on 30 September 2025 an assurance rating of Substantially compliant was submitted as two standards were considered as partially compliant. Action plans to improve position in these standards going forward, was included in the report

FLT queried where the actions would be tracked and RW confirmed through the Performance and Transformation Board and then to Quality Assurance Committee.

RESOLVED:
The Board of Directors ***approved*** the EPRR Core Standards Report.

TB143/25 Questions to the Board

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

AGENDA ITEM	DESCRIPTION	Action Lead

TB144/25 Feedback from Board Walkabouts

MN reported visiting Waters Meeting Health Centre, where he observed neighbourhood-working arrangements in practice. The service had achieved BOSCA Gold accreditation and was working towards Platinum.

AS visited Pharmacy, noting that although the physical environment required improvement, staff demonstrated strong enthusiasm and commitment.

RG had visited the Antenatal Department. She reported that RAAC works had impacted the environment; however, staff provided positive feedback regarding the senior management team. She also highlighted that the waiting room had been cold, though FN confirmed this issue had since been resolved. The area was also experiencing the effects of the administrative review.

FLT visited Cardiology and had supported facilitation of the Our Leaders session. She noted the high level of energy and engagement from staff and reflected on the importance of supporting leaders to apply learning within their respective departments.

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

TB145/25 Messages from the Board

The messages from the Board were agreed.

TB146/25 Any Other Business

There being no further any other business, the Chair thanked all for attending and brought the meeting to a close at 16:00.

The next Board of Directors meeting would be held on Thursday 29 January 2026 at 1pm in the Boardroom.

Meeting Attendance 2025						
Members	**Jan**	**March**	**May**	**July**	**Sept**	**Nov**
Niruban Ratnarajah	✓	✓	✓	A	✓	✓

Fiona Noden	✓	✓	✓	✓	A	✓
Francis Andrews	✓	✓	✓	✓	✓	✓
James Mawrey	A	✓	✓	A	✓	✓
Tyrone Roberts	✓	✓	✓	✓	✓	✓
Annette Walker	✓	✓	✓	✓	✓	✓
Rae Wheatcroft	✓	✓	✓	✓	✓	✓
Sharon White	✓	✓	✓	A	✓	✓
Rebecca Ganz	✓	✓	✓	✓	✓	✓
Martin North	✓	✓	✓	✓	✓	✓
Alan Stuttard	✓	✓	✓	✓	✓	✓
Sean Harriss	✓	✓	A	✓	✓	✓
Fiona Taylor	✓	✓	✓	✓	✓	✓
Seth Crofts	✓	✓	✓	✓	✓	✓
Tosca Fairchild	✓	A				
Sharon Katema	✓	A	✓	✓	✓	✓
✓ = In attendance A = Apologies						

Status

Red	Overdue (Significantly delayed)
Amber	Due
Green	Completed
Yellow	Included on Agenda
Blue	Not yet due

Board of Directors

Matters Arising Action Log

Action Log updated November 2025

NHS Bolton NHS Foundation Trust

ONGOING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
TB088/25	31/07/2025	Our Leaders Programme and Culture Update	HS and RK to return to a Board of Directors meeting in 12 months' time to provide a progress update.	LR	Jul-26	Jul-26		Blue

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
TB076/25	31/07/2025	Patient Story	Prepare a report reviewing the patient story, with particular focus on the differing outcomes and the incorrect prognosis given to the patient.	FA	Sep-25	Sep-25	FA reported that, upon investigation, it was established the patient had been admitted to the spinal unit and subsequently became a patient under the care of Northern Care Alliance at the time their prognosis was provided. As a result, FA was unable to produce a report on this matter, as the relevant care and associated documentation were managed by another organisation.	Green
TB105/25	25/09/2025	Senior Information Risk Owner (SIRO) Report	SW to verify and confirm the current status of the Trust's ISO27001 and report any changes, if applicable, to the Board at the next meeting.	SW	Nov-25	Nov-25	Deiler Carrillo confirmed there were no changes. The accreditation had been held for seven consequtive years.	Green
TB118/25	2509/25	Audit and Risk Committee Chair's Report	SW to ascertain whether the Trust could insure itself against cyber-attacks.	SW	Nov-25	Nov-25	Director of Digital looked at the possibility of the organisation purchasing cyber insurance to help maintain a fast recovery and cover costs in the event of a cyber-attack. Discussed with a number of sources and in particular NHS England (Cyber). Advice we continue our own cyber resilience programme and in the event of an incident use the national Cyber Security Operations Centre (CSOC) who bring together and co-ordinate response and liaison with all agencies. The national team have a proven track record in these incidents.	Green

Report Title:	Chief Executive's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		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 are 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**	

Is a Quality Impact Assessment required	**No**	

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

Ambition 1: Improving care, transforming lives

As 2025 drew to a close, we looked back at what all our staff have achieved for our patients over the last twelve months reflecting our strategy to improve care and transform the lives of our local population. Achievements included being the first hospital in Greater Manchester to introduce digital autopsies, working with Digital Autopsy UK. We were amongst the first hospitals in the world to use the Genedrive System, a ground-breaking gene test that helps prevent lifelong hearing loss in babies. And we introduced AI technology to speed up skin cancer diagnosis by fast-tracking urgent cases, reducing unnecessary appointments, and improving outcomes for thousands of patients in Bolton.

Our staff have gone above and beyond to make sure the festive period has been as special as possible for our patients and their loved ones. Examples include Lydia Hill, a play specialist, who spent Christmas Day supporting children on our Children's Ward at Royal Bolton Hospital. Play specialists provide cover all year round, but December can be their busiest and most meaningful time. Working closely with clinical teams to reduce anxiety and support children's treatment, they help ensure that only children who truly need hospital care are on the ward on Christmas Day.

Our maternity teams supported families as they welcomed some very special babies into the world on both Christmas Day and New Year's Day. It's a real privilege for us to be able to support families in Bolton and our surrounding areas, and to be part of memories that our communities will treasure forever.

The annual Christmas light switch-on took place outside the main entrance of Royal Bolton Hospital. Thanks to the support of our iFM team and partners. Robertson Construction, who are currently working on the £38 million redevelopment of the Maternity and Women's Health Unit, who kindly sponsored the trees through their ongoing support of Our Bolton NHS Charity. Refreshments were provided by Carrs Pasties, courtesy of Geoffrey Robinson, and there was also a special visit from Father Christmas thanks to EFT Construction.

We highlighted the significant impact of our screening programme for blood borne viruses to mark World AIDS Day, a global movement to unite people in the fight against HIV and AIDS. The initiative aims to routinely test people aged 16 and over who are having a blood test in the hospital's Emergency Department for HIV, Hepatitis B (HBV) and Hepatitis C (HCV). We have carried out nearly 20,000 tests for HIV so far in a major step to improve detection and support people with their care and treatment.

Bolton Family Hubs have been awarded a Certificate of Commitment in its first step towards gaining recognition from UNICEF UK's Baby Friendly Initiative. The Hubs are delivered by Bolton NHS Foundation Trust and Bolton Council and offer a range of activities and integrated support services to help with parenting, so children get the best possible start in life. The Baby Friendly Initiative is a global programme which aims to transform healthcare for babies, their mothers and families as part of a wider global partnership between UNICEF and the World Health Organization (WHO).

Our teams have achieved a world first by using Artificial Intelligence to improve the accuracy of a test that identifies if a baby has a high chance of being born with Down's syndrome. The AI technology aims to improve how the data collected during the testing stage is read to increase accuracy and improve detection to make sure only the mothers of babies with the highest chance of being born with Down's

syndrome are sent for more tests. The journal, 'A novel machine-learning algorithm to screen for trisomy 21 in first-trimester singleton pregnancies', is available to read in full on the Taylor and Francis website.

Ambition 2: A great place to work

Dr Francis Andrews has now retired from his roles as Medical Director and Consultant in Emergency Medicine. Over a remarkable career spanning 36 years, Francis has led with quiet strength, clinical excellence, and an unwavering commitment to doing the right thing - for our patients, our staff, and for the future of healthcare. His belief in compassionate, high-quality care has been a constant source of inspiration to us all and we thank him for his incredible service. His legacy will continue through all those who have had the privilege of working alongside him.

Francis' successor Dr Rauf Munshi has now commenced in post as our Medical Director, bringing a deep commitment to inclusivity and tackling health inequalities, and championing quality, compassion, dignity and respect. As a result of Rauf's promotion, Dr Arun Kallat has been appointed substantively as Divisional Medical Director for our Medicine Division.

Our Non-Executive Directors (NEDs) provide independent oversight and constructive challenge as part of our unitary Board of Directors, bringing an external perspective that helps ensure the Trust acts in the best interests of our patients, staff and wider community. Two of our long-standing NEDs, Alan Stuttard and Becks Ganz, have completed their tenures with the Trust, and we are grateful for the significant contribution they have made during their time with us.

As a result, and following another NED vacancy due to Tosca Fairchild's departure last year, we have appointed three new NEDs - Tony Alan, Janat Hulston and Ian Williamson - along with two new Associate NEDs, Gita Bhutani and Tiri Mutambasere. Each brings valuable experience and diverse perspectives that will strengthen our Board. They will join us over the coming months, and we look forward to the insight and expertise they will bring.

We continue to champion and lead through equality, diversity and inclusion, and that has included a number of different initiatives. Within the Our Leaders training programme, four hours of face-to-face reflection and learning are dedicated to the 'We Belong' module, which focuses on Workforce Race Equality Standard (WRES) awareness, anti-racism, inclusive recruitment, unconscious bias and active bystander approaches. We continue to aspire to create a culture of belonging where everyone feels respected, valued, and able to thrive.

The programme also enables leaders to extend their growth in this area with self-serve embed activities, such as Blended Learning Bundles on a range of EDI topics including race equality and health inequalities. The programme is intended to build leadership skills, confidence, and the ability to influence change. It also aims to address barriers within the talent pipeline, while strengthening confidence, capacity, and influence.

Our Equality, Diversity and Inclusion Team has also developed a digital inclusion calendar which provides a clear, year-round framework for recognising and celebrating the diverse cultures, identities, and lived experiences within our workforce and communities. It highlights key awareness days, religious observances, heritage months, and equality-related milestones, supporting teams to plan inclusive communications, events, and staff engagement activities. More importantly, it acts as a practical tool for

fostering belonging - helping managers anticipate the needs of staff around significant dates, encouraging thoughtful scheduling, and prompting conversations that continue to develop cultural awareness. By embedding the calendar into organisational planning, our teams can create more responsive, respectful, and equitable environments where everyone feels seen, supported, and valued.

Our teams were highly commended at the HPMA Excellence in People Awards 2025, after being shortlisted for their work to support neurodivergent colleagues. Our approach to celebrating diversity in the workplace includes a widely adopted Neurodiversity in Our Workplace toolkit, which is now used by other NHS Trusts and local organisations. Neurodiversity Awareness Training, has been co-delivered with lived experiences experts and specialists, reaching more than 200 colleagues across the Trust and partner organisations. These initiatives have driven culture change in line with the Trust's values, improved employee engagement, and influenced organisational processes including a Reasonable Adjustments process and digital accessibility. This year's awards attracted over 250 entries nationwide, making shortlisting a significant achievement.

Ambition 3:
A high performing, productive organisation

Flu and respiratory infections have been extremely high across the country, and we have seen increased numbers of patients with flu in our Emergency Department and on our wards. As a temporary measure, we have been advising patients and visitors to wear face masks in our Emergency Department where possible, and have encouraged uptake of the flu vaccination across our patients and communities.

Our resident doctors participated in another round of strikes from 7am on Wednesday 17 December until 7am on Monday 22 December. Robust plans were put in place to minimise the impact on our patients and their relatives. Throughout this challenging period, we reminded the public that our urgent and emergency services are still here to help those who need them, but if their condition is not an emergency or life or limb threatening, asked them to consider using a different service for their care.

NHS England's Medium Term Planning Framework sets out a three-year roadmap to improve performance, reduce waiting times, strengthen prevention, and accelerate the transition to more sustainable, digitally enabled models of care. It replaces the previous annual planning cycle with a three-year planning round, which provides greater clarity on national targets and expectations over the coming years. In response, we are developing an affordable, credible and deliverable plan for our organisation, which will be submitted to NHS England in February.

A further iteration of the NHS Oversight Framework was published in December, which in essence is the league table for trusts in terms of how we are performing against several nationally set metrics. The metrics for Quarter 2 show that our position was 55 out of 134, an improvement from Quarter 1 where we were in position 59. We remain in segment 3 but are proud to be making progress against a backdrop of significant challenges.

Louise Shepherd CBE (North West Regional Director for NHS England), Jo Stringer (Chief of Staff), and Andrew Furber OBE (Regional Director of Public Health), visited our organisation to better understand our performance and impact. They spent time with our colleagues and teams in elective, maternity, urgent and emergency, and laboratory medicine. The regional team fed back to say they enjoyed seeing firsthand the innovation, tenacity, and compassionate care that define our organisation. It was great to see such enthusiasm from our staff who gave insight into their areas of work.

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

In line with the 10 Year Health Plan for England, a huge amount of work is already underway to shift care from our hospital to community and the places people call home. As part of this work, we celebrated a day in the life of our Admission Avoidance team to highlight the incredible work they do to support Bolton residents to avoid a trip to hospital. The team consistently help 400 people every month avoid a trip to the Emergency Department. The team is made up of a wide-range of roles, including Advanced Clinical Practitioners, Social Workers, Consultants and Nurses, who can carry out assessments, order tests, diagnose and so much more. Patients are referred to the team from care homes, General Practice (GP), 999 and 111, social care, and Royal Bolton Hospital.

We have launched digital check-in kiosks across our outpatient departments, as part of our commitment to modernising services and making sure that they are fit for the future. The new kiosks allow patients to check in quickly and securely upon arrival, without the need to queue at reception. This innovation is designed to make visits smoother, reduce congestion in waiting areas, and give patients more control over their appointment process. As well as being able to confirm their arrival in the department in seconds, patients can also download the InTouch Appointment Manager app before appointments and check in on their mobile device. In the near future, the kiosks will go live across the majority of outpatient departments, both at the hospital and community health centres across Bolton.

A new vision for Health Innovation Bolton, a strategic partnership between ourselves, Bolton Council, Peel Land, the University of Greater Manchester and Bradford Estates, has been unveiled following an event showcasing the NorthFold growth location. Health Innovation Bolton (HIB) is a place-based growth initiative aimed at improving health and wellbeing while driving economic regeneration and better social outcomes. It is one of the most exciting and innovative schemes in the North West. Whilst in its early stages, the development is set to tackle health inequalities and improve health outcomes for our Bolton communities and beyond.

Ambition 5: A positive partner

Fiona Noden, our Chief Executive has been appointed as an honorary professor by the University of Salford and is looking forward to working in partnership with Salford University to inspire fellow allied health professionals to embrace the full potential of their careers. A radiographer by background, and as well as being the Trust's Chief Executive, serves as the Place Based Lead for Bolton, overseeing the integration of health and social care for the borough on behalf of Greater Manchester Integrated Care.

The University of Greater Manchester has official opened its state-of the-art medical training building on our Royal Bolton Hospital site. University Chancellor, Earl of St Andrews, welcomed guests to the £40m Institute of Medical Sciences (ISM) for the special ceremony. The year 2025 also marks a pivotal chapter in Bolton's healthcare journey, as the University of Greater Manchester welcomes its first cohort of medical students to the Institute of Medical Sciences, right here in the grounds of our Royal Bolton Hospital.

The partnerships we foster across Bolton are invaluable, and we continue to be truly grateful for the overwhelming support shown through Our Bolton NHS Charity.

Thanks to the generous support of a local family, who chose to channel their heartbreaking loss into something positive, other patients can now benefit from dedicated bereavement rooms within our hospital. These quiet, comfortable spaces are thoughtfully designed to give parents a peaceful environment to spend time with their baby, away from the main unit. The family organised a series of fundraising activities, including a charity football match at Winton Social Club, raising more than £5,000 for several charities, including Our Bolton NHS Charity.

Their donations have enabled us to provide items that make these rooms feel more homely and supportive, such as comfortable bedding, lamps with USB ports, white noise machines, and equipment for making hot drinks. They have also funded five privacy prams through the 4Louis Charity, offering a discreet and dignified way to move babies within the hospital.

This festive season, the Bolton Wanderers team and management staff helped bring joy to our patients in hospital. Players from the first team, manager Steven Schumacher, and club mascot Lofty the Lion generously gave their time to visit patients on wards including Complex Care and the Children's Ward E5, spreading Christmas cheer to staff, patients and visitors.

Students at Eccles Sixth Form College have made a meaningful difference through their heart-warming Christmas box initiative, created to support patients who may feel isolated over the festive period. Developed through the Trust's Volunteering Programme and the strong partnership between the Trust and the college, the project gives students a valuable opportunity to support their local community.

Christmas came early for children and young people in our hospital thanks to BRIT Award winner and I'm A Celebrity campmate Aitch, who delivered gifts ahead of the big day. 'Santa Aitch' joined Porsche Centre Bolton for their annual gift appeal, helping to bring festive magic to those spending Christmas in hospital while receiving care.

Our patients will now benefit from extra comfort and distraction thanks to the donation of bespoke 'twiddle muffs' and lap blankets from Emmaus Bolton. An amazing team of sewing volunteers from the social community and social enterprise charity converted scrap and redundant textiles into the twiddle muffs and blankets, which provide sensory stimulation and distraction. The muffs and blankets will be shared with patients on the hospital's acute adult wards and Emergency Department. The designs feature a range of different colours and textiles with the aim of keeping people's hands active and busy.

Report Title:	Board Effectiveness Survey			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	To present the findings from the 2025 Board Evaluation and outline key themes and recommendations

Previously considered by:	Report reviewed by Chair and Director of Corporate Governance

Executive Summary	The 2025 Board Evaluation reveals a high level of effectiveness, with the Board achieving an overall score of 92%. Respondents expressed strong confidence in the Board's governance, culture, and strategic focus. There was particular praise for a cohesive Board culture and a clearly defined strategic agenda. However, the evaluation also highlighted areas for improvement, specifically a shift in agenda time from routine reporting to more in-depth strategic discussions. The high effectiveness score and positive feedback confirm that the Board is functioning well, indicating a solid foundation for leadership and decision-making. The identified areas for development are not critical failures but represent opportunities to enhance the Board's impact further. If these areas are not addressed, there is a risk that the Board may not fully realise its strategic ambitions potentially limiting the Trust's long-term success. To address these findings, a review of the agenda structure will be undertaken to ensure more time is dedicated to strategic matters. Efforts will also focus on maintaining ongoing investment in Board development to sustain and build upon current strengths.

Proposed Resolution	The Board is asked to receive the findings of the 2025 Board Evaluation and support the identified development actions.

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 Implications	**No**	The Board Evaluation identifies developmental actions only. No financial implications arise from the findings or recommendations.
Legal/ Regulatory	**No**	Board evaluations are a core requirement of the NHS Provider Licence and the CQC Well-Led Framework. The positive results provide assurance of compliance. Recommendations strengthen ongoing adherence.
Impact on Health Inequalities	**No**	The evaluation focuses on Board governance processes. No direct impact on health inequalities is identified.
Impact on Equality, Diversity and Inclusion	**No**	No direct EDI implications arise. However, the positive cultural themes (psychological safety, open challenge) indirectly support inclusive leadership.
Is a Quality Impact Assessment required	**No**	The report does not propose changes to service delivery or clinical pathways; therefore, a QIA is not required

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

1. Introduction

1.1. This report summarises the findings from the Bolton NHS Foundation Trust Board Evaluation conducted in December 2025. The evaluation sought to assess the Board's effectiveness in fulfilling its statutory duties, strategic oversight, and contribution to the Trust's long-term aims.

1.2. Eleven respondents completed the survey, providing both quantitative scores and qualitative comments across 30 statements relating to Board functioning, leadership, behaviours, and governance processes. The qualitative comments provide useful insights into areas of particular strength and highlight opportunities for further enhancement, particularly around strategic focus and meeting structure.

2. Background

2.1. The annual Board Evaluation is a core component of the Trust's governance framework and supports compliance with the NHS Provider Licence and the Well Led Framework.

2.2. The 2025 evaluation was conducted through the Evalu8 online tool, with outputs summarised in this report

2.3. The evaluation explores:

- Board composition, culture, behaviours and effectiveness
- Strategic focus and alignment
- Quality of information and decision making
- Meeting structure, agenda balance, and operational rhythm

3. Key Findings

3.1. Overall, the results indicate a high level of confidence in the Board's effectiveness, with an aggregate score of 1,519 out of a possible 1,650, equating to an overall performance score of 92%.

3.2. The majority of responses fell into the *Agree* or *Strongly Agree* categories, representing approximately 95% of all answers. No respondents selected *Strongly Disagree* or *Disagree.*

3.3. .Overall Scoring Profile

- Analysis of the scoring distribution shows:
- Strongly Agree: 217 responses (65.8%)
- Agree: 96 responses (29.1%)
- Neutral: 16 responses (4.8%)
- Disagree / Strongly Disagree: 0 responses
- N/A: 0.3%

3.4. This profile demonstrates a consistently positive perception of the Board's performance, with very few neutral observations and virtually no negative feedback.

4. Thematic Analysis of Qualitative Feedback

The survey captured free-text comments against key statements. The following themes summarise the collective feedback.

4.1. Strategic Focus and Board Agenda

Respondents generally feel that the Board agenda is well-structured, purposeful, and focused on the right matters. Comments highlighted:

- The agenda "is focused on the right things" and the work plan "adapts to the changing NHS landscape."
- Respondents value the balance between long-term strategy and performance oversight.
- Some felt Part 1 of the agenda is "very full and driven by reporting," with an appetite for:
  - further strengthening alignment with the 10-year plan
  - ensuring enough time for emerging or complex issues
  - enhancing the strategic nature of discussions

These observations suggest that while governance fundamentals remain strong, there may be an opportunity to recalibrate time spent on operational reporting versus strategic foresight.

4.2. Frequency and Structure of Board Meetings

The frequency of meetings was viewed as appropriate, enabling the Board to effectively discharge its duties.

Themes included:

- A "good balance" and appropriate operational rhythm
- Recognition that Trust business operates monthly, with some suggesting a monthly Board meeting would align better
- General satisfaction with meeting scheduling and structure

While there is no pressing concern regarding frequency, opportunities remain to streamline agendas and explore sequencing improvements.

4.3. Board Culture and Leadership Behaviours

A notable theme was the positive culture within the Board. Comments referenced:

- A "cohesive and purposeful group"
- A strong sense of psychological safety
- Honesty and openness contributing to productive dialogue
- A good mix of business and development discussions

These reflections indicate healthy Board dynamics and confidence in leadership behaviours, which supports effective decision-making.

4.4. **Overall Assessment**

The evaluation results reflect a highly effective Board with strong foundations in governance, leadership, and culture. The notable strengths include:

- Clear focus on the Trust's priorities and long-term strategic direction
- A well-organised agenda and work plan
- Positive Board behaviours supporting robust debate and collective responsibility
- Appropriately structured meetings with a balance of operational and developmental content

The few areas for improvement relate less to deficits and more to opportunities for refinement, particularly:

- increasing emphasis on longer-term strategic planning
- reviewing the volume of operational reporting in public meetings
- ensuring sufficient time for complex or emerging issues

5. Chair's Reflection and suggested action plans:

The evaluation report reflects a Board that is high-performing, cohesive, and well-led, with strong culture and governance foundations. The development areas are opportunities to elevate strategic oversight, streamline processes, and strengthen system leadership.

Positives:

1. Chair Leadership
2. Board Culture
3. Clear Governance Processes
4. Balanced & well-constructed Agendas
5. Strategic Oversight

Areas for Development:

a) Agenda balance: too much reporting in Part 1: The board to reflect on the current work plan with a view of balancing strategic discussions with statutory reporting. Would there be further opportunities to delegate to the committees of the board along with utilising the consent agenda to discharge some of the duties.

b) Increased strategic focus and local health economy insight: continue to align the agenda to the trust strategy while reflecting on its alignment with the 10y plan. Highlight the ongoing shift within the organisation that aligns with the 3 shifts.

c) Timeliness & conciseness of papers: review timelines for submission of papers.

d) Strengthening triangulation between committees: Ensure time is spent within Part 1&2 aligning the outputs form the committees of the board.

e) Diversity, new NED integration & risk of groupthink: ongoing OD support in the board development process and continue to maintain a challenging board environment.

Rebalance the Board Agenda Toward Strategy:

a) Introduce a Strategic Focus Slot (minimum 30 minutes) in every meeting.
b) Shift routine reporting into committees with AAA summaries.
c) Explicitly highlight the strategic decisions to the 10-year plan (e.g. workforce, digital, population health).

Enhance Risk Appetite & Foresight:

a) Improve clarity of risk appetite and future-focused risk planning.

b) Consider a future scenarios dashboard

6. Recommendations

The Board is asked to receive and note the findings of the 2025 Board Evaluation and support the suggested action plan set out in the report.

This summary report shows total scores, total percentage scores and a breakdown of responses by category and by individual statement.

Key and Scoring

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

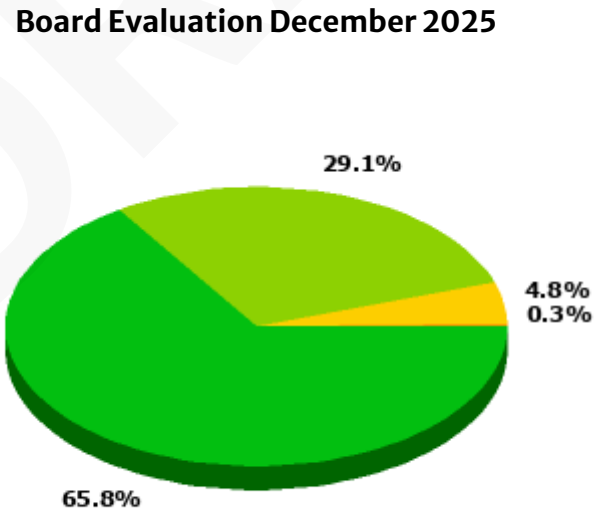
Board Evaluation December 2025

Number of respondents: 11
Number of statements: 30

Table 1

							Score	%age
Board Evaluation December 2025	0 [0%]	1 [0.3%]	16 [4.8%]	96 [29.1%]	217 [65.8%]	0 [0%]	1519/1650	92%

Display 1



Breakdown of report by category

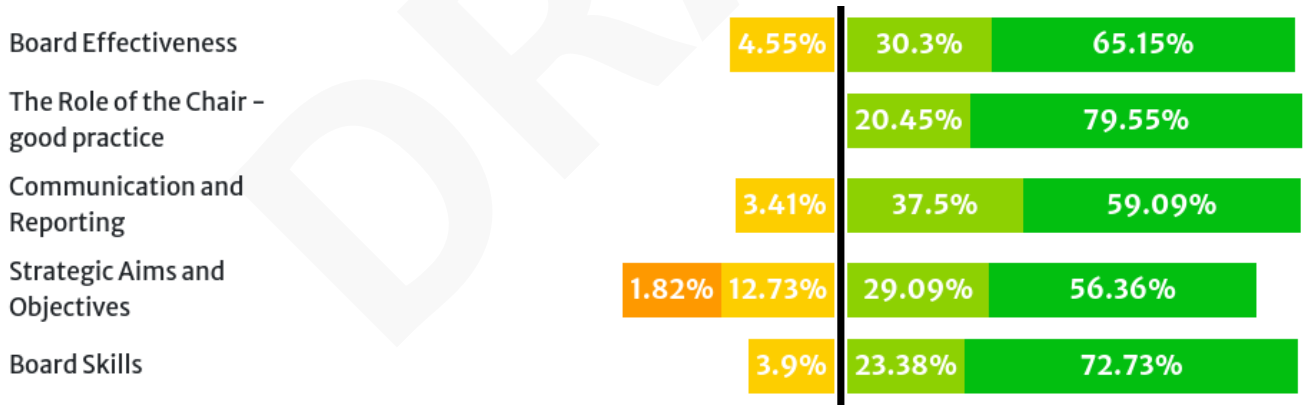
Table 2

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

Board Evaluation December 2025							Score	%age
Board Effectiveness	0	0	3	20	43	0	304/330	92%
The Role of the Chair – good practice	0	0	0	9	35	0	211/220	96%
Communication and Reporting	0	0	3	33	52	0	401/440	91%
Strategic Aims and Objectives	0	1	7	16	31	0	242/275	88%
Board Skills	0	0	3	18	56	0	361/385	94%

Display 2

The following diverging stacked barchart has a common baseline allowing for easy comparison of the data by the length of each bar.



Breakdown of report by individual statements

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

	Board Evaluation December 2025							Score	%age
Board Effectiveness									
1	The Trust's board agenda is dynamic and focused on the right things	0	0	0	4	7	0	51/55	93%
2	The frequency of meetings is appropriate and enables the Board to effectively carry out all of its duties	0	0	1	0	10	0	53/55	96%
3	The balance of time spent on performance management and strategy development is about right	0	0	1	3	7	0	50/55	91%
4	Where the Board has set out the roles and responsibilities of sub-committees, the Board receives full and appropriate reports from them	0	0	0	3	8	0	52/55	95%
5	There are no gaps in reporting lines between committees	0	0	1	6	4	0	47/55	85%
6	There is appropriate detailed discussion focused on decisions required and decision making is clear and transparent	0	0	0	4	7	0	51/55	93%
The Role of the Chair - good practice									
7	The chair leads meetings well with a clear focus on the big issues facing the organisation and allows full and open discussion before major decisions are taken	0	0	0	2	9	0	53/55	96%
8	Sufficient time is given to the proper debate and understanding of business items	0	0	0	2	9	0	53/55	96%
9	The business is appropriately prioritised and debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc	0	0	0	3	8	0	52/55	95%
10	Board meetings are managed effectively	0	0	0	2	9	0	53/55	96%
Communication and Reporting									
11	Papers are received in sufficient time to allow proper consideration and understanding	0	0	0	7	4	0	48/55	87%

Board Evaluation December 2025								Score	%age
12	The quality of Board papers received allows me to perform my role effectively	0	0	0	4	7	0	51/55	93%
13	We listen to ideas and concerns from our patients and service users	0	0	1	5	5	0	48/55	87%
14	We listen to concerns and comments from our staff	0	0	0	4	7	0	51/55	93%
15	Minutes clearly identify debate, actions and who is responsible for them	0	0	1	2	8	0	51/55	93%
16	Performance information is timely and relevant	0	0	0	3	8	0	52/55	95%
17	We receive assurance that the culture we are leading is open, accountable and aligned to purpose, strategy and values	0	0	1	2	8	0	51/55	93%
18	The balance of reporting on quality, operational performance and finance is appropriate	0	0	0	6	5	0	49/55	89%
Strategic Aims and Objectives									
19	The Board monitors the Trust's strategic risks properly and is satisfied that there is the right level of independent scrutiny or constructive challenge from within the organisation	0	0	1	2	8	0	51/55	93%
20	The board understands the implications for the Trust of all relevant local health economy factors and incorporates these into strategic planning	0	0	2	3	6	0	48/55	87%
21	The main risks associated with current and future services are identified, with no significant control issues/gaps and clear responsibilities	0	1	2	3	5	0	45/55	82%
22	The Board receives the right information for board meetings to allow monitoring of the Trust's strategy and its implementation	0	0	1	4	6	0	49/55	89%
23	There are effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services and these are regularly reviewed and improved	0	0	1	4	6	0	49/55	89%
Board Skills									
24	The Board is clear about what the role of the chair and non-executive directors should be	0	0	1	2	8	0	51/55	93%
25	There is trust and respect between executive and non-executive directors	0	0	0	1	10	0	54/55	98%

Board Evaluation December 2025								Score	%age
26	The Board has the right skills to enable it to operate as an effective board	0	0	0	2	9	0	53/55	96%
27	The Board is cohesive and combines being supportive of management with providing appropriate challenge	0	0	0	1	10	0	54/55	98%
28	Working as a team - the Board has the right blend of skills and expertise and personalities and the appropriate degree of diversity to enable it to face challenges successfully	0	0	1	6	4	0	47/55	85%
29	the Board is assured that it has the experience, capability and capacity needed to lead the organisation	0	0	1	2	8	0	51/55	93%
30	Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	0	0	0	4	7	0	51/55	93%

This report shows comments associated with each statement and are coloured to correspond with the given response.

Key

Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A

1. The Trust's board agenda is dynamic and focused on the right things

Part 2 is very good and strategic - Part 1 is very full and driven unfortunately by a lot of requirement reporting ...

The Agenda is focused on the right things.

I think the Board is focussed on the right things but could be even better if there was greater focus on our contribution to the 10 year plan.

We get time to respond and discuss emerging issues
n/a

good range of issues brought up in papers

The Board is a cohesive and purposeful group where honesty and a safe space is created to focus on and transact the Trust business.

Generally yes

Excellent work plan that adapts to the changing ask of the NHS.

Well structured and a good balance between long term strategy and performance management.

agenda feels right

2. The frequency of meetings is appropriate and enables the Board to effectively carry out all of its duties

Monthly would be better as our business is on a monthly cycle. We end up putting in more meetings anyway.
n/a

Good balance

appropriate

The right frequency and good mix of business and development.

The balance between formal Board meetings and the Development sessions works well.

generally yes, and urgent meetings are added when required.

I believe the timings are effective

Yes

The restructuring of board meetings has allowed a more focused approach and provided opportunities for board development in the spaces created.

no issues

3. The balance of time spent on performance management and strategy development is about right

Due to the pressures more time currently is spent on performance management. However to achieve longer term success the balance needs to move towards a more strategic focus.
To the extent that this is in the board's gift I would agree but too much of the agenda is externally mandated

The current agenda has forced more of a focus on the immediate performance agenda. However, the Trust has a strong strategy that is regularly monitored in the strengthened committee structures and development sessions.

Agree
n/a

the time spent on strategy is appropriate

sometimes we need to spend more time on performance and this is usually well managed by the chair.

There's a good balance with the use of the development sessions. Perhaps greater time could be spent on strategy through those sessions.

Good assurance va time spent on strategic direction

As stated in 1.

agree

4. Where the Board has set out the roles and responsibilities of sub-committees, the Board receives full and appropriate reports from them

This work has continued to develop in 2025 with triple A reports drawing out the more salient

points and the Chairs of the committees utilising their skills and experiences to draw out the relevant points at Board.

A very good system of delegation is working well.

The AAA are sometimes lengthy and more like minutes, they need to be more succinct.
This is a strength

yes

Yes

5. There are no gaps in reporting lines between committees

This is essentially the case and the chair's try to manage overlaps and gaps but there is a need to guard against silos

This work has continued to develop in 2025 with triple A reports drawing out the more salient points and the Chairs of the committees utilising their skills and experiences to draw out the relevant points and provide triangulation for the Board.

perhaps better triangulation between the 3 committee's would make the board even more effective.

Committees have refocused their emphasis over the last year. This is being kept under constant review.

Agree
X

6. There is appropriate detailed discussion focused on decisions required and decision making is clear and transparent

As strength

This could be even better if presentations related to key decisions were shared in advance of the meeting.

Agree
The Board is very well chaired and the style of chairing enables the required detailed discussions to draw consensus to decisions.

yes

The discussions are safe but robust and challenging

7. The chair leads meetings well with a clear focus on the big issues facing the organisation and allows full and open discussion before major decisions are taken

Chair is very good and open

Chair brings in all board members
n/a

chair is very inclusive and reads the room very well

He is excellent!

Absolutely.

well chaired and everyone is brough in to speak and have their opinions made.

The Chair always allows full discussion before major decisions are taken.

X

The chair has good insight into this area and ensures the board is focused on key strategic issues. Open discussion is achieved and the board is inclusive.

Great chair always ensures input

8. Sufficient time is given to the proper debate and understanding of business items

This is managed well in Part 2

Agree
The style of chairing enables the required detailed discussions to draw consensus to decisions.

chair handles the meeting well

X

9. The business is appropriately prioritised and debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc

This is a strength

Time management can sometimes be an issue simply down to the volume of business. However a lot of the business has been moved to the Committees which helps.

Chair focusses on important items and paces through other items for information
n/a

definitely good levels of debate

The agendas are well constructed and papers have improved to allow the Board to focus on the important matters and hone the decision making.

yes

The chair has to manage the meeting to time, however, he does allow for debate and the meetings don't feel rushed in anyway.

X

This is a strong feature of this board, the chair is analytical in ensuring that business is appropriately prioritised.

debate is always allowed

10. Board meetings are managed effectively

Work well overall

agree
Agendas and papers are now timely and the Board meetings run smoothly and very professionally.

yes

X

11. Papers are received in sufficient time to allow proper consideration and understanding

Generally this is the case but the dynamic and fast moving nature of some of the issues mean that information is presented at the meeting

This is ongoing and has improved in 2025.

Generally yes although due to time pressures some of the papers do come out a bit late.

As above, sometimes presentations are shared on the day which I don't feel allow sufficient consideration.

Generally papers are on time but could be more succinct

Works well on the vast majority of occasions.

Sometimes papers are late but often due to the dynamic environment we are working in
n/a

the time allowed is appropriate prior to the meeting

yes

agree

12. The quality of Board papers received allows me to perform my role effectively

Reports are too long in my opinion

This is ongoing and has improved in 2025.

Worth exploring if we could make some papers more concise.

agree
yes, but the packs are very large

Could be succinct

13. We listen to ideas and concerns from our patients and service users

We have a patient and staff voice presentation but I am somewhat sceptical about the benefit on occasion
This is ongoing and has improved in 2025.

We have a patient story at our Board meetings which are supported by staff. Board members also have walkabouts which are reported on .

Yes but could do better at getting the community involved

This is well established, worth exploring if we could make this even more prevalent.

agree - but not sure what actions we take as a result, what difference does it make
n/a

good patient and staff stories

always start with a service user voice.

There is a patient story included at every Board and feedback from Board walk-abouts.

agree

14. We listen to concerns and comments from our staff

This is ongoing and has improved in 2025.

We do have staff stories both at the Board and Committee but perhaps we should have more of these. We also have reports at Committees which are more focused on staff issues.

Yes this works well.

agree
n/a

This is a strength

definitely effective regarding this

yes, service user and patient voice starts and sets the tone of the meeting.

There is a staff story included at every Board meeting and feedback from Board walk-abouts.

Yes

agree

15. Minutes clearly identify debate, actions and who is responsible for them

i would need to study the minutes more to assess this - if i had the time
Minutes are good
The minute taking for the Board is accurate and timely.

yes

Yes

agree

16. Performance information is timely and relevant

usually, though it is rear view, and we could introduce more recent information on ops to include how it is currently going in the week of board
Good data and supporting presentation

Data and information is very relevant and presented to the Board in a useable format allowing timely decision making.

yes. as finance meeting is only the day before this information can be delayed.

Yes

17. We receive assurance that the culture we are leading is open, accountable and aligned to

purpose, strategy and values

I cannot say that I can get this from the papers easily, lots of information and papers on this but not sure overall I could answer this question
Good approach to an open culture
This comes strongly through the people committee

Absolutely, the Board is a safe space for transparent and open conversations.

yes and through people committee and soft intelligence of visits

18. The balance of reporting on quality, operational performance and finance is appropriate

Yes - in the context previously described of insufficient local choice re some agenda items

bit more on quality as opposed to finance would be helpful

This is well triangulated and during 2025 there has been a much closer synergy across these areas. Quality and operational performance are synonymous and both are now considered in the QAC.

finance can often dominate.

We constantly reflect on this question , it is something that we need to keep challenging as financial and operational pressures can demand a lot of attention.

agree
n/a

This will vary depending on the issues at the time but overall there is a good balance.

There is also reporting on our people agenda too.

X

agree

19. The Board monitors the Trust's strategic risks properly and is satisfied that there is the right level of independent scrutiny or constructive challenge from within the organisation

I think the BAF has moved on but other Trusts have managed to keep it more simple and strategic. The BAF has come a long way in helping the Board look at risks. Probably more work required on Risk Appetite.
The BAF and CRR have been scrutinised in detail at all committees as appropriate. The committees have fed into the Board level discussion. The BAF is a dynamic document and I have seen its evolution over the last 2 years to a tool that is understood, valued and fully utilised at the Board to underpin the Trust business. Its ownership now spanning corporately rather than just with the

Director of Corporate Governance.

yes

20. The board understands the implications for the Trust of all relevant local health economy factors and incorporates these into strategic planning

I believe the Board understands the local health economy, however, the Board could do even better if this was factored into strategic planning more.

We need to put this q to the board, I am not sure
Bolton is a multi cultural community and the Board is aware of these in its planning.

more could potentially be done on health economics.

We are highly focused on this issue, however I believe we need to continually seek assurance in relation to meeting the needs of local communities.
n/a

Good at wider determinants of this is not the focus of NHSE etc

this is reflected in discussions as well as papers

The benefit of being an integrated trust allows the Board to have a very wide ranging reach and focus. The Trust Board understands the place and importance in the local economy and has developed a strategic and locality plan that dovetails nicely to ensure that the focus is broader than the hospital.

X

agree

21. The main risks associated with current and future services are identified, with no significant control issues/gaps and clear responsibilities

I could not be certain that there were no gaps in controls with regards to risks of future services. Possibly not as big a focus as the here and now of finance and performance

We have a risk committee and it reports via audit so it should be in there
The BAF is dynamic and identifies main risks and responsibilities. All controls and gaps are clear, and by its very nature, it is always work in progress.

The only area of possible uncertainty in this area is around future services given the impact of the NHS Plan and how this might play out across GM.

Yes , I think we are strong in this aspect.

n/a

clearly articulated

yes - more work on PLICS please

X

agree

22. The Board receives the right information for board meetings to allow monitoring of the Trust's strategy and its implementation

i think this is a gap
This will always be work in progress and the Board has a strong oversight to allow it to be monitored
yes

23. There are effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services and these are regularly reviewed and improved

we get an annual review of this via internal audit
These have been strengthened and allows a stream lined decision making.

yes

24. The Board is clear about what the role of the chair and non-executive directors should be

Could do with an annual refresher on the different roles
There is real clarity in the role of NED/Chair v Exec team.

Board development been fundamental to supporting the board to act more effectively within a psychological safe space.

We are constantly exploring this issue during board development work.

25. There is trust and respect between executive and non-executive directors

agree
This has grown and matured this year.

yes absolutely with the above.

26. The Board has the right skills to enable it to operate as an effective board

However, the Board is about to change with three new non-executive directors

although significant change in NEDs will create instability in the short term
The Board dynamics will change shortly as two of the NEDs stand down. Currently the Board is well balanced.

yes

27. The Board is cohesive and combines being supportive of management with providing appropriate challenge

but is it a bit too cosy?
n/a

Good board dynamics - the retiring NEDs will be a loss

there is plenty of this in board

The Board is certainly cohesive and provides critical challenge in a constructive and supportive manner.

A very strong Unitary Board where the members are encouraged and allowed to express their views. The same is true of the Committees.

yes

I agree

Developed a good varied team

A good board culture exists and colleagues are constructive in their challenge and respectful to each other.

agree

28. Working as a team - the Board has the right blend of skills and expertise and personalities and the appropriate degree of diversity to enable it to face challenges successfully

Yes to the previous board, but new members on it so need to see
There is a slight risk of group think - there are only one or two different voices - they need to be encouraged

Still some room for further diversity

The Board could benefit from further diversity.

The only issue is the extent to which we are diverse as a Board in terms of its representation.

Note my comment above

The board is going through a phase of transition, following the appointment of a number of new members. We need to ensure that we effectively support new colleagues.
n/a

yes - however changes to the NEDS will mean change to the Board.

Good team approach with unitary accountability

agree

29. the Board is assured that it has the experience, capability and capacity needed to lead the organisation

need to see impact of new NEDs and also need to skill up in view of the changes nationally around the expectations of boards
All committees undertake an effectiveness audit, the Chair does the NED appraisals and utilises the skills of the NEDs accordingly. These appraisals are mirrored in the Exec team. There is a wide variety of skills and expertise across Board members that give the organisation assurance of an experienced and skilled Board. There is always room for further development and improvement and the Board development sessions have contributed to our growth this year.

as above.

30. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance

Generally this is the case and the chair's is good at addressing this

There are occasions where clarification is sought, however, on the whole there is real and genuine challenge.

I believe that mature and well considered challenge is demonstrated by the non executives. This is done in such a way as to move the organisation forward.

challenge is always constructive
n/a

the challenge is proportionate and appropriate

The Board provides critical challenge in a constructive and supportive manner.

I think the strength of the Board is also down to the strength of the Committees where much of the discussion and debate takes place.

especially over the period of the board development programme. The Chair has led on this, and should be proud of their achievements.

Yes

great and safe challenge

General comments for the Board Evaluation December 2025 appraisal.

Board is always a supportive environment – i think it just needs to respond to the new challenges facing the trust

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Overall It is a strong Board and works effectively with genuine support and respect for each other. The upcoming challenges will test this and it is important to remain committed as a Unitary Board during this time.

It is a great Board to work in and the relationships have flourished this year to creates and promotes a safe space in a tough and challenging environment. This culture allows for all to be the best they can be and face these challenges as a cohesive Board together.

Overall an excellent, talented and cohesive board – main risks are responding to NHSE dictats and guarding against group think – keep working on recognising challenging voices

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A well chaired board, which is characterised by reflective practice and continuous improvement. This board is constantly seeking to enhance governance and to build a strong culture of accountability. I believe we work well well as a unitary board and demonstrate respect and insight in their challenge way we conduct our business.

Report Title:	Corporate Governance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	✓
Executive Sponsor	Director of Corporate Governance		Decision	✓

Purpose of the report	This report details the corporate structure and plans for 2026, supporting the Board's workplan and ensuring strong, aligned governance.

Previously considered by:	The report forms part of the annual Board update and incorporates feedback from the Committee Effectiveness Surveys.

Executive Summary	This report summarises the arrangements planned for 2026 and provides an overview of the annual Committee Effectiveness Reviews for 2025. Its purpose is to give the Board clear assurance that all five Board committees are functioning effectively, meeting their Terms of Reference, and making valuable contributions to the Trust's governance framework. Overall effectiveness scores ranged from **92% to 96%**, reflecting sustained high performance and further improvement compared with previous years. Consistent themes of strength included effective chairing, disciplined meeting management, high-quality papers, timely information, and well-established assurance processes across all committees. Each committee demonstrated clear alignment to its remit, whether overseeing quality, finance, workforce, charitable funds, or corporate control and risk, ensuring robust scrutiny and support for the Trust's strategic ambitions. Cross-cutting development themes emerged around strengthening triangulation between committees, balancing operational and strategic agenda items, further developing analytical capability, and enhancing the flow of assurance across the governance system. Taken together, the results confirm a mature and continuously improving governance environment, with targeted opportunities identified to refine strategic oversight and inter-committee connectivity to further strengthen the Trust's assurance model.

Proposed Resolution	The Board is asked to receive the Corporate Governance 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**	
Quality Impact	**No**	

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

1. Introduction

1.1. NHS Foundation Trusts (FTs) are established as public benefit corporations under the National Health Service Act 2006. This legislation gives FT Boards of Directors the authority to make their own financial and strategic decisions, within a governance system that also ensures local accountability through a Council of Governors elected by members.

1.2. While FTs remain part of the NHS, they are authorised by NHS England and operate under its licence, rather than being directly accountable to the Secretary of State for Health & Social Care.

2. Corporate Governance

2.1. Corporate governance is the system by which an organisation is directed and controlled at its most senior levels, to achieve its objectives and meet the necessary standards of accountability and probity.

2.2. Effective corporate governance, along with clinical governance, is essential for the Trust to achieve its clinical, quality, and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control which is achieved through independent review and assurance.

2.3. Bolton NHSFT aspires to have a leading edge system of governance, learning from best practice elsewhere and enabling it to deliver the highest standards of conduct and accountability.

3. Board of Directors

3.1. The Board plays a key role in shaping the strategy, vision, and purpose of the organisation. It is responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money.

3.2. The Board provides proactive leadership within a framework of prudent and robust controls, facilitating thorough risk assessment and management. Collectively, the Board is accountable for ensuring that risks to the organisation and the public are effectively identified, managed, and mitigated.

3.3. The Board reinforces its commitment to openness and transparency in its work. All Board meetings are held in public with all dates, times and meeting papers published on the Trust website

4. Board Composition

4.1. The Constitution states that the Board of Directors must comprise a non-executive Chair, a minimum of five non-executive directors (NEDs) and a minimum of five executive directors. The number of executive directors must not exceed the number of NEDs including the Chair.

4.2. The Code of Governance, which the Trust has due regard to, states that every Trust should be led by an effective and diverse Board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the Trust and generating value for members, patients, service users and the public.

4.3. There is a separation of powers between the Chair, who is independent and chairs both the Board of Directors and the Council of Governors, and the Chief Executive who holds executive responsibility for the management of the organisation.

4.4. The following changes took place during 2025

- Rebecca Ganz stepped down from her role as a NED on 31 December 2025. Rebecca joined the Trust in 2018 firstly as Chair of IFM before becoming a NED with the Trust in January 2019.
- Alan Stuttard joined the Trust as a NED in January 2018 and his tenure concluded on 7 January 2026 following joining
- Dr Francis Andrews will be retiring from his role as the Medical Director on 31 January 2025. Dr Rauf Munshi will take up the role of Executive Medical Director from 1 February 2026

4.5. To this end, the Trust undertook a comprehensive recruitment exercise with a view to appoint two NEDs and a Chair for the Audit and Risk Committee. The following individuals have joined the Baord from 1 January 2026.

- Tony Allen will assume the role of Chair of the Audit and Risk Committee
- Ian Williamson
- Janat Hulston
- Tirivake Mutambasere appointed as Associate NEDs
- Gita Bhutani is joining the Trust as an Associate NED under the NHS England NExT Director programme.

5. 2026 Board Development and Strategy Sessions

5.1. Bolton NHS FT reinforces its commitment to openness and transparency in its work. All dates, times and meeting papers of the Board are published on the Trust website.

5.2. Meetings of the Board of Directors will continue to be held on the last Thursday of every other month. The meetings will all be held in the Boardroom, Trust HQ.

5.3. While the implementation of robust governance documentation and structures is essential, these measures alone are insufficient to achieve the Board's objectives. The Board recognises that attaining the highest standards of governance depends fundamentally on its operational approach, organisational culture, and behaviours. To this end, a continuous programme of Board and organisational development will be maintained to reinforce and support the Board's commitment to regular evaluations of performance, ensuring the organisation consistently meets its aspirations.

5.4. In those months where a Board meeting is not scheduled, discrete sessions focussing on Strategy or Board development are usually held.

5.5. For 2026, it is proposed that these sessions will be held as follows:

- 26 February Board Strategy Session
- 30 April Board Development Session
- 25 June ExtraOrdinary Board
- 01 July Annual Service Review Day
- 13 August Board Development Session
- 29 October Board Strategy Session
- 17 December Board Strategy Session

6. Board Committees

6.1. A governance framework and associated processes are in place across the organisation to ensure that information flows clearly to the Board, providing assurance where possible and highlighting risks identified through gaps in control or gaps in assurance.

6.2. In line with statutory requirements, the Trust has an Audit and Risk Committee and Remuneration Committee whose membership consists of NEDs.

6.3. The Board has delegated scrutiny of assurance process relating to workforce, quality and finance to the following assurance committees:

- Finance and Investment Committee
- Quality Assurance Committee
- People Committee

6.4. The Committees work together to provide an integrated approach to governance which is supported by common membership of Board members across the committees. Each Committee is chaired by a Non-Executive Director and both Executive and Non-Executive Directors form part of the membership. Each of the Committees has Terms of Reference

and a plan of work which are reviewed annually and used as the basis of an annual assessment of Committee effectiveness.

6.5. In accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, the Trust Board has formally established the following Committees and delegated authority to these via agreed Terms of Reference:

- Audit and Risk Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People Committee
- Charitable Funds Committee

7. Committee Effectiveness Reviews 2025

In line with the Trust's governance framework and good practice, annual effectiveness reviews were undertaken for all Board committees during 2025. The reviews provide independent assurance to the Board that each committee is fulfilling its Terms of Reference, operating effectively, and offering robust oversight across its respective domains. The surveys were conducted between October and November 2025 and demonstrate consistently strong levels of performance across all committees (92–96%), with clear evidence of continued improvement from previous years.

A detailed report was presented to each Committee during November meeting cycle to enable the committees to review the results and address any recommendations stemming from the reviews.

7.1. Cross-Committee Themes (Comparative Review)

Overall Effectiveness Scores

- F&I – 96%
- ARC – 93%
- QAC – 93%
- People – 92%

7.2. **Common Strengths**

- Strong chairing, meeting discipline, and clarity of purpose.
- High quality of papers and timeliness.
- Committees viewed as effective and valuable assurance forums.

7.3. **Cross-Cutting Development Themes**

- **Balanced agendas:** Need to ensure an appropriate balance between quality, performance, finance, governance, and risk.
- **Improved triangulation:** Strengthen inter-committee assurance flow to enhance collective oversight.

- **Enhanced strategic focus:** Use dashboards, benefit-realisation reporting, and improved analytics to elevate strategic discussions.
- **Membership resilience:** Noted particularly for ARC.
- **Technical capability:** Required for specific areas with

A summary of the key findings, strengths, and development themes from each committee, as well as cross-cutting insights identified through the comparative review is included below:

7.4. Finance and Investment Committee

The Finance and Investment Committee is a decision making committee of the Board and provides assurance to the Board on finance, estates, digital and sustainability matters. It holds responsibility for approving decisions within the Financial Scheme of Delegation, and reviews financial strategy, plans, and performance for the Trust and its wholly owned subsidiary IFM.

In 2025, the Committee was chaired by Rebecca Ganz (Non-Executive Director). Each meeting maintained an appropriate balance of executive directors and non-executive directors in attendance. All meetings were duly constituted, with participation from executive directors, non-executive directors, and, as needed, senior management presenting their reports.

Summary of Findings

The Committee continues to benchmark strongly, achieving the highest effectiveness score (96%). Financial governance is well established, with rigorous scrutiny of financial plans, investment cases, and performance reporting.

- Results were highly positive, comparing favourably with 2023 and 2024.
- The Committee provides robust financial oversight and rigorously reviews business cases and investment decisions.

Strengths

- Strong financial scrutiny and linkage to strategic ambitions.
- Effective monitoring of financial performance, risks, and sustainability.
- Good review of CIPs and major business cases.

Areas for Development

- Need to better balance cost and income considerations within discussions.
- Requests for papers and presentations to be circulated earlier.
- Opportunities to strengthen technical capability (mirroring comparative review themes).

7.5. Quality Assurance Committee (QAC)

The Quality Assurance Committee is responsible for providing assurance to the Board on the quality and safety of patient care, promoting systems that safeguard and improve the experience and outcomes of patients, carers, staff and visitors.

In 2025, the Committee was chaired by Fiona Taylor (Non-Executive Director). Each meeting maintained an appropriate balance of executive directors and non-executive directors in attendance. All meetings were duly constituted, with participation from executive directors, non-executive directors, and, as needed, senior management presenting their reports

Summary of Findings

QAC continues to strengthen its role in providing assurance on quality, safety, patient experience, and clinical governance. The Committee demonstrates strong alignment with Trust strategic objectives and increasingly effective scrutiny of quality risks.

- Results were positive, confirming continued improvement since 2024.
- The Committee maintains strong oversight across quality, governance, patient safety, and risk.

Strengths

- Effective assurance processes and clear governance pathways.
- Good alignment with strategic objectives.
- Constructive challenge and well-structured scrutiny of quality and risk performance.

Areas for Development

- Opportunities to refine dashboards and increase triangulation with other committees
- Further enhancement of strategic focus within agendas.

7.6. Audit and Risk Committee

The Audit and Risk Committee is a statutory Board committee that reviews governance and assurance processes, including internal controls, risk management, and audit functions. The Audit and Risk Committee provides independent assurance on the Trust's governance, risk management, and internal controls for all activities, ensuring compliance with legal and regulatory standards.

In 2025, the Committee was chaired by Alan Stuttard, Non-Executive Director. All meetings were properly constituted, attended by non-executive directors who serve as committee members. The internal audit, external audit, and counter fraud functions provided regular input.

Summary of Findings

The Audit & Risk Committee continues to provide robust oversight of governance, risk management, compliance, and internal control. Results show further improvement since 2024, with strong chairing, effective challenge, and well-structured scrutiny processes consistently in evidence.

- Overall results were positive, showing further improvement since November 2024.
- The Committee continues to meet its Terms of Reference effectively and remains a strong oversight mechanism for audit, risk management, governance, and internal control.

Strengths

- Strong chairing and structured meetings.
- Effective challenge and oversight of key risk and assurance processes.
- Continued progress in embedding strong governance arrangements.

Areas for Development

- Some opportunities identified to strengthen specific assurance areas (minor and non-critical).
- Continued focus needed on deepening assurance triangulation and ensuring consistency of scrutiny across the full risk spectrum.

7.7. Charitable Funds Committee (CFC)

The Charitable Funds Committee oversees the control, management and use of charitable funds on behalf of the Corporate Trustee, ensuring all decisions comply with Charity Commission requirements and delegated powers while assuring the effective operation of *Our Bolton NHS Charity*

In 2025, the Committee was chaired by Martin North (Non-Executive Director). Each meeting maintained an appropriate balance of executive directors and non-executive directors in attendance. All meetings were duly constituted, with participation from executive directors, non-executive directors, and, as needed, senior management presenting their reports

Summary of Findings

CFC demonstrates strong governance in the oversight and management of charitable funds, with clear alignment to Charity Commission expectations and Trust charitable strategy. Overall performance was positive with maturing committee processes. Overall performance was positive, indicating compliance with Terms of Reference and maturing governance processes.

Strengths

- Clear governance framework and effective use of delegated authority.
- High satisfaction with documentation, clarity of committee purpose, and operational support.
- Strong alignment with broader Trust charitable objectives.

Areas for Development

- Minor opportunities identified through free-text comments, mainly relating to increased strategic focus and process enhancements.

7.8. People Committee

The People Committee oversees workforce-related governance, ensuring the Trust has effective systems for leadership, wellbeing, recruitment, retention, culture and workforce performance in line with strategic ambitions.

In 2025, the Committee was chaired by Sean Harriss (Non-Executive Director). Each meeting maintained an appropriate balance of executive directors and non-executive directors in attendance. All meetings were duly constituted, with participation from executive directors, non-executive directors, and, as needed, senior management presenting their reports

Summary of Findings

The People Committee continues to be a valued forum for workforce assurance, achieving an effectiveness score of 92%. Strong chairing, high engagement, and well-organised meetings were noted throughout the year. Overall effectiveness score of 92%, reflecting a well-functioning committee with strong engagement.

Strengths

- High levels of agreement across statements, indicating confidence in governance and oversight.
- Excellent chair facilitation (98% score).
- Strong secretariat support and meeting management.
- Committee recognised as a valuable leadership forum on workforce matters.

Areas for Development

- A more consistent strategic focus is required, with the committee spending proportionately more time on operational matters than intended.
- Need for enhanced critical challenge on workforce metrics and improved workforce profiling.

8. Conclusion

The 2025 Committee Effectiveness Reviews confirm that the Trust's governance system is strong, high-performing, and continuously improving. Committees are functioning effectively and providing the Board with robust assurance. The recommendations outlined in this report offer targeted opportunities to further enhance triangulation, strategic focus and analytical capability, ensuring the Trust maintains a modern, integrated, and forward-looking governance framework.

Report Title:	Integrated Performance Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	✓
Executive Sponsor	Deputy Chief Executive/Chief People Officer		Decision	

Purpose of the report	To present the Month 9 Integrated Performance Report

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

Executive Summary	The Integrated Performance Report provides an overview of the Trust's performance against the reported metrics during December 2025. This report is intended to offer a transparent and accessible account of the Trust's outcomes for both patients and staff. The narrative included describes issues that are affecting performance and any mitigating actions to improve performance and meet key standards. Each of the relevant Executive Directors will provide a short overview of the key critical areas outlined in the report.

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	**No**	
Legal / Regulatory	**No**	
Health Inequalities	**No**	
Equality, Diversity and Inclusion	**No**	

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

Bolton NHS Foundation Trust

Integrated Performance Report

December 2025

Guide to Statistical Process Control

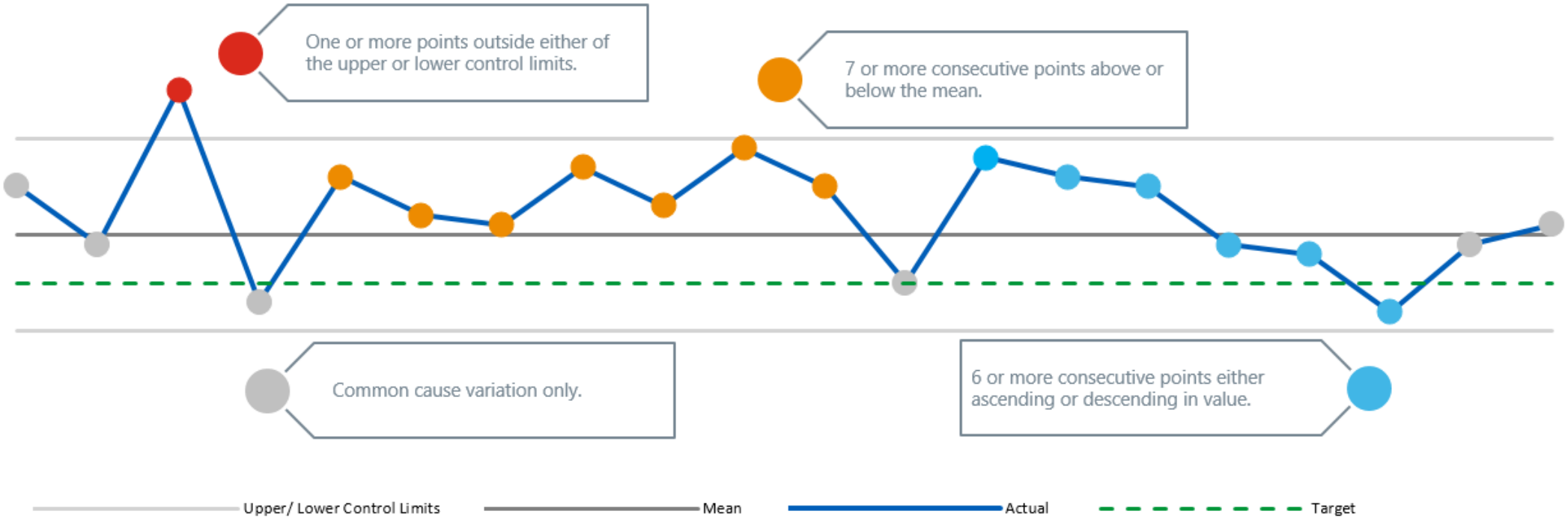
NHS Bolton NHS Foundation Trust

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		
		H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	12	2	3	1	1	1	3	12
Infection Prevention and Control	9	0	0	0	0	0	0	7
Mortality	5	2	1	0	0	0	0	3
Patient Experience	12	1	0	0	3	2	0	14
Maternity	6	3	1	0	0	1	0	8
Operational Performance								
Urgent Care	10	1	1	0	1	2	6	5
Elective Care	8	0	5	1	1	1	7	4
Cancer	2	1	0	0	0	1	0	2
Community Care	5	2	1	0	0	0	2	6
Workforce								
Sickness, Vacancy and Turnover	1	0	2	1	0	0	2	1
Organisational Development	3	1	0	0	2	1	2	3
Agency	1	0	2	0	0	0	2	1
Finance								
Finance	1	0	0	0	2	1	1	1
Appendices								
Heat Maps								

Variation

	Common cause variation.
H	Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
L	Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
H	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
L	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.

Assurance

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

Bolton NHS Foundation Trust

Pressure Ulcers

During the reporting period, Category 2 and Category 3 pressure ulcers across both inpatient and community services remained within common cause variation. Community acquired Category 4 pressure ulcers demonstrated special cause variation with an astronomical point suggesting review required, with three cases reported thereby outside of control limits. To note these are subject to minimum 90 day validation and require understanding of location (e.g. residential / nursing / private dwelling). To date, no significant learning identified as per chart 536 and 537.

Within inpatient settings, hospital acquired Category 2 pressure ulcers remain in common cause variation.

Following the Chief Nurse's request, a full review of all Category 4 pressure ulcers across all areas has been completed to support learning and improvement. Early findings indicate that a proportion of cases featured patient vulnerability—such as malnutrition, moisture damage, vascular disease, or end of life care where comfort was appropriately prioritised. The review also identified variation in documentation, inconsistency in the application of preventative interventions, and delays in recognising deterioration, which together suggest elements of potential avoidability in some cases.

The findings will be presented through the formal governance committees, with targeted improvement actions overseen by the Pressure Ulcer Steering Group to strengthen clinical practice and support ongoing learning across all divisions.

Note: Pressure ulcer data remains unvalidated for 90 days post-reporting to allow for PSIRF review and category evolution

Falls

Falls per 1,000 bed days has returned to common cause variation following a period (9 months) of special cause variation (reduced falls). No specific action required at present. Data will continue to be monitored with analysis of any emerging themes (if any) the driver for any additional improvement activity.

During the reporting period, four falls resulted in harm, noting also the variable range month on month demonstrates potential for increased reliability with interventions targeted at reducing falls. All falls with harm were reviewed through the Patient Safety Review Panel, where learning was identified relating to the completion of falls assessments and the importance of communicating with patients about seeking assistance.

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 was approved at Clinical Governance and Quality Committee in November and this changes will be reflected in the next published report in February.

Patient Safety Incident Investigation turnaround performance by agreed deadline

In Month 9 there was one PSII report for approval from Surgery Division. This was not approved within the 60 day approval deadline due to a delay in the report being submitted by the specialty and then requiring further amendments. The report has subsequently been received and signed off and the Executive Sign off Panel.

	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%	94.9%	Dec-25		>= 95%	94.9%	Nov-25	>= 95%	95.3%	
9 - Never Events	= 0	0	Dec-25		= 0	0	Nov-25	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	6.43	Dec-25		<= 5.30	4.55	Nov-25	<= 5.30	5.90	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	4	Dec-25		<= 1.6	5	Nov-25	<= 14.4	21	
15 - Number of Acute Inpatient incidences - pressure damage (category 2)	<= 6.0	16.0	Dec-25		<= 6.0	5.0	Nov-25	<= 54.0	105.0	
620 - Number of Acute Inpatient incidences - pressure damage (category 3 plus unstageables)	<= 1	4	Dec-25		<= 1	4	Nov-25	<= 5	34	
17 - Number of Acute Inpatient incidences - pressure damage (category 4)	= 0.0	0.0	Dec-25	L	= 0.0	0.0	Nov-25	= 0.0	0.0	
18 - Number of Community incidences - pressure damage (category 2)	<= 7.0	18.0	Dec-25		<= 7.0	2.0	Nov-25	<= 63.0	102.0	
621 - Number of Community incidences - pressure damage (category 3 plus unstageables)	<= 4	3	Dec-25		<= 4	7	Nov-25	<= 36	60	
20 - Number of Community incidences - pressure damage (category 4)	<= 1.0	3.0	Dec-25	H	<= 1.0	0.0	Nov-25	<= 9.0	10.0	
535 - Community patients acquiring pressure damage - significant learning category 2		0	Dec-25	L		0	Nov-25		0	
536 - Community patients acquiring pressure damage - significant learning category 3		0	Dec-25			0	Nov-25		0	
537 - Community patients acquiring pressure damage - significant learning category 4		0	Dec-25	L		0	Nov-25		0	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	79.2%	Dec-25	H	>= 95%	77.7%	Nov-25	>= 95%	77.9%	F
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	58.3%	Dec-25	L	>= 95.0%	62.8%	Nov-25	>= 95.0%	60.5%	F
86 - Patient Safety Alerts - Trust position	= 100%	100.0%	Dec-25		= 100%	100.0%	Nov-25	= 100%	72.2%	

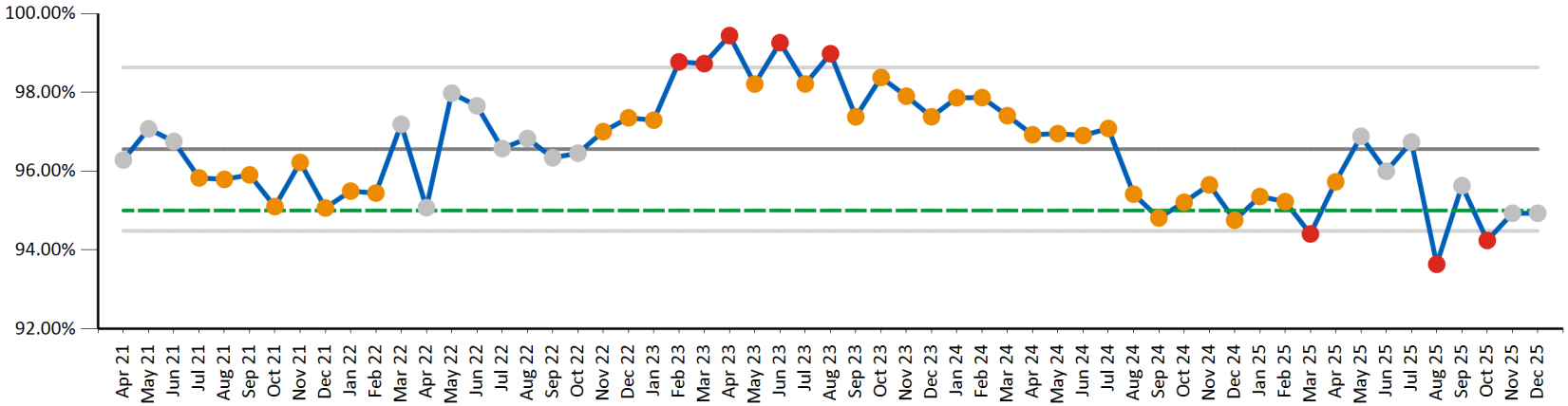
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
88 - Nursing KPI Audits	>= 85%	96.3%	Dec-25	H	>= 85%	96.1%	Nov-25	>= 85%	96.2%	P
91 - Patient Safety Incident Investigation turnaround performance by agreed deadline	= 100%	100.0%	Dec-25		= 100%	50.0%	Nov-25	= 100%		?
8 - Same sex accommodation breaches	= 0	13	Dec-25		= 0	24	Nov-25	= 0	121	F

6 - Compliance with preventative measure for VTE

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 95%	94.9%	Dec-25

Previous

Plan	Actual	Period
>= 95%	94.9%	Nov-25

Year to Date

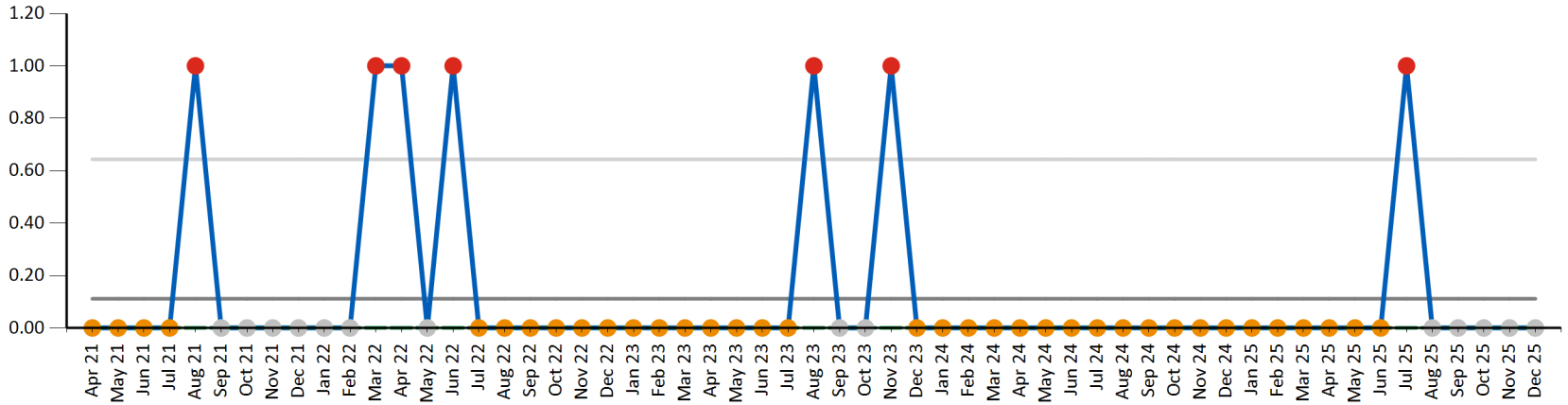
Plan	Actual
>= 95%	95.3%

9 - Never Events

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
= 0	0	Dec-25

Previous

Plan	Actual	Period
= 0	0	Nov-25

Year to Date

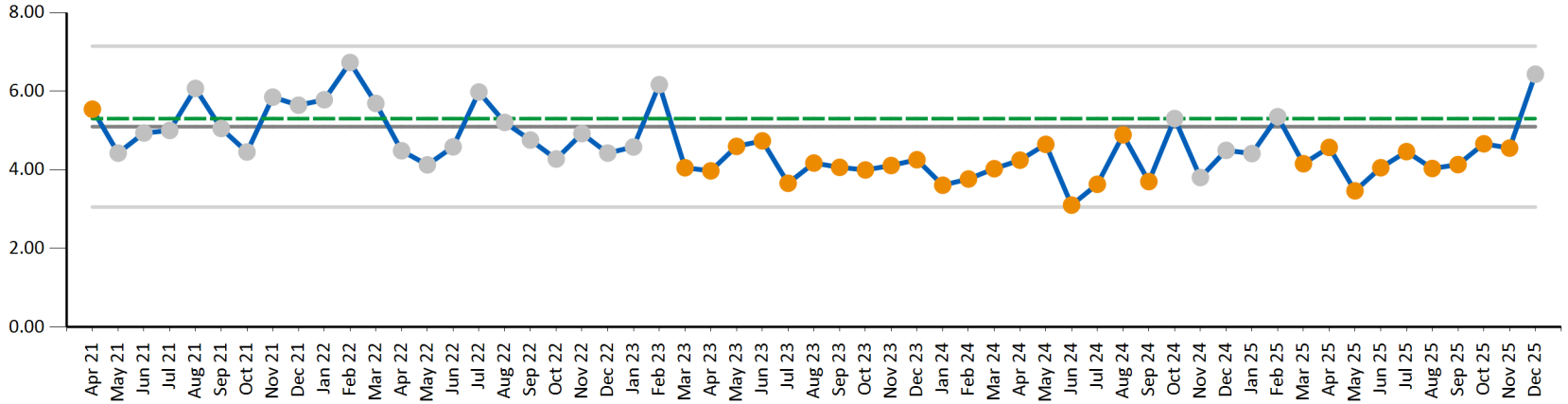
Plan	Actual
= 0	1

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	6.43	Dec-25

Previous

Plan	Actual	Period
<= 5.30	4.55	Nov-25

Year to Date

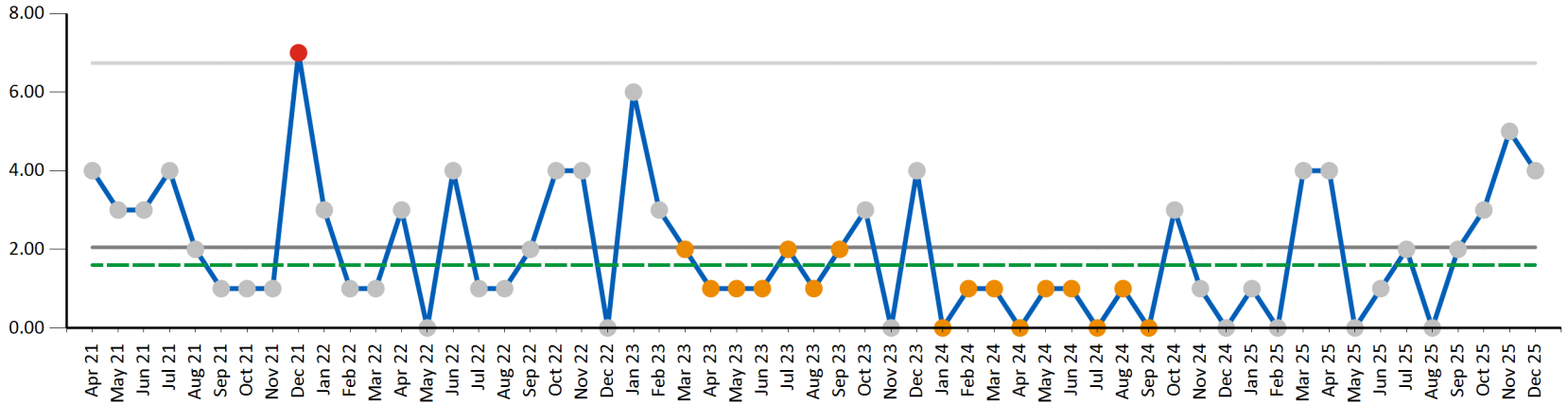
Plan	Actual
<= 5.30	5.90

14 - Inpatient falls resulting in Harm (Moderate +)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
<= 1.6	4	Dec-25

Previous

Plan	Actual	Period
<= 1.6	5	Nov-25

Year to Date

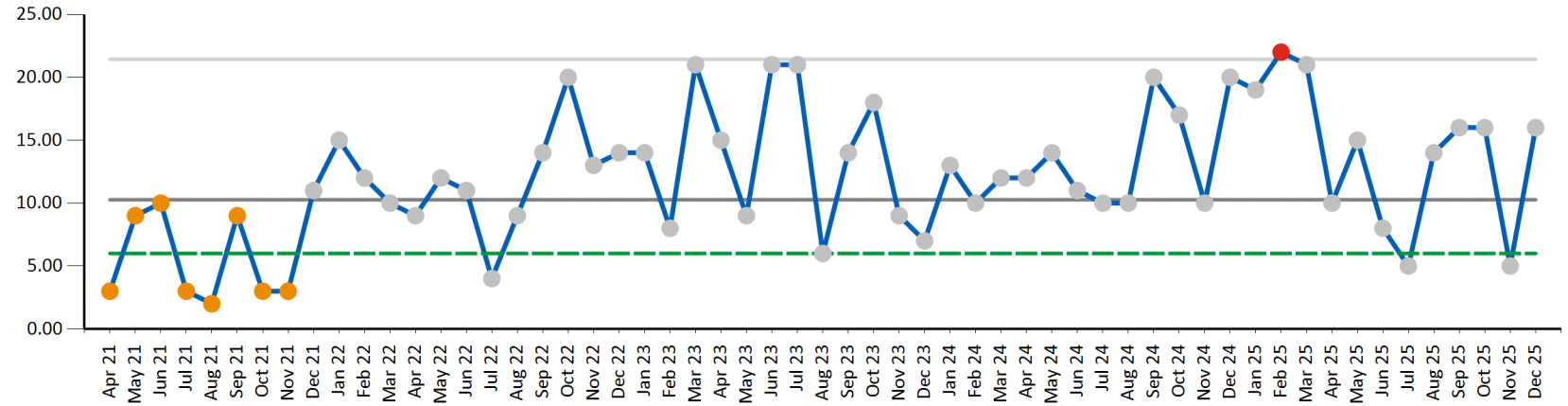
Plan	Actual
<= 14.4	21

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 6.0	16.0	Dec-25

Previous

Plan	Actual	Period
<= 6.0	5.0	Nov-25

Year to Date

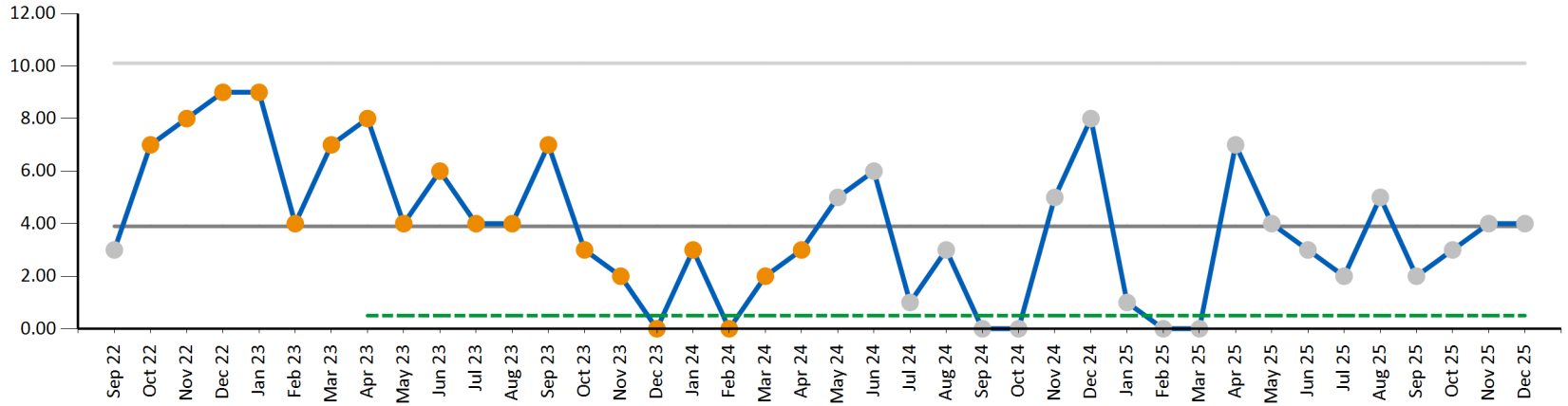
Plan	Actual
<= 54.0	105.0

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.

0/6



Latest

Plan	Actual	Period
<= 1	4	Dec-25

Previous

Plan	Actual	Period
<= 1	4	Nov-25

Year to Date

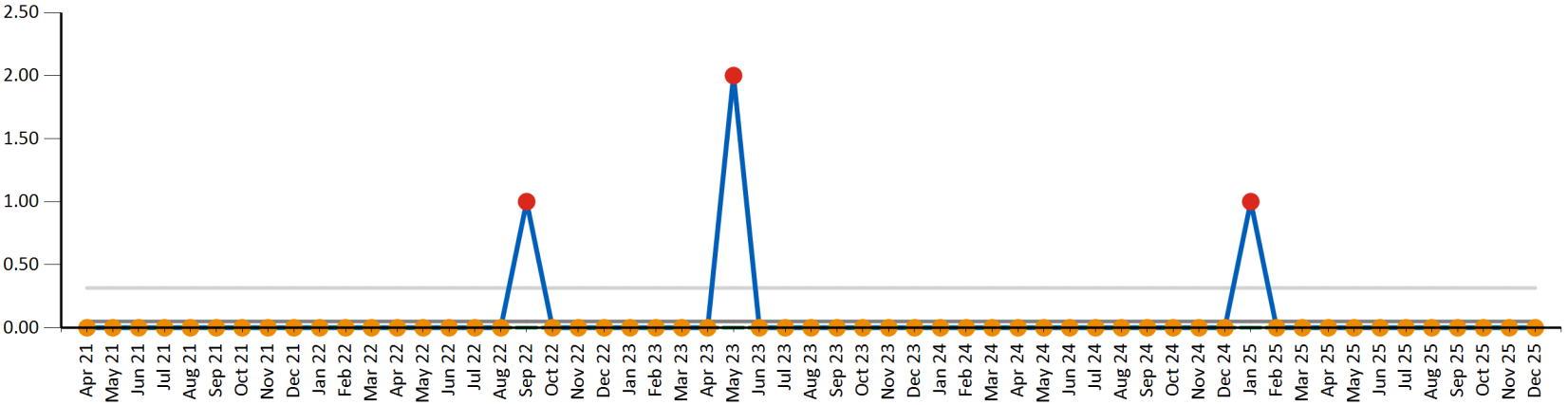
Plan	Actual
<= 5	34

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	Dec-25

Previous

Plan	Actual	Period
= 0.0	0.0	Nov-25

Year to Date

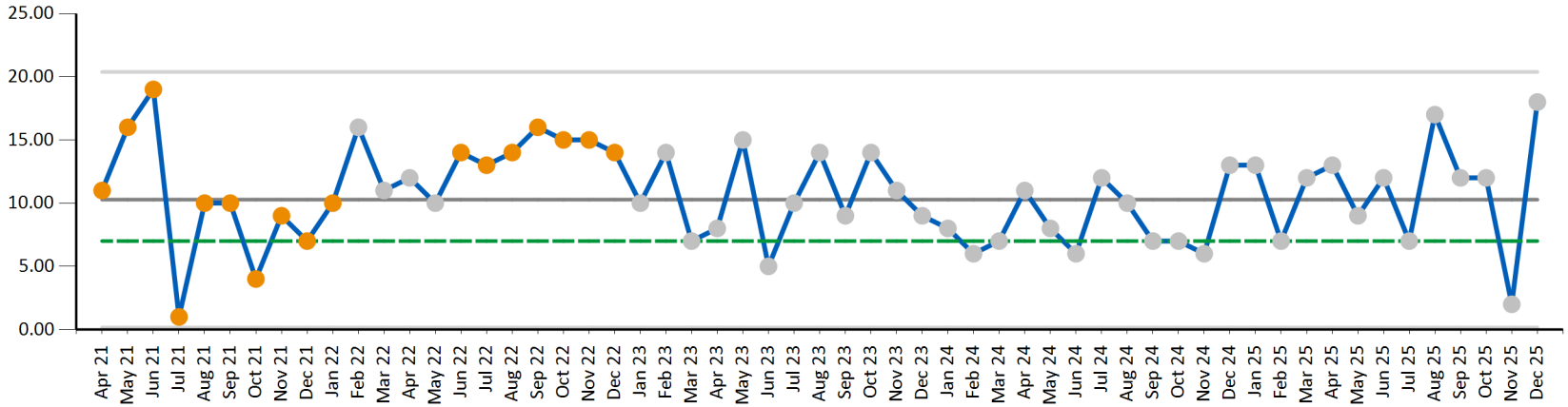
Plan	Actual
= 0.0	0.0

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 7.0	18.0	Dec-25

Previous

Plan	Actual	Period
<= 7.0	2.0	Nov-25

Year to Date

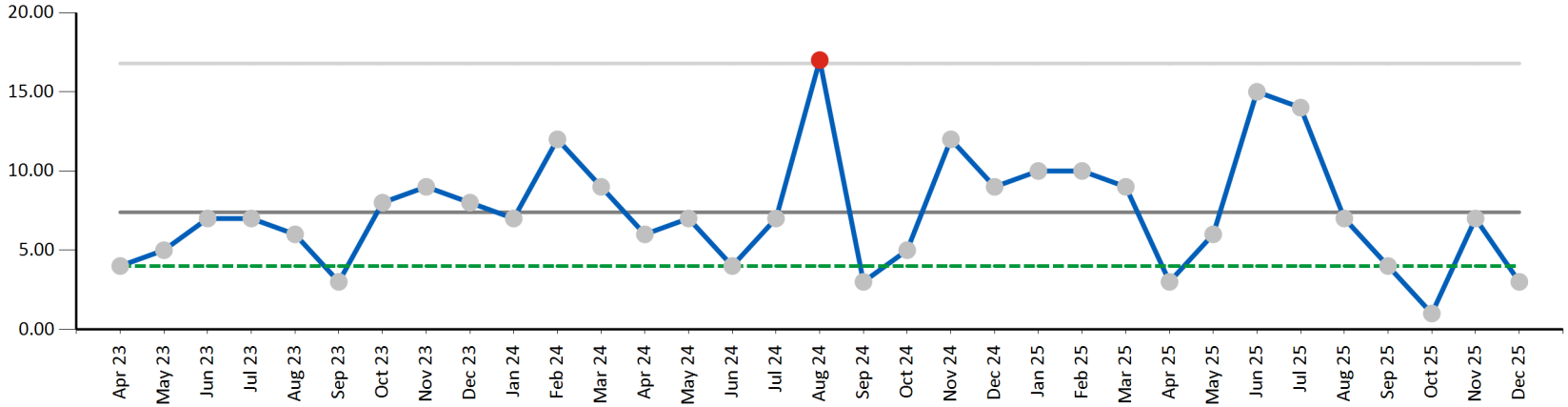
Plan	Actual
<= 63.0	102.0

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.

3/6



Latest

Plan	Actual	Period
<= 4	3	Dec-25

Previous

Plan	Actual	Period
<= 4	7	Nov-25

Year to Date

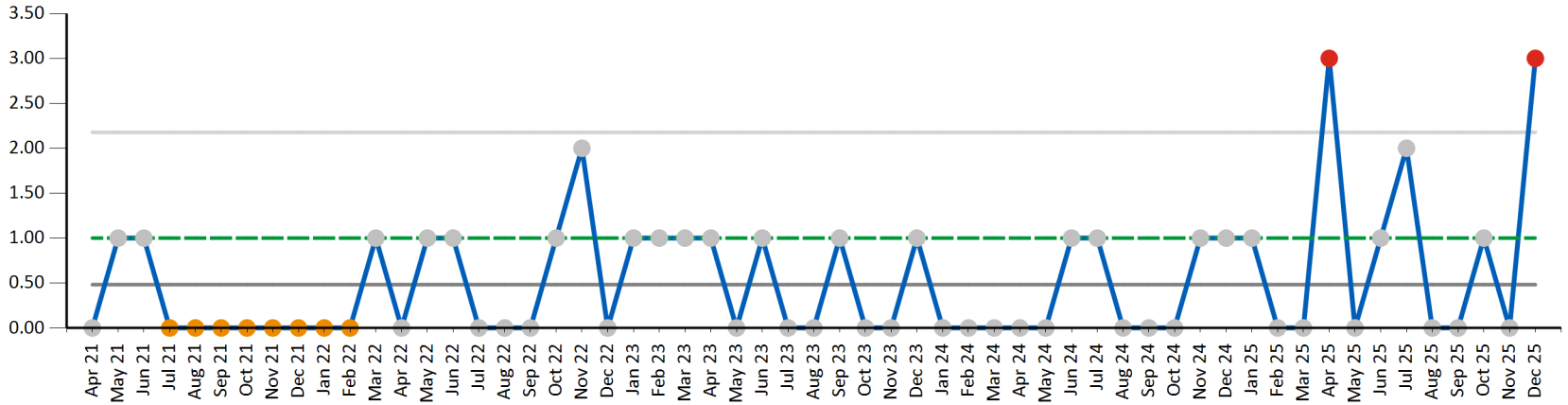
Plan	Actual
<= 36	60

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

Special cause variation with deteriorating performance

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

4/6



Latest

Plan	Actual	Period
<= 1.0	3.0	Dec-25

Previous

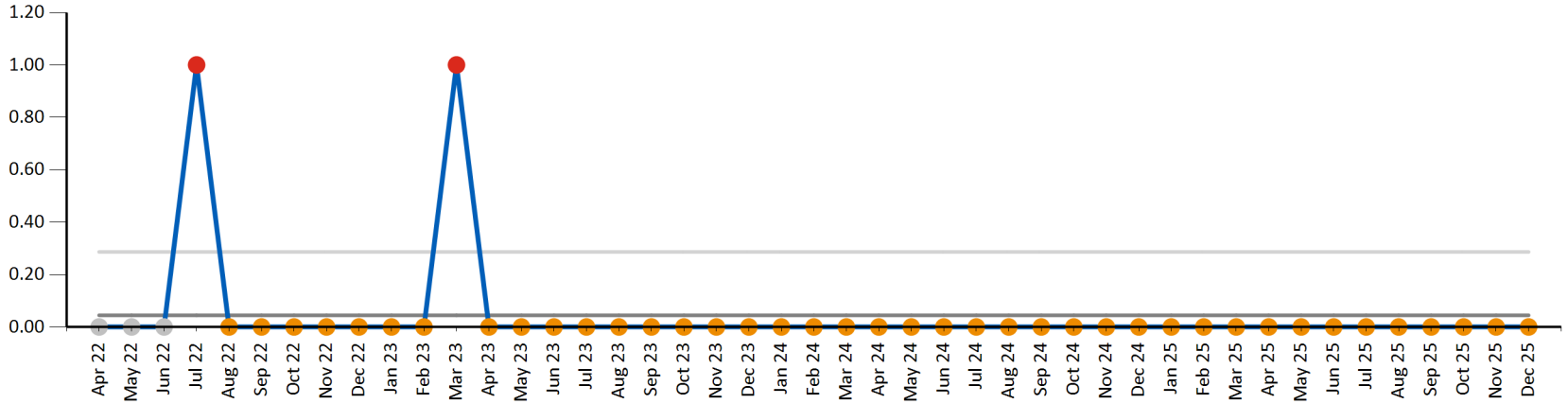
Plan	Actual	Period
<= 1.0	0.0	Nov-25

Year to Date

Plan	Actual
<= 9.0	10.0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Dec-25

Previous

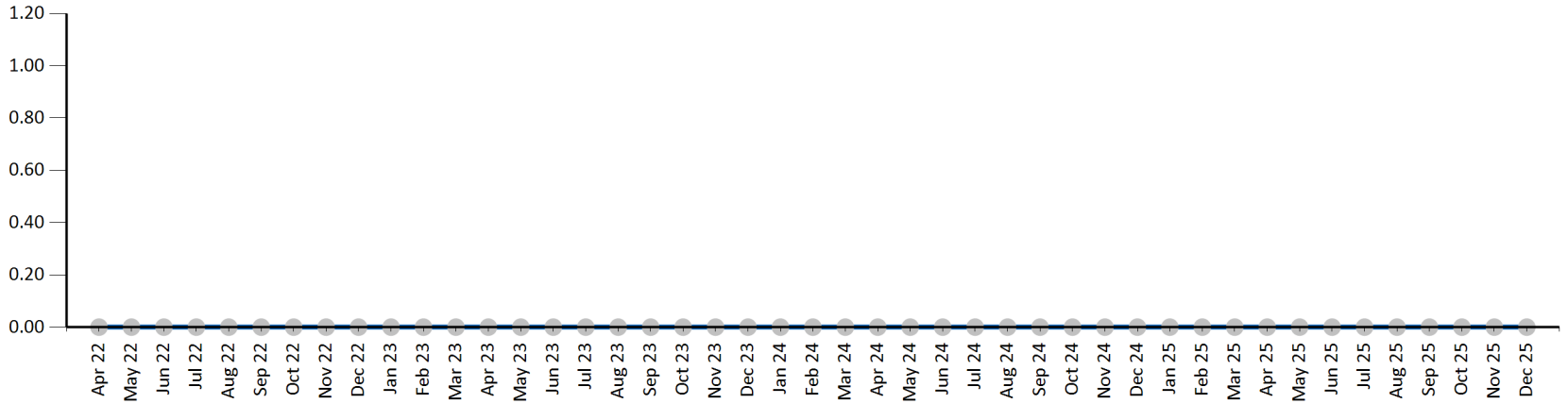
Plan	Actual	Period
	0	Nov-25

Year to Date

Plan	Actual
	0

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

Common cause variation.



Latest

Plan	Actual	Period
	0	Dec-25

Previous

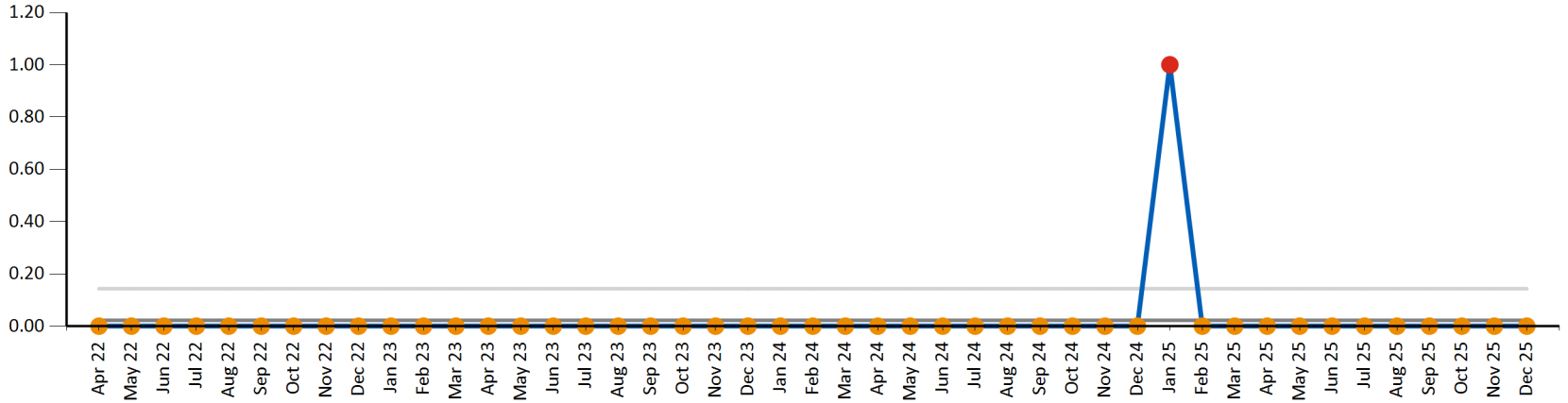
Plan	Actual	Period
	0	Nov-25

Year to Date

Plan	Actual
	0

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Dec-25

Previous

Plan	Actual	Period
	0	Nov-25

Year to Date

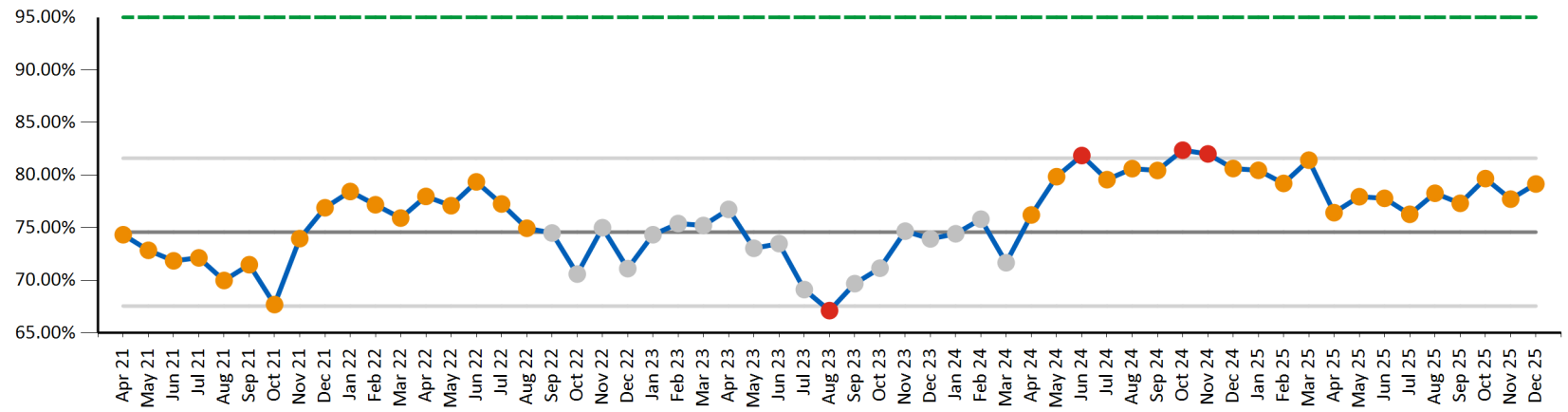
Plan	Actual
	0

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%	79.2%	Dec-25

Previous

Plan	Actual	Period
>= 95%	77.7%	Nov-25

Year to Date

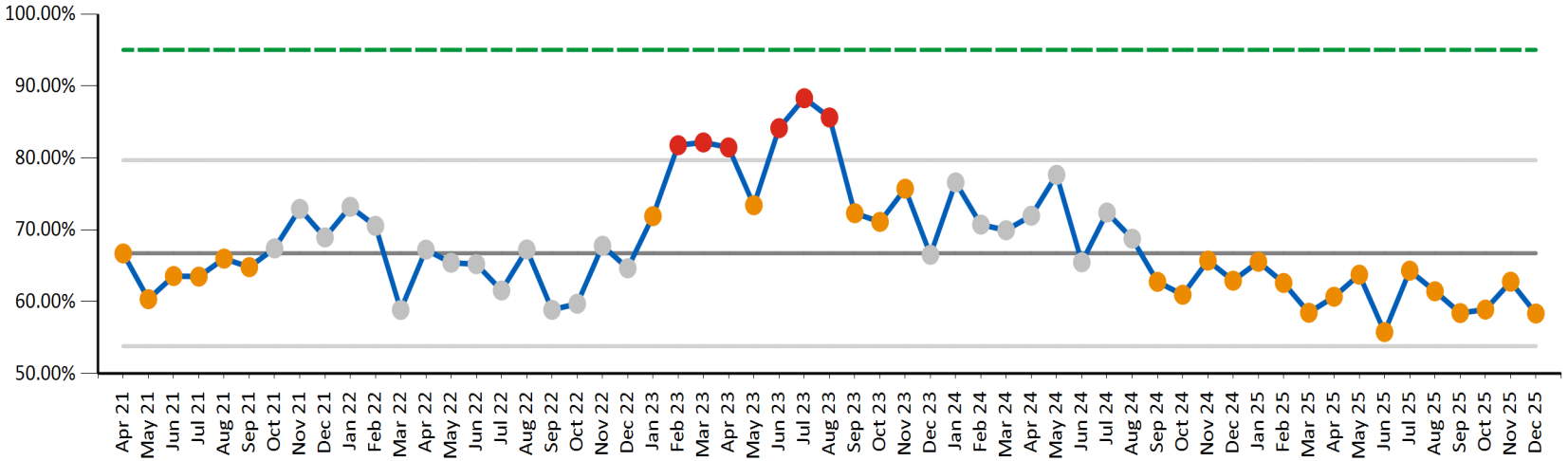
Plan	Actual
>= 95%	77.9%

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%	58.3%	Dec-25

Previous

Plan	Actual	Period
>= 95.0%	62.8%	Nov-25

Year to Date

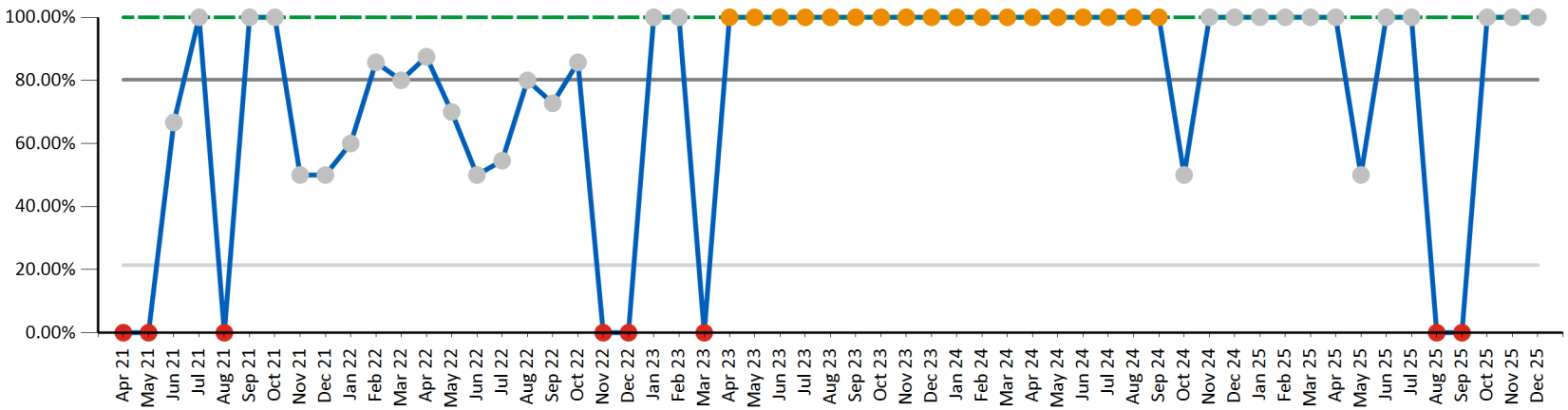
Plan	Actual
>= 95.0%	60.5%

86 - Patient Safety Alerts - Trust position

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
= 100%	100.0%	Dec-25

Previous

Plan	Actual	Period
= 100%	100.0%	Nov-25

Year to Date

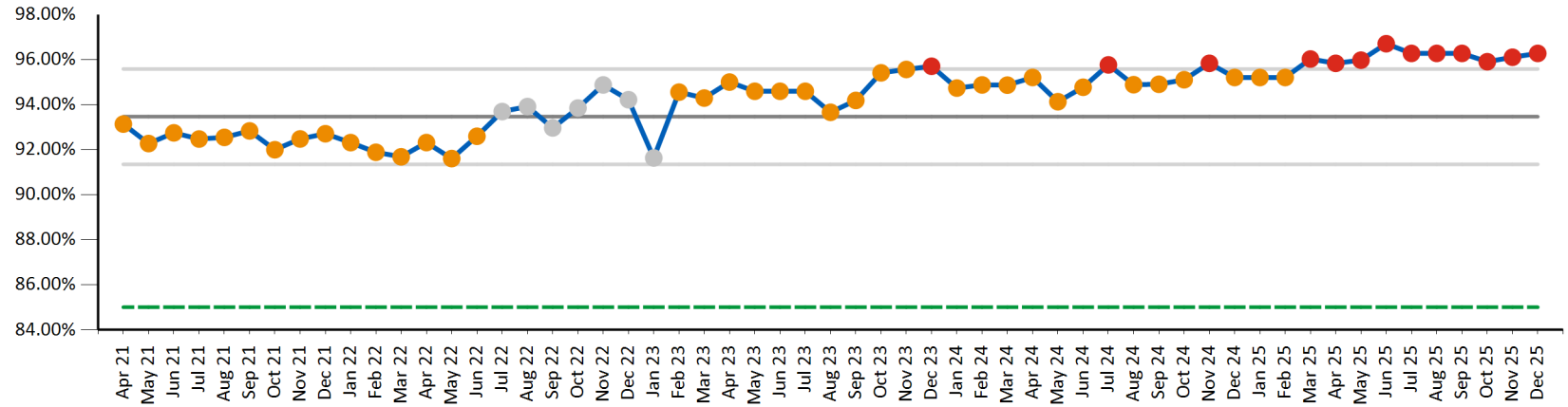
Plan	Actual
= 100%	72.2%

88 - Nursing KPI Audits

Special cause variation with improving performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	96.3%	Dec-25

Previous

Plan	Actual	Period
>= 85%	96.1%	Nov-25

Year to Date

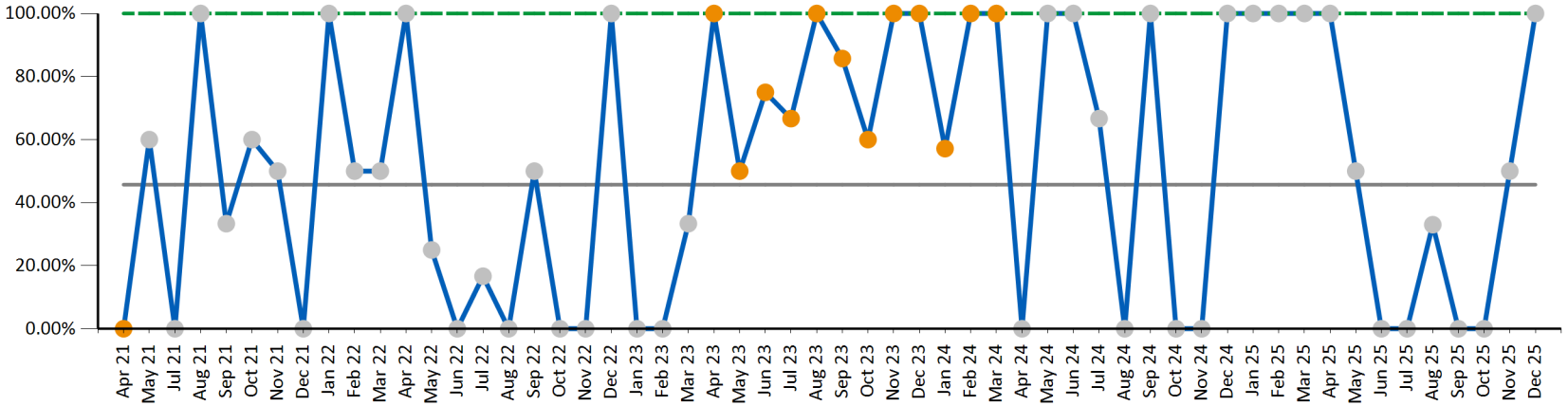
Plan	Actual
>= 85%	96.2%

91 - Patient Safety Incident Investigation turnaround performance by agreed deadline

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
= 100%	100.0%	Dec-25

Previous

Plan	Actual	Period
= 100%	50.0%	Nov-25

Year to Date

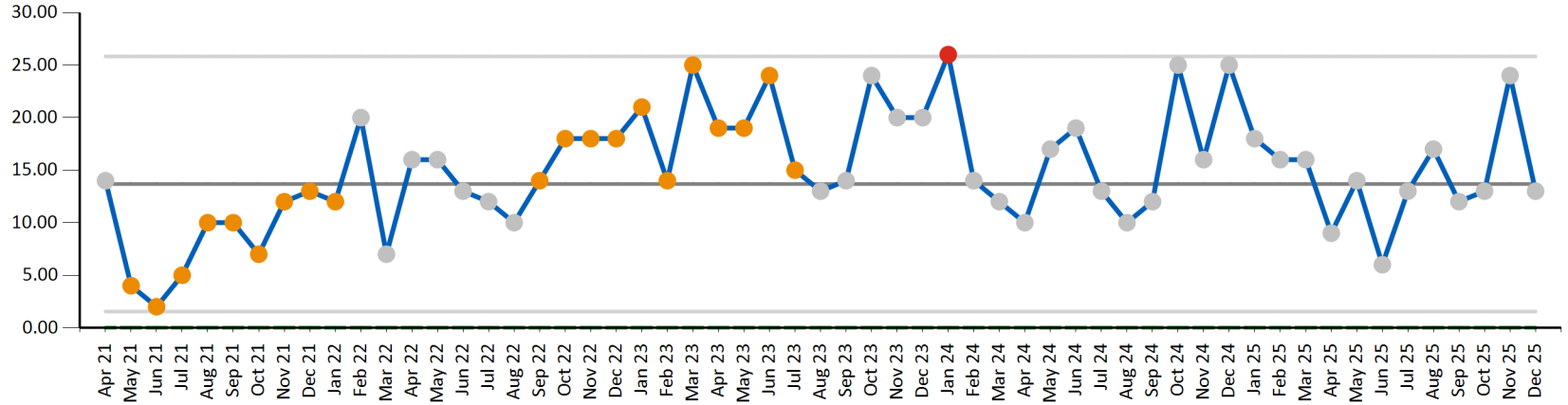
Plan	Actual
= 100%	

8 - Same sex accommodation breaches

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	13	Dec-25

Previous

Plan	Actual	Period
= 0	24	Nov-25

Year to Date

Plan	Actual
= 0	121

Quality and Safety - Infection Prevention and Control

NHS Bolton NHS Foundation Trust

There have been seven healthcare associated CDT cases in December, over two cases under the monthly target; the Trust is more than 14 cases under target with 69 cases against a target of no more than 83 cases for this point in the year. There have been 27 fewer cases in 2025/26 compared to the same point in 2024/25.

There have been no MRSA or Pseudomonas aeruginosa bacteraemias in December. It has been more than 634 days since the last MRSA case which is the second longest duration between cases since 2009 with the longest duration being 788 days. It has been more than 206 days since the last Pseudomonas aeruginosa case which is the third longest duration between cases since 2019 when this measure was first formally reported with the longest durations being 409 and 217 days. For both measures there has been an improvement in both of one case from the same point in 2024/25.

Respiratory viruses have now peaked but the beginning of January has seen more viral gastroenteritis circulating nationally and the has impacted on patients at Bolton. The IPC team continue to work closely with the affected areas and the site management team to mitigate the impact.

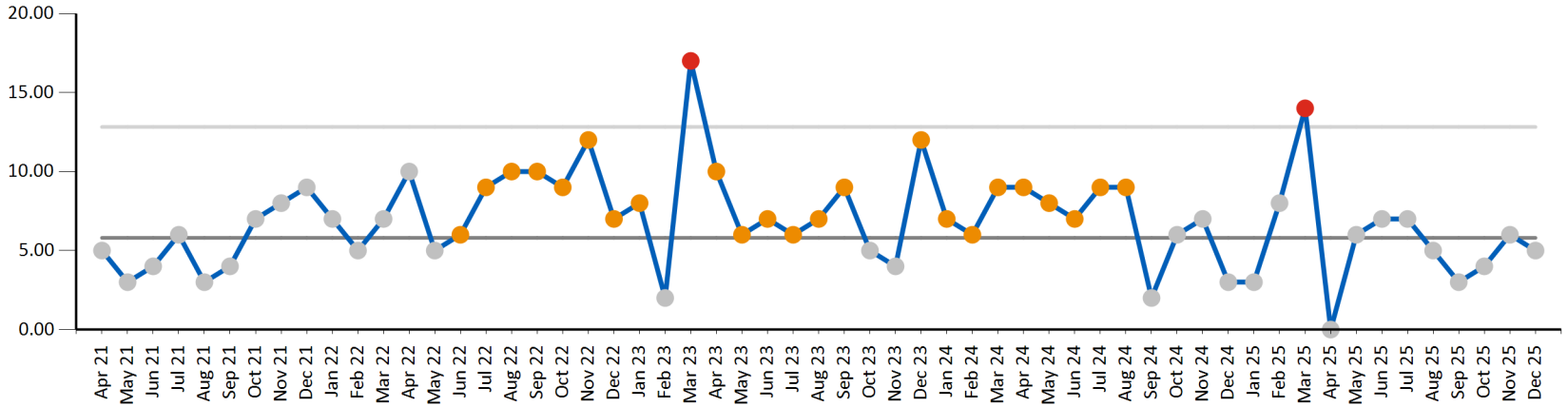
For noting: externally the Trust is measured on C. difficile Toxin cases, E. coli, Klebsiella spp. and Pseudomonas aeruginosa bacteraemias as healthcare associated case numbers and rates. The denominator measure for the community onset, healthcare-associated (COHA) cases has been expanded. Since inception, this model has been measured as a rate per 100,000 occupied bed days as the hospital onset, healthcare-associated (HOHA) cases; this has now been expanded to include day admission rates. As there are very few HCAIs connected to day admissions, this has a dilutional effect on the rates, artificially lowering them across the NHS. For most provider trusts this will mean a reduction in rates for most measures including Bolton. For the IPM data this will be relevant for measures 546-548 which notes these rates for comparison - to illustrate this, there were seven CDI cases in both May 2025 and December 2026, in May, the Trust rate was 38.7 and in December the rate is 35.9 cases.

	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		5	Dec-25			6	Nov-25		43	
346 - Total Community Onset Hospital Associated C.diff infections		2	Dec-25			2	Nov-25		26	
347 - Total C.diff infections contributing to objective	<= 10	7	Dec-25		<= 10	8	Nov-25	<= 89	69	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Dec-25		= 0	0	Nov-25	= 0		
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 5	2	Dec-25		<= 5	7	Nov-25	<= 47	45	
219 - Blood Culture Contaminants (rate)	<= 3%	2.9%	Dec-25		<= 3%	4.2%	Nov-25	<= 3%		
304 - Total Trust apportioned MSSA BSIs	<= 1.0	2.0	Dec-25		<= 1.0	1.0	Nov-25	<= 9.0	18.0	

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
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	1	Dec-25		<= 1	1	Nov-25	<= 5	14	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	0	Dec-25		= 0	1	Nov-25	= 0		
637 - Healthcare Associated Pseudomonas Aeruginosa Cases (12 month rolling average)										

215 - Total Hospital Onset C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	5	Dec-25

Previous

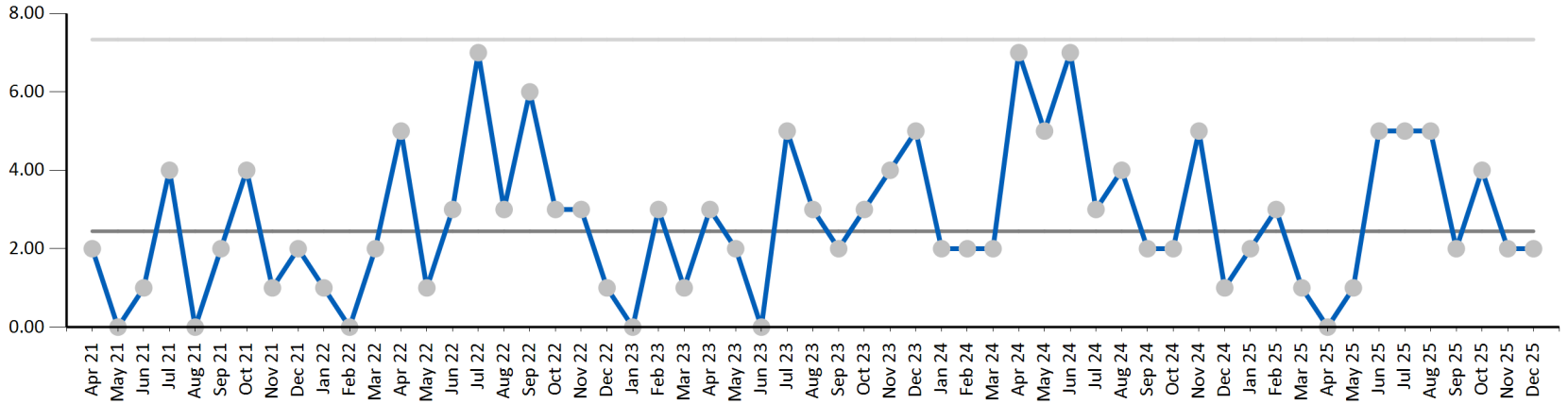
Plan	Actual	Period
	6	Nov-25

Year to Date

Plan	Actual
	43

346 - Total Community Onset Hospital Associated C.diff infections

Common cause variation.



Latest

Plan	Actual	Period
	2	Dec-25

Previous

Plan	Actual	Period
	2	Nov-25

Year to Date

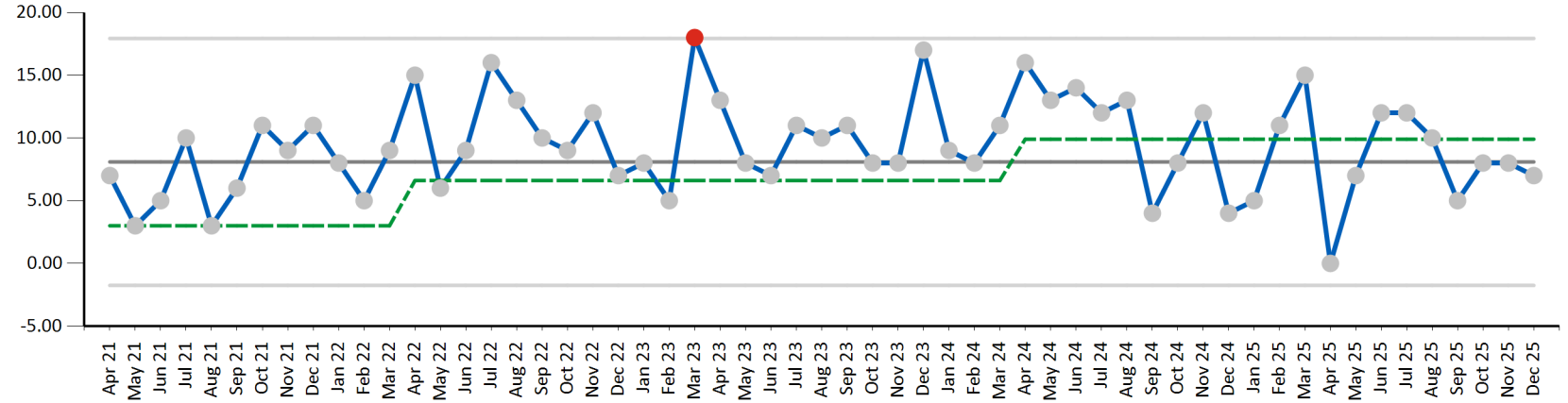
Plan	Actual
	26

347 - Total C.diff infections contributing to objective

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 10	7	Dec-25

Previous

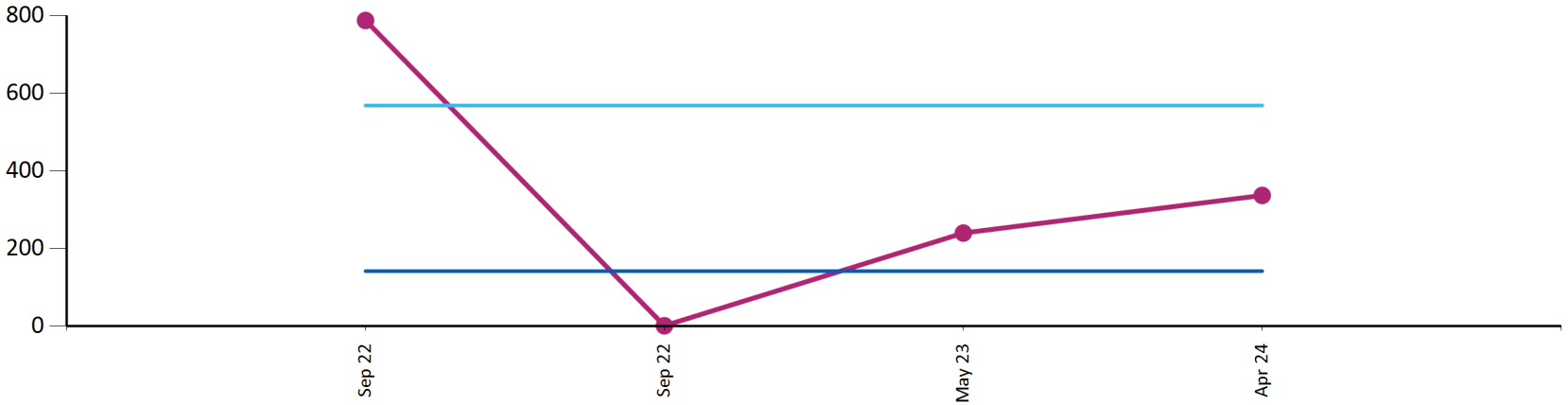
Plan	Actual	Period
<= 10	8	Nov-25

Year to Date

Plan	Actual
<= 89	69

217 - Total Hospital-Onset MRSA BSIs

0/6



Latest

Plan	Actual	Period
	0	Dec-25

Previous

Plan	Actual	Period
	0	Nov-25

Year to Date

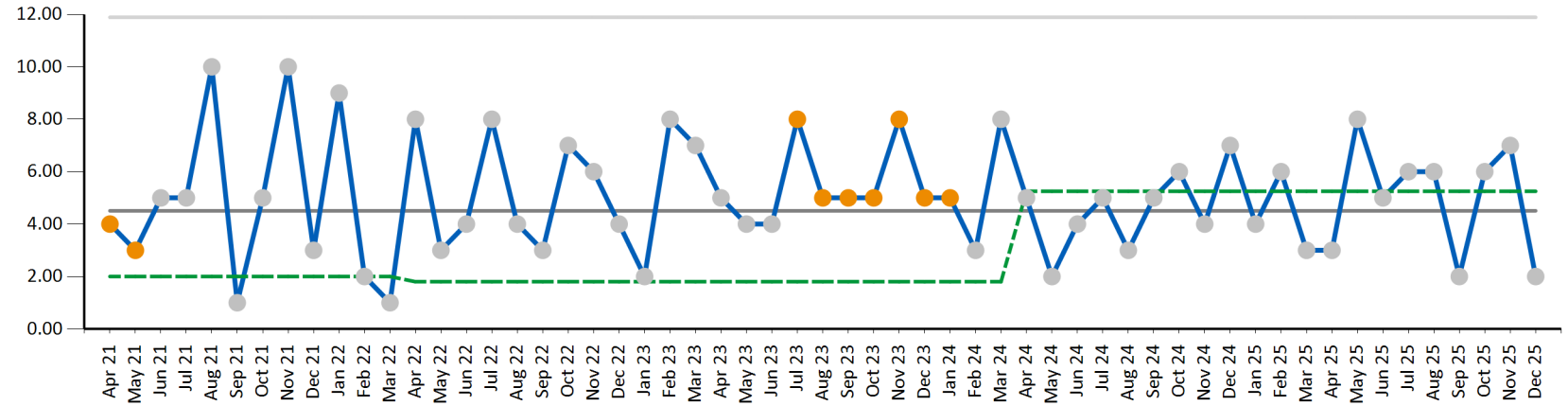
Plan	Actual

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

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 5	2	Dec-25

Previous

Plan	Actual	Period
<= 5	7	Nov-25

Year to Date

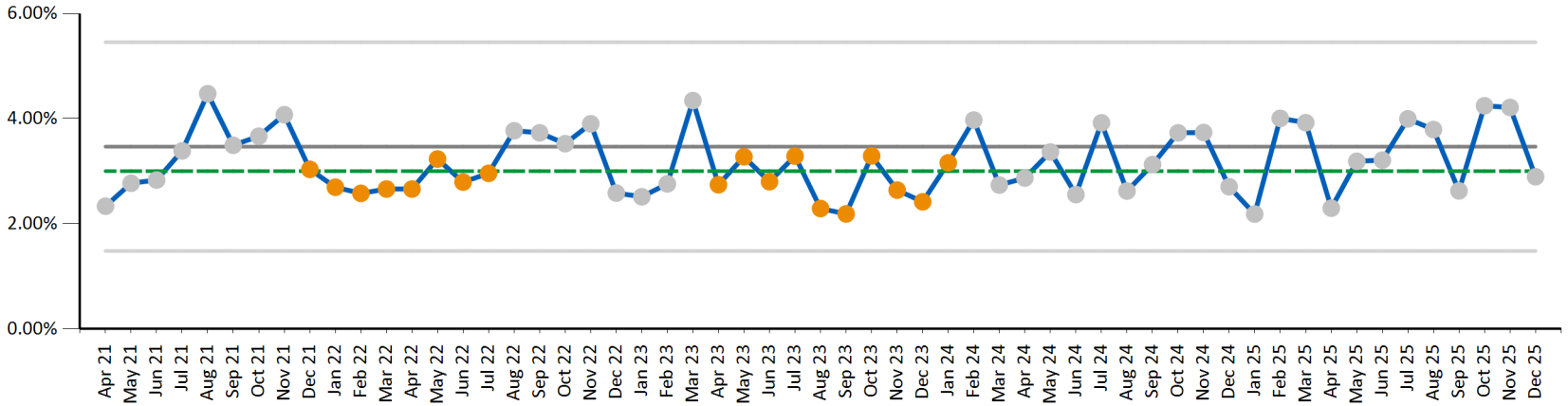
Plan	Actual
<= 47	45

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%	2.9%	Dec-25

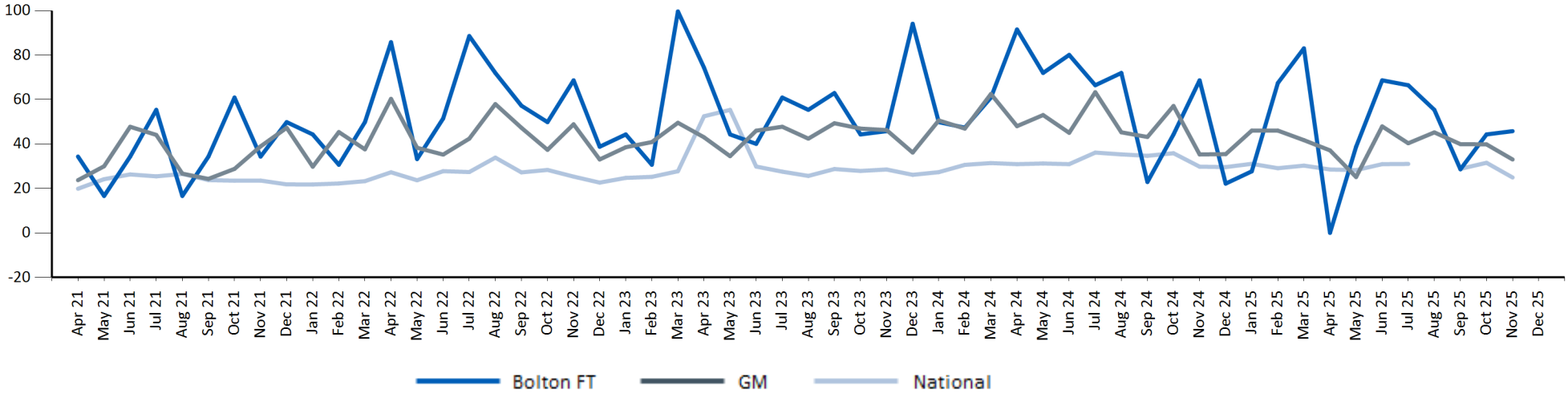
Previous

Plan	Actual	Period
<= 3%	4.2%	Nov-25

Year to Date

Plan	Actual
<= 3%	

549 - C Diff Rate Comparison

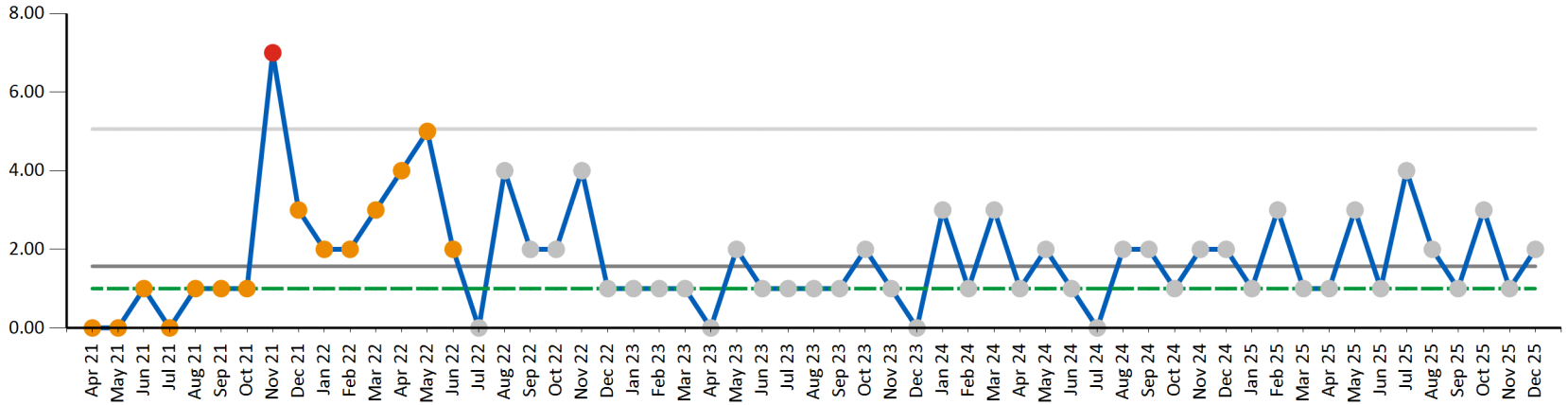


304 - Total Trust apportioned MSSA BSIs

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
<= 1.0	2.0	Dec-25

Previous

Plan	Actual	Period
<= 1.0	1.0	Nov-25

Year to Date

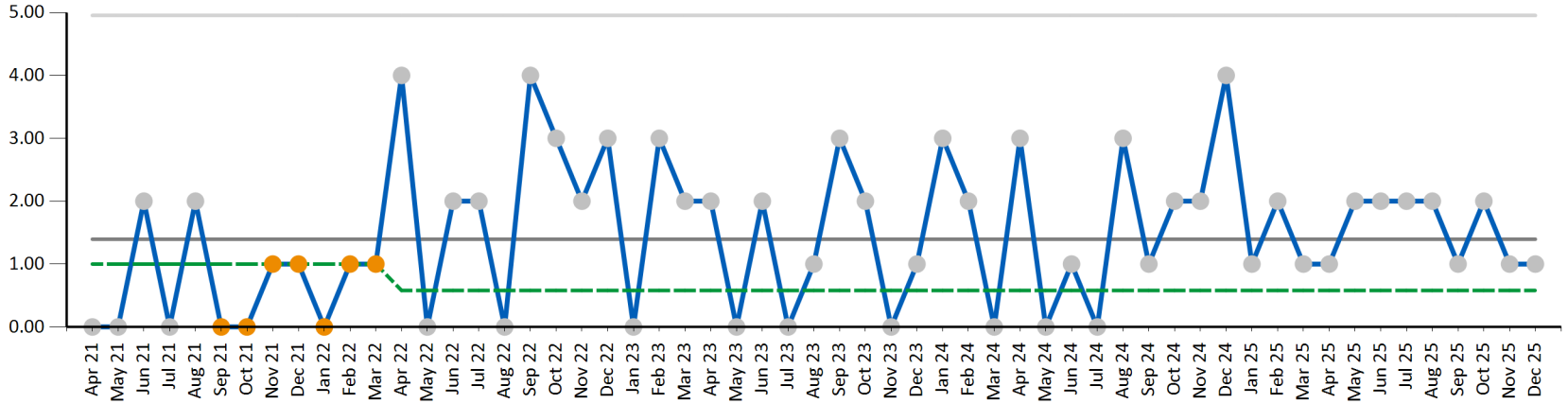
Plan	Actual
<= 9.0	18.0

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	1	Dec-25

Previous

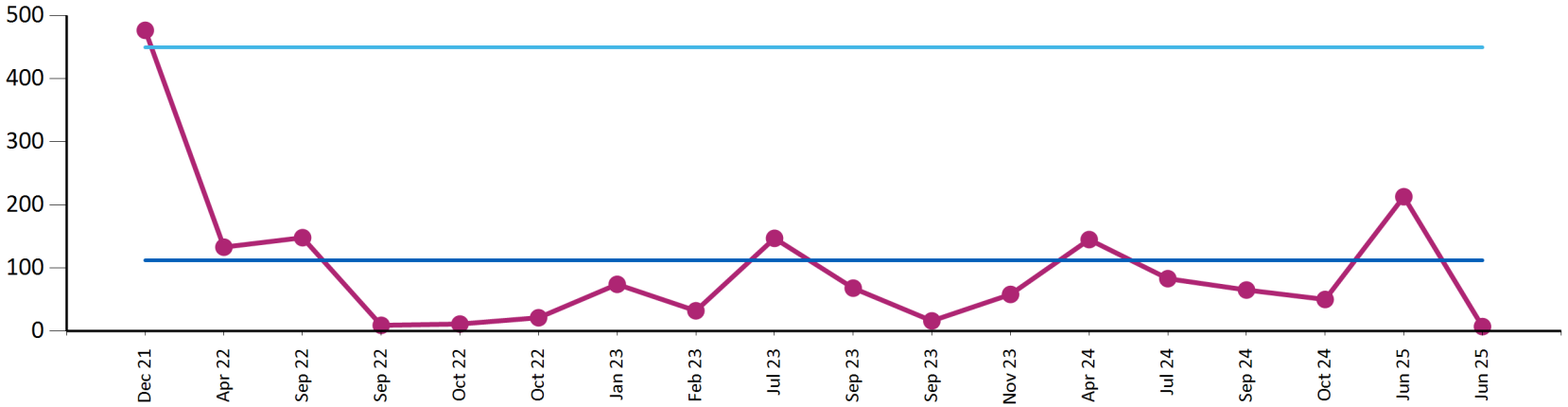
Plan	Actual	Period
<= 1	1	Nov-25

Year to Date

Plan	Actual
<= 5	14

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

0/6



Latest

Plan	Actual	Period
	0	Dec-25

Previous

Plan	Actual	Period
	0	Nov-25

Year to Date

Plan	Actual

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 19 points below the mean showing improved special cause. It has now remained in control for more than three years.

HSMR – in month figure is below average for the period and remains in control. The 12 month rolling average to September 2025 is 107.3, remaining at an 'Amber' alert when compared to other Trusts.

SHMI – in month figure is just below the average for the time period and remains in control. The published rolling average for the period September 2024 to August 2025 is 108.9 which is 'as expected'.

The proportion of Charlson comorbidities is above average for the time frame and the current month is part of a run of improved special cause. The depth of recording remains in control and is slightly below the 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%	83.5%	Dec-25		>= 85%	100.0%	Nov-25	>= 85%	93.8%	
495 - HSMR		92.68	Sep-25			114.75	Aug-25		92.68	
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	109.13	Jul-25		<= 100.00	96.23	Jun-25	<= 100.00	109.13	
12 - Crude Mortality %	<= 2.9%	2.2%	Dec-25	L	<= 2.9%	2.1%	Nov-25	<= 2.9%	1.8%	
519 - Average Charlson comorbidity Score (First episode of care)		5	Sep-25	H		4	Aug-25		26	
520 - Depth of recording (First episode of care)		6	Sep-25			6	Aug-25		37	
521 - Proportion of fully coded records (Inpatients)		98.5%	Sep-25	H		98.5%	Aug-25		98.3%	

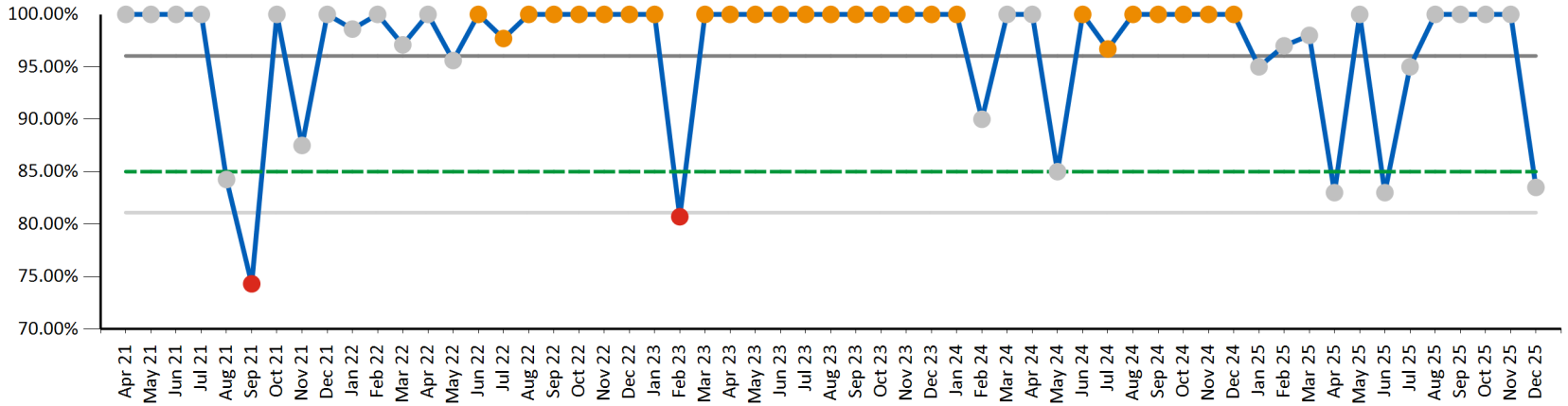
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
604 - Early neonatal mortality (< 7 days), rate per 1000 births (all areas including SCBU and CDS)		0.00	Dec-25			0.00	Nov-25			

3 - National Early Warning Scores to Gold standard

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 85%	83.5%	Dec-25

Previous

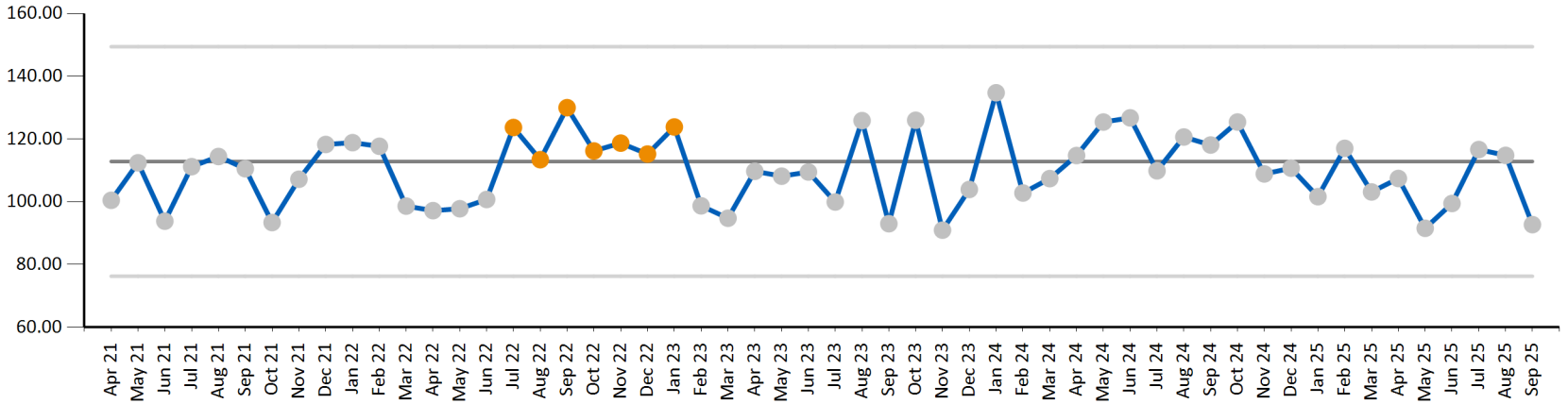
Plan	Actual	Period
>= 85%	100.0%	Nov-25

Year to Date

Plan	Actual
>= 85%	93.8%

495 - HSMR

Common cause variation.



Latest

Plan	Actual	Period
	92.68	Sep-25

Previous

Plan	Actual	Period
	114.75	Aug-25

Year to Date

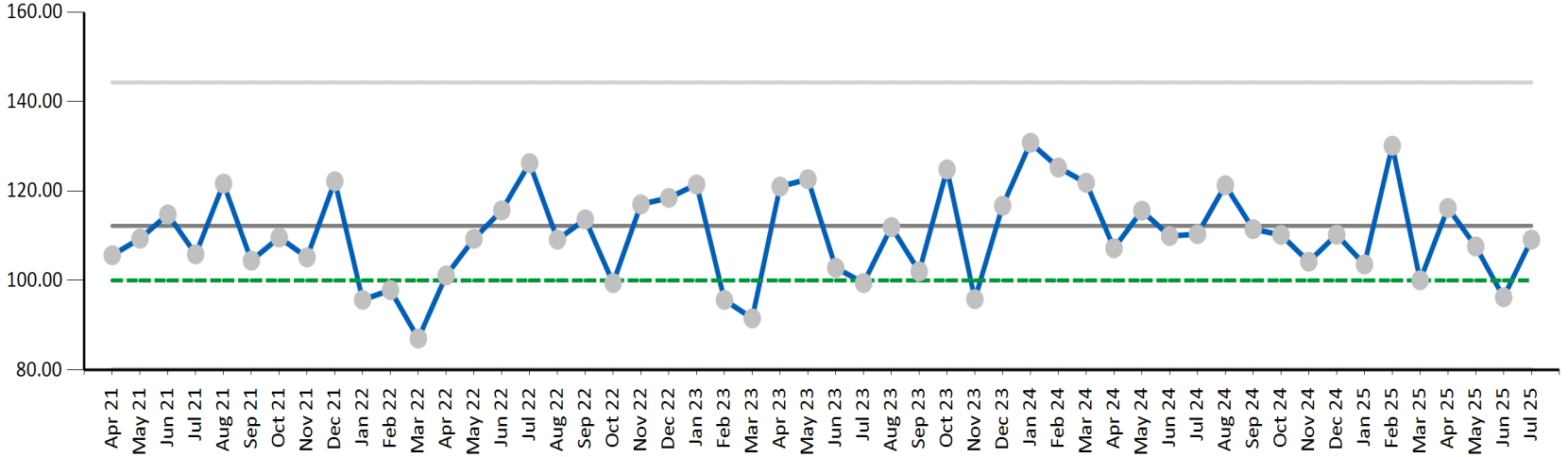
Plan	Actual
	92.68

11 - Summary Hospital-level Mortality Indicator (SHMI)

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
< = 100.00	109.13	Jul-25

Previous

Plan	Actual	Period
< = 100.00	96.23	Jun-25

Year to Date

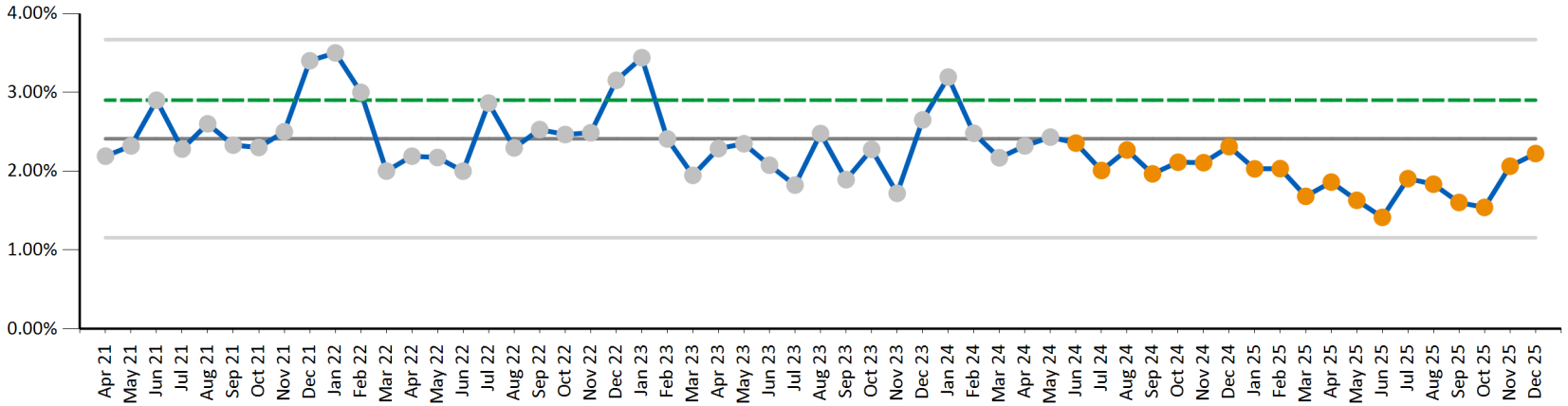
Plan	Actual
< = 100.00	109.13

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%	2.2%	Dec-25

Previous

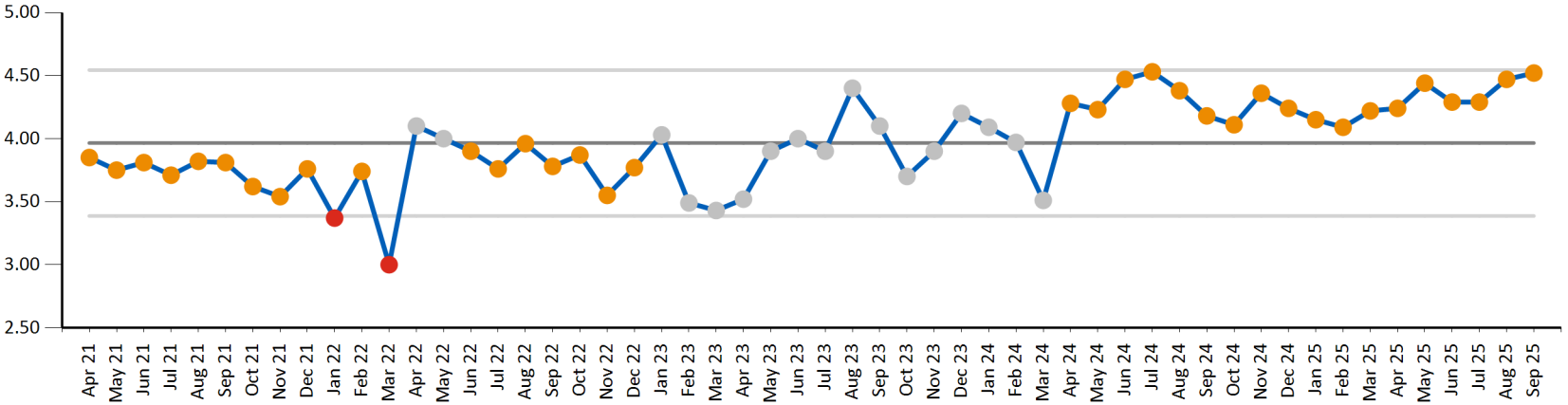
Plan	Actual	Period
<= 2.9%	2.1%	Nov-25

Year to Date

Plan	Actual
<= 2.9%	1.8%

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

Special cause variation with improving performance



Latest

Plan	Actual	Period
	5	Sep-25

Previous

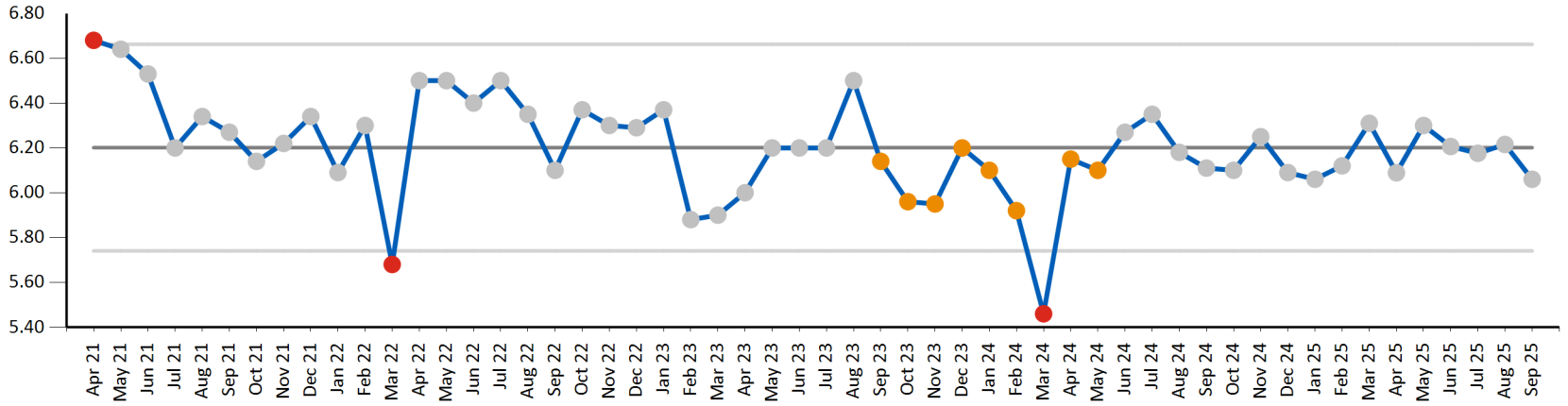
Plan	Actual	Period
	4	Aug-25

Year to Date

Plan	Actual
	26

520 - Depth of recording (First episode of care)

Common cause variation.



Latest

Plan	Actual	Period
	6	Sep-25

Previous

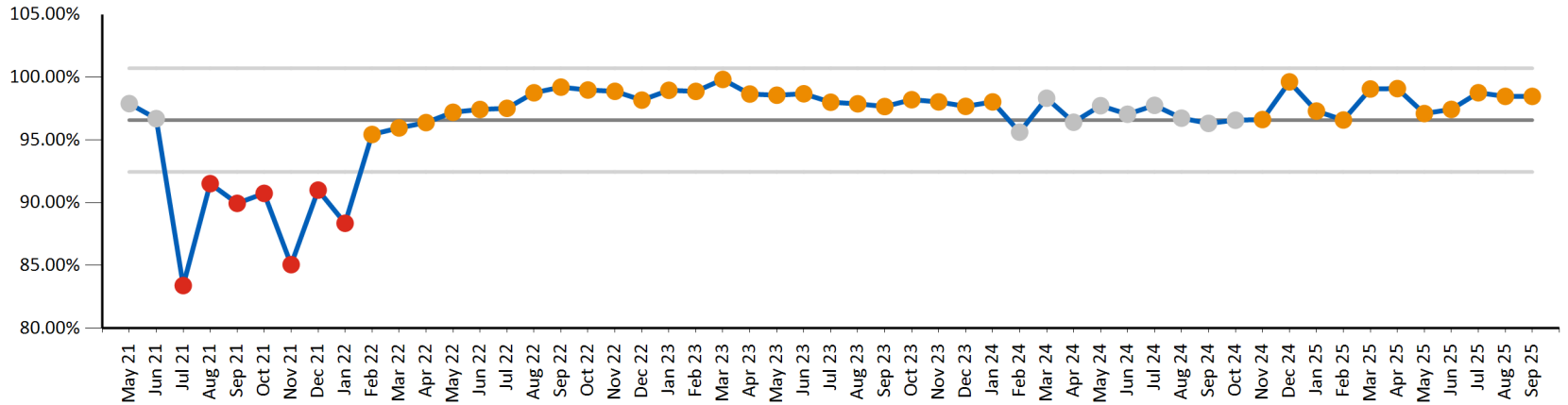
Plan	Actual	Period
	6	Aug-25

Year to Date

Plan	Actual
	37

521 - Proportion of fully coded records (Inpatients)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	98.5%	Sep-25

Previous

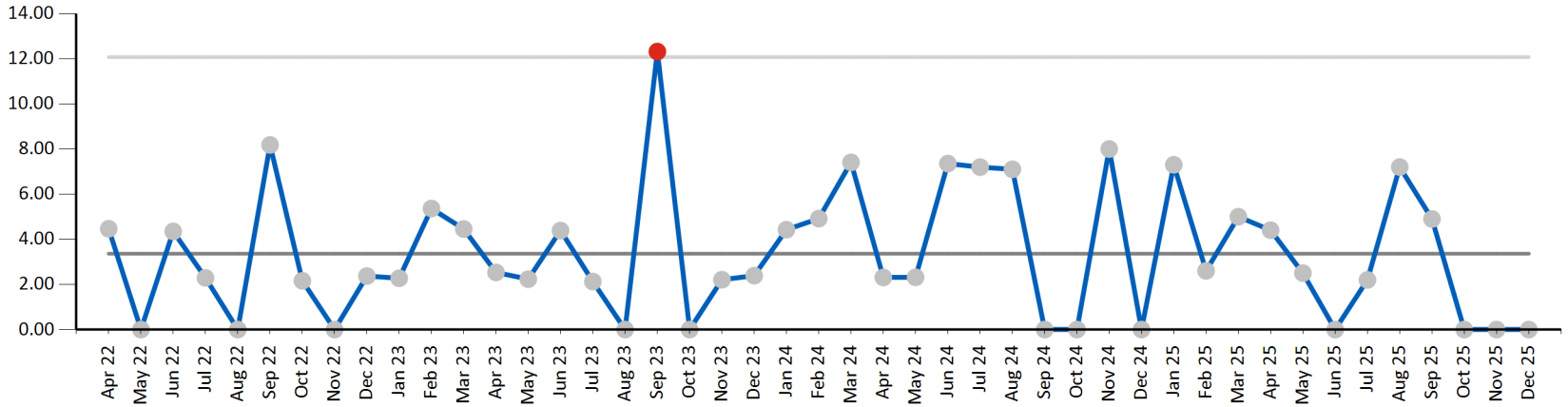
Plan	Actual	Period
	98.5%	Aug-25

Year to Date

Plan	Actual
	98.3%

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	Dec-25

Previous

Plan	Actual	Period
	0.00	Nov-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% local target rate. ED satisfaction rates remain below the target of 90% but are within the range of common cause variation. ED predominately use an electronic text message system for FFT responses messages. They also review patient experience feedback from a variety of other different sources and have a Patient Experience Improvement Plan with oversight at ED Governance. A key theme is the environment both in terms of it being busy, overcrowded and the subsequent long waits.

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

Complaints

Formal complaints acknowledged within 3 working days is 84.6%. Compliance rate has not been achieved due multifactorial reasons which predominately relate to an increase in the number of complaints received and reduced staffing due to long term sickness and vacancies unable to be recruited to due to vacancy freeze. Recruitment to the vacant posts has been approved and recruitment is underway. Sickness remains an issue however this is being managed in line with workforce processes

Complaints responded to during this date is below the planned 95% but is within common cause variation.

Across four divisions there were a total of 27 responses due. Of these, nine remain outstanding across, Community, Surgery and Families and Diagnostic Divisions.

	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%	16.0%	Dec-25		>= 20%	12.0%	Nov-25	>= 20%	14.1%	?
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	79.9%	Dec-25	L	>= 90%	79.4%	Nov-25	>= 90%	83.1%	?
80 - Inpatient Friends and Family Response Rate	>= 30%	21.7%	Dec-25		>= 30%	21.7%	Nov-25	>= 30%	23.7%	?
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.6%	Dec-25		>= 90%	97.5%	Nov-25	>= 90%	97.2%	P
81 - Maternity Friends and Family Response Rate	>= 15%	26.4%	Dec-25		>= 15%	26.4%	Nov-25	>= 15%	23.1%	?
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	93.4%	Dec-25		>= 90%	95.3%	Nov-25	>= 90%	92.5%	?
82 - Antenatal - Friends and Family Response Rate	>= 15%	14.7%	Dec-25		>= 15%	14.7%	Nov-25	>= 15%	14.7%	?

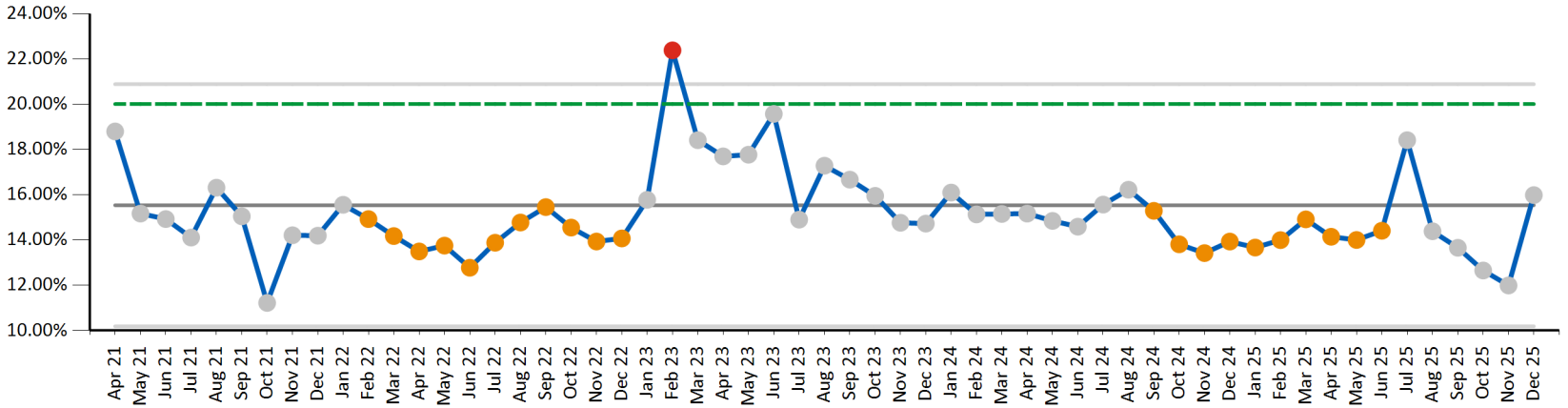
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Dec-25		>= 90%	100.0%	Nov-25	>= 90%	96.9%	
83 - Birth - Friends and Family Response Rate	>= 15%	41.1%	Dec-25		>= 15%	41.1%	Nov-25	>= 15%	37.9%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	93.8%	Dec-25		>= 90%	93.4%	Nov-25	>= 90%	90.2%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	20.3%	Dec-25		>= 15%	24.7%	Nov-25	>= 15%	19.6%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	86.4%	Dec-25		>= 90%	95.0%	Nov-25	>= 90%	88.9%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	12.6%	Dec-25		>= 15%	26.5%	Nov-25	>= 15%	20.3%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.2%	Dec-25		>= 90%	95.6%	Nov-25	>= 90%	95.3%	
89 - Formal complaints acknowledged within 3 working days	= 100%	84.6%	Dec-25		= 100%	84.6%	Nov-25	= 100%	92.0%	
90 - Complaints responded to within the period	>= 95%	60.0%	Dec-25		>= 95%	60.0%	Nov-25	>= 95%	74.5%	

200 - A&E 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
>= 20%	16.0%	Dec-25

Previous

Plan	Actual	Period
>= 20%	12.0%	Nov-25

Year to Date

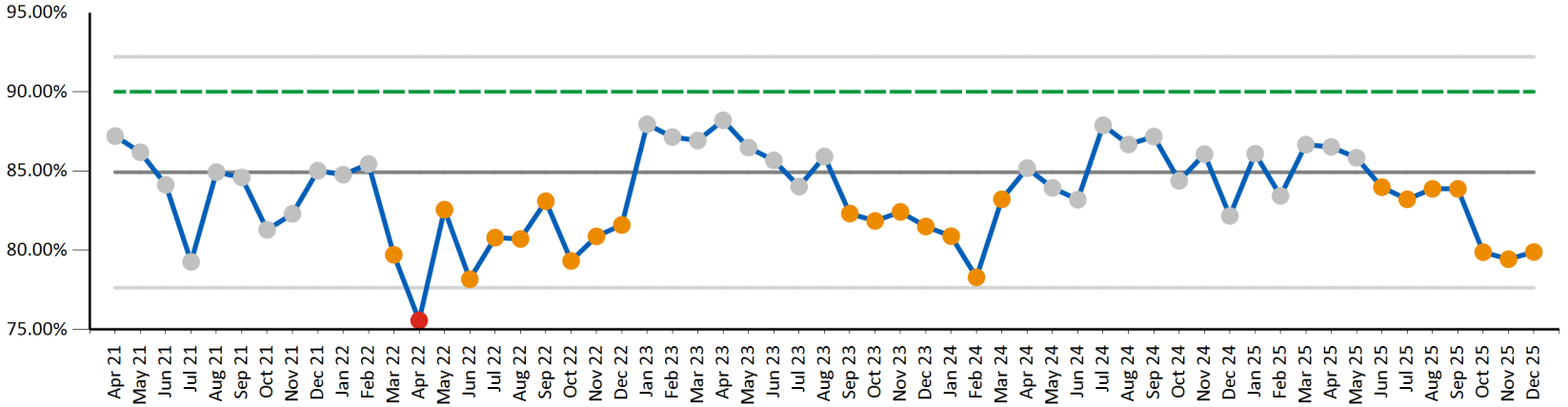
Plan	Actual
>= 20%	14.1%

294 - A&E Friends and Family Satisfaction Rates %

Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 90%	79.9%	Dec-25

Previous

Plan	Actual	Period
>= 90%	79.4%	Nov-25

Year to Date

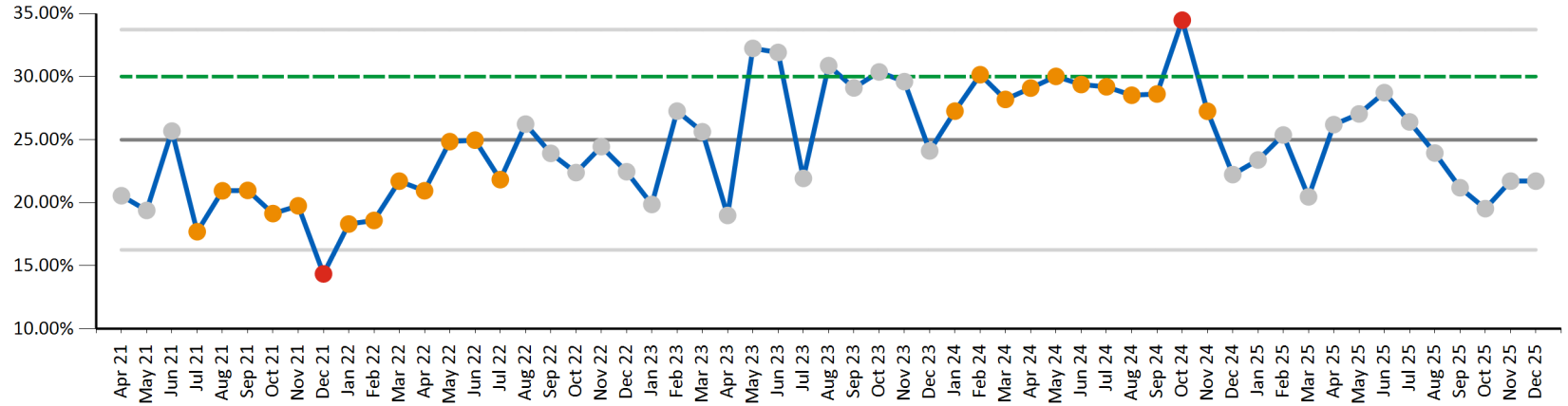
Plan	Actual
>= 90%	83.1%

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%	21.7%	Dec-25

Previous

Plan	Actual	Period
>= 30%	21.7%	Nov-25

Year to Date

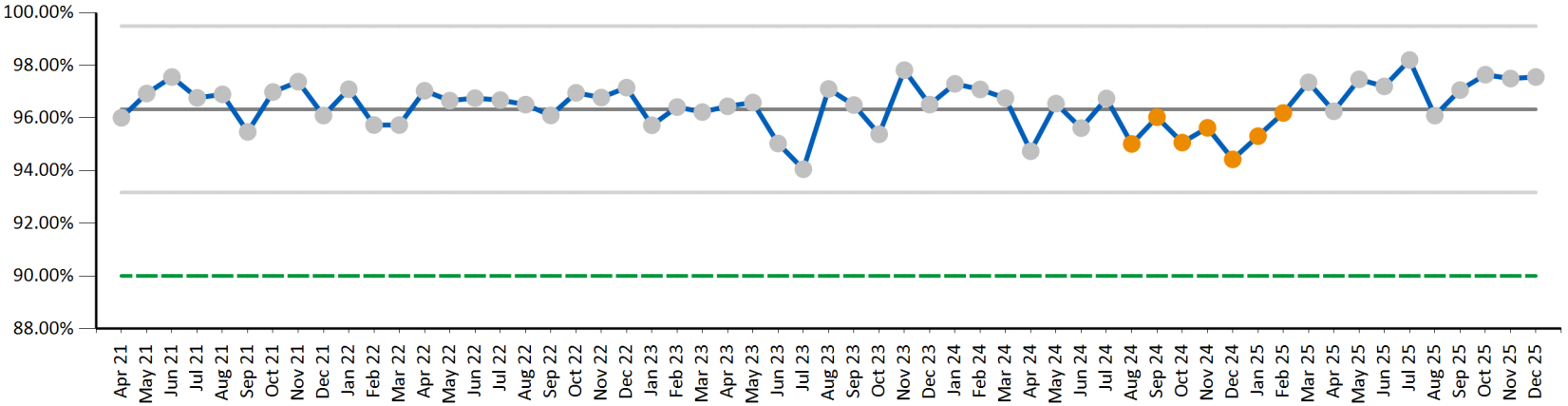
Plan	Actual
>= 30%	23.7%

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

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 90%	97.6%	Dec-25

Previous

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

Year to Date

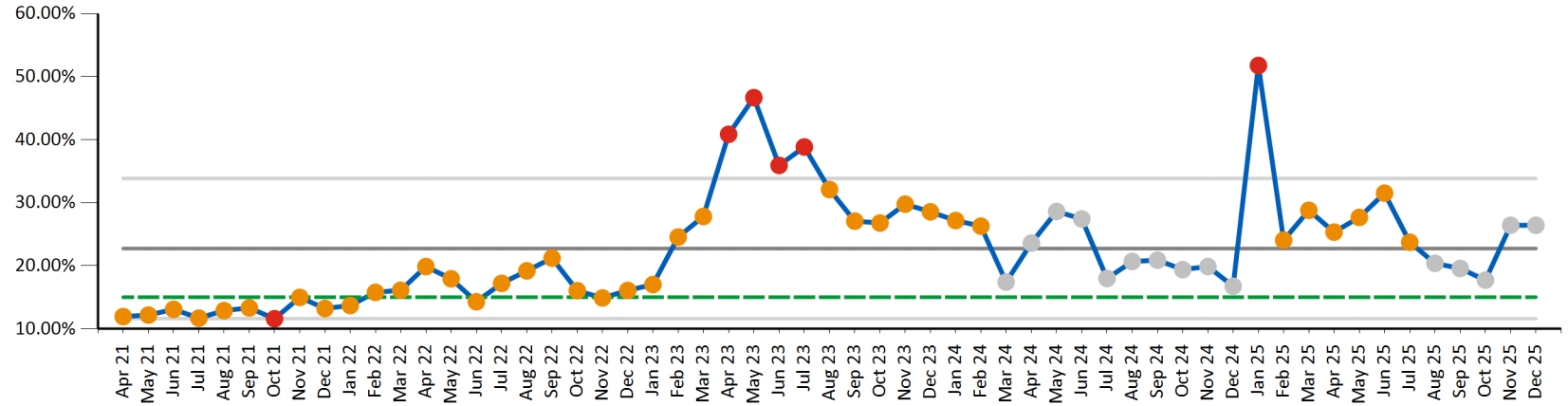
Plan	Actual
>= 90%	97.2%

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%	26.4%	Dec-25

Previous

Plan	Actual	Period
>= 15%	26.4%	Nov-25

Year to Date

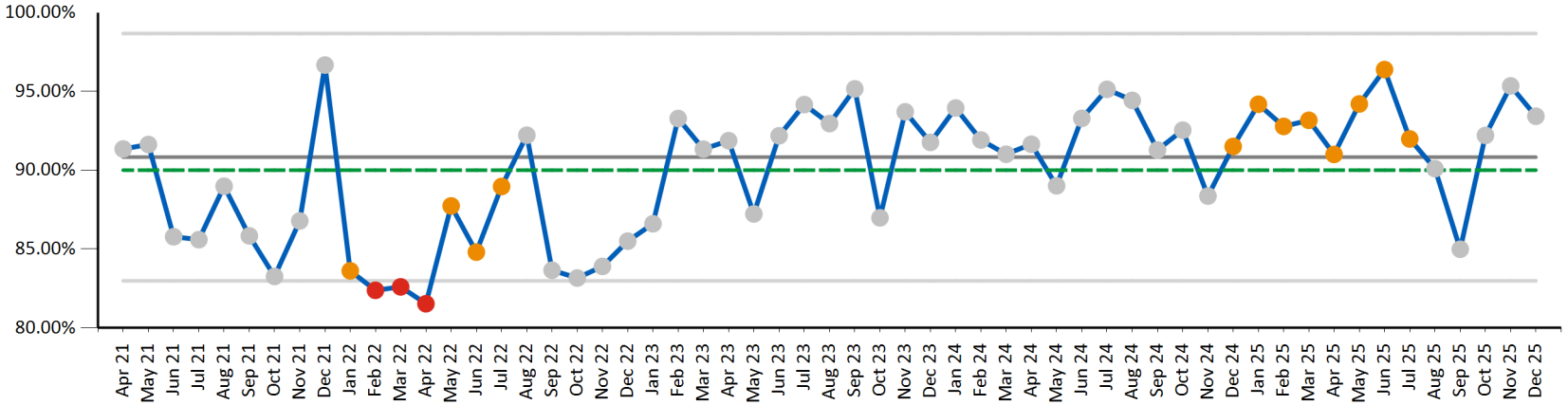
Plan	Actual
>= 15%	23.1%

241 - Maternity Friends and Family Test - Satisfaction %

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
>= 90%	93.4%	Dec-25

Previous

Plan	Actual	Period
>= 90%	95.3%	Nov-25

Year to Date

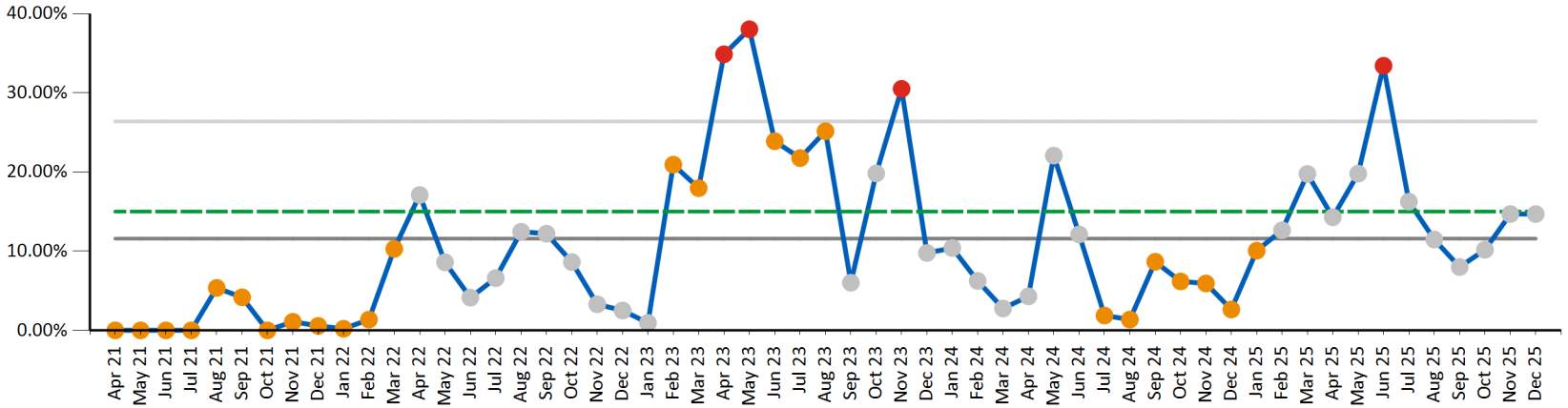
Plan	Actual
>= 90%	92.5%

82 - Antenatal - Friends and Family Response Rate

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 15%	14.7%	Dec-25

Previous

Plan	Actual	Period
>= 15%	14.7%	Nov-25

Year to Date

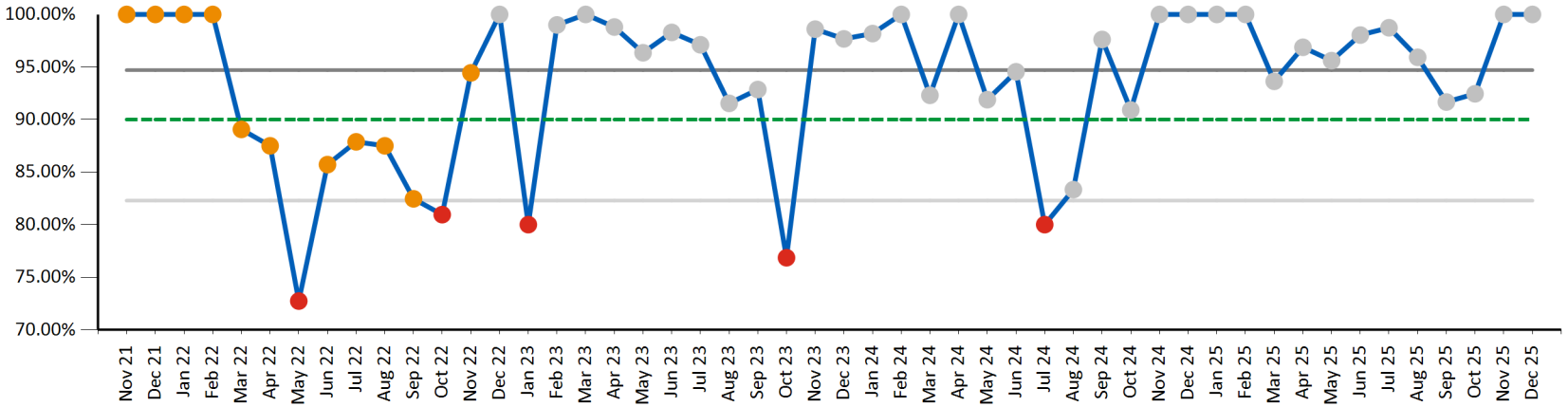
Plan	Actual
>= 15%	14.7%

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%	100.0%	Dec-25

Previous

Plan	Actual	Period
>= 90%	100.0%	Nov-25

Year to Date

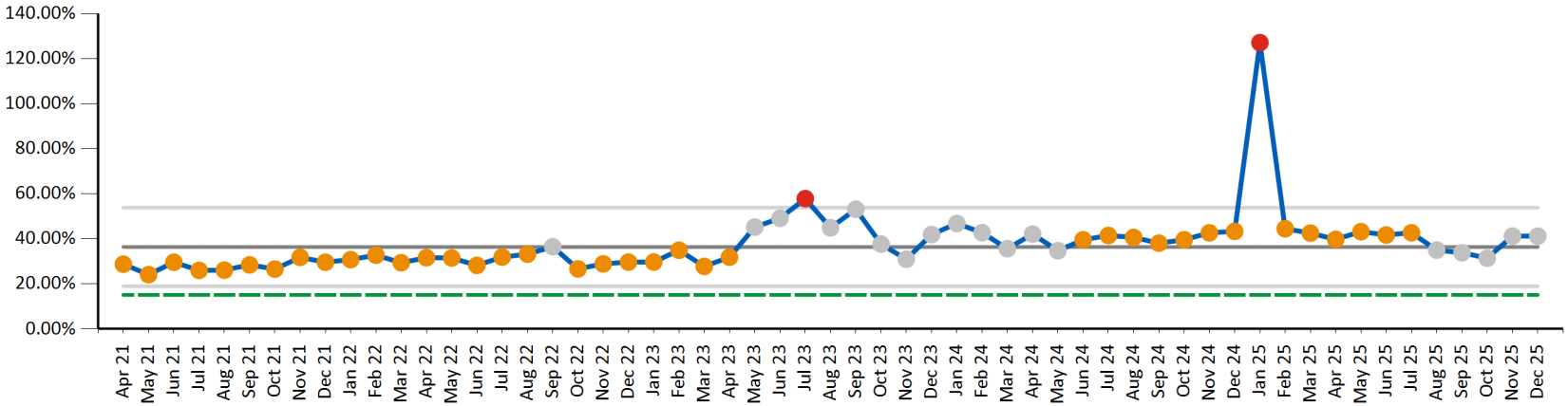
Plan	Actual
>= 90%	96.9%

83 - Birth - Friends and Family Response Rate

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 15%	41.1%	Dec-25

Previous

Plan	Actual	Period
>= 15%	41.1%	Nov-25

Year to Date

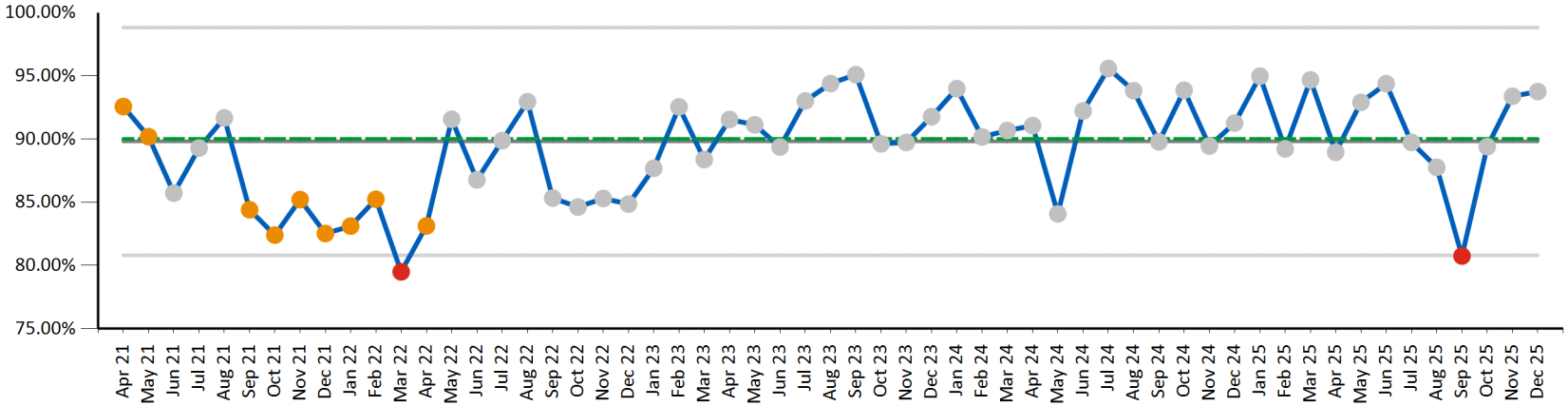
Plan	Actual
>= 15%	37.9%

243 - Birth Friends and Family Test - Satisfaction %

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90%	93.8%	Dec-25

Previous

Plan	Actual	Period
>= 90%	93.4%	Nov-25

Year to Date

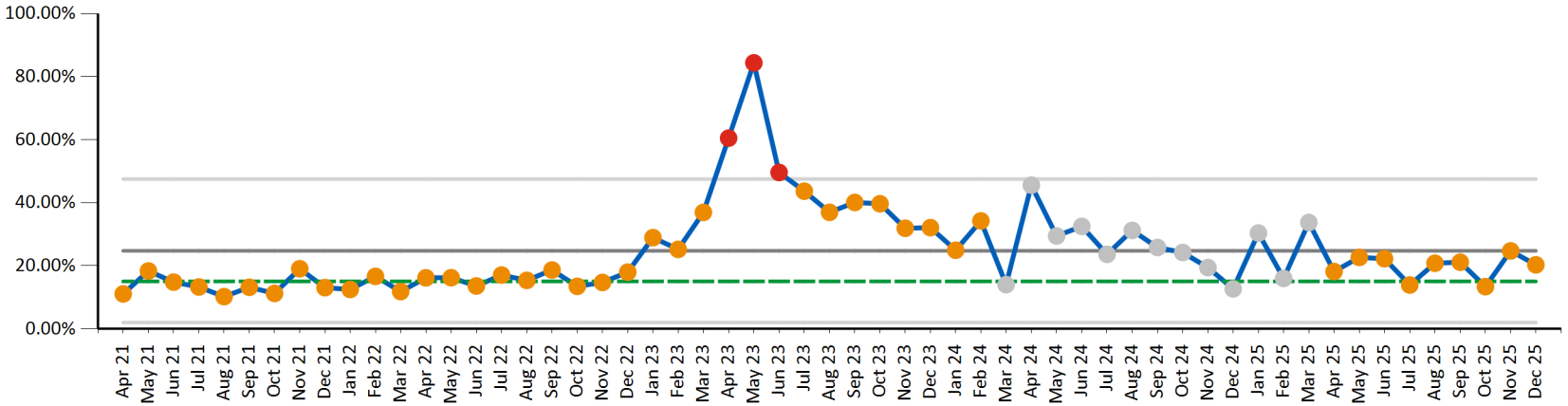
Plan	Actual
>= 90%	90.2%

84 - Hospital Postnatal - Friends and Family Response Rate

Special cause variation with deteriorating performance

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

4/6



Latest

Plan	Actual	Period
>= 15%	20.3%	Dec-25

Previous

Plan	Actual	Period
>= 15%	24.7%	Nov-25

Year to Date

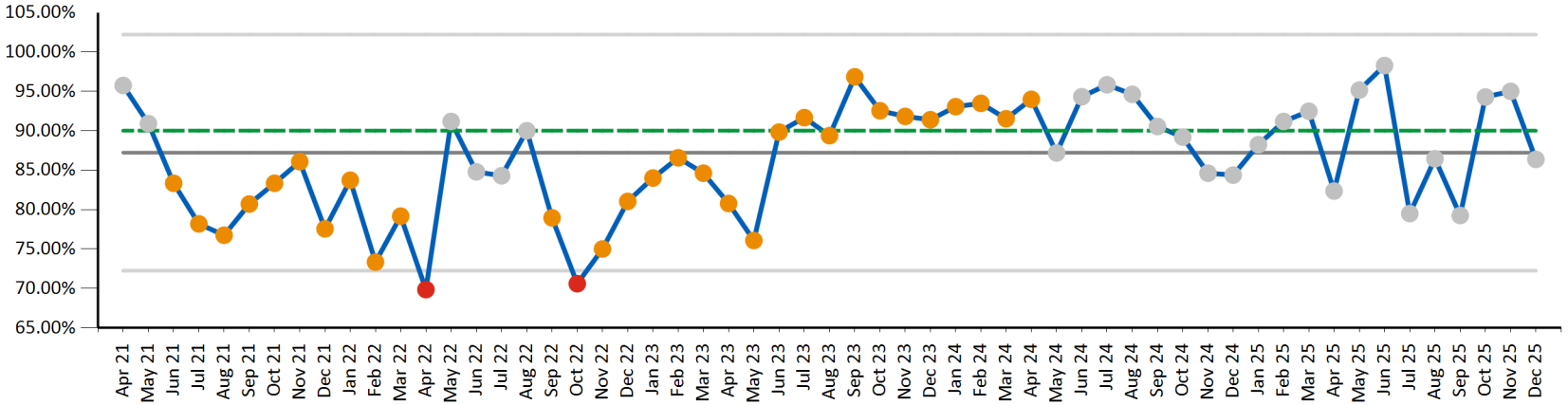
Plan	Actual
>= 15%	19.6%

244 - Hospital Postnatal Friends and Family Test - Satisfaction %

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
>= 90%	86.4%	Dec-25

Previous

Plan	Actual	Period
>= 90%	95.0%	Nov-25

Year to Date

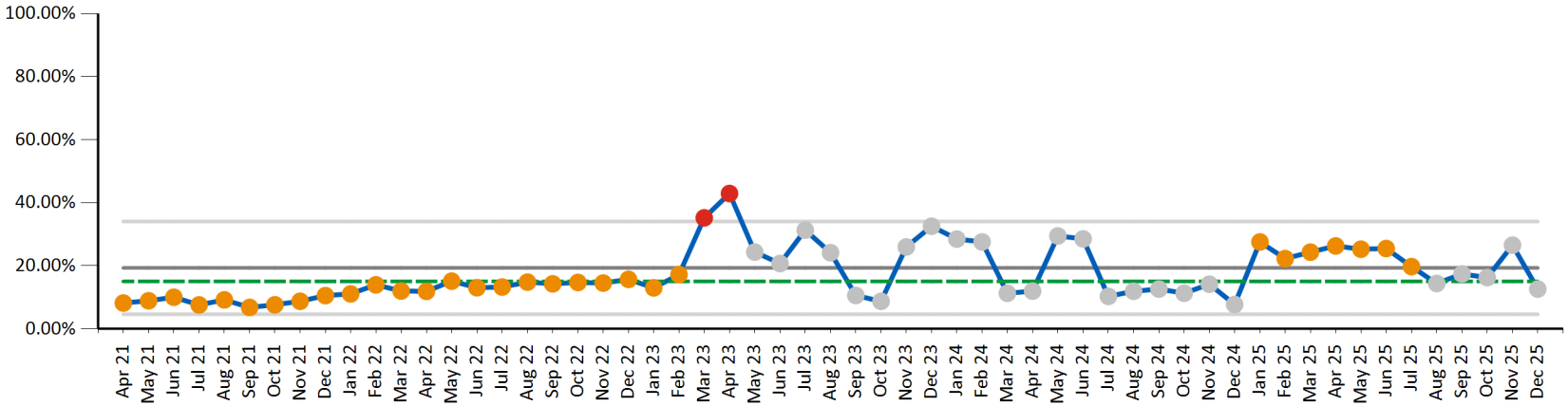
Plan	Actual
>= 90%	88.9%

85 - Community Postnatal - Friend and Family Response Rate

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
>= 15%	12.6%	Dec-25

Previous

Plan	Actual	Period
>= 15%	26.5%	Nov-25

Year to Date

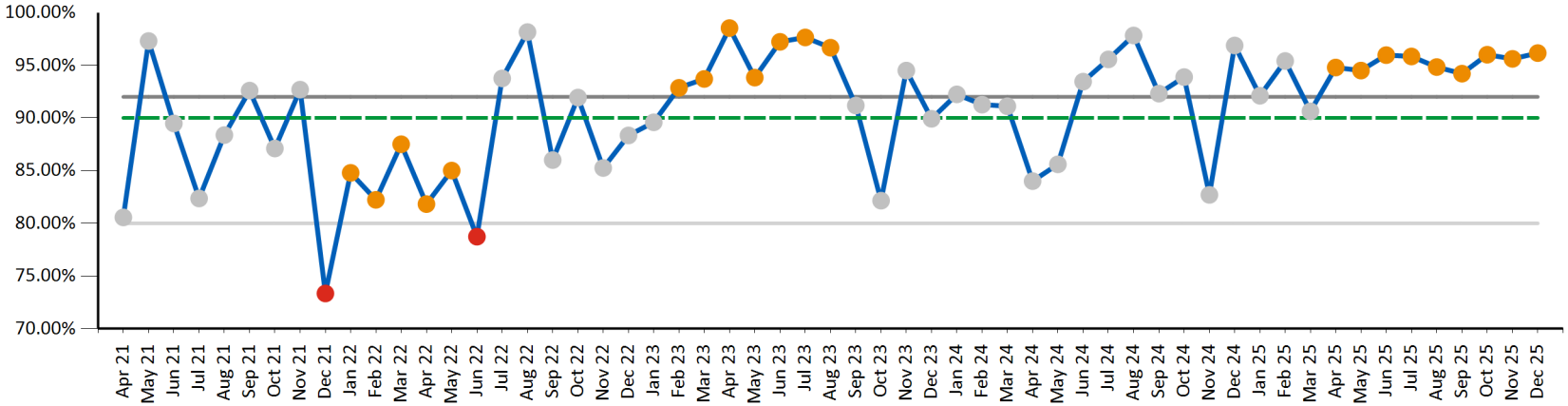
Plan	Actual
>= 15%	20.3%

245 - Community Postnatal 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%	96.2%	Dec-25

Previous

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

Year to Date

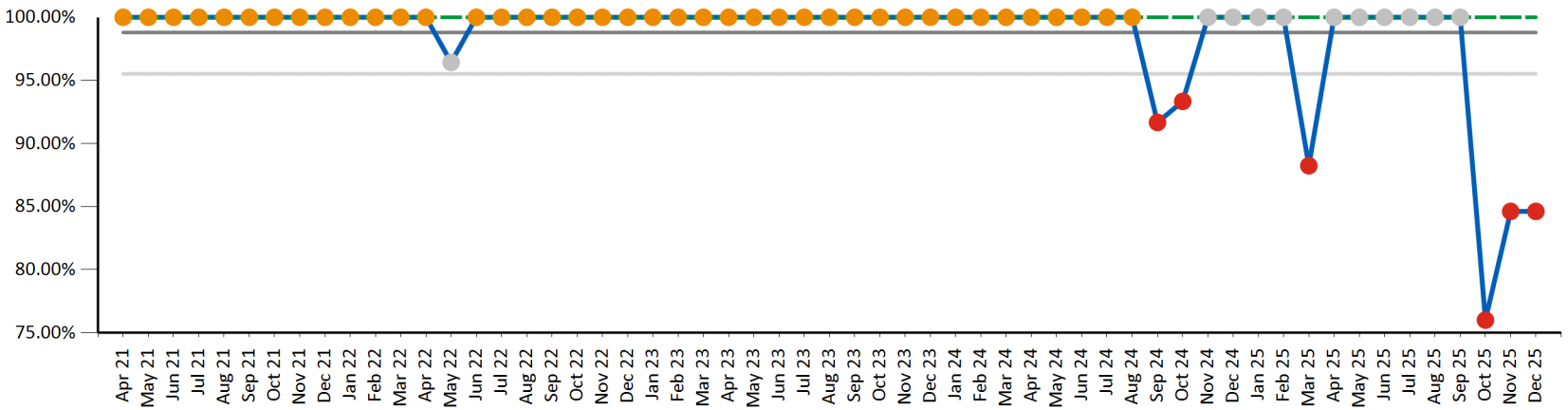
Plan	Actual
>= 90%	95.3%

89 - Formal complaints acknowledged within 3 working days

Special cause variation with deteriorating performance

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

3/6



Latest

Plan	Actual	Period
= 100%	84.6%	Dec-25

Previous

Plan	Actual	Period
= 100%	84.6%	Nov-25

Year to Date

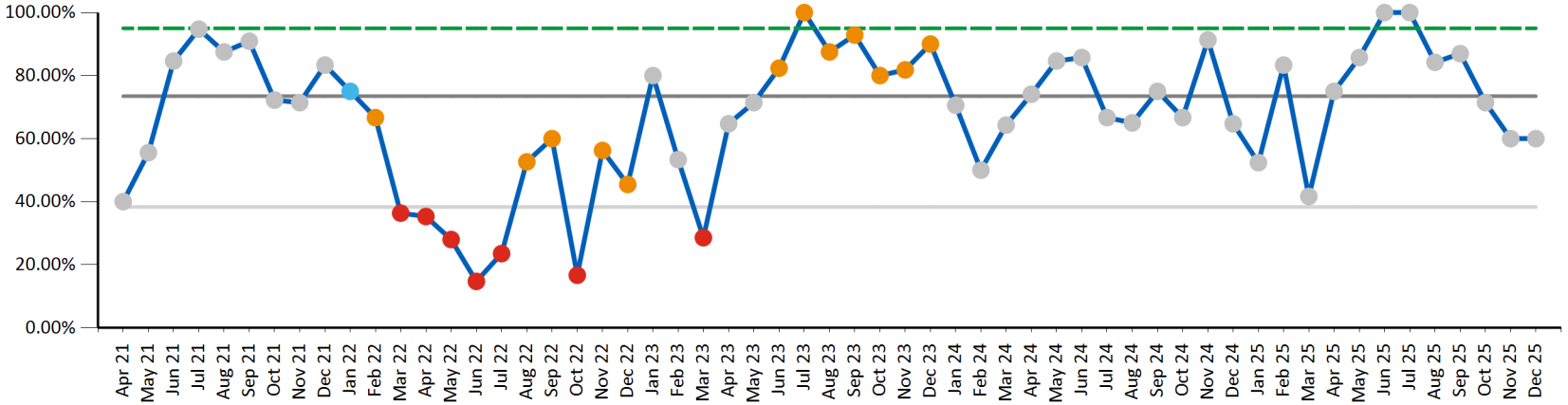
Plan	Actual
= 100%	92.0%

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%	60.0%	Dec-25

Previous

Plan	Actual	Period
>= 95%	60.0%	Nov-25

Year to Date

Plan	Actual
>= 95%	74.5%

Quality and Safety - Maternity

Friends and Family Response Rate – Response rate has decreased to 20.2% in month from 26.4% alongside a small decrease in satisfaction noted in birth responses this month to 93.7%. Feedback from the Matrons indicates that the feedback response rate is related to limited administrative provision to input the paper entries on the electronic Envoy system and with persons not completing the QR questionnaire in full.

Maternity Stillbirth Rate (excluding termination of pregnancy (TOPS) – 2 term (>37+ weeks) gestation cases reported in December 2025. Both cases will be subject to a detailed review using the perinatal mortality review tool. Excellent engagement continues with clients in first three REACH groups and an increase in overall contact time from 4.5hrs on average to 8 hours contact time with a community midwife reported due to the group teaching model.

¾ degree tears – Common cause variation noted in rate within month (incidence 3.8%). Perinatal pelvic health service implementation continues.

1:1 care in labour – Common cause variation of rate noted with incidence of 98.9% reported. Action plan in place as per CNST requirements – staff recruitment extremely positive – 2.09WTE Registered Midwife deficit anticipated by February 2026.

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. Special cause variation with improving performance noted again in December 2025 with 92.3% booked by 12+6 in December 2025 following the introduction of an early bird antenatal session as a pilot at Ingleside. Expansion of the early bird offer to additional areas of Bolton is in progress.

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 seen a special cause variation with improving performance with 67.9% compliance reported in following the introduction of the early bird antenatal session.

Inductions of labour delayed by >24 hours – 3 induction of labour cases were delayed by 24 hours in December 2025 throughout all the induction of labour pathway. Performance noted to be a common cause variation in the statistical process chart evaluation. The current escalation process has been reviewed and a new Maternity escalation tool has been implemented, alerting the senior team to delays of more than 24hrs and is supported by the introduction of a Matron of the Day to support clinical oversight.

Breastfeeding initiation – Special cause variation is noted in December 2025 with breast feeding initiation rates increased to 78.4% from 69.47% in November 2025. Service will be requesting the external assessment for the stage 2 Baby Friendly implementation to be undertaken in May 2026.

Preterm birth (less than 37 weeks gestation) – A common cause variation in incidence noted in month with 7.8% reported in December 2025. Introduction of the partner trial and decision making tool in progress that will assist in the screening to detect high risk pre term cases and enable the early allocation to appropriate pathways with ongoing monitoring.

HIE - A request has been made for the HIE indicator to be added to the integrated performance pack due to the identification of elevated incidence within Greater Manchester and Eastern Cheshire in past quarterly reviews. Analysis of metric undertaken in deep dive review being presented at Quality Assurance Committee in November 2025 and thematic review undertaken to identify themes from cases that were reported from April 2024-2025.

575 – Induction of Labour (IOL) delays refers to delays within the total process of induction (inclusive of any delays waiting transfer to Central Delivery Suite CDS). This is defined from the time of admission to the birth of the baby, the 3 delays reported within month relate to a delay in transfer to CDS of greater than 24hrs.

There is a new piloted Daily National Maternity Sitrep (introduced mid November 2025) which reports against the number of women whose commencement of induction of labour is delayed >6hrs. The measured parameters would be date and time of admission to the administration of the first medical intervention that would start the induction process. This would either be insertion of a pessary or artificial rupture of membranes.
The induction of labour delay metric is therefore under review and subsequent Board data will likely change to reflect changes to national guidance. Due to this, the outputs in respect to IOL delays will likely change in the near future.

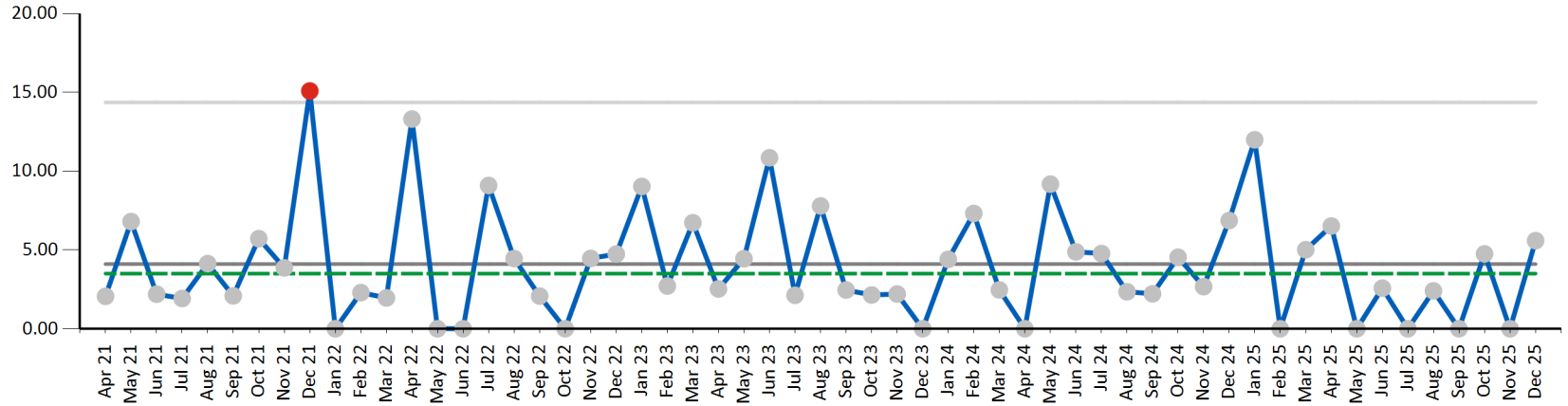
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births (excludes termination of pregnancy)	<= 3.50	5.59	Dec-25		<= 3.50	0.00	Nov-25	<= 3.50	2.46	
23 - Maternity -3rd/4th degree tears	<= 3.5%	3.8%	Dec-25		<= 3.5%	1.5%	Nov-25	<= 3.5%	2.5%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.9%	Dec-25		>= 95.0%	99.0%	Nov-25	>= 95.0%	99.0%	
203 - Booked 12+6	>= 90.0%	92.3%	Dec-25		>= 90.0%	92.3%	Nov-25	>= 90.0%	91.5%	
586 - Booked 10+0		67.9%	Dec-25			66.6%	Nov-25		67.6%	
204 - Percentage of women induced	<= 40%	33.1%	Dec-25		<= 40%	36.1%	Nov-25	<= 40%	35.4%	
210 - Initiation breast feeding	>= 65%	78.47%	Dec-25		>= 65%	69.47%	Nov-25	>= 65%	70.70%	
213 - Maternity complaints	<= 5	1	Dec-25		<= 5	0	Nov-25	<= 45	16	
319 - Maternal deaths (direct)	= 0	0	Dec-25		= 0	0	Nov-25	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	7.8%	Dec-25		<= 6%	10.2%	Nov-25	<= 6%	8.2%	
631 - Number of Neonates with suspected HIE Grade 2 and 3, = 37 Weeks (Bolton Babies only)		0	Dec-25			0	Nov-25		0	

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

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.50	5.59	Dec-25

Previous

Plan	Actual	Period
<= 3.50	0.00	Nov-25

Year to Date

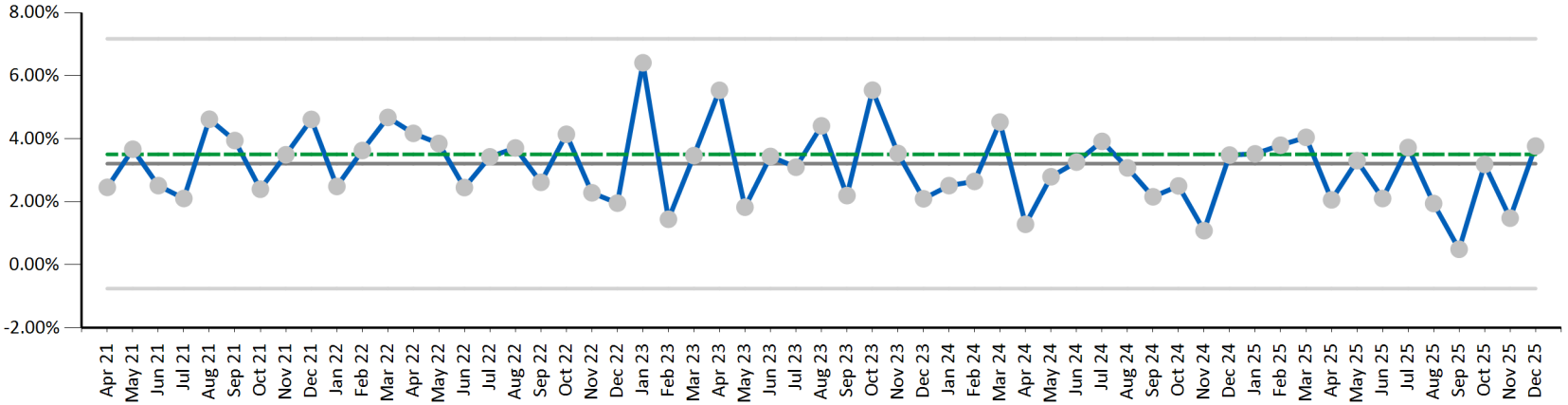
Plan	Actual
<= 3.50	2.46

23 - Maternity -3rd/4th degree tears

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 3.5%	3.8%	Dec-25

Previous

Plan	Actual	Period
<= 3.5%	1.5%	Nov-25

Year to Date

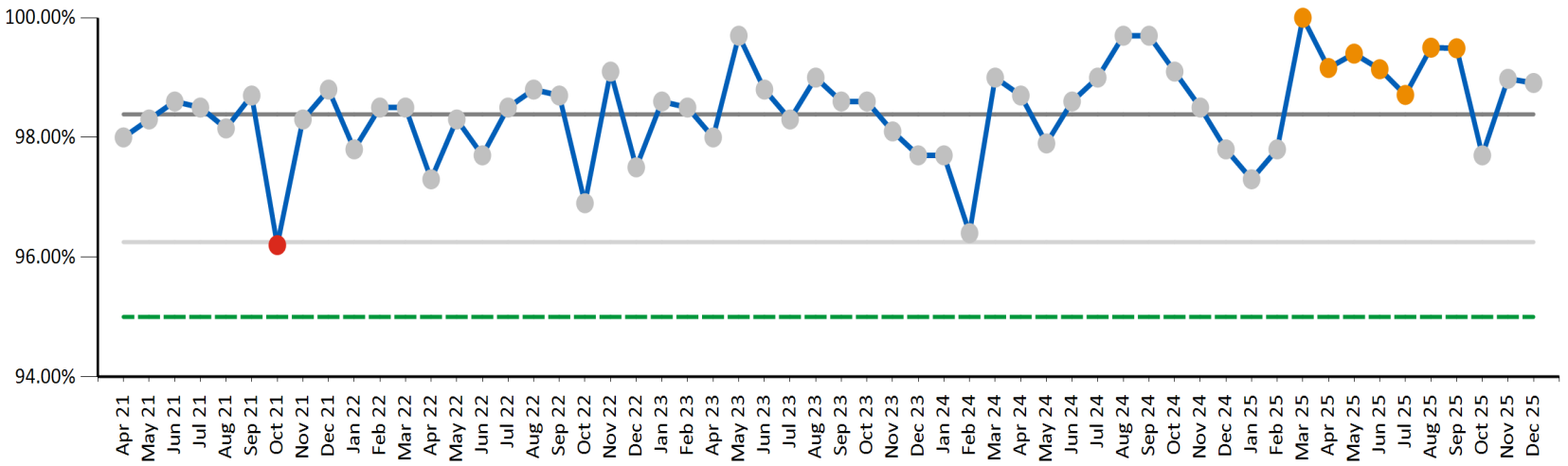
Plan	Actual
<= 3.5%	2.5%

202 - 1:1 Midwifery care in labour

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
> = 95.0%	98.9%	Dec-25

Previous

Plan	Actual	Period
> = 95.0%	99.0%	Nov-25

Year to Date

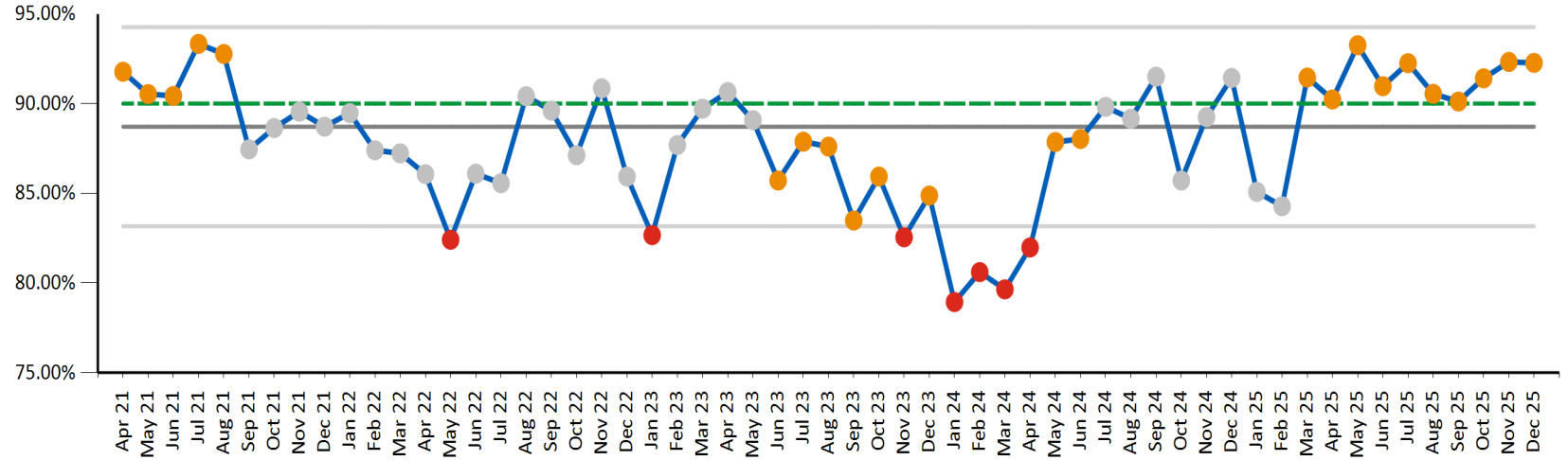
Plan	Actual
> = 95.0%	99.0%

203 - Booked 12+6

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%	92.3%	Dec-25

Previous

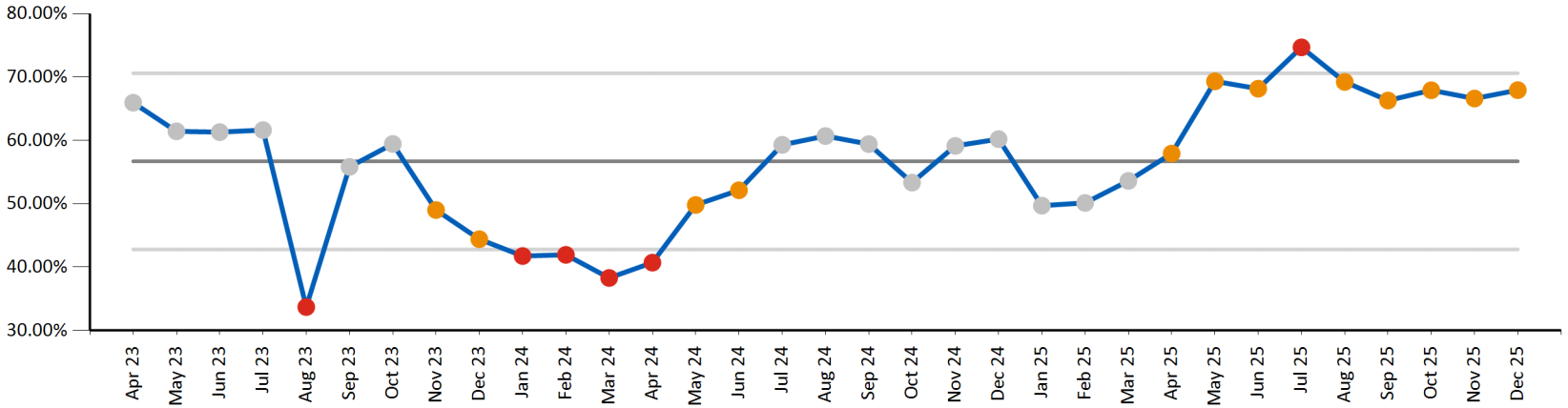
Plan	Actual	Period
> = 90.0%	92.3%	Nov-25

Year to Date

Plan	Actual
> = 90.0%	91.5%

586 - Booked 10+0

Special cause variation with improving performance



Latest

Plan	Actual	Period
	67.9%	Dec-25

Previous

Plan	Actual	Period
	66.6%	Nov-25

Year to Date

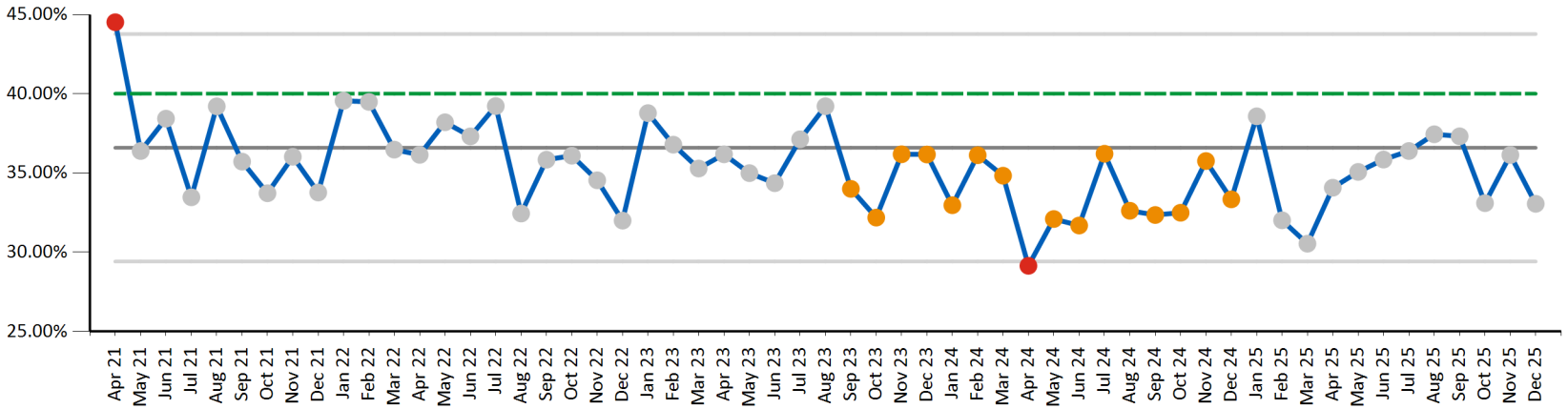
Plan	Actual
	67.6%

204 - Percentage of women induced

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 40%	33.1%	Dec-25

Previous

Plan	Actual	Period
<= 40%	36.1%	Nov-25

Year to Date

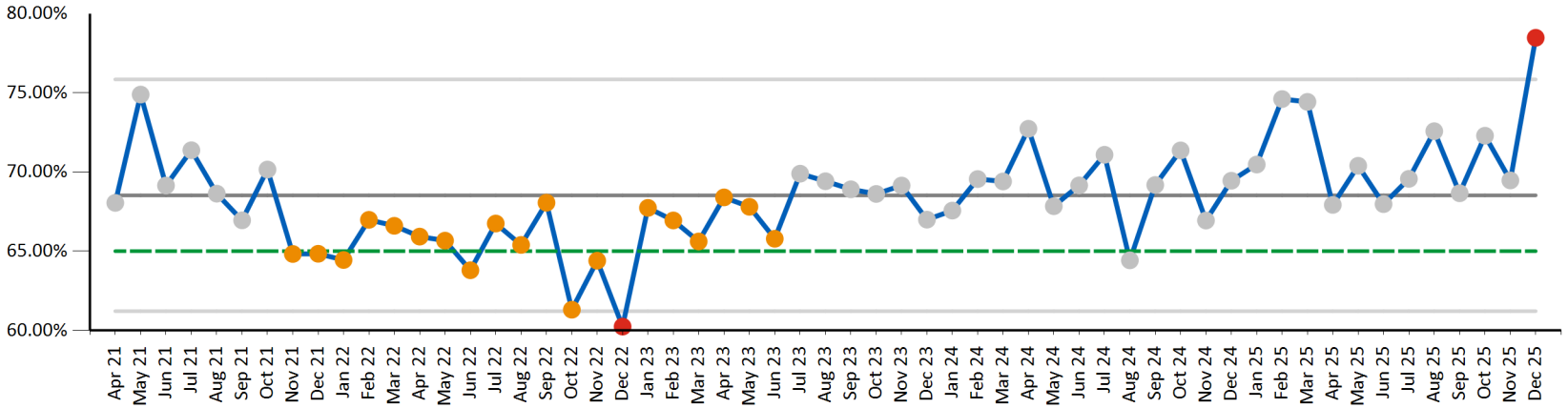
Plan	Actual
<= 40%	35.4%

210 - Initiation breast feeding

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
>= 65%	78.47%	Dec-25

Previous

Plan	Actual	Period
>= 65%	69.47%	Nov-25

Year to Date

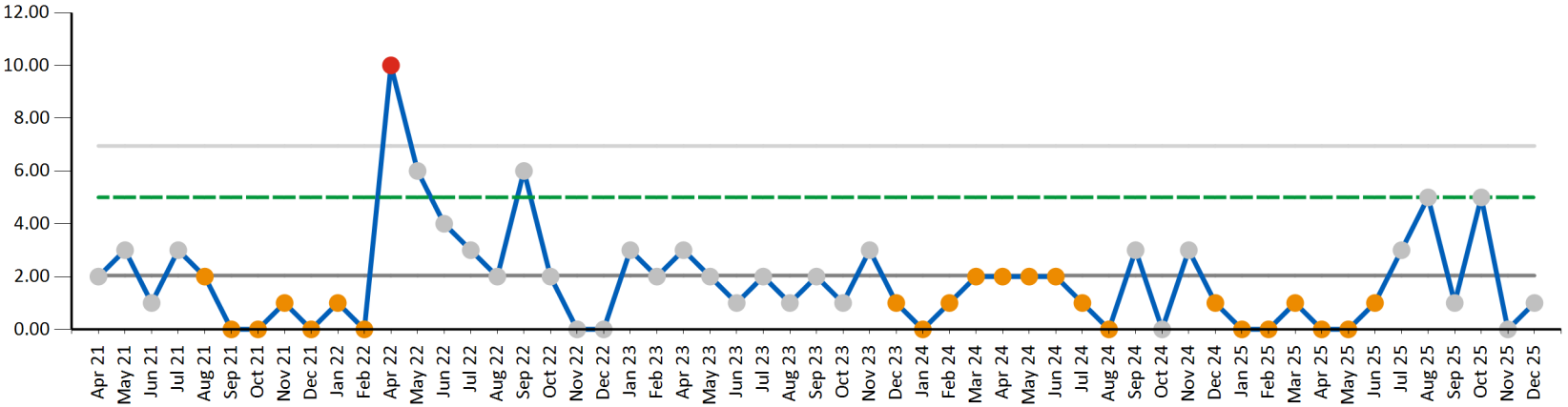
Plan	Actual
>= 65%	70.70%

213 - Maternity complaints

Common cause variation.

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

6/6



Latest

Plan	Actual	Period
<= 5	1	Dec-25

Previous

Plan	Actual	Period
<= 5	0	Nov-25

Year to Date

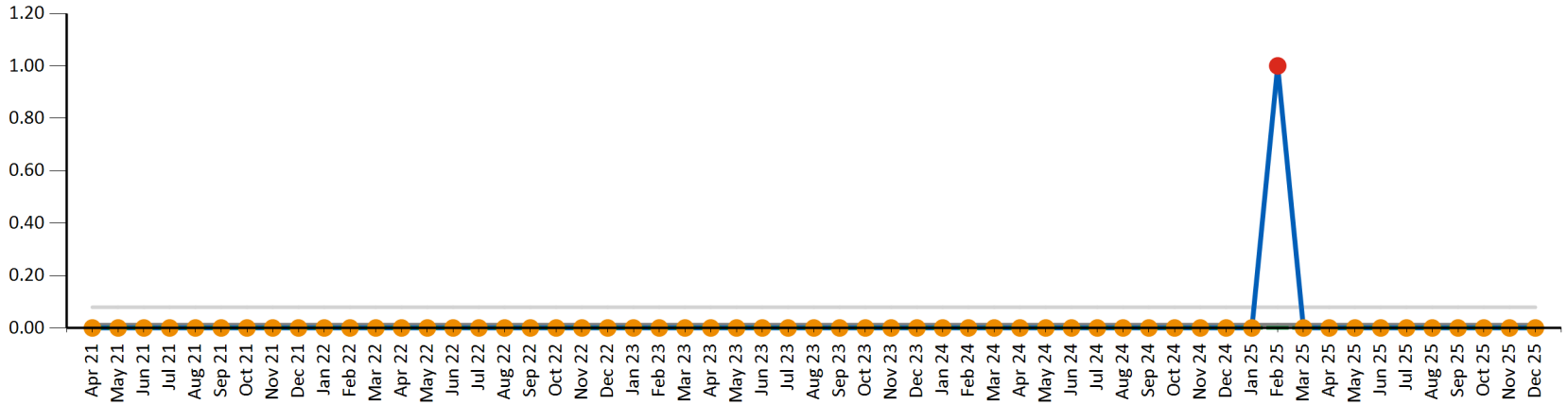
Plan	Actual
<= 45	16

319 - Maternal deaths (direct)

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	Dec-25

Previous

Plan	Actual	Period
= 0	0	Nov-25

Year to Date

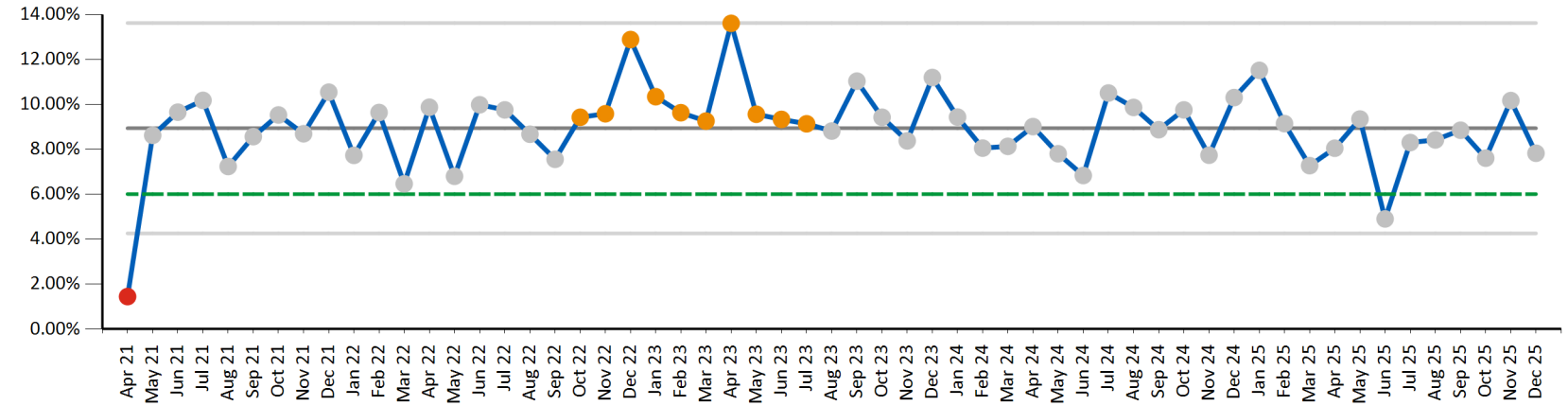
Plan	Actual
= 0	0

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.

0/6



Latest

Plan	Actual	Period
<= 6%	7.8%	Dec-25

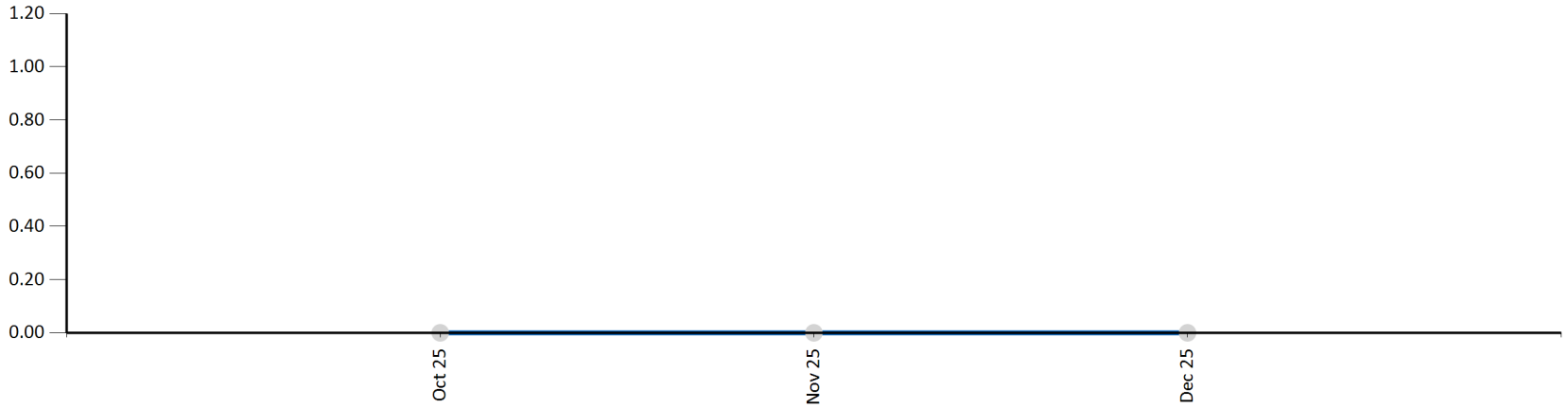
Previous

Plan	Actual	Period
<= 6%	10.2%	Nov-25

Year to Date

Plan	Actual
<= 6%	8.2%

631 - Number of Neonates with suspected HIE Grade 2 and 3, = 37 Weeks (Bolton Babies only) - SPC data available after 20 data points



Latest

Plan	Actual	Period
	0	Dec-25

Previous

Plan	Actual	Period
	0	Nov-25

Year to Date

Plan	Actual
	0

Operational Performance - Urgent Care

Bolton NHS Foundation Trust

Urgent Care

In December 2025, performance against the all types 4 hour standard was 60.3%, representing a 0.7% deterioration compared to November 2025 (61%). Ambulance handovers within 15 minutes improved slightly to 41.8% (41.3% in November), handovers within 30 minutes increased to 74.1% (up from 73%), while those completed within 60 minutes remained relatively stable at 90.32% (90.21% in November).

The total number of 12 hour waits rose by 161 patients in December compared to 1,046 in November. Non elective length of stay also increased slightly, rising to 4.96 days in December from 4.86 days in November.

NOF

For December, our fractured neck of femur performance improved to 67.6%, with 25 of 37 eligible patients getting to theatre within the 36 hour window.

Of the 12x patients who breached the target, 7x related to delays awaiting a plan and optimisation of patients, including delays for patients taking anticoagulants and patients awaiting complex equipment prior to surgery. The remaining patients were due to delays to theatre (5x patients), including to having a half-day list on a Sunday the impact of bank holidays on provision of theatre capacity. Mortality remains under the national average when adjusted for casemix, and our average number of hours to operation has fallen for the eighth successive month on an annual rolling average.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
53 - A&E 4 hour target	>= 73%	60.3%	Dec-25	L	>= 74%	61.0%	Nov-25	>= 73%	64.4%	?
538 - Percentage of Ambulance handovers - Proportion of patients handed over within 15 minutes	>= 65.0%	41.8%	Dec-25		>= 65.0%	41.3%	Nov-25	>= 65.0%	52.4%	F
70 - Percentage of Ambulance handovers - Proportion of patients handed over within 30 mins	>= 95.0%	74.1%	Dec-25		>= 95.0%	73.0%	Nov-25	>= 95.0%	81.8%	F
71 - Percentage of Ambulance handovers - Proportion of patients handed over within 60 minutes	= 100%	90.32%	Dec-25		= 100%	90.21%	Nov-25	= 100%	94.25%	?
539 - A&E 12 hour waits	= 0	1,207	Dec-25		= 0	1,046	Nov-25	= 0	7,726	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	67.6%	Dec-25		>= 75%	60.0%	Nov-25	>= 75%	48.0%	?
56 - Stranded patients - over 7 days	<= 200	268	Dec-25		<= 200	232	Nov-25	<= 200	268	F

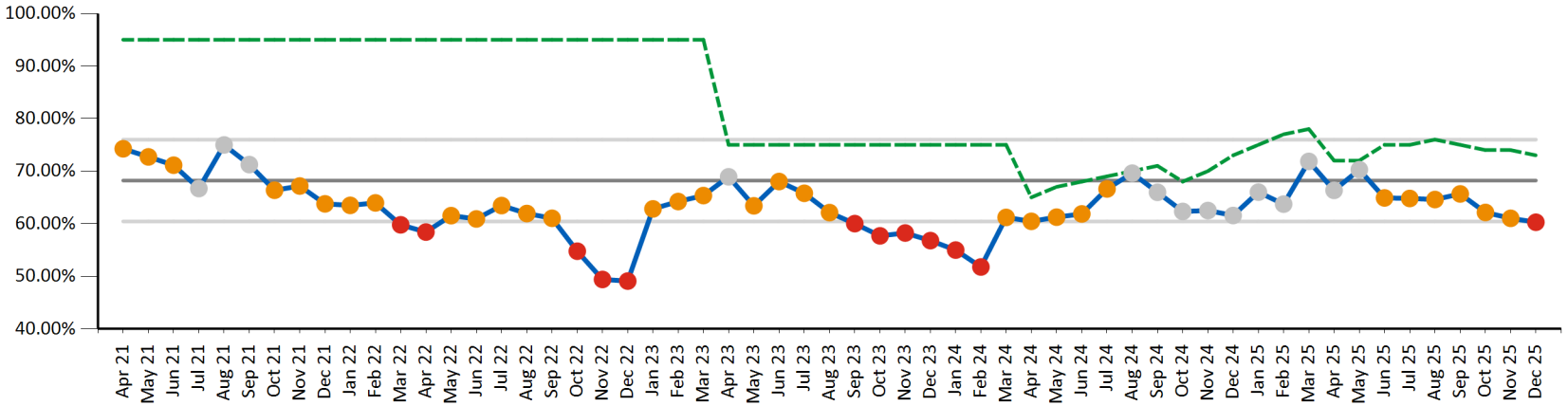
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
307 - Stranded Patients - LOS 21 days and over	<= 69	92	Dec-25		<= 69	76	Nov-25	<= 69	92	?
541 - Adult G&A bed occupancy	<= 92.0%	86.6%	Dec-25		<= 92.0%	89.6%	Nov-25	<= 92.0%	86.8%	P
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.96	Dec-25	L	<= 3.70	4.86	Nov-25	<= 3.70	4.87	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.5%	Nov-25		<= 13.5%	10.4%	Oct-25	<= 13.5%	10.9%	P
554 - 2 Hour Urgent Community Response %	<= 70.0%	90.9%	Dec-25		<= 70.0%	81.7%	Nov-25	<= 70.0%	83.9%	?
555 - 2 Hour Urgent Community Response Referrals	>= 358	373	Dec-25	H	>= 358	323	Nov-25	>= 3,222	2,584	F

53 - A&E 4 hour target

L Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 73%	60.3%	Dec-25

Previous

Plan	Actual	Period
>= 74%	61.0%	Nov-25

Year to Date

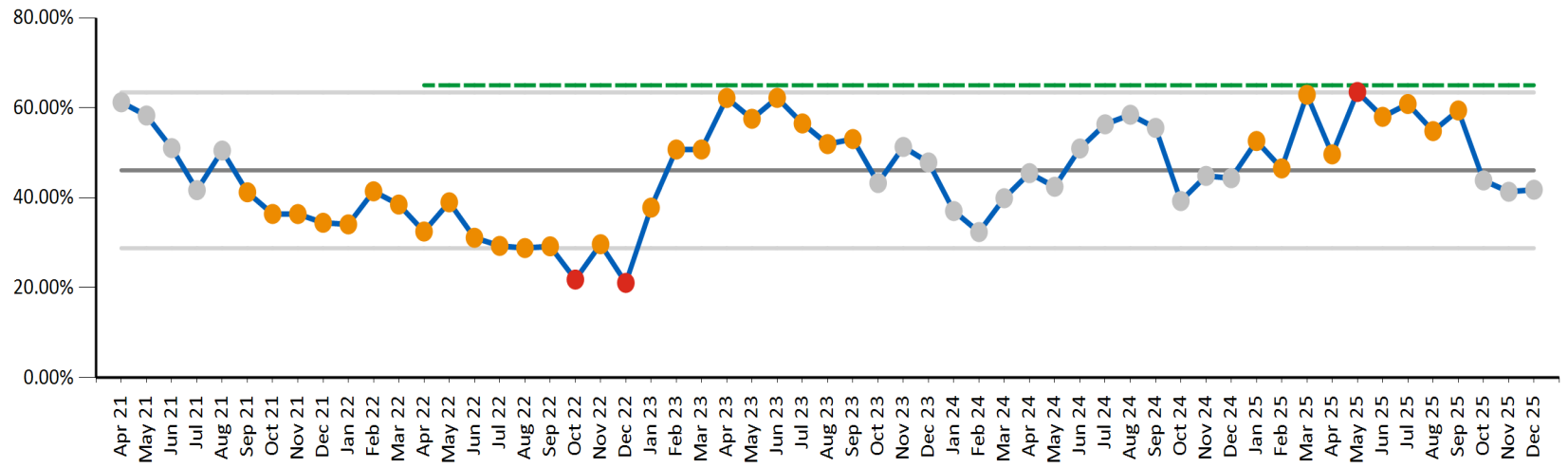
Plan	Actual
>= 73%	64.4%

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%	41.8%	Dec-25

Previous

Plan	Actual	Period
>= 65.0%	41.3%	Nov-25

Year to Date

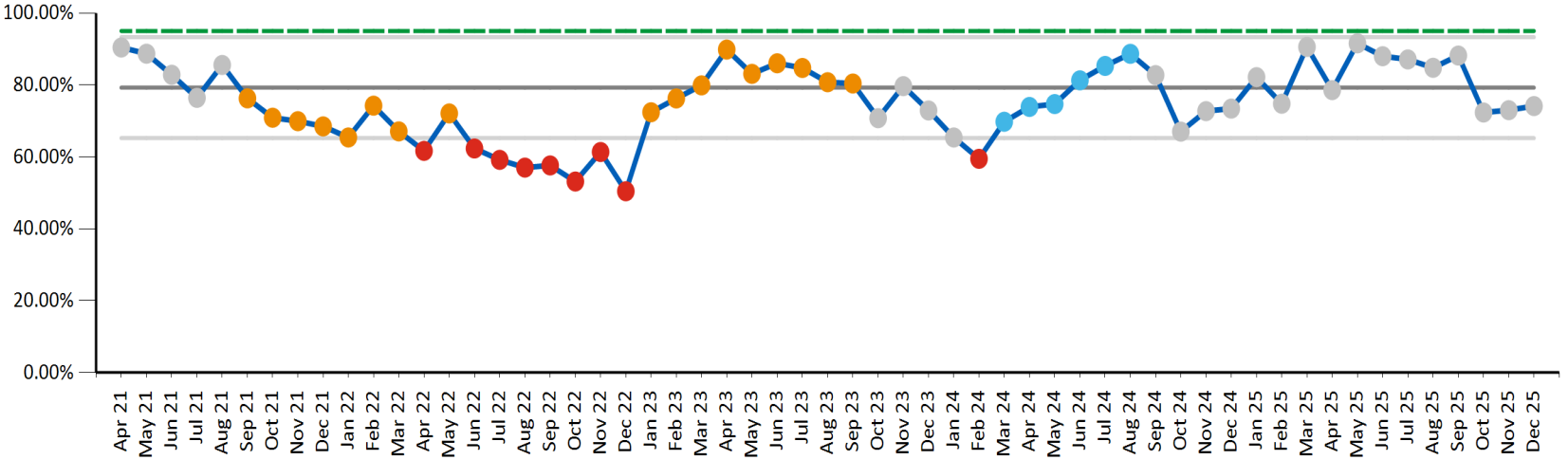
Plan	Actual
>= 65.0%	52.4%

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%	74.1%	Dec-25

Previous

Plan	Actual	Period
>= 95.0%	73.0%	Nov-25

Year to Date

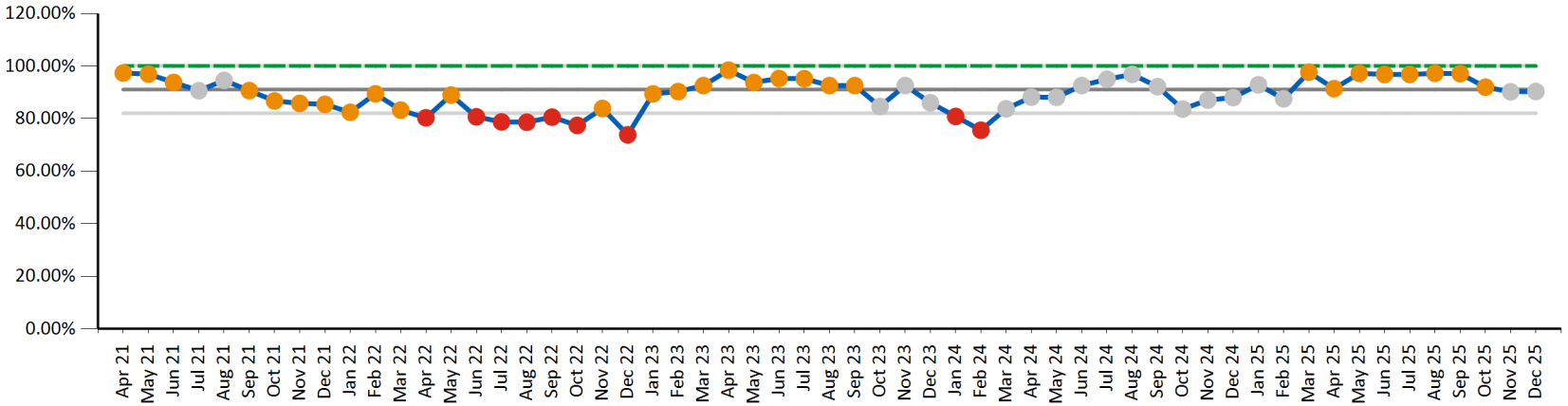
Plan	Actual
>= 95.0%	81.8%

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%	90.32%	Dec-25

Previous

Plan	Actual	Period
= 100%	90.21%	Nov-25

Year to Date

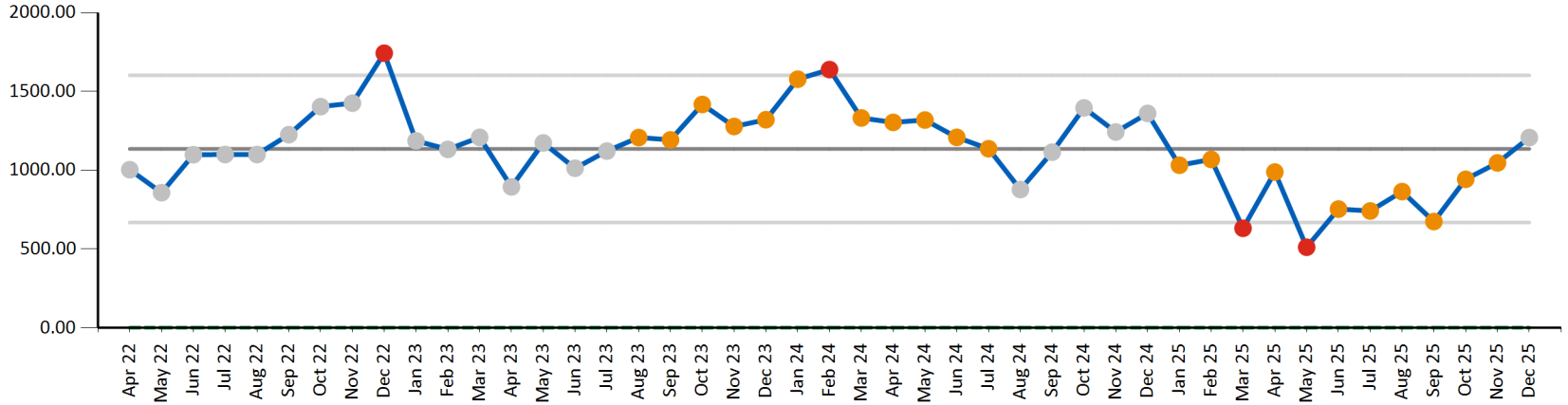
Plan	Actual
= 100%	94.25%

539 - A&E 12 hour waits

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
= 0	1,207	Dec-25

Previous

Plan	Actual	Period
= 0	1,046	Nov-25

Year to Date

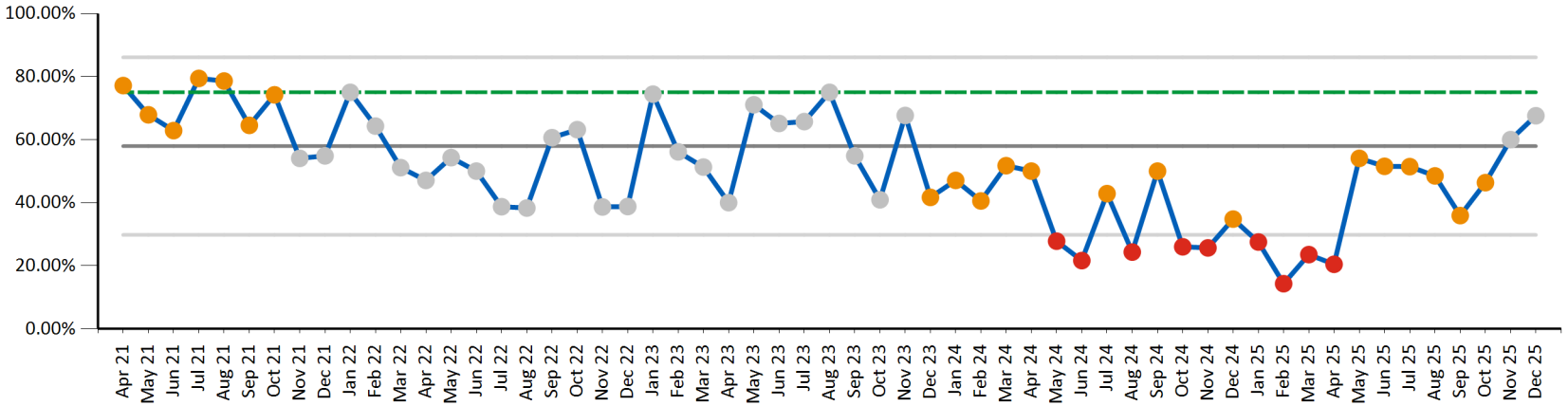
Plan	Actual
= 0	7,726

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

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 75%	67.6%	Dec-25

Previous

Plan	Actual	Period
>= 75%	60.0%	Nov-25

Year to Date

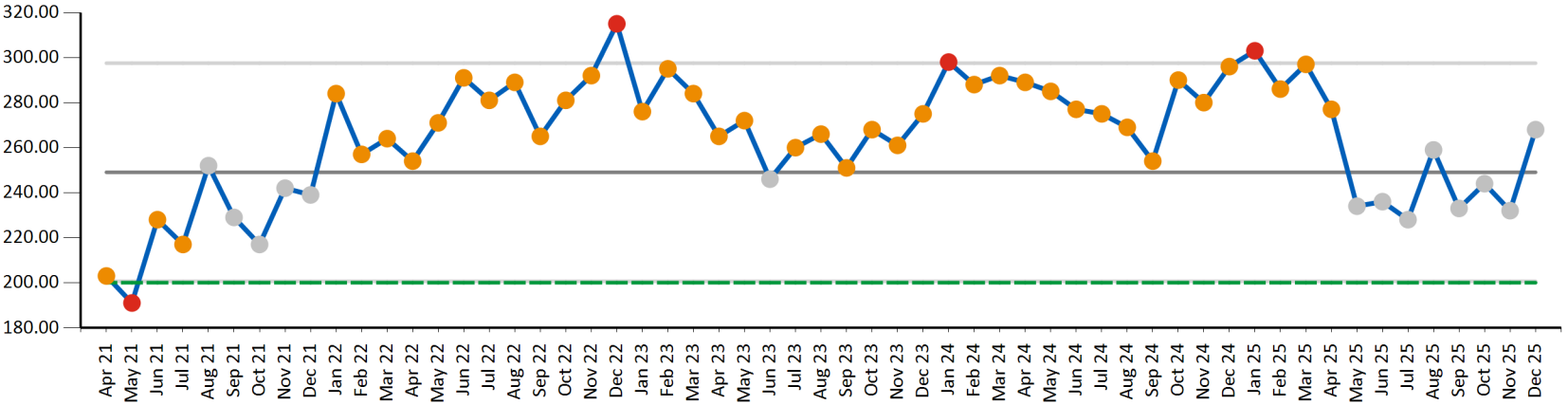
Plan	Actual
>= 75%	48.0%

56 - Stranded patients - over 7 days

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 200	268	Dec-25

Previous

Plan	Actual	Period
<= 200	232	Nov-25

Year to Date

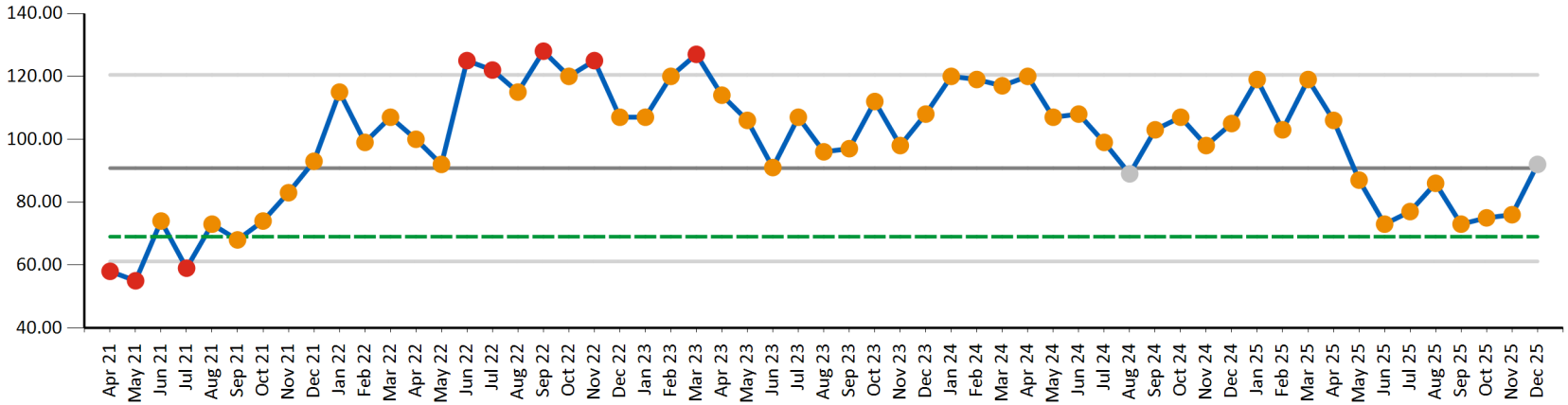
Plan	Actual
<= 200	268

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	92	Dec-25

Previous

Plan	Actual	Period
<= 69	76	Nov-25

Year to Date

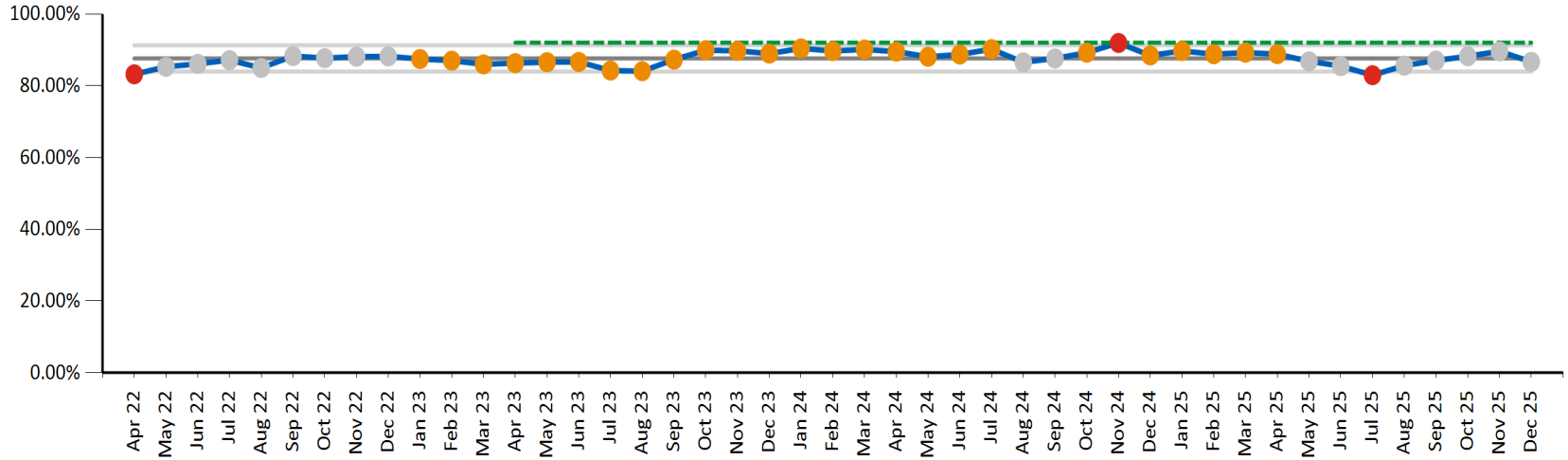
Plan	Actual
<= 69	92

541 - Adult G&A bed occupancy

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
<= 92.0%	86.6%	Dec-25

Previous

Plan	Actual	Period
<= 92.0%	89.6%	Nov-25

Year to Date

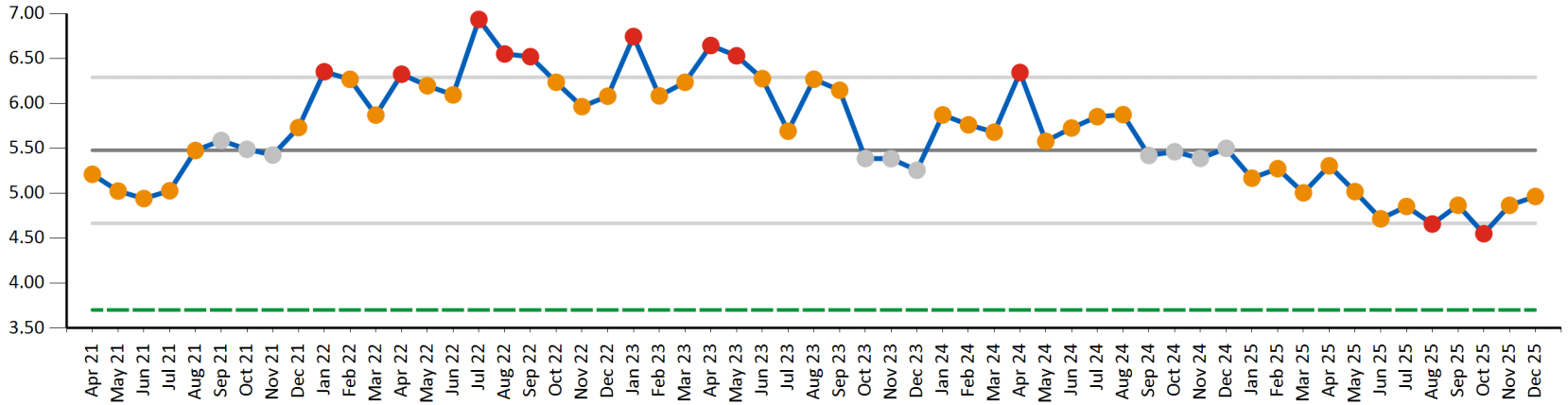
Plan	Actual
<= 92.0%	86.8%

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	4.96	Dec-25

Previous

Plan	Actual	Period
<= 3.70	4.86	Nov-25

Year to Date

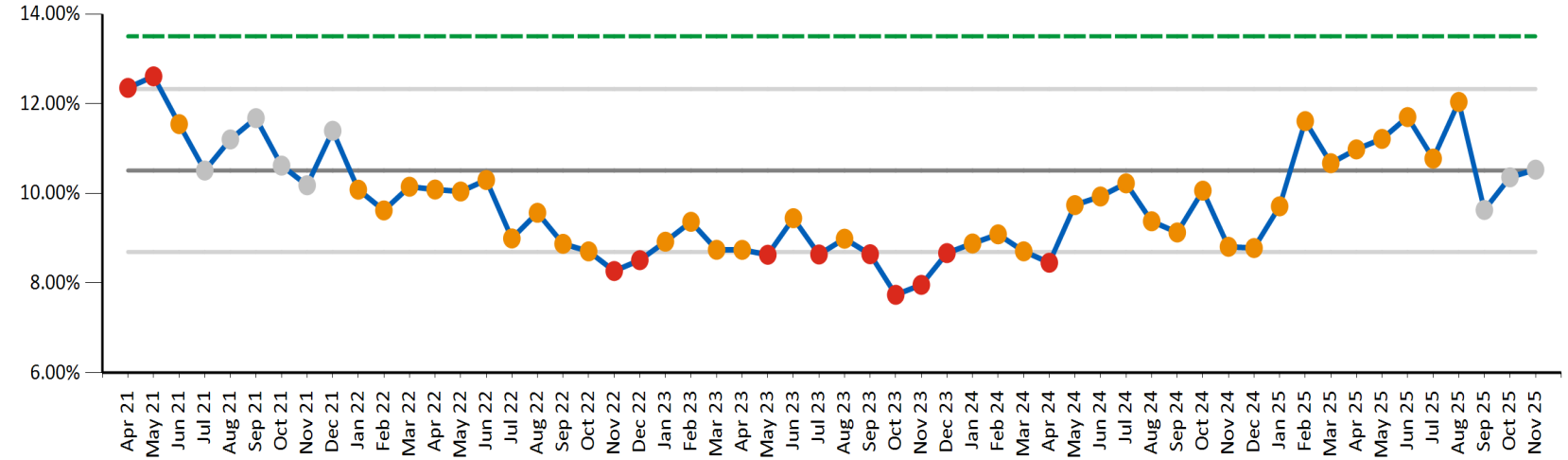
Plan	Actual
<= 3.70	4.87

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%	10.5%	Nov-25

Previous

Plan	Actual	Period
<= 13.5%	10.4%	Oct-25

Year to Date

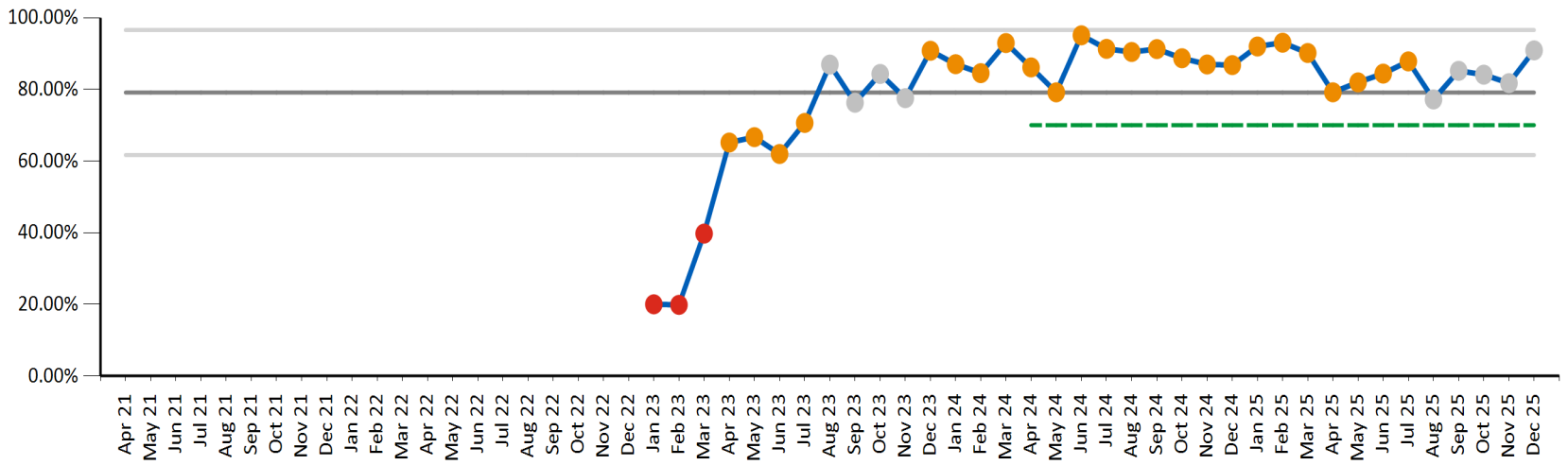
Plan	Actual
<= 13.5%	10.9%

554 - 2 Hour Urgent Community Response %

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
< = 70.0%	90.9%	Dec-25

Previous

Plan	Actual	Period
< = 70.0%	81.7%	Nov-25

Year to Date

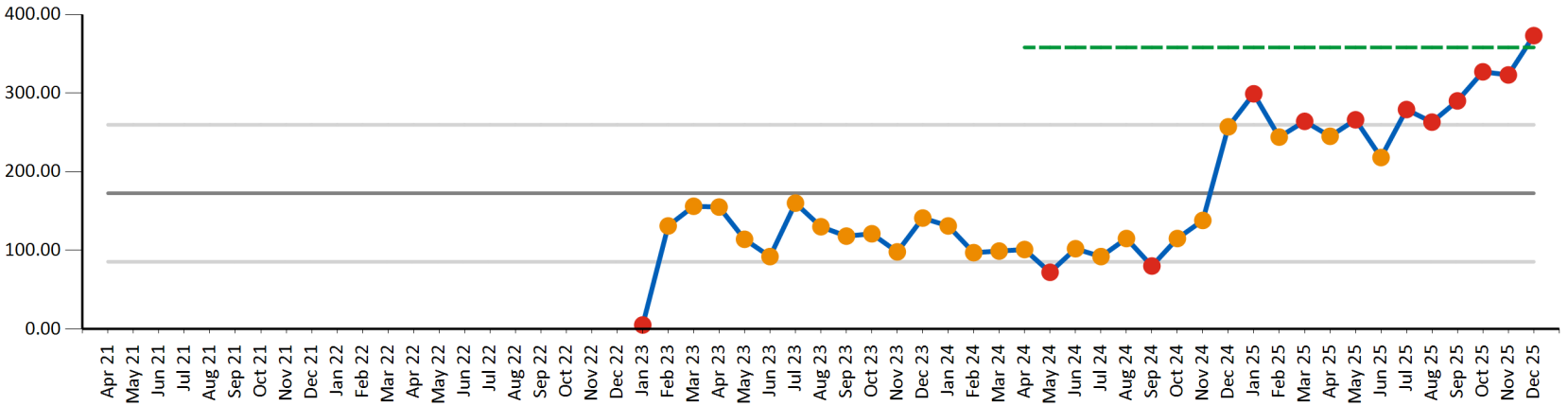
Plan	Actual
< = 70.0%	83.9%

555 - 2 Hour Urgent Community Response Referrals

Special cause variation with improving performance

We will regularly fail to meet the target.

1/6



Latest

Plan	Actual	Period
> = 358	373	Dec-25

Previous

Plan	Actual	Period
> = 358	323	Nov-25

Year to Date

Plan	Actual
> = 3,222	2,584

Operational Performance - Elective Care

NHS Bolton NHS Foundation Trust

RTT

We finished December with 0x 78-week breaches (5th successive month).

We finished December with 2x 65-week breaches. Both patients were Plastic Surgery patients with complex pathways. 2 patients was greater than the NHS England mandate of zero tolerance, however, was a reduction of 30x patients compared to the previous month.

We finished December with 910x 52-week breaches. This is a reduction of 193x patients from last month. We remain off-track against our plan due to challenges in a few key specialties, however we have resubmitted a reprofiled trajectory to return to our end of March position, which also takes into account the impact of industrial action on our performance, and we remain on track against this trajectory.

Our overall waiting list size remained largely static at 37,532 patients, and has remained static for the previous few months.

Due to decreased demand in December, we have dipped below our RTT performance against the operational plan by 1.7%, however we remain ahead of our operational plan with regards to the percentage of patients waiting longer than 18 weeks for their 1st appointment. Confidence remains high of returning to the projected end of year RTT position of 60.3%.

DM01

DM01 performance for the month was 4.98%, with 164 breaches, representing a 0.68% deterioration from the previous month. The decline is primarily attributable to reduced performance in cystoscopy and urodynamics.

There remains a risk to sustaining performance within the 5% standard if the cystoscopy service is unable to balance cancer and urgent activity alongside routine capacity, even with the additional activity currently in place. The speciality is developing a sustainability plan to stabilise performance and ensure future compliance.

	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%	57.4%	Dec-25	L	>= 92%	58.6%	Nov-25	>= 92%	57.4%	F
314 - RTT 18 week waiting list	<= 36,967	37,532	Dec-25	H	<= 37,248	37,478	Nov-25	<= 36,967	37,532	P
42 - RTT 52 week waits (incomplete pathways)		910	Dec-25	L		1,103	Nov-25		10,252	
540 - RTT 65 week waits (incomplete pathways)	= 0	2	Dec-25	L	= 0	32	Nov-25	<= 4,613	209	F
526 - RTT 78 week waits (incomplete pathways)	= 0	0	Dec-25	L	= 0	0	Nov-25	= 0	5	F
527 - RTT 104 week waits (incomplete pathways)	= 0	0	Dec-25	L	= 0	0	Nov-25	= 0	0	F

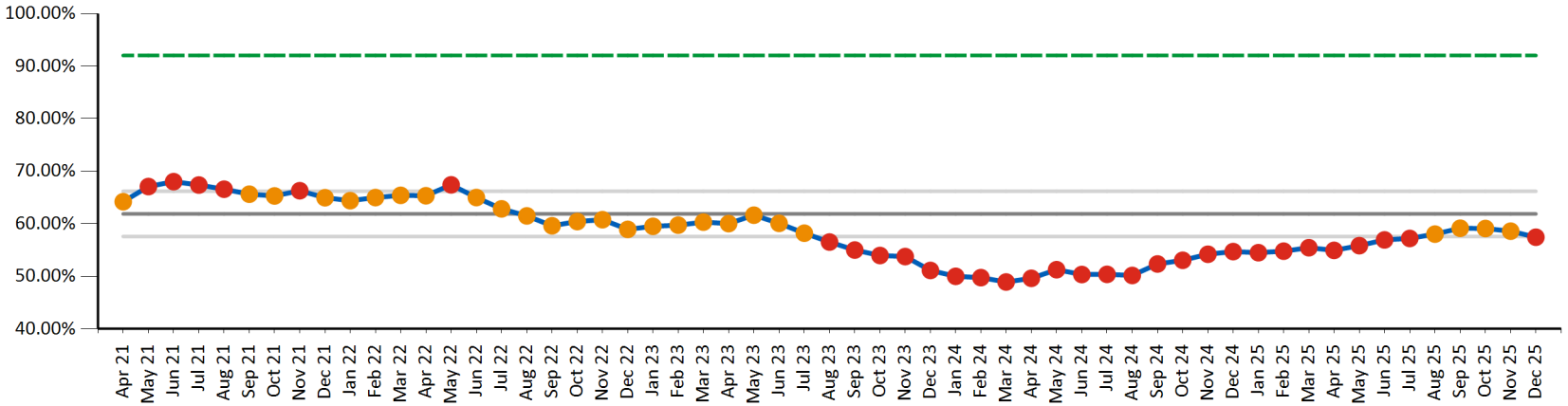
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
72 - Diagnostic Waits >6 weeks %	<= 5%	5.0%	Dec-25		<= 5%	4.3%	Nov-25	<= 5%	11.6%	
489 - Daycase Rates	>= 85%	82.6%	Dec-25		>= 85%	84.0%	Nov-25	>= 85%	81.9%	
582 - Theatre Utilisation - Capped		76.9%	Dec-25			78.8%	Nov-25		76.2%	
583 - Theatre Utilisation - Uncapped		79.6%	Dec-25			82.4%	Nov-25		79.8%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.6%	Oct-25		<= 1%	1.8%	Sep-25	<= 1%	1.7%	
62 - Cancelled operations re-booked within 28 days	= 100%	60.9%	Sep-25		= 100%	76.0%	Aug-25	= 100%	30.4%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	3.01	Dec-25		<= 2.00	3.01	Nov-25	<= 2.00	2.95	
309 - DNA Rate - New	<= 6.3%	9.5%	Dec-25		<= 6.3%	8.8%	Nov-25	<= 6.3%	9.4%	
310 - DNA Rate - Follow up	<= 5.0%	9.5%	Dec-25		<= 5.0%	8.7%	Nov-25	<= 5.0%	9.0%	

41 - RTT Incomplete pathways within 18 weeks %

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 92%	57.4%	Dec-25

Previous

Plan	Actual	Period
>= 92%	58.6%	Nov-25

Year to Date

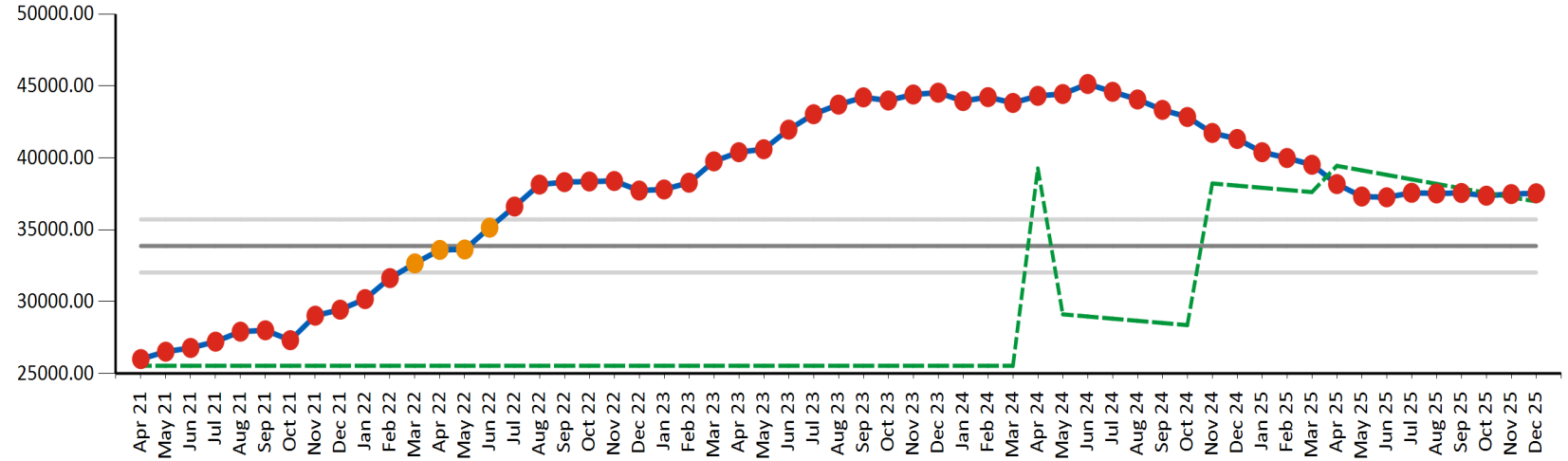
Plan	Actual
>= 92%	57.4%

314 - RTT 18 week waiting list

Special cause variation with deteriorating performance

Target will be regularly met.

4/6



Latest

Plan	Actual	Period
<= 36,967	37,532	Dec-25

Previous

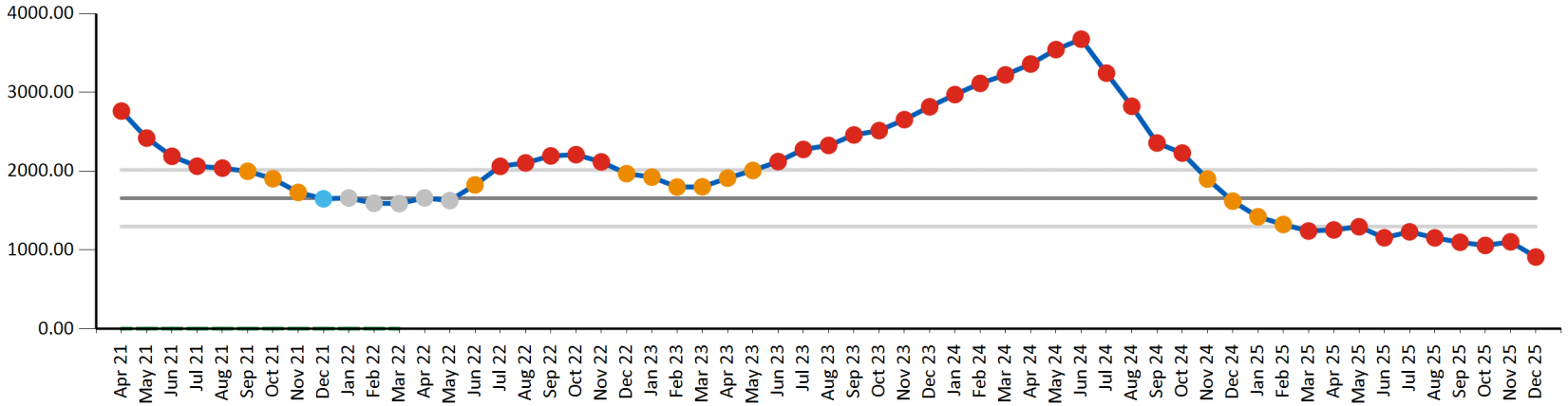
Plan	Actual	Period
<= 37,248	37,478	Nov-25

Year to Date

Plan	Actual
<= 36,967	37,532

42 - RTT 52 week waits (incomplete pathways)

Special cause variation with improving performance



Latest

Plan	Actual	Period
	910	Dec-25

Previous

Plan	Actual	Period
	1,103	Nov-25

Year to Date

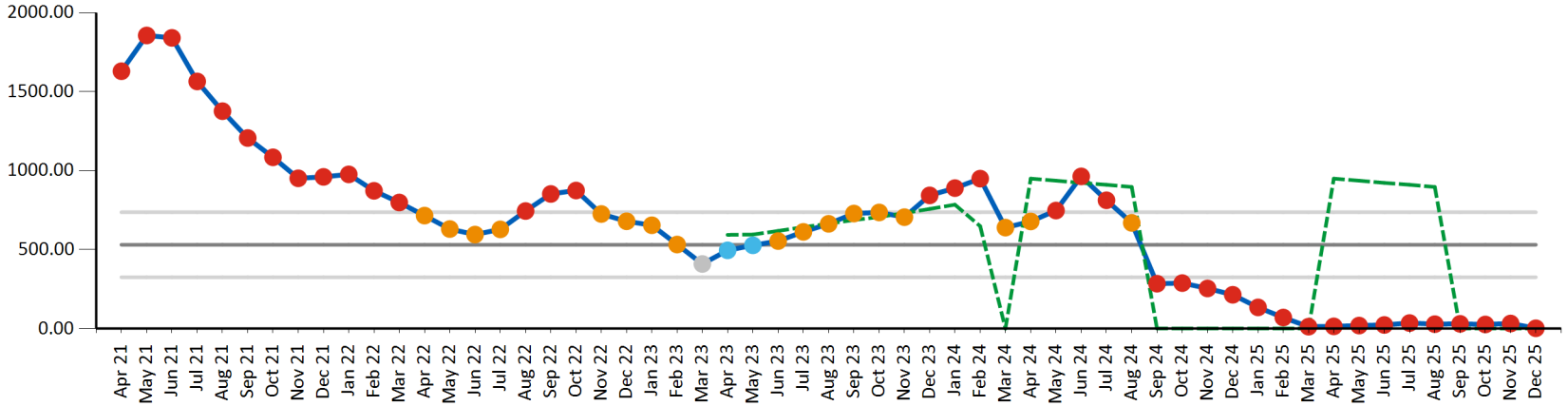
Plan	Actual
	10,252

540 - RTT 65 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6



Latest

Plan	Actual	Period
= 0	2	Dec-25

Previous

Plan	Actual	Period
= 0	32	Nov-25

Year to Date

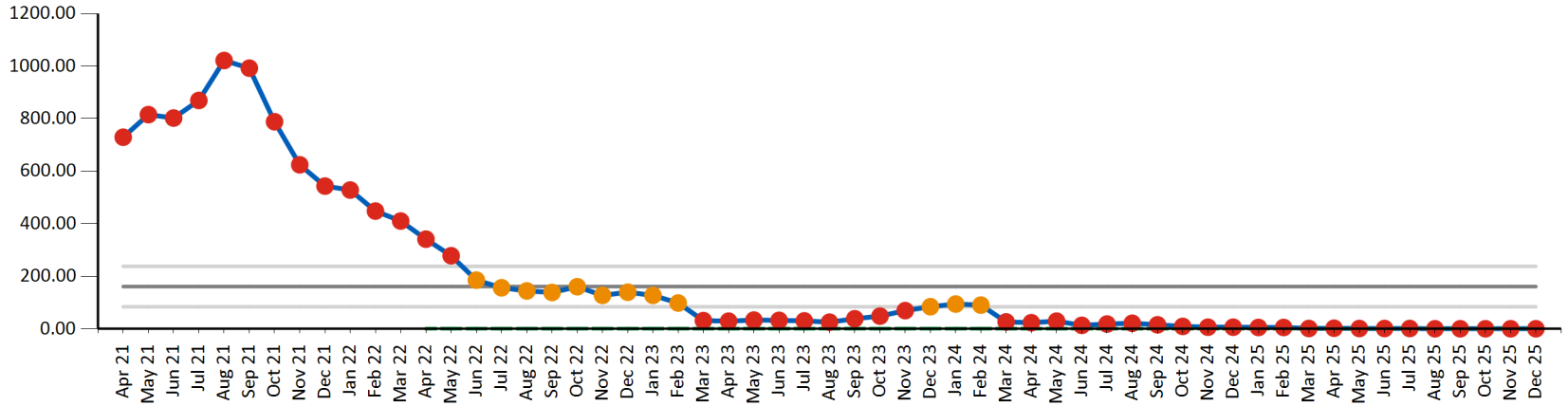
Plan	Actual
<= 4,613	209

526 - RTT 78 week waits (incomplete pathways)

Special cause variation with improving performance

We will regularly fail to meet the target.

5/6



Latest

Plan	Actual	Period
= 0	0	Dec-25

Previous

Plan	Actual	Period
= 0	0	Nov-25

Year to Date

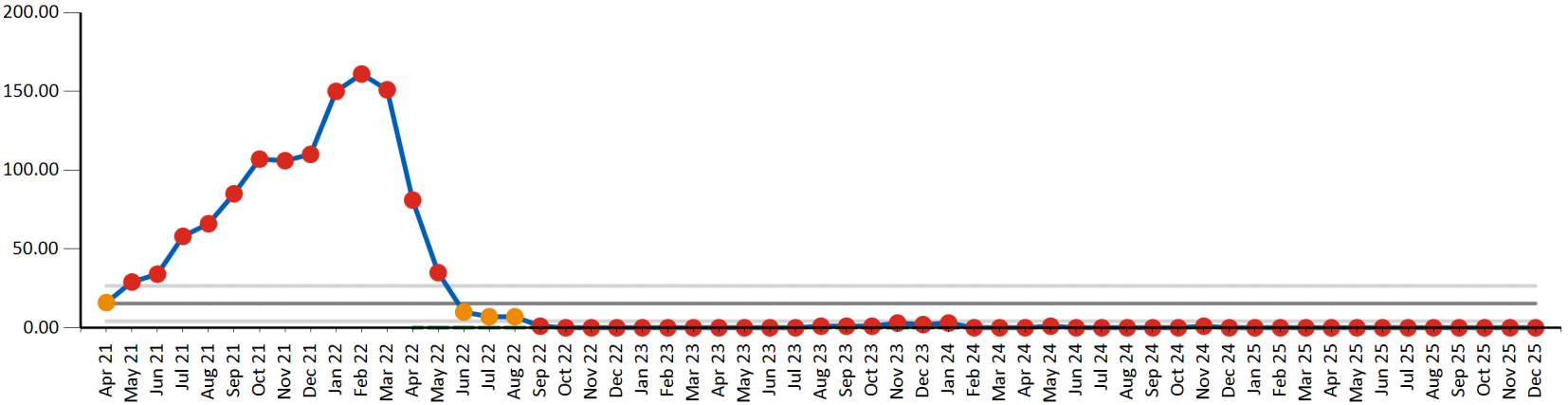
Plan	Actual
= 0	5

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	Dec-25

Previous

Plan	Actual	Period
= 0	0	Nov-25

Year to Date

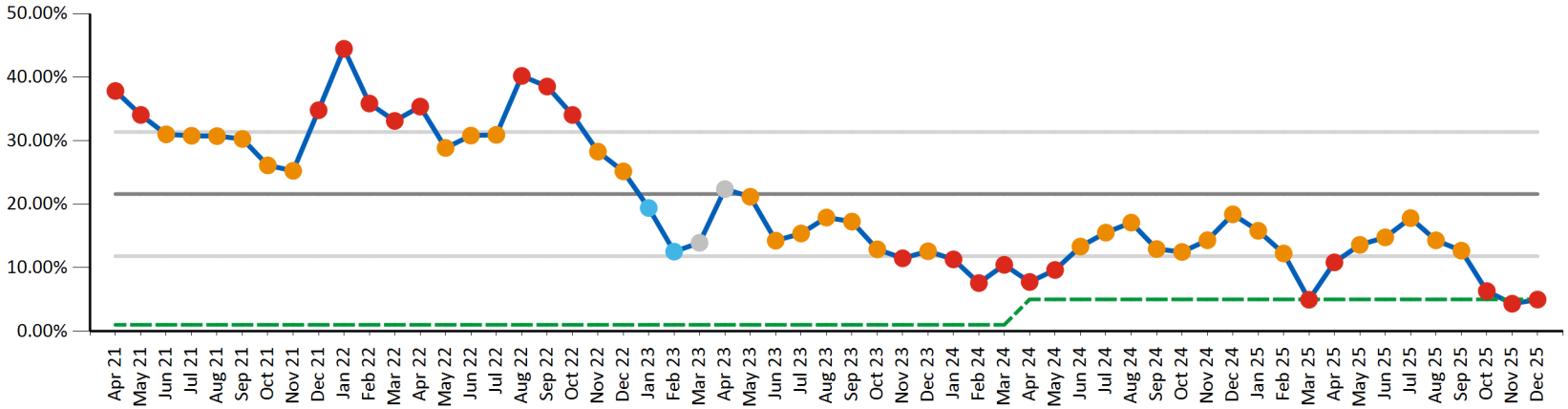
Plan	Actual
= 0	0

72 - Diagnostic Waits >6 weeks %

Special cause variation with improving performance

We will regularly fail to meet the target.

2/6



Latest

Plan	Actual	Period
<= 5%	5.0%	Dec-25

Previous

Plan	Actual	Period
<= 5%	4.3%	Nov-25

Year to Date

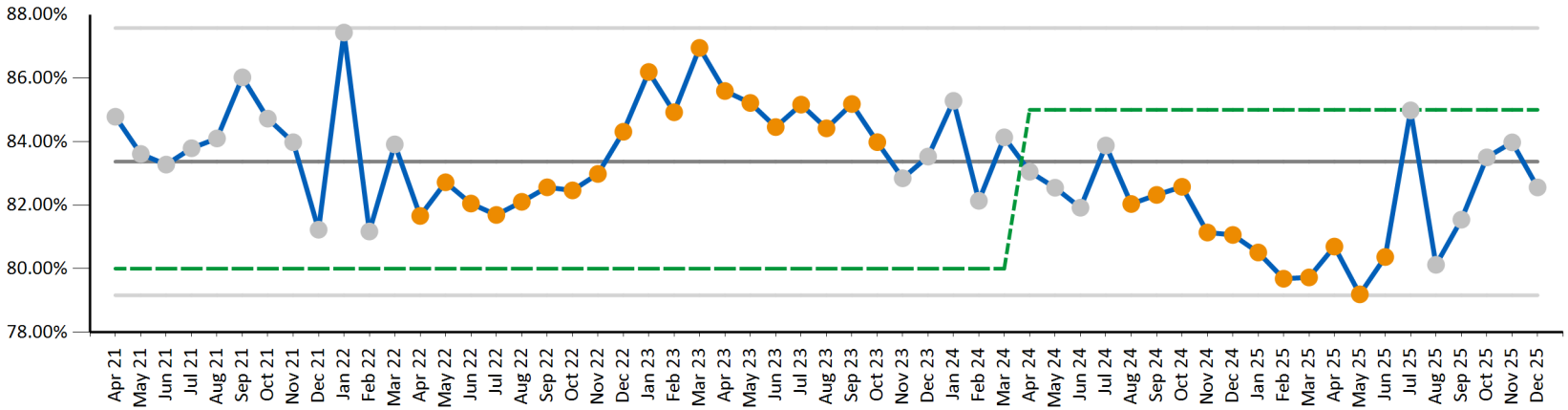
Plan	Actual
<= 5%	11.6%

489 - Daycase Rates

Common cause variation.

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

0/6



Latest

Plan	Actual	Period
>= 85%	82.6%	Dec-25

Previous

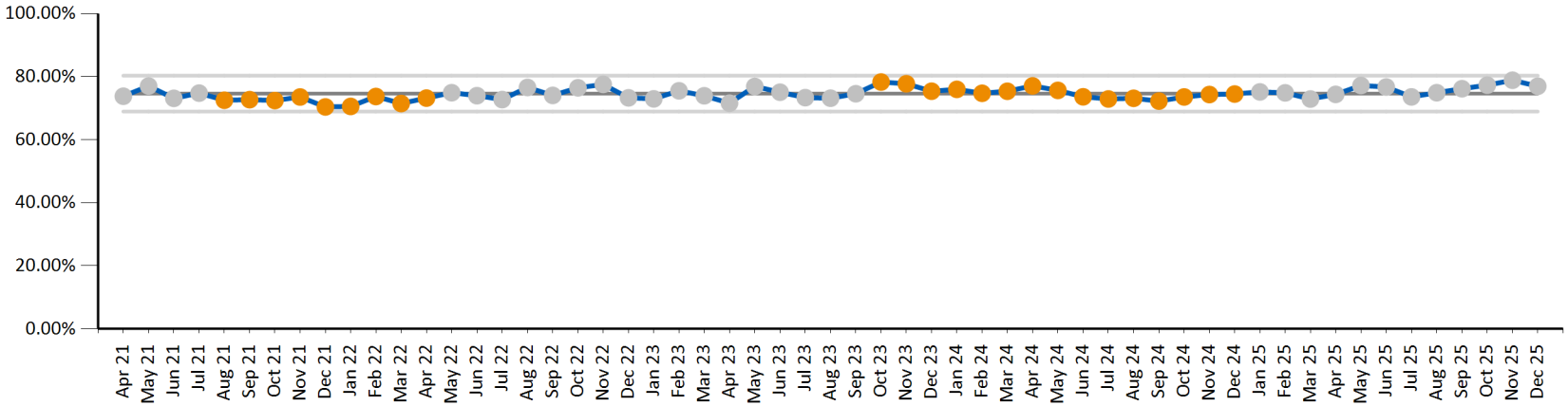
Plan	Actual	Period
>= 85%	84.0%	Nov-25

Year to Date

Plan	Actual
>= 85%	81.9%

582 - Theatre Utilisation - Capped

Common cause variation.



Latest

Plan	Actual	Period
	76.9%	Dec-25

Previous

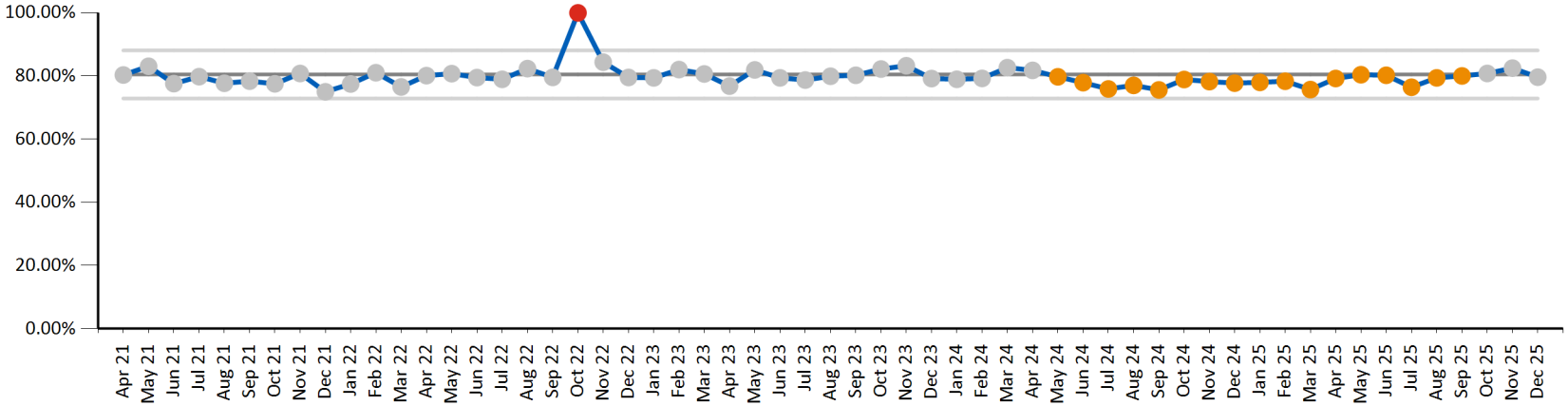
Plan	Actual	Period
	78.8%	Nov-25

Year to Date

Plan	Actual
	76.2%

583 - Theatre Utilisation - Uncapped

Common cause variation.



Latest

Plan	Actual	Period
	79.6%	Dec-25

Previous

Plan	Actual	Period
	82.4%	Nov-25

Year to Date

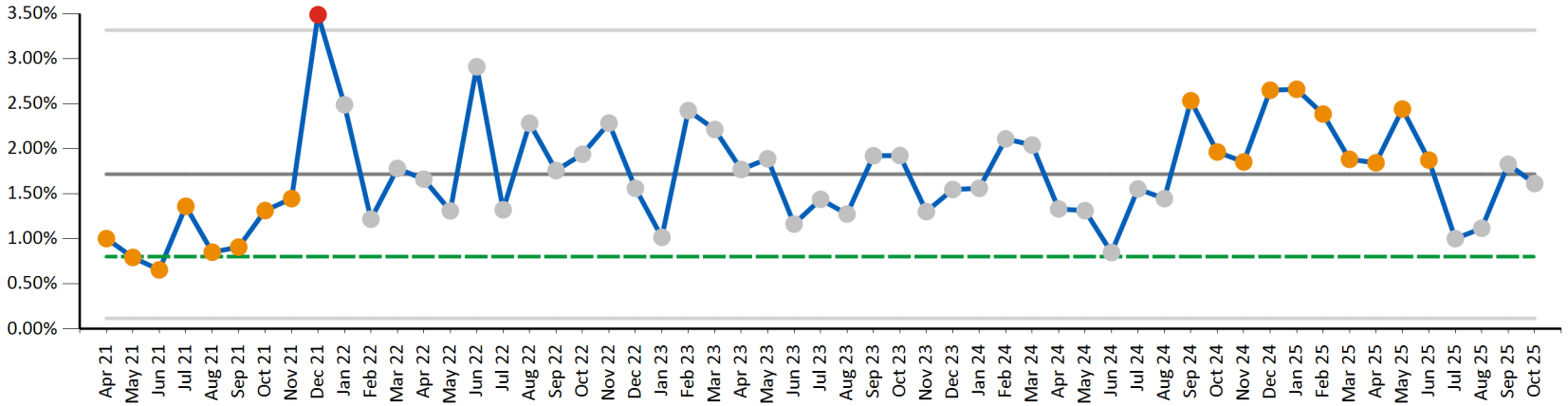
Plan	Actual
	79.8%

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%	1.6%	Oct-25

Previous

Plan	Actual	Period
<= 1%	1.8%	Sep-25

Year to Date

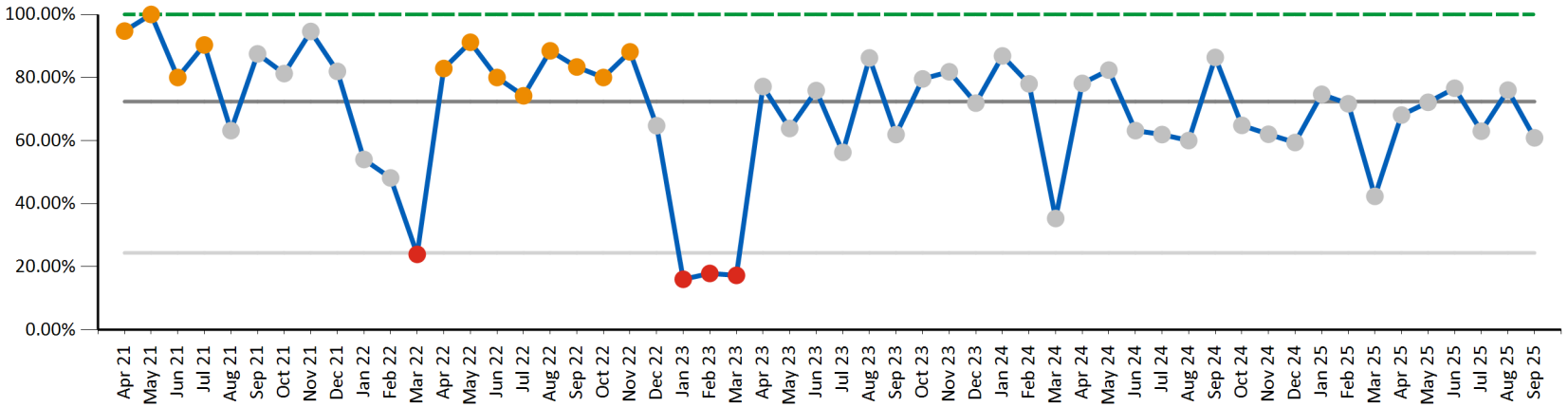
Plan	Actual
<= 1%	1.7%

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%	60.9%	Sep-25

Previous

Plan	Actual	Period
= 100%	76.0%	Aug-25

Year to Date

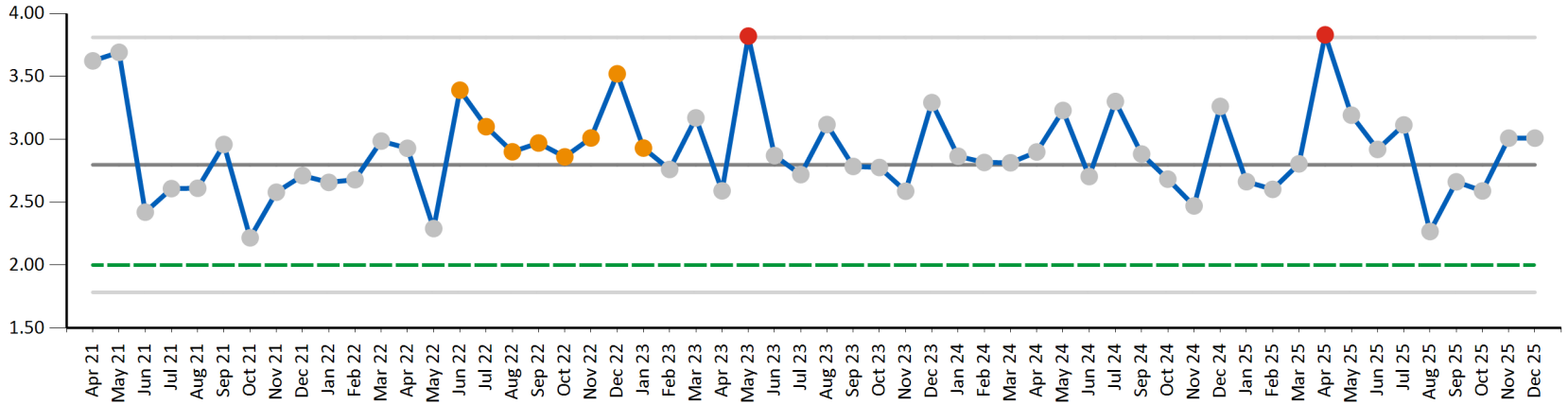
Plan	Actual
= 100%	30.4%

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	3.01	Dec-25

Previous

Plan	Actual	Period
<= 2.00	3.01	Nov-25

Year to Date

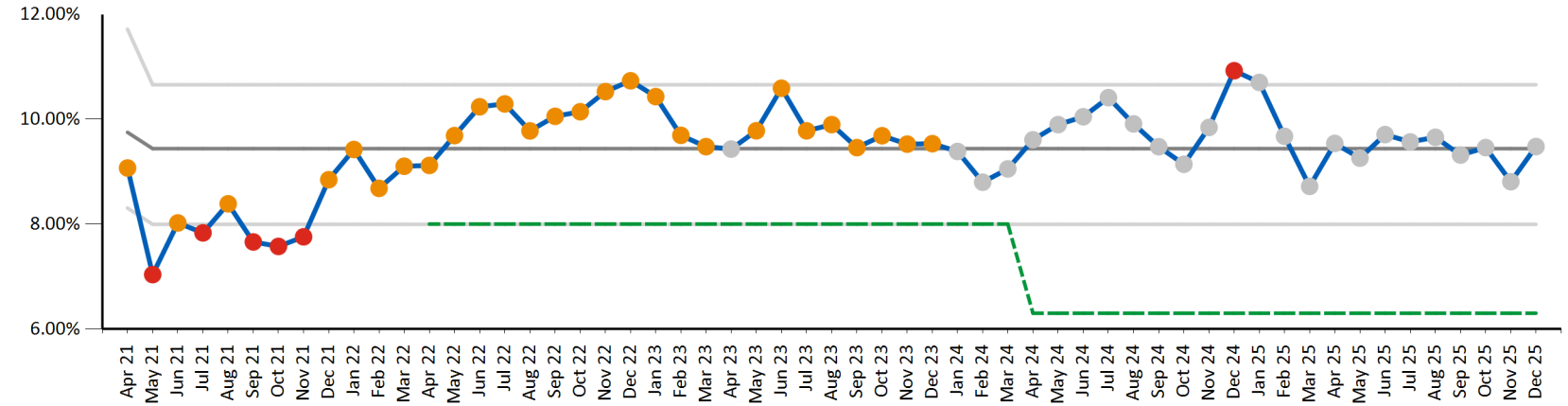
Plan	Actual
<= 2.00	2.95

309 - DNA Rate - New

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 6.3%	9.5%	Dec-25

Previous

Plan	Actual	Period
<= 6.3%	8.8%	Nov-25

Year to Date

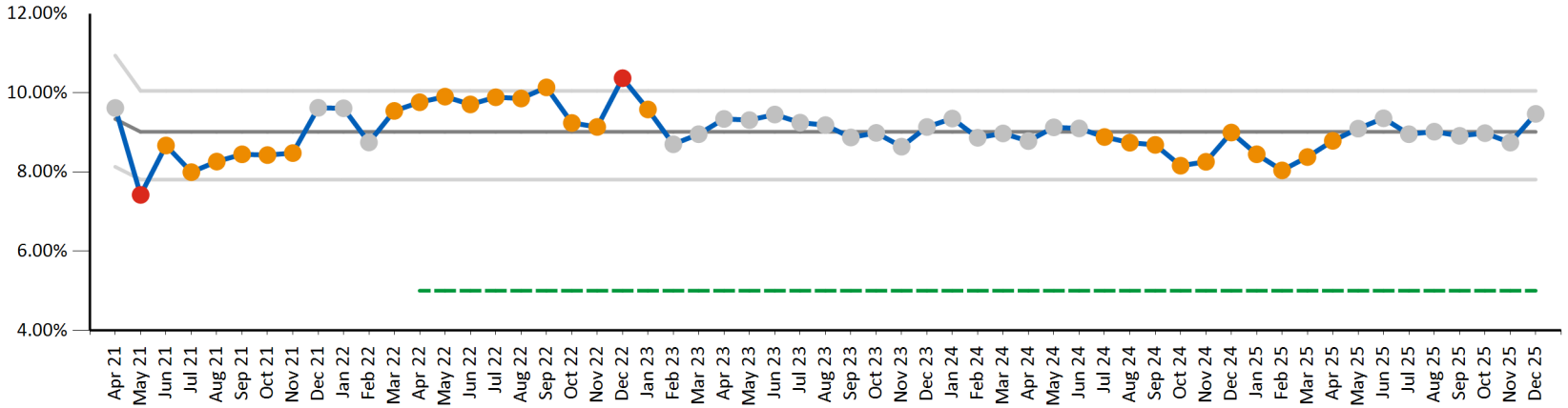
Plan	Actual
<= 6.3%	9.4%

310 - DNA Rate - Follow up

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 5.0%	9.5%	Dec-25

Previous

Plan	Actual	Period
<= 5.0%	8.7%	Nov-25

Year to Date

Plan	Actual
<= 5.0%	9.0%

Operational Performance - Cancer

NHS Bolton NHS Foundation Trust

For November, we achieved the faster diagnosis standard, and the 31-day treatment standard.
We failed to achieve the 62-day standard for November; this is driven by performance linked to capacity within Breast, and complex multi-stage patient pathways in Gynaecology and Lung. November's performance was an improvement on October's performance. It is expected that performance will deteriorate slightly in December due to capacity challenges within Breast, Urology, and Skin.

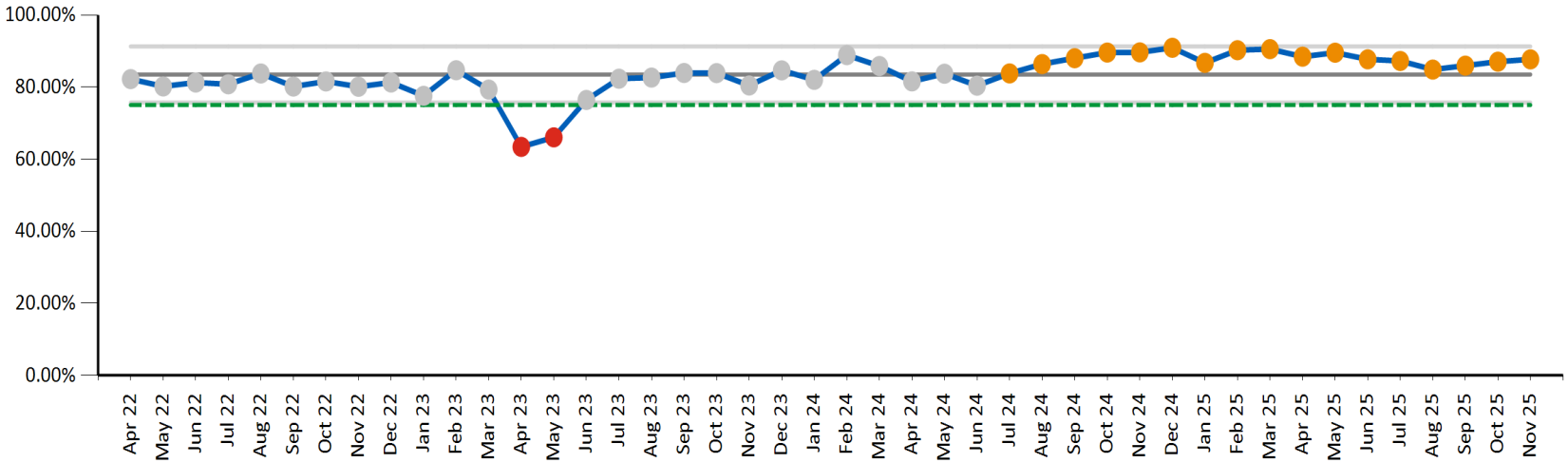
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
542 - Cancer: 28 day faster diagnosis	>= 75.0%	87.7%	Nov-25	H	>= 75.0%	87.0%	Oct-25	>= 75.0%	87.3%	P
584 - 31 Day General Treatment Standard	>= 96%	100.0%	Nov-25		>= 96%	97.4%	Oct-25	>= 96%	98.0%	?
585 - 62 Day General Standard	>= 85%	82.9%	Nov-25		>= 85%	80.4%	Oct-25	>= 85%	83.4%	?

542 - Cancer: 28 day faster diagnosis

H Special cause variation with improving performance

P Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 75.0%	87.7%	Nov-25

Previous

Plan	Actual	Period
>= 75.0%	87.0%	Oct-25

Year to Date

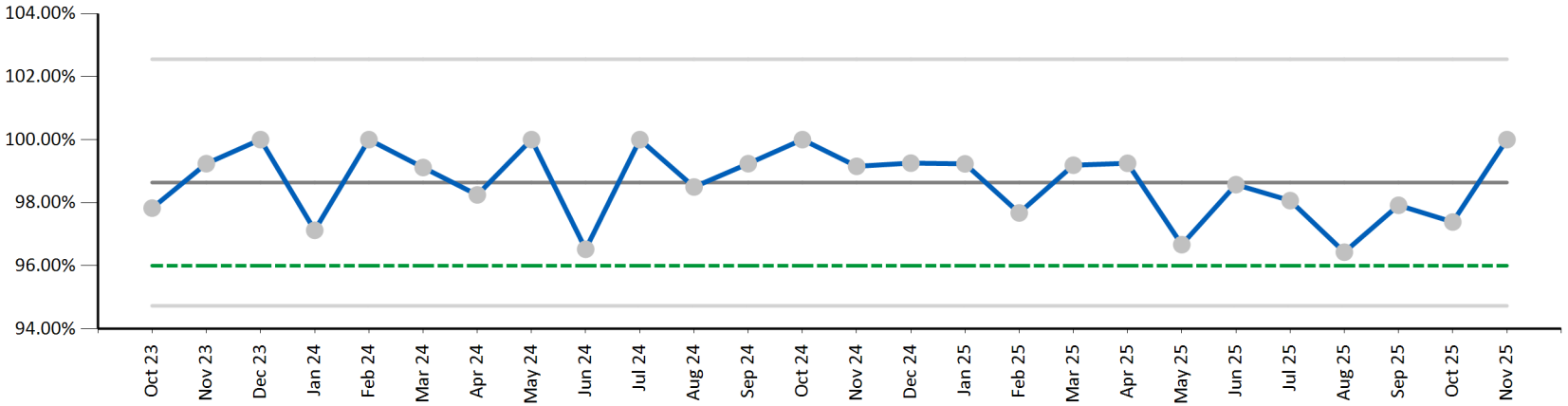
Plan	Actual
>= 75.0%	87.3%

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%	100.0%	Nov-25

Previous

Plan	Actual	Period
>= 96%	97.4%	Oct-25

Year to Date

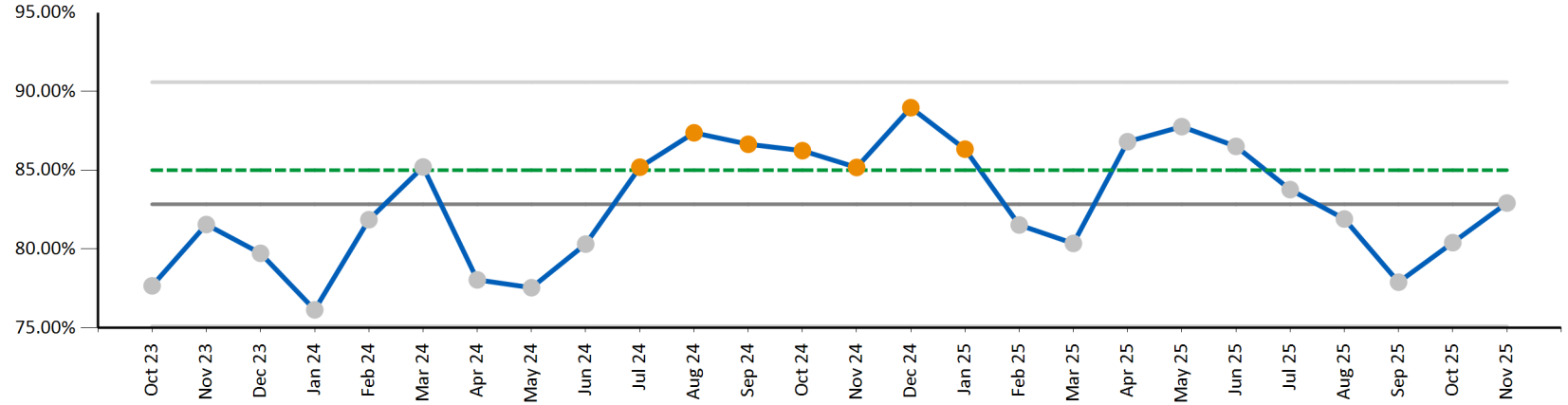
Plan	Actual
>= 96%	98.0%

585 - 62 Day General Standard

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 85%	82.9%	Nov-25

Previous

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

Year to Date

Plan	Actual
>= 85%	83.4%

Operational Performance - Community Care

NHS Bolton NHS Foundation Trust

NCTR

Month 9 NCTR numbers reduced slightly to 88 (from 90), remaining below the target of 90. Lost bed days reduced to 612 (from 794) but remain above the target of 400, mainly due to Pathway 2/3 delays linked to IPC closures and complex dementia placement needs. Twice weekly system escalation continues to unblock delays. Over Christmas/New Year, IDT and Therapies focused on preparedness, MADE events, LLOS reviews and increased escalation activity. Longer term improvement work continues across community services (N block IMC, Hospital at Home expansion, ITOCH). Although the GM target of 75 wasn't maintained in M9, performance has quickly recovered. Bolton remains one of the top GM performers and the only locality to meet the target weekly from April–November 2025.

Emergency Department Deflections & 2 Hour UCR

AAT/Home First ED deflections were 633, slightly down from 646 but well above plan (400) due to proactive screening and early identification. AAT continue to promote 2 hour UCR pathways across NWAS, Primary Care, and Care Homes, supported by strong social media engagement. 2 hour UCR performance remained high at 90.2% (target 70%) with referrals increasing to 371. Embedding of "call before you convey," pathway expansion, and ongoing training (e.g., urinary retention pathway due mid February, +30 referrals/month expected) will support further improvement.

0–5 Years Mandated Contacts

Performance remains below target (88% vs 95%) but shows sustained improvement and stability despite service changes and financial pressures. These measures are now embedded within divisional IPM for strengthened assurance.

EHCP Compliance

EHCP compliance remained 100%, consistently exceeding the 95% target, supported by strong monitoring and escalation processes.

Looked After Children

Initial Health Assessments dropped to 84% (from 100%) due to festive period DNAs and short notice cancellations. Review Health Assessments in Special Schools remained 100%, continuing to exceed target.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	633	Dec-25		>= 400	646	Nov-25	>= 3,600	5,311	?
493 - Average Number of Patients: with no Criteria to Reside	<= 97	88	Dec-25	L	<= 96	90	Nov-25	<= 97	88	?
494 - Average Occupied Days - for no Criteria to Reside	<= 360	612	Dec-25		<= 360	794	Nov-25	<= 3,240	5,354	F
267 - 0-5 Health Visitor mandated contacts	>= 95%	88%	Dec-25	H	>= 95%	86%	Nov-25	>= 95%	87%	F

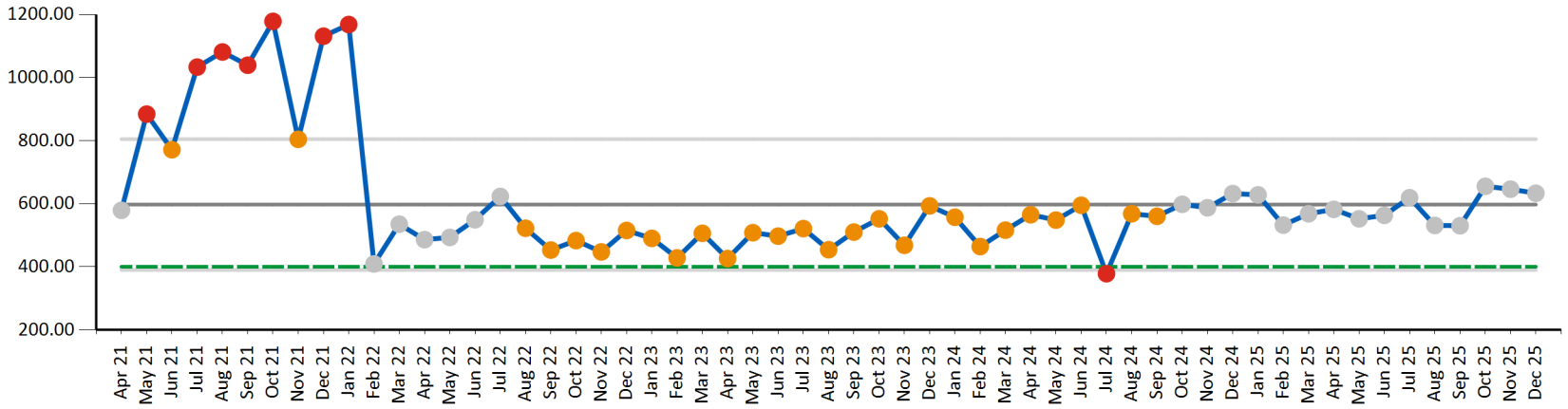
Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
269 - Education, health and care plan (EHC) compliance	>= 95%	100%	Dec-25		>= 95%	100%	Nov-25	>= 95%	97%	
550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse	>= 90.0%	87.0%	Dec-25		>= 90.0%	82.0%	Nov-25	>= 90.0%		
551 - Looked After Children Initial Health Assessments completed within 4 weeks statutory timescales	>= 90.0%	84.0%	Dec-25		>= 90.0%	100.0%	Nov-25	>= 90.0%		
552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools	>= 90.0%	100.0%	Dec-25		>= 90.0%	100.0%	Nov-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	633	Dec-25

Previous

Plan	Actual	Period
>= 400	646	Nov-25

Year to Date

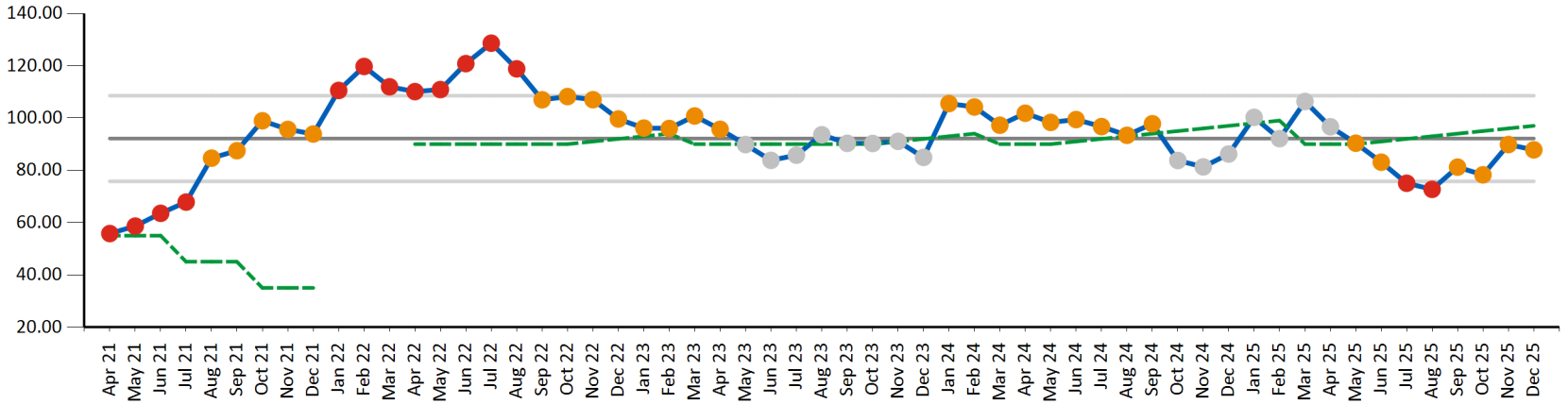
Plan	Actual
>= 3,600	5,311

493 - Average Number of Patients: with no Criteria to Reside

Special cause variation with improving performance

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

6/6



Latest

Plan	Actual	Period
<= 97	88	Dec-25

Previous

Plan	Actual	Period
<= 96	90	Nov-25

Year to Date

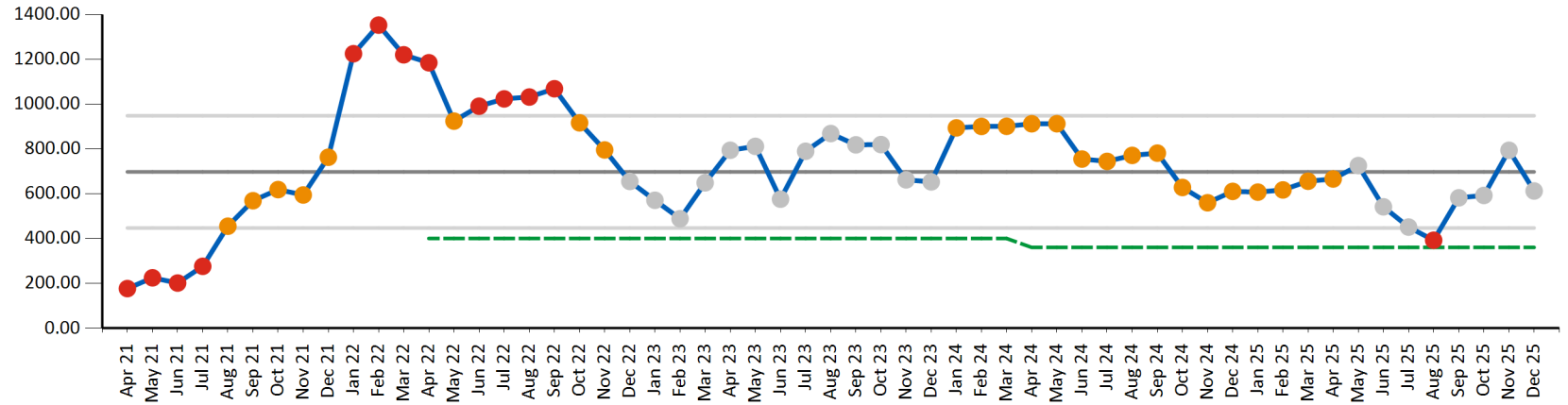
Plan	Actual
<= 97	88

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	612	Dec-25

Previous

Plan	Actual	Period
<= 360	794	Nov-25

Year to Date

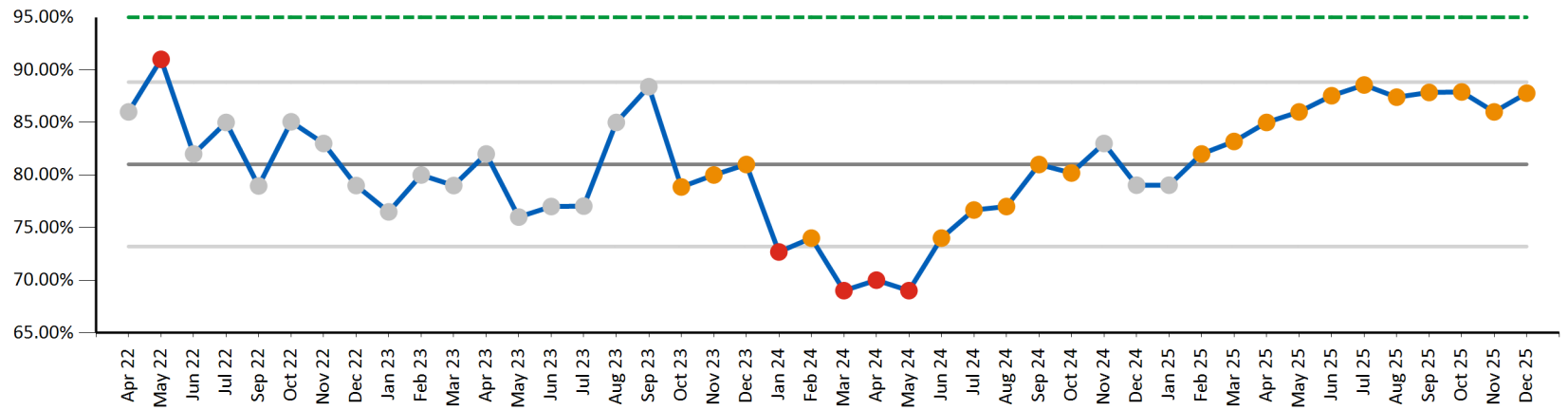
Plan	Actual
<= 3,240	5,354

267 - 0-5 Health Visitor mandated contacts

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 95%	88%	Dec-25

Previous

Plan	Actual	Period
>= 95%	86%	Nov-25

Year to Date

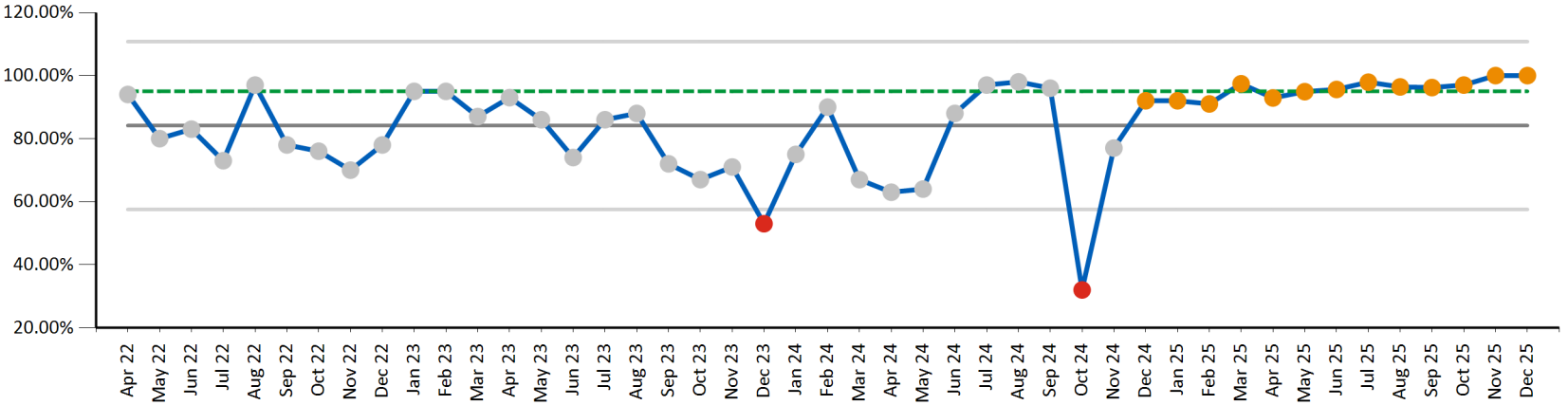
Plan	Actual
>= 95%	87%

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.

6/6



Latest

Plan	Actual	Period
>= 95%	100%	Dec-25

Previous

Plan	Actual	Period
>= 95%	100%	Nov-25

Year to Date

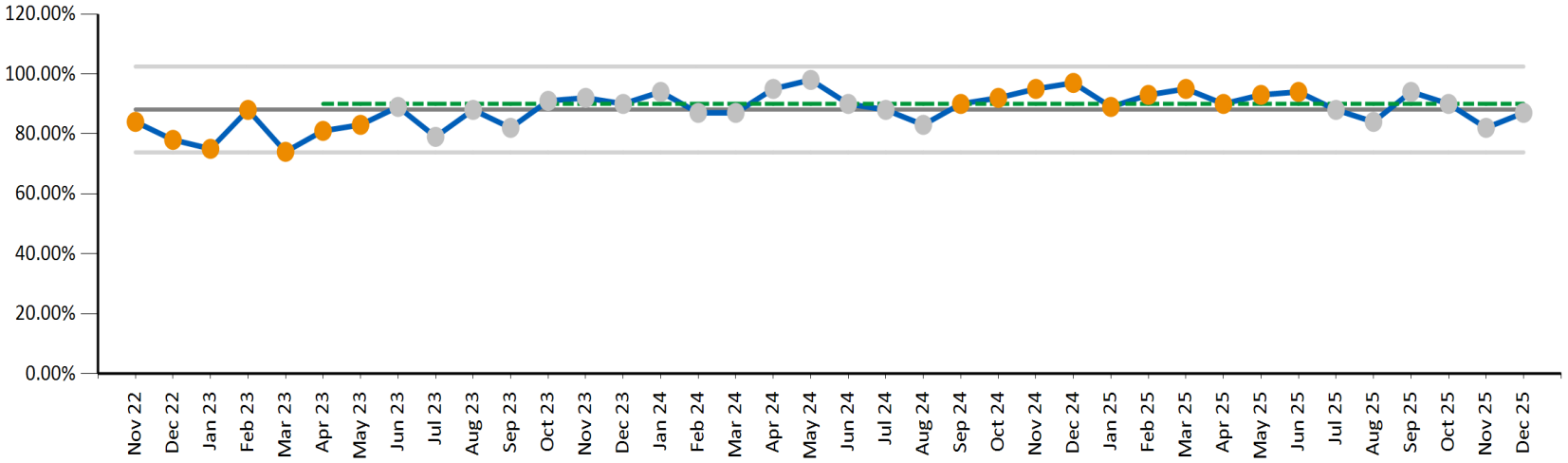
Plan	Actual
>= 95%	97%

550 - Percentage of Looked After Children Review Health Assessments completed within timescale by Health Visitor & School Nurse

Common cause variation.

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

2/6



Latest

Plan	Actual	Period
> = 90.0%	87.0%	Dec-25

Previous

Plan	Actual	Period
> = 90.0%	82.0%	Nov-25

Year to Date

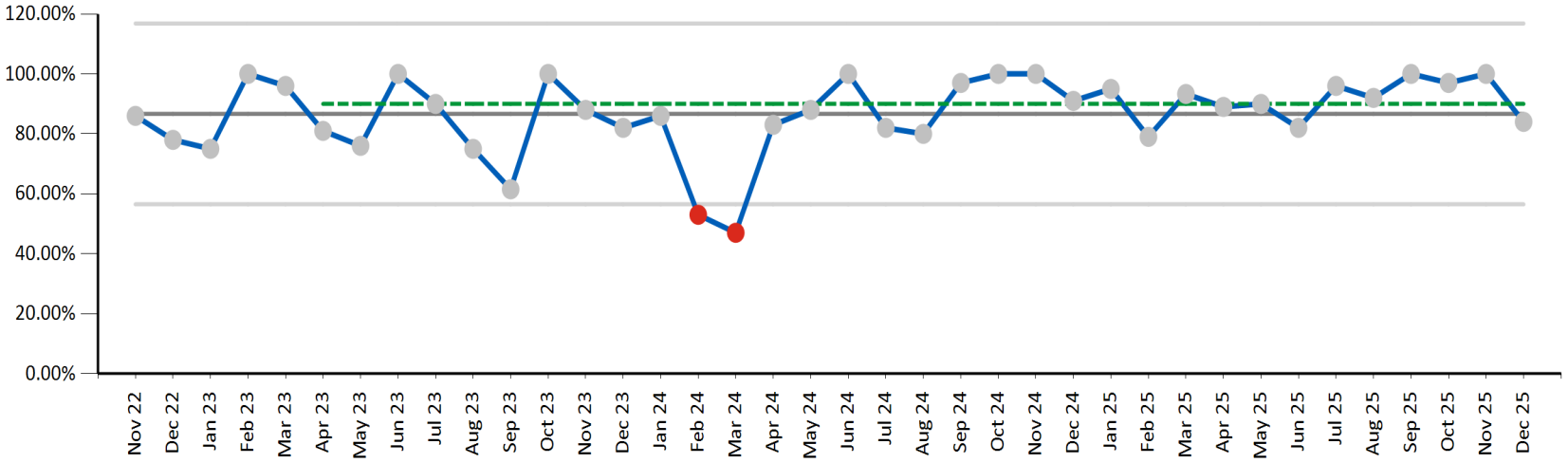
Plan	Actual
> = 90.0%	

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.

5/6



Latest

Plan	Actual	Period
> = 90.0%	84.0%	Dec-25

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Nov-25

Year to Date

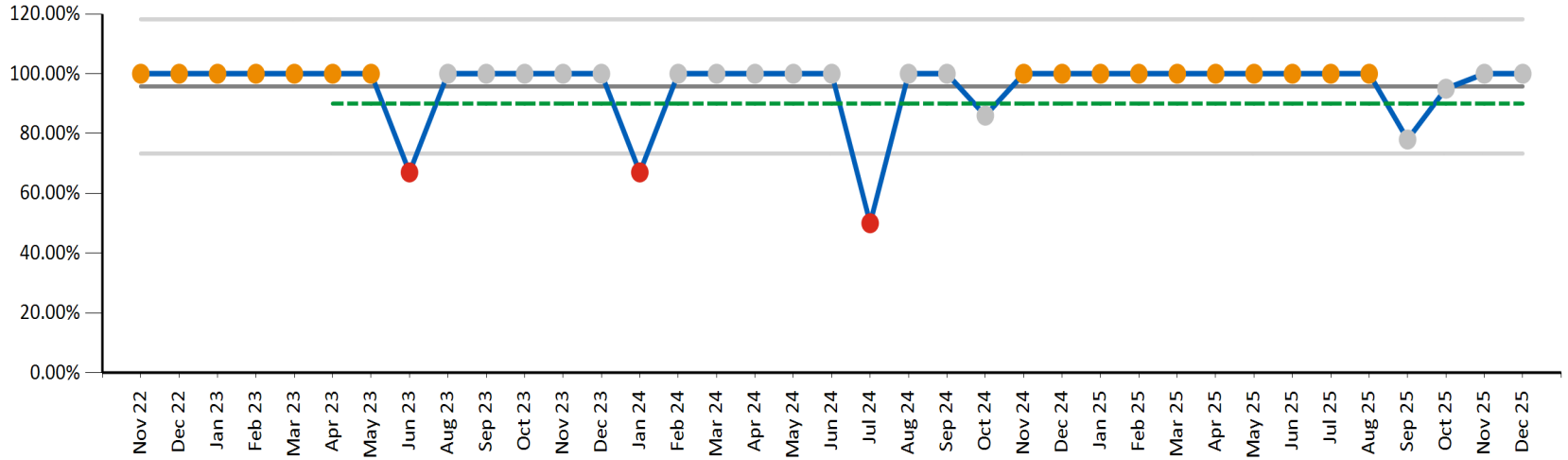
Plan	Actual
> = 90.0%	

552 - Looked After Children Review Health Assessments completed by within expected timescale over 5s in Special Schools

Common cause variation.

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

5/6



Latest

Plan	Actual	Period
> = 90.0%	100.0%	Dec-25

Previous

Plan	Actual	Period
> = 90.0%	100.0%	Nov-25

Year to Date

Plan	Actual
> = 90.0%	

Workforce - Sickness, Vacancy and Turnover

NHS Bolton NHS Foundation Trust

Sickness:
Sickness has remained high in December 25 at 6.70% compared to 6.26% in November 2025. There has been an increase in sickness absence in across the majority of Divisions and teams. There continues to be a significant increase in seasonal absence (cold, Flu and D&V), the Trust is continuing with its current Flu campaign and remains the highest uptake in GM for vaccines to support staff.
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. In addition, the Trust has commenced its flu vaccine programme to support attendance over the remaining winter months.

Turnover:
Turnover has remained fairly static and continues to be within range. There has been no significant fluctuations in turnover in the previous 6 months.

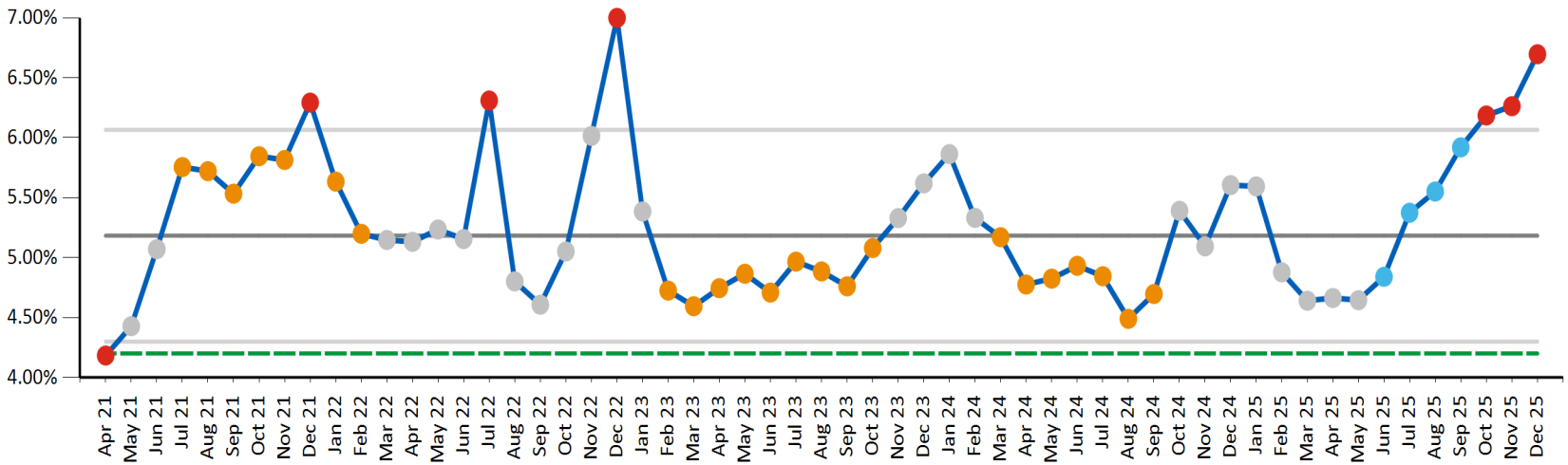
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	6.70%	Dec-25	H	<= 4.20%	6.26%	Nov-25	<= 4.20%	5.57%	F
120 - Vacancy level - Trust	<= 6%	4.62%	Mar-25		<= 6%	5.08%	Feb-25	<= 6%		?
121 - Turnover	<= 9.90%	11.61%	Dec-25	L	<= 9.90%	11.54%	Nov-25	<= 9.90%	11.45%	F
366 - Ongoing formal investigation cases over 8 weeks		0	Dec-25	L		1	Nov-25		2	

117 - Sickness absence level - Trust

Special cause variation with deteriorating performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 4.20%	6.70%	Dec-25

Previous

Plan	Actual	Period
<= 4.20%	6.26%	Nov-25

Year to Date

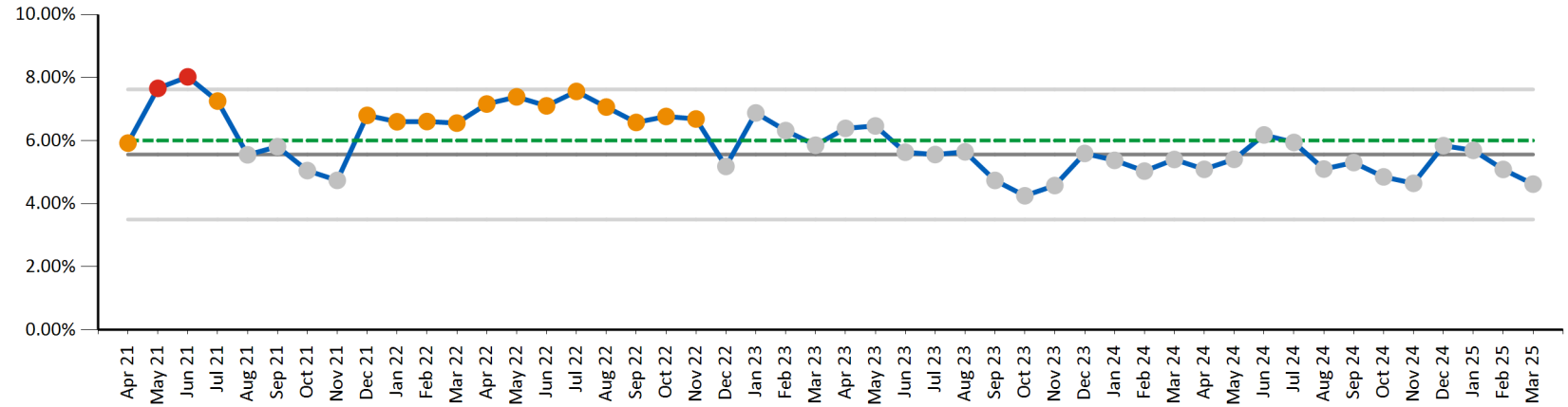
Plan	Actual
<= 4.20%	5.57%

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

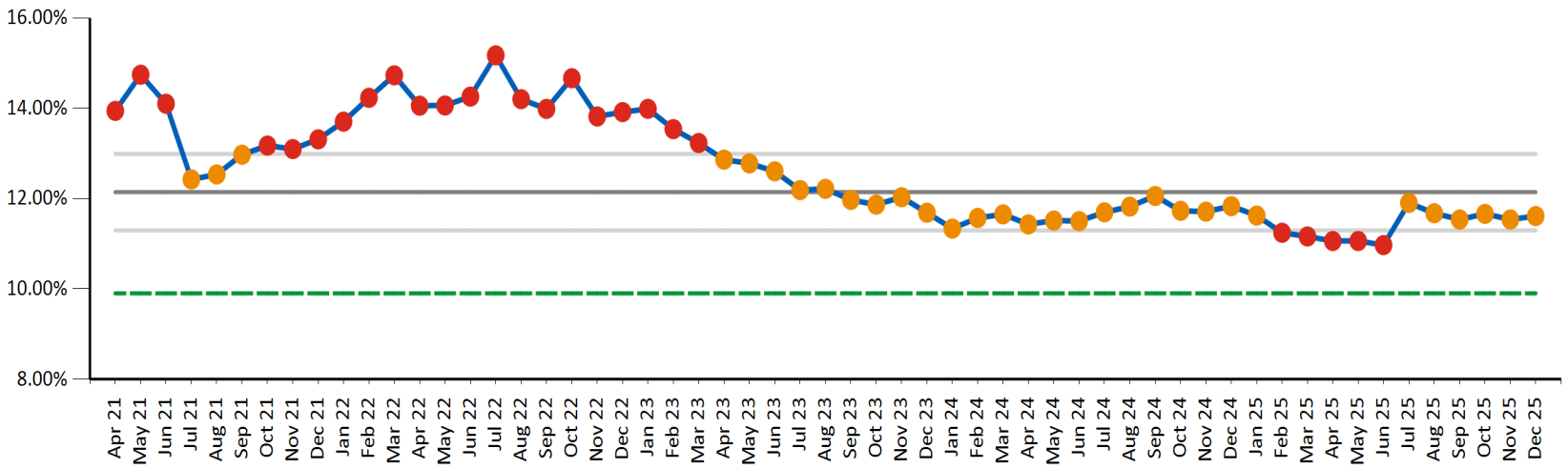
Plan	Actual
<= 6%	5.31%

121 - Turnover

Special cause variation with improving performance

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
<= 9.90%	11.61%	Dec-25

Previous

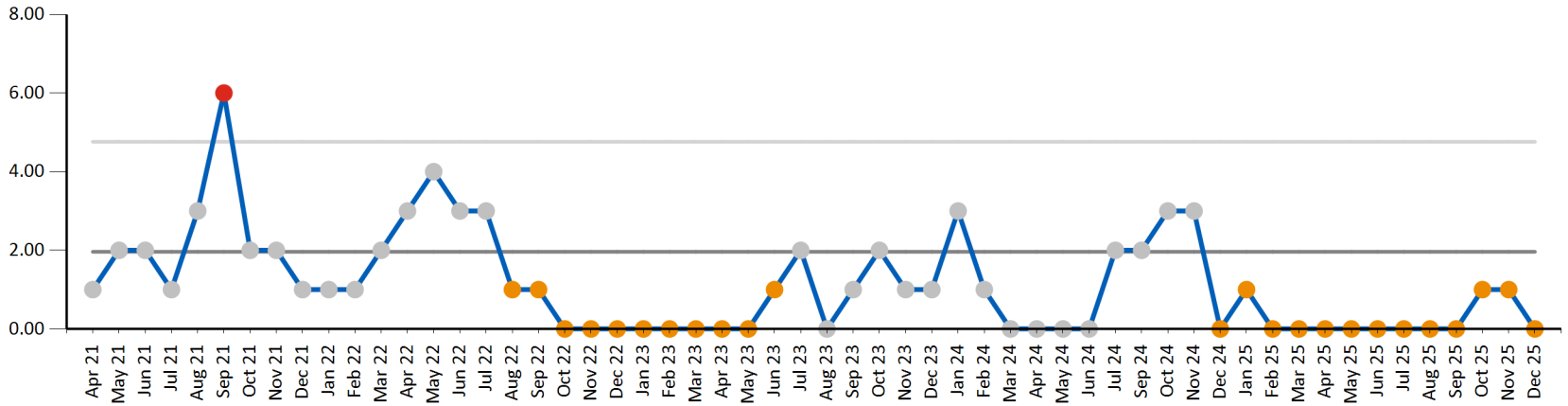
Plan	Actual	Period
<= 9.90%	11.54%	Nov-25

Year to Date

Plan	Actual
<= 9.90%	11.45%

366 - Ongoing formal investigation cases over 8 weeks

Special cause variation with improving performance



Latest

Plan	Actual	Period
	0	Dec-25

Previous

Plan	Actual	Period
	1	Nov-25

Year to Date

Plan	Actual
	2

Workforce - Organisational Development

NHS Bolton NHS Foundation Trust

Compulsory Training

There has been a 0.5% overall improvement in December, 94% (improved from 93.5%) against the target of 95%. This is a great position to be in at the beginning of January 2026. However, this improved position has been supported by agreed changes in the reporting of Fire Safety (now every 2 years instead of annually) and Infection, Prevention and Control (IPC) level 1 now undertaken every 3 years instead of every 2 years. These changes, supported by the National Mand/Stat programme and agreed at People Committee, have been achieved due to the improved offer of face-to-face Fire Safety, Health and Safety and IPC level 1 as part of Corporate/ Clinical Induction from January 2026.

Trust Mandated Training

There has been a very slight reduction in compliance for Trust Mandated Training from 90.8% to 90.6%. The challenged area of concern remains Aseptic Non-Touch Technique training and additionally the importance of recording of completed training at a divisional level on ESR. The Practice Educators for the clinical divisions are continuing to provide the annual training.

Appraisal Training

Appraisal training compliance remains static at 82.7% against the target of 85%. The Our Leaders programme and the FABB Conversations/ Appraisals training continues to be monitored. The Our Leaders Programme attendance showed a slight decline at the end of 2025. We are continuing to review attendances and will continue to provide quarterly reports on Our Leaders to divisions and are focusing on encouraging attendance particularly in areas which require improvement and/or for targeted staff groups.

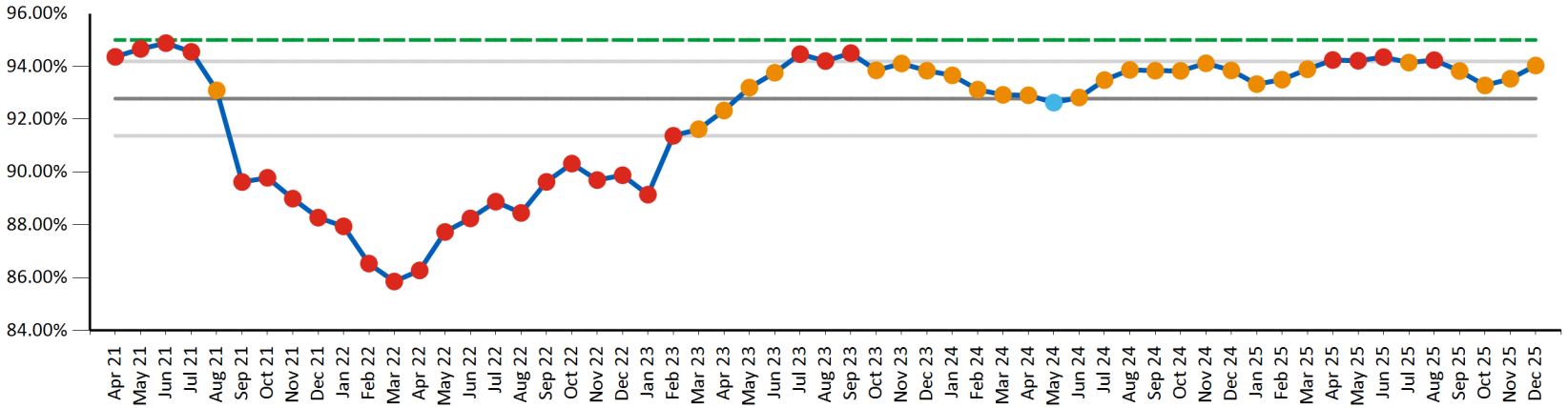
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Compulsory Training	>= 95%	94.0%	Dec-25	H	>= 95%	93.5%	Nov-25	>= 95%	94.0%	F
38 - Staff completing Trust Mandated Training	>= 85%	90.6%	Dec-25		>= 85%	90.8%	Nov-25	>= 85%	91.4%	P
39 - Staff completing Safeguarding Training	>= 95%	92.44%	Dec-25		>= 95%	92.19%	Nov-25	>= 95%	93.57%	?
101 - Increased numbers of staff undertaking an appraisal	>= 85%	82.7%	Dec-25		>= 85%	82.6%	Nov-25	>= 85%	84.1%	?
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	43.2%	Q2 2025/26	L	>= 66%	45.5%	Q1 2025/26	>= 66%		?
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	52.6%	Q2 2025/26	L	>= 80%	51.4%	Q1 2025/26	>= 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%	94.0%	Dec-25

Previous

Plan	Actual	Period
>= 95%	93.5%	Nov-25

Year to Date

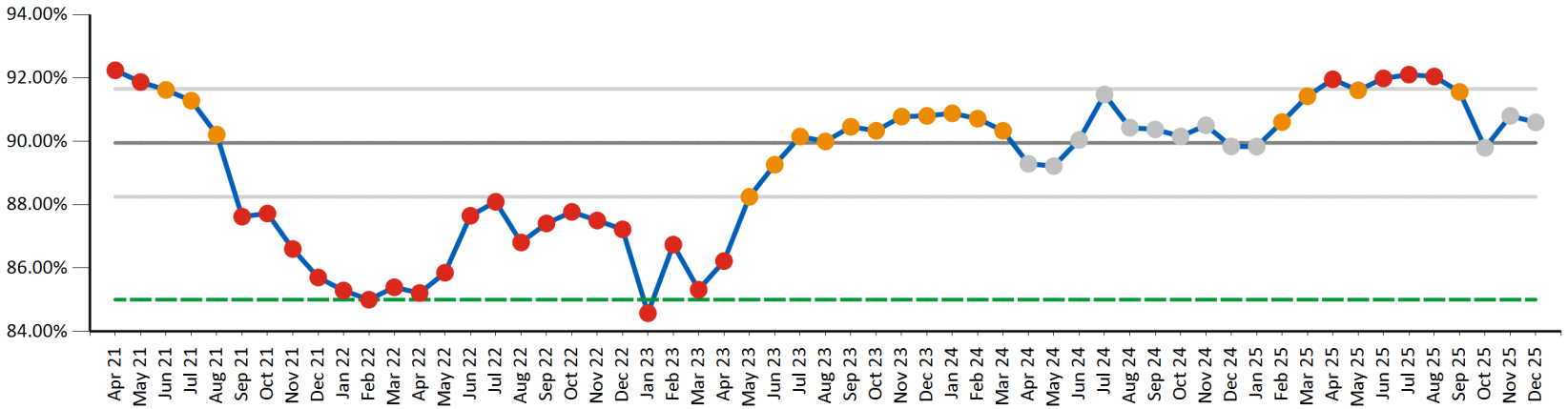
Plan	Actual
>= 95%	94.0%

38 - Staff completing Trust Mandated Training

Common cause variation.

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= 85%	90.6%	Dec-25

Previous

Plan	Actual	Period
>= 85%	90.8%	Nov-25

Year to Date

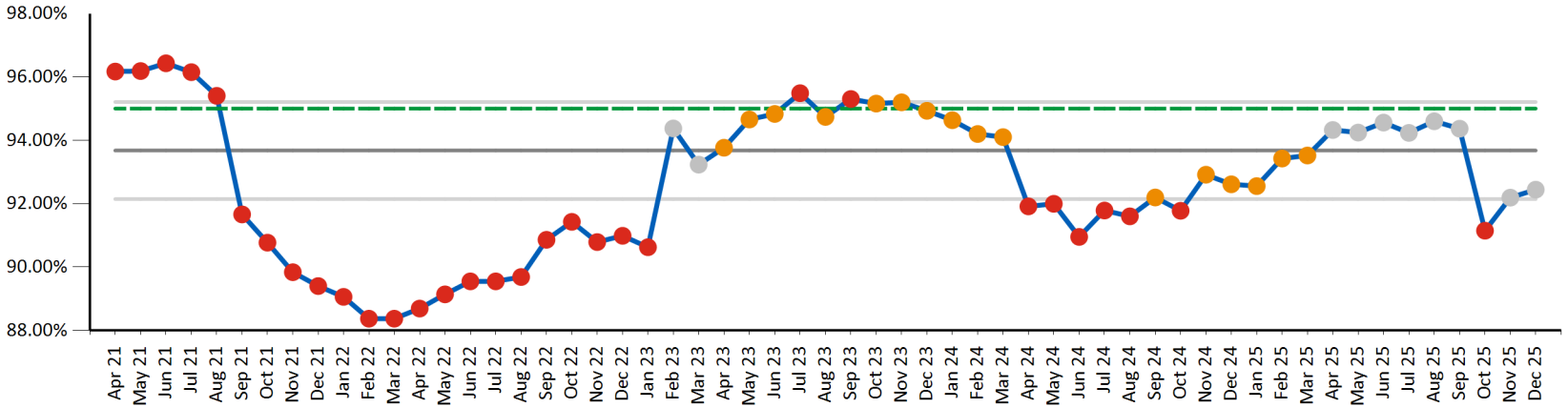
Plan	Actual
>= 85%	91.4%

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%	92.44%	Dec-25

Previous

Plan	Actual	Period
>= 95%	92.19%	Nov-25

Year to Date

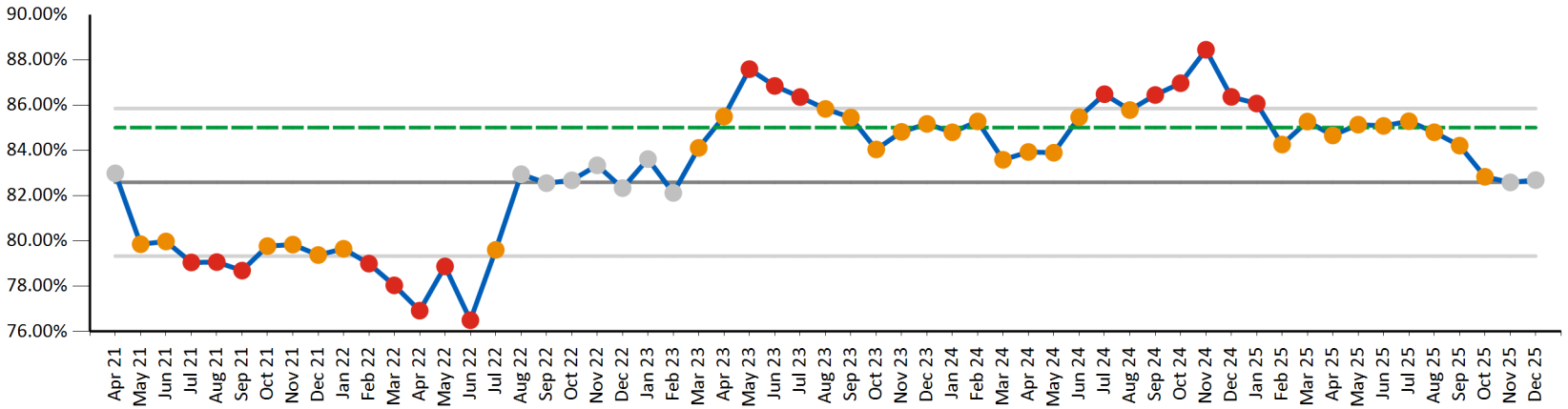
Plan	Actual
>= 95%	93.57%

101 - Increased numbers of staff undertaking an appraisal

Common cause variation.

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

1/6



Latest

Plan	Actual	Period
>= 85%	82.7%	Dec-25

Previous

Plan	Actual	Period
>= 85%	82.6%	Nov-25

Year to Date

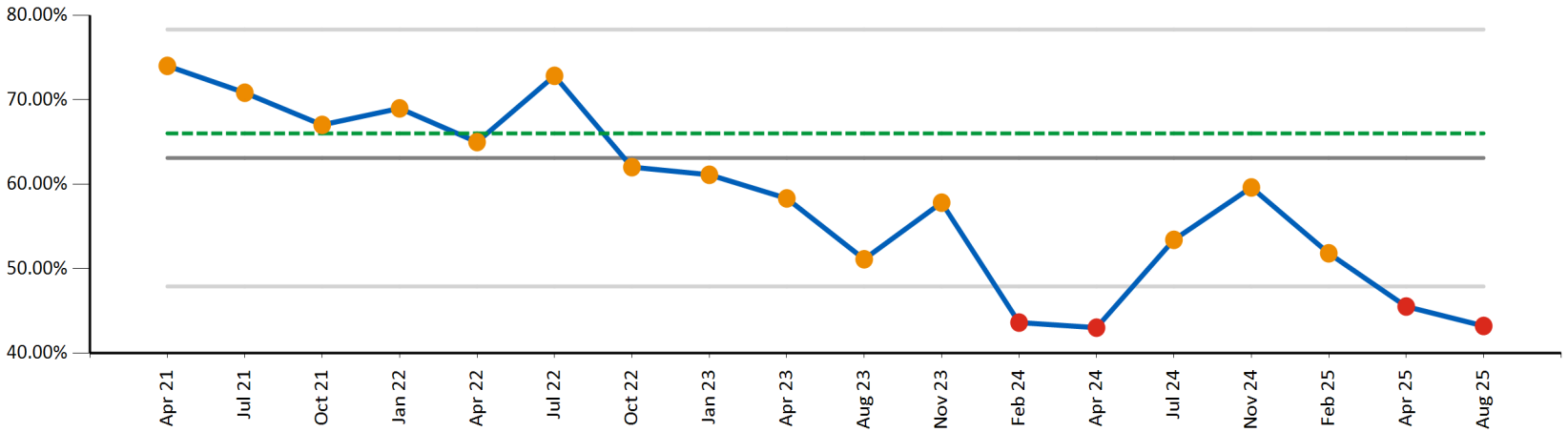
Plan	Actual
>= 85%	84.1%

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%	43.2%	Q2 2025/26

Previous

Plan	Actual	Period
>= 66%	45.5%	Q1 2025/26

Year to Date

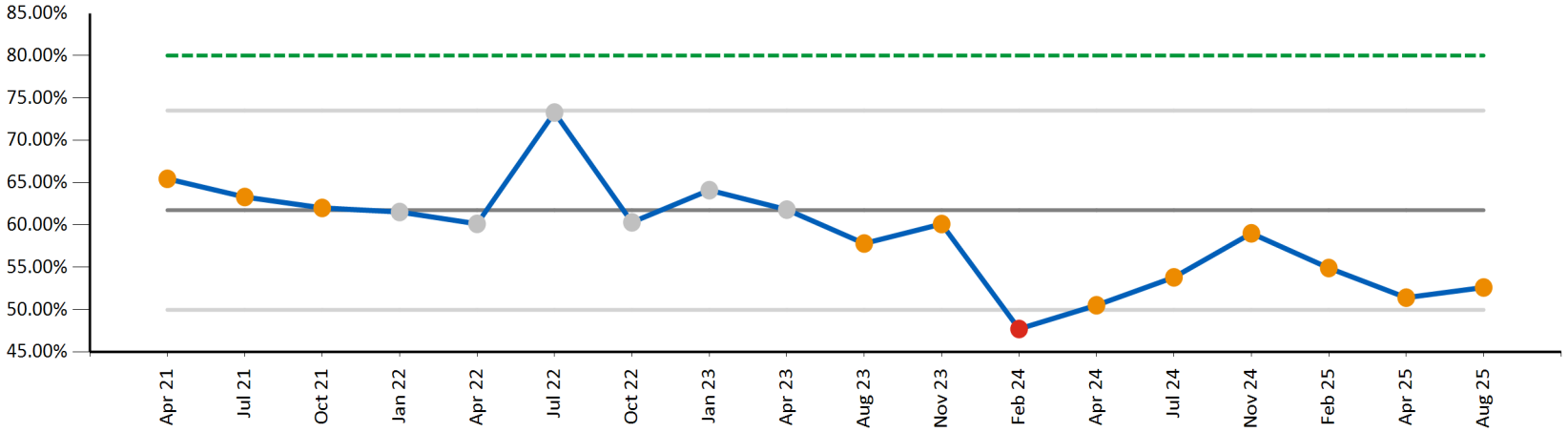
Plan	Actual
>= 66%	

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%	52.6%	Q2 2025/26

Previous

Plan	Actual	Period
>= 80%	51.4%	Q1 2025/26

Year to Date

Plan	Actual
>= 80%	

Workforce - Agency

Bolton NHS Foundation Trust

Agency usage continues to be low and within the Trusts plan. There continues to be a small usage of agency mainly supporting medical vacancies, with some AHP roles. Recruitment is ongoing, with ongoing activity to fill vacancies and ensure that agency usage remains low. The Trust continues to approach any temporary requirements predominantly through bank to ensure agency usage remains low.

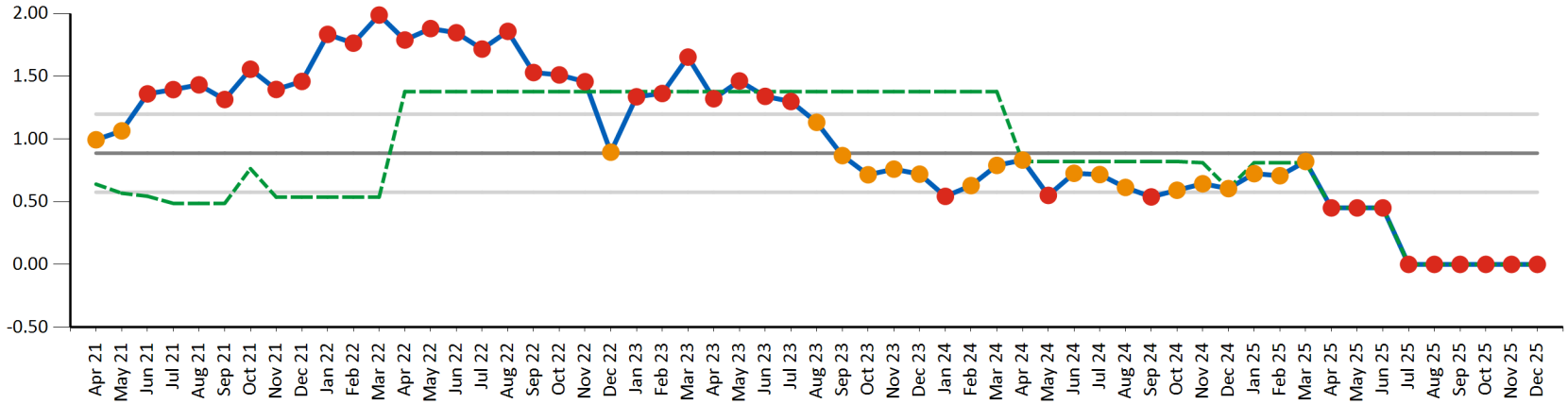
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	= 0.00	0.00	Dec-25	L	= 0.00	0.00	Nov-25	<= 1.35	1.35	F
111 - Annual ceiling for Nursing Staff agency spend (£m)	= 0.00	0.00	Dec-25	L	= 0.00	0.00	Nov-25	<= 0.12	0.13	F
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.37	0.37	Dec-25		<= 0.37	0.37	Nov-25	<= 4.19	4.17	?

198 - Trust Annual ceiling for agency spend (£m)

L Special cause variation with improving performance

F We will regularly fail to meet the target.

6/6



Latest

Plan	Actual	Period
= 0.00	0.00	Dec-25

Previous

Plan	Actual	Period
= 0.00	0.00	Nov-25

Year to Date

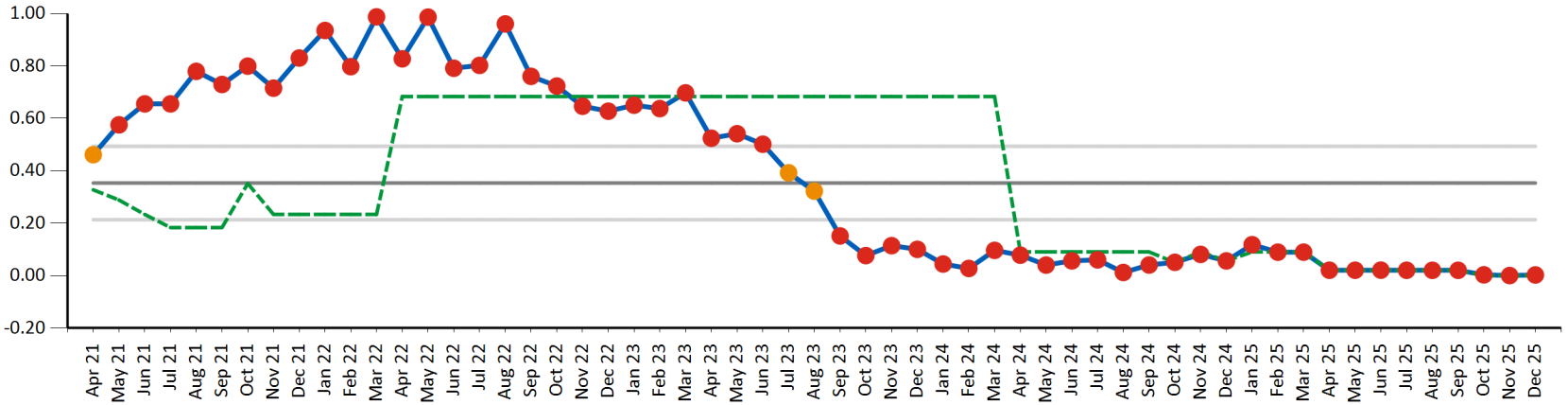
Plan	Actual
<= 1.35	1.35

111 - Annual ceiling for Nursing Staff agency spend (£m)

Special cause variation with improving performance

We will regularly fail to meet the target.

3/6



Latest

Plan	Actual	Period
= 0.00	0.00	Dec-25

Previous

Plan	Actual	Period
= 0.00	0.00	Nov-25

Year to Date

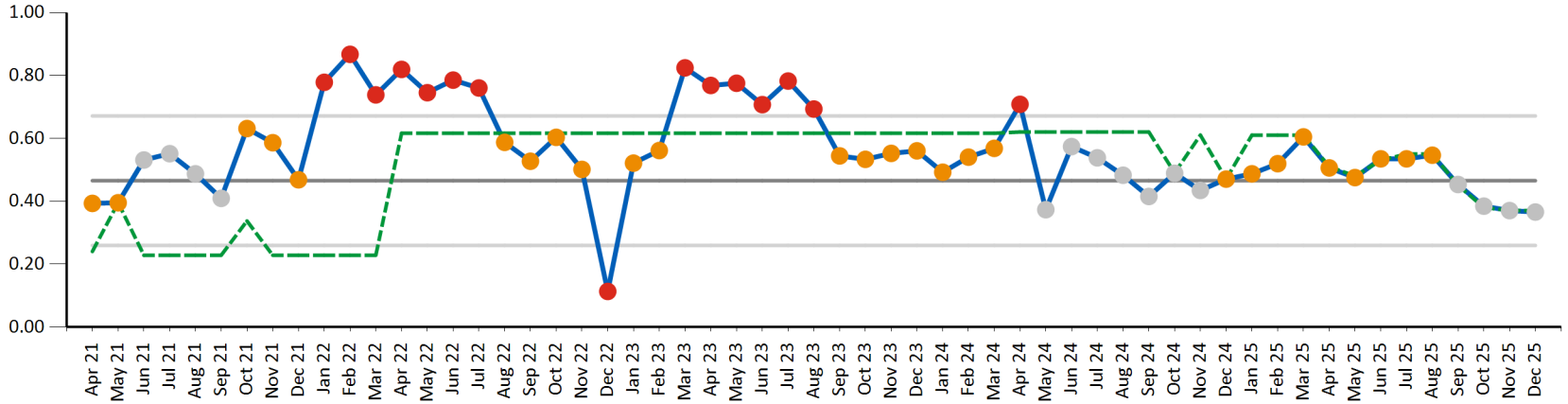
Plan	Actual
<= 0.12	0.13

112 - Annual ceiling for Medical Staff agency spend (£m)

Common cause variation.

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

4/6



Latest

Plan	Actual	Period
<= 0.37	0.37	Dec-25

Previous

Plan	Actual	Period
<= 0.37	0.37	Nov-25

Year to Date

Plan	Actual
<= 4.19	4.17

Finance - Finance

Surplus / (Deficit)
The Trust is reporting a cumulative deficit of £17.4m largely due to CIP under-delivery. The adjusted deficit, which compares to the break-even full year plan, is £17.3m including technical adjustments relating to donated capital equipment.

Adjusted Surplus / (Deficit)
Adjusting for allowable deductions/adjustments, the Trust is reporting a deficit of £0.6m YTD.

Forecast
The external forecast has been reported as meeting plan. 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 worst-case forecast is a deficit of £30.9m, the realistic case is a deficit of £25.8m, realistic best-case is a deficit of £14.4m. The range of forecasts will narrow as the year progresses and risks/mitigations materialise.

Income
Commissioner income is based on contractual and budget values, Planned Care Variable Income performance has now dropped below plan YTD by £0.2m, although it is assumed that activity lost due to Industrial Action will not be clawed back. Injury Cost Recovery Scheme income of £3.3m, net of a £0.6m provision for claims not paid, has been recognised YTD, of which £1.9m relates to a change in accounting treatment. Q1-3 Deficit Support funding is now secured at £4.9m, it is anticipated that Q4 will be paid. It is assumed that there will be no clawback of any variable income such as CDC although this presents a further risk.

Pay
WTEs and underlying pay costs have reduced in-month due to the impact of pay controls. Worked WTEs are now favourable to the Trust plan, this is expected to improve in future months due to ongoing pay controls. There is an adverse variance against CIP delivery.

Non Pay
Non Pay costs have increased by £0.2m since M8, mainly due to the recognition of a rebate on carbon penalties last month. The main driver of the adverse YTD variance is under-delivery of CIP.

Non Operating
Interest received has been slightly higher than planned year-to-date, PDC Dividends have been re-calculated cumulatively resulting in a £0.2m in-month adverse variance.

Cash
The Trust was above plan by £2.7m in Month 9. PDC funding cash has provided a temporary benefit of £1.5m and some other cash has been received in advance of being paid out, the underlying cash is an overdrawn position of £12.7m. The Trust has received cash support from NHSE of £8.3m in November and £5.5m in December, a total of £13.8m. NHSE approved £3.9m of the January application for £5.5m. The February application for £3.3m has been rejected on the basis that we will receive £1.4m of Industrial Action funding, at the time of writing the Trust is seeking clarity as to whether there will be any support paid in February. Mitigations are being worked up, in the event that the February application is rejected in full or that the March application is not approved.

CIP Delivery

Reduction in in-month delivery from M8 to M9 due to the non-recurrent benefit of a carbon penalty rebate at M8, achievement is still under plan in-month and YTD. There are minimal opportunities for further central non-recurrent items to support delivery in 2025/26 therefore the focus is on run-rate reducing schemes.

Capital

Capital allocation reduced to £36.3m, reduction of £12.2m. Significant expenditure forecasted for Q4 although RAAC spend of £14.8m has been deferred to 26/27 and £1.5m of Paeds ED will now be deferred to 2026/27.

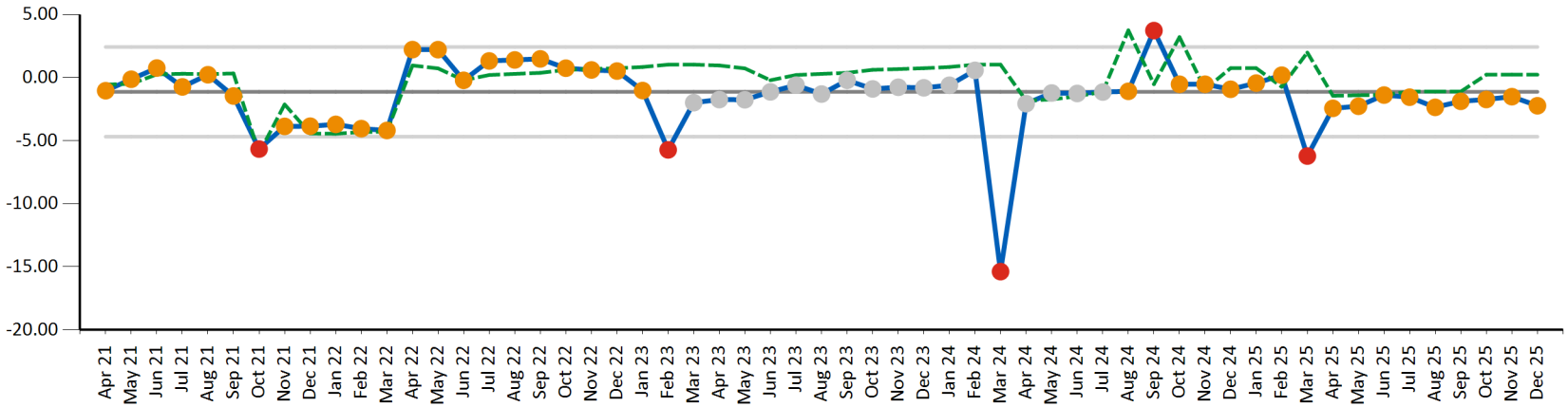
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 0.2	-2.2	Dec-25	L	>= 0.2	-1.5	Nov-25	>= -6.9	-17.4	?
222 - Capital (£ millions)	>= 5.9	3.7	Dec-25		>= 5.5	2.5	Nov-25	>= 28.7	13.3	F
223 - Cash (£ millions)	>= -6.3	6.4	Dec-25	L	>= -7.1	7.3	Nov-25	>= -6.3	6.4	P

220 - Control Total (£ millions)

L Special cause variation with deteriorating performance

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

0/6



Latest

Plan	Actual	Period
>= 0.2	-2.2	Dec-25

Previous

Plan	Actual	Period
>= 0.2	-1.5	Nov-25

Year to Date

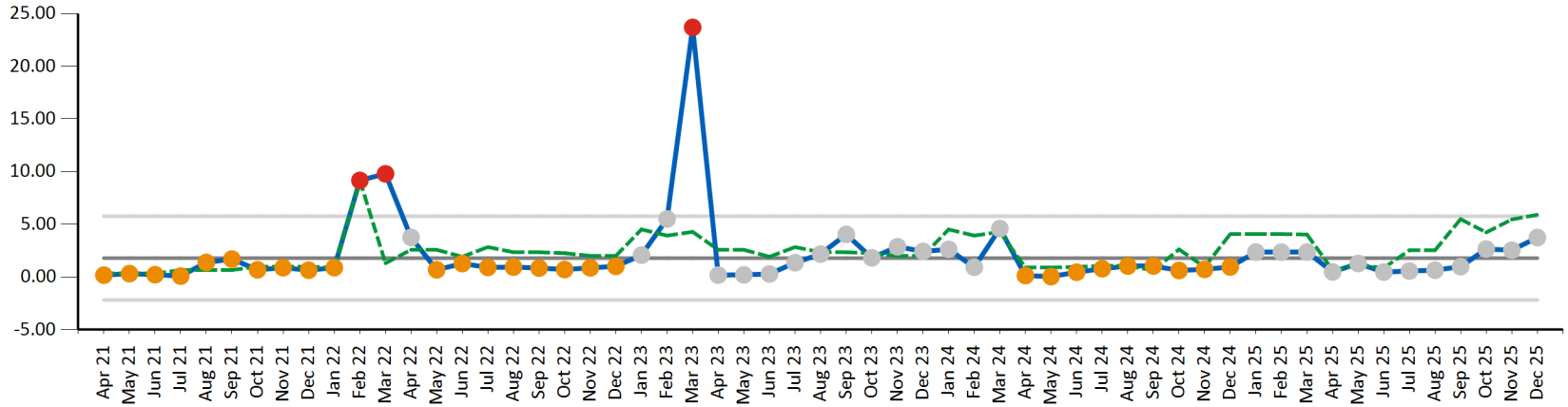
Plan	Actual
>= -6.9	-17.4

222 - Capital (£ millions)

Common cause variation.

We will regularly fail to meet the target.

0/6



Latest

Plan	Actual	Period
>= 5.9	3.7	Dec-25

Previous

Plan	Actual	Period
>= 5.5	2.5	Nov-25

Year to Date

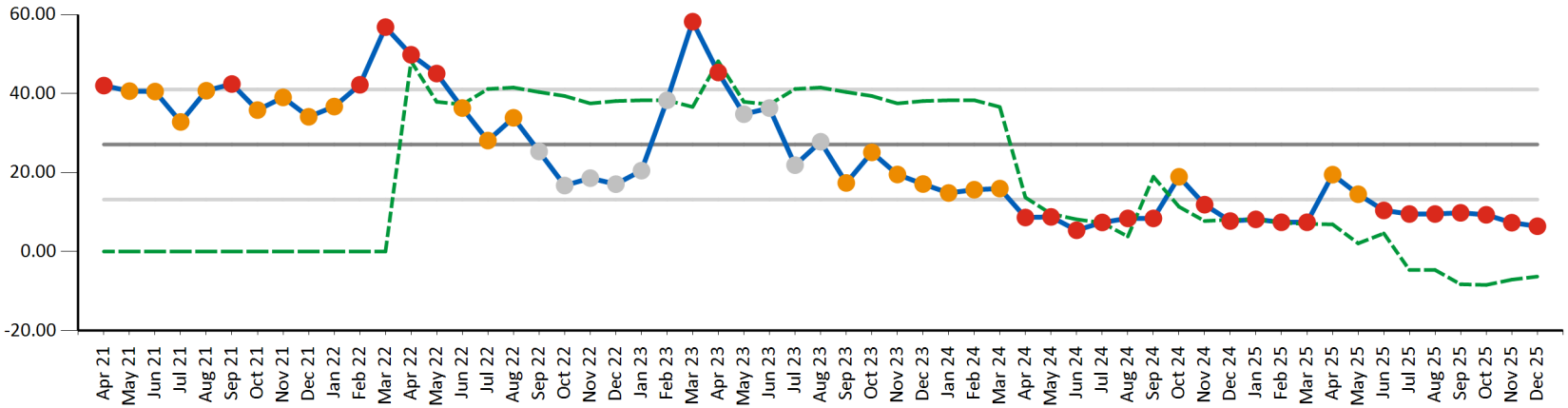
Plan	Actual
>= 28.7	13.3

223 - Cash (£ millions)

Special cause variation with deteriorating performance

Target will be regularly met.

6/6



Latest

Plan	Actual	Period
>= -6.3	6.4	Dec-25

Previous

Plan	Actual	Period
>= -7.1	7.3	Nov-25

Year to Date

Plan	Actual
>= -6.3	6.4

Report Title:	Quality Assurance Committee Chair's Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	
Executive Sponsor	Quality Assurance Committee Chair		Decision	

Purpose of the report	This report provides an update and assurance to the Board of Directors on the work delegated to the Quality Assurance Committee.

Previously considered by:	N/A

Executive Summary	This report provides an overview of the key topics scheduled for discussion at the Quality Assurance Committee meeting on 28 January 2026. It highlights the areas where the Committee expects to receive assurance relating to the Trust's operational performance, quality governance, patient safety, and clinical effectiveness. As the January Board meeting takes place before the QAC convenes, this Chair's Report is submitted in advance and therefore summarises the main items planned for consideration, rather than presenting detailed outcomes. Any urgent or significant issues arising from the QAC meeting will be escalated verbally to the Board by the Committee Chair at the meeting. The report aims to ensure the Board remains sighted on forthcoming areas of focus within the QAC agenda and is aware of any potential matters that may require attention or future discussion.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Quality Assurance 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	No	
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	

Prepared by:	Sharon Katema, Director of Corporate Governance	**Presented by:**	Fiona Taylor, Quality Assurance Committee Chair

Report Title:	Clinical Negligence Scheme for Trusts (CNST) year 7 update			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	✓
Executive Sponsor	Chief Nursing Officer		Decision	✓

Purpose of the report	The purpose of this report is to confirm the final compliance position with regard to attainment of the ten safety actions detailed within the CNST Maternity Incentive Year 7 Scheme (MIS).

Previously considered by:	The report will be considered at the Quality Assurance Committee on 28 January 2026

Executive Summary	This report confirms that compliance with all requirements of the CNST year 7 MIS can be evidenced in accordance with the requirements detailed in the declaration form. It also provides assurance that all defined action plans within the incentive scheme will continue to be monitored until commencement of the CNST year 8 scheme and detailed updates are provided within this report. Assurance can be provided that the service successfully met the requirements of the external Local Maternity and Neonatal System (LMNS) checkpoint review undertaken on the 06 January 2026. The report provides assurance that the service has not received any external reports that may contradict the MIS declaration and confirms that the final position has been shared with commissioners prior to submission to the Board of Directors. The report provides evidence that the Trust is working towards implementation of the quarterly reporting requirements of the perinatal quality oversight model published in August 2025 reflecting the Q2 2025/2026 reporting period. The revisions to the report include changes to reported outcome and process measures underpinned by the national maternity and neonatal delivery plan.

Proposed Resolution	The Board of Directors are asked to: • Receive the contents of the report. • Approve the action plans detailed within this report. • Authorise the signing of the declaration form by the Chief Executive prior to submission to NHS Resolution by the 03 March 2026.

	• Approve the sharing of this report within the local maternity and neonatal system and 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 if all requirements of the scheme not fulfilled.
Legal/ Regulatory	No	
Health Inequalities	No	
Equality, Diversity and Inclusion	No	
Is a Quality Impact Assessment required	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

A summary of progress to date with regard to the attainment of all MIS ten safety actions identified within the CNST year 7 scheme is detailed in table 1 as reflected in the Trust declaration document.

Table 1: - CNST year 7 progress tracker as of 2 January 2026

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	7	0	7
2	0	0	2	0	2
3	0	0	6	0	6
4	0	0	19	0	19
5	0	0	12	0	12
6	0	0	9	0	9
7	0	0	4	0	4
8	0	0	21	0	21
9	0	0	9	0	9
10	0	0	9	0	9
Total	0	0	98	0	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sctions will not be included in this table.

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 1 December 2024.

The maternity service has met all CNST reporting requirements relating to the national perinatal mortality review scheme.

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 of the maternity services dataset (MSDS) was used for the assessment of data fields relating to the birth weight and ethnic category in the year 7 scheme. The Trust scorecard has been published (Appendix 2) and confirms the Trust submission met all CNST scheme reporting requirements.

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 shared a detailed action plan in the September 2025 Board of Directors report to demonstrate progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice. The action plan will continue to be shared periodically to evidence ongoing progression of the actions as per scheme requirements.

The national Newborn Early Warning Track and Trigger chart (NEWTT2) has now been implemented within the service. An audit of compliance was undertaken in November 2025 that demonstrated 91% compliance with the defined standards. The audit has provided assurance that the new guideline has been implemented effectively, and the guideline will continue to be audited quarterly.

A further update on the progression of the quality improvement project titled 'improving thermoregulation and first feed management following elective caesarean section to reduce term admissions to the Neonatal Unit was presented to the LMNS in November 2025.

Modelling of staffing for the future transitional care model has been included in the current staffing model, and any amends will be included in the ongoing Birth Rate Plus reassessment that commenced in September 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 in 2027.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a**) Obstetric medical workforce**

An internal assurance audit was undertaken in September 2025 to demonstrate the implementation of the RCOG guidance on engagement of long-term locums. The results provide significant assurance the Trust has implemented the required standards. Further action is still required to enhance access for the locum doctors to all digital systems and provide training prior to the shift commencement date. A digital QR code has been implemented to ensure efficient capture of feedback to the locum doctors is collated to inform the future audits.

b) Anaesthetic medical workforce

All standards met

c) Neonatal medical workforce

The Tier 3 standard requires Consultant Neonatologist presence for a minimum of 12 hours per day for a service with less than 4000 intensive care days per annum which is applicable to the service at Bolton. The service is currently not fully compliant with the required standard although progress has been demonstrated from the CNST year 6 scheme. Completion of the business case to uplift the Tier 3 staffing to meet the required standard remains ongoing.

d) Neonatal nursing workforce

Completion of the business case to uplift the nurse staffing establishment to meet the required neonatal nurse staffing standard for 100% occupancy remains ongoing. Bank staffing is being deployed to mitigate the staffing gap and any clinical risk in the interim period.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

All standards met

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?

The LMNS/ICB have formally notified the Trust that they are assured that the CNST requirements relating to attainment of the CNST year 7 scheme have been fulfilled (Appendix 3). The service is currently 99% compliant with the required implementation and progress with regard to attainment of all required standards continues to be monitored by the LMNS at quarterly intervals with the last meeting being held on the 16 December 2025.

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce service with users.

The Trust declared non-compliance with the element within Safety Action 7 relating to the Maternity and Neonatal Voices Partnership (MNVP) Lead infrastructure requirements as the service was currently unable to fulfil quorate attendance at the defined meetings with the current establishment funded by the Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) by 30 November 2025 as per requirements. For assurance NHS Resolution have confirmed that providers can still attain full compliance with this element if appropriate escalation is undertaken by the provider via the LMNS to the regional perinatal quality surveillance meeting during the CNST year 7 period.

Verification has been received that LMNS has escalated the Trust position to the regional perinatal quality surveillance as per CNST requirements. In response the Integrated Care Board will then be expected to develop an action plan in response to the escalation and monitor progress. There is an expectation that MNVP's are required to be commissioned and function in line with the guidance by the end of the Three-Year Delivery plan in 2026.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house, one day multi-professional training?

The service attained all required profession specific CNST training elements as detailed in table 2 prior to the deadline of 30 November 2025.

Table 2 – Training compliance as of 25 November 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	99.53%	NA	100.00%	100.00%	93.33%	100.00%	100.00%	NA	NA	NA	100.00%	100.00%
Fetal Monitoring Core Competency Stds.	100.00%	NA	100.00%	100.00%	NA	NA	100.00%	NA	NA	NA	NA	NA
Neonatal Life Support	99.52%	100.00%	NA	NA	93.33%	NA	100.00%	100.00%	100.00%	98.21%	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 13 November 2025.

At the meeting the findings of the deep dive review of the maternity performance metrics undertaken in October 2025 were shared and an overarching safety improvement plan for the service has been developed in response. The action plan includes work ongoing being to improve the working culture within the maternity service highlighted in the SCORE survey and recent feedback provided by staff members.
As part of the work of the safety champions / perinatal quadrumvirate walkabouts continue to be 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). Ongoing engagement with staff continues using the monthly Team Talk led by the Director of Midwifery and Curiosity Cafes facilitated by the Assistant Divisional Midwifery and Nursing Director.

One of the defined requirements of this safety action relates to the presentation of a quarterly perinatal quality oversight report to the Board of Directors and evidence of the Trust working towards implementation of the revised Perinatal Quality Oversight Model published in August 2025, which has been incorporated into this report.
Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

The Q2 2025/2026 audit findings confirmed that there were 2 eligible cases reported to MNSI during the period 1 July 2025 to the 30 September 2025. Both cases were appropriately referred to the Early Notification Scheme (ENS) due to a potential brain injury, namely Hypoxic Ischemic Encephalopathy (HIE). Both families received written information about the role of MNSI, and the early notification scheme and duty of candour has been satisfied in both cases. The formal duty of candour letters were included in the formal audit report collated. Formal review of all duty of candour letters has been undertaken by the Director of Clinical Governance.

No further cases were reported in the subsequent period up to the 30 November 2025 and thus all clinical requirements of the CNST year 7 scheme have been fulfilled.

4. Perinatal Quality Oversight Monitoring (PQOM)

The requirement for maternity services to ensure consistent and methodical service oversight was defined in the Ockenden report published in 2020 recommendations and in response the 'perinatal quality surveillance model (PQSM) guidance was published in 2020. A revised the Perinatal Quality Oversight Model (PQOM) was published in August 2025.

The revised model requires Trusts to carry out dynamic monitoring of the quality of the maternity and neonatal services, supported by clinically relevant data which should be informed by key data items and wider insights.

As minimum quarterly presentations are required by a member of the perinatal leadership team regarding service trends, concerns raised by staff and service users and progress relating to the local safety improvement plan.

Board oversight will continue to be enhanced by the Board safety champion and Non-Executive Director who meet on a bi-monthly basis with the maternity and neonatal safety champions to monitor progress.

This report has been revised to incorporate the minimum data measures required for Board oversight as detailed in the Perinatal Quality Oversight Model published in August 2025 and reflects the quarterly data from July – September 2025.

4.1 Maternity and Neonatal Service Metrics

The maternity and neonatal safety champions dashboard (Table 3) was introduced in 2022 to evidence ongoing monitoring of key outcomes and service trends relating to perinatal safety intelligence.

Table 3 – Maternity and Neonatal safety champions 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	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25
CNST attainment	Information only							
Critical Safety Indicators								
Births	Information only		387	446	415	407	419	364
Maternal deaths direct	0	1	0	0	0	0	0	0
Still Births			1	0	1	0	2	0
Still Birth rate per thousand	3.5	≥4.3	2.6	0	2.4	0	4.75	0
HIE Grades 2&3 (Bolton Babies only)	0	1	1	3	2	0	0	0

Indicator	Goal	Red Flag	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25
Early Neonatal Deaths (Bolton Births only)	Information only		0	1	3	2	0	0
END rate in month <7days	Information only		2.6	0.2	0.7	0.5	0.0	0.0
Late Neonatal deaths	Information only		1	0	0	1	0	1
PSII Incidents (New only)	0	2	1	0	0	1	0	0
MNSI referrals (Steis reportable)			1	2	1	0	0	1
Coroner Regulation 28 orders	Information only		0	0	0	0	0	0
Moderate harm events	0	1	1	0	3	1	3	2
1:1 Midwifery Care in Labour (Euroking data)	95%	<90%	99.1%	98.7%	99.5%	99.5%	97.70%	98.98%
The Co-ordinator is the named person providing 1:1 care (Br+)	0	1	0	0	0	1	0	0
BAPM compliance ratio/nurses acuity indirect (neonatal unit)	>99%	<79%	100%	100%	100%	91%	96%	85.87%
Fetal monitoring training compliance (overall)	<90%	>80%	94%	96%	91%	88%	90%	97%
PROMPT training compliance (overall)	<90%	>80%	96.00%	96.00%	89.00%	90.00%	90.00%	97%
Midwife /birth ratio (rolling) actual worked Inc. bank	Information only		1:19	1:19	1:19	1:19	1:19	1:20
RCOG benchmarking compliance	Information only		83%	86%	100%	94%	NA	NA
Compensatory rest breaches			0	0	0	0	0	0

Proportion of MWs who would recommend the Trust as a place to work or receive treatment

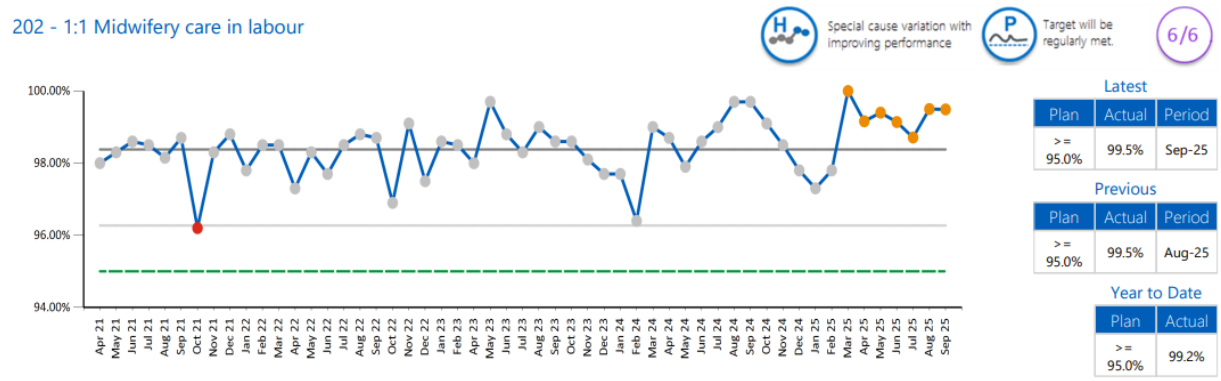
	Response 1-5	1 (Worst)		2 (Poor)		3 (Neutral)		4 (Good)		5 (Best)	
Indicator	Question	%	Count	%	Count	%	Count	%	Count	%	Count
Overall Experience	How likely are you to recommend this practice placement or training post location to friends and family if they ever need the care or treatment provided there?	11.11%	3	7.41%	2	7.41%	2	48.15%	13	25.93%	7

Proportion of speciality trainees in obs and gynae who responded excellent or good on the rating of clinical supervision out of hours

	Response 1-5	3 (Neutral)		4 (Good)		5 (Best)	
Indicator	Question	%	Count	%	Count	%	Count
Supervision	The overall supervision I received during the practice placement or training post	45.45%	5	45.45%	5	9.09%	1

A special cause variation in midwifery 1:1 care in labour rates was noted in August 2025 (Table 4) that appears to have coincided with the reduction in the Registered Midwifery deficit within the service.

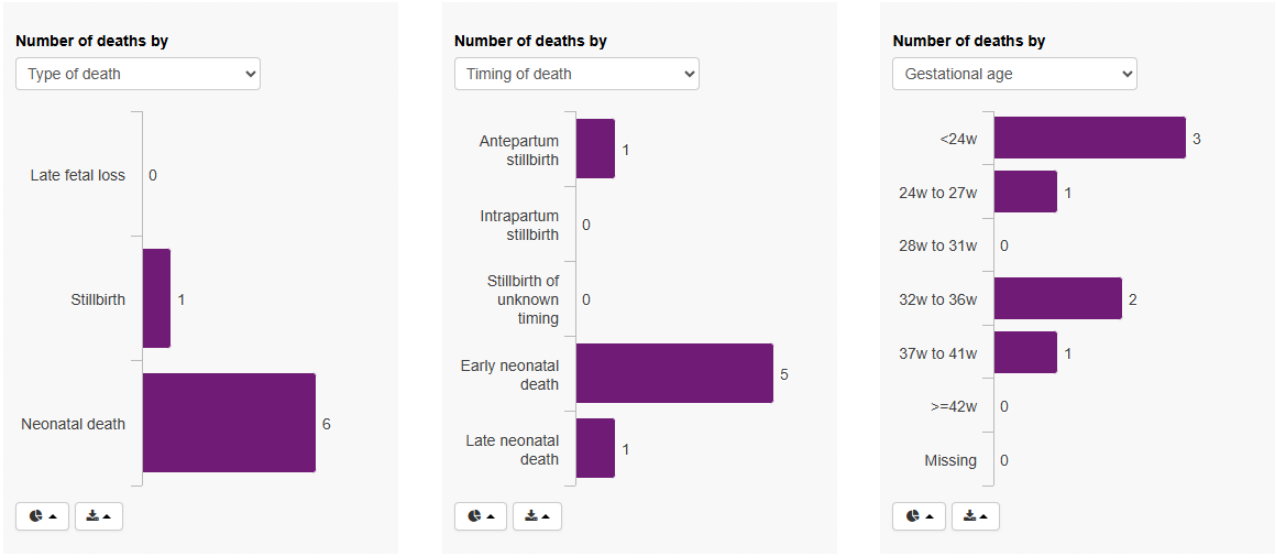
Table 4 – 1:1 midwifery care in labour rate up to September 2025



Perinatal Mortality

All perinatal deaths reported on the dashboard are also monitored using the MBRRACE real time data monitoring tool (Table 5). This tool enables the maternity service to identify trends in the incidence of deaths and associated actions.

Table 5: MBRRACE real time monitoring tool data reflecting deaths reported by type to MBRRACE during the Q2 period July 2025 – September 2025.



Three of the neonatal deaths in Q2 related to neonatal deaths and occurred in our extreme prematurity cohort of babies on the Neonatal Unit (3 cases less than 24 weeks) and a further case occurred in the 24-27 week category.

The cases have been reviewed in detailed by the neonatal service and the review identified no care issues were identified for 1 baby (Grade A) and care issues identified which would have made no difference to the outcome were identified for 5 babies (Grade B).

Learning points were identified from the reviews and two actions were identified relating to the need for early initiation of a palliative care plan for very sick preterm babies and teaching

to be undertaken relating to the use of vaso active agents based on cardio physiology. No system errors or failures in care were identified in the reviews undertaken.

One intrapartum stillbirth was reported during the Q2 period, and the case was reported to MNSI. Initial learning from the case related to ensuring appropriate escalation was undertaken when delays occur in the induction of labour pathway. In response a full review of the escalation pathway and flow reporting arrangements has been undertaken. The final copy of the MNSI report is currently awaited.

4.2 Culture of learning and support

Maternity Patient Safety Incident Response Framework: Thematic learning

A peak in the incidence of Hypoxic Ischaemic Encephalopathy (HIE) flagged on the Trust level statistical process chart (SPC) analysis chart in July 2025 and also on the LMNS comparative performance dashboard. In response a thematic review of HIE cases that occurred between April 2024 and July 2025 was completed.

The thematic review of the 10 maternity cases highlighted areas for improvement in the clinical care pathway, particularly concerning antenatal CTG interpretation, escalation processes, triage systems, and documentation practices. While established protocols like the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) and Trust guidelines for CTG interpretation exist to safeguard maternal and fetal wellbeing, the findings demonstrated that deviations from these standards are often driven by human factors, resource constraints, and systemic challenges were evident within the cases reviewed.

The actions identified within the thematic review have been incorporated into a safety improvement plan.

A request has been made for the statistical process chart analysis of this indicator to be added to the integrated performance pack published monthly for ongoing oversight.

Cases reported to Maternity and Neonatal Safety Investigation branch.

Three cases were reported to MNSI during the July – September 2025 reporting period.

Date of incident	MNSI ref	Type of incident	Current	Learning
04.07.2025	MI 044368	HIE	MNSI review declined by family	Trust Review – Improvements required to working relations between ANDU and Triage. Listening meeting held with staff groups.
05.07.2025	MI 044367	HIE	MNSI closed the case due to lack of engagement of family.	Trust Review – No learning identified
01.08.2025	MI045052	Intrapartum Stillbirth	Final copy awaited	

External assurance requests

During the period July – September 2025 the service received 2 requests for additional information from the Care Quality Commission. The requests primarily related to incidents reported on the Safeguard system that were identified as learning from patient safety incidents.

Claims Scorecard

The Q2 2025/2026 scorecard review (Appendix 5) triangulates the Trust claims score card (that includes claim data from 1 April 2015 – 31 March 2025) with contemporary incident and complaint data received within the maternity service during Q2 2025/2026.

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.

In October 2025 a deep dive review of performance metrics, themes identified from the claims scorecard reported during the period 2015 – 2025 and incident themes was undertaken in order to identify further areas of improvement within the service.

Interestingly the overarching themes identified in the deep dive review related to:

- Maternity Triage and management of reduced fetal movements
- Fetal monitoring
- Escalation of care
- Delays in treatment and diagnosis

In response a detailed safety improvement plan was collated based upon the themes identified which will continue to be monitored at Divisional level with progress updates provided to Trust Clinical Governance and Quality Committee as required.

4.3 Workforce

As a minimum standard Trust Boards should consider minimum staffing in maternity and neonatal services to include obstetric cover on Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual staffing levels.

Safe staffing indicators

Midwifery Staffing Levels

The planned versus actual staffing levels are published in the bi-annual staffing paper in retrospect and are therefore no current data is available for the July 2025 – September 2025 period as yet. The last Board report reflecting the January – June 2025 staffing period was presented at Board in November 2025 and published in the public Board papers.

Monthly safe staffing reports however are published on the Trust website highlighting the fill rate of non-registered and registered staff groups.

The August 2025 report detailed in table 6 highlights an overfill of shifts on ward G3 in month and an underfill of non-registered staffing on Central Delivery Suite. In response a professional judgement review of staffing levels was undertaken to realign staffing in

accordance with professional judgement and the last Birth Rate Plus report recommendation published in 2023.

A formal staffing consultation commenced in June 2025 to realign the non-registered staff in accordance with the NHS England Maternity Support Worker Competency, Education and Career Development Framework (NHS England 2024) and the skill mix advised in the 2023 Birth Rate Plus findings. This consultation has now been completed, and staff are due to commence their new roles in January 2026.

Table 6: Trust safe staffing report – August 2025

Ward name	Specialty 1	Day		Night		This months CHPPD	Last Months CHPPD	CHPPD Difference from Last month		Comments
		Registered Nurse/ Midwife	Non-registered Nurses/ Midwives (Care Staff)	Registered Nurse/ Midwife	Non-registered Nurses/ Midwives (Care Staff)					
Total		90.83%	95.34%	92.27%	102.24%	8.91	9.17	-0.27	↓	
Ward B1 [E00028]	300 - GENERAL MEDICINE	89.66%	99.73%	100.42%	121.01%	7.68	8.34	-0.66	↓	
CCU (Coronary Care Unit	320 - CARDIOLOGY	98.55%	97.27%	100.00%	119.35%	9.58	9.33	0.25	↑	
Ward C1 [E00005]	320 - CARDIOLOGY	100.26%	99.03%	100.28%	105.43%	5.60	5.79	-0.19	↓	
Ward C2 [E00007]	300 - GENERAL MEDICINE	99.87%	99.65%	100.84%	104.86%	7.15	7.09	0.06	↑	
Ward C3 [E00011]	301 - GASTROENTEROLOGY	96.70%	94.26%	100.00%	100.81%	6.85	6.88	-0.03	↓	
Ward C4 (E00035)	300 - GENERAL MEDICINE	94.80%	103.79%	116.13%	100.14%	7.61	7.20	0.41	↑	
Ward D3 [E00013]	340 - RESPIRATORY MEDICINE	98.24%	100.47%	100.00%	105.03%	7.23	7.23	0.00	↑	
Ward D4 [E00015]	340 - RESPIRATORY MEDICINE	99.81%	94.09%	100.45%	104.72%	8.02	8.02	0.00	↑	
Ward H3 - Stroke [E0002	328 - STROKE MEDICINE	97.29%	101.06%	101.61%	101.09%	6.63	6.85	-0.22	↓	
Critical Care Unit (E0014	192 - CRITICAL CARE MEDICINE	75.95%	84.50%	81.68%	58.06%	22.99	25.10	-2.10	↓	
Surgery E3 (E00119)	100 - GENERAL SURGERY	101.52%	102.61%	100.37%	115.06%	6.97	6.85	0.12	↑	
Orthopaedic Male E4 (E0	110 - TRAUMA & ORTHOPAEDICS	98.06%	100.81%	101.25%	100.07%	8.46	8.86	-0.40	↓	
Orthopaedic Female F4 (	110 - TRAUMA & ORTHOPAEDICS	103.70%	121.77%	104.01%	132.94%	8.75	8.58	0.17	↑	
Antenatal - Ward G3 [E0	501 - OBSTETRICS	106.92%	97.58%	90.80%	96.77%	5.33	5.17	0.16	↑	
Postnatal G4 [E00177]	501 - OBSTETRICS	94.54%	96.86%	88.76%	94.53%	8.20	8.11	0.09	↑	
Central Delivery Suite (C	501 - OBSTETRICS	91.25%	80.09%	86.27%	93.09%	30.70	33.52	-2.82	↓	
Neonatal Unit [E00185]	422 - NEONATOLOGY	78.78%	33.87%	84.43%	74.19%	12.75	16.27	-3.52	↓	
Ward E5 [E00154]	420 - PAEDIATRICS	74.31%	51.56%	77.50%	51.61%	16.02	16.45	-0.43	↓	
Ward M1 [E00194]	502 - GYNAECOLOGY	102.34%	94.53%	95.86%	106.59%	14.35	16.23	-1.87	↓	
OPAU (E00059)	300 - GENERAL MEDICINE	98.38%	100.00%	143.96%	100.77%	8.19	8.41	-0.21	↓	
ENT F6 (E00120)	120 - ENT	86.21%	82.14%	82.04%	84.62%	7.24	8.32	-1.08	↓	
Ward N3	300 - GENERAL MEDICINE	103.31%	95.33%	100.63%	99.93%	6.66	6.94	-0.29	↓	
AMU2 (E00061)	430 - GERIATRIC MEDICINE	90.61%	112.70%	97.90%	161.40%	8.25	8.34	-0.09	↓	
Elective Care Centre - Fi	110 - TRAUMA & ORTHOPAEDICS	98.39%	79.24%	97.16%	96.77%	15.46	23.38	-7.92	↓	

Obstetric cover

During the period July – September 2025 two maternity diverts were enacted due to obstetric staffing issues in Q2 although no staffing rota gaps were declared.

The Q2 2025/2026 RCOG clinical attendance audit report reflected activity between July - September 2025. The audit demonstrated 94% compliance with the required standards with a consultant being in attendance for 30/32 of the cases. The 2 cases of non-compliance related to failure to attend a post-partum haemorrhage which is a time sensitive event in which management cannot be delayed whilst the consultant attends.

Between August 2024 and August 2025, a total of 133 incidents concerning insufficient staffing within Obstetrics and Gynaecology were reported, with over 51% of these incidents occurring within the three-month period of June-August. Data indicates that the rise in incidents correlates with the implementation of the GMEC rates introduced in April 2025.

In response a business case has been collated and submitted for consideration to increase the obstetric staffing establishment.

Neonatal medical cover

The neonatal medical staffing levels currently do not meet the British Association of Perinatal Medicine national standards of medical staffing as the service is not currently compliant with the Tier 3 staffing requirements.

The Tier 3 standard requires Consultant Neonatologist presence for a minimum of 12 hours per day for a service with less than 4000 intensive care days per annum which is applicable to the service at Bolton.

A detailed review of the medical workforce has been undertaken by the Clinical Director using a neonatal medical workforce tool and this identified a gap of 7.5PAs in the current Tier 3 staffing level. Progress has been made since the assessment undertaken of the neonatal medical staffing levels undertaken in 2024 as part of the CNST year 6 scheme in 2024 and the service has increased the 12 hours consultant presence over the past year from 2 days a week in 2024 up to 214 days in 2025.

A business case is in progress the additional staffing resource required.

Neonatal nursing cover

The BAPM staffing levels highlight that safe neonatal nursing cover was provided during the Q2 period with an average BAPM compliance of 95.67% during Q2.

Bank approval was authorized during this period to mitigate the acknowledged circa 18wte Registered Nurse staffing deficit subject to ongoing recruitment and daily oversight of the BAPM compliance was undertaken.

Training Compliance

In collaboration with national maternity and neonatal partner organisations, the Maternity Transformation Programme published the Core Competency Framework version 2 (CCFv2) in June 2023 that set out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. The framework ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

Trust performance is reported on a quarterly basis to the LMNS (Table 7) to evidence progress with the required standards. The minimum standard of attainment for all elements is 90% across all professions.

The core competency training includes additional profession specific elements that are required in addition to the training requirements detailed in the CNST maternity incentive scheme. To be noted elements of training requirements differ between the CNST and CCV2 scheme (example newborn life support for medical staff is not required in CNST yet is required in the CCTV2 scheme.) and thus due to the extent of THE profession specific training

demands that exceed the allocated training uplift all CNST training requirements are prioritised.

Assurance can be provided that all CNST training requirements were attained in full by the 25 November 2025 as per table 2.

Table 7 – Training compliance in accordance with core competency framework as of end of September 2025 submitted for the Q2 reporting period.

Qualifying period and submission dates to LMNS (Use LMNS Email GMEC.LMNS@nhs.net)			May - August 2025 (Submit to LMNS by 26.9.25)				
Core Competency Number	Core Competency	Type of Training	Midwives	Maternity Care Assistants	Obstetricians	Anaesthetists	Theatre Staff
1	**Saving Babies Lives**						
	Element 1: Smoking	Face to face training	95%	100%	79%		
		NCSCT E-learning	100%	100%	N/A		
		Risk Perception Training for ANC staff	55%	N/A	N/A		
	Element 2: Fetal Growth Surveillance	E-learning for Health Module	97%		75%		
		Serial Fundal Height Face to face training and competency	95%		79%		
		Face to face training	95%		79%		
	Element 3: Reduced Fetal Monitoring	E-learning for Health module	97%		75%		
		Face to face training	95%		79%		
	Element 4: Fetal monitoring	see Core Competency 2					
	Element 5: Preterm Birth	E-learning for Health module	97%	0%	75%	0%	0%
		Face to face training	95%	0%	79%	0%	0%
	Element 6: Diabetes in Pregnancy	Face to face training	95%	0%	79%		
2	**Fetal Monitoring GMEC Package:**						
	Full day Fetal monitoring training to include CTG, Antenatal and Intermittent Auscultation	Face to face training	94%		75%		
	CTG competency	GMEC Competency document	92%		91%		
	Intermittent Auscultation Competency	GMEC Competency document	97&				
3	**Maternity Emergencies - Multidisciplinary Team - Full day**	Face to face training	95%	97%	61%	69%	0%
4	**Equality, Equity and Personalised Care**	Face to face training	91%	0%	63%	0%	0%
	Cultural Competency and Cultural Safety in maternity care	Face to face training	34%	0%	32%	0%	0%
5	**Care during Labour and Immediate Postnatal Period**	Face to face training	91%	0%	63%	0%	
6	**Neonatal Basic Life Support**	Face to face training	91%	97%	0%	0%	0%

Staff feedback

The board safety champions and perinatal leadership team last met on the 13 November 2025 and discussed the cultural action plan and the listening events undertaken in response.

In August 2025 escalations were received from staff working within the maternity service relating to cultural issues and working practices between staff members (medical and midwifery). In response a bespoke listening group was held with the Chief Nurse (Board Safety Champion) on the 10 October 2025 and associated medical and midwifery colleagues to understand the concerns in detail and identify actions to be taken in response.

In order to triangulate the feedback with themes from incidents, performance metrics and claims received a deep dive review was undertaken in October 2025 and presented at Quality Assurance Committee in November 2025. The review triangulated the learning from a review of the performance metrics with the NHSR claims scorecard analysis for the period 2025 and 2025 and identified areas of improvement and factors associated with human factors relating to culture and performance to be addressed. In response an overarching safety improvement plan for the service was collated. The action plan will continue to be monitored at Divisional level and at Quality Assurance Committee until completed.

Additional staff and service user feedback received from the safety champion walkabouts is detailed in Appendix 4.

Freedom to speak up.

There were 3 concerns raised from Maternity/Neonatal via FTSU in Q2 2025/2026.

1 case related to a facilities concern, 1 case related to inappropriate attitudes and behaviours (Peer), 1 case related to inappropriate attitudes and behaviours (manager).

Cultural surveys / SCORE survey

Work to improve the working culture between medical and midwifery staff has continued since publication of the SCORE survey in March 2025.

Recent escalation of concerns were received from obstetric and midwifery colleagues and related to:

• Lack of overall medical engagement in speciality and system level meetings/fora

• Concern relating to the clinical practice of professionals with regard to forceps delivery – (thematic review in progress)

• The lack of team empowerment in clinical decision making

• The impact of bed capacity pressures upon staff groups

• Incivility behaviours reported from both the medical and midwifery team resulting in escalation.

Actions taken to date

- Introduction of wellbeing events for all obstetric and midwifery team members

- Bespoke survey of consultant feedback undertaken to identify ways to improve culture
- Curiosity café listening events held with small group of professionals
- Collation of business case to uplift the obstetric staffing levels commenced
- Communications shared with staff members regarding opportunities to share their opinion.
- Thematic review of forceps incidents undertaken to identify opportunities for future learning Actions taken in response.

Actions planned

- Introduction of additional ward round on CDS to improve care planning and communication - completed.
- Review of the timing of the maternity huddle to be undertaken to encourage MDT attendance - completed.
- Review of obstetric responsibilities to be undertaken when allocated to Delivery Suite as Consultant of the Week to ensure they relate to obstetric duties only - completed.
- Review of neonatal policies to be undertaken to align the neonatal period of observation with best practice - ongoing
- Access to all neonatal policies on BOB to be improved to facilitate quick access - ongoing.
- Review of maternity ward discharge arrangements to be undertaken and consideration to be given to use of Trust discharge lounge for mums and babies - completed.

4.1 Listening to families

Service user feedback

A fifteen steps review was conducted by the MNVP lead and services users on the 19 November 2025. This review was undertaken by service users and staff colleagues visiting the clinical areas and involved a review of the current signage and service provision in the clinical areas.

Positive feedback was received from service users regarding the relocation of triage to ward R1 and the improvement in privacy and the ward environment.

Service improvements to the wayfinding to help service users were also highlighted as an area of improvement. In response the service will link with the IFM team to make the required improvements, and any outstanding actions will be included in the co-produced maternity/MNVP improvement plan.

Friends and Family

In Q2 there was a decrease in the number of Friends and Family responses leading up to September 2025 to 19.6% with a decrease in satisfaction noted in birth responses to 80.7%. This decrease coincided with increased levels of birthing activity and two maternity unit

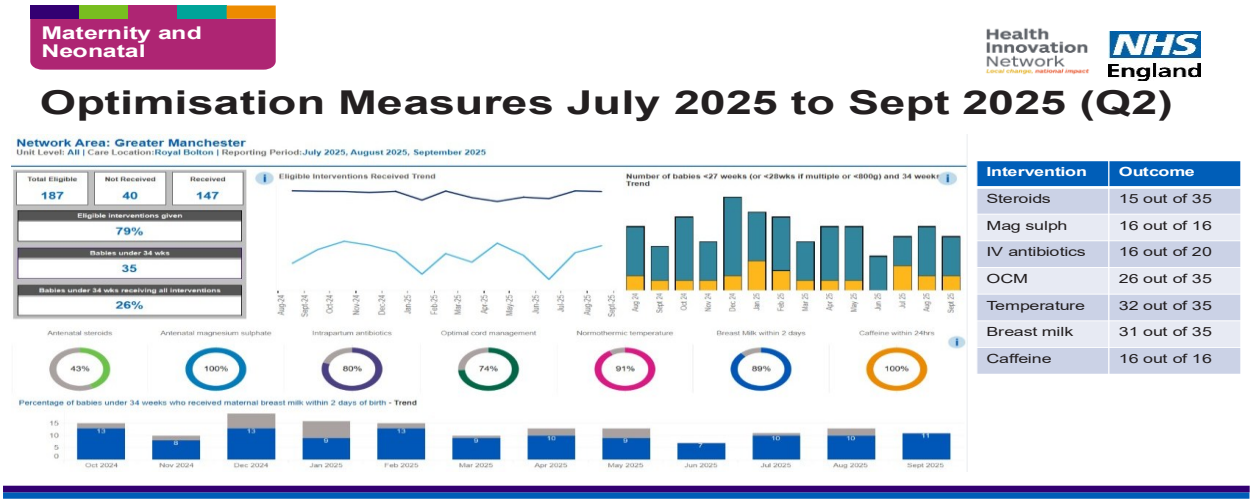
closures in September 2025 that impacted upon the care pathway of 13 women diverted to other units in Greater Manchester.

5. Structures and Standards Underpinning Safe Care

Perinatal Optimisation

Bolton maternity and neonatal services are performing well with regard to implementation of all perinatal optimisation measures. The recent audit data highlighted that 79% of eligible interventions were administered in Q2 and highlighted an overall improvement in performance. Further improvement is required with regard to the uptake of antenatal steroids prior to birth.

Table 8 Perinatal optimisation measures Q2



Intervention	Outcome
Steroids	15 out of 35
Mag sulph	16 out of 16
IV antibiotics	16 out of 20
OCM	26 out of 35
Temperature	32 out of 35
Breast milk	31 out of 35
Caffeine	16 out of 16

Saving Babies Lives Care Bundle Implementation

In June 2025 the Trust received a significant assurance grading with an overall 99% compliance rating with regard to completion of all required process indicators relating to implementation of the Saving Babies Lives Care Bundle v3 (SBLV3) as per national and LMNS requirements (Appendix 3). 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.

A further quarterly assurance SBLV3 implementation update session was held on the 16 December 2025 chaired by the LMNS acting on behalf of the ICB and Trust providers. During the session the service was assessed against the clinical outcome measures. This approach is unique to Greater Manchester and is designed to reduce the burden on providers, rather than revisiting all process and clinical indicators together every three months as with the national toolkit. Formal feedback from the update is awaited.

6. 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 detailed within the perinatal quality oversight model published in August 2025.

7. Recommendations

It is recommended that the Board of Directors:

1. Receive the contents of the report.
2. Approve the action plans detailed within this report.
3. Authorise the signing of the declaration form by the Chief Executive prior to submission to NHS Resolution by the 3 March 2026.
4. Approve the sharing of this report within the local maternity and neonatal system and 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 Twins	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 Support 06.07.2025**	06.07.2025
96865	SB	0	31+4	11.01.2025	11.03.2025	13.01.2025	**External Support**	11.07.2025

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
							22.05.2025	
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 MNSI	ENND	0	32+3	02.02.2025	02.06.2025	02.02.2025	**External Support 10.07.2025**	02.08.2025
97672	NND	1	26+2	07.01.2025 09.03.2025	09.05.2025 Post neonatal Death, excluded CNST standards	10.03.2025	**External Support 14.08.2025**	09.09.2025
97729	SB	1	24+3	12.03.2025	12.05.2025	13.03.2025	**External Support 14.08.2025**	12.09.2025
97757	SB	1	38+5	13.03.2025	13.05.2025	13.03.2025	**External Support 10.07.2025**	13.09.2025
97832	NND	1	28	18.03.2025	18.05.2025	19.03.2025	**External Support 10.07.2025**	18.09.2025
97882	NND	0	23	23.03.2025	23.05.2025	27.03.2025	**Extremal Support 31.07.2025**	23.09.2025
98014	NND	1	23	01.04.2025	01.06.2025	02.04.2025	**External Support 19.06.2025**	01.10.2025
98019	NND	0	36+2	02.04.2025	02.06.2025	02.04.2025	**External Support 14.08.2025**	02.10.2025
98062 MNSI	SB	1	40+4	04.04.2025	04.06.2025	04.04.2025	**External Support 28.08.2025**	04.10.2025
98164	SB	1	34+0	14.04.2025	15.06.2025	14.04.2025	**External Support 11.09.2025**	15.10.2025
98259	LFL	1	22+1	18.04.2025	18.06.2025	19.04.2025	**External Support 11.09.2025**	18.10.2025
98238	LFL	2	22+6	19.04.2025	19.06.2025	21.04.2025	**External Support 11.09.2025**	19.10.2025
98346	SB	3	39+6	25.04.2025	25.06.2025	28.04.2025	**External Support 25.09.2025**	25.10.2025
98847	NND	1	22+2	03.06.2025	03.08.2025	03.06.2025	**External Support 06.11.2025**	03.12.2025
99066	SB	1	37+4	18.06.2025	18.08.2025	19.06.2025	**External Support 25.09.2025**	18.12.2025

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
99250	NND	1	24+4	14.04.2025 To 01.07.2025	01.09.2025	02.07.2025	**External Support 06.11.2025**	01.01.2026
99636	NND	1	23+3	29.07.2025 To 30.07.2025	30.09.2025	31.07.2025	ARRANGED 08.01.2026	31.01.2026
99736 MNSI	SB	4	41+6	01.08.2025	01.10.2025	04.08.2025	TBC MNSI case 29.01.2026	01.02.2026
99799	NND	1	36+3	11.08.2025	11.10.2025	12.08.2025	External Support 27.11.2025	11.02.2026
100037	NND	1	23+1	30.08.2025	30.10.2025	31.08.2025	ARRANGED 08.01.2026	30.02.2026
100038	NND	1	27+5	28.08.2025 To 30.08.2025	30.10.2025	31.08.2025	ARRANGED 08.01.2026	30.02.2026
100164	NND	1	36+0	14.08.2025 To 07.09.2025	07.11.2025	07.09.2025	ARRANGED 15.01.2026	07.03.2026
100265	NND	0	23+5	10.09.2025 To 13.09.2025	13.11.2025	13.09.2025	ARRANGED 15.01.2026	13.03.2026
100728	SB	1	37+0	12.10.2025	12.12.2025	13.10.2025	TBC 26.02.2026	12.04.2026
100844	SB	1	39+0	23.10.2025	24.10.2025	23.12.2025	TBC 26.02.2026	23.04.2026
101147	SB/NND	1	23+3	12.11.2025	13.11.2025	12.01.2026	TBC 02.04.2026	12.05.2026
101263	NND Twins X2	2	23+6	18.11.2025	20.11.2025	18.01.2026	TBC 02.04.2026	18.05.2026
101389	NND	0	32+1	27.11.2025	Post NND excluded from CNST standard	27.01.2026	TBC 16.04.2026	27.05.2026

The above table is inclusive of two cases; 97672 and 101389, although these do meet CNST standards as the infants died after 29 days of age, Bolton NHS Foundation Trust ensure a full review is included to ensure any learning identified can be implemented.

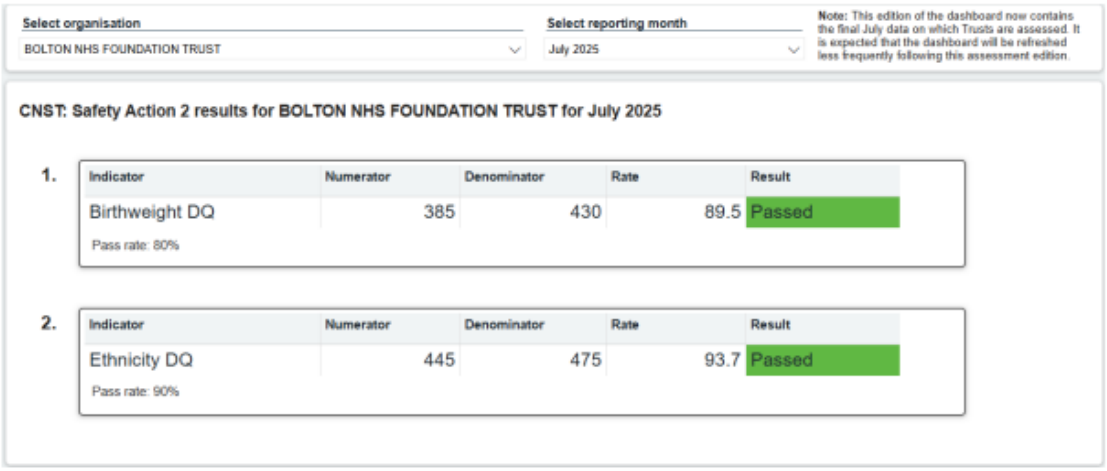
Appendix 1a – Ongoing themes actions highlighted in completed reviews relevant to the deaths reviewed.

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	To ensure training is delivered during induction in relation to ventilation.	31.03.26	Sundaram Shanmuga		**2**
2.	To ensure training is delivered during induction in relation to fluid management.	31.03.26	Sundaram Shanmuga		**2**
3.	GROW 2.0 customised growth chart was not completed accurately. To continue with annual audit and provide audit assurance	31.03.26	Lauren Goddard, SBL lead		**2**
4.	Learning within GMEC to be undertaken relating to the sharing of information for clients who access care at multiple Trusts.	31.03.26	Sara Luke, Risk and Assurance Midwife	Discussion at LMNS safety SIG on the Email to lead at LMNS 22.09.2025 Email trail available. 21.10.2025 update from LMNS lead to arrange focus groups in January 2026 to explore the possibility of a GMES SOP for sharing of information.	**3**
5.	Evident throughout labour and postnatal period that xx was not reviewed by a doctor.	31.03.26	Anjum Noureen, Consultant Obstetrician .	Evidence within huddles about the importance of doctor reviews for bereavement women, shared with the maternity staff.	**2**

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
	This is due to labour progressing Share learning throughout obstetric and midwifery teams that bereaved patients require a review.		Kathryn Bolton, Central Delivery Suite, Ward Manager		
6.	Visual slide on observations in labour and partogram should be created to share within the areas.	31.03.26	Sara Luke, Risk and Assurance Midwife		**2**
7.	Liaise with consultant obstetricians and review referral process to diabetic teams for cases of with accelerated growth.	31.03.26	Dr Singh, Obstetric Consultant		**2**
8.	Extreme Preterm Delivery Integrated Care Pathway was not completed therefore it could not be ascertained whether an obstetric discussion had been had about fetal monitoring and mode of delivery. To share with obstetric and neonatal team about importance of this documentation and pathway.	31.01.26	Dr Anjum Noureen, Obstetric Consultant		
9.	Ensure GMEC guideline is updated to include need	31.03.26	MDT approach	SOP immediately removed from practice.	**3**

Ref	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
	for Consultant review following 3 or more reported incidents			Director of Midwifery has liaised with author of RFM North West Guideline in relation to obstetric reviews. PSII commissioned and action plan created	

Appendix 2 – Safety Action 2 - Trust scorecard



Select organisation: BOLTON NHS FOUNDATION TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for BOLTON NHS FOUNDATION TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	385	430	89.5	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	445	475	93.7	Passed

Pass rate: 90%

Appendix 3 – Notification from LMNS/ICB of Safety Action 6 implementation

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3.2?

Reporting period: 2 April 2025 until 30 November 2025

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

Date of 1st Assurance Meeting - 30/06/2025

Date of 2nd Assurance Meeting – 16/09/2025

Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the trajectory.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?

Is the LMNS confident MIS Year 7 requirements have been met? Yes ☒ No ☐

Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?

Note: It is a GMEC LMNS requirement to present, discuss and share learning relating to the SBLCBv3.2 to neighbouring trusts via GMEC LMNS SBL Champions Network Meeting.

Has this been provided by the provider SBL Champion? Yes ☒ No ☐ Date Provided: 17/06/2025

X

Eileen Stringer
Clinical Lead Midwife

Date signed: 24/11/2025

Appendix 4 - Staff and patient feedback from the safety walk rounds.

You Said	We did
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 Action plan developed in response
May 2025 Hot cot implementation	Training in use of hot cots continues – implementation delayed until June 2025 Hot cots now in use
Maternity Triage	Lack of capacity remains an issue – options appraisal to be submitted re sourcing additional space. R1 to be used as combined ANDU/Triage space from 22 September 2025.
July 2025 Clients stated that refreshments were required in waiting areas.	Refreshment options and water coolers to be scoped for us in waiting areas. Request for costings made to Estates. Refreshment provided to clinical area for use by clients for distribution.
September 2025	Cultural concerns raised by staff with regard to incivility relating to reduced bed capacity and increasing staff pressures. Listening event held with staff to understand concerns and improvement plan collated.

Appendix 5 – Triangulation of Trust Claims scorecard and incident and complaint data Q2 2025-2026

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NHS Bolton NHS Foundation Trust

Triangulation of Trust Scorecard, incident and complaints review – Q2 2025 - 2026

Claims Scorecard April 2015 – March 2025

Top 5 injuries by volume for Obstetrics	Top 5 causes by volume for Obstetrics
Injury	Injury
1. Unnecessary Pain	1. Fail to Recognise Complications Of
2. Stillborn	2. Failure/Delay Diagnosis
3. Brain Damage	3. Fail/Delay Treatment
4. ADTN/Unnecessary Operation(s)	4. Fail to Make Resp To Abnrm FHR
5. Fatality	5. Fail to Act On Abnormal Test Result
Top 5 injuries by value for Obstetrics	**Top 5 causes by value for Obstetrics**
Injury	Injury
1. Brain Damage	1. Fail to make Resp to Abnrm FHR
2. Cerebral Palsy	2. Fail/Delay Treatment
3. Hypoxia	3. Fail to Act on Abnormal Test Result
4. Developmental delay	4. Fail to Interpret USS
5. Psychiatric/Psychological	5. Fail to Recognise Complications Of

Triangulation of learning Q2

The following themes were identified following triangulation of the maternity incidents and complaints for Q2 2025 with the new claims scorecard 2015-2025.

- Maternity Triage and management of reduced fetal movements
- Fetal monitoring
- Escalation of care
- Delays in treatment and diagnosis

Incident themes: Cause Group 1

583 incidents were reported within the maternity specialty throughout Q2 2025, 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.

Maternity Incidents - Q2	Actual Harm
Cause 1	1-No Harm (No Harm Occurred)
NNU - Unexpected Admission	29
Post Partum Haemorrhage	33
Delay>30 Mins Btwn Presentation&Triage	21
Delayed/Cancelled Time Critical Activity	20
Fetal Monitoring	7
Grand Total	110

Themes from complaints Q2

Complaints have been divided into informal and formal complaints and themes have been outlined below.

- Clinical treatment
- Communication
- Attitude

A bespoke safety improvement plan has been collated based upon the analysis undertaken of themes from claims, complaints and a recent review of factors relating to performance metrics. This is due to be approved at Quality Assurance Committee in November 2025

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Bolton NHS Foundation Trust**
Trust Code	**T264**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact nhsr.mis@nhs.net

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.
Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	N/A
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	Yes
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes

6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	No
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
12	Was the above action plan shared with the LMNS?	Yes
13	Was the above action plan shared with the Neonatal ODN?	Yes
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

Return to Guidance Sheet

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes

4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	No
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	Yes

Return to Guidance Sheet

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

Return to Guidance Sheet

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes

6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

Return to Guidance Sheet

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes

10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Return to Guidance Sheet

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review 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 and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes

8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Return to Guidance Sheet

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

Return to Guidance Sheet

NHS Resolution

Section A : Maternity safety actions - Bolton NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

NHS Resolution

Section B : Action plan details for Bolton NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Bolton NHS Foundation Trust**
Trust code	**T264**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Bolton NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Bolton NHS Foundation Trust
Name:	
Position:	
Date:	

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Families and Diagnostics Division

CNST year 7 Update
29 January 2026

Our new Maternity and Women's Health Unit

NHS Bolton NHS Foundation Trust

CNST Year 7 summary

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

Headlines

- ✓ All 10 safety actions achieved
- ✓ Trust level quality improvement and transformational project support received throughout programme
- ✓ External LMNS checkpoints have supplemented the evidential verification process
- ✓ External Future Collaboration platform used to enhance ICB/LMNS visibility

NHS Bolton NHS Foundation Trust

Highlights

Frequent oversight of evidence for approval of Board or Committee

- Regular Board level and Executive oversight has ensured timely escalation of concerns and provision of support
- Revisions made to reporting requirements in accordance with the perinatal quality oversight model published in August 2025.

Training & education

- Dedicated administrative support has improved management and oversight of training database and compliance
- Enhanced oversight of training compliance multi-disciplinary leads.

LMNS support

- LMNS checkpoints continued and data externally reviewed by dedicated LMNS panel

Bolton NHS Foundation Trust

Next Steps

- Approval of presentation and declaration on 29 January 2025
- Final CEO sign off and submission of declaration form to LMNS after Trust Board
- LMNS will then submit the completed form to the Accountable Officer for the Integrated Care Board and then return to the Trust
- Trust submission of the signed declaration form by the Chief Executive Officer to NHS Resolution by the 3 March 2026

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Bolton NHS Foundation Trust
Royal Bolton Hospital
Minerva Road, Farnworth
Bolton, BL4 0JR

t| 01204 390390 **w|** boltonft.nhs.uk

Our new Maternity and Women's Health Unit

Report Title:	Mortality report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	28 January 2026		Discussion	✓
Executive Sponsor:	Dr Rauf Munshi, Medical Director		Decision	

Purpose of the report	To provide assurance to the Board of Directors on the Trust mortality metrics status and to outline actions for further improvement.

Previously considered by:	This report will be considered by the Quality Assurance Committee at the meeting to be held on 28 January 2025.

Executive Summary	Mortality indicators continue to show positive progress. The SHMI has reduced to 108.19 and is now within the expected range, while the HSMR has improved to 105.95 and is no longer an outlier. The Trust's crude mortality rate also remains low compared with national benchmarks. Improvements in clinical coding are narrowing the gap between the Trust's Charlson Comorbidity scores and national comparators, following enhancements to EPR documentation and staff training. Some data quality issues remain: uncoded episodes are currently alerting due to Virtual Ward activity being incorrectly captured in the latest HES refresh, which is being addressed with NHSE. In addition, updated national coding guidance regarding "Well babies" is expected to resolve the "Other perinatal conditions" alert within the next six months. Sepsis continues to flag as an outlier and findings from the recent review are included within the report. Further work is underway to strengthen data accuracy, including updates to EPR forms and targeted training for ward clerks to reduce the risk of "short-stay" errors. The Board should also note that the introduction of Type 5 attendances by NHS Digital is expected to have a negative impact on mortality metrics going forward.

Proposed Resolution	The Board of Directors are asked to ***receive*** the Quarterly Mortality 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	Mortality metrics form part of the NOF for Trusts and failure to meet expected standards *may* impact on Trust finances.
Legal/ Regulatory	Yes	Mortality reporting is a regulatory requirement.
Health Inequalities	Yes	There is recognised variation in mortality rates between those from groups with different protected characteristics; Trust understanding of this and monitoring where feasible will mitigate this.
Equality, Diversity & Inclusion	No	
Is a Quality Impact Assessment Required	No	

Prepared by	Liza Scanlon, Business Intelligence Analyst Michelle Parry, Clinical Effectiveness Sophie Kimber Craig, Associate Medical Director Carrie Dewitt, ANP and lead for sepsis Philip Taylor, Clinical Coding Manager	**Presented by**	Dr Rauf Munshi, Medical Director

Glossary – definitions for technical terms and acronyms used within this document

DPG	**Deteriorating Patient Group**
MSG	**Mortality Steering Group**
SHMI	**Summary hospital-level mortality indicator** The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.
HSMR	**Hospital standardised mortality ratio** A quality indicator in healthcare that compares the number of deaths in a hospital to the expected number of deaths, taking into account patient factors like age and illness severity. An HSMR of 100 means the number of deaths is as expected, while a score over 100 indicates more deaths than expected, and a score under 100 indicates fewer than expected.
FCE	**Finished consultant episode –** A period of hospital care from a single consultant which forms the dataset for all hospital episode statistics
HED, HES, SUS, "flex" and "freeze"	Healthcare evaluation Data (HED) is a tool for viewing and benchmarking Hospital Episode Statistics (HES) data which are created from an extract of records taken from a data mart in the Secondary Uses Service (SUS). Data are submitted to SUS to enable providers to get paid for the activity they have undertaken. Under the NHS Standard Contract there is a two-stage reconciliation process for such payments where providers make an initial submission of a month's activity by the published 'inclusion date' of the following month. This is the reconciliation date (often referred to as the 'flex' date) and a snapshot of the data mart in SUS at this point is used to create that month's HES extract. The inclusion date in the following month (i.e. two months after the month of hospital activity), is the post-reconciliation date (referred to as the 'freeze' date) for that month's activity. The period between flex and freeze allows providers to improve the coverage and completeness of their records in order to get paid accurately for the activity they have undertaken.

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Bolton NHS Foundation Trust Mortality Report

1. Introduction

This report provides details of:

- The current mortality metrics for the Trust
- Outlying diagnostic groups with narrative on that status and actions for improvement
- Progress on the mortality action plan, including actions to improve accurate recording of diagnosis and Charlson comorbidities, with the steps to reduce the number of short spells
- A summary of the findings of a review into Sepsis care
- Coding compliance

2. Neonatal and paediatric mortality reporting

The previous quarter's report contained the most recent neonatal mortality report; the last neonatal death is reported as having been on 13 September 2025 and there has not been another update since September. The next report will therefore be shared in 2026.

Future iterations of this report will include the paediatric mortality data; this has not been included in this quarter's report to allow time to validate the data with the clinical team and Business Intelligence and to align definitions around child death that ensure appropriate learning for the organisation.

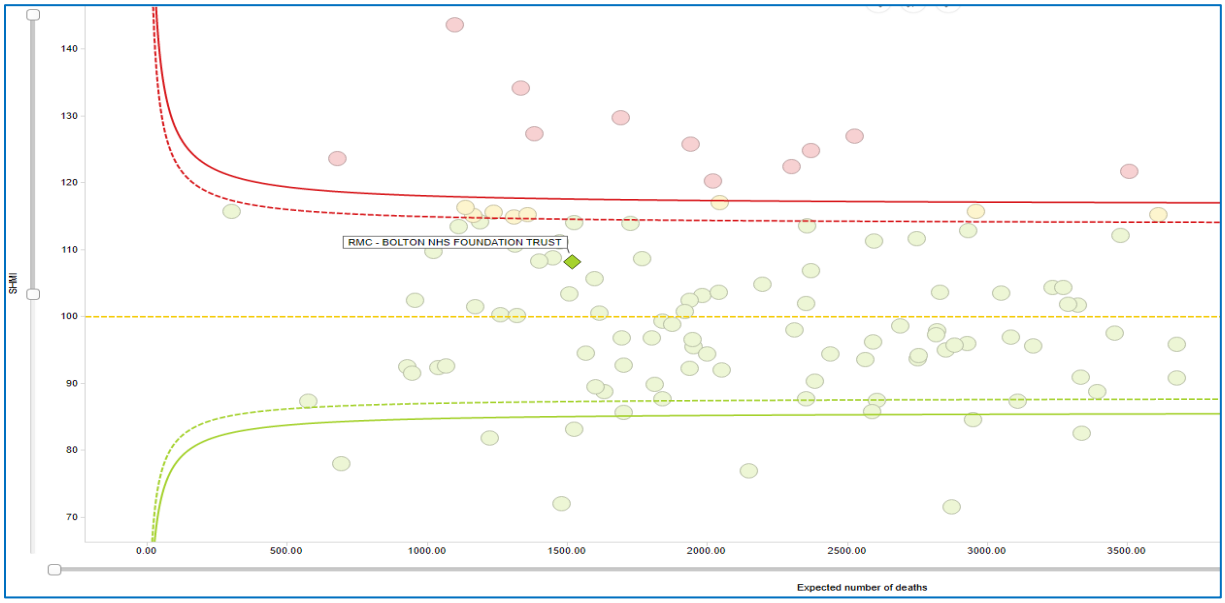
3. Headline mortality metrics for Trust

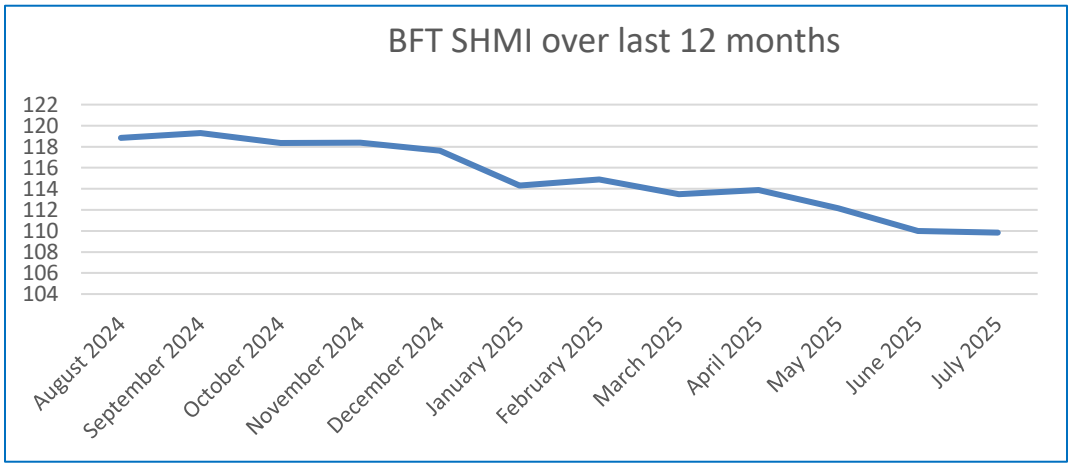
Having gone outside the expected range in 2024, SHMI and HSMR are both no longer mortality outliers. SHMI is now within range and HMSR is moving towards that position.

3.1 SHMI

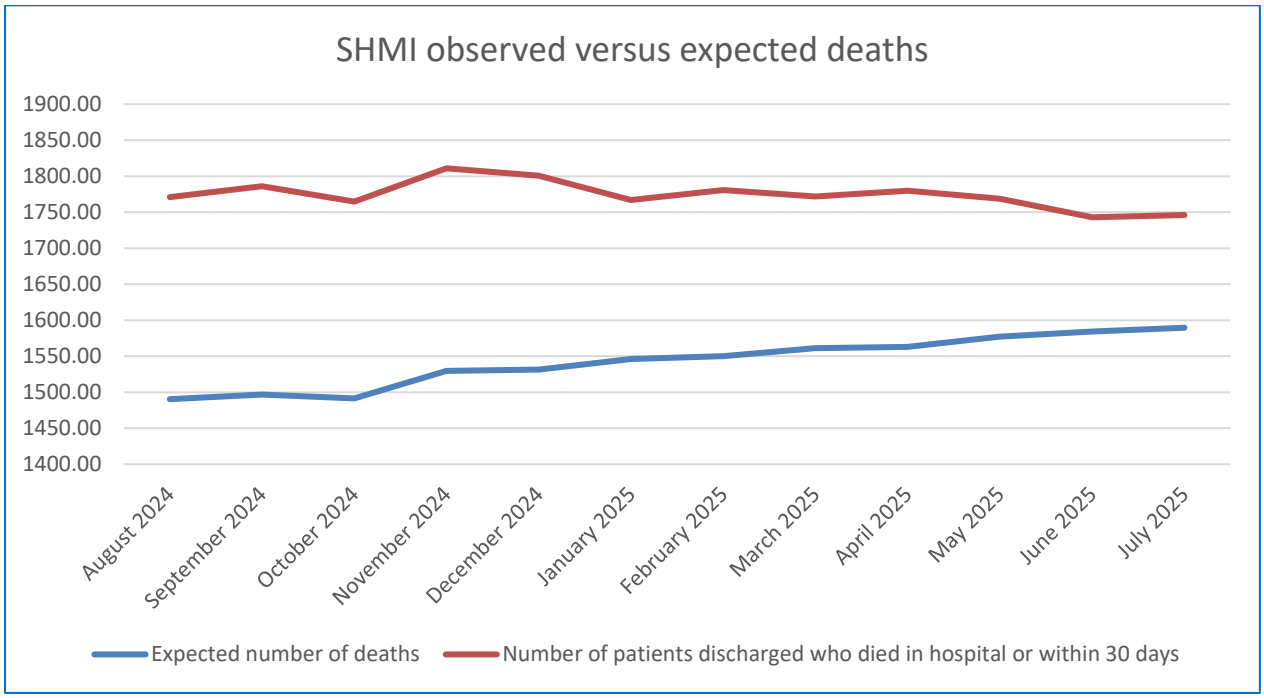
NHS Digital data for SHMI (October 2024-September 2025) shows Bolton at 108.19, which is "within expected" range. The SHMI has fallen since the last report, when it was 114.88[1]. This is shown in the funnel plot on the next page with the reduction over time shown in the next graph.

[1] Patients with Covid are now included in SHMI if the discharge date is from September 2021. This is following a national change in the NHS Digital methodology.





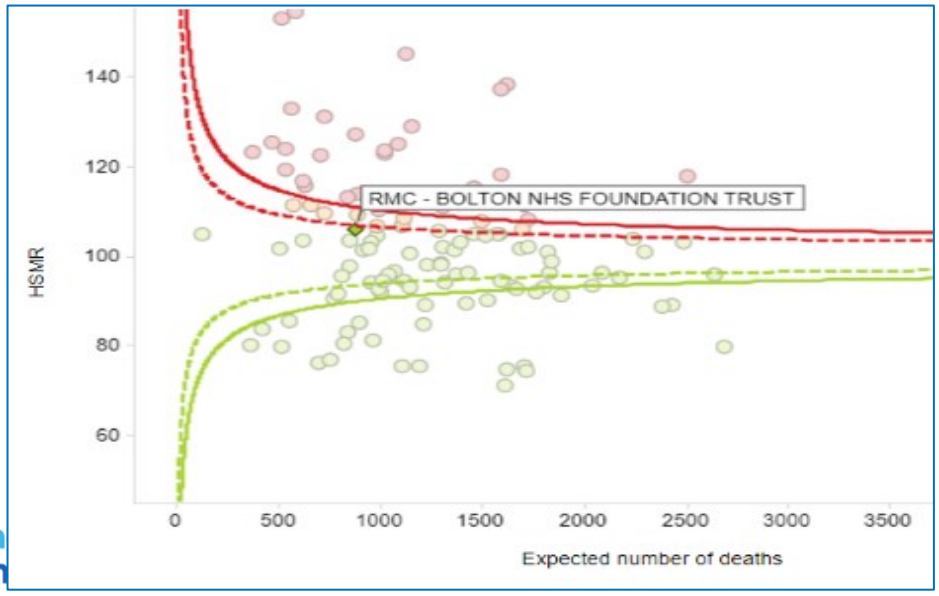
This graph shows the changes in observed versus expected deaths, showing a slight reduction in the number of people dying, but a relatively larger proportion of expected deaths – which is why the SHMI is being seen to reduce.



The number of expected deaths is rising in response to the improved average Charlson scoring and depth of coding for our patients. The data is starting to reflect the true risks the patients have more accurately as the data quality improves.

3.2 HSMR (November 2024-October 2025)

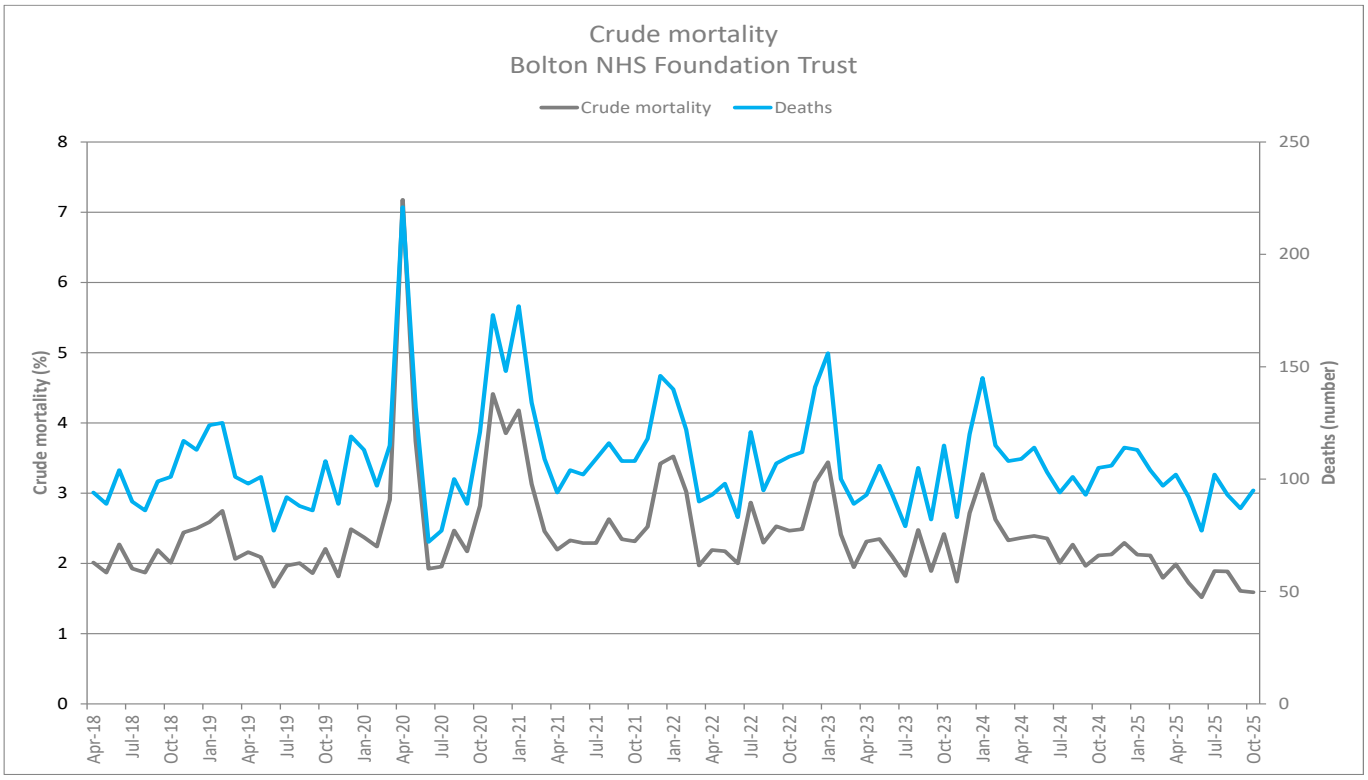
HSMR for the period August 2024 to July 2025 is at 105.95, compared with 112.16 for the last quarter's data. This has improved from the previous quarter's position of being outside the "as expected" range and is no longer alerting.



3.3 Crude mortality rate (excluding day cases)

There has been a drop in the number of observed deaths over Spring 2025 which is the normal cyclical pattern. This will help to bring SHMI/HSMR down as the number of observed deaths will be lower.

The crude rate continues to fall and is now at a level that is lower than pre-Covid.



4. Outlying groups (August 2024 to July 2025)[2,3]

4.1 SHMI

Red Alert – Invalid Primary Diagnosis Group
This alert relates to patients that were uncoded at the time of 'freeze' position of data submission. Upon investigation by Business Intelligence, this diagnosis group is flagging due to Virtual Ward activity. Such activity is not considered an inpatient spell, is not coded (in line with national standards) and should not be submitted to SUS. However, at BFT, the activity is recorded in LE2.2 as a spell as there is currently no other way to record the activity. This data is then manually removed before submission to SUS. Unfortunately, during the annual refresh of data in April, routinely performed at the end of every financial year, this activity was automatically included, leading to approximately 1000 spells being included that should not have been – all of which were uncoded records. To rectify this, the data is currently being resubmitted to NHSE, excluding this Virtual Ward activity. This resubmitted data will be used in future iterations of SHMI and HSMR once it is available. This is expected to stop this diagnosis group from alerting and improve the overall SHMI for the Trust.
Red Alert – Septicaemia (except in labour)
The SHMI for Septicaemia is 120.5, which is sitting outside the 95% confidence interval as a red alert. Work is ongoing between clinical, Coding, Business Intelligence and Data Quality teams to understand this rise. The findings of this review were presented at CGQG in December and are included in section 4.3 of this paper for the QAC's information.
Amber alert
There were no diagnosis groups causing an alert for the period August 2024 to July 2025.

[2] All data in this section is data from Healthcare Evaluation Data (HED) which excludes patients who have 'opted out' of their data being shared for research purposes so may vary slightly from published NHS Digital figures.
[3] For SHMI, using control limits in line with NHS Digital, any group alerting 'Red' would be outside of the 95% over dispersed confidence limit; 'Amber' over the 90% confidence limit. For HSMR, Any diagnosis group alerting 'Red' would be outside of the 99.8% confidence limit, 'Amber' would be over 95%.

4.2 HSMR4

Red Alert – Pneumonia

This has just begun to alert following a period of being within the expected limits. The outcomes of a full review of patients recorded with pneumonia have been escalated via Mortality Data Group to Mortality Steering Group for Action.

Findings of the clinical review included:

- Median age of patients was 86 years old with a 1/3 of patients having a diagnosis of dementia
- Cause of death in the majority of cases is old age and frailty, or related to their comorbidities (e.g. MND, cancer)
- 12 out of 31 patients did not have conclusive chest x-ray findings of pneumonia (equates to only 62% of patients having a diagnosis of pneumonia that were coded in this group) – this is a recurrent theme when undertaking clinical reviews of this group, that the main condition being treated on admission is pneumonia (or appears to be that from the records to the Clinical Coders), when there is actually diagnostic uncertainty and/or later confirmation of another diagnosis
- Stranded patients coded as pneumonia as that was main admission being treated on admission, but after >1 year as an in-patient, this is no longer the ongoing issue

The Trust continues to submit data to AquA's Advancing Quality system for emergency admissions with pneumonia. This shows that we exceed the AQ overall score in all areas, but there are areas where action will improve our Appropriate Care Score (perfect care), as shown in the table below.

	CPS rank	Data completeness	Exclusions	PN-01 Oxygen assessment	PN-02 Chest x-ray	PN-03 Initial antibiotics	PN-04 CURB-65	PN-05 Appropriate antibiotics	ACS Appropriate Care Score (perfect care)	CPS Composite Process Score
Bolton	5	91.4%	20.6%	100%	72.5%	69.5%	72.2%	91.0%	46.1%	81.0%
AQ overall (%)	-	68.1	30.8	99.2	72.0	58.1	62.6	86.0	40.0	76.1

[4] Any diagnosis group alerting "red" fall outside the 99.8% confidence limit; "amber" is >95%.

Amber alert – Septicaemia (except in labour)
As for this same metric in SHMI, the details of this alert are in section 4.3.
Amber alert - Other perinatal conditions
A review of the patients that make up the denominator of this group. On its completion and following advice from the national coding team, a change in coding practice has been for newborn babies. Historically, babies born without any clinical concern, whether the mother or pregnant parent had had *any intervention to aid delivery* due to fetal concerns or not, were recorded as "Well babies." The national team have advised that in cases where staff intervented due to a fetal concern (e.g. category 1 caesarean birth due to an abnormal fetal heart trace), that is recorded in the primary position – therefore, moving these babies into a higher risk category. As anticipated, the "expected" rate (the denominator) for this group has tripled from when the process was changed (July 2025). It is therefore expected that this group will stop alerting by the 12 month period to October 2025 (discharges in November 2024 to October 2025), due in early 2026.

4.3 Sepsis review

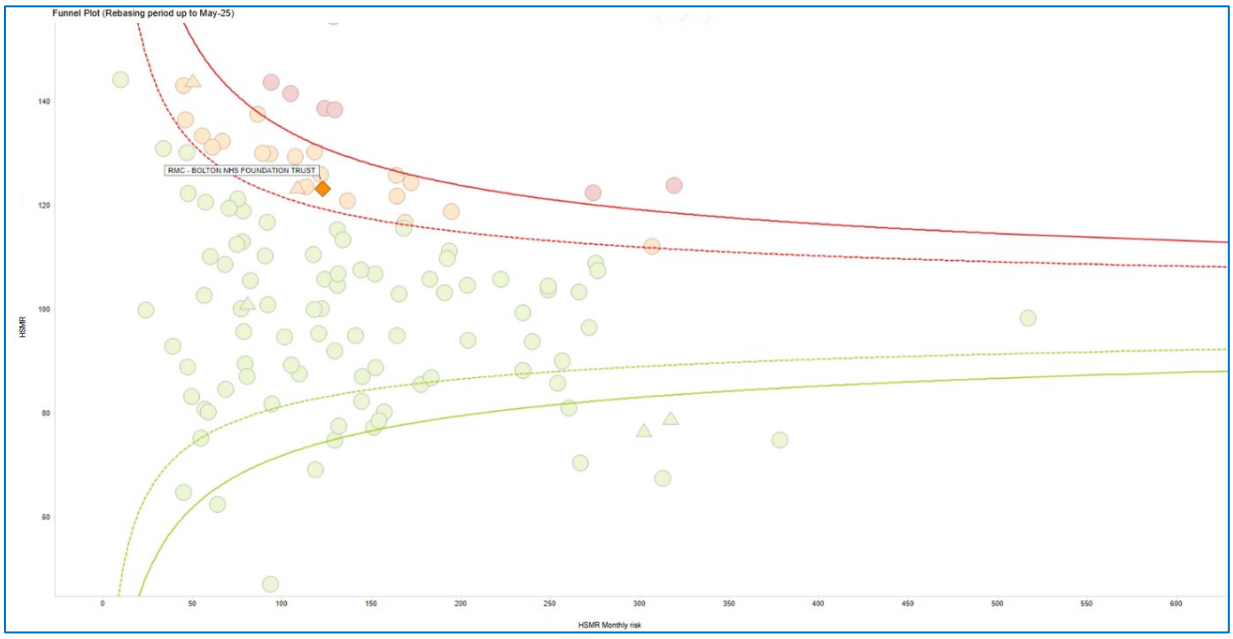
Septicaemia (except in labour) has triggered as an alert for both SHMI and HSMR. A deep dive into the data forming these metrics was undertaken and audits of practice were undertaken to establish Trust performance against expected clinical standards.

Sepsis mortality metrics[5]

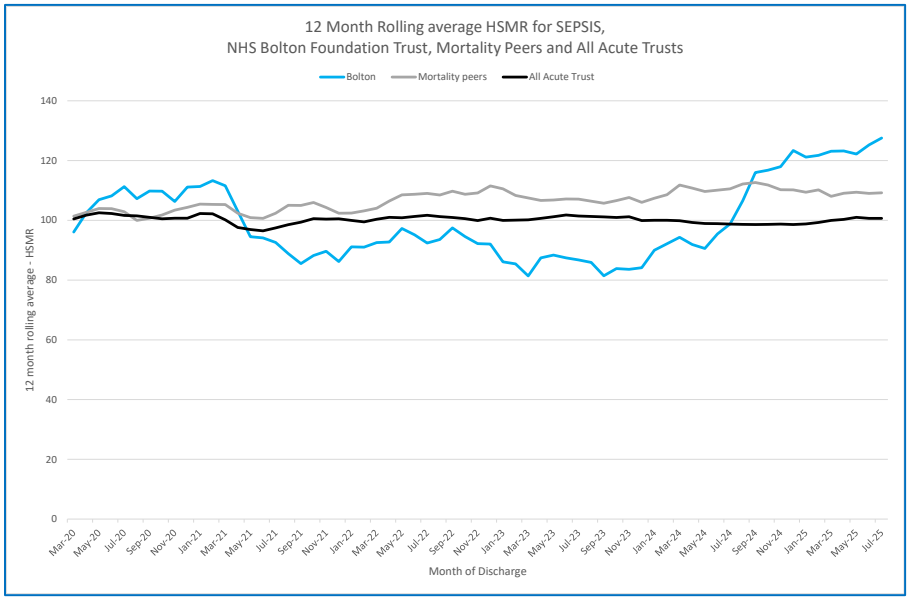
Hospital Standardised Mortality Ratio (HSMR) for septicaemia

The HSMR for CCS group 2 (Septicemia except in labour) is alerting Amber and is higher than the All Acute Trust average for the period August 2024 to July 2025.

[5] *Healthcare Evaluation Data (HED)* https://www.hed.nhs.uk/portal/



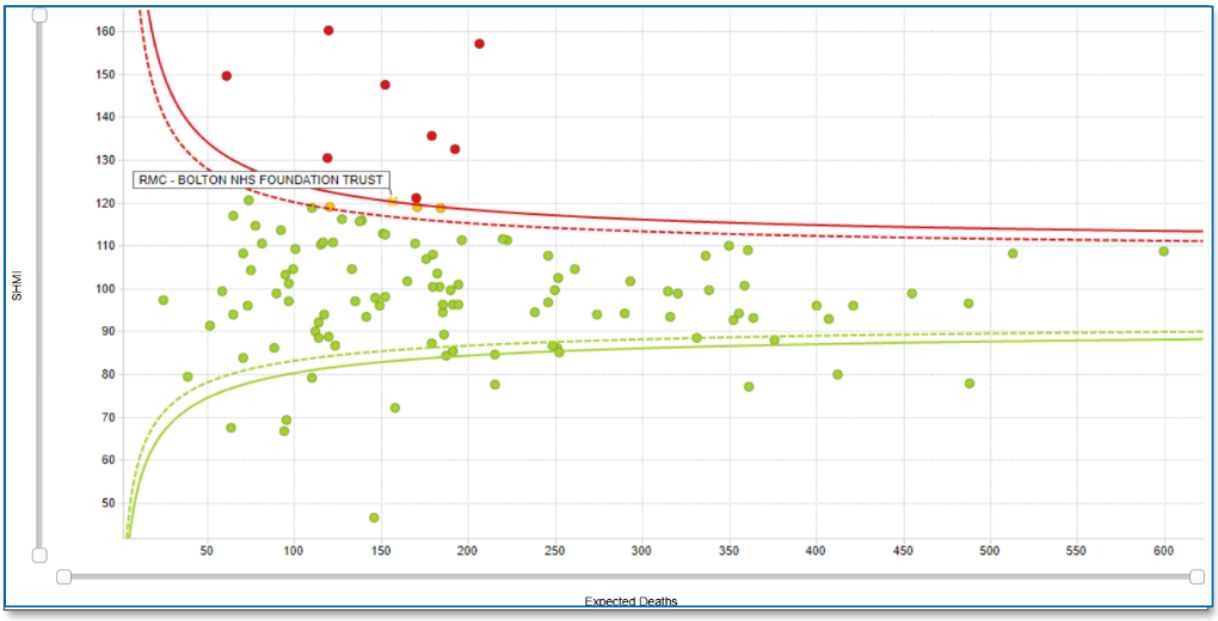
The rolling average trend for HSMR Septicemia remained below the peer average until the 12 months to May 2020, where it has been consistently above the peer group and England average; this indicates that deaths from Covid-19 impacted upon the HSMR. The rolling average fell back below that of the peer group and national average from May 2021, but increased once again above that of All Acute Trusts in July 2024. From September 2024 the HSMR is also above that of peers. The chart is a rolling average for the whole period.[6]



[6] HSMR is adjusted for covid, however, only at the first or second episode. If the Covid-19 coding appears elsewhere in the spell or in subsidiary diagnoses the patient will be included in the HSMR.

Summary Hospital Level Mortality (SHMI) for septicaemia[7]

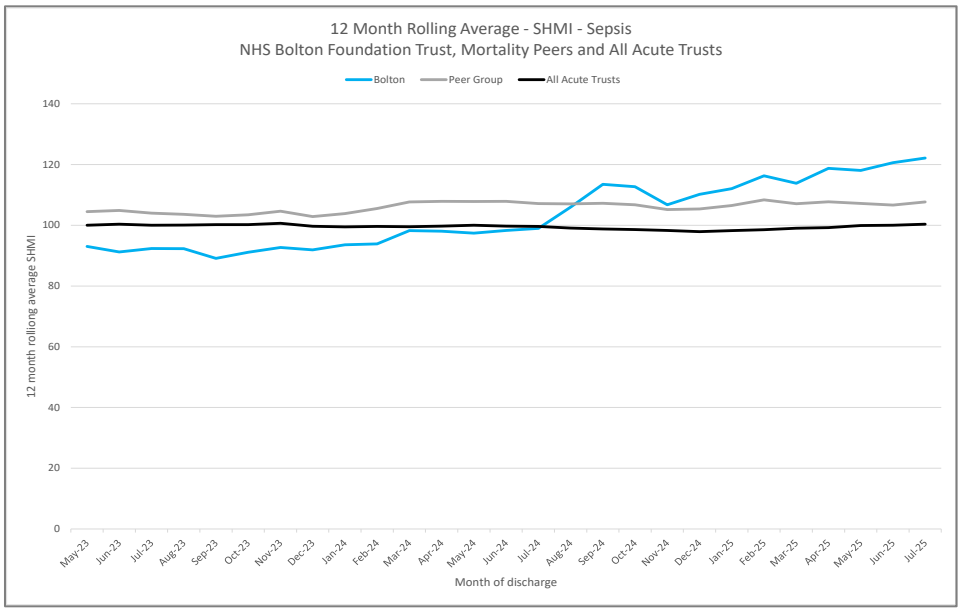
The SHMI for Septicemia (except in labour) is higher than expected for the 12 months to July 2025, sitting at 120.5, outside the 95% confidence interval as a red alert. SHMI uses different risk adjustments than HSMR.



The SHMI rolling average for Septicemia (shown on the next page) remained below the All Acute Trusts and Mortality peers until July 2024, when it started to rise above both the peer group and the rest of England.

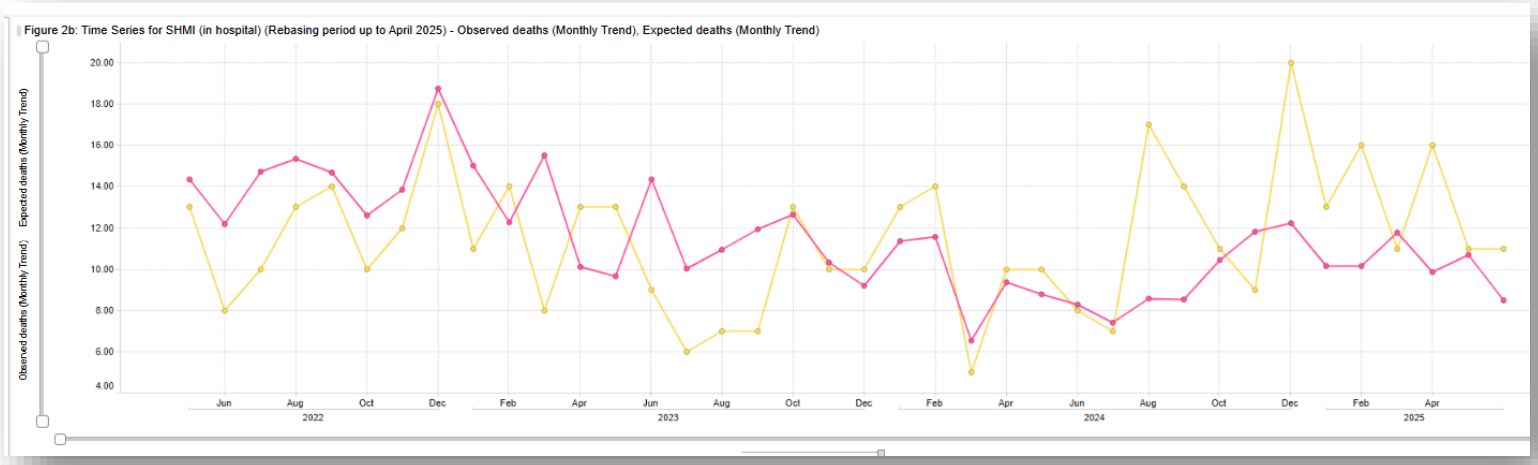
It should be noted that the methodology for calculating SHMI was changed at national level and now retrospectively includes all Covid-19 deaths from a discharge date of December 2021 onwards. Covid-19 is included even if it is at a secondary level or diagnosed at a later point during the spell – all these discharges and deaths were once excluded. The methodology change has been retrospectively applied across all records below. Given the high incidence of Covid-19 in Bolton patients, it is possible that this has influenced this metric, but that would require more analysis to be fully assured of its influence.

[7] SHMI is available via HED in a more timely and detailed manner than available via NHS Digital and forms the basis of this report. However, this includes patients who have opted out of the NHS Data Sharing therefore will be slightly different to the published data by NHS Digital.



Analysis of the mortality metric dataset

The relationship between observed and expected deaths has changed over the review period. The number of expected deaths has fallen over time, while there has been an increase in the observed deaths, particularly since 2024 – this leads to an increase in the mortality metrics, as has been seen.



The data was reviewed clinically and there was good face validity with regards to the age, speciality of admission and the comorbidity status of the patients that died. They tended to be older in age, admitted under medicine or elderly care and more comorbid than those that survived to discharge and the following 30 days, which is consistent with what is seen clinically.

The data shows that there is variation between the current coding practice in Bolton compared to mortality peers and all other acute trusts. BFT has a higher proportion of cases recorded as sepsis compared to these other groups, but this is tending to be reported in a secondary position (i.e. not as the main condition being treated). A coding review found that in 14 out of 48 cases, sepsis may have been incorrectly coded in terms of sequencing; this may have influenced the change in metrics.

This data does demonstrate that there have been changes in how sepsis is recorded and coded and this will have contributed to the rise in mortality metrics. The Coding team are reviewing their practice and have been working with clinicians to improve their understanding of clinical decision making.

In addition to this data analysis and coding review, clinical practice has been analysed to provide assurance about the quality of care for patients with sepsis.

Clinical review

Quarterly audit has repeatedly shown good compliance with sepsis screening and Sepsis 6 treatment standards in our Emergency Department emergency admissions. This is backed up by AQuA data, that shows BFT as 3rd out of 14 Trusts for composite process score and above average for that metric (BFT 85.0% versus average 74.4%).

The audit data for adult inpatients is less reassuring, in that it has repeatedly been shown that <40% of patients scoring on their NEWS are being screened as per the current sepsis screening policy. It must be noted, however, that there is good assurance through the most recent audit that these patients have been appropriately escalated for review by medical teams and that 100% of those requiring antibiotics received them within the hour.

This is important, as there has been a change in NICE guidance for Sepsis and screening no longer forms a component of the processes of managing someone with sepsis. It currently continues to form part of the BFT audit as it complies with the previous CQUIN in the Standard Contract, but a decision to amend this to align with the national recommendations instead needs consideration.

In summary, there is evidence that we do comply with escalation processes when people are highlighted by their NEWS as deteriorating from Trust audits, but further work still needs to be done to ensure that there is complete understanding of why our sepsis sits as a mortality outlier.

Proposed next steps

The AMD will continue to work with the Clinical Coders, BI and clinicians to ensure there is complete clarity about the factors influencing the mortality metrics for sepsis. There is reasonable evidence that data quality is contributing significantly to these rises. It is essential that quality of care is tracked against national standards to ensure patients are cared for optimally.

The next steps are to:

- Update the Trust policy to ensure alignment with current NICE guidelines for both sepsis and NEWS
- Amend the audit process to ensure national recommendations are met, to ensure a focus on appropriate escalation for intervention for those with suspected sepsis (as opposed to the compliance with screening)
- Utilise Patientrack data for NEWS compliance (in progress with divisional teams and BI)
- Scope the use of Patientrack and EPR to automate sepsis compliance reporting

5. Progress on the mortality action plan

The action plan set out 3 key areas of focus for improving mortality across all divisions with the overarching emphasis on the assurance of care provided:

- Theme 1 – Accuracy of the primary diagnosis in the first FCE
- Theme 2 – Average comorbidity recording
- Theme 3 – Coding to flex date to allow collaboration between clinicians and coders

5.1. Theme 1- Accuracy of the primary diagnosis in the first FCE

Diagnostic groups

The mortality metrics are based around the diagnostic group into which the patient is entered, which is determined by the Coding Team's interpretation of the information recorded by the clinical team. The primary diagnosis, or *main condition being treated*, is important as it forms one element of the calculation around whether a patient is expected to die or not; the more serious conditions carry a heavier weighting in the statistical analysis for predicting death.

Previous audits have identified that the initial diagnosis does not always agree with the clinical picture as it evolves. Additionally, there is often difference with the cause of death, although it is acknowledged that in many cases the admission reason may not be why the patient died.

Clinical Coders have to determine from the records what constitutes the *main condition being treated*. As evidenced by the audit undertaken by the Respiratory team, this does not always translate into the clinical diagnosis, or what the clinicians might consider the key concern.

Historic changes to the EPR were designed to try and aid identification of the main condition being treated or working diagnosis. These pulled through between records, but were rarely updated during the inpatient stay, so provided another potential source of inaccuracy. It is acknowledged that the clerking document and ward round document in the EPR do not support staff to easily record patients' information and therefore work is planned to review these documents to improve recording and coding of data.

Short spells

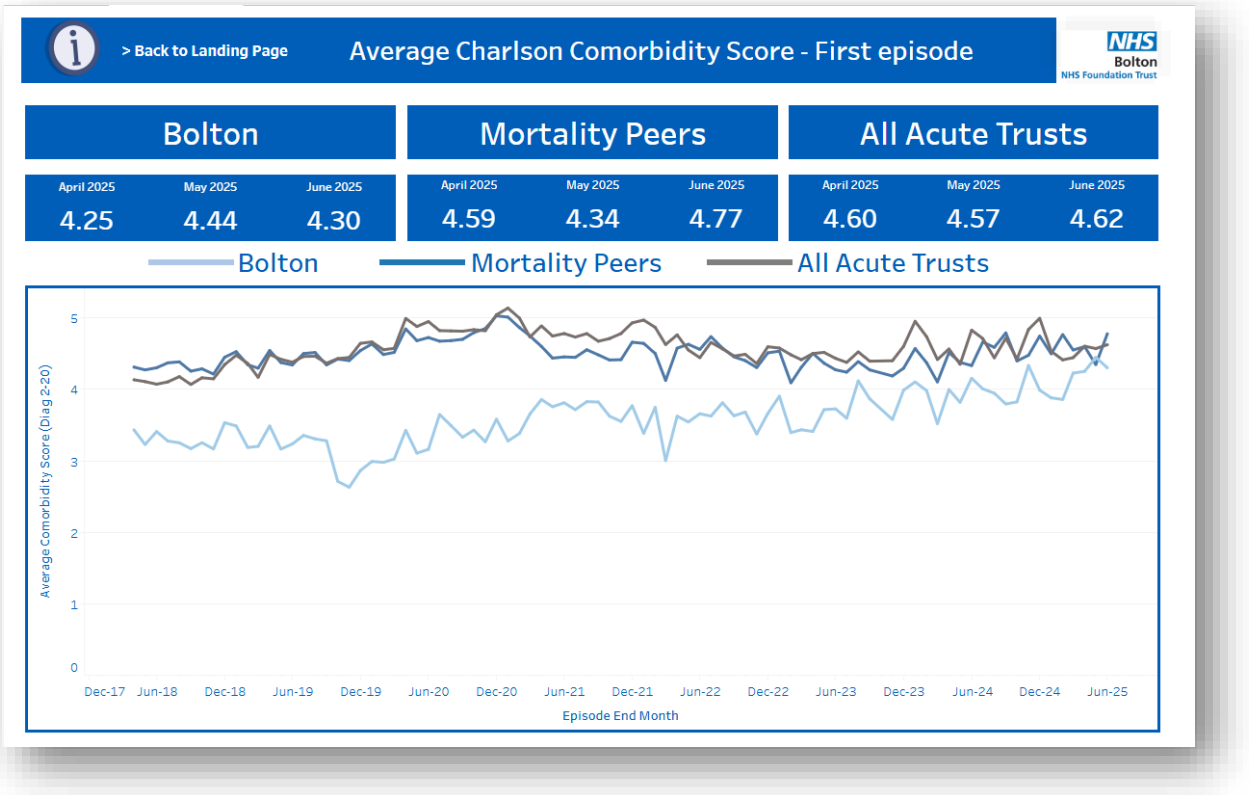
An issue with "short spells" has previously been identified, where patients appear to have admission of very short duration, usually due to them being erroneously admitted to the Trust when they should not have been (e.g. ward attenders), or when they are admitted under the care of the wrong consultant and that error is mishandled (i.e. their care is transferred to another consultant, rather than the original consultant's name being corrected). This impacts mortality data as it affects our denominator data in all groups.

Training has been provided to staff to reduce the incidence of this issue. To mitigate any risk from this, the Data Quality team perform weekly audits and correct any errors. Data will be sought on whether the incidence of errors has decreased since the training was implemented.

5.2. Theme 2 – Average comorbidity recording

On average, Bolton patients have been showing a recorded Charlson average score, approximately 1 score less than peers and the national average; this has slowly improved with the gap reducing to around 0.5 average comorbidity score difference in the latest data available. This still suggests our patients have less ill health than the general population, which does not equate with what is known about our patient population and the deprivation in the local area.

The successful inclusion of mandatory comorbidity recording with auto-population of the Health Issues section of our EPR has shown a slow but increasing trend since its introduction in February 2024, resulting in this gap between Bolton, peer groups and All Acute Trusts closing. In fact, in May 2025, Bolton's average Charlson Comorbidity score exceeded that of its mortality peers for the first time in more than seven years.



It is worth noting that as the average Charlson Comorbidity score has risen, the SHMI and HSMR have improved and moved either into or towards being in range, supporting the narrative of the major driver for the Trust's mortality metrics being outliers in recent years as being that of a data quality issue.

Specialty split of Charlson recording

The Charlson score is calculated at first FCE, which is where in general the majority of data on comorbidities that informs the SHMI and HSMR is inputted. Whilst Surgery specialties fair reasonably when compared nationally, they are below the recording of Medicine peers. This may be a result of how different teams use the EPR and specific forms within it.

When reviewing patients who are readmitted, variation between admissions in noted (with wild difference seen in some cases), with the quantity and quality of Charlson comorbidities not being consistently recorded between admissions, sometimes with significant impact on the prediction as to whether they are expected to die or not. However, throughout the Trust this

can be improved by completing Health Issues in EPR so the next admission of the patient will have the comorbidities already entered.

> Back to Landing Page

Average Comorbidity Charlson Score - First episode

Bolton

April 2025	May 2025	June 2025
4.25	4.44	4.30

All Acute Trusts

April 2025	May 2025	June 2025
4.60	4.57	4.62

Medicine

April 2025	May 2025	June 2025
9.61	10.04	9.69

Surgery

April 2025	May 2025	June 2025
5.20	4.69	4.34

Families & Diagnostics

April 2025	May 2025	June 2025
0.31	0.35	0.35

Bolton - Specialty

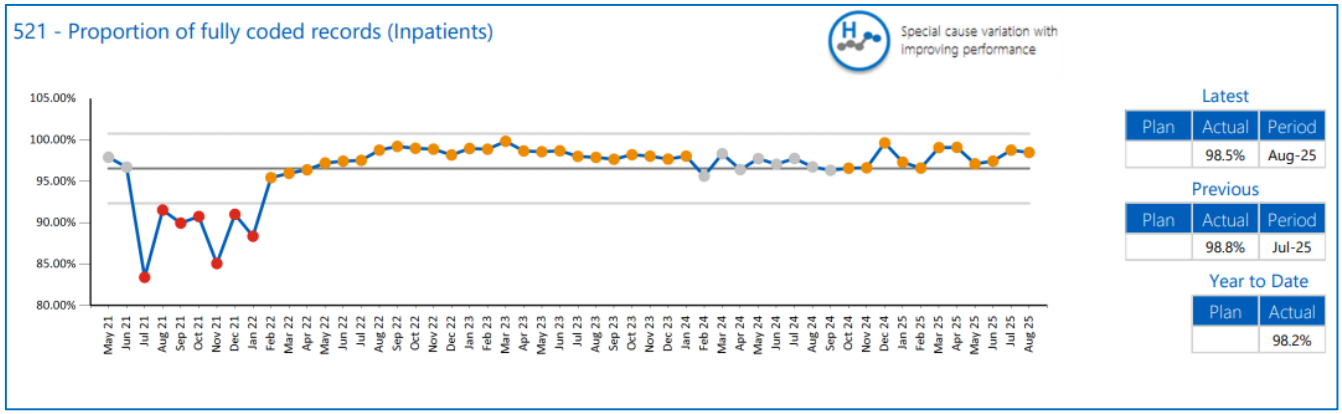
	April 2025	May 2025	June 2025
100 - General surgery	5.06	4.02	4.20
101 - Urology	5.58	6.72	5.20
103 - Breast surgery	4.33	4.50	6.92
104 - Colorectal surgery	7.33	9.75	1.33
110 - Trauma & orthopaedics	5.98	5.37	4.58
120 - Ear nose and throat	3.37	2.80	3.15
130 - Ophthalmology	4.20	1.00	2.00
180 - Emergency medicine	0.80	9.25	5.00
300 - General internal medicine	9.22	8.98	9.02
301 - Gastroenterology	8.50	16.53	10.22
302 - Endocrinology		10.73	6.25
303 - Clinical haematology	12.00	3.50	11.00
320 - Cardiology	11.67	15.38	14.84
340 - Respiratory medicine	8.12	10.44	9.18
420 - Paediatrics	0.25	0.31	0.28
422 - Neonatal critical care	0.00	0.00	0.00
424 - Well babies	0.00	0.00	0.00
430 - Elderly medicine	10.62	12.52	11.34
501 - Obstetrics	0.28	0.25	0.28
502 - Gynaecology	0.74	0.92	0.83

All Acute Trusts - Specialty

	April 2025	May 2025	June 2025
100 - General surgery	3.52	3.51	3.57
101 - Urology	5.23	5.21	5.17
103 - Breast surgery	5.99	6.04	6.71
104 - Colorectal surgery	4.05	4.07	4.18
110 - Trauma & orthopaedics	4.61	4.43	4.43
120 - Ear nose and throat	2.67	2.63	2.59
130 - Ophthalmology	2.69	2.54	2.58
180 - Emergency medicine	4.15	4.21	4.09
192 - Intensive care medicine	6.63	6.72	6.59
300 - General internal medicine	7.70	7.68	7.68
301 - Gastroenterology	6.65	7.09	6.67
302 - Endocrinology	9.05	8.85	8.81
303 - Clinical haematology	6.28	6.16	6.10
320 - Cardiology	8.13	8.19	8.07
340 - Respiratory medicine	8.16	8.23	8.36
420 - Paediatrics	0.29	0.30	0.32
422 - Neonatal critical care	0.02	0.01	0.02
424 - Well babies	0.00	0.00	0.00
430 - Elderly medicine	11.93	11.77	12.17
501 - Obstetrics	0.40	0.42	0.42
502 - Gynaecology	0.97	1.02	1.05

5.3. Theme 3 – Coding to flex date to allow collaboration between clinicians and coders

Our Clinical Coding team are performing at a very high standard currently and complying well with national standards on the number of fully coded inpatient records, as shown here in data from the IPM report:



To provide the best understanding of our patient data, ideally, our Clinical Coders would work alongside clinical colleagues to input coding data in real-time, facilitating clear communication on clinical data interpretation. This has never been feasible owing to previous capacity issues in the Coding Team. The standard operating procedure for the Coding Team is to prioritise the coding of data for the patients who have died in the Trust, with Senior Coders coding these spells. It is acknowledged though that may impact on the coding quality of the patients who have not died, who make up part of the denominator data on expected deaths in any given group. The Clinical Coding team undertake regular audits to assess this and are subject to national peer review annually and perform very well in these.

6. Changes in NHS Digital methodology – impact on mortality metrics

The CGQG should note that the mortality metrics will be impacted negatively by the NHS Digital introduction of Type 5 attendances, which is for patients attending SDEC (or similar type areas, such as AAU and STU). In summary, modelling undertaken by the Business Intelligence lead for mortality suggests that there may be an increase in SHMI of around 7% with this change. Understanding the impact is difficult as there are multiple assumptions to be made and not all organisations will switch over their reporting methods at the same time. To that end, the peer group to whom the Trust is compared will also be reviewed to ensure it provides the best comparator organisations.

A full paper produced in collaboration with the Chief Data Analyst on the impact of this change is expected to be tabled at QAC early in 2026 when the methods for enacting this change practically is understood.

Report Title:	Thematic Review: Review of Total Laparoscopic Hysterectomy Injuries from August 2024 to November 2024.			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2025		Discussion	✓
Executive Sponsor	Medical Director		Decision	

Purpose of the report	The report details the findings of a thematic review in response to complications which occurred due to total laparoscopic hysterectomies (TLH) in four cases between August and November 2024.

Previously considered by:	Clinical Governace and Quality Committee (Extraordinary meeting in January 2026) Quality Assurance Committee (January 2026)

Executive Summary	Between August and November 2024, three women sustained a ureteric injury and one woman a bowel injury during total laparoscopic hysterectomy (TLH) surgery. All women required further surgical intervention and management due to their complications. The incident rate at Bolton Foundation Trust in 2024 compared with reported rates (1) was found to higher for ureteric (5.5% vs 1.3%), bladder (1.9% vs 1%) and bowel complications (1.8% vs 0.3%). A thematic review was requested to identify learning and ensure the safety of the patients and the staff. The review has identified the following as key areas for improvement • Standard procedure for identifying the ureters throughout surgery and clear documentation in operating notes. • Training and maintaining skills in the workforce that will deliver TLHs when service resumes. Learning and updates on electrocautery needed for all operators. • Multidisciplinary meetings with urology and/or general surgeons for predicted difficult cases and appropriate patient selection for TLHs. • Number of staff delivering TLHs will be reduced so those undertaking the procedure perform higher numbers of cases to increase and maintain skills. The TLH service was paused in August 2025 to maintain the safety of patients and the staff. An external review is being conducted to identify learning and improvements. Training around electrocautery practice has been delivered and a review of the workforce, consent process and training requirements has commenced. A TLH working group has been established which is overseeing the recommendations and actions. This group reports to the divisional medical director and to divisional governance.

Proposed Resolution	The Board of Directors is asked to ***receive*** the Thematic Review: Review of Total Laparoscopic Hysterectomy Injuries from August 2024 to November 2024.

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		

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Glossary – definitions for technical terms and acronyms used within this document

AAR	After Action Review
BFT	Bolton Foundation Trust
BMI	Body Mass Index
BSO	Bilateral salpingo –oophorectomy – removal of both tubes and ovaries.
BSGE	British Society of Gynaecological Endoscopy
Colostomy	Surgery to create an opening for the large bowel through the abdomen.
CPD	Continued Professional Development
CS	Caesarean Section
CT scan	Computed tomography scan
Energy device / electro cautery	Using a device that is electrically heated. It is used to cut tissue.
EPR	Electronic Patient Record
ESGE	European Society of Gynaecological Endoscopy
Fistula	Is a connection between 2 body parts or 2 organs
GIRFT	Getting It Right First Time, NHS E Transformation
Hartmann's operation	Type of bowel surgery which involves removal of damaged section of the large bowel and rectum creating an opening in the abdomen to allow passage of waste and sealing off the remaining end of the rectum. This could be temporary colostomy or permanent.
ICG	Indocyanine Green Dye
JCF	Junior Clinical Fellow
JG	Junior grade doctor
LSO	Left salpingo-oophorectomy (removal of left tube and ovary)
MRI scan	Magnetic resonance imaging scan
Nephrostomy	Draining the kidney with a tube
NHSE	National Health Service England
PSII	Patient Safety Incident Investigation
PSIIRT	Patient Safety Incident Investigation Review Tool.
RCOG	Royal College of Obstetricians & Gynaecologist
SITM	Special Interest training Module
SOP	Standard Operating Policy
ST	Specialist Trainee
TLH	Total laparoscopic hysterectomy
Ureter	Tube which drains the kidney into the bladder.

Ureteric reimplantation	Reimplantation of ureter into the bladder
Uretero-vaginal fistula	Is a connection between the ureter and the vagina (front passage)
Uterus	Womb
VH	Vaginal hysterectomy

1. Introduction:

This report details the findings of a thematic review undertaken in response to a series of four incidents relating to complications which occurred during laparoscopic hysterectomy procedures in the women's health department between 01 August 2024 and 15 November 2024. These complications were unrecognised at the time of the procedure and women re-presented with related symptoms following routine post-operative discharge from the hospital. The details of the four cases are shown in the table below.

	Case 1-TD	Case 2 -SM	Case 3- SMU	Case 4- DW
Surgeon grades *(Lead surgeons-listed first)	Independent consultant ST4 & JCF- assistants	Consultant x 2 joint JG- assistant	ST7 (oncology SITM) Con (independent) - assist/ supervisor JG - assistant	Cons in training Con (independent)- assistant / supervisor JG- assistant
Procedure	TLH + LSO	TLH + BSO	TLH + BSO	TLH + BSO + omental biopsy
Indication for surgery	Pelvic pain Possible endometriosis.	Enlarged Fibroid uterus 10x11cms.	Atypical endometrial hyperplasia. BMI >40	55-year-old lady with a 6 cm ovarian cyst and an elevated CA125 (tumour marker) of 55 U/ml. Normal Ca 125 is < 35.
Findings during surgery	Uterus – normal size Left ovary and tube normal. Bowel adhesions to left pelvic side wall. The bladder was densely stuck, a 2 cm hole in the bladder noticed intra-operatively and urologist called. Bladder injury sutured by the gynaecology team. Cystoscopy or ureteric stenting was not performed as there was no leak following hydrodistension of the bladder.	The Uterus was cored to facilitate removal vaginally. The vault was sutured vaginally which is accepted practice.	No documentation of size of uterus or procedure being difficult in the op notes.	Uterus normal size, right tube and ovary normal. Left ovarian cyst 6 cm in size attached to left pelvic side wall.
Discharge after operation	Day 1	Day 1	Day 1	Day 1
Readmission-post-operative day	Day 30. Had symptoms of urinary leakage since day 11 post-operatively. Cystogram day 14 post operatively did not reveal any leak.	Day 27 (had symptoms of urinary leakage since day 5 post op) Treated as UTI 3 weeks after surgery. Readmitted on day 27 with urinary incontinence since day 5 post op.	Day 4 – admitted with abdominal pain and bruising around umbilicus and flanks.	Day 3 admitted to A&E with septic shock being acutely unwell.
Complication	Right Uretero vaginal fistula	Left Uretero vaginal fistula	Left ureter complete transection	Bowel injury
Treatment	• Nephrostomy • Awaiting ureteric reimplantation / fistula repair	• Nephrostomy • Awaiting ureteric reimplantation	• Nephrostomy • Ureteric re implantation	Bowel surgery. colostomy

Following a cluster of four incidents, three of which were iatrogenic ureteral injuries and one bowel injury during TLH, a PSIIRT was completed for the ureteric injuries, and an after-action review was undertaken for the case of bowel injury.

An overarching thematic review was subsequently requested by the Divisional Medical Director due to the number of significant incidents in a short period of time. The thematic review was undertaken to robustly review the cases of injury to the ureter and bowel during laparoscopic hysterectomy and identify any trends, themes or areas of improvement that are required to prevent future harm.

A TLH working group was established on 12 September 2025, which includes eight gynaecology surgeons involved in TLH surgery and the governance lead, with oversight from the divisional medical director/governance lead.

An external review has been requested separately and will be reported independently to the internal thematic review to ensure there is no bias. There was a delay in commencing the external review due to ensuring appropriate funding arranged and information governance was robustly adhered to in the transfer of electronic patient records to the independent external reviewer. This review is now being undertaken with an ask for from the Medical Director for this to be completed by 06 January 2026.

TLH procedures were paused from 08 August 2025, pending an overarching thematic review and the triangulation of recommendations with the independent external review. A Quaility Impact Assessment was completed for this by the clinical lead in gynaecology and the divisional medical director in families and diagnostics. Women who would benefit from a TLH have been referred to The Christie for their surgery. TLH surgery will not be resumed until the divisional governance team and medical director are assured by the findings of both reviews and any concerns have been fully addressed.

2. Background and Literature Review

Total laparoscopic hysterectomy involves removing the uterus through several small cuts in the abdomen (keyhole surgery), with the aid of an internal telescope and camera.

The aim of a laparoscopic approach to hysterectomy is to provide a treatment option with smaller incisions and scars, shorter hospital stays (2 days versus 5 days), a shorter recovery period than for open abdominal hysterectomy and lower risk of post-operative infection.

Patient selection for laparoscopic hysterectomy is very important. TLH is preferable in women with a raised BMI compared to open surgery due to a quicker recovery, lower infection risk and potentially lower deep vein thrombosis risk (due to earlier mobilisation). However, in morbidly obese patients there can be additional surgical and anaesthetic challenges. In Bolton FT gynaecology department, 54 TLH were undertaken between January and December 2024 by nine consultants undertaking this procedure. The thematic review includes the four incidents of injuries relating to TLH within the 54 cases which were undertaken in 2024. This translated to rates of 5.5% ureteric injury, 1.9% bladder injury and 1.8% bowel injury.

The rates of minimal access hysterectomy (laparoscopically or vaginally) have been increasing in Bolton FT over recent years to bring practice in line with the GIRFT target of 75% hysterectomies to be done by minimal access. Since 2023, minimal access hysterectomy rates increased from 39% in 2023 to 55% in 2024 and 63% during 7 months in 2025 (before TLH stopped). This increase is predominantly due to a doubling of TLH rates rather than increases in vaginal hysterectomy rates, with TLH rates being 20% in 2023 to 45% in 2025.

There is variation in the published evidence on the incidence of complications associated with laparoscopic surgery. A large case series of 5104 women was reported by NICE in 2007 and identified rates of ureteric injury in 1.3%, bladder injury in 0.4%, vesicovaginal fistula in 0.2%, intestinal injury in 0.3% and major vascular injury in 0.02% (1). A further NICE review in 2010 which included an RCT of 2616 patients and a smaller comparative study of 309 patients, showed bowel injury in 2%, bladder injury in 1% and ureteric injury in less than 1%. (2) A more recent systematic review of bowel injuries during laparoscopic gynaecology procedures in 2015 reported lower rates of injury (0.39%) but nearly half (48%) were not recognised at the time of surgery (3, 4). Similarly, ureteric injury is reported to have a delayed presentation in 45 - 63% of cases (5).

The literature reviewed and included is the most recent information on TLHs.

3. Methodology

The PSIIRT tool was used to analyse the three cases of ureteric injury, and an after-action review was undertaken on one of the cases which had a bowel injury during total laparoscopic hysterectomy.

All four cases were discussed and presented in the below meetings

- Gynaecology speciality governance meeting, 06.01.25
- Presented in a meeting with the divisional director, 22.05.25
- Presented in the consultants meeting and an action plan was discussed, 23.05.25.
  This action plan included refresher training on electrocautery, identification of ureters and clear documentation. All actions included in this review,
- Presented in the trust divisional independent review panel meeting, 28.05.25

The thematic review was undertaken by a consultant obstetrician and gynaecologist who is the deputy governance lead for the service. The review included notes review, EPR operation notes review, and individual discussions with the surgeons involved.

4. Findings

The thematic review found that in all four cases, the complications were identified following discharge. The three women with ureteric injuries were readmitted with pain (two cases) and vaginal discharge/ urinary incontinence (two cases). The CT scan performed on readmission confirmed a ureterovaginal fistula in two cases and a ureteric injury with leaking of urine into the abdomen in one of the cases. The woman with bowel injury was readmitted generally unwell with abdominal pain.

	Case 1-TD	Case 2 -SM	Case 3- SMU	Case 4- DW
Surgeon grades	Consultant (TLH trained) 1st assistant -ST4 2nd assistant -JCF	2 Consultants (TLH trained) – joint case 2nd assistant-JG	ST7 (oncology SITM) 1st assistant/ supervisor - consultant (TLH trained) 2nd Assistant – JG	Consultant (in training for TLH) 1st assistant-consultant (TLH trained) 2nd assistant-JG
Procedure	TLH + LSO	TLH + BSO	TLH + BSO	TLH + BSO
Discharge after operation	Day 1	Day 1	Day 1	Day 1
Readmission-post-operative day	Day 30	Day 27	Day 4	Day 3
Complication	Right Uretero vaginal fistula	Left Uretero vaginal fistula	Left ureter complete cut	Bowel injury recto sigmoid
Symptomatic of complication	Day 11	Day 5	Day 4	Day 3
Treatment	• Nephrostomy • Awaiting ureteric reimplantation / fistula repair	• Nephrostomy • Awaiting ureteric reimplantation	• Nephrostomy • Ureteric re implantation	Bowel surgery. Colostomy Which is not reversed yet.

The mechanisms of injury are as follows;

Case 1: Sustained a right ureteric injury, likely to have been due to a diathermy injury and resulted in a ureterovaginal fistula.

Case 2: Sustained a left ureteric injury and subsequent ureterovaginal fistula which may have been due to electrosurgery injury and or injury relating to suturing during closure of the vaginal vault.

Case 3: Sustained an unrecognised transection of the left ureter during the supervised TLH performed by the ST7. The mechanism of injury is most likely to be due to electrosurgery using the energy device called ENSEAL to coagulate and cut ligaments and tissues. This resident doctor was supervised by an experienced consultant who also did not recognise the ureteric injury.

Case 4: The bowel injury occurred either by direct burn or heat spread with delayed burn of the sigmoid from electrosurgical instrument. No obvious bowel leakage was noted during the procedure, so it is unlikely that there was a full thickness injury causing visible intraoperative perforation of the sigmoid.

Safety barrier 1: Intraoperative identification of ureteric injury

What was supposed to happen?	What did happen?
Ureters should routinely be identified at the beginning and at the end of surgery in all laparoscopic hysterectomy procedures. Awareness of the proximity of the ureters must be maintained throughout surgery.	There was no documentation of ureters being identified in all 4 cases; hence it is unknown if they were not identified or checked but not documented. Ureteric injuries were not identified intra operatively in cases 1, 2 & 3 suggesting that the ureteric course was not identified correctly intra operatively or not recognised that the ureters were close to or involved in the surgical sites.
Why was there a difference?	**What can we learn from this?**
It is not always easy to identify the ureters during surgery depending on the body habitus and distorted anatomy (due to fibroids, adhesions and previous LSCS, previous abdominal surgery). Therefore, it may be that the ureters were not easily seen. There was no documentation in the operation notes of the ureters being identified in any of the cases. Identification of ureters may have occurred but if this was only at the start of the surgery, later ureteric damage has been missed. In one case, there was focus on the bladder injury only by the operating gynaecologist and the urologist who was asked to attend. The urologist could not close the bladder laparoscopically and supervised the gynaecologist to do this. Both agreed that the closure appeared watertight and appropriate. Neither specifically checked the ureters. There may have been some hesitancy by the urologist to ask for the ureter to be identified and ensure it was uninjured. Similarly, there may have been an assumption by the gynaecologist that the urologist had no concerns about the ureter as	All surgeons must identify ureters before, during and at the end of the procedure. Although ureteric injuries during hysterectomy are not always avoidable, improved ureteric awareness can help reduce this risk of injury or detect it intraoperatively. Documentation of ureters needs to improve to confirm ureters are checked during surgery. This will be included in future TLH audits. Introduction of a standard TLH procedure template is required as a habit-forming prompt and will improve documentation. Where ureters are difficult to identify, there should be consideration of additional intra operative ureteral visualisation /urology involvement or day 1 CT urogram. Where there is a bladder injury, the ureters must routinely be visualised by the surgeon. If not possible or ureteric integrity is uncertain, then the urologist should assist and identify or stent the ureters. Currently none of the urologists undertake laparoscopic surgery, so if they need to perform ureterolysis (a surgical procedure to identify the ureteric course), it will need to be open surgery. This must be supported although the potential of laparoscopic urological expertise should be explored as part of a longer-term wider project. Increased use of ureteric visualisation procedures must be considered for all high-risk cases where significant anatomical distortion is predicted or found at operation. Joint agreement with urology consultants on optimal methods of ureteral visualisation procedures (such as ICG, stenting and catheterisation). This must be underpinned

What was supposed to happen?	What did happen?
none were raised. Professional courtesy may have influenced this.	by a Standard Operating Policy (SOP). A business case may be needed to purchase equipment.

Safety barrier 2: Patient selection factors

What was supposed to happen?	What did happen?
Patient selection is important for all TLH procedures. Women with distorted pelvic anatomy due to large fibroids, endometriosis, previous Caesareans sections, and adhesions due to previous surgery or urological abnormalities are all at higher risk of surgical complications. High risk cases should have preoperative planning with urologists or general surgeons as required. Patient selection was appropriate in case 1, 3, and 4. Two women had BMI> 38 but this is not a contraindication to TLH. There are clear benefits in terms of recovery, reduced hospital stay, and reduced infections rates compared to open surgery. In case 2, the uterus was enlarged with fibroids, and it may have been appropriate to have incorporated ureteric visualisation techniques (such as stenting) to aid the TLH approach or consider open surgery.	Case 2 had an enlarged fibroid uterus. There was difficulty in removal of the uterus through the vagina due to the large size of the uterus (uterus was 11x 10cm). A normal size of uterus is 6-7cm in post-menopausal women. The dimensions of the uterus were reduced by a technique called surgical coring of the uterus (which is cutting the uterus in the middle to reduce the bulk of the uterus and assist removal). This facilitates removal of the uterus vaginally and is a well-established practice. The vaginal vault was closed vaginally, which is an acceptable method of closure at laparoscopic surgery. It is difficult to ascertain with certainty the mechanism of ureteric injury. There may have been a diathermy injury to the ureter which later broke down causing leakage through the vaginal wound due to its proximity. Alternatively, it may be that there was an extension of the vaginal vault wound during retrieval of the big uterus which may have extended closer to the ureter. This could have resulted in the ureter being caught by the sutures during the vaginal angle and vault repair. Subsequent tissue breakdown could have occurred by 5 days postoperatively, resulting in a fistula.
Why was there a difference?	**What can we learn from this?**
Robust pre-op risk assessment was not undertaken with involvement of urology. There was difficulty in removing the enlarged uterus vaginally due to the fibroids. This required additional surgical steps (coring of	Case selection is very important. Pelvic anatomy may be distorted in women with large fibroids, endometriosis, previous Caesareans sections, adhesions due to previous surgery or urological abnormalities may be at higher risk of urological or surgical complications. High risk cases should have pre-op MDT planning with urologists or general surgeons as required.

the uterus and suturing of the vault vaginally). It is possible that extension of the vaginal vault wound required additional sutures that caused ureteric injury.	The criteria for this have been reviewed by the TLH working group and a Preoperative MDT Pathway is in development with the Urology and General Surgeons. Careful planning for high risk open or laparoscopic hysterectomy will allow appropriate use of ureteric visualisation techniques to reduce the chance of ureteric injury. Options of stenting versus catheterisation of the ureters should be considered preoperatively with urology colleagues.

Safety barrier 3: Individual staff factors: training

What was supposed to happen	What did happen?
Appropriately trained or supervised surgeons should perform TLH. It is well recognised that there are increased complication rates during training. (Journal of Gynaecology Obstetrics & Human Reproduction – Effect of surgeon's experience on complications from laparoscopic hysterectomy. Feb 2018). Training and direct supervision by TLH trained consultants is required for specialty resident doctors during special interest training modules and for consultants developing new skills. All consultants undertaking TLH must have completed appropriate training. In some cases, this is during their specialist training programme before becoming a consultant. In others, it can be by self-directed education, attendance on laparoscopic courses, attendance at simulation and cadaveric training, and completing satisfactory supervised TLH before performing them independently. Annual in-house laparoscopic complication and electrosurgery safety teaching is required.	Cases 1 and 2 were performed by trained TLH surgeons. Case 3 and 4, were supervised by a trained TLH surgeon. Cases 1, 3 & 4 sustained injuries due to electrosurgery to ureters or sigmoid bowel. One was performed by a consultant who has completed training for TLH and in 2 cases the TLH was performed by a ST7 or consultant training to do TLH, both supervised by the same trained consultant. In case 2, the mechanism of ureteric injury is less clear and may have involved electrosurgery injury, vault suturing injury or both. This surgery was performed by a trained TLH consultant and assisted by another trained consultant. Of the four cases, three had potential risk factors making identification of ureters difficult (1 was morbidly obese; 1 had distorted anatomy and an extension of the vaginal vault wound due to due to fibroid uterus; 1 had bowel adhesions with possible endometriosis found at operation). The case involving a bowel injury did not have any obvious risk factors. Annual in-house laparoscopic complication and electrosurgery safety teaching has not been consistent but tends to happen every 1- 2 years as part of the teaching or audit programme. There has been recent departmental teaching on the TLH complications in January 2025 and on safe use of electro cautery on 20th June 2025.

Consultants undertaking TLH should maintain their skill and knowledge by performing regular procedures and engaging in relevant continued professional development (CPD) on laparoscopic surgery.	Consultants performing TLH have attended appropriate laparoscopic courses and cadaveric or simulation courses as well as having had a period of supervised surgery. All (except 1) have attended a national /international laparoscopic course or conference within the past year. The consultant who has not done this has registered to attend courses in the next 6 months.
Why was there a difference?	***What can we learn from this?***
Inadequate identification of ureters intraoperatively suggests there may be a training need for TLH trained surgeons and suboptimal awareness of risks of electrosurgical injury. Trainers and senior surgical assistants have an important role in ensuring safety for the patient as well as colleagues in training. Clarity of the training/ supervisor role can become more blurred with senior colleagues due to professional courtesy or inattention (due to presumed safety). It was not a standard procedure to check the ureteric course rigorously in any of the cases, and trainers have a particular responsibility in teaching this. Task focused human factors may have influenced these incidents as surgeons can lose awareness of other risks if they become very task focused.	Consultants training in TLH or maintaining competency in TLH require advanced laparoscopy training. The training requirements have recently been agreed by the TLH working group who will be required to monitor this. Appropriate conferences, courses and simulation training are available through reputable organisations such as the RCOG/BSGE/ ESGE and other laparoscopic centres. Minimum competency requirements have also been agreed by the TLH working group. Consultants training in TLH are required to undertake similar levels of training along with supervised TLH until competent. The TLH working group requires a minimum standard of confirmation of 5 competent TLH procedures before consultants can undertake straightforward TLH independently. Complex cases require appropriate pre-op planning and more experienced surgeons. To maintain competency, consultants must undertake 1-2 TLH per month. Buddy operating with TLH trained consultants is needed to address training gaps and maintain competency. Advanced laparoscopic competency needs to be maintained by undertaking at least 1-2 procedures a month. This will be monitored by the division. Fewer gynaecology surgeons should undertake TLH to ensure training and competency is maintained. The TLH working group has agreed that going forward only 8 consultants will be undertaking TLH on dual consultant operating to maintain competency requirements of 1-2 hysterectomies per month. This reflects the numbers currently trained, numbers of cases expected in line with GIRFT and future proofing as at least 2 of these consultants are approaching retirement. The central pooled listing system needs to be amended urgently to ensure a minimum of 1 TLH procedure per month is allocated to the 8 consultants who will be undertaking the procedure. This will need to be monitored by the division.

	Trainer roles need clarity and agreement prior to TLH surgery recommencing. Trainers must stringently apply and demonstrate surgical safety steps such as maintaining awareness of surgical electrosurgical risks and checking proximity of ureters/ other organs. Specific references made to avoiding and recognising ureteric injuries, ureteric identification at the start and end of surgery, as well as awareness of proximity throughout the TLH. If ureteric injury is suspected, then urologists should be involved intra operatively which would reduce the risk of subsequent fistula. Trainers do carry accountability and need to overcome interpersonal inhibitions when training senior colleagues. As all consultants are surgical trainers, they need to undertake up to date mentoring / teaching skills to support them in this role. They will all have undertaken this training in the past. Awareness of human factors (such as when a surgeon becomes very focused on specific tasks and loses awareness of other risks), can be mitigated by team approach to safety and confidence in raising concerns such as unclear of position of ureter

Safety barrier 4: Patient factors: Delayed Diagnosis

What was supposed to happen	What did happen?
Ideally surgical complications are best diagnosed intraoperatively. Macroscopic urological or bowel injuries are easily identified intraoperatively. However, microscopic injuries and some electrosurgery burns are not easily identified. Published evidence indicates that 85% of bladder injuries are recognised intraoperatively. (5) Conversely, 45-63% of ureteric injuries are not recognised intraoperatively and therefore have a delayed diagnosis.(5)	The two women with ureteric fistulas (cases 1 and 2) were diagnosed 27-30 days post operatively. In retrospect, earlier symptoms of urinary leakage were attributed to bladder infection. Both were readmitted with symptoms and had confirmation of ureteric injuries by CT urogram and required urological care. Both required nephrostomy tubes to be inserted into the renal pelvis and were planned for ureteric reimplantation. The woman who sustained transection of her ureter (Case 3) was readmitted with pain on day 4 post operatively. She required a CT urogram and a nephrostomy. She is also awaiting ureteric reimplantation.

Similarly, 40-48% of bowel injuries during laparoscopic surgeries are not recognized during the initial procedure, leading to a delayed presentation postoperatively (3,4)	The woman who sustained a sigmoid bowel injury (case 4), was readmitted very unwell on day 3 post operatively. She required emergency laparotomy and bowel diversion with colostomy. Due to faecal peritonitis, she was managed initially on the intensive care unit. She is awaiting reversal of colostomy
Why was there a difference?	***What can we learn from this?***
Diathermy injury to the bowel and ureter may not be recognised at the time of the operation. In some cases, the damage is initially a burn injury that leads to ischaemic tissue due to lack of blood supply following diathermy injury and subsequent tissue breakdown. Leakage of urine or bowel content occurs once there is a tissue breakdown. The depth of thermal energy can extend beyond what is visible, leading to delayed necrosis of the tissue leading to a delayed perforation of the bowel or ureter. If the injury is small, it may present later with signs of inflammation or leakage. Around half of ureteric injuries have delayed presentation indicating they are not recognised intra operatively. (5) Similarly, 40-48% of bowel injuries are not noticed during surgery. (3,4) Unrecognised thermal injuries intra-operatively can present from a few hours to up to two weeks post operatively. This is likely due to the difficulty identifying intraoperative burns and the delayed tissue ischaemia.	All three women with ureteric injury developed symptoms of injury between day 4 and day 11 post op. The case with bowel injury presented with symptoms of bowel perforation and peritonitis on day 3 post op. The delayed presentation is consistent with published evidence. However, appropriate patient selection and use of ureteric visualisation techniques or open surgery may be more appropriate in high-risk cases. Agreed pre-operative MDT pathways with urologists and general surgeons are required and currently are being agreed. It is essential for the surgeon to identify the ureters at the start of surgery and maintain awareness of the proximity of nearby structures (like ureters, bladder, and bowel) throughout the surgery. This would help avoid electrosurgery injury in some cases. In addition, ureteric visualisation with catheterisation or stents may allow earlier detection of injury and intra operative repair. In high-risk cases with distorted anatomy from previous surgery, fibroids, endometriosis or cancer, ureteric visualisation must be considered preoperatively with timely involvement with urological colleagues in the planning of surgery. Safety netting of women to return with urinary symptoms following TLH is important to identify urological injuries sooner. There should be a low threshold to consider this and perform a CT urogram. Although this is unlikely to alter the need for nephrostomy or further surgery.

Safety barrier 5; Organisational factors

What was supposed to happen?	What did happen?
Adequate access to caseload to ensure maintenance of competency	The Gynaecology department has access to seven theatre lists per week that are shared amongst 21 consultants. This is supplemented by Consultants' backfilling lists due to colleagues being on leave/ hot weeks and ad hoc WLIs (to meet performance needs). Therefore, each consultant has 1-2 lists per month. The Gynaecology service has been unable to increase theatre capacity due to additional pressures from other specialties, impact of delayed theatre upgrades due to air handling unit replacements and RAAC recovery works. In addition, central pooling and listing teams coordinate the population of these lists with a focus on waiting time rather than surgeon's competency requirements. This is an issue that began during COVID, and long gynaecology waiting times have caused huge pressure regionally and nationally. NHSE targets have added specific time sensitive pressures on waiting list management which has compounded issues around maintaining numbers and competency. Consultants have raised concerns with this process over recent years, but waiting lists remained prioritised based on waiting times or cancer diagnosis.
Why was there a difference?	**What can we learn from this**
Increased gynaecological pressures and waiting lists have not been recognised at a higher trust level, resulting in no regular increased theatre sessions. Ad hoc waiting list initiative (WLI) allocations do not support competency requirements as consultants' job plans contain other fixed clinical activities that prevent using all WLIs offered. The division was under pressure to address the long elective surgery waiting times to meet NHSE targets that nobody was waiting > 65 weeks for treatment by March 2025. This target was adjusted to September 2025 when it was acknowledged that March was unobtainable for most Trusts. There was a strong focus on waiting times rather than case mix which has been detrimental to surgical competency and skill maintenance.	There is a need to increase theatre capacity for the gynaecology service and to restructure the gynaecology workforce. This will result in fewer dedicated gynaecologists with more dedicated theatre sessions and clinics. From 12th September 2025, the TLH working group was established and agreed to permanently reduce the number of gynaecology surgeons performing TLH surgery to build skillset and competency but also futureproof the service. Once TLH surgery resumes, this will be done only by the 8 TLH trained consultants who will initially undertake dual operating for a minimum of 6 months to support competency, provide assurance and rebuild team confidence. It would not be feasible to reduce to less than 8 consultants as this would impact ability to meet demand or build competency to futureproof against the natural attrition of an ageing consultant group (2 of the TLH surgeons are partially retired). Fewer than 8 TLH surgeons would also negatively impact the ability of the service

	to work towards GIRFT targets of 75% of hysterectomies needing to be done laparoscopically or as a vaginal hysterectomy. Clearly increasing the TLH rates must be done safely once competency is assured and maintained. Resumption of the TLH service would require robust oversight and governance. The TLH working group was established In September 2025 and the core membership includes the Divisional Medical Director, Clinical Lead, Governance Lead and TLH surgeons. This will meet quarterly and oversee performance logs of TLH surgeons, TLH related incidents and ensuring laparoscopy competency and training requirements are met. It will also provide regular updates at the monthly Gynaecology Specialty Governance meeting, quarterly reports to Divisional Governance and an annual report to Clinical Governance and Quality Committee. This will ensure there is further governance oversight on activity levels, incidents and concerns. Any concerns regarding performance or incidents will be escalated through the governance mechanism. The department has already completed an annual Gynaecology Surgical Complications Audit which includes TLH complications. This benchmarks our surgical complication rates against RCOG and published evidence. The next audit is due to start in January 2026 to review all surgical complications of the preceding year. Going forward, this audit report will be shared within the department and at the Divisional Governance meeting. In addition, once TLH surgery is resumed, a dedicated TLH audit will be undertaken by the TLH working group to monitor performance numbers per consultant, patient selection, incidents and operative notes to ensure ureteric identification is always done. Initially, this will be done 6 months after resumption of service to provide assurance. Immediate control of surgical theatre diaries to return to the clinicians to ensure competency and skill development. Involvement of surgeons in caseload management that involves safety/competency considerations as well as waiting times.

5. Identified contributory and mitigating factors

5.1 External contextual factors (national guidelines and policies, economic and regulatory context and societal factors)

Contributory:

- National and trust pressure to reduce waiting lists in 2023-2024 were driven by NHSE targets of nobody waiting more than 78 weeks by September 2024, 65 weeks by March 2025 (this was later pushed back to September 2025) and 52 weeks by March 2026. . This led to centralised theatre listing that focused on time order rather than surgical caseload to support competency.

- The NICE guidance 2010 on Laparoscopic hysterectomy (including laparoscopic total hysterectomy and laparoscopically assisted vaginal hysterectomy) for endometrial cancer.

  Current evidence on the safety and efficacy of laparoscopic hysterectomy (including laparoscopic total hysterectomy and laparoscopically assisted vaginal hysterectomy) for endometrial cancer is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit. These criteria are being met.

- Patient selection for laparoscopic hysterectomy for endometrial cancer should be carried out by a multidisciplinary gynaecological oncology team. NICE 2010. This is routinely done as all cases are discussed through the treatment planning MDT.
- One case involved a trainee who was undertaking an oncology SITM. They performed supervised TLH along with another consultant as a training requirement to complete the module. This was in line with RCOG training requirements for this SITM.

- There was a consultant colleague training and learning on the job along with another consultant in one of the cases. This was due to a personal career aspiration. This has now ceased as there are concerns about the dilutional effect on the existing TLH consultant's competency needs. No additional consultants will train in TLH without clinical lead approval and service requirement.

Mitigating:

- All doctors training to undertake any operative gynecological laparoscopy must have completed training on safe use of diathermy and electrosurgery. This training is available in many formats and is a mandatory component of specialist training in the UK. Suggested courses:
  a. RCOG courses and modules on benign abdominal surgery, including basic surgical skills course and relevant modules
  b. BSGE laparoscopy course/modules and usually all basic/intermediate laparoscopy courses

- Advanced laparoscopic skills are required for this procedure, and clinicians should undergo specialist training and mentorship. The Royal College of Obstetricians and

Gynaecologists has developed an Advanced Training Skills Module. This needs to be supplemented by further training to achieve the skills required for laparoscopic hysterectomy. NICE 2010.

- Consultants who undertake laparoscopic hysterectomy have attended the laparoscopic hysterectomy course organised regionally and attended national conferences (BSGE / ESGE) where there is a live surgical demonstration of the technique for laparoscopic hysterectomy. All consultants undertaking TLH have previously attended cadaveric laparoscopy courses where hands on experience on simulations and pig cadavers takes place. These courses are expensive, and not all can be covered within the study leave budget.

- All consultant undertaking TLH (except 1) have attended national /international laparoscopic courses or conferences within the past year. The consultant who has not done this has registered to attend courses in the next six months.

- GESEA (Gynaecological Endoscopic Surgical Education and Assessment) Level 1, e - learning and certification course have been completed by one of the consultants and another has commenced the online component. Due to cost involved this may not be possible for all the consultants to undertake this certification but will be tabled at the TLH working group. However, safe electrosurgery will be updated annually in-house educational programme, is included in annual medical devices competency self-certification and is included in most laparoscopy courses and meetings.

5.2 Organisational strategic factors

- There are not enough theatre sessions for 21 consultants to undertake gynaecological surgeries and maintain their skills. TLH service will now be provided by eight consultants with dual operating to ensure competency needs of 1-2 cases per month met. These consultants will be identified by the TLH working group based on numbers of TLHs they are undertaking.

- Gynaecology surgeons currently have access to at least two lists per 4-week block. 13 consultants have one fixed list, and one flexible backfill list per 4-week cycle. The rest have two fixed theatre sessions per 4-week cycle. When developing new skills, whenever possible consultants attend additional lists with colleagues within their SPA time. Review of gynaecology workforce is underway with a view of developing a smaller gynaecology surgical workforce with more frequent theatre sessions. This will mitigate challenges in skill development and maintaining competency.

- Gynaecology theatre list management is currently managed by the centralised booking team who fill the operating lists based on the waiting times of women and priority of surgery. There seems to be a discrepancy between the numbers of TLH procedures listed on the eight consultant's theatre lists. This is being reviewed by the TLH working group. There needs to be a clear process in place for the booking team and TLH working group to list TLH procedures fairly amongst the eight consultants performing TLHs. The aim is to help maintain the skills and competence of the surgeons. Each of the Consultants' operating lists are to include 1-2 TLH every month. It is of note that these consultants will also perform open hysterectomy which involves some transferrable skills

for laparoscopic surgery, in particular ureteric mapping. Operating list management should be led by or have input from consultants undertaking TLH procedures.

- Rates of TLH in the unit have been increasing with aspiration to meet the GIRFT target for 75% of hysterectomies to be done laparoscopically or vaginally. In 2023 - 39/101 hysterectomies (39%) were by TLH or VH; in 2024 - 74/134 hysterectomies (55%) were performed by TLH or VH; in 2025 (till 31.7.25). 52/87 hysterectomies (63%) were performed by TLH or VH. The increase seen is predominantly due to increased TLH rates rather than vaginal hysterectomy.

- In our gynaecology complications audit for 2024, the TLH complication rate was 9% (5 out of 54 TLH's) – three involved ureteric injury, one bladder injury and one bowel injury. This shows that there are potential training, competency, and patient selection factors contributing to complications.

5.3 Operational management factors

- There were no concerns with operational management factors in this review. There is an existing Trust Policy for the safe introduction of new and innovative clinical procedures, methods, techniques, technologies, and therapies in place.

5.4 Workplace factors

- Case 2 had dual consultants operating due to an enlarged fibroid uterus and the complexity of the case. This is good practice. However, there needs to be clear documentation of who the lead consultant is as they carry overall responsibility, including check of the ureters are completed during the procedure.

- In-house teaching on ENSEAL has been provided in the past by the medical representative from the company. However, there has not been regular departmental teaching on the use of an energy device during surgical procedures such as hysterectomy / removal of tubes or ovaries. This has been established as a rolling programme from 2026 (as there have been 2 teaching sessions in 2025 already). This teaching entailed laparoscopic cases and complications. It included safe electosurgery practice.

- Annual self-reported medical devices competencies are required for all medical staff. Unfortunately, it lapsed in 2024 but has been completed in June 2025. All Consultants recorded competency in electrosurgical equipment. The resident undertaking the oncology SITM had recorded training required but as she was still supervised and training, this was satisfactory. Two other residents also recorded training requirements around how to set up equipment that is usually done by theatre teams rather than the surgeon. These residents are never unsupervised in theatres, and they have been asked to address this competency requirement by reviewing the set up with the relevant members of the theatre team during their theatre sessions.

- Departmental teaching on the use of electrocautery and energy device was provided in June 2025.

- Assurance is required that routine identification of ureters is practised and taught to trainees. This has been individually discussed with the eight TLH consultants and a TLH procedure template has been drafted that includes this in standard documentation. Pre op MDT pathways are being agreed with Urology and General Surgeons to consider additional steps needed in high risk patients.

- Assurance is required for maintenance of surgical competency in TLH in terms of appropriate training course/ CPD and adequate numbers. This information will be monitored by the TLH working group, Clinical lead and Divisional Medical Director.

- Annual gynaecology complications audit will continue to include TLH complications. A wider TLH audit will be undertaken six months after resuming TLH surgery to ensure pre op MDT planning, operation documentation of ureters and complications are reviewed through the TLH working group. This will be shared with the Divisional Governance Lead. Thereafter this will be repeated annually until the process is embedded.

5.5 Equipment and technology factors

- Energy devices such as ENSEAL and electrocautery are routinely used for the procedure; there were no issues relating to any mechanical problems during use of the device during the operations.

- Medical device competency should be self-assessed annually and evidenced by completion of a form. However, it was overdue in 2024, but it has been completed in June 2025.

- We currently do not use an ICG – Indocyanine green is a fluorescent green dye to delineate the ureters at the time of surgery. It is used in many UK centres that undertake robotic or cancer surgeries. It can be used during laparoscopic surgery to aid visualisation of the ureter during surgery to avoid injury. This requires cystoscopy, insertion of a ureteral catheter so that ICG can be instilled directly into the ureteral lumen. It requires compatible laparoscopic camera systems and light filters which we already stock in Bolton theatres. Although the data is limited, it is considered safe by many peers and already established in use in several UK trusts. However, this requires joint agreement with urologists to develop the technique, and discussions are underway to review the evidence and devise an agreed pathway. This will increase urology workload until enough gynaecologists can be trained to perform ureteral catheterisation. It is of note that three TLH surgeons have previously performed ureteral catheterisation during their training and would likely only require refresher training. We are currently gathering data on the safety of this dye from other Trusts using this dye. Data gathered will also need to be include in a business case to stock the ICG dye and the additional costs of cystoscopy and ureteral catheterisation.

5.6 Team and social factors

- There was a positive example of dual Consultants operating together in case 2 which was a complex case with an enlarged fibroid uterus. This practice needs to be safely expanded to ensure Consultants can maintain competency requirements.

- Risk of complications seem to be higher with TLH surgery especially when being trained and when experience and operating numbers are low. The learning curve to acquire competence and skills is well recognised for any new surgical procedure during the initial training period. Trainers are responsible for safeguarding patients and trainees by careful supervision, adherence to safety steps and support intraoperative guidance. Senior Residents undertaking the oncology module or benign abdominal surgery are expected to undertake a certain number of cases under direct and indirect supervision prior to completing the module as a part of the curriculum. Case 3 involved a resident doctor supervised by a TLH consultant where the ureteric transection was unrecognised during the operation.

- Improved communication between trainer and trainee as well as clarity of responsibility of trainer role is essential. This clear communication and teaching of safe surgical techniques, attentive supervision throughout the surgery, empowerment of trainee to question surgical steps, managing trainee expectation that the trainer may need to take over certain parts of surgery and empowerment of trainers to take over surgery professionally without inhibitions to maintain safety. Clear expectations of responsibility on the trainer to embed safe techniques and actively check the ureteric course throughout surgery.

- Clarity of roles is also important in buddy / dual consultant operating. The lead surgeon must be clearly identified and carries ultimate responsibility for the surgery. However, assistant consultant colleagues must also be empowered to speak up if they have any surgical concerns or uncertainty. Flattened hierarchy is a well-recognised and important method of improving patient safety by mitigating some human factors (such becoming too task focussed).

- Improved team working with urologists in pre-operative planning of high risk cases that may require planned urological input and when seeking intra-operatively assistance due to concerns with bladder or ureteric injuries or identification issues.

- Improved team working with pre op planning of high risk cases with general surgeons is also required.

- Individual patient factors

1. Two women had anticipatable risk factors (previous Caesarean section and large fibroid uterus). Although it would have been appropriate to have pre-operative MDT input from urologists in the case of fibroid uterus, this alone was not a reason to avoid TLH. Two women were obese (BMI 38 and 39). Raised BMI is not a contraindication for TLH, conversely TLH has a lower infection risk for women and avoids a large incision, prolonged length of stay and increased morbidity with open surgery.

2. One woman had a previous caesarean section, and the bladder was densely adherent to the uterus. The bladder was injured during reflecting the bladder whilst operating. The bladder injury was recognised during the procedure, and the urology team were asked to attend. The bladder injury was sutured by the gynaecologist under supervision by the urologist as the urologist do not undertake laparoscopic suturing. In this case, the ureters were not checked as there were no concerns at the time and this woman presented after 4 weeks with a right sided uretero vaginal fistula.

3. One woman had an enlarged uterus due to fibroids, and the uterus was approximately 10 weeks size. There was difficulty in removing the uterus vaginally and she needed coring of the uterus to reduce the bulk of the uterus to enable removal vaginally.

- Individual staff factors

Two of the four cases were operated by consultants who were skilled in undertaking a laparoscopic hysterectomy.
One procedure was performed by a consultant who was being trained by a TLH consultant to do the procedure.
One procedure was undertaken by a senior resident under supervision by a TLH consultant.

6. Conclusion

Published evidence describes incidences of urological injures associated with TLH ranging from 0.13% to 1% for bladder injury and 0.1% to 1.8% for ureteral injury. In 45% there can be a delay in diagnosis of iatrogenic ureteric injury. (5) The overall incidence of bowel injury in gynaecological laparoscopic surgery reported as 0.39% in laparoscopic hysterectomy. Between 40-48% of bowel injuries during laparoscopic surgeries are not recognised during the initial procedure, leading to a delayed presentation postoperatively (3, 4)

In our department 54 TLH were undertaken in 2024 with an incidence of ureteric injury in 3/54 (5.5%), bladder injury 1/54 (1.9%) and bowel injury 1/54 (1.9%). Our injury rates in 2024 were above published data.

This thematic review was undertaken in response to this series of incidents relating to three ureteric injuries and one bowel injury which occurred due to undertaking a TLH procedure between August and November 2024. These cases were initially investigated using the PSIRF review tools and AAR but were expanded to an overarching thematic review to ensure themes were triangulated and addressed. TLH procedures were stopped on 8.8.25 to ensure patient safety, and an external review was commissioned to provide additional independent assurance. The external review is due to be reported separately.

Themes identified in our thematic review included the judicious use of electrosurgery, attention to ureteric identification intraoperatively, patient selection and clear MDT planning for high-risk cases, maintenance of competency and laparoscopic CPD and the requirement of robust governance oversight especially around consultant personal training and the training other colleagues.

As the ultimate benefit of TLH is clear compared to open surgery, there is obvious benefit in safely developing this technique. Our rates of TLH have been increasing over the past 3 years but we have not yet achieved the GIRFT target of 75% of hysterectomies being performed either laparoscopically or vaginally. Resumption of TLH surgery will not occur until both the internal thematic and external reviews are reported and triangulated to address clear safety steps which are assured by the Divisional Medical Director. Clear stringent governance assurance must include that surgeon training requisites are met, there is training of wider theatre teams as well as surgeons, a consultant buddy system with more experienced surgeons in initiated, competency is developed and maintained with appropriate caseload

which requires restructuring of the workforce and succession planning. Several actions have already been completed and are laid out below.

Action plan / Improvements that have been made since the incidents are:

1. All cases have been discussed in the gynaecology speciality governance meeting, 06.01.25
2. PSIIRT was completed for the three cases with ureteric injury by 06.01.25
3. After action review has been completed for the case with bowel injury by 06.01.25
4. All cases presented in a meeting with the divisional medical director, 22.05.25
5. Presented in the consultants meeting and an action plan was discussed,.23.05.25
6. Presented in the trust divisional independent review panel meeting, 28.05.25
7. Cases discussed at departmental Gynaecology Complications Audit meeting, 17.07.25
8. All cases will be re-discussed at the quarterly Learning from Incident governance meeting on 09.01.26.
9. An educational session for all medical staff has been undertaken for safe use of energy devices and use of electrocautery on 20.06.25
10. Updated dedicated TLH consent forms to include complications in more detail and to include need for additional surgery such as stenting of ureter, nephrostomy and re-implantation of ureter at a later date, bowel injury which may require a colostomy.
11. TLH surgery ceased on 08.08.25.
12. Review of the workforce model more broadly has been undertaken. The proposal is that there will be fewer dedicated gynaecologists undertaking surgery which will to increase the caseload and maintenance of competency for each consultant. Business case submitted for expansion to support this. (Awaiting additional information.)
13. A TLH working group was established in September 2025 and includes eight gynaecology surgeons involved in TLH surgery, the departmental governance lead, with oversight from the divisional medical director/governance lead.

TLH working group have already agreed the following steps to improve competency, minimise the risks of iatrogenic injury to ureters and bowels

- Established in September 2025 and will meet quarterly (deferred to January 2026 due to planned strikes)
- Core membership agreed (Eight dedicated TLH surgeons, Divisional Governance Lead and the Divisional Medical Director). This will have oversight of the action plan and the delivery of a future TLH service and is answerable to the Medical Director.

- Ensuring laparoscopic education and training is appropriate and remains up to date for all TLH consultants.
- No further consultants are trained in TLH until the workforce or caseload requires this.
- Implementation of a standard TLH operation template with includes ureteric identification,
- Before resumption of TLH service, there will be refresher sessions planned for the TLH consultants utilising BGSE video library, attending meetings / conferences and potentially observing colleagues in other trusts (though this would require honorary contracts to be arranged).
- Buddy surgeon operating to re-establish service pending six-month review once TLH service is resumed. Buddy operating will continue if needed to maintain competency (1-2 TLH per consultant per month) and in complex cases.
- To limit the number of TLH surgeons to eight. This allows consolidation of skills and futureproofing of service. (This is in additional to ongoing workforce restructure.)
- Monitors that surgeons' operation numbers are appropriate to maintain competency,
- Monitors closely incidents and escalates concerns promptly
- Provides monthly updates to the Gynaecology Specialty Governance and quarterly updates Divisional Governance meetings.
- An annual paper will be taken to Clinical Governance and Quality Committee detailing compliance and progress with action plans, case numbers, outcomes and complications.
- Ensure benchmarking of TLH within the annual Gynaecological Surgery Complications audit and that findings are shared with Divisional Governance Meeting. The next audit commences in January 2026 to review complications during 2025.
- Undertakes specific annual TLH audits to ensure the above measures are adhered to and this will be reported to the Divisional Governance Lead. There will be an initial six-month review once TLH resumes and following that annual TLH audits will take place.
- To develop a joint urology/ gynaecology pathway for the management of urological injuries and role of ureteric visualisation procedures. Version 1 draft is awaiting comments from 11.12.25
- Agreement that urologists to support training of gynaecology consultants in ureteral catheterisation to help mitigate risk in some women. Introduction of ICG that can be used with the ureteral catheter is currently under consideration by the urology clinical lead. If agreed this will require a divisional business case.
- Establish a pre op MDT pathway with urologists and general surgeons for high-risk women requiring gynaecological surgery. 1st draft completed 11.12.25. Initial meetings with urologists to discuss this took place on 14.08.25 and 27.11.25.

References:

1. Laparoscopic techniques for hysterectomy. NICE Interventional procedures guidance. Published: 28 November 2007

2. Laparoscopic hysterectomy (including laparoscopic total hysterectomy and laparoscopically assisted vaginal hysterectomy) for endometrial cancer. NICE Interventional procedures guidance. Published: 22 September 2010

3. Bowel injury in gynaecological laparoscopy: a systematic review, Natalia 1, Anup B Shah, Magdy P Milad. Obstet Gynecol. 2015 Jun; 125(6):1407-1417

4. Delayed manifestations of laparoscopic bowel injury. Sebastiano Cassaro. Am Surg. 2015 May; 81(5):478 82.

5. A delayed diagnosis of iatrogenic ureteral injury results in increased morbidity. (Maheswaran, R., Beisland, C., Bergesen, A.K. et al. Sci Rep 14, 13771 (2024).

Appendix 1: Cases included in the thematic review

Cases included in the review/description of the reference cases

Date of ref case	Source	Level of Harm (if known)	Reference number	Level of investigation / learning response	Description	Actions Taken
18/09/24 -TD	Gynaecology theatre	4	279278	PSIIRT	Uretero vaginal fistula.	Nephrostomy / awaiting ureteric surgery - ? Re implantation for ureter /? fistula repair
09/08/24 - SM	Gynaecology theatre	4	260872	PSIIRT	Uretero vaginal fistula.	Nephrostomy Awaiting ureteric reimplantation
08/11/24 –S MU	Gynaecology theatre	4	261357	PSIIRT	Ureter injury	Nephrostomy. Had ureteric re implantation
08/11/24 -DW	Gynaecology theatre	4	259185	AAR	Bowel injury	Bowel surgery and colostomy

Appendix 2: Identified contributory and mitigating factors

Contributory Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES and STRENGTHS				
Reference case numbers			1	2	3	4	
CONTRIBUTORY and MITIGATING FACTORS Described as they relate to the PROBLEMS/WEAKNESSES and STRENGTHS identified (NB: There may be none, one or more CF/MF in each category)	**External Contextual Factors**	*National guidelines and policies*	X	X	X	X	TLH is best practice
		Economic and regulatory context					
		Societal factors					
		Total					
	Organisational Strategic Factors	*Structure*			x	x	Incidents 3 &4 – possible diathermy related issue.
		Priorities/resource					
		Safety culture	x	x	x	x	In all cases there was a Delay in incident reporting due to incident not being reported by medical / nursing staff on readmission to the hospital / gyn ward.
		Policies, standards, and goals	x	x	x	x	Need to have a better process to notify gyn governance when incidents reported by the theatre team.
		Total					
	Operational Management Factors	*Safety focus*	x	x	x		Scheduling process needs to be investigated. Not documenting if ureters identified at the beginning and end of the procedure
		Work planning and delivering	x	x	x	x	Consultants need ownership of case bookings for TLHs
		Staffing levels and skill mix			x	x	Teaching skills
		Workload, shift pattern, hours of work					
		Training			x	x	Training needs analysis

Contributory Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES and STRENGTHS				
	Reference case numbers		1	2	3	4	
							Need for regular training on diathermy Teaching / training skills
		Staff supervision			x	x	
		Staff competence			x	x	Training the trainer and trainee/ Mentoring skills
		Total					
	Workplace Factors	*Environment factors*					
		Design of physical environment					
		Administrative factors					
		Total					
	Equipment & Technology Factors	*Display*					
		Integrity and maintenance					
		Positioning and availability					
		Usability/design					
		Total					
	Team & Social Factors	*Culture*	x	x	x	x	Incident reporting culture
		Team structure and consistency			x	x	Too much mutual respect for colleagues. Shared understanding of taking over when complex situations.
		Leadership					
		Communication management	x	x	x	x	Review of consent process with risks involved with procedure. Incident 4. The woman complained about lack of communication following the complication.

Contributory Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES and STRENGTHS				
Reference case numbers			1	2	3	4	
		Verbal communication	X		X	x	Style of verbal communication and agreed lead surgeon in joint consultant cases
		Written communication	x	x	x	x	No documentation in operation notes of ureteric visulisation
		Non-verbal communication					
		Total					
	Task Factors	*Clinical condition*	X	x		X	Inc. 2 – large fibroid uterus. Inc. 1 – bladder densely stuck Inc. 4- 6 cm ovarian cyst BMI raised – 3 & 4
		Plans/policies/procedures in place for task					No SOP / local guideline available
		Decision making aids	x				Sop for urology procedure during gyn bladder injury
		Procedural or task design and clarity	x	x	x	x	Ureteric identification in all cases
		Total					
	Individual Patient Factors	*Physical factors*					BMI raised – 3 & 4
		Social factors					
		Psychological factors					
		Total					
	Individual Staff Factors	*Physical health*					
		Psychological factors					
		Social/domestic factors					
		Personality factors				x	Risk awareness issues
		Social factors				x	Surgical log to show competency during appraisal.
		Cognitive factors					
Reference case numbers			**1**	**2**	**3**	**4**	

Section B: Narrative Analysis

External contextual factors	1. Most residents and consultants who undertake laparoscopic hysterectomy have attended national conferences (BSGE) where there is a live surgical demonstration of laparoscopic hysterectomy. 2. There are live video modules on TLH on the BSGE website/ equivalent. 3. There was a resident undertaking an oncology SITM who needed to get trained in TLH to get the required numbers to complete their module. 4. There was a consultant colleague training in advanced laparoscopic surgery and learning on the job operating along with another consultant.
Organisational strategic factors	1. There are not enough theatre sessions for 21 consultants to undertake gynaecological surgeries and maintain their skills 2. Most consultants have 1 or 2 theatre sessions in 4 weeks to maintain skills with new procedures. 3. There has been a discussion in the consultant meeting to have 8 consultants only undertaking TLH, to enable them to maintain their skill.
Operational management factors	1. Booking team decentralisation enable appropriate listing of procedures to the appropriate consultants. 2. More theatre sessions are needed for the department for all consultants to develop and maintain skills for any gyn surgical procedures. 3. Support with training needs. 4. ICG business case to be considered after agreement by the urology team.
Workplace factors	1. Medical device competency completed annually except in 2024 when there was a delay, but it has been completed in June 2025. 2. Team working with urologist for complex cases. 3. ICG to be agreed with Urology team
Equipment and technology factors	1. Energy devices such as ENSEAL and electrocautery are routinely used for the procedure, but there were no problems relating to the use of these devices during the operation. 2. Medical device competency forms are routinely completed annually by all consultants. The completion of the forms was overdue in 2024 but has been completed this year. 3. We currently do not use an ICG – Indocyanine green dye to visualize the ureters at the time of surgery. It will be a good idea to use it initially with all procedures and then to use it with complex or difficult surgery.
Team and social factors	1. There was a positive example of dual consultant operating together in one of the complex cases. 2. Training / trainer - improving interpersonal relationship and communication between the trainer and trainee. 3. Team building and working alongside the urology team for ureteral visualization. 4. TLH working group to identify training needs in allied teams to improve team working.
Task factors	1. Pt selection is important. 2.A SOP will be developed for pre-op planning of complex cases needing urological support. 3. 3 of these women were complex due to an enlarged fibroid uterus, a densely adherent bladder due to a previous caesarean section and a raised BMI of 39.

Individual patient factors	Patient selection: Case 1. There was a woman with a previous caesarean section with a densely stuck bladder causing bladder injury when separating the bladder from the uterus. Case 2: There was a woman with an enlarged uterus due to fibroids. Case 3& 4: There were 2 women with a raised BMI
Individual staff factors	There were a resident and another consultant being trained to undertake 2 of the procedures.

Appendix 3: Detailed action plan from the thematic review

Safety action summary table

Area for improvement:								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool /measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight**	**Planned review date**
1	TLH working group with an agreed TOR to oversee the learning and recommendations from this review and the external review. To oversee the training, development, logbooks, audits, MDT working and pathways for the TLH service. TLH group will implement the safe resumption of the TLH service	Nadia Ali Ross, CL for O&G		20.09.2025	Minutes, audits and training logs	Quarterly	DMD, Sue Moss	Annual report to Divisonal Board and CG&QC
2	Teaching session for all consultant gynaecologists regarding safety and electrosurgery.	Prasanta Chattopadhyay, Consultant O&G		20/06/2025	Training records and medical devices reports	Annual medical devices self assessment updates	Nadia Ali Ross, CL for O&G	Annually
3	To reduce the group of gynaecologists perfroming TLHs down to a cohort of 8 staff to allow for training and succession planning	Nadia Ali Ross, CL for O&G		20.09.2026		Annual Job planning	TLH working group	Annual
4	For TLH surgeons to complete modules on the BSGE website for laparoscopic surgery.	All consultants performing TLH	01.02.26			One off	TLH working group	Quarterly oversight through TLH group

Area for improvement:								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool /measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight**	**Planned review date**
5	TLH surgeons to watch live video demonstrations of TLHs before resuming TLH service.	All consultants performing TLH	01.02.26			One off	TLH working group	
6	SOP/Pathway for pre-operative MDT planning, intraoperative support and post op care by Urology and General Surgical teams for complex cases.	Nadia Ali Ross, CL for O&G with CL for Urology and CL for General Surgery	01.04.26		Completed SOP and subPD meeting summary		Neeraja Singh, Governance lead and Consultant in O&G	Annually
7	Use of ICG – Indocyanine green dye to visualize ureters during surgery. To review safety profile with urologists and to review cost of implementation if safe.	Nadia Ali Ross, CL for O&G	30.06.26		BC if safe to use and training plan for implementation.		Neeraja Singh, Governance lead and Consultant in O&G	Annual audit after implementation
8	Update customised consent form for total laparoscopic hysterectomy to include all the risks of surgery such as damage to ureter / bowel / need for additional ureteric surgery / colostomy.	Prasanta Chattopadhyay, Consultant O&G	28.02.26		Completed consent form with evidence of governance and implementation		Nadia Ali Ross, CL for O&G	

Area for improvement:								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool /measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight**	**Planned review date**
9	TLH group to agree the criteria for listing a hysterectomy as a laparoscopic rather than an open procedure.	Nadia Ali Ross, CL for O&G	01.03.2026		List of critieria	Annual	TLH working group	Annual
10	Listing of TLH procedures to be decentralized from the booking team and to be under the control of the TLH working group.	Nadia Ali Ross, CL for O&G	01.03.26		Minutes of TLH meeting		Neeraja Singh, Governance lead and Consultant in O&G	
11	Increase operating theatre capacity for gynaecology. Capacity and demand work needed for theatres; this would sit with surgical division.	DDDO/ POCL for Surgery Division	30.12.26				S Moss, DMD F&D	
12	Staff to keep logbook of operating cases, to include outcomes and complications. Logbook to be overseen by TLH group.	Nadia Ali Ross, CL for O&G	01.02.2026		Quarterly submission of logbooks to TLH group	Quarterly submission of logbooks to TLH group	S Moss, DMD F&D	Annually
13	Trust to agree a process for all surgeons on how and what to record around complications relating to surgical procedures	Angela Volleamere, DMd for Surgical Division	30.03.2026		SOP for reporting and recording surgical compliactions	Annual	Rauf Munchi, Medical Director	Annually

Area for improvement:								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool /measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight**	**Planned review date**
14	Operative documentation to be amended to include the visualisation of the ureters during and at the end of the operation and by whom.	Prasanta Chattopadhyay, Consultant O&G	30.03.2026		Copy of ameded operation note. Audit of operation notes	Annual	Nadia Ali Ross, CL for O&G	Annual
15	To work with the general surgeons to build laparoscopic skills in gynaecology and improve team working between the specialites.	Sangeeta Das, Consultant O&G with Paul Harris and James Pollard, Consultant General Surgeons	30.04.2026		Set up preop MDT pathway and laparoscopic MDT study day	One off study day with general surgeons. MDT will be ongoing	Nadia Ali Ross, CL for O&G and Dave Smith CL for Gen suurgery	30.04.2027
16	QIA to assess the impact of pausing the TLH service	Nadia Ali Ross, CL for O&G		10.09.2025	QIA		Sue Moss, DMD for F&D	01.03.2026
17	Review and embed learning and recommendations from the external review which is due for return early January 2026.	Nadia Ali Ross, CL for O&G and Sue Moss DMD		01.02.2026	Action plan to capture recommendation and learning	Quarterly in TLH group meetings	Medical Director	Quarterly

Area for improvement:								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool /measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight**	**Planned review date**
18	Trainers must undertake mentoring/teaching skills training to evidence their ability to train others and receive regular feedback from trainees.	Sameh Mahamoud, Education lead and Consultant O&G	30.06.2026		Feedback and reflection on training. Evidence of training updates.	Quarterly in TLH group meetings	Nadia Ali Ross, CL for O&G	Annual
19	Safety netting advice to be agreed in TLH group for patients having a TLH which must be shared with all patients prior to discharge.	Neeraja Singh, Governance lead for O&G and Consultant Obstetrician	30.04.2026		Patient Leaflet		TLH Working Group	2 yearly
20	A buddy system will be in place once the TLH service resumes. This will allow support for colleagues and increase exposure to cases to build experience. There will always be a lead surgeon who will take responsibility for the case. This practice will be in place for 6 months and then for more high risk cases.	Nadia Ali Ross, CL for O&G		30.04.2026	ORMIS data	Quarterly in TLH Group	TLH Working Group	30.10.2026

Report Title:	People Committee Chair Report			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	
Executive Sponsor	Deputy Chief Executive/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.
Executive Summary	The attached report from the Chair of the People Committee provides an overview of matters discussed at the meeting held on 20 January 2026. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors.
Proposed Resolution	The Board of Directors are 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 Implications		
Legal/ Regulatory		
Impact on Health Inequalities		
Impact on Equality, Diversity and Inclusion		
Is a Quality Impact Assessment required		

Prepared by:	Deputy Chief Executive/Chief People Officer	**Presented by:**	Martin North, People Committee Chair

ALERT | ADVISE | ASSURE (AAA) Key Issues Highlight Report

Name of Committee /Group:	People Committee	**Reports to:**	Board of Directors
Date of Meeting:	20 January 2026	**Date of next meeting:**	17 March 2026
Chair	Martin North, Non-Executive Director	**Meeting Quoracy**	Yes

AGENDA ITEMS DISCUSSED AT THE MEETING

- Chair's Update on recent developments
- Board and People Committee Workplan
- Workforce Planning Delivery
- OD & Cultural Update including our leaders update and Genera Pay Gap Report
- Freedom to Speak Up (FTSU) Q2&3 update
- Guardian of Safe Working Q3 update
- Job Evaluation Data
- 10 Point plan to improve Resident Doctor's working lives
- Artificial Intelligence Update
- iFM Monthly People and Culture Report
- Steering Group Chair Reports
- Divisional People Committee Chair Reports

ALERT

Workforce Planning Delivery Some key workforce metrics, such as sickness absence, appraisal completion and engagement, were noted to be worsening. While partly seasonal, this reflected growing pressure on staff. The Committee also discussed reductions in Worked WTE for 2025/26 and modelling for 2026/27, noting that planned workforce reductions are not yet sufficient to meet the financial challenge.	**Action** A Health and Wellbeing report to be presented in March to address the concerns related to absence levels. A discussion to take place at Board of Directors around further required reductions in WWTE and how this can be achieved.

ADVISE

Chair's Update on Recent Developments

The Chief People Officer noted the organisational pressures, thanked staff for their continued hard work, and highlighted that the Trust had recently been on OPEL 4. A further round of industrial action had taken place, with no new dates announced, though national negotiations remain unresolved.

ASSURE

- The 2025 workplans had been reviewed and amended to confirm alignment with critical workforce priorities.
- The culture update confirmed that workforce cultural themes remain consistent with previous reporting and were reinforced by early 2025 staff survey findings, which indicated a decline in staff engagement amid a short-term organisational focus on financial challenges.
- The Committee received an update on the leadership programme noting that over 665 leaders had attended the programme. The focus of the programme was on values, behaviours and inclusivity. Discussion took place on the Our Future Programme which had been specifically designed to assist staff manage and lead through change.

- Gender Pay Gap – the 2025 data showed a predominantly female workforce (84%) with a gender pay gap mainly driven by men occupying senior medical roles. The mean gap was 26.8% and the median 12.68%, reducing to 5.1% and 1.5% when medical and dental staff were excluded. Bolton's position aligned with other Greater Manchester (GM) acute trusts. Closing the gap remained a long-term priority, with actions focused on inclusive recruitment, developing female leadership pipelines and improving access to senior flexible roles.
- FTSU Q2 & 3 update – the FTSU service remained a key, trusted route for staff to raise concerns, supported by two part-time Guardians and 89 Champions, with further training planned to increase visibility and diversity. Strong governance and regular senior-level engagement continued to ensure themes and issues were addressed promptly while maintaining confidentiality.
- Guardian of Safe Working Q3 update – in Q3, 117 exception reports were submitted, over twice the number from the same period in 2024, with 93% relating to additional hours. Most were actioned through payment or time off, and no safety concerns, rota reviews, fines or work schedule reviews were triggered. The GOSW continued to work closely with Medical Education to support timely responses.
- Exception report themes highlight ongoing workforce pressures in some specialties, particularly ENT, where reduced staffing and limited cover continue to raise concerns around training and patient safety. These issues have been escalated and remain under active review by the Medical Director.
- Job Evaluation (JE) data - national changes to the NHS JE Scheme, including new nursing and midwifery profiles published in June 2025, required Trusts to provide board-level assurance of fair and lawful JE processes. The Trust had appointed a Senior Responsible Officer, delegated to the Deputy Chief Nurse, and established a multidisciplinary working group. A review of nursing and midwifery job descriptions and JE history was underway, prioritising higher-risk roles and assessing local JE capacity, training needs and associated risks.
- 10-Point Plan to Improve Resident Doctors' Working Lives - NHS England's August 2025 national 10-point plan aims to address long-standing issues affecting resident doctors by improving wellbeing, ensuring fair and transparent rotas and leave, reducing administrative and payroll errors, and strengthening leadership accountability and peer representation. All NHS organisations must act across all ten areas, report progress to their boards, explain any unmet actions and embed delivery within their Board Assurance Framework and annual reporting.
- The Trust has committed to implementing the full 10-point plan and developed an issue-to-action matrix outlining local measures and accountable leads. Oversight will be provided by the Deputy Medical Director, supported by a Resident Doctor Peer Lead. Progress will be reported to the People Committee every six months until embedded into business-as-usual and the Guardian of Safe Working annual report.
- Work was underway to develop an HR Chatbot to improve staff access to timely, consistent HR information on areas such as pay, leave, policies, recruitment and employee lifecycle queries. The chatbot supported self-service, aims to enhance staff experience, improve consistency of advice and reduce HR workload, with ongoing assurance and learning guiding its safe implementation.
- IFM Monthly People and Culture Report – the iFM report showed a deterioration in key workforce indicators: sickness absence rose to 8.33%, mandatory training compliance fell to 86.90%, and appraisal completion remained low at 69.02%. The rise in absence was consistent with last winter and linked to increased flu cases. Bank hours had been incorporated to give a clearer picture of workforce usage, and IFM continued to work with the Trust to streamline systems, improve data accuracy and strengthen workforce planning and reporting.

• The Committee received the Chair reports from the Steering Group meetings which have taken place since the last People Committee. There was nothing to note. • Divisional People Committee Chair Reports - The Committee received the Chair reports from the Divisional meetings which have taken place since the last People Committee. There was nothing to note.
New Risks identified at the meeting: None
Review of the Risk Register: None

Meeting Attendance 2026						
Members	**Jan**	**Mar**	**May**	**Jul**	**Sep**	**Nov**
Seth Crofts	✓					
Sharon Katema	✓					
Sean Harriss	✓					
James Mawrey	✓					
Tyrone Roberts	✓					
Fiona Taylor	✓					
Sharon White	✓					
Annette Walker	✓					
Rauf Munshi	✓					
Martin North	✓					
Fiona Noden	✓					
Ian Williamson	✓					
Janat Hulston	✓					
✓ = In attendance	A = Apologies		NA = No longer a member			

Report Title:	Finance & Investment Committee AAA Chairs' Reports			
Meeting:	Board of Directors	**Action Required**	Assurance	✓
Date:	29 January 2026		Discussion	
Executive Sponsor	Chief Finance 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 Finance & Investment Committee.
Previously considered by:	The matters included in the Chair's report were discussed and agreed at the Finance & Investment Committee.
Executive Summary	The attached report from the Chair of the Finance & Investment Committee provides an overview of matters discussed at the meeting held on 26 November 2025. The report also sets out the assurances received by the committee and identifies the specific concerns that require the attention of the Board of Directors. In light of the scheduling of the January meeting a verbal update will be provided and a written report will be submitted to the March Board of Directors' meeting.
Proposed Resolution	The Board of Directors are asked to ***receive*** the Finance & Investment Committee Chair's Report from the meeting held on the 26 November 2025 and the verbal update provided from the meeting held on the 28 January 2026.

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 Implications		
Legal/ Regulatory		
Impact on Health Inequalities		
Impact on Equality, Diversity and Inclusion		
Is a Quality Impact Assessment required		

Prepared by:	Rebecca Ganz, Chair Finance & Investment Committee (November 25) Sean Harriss, Chair, Finance & Investment Committee (January 26)	**Presented by:**	Sean Harriss, Chair of the Finance & Investment Committee

ALERT | ADVISE | ASSURE (AAA)
Key Issues Highlight Report

Name of Committee /Group:	**Finance & Investment Committee Meeting**	**Reports to:**	**Board of Directors**
Date of Meeting:	**26 November 2025**	**Date of next meeting:**	**28 January 2026**
Chair	**Rebecca Ganz**	**Meeting Quoracy**	**Yes**

AGENDA ITEMS DISCUSSED AT THE MEETING

- Finance & Investment Committee Effectiveness Survey
- Board Assurance Framework
- Forecast Outturn
- Month 7 Finance Report
- NHSE Revenue support quarter 4
- Debt Collection Procedure
- IFM Yearly Performance Report 2024/25
- IFM Yearly Performance Report 2024/25
- Digital Programme Update
- EPR/PAS update
- Artificial Intelligence (AI) Steering Group update
- Contract Award recommendation for the GM Internal & External Fixation (Trauma)
- Main Entrance Redevelopment

ALERT

Forecast Outturn

- The different scenarios were explained with the focus on the mid case scenario of a deficit of £14.4m and the associated risks and mitigation
- To achieve this the underlying position on Worked Whole Time Equivalents (WWTE) was clarified alongside further recurrent and non-recurrent priorities in order to meet the expected outturn.

Action

The Finance & Investment Committee agreed to recommend to the Board of Directors that the Trust adopt a mid-case scenario deficit of £14.4m for the 25/26 year.

Month 7 Finance Report

- The Trust had an accounts deficit in Month 7 of £1.7m. This is £1.9m adverse to plan, driven mainly by under-delivery of CIP.
- Cumulatively the adjusted deficit was £13.7m, which is adverse to plan by £6.2m. The adjusted deficit, excluding capital donations was £13.6m.
- Under-delivery of CIP is driving a £2.1m adverse variance in-month, £6.7m cumulatively partly mitigated by income inflation not yet being spent yet, i.e. incremental drift and non-pay inflation.
- To hit the mid case scenario there is a need to reduce the run rate by at least £1m a month.

NHSE Revenue support quarter 4

The Committee supported the application for Provider Revenue Support of £6.4m in January with further submissions likely for February of £5.2m and March £7.9m. It was understood the quantum of each submission is subject to change.

Digital Programme Update

- By the end of this financial year (25/26), EPR implementation will almost be complete across Inpatient, Outpatient, Community and Maternity services.

- There are currently issues with clinical user acceptance testing of Maternity EPR that are red rated, which may impact the February 2026 go live date.
- There is a need to improve the governance around prioritisation of projects to support the teams to deliver within the resource constraints.
- The update detailed some of the challenges that the Digital Programme is facing and the risks to delivery of some of the schemes. One of the key challenges is resource, not only within the Digital Transformation team, but across Digital as a whole.

ADVISE

Board Assurance Framework

The Finance and Investment Committee was asked to receive the BAF, assess the effectiveness of existing controls, and review the proposed actions for addressing any identified gaps in control and assurance. The BAF had been to the Risk Management Committee, and all major risks remain highly rate with specific attention to digital enablement and inclusivity. The framework has been updated to reflect changes in the Committee remits and operational oversight. The Committee approved the amended BAF.

ASSURE

Finance & Investment Committee Effectiveness Survey

The Annual Effectiveness Survey received 6 responses, matching the previous year. The survey included 15 statements with no 'strongly disagree' responses, 4 neutral scores, and 1 'disagree'. Overall, the results were positive and benchmarked favourably against the Effectiveness Survey results from both 2024 and 2023. It was recommended the Committee's work plan be reviewed around the balance of agenda items on cost & income and digital oversight.

Debt Collection Procedure

The report outlined the debt management procedure that is in place to ensure the Trust collects cash on a timely basis and that processes are in place for regular debt reviews to avoid/reduce debt write offs.

IFM Yearly performance report

The IFM Annual Performance Report provides an overarching review of the performance of iFM, including the key achievements and challenges for the period April 2024 to March 2025. The report also included iFM Outlook Priorities for 2025/26 and closing thoughts on the 2024/25 financial year. The report reflected strong performance with an expectation that a new six facet survey would inform future planning, the timing of which is impacted by national work around standardisation to enable a clearer national picture of NHS estates.

EPR/PAS update

The Committee supported the EPR & PAS re-procurement proposal.

Artificial Intelligence (AI) Steering Group update

The Chief Data Officer informed the Committee of the progress made around Artificial Intelligence including a huge amount of work on Governance and establishing an AI Policy with guidance for projects, an AI register and education resources including a staff training session. Communications are working on creating a bite size version of the policy. The Committee encouraged a 'step' change to embracing the opportunities and risks of AI including resourcing, by embedding it into the Improvement and Medium Term Plans, aligned to the NHS 10 year plan.

Contract Award recommendation for the GM Internal & External Fixation (Trauma)
The Committee recommended the Contract Award Recommendation for the GM Internal & External Fixation for approval to the Trust Board. The new contract will provide an annual saving of £137,636 and avoids inflationary cost pressures an ensures clinical stability.

Main Entrance Redevelopment
The Committee recommended the redevelopment of the main entrance for approval to the Boad of Directors supported by additional insights around similar retail lead projects in the NHS and related learnings and success factors including resourcing.

New Risks identified at the meeting: *None identified.*

Review of the Risk Register: NA

Meeting Attendance 2025										
Members	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**
Rebecca Ganz	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annette Walker	✓	✓	✓	**A**	✓	**A**	✓	✓	✓	✓
Rae Wheatcroft	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sharon Katema	✓	**A**	**A**	✓	✓	✓	✓	✓	✓	✓
James Mawrey	✓	✓	✓	**A**	✓	**A**	**A**	✓	A	✓
Sharon White	✓	✓	✓	✓	✓	A	✓	✓	✓	✓
Sean Harriss	✓	**A**	✓	✓	**A**	✓	✓	✓	✓	✓
Martin North	✓	✓	✓	✓	✓	**A**	✓	✓	✓	✓
In Attendance	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**